

January 6, 2012

# Montana Health Care Programs Notice All Providers

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## Psychiatric Residential Treatment Facility Prior Authorization Start Date Must Match Admission Date

**This is a reminder to psychiatric residential treatment facility (PRTF) that a youth's admission date and the start date of the prior authorization (PA) from Magellan for Medicaid reimbursement must be the same.**

Effective immediately, if the PRTF admission date is different from the first date on the PRTF's PA, the PRTF must complete the Magellan *Montana Medicaid Youth Data Corrections Request Form* (attached) to correct the PA start date. The form must be completed the day the youth is admitted to the PRTF. Other Medicaid provider claims may be denied payment if the PRTF PA start date and PRTF admission date do not match. The information Magellan receives on this form will be used to update the MMIS (payment) system and allow other Medicaid provider claims to pay correctly.

In addition, on the day of discharge, the PRTF must complete the *Montana Medicaid Youth Discharge Notification Form* (attached) in order to ensure correct payment of other Medicaid provider claims. This form is also used to update the MMIS system.

The forms are included with this provider notice and are also on the Magellan website <https://montana.fhsc.com/Providers/YouthForms.asp>.

Per Administrative Rule of Montana 37.87.1222 (16), the Department may impose a \$100 fine for each time a PRTF fails to update the PA admission or discharge date on the youth's admission or discharge from the facility. This is required because the MMIS system will not reimburse any ancillary services for youth in a PRTF. MMIS uses the admission and discharge dates received from Magellan to determine whether to reimburse other Medicaid providers when a youth is in a PRTF. Magellan submits the dates from the PRTFs; therefore, it is important that PRTF reports of admission and discharges dates are timely and accurate.

If the admission and discharge dates are not updated with these forms when the dates do not match the PA span, and other Medicaid services are provided to the youth, the other provider's claims will deny and indicate the youth is ineligible for the service. During the time a youth is in a PRTF, a provider will be instructed to contact the facility for payment (in this case a PRTF) when the youth's eligibility is checked in the MEVS system.

If a PRTF does not want to be charged a fine or be responsible to pay another provider's claims, please remember to update the youth's admission and discharge date with the Magellan forms.

For more information regarding this provider notice, contact Diane White, Clinical Program Officer, at Children's Mental Health Bureau, P.O. Box 4210, Helena, MT 59604-4210, (406) 444-1535, [dwhite@mt.gov](mailto:dwhite@mt.gov).

## **Contact Information**

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**E-mail: [MTPRHelpdesk@ACS-inc.com](mailto:MTPRHelpdesk@ACS-inc.com)**

Visit the Provider Information website:

**<http://medicaidprovider.hhs.mt.gov>**



## Montana Medicaid Youth Data Corrections Request Form

Correction to Youth Information

DATE OF REQUEST:

**Provider Information**

FACILITY NAME:		FACILITY'S MEDICAID NUMBER:	
CONTACT NAME:	PHONE NUMBER:	EXTENSION:	FAX NUMBER:

**Description of the Problem:**

**Requested change or correct information: :**

**Youth Information**

YOUTH NAME:		MEDICAID NUMBER:	SOCIAL SECURITY NUMBER:
DATE OF BIRTH:	ADMISSION DATE:	DISCHARGE DATE:	

**Prior Authorization Information**

PRIOR AUTHORIZATION NUMBER:	REQUEST ID NUMBER:
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**Magellan Medicaid Administration's Use Only**

<b>NURSE OR CCS ASSIGNED:</b>	
<b>DATE CORRECTION DETERMINATION:</b>	
<b>SIGNATURE:</b>	<b>DATE:</b>

**Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.**

## Montana Medicaid Youth Discharge Notification Form Notice of Discharge from Services

Please check the service from which the youth was discharged:

- Acute Inpatient   
  Outpatient   
  Partial Hospital Program   
  Psychiatric Residential Treatment Facility
- THERAPEUTIC GROUP CARE:
- THERAPEUTIC FAMILY CARE:   
  Moderate   
  Permanency
- CASE MANAGEMENT
- PRTF WAIVER

Please type or print clearly.

<i>Youth Information</i>					
YOUTH NAME:					
ADDRESS:			CITY:		STATE: ZIP:
COUNTY:		SSN:		DOB: MEDICAID NUMBER:	
PROVIDER NUMBER:		NPI NUMBER:		TAXONOMY:	
<i>Provider Information</i>					
PROVIDER NAME:					
NAME OF PERSON SUBMITTING FORM:				PHONE NUMBER:	
TODAY'S DATE (MM/DD/CCYY):			YOUTH DISCHARGED TO (I.E., HOME, ANOTHER LEVEL OF SERVICE):		
CLINICIAN/THERAPIST:					
DATE OF ADMISSION (MM/DD/CCYY):			DATE OF DISCHARGE (MM/DD/CCYY):		

**Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.**