Montana Healthcare Programs

Pediatric Complex Care Assistant (PCCA) Services

Effective September 1, 2025

Pediatric Complex Care Assistant Services

Printing the manual material found at this website for long-term use is not advisable. Department of Public Health and Human Services (DPHHS) policy material is updated periodically, and users are responsible for ensuring the policy they are researching or applying has the correct effective date for their circumstances.

Publication History

This publication is the initial Pediatric Complex Care Assistant (PCCA) Services Manual. Published by the Montana Department of Public Health and Human Services (DPHHS) on 09/01/2025.

Montana Code Annotated (MCA) 53-6-1402 (3) (a) allows the Department or an auditor to request up to six months of records from a provider for claims paid by the Medicaid program up to three years before the request date.

Pediatric Complex Care Assistant (PCCA) Services Manual updates include:

09/01/2025

- Initial publication

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Key Contacts and Websites

Refer to the Contact Us page on the Montana Healthcare Programs Provider Information website for a list of key contacts and websites.

- Refer to the **Department of Public Health and Human Services (DPHHS) tab** for Pediatric Complex Care Assistant Service staff and other DPHHS contact information.
- Refer to the Utilization Review Contractor tab for prior authorization (PA) information.
- Refer to the E**lectronic Visit Verification (EVV) Contractor tab** for EVV information.

To access the provider type page from the Home page of the Provider Information website, access **Resources by Provider Type** in the lefthand menu. Once you have read and accepted the End User Agreement, you can access the Pediatric Complex Care Assistant webpage from the alphabetical list of provider types on the provider type page.

Introduction

Thank you for your willingness to serve members of Montana Healthcare Programs, administered by DPHHS.

Pediatric Complex Care Assistant (PCCA) Services support Montana Healthcare Programs (Medicaid) members under the age of 21 who have medically complex needs, by compensating family caregivers for specialized care. These services fill care gaps without replacing existing programs such as Private Duty Nursing, Community First Choice Services (CFCS)/Personal Care Services (PCS), or Home Health Services.

Manual Organization

This manual provides information specifically for providers of Pediatric Complex Care Assistant (PCCA) services. Other essential information for providers is contained in the separate General Information for Providers Manual. Providers are required to read both manuals.

Manual Maintenance

Notification of manual updates are provided through the weekly web postings under Recent Website Posts, which is accessed at the bottom of the Home page on the Provider Information website or through the Site Index drop-down in the left menu.

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Rule References

Providers, office managers, billers, and other medical staff should familiarize themselves with all current administrative rules and regulations governing Montana Healthcare Programs.

Provider manuals are to assist providers in billing Montana Healthcare Programs: they do not contain all Montana Healthcare Programs rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **If a manual conflicts with a rule, the rule prevails.**

Rules are available to print through the Secretary of State's website.

Providers are responsible for knowing and following current laws and regulations specific to Medicaid. Links to rules are also available on your provider type page on the Provider Information website.

In addition to the general rules outlined in the General Information for Providers Manual, the following rules and regulations are also applicable to PCCA services:

- Code of Federal Regulations (CFR)
  - 42 CFR 440.100
  - Section 1905(a)(10) of the Social Security Act

- Montana Code Annotated (MCA)
  - 37-2-603, MCA
  - 37-2-610, MCA

- Administrative Rules of Montana (ARM))
  - ARM 24.160.501
  - ARM 24.160.505
  - ARM 37.40.1501
  - ARM 37.40.1502
  - ARM 37.40.1503

- 21st Century Cures Act
  - Section 12006(a)
  - Section 1903(I) of the Social Security Act (the Act)

Claims Review (53-6-111, MCA; ARM 37.85.406)

DPHHS is committed to processing claims as quickly as possible. Claims are handled electronically and may not always be reviewed prior to payment to ensure services were billed appropriately. Although the computerized system can detect and deny some erroneous claims, it cannot detect all of them. For this reason, payment of a claim does not mean the service was correctly billed, or the payment made to the provider was correct. DPHHS performs periodic retrospective reviews, which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid, and DPHHS later discovers the service was incorrectly billed or paid or the claim was erroneous in some other way, DPHHS is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of a DPHHS error, a provider error, or some 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 utilization review contractor). See the Contact Us page on the Provider Information website.

Montana Healthcare Programs manuals, provider notices, fee schedules, forms, and much more are available on the Provider Information website.

Covered Services

This chapter provides covered services information that applies specifically to PCCA services provided to members, which must also meet the general requirements listed in the Provider Requirements chapter of the General Information for Providers Manual. A link to this manual can be found on the Provider Information website under the provider type listing for PCCA.

Provider Requirement (ARM 37.85.402)

The service agency providers must be enrolled in the Montana Healthcare Program to receive reimbursement for Montana Healthcare Program services. Current enrollment requirements can be found on the Provider Enrollment page on the Provider Information website.

Pediatric Complex Care Assistant Certification (37-2-603, MCA; ARM 24.160.501; and ARM 24.160.505)

An individual may not practice as a PCCA unless licensed under Title 37, chapter 1, and chapter 2.

An applicant for licensure must have completed a training program approved by the Department of Labor and Industry (DLI) and received a valid certificate from the training program; and passed a hands-on examination approved by the DLI that demonstrates the applicant's competence.

The training program approved by the DLI must include medication administration, airway clearance therapies, tracheostomy care, and enteral care and therapy for an individual under 21 years of age.

A PCCA may provide services only to an individual under 21 years of age for whom the care assistant is a parent, guardian, other family member, or kinship care or foster care provider.

The services must be:

- Ordered by a physician and consistent with the individual's plan of care; and
- Limited to the following services per 37-2-603, MCA.
    - Duties considered by the Department to be equivalent to those of a certified nursing assistant;
    - Medication administration;
    - Tracheostomy care;
    - Enteral care and therapy;
    - Airway clearance therapies; and
    - Other services as allowed by the Department by rule.

In addition to those services above, per ARM 24.160.501 , a licensee may perform:

- Bowel care, including enema administration and ostomy care;
- Wound care;
- Central line care or IV fluid administration; and
- Airway management, including oxygen management.

A PCCA may only provide services based on training received and licensure provided by the DLI. The license displays the services the PCCA is certified to perform. If the member requires additional PCCA services and the licensed PCCA becomes certified for the additional services by the member's physician and/or by a training program enrolled with the Montana Department of Labor, these additional PCCA services must be added to the existing PCCA license.

Services require a physician's order and PA before they can be rendered. It is the policy of the DPHHS Medicaid programs that services provided to members shall not be duplicative of services available through other federal, state, or local programs. To ensure the efficient and effective use of resources, and to avoid redundancy, all services must be evaluated to confirm that they do not replace private duty nursing (PDN) or duplicate services accessible through other Medicaid-funded initiatives or any other public or private programs.

If a physician determines a member's condition requires skilled nursing, PDN remains mandatory. PCCA services should only apply when a physician explicitly certifies that tasks are within a caregiver's training as a licensed PCCA.

PCCA services may be used when PDN services are not available in the service area when such services align with the member's medical needs and goals. This policy aims to maximize the utility of available resources, while delivering comprehensive and non-redundant services to beneficiaries.

Two individual PCCAs cannot provide PCCA services concurrently to a single member unless the utilization contractor service profile specifically states that it is medically necessary.

The Department does not directly contract or reimburse individual PCCAs as providers of pediatric complex care services.

Definitions

1. **Certified** – Documentation accepted by the DLI setting forth completed training of a licensee or license applicant by an approved provider.

2. **Medical Provider** – A primary care provider and specialist care providers.

3. **Pediatric Complex Care Assistant (PCCA)** – A person who is employed by a provider agency and meets the qualifications and licensing of a PCCA to perform certain health-related services as described 37-2-603, MCA. Providers of PCCA services cannot be on the List of Excluded Individuals and Entities as provided by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services, or other applicable lists excluding individuals or entities from participating in Montana Healthcare Programs under state or federal law.

4. **PCCA Services** – Refers to medically necessary services as described in 37-2603, MCA. The services are further defined in the plan of care delivered to PCCA beneficiaries:
    a. medication administration;
    b. tracheostomy care – provides suctioning, changes ties, changes tracheostomy tube for routine change, and cares for surrounding skin. Provides bag-mask ventilation in the event of an emergency. Emergently replaces tracheostomy tube;
    c. enteral care and therapy;
    d. airway clearance therapies – oral (dental) suction to remove superficial oral secretions. Provides suctioning of superficial secretions in the oral cavity, includes setup and cleaning of suction device; and
    e. other services as allowed by the Department by rule, ARM 24.160.501 and ARM 24.160.505.
        1) Bowel care, including enema administration rectally or via an anterograde continence enema and ostomy care;
        2) Wound care;
        3) Central line care or IV fluid administration – enteral G-tube/J-tube feedings. Includes pump set up/discontinuation and/or administering bolus feeds; does not include changing or replacing of equipment. Mixing feeds as directed by physician or dietician; and
        4) Airway management, including oxygen management – provides assistance to replace oxygen tubing or nasal canula and set oxygen at ordered flow rate so long as the care is not in response to a respiratory event requiring the judgement and assessment of a nurse. Sets up, places, and starts CPAP, BiPAP, or ventilator device. Changes ventilator settings or modes as ordered by the physician.

5. **Place of Service** – The setting in which normal life activities take place. PCCA services are provided in the residence of the child.
    a. Place of service does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.
    b. PCCA services cannot be billed when a member is under the direct care of a hospital or emergency room, nursing facility, intermediate care facility, or any other institutional facility providing medical, nursing, rehabilitative, or related care.

Non-Covered Services

Per the Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0016, PCCA services do not:

1. Replace private duty nursing (PDN) services.
2. Supplant health maintenance activities available under Montana's Community First Choice Services (CFCS)/Personal Care Services (PCS).
3. Supplant Home Health Services.

Additional information about non-covered services in Montana Healthcare Programs can be found in the General Information for Providers Manual on your provider type page.

Verifying Coverage

Member eligibility may change monthly. Providers should verify eligibility at each visit. To verify coverage for a specific service is to check the Department's fee schedule for PCCA 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 CPT and Healthcare Common Procedure Coding system (HCPCS) coding books. Use the fee schedule and coding books that pertain to the date of service. Fee schedules are available on the Provider Information website.

Prior Authorization (PA)

PA is required for PCCA services. This authorization must be obtained before the initial provision of services. Additionally, if the member's condition changes in a way that affects the type, number, or duration of service hours, a new authorization must be obtained to reflect these changes. Regardless of any changes in condition, the Department mandates that the PA must be renewed every 90 days during the first six months of service and every six months thereafter, or any time the condition of the child changes, resulting in a change to the amount, type, or duration of PCCA services required.

The PA is initiated by the Montana Healthcare Program-enrolled service provider agency for PCCA services. The PA must have a national provider identification (NPI) and all the other information required by the Centers for Medicare & Medicaid Services (CMS). An order is valid for 90 days from the date it is written by the physician. The physician provides the order to the service provider agency.

To request a PA, submit a completed Request for Authorization, PCCA Services form, which is on the Forms page of the Provider Information website.

PA determinations are handled by a utilization review contractor. The Department determines the contractor. The contractor must have the staff and medical knowledge to make an informed determination. The contractor can use a variety of tools and resources necessary to make determinations for PAs. PCCA services are a Medicaid state plan service. PCCA is not a Medicaid waiver service.

Montana Healthcare Programs authorizes the number of PCCA hours based upon the needs of the individual child. Services are authorized for a specific time. Documentation supporting the

need for PCCA hours must be submitted at the time of the PA request. The Department's contractor may request additional supporting documents at any time. Medical conditions do not come with pre-set care hours; PAs are tailored to each member's unique needs and are approved on a case-by-case basis. It is expected the contractor will provide PA approval/disproval within seven (7) calendar days from the date of submission to the contractor.

The PA request must include the following elements:

- A medical order provided by the member's primary care physician consistent with the member's plan of care
- Principal diagnosis
- Specific PCCA services and treatments to be provided
- Frequency of the services/treatments
- Requested time per task
- When medication administration is ordered, the medication, amount, frequency, and route of administration must be included
- Any other documentation requested by the Department's contractor shall include a copy of the current PCCA license of the individual licensed to provide PCCA services

The goal is to ensure PCCA services are authorized only for specific skilled care allowable under pediatric complex care and to adjust the level of services as the member's needs change.

Services provided during the summer months are additional services that require a separate PA.

The number of approved PCCA service units is based on the time required to perform the identified tasks. Scheduling of authorized hours should be mutually agreed upon by the provider agency and the member or their authorized representative. Members may use their authorized number of hours [units] for PCCA services within the two-week pay period. Hours do not carry over, nor can they be banked.

PCCA services shall be reimbursed by a 15-minute unit of service not to exceed 24 hours, or 96 units, in a single day.

If a provider receives PA for a service, the member must be eligible for Medicaid at the time the service is provided. If the recipient is not eligible for Medicaid, payment will be denied based on member eligibility, even if services were prior authorized. The number of hours the Department authorized may be different from the number of hours the provider requested. Federal regulations require Montana Healthcare Programs to authorize reimbursement only for the time required to perform the identified skilled task. Other services such as PCS, certified nursing assistance, home health care, etc. may be obtained under other programs please refer to the Other Department Programs section in the Covered Services chapter of this manual.

Additional medically necessary PCCA services (units) may be approved and amended into the care plan if the member has a change in condition. Such changes must be reflected in the PCCA certification and license prior to implementation.

PCCA hours for new members will be reviewed as requests are received from providers, and as members are discharged from the hospital or other medical settings. The PA must be requested at the time of the initial submission of the plan of care.

For members currently receiving PCCA services, providers are required to renew PA requests two (2) weeks before the end date on the current PA request. PA requests must be renewed every 90 days during the first six months of service and every six months thereafter. PA also must be requested any time the plan of care is amended.

To request a PA, submit a completed Request for Authorization, Pediatric Complex Care Assistance Services form, which is on your provider type page on the Provider Information website.

The service provider enters the PA request into the third party's online portal which requires enrollment in Montana Medicaid and is tied to their NPI. The third-party issues approval or denial of the PA within seven (7) calendar days.

The service provider agency should reach out to the contractor to request an adjustment be made to the associated PAs. The contractor will review and adjust the appropriate PAs and assessments for whichever services are impacted, ensuring no duplication of services and that the member remains eligible for each service as a result of this change.

Adjusting the PA may take up to 14 days; however, the adjusted PAs for PCCA and provider can be dated retroactively to account for the time when the change took place. This adjustment can be retroactive to the date of the actual change, to ensure no gaps in billing/care. Please note, for PCA services, the PA adjustment cannot be dated retroactively, and a physician's signature is required in some circumstances, so this process may take longer.

The utilization review contractor uses an automated PA system. A record of each authorization will be entered into the claims processing system. A PA number will be assigned, and notification of all PA approvals and denials will appear on your remittance advice. This 10-digit number is specific to each PA request and must be entered in Field 23 of the CMS-1500 claim form as proof of authorization.

Administrative Review/Fair Hearing

Complete information about administrative reviews and fair hearings is found in the General Information for Providers Manual and in the Administrative Rules of Montana, under Administrative Reviews and Fair Hearings (ARM 37.5.310) and the Montana Administrative Procedure Act.

For PCCA services that result in denial, the parents/legal representative or provider can seek further clinical review through a request for a peer-to-peer review if they believe there has been an adverse action regarding denial determination. This step is done prior to an administrative review.

A peer-to-peer review is a telephonic review between an advocating clinician, chosen by either the parents/legal representative or the physician reviewer who rendered the adverse determination. The peer-to-peer review:

1. Is based upon the original clinical documentation and may consider clarification or updates.
2. Must be:
    a. Requested within 10 business days of the adverse determination date; and
    b. Scheduled by the physician reviewer within five business days of the request.

The parents/legal representative or provider must submit a written request to the utilization review contractor for the peer-to-peer review and for naming an advocating physician.

The determination letter from the utilization review contractor includes instructions on how to request a review. If new clinical information becomes available after a reconsideration review denial for prior-authorized services, the provider may submit a new PA request based on the updated information.

Service Provider Agency Enrollment, Oversight, and Supervision

The service provider agency's role is two-fold: to provide a licensed PCCA who can be compensated for delivering authorized services to eligible children, and to facilitate pathways to natural supports. The service provider agency is a mandatory reporter for child abuse and neglect per 41-3-201 MCA.

Provider Enrollment

Existing Medicaid-enrolled providers of Private Duty Nursing, Home Health, or Community First Choice Services **must meet** the following requirements:

- The enrolling agency must be in good standing with Montana Medicaid. Good standing means that the provider is actively enrolled with Montana Medicaid, has no outstanding program integrity issues, sanctions, payment suspensions, and are in compliance with all applicable state and federal regulations.
- Demonstrated compliance with all program rules, regulations, and billing requirements. This includes but is not limited to, a clean record free from program integrity investigations, sanctions, or payment suspensions for the preceding 24 months.

Provider Compliance

- Annual Revalidation: PCCA providers will be subject to annual revalidation processes to ensure continued compliance with all enrollment requirements.
- Monitoring and Audits: Montana Medicaid will conduct ongoing monitoring and audits of PCCA providers to ensure adherence to service policies, quality standards, and billing requirements.
- Reporting Changes: PCCA providers must promptly notify Montana Medicaid of any changes to their organizational structure, licensure status, key personnel, or any other information about their enrollment.
- Sanctions: Failure to comply with provider requirements may result in sanctions, including but not limited to, corrective action plans, payment suspension, and termination of Montana Medicaid enrollment.

Per the Federal Register Medicaid Ensuring Access to Medicaid Services Rule to protect the health and welfare of Medicaid beneficiaries, especially those receiving services in home and community-based settings, the following critical incidents must be reported via QAMs within one business day. For those providers not using QAMS, send through Montana File Transfer Service within one business day. Instructions for creating an account, logging in, sending and receiving files and more are available on the Instruction page on File Transfer Service.

The listed items below require reporting within one business day:

- Unexpected hospitalization
- Injuries requiring medical intervention or of unknown origin
- Medication errors that result in harm, ER visit, hospitalization, or death.
- Suicide attempt or threat
- Unexplained or unanticipated death
- Loss of contact or elopement
- Any event reported to CPS or law enforcement

Service provider agencies may conduct an initial background check. They must annually review the List of Excluded Individuals and Entities (LEIE) as provided by the OIG of the U.S. Department of Health and Human Services, or other applicable lists excluding individuals or entities from participating in Montana Healthcare Programs under state or federal law.

The related websites are:

- Special Advisory Bulletin on the Office of Inspector General website.
- Montana Department of Labor and Industry Record Search Portal
- Office of Inspector General (OIG) Exclusions Database
- System for Award Management Home | SAM.gov

It is the responsibility of the service agency provider to be knowledgeable about sections of the Administrative Rules of Montana that relate to their provider type, provider policies, and covered services.

The service provider agency does not provide clinical oversight of the PCCAs employed by the organization. A licensed PCCA is an “other licensed professional” who assumes their own liability for service provision.

The service provider agency will enroll in PCCA services and will obtain a provider identifier (PID) for each physical office location.

The service provider agency will register with the electronic visit verification (EVV) service once enrolled to provide PCCA services.

The service provider agency hires the licensed PCCA(s) to provide pediatric complex care-authorized services as ordered (or in accordance with the orders provided) by the member’s physician and approved by the utilization review contractor.

The service provider agency will assure all its PCCA employees have a current PCCA license in good standing and retains a copy. The PCCA and the employing agency will complete the Attestation Form found on the provider page. The Community Services Bureau may conduct a review of licenses.

The service provider agency is responsible for all employment requirements such as agency specific onboarding, EVV registration and training, Health Insurance Portability and Accountability Act (HIPAA) training, liability insurance, worker's compensation coverage, and employment benefits of working for the organization that the individual PCCA is eligible for such as vacation, sick leave, health insurance, agency-related training, and any additional service provider agency requirements.

PCCA service agency providers must employ oversight staff to perform the following:

1. provide documentation showing all employed PCCAs are certified by a medical professional and have a current license in good standing to provide care, with licenses renewed annually by the individual PCCAs.
2. assist members and their PCCAs to identify resources for backup plans;
3. advise the member and their PCCAs regarding PCCA service requirements;
4. complete compliance documentation and follow-up if the member receiving PCCA services does not comply with service requirements; and
5. provide documentation to verify service oversight staff
6. act as the employer of record for PCCA workers for the purposes of payroll and federal hiring practices
7. require each PCCA to comply with EVV.

The service provider agency will require each PCCA to comply with EVV to include participation in EVV training, track time, as well as confirm the services provided that fall within service parameters. PCCAs may choose to complete tasks via unscheduled visits, or they may schedule blocks of time when the majority of care is expected to be delivered.

Each PCCA will provide brief daily case notes within the EVV system regarding each PCCA service provided. This note becomes part of the health record for the individual receiving PCCA services and can aid in providing member information to the physician as well as be used to determine utilization of services in the plan and whether additional or fewer hours are needed to conduct the PCCA services.

For more information on EVV, please visit the EVV webpage on the DPHHS website.

The agency may opt to conduct check-in visits and calls with the PCCA and family on a planned schedule, such as quarterly, or at an interval agreeable to the family and agency.

Licensed Pediatric Complex Care Assistant and Member Requirements

To be eligible for PCCA services, a child must be under the age of 21, qualify for Medicaid, have complex care needs, and have a parent, sibling, kinship care, or foster parent who is a licensed PCCA. The licensed PCCA must:

1. Be capable of providing the approved care and assuming the management responsibilities of the child's complex care needs. Management responsibilities include the following:
    a. Developing backup a plan, implementing it when necessary, and informing the agency of the plan and of situations in which the plan is enacted.
    b. Reviewing, approving, signing, and dating all service delivery records, to provide assurance that the service plan has been followed; and
    c. Assuming medical and related liability regarding the delivery of PCCA services.
2. Obtain PCCA certification from a physician or health care professional to become licensed;
3. Obtain licensure prior to service delivery and maintain annually thereafter; and
4. Be capable of making choices about activities of daily living, understand the impact of these choices, and assume the responsibility of these choices.

Kinship and Foster Care

In the case of a member in kinship care or a foster care home, the foster care provider only needs one PCCA license regardless of the number of children, who are members, with pediatric complex care needs residing within the home.

For licensure, the PCCA applicant must provide an attestation from the provider and indicate the training they are certified to perform. The certified PCCA services are displayed on the license certificate.

In situations where foster care members in a foster care home do not have the same medical provider, the PCCA licensee can either obtain training from their individual medical care providers or complete an available training program from a Montana DLI-registered training provider. Additional PCCA service training and certifications can be added to the PCCA license by Montana DLI.

While a PCCA is only required to have one PCCA license for all eligible members in a foster care home, each individual member will have their own PA for PCCA services. The PCCA license must have the required certifications noted on their license for the PA services. When it comes to EVV and claim submission for reimbursement, each will be based upon the individual. For example, if a PCCA provides services to two or more foster care members, the PCCA will need to schedule, clock-in, and clock-out for each individual child. Grouping services for multiple members is not allowed for EVV or for reimbursement of claims. The service provider agency will submit claims based upon the individual services provided to an individual member.

Reimbursement

In-State PCCA Services

PCCA Reimbursement

DPHHS establishes a set fee schedule for PCCA service rates. PCCA services may not exceed 24 hours, or 96 units, in a single day for an individual. The rate for PCCA services is the lesser of $10.78 per 15-minute unit of service, which equates to $43.12 per hour of service provided; or the provider's usual and customary charge.

DPHHS assures PCCA services do not replace private duty nursing (PDN) or supplant health maintenance activities (HMA) available under CFCS.

Montana Healthcare Programs regulations do not restrict the hours when a PCCA may provide services. Provider agencies will work with their employees to establish schedules based on the member's care needs, the PA, and plan of care. Members may use their authorized number of hours [units] for PCCA services within the two-week pay period. Hours do not carry over, nor can they be banked. Montana Healthcare Programs do not have an overtime rate for PCCA services.

The reimbursement billing code is T1000 with modifier SC.

The Department reimbursement is based on each Medicaid unit of PCCA services. A unit of service means a unit of PCCA service. A unit of PCCA service is 15 minutes and means an on-site visit specific to the individual. The on-site visit unit rate includes the administrative components of providing the direct care service, including planning, training, and oversight components.

Medicaid reimbursement for PCCA services is not allowable for services provided in a hospital or nursing facility.

Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or provider relations.

When Members Have Other Insurance

If a Montana Healthcare Programs member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's healthcare, see the Coordination of Benefits chapter in this manual.

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Montana Healthcare Programs, the provider has 12 months from the date retroactive eligibility was determined to bill for those services.

When submitting claims for retroactively eligible members, attach a copy of the 160-M form to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. In the case of PCCA services, a licensed PCCA must have been licensed as a PCCA and be in good standing with licensure.

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Montana Healthcare Programs for the services.

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the General Information for Providers Manual.

Place of Service

Place of service must be entered correctly on each line. PCCA services cannot be provided in hospitals and in-patient facilities. See the Place of Service Code Set on the CMS website.

Using the Montana Healthcare Programs Fee Schedule

When billing Montana Healthcare Programs, it is important to use the DPHHS fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the CPT and HCPCS coding books. In addition to covered services and payment rates, fee schedules often contain helpful information, such as appropriate modifiers. DPHHS fee schedules are updated each January and July. Fee schedules are available on your provider type page on the Provider Information website.

Using Modifiers

Review the guidelines for using modifiers in the CPT, HCPCS, or other helpful resources.

- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- Always refer to the long description in coding books.
- The Montana Healthcare Programs claims processing system for PCCA will use one code and modifier combination: T1000 with SC modifier per claim line on the CMS-1500 form.

Submitting a Claim

See the Billing Procedures tab on the Claim Instructions page of the Provider Information website.

Remittance Advices and Adjustments

For information on remittance advices and adjustments, see the Remittance Advice and Adjustments tab on the Claim Instructions page of the Provider Information website.

How Payment Is Affected

PCCA services are separate and distinct from other services delivered on the same day.

Charge Cap

For the services covered in this manual, the Montana Healthcare Program pays the lower of the established Montana Healthcare Programs fee or the provider's charge.