Title: **BSW 605**
Section: **ADMINISTRATIVE REQUIREMENTS**
Subject: **Payment Processing**
Reference: **Big Sky Waiver application 01-01-2018; ARM 37.85.401-.415, ARM 37.40.1415**
Supersedes: **BSW 605 (01/01/2012)**

REQUIREMENT

Providers of Big Sky Waiver (BSW) Services must be enrolled as a Medicaid provider. Payment for services must be made directly to the provider of service. No payment may be made to the member or any entity other than the direct provider of services unless otherwise specified by the Department.

Under certain rare circumstances, BSW case management teams may bill for a service provided by another entity to facilitate payment (a pass-through payment) when a member goes out-of-state, for a one-time purchase, or a temporary service. All pass-through requests require prior authorization. Refer to BSW 403.

When billing for a service provided by another entity, the Case Management Team (CMT) must obtain an invoice for the cost of the service. The CMT or other entity may not add on a charge for processing the claim.

DEFINITIONS

Clean Claim: A claim that can be processed without additional information or documentation or action by the provider of the service.

Submission date: The date the claim was received by the Department or BSW's Fiscal Intermediary Contractor.

CLAIM FORM

The provider of services requests payment for BSW covered services from Medicaid's Fiscal Intermediary Contractor via a CMS-1500 claim form or 837-P transaction.

CASE MANAGEMENT TEAM (CMT) APPROVAL

All Big Sky Waiver Services, except case management, must be prior authorized by the CMT. The prior authorization number must be noted on the CMS-1500 claim form or 837-P transaction for all submitted charges.

Refer to BSW's Fiscal Intermediary Contractor for instructions to create, change or deny prior authorizations.

The CMT must establish more than one prior authorization number for a member in a time period, if there is more than one provider providing the same service at the same time, such as personal assistance, or moving from one assisted living facility to another. This will eliminate the chance of one provider billing for more units than they were authorized and the other provider having their claims denied.

The CMT must send providers a referral which meets BSW's Fiscal Intermediary Contractor's proper claim submission guidelines. The referral must include, at a minimum, the following information:

1. Prior Authorization Number;
2. Provider's name and Medicaid BSW provider number;
3. Member's name, address, telephone number and date of birth;
4. Member's Medicaid ID number;
5. Member's primary diagnosis and ICD-10 code;
6. Prior authorization number and date span;
7. List of procedure code(s) and modifier(s) this provider is authorized to provide and bill;
8. Dollar amount or number of units and date span for each procedure code authorized. To avoid overbilling, it is preferable to use dollar amounts when the service has an upper limit as the provider could erroneously bill at the higher rate;
9. Any comments that would benefit the provider; e.g., number of hours per week; and
10. Case management contact person and telephone number.

MEMBER DISCHARGE

The CMT must end-date the prior authorization at discharge of a waiver member.

PAYMENT DEADLINES

Providers must submit clean claims to BSW's Fiscal Intermediary Contractor within:

Twelve months from the latest of:

- the date of service, or
- the date retroactive eligibility or disability is determined.

NOTE: All problems with claims must be resolved within this 12-month period.

QUESTIONS ON CLAIMS

Questions about the filing of claims or payments should be directed to:

BSW's Fiscal Intermediary Contractor 1-800-624-3958; or
Community Services Bureau at (406) 444-4376.