



Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

*Medicaid and Other Medical
Assistance Programs*

This publication supersedes all previous Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

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My NPI/API:

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Key Contacts

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

Claims

Send paper claims to:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Direct Deposit Arrangements

Providers who need to enroll in electronic funds transfer (EFT) and sign up for electronic remittance advices (RAs) should contact Provider Relations. Completed documentation should be mailed or faxed to Provider Relations.

Provider Relations
P.O.Box 4936
Helena, MT 59604
800.624.3958 or **406.442.1837**
406.442.4402 Fax

Fraud and Abuse

If you suspect fraud or abuse by a Medicaid member or provider, call one of the Program Compliance Bureau’s fraud hotlines:

800.201.6308 Member Eligibility Fraud
800.362.8312 Medicaid Help Line
(Call this number to report suspected member abuse of Medicaid.)
800.376.1115 Provider Fraud

Member Eligibility

There are several methods for verifying member eligibility. The most common are below. Also see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

FaxBack
800.714.0075 (24 hours)

Integrated Voice Response
800.714.0060 (24 hours)

Montana Access to Health Web Portal
<http://mtaccesstohealth.acs-shc.com/>

Medifax EDI
800.444.4336, X 2072 (24 hours)

Nurse First

For questions regarding the Nurse First Advice Line (800.330.7847) contact.

406.444.4540 Phone
406.444.1861 Fax

Nurse First Program Officer
Health Resources Division
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Pricing, Data Analysis, and Coding (PDAC)

For coding advice and other information:

877.735.1326 Toll-free
8:30 a.m. to 4 p.m. Mon– Fri Central Time
PDAC
P.O. Box 6757
Fargo ND 58108-6757

Prior Authorization

Mountain Pacific Quality Health

For prior authorization on durable medical equipment (DME):

Phone:

877.443.4021, X5887 Long-distance
406.457.5887 Local

Fax:

406.513.1922
877.443.2580 Toll-free

Send written inquiries to:

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

Provider Enrollment

For enrollment changes or questions:

800.624.3958 In/Out of state
406.442.1837 Helena

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

Provider Relations

For questions about eligibility, payments, denials, or Passport:

800.624.3958 In/Out of state
406.442.1837 Helena

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604
MTPRHelpdesk@xerox.com

Provider's Policy Questions

For policy questions or issues:

406.444.5296 Program Officer
406.444.1861 Fax

Secretary of State

The Secretary of State's office publishes the Administrative Rules of Montana (ARM):

406.444.2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Team Care Program

For questions regarding Team Care:

406.444.4540 Phone
406.444.1861 Fax

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

Third Party Liability

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

800.624.3958 In/Out of state
406.442.1837 Helena
406.442.0357 Fax

Send written inquiries to:

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

Xerox EDI Solutions Help Desk

For questions regarding electronic claims submission:

800.987.6719 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

Xerox EDI Solutions – Montana
P.O. Box 4936
Helena, MT 59604
MTPRHelpdesk@xerox.com

Key Websites	
Web Address	Information Available
Healthy Montana Kids (HMK) www.hmk.mt.gov/	Information on HMK.
Montana Medicaid Member Information http://www.dphhs.mt.gov/medicaid/member/	<ul style="list-style-type: none"> • Big Sky Rx • Dental Services • EPSDT • Find a Health Care Provider • Member Guide • Health Improvement Program • Health Insurance Premium Payment • Healthy Montana Kids (HMK) • Home- and Community-Based Waiver Services • My Health Record • Nurse First • Passport to Health • Plan First • Prescription Drug Coverage • Team Care • Transportation Services
Montana Access to Health Web Portal https://mtaccesstohealth.acs-shc.com/ Montana Medicaid Provider Information http://medicaidprovider.hhs.mt.gov/ (www.mtmedicaid.org)	<ul style="list-style-type: none"> • <i>Claim Jumper</i> newsletters • Electronic billing information • Fee schedules • Forms • Frequently asked questions (FAQs) • Key contacts • Links to other websites • Medicaid news and information • Member eligibility (web portal) • Provider enrollment (web portal) • Provider manuals • Provider notices and manual replacement pages • Remittance advice notices (web portal) • Training resources • Upcoming events
Medicare Pricing, Data Analysis and Coding (PDAC) www.dmepdac.com 877.735.1326	PDAC assists manufacturers and suppliers with DMEPOS billing and coding information.
Noridian Administrative Services https://www.noridianmedicare.com/	Durable Equipment Regional Carriers (DMERC) website. DMERC processes durable medical equipment, prosthetics, orthotics and supplies for Medicare.

Key Websites

<p>Secretary of State www.sos.mt.gov</p> <p>ARM Rules http://www.sos.mt.gov/ARM/index.asp</p>	<p>Montana Secretary of State website and Administrative Rules of Montana (ARM).</p>
<p>Washington Publishing Company www.wpc-edi.com</p> <p>There is a charge for documents; however, value codes are viewable online at no cost.</p>	<ul style="list-style-type: none"> • HIPAA 4010 tools and information • HIPAA 5010 tools and information • Code lists
<p>Xerox EDI Solutions http://acs-gcro.com/</p>	<p>Xerox EDI Solutions (ACS EDI Gateway) is the Xerox clearinghouse. Visit this website for information on:</p> <ul style="list-style-type: none"> • EDI enrollment • EDI support • Electronic transaction instructions for HIPAA 5010 • Manuals and guides • Software (WINASAP5010) downloads

Introduction

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

Manual Organization

This manual provides information specifically for providers of Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS). Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both the general manual and the specific manual for his/her provider type.

A table of contents and an index allow providers to quickly find answers to most questions. The margins contain important notes and space for writing notes. There is a list of Key Contacts at the beginning of each manual. We have also included a space on the back of the inside front cover for providers to record their NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

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

Rule References

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

The following rules and regulations are specific to the DMEPOS program. Additional Medicaid rule references are available in the *General Information for Providers* Manual.

- Administrative Rules of Montana (ARM)
 - ARM 37.86.1801 – ARM 37.86.1807 Prosthetic Devices, Durable Medical Equipment and Medical Supplies



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

Claims Review (MCA 53-6-111 and ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of Key Contacts at the front of this manual has important phone numbers and addresses pertaining to this manual. The Introduction chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information [website](#). (See Key Websites.)

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by Durable Medical Equipment, Prosthetic, Orthotic and Medical Supply (DMEPOS) providers. Like all health care services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Montana Medicaid follows Medicare's coverage requirements for most items. A Medicare manual is available from the Durable Medical Equipment Regional Carriers (DMERC) website, www.noridianmedicare.com. Montana Medicaid considers Medicare, Region D, DMERC medical review policies as the minimum DMEPOS industry standard. This manual covers criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Montana Medicaid coverage determinations are a combination of Medicare, Region D DMERC policies, Centers for Medicare and Medicaid Services (CMS) national coverage decisions (NCDs), local coverage determinations (LCDs), and Department designated medical review decisions. DMEPOS providers are required to follow specific Montana Medicaid policy or applicable Medicare policy when Montana Medicaid policy does not exist. When Medicare makes a determination of medical necessity, that determination is applicable to the Medicaid program.

Essential for Employment Program

In limited circumstances, Medicaid will cover a DME service normally excluded under Basic Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the member will present a signed Medicaid Services Essential for Employment form (DPHHS-HCS-782). Prior to receiving DME services as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their Local Office of Public Assistance.

- Service/limitations, coverage, and reimbursement may be the same for approved services as they would be for a Full Medicaid member.
- Claims must be accompanied by a completed DPHHS-HCS-782, found on the Provider Information [website](#).
- If the item/equipment requires prior authorization, the Essentials and all documentation will be sent for PA after the Essential is approved.

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a comprehensive approach to health care for Medicaid members under age 21. 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 DMEPOS items/services described in this manual. All applicable prior authorization requirements apply.

Basic Medicaid

Medicaid generally does not cover DMEPOS for members on Basic Medicaid. Providers should verify members’ eligibility before providing services. The **only** HCPCS codes covered under Basic Medicaid are:

A4206 through A4259	A4310 through A4554	A4611 through A4629
A4772	A5051 through A5513	A6530 through A6544
A7027 through A7046	E0424 through E0450	E0457 through E0460
E0463 through E0480	E0550 through E0570	E0575 through E0601
E0605 through E0607	E0781	E0784
E1372	E1390	E1405 and E1406
K0455	K0552	L5000 through L8510

DMEPOS suppliers must obtain a written prescription in accordance with Administrative Rule of Montana (ARM) 37.86.1802. Suppliers should also maintain documentation showing the member meets the Medicare coverage criteria.

Other DME items for Basic Medicaid members may be covered under the Essentials for Employment program if they are necessary to obtaining or maintaining employment. When this is the case, the member will present a signed Medicaid Services Essential for Employment form. Prior to receiving DME items as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their Local Office of Public Assistance.

Provision of Services (ARM 37.86.1802)

Federal regulations require that items/services covered by the Department are reasonable and necessary in amount, duration and scope to achieve their purpose. DMEPOS items/supplies must be medically necessary, prescribed in writing and delivered in the most appropriate and cost effective manner, and may not be excluded by any other state or federal rules or regulations.

Supplier Documentation (ARM 37.86.1802)

All covered DMEPOS items for members with Medicaid as the primary payer, must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of the provider’s practice as defined by state law. The pre-

Prescriptions for DMEPOS items must include the diagnosis, medical necessity, and projected length of need for the item.



The effective date of an order/script is the date in which it was signed.

scription must indicate the diagnosis, the medical necessity, projected length of need for the covered item, and utilization instructions. Prescriptions for oxygen must also include the liter flow per minute, hours of use per day and the member's PO₂ or oxygen saturation blood test results.

DMEPOS suppliers must obtain a written prescription in accordance with ARM 37.86.1802. Suppliers should also maintain documentation showing the member meets the Medicare coverage criteria.

ARM 37.86.1802 describes how prescriptions/orders can be transmitted. The prescription/order must indicate the diagnosis, the medical necessity, quantity and the length of need. The rule refers providers to the Medicare guidelines. Prescriptions can be oral, faxed or hard copy. For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements in Chapter 3 of the Medicare Supplier Manual. The rule refers to current Medicare rules and regulations in the Region D Supplier manual (including the most current LCDs). Chapters 3 and 4 of the Medicare manual outline the documentation requirements for suppliers.

Although a prescription is required, coverage decisions are not based solely on the prescription. Coverage decisions are based on objective, supporting information about the member's condition in relation to the item/service prescribed. Supporting documentation may include, but is not limited to (if applicable) a Certificate of Medical Necessity (CMN), DME Information Form (DIF), and/or a physician's, therapist's or specialist's written opinion/attestation for an item/service based on unique individual need.

The member's medical record must contain sufficient documentation of the member's medical condition to substantiate the necessity for the prescribed item/service. The member's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists. It is recommended that suppliers obtain (for their files) sufficient medical records to determine whether the member meets Medicaid coverage and payment rules for the particular item.

Proof of delivery is required in order to verify that the member received the DMEPOS item. Proof of delivery documentation must be made available to the Department upon request. Medicaid does not pay for delivery, mailing or shipping fees or other costs of transporting the item to the member's residence.

Providers must retain the original prescription, supporting medical need documentation and proof of delivery. For additional documentation requirements, see the *General Information for Providers* manual, Provider Requirements chapter, and Chapters 3 and 4 of the Medicare manual.

Certificate of Medical Necessity

For a number of DMEPOS items, a certificate of medical necessity (CMN) is required to provide supporting documentation for the member's medical indications. The CMN column of the Montana Medicaid fee schedule indicates if a CMN is required. Montana Medicaid adopts the CMNs used by Medicare DMERCs, approved by the Office of Management and Budget (OMB), and required by the Centers for Medicare and Medicaid Services (CMS). These forms are available on the Provider Information website, the CMS website (<http://www.cms.hhs.gov> and the Noridian website (<https://www.noridian-medicare.com/>).

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. **If any discrepancies exist between these referenced forms and what is published by CMS and Medicare, the CMS and Medicare policy shall take precedence.** See Chapter 4 of the Medicare policy manual.

Certificate of Medical Necessity (CMN) Forms

Item	Form	Form Date
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	09/05
Osteogenesis Stimulators	CMS-847	09/05
Oxygen	CMS-484	09/05
Seat Lift Mechanisms	CMS-849	09/05
Section C Continuation Form	CMS-854	09/05
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	09/05

DME Information Forms

Item	Form	Form Date
External Infusion Pumps	CMS-10125	09/05
Enteral and Parental Nutrition	CMS-10126	09/05

Rental/Purchase (ARM 37.86.1801–1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 13 months of rental reimbursement. After 13 months of continuous rental, the item is considered owned by the member and the provider must transfer ownership to the member. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to the purchase price for that item listed on the Medicaid fee schedule. If purchasing the rental item is cost effective, the Department may cover the purchase of the item. See Chapter 5 of the [Medicare supplier manual](#).

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 13-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments, and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 13-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 13-month rental period when ownership of the item is transferred to the member, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 13-month rental limit does not apply and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 13-month period or new purchase price limit. Periods in which service is interrupted do not count toward the 13-month rental limit.

Change in supplier. A change in supplier during the 13-month rental period will not result in the start of a new 13-month period or new purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the member; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written member statement that another supplier has not been providing the item, unless the provider



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



No more than one month's medical supplies may be provided to a member at one time.

has knowledge of other facts or information indicating that another supplier has been providing the item. The supplier providing the item in the 13th month of the rental period is responsible for transferring ownership to the member.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 13-month period or new purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the member's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

Noncovered Services (ARM 37.86.1802)

Below are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by CMS, including the Medicare program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a member in a nursing facility setting (see the *Nursing Facility Services* manual for details)
- Furniture associated with the use of a seat lift mechanism.
- Scales (covered if monitoring weight is part of any congestive heart failure (CHF)) treatment regimen.
- Backup equipment
- Items included in the nursing home per diem

Verifying Coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the detailed coding descriptions listed in the CPT and HCPCS coding books. **Use the fee schedule and coding books that pertain to the date of service.** Fee schedules are available on the Provider Information website.

Coverage of Specific Services

The following are specific criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS
- Infant has symptomatic apnea
- Observation of apparent life-threatening events (ALTE)
- Infant is on oxygen
- Symptomatic apnea due to neurological impairment

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms (log must be kept on file)
- Unresolved symptomatic apnea

Custom-Made Equipment, Prosthetics or Orthotics

DME must be billed using the date of service the member receives the equipment or item.

The only exception is in the case of custom-made equipment, prosthetics or orthotics. In these instances the date when the item is casted, molded and/or fitted may be used. **Before a provider can bill for any custom-made equipment, prosthetic or orthotic, the work on the item must be complete and the member must have signed the delivery ticket.**

Because Medicaid eligibility is determined on a month-to-month basis, providers must check eligibility **before** an item is ordered or work has begun and **document** the member's eligibility in their file.

Diapers, Underpads, Liners/Shields

The T codes listed below are more specific to the type of incontinence products being distributed by Montana Medicaid DME providers. These codes will be paid the “by report” percentage of 75% of billed charges. Also, maximum allowable amounts will be attached to each code. The allowables are 180 disposable diapers per month, 36 reusable diapers, underpads, liners/shields per year (3 per month), and 240 disposable underpads per month.

HCPSC Code	Description
T4521	Adult sized disposable incontinence product, brief/diaper, small, each
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small, each
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium, each
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large, each
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each
T4533	Youth sized disposable incontinence product, brief/diaper, each
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each
T4535	Disposable liner/shield/guard/pad/ undergarment, for incontinence, each
T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each
T4537	Incontinence product, protective underpad, reusable, bed size, each
T4539	Incontinence product, diaper/brief, reusable, any size, each
T4540	Incontinence product, protective underpad, reusable, chair size, each
T4541	Incontinence product, disposable underpad, large, each
T4542	Incontinence product, disposable underpad, small size, each
T4543	Disposable incontinence product, brief/diaper, bariatric, each

Diapers, underpads, and liners/shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for members under 3 years of age or members in long-term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable underpads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year (3 per month).

Electric Breast Pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Member has a pre-term infant of 37 weeks or less gestation
- Member's infant has feeding difficulties due to neurological or physical conditions which impairs adequate suckling
- Illness of mother and/or infant that results in their separation
- Mother is on medication that compromises milk supply

Electric breast pump rental is limited for 2 months unless additional months are prior authorized by the Department. Medicaid covers all supplies, maintenance, repair, components, adjustments and services related to the pump. Payment may not be provided through the infant's eligibility for Medicaid.

Gait Trainers

A gait trainer (GT) is a device used to support a patient during ambulation. Criteria for coverage of a gait trainer include:

- The member is unable to ambulate independently with a standard front or reverse walker because of the need for postural support, due to a chronic neurological condition including abnormal movement patterns, poor balance, poor endurance, or other clearly documented reasons.
- The anticipated functional benefits of walking are not attainable with the use of a walker.
- Must demonstrate tolerance for standing and weight bearing through the lower extremities.
- Potential benefits to the individual of assisted walking must be clearly documented as follows:
- The member must be involved in a therapy program established by a physical therapist. The program must include measurable documented objectives and functional goals related to the member and equipment that includes a written carry over plan to be utilized by the member and/or caregiver. The equipment must match the user's needs and ability level.

- The member has had a trial of the requested gait trainer (GT) and the member shows compliance, willingness, and ability to use the GT in the home.
- Video of member using the requested GT home demonstrating ability to use GT by showing potential for progress to meet goals and objectives.

Group 2 Support Surfaces

Rentals will be reviewed on a monthly basis for members.

In the event that Prior Authorization staff receives additional medical information directly from the care provider, that information will be included in the cover letter to the DME vendor along with a copy of the authorization.

The criteria for “reasonable and necessary” for Group 2 support surfaces are defined by the indications and limitations of coverage below and/or medical necessity.

A Group 2 support surface is covered if the patient meets:

- Criterion 1 and 2 and 3; or
 - Criterion 4; or
 - Criterion 5 and 6.
1. Multiple stage II pressure ulcers located on the trunk or pelvis.
 2. Patient has been on a comprehensive pressure ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface.
 3. The pressure ulcers have worsened or remained the same over the past month.
 4. Large or multiple Stage III or IV pressure ulcers on the trunk or pelvis.
 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).
 6. The patient has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive pressure ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a patient with a Stage III or IV ulcer).
- Appropriate turning and positioning.
- Appropriate wound care (for a Stage II, III, or IV ulcer).

- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a Group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not “bottom out.”

When a Group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a Group 2 mattress or bed are not met, ***an authorization will not be issued*** unless there is clear documentation which justifies the medical necessity for the item in the individual case.

Continued use of a Group 2 support surface ***is determined on a case-by-case basis***. It is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.

A Group 2 support surface will be considered for purchase if the following criteria are met:

- Has met the above Indications and Limitations of Coverage and/or Medical Necessity for rental and is necessary for wound management for more than 6 months; or
- Has met the above indications of Coverage and/or Medical Necessity for rental and the ulcers have healed. However, the member has a history of previous decubitus ulcers and is at significant risk for recurrent breakdown if the surface is removed.

The purchase of a Group 2 support surface will be reviewed on a case-by-case basis. It must be determined that:

- The member is compliant with the use of the surface; and
- Other factors have been addressed that are/may be contributing to the recurrent breakdown such as infection, nutrition, incontinence management, repositioning, etc.

Oral Nutrition

Medicaid may cover oral nutritional products for members under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrients. The member must also have a measurable nutrition plan developed by a nutritionist and the member's primary care provider (PCP). Use modifier -BO when nutrition is orally administered, not by a feeding tube (only for members under age 21).

Phototherapy (Bilirubin) Light with Photometer

The E0202 RR will be reimbursed for infants ages 0–2. One unit of service is to be billed for each day. Units billed are not to exceed a 5-day limit. To assure correct coding, providers are encouraged to refer to the current HCPCS coding manual. DMEPOS suppliers must obtain a written prescription in accordance with ARM 37.86.1802. Suppliers should also maintain supporting documentation showing the member meets the Medicaid coverage criteria.

Services for adults and children over age 1 will be reviewed for medical necessity by the DME Program Officer at Health Resources Division.

Pulse Oximetry Meter

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO₂), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO₂).

A pulse oximetry meter is covered for ventilator dependent patients. Continuous read oximetry meters and any meter used for diagnostic purposes are not covered. A pulse oximetry meter is covered for pediatric patients when all of the following criteria are met:

- The member has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- Oxygen need varies from day to day or per activity (e.g., feeding, sleeping, movement), and a medical need exists to maintain oxygen saturation within a very narrow range in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

Standing Frame

A standing frame is used to develop weight bearing through the legs for those who cannot stand independently. Standers may be fixed or adjustable in their design. Accessories must contribute significantly to the therapeutic function of the device. Designs and accessories primarily for a caregiver's convenience are not considered medically necessary.

For the coverage of a standing frame, the following conditions must be met:

- Member can demonstrate tolerance for standing and partial weight bearing
- Member and/or caregivers demonstrate the capability and motivation to be compliant in the use of the standing frame
- Member is unable to stand without the aid of adaptive equipment
- Members must be involved in a therapy program established by a physical or occupational therapist. The program must include measurable documented objectives related to the member and equipment that includes a written carry over plan to be utilized by the member and/or caregiver. The equipment must match the user's needs and ability level.

Wheelchair Seating in the Nursing Facility

Indications and limitations for a wheelchair seating system for an existing wheelchair such as a facility wheelchair, patient owned wheelchair or a donated wheelchair. The seating system would be the least costly alternative that is able to be adapted to meet the positioning needs of a resident in a nursing home and will be covered under the following conditions:

There must be a comprehensive written evaluation by a licensed clinician who is not an employee of or otherwise paid by a supplier.

Included in the evaluation referenced above would be the following:

- Seating systems for increased independence
 - Documentation must support all of the following:
 - The member must be able to self-propel to specific destinations (e.g., to and from the dining room, to and from the activity room).
 - Be able to do a functionally independent task as a result of the seating system such as feed self.
 - The member must be evaluated to determine that he/she is able to safely self-propel and does not have the potential cause harm.
 - Be alert and oriented and capable of being completely independent in use of the wheelchair after adapted seating system is placed.

OR

- Seating systems for positioning purposes
 - Seating for positioning purposes will be reviewed on a case-by-case basis.
 - Documentation must support that all other less costly alternatives have been ruled out, to include but not be limited to the following:
 - Use of Geri-Chairs provided by nursing home and use of standard off-the-shelf seating products have been tried and ruled out; and

- Use of rolled towels, blankets, pillows, wedges or similar devices by facility caregivers to reasonably position and reposition member; and
- Documentation that has determined that nursing staff is unable to accomplish repositioning by any other means while resident is up and out of bed; and
- Resident is not incapacitated to the point that he/she is bedridden.

Wheelchairs

In addition to the Medicare, Region D, DMERC Medical Review Policies for wheelchairs, to meet the needs of a particular individual, various wheelchair options or accessories are typically selected. The addition of options or accessories does not deem the wheelchair as a custom wheelchair.

Wheelchairs in Nursing Facilities

Nursing facilities are expected to make available wheelchairs with typical options or accessories in a range of sizes to meet the needs of its residents. If a typical option or accessory is not available for a currently owned nursing facility wheelchair, an accommodating wheelchair is expected to be made available by the nursing facility. Only wheelchairs (including power chairs) that cannot be reasonably used by another nursing home resident will be considered for purchase. Wheelchairs must be used primarily for mobility. Roll-about chairs which cannot be self propelled are specifically designed to meet the needs of ill, injured, or otherwise impaired individuals and are considered similar to wheelchairs. Roll-about chairs may be called by other names such as *transport* or *mobile geriatric* chairs (Geri-Chairs). Roll-about chairs are not wheelchairs; however, many of the same options and accessories can be found for use on them. Like standard wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

Other Programs

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

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the mental health manual on the Provider Information website. (See Key Websites.)

Healthy Montana Kids (HMK)

The information in this manual does not apply to HMK members. For an HMK medical manual, contact Blue Cross and Blue Shield of Montana at 1.800.447.7828m X8647. Additional information regarding HMK is available on the HMK website. (See Key Websites.)

Passport to Health Program

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

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HM *Plus* members and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services. **Passport approval is not required for DMEPOS services, and Team Care does not apply.**

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

Medicaid and HMK *Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). Each enrollee has a designated Passport provider who is typically a physician, mid-level 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 members. This means he/she provides or coordinates the member's care and makes referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid, and HMK *Plus* members choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept that encourages a strong doctor–member relationship. An effective medical home is accessible, continuous, comprehensive, coordinated, and operates within the context of family and community.

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

Team Care (ARM 37.86.5303)

Team Care is designed to educate members to effectively access medical care. Members with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Members enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules



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



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the claim form, if appropriate.

and guidelines for referrals, enrollment/disenrollment, prior authorization, and billing processes. However, while Passport members can change providers without cause, as often as once a month, Team Care members 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 members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members. When checking Medicaid or HMK *Plus* eligibility on the MATH web portal, a Team Care member's provider and pharmacy will be listed. (See Key Websites.) Write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line, 1-800-330-7847, is a 24/7, toll-free, confidential nurse triage line staffed by licensed registered nurses, and is available to all Montana Medicaid/HMK *Plus* and HMK members. There is no charge to members or providers. Members 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 members 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 members calls to be triaged.

Passport providers are encouraged to provide education to their members 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)

The Health Improvement Program (HIP) is for Medicaid and HMK *Plus* members 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 HMK *Plus* members eligible for the Passport program are enrolled and assigned to a health center for case management. Current Passport members stay with their PCPs for primary care, but are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate members in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind members about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members who have not received a diagnosis or generated claims. PCPs may

also identify and recommend Passport members at high risk for chronic health conditions that would benefit from case management from HIP using the HIP referral form included at the health Improvement Program link on the Provider Information [website](#). (See Key Websites.)

In practice, providers will most often encounter Medicaid and HMK *Plus* members who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the member is a Passport enrollee. Specific PA requirements can be found in the provider fee schedules. For more information on Passport to Health, see the *General Information for Providers* manual.

Other Programs

Members who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK) are not enrolled in Passport, so the Passport requirements in this chapter do not apply.

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-800-447-7828 (toll-free) or 447-7828 (Helena) Additional HMK information is available on the HMK [website](#). (See Key Websites.)

Prior Authorization

What Is Prior Authorization? (ARM 37.85.410 and ARM 37.86.1806)

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid member. These items/services are reviewed for appropriateness based on the member's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the member.

Prior authorization **is not** required for dispensing units over the maximum allowable; however, documentation supporting medical necessity must be kept on file.

When requesting prior authorization, remember:

- Only Medicaid enrolled DMEPOS providers may request PA for items/services.
- In circumstances where another insurance carrier is primary and payment has been made, PA is not required.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the member.
- Documentation must be complete, including appropriate signatures and dates.
- Member must be eligible for Medicaid.
- Use the correct CMN for the item/service (if required).
- Use current correct coding.
- Use the appropriate place of service: 12 for home or 32 for nursing facility. (See Appendix B: Place of Service Codes.)
- Do not submit a PA request solely for denial in order to receive payment from another source. Instead, provide the requesting payer with documentation supporting noncoverage of the item (e.g., provider manuals, provider notices, newsletters, or request documentation from Provider Relations).



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

Granting of prior authorization does not guarantee payment for the item/service.



To request prior authorization for an item/service:

- Submit a completed DMEPOS Prior Authorization Request Form.
- Include appropriate supporting documentation with the request.
- Fax or mail the request and supporting documentation to the Mountain Pacific Quality Health. (See the PA Criteria table below.)
- Upon completion of the review, the member and requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations. (See Key Contacts.)

PA Criteria		
Covered Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Item/Service over \$1,000 (when the Department fee for any single line item is greater than or equal to \$1,000) • Item/Service shown on the Department fee schedule with a PA indicator • Items/services that are unique in their function/use in comparison to other items/services in the same category 	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: 406.457.5887 Local 877.443.4021, X 5887 Long-distance</p> <p>Fax: 877.443.2580 Toll-free local and long-distance</p>	<p>Medical necessity documentation must include all of the following:</p> <ul style="list-style-type: none"> • Completed DMEPOS Prior Authorization Request form • Supporting documentation, which must include at a minimum: <ul style="list-style-type: none"> • Prescription • Certificate of medical need (if required for the item) • Narrative summary from the prescribing authority detailing the need for the item • A manufacturers retail price sheet and product warranty information • For members being treated by a licensed therapist, a copy of the member’s plan of care in relation to the item/service is required • Video, if applicable

Remittance Advices and Adjustments

The Remittance Advice

Providers are now required to register for electronic funds transfer (EFT) and receive electronic remittance advices (RAs).

The RA is the best tool providers have for determining the status of a claim. RAs accompany payment for services rendered. The RA provides details of transactions that have occurred during the previous RA cycle. Providers are paid weekly. Each line of the RA represents all or part of a claim and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

To receive an electronic RA, the provider must have Internet access, must complete the Trading Partner Agreement, and must register for the Montana Access to Health (MATH) web portal. Providers access their electronic RA through the Provider Information website by selecting Log in to Montana Access to Health option in the left menu. Providers may want to mark both pages as favorites/bookmarks for later reference.

After the forms have been processed, the provider receives a user ID and password that he/she uses to log onto the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an EDI Trading Partner Agreement; however, if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider NPI and submitter ID fields. Otherwise, enter the provider NPI in the provider NPI field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the MATH web portal home page. Due to space limitations, each RA is only available for 90 days. The RA is divided into the following sections:

RA Notice

The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.



Electronic RAs are available for only 90 days on the web portal.

Paid Claims

This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted. (See Adjustments later in this chapter.)

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column. The reason and remark code description explains why the claim was denied and is located at the end of the RA. See the section titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter.

Pending Claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column. The Reason and Remark Code Description located at the end of the RA will explain why the claim is suspended. This section is informational only. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balance Claims

Credit balance claims are shown in this section until the credit has been satisfied.

Gross Adjustments

Any gross adjustments performed during the previous cycle are shown here.

Reason and Remark Code Description

This section lists the reason and remark codes that appear throughout the RA with a brief description of each.



If a claim was denied, read the Reason and Remark Code Description before taking any action on the claim.

Credit Balance Claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By “working off” the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to Medicaid for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please include a note stating that the check is to pay off a credit balance and include your provider NPI. Send the check to the attention of the Third Party Liability 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.

Timeframe for Rebilling or Adjusting a Claim

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

Rebilling Medicaid

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

When to Rebill Medicaid

- ***Claim denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the Adjustment form).
- ***Line denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. An adjustment form should be used for claims with denied lines that have codes that must be billed together. (See Adjustments.)

- **Claim returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to Rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider should call Provider Relations. Once an incorrect payment has been verified, the provider should submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations. (See Key Contacts.)

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 over will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as claims.

When to Request an Adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., client ID, provider NPI, date of service, procedure code, diagnoses, units).

How to Request an Adjustment

To request an adjustment, use the *Individual Adjustment Request* form, available on the Forms page of the Provider Information website. The requirements for adjusting a claim are:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service. (See Timely Filing in the Billing Pro-

cedures chapter of this manual.) After this time, *gross adjustments* are required. (See Definitions.)

- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section.

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the [Forms](#) page of the Provider Information website. Complete Section A first with provider and member information and the claim’s ICN number.
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected:
 - Enter the date of service or the line number in the Date of Service or Line Number column.
 - Enter the information from the claim form that was incorrect in the Information on Statement column.
 - Enter the correct information in the column labeled Corrected Information.
3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Provider Relations. (See Key Contacts.)
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the



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



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



Rebill denied claims only after appropriate corrections have been made.



Montana Health Care Programs
 Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

Instructions:
 This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the General Information for Providers manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1517 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address	3. Internal Control Number (ICN)
Name _____	_____
Street or P.O. Box _____	4. NPI/API _____
City _____ State _____ ZIP _____	5. Member ID Number _____
2. Member Name _____	6. Date of Payment _____
_____	7. Amount of Payment \$ _____

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature _____ Date _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:
 Claims
 P.O. Box 8000
 Helena, MT 59604

Updated 03/2013

provider. This can be done in two ways: by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims. (See Credit Balance in this chapter.)

- Any questions regarding claims or adjustments should be directed to Provider Relations. (See Key Contacts.)

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Member Name	The member's name.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider NPI	The provider's NPI.
5.* Member Medicaid Number	Member's Medicaid ID number.
6. Date of Payment	Date claim was paid (found on RA).
7. Amount of Payment	The amount of payment (found on RA).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/NDC/Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

Mass Adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

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

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly *Claim Jumper*, or provider notices. Mass adjustment claims shown on the RA have an ICN that begins with a 4.

Payment and the RA

Providers receive their Medicaid payment and remittance advice weekly. Providers who enrolled in Medicaid after July 2013 were required to enroll in electronic funds transfer (also referred to as direct deposit) and register to receive electronic RAs via the Montana Access to Health web portal. Providers who had enrolled in Medicaid prior to July 2013 who receive paper checks or paper remittance advices (RAs) will be transitioned to the electronic-only system by January 1, 2014.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This also affects delivery of the remittance advice that providers receive with payments.

To participate in EFT, providers must complete an EFT form. Once EFT testing shows payment to the provider's account, all Medicaid payments will be made through EFT. Contact Provider Relations for assistance enrolling in EFT, completing the Trading Partner Agreement, and registering on the web portal.

Required Forms for EFT and/or ERA

Form	Purpose	Where to Get	Where to Send
EFT/ERA	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information website (Forms page) • Provider Relations 	Fax to Provider Relations 406.442.4402
EDI Trading Partner Agreement	Allow provider to register for the Montana Access to Health (MATH) web portal in order to view their RA.	<ul style="list-style-type: none"> • Provider Information website (Forms page) • Provider Relations 	Fax to Provider Relations 406.442.4402

ERAs can be printed and/or saved to the provider's computer harddrive or an external drive.

Coordination of Benefits

When Members Have Other Coverage

Medicaid member's often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions. (See Exceptions to Billing Third Party First in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The member's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the *General Information for Providers* manual, Member Eligibility and Responsibilities. If Medicare or other carrier information is known, the Medicare ID number is provided or the carrier is shown on the eligibility information. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation Insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long-term care insurance

*These third party payers (and others) may **not** be listed on the member's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid members as for their non-Medicaid members. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Member Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability (TPL), but Medicare is not considered TPL.

Medicare Part B Crossover Claims

DMEPOS items and services are covered under Medicare Part B. The Department has an agreement with Medicare Part B carriers for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with a magnetic tape of professional claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

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

Providers should submit Medicare crossover claims to Medicaid only when:

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

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

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the provider NPI and taxonomy and Medicaid member ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit. (See the Billing Procedures chapter in this manual.)

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

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

When a Member Has TPL (ARM 37.85.407)

When a Medicaid member has additional medical coverage (other than Medicare), it is often referred to as TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their members that any funds the members receive from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the member's statement will fulfill this obligation: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid*

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

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

Requesting an Exemption

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

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no member name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 - The third party carrier has been billed, and 30 days or more have passed since the date of service.
 - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company. Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the Third Party Pays or Denies a Service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward member's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the Third Party Does Not Respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit. (See Key Contacts.)

Blanket Denials

Providers who routinely bill for Medicaid covered services that other insurance companies do not cover, may request a blanket denial letter. Providers may complete a Request for Blanket Denial Letter (located on the Provider Information website) and submit the form to the Third Party Liability Unit. (See Key Contacts.) The TPL Unit usually requests the provider send an EOB showing the services have been denied by the member's other insurance company. The provider is then notified that the services have been approved for a blanket denial.

Providers who bill electronically (ANSI ASC X12N 837 transactions) will receive a letter from the TPL Unit with a tracking number for use when billing Medicaid. This number must be included in the Paperwork Attachment Indicator field when billing electronically for the specific services.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

Providers who bill on paper will receive a letter from the TPL Unit. This letter must be copied and submitted with each claim for the approved procedure codes.

The number can be used for two years, and then the provider must submit a new Request for Blanket Denial Letter. Any claims submitted with procedure codes not listed (or not approved) on the letter must be submitted with a specific denial from the other insurance company or Medicaid will deny those services.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- Twelve months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined

For claims involving Medicare or TPL, if the 12-month time limit has passed, providers must submit clean claims to Medicaid within:

- **Medicare crossover claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the member was eligible for Medicare at the time the Medicare claim was filed).
- **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

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

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- If a claim submitted to Medicaid does not appear on the RA within 30 days, contact Provider Relations for claim status. (See Key Contacts.)
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. (See the Coordination of Benefits chapter in this manual for more information.)
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Coordination of Benefits chapter in this manual.

Usual and Customary Charge (ARM 37.85.406 and ARM 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For more information on reasonable charges, see the How Payment Is Calculated chapter.

When to Bill Medicaid Members (ARM 37.85.406)

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

More specifically, providers cannot bill members directly:

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

Under certain circumstances, providers may need a signed agreement to bill a Medicaid member. See the table on the following page.



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

When to Bill a Medicaid Patient (ARM 37.85.406)		
	Patient is Medicaid-enrolled and provider accepts him/her as a Medicaid member	Patient is Medicaid-Enrolled but provider does not accept him/her as a Medicaid member
Service is covered by Medicaid	Provider can bill patient only for cost sharing	Provider can bill Medicaid patient if the patient has signed a routine agreement
Service is not covered by Medicaid	Provider can bill patient only if custom agreement has been made between patient and provider before providing the service	Provider can bill Medicaid patient if the patient has signed a routine agreement

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

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

Member Cost Sharing (ARM 37.85.204 and ARM 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for DMEPOS items/services is \$5.00 per visit. The following members are exempt from cost sharing:

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

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the

member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.

When Members Have Other Insurance

If a Medicaid member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's health care, see the Coordination of Benefits chapter in this manual.

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

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

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual

If the item/equipment requires prior authorization, see the Prior Authorization chapter.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the Coding Resources table on the following page.

Coding Tips

The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS Level II, and ICD diagnosis coding books.
- If a provider is unable to determine the appropriate code for a covered item/service from such publications, contact the manufacturer or distributor of the item/service for coding guidance. Providers may also contact Pricing, Data Analysis, and Coding (PDAC) for coding advice. (See Key Contacts.)
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-and HCPCS billing manuals. Always check the long text of the code description. When billing for rentals, for example, 1 unit equals one month of rental.



Always refer to the long descriptions in coding books.

Miscellaneous/Not Otherwise Specified HCPCS Codes

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes (e.g., equipment, orthotics, prosthetics, supplies). Providers must determine if an alternative HCPCS Level II code better describes the item/service being reported. These codes should only be used if a more specific code is unavailable. Claims containing a miscellaneous/not otherwise specified HCPCS must have one of the following:

- A description of the item/service attached to the claim. (See the Billing Electronically with Paper Attachments section in the Submitting a Claim chapter of this manual.)
- A description of the item included on the claim form directly to the right or below the code used (paper claim).

Failure to include such descriptions will result in the claim being denied.

Claims containing miscellaneous/not otherwise specified HCPCS codes are subject to prepayment review. Review of these claims may result in processing and payment delays. Claim processing staff are dedicated to processing claims as quickly as possible to avoid lengthy delays in payment. Providers must provide clear and complete descriptions of the item/service on the claim line or on an attachment to assist in minimizing delays. For more information on claim status, see the Remittance Advices and Adjustments chapter in this manual.

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does not mean that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are subject to retrospective review auditing.

Coding Resources		
The Department does not endorse the products of any particular publisher.		
	Description	Contact
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association 800.621.8335 www.amapress.com or Optum 800.765.6588 www.optumcoding.com
CPT Assistant	A newsletter on CPT coding issues	American Medical Association (800) 621-8335 www.amapress.com
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov/ .
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
Medicare Pricing, Data Analysis and Coding (PDAC)	PDAC (formerly SADMERC) information is available under Other Partners. This website assists manufacturers and suppliers with DMEPOS billing and coding information.	www.dmepdac.com 877.735.1326
Miscellaneous Resources	Various newsletters and other coding resources.	Optum 800.765.6588 www.optumcoding.com
NCCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service 800.363.2068 703.605.6060 http://www.ntis.gov/products/cci.aspx

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT and HCPCS coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

Place of Service

Place of service must be entered correctly on each line. (See Appendix B: Place of Services Codes.) Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Date of Service

The date of service for custom molded or fitted items is the date upon which the provider completes the mold or fitting and either orders the equipment from another party or makes an irrevocable commitment to the production of the item.

Rental

Payment includes the entire initial month of rental even if actual days of use are less than the full month. Payment for second or subsequent months is allowed only if the item is used at least 15 days in such months.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only three pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first three modifier fields.
- Use modifier -BO when nutrition is orally administered, not by a feeding tube (only for members under age 21).

Claims where Medicaid is the primary payer are paid on a monthly basis. These claims are submitted using the -RR modifier with one unit of service. For example, a member rents a nebulizer. The first rental month is billed as one unit as shown:

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From	To	PROCEDURES, SERVICES, OR SUPPLIES		MODIFIER												
MM	DD	YY	MM	DD	YY			CPT/HCPCS									
08	21	04	08	31	04	12	0	E0570	RR	1	25.00	1					

Another example is a member who uses oxygen. Regardless of how much oxygen is used during a month, it is billed as 1 unit as follows:

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From	To	PROCEDURES, SERVICES, OR SUPPLIES		MODIFIER												
MM	DD	YY	MM	DD	YY			CPT/HCPCS									
08	01	04	08	31	04	12	0	E1390	RR	1	250.00	1					

Submitting a Claim

See the Submitting a Claim chapter in this manual for instructions on completing claims forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double-check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claim
Provider NPI missing or invalid	The provider NPI is a 10-digit number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be computer-generated, typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an electronic professional claim or a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the member: <ul style="list-style-type: none"> • View the member's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual.
Duplicate claim	<ul style="list-style-type: none"> • Check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form. (See the Remittance Advices and Adjustments chapter in this manual.) • Allow 45 days for the Medicare/Medicaid Part B cross-over claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. (See the Passport to Health and Prior Authorization chapters in this manual.)

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claim
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. See Coordination of Benefits in this manual. • If the member's TPL coverage has changed, providers must notify the TPL Unit before submitting a claim. (See Key Contacts.)
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in Key Contacts.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included. (See Billing Electronically with Paper Attachments in the Submitting a Claim chapter in this manual.)
Provider is not eligible during dates of services, or provider NPI terminated	<ul style="list-style-type: none"> • Out-of-state providers must receive authorization for a Montana resident to assure the provider NPI is current and other provider information is updated for each approved stay. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using applicable HCPCS and CPT billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

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

- **WINASAP 5010.** This free software is available for providers to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers, and creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox EDI Solutions Clearinghouse.** Providers can send claims to Xerox EDI Solutions (previously ACS EDI Gateway) clearinghouse 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 EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **Clearinghouse.** Providers can contract with a clearinghouse and send claims to the clearinghouse in whatever format they accept. The provider's clearinghouse then sends the in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims. EDIFECS certification is completed through EDI Solutions. For information on electronic claims submission, contact Provider Relations. (See Key Contacts.)
- **Montana Access to Health (MATH) web portal.** Providers can upload and download electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **ACS B2B Gateway SFTP/FTPS site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high-frequency submitters.
- **ACS MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.

Providers should be familiar with the federal rules and regulations on preparing electronic transactions.

Billing Electronically with Paper Attachments

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

9999999999	- 8888888888	- 11182003
Provider NPI	Member ID Number	Date of Service (mmdyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet (located on the Provider Information website). The number in the paper Attachment Control Number field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the Xerox EDI Solutions website. (See Key Websites.)

Paper Claims

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

Claims are completed differently for the different types of coverage a member has. See the [Forms page](#) of the website for sample claims for various scenarios.

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 member are indicated by “**”.

Field 24h, EPSDT/Family Planning, is used as an indicator to specify additional details for certain members or services.

The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Member/Service	Purpose
1	EPSDT	Used when the member is under age 21
2	Family planning	Used when providing family planning services
3	EPSDT and family planning	Used when the member is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	Used when providing services to pregnant women
6	Nursing facility member	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

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, member eligibility. (See Key Contacts.)

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double-check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the Billing Procedures chapter in this manual.

Common Claim Errors	
----------------------------	--

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

How Payment Is Calculated

Overview

Although 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.

Usual and Customary Charge (ARM 37.85.406 and ARM 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For DMEPOS providers, a charge is considered reasonable if it is less than or equal to the manufacturer's suggested list price.

For items without a manufacturer's suggested list price, the charge is considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

Payment for DMEPOS Items/Services (ARM 37.86.1807)

Payment for DMEPOS is equal to the lowest of either the provider's usual and customary charge for the item or the Medicaid fee schedule amount in effect for the date of service.

Medicaid payment is equal to 100% of Medicare Region D fee schedule for current procedure codes where a Medicare fee is available, less applicable cost sharing, incurment and/or other applicable fees. Generic or miscellaneous procedure codes are excluded from the Medicare fee schedule. Payment for such excluded procedure codes is 75% of the provider's submitted charge. For all other procedure codes where no Medicare fee is available, payment is 75% of the submitted charge.

Rental Items

If the purchase of a rental item is cost effective in relation to the patient's need of the item, the purchase may be negotiated. The purchase price would be the amount indicated on the applicable fee schedule, less previous payments made to the provider of the item.

Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental is limited to the purchase price for that item. Monthly rental fees are limited to 10% of the purchase for the item, limited to 13 monthly payments. Interruptions in the rental period of less than 60 days do not result in the start of a new 13-month period or new purchase price limit, but periods during which service is interrupted will not count toward the 13-month limit.

How Cost Sharing is Calculated on Medicaid Claims

Member cost sharing for services provided by DMEPOS providers is \$5.00 per visit. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in this manual.) For example, a DMEPOS provider supplies a Medicaid member with a set of crutches (E0114). The Medicaid allowed amount in July 2013 for this item is \$9.28. The member owes the provider \$5.00 for cost sharing, and Medicaid would pay the provider the remaining \$4.28.

How Payment is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a Medicaid member who also has insurance through her job receives a nebulizer (E0570) for her bronchitis. The member's other insurance is billed first and pays \$10.00. The Medicaid allowed amount for this service is \$17.44. The amount the other insurance paid (\$10.00) is subtracted from the Medicaid allowed amount (\$17.44), leaving a balance of \$7.44. The Medicaid cost sharing (\$5.00) is deducted from the balance, leaving a net payment of \$2.44 on this claim.

How Payment is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the Coordination of Benefits chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing.

Appendix A: Forms

See the [Forms page](#) of the Montana Medicaid Provider Information website for the forms listed below.

- **Montana Health Care Programs Individual Adjustment Request**
- **Request for Blanket Denial Letter**
- **Paperwork Attachment Cover Sheet**
- **Certificates of Medical Necessity**
 - Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)
 - Osteogenesis Stimulators (CMS-847)
 - Oxygen (CMS-484)
 - Seat Lift Mechanisms (CMS-849)
 - Section C Continuation Form (CMS-854)
 - Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)

DME Information Forms

- External Infusion Pumps DME 09.03 (CMS 10125)
- Enteral and Parenteral Nutrition DME 10.03 (CMS 10126)

DMEPOS Medical Review Request Form

Appendix B: Place of Service Codes

Place of Service Codes		
Codes	Names	Descriptions
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05)
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Freestanding Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Freestanding Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

Place of Service Codes (Continued)		
Codes	Names	Descriptions
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-In Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment/ Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Unassigned	N/A
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room -- hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 -- 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 -- 40	Unassigned	N/A

Place of Service Codes (Continued)		
Codes	Names	Descriptions
41	Ambulance -- Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance -- Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 -- 48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility -- Partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-Residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 -- 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

Place of Service Codes (Continued)		
Codes	Names	Descriptions
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 -- 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 -- 70	Unassigned	N/A
71	State or local public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 -- 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 -- 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

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

Accessory

A medically necessary device or supply which augments or complements the functions of the equipment to which it is connected.

Administrative Rules of Montana (ARM)

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

Allowed Amount

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

Ancillary Provider

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

Assignment of Benefits

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

Authorization

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

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the *General Information for Providers* manual, Medicaid Covered Services.

By Report

For services, supplies, or equipment that do not have a maximum allowance established, Montana Medicaid reimburses the provider based on a percentage of the provider's usual and customary charge for the allowed item or service. These items are identified in the Department's fee schedule.

Capped Rental

Rentals classified by Montana Medicaid and Medicare as capped rental items are limited to a 13-month rental period. Total monthly rental reimbursement is not to exceed 120% of the item's purchase price. All necessary supplies needed to operate the rented equipment item are included in the rental amount. No additional allowances are made.

Cash Option

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

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs.

Certificate of Medical Need (CMN)

A CMN form contains all the information needed for the Department to determine if an item is medically necessary for the Medicaid member.

Children's Health Insurance Plan (CHIP)

The Montana plan is now Healthy Montana Kids (HMK).

Children's Special Health Services (CSHS)

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

Clean Claim

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

Code of Federal Regulations (CFR)

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

Coinsurance

The member's financial responsibility for a medical bill as assigned by Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor

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

Copayment

The member's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing

The member's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers

Claims for members who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Montana Health Care Programs. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Members who are covered by Medicare and Medicaid are often referred to as *dual eligibles*.

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

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

Emergency Services

A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with CPT Code 99284 or 99285
- The member has a qualifying emergency diagnosis code. A list of emergency diag-

nosis codes is available on the Provider Information website.

- The services did not meet one of the previous two requirements, but the hospital believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the service must be mailed to the emergency department review contractor (see *Key Contacts* on your provider type page or in your provider manual)

.Experimental

A noncovered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent

Note: As of April 1, 2012, ACS State Healthcare, LLC, became Xerox State Healthcare.) Xerox State Healthcare, LLC, is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Frequently Maintained Rental

Rentals that need frequent and substantial servicing are not subject to a cap and the provider may continue to rent the item as long as it is medically necessary. All supplies needed to operate the equipment are included in the rental fee.

Full Medicaid

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

Gross Adjustment

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

Healthy Montana Kids (HMK)

HMK offers low-cost or free health care coverage for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program with Blue Cross and Blue Shield of Montana (BCBSMT). For eligibility and enrollment information, contact HMK at 1.877.543.7669 (toll-free, follow menu) or 1.855.258.3489 (toll-free, direct). For information about medical benefits, contact BCBSMT at 1.406.447.8647 (Helena) or 1.800.447.7828 (toll-free). HMK dental and eyeglasses benefits are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing.

Incurment

That portion of a medically needy individual's or couple's income that exceeds the Medically Needy Income Level (MA 002); the amount of medical expenses for which the individual is responsible before Medicaid will begin paying any medical bills.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

A noncovered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

Maximum Allowable

The maximum dollar amount for specific services, supplies, and/or equipment.

Medicaid/HMK Plus

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled members.

Member

An individual enrolled in a Department medical assistance program.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a severe disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Access to Health (MATH) Web Portal

A secure website on which providers may view members' medical history, verify member eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Montana Breast and Cervical Cancer Treatment Program

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

Passport to Health

The Medicaid medical home program where the member selects a primary care provider who manages the member's health care needs.

Prior Authorization (PA)

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

Private-Pay

When a member chooses to pay for medical services out of his/her own pocket.

Provider or Provider of Service

An institution, agency, or person having a signed agreement with the Department to furnish medical care, goods and/or services to members, and eligible to receive payment from the Department.

Qualified Individual

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

Qualified Medicare Beneficiary (QMB)

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

Relative Value Scale (RVS)

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

Relative Value Unit

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

Remittance Advice (RA)

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

Resource-Based Relative Value Scale (RBRVS)

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

Retroactive Eligibility

When a member 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.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these members, 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

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

Team Care

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist members in making better health care decisions so that they can avoid overutilizing health services. Team Care members are joined by a team assembled to assist them in accessing health care. The team consists of the member, 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/CHIP member.

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:

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

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

WINASAP 5010

WINASAP 5010 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk. (See Key Contacts.)

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