

Montana Healthcare Programs

Claim Jumper

Volume XXXIII, Issue 10, October 2018

In This Issue

PUBLICATION REMINDER — 1
MEDICAID EHR INCENTIVE — 1
SCHOOL BASED FMAP RATE— 2
INSIDE PROVIDER RELATIONS — 2
UPCOMING TRAINING- 2
FIELD REP CORNER — 3
RECENT WEBSITE POSTS — 4
YOU ASKED - WE ANSWERED - 4
TOP 15 CLAIM DENIAL REASONS — 4
KEY CONTACTS — 6

Hospitals WebEx

Tuesday,
September 25, 2018

Register Now!

Publications Reminder

It is the responsibility of all providers to be familiar with Medicaid manuals, fee schedules, provider notices for their provider type, and information published in *Claim Jumper* issues and on the [Montana Healthcare Programs Provider Information website](#).

Medicaid EHR Incentive Program

What to expect for Program Year 2018

- All participants must attest to Meaningful Use, either Modified Stage 2 or Stage 3 - no attestations will be accepted for AIU (Adopt, Implement or Upgrade).
- All EPs will report on a continuous 90-day EHR reporting period with a CQM reporting period of a full year for returning meaningful users, or 90 days for first time meaningful users. Six (6) CQMs must be reported, regardless of Stage
- All providers must attest using Certified EHR Technology (CEHRT) that is certified (at minimum) to the 2014 Edition. However EPs who wish to attest to Stage 3 objectives must use Certified EHR Technology (CEHRT) that is certified to the 2015 Edition or a combination of 2014/2015 Edition CEHRT.
- There are 10 Objectives including 2 Public Health Measures for Modified Stage 2, and 8 Objectives including 2 Public Health Measures for Stage 3.
- Unlike in previous years, there are no alternate exclusions or specifications available.
- Security Risk Assessment must be conducted by both EHs and EPs during every Calendar Year.

Program Year 2016 was the last year an EP could begin participation in the Medicaid EHR Incentive Program. Montana has not yet decided exact dates yet for Providers and Hospitals to attest for PY 2018.

For more information, visit the Montana Provider Outreach page at <http://mt.ara incentive.com>. There you will find helpful links to CMS as well as a link to Mountain Pacific Quality Health's Meaningful Use page and Blog written by Patty Kosednar.

Submitted by Jessica Brown
EHR Incentive Program Payment Coordinator
DPHHS

School Based Health Services FMAP Rate Change

Effective October 1, 2018, the School Based Health Services reimbursements will utilize the 2019 Federal Medical Assistance Percentage or FMAP of 65.54%.

For your information, the FMAP rates are adjusted annually and coincide with the Federal Fiscal Year, from October through September. These changes are published in the Federal Register and are put into effect every October. Current FMAP rates can be accessed through the following link to the Federal Register website: [FY 2019 current FMAP](#)

The school-based services fee schedule is published utilizing the established RBRVS fee and the Department's Medicaid fee. Therefore, when you are reviewing the fee schedule, you would take the published fee for schools and multiply by the appropriate FMAP rate that was in effect during the time your claim was priced within our system.

*Submitted by Rena Steyaert
School Based Services Program Officer
DPHHS*

Inside Provider Relations

Supervision of In-Training Mental Health Professionals

The SURS unit has recently found several individual mental health providers billing for supervision of unlicensed candidate in-training practitioners. An individual mental health professional cannot bill Montana Medicaid for services provided by the supervised candidates outside of a licensed Medicaid Mental Health Center. Based on the Mental Health Center. Administrative Rules of Montana, ARM 37.85.406(16), 37.88.901(9), and 37.87.702(3), a person enrolled as an individual provider may not submit a claim for services they did not personally provide. Only a mental health center can bill and receive reimbursement from Montana Medicaid for services provided by mental health professional candidates in training.

*Submitted by Julia Harris
Provider Relations Manager
Montana Provider Relations*

Recent and Upcoming WebEx Training

The September WebEx Training will be Hospitals with Valerie St. Clair, Hospital Program Officer, on Tuesday September 25, 2018 at 2pm. Register on the [WebEx Registration page](#).

The image below is from the August WebEx training. The PowerPoint presentations from prior trainings may be found on the [Training Page](#) of the provider website.

Look for changes on the provider website

Daily Announcements Provider Notices	Weekly Fee Schedules New Posts	Monthly Proposed Fee Schedules Claim Jumper Manuals Training
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.....And Every Time You Bill

Field Rep Corner

Top Two Claim Denial Reasons

In last month's Claim Jumper the top 2 Claim denial reasons were for Exact Duplicate at number 1 and PA missing or Invalid at number 2.

Exact Duplicates

Exact Duplicates happen when the claim is submitted more than once for the exact same dates of service, procedure codes, member, and have been paid. This can happen due to a billing oversight and the same claim is submitted more than once or "just to make sure we have the claim". For Medicare crossovers we ask that you wait 45 days from the delivery of the Medicare EOB before submitting the claim directly to Medicaid. You can find this reference in the General Manual in the Medicare part B instructions for when to submit directly to Medicaid.

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but there is no response from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim. The provider may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

Some tips for preventing Duplicate claims can also be found in the General Manual in the section about common billing Errors. The General Manual states:

"Reasons for Return or Denial: Duplicate claim

How to Prevent Returned or Denied Claims:

- Check all remittance advices for previously submitted claims before resubmitting.
- When making changes to previously paid claims, submit an adjustment form rather than a new claim form. (See Remittance Advices and Adjustments in this manual.)

Missing or Invalid PA Numbers.

This exception will post when the required PA information is missing or can't be found in the claims system. Certain Medicaid services require a Prior Authorization and this information needs to be on the Claim form.

If you get this denial and put a PA on the claim, double check the PA number on the claim form. If you sent the information electronically check with provider relations to see if that claim had a PA number with the electronic file.

Montana Medicaid requires that the Prior Authorization information comes in a specific spot in the electronic claim file. This spot is designated as 'G1' in loop 2300 in REF01. This is something that your clearing house or billing software may need to correct to correctly send this information.

*Submitted by Dan Hickey
Field Representative
Montana Provider Relations*

Recent Website Posts

Below is a list of recently published Medicaid information and updates available on the [Provider Information website](#). On the website, select Resources by Provider Type in the left menu to locate information specific to your provider type. If you cannot locate the information below, contact Provider Relations at 1.800.624.3958 or 406.442.1837 in Helena.

Provider Notices		
08/03/2018	Chemical Dependency	SUD Prior Authorization - ASAM 3.7
08/17/2018	Outpatient Hospitals, Critical Access Hospitals	AMDD Adult Mental Health and SDMI Rates
08/14/2018	Pharmacy	New Universal Claim Form for Outpatient Pharmacy Paper Claims
PROPOSED July 2018 Fee Schedules		
Proposed July 2018 fee schedules are listed on the provider website on the Proposed Fee Schedule page .		
August 2018 Fee Schedule		
Youth Mental Health		
July 2018 Fee Schedule		
IHS July 2018 RBRVS July 2018		
June 2018		
IHS June 2018		
Forms		
Prior Authorization for Orkambi® Revised Form, Prior Authorization for Sublocade® Form, T-HIP Member Opt-Out Form, School-Based Personal Care Paraprofessional task and Hour Guide Revised Form, School Based Paraprofessional Child Profile Revised Form,		
Manuals Revised		
Proposed Dental and Denturist Services Manual,		
Other Resources		
<ul style="list-style-type: none"> • FY 2018 Medicaid Statistics • Math Portal Navigation WebEx PowerPoint • Provider Website Navigation WebEx PowerPoint • PDL Revised • IHS Meeting Agenda for August 27, 2018 • IHS Medicaid Enrollment Training PowerPoint (In PDF) • Announcement: AMDD Adult Mental Health and SDMI Rates 		

You Asked - We Answered

The Training Survey gives providers an opportunity to request training. It also provides a venue to ask questions. In this new monthly feature the Provider Relations Team will answer questions from the Training Survey responses.

Provider Question: What is the difference between an Individual adjustment request & Paperwork attachment cover sheet? How do you submit & what are all the scenarios for each one.

The simple answer is the Individual Adjustment Request (IAR) is used to correct or change specific information for a claim that has already been paid and the Paperwork Attachment Coversheet is used when the claim is sent electronically and there is additional paperwork required like an EOB from the primary insurance, or a sterilization consent form.

There is an in-depth article on Individual Adjustment Requests in the Claim Jumper Newsletter from Oct 2017. There is also an article in the June 2018 Claim Jumper. Some important things to remember about Individual adjustment requests are:

- When submitting the adjustment form, the Medicaid Statement of Remittance is always required; otherwise the adjustment will be rejected.
- If the claim has been split into multiple claims, enter all Internal Control Numbers (ICNs) on the Individual Adjustment Form (IAF) on line A3. Be sure to attach the remittance(s) from all the relevant split claims.
- When changing units, remember to change the charge amounts, if applicable.
- When adjusting a claim that initially calls for supporting documentation, include a copy of all the original documentation with the adjustment.
- Denied claims cannot be adjusted.
- When a professional claim has some lines paid and others that deny, you may resubmit the claim with all lines (previously paid lines will deny as duplicates) or only those lines that previously denied for payment. If any of the previously paid lines need adjusted, you must complete the IAR.
- Box 8 may be used to describe reason for adjustment if it cannot be explained within boxes 1 through 7 or to provide additional information.

Some examples of when to submit an IAR:

- Claim was overpaid or underpaid.
- Claim was paid but the information on the claim was incorrect (e.g. member ID, provider number, date of service, procedure code, diagnoses, units).
- Individual line is denied on a multiple-line UB-04 claim. The denied service must be submitted as an adjustment rather than a rebill.

The Paperwork attachment cover sheet is used when there is an electronically submitted claim that Medicaid requires paperwork. The electronic claim needs to indicate that there is paperwork. This is done by using the PWK indicator in the electronic claim at loop 2300. This indicator, when it is received in the electronic claim will place the claim in suspense while the claims agent looks for the required paperwork to be on file. If the paperwork isn't found after 30 days, or the paperwork is incomplete or missing information the claim will deny. An example is an electronic claim with sterilization, we require the completed sterilization form, or the claim will deny, you can send the claim electronically with the PWK indicator then use the Paperwork Attachment Coversheet with the Control number:

The NPI XXXXXXXXXX	The Member's ID Number MMMMMMMM	The Date of Service MMDDYYYY
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The Paperwork Attachment Coversheet and the required paper work can be either Faxed or Mailed to:

(406) 442-4402 Fax

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

Continued on page 6

Top 15 Claim Denial Reasons

Exception	AUGUST 2018	JULY 2018
EXACT DUPLICATE	1	1
REFILL TOO SOON	2	4
FILL TOO SOON	3	3
PA MISSING OR INVALID	4	2
RECIPIENT NOT ELIGIBLE DOS	5	6
MISSING/INVALID INFORMATION	6	5
DRUG CONTROL CODE =2 (DENY)	7	7
PASSPORT PROVIDER NO. MISSING	8	8
RATE TIMES DAY NOT = CHARGE	9	9
NDC MISSING OR INVALID	10	12
RECIPIENT COVERED BY PART B	11	13
DAYS SUPPLY MISISNG	12	14
CLAIM INDICATES TPL	13	15
CLAIM DATE PAST FILING LIMIT	14	17
SLMB OR QI-1 ELIGIBILITY ONLY	15	22

You Asked - We Answered *(Continued from page 5)***Provider Question: What is the best process to submit the primary EOB if we send a secondary claim?**

If the primary paid in any way you can submit the claim electronically. We would need the primary EOB if the primary claim was denied or paid at zero.

In cases where an EOB is required you can submit the claim electronically with the PWK segment of the electronic claim (may need to check with your software vendor), then send the EOB with a Paperwork Attachment coversheet. More information is in the previous article about the Paperwork Attachment Coversheet.

Do you have a general question you would like answered?

Visit the Training Survey! We can answer your question in a future issue of the Claim Jumper or, if you leave your contact information, Provider Relations will respond directly to you. You can also email MTPRHelpdesk@conduent.com.

Key Contacts

**Montana Healthcare Programs
Provider Information**
<https://medicaidprovider.mt.gov/>
Conduent EDI Solutions <http://edisolutionsmmis.portal.conduent.com/gcro/>
Provider Relations
MTPRHelpdesk@conduent.com
P.O. Box 4936
Helena, MT 59602
(800) 624-3958 In/Out of state
(406) 442-1837 Helena
(406) 442-4402 Fax

Third Party Liability

P.O. Box 5838
Helena, MT 59604
(800) 624-3958 In/Out of state
(406) 443-1365 Helena
(406) 442-0357 Fax

Claims Processing

P.O. Box 8000
Helena, MT 59604

EFT and ERA

Fax completed documentation to
Provider Relations,
(406) 442-4402.

Verify Member Eligibility

FaxBack (800) 714-0075 or
Voice Response (800) 714-0060

POS Help Desk for Pharmacy

(800) 365-4944

Passport

(800) 362-8312

PERM Contact Information

KCronholm@mt.gov
(406) 444-9365
website: <http://dphhs.mt.gov/qad/PC/PERMPC>

Prior Authorization

OOS Acute & Behavioral Health
Hospital, Transplant, Rehab &
PDN:

(406) 457-3060 (Helena) or
(877) 443-4021 (Toll Free)

Fax:

(406) 513-1923 Helena or
(877) 443-2580 (Toll Free)
MPQH – DMEPOS/Medical
(406) 457-3060 Helena or
(877) 443-4021

Fax:

(406) 513-1923 Helena or
(877) 443-2580

Magellan Medicaid**Administration**

Phone: (800)770-3084 (opt 3)
Fax: (800) 639-8982