Critical Access Hospital Services

Medicaid and Other Medical Assistance Programs

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

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My NPI/API:

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Key Contacts and Websites

See the Contact Us link in the menu on the Provider Information website for a list of key contacts and websites.

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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 Critical Access Hospitals (CAHs). 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). Additional information for providers is contained in the separate *General Information for Providers* manual. Providers are responsible for reviewing both manuals.

A table of contents and an index allows providers to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts and websites on the Contact Us page on the Provider Information website. There is space on the inside of the front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old page and notice in the back of the manual for use with claims that originated under the old policy.

Rule References

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

Providers are responsible for knowing and following current Medicaid rules and regulations.

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the Hospital Inpatient and Outpatient programs:

- Code of Federal Regulations (CFR)
  - 42 CFR 440.10 Inpatient Hospital Services, Other than Services in an Institution for Mental Disease
  - 42 CFR 440.20 Outpatient Hospital Services and Rural Health Clinic Services

- Montana Codes Annotated (MCA)
  - MCA 50-5-101 – MCA 50-5-1205 Hospitals and Related Facilities
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2801 – ARM 37.86.3025 Hospital Services
  - ARM 37.106.704 Standards for Critical Access Hospitals

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.

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). See the Contact Us link on the Provider Information website for a list of contacts.

Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information website.

Covered Services

General Coverage Principles

Medicaid covers hospital services when they are medically necessary. This chapter provides covered services information that applies specifically to inpatient and outpatient hospital services provided by CAHs. Like all healthcare services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Hospital Inpatient Services (ARM 37.86.2901–2947)

Inpatient hospital services are provided to Medicaid members who are formally admitted as an inpatient and whose expected hospital stay is greater than 24 hours. Inpatient services must be ordered by a licensed physician, dentist, or other practitioner and provided in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases. The institution must be currently licensed as an acute care hospital by the designated state licensing authority in the state where the institution is located, must meet the requirements for participation in Medicare as a hospital, and must have in effect a utilization review plan that meets the requirements of 42 CFR 482.30, or provide inpatient psychiatric hospital services for individuals under age 21 according to ARM 37.88.1101–1119.

Hospital Outpatient Services (ARM 37.86.3001–3025)

Outpatient hospital services are provided to members whose expected hospital stay is less than 24 hours. Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by or under the direction of a physician, dentist, or other practitioner as permitted by federal law. Hospitals must meet all of the following criteria:

- Licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
- Meet the requirements for participation in Medicare as a hospital.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (ARM 37.86.2201–2235)

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

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

- Nutritionist services
- Private duty nursing
- Respiratory therapy

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- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. See the Prior Authorization chapter in the *General Information for Providers* manual, the Prior Authorization Information page on the Provider Information website, and the *Passport to Health* manual.

For more information about the recommended well-child screen and other components of EPSDT, refer to the EPSDT Well-Child chapter in the *General Information for Providers* manual.

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. 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, ICD, and HCPCS coding books that pertain to the date of service. Fee schedules are available on the Provider Information website. CAHs should refer to the hospital inpatient and outpatient fee schedules for coverage information. Fee schedules for CAHs provide coverage information only; they do not provide reimbursement information.

Physician Attestation and Acknowledgment (ARM 37.86.2904)

At the time a claim is submitted, the hospital must have a signed and dated acknowledgment on file from the attending physician that the physician has received the following notice:

> ***Notice to physicians:*** *Medicaid payment to hospitals is based on all of each patient's diagnoses and the procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws.*

The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital; or before or at the time the physician admits his/her first patient to the hospital. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The provider may, at his/her discretion, add to the language of this statement the word *Medicare* so that two separate forms will not be required by the provider to comply with both state and federal requirements.

Utilization Reviews (42 CFR 456)

The Department or its contractor may at any time review paid claims, provider documentation for medical necessity, appropriate billing, etc. Providers must maintain documentation of medical necessity for services such as initial hospitalization, transfers, and readmissions. For more information on provider requirements for maintaining documentation, see the Record Keeping section in the Provider Requirements chapter of the *General Information for Providers* manual. Also see the Claims Review section in the Introduction chapter of this manual.

Nursing Facility Placement (ARM 37.40.202)

Hospitalized Medicaid members and Medicaid applicants being considered for nursing facility placement from the hospital shall be referred in a timely manner to the preadmission screening team.

The preadmission screening (Form DPHHS-SLTC-61) must be completed before placement and payment is made on their behalf.

For information on requesting a Level I and/or Level of Care screen, see the Mountain-Pacific Quality Health entry on the Contact Us page on the Provider Information the Provider Information website.

Coverage of Specific Services (ARM 37.86.2902)

The following are coverage rules for specific inpatient and outpatient hospital services. Services are for both inpatient and outpatient hospitals unless designated an inpatient-only or outpatient-only service. Except as otherwise permitted by federal law, inpatient hospital services must be ordered by a physician or dentist licensed under state law. For inpatient hospital services, the following routine services are included in the stay; they cannot be billed separately:

- Bed and board;
- Nursing services and other related services;
- Use of hospital facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Other diagnostic or therapeutic items, or services provided in the hospital and not specifically excluded in ARM 37.85.207 (See the Non-Covered Services section in this chapter.); and
- Medical or surgical services provided by interns or residents-in-training in hospitals with teaching programs approved by the Council on Medical Education of the American Medical Association, the Bureau of Professional Education of the American Osteopathic Association, the Council on Dental Education of the American Dental Association, or the Council on Podiatry Education of the American Podiatry Association.

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Abortions (ARM 37.86.104)

Coverage of physician services for abortions is limited as follows:

- The life of the mother will be endangered if the fetus is carried to term.
- The pregnancy is the result of an act of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the member's life is not endangered if the fetus is carried to term.

Physician services for abortions in a case of endangerment of the mother's life must meet the following requirements to receive Medicaid reimbursement:

- The physician must find, and certify in writing, that in the physician's professional judgment, the life of the mother will be endangered if the fetus is carried to term. The certification must contain the name and address of the patient and must be on or attached to the Medicaid claim.

Physician services for abortions in cases of pregnancy resulting from an act of rape or incest must meet the following requirements to receive Medicaid reimbursement:

- The member certifies in writing that the pregnancy resulted from an act of rape or incest; and
- The physician certifies in writing either that:
  - The recipient has stated to the physician that she reported the rape or incest to a law enforcement or protective services agency having jurisdiction over the matter, or if the recipient is a child enrolled in a school, to a school counselor; or
  - In the physician's professional opinion, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

A completed Physician Certification for Abortion Services (MA-37) form must be submitted with every abortion claim or payment will be denied. This form is the only form Medicaid accepts for abortion services. Complete only one section. See the Provider Information website for instructions.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the member the prescribing information for mifepristone.

Air Transports

Air transport providers must be registered with Medicaid as an ambulance provider. Claims for these services are billed on a CMS-1500 claim form. See the *Ambulance Services* manual available on the Provider Information website.

Chemical Dependency Treatment

Chemical dependency services are limited. Providers must be approved by the Department before providing this service. Contact the Chemical Dependency Bureau for more information.

Detoxification

Detoxification services are covered for up to 7 days. More than 7 days may be covered if a hospital setting is required and the service has been authorized. Services may also be covered if the authorization contractor determines that the member has a concomitant condition that must be treated in an inpatient hospital setting, and the detoxification treatment is a necessary adjunct to the treatment of the concomitant condition.

Diabetes Education

Medicaid covers diabetes education services for members who have been newly diagnosed with diabetes and/or members with unstable diabetes (e.g., members with long-term diabetes now experiencing management problems). The diabetes education protocol must meet the following Medicare Part A requirements:

- The program must train and motivate the member to self-manage their diabetes through proper diet and exercise, blood glucose self-monitoring, and insulin treatment.
- The plan of treatment must include goals for the member and how they will be achieved, and the program duration must be sufficient to meet these goals.
- The physician must refer only his/her members to the program.
- The program must be provided under the physician's order by the provider's personnel and under medical staff supervision.
- The education plan must be designed specifically for the member to meet his/her individual needs. Structured education may be included in the plan, but not substituted for individual training.

Discharges

A hospital's utilization review (UR) committee must comply with the Code of Federal Regulations (42 CFR 456.131–137) prior to notifying a Montana Medicaid member that he/she no longer needs medical care. The hospital is not required to obtain approval from Montana Medicaid at the member's discharge; however, a hospital's UR plan must provide written notice to Montana Medicaid if a member decides to stay in the hospital when it is not medically necessary. See the section titled Hospital Services Beyond Medical Necessity in the Billing Procedures chapter of this manual.

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Donor Transplants

Medicaid covers harvesting from organ donors and transplants, but does not cover expenses associated with the donor search process.

Elective Deliveries

Effective July 1, 2014, all facilities must have a "hard-stop" policy in place regarding non-medically necessary inductions prior to 39 weeks and non-medically necessary Cesarean sections at any gestational age. The policy must contain the following:

- No non-medically necessary inductions and Cesarean sections prior to 39 weeks and 0/7 days gestation, and no non-medically necessary Cesarean sections at any gestational age.
- Confirmation of weeks gestation by ACOG guidelines (at least one of the following guidelines must be met to show gestational age):
  - Fetal heart tones have been documented for 20 weeks by non-electronic fetoscope or 30 weeks by Doppler;
  - 36 weeks since a positive serum or urine pregnancy test that was performed by a reliable laboratory; or
  - An ultrasound prior to 20 weeks that confirms the gestational age of at least 39 weeks.
- If pregnancy care was not initiated prior to 20 weeks gestation, the gestational age may be documented from first day of the last menstrual period (LMP).
- Policy must have a multistep review process prior to all inductions and Cesarean sections including final decision being made by the Perinatology Chair/Obstetrical Chair, OB Director, or Medical Director.

As of October 1, 2014, Montana Medicaid reduced reimbursement rates for non-medically necessary inductions prior to 39 weeks, and non-medically necessary Cesarean sections at any gestational ages. All hospital claims with an admit date on or after October 1, 2014, require coding changes to delivery claims.

Hospital inpatient claims and birthing center claims will require the use of condition codes for all induction and Cesarean section deliveries. These claims will be reviewed for medical necessity based on an approved list of diagnosis codes. The condition codes are:

- 81 – Cesarean section or induction performed at less than 39 weeks gestation for medical necessity.
- 82 – Cesarean section or induction performed at less than 39 weeks gestation electively.
- 83 – Cesarean section or induction performed at 39 weeks gestation or greater.

Emergency Medical Services

Emergency services are services required to treat and stabilize an emergency medical condition.

Mental Health Services

Medicaid covers inpatient mental health services for Medicaid-enrolled members when prior authorized. Inpatient hospital services are not covered for adults enrolled in the Mental Health Service Plan (MHSP) or children enrolled in the Children's Mental Health Service Plan (CMHSP). Some mental health services may not be billed separately. These services include:

- Services provided by a psychologist who is employed or under a contract with a hospital.
- Services provided for purposes of discharge planning as required by 42 CFR 482.21.
- Services that are required as a part of licensure or certification, including but not limited to group therapy.

Mental health services provided by physicians and psychiatrists in an inpatient setting are the only services that can be billed separately. Providers should refer to the mental health manual available on the Provider Information website.

Observation Bed

Members in observation beds (admission of 24 hours or less) are considered outpatients, and claims should be filed accordingly.

Outpatient Cardiac and Pulmonary Rehabilitation

Effective July 1, 2014, services for procedure codes G0423, and G0424 must be prior authorized by Mountain-Pacific Quality Health.

Coverage for outpatient cardiac and pulmonary rehabilitation services must be medically necessary.

Patients with one or more contraindications are not eligible for cardiac and pulmonary rehabilitation. The following conditions are contraindications to cardiac pulmonary rehabilitation.

- Severe psychiatric disturbance including, but not limited to, dementia and organic brain syndrome; or
- Significant or unstable medical conditions including, but not limited to, substance abuse, liver dysfunction, kidney dysfunction, and metastatic cancer.

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Cardiac Rehabilitation

Services are limited to the following:

- Cardiac rehabilitation services are limited to a maximum of two 1-hour sessions per day for up to 36 sessions, limited to the following cardiac events and diagnoses:
  - Myocardial infarction within the preceding 12 months;
  - Coronary artery bypass surgery;
  - Heart-lung transplant;
  - Current stable angina pectoris;
  - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
  - Heart valve repair or replacement; and
  - Chronic stable heart failure.

Pulmonary Rehabilitation

Services are limited to the following:

- A maximum of two 1-hour sessions per day for up to 36 sessions, for patients with moderate to severe COPD (defined as GOLD classification II, III, and IV).
- If applicable, the patient must have ceased smoking or be in a smoking cessation class.

The following pulmonary rehabilitation services are not covered:

- Education, treatment, and therapies that are no individualized to a specific patient need or are not an integral part of the treatment session;
- Routine psychological screening and treatment where intervention is not indicated;
- Films/videos;
- Duplicate services;
- Maintenance care when there is no expectation of further improvement;
- Treatment that is not medically necessary because the patient requires a general strengthening and endurance program only; and
- Treatment that is not medically necessary because the patient is at an early state of pulmonary disease as demonstrated by a lack of significant findings in diagnostic testing.

Outpatient Clinic Services

The Department will pay for services provided in an outpatient clinic, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Hospitals that wish to have outpatient clinics paid as hospital-based providers must send a copy of the Medicare letter granting provider-based status to the Department's hospital program officer.

Partial Hospitalization

The partial hospitalization program is an active treatment program that offers therapeutically intensive, coordinated, structured clinical services. These services are provided only to members who are determined to have a serious emotional disturbance (SED) or a severe disabling mental illness (SDMI). Definitions for SED and SDMI are on the Provider Information website on the Definitions and Acronyms webpage. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services include day, evening, night and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatment or therapeutic activities. These services require prior authorization. For more information, see the mental health manual, available on the Provider Information website.

Services Provided by Interns or Residents-in-Training (ARM 37.86.2902)

Medicaid covers medical or surgical services provided by interns or residents-in-training only when they are provided in hospitals with teaching programs approved by one of the following:

- Council on Medical Education of the American Medical Association
- Bureau of Professional Education of the American Osteopathic Association
- Council on Dental Education of the American Dental Association
- Council on Podiatry Education of the American Podiatry Association

Sterilization (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Member must complete and sign the Informed Consent to Sterilization (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations. See the Forms page on the Provider Information website for the form and instructions. **If this form is not properly completed, payment will be denied.**

   The 30-day waiting period may be waived for either of the following:

   - **Premature Delivery**. The Informed Consent to Sterilization must be completed and signed by the member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
   - **Emergency Abdominal Surgery**. The Informed Consent to Sterilization form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.

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2. Member must be at least 21 years of age when signing the form.

3. Member must not have been declared mentally incompetent by a federal, state, or local court, unless the member has been declared competent to specifically consent to sterilization.

4. Member must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

   Before performing a sterilization, the following requirements must be met:
   - The member must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
   - The member must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
   - The member must be made aware of available alternatives of birth control and family planning.
   - The member must understand the sterilization procedure being considered is irreversible.
   - The member must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
   - The member must be informed of the benefits and advantages of the sterilization procedure.
   - The member must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
   - An interpreter must be present and sign for those members who are blind, deaf, or do not understand the language to assure the person has been informed.

   Informed consent for sterilization may not be obtained under the following circumstances:
   - If the member is in labor or childbirth.
   - If the member is seeking or obtaining an abortion.
   - If the member is under the influence of alcohol or other substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies.

Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

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

  When submitting claims for retroactively eligible members for which the date of service is more than 12 months earlier than the date the claim is submitted, contact the member's local Office of Public Assistance and request a Notice of Retroactive Eligibility (160-M). Attach the form to the claim. **Claims without the 160-M will not be paid.**

Therapy Services

Physical, occupational, and speech/language therapy services are available to Montana Medicaid members. See the *Therapy Services* manual for more information.

Transfers

All transfers are subject to review for medical necessity. The initial hospitalization, all subsequent hospitalizations, and the medical necessity for the transfer itself may be reviewed. For information on billing and payment for transfers, see the Billing Procedures and How Payment Is Calculated chapters in this manual.

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Transplants (ARM 37.86.4701–37.86.4706)

Prior authorization is required for all transplant services. See the Prior Authorization Information page on the Provider Information website. Medicaid covers only the following organ and tissue transplantation services:

- Allogenic and autologous bone marrow
- Cornea
- Enteral
- Heart/Lung
- Heart only
- Kidney only
- Kidney/Pancreas
- Pancreas only
- Lung only

Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities must be performed at a Medicare approved transplant facility and may include:

- Evaluation of the member as a potential transplant candidate.
- Pre-transplant preparation including histocompatibility testing procedures.
- Post-surgical hospitalization.
- Outpatient care, including Federal Drug Administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications.

Tissue transplantation includes only corneal, bone marrow, and peripheral stem cell transplants. Providers should refer to ARM 37.86.4705 for more information on the coverage of transplant services.

Non-Covered Services (ARM 37.85.207 and 37.86.2902)

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

- Acupuncture
- Chiropractic services
- Dietician/nutritional services
- Massage services
- Dietary supplements
- Homemaker services
- Infertility treatment
- Delivery services not provided in a licensed healthcare facility unless as an emergency service

- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy. Refer to the *Therapy Services* manual available on the Provider Information website.
- Administrative days. These are days of inpatient hospital service for which an inpatient hospital level of care is not necessary. A lower level of care is necessary, and an appropriate placement is not available.
- Inpatient hospital services beyond the period of medical necessity. See the Billing Procedures chapter in this manual.
- Inpatient hospital services provided outside the United States
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- All gastric bypass related services (including initial bypass and revisions)
- Circumcisions not authorized by the Department as medically necessary
- Services considered experimental or investigational (Phase II clinical trials are considered experimental and therefore are not covered.)
- Claims for pharmaceuticals and supplies only
- Reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves.
- Nutritional programs
- Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. Passport approval is required, and prior authorization may also be required for certain services. See the *Passport to Health* manual, the Prior Authorization chapter in the *General Information for Providers* manual and the Prior Authorization Information page on the Provider Information website.
  - The Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
  - Out-of-state medical services and all related expenses are less costly than in-state services.
  - Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.
  - Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid member is financially responsible for these services if the member agree in writing before the services are provided. See the section titled When to Bill Medicaid Members in the Billing Procedures chapter of the *General Information for Providers* manual.

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  - Donor search expenses
  - Autopsies
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Other Programs

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

Mental Health Services Plan (MHSP)

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website.

Healthy Montana Kids (HMK)

The information in this chapter does not apply to HMK members. Hospital services for children with HMK coverage are covered by Blue Cross and Blue Shield of Montana (BCBSMT). For more information, contact BCBSMT at 1-800-447-7828. Information about HMK is available on the HMK website.

Passport to Health Program

See the *Passport to Health* manual for information on the Passport program. The manual is found on the Passport to Health page on the Provider Information website and on applicable provider type pages.

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Prior Authorization

What is Prior Authorization (ARM 37.86.2801)

In addition to the requirements in the *General Information for Providers* manual, the following is specific to CAHs.

Whether the member is enrolled in Passport or Team Care, the eligibility information denotes the member's PCP. Services are only covered when they are provided or approved by the designated Passport provider or Team Care pharmacy shown in the eligibility information. Specific services may require both prior authorization and Passport referral. To be covered by Medicaid, all services must also be provided in accordance with the requirements listed in this manual.

When seeking prior authorization, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the Medicaid fee schedule that corresponds with the dates of service to verify whether prior authorization is required for the services.
- When requesting prior authorization for members with partial eligibility, request prior authorization from the first date the member was Medicaid eligible, not the first date of the member's hospital stay.
- The Prior Authorization Criteria for Specific Services table on the Prior Authorization Information webpage lists services that require prior authorization, who to contact for authorization, and documentation requirements. See the Prior Authorization Information link in the left menu on the Provider Information website.
- Have all required documentation included in the packet before submitting a prior authorization request. See the Prior Authorization Information link in the left menu on the Provider Information website.
- When prior authorization is granted, providers will receive notification containing a prior authorization number. This prior authorization number must be included on the claim.
- The hospital can document that at the time of admission it did not know, or have any basis to assume that the member was a Montana Medicaid member.

Prior Authorization for Specific Services

See the Prior Authorization Information link in the left menu on the Provider Information website. The webpage includes contact information and document requirements for prior authorization for specific services.

Coordination of Benefits

When a Member Has Other Coverage

See the *General Information for Providers* manual for additional information.

When a Member Has TPL (ARM 37.85.407)

See the *General Information for Providers* manual for additional information.

Other Programs

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website.

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

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Billing Procedures

In addition to the information in this chapter specific to CAHs, the *General Information for Providers* manual has additional information on billing.

Claim Forms

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

When to Bill Medicaid Members (ARM 37.85.406)

In addition to the information in this chapter specific to CAHs, the *General Information for Providers* manual has additional information on billing.

Hospital Services Beyond Medical Necessity

The Montana Medicaid member who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as a Montana Medicaid noncovered service. The member must have been informed in writing and agreed in writing prior to provision of services to accept financial responsibility. The agreement must state the specific services the Medicaid member has agreed to pay for. In this case, a routine agreement will not suffice.

A hospital's utilization review plan must provide written notice to Montana Medicaid if a Montana Medicaid member decides to stay in the hospital when it is not medically necessary. This written notice must be sent to the hospital program officer.

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing for inpatient services is $75 per discharge, and cost sharing for outpatient services is $4.00 per visit. See the *General Information for Providers* manual for additional information on member cost sharing.

Billing for Members with Other Insurance

In addition to the information in this chapter specific to CAHs, the *General Information for Providers* manual has information regarding billing for members with other insurance.

Montana Medicaid does not allow physician/professional charges to be billed on a UB-04. Physician/professional charges must be billed to Montana Medicaid on a CMS-1500. However, the exception for CAHs is when a member has Medicare

and Medicaid, Medicare may be billed using the All Inclusive Payment/Option II Billing Method, in which physician/professional charges and facility charges are billed together on a UB-04.

CAHs are permitted to bill their institutional charges and their physician/professional charges on a UB-04 if the member is dually eligible (a beneficiary of both Medicare and Medicaid). This permits claims for dually eligible members to cross over electronically from Medicare. Medicaid processes these claims and pay Medicare coinsurance and deductible less incurment and third party payments.

Medicare Benefits Exhausted

If/when a Medicare/Medicaid member exhausts the Medicare benefit (including Lifetime Reserve Days), the claim will be treated as a Medicaid-only claim from the date the Medicare benefits were exhausted. The claim should be submitted reflecting a covered stay from the day the Medicare benefits were exhausted to discharge.

Services Provided to Passport to Health Members

A Medicaid member covered by the Passport to Health program must have hospital services approved by the member's PCP. The Passport approval codes must be on the claim or the services will be denied. If the claim indicates that the member was admitted from the emergency room, Passport approval is not required. See the *Passport to Health* manual, the Prior Authorization chapter in the *General Information for Providers* manual, and the Prior Authorization Information page on the Provider Information website.

Services That Require Prior Authorization

Prior authorization is required for some hospital services. Passport and prior authorization are different, and some services may require both. (See the Passport and Prior Authorization chapters in the *General Information for Providers* manual.) Different codes are issued for each type of approval and must be included on the claim form or the claim will be denied. (See the Submitting a Claim chapter in this manual.)

Discharges and Transfers

Claims can be filed only after the member has been discharged. A member is considered discharged when he/she:

- Is formally released from the hospital;
- Transfers to another hospital or rehabilitation unit;
- Dies in the hospital; or
- Leaves the hospital against medical advice (AMA).

All transfers are subject to review for medical necessity. Initial hospitalizations, subsequent hospitalizations, and transfers may be reviewed for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

The patient status code should contain the appropriate discharge status code. The following discharge status codes are valid for Montana Medicaid.

Discharge Status Codes

Status Code	Description	Status Code	Description
01	Discharged to home or self-care (routine discharge)	40	Expired (death) at home
02	Discharge/Transfer to another short-term general hospital for inpatient care	41	Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing hospice)
03	Discharge/Transfer to skilled nursing facility (SNF)	42	Expired – place unknown
04	Discharge/Transfer to an intermediate care facility (ICF)	43	Discharge/Transfer to Federal hospital
05	Discharge/Transfer to another type of institution for inpatient care	50	Hospice – home
06	Discharge/Transfer to home under care of organized home health service organization	51	Discharge/Transfer to hospice medical facility
07	Left against medical advice or discontinued care	61	Discharge/Transfer within this institution to hospital-based Medicare-approved swing bed
08	Discharge/Transfer to home under care of a Home IV provider	62	Discharge/Transfer to another rehabilitation facility including rehabilitation distinct part units of a hospital
09	Admitted as an inpatient to this hospital	63	Discharge/Transfer to a long-term care hospital
20	Expired (death)	64	Discharge/Transfer to nursing facility certified under Medicaid, but not Medicare
30	Still a patient (Neonate providers discharge status code for interim billing.)	65	Discharge/Transfer to a psychiatric hospital or psychiatric distinct part unit of a hospital

Split / Interim Billing

Hospitals can split bill under the following circumstances. When split billing, only include charges for the dates of service covered by the member's eligibility period.

- ***At the provider's fiscal year end***.
- ***When the member has partial eligibility.*** In cases where the member has partial Medicaid eligibility for a hospital stay and Medicare has paid, the claim must be split and only Medicaid eligible charges billed. Pro-rate the coinsurance over the entire stay, and indicate the portion related to the Medicaid eligible period. For example, a member had a 15-day hospital stay in which she was eligible for Medicaid during 10 of those days. The member has a $300 Medicare coinsurance, which is divided by the 15 days for a total of $20 per day.

Multiply $20 x the 10 Medicaid eligible days for a total of $200 coinsurance, which can be billed to Medicaid. The Medicare deductible can only be applied on the Medicaid claim if the member is eligible for Medicaid on the first day of the hospital stay. Otherwise, the deductible may not be billed to Medicaid. If Medicare does not pay, then bill the claim as usual. The claim will automatically be prorated based on the partial eligibility.

- ***When the member has both Medicare and Medicaid, and Medicare does not cover the service.*** When the services provided are outside the Medicare covered days, submit only Medicaid covered days to Medicaid.
- ***When the number of lines on a paper claim reaches 40.*** Providers are asked to limit claims lines on a UB-04 paper claim to 40. Although additional lines may be billed on the claim form, the Department's claims processing system is most efficient for claims with 40 lines or less.

Incurment

All hospitals must bill from the date incurment/spend down was met. For more information on incurment, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Other Programs

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers can find information on mental health services in the mental health manual available on the Provider Information website.

These billing procedures do not apply to Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCSMT) at 1-800-447-7828. Additional information regarding HMK is available on the HMK website.

Submitting a Claim

The services described in this manual are billed on UB-04 claim forms. Use this chapter with the UB-04 claim instructions on the Provider Information website.

Claims submitted with all of the necessary information are referred to as *clean* and are usually paid in a timely manner. (See the Billing Procedures chapter in the *General Information for Providers* manual.)

Passport and Cost Sharing Indicators	
Passport to Health Indicators	
Code	**Used When Providing**
FPS	Family planning services.
OBS	Obstetrical services.
TCM	Targeted case management services.
Cost Sharing Indicators	
Code	**Used When Providing**
C	Services to a child or EPSDT exempt.
E	Emergency services.
F	Family planning services.
I	Services to any IHS referral.
P	Services to pregnant women.
N	Services to nursing facility residents.

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Remittance Advices and Adjustments

See the *General Information for Providers* manual for information on remittance advices and adjustments.

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How Payment Is Calculated

Overview

Although providers do not need the information in this chapter to submit claims to Montana Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

CAHs are reimbursed for their costs of providing care, as determined through the annual cost settlement process. In the interim, these hospitals are paid a hospital-specific percentage of their charges. The percentage equals the hospital's estimated cost-to-charge ratio as determined from time-to-time by the Department. The percentage includes payments for medical education and capital expenses.

Charge Cap

For services covered in the hospital setting, Medicaid pays a cost to charge ratio, not the lower of the Medicaid fee or the provider's charge. The charge cap is not applied.

Status Indicator Codes

The code set used by DPHHS is based on the code set used by Medicare but with several additions. See the following table of status indicator codes.

Status Indicator Codes Used by DPHHS

Code	Description	Origin
W	Excluded service	DPHHS
G	Drug/biological under trans. pass-through	Medicare
H	Device under trans. pass-through	Medicare
J	New drug/biological under trans. pass-through	Medicare
N	Incidental services (bundled)	Medicare
T	Surgical services	Medicare
C	Inpatient services	Medicare
K	Non-pass-through drugs and biologicals	Medicare
S	Significant procedures	Medicare
X	Ancillary service	Medicare
V	Medical visit	
B	Services not paid under OPPS	Medicare
P	Partial hospitalization	Medicare
Q	Clinical lab	DPHHS
Y	Therapy	DPHHS
M	Misc. codes	DPHHS

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Payment for Specific Services

Immunizations

If the member is under 19 years old and the vaccine is available to providers for free under the Vaccines for Children program, then the payment to the hospital is zero. Immunization administration is considered an incidental service. The claims processing system bundles immunization administration with other services on the claim and pays it at zero.

Transfers

When a member is transferred between two hospitals, the transferring and/or discharging hospitals are paid a hospital-specific cost to charge ratio for their services if they are CAHs.

Occasionally, a member is transferred from one hospital to another and then back to the original hospital when the condition causing the transfer is alleviated. Thus a hospital can be a transferring and discharging hospital. The discharging hospital should submit separate claims, one for the original admission and transfer and a second for the final discharge.

Observation Services (ARM 37.86.3020)

DPHHS follows the Medicare program, with the exception of obstetric complications, in making separate payment for observation care procedure codes if the following criteria are met.

- Observation time must be documented in the medical record.
- The number of units reported must equal or exceed eight hours.

In addition, the claim for observation must include one of the following services to the reported observation:

- High level emergency department visit; or
- High level clinic visit; or
- High level critical care; or
- Direct admit for observation care after being seen by a healthcare provider on the same date of service as the date reported for observation services.

The Department will also pay for observation care in a case with the potential obstetric complications if the following criteria are met:

- Must have a qualifying diagnosis; and
- Must be at least one hour in length of service.

If an observation service does not meet the criteria according to the above, then payment for observation care is considered bundled into the payment for other services.

Outpatient Clinic Services

When Medicaid pays a hospital for outpatient or provider-based clinic services, the facility must bill the technical services on a UB-04 and the professional must bill the physician services on a CMS-1500.

The separate claim for the physician's services must show the hospital as the place of service (i.e., POS 22 for hospital outpatient). This place of service code will result in lower payment to the physician, thus minimizing what would otherwise be double payment for office expenses.

Pass-Through Payments

Payments for certain drugs, devices and supplies are designated as *pass-through* and paid a hospital-specific cost-to-charge ratio.

Procedures Considered Inpatient Only by Medicare

Medicare has designated some procedures as inpatient-only. Medicaid has also adopted that designation. When these procedures are performed in the outpatient hospital setting, the claim is denied. Hospitals may appeal the denial to the Department. If the service is approved, the claim will be paid.

Calculating Payment

The sections below explain how to calculate payment for claims involving Medicare or third party liability.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer, and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount. See the When a Member Has TPL section in the *General Information for Providers* manual.

How Payment Is Calculated on Medicare Crossover Claims

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

Payment Examples for Dually Eligible Members

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

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

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

Other Programs

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website.

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

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Appendix A: Forms

These forms and others are available on the Forms page on the Provider Information website.

- Individual Adjustment Request
- Physician Certification for Abortion Services (MA-37)
- Informed Consent to Sterilization (MA-38)
- Medicaid Hysterectomy Acknowledgment (MA-39)
- Paperwork Attachment Cover Sheet

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Definitions and Acronyms

See the Definitions and Acronyms page on the Provider Information website

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