Medical Billers Play an Important Role in Healthcare

National Medical Billers Day is coming up this month and it is worthwhile to recognize the important contribution these individuals and organizations play in the health care ecosystem.

Submitting claims and getting them processed by payers is not an easy chore nor is it exciting or flashy. There are TV shows about Doctors and Nurses but when was the last time you saw a TV show about Medical Billers?

Medical Billers provide a valuable service to both providers and payers by becoming experts in the process of completing a claim, submitting it to the right payer, and then working with both their provider clients and the payers to overcome any issues to get those claims paid.

It’s good to see these unsung but important partners in this process get recognition. My hat is off to them. Thank you Medical Billers!

Submitted by Kenneth W. Fody, Esq.
Account Executive
Conduent (formerly Xerox)

New General Manual Edition Released

A new edition of the General Information For Providers has was released on February 6, 2017. The manual can be found on your provider type page on the provider website. The primary changes to the new edition include a new Telemedicine chapter which explains requirements for telemedicine billing including when to use telemedicine, confidentiality requirements, general billing requirements unique to this type of service, originating provider requirements, and distance provider requirements. The new edition also clarified coverage for the medically needy found in Chapter 6, the Member Responsibilities chapter. The new section explains incurred as spend down and provides some additional information about the billing process for those members using the medically needy program.

New Telehealth Place of Service Code

Effective January 1, 2017 the new place of service “02” will be required for use by physicians or other medical practitioners that provide telehealth services at the distant site. Telehealth services billed by providers at the distant site will be paid at the office setting rates as published in the applicable provider fee schedule.

When billing telehealth services, you must include modifier GT.

Submitted by Michelle Gillespie
DPHHS Physician Services Supervisor
Nurse First: All Heart; Women, Men & Heart Disease

This is one time when being number one isn’t cause to celebrate. Heart disease is the number one cause of death in the world, and the leading cause of death in the United States, killing over 370,000 Americans a year (about every 43 seconds). It’s the number one killer of women in the U.S., taking more lives than all forms of cancer combined. It’s also the number one killer of men, so it doesn’t discriminate, except that its symptoms in women can be more subtle—dangerous, because women often misread the trouble signs for things like acid reflux or flu, while experiencing an actual heart attack.

Perhaps the best, all-too-real depiction of the multi-tasking Super Woman who spends so much time taking care of everyone else, that she often lets her own health slide, is in the short film, “Just a Little Heart Attack” (www.goredforwomen.org). Directed by and starring actress Elizabeth Banks, it begins with her character phoning 911 from the kitchen floor following the mad flurry of getting her family off: “Hi, sorry to bother you, but I think I may be having a little heart attack . . .”. The call-to-action to take charge of her own health is clear; she phones with the horrifying realization that the ambulance is going to reach her house faster than she has time to pick up the mess from the morning mayhem.

According to the Montana Department of Health and Human Services, Montana heart disease cases are projected to reach 304,870 cases by the year 2030, even though a September 2016 State of Obesity study cites Montana as having the fourth lowest adult obesity rate in the nation, at 23.6 percent (albeit up from 15.6 percent in 2000).

Heart disease strikes more women than men, but symptoms vary. Chest pressure or pain is not always a tell-tale sign of heart attack, especially in women, who are more likely to feel dizziness, lightheadedness, or fainting, abdominal, back, lower-chest, arm, or jaw pain, extreme fatigue, nausea/vomiting, and/or shortness of breath. 64 percent of women who die from coronary heart disease had no previous symptoms.

Reduce your risk for heart disease up to 80 percent: Eat right with portion control. Choose low fat, fresh veggies, whole grains. Reduce salt and sugar. Exercise five times per week for 30 minutes and include cardio to help maintain healthy blood pressure and weight. Don’t smoke.

If heart disease runs in your family, start cholesterol screenings at age 20 or earlier. Ask your doctor to assess your risk factors before giving you a personal goal number. If your cholesterol is high, learn how to make impactful changes through diet and exercise first, and explore alternative treatments; you may be able to prevent the need for a prescription medication.

Sleep six to eight hours per night. Getting too little or too much sleep has been linked to slowing metabolism and high blood pressure.

Nurse First’s advice? Start taking care of you. Your heart (and your family) will say thanks.

Nurse First is a confidential, 24/7, year-round advice line staffed by licensed, registered nurses. It provides Medicaid members with current recommendations from the Centers for Disease Control and Prevention (CDC) and the American Congress of Obstetricians and Gynecologists (ACOG). Patients can call 1 (800) 330-7847 or visit http://dphhs.mt.gov/MontanaHealthcarePrograms/NurseFirst.aspx under “Would you like more Montana Health and Wellness Information?”

Submitted by Connie Olson, DPHHS Nurse Advice Line Program Office
Spring Training Ideas

WANTED

Every record, electronic or handwritten MUST have a valid electronic or wet signature and date by the rendering provider.

Utilize the time in and out on all records/documentation as a standard of practice.

Field Rep Corner
Spring Training Suggestions Sought

The Field Reps are in the early planning stages of the 2017 Spring Training. Training this spring will be in Whitefish, Great Falls, and Billings. The specific dates and locations as well as registration will be available soon on the Training Page of the provider website. Training will likely be during the month of May near the end of the week in each community.

We received great feedback from the Fall trainings and, based on provider comments, we are planning on having a section that is for new providers and having additional content geared toward existing or long-term providers and billers of Montana Healthcare Programs.

If you have a suggestion for a topic it there is still time for it to be included! Email MTPRHelpdesk@conduent.com with the subject of “Spring Training 2017”. The sooner you send us your suggestion the more likely it is to be included!

March 30, 2017 WebEx

March 30th Provider Relations will be hosting a WebEX with Paula Soll, DPHHS Program Specialist/Claims Examiner. The topic will be the Waiver Program including what qualifies a member for the Waiver Program and a review of what fields on the CMS-1500 form need to be filled out for claims. Please watch the Training Page on the Provider Website for more details and registration.

Submitted by Dan Hickey
Provider Relations Field Representative

SURS Audit Revelations

All Provider Signature, Date, and Time Duration on Documentation

The Surveillance and Utilization Review Section (SURS) has identified a trend occurring across all providers types. Due to the extreme importance, the state needs to reinforce that all records and/or documentation of services (electronic or handwritten) must have the rendering provider’s signature and date. Every record, electronic or handwritten, must have a valid electronic or wet signature and date by the rendering provider. The electronic or handwritten record/documentation must be accurate and complete within 90 days of submitting the claim to Medicaid for processing. ARM 37.85.414.

In addition, if the code being billed is time based, the full amount of time spent with the patient or the time in and out needs to be present on the record/documentation. SURS encourages providers to utilize the time in and out on all records/documentation as a standard of practice. This will benefit the documentation by making it more accurate and complete.

Submitted by Jennifer Bergmann, CPC
Program Integrity Auditor
Quality Assurance Division
**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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/2017</td>
<td>Social Workers, Mid-Level Practitioners, PRTF, CSCT</td>
<td>New Guidelines for Outpatient Psychotherapy</td>
</tr>
<tr>
<td>01/13/2017</td>
<td>Physician, Psychiatrist, Mid-Level, Lab and Imaging</td>
<td>Update to January 2017 Fee Schedules</td>
</tr>
<tr>
<td>01/13/2017</td>
<td>Audiologist, Hearing Aids, Physician</td>
<td>Audiology Referrals and Physician Authorization for Hearing Aids</td>
</tr>
<tr>
<td>01/13/2017</td>
<td>DME</td>
<td>New HCPCS Codes for Insulin Pump Supplies</td>
</tr>
</tbody>
</table>

**Fee Schedules**

*Each of the following fee schedules went in force on January 1, 2017:*

- Ambulance
- APC
- ASC
- ATP
- Hearing Aid Services
- IDTF
- IHS
- Lab and Imaging
- Medicaid Mental Health Youth Under 18
- Mid-Levels

**Manuals with Replacement Pages**

- DMEPOS
- Home Infusion Therapy
- Hospice

**Other Resources**

- FAQs - TPL Section Updated
- Quarterly Rebateable Labelers for Q1 2017
- Pharmacy DURB Agenda for 01/25/2017
- Pharmacy DUR PDL Meeting Agenda for 02/15/2017

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**Attention: Mental Health Targeted Case Managers**

Addictive Mental Disorders Division would like to publish a question and answer article for all mental health targeted case managers.

If you have a question you would like answered, please send it to:
Barbara Graziano, Clinical Program Manager, AMDD
bgraziano@mt.gov or (406) 444-9330.
### Top 15 Claim Denial Reasons

<table>
<thead>
<tr>
<th>Exception</th>
<th>January 2017</th>
<th>December 2016</th>
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</thead>
<tbody>
<tr>
<td>EXACT DUPLICATE</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PA MISSING OR INVALID</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>REFILL TOO SOON</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>RECIPIENT NOT ELIGIBLE DOS</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>DRUG CONTROL CODE = 2 (DENY)</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>RATE TIMES DAYS NOT = CHARGE</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>PASSPORT PROVIDER NO. MISSING</td>
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<td>6</td>
</tr>
<tr>
<td>MISSING/INVALID INFORMATION</td>
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<td>8</td>
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<tr>
<td>NDC MISSING OR INVALID</td>
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<td>9</td>
</tr>
<tr>
<td>PROC. FACT. CODE=4 (NOT ALLOW)</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>RECIPIENT COVERED BY PART B</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>CLAIM INDICATES TPL</td>
<td>12</td>
<td>15</td>
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<tr>
<td>SLMB OR QI-1 ELIGIBILITY ONLY</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>RECIP NON COVERED SERVICES</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>DAYS MISSING SUPPLY</td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>

### An Ounce of Prevention

This is what your billers can do to prevent denied claims based on a few of this month’s top denial reasons.

**PASSPORT PROVIDER NO. MISSING**

About 70% of HMK/HMK Plus are enrolled in the Passport to Health (Passport) program. The Passport referral number is the number the PCP gives to providers when approving services. This is a number issued to the Passport provider and must be on the requesting provider’s claim or Medicaid will deny the service if it requires a Passport referral. The Passport referral number is recorded in Box 17a on a CMS-1500 claim and Box 7 on a UB-04 claim. The referring provider’s NPI is not required.

**CLAIM DATE PAST FILING LIMIT**

Page 8.1 of the General Manual explains timely filing limits in detail. Filing limits are defined in ARM 37.85.406. In short, the General Manual states:

> “Providers must submit clean claims to Medicaid within:
> 1. Twelve months from whichever is later:
>    - the date of service
>    - the date retroactive eligibility or disability is determined
> 2. Six months from the date on the Medicare explanation of benefits approving the service.
> 3. Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the period described above.”