

# Billing Procedures

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## Claim Forms

Services provided by the health care professionals covered in this manual must be billed to Medicaid 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, the authorizing agency, 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
- **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 errors and 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*).



It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit.

## When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. However, providers may bill the client if Medicaid denies a claim because the client is not enrolled in Medicaid.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a client cancels or fails to arrive for a scheduled transport. Medicaid may not be billed for cancellations or no-show appointments either.

When Medicaid covers the service, providers must accept Medicaid rates as payment in full.

## Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to others for that service.

## Coding

Standard use of medical coding conventions is required when billing Medicaid. When the Transportation Center faxes the provider a list of approved transports, that list will contain important billing information. The following are some coding tips for billing Medicaid.

### ***Procedure code***

A procedure code is required for billing Medicaid. This code is provided by the Transportation Center on the transport confirmation list. Procedure codes are also listed in the following *Transportation Codes* table and on the Transportation fee schedule on the Provider Information website (see *Key Contacts*) and in current coding manuals (see following table of *Coding Resources*). The following is a list of valid transportation codes. These codes require prior authorization (see the *PASSPORT and Prior Authorization* chapter in this manual).

<b>Non-Emergency Transportation Codes</b>			
<b>Commercial Transportation - Taxicab - Provider Type 23</b>			
<b>Code</b>	<b>Use</b>	<b>Reimbursement</b>	<b>PA</b>
A0100	Taxicab over 16 miles	per mile	Y
A0140	Taxicab under 16 miles	one way flat fee	Y
<b>Specialized Non-Emergency Transportation - Provider Type 24</b>			
A0100	Wheelchair van - over 16 miles	per mile	Y
A0130	Wheelchair van - under 16 miles	one way flat fee	Y



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