



Montana Healthcare Programs

Federal Qualified Health Centers and Rural Health Clinics

Provider Information and Documentation

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

Visit the [Montana Healthcare Programs Provider Information website at www.medicaprovider.mt.gov](http://www.medicaprovider.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 a provider's responsibility to check provider notices and fee schedules 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, remittance advices, and adjustments.

Who do I contact for information such as claim denials, eligibility, enrollment?

Provider Relations (PR)

Telephone

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

Automated Services

(800) 624-3958 Provider Relations
(800) 714-0060 IVR
(800) 714-0075 FaxBack

[MATH Web Portal](#)

[Provider Website](#)

Fax

(406) 442-4402 Primary
(888) 772-2341 If the primary number is busy, please use this line; both can be used for faxing PR.

Email

[Enrollment – MTenrollment@conduent.com](mailto:MTenrollment@conduent.com)

[Provider Relations – MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)

U.S. Mail

Provider Relations Unit
PO Box 4936
Helena, MT 59604

Manual Maintenance

Changes to manuals are provided on the update log. Policy changes are also updated through provider notices located on the RHC and FQHC provider type webpage.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Healthcare Programs program. 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 provider manual conflicts with a rule, the rule prevails. Providers are responsible for knowing and following current Montana Healthcare Programs rules and regulations.

Links to the rules are available on the [Montana Secretary of State website](#). Paper copies of rules are available through the Secretary of State office. Choose the Contact Us option under the ARM menu.

The following rules and regulations are also applicable to RHCs and FQHCs:

- Code of Federal Regulations (CFR)
 - 42 CFR 405.2400–42 CFR 405.2472
- Montana Code Annotated (MCA)
 - MCA 53-2-201, 53-6-101, 53-6-111, and 53-6-113
- Administrative Rules of Montana (ARM)
 - ARM 37.86.4401–37.86.4420

Definitions and Acronyms

[For general Montana Healthcare Programs definitions and acronyms, see the Definitions and Acronyms link in the left menu on the Provider Information website.](#)

RHC and FQHC Reimbursement Methodology

All RHC and FQHC services are reimbursed per visit. Services eligible for an encounter payment are reimbursed utilizing the facility-specific prospective payment system (PPS) rate. The PPS rate is a facility-specific, predetermined rate, regardless of the allowable RHC or FQHC service.

Since RHCs and FQHCs are reimbursed at their PPS rate for most services, they do not have their own fee schedule. RHCs and FQHCs utilize the Outpatient Prospective Payment System (OPPS) fee schedule for reimbursable codes, including allowable dental service codes.

Please note, the OPPS fee schedule is for reference of allowable versus non-allowable codes only. A code appearing on the OPPS fee schedule does not indicate if the code is an RHC or FQHC service, or if the code is considered an incident to a core provider encounter.

Certain services are deemed non-RHC or non-FQHC services and are paid at the appropriate fee schedule amount. The Department determines which non-FQHC and non-RHC services are eligible for reimbursement outside of PPS reimbursement.

How is the Prospective Payment System (PPS) rate calculated?

Upon enrollment with Montana Healthcare Programs, an RHC or FQHC is issued an interim PPS rate for two complete fiscal years. After two complete fiscal years, a baseline PPS rate will be established.

Non-RHC or non-FQHC services reimbursed outside of the PPS reimbursement methodology are not factored into the PPS rate. The list of services that are not calculated into the PPS rate includes:

- Peer support services
- Long acting reversible contraceptives (LARCs)
- Promising Pregnancy Care
- Originating telemedicine site

Establishment of Interim PPS Rate for New RHC or FQHC (ARM 37.86.4413)

Upon enrolling as a new provider with Montana Healthcare Programs the RHC or FQHC is issued an interim PPS rate.

An interim PPS rate must be assigned when an enrolled RHC or FQHC acquires ownership of an existing RHC or FQHC. The interim PPS rate can be set two ways:

- 100% of the average PPS rate of other RHCs or FQHCs located in the same or adjacent area with a similar caseload; or
- If there is no RHC or FQHC located in the same or adjacent area with a similar caseload, the temporary PPS rate will be equal to the RHC's or FQHC's total projected allowable costs divided by the total projected allowable visits.

Establishment of Baseline PPS Rate (ARM 37.86.4413)

Two complete fiscal years after an RHC or FQHC has been enrolled with Montana Healthcare Programs, a baseline PPS rate will be established by the department.

The baseline PPS rate is established using the RHC's or FQHC's first two complete as-filed Medicare cost reports. The cost reports are due six months after the end of the second complete fiscal year.

If the cost reports are not received **30 days prior** to the six-month deadline, the Department will send notification to the RHC or FQHC advising them payment will be suspended on all Montana Healthcare Programs claims if the cost reports are not received in a timely manner.

Within 90 days from receiving the cost reports (and any additional requested information) the Department will calculate the baseline PPS rate and send a letter to the RHC or FQHC.

The baseline PPS rate of a newly enrolled RHC or FQHC will be retroactive to the date that the RHC or FQHC was enrolled with Montana Healthcare Programs. A mass adjustment of claims will be submitted for any increase or decrease from the interim PPS rate.

Can the baseline PPS rate change?

The baseline PPS rate can change through two methods:

1. Annual Medicare Economic Index changes – On the first day of each calendar year, the RHC's or FQHC's baseline PPS rate will be adjusted to factor in the Medicare Economic Index (MEI).
2. Change in scope of service – A change in scope of service can result in an incremental change to the baseline PPS rate; incremental changes can be either positive or negative. The baseline PPS rate may also remain the same after a change in scope of service calculation.

Change in Scope of Service

What is a change in scope of service?

A change in scope of service occurs when an RHC or FQHC has experienced a change in the type, intensity (quantity of labor and materials consumed), duration (length of encounter), or amount of a service.

The RHC or FQHC will submit a prospective change in scope of services, or retrospective change in scope of services, dependent on when the change in scope of services documentation is received by the Department.

ARM 37.86.4409 Prospective change – A change the RHC or FQHC plans to implement in the future.

ARM 37.86.4410 Retrospective change – A change which took place in the past.

What formula is utilized for calculating the incremental change to the baseline PPS rate?

The Department uses the following calculations to determine the amount of an incremental change, if any, when an RHC or FQHC applies for a change in scope of service:

$$A/B = C$$

$$D/E = F$$

$$F - C = IC$$

Current baseline PPS rate + IC = New baseline PPS rate

A – represents allowable costs before the change in scope of service

B – represents total visits before the change in scope of service

C – represents the cost per visit before the change in scope of service

D – represents allowable costs after the change in scope of service

E – represents total visits after the change in scope of service

F – represents cost per visit after the change in scope of service

IC – represents the incremental change due to the change in scope of service. This value can be positive or negative.

What are examples of a change in scope of service?

- The addition or deletion of a service that was not originally calculated into the baseline PPS rate
- The addition or deletion of a covered Medicaid RHC or FQHC service under the State Plan
- A change necessary to maintain compliance with amended state or federal regulations
- A change in applicable technology or medical practices utilized by the RHC or FQHC that is not funded by state or federal funds
- A change in the type of patients served, including but not limited to, populations with HIV/AIDS, other chronic diseases, homeless, elderly, migrant, or other special populations that require more intensive and frequent care
- A change in operating costs attributable to capital expenditures corresponding to a change in the services provided by the RHC or FQHC
- A change in the provider mix, including but not limited to:
 - A transition from mid-level providers to physicians with a corresponding change in services provided by the RHC or FQHC
- The addition or removal of specialty providers with a corresponding change in services provided by the RHC or FQHC

What are examples of situations not eligible for a change in scope of service?

- A change in ownership, including acquisition by another healthcare entity, RHC, or FQHC
- A change in the number of staff furnishing an existing service
- An increase or decrease in administrative staff
- A change in the number of encounters
- A change in the cost of supplies for existing services
- A change in salaries and benefits not directly related to a change in scope of service
- A change in patient type and/or volume without a corresponding change in the services provided by the RHC or FQHC
- Capital expenditures for losses covered by insurance
- A change in office location or office space
- The addition of a new site or removal of an existing site, which offers the same RHC or FQHC services.
- Services paid at a fee-for-service rate
 - Example: Peer support services

How does an RHC or FQHC apply for a change in scope of service?

An RHC or FQHC may apply for a prospective or a retrospective change in scope of service. All change in scope of service requests must be submitted directly to the Department in writing.

An RHC or FQHC must apply for a change in scope of service, even if it will not result in a positive incremental change to the baseline PPS rate.

What information is required to submit with a prospective change in scope of service?

The following information must be submitted in order to apply for a prospective change in scope of service:

- A narrative description of each change in scope of service
- The date on which the change in scope of service is scheduled to occur
- A description of each cost center(s) on the cost report that will be affected by the change in scope of service
- The cost report for the fiscal year prior to the year in which the change in scope of service is implemented, which considers the change in scope of service.
 - If a projected cost report cannot be completed, the RHC or FQHC must provide sufficient cost and encounter information to establish a temporary rate

What are the deadlines and effective dates associated with a prospective change in scope of service request?

The completed application must be received no later than 120 days in advance of the prospective change in scope of service to be considered timely.

- For timely applications, the effective date of the temporary PPS rate will be the date that the change in scope of service is implemented.
- For untimely applications, the effective date of the temporary PPS rate is the later of:
 - The date that the Department receives the RHC's or FQHC's completed application materials; or
 - The date that the change in scope is implemented.

What is a temporary PPS rate?

A temporary PPS rate is established utilizing the materials requested in ARM 37.86.4409. It is a rate assigned during the time period of the change in scope of service and the establishment of the final incremental change to the PPS rate. The Department will establish a temporary PPS rate within 90 days from receiving the completed application and notify the RHC or FQHC.

Once the change in scope of service is implemented, the RHC or FQHC must notify the Department, even if the change is implemented on the scheduled date.

What is required to submit to the Department to finalize the incremental change to the baseline PPS rate?

Six months after the close of the RHC's or FQHC's fiscal year in which the change in scope of service has ended the RHC or FQHC must supplement its application by submitting the following materials:

- A narrative description of each change in scope of service, including how the services were provided, both before and after the change.
- The date that the change in scope of service was implemented.
- The RHC's or FQHC's as-filed Medicare cost reports for the fiscal year in which the change in scope of service occurred.
- The Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred.
 - Not applicable to RHCs or Urban FQHCs.
- A description of each cost center on the cost report affected by the change in scope of service.

- An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC or FQHC.
- Any approved changes in scope of project as defined by the federal Health Resources and Service Administration (HRSA).

What if we are late in submitting our supplemental information?

If the supplemental material is not received 30 days prior to the six-month deadline, the Department will send notification to the RHC or FQHC advising them that payment for Montana Healthcare Programs claims will be suspended if the required documentation is not received in a timely manner.

When will the Department calculate the new baseline PPS rate for a prospective change in scope of service?

Once all the supplemental materials are received, the Department will calculate the incremental change to the baseline PPS rate and will notify the RHC or FQHC of the determination.

What will be the effective date of the baseline PPS rate bet for prospective change in scope of service?

The effective date of the baseline PPS rate will be retroactive to the date that the change in scope was implemented.

What happens if the baseline PPS rate is different than the temporary PPS rate?

If your baseline PPS rate is greater than your temporary PPS rate, the Department will reimburse you the difference through a mass adjustment.

If your baseline PPS rate is less than your temporary PPS rate, the Department will recoup the difference through a mass adjustment.

How often can an RHC or FQHC submit a retrospective change in scope of service?

An RHC or FQHC may apply for a retrospective change in scope of service once per calendar year.

What effective date will be issued after the baseline PPS rate has been calculated for a retrospective change in scope of service?

The completed application must be received six months after the close of the RHC's or FQHC's fiscal year in order to be receive a timely effective date (see below).

- For timely applications, the effective date of the incremental change to the baseline PPS rate is the beginning of the facility's fiscal year following the retrospective change in scope of service.
- For untimely applications, the effective date of the incremental change to the baseline PPS rate is the date that the Department received all required information

What information is required to submit with a retrospective change in scope of service?

The following information must be submitted in order to apply for a retrospective change in scope of services:

- A narrative description of each change in scope of service, including how services were provided before and after the change
- The RHC's or FQHC's as-filed Medicare cost reports for the fiscal year prior to the change in scope of service and year in which the change in scope of service occurred
- The Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred
 - Does not apply to RHCs or Urban FQHCs
- A description of each cost center on the cost report affected by the change in scope of service
- An attestation statement that certifies the truth, accuracy, and completeness of the information in the application signed by an officer or administrator
- Any approved changes in the scope of project as defined by the Health Resources and Services Administration (HRSA).

When will the Department calculate the incremental change to the baseline PPS rate for a retrospective change in scope of service?

The department will notify the RHC or FQHC of the determination and any change to the PPS rate within 90 days from receiving the complete application and any requested information.

Claim Forms

RHC and FQHC services must be billed either electronically or on a paper UB-04 claim form. UB-04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

RHC and FQHC services performed in a hospital setting must be billed on a CMS-1500 claim form. The RHC or FQHC NPI number must be submitted as the billing provider and the individual provider that provided services must be submitted as the rendering provider on the CMS-1500 claim form.

Please note, services submitted on a CMS-1500 claim form will be paid a fee for service rate, not the PPS rate.

Unless otherwise stated, all paper claims must be mailed to the following address:

Claims
P.O. Box 8000
Helena, MT 59604

Revenue Codes

The following revenue codes are reimbursable when billed by an RHC or FQHC with a valid, allowable procedure code:

- 0512 – Dental
- 0521 – RHC/FQHC clinic visit
- 0522 – RHC/FQHC home visit
- 0524 – Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility
- 0525 – Visit by RHC/FQHC practitioner to a member in a skilled nursing facility (not in a covered Part A stay) or nursing facility or intermediate care facility for the MR or other residential facility
- 0527 – RHC/FQHC visiting nurse services to a member’s home when in a home health shortage area
- 0528 – Visit by an RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)
- 0529 – Other freestanding clinic
- 0636 – HMK vaccine reimbursements and long-acting reversible contraceptives
- 0771 – Vaccine administration fee
- 0779 – Clinical Pharmacist Practitioner
- 0780 – Telehealth originating site
- 0900 – Behavioral health services
- 0910 – Behavioral health peer support services
- 0911 – Substance use disorder peer support services
- 0942 – Health education
- 0944 – Substance use disorder
- 0969 – Promising Pregnancy Care (group education session)
- 0982 – Professional fees outpatient services

Number of Lines on Claim

Claims that are submitted with the same revenue code for the same date of service will bundle and be reimbursed at the PPS rate. Claims submitted with different revenue codes to distinguish distinct face-to-face encounters with core providers of differing specialties will be reimbursed at the PPS rate for each revenue code.

Multiple Services on Same Date (ARM 37.86.4402)

A visit is a face-to-face encounter between a patient and a health professional for the purpose of providing RHC or FQHC services.

Reimbursement is available for one encounter per day per eligible member unless it is necessary for the member:

- To be seen by different health professionals with different specialties; or
- To be seen multiple times per day due to unrelated diagnoses
 - When a member is seen by providers of the same specialty within the same visit, services rendered are reimbursable as one face-to-face encounter

Span Billing

Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim.

RHC and FQHC Limitations

Like all healthcare services received by Medicaid members, RHC and FQHC services must also meet the general requirements listed in the Provider Requirements chapter of the General Information for Providers Manual.

Although an RHC or FQHC receives a facility-specific prospective payment system (PPS) rate for most services they provide, the clinic is still obligated to follow the same limits on amount, scope, and duration of services covered by the Medicaid program. For example, if the clinic is providing dental services, the dental program limits still apply, such as an individual dental provider requiring an AbCd certification in order to submit claims to AbCd procedure codes.

As an RHC or FQHC, it is the responsibility of the provider to ensure that they are in compliance with requirements disclosed each program's provider manual.

Each clinic and individual provider rendering the service must maintain a current Medicaid provider enrollment. [The enrollment link can be found at https://www.medicicaidprovider.mt.gov/](https://www.medicicaidprovider.mt.gov/).

Service Settings

Clinic services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office), or a member's place of residence. A member's place of residence may be a nursing facility or other institution used as the member's home.

Allowable services are reimbursed when provided in outpatient settings including the clinic, other medical facility (including a dental office) or a member's place of residence. A member's place of residence may be a nursing facility or other institution used as the member's home. Clinic services are covered off-site if the service is normally furnished within the scope of the clinic's professional services. RHC and FQHC providers who perform services in a hospital setting must bill the service on a CMS-1500 form. The RHC or FQHC must be submitted as the billing provider and the individual provider that provided services must be submitted as the rendering provider on the CMS-1500 claim form.

Satellite Clinics

[Per 45 CFR 162.410, if the subparts are part of the same legal entity as the parent company, a separate NPI number for each subpart is not required, only optional. If separate NPI numbers are obtained, each location must identify themselves with their assigned NPI numbers on all standard transactions that require the identifier.](#)

Clinic Covered Core Services

The following are covered core services in RHCs (R), FQHCs (F), or both (B) and may be billed as a visit when there is a face-to-face encounter with the member:

- B – Physician services
- B – Nurse practitioner, nurse specialist, certified nurse midwife, or physician’s assistant services
- B – Clinical psychologist, clinical social worker, licensed professional counselor services, licensed addiction counselor, and licensed marriage & family therapist
- B – Dental services
- B – Visiting nurse; all requirements in 42 CFR 2416 must be adhered to
- B – Clinical Pharmacist Practitioner
- F – Preventive primary services; does not include eyeglasses or hearing aids, but does include
 - Perinatal care for high-risk members
 - Tuberculosis testing for high-risk members
 - Risk assessment and initial counseling regarding risks
 - Preventive dental

Services and supplies furnished as incidental to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in the provider’s rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B – Furnished as an incidental, although integral, part of the physician’s or mid-level practitioner’s professional service (i.e., influenza vaccine/administration)
- B – Service commonly rendered without charge or included in the clinic’s claim
- B – Service that is commonly furnished in a physician’s office or a clinic
- B – Basic lab services essential to the immediate diagnosis and treatment of the member
- B – Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist, or social worker.
- B – In the case of a service, furnished by a member of the clinic’s healthcare staff who is an employee of the clinic
- B – Drugs and biologicals that cannot be self-administered
- B – Radiology, including ultrasound
- B – Pharmacist-only visits of any kind
- B – Outreach
- B – Transportation

Dental Hygienist and Dental Hygienist with limited access permit (LAP) Services

A billable dental encounter includes services performed by dental hygienists under the general supervision of a licensed dentist and by dental hygienists with limited access permit (LAP). LAP hygienists must ensure compliance in accordance with MCA 37-4-405.

Fluoride varnish application only encounters are included in the provider’s PPS rate. This service is an incidental to the preventative screening or dental visit and is not billable as a stand-alone visit.

Ambulatory Services

Ambulatory services are services other than core services that would be covered under Montana Healthcare Programs, if provided by an individual or entity other than a clinic in accordance with Medicaid requirements.

Ambulatory services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program (e.g., medical necessity criteria).

Many services require Passport referral, and some services may require prior authorization.

Promising Pregnancy Care (ARM 37.86.4412, ARM 37.86.4501, ARM 37.86.4502, ARM 37.86.4503)

Providers must receive approval from the department to be eligible for reimbursement. Contact the Program Officer for more information.

The obstetric visit will be reimbursed at the FQHC/RHC PPS rate, and the group educational component will be reimbursed at the fee schedule rate.

Long-Acting Reversible Contraceptive Devices (LARCs)

Reimbursement for LARCs is the lower of submitted charges or the average acquisition cost (AAC) as defined in ARM 37.86.1106.

Reimbursement will be made only on those drugs manufactured by companies that have a signed rebate agreement with CMS (ARM 37.85.905).

Certified Peer Support Behavioral Health Services Covered Services

RHC and FQHC providers are eligible to be reimbursed for certified peer support specialist services, effective July 1, 2019. [Please see the Addictive & Mental Disorders Division \(AMDD\) Provider Manual for Program requirements.](#)

Certified peer support specialist services are reimbursable at a fee-for-service rate utilizing the OPPS fee schedule.

Clinical Pharmacist Practitioner (CPP) Services

Upon approval of a change in scope of services request, Clinical Pharmacist Practitioner (CPP) services must be billed with revenue code 779 and procedure code 99605 or 99606 for each qualifying visit between a CPP and Montana Healthcare Programs member. Reimbursement will be provided at the facility-specific prospective payment system (PPS) rate.

The legal basis for the Collaborative Practice Drug Therapy Management Program can be found in ARM 37.86.901; ARM 37.86.902; and ARM 37.86.905.

Collaborative Practice Drug Therapy Management (ARM 37.86.901, ARM 37.86.902, and ARM 37.86.905)

Members who have at least one chronic condition needing at least one maintenance medication are eligible for collaborative practice drug therapy management to be reimbursed the FQHC/RHC PPS rate. The Clinical Pharmacist Practitioner (CPP) must manage a member's drug therapy by providing face-to-face, direct care.

The CPP must be a pharmacist that meets the requirements as outlined in ARM 24.174.526, must be enrolled with Montana Medicaid, and must have a collaborative practice agreement with the medical practitioner, as provided in ARM 24.174.524

Visiting Nurses (42 CFR 2416)

Part-time or intermittent nursing care and related medical services other than drugs and biologicals may be provided to a homebound individual (see definition below) by a clinic:

- Only in geographic areas designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services;
- **When services are rendered to a homebound member only. A homebound individual is a person who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long-term care facility.**
- When a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either established and periodically reviewed (at least every 60 days) by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).

Vaccine Reimbursement

The Vaccines for Children (VFC) program makes selected vaccines available at no cost to providers for eligible children 18 years and under.

Vaccines and the administration of vaccines are not covered services in an RHC or FQHC setting and are not separately billable, except for services provided to children enrolled in Healthy Montana Kids (HMK). Vaccinations for Medicaid members are considered an incident to the face-to-face visit with the core provider.

Since HMK-enrolled children are not entitled to the VFC program, RHC and FQHC providers may bill Montana Healthcare Programs for vaccines using revenue code 0636 and the vaccine procedure code. A nurse-only administration visit for an HMK member is reimbursed with revenue code 0771. If the administration was part of a visit with core provider, the administration will bundle with the revenue code submitted for the face-to-face visit.

Nurse only vaccine administration visits are not reimbursable for Montana Medicaid members.

Non-Covered Services (ARM 37.85.207)

Please refer to ARM 37.85.207 for a list of non-covered services.

Prior Authorization

[For information regarding prior authorization, please refer to the Prior Authorization link at www.medicaprovider.mt.gov.](http://www.medicaprovider.mt.gov)

[You can also refer to the General Information for Providers Manual.](#)

A few things to keep in mind:

- Please refer to the most recent OPPS fee schedule to reference the code in question. The fee schedule will indicate if the code needs prior authorization.
- The referring provider should initiate all authorization requests.
- When prior authorization is granted, the provider will receive an authorization number that will be required on the claim. The prior authorization number and Passport number are two different numbers.
 - For Passport information, please refer to the Passport to Health manual located at <https://www.medicaprovider.mt.gov/>.
- Providers must adhere to all prior authorization requirements to avoid claim denials

Medicare Claims

The Department's fiscal agent must have the provider's Medicare number on file to process claims, and providers should include their NPI/API on their Medicare claims.

RHC and FQHC claims automatically cross over from Medicare for dually eligible members, so providers do not need to send in their crossovers on paper. RHC and FQHC claims that cross over to Medicaid are paid the Medicare coinsurance and deductible less any TPL coverage.

Members can be eligible for Qualified Medicare Beneficiary (QMB) Only, or QMB Plus. QMB Plus is dual eligibility, which includes QMB and a Medicaid policy.

- RHC QMB Reimbursement:
 - QMB Only & QMB Plus: Reimbursed for the full Medicare deductible and/or coinsurance.
- FQHC QMB Reimbursement:
 - QMB Only: Reimbursed the Medicare deductible and/or coinsurance
 - QMB Plus: Reimbursed the difference between the Medicare payment and the PPS rate.

When an RHC or FQHC provides services rendered by an LCPC, LAC, or CPP, the Medicare EOB is not required if the rendering provider is enrolled in Montana Healthcare Programs. Montana Healthcare Programs recognizes these services are not covered by Medicare, so the denial for the primary carrier EOB is bypassed.

Third Party Liability

When a member is eligible with Montana Healthcare Programs and another carrier, the other carrier is often referred to as third party liability (TPL). In these cases, the other carrier is typically considered the primary payer and Medicaid will only reimburse the provider when the TPL payment is less than the Medicaid allowable amount.

[For more information regarding TPL, please refer to the General Information for Providers Manual.](#)