

School-Based Services

*Medicaid and Other Medical
Assistance Programs*

MONTANA
Department of Public Health & Human Services

August, 2005

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My Medicaid 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 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, PASSPORT, payments, denials, general claims questions, or to request provider manuals or fee schedules:

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

Send written inquiries to:

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

Claims

Send paper claims and adjustment requests 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 and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

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

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client’s designated provider.

Client Help Line

Clients who have general Medicaid or PASSPORT 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

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

Provider 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.

CSCT Program

For more information on the Comprehensive School and Community Treatment (CSCT) program, contact the school-based program specialist or the Children's Mental Health Bureau.

(406) 444-4540 Phone

(406) 444-1861 Fax

Send written inquiries to:

School-Based Program Specialist or
Children's Mental Health Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

For inquiries related to licensure/endorsement, contact the Quality Assurance Division, licensing Bureau:

(406) 444-2676 Phone

(406) 444-1742 Fax

Send written inquiries to:

Quality Assurance Division
Licensing Bureau
2401 Colonial Drive, Third Floor
Helena, MT 59602-2693

CHIP Program

(877) 543-7669 Phone toll-free in and out-of-state

(406) 444-6971 Phone in Helena

(406) 444-4533 Fax In Helena

(877) 418-4533 Fax Toll-free in and out-of-state

chip@state.mt.us E-mail

CHIP Program Officer
P.O. Box 202951
Helena, MT 59620-2951

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

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-3964 Phone

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

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.

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for transplant services, private duty nursing services, medical necessity therapy reviews, and emergency department reviews:

Phone:

(800) 262-1545 X150 In state

(406) 443-4020 X150 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

Covered Services

General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge
- For CSCT services, children must have a serious emotional disturbance (SED) diagnosis as specified under ARM 37.86.3702(2).

Refer to the IEP requirements in this chapter and the Coordination of Benefits chapter regarding billing services included/not included in a child's IEP.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology)
- Audiology
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply (see the *PASSPORT and Prior Authorization* chapter in this manual).

Services within scope of practice (ARM 37.85.401)

Services provided under the school-based services program are covered only when they are within the scope of the provider’s license.

Provider requirements

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher’s aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: <ul style="list-style-type: none"> • Licensed registered nurse • Licensed practical nurse 	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: <ul style="list-style-type: none"> • Credentialed school psychologist • Licensed psychologist • Licensed clinical professional counselor • Licensed clinical social worker 	Mental health providers must be licensed according to Montana’s state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: <ul style="list-style-type: none"> • Licensed occupational therapist • Licensed physical therapist • Licensed speech language pathologists 	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Audiology	Must meet credentialing requirements as defined by the Montana Licensing Board
Personal care paraprofessional	No licensing requirements
Comprehensive School & Community Treatment (CSCT)	Must be provided by a licensed mental health center with a CSCT endorsement

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner’s license, certification, registration or credential to practice in Montana. Medicaid providers who have had their license suspended by a state or federal government entity may not provide school-based services.

IEP requirements

Services provided to Medicaid clients must be covered by Medicaid and documented in the client’s Individualized Education Plan (IEP), unless otherwise specified. School-based providers may bill Medicaid for Medicaid-covered health-related services provided to children with those services written into the

Services provided to Medicaid clients must be documented in the client’s IEP.

IEP, even though the services may be provided to non-Medicaid children for free. However, if a child is covered by both Medicaid and private insurance, the private insurance must be billed prior to Medicaid. Exception to billing other insurance: BC/BS of Montana and CHIP.

Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

Client qualifications

To qualify for Medicaid school-based services, the client must be a Medicaid client and meet all the following criteria:

- Be Medicaid eligible on the date of service
- Be between the ages 3 and 20
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA)
- Have Medicaid reimbursable services referenced in his or her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
- In the case of CSCT services, the client must have an SED diagnosis and services may or may not be included in the client's IEP.

School qualifications

Only public school districts, full-service education cooperatives and joint boards of trustees may enroll in the Montana Medicaid school-based services program. To qualify, the district, cooperative or joint board must receive special education funding from the state's Office of Public Instruction general fund for public education. School districts include elementary, high school and K-12 districts that provide public educational services. Full-service education cooperatives and joint boards include those cooperatives eligible to receive direct state aid payments from the Superintendent of Public Instruction for special education services.

Schools that employ medical service providers

- Schools who employ all or most of their medical service providers for whom the school submits bills can be enrolled with a single provider number for all services.



Cooperatives, joint boards, and non-public schools that do not receive state general funds for special education can not participate in the Medicaid program as a school-based provider.

- Schools may use this single provider number to bill for any Medicaid covered service provided by a licensed provider.
- Schools that wish to have separate provider numbers for each provider type (e.g., speech therapists, occupational therapists, and physical therapists) can request separate provider numbers from Provider Enrollment (see *Key Contacts*).

Schools that contract with external medical service providers

- Schools that contract with all or most of their medical service providers for whom the school submits bills cannot be enrolled with a single provider number.
- Schools that contract with all or most of their providers must have the provider of service bill for each service they provide with their own individual Medicaid provider number.
- Providers and schools can arrange with the Department for payments to be made to the school. If payments are assigned to the school, the school will also have the responsibility to collect third party liability payments on behalf of the service providers.

For more information on enrollment, visit the Provider Information website or contact Provider Enrollment (see *Key Contacts*).

Physician order/referral

Medicaid does not require physician orders or referrals for health-related services that are documented in the client's IEP. The exception is private duty nursing services, which require both a written order and PASSPORT approval. Other health-related services can be authorized by a licensed school practitioner meeting the State of Montana provider requirements to secure health-related services under an IEP. For instructions on getting PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual. See the table of authorization requirements later in this chapter.

Documentation requirements

School-based services providers must maintain appropriate records. All case records must be current and available upon request. Records can be stored in any readily accessible format and location, and must be kept for six years and three months from the date of service. For more information on record keeping requirements, see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual. Medical documentation must include the following:

- Date of service and the child's name
- The service(s) provided during the course of each treatment and how the child responded.

- Except for CSCT, the services for which the school is billing Medicaid must be written into the child's IEP.
- If the service is based on time units, (i.e. 15 minutes per unit), the provider of service should indicate begin and end times or the amount of time spent for each service.
- Providers must sign and date each record documented on the day the medical service was rendered. Provider initials on daily records are acceptable providing their signature is included in other medical documentation within the child's record.
- Documentation must, at least quarterly, include notes on client progress towards their goals.
- The service provider must keep sufficient documentation to support the procedure(s) billed to Medicaid.
- Documentation must not be created retroactively. Providers are responsible for maintaining records at the time of service.
- CSCT services are not required to be included in the IEP because often clients that require these services do not fit the special education requirements. The clinical assessment must document the medical necessity and the clinical treatment plan must demonstrate how the CSCT services will address the medical necessity. In addition to the above requirements, CSCT documentation must also include:
 - Where services were provided;
 - Result of service and how service relates to the treatment plan and goals;
 - Progress notes for each individual therapy and other direct service;
 - Monthly overall progress notes;
 - Individual outcomes compared to baseline measures and established benchmarks.

The Montana Medicaid School-Based Services Program is subject to both state and federal audits. As the Medicaid provider, the school certifies that the services being claimed for Medicaid reimbursement are medically necessary and furnished under the provider's direction. Both fiscal and clinical compliance are monitored. In the event of adverse findings, the district/cooperative (not the mental health provider) will be held responsible for any paybacks to Medicaid. If school districts have included a program area for CSCT in their accounting system, then the district can book revenue received from third party insurers or parents that paid privately for CSCT services, providing audit documentation (see the *Comprehensive School and Community Treatment* section in this chapter). To assist in document retention for audit purposes, see the *Audit Preparation Checklist* in *Appendix A: Forms*.

Non-covered services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Medicaid.

- A provider's time while attending client care meetings, Individual Educational Plan (IEP) meetings, individual treatment plan meetings, or client-related meetings with other medical professionals or family members
- A provider's time while completing IEP related paperwork or reports, writing the CSCT individualized treatment plans or documenting medical services provided
- CSCT services provided without an individualized treatment plan for this service
- Services considered experimental or investigational
- Services that are educational or instructional in nature
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's school-based services fee schedule. 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 website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific school-based services.

Assessment to initiate an IEP

Medicaid covers medical evaluations (assessments) to develop an IEP as long as an IEP is subsequently established and health-related needs are identified.

Comprehensive School and Community Treatment (CSCT)

Comprehensive School and Community Treatment (CSCT) is a very intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community. CSCT provides a comprehensive, planned course of outpatient treatment provided primarily in the school to a child with a serious emotional disturbance (SED). These services are provided through a program operated by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center. CSCT services include, among other services, individual, group and family therapy and behavioral interventions.



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



The CSCT Program must follow *free care rules* (see *Definitions*).

CSCT requirements

A licensed mental health center must have a CSCT endorsement issued by the Quality Assurance Division, Licensing Bureau. For more information on how to apply for program endorsement, contact the Montana Department of Public Health and Human Services (see *CSCT Program* in *Key Contacts*). For information on CSCT Program requirements, see *Appendix C: CSCT Program*.

- ***Services provided by a Mental Health Center.*** Services under the CSCT program must be provided by a school that is a licensed mental health center or a licensed mental health center that has contracted with the schools. Schools are required to lead the program management and are specifically required to meet all of the requirements described in this chapter.
- ***Program endorsed before providing services.*** Program endorsement must be obtained by the licensed mental health center prior to the service implementation in order for school districts or cooperatives to implement CSCT programs.
- ***Program staff requirements.*** Program staff must include at least two mental health workers and one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor or in-training mental health professional (ARM 37.88.901). The Department of Public Health and Human Services must approve an in-training mental health professional prior to program approval, but approval is not required for licensed providers.
- ***Children must have serious emotional disturbances*** (ARM 37.86.3702(2)). The CSCT program is intended specifically for children who have serious emotional disturbances, regardless of whether the child is eligible for special education services. This program is not intended for children with functional limitations who require support for activities of daily living (ADL). Children that require ADL support are covered by other Medicaid services like personal care paraprofessionals.
- ***Services must be medically necessary*** (ARM 37.82.102 and 37.85.410). CSCT services must be medically necessary. See *medically necessary* in the *Definitions* section of this manual. Medicaid considers experimental services or services which are generally regarded by the medical profession as unacceptable treatment not medically necessary.
- ***Services must be available to all qualifying children.*** CSCT services must be made available to all children that meet criteria for those services, not just because the child has Medicaid benefits. In the case of school-based programs that provide services to children

that do not have IEPs, Medicaid will pay for covered services if the following are in place:

- A fee schedule is established (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

The exception to this policy is the services that are provided to Medicaid eligible children and the services are written into the children's IEPs (see *IEP Requirements* in this chapter).

- ***Program must follow free care rule.*** Everyone who receives CSCT services must be billed for the services. If a service is free for non-Medicaid clients, then it is free for all children. Medicaid billable services provided under an IEP are not subject to the *free care rule* (see *IEP Requirements* in this chapter).

Services included

Strategies, coordination and quality improvement activities related to the individual child's treatment plans are included in the CSCT program in addition to the following services:

- Individual, family and group therapy
- Behavior intervention
- Crisis intervention services
- Coordination with other addictive and mental health treatment services the child receives outside the CSCT program
- Other evidence and research-based practices effective in the treatment of children or adolescents with SED
- Access to emergency services
- Referral and aftercare coordination with inpatient facilities, residential treatment programs or other appropriate out of home placement programs
- Continued treatment that includes services during non-school days integrated in a manner consistent with the child or adolescent's treatment plan.

Service requirements

The CSCT program must be provided through a program of services staffed by at least two mental health workers who work exclusively in the school. At least one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counse-

lor, or a DPHHS approved in-training mental health professional. The minimum staffing requirement for a program is one team with the capacity to provide up to 720 units per calendar month to children with SED. Part-time staff may be utilized but the billing units must be reduced proportionately.

- *Caseload* refers to the total number of units the CSCT program team may provide in a calendar month. Ideally the staff and CSCT clients should be all contained in one school. It is acceptable, however, for a CSCT program team to provide up to 720 units to be spread across no more than two schools located in close proximity of one another. Coverage by a CSCT team of more than two school campuses is not acceptable.
- The expectation is that the full-time CSCT staff will be available throughout each day to meet the needs of the CSCT clients. It is not generally appropriate, therefore, for the licensed or in-training mental health professional CSCT worker to have an outpatient caseload in addition to CSCT duties. The only exception is youth transitioning out of CSCT who need some therapeutic support.
- The use of an “in-training mental health professional” in a CSCT program is allowed on an infrequent and exceptional basis. It is recognized that recruitment of licensed professionals may be difficult in some parts of the state. Approval for such an arrangement must be obtained from the Children’s Mental Health Bureau in writing. In its request to use an in-training mental health professional the CSCT program must document the following:
 - The program has advertised for a licensed professional unsuccessfully in newspapers and through Job Service for at least three weeks. The program must have offered a salary that is competitive for the community in which the program is located. The Department will not approve the use of an in-training mental health professional unless a salary of at least state pay plan grade 15, entry level plus benefits including health insurance, has been offered during the unsuccessful recruitment.
 - The in-training mental health professional has completed all academic work required for the license and has begun the post-degree supervised experience required for licensure.
 - A licensed professional has entered into a written agreement to provide supervision of the post degree experience required for licensure.
 - A licensure examination date (or at least an approximate date) has been selected.
 - The in-training mental health professional may serve in lieu of a licensed CSCT staff for no more than 2 years.

- The in-training mental health professional has had relevant prior experience serving SED children.
- The CSCT program offers, at a minimum, face-to-face supervision by a licensed professional that meets the appropriate discipline licensing standard, at the CSCT site.
- CSCT services must also be available for non-Medicaid clients who meet the CSCT program requirements. In addition to providing these services, districts/cooperatives must also request payment for these services. Services may be billed based on a sliding fee schedule to non-Medicaid children. Schools may contract with their CSCT provider to bill Medicaid, private-pay patients and insurance carriers.
- CSCT services not specified in the IEP must be made available and billed to **all** children who receive services.
- Providers may not bill Medicaid for any CSCT services that are generally offered to all clients without charge.
- CSCT services do not require PASSPORT approval or inclusion in the child's IEP.
- CSCT services must be provided according to an individualized treatment plan. The treatment plan must be reviewed and approved by a licensed professional who is a CSCT staff member.

Billable Services

- Face to face service
 - Individual
 - Family
 - Group
 - Behavioral interventions

Services restricted

Medicaid does not cover the following services under the CSCT program:

- Observation
- Non-face to face service
- Time in meetings
- More than 720 units of service per CSCT team per calendar month
- Prior authorization is required for outpatient therapy services provided concurrently or outside the CSCT program.

Therapy services

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's Medicaid provider number (see the *Billing Procedures* chapter in this manual).

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.
- **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.

Services included

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the client's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the client's IEP.
- Assessment services to determine client medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

Service requirements

For clients who are enrolled in the PASSPORT To Health program, the client's PASSPORT provider's approval is required before providing therapy services. For instructions on receiving PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Services restricted

- Montana Medicaid does not cover therapy services that are intended to maintain a client's current condition but only covers services to improve client functions.
- Therapy services are limited to 40 hours per state fiscal year (July 1 - June 30) for each type of therapy. This limit may be exceeded if the client is still progressing in his or her treatment.

Private duty nursing services

Private duty nursing services are skilled nursing services provided by a registered or licensed practical nurse.

Service requirements

Medicaid covers private duty nursing services when all of the following requirements are met:

- When the client's attending physician or mid-level practitioner orders these services in writing
- When the client's PASSPORT provider or primary care provider approves the service (see the *PASSPORT and Prior Authorization* chapter in this manual)
- When prior authorization (PA) is obtained (see the *PASSPORT and Prior Authorization* chapter in this manual for PA requirements)

School psychologists and mental health services

Psychological services in schools are based on determining eligibility for inclusion in special education programming and not necessarily to determine a medical diagnosis outside of the guidelines of the Individuals with Disabilities Education Act.

Services included

Psychological and mental health services include the following:

- Individual psychological therapy
- Psychological tests and other assessment procedures when the assessment results in health-related services being written into the IEP
- Interpreting assessment results
- Obtaining, integrating and interpreting information about child behavior and conditions as it affects learning, if it results in an IEP. This only includes direct face-to-face service.
- Mental health and counseling services that are documented on the client's IEP
- Consultation with the child's parent as part of the child's treatment

Service requirements

Medicaid covers psychological counseling services when the following two criteria are met:

- The client's IEP includes a behavior management plan that documents the need for the services
- Service is not provided concurrently with CSCT services (unless prior authorization has been obtained).

Services restricted

Montana Medicaid does not cover the following psychological services:

- Testing for educational purposes
- Psychological evaluation, if provided to a child when an IEP is not subsequently established
- Review of educational records
- Classroom observation
- Scoring tests

Personal care paraprofessional services

Personal care paraprofessional services are medically necessary in-school services provided to clients whose health conditions cause them to be limited in performing activities of daily living. That is, these services are provided for clients with functional limitations.



Personal care services are not covered when provided by an immediate family member.

Services included

These activities of daily living services include:

- Dressing
- Eating
- Escorting on bus
- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

Service requirements

- These services must be listed on the client's IEP.
- Approval must be given by the client's PASSPORT provider or primary care provider prior to billing for Medicaid covered services. For instructions on obtaining PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Services restricted

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

Please see *Appendix B: Personal Care Paraprofessional Services Documentation*, which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

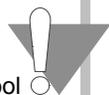
Special needs transportation

Special needs transportation includes transportation services for clients with special needs that are outside of traditional transportation services provided for clients without disabilities.

Services include

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided
- The Medicaid-covered service is included in the client's IEP
- The client's IEP includes specialized transportation service as a medical need.



The school district must maintain documentation of each service provided, which may take the form of a trip log.

Specialized transportation services are covered if one of the following conditions exists:

- A client requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus
- A client resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered

Services included

Special needs transportation includes the following:

- Transportation from the client's place of residence to school (where the client receives health-related services covered by the Montana School-based Services program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-based Services program, and return to school.

Services restricted

Clients with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana School-based Services program. The fact that clients may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

Audiology

Audiology assessments are performed by individuals possessing the state of Montana credentials for performing audiology services.

Services included

Covered audiology services include the following:

- Assessment to determine client's medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.
- Services provided must be documented in the client's IEP.

Service requirements

Medicaid covers audiology services when the services to be provided during a school year are written into the child's IEP.



Medicaid does not cover special transportation services on a day that the client does not receive a Medicaid-covered service that is written into the IEP.

Services restricted

Medicaid does not cover the following audiology services:

- Testing for educational purposes
- Services provided during Child Find assessments

Authorization requirements summary

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and PASSPORT provider approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Authorization Requirements			
Service	Prior Authorization	PASSPORT Provider Approval	Written Physician Order/Referral
CSCT services*	No	No	No
Therapy services	No	Yes	No
Private duty nursing services	Yes	Yes	Yes
School psychologist and mental health services	No	No	No
Personal care paraprofessional services	No	Yes, if applicable (If the client is enrolled in PASSPORT, PASSPORT provider approval is required.)	Yes, if applicable (If the client is not enrolled in PASSPORT, the client's primary care provider must provide a written order/referral.)
Specialized transportation services	No	No	No
Audiology	No	No	No

* Outpatient mental health services provided by a private therapist or mental health professional must have prior approval when providing services concurrently with CSCT (concurrently means services provided during the same time or in combination to a youth that is receiving CSCT services).

Other Programs

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

Children's Mental Health Services Plan (CMHSP)

The school-based services in this manual are not covered benefits of the Children's Mental Health Services Plan (CMHSP) administered by the Children's Mental Health Bureau. However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the CMHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

PASSPORT and Prior Authorization

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

PASSPORT To Health, Team Care and prior authorization are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim (see the *Completing 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 utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. 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. Team Care is a component of PASSPORT, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, 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, PASSPORT, or Team Care Program 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. In the few cases where an eligibility verification shows that a client is restricted to a certain provider or pharmacy, all providers must follow the restrictions on the eligibility documentation.

How to Identify Clients on PASSPORT

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available on the eligibility verification, and the client may have full or basic coverage. 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 medical service that requires PASSPORT approval, check the child's eligibility information for the client's primary care provider. Contact the primary care provider and request approval. It is important to communicate results of the health-related services provided by school-based medical providers to the child's primary care provider to promote coordination and continuity of care. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual).

How to Obtain Extended PASSPORT Approval

You may want to consider getting an extended approval from PASSPORT providers in your area. The school can write to all the client's primary care providers at the beginning of each year. Ask providers to sign an extended approval, good for that entire year, for health-related services that will be provided to the child during the school year as indicated in the child's IEP. This extended approval is only good for health-related services requested for each individual child. A provider is not obligated to and may choose not to approve requested services. In signing this extended approval, the PASSPORT provider gives his or her PASSPORT provider number to use when submitting claims. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual). PASSPORT numbers may change within a given year. If a wrong PASSPORT number is used, the claim will deny. Providers should check clients' eligibility verification monthly. If a new PASSPORT provider is shown, contact that provider for a new PASSPORT number.

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 *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client Help Lines are available to answer almost any PASSPORT or general Medicaid question.

Prior Authorization

Some services require prior authorization (PA) before they are provided, such as private duty nursing services. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

PA Criteria for Specific Services		
Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Private Duty Nursing Services 	<p>Medicaid Utilization Review Department Mountain Pacific Quality Health Foundation P.O. Box 6488 Helena, MT 59604-6488</p> <p>Questions regarding this process can be answered by calling:</p> <p>Helena: (406) 443-4020 ext. 150</p> <p>Outside Helena: (800) 262-1545 ext. 150</p> <p>Fax: (406) 443-4585</p>	<p>The number of units approved for private duty nursing services is based on the time required to perform a skilled nursing task.</p> <ul style="list-style-type: none"> • A prior authorization request must be sent to the Medicaid Utilization Review Department’s peer review organization accompanied by a physician or mid-level practitioner order/referral for private duty nursing. • Prior authorization must be requested at the time of initial submission of the nursing plan of care and any time the plan of care is amended. • Providers of private duty nursing services are responsible for requesting prior authorization and obtaining renewal of prior authorization. • Requests for prior authorization must be renewed every ninety days during the first six months of services, and every six months thereafter. • Providers are required to send in prior authorization requests two weeks prior to the current prior authorization request end date for recipients receiving ongoing services. • Total number for units of service paid on claims must not exceed those authorized by the Medicaid Utilization Review Department. Payment will not be made for units of service in excess of those approved. • No retrospective prior authorization reviews will be allowed. • To request prior approval submit a completed <i>Request for Private Duty Nursing Services</i> form located in <i>Appendix A: Forms</i> of this manual and on the Provider Information website under <i>Forms</i>. Send completed requests to the contact shown in the second column.
<ul style="list-style-type: none"> • Outpatient mental health therapy provided outside or concurrently with CSCT 	<p>First Health Phone: (800) 770-3084 FAX: (800) 639-8982 Address: 4300 Cox Road Glen Allen, VA 23060</p>	<p>Client Name and ID MHC Provider Number Procedure code(s) Diagnosis (es)</p>

Other Programs

The Children’s Mental Health Services Plan (CMHSP) and the Children’s Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*).

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.

If a parent determines that billing their insurance would cause a financial hardship (e.g., decrease lifetime coverage or increase premiums), and refuses to let the school bill the insurance plan, the school cannot bill Medicaid for these services based on requirements of IDEA.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client’s statement will fulfill this requirement: “When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid.”

Billing for Medicaid covered services when no IEP exists

In order to bill for Medicaid covered services that are not in the client’s IEP, the school must meet all the following requirements:

- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

If the school bills private pay clients, then they must bill as follows for the services provided:

Client Insurance Status	Billing Process
Medicaid only	Bill Medicaid
Private pay, no Medicaid	Bill family
Private insurance/Medicaid	Bill private insurance before Medicaid
Private insurance, no Medicaid	Bill private insurance

Billing for Medicaid covered services under an IEP

If a child is covered by both Medicaid and private insurance, and the services are provided under an IEP, providers must bill as follows:



If a parent refuses to let the school bill their insurance plan, Medicaid cannot be billed either.

Client Insurance Status	Billing Process
Medicaid only	Bill Medicaid
Private pay, no Medicaid	Not required to bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid	Not required to bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

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 Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Children's Mental Health Services Plan (CMHSP) eligibility for the same month, Medicaid must be billed before CMHSP.
- When a child is covered under BlueCross BlueShield or CHIP, providers may bill Medicaid first since these insurances do not cover services provided in a school setting.
- Medicaid must be billed before IDEA funds are used.

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, include a note with the claim 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 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 directly to Medicaid in order to avoid missing the timely filing deadline.
- 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:

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible 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. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*).

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 services before billing Medicaid for the services.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.



Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

School-Based Services Codes		
Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15 minute unit
School Psychologist/Mental Health Services		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96100	Per hour
CSCT Program		
CSCT services	H0036	15 minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15 minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip
Audiology		
Audiology evaluation	92557	Per visit
Tympanometry	92567	Per visit

Using modifiers

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers may be used in schools:

- Modifier “52” is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.

- Modifier “22” is billed with the procedure code when a service is greater than the customary service normally entails. For example, this modifier may be used when a service is more extensive than usual or there was an increased risk to the individual. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- Modifiers may also be required when providing two services in the same day that use the same code. See *Multiple Services on Same Date* for more information.

Multiple services on same date

When a provider bills Medicaid for two services that are provided on the same day that use the same CPT code and are billed under the same provider number, a modifier should be used to prevent the second service from being denied. The modifier “GO” is used for occupational therapy, and “GP” is used for physical therapy. For example, a school bills with one provider number for all services. The school provided occupational therapy for a client in the morning, and physical therapy for the same client in the afternoon of October 14, 2003. The claim would be billed like this:

24.	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	MM	DD	YY	MM										
1	10	14	03	10	14	03	03	0	97530	GO	1	\$ 22:00	1			
	10	14	03	10	14	03	03	0	97530	GP	1	\$ 22:00	1			

Time and units

- A provider may bill only time spent directly with a client. Time spent traveling to provide a service and paperwork associated with the direct service cannot be included in the time spent providing a service.
- Some CPT codes are designed to bill in units of 15 minutes (or other time increment) and others are “per visit”.
- If the service provided is using a “per visit” code, providers should use one unit of service per visit.
- When using codes that are based on a 15-minute time unit, providers should bill one unit of service for each 15-minute period of service provided. Units round up to the next unit after 8 minutes. Please use the following table as an average of the number of units of service to use. If the actual number of minutes providing a service falls between the range of minutes in the first two columns of the chart below, use the number of units in the third column.
- If a CSCT provider sees a client more than one time in a day, the entire time spent with the client that day should be totaled and billed once with the correct number of units as described in the following table.

Billing for Time in Units		
Minutes Greater Than	Minutes Less Than	Number of Units
8	23	1
24	38	2
39	53	3
54	68	4
69	83	5
84	98	6
99	113	7
114	128	8

Place of service

The only place of service code Montana Medicaid will accept is “03” (schools).

Billing for Specific Services

The following are instructions for billing for school-based services. For details on how to complete a CMS-1500 claim form, see the *Completing a Claim* chapter in this manual.

School-based providers can only bill services in the amount, scope, and duration listed in the IEP. Medicaid covered services provided under an Individual Education Plan (IEP) are exempt from the “free care” rule. That is, providers may bill Medicaid for a covered service provided to a client under an IEP even though they may be provided to non-Medicaid clients for free.

Medicaid covered services provided under and IEP are exempt from the “free care” rule.

Assessment to initiate an IEP

When billing for assessments (evaluations), use the CPT code for the type of service being billed. When the unit measurement is “per visit”, only one unit may be billed for the assessment/evaluation. If the evaluation is completed over the course of several days, it is considered one evaluation. Bill the date span with 1 unit of service, not multiple units of service. For example, a speech/hearing evaluation completed over a three-day period would be billed like this:

24.	A DATE(S) OF SERVICE					B	C	D PROCEDURES, SERVICES, OR SUPPLIES		E	F	G	H	I	J	K
	From To					Place of Service	Type of Service	(Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER							
	09	23	03	09	26	03	03	0	92506		1	\$ 65.00	1			

A two-hour psychological assessment (evaluation) would be billed like this (the unit measurement for this code is “per hour”):

24.	A DATE(S) OF SERVICE					B	C	D PROCEDURES, SERVICES, OR SUPPLIES		E	F	G	H	I	J	K
	From To					Place of Service	Type of Service	(Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER							
	09	23	03	09	23	03	03	0	96100		1	\$ 90.00	2			

Comprehensive School and Community Treatment (CSCT)

If a provider spent 30 minutes for individual counseling with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES				DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
From MM	From DD	From YY	To MM	To DD	To YY			CPT/HCPCS	MODIFIER												
11	05	03	11	05	03	03	0	H0036				2	\$ 40	00	2						



The CSCT program must follow the free care rule.

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

Therapy services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist’s (or school’s) Medicaid provider number. Schools are responsible for assuring the proper supervision is provided for aides/assistants (see Covered Services Chapter). Remember to include the client’s PASSPORT provider’s PASSPORT approval number on the claim (field 17a of the CMS-1500 form). See the *Completing a Claim* chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is “15 minute unit”):

24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES				DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
From MM	From DD	From YY	To MM	To DD	To YY			CPT/HCPCS	MODIFIER												
12	02	03	12	02	03	03	0	97530				1	\$ 40	00	2						

Private duty nursing services

Both PASSPORT and prior authorization are required for these services, so remember to include the PASSPORT provider’s PASSPORT number and the prior authorization number on the claim (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES				DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
From MM	From DD	From YY	To MM	To DD	To YY			CPT/HCPCS	MODIFIER												
09	02	03	09	02	03	03	0	T1000				1	\$ 5	00	1						

School psychologists and mental health services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is “per 30 minute unit”):

24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES				DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
From MM	From DD	From YY	To MM	To DD	To YY			CPT/HCPCS	MODIFIER												
09	02	03	09	02	03	03	0	90804				1	\$ 50	00	1						

Personal care paraprofessional services

Remember to include the client’s PASSPORT provider number on the claim (see the *Completing a Claim* chapter in this manual). Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

24. A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES				DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE			
From MM	From DD	From YY	To MM	To DD	To YY			CPT/HCPCS	MODIFIER												
09	02	03	09	02	03	03	0	T1019				1	\$ 24	00	8						

Special needs transportation

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school and received Medicaid covered health-related services that day, and then transported back to his or her residence, it would be billed like this:

24.	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	To	MM	DD	YY	MM										
	09	02	03	09	02	03	03	0	T2003	1	\$ 20 00	2				

Audiology

An audiology assessment would be billed like this (the unit measurement for this code is “per visit”):

24.	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	To	MM	DD	YY	MM										
	09	02	04	09	02	04	03	0	92557	1	\$ 35 00	1				

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 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

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. 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).

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

Sample Claim

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a**	Insured's ID number	Leave this field blank for Medicaid only claims. For clients with Medicare, enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
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 their ID card.
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 (UPIN).
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>Place of service</i> in the <i>Billing Procedures</i> chapter).
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 reference number (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).
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. The Medicare payment amount will be determined from the EOMB attached to the claim.
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

Credit balances

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:

1. 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.
2. 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 or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These 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 requesting Provider Relations (see *Credit balances #2* above) to complete a gross adjustment.

Rebilling Medicaid

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

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Reason and/or Remark code, make the appropriate corrections, and resubmit the claim (not an adjustment).



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 *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. Do not use an adjustment form.
- **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 your claim.

How to rebill

- Check any Reason and/or Remark code listed and make your 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 cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information, and submit to Medicaid.

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 the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a 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.).

Adjustments
can only be
made to paid
claims.



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 payment methods described do not apply to services provided under the Children's Health Insurance Program (CHIP).

Certification of State Match

A state certification of match process allows the state to leverage public education dollars to draw down federal funds. The state of Montana has implemented a state certification of match process for purposes of drawing down Federal Medical Assistance Percentage (FMAP) for the school based fee-for-service program. The FMAP rate fluctuates each year and will be reflected in reimbursements to schools. DPHHS is working in conjunction with the Office of Public Instruction (OPI) in the certification of match process for Medicaid covered school-based health-related services. This process includes all direct services billed to Medicaid under the School-based Health Services program including CSCT services that are written into an IEP.

CSCT services included in IEP

If CSCT services are included on a child's IEP, then the school district/cooperative does not need to do anything else to certify match for federal funds to be drawn down. Health services that are part of the Medicaid School-based Health Services program and are included on the IEP are covered by OPI's certification of match procedure that is based on the trustees' financial summary report utilizing special education expenditures that are documented and maintained at the state level. This greatly simplifies the process for matching federal funds.

CSCT services not included in IEP

The CSCT program, like all other services that are included in the Medicaid School-based Health Services program require certification of the use of local and state funds to match the state portion of the Medicaid funds. Because services are provided to children who do not have an IEP there is a requirement that schools who administer the CSCT program verify that the district has sufficient state and local funds to support the CSCT program in order to draw down the federal funds for children that are receiving CSCT services that are not included on an IEP. This match is required on an annual basis to DPHHS.

This match must come from non-federal sources. State special education funds and federal funds cannot be used for purposes of this match. The following formula will assist district in calculating the district's match obligation:

Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match

The annual certification of match will be due at the end of December of each year. CSCT services are reimbursed to schools by federal Medicaid funds. This means that a school is required to certify non-federal expenditures to cover the district costs associated with CSCT services. Insufficient match will result in a payback.

Appendix C: CSCT has a Sample Certification of Match Statement, which shows a sample of the document that the school district/cooperative will receive annually for DPHHS that shows the amount of money that has been expended on CSCT services and the required state and local funds that must be certified for the federal match. The school district/cooperative must certify, by signing the document, that sufficient state and local expenditures (the amount listed in item 3 of the Sample Certification of Match Statement) have been used to support this program. The Certification of Match Statement must be returned to DPHHS. If the school district/cooperative have provided CSCT services to clients as part of the IEP, please contact DPHHS to obtain a breakdown by client to calculate reimbursement for services that were not included on IEPs for matching purposes.

For audit purposes, the district must maintain documentation that validates that local and state dollars were spent. This documentation does not necessarily have to show the exact funds that are certified but must demonstrate that sufficient state and local funds were spent (and that these funds were not used as certification of federal match elsewhere). The documentation that validates non-federal funds used to certify to match must be retained for seven years.

Appendix C: CSCT Program

- *CSCT Program Endorsement*
- *CSCT Program Audit Checklist*
- *Sample Certification of Match Statement*

CSCT Program Endorsement

Prior to CSCT program implementation, the mental health center must be licensed and have a CSCT endorsement issued by the Department of Public Health and Human Services. (See also the following rules: 37.86.2225, 37.106.1955, 37.106.1956, 37.106.1960, 37.106.1961 and 37.106.1965.)

1. The CSCT program must be able to provide the following services as needed, to children or adolescents with a serious emotional disturbance:
 - a. Individual, family and group therapy;
 - b. Behavior intervention;
 - c. Other evidence and research-based practices effective in the treatment of children or adolescents with a serious emotional disturbance;
 - d. Direct crisis intervention services during the time the child or adolescent is present in school;
 - e. Crisis intervention services by telephone during the time(s) the child or adolescent is not present in school;
 - f. Treatment plan coordination with addictive and mental health treatment services provided outside the CSCT program;
 - g. Access to emergency services;
 - h. Referral and aftercare coordination with inpatient facilities, residential treatment programs or other appropriate out-of-home placement programs; and
 - i. Continuous treatment that includes services during non-school days, integrated in a manner consistent with the child or adolescent's treatment plan.
2. The CSCT program must have written admission and discharge criteria.
3. The program must assess the needs of a child or adolescent with a serious emotional disturbance and the appropriateness of the CSCT program to meet those needs.
4. If the CSCT program utilizes time-out or aversive treatment procedures, there must be written procedures regarding the use of these procedures.
5. The CSCT services must be provided by two staff that consist of at least one licensed mental health professional (licensed psychologist, licensed social worker or licensed clinical professional counselor) and one non-licensed mental health aide.
6. Adequately trained staff must deliver services provided through the CSCT program. Training must be documented and maintained in the personnel files.
7. Services provided through the CSCT program must be adequately documented to support services billed to Medicaid.
8. The CSCT program must be coordinated with the child or adolescent's special education program, if any.

CSCT Program Audit Checklist

For the Comprehensive School and Community Treatment Program, school districts and cooperatives retain responsibility for ensuring that all program requirements are met. School districts/cooperatives may not be in compliance if any statement below is checked "No."

Program Endorsement – The school district/cooperative or the licensed mental health center with whom the district/cooperative is contracting must have a CSCT endorsement from the Montana DPHHS. CSCT providers must follow the Administrative Rules of Montana and the policy manual related to these services as set forth by the Department of Public Health and Human Services (DPHHS).

___ Yes	___ No	___ N/A	Has the school district/cooperative identified a primary contact person at the mental health center that is providing the CSCT program services?
___ Yes	___ No	___ N/A	Does the school district/cooperative or the mental health center have a CSCT endorsement from the Montana DPHHS?
___ Yes	___ No	___ N/A	Does the school district/cooperative have a signed contract with the mental health center that provides CSCT services?

Service/Billing Documentation – Services provided through the CSCT program must be documented in the same manner as all other services included in the Montana School-Based Services Program. The only exception is that services in this program can be provided to students both with or without special education needs or without services being included on a student's IEP.

___ Yes	___ No	___ N/A	Is an individual treatment plan in place to provide CSCT services for each student?
___ Yes	___ No	___ N/A	Is the billing documentation accurate for services performed (including student name, date of service, duration of service, type of service and notes that show progress toward student goals)?
___ Yes	___ No	___ N/A	Does CSCT program staff keep daily detailed records on services provided through the program?
___ Yes	___ No	___ N/A	Does the CSCT program staff keep overall monthly progress notes?
___ Yes	___ No	___ N/A	Does the CSCT program staff track individual outcomes compared to baseline measures and established benchmarks?

Certification of Match – School districts/cooperatives are responsible for certifying non-federal match for services provided to students who do not have CSCT services included on their IEPs.

___ Yes	___ No	___ N/A	Does the school district/cooperative maintain documentation of costs incurred by the CSCT program?
___ Yes	___ No	___ N/A	Are the documented costs greater than the Medicaid funding provided (by at least the amount required for certification of match)?
___ Yes	___ No	___ N/A	Can the school district/cooperative demonstrate that there are enough state/local funds being

CSCT Program Audit Checklist

			<p>expended by the district that:</p> <ul style="list-style-type: none"> • Are not used to match other federal funds being received, • Are not IDEA funds or state special education funds, and • Are not Medicaid dollars?
___ Yes	___ No	___ N/A	Has the school district/cooperative maintained a budget or work papers that verify the certification of match documentation?
Free Care Rule – For CSCT programs that are providing services to students with serious emotional disturbances who do not have services documented on the IEP the school district/cooperative must ensure that they are following the free care rule.			
___ Yes	___ No	___ N/A	Is the CSCT program offered to students based on service needs, regardless of the students' Medicaid eligibility status?
___ Yes	___ No	___ N/A	If the school district/cooperative provides services to students who do not have CSCT services included on the IEP, has a sliding scale been developed for CSCT services?
___ Yes	___ No	___ N/A	Has the school district/cooperative identified all third parties that may be financially responsible for services provided that are not included in a student's IEP?
___ Yes	___ No	___ N/A	Has the CSCT program billed the third parties that are financially responsible for services, including the students' insurers or their parents?
Program Documentation – The school district/cooperative must have access to any CSCT program records that may be audited.			
___ Yes	___ No	___ N/A	Has the school district/cooperative developed a program area for CSCT in the accounting system?
___ Yes	___ No	___ N/A	Has the school district/cooperative booked revenues and expenditures for the CSCT program?
___ Yes	___ No	___ N/A	Is documentation retained for a period of six years and three months from the date of service?
___ Yes	___ No	___ N/A	Are all service documentation records available at a central district location or available for audit?

Sample Certification of Match Statement

This statement is provided annually by DPHHS and must be returned to verify certification of local and state expenditures to support the federal match.

Montana Department of Public Health and Human Services
Health Resources Division
P.O. Box 202951
Helena, MT 59620 - 2951

RE: Annual Certification of State and Local Expenditures

Dear _____:

I, as financial officer of the _____ School District/Cooperative, am charged with the duties of supervising the administration of the provision and billing for the Comprehensive School and Community Treatment (CSCT) Services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school district has expended the state and local share of public, non-federal funds needed to match the federal share of medical claims billed to the state Medicaid agency for School District CSCT services provided to eligible children during the _____ school year.

1. DPHHS has completed calculation of reimbursement for CSCT services for the year _____.
2. The amount paid by DPHHS for CSCT services is _____.
3. The state and local expenditures that are required to support a certification of match is, _____ . (Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match)

____ These certified expenditures are separately identified and supported in our accounting system, or
____ Sufficient State and local revenues are available to meet or exceed the match.

I certify that the school district/cooperative's state and local expenditures (shown in # 3 above) were incurred in accordance with provisions of Montana's policies. These certified expenditures are separately identified and supported in our accounting system.

Name (please print): _____

Signature: _____

Title: _____

School District or Cooperative: _____

Date: _____

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.

Mentally Incompetent

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

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 Authorization Number

When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

PASSPORT To Health

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

Pay and Chase

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

Pending Claim

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

Potential Third Party Liability

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

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.

Protocols

Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must be updated and approved by a physician at least annually.

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.

Reason and Remark Code

A code which prints on the Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the Reason/Remark codes is found at the end of the RA (formerly called EOB code).

Referral

When providers refer clients to other Medicaid providers for medically necessary services that the PASSPORT provider does not provide.

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.

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.

School-Based Services

Medically necessary health-related services provided to Medicaid eligible children up to and including age 20. These services are provided in a school setting by licensed medical professionals.

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.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

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.

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