



# Nursing Facility Services Bureau

**Department of Public Health and Human Services**

**Provider Fair - May 21, 2014**

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# Provider Manual

- Available on the website [www.mtmedicaid.org](http://www.mtmedicaid.org) or <http://medicaidprovider.hhs.mt.gov/>
- Please make use of this resource.



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## *Nursing Facility and Swing Bed Services*

*Medicaid and Other Medical  
Assistance Programs*



# NPI

## National Provider Identifier



- **This may also include a taxonomy number.**
- **It is the number used on claims.**
- **It is the number to use if a report or form for SLTC requires a provider #.**

*This publication supersedes all previous Nursing Facility and Swing Bed Services handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.*

*CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.*

My Medicaid Provider ID Number:



# Resources Available on Web

## [www.mtmedicaid.org](http://www.mtmedicaid.org)



- [Provider Manuals](#)
- [Medicaid Rules/Regulations](#)
- [Fee Schedules](#)
- [Notices and Replacement Pages](#)
- [Other Resources](#)
- [Remittance Advice Notice](#)
- [Key Contacts](#)

### Provider Manuals

#### [General Information For Providers](#)

Medicaid billing manual with general information for all provider types.

#### [Nursing Facility and Swing Bed Services](#)

This manual has billing instructions specific to your provider type.

<http://medicaidprovider.hhs.mt.gov/providerpages/providertype/26>

### Administrative Rules of Montana

<http://www.mTRules.org/gateway/departement.ASP?ID=18>

Helpful hints for applying to Medicaid

<http://www.dphhs.mt.gov/sltc/programs/Medicaid/IndexMedicaid.shtml>



# Resources Available on Web Senior and Long Term Care



<http://www.dphhs.mt.gov/sltc/index.shtml>

- MDS 3.0 Sec Q
- Swing Beds
- Rate Setting
- Facility Medicaid Rates
- Direct Care Wage Program
- At Risk Payment Program (IGT)
- Level of Care (LOC)
- Medicaid Cost Report form and instructions



# *Claim Jumper* on Provider Website

<http://medicaidprovider.hhs.mt.gov/providerpages/newsletters.shtml>

- Please read the *Claim Jumper* EVERY month. It has important information for everyone.
- The *Claim Jumper* newsletter is only available on the website.



# Contacts



Replacement Page, January 2011

## Key Contacts

### ACS EDI Gateway, Inc.

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state  
(406) 442-1837 Helena  
(406) 442-4402 Fax

Send e-mail inquiries to:  
MTPRHelpdesk@ACS-inc.com

Mail to:  
Montana EDI  
ACS  
P.O. Box 4936  
Helena, MT 59604

### Certification for Medical Need

Swing Bed Hospitals must obtain a certificate of need from the Quality Assurance Division in order to provide swing bed services.

(406) 444-2099 Phone

Send written inquiries to:  
Quality Assurance Division  
P.O. Box 202953  
Helena, MT 59620-2953

### Claims

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

### Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information for Providers* manual.

### Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

### Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961  
(406) 443-6002 6003? (Helena)  
8:00 a.m. to 5:00 p.m., Monday–Friday  
(Mountain Time)

Mail backup documentation to:  
Mountain-Pacific Quality Health  
3404 Cooney Drive  
Helena, MT 59602

Fax backup documentation to:  
(800) 294-1350  
(406) 443-7014 (Helena)

### Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

**Client Eligibility Fraud**  
(800) 201-6308

**Medicaid Client Help Line**  
(800) 362-8312

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Nursing Facility and Swing Bed Services

### Lien and Estate Recovery

Providers must give any personal funds they are holding for a Medicaid-eligible resident to the Department within 30 days following the resident's death.

Phone:  
(800) 694-3084 In-state  
(406) 444-7313 Out-of-state and Helena

Fax:  
(800) 457-1978 In-state  
(406) 444-1829 Out-of-state and Helena

Send written inquiries to:  
Third Party Liability Unit  
Lien and Estate Recovery  
DPHHS  
P.O. Box 202953  
Helena, MT 59620-2953

### Nurse Aide Registry

To verify the nurse aide's certification status:  
(406) 444-4980

Send written inquiries to:  
Montana Nurse Aide Registry  
2401 Colonial Drive, 2nd Floor  
P.O. Box 202953  
Helena, MT 59620

### Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

ACS, Atlanta  
Technical POS Help Desk

(800) 365-4944  
6:00 a.m. to midnight, Monday–Saturday  
10:00 a.m. to 9:00 p.m., Sunday,  
(Eastern Time)

### Preadmission Screening

For preadmission screening and level-of-care screening for clients entering a nursing facility or swing bed hospital, contact:

Phone:  
(800) 219-7035 In and out-of-state  
(406) 443-0320

Fax:  
(800) 413-3890 In and out-of-state  
(406) 443-4585

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

### Provider's 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.

### Provider Relations

For questions about eligibility, payments, or denials, general claims questions, Passport, or to request provider manuals, fee schedules:

(800) 624-3958 In- and out-of-state  
(406) 442-1837 Helena  
(406) 442-4402 Fax

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

Send e-mail inquiries to:  
MTPRHelpdesk@ACS-inc.com



# Contacts

Nursing Facility and Swing Bed Services

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## **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

## **Senior and Long-Term Care**

Contact the Nursing Facility Services Bureau for the following:

- Nursing facility or swing bed program information
- Out-of-state nursing facility services
- Admission, transfer or discharge waivers
- Eligibility or claim issues that cannot be resolved through the county office of Public Assistance or Provider Relations
- Authorization for services described in the *Prior Authorization* chapter of this manual

(406) 444-4077 Phone  
(406) 444-7743 Fax

Send written inquiries to:

Nursing Facility Services Bureau  
Senior and Long-Term Care  
P.O. Box 4210  
Helena, MT 59604-4210

## **Third Party Liability**

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In- and out-of-state  
(406) 443-1365 Helena  
(406) 442-0357 Fax

Send written inquiries to:

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



# Level of Care Screenings

## Mountain-Pacific Quality Health



- Level of care determinations must be completed by Mountain-Pacific Quality Health for all residents meeting all level of care criteria.
- If you have any questions on LOC(s), please contact Mountain-Pacific Quality Health at 443-0320 or 1-800-219-7035.
- The facility SHOULD make sure it completes a level of care screening. The LOC is the equivalent of your prior authorization (or determination of medical necessity) for Nursing Facility Services. WITHOUT the level of care screening a nursing home span WILL NOT be opened and your claims will not be paid.
- Clearly some residents are not Medicaid eligible and the facility should not complete inappropriate screenings to MPQH on non-Medicaid residents upon admissions.
- The LOC is the equivalent of a prior authorization (or determination of medical necessity) for Nursing Facility Services under Medicaid.
- Here is a link to information on LOC screens  
<http://www.dphhs.mt.gov/sltc/services/nursingfacilities/LOC.shtml>



# Medicaid Eligibility

Medicaid eligibility determination is a separate process of **financial eligibility** determination.

Sometimes the eligibility determination is hindered by the resident/family/authorized representative because of timeliness, incomplete applications, documentation, etc. The facility should notify the resident, etc. that without Medicaid they will be private pay.

As part of its admission procedures the Nursing Facility SHOULD:

- ASK the family or authorized representative and learn whether the resident has adequate means to pay the facility or ask them if they plan on applying for Medicaid.
- HAVE a supply of Medicaid applications on file to provide to the family.

The applications can be found online at:

<http://www.dphhs.mt.gov/programsservices/publicassistanceprograms.shtml>

The facility should follow up with the resident's/residents' authorized representatives if the Medicaid determination is being delayed by information not being supplied to the Medicaid case worker.

Remember there may be a portion of resident's care which must be paid by the resident.



# Monthly Nursing Facility Staffing Report



- **Electronic version of form is available contact me at [bmcanally@mt.gov](mailto:bmcanally@mt.gov).**
- **Facility is required by the 10<sup>th</sup> of every month for previous month's data**
- **Tracks staffing trends**
- **Enter direct care hours and actual number of people working those hours.**
- **Bed days by level of care and payment source**
- **Used in Medicaid budgeting process as a method of projecting Medicaid utilization**

MONTHLY NURSING HOME STAFFING REPORT							
<b>MONTANA STATE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES</b> Nursing Facility Services Bureau PO Box 4210 Helena, MT 59604-4210 Phone 406-444-4077 FAX 406-444-7743							
FACILITY NAME: _____						Provider # _____	
FACILITY ADDRESS: _____						City _____	
MONTH ENDING: _____							
STAFFING REQUIREMENT: Facilities must provide staffing at levels which are adequate to meet federal law, regulations and requirements.							
<b>HOURS/EMPLOYEES DURING REPORTING PERIOD:</b>							
Please list the total number of hours worked and number of employees in each of the listed categories for the month:							
	TOTAL EMPLOYEE HOURS	TOTAL CONTRACT HOURS	TOTAL HOURS WORKED		NUMBER OF FACILITY EMPLOYEES	NUMBER OF CONTRACT STAFF	TOTAL NUMBER OF RN, LPN, CNA
RN'S				RN'S			
LPN'S				LPN'S			
CNA / AIDES:				CNA / AIDES:			
<b>TOTAL</b>				<b>TOTAL</b>			
Note: Include all RN, LPN and AIDE hours for direct care staff. Director of Nursing hours may be included if spent dispensing meds, on rounds or charting - do not include administrative hours. Do not include time spent on in-service training, time for laundry or maintenance staff even if they are certified as aides or other non-direct care staff. Contract employees / hours are direct care hours provided by agency staff, temp. service staff, etc. who are not employees of the facility.							
<b>PATIENT DAYS:</b>							
Please list the total number of occupied days by each category for the month:							
LEVEL OF CARE	MEDICAID	MEDICARE	LONG TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (Work Comp Ins., Auto Ins, Medigap Ins, etc)	TOTAL
Skilled Care (SNF)							
Nursing Care (NF)							
Hospice							
Billable Bed Holds							
Other							
<b>TOTAL (5 rows)</b>							
Medicare Co-Insurance Payments (duplicated )							
<b>CERTIFICATION:</b>							
I certify that this information, to the best of my knowledge, is true, accurate, and complete:							
Signed: _____				Title: _____			
Date: _____							
MAIL THIS FORM TO: SENIOR AND LONG TERM CARE DIVISION, PO BOX 4210, HELENA, MT 59604-4210							
TIME LINE: This form is to be submitted to the department within 10 days following the end of each calendar month.							



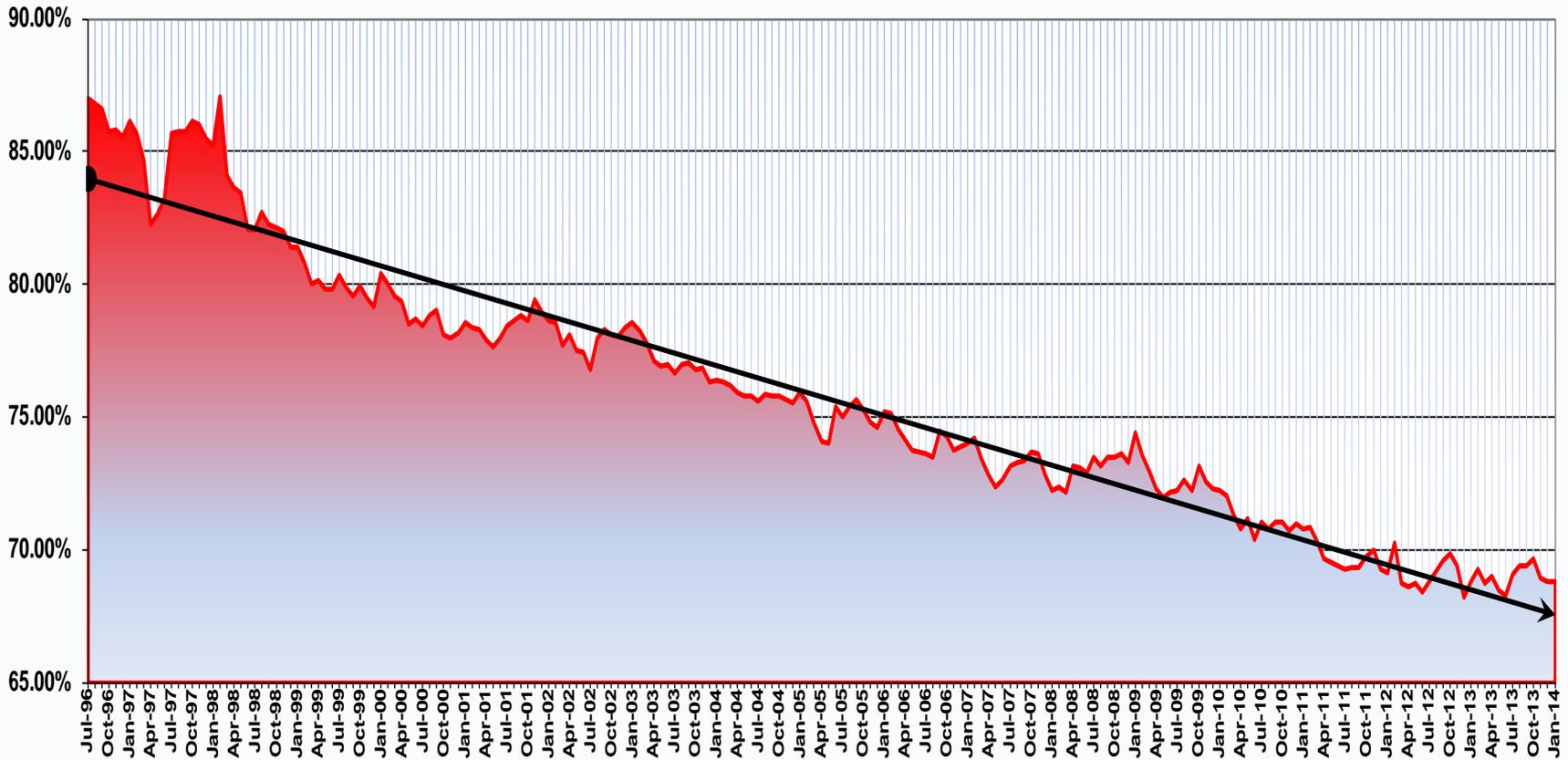
# Instructions for Staffing Reports

- Check our website at [www.medicaprovider.hhs.mt.gov](http://www.medicaprovider.hhs.mt.gov) and click on the Nursing Facility and Swing Bed Services.
- Any questions, please contact Becky McAnally 406-444-3997 or e-mail me at [bmcanally@mt.gov](mailto:bmcanally@mt.gov).



# Total Nursing Facility Occupancy

## MT Nursing Home Total Occupancy

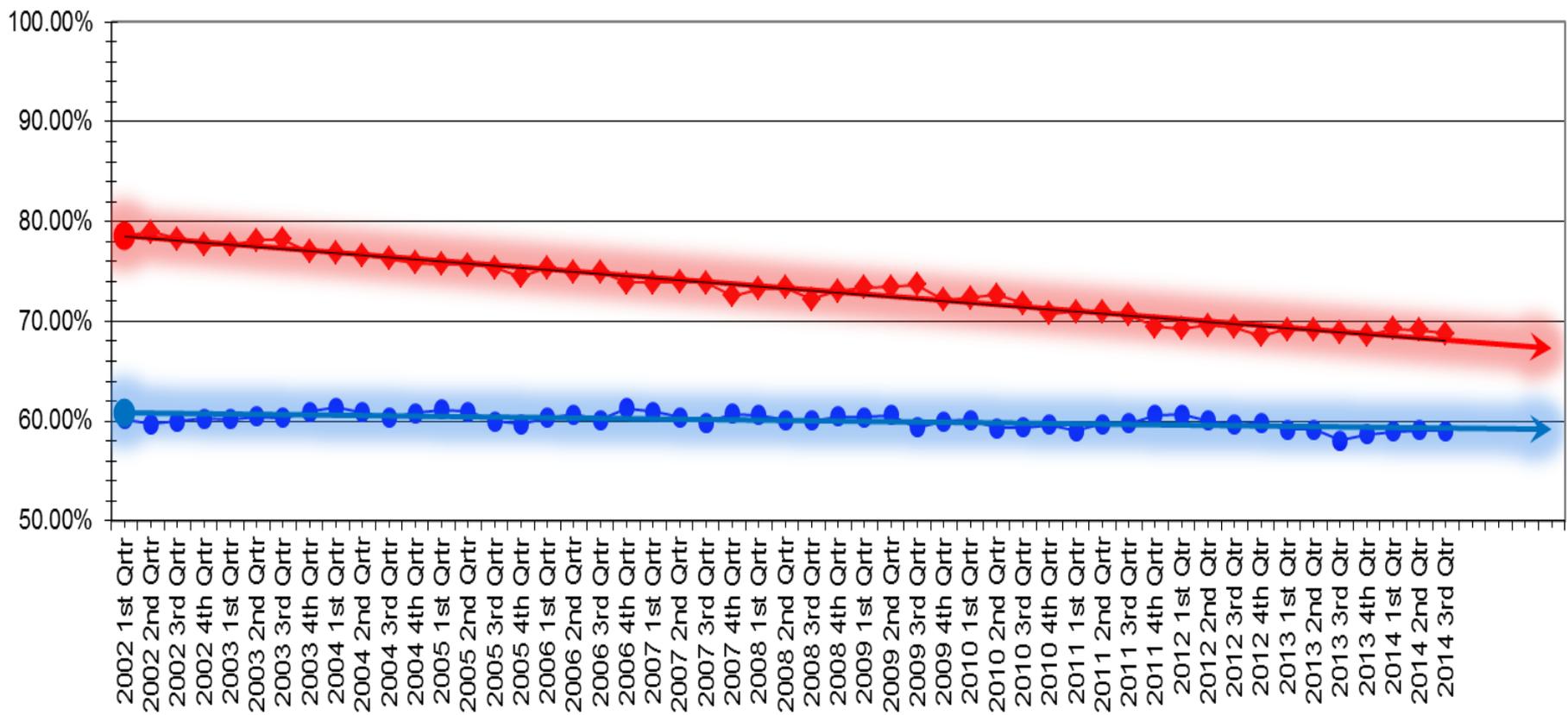




# Nursing Facility Total & Medicaid Occupancy

### MT Nursing Home Total and Medicaid Occupancy %

—◆— Total % of Beds Occupied    —◆— Medicaid % of Occupied Beds    —◆— Linear (Total % of Beds Occupied)    — Linear (Total % of Beds Occupied)





# CNA Training & Testing Report



- **Quarterly report due within 1<sup>st</sup> month after quarter ends**  
**July – Sept due in October**  
**Oct – Dec due in January**  
**Jan – March due in April**  
**April – June due in July**
- **Initial Certification T&T only**
- **Facilities are reimbursed thru the Medicaid per diem rate – no separate funding available.**
- **We collect data to meet Federal Medicaid Reporting requirements.**
- **If the facility has no activity for that quarter, this report must be submitted reporting as “No Activity.”**
- **If you have any questions on the CNA Training & Testing program information , please visit this website:**  
<http://www.dphhs.mt.gov/sltc/services/nursingfacilitie/s/index.shtml>

## Sample Only

First Quarter FY 2005 Costs (July 1, 2004 through September 30, 2004)

Please return completed form by **November 1, 2004** to:

Lucinda Fleming, Human Services Specialist  
Senior and Long Term Care Division  
Department of Public Health and Human Services  
P.O. Box 4210  
Helena, MT 59604-4210

**EFFECTIVE JULY 1, 1998 TESTING FEES PAID TO HEADMASTER WILL BE INCLUDED ON THIS FORM.**

CATEGORY	AMOUNT	DESCRIPTION
1. Supplies and Equipment:	\$	
2. Facility Personnel:	\$	
3. Sub-Contracted Services:	\$	
4. Number of CNAs Trained During Quarter:		
5. Competency Evaluation Testing	\$	
6. Number of CNAs tested during Quarter:		
Signature of Administrator:		
Facility:		
Facility Medicaid Provider #	City:	

ARM 37.40.322 (2)(b) states "if a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346 (4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form."



# Bed Hold Days



Covered by ARM 37.40.338

- Therapeutic Home Visits Less Than 72 Hours
  - Form DPHHS-SLTC-041
- Therapeutic Home Visits Greater Than 72 Hours
  - Form DPHHS-SLTC-042
- Hospital Holds
  - Form DPHHS-SLTC-052

**If you need more of these forms, please e-mail Becky @ [bmcanally@mt.gov](mailto:bmcanally@mt.gov).**



# Therapeutic Home Visit (THV) Less Than 72 Hours



- **Form DPHHS-SLTC-041**
- **Does not require prior authorization.**
- **Please submit this form monthly.**
- **More than one resident per form**
- **The form cannot be submitted later than 90 days of the 1<sup>st</sup> day of the requested bed hold reservation (THV) on the form.**
- **Do not continue to reflect residents reports in previous months.**

DPHHS-SLTC-041  
(Rev. 05/04)

STATE OF MONTANA  
Department of Public Health and Human Services  
Senior and Long-Term Care Division  
P. O. Box 4210 Helena, Montana 59604-4210  
(406) 444-4077

**REQUEST FOR THERAPEUTIC HOME VISIT BED RESERVATION**

\_\_\_\_\_  
(NAME OF FACILITY) (ADDRESS OF FACILITY)

\_\_\_\_\_  
(FACILITY ID NUMBER)

I certify that a bed is being held for the following resident(s) and the care plan for each resident listed provides for therapeutic home visits. I understand there is a seventy-two (72) hour limitation per visit and a limit of twenty-four (24) days annually. Longer hours per absence must be prior authorized.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT		TOTAL DAYS USED YEAR TO DATE	NAME OF ATTENDING PHYSICIAN
		FROM	TO		

\_\_\_\_\_  
(SIGNATURE OF ADMINISTRATOR / DESIGNEE) (DATE) (AUTHORIZING SIGNATURE) (DATE)

**INSTRUCTIONS**

If residents listed are within the twenty-four (24) day annual limit and this visit is no more than seventy-two (72) hours, mail **copy only** to the Senior and Long-Term Care Division. Keep original for your file. Submit on a monthly basis. Request must be submitted to the Department within 90 days after the first day of the requested bed hold period.

Prior authorization requests for absences in excess of the 72-hour per visit limitation must be submitted to the Senior and Long-Term Care Division, Department of Public Health and Human Services for review and authorization. (See form DPHHS-SLTC-042).

\*Total Days Used Year To Date\* refers to the State Fiscal Year (July 1 - June 30).

To compute the number Therapeutic Home Visit days used on this visit, **do** count the day the resident leaves – **do not** count the day of return. Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. Example: If a resident leaves Friday and returns Sunday, the days absent are counted as two (Friday and Saturday). For billing instructions please refer to the Nursing Facility Services Manual.



# Therapeutic Home Visit (THV) in Excess of 72 Hours



- Form DPHHS-SLTC-042
- Does require prior authorization before resident leaves facility.
- Request must be submitted to SLTC for review and prior authorization – call 406-444-3997 or fax 406-444-7743.
- Must be on care plan that extended visits are appropriate, and the resident’s doctor must approve the resident to leave the facility.
- After prior authorization is approved, the form must be submitted within 90 days of the 1<sup>st</sup> day of the requested bed reservation period.

DPHHS-SLTC-042 (Rev. 05/04) STATE OF MONTANA  
 Department of Public Health and Human Services  
 Senior and Long-Term Care Division  
 P.O. Box 4210 Helena, Montana 59604-4210  
 (406) 444 - 4077

**REQUEST FOR BED RESERVATION FOR THERAPEUTIC HOME VISIT IN EXCESS OF 72 HOURS**

\_\_\_\_\_  
 (NAME OF FACILITY) (ADDRESS OF FACILITY)

\_\_\_\_\_  
 (FACILITY ID NUMBER)

I certify that a bed is being held for the following resident and the care plan for this resident provides for therapeutic home visits. I understand that this request for a therapeutic home visit in excess of 72 hours must be prior authorized and that there is a limit of 24 days annually.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT		TOTAL DAYS USED YEAR TO DATE	NAME OF ATTENDING PHYSICIAN
		FROM	TO		

REASON FOR REQUEST: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Administrator / Designee: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE SENIOR AND LONG TERM CARE DIVISION, DEPARTMENT OF PHHS.**

Authorized  Not Authorized Date: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 (Authorizing Signature) (Date)

**INSTRUCTIONS**

This request must be referred to the Senior and Long Term Care Division, Nursing Facility Services Bureau, P.O. Box 4210, Helena, Montana 59604-4210, for review and prior authorization. Prior authorization can be obtained by calling the Department or by sending the SLTC-042 before the date of departure. If the form is mailed, it must be received by the department prior to the first day of the visit if not prior authorized by phone. The visit must be prior authorized before the resident leaves the facility. The completed form must be submitted to the Department within 90 days after the first day of the requested bed hold period. The original, with authorization signature or denial, will be returned for your records. A copy will be retained by SLTC Division, DPHHS.

\*Total Days Used Year To Date\* refers to the State Fiscal Year (July 1 - June 30).

Enter the date the resident leaves in the 'From' column and the date the resident returns in the 'To' column. To compute the number Therapeutic Home Visit days used on this visit, do count the day the resident leaves – do not count the day of return. . .  
 Example: if resident leaves Friday and returns Tuesday, the days absent are counted as four (Friday, Saturday and Sunday, Monday).  
 Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. For billing instructions please refer to the Nursing Facility Services Manual.





# Swing Bed Providers

- Administrative Rules of Montana at 37.40.401-421 pertain to the Medicaid requirements and payments for services in Swing Bed Hospitals.
- Be a licensed hospital, Licensed Medical Assistance Facility (MAF) or Critical Access Hospital (CAH), which is Medicare certified to provide swing bed services
- Enroll as a Medicaid swing bed hospital provider
- Be located in a rural area of the state



# Swing Bed Providers

# Admission Requirements

- Swing beds are to be used only when there is no appropriate nursing facility bed available, within a 25-mile radius of the swing bed hospital that can meet the resident's needs.
- Swing bed hospitals & CAH must canvas all of the nursing facilities within the 25-mile radius to determine the availability of an appropriate nursing facility bed prior to admission of the individual to the swing bed.
- Swing bed hospital & CAH must include in medical record documentation that supports that no nursing facility bed was available in order to document the appropriateness of the admission into the swing bed and the billing to Medicaid.
- Medicaid recipient must meet level of care requirements based on screening completed by the Mountain-Pacific Quality Health.



# Swing Bed Transfer Requirements

A swing bed Medicaid recipient must be discharged to an appropriate nursing facility bed within the 25-mile radius of the swing bed facility once a nursing facility bed becomes available.



# Swing Bed Provider

# Waiver of Transfer Requirement

- Physician may request in writing a waiver of the 25 mile transfer requirement if:
  - The recipient's condition would be endangered by the transfer to an appropriate nursing facility bed; or
  - The individual has a medical prognosis or terminal condition where by his/her life expectancy is six months or less.
- Senior and Long Term Care Division evaluate this information and will either approve or deny this request for a waiver in writing to the swing bed hospital or CAH.
- For waiver of the transfer requirements, contact Becky McAnally at 406-444-3997.



# Swing Bed Provider Billing

- Swing bed providers bill the per diem rate established by Medicaid on the Form MA-3.
- Beginning March 4, 2010, swing bed facilities may now bill Montana Medicaid electronically for per diem charges. Services that are included in the swing bed per diem rate and the services that can be billed in addition to the per diem are the same as for nursing facility providers.



# Claims



- All **paper** NF claims submitted on an MA-3 or a CMS-1500.
- Paper claims and TADs (turn around documents) require manual input at several points in the claims process.
- Electronic claims generally only require manual input at one point – **THEREFORE** – electronic claims are less likely to be inaccurate due to human error.
- Electronic claims filing will be required in the new MMIS system.
- There may be a learning curve with electronic claims but once that has passed, electronic claims are generally faster and more accurate. When there are errors, there are more opportunities (*weekly billing is an option*) to correct the errors within timely filing limits (365 days).
- If EFT (Electronic Funds Transfer) is also selected then the payment does not have to wait for the check printing cycle.



# TADS (Turn Around Documents)



- TADs are a system generated MA-3 based on the paper claims submitted in the previous month.
- These are provided to expedite billing for Nursing Facilities but should not be assumed to be accurate.
- Nursing Facility personnel need to review the documents for accuracy – if a resident was not in the facility the previous month, he or she will have to be added. If a resident left the facility the number of days may need to be changed or the resident may need to be deleted from the document if discharged or expired.
- If a resident was not in the facility a full month the previous month or had a different personal resource amount those differences will be on the TAD and will need to be updated.
- Coding numbers change from time to time and just because the diagnosis code (for instance) was accurate last month it does not mean that it is accurate this month.



# Claims Accuracy



- Submit claims promptly.
- From and To dates – use the dates being claimed.
- The cleaner your submission, the better the system works.

STATE OF MONTANA - DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

FOR USE BY NURSING FACILITIES PLEASE TYPE OR PRINT FORM NO. MA-3

NURSING FACILITY - NAME AND ADDRESS (1) Assisted Living Services 112 Eastview Road Anytown, MT 59999		PROV. NO. (2) 0099999	MAIL TO <b>MONTANA MEDICAID</b> DEPT. MA-3 P.O. BOX 8000 HELENA, MT. 59604 TELEPHONE NUMBER 1-800-624-3958		(5)
PATIENT: LAST NAME FIRST MIDDLE INITIAL (3) Moreover, Dottie K. (4)		M S F COUNTY M E I 20	INDIVIDUAL NUMBER AUTH.		(6) 999999999
DIAGNOSIS (7) Osteoarthritis	DIAG CODE (8) 715.9	DATE OF BIRTH MO. DAY YEAR (9) 10 29 15	DATE ADMITTED MO. DAY YEAR (10) 12 20 02	STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR (11) 02 29 04	
NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG CODE	NO. OF DAYS (12) 029	LEVEL OF CARE (13) 2	TOTAL CHARGES (14) 3,595.79	LESS PERSONAL RESOURCES (15) 430.00
				NET CHARGES (16) 3,165.79	
PATIENT: LAST NAME FIRST MIDDLE INITIAL		M S F COUNTY	INDIVIDUAL NUMBER AUTH.		
DIAGNOSIS		DIAG CODE	DATE OF BIRTH MO. DAY YEAR	DATE ADMITTED MO. DAY YEAR	STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES LESS PERSONAL RESOURCES NET CHARGES
PATIENT: LAST NAME FIRST MIDDLE INITIAL		M S F COUNTY	INDIVIDUAL NUMBER AUTH.		
DIAGNOSIS		DIAG CODE	DATE OF BIRTH MO. DAY YEAR	DATE ADMITTED MO. DAY YEAR	STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES LESS PERSONAL RESOURCES NET CHARGES
PATIENT: LAST NAME FIRST MIDDLE INITIAL		M S F COUNTY	INDIVIDUAL NUMBER AUTH.		
DIAGNOSIS		DIAG CODE	DATE OF BIRTH MO. DAY YEAR	DATE ADMITTED MO. DAY YEAR	STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES LESS PERSONAL RESOURCES NET CHARGES
PATIENT: LAST NAME FIRST MIDDLE INITIAL		M S F COUNTY	INDIVIDUAL NUMBER AUTH.		
DIAGNOSIS		DIAG CODE	DATE OF BIRTH MO. DAY YEAR	DATE ADMITTED MO. DAY YEAR	STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES LESS PERSONAL RESOURCES NET CHARGES
				TOTAL CHARGES THIS SHEET	
				TOTAL CHARGES THIS MONTH	
I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees is made in accordance with established schedules is accepted as payment in full. I further certify that the services indicated above have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DPHS, the Comptroller (Director) of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.					
<b>UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</b> I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.					
PROVIDER'S SIGNATURE <i>Adria Administrator</i>			DATE 03/01/04	(17)	(18)



# Separately Billable Items i.e. Ancillary Items



- Billed on **CMS-1500**
- Fee schedule is a list of items which are separately billable and the codes to use. You can find the fee schedule at this website [www.medicaprovider.hhs.mt.gov](http://www.medicaprovider.hhs.mt.gov).
- Billable at acquisition cost with no markup, i.e. Ancillary Items. ARM site 37.40.330
- Some items may be billable for nursing facility residents by other provider types (DME, Therapy, Pharmacy).



# Prior Authorizations



## Required for following services

- ARM 37.85.205 & 37.86.5101– 5120
- Feeding solutions
  - When sole source of nutrition (Medicare may also pay – so Medicare Explanation of Benefits (EOB) may be required), Medicaid may pay when it is primary source of nutrition.
- Routine Supplies used in extraordinary amounts
- Oxygen Concentrators

*All require Doctor's orders and documentation of cost.*



# Claims Problem Resolution



## Denied Claims –

Check Error Codes and correct claims – some issues are:

- Eligibility issues:
  - Verify that dates being claimed are within an eligibility span. There are a number of ways to check eligibility: Medicaid card, Provider web portal, and FaxBack as examples.
  - If unable to confirm eligibility and resident claims eligibility, check with County OPA.



# Claims Problem Resolution

Denied Claims –

Check Error Codes and correct claims – some issues are:

- No NH span –
  - make sure dates are entered correctly change if appropriate
  - If dates are correct – check with county office as to dates on NH span
  - If county office says the span has been entered and dates agree with your dates - if claim denies the next month call Provider Relations.
  - If claims continue to deny - call SLTC
- Diagnosis Code
  - If code has been used previously make sure there has not been a coding change. Use the most specific code available



# Claims Problem Resolution



- **Claims paid incorrectly**
  - **Paid claims must be adjusted**
    - do not submit a new claim to adjust an already paid claim
  - Use the adjustment form to submit an adjustment
    - Fill in top box completely
    - Fill in only info being changed in the bottom
  - Claims and adjustments must be completed within 365 days of dates of service

Updated 04/2011

## 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 Advice and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (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 & Address	3. Internal Control Number (ICN)
Name _____	_____
Street or P.O. Box _____	4. NPI/API _____
City _____ State _____ ZIP _____	5. Client ID Number _____
2. Client Name _____	6. Date of Payment _____
	7. Amount of Payment \$ _____

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

	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.



Mail to: ACS  
P.O. Box 8000  
Helena, MT 59604





# Tips to Avoid Timely Filing Denials



- **Submit claims in a timely manner.**
- **Correct and resubmit denied claims promptly** Some areas to watch for include the following:
  - **Ensure coding is correct and valid for your provider type**
  - **Make sure the dates of service are the days being claimed.**
  - **Confirm that the resident's Medicaid ID number is correct**
  - **If a claim continues to deny, contact Provider Relations for assistance in resolving the claim (see Key Contacts).**
- **If a provider has made several attempts to resolve a claim, including working with Provider Relations, and the provider believes that the claim is a clean claim, and it still denies, contact Senior and Long Term Care for review of the claim (see Key Contacts).**
- **Under very limited circumstances, providers may need to submit an adjustment for a claim over 365 days from the date of service. In these cases, submit the claim to Senior and Long Term Care for review and special handling.**
- **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).**



# SLTC CONTACTS



**BUREAU CHIEF: RICK NORINE 406-444-4209 or e-mail [rnorine@mt.gov](mailto:rnorine@mt.gov)**

Rick is responsible for the overall management and coordination of the Medicaid nursing facility program including policy, reimbursement and program development. The Bureau Chief acts as the supervisor for the following positions: Institutional Superintendent of Montana Veterans Home, two Human Services Specialists, and an Administrative Officer at Eastern Montana Veterans Home.

**HUMAN SERVICES SPECIALIST: STEVE BLAZINA 406-444-4129 or e-mail [sblazina@mt.gov](mailto:sblazina@mt.gov)**

Steve sets the Nursing Facility Medicaid Per Diem Rates and the Medicaid Swing Bed Per Diem Rates for Hospital and Critical Access Hospital Providers. He maintains the Medicaid Nursing Facility Cost Reports for each fiscal year.

**HUMAN SERVICES SPECIALIST: Becky McAnally 406-444-3997 or e-mail [bmcanally@mt.gov](mailto:bmcanally@mt.gov)**

Becky is responsible for prior authorizations on therapeutic home visits, enteral and parenteral feeding solution, and extraordinary use of routine supplies. Becky is also responsible for nursing facility problem claim reviews, and the monitoring and verification of the following nursing facility reporting requirements:

- ✓ Monthly Nursing Home Staffing Report (DPHHS-SLTC-015)
- ✓ Request for Nursing Home Bed Reservation During Resident's Temporary Hospitalization (DPHHS-SLTC-052)
- ✓ Request for Therapeutic Home Visit Bed Reservation (DPHHS-SLTC-041)
- ✓ Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours (DPHHS-SLTC-042)
- ✓ Quarterly Nurse Aide Certification/Training and Competency Evaluation Survey Form



# Nursing Facility Services Bureau WebEx Trainings



The Nursing Facility Services Bureau is providing quarterly provider training via WebEx for Nursing Facility providers and staff.

- ✓ The first training on November 6, 2013, on monitoring and verification of nursing facility reporting requirements which was presented by Becky McAnally, Human Service Specialist, Senior and Long Term Care, Department Public Health and Human Services;
- ✓ The February 5, 2014, training was on Service First Long Term Care Specialization and was presented by Lynnette Nilan, Special Projects Manager, Human and Community Services Division, Montana Department of Public Health and Human Services.

Our NEXT training is scheduled for May 7, 2014. Additional information and an agenda will be sent to all Nursing Facility providers.

The Bureau would like feedback on topics that we should include in these trainings. Please contact Becky McAnally, Nursing Facility Services Program Officer at [bmcanally@mt.gov](mailto:bmcanally@mt.gov)



# Continued Stays & Level of Care



- Please be reminded that Mountain-Pacific Quality Health nursing staff is responsible for completing continued stay/ level of care reviews every six months for all Medicaid residents, and every 60 days for skilled Medicaid residents in your nursing facility.
- Mountain-Pacific continues to ask you to fax your list of Medicaid residents for the month being reviewed. This will allow Mountain-Pacific to provide you with an inclusive and current list of Medicaid residents who will need to be reviewed.
- Mountain-Pacific review nurses fax the level of care information from the previous review to the nursing facilities' identified contact person; typically the director of nursing, floor nurse or MDS coordinator. This information must be updated by the facility for those residents being reviewed and returned to MPQH.

If you have any questions, please contact:

**Jennifer Zody, RN**  
*Clinical Review Manager*



3404 Cooney Drive | Helena, MT 59602  
Ph: (800) 268-1145 | Fax: (406) 513-1927 | [www.mpqhf.org](http://www.mpqhf.org)





# Service First Long Term Care Specialization



## LTC Specialized Unit

The Long Term Care Field Office will focus almost exclusively on managing nursing home Medicaid cases.

The Staff will receive specialized training to be able to manage the complexities of Medicaid Long Term Care rules and regulations.



# Technical Support

- **In-person interviews** with information entered directly into an electronic application
- **Telephone interview** with information entered into an electronic application
- **Online Application** ([apply.mt.gov](http://apply.mt.gov)) entered directly into CHIMES EA (eligibility system)
- **Phone CLOUD**



# Phone CLOUD

## **Why a Phone Cloud?**

- Warm Transfers
- Skill-based Call Assignment
- Shorter Wait Times
- NO Voicemail
- Timely Call Return
- Toll-free Calling
- Quality Improvement
- Quality Assurance



# Focused Case Management

Case Managers will all be co-located in the LTC Field Office and will be working in concert to meet the clients', families' and providers' needs in a timely and effective manner.



Jean  
Perrotta  
([jperrotta@  
mt.gov](mailto:jperrotta@mt.gov))  
496-4955

Any verification documents or application materials for Long Term Care can be faxed toll-free to 1-877-418-4533 or mailed to:

State of Montana Office of Public Assistance  
PO Box 202925  
Helena, MT 59620-2925

Julie  
Sonderegger  
([jsonderegger@  
mt.gov](mailto:jsonderegger@mt.gov))  
751-2494.

Clients and their representatives may also provide verification documents to any one of our Office of Public Assistance offices across the state.

The Office receiving the information will promptly forward the information to the Long Term Care Field Office. If you have any questions regarding services offered by the Long Term Care Field Office, please contact an LTC Field Office Client Service Coordinator using our toll-free number 1-888-706-1535.



# Payment Error Rate Measurement (PERM) Provider Education Webinar/Conference



The Centers for Medicare & Medicaid Services (CMS) will host four Payment Error Rate Measurement (PERM) provider education webinar/conference calls during Cycle 3 (2014). The purpose is to provide opportunities for the providers of the Medicaid and Children's Health Insurance Program (CHIP) communities to enhance their understanding of specific Provider responsibilities during the PERM.

The PERM program is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA).

Webinar/Conference call participants will learn from presentations that feature;

- The PERM process and provider responsibilities during a PERM review
- Recent trends, frequent mistakes and, best practices
- The Electronic Submission of Medical Documentation, esMD program
  - 1) Tuesday June 10, 2014 1:00 – 2:00 pm MST
  - 2) Thursday June 26, 2014 1:00 – 2:00 pm MST
  - 3) Wednesday July 16, 2014 1:00 – 2:00 pm MST
  - 4) Wednesday July 30, 2014 1:00 – 2:00 pm MST

Web link: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/PERM/Providers.html>



# QUESTIONS?

