

Provider Requirements

Provider Enrollment

To be eligible for enrollment, a provider must:

- Provide proof of licensure, certification, accreditation, or registration according to Montana state laws and regulations.
- Provide a completed W-9.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.

Providers must complete a Montana Healthcare Programs Provider Enrollment Form, which is a contract between the provider and the Department. Healthcare providers must have a National Provider Identifier (NPI) or atypical provider identifier (API), which should be used in all correspondence with Medicaid. Providers must enroll for each type of service they provide. For example, a pharmacy that also sells durable medical equipment (DME) must enroll for the pharmacy and again for DME.

To enroll online as a Montana Medicaid provider, visit the Montana Access to Health (MATH) web portal directly at <https://mtaccesstohealth.acs-shc.com> or the Montana Healthcare Programs Provider Information [website](#) and click the MATH Web Portal link near the top left, or contact Provider Relations at 1-800-624-3958.

Enrollment Materials

Each newly enrolled provider is sent an enrollment letter confirming enrollment. The letter includes instructions for obtaining additional information from the Provider Information [website](#).

Letters to atypical providers include their API.

Medicaid-related forms are available on the Provider Information [website](#). However, providers must order CMS-1500, UB-04, and dental claim forms from an authorized vendor.

Medicaid Renewal

For continued Medicaid participation, providers must maintain a valid license or certificate. For Montana providers, licensure or certification is automatically verified and enrollment renewed each year. If licensure or certification cannot be confirmed, the provider is contacted. Out-of-state providers are notified when Medicaid enrollment is about to expire. To renew enrollment, providers should mail or fax a copy of their license or certificate to Provider Relations. See the Contact Us link on the Provider Information [website](#).



Medicaid payment is made only to enrolled providers.



Out-of-state providers can avoid denials and late payments by renewing Medicaid enrollment early.

To avoid payment delays, notify Provider Relations of an address change in advance.



Changes in Enrollment

Changes in address, telephone/fax, name, ownership, legal status, tax ID, or licensure must be submitted in writing to Provider Relations. Faxes are not accepted because the provider's original signature and NPI (healthcare providers) or API (atypical providers) are required. For change of address, providers can use the form on the website; for a physical address change, providers must include a completed W-9 form.

Change of Ownership

When ownership changes, the new owner must re-enroll in Montana Medicaid. For income tax reporting purposes, the provider must notify Provider Relations at least 30 days in advance about any changes to a tax identification number. Early notification helps avoid payment delays and claim denials.

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. For more information on electronic claims submission options, see the Electronic Claims section in the Billing Procedures chapter in this manual.

Terminating Medicaid Enrollment

Medicaid enrollment may be terminated by writing to Provider Relations; however, some provider types have additional requirements. Providers should include their NPI (healthcare providers) or API (atypical providers) and the termination date in the letter. The Department may also terminate a provider's enrollment under the following circumstances:

- Breaches of the provider agreement.
- Demonstrated inability to perform under the terms of the provider agreement.
- Failure to abide by applicable Montana and U.S. laws.
- Failure to abide by the regulations and policies of the U.S. Department of Health and Human Services or the Montana Medicaid program.

Authorized Signature (ARM 37.85.406)

All correspondence and claim forms submitted to Medicaid must have an NPI (healthcare providers) or API (atypical providers) and an authorized signature. The signature may belong to the provider, billing clerk, or office personnel, and may be handwritten, typed, stamped, or computer-generated. When a signature is from someone other than the provider, that person must have written authority to bind and represent the provider for this purpose. **Changes in enrollment information require the provider's original signature.**

Provider Rights

- Providers have the right to end participation in Medicaid in writing at any time; however, some provider types have additional requirements.
- Providers may bill Medicaid members for cost sharing (ARM 37.85.204).
- Providers may bill a member for the copayments specified in ARM 37.83.826 and may bill certain members for amounts above the Medicare deductibles and coinsurance as allowed in ARM 37.83.825.
- Providers may bill Medicaid members for services not covered by Medicaid if the provider and member have agreed in writing prior to providing services.
- When the provider **does not** accept the member as a Medicaid member, a specific custom agreement is required stating that the member agrees to be financially responsible for the services received.
- A provider may bill a member for non-covered services if the provider has informed the member in advance of providing the services that Medicaid will not cover the services and that the member will be required to pay privately for the services, and if the member has agreed to pay privately for the services. Non-covered services are services that may not be reimbursed for the particular member by the Montana Medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana Medicaid program for the particular member if all applicable requirements, including medical necessity, are met (ARM 37.85.406).
- Providers have the right to choose Medicaid members, subject to the conditions in Accepting Medicaid Members later in this chapter.
- Providers have the right to request administrative reviews and fair hearings for a Department action that adversely affects the provider's rights or the member's eligibility (ARM 37.85.411).

Administrative Reviews and Fair Hearings (ARM 37.5.310)

A provider may request an administrative review if he/she believes the Department has made a decision that fails to comply with applicable laws, regulations, rules, or policies.

To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department. The Department must receive the request within 30 days from the date the Department's contested determination was mailed. Providers may request extensions in writing within this 30 days. See the Contact Us link on the Provider Information [website](#).

If the provider is not satisfied with the administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules, or policies. This document must be signed and received by the Fair Hearings Office within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered or mailed to the division that issued the determination within 3 working days of filing the request.

Provider Participation (ARM 37.85.401)

By enrolling in the Montana Medicaid program, providers must comply with all applicable state and federal statutes, rules, and regulations, including but not limited to, federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Medicaid program and all applicable Montana statutes and rules governing licensure and certification.

Accepting Medicaid Members (ARM 37.85.406)

Institutional providers, eyeglass providers, and non-emergency transportation providers **may not** limit the number of Medicaid members they will serve. Institutional providers include nursing facilities, skilled care nursing facilities, intermediate care facilities, hospitals, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities.

Other providers may limit the number of Medicaid members. They may also stop serving private-pay members who become eligible for Medicaid. Any such decisions must follow these principles:

- No member should be abandoned in a way that would violate professional ethics.
- Members may not be refused service because of race, color, national origin, age, or disability.
- Members enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- In service settings where the patient is admitted or accepted as a Medicaid member by a provider, facility, institution, or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a Medicaid member and may not bill the patient for the services unless, prior to provision of services, the particular provider informed the patient of their refusal to accept Medicaid and the member agreed to pay privately for the services. See ARM 37.85.406(11)(d) for details.
- Most providers may begin Medicaid coverage for retroactively eligible members at the current date or from the date retroactive eligibility was effective. See the Retroactive Eligibility section in the Member Eligibility and Responsibilities chapter of this manual for details.

- When a provider bills Medicaid for services rendered to a patient, the provider has accepted the patient as a Medicaid member.
- Once a patient has been accepted as a Medicaid member, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

Non-Discrimination (ARM 37.85.402)

Providers may not discriminate illegally in the provision of service to eligible Medicaid members or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age, or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), the Age Discrimination Act of 1975 (42 USC 6101, et seq.), the Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes.

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Member must be enrolled in Medicaid and be nonrestricted. See Member Eligibility and Responsibilities for restrictions. (ARM 37.85.415 and ARM 37.85.205)
- Service must be medically necessary. The Department may review medical necessity at any time before or after payment. (ARM 37.85.410)
- Service must be covered by Medicaid and not be considered cosmetic, experimental, or investigational. (ARM 37.82.102, ARM 37.85.207, and ARM 37.86.104)
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the Billing Procedures chapter, current provider notices and manual replacement pages, and according to ARM 37.85.406 (Billing, reimbursement, claims processing and payment) and ARM 37.85.407 (third party liability).
- Charges must be usual and customary. (ARM 37.85.212 and ARM 37.85.406)
- Reimbursement to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties (\$75.00) is greater than the Medicaid fee (\$70.00), Medicaid will pay at \$0. (ARM 37.85.406)
- Claims must meet timely filing requirements. See the Billing Procedures chapter in this manual for timely filing requirements. (ARM 37.85.406)

- Prior authorization requirements must be met. (ARM 37.85.406)
- Passport approval requirements must be met. (ARM 37.86.5101–5112)

Medicaid Payment Is Payment in Full (ARM 37.85.406)

Providers must accept Medicaid payment as payment in full for any covered service, except applicable cost sharing that should be charged to the member.

Payment Return (ARM 37.85.406)

If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

Disclosure

- Providers are required to fully disclose ownership and control information when requested by the Department. (ARM 37.85.402)
- Providers are required to make all medical records available to the Department. (ARM 37.85.410 and ARM 37.85.414)

Member Services

- All services must be made a part of the medical record. (ARM 37.85.414)
- Providers must treat Medicaid members and private-pay members equally in terms of scope, quality, duration, and method of delivery of services unless specifically limited by regulations. (ARM 37.85.402)
- Providers may not deny services to a member because the member is unable to pay cost sharing fees. (ARM 37.85.402)

Confidentiality (ARM 37.85.414)

All Medicaid member and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of healthcare information subject to applicable laws.

Record Keeping (ARM 37.85.414)

Providers must maintain all Medicaid-related medical and financial records for 6 years and 3 months following the date of service. The provider must furnish these records to the Department or its designee upon request. The Department or its designee may audit any Medicaid-related records and services at any time. Such records may include but are not limited to:

- Original prescriptions
- Certification of medical necessity
- Treatment plans
- Medical records and service reports including but not limited to:
 - Patient's name and date of birth
 - Date and time of service
 - Name/title of person providing service (other than billing practitioner)

- Chief complaint or reason for each visit
- Pertinent medical history
- Pertinent findings on examination
- Medication, equipment, and/or supplies prescribed or provided
- Description and length of treatment
- Recommendations for additional treatments, procedures, or consultations
- X-rays, tests, and results
- Dental photographs/teeth models
- Plan of treatment and/or care, and outcome
- Specific claims and payments received for services
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid members
- Records/original invoices for items prescribed, ordered, or furnished
- Any other related medical or financial data

Compliance with Applicable Laws, Regulations, and Policies

All providers must follow all applicable rules of the Department and all applicable state and federal laws, regulations, and policies. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.**

The following are references for some of the rules that apply to Montana Medicaid. The provider manual for each individual program contains rule references specific to that program.

- Title XIX Social Security Act 1901 et seq.
 - 42 U.S.C. 1396 et seq.
- Code of Federal Regulations (CFR)
 - CFR Title 42 – Public Health
- Montana Codes Annotated (MCA)
 - MCA Title 53 – Social Services and Institutions
- Administrative Rules of Montana (ARM)
 - ARM Title 37 – Public Health and Human Services

Links to rules are available on the provider type pages of the Provider Information [website](#). Paper copies of rules are available through the Secretary of State's office.

Provider Sanctions (ARM 37.85.501–507 and ARM 37.85.513)

The Department may withhold a provider's payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations, and policies.

Other Programs

Below is a list of non-Medicaid Department of Public Health and Human Services (DPHHS) programs.

- Chemical Dependency Bureau Substance Dependency/Abuse Treatment
<http://dphhs.mt.gov/amdd/SubstanceAbuse.aspx>
- Children's Mental Health Bureau Non-Medicaid Services
<http://dphhs.mt.gov/dsd/CMB/Manuals.aspx>
- Health Insurance Premium Payment (HIPPP)
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP>
- Healthy Montana Kids (HMK)
<http://dphhs.mt.gov/HMK>
- Mental Health Services Plan (MHSP)
<http://dphhs.mt.gov/amdd/Mentalhealthservices>
- Plan First
<http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst>



Providers are responsible for keeping informed about applicable laws, regulations, and policies.