

Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual may be billed electronically or on paper claim forms, which are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- Twelve months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- Six months from the date on the Medicare explanation of benefits approving the service.
- 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 periods described above.

For claims involving Medicare or TPL, if the 12-month time limit has passed, providers must submit clean claims to Medicaid within:

- **Medicare Crossover Claims.** Six months from the date on the Medicare explanation of benefits, if the Medicare claim was timely filed and the member eligible for Medicare at the time the Medicare claim was filed.
- **Claims Involving Other Third Party Payers (excluding Medicare).** 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 periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status.
- If another insurer has been billed and 90 days have passed with no response, a provider can bill Medicaid. (See the Member Eligibility and Responsibilities chapter in this manual for more information.)

- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Member Eligibility and Responsibilities chapter in this manual and, if applicable, the Coordination of Benefits chapter in your provider type manual.

When to Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid. The main exception is that providers may collect cost sharing from members.



If a provider bills Medicaid and the claim is denied because the member is not eligible, the provider may bill the member directly.

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third party payer does not respond.
- When a member fails to arrive for a scheduled appointment.
- When services are free to the member and free to non-Medicaid covered individuals, such as in a public health clinic.

Under certain circumstances, providers may need a signed agreement to bill a patient.

Billing a Patient (ARM 37.85.406)		
Service	Patient is Medicaid-enrolled and provider accepts patient as a Medicaid member	Patient is Medicaid-enrolled and provider does not accept patient as a Medicaid member
Is covered by Medicaid	Provider can bill patient only for cost sharing.	Provider can bill Medicaid patient if patient has signed a private pay agreement.
Is not covered by Medicaid	Provider can bill patient only if custom agreement has been made between patient and provider before he/she provides the service.	Provider can bill patient if patient has signed a custom agreement.

Private-Pay Agreement. A nonspecific private-pay agreement between the provider and member stating that the patient is not accepted as a Medicaid member, and that he/she must pay for the services received.

Custom Agreement. A specific agreement that includes the dates of service, actual services or procedures, and the cost to the patient. It states the services are not covered by Medicaid and the member will pay for them.

Member Cost Sharing (ARM 37.85.204)

Each Medicaid member must pay cost share to the provider of service unless otherwise noted. Members with income at or below 100% Federal Poverty Level (FPL) have a set payment amount:

- \$4 for outpatient services
- \$75 for inpatient services
- \$4 for pharmacy – preferred brand
- \$8 for pharmacy – non-preferred brand

Members with income above 100% of the FPL are responsible for cost share of 10% of the provider reimbursed amount; except for pharmacy:

- \$4 for pharmacy – preferred brand
- \$8 for pharmacy – non-preferred brand



Do not show cost sharing as a credit on the claim; it is automatically deducted.

Members with the following statuses are exempt from cost sharing:

- persons under 21 years of age;
- pregnant women;
- American Indians/Alaska Natives who are eligible for, currently receiving, or have ever received an item or service furnished by:
 - o An Indian Health Service (IHS) provider;
 - o A Tribal 638 provider;
 - o An IHS Tribal or Urban Indian Health provider; or
 - o Through referral under contract health services.
- Persons who are terminally ill receiving hospice services;
- Persons who are receiving services under the Medicaid breast and cervical cancer treatment category;
- Institutionalized persons who are inpatients in a skilled nursing facility, intermediate care facility, or other medical institution if the person is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.

Cost sharing may not be charged to members for the following services:

- Emergency services;
- Family planning services;
- Hospice services;
- Home and community based waiver services;
- Transportation services;
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement;

- Early and periodic screening, diagnostic and treatment (EPSDT) services;
- Provider preventable health care acquired conditions as provided for in 42 CFR 447.26(b);
- Generic drugs;
- Preventive services as approved by CMS through the Health and Economic Livelihood Plan (HELP) Medicaid 1115 waiver;
- Services for Medicare crossover claims where Medicaid is the secondary payer under ARM 37.85.406(18). If a service is not covered by Medicare but is covered by Medicaid, cost sharing will be applied; and
- Services for third party liability (TPL) claims where Medicaid is the secondary payor under ARM 37.85.407. If a service is not covered by the TPL but is covered by Medicaid, cost sharing will be applied.

Cost share may not be charged to the member until the claim has been processed through the claims adjudication process and the provider has been notified of payment and amount owing.

The total of Medicaid premiums and cost sharing incurred by a Medicaid household may not exceed an aggregate limit of five percent of the family's income applied quarterly. There may not be further cost sharing applied to the household members in a quarter once a household has met the quarterly aggregate cap.

Billing for Members with Other Insurance

A Medicaid member may also be covered by Medicare or have other insurance, or some other third party is responsible for the cost of the member's healthcare,

When completing a claim for members with Medicare and Medicaid, Medicare coinsurance and deductible amounts must correspond with the payer listed. For example, if the member has Medicare and Medicaid, any Medicare deductible and coinsurance amounts must be listed and preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare must be listed in the corresponding field. (See the Submitting a Claim section in this manual.)

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.

Always refer to the long descriptions in coding books.



- Require the member to continue as a private-pay member.

When the provider accepts the member's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date the claim is submitted, attach a copy of the Provider Notice of Eligibility (Form 160-M). To obtain this form, the provider should contact the member's county Office of Public Assistance. See <http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance>.

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

Coding Tips

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. See the Coding Resources table. The following may reduce coding errors and unnecessary claim denials:

- Use current CPT, CDT, HCPCS, and ICD diagnosis coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes.
- Bill for the appropriate level of service provided. Evaluation and management services have 3 to 5 levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to but not over the time spent.
- Revenue Codes 25X are required to have valid and rebateable National Drug Codes (NDCs) on each line to be paid.
- Revenue Codes 27X do not require CPT or HCPCS codes; however, providers are advised to place appropriate NDC, CPT, and/or HCPCS codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, hospitals may be underpaid.
- Take care to use the correct units measurement. In general, Medicaid follows the definitions in the CPT and HCPCS coding books. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes." Always check the long text of the code description published in the CPT or HCPCS coding books.

Coding Resources

The Department does not endorse the products of any particular publisher.

Resource	Description	Contact
CDT	The CDT is the official coding used by dentists.	American Dental Association 312-440-2500 http://www.ada.org/en/publications/
CPT	CPT codes and definitions Updated each January	American Medical Association 800-621-8335 https://commerce.ama-assn.org/store/
CPT Assistant	A newsletter on CPT coding issues	American Medical Association 800-621-8335 https://commerce.ama-assn.org/store/
HCPCS	HCPCS codes and definitions Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov/ .
ICD	ICD diagnosis and procedure codes definitions Updated each October	Available through various publishers and bookstores.
Miscellaneous Resources	Various newsletters and other coding resources.	Optum360 800-464-3649 www.optumcoding.com/
NCCI Policy and Edits Manual	Contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service 800-363-2068/703-605-6060 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html
UB-04 National Uniform Billing Expert	National UB-04 billing instructions	Available through various publishers and editors.

Number of Lines on Claim

The Montana claims processing system supports 40 lines on a UB-04 claim, 21 lines on a CMS-1500, and 21 lines on a dental claim.

Multiple Services on Same Date

Outpatient hospital providers must submit a single claim for all services provided to the same member on the same day. If services are repeated on the same day, use appropriate modifiers. The only exception to this is if the member has multiple emergency room visits on the same date. Two or more emergency room visits on the same day must be billed on separate claims with the correct admission hour on each claim.

Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, so long as the service is paid by fee schedule (e.g., partial hospitalization, therapies) and the date is shown on the line. However, the Outpatient Code Editor (OCE) will not price APC procedures when more than one date of service appears at the line level, so we recommend billing for only one date at a time when APC services are involved.

Reporting Service Dates

All line items must have a valid date of service. The revenue codes on the following page require a separate line for each date of service and a valid CPT or HCPCS code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code			
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26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis – Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis – Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD – Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT book, HCPCS book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter, and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- Medicaid accepts most of the same modifiers as Medicare, but not all.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line on the CMS-1500. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Discontinued or reduced service modifiers must be listed before other pricing modifiers on the CMS-1500. For a list of modifiers that change pricing, see the How Payment Is Calculated chapter in this manual.

Billing Tips for Specific Services

Prior authorization is required for some services. Passport and prior authorization are different; some services may require both. Different numbers are issued for each type of approval and must be included on the claim form.

Abortions

A completed Montana Healthcare Programs Physician Certification for Abortion Services (MA-37) form must be attached to every abortion claim or payment will be denied. **Complete only one section of this form.** This is the only form Medicaid accepts for abortions.

Drugs and Biologicals

While most drugs are bundled, there are some items that have a fixed payment amount and some that are designated as transitional pass-through items. (See the Pass-Through section in the How Payment Is Calculated chapter of this manual.) Bundled drugs and biologicals have their costs included as part of the service with which they are billed. The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs
- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Lab Services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day) bill the panel code with units corresponding to the number of times the panel was performed.

Outpatient Clinic Services

When Medicaid pays a hospital for outpatient clinic or provider-based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., POS 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must bill only for the professional component if the hospital is going to bill Medicaid for the technical component. Refer to the *Physician-Related Services* manual and the Billing Procedures chapter in this manual for more information. Provider type manuals are located on the provider type pages of the Provider Information [website](#).

Partial Hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization		
Code	Modifier	Service Level
H0035	—	Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

Sterilization/Hysterectomy (ARM 37.86.104)

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when **all** of the following requirements are met:

1. Member must complete and sign the Informed Consent to Sterilization (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied.

The 30-day waiting period may be waived for either of the following:

- **Premature Delivery.** The Informed Consent to Sterilization must be completed and signed by the member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
 - **Emergency Abdominal Surgery.** The Informed Consent to Sterilization form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.
2. Member must be at least 21 years of age when signing the form.
 3. Member must not have been declared mentally incompetent by a federal, state, or local court, unless the member has been declared competent to specifically consent to sterilization.
 4. Member must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The member must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The member must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The member must be made aware of available alternatives of birth control and family planning.
- The member must understand the sterilization procedure being considered is irreversible.
- The member must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The member must be informed of the benefits and advantages of the sterilization procedure.
- The member must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for members who are blind or deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the member is in labor or childbirth.
- If the member is seeking or obtaining an abortion.
- If the member is under the influence of alcohol or other substance which affects his/her awareness.

For elective sterilizations, a completed Informed Consent to Sterilization (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

For medically necessary sterilizations, including hysterectomies, oophorectomies, salpingectomies, and orchiectomies, one of the following must be attached to the claim, or payment will be denied:

- A completed Medicaid Hysterectomy Acknowledgement form (MA-39) for each provider submitting a claim. It is the billing provider's responsibility to obtain a copy of the form from the primary or attending physician. **Complete only one section of this form.** When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member (or representative, if any) and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.) Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used.
- For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible members, for which the date of service is more than 12 months earlier than the date the claim is submitted, contact the member's local Office of Public Assistance and request a Notice of Retroactive Eligibility (160-M). Attach the form to the claim.

Supplies

Supplies are generally bundled, so they usually do not need to be billed individually. A few supplies are paid separately by Medicaid. The fee schedules on the [website](#) lists the supply codes that may be separately payable.

Submitting a Claim

Paper Claims

Unless otherwise stated, all **paper claims** must be mailed to:

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

On the CMS-1500, EPSDT/Family Planning, is used as an indicator to specify additional details for certain members or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Member/Service	Purpose
1	EPSDT	Used when the member is under age 21
2	Family planning	Used when providing family planning services
3	EPSDT and family planning	Used when the member is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	Used when providing services to pregnant women
6	Nursing facility member	Used when providing services to nursing facility residents

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted using the methods below. For detailed submission methods, see the electronic submissions manual on the HIPAA 5010 page of the [website](#).

- **WINASAP 5010.** Xerox makes this free software available to providers for submitting electronic claims via telephone modem or MATH web portal upload for Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department. **Separate EDI enrollment is required.**
- **Xerox EDI Solutions.** Providers can send claims to the Xerox clearinghouse (EDI Solutions) in X12 837 format using a dial-up connection or MATH web portal upload. **Separate EDI enrollment is required.** Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.

- **Clearinghouses.** Providers can contract with a clearinghouse to send claims in whatever format the clearinghouse accepts. The provider's clearinghouse sends the claims to EDI Solutions in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Xerox. EDIFECS certification is completed through EDI Solutions.
- **Montana Access to Health (MATH) Web Portal.** A secure [website](#) on which providers may view members' medical history, verify member eligibility, check claim status, verify payment status, upload 5010 X12 files, and download remittance advices.
- **B2B Gateway SFTP/FTPS Site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high frequency submitters.
- **MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.

Billing Electronically With Paper Attachments

When submitting claims that require additional supporting documentation, the Attachment Control Number field must be populated with an identifier.

Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the member's ID number and the date of service, each separated by a dash:

999999999	-	888888888	-	11182015
NPI		Member ID Number		Date of Service

When submitting claims that require additional supporting documentation, the Attachment Control Number field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. (See Forms page on the Provider Information [website](#).) The number in the paper Attachment Control Number field must match the number on the cover sheet.

Claim Inquiries

Contact Provider Relations for general claim questions and questions regarding payments, denials, member eligibility.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims, both paper and electronic, are denied. To avoid unnecessary returns and denials, double-check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider's National Provider Identifier (NPI) and/or Taxonomy is missing or invalid	<ul style="list-style-type: none"> The provider NPI is a 10-digit number assigned to the provider by the national plan and provider enumerator system. Verify the correct NPI and Taxonomy are on the claim.
Authorized signature missing	<ul style="list-style-type: none"> Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer-generated.
Signature date missing	<ul style="list-style-type: none"> Each claim must have a signature date.
Incorrect claim form used	<ul style="list-style-type: none"> The claim must be the correct form for the provider type.
Information on claim form not legible	<ul style="list-style-type: none"> Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Member ID number not on file, or member was not eligible on date of service	<ul style="list-style-type: none"> Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of this manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider referral – No Passport provider number on claim	<ul style="list-style-type: none"> A Passport provider number must be on the claim form when a referral is required. Passport approval is different from prior authorization. See the <i>Passport to Health</i> provider manual.
Prior authorization number is missing	<ul style="list-style-type: none"> Prior authorization is required for certain services, and the prior authorization number must be on the claim form. Prior authorization is different from Passport. See the Prior Authorization chapter in this manual.
Prior authorization does not match current information	<ul style="list-style-type: none"> Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	<ul style="list-style-type: none"> 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.)
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. If the member's TPL coverage has changed, providers must notify the TPL unit before submitting a claim.
Claim past 365-day filing limit	<ul style="list-style-type: none"> The Claims Processing unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. To ensure timely processing, claims and adjustments must be mailed to Claims Processing.
Missing Medicare EOMB	<ul style="list-style-type: none"> All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.

Common Billing Errors (Continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied. • After updating his/her license, the claims that have been denied must be resubmitted by the provider.
Procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT coding books. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The information in this chapter also applies to those services covered under the Mental Health Services Plan (MHSP).