



Physician Related Services

Provided by:

*Physicians, Mid-Level Practitioners,
Podiatrists, Laboratories, Imaging
Facilities, Independent Diagnostic
Testing Facilities, and Public Health
Clinics*

*Medicaid and Other Medical
Assistance Programs*



January 2005

This publication supersedes all previous Physician, Mid-Level Practitioner, Podiatrist, Laboratory, Imaging Facility, Independent Diagnostic Testing Facility, and Public Health Clinic provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2002.

Updated September 2002, January 2003, June 2003, August 2003, September 2003, December 2003, July 2004, September 2004, November 2004, January 2005.

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My Medicaid Provider ID Number:

My CHIP Provider ID Number:

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Key Contacts

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 state
(406) 442-1837 Out of state and 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 state
(406) 442-1837 Out of state and 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

Third Party Liability

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

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS 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

PASSPORT Program Officer

Send inpatient stay documentation to:

PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

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.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone

(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state

(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:

DPHHS
Lab & X-ray Services
Health Policy & Services Division
P.O. Box 202951
Helena, MT 59620

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone

(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killlearn Center Blvd.
Tallahassee, FL 32309

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone

(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

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

Client Eligibility

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

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

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

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services, or emergency department reviews, contact:

Phone:

(800) 262-1545 X5850 In state

(406) 443-4020 X5850 Out of state and
Helena

Fax:

(800) 497-8235 In state

(406) 443-4585 Out of state and Helena

Send written inquiries to:

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

Key Web Sites	
Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • Senior and Long Term Care: Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • DPHHS: 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. • Health Policy and Services Division: Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org	<ul style="list-style-type: none"> • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm	<ul style="list-style-type: none"> • Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

Key Web Sites (continued)

Web Address	Information Available
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for physicians, mid-level practitioners, podiatrists, public health clinics, independent laboratories, independent imaging facilities, and independent diagnostic testing facilities.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). 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.

Manual Maintenance

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

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key*



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

Contacts). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the physician related services programs:

- Code of Federal Regulations (CFR)
 - 42 CFR 410 Supplementary Medical Insurance (SMI) Benefits
 - 42 CFR 440 Services: General Provisions
 - 42 CFR 441 Services: Requirements and Limits Applicable to Specific Services
- Montana Codes Annotated (MCA)
 - MCA Title 37-2-101 - 37-2-313 General Provisions Relating to Health Care Practitioners
 - MCA 37-3-101 - 37-3-405 Medicine
 - MCA 37-6-101 - 37-6-312 Podiatry
 - MCA 37-14-101 - 37-14-102 Radiologic Technologists
 - MCA 37-34-101 - 37-34-307 Clinical Laboratory Science Practitioners
- Administrative Rules of Montana (ARM)
 - ARM 37.85.220 Independent Diagnostic Testing Facility
 - ARM 37.86.101 - 37.86.105 Physical Services
 - ARM 37.86.201 - 37.86.205 Mid-Level Practitioner Services
 - ARM 37.86.501 - 37.86.506 Podiatry Services
 - ARM 37.86.3201 - 37.86.3205 Non-Hospital Lab and Radiology (X-Ray) Services
 - ARM 37.86.1401 - 38.86.1406 Public Health Clinic Services

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 (42 CFR 456.3).

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* web site (see *Key Contacts*).

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

Cosmetic services (ARM 37.86.104)

Medicaid covers cosmetic services only when it can be demonstrated that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment. Before cosmetic services are performed, they must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Services are authorized on a case-by-case basis.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages (see the *EPSDT* chapter in this manual). Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.



All forms required for abortions can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or downloaded from the *Provider Information Web Site* (see *Key Contacts*).

Family planning services (ARM 37.86.1701)

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the PASSPORT provider is not required for family planning services. See the *Completing a Claim* chapter in this manual for PASSPORT overrides. Specific billing procedures must be followed for family planning services (see *Billing Procedures*).

Home obstetrics (ARM 37.85.207)

Home deliveries are only covered on an emergency basis (see *Definitions*) by a physician or licensed midwife.

Immunizations

The Vaccines For Children (VFC) Program makes available at no cost to providers selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization Program at (406) 444-5580.

Medicaid does not cover pneumonia and flu vaccines for clients with Medicare Part B insurance because Medicare covers these immunizations.

Infertility (ARM 37.85.207)

Medicaid does not cover treatment of infertility.

Prescriptions (ARM 37.86.1102)

- Drugs are limited to a 34-day supply.
- No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
 - Antibiotics
 - Schedule II and III drugs
 - Antineoplastic agents

PA Criteria for Specific Services (continued)		
Service	PA Contact	Documentation Requirements
<ul style="list-style-type: none"> Circumcision 	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs: <ul style="list-style-type: none"> Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated. Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene Urinary obstruction Urinary tract infections
<ul style="list-style-type: none"> Dispensing and fitting of contact lenses 	<p>Provider Relations P.O. Box 4936 Helena, MT 59604</p> <p>Phone: (406) 442-1837 In/out-of-state (800) 624-3958 In state</p>	<ul style="list-style-type: none"> PA required for contact lenses and dispensing fees. Diagnosis must be one of the following: <ul style="list-style-type: none"> Keratoconus Aphakia Sight cannot be corrected to 20/40 with eyeglasses
<ul style="list-style-type: none"> Prescription Drugs <p>(For a list of drugs that require PA, refer to the <i>PA Criteria for Prescription Drugs</i> later in this chapter.)</p>	<p>Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 443-6002 Helena (800) 395-7961 In/out-of-state</p> <p>Fax: (406) 443-7014 Helena (800) 294-1350 In/out-of-state</p>	<ul style="list-style-type: none"> Refer to the <i>PA Criteria for Prescription Drugs</i> table in this chapter for a list of drugs that require PA. Providers must submit the information requested on the <i>Request for Drug Prior Authorization Form</i> to the Drug Prior Authorization Unit. This form is in <i>Appendix A: Forms</i>. The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the <i>PA Criteria for Specific Services</i> table.
<ul style="list-style-type: none"> Maxillofacial/Cranial Surgery 	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> Surgical services are only covered when done to restore physical function or to correct physical problems resulting from: <ul style="list-style-type: none"> Motor vehicle accidents Accidental falls Sports injuries Congenital birth defects Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> Client's condition Proposed treatment Reason treatment is medically necessary Medicaid does not cover these services for the following: <ul style="list-style-type: none"> Improvement of appearance or self-esteem (cosmetic) Dental implants Orthodontics

PA Criteria for Specific Services (continued)

Montana Department of Public Health and Human Services

Service	PA Contact	Documentation Requirements																		
<p>• Blepharoplasty</p>	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • Reconstructive blepharoplasty may be covered for the following: <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). • Documentation must include the following: <ul style="list-style-type: none"> • Surgeon must document indications for surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Pre-operative photographs • Medicaid does not cover cosmetic blepharoplasty 																		
<p>• Botox Myobloc</p>	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see <i>Key Contacts</i>) • Botox is covered for treating the following: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td>Laryngeal spasm</td> <td>Multiple Sclerosis</td> </tr> <tr> <td>Blepharospasm</td> <td>Spastic hemiplegia</td> </tr> <tr> <td>Hemifacial spasm of the nerve</td> <td>Infantile cerebral palsy</td> </tr> <tr> <td>Torticollis, unspecified</td> <td>Other specified infantile cerebral palsy</td> </tr> <tr> <td>Torsion dystonia</td> <td>Achalasia and cardiospasm</td> </tr> <tr> <td>Fragments of dystonia</td> <td>Spasm of muscle</td> </tr> <tr> <td>Hereditary spastic paraplegia</td> <td>Hyperhidrosis</td> </tr> <tr> <td>Strabismus and other disorders of binocular eye movements</td> <td></td> </tr> <tr> <td>Other demyelinating diseases of the central nervous system</td> <td></td> </tr> </table> • Documentation requirements include a letter from the attending physician supporting medical necessity including: <ul style="list-style-type: none"> • Client's condition (diagnosis) • A statement that traditional methods of treatments have been tried and proven unsuccessful • Proposed treatment (dosage and frequency of injections) • Support the clinical evidence of the injections • Specify the sites injected • Myobloc is reviewed on a case-by-case basis 	Laryngeal spasm	Multiple Sclerosis	Blepharospasm	Spastic hemiplegia	Hemifacial spasm of the nerve	Infantile cerebral palsy	Torticollis, unspecified	Other specified infantile cerebral palsy	Torsion dystonia	Achalasia and cardiospasm	Fragments of dystonia	Spasm of muscle	Hereditary spastic paraplegia	Hyperhidrosis	Strabismus and other disorders of binocular eye movements		Other demyelinating diseases of the central nervous system	
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<p>• Excising Excessive Skin and Subcutaneous Tissue</p>	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • Required documentation includes the following: <ul style="list-style-type: none"> • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures • Pre-operative photographs • This procedure is contraindicated for, but not limited to, individuals with the following conditions: <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy • Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance. 																		

Create eardrum opening (69436)

3.760 RVUs x transition adjustor of 1.36 x conversion factor of \$31.90 = \$163.12

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 2002 fee for a normal delivery and associated care (59400) was calculated as follows:

38.416 RVUs x policy adjustor of 1.10 x conversion factor of \$31.90 = \$1,348.02

Global periods

For many surgical services and maternity services, the fee covers both the service and all related care within a specified “global” period. For almost all such codes, the global periods used by Medicaid are identical to those used by Medicare, but in cases of differences the Medicaid policy applies. See the *Billing Procedures* chapter in this manual for more information on global periods.

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 chest x-ray (71010) as an example:

71010-TC: 0.409 RVUs x conversion factor of \$31.90 = \$13.05

71010-26: 0.231 RVUs x conversion factor of \$31.90 = \$7.37

71010: 0.640 RVUs x conversion factor of \$31.90 = \$20.42

Other modifiers

Under the RBRVS fee schedule, certain other modifiers also affect payment. As of July 2002, these are shown in the following table.



The numerical examples on this page do not reflect current rates and should not be used to calculate payment.



Providers must take extra care in billing codes that have global periods or are divided into technical and professional components.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services. For services paid via the RBRVS fee schedule, the fee schedule shows the list of services for which modifiers 26, TC, 50, 51, 62, 66 and 80 apply.
- If a modifier does not appear in this list, then it does not affect pricing.
- The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.

Modi-fier	Definition	How it affects payment
21	Prolonged evaluation and management	This service is paid at 110% of the fee.
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.
47	Anesthesia by surgeon	Pay by report
50	Bilateral procedure	The procedure is paid at 150% of the fee.
51	Multiple procedures	Each procedure is paid at 50% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
53	Discontinued procedure	The service is paid at 50% of the fee.
54	Surgical care only	The service is paid at 75% of the fee.
55	Postoperative management only	The service is paid at 25% of the fee.
56	Preoperative management only	The service is paid at 25% of the fee.
62	Two surgeons	Each surgeon is paid at 62.5% of the fee.
66	Surgical team	Each surgeon is paid by report.
80	Assistant surgeon	The service is paid at 16% of the fee.
81	Minimum assistant surgeon	The service is paid at 16% of the fee.
82	Assistant surgeon; qualified resident surgeon not available	The service is paid at 16% of the fee.
90	Reference laboratory	Modifier not allowed
AD	Medical supervision of more than four concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
AS	Physician assistant, nurse practitioner or clinical nurse specialist as assistant at surgery	The service is paid at 16% of the fee.
QK	Medical supervision of 2-4 concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
QX	Certified registered nurse anesthetist service: medically directed by MD	Each service is paid at 52.5% of the fee.
QZ	Certified registered nurse anesthetist service without medical direction	The modifier does not reduce the fee, but a professional differential of 90% is applied due to provider type. See <i>Professional differentials</i> in this chapter.
SA	Nurse practitioner	Payment equals 90% of the fee for some services but 100% for others. See <i>Professional differentials</i> in this chapter.
SB	Nurse midwife	Payment equals 90% of the fee for some services but 100% for others. See <i>Professional differentials</i> in this chapter.
TC	Technical component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 60% of the fee.