Montana Healthcare Programs

Plan First
1115 Family Planning Waiver

Effective July 1, 2026

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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Provider Information and Documentation

Where can I get necessary Montana Healthcare Programs provider information and documentation?

Visit the Montana Healthcare Programs Provider Information website at www.medicaidprovider.mt.gov.
The Montana Healthcare Programs Provider Information website is where Montana Healthcare Programs posts provider notices, fee schedules, provider manuals, and forms. Most information can be located under the "Resources by Provider Type" tab. Please note that it is the provider's responsibility to check provider notices and fee scheduled on a frequent basis to ensure proper billing.

The Montana Healthcare Programs Provider Information webpage is also where the General Information for Providers Manual is posted. The General Information for Providers Manual is the resource for information such as telemedicine, Passport, cost share, readmittance advices, and adjustments.

Who do I contact for information such as claim denials, eligibility, and/or enrollment?
Provider Relations (PR)

Telephone
(800) 624-3958 In/Out of State
(406) 442-1837 Helena

Fax
(406) 442-4402 Primary
(888) 772-2341 Alternate

Email
Enrollment – MTenrollment@conduent.com
Provider Relations – MTPRHelpdesk@conduent.com

Automated Services
(800) 624-3958 Provider Relations
(800) 714-0060 IVR
(800) 714-0075
MATH Web Portal
Medicaid Provider Website

U.S. Mail
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Manual Organization and Maintenance

This manual provides information for Family Planning Clinics, Doctors, Nurse Practitioners, Physician Assistants, Pharmacies, Laboratories, and any other providers who provide family planning services.

This manual includes information for Plan First providers. Changes to manuals are provided on the update log. Policy changes are also updated through provider notices located on the Plan First provider type webpage. Manuals must be kept current, and updates can be found at https://medicaidprovider.mt.gov. Notification of manual updates are provided through the weekly web postings under "Recent Website Posts" on the home page of the provider website and under Provider Notices on the provider type page of the provider website.

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 that the policy they are researching or applying has the correct effective date for their circumstances.

Key Contacts and Websites

- DPHHS Plan First Website and Covered Billing Codes: Plan First (mt.gov)
- 1115 Plan First Waiver: Section 1115(a) Waiver Application Template (mt.gov)
- Office of Public Assistance: 1-888-706-1535 or https://apply.mt.gov
- Provider Website: https://medicaidprovider.mt.gov
- Plan First Program Officer: 406-444-6868

Introduction and Program Overview

Thank you for serving our Plan First members! Plan First is a Section 1115 Waiver approved by the Centers for Medicare & Medicaid Services (CMS) and can serve up to 4,000 eligible women a year. This program is administered by the Department of Public Health and Human Services. Plan First is a program that provides family planning and family planning related services to women who do not qualify for Standard Medicaid benefits. The Plan First Waiver has been approved through December 31, 2028.

Plan First is a Medicaid program different from Standard Medicaid. Those who are eligible for Plan First are not eligible for Standard Medicaid benefits and only receive limited covered services related to family planning. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of sexually transmitted diseases (STDs).

Provider Information

Provider enrollment information can be found on the Provider Website. Providers who are enrolled with Montana Medicaid and operating within their scope of practice are eligible to provide Plan First services. Those services are reimbursable in accordance with established Montana Medicaid reimbursement guidelines. Plan First provides limited coverage for members and is different from Standard Medicaid. Please be sure to read the provider manual for the services

covered under this plan and how to bill accordingly to ensure reimbursement. Providers must comply with all applicable state and federal statutes, rules, and regulations. Provider participation and requirements can also be further defined in ARMs 37.85.401, 37.85.406, 37.85.402, and 37.85.414.

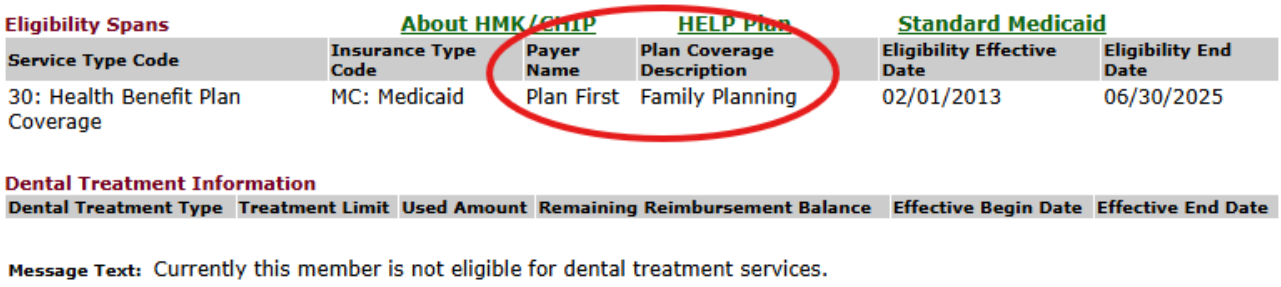
This manual presents an overview of Plan First and reimbursement material. It has been made to be used as a reference tool and does not contain every specific detail on billing requirements. The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, provider relations, or a prior authorization unit). You may also need to refer to your specific provider manual and/or fee schedule for additional information. Medicaid manuals, provider notices, fee schedules, forms, and more are available on the Provider Information website.

Provider Website Information

The website for providers is https://medicaidprovider.mt.gov and the following information is available: Medicaid information and news, Provider manuals, Provider notices and announcements, Fee schedules, Forms, Frequently asked questions (FAQs), Training, Newsletters, Key contacts. You may also find additional billing information under your specific provider type.

Verifying Member Eligibility

Member eligibility may change monthly. Providers should verify eligibility at each visit. For further information on how to verify member eligibility, visit the Provider Website.



Eligibility Spans About HMK/CHIP HELP Plan Standard Medicaid

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Plan First	Family Planning	02/01/2013	06/30/2025

Dental Treatment Information

Dental Treatment Type	Treatment Limit	Used Amount	Remaining Reimbursement Balance	Effective Begin Date	Effective End Date

Message Text: Currently this member is not eligible for dental treatment services.

Provider Rights

- Providers have the right to end participation in Montana Healthcare Programs in writing at any time; however, some provider types have additional requirements.
- Providers may bill Montana Healthcare Programs members when the conditions outlined in ARM 37.85.204 are met.
- Providers may bill Montana Healthcare Programs members for services not covered by Montana Healthcare Programs if the provider and members have agreed in writing prior to providing services.
- When the provider does not accept the member as a Montana Healthcare Programs member, a specific custom agreement is required stating that the member agrees to be financially responsible for the services received.

- A provider may bill a member for non-covered services if the provider has informed the member in advance of providing the services that Montana Healthcare Programs will not cover the services and the member will be required to pay privately for the services, and if the member has agreed to pay privately for the services. Non-covered services are services that may not be reimbursed for the member by the Montana Healthcare Programs under any circumstances and the services covered are services that may be reimbursed by the Montana Healthcare Programs program for the member if all applicable requirements, including medical necessity, are met (ARM 37.85.406).
- Providers have the right to choose Montana Healthcare Programs members, subject to conditions as per Accepting Montana Healthcare Programs Members (ARM 37.85.406).
- Providers who are aggrieved by an adverse action by the Department which directly affects the rights of the provider or are aggrieved by an adverse department action affecting the member's eligibility may request an administrative review or fair hearing. (ARM 37.85.411).

Rules and Regulations

Links to rules are on your provider type page and below:

- Code of Federal Regulations
- Montana Codes Annotated
- Administrative Rules of Montana

Rule References

Providers, office managers, billers, and other medical staff must be familiar with current rules and regulations governing the 1115 Plan First Waiver. Provider manuals are to assist providers in billing Medicaid programs; they do not contain all Medicaid program rules and regulations. Rules citation in the text is a reference tool; they are not a summary of the entire rule. If a manual conflicts with a rule, the rule prevails. Paper copies of the rules are available through the Secretary of State's office. The following rules are in reference to Plan First.

- ARM 37.86.1701
- ARM 37.86.1707
- ARM 37.82.701

Definitions and Acronyms

Additional definitions and acronyms are found on the Definitions and Acronyms page found in the Site Index in the left-hand menu of the Provider Information website.
https://medicaidprovider.mt.gov/enduserproviders

Eligibility:

1. Montana resident;
2. Women ages 19 through 44;
3. Women who are not eligible for other Medicaid benefits;
4. Women who are able to bear children but are not currently pregnant; and
5. Women earning a household income up to and including 211% of the Federal Poverty Level (FPL). For current FPL information visit the DPHHS Plan First page. https://dphhs.mt.gov/MontanaHealthcarePrograms/planfirst

Covered Services:

Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and provided in a family planning setting. As the Montana Plan First Family Planning Waiver is limited to a specific category of benefits to treat specific medical conditions.

Family planning services and supplies are reimbursable including:

a) Approved methods of contraception;
b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams. The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements);
d) Contraceptive management, patient education, and counseling; and
   Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit.

Examples of family planning-related services and supplies include:

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
d) Other medical diagnosis, treatment, and preventive services routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
e) Treatment of major complications arising from a family planning procedure such as:
    i) Treatment of a perforated uterus due to an intrauterine device insertion;
    ii) Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii) Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Primary care referrals to other social services and health care providers as medically indicated may be provided; however, the costs of those primary care services are not covered for enrollees of this waiver. Services provided through this waiver are paid fee for service (FFS).

Coordination of Benefits:

Plan First members may also have other insurance coverage. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Plan First. Plan First will pay for family planning services not covered under a primary policy. Co-pays, co-insurance, and deductibles are not covered under Plan First. Providers may bill Montana Healthcare Programs members, including Plan First members, for services not covered by Montana Healthcare Programs if the provider and member have agreed in writing prior to providing services.

When a Plan First member has additional medical coverage (other than Medicare), the other insurance is often referred to as third party liability (TPL). In most cases, the providers must bill other insurance carriers before billing Plan First. Medicaid programs are the payer of last resort in most situations.

Administrative Reviews and Fair Hearings (ARM 37.5.310)

A provider may request an administrative review if he/she believes the Department has made a decision that fails to comply with applicable laws, regulations, rules, or policies.

To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department. The Department must receive the request within 30 days from the date the Department's contested determination was mailed. Providers may request extensions in writing within the 30-day time period. See the Contact Us link on the Provider Information website.

If the provider is not satisfied with the administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules, or policies. This document must be signed and received by the Office of Administrative Hearings within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered or mailed to the division that issued the determination within three working days of filing the request.

Provider Sanctions (ARM 37.85.501–507 and ARM 37.85.513)

The Department may withhold a provider's payment or suspend or terminate Montana Healthcare Programs enrollment if the provider has failed to abide by terms of the Montana Healthcare Programs contract, federal and state laws, regulations, and policies.

Contract Services

Montana Healthcare Programs works with various contractors who represent Montana Healthcare Programs through the services they provide. While it is not necessary for providers to know contractor duties, the information below is provided as informational.

- *Conduent State Healthcare, LLC.* Answers provider inquiries and enrolls providers in Montana Healthcare Programs and processes claims for many Montana Healthcare Programs.
- *Mountain Pacific.* Provides prior authorization for many Montana Healthcare Programs services.

Billing Procedures

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

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

The Department is committed to paying Plan First providers' claims as quickly as possible. Plan First claims are electronically processed and usually 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 it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid, and the Department later discovers 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 (42 CFR 456.3).

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean Plan First claims to Medicaid within:

- Twelve months from the latest of:
    - the date of service;
    - the date retroactive eligibility is determined; or
    - the date disability was determined;
- Six months from the date on the Medicare explanation of benefits approving the service, if the Medicare claim was timely filed and the recipient was Medicare eligible at the time the Medicare claim was filed; or
- Six months from the date on an adjustment notice from a third-party payor, where the third-party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date the claim was received by the Department

or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Providers billing Plan First should use the Department's fee schedule, designated by provider type, as well as the detailed coding descriptions listed in the CPT and Healthcare Common Procedure Coding System (HCPCS) coding books. Current fee schedules are available on the Provider Website under the Provider Type page. Plan First covered codes can be found at https://medicaidprovider.mt.gov/planfirst. These codes will coincide with your specific provider fee schedule found on the provider website.

In most circumstances, providers may not bill Plan First members for services covered under Plan First.

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Plan First paid.
- For a covered service provided to a Plan First-enrolled member who was accepted as a Plan First member by the provider, even if the claim was denied.
- When the provider bills Plan First for a covered service, and Plan First denies the claim because of billing errors.
- When a third-party payor does not respond.
- When a member fails to arrive for a scheduled appointment.
- When services are free to the member and free to non-Medicaid programs covered individuals, such as in a public health clinic.

Providers may bill a member when:
Patient is Plan First enrolled, and provider accepted them as a Plan First member.

- If the service is not covered by Plan First, the provider can bill the member only if a custom agreement was signed between the member and the provider before the service was performed.
- Patient is Plan First enrolled, and provider did not accept them as a Plan First member.
- The provider can bill the member only if a custom agreement was signed between the member and the provider before the service was performed.

Billing for Retroactively Eligible Members

When the provider accepts the member's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date the claim is submitted, attach a copy of the Provider Notice of Eligibility (Form 160-M). The provider must request the form from the member's local Office of Public Assistance. See https://dphhs.mt.gov/hcsd/OfficeofPublicAssistance.

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

Using the Medicaid and Plan First Fee Schedules

When billing Plan First, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT and HCPCS diagnosis coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers, global periods, if multiple surgery guidelines apply, if the procedure can be done bilaterally, if an assistant, co-surgeon, or team is allowed for the procedure, if the code is separately billable, and more. Department fee schedules are updated each January and July. Fee schedules are available on the Provider Information website under the Resources by Provider Type button.

Using Modifiers

Codes in the "May be family planning or family planning-related service" category must be billed with either an FP modifier or a Z30.XXX diagnosis to receive reimbursement.
Procedure and Services codes for Plan First are located at Plan First Code List and Descriptions (mt.gov).

Submitting a Claim

The services described in this manual are billed either electronically on a professional claim or on a CMS-1500 paper claim form. Claims submitted with all the necessary information are referred to as *clean* and are usually paid in a timely manner. (See the Billing Procedures chapter in the General Manual)

Submitting Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted using the methods below. For detailed submission methods, see the electronic submissions manual on the Electronic Billing page of the website.

Submitting Paper Claims

For instructions on completing a paper claim, see the Submitting a Claim chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:
Claims Processing
P.O. Box 8000
Helena, MT 59604
Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

Claim Inquiries

Contact Provider Relations for general claim questions and questions regarding member eligibility, payments, and denials.
Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double-check each claim to confirm the following items are included and accurate.