



Hospital Inpatient Services

*Hospitals that are paid under the
Prospective Payment System*

*Medicaid and Other Medical
Assistance Programs*

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

Updated December 2010, October 2011, April 2012, and April 2013.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

My NPI:

Table of Contents

Key Contacts	ii.1
Key Websites	ii.4
Introduction.....	1.1
Manual Organization	1.1
Manual Maintenance.....	1.1
Rule References	1.1
Claims Review (MCA 53-6-111, ARM 37.85.406).....	1.2
Getting Questions Answered	1.2
Covered Services	2.1
General Coverage Principles	2.1
Hospital Inpatient Services (ARM 37.86.2801–2947)	2.1
Services for Children (ARM 37.86.2201–2234)	2.1
Importance of Fee Schedules	2.1
Physician Attestation and Acknowledgment (ARM 37.86.2904)	2.2
Utilization Reviews (42 CFR 456)	2.2
Obtaining Resident Status (ARM 37.86.2921).....	2.2
Nursing Facility Placement.....	2.3
Coverage of Specific Services (ARM 37.86.2902)	2.3
Abortions (ARM 37.86.104).....	2.3
Air Transports.....	2.4
Chemical Dependency Treatment.....	2.4
Detoxification	2.4
Discharges.....	2.4
Donor Transplants.....	2.5
Emergency Department Admissions	2.5
Mental Health Services.....	2.5
Observation Bed	2.5
Out-of-State Inpatient Services (ARM 37.86.2801).....	2.5
Readmissions	2.6
Same Day Readmission	2.6
Sterilization/Hysterectomy (ARM 37.86.104)	2.7
Transfers	2.9
Transplants (ARM 37.86.4701–ARM 37.86.4706)	2.9
Noncovered Services (ARM 37.85.207 and 37.86.2902).....	2.10
Other Programs	2.11
Mental Health Services Plan (MHSP)	2.11
Healthy Montana Kids (HMK).....	2.11
Passport to Health Program	3.1
What Is Passport to Health? (ARM 37.86.5101–5120, 37.86.5303, 37.86.5201–5206) ...	3.1
Passport to Health Primary Care Case Management (ARM 37.86.5101-5120).....	3.1
Team Care (ARM 37.86.5303).....	3.1

- Nurse First Advice Line3.2
- Health Improvement Program (ARM 37.86.5201–5206).....3.2
- Prior Authorization4.1**
 - What is Prior Authorization (ARM 37.85.205, 37.86.2801, and 37.86.5101–5306)4.1
 - Other Programs4.2
- Coordination of Benefits5.1**
 - When Members Have Other Coverage5.1
 - Identifying Other Sources of Coverage5.1
 - When a Member Has Medicare5.1
 - Medicare Part A Claims5.2
 - When Medicare Pays or Denies a Service5.2
 - Submitting Medicare Claims to Medicaid5.2
 - When a Member Has TPL (ARM 37.85.407)5.2
 - Exceptions to Billing Third Party First.....5.3
 - Requesting an Exemption5.3
 - When the Third Party Pays or Denies a Service.....5.4
 - When the Third Party Does Not Respond5.4
 - Other Programs5.4
- Billing Procedures.....6.1**
 - Claim Forms6.1
 - Timely Filing Limits (ARM 37.85.406).....6.1
 - Tips to Avoid Timely Filing Denials6.1
 - When to Bill Medicaid Members (ARM 37.85.406)6.2
 - Hospital Services Beyond Medical Necessity6.3
 - Member Cost Sharing (ARM 37.85.204 and 37.85.402)6.3
 - Coding.....6.4
 - Billing for Retroactively Eligible Members6.5
 - Billing for Members with Other Insurance.....6.5
 - Medicare Benefits Exhausted6.6
 - memberServices Provided to Passport to Health Members6.6
 - Services That Require Prior Authorization (PA)6.6
 - Discharges and Transfers6.6
 - Bundled Services6.8
 - Split/Interim Billing6.8
 - Member Partial Eligibility6.9
 - Incurment6.9
 - Billing for Abortions and Sterilizations6.9
 - Abortions6.9
 - Sterilization.....6.10
 - Submitting a Claim6.10
 - The Most Common Billing Errors and How to Avoid Them.....6.11
- Submitting a Claim.....7.1**
 - Electronic Claims7.1
 - Billing Electronically with Paper Attachments7.2

Paper Claims 7.2

Present on Admission 7.3

Claim Inquiries 7.3

UB-04 7.4

UB-04 Sample. 7.5

UB-04 Agreement. 7.6

Other Programs 7.7

Remittance Advices and Adjustments8.1

 Remittance Advice Description 8.1

 RA Notice 8.1

 Paid Claims 8.1

 Denied Claims. 8.1

 Pending Claims. 8.1

 Sample Remittance Advice. 8.2

 Credit Balances 8.4

 Rebilling and Adjustments 8.4

 How Long Do I Have to Rebill or Adjust a Claim? 8.4

 Rebilling Medicaid 8.4

 Adjustments 8.5

 Mass Adjustments. 8.8

 Payment and the RA 8.9

 Electronic Funds Transfer/Direct Deposit 8.9

 Electronic Remittance Advice 8.9

 Other Programs 8.10

How Payment Is Calculated.....9.1

 Overview. 9.1

 The Inpatient Prospective Payment System (PPS) 9.1

 The Inpatient Prospective Payment Method Using All Patient Refined Diagnosis Related Groups (APR-DRG) 9.1

 Relative Weights and Reimbursement Data 9.2

 APR-DRG Relative Weights 9.2

 DRG Base Price 9.3

 APR-DRG Base Payment 9.3

 Computational Formulas and Definitions. 9.3

 Payment Factors 9.4

 Capital Related Costs 9.4

 Cost Outlier Payments 9.4

 Transfer Payment Adjustments. 9.4

 Prorated Payment Adjustment 9.5

 The Cost-Based Payment Method for Exempt Hospitals and Services. 9.5

 Exempt Services and Costs. 9.5

 Reasonable Cost Reimbursement 9.5

 Hospital Residents 9.6

 Partial Member Eligibility 9.6

Transfers9.7

How Payment Is Calculated on TPL Claims9.7

How Payment Is Calculated on Medicare Crossover Claims9.7

Payment Examples for Dually Eligible Members9.7

Disproportionate Share Hospital (DSH) Payments (ARM 37.86.2925).....9.8

Other Programs9.8

Appendix A: FormsA.1

 Individual Adjustment Request A.2

 Medicaid Abortion Certification (MA-37) A.3

 Informed Consent to Sterilization (MA-38) A.4

 Medicaid Hysterectomy Acknowledgment (MA-39)..... A.6

 Paperwork Attachment Cover Sheet..... A.8

Definitions and Acronyms..... B.1

Index..... C.1

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated **only** “In state” will not work outside Montana.

Chemical Dependency Bureau

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

(406) 444-3964 Phone

(406) 444-4435 Fax

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

Claims

Send paper claims to:
Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone

(406) 444-3456 Fax

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

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should fax their information to Provider Relations:

(406) 442-4402

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In/Out of state

(406) 442-1837 Helena

(406) 442-4402 Fax

Montana EDI
P.O. Box 4936
Helena, MT 59604

Send e-mail inquiries to:
MTEDIHelpdesk@xerox.com

Health Improvement Program

(406) 444-1292 Phone

(406) 444-1861 Fax

Health Improvement Program Officer
Managed Care Bureau
DPHHS
P.O. Box 20291
Helena, MT 59620-2951

Hospital Program

To qualify a member for residency status or to submit claims for hospital residents:

(406) 444-7018 Phone
(406) 444-4441 Fax
 Hospital Program Officer
 Health Resources Division
 P.O. Box 202951
 Helena, MT 59620

Lab

Public Health Lab assistance:

(800) 821-7284 In state
(406) 444-3444 Helena/Out of state

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

Medicaid Help Line

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

(800) 362-8312
 Passport to Health
 P.O. Box 254
 Helena, MT 59624-0254

Member Eligibility

There are several methods for verifying member eligibility. For details on each, see the Member Eligibility and Responsibilities chapter of 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, X2072 (24 hours)

Nurse First

For questions regarding the Nurse First Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

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

Nursing Facility/Swing Bed Pre-Admission Screening

For pre-admission screening and level-of-care screening for members entering a nursing facility or swing bed hospital, contact:

Phone:
(800) 219-7035 In/Out of state
(406) 443-0320 Helena

Fax:
(800) 413-3890 In/Out of state
(406) 443-4585 Helena

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

Passport to Health Program

Send inpatient stay documentation to:

(406) 444-4540 Phone
(406) 444-1861 Fax

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

Prior Authorization

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

Mountain-Pacific Quality Health

For questions regarding prior authorization for transplant services, private duty nursing services, out-of-state inpatient services, medical necessity therapy reviews, interim inpatient hospital stays, other services requiring prior authorization, and case management assistance:

Phone:

(800) 262-1545 X5850 In/Out of state

(406) 443-4020 X5850 Helena

Fax:

(800) 497-8235 In/Out of state

(406) 443-4585 Helena/Out of state

Mountain-Pacific Quality Health

3404 Cooney Drive

Helena, MT 59602

For questions regarding prior authorization for alcohol and drug detoxification:

(406) 444-0061 Phone

(406) 444-4441 Fax

Magellan Medicaid Administration

(previously dba First Health)

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

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

Magellan Medicaid Administration

4300 Cox Road

Glen Allen, VA 23060

Provider Policy Questions

For policy questions, contact the appropriate division of DPHHS; see the Introduction chapter in the *General Information for Providers* manual.

Provider Relations

For questions about provider enrollment, eligibility, payments, denials, general claims questions, or Passport, or to request provider manuals or fee schedules:

(800) 624-3958 In/Out of state

(406) 442-1837 Helena

(406) 442-4402 Fax

Provider Relations Unit

P.O. Box 4936

Helena, MT 59604

Secretary of State

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

(406) 444-2055 Phone

Secretary of State

P.O. Box 202801

Helena, MT 59620-2801

www.mtrules.org/

Team Care Program

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer

Managed Care 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) 443-1365 Helena

(406) 442-0357 Fax

Third Party Liability Unit

Xerox State Healthcare, LLC

P.O. Box 5838

Helena, MT 59604

Key Websites	
Web Address	Information Available
ACS EDI Gateway www.acs-gcro.com/	ACSEDI Gateway is Montana’s HIPAA clearinghouse. From the EDI Gateway Clients tab, select the Montana Department of Public Health and Human Services link for information on: <ul style="list-style-type: none"> • EDI enrollment • EDI support • Electronic transaction instruction for HIPAA 5010 • Manuals • Provider services • Related links • Software
Centers for Disease Control and Prevention (CDC) www.cdc.gov/vaccines	<ul style="list-style-type: none"> • Immunization and other health information
Healthy Montana Kids (HMK) http://hmk.mt.gov	<ul style="list-style-type: none"> • Information on the Healthy Montana Kids (HMK) Plan
Montana Access to Health (MATH) https://mtaccesstohealth.acs-shc.com/ Montana Medicaid Provider Information http://.medicaidprovider.hhs.mt.gov	<ul style="list-style-type: none"> • FAQs • Fee schedules • Forms • HIPAA update • Key contacts • Links • Newsletters • Medicaid news • Provider enrollment • Provider manuals • Provider manual replacement pages • Provider notices • Remittance advice notices • Passport to Health information • Team Care information • Training resources • Upcoming events
Public Assistance Toolkit https://dphhs.mt.gov/	Select Human Services for information on: <ul style="list-style-type: none"> • Medicaid: Member information, eligibility information, and provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
Secretary of State www.sos.mt.gov	Secretary of State
ARM Rules Home Page www.mtrules.org	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com A fee is charged for most documents; code lists are viewable online at no cost.	<ul style="list-style-type: none"> • HIPAA 5010 guides • Code lists

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 hospital inpatient services. Most chapters have a section titled Other Programs that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK). 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 you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts at the beginning of each manual. We have also included a space on the inside front cover to record your NPI 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. Manual replacement pages can be downloaded from the [website](#) and are identified by a note at the top of the page indicating Replacement Page and the date. They are designed to be printed on the front and back of each page, so they are always in sets of two beginning with an odd page followed by an even page, even though one of the pages may not have any changes. 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 rules are available on the Provider Information [website](#). Paper copies of rules are available through the Secretary of State's office. (See Key Contacts.)



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

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the hospital inpatient program:

- Code of Federal Regulations (CFR)
 - 42 CFR 440.10, Inpatient Hospital Services, Other Than Services in an Institution for Mental Disease
- Montana Codes Annotated (MCA)
 - MCA Title 50-5-101–50-5-1205, Hospitals and Related Facilities
- Administrative Rules of Montana (ARM)
 - ARM Title 37.86.2801–37.86.2947, Inpatient Hospital Services

Claims Review (MCA 53-6-111, 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 it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers 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 contacts at the front of this manual has important phone numbers and addresses pertaining to this manual. The *General Information for Providers* manual also has a list of contacts for specific program policy information. (See the Introduction chapter.) Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information [website](#). (See Key Websites.)

Covered Services

General Coverage Principles

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

Hospital Inpatient Services (ARM 37.86.2801–2947)

Inpatient hospital services are provided to Medicaid members who are formally admitted as an inpatient and whose expected hospital stay is greater than 24 hours. Inpatient services must be ordered by a licensed physician or dentist and provided in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases. The institution must be currently licensed by the designated state licensing authority in the state where the institution is located, must meet the requirements for participation in Medicare as a hospital, and must have in effect a utilization review plan that meets the requirements of 42 CFR 482.30.

Services for Children (ARM 37.86.2201–2234)

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 inpatient hospital services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

Importance of Fee Schedules

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 more detailed coding descriptions listed in the current ICD coding book. Take care to use the fee schedule and coding books that pertain to the date of service. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

Physician Attestation and Acknowledgment (ARM 37.86.2904)

At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

Notice to physicians: Medicaid payment to hospitals is based on all of each patient's diagnoses and the procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws.

The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his/her first member to the hospital. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The provider may, at its discretion, add to the language of this statement the word *Medicare* so that two separate forms will not be required by the provider to comply with state and federal requirements.

Utilization Reviews (42 CFR 456)

The Department or its contractor may at any time review paid claims, provider documentation for medical necessity, appropriate billing, etc. Providers must maintain documentation of medical necessity for services such as initial hospitalization, transfers, and readmissions. For more information on provider requirements for maintaining documentation, see the Record Keeping section in the Provider Requirements chapter of the *General Information for Providers* manual. Also see the Claims Review section in the Introduction chapter of this manual.

Obtaining Resident Status (ARM 37.86.2921)

Providers must contact the Department to obtain hospital residence status prior to billing Medicaid. (See Key Contacts.) To qualify for residency status, a member must meet the following requirements:

- Use a ventilator for a continuous period of not less than 8 hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period.
- Must have been an inpatient in an acute care hospital for a minimum of 6 continuous months within the requesting facility.

It is the provider's responsibility to determine whether services could be provided in a skilled nursing care facility or by the home- and community-based waiver program. The provider must maintain written records of inquiries and responses about the present and future availability of openings in nursing facilities and the home- and community-based waiver program. A redetermination of nursing facility or waiver availability must be made at least every 6 months.

Nursing Facility Placement

Hospitalized Medicaid members and Medicaid applicants being considered for nursing facility placement from the hospital shall be referred in a timely manner to the Department's designated review organization. This will allow preadmission screening to be accomplished before placement and payment is made on their behalf.

Coverage of Specific Services (ARM 37.86.2902)

Clinical trials are limited to Medicaid coverage of routine costs plus reasonable and necessary items and services used to diagnose and treat complications arising from participation in all qualifying clinical trials. Qualifying clinical trials include those that are directly funded or supported by centers or cooperating groups funded by the National Institutes of Health (NIH), Centers for Disease Control (CDC), Agency for Healthcare Research and Quality (AHRQ), Department of Defense (DOD), or Veterans Affairs (VA).

Clinical trial drugs, devices, and procedures are not reimbursable.

The following are coverage rules for specific inpatient hospital services. Inpatient hospital services included in the All Patient Refined Diagnosis-Related Group (APR-DRG) payment methodology include all routine services such as the following:

- Bed and board
- Nursing services and other related services
- Use of hospital facilities
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment furnished by the hospital for the care and treatment of inpatients
- Other diagnostic or therapeutic items or services provided in the hospital that are not specifically excluded (ARM 37.85.207). See the Noncovered Services section in this chapter.
- Outpatient services provided by the hospital facility the day of admission or the day before.

Abortions (ARM 37.86.104)

Abortions are covered when one of the following conditions are met:

- The member's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the member's life is not endangered if the fetus is carried to term.

A completed Medicaid Recipient/Physician Abortion Certification (MA-37) form must be submitted with every abortion claim or payment will be denied. (See Appendix A for instructions for completing this form.) **Complete only**

one section (I, II, or III) of this form; the section used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

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

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

Air Transports

Air transport providers must be registered with Medicaid as an ambulance provider. Claims for these services are billed on a CMS-1500 claim form. See the *Ambulance Services* manual available on the Provider Information [website](#). (See Key Websites.)

Chemical Dependency Treatment

Chemical dependency services are limited. Providers must be approved by the Department before providing this service. Contact the Chemical Dependency Bureau for more information. See Key Contacts.

Detoxification

Detoxification services are covered for up to 7 days. More than 7 days may be covered if a hospital setting is required and the service has been authorized. (See the Passport and/or Prior Authorization chapters in this manual). Services may also be covered if the Department or the Department's designated review organization determines that the member has a concomitant condition that must be treated in an inpatient hospital setting, and the detoxification treatment is a necessary adjunct to the treatment of the concomitant condition.

Discharges

A hospital's utilization review (UR) committee must comply with the Code of Federal Regulations 42 CFR 456.131 through 42 CFR 456.137 prior to notifying a Montana Medicaid member that he/she no longer needs medical care. The hospital is not required to obtain approval from Montana Medicaid at the member's discharge; however, a hospital's UR plan must provide written notice to Montana Medicaid if a member decides to stay in the hospital when it is not medically necessary. (See the Hospital Services Beyond Medical Necessity section in the Billing Procedures chapter of this manual.)

Donor Transplants

Medicaid covers successful donor-related testing and services and organ acquisition services, which are bundled into the Medicaid member's transplant hospitalization, and are covered in this APR-DRG payment.

Emergency Department Admissions

Emergency medical services are those services required to evaluate, treat and stabilize an emergency medical condition.

Mental Health Services

Medicaid covers inpatient mental health services for Medicaid-enrolled members when prior authorized. (See the Prior Authorization chapter in this manual.)

Providers should refer to the mental health manual available on the Provider Information [website](#). See Key Websites.

Observation Bed

Members in observation beds (admission of 72 hours or less) are considered outpatients and claims should be filed accordingly. See the *Hospital Outpatient Services* manual available on the Provider Information [website](#).

Out-of-State Inpatient Services (ARM 37.86.2801)

Medicaid covers treatment in an out-of-state facility only when all of the following requirements are met:

- The member cannot be treated in state, and the provider contacts the prior authorization designated review organization to determine if services are available in Montana before considering placement in an out-of-state facility.
- The provider received prior authorization for out-of-state services **before** the member is sent to an out-of-state hospital. See the Prior Authorization chapter in this manual for more information.

It is not the intent of the Montana Medicaid program to interfere or delay a transfer when a physician has determined a situation to be emergent. Prior authorization is not required in emergency situations. Emergency inpatient admissions must be authorized within 2 working days (Monday–Friday) of admission to an out-of-state hospital.

If a hospital that is located over 100 miles outside of the borders of Montana or a Center for Excellence hospital fails to obtain prior authorization before providing services to a Montana Medicaid member, retrospective authorization may be granted under the following circumstances only:

All out-of-state hospital services require prior authorization and may require Passport provider approval before services are provided.

- The person to whom services were provided was determined by the Department to be retrospectively eligible for Montana Medicaid benefits;
- The hospital can document that the admission was an emergency admit for the purpose of stabilization or stabilization for transfer;
- The hospital must call for authorization within two working days (Monday–Friday) of the admission or knowledge of the member’s Medicaid eligibility;
- Interim claims equal to or greater than 30 days of continuous inpatient services at the same facility; or
- The hospital is retroactively enrolled as a Montana Medicaid provider, and the enrollment includes the dates of service for which authorization is requested; provided the hospital’s retroactive enrollment is completed, allowing time for the hospital to obtain prior authorization and to submit a clean claim within timely filing deadlines in accordance with ARM 37.85.406.

Readmissions

All readmissions are subject to review for medical necessity of the initial as well as the subsequent hospitalization stays. Reimbursement cannot be made to a provider unless the service provided was medically necessary. Readmission may be reviewed on a retrospective basis to determine if additional payment for the case is warranted. If complications have arisen because of premature discharge and/or other treatment errors, then the APR-DRG payment for the first admission must be combined with the current admission before billing Medicaid. If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the two admissions must be combined into one admission for payment purposes.

A member readmission occurring in an inpatient rehabilitation hospital three days prior to the date of discharge must be combined into one admission. Inpatient readmits within 24 hours must be combined if the same condition is coded.

Same Day Readmission

If a member is readmitted on the same day of discharge for the same condition, the entire stay must be billed as one admission.

If a member is readmitted on the same day of discharge for a separate condition, Medicaid may be billed for the new condition. The claim for the new condition and a letter of explanation including documentation for the separate condition must be sent directly to the Hospital Program Officer for review. (See Key Contacts.)

A member readmission occurring in an inpatient rehabilitation hospital three days prior to the date of discharge must be combined into one admission. Inpatient readmits within 24 hours must be combined if the same condition is coded.

Initial hospitalizations and readmissions are subject to review for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

Sterilization/Hysterectomy (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Member must complete and sign the Informed Consent to Sterilization (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations. (See Appendix A: Forms for the form and instructions.) If this form is not properly completed, payment will be denied.

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The Informed Consent to Sterilization must be completed and signed by the member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
 - **Emergency Abdominal Surgery.** The Informed Consent to Sterilization form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.
2. Member must be at least 21 years of age when signing the form.
 3. Member must not have been declared mentally incompetent by a federal, state or local court, unless the member has been declared competent to specifically consent to sterilization. (See the Definitions chapter.)
 4. Member must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The member must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.

- The member must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The member must be made aware of available alternatives of birth control and family planning.
- The member must understand the sterilization procedure being considered is irreversible.
- The member must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The member must be informed of the benefits and advantages of the sterilization procedure.
- The member must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those members who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the member is in labor or childbirth.
- If the member is seeking or obtaining an abortion.
- If the member is under the influence of alcohol or other substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed Medicaid Hysterectomy Acknowledgement form (MA-39). See Appendix A: Forms. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. **Circle one alpha character (A, B, C) to indicate which section you are completing. If no alpha character is circled, the form will be rejected.**

When no prior sterility (Section B) or no life-threatening emergency (Section C) exists, the member and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for

Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used. Refer to Appendix A: Forms for instructions on completing the form.

- For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

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.

Transfers

All diagnostic services are included in the APR-DRG payment. Diagnostic services that are performed at a second APR-DRG hospital, because the services are not available at the first hospital (e.g., a CT scan), are included in the first hospital's APR-DRG payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.

All transfers are subject to review for medical necessity. The initial hospitalization, all subsequent hospitalizations, and the medical necessity for the transfer itself may be reviewed. For information on billing and payment for transfers, see this manual's Billing Procedures and How Payment Is Calculated chapters.

Transplants (ARM 37.86.4701–ARM 37.86.4706)

Medicaid covers organ and tissue transplants that are medically necessary and not considered experimental or investigational. Organ transplants must be performed in a Medicare-certified facility. If Medicare has not designated a facility as being certified, the transplant must be performed by a program located in a hospital or parts of a hospital certified by the Organ Procurement and Transplantation Network (OPTN) for the specific organ being transplanted. A list of CMS-certified facilities is located on the CMS website, <http://www.cms.hhs.gov>, then search for “transplant program certification listing.”

Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities may include:

- Evaluation of the member as a potential transplant candidate
- Pre-transplant preparation including histocompatibility testing procedures
- Post-surgical hospitalization
- Outpatient care, including federal drug administration (FDA) approved medications deemed necessary for maintenance or because of resulting complications
- Associated medical expenses for the successful donor only. (These will be bundled into the Medicaid member's inpatient transplant hospitalization.)

These activities are covered by Medicaid as long as the member remains Medicaid-eligible and transplantation is prior approved. Services must comply with Medicare coverage guidelines for organ and tissue transplant services. If Medicare coverage guidelines are not available, the Department or the Department's designated review organization will review the requested transplant surgery to determine whether the surgery is experimental or investigational.

Noncovered Services (ARM 37.85.207 and 37.86.2902)

The following medical and nonmedical services, except as otherwise specified in program-specific rules as a waiver service or an EPSDT service, are explicitly excluded from the Montana Medicaid program, except for those services specifically available, as listed in ARM 37.40.1406, 37.90.402, and Title 37, Chapter 34, Subchapter 9, to persons eligible for home- and community-based services; and except for those Medicare-covered services, as listed in ARM 37.83.812 to qualified Medicare beneficiaries for whom the Montana Medicaid program pays the Medicare premiums, deductible, and coinsurance.

- Chiropractic services
- Acupuncture
- Naturopathic services
- Dietician services (some services covered per ARM 37.86.3002)
- Physical therapy aide services
- Surgical technician services (technicians who are not physicians or mid-level practitioners)
- Nutritional services
- Masseur/Masseuse services
- Dietary supplements
- Homemaker services
- Home telephone service, remodeling of home, plumbing service, car repair, and/or modification of automobile

- Delivery services not provided in a licensed health care facility or nationally accredited birthing center unless as an emergency service
- Treatment services for infertility, including sterilization reversals
- Experimental services
- Bariatric services and surgery-related services (including bypass and revisions)
- Circumcisions not authorized by the Department as medically necessary
- Erectile dysfunction products, including but not limited to injections, devices, and oral medications used to treat impotence
- Sexual aids, including but not limited to devices, injections and oral medications
- Medical services furnished to Medicaid-eligible members who are absent from the state including a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments are covered as in each program-specific rule and subject to the applicable conditions of those rules.
- Experimental services, services that do not comply with national standards of medical practice, non-FDA approved drugs, biologicals, and devices and clinical trials are excluded from coverage.
- Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana Medicaid program.

Other Programs

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

Mental Health Services Plan (MHSP)

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the [Provider Information website](#). See Key Websites.

Healthy Montana Kids (HMK)

The information in this chapter does not apply to Healthy Montana Kids (HMK) members. Hospital inpatient services for children with HMK coverage are covered by Blue Cross and Blue Shield of Montana (BCBSMT). For more information, contact BCBSMT at 1-800-447-7828 (toll-free) or 447-7828 (Helena). 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, 37.86.5303, 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 HMK *Plus* members and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services:

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

Medicaid and HMK *Plus* 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, midlevel practitioner, or primary care clinic.

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

The Passport provider provides primary care case management (PCCM) services to their 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-patient relationship. An effective medical home is accessible, continuous, comprehensive, and 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. (See the section titled Services That Do Not Require Passport Provider Approval in this chapter.) The member's Passport provider is also referred to as the primary care provider (PCP).

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

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. 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 and confidential nurse triage line staffed by licensed registered nurses 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 Montana Health Improvement Program (HIP) is for Medicaid/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 under the Health Improvement Program link on the [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 and additional Passport information is found in the *General Information for Providers* manual.

Prior Authorization

What is Prior Authorization (ARM 37.85.205, 37.86.2801, and 37.86.5101–5306)

Prior authorization (PA) is the approval process required before certain services are paid by Medicaid. If a service requires PA, the requirement exists for all Medicaid members. When PA is granted, the provider is issued a PA number, which must be on the claim.

PA is not a guarantee of payment. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- When requesting PA for members with partial eligibility, request PA from the first date the member was Medicaid eligible, not the first date of the member's hospital stay.
- The table (PA Criteria for Specific Services lists services that require PA, who to contact, and specific documentation requirements. There may be other services that require PA.
- Have all required documentation included in the packet before submitting a request for PA. See the PA Criteria for Specific Services table for documentation requirements.
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim (FL 63 on the UB-04 paper claim form).

PA must be obtained before any member receives services, even when the member has Medicare or any other third party liability and the service has a PA requirement. PA is required for:

- All psych inpatient services except if patient has Medicare.
- All out-of-state inpatient services except if the patient has Medicare and the only reason for prior authorization is for out-of-state services.
- Services that require prior authorization.
- Interim claims for PPS.

It is not the intent of the Montana Medicaid program to interfere or delay a transfer when a physician has determined a situation to be emergent. PA is not required in emergency situations. Emergency inpatient admissions must be authorized within two working days (Monday–Friday) of admission to an out-of-state hospital.

Distinct authorization numbers are issued for Passport approval and prior authorization, and both must be recorded on the claim in the appropriate location.

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

Prior authorization is not required in emergency room situations.

Retrospective authorization may be granted only under the following circumstances:

- The Montana Medicaid member qualifies for retroactive eligibility for Montana Medicaid hospital benefits.
- The hospital is retroactively enrolled as a Montana Medicaid provider during the dates of service for which authorization is requested.
- The hospital can document that at the time of admission it did not know, or have any basis to assume that the member was a Montana Medicaid member.

For more information, see the Prior Authorization chapter in the *General Information for Providers* manual available on the Provider Information [website](#).

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 the previous chapter do not apply.

However, prior authorization may be required for certain services. Refer to the mental health manual or contact Blue Cross and Blue Shield of Montana at 800-447-7828 (toll-free) or 406-447-7828 (Helena). Additional HMK information is available on the [HMK website](#). (See Key Websites.)

PA Criteria for Specific Services		
Service	PA Contact	Document Requirements
<p>All transplant services</p> <p>Chemical dependency treatment over the 7-day limit</p> <p>Interim claims greater than or equal to 30 days</p> <p>New technology codes (Category III CPT codes)</p> <p>Other reviews referred by Medicaid program staff</p> <p>Out-of-state and Center of Excellence hospital inpatient services</p> <p>Therapy services over limit for children</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.4020 X5850 Helena 800.262.1545 X5850 In/Out of state</p> <p>Fax 406.443.4585 Helena 800.497.8235 In/Out of state</p>	<ul style="list-style-type: none"> Required information includes: <ul style="list-style-type: none"> Member's name Member's Medicaid ID number State and hospital where member is going Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health will instruct providers on required documentation on a case-by-case basis.
<p>Inpatient hospital services for psychiatric diagnosis</p>	<p>Magellan Medicaid Administration <i>(previously dba First Health Services)</i> 4300 Cox Road Glen Allen, VA 23060</p> <p>Phone 1.800.770.3084</p> <p>Fax 1.800.639.8982 1.800.247.3844</p>	<ul style="list-style-type: none"> Member's diagnosis Summary of reason the member was admitted
<p>Partial hospitalization</p>	<p>Magellan Medicaid Administration <i>(previously dba First Health Services)</i> 4300 Cox Road Glen Allen, VA 23060</p> <p>Phone 1.800.770.3084</p> <p>Fax 1.800.639.8982 1.800.247.3844</p>	<ul style="list-style-type: none"> A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission. The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the member's psychiatric condition.

PA Criteria for Specific Services (Continued)		
Service	PA Contact	Document Requirements
<p>Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)</p> <p>For emergency ambulance transport services, providers have 60 days following the service to obtain authorization. See the <i>Ambulance</i> manual.</p>	<p>Mountain-Pacific Quality Health Medicaid Transportation P.O. Box 6488 Helena, MT 59604</p> <p>Phone 1.800.292.7114</p> <p>Fax 1.800.291.7791</p> <p>E-Mail ambulance@mpqhf.org</p>	<ul style="list-style-type: none"> • Ambulance providers may call, leave a message, fax, or e-mail requests. • Required information includes: <ul style="list-style-type: none"> • Name of transportation provider • Provider's Medicaid ID Number • Member's name • Member's Medicaid ID number • Point of origin to the point of destination • Date and time of transport • Reason for transport • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen) • Providers must submit the trip report and copy of the charges for review after transport. • For commercial or private vehicle transportation, members call and leave a message, or fax travel requests prior to traveling.
<p>Eye prosthesis</p>	<p>Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604</p> <p>Phone 1.800.292.7114</p> <p>Fax 1.800.291.7791</p>	<ul style="list-style-type: none"> • Documentation that supports medical necessity • Documentation regarding the member's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.
<p>Circumcision</p>	<p>Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604</p> <p>Phone 1.800.292.7114</p> <p>Fax 1.800.291.7791</p>	<p>Description</p> <p>Circumcision is the surgical removal of the sleeve of the skin and mucosal tissue that normally covers the glans (head) of the penis. The request for a circumcision will be reviewed on a case-by-case basis, based on medical necessity. Routine circumcisions are not covered.</p> <p>Indications for Circumcision</p> <ul style="list-style-type: none"> • The one absolute indication for circumcision is scarring of the opening of the foreskin making it non-retractable (pathological phimosis). The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids, before circumcision is indicated). • Urinary obstruction • Urinary tract infection • Balanitis

PA Criteria for Specific Services (Continued)		
--	--	--

Service	PA Contact	Document Requirements
Maxillofacial/cranial surgery	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • Surgical services are only covered when done to restore physical function or to correct physical problems resulting from injuries or congenital defects. • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Medicaid does not cover these services for the following: <ul style="list-style-type: none"> • Improvement of appearance or self-esteem (cosmetic) • Dental implants • Orthodontics
Blepharoplasty	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • Reconstructive blepharoplasty may be covered for the following: <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). • Documentation must include the following: <ul style="list-style-type: none"> • Surgeon must document indications of surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Pre-operative photographs • Medicaid does not cover cosmetic blepharoplasty

PA Criteria for Specific Services (Continued)		
Service	PA Contact	Document Requirements
Botox Myobloc	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • For more details on botox criteria, coverage, and limitations, visit the Provider Information website. (See Key Contacts.) • Botox is covered for treating the following: <ul style="list-style-type: none"> • Laryngeal spasm • Blepharospasm • Hemifacial spasm of the nerve • Torticollis, unspecified • Torsion dystonia • Fragments of dystonia • Hereditary spastic paraplegia • Multiple sclerosis • Spastic hemiplegia • Infantile cerebral palsy • Other specified infantile cerebral palsy • Achalasia and cardiospasm • Spasm of muscle • Hyperhidrosis • Strabismus and other disorders of binocular eye movements • Other demyelinating disease of the central nervous system • Documentation requirements include a letter from the attending physician supporting medical necessity including: <ul style="list-style-type: none"> • Member's condition (diagnosis) • A statement that traditional methods of treatments have been tried and proven unsuccessful • Proposed treatment (dosage and frequency of injections) • Support the clinical evidence of the injections • Specify the sites injected • Myobloc is reviewed on a case-by-case basis
Excising excessive skin and subcutaneous tissue	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • Required documentation includes the following: <ul style="list-style-type: none"> • The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures • Pre-operative photographs • This procedure is contraindicated for, but not limited to, individuals with the following conditions: <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy • Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a member's appearance.

PA Criteria for Specific Services (Continued)
--

Service	PA Contact	Document Requirements
Rhinoplasty septorhinoplasty	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • The following do not require PA: <ul style="list-style-type: none"> • Septoplasty to repair deviated septum and reduce nasal obstruction • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction • Medicaid covers rhinoplasty in the following circumstances: <ul style="list-style-type: none"> • To repair nasal deformity caused by a cleft lip/cleft palate deformity for members 18 years of age and younger • Following a trauma (e.g., a crushing injury) which displaced nasal structures and causes nasal airway obstruction. • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Not covered <ul style="list-style-type: none"> • Cosmetic rhinoplasty done alone or in combination with a septoplasty • Septoplasty to treat snoring
Dermabrasion/ Abrasion chemical peel	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • Services covered for the following: <ul style="list-style-type: none"> • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined. • The removal of pre-cancerous skin growths (keratoses) • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary • Pre-operative photographs

PA Criteria for Specific Services (Continued)		
Service	PA Contact	Document Requirements
Temporomandibular joint (TMJ) arthroscopy/surgery	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	<ul style="list-style-type: none"> • Non-surgical treatment for TMJ disorders must be utilized first to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case: <ul style="list-style-type: none"> • Fabrication and insertion of an intra-oral orthotic • Physical therapy treatments • Adjunctive medication • Stress management • Surgical treatment may be considered when both of the following apply: <ul style="list-style-type: none"> • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery. • There are specific, severe structural problems in the jaw joint. These include problems caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review. • Not covered: <ul style="list-style-type: none"> • Botox injections for the treatment of TMJ are considered experimental. • Orthodontics to alter the bite • Crown and bridge work to balance the bite • Bite (occlusal) adjustments

PA Criteria for Specific Services (Continued)		
--	--	--

Service	PA Contact	Document Requirements
Reduction mammoplasty	Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604 Phone 1.800.292.7114 Fax 1.800.291.7791	Both referring physician and surgeon must submit documentation. Back pain must have been documented and present for at least 6 months, and causes other than breast weight must have been excluded. Indications for female member <ul style="list-style-type: none"> • Contraindicated for pregnant women and lactating mothers. A member must wait 6 months after the cessation of breast feeding before requesting this procedure. • Female member 16 years or older with a body weight less than 1.2 times the ideal weight. • There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a 6-month period. This must include at least two of the following: <ul style="list-style-type: none"> • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted. • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy. • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.

PA Criteria for Specific Services (Continued)												
Service	PA Contact	Document Requirements										
<p>Reduction mammoplasty, cont'd</p>	<p>Mountain-Pacific Quality Health P.O. Box 6488 Helena, MT 59604</p> <p>Phone 1.800.292.7114</p> <p>Fax 1.800.291.7791</p>	<p>Documentation in the member's record must indicate and support:</p> <ul style="list-style-type: none"> • History of the member's symptoms related to large, pendulous breasts. • The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain). • Guidelines for the anticipated weight of breast tissue removed from each breast related to the member's height (which must be documented): <table border="0"> <tr> <td>Height</td> <td>Weight of tissue per breast</td> </tr> <tr> <td>Less than 5 feet</td> <td>250 grams</td> </tr> <tr> <td>5 feet to 5 feet, 2 inches</td> <td>350 grams</td> </tr> <tr> <td>5 feet, 2 inches to 5 feet, 4 inches</td> <td>450 grams</td> </tr> <tr> <td>Greater than 5 feet, 4 inches</td> <td>500 grams</td> </tr> </table> <ul style="list-style-type: none"> • Preoperative photographs of the pectoral girdle showing changes related to maromastia. • Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery. <p>Indications for male member</p> <ul style="list-style-type: none"> • If the condition persists, a member may be considered a good candidate for surgery. Members who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first. • Documentation required: length of time gynecomastia has been present, height, weight, and age of the member, preoperative photographs 	Height	Weight of tissue per breast	Less than 5 feet	250 grams	5 feet to 5 feet, 2 inches	350 grams	5 feet, 2 inches to 5 feet, 4 inches	450 grams	Greater than 5 feet, 4 inches	500 grams
Height	Weight of tissue per breast											
Less than 5 feet	250 grams											
5 feet to 5 feet, 2 inches	350 grams											
5 feet, 2 inches to 5 feet, 4 inches	450 grams											
Greater than 5 feet, 4 inches	500 grams											

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 the Exceptions to Billing Third Party First section 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 the Member Eligibility and Responsibilities chapter 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 third party liability (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, but Medicare is not.

Medicare Part A Claims

Medicare Part A covers inpatient hospital care, skilled nursing care, and other services. To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid on paper.

When Medicare Pays or Denies a Service

When inpatient hospital claims for members with Medicare and Medicaid:

- Are paid, submit the claim to Medicaid on a UB-04 form with the Medicare coinsurance and deductible information in value code form locators (FLs 39–41) and Medicare paid amounts in prior payments FL 54. See the Billing Procedures and Submitting a Claim chapters in this manual.
- Are allowed, and the allowed amount went toward member's deductible, include the deductible information in value code FLs 39–41 and submit the claim to Medicaid on paper.
- Are denied, 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.

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

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 Medicaid member ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

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 third party liability (or 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

Medicare Part A crossover claims automatically cross over from Medicare.

When billing Medicaid for a member with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

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.*

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 Service (IHS) or the Montana Crime Victim Compensation Fund, providers must bill Medicaid before IHS or Crime Victims. These are not considered third party liability.
- When a member has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- 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 form. 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 must be sent directly to the Third Party Liability Unit. (See Key Contacts.)

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim 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 provider has billed the third party insurance and has received a nonspecific 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 directly to Medicaid in order to avoid missing the timely filing deadline.
- When the Child Support Enforcement Division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
 2. 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.

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 in the prior payments form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward the member's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. These claims may be submitted on paper or electronically with the paper attachment mailed separately. The Paper Attachment Cover Sheet is available on the Provider Information [website](#). (See Key Websites.)
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

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:

- Attach a note to the paper claim 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.
- Send this information to the Third Party Liability Unit. (See Key Contacts.)

Other Programs

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manuals available on the Provider Information website. (See Key Websites.)

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 800-447-7828 (toll-free) or 406-447-7828 (Helena).

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.

For details on how Medicaid calculates payment for TPL claims, see the How Payment Is Calculated chapter in this manual.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-04 claim form. UB-04 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 Medicaid 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 as follows:

- **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 recipient 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 the 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

- Bill initial claim promptly after date of service.
- 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 remittance advice within 45 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.

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 exceptions are that providers may collect cost sharing from members and may bill members for hospital services provided beyond the period of medical necessity.

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.
- When services are free to the member and free to non-Medicaid covered individuals, such as in a public health clinic. Medicaid may not be billed for those services.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid member. (See below.)

When to Bill a Medicaid Member (ARM 37.85.406)			
	Patient Is Medicaid-Enrolled; Provider Accepts Patient as a Medicaid Member	Patient Is Medicaid-Enrolled; Provider Does Not Accept Patient as a Medicaid Member	Patient Is Not Medicaid-Enrolled
Service is covered by Medicaid	Provider can bill the member only for cost sharing	Provider can bill the Medicaid member if the member has signed a routine agreement.	Provider can bill member.
Service is not covered by Medicaid	Provider can bill the member only if custom agreement has been made between member and provider before providing the service	Provider can bill the Medicaid member if the member has signed a routine agreement.	Provider can bill the member.

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

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



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

Hospital Services Beyond Medical Necessity

The Montana Medicaid member who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as a Montana Medicaid noncovered service. The member must have been informed in writing and agreed in writing prior to provision of services to accept financial responsibility. The agreement must state the specific services the Medicaid member has agreed to pay for. In this case, a routine agreement will not suffice. Medicaid may not be billed for hospital services that are not medically necessary.

A hospital's utilization review plan must provide written notice to Montana Medicaid if a Montana Medicaid member decides to stay in the hospital when it is not medically necessary. This written notice must be sent to the hospital program officer. (See Key Contacts.)

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing for hospital inpatient services is \$100 per discharge. 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.

The following members are exempt from cost sharing:

- Members under 21 years of age (i.e., EPSDT services)
- 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 if 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 payments from non-Medicaid members, that same policy may be used for Medicaid members.



Providers must notify the Department when a member chooses to stay in the hospital when it is not medically necessary.



Member cost sharing for hospital inpatient services is \$100 per discharge.



Do not show cost sharing as a credit on the claim; it is automatically deducted.

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

- Use the current ICD manual and the UB-04 Editor.
- 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.



Always refer to the long descriptions in coding books.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure code definitions • Updated each October 	Available through various publishers and bookstores.
Miscellaneous Resources	Various newsletters and coding resources	Optum 1.800.464.3469 https://www.optumcoding.com/
UB-04 National Uniform Billing Data Element Specifications	National UB-04 billing instructions	National Uniform Billing Committee www.nubc.org
UB-04 Editor	National UB-04 billing instructions	Available through various publishers and editors.

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the hospital provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.

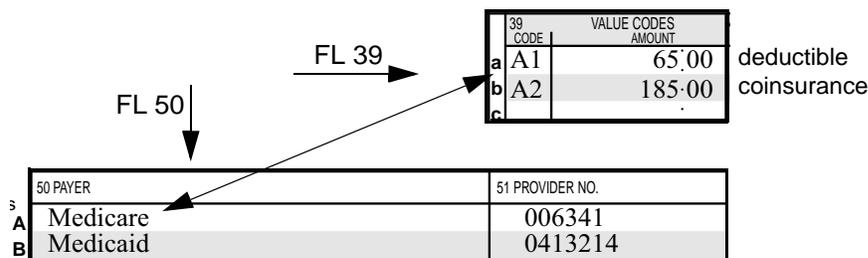
When the provider accepts the member’s retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the member’s local office of public assistance. (See Appendix C: Local Offices of Public Assistance in *General Information for Providers.*)

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.

Billing for Members with 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, the Passport, and/or Prior Authorization chapters in this manual.

When completing a paper claim for members with Medicare and Medicaid, Medicare coinsurance and deductible amounts listed in FL 39 must correspond with the payer listed in FL 50. For example, if the member has Medicare and Medicaid, any Medicare deductible and coinsurance amounts should be listed in FL 39 preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare should be listed in FL 50A. (See the Submitting a Claim chapter in this manual.)



Medicare Benefits Exhausted

Medicare crossovers are claims for hospital patients who are eligible for Medicare Part A benefits as well as Montana Medicaid. For these patients, Montana Medicaid pays the deductibles and coinsurance related to the inpatient hospital services. (See the Coordination of Benefits chapter in this manual.) Should a Medicare/Medicaid member exhaust the Medicare benefit (including Lifetime Reserve Days), the claim will be treated as a Medicaid-only claim from the date the Medicare benefits were exhausted. The claim should be submitted reflecting a covered stay from the day the Medicare benefits were exhausted to discharge. This situation is the only instance in which a hospital should submit a split bill for a case that will be paid using prospective payment principles.

memberServices Provided to Passport to Health Members

A Medicaid member covered by the Passport to Health program must have inpatient hospital services approved by the member's primary care provider (PCP). The Passport provider number must be on the claim (FL 7 on a paper claim) or the service will be denied.

Services That Require Prior Authorization (PA)

Prior authorization (PA) is required for some hospital services. Passport and prior authorization are different, and some services may require both. See the Passport and/or Prior Authorization chapters in this manual. Different codes are issued for each type of approval and must be included on the claim form, or the claim will be denied. See the Submitting a Claim chapter in this manual. The PA number is located in FL 63 on the paper claim.

Discharges and Transfers

Claims can be filed only after the member has been discharged. A member is considered discharged when he or she is:

- Formally released from the hospital
- Transferred to another hospital or rehabilitation unit
- Dies in the hospital
- Leaves the hospital against medical advice (AMA)
- Discharge to hospice
- Transferred to a LTCF, SNF, ICF, or swing bed

The hospital that ultimately discharges the member bills Medicaid. When a member is transferred from one hospital to another for services the first hospital does not provide (e.g., CT scan) and then back to the first hospital, all diagnostic services are included in the APR-DRG payment to the first hospital. Also included in



When a service requires Passport approval or prior authorization (or both), distinct authorization numbers are issued for each and must be recorded on the claim in the appropriate location, or it will be denied.

the same payment are the services that were provided at the second hospital and transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital must be arranged between the first and second hospital and the transportation provider.

All transfers are subject to review for medical necessity. Initial hospitalizations, subsequent hospitalizations, and transfers may be reviewed for medical necessity. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

The patient status code (FL 17 of the UB-04 paper claim form) should contain the appropriate discharge status code. The following discharge status codes are valid for Montana Medicaid.

Discharge Status Codes			
Status Code	Description	Status Code	Description
01	Discharged to home or self care (routine discharge)*	43	Discharged/Transferred to federal hospital
02	Discharged/Transferred to a short-term general hospital for inpatient care*	50	Hospice – home
03	Discharged/Transferred to skilled nursing facility (SNF)*	51	Discharged/Transferred to hospice medical facility
04	Discharged/Transferred to an intermediate care facility (ICF)*	61	Discharged/Transferred within this institution to hospital-based Medicare approved swing bed*
05	Discharged/Transferred to another type of institution for inpatient care*	62	Discharged/Transferred to an inpatient rehabilitation facility including distinct part units of a hospital
06	Discharged/Transferred to home under care of organized home health service organization*	63	Discharged/Transferred to a long-term care hospital
07	Left against medical advice or discontinued care	64	Discharged/Transferred to nursing facility certified under Medicaid, but not Medicare
09	Admitted as an inpatient to this hospital*	65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
20	Expired (death)	66	Discharged/Transferred to a critical access hospital (CAH)
21	Discharged/Transferred to court/law enforcement	70	Discharged/Transferred health institution undefined
30	Still a patient* (Neonate providers discharge status code for interim billing)		

*If patient is discharged to PRTF, use Status Code 01.

*Please review Usage Notes in the UB-04 Billing Manual.



When a member is moved from an acute care bed to a distinct part rehabilitation unit bed, it is considered a transfer.

Bundled Services

Services that are included in the APR-DRG payment are considered bundled and include the following:

- Services provided on the day of admission or on the day preceding admission.
- All routine services. (See Coverage of Specific Services in the Covered Services chapter of this manual.)
- All diagnostic services (e.g., radiology). This includes diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., CT scan) as well as transportation between the two hospitals. See the Transfers section in this chapter.
- Donor/Harvesting.
- All ancillary services provided by the hospital or performed by another entity under contract with the hospital (e.g., hospital has a contractual agreement with an enrolled independent laboratory).

Split/Interim Billing

Some inpatient hospital services necessitate the use of split or interim bills for Medicaid reimbursement. In general, providers cannot split bill APR-DRG claims, except in a few cases:

- When Medicare lifetime reserve days have been exhausted, inpatient claims must be submitted to the Department for review. (See Key Contacts.) Documentation of exhaustion must be attached to the claim.
- ***For members classified as hospital residents.*** Claims for members approved and classified as *hospital residents* may be interim billed on a monthly basis after the first 180 days. These claims must be sent to the Department with a letter of explanation for manual pricing. (See Key Contacts.) The Department may approve the special billing and forward the claim to the claims processing contractor for processing with pricing instructions. Before billing for residents, the provider must obtain resident status for the member. (See the Obtaining Resident Status section in the Covered Services chapter of this manual.)
- Hospitals subject to the inpatient hospital prospective payment reimbursement method may only interim bill when the member has been a patient in the same facility at least 30 days, is Medicaid-eligible for a minimum of these 30 days, and has received prior authorization, in which case the hospital may bill every 30 days. Interim claims are paid by a per diem amount multiplied by the number of covered Medicaid eligible days. Upon patient discharge, the interim claims will be voided or credited by the hospital and the hospital must bill a single admit through a discharge claim which will be paid by APR-DRG.
- The Department will not accept late charges (Type of bill = 115). Instead, hospitals are instructed to adjust earlier claims if appropriate.

memberPartial Eligibility

- APR-DRG hospitals do not split bill. Bill the entire claim from the date of admit, and the claim will be prorated during processing.

Incurment

All APR-DRG hospitals must bill from the date of admission. For more information on incurment, see the Member Eligibility and Responsibilities chapter in the General Information for Providers manual.



Do not split bill Medicaid for APR-DRG claims; providers must report the entire hospital stay, not just the Medicaid-eligible days.

When to Split Bill Medicaid					
Facility or Admission Type	Fiscal Year End	When Claim Charges meet \$100,000	Hospital Residents	Paper Claims Over 40 Lines	Medicaid/Medicare Crossover Claims
<ul style="list-style-type: none"> • MT inpatient APR-DRG hospitals • Border hospitals (within 100 miles of MT border) • Inpatient rehab units 	No	No	Yes	No	Yes. Split bill only when Medicare lifetime reserve days have been exhausted.
Out-of-state hospitals	No	No	Yes	No	No
Designated neonatal units	No	No	N/A	No	No
Psychiatric admissions	No	No	Yes	No	No
Critical access hospitals	Yes	No	N/A	No	No

Billing for Abortions and Sterilizations

In order to be covered by Medicaid, abortions and sterilizations require specific forms to be completed and submitted with the claim. For more information on abortion and sterilization requirements, see the Covered Services chapter in this manual. Forms are available on the Provider Information [website](#).

Abortions

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

Sterilization

- For elective sterilizations, a completed Informed Consent to Sterilization (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
 - A completed Medicaid Hysterectomy Acknowledgement form (MA-39) for each provider submitting a claim. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. **Complete only one section (A, B, or C) of this form. Indicate which section you are completing by circling the alpha character (A, B, or C), otherwise, the form will be rejected.** When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.) Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used. Refer to Appendix A for detailed instructions on completing the form.
 - For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

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. For more information on sterilizations, see the Covered Services chapter in this manual.

Submitting a Claim

See the Submitting a Claim chapter in this manual for instructions on completing claim 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. An explanation of benefits/reason and remark code cross-walk is available on the Provider Information [website](#).

Common Billing Errors	
Reason for Return or Denial	How to Prevent Returned or Denied Claims
National Provider ID (NPI) missing or invalid	The NPI is a 10-digit number. Verify the correct NPI is on the claim.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-04 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 form locator. Information must not be obscured by lines.
Member number not on file, or member was not eligible on date of service	Before providing services to the member, 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. Medicaid eligibility may change monthly.
Procedure requires Passport provider approval – No Passport approval number on claim	A Passport provider approval number must be on the claim form when such approval is required. Passport approval is different from prior authorization. See the Passport and/or Prior Authorization chapters in this manual.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from Passport authorization. (See the Passport and/or Prior Authorization chapters in this manual.)
Present on admission (POA) indicator missing	Each claim must be completed with POA indicators for each diagnosis on an inpatient claim.
Prior authorization does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	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 Remittance Advices and Adjustments in this manual.)
TPL on file and no credit amount on claim	If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. See the Coordination of Benefits chapter in this manual. If the member's TPL coverage has changed, providers must notify the TPL Unit before submitting a claim. (See Key Contacts.)

Common Billing Errors (Continued)

Reason for Return or Denial	How to Prevent Returned or Denied Claims
Claim past 12-month 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 at the address in Key Contacts.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • 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. • After updating license, the claims that have been denied must be resubmitted by the provider.
Procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service. • Verify the procedure code is correct using the ICD manual.
Incorrect bill type	<ul style="list-style-type: none"> • The correct bill type for your provider type must be entered in FL 4.
Admission date missing	<ul style="list-style-type: none"> • The member’s admission date must be included in FL 12 or the claim will be denied. See the Submitting a Claim chapter in this manual.
Informed Consent to Sterilization or Hysterectomy Acknowledgement form missing or incomplete	All claims for sterilizations and hysterectomies must be accompanied by a completed Informed Consent to Sterilization form (MA-38) or a Medicaid Hysterectomy Acknowledgement form (MA-39). See the Billing Procedures chapter and Appendix A for instructions on completing these forms.

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. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** Xerox makes this free software available. Providers can use it 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. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded from EDI Gateway website. For more information on WINASAP 5010, visit the EDI Gateway website or call the EDI Help Desk. (See Key Contacts.)
- **Xerox Clearinghouse.** Providers can send claims to the Xerox clearinghouse, ACS EDI Gateway, in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through ACS EDI Gateway. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Gateway. For more information on using EDI Gateway, contact the EDI Help Desk. (See Key Contacts.)
- **Clearinghouse.** Providers can contract with a clearinghouse so that the/she can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to ACS EDI Gateway in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to ACS EDI Gateway. EDIFECS certification is completed through ACS EDI Gateway. For more information on electronic claims submission, contact the EDI Technical Help Desk. (See Key Contacts.)
- **Montana Access to Health (MATH) Web Portal.** Providers can download electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **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.
- **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 large volume of physical files (in excess of 20 per day) or whose physical files sizes regularly exceed 2 MB.

Present on Admission

The present on admission (POA) indicator is required for all inpatient claims. The claim will deny if there is no valid POA indicator for each diagnosis. Valid values for POA are:

- Y = Present at the time of inpatient admission
- N = Not present at the time of inpatient admission
- U = Documentation is insufficient to determine whether condition is present on admission.
- W = Provider is unable to clinically determine whether condition was present on admission.

Claim Inquiries

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

Provider Relations will respond to the inquiry within 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The table below lists important fields on the UB-04 claim form for providers who are billing with their NPI. **Fields that are not listed are not needed to process a claim for Montana Medicaid.**

Member Has Medicaid Only		
UB-04		
Field	Field Title	Instructions
1*	Provider Physical Address	Enter provider's physical address with a 9-digit ZIP code.
3a**	Control Number	Member's control number used by provider.
4*	Bill Type	Enter billing code.
6*	Statement Covers Period	The beginning and ending service dates of the period included on this bill.
7*	Unlabeled field	Passport (beginning with 99) OR override indicator (beginning with alpha character); a qualifier is not necessary.
8b*	Patient's Name	Enter member's name as seen on member's Medicaid information.
12-15**	Admission	For inpatient used, enter the admission date, hour, type and source.
17*	Patient Status	A code indicating member discharge status as of the ending service date of the period covered on this bill.
18-28**	Condition Codes	Condition codes that are applicable A4 and B3.
42*	Revenue Codes	A code that identifies a specific accommodation, ancillary service or billing calculation.
43**	NDC Coding Revenue Description	Enter NDC if drugs were administered. Enter numeric NDC without punctuation, dashes, or spaces.
44*	HCPCS/RATE/HIPPS Code	Outpatient: Coding for HCPCS/NDC Inpatient: Not required.
45**	Service Dates	Outpatient: Enter dates of service for each line item with revenue code. Inpatient: Not required.
46*	Service Units	A quantitative measure of services rendered by revenue category to or for the member to include items such as number of accommodation day, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed.
47*	Charges	Enter charges (covered and noncovered) for each line containing a revenue code.
Line 23*	Creation Date	Enter the date the claim was created (bill date).
50*	Payer Name	Not required if only Medicaid is billed.
54*	Prior Payments	If applicable.
56*	NPI	Enter billing provider's NPI.
58*	Insured's Name	Enter name of the individuals in whose name the insurance is carried.
59*	P. Rel.	Patient's relationship to insured.
60*	Insured's ID	ID of the individual in whose name the insurance is carried.
Note: All information related to Medicaid needs to be on the corresponding line (A, B, C) in Fields 50, 54, 56, 57, 58, and 60.		
63**	Treatment Authorization	Enter a PA number if applicable to the service.
66*first box	Primary Diagnosis	Enter primary diagnosis code.
67*A-Q*		Not numbered.
69**	Admitting Diagnosis	Inpatient: Enter diagnosis identified at the time of hospitalization.
72**	ECI	External cause of injury
73**	Unlabeled	Not used.
74a-e**	Procedure Code	Inpatient procedure codes. System does not currently accept ICD-10-CM codes.
76*	Attending Provider	1st box: Attending provider NPI; 2nd box: ZZ = ID qualifier for taxonomy code
77-79**	Operating and Other Providers	1st box: Operating/Other provider NPI; 2nd box: ZZ = ID qualifier for taxonomy code; Last name, first name for both operating/other provider NPI and taxonomy code ZZ = ID identifier
80	Remarks	Additional information to adjudicate the claim or fulfill state reporting requirements.
81cc*	Taxonomy	1st box: B3 = Qualifier; 2nd box: Enter billing provider's taxonomy code
*Required fields. **Conditional fields (required if applicable)		

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		c	d
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR	17 STAT	18	19
20	21	22	23
24	25	26	27
28	29 ACDT STATE	30	
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE
35 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH	
a			
b			
38	39 CODE	40 VALUE CODES AMOUNT	41 CODE
	a		42 VALUE CODES AMOUNT
	b		
	c		
	d		
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23	PAGE ____ OF ____	CREATION DATE	TOTALS →
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASGI BEN.
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
A			
B			
C			
58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.			
A			
B			
C			
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			
B			
C			
66 DX	67	A	B
	C	D	E
	F	G	H
	I	J	K
	L	M	N
	O	P	Q
	R	S	T
	U	V	W
	X	Y	Z
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
73	a	b	c
74 PRINCIPAL PROCEDURE CODE	75 a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE	c. OTHER PROCEDURE CODE
76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI
QUAL	QUAL	QUAL	QUAL
LAST	LAST	LAST	LAST
FIRST	FIRST	FIRST	FIRST
80 REMARKS	81CC a	b	c
	d		

SAMPLE UB-04

UB-04 Agreement

This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

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 form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Member ID number missing or invalid	This is a required form locator (FL 60); verify that the member's Medicaid ID number is listed as it appears on the member's eligibility verification. (See the <i>General Information for Providers, Member Eligibility and Responsibilities</i> chapter.)
Member name missing	This is a required form locator (FL 8b); check that it is correct.
Medicaid NPI missing or invalid	The provider number is national provider identifier. Verify the correct NPI is on the claim (FL 56).
Passport ID number missing	When services are not provided by the member's Passport provider, include the provider's Passport number (FL 7). See the Passport chapter in this manual.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in FL 63. See the Prior Authorization chapter in this manual.
Not enough information regarding other coverage	Form locators 39–41, 50, and in some cases 54, are required when a member has other coverage.
Incorrect claim form used	Services covered in this manual require a UB-04 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 form locator. Information must not be obscured by lines.

Other Programs

This chapter also applies to claim forms completed for MHSP services.

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 800-447-7828 (toll-free) or 406-447-7828 (Helena).

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered and are sent out weekly. The RA provides 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 has been paid, denied, or suspended (also called pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

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 affect providers and claims.

Paid Claims

This section shows claims paid 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 and the provider having 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 Codes column (Field 18). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See the table titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter. Make necessary changes to the claim before rebilling Medicaid.

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 (Field 18). 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.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
 HELENA, MT 59604
 REMITTANCE ADVICE FOR MEDICAID/HMK/MHSP

1
 COMMUNITY HOSPITAL
 2100 NORTH MAIN STREET
 CENTRAL CITY MT 59988

2
 3
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19

VENDOR # 00012134567 REMIT ADVICE # 123456 EFT/CHK # 654321 DATE:02/15/2002 PAGE 2
 NPI # 1234567890 TAXONOMY # 1234567890

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON/REMARK CODES
----------	------	-----------------------	-------------	-----------------------	---------------	---------	--------	---------------------

PAID CLAIMS - MISCELLANEOUS CLAIMS

123456789	DOE, JOHN EDWARD	010305 010505	3	120	1281.00	0.00	N	
ICN	00504611350000700	010305 010505	13	250	450.39	0.00		
		010305 010505	11	258	178.83	0.00		
		010305 010505	16	259	515.60	0.00		
		010305 010505	55	270	720.92	0.00		
		010305 010505	4	300	42.00	0.00		
		010305 010505	3	301	188.50	0.00		
		010305 010505	10	305	476.00	0.00		
		010305 010505				0.00		
		010305 010505	2	320	217.00	0.00		

LESS MEDICARE PAID**

CLAIM TOTAL**

4212.24 2957.13 876.00

DENIED CLAIMS - MISCELLANEOUS CLAIMS

123456789	DOE, JOHN EDWARD	013005 013105	1	270	16.00	0.00	Y	
ICN	00504611350000800	012005 013105	1	916	187.00			
		013005 013105	1	450	152.00			
		013003 013105	5	300	352.00			
		CLAIM TOTAL**			3330.00	0.00		31 MA61

PENDING CLAIMS - MISCELLANEOUS CLAIMS

ICN	00504611350000900	013005 013105	1	270	16.00	0.00		
		013005 013105	1	916	187.00			
		013005 013105	1	450	152.00			31
		013005 013105	5	300	352.00			
		CLAIM TOTAL**			3330.00	0.00		

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE*****

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Vendor #	For Montana Medicaid internal use and the billing number for atypical providers.
3. Remit advice #	The remittance advice number.
4. EFT/CHK #	The transaction check number.
5. Date	The date the RA was issued.
6. Page number	The page number of the RA.
7. NPI #	A unique HIPAA-mandated 10-digit identification number assigned to health care providers by the National Plan and Provider Enumeration System (NPPES) through the Centers for Medicare and Medicaid Services (CMS).
8. Taxonomy	Alphanumeric code that indicates the provider's specialty.
9. Member ID	The member's Medicaid ID number.
10. Name	The member's name.
11. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u></p> <p>A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing facility turn-around document, or point-of-sale (POS) pharmacy claim) 6 = Pharmacy</p> <p>B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim</p> <p>D = Batch number E = Claim number</p> <p>If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
12. Service dates	Date services were provided. If services were performed in a single day, the same date will appear in both columns.
13. Unit of service	The units of service rendered under this procedure, NDC code, or revenue code.
14. Procedure/Revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
15. Total charges	The amount a provider billed for this service.
16. Allowed	The Medicaid allowed amount.
17. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
18. Reason/Remark codes	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
19. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

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 7 days. If Medicaid receives eligibility information within the 7-day period, the claim will continue processing. If no eligibility information is received within 7 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 Balances

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

Credit balances can be resolved in two ways:

1. By working off the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Attach a note stating that the check is to pay off a credit balance and include your NPI. Send the check to the Third Party Liability Unit. (See Key Contacts.)

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How Long Do I Have to Rebill or Adjust a Claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking the Third Party Liability 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 provider's NPI is missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures and Submitting a Claim chapters.



Rebill denied claims only after appropriate corrections have been made.

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 all reason and remark codes listed and make your corrections on a copy of the claim, or submit a new claim with the correct information.
- Enter all insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims. (See Key Contacts.)

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or submit a claim inquiry for review. (See the Claim Inquiries section in the Billing Procedures chapter.) Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations.

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



Adjustments can only be made to paid claims. Claims that have been denied must be resubmitted with corrections.

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 (e.g., member ID, provider NPI, date of service, procedure code, diagnoses, units).
- Request an adjustment when a single line on a multi-line claim was denied.

How to Request an Adjustment

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

- Claims 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 adjustment form.

Completing an Adjustment Request Form

1. Download the Montana Medicaid Individual Adjustment Request form from the Provider Relations [website](#). (See Key Websites.) Complete Section A first with provider and member information and the claim's ICN number. (See the following table and sample RA.)
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.

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 is here.
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.* NPI	The provider's NPI.
5.* Member Medicaid number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field 5. (See the sample RA earlier in this chapter.)
7. Amount of payment	The amount of payment from the remittance advice field 19. (See the sample RA earlier in this chapter.)
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.

* Indicates a required field. Signature and date are also required.

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 the Claims Unit. (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.)

Sample Adjustment Request

MONTANA DPHHS
Healthy People. Healthy Communities.

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 Community Hospital	3. Internal Control Number (ICN) 0043601125000600
Name	
123 Medical Drive	4. NPI/API 1234567980
Street or P.O. Box	
Anytown MT 99999	5. Member ID Number 3331112
City State ZIP	
2. Member Name Jane Doe	6. Date of Payment 02/15/2003
	7. Amount of Payment \$ 11.49

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	01/23/03	01/25/03
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 John R. Smith, M.D. Date **04/05/2003**

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

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. (See Key Fields on the Remittance Advice earlier in this chapter.)

Payment and the RA

Providers receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT)/direct deposit.

Electronic Funds Transfer/Direct Deposit

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 process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a Direct Deposit Sign-Up Form (Standard Form 1199A). 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. To arrange for EFT, see the Direct Deposit form on the Provider Information [website](#). Fax your information to the number under Direct Deposit Arrangements in Key Contacts.

Electronic Remittance Advice

The Montana Access to Health (MATH) web portal provides the tools and resources to help health care providers conduct business electronically.

To receive an electronic RA, a provider must be enrolled in electronic funds transfer and have Internet access. You can access your electronic RA through the MATH web portal. Due to space limitations, each RA is only available for 90 days.

For instructions on enrolling, registering, and using the web portal, contact Provider Relations or view the Montana Access to Health tutorial on the Provider Information [website](#). (See Key Websites.)



Electronic RAs are available for only 90 days on MATH.

Required Forms for EFT and/or Electronic RA

Form	Purpose	Where to Get	Where to Send
<ul style="list-style-type: none"> • Direct Deposit Sign-Up Form, Standard Form 1199A 	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information website • Provider's bank 	Provider Relations (See Key Contacts.)
MATH Forms: <ul style="list-style-type: none"> • Trading Partner Agreement • Electronic Billing Agreement • EDI Enrollment Form 	Allows provider to receive a password to access their RA on the web portal.	<ul style="list-style-type: none"> • Provider Relations • MATH web portal 	Fax (406) 442-4402

Other Programs

The information in this chapter applies to hospital services for members who are enrolled in the Mental Health Services Plan (MHSP).

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 800-447-7828 (toll-free) or 406-447-7828 (Helena).

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The Inpatient Prospective Payment System (PPS)

Several methods of payment are used for inpatient hospital services. These include prospective payment using the All Patient Refined Diagnosis-Related Group (APR-DRG), cost-based payment that is retrospectively adjusted at the end of a reporting period and payment based on a percentage of allowed charges.

- Prospective payment using the APR-DRG method is used for:
 - In-State Prospective Payment System Hospitals
 - Border hospitals (within 100 miles of Montana's border)
 - Distinct-part units of Montana APR-DRG hospitals and border hospitals.
 - Acute care psychiatric hospitals
 - Center of Excellence Facilities
 - Out-of-state hospitals
- Hospitals and services subject to the cost based payment method include:
 - Critical access hospitals (CAHs)

The Inpatient Prospective Payment Method Using All Patient Refined Diagnosis Related Groups (APR-DRG)

For most cases, payment equals the relative weight for the APR-DRG times the base price plus the applicable additive factors, such as cost outliers and disproportionate share hospital payment. The overall method is patterned after similar payment policies used by Medicare. When specific details of the payment method differ between Medicare and Medicaid, then the Medicaid policy prevails.

Upon the discharge or transfer of each member, hospitals submit a claim to Montana Medicaid. For admissions dated October 1, 2008, and after, the Department will reimburse hospitals a per-stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). The claim will provide, among other information, the member's principal diagnosis, additional diagnoses, principal and secondary procedures, age, sex and discharge status. These variables are passed through an APR-DRG grouper program to determine the appropriate APR-DRG for each discharge. Although hospitals may indicate the anticipated APR-DRG on

the billing invoice, the Medicaid grouper program is the final determinant in assigning the payable APR-DRG to each case. Interim billing is only allowed in specific situations noted in this chapter.

The Medicaid grouper is updated in October of each year or when updates are published. The fee schedule will be updated in July of each year.

After Medicaid has determined the allowed payment amount, that amount is reduced by any reported third party liability (TPL) amount, cost share amount, Medicare Part A payment amount and member responsibility (Incurment), then Medicaid pays the remainder.

Hospitals reimbursed using the inpatient prospective payment method are not subject to retrospective cost reimbursement.

Hospitals are not required to purchase grouping software and need not indicate the APR-DRG on the claim.

Relative Weights and Reimbursement Data

Please refer to the Provider Information website for relative values, cost outlier thresholds and average length of stay information by APR-DRG code. (See Key Websites.)

APR-DRG Relative Weights

For each APR-DRG, a relative weight factor is assigned. The relative weight is applied to determine the APR-DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the length of stay. The APR-DRG relative weight is a weight assigned that reflects the typical resources consumed.

APR-DRG weights are reviewed and updated periodically by the Department. The weights are adapted from national databases of millions of inpatient stays and are then “re-centered” so that the average Montana Medicaid stay in a base year has a weight of 1.00.

When the Department determines that adjustments to relative weights for specific APR-DRGs are appropriate to meet Medicaid policy goals related to access to quality care, a “policy adjustor” may be explicitly applied to increase or decrease these relative weights. Policy adjusters are intended to be budget neutral, that is, they change payments for one type of service relative to other types without increasing or decreasing payments overall.

DRG Base Price

There are two different base prices for stays in acute care hospitals and Center of Excellence hospitals. The base price is a dollar amount that is reviewed by the Department each year. Changes in the APR-DRG Base Price are subject to the public notice requirements of the Montana Code Annotated.

APR-DRG Base Payment

For each stay, the DRG Base Payment equals the DRG Relative Weight multiplied by the DRG Base Price.

Computational Formulas and Definitions

- Covered Charges = Sum of line item charges minus line noncovered charges from the claim.
- Statewide Cost-to-Charge Ratio = Ratio published in the Administrative Rules of Montana. A table outlining the statewide cost-to-charge ratio and effective dates is available on the Provider Information website. (See Key Websites.)
- Base Price = Statewide average cost per discharge. The base price is published in the Administrative Rules of Montana. A table outlining the APR-DRG Base Price and effective dates is available on the Provider Information website. (See Key Websites.)
- Gross APR-DRG Amount = Base price multiplied by APR-DRG relative weight.
- Cost Outlier Amount = (Allowed charges multiplied by the statewide cost-to-charge ratio) minus the cost outlier threshold) multiplied by the marginal cost outlier percentage (60%).
- Allowed Medicaid APR-DRG payment = Gross APR-DRG amount plus cost outlier amount.
- Per Diem = Allowed Medicaid APR-DRG payment / national average length of stay for the APR-DRG.
- Transferring hospitals: First Day = $2 \times \text{Gross} / \text{LOS} + \text{outlier}$ Subsequent Days = $\text{Gross} / \text{LOS}$.
- Partial eligibility = APR-DRG per diem x eligible days

Payment Factors

Capital Related Costs

Capital cost is included in the DRG-based payment and will not be paid separately.

Cost Outlier Payments

It is recognized that there are occasional stays that are extraordinarily costly in relation to other stays within the same APR-DRG because of the severity of the illness or complicating conditions. These variations are recognized by the cost outlier payment which is an add-on payment for expenses that are not predictable by the diagnosis, procedures performed, and other statistical data captured by the APR-DRG grouper.

Cost outlier stays are stays that exceed the cost outlier threshold for the APR-DRG. To determine if a hospital stay exceeds the cost outlier threshold, the Montana Medicaid program excludes all services that are not medically necessary. Montana Medicaid then converts the charge information for medical necessary services into the estimated cost of the stay by applying the state-wide average PPS inpatient cost-to-charge ratio (CCR). The estimated cost for medically necessary services is then compared to the cost outlier threshold for the appropriate APR-DRG to determine if the stay qualifies for reimbursement as a cost outlier. Costs exceeding the threshold are multiplied by a marginal cost ratio to determine the cost outlier payment.

Transfer Payment Adjustments

The transfer payment adjustment applies when a patient is transferred to another acute care hospital. It does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility. The receiving hospital is not impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

In the transfer payment adjustment, payment is calculated as if the beneficiary were not a transfer, then payment is adjusted. The APR-DRG Gross Payment is divided by the nationwide average length of stay for the assigned APR-DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day to reflect costs related to the admitting process. If the transfer payment adjustment results in an amount greater than the amount without the adjustment, the transfer payment adjustment is disregarded. The cost outlier payment, if applicable, is then added to the APR-DRG base payment, with the transfer adjustment made as needed.

The transfer payment adjustment is not applicable to providers and services that are exempt from the Inpatient Prospective Payment Method.

Prorated Payment Adjustment

When a beneficiary has Medicaid coverage for fewer days than the length of stay, the payment is prorated. The APR-DRG Gross Payment plus cost outlier payments, if applicable, is divided by the nationwide average length of stay for the assigned APR-DRG to arrive at a per diem amount. The per diem amount is then multiplied by the number of days the beneficiary is eligible for Medicaid during the stay. If the prorated payment adjustment results in a payment amount greater than the amount without the adjustment, the prorated payment is disregarded.

The Prorated Payment Adjustment is not applicable to providers and services that are exempt from the Inpatient Prospective Payment Method. See the section titled Exempt Services and Costs.

The Cost-Based Payment Method for Exempt Hospitals and Services

The following providers are exempt from the Inpatient Prospective Payment Method. In the interest of clarity, this list includes acute care hospitals as well as facilities that provide similar inpatient services.

- Indian Health Service hospitals
- The Montana State Hospital
- Psychiatric residential treatment facilities
- Critical access hospitals

Exempt Services and Costs

The following services are exempt from the Inpatient Prospective Payment method even when provided by hospitals that are otherwise subject to prospective payment.

- Services where Medicare is the primary payer (crossover claims)
- Certified Registered Nurse Anesthetist costs as defined by Medicare

Reasonable Cost Reimbursement

Hospitals exempt from prospective payment will continue to use the Title XVIII retrospective reasonable cost principals for reimbursing Medicaid inpatient hospitals services. Allowable costs will be determined in accordance with generally accepted accounting principals as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Pub. 15-1, subject to the exceptions and limitations provided in the Department's Administrative Rules. Pub. 15 is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, which provides guidelines and policies to imple-

ment Medicare regulations which set forth principals for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

Hospitals subject to retrospective reasonable cost reimbursement shall receive interim payments weekly or biweekly during the facility's fiscal year by submitting claims to the Department's fiscal intermediary. The interim payment rate will be based on a percentage of customary (billed) charges to costs as determined by the facility's most recently settled Medicaid cost report. If a provider fails to submit financial information to compute the rate, the provider will be reimbursed at 50 percent of its usual and customary billed charges. Hospital providers are required to submit the CMS 2552-96 to the Medicare Fiscal Intermediary (FI) and the Department within five months of their fiscal year end. The FI either audits or desk reviews the cost report, then sends the Department the "as adjusted" cost report. Medicaid settlements are made from the "as adjusted" cost report.

For each hospital that is a critical access hospital, reimbursement for reasonable costs of inpatient hospital services shall be limited to the lesser of 101 percent of allowable costs or the upper payment limit.

Services where Medicare is the primary payer (crossover claims) are not reimbursed using retrospective cost principles. Reimbursement for these services is the remaining coinsurance and deductible. The Department shall reimburse cost-based inpatient hospital service providers for certified registered nurse anesthetists costs on a reasonable cost basis.

Hospital Residents

Payment for hospital residents will be made as follows:

- Payment for at least the first 180 days of inpatient care at the same facility will be the APR-DRG payment plus any appropriate outliers; and
- Payment for all medically necessary member care subsequent to the request date, which must be greater than 180 days, will be reimbursed at 80% of the hospital-specific estimated cost-to-charge ratio as computed by the Department without cost settlement.
- Services must be prior authorized.

Partial Member Eligibility

If the member is only eligible during a portion of the hospital stay, the Gross APR-DRG is prorated by dividing the Gross APR-DRG amount by the APR-DRG days (average length of stay), then multiplied by the eligible days. Payment will not exceed the allowed Medicaid APR-DRG payment computed without proration.

Transfers

When a member is transferred between two hospitals, the transferring hospital is paid a per diem rate of two times the average per diem amount for the first inpatient day plus one average per diem payment for each subsequent day of inpatient care. Per diem is calculated by dividing the gross APR-DRG payment for the case by the statewide average length of stay for the APR-DRG, then cost outlier, if applicable, is added.

The hospital that member ultimately discharges the member receives the allowed Medicaid APR-DRG payment.

Occasionally, a member is transferred from one hospital to another and then back to the original hospital when the condition causing the transfer is alleviated. Thus a hospital can be a transferring and discharging hospital. The discharging hospital should submit separate claims, one for the original admission and transfer and a second for the final discharge. The hospital that treats and transfers the member back to the original hospital is considered the transferring hospital and is eligible for the per diem.

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 (TPL). In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter in this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on inpatient hospital claims for these dually eligible individuals.

Payment Examples for Dually Eligible Members

Member Has Medicare and Medicaid Coverage. A provider submits an inpatient hospital claim for a member with Medicare and Medicaid. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$250.00) as long as no TPL or incurment amounts are applicable.

Member Has Medicare, Medicaid, and TPL. A provider submits an inpatient hospital claim for a member with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the

Medicaid allowed amount. The other insurance company paid \$225.00. This amount is subtracted from the Medicaid allowed amount leaving \$25.00. Medicaid pays \$25.00 for this claim. If the TPL payment had been \$250.00 or more, this claim would have paid at \$0.00.

Member has Medicare, Medicaid, and Medicaid incurment. A provider submits an inpatient hospital claim for a member with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The member owes \$150 for his Medicaid incurment, so this amount is subtracted from the \$250.00. Medicaid will pay the provider \$100.00 for this claim.

Disproportionate Share Hospital (DSH) Payments (ARM 37.86.2925)

Disproportionate Share Hospital (DSH) payments, including routine and supplemental DSH payments, will be limited to the cap established by the Federal Centers for Medicare and Medicaid Services (CMS) for Montana.

Routine DSH shall receive an additional payment amount equal to the product of the hospital's prospective base rate x the adjustment percent of 4% rural hospital and 10% urban hospitals. All Supplemental Disproportionate Share Hospitals (SDSH) shall receive an SDSH payment. DSH payments will only be given to eligible in-state hospitals.

Other Programs

This chapter does not apply to members who are enrolled in the Mental Health Services Plan (MHSP). Providers will find more information on mental health services in the mental health manual available on the [Provider Information website](#).

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 800-447-7828 (toll-free) or 447-7828 (Helena).

Appendix A: Forms

- **Individual Adjustment Request**
- **Medicaid Abortion Certification (MA-37)**
- **Informed Consent to Sterilization (MA-38)**
- **Medicaid Hysterectomy Acknowledgment (MA-39)**
- **Paperwork Attachment Cover Sheet**

MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name: _____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physical condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

- ___ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or
- ___ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked for

(Doctor or Clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____ (month) (day) (year)

I, _____, hereby consent of my own free will to be sterilized by _____

(Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(Signature)

(Date)

You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):

- American Indian or Alaskan Native
- Black (not of Hispanic origin)
- Asian or Pacific Islander
- Hispanic
- White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter)

(Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed

(name of individual)

the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Signature of person obtaining consent)

(date)

(Facility)

(Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

(Name of person being sterilized)

on _____

(date of sterilization operation)

I explained to him/her the nature of the sterilization operation

_____, the fact that it is

(specify type of operation)

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
- Individual's expected date of delivery: _____
- Emergency abdominal surgery: _____
(describe circumstances): _____

(Physician)

(Date)

Instructions for Completing the Informed Consent to Sterilization (MA-38)

No fields on this form may be left blank, except the interpreter's statement.

- This form must be legible and accurate, and revisions are not accepted.
- Do not use this form for hysterectomies. (See the Hysterectomy Acknowledgment form.)

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy).
3. Enter the member's date of birth in month/day/year format. The member must be at least 21 years old at the time of consent.
4. Enter the member's full name. Do not use nicknames. The name should match the member's name on the Medicaid ID card.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the member sign and date the form. This date must be at least 30 days before the sterilization procedure is to be performed. (See Covered Services for exceptions.)

Interpreter's Statement

Complete this section only if the member requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the member clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation (e.g., Spanish, sign language)
2. Have the interpreter sign and date the form. This date should be the same as the date the member signs the form.

Statement of Person Obtaining Consent

1. Enter the member's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the member and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the member.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under Instructions for use of alternative final paragraphs to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the member's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.

The physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

Signature of Representative (If Required): _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____
(Name of Recipient)
both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____
(Name of Recipient)
was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____
(Name of Recipient)
was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the Medicaid Hysterectomy Acknowledgment Form (MA-39)

Complete only one section of this form. **Indicate which section you are completing by circling the corresponding alpha character (A, B, or C), otherwise the form will be rejected.** The member does not need to sign this form when Sections B or C are used. This form may be used as a substitute for the Informed Consent to Sterilization form for sterilization procedures where the member is already sterile, and for sterilization procedures (e.g., salpingo-oophorectomy, orchiectomy) done only for medical reasons. In these cases, replace the word “hysterectomy” with the appropriate procedure name.

Recipient Acknowledgment Statement

This section is used to document that the member received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The member and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The member or representative must sign and date the form prior to the procedure.
2. Enter the member’s name.
3. The physician must sign and date the form prior to the procedure.
4. If interpreter services are used, the interpreter must sign and date the form prior to the procedure.

Statement of Prior Sterility

Complete this section if the member was already sterile at the time of the hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the member’s name.
2. Explain the cause of the member’s sterility (e.g., post menopausal, post hysterectomy).
3. The physician must sign and date this portion of the form.

Statement of Life Threatening Emergency

Complete this section in cases where the Medicaid Hysterectomy Acknowledgment could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the member’s name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

Billing NPI/API _____

Member ID Number _____

Type of Attachment _____

Instructions

This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to the address below.

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the member's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-999999999-99999999/Atypical Provider ID: 9999999-999999999-99999999).

This form may be copied or downloaded from the Provider Information website (<http://medicaidprovider.hhs.mt.gov/>).

If you have questions about paper attachments that are necessary for a claim to process, call Provider Relations at 1.800.624.3958 or 406.442.1837.

Completed forms can be mailed or faxed to: P.O. Box 8000
Helena, MT 59604
Fax: 1.406.442.4402

Definitions and Acronyms

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

Acute Care Psychiatric Hospital

A psychiatric facility accredited by the Joint Commission on Accreditation of Health Care Organizations that is devoted to the provision of inpatient psychiatric care for persons under the age of 21 and licensed as a hospital by the Department or an equivalent agency in the state in which the facility is located.

Administrative Rules of Montana (ARM)

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

Administratively Necessary Days

“Inappropriate level of care services” means those services for which alternative placement of a patient is planned and/or effected and for which there is no medical necessity for acute level inpatient hospital care.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid, MHSP, or HMK or another payer. Other cost factors, (such as cost sharing, third party liability, 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 member as a Medicaid member.

APR-DRG

All Patient Refined Diagnosis Related Group.

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.

Bad Debt

Inpatient and outpatient hospital services provided in which full payment is not received from the patient or from a third party payer, for which the provider expected payment and the persons are unable or unwilling to pay their bill.

Base Price

Statewide average cost per stay.

Basic Medicaid

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

Border Hospital

A hospital located outside Montana, but no more than 100 miles from the border.

Bundled

Items or services that are deemed integral to performing a procedure or visit that are not paid separately in the APC system. They are packaged (also called bundled) into the pay-

ment for the procedure or visit. Medicare developed the relative weights for surgical, medical, and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of N.

Capital Related Costs

A cost incurred in the purchase of land, buildings, construction, and equipment as provided in 42 CFR 413.130.

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.

Center of Excellence

A hospital specifically designated by the Department as being able to provide a higher level multi-specialty of comprehensive care and meets the criteria in [ARM 37.86.2947\(3\)](#).

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs.

Charity Care

Inpatient and outpatient hospital services in which hospital policies determine the patient is unable to pay and did not expect to receive full reimbursement.

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.

Clinical Trials

Trials that are directly funded or supported by centers or cooperating groups funded by the National Institutes of Health (NIH), Center for Disease Control (CDC), Agency for Healthcare Research and Quality (AHRQ), Center for Medicare and Medicaid Services (CMS), Department of Defense (DOD), or the Veterans Administration (VA).

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.

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-Based Hospital

A licensed acute care hospital that is reimbursed on the basis of allowable costs.

Cost Outlier

An added payment for an unusually high cost case that exceeds the cost outlier thresholds.

Cost Sharing

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

Critical Access Hospital (CAH)

A limited-service rural hospital licensed by DPHHS.

Crossovers

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

Direct Nursing Care

The care given directly to a member which requires the skills and expertise of an RN or LPN.

Discharging Hospital

A hospital, other than a transferring hospital that formally discharges an inpatient. The release of a patient to another hospital or a leave of absence from the hospital is not considered a discharge.

Disproportionate Share Hospital

A hospital serving a disproportionate share of low income members as defined in Section 1923 of the Social Security Act.

Distinct Part Rehabilitation Unit

A unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 42 CFR 412.29.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Medicaid program. 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 ARM 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 Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
 - There is inadequate time to effect a safe transfer to another hospital before delivery; or
 - Transfer may pose a threat to the health or safety of the woman or the unborn child.

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 diagnosis 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.

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 LLC.) 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.

Full Medicaid

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

Graduate Medical Education (GME)

means a postgraduate primary care residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) offered by an eligible in-state hospital for the purpose of providing formal hospital-based training and education under the supervision of a licensed medical physician.

Gross Adjustment

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

Health Improvement Program

A service provided under the Passport to Health program for members who have one or more chronic health conditions. Care management focuses on helping members improve their health outcomes through education, help with social services, and coordination with the member's medical providers.

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 877-543-7669 (toll-free, follow menu) or 855-258-3489 (toll-free, direct). For information about medical benefits, contact BCBSMT at 406-447-7828 (Helena) or 800-447-7828 (toll-free). HMK dental and eyeglasses benefits are provided by DPHHS through the contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing. This set of manuals applies to HMK dental and eyeglass providers only. See the Other Programs section.

Hospital Acquired Condition

A condition that occurs during an inpatient hospital stay and results in high cost or high volumes of care or both; results in a claim being assigned to a diagnose-related group (DRG) that has a higher payment when present as a secondary diagnosis; and could have reasonably been prevented through the application of evidence based on guidelines defined in Section 5001(c) of the Deficit Reduction Act of 2005.

Hospital Reimbursement Adjustor (HRA)

A payment to a Montana hospital as specified in [ARM 37.86.2928](#) and [ARM 37.86.2940](#).

Hospital Resident

A member who is unable to be cared for in a setting other than the acute care hospital. See Obtaining Resident Status in the Covered Services chapter of this manual.

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.

Inpatient

A member who has been admitted to a hospital with the expectation that he/she will remain more than 24 hours.

Inpatient Hospital Services

Services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other practitioner as permitted by federal law.

Interim Claim

In a prospective payment system (PPS), hospital means a claim being billed for an inpatient hospital stay equal to or exceeding 30 days at the same facility as referenced in [ARM 37.86.2905](#).

Investigational

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

Low Income Utilization Rate

A hospital's percentage rate as specified in ARM 37.86.2935.

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.

Medicaid/HMK Plus

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, dis-

abled people, and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medical Inpatient Utilization Rate

A hospital's percentage rate as specified in ARM 37.86.2932.

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

Mentally Incompetent

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdic-

tion for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

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.

Nurse First Advice Line

The Nurse First Advice Line is a toll-free, confidential number members may call any time any day for advice from a registered nurse about injuries, diseases, health care or medications.

Outpatient

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

Outpatient Hospital Services

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

Partial Eligibility

A member who is only eligible for Medicaid benefits during a portion of the inpatient hospital stay as specified in [ARM 37.86.2918](#).

Passport Referral Number

This is a 7-digit number assigned to Passport providers. When a Passport provider refers a member to another provider for services, this number is given to the other provider and is required when processing the claim.

Passport to Health

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

Present on Admission (POA)

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

Prior Authorization (PA)

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

Private-Pay

When a 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 and goods and/or services to members; and eligible to receive payment from the Department.

Provider-Based Services

A provider-based entity is a health care provider "that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from

those of the main provider under the name, ownership, and administrative and financial control of the main provider.”

Public Assistance Toolkit

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

Qualified Individual (QI)

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 deductible.

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.

Reference Lab Billing

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

Relative Weight

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

Remittance Advice (RA)

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

Resource-Based Relative Value Scale (RBRVS)

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

Retroactive Eligibility

When a member is determined to be eligible for Medicaid effective prior to the current date.

Routine Disproportionate Share Hospital

A hospital in Montana which meets the criteria of [ARM 37.86.2931](#).

Routine Podiatric Care

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

Rural Hospital

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

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Sole Community Hospital

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

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 deductible.

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 that month.

Supplemental Disproportionate Share Hospital

A hospital in Montana which meets the criteria of [ARM 37.86.2925](#).

Team Care

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist members in making better health care decisions so that they can avoid over-utilizing 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 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 payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Transplant

Means to transfer either tissue or an organ from one body or body part to another as referenced in [ARM 37.86.4701](#). A transplant may be either:

- Organ transplantation: the implantation of a living, viable, and functioning human organ for the purpose of maintaining all or a major part of that organ function in the client; or
- Tissue transplantation: the implantation of living, human tissue.

Transferring Hospital

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

Uncompensated Care

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

Urban Hospital

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

Usual and Customary

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

Index

A

Abortions, billing for	6.9
Abortions, coverage of	2.3
Absent parent	5.1, 5.3
Acronyms and definitions	B.1
ACS EDI Gateway	ii.4
Adjust or rebill, time limit	8.4
Adjustment request form	8.6
Adjustment, how to request	8.6
Adjustment, when to request	8.6
Adjustments	8.4, 8.5
Adjustments, mass	8.8
Administrative Rules of Montana (ARM)	ii.3, ii.4, 1.2, B.1
Administratively necessary days	B.1
Air transports	2.4
Allowed amount	B.1
Ancillary provider	B.1
Ancillary services, bundled	6.8
APR-DRG	9.1, B.1
ARM rule reference	1.2
Assignment of benefits	B.1
Audit	8.1
Authorization	B.1

B

Bad debt	B.1
Base price	B.1
Basic Medicaid	B.1
Benefits, Medicare exhausted	6.6
Bill Medicaid first, provider may request	5.3
Bill Medicaid members, when providers can and cannot	6.2
Bill third party insurance first	5.2
Billing electronically with paper attachments	7.2
Billing errors, how to avoid	6.11
Billing for abortions and sterilizations	6.9
Billing for members with other insurance	6.4, 6.5
Billing for retroactively eligible members	6.5
Billing problems, how to correct	8.4
Billing third party first, exceptions	5.3
Billing, split or interim	6.8
Border hospital	B.1
Bundled	B.1
Bundled services	6.8

C

Capital related costs	B.2
Cash option	B.2
Center for Disease Control and Prevention (CDC) website	ii.4
Center of Excellence	B.2
Centers for Medicare and Medicaid Services (CMS)	B.2
CFR rule references	1.2
Charity care	B.2
Chemical dependency treatment	2.4
Children's Special Health Services (CSHS)	B.2
Claim denied	8.5
Claim forms	6.1
Claim paid incorrectly	8.1, 8.5
Claim returned	8.5
Claim, submitting	6.10, 7.1
Claim, suspended or pending	8.1
Claims pending with Reason Code 133	8.4
Claims review	1.2, 2.2
Claims, mail to	7.2
Claims, submitting Medicare claims to Medicaid	5.2
Clean claim	6.1, B.2
Clearinghouse	7.1
Clinical trials	B.2
CMS	B.2
Code of Federal Regulations (CFR)	B.2
Coding	6.4
Coding resources	6.4
Coinsurance	B.2
Common billing errors	6.11
Common claim errors	7.7
Completing an individual adjustment request form	8.7
Computational formulas and definitions	9.3
Copayment	B.2
Corrections to a claim	8.5
Cosmetic	B.2
Cost outlier	9.4, B.2
Cost sharing	6.3, B.2
members	6.3
Cost sharing indicators	7.2
Cost-based hospital	B.2
Coverage, other insurance	5.1
Covered services	2.1
Crime Victim Compensation Fund	5.3
Critical access hospital (CAH)	B.2
Critical access hospitals, how payment is calculated for	9.8
Crossovers	B.3
Custom agreement	6.2

D

Definitions and acronyms B.1
 Denial, non-specific by third party 5.3
 Detoxification 2.4
 Diagnostic services, bundled 6.8
 Direct nursing care B.3
 Discharge status codes 6.7
 Discharges 2.4
 Discharges and transfers 6.6
 Discharging hospital B.3
 Disproportionate share hospital 9.1, 9.8, B.3
 Distinct part rehabilitation unit B.3
 Documentation review 2.2
 Donor transplants 2.5
 DPHHS, State agency B.3
 Dual eligibles 9.7, B.3

E

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) 2.1, B.3
 Elective sterilization 2.7, 6.10
 Electronic claims 7.1
 Electronic funds transfer (EFT) 8.9
 Electronic remittance advice 8.9
 Eligibility determination letter (FA-455), attach to claim 6.5
 Eligibility, partial 6.9
 Emergency department visits 2.5
 Emergency medical condition B.3
 Emergency services B.3
 EPSDT 2.1
 Exemption, how to request 5.3
 Experimental B.4

F

Fee schedules 2.1
 Fiscal agent B.4
 Forms 6.1
 Informed Consent to Sterilization (MA-38) A.4
 Instructions for MA-38 A.5
 Instructions for MA-39 A.7
 Medicaid Abortion Certification (MA-37) A.3
 Medicaid Hysterectomy Acknowledgement (MA-39) A.6
 Paperwork Attachment Cover Sheet A.8
 Full Medicaid B.4

G

Graduate Medical Education (GME) B.4

Gross adjustment B.4

H

Health Improvement Program 3.1, 3.2, B.4
 Healthy Montana Kids (HMK) ii.4, 2.11, 5.4, 7.7, 8.10, 9.8, B.4
 Hospital acquired condition B.4
 Hospital inpatient services 2.1
 Hospital Reimbursement Adjustor (HRA) B.4
 Hospital resident 2.2, 9.6, B.4
 Hospital services beyond medical necessity 6.3

I

Incurment 6.9
 Indian Health Service (IHS) B.5
 Indian Health Services (IHS) 5.3
 Indicators for Passport and cost sharing 7.2
 Individual adjustment 8.6, 8.7, B.5
 Informed Consent to Sterilization 2.7
 Inpatient B.5
 Inpatient hospital services B.5
 Inpatient Prospective Payment System 9.1
 Insurance, when members have other 5.1
 Interim billing 6.8
 Interim claim B.5
 Internal control number (ICN) 8.3, 8.7
 Investigational B.5

K

Key websites ii.4

L

Low income utilization rate B.5

M

Manual maintenance 1.1
 Manual organization 1.1
 Mass adjustment 8.8, B.5
 MCA rule references 1.2
 Medicaid B.5
 Medicaid Client/Physician Abortion Certification (MA-37) 2.3
 Medicaid Hysterectomy Acknowledgement (MA-39) 2.8, 6.10
 Medicaid payment and remittance advice 8.9
 Medical inpatient utilization rate B.5
 Medical necessity 6.3
 Medically necessary B.5
 Medically necessary sterilization 2.8, 6.10

Medicare B.5

Medicare benefits exhausted 6.6

Medicare crossover claims, how payment is calculated for 9.7

Medicare Part A 5.2

Medicare, submitting claims to Medicaid 5.2

Member/Members B.5

 has Medicare 5.1

 with other insurance 5.1

Mental health services 2.5

Mental Health Services Plan (MHSP) 2.11, 8.10, B.5

Mental Health Services Plan and Medicaid coverage 5.3

Mentally incompetent B.5

Montana Access to Health (MATH) web portal ii.4, 8.9, B.6

Montana Breast and Cervical Cancer Health (MBCCH) program B.6

N

Noncovered services 2.10

Nurse First Advice Line 3.1, 3.2, B.6

Nursing facility placement 2.3

O

Observation bed 2.5

Obtaining resident status 2.2

Other programs 5.4

Other sources of coverage, how to identify 5.1

Out-of-state facility requirements 2.5

Out-of-state inpatient services 2.5

Outpatient B.6

Outpatient hospital services B.6

Overpayment 8.1, 8.4

P

Paper claims 7.2

Passport

 primary case management 3.1

Passport and cost sharing indicators 7.2

Passport referral authorization number B.6

Passport to Health indicators 7.2

Passport to Health program 3.1, B.6

Patient status code 6.7

Payment by Medicaid, weekly or biweekly 8.9

Physician attestation and acknowledgment 2.2

Present on admission (POA) 7.3, B.6

Prior authorization (PA) 2.5, 4.1, B.6

Private pay B.6

Provider B.6

Provider information website	ii.4
Provider notices	1.1
Provider of service	B.6
Provider-based services	B.6
Public Assistance Toolkit	ii.4, B.7

Q

Qualified individual	B.7
Qualified Medicare Beneficiary (QMB)	B.7
Questions answered	1.2

R

Readmissions	2.6
Rebilling	8.4
Reference lab billing	B.7
Refund overpayments	8.4
Relative weight	B.7
Relative weights and reimbursement data	9.2
Remittance advice (RA)	8.1, B.7
key fields on	8.3
Replacement pages	1.1
Requesting an exemption	5.3
Resource-Based Relative Value Scale (RBRVS)	B.7
Retroactive eligibility	B.7
Routine agreement	6.2
Routine disproportionate share hospital	B.7
Routine podiatric care	B.7
Routine services	2.3
Rule references	1.1
Rural hospital	B.7

S

Sanction	B.7
Services for children	2.1
Services provided by hospital or HCBS	2.2
Sole community hospital	B.7
Specified Low-Income Medicare Beneficiaries (SLMB)	B.7
Spending down	B.8
Split bill	6.9
Sterilizations	2.7, 6.9
Submitting a claim	6.10
Supplemental disproportionate share hospital	B.8
Suspended claim	8.1

T

Team Care	3.1, B.8
-----------------	----------

Third party insurance5.4
 Third party liability (TPL) B.8
 Timely filing 6.1, 7.1, B.8
 TPL claims, how payment is calculated for9.7
 TPL, when a member has5.2
 Transferring hospital B.8
 Transfers 2.9, 9.7
 Transfers, reviewed for medical necessity6.7
 Transplant B.8
 Transplants2.9

U

UB-04 claim form7.2
 UB-04 sample7.5
 Uncompensated care B.8
 Urban hospital B.8
 Usual and customary B.8
 Utilization reviews2.2

W

Washington Publishing Company ii.4
 Websites ii.4
 WINASAP 50107.1

