



Nursing Facility and Swing Bed Services

*Medicaid and Other Medical
Assistance Programs*

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My NPI/API:

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Key Contacts

ACS EDI Gateway, Inc.

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Mail to:
Montana EDI
ACS
P.O. Box 4936
Helena, MT 59604

Certification for Medical Need

Swing Bed Hospitals must obtain a certificate of need from the Quality Assurance Division in order to provide swing bed services.

(406) 444-2099 Phone

Send written inquiries to:
Quality Assurance Division
P.O. Box 202953
Helena, MT 59620-2953

Claims

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

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information for Providers* manual.

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

Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961
(406) 443-6002 6003? (Helena)
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Mail backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:
(800) 294-1350
(406) 513-1928 (Helena)

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

Client Eligibility Fraud
(800) 201-6308

Medicaid Client Help Line
(800) 362-8312

Lien and Estate Recovery

Providers must give any personal funds they are holding for a Medicaid-eligible resident to the Department within 30 days following the resident's death.

Phone:

(800) 694-3084 In-state
(406) 444-7313 Out-of-state and Helena

Fax:

(800) 457-1978 In-state
(406) 444-1829 Out-of-state and Helena

Send written inquiries to:

Third Party Liability Unit
Lien and Estate Recovery
DPHHS
P.O. Box 202953
Helena, MT 59620-2953

Nurse Aide Registry

To verify the nurse aide's certification status:
(406) 444-4980

Send written inquiries to:

Montana Nurse Aide Registry
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

ACS, Atlanta
Technical POS Help Desk

(800) 365-4944
6:00 a.m to midnight, Monday–Saturday
10:00 a.m. to 9:00 p.m., Sunday,
(Eastern Time)

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- and out-of-state
(406) 443-0320

Fax:

(800) 413-3890 In- and out-of-state
(406) 443-4585

Send written inquiries to:

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

Provider's 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 eligibility, payments, or denials, general claims questions, Passport, or to request provider manuals, fee schedules:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

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

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.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

Senior and Long-Term Care

Contact the Nursing Facility Services Bureau for the following:

- Nursing facility or swing bed program information
- Out-of-state nursing facility services
- Admission, transfer or discharge waivers
- Eligibility or claim issues that cannot be resolved through the county office of Public Assistance or Provider Relations
- Authorization for services described in the *Prior Authorization* chapter of this manual

(406) 444-4077 Phone

(406) 444-7743 Fax

Send written inquiries to:

Nursing Facility Services Bureau
Senior and Long-Term Care
P.O. Box 4210
Helena, MT 59604-4210

Third Party Liability

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

(800) 624-3958 In- and out-of-state

(406) 443-1365 Helena

(406) 442-0357 Fax

Send written inquiries to:

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

Key Websites

Web Address	Information Available
<p>ACS EDI Gateway, Inc. http://www.acs-gcro.com/</p>	<p>ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on:</p> <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
<p>Addictive and Mental Disorders Division (AMDD) http://www.dphhs.mt.gov/amdd/</p>	<ul style="list-style-type: none"> • Contact information • Adult/Children's Mental Health • Chemical Dependency Services • Montana State Hospital • Montana Chemical Dependency Center • Montana Mental Health Nursing Care Center • Local Advisory Council and Service Area Authority Information • Mental Health Oversight Advisory Council • Online Resources • Prevention Resource Center • Forms and Applications • Plans and Publications
<p>Healthy Montana Kids (HMK) www.hmk.mt.gov/</p>	<ul style="list-style-type: none"> • Information on Healthy Montana Kids (HMK).
<p>Provider Information Website http://medicaidprovider.hhs.mt.gov/</p> <p>Provider Information Web Portal https://mtaccesstohealth.acs-shc.com/mt/general/home.do</p>	<ul style="list-style-type: none"> • Medicaid: Medicaid provider information including provider manuals, fee schedules, notices, replacement pages, forms, frequently asked questions, newsletters, and key contacts. • HMK: Information on Healthy Montana Kids (HMK) • Public Health: Disease prevention (immunizations), health and safety, health planning, and laboratory services • Administration: HPSD budgets, staff, program names and phone numbers, program statistics, and systems information. • News: Recent developments • Preferred Drug List (PDL) • Montana Access to Health (MATH): Eligibility, provider summary information, claim status, payment amounts, X12 transactions, remittance notices, medical claims history, prior authorization, hospitals, physicians, mid-levels, enrollment
<p>Secretary of State www.sos.mt.gov</p> <p>Administrative Rules of Montana Home Page www.mtrules.org</p>	<ul style="list-style-type: none"> • Secretary of State home page • Administrative Rules of Montana

Key Websites (Continued)	
Web Address	Information Available
<p>Senior and Long-Term Care http://www.dphhs.mt.gov/sltc/index.shtml</p>	<ul style="list-style-type: none"> • Facility Search • Contact Information • Brochures, Forms, and Reports • Rules and Regulations • Goals and Objectives • What's New • Financial Planning • Government Programs • Healthy Living • Home/Housing Options • Protective/Legal Services • Adult Protective Services • Aging Services • Information and Referral • Legal Resources • Long-Term Care Ombudsman • State Health Insurance Program • Community Services • Nursing Facility Services • Veterans' Homes • Related Sites/Information
<p>Public Assistance Toolkit https://dphhs.mt.gov/</p>	<p>Select <i>Human Services</i> for information on:</p> <ul style="list-style-type: none"> • Medicaid: Client information, eligibility information, and provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
<p>State of Montana DPHHS Website http://www.dphhs.mt.gov</p>	<ul style="list-style-type: none"> • General information about DPHHS: Advisory councils, director's office, divisions and websites, goals and objectives, organizational charts, phone numbers, and policies and procedures • Legal Information: ADA commendation notice, ARM, Emergency notices, MAR, Other State and Federal legal resources, proposed manual changes, requests for bids or proposals, requests for information • News: Bulletins, events calendar consumer product safety commission, meeting minutes, Montana Medicaid DUR board, press releases • Services: Applications and forms, guidelines, office locations, plans, programs available, publications, related website, reports, statistical information, Public Assistance Toolkit
<p>Washington Publishing Company www.wpc-edi.com</p>	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

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 nursing facilities and swing bed providers. 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 or her provider type.

Information on the services Medicaid covers can be found in the *Covered Services* chapter, while the instructions on billing for these services are in the *Billing Procedures* chapter. Billing procedures for clients who are covered by both Medicaid and Medicare are in the *Coordination of Benefits* chapter.

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* 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

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

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 Provider Relations, the Department (Senior and Long-Term Care) and 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 nursing facility and swing bed programs:



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

- Code of Federal Regulations (CFR)
 - 42 CFR 483 – Requirements for States and Long-Term Care Facilities
 - 42 CFR 409 – Hospital Insurance Benefits
 - 42 CFR 482.66 – Medicare Swing Bed Requirements
 - 42 CFR 488 – Survey
 - 42 CFR 489.100 – Advanced Directives
- Montana Codes Annotated (MCA)
 - MCA Title 37, Chapter 9 – Nursing Home Administrators
- Administrative Rules of Montana (ARM)
 - ARM 37.40.101–37.40.361 – Nursing Facility
 - ARM 37.40.401–37.40.421 – Swing Bed

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 which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that 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, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services provided by nursing facilities and swing bed providers. For information on billing for these services, see the *Billing Procedures* chapter in this manual. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

Services within scope of practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license.

Preadmission screening and level of care determinations (ARM 37.40.101–37.40.120, ARM 37.40.201, and ARM 37.40.402 and 42 CFR 483.100-483.138)

All individuals seeking long-term care (e.g., nursing facility or swing bed services) must have a preadmission screening before entering a facility. Preadmission screening and level of care reviews are performed by the Department's contractor (see *Key Contacts*).

Preadmission/Level I screening. This screening is also called preadmission screening annual resident review (PASARR). Level I screening is the review of a long-term care applicant to identify whether the applicant has a primary or secondary diagnosis or indications of mental retardation or mental illness. If an applicant shows indications of mental retardation or mental illness, a Level II screening is required (see below). If the applicant does not have indications of mental retardation or mental illness, the applicant is approved for long-term care placement. The provider must then request a *level-of-care determination* in order to be approved for Medicaid reimbursement.

To request a Level I screening, providers mail or fax a completed form DPHHS-SLTC-145 to the Department's contractor (see *Key Contacts*). This form is available in *Appendix A: Forms* in this manual and on the Provider Information website.

Preadmission/Level II screening. When applicants have indications of mental retardation or mental illness, the Department's contractor refers them to either the appropriate regional center or the regional mental retardation authority for a Level II screening. This screening determines whether the applicant requires specialized services and is appropriate for long-term care placement.

A level-of-care determination must be completed for all Medicaid clients and should be done for potential Medicaid clients.



Level-of-care determination. The Department's contractor performs a level-of-care determination to assess medical necessity and appropriateness of placement for Medicaid clients seeking long-term care services. A level-of-care determination must be completed before Medicaid payment can be authorized. For this reason, the Department recommends that a level-of-care determination be completed for any resident who has even the possibility of becoming Medicaid-eligible. Even if a resident is found to be retroactively eligible for Medicaid, the facility cannot be paid if a level-of-care determination has not been completed. Level-of-care and continued-stay reviews are performed regularly to verify medical necessity and skilled or intermediate determinations.



To request a level-of-care review, providers mail or fax a completed DPHHS-SLTC-86 (located in *Appendix A: Forms*) to the Department's contractor (see *Key Contacts*). The Department's contractor must receive the request on or before the date the applicant is admitted to the facility. Once the applicant is approved, the provider may bill Medicaid for the services.

Nurse Aide Requirements (ARM 37.40.322)

Under Federal regulation, nursing facilities may not employ a nurse aide for more than four months, unless the individual completes a state-approved Nurse Aide Training and Competency Evaluation Program (NATCEP) and is certified competent to provide nursing and nursing-related services.

Nursing facilities may employ an individual as a nurse aide for up to four months so long as the individual meets one of the following:

- Is a full-time employee enrolled in a state-approved training and competency evaluation program
- Has applied to complete the competency evaluation program
- Has demonstrated competence for all nursing tasks to be performed by participating in such a program

Anyone who wants to be employed in a nursing facility as a nurse aide must successfully complete a NATCEP and become a certified nurse aide (CNA). Nurse aide training programs in Montana are offered by nursing facilities, community colleges, adult education programs, and independent contractors.

Nurse aide registry

Federal regulation requires the state to establish and maintain a registry of all individuals who successfully complete a NATCEP or CEP. This registry is maintained by the Quality Assurance Division (QAD) and is used by nursing facilities to verify the nurse aide's certification status (see *Key Contacts*). The names of individuals who have successfully completed the competency evalu-

ation are reported to QAD by the testing program. QAD also documents findings of abuse, neglect, or misappropriation of property by nurse aides on the registry.

Nurse aides are recertified every two years. Sixty days before their certification expires, nurse aides receive a recertification application from QAD, which must be completed and returned in a timely manner. The application asks for verification that the nurse aide has met the minimum work requirement for recertification (at least one 8-hour shift within the 24-month period). Nurse aides who have not performed paid nursing or nursing-related services for a continuous period of 24 consecutive months since completing a NATCEP must complete a new NATCEP or CEP. If a nurse aide fails to return the recertification application, he or she will lose certification and must complete a new NATCEP or CEP to be recertified.

Payment for nurse aide training and competency evaluation

Nursing facilities are required to pay for nurse aides' certification training and testing costs when the aide is employed by the facility or has an offer of employment by the facility on the date he or she begins a NATCEP. Medicaid reimburses these costs to the facility through the facility's per diem rate (see *Nurse aide training reimbursement* in the *How Payment Is Calculated* chapter of this manual). Federal regulations explicitly prohibit NATCEPs or CEPs from charging nurse aides for costs associated with training and testing when the aide has an offer of employment from or is employed by a nursing facility. Additionally, federal regulations require that nurse aides who become employed or who are offered employment within 12 months of completing a NATCEP or CEP be reimbursed for their training and testing costs.

The nursing facility may determine which NATCEP or CEP program the nurse aide in its employ attends. If a nurse aide chooses to attend another program without the facility's consent, then the facility is not required to reimburse costs incurred by the nurse aide. The nurse aide has the option to have the competency evaluation conducted at the facility in which the nurse aide is or will be employed.

The first nursing facility that employs or offers an aide employment within 12 months of the aide completing a NATCEP or CEP is required to reimburse the nurse aide for training and testing costs. The facility may provide this reimbursement of costs over a reasonable period of time (about six months) while the individual is employed as a nurse aide and stop payment if the nurse aide ceases to be employed. The nursing facility may require the nurse aide to work for a period of time before reimbursement begins, but not more than six months.

If the nurse aide leaves the facility before qualifying for full reimbursement, the nursing facility must partially reimburse the nurse aide. The partial reimbursement should be based on the percentage of the qualifying period that the nurse aide is actually employed. For example, if a facility uses a 180-day qualifying period and the nurse aide terminates employment after 90 days, then the facility must reimburse the nurse aide for half of the aide's training and testing costs.

Facilities should develop written policies specifying how nurse aides will be reimbursed for training and testing costs. These policies should describe the facility's qualifying period, if any, and the method of reimbursement, if necessary. Facilities should inform their nurse aides of these policies at the time of hiring. It is recommended that nurse aides retain receipts for their training and testing costs to present to the nursing facility for reimbursement.

Nurse aide cost reporting (ARM 37.40.322 and ARM 37.40.346)

The initial training and testing costs are tracked by the Senior and Long-Term Care Division on a quarterly basis through the *Nurse Aide Certification/ Training and Competency Evaluation (Testing) Survey*. This report does not include costs associated with in-service or ongoing CNA training, only the certification training and testing. Nursing facilities are required to file the survey each quarter to report their training and testing costs. If a facility did not have any training or reimbursement to CNA employees for their training outside of the facility during the quarter, the facility must file a report stating that fact.

The facility should report costs for recertification tests. Medicaid does not distinguish between tests taken for initial certification and tests taken in order to regain certification. If a nurse aide is not successful in passing the certification tests, the facility should report the costs for subsequent tests. The nurse aide has three opportunities within a quarter to complete the testing successfully, and Medicaid will allow the cost for all three attempts.

The facility is not required to reimburse a CNA for recertification testing if the CNA allowed certification to lapse, but the facility may choose to in order to hire and/or retain the CNA.

For each quarter of the state fiscal year (July 1–June 30), the Senior and Long-Term Care Division will send out a letter and a survey form with the instructions on how to complete the form. Please complete this form and return it within the given deadline for reporting. Each facility must complete and return this report quarterly, whether there are expenses to report or not. If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the Department may withhold reimbursement payments. If the provider fails to submit the required information within the time frame, the Department will withhold 10% of the reimbursement for the



Nursing facilities can only report training and testing costs for nurse aides who are employed on either a full-time or part-time basis as nurse aides.

month following the deadline. If the information is not received the following month, 20% will be withheld, and for the third and subsequent months the entire reimbursement will be withheld. Withheld funds will be returned to the provider upon receipt of the completed survey. A sample copy of the survey form and instructions are located in *Appendix A: Forms*.

Coverage Requirements for Nursing Facilities

The following are coverage requirements for nursing facilities.

Nursing facility requirements (ARM 37.40.306)

Nursing facilities must meet all of the following requirements:

- Comply with applicable laws, rules, and regulations (see the *Provider Requirements* chapter in the *General Information for Providers* manual)
- Maintain current licensure in the state in which the facility is licensed
- Maintain Medicaid certification
- Maintain a current agreement with the Department to provide the level of care that the facility is billing for
- Operate under the direction of a licensed nursing facility administrator or other qualified supervisor according to laws, rules, and regulations
- Have admission policies that comply with nondiscrimination laws and regulations and do not discriminate on the basis of diagnosis or handicap (see *Nondiscrimination* in the *Provider Requirements* chapter of the *General Information for Providers* manual).
- Must give the Department 30 days' advance written notice to terminate Medicaid enrollment
 - It is the provider's responsibility to provide appropriate transfer and/or discharge planning for Medicaid residents and to care for them until appropriate transfers or discharges are completed, regardless of the facility's planned termination date.
 - Providers terminating Medicaid enrollment must prepare and file a closeout cost report that covers the end of the provider's previous fiscal year through the date of termination. New providers assuming operation from a terminating provider must enroll in the Medicaid program.
- Notify Medicaid residents (or their representative) of a transfer or discharge. Providers must follow transfer regulations according to 42 CFR 483.12. The *Transfer Discharge* form located in *Appendix A: Forms*, can be used, or providers can use their own form as long as it contains all of the following information:
 - Reason for transfer or discharge
 - Effective date of transfer or discharge
 - The location to which the resident is transferred or discharged

- A statement that the resident has the right to appeal the action to the state and information on how to appeal
- The name, address and phone number of the state long-term care ombudsman
- For residents who are disabled or mentally ill, the mailing address and telephone number of the agency responsible for the protection of and advocacy for these individuals

Out-of-state nursing facility (ARM 37.40.337)

Medicaid may cover services for Montana residents seeking services from out-of-state providers. Out-of-state providers must obtain authorization from the Department before providing services. Out-of-state services may be authorized when one or more of the following criteria is met:

- The resident's health would be endangered if he or she was to return to Montana for medical services. The medical emergency must be documented.
- The required services are not provided in Montana.
- The required services are less costly out-of-state than in Montana.
- The resident is a child for whom Montana provides adoption or foster care assistance.
- The Department has determined that it is general practice for clients in the resident's locality to use medical resources located in another state.

To request authorization for out-of-state nursing facility services, providers must contact the Senior and Long-Term Care Division (see *Key Contacts*) and have the following information available:

- The resident's full name, Medicaid ID number and expected date of admission.
- A physician's orders describing the reason for placement and the expected duration of the stay.

Upon approval, providers are given additional instructions on requirements for providing services to the Montana resident. In addition to meeting the requirements described under the *Coverage Requirements for Nursing Facilities* and *Nursing facility requirements* sections earlier in this chapter, out-of-state providers must also supply the Department with the following information:

- Copy of current license to operate as a nursing facility in the state in which the facility is located.
- Copies of documents from the facility's state Medicaid agency establishing or stating the Medicaid per diem rate for the resident's level of care during the period services are provided

- A copy of the certification notice from the facility's state survey agency showing certification for Medicaid services
- Assurances that the facility is not operating under Medicare or Medicaid sanctions during the period services are provided



Staffing and reporting (ARM 37.40.315)

Nursing facility staffing levels must meet federal law, regulations and requirements. Providers must submit a complete and accurate DPHHS-SLTC-015 *Monthly Nursing Facility Staffing Report* (see *Appendix A: Forms*) to the Department monthly. The completed form must be submitted by the 10th of the following month (e.g., January's report must be submitted by February 10). The Department may withhold all Medicaid payment from the provider until this requirement is met.

Change in provider (ARM 37.40.325)

When a facility experiences a change in provider, ownership or management, the provider must supply the Department with 30 days' advance written notice of the change and file closeout cost reports. The new owner/management must obtain a new National Provider Identifier (NPI) and enroll in Medicaid (see *Key Contacts*).

The following are considered a change in provider. See the *Definitions* chapter in this manual for a description of *related party* and *unrelated party*.

- ***All providers.*** An unrelated party acquires:
 - The provider's title or interest or a leasehold interest in the facility.
 - The right to control and manage the facility's business.
- ***Sole proprietorship providers.*** The entire sole proprietorship is sold to an unrelated party, and the seller does not retain a right of control over the business.
- **Partnership providers.**
 - A new partner acquires an interest in the partnership greater than 50%. The new partner is not a related party to either a current partner or a former partner.
 - The new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest and the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest (new Medicaid Provider ID required).
- ***Corporate providers.*** An unrelated party acquires stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation.



Providers must submit a complete and accurate DPHHS-SLTC-015 *Monthly Nursing Facility Staffing Report* to the Department monthly (see *Appendix A: Forms*).



When a provider gets a new Federal tax ID number, the provider must enroll in Medicaid with

Personal resources (ARM 37.40.302)

Personal resources (patient contribution) is the total of all the resident's income from all sources available to pay for the cost of care, less the resident's personal needs allowance. Personal needs allowance is money used for the resident's personal expenses. It cannot be used for items included in the facility's per diem rate or separately billable supplies (e.g., routine nursing expenses, transportation charges for physician visits). Providers may contact the local office of public assistance for a determination of the client's personal resources. Personal needs allowances are based on income sources and are as follows:

Personal Needs Allowance	
Income Source	Monthly Allowance
Supplemental Security Income (SSI) only	\$30.00
Retirement or Social Security or both	\$50.00
VA reduced pension	\$90.00

Resident trust accounts (ARM 37.40.306, MCA 53-6-168, and 42 CFR 483.10(c))

Providers must retain resident trust accounts for residents who request them. Providers who maintain resident trust accounts:

- Must ensure that these funds are used only for those purposes stated in writing by the resident (or legal representative).
- Must maintain personal funds in excess of \$50 in an interest bearing account and must credit all interest earned to the resident's account.
- Must allow the resident convenient access to personal funds up to \$50.
- May not borrow funds from these accounts or commingle resident and facility funds.
- Must notify the resident when total funds and assets (to the extent of the facility's knowledge) are within \$200.00 of the resource limit for Medicaid eligibility. The facility must also notify the resident that he or she may lose Medicaid benefits if resources exceed that limit.

Following the death of a resident who has received Medicaid benefits at any time, any of the resident's personal funds that a provider is holding must be turned over to the Department. The provider may first receive payment from the account for items usually billed to client, and the remainder must be issued to the Lien and Estate Recovery Unit within 30 days (see *Key Contacts*).

If a facility is not aware of a deceased resident ever having received Medicaid benefits, all personal monies held by the facility should be disbursed according to Montana probate laws and regulations (MCA, Title 72, Chapters 1–3).

Resident trust funds are subject to the same auditing procedures as other nursing facility records.



Coverage Requirements for Swing Bed Providers

The following are coverage requirements for swing bed providers.

Swing bed requirements (ARM 37.40.402 and 37.40.408)

Swing bed providers must meet all of the following requirements. The Department may terminate a provider's enrollment if the facility is not in compliance with requirements.

- Comply with applicable laws, rules, and regulations (see the *Provider Requirements* chapter in the *General Information for Providers* manual).
- Be a licensed hospital, critical access hospital (CAH) or licensed medical assistance facility which is Medicare-certified to provide swing bed hospital services (42 CFR 482.66).
- Maintain Medicaid certification and provide requested documentation for continued enrollment.
- Have fewer than 49 hospital beds. The hospital bed count is determined by excluding from the total licensed hospital beds newborn and intensive care beds, beds in a separately certified nursing or skilled nursing facility, beds in a distinct part of the facility such as a psychiatric or rehabilitation unit, and beds which are not consistently staffed and utilized by the hospital.
- A critical access hospital (CAH) with swing bed approval has no more than 25 acute care inpatient beds, of which no more than 15 are used for acute care at any one time for providing inpatient care.
- Be located in a rural area of the state. A rural area is an area which is not designated as "urbanized" by the most recent official census.
- Have a certificate of need from the state DPHHS to provide swing bed hospital services. To obtain a certificate of need, contact the Department's QAD (see *Key Contacts*).
- Must not have in effect a 24-hour nursing waiver.
- Must not have had its Medicare or Medicaid swing bed certification or approval terminated within two years prior to applying for enrollment as a Medicaid swing bed hospital services provider.
- Protect the rights of each resident as described in 42 CFR 483 and ARM 37.40.416.
- Provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident as defined in ARM 37.40.412.
- Provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as described in ARM 37.40.412.

Admission, transfer, discharge and waiver requirements (ARM 37.40.405 and 37.40.420)

Swing bed hospital providers must meet all of the following requirements.

- Before admitting a Medicaid resident to its swing bed facility, the hospital must obtain a prescreening by the Department's contractor (see *Key Contacts*). The screening determines the level of care required by the client's medical condition.
- The hospital must determine that no appropriate nursing facility bed is available to the Medicaid client within a 25-mile radius of the swing bed hospital.
- The hospital must maintain written documentation of inquiries to nursing facilities about the availability of a nursing facility bed. The hospital must indicate to the nursing facility that if a bed is not available, the hospital will provide swing bed services to the client. The swing bed hospital is encouraged to enter into availability agreements with Medicaid participating nursing facilities in its geographic region that require the nursing facility to notify the hospital of the availability of nursing facility beds and dates when a bed will be available.
- A Medicaid client admitted to a swing bed must be discharged to an appropriate nursing facility bed within a 25-mile radius of the swing bed hospital within 72 hours of an appropriate nursing facility bed becoming available. To ensure that residents are sufficiently prepared and oriented when discharged to a nursing facility, the swing bed hospital must inform residents of the transfer requirement upon admission.
- Swing bed providers may request a waiver of the 25-mile transfer requirements for their acute care clients under certain conditions. The waiver should be requested within the 72-hour period to assure the facility can bill Medicaid for services. The client's attending physician must verify in writing that the client's condition would be endangered by transfer to an appropriate nursing facility or that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. The Senior and Long-Term Care Division must receive the waiver request and physician's verification within five working days of admission to the swing bed hospital or within five days of availability of an appropriate nursing facility bed (see *Key Contacts*). Approval must be obtained before billing Medicaid for the services.
- When the facility anticipates discharge, a resident must have a discharge summary that includes all of the following:
 - A recapitulation of the resident's stay
 - A post-discharge plan of care that is developed with the participation of the resident and family, which will assist the resident to adjust to the new living environment

Clients who are covered by Medicare and Medicaid are subject to transfer requirements as soon as Medicaid becomes a payer (see the *Coordination of Benefits* chapter).

A Medicaid client admitted to a swing bed must be discharged to an appropriate nursing facility bed within a 25-mile radius of the swing bed hospital within 72 hours of an appropriate nursing facility bed becoming available.

- A final summary of the resident's status to include the following:
 - Medically-defined conditions and prior medical history
 - Medical status measurement
 - Physical and mental functional status
 - Sensory and physical impairments
 - Nutritional status and requirements
 - Special treatments or procedures
 - Mental and psychosocial status
 - Discharge potential
 - Dental condition
 - Activities potential
 - Cognitive status
 - Drug therapy



Waiver approvals granted by county offices are not valid.

Bed Hold Days for Nursing Facilities

Medicaid covers bed hold days when a nursing facility is holding a bed for a resident who is temporarily away from the facility. Medicaid does not cover bed hold days for swing bed providers. These services require authorization. For instructions on obtaining authorization for these services (including required forms), see the *Prior Authorization* chapter in this manual.

- **Hospital hold days.** Hospital holds days are days when the provider holds a bed for a resident who is temporarily receiving medical services outside the facility other than another nursing facility. Facilities must obtain authorization before billing Medicaid for these services. Medicaid covers hospital hold days under the following circumstances:
 - All Medicaid-certified beds in the facility are occupied or being held for a resident who is either on a therapeutic home visit or who is receiving temporary medical services elsewhere, except in another nursing facility, and is expected to return.
 - The facility has a current waiting list of potential residents for each bed day claimed for reimbursement.
 - The resident's hospitalization is temporary, and he or she is expected to return to the facility.
 - The cost of holding the bed is less costly than the cost of extending the hospital stay until an appropriate long-term care bed would otherwise become available.
- **Therapeutic home visits (THV).** Medicaid covers an accumulative total of 24 days of therapeutic home visits in a fiscal year (July 1–June 30).
 - **Visits of 72 hours or less.** Providers must complete a monthly form when a resident is spending at least overnight but not more than 72 hours (3 days) at home. Prior authorization is not required, but the form must be submitted to the Department within 90 days from the first day of leave.

Medicaid does not pay for more than 24 THV days in a state fiscal year (July 1– June 30).

- **Unexpected delay.** If a resident on a THV of 72 hours or less is unexpectedly delayed, the facility must obtain telephone authorization in order to bill for the visit. As soon as the facility is notified that the resident will not return within the 72 hours or if the resident does not return when expected, the facility must call for authorization. If this occurs after business hours or on a weekend or holiday, the facility must call for authorization on the next working day or the entire visit will be denied.
- **Visits over 72 hours.** Prior authorization is required for therapeutic home visits over 72 hours.

See the *Prior Authorization* chapter in this manual for details on the requirements for THVs.

Covered Services Included in the Daily Rate (ARM 37.40.304, ARM 37.40.305 and ARM 37.40.406)

The following coverage rules apply to nursing facilities and swing bed providers unless otherwise stated. These services are included in the facility's per diem rate and may not be billed separately to Medicaid.

If prior authorization is not obtained for visits over 72 hours, payment for the entire visit will be denied.

Routine supplies

The nursing facility per diem rate includes (but is not limited to) the following:

- Use of facility, equipment, and a room.
- All general nursing services including the administration of oxygen and medication, hand feeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitus treatment.
- Dietary services including dietary supplements used for tube feeding or oral feeding (e.g., straws and tubes for drinking). For sole source parenteral or enteral nutritional services, please refer to the *Ancillary items* section in the *Billing Procedures* chapter of this manual.
- Laundry services except for residents' clothing which is dry cleaned outside of the facility
- Personal hygiene items and services such as the following:
 - Bathing items (e.g., towels, washcloths, soap)
 - Hair care items (e.g., shampoo, brush, comb)
 - Incontinence care and supplies (e.g., incontinence pads)
 - Nail care items
 - Shaving items (e.g., razors, shaving cream)
 - Skin care and hygiene items (e.g., lotions, ointments, hand and bacteriostatic soaps, specialized cleaning agents to treat special skin problems or fight infection)

- Tooth and denture care items (e.g., toothpaste, toothbrush, floss, denture cleaner and adhesive, denture cups)
- Waste bags
- Other miscellaneous items (e.g., cotton balls, swabs, deodorant, hospital gowns, sanitary napkins, facial tissues, paper towels, safety pins)
- First aid and medical supplies such as the following:
 - Antibacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution
 - Cotton
 - Enema equipment and/or solutions
 - Finger cots
 - Gloves (sterile and unsterile)
 - Hypodermic needles (disposable and non-disposable)
 - Ice bags
 - Medication dispensing cups and envelopes
 - Antibacterial ointments
 - Sterile water and normal saline for irrigating
 - Supplies necessary to maintain infection control (e.g., supplies required for isolation-type services)
 - Surgical tape and dressings
 - Suture removal kits
 - Swabs (including alcohol swab)
 - Syringes (disposable or non-disposable hypodermic; insulin, irrigating)
 - Thermometers, clinical
 - Tongue blades
 - Wound-cleaning beads or paste
- Over-the-counter medications (or their equivalents)
 - Acetaminophen (regular and extra-strength)
 - Aspirin (regular and extra-strength)
 - Cough syrups
 - Therapeutic Class 1 and Class 6 antacids and laxatives (e.g., milk of magnesia, mineral oil, suppositories for evacuation (dulcolax and glycerine), maalox, mylanta)
 - Nasal decongestants and antihistamines
- Reusable items and equipment such as the following:
 - Baths, whirlpool and sitz
 - Bathtub accessories (e.g., seat, stool, rail)
 - Beds, mattress, linens, sheepskins and other fleece type pads, and bed-side furniture

- Bedboards, foot boards, cradles
- Bedside equipment (e.g., bedpans, urinals, emesis basins, water pitchers, serving trays)
- Bedside safety rails
- Blood-glucose testing equipment
- Blood pressure equipment and stethoscope
- Canes, crutches
- Cervical collars
- Commode chairs
- Enteral feeding pumps
- Geriatric chairs
- Heat lamps (e.g., infrared lamps)
- Humidifiers/vaporizers (steam)
- Isolation cart
- IV poles
- Mattress (foam-type and water)
- Patient lift apparatus
- Physical examination equipment
- Postural drainage board
- Raised toilet seats
- Suction machines
- Tourniquets
- Traction equipment
- Trapeze bars
- Walkers (regular and wheeled)
- Wheelchairs (standard)

Routine transportation

Nonemergency routine transportation (visits to physicians, pharmacy or other medical providers or routine outings) is the responsibility of the nursing facility when the destination is within 20 miles of the facility.

Covered Services Separately Billable (ARM 37.40.330 and ARM 37.40.406)

The following coverage rules apply to nursing facilities and swing bed providers unless otherwise stated. Providers of following services may bill Medicaid separately from the facility's per diem rate. Some of these services require prior authorization. For more information on requesting prior authorization, see the *Prior Authorization* chapter in this manual.

Ancillary items

The following are coverage rules for ancillary items. A list of these items with prior authorization indicators is available on the Nursing Facility/Swing Bed fee schedule, which is available on the Provider Information website or from Provider Relations (see *Key Contacts*). Some ancillary items with special criteria include the following:

- **Oxygen.** Medicaid covers oxygen concentrators and portable oxygen units (cart, E tank, and regulators) only when the following requirements are met and prior authorized (see the Prior Authorization chapter in this manual). Medicaid does not cover maintenance costs.
 - The provider must submit documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice to the Department (see *Key Contacts*).
 - The provider must maintain a certificate of medical necessity stating the PO₂ level or oxygen saturation level for each resident. The resident's physician must sign and date the certificate. The criteria must meet or exceed Medicare's. The Department will recover inappropriate payments if the certificate is not available upon request.
- ***Parenteral/enteral nutritional solutions.*** Parenteral/enteral nutritional solutions are covered only when the following requirements are met:
 - The solutions are the sole source of nutrition
 - The solutions are medically necessary and appropriate
 - The services have been prior authorized (see the *Prior Authorization* chapter in this manual)
- ***Routine supplies used in extraordinary amounts.*** Routine nursing supplies used in extraordinary amounts may be covered if they are prior authorized (see the *Prior Authorization* chapter in this manual).

Dental care

Facilities must assist residents in obtaining routine and 24-hour emergency dental care. This includes helping to make dental appointments, arranging for transportation, and promptly referring residents with lost or damaged dentures to a dentist. Dental services are billed to Medicaid by the dentist or denturist providing the service (see the *Dental and Denturist* manual).

DME and medical supplies

Certain durable medical equipment (DME) and supplies are included in the nursing facility per diem rate. However, when a resident has a condition that requires supplies not provided under nursing facility services, these items may be separately billable by the DME provider in accordance with DME service delivery requirements (see the *Durable Medical Equipment, Orthotics, Prosthetics and Supplies* manual).

Pharmacy items

Prescribed medications, including flu shots, tine tests and IV solutions, are not included in the per diem rate and must be billed separately by the pharmacy providing the services in accordance with pharmacy service delivery requirements (see the *Prescription Drug Program* manual).

Therapy services

Medicaid covers physical, occupational, and speech therapies which are not considered part of routine nursing facility services. Maintenance therapy is included in the nursing facility's daily rate, but restorative therapy services are provided and billed separately by a licensed therapist in accordance with therapy service delivery requirements (see the *Therapy Services* manual, which includes physical therapy, occupational therapy, and speech therapy, for billing procedures).

Transportation

Medicaid may cover transportation costs separately billable to Medicaid in one of the following circumstances:

- When a resident is wheelchair-bound or requires transport by stretcher
- When a resident must travel farther than 20 miles to a Medicaid-covered appointment
- When a resident requires emergency transportation by ambulance

The facility must be enrolled with Medicaid as a transportation provider and follow policy and billing instructions in the *Commercial and Specialized Non-Emergency Transportation* manual. Another option is to utilize an approved transportation provider.

Noncovered Services (ARM 37.40.331 and ARM 37.85.207)

Some services are not covered by Medicaid and may be billed directly to the resident. The resident must be informed in advance that they will be charged for these items and the amount of the charge. The following items are included:

- Gifts purchased by resident
- Social events and entertainment outside the scope of the provider's activities program
- Cosmetic and grooming items and services that Medicare and Medicaid do not cover (e.g., beauty shop services)
- Television, radio and private telephone rental
- Less-than-effective drugs (exclusive of stock items)
- Vitamin and mineral supplements
- Personal reading material
- Personal clothing
- Flowers and plants

- Privately hired nurses or aides
- Specially prepared or alternative food requested by the resident instead of food generally prepared by the facility
- The difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers)
- Personal comfort items (e.g., tobacco products and accessories, notions, novelties, and confections)
- Personal dry cleaning
- Private rooms that are not medically necessary. Medicaid pays the same rate for private rooms as double occupancy rooms. If a private room is medically necessary, the facility may not bill the resident for the difference between the amount Medicaid pays and the amount of the room. If the resident requests a private room but it is not medically necessary, the facility may bill the resident for the difference. Before providing the service, the facility must clearly inform the resident that he or she must pay extra for the private room and the resident will no longer have a private room when payment stops.

Other Programs

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). Clients who qualify for MHSP may receive mental health services during nursing facility care. For more information on the MHSP program, see the mental health manual available on the Provider Information website (see *Key Websites*) or call (406) 444-3964.

Healthy Montana Kids (HMK) Plan

The information in this manual does not apply to HMK clients. For an HMK medical manual, contact Blue Cross and Blue Shield of Montana on the direct toll-free line at 855-258-3489. Additional information regarding HMK is available on the HMK website (see *Key Websites*).

Prior Authorization

What Are Prior Authorization, Passport and Team Care? (ARM 37.85.205 and 37.86.5101–5120)

Prior authorization (PA), Passport to Health, and the Team Care Program are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. Nursing facility and swing bed residents are not enrolled in Passport or Team Care, so Passport approval is not required for nursing services. Prior authorization, however, is required for some services as described in the following section. For more information on Passport and Team Care, see the *Passport* and *Prior Authorization* chapters in the *General Information for Providers* manual.

Occasionally a nursing facility claim will deny for lack of Passport approval. This happens when a Passport client enters a facility during a month when his or her Passport enrollment is still active. When this happens, call Provider Relations and ask them to force the claim (see *Key Contacts*).

Prior Authorization

Some services require authorization before billing Medicaid, and other services require prior authorization (PA) before the service is provided. When seeking authorization, keep in mind the following:

- The following table (*Authorization Criteria for Specific Services*) lists services that require authorization, who to contact, and documentation requirements.
- Authorization requirements apply to both nursing facility and swing bed providers, except for hospital hold days and therapeutic home visits, which are not benefits for swing bed providers.
- Have all required documentation included in the packet before submitting a request for authorization (see the following *Authorization Criteria for Specific Services* table for documentation requirements).
- Once prior authorization (PA) is granted for ancillary services, providers will receive notification containing a PA number. This PA number must be included on the claim form (see the *Submitting a Claim* chapter in this manual).
- All forms required for authorization are located in *Appendix A: Forms*.
- If authorization is not granted for services that require authorization, Medicaid will not pay for the service or may recover unauthorized payments.



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

Authorization Criteria for Specific Services

Services	Contacts	Requirements
<p>Oxygen Concentrator</p>	<p>Nursing Facility Services Senior and Long-Term Care P.O. Box 4210 Helena, MT 59604</p> <p>Phone: (406) 444-3997 (406) 444-4077</p> <p>Fax: (406) 444-7743</p>	<ul style="list-style-type: none"> • Documentation includes the following and must be maintained in the provider’s records: <ul style="list-style-type: none"> • Resident’s name and Medicaid ID number • Provider name and provider’s NPI • A certificate of medical necessity, signed and dated by the resident’s physician, stating the PO2 level or oxygen saturation level. The criteria must meet or exceed Medicare’s. If the certificate is not available upon request, inappropriate payments may be recovered • Cost and useful life of the concentrator or portable oxygen unit and a copy of the purchase invoice • Period of coverage being requested (authorizations are reevaluated at least quarterly) • Once approved, providers will receive an authorization number that must be included on the claim. • For more information on oxygen concentrators, see the <i>Covered Services</i> chapter in this manual.
<ul style="list-style-type: none"> • Parenteral/Enteral Nutritional (PEN) Solutions 	<p>Nursing Facility Services Senior and Long-Term Care P.O. Box 4210 Helena, MT 59604</p> <p>Phone: (406) 444-3997 (406) 444-4077</p> <p>Fax: (406) 444-7743</p>	<ul style="list-style-type: none"> • Documentation includes the following and must be maintained in the provider’s records: <ul style="list-style-type: none"> • Resident’s name and Medicaid ID number • Provider name and provider’s NPI/API. • Copy of a current signed and dated physicians’ order • Period of coverage being requested (authorizations are reevaluated at least quarterly) • Name of solution • Total projected monthly usage (quantity, cans) and acquisition cost (dollar amount). The cost must be documented by a receipt or bill. • Procedure code for the solution • A Medicare EOMB or denial must be attached if resident is covered by Medicare • Once approved, providers will receive an authorization number that must be included on the claim form. • For more information on parenteral/enteral nutritional solutions, see the <i>Covered Services</i> chapter in this manual.

Authorization Criteria for Specific Services (Continued)		
Services	Contacts	Requirements
<ul style="list-style-type: none"> • Routine Supplies Used in Extraordinary Amounts 	<p>Nursing Facility Services Senior and Long-Term Care P.O. Box 4210 Helena, MT 59604</p> <p>Phone: (406) 444-3997 (406) 444-4077</p> <p>Fax: (406) 444-7743</p>	<ul style="list-style-type: none"> • Documentation includes the following and must be maintained in the provider's records: <ul style="list-style-type: none"> • Resident's name and Medicaid ID number • Provider name and provider's NPI/API. • Copy of a current signed and dated physicians' order • Period of coverage being requested (authorizations are reevaluated quarterly) • Type of supplies used in extraordinary amounts • Quantity used (itemize each item individually) • Cost of item documented on invoice • Dollar amount being requested • Upon approval, providers will receive an authorization number that must be included on the claim. • For more information on routine supplies used in extraordinary amounts, see the <i>Covered Services</i> chapter in this manual.
<ul style="list-style-type: none"> • Hospital Hold Days (nursing facility only) 	<p>Nursing Facility Services Senior and Long-Term Care P.O. Box 4210 Helena, MT 59604</p> <p>Phone: (406) 444-3997 (406) 444-4077</p> <p>Fax: (406) 444-7743</p>	<ul style="list-style-type: none"> • Facility must be full with a waiting list. • Documentation includes the following: <ul style="list-style-type: none"> • For authorization, submit DPHHS-SLTC-052, <i>Request for Nursing Facility Bed Reservation During Resident's Temporary Hospitalization</i> form monthly. The Department must receive this form within 90 days from the day the resident leaves the facility. The form is located in <i>Appendix A: Forms</i>, and on the Provider Information website (see <i>Key Websites</i>). • Copy of facility waiting list • For more information on requesting hospital hold days, see the <i>Bed hold days</i> section of the <i>Covered Services</i> chapter in this manual.

Authorization Criteria for Specific Services (Continued)

Services	Contacts	Requirements
<ul style="list-style-type: none"> • Therapeutic Home Visits (nursing facility only) 	<p>Senior and Long-Term Care P.O. Box 4210 Helena, MT 59604</p> <p>Phone: (406) 444-3997 (406) 444-4077</p> <p>Fax: (406) 444-7743</p>	<p>Visit of 72 hours or less</p> <ul style="list-style-type: none"> • Prior authorization is not required. However, DPHHS-SLTC-041, <i>Therapeutic Home Visit Reservation</i>, must be completed monthly. The Department must receive the form within 90 days from the day a resident leaves the facility. If the form is not received within 90 days, the Department will recover any unauthorized payment. • Unexpected delay. If a resident on a THV of 72 hours or less is unexpectedly delayed, the facility must obtain phone authorization from the Department to bill for the visit. As soon as the facility is notified that the resident will not return with the 72 hours, or if the resident does not return when expected, the facility must call for authorization. If this occurs after business hours or on a weekend or holiday, the facility must call for authorization on the next working day or the entire visit will be denied. The facility must complete DPHHS-SLTC-042, <i>Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours</i>, and submit it to the Department within 90 days of the first day of the visit. <p>Visits over 72 hours</p> <ul style="list-style-type: none"> • Prior authorization is required for therapeutic home visits over 72 hours before the resident leaves the facility. If insufficient time is available to obtain authorization by mail, the facility may receive verbal authorization by calling the Department. The facility must complete DPHHS-SLTC-042, <i>Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours</i>, and submit it to the Department within 90 days from the day the resident leaves for the visit. • Form DPHHS-SLTC-042 must be approved and signed by the Department to receive payment. If the form is not received within 90 days, the Department will recover any unauthorized payment. • The following forms are available in <i>Appendix A: Forms</i> and on the Provider Information website (see <i>Key Websites</i>). <ul style="list-style-type: none"> • DPHHS-SLTC-041, <i>Therapeutic Home Visit Reservation</i> • DPHHS-SLTC-042, <i>Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours</i> • Medicaid will not pay the facility for more than 24 days of therapeutic home visits in a fiscal year (July 1–June 30). • For more information on requesting therapeutic home visits, see the <i>Bed hold days</i> section of the <i>Covered Services</i> chapter in this manual.

Coordination of Benefits

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 should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to billing third party first* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see the *General Information for Providers* manual, *Client Eligibility and Responsibilities*). If a client has Medicare, the Medicare ID number is provided. If a client has additional coverage, the carrier is shown. Some 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 eligibility verification.

Providers should 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 other non-Medicaid claims. The other sources of coverage are called "third party liability," but Medicare is not.

Medicare claims

Medicare Part A covers skilled nursing services for the first 100 days following a qualifying inpatient hospitalization. Any claims for services covered by Medicare must be submitted to Medicare before submitting to Medicaid. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider, and the provider can then bill Medicaid.

When a Medicaid resident is also covered by Medicare and returns to a nursing facility or swing bed hospital following a qualifying inpatient hospital stay, and the resident continues to qualify for skilled level of care, Medicaid may assist with Medicare coinsurance for Days 21 through 100. Services through the first 100 days must be billed to Medicare first, but Days 101 and following may be billed directly to Medicaid (see the *Medicare coinsurance days* section in the *Billing Procedures* chapter of this manual). See the following table for more examples of when to bill Medicare or Medicaid first.

Bill Medicare First	Bill Medicaid First
The first 100 days of skilled nursing facility care following a resident's qualifying inpatient hospitalization	The 101st and remaining days following a resident's qualifying inpatient hospitalization
Parenteral/enteral feeding solutions	Nonqualifying inpatient hospitalization (i.e., less than three days)
Some ancillary services	Oxygen
	Some ancillary services
	Bed hold days
	Nonemergency transportation provided by the facility that is over 20 miles from the facility

When submitting electronic claims with paper attachments (e.g., Medicare EOMB), see the *Billing Electronically with Paper Attachments* section of the *Submitting a Claim* chapter.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the provider's NPI and the Medicaid client's ID number.

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 or 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 (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source for the Medicaid covered service must be turned over to Medicaid."



Exceptions to billing third party first

When a Medicaid client is also covered by Indian Health Services (IHS), providers must bill Medicaid first. IHS is not considered a third party liability.

If the third party has only potential liability, the provider may bill Medicaid first. **Do not indicate the potential third party on the claim.** Instead, send 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 should be sent directly to the Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a nonspecific 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.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed or with 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 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 when submitting the claim to Medicaid for processing.
- ***Allows the claim***, and the allowed amount went toward client's deductible, include the insurance explanation of benefits (EOB) when billing Medicaid.



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.

- **Denies the claim**, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- **Denies a line on the claim**, bill the denied lines together on a separate claim and submit to Medicaid. Include the EOB from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

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:

- Submit the claim with a note explaining that the insurance company has been billed or with 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 ACS Third Party Liability Unit (see *Key Contacts*).

Blanket denials

Providers who routinely bill for Medicaid covered ancillary services that other insurance companies do not cover, may request a blanket denial letter. Providers may complete a *Request for Blanket Denial Letter* (located in *Appendix A: Forms* and on the Provider Information website) and submit the form to the Third Party Liability Unit (see *Key Contacts*). The TPL Unit usually requests the provider send an explanation of benefits showing the services have been denied by the client's other insurance company. The provider is then notified that the services have been approved for a blanket denial.

Providers who bill electronically (ANSI ASC X12N 837 transactions) will receive a memo from the TPL Unit with a tracking number for use when billing Medicaid. This number must be included in the *paperwork attachment indicator* field when billing electronically for the specific services.

Providers who bill on paper will receive a memo from the TPL Unit. This memo must be copied and submitted with each claim for the approved procedure codes.

The number can be used for two years, and then the provider must submit a new *Request for Blanket Denial Letter*. Any claims submitted with procedure codes not listed (or not approved) on the memo must be submitted with a specific denial from the other insurance company or Medicaid will deny those services.

Billing Procedures

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- 12 months from the latest of:
 - The date of service
 - The date retroactive eligibility is determined; or
 - The date disability was determined
- Six months from the date on the Medicare EOB approving the service, if the Medicare claim was timely filed and the recipient was Medicare-eligible at the time the Medicare claim was filed; or
- Six months from the date on an adjustment notice from a third party payer, where the third party payer 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 documentation from or action by the provider of the service. The submission date is defined as the date the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within the timeframes shown above.



Tips to Avoid Timely Filing Denials

- Submit claims in a timely manner.
- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual). When reviewing denied claims, pay particular attention to the reason for denial, and correct the claim as appropriate. Some areas to watch for include the following:
 - Ensure coding is correct and valid for your provider type
 - Make sure the the dates of service are the days being claimed. For example, the day of discharge cannot be claimed so should not be included in the dates of service.
 - Confirm that the resident's Medicaid ID number is correct
- If a claim continues to deny, contact Provider Relations for assistance in resolving the claim (see *Key Contacts*).
- If a provider has made several attempts to resolve a claim and the provider believes that the claim is a clean claim, and it still denies, contact Senior and Long-Term Care for review of the claim (see *Key Contacts*).
- Under very limited circumstances, providers may need to submit an adjustment for a claim over 365 days from the date of service (for reasons such as an audit

that has revealed that Medicaid was overbilled, or a resident's personal resource obligation changed). In these cases, submit the claim to Senior and Long-Term Care for review and special handling.

- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for 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).

Billing for Retroactively Eligible Clients (ARM 37.40.202)

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, submit a copy of the FA-455 (eligibility determination letter) when the date of service is outside the 12-month limit. In order to bill for retroactive services, a level of care screening must have been completed at the time services were provided (see *Preadmission screening and level of care determinations* in the *Covered Services* chapter of this manual).

Institutional providers (including nursing facilities and swing bed providers) must accept the client as a Medicaid client from the date retroactive eligibility was effective. If 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.

When Clients Have 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 *Coordination of Benefits*.

When Can I Bill a Medicaid Client Directly? (ARM 37.85.406)

In most circumstances, providers may not bill clients for services covered under Medicaid. Medicaid does not cover some items and services, which may be billed directly to the resident, as long as the resident is informed of and agrees to the charges. For a list of these items and services, see *Noncovered Services* in the *Covered Services* chapter of this manual.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid. There are exceptions covered under ARM 37.40.331:
 - Medicaid does not reimburse the facility for private rooms, and a facility must provide a medically necessary private room at no additional

In order to bill for retroactive services, a level-of-care screening must have been completed at the time services were provided.

charge. If a resident requests a private room that is not medically necessary, the facility may charge the resident for the difference between the amount that Medicaid pays and the cost of the private room. The resident must be clearly informed that there will be an additional charge, the amount of that charge, and that the choice of a private room with the additional charge is voluntary.

- If a resident requests a specific brand of an item that is different than the brand the facility routinely supplies (e.g., incontinence products, lotions, soaps), the facility may charge the resident the difference in cost between the item routinely supplied and the specific brand item requested.
- When a third party payer does not respond.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When services are being provided free to the client. Medicaid may not be billed for those services either.

Providers may bill Medicaid clients directly under the following circumstances:

- For the items and services listed in the *Noncovered Services* section of the *Covered Services* chapter in this manual.
- For services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services. For example, if a resident wants a private room that is not medically necessary, the resident must be informed and agree in writing that he or she is responsible for the additional charges. Likewise, if a resident requests a specific brand of item, such as lotion or soap, that is more expensive than the brand the facility normally provides, the resident can be charged the difference as long as he or she has agreed in writing to pay for the difference.

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT edition and HCPCS Level II coding books. Department fee schedules are updated each January and July. Current fee schedules are available on the Provider Information website (see *Key Websites*).

Coding

Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used:

- ICD
- CPT
- HCPCS Level II



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

There are many variables to selecting the correct codes for billing for services. It is Department policy that Provider Relations or the Department do not suggest specific codes to be used in billing for services. If the facility does receive coding suggestions, the facility may not rely on the suggestion unless it is in writing (such as a prior authorization). The facility is responsible for using the correct codes for the services provided. The following suggestions may help reduce coding errors:

- Refer to the Montana Medicaid fee schedule for covered codes that are valid for your provider type (available on the Provider Information website; see *Key Websites*).
- Use current CPT, HCPCS Level II, and ICD coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.
- Providers who are submitting ANSI ASC X12N 837 transactions must use the current revenue codes.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than miscellaneous codes. For example, rather than using Diagnosis Code 250.0, use 250.09.
- Pay close attention to modifiers used with CPT and HCPCS codes on claims. Modifiers are becoming more prevalent in health care billing, and they often affect payment calculations.
- Use the correct “units” measurement on claims. In general, Medicaid follows the definitions in the CPT and HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.



Always refer to the long descriptions in coding books.

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 Correct Coding Initiative (CCI) 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 (800) 363-2068 (703) 605-6060 http://www.ntis.gov/products/cci.aspx
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association (800) 621-8335 https://catalog.ama-assn.org/Catalog/home.jsp or Medicode (Ingenix) (800) 765-6588 http://www.shopingenix.com
CPT Assistant	A newsletter on CPT coding issues	American Medical Association (800) 621-8335 https://catalog.ama-assn.org/Catalog/home.jsp
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS www.cms.gov/
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 http://www.shopingenix.com
UB-04 National Uniform Billing Data Element Specifications	Montana UB-04 billing instructions	National Uniform Billing Committee www.nubc.org

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Nursing facility and swing bed residents are exempt from cost sharing beyond their personal resource obligation, so cost sharing fees cannot be collected for these clients.

Billing for Services Included in the Daily Rate

Most services provided by nursing facilities and swing bed providers are included in a daily rate and billed to Medicaid on an MA-3 claim form or an MA-3 turn around document (TAD).

Bed hold days

Therapeutic home visits (THV) and hospital hold (HH) days are billed on three separate claim lines as follows.

Claim line one. On the first claim line, claim the dates and the number of days the resident was at the facility before THV or HH. Do not claim the date the resident leaves the facility. If the resident’s personal resources are greater than or equal to the Total Charges amount, enter the same amount as the Total Charges in the Personal Resources field. This results in a Net Charges amount of zero (0). Then subtract the amount used from the personal resources for a remaining personal resources balance (see following example).

Claim line two. On the second claim line, bill for the remaining days in the month following the THV or HH days. Claim the date the resident returned to the facility. If there is any remaining personal resource amount, deduct it on this claim line.

Claim line three. The third claim line is for THV or HH days, but these days cannot be billed until the facility receives an approved THV form (DPHHS-SLTC-042), or an approved HH form (DPHHS-SLTC-052). This claim includes the date the client left the facility, but not the date the client returns to the facility. Enter THV or HH on the claim.

For example, Jane Smith was a resident the entire month of May and she went on a home visit from May 4–9 (5 days). She has a personal resource amount of \$525.00 and the facility’s per diem rate is \$105.00.

Claim #1 for days 05/1/04–05/03/04

3 days x \$105.00 (facility rate per day) = \$315.00 (total charges)

\$315.00 (total charges) - 315.00 (personal resources) = \$0.00

Net Charges = \$0.00

Claim #1

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M S F X	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.	
DIAGNOSIS Osteoarthritis		DIAG. CODE 715.9	DATE OF BIRTH MO. DAY YEAR 10 29 15	DATE ADMITTED MO. DAY YEAR 02 15 04	STATEMENT PERIOD MO. FROM DAY YEAR TO MO. DAY YEAR 05 01 04 05 03 04			
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE	NO. OF DAYS 3	LEVEL OF CARE 2	TOTAL CHARGES 315.00	(LESS) PERSONAL RESOURCES 315.00	NET CHARGES 0.00	

Personal resources of \$525.00 - \$315.00 = \$210.00 remaining personal resources

Do not claim the day the resident leaves for THV.



Claim #2 for days 05/09/04–05/31/04

23 days x \$105.00 (facility rate) = \$2,415.00 (total charges)
 \$2,415 (total charges) - \$210.00 (remaining personal resources) = \$2,205.00
 Net Charges = \$2,205.00

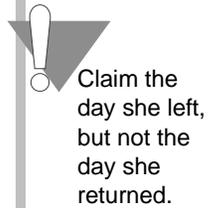


Claim #2

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M	S	F	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.
		DIAG. CODE 715.9		DATE OF BIRTH MO. DAY YEAR 10 29 15		DATE ADMITTED MO. DAY YEAR 02 15 04		STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR 05 09 04 05 31 04	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS 23	LEVEL OF CARE 2	TOTAL CHARGES 2,415.00	(LESS) PERSONAL RESOURCES 210.00	NET CHARGES 2,205.00	

Claim #3 for THV or HH days 05/04/04–05/08/04

5 days x \$105.00 (facility rate) = \$525.00 (total charges)
 \$525.00 (total charges) - \$0.00 (personal resources remaining) = \$525.00
 Net Charges = \$525.00



Claim #3

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M	S	F	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.
		DIAG. CODE 715.9		DATE OF BIRTH MO. DAY YEAR 10 29 15		DATE ADMITTED MO. DAY YEAR 02 15 04		STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR 05 04 04 05 08 04	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS 5	LEVEL OF CARE 2	TOTAL CHARGES 525.00	(LESS) PERSONAL RESOURCES 0.00	NET CHARGES 525.00	

When completing claims for THV or HH, remember the following:

- Enter THV or HH in the memo field (New Diagnosis/Recent Complications) on the paper claim.
- Enter only the dates being claimed in the From and To fields. This will reduce delays or denials because of overlapping service dates.
- Any unused personal resources from previous claims should be applied to hold days.
- Do not include copies of the THV or HH bed hold forms with your claims.

Medicare coinsurance days

When a Medicaid resident is covered by Medicare and Medicaid and returns to a nursing facility or swing bed hospital following a qualifying inpatient hospital stay, Medicaid assists with Medicare coinsurance for Days 21–100 as long as the resident continues to meet skilled level of care. To bill Medicaid for coinsurance days, first determine whether the facility’s per diem rate or the coinsurance rate is lower. Medicaid must be billed the lower of the two rates.

For example, the provider’s per diem rate is \$115.97 and the Medicare coinsurance rate for the calendar year is \$109.50. Bill Medicaid \$109.50 for each coinsurance day. As long as a resident meets the criteria for Medicare payment (e.g., qualifying stay, level of care, available benefit), Medicare pays completely for Days 1–20. These days may not be billed to Medicaid.

Ancillary services included in Medicare's bundled rate may not be billed during Medicare qualifying days. To determine how many days Medicare allowed as coinsurance days, divide the coinsurance amount by \$109.50 (or the coinsurance rate at the time of service). The Medicare EOMB shows a coinsurance of \$1,095.00; divide that by \$109.50 for 10 coinsurance days.

If the provider's per diem rate is \$105.00 and the Medicare coinsurance rate is \$109.50. The facility bills the days at their per diem rate.

NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES
10	2	1,095.00	350.00 →	\$ 745.00

Separately Billable Services

Ancillary items

Some ancillary items may be billed separately to Medicaid. These items must be billed at the facility acquisition cost with no markup. The Nursing Facility/Swing Bed fee schedule includes these items, with prior authorization (PA) indicators, and is located on the Provider Information website (see *Key Websites*). These items are billed either electronically or on a CMS-1500 claim form. If the service requires PA, the PA number must be included on the claim (see the *Prior Authorization* and *Submitting a Claim* chapters in this manual).

Parenteral/enteral nutritional solutions

Medicaid pays the facility's acquisition cost only, with no additional markup for parenteral/enteral (PEN) solutions. The PA number must be included on the claim (see the *Prior Authorization* chapter in this manual). When a resident has both Medicaid and Medicare, submit the claim first to Medicare. If Medicare pays in excess of the acquisition cost, do not bill Medicaid.

Routine supplies used in extraordinary amounts

Routine supplies used in extraordinary amounts are billed either electronically or on a CMS-1500 claim, and the PA number must be included.

Other services

Some Medicaid covered services are provided in a nursing facility setting but may not be billed by the nursing facility under a nursing facility NPI. Some examples include hospice services, waiver respite care and some durable medical equipment (DME) and therapy services. These services must be billed to Medicaid by the provider of the service. If the nursing facility is providing the service, the facility must be enrolled as a Medicaid provider for each type of service provided. See the Medicaid billing manual for type of services being billed (e.g., *Hospice Care Services* manual, *Durable Medical Equipment, Orthotics, Prosthetics and Supplies* manual). Waiver respite care is billed with the Home- and Community-Based Services provider number. Contact the referring case management team for instruction on billing respite.

Recording Changes on TADs

Turn around documents (TADs) are MA-3 reports pre-completed with billing information for residents who were in the facility the previous month. These are generated and sent to facilities during the third week of the month.

Providers must make all necessary changes to the TADs before returning them for processing. If the resident is discharged, hospitalized with no authorized bed hold days, expires, has unauthorized or over the limit (24 days per fiscal year) therapeutic home visits, or has a change in personal resources, mark out No. of Days, Total Charges, Personal Resources, and/or Net Charges, and enter the corrected information. Any new or additional information such as new diagnosis/recent complications may also be entered.

The authorized agent must sign and date the reports after all changes are made and after the last billing date, and the TAD should be returned to Claims Processing unit at the following address:

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

Submitting a Claim

See the *Submitting a Claim* chapter in this manual for instructions on completing claims 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 others are denied. To avoid returns and denials, double-check each claim form to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return	How to Prevent Returned Claims
Provider NPI missing or invalid	The provider NPI is a 10-digit number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim.
Authorized signature missing	Each claim form must have an authorized signature belonging to the provider, billing clerks, or office personnel. The signature may be typed, stamped, computer-generated, or handwritten.
Signature date missing	Each form must have a signature date.
Incorrect claim form used	The claim form must be the correct form for the services being billed.
Information on claim form not legible	Information on the claim form should be legible. Use dark ink and center the information in the field – information should not be obscured by lines.
Recipient number not on file, or recipient 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>General Information for Providers</i> manual, <i>Client Eligibility and Responsibilities</i> chapter. See <i>Resolving Client Eligibility Problems</i> in this chapter.
Duplicate claim	<ul style="list-style-type: none"> • Please check all RAs for previously-submitted claims before resubmitting. • When making changes to previously-paid claims, submit an adjustment form rather than a new claim form, even if the claim is paid and the payment amount is “0” (see <i>Remittance Advices and Adjustments</i>). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires Passport provider approval – No Passport approval number on claim	<ul style="list-style-type: none"> • Occasionally a nursing facility claim will deny for lack of Passport approval. This happens when a Passport client enters a facility during a month when his or her Passport enrollment is still active. When this happens, call Provider Relations and ask them to force the claim (see <i>Key Contacts</i>).
Prior authorization number is missing	<ul style="list-style-type: none"> • PA is required for certain services, and the PA number must be on the claim form. Refer to your specific provider manual.
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i>. • If the client’s TPL coverage has changed, providers must notify the TPL Unit (see <i>Key Contacts</i>) before submitting a claim.

Common Billing Errors (Continued)	
Reasons for Return	How to Prevent Returned Claims
Claim past 365-day filing limit	<ul style="list-style-type: none"> • To ensure timely processing, paper claims and adjustments should be mailed to Claims Processing at the address shown in <i>Key Contacts</i>. • See <i>Tips to Avoid Timely Filing Denials</i> in this chapter.
Missing Medicare EOMB	Paper Medicare crossover claims on CMS-1500 forms must have an EOMB attached.
Provider is not eligible during dates of services, or provider NPI terminated	<ul style="list-style-type: none"> • Out-of-state providers must receive authorization for a Montana resident to assure provider NPI is current and other provider information is updated for each approved stay. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.
Date of service not in nursing facility span	<ul style="list-style-type: none"> • Verify the correct billing dates were used • Verify the nursing facility span dates authorized for the resident with the county office. If county office confirms span is correct and the claim still denies for date of service not in span, contact Senior and Long-Term Care (see <i>Key Contacts</i>).
Accommodation rate x days not equal to charge	<ul style="list-style-type: none"> • Verify that the correct number of days were billed • Verify that charges were calculated correctly
Date of service later than date of death	<ul style="list-style-type: none"> • Check that both the correct dates of service and number of days were billed

Resolving Client Eligibility Problems

When a claim is denied because the client is not eligible for Medicaid, providers should contact Provider Relations (see *Key Contacts*). If Provider Relations shows the client is not Medicaid-eligible, providers should contact the Local Office of Public Assistance (see *Appendix B: Local Offices of Public Assistance* in the *General Information for Providers* manual). If the problem cannot be resolved through the Local Office of Public Assistance or Provider Relations, providers may contact Senior and Long-Term Care (see *Key Contacts*). Providers should make every effort to resolve claim issues within the timely filing limits (see *Timely Filing Limits* in this chapter). For information on correcting and resubmitting claims, see the *Remittance Advices and Adjustments* chapter in this manual.

Other Programs

The Mental Health Services Plan (MHSP) and the Healthy Montana Kids (HMK) Plan do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Submitting a Claim

Electronic Claims

Professional and 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:

- **ACS field software WINASAP 5010.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS 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 ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see Key Contacts).
- **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.

Providers should be familiar with the *Implementation Guides* that describe Federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Websites*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Websites*).

Paper Claims

Clean claims (see *Definitions*) submitted with all of the necessary information are usually paid in a timely manner. Nursing facilities may submit claims on MA-3s, TADs, or CMS-1500s.

MA-3s

Nursing facilities and swing bed providers bill routine services to Medicaid on the MA-3 form. MA-3 forms are used when billing for new residents and coinsurance days. Below are instructions for completing an MA-3. Required fields are indicated by an asterisk (*).

Completing an MA-3 Form		
Entry	Field Name	Instructions
1	Nursing facility – name and address	List facility name and address
2*	Prov. Information	The provider's NPI/API/taxonomy.
3*	Patient	Resident's last name, first name, and middle initial. Do not use nicknames.
4	Sex	F for female or M for male.
5	County	Enter the two-digit county number where the facility is located.
6*	Individual Number	Resident's nine-digit Medicaid ID number
7	Diagnosis	Description of diagnosis
8*	Diagnosis Code	ICD diagnosis code
9*	Date of Birth	Resident's birthdate in MMDDYY format
10*	Date Admitted	Day of admission to the nursing facility
11*	Statement Period	Enter the "from" and "to" dates being billed in MMDDYY format. Do not enter the day of discharge as "to" date.
12*	No. of Days	Number of billable days during the statement period. Billable days do not include unauthorized hospital hold days or unauthorized THV days, or the day of discharge.
13*	Level of Care	Enter 1 for skilled and 2 for intermediate. Medicaid pays the same daily rate regardless of the level of care; however, this field must be completed. Continued-stay reviews indicate whether the facility is a Level 1 or 2. If continued-stay reviews are not available, nursing staff are usually familiar with the level of care.
14*	Total Charges	Number of days multiplied by the Medicaid per diem rate. See the <i>How Payment Is Calculated</i> chapter in this manual for more information on the per diem rate.
15*	Personal Resources	This is the resident's monthly obligation toward nursing facility care.
16*	Net Charges	Subtract the <i>Personal Resources</i> amount from <i>Total Charges</i> and enter the result here.
17*	Provider Signature	Authorized signature. This can be handwritten, stamped, or computer-generated.
18*	Date	Billing date in MMDDYYY format. This date must be later than the "to" date of the statement period (Field 11).

STATE OF MONTANA - PUBLIC HEALTH & HUMAN SERVICES

FOR USE BY NURSING HOMES

PLEASE TYPE OR PRINT

FORM NO. MA-3

NURSING HOME - NAME AND ADDRESS	PROV. INFORMATION.	MAIL TO: MONTANA MEDICAID DEPT. MA-3 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958
---------------------------------	--------------------	--

1	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

2	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

3	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

4	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

5	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

6	PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	<input type="checkbox"/> M <input checked="" type="checkbox"/> X <input type="checkbox"/> F	COUNTY	INDIVIDUAL NUMBER	AUTH.		
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD	
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR TO DAY YEAR	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES		NET CHARGES

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.

I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

TOTAL CHARGES THIS SHEET	
TOTAL CHARGES THIS MONTH	

PROVIDER'S SIGNATURE _____ DATE _____

Turn around documents (TADs)

Turn around documents (TADs) are MA-3 forms pre-completed with billing information for residents who were in the facility the previous month. Providers make applicable changes to TADs, sign them, and submit them to Medicaid for processing (see the *Billing Procedures* chapter in this manual). When submitting TADs to Medicaid, please keep in mind the following:

- A Medicaid *Payment and TAD Schedule* is available on the Provider Information website and shows payment cycles and TAD printing dates.
- Medicaid must receive TADs the day before payment cycle in order to get them processed in that cycle. See the *Payment and TAD Schedule* for payment cycle dates located on the Provider Information website.
- To receive preprinted TADs (including new residents added during the month), providers must have submitted all claims (including new additions) to Medicaid, and the claims must be clean claims that were processed before the TAD printing date. See the *Payment and TAD Schedule* on the Provider Information website.
- After Medicaid receives claims containing new additions to nursing facilities, it takes approximately three to five business days to add the new residents. New residents will be included on the TAD for the following month if the claim for the new addition was processed before the TAD printing date. See the *Payment and TAD Schedule* on the Provider Information website. Medicaid does not guarantee processing or payment within this time frame.
- When the payment cycle is within the first three business days of the month, Medicaid must receive TADs by 1:00 p.m. Mountain Standard Time on the scheduled payment date in order to be processed in that cycle. See the *Payment Schedule* document on the Provider Information website. Sending TADs by overnight mail is recommended.
- Faxed TADs are accepted **only** during months where the first payment cycle is within the first three business days of the month. When faxing TADs, providers must follow these guidelines:
 - Darken and shrink TADs to 96% on your copier before faxing.
 - Feed TADs into the fax machine signature date line first.
 - Medicaid must receive faxed TADs by 1:00 p.m. Mountain Standard Time on the payment cycle date in order to ensure processing.
 - Follow up faxed TADs with a phone call after 1:00 p.m. to ensure faxed copies were received and were legible.
- Even though TADs are received and processed before the payment cycle, Medicaid do guarantee payment since the claim may deny or pend for several reasons. See the *Remittance Advice and Adjustments* chapter in this manual.



Medicaid does not guarantee payment for any claim, since a claim may deny or pend for several reasons.

CMS-1500s

Ancillary services are billed to Medicaid on a CMS-1500 claim form. When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

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

CMS-1500 Claim Form Instructions

Field#	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as it appears on client's Montana Health Care Programs information.
10d*	Client's ID	Enter the client's ID number as it appears on the client's Montana Health Care Programs information.
1a, 9a, 11**	Client's ID	If client's ID is not located in 10d, these three fields are searched for the number.
Provider Information		
17a**	Referring Provider's Passport #	Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI	Enter referring provider's NPI.
24a shaded area	NDC	Enter Qualifier N4 followed by the NDC units qualifier and units as described by the qualifier. (NDC should not have punctuation, dashes, or spaces.)
24i shaded**	ID Qualifier	ZZ for the taxonomy qualifier.
24j shaded**	Taxonomy Code	Enter the taxonomy code for the rendering provider.
24j**	NPI, Rendering Provider	Enter NPI for the rendering provider.
31*	Signature and Date	Enter signature and date.
33*	Billing Provider Info	Enter physical address with a 9-digit ZIP code and phone number.
33a*	NPI	Enter NPI for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis Codes	Enter at least one diagnosis.
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date, even if same.
24b*	Place of Service	Enter the code for place of service.
24c**	EMG	Emergency indicator if applicable.
24d*	Procedure Code	Enter the procedure code used. Enter modifiers if applicable.
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21.
24f*	Charges	Enter the total charge for this line.
24g*	Days/Units	Enter the days or units used for the procedure.
28*	Total Charges	Enter total charges from all line items.

*Required field **Required if applicable

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Moreover, Dottie K.										3. PATIENT'S BIRTH DATE MM DD YY 10 29 15 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same																																																																															
5. PATIENT'S ADDRESS (No., Street) 112 Rocky Rd.										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																																															
CITY Bedrock					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																																																															
ZIP CODE 54321-1234					TELEPHONE (Include Area Code) (406) 765-4321					Employed <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																																																															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 123456789										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																									
14. DATE OF CURRENT: MM DD YY 04 01 04 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. 9954321 17b. NPI 1234567890										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																															
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 318 2 2. 345 80 3. 783 3 4.										23. PRIOR AUTHORIZATION NUMBER																																																																																									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1 04 01 04 04 30 04 32										B4035																				1										425 00 30 6										ZZ										36LP00000X																																							
2 04 01 04 04 30 04 32										B4150																				1										250 00 267 6										NPI										36LP00000X																																							
3																																																		NPI																																																	
4																																																		NPI																																																	
5																																																		NPI																																																	
6																																																		NPI																																																	
25. FEDERAL TAX I.D. NUMBER 99-9999999										SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 123456789										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 675 00										29. AMOUNT PAID \$										30. BALANCE DUE \$ 675 00																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Sally Jones 05/01/04 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (406) 555-5555 Assisted Living Services 112 Eastview Road Anytown, MT 59999-1234 a. 9876543210 b. ZZ 400RT0010X																																																																															

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Agreement

Your signature on the CMS-1500 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).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Mailing Paper Claims and TADs

Unless otherwise stated, all paper claims and TADs are mailed to:

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

All Medicaid claims must be submitted on Department approved claim forms. Nursing Facility MA-3 claim forms are available through Provider Relations (see *Key Contacts*). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations. A *Medicaid Form Order* sheet is available under the *Forms* section of the Provider Information website.

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 NPI/API followed by the client's ID number and the date of service, each separated by a dash:

999999999	- 888888888	- 11182003
Provider NPI	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. (See *Appendix A: Forms* or the Provider Information website.) The number in the paper Attachment Control Number field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Websites*).

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. See the *Companion Guides* located on the ACS EDI Gateway website for more information on electronic transactions (see *Key Websites*). Providers may contact Provider Relations for questions regarding payments and denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the Montana Health Care Programs *Claim Inquiry Form* in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response includes 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).

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 form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors	
Claim Error	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 ID card.
Client name missing	This is a required field (Field 2); check that it is correct.
Provider NPI missing or invalid	The provider NPI is a 10-digit number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim.
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 on a CMS-1500 claim form 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, computer-generated, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	When billing on paper, services covered in this manual require an MA-3 per diem claim form for routine services or a CMS-1500 claim form for ancillary services.
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.
Missing Medicare EOMB	When Medicare is involved in payment on a claim, the Medicare EOMB must be submitted with the claim or it will be denied. When billing electronically, see <i>Billing Electronically with Paper Attachments</i> in this chapter.

Other Programs

The Mental Health Services Plan (MHSP) and the Healthy Montana Kids (HMK) Plan do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Remittance Advice and Adjustment

The Remittance Advice

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 RA cycle. Providers may select a one- or two-week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or line has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic remittance advice

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have Internet access, and be registered for the Montana Access to Health (MATH) web portal. You can access your electronic RA through the MATH web portal by going to the Provider Information website (see *Key Websites*) and selecting Log In to Montana Access to Health. To access the MATH web portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the MATH web portal home page. Due to space limitations, each RA is only available for 90 days.

Paper RA

Paper RAs accompany payment for services rendered. The paper RA is divided into the following sections: RA Notice, Paid Claims, Denied Claims, Pending Claims, and Reason and Remark Codes and Descriptions. See the following sample paper RA and the *Key to the Paper RA* table.

! Electronic RAs are available for only 90 days on the web portal.

! If a claim was denied, read the Reason and Remark Code Description before taking any action on the claim.

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

Sections of the Paper RA	
Section	Description
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 may affect providers and claims.
Paid Claims	This section shows claims paid and any claims paid with denied lines 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 requiring the provider 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 <i>Adjustments</i> 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 column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending Claims	<p>All claims that have not reached final disposition (are still in process) 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 16). 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. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>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.</p>
Reason and Remark Code Description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Vendor NPI	The 10-digit number assigned to the provider by the National Plan and Provider Enumeration System (NPPES)
3. Remittance advice (RA) number	The RA number
4. EFT/CHK	The number of the check issued or the electronic fund transfer
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. 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 00111 11 123 000123</u> A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing facility turn around document, or POS pharmacy claim) 6 = Pharmacy B = Julian date (e.g., April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
10. Service dates	Dates services were provided. If services were performed in a single day; the same date will appear in both columns
11. Unit of service	The number of services rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	Not applicable for nursing facility residents.
16. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, Billed Amount, and Paid Amount	Any deductions, such as personal resources or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

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:

- 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.
- 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. Please attach a note stating that the check is to pay off a credit balance and include your NPI. Send the check to the attention of the Third Party Liability Unit (see *Key Contacts*).

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers 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, modify, or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter. A clean claim must be submitted within timely filing limits in order for the provider to be paid. If a claim denies, and you have reviewed the claim and believe that it is a clean claim, and Provider Relations and the county office of public assistance cannot resolve it, contact Senior and Long-Term Care for review of the claim (see *Key Contacts*). If there are circumstances beyond the facility’s control (e.g., eligibility issues or resource adjustments) that causes a claim to continue to deny past the timely filing limit, and a clean claim was originally submitted within the timely filing limit, you may contact Senior and Long-Term Care and request a review of the claim.

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 the NPI/API or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.



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



Rebill denied claims only after appropriate corrections have been made.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).
- ***Line Denied.*** When an individual line is denied on a multiple-line CMS-1500 claim, correct any errors and rebill Medicaid for the denied line only. An adjustment form should be used for claims with denied lines that have codes that must be billed together (see *Adjustments*).
- ***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 the claim.

How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

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 *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS 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 or 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 over will be a 2, indicating an adjustment. See the *Key to the Paper RA* earlier in this chapter. Adjustments are processed in the same time frame as claims.

If an adjustment needs to be made after the timely filing limits, send documentation explaining the reason the adjustment needs to be made and what adjustment is being requested to Senior and Long-Term Care. They will determine whether an adjustment is appropriate and either force special handling or initiate a gross adjustment.

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., client ID, NPI, date of service, procedure code, diagnoses, units).

How to request an adjustment

To request an adjustment, use the *Montana Health Care Programs Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual).
- 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.

Sample Adjustment Request

Completing an Adjustment Request Form

1. Download the *Individual Adjustment Request* form from the Provider Information website. Complete Section A with provider and client information and the claim’s ICN number (see table on following page).

2. Complete Section B with information about the claim. Remember to 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.



Updated 6/4/2011

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 (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 & Address Assisted Living Services Name 112 Eastview Road Street or P.O. Box Anytown MT 59999 City State ZIP	3. Internal Control Number(ICN) 00404011250000600
2. Client Name Jane Doe	4. NPI/APL 1234567
	5. Client ID Number 123456789
	6. Date of Payment 10/01/01
	7. Amount of Payment \$ 180.00

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

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	2	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)	Line 3	09/01/04	09/15/04
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: *Mary Bender* Date: 10/15/04
 When the form is complete, attach a copy of the RA and a copy of the corrected claim.

Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604

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, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Client Name	The client's name is 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.* NPI/API	The provider's NPI/API.
5.* Client ID Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field 5 (see the sample RA earlier in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field 17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of Service (number of patient days)	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 are incorrect, complete this line.
3. Dates of Service (DOS)	If the dates of service are 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 – 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 TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, or if clarification is necessary, complete this line.

* Indicates a required field

- 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 an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways: by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* earlier in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They are usually initiated by the Department and 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 (Title XIX, SEC. 1923. [42 U.S.C. 1396r-4]).
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the RA (*RA Notice* section), the monthly *Claim Jumper*, or provider notices. 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 may receive their Medicaid payment and RAs either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

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 RA 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 table on the following page. One form must be completed for each NPI.

Once electronic transfer testing shows payment to the provider’s account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.



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

Required Forms for EFT and/or Electronic RA All four forms are required for a provider to receive weekly payment			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health web portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	<ul style="list-style-type: none"> • Provider Information website • Provider Relations (see <i>Key Contacts</i>) 	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"> • Provider Information website (see <i>Key Websites</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	<ul style="list-style-type: none"> • Provider Information website • ACS EDI Gateway website (see <i>Key Websites</i>) 	ACS address on the form

Other Programs

The Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

How Payment Is Calculated

Nursing Facility and Swing Bed Payment

Medicaid pays nursing facilities and swing bed providers a per diem rate for routine services, less the resident's personal resource amount. Medicaid also pays the facility's cost for some ancillary supplies. Per diem rates are different for each facility, depending on the facility's case mix index.

Nursing facility per diem rate (ARM 37.40.307)

Each facility's per diem rate is individually calculated and is made up of two components, the *operating component* and the *direct resident care component*. A statewide nursing facility rate is calculated annually on the state fiscal year (July 1–June 30) using a price-based reimbursement methodology. The *operating component* is 80% of the statewide nursing facility rate. The *direct resident care component* is 20% of the statewide rate, and is adjusted for the acuity of the Medicaid residents served in each facility.

Nurse aide training reimbursement

Medicaid does not reimburse individual nurse aides; nursing facilities are reimbursed for their nurse aide training and testing costs through their per diem rate. These costs are reported on the facility's cost report and become part of the cost consideration in calculating the facility Medicaid per diem rate. The State must report nurse aide training and testing costs separately to the Federal government as part of the Federal reimbursement process. For more information on reporting costs, see *Nurse aide cost reporting* in the *Covered Services* chapter of this manual.

Swing bed hospital per diem rate (ARM 37.40.406)

The per diem rate for swing bed facilities is calculated on the calendar year and is the same for all facilities. The rate is the average Medicaid per diem rate paid to nursing facilities for the previous calendar year.

Ancillary items (ARM 37.40.330)

Medicaid pays for some ancillary supplies (separately billable items) at the facility's cost. Medicaid only pays the amount shown on the invoice billed to the facility, with no added charges or markups. For purposes of combined facilities where the nursing facility acquires supplies through the hospital, the direct cost will be the hospitals invoiced cost with no indirect markup. See the nursing facility/swing bed fee schedule for a list of covered items.

Medicaid does not pay for ancillary supplies when the resident's nursing facility stay is also covered by Medicare Part A.

Medicare coinsurance days (ARM 37.40.307)

Medicaid pays for Medicare coinsurance days at the facility's per diem rate or the Medicare coinsurance rate, whichever is lower, less the resident's personal resource amount.

Interim Per Diem Rates (ARM 37.40.307 and ARM 37.40.326)

New facilities that have not filed a cost report for a period of at least six months participation in the Medicaid program will be paid at the statewide average rate established for the current rate year.

When a change in provider occurs, the per diem rate for the new provider is the same rate paid to the previous provider. For more information on provider changes, see the *Change in provider* section of the *Covered Services* chapter in this manual.

Payment to Out-of-State Facilities (ARM 37.40.337)

When payment is prior authorized, out-of-state facilities are paid at the Medicaid rate established by the Medicaid agency in the state where the facility is located, less the resident's patient contribution.

Other Programs

The Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services and payment. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Appendix A: Forms

- **Montana Health Care Programs *Individual Adjustment Request***
- **Montana Health Care Programs *Claim Inquiry Form***
- ***Level I Screen (DPHHS-SLTC-145)***
- ***Level of Care Determination (DPHHS-SLTC-86)***
- ***Notice of Transfer or Discharge***
- ***Monthly Nursing Facility Staffing Report (DPHHS-SLTC-015)***
- ***Request for Therapeutic Home Visit Bed Reservation (DPHHS-SLTC-041)***
- ***Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours (DPHHS-SLTC-042)***
- ***Request for Nursing Facility Bed Reservation During Resident's Temporary Hospitalization (DPHHS-SLTC-052)***
- ***Nurse Aide Certification/Training and Competency Evaluation (Testing) Survey Form***
- ***Request for Blanket Denial Letter***
- ***Paperwork Attachment Cover Sheet***

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 (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.

<p>1. Provider Name & Address</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Street or P.O. Box</p> <p>_____</p> <p>City State ZIP</p>	<p>3. Internal Control Number (ICN)</p> <p>_____</p> <p>4. NPI/API</p> <p>_____</p> <p>5. Client ID Number</p> <p>_____</p> <p>6. Date of Payment _____</p> <p>7. Amount of Payment \$ _____</p>
<p>2. Client Name</p> <p>_____</p>	

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

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
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: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.



Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604



Montana Health Care Programs Claim Inquiry Form

Provider Name _____
 Contact Person _____
 Address _____
 Date _____
 Phone Number _____
 Fax Number _____



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

NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____
---	---

NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____
---	---

NPI/API _____ Client Number _____ Date of Service _____ Total Billed Amount _____ Date Submitted for Processing _____	ACS Response _____ _____ _____ _____ _____ _____
---	---

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

Fax to: (406) 442-4402

STATE OF MONTANA
 Department of Public Health and Human Services

Level I Screen

Please read the instructions on the second page of this form for details.
 History and physical (H&P) and list of medications must be included with this fax.

Fax: 1-800-413-3890/443-4585

Telephone: 1-800-219-7035/443-0320

Applicant's Name _____ SSN _____ Date of Birth _____
 Diagnosis Primary _____ Physician _____
 Secondary _____ Provider _____
 Other _____ City _____
 Is there a current H&P? [] Yes [] No If no, call Mountain-Pacific Quality Health for instructions.

- A. MENTAL ILLNESS** YES NO
- Does the individual have a diagnosis of serious mental illness (MI)? [] []
 Diagnosis _____
 - Does the individual have any indications of mental illness? If yes, describe. [] []

 - If the applicant has a diagnosis or indication of mental illness, does the individual have a primary diagnosis of dementia? [] []

 - Is the individual on antipsychotic medication? If yes, what is individual's a) current mental status; b) reasons for medications; c) length of time on medications. [] []

 - Is individual on an antidepressant? If yes, indicate a) history of depression; b) length of depression; c) current depressive status; d) whether depression is situational due to circumstances. [] []

- B. MENTAL RETARDATION OR RELATED CONDITIONS** YES NO
- Does the individual have a diagnosis of mental retardation (MR)? [] []
 - Does the individual have a diagnosis of a related condition (e.g., cerebral palsy, autism, seizures)? [] []
 Has the individual ever been referred to or served by an agency/institution serving persons with
 - mental retardation or related conditions? [] []
 - Does the individual have any indications of mental retardation or a related condition? [] []
 - Does the individual have a brain injury? [] []

C. INFORMATION SOURCE
 The information above has been provided by _____ Date _____
 Agency _____ Phone No. _____ Fax No. _____

D. APPROVED YES [] NO []
 Referral for Level II MI [] MR [] MI/MR []
 MI referral made to: _____ Date _____
 MR referral made to: _____ Date _____
 Comments: _____

 Name: _____ Date _____

STATE OF MONTANA
Department of Public Health and Human Services

INSTRUCTIONS:

A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment; **and** as a result of the diagnosed mental condition, the applicant presently suffers from significant impairment in at least two of the following functional areas:

1. Ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;
2. Ability to maintain community living without dependence on public support systems and monitoring;
3. Ability to develop and maintain personal relationships and support systems;
4. Ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities.

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required by these persons. It is manifested before the person reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

- C. Self-explanatory.
- D. Do not fill out. For Mountain-Pacific Quality Health use only.
- E. Do not fill out. For Mountain-Pacific Quality Health use only.

LEVEL OF CARE INSTRUCTIONS:

A level-of-care determination is required prior to Medicaid making payment to a nursing facility or the Home- and Community-Based Services Program (waiver). Any individual currently eligible, applying, or who intends to apply for Medicaid needs to request a determination. **Submit the DPHHS-SLTC-86 (Level-of-Care Determination) with at least identifying information via fax or phone to Mountain-Pacific Quality Health.** They will notify the applicant, referral source, and county Office of Human Services of the results.

STATE OF MONTANA
Department of Public Health and Human Services
Level-of-Care Determination

Program Requested: **Nursing Facility** **HCBS (Initial)** **HCBS Yes/Discretionary** **Unknown**

Identifying Information

Applicant SSN: _____
Address: _____
City/State/ZIP: _____
Phone: _____
DOB _____ Age: _____ Sex: _____
Medicaid Status: _____
Veteran: Yes No
County of Application: _____
Nursing Facility Admit Date: _____
Medicare Skilled? ____ Date _____
Previous Medicaid Screen? ____ Date _____

Date of Request: _____
Anticipated LOS: _____
Screen Request By: _____
Agency: _____ Phone: _____
Applicant Location: _____
Significant Other: _____
Relationship: _____ Phone: _____
Address: _____
City/State/ZIP: _____
Other Contacts: _____

Health Care Professional: _____ Phone: _____
Medical Diagnoses/Summary: _____

Special Treatments/Medications/Therapies/Equipment: _____

Social and Other Information: _____

Dementia: Yes No Traumatic Brain Injury: Yes No Communication Deficit: Yes No

For Mountain-Pacific Quality Health Use Only

Review Start Date: _____
NF Level of Care: Yes No Level I Date: _____
Temporary Stay: _____ to _____
RPO Technical Assist: RPO Onsite:
Comments: _____

Criteria Met: _____

HCBS Referral: Yes No Date: _____
CMT: _____
NF Placement: _____
Effective Date: _____
Screener: _____ Complete Date: _____
Mountain-Pacific Quality Health Contact Name/Phone
Number
1) _____
2) _____
3) _____
4) _____

Compliance Review Yes No By: _____ Date: _____
cc: Case Management Team _____; Nursing Facility _____; Referral Source _____

Rating Scale Definitions:

Follow this scale when completing the Functional Assessment Portion of the Screen.

- 0 = Independent: The individual is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting or supervision.
- 1 = With Aids/Difficulty: To fulfill ADL/IADL, the individual requires consistent availability of mechanical assistance or the expenditure of undue effort.
- 2 = With Help: The individual requires consistent human assistance, prompting or supervision, in the absence of which the ADL/IADL cannot be completed. The individual does however actively participate in the completion of the activity.
- 3 = Unable: The individual cannot meaningfully contribute to the completion of the task.

Follow this scale when completing the Functional Capabilities Portion of the Screen.

- 0 = Good: Within normal limits.
- 1 = Mild Impairment: Some loss of functioning, however, loss is correctable and/or loss does not prevent the individual's capacity to meet his/her needs.
- 2 = Significant Impairment: Loss of functioning that prevents the individual from meeting his/her needs.
- 3 = Total Loss: No reasonable residual capacity.

Functional Assessment

Coding for Functional Assessment: 0 – Independent 1 – With Mechanical Aids 2 – With Human Help 3 – Unable

MOUNTAIN-PACIFIC QUALITY HEALTH USE ONLY

	Current Status/Service	Adequate (circle)	Comments
	Bathing	Yes No	
	Mobility	Yes No	
	Toileting/ Continence	Yes No	
	Transfers	Yes No	
	Eating	Yes No	
	Grooming	Yes No	
	Environmental Modification	Yes No	
	Medication	Yes No	
	Equipment	Yes No	
	Dressing	Yes No	
	Respite	Yes No	
	Shopping	Yes No	
	Cooking	Yes No	
	Housework	Yes No	
	Laundry	Yes No	
	Money Management	Yes No	
	Telephone	Yes No	
	Transportation	Yes No	
	Socialization/ Leisure Activities	Yes No	
	Ability to Summon Emergency Help	Yes No	

Patient Mental Status: (check all appropriate responses) Oriented: Person Place Time

Coding for Functional Capabilities: 0 – Good 1 – Mild Impairment 2 – Severe Impairment 3 – Total Loss

- | | | | |
|------------------------------|----------------------------|---------------------------|---|
| () Occasionally disoriented | () Inappropriate Behavior | () Medication Misuse | () Sleep Problems |
| () Disoriented | () Confused | () Alcohol/Drug Misuse | () Worried/Anxious |
| () Unresponsive | () Long-Term Memory Loss | () Isolation | () Loss of Interest |
| () Impaired Judgment | () Short-Term Memory Loss | () Danger to Self/Others | 24-Hour Supervision Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| () Ambulation _____ | () Hearing _____ | () Speech _____ | () Vision _____ |

Respiratory Status: _____

Comments: _____

NOTICE OF TRANSFER OR DISCHARGE

Resident's Name Date

Nursing Facility Name Family Member/Legal Representative

Nursing Facility Address

You are being provided this notice to inform you that, for the reasons explained below, you will be transferred or discharged from this facility.

You will be transferred/discharged for the following reason(s):

A list of the permitted reasons for transfer and discharge is found at 42 CFR 483.12(a)(2).

Transfer/Discharge Location (Mark and complete one of the following.)

_____ You will be _____ to the following location _____
Transferred/Discharged

Placement Location/Facility

on _____
Effective Date of Transfer/Discharge

OR

_____ The location to which you will be transferred or discharged is unknown at the time of this notice. This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

_____ Bed hold information has been provided to the resident regarding transfer/discharge.

BY: _____ TITLE: _____
Facility Representative Signature

ADVOCATES/ASSISTANCE

For assistance in understanding your rights or filing an appeal, contact the State Long-Term Care Ombudsman:

Tom Sweely
 Montana Long-Term Care Ombudsman
 P.O. Box 4210
 Helena, MT 59604-4210
 1-800-332-2272
 406-444-7785

If you are developmentally disabled or mentally ill and need assistance understanding and asserting your rights, contact the Montana Advocacy Program:

Montana Advocacy Program
 P.O. Box 1680
 316 North Park Avenue, Room 211
 Helena, MT 59624-1680
 1-800-245-4743
 406-449-2344

FAIR HEARING RIGHTS

If you disagree with the facility's decision to transfer or discharge you, **you may request a hearing within 30 days** of the date of this letter. A hearing may be requested for you, by a family member, a friend, legal counsel, an advocate, or other representative of your choice. Your request must be mailed or delivered to:

Office of Fair Hearings
 Department of Public Health and Human Services
 P.O. Box 202953
 2401 Colonial Drive, 3rd Floor
 Helena, MT 59620-2953

Upon receipt of your timely request, a hearings officer will be appointed by the Department of Public Health and Human Services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility's decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the Department's Senior and Long-Term Care Division at (406) 444-4077.

REQUEST FOR A FAIR HEARING

If you would like to request a fair hearing, you may fill out the information below and mail it to the Office of Fair Hearings address above.

TO: Fair Hearings Officer. I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.

Please print information other than signature.

Nursing Facility Name	Resident's Name

Requestor's Name (if different than resident's)	

Requestor's Signature	Date of Request

Requestor's Address	Telephone Number

MONTHLY NURSING HOME STAFFING REPORT

Montana State Department of Public Health and Human Services
Nursing Facility Services Bureau
P.O. Box 4210
Helena, MT 59604-4210
Phone 406-444-4077 Fax 406-444-7743

Facility Name _____ NPI/API _____
 Facility Address _____ City _____
 Month Ending _____

STAFFING REQUIREMENT: Facilities must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

HOURS/EMPLOYEES DURING REPORTING PERIOD

Please list the total number of hours worked and number of employees in each of the listed categories for the month:

	TOTAL EMPLOYEE HOURS	TOTAL CONTRACT HOURS	TOTAL HOURS WORKED
RNs			
LPNs			
CNAs/ AIDES			
TOTAL			

	NUMBER OF FACILITY EMPLOYEES	NUMBER OF CONTRACT STAFF	TOTAL NUMBER OF RNs, LPNs, and CNAs
RNs			
LPNs			
CNAs/ AIDES:			
TOTAL			

Note: Include all RN, LPN and AIDE hours for direct care staff. Director of Nursing hours may be included if spent dispensing meds, on rounds or charting - do not include administrative hours. Do not include time spent on in-service training, time for laundry or maintenance staff even if they are certified as aides or other non-direct care staff. Contract employees / hours are direct care hours provided by agency staff, temp. service staff, etc. who are not employees of the facility.

PATIENT DAYS

Please list the total number of occupied days by each category for the month:

LEVEL OF CARE	MEDICAID	MEDICARE	LONG-TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (e.g., Workers Compensation Ins., Auto Ins., Medigap Ins.)	TOTAL
Skilled Care (SNF)							
Nursing Care (NF)							
Hospice							
Billable Bed Holds							
Other							
TOTAL (5 rows)							
Medicare Coinsurance Payments (duplicated)							

CERTIFICATION

I certify that this information, to the best of my knowledge, is true, accurate, and complete:

Signed: _____ Title: _____

Date: _____

Mail this form to Senior and Long-Term Care Division, P.O. Box 4210, Helena, MT 59604-4210

TIME LINE: This form is to be submitted to the department within 10 days following the end of each calendar month.

STAFFING REPORTS (DPHHS-SLTC-015): DPHHS-SLTC-015 Instructions

Staffing Report information is used to document occupancy levels for budget projections. It is very important that it be filled out accurately and submitted by the 10th of the month. *Please mail or fax completed forms to the Senior- and Long-Term Care Division using information on the top of the form. If you are using the electronic version you may e-mail the form using the e-address included on the electronic version of the form.*

Hours/Employee Info:

The information on nursing staff hours and numbers of employees is being collected for statistical purposes. However, if staffing level information or reporting should ever become mandated, this is the documentation that will be used to track compliance with staffing minimums.

1. The staffing hours that should be reported are direct patient care hours as described on the form. Under number of employees, we want actual numbers of people providing the service, not Full Time Equivalent (FTEs).
2. If a facility uses contract staff (e.g., pool staff, travelers, temporary agency staff), those hours and people should be reported as well since they contribute to patient care. The facility should list these hours and individuals under contract hours and staff, in the category of employee that is being contracted for.
3. When the data is compiled, an FTE calculation will be made. Occasionally there may be overtime situations where the FTE will be greater than the number of employees. If the FTE calculation is significantly more than the number of employees reported, we will ask the facility to double-check the figures for accuracy.

The 'Patient Days' section:

Tracks census days by payee classification. Payer source is across the top and level of care is down the side.

1. Level of care: SNF (Skilled Nursing Facility) meets the Medicare requirements for skilled care.
 - Medicare days should be reported on the SNF line unless they are exceptions to the skilled criteria (such as hospice).
 - Medicaid days meet the requirements for billing Medicaid and are either skilled care (SNF) or intermediate care (NF) or billable hold days (Bed Hold), (Hospice) these days are paid by the hospice provider for Medicaid eligible residents. Use (other) for nonbillable but unavailable bed days (such as hospital hold days when facility is not full with a waiting list)
2. Payer source: Medicaid, Medicare, Long-Term Care Insurance, Veterans, Private Pay, or Other. The 'Other' category includes all payer sources not individually listed (e.g., auto insurance, workers comp. insurance)
 - Please do not double report bed days in the first 5 lines. Choose the most appropriate category (i.e., the primary payer) and use that.
 - If a resident is dually eligible and Medicaid is being billed for copay days, enter the days under Medicare and on Line 7 (Medicare coinsurance row), in the Medicaid column. If the resident is Medicare with private pay or private insurance, enter the days under Medicare and the coinsurance in the appropriate payer column / Medicare coinsurance row.
 - Do not report copayments or noncovered services under private pay.
 - The total bed days, reported in the first five (5) lines, will be divided by the number of days in the month for an average occupancy and compared to your facility's licensed beds.

Please use these criteria for filling out the staffing report from now on. There is no need to revise forms submitted previously. If you have any questions, please contact SLTC (see *Key Contacts* in this manual).

LEVEL OF CARE	MEDICAID	MEDICARE	LONG TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (Work Comp Ins., Auto Ins, Medigap, etc)	TOTAL
Skilled Care (SNF)		<i>Most if not all Medicare Days will be entered here.</i>					
Nursing Care (NF)							
Hospice	<i>Hospice provider pays for Medicaid eligible Resident</i>						
Bed Holds	<i>Billable Bed Holds (THV & HH)</i>						
Other	<i>Non-Billable Bed Holds (HH if not full and THV > 24 days or not pre-approved > 72 hr visits)</i>						<i>This total divided by days in month to calculate avg. occupancy</i>
TOTAL (lines 1-5)							
Medicare Co-Insurance Payments (duplicated reporting)	<i>Medicare co-ins. days for dually eligible residents</i>		<i>Co-insurance days for Medicare covered days (21-100)</i>			<i>Co-insurance days for Medicare covered days (21-100)</i>	

Please use these criteria for filling out the staffing reports. If you have any questions please feel free to contact SLTC (see Key Contacts in this manual).

Bed Hold Forms

The 24-day allotment for THVs (Therapeutic Home Visits) begins July 1 and ends June 30. Submit forms to the address on the form.

It is the facility's responsibility to make sure that all forms are signed and received by the Senior and Long-Term Care Division within 90 days of the first day of the resident's visit or hospitalization. Most forms will be returned to the facility within a two-week time period. If you have not received your forms, you may want to call Senior and Long-Term Care and make sure that the Department received your request. For more information on obtaining authorization for these services, see the *Prior Authorization* chapter in this manual. If you have any questions regarding these forms, call (406) 444-4077 or (406) 444-3997.

DPHHS-SLTC-041 Request for Therapeutic Home Visits Under 72 Hours

Use this form when a resident leaves the facility for under 72 hours (3 days). Complete the DPHHS-SLTC-041 monthly, and send the yellow copy (or photocopy) to the Nursing Facility Services Bureau (see *Key Contacts*). To be reimbursed for these visits, this form must be received in our office within 90 days of the resident's first day of absence. The facility will not receive a return copy of this form unless a problem arises.

DPHHS-SLTC-042 Request for Therapeutic Home Visits in Excess of 72 Hours

Use this form when a resident leaves the facility longer than 72 hours (3 days). A visit that is over 72 hours must be prior-authorized by the resident's physician and the Department **before** the resident leaves the facility. Prior authorization can be obtained by calling (406) 444-3997 or (406) 444-4077 or by sending DPHHS-SLTC-042 to the Department before the date of departure. A prior authorization by phone is only valid if the Department also receives the DPHHS-SLTC-042 form within 90 days. If you send the DPHHS-SLTC-042 form without prior authorization by phone, it must be received by the Department before the resident leaves the facility. To be reimbursed for these days, the form must be submitted within 90 days from the resident's first day of absence and signed by an authorized designee of the Senior and Long-Term Care Division. If prior authorization is not obtained for a THV in excess of 72 hours, the entire visit will be denied, and any reimbursement made for these days will be recovered. Send the white and yellow copies or two photocopies. The facility will receive the white copy back with the signature of the authorized designee.

If the resident leaves the facility unexpectedly on the weekend for a visit longer than 72 hours, you must call in on the next business day to receive prior authorization. If a resident left the facility on a visit, and is unexpectedly delayed, you must phone the Department and either get a prior authorization if the visit is going to be over 72 hours or obtain an extension for the visit. THVs cannot exceed 24 days in a period from July 1 through June 30.

DPHHS-SLTC-052 Request for Bed Hold During Hospitalization

Use this form when a Medicaid resident is temporarily receiving medical treatment in another facility (usually a hospital; not another nursing facility or swing bed), but is expected to return to the facility. This form must be submitted within 90 days of the resident's first day of absence and must be accompanied by a current waiting list. Send the white and yellow copies or two photocopies to the Department. The facility will receive the white copy back with the authorizing signature. Facilities may only bill for hospital hold days if they are currently full with a waiting list.



Medicaid does not pay for more than 24 THV days in a state fiscal year (July 1 - June 30).

STATE OF MONTANA
Senior and Long-Term Care Division
Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210
Phone (406) 444-4077

Request for Therapeutic Home Visit Bed Reservation

Name of Facility

Address of Facility

Facility ID Number

I certify that a bed is being held for the following resident(s) and the care plan for each resident listed provides for therapeutic home visits. I understand there is a seventy-two (72) hour limitation per visit and a limit of twenty-four (24) days annually. Longer hours per absence must be prior authorized.

Name of Resident	Social Security Number	Absent		Total Days Used Year to Date	Name of Attending Physician
		From	To		

Signature of Administrator/Designee

Date

Authorizing Signature

Date

INSTRUCTIONS

If residents listed are within the twenty-four (24) day annual limit and this visit is no more than seventy-two (72) hours, mail **copy only** to the Senior and Long-Term Care Division. Keep original for your file. Submit on a monthly basis. Request must be submitted to the Department within 90 days after the first day of the requested bed hold period.

Prior authorization requests for absences in excess of the 72-hour per visit limitation must be submitted to the Senior and Long-Term Care Division, Department of Public Health and Human Services, for review and authorization (See DPHHS-SLTC-042).

Total Days Used Year to Date refers to the State Fiscal Year (July 1–June 30).

To compute the number of Therapeutic Home Visit days used on this visit, **do** count the day the resident leaves; **do not** count the day of return. Add the days of the current visit to days used previously in the fiscal year (July 1–June 30) for Total Days Used Year to Date. Example: If a resident leaves Friday and returns Sunday, the days absent are counted as two (Friday and Saturday). For billing instructions, please refer to the *Nursing Facility and Swing Bed Services* manual.

**NURSE AIDE CERTIFICATION/TRAINING AND
COMPETENCY EVALUATION (TESTING) SURVEY FORM**

Directions: Please provide the following information related to documentable nurse aide certification training and competency evaluation (testing) costs for the **FY 2005 1st quarter, July 1, 2004 through September 30, 2004**. The costs are divided into four categories:

1. Equipment and Supplies – Includes materials purchased that directly relate to providing certification training. A self-paced instructional package such as ProCare is an example of this kind of material. Purchases should be supported by documentation in the form of receipts or purchase orders.
2. Facility Personnel Costs – Includes costs for wages and benefits of facility personnel **who provide certification training**. Expenditures in this category should be documented through time sheets, payroll records or other appropriate ways of tracking staff activities.

Consistent with Federal guidelines, this category **does not include salaries of nurse aides in training or replacement aides** for those in training or testing status; **nor does it include required ongoing education**.

Salaries of NF administrators or other NF personnel are not to be considered unless they are conducting the State-approved, in-house training program. In that instance, the portion of the person's salary that is attributable to the Nurse Aide Training and Competency Evaluation Program (NATCEP) is claimable as an administrative cost.

No indirect costs (supervisory time or any other allocated indirect cost) may be claimed. Only direct salaries, utilities, space, etc. (Space must be 100% dedicated to training functions.) required to provide training/testing may be claimed. All directly-allocable costs, including space, utilities, and salaries of personnel not involved full-time in this task, must be documented to support an acceptable allocation methodology between nursing facility operations and NATCEP.

3. Sub-Contracted Services – Includes non-facility personnel or other costs associated with providing training. Examples include tuition expenses, consultant costs, and travel expenses for nurse aides who travel to other locations for training, and nurse aide reimbursement costs. Expenditures in this category should be documented through invoices, receipts, purchase orders or contracts.
4. Competency Evaluation/Testing – Includes cost of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing).

SAMPLE ONLY

Amount: List the total amount incurred for each category of expenditure.

Description: Provide a brief explanation of what is contained in this category of expenditure (e.g., Procure, training tapes, consultant fees, testing fees).

First Quarter FY 2005 Costs (July 1, 2004 through September 30, 2004)

Please return completed form by **November 1, 2004** to:

Becky McAnally, Human Services Specialist
 Senior and Long-Term Care Division
 Department of Public Health and Human Services
 P.O. Box 4210
 Helena, MT 59604-4210

Effective July 1, 1998, testing fees paid to headmaster will be included on this form.

CATEGORY	AMOUNT	DESCRIPTION
1. Supplies and Equipment:	\$	
2. Facility Personnel:	\$	
3. Sub-Contracted Services:	\$	
4. Number of CNAs Trained During Quarter:		
5. Competency Evaluation Testing	\$	
6. Number of CNAs tested during Quarter:		
Signature of Administrator:		
Facility:		
Facility Medicaid Provider #	City:	

ARM 37.40.322 (2)(b) states “if a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the Department may withhold reimbursement payments in accordance with ARM 37.40.346 (4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.”

Contacts for Further Information about NATCEP or CEP

Questions about the nurse aide registry and State-approved NATCEP and CEP programs should be directed to:

Quality Assurance Division
Department of Public Health and Human Services
P.O. Box 202951
Helena, MT 59620-2951
(406) 444-2037 or 406-444-4980 Phone
<http://dphhs.mt.gov/cna/index.shtml>

Questions about Medicaid reimbursement should be directed to:

Senior and Long-Term Care Division
DPHHS
P.O. Box 4210
Helena, MT 59604-4210
(406) 444-4077 Phone

**REQUEST FOR BLANKET DENIAL LETTER
ACS – State of Montana Medicaid**

Effective Date Requested _____ Provider / NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____

2. _____

3. _____

4. _____

5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Please fax all requests to (406) 442-0357.

Request must include an EOB stating the services are not covered.

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 ACS.

The *Paperwork Attachment Control Number* must be the same number as the *attachment control number* on the corresponding electronic claim. This number should consist of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-999999999-999999999/Atypical Provider ID: 9999999-999999999-99999999).

This form may be copied or downloaded from the Provider website (<http://medicaidprovider.hhs.mt.gov/>). If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

Completed forms can be mailed or faxed to: ACS
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.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

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

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

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

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, one of the 6 Designated Standards Maintenance Organizations (DSMO), that has 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.

Adjustment

When a claim has been incorrectly paid, the payment amount can be changed by submitting an adjustment request.

Administrative Review

Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing.

The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

Administrative Rules of Montana (ARM)

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

Administrator

The person licensed by the State as a nursing facility or hospital administrator with daily responsibility for operation of the facility. This person may be someone other than the titled administrator of the facility.

Assignment of Benefits

When a provider accepts the maximum allowable charge offered for a given procedure by the insurance company, it is said that the provider accepts assignment.

Audit

A formal or periodic verification of accounts.

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. Authorization may be required before billing for a service or before providing a service. *Prior authorization* is authorization required before providing and/or billing Medicaid for a service.

Basic Medicaid

Clients with Basic Medicaid have limited Medicaid services. See *Appendix A: Medicaid Covered Services* in the *General Information for Providers* manual.

Carrier

A private insurance company.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the State Medicaid program. Formerly the Health Care Financing Administration (HCFA).

Children's Special Health Services (CSHS)

CSHS provides assistance for children with special health care needs. CSHS assists in paying for medical expenses related to specific conditions, specialty clinics, and finding resources. Medicaid-eligible children do not receive assistance with medical expenses from CSHS, but specialty clinics are open to all children with special health care needs. CSHS is funded by Title V, the Maternal and Child Health Block Grant.

Claims Attachment

Supplemental information about the services provided to a client that supports medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim.

Claims Clearinghouse

When a provider contracts with a clearinghouse, the clearinghouse supplies the provider with software that electronically transmits claims to the clearinghouse. The clearinghouse then transmits the claims to the appropriate payers.

Clean Claim

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

Client

An individual enrolled in a Department medical assistance program.

Coinsurance

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

Companion Guide

A document provided by some health plans to supplement or clarify information about HIPAA standard transactions (available on the ACS EDI Gateway website).

Copayment

The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

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, usually in the form of a flat fee.

CPT – Current Edition

Physicians' Current Procedural Terminology reference manuals contain procedure codes that are used by medical practitioners in billing for services rendered. These books are published by the American Medical Association.

Credit Balance Claims

Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers

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

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. 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 & Periodic Screening, Diagnosis & Treatment (EPSDT) Program

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

Electronic Data Interchange (EDI)

The communication of information in a stream of data from one party's computer system to another party's computer system.

Electronic Funds Transfer (EFT)

Payment of medical claims that are deposited directly to the provider's bank account.

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.

Definitions and Acronyms

Experimental

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

Explanation of Benefits (EOB) Codes

A three-digit code which prints on a Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The EOB codes are found at the end of the RA.

Explanation of Medicare Benefits (EOMB)

A notice sent to providers informing them of the services which have been paid by Medicare.

Fair Hearing

Providers may request a fair hearing when they believe the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearing officer, attorneys, and witnesses for both parties.

Fiscal Agent

ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.85 *et seq.*

Full Medicaid

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

Gross Adjustment

These adjustments are done in a lump-sum payment or reduction without regard to individual claims.

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. citizen-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 (ACS) that handles Medicaid provider relations and claims processing.

HCPCS

Acronym for the Healthcare Common Procedure Coding System, and is pronounced “hick-picks.” There are three types of HCPCS codes:

- Level 1 includes the CPT codes.
- Level 2 includes the alphanumeric codes A–V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT coding.
- Level 3 includes the alphanumeric codes W–Z which are assigned for use by State agencies (also known as local codes).

Health Improvement Program

An enhanced primary care case management program that is part of Passport to Health. Services for high-risk and/or high-cost Medicaid and HMK*Plus* Passport patients provided by nurses and health coaches to prevent or slow the progression of disease, disability, and other health conditions, prolong life, and promote physical and mental health. Services are provided through community and tribal health centers on a regional basis and include health assessment, care planning, hospital discharge planning, help with social services and education, and support for clients in self-management of health conditions. Predictive modeling software and provider referral are used to identify patients with the most need.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

B.4

ICD – Current Edition

The International Classification of Diseases reference manuals contain diagnosis codes used in coding claims and the procedure codes used in billing for services performed in a hospital setting.

Implementation Guide (IG)

The official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented (available on the Washington Publishing Company website).

Indian Health Services (IHS)

IHS provides Federal health services to American Indians and Alaska Natives.

Internal Control Number (ICN)

The unique number assigned to each claim transaction that is used for tracking.

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

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled 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 and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

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.

Newsletter

An informational letter sent to providers (such as the Montana Health Care Programs *Claim Jumper* or the *Passport to Health* provider newsletter).

Nursing Facility Services

Services provided by a nursing facility in accordance with 42 CFR, Part 483, Subpart B.

Nurse First Advice Line

A 24/7 nurse line. Clients can call in with general health questions, medication questions, or questions about illness or injury. If the caller or person they are calling about is symptomatic, a registered nurse follows clinically based algorithms to an end point care recommendation. The care recommendation explains what level of health care is needed, including self-care. If self-care is recommended, clients are given detailed self-care instructions.

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 primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client’s health care needs.

Patient Contribution

Also called *personal resource*, this is the total of all of the resident’s income from any source available to pay for the cost of care, less the resident’s personal needs allowance.

Patient Day

A 24-hour period that a person is present and receiving nursing facility services regardless of payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, these days will be considered patient days. For nursing facilities only (not swing bed providers), when authorized by the Department, a resident may take a temporary leave from the facility to be hospitalized or to make a home visit. A 24-hour period of absence is considered a patient day. The day of discharge is not a billable day.

Pay-and-Chase

Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim

These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

Personal Resource

Also called *patient contribution*, this is the total of all of the resident's income from any source available to pay for the cost of care, less the resident's personal needs allowance.

Potential Third Party Liability

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

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.

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.

Public Assistance Toolkit

This Internet site (<https://dphhs.mt.gov/>) contains information about employment and health services, energy assistance, justice, commerce, labor & industry, education, voter registration, the Governor's Office, and Montana.

Rebilling

When a provider submits a claim that was previously submitted for payment but was either returned or denied.

Referral

When providers refer clients to other Medicaid providers for medically-necessary services that they cannot provide.

Related Party

A related party may be any of the following:

- A person or corporation who is an owner, partner, or stockholder of the current provider and who has a direct or indirect interest of 5% or more, or a power, whether or not legally enforceable, to directly or indirectly influence or direct the actions or policies of the entity.
- A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of the person mentioned above.
- A spouse of an ancestor, descendant, sibling, uncle, aunt, niece, or nephew of the person mentioned above.
- A sole proprietorship, partnership corporation or other entity in which a person described above has a direct or indirect interest of 5% or more, or a power, whether or not legally enforceable, to directly or indirectly influence or direct the actions or policies of the entity.

Remittance Advice (RA)

Provides details of all transactions that have occurred during the previous two weeks, includes paid, denied, and pending claims.

Remittance Advice Notice

The first page of the RA that contains important messages for providers.

Resident

A person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

Retroactive Eligibility

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

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.

Swing Bed Services

Services provided by a licensed hospital or licensed medical assistance facility which is Medicare certified to provide post-hospital SNF care as defined in 42 CFR 409.20.

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 over-utilizing 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 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 the latest of:

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare EOB approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Trust Funds

Resident accounts maintained by the nursing facility at the resident's request.

Unrelated Party

A person or entity that is not a related party.

Usual and Customary

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

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