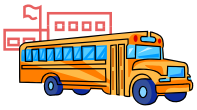

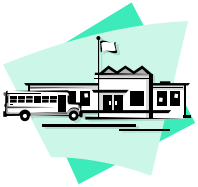

School-Based Services

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

May 2013

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My NPI:

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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

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

(406) 444-3964 Phone

Send written inquiries to:
Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Claims

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

CSCT Program

For more information on the Comprehensive School and Community Treatment (CSCT) program, contact the school-based program-specialist.

(406) 444-4066 Phone
(406) 444-3846 Fax
Send written inquiries to:
School-Based Program Specialist
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Direct Deposit Arrangements

Providers who would like to receive their electronic remittance advices 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/Our of state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:
MTPRHelpdesk@xerox.com
Montana EDI
P.O. Box 4936
Helena, MT 59604

Healthy Montana Kids (HMK)

(877) 543-7669 Phone (toll-free)
(877) 418-4533 Fax (toll-free)
(406) 444-6971 Phone (Helena)
(406) 444-4533 Fax (Helena)
hmk@mt.gov E-Mail

HMK Program Officer
P.O. Box 202951
Helena, MT 59620-2951

Member Eligibility

There are several methods for verifying member eligibility. For details on each, see Verifying Member Eligibility in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual.

FaxBack
(800) 714-0075 (24 hours)
Voice Response System
(800) 714-0060 (24 hours)
Montana Access to Health Web Portal
http://mtaccesstohealth.acs-shc.com/
Medifax EDI
(800) 444-4336, X 2072 (24 hours)

Member Help Line

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

(800) 362-8312

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

Nurse First

For questions regarding the Nurse First Advice Line, contact:

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

Nurse First 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. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Mountain-Pacific Quality Health

For prior authorization for school-based private duty nursing services:

(406) 443-4020 X150 Helena
(800) 262-1545 X150 Outside Helena
(406) 443-4585 Fax

Send written inquiries to:
Medicaid Utilization Review
Mountain-Pacific Quality Health
Helena, MT 59602

For questions regarding prior authorization for medical necessity therapy reviews:

(406) 457-5887 Local
(877) 443-4021 X5887 Toll-free
(877) 443-2580 Fax local/long distance

Send written inquiries to:
Mountain Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Magellan Medicaid Administration

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

Magellan Medicaid Administration
4300 Cox Road
Glen Allen, VA 23060

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In/Our of state
(406) 442-1837 Helena

Send written inquiries to:
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the Introduction chapter in the *General Information for Providers* manual. For inquiries related to licensure/endorsement, contact the Quality Assurance Division, Licensing Bureau:

(406) 444-2676 Phone
(406) 444-1742 Fax

Send written inquiries to:
Quality Assurance Division
Licensing Bureau
2401 Colonial Drive, Third Floor
Helena, MT 59602-2693

Provider Relations

For general claims questions, questions about eligibility, Passport to Health, payments, and denials:

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

Send e-mail inquiries to:
MTPRHelpdesk@xerox.com

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Secretary of State

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

(406) 444-2055 Phone

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

Surveillance / Utilization Review

To report suspected provider fraud/abuse:
(406) 444-4586
(800) 376-1115

To report suspected member fraud/abuse:
(800) 201-6308

Send written inquiries to:
Fraud and Abuse
SURS
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Team Care Program

For questions regarding Team Care:

(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 In/Out of state

Send written inquiries to:
Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Montana Department of Public Health and Human Services

Key Websites

Web Address	Information Available
EDI Gateway www.acs-gcro.com/	EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • EDI enrollment • EDI support • FAQs • Manuals • Provider services • Related links • Software
HMK Website www.hmk.mt.gov/	• Information on Healthy Montana Kids (HMK)
Montana Access to Health Web Portal https://mtaccesstohealth.acs-shc.com **Provider Information Website** http://medicaidprovider.hhs.mt.gov/index.shtml (www.mtmedicaid.org)	• FAQs • Fee schedules • HIPAA update • Key contacts • Links to other webistes • Medicaid forms • Medicaide news • Newsletters • Notices and manual replacement pages • Passport to Health information • Provider enrollment • Provider manuals • Remittance advice notices • Training resources • Upcoming events
Washington Publishing Company www.wpc-edi.com A fee is charged for documents; however, code lists are viewable online at no charge.	• HIPAA guides • HIPAA tools

Introduction

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

Manual Organization

This manual provides information specifically for the School-Based Services Program.

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

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

Manual Maintenance

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

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

Rule References

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

The following rules and regulations are specific to the school based services program. Additional Medicaid rule references are available in the *General Information for Providers manual*.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.2201 EPSDT Purpose, Eligibility and Scope
  - ARM 37.86.2206–2207 EPSDT Medical and Other Services; Reimbursement
  - ARM 37.86.2217 EPSDT Private Duty Nursing
  - ARM 37.86.2230–2235 EPSDT, School-Based Health Related Services

Getting Questions Answered

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

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

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims 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 (42 CFR 456.3).

Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance to certain individuals and families with low income. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments. Federal oversight for the Medicaid program lies with the Centers for Medicare and Medicaid Services (CMS) in the Department of Public Health and Human Services (DPHHS).

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a special program for Medicaid beneficiaries under 21 years of age. The purpose of EPSDT is to ensure that through periodic checkups and early detection, children's health problems are prevented and/or ameliorated. The EPSDT program allows states to provide services even if these services are not covered under the Medicaid state plan for other beneficiaries.

The Medicare Catastrophic Coverage Act, enacted in 1988, contained provisions which permit state Medicaid programs to provide reimbursement for health-related services provided as part of a child's Individualized Education Plan (IEP). This reversed a previous policy that Medicaid could not reimburse for services provided by schools. As a result of this act, the State of Montana allows schools and cooperatives to bill for Medicaid services provided to Medicaid members pursuant to an IEP.

Medicaid reimburses health-related services provided by schools that are written into an IEP, if the services are covered under the Medicaid state plan or are covered under EPSDT. Services billed to Medicaid must be provided by qualified practitioners with credentials meeting state and federal Medicaid program requirements. Medicaid provides reimbursement for health-related services and does not reimburse for services that are educational or instructional in nature.

Medicaid can be an important source of funding for schools, particularly because the cost of providing special education can greatly exceed the federal assistance provided under the Individuals with Disabilities Education Act (IDEA). Children who qualify for IDEA are frequently eligible for Medicaid services. Although Medicaid is traditionally the "payer of last resort" for health care services, it is required to reimburse for IDEA related medically necessary services for eligible children before IDEA funds are used.

In Montana, the Department of Public Health & Human Services, Medicaid Services Bureau, administers the Medicaid School-Based Services Program. This guide contains specific technical information about program requirements associated with seeking payment for covered services rendered in a school setting. The purpose of this guide is to inform schools on the appropriate methods for claiming reimbursement for the costs of health-related services provided.

Covered Services

General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA).
- The services are written into an Individual Education Plan (IEP).
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all members without charge.
- For CSCT services, children must have a serious emotional disturbance (SED) diagnosis as specified under ARM 37.87.303.

Refer to the IEP requirements in this chapter and the Coordination of Benefits chapter regarding billing services included/not included in a child's IEP.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in this manual and the *General Information for Providers* manual. School-based services provided to Medicaid members include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology)
- Audiology
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation
- Orientation and Mobility Specialist services (for blind and low vision)

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a comprehensive approach to health care for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health

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problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable prior authorization requirements apply. (See the Prior Authorization chapter in this manual.)

Services within Scope of Practice (ARM 37.85.401)

Services provided under the School-Based Services Program are covered only when they are within the scope of the provider's license.

Provider Requirements

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: • Licensed registered nurse • Licensed practical nurse	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: • Credentialed school psychologist • Licensed psychologist • Licensed clinical professional counselor • Licensed clinical social worker	Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: • Licensed occupational therapist • Licensed physical therapist • Licensed speech language pathologists	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Audiology	Must meet credentialing requirements as defined by the Montana Licensing Board
Personal care paraprofessional	No licensing requirements
Comprehensive School and Community Treatment (CSCT)	Must be provided by a licensed mental health center with a CSCT endorsement
Orientation and Mobility Specialist	Must have certification of the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP) or a National Blindness Professional Certification (NOMC) from the National Blindness Professional Certification Board (NBPCB)

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Medicaid providers who have had their license suspended by a state or federal government entity may not provide school-based services.

Services provided to Medicaid members must be documented in the member's IEP.

IEP Requirements

Services provided to Medicaid members must be covered by Medicaid and documented in the member's Individualized Education Plan (IEP), unless otherwise specified. School-based providers may bill Medicaid for Medicaid-covered health-related services provided to children with those services written into the IEP, even though the services may be provided to non-Medicaid children for free. However, if a child is covered by both Medicaid and private insurance, the private insurance must be billed prior to Medicaid. Exception to billing other insurance: Blue Cross and Blue Shield of Montana and HMK.

Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid.
- Services are medically necessary.
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes).
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis.
- The provider bills all individuals and/or the insurance carrier for the medical service provided.

Member Qualifications

To qualify for Medicaid school-based services, the member must be a Medicaid member and meet all the following criteria:

- Be Medicaid-eligible on the date of service.
- Be between the ages 3 and 20.
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA).
- Have Medicaid reimbursable services referenced in his or her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
- In the case of CSCT services, the member must have an SED diagnosis and services may or may not be included in the client's IEP.

Cooperatives, joint boards, and non-public schools that do not receive state general funds for special education can not participate in the Medicaid program as a school-based provider.

School Qualifications

Only public school districts, full-service education cooperatives and joint boards of trustees may enroll in the Montana Medicaid School-Based Services Program. To qualify, the district, cooperative or joint board must receive special education funding from the state's Office of Public Instruction general fund for public education. School districts include elementary, high school and K–12 districts that provide public educational services. Full-service education cooperatives and joint boards include those cooperatives eligible to receive direct state aid payments from the Superintendent of Public Instruction for special education services.

Schools That Employ Medical Service Providers

- Schools that employ all or most of their medical service providers for whom the school submits bills can be enrolled with a single NPI for all services.
- Schools may use this single NPI to bill for any Medicaid covered service provided by a licensed provider.
- Schools that wish to have separate NPIs for each provider type (e.g., speech therapists, occupational therapists, and physical therapists) can request separate NPIs from the National Plan and Provider Enumeration System (NPPES).

Schools That Contract with External Medical Service Providers

- Schools that contract with all or most of their providers must have the provider of service bill for each service they provide with their own individual NPI.
- Providers and schools can arrange with the Department for payments to be made to the school. If payments are assigned to the school, the school will also have the responsibility to collect third party liability payments on behalf of the service providers.

For more information on enrollment, visit the Provider Information website or contact Provider Enrollment. (See Key Contacts.)

Physician Order/Referral

Medicaid does not require physician orders or referrals for health-related services that are documented in the member's IEP. The exception is private duty nursing services and personal care assistant services, which require a written order for private-duty nursing or physician signature for personal care assistance services. Other health-related services can be authorized by a licensed school practitioner meeting the State of Montana provider requirements to secure health-related services under an IEP.

Documentation Requirements

School-based services providers must maintain appropriate records. All case records must be current and available upon request. Records can be stored in any readily accessible format and location, and must be kept for six years and three months from the date of service. For more information on record keeping requirements, see the Surveillance/Utilization Review chapter in the *General Information for Providers* manual.

Medical documentation must include the following:

- Keep legible records.
- Date of service and the child's name.
- The services provided during the course of each treatment and how the child responded.
- Except for CSCT, the services for which the school is billing Medicaid must be written into the child's IEP.
- If the service is based on time units, (i.e., 15 minutes per unit), the provider of service should indicate begin and end times or the amount of time spent for each service. A service must take at least 8 minutes to bill one unit of service if the procedure has "per 15 minutes" in its description.
- Providers must sign and date each record documented on the day the medical service was rendered. Provider initials on daily records are acceptable providing their signature is included in other medical documentation within the child's record.
- Documentation must, at least quarterly, include notes on member progress toward their goals.
- The service provider must keep sufficient documentation to support the procedures billed to Medicaid. If a service is not documented, it did not happen.
- Documentation must not be created retroactively. Providers are responsible for maintaining records at the time of service.
- CSCT services are not required to be included in the IEP because often members that require these services do not fit the special education requirements. The clinical assessment must document the medical necessity and the clinical treatment plan must demonstrate how the CSCT services will address the medical necessity. In addition to the above requirements, CSCT documentation must also include:
    - Where services were provided;
    - Result of service and how it relates to the treatment plan and goals;
    - Progress notes for each individual therapy and other direct service;
    - Monthly overall progress notes; and
    - Individual outcomes compared to baseline measures and established benchmarks.

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The Montana Medicaid School-Based Services Program is subject to both state and federal audits. As the Medicaid provider, the school certifies that the services being claimed for Medicaid reimbursement are medically necessary and furnished under the provider's direction. Both fiscal and clinical compliance are monitored. In the event of adverse findings, the district/cooperative (not the mental health provider) will be held responsible for any paybacks to Medicaid. If school districts have included a program area for CSCT in their accounting system, then the district can book revenue received from third party insurers or parents that paid privately for CSCT services, providing audit documentation. To assist in document retention for audit purposes, see the Audit Preparation Checklist on the Montana Medicaid Provider Information website.

Noncovered Services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Medicaid.

- A provider's time while attending member care meetings, Individual Educational Plan (IEP) meetings, individual treatment plan meetings, or member-related meetings with other medical professionals or family members
- A provider's time while completing IEP related paperwork or reports, writing the CSCT individualized treatment plans or documenting medical services provided
- CSCT services provided without an individualized treatment plan for this service
- Services considered experimental or investigational
- Services that are educational or instructional in nature
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment.

Use the current fee schedule for your provider type to verify coverage for specific services.

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department's school-based services fee schedule. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT and HCPCS coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Fee schedules are available on the Provider Information website. (See Key Websites.)

The CSCT Program must follow free care rules. See the *Definitions* chapter.

Coverage of Specific Services

The following are coverage rules for specific school-based services.

Assessment to Initiate an IEP

Medicaid covers medical evaluations (assessments) to develop an IEP as long as an IEP is subsequently established and health-related needs are identified.

Comprehensive School and Community Treatment (CSCT)

As of July 2012, the CSCT program moved from the Health Resources Division to the Children's Mental Health Bureau (CMHB). Guidance related to the CSCT program can now be found in the Youth Mental Health Services manual, which can be found on the Provider Information.

Therapy Services

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's NPI. (See the Billing Procedures chapter in this manual.)

- Speech therapy aides require personal, direct supervision by the licensed provider in accordance with the following guidelines:
- Speech therapy aides:
  - Aide 1 = supervised on-site a minimum of 10% of member contact time. At the discretion of the supervising speech-language pathologist, the on-site supervision requirement may be reduced to 2% after the first year of supervision.
  - Aide 2 = shall be supervised on-site 10% of member contact time.
  - Aide 3 = shall be supervised on-site 20% of member contact time. Refer to ARM 24.222.702.

The levels of supervision for occupational and physical therapy aides and assistants are as follows:

- **Direct:** The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the member-related procedure being performed.
- **Routine:** The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- **General:** Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.
- Temporary Practice Permit holders (new graduates from occupational therapy school who are waiting for their national exam results) **must** work **under routine** supervision of the licensed therapist. **If the exam is failed, the Temporary Practice Permit immediately becomes void.** Routine supervision requires direct contact at least daily at the site of work.
- Occupational Therapy Assistants require **general** supervision, meaning the licensed provider does not have to be physically on the premises at the time

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of the service. However, the licensed therapist must provide face-to-face supervision at least monthly.

- Occupational Therapy Aides require **direct** supervision by a licensed occupational therapist or a certified occupational therapy assistant. This means the licensed provider must be present in the office and immediately available to the aide.
- Physical Therapy Aides/Assistants require **general** supervision, meaning that the licensed provider must be on the premises.
- Temporarily licensed therapists can never supervise anyone.

Services Included

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the member's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the member's IEP.
- Assessment services to determine member medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

Service Requirements

For all therapies being billed, they must be included in the student's IEP.

Services Restricted

- Montana Medicaid does not cover therapy services that are intended to maintain a member's current condition but only covers services to improve member functions.
- Therapy services are limited to 40 hours per state fiscal year (July 1-June 30) for each type of therapy. **Note:** Early Periodic Screening, Diagnosis, and Treatment (EPSDT) rules make this limit an exception to the 40 hours.

Private Duty Nursing Services

Private duty nursing services are skilled nursing services provided by a registered or licensed practical nurse.

Service Requirements

Medicaid covers private duty nursing services when all of the following requirements are met:

- When the member's attending physician or mid-level practitioner orders these services in writing
- When prior authorization (PA) is obtained. (See the Prior Authorization chapter in this manual for PA requirements.)

School Psychologists and Mental Health Services

Psychological services in schools are based on determining eligibility for inclusion in special education programming and not necessarily to determine a medical diagnosis outside of the guidelines of the Individuals with Disabilities Education Act.

Services Included

Psychological and mental health services include the following:

- Individual psychological therapy.
- Psychological tests and other assessment procedures when the assessment results in health-related services being written into the IEP.
- Interpreting assessment results.
- Obtaining, integrating and interpreting information about child behavior and conditions as it affects learning, if it results in an IEP. This only includes direct face-to-face service.
- Mental health and counseling services that are documented on the member's IEP.
- Consultation with the child's parent as part of the child's treatment.

Service Requirements

Medicaid covers psychological counseling services when the following two criteria are met:

- The member's IEP includes a behavior management plan that documents the need for the services.
- Service is not provided concurrently with CSCT services (unless prior authorization has been obtained).

Services Restricted

Montana Medicaid does not cover the following psychological services:

- Testing for educational purposes
- Psychological evaluation, if provided to a child when an IEP is not subsequently established
- Review of educational records
- Classroom observation
- Scoring tests

Personal Care Paraprofessional Services

Personal care paraprofessional services are medically necessary in-school services provided to members whose health conditions cause them to be limited in performing activities of daily living. That is, these services are provided for members with functional limitations.

The school district must maintain documentation of each service provided, which may take the form of a trip log.

Medicaid does not cover special transportation services on a day that the member does not receive a Medicaid-covered service that is written into the IEP.

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Services Included

These activities of daily living services include:

- Dressing
- Eating
- Escorting on bus
- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

Service Requirements

- These services must be listed on the member's IEP.
- Approval must be given by the member's primary care provider prior to billing for Medicaid covered services. This is done by the use of the Child Profile Form located in Appendix B.

Services Restricted

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

See the Personal Care Paraprofessional Services Documentation, which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

Special Needs Transportation

Special needs transportation includes transportation services for members with special needs that are outside of traditional transportation services provided for members without disabilities.

Services Include

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided.
- The Medicaid-covered service is included in the member's IEP.
- The member's IEP includes specialized transportation service as a medical need.

Specialized transportation services are covered if one of the following conditions exists:

- A member requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus.
- A member resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered.

Services Included

Special needs transportation includes the following:

- Transportation from the member's place of residence to school (where the member receives health-related services covered by the Montana School-Based Services Program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-Based Services Program, and return to school.

Services Restricted

Members with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana School-Based Services Program. The fact that members may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

Audiology

Audiology assessments are performed by individuals possessing the state of Montana credentials for performing audiology services.

Services Included

Covered audiology services include the following:

- Assessment to determine member's medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.
- Services provided must be documented in the member's IEP.

Service Requirements

Medicaid covers audiology services when the services to be provided during a school year are written into the child's IEP.

Services Restricted

Medicaid does not cover the following audiology services:

- Testing for educational purposes.
- Services provided during Child Find assessments.

Orientation and Mobility Specialist Services

Orientation and Mobility Specialist services are medically necessary in-school services provided to students to alleviate movement deficiencies resulting from a lack of vision.

Orientation and Mobility Specialists need to have a certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or a National Orientation & Mobility Certification (NOMC) offered by the National Blindness Professional Certification Board (NBPCB). The credential is valid for a period of 5 years and is renewable by documenting work and/or participation in professional activities.

Services Included

Orintation & Mobility Specialist service include the following:

- Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct one-on-one patient contact by provider.
- Self-care/home management training (e.g., ADLs and compensatory training, instruction in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider.
- See School-Based fee schedule online for the correct CPT codes to use when billing.

Authorization Requirements Summary

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and Passport provider approval, see the Prior Authorization and Passport to Health chapters in this manual.

Authorization Requirements

Service	Prior Authorization	Passport Provider Approval	Written Physician Order/Referral
Therapy	**No**	**No**	**No**
Private Duty Nursing	**Yes**	**No**	**Yes**
School Psychologist and Mental Health	**No**	**No**	**No**
Personal Care Paraprofessional	**No**	**No**	**Yes** (Child Profile Form is signed by child's physician.)
Specialized Transportation	**No**	**No**	**No**
Audiology	**No**	**No**	**No**
Orientation & Mobility	**No**	**No**	**No**

Other Programs

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

Children's Mental Health Services Plan (CMHSP)

The school-based services in this manual are not covered benefits of the Children's Mental Health Services Plan (CMHSP) administered by the Children's Mental Health Bureau. However, the mental health services in this chapter are covered benefits for Medicaid members. For more information on the CMHSP program, see the mental health annual available on the Provider Information website (see Key Contacts).

Healthy Montana Kids (HMK)

The school-based services in this manual are not covered benefits of Healthy Montana Kids (HMK). Additional information regarding HMK benefits is available by contacting Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828 (toll-free) or 406-447-7828 (Helena).

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Passport to Health Program

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

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HM *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.

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

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–member relationship. An effective medical home is accessible, continuous, comprehensive, 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 PCP. (See the section titled Services That Do Not Require Passport Provider Approval in this chapter.)

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

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 MATH web portal, a Team Care member's provider and pharmacy will be listed. (See Key Websites.) Write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

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

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

Health Improvement Program (ARM 37.86.5201–5206)

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

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

conditions that would benefit from case management from HIP using the HIP referral form included at the health Improvement Program link on the Provider Information website. (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. Specific PA requirements can be found in the provider fee schedules. For more information on Passport to Health, see the *General Information for Providers* manual.

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.

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

Prior Authorization

What Is Prior Authorization (ARM 37.86.5101–5120)

Prior authorization (PA), Passport to Health, and Team Care are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, 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. (See the Submitting a Claim chapter in this manual.)

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. See below for instructions on how to obtain PA for covered services.

Some services require PA before they are provided, such as private duty nursing services. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The PA Criteria for Specific Services table 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 PA Criteria for Specific Services table for documentation requirements.)
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

Getting Questions Answered

The Key Contacts chapter at the front of this manual provides important phone numbers and addresses. Help lines are available to get general Medicaid questions answered.

PA Criteria for Specific Services		
Service	**PA Contact**	**Requirements**
Private duty nursing	Medicaid Utilization Review Dept. Mountain Pacific Quality Health P.O. Box 6488 Helena, MT 59604-6488 Questions regarding this process can be answered by calling: **Helena** (406) 443-4020 X150 **Outside Helena** (800) 262-1545 X50 **Fax** (406) 443-4585	The number of units approved for private duty nursing services is based on the time required to perform a skilled nursing task. • A prior authorization request must be sent to the Medicaid Utilization Review Department's peer review organization accompanied by a physician or mid-level practitioner order/referral for private duty nursing. • Prior authorization must be requested at the time of initial submission of the nursing plan of care and any time the plan of care is amended. • Providers of private duty nursing services are responsible for requesting prior authorization and obtaining renewal of prior authorization. • Requests for prior authorization must be obtained for the regular school year (August/September through May/June). Services provided during the summer months must be prior authorized in addition to the services provided during the regular school year. Remember, schools are responsible for obtaining the physician orders for new or amended requests for prior authorization. Prior authorization requests must be submitted to Mountain Pacific Quality Health ***in advance*** of providing the service. • Providers are required to send in prior authorization requests two weeks prior to the current prior authorization request end date for members receiving ongoing services. • Total number for units of service paid on claims must not exceed those authorized by the Medicaid Utilization Review Department. Payment will not be made for units of service in excess of those approved. • No retrospective prior authorization reviews will be allowed. • To request prior approval submit a completed Request for Private Duty Nursing Services form located on the Provider Information website under Forms. Send completed requests to the contact shown in the second column.

Other Programs

The Children's Mental Health Services Plan (CMHSP) and Healthy Montana Kids (HMK) do not cover school-based services. For more information on these programs, visit the Provider Information website. (See Key Websites.)

Coordination of Benefits

When Members Have Other Coverage

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

Identifying Other Sources of Coverage

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

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

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

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

When a Member Has Medicare

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

Medicare Part B Crossover Claims

Medicare Part B covers outpatient hospital care, physician care, and other services including those provided in a school setting. The Department has an agreement with Medicare Part B carrier for Montana (Noridian) and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement,

the carrier provide the Department with a magnetic tape of claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their NPI on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit. (See Billing Procedures.)

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.
- 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 submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Billing Procedures chapter in this manual.

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 with a copy of the Medicare EOMB to Medicaid for processing.

Submitting Medicare Claims to Medicaid

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

All Part B crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

Remember to submit Medicare crossover claims to Medicaid only when:
• The referral to Medicaid statement is missing from the provider's EOMB. • The provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB. • Medicare denies the claim.

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.

If a parent determines that billing their insurance would cause a financial hardship (e.g., decrease lifetime coverage or increase premiums), and refuses to let the school bill the insurance plan, the school cannot bill Medicaid for these services based on requirements of IDEA.

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."

If a parent refuses to let the school bill their insurance plan, Medicaid cannot be billed either.

CSCT Services

Procedure H0036 is a Medicaid-only code and other insurances do not recognize it as a valid procedure code. Providers of CSCT services must bill the appropriate CPT codes to other payers, as those payers require (i.e., licensed staff may provide an individual therapy to a child in CSCT, bill CPT code that best describes service provided). When billing Medicaid after TPL, submit total charges/units for that date under the H0036 code and enter the amount paid by the other insurance on the claim. Do not bill CSCT services under any other code than H0036 to Medicaid.

Billing for Medicaid Covered Services When No IEP Exists

In order to bill for Medicaid covered services that are not in the member's IEP, the school must meet all the following requirements:

- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

If the school bills private pay members, then they must bill as follows for the services provided:

Member Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid*	Bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Billing for Medicaid Covered Services under an IEP

If a child is covered by both Medicaid and private insurance, and the services are provided under an IEP, providers must bill as follows:

Member Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Not required to bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid	Not required to bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first.

- When a Medicaid member is also covered by Indian Health Service (IHS) or the Montana Crime Victims Compensation Fund, providers must bill Medicaid before IHS or Crime Victims. These are not considered third party liability.
- When a member has Medicaid eligibility and Children's Mental Health Services Plan (CMHSP) eligibility for the same month, Medicaid must be billed before CMHSP.
- When a child is covered under BCBSMT or HMK, providers may bill Medicaid first since these insurances do not cover services provided in a school setting.
- Medicaid must be billed before IDEA funds are used.
- Effective April 1, 2013, when a child is also covered by another insurance, and the service is provided by a school-based provider, no blanket denial form is required nor is any information from the third party liability.

Requesting an Exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the TPL Unit. (See Key Contacts.)

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

- When the Child Support Enforcement Division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  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 EOB when billing Medicaid.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim and submit to Medicaid. If a blanket denial is provided, the Department will accept and allow this denial for a period of no more than two years. The school must include a copy of this blanket denial with each submission for health-related services for each member. The blanket denial must be specific to the provider, member, and health-related services provided to the member. Blanket denials issued to schools without a member's name will not be accepted.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

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.

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:

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

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically on a Professional claim or on a CMS-1500 paper claim form. CMS-1500 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.

- ***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 Providers Cannot Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid.

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

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a member fails to arrive for a scheduled appointment.
- When services are free to the member and free to non-Medicaid covered individuals.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

There is no member cost sharing for school-based services.

Billing for Members with Other Insurance

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

Billing for Retroactively Eligible Members

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

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

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

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.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

The procedure codes listed in the following table are valid procedures for schools to use for billing Medicaid.

School-Based Services Codes

Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15-minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15-minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15-minute unit
School Psychologist / Mental Health Services		
Psychological therapy – individual	90804	Per 30-minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96101	Per hour
CSCT Program		
CSCT services	H0036	15-minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15-minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip
Audiology		
Audiology evaluation	92557	Per visit
Tympanometry	92567	Per visit
Evoked otoacoustic emission; limited	92587	Per visit

Using Modifiers

School-based services providers only use modifiers for coding when the service provided to a member is not typical. The modifiers are used in addition to the CPT codes. The following modifiers may be used in schools:

- Modifier 52 is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.
- Modifier 22 is billed with the procedure code when a service is greater than the customary service normally entails. For example, this modifier may be used when a service is more extensive than usual or there was an increased risk to the individual. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- Modifier 59 is billed for therapies in accordance with the Correct Coding Initiative (CCI) and to be used when codes are considered mutually exclusive or a component of one another.
- Modifiers may also be required when providing two services in the same day that use the same code. See the section titled Multiple Services on the Same Date" for more information.

Multiple Services on the Same Date

When a provider bills Medicaid for two services that are provided on the same day that use the same CPT code and are billed under the same NPI and taxonomy, a modifier should be used to prevent the second service from being denied. The modifier GO is used for occupational therapy, and modifier GP is used for physical therapy. One of the codes needs to have modifier 59 also for the CCI edit. For example, a school bills with one NPI and taxonomy for all services. The school provided occupational therapy for a member in the morning, and physical therapy for the same member in the afternoon of October 14, 2003. The claim would be billed like this:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	14	03	10	14	03	03	0	97530	GO 59	1	22 00		1			
2 10	14	03	10	14	03	03	0	97530	GP	1	22 00		1			

Time and Units

- A provider may bill only time spent directly with a member. Time spent traveling to provide a service and paperwork associated with the direct service cannot be included in the time spent providing a service.
- Some CPT codes are designed to bill in units of 15 minutes (or other time increment) and others are per visit.
- If the service provided is using a per visit code, providers should use one unit of service per visit.
- When using codes that are based on a 15-minute time unit, providers should bill one unit of service for each 15-minute period of service provided. Units round up to the next unit after 8 minutes.

Place of Service

The only place of service code Montana Medicaid will accept is “03” (schools).

Billing for Specific Services

The following are instructions for billing for school-based services. For details on how to complete a CMS-1500 claim form, see the Submitting a Claim chapter in this manual.

School-based providers can only bill services in the amount, scope, and duration listed in the IEP. Medicaid covered services provided under an Individual Education Plan (IEP) are exempt from the “free care” rule. That is, providers may bill Medicaid for a covered service provided to a member under an IEP even though they may be provided to non-Medicaid members for free.

Assessment to Initiate an IEP

When billing for assessments (evaluations), use the CPT code for the type of service being billed. When the unit measurement is “per visit,” only one unit may be billed for the assessment/evaluation. If the evaluation is completed over the course of several days, it is considered one evaluation. Bill the date span with 1 unit of service, not multiple units of service. For example, a speech/hearing evaluation completed over a three-day period would be billed like this:

24. A						B	C	D		E	F		G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY												
1 09	23	03	09	26	03	03	0	92506		1	$65	00	1				

Montana Department of Public Health and Human Services

A two-hour psychological assessment (evaluation) would be billed like this (the unit measurement for this code is “per hour”):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	23	03	09	23	03	03	0	96100		1	$ 90 00	2				

Therapy Services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school’s NPI and taxonomy. Schools are responsible for assuring the proper supervision is provided for aides/assistants. (See the Covered Services chapter.) Remember to use the CCI edit modifier for all three types of therapy: speech, occupational and physical. See the Submitting a Claim chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is “15-minute unit”):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
12	02	03	12	02	03	03	0	97530		1	$ 40 00	2				

Private Duty Nursing Services

Prior authorization is required for these services, so remember to include the prior authorization number on the claim. (See the Submitting a Claim chapter in this manual.) Private duty nursing services provided for 15 minutes would be billed like this:

Medicaid covered services provided under an IEP are exempt from the “free care rule.”

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1000		1	$ 5 00	1				

School Psychologists and Mental Health Services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is per 30-minute unit):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	90804		1	$50 00	1				

Personal Care Paraprofessional Services

Personal care services provided to a member for 2 hours during a day would be billed like this (the unit measurement for this code is per 15-minute unit):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1019		1	$24 00	8				

Special Needs Transportation

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a member was transported from his/her residence to school and received Medicaid covered health-related services that day, and then transported back to his/her residence, it would be billed like this:

24. A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY											
09	02	03	09	02	03	03	0	T2003		1	$20 00	2				

Audiology

An audiology assessment would be billed like this (the unit measurement for this code is per visit):

24. A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY											
09	02	03	09	04	03	03	0	92557		1	$35 00	1				

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** Xerox makes this free software available for providers to create and submit claims to Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox clearinghouse.** Providers can send claims to the Xerox clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format they accept. The provider's clearinghouse then sends the claim to ACS EDI Gateway in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Xerox. EDIFECS certification is completed through EDI Gateway. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see Key Contacts).

- **Montana Access to Health (MATH) web portal.** Providers can acccess electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **B2B Gateway SFTP/FTPS site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high frequency submitters.
- **MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.

For more information on electronic claims submission options, contact Provider Relations or the EDI Technical Help Desk. (See the Key Contacts chapter.) Providers should be familiar with federal rules and regulations and Montana-specific information for sending and receiving electronic transactions. They are available on the EDI Gateway website. (See Key Websites.)

Billing Electronically with Paper Attachments

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

9999999999 - **888888888** - **11182003**

Provider NPI | Member ID | Date of Service MMDDYYYY

The supporting documentation must be submitted with a paperwork attachment cover sheet. See the Forms page of the Provider Information website. The number in the paper Attachment Control Number field must match the number on the cover sheet.

Submitting Paper Claims

For instructions on completing a paper claim, see the Submitting a Claim chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

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

Claim Inquiries

Contact Provider Relations for claim questions, or questions regarding payments, denials, member eligibility.

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

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied.

To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider NPI missing or invalid	The provider NPI is a **10-digit** number assigned to the provider by the National Plan and Provider Enumeration System. Verify the **correct provider NPI** 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, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
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.
Member number not on file, or member was not eligible on date of service	Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual. Medicaid eligibility may change monthly.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim. See the 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.

Common Billing Errors	
Reasons for Return or Denial	**How to Prevent Returned or Denied Claims**
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 (see the Remittance Advices and Adjustments chapter 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 (see the Key Contacts chapter) before submitting a claim.
Claim past 12-month 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 the Key Contacts chapter.
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 NPI 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

The Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) do not cover school-based services. For more information on these programs, visit the Provider Information website.

Additional information regarding HMK benefits is available on the HMK website or by contacting Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828 (toll-free) or 406-447-7828 (Helena).

Submitting a Claim

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the Billing Procedures chapter in this manual).

When completing a claim, remember the following:

- Required fields are indicated by *.
- Fields that are required if the information is applicable to the situation or member are indicated by **.
- Field 24h, EPSDT/Family Planning, is used as an indicator to specify additional details for certain members or services. The following are accepted codes:

EPSDT/Family Planning Indicators

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

- Unless otherwise stated, all paper claims must be mailed to the following address:

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

Montana Department of Public Health and Human Services

Sample Claim

Field	Field Title	Instructions
Member Information		
2*	Member's Name	Enter patient's name as seen on member's Montana Health Care Programs information
10d *	Member's ID	Enter the member's ID number as it appears on the member's Montana Health Care Programs information.
1a, 9a, 11**	Member's ID	If member's ID is not located in 10d these three fields are searched for the number
24h*	EPSDT Family Planning	When billing electronically, use "Y." When billing on paper, use "1."
Provider Information		
24a shaded area	NDC	Enter the qualifier, N4, followed by the NDC (NDC should not have punctuation, dashes or spaces), units qualifier and units as described by the qualifier
24i shaded **	ID Qualifier	ZZ for the Taxonomy qualifier
24j shaded **	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j **	NPI, Rendering Prov	Enter NPI Number for the rendering provider.
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used. Enter modifiers if applicable.
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1,2,3,or 4) that refers to the codes in field 21
24f*	Charges	Enter the total charge for this line
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

*Required Field **Required if applicable

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE MM 04 DD 28 YY 92 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. RESERVED FOR LOCAL USE: 999999999

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM 01 DD 01 YY 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 313.31 3. .

2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	09	03	09	09	03	03		92507					1	$ 30 00	1		NPI	ZZ 36LP00000X
2	09	16	03	09	16	03	03		92507					1	$ 30 00	1		NPI	1213456789 ZZ 36LP00000X
3	09	22	03	09	22	03	03		92508					1	$ 12 50	1		NPI	1213456789 ZZ 36LP00000X
4																		NPI	1213456789
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $

29. AMOUNT PAID $ $72 50

30. BALANCE DUE $ $72 50

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Sally Jones DATE 09/30/03

32. SERVICE FACILITY LOCATION INFORMATION

Public School
123 Education Drive
Anytown, MT 59999

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 555-1234

Public School
P.O. Box 999
Anytown, MT 59999-1234

a. 9876543210 b. ZZ400RT0010X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CMS-1500 Agreement

Your signature on the CMS-1500 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).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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 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 field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Member ID number missing or invalid	This is a required field (field 10d); verify that the member's Medicaid ID number is listed as it appears on the member's ID card.
Member name missing	This is a required field (field 2); check that it is correct.
Provider NPI missing or invalid	The provider NPI is a **10-digit** number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23. (See the Prior Authorization chapter in this manual.)
Not enough information regarding other coverage	Fields 1a and 11d are required fields 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 hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Other Programs

This chapter also applies to claims forms completed for MHSP services and Healthy Montana Kids (HMK) eyeglass services.

Montana Department of Public Health and Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending).

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

If the claim was suspended or denied, the RA also shows the reason.

To access the MATH web portal, you must first complete a Provider Enrollment Form and an Trading Partner Agreement (see the following table). To receive an electronic RA, the provider must complete a Trading Partner Agreement and register 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 selecting Log in to Montana Access to Health.

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

If a claim was denied, read the description of the EOB before taking any action on the claim.

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

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

The RA is divided into the following sections:

Sections of the Paper RA	
Section	**Description**
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 may 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 requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted. (See Adjustments later in this chapter.)
Denied Caims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 18). The Reason and Remark Code Description located at the end of the RA explains why the claim was denied. See the section titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter.
Pending Caims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). 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 section (Field 18) located at the end of the RA will explain why the claim is suspended. This section is informational only. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. 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 Balance Claims	Credit balance claims are shown here until the credit has been satisfied.
Gross Adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and Remark Code Description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Montana Department of Public Health and Human Services

Sample Remittance Notice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

1

PUBLIC SCHOOL
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

2 VENDOR# 00012134567
NPI# 12134567890 7

3 REMIT ADVICE# 123456
REMIT ADVICE# 1234567890 8

4 EPT/CHK# 654321

5 DATE 02/15/2010

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RECIP ID	NAME	SERVICE DATES FROM (12)	TO	UNIT OF SVC (13)	PROCEDURE REVENUE NDC (14)	TOTAL CHARGES (15)	ALLOWED (16)	CO-PAY (17)	REASON/ REMARK CODES (18)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789 9	DOE, JOHN EDWARD 10	100103	100103	1	97530	23.74	23.74	N	
11 ICN	00327411250000700								
		LESS MEDICARE PAID*******					21.25		
		CLAIM TOTAL*******				23.74	2.49 19		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	100203	100203	1	92507	53.54	0.00	N	
ICN	00327511250000800								
		100203	100203	1	92508	21.76	0.00 19	N	31MA61
		CLAIM TOTAL*******				75.30			
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	100303	100203	1	90804	51.67	0.00 19	N	133
ICN	00327611250000900	100203	100203	1	92507	53.54	0.00	N	133
		CLAIM TOTAL*******				105.21			

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

31 PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 MISSING/INCOMPLETE/INVALID HEALTH INSURANCE CLAIM NUMBER.

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. Vendor #	The 7-digit number assigned to the provider.
3. Remittance advice number	The remittance advice number.
4. EFT/Check number	The EFT or check number of payment
5. Date	The date the RA was issued.
6. Page number	The page number of the RA.
7. NPI	A unique 10-digit identification number requried by HIPAA for all U.S. health care providers. Providers must use their NPI to identify themselves in all HIPAA transactions.
8. Taxonomy	Alphanumeric code that indicate's the provider's specialty.
9. Member ID	The member's Medicaid ID number.
10. Name	The member's name.
11. Internal control number (ICN)	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: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) 6 = Pharmacy B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
12. Service dates	Dates services were provided. If services were performed in a single day, the same date will appear in both columns.
13. Unit of service	The units of service rendered under this procedure or NDC code.
14. Procedure/Revenue/NDC	The procedure code (CPT or HCPCS), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
15. Total charges	The amount a provider billed for this service.
16. Allowed	The Medicaid allowed amount.
17. Copayment	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
18. Reason and remark codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
19. 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.

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.

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

Credit balances can be resolved in two ways:

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

Rebilling and Adjustments

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

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

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 Billings Procedure chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking the TPL unit to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as NPI and taxonomy or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures and Submitting a Claim chapters.

When to Rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Reason and Remark Code/ Description, make the appropriate corrections, and resubmit the claim (not an adjustment).

Rebill denied claims only after appropriate corrections have been made.

Montana Department of Public Health and Human Services

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an 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.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information, and submit to Medicaid.

Adjustments can only be made to paid claims.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or submit a claim inquiry for review. (See the Billing Procedures chapter, Claim Inquiries.) Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request 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.

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, provider NPI, date of service, procedure code, diagnoses, units).

How to Request an Adjustment

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

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

Sample Adjustment Form

MONTANA DPHHS

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

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

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address
   Name: Public School
   Street or P.O. Box: 2100 North Main Street
   City State ZIP: Western City, MT 59988
2. Member Name: Jane Doe
3. Internal Control Number (ICN): 00327211250000600
4. NPI/API: 1234567
5. Member ID Number: 123456789
6. Date of Payment: 10/15/02
7. Amount of Payment: $ 11.49

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

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	2	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)	Line 3	10/01/02	10/02/02
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature: John R. Smith, M.D. Date: 10/31/03

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

Completing an Adjustment Request Form

1. Download the Individual Adjustment Requst from the Provider Information website. (See Key Websites.) Complete Section A with provider and member information and the claim's ICN number.
2. Complete Section B with information about the claim. Fill in only the items that need to be corrected:
   - Enter the date of service or the line number in the Date of Service or Line Number column.
   - Enter the information from the claim that was incorrect in the Information on Statement column.
   - Enter the correct information in the Corrected Information column.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Member name	The member's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider NPI	The provider's NPI.
5.* Member Medicaid number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field 5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field 17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the date of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (nursing facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.
*Indicates a required field.	

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing. (See Key Contacts.)
   - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.

- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check. (See Credit Balances earlier in this chapter.)
- Any questions regarding claims or adjustments must be directed to Provider Relations. (See Key Contacts.)

Mass Adjustments

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

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

Providers are informed of mass adjustments on the first page of the RA in the 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.)

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

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.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a Direct Deposit Sign-Up Form (Standard Form 1199A). One form must be completed for each provider NPI. See the following table, Required Forms for EFT and/or Electronic RA.

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.

Montana Department of Public Health and Human Services

Required Forms for EFT and/or Electronic RA			
Form	**Purpose**	**Where to Get**	**Where to Send**
• EDI Provider Enrollment Form • EDI Trading Partner Agreement	Allows providers to access their RAs on the Montana Access to Health (MATH) web portal. Must also include: • EDI Provider Enrollment Form • EDI Trading Partner Agreement	• Provider Information website • Provider Relations (See Key Contacts.)	Fax to number on form.
• Direct Deposit Sign-Up Form (Standard Form 1199A)	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (Forms) • Provider's bank	Provider Relations (See Key Contacts.)

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. The payment methods described do not apply to services provided under Healthy Montana Kids (HMK)/Children's Health Insurance Program (CHIP).

Payment for School-Based Services

Federal regulations specify that one government entity may not bill another government entity more than their cost (OMB A-87). The following describes payment methods for various services that can be provided in the school setting. Payment for these services is limited to the lower of the calculated fee or the billed amount.

Speech, Occupational and Physical Therapy Services

Speech and language therapy services, occupational therapy services and physical therapy services are paid by the Resource Based Relative Value Scale (RBRVS) method of reimbursement. As noted above, only the federal portion will be paid. For more detail on the RBRVS system, see the How Payment Is Calculated chapter of the *Physician-Related Services* provider manual, which is available on the Provider Information website. (See Key Websites.)

Each RBRVS fee is the product of a relative value times a conversion factor. This total is always multiplied by the current Federal Matching Assistance Percentage (FMAP).

The Department publishes relative weights, the current conversion factor, and the current FMAP figure. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

Private Duty Nursing

The only code available for this service is T1000. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15-minute units = payment

The current FMAP is then calculated against this total for final reimbursement

School Psychologist

Both codes available for billing school psychologist services are paid by the RBRVS method.

Each RBRVS fee is the product of a relative value times a conversion factor. This total is always multiplied by the current FMAP for a total reimbursement.

The Department publishes relative weights, the current conversion factor, and the current FMAP figure. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

Personal Care Paraprofessionals

The only code available for this service is T1019. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units = payment

The current FMAP is then calculated against this total for final reimbursement

CSCT Program

The only code available for this service is H0036. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units = payment

The current FMAP is then calculated against this total for final reimbursement

All payments for CSCT services are made to the school district/cooperative. Schools may not assign payment from Medicaid directly to the mental health center provider. The purpose of this policy is to:

- Ensure that districts are fully aware of the amount of federal Medicaid funds generated by their CSCT providers, allowing districts to determine their obligation for match.
- Control variables are in place to account for districts revenue and expenditures.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is 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 paymenonly when the TPL payment is less than the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible amounts for these dually eligible individuals. See the How Payment is Calculated chapter in the *Physician-Related Services* manual for examples on how payment is calculated on Medicare crossover claims.

Appendix A: Forms

- **Individual Adjustment Request**
- **Audit Preparation Checklist**
- **Request for Private Duty Nursing Services**
- **Paperwork Attachment Cover Sheet**

Montana Health Care Programs

Medicaid ● Mental Health Services Plan ● Healthy Montana Kids

Individual Adjustment Request

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

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address

   _____
   Name

   _____
   Street or P.O. Box

   _____
   City State ZIP

2. Member Name

   _____

3. Internal Control Number (ICN)

   _____

4. NPI/API

   _____

5. Member ID Number

   _____

6. Date of Payment _____

7. Amount of Payment $ _____

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

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature _____ Date _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims
P.O. Box 8000
Helena, MT 59604

Updated 03/2013

Audit Preparation Checklist

For the Montana Medicaid School-Based Services Program, school districts and cooperatives retain responsibility for ensuring that program requirements are met. Schools may not be in compliance if any statement below is checked "No."

Service Provider Qualifications			
___ Yes	___ No	___ N/A	Do all individual service providers meet the established provider qualifications for the Montana Medicaid School-Based Services Program for their discipline?
___ Yes	___ No	___ N/A	Is there documentation that the service providers are credentialed?
___ Yes	___ No	___ N/A	Do you verify and maintain contractor provider credentials?
Services Indicated on IEP			
___ Yes	___ No	___ N/A	Is the service that is being billed included in the IEP?
___ Yes	___ No	___ N/A	Does the IEP document services that are necessary and being provided as part of the school-based health services program?
___ Yes	___ No	___ N/A	Does a team that includes school personnel and qualified providers of health services develop all IEPs?
___ Yes	___ No	___ N/A	Does the IEP confirm that services are authorized as medically necessary as certified by a practitioner of the healing arts within their scope of practice?
Service Documentation			
___ Yes	___ No	___ N/A	Is the billing documentation accurate for services performed (including student name, date of service, duration of service, type of service and notes that show progress toward student goals)?
___ Yes	___ No	___ N/A	Are all service documentation records regularly maintained by the service provider on the day that services are provided?
___ Yes	___ No	___ N/A	Are all service documentation records available at a central district location during an audit?
___ Yes	___ No	___ N/A	Is evaluation reimbursement only requested for health related evaluations that are completed to determine if a student requires special education services?
Special Needs Transportation Services			
___ Yes	___ No	___ N/A	Are special transportation services listed on the IEP?
___ Yes	___ No	___ N/A	Did the student receive Medicaid reimbursable services on the same day that transportation reimbursement is being requested?
Billing Information			
___ Yes	___ No	___ N/A	Is third party insurance pursued for students with dual insurance coverage?
___ Yes	___ No	___ N/A	Do you have documentation retained for a period of six years and three months from the date of service?
___ Yes	___ No	___ N/A	Do you have a process in place to maintain contracted providers' service documentation?

Private Duty Nursing Services
School Based Services

Requests for authorizations should be sent to:

Mountain Pacific Quality Health, 3404 Cooney Drive, Helena MT 59602
Phone: (406) 443-4020 or (800) 262-1545 ext. 5850 Fax: (406) 443-4585 or (800) 497-8235

Request for Authorization

Client Name: Last First MI		Medicaid ID#:	
Street Address:	City:	State:	Zip:
DOB:	Age:	Sex: M	
Will any member of the client's family, or household, who is a licensed RN or LPN, be providing nu ☐ No ☐ Yes			
School/Provider Name:		NPI:	
School Contact:	Phone #:	Fax:	
School Nurse/Caregiver's name:		Title/Position:	
Physician's name:		Phone:	
Principal diagnosis:			

Request for services to be provided in the school

Number of skilled service hours requested per day:					Total
Mon –	Tues –	Wed –	Thur –	Fri–	
Date school year starts:	Date school year ends:	Summer school dates:			

Skilled services and treatments to be provided (frequency, estimated time/service):

☐ Medication administration ☐ ☐ ☐ G-Tube ☐ ☐ IM ☐ SQ

List medications and frequency:

Name of person who actually administers medications to students: *Position:*

☐ Trach suctioning/care

☐ Vent care

☐ Sterile dressing changes

☐ Tube Feeding ☐ Continuous ☐ Bolus ☐ pump

☐ Other:

If meds or treatments are ordered PRN, accurate records of date, time and duration of the treatments must be submitted at the end of the date span.

☐ Signed Doctor's orders are attached

Signature of person submitting request Date

All private duty nursing services must be prior authorized. Requests for services provided in the school may be authorized for the duration of the regular school year. Services provided during the summer months are additional services that require separate prior authorization. Additional requests may be submitted any time the condition of the child changes, resulting in a change to the amount of skilled nursing services required.

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of Service: _____

Billing NPI/API: _____

Member ID Number: _____

Type of Attachment: _____

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

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-999999999-99999999/Atypical Provider ID: 9999999-999999999-99999999).

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

If you have questions about paper attachments that are necessary for a claim to process, call Xerox Provider Relations at (800) 624-3958 or (406) 442-1837.

Completed forms can be mailed or faxed to:

P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

Appendix B: Personal Care Paraprofessional Services Documentation

- **Child Profile**
- **Child Profile Form**
- **Task/Hour Guide Instructions**
- **Task/Hour Guide**

Personal Care Paraprofessional Services Provided in Schools – Child Profile

Purpose

The Child Profile is intended to:

- To provide an instrument for collecting and documenting essential information needed to establish the Medicaid child's functional limitations and ability to perform activities of daily living.
- To document information on service planning issues for personal care services.
- To provide a worksheet for determining the daily units per week needed by the child.

Procedure

The Profile must be completed by the Individualized Education Plan (IEP) team at the initial meeting for services, at the annual review, and whenever a significant change in the child's condition occurs causing the service need to change.

Instructions

1. Child Name: Enter the child's full name.
2. Child ID: Enter child's Medicaid ID number.
3. DOB: Child's date of birth.
4. Date Span: The time period the child will receive personal care services, up to one year.
5. Level of Impairment: Rate the child's impairment level according to the following scale for each task listed:
   - 0 = Independent: No functional impairment. The child is able to conduct the activities without difficulty and has no need for assistance. Need is met with adaptive equipment or service animal.
   - 1 = Standby/Cuing: Mild functional impairment. The child is able to conduct the activity but does require standby assist or cuing.
   - 2 = Limited Assist: Moderate functional impairment. The child is able to conduct the activity with moderate difficulty and requires minimal assistance.
   - 3 = Extensive Assist: Severe functional impairment. The child has considerable difficulty completing the activity and requires extensive assistance.
   - 4 = Total Dependence: Total functional impairment. The child is completely unable to carry out any part of the activity.

An IEP team member must decide which of the five impairment levels best describes the child reviewed. An impairment in this context is a functional limitation (i.e., a limitation in the ability to carry out an activity or function). A member is considered to have an impairment with respect to a particular activity if he/she is limited, either physically or mentally, in his/her ability to carry out that activity.

The “0” and “4” rating is absolute in the sense that they indicate no functional impairment or total dependency. For example, if a child can perform any of the dressing tasks for themselves, a “4” is not appropriate. If he/she can perform the dressing task without difficulty, a “0” is appropriate.

If a child is able to conduct an activity only with difficulty, and the difficulty is such that the child frequently cannot complete some part of the activity, then the child is impaired, even if the child at other times can complete the entire activity. In addition, if the degree of difficulty is such that the child should have at least minimal assistance with that activity, then the child is impaired, even if the child can (with difficulty) conduct the activity without assistance. If the child can complete the activity but needs cuing to do so, or, because of safety considerations needs someone there while completing the task, they would require standby assistance. If the difficulty with an activity does not affect the child's conduct of the activity or does not cause any problems for the child, the child is not impaired.

Enter a Level for Each Task

The Personal Care Paraprofessional Services Profile is designed to rate a child's capacity for self-care. Determine the level for each task according to the capacity for self-care and not according to the child's access to a resource to assist with the task. In rating each item, use the child's response, your own observations of activity, and any knowledge provided about the child from other sources. To determine the severity of the child's impairment, consider the following factors:

1. Child Perception of the Impairment: Does the child view the impairment as a major or minor problem?
2. Congruence: Is the child's response to a particular question consistent with the child's response to other questions and, also, consistent with what you have observed?
3. Child History: Probe for an understanding of the child's history as it relates to the current situation and of the child's attitude about the severity of the impairment. How has the impairment changed the child's lifestyle?
4. Adaptation: If the child has adapted his physical environment or clothing to the extent that he is able to function without assistance, the degree of impairment will be lessened, but the child will still have an impairment. This includes the use of adaptive equipment.

Use the following examples for each item to help you differentiate between scores of 2 or 3.

ADL	2 = Limited Assist	3 = Extensive
Dressing	Child needs *occasional* help with zippers, buttons, or putting on shoes and socks. Child may need help laying out and selecting clothes.	Child needs help with zippers, buttons, or shoes and socks. Child needs help getting into garments, including putting arms in sleeves, legs in pants, or pulling up pants. Child may dress totally inappropriately without help or would not finish dressing without physical assistance.
Grooming	Child may set out supplies. Child may accomplish tasks an adaptive device for assistance.	Child needs to have help with shaving *or* shampooing, etc., because of inability to see well, to reach, or to successfully use equipment. Child needs someone to put lotion on body or to comb or brush hair.

ADL	2 = Limited Assist	3 = Extensive
Toileting	Child has instances of urinary incontinence, and needs help because of this from time to time. Fecal incontinence does not occur unless child has a specific illness episode. Child may have catheter or colostomy bag, and occasionally needs assistance with management.	Child often is unable to get to the bathroom on time to urinate. Child has occasional episodes of fecal incontinence. Child may wear diapers to manage the problem and needs some assistance with them. Child usually needs assistance with catheter or colostomy bag.
Dressing	Child needs *occasional* help with zippers, buttons, or putting on shoes and socks. Child may need help laying out and selecting clothes.	Child needs help with zippers, buttons, or shoes and socks. Child needs help getting into garments, including putting arms in sleeves, legs in pants, or pulling up pants. Child may dress totally inappropriately without help or would not finish dressing without physical assistance.
Transferring	Child usually can get out of bed or chair with minimal assistance.	Child needs hands-on assistance when rising to a standing position or moving into a wheelchair to prevent losing balance or falling. Child is able to help with the transfer by holding on, pivoting, and/ or supporting himself.
Ambulation	Child walks alone without assistance for only short distances. Child can walk with minimal difficulty using an assistive device or by holding onto walls or furniture.	Child has considerable difficulty walking even with an assistive device. Child can walk only with assistance from another person. Child never walks alone outdoors without assistance. Child may use a wheelchair periodically.
Eating	Child may need occasional physical help. Child eats with adaptive devices but requires help with their positioning.	Child usually needs extensive hands-on assistance with eating. Child may hold eating utensils but needs continuous assistance during meals. Child would not complete meal without continual help. Spoon-feeding of most foods is required, but child can eat some finger foods.
Exercise	Child may need occasional assistance in completing exercise routine. Child may need occasional support or guidance.	Child needs some assistance in completing exercise routine. Child needs support or guidance.
Bus Escort	Child requires minimal assistance on bus en route to or from school. Child does not have family or caregiver to assist. Child receives a medical service at school on this date.	Child requires assistance on bus en route to or from school. Child does not have family or caregiver to assist. Child receives a medical service at school on this date.

Check the appropriate column that indicates the degree to which the child's need for help in the completion of each task is met. Check one column for each task:

M = Met: The child's needs are met. The child may be independent in this task or someone other than the Personal Care Paraprofessional is meeting the child's need for help. Other sources for meeting the need include family or friends. No time can be authorized for any task coded with an "M".

P = Partially Met: The child requires help with the task. Someone other than the personal care paraprofessional is providing that help part of the time, or the child may participate in the task.

U = Unmet: The child requires help with the task and the need is currently unmet.

5. Notes: Enter any appropriate notes.
6. Minutes Per Day: For each task to be provided, enter the daily number of minutes needed to conduct that task.
7. Days Per Week: For each task to be provided, enter the number of days per week the child will require assistance with the task.
8. Total Minutes: Multiply the minutes per day times the days per week to obtain the total minutes per week for each task.

The amount of time allowed for any particular task should be determined by taking into account:

1. The amount of assistance the child will usually need.
2. Which specific activities need to be accomplished.
3. Environmental/housing factors that may hinder (or facilitate) service delivery.
4. Child's unique circumstances.

Task/Hour Guide Instructions

Purpose

The purpose of this form is to record the amount of time that is spent providing Personal Care services. This form is a sample and can be recreated by district personnel to meet specific needs.

Specific Tasks

Each task has one or more activities or sub-tasks that forms the overall task. When calculating time, carefully consider which activities were provided.

1. Dressing:
   - Dressing member
   - Undressing member
   - Cuing assistance
2. Exercise:
   - Range of motion
3. Grooming:
   - Brushing teeth
   - Laying out supplies
   - Combing/brushing hair
   - Applying nonprescription lotion to skin
   - Washing hands and face
   - Cuing assistance
4. Toileting:
   - Changing diapers
   - Changing colostomy bag/emptying catheter bag
   - Assisting on/off bed pan
   - Assisting with use of urinal
   - Assisting with feminine hygiene needs
   - Assisting with clothing during toileting
   - Assisting with toilet hygiene: includes use of toilet paper & washing hands
   - Set-up supplies and equipment (Does NOT include preparing catheter equipment)
   - Standby assistance
5. Transfer:
   - Non-ambulatory movement from one stationary position to another (transfer)
   - Adjusting/changing member's position in bed or chair (positioning)
6. Ambulation (Walking):
   - Assisting child in rising from a sitting to a standing position and/or position for use of walking apparatus
   - Assisting with putting on and removing leg braces and prostheses for ambulation

- Assisting with ambulation/using steps
- Standby assistance with ambulation
- Assistance with wheelchair ambulation
  NOTE: Do not include exercise as ambulation.

7. Eating:
   - Spoon feeding
   - Bottle feeding
   - Set up of utensils/adaptive devices
   - Assistance with using eating or drinking utensils/adaptive devices
   - Cutting up foods
   - Standby assistance/encouragement
     NOTE: Tube feeding is not an allowable service.
8. Bus Escort:
   - Accompanying a child on the bus when the child is functionally limited and receives medical service at the school on that date. Not for purposes of behavioral management.

Task/Hour Guide

Child Name:				Child ID:		
		Monday	Tuesday	Wednesday	Thursday	Friday
	Date					
Grooming						
Dressing Assistance						
Exercise						
Toileting						
Transfer Assistance						
Ambulation Assistance						
Eating Assistance						
Bus Escort						
Notes:						
Signature/Date						
		Monday	Tuesday	Wednesday	Thursday	Friday
	Date					
Grooming						
Dressing Assistance						
Exercise						
Toileting						
Transfer Assistance						
Ambulation Assistance						
Eating Assistance						
Bus Escort						
Notes:						
Signature/Date						

Definitions and Acronyms

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

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that created and is tasked with maintaining the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid/MHSP/HMK or another payer. Other cost factors, (such as cost sharing, 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 member 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 Medicaid Covered Services chapter *General Information for Providers* manual.

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

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

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs.

Children's Health Insurance Program (CHIP)
The Montana plan is now known as Healthy Montana Kids (HMK).

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

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

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 by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

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

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

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

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

CPT
Physicians' *Current Procedural Terminology* contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

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 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.

Early and Periodic Screening, Diagnosis,and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider’s bank account.

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

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

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

Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

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.

Free Care Rule
If a service is free to non-Medicaid members, then it must also be free to Medicaid members. Medicaid cannot be billed for services that are provided free to non-Medicaid members.

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.

HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced “hick-picks.” There are two types of HCPCS codes:

- Level 1 includes the CPT codes.
- Level 2 includes the alphanumeric codes A–V which CMS maintains for a

wide range of services from ambulance trips to hearing aids which are not addressed by CPT coding.

Health Improvement Program (HIP)
A service provided under the Passport to Health program for members who have one or more chronic health conditions. Care management focuses on helping members improve their health outcomes through education, help with social services, and coordination with the member's medical providers.

Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

Healthy Montana Kids (HMK)
HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing.

International Classification of Disease (ICD)
The International Classification of Diseases contains the diagnosis codes used in coding claims and the procedure codes used in billing for services performed in a hospital setting.

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.

Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

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

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

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

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

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

Mental Health Services Plan (MHSP)
This plan is for individuals who have 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.

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.

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 Full 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 pre-cancerous condition.

Nurse First Advice Line
The Nurse First Advice Line is a toll-free, confidential number members may call any time any day for advice from a registered nurse about injuries, diseases, health care, or medications.

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
A Medicaid medical home program where the member selects a primary care provider who manages the member's health care needs.

Pay-and-Chase
Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim
These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for member eligibility information.

Potential Third Party Liability
Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or HMK member.

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 by updated and approved by a physician at least annually.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to members; and
- Eligible to receive payment from the Department.

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.

Reason and Remark Code

A code which prints on the Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the Reason/Remark codes is found at the end of the RA (formerly called EOB code).

Referral

When providers refer members to other Medicaid providers for medically necessary services that they cannot provide.

Remittance Advice (RA)

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

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit (RVU)

The numerical value given to each service in a relative value scale.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

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

Sanction

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

School-Based Services

Medically necessary health-related services provided to Medicaid eligible children up to and including age 20. These services are provided in a school setting by licensed medical professionals.

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 overutilizing 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; or
- 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.

WINASAP 5010

WINASAP 5010 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information, contact the EDI Technical Help Desk. (See Key Contacts.)

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