

# *Critical Access Hospital Services*

*Medicaid and Other Medical  
Assistance Programs*



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March 2014

*This publication supersedes all previous Critical Access and Exempt Hospital Inpatient and Outpatient Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2005.*

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**My NPI/API:**

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# Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

## Chemical Dependency

(406) 444-3964 Phone  
(406) 444-4435 Fax

555 Fuller Avenue  
P.O. Box 202905  
Helena, MT 59620-2905

## Claims Processing

Send paper claims to:  
Claims Processing Unit  
P.O. Box 8000  
Helena, MT 59604

## CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-2099 Phone  
(406) 444-3456 Fax

Send written inquiries to:  
Quality Assurance Division  
Certification Bureau  
DPHHS  
2401 Colonial Drive  
P.O. Box 202953  
Helena, MT 59620-2953

## Client Eligibility

There are several methods for verifying client eligibility. For additional methods and details on each, see the *Client Eligibility and Responsibilities* chapter in the *General Information for Providers* manual.

### FaxBack

(800) 714-0075 (24 hours)

## Integrated Voice Response (IVR)

(800) 714-0060 (24 hours)

### MATH Web Portal

<http://mtaccesstohealth.acs-shc.com>

### Medifax EDI

(800) 444-4336, X2072 (24 hours)

## Critical Access Hospital Program

For questions regarding critical access hospital policies:

(406) 444-4540 Phone  
(406) 444-1861 Fax

Send written inquiries to:

Critical Access Hospital Program Officer  
Health Resources Division  
P.O. Box 202951  
Helena, MT 59620

## Diabetic Education Services

The hospital’s diabetic education protocol must be approved by:

Medicare Part A Program  
P.O. Box 5017  
Great Falls, MT 59403

## Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

## EDI Technical Help Desk

For questions regarding electronic claims submission:

**(800) 987-6719** In/Out of state  
**(406) 442-1837** Helena  
**(850) 385-1705** Fax

Montana EDI  
 P.O. Box 4936  
 Helena, MT 59604

## Lab

Public Health Lab assistance:

**(800) 821-7284** In state (24 hour)  
**(406) 444-3444** Helena/Out of state  
**(406) 444-5527** Fax

DPHHS Public Health Laboratory  
 1400 Broadway, Room B206  
 P.O. Box 6489  
 Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:

Laboratory Services  
 Managed Care Bureau  
 DPHHS  
 P.O. Box 202951  
 Helena, MT 59620

## Medicaid Client Help Line

Clients who have Medicaid or Passport questions may call the Montana Medicaid Client Help Line:

**(800) 362-8312**

Passport to Health  
 P.O. Box 254  
 Helena, MT 59624-0254

## Nurse First

For questions regarding the Nurse First Advice Line, contact:

**(406) 444-4540** Phone  
**(406) 444-1861** Fax

Nurse First Program Officer  
 DPHHS  
 Managed Care Bureau  
 P.O. Box 202951  
 Helena, MT 59620-2951

## Nursing Facility/Swing Bed Preadmission Screening

For preadmission screening and level-of-care screening for clients entering a nursing facility or swing bed hospital, contact:

Phone:

**(800) 219-7035** In/Out of state  
**(406) 443-0320**

Fax:

**(800) 413-3890** In/Out of state  
**(406) 443-4585**

Mountain-Pacific Quality Health  
 3404 Cooney Drive  
 Helena, MT 59602

## Passport to Health Program

Passport providers report errors, omissions, or discrepancies in enrollee utilization and cost reports to:

Send inpatient stay documentation to:

Passport Program Officer  
 Managed Care Bureau  
 DPHHS  
 P.O. Box 202951  
 Helena, MT 59620-2951

**(406) 444-4540** Phone  
**(406) 444-1861** Fax

## Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

***Mountain-Pacific Quality Health***

For questions regarding prior authorization for some medical or surgical procedures (see the *Prior Authorization* chapter in this manual), contact MPQH:

Phone:

**(406) 457-5887** Local  
**(877) 442-4021 X5887** Helena/Out of state

Fax:

**(406) 513-1922** Local  
**(877) 443-2580** Helena/Out of state

Mountain-Pacific Quality Health  
 3404 Cooney Drive  
 Helena, MT 59602

***Magellan Medicaid Administration (dba First Health)***

For questions regarding prior authorization and continued stay review for selected mental health services.

**(800) 770-3084** Phone  
**(800) 639-8982** Fax  
**(800) 247-3844** Fax

Health Care Management Administration  
 Magellan Medicaid Administration  
 4300 Cox Road  
 Glen Allen, VA 23060

**Provider Policy Questions**

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information for Providers* manual.

**Provider Relations**

For questions about provider enrollment, eligibility, payments, denials, or Passport, and general claims questions:

**(800) 624-3958** In/Out of state  
**(406) 442-1837** Helena  
**(406) 442-4402** Fax

Provider Relations Unit  
 P.O. Box 4936  
 Helena, MT 59604  
[MTPRHelpDesk@xerox.com](mailto:MTPRHelpDesk@xerox.com)

**Secretary of State**

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

**(406) 444-2055** Phone

Secretary of State  
 P.O. Box 202801  
 Helena, MT 59620-2801

**Team Care Program**

For questions regarding Team Care:

**(406) 444-4540** Phone  
**(406) 444-1861** Fax

Team Care Program Officer  
 Managed Care Bureau  
 DPHHS  
 P.O. Box 202951  
 Helena, MT 59620-2951

**Third Party Liability**

For questions about private insurance, Medicare, or other third party liability:

**(800) 624-3958** In/Out of state  
**(406) 443-1365** Helena  
**(406) 442-0357** Fax

Send written inquiries to:

Third Party Liability Unit  
 P.O. Box 5838  
 Helena, MT 59604

| <h1>Key Websites</h1>  |   |
|--|---|
| Web Address  | Information Available   |
| <b>Administrative Rules of Montana (ARM)</b><br><a href="http://www.mtrules.org/">www.mtrules.org/</a>   | Montana’s rules for Medicaid programs.  |
| <b>Centers for Disease Control and Prevention (CDC) website</b><br><a href="http://www.cdc.gov/">www.cdc.gov/</a>  | Immunization and other health information.  |
| <b>EDI Gateway</b><br><a href="http://www.acs-gcro.com/">www.acs-gcro.com/</a>   | EDI Gateway is Montana’s HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> <li>• EDI support</li> <li>• Enrollment</li> <li>• Frequently Asked Questions (FAQs)</li> <li>• Manuals</li> <li>• Provider services</li> <li>• Related links</li> <li>• Software</li> </ul>   |
| <b>HMK website</b><br><a href="http://www.hmk.mt.gov">www.hmk.mt.gov</a>   | Information on Healthy Montana Kids (HMK).  |
| <b>Montana Codes Annotated</b><br><a href="http://data.opi.mt.gov/bills/mca_toc/index.htm">http://data.opi.mt.gov/bills/mca_toc/index.htm</a>  | Montana laws.   |
| <b>Provider Information website</b><br><a href="http://medicaidprovider.hhs.mt.gov/index.shtml">http://medicaidprovider.hhs.mt.gov/index.shtml</a><br><br><b>Montana Access to Health (MATH) web portal</b><br><a href="https://mtaccesstohealth.acs-shc.com/">https://mtaccesstohealth.acs-shc.com/</a> | <ul style="list-style-type: none"> <li>• Fee schedules</li> <li>• Forms</li> <li>• Frequently asked questions (FAQs)</li> <li>• HIPAA updates</li> <li>• Key contacts</li> <li>• Links to other websites</li> <li>• Medicaid news</li> <li>• Newsletters</li> <li>• Passport and Team Care information</li> <li>• Provider enrollment</li> <li>• Provider manuals and manual replacement pages</li> <li>• Provider notices</li> <li>• Remittance advice notices</li> <li>• Upcoming events</li> </ul> |
| <b>Public Assistance Toolkit</b><br><a href="https://dphhs.mt.gov/">https://dphhs.mt.gov/</a>  | Select <i>Human Services</i> for information on: <ul style="list-style-type: none"> <li>• Medicaid: Client information, eligibility information, and provider information</li> <li>• Montana Access Card</li> <li>• Provider Resource Directory</li> <li>• Third Party Liability Carrier Directory</li> </ul>   |
| <b>Secretary of State</b><br><a href="http://www.sos.mt.gov/">www.sos.mt.gov/</a>  | Montana Secretary of State  |

# Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

## Manual Organization

This manual provides information specifically for critical access hospitals. Most chapters have a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK). Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both the general manual and the specific manual for his/her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* and *Key Websites* at the beginning of each manual. We have also included a space on the back side of the front cover to record your NPI/API for quick reference when calling Provider Relations.

## Manual Maintenance

Changes to manuals are provided through notices and replacement pages. When replacing a page in a paper manual, file the old page and notice in the back of the manual for use with claims that originated under the old policy. File all notices behind the tab marked “Notices.”

## Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. 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.** Links to rules are available on the Provider Information website (see *Key Websites*). Paper copies of rules are available through the Secretary of State’s office (see *Key Websites*).

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the hospital inpatient program:

- Code of Federal Regulations (CFR)
  - 42 CFR 440.10 Inpatient Hospital Services, Other than Services in an Institution for Mental Disease



Providers are responsible for knowing and following current laws and regulations.

- 42 CFR 440.20 Outpatient Hospital Services and Rural Health Clinic Services
- Montana Codes Annotated (MCA)
  - MCA Title 50-5-101–50-5-1205 Hospitals and Related Facilities
- Administrative Rules of Montana (ARM)
  - ARM Title 37.86.2801–37.86.3025 Hospital Services
  - ARM 37.106.704 Standards for Critical Access Hospitals

### **Claims Review (MCA 53-6-111, ARM 37.85.406)**

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by Federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

### **Getting Questions Answered**

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

# Covered Services

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## General Coverage Principles

Medicaid covers hospital services when they are medically necessary. This chapter provides covered services information that applies specifically to inpatient and outpatient hospital services provided by critical access hospitals. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

### ***Hospital inpatient services (ARM 37.86.2901–2947)***

Inpatient hospital services are provided to Medicaid clients who are formally admitted as an inpatient and whose expected hospital stay is greater than 24 hours. Inpatient services must be ordered by a licensed physician, dentist, or other practitioner and provided in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases. The institution must be currently licensed as an acute care hospital by the designated state licensing authority in the state where the institution is located, must meet the requirements for participation in Medicare as a hospital, and must have in effect a utilization review plan that meets the requirements of 42 CFR 482.30, or provide inpatient psychiatric hospital services for individuals under age 21 according to ARM 37.88.1101–1119.

### ***Hospital outpatient services (ARM 37.86.3001–3025)***

Outpatient hospital services are provided to clients whose expected hospital stay is less than 24 hours. Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by or under the direction of a physician, dentist, or other practitioner as permitted by Federal law. Hospitals must meet all of the following criteria:

- Licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
- Meet the requirements for participation in Medicare as a hospital

### ***Services for children (ARM 37.86.2201–2234)***

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent and identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

### ***Importance of fee schedules***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT, ICD, and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Websites*). Fee schedules for critical access hospitals provide coverage information only; they do not provide reimbursement information. Critical access hospitals should refer to the hospital inpatient and outpatient fee schedules for coverage information.

## **Physician Attestation and Acknowledgment (ARM 37.86.2904)**

At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

*Notice to physicians: Medicaid payment to hospitals is based on all of each patient's diagnoses and the procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment or civil penalty under applicable Federal laws.*

The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his/her first patient to the hospital. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The provider may, at his/her discretion, add to the language of this statement the word *Medicare* so that two separate forms will not be required by the provider to comply with both State and Federal requirements.

## **Utilization Reviews (42 CFR 456)**

The Department or its contractor may at any time review paid claims, provider documentation for medical necessity, appropriate billing, etc. Providers must maintain documentation of medical necessity for services such as initial hospitalization, transfers and readmissions. For more information on provider require-

ments for maintaining documentation, see *Record keeping* in the *General Information for Providers* manual, *Provider Requirements* chapter. See also *Claims Review* in the *Introduction* chapter of this manual.

## Nursing Facility Placement

Hospitalized Medicaid clients and Medicaid applicants being considered for nursing facility placement from the hospital shall be referred in a timely manner to the screening team. This will allow preadmission screening to be accomplished before placement and payment is made on their behalf.

## Coverage of Specific Services (ARM 37.86.2902)

The following are coverage rules for specific inpatient and outpatient hospital services. Services are for both inpatient and outpatient hospitals unless designated an *Inpatient only* or *Outpatient only* service. Except as otherwise permitted by federal law, inpatient hospital services must be ordered by a physician or dentist licensed under state law.

For inpatient hospital services, the following routine services are included in the stay; they cannot be billed separately:

- Bed and board;
- Nursing services and other related services;
- Use of hospital facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Other diagnostic or therapeutic items, or services provided in the hospital and not specifically excluded in ARM 37.85.207 (see *Noncovered Services* in this chapter); and
- Medical or surgical services provided by interns or residents-in-training in hospitals with teaching programs approved by the Council on Medical Education of the American Medical Association, the Bureau of Professional Education of the American Osteopathic Association, the Council on Dental Education of the American Dental Association or the Council on Podiatry Education of the American Podiatry Association.

### ***Abortions (ARM 37.86.104)***

Coverage of physician services for abortions is limited as follows:

- The life of the mother will be endangered if the fetus is carried to term.
- The pregnancy is the result of an act of rape or incest.

Physician services for abortions in a case of endangerment of the mother's life must meet the following requirements in order to receive Medicaid reimbursement:

- The physician must find, and certify in writing, that in the physician's professional judgement, the life of the mother will be endangered if the fetus is carried to term. The certification must contain the name and address of the patient and must be on or attached to the Medicaid claim.

Physician services for abortions in cases of pregnancy resulting from an act of rape or incest must meet the following requirements in order to receive Medicaid reimbursement:

- The recipient certifies in writing that the pregnancy resulted from an act of rape or incest; and
- The physician certifies in writing either that:
  - The recipient has stated to the physician that she reported the rape or incest to a law enforcement or protective services agency having jurisdiction over the matter, or if the recipient is a child enrolled in a school, to a school counselor; or
  - In the physician's professional opinion, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

A completed *Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

### ***Air transports***

Air transport providers must be registered with Medicaid as an ambulance provider. Claims for these services are billed on a CMS-1500 claim form. See the *Ambulance Services* manual available on the Provider Information website (see *Key Websites*).

***Chemical dependency treatment***

Chemical dependency services are limited. Providers must be approved by the Department before providing this service. Contact the Chemical Dependency Bureau for more information (see *Key Contacts*).

***Detoxification***

Detoxification services are covered for up to 7 days. More than 7 days may be covered if a hospital setting is required and the service has been authorized (see the *Prior Authorization* chapter in this manual). Services may also be covered if the authorization contractor determines that the client has a concomitant condition that must be treated in an inpatient hospital setting, and the detoxification treatment is a necessary adjunct to the treatment of the concomitant condition.

***Diabetic education***

Medicaid covers diabetic education services for newly diagnosed and/or unstable diabetics (e.g., a long-term diabetic with current management problems). The diabetic education protocol must meet the following Medicare Part A requirements:

- The program must train and motivate the client to self-manage their diabetes through proper diet and exercise, blood glucose self-monitoring, and insulin treatment.
- The plan of treatment must include goals for the client and how they will be achieved, and the program duration must be sufficient to meet these goals.
- The physician must refer only his/her clients to the program.
- The program must be provided under the physician's order by the provider's personnel and under medical staff supervision.
- The education plan must be designed specifically for the client to meet his/her individual needs. Structured education may be included in the plan, but not substituted for individual training.

***Discharges***

A hospital's utilization review (UR) committee must comply with the Code of Federal Regulations 42 CFR 456.131–137 prior to notifying a Montana Medicaid client that he or she no longer needs medical care. The hospital is not required to obtain approval from Montana Medicaid at the client's discharge; however, a hospital's UR plan must provide written notice to Montana Medicaid if a client decides to stay in the hospital when it is not medically necessary (see *Hospital services beyond medical necessity* in the *Billing Procedures* chapter of this manual).

***Donor transplants***

Medicaid covers harvesting from organ donors and transplants, but does not cover expenses associated with the donor search process.

### ***Emergency medical services***

Emergency medical services are those services required to treat and stabilize an emergency medical condition.

If an inpatient hospitalization is recommended for stabilization, the hospital must contact the client's Passport provider. If the provider does not respond within 60 minutes, the inpatient stay will be reimbursed after documentation is sent to the Passport program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60-minute time lapse between these two events.

### ***Mental health services***

Medicaid covers inpatient mental health services for Medicaid-enrolled clients when prior authorized (see the *Prior Authorization* chapter in this manual). Inpatient hospital services are not covered for adults enrolled in the Mental Health Service Plan (MHSP) or children enrolled in the Children's Mental Health Service Plan (CMHSP). Some mental health services may not be billed separately. These services include the following:

- Services provided by a psychologist who is employed or under a contract with a hospital
- Services provided for purposes of discharge planning as required by 42 CFR 482.21
- Services that are required as a part of licensure or certification, including but not limited to group therapy

Mental health services provided by physicians and psychiatrists in an inpatient setting are the only services that can be billed separately. Providers should refer to the mental health manual available on the Provider Information website (see *Key Websites*).

### ***Observation bed***

Clients in observation beds (admission of 24 hours or less) are considered outpatients, and claims should be filed accordingly.

### ***Outpatient clinic services***

The Department will pay for services provided in an outpatient clinic, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Hospitals that wish to have outpatient clinics paid as hospital-based providers must send a copy of the Medicare letter granting provider-based status to the Department's hospital program officer at the address shown under *Key Contacts*.

### ***Partial hospitalization***

The partial hospitalization program is an active treatment program that offers therapeutically intensive, coordinated, structured clinical services. These services are provided only to clients who are determined to have a serious emotional disturbance (SED) or a severe disabling mental illness (SDMI). Definitions for SED and SDMI are on the Provider Information website under *Definitions and Acronyms*. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services include day, evening, night and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatment or therapeutic activities. These services require prior authorization (see the *Prior Authorization* chapter in this manual). For more information, see the mental health manual, which is available on the Provider Information website (see *Key Websites*).

### ***Services provided by interns or residents-in-training (ARM 37.86.2902)***

Medicaid covers medical or surgical services provided by interns or resident-in-training only when they are provided in hospitals with teaching programs approved by one of the following:

- Council on Medical Education of the American Medical Association
- Bureau of Professional Education of the American Osteopathic Association
- Council on Dental Education of the American Dental Association
- Council on Podiatry Education of the American Podiatry Association

### ***Sterilization (ARM 37.86.104)***

#### **Elective Sterilization**

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. Client 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 (see *Appendix A: Forms* for the form and instructions). 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 client 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 client at least 72 hours prior to the sterilization procedure.

2. Client must be at least 21 years of age when signing the form.
3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a Federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
4. Client 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 client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client 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 client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client 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 those clients who are blind, 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 client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

### ***Medically Necessary Sterilization***

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39) for each provider submitting a claim. See *Appendix A: Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client (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 client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when Sections B or C are used. Refer to *Appendix A* for detailed instructions on completing the form.
- For clients 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 client permanently incapable of reproducing.
  - The reason for the hysterectomy was a life-threatening emergency.
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of either the FA-454 or FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

### ***Therapy services***

Physical, occupational, and speech/language therapy services are limited to 40 hours each during a state fiscal year (July 1–June 30) for adults age 21 years and older. Children may qualify for more than 40 hours if medically necessary, and prior authorization is required (see the *Prior Authorization* chapter in this manual).

### ***Transfers***

All transfers are subject to review for medical necessity. The initial hospitalization, all subsequent hospitalizations, and the medical necessity for the transfer itself may be reviewed. For information on billing and payment for transfers, see the *Billing Procedures* and *How Payment Is Calculated* chapters in this manual.

***Transplants (ARM 37.86.4701–37.86.4706)***

Prior authorization is required for all transplant services (see the *Prior Authorization* chapter in this manual). Medicaid covers only the following organ and tissue transplantation services:

- Allogenic and autologous bone marrow
- Cornea
- Enteral
- Heart/Lung
- Heart only
- Kidney only
- Kidney/Pancreas
- Pancreas only
- Lung

Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities must be performed at a Medicare approved transplant facility. These activities may include:

- Evaluation of the client as a potential transplant candidate
- Pre-transplant preparation including histocompatibility testing procedures
- Post-surgical hospitalization
- Outpatient care, including Federal Drug Administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications

Tissue transplantation includes only corneal, bone marrow, and peripheral stem cell transplants. Providers should refer to ARM 37.86.4705 for more information on the coverage of transplant services.

***Noncovered services (ARM 37.85.207 and 37.86.2902)***

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program (see the *Eligibility* chapter in the *General Information for Providers* manual).

- Acupuncture
- Chiropractic services
- Dietician/nutritional services
- Massage services
- Dietary supplements
- Homemaker services
- Infertility treatment
- Delivery services not provided in a licensed health care facility unless as an emergency service

- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy. Providers should refer to the *Therapy Services* manual available on the Provider Information website (see *Key Websites*).
- Administrative days. These are days of inpatient hospital service for which an inpatient hospital level of care is not necessary. A lower level of care is necessary, and an appropriate placement is not available.
- Inpatient hospital services beyond the period of medical necessity. See the *Billing Procedures* chapter in this manual.
- Inpatient hospital services provided outside the United States
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- All gastric bypass related services (including initial bypass and revisions)
- Circumcisions not authorized by the Department as medically necessary
- Services considered experimental or investigational. (Phase II clinical trials are considered experimental and therefore are not covered.)
- Claims for pharmaceuticals and supplies only
- Reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves.
- Exercise programs and programs that are primarily educational, such as:
  - Cardiac rehabilitation exercise programs
  - Pulmonary rehabilitation programs
  - Nutritional programs
  - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
  - Services provided to Medicaid clients who are absent from the state, with the following exceptions:
- Medical emergency
- Required medical services are not available in Montana. Passport approval is required and prior authorization may also be required for certain services (see the *Passport* and *Prior Authorization* chapters in this manual).
  - The Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
  - Out-of-state medical services and all related expenses are less costly than in-state services
  - Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state
  - Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid client is financially responsible for these services and the Department recommends the client agree in writing before the services are provided. See *When to Bill Medicaid Clients* in the *Billing Procedures* chapter of this manual.

- Donor search expenses
- Autopsies
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

## Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

### ***Mental Health Services Plan (MHSP)***

This chapter does not apply to clients who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website (see *Key Websites*).

### ***Healthy Montana Kids (HMK)***

The information in this chapter does not apply to HMK clients. Hospital services for children with HMK coverage are covered by Blue Cross and Blue Shield of Montana (BCBSMT). For more information, contact BCBSMT at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct).

# Passport to Health Program

## What Is Passport to Health? (ARM 37.86.5101–5120, ARM 37.86.5303, and ARM 37.86.5201–5206)

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* clients. The four Passport programs encourage and support Medicaid and HM *Plus* clients and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK *Plus* clients who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* clients are eligible). Each enrollee has a designated Passport provider who is typically a physician, midlevel practitioner, or primary care clinic.

### ***Passport to Health Primary Care Case Management (ARM 37.86.5101–5120)***

The Passport provider provides primary care case management (PCCM) services to their clients. This means he/she provides or coordinates the client's care and makes referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid, and HMK *Plus* clients choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept that encourages a strong doctor–client relationship. An effective medical home is accessible, continuous, comprehensive, coordinated, and operates within the context of family and community.

With some exceptions (see *Services That Do Not Require Passport Provider Approval* in this chapter), all services to Passport clients must be provided or approved by the client's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The client's Passport provider is also referred to as the PCP.

### ***Team Care (ARM 37.86.5303)***

Team Care is designed to educate clients to effectively access medical care. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Clients enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules and guidelines for referrals, enrollment/disenrollment, prior authorization, and billing processes. However, while Passport clients can change providers without



Medicaid does not pay for services when prior authorization or Passport requirements are not met.



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the claim form, if appropriate.

cause, as often as once a month, Team Care clients are locked in to one provider and one pharmacy. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their clients is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care clients. When checking Medicaid or HMK *Plus* eligibility on the MATH web portal (see *Key Websites*), a Team Care client's provider and pharmacy will be listed. Write all Medicaid and HMK*Plus* prescriptions to the designated pharmacy.

### ***Nurse First Advice Line***

The Nurse First Advice Line at 1-800-330-7847 is a 24/7, toll-free, and confidential nurse triage line staffed by licensed registered nurses and is available to all Montana Medicaid, HMK, and HMK *Plus* clients. There is no charge to clients or providers. Clients are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7 to triage clients over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their clients calls to be triaged.

Passport providers are encouraged to provide education to their clients regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line before going to the ED.

### ***Health Improvement Program (ARM 37.86.5201–5206)***

The Health Improvement Program (HIP) is for Medicaid and HMK *Plus* clients with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK *Plus* clients eligible for the Passport program are enrolled and assigned to a health center for case management. Current Passport clients stay with their PCPs for primary care, but are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate clients in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind clients about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill clients. This software uses medical claims, pharmacy and demographic information to generate a risk score for each client. Although the software will provide a great deal of information for interventions, it will not identify clients who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport clients at high risk for chronic health conditions that

would benefit from case management from HIP using the HIP referral form included at the [Health Improvement Program link](#) on the Provider Information website (see *Key Websites*).

In practice, providers will most often encounter Medicaid and HMK *Plus* clients who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the client is a Passport enrollee. Passport referral and approval requirements and PA requirements are described below. Specific PA requirements can be found in the provider fee schedules.

## Role of the Passport Provider

- Maintain a written record of all referrals given and received for every Passport client treated.
- Provide primary and preventive care, health maintenance, treatment of illness and injury, and coordination of client's access to medically necessary specialty care by providing referrals and follow-up.
- Provide well-child checkups, EPSDT services, blood lead screenings and immunizations.
- Develop an ongoing relationship with Passport clients for the purpose of providing continuity of care.
- Educate clients about appropriate use of office visits, the emergency department (ED), and urgent care clinics.
- Identify and refer clients to the Team Care program whose use of services is excessive and inappropriate with respect to medical need.
- Coordinate and collaborate with care managers in Medicaid HIP, including providing information regarding the needs of the client, reviewing and commenting on care plans prepared by care managers, and providing copies of medical records when requested.
- Provide coverage for needed services, consultation, and approval or denial of referrals during regular office hours.
- Provide 24-hour availability of information for seeking emergency services.
- Accept auto assignment of clients when PCP has openings and the clients meet the PCP-defined restrictions.
- Provide appropriate and HIPAA-compliant exchange of information among providers.
- Educate and assist clients in finding self-referral services (e.g., family planning, mental health services, immunizations, and other services).
- Maintain a client medical record for each Passport client. Providers must transfer the client's medical record to a new primary care provider if requested in writing and authorized by the client.

### ***Providing Passport referral and authorization***

- Before referring a Passport client to another provider, verify that the provider accepts Medicaid.
- When referring a client to another provider, give that provider your Passport number.
- All referrals must be documented in the client's medical record or a telephone log. Documentation should not be submitted with the claim.
- Passport approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the Passport provider.

See the *Passport Referral and Approval* section on the next page for details.

### ***Client disenrollment***

A provider can ask to disenroll a Passport client for any reason including:

- The provider-client relationship is mutually unacceptable.
- The client fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The client is abusive.
- The client could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-client relationship in mid-treatment. To disenroll a client, write to Passport to Health (see *Key Contacts*). A provider must continue to provide Passport management services to the client while the disenrollment process is being completed.

### ***Termination of Passport agreement***

To terminate a Passport agreement, notify Passport to Health (see *Key Contacts*) in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30-day time period to elapse.

### ***Utilization review***

Passport providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

### ***Caseload limits***

Passport providers may serve as few as one or as many as 1,000 Medicaid clients. Group practices and clinics may serve up to 1,000 clients for each full-time equivalent provider.

## Client Eligibility Verification

Client eligibility verification will indicate whether the client is enrolled in Passport. The client's Passport provider and phone number are also available, and whether the client has Full or Basic Medicaid coverage. To check a client's eligibility, go to the MATH web portal (see *Key Websites*). Other methods of checking client eligibility can be found in the *Client Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.

## Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in the *Covered Services* chapter of this manual. PA and Team Care requirements must also be followed.

## Passport Referral and Approval (ARM 37.86.5110)

If a client is enrolled in Passport, most services must be provided or approved by the client's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the client's Passport provider does not provide there are some exceptions (see *Services That Do Not Require Passport Provider Approval* in the following section).

### ***Making a referral***

Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the Passport provider's Passport approval number. Passport providers are required to document Passport referrals in the client's records or in a log book. Documentation should not be submitted with the claim. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy. An optional referral form is available at the Passport link on the Provider Information [website](#) (see *Key Websites*).

### ***Receiving a referral as the non-PCP***

The client's Passport provider must be contacted for approval for each visit unless another time parameter was established. It is best to get Passport approval in advance, in writing, and specific to services and dates. Using another provider's Passport number without approval is considered fraud. If a provider accepts a client as a Medicaid client and provides a service that requires Passport provider approval without the client's Passport provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the client. The provider can bill the client if the client agreed to pay privately before services were rendered (ARM 37.85.406).

For details on when providers can bill Medicaid clients, see the *Billing Procedures* chapter in the Medicaid billing manual for your provider type.

If a Passport provider refers a client to you, do not refer that client to someone else without the Passport provider's approval, or Medicaid will not cover the service.

### ***Passport approval and prior authorization (PA)***

Passport approval and PA are different, and both may be required for a service. PA refers to a list of services that require prior authorization through a Department contractor, Mountain-Pacific Quality Health. See the *Additional Medicaid Requirements for Passport Clients* in the *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on PA and Passport. The *Medicaid Covered Services* chapter of the *General Information for Providers* manual is an overview of services with PA and Passport indicators.

## **Services That Do Not Require Passport Provider Approval (ARM 37.86.5110)**

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Durable medical equipment
- Emergency department
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities for the mentally retarded
- Laboratory tests
- Licensed clinical counseling
- Mental health case management

- Mental health services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance services in a client's home
- Pharmacy
- Podiatry
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)
- X-rays

### **Passport and Emergency Services (ARM 37.86.5110)**

Passport providers must provide **direction** to clients in need of emergency care 24 hours a day/7 days a week. For more information on direction, education, and suitable coverage for emergency care, see the *Passport to Health Provider Handbook*.

- **Emergency services provided in the ED.** Passport provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. For more information, see *Emergency Services* on the Provider Information website (see *Key Websites*) or in the Medicaid billing manual for your provider type.
- **Post stabilization and Passport.** Services for clients admitted through an emergency room (identified by the presence of Revenue Code 45X or 65X on the claim) will be exempt from Passport requirements and from cost share requirements.

### **Passport and Indian Health Services**

Clients who are eligible for both Indian Health Service (IHS) and Medicaid may choose IHS or another provider as their Passport provider. Clients who are eligible for IHS do not need a referral from their Passport provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the Passport provider must provide the referral.

## Complaints and Grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the Passport Program Officer (see *Key Contacts*). See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

## Getting Questions Answered

The *Key Contacts* list provides important phone numbers and addresses. Provider and client help lines are available to answer almost any Passport or general Medicaid question. Providers may call Provider Relations to discuss any problems or questions regarding your Passport clients, or to enroll as a Passport provider. Providers can keep up with changes and updates to the Passport program by reading newsletters and other information available on the Provider Information website (see *Key Websites*). For claims questions, call Provider Relations.

## Becoming a Passport Provider (37.86.5111–5112)

A PCP can be a physician, primary care clinic, or mid-level practitioner (other than a certified registered nurse anesthetist) who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his/her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. Passport providers receive a primary case management fee of \$3.00 a month for each enrollee.

To enroll in Passport, Medicaid providers must complete and sign a Passport provider agreement. The Passport provider agreement and the *Passport to Health Provider Handbook* are available on the Provider Information website (see *Key Websites*). Providers may also call Provider Relations (see *Key Contacts*) for information on becoming a Passport provider and to get the Passport provider agreement.

### ***Solo Passport provider***

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the client's Passport provider. The solo provider is responsible for managing his/her individual Passport caseload. For details on referral documentation, see *Passport Referral and Approval* in this section of the manual. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

### ***Group Passport provider***

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the client's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or IHS. All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, clients may visit any provider within the group practice without a Passport referral. Case management fees are paid as a group under the group Passport number in addition to the fee-for-service reimbursement.

## **Passport Tips**

- View the client's Medicaid eligibility verification at each visit by going to the MATH web portal on the Provider Information website (see *Key Websites*) or by using one of the other methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's Passport PCP, include the Passport PCP's Passport approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to Passport and non-Passport Medicaid clients and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

## **Other Programs**

Clients who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK) are not enrolled in Passport, so the Passport requirements in this chapter do not apply.

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-877-543-7669 (toll-free, follow menu) or 1-855-258-3489 (toll-free, direct). Additional HMK information is available on the HMK website (see *Key Websites*).



# Prior Authorization

## What is Prior Authorization (ARM 37.86.2801)

Prior authorization (PA) refers to a list of services that require approval from the Medicaid program prior to the service being rendered. If a service requires PA, the requirement exists for all Medicaid clients. When PA is granted, the provider is issued a PA number that must be on the claim.

If both Passport referral and PA are required for a service, both numbers must be recorded in different fields on the Medicaid claim form (see the *Submitting a Claim* chapter in the manual for your provider type. Most Montana fee schedules indicate when PA is required for a service. For more information on PA, see the *Passport* and *Provider Authorization* chapters in the Medicaid billing manual for your provider type.

Whether the client is enrolled in Passport or Team Care, the eligibility information denotes the client's PCP. Services are only covered when they are provided or approved by the designated Passport provider or Team Care pharmacy shown in the eligibility information. Specific services may require both PA and Passport referral. To be covered by Medicaid, all services must also be provided in accordance with the requirements listed in this manual.

When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- When requesting PA for clients with partial eligibility, request PA from the first date the client was Medicaid eligible, not the first date of the client's hospital stay.
- The *PA Criteria for Specific Services* table lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA. See the following *PA Criteria for Specific Services* table for documentation requirements.
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim in form locator (FL) 63 on the UB-04 paper claim form.
- Authorization is requested.
- The hospital can document that at the time of admission it did not know, or have any basis to assume that the client was a Montana Medicaid client.



Prior authorization is not required in emergency room situations.

| PA Criteria for Specific Services  |   |   |
|--|---|---|
| Service  | PA Contact  | Document Requirements   |
| <ul style="list-style-type: none"> <li>• All transplant services</li> <li>• All rehab services</li> <li>• Therapy services over limit for children</li> <li>• Chemical dependency treatment over the 7-day limit</li> <li>• New technology codes (Category III CPT codes)</li> <li>• Other reviews referred by Medicaid program staff</li> </ul> | <p>Mountain-Pacific Quality Health<br/>3404 Cooney Drive<br/>Helena, MT 59602</p> <p><b>Phone:</b><br/>(406) 443-4020 X5850 Helena<br/>(800) 262-1545 X5850 In/out of state</p> <p><b>Fax:</b><br/>(406) 443-4585 Helena<br/>(800) 497-8235 In/out of state</p> | <ul style="list-style-type: none"> <li>• Required information includes: <ul style="list-style-type: none"> <li>• Client's name</li> <li>• Client's Medicaid ID number</li> <li>• State and hospital where client is going</li> <li>• Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health will instruct providers on required documentation on a case-by-case basis.</li> </ul> </li> </ul>   |
| <ul style="list-style-type: none"> <li>• Maxillofacial/cranial surgery</li> </ul>  | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114</p> <p><b>Fax:</b><br/>(800) 291-7791</p>   | <ul style="list-style-type: none"> <li>• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from injuries or congenital defects.</li> <li>• Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> <li>• Client's condition</li> <li>• Proposed treatment</li> <li>• Reason treatment is medically necessary</li> </ul> </li> <li>• Medicaid does not cover services for: <ul style="list-style-type: none"> <li>• Improvement of appearance or self-esteem (cosmetic)</li> <li>• Dental implants</li> <li>• Orthodontics</li> </ul> </li> </ul>   |
| <ul style="list-style-type: none"> <li>• Blepharoplasty</li> </ul>   | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114</p> <p><b>Fax:</b><br/>(800) 291-7791</p>   | <ul style="list-style-type: none"> <li>• Reconstructive blepharoplasty may be covered for: <ul style="list-style-type: none"> <li>• Correct visual impairment caused by drooping of the eyelids (ptosis)</li> <li>• Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)</li> <li>• Treat periorbital sequelae of thyroid disease and nerve palsy</li> <li>• Relieve painful symptoms of blepharospasm (uncontrollable blinking).</li> </ul> </li> <li>• Documentation must include: <ul style="list-style-type: none"> <li>• Indications of surgery documented by surgeon</li> <li>• A reliable source for visual-field charting when visual impairment is involved</li> <li>• Complete eye evaluation</li> <li>• Preoperative photographs</li> </ul> </li> <li>• Medicaid does not cover cosmetic blepharoplasty.</li> </ul> |

**PA Criteria for Specific Services (Continued)**

| Service  | PA Contact   | Document Requirements   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• <b>Botox Myobloc</b></li> </ul>                                   | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p> | <ul style="list-style-type: none"> <li>• For details on botox criteria, coverage, and limitations, visit the Provider Information website (see <i>Key Websites</i>).</li> <li>• Botox is covered for treating the following:                             <ul style="list-style-type: none"> <li>• Laryngeal spasm</li> <li>• Blepharospasm</li> <li>• Hemifacial spasm of the nerve</li> <li>• Torticollis, unspecified</li> <li>• Torsion dystonia</li> <li>• Fragments of dystonia</li> <li>• Hereditary spastic paraplegia</li> <li>• Multiple sclerosis</li> <li>• Spastic hemiplegia</li> <li>• Infantile cerebral palsy</li> <li>• Other specified infantile cerebral palsy</li> <li>• Achalasia and cardiospasm</li> <li>• Spasm of muscle</li> <li>• Hyperhidrosis</li> <li>• Strabismus and other disorders of binocular eye movements</li> <li>• Other demyelinating disease of the central nervous system</li> </ul> </li> <li>• Documentation requirements include a letter from the attending physician supporting medical necessity including:                             <ul style="list-style-type: none"> <li>• Client's condition (diagnosis)</li> <li>• A statement that traditional methods of treatments have been tried and proven unsuccessful</li> <li>• Proposed treatment (dosage and frequency of injections)</li> <li>• Support the clinical evidence of the injections</li> <li>• Specify the sites injected</li> </ul> </li> <li>• Myobloc is reviewed on a case-by-case basis.</li> </ul> |
| <ul style="list-style-type: none"> <li>• <b>Excising excessive skin and subcutaneous tissue</b></li> </ul> | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p> | <ul style="list-style-type: none"> <li>• Required documentation includes the following:                             <ul style="list-style-type: none"> <li>• The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss.</li> <li>• The duration of symptoms of at least six months and the lack of success of other therapeutic measures</li> <li>• Pre-operative photographs</li> </ul> </li> <li>• This procedure is contraindicated for, but not limited to, individuals with the following conditions:                             <ul style="list-style-type: none"> <li>• Severe cardiovascular disease</li> <li>• Severe coagulation disorders</li> <li>• Pregnancy</li> </ul> </li> <li>• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.</li> </ul>   |

| PA Criteria for Specific Services (Continued)  |   |  |
|--|---|--|
| Service  | PA Contact  | Document Requirements  |
| <ul style="list-style-type: none"> <li><b>Rhinoplasty septorhinoplasty</b></li> </ul>                          | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p>  | <ul style="list-style-type: none"> <li>The following do not require PA:                             <ul style="list-style-type: none"> <li>Septoplasty to repair deviated septum and reduce nasal obstruction</li> <li>Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction</li> </ul> </li> <li>Medicaid covers rhinoplasty in the following circumstances:                             <ul style="list-style-type: none"> <li>To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger</li> <li>Following a trauma (e.g., a crushing injury) which displaced nasal structures and causes nasal airway obstruction.</li> </ul> </li> <li>Documentation requirements include a letter from the attending physician documenting:                             <ul style="list-style-type: none"> <li>Client's condition</li> <li>Proposed treatment</li> <li>Reason treatment is medically necessary</li> </ul> </li> <li>Not covered                             <ul style="list-style-type: none"> <li>Cosmetic rhinoplasty done alone or in combination with a septoplasty</li> <li>Septoplasty to treat snoring</li> </ul> </li> </ul> |
| <ul style="list-style-type: none"> <li><b>Dermabrasion/abrasion chemical peel</b></li> </ul>                   | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p>  | <ul style="list-style-type: none"> <li>Services covered for the following:                             <ul style="list-style-type: none"> <li>Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.</li> </ul> </li> <li>The removal of pre-cancerous skin growths (keratoses)</li> <li>Documentation requirements include a letter from the attending physician documenting:                             <ul style="list-style-type: none"> <li>Client's condition</li> <li>Proposed treatment</li> <li>Reason treatment is medically necessary</li> </ul> </li> <li>Pre-operative photographs</li> </ul>   |
| <ul style="list-style-type: none"> <li><b>Inpatient hospital services for psychiatric diagnosis</b></li> </ul> | <p>Magellan Medicaid Administration<br/>(previously dba First Health Services)<br/>4300 Cox Road<br/>Glen Allen, VA 23060</p> <p><b>Phone:</b><br/>(800) 770-3084<br/><b>Fax:</b><br/>(800) 639-8982<br/>(800) 247-3844</p> | <ul style="list-style-type: none"> <li>Client's diagnosis</li> <li>Summary of reason the client was admitted.</li> </ul>   |

| <b>PA Criteria for Specific Services (Continued)</b>   |   |  |
|--|---|--|
| <b>Service</b>   | <b>PA Contact</b>   | <b>Document Requirements</b>   |
| <ul style="list-style-type: none"> <li>• <b>Partial hospitalization</b></li> </ul>   | Magellan Medicaid Administration<br>(previously dba First Health Services)<br>4300 Cox Road<br>Glen Allen, VA 23060<br><br><b>Phone:</b><br>(800) 770-3084<br><b>Fax:</b><br>(800) 639-8982<br>(800) 247-3844 | <ul style="list-style-type: none"> <li>• A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission.</li> <li>• The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the client's psychiatric condition.</li> </ul>  |
| <ul style="list-style-type: none"> <li>• <b>Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)</b></li> </ul> <p style="font-size: small; margin-top: 10px;">For emergency ambulance transport services, providers have 60 days following the service to obtain authorization. See the <i>Ambulance</i> manual.</p> | Mountain-Pacific Quality Health Medicaid Transportation<br>P.O. Box 6488<br>Helena, MT 59604<br><br><b>Phone:</b><br>(800) 292-7114<br><b>Fax:</b><br>(800) 291-7791<br><b>E-Mail:</b><br>ambulance@mpqhf.org | <ul style="list-style-type: none"> <li>• Ambulance providers may call, leave a message, fax, or e-mail requests.</li> <li>• Required information includes:               <ul style="list-style-type: none"> <li>• Name of transportation provider</li> <li>• Provider's Medicaid ID Number</li> <li>• Client's name</li> <li>• Client's Medicaid ID number</li> <li>• Point of origin to the point of destination</li> <li>• Date and time of transport</li> <li>• Reason for transport</li> <li>• Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen)</li> </ul> </li> <li>• Providers must submit the trip report and copy of the charges for review after transport.</li> <li>• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.</li> </ul> |
| <ul style="list-style-type: none"> <li>• <b>Eye prosthesis</b></li> </ul>  | Mountain-Pacific Quality Health<br>P.O. Box 6488<br>Helena, MT 59604<br><br><b>Phone:</b><br>(800) 292-7114<br><b>Fax:</b><br>(800) 291-7791  | <ul style="list-style-type: none"> <li>• Documentation that supports medical necessity</li> <li>• Documentation regarding the client's ability to comply with any required after care</li> <li>• Letters of justification from referring physician</li> <li>• Documentation should be provided at least two weeks prior to the procedure date.</li> </ul>  |

| PA Criteria for Specific Services (Continued)  |  |   |
|--|--|---|
| Service  | PA Contact   | Document Requirements   |
| <ul style="list-style-type: none"> <li>• <b>Circumcision</b></li> </ul>                                      | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p> | <p><b>Description</b><br/>Circumcision is the surgical removal of the sleeve of the skin and muscosal tissue that normally covers the glans (head) of the penis. The request for a circumcision will be reviewed on a case-by-case basis, based on medical necessity. Routine circumcisions are not covered.</p> <p><b>Indications for Circumcision:</b></p> <ul style="list-style-type: none"> <li>• Requests are reviewed case-by-case basis based on medical necessity when one of the following occurs: <ul style="list-style-type: none"> <li>• The one absolute indication for the circumcision is scarring of the opening of the foreskin making it nonretractable (pathological phimosis). The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.</li> <li>• Urinary obstruction.</li> <li>• Urinary tract infections.</li> <li>• Balanitis.</li> </ul> </li> </ul>  |
| <ul style="list-style-type: none"> <li>• <b>Temporomandibular joint (TMJ) arthroscopy/surgery</b></li> </ul> | <p>Mountain-Pacific Quality Health<br/>P.O. Box 6488<br/>Helena, MT 59604</p> <p><b>Phone:</b><br/>(800) 292-7114<br/><b>Fax:</b><br/>(800) 291-7791</p> | <ul style="list-style-type: none"> <li>• Non-surgical treatment for TMJ disorders must be utilized <b>first</b> to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case: <ul style="list-style-type: none"> <li>• Fabrication and insertion of an intra-oral orthotic</li> <li>• Physical therapy treatments</li> <li>• Adjunctive medication</li> <li>• Stress management</li> </ul> </li> <li>• Surgical treatment may be considered when both of the following apply: <ul style="list-style-type: none"> <li>• Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.</li> <li>• There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.</li> </ul> </li> <li>• Not covered: <ul style="list-style-type: none"> <li>• Botox injections for the treatment of TMJ are considered experimental.</li> <li>• Orthodontics to alter the bite</li> <li>• Crown and bridge work to balance the bite</li> <li>• Bite (occlusal) adjustments</li> </ul> </li> </ul> |

| <b>PA Criteria for Specific Services (Continued)</b>                             |  |   |
|--|--|---|
| <b>Service</b>   | <b>PA Contact</b>  | <b>Document Requirements</b>  |
| <ul style="list-style-type: none"> <li>• <b>Reduction Mammoplasty</b></li> </ul> | Mountain-Pacific Quality Health<br>P.O. Box 6488<br>Helena, MT 59604<br><br><b>Phone:</b><br>(800) 292-7114<br><br><b>Fax:</b><br>(800) 291-7791 | <ul style="list-style-type: none"> <li>• Both referring physician and the surgeon must submit documentation.</li> <li>• Back pain must have been documented and present for at least six months, and causes other than breast weight must have been excluded.</li> </ul> <b>Indications for female client:</b> <ul style="list-style-type: none"> <li>• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.</li> <li>• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.</li> <li>• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six-month period. This must include at least two of the following:               <ul style="list-style-type: none"> <li>• Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises</li> <li>• Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.</li> <li>• Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.</li> <li>• Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.</li> </ul> </li> </ul> |

## PA Criteria for Specific Services (Continued)

| Service  | PA Contact                  | Document Requirements   |        |                             |                  |           |                            |           |                                      |           |                               |           |
|--|-----------------------------|---|--------|-----------------------------|------------------|-----------|----------------------------|-----------|--------------------------------------|-----------|-------------------------------|-----------|
| <ul style="list-style-type: none"> <li>• <b>Reduction Mammoplasty, cont'd</b></li> </ul> |                             | <p><b>Documentation in the client's record must indicate and support:</b></p> <ul style="list-style-type: none"> <li>• History of the client's symptoms related to large, pendulous breasts.</li> <li>• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain).</li> <li>• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):</li> </ul> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;">Height</th> <th style="text-align: right;">Weight of tissue per breast</th> </tr> </thead> <tbody> <tr> <td>Less than 5 feet</td> <td style="text-align: right;">250 grams</td> </tr> <tr> <td>5 feet to 5 feet, 2 inches</td> <td style="text-align: right;">350 grams</td> </tr> <tr> <td>5 feet, 2 inches to 5 feet, 4 inches</td> <td style="text-align: right;">450 grams</td> </tr> <tr> <td>Greater than 5 feet, 4 inches</td> <td style="text-align: right;">500 grams</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• Preoperative photographs of the pectoral girdle showing changes related to mamomastia.</li> <li>• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.</li> </ul> <p><b>Indications for male client:</b></p> <ul style="list-style-type: none"> <li>• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.</li> <li>• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, preoperative photographs.</li> </ul> | Height | Weight of tissue per breast | Less than 5 feet | 250 grams | 5 feet to 5 feet, 2 inches | 350 grams | 5 feet, 2 inches to 5 feet, 4 inches | 450 grams | Greater than 5 feet, 4 inches | 500 grams |
| Height   | Weight of tissue per breast |   |        |                             |                  |           |                            |           |                                      |           |                               |           |
| Less than 5 feet   | 250 grams                   |   |        |                             |                  |           |                            |           |                                      |           |                               |           |
| 5 feet to 5 feet, 2 inches   | 350 grams                   |   |        |                             |                  |           |                            |           |                                      |           |                               |           |
| 5 feet, 2 inches to 5 feet, 4 inches   | 450 grams                   |   |        |                             |                  |           |                            |           |                                      |           |                               |           |
| Greater than 5 feet, 4 inches  | 500 grams                   |   |        |                             |                  |           |                            |           |                                      |           |                               |           |

### Other Programs

Prior authorization may be required for certain services for clients who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK).

For HMK information, contact Blue Cross and Blue Shield of Montana at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct). Additional HMK information is available on the HMK website (see *Key Websites*).

# Coordination of Benefits

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## When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to billing third party first* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

## Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information for Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the TPL section. Examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance\*
- Health insurance from an absent parent
- Automobile insurance\*
- Court judgments and settlements\*
- Long-term care insurance

\*These third party payers (and others) may **not** be listed on the client's Medicaid eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

## When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as third party liability (TPL), but Medicare is not.

### ***Medicare Part A claims***

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers



Medicare Part A crossover claims do not automatically cross over from Medicare.

must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid on paper.

### ***Medicare Part B crossover claims***

Medicare Part B covers outpatient hospital care, physician care and other services. Although outpatient hospital care is covered under Part B, it is processed by Medicare Part A. This means that outpatient hospital claims are completed on a UB-04 form and must be submitted directly to Medicaid. These claims do not automatically cross over from Medicare.

### ***When Medicare pays or denies a service***

When inpatient hospital claims for clients with Medicare and Medicaid:

- Are paid, submit the claim to Medicaid on a UB form with the Medicare coinsurance and deductible information in Value Codes form locators, FL 39–41 and Medicare paid amounts in Prior Payments, FL 54. See the *Billing Procedures* and *Submitting a Claim* chapters in this manual.
- Are allowed, and the allowed amount went toward the client's deductible, include the deductible information in Value Codes FL 39–41, and submit the claim to Medicaid on paper.
- Are denied, the provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.



When billing Medicaid for a client with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

When submitting electronic claims with paper attachments, see *Billing Electronically with Paper Attachments* in the *Submitting a Claim* chapter in this manual.

### ***Submitting Medicare claims to Medicaid***

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required if the claim was denied or if the hospital billed Medicare using the All Inclusive Payment/Option II Billing Method (see the *Billing Procedures* chapter, *Billing for Clients with Other Insurance* section in this manual).

## **When a Client Has TPL (ARM 37.85.407)**

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: *When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid.*

### ***Exceptions to billing third party first***

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim Compensation Fund, providers must bill Medicaid before IHS or Crime Victims. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability Unit (see *Key Contacts*).

### ***Requesting an exemption***

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company. Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the Child Support Enforcement Division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  - The third party carrier has been billed, and 30 days or more have passed since the date of service.
  - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

! If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

### ***When the third party pays or denies a service***

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the Prior Payments form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. These claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information [website](#) (see *Key Websites*).
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

### ***When the third party does not respond***

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the paper claim a note explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit (see *Key Contacts*).

! For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

## **Other Programs**

This chapter does not apply to clients who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information [website](#) (see *Key Websites*).

The information in this chapter does not apply to clients enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct).

# Billing Procedures

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## Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-04 claim form. UB-04 forms 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 12 months from whichever is later:

- the date of service
- the date retroactive eligibility or disability is determined

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 approving the service (if the Medicare claim was timely filed and the client was 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 the claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

## When to Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exceptions are that providers may collect cost sharing from clients and may bill clients for hospital services provided beyond the period of medical necessity.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client 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 client fails to arrive for a scheduled appointment.
- When services are free to the client 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 Medicaid client (see the following table).

| When to Bill a Medicaid Client (ARM 37.85.406) |  |   |                                 |
|--|--|---|---------------------------------|
|  | Client Is Medicaid-Enrolled, and Provider Accepts Client as a Medicaid Client  | Client Is Medicaid-Enrolled, and Provider Does Not Accept Client as a Medicaid Client | Client is Not Medicaid-Enrolled |
| <b>Service is covered by Medicaid</b>          | Provider can bill client <b>only</b> for cost sharing.   | Provider can bill Medicaid client if the client has signed a custom agreement.        | Provider can bill client.       |
| <b>Service is not covered by Medicaid</b>      | Provider can bill client <b>only</b> if custom agreement has been made between client and provider before providing the service. | Provider can bill Medicaid client if the client has signed a private-pay agreement.   | Provider can bill client.       |

**Private-Pay Agreement:** This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he/she must pay for the services received.

**Custom Agreement:** This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

### ***Hospital services beyond medical necessity***

The Montana Medicaid client who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as a Montana Medicaid noncovered service. The client must have been

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



informed in writing and agreed in writing prior to provision of services to accept financial responsibility. The agreement must state the specific services the Medicaid client has agreed to pay for. In this case, a routine agreement will not suffice.

A hospital's utilization review plan must provide written notice to Montana Medicaid if a Montana Medicaid client decides to stay in the hospital when it is not medically necessary. This written notice must be sent to the hospital program officer (see *Key Contacts*).

### Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing for inpatient services is \$100 per discharge, and cost sharing for outpatient services is \$5.00 per visit. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice.

The following clients are exempt from cost sharing:

- Clients under 21 years of age (i.e., EPSDT services)
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing if the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

- Emergencies (see the *Covered Services* chapter in this manual)
- Emergency services
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home- and community-based waiver services
- Nonemergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- Well-child EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients.



Providers must notify the Department when a client chooses to stay in the hospital when it is not medically necessary.



Client cost sharing for hospital inpatient services is \$100 per discharge.



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

## Coding

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. For coding assistance and resources, see the following table of *Coding Resources*. The following suggestions may help reduce coding errors and unnecessary claim denials:

Always refer to the long descriptions in coding books.

- Use current versions of the ICD manual.
- 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.

### Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

| Resource   | Description  | Contact  |
|--|--|--|
| CCI Policy and Edits Manual                                | This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service. | National Technical Information Service<br>(800) 363-2068<br>(703) 605-6060   |
| CPT  | <ul style="list-style-type: none"> <li>• CPT codes and definitions</li> <li>• Updated each January</li> </ul>  | American Medical Association<br>(800) 621-8335<br><a href="http://www.amapress.com">www.amapress.com</a><br>or<br>Ingenix (now OptumInsight)<br>(800) 765-6588<br><a href="http://www.optumcoding.com">www.optumcoding.com</a> |
| CPT Assistant  | A newsletter on CPT coding issues  | American Medical Association<br>(800) 621-8335<br><a href="http://www.amapress.com">www.amapress.com</a>   |
| HCPCS Level II   | <ul style="list-style-type: none"> <li>• HCPCS Level II codes and definitions</li> <li>• Updated each January and throughout the year</li> </ul>   | Available through various publishers and bookstores or from CMS at <a href="http://www.cms.gov">www.cms.gov</a> .  |
| ICD  | <ul style="list-style-type: none"> <li>• ICD diagnosis and procedure codes definitions</li> <li>• Updated each October.</li> </ul>   | Available through various publishers and bookstores.   |
| Miscellaneous Resources                                    | Various newsletters and other coding resources.  | Ingenix (now OptumInsight)<br>(800) 765-6588<br><a href="http://www.optumcoding.com">www.optumcoding.com</a>   |
| UB-04 Editor   | National UB-04 billing instructions  | Available through various publishers and editors.  |
| UB-04 National Uniform Billing Data Element Specifications | Montana UB-04 billing instructions   | National Uniform Billing Committee<br><a href="http://www.nubc.org">www.nubc.org</a>   |

## Billing for Retroactively Eligible Clients

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

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

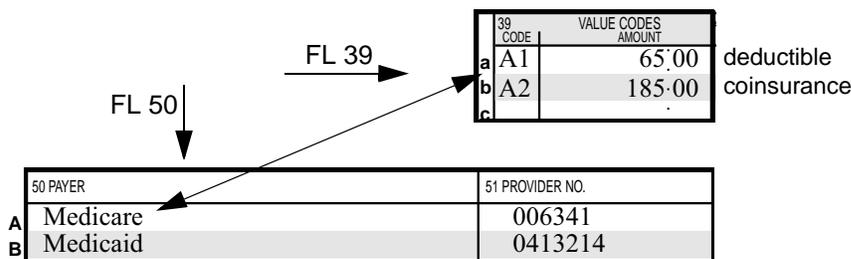
When the provider accepts the client’s retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of either the FA-454 or FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client’s local office of public assistance (see the *General Information for Providers manual, Appendix C: Local Offices of Public Assistance*).

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

## Billing for Clients with Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client’s health care, see the *Coordination of Benefits* chapter in this manual.

When completing a paper claim for clients with Medicare and Medicaid, Medicare coinsurance and deductible amounts listed in FL 39 must correspond with the payer listed in FL 50. For example, if the client has Medicare and Medicaid, any Medicare deductible and coinsurance amounts should be listed in FL 39 preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare should be listed in FL 50A (see the *Submitting a Claim* chapter in this manual).



When a client has Medicare and Medicaid, Medicare may be billed using the All Inclusive Payment/Option II Billing Method, in which physician/professional charges are billed together on a UB-04 claim. Montana Medicaid does not allow physician/professional charges to be billed on UB-04 claim forms. Physician/professional charges **must** be billed to Montana Medicaid on a CMS-1500.

Critical access hospitals will be permitted to bill their institutional charges and their physician/professional charges on a UB-04 claim form if the client is dually eligible (a beneficiary of both Medicare and Medicaid). This will permit claims for dually eligible clients to cross over electronically from Medicare. Medicaid will process these claims and pay Medicare coinsurance and deductible less incurment and third party payments.

### Medicare Benefits Exhausted

If/when a Medicare/Medicaid client exhausts the Medicare benefit (including Lifetime Reserve Days), the claim will be treated as a Medicaid-only claim from the date the Medicare benefits were exhausted. The claim should be submitted reflecting a covered stay from the day the Medicare benefits were exhausted to discharge.

### Services Provided to Passport to Health Clients

A Medicaid client covered by the Passport to Health program must have hospital services approved by the client's PCP. PCP approval is required even if the client was admitted to the hospital from the emergency room and the diagnosis is one of the diagnoses that doesn't require the PCP's authorization for emergency room treatment. The Passport approval codes must be on the claim (FL 11 on a paper claim), or the service will be denied.

### Services That Require Prior Authorization (PA)

Prior authorization (PA) is required for some hospital services. Passport and prior authorization are different, and some services may require both (see the *Passport* and *Prior Authorization* chapters in this manual). Different codes are issued for each type of approval and must be included on the claim form, or the claim will be denied (see the *Submitting a Claim* chapter in this manual). The PA code is located in FL 63 on the paper claim.

### Discharges and Transfers

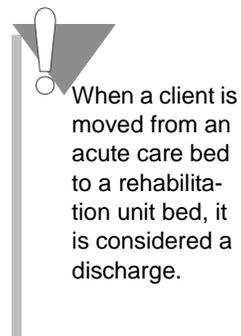
Claims can be filed only after the client has been discharged. A client is considered discharged when he/she:

- Is formally released from the hospital
- Transfers to another hospital or rehabilitation unit
- Dies in the hospital
- Leaves the hospital against medical advice (AMA)

When a service requires Passport approval or prior authorization (or both), different codes are issued for each and must be included on the claim, or it will be denied.

All transfers are subject to review for medical necessity. Initial hospitalizations, subsequent hospitalizations, and transfers may be reviewed for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

The patient status code (FL 22 on the UB-04 paper claim form) should contain the appropriate discharge status code. The following discharge status codes are valid for Montana Medicaid.



| Discharge Status Codes |   |             |  |
|------------------------|---|-------------|--|
| Status Code            | Description   | Status Code | Description  |
| 01                     | Discharged to home or self-care (routine discharge)                                 | 40          | Expired (death) at home  |
| 02                     | Discharge/Transfer to another short-term general hospital for inpatient care        | 41          | Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing hospice)                               |
| 03                     | Discharge/Transfer to skilled nursing facility (SNF)                                | 42          | Expired – place unknown  |
| 04                     | Discharge/Transfer to an intermediate care facility (ICF)                           | 43          | Discharge/Transfer to Federal hospital   |
| 05                     | Discharge/Transfer to another type of institution for inpatient care                | 50          | Hospice – home   |
| 06                     | Discharge/Transfer to home under care of organized home health service organization | 51          | Discharge/Transfer to hospice medical facility   |
| 07                     | Left against medical advice or discontinued care                                    | 61          | Discharge/Transfer within this institution to hospital-based Medicare-approved swing bed                         |
| 08                     | Discharge/Transfer to home under care of a Home IV provider                         | 62          | Discharge/Transfer to another rehabilitation facility including rehabilitation distinct part units of a hospital |
| 09                     | Admitted as an inpatient to this hospital   | 63          | Discharge/Transfer to a long-term care hospital  |
| 20                     | Expired (death)   | 64          | Discharge/Transfer to nursing facility certified under Medicaid, but not Medicare                                |
| 30                     | Still a patient (Neonate providers discharge status code for interim billing.)      | 65          | Discharge/Transfer to a psychiatric hospital or psychiatric distinct part unit of a hospital                     |

### Bundled Services

**Outpatient hospital services preceding an inpatient hospital admission must not be bundled into the inpatient claim.**

### Multiple Services on Same Date

Hospital providers must submit a single claim for all services provided to the same client on the same day. If services are repeated on the same day, use appropriate modifiers.

## Reporting Service Dates

- All line items must have a valid date of service in FL 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:

### Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code for Outpatient Services Only

|     |                                |     |   |
|-----|--------------------------------|-----|---|
| 26X | IV Therapy                     | 51X | Clinic  |
| 28X | Oncology                       | 52X | Freestanding 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 current CPT book, HCPCS Level II book, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in FL 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.
- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers. For a list of modifiers that change pricing, see the *How Payment Is Calculated* chapter in this manual.

## Number of Lines on Claim

Providers are requested to put no more than 40 lines on a UB-04 paper claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for claims with 40 lines or fewer. Providers can choose to combine lines or bill electronically. The electronic billing system is designed to handle more than 40 lines.

## Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, but the date must be shown on the line.

## Split/Interim Billing

Hospitals can split bill under the following circumstances. When split billing, only include charges for the dates of service covered by the client's eligibility period.

- ***At the provider's fiscal year end.***
- ***When the client has partial eligibility.*** In cases where the client has partial Medicaid eligibility for a hospital stay and Medicare has paid, the claim must be split and only Medicaid eligible charges billed. Pro-rate the coinsurance over the entire stay, and indicate the portion related to the Medicaid eligible period. For example, a client had a 15-day hospital stay in which she was eligible for Medicaid during 10 of those days. The client has a \$300 Medicare coinsurance, which is divided by the 15 days for a total of \$20 per day. Multiply \$20 x the 10 Medicaid eligible days for a total of \$200 coinsurance, which can be billed to Medicaid.

The Medicare deductible can only be applied on the Medicaid claim if the client is eligible for Medicaid on the first day of the hospital stay. Otherwise, the deductible may not be billed to Medicaid.

If Medicare does not pay, then bill the claim as usual. The claim will automatically be prorated based on the partial eligibility.

- ***When the client has both Medicare and Medicaid, and Medicare does not cover the service.*** When the services provided are outside the Medicare covered days, submit only Medicaid covered days to Medicaid.
- ***When the number of lines on a paper claim reaches 40.*** Providers are requested to put no more than 40 lines on a UB-04 paper claim. Although additional lines may be billed on the same claim, the Department's claims processing system is most efficient for claims with 40 lines or fewer.

## Incurment

All hospitals must bill from the date incurment/spend down was met. For more information on incurment, see the *Client Eligibility* chapter in the *General Information for Providers* manual.

## Billing for Specific Services

Prior authorization is required for some hospital services. Passport and prior authorization are different, and some services may require both (see the *Passport* and *Prior Authorization* chapters in this manual). Different codes are issued for each type of approval and must be included on the claim form (see the *Submitting a Claim* chapter in this manual).

In order to be covered by Medicaid, abortions and sterilizations require specific forms to be completed and submitted with the claim. For more information on abortion and sterilization requirements, see the *Covered Services* chapter in this manual. Forms are available on the Provider Information website ([Forms page](#)), and a samples are in *Appendix A: Forms*.

### **Abortions**

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

### **Drugs and biologicals**

While most drugs and biologicals are bundled (packaged), there are some items that will receive a payment amount and some that are designated as transitional pass-through items (see *Pass-Through* in the *How Payment Is Calculated* chapter of this manual).

The following may generate additional payment:

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

When a client has both Medicare and Medicaid and Medicare denies the pharmacy portion of a claim, providers must report Revenue Code 250 on a separate UB-04 claim form when submitting the claim to Medicaid.

### **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.

### ***Sterilization***

- 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, and revisions are not accepted. 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), 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. See the *Forms* page on the Provider Information website or *Appendix A: Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client (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 client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Refer to *Appendix A: Forms* for instructions on completing the form.
  - For clients 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 client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of either the FA-454 or FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

### ***Supplies***

Most supplies have their costs included (bundled) as part of the service that is billed. A few especially expensive supplies are paid separately by Medicaid. For guidance consult the Department's hospital fee schedule.

### **Submitting a Claim**

See the *Submitting a Claim* chapter in this manual for instructions on completing claim forms, submitting paper and electronic claims, and inquiring about a claim.

### **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. An explanation of benefits/reason and remark code cross-walk is available on the Provider Information [website](#).

| <b>Common Billing Errors</b>  |   |
|---|---|
| <b>Reasons for Return or Denial</b>   | <b>Preventing Returned or Denied Claims</b>   |
| NPI number missing or invalid.  | The provider number is a <b>10-digit</b> number assigned to the provider during Medicaid enrollment. Verify the correct <b>NPI and Taxonomy</b> are on the claim.   |
| Authorized signature missing.   | Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, handwritten, or computer-generated.  |
| Signature date missing.   | Each claim must have a signature date.  |
| Incorrect claim form used.  | The claim must be the correct form for the provider type. Services covered in this manual require a UB-04 claim form.   |
| Information on claim form not legible.  | 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.  |
| Client number not on file, or client was not eligible on date of service.             | Before providing services to the client, verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information for Providers</i> manual. Medicaid eligibility may change monthly. |
| Procedure requires Passport provider referral – No Passport provider number on claim. | A Passport provider number must be on the claim form when such a referral is required. See the <i>Passport</i> chapter in this manual.  |

| <b>Common Billing Errors (Continued)</b>   |  |
|--|--|
| <b>Reasons for Return or Denial</b>  | <b>Preventing Returned or Denied Claims</b>  |
| Prior authorization number is missing.   | PA is required for certain services, and the PA number must be on the claim form. PA is different from Passport referral. See the <i>Passport</i> and <i>Prior Authorization</i> chapters in this manual.  |
| Prior authorization does not match current information.  | 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.   | <p>Please check all remittance advices (RAs) for previously submitted claims before resubmitting.</p> <p>When making changes to previously paid claims, submit an adjustment form rather than a new claim form. See the <i>Remittance Advices and Adjustments</i> chapter in this manual.</p>  |
| TPL on file and no credit amount on claim.   | <p>If the client has other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual.</p> <p>If the client's TPL coverage has changed, providers must notify TPL (see <i>Key Contacts</i>) before submitting a claim.</p>  |
| Claim past 12-month filing limit.  | <p>The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.</p> <p>To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.</p>   |
| Missing Medicare EOMB  | 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.  |
| Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated. | <p>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.</p> <p>New providers cannot bill for services provided before Medicaid enrollment begins.</p> <p>If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.</p> |
| Procedure is not allowed for provider type.  | Provider is not allowed to perform the service. Verify the procedure code is correct using the current ICD manual.   |

**Common Billing Errors (Continued)**

| Reasons for Return or Denial  | Preventing Returned or Denied Claims   |
|---|--|
| Incorrect bill type.  | The correct bill type for your provider type must be entered into FL 4.  |
| Admission date missing.   | The client’s admission date must be included in FL 17 or the claim will be denied (see the <i>Submitting a Claim</i> chapter in this manual).  |
| <i>Informed Consent to Sterilization or Hysterectomy Acknowledgement</i> form missing or incomplete | All claims for sterilizations and hysterectomies must be accompanied by a completed <i>Informed Consent to Sterilization</i> form (MA-38) or a <i>Medicaid Hysterectomy Acknowledgement</i> form (MA-39). See <i>Appendix A: Forms</i> for instructions on completing these forms. |

**Other Programs**

This chapter does not apply to clients who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website (see *Key Contacts*). These billing procedures do not apply to Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct).

# Submitting a Claim

## Electronic Claims

Institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** Free software that providers can use to create and submit claims for Montana Medicaid, MHSP, HMK (dental and eyeglasses only), FQHCs and RHCs. 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.
- **Montana Access to Health (MATH) web portal.** Providers can upload and download electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **Xerox clearinghouse.** Providers can send claims to EDI Gateway in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the Xerox clearinghouse. Edifecs certifies the 837 HIPAA transactions at no cost to the provider. Edifecs certification is completed through EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse to send the claims through the clearinghouse in whatever format they accept. The provider's clearinghouse then sends the claim to Xerox 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 Gateway.
- **Xerox 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.

Providers should be familiar with Federal rules and regulations regarding electronic transactions.

***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 client's ID number and the date of service, each separated by a dash:

|                  |                     |                                |
|------------------|---------------------|--------------------------------|
| <b>999999999</b> | <b>888888888</b>    | <b>11182003</b>                |
| NPI/API          | Client ID<br>Number | Date of<br>Service<br>(mmdyyy) |

The supporting documentation must be submitted with the Paperwork Attachment Cover Sheet (see the Provider Information [website](#) and *Appendix A: Forms*). The number in the paper Attachment Control Number field must match the number on the cover sheet.

**Paper Claims**

The services described in this manual are billed electronically or on UB-04 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claim preparation is different for various types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Most form locators (FLs) shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or client and are indicated by “\*”.
- FL 11 is used for Passport and FL 78 is used for cost sharing indicators (see following table and instructions in this chapter).

| <b>Passport and Cost Sharing Indicators</b> |   |
|---|---|
| <b>Passport to Health Indicators</b>        |   |
| <b>Code</b>                                 | <b>Description</b>  |
| FPS   | This indicator is used when providing family planning services.               |
| OBS   | This indicator is used when providing obstetrical services.                   |
| TCM   | This indicator is used when providing targeted case management services.      |
| <b>Cost Sharing Indicators</b>              |   |
| E   | This indicator is used when providing emergency services.                     |
| F   | This indicator is used when providing family planning services.               |
| P   | This indicator is used when providing services to pregnant women.             |
| N   | This indicator is used when providing services to nursing facility residents. |

- Unless otherwise stated, all paper claims must be mailed to the following address:

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

## Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, client eligibility, or for general claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Claim Inquiry* form on the Provider Information website (also see *Appendix A: Forms*). Complete and submit the form to Provider Relations (see *Key Contacts*).

Provider Relations will respond to the inquiry within 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

## Client Has Medicaid Coverage Only

| Field  | Field Title                   | Instructions   |
|--|-------------------------------|--|
| 1*   | Unlabeled fields              | Provider name and address at which services were rendered.   |
| 2**  | Unlabeled field               | Provider name and pay-to address if different from 1.  |
| 3a**   | Patient Control Number        | Client's account number used by the provider.  |
| 4*   | Type of bill                  | Enter billing code.  |
| 6*   | Statement covers period       | The beginning and ending service dates of the period included on this bill.  |
| 8a*  | Patient Name                  | Enter the Medicaid client's last name, first name and middle initial.  |
| 9a-e*  | Patient Address               | The client's mailing address including street name/P.O. box, city, state, and ZIP code.  |
| 10*  | Birthdate                     | The client's month, day, and year of birth.  |
| 11*  | Sex                           | Use M (male), F (female), or U (unknown).  |
| 12-15*   | Admission                     | For inpatient use, enter admission date, hour, type, and source.   |
| 17*  | Patient Status                | A code indicating client discharge status as of the ending service date of the period covered on this bill (see the table of <i>Discharge Status Codes</i> in the <i>Billing Procedures</i> chapter of this manual).           |
| 18-28*   | Condition Codes               | Condition codes that are applicable: A4 and B3.  |
| 42*  | Revenue Code                  | A code that identifies a specific accommodation, ancillary service or billing calculation.   |
| 43*  | Description                   | Revenue code description (may abbreviate).   |
| 46*  | Service Units                 | A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed. |
| 47*  | Total Charges                 | Total covered and noncovered charges for each line containing a revenue code.  |
| Line 23  | Creation Date                 | Enter the date the claim was created (bill date).  |
| 50*  | Payer Name                    | Not required when client has only Medicaid coverage.   |
| 54*  | Prior Payments                | The amount the provider has received toward payment of this bill, if applicable.   |
| 56*  | NPI                           | Enter billing provider's NPI.  |
| 58*  | Insured's Name                | Enter the first/last name of the individual in whose name the insurance is carried.  |
| 60*  | Insured's Unique ID           | Client's Medicaid ID number.   |
| <b>Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.</b> |                               |  |
| 63**   | Treatment Authorization Codes | Enter a PA number if applicable to the service.  |
| 66* first box  | Diagnosis                     | Use the ICD code for the diagnosis or reason for admittance.   |
| 67A-Q**  | Unlabeled fields              | Enter diagnosis codes.   |
| 69**   | Admitting Diagnosis           | Inpatient: Enter diagnosis identified at the time of the hospitalization.  |
| 72**   | EMG                           | Emergency code   |
| 73**   | Unlabeled                     | Cost share indicator   |
| 74a-e**  | Principal Procedure Code      | Inpatient only: procedure codes. Enter the code identifying the principal surgical or obstetrical procedure and date. Enter codes identifying all significant procedures other than the principal procedure and dates.         |
| 76*  | Attending                     | 1st box: Attending provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for attending provider.   |
| 77-79**  | Operating Other               | 1st box: Operating and Other provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for operating and other providers.  |
| 80*  | Remarks                       | This field is used to report additional information necessary to process the claim.  |
| 81a-d  |                               |  |

\*Required field \*\*Required, if applicable



## Client Has Medicaid and Medicare Coverage Only

| Field  | Field Title                   | Instructions   |
|--|-------------------------------|--|
| 1–2*   | Unlabeled fields              | Provider first and last name and complete physical and mailing address.  |
| 3a**   | Patient Control Number        | Client’s unique alphanumeric number used by the provider.  |
| 4*   | Type of bill                  | Enter billing code.  |
| 6*   | Statement covers period       | The beginning and ending service dates of the period included on this bill.  |
| 7*   | Unlabeled field               | Enter Passport referral number (beginning with 99) or override indicator (beginning with alpha character); a qualifier is not necessary.   |
| 8a*  | Patient Name                  | Enter the Medicaid client’s last name, first name and middle initial.  |
| 8b*  | Patient Address               | The client’s mailing address including street name/P.O. box, city, state, and ZIP code.  |
| 10*  | Birthdate                     | The client’s month, day, and year of birth.  |
| 11*  | Sex                           | Use M (male), F (female), or U (unknown).  |
| 12–15*   | Admission                     | For inpatient use, enter admission date, hour, type, and source.   |
| 17*  | Patient Status                | A code indicating client discharge status as of the ending service date of the period covered on this bill (see the table of <i>Discharge Status Codes</i> in the <i>Billing Procedures</i> chapter of this manual).           |
| 18–28*   | Condition Codes               | Condition codes that are applicable: A4 and B3.  |
| 42*  | Revenue Code                  | A code that identifies a specific accommodation, ancillary service or billing calculation.   |
| 43*  | Description                   | Revenue code description (may abbreviate).   |
| 46*  | Service Units                 | A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed. |
| 47*  | Total Charges                 | Total covered and noncovered charges for each line containing a revenue code.  |
| Line 23  | Creation Date                 | Enter the date the claim was created (bill date).  |
| 50*  | Payer Name                    | Enter Medicaid.  |
| 54*  | Prior Payments                | The amount the provider has received toward payment of this bill, if applicable.   |
| 56*  | NPI                           | Enter billing provider’s NPI.  |
| 58*  | Insured’s Name                | Enter the first/last name of the individual in whose name the insurance is carried.  |
| 60*  | Insured’s Unique ID           | Client’s Medicaid ID number.   |
| <b>Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.</b> |                               |  |
| 63**   | Treatment Authorization Codes | Enter a PA number if applicable to the service.  |
| 66* first box  | Diagnosis                     | Use the ICD code for the diagnosis or reason for admittance.   |
| 67A–Q**  | Unlabeled fields              | Enter diagnosis codes.   |
| 69**   | Admitting Diagnosis           | Inpatient: Enter diagnosis identified at the time of the hospitalization.  |
| 72**   | EMG                           | Emergency code   |
| 73**   | Unlabeled                     | Cost share indicator   |
| 74a–e**  | Principal Procedure Code      | Inpatient only: procedure codes. Enter the code identifying the principal surgical or obstetrical procedure and date. Enter codes identifying all significant procedures other than the principal procedure and dates.         |
| 76*  | Attending                     | 1st box: Attending provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for attending provider.   |
| 77–79**  | Operating Other               | 1st box: Operating and Other provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for operating and other providers.  |
| 80*  | Remarks                       | An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill   |

# Client Has Medicaid and Medicare Coverage

|  |                   |  |               |                                 |        |                             |          |
|--|-------------------|--|---------------|---------------------------------|--------|-----------------------------|----------|
| 1 Local Hospital<br>12 Medical Drive<br>Anytown, MT 99999-9999 |                   | 2  |               | 3a PAT. CNTL.# 456789           |        | 4 TYPE OF BILL<br>111       |          |
| 5 FED. TAX NO. 456789  |                   | 6 STATEMENT COVERS PERIOD FROM 06/14/2010 THROUGH 06/26/2010 |               | 7                               |        |                             |          |
| 8 PATIENT NAME a Rhoades, Sandy                                |                   | 9 PATIENT ADDRESS a 45 Maple Street                          |               |                                 |        |                             |          |
| b  |                   | b Anytown  |               |                                 |        | c MT d 99999-9999 e         |          |
| 10 BIRTHDATE 03/26/1955  |                   | 11 SEX F   |               | 12 DATE OF ADMISSION 06/14/2010 |        | 13 HR 17 14 TYPE 2 15 SRC 7 |          |
| 31 OCCURRENCE DATE   |                   | 32 OCCURRENCE DATE   |               | 33 OCCURRENCE DATE              |        | 34 OCCURRENCE DATE          |          |
| 35 OCCURRENCE SPAN FROM THROUGH                                |                   | 36 OCCURRENCE SPAN FROM THROUGH                              |               | 37                              |        |                             |          |
| 38 Rhoades, Sandy<br>45 Maple Street<br>Anytown, MT 99999-9999 |                   | 39 CODE A1   |               | 40 VALUE CODES AMOUNT 91200     |        | 41 VALUE CODES AMOUNT       |          |
| 42 REV. CD.  |                   | 43 DESCRIPTION   |               | 44 HCPCS / RATE / HIPPS CODE    |        | 45 SERV. DATE               |          |
| 46 SERV. UNITS   |                   | 47 TOTAL CHARGES   |               | 48 NON-COVERED CHARGES          |        | 49                          |          |
| 1  | 120               | Room and Board   |               |                                 | 13     | 7540 00                     |          |
| 2  | 250               | General Class Pharmacy                                       |               |                                 | 261    | 1435 50                     |          |
| 3  | 258               | IV Solutions   |               |                                 | 30     | 1410 00                     |          |
| 4  | 259               | Other Pharmacy   |               |                                 | 367    | 2550 65                     |          |
| 5  | 270               | General Class Medical/Surgical Supply                        |               |                                 | 419    | 5266 83                     |          |
| 6  | 278               | Other Implants   |               |                                 | 7      | 5655 72                     |          |
| 7  | 300               | General Class Laboratory                                     |               |                                 | 126    | 2346 12                     |          |
| 8  | 320               | General Class Radiology – Diagnostic                         |               |                                 | 3      | 654 00                      |          |
| 9  | 324               | Chest X-Ray  |               |                                 | 2      | 178 00                      |          |
| 10   | 360               | General Class Operating Room                                 |               |                                 | 10     | 2834 20                     |          |
| 11   | 370               | General Class Anesthesia                                     |               |                                 | 1      | 372 00                      |          |
| 12   | 390               | General Class Blood Storage/Processing                       |               |                                 | 8      | 1296 00                     |          |
| 13   | 402               | Ultrasound   |               |                                 | 1      | 501 00                      |          |
| 14   | 412               | Inhalation Services  |               |                                 | 57     | 1839 39                     |          |
| 15   | 420               | General Class Physical Therapy                               |               |                                 | 24     | 1014 96                     |          |
| 16   | 710               | Recovery Room General Class                                  |               |                                 | 1      | 201 00                      |          |
| 17   | 730               | Electrocardiogram – General Class                            |               |                                 | 2      | 315 00                      |          |
| 23   | PAGE ____ OF ____ |  | CREATION DATE |                                 | TOTALS |                             | 35410 37 |
| 50 PAYER NAME  |                   | 51 HEALTH PLAN ID  |               | 52 REL INFO                     |        | 53 ASG BEN.                 |          |
| A Medicare   |                   | 006341   |               |                                 |        | 22642 90                    |          |
| B Medicaid   |                   | 0413214  |               |                                 |        | OTHER PRV ID                |          |
| 58 INSURED'S NAME  |                   | 59 P REL   |               | 60 INSURED'S UNIQUE ID          |        | 61 GROUP NAME               |          |
| A Rhoades, Sandy   |                   |  |               | 9876543210                      |        |                             |          |
| 63 TREATMENT AUTHORIZATION CODES                               |                   | 64 DOCUMENT CONTROL NUMBER                                   |               | 65 EMPLOYER NAME                |        |                             |          |
| A  |                   | B  |               | C                               |        |                             |          |
| 66 DX  |                   | 67   |               | 68                              |        | 69                          |          |
| 820.8  |                   | 486  |               | 584.9                           |        | 783.21                      |          |
| 530.81   |                   | 7877.2   |               | 496                             |        | 250.60                      |          |
| 536.80   |                   |  |               |                                 |        | 68                          |          |
| 69 ADMIT DX 959.6  |                   | 70 PATIENT REASON DX   |               | 71 PPS CODE                     |        | 72 ECI                      |          |
| 74 PRINCIPAL PROCEDURE CODE DATE                               |                   | a. OTHER PROCEDURE CODE DATE                                 |               | b. OTHER PROCEDURE CODE DATE    |        | 75                          |          |
| 08152 06162010   |                   | 04513 06182010   |               |                                 |        | 76 ATTENDING NPI 0006240    |          |
| c. OTHER PROCEDURE CODE DATE                                   |                   | d. OTHER PROCEDURE CODE DATE                                 |               | e. OTHER PROCEDURE CODE DATE    |        | 77 OPERATING NPI 0006240    |          |
|  |                   |  |               |                                 |        | QUAL                        |          |
| 80 REMARKS   |                   | 81CC a   |               | b                               |        | c                           |          |
|  |                   | b  |               | c                               |        | d                           |          |
|  |                   | c  |               | d                               |        | 78 OTHER NPI                |          |
|  |                   | d  |               |                                 |        | QUAL                        |          |
|  |                   |  |               |                                 |        | 79 OTHER NPI                |          |
|  |                   |  |               |                                 |        | QUAL                        |          |
|  |                   |  |               |                                 |        | LAST FIRST                  |          |
|  |                   |  |               |                                 |        | LAST FIRST                  |          |
|  |                   |  |               |                                 |        | LAST FIRST                  |          |

## Client Has Medicaid and Third Party Liability Coverage

| Field  | Field Title                   | Instructions   |
|--|-------------------------------|--|
| 1-2*   | Unlabeled fields              | Provider first and last name and complete physical and mailing address.  |
| 3a**   | Patient Control Number        | Client's unique alphanumeric number used by the provider.  |
| 4*   | Type of bill                  | Enter billing code.  |
| 6*   | Statement covers period       | The beginning and ending service dates of the period included on this bill.  |
| 7*   | Unlabeled field               | Enter Passport referral number (beginning with 99) or override indicator (beginning with alpha character); a qualifier is not necessary.   |
| 8a*  | Patient Name                  | Enter the Medicaid client's last name, first name and middle initial.  |
| 8b*  | Patient Address               | The client's mailing address including street name/P.O. box, city, state, and ZIP code.  |
| 10*  | Birthdate                     | The client's month, day, and year of birth.  |
| 11*  | Sex                           | Use M (male), F (female), or U (unknown).  |
| 12-15*   | Admission                     | For inpatient use, enter admission date, hour, type, and source.   |
| 17*  | Patient Status                | A code indicating client discharge status as of the ending service date of the period covered on this bill (see the table of <i>Discharge Status Codes</i> in the <i>Billing Procedures</i> chapter of this manual).           |
| 18-28*   | Condition Codes               | Condition codes that are applicable: A4 and B3.  |
| 42*  | Revenue Code                  | A code that identifies a specific accommodation, ancillary service or billing calculation.   |
| 43*  | Description                   | Revenue code description (may abbreviate).   |
| 46*  | Service Units                 | A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed. |
| 47*  | Total Charges                 | Total covered and noncovered charges for each line containing a revenue code.  |
| Line 23  | Creation Date                 | Enter the date the claim was created (bill date).  |
| 50*  | Payer Name                    | Enter Medicaid.  |
| 54*  | Prior Payments                | The amount the provider has received toward payment of this bill, if applicable.   |
| 56*  | NPI                           | Enter billing provider's NPI.  |
| 58*  | Insured's Name                | Enter the first/last name of the individual in whose name the insurance is carried.  |
| 60*  | Insured's Unique ID           | Client's Medicaid ID number.   |
| <b>Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.</b> |                               |  |
| 63**   | Treatment Authorization Codes | Enter a PA number if applicable to the service.  |
| 66* first box  | Diagnosis                     | Use the ICD code for the diagnosis or reason for admittance.   |
| 67A-Q**  | Unlabeled fields              | Enter diagnosis codes.   |
| 69**   | Admitting Diagnosis           | Inpatient: Enter diagnosis identified at the time of the hospitalization.  |
| 72**   | EMG                           | Emergency code   |
| 73**   | Unlabeled                     | Cost share indicator   |
| 74a-e**  | Principal Procedure Code      | Inpatient only: procedure codes. Enter the code identifying the principal surgical or obstetrical procedure and date. Enter codes identifying all significant procedures other than the principal procedure and dates.         |
| 76*  | Attending                     | 1st box: Attending provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for attending provider.   |
| 77-79**  | Operating Other               | 1st box: Operating and Other provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for operating and other providers.  |
| 80*  | Remarks                       | An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill   |

# Client Has Medicaid and Third Party Liability Coverage

|  |                   |  |               |                                   |        |   |         |
|--|-------------------|--|---------------|-----------------------------------|--------|---|---------|
| 1 Local Hospital<br>12 Medical Drive<br>Anytown, MT 99999-9999   |                   | 2  |               | 3a PAT. CNTL. #<br>b. MED. REC. # |        | 4 TYPE OF BILL<br>111                   |         |
| 5 FED. TAX NO.<br>4806   |                   | 6 STATEMENT COVERS PERIOD FROM<br>06/22/2010 |               | 7 THROUGH<br>06/23/2010           |        |   |         |
| 8 PATIENT NAME<br>a Flowers, Lily T.                             |                   | 9 PATIENT ADDRESS<br>a 33 Flower Lane        |               | c MT                              |        | d 99999-9999                            |         |
| b  |                   | b Anytown                                    |               | e                                 |        |   |         |
| 10 BIRTHDATE<br>08/04/1994                                       |                   | 11 SEX<br>F                                  |               | 12 DATE<br>06/22/2010             |        | 13 HR 14 TYPE 15 SRC<br>20 01 07        |         |
| 16 DHR   |                   | 17 STAT                                      |               | 18 19 20 21                       |        | CONDITION CODES<br>22 23 24 25 26 27 28 |         |
| 29 ACCT STATE  |                   | 30   |               |                                   |        |   |         |
| 31 OCCURRENCE DATE   |                   | 32 OCCURRENCE DATE                           |               | 33 OCCURRENCE DATE                |        | 34 OCCURRENCE DATE                      |         |
| 35 OCCURRENCE SPAN FROM THROUGH                                  |                   | 36 OCCURRENCE SPAN FROM THROUGH              |               | 37                                |        |   |         |
| 38 Flowers, Lily T.<br>45 Maple Street<br>Anytown, MT 99999-9999 |                   | 39 CODE VALUE CODES AMOUNT<br>a A1 65 00     |               | 40 CODE VALUE CODES AMOUNT        |        | 41 CODE VALUE CODES AMOUNT              |         |
| 42 REV. CD.  |                   | 43 DESCRIPTION                               |               | 44 HCPCS / RATE / HIPPS CODE      |        | 45 SERV. DATE                           |         |
| 46 SERV. UNITS   |                   | 47 TOTAL CHARGES                             |               | 48 NON-COVERED CHARGES            |        | 49                                      |         |
| 1  | 110               | Room and Board                               |               |                                   | 2      | 1246 00                                 |         |
| 2  | 250               | General Class Pharmacy                       |               |                                   | 14     | 54 60                                   |         |
| 3  | 258               | IV Solutions                                 |               |                                   | 6      | 154 20                                  |         |
| 4  | 259               | Other Pharmacy                               |               |                                   | 1      | 24 95                                   |         |
| 5  | 270               | Chemistry                                    |               |                                   | 4      | 59 80                                   |         |
| 6  | 301               | Chemistry                                    |               |                                   | 7      | 385 63                                  |         |
| 7  | 305               | Hematology                                   |               |                                   | 1      | 37 95                                   |         |
| 8  | 307               | Urology                                      |               |                                   | 1      | 29 65                                   |         |
| 9  | 320               | General Class Radiology - Dig.               |               |                                   | 1      | 229 05                                  |         |
| 10   | 450               | General Class Emergency Room                 |               |                                   | 1      | 395 42                                  |         |
| 11   |                   |  |               |                                   |        |   |         |
| 12   |                   |  |               |                                   |        |   |         |
| 13   |                   |  |               |                                   |        |   |         |
| 14   |                   |  |               |                                   |        |   |         |
| 15   |                   |  |               |                                   |        |   |         |
| 16   |                   |  |               |                                   |        |   |         |
| 17   |                   |  |               |                                   |        |   |         |
| 18   |                   |  |               |                                   |        |   |         |
| 19   |                   |  |               |                                   |        |   |         |
| 20   |                   |  |               |                                   |        |   |         |
| 21   |                   |  |               |                                   |        |   |         |
| 22   |                   |  |               |                                   |        |   |         |
| 23   | PAGE ____ OF ____ |  | CREATION DATE |                                   | TOTALS |   | 2617 25 |
| 50 PAYER NAME  |                   | 51 HEALTH PLAN ID                            |               | 52 REL INFO                       |        | 53 ASG BEN.                             |         |
| A Double Indemnity Insurance                                     |                   | 340367                                       |               |                                   |        | 852.90                                  |         |
| B Medicaid   |                   | 0413213                                      |               |                                   |        | OTHER                                   |         |
| C  |                   |  |               |                                   |        | PRV ID                                  |         |
| 58 INSURED'S NAME  |                   | 59 P REL                                     |               | 60 INSURED'S UNIQUE ID            |        | 61 GROUP NAME                           |         |
| A Flowers, Buddy   |                   |  |               | 432701763                         |        |   |         |
| B Flowers, Lily  |                   |  |               | 134638572                         |        |   |         |
| C  |                   |  |               |                                   |        |   |         |
| 63 TREATMENT AUTHORIZATION CODES                                 |                   | 64 DOCUMENT CONTROL NUMBER                   |               | 65 EMPLOYER NAME                  |        |   |         |
| A  |                   |  |               |                                   |        |   |         |
| B  |                   |  |               |                                   |        |   |         |
| C  |                   |  |               |                                   |        |   |         |
| 66 DX  |                   | 67   |               | 68                                |        |   |         |
| 536.30   |                   | 237.70                                       |               | 780.39                            |        | 564                                     |         |
| E936.3   |                   | 7877.2                                       |               |                                   |        |   |         |
| 69 ADMIT DX  |                   | 70 PATIENT REASON DX                         |               | 71 PPS CODE                       |        | 72 ECI                                  |         |
| 789.00   |                   |  |               |                                   |        |   |         |
| 74 PRINCIPAL PROCEDURE CODE                                      |                   | a OTHER PROCEDURE CODE                       |               | b OTHER PROCEDURE CODE            |        | 75                                      |         |
|  |                   |  |               |                                   |        |   |         |
| c OTHER PROCEDURE CODE   |                   | d OTHER PROCEDURE CODE                       |               | e OTHER PROCEDURE CODE            |        | 76 ATTENDING NPI 0667406674             |         |
|  |                   |  |               |                                   |        | QUAL                                    |         |
|  |                   |  |               |                                   |        | LAST Golde                              |         |
|  |                   |  |               |                                   |        | FIRST Midas                             |         |
|  |                   |  |               |                                   |        | 77 OPERATING NPI                        |         |
|  |                   |  |               |                                   |        | QUAL                                    |         |
|  |                   |  |               |                                   |        | LAST                                    |         |
|  |                   |  |               |                                   |        | FIRST                                   |         |
| 80 REMARKS   |                   | 81CC a                                       |               |                                   |        | 78 OTHER NPI                            |         |
|  |                   | b  |               |                                   |        | QUAL                                    |         |
|  |                   | c  |               |                                   |        | LAST                                    |         |
|  |                   | d  |               |                                   |        | FIRST                                   |         |
|  |                   |  |               |                                   |        | 79 OTHER NPI                            |         |
|  |                   |  |               |                                   |        | QUAL                                    |         |
|  |                   |  |               |                                   |        | LAST                                    |         |
|  |                   |  |               |                                   |        | FIRST                                   |         |

## Client Has Medicaid, Medicare, and Third Party Liability Coverage

| Field  | Field Title                   | Instructions   |
|--|-------------------------------|--|
| 1–2*   | Unlabeled fields              | Provider first and last name and complete physical and mailing address.  |
| 3a**   | Patient Control Number        | Client's unique alphanumeric number used by the provider.  |
| 4*   | Type of bill                  | Enter billing code.  |
| 6*   | Statement covers period       | The beginning and ending service dates of the period included on this bill.  |
| 7*   | Unlabeled field               | Enter Passport referral number (beginning with 99) or override indicator (beginning with alpha character); a qualifier is not necessary.   |
| 8a*  | Patient Name                  | Enter the Medicaid client's last name, first name and middle initial.  |
| 8b*  | Patient Address               | The client's mailing address including street name/P.O. box, city, state, and ZIP code.  |
| 10*  | Birthdate                     | The client's month, day, and year of birth.  |
| 11*  | Sex                           | Use M (male), F (female), or U (unknown).  |
| 12–15*   | Admission                     | For inpatient use, enter admission date, hour, type, and source.   |
| 17*  | Patient Status                | A code indicating client discharge status as of the ending service date of the period covered on this bill (see the table of <i>Discharge Status Codes</i> in the <i>Billing Procedures</i> chapter of this manual).           |
| 18–28*   | Condition Codes               | Condition codes that are applicable: A4 and B3.  |
| 42*  | Revenue Code                  | A code that identifies a specific accommodation, ancillary service or billing calculation.   |
| 43*  | Description                   | Revenue code description (may abbreviate).   |
| 46*  | Service Units                 | A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed. |
| 47*  | Total Charges                 | Total covered and noncovered charges for each line containing a revenue code.  |
| Line 23  | Creation Date                 | Enter the date the claim was created (bill date).  |
| 50*  | Payer Name                    | Enter Medicaid.  |
| 54*  | Prior Payments                | The amount the provider has received toward payment of this bill, if applicable.   |
| 56*  | NPI                           | Enter billing provider's NPI.  |
| 58*  | Insured's Name                | Enter the first/last name of the individual in whose name the insurance is carried.  |
| 60*  | Insured's Unique ID           | Client's Medicaid ID number.   |
| <b>Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.</b> |                               |  |
| 63**   | Treatment Authorization Codes | Enter a PA number if applicable to the service.  |
| 66* first box  | Diagnosis                     | Use the ICD code for the diagnosis or reason for admittance.   |
| 67A–Q**  | Unlabeled fields              | Enter diagnosis codes.   |
| 69**   | Admitting Diagnosis           | Inpatient: Enter diagnosis identified at the time of the hospitalization.  |
| 72**   | EMG                           | Emergency code   |
| 73**   | Unlabeled                     | Cost share indicator   |
| 74a–e**  | Principal Procedure Code      | Inpatient only: procedure codes. Enter the code identifying the principal surgical or obstetrical procedure and date. Enter codes identifying all significant procedures other than the principal procedure and dates.         |
| 76*  | Attending                     | 1st box: Attending provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for attending provider.   |

# Client Has Medicaid, Medicare, and Third Party Liability Coverage

|   |                   |   |               |                                 |        |  |         |
|---|-------------------|---|---------------|---------------------------------|--------|--|---------|
| 1 Weeds Community Hospital<br>911 Medical Drive<br>Anytown, MT 99999-9999 |                   | 2                                       |               | 3a PAT. CNTL # 4806             |        | 4 TYPE OF BILL 111   |         |
| 8 PATIENT NAME a Lyons, Dan D.  |                   | 9 PATIENT ADDRESS a 4854 Grassy Fields  |               | 5 FED. TAX NO.                  |        | 6 STATEMENT COVERS PERIOD FROM 06/21/2010 THROUGH 06/23/2010 |         |
| b   |                   | b Weeds                                 |               | c MT                            |        | d 99999-9999   |         |
| 10 BIRTHDATE 08/04/1994   |                   | 11 SEX M                                |               | 12 DATE OF ADMISSION 06/22/2010 |        | 13 HR 20   |         |
| 14 TYPE 01  |                   | 15 SRC 07                               |               | 16 DHR                          |        | 17 STAT  |         |
| 18  |                   | 19                                      |               | 20                              |        | 21   |         |
| 22  |                   | 23                                      |               | 24                              |        | 25   |         |
| 26  |                   | 27                                      |               | 28                              |        | 29 ACCT STATE  |         |
| 30  |                   | 31 OCCURRENCE DATE                      |               | 32 OCCURRENCE DATE              |        | 33 OCCURRENCE DATE   |         |
| 34 OCCURRENCE DATE  |                   | 35 OCCURRENCE SPAN FROM                 |               | 36 OCCURRENCE SPAN THROUGH      |        | 37   |         |
| 38 Lyons, Dan D.<br>45 Maple Street<br>Anytown, MT 99999-9999             |                   | 39 CODE A1                              |               | 39 VALUE CODES AMOUNT 851 00    |        | 40 CODE A2   |         |
|   |                   | 40 VALUE CODES AMOUNT 25 33             |               | 41 CODE                         |        | 41 VALUE CODES AMOUNT  |         |
| 42 REV. CD.   |                   | 43 DESCRIPTION                          |               | 44 HCPCS / RATE / HIPPS CODE    |        | 45 SERV. DATE  |         |
| 46 SERV. UNITS  |                   | 47 TOTAL CHARGES                        |               | 48 NON-COVERED CHARGES          |        | 49   |         |
| 1   | 110               | Room and Board                          |               |                                 | 3      | 2175 00  |         |
| 2   | 258               | IV Solutions                            |               |                                 | 2      | 7 00   |         |
| 3   | 259               | Other Pharmacy                          |               |                                 | 18     | 419 00   |         |
| 4   | 270               | General Class Medical/Surgical Supplies |               |                                 | 45     | 393 00   |         |
| 5   | 300               | General Class Laboratory                |               |                                 | 30     | 697 50   |         |
| 6   | 390               | General Class Blood Storage/Process     |               |                                 | 1      | 185 00   |         |
| 7   | 391               | Blood Administration                    |               |                                 | 1      | 87 00  |         |
| 8   | 450               | General Class Emergency Room            |               |                                 | 1      | 285 00   |         |
| 9   | 761               | Treatment Room                          |               |                                 | 3      | 144 05   |         |
| 10  |                   |   |               |                                 |        |  |         |
| 11  |                   |   |               |                                 |        |  |         |
| 12  |                   |   |               |                                 |        |  |         |
| 13  |                   |   |               |                                 |        |  |         |
| 14  |                   |   |               |                                 |        |  |         |
| 15  |                   |   |               |                                 |        |  |         |
| 16  |                   |   |               |                                 |        |  |         |
| 17  |                   |   |               |                                 |        |  |         |
| 18  |                   |   |               |                                 |        |  |         |
| 19  |                   |   |               |                                 |        |  |         |
| 20  |                   |   |               |                                 |        |  |         |
| 21  |                   |   |               |                                 |        |  |         |
| 22  |                   |   |               |                                 |        |  |         |
| 23  | PAGE ____ OF ____ |   | CREATION DATE |                                 | TOTALS |  | 4392 50 |
| 50 PAYER NAME   |                   | 51 HEALTH PLAN ID                       |               | 52 REL INFO                     |        | 53 ASSO BEN.   |         |
| A Medicare  |                   | 011111341                               |               |                                 |        | 54 PRIOR PAYMENTS 3227 55                                    |         |
| B Double Indemnity Insurance  |                   | 340367                                  |               |                                 |        | 55 EST. AMOUNT DUE 264 00                                    |         |
| C Medicaid  |                   | 0413213                                 |               |                                 |        | 56 NPI   |         |
| 58 INSURED'S NAME   |                   | 59 P REL                                |               | 60 INSURED'S UNIQUE ID          |        | 61 GROUP NAME  |         |
| A Lyons, Dan D.   |                   |   |               | 123776601                       |        |  |         |
| B Lyons, Dan D.   |                   |   |               | 123776601 D11                   |        |  |         |
| C Lyons, Dan D.   |                   |   |               | 123776601                       |        |  |         |
| 63 TREATMENT AUTHORIZATION CODES  |                   | 64 DOCUMENT CONTROL NUMBER              |               | 65 EMPLOYER NAME                |        |  |         |
| A 3073164723  |                   |   |               |                                 |        |  |         |
| B   |                   |   |               |                                 |        |  |         |
| C   |                   |   |               |                                 |        |  |         |
| 66 DX   |                   | 67                                      |               | 68                              |        |  |         |
| A 578.9   |                   | 285.1                                   |               | 276.5                           |        | 276.8  |         |
| B   |                   |   |               |                                 |        |  |         |
| C   |                   |   |               |                                 |        |  |         |
| 69 ADMIT DX 808.0   |                   | 70 PATIENT REASON DX                    |               | 71 PPS CODE                     |        | 72 ECI   |         |
| 74 PRINCIPAL PROCEDURE CODE   |                   | a OTHER PROCEDURE CODE                  |               | b OTHER PROCEDURE CODE          |        | 75   |         |
| 76 ATTENDING NPI 0921436587   |                   | QUAL                                    |               | LAST Roundup                    |        |  |         |
| 77 OPERATING NPI  |                   | QUAL                                    |               | FIRST Max                       |        |  |         |
| 78 OTHER NPI  |                   | QUAL                                    |               | LAST                            |        |  |         |
| 79 OTHER NPI  |                   | QUAL                                    |               | FIRST                           |        |  |         |
| 80 REMARKS  |                   | 81CC a                                  |               | LAST                            |        |  |         |
|   |                   | b                                       |               | FIRST                           |        |  |         |
|   |                   | c                                       |               | QUAL                            |        |  |         |
|   |                   | d                                       |               | LAST                            |        |  |         |
|   |                   |   |               | FIRST                           |        |  |         |

## Client Has Medicaid, Medicare, and Medicare Supplement

| Field  | Field Title                   | Instructions   |
|--|-------------------------------|--|
| 1-2*   | Unlabeled fields              | Provider first and last name and complete physical and mailing address.  |
| 3a**   | Patient Control Number        | Client's unique alphanumeric number used by the provider.  |
| 4*   | Type of bill                  | Enter billing code.  |
| 6*   | Statement covers period       | The beginning and ending service dates of the period included on this bill.  |
| 7*   | Unlabeled field               | Enter Passport referral number (beginning with 99) or override indicator (beginning with alpha character); a qualifier is not necessary.   |
| 8a*  | Patient Name                  | Enter the Medicaid client's last name, first name and middle initial.  |
| 8b*  | Patient Address               | The client's mailing address including street name/P.O. box, city, state, and ZIP code.  |
| 10*  | Birthdate                     | The client's month, day, and year of birth.  |
| 11*  | Sex                           | Use M (male), F (female), or U (unknown).  |
| 12-15*   | Admission                     | For inpatient use, enter admission date, hour, type, and source.   |
| 17*  | Patient Status                | A code indicating client discharge status as of the ending service date of the period covered on this bill (see the table of <i>Discharge Status Codes</i> in the <i>Billing Procedures</i> chapter of this manual).           |
| 18-28*   | Condition Codes               | Condition codes that are applicable: A4 and B3.  |
| 42*  | Revenue Code                  | A code that identifies a specific accommodation, ancillary service or billing calculation.   |
| 43*  | Description                   | Revenue code description (may abbreviate).   |
| 46*  | Service Units                 | A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed. |
| 47*  | Total Charges                 | Total covered and noncovered charges for each line containing a revenue code.  |
| Line 23  | Creation Date                 | Enter the date the claim was created (bill date).  |
| 50*  | Payer Name                    | Enter Medicaid.  |
| 54*  | Prior Payments                | The amount the provider has received toward payment of this bill, if applicable.   |
| 56*  | NPI                           | Enter billing provider's NPI.  |
| 58*  | Insured's Name                | Enter the first/last name of the individual in whose name the insurance is carried.  |
| 60*  | Insured's Unique ID           | Client's Medicaid ID number.   |
| <b>Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.</b> |                               |  |
| 63**   | Treatment Authorization Codes | Enter a PA number if applicable to the service.  |
| 66* first box  | Diagnosis                     | Use the ICD code for the diagnosis or reason for admittance.   |
| 67A-Q**  | Unlabeled fields              | Enter diagnosis codes.   |
| 69**   | Admitting Diagnosis           | Inpatient: Enter diagnosis identified at the time of the hospitalization.  |
| 72**   | EMG                           | Emergency code   |
| 73**   | Unlabeled                     | Cost share indicator   |
| 74a-e**  | Principal Procedure Code      | Inpatient only: procedure codes. Enter the code identifying the principal surgical or obstetrical procedure and date. Enter codes identifying all significant procedures other than the principal procedure and dates.         |
| 76*  | Attending                     | 1st box: Attending provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for attending provider.   |
| 77-79**  | Operating Other               | 1st box: Operating and Other provider NPI.<br>2nd box: ZZ = qualifier for taxonomy code.<br>Last and first name, NPI and taxonomy code for operating and other providers.  |
| 80*  | Remarks                       | An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill   |

# Client Has Medicaid, Medicare, and Medicare Supplement

|  |                          |  |                            |                                   |                         |                                |                        |
|--|--------------------------|--|----------------------------|-----------------------------------|-------------------------|--------------------------------|------------------------|
| 1<br>Open Range Community Hospital<br>122 Lariat Loop<br>Open Range, MT 99099-9099 |                          | 2  |                            | 3a PAT. CNTL. #<br>b. MED. REC. # |                         | 4 TYPE OF BILL<br>111          |                        |
| 5 FED. TAX NO.   |                          | 6 STATEMENT COVERS PERIOD FROM<br>06/20/2010                                     |                            | 7 THROUGH<br>06/24/2010           |                         |                                |                        |
| 8 PATIENT NAME<br>a Rhoades, Sandy   |                          | 9 PATIENT ADDRESS<br>a 45 Maple Street<br>b Anytown<br>c MT<br>d 99999-9999<br>e |                            |                                   |                         |                                |                        |
| 10 BIRTHDATE<br>03/10/1955   |                          | 11 SEX<br>F  |                            | 12 DATE<br>06/20/2010             |                         | 13 HR 14 TYPE 15 SRC<br>16 2 2 |                        |
| 17 STAT<br>01  |                          | 18 19 20 21 22 23 24 25 26 27 28   |                            |                                   |                         |                                |                        |
| 29 ACCT STATE<br>30  |                          |  |                            |                                   |                         |                                |                        |
| 31 OCCURRENCE DATE   |                          | 32 OCCURRENCE DATE   |                            | 33 OCCURRENCE DATE                |                         | 34 OCCURRENCE DATE             |                        |
| 35 CODE  |                          | 36 CODE  |                            | 37 CODE                           |                         | 38                             |                        |
| 39 VALUE CODES AMOUNT<br>a A2 25.00  |                          | 40 VALUE CODES AMOUNT  |                            | 41 VALUE CODES AMOUNT             |                         |                                |                        |
| 42 REV. CD.  |                          | 43 DESCRIPTION   |                            | 44 HCPCS / RATE / HIPPS CODE      |                         | 45 SERV. DATE                  |                        |
| 46 SERV. UNITS   |                          | 47 TOTAL CHARGES   |                            | 48 NON-COVERED CHARGES            |                         | 49                             |                        |
| 1  | 110                      | Room and Board   |                            |                                   | 5                       | 2625 00                        |                        |
| 2  | 250                      | General Class Pharmacy   |                            |                                   | 139                     | 799 25                         |                        |
| 3  | 254                      | Drugs Incident to Other Diagnostic Services                                      |                            |                                   | 13                      | 571 35                         |                        |
| 4  | 258                      | IV Solutions   |                            |                                   | 2                       | 60 50                          |                        |
| 5  | 259                      | Other Pharmacy   |                            |                                   | 52                      | 881 40                         |                        |
| 6  | 270                      | General Class Medical/Surgical Supply  |                            |                                   | 11                      | 332 75                         |                        |
| 7  | 300                      | General Class Laboratory   |                            |                                   | 4                       | 335 40                         |                        |
| 8  | 301                      | Chemistry  |                            |                                   | 10                      | 637 50                         |                        |
| 9  | 305                      | Hematology   |                            |                                   | 4                       | 129 40                         |                        |
| 10   | 310                      | General Class Laboratory/Pathology   |                            |                                   | 5                       | 45 50                          |                        |
| 11   | 324                      | Chest X-Ray  |                            |                                   | 1                       | 95 00                          |                        |
| 12   | 410                      | General Class Respiratory Services   |                            |                                   | 9                       | 64 30                          |                        |
| 13   | 420                      | General Class Physical Therapy   |                            |                                   | 2                       | 134 50                         |                        |
| 14   | 450                      | General Class Emergency Room   |                            |                                   | 1                       | 135 00                         |                        |
| 15   | 730                      | Electrocardiogram - General Class  |                            |                                   | 3                       | 476 10                         |                        |
| 16   |                          |  |                            |                                   |                         |                                |                        |
| 17   |                          |  |                            |                                   |                         |                                |                        |
| 18   |                          |  |                            |                                   |                         |                                |                        |
| 19   |                          |  |                            |                                   |                         |                                |                        |
| 20   |                          |  |                            |                                   |                         |                                |                        |
| 21   |                          |  |                            |                                   |                         |                                |                        |
| 22   |                          |  |                            |                                   |                         |                                |                        |
| 23   | PAGE ____ OF ____        |  | CREATION DATE              |                                   | TOTALS                  |                                | 7322 95                |
| 50 PAYER NAME  |                          | 51 HEALTH PLAN ID  |                            | 52 REL. INFO                      | 53 ASG. BEN.            | 54 PRIOR PAYMENTS              | 55 EST. AMOUNT DUE     |
| A Medicare   |                          | 340367041B   |                            |                                   |                         | 3502 55                        | 57                     |
| B AARP   |                          | 000540767  |                            |                                   |                         | 183 76                         | OTHER                  |
| C Medicaid   |                          | 020113240  |                            |                                   |                         |                                | PRV ID                 |
| 58 INSURED'S NAME  |                          | 59 P. REL.   | 60 INSURED'S UNIQUE ID     |                                   | 61 GROUP NAME           |                                | 62 INSURANCE GROUP NO. |
| A Summers, Stormie   |                          |  | 340367041                  |                                   |                         |                                |                        |
| B Summers, Stormie   |                          |  | 000540767                  |                                   |                         |                                |                        |
| C Summers, Stormie   |                          |  | 020113240                  |                                   |                         |                                |                        |
| 63 TREATMENT AUTHORIZATION CODES   |                          |  | 64 DOCUMENT CONTROL NUMBER |                                   |                         | 65 EMPLOYER NAME               |                        |
| A  |                          |  | B                          |                                   |                         | C                              |                        |
| 66 DX  | 414.00                   | V71.7  | 786.52                     | 490                               | 300.4                   | V10.3                          | 493.90                 |
|  |                          |  |                            |                                   |                         |                                | 401.9                  |
| 68   |                          |  |                            |                                   |                         |                                |                        |
| 69 ADMIT DX  | 414.00                   | 70 PATIENT REASON DX   | a                          | b                                 | c                       | 71 PPS CODE                    | 72 ECI                 |
| 74   | PRINCIPAL PROCEDURE CODE | DATE   | a. OTHER PROCEDURE CODE    | DATE                              | b. OTHER PROCEDURE CODE | DATE                           | 75                     |
| c.   | OTHER PROCEDURE CODE     | DATE   | d.                         | OTHER PROCEDURE CODE              | DATE                    | e.                             | OTHER PROCEDURE CODE   |
| 80 REMARKS   |                          | 81CC a   | b                          | c                                 | d                       | 76 ATTENDING NPI               | 0016703246             |
|  |                          |  |                            |                                   |                         | QUAL                           |                        |
|  |                          |  |                            |                                   |                         | LAST Beach                     | FIRST Pebbles          |
|  |                          |  |                            |                                   |                         | 77 OPERATING NPI               | QUAL                   |
|  |                          |  |                            |                                   |                         | LAST                           | FIRST                  |
|  |                          |  |                            |                                   |                         | 78 OTHER NPI                   | QUAL                   |
|  |                          |  |                            |                                   |                         | LAST                           | FIRST                  |
|  |                          |  |                            |                                   |                         | 79 OTHER NPI                   | QUAL                   |
|  |                          |  |                            |                                   |                         | LAST                           | FIRST                  |

## UB-04 Agreement

Your signature on the UB-04 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

## Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double-check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

| Common Claims Errors                                      |  |
|---|--|
| Claim Errors  | Prevention   |
| Required field is blank                                   | Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.   |
| Client ID number missing or invalid                       | This is a required field (Field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.                           |
| Patient name missing                                      | This is a required field (Field 2); check that it is correct.  |
| Provider NPI and taxonomy missing or invalid              | Verify the correct <b>NPI and taxonomy</b> are on the claim.   |
| Referring or Passport provider name and ID number missing | When a provider refers a client to another provider, include the referring provider's name and ID number or Passport number. See the <i>Passport</i> chapter in this manual. |
| Prior authorization number missing                        | When prior authorization (PA) is required for a service, the PA number must be listed on the claim in Field 23. See the <i>Prior Authorization</i> chapter in this manual.   |
| Not enough information regarding other coverage           | Fields 1a and 11d are required fields when a client has other coverage. Refer to the examples earlier in this chapter.   |
| Authorized signature missing                              | Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.            |
| Signature date missing                                    | Each claim must have a signature date.   |
| Incorrect claim form used                                 | Services covered in this manual require a CMS-1500 claim form or an electronic professional claim.   |
| Information on claim form not legible                     | Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.                              |
| Medicare EOMB not attached                                | When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.   |

## Other Programs

This chapter also applies to claims forms completed for Mental Health Services Plan (MHSP) services and Healthy Montana Kids (HMK) eyeglass services.



# Remittance Advices and Adjustments

## Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers are paid weekly (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also called pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

### **RA Notice**

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

### **Paid Claims**

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

### **Denied Claims**

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 19). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Make necessary changes to the claim before rebilling Medicaid.

### **Pending Claims**

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 18). The Reason and Remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.



If a claim was denied, read the description of the reason and remark code before taking any action on the claim.



The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

# Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES  
 HELENA, MT 59604  
 REMITTANCE ADVICE FOR MEDICAID/HMK/MHSP

1  
 COMMUNITY HOSPITAL  
 2100 NORTH MAIN STREET  
 CENTRAL CITY MT 59988

2  
 VENDOR # 00012134567  
 NPI # 1234567890

3  
 REMIT ADVICE # 123456  
 TAXONOMY # 1234567890

4  
 EPT/CHK # 654321

5  
 DATE:02/15/2002

PAGE 2 6

| 7<br>RECIP ID | 10<br>NAME | 8<br>SERVICE DATES<br>FROM TO | 13<br>UNIT<br>OF<br>SVC | 14<br>PROCEDURE<br>REVENUE<br>NDC | 15<br>TOTAL<br>CHARGES | 16<br>ALLOWED | 17<br>CO-<br>PAY | 18<br>REASON/<br>REMARK<br>CODES |
|---------------|------------|-------------------------------|-------------------------|-----------------------------------|------------------------|---------------|------------------|----------------------------------|
|---------------|------------|-------------------------------|-------------------------|-----------------------------------|------------------------|---------------|------------------|----------------------------------|

11  
**PAID CLAIMS - MISCELLANEOUS CLAIMS**

|           |                   |               |    |     |         |      |  |    |
|-----------|-------------------|---------------|----|-----|---------|------|--|----|
| 123456789 | DOE, JOHN EDWARD  | 010305 010505 | 3  | 120 | 1281.00 | 0.00 |  | N  |
| ICN       | 00504611350000700 | 010305 010505 | 13 | 250 | 450.39  | 0.00 |  |    |
|           |                   | 010305 010505 | 11 | 258 | 178.83  | 0.00 |  |    |
|           |                   | 010305 010505 | 16 | 259 | 515.60  | 0.00 |  |    |
|           |                   | 010305 010505 | 55 | 270 | 720.92  | 0.00 |  |    |
|           |                   | 010305 010505 | 4  | 300 | 42.00   | 0.00 |  | 19 |
|           |                   | 010305 010505 | 3  | 301 | 188.50  | 0.00 |  |    |
|           |                   | 010305 010505 | 10 | 305 | 476.00  | 0.00 |  |    |
|           |                   | 010305 010505 |    |     |         | 0.00 |  |    |
|           |                   | 010305 010505 | 2  | 320 | 217.00  | 0.00 |  |    |

\*\*\*LESS MEDICARE PAID\*\*\*\*\*  
 \*\*\*CLAIM TOTAL\*\*\*\*\* 4212.24 2957.13 876.00

**DENIED CLAIMS - MISCELLANEOUS CLAIMS**

|           |                   |               |   |     |         |      |  |         |
|-----------|-------------------|---------------|---|-----|---------|------|--|---------|
| 123456789 | DOE, JOHN EDWARD  | 013005 013105 | 1 | 270 | 16.00   | 0.00 |  | Y       |
| ICN       | 00504611350000800 | 012005 013105 | 1 | 916 | 187.00  |      |  | 19      |
|           |                   | 013005 013105 | 1 | 450 | 152.00  |      |  |         |
|           |                   | 013003 013105 | 5 | 300 | 352.00  |      |  |         |
|           |                   |               |   |     |         |      |  | 31 MA61 |
|           |                   |               |   |     | 3330.00 | 0.00 |  |         |

**PENDING CLAIMS - MISCELLANEOUS CLAIMS**

|     |                   |               |   |     |         |      |  |    |
|-----|-------------------|---------------|---|-----|---------|------|--|----|
| ICN | 00504611350000900 | 013005 013105 | 1 | 270 | 16.00   | 0.00 |  |    |
|     |                   | 013005 013105 | 1 | 916 | 187.00  |      |  | 31 |
|     |                   | 013005 013105 | 1 | 450 | 152.00  |      |  |    |
|     |                   | 013005 013105 | 5 | 300 | 352.00  |      |  |    |
|     |                   |               |   |     | 3330.00 | 0.00 |  |    |

\*\*\*\*\*THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE\*\*\*\*\*

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.  
 MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Montana Department of Public Health and Human Services

## Key Fields on the Remittance Advice

| Field  | Description   |
|--|---|
| 1. Provider name and address                   | Provider's business name and address as recorded with the Department  |
| 2. Vendor number                               | For Montana Medicaid internal use and the billing number for atypical providers.  |
| 3. Remit advice #                              | The remittance advice number  |
| 4. EFT/CHK #                                   | The number of the electronic funds transfer or the check number.  |
| 5. Date  | The date the RA was issued  |
| 6. Page number                                 | The page number of the RA   |
| 7. NPI #                                       | A unique HIPAA-mandated 10-digit identification number assigned to health care providers by the National Plan and Provider Enumeration System (NPPES) through the Centers for Medicare and Medicaid Services (CMS).   |
| 8. Taxonomy                                    | Alphanumeric code that indicates the provider's specialty   |
| 9. Recipient ID                                | The client's Medicaid ID number   |
| 10. Name                                       | The client's name   |
| 11. Internal control number (ICN)              | <p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u><br/> A    B    C    D    E</p> <p>A = Claim medium<br/> 0 = Paper claim<br/> 2 = Electronic claim<br/> 3 = Encounter claim<br/> 4 = System generated claim (mass adjustment, nursing facility turn-around document, or point-of-sale (POS) pharmacy claim)<br/> 6 = Pharmacy</p> <p>B = Julian date (e.g. April 20, 2000 was the 111th day of 2000)<br/> C = Microfilm number<br/> 00 = Electronic claim<br/> 11 = Paper claim</p> <p>D = Batch number<br/> E = Claim number</p> <p>If the first number is:<br/> 0 = Regular claim<br/> 1 = Negative side adjustment claim (Medicaid recovers payment)<br/> 2 = Positive side adjustment claim (Medicaid reprocesses)</p> |
| 12. Service dates                              | Date services were provided. If services were performed in a single day, the same date will appear in both columns.   |
| 13. Unit of service                            | The units of service rendered under this procedure, NDC code, or revenue code.  |
| 14. Procedure/revenue/NDC                      | The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.  |
| 15. Total charges                              | The amount a provider billed for this service.  |
| 16. Allowed                                    | The Medicaid allowed amount.  |
| 17. Copay                                      | A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.  |
| 18. Reason/Remark code                         | A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.  |
| 19. Deductions, billed amount, and paid amount | Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.   |

Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

### ***Credit balances***

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By working off the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to Third Party Liability (see *Key Contacts*).

## **Rebilling and Adjustments**

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

### ***How long do I have to rebill or adjust a claim?***

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking TPL to complete a gross adjustment.



The credit balance section is informational only. Do not post from credit balance statements.



Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

### ***Rebilling Medicaid***

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Submitting a Claim* chapters.

#### ***When to rebill Medicaid***

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make the appropriate corrections, and resubmit the claim on a UB-04 form (not the adjustment form).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

#### ***How to rebill***

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims (see *Key Contacts*).

### ***Adjustments***

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form to Provider Relations. If incorrect payment was the result of an Xerox keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will



Rebill denied claims only after appropriate corrections have been made.



Adjustments can only be made to paid claims.

be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

### ***When to request an adjustment***

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (e.g., client ID, provider number, date of service, procedure code, diagnoses, units).
- Request an adjustment when a single line on a multi-line claim was denied.

### ***How to request an adjustment***

To request an adjustment, use the *Individual Adjustment Request* form, available on the *Forms* page of the Provider Information [website](#). The requirements for adjusting a claim are as follows:

- Claims must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, gross adjustments are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section of the adjustment form.

### ***Completing an Adjustment Request Form***

1. Download the *Individual Adjustment Request* form from the Provider Information [website](#). (See *Appendix A: Forms* also.) Complete Section A with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Fill in only the items that need to be corrected (see following table):
  - Enter the date of service or the line number in the Date of Service or Line Number column.
  - Enter the information from the claim form that was incorrect in the Information on Statement column.
  - Enter the correct information in the column labeled Corrected Information.

| <b>Completing an Individual Adjustment Request Form</b> |   |
|---|---|
| <b>Field</b>  | <b>Description</b>  |
| <b>Section A</b>  |   |
| 1. Provider name and address                            | Provider's name and address (and mailing address if different).   |
| 2. Recipient name                                       | The client's name goes here.  |
| 3.* Internal control number (ICN)                       | There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.                        |
| 4.* Provider number                                     | The provider's Medicaid ID number.  |
| 5.* Recipient Medicaid number                           | Client's Medicaid ID number.  |
| 6. Date of payment                                      | Date claim was paid is found on remittance advice Field _____ (see the sample RA earlier in this chapter).  |
| 7. Amount of payment                                    | The amount of payment from the remittance advice Field 19 (see the sample RA earlier in this chapter.).   |
| <b>Section B</b>  |   |
| 1. Units of service                                     | If a payment error was caused by an incorrect number of units, complete this line.  |
| 2. Procedure code/NDC/Revenue code                      | If the procedure code, NDC, or revenue code is incorrect, complete this line.   |
| 3. Dates of service Required field (DOS)                | If the date of service is incorrect, complete this line.  |
| 4. Billed amount  | If the billed amount is incorrect, complete this line.  |
| 5. Personal resource (Nursing facility)                 | If the client's personal resource amount is incorrect, complete this line.  |
| 6. Insurance credit amount                              | If the client's insurance credit amount is incorrect, complete this line.   |
| 7. Net (Billed Q – TPL or Medicare paid)                | If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid. |
| 8. Other/Remarks  | If none of the above items apply, or if you are unsure what caused the payment error, complete this line.   |

\*Required Field

3. Attach copies of the RA and a corrected claim if necessary.
  - If the original claim was billed electronically, a copy of the RA will suffice.
  - If the RA is electronic, include a screen print of that RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims (see *Key Contacts*).
  - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
  - If an original payment was overpaid by Medicaid, the adjustment is recovered through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance (see previous section, *Credit balances*).
  - Questions regarding claims or adjustments can be directed to Provider Relations (see *Key Contacts*).



**Montana Health Care Programs**  
 Medicaid • Mental Health Services Plan • Healthy Montana Kids

### Individual Adjustment Request

**Instructions:**  
 This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

**A. Complete all fields using the remittance advice (RA) for information.**

|  |  |
|--|--|
| 1. Provider Name and Address<br>Community Hospital<br>Name | 3. Internal Control Number (ICN)<br>0043601125000800 |
| 123 Medical Drive<br>Street or P.O. Box                    | 4. NPI/API<br>1234567                                |
| Anytown MT 59999<br>City State ZIP                         | 5. Client ID Number<br>999999999                     |
| 2. Client Name<br>Jane Doe                                 | 6. Date of Payment 02/15/2003                        |
|  | 7. Amount of Payment \$ _____                        |

**B. Complete only the items which need to be corrected.**

| Item                                    | Date of Service or Line Number | Information on Statement | Corrected Information |
|---|--------------------------------|--------------------------|-----------------------|
| 1. Units of Service                     |                                |                          |                       |
| 2. Procedure Code/NDC/Revenue Code      | Line 3                         | 02/01/2003               | 01/23/2003            |
| 3. Dates of Service (DOS)               |                                |                          |                       |
| 4. Billed Amount                        |                                |                          |                       |
| 5. Personal Resource (Nursing Facility) |                                |                          |                       |
| 6. Insurance Credit Amount              |                                |                          |                       |
| 7. Net (Billed – TPL or Medicare Paid)  |                                |                          |                       |
| 8. Other/Remarks (Be specific.)         |                                |                          |                       |

Signature John R. Smith, M.D. Date 04/15/2003

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:  
 Claims  
 P.O. Box 9000  
 Helena, MT 59604

**Sample Adjustment Request**

Updated 07/2012

### ***Mass adjustments***

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case Federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key Fields on the Remittance Advice* earlier in this chapter).

## Payment and the RA

Providers receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment.

### ***Electronic Funds Transfer***

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number. See the *Required Forms for EFT and/or Electronic RA* table on the next page.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See Direct Deposit Arrangements under Key Contacts for questions or changes regarding EFT.

### ***Electronic Remittance Advice***

To receive an electronic RA, the provider must be enrolled in electronic funds transfer and have Internet access. You can access your electronic RA through the Montana Access to Health (MATH) web portal (see *Key Websites*). In order to access the web portal, you must complete an *Access Request Form* (see the following table).



Weekly payments are available only to providers who receive both EFT and electronic RAs.



Electronic RAs are available for only six weeks on the web portal.

## Required Forms for EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

| Form   | Purpose   | Where to Get   | Where to Send                                 |
|--|---|--|---|
| Electronic Remittance Advice • Payment Cycle Enrollment Form                                 | Allows provider to receive electronic remittance advices on MATH (must also include Montana Enrollment Form MATH forms below) | <ul style="list-style-type: none"> <li>• Provider Information <a href="#">website</a></li> <li>• Provider Relations (see <i>Key Contacts</i>)</li> </ul>                                     | Provider Relations (see <i>Key Contacts</i> ) |
| Direct Deposit Sign-up Form, Standard Form 1199A   | Allows the Department to automatically deposit Medicaid payment into provider's bank account                                  | <ul style="list-style-type: none"> <li>• Provider Information <a href="#">website</a></li> <li>• Provider's bank</li> </ul>  | Provider Relations (see <i>Key Contacts</i> ) |
| MATH Forms: • Trading Partner Agreement • Electronic Billing Agreement • EDI Enrollment Form | Allows provider to receive a password to access their RA on MATH.   | <ul style="list-style-type: none"> <li>• Provider Relations (see <i>Key Contacts</i>)</li> <li>• MATH Web Portal</li> <li>• Direct Deposit Arrangements (see <i>Key Contacts</i>)</li> </ul> | Fax to (406) 442-4402                         |

### Other Programs

The information in this chapter applies to outpatient hospital services for clients who are enrolled in the Mental Health Services Plan (MHSP). The information in this chapter does not apply to clients enrolled in the Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield at (877) 543-7669.

# How Payment Is Calculated

## Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Critical access hospitals (CAHs) are reimbursed for their costs of providing care, as determined through the annual cost settlement process. In the interim, these hospitals are paid a hospital-specific percentage of their charges. The percentage equals the hospital’s estimated cost-to-charge ratio as determined from time-to-time by the Department. The percentage includes payments for medical education and capital expenses.

## Charge Cap

For services covered in the hospital setting, Medicaid pays a cost to charge ratio, not the lower of the Medicaid fee or the provider’s charge. The charge cap is not applied.

## Status Indicator Codes

The codeset used by DPHHS is based on the codeset used by Medicare but with several additions. See the following table of status indicator codes.

| Status Indicator Codes Used by DPHHS |   |          |
|--------------------------------------|---|----------|
| Code                                 | Description                                   | Origin   |
| W                                    | Excluded service                              | DPHHS    |
| G                                    | Drug/biological under trans. pass-through     | Medicare |
| H                                    | Device under trans. pass-through              | Medicare |
| J                                    | New drug/biological under trans. pass-through | Medicare |
| N                                    | Incidental services (bundled)                 | Medicare |
| T                                    | Surgical services                             | Medicare |
| C                                    | Inpatient services                            | Medicare |
| K                                    | Non-pass-through drugs and biologicals        | Medicare |
| S                                    | Significant procedures                        | Medicare |
| X                                    | Ancillary service                             | Medicare |
| V                                    | Medical visit                                 |          |
| B                                    | Services not paid under OPPS                  | Medicare |
| P                                    | Partial hospitalization                       | Medicare |
| Q                                    | Clinical lab                                  | DPHHS    |
| Y                                    | Therapy                                       | DPHHS    |
| M                                    | Misc. codes                                   | DPHHS    |

## Payment for Specific Services

### ***Immunizations***

If the client is under 19 years old and the vaccine is available to providers for free under the Vaccines for Children program, then the payment to the hospital is zero. Immunization administration is considered an incidental service. The claims processing system bundles immunization administration with other services on the claim and pays it at zero.

### ***Transfers***

When a client is transferred between two hospitals, the transferring and/or discharging hospitals are paid a hospital-specific cost to charge ratio for their services if they are critical access hospitals.

Occasionally, a client is transferred from one hospital to another and then back to the original hospital when the condition causing the transfer is alleviated. Thus a hospital can be a transferring and discharging hospital. The discharging hospital should submit separate claims, one for the original admission and transfer and a second for the final discharge.

### ***Observation services***

DPHHS follows the Medicare program in making separate payment for observation care procedure codes only if the patient has a primary diagnosis of asthma, chest pain or congestive heart failure, and has met certain other conditions. In addition, the Department will pay for observation care in cases with the potential for obstetric complications. The list of diagnoses that is used to define a potential obstetric qualification is taken from Diagnosis Related Groups 382 (false labor) and 383 (other antepartum diagnoses with medical complications). If an observation service does not meet the criteria for asthma, chest pain, CHF or obstetric complications then payment for observation care is considered bundled into the payment for other services.

### ***Outpatient clinic services***

When Medicaid pays a hospital for outpatient or provider based clinic services, the separate claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). This place of service code will result in lower payment to the physician, thus minimizing what would otherwise be double payment for office expenses.

### ***Pass-through payments***

Payments for certain drugs, devices and supplies are designated as *pass-through* and paid a hospital-specific cost-to-charge ratio.

***Procedures considered inpatient only by Medicare***

Medicare has designated some procedures as “inpatient only.” Medicaid has also adopted that designation. When these procedures are performed in the outpatient hospital setting, the claim is denied. Hospitals may appeal the denial to the prior authorization contractor (see *Key Contacts*). If the service is approved, the claim will be paid.

**Calculating Payment**

The following explain how to calculate payment for claims involving Medicare or third party liability.

***How payment is calculated on TPL claims***

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

***How payment is calculated on Medicare crossover claims***

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on hospital claims for these dually eligible individuals.

***Payment examples for dually eligible clients***

***Client has Medicare and Medicaid coverage.*** A provider submits an inpatient hospital claim for a client with Medicare and Medicaid. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$250.00) as long as no TPL or incurment amounts are applicable.

***Client has Medicare, Medicaid, and TPL.*** A provider submits an inpatient hospital claim for a client with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The other insurance company paid \$225.00. This amount is subtracted from the Medicaid allowed amount leaving \$25.00. Medicaid pays \$25.00 for this claim. If the TPL payment had been \$250.00 or more, this claim would have paid at \$0.00.

***Client has Medicare, Medicaid, and Medicaid incurment.*** A provider submits an inpatient hospital claim for a client with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The client owes \$150 for his Medicaid incurment, so this amount is subtracted from the \$250.00. Medicaid will pay the provider \$100.00 for this claim.

## Other Programs

This chapter does not apply to clients who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the Provider Information website (see *Key Websites*).

The information in this chapter does not apply to clients enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at (877) 543-7669 (toll-free, follow menu) or (855) 258-3489 (toll-free, direct).

## Appendix A: Forms

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- **Montana Health Care Programs**  
*Individual Adjustment Request*
- *Medicaid Abortion Certification (MA-37)*
- *Informed Consent to Sterilization (MA-38)*
- *Medicaid Hysterectomy Acknowledgment (MA-39)*
- **Montana Health Care Programs**  
*Claim Inquiry Form*
- *Paperwork Attachment Cover Sheet*



## MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

**MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.**

Recipient Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_

**Part I, II or III must be completed and the physician completing the procedure must sign below.**

**I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:**

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physical condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed.

(attach additional sheets as necessary)

**II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:**

**RECIPIENT CERTIFICATION:** I Hereby certify that my current pregnancy resulted from an act of rape or incest.

**PHYSICIAN CERTIFICATION:** If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

- \_\_\_ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or
- \_\_\_ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

**III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:**

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES  
INFORMED CONSENT TO STERILIZATION

**NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.**

**■ CONSENT TO STERILIZATION ■**

I have asked for and received information about sterilization from \_\_\_\_\_ . When I first asked for \_\_\_\_\_  
(Doctor or Clinic)  
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_  
(month) (day) (year)

I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_  
(Doctor)

by a method called \_\_\_\_\_. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:  
Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

\_\_\_\_\_  
(Signature) (Date)

You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):

- American Indian or Alaskan Native  
 Black (not of Hispanic origin)  
 Asian or Pacific Islander  
 Hispanic  
 White (not of Hispanic origin)

**■ INTERPRETER'S STATEMENT ■**

If an interpreter is provided to assist the individual to be sterilized:  
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_  
(Interpreter) (Date)

**■ STATEMENT OF PERSON OBTAINING CONSENT ■**

Before \_\_\_\_\_ signed  
(name of individual)  
the consent form, I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

\_\_\_\_\_  
(Signature of person obtaining consent) (date)

\_\_\_\_\_  
(Facility)

\_\_\_\_\_  
(Address)

**■ PHYSICIAN'S STATEMENT ■**

Shortly before I performed a sterilization operation upon \_\_\_\_\_  
(Name of person being sterilized)  
on \_\_\_\_\_  
(date of sterilization operation)

I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is \_\_\_\_\_  
(specify type of operation)

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

**(Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery  
 Individual's expected date of delivery: \_\_\_\_\_  
 Emergency abdominal surgery:  
(describe circumstances): \_\_\_\_\_

\_\_\_\_\_  
(Physician) (Date)

## Instructions for Completing the MA-38

No fields on this form may be left blank, except the Interpreter's Statement.

- This form must be legible and accurate, and revisions are not accepted.
- Do not use this form for hysterectomies. (See the Hysterectomy Acknowledgment form.)

### Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy).
3. Enter the client's date of birth in month/day/year format. The client must be at least 21 years old at the time of consent.
4. Enter the client's full name. Do not use nicknames. The name should match the client's name on the Medicaid ID card.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the client sign and date the form. This date must be at least 30 days before the sterilization procedure is to be performed (see *Covered Services* for exceptions).

### Interpreter's Statement

Complete this section only if the client requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the client clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation (e.g., Spanish, sign language)
2. Have the interpreter sign and date the form. This date should be the same as the date the client signs the form.

### Statement of Person Obtaining Consent

1. Enter the client's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the client and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

### Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the client.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under Instructions for use of alternative final paragraphs to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the client's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.

The Physician signs and dates on or after the date of the procedure. If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied.

If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature delivery or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must be completed in this field as well.

# MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

## A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Representative (If Required): \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised \_\_\_\_\_  
*(Name of Recipient)*  
both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_\_

## B. STATEMENT OF PRIOR STERILITY

I certify that \_\_\_\_\_  
*(Name of Recipient)*  
was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on \_\_\_\_\_  
*(Name of Recipient)*  
was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

## Instructions for Completing the MA-39

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when Sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (e.g., salpingo-oophorectomy, orchiectomy) done only for medical reasons. In these cases, replace the word “hysterectomy” with the appropriate procedure name.

### A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The client and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or representative must sign and date the form prior to the procedure.
2. Enter the client’s name.
3. The physician must sign and date the form prior to the procedure.
4. If interpreter services are used, the interpreter must sign and date the form prior to the procedure.

### B. Statement of Prior Sterility

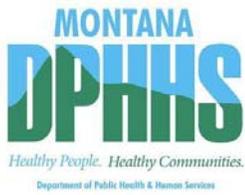
Complete this section if the client was already sterile at the time of the hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client’s name.
2. Explain the cause of the client’s sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

### C. Statement of Life-Threatening Emergency

Complete this section in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the client’s name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.



# Montana Health Care Programs Claim Inquiry Form

Provider Name \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Fax Number \_\_\_\_\_

**Mail to:**  
 Provider Relations  
 P.O. Box 8000  
 Helena, MT 59604

**Fax to:**  
 (406) 442-4402

For status on a claim, please complete the information on the **left side** of this form and mail to the address above or fax to the number shown. You may include a copy of the claim, but it is not required.

|   |   |
|---|---|
| NPI/API _____<br><br>Client Number _____<br><br>Date of Service _____<br><br>Total Billed Amount _____<br><br>Date Submitted for Processing _____ | Xerox Response _____<br>_____<br>_____<br>_____<br>_____<br>_____ |
| NPI/API _____<br><br>Client Number _____<br><br>Date of Service _____<br><br>Total Billed Amount _____<br><br>Date Submitted for Processing _____ | Xerox Response _____<br>_____<br>_____<br>_____<br>_____<br>_____ |
| NPI/API _____<br><br>Client Number _____<br><br>Date of Service _____<br><br>Total Billed Amount _____<br><br>Date Submitted for Processing _____ | Xerox Response _____<br>_____<br>_____<br>_____<br>_____<br>_____ |



# Paperwork Attachment Cover Sheet

**Paperwork Attachment Control Number:** \_\_\_\_\_

**Date of Service:** \_\_\_\_\_

**Billing NPI/API:** \_\_\_\_\_

**Client ID Number:** \_\_\_\_\_

**Type of Attachment:** \_\_\_\_\_

**Instructions:**

This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to the address below.

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-9999999999-99999999/Atypical Provider ID: 9999999-9999999999-99999999).

This form may be copied or downloaded from the Provider Information website (<http://medicaidprovider.hhs.mt.gov>).

If you have questions about paper attachments that are necessary for a claim to process, call Xerox Provider Relations at (800) 624-3958 or (406) 442-1837.

Completed forms can be mailed or faxed to: P.O. Box 8000  
Helena, MT 59604  
**Fax:** 1-406-442-4402



# Definitions and Acronyms

---

This section contains definitions, abbreviations, and acronyms used in this manual.

## **Administrative Rules of Montana (ARM)**

The rules published by the executive departments and agencies of the state government.

## **Allowed Amount**

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid/MHSP/HMK or another payer. Other cost factors, (such as cost sharing, third party liability (TPL), or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

## **Ancillary Provider**

Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

## **Assignment of Benefits**

A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

## **Authorization**

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

## **Basic Medicaid**

Patients with Basic Medicaid have limited Medicaid services. See the *General Information for Providers* manual, *Medicaid Covered Services*.

## **Bundled**

Items or services deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical, and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive status code N.

## **Cash Option**

Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

## **Centers for Medicare and Medicaid Services (CMS)**

Administers the Medicare program and oversees the state Medicaid programs.

## **Clean Claim**

A claim that can be processed without additional information from or action by the provider of the service.

## **Client**

An individual enrolled in a Department medical assistance program.

## **Code of Federal Regulations (CFR)**

Rules published by executive departments and agencies of the Federal government.

**Coinsurance**

The client's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

**Cosmetic**

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

**Cost Sharing**

The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

**Critical Access Hospital**

A limited-service rural hospital licensed by DPHHS.

**Crossovers**

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

**Direct Nursing Care**

The care given directly to a client which requires the skills and expertise of an RN or LPN.

**Discharging Hospital**

A hospital, other than a transferring hospital, that formally discharges an inpatient. The release of a patient to another hospital or a leave of absence from the hospital is not considered a discharge.

**Distinct Part Rehabilitation Unit**

A unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 412.29.

**DPHHS, State Agency**

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers

the Montana Health Care Programs. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

**Dual Eligibles**

Clients who are covered by Medicare and Medicaid are often referred to as *dual eligibles*.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

**Emergency Medical Condition**

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could result in:

- Placing the health of the individual in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
  - There is inadequate time to effect a safe transfer to another hospital before delivery; or
  - Transfer may pose a threat to the health or safety of the woman or the unborn child.

## Emergency Services

A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with CPT Code 99284 or 99285
- The client has a qualifying emergency diagnosis code.
- The services did not meet one of the previous two requirements, but the hospital believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the service must be mailed to the emergency department review contractor (see Key Contacts on your provider type page or in your provider manual).

## Experimental

A noncovered item or service that researchers are studying to investigate how it affects health.

## Fiscal Agent

Xerox State Healthcare, LLC (formerly ACS State Healthcare, LLC) is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

## Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information for Providers* manual, *Medicaid Covered Services*.

## Gross Adjustment

A lump sum debit or credit that is not claim-specific made to a provider.

## Healthy Montana Kids (HMK)

HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers

the program and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing.

## Healthy Montana Kids *Plus* (HMK *Plus*)

Medicaid eligibility group for children under age 19.

## Hospital Resident

A client who is unable to be cared for in a setting other than the acute care hospital.

## Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

## Individual Adjustment

A request for a correction to a specific paid claim.

## Inpatient

A client who has been admitted to a hospital with the expectation that he or she will remain more than 24 hours.

## Investigational

A noncovered item or service that researchers are studying to investigate how it affects health.

## Mass Adjustment

Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

## Medicaid/HMK *Plus*

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, dis-

abled people and the elderly. Medicaid is administered by state governments under broad Federal guidelines.

### **Medically Necessary**

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, “course of treatment” may include mere observation or, when appropriate, no treatment at all.

### **Medicare**

The Federal health insurance program for certain aged or disabled clients.

### **Mental Health Services Plan (MHSP)**

This plan is for individuals who have a severe disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department

### **Mentally Incompetent**

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

### **Montana Access to Health (MATH) Web Portal**

A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

### **Montana Breast and Cervical Cancer Treatment Program**

This program provides Full Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a precancerous condition.

### **Nurse First Advice Line**

The Nurse First Advice Line is a toll-free, confidential number clients may call any time any day for advice from a registered nurse about injuries, diseases, health care or medications.

### **Outpatient**

A person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services in the hospital for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services, other than supplies or prescription drugs alone, from the hospital.

### **Outpatient Hospital Services**

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, palliative items or services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner.

**Passport Referral Number**

This is a 7-digit number assigned to Passport providers. When a Passport provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

**Passport to Health**

The Medicaid medical home program where the client selects a primary care provider who manages the client's health care needs.

**Prior Authorization (PA)**

The approval process required before certain services or supplies are paid by Medicaid. PA must be obtained before providing the service or supply.

**Private-Pay**

When a client chooses to pay for medical services out of his/her own pocket.

**Provider or Provider of Service**

An institution, agency, or person having a signed agreement with the Department to furnish medical care and goods and/or services to clients, and eligible to receive payment from the Department.

**Qualified Medicare Beneficiary (QMB)**

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

**Reference Lab Billing**

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a reference lab for processing. The reference lab then sends the results back to the Medicaid provider. Medicaid does not cover lab services when they are billed by the referring provider.

**Remittance Advice (RA)**

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

**Resource-Based Relative Value Scale (RBRVS)**

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

**Retroactive Eligibility**

When a client is determined to be eligible for Medicaid effective prior to the current date.

**Routine Podiatric Care**

Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

**Sanction**

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

**Special Health Services (SHS)**

SHS or Children's Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

**Specified Low-Income Medicare Beneficiaries (SLMB)**

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

**Spending Down**

Clients with high medical expenses relative to their income can become eligible for Medicaid by spending down their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

**Team Care**

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist clients in making better health care decisions so that they can avoid overutilizing health services. Team Care clients are joined by a team assembled to assist them in accessing health care. The team consists of the client, the PCP, a pharmacy, the Department, the Department's quality improvement organization, and the Nurse First Advice Line. The team may also include a community-based care manager from the Department's Health Improvement Program.

**Third Party Liability (TPL)**

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or HMK client.

**Timely Filing**

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) 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.

**Transferring Hospital**

A hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

**Usual and Customary**

The fee that the provider most frequently charges the general public for a service or item.

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