

Montana Healthcare Programs

Claim Jumper

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**CSCT
WebEx
Register Now!**
**To Be Notified
When This
Training Is
Scheduled.**

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](#).

Billing for Non-Covered Services

There has been an increase in questions about balance billing and non-covered services across all provider types and for many types of services. It is the provider's responsibility to verify the member's eligibility on the date of service prior to the service being performed. Unlike other types of commercial health insurance, providers may NOT bill Medicaid members for the balance of their account whether the balance is from denied claims or expenses after a claim is paid. This is established by [Administrative Rules of Montana \(ARM\) 37.85.406](#).

Based on ARM 37.85.406, there are some guidelines for billing, reimbursement, claims processing, and payment that are important for providers to remember:

- Providers are required to accept, as payment in full, the amount paid by the Montana Healthcare Programs for a service or item provided to an eligible Medicaid member.
- A provider may not bill a member after Medicaid has denied payment for covered services.
- A provider may bill a member for the copayments specified in ARM [37.83.826](#) and [37.85.204](#) and may bill certain members for amounts above the Medicare deductibles and coinsurance as ARM [37.83.825](#).

A provider may offer a private pay agreement IF the services are:

- Agreed to in writing prior to services rendered.
- The written agreement to pay privately must be based upon definite and specific information given by the provider to the member prior to the services being delivered/performed indicating that the service will not be paid by Medicaid under any circumstances.
- The agreement may not require the member to pay the balance of usual and customary fees after Medicaid has paid.
- The private pay agreement must be in writing per occasion. This does not include routine and general contracts signed by the member at the time of acceptance into the office.
- Providers cannot pick and choose which codes to have members privately pay. If it is a covered service by Medicaid they must accept the Medicaid fee in full.
- A provider may utilize the [Custom Agreement for Medicaid Non-Covered Services](#) found on the forms page of the provider website

*Submitted by Katie Hawkins
Hospital Section Supervisor
Hospital & Physicians Services Bureau
Health Resources Division
DPHHS*

Medicaid Fee Schedules

Medicaid Fee Schedules

MAR 37-863 and MAR 37-866 pertaining to updating the effective dates of non-Medicaid and Medicaid fee schedules were published in the Montana Register September 7, 2018 and September 21, 2018. The Department is proposing a number of provider rate increases effective July 1, 2018. The entire MAR notices are published at the following links:

- MAR 37-863 <http://www.mtrules.org/gateway/ShowNoticeFile.asp?TID=8777>
- MAR 37-866 <https://dphhs.mt.gov/Portals/85/rules/37-866pro-arm.pdf>

The Department has posted proposed fee schedules to <https://medicaidprovider.mt.gov/proposedfs>.

The Department will publish additional provider type specific notices after the MARs are adopted. It will be important for providers to review future notices for more detailed information. The Provider Notices will be available on the Montana Healthcare Programs Provider Information Website under the menu option, Resources by Provider Type. In addition, the monthly Claim Jumper newsletter lists all recently posted publications. The Department will handle the adjustment process for impacted claims with a date of service on or after July 1, 2018. No action on your part is needed at this time.

Thank you for serving Montana' Healthcare Programs' Members.

*Submitted by Gene Hermanson
MMIS Operations Manager
DPHHS*

**Remember,
Please Frequently Check
For New Provider Notices
On Your Provider Type Page!**

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 covered by the different types of Medicaid?

The [General Manual](#) states “Providers must verify eligibility before providing services.” The manual also notes that all services must be medically necessary and all required prior authorizations and passport provider referrals must be in place prior to a provider receiving payment. All covered services are described in the General Manual and/or provider type specific manuals. The [Introduction chapter of the General Manual](#) states “Standard Medicaid...Covered services include, but are not limited to, audiology services, clinic services, community health centers services, dental services, doctor visits, hospital services, immunizations, Indian Health Services, laboratory services, mental health services, Nurse First services, nursing facility, occupational therapy, pharmacy, public health clinic services, substance dependency services, tobacco cessation, transportation, vision services, well-child checkups, and x-rays.

The [Introduction chapter](#) also describes HELP Plan Benefits to include Behavioral Health (Mental Health and Substance Use Disorder), Convalescent Home (excludes Custodial Care), Durable Medical, Equipment/Supplies, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Emergency, Hospital, Lab and X-Ray (Medical), Medical Vision and Exams, Mid-Level, Physician, Preventive, Rehabilitative and Habilitative, Surgical, Audiology, Dental, Diabetes Prevention Program, Eyeglasses, Federally Qualified Health Center, Hearing Aids, Home Infusion, Indian Health Services/Tribal Health, Pharmacy, Rural Health Clinic, and Transportation.

In addition to Medicaid, the [General Manual](#) also notes that DPHHS offers other programs including Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Programs, Children’s Mental Health Bureau Non-Medicaid Services, Children’s Special Health Services, Health Insurance Premium Payment, Healthy Montana Kids, Mental Health Services Plan, and Plan First.

Provider Question: What is the process for billing vaccines in the ER for an HMK Kids member when the bill goes to MCD instead of BCBS. Does it go on UB04 or CMS1500?

HMK vaccine questions should be directed to Blue Cross Blue Shield and follow their billing requirements. Claims for HMK members that receive services at an FQHC, RHC, or IHS should be submitted to Conduent on the required UB-04.

There are guidelines for HMK vaccine billing found in CAH, Physician, Hospital Outpatient, and FQHC/RHC manuals. Additionally, guidelines are listed on the [Training page](#) under the “Spring Training 2017” tab on page 13 of the FQHC and RHC Billing Guidelines. Items of note are:

- HMK eligible members are not entitled to the Vaccines for Children (VFC) program.
- If a HMK member receives a face-to-face visit with a physician or mid-level visit, vaccines will be paid and administration fees will bundle and pay at zero.
- If vaccines are administered without a face-to-face physician or mid-level visit, provider may also bill for vaccine administration fees using revenue code 771 and vaccine administration procedure codes.
- An immunization-only visit does not qualify to be reimbursed the PPS rate.

Claims of members that are HMKPlus should be submitted to Conduent and follow Medicaid procedures.

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.

WebEx

Date To Be Determined Comprehensive School and Community Treatment (CSCT) with Jamie Olson, Children's Mental Health Bureau, DPHHS

Register Now to be notified when this training date is announced!

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		
09/19/2018	Hospital Outpatient, CAH, IDTF, Physicians, Mid-Levels	MRI Brain With Contrast Radiology - Revised
09/19/2018	Hospital Outpatient, CAH, IDTF, Physicians, Mid-Levels	CT of the Brain Radiology - Revised
09/19/2018	School-Based Services	2019 FMAP Rate Reflects Changes to Reimbursement on the Fee Schedule
09/24/2018	Mental Health Centers, Licensed Professional Counselors, Physicians, Mid-Levels, PRTF, Psychiatrist, Psychologists, School-Based Services, Therapeutic Foster Care, Therapeutic Group Home, Laboratory, Hospital Outpatient	Prior Authorization for Genetics Testing for Youth Mental Health
09/24/2018	Mental Health Centers, PACT Teams	Medicaid Reimbursement for PACT Teams
August 2018 Fee Schedules		
Targeted Case Management - Mental Health		
PROPOSED July 2018 Fee Schedules		
Proposed July 2018 fee schedules are listed on the provider website on the Proposed Fee Schedule page .		
Forms		
Ownership Update Provider Disclosure Statement Form Revised,		
Manuals Revised		
Proposed Dental and Denturist Services Manual,		
Other Resources		

Inside Provider Relations

Provider File Updates

Provider Relations has seen a slight rise in inquires of provider file updates. There are guidelines and requirements for these updates.

Written requests are required for all changes and must include the NPI(s) along with an authorizing signature. Different types of updates may have different requirements. [Please see the table found at https://medicaidprovider.mt.gov/Portals/68/docs/current/ProviderFileUpdateTable10012018.pdf](https://medicaidprovider.mt.gov/Portals/68/docs/current/ProviderFileUpdateTable10012018.pdf) for a handy guideline in submitting these requests.

Please remember, it is the responsibility of the provider to keep Montana Healthcare Programs updated with any changes in information and to do so within 30 days of the change. Failure to keep us updated can cause issues in communication, denied claims or undeliverable payment. Timely updates decrease issues.

If you have questions, please call Provider Relations for clarification before submitting. (800) 624-3958

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

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

[email: KCronholm@mt.gov](mailto:KCronholm@mt.gov)
(406) 444-9365
[website: http://dphhs.mt.gov/qad/PC/PERMPC](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

Top 15 Claim Denial Reasons		
Exception	SEPT 2018	OCT 2018
EXACT DUPLICATE	1	5
RECIPIENT NOT ELIGIBLE DOS	2	1
FILL TOO SOON	3	3
REFILL TOO SOON	4	2
PA MISSING OR INVALID	5	4
RATE TIMES DAY NOT = CHARGE	6	9
MISSING/INVALID INFORMATION	7	6
PASSPORT PROVIDER NO. MISSING	8	8
DRUG CONTROL CODE =2 (DENY)	9	7
NDC MISSING OR INVALID	10	10
SUSPECT DUPLICATE	11	21
CLAIMSGUARD ONE E&M PER DOS	12	17
RECIPIENT COVERED BY PART B	13	11
PROC. CODE NOT COVERED	14	20
DAYS SUPPLY MISSING	15	12