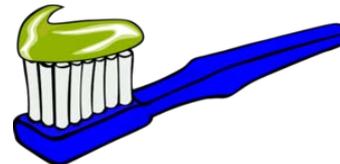
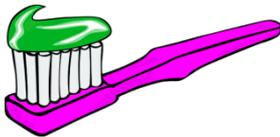


# Healthy Montana Kids *Plus*, Medicaid and HELP Dental Program

## Reviews and Updates May 2017

Welcome to the MDA Annual Meeting!

*Presented by Jan Paulsen, Program Officer*



# For Successful MT Healthcare Program Claims

## *SELF-SERVICE, WHEN EVER POSSIBLE*

### **Every Week Visit:**

1. The Montana Healthcare (MATH)Web Portal
2. Recent Website Posts Page
3. The Announcements Page
4. Forms Page
5. Your Provider Type Page.  
*Resources by Provider Type: fee schedules, provider notices, provider manual, etc*
6. The Training Page
7. Claim Jumper
8. Resources



[www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov)

Regardless of which card is presented it is **STANDARD Medicaid**  
**Medicaid HMK**

Plus



**HELP MEDICAID**

Subscriber Name: <F_NAME M_INIT L_NAME>	HELP Plan
Identification Number: YDM<SBSB_ID>	
Plan Code 752	RxBin: 610084 RxGroup: 1509040 RxPCN: DRMTPROD

[www.bcbsmt.com](http://www.bcbsmt.com)

	Participant Services 1-877-233-7055 HELP Med Services 1-877-296-8206 24/7 Nurse Advice Line 1-877-213-2568
Providers medical and accident-related dental claims: BCBSMT PO Box 3387 Scranton, PA 18505. 1-877-233-7055. Inpatient Admissions and Major Medical procedures: BCBSMT 1-877-296-8206.	Dental, pharmacy and other benefits administered by DPHHS 1-800-362-8312.
This participant has limited benefits outside of Montana. Providers should request eligibility/benefit information.	BlueCross and Blue Shield of Montana, an independent licensee of BlueCross and Blue Shield Association, provides claims processing only and assumes no financial risk for claims.

# Standard Dental Benefits

(EVERYONE HAS THE STANDARD PLAN OF BENEFITS)

*...Some have the \$ limit and some do not*

New cycle effective July 1, 2017- June 30, 2018

- ❖ All adult Medicaid members will have an annual dental **treatment limit** of \$1,125 (this excludes diagnostic, preventive, dentures, and anesthesia services)
- ❖ The \$1125 limit is claims paid per date of service between July-June at the Medicaid paid rate.
- ❖ Some adult members are excluded from the annual **treatment limit**, those with a category of eligibility that includes Aged, Blind, or Disabled, and children under age 21. Service limits still apply.
- ❖ At this time you must call the Help-line to inquire on detail of eligibility, the system upgrades are not completed.

# Standard Medicaid

Second to the \$1125 adult  
**treatment limit** are

## ***Adult SERVICE LIMITS***

*Good Bye Basic and Full Medicaid,  
Hello Standard Medicaid*

Always check eligibility  
status prior to sitting in the  
dental chair.

Check service limits-adults

- Diagnostics
- Radiographs
- Prophys and Fluoride
- Crowns
- Periodontics
- Dentures, full/partial



# Adult Treatment Services

Treatment services included in the annual \$1,125 cap are:

D2XXX: Fillings and crowns

D3XXX: Root canals

D4XXX: Periodontal services

D6950: No Bridge benefit for adults-paid through age 20 only

D7XXX: Dental surgery



**Always check status of paid claims and amount used toward the limit prior to sitting in the dental chair.**

# Excluded from financial limit

Services not included in the \$1125 financial limit are:

Diagnostic: D0XXX

Preventive: D1XXX

Denture: D5XXX

Anesthesia services: D9223, D9243 and D9248.



**Periodic service limits apply (cleanings 2/yr., etc.), always check on historical utilization. If appropriate, these claims will pay even when the financial limit has been met. Copays may apply.**

# No Financial Limit

Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual limit, although service limits apply.

Children age 0–20 are not subject to the annual limit.

System upgrades are not yet completed, call to verify the category of eligibility.



# Private Pay Agreement (PPA)

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. If it is not on the fee schedule it can be pre-agreed for private pay. (Treatment services beyond the \$1125 limit are considered non-covered services and require a PPA).

ARM 37.85.406 (11)(a)



## FREQUENTLY ASKED QUESTIONS

1. Can I limit the numbers of Medicaid patients I see in my office?

*Yes, simply make a business decision as to how many Medicaid members your office can handle. Many offices do this.*

2. Can I accept or reject them on a case-by-case basis?

*Yes, as long as you do not discriminate. When you sign up as a Medicaid provider you agree not to discriminate on the grounds of race, creed, religion, color, sex, national origin, marital status, age or disability.*

3. Will I be listed anywhere as a Medicaid provider?

*Yes, the Department does maintain a list of participating providers on the Montana Access to Health web portal. An updated list of dental providers who are currently accepting Medicaid patients is also on the Department's website, [www.medicaprovider.mt.gov](http://www.medicaprovider.mt.gov), and is updated quarterly.*

## Frequently Asked Questions, continued

4. When do I file an adjustment? *If the claim paid wrongly you file an adjustment. If the claim denied, file a new claim.*
5. Since Medicaid does not mail out new information, how will I find out when things change? *Provider notices are located at [www.medicicaidprovider.mt.gov](http://www.medicicaidprovider.mt.gov) go to resources by provider type. We recommend providers go to this site at least monthly to find updates including the monthly Claim Jumper newsletter.*
6. If I am not an enrolled Medicaid Provider, can I have another provider bill for me the services I provided to a Medicaid member?  
***NO***, *an enrolled provider can not bill for services they did not personally provide.*

## Frequently Asked Questions, continued

7. If I sign up as a Medicaid provider, do I have to accept all patients that call my office?

*NO, simply make a business decision as to how many Medicaid members your office can handle. Many offices do this.*

8. When the ADA releases a new procedure code that more accurately describes a procedure, but it is not a covered procedure on the Medicaid fee schedule, should we still bill the old code?

*The doctor must choose a code that most accurately matches the procedure that was performed. If there is not one on the Medicaid fee schedule, you may decide PRIOR to the procedure occurring, to set up a private pay agreement for the procedure code not on the fee schedule that the dentist is recommending for treatment. The medical record must match the claim.*

9. What happens when a patient is not satisfied with the dental work performed?

*If they contact Medicaid and we verify the service was provided and the claim was paid, there is no adverse action. We refer them to the Board of Dentistry as that group provided oversight in regards to professional behavior of each licensed dentist.*

## Frequently Asked Questions, continued

10. Does Medicaid cover Bridges?  
*Yes, through age 20 on anterior teeth only.*
  
11. Does Medicaid cover dental implants?  
*No, no one's plan of benefits includes dental implants.*
  
12. Does Medicaid cover mouth guards?  
*Yes, through age 20. There is no provision for disabled adults.*
  
13. I do not like my new dentures, what can I do about that?  
By licensing requirements, Denturist have a 90-day guarantee rule to continue adjusting and re- working the denture to make them work without charge.

## Frequently Asked Questions, continued

14. What amount counts towards the limit, the amount billed or the amount paid? *Amount paid out by Medicaid.*
15. After the limit is met, do I have to charge the member the Medicaid fee? *You can charge your U & C or the Medicaid fee, your decision.*
16. Generally, how will I know what codes pay, how much they pay and for what ages?  
*The fee schedule is located at [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov), go to resources by provider type. Also listed on the fee schedule are service limits for adults.*
17. At what age is a Medicaid member considered an adult?  
*21*

## Frequently Asked Questions, continued

18. How do I know what codes represent Diagnostic, Preventive and Denture (Prosthodontics, removable)?  
*We follow the same classification of Materials as listed in the ADA CDT Dental Procedure Codes book.*
  
19. What happens when I prepare a denture for a patient and they decide they do not want it (for various reasons) and/or they went somewhere else and got another one prepared?  
*We recommend you have the patient sign a 'Member Acknowledgment' once the final impression is sent to the lab (page 2.11 of manual).*
  
20. Are there any allowable reasons that someone can get needed services over the \$1125 limit?  
*No, there are no provisions for extended benefits.*

# TOP THREE FRUSTRATIONS

## 1. No Show/Broken Appointments

- Each office is encouraged to have a general office procedure for reminders.
- All patients need to be treated the same in terms of reminders and no shows.  
Cannot bill patient.
- There are a variety of best practices; find what works for your office.
- Consistency is important.
- No show, no procedure performed, nothing to claim. Cannot bill patient.



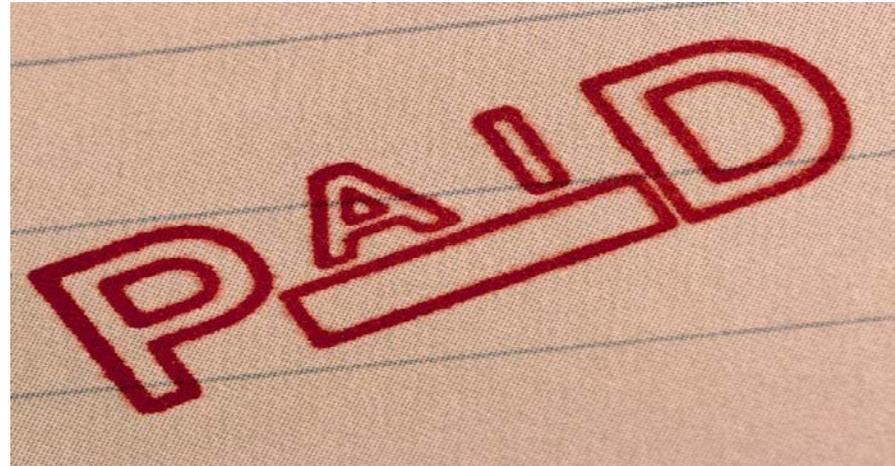
## 2. Minimize Administrative Hassles

- Use the ADA form dated 2012.
- Attach special forms, such as EOBs for other insurance or a blanket denial letter. Staple any form on top of the claim.
- Document disability or the reason for exceeding limits in box 35.
- Include PA number in box 2; do not attach the approval notice.
- Consider filing electronically.
- Follow up on e!SOR sooner rather than later.



# 3. Reimbursement Too Low?

- File claims with your usual and customary fee.
- Get paid for what you do, verify eligibility, check fee schedule, be aware of allowable procedures, limits, etc.
- If prior authorization is required make sure you go through the process and put the PA number in box 2.



# OTHER BARRIERS IDENTIFIED

- Limited availability of dental providers
- Lack of clear information for beneficiaries explaining their dental benefits
- Transportation (1-800-292-7114)
- Cultural and language competency (may require the services of an interpreter)
- Need for consumer education about the benefits of dental care



# Who is Eligible for Dental Services

Patients on Standard Medicaid  
That is EVERYONE

- Aged, Blind, Disabled;
- 20 years and under;
- Pregnant woman;
- Families and Transitional and
- HELP Expansion group.

**NOT QMB or SLMB**



# Verifying Member Eligibility

- FaxBack: 800-714-0075
- Integrated Voice Response (IVR): 800-714-0060
- MATH Web Portal  
<https://mtaccesstohealth.acs-shc.com/mt/secure/home.do>
- Xerox Provider Relations: 800-624-3958



## 2- Websites

### Provider Information Website (open to the public)

[www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov)

- Member information link
- Provider Information page
- Claim Jumper newsletter
- Provider Enrollment link (new or existing providers).
- MATH Web Portal link
- Provider Locator link (user is brought to web portal)
- Resources by Provider Type (manuals, fee schedules, notices)



### Montana Access to Health Web Portal (requires login)

<https://mtaccesstohealth.acs-shc.com/mt/secure/home.do>

- Check eligibility
- Claim status
- Payment summary
- e!SOR

# Montana Dental Rate Setting Process

- The Department reimburses dental and denturist services on a fee-for-service basis. Reimbursement rates are established by multiplying a nationally recognized unit value for each procedure by the Department's conversion factor.
- *Relative Values for Dentists* (RVD) is an accurate and comprehensive relative value system. The relative values for each procedure are determined by dental practitioner input.
- Six criteria are used to rate each procedure.



## The six criteria used to rate a procedures value

1. Time
2. Skill
3. Risk to the patient
4. Risk to the dentist (medico-legal)
5. Severity of the problems  
(i.e., emergent, acute, chronic, prophylactic).
6. Unique supplies not separately billable



# Department Calculation of Rate

1. Determine utilization of each procedure from previous year.
2. Multiply each procedure code's utilization by its unit value based on the Relative Values for Dentists.
3. Obtain the upcoming year's budget amount.
4. Total budgeted dollar amount is divided by previous year's utilization of all procedures.
5. The result determines the Montana Medicaid Dental conversion factor (CF) = \$33.78 for SFY18.
6. The rate for each procedure is determined by multiplying the unit value by the conversion factor.
7. Examples:
  - (a) D1110 has a unit value of 1.50 multiplied by the CF = \$50.67.
  - (b) D2140 has an assigned unit value of 2.0 times CF = \$67.56.

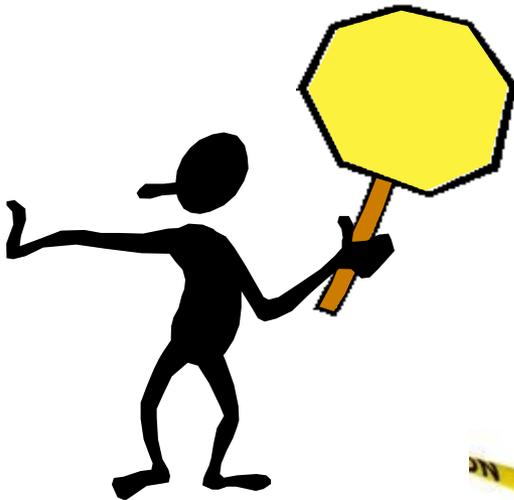


# What needs Special Processing

- Check service limits-adults
  - Diagnostics
  - Radiographs
  - Prophys and Fluoride
  - Crowns
  - Periodontics
  - Dentures, full/partial

## Prior Authorizing (PA)

- All Orthodontia



# ***Orthodontia Services***

***D8XXX – Orthodontia codes are payable for ages 0-20***

## ***Prior Authorization Process***

HLD-Index, pano, ceph and photos.

Banding fee (D8050, D8060, D8070, D8080, and D8090,

Periodic visits (D8670), de-band and final retention (D8680).

Eligibility must be on-going, private pay agreement in place. TPL-Blanket Denial.



# FORMS

[www.medicicaidprovider.mt.gov](http://www.medicicaidprovider.mt.gov)

- ADA Dental Claim Form, Prior Authorization box checked
- Handicapping Labio-Lingual Deviations Form (HLD Index)
- Revised 9/2013, added posterior impactions and anterior crossbite

http://medicaidprovider.mt.gov

MONTANA.GOV  
OFFICIAL STATE WEBSITE

SERVICES AGENCIES LOGIN SEARCH

[Claim Instructions](#)

[Claim Jumper Newsletters](#)

[Contact Us](#)

[Definitions and Acronyms](#)

[Enhanced Payment](#)

[Electronic Billing](#)

[EPSDT](#)

[FAQs](#)

[Forms](#)

[Health Improvement Program](#)

[ICD-10](#)

[CMS-1500 \(04.14\)](#)

As of April 1, 2014, this is the accepted version of the CMS-1500.

[CSCT Team Enrollment 04.2013](#)

[Cultural and Language Services Invoice 04.2015](#)

[Cultural and Language Services Policy 04.2015](#)

[Dental Claim Form 2012 04.2014](#)

[Dental Emergency Services Form 07.2013](#)

All fields must be completed **and** the form must be signed, dated, and attached to an ADA Dental claim form.

[Dental HLD Index and Prior Authorization Treatment Plan 09.2013](#)

[DME CMN Augmentative Communication Device 10.2014](#)

[DME CMN Enteral Therapy 10.2014](#)

[DME CMN EPSDT Nutrition 10.2014](#)

[DME CMN Hospital Bed 10.2014](#)

[DME CMN Manual Wheelchair 10.2014](#)

# Crown Service Limits for Adults

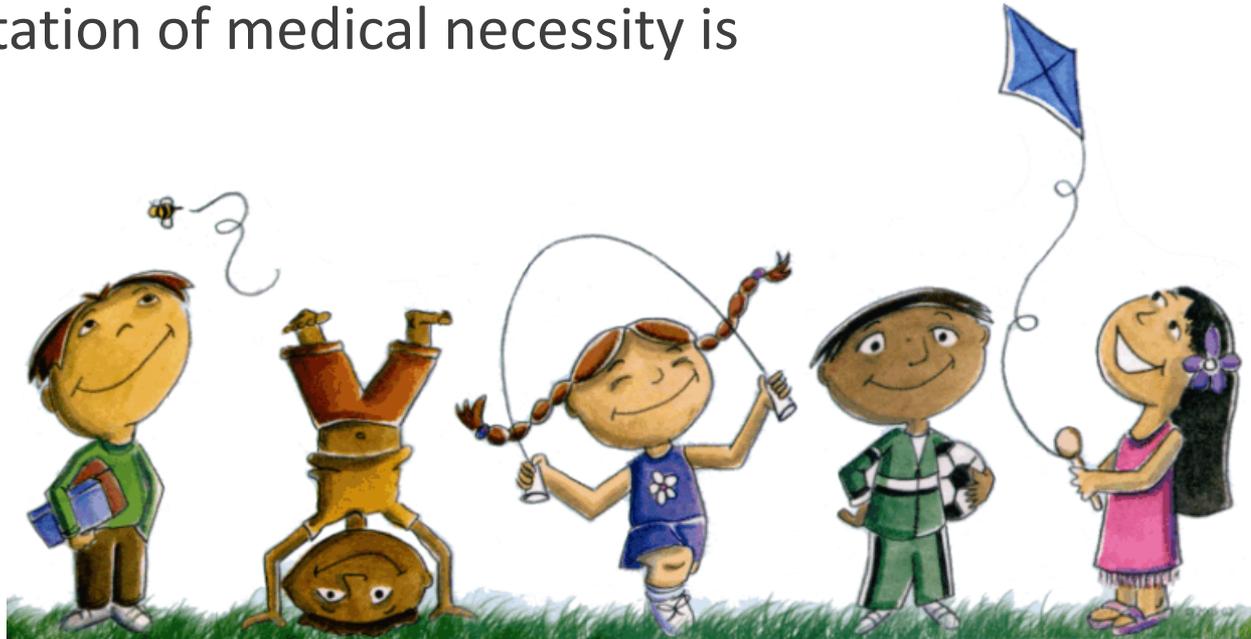
- D2751
- 2 per calendar year per person
- Second Molars:  
#2-15-18-31= D2781 or D2791
- Re-treatment of the same tooth number, 1/5 years.



# Early and Periodic Screening, Diagnosis and Treatment – EPSDT

When a Medicaid-eligible child (20 and under) requires medically necessary services, those services may be covered under Medicaid even if they are not typically covered services or if periodic limits need to be waived.

Documentation of medical necessity is  
**VITAL.**



# Medical Necessity definition

ARM 37.79.102 (23) "Medically necessary" or "medically necessary covered services" means services and supplies which are necessary and appropriate for the diagnosis, prevention, or treatment of physical or mental conditions as described in this subchapter and that are not provided only as a convenience.



# Medical Necessity

Medicaid does not cover cosmetic dental services.



# MONTANA MEDICAID SUPPORTS THE PRACTICE STANDARD: AbCd

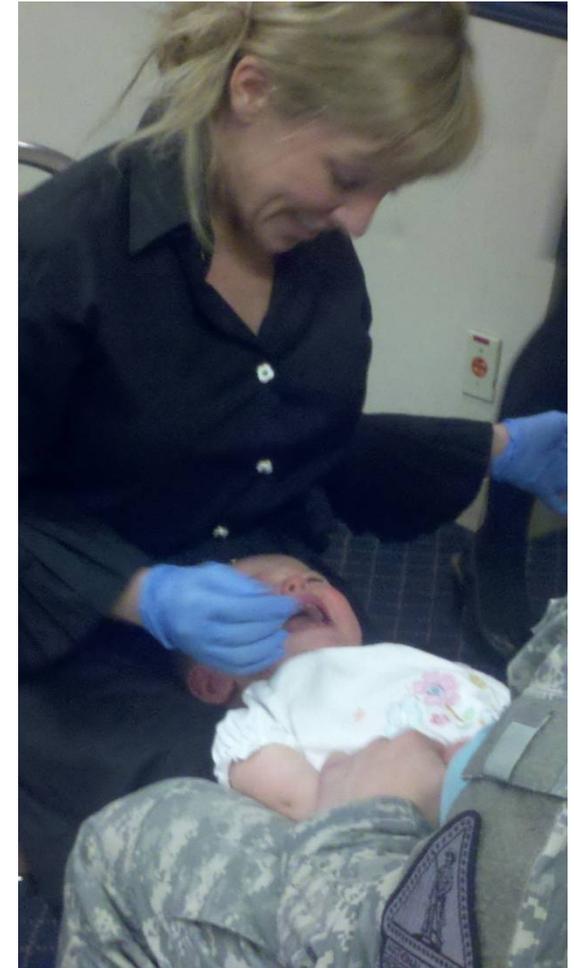
Access to Baby and Child Dentistry – AbCd

First Birthday, First Dental Appointment

Dentists must receive continuing education in early pediatric dental techniques to qualify as an AbCd specialist.

This specialty endorsement will allow AbCd dentists to be reimbursed for the following procedures:

- D0145, Oral evaluation (age 0–2),
- D0425, Caries Susceptibility Test (age 0–2)
- D1310, Nutritional Counseling (age 0–5),
- D1330, Oral Hygiene Instruction (age 0–5).



**265 Medicaid Providers have been trained in AbCd, thanks Dr. G!**

# CHIPRA LEGISLATION



List of dental providers who are currently accepting Medicaid for under age 21 will be posted.

Updated quarterly, expect an e-mail!

[www.insurekidsnow.gov](http://www.insurekidsnow.gov)

CMS/HRSA/IKN completes annual survey to verify data.

# ***BE IN THE KNOW and be ready!***

- PA means prior authorization NOT periapical.
- When you call, have ready:
  1. Member ID (Use Medicaid ID not SS #)
  2. Date of service
- Resources by Provider Type  
[www.medicicaidprovider.mt.gov](http://www.medicicaidprovider.mt.gov)
- Multiple units
- ‘Pay to dentist’ and ‘Rendering dentist’ NPI’s and Taxonomy.



# Dental Advisory Committee (DAC)

- ✓ General Dentist
- ✓ Denturist
- ✓ Pediatric Dentist
- ✓ Orthodontist
- ✓ Oral Surgeon
- ✓ Dental Hygienist
- ✓ MT Dental Association
- ✓ DPHHS



# Montana Medicaid

## Enrolled Dental Resources

- 491 Dentists
- 26 Hygienists (15 active LAP)
- 21 Denturists
- 11 Community Health Center Dental Clinics
- 5 IHS Dental Clinics

# ADA Claim Form 2012 version - Required

The ADA Dental Claim Form has been revised to incorporate key changes to the HIPAA standard electronic dental claim transaction. Some of the changes include the reporting of diagnosis codes and diagnosis code pointers, place of service codes, and other medical and dental coverage. It also includes a column for units of service.

Use of this form is required now.

ADA American Dental Association® Dental Claim Form															
<b>HEADER INFORMATION</b>															
1. Type of Transaction (Mark as applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Pre-determination/Preauthorization <input type="checkbox"/> EPSDT / The NIX															
2. Provider/Member/Prescription Number															
<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #1)															
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>															
3. Company/Plan Name, Address, City, State, Zip Code															
14. Date of Birth (MM/DD/CCYY)    15. Gender <input type="checkbox"/> M <input type="checkbox"/> F    16. Policyholder/Subscriber ID (SSN or ID#)															
<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)															
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)															
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other															
17. Employer Name															
<b>PATIENT INFORMATION</b>															
6. Date of Birth (MM/DD/CCYY)    7. Gender <input type="checkbox"/> M <input type="checkbox"/> F    8. Policyholder/Subscriber ID (SSN or ID#)															
19. Reserved For Future Use															
9. Relationship Number    10. Patient's Relationship to Person named in #1: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code															
21. Date of Birth (MM/DD/CCYY)    22. Gender <input type="checkbox"/> M <input type="checkbox"/> F    23. Patient ID/Account # (Assigned by Dentist)															
<b>RECORD OF SERVICES PROVIDED</b>															
24. Procedure Code (MM/DD/CCYY)	25. Area of Care (Code)	26. Tooth System	27. Tooth Number(s) of Tooth(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Factor	29b. Qty.	30. Description	31. Fee						
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100															
33. Missing Teeth Information (Place an "X" on each missing tooth.)															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
34. Diagnosis Code (or Qualifier)	35. Diagnosis Code(s)										36. Other Fee(s)				
A	B										C				
37. Remarks															
<b>AUTHORIZATIONS</b>															
38. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.															
39. Patient/Guardian Signature _____ Date _____															
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.															
38. Subscriber Signature _____ Date _____															
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)															
40. Name, Address, City, State, Zip Code															
41. NPI _____ 42. License Number _____ 43. SSN or TIN _____															
44. Phone Number ( ) - _____ 45. Fax Number ( ) - _____ 46. Billing Provider ID _____															
<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>															
40. Place of Treatment (Use 1-11 for office, 12-18 for Hospital (Use "Place of Service Codes for Professional Claims")															
41. Enclosures (Y or N) <input type="checkbox"/>															
42. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 4-4-2) <input type="checkbox"/> Yes (Complete 4-4-2)															
43. Date Appliances Placed (MM/DD/CCYY)															
44. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 4-4-2)															
45. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 4-4-2)															
44. Date of Prior Placement (MM/DD/CCYY)															
45. Treatment Involving Root <input type="checkbox"/> Occupational stress/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident															
46. Date of Accident (MM/DD/CCYY)															
47. Auto Accident State															
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>															
48. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.															
49. Signature (Treating Dentist) _____ Date _____															
50. Address, City, State, Zip Code															
51. License Number _____ 52. NPI _____ 53. SSN or TIN _____															
54. Phone Number ( ) - _____ 55. Fax Number ( ) - _____ 56. Billing Provider ID _____															
©2012 American Dental Association    ADA00 (Claims on ADA Dental Claim Form - ADA00, ADA1, ADA2, ADA3, ADA4)															

# Record Keeping

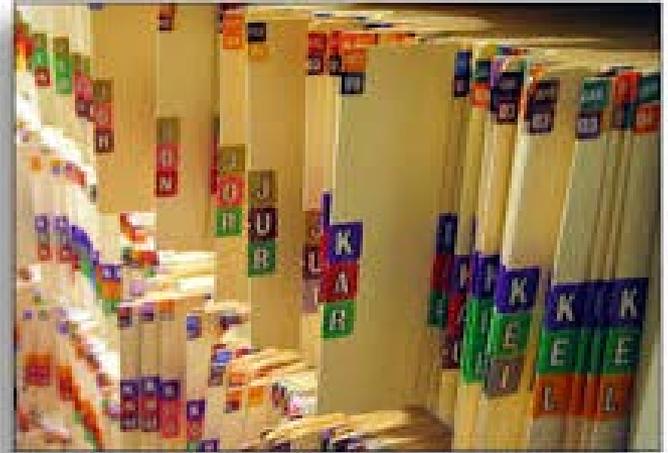
The dental record must be:

Authentic

Legible

Objective

Clear on the disease condition that made the treatment necessary



#1 Rule of Documentation

If you didn't write it, it didn't happen!

## Copayment Requirements for ALL Members

- Copayments are assessed only after the claim is processed. See your weekly remittance advice for amount you can bill the member.

# Example of Copay as displayed on the eSOR!

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
	[REDACTED]		03012016 03012016	1.000	05225	706.73	706.73		T
ICN 01606411507004300 PATIENT NUMBER=									
	00 [REDACTED]		03012016 03012016	1.000	05226	706.73	706.73		T
			03012016 03012016	1.000	02391	66.36	66.36		T
***LESS COPAY DEDUCTION*****								78.97	
***CLAIM TOTAL*****						1479.82	1400.85		

# HELP Plan Copayment Requirements

Services Exempt from Copayment  
under Federal or State Law:

- ✓ Emergency Services
- ✓ Preventive Services  
(including primary,  
secondary, or tertiary)
- ✓ Family Planning Services
- ✓ Pregnancy Related  
Services
- ✓ Generic Drugs
- ✓ Immunizations
- ✓ Medically Necessary

*Important: Copayments may not be charged to the participant until the claim has been processed through the claims adjudication process and the providers has been notified of payment and amount owing.*

# Medicaid Transportation Services

- *The Medicaid Transportation Center must approve all trips before the travel in order to get paid.*

- Personal transportation (privately owned vehicle)



- Specialized non-emergency transportation (wheelchair or stretcher van)



- Commercial transportation (taxi, bus, etc.)



# How we Communicate with your Office

- Notices from MMIS
- [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov)

- Provider notices
- Fee schedules
- Provider manuals
- Remittance advice
- Claim Jumper
- Web Portal

<https://mtaccesstohealth.uccshc.com/mt/secure/home.do>



# Again, proceed with caution. Refer to the provider manual.



There may be limits per procedure, per tooth, per quadrant, anterior/posterior, or prior authorization requirements.

See the fee schedule and provider manual online for reimbursement rates.

Additional resources are found at [www.medicicaidprovider.mt.gov](http://www.medicicaidprovider.mt.gov). Click the Resources by Provider Type link.

Xerox Provider Relations  
800-624-3958.



# Thank you for your time!

I am a resource as well. Feel free to contact me with any further questions or unique issues to discuss.

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