Add-On Process Instructions

1. Please write a projected, **specific** time period/date range (EXAMPLE: 01/01/21-06/30/21).
2. If you expect this request to be long-term, a new request will be required every 6 months.
3. Typical examples of projected time frames for each add on can be as follows:
   - Wound Care: 3 months or more.
   - Behavior: 6 months or more.
   - TBI (Brain Injury): 1 year.
   - Bariatric Care: 6 months to a year.
   - Tracheostomy: 1 year.
   - Ventilator Care: 1 year
4. Please note, TBI and behaviors cannot both be selected at the same time. It is one or the other. However, if the resident has wound care needs on top of behaviors, those would be allowable to submit for review together.
5. Any add-ons being requested will need to include:
   - Detailed itemized list/medical records, with any add-ons not listed on the fee schedule. (Records must be **current** as of the date of your request, and **only** submit records that **pertain to** the issue sent in for consideration, please.)
   - Medical Care Plan documentation support. (What are the issues at hand and how do you plan to improve them, please be specific.)
   - Proof of Vent/Trach rate (if applicable).(Must need help with care.)
6. If you are requesting extra care hours, please include a breakdown of the extra hours and what they will be used for. Extra care hours are **only** for extraordinary cases on a **short-term basis.** Please Call Dee or Jenifer in advance to discuss before submitting.
7. If the add-on request is approved, you will receive an approval letter with a prior authorization number. This number needs to be used when billing for the services requested. Every time a new request is granted, a new authorization number will be given, and needs to be used when billing.
8. Add-on charges are to be billed on a CMS-1500 form with procedure code A9999.
9. Please ensure that a Level of Care is submitted to Mountain-Pacific Quality Health (MPQH) for eligibility determination to be made. **Approval of add-ons is not an approval of Medicaid eligibility.**

Submit **out of state add-on requests** to Dee Burnham at Dee.Burnham@mt.gov or by fax at (406) 444-7743. If you have questions for out-of-state add-ons, please contact Dee at (406) 444-4129.

Submit **in-state add-on requests** to Jenifer Thompson at Jenifer.Thompson@mt.gov or by fax to (406) 444-7743. If you have any questions for in-state add-ons, please call Jenifer at (406) 444-3997.

Add-On Rate Request Form

Patient Name: _____

Medicaid ID #: _____

Facility Name/NPI: _____

Projected Time Period: _____

Out of State Facility Medicaid Per Diem Rate:$ _____

Requested Rate.

- Please submit medical care plan documentation support with your request. Be Specific.
- If you are requesting vent/trach care, please attach documentation of vent/trach daily rate.
- Vent/Trach requests are approved on a case-by-case basis.

Type of Care (if applicable)	Requested Rate Per Day
☐ Wound Care	$
☐ Behavior	$
☐ TBI	$
☐ Bariatric Care	$
☐ Tracheostomy Care	$
☐ Ventilator Care	$

Additional Staffing. (USE **ONLY** FOR VENT/TRACH REQUESTS.)

Type of Staff	Number of Staff	Cost Per Hour	Cost Per Day
LPN		$	$
RN		$	$
CNA		$	$
R.T.		$	$
Total		$	$

Cost Per Day. (USE **ONLY** FOR VENT/TRACH REQUESTS.)

Type of Cost	Cost Per Day
Staffing	$
Equipment	$
Medical	$
Supplies Other	$
Sub-Total Requested Rate	$

Request Total.

Request Category	Request Amount
Sub-Total Requested Rate	$
Current Out-of-State Per Diem Rate	$
Total Per Day	$