

Provider 102

October 2015



Welcome to Montana Healthcare Programs

Medicaid ▪ Healthy Montana Kids ▪ Mental Health Services Plan

Thank you for choosing to serve the healthcare needs of our members through Montana Healthcare Programs. Your commitment to providing high quality services to our members is important to them and to those of us who administer the program.

We are dedicated to making your participation in the program as straightforward and productive as possible.



What happens now?

Welcome Letter

You will receive a Welcome to Montana Healthcare Programs letter in the mail. This letter indicates your provider number which is either your NPI (National Provider Identifier) or a Montana Medicaid assigned API (Atypical Provider Identifier, sometimes referred to as a Waiver number) and your provider type.

The letter provides a list of valuable materials on the Montana Healthcare Programs Provider Information website:

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

Montana Healthcare Programs Website

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

- The Montana Healthcare Programs Provider Information website is available 24/7/365.
- Contains general manual and provider manuals that apply to specific provider types. Manual replacement pages are usually titled by subject.
- Provider notices report important updates including, but not limited to, policy, program, coding, and rule changes.

Resources on the Website

Montana Access to Health (MATH) Web Portal

The MATH web portal is a secure website from which providers can verify eligibility, check claim status, view and download remittance advices, and more. Click the MATH Web Portal link in the gray box in the left menu.

Claim Jumper Newsletters

The Montana Healthcare Programs newsletter, the *Claim Jumper*, is available online only; however, you may choose to print for your use.

What's New on the Site

A list of documents that have been posted to the website. This is located in the Quick Links section.

Announcements

Important announcements for providers. These are on the Provider Information page and may link to additional information.

Provider Type

See your provider type webpage for specific resources.

Resources by Provider Type

- On your provider type page, see:
 - **Provider Manuals section.** Print the provider manuals for your provider type(s). All providers should be familiar with the *General Information for Providers* manual, their provider type manual, and other information. This applies to all providers.
 - **Provider Manuals – Replacement Pages section.** Print the manual replacement pages for your provider type.
 - **Provider Notices section.** Refer to notices for your provider type.
 - **Fee Schedules section.** Refer to fee schedules for your provider type.
 - **Other Resources.** Most provider type pages have an area for miscellaneous resources.

We encourage you and your billing staff to visit the website weekly for important program updates.



Resources by Provider Type

Provider type information is found by left clicking on the **Resources by Provider Type** link in the menu.



[Resources by Provider Type](#)

[Team Care](#)

[Terminated/Excluded Medicaid Providers](#)

[Training](#)

Read and accept the End User Agreement to access the resources.

[I ACCEPT](#)

[I DO NOT ACCEPT](#)

Resources by Provider Type

Select Your Provider Type

Providers are listed in alphabetical order.

[A – C](#)

[D – F](#)

[G – K](#)

[L – O](#)

[P – Q](#)

[R – Z](#)

Providers A – C

 [Ambulance](#)

02.11.2015 [Ambulatory Surgical Center](#)

02.11.2015 [Audiologist](#)

02.11.2015 [Chemical Dependency](#)

02.11.2015 [Chiropractor](#)

02.11.2015 [Clinic \(Freestanding Dialysis\)](#)

02.11.2015 [Clinic \(Public Health\)](#)

- Navigate by clicking a button to jump to that section in the alphabetical list or by scrolling.
- Click on a provider type name to open the provider type webpage.

Example: Ambulance

All provider type pages have these sections.

Ambulance



Provider Manuals

[General Information for Providers](#) 08.2015

Medicaid manual with general information for all provider types.

[Ambulance Services](#) 03.2015

This manual has information specific to your provider type.



Provider Manuals – Replacement Pages

General Information for Providers

07.31.2015 [General Information for Providers: Entire Manual](#)

11.19.2014 [Billing Procedures](#)

10.08.2014 [Billing Procedures](#)

07.22.2014 [Member Eligibility and Responsibilities](#)

06.30.2014 [General Information for Providers](#)

If information is found on the website, it has been removed from the manual, and a link to the source is provided.

Example: Ambulance

All provider type pages have this section.



Medicaid Rules and Regulations

[Code of Federal Regulations \(Title 42\)](#)

[Montana Code Annotated \(Title 53, Chapter 6\)](#)

[Administrative Rules of Montana \(Title 37\)](#)

- [Chapter 79 Healthy Montana Kids](#)
- [Chapter 82 Medicaid Eligibility](#)
- [Chapter 83 Medicaid for Certain Medicare Beneficiaries and Others](#)
- [Chapter 85 General Medicaid Services](#)
- [Chapter 86 Medicaid Primary Care Services](#)

Example: Ambulance

Most provider type pages have this section.



Fee Schedules

PDF	Excel
01/2015 January 2014 Ambulance	01/2015 January 2015 Ambulance
07/2014 July 2014 Ambulance	07/2014 July 2014 Ambulance
01/2013 January 2013 Ambulance	01/2013 January 2013 Ambulance
07/2012 July 2012 Ambulance	07/2012 July 2012 Ambulance
01/2012 January 2012 Ambulance	01/2012 January 2012 Ambulance
07/2011 July 2011 Ambulance	07/2011 July 2011 Ambulance
01/2011 January 2011 Ambulance	01/2011 January 2011 Ambulance
07/2010 July 2010 Ambulance	07/2010 July 2010 Ambulance
07/2009 July 2009 Ambulance	07/2009 July 2009 Ambulance
01/2009 January 2009 Ambulance	01/2009 January 2009 Ambulance
10/2008 October 2008 Ambulance	10/2008 October 2008 Ambulance
07/2008 July 2008 Ambulance	07/2008 July 2008 Ambulance
10/2007 October 2007 Ambulance	10/2007 October 2007 Ambulance

Example: Ambulance

All provider type pages have this section.



Provider Notices 2010–2015

2015

- 08.03.2015 [ICD-10 Guidance for Implementing International Classification of Diseases, 10th Edition \(ICD-10\)](#)
- 07.31.2015 [Adult and Pediatric Specialty Table of Services Available in Montana](#)
- 07.08.2015 [Ambulance Provider Reimbursement Rate Changes](#)
- 02.11.2015 [New HCPCS Modifiers – XE, XP, XS, and XU](#)

2014

- 12.18.2014 [Electronic Funds Transfer \(EFT\) and Electronic Remittance Advice \(ERA\) Changes Final Notice](#)
- 09.16.2014 [Adoption of the New Children's Mental Health Bureau's Medicaid Provider Manual into Administrative Rules of Montana](#)
- 08.05.2014 [Montana Prescription Drug Registry](#)
- 07.01.2014 [Ambulance Provider Reimbursement Rate Changes](#)
- 06.12.2014 [ICD-10 Delay](#)
- 05.13.2014 [PERM Provider Educational Webinars](#)
- 04.22.2014 [Modifier Changes for Professional Claim Billers](#)
- 03.18.2014 [Information Regarding CMS-1500](#)

Example: Ambulance

Most provider type pages have this section.



Other Resources

[EOB R&R Crosswalk](#) PDF and [EOB R&R Crosswalk](#) Excel 02.2011

With the implementation of HIPAA, Medicaid discontinued the use of Medicaid EOB codes and began using HIPAA standard reason and remark (R&R) codes. This document crosswalks the HIPAA standard R&R codes to the Medicaid EOB codes.

[Lab Panels 2007](#) 01.2007

List of codes that make up lab panels for 2004–2007

[Most Commonly Used NDCs](#) 02.2011

[Rebateable Manufacturers](#) 07.2015

[TPL Insurance Carrier ID List by Carrier ID](#) and [TPL Insurance Carrier ID List by Name](#) 05.2012

The *Claim Jumper*

The monthly Montana Healthcare Programs newsletter containing information on policy, program, coding, and rule changes, a list of recent documents posted to the website, the Top 15 claim denial reasons, a monthly Nurse First article, and more.

End User Agreement

Read and accept the End User Agreement to access the newsletters.



Claim Jumper Newsletters

Much of the provider information contained on the Montana Healthcare Programs Provider Information website is copyrighted by the American Medical Association and the American Dental Association. This includes items such as CPT codes and CDT codes.

Before you can enter the *Claim Jumper Newsletters* section of the website, read and accept an agreement to abide by the copyright rules regarding the information you find within this section. If you choose not to accept the agreement, you will return to the Montana Healthcare Programs Provider Information home page.

[I ACCEPT](#)

[I DO NOT ACCEPT](#)

The *Claim Jumper*

Claim Jumper

- ▶ [Claim Jumper 2015](#)
- ▶ [Claim Jumper 2014](#)
- ▶ [Claim Jumper 2013](#)
- ▶ [Claim Jumper 2012](#)
- ▶ [Claim Jumper 2011](#)
- ▶ [Claim Jumper 2010](#)
- ▶ [Claim Jumper 2006–2009](#)
- ▶ [Claim Jumper 2000–2005](#)

The *Claim Jumper*

Claim Jumper

▼ [Claim Jumper 2015](#)

[Volume XXX, Issue 10, October 2015](#)

Publications Reminder
Free Webinars in 2015
ICD-10 Is Coming October 1, 2015!
Mental Health Services and Targeted Case Management
Passport: Provider Change Form Reminder
DME Proof of Delivery
Five Signs Someone May Be Considering Suicide
Publications Available on the Website
Attention RHC and FQHC Providers!
Top 15 Claim Denial Reasons
Xerox Field Representatives' Corner
Key Contacts

[Volume XXX, Issue 9, September 2015](#)

Publications Reminder
Free Webinars in 2015
Provider Training Fall 2015
ICD-10 Is Coming October 1, 2015!
Provider Specialty Table of Services in Montana
Provider Requirements for CANS
Parent's Guide to Vaccinations

The Claim Jumper

Montana Healthcare Programs *Claim Jumper*
October 2015

Montana Healthcare Programs *Claim Jumper*
October 2015

Montana Healthcare Programs *Claim Jumper*
October 2015



Volume XXX, Issue 10, October 2015

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Top 15 Claim Denial Reasons 4

Xerox Field Representatives' Corner 4

Key Contacts 4

ICD-10 Is Coming October 1, 2015!

Montana Medicaid is getting the word out that ICD-10 will not be delayed. The implementation date for ICD-10 is October 1, 2015!

The claims processing system will look at the Date of Service field or the Date of Discharge (inpatient claims) field to determine which diagnosis version is required.

ICD-10 Claims Testing Available
Are you ready to submit test claims with ICD-10 diagnosis codes? It is up to you to have the resources in place to submit ICD-10 codes on claims as of October 1, 2015.

Testing is available for all Montana Medicaid providers to ensure they are using valid ICD-10 codes in the right format.

We recommend you submit 10-20 claims to get a good sample.

In the test region, the effective date for an ICD-10 diagnosis code or ICD-10 surgical procedure code is January 1, 2015.

For claims to be tested and results returned as an 835 X12 file or as an eSOR by October 1, 2015, files must be sent by September 4, 2015.

Files received after this date have no guarantee of an 835 X12 file or eSOR until after the October 1, 2015 implementation date.

Contact [Tom Keith](#) or [Janet Reifschneider](#), or call Provider Relations at 1.800.624.3958 to make arrangements to send test claims.

Additional information about **ICD-10** is available on the Provider Information website.

Submitted by Janet Reifschneider, DPHHS

Mental Health Services and Targeted Case Management

It has been brought to the attention of Surveillance and Utilization Review (SURS) that Montana Medicaid members have been misinformed regarding psychiatrist and targeted case management services. Members mistakenly believe that in order to receive psychiatric services, they were also required to have targeted case management services.

Mental health centers cannot require Montana Medicaid members who need the care of a psychiatrist to also receive targeted case management services. (ARM 37.85.402 and 42 CFR § 441.18)

ARM 37.85.402 (5) states that providers shall render services to an eligible Medicaid member in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

42 CFR § 441.18 dictates that a state must meet the following requirements:

... (2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan.

... (3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.

... (6) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.



Provider Relations

The Provider Relations Department communicates Montana Healthcare Programs policies to the provider community.

Customer Care Services

Enrolls new providers and updates existing provider files.

Provides support to providers for billing, member eligibility, and claims inquiry.

Enrolls and provides support for electronic billing (EDI).

Field Representatives

Provides on-site support to Montana providers.

Conducts provider training and fairs.

Publication Specialist

Maintains the Provider Information website <http://medicaidprovider.mt.gov>.

Develops and maintains provider manuals.

Claim Jumper

Provider Relations Contacts

Frequent call topics for Provider Relations:

- Eligibility verification
- Passport provider verification
- Procedure code information
- Assist providers with enrolling, billing claims, etc.
- Questions regarding a provider file or payment information

Provider Relations Call Center

P.O. Box 4936
Helena, MT 59604

Out of State and Helena

800-624-3958

Helena and Local Area

406-442-1837

Fax

406-442-4402

Field Reps

Aaron Hahm 406-457-9598

Provider Relations Phone Tree

Placing your call into the appropriate queue ensures you receive the fastest customer service from the appropriate agents.

Queue

- 1 – Eligibility
- 2 – PR Rep
- 3 – EDI
- 4 – TPL

Options

- | | | |
|---------------|---------------|-----------|
| #1 IVR | #2 FaxBack | #3 PR Rep |
| #1 Claims | #2 Enrollment | |
| #1 Web Portal | #2 EDI | |
| #1 Provider | #2 Client | |

EDI Support Unit

Frequent call topics for EDI Support:

- Individual file rejection
- File errors
- Clearinghouse rejections
- WINASAP 5010 support

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

Out of State and Helena
1-800-987-6719
Fax
406-442-4402

Third Party Liability

TPL Processes
Suspended claims due to TPL issues
Blanket denials
Insurance Verifications
Carrier billing/Carrier codes
Check logs
Eligibility reconciliation
Trauma letters
Credit balance
Retro Medicare

Third Party Liability Contacts

Contact TPL for resolution to:

- Member eligibility issues
- A member's claim is denied due to other insurance listed in the MMIS and the member no longer has that insurance
- Issues with check log/daily deposit balance
- TPL information in MMIS does not match TPL information in PDCS
- TPL information in CHIMES and MMIS do not match
- Questions regarding trauma letters

TPL Unit

P.O. Box 5838

Helena, MT 59604

Out of State and Helena

800-624-3958

Helena

406-443-1365

Fax

406-442-0357

Definitions and Acronyms

[MATH Web Portal](#)

Log in to
Montana Access to Health

[Member Information](#)

[Provider Information](#)

[Claim Instructions](#)

[Claim Jumper Newsletters](#)

[Contact Us](#)

[Definitions and Acronyms](#)

[Enhanced Payment](#)

[Electronic Billing](#)

[EPSDT](#)

[FAOs](#)

Definitions and Acronyms

[DPHHS Acronyms](#)

▼ [Numeric – A](#)

270/271 Transactions

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

276/277 Transactions

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

278 Transactions

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

835 Transactions

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

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions.

Frequently Asked Questions (FAQs)

[Member Information](#)

[Provider Information](#)

[Claim Instructions](#)

[Claim Jumper Newsletters](#)

[Contact Us](#)

[Definitions and Acronyms](#)

[Enhanced Payment](#)

[Electronic Billing](#)

[EPSDT](#)

[FAQs](#)

[Forms](#)

[Health Improvement Program](#)

Frequently Asked Questions (FAQs)

- ▶ [Adjustments](#)
- ▶ [Billing and Electronic Transactions](#)
- ▶ [Claim Processing](#)
- ▶ [Enrollment](#)
- ▶ [Eligibility](#)
- ▶ [Fraud and Abuse](#)
- ▶ [MATH Web Portal, FaxBack, and IVR](#)
- ▶ [Medicaid Policy](#)
- ▶ [Passport](#)
- ▶ [Payment-Related](#)
- ▶ [Prior Authorization](#)
- ▶ [TPL/Medicare](#)
- ▶ [Other/Miscellaneous Policy](#)



Claims Process

Eligibility for Patient and Provider

Patient

- Individuals apply for benefits through local Offices of Public Assistance (OPA).
- Once qualified, many will additionally enroll in Passport.
- May then seek medical treatment from their PCP or any provider who accepts Medicaid. (May need PCP Referral)

Provider

- Enroll and approved Montana Healthcare Programs provider.
- May additionally enroll as Passport provider.
- After services are rendered, submit standardized claim forms for reimbursement of services.

Claims

Medicaid is payer of last resort.

Instructions for completing CMS-1500 and UB-04 forms are on the Provider Information website.

Montana-specific EDI 5010 requirements on the Provider Information website.

An automatic co-pay override is performed for members who have a Member Race indicator of Native American. Prescriptions filled at an IHS pharmacy are also exempt from copay.

Submission

Paper

Providers send their claims via mail or fax.

Electronic

Electronic claims are processed in exactly the same manner — cuts back on “human factor”

Methods of Submission

- WINASAP 5010 is free electronic billing software provided by Xerox.
- Third party software
- Clearinghouse

Submission: Electronic Claims

HIPAA created a standard format for electronic submissions. Maintained by the American National Standards Institute (ANSI) and the standards on transactions and code sets have only become stricter.

Claims can be submitted via paper or electronically. specific instructions are found in each provider manual by provider type and claim form type.

CMS-1500

- Professional
- 837 P

UB-04

- Hospital/Facility
- 837 I

Dental

- 837 D

MA-3 Nursing Home Claim

- TADs

MA-5 Pharmacy Claim

- Rare

Crossovers

- Medicare

Adjudication

- Three-day waiting period (or more if waiting for paperwork).
- MMIS cycles claims on Monday and Wednesday night.
- Payment file is sent on Wednesday.

Resolution: Suspended Claims

- Edit/Exception posts on claim or line.
- Xerox Resolution Team work each suspended claim by DPHHS approved text/instruction.
- Determine if line or claim can be denied or forced to pay.

Payment

- MMIS processes adjudicated claims for accounting.
- Generates files for the creation of warrants and remittance advices.
- Payment cycle runs every Wednesday.
- Provider payment mandatory through electronic fund transfer (EFT) from DPHHS.

Payment: Remittance Advice

Remittance advice are payment explanations which provide details about a provider's claims.

- The Statement of Remittance (SOR) contains paid, denied, in process regular claims and 'history only' gross adjustment claims.
- All providers must access remittance advice data through the MATH web portal.
- Providers can receive an 835 transaction delivery directly or via a clearinghouse.

Claim Type Billers

CMS-1500 Professional Claim		
EPSDT	Podiatry	Physical Therapy
Speech Therapy	Audiology	Hearing Aids
Occupational Therapy	Personal Care	Private Duty Nursing
Ambulatory Surgical Centers	Psychologists	Durable Medical Equipment
Optometric	Opticians/Eyeglasses	Commercial Transportation
Non-Emergency Transportation	Ambulances	Ancillary Services in Nursing Home
Physician	Home and Community Based Services (Waiver)	Targeted Case Management
Chemical Dependency (Outpatient)	Nutrition	Lab and X-Ray
Social Worker	Mid-Levels	Schools
Home Infusion Therapy	QMB Chiropractors	Group/Clinic
Licensed Professional Counselors	Mental Health Centers	Mental Health Case Management
Therapeutic Group Homes	Public Health Clinics	Therapeutic Family Care
Psychiatrists	Independent Diagnostic Testing Facilities	Family Planning Clinics
Birth Centers	Home Health Agency	

Items to Note

- **Box 17 Name of Referring Provider or Other Source.**
 - Montana Medicaid continues to accept for the referring provider's name.
 - ACA mandate requires referring/ordering provider identification
- **Box 17a Unlabeled**
 - Montana Medicaid reserves for Passport to Health referral number.
- **Box 23 Prior Authorization Number**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
				17b. NPI								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____							22. RESUBMISSION CODE ORIGINAL REF. NO.					
							23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
									NPI			
									NPI			
									NPI			

ADDITIONAL INFORMATION

Items to Note

- **Box 21 Diagnosis or Nature of Illness or Injury**
 - Numeric Diagnosis Code Pointers are not allowed (e.g., 1, 2) on the line items; use alpha characters (e.g., A, B)
 - As of October 1, 2015, the Department will begin accepting diagnosis codes A–L and the corresponding Diagnosis Code Pointers (A–L).

21. ADDITIONAL CLAIM LINE INFORMATION (Designated by HEDIS)											22. OUTSIDE L		
											<input type="checkbox"/> YES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)											22. RESUBMIS CODE		
ICD Ind.													
A. _____			B. _____			C. _____			D. _____			23. PRIOR AUT	
E. _____			F. _____			G. _____			H. _____				
I. _____			J. _____			K. _____			L. _____				
24. A. DATE(S) OF SERVICE													
From To													
MM DD YY MM DD YY													
B. PLACE OF SERVICE													
C. EMG													
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)													
CPT/HCPCS													
MODIFIER													
E. DIAGNOSIS POINTER													
F. \$ CHARGE													
1													

Claim Type Billers

UB-04 Institutional/Facility Claims	
Inpatient Hospital	Outpatient Hospital
Swing Bed Hospital	SNF/ICF Mental Aged
Residential Treatment Centers	ICF Mentally Retarded
Freestanding Dialysis Clinic	Rural Health Clinic (RHC)
Home Health	Hospice
Critical Access Hospital (CAH)	Federally Qualified Health Center (FQHC)
Indian Health Service (IHS)	

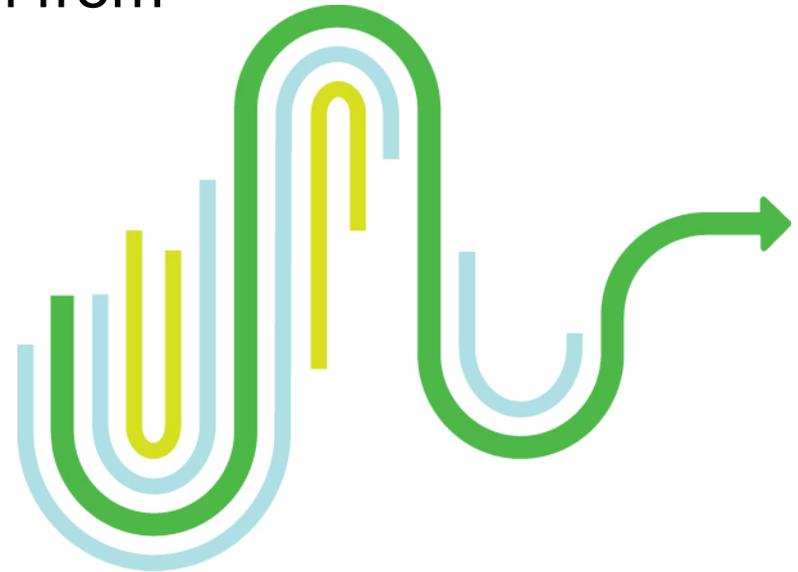


Remittance Advice

Ways to Receive Remittance Advices

Web portal download (TPA required)

835 Transactions (MT 835 form from clearinghouse is required)



Remittance Advice

First Page: Important Information

- NEWSLETTER UPDATE -

PROVIDERS ARE REMINDED TO USE THE MEDICAID MEMBER ID NUMBER, NOT THE MEMBER'S SSN, FOR BILLING PURPOSES AND CHECKING ELIGIBILITY TO ENSURE THE EXPENDITURES ARE APPLIED TO THE CORRECT AND ANY QUERY INFORMATION IS FOR THE CORRECT MEMBER. ERRORS CAN OCCUR USING THE SSN FOR EITHER BILLING/REQUESTING ELIGIBILITY INFORMATION. CONTACT PROVIDER RELATIONS AT 1.800.624.3958. (PSTD 01/08/14)

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THE 2014 SPRING PROVIDER FAIR IS BEING HELD MAY 20-21 IN HELENA, MT AT THE GREAT NORTHERN HOTEL. VISIT THE TRAINING PAGE ON THE MONTANA MEDICAID PROVIDER INFORMATION WEBSITE TO REGISTER, VIEW THE AGENDA, AND TO GET UP-TO-DATE INFORMATION ABOUT THE PROVIDER FAIR. (PSTD 03/05/14)

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IMPORTANT: FOR INFORMATION ABOUT MEDICAID AND G-CODES, SEE THE PROVIDER INFORMATION WEBSITE, [HTTP://MEDICAIDPROVIDER.HHS.MT.GOV/](http://MEDICAIDPROVIDER.HHS.MT.GOV/). (PSTD 01/15/14)

===

A PROVIDER WHO BILLS MEDICAID FOR SERVICES RENDERED TO AN ELIGIBLE MEDICAID MEMBER WILL BE DEEMED TO HAVE ACCEPTED THE PATIENT AS A MEDICAID MEMBER AND MAY NOT BILL THE MEMBER FOR THE SERVICES. (PSTD 11/26/12)

===

AS OF APRIL 1, 2014, THE CMS-1500 (08/05) FORM WILL NO LONGER BE A VALID FORM FOR THE SUBMISSION OF PROFESSIONAL CLAIMS. YOU MUST USE THE CMS-1500 (02/12) CLAIM FORM FOR SUBMISSION OF MEDICAID CLAIMS FOR PAYMENT. CMS-1500 (08/05) CLAIMS ARRIVING AFTER THAT DATE WILL BE RETURNED TO THE PROVIDER. SEE THE APRIL 2014 ISSUE OF THE CLAIM JUMPER FOR MORE INFORMATION ABOUT BILLING WITH THE 02/12 VERSION. FOR INFORMATION ON THE 02/12 VERSION, YOU MAY ALSO VISIT WWW.NUCC.ORG. (PSTD 03/17/14)

Tips

- Grouped by status.
- ICN is located under member's name.
- Do not resubmit a claim in PENDED (133) status.
- Work all denial reasons before resubmitting.
- Always contact Provider Relations if you have questions.

Remittance Advice

AS OF 08/08/2013

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

THE CLINIC
123 MAIN STREET
ANYWHERE, MT 59999

VENDOR # REMIT ADVICE # 228928 EFT/CHK # DATE 08/12/2013 PAGE 2

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	CO-PAID ALLOWED	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM								
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	1878.90	
	PATIENT NUMBER=							
CLAIM TOTAL**						1878.90	1878.90	
PAID CLAIM TOTALS - MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	1878.90	
CLAIMS PENDING: MISCELLANEOUS CLAIM								
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	0.00	133
	PATIENT NUMBER=							
CLAIMS PENDING TOTALS -MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	0.00	
TOTAL WARRANT AMOUNT							1878.90	

Reason and Remark Codes

HOpR: Standardized codes.

See R&R EOB Crosswalk for further explanation.

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

- B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
- B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
- B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.
- M57 MISSING/INCOMPLETE/INVALID PROVIDER IDENTIFIER.
- M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.
- M77 MISSING/INCOMPLETE/INVALID PLACE OF SERVICE.
- M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
- N30 PATIENT INELIGIBLE FOR THIS SERVICE.
- 125 PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
- 22 PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
- 29 THE TIME LIMIT FOR FILING HAS EXPIRED.
- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

Gross Adjustment

Listed as:

- Paid claims – Gross Adjustment
- History only – Gross Adjustment

Lists provider, facility, or member for which the adjustment belongs.

PAID CLAIMS - GROSS ADJUSTMENT

ICN 00000000000000000000	08062004 03302005	0.000	346.42-	346.42-
	MOVE CREDIT BALANCE FROM 12345			
ICN 00000000000000000000	11142007 11142007	0.000	45.74-	45.74-
	MOVE CREDIT BALANCE FROM 54321			
ICN 00000000000000000000	11142007 11142007	0.000	30.15-	30.15-
	MOVE CREDIT BALANCE FROM 11111			

Credit Balance

- Under member ID, the status of the claim is listed.
- Do not post a credit balance.
- The Internal Control Number (ICN) of a credit balance does not change.



Adjustment Requests

Forms

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Forms

These documents are listed in alphabetical order.

▼ [Forms A – F](#)

[Abortion Services Physician Certification Form MA-37](#) 03.2015

[MA-37 Instructions](#)

[Address Correction Form for Providers](#) 02.2015

Pay-To/1099 changes must be accompanied by a completed W-9 form. This form must be printed and signed, and may be mailed or faxed.

[Adjustment Request Individual](#) 02.2015

This form may be completed online; however, you must print, sign, and date before mailing to the address indicated.

[Ambulance Trip Log](#) 01.2008

[Attachment Cover Sheet for Paperwork](#) 03.2013

[Authorization for Health Disclosure](#) 03.2003

[Blanket Denial Request for TPL](#) 07.2012



Adjustment Request Form

- Complete all required sections.
- Make sure the information is legible.
- Double-check that your adjustments are correct.
- Attach a copy of the remittance advice with Reason and Remark Codes.
- **Do not adjust a denied claim.**

TIP!

You may wish to void and reprocess a claim at the same time rather than waiting for the adjustment process and resubmitting. To do this, indicate “reprocess with attached corrected claim” in box 8 and attach the new claim to the form and remittance advice.



Montana Healthcare 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 remittance statement. Complete only the items in Section B that 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 Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number Name _____ Street or P.O. Box _____ City _____ State _____ ZIP _____ Telephone Number _____	3. Internal Control Number (ICN) _____
2. Member Name _____	4. NPI/API _____
	5. Member ID Number _____
	6. Date of Payment _____
	7. Amount of Payment \$ _____

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

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

Signature _____ Date _____

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.



Adjustment Request Form: Section A

Montana Healthcare 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 remittance statement. Complete only the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the General Information for Providers manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

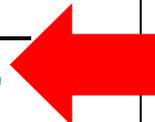
A. Complete all fields using the remittance advice for information.	
1. Provider Name, Address, and Telephone Number	3. Internal Control Number (ICN)
The Clinic	214010001200000
Name	
123 Main Street	4. NPI/API
Street or P.O. Box	1234567891
City Anywhere State MT ZIP 59991	5. Member ID Number
	1133111
Telephone Number	
2. Member Name	6. Date of Payment
John Doe	01/01/2013
	7. Amount of Payment
	\$ 558.86

Adjustment Request Form: Section B

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 3	4	2
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 John R. Smith, M.D. Date 02/02/2014

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.



Remittance Advice

Must Be Attached to Request

AS OF 08/08/2013

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

THE CLINIC
123 MAIN STREET
ANYWHERE, MT 59999

VENDOR # 0000121754 REMIT ADVICE # 228928 EFT/CHK # DATE 08/12/2013 PAGE 2

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM									
ICN 0132	PATIENT NUMBER=	06012013	06302013	30.000	T2031 UA	1878.90	1878.90		
CLAIM TOTAL**						1878.90	1878.90		
PAID CLAIM TOTALS - MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	1878.90		
CLAIMS PENDING: MISCELLANEOUS CLAIM									
ICN 0132	PATIENT NUMBER=	06012013	06302013	30.000	T2031 UA	1878.90	0.00		133
CLAIMS PENDING TOTALS -MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	0.00		
TOTAL WARRANT AMOUNT							1878.90		



Reason and Remark Codes

HOpR: Standardized these codes.

See R&R EOB Crosswalk for further explanation.

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

- B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
- B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
- B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.
- M57 MISSING/INCOMPLETE/INVALID PROVIDER IDENTIFIER.
- M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.
- M77 MISSING/INCOMPLETE/INVALID PLACE OF SERVICE.
- M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
- N30 PATIENT INELIGIBLE FOR THIS SERVICE.
- 125 PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
- 22 PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
- 29 THE TIME LIMIT FOR FILING HAS EXPIRED.
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Electronic Billing

Electronic Billing Page

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Electronic Billing

Whether you submit one claim a month or hundreds, any provider can benefit from switching from paper to electronic billing. Whether by using the free WINASAP 5010 software or by using a clearinghouse to submit claims, electronic billing is faster, more accurate, and more secure.

You need a personal computer with Windows 98 and above to submit electronically via WINASAP 5010.

See Electronic Submission Setup below to begin the process.

[For information about HIPAA 5010, click here.](#)

▶ [Electronic Submission Setup](#)

▶ [Software Downloads and Users' Guides](#)

▶ [Montana Healthcare Programs Information, News Briefs, and Provider Notices](#)



EDI Transaction Descriptions

- 270 / 271 – Eligibility inquiry
- 277 – Claim status inquiry
- 277CA – Claim acknowledgment
- 999 – Implementation acknowledgment
 - Contains accept or reject information
- 835 – Electronic Remittance Advice (ERA)

837P – General Montana Submission Rules

- To indicate prior authorization, use 'G1' in Loop 2300, REF01 at the header.
- To indicate a Passport referral number, use '9F' in Loop 2300, REF01 at the header.
- If the billing provider is an atypical provider, the 10-digit Montana Provider ID must be submitted in Loop 2010BB, segment REF with qualifier G2 Provider Commercial Number.

837 – Montana Specific Submission Rules

Montana processes 4 diagnoses only. See the Electronic Transaction Instructions for HIPAA 5010 on the website, <http://medicaidprovider.mt.gov>, for details regarding:

- Comprehensive School and Community Treatment
- Pregnancy
- Family Planning

837 – Paperwork Attachment Requirements

- Use Loop 2300, PWK segment to indicate paperwork is being sent.
- Use the Paperwork Attachment Cover Sheet located on the Forms page of the website (<http://medicaidprovider.mt.gov/forms>).
- Detailed instructions are included on the Paperwork Attachment Cover Sheet.
- The claim will pend for 30 days awaiting receipt of the paperwork.

Common Errors and Rejections

- Missing or invalid taxonomy code
- Non-matched ZIP + 4
- Missing Team number
- National Provider Identification (NPI) not enrolled
- Rendering provider
- Clearinghouse not sending Montana specific requirements

WINASAP 5010

Windows-based electronic claims entry application offered by Xerox.

- Submission to Montana Healthcare Programs only
- Requires EDI enrollment.
- Requires basic Web navigation and computer skills.
- Detailed instruction manual available on the Electronic Billing page.
- ICD-10 instructions added
- WebEx presentation posted on Training page
- Support is limited. Troubleshooting for modem, computer hardware, and software is not offered.



Provider Specialty Table

July 30, 2015

Montana Healthcare Programs Notice

All Providers

Adult and Pediatric Specialty Table of Services Available in Montana

Mountain-Pacific Quality Health (MPQH) and Montana Medicaid have developed a provider specialty table that lists specialty providers for adult and pediatric services in Montana.

The table includes Montana facilities, physician specialties, Montana Medicaid-enrolled physicians who perform specialized services, and contact numbers.

This unique tool can be used as a quick reference in determining which facility to send Montana Medicaid members to for specialized services (adult and pediatric) if the services cannot be provided in the current facility.

The table is available on the MPQH website at <http://mpqhf.com/corporate/medicaid-utilization-review/>. Click on the Out-of-State Inpatient Admissions link and scroll to the link for the database of specialty services available in Montana.

Montanans with Medicaid **Medicaid Utilization Review**



Under contract with the Montana Department of Public Health and Human Services (DPHHS), Mountain-Pacific Quality Health helps authorize certain health care services and equipment for Montanans with Medicaid. To provide different kinds of utilization review services, our team works with:

- hospitals
- physicians
- case managers
- therapists
- schools
- suppliers
- consumers
- families

Together, our goal is to make sure each Medicaid patient in Montana gets what he or she needs in the most appropriate, cost-effective way.

- + **Out-of-State Inpatient Admissions**
- + **Durable Medical Equipment and Physician-Related Services**
- + **Private Duty Nursing**
- + **Case Management for Discharge Planning**

Authorized Provider

When requesting prior authorization, the provider who needs to be authorized is the provider who will be rendering the services.

For example, if a provider is doing a procedure at a clinic, the prior authorization request needs to be submitted for the rendering provider's NPI number, not the clinic's NPI number.



Provider Notice Regarding Ordering and Referring Providers



Effective Immediately

Identification of Ordering and Referring Providers on CMS-1500 and 837P X12 Transactions

Requirements

The Patient Protection and Affordable Care Act and 42 CFR 455.440 mandates that all State Medicaid Programs require the National Provider Identifier (NPI) of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other health professional.

Claims Submission CMS-1500

This information is found at NUCC.org. Please see examples provided for protocol.

- Box 17 must include the appropriate qualifier to indicate whether the provider is Referring (DN) or Ordering (DK).
- Box 17b must include the NPI of the referring or ordering provider.

Referring Provider Qualifier – DN

HCF-10-ENV	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
	DN	Brian Jones, MD.	17b.	NPI 1234567891

Ordering Provider Qualifier – DK

HCF-10-ENV	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
	DK	Brian Jones, MD.	17b.	NPI 1234567891

Passport and Team Care

- Box 17 can include name of the provider.
- Box 17a must include the Passport/Team Care referral number, if applicable.

HCF-10-ENV	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	99999999
	DN	Brian Jones, MD.	17b.	NPI 1234567891

837P X12 for Referring Provider

Loop 2310: REF*9F*99999999~

Claims Submission 837P X12

837P X12 for Referring Provider

Loop 2310A: NM1*DN*1*JONES*BRIAN****XX*1234567891

837P X12 for Ordering Provider

Loop 2420E: NM1*DK*1*JONES*BRIAN****XX*1234567891

If you have questions regarding the above requirements, please contact Bob Wallace, Physician Services Supervisor, at 406-444-5778 or via e-mail at bwallace@mt.gov; or Dan Peterson, Bureau Chief, Allied Health Services Bureau, at 406-444-4144 or via e-mail at danpeterson@mt.gov.

Effective Immediately

Identification of Referring Providers on ADA Claim Form and 837D X12 Transactions

Requirements

The Patient Protection and Affordable Care Act and 42 CFR 455.440 mandate that all state Medicaid programs require the National Provider Identifier (NPI) of any ordering or referring dentist or other professional to be specified on any claim for payment that is based on an order or referral of the dentist or other health professional.

Montana Medicaid providers are now required to identify ordering or referring dentists or other professionals on claims following the examples that follow.

ADA Claim Forms

Claim Submission ADA Paper Claim Form

Please see example provided for protocol. For denturists billing for services, include the referring dentist's NPI and name in Box 35, Remarks.

35. Remarks

1234567891

Brian Jones, DDS

Electronic Dental Claim Submission 837D X12

For denturists billing for services, include the referring dentist's NPI and name on the 837D X12 transaction:

Loop 2310A: NM1*DN*1*JONES*BRIAN****XX*1234567891~

Contact Information

If you have questions regarding the requirements, please contact Jan Paulsen, Dental Program Officer, at 406-444-3182 or via e-mail at jpaulsen@mt.gov.

For claims questions or additional information, contact Provider Relations at 1-800-624-3958 (toll-free, in/out of state) or 406-442-1837 (Helena) or via e-mail at MTPRHelpdesk@xerox.com.

ICD-10 Is Here!

Montana-Specific Instructions



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[Local Offices of Public Assistance](#)

[Medicaid Fraud and Abuse](#)

[Nurse First](#)

[Passport to Health](#)

[Plan First](#)

[Preferred Drug List](#)

[Presumptive Eligibility](#)

ICD-10 Information

[ICD-10 Final Rule](#)

From the link: This final rule implements section 212 of the Protecting Access to Medicare Act of 2014 by changing the compliance date for the international Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS Guidelines for Coding and Reporting, from October 1, 2014 to October 1, 2015. It also requires the continued use of the International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2 (diagnoses), and 3 (procedures) (ICD-9-CM), including the Official ICD-9-CM Guidelines for Coding and Reporting, through September 30, 2015.

▶ [Testing](#)

▶ [Introduction](#)

▶ [ICD-10 Comparison](#)

▶ [ICD-10 Informational Resources](#)

▶ [ICD-10 Timeline](#)

▶ [Provider Notices and Training](#)

▶ [Contact Information](#)



Claims

No span billing between September 2015 and October 2015 DOS allowed on CMS-1500 claims.

When adjusting claims for **DOS prior to 10/01/15**, you must use **ICD-9** diagnosis codes.

When adjusting for **DOS on or after 10/01/15**, you must use **ICD-10** diagnosis codes.

You cannot submit a claim with both ICD-9 and ICD-10 codes; the claim will deny.

TADs (Nursing Homes)

Beginning on or after date of service October 1, 2015, all claims must be billed with ICD-10 diagnosis codes.

The State has determined that claims should be billed with the proper ICD-10 diagnosis code. In preparation for the October 2015 date of service billing cycle, the diagnosis codes boxes will be intentionally left blank on the TADs that you receive near the end of October 2015.

When billing for dates of service on or after October 1, 2015, providers must complete the TAD and return it with new ICD-10 diagnosis codes. It will be the responsibility of each nursing facility provider to research and determine the proper ICD-10 diagnosis codes to use.

To assist you, there is a free ICD-10 code look-up website:
<http://www.icd10data.com/ICD10PCS/Codes> (link on ICD-10 information page.)

TADs (Nursing Homes)

Once you have completed and returned your TADs with the proper ICD-10 codes for each of your members, this data will be included on your future TADs, beginning with the November billing cycle.

For those who use TADs for billing nursing facility claims, this should be a one-time process if you have properly billed your October claims and we have received them by October 14, 2015.

Claim denials will occur if you leave the first/primary diagnosis code field blank or if you submit a claim with ICD-9 diagnosis codes for date of service on or after October 1, 2015. In order to avoid delays in your payments, ensure the coding is accurate.

See the screenshot below to find the diagnosis code fields on your TADs. Fill in the first diagnosis code field, and if applicable, the secondary diagnosis code field, with the appropriate ICD-10 code when billing for dates of service on or after October 1, 2015.

TADs (Nursing Homes)

PATIENT: LAST NAME			FIRST		MIDDLE INITIAL		M SEX F		COUNTY	INDIVIDUAL NUMBER			AUTH.	
DIAGNOSIS			DIAG. CODE XXXXXXX		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD					
					MO. DAY YEAR		MO. DAY YEAR		MO. FROM DAY YEAR		TO DAY YEAR			
NEW DIAGNOSIS/RECENT COMPLICATIONS			DIAG. CODE XXXXXXX		NO. OF DAYS	LEVEL OF CARE		TOTAL CHARGES		(LESS) PERSONAL RESOURCES			NET CHARGES	
										→				
PATIENT: LAST NAME			FIRST		MIDDLE INITIAL		COUNTY		INDIVIDUAL NUMBER			AUTH.		

Contact Information

For claims questions or additional information, contact Provider Relations at 1-800-624-3958 (toll-free, in/out of state) or 406-442-1837 (Helena) or via e-mail at MTPRHelpdesk@xerox.com. Visit the Montana Healthcare Programs Provider Information website at <http://medicaidprovider.mt.gov/>.

Montana-Specific Forms for Benefit Plan Limitations



Emergency Dental for Basic Medicaid

Basic Medicaid

The **only** time members who have Basic Medicaid benefits are eligible for dental coverage is when emergency dental services are necessary and/or when dental work is essential for employment.

The Emergency Dental form **must** accompany a paper claim (or use PWK and PWK coversheet for electronic claim).

The **only** codes covered are on the Emergency Dental form.

Emergency Dental for Basic Medicaid

Emergency dental services are covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

Emergency Dental for Basic Medicaid

All other program limits still apply. RHCs and FQHCs will continue to bill revenue code 512 for these services.

Routine restorative or preventive treatments are specifically excluded from any emergency dental services.

Document any delay between date of diagnosis and date of treatment. This timeframe must be within 30 days of initial date of exam.

A copy of this form must be attached to the dental claim. Providers should retain the original copy in their files. Send a copy of the form and your claims to:

Xerox State Healthcare, LLC
Claims Processing Unit
P.O. Box 8000
Helena, Montana 59604



The *only* Dental codes covered under Basic Medicaid are:

Codes listed are as of 08/2015.

Emergency Dental Codes for Adults on Basic Medicaid

D0140	D0273	D2161	D3346	D7270	D9420
D0220	D0274	D2330	D7140	D7510	D9612
D0230	D0275	D2331	D7210	D7520	D9920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2940	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9248	

Emergency Dental Form

Dental Emergency Services Form 07.2013

All fields must be completed **and** the form must be signed, dated, and attached to an ADA Dental claim form.


MONTANA
DPHHS
Healthy People. Healthy Communities.

Emergency Dental Services Form

For Basic Medicaid Adults Age 21 and Over

Member Name _____

Medical ID _____ Date of Injury/Infection _____

The above-named person has received emergency dental services. Describe in detail the reason for the emergency dental services and the treatment that was required.

Provider Signature _____ NPI _____ Date _____

Emergency dental services are covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

Emergency Dental Codes for Adults on Basic Medicaid

D0140	D0273	D2161	D3346	D7270	D8420
D0220	D0274	D2330	D7140	D7510	D8612
D0230	D0275	D2331	D7210	D7520	D8920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2840	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9246	

All other program limits still apply. RHCs and FQHCs will continue to bill revenue code 512 for these services. Routine restorative or preventive treatments are specifically excluded from any emergency dental services.

Document any delay between date of diagnosis and date of treatment. This timeframe must be within 30 days of initial date of exam. A copy of this form must be attached to the dental claim. Providers should retain the original copy in their files. Send a copy of the form and your claims to:

Xerox State Healthcare, LLC
Claims Processing Unit
P.O. Box 8000
Helena, Montana 59604

Updated 07/2013

Essential for Employment

Dental services for Basic Medicaid members may be covered under the Essentials for Employment program if they are necessary to obtaining or maintaining employment.

When this is the case, the member will present a signed Medicaid Services Essential for Employment form. Prior to receiving services items as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their Local Office of Public Assistance.

Basic Medicaid and DME

Basic Medicaid

Medicaid generally does not cover DMEPOS for members on Basic Medicaid. Providers should verify members' eligibility before providing services. DMEPOS suppliers must obtain a written prescription in accordance with ARM 37.86.1802.

Suppliers should also maintain documentation showing the member meets the Medicare coverage criteria.

The *only* HCPCS codes covered under Basic Medicaid are:

Codes listed are as of 08/2015

A4206 through A4259

A4310 through A4554

A4611 through A4629

A4772

A5051 through A5513

A6530 through A6544

A7027 through A7046

E0424 through E0450

E0457 through E0460

E0463 through E0480

E0550 through E0570

E0575 through E0601

E0605 through E0607

E0781

E0784

E1372

E1390

E1405

E1406

K0455

K0552

L5000 through L8510

Essential for Employment

DME services for Basic Medicaid members may be covered under the Essentials for Employment program if they are necessary to obtaining or maintaining employment.

When this is the case, the member will present a signed Medicaid Services Essential for Employment form. Prior to receiving services items as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their Local Office of Public Assistance.

Xerox Internal Department Tips and Tricks



Document Control (Mailroom)

- Claim needs to be signed and dated.
- Claims should be legible, including handwriting. If the scanner cannot read the claim, it will have to be keyed manually.
- Handwritten claims take longer to process
- Do not use staples or use only one if necessary.
- If more than one claim shares the same EOB, send a copy of the EOB with each claim.
- For Medicare Crossover claims, write/print the word *Medicare* on the face of the claim.
- Claims should be on the red line CMS-1500 claim forms. They will be hand keyed if submitted on black and white.
- Do not use a dot matrix printer, these need to be hand-keyed.
- Do not overstuff claims envelope. Mailroom letter opening equipment may slice claims.

Document Control receives thousands of paper claims every day. Following these simple steps will eliminate some of the manual processes and will shorten the time it takes to process your claims.



Third Party Liability (TPL)

Primary Insurance

If a claim to a primary insurance is denied for terminated coverage or if you are notified of new primary insurance, please call Provider Relations and provide the following to the Call Center Agent:

- Member name
- SSN or Card ID
- Insurance company name
- Date of termination if provided

Credit Balance

Give Provider Relations the reference number listed on your letter. All information is contained in the CRN. If the Call Center Agent cannot answer the question, he/she will forward the call to the TPL unit.

Third Party Liability (TPL)

Blanket Denials

If a primary insurance never covers services or products, a provider can request a blanket denial from TPL to allow them to by-pass the primary provider and bill Medicaid directly.

Blanket denials are good for two years.

The blanket denial request form is available on the Forms page of the Provider Information website, www.medicicaidprovider.mt.gov. Fax the form to 406-442-0357 and include an EOB.

Blanket denials are processed the last Friday of each month only.

Forms



Trading Partner Agreement 10.2014

Click here for the [complete provider enrollment package](#).

The TPA grant an individual/group access to the MATH web portal to view eligibility, remittance advices, claims, provider payment summary, and more.

Download the form, indicate NPI or API, sign and date. Send the completed form to Provider Relations via fax, e-mail, or mail.

ACS EDI Gateway, Inc., A Xerox Company Trading Partner Agreement

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between SUBMITTER ("Submitter") and ACS EDI GATEWAY, INC. ("Trading Partner"), collectively "the Parties."

Whereas, Submitter desires to transmit Transactions to Trading Partner for the purpose of submitting data to a Health Plan;

Whereas, Trading Partner desires to receive such Transactions for this purpose recognizing that Trading Partner performs such services on behalf of the Health Plan; and

Whereas, Submitter is subject to the Transaction and Code Set Regulations with respect to the transmission of such Transactions;

Now, therefore, the Parties agree as follows:

1. Definitions

Trading Partner means ACS EDI Gateway, Inc. Submitter means the party identified as "Submitter" on the signature line of this Agreement who is a Health Care Provider as defined in 45 CFR 164.103. Standard is defined in 45 CFR 160.103. Transaction is defined in 45 CFR 160.103. Transactions and Code Set Regulations mean those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Submitter

A. The Parties agree, in regard to any electronic Transactions between them:

- (1) They will exchange data electronically using only those Transaction types as selected by Submitter on the ACS EDI Gateway Trading Partner Enrollment Form (TPEF).
- (2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.
- (3) They will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically.
- (4) They will not add any data elements or segments to the Maximum Defined Data Set.
- (5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.
- (6) They will not change the meaning or intent of a Standard's implementation specification.
- (7) Trading Partner may reject a Transaction submitted by Submitter if the Transaction is not submitted using the data elements, format, or Transaction types set forth in the TPEF. Trading Partner may refuse to accept any claims from Submitter if Submitter repeatedly submits Transactions which do not meet the criteria set forth in a TPEF or if Submitter repeatedly submits inaccurate or incomplete Transactions to Trading Partner.

B. Submitter understands that Trading Partner or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Submitter will participate fully with Trading Partner in the testing, verification, and implementation of a modification to a Transaction affected by the change.

C. Trading Partner understands that DHHS may modify the Transaction and Code Set Regulations. Trading Partner will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Submitter and Trading Partner.

D. Neither Submitter nor Trading Partner accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Submitter and Trading Partner.

E. Submitter and Trading Partner will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Submitter and Trading Partner will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

F. Trading Partner may publish data clarifications to complement each Implementation Guide. Submitter should use the Electronic Transactions Instruction for HIPAA available at <http://www.acs-gero.com/docs/inf-home-transaction/>. Submitter should use these in conjunction with the HIPAA Implementation Guides available at <http://www.stree.w12.org/store/healthcare-5010-consolidated-guides>.

G. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will promptly transmit an electronic acknowledgment that conclusively constitutes evidence of properly received transactions. Each party will subject information to a virus check before transmission to the other party.

H. Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.



Link Request, Montana Access to Health Web Portal 04.2014

For multiple providers to appear on your drop-down list in the MATH web portal, you must submit a Link Request.

Each NPI or API used as the billing or pay-to provider will have an electronic statement of remittance (e!SOR) generated; therefore, it is important to have the NPI/API linked to the submitter/trading partner number for retrieval.

You may verify your submitter number by selecting My Profile in the MATH web portal. This form is also used to link your Passport number for your capitation payments.



**Montana Access to Health Web Portal
Link Request**

For multiple providers to appear on your drop-down list in the Montana Access to Health web portal, you must submit a Link Request.

Each National Provider Identifier (NPI) or Atypical Provider Identifier (API) used as the billing or pay-to provider will have an electronic statement of remittance (e!SOR) generated; therefore, it is important to have the NPI/API linked to the submitter/trading partner number for retrieval. You may verify your submitter number by selecting "My Profile" in the MATH web portal.

Complete the information below. Complete a separate form for each NPI/API you want linked. The form must be signed by the provider or an authorized representative. Mail or fax to Provider Relations, P.O. Box 8000, Helena, MT 59604, 406.442.4402.

Allow up to 10 days for Provider Relations to process the request.

Provider Name _____

NPI/API _____
Complete a separate form for each NPI/API you want linked.

Submitter ID _____

Printed Name _____

Title _____

Signature _____ Date _____

Updated 04/2014

Request for Blanket Denial for TPL 04.2014

If a primary insurance never covers services or products, a provider can request a Blanket Denial from TPL to allow them to by-pass the primary provider and bill Medicaid directly.

Blanket denials are good for two years.


Healthy People. Ability Connections.
Division of Health Care Services

Request for Blanket Denial Letter State of Montana Medicaid

Effective Date Requested Provider/NPI

Member Name

Medicaid ID Number

Name of Insurance Company on File

Procedure Codes Requested

-
-
-
-
-

Requesting Agency

Fax Number

Contact Person

Contact Phone Number

Number of Pages that Follow Request

Fax all requests to 406-442-0357.
Request must include an explanation of benefits (EOB) stating the services are not covered.

Updated 04/2014

Address Correction Form for Providers 02.2015

Pay-To/1099 changes must be accompanied by a completed W-9 form. This form must be printed and signed, and may be mailed or faxed.

Provider Relations
P.O. Box 4936
Helena, MT 59604
406.442.1937 (Local)
1.800.824.3959 (In/Out of State)
406.442.4402 (Fax)

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

Montana Healthcare Programs Provider Address Correction Form

Pay-To/1099 address changes require a completed W-9. Incomplete forms or forms with missing or incorrect information will delay processing. The form may be mailed or faxed.

NPI Number

Are you a Passport to Health provider?

Yes If yes, indicate your Passport provider type, enter your Passport ID number, indicate that you want the Passport provider file updated, and provide your address changes below.

No If no, provide your address changes below.

Passport Provider Type Individual/Solo Group

The Passport provider address must match for all linked providers.

Passport ID Number Update My Passport Provider File

In order for your Passport provider file to be updated, you must provide your Passport number above and check the box indicating the provider file should be updated.

Indicate correspondence types to be mailed to Address 1. Address 1 must always be the physical location of the office where services are rendered but may include some or all correspondence.

Address 1

Physical Pay-To/1099 Correspondence

Indicate correspondence types to be mailed to Address 2. If not applicable, leave blank.

Address 2

Pay-To/1099 Correspondence

Indicate correspondence types to be mailed to Address 3. If not applicable, leave blank.

Address 3

Correspondence

Phone Number Fax Number

Signature and date stamps are not accepted. Original signature required.

Authorized Signature _____ Date _____

Rev. 02/2015

Paperwork Attachment Cover Sheet 05.2015

This form is used as a cover sheet for attachments for electronic and paper claims.



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number

Date of Service

Billing NPI/API

Member ID Number

Type of Attachment

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

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the member's ID number and the date of service (mmdd/yyyy), each separated by a dash (NPI: 999999999-99999999-99999999/Atypical Provider ID: 999999-99999999-99999999).

This form may be downloaded from the Provider Information website (<http://www.medicallidprovider.mt.gov>).

If you have questions about paper attachments that are necessary for a claim to process, call Provider Relations at 1-800-824-3658 or 406-442-1037.

Completed forms can be mailed or faxed to: P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

Updated 05.2015

Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement 02.2014

A letter/form on your financial institution's letterhead verifying legitimacy of the account is also required. The letter/form must include the name and contact information of the bank representative, be signed by the bank representative, and verify both the financial institution routing number and provider account number.

 **Montana Medicaid**
Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement



The following information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the payer to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Electronic Funds Transfer Program.

Please make arrangements with the financial institution receiving the EFT to ensure proper delivery of payments for services provided.

All fields on this form are **required** in order to enroll in electronic funds transfer and to ensure proper delivery of your electronic remittance advice.

If you have any questions about this form, contact Xerox Provider Relations at 1.800.624.3958 (In/Out of State) or 406.442.1837 (Helena).

DATA ELEMENT GROUP #1 – PROVIDER INFORMATION

Provider Name _____
(to include legal name of institution, corporate entity, practice, or individual provider)

Provider Address

Street _____
City _____
State/Province _____ ZIP Code/Postal Code _____

DATA ELEMENT GROUP #2 – PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Trading Partner ID _____

DATA ELEMENT GROUP #7 – FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____
Financial Institution Routing Number _____
Type of Account at Financial Institution _____
(The type of account provider will use to receive EFT payments, e.g., checking, savings)

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier. Select one from below.

Provider Tax Identification Number

National Provider Identifier

(Provider preference for grouping [bulking] claim payments – must match preference for v5010 X12 835 remittance advice.)

Preference for Aggregation of Remittance Data, e.g., account number linkage to provider identifier. Select one from below.

Provider Tax Identification Number

National Provider Identifier

Page 31 of 56 P

Exception to 24 Sessions Request Form 08.2015

Under Montana Medicaid rules (ARM 37.85.410), a maximum of 24 sessions may be reimbursed per state fiscal year for individual and family outpatient therapy. Prior authorization for sessions beyond 24 is required when medical necessity requirements are satisfied.

The provider may complete an Exception to 24 Sessions Request Form.

Adult Mental Health Services DPHHS Montana Medicaid Exception to 24 Sessions Request Form			
Fax confidential request information to 1-406-444-7391.			
PLEASE PRINT OR TYPE:		Date <input type="text"/>	
PATIENT INFORMATION			
Patient Name <input type="text"/>	Medicaid Number <input type="text"/>	Birthdate <input type="text"/>	
PROVIDER INFORMATION			
Provider Name <input type="text"/>			
Address <input type="text"/>		Provider NPI Number <input type="text"/>	
City, State, and ZIP Code <input type="text"/>		Medicaid Provider ID Number <input type="text"/>	
Telephone Number <input type="text"/>		Fax Number <input type="text"/>	
CLINICAL INFORMATION			
Any changes in DSM diagnoses, including co-occurring disorders, medical conditions			
Code <input type="text"/>	Narrative <input type="text"/>		
Code <input type="text"/>	Narrative <input type="text"/>		
Code <input type="text"/>	Narrative <input type="text"/>		
Date of Session 24 <input type="text"/>		Number of Additional Sessions Requested: <input type="text"/>	
Current Psychological Symptoms, Behaviors, and Level of Functioning That Necessitate Continued Outpatient Sessions <input type="text"/>			
Changes to Medication or Treatment Plan <input type="text"/>			
Discharge Plan <input type="text"/>			
PLEASE PRINT	Assessment Completed By <input type="text"/>		
Signature <input type="text"/>	Title <input type="text"/>	Date <input type="text"/>	
CPT code requested <input type="text"/>		PA # <input type="text"/>	
State of Montana DPHHS – AMDD			
Rev. 07/2015 1			



Individual Adjustment Request 08.2015

This form may be completed online; however, you must print, sign, and date before mailing to the address indicated.



MONTANA DPHHS
Healthy People. Healthy Communities.
Advanced. Affordable. Accessible.

**Montana Healthcare 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 remittance statement. Complete only the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number	3. Internal Control Number (ICN)
Name _____	_____
Street or P.O. Box _____	4. NPI/API _____
City _____ State _____ ZIP _____	5. Member ID Number _____
Telephone Number _____	_____
2. Member Name _____	6. Date of Payment _____
_____	7. Amount of Payment \$ _____

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

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

Signature _____ Date _____

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.

Updated 02.2015

W-9 Form (Rev. 12/2011)

Instructions for completing the form are included.

Form **W-9** Request for Taxpayer Identification Number and Certification

Department of the Treasury Internal Revenue Service

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name (disregarded entity name, if different from above)

Check appropriate box for federal tax classification:

Individual/sole proprietor C Corporation S Corporation Partnership Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ Exempt payee

Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Last account number(s) here (optional)

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien.
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Cat. No. 10231X Form **W-9** (Rev. 12-2011)



Denials



Top 15 Claim Denial Reasons

Exact duplicate

Resubmission of paid or pending claim or modifier issue.

Recipient not eligible DOS

Eligibility terminated or lapsed. Verify eligibility and resubmit if coverage is active.

PA missing or invalid

Prior authorization missing from claim, expired, or code not listed.

Rate times days not = charge

Verify calculation of charges.

Passport provider no. missing

Verify Passport information from referral against MATH/IVR/FaxBack.

Recipient covered by Part B

Medicare payment information missing.

Top 15 Claim Denial Reasons

SLMB or QI-1 eligibility only

Verify eligibility and resubmit if coverage is updated.

Missing/invalid information

Variety of reasons. Call Provider Relations for explanation.

Deprivation code restricted

Client eligibility issue. Call Provider Relations for explanation.

Provider type/Procedure mismatch

Some codes are provider type specific. See fee schedule or call Provider Relations for explanation.

Suspect duplicate

Variety of reasons. Call Provider Relations for explanation.

Claim indicates TPL

Client does not have TPL and claim indicates active TPL, or TPL information missing.



Ready For Real Business