



Hospital Inpatient Services

*(Hospitals that are paid under the
Prospective Payment System)*

*Medicaid and Other Medical
Assistance Programs*

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Passport to Health Program

What Is Passport to Health? (ARM 37.86.5101–5120, 37.86.5303, 37.86.5201–5206)

Passport to Health is the managed care organization for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* clients. Our four Passport programs encourage and support Medicaid and HMK *Plus* clients and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK*Plus* clients who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK*Plus* clients are eligible). Each enrollee has a designated Passport provider who is typically a physician, midlevel practitioner, or primary care clinic.

Passport to Health Primary Care Case Management (ARM 37.86.5101-5120)

The Passport provider provides primary care case management (PCCM) services to their clients. This means they provide or coordinate the client's care and make referrals to other Montana Medicaid and HMK*Plus* providers when necessary. Under Passport, Medicaid and HMK*Plus* clients choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept which encourages a strong doctor-patient relationship. An effective medical home is accessible, continuous, comprehensive, and coordinated, and operates within the context of family and community.

With some exceptions (see *Services That Do Not Require Passport Provider Approval* in this chapter), all services to Passport clients must be provided or approved by the client's Passport provider or Medicaid/HMK*Plus* will not reimburse for those services. The client's Passport provider is also referred to as the primary care provider or PCP.

Team Care (ARM 37.86.5303)

Team Care is designed to educate clients on how to effectively access medical care. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Clients enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules and guidelines for referrals, enrollment/disenrollment, prior authorization, and

billing processes. However, while Passport clients can change providers without cause, as often as once a month, Team Care Clients are locked in to one provider and one pharmacy. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their clients is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care clients. When checking Medicaid or HMKPlus eligibility on the MATH web portal on the Provider Information website (see *Key Websites*), a Team Care client's provider and pharmacy will be listed. Write all Medicaid and HMKPlus prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line at 1-800-330-7847 is a 24/7, toll-free and confidential nurse triage line staffed by licensed registered nurses is available to all Montana Medicaid and HMK clients. There is no charge to clients or providers. Clients are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7 to triage clients over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their clients calls to be triaged.

Passport providers are encouraged to provide education to their clients regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line, before going to the ED.

Health Improvement Program (ARM 37.86.5201–5206)

Montana has a new Health Improvement Program (HIP) for Medicaid and HMKPlus patients with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMKPlus patients eligible for the Passport program are enrolled and assigned to a health center for case management. ***Current Passport patients stay with their providers for primary care, but are eligible for case management through HIP.*** Nurses and health coaches certified in Professional Chronic Care will conduct health assessments; work with the PCP to develop care plans; educate patients in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind patients about scheduling needed screening and medical visits.

Montana uses predictive modeling software to identify chronically ill patients. This software uses medical claims, pharmacy and demographic information to generate a risk score for each patient. Although the software will provide a great deal of information for interventions, it will not identify patients who

have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport patients at high risk for chronic health conditions that would benefit from case management from HIP.

In practice, providers will most often encounter Medicaid and HMK *Plus* clients who are enrolled in Passport. Specific services may also require prior authorization (PA) regardless of whether the client is a Passport enrollee. Passport referral and approval requirements and PA requirements are described below. Specific PA requirements can be found in the provider fee schedules.

Montana Access to Health (MATH) Web Portal

Provides the tools and resources to help health care providers conduct business electronically. Providers must complete a Montana Enrollment form (select the Provider Enrollment option for step-by-step instructions) **and** register to use the MATH web portal. Select the Web Registration option to begin.

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.

Nurse First Advice Line

A 24-hour, 7-day-a-week nurse triage line. Clients can call in with general health questions, medication questions, or questions about illness or injury. If the caller or person they are calling about is symptomatic, a registered nurse follows clinically-based algorithms to an "end point" care recommendation. The care recommendation explains what level of health care is needed, including self-care. If self-care is recommended, clients are given detailed self-care instructions.

Outpatient

A person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services in the hospital for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services, other than supplies or prescription drugs alone, from the hospital.

Outpatient Hospital Services

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, palliative items or services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner.

Passport Referral Authorization Number

This is a 7-digit number assigned to Passport providers. 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

The Medicaid primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client's health care needs.

Present on Admission (POA)

An indicator used to show if a diagnosis was present when the client was admitted to the facility or if the diagnosis appeared after the client was admitted.

Prior Authorization (PA)

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

Private-Pay

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

Provider or Provider of Service

An institution, agency, or person:

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

Provider-Based Services

A provider-based entity is a health care provider “that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider.”

Public Assistance Toolkit

This Internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor’s Office, and Montana. <https://dphhs.mt.gov/>

Qualified Individual (QI)

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.

Qualified Medicare Beneficiary (QMB)

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

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a “reference lab” for processing. Medicaid does not cover lab services when they are billed by the referring provider.

Relative Weight

Weight assigned that reflects the resources used in a particular procedure or service.

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.

Routine Disproportionate Share Hospital

A hospital in Montana which meets the criteria of ARM 37.86.2931.

Routine Podiatric Care

Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Rural Hospital

For the purposes of determining disproportionate share hospital payments, an acute care hospital that is located within a “rural area” as defined in 42 CFR 412.62(f)(iii).

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.

Sole Community Hospital

A DRG-reimbursed hospital classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 412.92(a) through (d) and/or hospitals with less than 51 beds.

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 that month.

Supplemental Disproportionate Share Hospital

A hospital in Montana which meets the criteria of ARM 37.86.2925.

Team Care

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist clients in making better health care decisions so that they can avoid over-utilizing health services. Team Care clients are joined by a team assembled to assist them in accessing health care.

The team consists of the client, the PCP, a pharmacy, the Department, the Department’s quality improvement organization, and the Nurse First Advice Line. The team may also include a community-based care manager from the Department’s Health Improvement Program.

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 HMK 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 payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Transferring Hospital

A hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

Uncompensated Care

Hospital services provided for which no payment is received from the patient or from a third-party payer. Uncompensated care includes charity care and bad debts.

Urban Hospital

An acute care hospital that is located within a metropolitan statistical area, as defined in 42 CFR 412.62(f)(2).

Usual and Customary

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

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