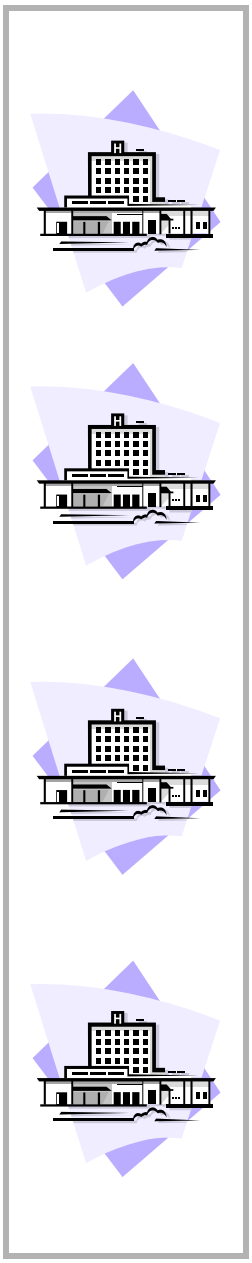

Hospital Outpatient Services

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

May 2015

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My NPI:

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Key Contacts and Key Websites

For contacts and websites, see the Contact Us link on the Montana Healthcare Programs Provider Information website.

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 **outpatient hospital services**. Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.

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. A list of contacts and websites is found on the Contact Us page of the Provider Information website. We have also included 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. 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. Remember to keep old policy pages when you add replacement pages to refer to for older claims.

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.

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

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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 outpatient hospital program:

- Code of Federal Regulations (CFR)
  - 42 CFR 419 Prospective Payment System for Hospital Outpatient Department Services
- Montana Code Annotated (MCA)
  - MCA 50-5-101 through MCA 50-5-1205 Hospitals and Related Facilities
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2801 and ARM 37.86.3001–ARM 37.86.3109 Outpatient Hospital Services

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

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

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website.

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Covered Services

General Coverage Principles

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

Hospital Outpatient Services (ARM 37.86.3001)

Outpatient hospital services are provided to members whose expected hospital stay is less than 24 hours. Outpatient services include preventive, diagnostic, therapeutic, rehabilitative, and palliative care provided by or under the direction of a physician, dentist, or other practitioner as permitted by federal law. Hospitals must meet **all** of the following criteria:

- Be licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located
- Meet the requirements for participation in Medicare as a hospital

Services for Children (ARM 37.86.2201–2235)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program is a comprehensive approach to healthcare 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 outpatient hospital services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

Non-Covered Services (ARM 37.85.207 and ARM 37.86.3003)

Items or medical services not specifically included within these rules as covered benefits of the Montana Medicaid program are not reimbursable.

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 and ARM 37.90.402, and Title 37, Chapter 34, Subchapter 9, to persons eligible for home and community-based services, and except for those Medicaid-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.

- Acupuncture services
- Autopsies
- Chiropractic services
- Circumcisions not authorized by the Department as medically necessary

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- Dietician services (some services covered per ARM 37.86.3002)
- Delivery services not provided in a licensed healthcare facility or nationally accredited birthing center unless as an emergency service. Delivery service means services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery. Emergency service is defined in ARM 37.82.102.
- Dietary supplements
- Donor search expenses
- Erectile dysfunction products, including but not limited to injections, devices, and oral medications used to treat impotence
- Experimental services, or services that are generally regarded by the medical profession as unacceptable treatment not medically necessary for purposes of the Montana Medicaid program.
- Homemaker services
- Independent exercise programs, such as pool therapy, swim groups, or health club memberships
- Invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding, or bariatric surgery, including all revisions
- Masseur/Masseuse services
- 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.
- Naturopathic services
- Nutritional services
- Outpatient hospital services provided outside the borders of the United States.
- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 37.86.601
- Physical therapy aide services, except as provided in ARM 37.86.601, ARM 37.86.605, ARM 37.86.606, and ARM 37.86.610.
- 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.
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid member is financially responsible for these services and the Department recommends the member agree in writing before the services are provided. See When to Bill a Medicaid Member in the Billing Procedures chapter of the *General Information for Providers* manual.
- Sexual aids, including but not limited to devices, injections, and oral medications

- Surgical technician services (technicians who are not physicians or mid-level practitioners)
- Treatment services for infertility, including sterilization reversals
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home, remodeling of home, plumbing service, car repair, and/or modification of automobile

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

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 CPT, CDT, and HCPCS coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Fee schedules are available on the provider type pages on the Provider Information website.

Coverage of Specific Services (ARM 37.86.3002)

The following are coverage rules for specific hospital outpatient services.

Abortions (ARM 37.86.104)

Abortions are covered when one of the following conditions is 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 Physician Certification for Abortion Services (MA-37) form must be submitted with every abortion claim or payment will be denied. Complete only one section of this form. This is the only form Medicaid accepts for abortion services. (See the Forms page of the Provider Information website for the form and instructions.)

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.

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- 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.
- Can assess for any possible adverse events.

Diabetes Education

Medicaid covers diabetes education services for members who have been newly diagnosed with diabetes and/or members with unstable diabetes (e.g., members with long-term diabetes experiencing management problems) in accordance with 42 CFR 410, Subpart H. The diabetes education protocol must meet the following Medicare Part A requirements:

- The program must train and motivate members to self-manage their diabetes through proper diet and exercise, blood glucose self-monitoring, and insulin treatment.
- The plan of treatment must include goals for the member and how they will be achieved, and the program duration must be sufficient to meet these goals.
- The physician must refer only his/her members to the program.
- The program must be provided under the physician's order by the provider's personnel and under medical staff supervision.
- The education plan must be designed specifically for members to meet their individual needs. Structured education may be included in the plan, but not substituted for individual training.

Donor Transplants

Medicaid covers successful donor-related testing and services and organ acquisition services, which are bundled into the Medicaid member's transplant hospitalization stay. Medicaid does not cover expenses associated with the donor search process.

Emergency Department Visits

Emergency medical services are those services required to screen, treat, and stabilize an emergency medical condition in an emergency room. **Passport to Health provider referral is not required for emergency room visits.** Inpatient services for members admitted through an emergency room (where the emergency room is billed on the inpatient claim) are also exempt from Passport requirements.

For emergency room visits, services are exempt from cost share.

For prospective payment hospitals, the two lowest level emergency room visits (CPT procedure codes 99281 and 99282) will be reimbursed based on the clinic visit APC rate.

Provider-Based Services

The Department will pay for services provided in an outpatient clinic, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Hospitals that wish to have outpatient clinics paid as hospital-based providers must send a copy of the Medicare letter granting provider-based status to the Department's hospital program officer.

Partial Hospitalization

The partial hospitalization program is an active treatment program that offers therapeutically intensive, coordinated, structured clinical services. These services are provided only to members who are determined to have a serious emotional disturbance (SED) or a severe disabling mental illness (SDMI).

Definitions for SED and SDMI are on the Provider Information website under Definitions and Acronyms. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services include day, evening, night, and weekend treatment programs that employ an integrated, comprehensive, and complementary schedule of recognized treatment or therapeutic activities. These services require prior authorization. See the Provider Information website for the mental health manual and prior authorization information.

Elective Deliveries

Effective July 1, 2014, all facilities must have a hard-stop policy in place regarding non-medically necessary inductions prior to 39 weeks and non-medically necessary Cesarean sections at any gestational age. The policy must contain the following:

- No non-medically necessary inductions and Cesarean sections prior to 39 weeks and 0/7 days gestation, and no non-medically necessary Cesarean sections at any gestational age.
- Confirmation of weeks gestation by ACOG guidelines (at least one of the following guidelines must be met to show gestational age):
  - Fetal heart tones have been documented for 20 weeks by non-electronicfetoscope or 30 weeks by Doppler;
  - 36 weeks since a positive serum or urine pregnancy test that was performed by a reliable laboratory; or
  - An ultrasound prior to 20 weeks that confirms the gestational age of at least 39 weeks.
- If pregnancy care was not initiated prior to 20 weeks gestation, the gestational age may be documented from first day of the last menstrual period (LMP).
- Policy must have a multistep review process prior to all inductions and Cesarean Sections including final decision being made by the Perinatology Chair/ Obstetrical Chair, OB Director, or Medical Director.

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Effective October 1, 2014, Montana Medicaid will reduce reimbursement rates for non-medically necessary inductions prior to 39 weeks, and non-medically necessary Cesarean sections at any gestational age. All hospital claims with an admit date on or after October 1, 2014, will require coding changes to delivery claims. Hospital inpatient claims and birthing center claims will require the use of condition codes for all induction and Cesarean section deliveries. These claims will be reviewed for medical necessity based on an approved list of diagnosis codes. The condition codes are:

- 81 – Cesarean section or induction performed at less than 39 weeks gestation for medical necessity.
- 82 – Cesarean section or induction performed at less than 39 weeks gestation elective.
- 83 – Cesarean section or induction performed at 39 weeks gestation or greater.

Outpatient Cardiac and Pulmonary Rehabilitation

Effective July 1, 2014, services for procedure codes G0423, and G0424 must be prior authorized by Mountain-Pacific Quality Health.

Coverage for outpatient cardiac and pulmonary rehabilitation services must be medically necessary.

Patients with one or more contraindications are not eligible for cardiac and pulmonary rehabilitation. The following conditions are contraindications to cardiac pulmonary rehabilitation.

- Severe psychiatric disturbance including, but not limited to, dementia and organic brain syndrome; or
- Significant or unstable medical conditions including, but not limited to, substance abuse, liver dysfunction, kidney dysfunction, and metastatic cancer.

Cardiac Rehabilitation

Services are limited to the following:

- Cardiac rehabilitation services are limited to a maximum of two 1-hour sessions per day for up to 36 sessions, limited to the following cardiac events and diagnoses:
  - Myocardial infarction within the preceding 12 months;
  - Coronary artery bypass surgery;
  - Heart-lung transplant;
  - Current stable angina pectoris;
  - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
  - Heart valve repair or replacement; and
  - Chronic stable heart failure.

Pulmonary Rehabilitation

Services are limited to the following:

- A maximum of two 1-hour sessions per day for up to 36 sessions, for patients with moderate to severe COPD (defined as GOLD classification II, III, and IV).
- If applicable, the patient must have ceased smoking or be in a smoking cessation class.

The following pulmonary rehabilitation services are not covered:

- Education, treatment, and therapies that are not individualized to a specific patient need or are not an integral part of the treatment session;
- Routine psychological screening and treatment where intervention is not indicated;
- Films/videos;
- Duplicate services;
- Maintenance care when there is no expectation of further improvement;
- Treatment that is not medically necessary because the patient requires a general strengthening and endurance program only; and
- Treatment that is not medically necessary because the patient is at an early state of pulmonary disease as demonstrated by a lack of significant findings in diagnostic testing.

Therapy Services

Physical, occupational, and speech/language therapy services are limited to 40 hours each during a state fiscal year (July 1–June 30) for adults age 21 years and older. Children may qualify for more than 40 hours if medically necessary, and prior authorization is required. (See the Prior Authorization chapter in this manual.)

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Prior Authorization

What is Prior Authorization (ARM 37.86.2801)

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

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

Prior authorization is not a guarantee of payment. When requesting prior authorization, keep in mind the following:

- The referring provider should initiate all authorization requests.
- For members with partial eligibility, request prior authorization from the first date the member was Medicaid-eligible, not from the first date of the member's hospital stay.
- Have all required documentation included in the packet before submitting a request for prior authorization. The Prior Authorization Information link on the Provider Information website lists some services that require prior authorization, who to contact, and specific documentation requirements. Also refer to the fee schedules.
- Prior authorization must be obtained before a member receives services. See the fee schedules for procedure codes that have *Y* as the prior authorization indicator. Prior authorization is also 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.
  - Interim claims for Prospective Payment System (PPS).
- When prior authorization is granted, providers receive notification containing a prior authorization number, which must be included on the claim.

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 two working days (Monday–Friday) of admission to an out-of-state hospital.

Prior authorization is not required in emergency situations.

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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, fee schedules, and the Prior Authorization Information page on the Provider Information website.

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Billing Procedures

Claim Forms

Services provided by the healthcare 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.

Coding Tips

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 table of Coding Resources in the *General Information for Providers* manual. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use applicable CPT, CDT, HCPCS, and ICD coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, do not use Code 53899 unlisted procedure of the urinary system when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have 3 to 5 levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to but not over the time spent. For example, a provider spends 60 minutes with the member. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Revenue Codes 25X and 27X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be underpaid.
- Take care to use the correct units measurement. In general, Medicaid follows the definitions in the CPT and HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be “each 15 minutes.” Always check the long text of the code description published in the CPT or HCPCS coding books.

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Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, so long as the service is paid by fee schedule (e.g., partial hospitalization, therapies) and the date is shown on the line. However, the Outpatient Code Editor (OCE) will not price APC procedures when more than one date of service appears at the line level, so we recommend billing for only one date at a time when APC services are involved.

Reporting Service Dates

All line items must have a valid date of service in form locator (FL) 45. The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS code.

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis – Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis – Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Using Modifiers

Review the guidelines for using modifiers in the most current CPT book, HCPCS book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).

Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.

Medicaid accepts most of the same modifiers as Medicare, but not all.

The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen.

Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers. For a list of modifiers that change pricing, see the How Payment Is Calculated chapter in this manual.

Billing Tips for Specific Services

Prior authorization is required for some outpatient hospital services. Passport and prior authorization are different, and some services may require both. Different numbers are issued for each type of approval and must be included on the claim form.

Abortions

A completed Physician Certification for Abortion Services (MA-37) form must be attached to every abortion claim or payment will be denied. Complete only one section of this form. This is the only form Medicaid accepts for abortions.

Drugs and Biologicals

While most drugs are bundled, there are some items that have a fixed payment amount and some that are designated as transitional pass-through items. (See Pass-Through Payments in the How Payment Is Calculated chapter in this manual.)

Bundled drugs and biologicals have their costs included as part of the service with which they are billed.

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The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs
- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Lab Services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day) bill the panel code with units corresponding to the number of times the panel was performed.

Provider-Based Services

When Medicaid pays a hospital for outpatient clinic or provider-based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., POS 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must bill only for the professional component if the hospital is going to bill Medicaid for the technical component. For more information, refer to the *Physician-Related Services* manual, Billing Procedures chapter. Manuals are on the Provider Information website.

Partial Hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization

Code	Modifier	Service Level	Payment Rate
H0035	—	Partial hospitalization, subacute, half day	Check current fee schedule for current payment rates.
H0035	U6	Partial hospitalization, subacute, full day	
H0035	U7	Partial hospitalization, acute, half day	
H0035	U8	Partial hospitalization, acute, full day	

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. 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, oophorectomies, salpingectomies, and orchiectomies, one of the following must be attached to the claim, or payment will be denied:
  - A completed Medicaid Hysterectomy Acknowledgement (MA-39) form 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 of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member (or representative, if any) 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.
  - 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 160-M (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.

Supplies

Supplies are generally bundled, so they usually do not need to be billed individually. A few supplies are paid separately by Medicaid. The fee schedule on the website lists the supply codes that may be separately payable.

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Submitting a Claim

Paper Claims

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

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

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** Free software that providers can use to create and submit claims for Montana Medicaid, MHSP, HMK (dental and eyeglasses) 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 transaction back from the Department.
- **Montana Access to Health (MATH) web portal.** A secure website on which providers can view members' medical history, verify member eligibility, submit electronic claims to Medicaid via HIPAA-compliant X12 837 file; check the status of the claim, verify the status of a warrant, and download electronic remittance advice reports.
- **Xerox EDI Solutions.** Providers can send claims to EDI Solutions in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **Clearinghouses.** Providers can contract with a clearinghouse to send the claims in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to Xerox in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims. EDIFECS certification is completed through EDI Solutions.
- **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.** This secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox, and is intended for those who submit more than physical files per day or whose file sizes regularly exceed 2 MB.

For more information on electronic claims submission options, contact Provider Relations and follow prompts for EDI.

The services described in this manual are billed on UB-04 claim forms. Use this chapter with the UB-04 claim instructions on the Provider Information website. For more information on submitting HIPAA-compliant 837 transactions, refer to the HIPAA 5010 page on the Provider Information website and the HIPAA EDI Implementation Guides on the EDI Solutions website.

Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner. See the *Billing Procedures* chapter in this manual.

Passport and Cost Sharing Indicators	
Passport to Health Indicators	
Code	**Used When Providing**
FPS	Family planning services.
OBS	Obstetrical services.
TCM	Targeted case management services.
Cost Sharing Indicators	
Code	**Used When Providing**
C	Services to a child or EPSDT Exempt.
E	Emergency services.
F	Family planning services.
I	Services to any IHS referral.
P	Services to pregnant women.
N	Services to nursing facility residents.

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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.

Critical Access Hospitals

Critical access hospitals (CAHs) are reimbursed for their costs of providing care, as determined through the annual cost settlement process. In the interim, these hospitals are paid a hospital-specific percentage of their charges. The percentage equals the hospital's estimated cost-to-charge ratio as determined from time to time by the Department.

The Outpatient Prospective Payment System

The outpatient prospective payment system (OPPS) applies to all facilities that are not designated CAHs or Indian Health Service (IHS) and includes border and out-of-state facilities. Most services in the outpatient hospital setting are paid using the Ambulatory Payment Classification (APC) system developed by Medicare. The Department has adopted Medicare definitions and weights for APCs for the most part. Exceptions are discussed below.

APC payments are based on CPT and HCPCS procedure codes. Most procedure codes are assigned to a specific APC. Each APC is assigned a relative weight reflecting the resources required for that particular group of procedures. APC assignments and relative weights are reviewed and updated several times each year by Medicare.

The following illustrates how APC payments are calculated. Relative weights and the current conversion factor are published by the Department and available in the fee schedules on the website. Weights are set by Medicare. The conversion factor is determined by the Department. Examples for illustration are below.

Fee calculation
Each APC fee is the product of a relative value times a conversion factor. For example, the fee for a chest x-ray (CPT Code 71010, APC 0260) is:

0.6539 relative weight x conversion factor of $55.53 = $36.31

The fee for a high-level emergency department visit (CPT Code 99285, APC 0616) is:

4.7846 relative weight x conversion factor of $55.53 = $265.69

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Exceptions to the APC Methodology

Several services in the outpatient setting are paid through methods other than APC. Those exceptions to the APC method include, but are not limited to:

- Laboratory services
- Therapy services (physical, speech, and occupational therapy)
- Partial hospitalization services
- Dental services
- Screening mammography
- Blood draws
- Immunizations

Lab Services

Almost all laboratory services are paid using the same fees that Medicare pays to Montana providers. The exceptions are those few laboratory codes that have an APC assignment from Medicare as well as several codes that are covered by Medicaid but not Medicare.

When lab codes that make up an organ or disease oriented panel are billed as individual tests, Medicaid will bundle these codes into the correct panel and pay the panel fee.

Therapy Services

Therapy services are paid using the same fee schedule that DPHHS pays therapists in private practice, which is the allied services RBRVS fee schedule for the applicable codes.

Partial Hospitalization Services

Partial hospitalization services are paid on a fee schedule. The appropriate code is H0035, which should be billed with Revenue Code 912.

For service levels other than subacute, half day, providers must use one of three Montana-specific modifiers listed in the following table.

Current Payment Rates for Partial Hospitalization

Code	Modifier	Service Level	Payment Rate
H0035	—	Partial hospitalization, sub-acute, half day	Check current fee schedule for current payment rates.
H0035	U6	Partial hospitalization, sub-acute, full day	
H0035	U7	Partial hospitalization, acute, half day	
H0035	U8	Partial hospitalization, acute, full day	

Dental Services

Some dental services have an APC assignment and are paid according to the APC payment method. Those dental services that are allowed in the outpatient setting but do not have an APC assignment are paid a fee according to the outpatient hospital fee schedule.

Blood Draws

Blood draws (HCPCS Code 36415) are paid using the fee schedule that pertain to the date of service. Procedure Code 36415 is paid per visit, not per blood draw.

Immunizations

Some immunizations are paid by APC and others are not. If an immunization service is not paid in the APC section then a fee is paid in the miscellaneous services section. The fee is the same as the RBRVS-based fee paid to physicians. If the member is under 19 years old and the vaccine is available to providers for free under the Vaccines for Children program, then the payment to the hospital is zero. Immunization administration is considered an incidental service. The claims processing system bundles immunization administration with other services on the claim and pays it at zero.

Other Issues

Observation Services

The Department will make separate payment for observation care procedure codes if the following criteria are met:

- Hours/units of service must be at least 8.
- Must be direct-admit or have a high-level clinic visit, high-level critical care, or high-level emergency room visit.
- Only obstetric observation must have a qualifying diagnosis and must be at least 1 hour.

Outpatient Clinic and Provider-Based Services

When Medicaid pays a hospital for outpatient or provider-based clinic services, the separate claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). This place of service code will result in lower payment to the physician, thus minimizing what would otherwise be double payment for office expenses.

Pass-Through Payments

Payments for certain drugs, devices and supplies are designated as "pass-through." In a few cases, these codes have APC weights; in most cases, payment is by report.

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Packaged Services

Payment for some services is always considered bundled into payment for other services. (The APC term for bundling is packaging.) In other cases, the services are bundled for some visits but not for others. For example, payment for IV therapy is considered bundled within the payment for a surgical visit but not for a medical 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.

Procedures Considered Inpatient Only by Medicare

Medicare has designated some procedures as "inpatient only." Medicaid has adopted that designation as well. When these procedures are performed in the outpatient hospital setting, the claim is denied.

Charge Cap

For services covered in the outpatient hospital setting, Medicaid pays the lower of the Medicaid fee or the provider's charge. The charge cap is applied at the claim level for outpatient hospital services, not at the line level. Therefore it is possible that a provider may be paid more than charges for any given line on a claim.

Status Indicator Codes

The line-level status indicator codes explain how payment was calculated at the line. The codeset used by DPHHS is based on the codeset used by Medicare but with several additions.

Status Indicator Codes Used by DPHHS

Code	Description
C	Inpatient services that are not payable under OPPS.
E	Not allowed under outpatient.
G	Pass-through drugs and biologicals.
H	Pass-through devices that are paid by report
K	Drugs and biologicals paid by APC.
M	Montana Medicaid specific fee.
N	Services for which payment is packaged into another service or APC.
Q	Montana Medicaid laboratory service.
R	Blood and blood products.
S	Significant procedures that are paid under OPPS but to which the multiple surgery reduction does not apply.
T	Significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
U	Brachytherapy sources.
V	Medical visits (including clinic or emergency department visits) that are paid under OPPS.
X	Ancillary services that are paid under OPPS.
Y	Montana Medicaid fee for physical therapy, occupational therapy, or speech and language therapy services. Some procedures may have a variable status that is dependent on if they are provider with another billable service. These codes are listed on the fee schedule as status N (bundled) but will have an APC and price shown.

Modifiers

Certain modifiers affect the way a service is paid. The modifiers that change pricing are shown below.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services.
- Modifiers affect surgical services differently. Services with status indicators of either S or T are affected by bilateral discounting and repeat procedure modifiers.
- The list below contains a few examples of modifiers that affect pricing. See CPT and HCPCS coding books for the full text.
- Reference the current Uniform Billing Expert book for coding information for modifiers.

How Modifiers Change Pricing

Code	Description	How It Affects Payment
50	Bilateral procedure	Conditionally, bilateral codes are priced at 150% of the APC. Inherent and independent bilateral procedures are priced at 100% of the APC regardless if Modifier 50 is present.
52	Reduced procedures	Status T and S procedures are priced at 50% of the APC price.
73	Procedure discontinued prior to anesthesia induction	Status T and S procedures are paid at 50% of the APC price or fee schedule.
L1	Separately payable lab test	Please reference the Medicaid Outpatient Laboratory Billing section of this manual for more information.
U6	Full day sub-acute partial hospitalization	The partial hospitalization service is paid at 133.32% of the base fee.
U7	Part day acute partial hospitalization	The partial hospitalization service is paid at 157.44% of the base fee.
U8	Full day acute partial hospitalization	The partial hospitalization service is paid at 209.92% of the base fee.

Medicaid Outpatient Laboratory Billing

Beginning July 1, 2014, Medicare revised the use of type of bill (TOB) 13X and 14X, and Medicaid will follow suit (ARM 37.85.105 and ARM 37.86.3007).

Beginning July 1, 2014, TOB 14X will only be used in the following instance:

- Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary who is neither an inpatient nor an outpatient of a hospital, but who has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital.

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Beginning July 1, 2014, TOB 13X, with a L1 modifier will be used for the following instances:

- When the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and
- When the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.

Critical access hospitals (CAHs) are exempt from this requirement.

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 outpatient hospital claims for dually eligible individuals.

Payment Examples for Dually Eligible Members

Member has Medicare and Medicaid coverage. A provider submits an outpatient 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 outpatient 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 outpatient 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) becomes the Medicaid allowed amount. The member owes $150.00 for his Medicaid incurment, so this amount is subtracted from the $250.00. Medicaid will pay the provider $100.00 for this claim.

Other Programs

The information in this chapter applies to outpatient 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 toll-free at 1-800-447-7828.

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Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms page of the Montana Healthcare Programs Provider Information website.

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