Montana Healthcare Programs

Hospital Program Officer – Valerie St. Clair

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Reminders/Updates

- Balance Billing members
  - ARM 37.85.406
- Unlisted/Unclassified Procedure Codes
- Inpatient Only procedure codes on an outpatient claim
  - ARM 37.86.3020
- Physician Administered Drug List
- Radiology
  - Original Provider Notice was posted on 03/14/18
- Fee Schedules and Provider Notices

Billing, Reimbursement, Claims Processing, and Payment – ARM 37.85.406

- Providers are required to accept, as payment in full, the amount paid by the Montana Healthcare Programs for a service or item provided to an eligible Medicaid member.
- A provider may not bill a member after Medicaid has denied payment for covered services.
- Administrative Rules of Montana - http://mtrules.org/

Private Pay Agreement – ARM 37.85.406 (11)(a)

- The agreement to pay privately must be in writing and based upon definite and specific information given by the provider to the member prior to the services being delivered/performed indicating that the service will not be paid by Medicaid. This gives them the option to deny the service.
- The private pay agreement must be in writing per occasion. This does not include routine and general contracts signed by the member at the time of acceptance into the office.
- Providers can not pick and choose which codes to have members privately pay. If it is a covered service by Medicaid they must accept the fee in full.

Unlisted Services or Procedures Codes

Provider notice posted on 04/21/17

Providers are reminded to use the most specific HCPCS code when billing a service or procedure to enable proper reimbursement. In the event an unlisted service or procedure code must be used, Montana Medicaid urges providers to send medical records with the claim. Reviewing the medical records with the claim allows the claims processing personnel to understand the situation and apply appropriate reimbursement, as well as decreases claims processing time. Medical records can be sent with electronic claims through the use of the paperwork attachment with the PWK indicator.

Cont. Billing Electronically with Paper Attachments

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

- The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. The number in the paper Attachment Control Number field must match the number on the cover sheet.

Inpatient ONLY codes on Outpatient claims

- ARM 37.86.3020 (1)(g) - The department follows Medicare guidelines for procedures defined as "inpatient only". When these procedures are performed in the outpatient hospital or birthing center setting, the claim will be denied.
- ARM 37.5.310 – Request an Administrative Review
  - Request must be in writing and received by the department within 30 days
  - State in detail the provider’s objections
  - Include substantiating documents and information for the department to reconsider

Prior Authorization – Physician Admin Drugs

Physician Administered Drugs

- Criteria published to the Medicaid provider prior authorization page
  - https://medicaidprovider.mt.gov/priorauthorization
  - Drugs are added to the list as necessary. Check your fee schedule **and** provider notices.
- Key Tips
  - Know the NPI of the provider submitting the claim
    - If the claim is to be submitted on a UB-04, know the facility's NPI
    - If the claim is to be submitted on a CMS-1500, know the group clinic or provider's NPI
  - Prior Authorization is drug specific. If the drug is billed on an unlisted code, prior authorization is still required
  - Understand the criteria prior to submission
  - Use the correct form – pharmacy prior authorization form will not work
- Timeline is generally within two to three business days
  - May take longer depending on case (have seen requests take up to 10 days)

Criteria - Radiology

Radiology

- InterQual criteria applies to CT of the Head and MRI of the Brain
- Claims system set up to authorize based on a list of approved diagnosis codes
  - CMS 1500 – Diagnosis pointer is essential for proper processing
  - UB-04 – System being updated to handle appropriately – **System updated 08/22/18**
- Headache as a primary diagnosis ***requires*** prior authorization
- Denied claims may be clinically reviewed by Mountain Pacific Quality Health
  - Send only if you believe InterQual criteria has been satisfied
- Department will monitor and phase in additional codes

As a reminder, any CT of the head or MRI of the brain where a prior authorization from MPQH has been granted must be submitted in paper form.

Fee Schedules and Provider Notices

Provider Notices and Fee schedules are updated frequently

- Provider type specific
- Archive provider notices

medicaidprovider.mt.gov

Archived Provider Notices

There are 3 Archive links to choose from:

Website Archives 1998 - 2005 Originally (Posted at http://www.dphhs.state.mt.us/)

Website Archives 2006-2016 (Originally Posted at medicaidprovider.hhs.mt.gov/index.shtml)

Website Archives 2016 - Present (Originally Posted at medicaidprovider.mt.gov)

There are 3 ways to search for a page or document:

If you remember approximately when and where you saw a document on the provider website:

1. Choose one of the links above as appropriate for the time period you are searching for..
2. Each archive link will bring you to a calendar. The calendar reflects the years the site was archived. The dates in blue are the dates in that year the site was archived and are live links.
3. If you are familiar with the document and the approximate year you are looking for, click on a date in the archive and follow the links to the page. For example, if you wish to look at the July 2006 Fee Schedule for Physicians and you remember seeing it in 2016, click on one of the links for the 2016-present archive, Choose "Provider Type", agree to the disclaimer, choose "Physician" then "Physician Fee Schedules" then "July 2006 Fee Schedule". NOTE: The search button that is housed within the webpage does not function in the archive.

Department contact list

Katie Hawkins	Hospital Section Supervisor	khawkins@mt.gov	406-444-0965
Valerie St. Clair	Hospital Program Officer	vstclair@mt.gov	406-444-4834
Becky Nettleton	Claims Resolution Physician	rnettleton@mt.gov	406-444-7002
Cassie O'Bryant	Program Officer Claims	cobryant@mt.gov	406-444-3995
Brenda Beardslee	Resolution Specialist	bbeardslee2@mt.gov	406-444-3337