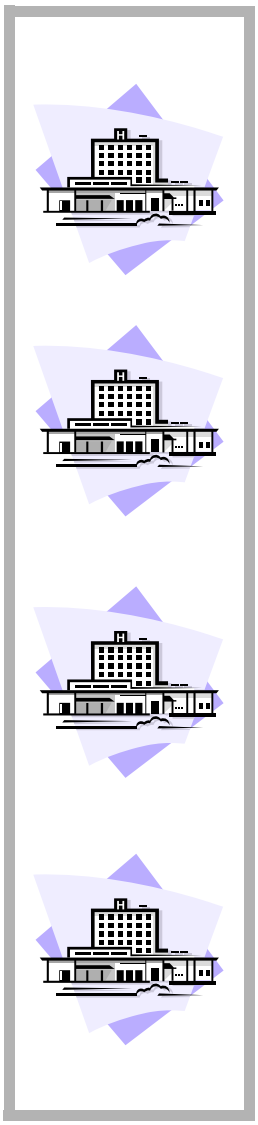

Hospital Outpatient Services

Medicaid and Other Medical Assistance Programs

July 2013

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My NPI:

Definitions and Acronyms

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

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

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

Ambulatory Payment Classification
APCs are the method of paying for facility outpatient services.

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

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

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

Bad Debt
Inpatient and outpatient hospital services for which a provider expected payment but full payment was not received because the patient or third party payer is unable or unwilling to pay the bill.

Bad debts may be for services provided to patients who have no health insurance or patients who are underinsured and are net of payments made toward these services. For the purpose of uncompensated care, bad debt is measured on the basis of revenue forgone, at full established rates, and bad debt does not include either provider discounts or Medicare bad debt.

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

Birthing Center
a facility that provides comprehensive obstetrical care for women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy and is either:

a. Licensed outpatient center for primary care with medical resources as defined at MCA 50-5-101; or
b. A private office of a physician or certified nurse midwife that is accredited by a national organization as an alternative to a homebirth or a hospital birth.

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

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

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs.

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

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

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

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

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

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

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

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

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or 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 the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Members who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) 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:

  - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental

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

Fiscal Agent

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 of the *General Information for Providers* manual.

Gross Adjustment

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

Healthy Montana Kids (HMK)

HMK offers low-cost or free health insurance 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 and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (Xerox) that handles Medicaid provider relations and claims processing.

Health Improvement Program (HIP)

An enhanced primary care case management program that is part of Passport to Health. Services for high risk and/or high cost Medicaid and HMK *Plus* Passport patients provided by nurses and health coaches to prevent or slow the progression of disease, disability and other health conditions, prolong life, and promote physical and mental health. Services are provided through community and tribal health centers on a regional basis and include: health assessment, care planning, hospital discharge planning, help with social services and education, and support for members in self-management of health conditions. Predictive modeling software and provider referral are used to identify patients with the most need.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

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

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

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

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

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

Member
An individual enrolled in a Department medical assistance program.

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

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

Minimal Services
According to CPT 2001, when a member's visit does not require the presence of the physician, but services are provided under the physician's supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

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

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

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

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

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

Outpatient Prospective Payment System (OPPS)
Medicare's outpatient prospective payment system mandated by the 1999 Balanced Budget Refinement Act (BBRA) and the 2000 Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA).

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

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

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. 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.

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

Provider or Provider of Service
An institution, agency, or person:

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

Public Assistance Toolkit
This Internet site (https://dphhs.mt.gov/) contains information about human services, justice, commerce, labor and industry, education, voter registration, the Governor's Office, and Montana.

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

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

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

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

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

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

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

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.

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.

Special Health Services (SHS)
SHS or Children's Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these members, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

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

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

the Department, the Department's quality improvement organization, and the Nurse First Advice Line. The team may also include a community-based care manager from tDepartment'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 the latest of

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

Usual and Customary

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

Index

A

Abortions
- billing for 6.8
- coverage of 2.3

Absent parent 5.3
Acronyms and definitions B.1
ACS B2B Gateway SFTP/FTPS site 6.11
ACS clearinghouse 6.11
ACS EDI Gateway ii.4
ACS MOVEit DMZ 6.11
Adjust or rebill, time limit 8.4
Adjustment Request form
- how to complete 8.6

Adjustments 8.4, 8.5
- how to request 8.6
- mass 8.8
- when to request 8.6

Administrative Rules of Montana (ARM) ii.4, B.1
Air transports 2.4
Allowed amount B.1
Ambulatory Payment Classification (APC) 9.1, B.1
Ancillary provider B.1
APC
- fee calculation 9.1
- methodology, exceptions to 9.2

Assignment of benefits B.1
Audit 8.1
Authorization B.1

B

Bad debt B.1
Basic Medicaid B.1
Bill Medicaid clients
- when providers can and cannot 6.2

Bill Medicaid first
- provider may request 5.3

Bill third party insurance first 5.2
Billing
- errors, how to avoid 6.12
- for clients with other insurance 6.4
- for retroactively eligible clients 6.4
- problems, how to correct 8.4
- third party first exceptions 5.3
- tips for specific services 6.8

Montana Department of Public Health and Human Services

Birthing center 2.2, B.1
Blood draws
payment for 9.3
Bundled B.2
drugs 6.8

C

Cash option B.2
Center for Disease Control and Prevention (CDC) website ii.4
Centers for Medicare and Medicaid Services (CMS) B.2
Charge cap 9.4
Chemical dependency treatment 2.4
Children's Special Health Services (CSHS) B.6
Claim
clean B.2
Claim forms 6.1
Claims
clean 6.1
denied 8.5
electronic 6.11
inquiries 6.12
mail to 7.1
number of lines 6.6
paid incorrectly 8.1, 8.5
paper 6.11
pending with Reason Code 133 ..... 8.4
returned 8.5
submitting 6.11
submitting Medicare claims to Medicaid 5.2
suspended or pending 8.1
tips 7.1
Clearinghouse 6.11
Client
cost sharing 6.3
has Medicare 5.1
with other insurance 5.1
CMS B.2
Code description, check long text 6.5
Coding
assistance and resources 6.5
books 2.3
conventions 6.5
resources 6.6
suggestions 6.5
tips 6.5
Coinsurance B.2

Montana Department of Public Health and Human Services

Common billing errors 6.12
Common claim errors 7.9
Conversion factor B.2
Copayment B.2
Corrections to a claim 8.5
Cosmetic B.2
Cost sharing 6.3, B.2
clients who are exempt 6.3
do not show when billing 6.3
indicators 7.1
services that do not require 6.3
Coverage
other insurance 5.1
CPT B.2
Crime Victim Compensation 5.3
Critical access hospitals
how payment is calculated 9.1
Crossovers 5.2, B.2
Custom agreement 6.2

D

Definitions and acronyms B.1
Denial
nonspecific by third party 5.3
Dental services
payment for 9.3
Diabetic education 2.4
Donor transplants 2.4
DPHHS, State Agency B.2
Drugs and biologicals 6.8
Dual eligibles B.2
Dually eligible clients, payment examples 9.7

E

Early and Periodic Screening Diagnosis and Treatment (EPSDT) B.2
Elective sterilization 2.5
billing for 6.10
coverage and requirements 2.5
Electronic claims 6.11
submission 6.11
Electronic funds transfer (EFT) 8.9
Electronic remittance advice 8.9
Eligibility determination letter
attach to claim 6.4
Emergency department visits 2.4
Emergency medical condition B.3

Montana Department of Public Health and Human Services

EPSDT 2.1
Exemptions
how to request 5.3
Experimental B.3

F

FA-454, FA-455, eligibility determination letters 6.4
Fee schedules 2.3
Fiscal agent B.3
Forms 6.1, A.1
Full Medicaid B.3

G

Gross adjustment B.3

H

Health Improvement Program 3.1, 3.2, B.3
Healthy Montana Kids (HMK) ii.4, 2.8, 4.2, 5.4, 6.13, 7.9, 8.10, 9.7, B.3
Hospital-based provider 2.5

I

Immunizations
payment for 9.3
Indian Health Service (IHS) 5.3, B.3
Indicators for Passport and cost sharing 7.1
Individual Adjustment Request 8.6, A.2, B.3
Informed Consent to Sterilization 2.6, A.4
Instructions
MA-38 ..... A.5
MA-39 ..... A.7
Insurance, when clients have other 5.1
Internal control number (ICN) 8.3, 8.7
Investigational B.3

K

Key websites ii.4

L

Lab services
payment for 9.2
Lab services, billing for 6.9

M

MA-37 ..... 2.3
MA-38 ..... A.5
MA-39 ..... A.7

Montana Department of Public Health and Human Services

Manual organization 1.1
Mass adjustments 8.8, B.4
Medicaid B.4
    payment and remittance advice 8.9
Medicaid Abortion Certification (MA-37) A.3
Medicaid Client/Physician Abortion Certification 2.3
Medicaid Hysterectomy Acknowledgement (MA-39) 2.7, 6.10, A.6
Medical coding conventions 6.5
Medically necessary B.4
Medically necessary sterilization
    billing for 6.10
    coverage of and requirements 2.7
Medicare B.4
    client has 5.1
    Part A 5.2
    Part B 5.2
    submitting claims to Medicaid 5.2
Medicare crossover claims
    how payment is calculated for 9.7
Mental Health Services Plan (MHSP) 2.8, 4.2, 5.4, 6.13, 7.9, 8.10, 9.7, B.4
    Medicaid coverage 5.3
Mentally incompetent B.4
Minimal services B.4
Modifiers 6.8
    that change pricing 9.6
Montana Access to Health (MATH) web portal ii.4, 6.11, 8.9
Montana Breast and Cervical Cancer Health Plan (MBCCH) B.4
Montana Health Care Programs Individual Adjustment Request 8.6
Multiple services on same date 6.6
Mutually exclusive code pairs B.4

N

Noncovered services 2.1
Number of lines on claim 6.6
Nurse First Advice Line 3.1, 3.2, B.4

O

Observation services
    payment for 9.3
Other insurance 5.1
Other programs 5.4, 6.13
Other sources of coverage, identifying 5.1
Outpatient clinic services, payment for 9.4, B.5
Outpatient hospital services B.5
Outpatient prospective payment system (OPPS) 9.1, B.5
Overpayments 8.1, 8.4

Montana Department of Public Health and Human Services

Montana Department of Public Health and Human Services

P

Packaged B.5
services, payment for 9.4
Panel code 6.9
Paper claims 6.11
Paperwork Attachment Cover Sheet A.8
Partial hospitalization 2.5
billing for 6.9
payment for services 9.2
payment rates 9.3
Passport
cost sharing indicators 7.1
primary case management 3.1
provider role 3.3
referral authorization number B.5
Passport to Health 3.1, B.5
indicators 7.1
Pass-through items 6.8
Pass-through payments 9.4
Payment
by Medicaid, weekly 8.9
by report 9.4
examples for dually eligible clients 9.7
rates for partial hospitalization 9.3
Potential liability 5.3
Prior authorization (PA) 4.1, B.5
Private-pay B.5
Procedures considered as inpatient only by Medicare 9.4
Protocols B.5
Provider Information website ii.4
Provider notices 1.1
Provider of service B.5
Provider-based services 2.5, 6.9, 9.4
Public Assistance Toolkit ii.4, B.5

Q

Qualified individual B.5
Qualified Medicare Beneficiary (QMB) B.6
Questions answered 1.2

R

Rebill or adjust a claim, time limit 8.4
Rebill, how to 8.5
Rebilling 8.5
Reference lab billing B.6
Refund overpayments 8.4
Relative value scale (RVS) B.6

Relative value unit RVU) B.6
Remittance advice
Denied Claims section 8.1
Key fields on 8.3
Notice section 8.1
Paid Claims section 8.1
Pending Claims section 8.1
Remittance advice (RA) 8.1, B.6
description 8.1
Replacement pages 1.1
Reporting service dates 6.7
Requesting an exemption 5.3
Resource-Based Relative Value Scale (RBRVS) B.6
Response
none from third party 5.4
Retroactive eligibility B.6
provider acceptance 6.4
Retroactively eligible clients, billing for 6.4
Revenue codes 6.7
Routine agreement 6.2
Routine podiatric care B.6

S

Sanction B.6
Secretary of State website ii.4
Sections of the RA 8.1
Serious emotional disturbance (SED) 2.5
Service dates
how to report 6.7
Services
multiple on same date 6.6
paid or denied by Medicare 5.2
that do not require copay 6.3
when providers cannot deny 6.3
Severe disabling mental illness (SDMI) 2.5
Span bills 6.7
Special Health Services (SHS) B.6
Specified low-income Medicare beneficiaries (SLMB) B.6
Spending down B.6
Status codes 9.4
Sterilization
billing for 6.10
coverage of 2.5
requirements 2.6
Submitting a claim 7.1
Suggestions for coding 6.5

Montana Department of Public Health and Human Services

Supplies
billing for 6.10
Suspended claim 8.1

T

Team Care 3.1, B.6
Therapy services 2.7
payment for 9.2
Third party
does not respond 5.4
pays or denies a claim 5.3
Third party liability (TPL) B.7
Timely filing 6.1, 7.1, B.7
denials, how to avoid 6.1
TPL
when a client has 5.2
TPL claims
how payment is calculated for 9.7

U

UB-04 agreement 7.8
UB-04 claim form 7.1
Usual and customary B.7

W

Washington Publishing Company ii.4
Websites ii.4
WINASAP 5010 .....6.11

Montana Department of Public Health and Human Services