Senior and Long-Term Care Provider Notice

November 13, 2026

Informational

Community First Choice Services, Nursing Facilities, Big Sky Waiver, Pediatric Complex Care Assistant, Personal Care Services, Home Health, Hospice, and Swing Bed Providers

Preventing Claim Denials and Resolving Claim Inquiries

This notice outlines common reasons for claim denials, steps providers can take to avoid processing delays, and procedures for resolving claim and prior authorization inquiries.

Verify Member Eligibility Before Providing Services

Member ineligibility is a leading reason for claim denials. Because eligibility, third-party liability (TPL), and waiver status may change from month to month, verify the member's eligibility before providing services.

Eligibility can be verified through either of the following resources:

- Provider Relations: 800-624-3958
- Montana Access to Health (MATH) web portal

Do not submit a claim if the member is ineligible for the date of service. For detailed instructions, refer to the "Member Eligibility and Responsibilities" section of the General Information for Providers Manual.

Preventing Duplicate Claim Submissions

Claims may be suspended or denied when they duplicate, or appear to duplicate, a previously submitted claim. To help prevent duplicate submissions:

- Do not resubmit a claim that is pending. Pending claims are identified by reason code 133 on the remittance advice.
- If you are unsure whether a claim has been paid, check its status through Provider Relations or the MATH web portal before resubmitting.
- Compare claim details with previously submitted claims.
- When span billing, ensure that service dates do not overlap between lines on the same claim or across separate claims.

Submit Required Supporting Documentation

Missing or incomplete supporting documentation may result in a claim denial. Follow the appropriate submission procedures for electronic and paper claims.

Electronic Claims

Use the Paperwork Attachment Indicator (PWK) when submitting electronic claims that require supporting documentation. If the claim involves a Medicare denial, include the Medicare denial documentation.

Deadline: Supporting documentation for electronic claims must be received within 15 calendar days of claim submission.

Submission procedures vary by method:

- MPATH Provider Services Portal: Upload documents during claim entry for electronic delivery or submit them by mail or fax according to the instructions provided.
- Other electronic submission methods: Use the PWK indicator to alert the claim examiner that supporting documentation must be located and reviewed.

When submitting an updated electronic claim following a denial, include the supporting paperwork. The Paperwork Attachment Cover Sheet is available on the Forms page of the Provider Information website. To locate it, select "Site Index" from the left menu, then navigate to "Forms." Follow the cover sheet instructions to create the Paperwork Attachment Control Number for electronic claims.

Paper Claims

Attach all required supplemental information directly to the paper claim. Claims submitted without required attachments will be denied. Review your remittance advice for pending claims and contact Provider Relations with questions.

Confirm Prior Authorization Requirements

Prior authorization (PA) requirements vary by program. Review the applicable Medicaid provider manual and fee schedule to determine whether authorization is required. Claims for services requiring PA must include a valid PA number. The claim information must also match the authorization.

Common PA-Related Denials

Issue	Processing outcome	Reason and remark codes
The PA number is missing or is not in the claims system.	Entire claim denied	Reason 198; remark M62
The rendering provider ID does not match the PA.	Entire claim denied	Reason 15
The member ID does not match the PA.	Entire claim denied	Reason 15; remark N54
Authorization dates, service code, modifier, tooth number, or tooth surface do not match.	Affected service line denied	Reason 15; remark N54
Authorized units or dollar amounts have been exceeded.	Affected service line denied	Reason 198; remark N54
Authorized units or dollar amounts have been fully used.	Affected service line denied	Reason 197

Steps to Reduce PA-Related Denials

- Confirm that the services being provided match the PA notification letter.
- Contact the approving agency, case manager, regional manager, or program to resolve discrepancies before billing.
- Update your billing system with new PA numbers as needed. Annual updates may be necessary for electronic billing.
- Do not span bill services under one PA number when the ending date falls under a different authorization.
- Do not bill for units or dollar amounts beyond those authorized.

- If a claim is denied because of the diagnosis code on the PA, contact case management to confirm an appropriate billable diagnosis code.

Resolve Electronic Visit Verification PA Issues

For prior authorization issues involving Electronic Visit Verification (EVV):

1. Contact the EVV Call Center at 833-483-5587.
2. Submit a support ticket and retain the reference number.
3. If the issue remains unresolved, email EVVQuestions@mt.gov.
4. If further escalation is necessary, contact CS and include the applicable information:
    - EVV reference number
    - Claim internal control number (ICN)
    - Medicaid member ID number
    - Date or dates of service

Submit and Escalate Claim Inquiries

Use the following process for claim questions or unresolved claim issues:

1. Contact Provider Relations:
    - Phone: 800-624-3958
    - Email: mtprhelpdesk@conduent.com
2. Record the reference number provided by Conduent.
    - If the issue remains unresolved, submit the inquiry to CSBClaims@mt.gov, please indicate if the request is regarding Nursing Facilities, Swing Beds or HCBS Services.

Include the applicable information with the escalated inquiry:

- Conduent reference number
- Claim internal control number (ICN)
- Medicaid member ID number
- Date or dates of service

Information containing protected health information (PHI) must be sent through the state's File Transfer Service.

Meet Timely Filing Requirements

Providers must submit clean claims within the timelines established in ARM 37.85.406. A clean claim is one that can be processed without additional information or action from the provider. For timely filing purposes:

- The submission date is the date the Department or its claims processing contractor receives the claim, as described in ARM 37.85.406(1)(c).
- All claim problems must be resolved within 365 days of the date of service.

For additional guidance, refer to the "Billing Procedures" section of the General Information for Providers Manual.

Contact and Website Information

For claims questions or additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email Montana Provider Relations Helpdesk.

Visit the Montana Healthcare Programs Provider Information website to access your provider type page. Choose Resources by Provider Type in the left-hand menu.

Visit the Contact Us page on the Provider Information website for additional DPHHS contact numbers.