Montana Healthcare Programs
Claim Jumper

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Upcoming Changes for Montana Healthcare Programs Providers - What You Need To Know

The Department of Public Health and Human Services (DPHHS) will be rolling out several changes to the Montana Healthcare Programs IT infrastructure over the next few years. A key early part of this change is a new provider services solution coming later this year. The new "Provider Services Module" includes a modern web-based Provider Enrollment Portal and the ability to update your provider information online.

In the upcoming months, DPHHS will be sending out communications to providers with more detail regarding the timing and functionality of the Provider Services Module. In addition, DPHHS will provide training opportunities and give providers the opportunity to participate in question and answer sessions with the Department.

Modernizing the Montana Healthcare Programs IT infrastructure will bring significant benefits to Montana taxpayers, members, and providers. In particular, the new provider enrollment, and self-service capabilities that the Provider Services Module delivers will make access to Montana Healthcare Programs tools and services more effective and efficient for all Montana providers.

We are excited to introduce innovative new tools to enhance provider interactions with DPHHS. We greatly value your input and your support is critical for the upcoming system changes to be successful.

Thank you in advance for your participation and cooperation.

Submitted by Mary LeMieux
MPATH Project Manager
DPHHS

Publications Reminder

It is the responsibility of all providers to be familiar with Medicaid manuals, fee schedules, provider notices for their provider type, and information published in *Claim Jumper* issues and on the Montana Healthcare Programs Provider Information website.

Help Us Help You!

Take the Training Survey!

Get Answers You Need!

You Asked - We Answered

Does Medicaid pay co-payments if Medicaid is secondary insurance?

In general, Montana Healthcare Programs do not pay primary co-payments, also known as co-insurance.   There is one exception according to the General Manual: A Qualified Medicare Beneficiary (QMB). If a member only has QMB, Medicaid will make payments toward the Medicare coinsurance and deductible only. Additionally, if the member has QMB as well as Medicaid, and the service is covered by Medicare but not Medicaid, Montana Healthcare Programs will pay all or part of the Medicare coinsurance and deductible. If a service is covered by Medicaid but not by Medicare, then Montana Healthcare Programs will be the primary payer for that service.

Could you please clarify differences between the SLMB program and the QMB program?

Both the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) programs are Medicare Savings Programs that provide Medicare Buy-in benefits to people with Medicare whose incomes are too high to qualify for Medicaid.

QMB may cover both Medicare Part A and B premiums, co-payments/coinsurance and deductibles. SLMB may cover Medicare Part-B premium only. Both programs entitle the member to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D). Below is an explanation which may be found in the Member Eligibility and Responsibilities chapter of the General Manual:

Medicaid Benefits for Dually Eligible Members

Type of Dual Eligible: QMB only
Medicare Premium Paid by: Medicaid
Medicare Coinsurance and Deductible Paid by: Medicaid*

Type of Dual Eligible: QMB/Medicaid
Medicare Premium Paid by: Medicaid
Medicare Coinsurance and Deductible Paid by: Medicaid*

Type of Dual Eligible: Other dual eligibles
Medicare Premium Paid by: Member
Medicare Coinsurance and Deductible Paid by: Medicaid*

Type of Dual Eligible: Specified Low-Income Medicare Beneficiary
Medicare Premium Paid by: Medicaid
Medicare Coinsurance and Deductible Paid by: Member

See the How Payment Is Made chapter in your provider type manual to learn how Medicaid calculates payment for Medicare coinsurance and deductibles.

Can Medicaid members be charged for missed appointments?

The Billing Procedures chapter of the General Manual provides a list of specific situations when providers may ***not*** bill members. Included in that list is "When a member fails to arrive for a scheduled appointment." Therefore, Medicaid members may not be charged for missed appointments.

Do you have a general question you would like answered?

Visit the Training Survey! Insert your question in the box under question five. We can answer your question in a future issue of the Claim Jumper or, if you leave your contact information, Provider Relations will respond directly to you. You may also email MTPRHelpdesk@conduent.com.

Billing of Medicaid Nursing and Swing Bed Facilities and Hospice Room and Board Charges

Hospices participating in the Montana Medicaid Hospice Program may bill for room and board for Medicaid hospice members. The Administrative Rule of Montana (ARM) 37.40.830 (4) states:

> *"The room and board rate to be paid a hospice for a Medicaid recipient who resides in a nursing facility will be the Medicaid rate established by the department in ARM 37.40.307 for the individual facility minus the amount the recipient pays toward his own cost of care. Payment for room and board will be made to the hospice and, in turn, the hospice will reimburse the nursing facility.*
>
> *General inpatient care or hospice respite care in a nursing facility will not be reimbursed directly by the Medicaid program when a Medicaid recipient elects the hospice benefit payment. Under such circumstances payment will be made to the hospice in accordance with this rule."*

Nursing or swing bed facilities (NF/SB) are not allowed to bill Medicaid directly for room and board charges when a member is receiving Medicaid hospice services. It is the NF/SB's responsibility to invoice the hospice provider for the member's room and board costs minus any amount the member pays toward his own cost of care. This amount is considered a "third party liability". General inpatient care or hospice respite care in a nursing facility will not be reimbursed directly by the Medicaid program when a Medicaid recipient elects the hospice benefit payment. Under such circumstances payment will be made to the hospice in accordance with this rule."

Hospice providers must submit the invoiced amount received from the NF/SB for the member's room and board to Medicaid. The hospice will reimburse the NF/SB upon receipt of the payment.

Please refer to the Nursing Facility Medicaid Rates which are updated annually. Rates are provided on the Department website: https://dphhs.mt.gov/sltc/csb/provider#287023784-nursing-facilities-and-swing-bed-services.

Please direct any questions regarding this policy to Micky Brown, Hospice Program Manager, at 406- 444-6064 or email at mbrown2@mt.gov.

Submitted by Mickey Brown
Medicaid Home Health and Hospice Program Manager
DPHHS

Register Now for Upcoming WebEx Training

Dental Update WebEx
Thursday, March 21, 2019 2PM MST
Presented by: Kelly Aughney, Montana Medicaid and HMK Dental Program Officer, Allied Health
	Services Bureau, DPHHS
Information about the restored adult dental services and rate increases.

SURS Update WebEx
Thursday, April 18, 2019 2PM MST
Presented by: Jennifer Tucker, CPC, SURS Supervisor,
DPHHS

Third Party Liability WebEx
Thursday, May 16, 2019 2PM MST
Presented by: Olivia J Roussan, Third Party Liability Section Supervisor, DPHHS
Information about Billing Medicaid when there is a primary insurance available.

Recent Website Posts

Below is a list of recently published Medicaid information and updates available on the Provider Information website. On the website, select "Resources by Provider Type" in the left menu to locate information specific to your provider type. If you cannot locate the information below, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena.

Provider Notices		
02/15/2019	FQHC, RHC	DOT Medical Examination
02/15/2019	CAS, Hospital Outpatient, IDTF, Mid-Levels, Physicians	Claims Processing for CT of the Brain and MRI of the Head
02/15/2019	CAS, Hospital Outpatient, IDTF, Mid-Levels, Physicians	Systematic Approval Diagnosis for MRI of the Head and CT of the Brain
02/19/2019	Dentists, Denturists	Deleted Dental Codes D1515 and D9940
02/20/2019	Hospital Inpatient, Hospital Outpatient	Reimbursement Rate Change
02/20/2019	CAS, FQHC, Inpatient Hospital, Outpatient Hospital, RHC	Telehealth Originating Site Facility Fee
02/21/2019	Dentists	Orthodontia Prior Authorization Procedure Change
02/21/2019	FQHC, RHC	Dental Hygienist and Dental Hygienist with Limited Access Permit (LAP)
02/27/2019	FQHC, Hospital Outpatient, RHC	Billing Multiple Same-Day Visits on a UB-04 or 837I and Condition Code G0

Manuals
RFC/FQHC Manual Revised

Fee Schedules
January 2019
APC, IHS, OPPS
July 2018 Fee Schedules
APR-DRG revised

Forms
Amendment to Passport and Team Care Agreement for Private Group Practices Form, HHS 687 Consent for Sterilization Form, MA-3 Form, T-HIP Member Opt-In Form, T-HIP Provider Referral Form

Other Resources
- DURB Agenda February 27, 2019   - DUR PDL Agenda March 27, 2019   - CMBH WebEx PowerPoint   - SURS Update WebEx Training Registration   - TPL Update WebEx Training Registration

Top 15 Claim Denial Reasons

Exception	December 2018	
EXACT DUPLICATE	1	2
PA MISSING OR INVALID	2	6
RECIPIENT NOT ELGIBLE DOS	3	3
FILL TOO SOON	4	5
REFILL TOO SOON	5	4
RATE TIMES DAY NOT = CHARGE	6	8
MISSING/INVALID INFORMATION	7	7
NDC MISSING OR INVALID	8	1
DRUG CONTROL CODE = 2 (DENY)	9	9
PASSPORT PROVIDER NO. MISSING	10	12
PROC. CODE NOT COVERED	11	10
RECIPIENT COVERED BY PART B	12	15
DISPENSE AS WRITTEN	13	23
INVALID REV CODE FOR FACILITY TO BILL	14	13
DAYS SUPPLY MISSING	15	16

SURS Audit Revelations

Documentation Matters

The Administrative Rule of Montana (ARM) 37.85.414 (1) states, "All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana Medicaid recipients. The records must support the fee charged or payment sought for the services and items and demonstrate compliance with all applicable requirements."

There are great tools out there to help providers with documentation. The Centers for Medicare & Medicaid Services (CMS) provides information on how to implement good documentation practices to assist providers in being compliant with State and Federal laws. The CMS Documentation Matters Toolkit includes presentations, handouts and fact sheets for Medical Professionals, Behavioral Health Practitioners and Medical Office Staff.

Documentation of medical records is critical to a successful practice – thorough and accurate documentation helps medical professionals provide needed information in a timely efficient manner. Please follow the link below for additional information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html.

Submitted by Scott Sala
Program Integrity Compliance Specialist
Quality Assurance Division
DPHHS

Key Contacts

Montana Healthcare Programs Provider Information
https://medicaidprovider.mt.gov/
Conduent EDI Solutions
http://edisolutionsmmis.portal.conduent.com/gcro/

Provider Relations
MTPRHelpdesk@conduent.com
P.O. Box 4936
Helena, MT 59602
(800) 624-3958 In/Out of state
(406) 442-1837 Helena
(406) 442-4402 Fax

Third Party Liability
P.O. Box 5838
Helena, MT 59604
(800) 624-3958 In/Out of state
(406) 443-1365 Helena
(406) 442-0357 Fax
Claims Processing
P.O. Box 8000
Helena, MT 59604

EFT and ERA
Fax completed documentation to Provider Relations,
(406) 442-4402.

Verify Member Eligibility
FaxBack (800) 714-0075 or
Voice Response (800) 714-0060

POS Help Desk for Pharmacy
(800) 365-4944

Passport
(800) 362-8312

PERM Contact Information
KCronholm@mt.gov
(406) 444-9365
website: http://dphhs.mt.gov/qad/PC/PERMPC

Prior Authorization

OOS Acute & Behavioral Health Hospital, Transplant, Rehab & PDN:
(406) 457-3060 (Helena) or
(877) 443-4021 (Toll Free)
Fax:

(406) 513-1923 Helena or
(877) 443-2580 (Toll Free)
MPQH – DMEPOS/Medical
(406) 457-3060 Helena or
(877) 443-4021
Fax:
(406) 513-1923 Helena or
(877) 443-2580
Magellan Medicaid Administration
Phone: (800)770-3084 (opt 3)
Fax: (800) 639-8982