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# *Therapy Services*

*Physical Therapy, Occupational  
Therapy and Speech Therapy*

*Medicaid and Other Medical  
Assistance Programs*

*This publication supersedes all previous Physical Therapy, Occupational Therapy and Speech Therapy handbooks. Published by the Montana Department of Public Health & Human Services, August 2004.*

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**My Medicaid Provider ID Number:**

**My CHIP Provider ID Number:**

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# Key Contacts

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

## Provider Enrollment

For enrollment changes or questions:

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

**(406) 442-1837** Helena

Send written inquiries to:

Provider Enrollment Unit

P.O. Box 4936

Helena, MT 59604

## Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

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

**(406) 442-1837** Helena

Send written inquiries to:

Provider Relations Unit

P.O. Box 4936

Helena, MT 59604

## Claims

Send paper claims to:

Claims Processing Unit

P. O. Box 8000

Helena, MT 59604

## 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**

## Third Party Liability

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

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

**(406) 442-1837** Helena

**(406) 442-0357** Fax

Send written inquiries to:

Third Party Liability Unit

P. O. Box 5838

Helena, MT 59604

## PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

**(800) 362-8312**

Send written inquiries to:

PASSPORT To Health

P.O. Box 254

Helena, MT 59624-0254

## 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.

## Client Eligibility

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

## EDI Technical Help Desk

For questions regarding electronic claims submission:

**(800) 987-6719** In and out-of-state

**(406) 442-1837** Helena

**(406) 442-4402** Fax

Mail to:

ACS

ATTN: MT EDI

P.O. Box 4936

Helena, MT 59604

## 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

## Prior Authorization

### *Surveillance/Utilization Review*

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

**(406) 444-3993** Phone

For clients with last names beginning with M - Z, call:

**(406) 444-0190**

Information may be faxed to:

**(406) 444-0778** Fax

Send written inquiries to:

Surveillance/Utilization Review

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

<b>Key Web Sites</b>	
<b>Web Address</b>	<b>Information Available</b>
<p><b>Virtual Human Services Pavilion (VHSP)</b> vhsp.dphhs.mt.gov</p>	<p><b>Select <i>Human Services</i> for the following information:</b></p> <ul style="list-style-type: none"> <li>• <b>Medicaid:</b> Medicaid Eligibility &amp; Payment System (MEPS). Eligibility and claims history information.</li> <li>• <b>Senior and Long Term Care:</b> Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning.</li> <li>• <b>DPHHS:</b> Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites.</li> <li>• <b>Health Policy and Services Division:</b> Children’s Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.</li> </ul>
<p><b>Provider Information Website</b> www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2</p>	<ul style="list-style-type: none"> <li>• Medicaid news</li> <li>• Provider manuals</li> <li>• Notices and manual replacement pages</li> <li>• Fee schedules</li> <li>• Remittance advice notices</li> <li>• Forms</li> <li>• Provider enrollment</li> <li>• Frequently asked questions (FAQs)</li> <li>• Upcoming events</li> <li>• HIPAA Update</li> <li>• Newsletters</li> <li>• Key contacts</li> <li>• Links to other websites and more</li> </ul>
<p><b>Client Information Website</b> www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm</p>	<ul style="list-style-type: none"> <li>• Medicaid program information</li> <li>• Client newsletters</li> <li>• Who to call if you have questions</li> <li>• Client Notices &amp; Information</li> </ul>
<p><b>ACS EDI Gateway</b> www.acs-gcro.com/Medicaid_Account/Montana/montana.htm</p>	<p>ACS EDI Gateway is Montana’s HIPAA clearinghouse. Visit this website for more information on:</p> <ul style="list-style-type: none"> <li>• Provider Services</li> <li>• EDI Support</li> <li>• Enrollment</li> <li>• Manuals</li> <li>• Software</li> <li>• Companion Guides</li> </ul>
<p><b>Secretary of State, ARM Rules Home Page</b> www.sos.state.mt.us/css/ARM/ARM.asp</p>	<p>Administrative Rules of Montana</p>
<p><b>Washington Publishing Company</b> www.wpc-edi.com</p>	<ul style="list-style-type: none"> <li>• EDI implementation guides</li> <li>• HIPAA implementation guides and other tools</li> <li>• EDI education</li> </ul>



# Introduction

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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 and Maintenance

This manual provides information specifically for physical, occupational and speech therapy 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.

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 Medicaid Provider ID number for quick reference when calling Provider Relations.

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. All manual replacement pages and notices are posted on the Provider Information website. For paper copies, contact Provider Relations (see *Key Contacts*).

## 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 rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). The following rules and regulations are specific to physical, occupational and speech therapy programs. Additional Medicaid rule references are available in the *General Information For Providers* manual.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.601 - 37.86.610 Therapy Services
- Montana Codes Annotated (MCA)
  - MCA Title 37, Chapter 11 Physical Therapy



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

- MCA Title 37, Chapter 15 Speech-language pathologists and audiologists
- MCA Title 37, Chapter 24 Occupational Therapy
- Code of Federal Regulations (CFR) 42 CFR 440.110

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

The Department is committed to paying Medicaid provider's 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 Contacts*).

# Covered Services

## General Coverage Principles

This chapter provides covered services information that applies specifically to services performed by independent physical, occupational and speech therapists. Therapists that are employed by a facility (e.g., hospitals, nursing facilities, home health agencies, etc.) should refer to the corresponding provider manual for requirements and billing procedures, which may vary. 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 37.86.606)***

Services are covered only when they are within the scope of the provider's license as permitted by state law.

### ***Services provided by therapists (ARM 37.86.601-605, 37.85.402)***

Therapy providers must maintain current licensure to practice from the state in which they are practicing. Providers must also be enrolled as Montana Medicaid providers. An assistant or aide may not enroll as a Medicaid provider. Providers cannot submit claims for services they did not provide, except for services provided by therapy assistants or aides. Services performed by an assistant or aide in accordance with Title 37 MCA must have their services billed to Medicaid under the licensed supervising therapist's Medicaid provider number. The levels of supervision are as follows:

- **General:** Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.
- **Direct:** The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the client-related procedure being performed.
- **Routine:** The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- **Temporary Practice Permit holders** (new grads from occupational therapy school who are waiting for their national exam results) **MUST** work under ROUTINE supervision of the licensed therapist. If the exam is failed the Temporary Practice Permit **IMMEDIATELY** becomes VOID. Routine supervision requires direct contact at least daily at the site of work.



Only licensed therapists may enroll as Montana Medicaid providers.

- Occupational and Speech Therapy Aides require personal, direct supervision by the licensed provider. This means the licensed provider must be face to face with the aide in the same room when procedures are being provided.
- Speech Therapy Aides:
  - Aide 1 = supervised a minimum of 30% while performing diagnostic and interpretive functions in the first year of non-allowable activities. The supervision requirement will be 5% of client contact time, of which 2% shall be direct contact after the first year, at the discretion of the supervising speech-language pathologist
  - Aide 2 = shall be supervised 10% of client contact time, of which 5% shall be direct contact
  - Aide 3 = shall be supervised 20% of client contact time, of which 5% shall be direct contact. Refer to ARM 24.222.702
- Occupational Therapy Assistants require general supervision, meaning the licensed provider does not have to be physically on the premises at the time of the service. However, the licensed therapist must provide face to face supervision at least monthly.
- Physical Therapy Aides/Assistants require general supervision, meaning that the licensed provider must be on the premises.
- Temporarily licensed therapists can never supervise anyone.

Providers must notify Provider Relations (see *Key Contacts*) of any changes to their status (e.g. address change, licensure status, or change in ownership of medical practice).

***Non-covered services (ARM 37.85.207 and 37.86.606)***

Some services not covered by Medicaid include but are not limited to the following:

- Maintenance therapy services (may be covered under the Home and Community Based Services [HCBS] program; refer to the HCBS manual)
- Services that do not require the performance or supervision of a licensed therapist, even if the services are performed by the therapist
- A therapist's time for the following:
  - Attending client care meetings
  - Client-related meetings with other medical professionals or family members
  - Completion of paperwork or reports
- Observation
- Acupuncture

- Naturopath services
- Masseur or Masseuse services
- Services considered experimental or investigational
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. Prior authorization may be required; see the *PASSPORT and Prior Authorization* chapter in this manual.
  - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
  - When out-of-state medical services and all related expenses are less costly than in-state services
  - When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

### ***Verifying coverage***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* web site, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).



Use the current fee schedule for your provider type to verify coverage for specific services.



An order/referral is valid for 180 days from the day the therapist receives it.

## Therapy Service Requirements (ARM 37.86.606)

Medicaid covers restorative therapy services when they are reasonable and necessary to the treatment of the client's condition and result in improved function. The amount and frequency of services provided must be within the therapy's generally accepted standard of practice. Therapy services are not restorative if the client's expected restoration potential is insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative when it is determined that function will not improve. All therapy services require an order or referral from the client's physician or mid-level practitioner and documentation on the client's progress. Some services may also require prior authorization or PASSPORT provider approval before they are provided (see the *PASSPORT and Prior Authorization* chapter in this manual).

### ***Order/referral***

Therapy services may be provided to a client when a current written or verbal order/referral has been received from the client's physician or mid-level practitioner. The therapy provider is responsible for obtaining the order/referral before providing services. Medicaid does not cover services provided before obtaining an order/referral. When the order/referral is verbal, the client's physician or mid-level practitioner must supply the therapist with the same order/referral in writing within 30 days of the verbal order/referral. The therapist should document in his or her records a verbal order/referral was provided by the client's physician or mid-level practitioner. The written order/referral must be signed and dated by the referring physician or mid-level practitioner. The Department considers an order/referral valid for no more than 180 days from the time the therapist receives the order/referral from the physician or mid-level practitioner. When a client is enrolled in the PASSPORT To Health Program, a PASSPORT approval is required and the referral number must be included on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual).

### ***Documentation***

Providers must maintain records that demonstrate compliance with Medicaid requirements. General record keeping requirements are described in the *General Information For Providers* manual, *Provider Requirements* chapter. All therapy case records must be current and available upon request from the Department. Case records must contain at least the following:

- Signed and dated order/referral from the client's physician or mid-level practitioner
- Client's name on each page of documentation
- Diagnosis, duration and time, course of treatment and expected outcomes
- Therapist treatment for each session
- Client's progress in meeting therapy goals to ensure therapy services are still restorative and not maintenance

- Support time spent for each procedure billed. Time should be indicated in the record, whether a start/end time documented at each visit or total time spent with the client at the visit.
- Documentation must be complete and representative of what the therapist has provided each time a client is seen and must support the procedures that are billed to Medicaid.
- Records signed and dated by the treating therapist

## Coverage of Specific Services

The following are coverage rules for specific services provided by physical, occupational and speech therapists. The Medicaid payment includes all related supplies and items used when providing therapy services, except for splints, braces, and slings, which are discussed later.

### ***Augmentative communications devices***

Medicaid covers augmentative communications devices when they are prior authorized. The Department's policy is to rent the communications device for eight weeks prior to purchase. For instructions on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

### ***Maintenance therapy plan***

Medicaid covers the development of a maintenance therapy plan by a licensed therapist. The maintenance plan must include all of the following:

- The client's initial evaluation
- Development of a plan that incorporates the prescribing physician's or mid-level practitioner's treatment objectives and is appropriate for the client's capacity and tolerance
- Instructions for others in carrying out the plan and further evaluations by a licensed therapist as required

### ***Occupational, physical, and speech therapy***

Medicaid covers a maximum of 40 hours of each type of therapy (i.e., occupational, physical and speech) for clients ages 21 and older during a fiscal year (July 1 - June 30). The payment system calculates the respective units/hours of therapy services as claims adjudicate. The system will calculate a procedure that has "each 15 minutes" in the description as one unit; four units equals one hour. A procedure code that does not have a delineated time unit is counted as one hour within the system, whether the service takes 30 minutes or three hours. When the limit on units or hours is reached for the respective therapy service, any additional claims are denied. Provider Relations can verify the number of therapy hours that have been processed for a client, but this amount would not include any outstanding claims (e.g., claims waiting to be keyed or therapy claims submitted by other providers).

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) covers all medically necessary services for children age 20 and under. Therapy services for children are not restricted to a specific number of hours or units as long as the therapy services are restorative, not maintenance. All other applicable requirements apply (e.g., current order/referral, provider requirements, prior authorization requirements, and PASSPORT approval). See the *PASSPORT and Prior Authorization* chapter in this manual.

### ***Splints, braces, and slings***

Medicaid covers the design, fabrication, fitting and instruction by a licensed therapist in the use of splints, braces and slings under the Durable Medical Equipment (DME) program. Therapists must be enrolled with Medicaid as DME providers in order to bill for these services. If a therapist is also enrolled as a DME provider, he or she must abide by the rules/policies set forth by the DME program.

## **Other Programs**

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

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

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

### ***Children's Health Insurance Plan (CHIP)***

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

# Prior Authorization and PASSPORT

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## What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120)

PASSPORT To Health, prior authorization (PA) and the Team Care Program are 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. PASSPORT approval and prior authorization are different, and some services may require both. A different authorization number is issued for each type of approval and must be included on the claim form (see the *Submitting a Claim* chapter in this manual).

- **PASSPORT To Health Managed Care Program** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately \$20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- **Team Care** is a component of the PASSPORT To Health program. Clients identified as excessively misusing or abusing the Medicaid system are enrolled in the program. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. All PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program, see the *PASSPORT and Prior Authorization* chapter in the *General Information For Providers* manual or the Team Care page on the Provider Information website (see *Key Contacts*).
- **Prior authorization** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.



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

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. PASSPORT approval requirements are described below.

## How to Identify Clients on PASSPORT

When a client is enrolled in PASSPORT, the client eligibility verification will list the PASSPORT provider's name and phone number. All services, except emergency services, rendered by a provider other than the PASSPORT provider must be authorized. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

## How to Obtain PASSPORT Approval

When providing a covered service that requires PASSPORT approval, contact the primary care provider listed on the client's eligibility verification to request approval. The client's PASSPORT provider must be contacted for approval for each visit. Using another provider's PASSPORT number without approval is considered fraud. The PASSPORT provider will supply a PASSPORT approval number which must be recorded on the claim (see the *Submitting a Claim* chapter in this manual).

## PASSPORT and Indian Health Services

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

## Getting questions answered

The list of *Key Contacts* (at the front of this manual) provides important phone numbers and addresses. Providers may contact Provider Relations for any questions regarding provider PASSPORT enrollment, disenrollment, changes and provider materials. Providers may contact the PASSPORT To Health and Medicaid Help Line for Clients for questions about client enrollment, disenrollment, changes, and client materials.

## Prior Authorization

Some Medicaid covered services require prior authorization (PA) before they are provided. Augmentative communication devices are the only therapy service that requires PA. Although augmentative communication devices are billed under the Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DME-POS) program rather than the therapy program, the therapist must document medical necessity (see following table). To obtain PA for augmentative communication devices:

1. The provider documents medical necessity (see following table for requirements).
2. The client chooses a vendor. The vendor must be enrolled (or willing to enroll) as a Medicaid DME provider.
3. The vendor completes a *Medicaid Prior Authorization Request* form (available in the DMEPOS manual and on the Provider Information website) and sends it with the provider's medical necessity documentation to the prior authorization unit.
4. When PA is granted, the provider receives notification containing a PA number. This PA number must be included on the claim.
5. The client must rent the device for eight weeks before Medicaid will cover the purchase.

PA Criteria for Specific Services		
Service	PA Contact	Requirements
<ul style="list-style-type: none"> <li>• <b>Augmentative Communication Devices</b></li> </ul>	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953  <b>Phone:</b> For clients with last names beginning with <b>A - L</b> , call: (406) 444-3993 In/out-of-state  For clients with last names beginning with <b>M - Z</b> , call: (406) 444-0190 In/out-of-state  <b>Fax:</b> (406) 444-0778	Medical necessity documentation must include all of the following: <ul style="list-style-type: none"> <li>• Speech/language evaluation</li> <li>• The extent of receptive vocabulary stating how the testing was done</li> <li>• Description of how the client currently communicates (Indicate how the client expresses needs and responds to yes/no questions.)</li> <li>• Evidence that current speech is not an adequate means of communication and if improvement is likely</li> <li>• Results of a communication needs assessment</li> <li>• Evidence of the ability to recognize pictures represent a spoken word if a membrane keyboard is used</li> <li>• Evidence of reading/writing levels if a keyboard is used</li> <li>• Evidence that the client and communication partners can understand synthesized speech if the device has that type of output</li> <li>• Evidence that the client can see the device adequately for either letter or picture recognition</li> <li>• Evidence that the individual understands the cause-effect relationship on the use of a switch</li> <li>• Justification for the particular device recommended</li> <li>• Description of previous experience with a device</li> <li>• Projection of the extent of use of the device</li> </ul>



# Coordination of Benefits

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## When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers 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 (TPL). 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 or TPL, but Medicare is not considered a TPL.

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

Occupational and physical therapy services provided by independent occupational and physical therapists are covered under Medicare Part B. The Department has an agreement with the Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of professional claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When clients have both Medicare and Medicaid covered claims, and have made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

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

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 Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

All Part B Crossover claims submitted to Medicaid before the 45-day response time from Medicare will be returned to the provider.

## 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 must be turned over to Medicaid."

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

In a few cases, providers may bill Medicaid first:

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

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

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information 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 non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  - The third party carrier has been billed, and 30 days or more have passed since the date of service.

- The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If 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 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.
- 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 line on a separate claim and submit to Medicaid. Include the explanation of benefits (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 and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit (see *Key Contacts*).

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.

# Billing Procedures

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## Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). 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 the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
  - **Medicare Crossover Claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

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

### ***Tips to avoid timely filing denials***

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 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).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

## When To Bill Medicaid Clients (ARM 37.85.406)

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

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

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

When to Bill a Medicaid Client (ARM 37.85.406)			
	<ul style="list-style-type: none"> <li>• Client Is Medicaid Enrolled</li> <li>• Provider Accepts Client as a Medicaid Client</li> </ul>	<ul style="list-style-type: none"> <li>• Client Is Medicaid Enrolled</li> <li>• Provider Does Not Accept Client as a Medicaid Client</li> </ul>	<ul style="list-style-type: none"> <li>• Client Is Not Medicaid Enrolled</li> </ul>
<b>Service is covered by Medicaid</b>	Provider can bill client <b>only</b> for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
<b>Service is not covered by Medicaid</b>	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client



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

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

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

## Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

Cost Sharing	
Service	Amount
Occupational therapy	\$2.00 per visit
Physical therapy	\$2.00 per visit
Speech therapy	\$3.00 per visit

The following clients are exempt from cost sharing:

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

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy must be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligations, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

## 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 the *Coordination of Benefits* chapter in this manual.

## PASSPORT Billing Tips

- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT number on the claim.
- The client's PASSPORT provider must be contacted for approval for therapy services to be provided. Using another provider's PASSPORT number without approval is considered fraud.
- For more information on PASSPORT To Health, see the *PASSPORT and Prior Authorization* chapter in the *General Information For Providers* manual.
- For claims questions, contact Provider Relations (see *Key Contacts*).

## Billing for Retroactively Eligible Clients

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, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

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

For more information on retroactive eligibility, see the *Client 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. See *Appendix B: Place of Service Codes*.

## Therapists Employed by Nursing Facilities, Hospitals or Home Health Agencies

The billing instructions in this chapter apply to independent therapists who bill on professional or CMS-1500 claims. Independent therapists must be individually enrolled Medicaid providers to bill for services. Therapists who are employed by nursing facilities do not need to be individually enrolled in the Medicaid program when their services are to be billed by the nursing facility directly to Medicaid. The nursing facility provider will be responsible for meeting the enrollment and

billing requirements under the therapy provider number. Therapists that are employed by hospitals or home health agencies should refer to the corresponding provider manual for requirements and billing procedures, which may vary.

## Billing for Evaluations

Evaluations are considered an encounter and should be reported as one unit; do not bill with multiple units. If the evaluation spans more than one day, providers should report the day of completion as the date of service when billing.

## Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM 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 the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. One unit may equal “one visit” or “each 15 minutes.” Always check the long text of the code description.
- When billing for “each 15 minutes”, one unit of service is equal to 8 minutes but less than 23 minutes. If a single modality or procedure is greater than 23 minutes, then time for more units of service should be counted as follows:

Units Over 23 Minutes	
Units	Time
2	Greater than or equal to 23 minutes, but less than 38 minutes
3	Greater than or equal to 38 minutes, but less than 53 minutes
4	Greater than or equal to 53 minutes, but less than 68 minutes
5	Greater than or equal to 68 minutes, but less than 83 minutes
6	Greater than or equal to 83 minutes, but less than 98 minutes
7	Greater than or equal to 98 minutes, but less than 113 minutes
8	Greater than or equal to 113 minutes, but less than 128 minutes

Count only the time spent treating a client. When counting time, if three modalities are provided and 20 total minutes are spent with the client in providing these services, bill only one unit using the code that best defines the greater amount of the service provided.



Always refer to the long descriptions in coding books.

<b>Coding Resources</b>		
Please note that the Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
ICD-9-CM	<ul style="list-style-type: none"> <li>• ICD-9-CM diagnosis and procedure codes definitions</li> <li>• Updated each October.</li> </ul>	Available through various publishers and bookstores
CPT-4	<ul style="list-style-type: none"> <li>• CPT-4 codes and definitions</li> <li>• Updated each January</li> </ul>	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	<ul style="list-style-type: none"> <li>• HCPCS Level II codes and definitions</li> <li>• Updated each January and throughout the year</li> </ul>	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 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 www.ntis.gov/product/correct-coding.htm

## 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-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* web site (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

## Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Use modifier 52 when a service or procedure is partially reduced or eliminated. This occurs when a code includes a procedure or service that was not completed, but the code most closely describes the service provided.
- Use modifier 22 when a service is more extensive than usual. This modifier can be used when a service is more difficult than usual or when there is an increased risk to the client. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- The TC modifier 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.

### ***Bundled services***

Certain 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 (e.g., hot or cold packs). Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

## 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 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.

<b>Common Billing Errors</b>	
<b>Reasons for Return or Denial</b>	<b>How to Prevent Returned or Denied Claims</b>
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct <b>Medicaid</b> provider number is 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 computer generated, typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an electronic professional claim or a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: <ul style="list-style-type: none"> <li>• View the client's eligibility information at each visit. Medicaid eligibility may change monthly.</li> <li>• Verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual.</li> </ul>
Duplicate claim	<ul style="list-style-type: none"> <li>• Please check all remittance advices (RAs) for previously submitted claims before resubmitting.</li> <li>• When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual).</li> <li>• Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.</li> </ul>
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. See the <i>PASSPORT and Prior Authorization</i> chapter in this <i>General Information For Providers</i> manual and the <i>Prior Authorization and PASSPORT</i> chapter in this manual.
Prior authorization number is missing	<ul style="list-style-type: none"> <li>• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the <i>PASSPORT and Prior Authorization</i> chapter in this manual).</li> </ul>
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> <li>• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual.</li> <li>• If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.</li> </ul>

<b>Common Billing Errors (continued)</b>	
<b>Reasons for Return or Denial</b>	<b>How to Prevent Returned or Denied Claims</b>
Claim past 365-day filing limit	<ul style="list-style-type: none"> <li>• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.</li> <li>• To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.</li> </ul>
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included (see <i>Billing Electronically with Paper Attachments</i> in the <i>Submitting a Claim</i> chapter in this manual.
Provider is not eligible during dates of services, or provider number terminated	<ul style="list-style-type: none"> <li>• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.</li> <li>• New providers cannot bill for services provided before Medicaid enrollment begins.</li> <li>• If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.</li> </ul>
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> <li>• Provider is not allowed to perform the service, or type of service is invalid.</li> <li>• Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.</li> <li>• Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.</li> </ul>
Therapy services are limited to 40 hours per fiscal year	<ul style="list-style-type: none"> <li>• Medicaid covers a maximum of 40 hours of each type of therapy (i.e., occupational, physical and speech) for clients ages 21 and older during a fiscal year (July 1 - June 30). The payment system calculates the respective units or hours of therapy services as claims adjudicate. When the limit on units or hours are reached for the respective therapy service, any additional claims are denied.</li> </ul>



# Submitting a Claim

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## Electronic Claims

Professional 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 2003.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- **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. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- **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.

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 Contacts*). *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 Contacts*).

### ***Billing electronically with paper attachments***

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

**9999999 - 888888888 - 11182003**  
 Medicaid Client ID Date of  
 Provider ID Number Service  
 (mmdyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). 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 Contacts*).

### Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

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

When completing a claim, remember the following:

- 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:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is 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

- Unless otherwise stated, all paper claims must be mailed to the following address:  
 Claims Processing Unit  
 P.O. Box 8000  
 Helena, MT 59604

## Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i> ).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code <b>reference number</b> (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

\* = Required Field

\*\* = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA OTHER
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky
3. PATIENT'S BIRTH DATE 04/28/96 SEX M

5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1
6. PATIENT RELATIONSHIP TO INSURED Self

7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS Single

CITY Anytown STATE MT
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

b. OTHER INSURED'S DATE OF BIRTH SEX
c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE 999999999

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Doug Ross, MD
17a. I.D. NUMBER OF REFERRING PHYSICIAN 9989999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Table with 6 rows and 11 columns (A-K) for service details including date of service, diagnosis code, charges, and units.

24. FEDERAL TAX I.D. NUMBER SSN EIN
25. PATIENT'S ACCOUNT NO. 99999
26. ACCEPT ASSIGNMENT? YES

27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
28. TOTAL CHARGE \$ 95.00
29. AMOUNT PAID \$ 0.00
30. BALANCE DUE \$ 95.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates, P.O. Box 999, Anytown, MT 59999

SIGNED DATE
PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

## Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i> ).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code <b>reference number</b> (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

\* = Required Field

\*\* = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Frost, Autumn 3. PATIENT'S BIRTH DATE MM DD YY 02 04 33 M F SEX F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same 5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) Same 8. PATIENT STATUS Single Married Other

CITY Anytown STATE MT 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

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: MM DD YY 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 PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

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.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates P.O. Box 999 Anytown, MT 59999

SIGNED DATE PIN# GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Montana Department of Public Health and Human Services

## Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i> ).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code <b>reference number</b> (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

\* = Required Field

\*\* = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Summer, Stormie 3. PATIENT'S BIRTH DATE MM DD YY 08 31 68 SEX M F X

5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

CITY Anytown STATE MT 8. PATIENT STATUS Single X Married Other

ZIP CODE 59999 TELEPHONE (Include Area Code) (406)999-9999 11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S DATE OF BIRTH MM DD YY M F

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F b. AUTO ACCIDENT? YES NO PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE 9999999 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

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

14. DATE OF CURRENT: 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 PHYSICIAN OR OTHER SOURCE Smith, Steven R. MD 17a. I.D. NUMBER OF REFERRING PHYSICIAN 9999999 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO X CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 824.0 3. 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE

Table with 11 columns (A-K) and 6 rows. Row 1: 05 03 04, 05 03 04, 11, 0, 97112, 1, 23.75, 1, , , . Row 2: 05 10 04, 05 10 04, 11, 0, 97116, 1, 21.00, 1, , , . Row 3: 05 17 04, 05 17 04, 11, 0, 97110, 1, 50.00, 2, , , .

Table with 11 columns (A-K) and 4 rows. Row 4: , , , , , , , , , , . Row 5: , , , , , , , , , , . Row 6: , , , , , , , , , , .

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ 94.75 29. AMOUNT PAID \$ 75.80 30. BALANCE DUE \$ 18.95

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.) Susan Pullman, D.P.T. 06/30/04 SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates P.O. Box 999 Anytown, MT 59999 PIN# 999999 GRP# (406) 999-9999

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.) Susan Pullman, D.P.T. 06/30/04 SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates P.O. Box 999 Anytown, MT 59999 PIN# 999999 GRP# (406) 999-9999

Montana Department of Public Health and Human Services

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

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

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9-9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i> ).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code <b>reference number</b> (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

\* = Required Field

\*\* = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  
999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
Knight, Tuesday

3. PATIENT'S BIRTH DATE  
MM DD YY 11 07 62 SEX M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)  
Same

5. PATIENT'S ADDRESS (No., Street)  
98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED  
Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street)  
Same

CITY Anytown STATE MT

8. PATIENT STATUS  
Single  Married  Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES  NO   
b. AUTO ACCIDENT? YES  NO   
c. OTHER ACCIDENT? YES  NO

11. INSURED'S POLICY GROUP OR FECA NUMBER  
999999999A

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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)  
MM DD YY

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES  NO  \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  
1. 722.52 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	A DATE(S) OF SERVICE			B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE	
	From MM DD YY	To MM DD YY	YY											
1	05	07	04	05	07	04	11 0	97032	1	15	00			
2	05	07	04	05	07	04	11 0	97035	1	20	00			
3	05	07	04	05	07	04	11 0	97110	1	25	00			
4														
5														
6														

24. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN

25. PATIENT'S ACCOUNT NO.

26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES  NO

27. TOTAL CHARGE \$ 60.00 28. AMOUNT PAID \$ 48.00 29. BALANCE DUE \$ 12.00

30. 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.)  
Mary Bender, D.P.T. 06/30/04  
SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  
Therapy Associates  
P.O. Box 999  
Anytown, MT 59999  
PIN# 999999 GRP# (406) 999-9999

Montana Department of Public Health and Human Services

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

## Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9-9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i> ).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code <b>reference number</b> (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

\* = Required Field

\*\* = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

APPROVED OMB-0938-0008

**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER   
 (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  
999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
Summers, Stormie

3. PATIENT'S BIRTH DATE  
MM DD YY 05 13 33 M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)  
Same

5. PATIENT'S ADDRESS (No., Street)  
123 Sun City Road

6. PATIENT RELATIONSHIP TO INSURED  
Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street)  
Same

CITY Anytown STATE MT

8. PATIENT STATUS  
Single  Married  Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:  
Employed  Full-Time Student  Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER  
999999999B

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 \_\_\_\_\_ DATE \_\_\_\_\_

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)  
MM DD YY

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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES  
 YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  
1. 781.2

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	A		B	C	D	E	F	G	H	I	J	K						
	From	To											Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS
1	05	20	04	05	20	04	11	0	97001		1	65	00	1				
2	05	20	04	05	20	04	11	0	97116		1	63	00	1				
3	05	20	04	05	20	04	11	0	97530		1	25	00	1				
4																		
5																		
6																		

24. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN

25. PATIENT'S ACCOUNT NO.

26. ACCEPT ASSIGNMENT? (For govt. claims, see back)  YES  NO

27. TOTAL CHARGE \$ 153.00

28. AMOUNT PAID \$ 122.40

29. BALANCE DUE \$ 30.60

30. 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.)  
Mary Bender, D.P.T. 06/30/04  
SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  
Therapy Associates  
P.O. Box 999  
Anytown, MT 59999  
PIN# 999999 GRP# (406) 999-9999

Montana Department of Public Health and Human Services

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 HCFA, 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 Humans 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.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

## 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.

<b>Common Claim Errors</b>	
<b>Claim Error</b>	<b>Prevention</b>
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct <b>Medicaid</b> provider number is on the claim.
Referring or PASSPORT provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or PASSPORT number (see <i>PASSPORT and Prior Authorization</i> in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see <i>PASSPORT and Prior Authorization</i> in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, computer generated, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be included with the claim or it will be denied.

# Remittance Advices and Adjustments

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## 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 service 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 RA**

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the “SOR Download” page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

### **Paper RA**

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



Electronic RAs are available for only six weeks on MEPS.



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 paper RA is informational only. Do not take any action on claims shown here.

<b>Sections of the Paper RA</b>	
<b>Section</b>	<b>Description</b>
<b>RA notice</b>	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.
<b>Paid claims</b>	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).
<b>Denied claims</b>	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.
<b>Pending claims</b>	<p>All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 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>
<b>Credit balance claims</b>	Credit balance claims are shown here until the credit has been satisfied.
<b>Gross adjustments</b>	Any gross adjustments performed during the previous cycle are shown here.
<b>Reason and remark code description</b>	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

# Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES  
HELENA, MT 59604

## MEDICAID REMITTANCE ADVICE

①  
THERAPY ASSOCIATES  
P.O. BOX 999  
ANYTOWN, MT 59999

② PROVIDER# 0001234567      ③ REMIT ADVICE #123456      ④ WARRANT # 654321      ⑤ DATE:02/15/04      PAGE 2 ⑥

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON/REMARK CODES
⑦	⑧	⑩	⑪	⑫	⑬	⑭	⑮	⑯
<b>PAID CLAIMS - MISCELLANEOUS CLAIMS</b>								
123456789	DOE, JOHN EDWARD	010304 010304	1	97001	65.00	51.21	Y	
⑨	ICN 00404011250000700	***LESS MEDICARE PAID*****				25.25		
		***LESS COPAY DEDUCTION*****				2.00		⑰
		***CLAIM TOTAL *****			65.00	23.96		
<b>DENIED CLAIMS - MISCELLANEOUS CLAIMS</b>								
123456789	DOE, JANE	020104 020104	1	97116	25.00	0.00	N	
	ICN 00404011250000800	020304 020304	1	97530	27.00	0.00	⑰	N
		***CLAIM TOTAL *****			52.00			31MA61
<b>PENDING CLAIMS - MISCELLANEOUS CLAIMS</b>								
123456789	DOE, SUSAN	020404 020404	1	97032	15.00	0.00	⑰	N 133
	ICN 00404011250000900	020504 020504	1	97035	12.00	0.00	N	133
		***CLAIM TOTAL *****			27.00			

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

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

## Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
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</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u>            A B C D E</p> <p>A = Claim medium            0 = Paper claim            2 = Electronic claim            3 = Encounter claim            4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim)</p> <p>B = Julian date (e.g. April 20, 2000 was the 111th day of 2000)</p> <p>C = Microfilm number            00 = Electronic claim            11 = Paper claim</p> <p>D = Batch number</p> <p>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	Date(s) services were provided. If service(s) 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. Co-pay	A "Y" indicates cost sharing was deducted, and an "N" indicates cost sharing was not deducted from the payment.
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 cost sharing 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 provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

## **Rebilling and Adjustments**

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

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

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

### ***Rebilling Medicaid***

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

### ***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).



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



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



Rebill denied claims only after appropriate corrections have been made.

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. For CMS-1500 claims, do not use an adjustment form. In the case of a UB-92, the line should be adjusted rather than rebilled (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 12<sup>th</sup> 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.

### ***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 (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

- Request an adjustment when an individual line is denied on a multiple-line UB-92 claim. The denied service must be submitted as an adjustment rather than a rebill.

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

To request an adjustment, use the *Montana Medicaid 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). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

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

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table).
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*.
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
<b>Section A</b>	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name 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.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid 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.).
<b>Section B</b>	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ NDC/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	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, 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 generally occur when:

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

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. 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 remittance advice 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 remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

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



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

<b>Required Forms For EFT and/or Electronic RA</b> All three 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 provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	<ul style="list-style-type: none"> <li>• Provider Information website</li> <li>• Provider Relations (see <i>Key Contacts</i>)</li> </ul>	Provider Relations (see <i>Key Contacts</i> )
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> <li>• Provider Information website (see <i>Key Contacts</i>)</li> <li>• Provider's bank</li> </ul>	Provider Relations (see <i>Key Contacts</i> )
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	<ul style="list-style-type: none"> <li>• Provider Information website</li> <li>• Virtual Human Services Pavilion</li> <li>• Direct Deposit Arrangements (see <i>Key Contacts</i>)</li> </ul>	DPHHS address on the form

# How Payment Is Calculated

## Overview

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

## The RBRVS Fee Schedule

Most services by therapists, physicians, mid-level practitioners and other providers are paid for using the Department's RBRVS fee schedule. RBRVS stands for Resource-Based Relative Value Scale. The fee schedule includes about 7,700 CPT-4 codes and about 1,600 HCPCS Level 2 codes. Within the CPT-4 coding structure, only anesthesia services (00100-01999) and clinical lab services (almost the entire 80000-89999 range) are not paid for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in August 1997. It is based largely on the Medicare model, with a few differences that will be described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the millions of dollars of research performed by the federal government and national associations of physicians and other health care professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, BlueCross BlueShield plans, workers' compensation plans and commercial insurers.

The following paragraphs elaborate on aspects of the RBRVS fee schedule used by the Department. All numerical examples are from July 2004 and may not apply at other times.

### ***Fee calculation***

Each fee is the product of a relative value times a conversion factor times 90%. For example, the fee for a speech/hearing evaluation in the office (92506) is:

$$3.187 \text{ relative value units} \times \text{conversion factor of } \$30.11 \times 90\% = \$86.36$$



Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

### **When Medicaid payment differs from the fee schedule, consider the following:**

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Modifiers (see *Other modifiers* in this chapter)
- Place of service (see *Site of service differential* in this chapter)
- Date of service (fees for services may change over time)
- Also check for cost sharing and Medicare or TPL payments which will be shown on the RA.

***Basis of relative values***

For almost all services, Medicaid uses the same relative values as Medicare does in Montana. (Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality.) For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

***Composition of relative values***

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated practice expense and the associated malpractice expense. For a speech/hearing evaluation in the office (92506), for example, the composition is as follows:

$$0.86 \text{ work RVUs} + 2.286 \text{ practice expense RVUs} + 0.041 \text{ malpractice expense RVUs} = 3.187 \text{ total RVUs}$$

***Site of service differential***

The Medicare program has calculated two sets of relative values for each code – one that reflects the practitioner’s practice cost of performing the service in an office and one that reflects the practitioner’s practice cost of performing the service in a hospital or ambulatory surgical center (ASC). When services are provided within a hospital or ASC (i.e., places of service 21–24), Medicaid typically pays a lower fee than if the service is provided in the office or another setting. The reason is that Medicaid typically also pays the hospital or ASC for the service. For example, in July 2004 Medicaid would pay a speech/language therapist for a speech/hearing evaluation in the office (92506) as follows:

$$\text{In office: } 3.187 \text{ RVUs} \times \text{conversion factor of } \$30.11 \times 90\% = \$86.36$$

$$\text{In hospital or ASC: } 1.251 \text{ RVUs} \times \$30.11 \times 90\% = \$33.90$$

***Conversion factor***

The Department sets the conversion factor for the state fiscal year (July through June). The conversion factor is typically reviewed (and often changed) in July of each year. In July 2004 it was updated to \$30.11, compared with the Medicare conversion factor for calendar year 2004 of \$37.3374

***Policy adjuster***

To encourage access to maternity services and family planning services, the Department increases fees for these codes. This is done by a “policy adjuster” that increases the fee by 10%. For example, the July 2004 fee for a physician for a normal delivery and associated care (59400) was calculated as follows:

$$40.66 \text{ RVUs} \times \text{policy adjuster of } 1.10 \times \text{conversion factor of } \$30.11 = \$1,346.60$$

**Professional and technical components**

Many imaging services as well as some other diagnostic services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with modifier TC; a practitioner who only interprets the test would bill with modifier 26; and a practitioner who performs both components would bill the code without a modifier. (Performance of both components is called the global service.) The fee schedule has separate fees for each component and for the global service. Consider a muscle test, one limb (95860) as an example:

- 95860-TC: 0.919 RVUs x conversion factor of \$30.11 x 90% =\$24.90
- 95860-26: 1.361 RVUs x conversion factor of \$30.11 x 90% = \$36.88
- 95860: 2.279 RVUs x conversion factor of \$30.11 x 90% = \$61.75

**Other modifiers**

Under the RBRVS fee schedule, certain other modifiers also affect payment. As of July 2004, these are shown in the following table.

<b>How Modifiers Change Pricing</b>		
<ul style="list-style-type: none"> <li>• If a modifier does not appear in this list, then it does not affect pricing.</li> <li>• The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.</li> </ul>		
Modi- fier	Definition	How it Affects Payment
22	Unusual procedural service	Pay by report
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
52	Reduced service	The service is paid at 50% of the fee.

**Charge cap**

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider’s charge.

**Payment by report**

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider’s charge. As of July 2004 the percentage was 45%; the Department typically reviews this percentage each July.

**Bundled codes**

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. An example is the application of hot or cold packs (97010). Because these services are covered by Medicaid, providers may not bill clients for them on a private pay basis.

**Status codes**

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

<b>Table A</b>			
<b>Medicare and Medicaid RBRVS Status Values</b>			
<b>Medicare Status</b>		<b>Medicaid Status</b>	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered
<b>Notes:</b>			
<ul style="list-style-type: none"> <li>• Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X.</li> <li>• Medicare uses the label “injections” for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day.</li> </ul>			

## How Cost Sharing is Calculated on Medicaid Claims

Client cost sharing for services provided by physical and occupational therapists is \$2.00 per visit and \$3.00 per visit for speech therapy. The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a therapist performs speech/hearing evaluation in her office (92506). The Medicaid allowed amount in July 2004 for this procedure is \$86.36. The client would owe the speech therapist \$3.00 for cost sharing, and Medicaid would pay the provider the remaining \$83.36.

## How Payment is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a Medicaid client who also has insurance through her job receives physical therapy (97530). The client's other insurance is billed first and pays \$15.00. The Medicaid allowed amount for this service is \$19.97. The amount the other insurance paid (\$15.00) is subtracted from the Medicaid allowed amount (\$19.97), leaving a balance of \$4.97 (less \$2.00 cost sharing). Medicaid will pay \$2.97 on this claim.

## How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.



Total payment to the provider from all sources may not exceed the Medicaid allowed amount.

**Scenario 1: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has already met Medicare deductible.**

Scenario 1	
\$ 44.27	Medicare allowed
x 80%	Medicare rate
\$ 35.42	Medicare paid
\$ 44.27	Medicare allowed
- 35.42	Medicare paid
\$ 8.85	Medicare coinsurance
\$ 41.36	Medicaid allowed
- 35.42	Medicare paid
\$ 5.94	
\$5.94	< \$8.85
\$5.94	Medicaid pays

A speech therapist provides speech/hearing therapy in her office to a client who is eligible for both Medicare and Medicaid. The client has already met Medicare's requirement for a \$100 deductible per year. The Medicare allowed amount for this service (92507) is \$44.27. As usual, the Medicare program pays the physician 80% of this amount, or \$35.42. The client would be personally responsible for the balance (or coinsurance) of \$8.85 except that he has Medicaid as secondary coverage.

Medicaid's allowed amount for this service is \$41.36. Because Medicare already paid \$35.42, that would leave a difference of \$5.94. Medicaid

then compares the coinsurance amount (\$8.85) to the Medicaid balance (\$5.94) and pays the lower of the two amounts. The provider will receive \$5.94 from Medicaid for this claim.

**Scenario 2: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.**

Scenario 2	
\$ 70.51	Medicare allowed
- 70.51	Applied to deductible
\$ 0.00	Medicare paid
\$ 51.17	Medicaid allowed
- 0.00	Medicare paid
\$ 51.17	
\$51.17	< \$70.51
\$51.17	(Medicaid Pays)

A physical therapist provides and evaluation in her office for a client who is eligible for both Medicare and Medicaid. The client has not yet met his \$100 Medicare deductible. The Medicare allowed amount for this services (97001) is \$70.51, but because that amount is applied to the client's deductible, Medicare pays zero. The Medicaid allowed amount is \$51.17. Medicaid will pay the lower of \$51.17 and \$70.51. The provider will receive \$51.17 from Medicaid for this claim.

Providers cannot bill Medicaid clients for the difference between charges and the amount Medicaid paid.

Scenario 3	
\$ 70.51	Medicare allowed
<u>x 80%</u>	Medicare rate
\$ 56.41	Medicare paid
\$ 70.51	Medicare allowed
<u>- 56.41</u>	Medicare paid
\$14.10	Medicare coinsurance
\$ 51.17	Medicaid allowed
<u>- 56.41</u>	Medicare paid
\$ -5.24	Negative value = 0
\$0 < \$14.10	
\$0	Medicaid pays

***Scenario 3: Dually eligible client, Medicare paid amount is higher than Medicaid allowed amount, client has met Medicare deductible.***

This example is the same as above, except the client has met his Medicare deductible. The Medicare allowed amount is \$70.51, which Medicare pays at 80% for \$56.41. This leaves the client with a \$14.10 Medicare coinsurance.

The Medicaid allowed amount is \$51.17. Because Medicare paid \$56.41, this would leave a difference of \$-5.24. Medicaid considers this negative value equal to \$0. Medicaid then compares the coinsurance balance (\$14.10) to the Medicaid balance (\$0) and pays the lower of the two amounts. Medicaid would pay the provider \$0.00 for this claim.

compares the coinsurance balance (\$14.10) to the Medicaid balance (\$0) and pays the lower of the two amounts. Medicaid would pay the provider \$0.00 for this claim.



# Appendix A: Forms

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- *Montana Medicaid /MHSP/CHIP Individual Adjustment Request*
- *Montana Medicaid Claim Inquiry Form*
- *Paperwork Attachment Cover Sheet*



# Montana Medicaid 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.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
Provider number _____ 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

# Paperwork Attachment Cover Sheet

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

**Date of service:** \_\_\_\_\_

**Medicaid provider number:** \_\_\_\_\_

**Medicaid client ID number:** \_\_\_\_\_

**Type of attachment:** \_\_\_\_\_

## **Instructions:**

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. 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 Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website [www.mtmedicaid.org](http://www.mtmedicaid.org). If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

## Appendix B: Place of Service Codes

<b>Place of Service Codes</b>		
<b>Codes</b>	<b>Names</b>	<b>Descriptions</b>
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

### Place of Service Codes (continued)

Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

<b>Place of Service Codes (continued)</b>		
<b>Codes</b>	<b>Names</b>	<b>Descriptions</b>
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

**Place of Service Codes (continued)**

<b>Codes</b>	<b>Names</b>	<b>Descriptions</b>
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

\*\* Revised, effective October 1, 2005

# Definitions and Acronyms

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**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, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

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

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

## **Allowed Amount**

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

## **Ancillary Provider**

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

## **Assignment of Benefits**

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

## **Assistant/Aide**

A person who assists in the provision of therapy services. The assistant/aide must be under supervision and authorized to assist according to Montana law.

## **Authorization**

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

**Basic Medicaid**

Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

**Cash Option**

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

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

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

**Children's Health Insurance Plan (CHIP)**

This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

**Clean Claim**

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

**Client**

An individual enrolled in a Department medical assistance program.

**Code of Federal Regulations (CFR)**

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

**Coinsurance**

The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance

is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

**Conversion Factor**

A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

**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 assessed by flat fee or percentage of charges.

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

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

**Emergency Services**

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

**Experimental**

A non-covered item or service that researchers are studying to investigate how it affects health.

**Fiscal Agent**

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

**Full Medicaid**

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

**Gross Adjustment**

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

**Indian Health Service (IHS)**

IHS provides health services to American Indians and Alaska Natives.

**Individual Adjustment**

A request for a correction to a specific paid claim.

**Investigational**

A non-covered item or service that researchers are studying to investigate how it affects health.

**Maintenance Therapy**

Maintenance therapy is repetitive therapy services used to maintain functions with no expectation of progress. Maintenance therapy does not require licensed therapist evaluation or skills.

**Mass Adjustment**

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

**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.

**Medicaid Eligibility and Payment System (MEPS)**

A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

**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 mal-function. 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 serious emotional disturbance (SED) or 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.

### **Modalities**

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

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

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

### **PASSPORT To Health**

A Medicaid managed care program where the client selects a primary care provider who manages the client’s health care needs.

### **Prior Authorization (PA)**

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

### **Private-pay**

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

### **Provider or Provider of Service**

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

### **Qualified Medicare Beneficiary (QMB)**

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

### **Reference Lab Billing**

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

### **Relative Value Scale (RVS)**

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

### **Relative Value Unit**

The numerical value given to each service in a relative value scale.

### **Remittance Advice (RA)**

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

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

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

### **Restorative Therapy**

Therapy services are restorative when the client's function is expected to improve significantly in a reasonable and predictable period of time. Assessment of the client's restorative potential is completed by the client's physician or mid-level practitioner in consultation with the licensed therapist. Therapy services are not restorative if the client's expected restoration potential is insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative when it is determined that function will not improve.

### **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.

### **Special Health Services (SHS)**

SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

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

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

### **Spending Down**

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

### **Third Party Liability (TPL)**

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

### **Usual and Customary**

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

### **Virtual Human Services Pavilion (VHSP)**

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. <http://vhsp.dphhs.state.mt.us>

### **WINASAP 2003**

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

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