



Rural Health Clinics and Federally Qualified Health Centers

*Medicaid and Other Medical
Assistance Programs*

This publication supersedes all previous Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) handbooks. Published by the Montana Department of Public Health & Human Services, May 2006.

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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.

Chemical Dependency Bureau

For coverage information and details regarding chemical dependency treatment, call or write:

(406) 444-3964 Phone
(406) 444-4435 Fax
Addictive and Mental Disorders Division
Chemical Dependency Bureau
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Claims

Send paper claims to:

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

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax
Quality Assurance Division
Certification Bureau
DPHHS
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should fax their information to Provider Relations.

(406) 442-4402

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In/Out of state
(406) 442-1837 Helena
(406) 442-4402 Fax
MTEDIHelpdesk@xerox.com

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

FQHC Program

(406) 444-4540 Phone
(406) 444-1861 Fax

FQHC Program Officer
Hospital and Clinic Services Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Health Improvement Program

(406) 444-4540 Phone
(406) 444-1861 Fax
Health Improvement Program Officer
Managed Care Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Lab

Public Health Lab assistance:

(800) 821-7284 24-hour
(406) 444-3444 Helena/Out of state
DPHHS Public Health Lab
1400 Broadway, Room B-206
P.O. Box 6489
Helena, MT 59620

Member Eligibility

For member responsibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual. The most often used methods are below.

FaxBack

(800) 714-0075 (24 hours)

Integrated Voice Response System

(800) 714-0060 (24 hours)

Montana Access to Health Web Portal

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

Medifax EDI

(800) 444-4336, X2072 (24 hours)

Multiple Visits

Claims for multiple visits on the same day, send for review to:

Hospital and Clinic Section
Health Resources Division
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding the Nurse First Advice Line, contact:

(406) 444-9673 Phone
(406) 444-1861 Fax

Nurse First Program Officer
Managed Care Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Passport to Health Information

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

(800) 362-8312

Send written inquiries to:

Passport to Health
P.O. Box 254
Helena, MT 59624-0254

For questions regarding the Passport to Health Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Send inpatient stay documentation to:

Passport Program Officer
Managed Care Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

The following are some of the Department's prior authorization contractors.

Magellan Medicaid Administration (dba First Health)

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

<https://www.magellanmedicaid.com>

First Health Services
4300 Cox Road
Glen Allen, VA 23060

For policy questions, contact the appropriate division of DPHHS; see the Introduction chapter in the *General Information for Providers* manual.

Mountain-Pacific Quality Health

For questions regarding prior authorization for some medical or surgical procedures, contact Mountain-Pacific Quality Health. See the Prior Authorization chapter in this manual.

Phone:

(800) 262-1545 X5850 In state
(406) 443-4020 X5850
Helena//Out of state

Fax:

(800) 497-8235 In state
(406) 443-4585 Helena/Out of state

Mountain-Pacific Quality Health
 3404 Cooney Drive
 Helena, MT 59602
<http://www.mpqhf.org/>

For questions regarding alcohol and drug detoxification:

(406) 444-0061 Phone
(406) 444-4441 Fax

Provider Relations

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

(800) 624-3958 In/Out of state
(406) 442-1837 Helena
(406) 442-4402 Fax

Provider Relations
 P.O. Box 4936
 Helena, MT 59604
MTPRHelpdesk@xerox.com

RHC Program

(406) 444-4540 Phone
(406) 444-1861 Fax

RHC Program Officers
 Hospital and Clinic Services Bureau
 DPHHS
 P.O. Box 202951
 Helena, MT 59620-2951

Secretary of State

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

(406) 444-2055 Phone

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

www.sos.mt.gov
www.mtrules.org

Team Care Program

For questions regarding the Team Care program:

(406) 444-9673 Phone
(406) 444-1861 Fax

Team Care Program Officer
 Managed Care Bureau
 DPHHS
 P.O. Box 202951
 Helena, MT 59620-2951

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
(406) 442-0357 Fax

Third Party Liability
 P.O. Box 5838
 Helena, MT 59604

Key Websites	
Web Address	Information Available
ACS EDI Gateway www.acs-grco.com/	EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for information on: <ul style="list-style-type: none"> • EDI enrollment • EDI support • Electronic transaction instructions for HIPAA 5010 • Provider services • Manuals • Provider services • Software • Related links
Centers for Disease Control and Prevention (CDC) www.cdc.gov/	Immunization and health and safety information
Healthy Montana Kids (HMK) www.hmk.mt.gov/	Information on HMK
Provider Information http://medicaidprovider.hhs.mt.gov/ Montana Access to Health (MATH) Web Portal https://mtaccessstohealth.acs-shc.com/	<ul style="list-style-type: none"> • FAQs • Fee schedules • Forms • HIPAA updates • Key contacts • Links to other websites • Medicaid news • Newsletters • Notices and manual replacement pages • Passport to Health and Team Care information • Provider enrollment • Provider manuals • Remittance advice notices • Training resources • Upcoming events
Public Assistance Toolkit https://dphhs.mt.gov/	Select <i>Human Services</i> for information on: <ul style="list-style-type: none"> • Medicaid: Member information, eligibility information, and provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
Secretary of State www.sos.mt.gov ARM Rules Home Page www.mtrules.org	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com A fee is charged for most documents; code lists are viewable online at no cost.	<ul style="list-style-type: none"> • HIPAA 5010 guides • Code lists

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 rural health clinics (RHCs) and federally qualified health centers (FQHCs). Materials have been consolidated whenever possible. Specific mention will be made when information is for both RHCs and FQHCs (B), RHCs only (R), and FQHCs only (F). In this manual, the term clinic refers to both RHCs and FQHCs.

Additional information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.

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

Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and provider notices in the back of the manual for use with claims that originated under the old policy. File all notices behind the tab marked “Notices.”

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information [website](#). 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 general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to rural health clinics and federally qualified health centers:

- Code of Federal Regulations (CFR)
 - 42 CFR 405.2400–42 CFR 405.2472
- Montana Code Annotated (MCA)
 - MCA 53-2-201, 53-6-101, 53-6-111, and 53-6-113
- Administrative Rules of Montana (ARM)
 - ARM 37.86.4401–37.86.4420

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

The Department is committed to paying Medicaid provider’s 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 it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers 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, manual 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 almost all services provided in a rural health clinic (RHC) or federally qualified health center (FQHC) when they are medically necessary, including preventive primary services in FQHCs. This chapter provides covered services information that applies specifically to RHCs and FQHCs. Like all health care services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements”chapter of the *General Information for Providers* manual.

As a condition of participation in Medicaid, a clinic must meet all requirements generally applicable to Medicaid providers. The health professionals must meet the same requirements as if enrolled themselves, including licensure, certification, or registration for his/her provider type. Each clinic provider also must maintain a current Medicaid provider enrollment.

Clinics have the same limits on amount, scope, and duration of services covered by the Medicaid program such as medical necessity requirements and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements and restrictions.

Service Settings

Clinic services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office) or a patient’s place of residence. A patient’s place of residence may be a nursing facility or other institution used as the patient’s home. Clinic services are covered off-site as long as the service is normally furnished within the scope of the clinic’s professional services. Services provided off-site are part of the clinic benefit if the provider has an agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn’t compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

FQHCs and RHCs must not bill in the hospital setting (ARM 37.86.4406(3)(4)).

FQHC and RHC providers who perform services in a hospital setting must bill the service on a CMS-1500 form using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

Satellite Clinics

If clinic services are furnished at permanent units in more than one location, each unit is independently considered for approval as a clinic, unless prior approval was granted by CMS, to operate both locations under one provider number. To be considered a “satellite clinic” both sites must share medical staff, office staff, and/or administrative staff. DPHHS must be notified in writing of approval by CMS to operate under one provider number prior to billing for services at the satellite clinic.

Clinic Covered Core Services

The following are covered core services in RHCs (R), FQHCs (F), or both (B) and may be billed as a visit when there is a face-to-face encounter with the patient:

- B – Physician services
- B – Nurse practitioner, nurse specialist, certified nurse midwife or physician’s assistant services.
- B – Clinical psychologist, clinical social worker and licensed professional counselor services
- B – Dentist services
- R – Visiting nurse; see Coverage of Specific Services later in this chapter.
- F – Preventive primary services; does not include eyeglasses or hearing aids, but does include:
 - Perinatal care for high-risk patients
 - Tuberculosis testing for high-risk patients
 - Risk assessment and initial counseling regarding risks
 - Preventive dental

Services and supplies furnished as incident to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in your rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B – Furnished as an incidental, although integral, part of the physician’s or mid-level practitioner’s professional service (i.e., influenza vaccine/administration)
- B – Of a type commonly rendered without charge or included in the clinic’s claim
- B – Of a type that is commonly furnished in a physician’s office or a clinic
- B – Basic lab services essential to the immediate diagnosis and treatment of the patient

- B – Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist, or social worker.
- B – In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic
- B – Drugs and biologicals that cannot be self-administered.
- B – Radiology, including ultrasound
- B – Pharmacist-only visits of any kind
- B – Outreach
- B – Case management
- B – Transportation

Vaccines and the administration of vaccines is not a covered service in an RHC or FQHC setting and is not a separately billable service.

These services are considered as part of the covered core services offered by RHCs and FQHCs and are included within the facility's rate per visit when there is a face-to-face encounter with the member.

Regarding HMK qualified members, providers may bill Blue Cross and Blue Shield of Montana (BCBSMT) for vaccines. If vaccines are administered without a physician or mid-level visit, providers may also bill BCBSMT an administration fee for each immunization. Refer to page 2.6 of this manual for additional information regarding HMK qualified members and vaccines.

Dental hygienist services may be billed by clinics as a stand-alone visit provided they are performed by a licensed dental hygienist (under the direct personal supervision of a licensed dentist).

Ambulatory Services

Services other than "core" services that would be covered under the Montana Medicaid program if provided by an individual or entity other than a clinic in accordance with Medicaid requirements. ***These services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program (e.g., limits on hours for therapy services, medical necessity criteria).*** Many of these services also require Passport prior authorization and some emergency dental services for adults may require Department authorization. Please check the appropriate Medicaid manual for specific information concerning these services.

- B – Respiratory therapy and inhalation therapy services
- B – Physical therapy services
- B – Occupational therapy services
- B – Audiology services
- B – Dental services
- B – Mental health services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (ARM 37.86.2201–2221)

The Well Child EPSDT program covers all medically-necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages.

Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. See the Passport and Prior Authorization chapters in this manual.

For more information about the recommended well child screen and other components of EPSDT, see the Well Child EPSDT chapter in the *Physician-Related Services* manual.

Noncovered Services (ARM 37.85.207)

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program. (See the Eligibility chapter in the *General Information for Providers* manual.)

- Acupuncture
- Allergen immunotherapy services
- Chiropractic services
- Delivery services not provided in a licensed health care facility unless as an emergency service
- Dietician/nutritional services
- Dietary supplements
- Exercise programs and programs that are primarily educational, such as:
 - Cardiac rehabilitation exercise programs
 - Pulmonary rehabilitation programs
 - Nutritional programs
 - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Homemaker services
- Infertility treatment
- Massage services

Use current fee schedules to verify coverage for specific services.



- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid member is financially responsible for these services and the Department recommends the member agree in writing before the services are provided. See the Billing Procedures chapter of this manual.
- Vaccines and the administration of vaccines
- Medicaid does not cover services that are not direct patient care such as the following:
 - Missed or canceled appointments
 - Mileage and travel expenses for providers
 - Preparation of medical or insurance reports
 - Service charges or delinquent payment fees
 - Telephone services in home
 - Remodeling of home
 - Plumbing service
 - Car repair and/or modification of automobile

Coverage of Specific Services

The following are coverage rules for specific RHC and FQHC services.

Visiting Nurses

Part-time or intermittent nursing care and related medical services other than drugs and biologicals may be provided to a homebound (see definition below) individual by a clinic:

- Only in geographic areas designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services;
- **When services are rendered to a homebound patient only. A homebound individual is a person who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long-term care facility.**
- When a registered nurse, licensed practical nurse, or licensed vocational nurse that is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either:
 - Established and periodically reviewed (at least every 60 days) by a physician; or
 - Established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).

Laboratory Services

Clinics must send a copy of their Clinical Laboratory Improvement Act (CLIA) registration number to ACS. These numbers are assigned by CMS. See Key Contacts for further information.

Other Programs

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

Mental Health Services Plan (MHSP)

MHSP services are allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website. (See Key Websites.)

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521 and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Blue Cross and Blue Shield of Montana (BCBSMT) for vaccines. If vaccines are administered without a physician or mid-level visit, providers may also bill BCBSMT an administration fee for each immunization.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#). (See Key Websites.)

Passport

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

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

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

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

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

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

With some exceptions, all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The member's Passport provider is also referred to as the primary care provider or PCP.

Team Care (ARM 37.86.5303)

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

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

Nurse First Advice Line

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

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

Health Improvement Program (ARM 37.86.5201–5206)

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

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

ditions that would benefit from case management from HIP using the HIP referral form included under the Health Improvement Program link on the Provider Information [website](#) (see “Key Websites”).

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

Role of the Passport Provider

- Must be enrolled as a Montana Medicaid provider. Providers may download the provider enrollment information from the Provider Information website or contact Provider Relations (see *Key Websites* and *Key Contacts*).
- Sign and agree to the terms of the Passport Provider agreement.
- Must meet the requirements listed in the *Provider Requirements* and *Passport to Health* chapters of the *General Information for Providers* manual.
- Accept enrollees in the order in which members are enrolled. Providers are automatically assigned Passport enrollees as long as they have openings and the enrollees meet the PCP-defined restrictions.
- Provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordination of member’s access to medically necessary specialty care by providing referrals, authorizations, and follow-up.
- Authorize inpatient admissions.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider’s normal hours of operation.
- Provide an appropriate and confidential exchange of information among providers.
- Educate and assist members in finding self-referral services (e.g., family planning, mental health services, immunizations and other services).
- Educate members about appropriate use of the ED.
- Provide or arrange for well child checkups, EPSDT services, blood lead screenings and testings, and immunizations.
- Maintain a unified patient medical record for each Passport enrollee. This must include a record of all approved referrals to other providers. Providers must transfer a copy of the member’s medical record to a new PCP if requested in writing and authorized by the member.
- Provide all documentation requested by the Department (or its designee). The Department may review provider records to assure appropriate, timely, reasonably priced, quality services are being provided to Montana Medicaid members.

- May not discriminate against protected classes or in the selection of Passport members.
- Federal regulation requires you to provide interpreter services to all patients with limited English proficiency.

Providing Passport Referral and Authorization

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

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

Member Disenrollment

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

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

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

Termination of Passport agreement

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

Utilization review

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

Caseload limits

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

Member Eligibility Verification

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

Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual and in the Covered Services chapter of this manual. Prior authorization and Team Care requirements must also be followed.

Passport Referral and Approval (ARM 37.86.5110)

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

Making a Referral

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

Receiving a Referral as the Non-PCP

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

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

Passport Approval and Prior Authorization

Passport approval and prior authorization are different, and both may be required for a service. Prior authorization refers to a list of services that require authorization through a Department contractor, Mountain-Pacific Quality Health. See Additional Medicaid Requirements for Passport Members in your *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on prior authorization and Passport. The Medicaid Covered Services table in the *General Information for Providers* manual is an overview of services with prior authorization and Passport indicators.

Services That Do Not Require Passport Provider Approval (37.86.5110)

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Durable medical equipment
- Emergency department
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services

- Home infusion therapy
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities for the mentally retarded
- Laboratory tests
- Licensed clinical counseling
- Mental health case management
- Mental health services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance services in a member's home
- Pharmacy
- Podiatry
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)
- X-rays

Passport and Emergency Services (ARM 37.86.5110)

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

- **Emergency services provided in the emergency department (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. Nonemergencies 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, click the Emergency Services link on the Provider Information [website](#).
- **Post stabilization and Passport.** If inpatient hospitalization is recommended as post-stabilization treatment, the hospital must get a referral from the member's Passport provider. If the hospital attempts to

contact the Passport provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation must be sent to the Passport Program Officer for review. (See Key Contacts.) The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60-minute time lapse between these two events.

Passport and Indian Health Services

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

Complaints and Grievances

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

Getting Questions Answered

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

Becoming a Passport Provider (ARM 37.86.5111–5112)

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

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

Solo Passport Provider

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

Group Passport Provider

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

Passport Tips

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

Other Programs

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

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-800-447-7828. Additional HMK information is available on the HMK website. (See Key Websites.)

Prior Authorization

What Is Prior Authorization? (ARM 37.85.205 and 37.86.5101–5120)

Prior authorization (PA) is another example of the Department's efforts to ensure the appropriate use of Medicaid services. Providers need approval before services are provided to a particular member. Passport approval and PA are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form. (See the Submitting a Claim chapter in this manual.)

PA refers to a list of services. If a service requires PA, the requirement exists for all Medicaid members. When PA is granted, the provider is issued a PA number which must be on the claim.

In practice, providers will most often encounter members who are enrolled in Passport. Specific services may also require PA regardless of whether the member is a Passport enrollee. Refer to the Prior Authorization section below and fee schedules for PA requirements.

Prior Authorization Requirements

RHC and FQHC services do not require PA unless the procedure code requires it. If you are making a referral, remember that some services require PA before they are provided. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The table on the next page (PA Criteria for Specific Services) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA. (See the table entitled PA Criteria for Specific Services for documentation requirements.)
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included in FL 63 on the UB-04 claim form.
- Providers must comply with all requirements for Medicaid PA before providing services or before payment, as applicable to the particular category of services being provided.



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the UB-04 claim form.



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

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements
<ul style="list-style-type: none"> • All transplant services • Out-of-state hospital inpatient services • All rehab services • Therapy services over limit for children 	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 443-4020 X5850 Helena (800) 262-1545 X5850 In- and out-of-state</p> <p>Fax: (406) 443-4585 Helena (800) 497-8235 In- and out-of-state</p>	<ul style="list-style-type: none"> • Required information includes: <ul style="list-style-type: none"> • Member's name • Member's Medicaid ID number • State and hospital where member is going • Documentation that supports medical necessity. <p style="margin-left: 20px;">This varies based on circumstances. Mountain-Pacific Quality Health will instruct providers on required documentation on a case-by-case basis.</p>
<p>Emergency department reviews</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 443-4020 X5850 Helena (800) 262-1545 X5850 In- and out-of-state</p> <p>Fax: (406) 443-4585 Helena (800) 497-8235 In- and out-of-state</p>	<ul style="list-style-type: none"> • Required information includes: <ul style="list-style-type: none"> • A copy of the claim • A copy of the emergency department report
<p>• Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)</p> <p>For emergency ambulance transport services, providers have 60 days following the service to obtain authorization. (See the <i>Ambulance Services</i> manual.)</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791 E-Mail: ambulance@mpqhf.org</p>	<ul style="list-style-type: none"> • Ambulance providers may call, leave a message, fax, or e-mail requests. • Required information includes: <ul style="list-style-type: none"> • Name of transportation provider • Provider's NPI/API • Member's name • Member's Medicaid ID number • Point of origin to the point of destination • Date and time of transport • Reason for transport • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen) • Providers must submit the trip report and copy of the charges for review after transport. • For commercial or private vehicle transportation, members call and leave a message, or fax travel requests prior to traveling.
<p>Dispensing and fitting of contact lenses</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 442-1837 Helena (800) 624-3958 In- and out-of-state</p>	<ul style="list-style-type: none"> • PA required for contact lenses and dispensing fees. • Diagnosis must be one of the following: <ul style="list-style-type: none"> • Keratoconus • Aphakia • Sight cannot be corrected to 20/40 with eyeglasses

PA Criteria for Specific Services (Continued)

Service	PA Contact	Documentation Requirements
<ul style="list-style-type: none"> • Eye prosthesis • New technology codes (Category III CPT codes) • Other reviews referred by Medicaid program staff 	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791</p>	<ul style="list-style-type: none"> • Documentation that supports medical necessity • Documentation regarding the member's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.
Circumcision	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791</p>	<ul style="list-style-type: none"> • Circumcision requests are reviewed case-by-case basis based on medical necessity when one of the following occurs: <ul style="list-style-type: none"> • Member has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. Phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated. • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene • Urinary obstruction • Urinary tract infections
Maxillofacial/cranial surgery	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791</p>	<ul style="list-style-type: none"> • Surgical services are only covered when done to restore physical function or to correct physical problems resulting from: <ul style="list-style-type: none"> • Motor vehicle accidents • Accidental falls • Sports injuries • Congenital birth defects • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Medicaid does not cover these services for: <ul style="list-style-type: none"> • Improvement of appearance or self-esteem (cosmetic) • Dental implants • Orthodontics
Blepharoplasty	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791</p>	<ul style="list-style-type: none"> • Reconstructive blepharoplasty may be covered to: <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). • Documentation must include the following: <ul style="list-style-type: none"> • Surgeon must document indications for surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Preoperative photographs • Medicaid does not cover cosmetic blepharoplasty.

PA Criteria for Specific Services (Continued)

Service	PA Contact	Documentation Requirements
Botox myobloc	Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • For more details on botox criteria, coverage, and limitations, visit the Provider Information website. (See Key Websites.) • Botox is covered for treating the following: <ul style="list-style-type: none"> • Laryngeal spasm • Blepharospasm • Hemifacial spasm of the nerve • Torticollis, unspecified • Torsion dystonia • Fragments of dystonia • Hereditary spastic paraplegia • Multiple sclerosis • Spastic hemiplegia • Infantile cerebral palsy • Other specified infantile cerebral palsy • Achalasia and cardiospasm • Spasm of muscle • Hyperhidrosis • Strabismus and other disorders of binocular eye movements • Other demyelinating disease of the central nervous system • Documentation requirements include a letter from the attending physician supporting medical necessity including: <ul style="list-style-type: none"> • Member's condition (diagnosis) • A statement that traditional methods of treatments have been tried and proven unsuccessful • Proposed treatment (dosage and frequency of injections) • Support the clinical evidence of the injections • Specify the sites injected • Myobloc is reviewed on a case-by-case basis
Excising excessive skin and subcutaneous tissue	Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • Required documentation includes the following: <ul style="list-style-type: none"> • The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures • Preoperative photographs • This procedure is contraindicated for, but not limited to, individuals with the following conditions: <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy • Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a member's appearance.

PA Criteria for Specific Services (Continued)

Service	PA Contact	Documentation Requirements
Rhinoplasty septorhinoplasty	Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • The following do not require PA: <ul style="list-style-type: none"> • Septoplasty to repair deviated septum and reduce nasal obstruction • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction • Medicaid covers rhinoplasty in the following circumstances: <ul style="list-style-type: none"> • To repair nasal deformity caused by a cleft lip/cleft palate deformity for members 18 years of age and younger • Following a trauma (e.g., a crushing injury) which displaced nasal structures and causes nasal airway obstruction. • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Not covered <ul style="list-style-type: none"> • Cosmetic rhinoplasty done alone or in combination with a septoplasty • Septoplasty to treat snoring
Temporomandibular joint (TMJ) arthroscopy/surgery	Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • Nonsurgical treatment for TMJ disorders must be utilized first to restore comfort and improve jaw function to an acceptable level. Nonsurgical treatment may include the following in any combination depending on the case: <ul style="list-style-type: none"> • Fabrication and insertion of an intra-oral orthotic • Physical therapy treatments • Adjunctive medication • Stress management • Surgical treatment may be considered when both of the following apply: <ul style="list-style-type: none"> • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery. • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review. • Not covered: <ul style="list-style-type: none"> • Botox injections for the treatment of TMJ are considered experimental. • Orthodontics to alter the bite • Crown and bridge work to balance the bite • Bite (occlusal) adjustments

PA Criteria for Specific Services (Continued)

Service	PA Contact	Documentation Requirements
Partial hospitalization	Magellan Medicaid Administration (dba First Health Services) 4300 Cox Road Glen Allen, VA 23060 Phone: (800) 770-3084 Fax: (800) 639-8982 (800) 247-3844	<ul style="list-style-type: none"> • A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission. • The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the patient's psychiatric condition.
Dermabrasion/abrasion chemical peel	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • Services covered for the following: <ul style="list-style-type: none"> • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined. • The removal of precancerous skin growths (keratoses) • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Preoperative photographs
Positron emission tomography (PET) scans	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone: (800) 292-7114 Fax: (800) 291-7791	<ul style="list-style-type: none"> • PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the MPQH.) <ul style="list-style-type: none"> • Solitary pulmonary nodules (SPNs) – characterization • Lung cancer (non small cell) – Diagnosis, staging, restaging • Esophageal cancer – Diagnosis, staging, restaging • Colorectal cancer – Diagnosis, staging, restaging • Lymphoma – Diagnosis, staging, restaging • Melanoma – Diagnosis, staging, restaging. Not covered for evaluating regional nodes. • Breast cancer – As an adjunct to standard imaging modalities for staging members with distant metastasis or restaging members with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated. • Head and neck cancers (excluding central nervous system and thyroid) – Diagnosis, staging, restaging • Myocardial viability – Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan. • Refractory seizures – Covered for presurgical evaluation only. • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) – Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (Continued)

Service	PA Contact	Documentation Requirements										
<p>Reduction mammoplasty</p>	<p>Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604</p> <p>Phone: (800) 292-7114 Fax: (800) 291-7791</p>	<p>Both the referring physician and the surgeon must submit documentation. Back pain must have been documented and present for at least six months, and causes other than breast weight must have been excluded.</p> <p>Indications for female member:</p> <ul style="list-style-type: none"> • Contraindicated for pregnant women and lactating mothers. A member must wait 6 months after the cessation of breast feeding before requesting this procedure. • Female members 16 years or older with a body weight less than 1.2 times the ideal weight. • There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a 6-month period. This must include at least 2 of the following conditions: <ul style="list-style-type: none"> • Upper back, neck, shoulder pain that has been unresponsive to at least 6 months of documented and supervised physical therapy and strengthening exercises • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted. • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy. • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck, and upper back. <p>Documentation in the member's record must indicate/support:</p> <ul style="list-style-type: none"> • History of the member's symptoms related to large, pendulous breasts. • The duration of the symptoms of at least 6 months and the lack of success of other therapeutic measures (documented weight loss programs with 6 months of food and calorie intake diary, medications for back/neck pain, etc.). • Guidelines for the anticipated weight of breast tissue removed from each breast related to the member's height (which must be documented): <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: left;">Height</th> <th style="text-align: left;">Weight of tissue per breast</th> </tr> </thead> <tbody> <tr> <td>less than 5 ft.</td> <td>250 grams</td> </tr> <tr> <td>5 ft. to 5 ft., 2 in.</td> <td>350 grams</td> </tr> <tr> <td>5 ft., 2 in. to 5 ft., 4 in.</td> <td>450 grams</td> </tr> <tr> <td>greater than 5 ft., 4 in.</td> <td>500 grams</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Preoperative photographs of the pectoral girdle showing changes related to macromastia. • Medication use history. Breast enlargements may be caused by various medications (ex: sironolactone, cimetidine) or illicit drug abuse (ex: marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease and adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery. <p>Indications for male member:</p> <ul style="list-style-type: none"> • If the condition persists, a member may be considered a good candidate for surgery. Members who are alcoholic, illicit drug abusers (ex: steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first. <p style="text-align: right; margin-right: 20px;">4.7</p> <ul style="list-style-type: none"> • Documentation required: length of time gynecomastia has been present, height, weight, and age of the member, preoperative photographs. 	Height	Weight of tissue per breast	less than 5 ft.	250 grams	5 ft. to 5 ft., 2 in.	350 grams	5 ft., 2 in. to 5 ft., 4 in.	450 grams	greater than 5 ft., 4 in.	500 grams
Height	Weight of tissue per breast											
less than 5 ft.	250 grams											
5 ft. to 5 ft., 2 in.	350 grams											
5 ft., 2 in. to 5 ft., 4 in.	450 grams											
greater than 5 ft., 4 in.	500 grams											
<p>Prior Authorization</p>												

Other Programs

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

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-800-447-7828. Additional HMK information is available on the HMK 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 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

For RHCs, 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. For FQHCs, Medicare payments are handled as TPL payments.

For details on how Medicaid calculates payments to Medicare claims, see the How Payment Is Made chapter in this manual.

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

When billing Medicaid for a member with coverage from multiple sources, see the Billing Procedure chapter in this manual

Medicare Claims

Medicare covers RHC and FQHC covered services. These claims automatically cross over from Medicare for dually-eligible members, so providers do not need to send in their crossovers on paper. The Department's fiscal agent must have the provider's Medicare number on file to process claims, and providers should include their NPI/API on their Medicare claims.

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

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

RHC claims that cross over to Medicare are paid the Medicare coinsurance and deductible less any TPL coverage and less the copay.

When Medicare Pays or Denies a Service

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

When Medicaid Does Not Respond to Crossover Claims

- When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing. When Medicaid is a secondary payer to Medicare, and Medicare has paid the claim but not crossed it over to Medicaid, you must submit Medicare's payment in the Prior Payments field (FL 54) of the UB-04 form. When Medicare has denied the service, you must attach the denial and any explanation of denial codes to the claim.

Submitting Medicare Claims to Medicaid

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

When a Member Has TPL (ARM 37.85.407)

When a Medicaid member has additional medical coverage (other than Medicare), it is often referred to as third party liability (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 equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the member's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid."

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first.

- When a Medicaid member is also covered by Indian Health Service (IHS) or the Montana Crime Victim Compensation Fund, providers must bill Medicaid before IHS or Crime Victim. 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, send the claim and notification to Third Party Liability. (See Key Contacts.)

Requesting an Exemption

- Providers may ask to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to Third Party Liability. (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 nonspecific 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:
 1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
 2. 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 went toward member's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information [website](#). (See Key Contacts.)
- 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 a note to the paper claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to Third Party Liability. (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.



For details on how Medicaid calculates payment for TPL claims, see the How Payment Is Calculated chapter in this manual.

Other Programs

MHSP services are allowed for RHCs and FQHCs. Providers can find information on Medicaid mental health services and MHSP services in the mental health manual available on the Provider Information website. (See Key Websites.)

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 1-800-447-7828. Information about HMK is available on the HMK website. (See Key Websites.)

Billing Procedures

Claim Forms

RHC and FQHC services 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 a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status. (See Key Contacts.)
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. (See the Coordination of Benefits chapter in this manual for more information.)
- 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 Medicaid 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.
- When services are free to the member, such as in a public health clinic.

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

 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)			
	<ul style="list-style-type: none"> • Member is Medicaid-enrolled • Provider accepts member as a Medicaid member 	<ul style="list-style-type: none"> • Member is Medicaid-enrolled • Provider does not accept member as a Medicaid member 	<ul style="list-style-type: none"> • Member is not Medicaid-enrolled
Service is covered by Medicaid	Provider can bill member only for cost sharing	Provider can bill Medicaid member if the member has signed a routine agreement	Provider can bill member
Service is not covered by Medicaid	Provider can bill member only if custom agreement has been made between member and provider before providing the service	Provider can bill Medicaid member if the member has signed a routine agreement	Provider can bill member

Routine Agreement: This may be a routine agreement between the provider and member which states that the member is not accepted as a Medicaid member, and that he 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 RHC and FQHC 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 Definitions.)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home- and community-based waiver services
- Nonemergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

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

Billing for Members with Other Insurance

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

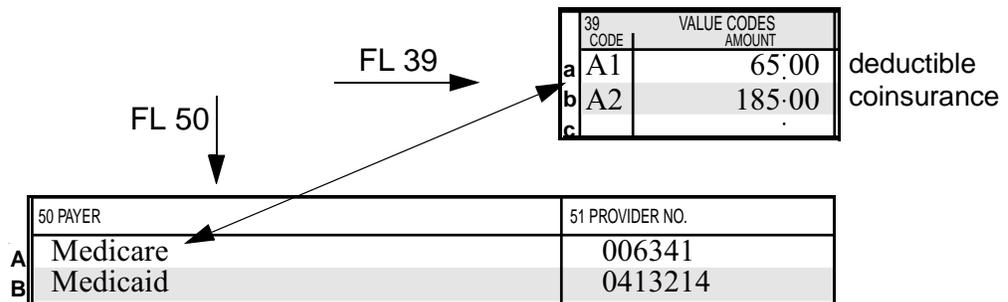


Cost sharing for RHC and FQHC services is \$5.00 per visit.



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

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. (See the Submitting a Claim chapter in this manual.)



Billing for Retroactively-Eligible Members

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

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

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

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 codes to be used. For coding assistance and resources, see the table of Coding Resources later in this chapter.

The following may help reduce coding errors and unnecessary claim denials:

- Use appropriate CPT, HCPCS Level II, and ICD coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, do not use Code 53899 (unlisted procedure of the urinary system) when a more-specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the member. The code choices are 45–50 minutes or 76–80 minutes. The provider must bill the code for 45–50 minutes.
- Take care to use the correct units measurement. In general, Medicaid follows the definitions in the CPT and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be “each 15 minutes.” Always check the long text of the code description published in the CPT or HCPCS Level II coding books.
- RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations to make sure they are valid for your facility. If invalid for your clinic, the use of these revenue codes will result in nonpayment.

B	512	Dental
B	521	RHC/FQHC clinic visit
B	522	RHC/FQHC home visit
B	524	Visit by RHC/FQHC practitioner to a member in an covered Part A stay at a skilled nursing facility
B	525	Visit by RHC/FQHC practitioner to a member in a skilled nursing facility (not a covered Part A stay) or nursing facility or intermediate care facility for the mentally retarded or other residential facility
B	527	RHC/FQHC visiting nurse services to a member’s home when in a home health shortage area
B	528	Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
B	900	Mental health visits



Always refer to the long descriptions in coding books.

Coding Resources		
The Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service 800.363.2068 703.605.6060 www.ntis.gov/products/cci.aspx
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association 800.621.8335 https://commerce.ama-assn.org/store/ or Optum 800.464.3649 https://www.optumcoding.com/
CPT Assistant	A newsletter on CPT coding issues	American Medical Association (800) 621-8335 https://commerce.ama-assn.org/store/
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov
ICD	<ul style="list-style-type: none"> • ICD CM diagnosis and procedure codes definitions • Updated each October 	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	Optum 800.464.3649 https://www.optumcoding.com/
UB-04 National Uniform Billing Data Element Specifications	Montana UB-04 billing instructions	National Uniform Billing Committee www.nubc.org
UB-04 Editor	National UB-04 billing instructions	Available through various publishers and editors

Number of Lines on Claim

Clinic claims are reimbursed using an all-inclusive rate of payment per visit. Only one line per claim will receive payment.

Multiple Services on Same Date (ARM 37.86.4402)

A clinic visit is defined as a face-to-face encounter between a clinic patient and a clinic health care professional for the purpose of providing clinic core or other ambulatory services or billable incident-to services. Encounters with more than

one clinic health care professional, and multiple encounters with the same clinic health care professional, on the same day at a single location constitute a single visit except when one of the following exists:

- After the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment, or
- The patient has a medical visit and a mental health visit, or a medical visit and a dental visit, or a mental health visit and a dental visit.

Span Bills

Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim. Spans greater than one date of service in FL 6 will result in payment for one date of service. Reimbursement of other dates of service within the span is not possible until the paid claim is adjusted to reflect one date of service only.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- All clinic revenue codes require a valid CPT or HCPCS Level II code in form locator (FL) 44 that is appropriate for clinics.

Using Modifiers

- Review the guidelines for using modifiers in the current CPT book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter, and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in FL 44. For example, Code 25680 (treatment of wrist fracture) when done bilaterally is reported as Code 2568050.
- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first.

Service Settings

Clinic services are covered when provided in an outpatient setting including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off site are part of the clinic benefit if the provider has an agree-



Clinics should put the most important modifiers in the first position.

ment with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic does not compensate the provider for services provided off site, the clinic may not bill Medicaid for those services.

FQHCs and RHCs must not bill in the hospital setting. FQHC and RHC providers that perform services in a hospital setting must bill the service on a CMS-1500 using their own provider number. Pre- and post-visits at the clinic are billed by the clinic on a UB-04 as a core service.

Submitting a Claim

Paper Claims

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

Claims
P.O. Box 8000
Helena, MT 59604

Electronic Claims

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

- **WINASAP5010.** Xerox makes this free software available for providers to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses, FQHC/RHC services, and community-based psychiatric rehabilitation services). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox clearinghouse.** Providers can send claims to the Xerox clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through EDI Gateway. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the Xerox clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to EDI Gateway. EDIFECS certification is completed through EDI Gateway.

For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk. (See Key Contacts.)

Claim Inquiries

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

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
National provider identifier (NPI) missing or invalid	The provider number is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI/API is 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 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider approval – No Passport approval number on claim	A Passport provider approval number must be on the claim form when such approval is required. Passport approval is different from prior authorization (PA). See the Passport and Prior Authorization chapters in this manual.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Prior authorization (PA) number is missing	PA is required for certain services, and the PA number must be on the claim form. PA is different from Passport authorization. See the Passport and Prior Authorization chapters in this manual.
Prior authorization does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	Check all remittance advices (RAs) for previously-submitted claims before resubmitting. When making changes to previously-paid claims, submit an adjustment form rather than a new claim form. (See Remittance Advices and Adjustments in this manual.)
TPL on file and no credit amount on claim	If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. See the Coordination of Benefits chapter in this manual. If the member's TPL coverage has changed, providers must notify the TPL Unit before submitting a claim. (See Key Contacts.)
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.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. New providers cannot bill for services provided before Medicaid enrollment begins. If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	Provider is not allowed to perform the service. Verify the procedure code is correct using current HCPCS and CPT billing manual. Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521 and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Blue Cross and Blue Shield of Montana (BCBSMT) for vaccines. If vaccines are administered without a physician or mid-level visit, providers may also bill BCBSMT an administration fee for each immunization.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#). (See Key Websites.)

Submitting a Claim

The services described in this manual are billed on UB-04 claim forms. Please use this chapter with the UB-04 [claim instructions](#) on the Provider Information website. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner. (See the *Billing Procedures* chapter in this manual.)

Claims are completed differently for the different types of coverage a member has. This chapter includes instructions and a sample claim for each of the following scenarios:

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

When completing a claim, remember the following:

- Please use this information with the [claim instructions](#).
- All form locators (FLs) shown in this chapter are required or situational. Situational FLs are required if the information is applicable to the situation or member and are indicated by “*”.
- FL 11 is used for Passport and FL 78 is used for cost sharing indicators. See the table below and instructions in this chapter.

Passport and Cost Sharing Indicators	
Passport to Health Indicators	
Code	Description
FPS	This indicator is used when providing family planning services.
OBS	This indicator is used when providing obstetrical services.
TCM	This indicator is used when providing targeted case management services.
Cost Sharing Indicators	
E	This indicator is used when providing emergency services.
F	This indicator is used when providing family planning services.
P	This indicator is used when providing services to pregnant women.

- Unless otherwise stated, all paper claims must be mailed to the following address:
 Claims
 P.O. Box 8000
 Helena, MT 59604

Member Has Medicaid Coverage Only

FL	Form Locator Title	Instructions
1–2	Unlabeled fields	Provider name, complete mailing address, and phone number.
3	Patient control number	The member's unique alphanumeric number assigned by the provider.
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs).
6	Statement covers period	The beginning and ending service date of the period included on this bill.
11*	Passport to Health	Enter Passport authorization number or indicator. See Passport and Cost Sharing Indicators earlier in this chapter.
12	Patient name	Enter the Medicaid member's last name, first name and middle initial.
13	Patient address	The member's mailing address including street name/P.O. box, city, state, and ZIP code
14	Patient birth date	The member's month, day, and year of birth.
15	Patient sex	Use M (male), F (female), or U (unknown).
17–20	Admission	The admission date, hour, type, and source.
22	Patient status	A code indicating member status as of the ending service date of the period covered on this bill.
42	Revenue code	A code that identifies a specific accommodation, ancillary service or billing calculation.
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service.
45	Service date	The date the indicated service was provided.
46	Service units	A quantitative measure of services rendered by revenue category to or for the member to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and noncovered) for this line.
50	Payer	Enter "Medicaid" when the member has Medicaid only coverage.
51	Provider number	Enter the provider's NPI/API.
54*	Prior payments	The amount the provider has received toward payment of this bill.
58	Insured's name	Name of the individual in whose name the insurance is carried.
60	Cert - SSN - HIC - ID #	Member's Medicaid ID number.
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67–75	Principal diagnosis code	Use the ICD code for the principal diagnosis. Enter additional diagnoses codes in FL 68–75.
76	Admitting diagnosis code	The ICD code for the member's diagnosis or reason for visit.
78	Unlabeled field	Enter applicable cost sharing indicator. See Passport and Cost Sharing Indicators earlier in this chapter.
82	Attending physician ID	For nonemergency outpatient services, enter the referring physician's NPI. For emergency services, enter the emergency department physician's NPI.
85–86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill.

* Required if applicable

Member Has Medicaid Coverage Only

1 Better Provider 33 Best Road Fitness, MT 59003										2										3a PAT. CNTL.# 343397 b. MED. REC.#					4 TYPE OF BILL 711																																																																																									
																				5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM 02/01/06 THROUGH 02/01/06					7 9989887																																																																																				
8 PATIENT NAME a Sunshine, Bright R.										9 PATIENT ADDRESS a 493 Lighthouse Way Fitness, MT 59003										c					d																																																																																									
10 BIRTHDATE 10/12/82										11 SEX F										12 DATE OF ADMISSION 02/01/06					13 HR 07					14 TYPE 2					15 SRC					16 DHR					17 STAT 01					18					19					20					21					22					23					24					25					26					27					28					29 ACDT STATE					30				
31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE					34 OCCURRENCE DATE					35 CODE					OCCURRENCE SPAN FROM THROUGH					36 CODE					OCCURRENCE SPAN FROM THROUGH					37																																																																
38										39 CODE					VALUE CODES AMOUNT					40 CODE					VALUE CODES AMOUNT					41 CODE					VALUE CODES AMOUNT																																																																															
42 REV. CD. 1 521										43 DESCRIPTION Office/Outpatient Visit/est.										44 HCPCS / RATE / HIPPS CODE 99213					45 SERV. DATE 02/01/06					46 SERV. UNITS 1					47 TOTAL CHARGES 68.90					48 NON-COVERED CHARGES					49																																																																					
PAGE ____ OF ____										CREATION DATE										TOTALS →					68.90																																																																																									
50 PAYER NAME A Medicaid										51 HEALTH PLAN ID 0413214										52 REL. INFO					53 ASG. BEN.					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI					57 OTHER PRV ID																																																																					
58 INSURED'S NAME A Sunshine, Bright R.										59 P.REL.										60 INSURED'S UNIQUE ID 123784560					61 GROUP NAME					62 INSURANCE GROUP NO.																																																																																				
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																																																																																														
66 DX										67										A					B					C					D					E					F					G					H					68																																																						
69 ADMIT DX 789										70 PATIENT REASON DX a										OTHER PROCEDURE DATE b					71 PPS CODE c					72 ECI					73																																																																															
74 PRINCIPAL PROCEDURE CODE 789										OTHER PROCEDURE CODE V22.2										75					76 ATTENDING NPI 0007653421					QUAL					LAST Smiling					FIRST Sam																																																																										
c. OTHER PROCEDURE CODE										d. OTHER PROCEDURE DATE										e. OTHER PROCEDURE DATE					77 OPERATING NPI					QUAL					LAST					FIRST																																																																										
80 REMARKS										81CC a					b					c					78 OTHER NPI					QUAL					LAST					FIRST																																																																										
										d										79 OTHER NPI					QUAL					LAST					FIRST																																																																															

Member Has Medicaid and Medicare Coverage

FL	Form Locator Title	Instructions
1–2	Unlabeled fields	Provider name, complete mailing address, and phone number.
3	Patient control number	The member's unique alphanumeric number assigned by the provider.
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs).
6	Statement covers period	The beginning and ending service date of the period included on this bill.
11*	Passport To Health	Enter Passport authorization number or indicator code. (See Passport and Cost Sharing Indicators earlier in this chapter.)
12	Patient name	Enter the Medicaid member's last name, first name and middle initial.
13	Patient address	The member's mailing address including street name/P.O. box, city, state, and ZIP code.
14	Patient birth date	The member's month, day, and year of birth.
15	Patient sex	Enter M (male), F (female), or U (unknown).
17–20	Admission	The admission date, hour, type, and source. For specific codes, see the CPT manual and the ICD-9 manual for hospital services.
22	Patient status	A code indicating member status as of the ending service date of the period covered on this bill. For specific codes, see the CPT manual and the ICD-9 manual for hospital services.
39–41*	Value codes and amounts	Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must correspond with the entries in form locator 50 (A, B). See the Billing Procedures chapter, Billing with Multiple Payers section in this manual.
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation. For specific codes, see the CPT manual and the ICD-9 manual for hospital services.
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service.
45	Service date	The date the indicated service was provided.
46	Service units	A quantitative measure of services rendered by revenue category to or for the member to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39–41. See the Billing Procedures chapter, Billing with Multiple Payers section in this manual.
51	Provider number	Enter the provider's TPL and Medicaid ID numbers
54	Prior payments	The amount the provider has received toward payment of this bill.
58	Insured's name	Name of the individual in whose name the insurance is carried.
60	Cert – SSN – HIC – ID #	Member's Medicaid ID number.
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68–75.
76	Admitting diagnosis code	The ICD-9-CM code for the member's diagnosis or reason for visit.
78	Unlabeled field	Enter applicable cost sharing indicator code. (See Passport and Cost Sharing Indicators earlier in this chapter.)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number.
85–86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill.

* Required if applicable

Member Has Medicaid and Medicare Coverage

1 Better Provider 33 Best Road Fitness, MT 59003		2		3a PAT. CNTL. # 45604 b. MED. REC. #		4 TYPE OF BILL 791	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 02/01/06 THROUGH 02/01/06		7	
8 PATIENT NAME a Leaves, Autumn T.		9 PATIENT ADDRESS a 45 Maple Lane Trees, MT 59400					
b		c		d		e	
10 BIRTHDATE 05/28/67		11 SEX F		12 DATE 02/01/06		13 HR 10	
14 TYPE 1		15 SRC		16 DHR		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37	
38		39 CODE A1		40 VALUE CODES AMOUNT 11.00		41 CODE	
42		43		44		45	
46		47		48		49	
1 529		Office/Outpatient Visit, est.		99212		02/01/06	
2		3		4		5	
6		7		8		9	
10		11		12		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
PAGE		OF		CREATION DATE		TOTALS 55.00	
50 PAYER NAME Medicare Medicaid		51 HEALTH PLAN ID 006341 0413214		52 REL. INFO		53 ASG. BEN.	
54 PRIOR PAYMENTS 75.58		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Leaves, Autumn T.		59 P. REL.		60 INSURED'S UNIQUE ID 134637825		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 692.9		67		68		69	
70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75	
76 ATTENDING NPI 0006240		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
LAST Patients		FIRST D.R.		LAST		FIRST	
LAST		FIRST		LAST		FIRST	
LAST		FIRST		LAST		FIRST	
80 REMARKS		81CC a		b		c	
81CC d		e		f		g	

Member Has Medicaid and Third Party Liability Coverage

FL	Form Locator Titlemember	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number.
3	Patient control number	The member's unique alphanumeric number assigned by the provider.
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs).
6	Statement covers period	The beginning and ending service date of the period included on this bill.
11*	Passport to Health	Enter Passport authorization number or indicator code. (See Passport and Cost Sharing Indicators earlier in this chapter.)
12	Patient name	Enter the Medicaid member's last name, first name and middle initial.
13	Patient address	The member's mailing address including street name/P.O. box, city, state, and ZIP code.
14	Patient birth date	The member's month, day, and year of birth.
15	Patient sex	Enter M (male), F (female), or U (unknown).
17-20	Admission	The admission date, hour, type, and source. For specific codes, see the CPT manual and the ICD-9 manual for hospital services.
22	Patient status	A code indicating member status as of the ending service date of the period covered on this bill. For specific codes, see the CPT manual and the ICD manual for hospital services.
39-41*	Value codes and amounts	Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must correspond with the entries in form locator 50 (A, B). See the Billing Procedures chapter, Billing with Multiple Payers section in this manual.
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation. For specific codes, see the CPT manual and the ICD-9 manual for hospital services.
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service.
45	Service date	The date the indicated service was provided.
46	Service units	A quantitative measure of services rendered by revenue category to or for the member to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. See the Billing Procedures chapter, Billing with Multiple Payers section in this manual.
51	Provider number	Enter the provider's TPL and Medicaid ID numbers.
54	Prior payments	The amount the provider has received toward payment of this bill.
58	Insured's name	Name of the individual in whose name the insurance is carried.
60	Cert – SSN – HIC – ID #	Member's Medicaid ID number.
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75.
76	Admitting diagnosis code	The ICD-9-CM code for the member's diagnosis or reason for visit.
78	Unlabeled field	Enter applicable cost sharing indicator code. (See Passport and Cost Sharing Indicators earlier in this chapter.)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number.
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill.

Member Has Medicaid and Third Party Liability Coverage

1 Take Time Medical Center 104 Time Square Anytown, MT 12345		2		3a PAT. CNTL. # 4806		4 TYPE OF BILL 711	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 02/01/06		7 THROUGH 02/01/06	
8 PATIENT NAME a Flower, Sammy L.		9 PATIENT ADDRESS a 33 Flower Lane Buds, MT 59000					
10 BIRTHDATE 02/24/99		11 SEX M		12 DATE 02/01/06		13 ACDT STATE 10	
14 TYPE 1		15 SRC 1		16 DHR 01		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
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42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
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54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
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94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
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38		39		40		41	
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46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
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54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
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74		75		76		77	
78		79		80		81	
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90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
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46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
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50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
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34		35		36		37	
38		39		40		41	
42		43		44		45	
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50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
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90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
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26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	
02		03		04		05	
06		07		08		09	
10		11		12		13	
14		15		16		17	
18		19		20		21	
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UB-04 Agreement

Your signature on the UB-04 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Avoiding Claim Errors

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

Common Claim Errors	
Claim Error	Prevention
Required form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Member ID number missing or invalid	This is a required form locator (FL 60); verify that the member's Medicaid ID number is listed as it appears on the member's eligibility verification. (See the <i>General Information for Providers</i> , Member Eligibility chapter.)
Member name missing	This is a required form locator (FL 12); check that it is correct.
National provider identifier (NPI) missing or invalid	The NPI is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI is on the claim (FL 56).
Passport provider name and ID number missing	When services are not provided by the member's Passport provider, include the provider's Passport number (FL 11). See the Passport and Prior Authorization chapters in this manual.
Prior authorization (PA) number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in FL 63. See the Passport and Prior Authorization chapters.
Not enough information regarding other coverage	FL 39–41, 50, and in some cases FL 54, are required when a member has other coverage. Refer to the examples earlier in this chapter.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a UB-04 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.

Other Programs

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK for RHC and FQHC clinic services.

Providers may bill HMK revenue codes 512, 521 and 900. Providers billing for HMK dental services must be enrolled as HMK dental providers.

Since HMK-enrolled children are not entitled to the Vaccines for Children (VFC) program, providers may bill Blue Cross and Blue Shield of Montana (BCBSMT) for vaccines. If vaccines are administered without a physician or mid-level visit, providers may also bill BCBSMT an administration fee for each immunization.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#). (See Key Websites.)

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one or two week payment cycle. (See Payment and the RA later in this chapter.) Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

RA Notice

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

Paid Claims

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

Denied Claims

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

Pending Claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.



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



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

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
 HELENA, MT 59604
 REMITTANCE ADVICE FOR MEDICAID/HMK/MHSP

1

COMMUNITY CLINIC
 2100 NORTH MAIN STREET
 CENTRAL CITY MT 59988

2 PROVIDER# 0001234567 3 REMIT ADVICE #123456 4 WARRANT # 654321 5 DATE:02/15/05 6 PAGE 2

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON/REMARK CODES
7	8	10	11	12	13	14	15	16
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	010305 010305	1	521	58.90	11.78	N	
9	ICN 00204011350000700							
		LESS MEDICARE PAID**				93.02		
		LESS COPAY DEDUCTION*						17
		CLAIM TOTAL**			58.90			
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020105 020105	1	521	325.50	0.00	Y	
	ICN 00204011350000800							
		020305 020305	1	521	539.00	0.00	N	17
		CLAIM TOTAL**			864.50	0.00		31 MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020405 020405	1	521	810.00	0.00	N	31
	ICN 00204011350000900							
		CLAIM TOTAL**			810.00			

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

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

Montana Department of Public Health and Human Services

Key Fields on the Remittance Advice	
Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department.
2. NPI	The 10-digit number assigned to the provider by Medicaid.
3. Remittance advice number	The remittance advice number.
4. Warrant number	Not used.
5. Date	The date the RA was issued.
6. Page Number	The page number of the RA.
7. Recipient ID	The member's Medicaid ID number.
8. Name	The member's name.
9. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g., April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
10. Service dates	Dates services were provided. If services were performed in a single day, the same date will appear in both columns.
11. Unit of service	The units of service rendered under this procedure, NDC code, or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for member eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balances

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

Credit balances can be resolved in two ways:

1. By “working off” the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please 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 THE Third Party Liability (TPL) address in the Key Contacts chapter.

Rebilling and Adjustments

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

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

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



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



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

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 in this manual.

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. (See Key Contacts.)

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations. Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations.

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



Rebill denied claims only after appropriate corrections have been made.



Adjustments can only be made to paid 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 (e.g., member ID, NPI, date of service, procedure code, diagnoses, units).
- Request an adjustment when a single line on a multi-line claim was denied.

How to Request an Adjustment

To request an adjustment, use the Montana Health Care Programs *Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

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

Completing an Adjustment Request Form

1. Download the Montana Health Care Programs Individual Adjustment Request form from the Provider Information website. (See *Key Websites*.) Complete Section A first with provider and member information and the claim's ICN number. (See the following table and sample RA.)
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected. (See the following table.)
 - Enter the date of service or the line number in the *Date of Service* or *Line Number* column.
 - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
 - Enter the correct information in the column labeled *Corrected Information*.

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 most recent claim.
4.*NPI/API	The provider's NPI/API.
5.*Member ID	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice Field 5. See the sample RA earlier in this chapter.
7. Amount of payment	The amount of payment from the remittance advice Field 17. See the sample RA earlier in this chapter.
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the date of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (nursing facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.

- If the original claim was billed electronically, a copy of the RA will suffice.
- If the RA is electronic, attach a screen print of the RA.

4. Verify the adjustment request has been signed and dated.

5. Send the adjustment request to Claims. (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
 Community Clinic
 123 Medical Drive
 Street or P.O. Box
 Anytown, MT 59999
 City State ZIP

2. Member Name
 Jane Doe

3. Internal Control Number/ICN
 0020401125000600

4. NP/APL
 1234567890

5. Member ID Number
 123456789

6. Date of Payment
 02/15/05

7. Amount of Payment
 \$ 11.49

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

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 3	02/01/05	01/23/05
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.)		04/15/05	

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

Sample Adjustment Form

Mass Adjustments

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

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

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

Payment and the RA

Providers receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who receive EFT must receive electronic RAs.

Electronic Funds Transfer

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

To participate in EFT, providers must complete a Standard Form 1199A Direct Deposit Sign-Up Form. (See the table on the following page.) 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. See Direct Deposit Arrangements under Key Contacts for questions or changes regarding EFT.

Electronic Remittance Advice

To receive an electronic RA, the provider must complete the Electronic Remittance Advice and Payment Cycle Enrollment Form, have Internet access, and be registered for the Montana Access to Health (MATH) web portal. You can access your electronic RA through the MATH web portal by going to the Provider Information [website](#) and clicking on the Log in to Montana Access to Health option. In order to access the MATH web portal, you must complete an EDI Provider Enrollment Form and an EDI Trading Partner Agreement

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

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



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.



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

Required Forms for EFT and/or Electronic RA

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

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health web portal. (Must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement.)	<ul style="list-style-type: none"> • Provider Information website • Provider Relations (See Key Contacts.) 	Provider Relations (See Key Contacts.)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account.	<ul style="list-style-type: none"> • Provider Information website • Provider's bank 	Provider Relations (See Key Contacts.)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health (MATH) web portal. (Must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form.)	<ul style="list-style-type: none"> • Provider Information website • EDI Gateway website (See Key Websites.) 	Address on the form

Other Programs

Healthy Montana Kids (HMK)

The information in this chapter applies to HMK-enrolled children when billing for dental, eyeglasses, RHC/FQHC clinic services or community-based psychiatric rehabilitation services.

For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#). (See Key Websites.)

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.

RHCs and FQHCs

RHCs and FQHCs are reimbursed for their costs of providing care using a prospective payment system. This payment allows for one all-inclusive rate of payment per visit. This payment is the same for core, other ambulatory and billable incident-to services.

Reimbursement Rates for Increase or Decrease in Scope of Service

An increase or decrease in the scope of service means the addition or deletion of a service or a change in the magnitude, intensity or character of services provided by a clinic or one of their sites. The increase or decrease in the scope of service must reasonably be expected to last at least one year. The term includes but is not limited to:

- An increase or decrease in intensity attributable to changes in the types of patients served, including but not limited to HIV/AIDS, the homeless, elderly, migrant or other chronic diseases or special populations;
- Any changes in services or provider mix provided by a clinic or one of their sites;
- Increases or decreases in operating costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new service facilities or regulatory compliance; and
- Any approved changes in scope of project as defined by the Health Resources and Service Administration (HRSA).

A clinic must notify the Department, in writing, of an increase or decrease in the scope of service offered by the clinic. Upon the request of a clinic, the Department will determine if a change qualifies as an increase or decrease in the scope of service, and if so, the amount and effective date of any rate increase or decrease.

How Payment Is Calculated

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 (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.

For example, a provider submits an RHC or FQHC claim for \$120.00 for a member with Medicaid and TPL. The Medicaid allowed amount is \$106.58. The other insurance company paid \$95.05. This amount is subtracted from the Medicaid allowed amount leaving \$11.53. Medicaid pays \$11.53 for this claim. If the TPL payment had been \$106.58 or more, this claim would have paid at \$0.00.

Medicare Crossover Claims for RHCs

When an RHC 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 RHC claims for these dually eligible individuals.

For example, an RHC provider submits a claim for a member with Medicare and Medicaid. The Medicare coinsurance and deductible total \$11.78. This total (\$11.78) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$11.78) as long as no TPL or incurment amounts are applicable.

Medicare Crossover Claims for FQHCs

When an FQHC member has coverage from both Medicare and Medicaid, Medicare is the primary payer, but any Medicare payment is treated like a TPL payment. Medicaid will make a payment only when the Medicare payment is less than the Medicaid allowed amount.

For example, an FQHC provider submits a claim for \$55 for a member with Medicare and Medicaid. The Medicaid allowed amount is \$106.58. Medicare paid \$75.58. This amount is subtracted from the Medicaid allowed amount leaving \$31.00. Medicaid pays \$31.00 for this claim. If the Medicare payment had been \$106.58 or more, this claim would have paid at \$0.00.

Other Programs

The information in this chapter does apply to HMK enrolled children when billing for dental, eyeglasses, RHC/FQHC clinic services, or community-based psychiatric rehabilitation services. For more information, contact BCBSMT at 1-800-447-7828. Additional information regarding HMK is available on the HMK website. (See Key Websites.)

Appendix A: Forms

- **Montana Health Care Programs Medicaid/MHSP/HMK
*Individual Adjustment Request***
- ***Medicaid Abortion Certification (MA-37)***
- ***Informed Consent to Sterilization (MA-38)***
- ***Medicaid Hysterectomy Acknowledgment (MA-39)***

Montana Health Care Programs Member/Physician Abortion Certification

Medicaid Abortion Certification (MA-37)

Montana Health Care Programs claims for abortion services will not be paid unless this form is completed in full and a copy is attached to the claim form.

Member Name _____ **Provider Name** _____

Part I, II, or III must be completed and the physician completing the procedure must sign below.

I. If the abortion is necessary to save the member's life, the following must be completed by the physician:

In my professional opinion, the member suffers from a physical disorder, physical injury, or physical illness (or life-endangering physical condition caused by or arising from the pregnancy itself) that would place the member in danger of death unless an abortion is performed.

(Attach additional sheets as necessary.)

II. If the pregnancy resulted from rape or incest, the following must be completed by the member and physician:

Member Certification: I hereby certify that my current pregnancy resulted from an act of rape or incest.

Physician Certification: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

- _____ a. The member has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or
- _____ b. Based upon my professional judgement, the member was and is unable for physical or psychological reasons to report the act of rape or incest.

III. If the abortion is medically necessary but the member's life is not in danger, the following must be completed by the physician:

In my professional opinion, an abortion is medically necessary for the following reasons:

(Attach additional sheets as necessary.)

Physician Signature _____ **Date** _____

The information contained in this form is confidential. This information is provided for purposes related to administration of Montana Health Care Programs and may not be released for any other purpose without the written consent of the member.

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked for
(Doctor or Clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____
(month) (day) (year)
I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(Signature) (Date)

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- American Indian or Black (not of Hispanic origin)
- Alaskan Native Hispanic
- Asian or Pacific Islander White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed
(name of individual)
the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Signature of person obtaining consent) (date)

(Facility)

(Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

(Name of person being sterilized)
on _____

(date of sterilization operation)
I explained to him/her the nature of the sterilization operation _____, the fact that it is
(specify type of operation)

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
- Individual's expected date of delivery: _____
- Emergency abdominal surgery:
(describe circumstances): _____

(Physician) (Date)

Instructions for Completing the MA-38

- No fields on this form may be left blank, except the interpreter's statement.
- This form must be legible and accurate, and revisions are not accepted.
- Do not use this form for hysterectomies. See Hysterectomy Acknowledgment form in this chapter.

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy).
3. Enter the member's date of birth in month/day/year format. The member must be at least 21 years old at the time of consent.
4. Enter the member's full name. Do not use nicknames. The name should match the member's name on the Medicaid ID card.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the member sign and date the form. **This date must be at least 30 days before the sterilization procedure is to be performed.** See *Covered Services* for exceptions.

Interpreter's Statement

Complete this section only if the member requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases, interpreter services must be used to assure that the member clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation. (e.g., Spanish, sign language)
2. Have the interpreter sign and date the form. This date should be the same as the date the member signs the form.

Statement of Person Obtaining Consent

1. Enter the member's name.
2. Enter the name of the sterilization procedure.
3. The person who explained the sterilization procedure to the member and obtained consent signs/dates.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the physician.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under *Instructions for use of alternative final paragraphs* to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the member's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.
5. The physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature delivery or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must also be indicated in this field.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

Signature of Representative (If Required): _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____
(Name of Recipient)
both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____
(Name of Recipient)
was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____
(Name of Recipient)
was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the MA-39

Complete only one section (A, B, or C) of this form. The does not need to sign this form when Sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the is already sterile, and for sterilization procedures (e.g., salpingo-oophorectomy, orchiectomy) done only for medical reasons. In these cases, replace the word “hysterectomy” with the appropriate procedure name.

Recipient Acknowledgment Statement (Section A)

This section is used to document that the received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The or representative must sign and date the form prior to the procedure.
2. Enter the 's name.
3. The physician must sign and date the form prior to the procedure.
4. If interpreter services are used, the interpreter must sign and date this portion of the form prior to the procedure.

Statement of Prior Sterility (Section B)

Complete this section if the was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy, orchiectomy).

1. Enter the 's name.
2. Explain the cause of the member's sterility (e.g., post menopausal, post hysterectomy).
3. The physician must sign and date this portion of the form.

Statement of Life-Threatening Emergency (Section C)

Complete this section in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the member's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

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 or another payer. Other cost factors, (such as cost sharing, 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

Any provider that is subordinate to the member's primary provider, or providing services in the facility or institution that has accepted the patient as a Medicaid member.

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.

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.

Clean Claim

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

Member

An individual enrolled in a Department medical assistance program.

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.

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 Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 Montana Code Annotated (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)

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

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental

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

Federally Qualified Health Center (FQHC)

An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet Medicare program requirements and is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 329, 330, or 340 of the Public Health Service Act. An FQHC may also be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

or by an Urban Indian Organization receiving funds under Title V of the Indian Health Care Improvement Act.

Fiscal Agent

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

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *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.

Health Improvement Program

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

Healthy Montana Kids (HMK)

This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by Blue Cross and Blue Shield of Montana (BCBSMT). Claims are sent to Xerox for HMK dental, eyeglasses, RHC/FOHC clinic services, or community-based psychiatric rehabilitation services.

Homebound

Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort.

Independent Entity

A rural health clinic or federally-qualified health center that is not a provider-based entity.

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

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

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

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the 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 avail-

able 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.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department. MHSP services are allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the mental health manual available on the Provider Information website. (See Key Contacts.)

Mentally Incompetent

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Minimal Services

According to CPT 2001, when member’s visit does not require the presence of the physician, but services are provided under the physician’s supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

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.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a precancerous condition.

Mutually Exclusive Code Pairs

These codes represent services or procedures that, based on either the CPT-4 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.

Nurse First Advice Line

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

Passport Referral Number

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

Passport to Health

The Medicaid primary care case management (PCCM) managed care program where the member selects a primary care provider (PCP) 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 or her own pocket.

Protocols

Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must be updated and approved by a physician at least annually.

Provider

The entity enrolled in the Montana Medicaid program as a provider of RHC or FQHC services.

Provider-Based Entity

An FQHC or RHC that is an integral or subordinate part of a hospital, skilled nursing facility, or home health agency that is participating in the Medicare program and that is operated with other departments of the provider under the common licensure, governance and professional supervision.

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.

Remittance Advice (RA)

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

Reporting Period

A period of 12 consecutive months specified by an RHC or FQHC as the period for which the entity must report its costs and utilization. The reporting period must correspond to the provider's fiscal year. The first and last reporting periods may be less than 12 months.

Retroactive Eligibility

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

Routine Podiatric Care

Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Rural Health Clinic (RHC)

A clinic located in a rural area designated as a shortage area by the Secretary of the U.S. Department of Health and Human Services to meet the rural health clinic conditions of certification specified in 42 CFR, Part 491, Subpart A.

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.

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 to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

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

Third Party Liability (TPL)

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

- Twelve months from whichever is later:
 - The date of service
 - The date retroactive eligibility or disability is determined
- Six months from the date on the Medicare explanation of benefits approving the service
- 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.

Usual and Customary

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

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