

Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed either electronically on a professional claim 837P or on a CMS-1500 paper claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- Twelve 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 explanation of benefits 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 payor, 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 action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in the General Information for Providers manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status.
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. (See the Coordination of Benefits chapter in this manual for more information.)
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Coordination of Benefits chapter in this manual.

When to Bill Medicaid Members (ARM 37.85.406)

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

More specifically, providers cannot bill members directly:

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

Under certain circumstances, providers may need a signed agreement to bill a Medicaid member (see the following table).

When to Bill a Patient (ARM 37.85.406)			
	Patient is Medicaid enrolled and provider accepts him/her as a Medicaid member	Patient is Medicaid enrolled and provider does not accept him/her as a Medicaid member	Patient is not Medicaid enrolled
Service is covered by Medicaid	Provider can bill member only for cost sharing.	Provider can bill Medicaid member if the member has signed a private-pay agreement	Provider can bill member
Service is not covered by Medicaid	Provider can bill member only if custom agreement has been made between member and provider before providing the service	Provider can bill Medicaid member if the member has signed a custom agreement	Provider can bill member

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



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

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

Member Cost Sharing (ARM 37.85.204 and ARM 37.85.402)

Please refer to the General Information for Providers Manual labeled Member Cost Sharing (ARM 37.85.204) or go to <http://www.medicaidprovider.mt.gov/costshare> for additional information.

When Members Have Other Insurance

If a Medicaid member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's healthcare, see the Coordination of Benefits chapter in this manual.

Billing for Retroactively Eligible Members

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

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Physician clinics that are affiliated with hospitals should be particularly careful. If the Department has granted a clinic *provider-based* status then the hospital can bill for facility charges even if the clinic is not on the hospital campus. In these situations the clinic must show *outpatient* (22) as the place of service.

Multiple Visits (E/M Codes) on Same Date

Medicaid generally covers only one visit (or hospital admission) per member per day. When a member requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit it to the appropriate Department program officer.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding resources, see the table of Coding Resources on the following page.

The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS, and ICD diagnosis coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than miscellaneous codes.
- Follow CPT guidelines on the difference between a new patient and an established patient.
- Bill for the appropriate level of service provided.
- Services covered within global periods for certain CPT procedures are not paid separately and must not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT service.
- 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.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the member. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.

Coding Resources		
The Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
CPT	CPT codes and definitions Updated each January	American Medical Association/800-621-8335 https://commerce.ama-assn.org/store/
CPT Assistant	A newsletter on CPT coding issues	American Medical Association/800-621-8335 https://commerce.ama-assn.org/store/
HCPCS	HCPCS codes and definitions, which are updated each January and throughout the year.	Available through various publishers and bookstores or from CMS at www.cms.gov/ .
ICD	ICD diagnosis and procedure codes definitions, which are updated each October.	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	OptumCoding/800-464-3649 www.optumcoding.com/
NCCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service 800-363-2068/703-605-6060 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

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 and HCPCS diagnosis coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers, global periods, if multiple surgery guidelines apply, if the procedure can be done bilaterally, if an assistant, co-surgeon, or team is allowed for the procedure, if the code is separately billable, and more. Department fee schedules are updated each January and July. Fee schedules are available on the Provider Information [website](#).



Always refer to the long descriptions in coding books.

Using Modifiers

- Review the guidelines for using modifiers in the CPT, HCPCS, or other helpful resources. Remember to use the modifiers in effect for the date of service of the claim
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first three modifier fields.
- When billing with Modifier 50 for bilateral services, put all information on one line with one unit.
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).
- Always bill your main surgical procedure code on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line.
- Do not separate out subsequent procedure codes on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate except when billing add-on codes and Modifier 51 exempt codes.

Billing Tips for Specific Provider Types

Mid-Level Practitioner Billing

Mid-level practitioners must bill under their own NPI and taxonomy number rather than under a physician number.

Physician Billing

Medicaid-enrolled providers may bill for locum tenens services using Modifier Q6.

Podiatrist Billing

Podiatrists must use appropriate codes and modifiers from their specific fee schedule.

Independent Diagnostic Testing Facilities

IDTF providers must use appropriate fee schedules, codes, and modifiers for their provider type.

Independent Labs

- The provider's current CLIA certification number must be on file with Provider Relations or all lab claims will be denied. See the Contact Us link on the [website](#) for CLIA certification information.
- This requirement also applies to public health labs. Questions regarding public health labs may be directed to the Public Health Lab Assistance hot-line. See the Contact Us link on the [website](#).

Imaging

- Repeat modifiers should be used to indicate multiple radiology services of the same radiology code performed on the same day for the same member by the same or different providers. Repeat modifiers are specific modifiers used to indicate that a service is a repeat rather than a duplicate. Examples are Modifiers 76 and 77.
- For multiple radiology services of the same code provided by the **same** provider on the same date of service, bill the first unit as one unit on one line, followed by additional units of the same code on an additional line with Modifier 76.
- For radiology services of the same code provided by a **different** provider on the same date of service as another provider, bill all units on one line with Modifier 77.
- If a claim is denied as a duplicate, send copies of the radiology report, the denial statement, and the claim to the appropriate Department program officer for review. (See the Contact Us link on the [website](#), Lab and Imaging entry.)
- For bilateral x-rays, bill on separate lines, one line with Modifier RT and one line with Modifier LT. The exception would be codes that are described as bilateral in their code description. These are to be billed on one line with one unit.
- Imaging providers must take particular care in the use of modifiers. Modifier TC is used when only the technical portion of the service is provided. The provider who interprets the results uses Modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

RHC/FQHC – Professional Services in Hospitals

RHC and FQHC practitioners (e.g., physicians, mid-level practitioners) performing services in a hospital setting should bill those services using the appropriate manual/rules that apply for that practitioner.

Billing Tips for Specific Services

Abortions

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

Anesthesia

With the exception of moderate conscious sedation, Montana Medicaid does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the practitioner performing the procedure.

When billing for anesthesia services, the date of service on the claim form must match the date of service that anesthesia was administered. **If the surgery overlaps days, then bill the anesthesia only with the start date.**

CPT states: *For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.*

The following payment method is used for anesthesia services, regardless of whether the service is billed by an anesthesiologist or another professional. Though the method differs from the RBRVS payment method, the two methods are linked and contain similar provisions.

- Use appropriate CPT anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT version.
- Include the total number of minutes on the claim. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the claim as the claims processing system determines the number of base units. (See the Submitting a Claim chapter in this manual.)

Bundled Services

Certain services with CPT codes (e.g., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically bundled with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the member separately for it.

Cosmetic Services

Include the prior authorization number on the claim. (See the Submitting a Claim chapter in this manual.)

EPSDT Well-Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E/M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with Modifier 52 (reduced services).
- See also the EPSDT Well-Child chapter in the *General Information for Providers* manual.
- For well-child EPSDT indicators, see the Submitting a Claim chapter in this manual.

Family Planning Services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

340B drugs may be billed for acquisition costs only. For family planning indicators, see the Submitting a Claim chapter in this manual.

Immunizations

Per CPT, Codes 90460 and 90461 replace deleted Code 90465– Code 90468 for Vaccines for Children (VFC), a program for members ages 0–18.

Code 90460 (non-VFC) is billed for the first component of a vaccine. Code 90461 SL is not allowed by the VFC Program.

Follow the CPT coding instructions as outlined in the CPT coding book for the proper use of these codes (i.e., face-to-face physician or qualified healthcare counseling time) member age, and add-on coding rules. Also, a combination of these two sets for the same date of service, member, and provider will result in an NCCI denial, with or without an NCCI modifier, because Codes 90471, 90472, 90473, and 90474 are component codes to Codes 90460 and 90461.

You may only bill for administrative services if performed by or under the direct supervision of a reimbursable professional (i.e., physician, mid-level). All administration of VFC vaccines must be billed on a CMS-1500.

The administration codes should have the appropriate modifier (SL) to be reimbursed for the federally mandated administration rate. Codes for the VFC supplied vaccines must be billed on the same claim with no charge (\$0.00). See the fee schedule on the Physician page on the Provider Information [website](#).

Note: If a significant separately identifiable Evaluation and Management (E/M) service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code with the appropriate modifier should be reported in addition to the vaccine and toxoid administrative codes.

Note: Administrative Code 90460 (VFC) may have multiple units per line because the code can be used for all VFCs. Codes 90471, 90473, and 90474 define route of administration.

Note: If a significant separately identifiable E/M service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code with the appropriate modifier should be reported in addition to the vaccine and toxoid administration codes.

Obstetrical Services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

When billing a medical or surgical procedure, the date of service on the claim form must match the date of service that the procedure was performed. If the procedure has a global component and the provider saw the patient before and after the procedure, then the provider must bill the global procedure code on the claim form with the date associated for services rendered. For instance, if a vaginal delivery with antepartum and postpartum care (CPT 59400) is performed, it must be billed using the date of delivery as the *from* and *to* dates of service.

Reference Lab Billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

For elective sterilizations, a completed Informed Consent to Sterilization (MA-38) form must be attached to the claim for each provider involved or payment will be denied. No fields may be left blank, except for the Interpreter's

Statement. This form must be legible and accurate. If revisions are made, they must be made with a single line through the incorrect information and initialed by the party making the change. patient information may only be changed by the patient and must be initialed by the patient. Documentation must be included explaining why revisions were made. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

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

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

When submitting claims for retroactively eligible members, attach a copy of the MA-160 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the Covered Services chapter in this manual.

Surgical Services

Medicaid does not provide additional payment for the operating room in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.

Reporting surgical services: Certain surgical procedures must not be reported together, such as:

- Procedures that are mutually exclusive based on the CPT code description or standard medical practice.
- When both comprehensive and component procedures are performed, only the comprehensive procedure should be billed.
- When the CPT manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed should be reported.

Medicaid edits for some surgical services using Medicaid's National Correct Coding Initiative (NCCI) edits and performs post-payment review on others. See Coding Resources earlier in this chapter for more information on NCCI.

Assistant at Surgery

When billing for an assistant at surgery, refer to the current Medicaid fee schedule to see if an assist is allowed for that procedure.

If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.

Physicians must bill assistant at surgery services using the appropriate surgical procedure code and Modifier 80, 81, or 82.

Mid-level practitioners must bill assistant at surgery services under their own NPI and taxonomy using the appropriate surgical procedure code and Modifier AS, 80, 81, or 82.

Global surgery periods: Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a member. For example, Dr. Armstrong performs orthopedic surgery on a member. The member comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid because the service was covered in the global period when Dr. Armstrong billed for the surgery.

For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.

For minor surgeries and some endoscopies, the spans are either 1 day or 10 days. They include any surgically related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.

For a list of global surgery periods by procedure code, see the current Department fee schedule for your provider type.

If the CPT manual lists a procedure as including the surgical procedure only (i.e., a “starred” procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.

In some cases, a physician (or the physician’s partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine Services

When performing a telemedicine consult, use the appropriate CPT E/M consult code. The place of service is the location of the provider providing the telemedicine service. Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number on the claim. See the Submitting a Claim chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the Prior Authorization chapter in this manual.

Weight Reduction

Providers who counsel and monitor members on weight reduction programs must bill Medicaid using appropriate E/M codes.

Unlisted Procedures

Unlisted CPT or HCPCS codes are to be sent to the Department at the address below for review.

Claim Review
Physician-Related Services
P.O. Box 202951
Helena, MT 59624

Submitting Electronic Claims

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically using these methods:

- **WINASAP 5010.** Xerox makes this free Windows-based software available to providers for submitting claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only), and FQHC and 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.
- **Montana Access to Health (MATH) web portal.** A secure website on which providers may view members' medical history, verify member eligibility, submit electronic claims to Medicaid via a HIPAA 5010-compliant X12 837 file, check the status of a claim, verify the status of a warrant, and download remittance advice reports. This availability is subject to scheduled and unscheduled host downtime.
- **Xerox EDI Solutions.** Providers can send claims to Xerox EDI Solutions 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 EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **Clearinghouse.** Providers can contract with a clearinghouse and send claims in whatever format the clearinghouse accepts. The provider's clearinghouse sends the claim to Xerox in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Xerox. EDIFECS certification is completed through EDI Solutions. For more information on electronic claims submission, contact Xerox EDI Solutions.
- **Xerox B2B Gateway SFTP/FTPS Site.** Providers can this method to send electronic transactions through this secure FTP process. This is typically encountered with high-volume/high-frequency submitters.
- **MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between Trading Partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2MB.

Providers should be familiar with federal rules and regulations related to electronic claims submission.

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

999999999	-	888888888	-	11182003
NPI and Taxonomy		Member ID		Date of Service (mm/dd/yyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. The number in the paper Attachment Control Number field must match the number on the cover sheet.

Submitting Paper Claims

For instructions on completing a paper claim, see the Submitting a Claim chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

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

Claim Inquiries

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Return or Denial	Preventing Returned or Denied Claims
Provider's NPI and/or taxonomy missing or invalid	Verify the correct NPI and taxonomy are on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the member: <ul style="list-style-type: none"> • View the member's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual.
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim. (See Remittance Advices and Adjustments in this manual.) • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the remittance advice before submitting the claim directly to Medicaid.
Procedure requires Passport provider referral – No Passport provider number on claim	A Passport provider number must be on the claim when such a referral is required. See the <i>Passport to Health</i> manual.
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the member has other insurance (or Medicare), bill the other carrier before Medicaid. See Coordination of Benefits in this manual. • If the member's TPL coverage has changed, providers must notify Xerox TPL unit before submitting a claim.

