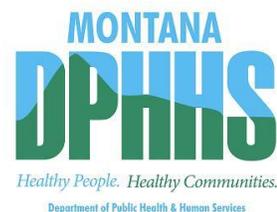


Healthy Montana Kids (HMK) and Children's Health Insurance Program (CHIP)

Dental Provider Manual

July 2014



This publication supersedes all previous Children's Health Insurance Program (CHIP) and Healthy Montana Kids (HMK) manuals. Published by the Montana Department of Public Health & Human Services, June 2000.

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My NPI/API:



Table of Contents

Key Contacts and Key Websites	1
General Information	5
Enrollment Information	5
Getting Assistance.....	5
Adjustment Requests and Claim Inquiry Forms	5
Department Responsibilities	6
Fiscal Agent Responsibilities.....	6
Verifying HMK/CHIP Eligibility	7
How to Verify Eligibility.....	7
Failure of Eligible HMK/CHIP Beneficiary to Notify Provider of HMK/CHIP Eligibility	7
HMK/CHIP Dental Benefit Plan.....	8
Reimbursement, Covered, and Noncovered Services	9
HMK/CHIP Reimbursement – Dental Plan.....	9
Determining HMK/CHIP Reimbursement	10
Billing the Beneficiary.....	10
Covered Services.....	11
Noncovered Services	11
Usual and Customary Charges	11
No-Show Appointments	11
Medical Necessity	11
Billing Instructions	13
Important Billing Guidelines	13
Coding Requirements – Current Dental Terminology, Dental Procedure Codes 2014	13
Montana HMK/CHIP Coding Guidelines.....	13
Types of Electronic Data Interchange (EDI) Transmissions	13
Software Available from Xerox	14
Cost.....	14
Users Guide.....	14
Paper Submission of Claims — ADA Dental Claim Form.....	14
Provider Specialty Codes.....	14
Authorized Signatures	15
Where to Send Claims	15
Timely Filing	15
Follow-Up on Claim Resolution	15
How to Appeal Timely Filing Denials.....	15
Billing Tips to Avoid Timely Filing Denials	16
The Remittance Advice	16
How to Resubmit a Denied Claim.....	17
Adjustments	17
When to Request an Adjustment	18
How to Request an Adjustment.....	18
How to File a Void or Adjustment Request.....	18
Completing an Individual Adjustment Request Form	19
Provider Responsibilities.....	23

Provider Number	23
Changes in Provider Enrollment	23
Recertification	23
Provider Participation	23
Accepting HMK/CHIP Patients — Provider-Patient Relationship	23
Record Keeping, Retention, and Access	24
Nondiscrimination Law	24
Discrimination Grievance Procedure.....	25
Discrimination Complaint Procedure	25
Appendix A: Forms	27
Appendix B: Definitions and Acronyms	31
Appendix C: Index	35

Key Contacts and Key Websites

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

Adjustment Requests and Claim Inquiry Forms

The Adjustment Request form and Claim Inquiry form are on the Provider Information website on the [Forms](#) page. A sample of the dental form is on the [Forms](#) page.

American Dental Association (ADA) dental claim forms and the Current Dental Terminology (CDT) procedure code manual are not supplied by Xerox State Healthcare, LLC.

To order from the ADA, call 800-947-4746 or online at www.adacatalog.org.

Dental Claims

Send dental claims to:

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

Dental Accident-Related Claims

Dental services related to an accident need to be reported to the HMK/CHIP Dental Manager for preapproval. Dental accidents are covered through the child’s HMK/CHIP medical insurance plan. Providers of these services should contact the HMK/CHIP office for additional information.

Dental Program Officer
Healthy Montana Kids (HMK)/CHIP
P.O. Box 202951
Helena, MT 59620-2951

877-418-4533, X 7046 or X 7045 (toll-free)
877-543-7669 (toll-free in Montana)
406-444-6971
406-444-7045 or 406-444-7046

Dental accident claims may be faxed to:
877-418-4533

Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERAs)

Providers must register for electronic funds transfer (EFT) and electronic remittance advices (ERAs) should mail or fax their completed documentation to:

Provider Relations

P.O. Box 4936
Helena, MT 59604
406-442-4402

EDI Solutions

For questions regarding electronic claims submission:

800-987-6719	In/Out of state
406-442-1837	Helena
406-442-4402	Fax

Xerox EDI Solutions – Montana
P.O. Box 4936
Helena, MT 59604

Member Eligibility

FaxBack 800-714-0075

FaxBack faxes a report of the HMK/CHIP child’s eligibility. To sign up, call Provider Relations at 1-800-624-3958 (in/out of state providers) or 406-442-1837 (Helena). Your provider NPI and fax number are needed to sign up for this service, and your provider NPI and the child’s member ID number are needed to access this system.

Integrated Voice Response (IVR) 800-714-0060

Providers may verify if a child is enrolled on a particular date of service. A touch-tone phone, your provider NPI, and the child’s member ID number are needed to access this system.

Montana Access to Health Web Portal

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

Contact Provider Relations to register or follow the instructions at the link above. FaxBack, **IVR, and the MATH web portal do not check program benefit limits.**

Information on benefit limits can only be obtained by contacting Provider Relations directly at 1.800-624.3958 or 406-442-1837.

Information on benefit limits is not a guarantee of payment. Information is available only for claims that have been processed. Claims that have been submitted, but not yet processed, may affect benefit limits.

Provider Relations

For questions about enrollment, eligibility, service limits, payments, and denials, or for general claims questions:

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

Send e-mail inquiries to:

MTPRHelpdesk@xerox.com

Send written inquiries to:

Provider Relations
P.O. Box 4936
Helena, MT 59604

Third Party Liability

For questions about private insurance or other third party liability:

800-624-3958	In/Out of state
406-442-1837	Helena

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

Key Websites

Web Address	Information Available
American Dental Association (ADA) http://www.ada.org	The leading source of oral health related information for dentists and their patients.
Blue Cross and Blue Shield of Montana www.bcbsmt.com	BCBSMT website.
Centers for Disease Control and Prevention (CDC) www.cdc.gov/vaccines	Immunization and other health information
Department of Public Health and Human Services www.dphhs.mt.gov	DPHHS website.
Healthy Montana Kids (HMK) http://hmk.mt.gov	Information on HMK/CHIP including eligibility, family and provider resources, enrollment, covered services, approved providers, copayments, how to become a provider, how to get a provider manual, and frequently asked questions.
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com/ Provider Information http://medicaidprovider.hhs.mt.gov/	Web Portal <ul style="list-style-type: none"> • Check eligibility • Provider enrollment • Remittance advice notices Website <ul style="list-style-type: none"> • Fee schedules • Forms • Frequently asked questions (FAQs) • HIPAA updates • Key contacts • Medicaid news • Newsletters • Passport to Health information • Provider manuals and replacement pages • Provider notices • Team Care information • Training resources • Upcoming events
Xerox EDI Solutions www.acs-gcro.com	Xerox EDI Solutions is the Xerox HIPAA-compliant clearinghouse. From the EDI Solutions Clients tab, select the Montana Department of Public Health and Human Services link for information on: <ul style="list-style-type: none"> • EDI enrollment • EDI support • Electronic transaction instructions for HIPAA 5010 • Software and Manuals • Provider services • Related links

General Information

Enrollment Information

For information about becoming a Healthy Montana Kids (HMK) provider, contact Provider Relations or the HMK/CHIP Dental Unit.

Provider Relations
P.O. Box 4936
Helena, MT 59604
800-624-3958 In/Out of state
406-442-1837 Helena

HMK/CHIP Dental Unit
877-543-7669, X7045 or X7046
406-444-7045 or 406-444-7046

Dental services related to a trauma need to be reported to the HMK/CHIP Dental Program Officer for preapproval. Dental trauma may be covered through the child's HMK/CHIP medical benefit. Providers of these services should contact the HMK/CHIP office toll-free in Montana at 1-877-543-7669 or 406-444-7045 for additional information.

Getting Assistance

Providers can call Provider Relations, e-mail the Help Desk at MTPRHelpdesk@xerox.com, or send an Ask Provider Relations request through the MATH web portal.

Provider Relations field representatives can make onsite visits to train office staff on HMK/CHIP and Medicaid/HMK *Plus* billing procedures or to resolve claim payment issues. Contact Provider Relations to arrange a visit.

When you call Provider Relations, the agent who takes the call will ask for a contact name, phone, and brief description of the issue, and then forward the visit request to a field rep, who will contact the provider and determine whether a field visit is necessary or whether the issue can be addressed over the phone or via WebEx.

Adjustment Requests and Claim Inquiry Forms

The Adjustment Request form is on the Provider Information website on the [Forms](#) page.

American Dental Association (ADA) dental claim forms and the Current Dental Terminology (CDT) procedure code manual are not supplied by Xerox. A sample form is on the Forms page of the website.

To order items from the ADA, call 800-947-4746 or order online at www.adacatalog.org.

Department Responsibilities

The Montana Department of Public Health and Human Services (the Department) administers HMK/CHIP in Montana. HMK/CHIP was created by Congress to serve children from families with limited financial resource who do not qualify for Medicaid and who do not have medical health insurance.

Montana has chosen to purchase private insurance coverage for the majority of health services available to HMK/CHIP beneficiaries. Dental services and eyeglasses are provided through private providers who contract with the Department. The Department is responsible for determining payment rates, benefit coverage, and beneficiary eligibility. The Department conducts oversight through retrospective utilization review.

This manual is a guide for the dental provider filing claims with HMK/CHIP. The manual is to be read and interpreted in conjunction with federal regulations, State statutes, administrative procedures, and federally approved State Plan amendments. This manual does not take precedence over federal regulation, State statutes, or administrative procedures.

For policy questions other than eligibility, call or write:

Healthy Montana Kids (HMK)/Children's Health Insurance Program (CHIP)
Department of Public Health and Human Services
P.O. Box 202951
Helena, MT 59620-2951
877-543-7669 (toll-free in Montana)
406-444-6971 (Helena and out-of-state providers)

Fiscal Agent Responsibilities

Xerox State Healthcare, LLC, is the fiscal agent for dental services for HMK/CHIP in Montana. Xerox processes claims and adjustments and responds to provider inquiries regarding claim status and payments.

Verifying HMK/CHIP Eligibility

How to Verify Eligibility

HMK/CHIP beneficiary eligibility must be verified at each provider visit. The easiest way to do this is to ask the responsible family member if the child is eligible for HMK/CHIP on the date of service and ask to see the child's HMK/CHIP identification card.

The child's member ID number is on the HMK/CHIP Blue Cross and Blue Shield of Montana insurance card issued to each HMK/CHIP child.

Accurate recording of the 9-digit HMK/CHIP eligibility ID number is essential. Payment cannot be made for claims with incorrect HMK/CHIP ID numbers.

After obtaining the child's HMK/CHIP ID number, verify his/her enrollment for the date of service by using one of the eligibility verification methods below.

- **FaxBack – 800-714-0075** (24 hours)
FaxBack will fax a report of the HMK/CHIP child's eligibility. To sign up for FaxBack, call Provider Relations at 1-800-624-3958 (in/out of state) or 406-442-1837 (Helena). Your provider NPI and fax number are needed to sign up for this service. Your provider NPI and the child's member ID number are needed to access this system.
- **Integrated Voice Response System (IVR) – 800-714-0060** (24 hours)
- Providers may verify if a child is enrolled on a particular date of service. A touch-tone phone, your provider NPI, and the child's member ID number are needed to access this system. **Montana Access to Health (MATH) Web Portal**
<http://mtaccesstohealth.acs-shc.com>
Contact Provider Relations to register or follow the instructions at the link above.

IVR, the MATH web portal, and FaxBack do not check program benefit limits. Information on benefit limits can only be obtained by contacting Provider Relations directly. Information on benefit limits is not a guarantee of payment. Information is available only for claims that have been processed. Claims that have been submitted, but not yet processed, may affect benefit limits.

The Department does not issue an eligibility card for HMK/CHIP dental benefits. The beneficiary will receive an insurance card with the HMK/CHIP member ID number. **The insurance card is issued when a child is first enrolled in HMK/CHIP and is not recalled if HMK/CHIP enrollment ends, so the cards cannot always be relied on to verify *current* eligibility.**

Failure of Eligible HMK/CHIP Beneficiary to Notify Provider of HMK/CHIP Eligibility

An HMK/CHIP beneficiary must notify a provider that he/she has HMK/CHIP benefits. If the beneficiary fails to do this, he/she is responsible for the bill unless the provider agrees to discontinue billing the beneficiary and to submit a claim to HMK/CHIP.

If the provider agrees to bill HMK/CHIP, timely filing limits and coverage limits are applied.

HMK/CHIP Dental Benefit Plan

Effective July 1, 2014, the HMK/CHIP Dental Plan benefit is \$1,900 in paid benefits for \$1,615 of dental services every benefit year.

The benefit year for the Basic HMK/CHIP dental benefit plan is July 1 through June 30 of the following year.

The dentist will expect the beneficiary to pay for services that are over the limit of \$1,900 .

All HMK/CHIP-enrolled children can obtain dental care under the Dental Plan.

Reimbursement, Covered, and Noncovered Services

HMK/CHIP Reimbursement – Dental Plan

A child may receive up to \$1,900 in dental services per benefit year from the Dental Plan. Dental services are reimbursed at 85% of the billed charges up to \$1,615 ($\$1,900 \times 85\% = \$1,615$).

- Providers may not balance bill the child's guardian for the remaining 15% of billed charges.
- Providers may bill the child's guardian for services in excess of \$1,900.
- Dental services provided to an HMK/CHIP member must be billed to the address in the Key Contacts section.
- Only children age 5 and under are approved for hospital same-day surgery.
- Accident-related dental claims should be submitted to the HMK/CHIP office at the address listed in the Key Contacts section.
- Preapproved **medically necessary dental and orthodontic** services **only** related to a **craniofacial anomaly or cleft palate** are covered under the child's medical portion of HMK/CHIP. This is handled through the Children's Special Health Services..

Payment from HMK/CHIP is payment in full for a covered service. Providers may never bill the HMK/CHIP beneficiary for:

- Billing errors that cause a claim to be denied, such as a wrong procedure code; an incorrectly completed claim form; or submission of a claim more than 365 days after the date of service.
- The balance between the \$1,615 HMK/CHIP annual benefit and the first \$1,900 in charges.

A provider **can** bill the HMK/CHIP beneficiary if:

- The beneficiary has been given a written explanation that a service is noncovered and he/she is responsible for the charges.
- The beneficiary is not HMK/CHIP-eligible at the time services are provided.
- The beneficiary has exceeded the HMK/CHIP Dental Plan benefit of \$1,900 per benefit year. .

Providers must comply with all applicable state and federal statutes, rules and regulations. These include the United States Codes governing HMK/CHIP and all applicable Montana statutes and rules governing licensure and certification. Providers must also comply with the requirements governing HMK/CHIP to the extent that these provisions are not inconsistent with the HMK/CHIP rule requirements.

HMK/CHIP dental providers must first bill the child's other dental insurance before they can submit dental claims to HMK/CHIP. The dental provider then submits the EOB from the primary dental insurance before HMK/CHIP reviews the claim. Fax the dental claim and EOB to 406-444-1861.

This is in accordance with 42 CFR 433.139, which establishes Medicaid and HMK/CHIP as the payer of last resort for all states.

Determining HMK/CHIP Reimbursement

HMK/CHIP pays 85% of billed charges up to \$1,900. per beneficiary in a benefit year for the Dental Plan benefit. A benefit year is July 1 through June 30 of the following year.

Thus for the first \$1,900 of charges, HMK/CHIP pays \$1,615 ($\$1,900 \times 85\% = \$1,615$). This payment amount of \$1,615 is payment in full for covered services that total \$1,900.

An HMK/CHIP beneficiary may not be billed the difference (15%) between the HMK/CHIP payment amount and the provider's charges, but the family can be billed for dental work over \$1,900. Once an HMK/CHIP beneficiary is accepted as a patient, the provider may not agree to accept HMK/CHIP reimbursement for some services and not for others.

The \$1,900 HMK/CHIP Dental Plan benefit is applicable to each enrolled child per benefit year (July 1–June 30). Your services and those services provided by other dentists are applied to this Dental Plan benefit.

Example

A child needs 4 teeth repaired with Composite-Two Surface Posterior Repair (D2392). The child also had two complete Root Canal Therapies (D3330).

The dentist charges \$1,600 for these dental services.

Total billed dental charges	\$2,100.00
HMK/CHIP maximum reimbursement is 85% of \$1,900	\$1,615.00
Dentist writes off 15% of charges up to \$1,900	
HMK/CHIP Dental reimbursement cap per child	\$1,900.00
HMK/CHIP reimbursement cap used Year To Date	00.00
HMK/CHIP payment to dentist	<u>\$1,615.00</u>
Amount billable to the beneficiary	
Total dental bill	\$2,100.00
Dental maximum	\$1,900.00
Line item charges billable to the family/beneficiary	<u>\$200.00</u>

An EOB code will appear on your Remittance Advice indicating the line item service billed was reduced or paid at zero because the \$1,615 HMK/CHIP Dental benefit cap has been met. A portion of the line item charges may then be billable to the beneficiary.

Billing the Beneficiary

When the \$1,900 Dental Plan benefit is exhausted, the HMK/CHIP beneficiary is responsible for payment for any additional services he/she wishes to have the provider perform.

HMK/CHIP will not enter into any dispute between the provider and the beneficiary regarding billing and payment issues. To avoid misunderstandings with HMK/CHIP beneficiaries, providers are advised to obtain written confirmation from HMK/CHIP beneficiaries whenever private payment arrangements are contemplated.

The HMK/CHIP beneficiary is also responsible for any services not covered by HMK/CHIP.

Covered Services

All non-medical dental services are covered by HMK/CHIP with the exception of those services listed below under Noncovered Services.

Noncovered Services

The following services described by the American Dental Association CDT codes are not covered benefits of HMK/CHIP.

Code	Description
D5900 – D5999	Maxillofacial Prosthetics
D7610 – D7780	Treatment of Fractures
D7920 – D7999	Other Repair Procedures
D7960	Frenulectomy/Frenectomy
D8000 – D8999	Orthodontics

HMK/CHIP does not cover experimental services, services generally regarded by dental professionals as unacceptable treatment, or any treatments that are not medically necessary.

Usual and Customary Charges

All charges for services submitted to HMK/CHIP must be made in accordance with an individual provider's **usual and customary** charges to the general public.

No-Show Appointments

Canceled or missed appointments by HMK/CHIP beneficiaries **cannot** be billed to HMK/CHIP. If your office policy is to bill **all** patients for canceled or missed appointments, HMK/CHIP beneficiaries may be billed for any no-show appointments.

Medical Necessity

All claims are subject to post-payment review for medical necessity by HMK/CHIP. Clinical records should substantiate the need for service by including the findings and information to support medical necessity and detailing the care rendered. If upon post-payment review the Department determines that services are not medically necessary, payment will be denied and action will be taken to recoup payment for those services. If the Department determines that a service was not medically necessary, the provider may not bill the HMK/CHIP beneficiary.

Each HMK/CHIP patient's clinical record must include sufficient documentation to enable the Department to determine the appropriateness of the treatment performed without requiring a patient examination. Each page of documentation must have the signature of the treating dentist.

Each HMK/CHIP clinical record shall include, at a minimum, documentation of clinical diagnoses, pertinent medical and dental history, a treatment plan, complete anesthesia record if applicable, and any radiographs used to facilitate the development of the treatment plan. HMK/CHIP clinical records shall be maintained for 6 years and 3 months.

Billing Instructions

Important Billing Guidelines

- Enter your NPI provider number on line 49 and 54 of the 2012 ADA Claim Form.
- Enter your Provider Specialty code or Taxonomy code on line 56A of the 2012 ADA Claim Form.
- The Department prefers electronic media claim (EMC) transmission.
- If using paper claims, the **2012 ADA Dental Claim form** is the preferred billing form. Effective January 1, 2015, the 2014 ADA Dental Claim Form is mandatory.
- CDT codes must be used.
- Use one claim per HMK/CHIP beneficiary.
- Claims must be submitted within 365 days of service.
- Date of submission is the date the claim is stamped as received by Xerox or the Department. If a claim is lost in the mail, the claim is not considered received.
- Information on the form must be legible.
- A clean or problem-free claim is usually processed within 35 days of receipt.
- Most payments for approved claims will be electronically deposited directly into the account the dentist specified when he enrolled as an HMK/CHIP provider. If the provider requests a check for I think this has changed to most everyone getting electronic payments, so this needs to be changed. claims approved for payment, it will be mailed in the same envelope with the Remittance Advice.

Coding Requirements – Current Dental Terminology, Dental Procedure Codes 2014

Montana HMK/CHIP Coding Guidelines

CDT codes and their respective definitions were developed by the American Dental Association. These codes are used by HMK/CHIP for claim adjudication. HMK/CHIP has established specific guidelines for covered services and reimbursement. (See the Reimbursement, Covered, and Noncovered Services chapter for details).

Types of Electronic Data Interchange (EDI) Transmissions

Xerox accepts several forms of electronic media including:

- Diskettes
- Direct Entry (via telephone modem with PC)
- Magnetic Tape
- File Transfer Protocol (FTP)

Submitting claims via electronic media speeds claims processing and increases accuracy. Providers may submit claims through an electronic medium or choose from several firms that offer electronic claim submission services for a small per-claim fee. A provider contracts with a vendor to submit claims via one of the above methods.

Software Available from Xerox

Xerox field software WINASAP 5010. Xerox makes this free software available to providers, who may use it to submit claims to Montana Medicaid, MHSP, and HMK/CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the Xerox EDI Solutions website. For more information on WINASAP 5010, visit the Xerox EDI Solutions website or call EDI Solutions.

Cost

Providers are responsible for securing their own computer equipment, associated operating supplies, and modem to transmit via telephone lines.

Users Guide

The Montana Users Guide contains important information required for billing. Answers to most questions can be found by referencing the Montana Users Guide, including those regarding hardware requirements. Please read the Montana Users Guide prior to calling Provider Relations with questions [1-800-624-3958 (in/out-of-state providers) or 406-442-1837 (Helena)]. Technical support is limited for this free software.

Paper Submission of Claims — ADA Dental Claim Form

The American Dental Association (ADA) 2012 Dental Claim is the preferred paper form for billing dental services authorized under the Montana HMK/CHIP Dental Program. Effective January 1, 2015, the 2012 ADA Dental Claim form will be mandatory to submit paper claims. **Xerox does not supply the ADA Dental Claim Form.** The ADA Dental Claim Form may be ordered from an independent printer or ADA Catalog Sales at 1-800-947-4746.

Provider Specialty Codes

56A Provider Specialty Code

Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as “Dentist” may be used instead of any other dental practitioner code. The provider specialty code must be the same code as the dentist enrolled with at Xerox.

Category/Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of the license.	122300000X
General Practice	1223G0001X
Dental Specialty	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral and Maxillofacial Pathology	1223P0106X
Oral and Maxillofacial Radiology	1223D0008X
Oral and Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set posted at www.wpc-edi.com/codes/taxonomy.

Updates to the ADA dental claim form instructions, should there be any, are posted on the ADA website at www.ada.org/goto/dentalcode.

Authorized Signatures

All claims must be signed by the provider in Box 53 of the 2012 ADA form. The signature may be handwritten, a stamped facsimile, typed, or computer-generated, or be the signature of an authorized representative. The signature certifies that all information on the claim is true, accurate, complete, and contains no false or erroneous information.

Where to Send Claims

Send completed ADA Dental Claim forms to:

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

Timely Filing

Providers must submit a clean claim within 365 days of the date of service. A clean claim is one that can be processed for payment without correction or additional information or documentation from the provider. **Timely filing cannot be waived when a claim is denied due to provider billing errors.**

Follow-Up on Claim Resolution

Timely follow-up of claims is the provider's responsibility. Events beyond a provider's control may affect claims. Regardless of the cause of the problem, it is the provider's responsibility to initiate appropriate action and follow-up to get claims issues resolved within the 365 day filing limit. The Department and the Xerox Claims Unit will not know if a claim is lost in the mail or if a keying error is made. A provider is the only one who can identify when these problems occur and when assistance is necessary to resolve them.

It is important for providers to review paid and denied claims on each RA and take corrective action to resolve denied claims. Correction of the problems listed on the RA does not guarantee all problems have been resolved. The system will report all problems identified at the time the claim is processed. Additional errors may occur at the time of resubmission. Provider Relations is available to assist a provider who is having difficulty correcting and resubmitting a claim.

How to Appeal Timely Filing Denials

The provider's appeal should be filed with HMK/CHIP, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, and should include the following:

- Documentation of previous claim submission
- An explanation of the problem
- A clean copy of the claim, along with any required documentation

Billing Tips to Avoid Timely Filing Denials

- File claims as soon as possible after services are provided.
- Carefully review error denial codes on the remittance advice including detail denial lines and additional errors reported beneath each claim.
- Resubmit the entire claim or denied detail line after **all** corrections have been made.
- If you have any questions regarding billing or denials, contact Provider Relations **before** resubmitting a claim.
- If you have not received payment within 45 days of submission, contact Provider Relations regarding the status of the claim.
- If you have had multiple denials on a claim, contact Provider Relations and request a review of the denials **before** resubmission.

Note: Once a provider has agreed to accept an HMK/CHIP patient, any loss of HMK/CHIP reimbursement due to provider failure to meet timely filing deadlines is the responsibility of the provider. The provider may not bill the family for any service within the \$1,900 cap. .

The Remittance Advice

The remittance advice summarizes the status of claims submitted to HMK/CHIP for payment whether they were paid, suspended, or denied. Aside from providing a record of transactions, the remittance advice assists in resolving possible errors.

- Claims are grouped by disposition category. For example, paid, denied, and suspended claims, and claim adjustments are listed in separate sections.
 - Claim Status — **PAID** group contains all the paid claims. If a claim has been paid that should not have been billed to HMK/CHIP, refer to How to File a Void or Adjustment Request in this chapter for instructions. **Only a paid claim can be voided or adjusted.**
 - Claim Status — **DENIED** group reports denied claims. A denied claim can be resubmitted with new or additional information. (See the section titled How to Resubmit a Denied Claim in this chapter.)
 - Claim Status — **SUSPENDED** group reports claims suspended for review. Do not rebill these claims. **Suspended claims cannot be adjusted or voided.** All claims in suspended status are reported each payment cycle until paid or denied.
- All paid, denied, and suspended claims and claim adjustments are itemized within each group in alphabetical order by beneficiary last name.

- Internal Control Numbers (ICNs) are assigned to all of the claims in the batch as they are microfilmed. The ICN assigned to each claim allows the claim to be tracked throughout the Montana HMK/CHIP system. The digits and groups of digits in the ICN have special meanings, as explained in this example:

0	00010	11	500	0001	00
					Claim number
					Type of document (0=new claim, 1=credit, 2=adjustment)
					Batch number
					Microfilm reel number
					Microfilm machine number
					Year/Julian date
					Claim input medium indicator
0 =					Exam entered paper claim
2 =					Electronic
4 =					Computer-generated

The RA Summary section reports the number of claim transactions, and total payment, or check amount. Each claim processed during the weekly cycle is listed on the remittance advice:

How to Resubmit a Denied Claim

Check the RA before submitting a second request for payment. Claims should be resubmitted if the claim has not appeared on an RA as paid, denied, or suspended and it has been 30 days since the claim was submitted; or the claim was denied due to incorrect or missing information.

Resubmit the claim on a new claim form or a legible photocopy after correcting any error or attaching requested documentation. Claims and attachments that cannot be clearly microfilmed or photocopied will be returned.

Adjustments

If a provider feels that a claim has been paid incorrectly and wants the claim to be adjusted, the provider must submit an Individual Adjustment Request form to Xerox.

An adjustment is a **post-payment** request by a provider to adjust a specific claim. No adjustment request can be submitted until a claim has been paid. **Denied claims cannot be adjusted.**

A provider should complete the adjustment request, attach a copy of the related remittance advice, and submit the form to Xerox, who reviews the adjustment requests for completeness and timely filing.

Adjustment requests must be submitted in accordance with the timely filing requirements. Incomplete forms or forms that are not received within the filing limit will be returned to the provider. Adjustment requests that pass the initial screening are submitted for processing.

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 (such as member ID, NPI, date of service, procedure code, diagnoses, units, etc.).

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 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). After this time, gross adjustments are required (see Definitions).
- Use a separate Individual Adjustment Request form for each ICN. See the Forms page.
- If you are correcting more than one error per ICN, use only one Individual 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.

How to File a Void or Adjustment Request

Adjustment requests must be submitted on the Individual Adjustment Request form. All pertinent information must be provided.

Completing an Individual Adjustment Request Form

Download the Individual Adjustment Request form from the website. Complete Section A first with provider and member information and the claim's ICN number. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected.

- 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.

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The member's name.
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 latest claim.
4. NPI	The provider's NPI.
5. Member HMK/CHIP number	Member's HMK/CHIP number.
6. Date of payment	Date claim was paid is found on remittance advice.
7. Amount of payment	The amount of payment from the remittance advice.
Section 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 (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 member's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - 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.

Adjustment requests **will not** be accepted by telephone. Correct all errors on the original claim form with one adjustment request by attaching a copy of the claim or remittance advice. Adjustments and voids are processed as replacement claims. In processing, the original payment is completely deducted and the adjustment is processed as a regular claim. The net result is a transaction that will increase or decrease your check.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider NPI number or taxonomy number missing or invalid	The NPI number is a 10-digit number assigned to the provider during HMK/CHIP enrollment. Verify the correct NPI number and taxonomy are on the claim. The taxonomy is a 7-digit alphanumeric number indicating the provider's specialty.
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 an ADA 2012 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 field. Information must not be obscured by lines.
Member number not on file, or member was not eligible on date of service	Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual. Eligibility may change monthly.
Prior authorization number is missing (implants only)	Prior authorization is required for certain services, and the prior authorization number must be on the claim form.
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>Check all remittance advices 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.</p>
TPL on file and no credit amount on claim	<p>If the member has any other insurance, bill the other carrier before HMK/CHIP. See the Coordination of Benefits section in this manual.</p> <p>If the member's TPL coverage has changed, providers must notify the TPL Unit at the address in the Key Contacts section before submitting a claim.</p>

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Claim past 365-day 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 Key Contacts.</p>
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or NPI terminated	<p>Out-of-state providers must update licensure for HMK/CHIP 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/her enrollment.</p> <p>New providers cannot bill for services provided before HMK/CHIP enrollment begins.</p> <p>If a provider is terminated from the HMK/CHIP program, claims submitted with a date of service after the termination date will be denied.</p>
Procedure is not allowed for provider type	<p>Provider is not allowed to perform the service. Verify the procedure code is correct using current CDT Dental Procedure Codes. Verify the procedure code is valid for your provider type</p>

Provider Responsibilities

Provider Number

Providers who bill both Montana HMK/CHIP and Montana Medicaid have the same NPI number.

If a dental clinic is to be reimbursed for the dental work by a treating dentist, then the clinic must also have an NPI number.

Changes in Provider Enrollment

If any information you listed on your original provider enrollment application changes, you must notify Provider Enrollment in writing. Examples include but are not limited to change of address, change of tax identification number, cessation of practice, and lapse of license.

Send provider enrollment changes to:

Provider Enrollment
P.O. Box 4936
Helena, MT 59604

Recertification

Each year Xerox requests a copy of your license or other certification. This documentation must be submitted within 60 days of the request.

Provider Participation

A provider may choose to stop participating in HMK/CHIP at any time; however, a 30-day written notice of voluntary termination is requested. Notice should be addressed to Provider Relations.

Montana HMK/CHIP can terminate a provider's participation in HMK/CHIP for fraud, abuse, or other misuse of services. Reinstatement will be contingent upon provisions of State law.

Providers convicted of fraud or abuse in the Medicaid or Medicare programs may not participate in HMK/CHIP.

Accepting HMK/CHIP Patients — Provider-Patient Relationship

A dental provider can decide whether or not to become an HMK/CHIP provider and how many HMK/CHIP beneficiaries to accept. This is true whether the beneficiary is new to the provider or is a current patient who becomes eligible for HMK/CHIP. Providers must notify HMK/CHIP beneficiaries **prior to accepting them as a patient** whether they will be accepted as an HMK/CHIP patient or if the provider will only see them as a private-pay patient. If a provider fails to fulfill this responsibility and an individual is an HMK/CHIP beneficiary, the state will assume that HMK/CHIP payment will be accepted. If an HMK/CHIP beneficiary and the provider cannot agree on the financial terms of their relationship, either party can sever the relationship. As with any other patient, providers should ensure that services to a patient are not terminated in a manner that could be considered a violation of professional ethics considerations.

Record Keeping, Retention, and Access

The provider agreement requires that clinical records fully disclose the extent of services provided. Clinical record documentation should meet the following standards:

- The record must be legibly written.
- The record must identify the patient on each page.
- **Entries must be signed and dated by the responsible licensed participating provider.** Care rendered by personnel under the direct, personal supervision of the provider, in accordance with HMK/CHIP policy, must be countersigned by the responsible licensed, participating provider.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services and the treatment plan must be documented in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the observed medical condition of the patient, the progress at each visit, any change in diagnosis or treatment, and the patient's response to treatment.
- Progress notes must be written for each visit billed to HMK/CHIP.
- Progress notes must be signed by the providing dentist.

Providers must retain clinical and financial records, including information regarding dates of service, diagnoses, services provided, and bills for services, for at least 6 years and 3 months from the end of the federal fiscal year (July 1 to June 30) in which the services were rendered. If an audit is in progress, the records must be maintained until the audit is resolved.

HMK/CHIP providers must allow access to all records concerning services and payment to authorized personnel of the Montana Department of Public Health and Human Services, United States Department of Health and Human Services, State Auditor's Office, Montana Attorney General's Office, and their designees. Records must be accessible to authorized personnel during normal business hours for the purpose of reviewing, copying, and reproducing documents. These entities shall have access to records even if the provider chooses to no longer participate in the program. Providers must furnish copies of claims and any other documentation upon request.

Nondiscrimination Law

Providers of HMK/CHIP services receive federal funds through the Department. Federal regulations specify that recipients of federal funds shall not discriminate in the provision of services and/or in employment practices as outlined in:

- Titles VI and VII of the Civil Rights Act of 1964 and the implementing regulations, prohibit discrimination on the grounds of race, color, sex, religion, or national origin;
- Section 504 of the Rehabilitation Act of 1973, Pub.L. 93-112, as amended by Pub.L. 93-516 and Pub.L. 95-602, 29 U.S.C.A. Section 794, and its implementing regulation, Title 45 CFR, Part 84, which prohibit discrimination on the basis of handicap;
- The Age Discrimination Employment Act of 1967 which prohibits employment discrimination based upon the factor of age; and
- Pub.L. 101-336, The Americans with Disabilities Act of 1990 which prohibits discrimination based upon handicap.

Discrimination Grievance Procedure

The Department's grievance procedure is outlined below. This procedure permits beneficiaries of programs monitored and/or administered by the Department, interested persons, and members of the public to file complaints of discrimination.

Copies of this procedure should be prominently displayed for public information and made available to anyone interested in filing a complaint. Additionally, a provider's policies on EEO and nondiscrimination should be made available to the general public.

Questions regarding these requirements may be directed to the Department's Chief Personnel Officer at 406-444.3136 or:

Chief Personnel Officer
Department of Public Health and Human services
P.O. Box 4210
Helena MT 59604-4210

Discrimination Complaint Procedure

The complaint procedure should be followed by anyone who is **not** a current employee of the Department. This includes applicants for agency employment or services, beneficiaries of Department programs and services, and/or members of the general public.

Any complaint relating to a discriminatory incident shall be presented in writing through the use of the Department's Discrimination Complaint Form. The written complaint must be submitted to the Department's Chief Personnel Officer at the address above within 15 working days of the alleged incident.

The Chief Personnel Officer or her designee shall have 30 working days from receipt of the written complaint to investigate the complaint and issue a written decision to the complainant or his/her representative.

Anyone may file a formal complaint of discrimination at any time during the informal complaint process with the State Human Rights Commission. The time limit for filing a complaint under the Montana Human Rights Act is 180 days.

If alleging discrimination under a federal regulation, the complaint must be filed with the appropriate entity within the time limits prescribed by the law under which the claimant is filing.

Montana State Human Rights Commission
616 Helena Avenue, Suite 302
Helena MT 59601

U.S. Department of Health and Human Services
Office of Civil Rights
1961 Stout Street, FOB Room 1185
Denver CO 80294-3538

Equal Employment Opportunity Commission
1801 L Street NW
Washington DC 20507

Appendix A: Forms

The forms listed below are available on the [Forms](#) page of the Provider Information website. The Dental Plan Fact Sheet is included in this chapter.

- Address Correction Form
- Individual Adjustment Form
- Paperwork Attachment Cover Sheet
- Dental Plan Fact Sheet



HMK/CHIP Dental Benefits

The Department of Public Health and Human Services (DPHHS) administers the Healthy Montana Kids (HMK)/CHIP program in Montana. DPHHS is responsible for determining payment rates, benefit coverage, beneficiary eligibility, and retrospective utilization review. A dentist enrolls as an HMK/CHIP provider through Xerox State Healthcare, LLC, the fiscal agent for the HMK/CHIP dental program. Xerox also processes dental claims and verifies benefits.

Billing and Payment Information

There are no copayments for HMK/CHIP covered dental services unless the child's dental work goes over the \$1,900 dental limit.

Effective July 1, 2014

- A child may receive up to \$1,900 in reimbursable dental services per benefit year. **Our benefit year now begins every July 1 through June 30 of the following year.**
 - Dental services are reimbursed at 85% of billed charges. HMK/CHIP dentists give a discount of 15% of the billed charges to the patient.
 - At the 85% reimbursement rate, the maximum benefit to the dentist is \$1,615. A code on the remittance advice indicates when the maximum has been paid.
- Only children **age 5 or under** are approved for same day hospital surgery and anesthesia for dental surgery. Bill Blue Cross and Blue Shield of Montana (BCBSMT) for the hospital and anesthesia services.
- Implant Services, CDT Codes D6000–D6199, are now covered **with prior approval and proven medical necessity**. The lifetime limit for implant services is \$1,500 per person. Dental implants are included in the dental benefits.
- Dentists may charge families for services exceeding \$1,900 per child per benefit year. Dentists and families can make payment arrangements.
- Dentists use the standard ADA billing forms and billing codes. Dental providers should begin using the 2012 ADA claim form immediately. Use of the form will be mandatory beginning January 2015.

All CDT ranges are covered, except:

D5900 – D5999: Maxillofacial Prosthetics
 D7610 – D7780: Treatment of Fractures**
 D7920 – D7999: Other Repair Procedures**
 D8000 – D8999: Orthodontic Services
 D7960 – Frenulectomy/Frenectomy

** A fractured jaw or other trauma to sound natural teeth & gums may be covered under the medical provisions of HMK/CHIP. See the reverse of this form for the address to submit dental claims related to a trauma.

Contact Information

Submit **dental claims** to Xerox:
 Xerox Claims Processing
 P.O. Box 8000
 Helena, MT 59604

Submit **trauma-related dental claims** to Healthy Montana Kids at the address at the bottom of the page. Claims will be processed under the medical benefit and submitted to the address below:

Healthy Montana Kids
P.O. Box 202951
Helena, MT 59620-2951
1-877-543-7669 (toll-free phone)
1-877-418-4533 (toll-free fax) or 1-406-444-1861

For **claims information, web portal information, or dental provider application**, contact:

Xerox Provider Relations
P.O. Box 4936
Helena, MT 59604
1-800-624-3958 (In/Out of state)
406-442-1837 Helena
These telephone lines are open Monday through Friday, 8 a.m. to 5 p.m.

Verifying Eligibility for a Particular Date of Service

Below are several methods for verifying member eligibility.

Integrated Voice Response (IVR) 1-800-714-0060

A touch-tone phone, your provider NPI, and the child's member ID are needed to access this system.

Web Portal

The direct link to the web portal is <https://mtaccesstohealth.acs-shc.com>. To access the web portal from the Montana Medicaid Provider Information page, click the Log in to Montana Access to Health link in the gray box near the top of the page.

FaxBack 1-800-714-0075

FaxBack will fax a report of the HMK/CHIP child's eligibility. To sign up for this service, call Xerox Provider Relations at 1-800-624-3958 (in-state providers) or 406-442-1837 in Helena. Your provider NPI and fax number are needed to sign up; your provider NPI and the child's member ID number are needed to access this system.

Additional Assistance

After contacting Xerox, if you need additional assistance, contact the HMK/CHIP program officer at 1-877-543-7669 (toll-free) or at 406-444-4533 (Helena).

You may also contact HMK/CHIP by fax at 1-877-418-4533 or by mail at:

HMK/CHIP
P.O. Box 202951
Helena, MT 59620-2951

Appendix B: Definitions and Acronyms

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

270/271 Transactions

ACS X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

ACS X12N claim status request (276) and response (277) transactions.

278 Transactions

ACS X12N request for services review and response used for prior authorization.

835 Transactions

ACS X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

ACS X12N professional, institutional, and dental claim transactions.

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, and 1 of the 6 designated standards maintenance organizations (DSMO), that created and is tasked with maintaining the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

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 HMK/CHIP or another payer. Other cost factors (such as cost sharing, 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.

Assignment of Benefits

A voluntary decision by the member to have insurance benefits paid directly to the provider rather than to the member. 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 HMK/CHIP member. This approval is only valid if the member is eligible on the date of service.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid and CHIP programs.

Clean Claim

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

Code of Federal Regulations (CFR)

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

Copayment

The member's financial responsibility for a bill as assigned by HMK/CHIP (usually a flat fee).

Department

The Montana Department of Public Health and Human Services or its agents, including but not limited to parties under contract to perform audit services, claim processing, and utilization review.

DPHHS, State Agency

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

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

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

Federally Qualified Health Center (FQHC)

An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet Medicare program requirements and is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or is receiving funding from such a

grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 329, 330, or 340 of the Public Health Service Act. An FQHC may also be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian Organization receiving funds under Title V of the Indian Health Care Improvement Act.

Fiscal Agent

Xerox 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.

Gross Adjustment

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

Healthy Montana Kids (HMK)

The Montana version of the federal Children's Health Insurance Program (CHIP). This program provides medical, dental, and vision coverage to specific populations and is administered by state governments under broad federal guidelines.

Hospital

A facility licensed, accredited or approved under the laws of Montana or a facility operated as a hospital by the State that provides, by or under the supervision of licensed physicians, services for the diagnosis, treatment, rehabilitation, and care of persons with mental disease.

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.

Investigational

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

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

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 member.

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 member 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 members.

Member

An individual enrolled in a Department medical assistance program.

Montana Access to Health (MATH) Web Portal

A secure website on which providers may view members' medical history, verify member eligibility, submit claims to HMK/CHIP, check the status of a claim, verify the status of a warrant, and download electronic remittance advice reports.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid or HMK/CHIP. Prior authorization must be obtained before providing the service or supply.

Private-Pay

When a member chooses to pay for dental 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 dental services to members; and
- Eligible to receive payment from the Department.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on RAs, which are available on the web portal.

Sanction

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

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the dental cost of care for an HMK/CHIP member.

Timely Filing

Providers must submit clean claims to HMK/CHIP 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.

Usual and Customary

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

WINASAP 5010

WINASAP 5010 is a free Windows-based electronic claims entry application for Montana Medicaid and HMK/CHIP and was developed as an alternative to submitting paper claims.

Appendix C: Index

<p>270/271 transactions24</p> <p>276/277 transactions24</p> <p>278 transactions24</p> <p>835 transactions24</p> <p>837 transactions24</p> <p>Accredited Standards Committee (ACS X12), Insurance subcommittee (ASC X12N)24</p> <p>Adjustment requests and claim inquiry forms ... 1</p> <p>Administrative Rules of Montana (ARM).....24</p> <p>Allowed amount.....24</p> <p>Assignment of benefits24</p> <p>Assistance 2</p> <p>Authorization24</p> <p>Centers for Medicare and Medicaid Services (CMS)24</p> <p>Clean claim24</p> <p>Code of Federal Regulations (CFR).....24</p> <p>Copayment.....25</p> <p>Dental accident claims..... 1</p> <p>Dental claims..... 1</p> <p>Department25</p> <p>Department responsibilities..... 3</p> <p>DPHHS, State Agency.....25</p> <p>EDI Solutions..... 1</p> <p>EFT and ERA 1</p> <p>Emergency services25</p> <p>Enrollment..... 2</p>	<p>Experimental 25</p> <p>Federally qualified health center (FQHC)..... 25</p> <p>Fiscal agent 25</p> <p>Fiscal Agent responsibilities 3</p> <p>Gross adjustment..... 25</p> <p>Healthy Montana Kids (HMK) 25</p> <p>Hospital 25</p> <p>Indian Health Service (IHS)..... 25</p> <p>Individual adjustment 25</p> <p>Investigational..... 25</p> <p>Mass adjustment..... 26</p> <p>Medically necessary 26</p> <p>Medicare..... 26</p> <p>Member 26</p> <p>Member eligibility 1</p> <p>Montana Access to Health (MATH) web portal 26</p> <p>Prior authorization (PA) 26</p> <p>Private-pay 26</p> <p>Provider 26</p> <p>Provider of service 26</p> <p>Provider Relations..... 2</p> <p>Remittance advice (RA) 26</p> <p>Sanction..... 26</p> <p>Third party liability (TPL) 2, 26</p> <p>Timely filing..... 26</p> <p>Usual and customary 26</p>
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