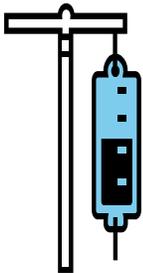


Dialysis Clinic Services



*Medicaid and Other Medical
Assistance Programs*



This publication supersedes all previous Dialysis Clinic Services handbooks. Published by the Montana Department of Public Health & Human Services, July 2005.

| Updated October 2013 and February 2014.

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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 **only** “In state” will not work outside Montana.

Claims

Send paper claims to:

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

Member Eligibility

Provider Relations

800-624-3958 or 406-442-1837

FaxBack

800-714-0075 (24 hours)

Integrated Voice Response (IVR)

800-714-0060 (24 hours)

Montana Access to Health Web Portal

<http://mtaccesstohealth.acs-shc.com/>

Medifax EDI

800-444-4336, X2072 (24 hours)

Dialysis Services Program

406-444-4540 Phone

406-444-1861 Fax

Send written inquiries to:

Dialysis Program Officer
Hospital and Clinic Services Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2801

EDI Support Unit

For questions regarding electronic claims submission:

800-987-6719 In/Out of state

850-385-1705 Fax

Electronic Funds Transfer/ Electronic Remittance Advice

Providers enroll in electronic funds transfer (EFT) and register for the Montana Access to Health web portal to receive electronic remittance advices (ERAs). Required documentation is available on the [Forms](#) page of the Montana Medicaid Provider Information website. Completed documentation should be mailed or faxed to Provider Relations.

Provider Relations
P.O. Box 4936
Helena, MT 59604
406-442-4402 Fax

Medicaid Help Line

Members who have Medicaid or Passport questions may call the Montana Medicaid Help Line:

800-362-8312

Send written inquiries to:

Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the Introduction chapter in the *General Information for Providers* manual.

Provider Relations

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

800-624-3958 In/Out of state

406-442-1837 Helena

406-442-4402 Fax

Send written inquiries to:

Provider Relations Unit

P.O. Box 4936

Helena, MT 59604

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

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

Third Party Liability Unit

P.O. Box 5838

Helena, MT 59604

Key Websites	
Web Address	Information Available
<p>Blue Cross and Blue Shield of Montana (BCBSMT) www.bcbsmt.com</p>	<p>BCBSMT processes HMK/CHIP medical claims. For an HMK medical manual, contact BCBSMT.</p>
<p>EDI Solutions http://www.acs-gcro.com/gcro/mt-home</p>	<p>EDI Solutions is the Xerox HIPAA clearinghouse. Visit this website for more information on:</p> <ul style="list-style-type: none"> • EDI support • EDI enrollment • Manuals • Provider services • Related links • Software
<p>Healthy Montana Kids (HMK) www.hmk.mt.gov/</p>	<p>Information on Healthy Montana Kids (HMK).</p>
<p>Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com</p> <p>Provider Information Website http://medicaidprovider.hhs.mt.gov/ www.mtmedicaid.org</p>	<ul style="list-style-type: none"> • FAQs • Fee schedules • HIPAA information • ICD-10 Information • Key contacts • Medicaid forms • Medicaid news • Newsletters (<i>Claim Jumper</i>) • Passport to Health information • Provider enrollment (web portal) • Provider manuals and replacement pages • Provider notices • Remittance advice notices (web portal) • Training resources • Upcoming events
<p>Public Assistance Toolkit https://dphhs.mt.gov/</p>	<p>Select Human Services for information on:</p> <ul style="list-style-type: none"> • Medicaid: Member information, eligibility information, an provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
<p>Secretary of State http://sos.mt.gov/ http://sos.mt.gov/ARM/index.asp</p> <p>Administrative Rules of Montana (ARM) http://www.mtrules.org/</p>	<p>Secretary of State website and Administrative Rules of Montana</p>
<p>Washington Publishing Company www.wpc-edi.com/</p> <p>A fee is charged for documents; however, code lists are viewable online for no charge.</p>	<ul style="list-style-type: none"> • HIPAA guides • HIPAA tools

Covered Services

General Coverage Principles

Medicaid covers most dialysis services when they are medically necessary. This chapter provides covered services information that applies specifically to dialysis clinics. Like all health care services received by Medicaid members, dialysis services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Dialysis Clinic Requirements (ARM 37.86.4201)

Dialysis clinics must be licensed to provide services in the state in which the clinic is located. The dialysis clinic must also be certified by the Centers for Medicare and Medicaid (CMS) to provide outpatient maintenance dialysis directly to end-stage renal disease (ESRD) members. Dialysis services are provided to only those members who have been diagnosed by a physician as suffering from chronic ESRD. Supporting documentation must be kept on file.

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all services described in this manual.

Coverage of Specific Services

Medicaid follows Medicare’s rules for coverage of most services. The following are Medicaid’s coverage rules for dialysis services.

Drugs and Biologicals

Most drugs and biologicals used in the dialysis procedure are covered under the composite rate and may not be billed separately. They include:

• Heparin	• Mannitol	• Glucose
• Antiarrhythmics	• Pressor drugs	• Dextrose
• Saline	• Antihypertensives	• Protamine
• Antihistamines	• Local anesthetics	• Heparin antidotes

Epoetin (EPO)

Medicaid covers EPO therapy for members who have been diagnosed with chronic ESRD. EPO is covered when administered in a facility; however, it is included in the composite rate.

Hemodialysis and Peritoneal Dialysis Services

Hemodialysis and peritoneal dialysis are covered under a composite rate for the dialysis facility.

Home Dialysis Training

Medicaid covers training for patients (and a helper/backup person) to learn to perform their own dialysis at home.

Home Dialysis Equipment, Support and Supplies

Medicaid covers home dialysis equipment, support and supplies. The patient has the option of having the facility provide the equipment under the composite rate, or of renting or purchasing such equipment directly from a supplier. The dialysis facility must provide the home dialysis patient with the following, which are included in the facility's composite rate:

- Periodic monitoring of the patient's home adaptation (including visits to the home, in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition)
- Emergency visits by qualified ESRD facility personnel
- Providing and arranging for supplies when dialysis equipment is provided by the facility
- Installation and maintenance of dialysis equipment when provided by the facility
- ESRD related laboratory tests
- Testing and appropriate treatment of water
- Monitoring the functioning of the dialysis equipment when provided by the facility

Some covered support services may involve indirect patient contact. The patient, for example, may need to consult with a nurse regarding dietary restrictions or with a social worker if he is having problems adjusting. The consultations may be by phone.

Supplies and Equipment

The supplies necessary to administer dialysis (e.g., needles, tubing) are included in the facility's composite rate.

Coordination of Benefits

When Members Have Other Coverage

Medicaid members 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 must bill other carriers before billing Medicaid, but there are some exceptions (see Exceptions to Billing Third Party First later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The member's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see Member Eligibility and Responsibilities in the *General Information for Providers* manual). If a member has Medicare, the Medicare ID number is provided. If a member has other coverage (excluding Medicare), it will be shown under the TPL section. 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 Medicaid eligibility verification.

Providers must 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 claims involving other payers. The other sources of coverage are referred to as third party liability (TPL), but Medicare is not.

Medicare Part A Claims

Medicare Part A covers dialysis services. Providers submit the claims to Medicare. After Medicare processes the claim, the claim crosses over to Medicaid electronically or on paper.

When Medicare Pays or Denies a Service

When dialysis claims for members with Medicare and Medicaid are submitted to Medicare, and Medicare:

- ***Pays the claim.*** Submit the claim to Medicaid on a UB-04 with the Medicare coinsurance and deductible information in value codes form locators (FL 39–41) and Medicare paid amounts in the prior payments form locator (FL 54). See the Billing Procedures and Submitting a Claim chapters in this manual.
- ***Allows the claim, and the allowed amount went toward the member's deductible.*** Include the deductible information in value codes form locators (FLs 39-41), and submit the claim to Medicaid on paper.
- ***Denies the claim.*** The provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.

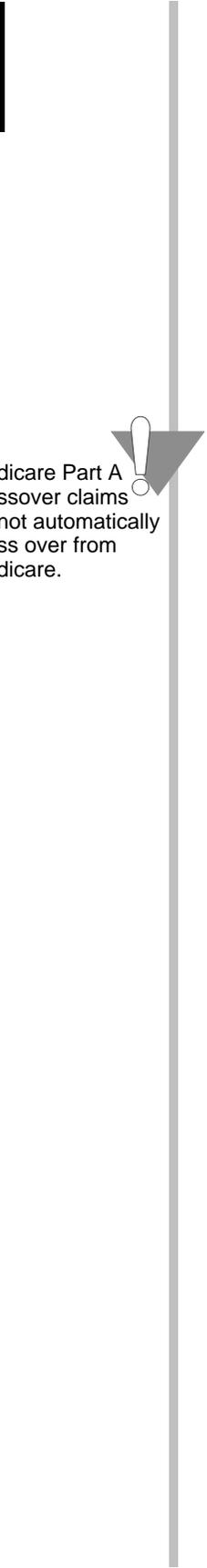
Submitting Medicare Claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the provider's NPI and member's Medicaid ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied. When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Submitting a Claim chapter in this manual.

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 member receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the member's statement will fulfill this requirement: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid.*



Medicare Part A crossover claims do not automatically cross over from Medicare.

Submitting a Claim

Electronic Claims

Institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Providers should be familiar with federal rules and regulations regarding electronic transactions. Claims may be submitted electronically by the following methods:

- **EDI Solutions.** Providers can send claims to EDI Solutions 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.
- **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.
- **Clearinghouse.** Providers can contract with a clearinghouse and send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the Xerox clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the Xerox clearinghouse. EDIFECS certification is completed through EDI Solutions. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk. (See Key Contacts.)
- **Montana Access to Health (MATH) Web Portal.** Providers can upload electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **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.
- **WINASAP 5010.** Xerox makes this field software available to providers free of charge. Providers can create and submit claims to Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. WINASAP does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.

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:

999999999	- 888888888	11182012
Provider NPI	Member ID Number	Date of Service (mmdyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet (see the Forms page of 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 [EDI website](#).

Paper Claims

The services described in this manual are billed on UB-04 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 of this manual).

Claims are completed differently depending on the types of coverage a member has. Sample UB-04 claims are posted on the Forms page of the website.

When completing a claim, remember the following:

- All form locators shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or member and are indicated by “**”.
- Form locator 78 is used for cost sharing override codes:
 - E – Overrides cost sharing for emergency services
 - P – Overrides cost sharing for pregnant women

Unless otherwise stated, all paper claims must be mailed to:

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

Contact Provider Relations for questions regarding payments, denials, general claim questions, member eligibility, or to request billing instructions, manuals, or fee schedules. (See Key Contacts.)

Remittance Advices and Adjustments

The Remittance Advice

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany weekly payment for services rendered and provide details of all transactions that have occurred during the previous remittance advice cycle. Each line of the remittance advice 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 remittance advice also shows the reason.

Providers who enroll in Montana Health Care Programs are required to enroll in electronic funds transfer (EFT) and register to receive electronic remittance advices (ERAs).

To enrollment in EFT (also known as direct deposit), providers must complete the Montana Medicaid Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement found on the [Provider Enrollment page](#) of the Montana Medicaid Provider Information website.

To receive ERAs, providers must have Internet access, complete the EDI Trading Partner Agreement, and register for the Montana Access to Health web portal. Providers access ERAs through the MATH web portal.

ERAs are available in PDF format, and providers can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Adobe website. **Due to space limitations, each RA is only available for 90 days.**

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 number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

After enrollment, providers receive a user ID and password to log on to the MATH web portal.



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



If a claim was denied, read the description of the reason and remark code before taking any action on the claim.



The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

Sections of the RA

RA Notice

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

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.

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.

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/Remark Code description located at the end of the RA explains 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 member 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 NPI/API was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

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 DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of Third Party Liability Unit in the Key Contacts chapter.

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.

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

Rebilling Medicaid

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

When to Rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make

the appropriate corrections, and resubmit the claim on a UB-04 form (not the adjustment form).

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

How to Rebill

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see Key Contacts).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider should contact Provider Relations.

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

When to Request an Adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied. The denied service must be submitted as an adjustment rather than a rebill.

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service. (See *Timely Filing Limits* in the *Billing Procedures* chapter.) After this time, *gross adjustments* are required. (See the *Definitions* chapter.)

- 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 of the Individual Adjustment Request.

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 first and last 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 recent claim.
4. Provider number	The provider's NPI.
5. Member Medicaid ID number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid. See your remittance advice.
7. Amount of payment	The amount of payment. See your remittance advice.
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 is 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 facility)	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 third party liability 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.

Completing an Individual Adjustment Request

- Download the form from the Provider Information website. Complete Section A with provider and member information and the claim's ICN number.
- Complete Section B with information about the claim. 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.

- 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.

- Verify the Adjustment Request has been signed and dated.
- Send the adjustment request to Claims Processing. (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 through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check. (See Credit Balances earlier in this chapter.)
- Any questions regarding claims or adjustments must be directed to Provider Relations. (See Key Contacts.)



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 406.442.1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.			
1. Provider Name and Address		3. Internal Control Number (ICN)	
Hometown Audiology		00404011250000600	
Name			
P.O. Box 999		4. NPI/API	
Street or P.O. Box		1234567	
Anytown, MT 59999		5. Member ID Number	
City	State	ZIP	123456789
2. Member Name		6. Date of Payment	
Jane Doe		10/01/12	
		7. Amount of Payment	
		\$ 180.00	

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	Line 2	2	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)	Line 3	09/01/05	09/15/05
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 <i>Mary Bender</i>		Date 10/15/12	

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 3000
 Helena, MT 59604

Updated 03/2013

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). Mass adjustment claims shown on the RA have an ICN that begins with a 4.

Payment and the RA

Providers are required to register for payment via electronic funds transfer (EFT) and electronic remittance advice (ERAs).

Direct deposit is another name for EFT. With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds and the RA will be available on the next business day.

To participate in EFT, providers must complete the Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement. One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. Contact Provider Relations for instructions enrolling for EFT and ERAs.

Required Forms for EFT and ERA			
Form	Purpose	Where to Get	Where to Send
EFT & ERA Authorization Agreement	Allows the Department to automatically deposit Medicaid payment into provider's bank account and allows the provider to access ERAs.	Provider Information website.	Fax to Provider Relations 406.442.4402.
EDI Trading Partner Agreement	In conjunction with the Authorization Agreement above, allows providers to access their ERAs on the Montana Access to Health (MATH) web portal.	Provider Information website.	Fax to Provider Relations 406.442.4402.

Forms

These forms below and others are available on the [Forms](#) page of the Montana Medicaid Provider Information website.

- Individual Adjustment Request
- Paperwork Attachment Cover Sheet

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