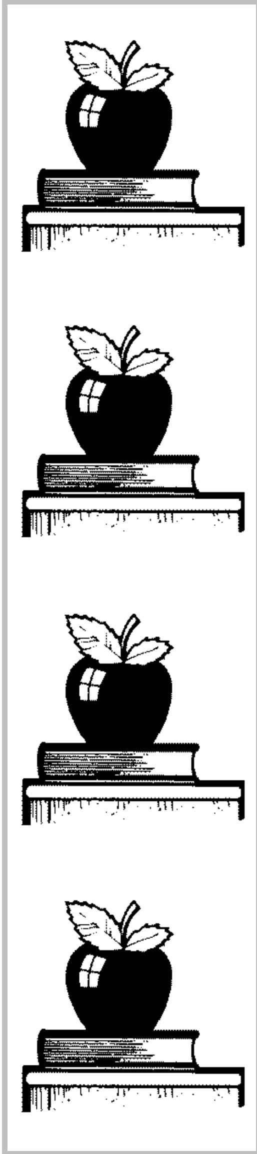

General Information for Providers

Montana Healthcare Programs

Medicaid and Other Medical Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

August 2015

This publication supersedes all versions of previous general information provider handbooks. This publication is to be used conjunction with provider type manuals. Published by the Montana Department of Public Health & Human Services, February 2002.

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Key Contacts and Key Websites

See the Contact Us link in the menu on the Montana Healthcare Programs Provider Information website, http://medicaidprovider.mt.gov/, for a list of contacts and websites.

Montana Department of Public Health and Human Services

Introduction

The Medicaid program plays an essential role in providing health insurance for Montanans. Before the enactment of Medicare and Medicaid, healthcare for the elderly and the indigent was provided through a patchwork of programs sponsored by governments, charities, and community hospitals.

Today, Medicare is a federal program that provides insurance for persons aged 65 and over and for people with severe disabilities, regardless of income. Medicaid provides healthcare coverage to specific populations, especially low-income families with children, pregnant women, disabled people, and the elderly. Medicaid is administered by state governments under broad federal guidelines. Recent healthcare laws have greatly increased the number of people who qualify for Medicaid. See the Montana Medicaid Program: Report to the 2015 Legislature.

Rule References

Providers must be familiar with current rules and regulations governing the Montana Medicaid program. The provider manuals are meant to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations.

Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available online on the provider type pages on the Provider Information website or at http://www.sos.mt.gov/ARM/index.asp.

Providers can order the Administrative Rules of Montana, including individual titles, online or by mail, through the Secretary of State website. Select the How to Order option in the Additional Resources section.

Manual Organization

The *General Information for Providers* manual provides answers to general Medicaid questions about provider enrollment, member eligibility, and surveillance and utilization review.

This manual is designed to work with Medicaid provider type manuals, which contain program information on covered services, prior authorization, and billing for specific services.

It is divided by chapters, and a table of contents and index allow providers to find answers to most questions. The margins contain important information and space for writing notes. For eligibility and coordination of benefit information, see the Member Eligibility and Responsibilities chapter in this manual. Provider-specific information is in provider type manuals. Contact Provider Relations at 1-800-624-3958 with questions.

Manual Maintenance

Changes and updates to manuals are provided through provider notices and replacement pages, which are posted on the Provider Information website. When replacing a page in a paper manual, file the old page in back of the manual for use with claims that originated under the old policy.

Providers are responsible for knowing and following current laws and regulations. Manuals, replacement pages, and provider notices are provided as a guide and do not create any contractual liability on the part of the Department to any provider.

Replacement pages are designed for front-to-back printing. The heading at the top indicates the date of the changes (e.g., Replacement Page, August 2015).

Website Information

Additional information is available through the Provider Information website.

Providers can stay informed with the latest Medicaid news and events, download provider manuals/replacement pages, provider notices, fee schedules, newsletters, and forms. Other resources are also available. See the menu for links.

The monthly Montana Healthcare Programs online newsletter, the *Claim Jumper*, covers Medicaid program changes and includes a list of documents posted to the Provider Information website during that time frame.

Provider Training Opportunities

Montana Healthcare Programs offers a variety of training opportunities that are announced on the Provider Information website and in the *Claim Jumper* newsletter. Recorded training sessions are available on the Training page of the website.

Contract Services

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

- **Xerox State Healthcare, LLC**. Answers provider inquiries and enrolls providers in Medicaid and Passport to Health; processes claims for Medicaid, MHSP, and HMK pharmacy, dental, and eyeglasses.
- **Mountain-Pacific Quality Health**. Provides prior authorization for many Medicaid services.
- **Magellan Medicaid Administration (dba First Health Services)**. Provides prior authorization, utilization review, and continued stay review for some mental health services.

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Basic Medicaid Versus Full Medicaid Benefits

Full Medicaid Benefits

Full Medicaid members are eligible for all services that Medicaid covers if medically necessary. Covered services include, but are not limited to, audiology services, clinic services, community health centers services, dental services, doctor visits, hospital services, immunizations, Indian Health Services, laboratory services, mental health services, Nurse First services, nursing facility, occupational therapy, pharmacy, public health clinic services, substance dependency services, tobacco cessation, transportation, vision services, well-child checkups, and x-rays.

Basic Medicaid Benefits

Basic Medicaid members are eligible for the full Medicaid benefits with the following services generally **excluded**: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids.

DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment.

Basic Medicaid Waiver

This waiver includes able-bodied adults and adults, ages 18–64 with severe disabling mental illness. Members receive basic Medicaid benefits. To apply or for more information, contact the Addictive and Mental Disorders Division at 1-406-444-2878 or visit the AMDD webpage.

Other Programs

In addition to Medicaid, the Department of Public Health and Human Services (DPHHS, the Department) offers other programs. In addition to those listed below, other subsidized health insurance plans may be available from programs funded by the federal government or private organizations.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Programs

For individuals who are ineligible for Medicaid and whose family income is within program standards. Call 406-444-3964 or visit http://dphhs.mt.gov/amdd/SubstanceAbuse for more information on these programs.

Children's Mental Health Bureau Non-Medicaid Services

Funding sources for short-term use, not entitlement programs. Planning efforts toward family reunification are the primary objective, with transition planning essential for youth in out-of-home care. For information, call 406-444-4545, or refer to the *Non-Medicaid Services Provider Manual* at http://dphhs.mt.gov/dsd/CMB/Manuals.

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Children's Special Health Services (CSHS)

A program that assists children with special healthcare needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics. For more information, call 406-444-3622 (local) or 800-762-9891 (toll-free in Montana) or visit http://dphhs.mt.gov/publichealth/cshs.

Health Insurance Premium Payment (HIPP)

A program that allows Medicaid funds to be used to pay for private health insurance coverage when it is cost effective to do so.

Visit http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP.

Healthy Montana Kids (HMK)

HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. Visit http://dphhs.mt.gov/HMK.

Mental Health Services Plan (MHSP)

A program for adults who are ineligible for Medicaid and whose family income is within program standards.

Visit http://dphhs.mt.gov/amdd/Mentalhealthservices.

Plan First

If a member loses Medicaid, family planning services may be paid by Plan First, which is a separate Medicaid program that covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of sexually transmitted diseases (STDs).

Visit http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst.

Montana Department of Public Health and Human Services

Provider Requirements

Provider Enrollment

To be eligible for enrollment, a provider must:

- Provide proof of licensure, certification, accreditation, or registration according to Montana state laws and regulations.
- Provide a completed W-9.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.

Providers must complete a Montana Healthcare Programs Provider Enrollment Form, which is a contract between the provider and the Department. Healthcare providers must have a National Provider Identifier (NPI) or atypical provider identifier (API), which should be used in all correspondence with Medicaid. Providers must enroll for each type of service they provide. For example, a pharmacy that also sells durable medical equipment (DME) must enroll for the pharmacy and again for DME.

Medicaid payment is made only to enrolled providers.

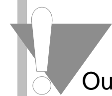
To enroll online as a Montana Medicaid provider, visit the Montana Access to Health (MATH) web portal directly at https://mtaccesstohealth.acs-shc.com or the Montana Healthcare Programs Provider Information website and click the MATH Web Portal link near the top left, or contact Provider Relations at 1-800-624-3958.

Enrollment Materials

Each newly enrolled provider is sent an enrollment letter confirming enrollment. The letter includes instructions for obtaining additional information from the Provider Information website.

Letters to atypical providers include their API.

Medicaid-related forms are available on the Provider Information website. However, providers must order CMS-1500, UB-04, and dental claim forms from an authorized vendor.



Out-of-state providers can avoid denials and late payments by renewing Medicaid enrollment early.

Medicaid Renewal

For continued Medicaid participation, providers must maintain a valid license or certificate. For Montana providers, licensure or certification is automatically verified and enrollment renewed each year. If licensure or certification cannot be confirmed, the provider is contacted. Out-of-state providers are notified when Medicaid enrollment is about to expire. To renew enrollment, providers should mail or fax a copy of their license or certificate to Provider Relations. See the Contact Us link on the Provider Information website.

To avoid payment delays, notify Provider Relations of an address change in advance.

Changes in Enrollment

Changes in address, telephone/fax, name, ownership, legal status, tax ID, or licensure must be submitted in writing to Provider Relations. Faxes are not accepted because the provider's original signature and NPI (healthcare providers) or API (atypical providers) are required. For change of address, providers can use the form on the website; for a physical address change, providers must include a completed W-9 form.

Change of Ownership

When ownership changes, the new owner must re-enroll in Montana Medicaid. For income tax reporting purposes, the provider must notify Provider Relations at least 30 days in advance about any changes to a tax identification number. Early notification helps avoid payment delays and claim denials.

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. For more information on electronic claims submission options, see the Electronic Claims section in the Billing Procedures chapter in this manual.

Terminating Medicaid Enrollment

Medicaid enrollment may be terminated by writing to Provider Relations; however, some provider types have additional requirements. Providers should Include their NPI (healthcare providers) or API (atypical providers) and the termination date in the letter. The Department may also terminate a provider's enrollment under the following circumstances:

- Breaches of the provider agreement.
- Demonstrated inability to perform under the terms of the provider agreement.
- Failure to abide by applicable Montana and U.S. laws.
- Failure to abide by the regulations and policies of the U.S. Department of Health and Human Services or the Montana Medicaid program.

Authorized Signature (ARM 37.85.406)

All correspondence and claim forms submitted to Medicaid must have an NPI (healthcare providers) or API (atypical providers) and an authorized signature. The signature may belong to the provider, billing clerk, or office personnel, and may be handwritten, typed, stamped, or computer-generated. When a signature is from someone other than the provider, that person must have written authority to bind and represent the provider for this purpose. **Changes in enrollment information require the provider's original signature.**

Provider Rights

- Providers have the right to end participation in Medicaid in writing at any time; however, some provider types have additional requirements.
- Providers may bill Medicaid members for cost sharing (ARM 37.85.204).
- Providers may bill a member for the copayments specified in ARM 37.83.826 and may bill certain members for amounts above the Medicare deductibles and coinsurance as allowed in ARM 37.83.825.
- Providers may bill Medicaid members for services not covered by Medicaid if the provider and member have agreed in writing prior to providing services.
- When the provider **does not** accept the member as a Medicaid 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 Medicaid will not cover the services and that 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 particular member by the Montana Medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana Medicaid program for the particular member if all applicable requirements, including medical necessity, are met (ARM 37.85.406).
- Providers have the right to choose Medicaid members, subject to the conditions in Accepting Medicaid Members later in this chapter.
- Providers have the right to request administrative reviews and fair hearings for a Department action that adversely affects the provider's rights or the member's eligibility (ARM 37.85.411).

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 this 30 days. See the Contact Us link on the Provider Information website.

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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 Fair Hearings Office 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 3 working days of filing the request.

Provider Participation (ARM 37.85.401)

By enrolling in the Montana Medicaid program, providers must comply with all applicable state and federal statutes, rules, and regulations, including but not limited to, federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Medicaid program and all applicable Montana statutes and rules governing licensure and certification.

Accepting Medicaid Members (ARM 37.85.406)

Institutional providers, eyeglass providers, and non-emergency transportation providers **may not** limit the number of Medicaid members they will serve. Institutional providers include nursing facilities, skilled care nursing facilities, intermediate care facilities, hospitals, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities.

Other providers may limit the number of Medicaid members. They may also stop serving private-pay members who become eligible for Medicaid. Any such decisions must follow these principles:

- No member should be abandoned in a way that would violate professional ethics.
- Members may not be refused service because of race, color, national origin, age, or disability.
- Members enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- In service settings where the patient is admitted or accepted as a Medicaid member by a provider, facility, institution, or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a Medicaid member and may not bill the patient for the services unless, prior to provision of services, the particular provider informed the patient of their refusal to accept Medicaid and the member agreed to pay privately for the services. See ARM 37.85.406(11)(d) for details.
- Most providers may begin Medicaid coverage for retroactively eligible members at the current date or from the date retroactive eligibility was effective. See the Retroactive Eligibility section in the Member Eligibility and Responsibilities chapter of this manual for details.

- When a provider bills Medicaid for services rendered to a patient, the provider has accepted the patient as a Medicaid member.
- Once a patient has been accepted as a Medicaid member, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

Non-Discrimination (ARM 37.85.402)

Providers may not discriminate illegally in the provision of service to eligible Medicaid members or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age, or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), the Age Discrimination Act of 1975 (42 USC 6101, et seq.), the Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes.

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Member must be enrolled in Medicaid and be nonrestricted. See Member Eligibility and Responsibilities for restrictions. (ARM 37.85.415 and ARM 37.85.205)
- Service must be medically necessary. The Department may review medical necessity at any time before or after payment. (ARM 37.85.410)
- Service must be covered by Medicaid and not be considered cosmetic, experimental, or investigational. (ARM 37.82.102, ARM 37.85.207, and ARM 37.86.104)
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the Billing Procedures chapter, current provider notices and manual replacement pages, and according to ARM 37.85.406 (Billing, reimbursement, claims processing and payment) and ARM 37.85.407 (third party liability).
- Charges must be usual and customary. (ARM 37.85.212 and ARM 37.85.406)
- Reimbursement to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties ($75.00) is greater than the Medicaid fee ($70.00), Medicaid will pay at $0. (ARM 37.85.406)
- Claims must meet timely filing requirements. See the Billing Procedures chapter in this manual for timely filing requirements. (ARM 37.85.406)

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- Prior authorization requirements must be met. (ARM 37.85.406)
- Passport approval requirements must be met. (ARM 37.86.5101–5112)

Medicaid Payment Is Payment in Full (ARM 37.85.406)
Providers must accept Medicaid payment as payment in full for any covered service, except applicable cost sharing that should be charged to the member.

Payment Return (ARM 37.85.406)
If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

Disclosure
- Providers are required to fully disclose ownership and control information when requested by the Department. (ARM 37.85.402)
- Providers are required to make all medical records available to the Department. (ARM 37.85.410 and ARM 37.85.414)

Member Services
- All services must be made a part of the medical record. (ARM 37.85.414)
- Providers must treat Medicaid members and private-pay members equally in terms of scope, quality, duration, and method of delivery of services unless specifically limited by regulations. (ARM 37.85.402)
- Providers may not deny services to a member because the member is unable to pay cost sharing fees. (ARM 37.85.402)

Confidentiality (ARM 37.85.414)
All Medicaid member and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of healthcare information subject to applicable laws.

Record Keeping (ARM 37.85.414)
Providers must maintain all Medicaid-related medical and financial records for 6 years and 3 months following the date of service. The provider must furnish these records to the Department or its designee upon request. The Department or its designee may audit any Medicaid-related records and services at any time. Such records may include but are not limited to:

- Original prescriptions
- Certification of medical necessity
- Treatment plans
- Medical records and service reports including but not limited to:
  - Patient's name and date of birth
  - Date and time of service
  - Name/title of person providing service (other than billing practitioner)

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- Chief complaint or reason for each visit
- Pertinent medical history
- Pertinent findings on examination
- Medication, equipment, and/or supplies prescribed or provided
- Description and length of treatment
- Recommendations for additional treatments, procedures, or consultations
- X-rays, tests, and results
- Dental photographs/teeth models
- Plan of treatment and/or care, and outcome
- Specific claims and payments received for services
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid members
- Records/original invoices for items prescribed, ordered, or furnished
- Any other related medical or financial data

Compliance with Applicable Laws, Regulations, and Policies

All providers must follow all applicable rules of the Department and all applicable state and federal laws, regulations, and policies. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.**

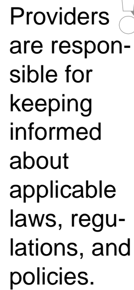
The following are references for some of the rules that apply to Montana Medicaid. The provider manual for each individual program contains rule references specific to that program.

- Title XIX Social Security Act 1901 et seq.
  - 42 U.S.C. 1396 et seq.
- Code of Federal Regulations (CFR)
  - CFR Title 42 – Public Health
- Montana Codes Annotated (MCA)
  - MCA Title 53 – Social Services and Institutions
- Administrative Rules of Montana (ARM)
  - ARM Title 37 – Public Health and Human Services

Links to rules are available on the provider type pages of the Provider Information website. Paper copies of rules are available through the Secretary of State's office.

Montana Department of Public Health and Human Services

Provider Sanctions (ARM 37.85.501–507 and ARM 37.85.513)



Providers are responsible for keeping informed about applicable laws, regulations, and policies.

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

Other Programs

Below is a list of non-Medicaid Department of Public Health and Human Services (DPHHS) programs.

- Chemical Dependency Bureau Substance Dependency/Abuse Treatment
  http://dphhs.mt.gov/amdd/SubstanceAbuse
- Children's Mental Health Bureau Non-Medicaid Services
  http://dphhs.mt.gov/dsd/CMB/Manuals
- Health Insurance Premium Payment (HIPP)
  http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
- Healthy Montana Kids (HMK)
  http://dphhs.mt.gov/HMK
- Mental Health Services Plan (MHSP)
  http://dphhs.mt.gov/amdd/Mentalhealthservices
- Plan First
  http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst

Montana Department of Public Health and Human Services

EPSDT Well-Child

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program is the federally sponsored, comprehensive healthcare benefits package for Medicaid-enrolled children through age 20. It helps families get early identification and treatment of medical, dental, vision, mental health, and developmental problems for their children. All Medicaid families are encouraged to use these services. See ARM 37.86.2201–2235.

EPSDT well-child checkups include:

- Assessment of physical, emotional, and developmental history
- Unclothed physical exams
- Assessment of mental/behavioral health
- Assessment of nutritional status
- Assessment of overall health, including referrals
- Laboratory tests
- Health education (also called anticipatory guidance)
- Family planning services and adolescent maternity care
- Appropriate immunizations
- Eye exams
- Hearing services
- Oral health

EPSDT includes a medical screen (sometimes called a well-child checkup), vision screen, dental screen, and hearing screen for all Medicaid-enrolled children. Montana Medicaid has adopted the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care. This schedule can be found at https://brightfutures.aap.org. Click on the Clinical Practice Tab, and choose the Get to Know the Bright Futures Guidelines and Core Tools option.

These screens help identify and take care of health problems early in a child's growth. Each screen includes a comprehensive health and developmental history; a comprehensive, unclothed physical exam; age-appropriate immunizations and laboratory tests (including blood lead levels); and health education. The screens are provided at specific periods throughout a child's growth.

When a Medicaid-eligible child requires medically necessary services that are safe and effective, those services may be covered under Medicaid even if they are not covered for adults. Healthcare, diagnostic services, treatments, and other measures that would correct or improve defects or physical or mental illnesses or conditions are available based on medical necessity. If these services are not a covered service

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of Montana Medicaid, prior authorization is required. For more information on prior authorization, see the Prior Authorization chapter of this manual, your provider type manual, and the Prior Authorization Information page on the Provider Information website.

Who Can Provide EPSDT Screenings?

- Physicians
- Advanced Registered Nurse Practitioners (ARNP)
- Physician assistants
- Registered nurse under guidance of a physician or ARNP may perform the screenings but not diagnose or treat.
- Providers must be Montana Medicaid-enrolled to receive payment from Medicaid.

The Well-Child Screen

The foundation of EPSDT is the well-child screen. These screens should begin as early as possible in a child's life or as soon as the child is enrolled in Medicaid. The well-child screens are based on a periodicity schedule established by medical, dental, and other healthcare experts, including the American Academy of Pediatrics. The Well-Child Screen Recommendations are found on the Bright Futures website, https://brightfutures.aap.org.

Every infant should have a newborn evaluation after birth. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time. If a well-child screen shows that a child is at risk based on the child's environment, history, or test results, the provider should perform required or recommended tests even though they may not be indicated for the child's age. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

Initial/Interval History

A comprehensive history, obtained from the parent or other responsible adult who is familiar with the child's history should be done during the initial visit. Once it is done, it only needs to be updated at subsequent visits. The history should include the following:

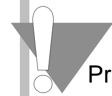
- Developmental history to determine whether the child's individual developmental processes fall within a normal range of achievement compared to other children of his/her age and cultural background.
- Discussion of the child's development, as well as techniques to enhance the child's development, with the parents.

- Nutritional history and status. Questions about dietary practices identify unusual eating habits, such as pica, or extended use of bottle feedings, or diets that are deficient or excessive in one or more nutrients.
- Complete dental history.

Developmental Assessments

Appropriate Developmental Surveillance. Providers should administer an age-appropriate developmental screen at each well-child visit. Any concerns raised during the surveillance should be promptly addressed with standardized developmental screening tests. See the recommended algorithm provided by Bright Futures at http://pediatrics.aappublications.org/content/118/1/405.full.

Appropriate Developmental Screening. Providers should administer an age-appropriate developmental screen at age 9, 18, and 30 months. Results should be considered in combination with other information gained through the history, physical examination, observation, and reports of behavior. If developmental problems are identified, appropriate follow-up and/or referral to proper resources should be made.



Providers must use medical judgement in determining applicability of performing specific tests.

Speech and language screens identify delays in development. The most important readiness period for speech is 9 to 24 months. Parents should be urged to talk to their children early and frequently. Refer the child for speech and language evaluation as indicated.

Parents of children with developmental disabilities should be encouraged to contact Parents Let's Unite for Kids (PLUK).

PLUK is an organization designed to provide support, training, and assistance to children with disabilities and their parents. Call, write, or visit the PLUK website, http://www.pluk.org/.

406-255-0540 Phone	PLUK
800-222-7585	516 North 32nd Street
406-255-0523 Fax	Billings, MT 59101-6003
E-Mail info@pluk.org	

Depression Screening. Signs and symptoms of emotional disturbances represent deviations from or limitations in healthy development. These problems usually will not warrant a psychiatric referral but can be handled by the provider. He/she should discuss problems with parents and give advice. If a psychiatric referral is warranted, the provider should refer the child to an appropriate provider. Recommended screening using the Patient Health Questionnaire (PHQ-2) or other tools found on the Bright Futures website.

Alcohol and Drug Use Screen. The provider should screen for risky behaviors (e.g., substance abuse, unprotected sexual activity, tobacco use, firearm possession). In most instances, indications of such behavior will not warrant a

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referral but can be handled by the provider, who should discuss the problems with the member and the parents and give advice. If a referral is warranted, the provider should refer to an appropriate provider. Recommended screening tool can be found on the Bright Futures website.

Nutritional Screen
Providers should assess the nutritional status at each well-child screen. Children with nutritional problems may be referred to a licensed nutritionist or dietician for further assessment or counseling.

Unclothed Physical Inspection
At each visit, a complete physical examination is essential. Infants should be totally unclothed and older children undressed and suitably draped.

Vision Screen
A vision screen appropriate to the age of the child should be conducted at each well-child screen. If the child is uncooperative, rescreen within six months.

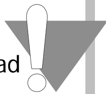
Hearing Screen
A hearing screen appropriate to the age of the child should be conducted at each well-child screen. All newborns should be screened.

Autism Screen
Autism screenings are recommended at age 18 and 24 months, and a recommended tool is provided on the Bright Futures website.

Critical Congenital Heart Defect Screen
Screening using pulse oximetry should be performed in newborns, after 24 hours old and before discharge.

Laboratory Tests
Providers who conduct well-child screens must use their medical judgment in determining applicability of performing specific laboratory tests. Appropriate tests should be performed on children determined at risk through screening and assessment.

Hematocrit and Hemoglobin. Hematocrit or hemoglobin tests should be done for at-risk (premature and low birth weight) infants at ages newborn and 2 months. For children who are not at risk, follow the recommended schedule.

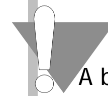


A blood lead level test should be performed on all children at 12 and 24 months of age.

Blood Lead Level. All children in Medicaid are at risk of lead poisoning. To ensure their good health, the federal government requires that all Medicaid-enrolled children be tested for lead poisoning. Testing is recommended at 12 and 24 months of age. Children up to age 6 years who have not been checked for lead poisoning before should also be tested.

All Medicaid children at other ages should be screened. Complete a verbal risk assessment for all Medicaid children up to age 6 years at each EPSDT screening:

- Does your child live in Butte, Walkerville, or East Helena, which are designated high-risk areas?
- Does your child live near a lead smelter, battery recycling plant, or other industry (operating or closed) likely to release lead?
- Does your child live in or regularly visit a house built before 1960, which contains lead paint?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does your child live in a home where the plumbing consists of lead pipes or copper with lead solder joints?
- Does your child frequently come in contact with an adult who works with lead, such as construction, welding, pottery, reloading ammunition (making own bullets), etc.?
- Is the child given any home or folk remedies? If yes, discuss.



A blood lead level test should be performed on all children at 12 and 24 months of age.

If the answer to all questions is no, a child is considered at low risk for high doses of lead exposure. Children at low risk for lead exposure should receive a blood test at 12 and 24 months.

If the answer to any question is yes, a child is considered at high risk for high doses of lead exposure and a blood lead level test must be obtained immediately regardless of the child's age.

Tuberculin Screening. Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination, or other risk factors so indicate.

Dyslipidemia Screening. Screening should be considered based on risk factors and family history at 24 months, 4, 6, 8, 12, 13, 14, 15, 16, and 17 years, and is indicated at or around 10 and 20 years of age.

STI/HIV Screening. All adolescent members should be screened for sexually transmitted infections (STIs) and HIV based on risk assessment starting at age 11 and reassessed annually with at least one assessment occurring between the ages of 16–18 years old.

Cervical Dysplasia Screening. Adolescents are not routinely screened for cervical dysplasia until age 21. See the 2010 AAP statement for indications at https://www.aap.org/en-us/Pages/Default.aspx.

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Immunizations

The immunization status of each child should be reviewed at each well-child screen. This includes interviewing parents or caretakers, reviewing immunization records, and reviewing risk factors.

The Recommended Childhood Immunization schedule is available on the AMA website and the Centers for Disease Control and Prevention website.

Dental Screen

The child's provider should perform annual dental screens, and results should be included in the child's initial/interval history. Annual dental screens include an oral inspection, fluoride varnish (as available) and making a referral to a dentist for any of the following reasons:

- When the first tooth erupts, and every six months thereafter.
- If a child with a first tooth has not obtained a complete dental examination by a dentist in the past 12 months.
- If an oral inspection reveals cavities or infection, or if the child is developing a handicapping malocclusion or significant abnormality.

Discussion and Counseling/Anticipatory Guidance

Providers should discuss examination results, address assessed risks, and answer any questions in accordance with parents' level of understanding. Age-appropriate discussion and counseling should be an integral part of each visit. Allow sufficient time for unhurried discussions.

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety: Car seats, seat belts, air bags, positioning young or lightweight children in the backseat.
- Recreational safety: Helmets and protective padding, playground equipment.
- Home hazards: Poisons, accidents, weapons, matches/lighters, staying at home alone, use of detectors for smoke, radon gas, and carbon monoxide.
- Exposure to sun and secondhand smoke.
- Adequate sleep, exercise, and nutrition, including eating habits and eating disorders.
- Peer pressure.
- General health: Immunizations, patterns of respiratory infections, skin eruptions, care of teeth.
- Problems such as whining, stealing, setting fires, etc. as indicated by parental concern.

- Behavior and development: Sleep patterns, temper, attempts at independence (normal and unpleasant behavior), curiosity, speech and language, sex education and development, sexual activities, attention span, toilet training, alcohol and tobacco use, substance abuse.
- Interpersonal relations: Attitude of father; attitude of mother; place of child in family; jealousy; selfishness, sharing, taking turns; fear of strangers; discipline, obedience; manners, courtesy; peer companionship/relations; attention getting; preschool, kindergarten and school readiness and performance; use of money; assumption of responsibility; need for affection and praise; competitive athletics.

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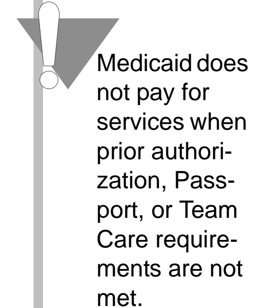
Prior Authorization

What Is Prior Authorization?

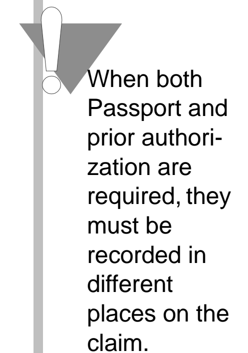
Prior authorization refers to a list of services that require Department authorization before they are performed. Some services may require both Passport referral and prior authorization.



To be covered by Medicaid, all services must also be provided in accordance with the requirements in the *Passport to Health* manual and on the Prior Authorization Information page of the Provider Information website, the Medicaid manual for your provider type, and the provider fee schedule.

In practice, providers will often encounter members who are enrolled in Passport. Whether the member is enrolled in Passport or Team Care, the eligibility information denotes the member's primary care provider. Services are only covered when they are provided or approved by the designated Passport provider or Team Care pharmacy shown in the eligibility information.

If a service requires prior authorization, the requirement exists for all Medicaid members. Prior authorization is usually obtained through the Department or a prior authorization contractor.



If both Passport referral and prior authorization are required for a service, then both numbers must be recorded in different fields on the Medicaid claim form. (See the Submitting a Claim section in this manual.)

Most Montana Medicaid fee schedules indicate when prior authorization is required for a service. For more information, see your provider type fee schedule and/or the Prior Authorization page of the Provider Information website.

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Member Eligibility and Responsibilities

Medicaid ID Cards

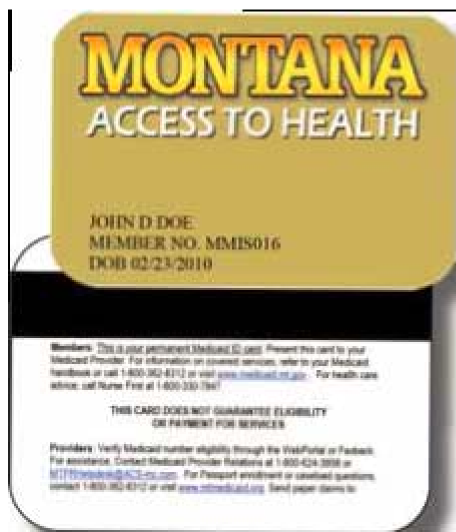
Each Medicaid member is issued his/her own permanent Montana Access to Health Medicaid ID card (including QMB only members), Healthy Montana Kids *Plus* (HMK *Plus*) card.

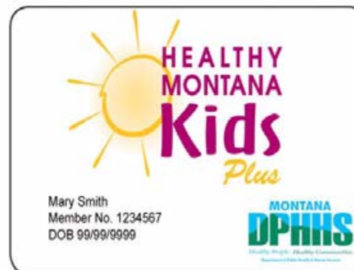
Members must never throw away the card, even if their Medicaid eligibility ends.

The ID card lists the member's name, member number, and date of birth. The member number may be used for checking eligibility and for billing Medicaid.

Since eligibility information is not on the card, providers must verify eligibility before providing services. See the Verifying Member Eligibility section below.

Providers should verify eligibility before providing services.





Verifying Member Eligibility

Member eligibility may change monthly. Providers should verify eligibility at each visit using any of the methods described in the following table.

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Verifying Member Eligibility

Contact	Information Available	Special Instructions
Member Eligibility **Hours are Mountain Time. Providers may use whichever method they find most convenient.**		
FaxBack **800-714-0075** Available 24/7	• Managed care and other restrictions • Member eligibility • Third party liability	Before using FaxBack, your fax number must be on file with Provider Relations. Call FaxBack and enter your NPI/API, the member's ID, and specific dates of service. When prompted, ask for the audit number or the transaction will not be completed.
Integrated Voice Response (IVR) **800-714-0060**	• Amount of last payment to provider • Managed care and other restrictions • Member eligibility • Third party liability	Call IVR and enter your NPI or provider number, a member ID, and specific dates of service. Verify eligibility for up to 5 members in one call. Program benefit limits not available here. Contact Provider Relations for limits.
Local Offices of Public Assistance	• Member eligibility.	For local office information, see the website: http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com Available 24/7	• Claim-based medical history • Electronic remittance advices • Managed care and service restrictions • Member demographics • Member eligibility • Member status history • Payment status • Provider enrollment • Third party liability	Before accessing the MATH web portal, providers must be Medicaid-enrolled and be registered for the MATH web portal. From the Provider Information website, click on the Log in to Montana Access to Health link. If the member is not currently eligible, any managed care or third party liability information will not be displayed. The user will receive a response with a status of "inactive" reported in the Member Demographic Information.
Provider Relations P.O. Box 8000 Helena, MT 59604 406-442-1837 **800-624-3958** In/Out of state **406-442-4402** Fax 8 a.m.–5 p.m. Monday–Friday	• Amount of last payment to provider • Claim status • Enrollment status • Member eligibility • Prior authorization status • Service limits	Have NPI and member ID number ready when calling.
Presumptive Eligibility		
1-406-655-7683 **or** 1-406-883-7848 8 a.m.–5 p.m. Monday–Friday	• Verify presumptive eligibility	To become a provider who determines presumptive eligibility, call 1-406-655-7683. To verify presumptive eligibility, call 1-406-655-7683 **or** 1-406-883-7848. For information on presumptive eligibility, visit the Presumptive Eligibility webpage: http://medicaidprovider.mt.gov/presumptiveeligibility

The list below shows information returned to the provider in response to an eligibility inquiry:

- **Member's Medicaid ID number**. Used when billing Medicaid.
- **Eligibility Status**. Medicaid eligibility status for the requested dates:
  - **Full Medicaid**. Member is eligible for all Medicaid covered services.
  - **Basic Medicaid**. Member is eligible for some Medicaid services.
  - **QMB**. Member is a qualified Medicare beneficiary. See the section titled When a Member Has Other Coverage in this chapter.
  - **Team Care.** TC indicator means member is enrolled in the Team Care program. All services must be provided or approved by the designated Passport provider.
- **Designated Provider**. The member's primary care provider's name and phone number are shown for members who are enrolled in Passport to Health or Team Care. In either case, all services must be provided or approved by the designated provider. See the *Passport to Health* provider manual.
- **TPL**. If the member has other insurance coverage (TPL), the name of the other insurance carrier is shown.
- **Medicare ID Number**. A Medicare identification number for members who are eligible for both Medicaid and Medicare.

Member without Card

Since eligibility information is not on the card, it is necessary for providers to verify eligibility before providing services whether or not the member presents a card. Confirm eligibility using one of the methods shown in the Verifying Member Eligibility table. If eligibility is not available, the provider may contact the member's local Office of Public Assistance (OPA).

Newborns

Care rendered to newborns can be billed under the newborn's original Medicaid ID number assigned by the mother's local OPA until a permanent ID number becomes available. The hospital or the parents may apply for the child's Social Security number. Parents are responsible for notifying their local OPA when they have received the child's new Social Security number.

Inmates in Public Institutions (ARM 37.82.1321)

Medicaid does not cover members who are inmates in a public institution.

Presumptive Eligibility

Presumptive eligibility is available to hospitals and their affiliated facilities that participate with Montana Medicaid.

Personnel must be trained and certified to make presumptive eligibility determinations for short-term, temporary coverage for the following coverage groups:

- Adults between the ages of 18 and 26 who were in Foster Care and receiving Medicaid at age 18
- Healthy Montana Kids *Plus*
- Healthy Montana Kids
- Parent/Caretaker Relative Medicaid
- Pregnant women (ambulatory prenatal care)
- Women between the ages of 19 and 64 who have been screened and diagnosed with breast or cervical cancer.

To encourage prenatal care, uninsured pregnant women may receive presumptive eligibility for Medicaid.

Presumptive eligibility may be for only part of a month and does not cover inpatient hospital services, but does include other applicable Medicaid services.

For more information about presumptive eligibility training or certification, see the Presumptive Eligibility page on the Provider Information website.

Retroactive Eligibility

When a member is determined retroactively eligible for Medicaid, the member should give the provider a Notice of Retroactive Eligibility (160-M). The provider has 12 months from the date retroactive eligibility was determined to bill for those services.

Retroactive Medicaid eligibility does not allow a provider to bypass prior authorization requirements. See specific provider manuals for requirements.

When a member becomes retroactively eligible for Medicaid, the provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.

Institutional providers (nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities) must accept retroactively eligible member from the date eligibility was effective. Non-emergency transportation and eyeglass providers cannot accept retroactive eligibility. For more information on billing Medicaid for retroactive eligibility services, see the Billing Procedures chapter in this manual.

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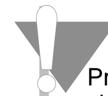
Coverage for the Medically Needy



Providers should verify if medically needy members are covered by Medicaid on the date of service to determine whether to bill the member or Medicaid.

This coverage is for members who have an income level that is higher than Medicaid program standards. However, when a member has high medical expenses relative to income, he/she can become eligible for Medicaid by spending down income to specified levels on a monthly basis. When the member chooses a spend down option, he/she is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Because eligibility does not cover an entire month, the member's eligibility information may show eligibility for only part of the month, or the provider may receive a Medicaid Incurment Notice. The Incurment Notice, sent by the local OPA, states the date eligibility began and the portion of the bill the member must pay. If the provider has not received an Incurment Notice, he/she should verify eligibility for the date of service by any method described in this chapter or by contacting the member's local OPA. Since this eligibility may be determined retroactively, the provider may receive the Incurment Notice weeks or months after services have been provided.

Members also have a cash option where they can pay a monthly premium to Medicaid, instead of making payments to providers, and have Medicaid coverage for the entire month. This method results in quicker payment, simplifies the eligibility process, and eliminates incurment notices. Providers may encourage but not require members to use the cash option.

Nurse First

Nurse First programs provide disease management and nurse triage services for Medicaid members throughout the state.

Nurse First Advice Line, 1-800-330-7847. A toll-free, confidential telephone number members may call 24/7/365 for advice from a registered nurse about injuries, diseases, healthcare, or medications. The nurses do not diagnose or provide treatment. Most Medicaid members are eligible to use the Nurse First Advice Line, except members in a nursing home/institution or members with both Medicare Part A and B and Medicaid coverage. The program is voluntary through participation is strongly encouraged.

Health Improvement Program (HIP). A service provided under the Passport to Health program for members who have one or more chronic health conditions. Care management focuses on helping members improve their health outcomes through education, help with social services, and coordination with the member's medical providers.

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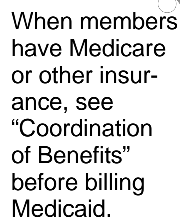
Montana Breast and Cervical Cancer Treatment Program

This program provides Full Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition. All other policies and procedures in this chapter apply. For information regarding screening through the MBCHP program, call 1-888-803-9343.

When a Member Has Other Coverage

Medicaid members often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions. (See the section titled Exceptions to Billing Third Party First in this chapter.) Medicare is processed differently than other sources of coverage.



When members have Medicare or other insurance, see "Coordination of Benefits" before billing Medicaid.

Identifying Additional Coverage

The member's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers. If a member has Medicare, the Medicare ID number is provided. If a member has additional coverage, the carrier is shown. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long-term care insurance

*These third party payers (and others) may **not** be listed on the member's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid members as for their non-Medicaid members. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Member Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not.

Medicare Part A Claims

Medicare Part A carriers and Medicaid use electronic exchange of institutional claims covering Part A services. Providers must submit these claims first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB and submits the claim to Medicaid.

Medicare Part B Crossover Claims

The Department has an agreement with the Medicare Part B carrier for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When members have both Medicare and Medicaid covered claims, and have made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an explanation of Medicare benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit. (See the Billing Procedures chapter in this manual.)

Providers should submit Medicare crossover claims to Medicaid only when:

- **The referral to Medicaid statement is missing.** In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- **The referral to Medicaid statement is present, but there is no response from Medicaid within 45 days of receiving the Medicare EOMB.** Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- **Medicare denies the claim.** The provider may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Billing Procedures chapter.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid member ID number. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

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When a Member Has TPL (ARM 37.85.407)

When a Medicaid member has additional medical coverage (other than Medicare) it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their members that any funds the member receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. These words printed on the member's statement fulfill this obligation: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid.*

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

- When a Medicaid member is also covered by Indian Health Service (IHS) or the Crime Victim Compensation Program, providers must bill Medicaid first. These are not considered a third party liability.
- When a member has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- ICD prenatal and ICD preventive pediatric diagnosis conditions may be billed to Medicaid first. In these cases, Medicaid will "pay and chase" or recover payment itself from the third party payer.
- The following services may also be billed to Medicaid first:
  - Nursing facility (as billed on nursing home claims)
  - Audiology
  - Eyeglasses
  - Hearing aids and batteries
  - Home and community-based services (waiver)
  - Optometry
  - Oxygen in a nursing facility
  - Personal assistance/Community First Choice
  - Transportation (other than ambulance)
  - If the third party has only potential liability, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department by sending the claim and notification to Third Party Liability, P.O. Box 5838, Helena, MT 59604.

Requesting an Exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the Third Party Liability unit.

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that he/she attempted to obtain assignment and certification that the attempt was unsuccessful.

- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no member name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the Child Support Enforcement Division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  - The third party carrier has been billed, and 30 days or more have passed since the date of service.
  - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the Third Party Pays or Denies a Service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward the member's deductible, include the insurance explanation of benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the EOB from the other payer and an explanation of the reason for denial (e.g., definition of denial codes).

When the Third Party Does Not Respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed, or submit a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit.

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Coordination Between Medicare and Medicaid

Coordination of benefits between Medicare and Medicaid is generally accomplished through electronic crossover of claims. It is important to always bill Medicare prior to Medicaid for healthcare services. After Medicare processes the claim, it will automatically cross over to Medicaid. If a claim does not cross automatically to Medicaid from Medicare, the provider should not submit the claim to Medicaid until Medicare has processed. Medicaid payment is subsequent to Medicare and will only pay up to the Medicaid fee after considering the payment from Medicare. See the How Payment Is Calculated chapter in the provider type manuals to learn how Medicaid payments are calculated.

- **Qualified Medicare Beneficiary (QMB)**. For QMBs, Medicaid pays their Medicare A and B premiums and some or all of the Medicare coinsurance and deductibles (up to the Medicaid fee). QMB members may or may not also be eligible for Medicaid benefits.

  QMB Only. Medicaid will make payments only toward the Medicare coinsurance and deductible.

  QMB and Medicaid. Covered services include the same services as for Medicaid only members. If a service is covered by Medicare but not by Medicaid, Medicaid will pay all or part of the Medicare coinsurance and deductible. If a service is covered by Medicaid but not by Medicare, then Medicaid will be the primary payer for that service.
- **Specified Low-Income Medicare Beneficiary (SLMB)**. Medicaid pays the Medicare Part B premium only.

  SLMB Only. Members do not receive Medicaid cards, are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

  SLMB and Medicaid. For services Medicare covers, Medicaid will pay the lower of the Medicare coinsurance and deductible or the Medicaid fee less Medicare payments for Medicaid covered services. If a service is covered by Medicare but not by Medicaid, Medicaid will not pay coinsurance, deductible, or any other cost of the service. For services Medicare does not cover but Medicaid covers, Medicaid will be the primary payer for that service.
- **Qualifying Individual (QI)**. Medicaid pays the Medicare Part B premium only. Members should not have a dual eligibility when qualifying under the QI program. In other words, members cannot have QI and Medicaid at the same time. When a QI recipient becomes Medicaid-eligible, the QI benefit is canceled and replaced by the Medicaid eligibility.

Medicaid Benefits for Dually Eligible Members		
Type of Dual Eligible	**Medicare Premium Paid by**	**Medicare Coinsurance and Deductible Paid by**
QMB only	Medicaid	Medicaid*
QMB/Medicaid	Medicaid	Medicaid*
Other dual eligibles	Member	Medicaid*
Specified Low-Income Medicare Beneficiary	Medicaid	Member
*See the How Payment Is Made chapter in your provider type manual to learn how Medicaid calculates payment for Medicare coinsurance and deductibles.		

Members with Other Sources of Coverage

Medicaid members may also have coverage through workers' compensation, employment-based coverage, individually purchased coverage, etc. Other parties also may be responsible for healthcare costs. Examples of these situations include communal living arrangements, child support, or auto accident insurance. These other sources of coverage have no effect on what services Medicaid covers. However, other coverage does affect the payment procedures. (See the How Payment Is Calculated chapter in your provider type manual.)

The Health Insurance Premium Payment (HIPP) Program

Some Medicaid members have access to private insurance coverage, typically through a job, but do not enroll because they cannot afford the premiums. In these cases, Medicaid **may** pay the premiums, at which time the private insurance plan becomes the primary insurer. The member also remains eligible for Medicaid. When Medicaid members have access to private insurance coverage, they may apply for the HIPP program.

Indian Health Service (IHS)

The Indian Health Service (IHS) provides federal health services to American Indians and Alaska Natives. IHS is a secondary payer to Medicaid. For more information, see the Subsidized Health Insurance Programs in Montana table at the end of this chapter.

Crime Victims

The Crime Victim Compensation Program is designed to help victims of crime heal. This program may provide funding for medical expenses, mental health counseling, lost wages support, funerals, and attorney fees. Crime Victim Compensation is a secondary payer to Medicaid. For more information, see the Subsidized Health Insurance Programs in Montana table later in this chapter.

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When Members Are Uninsured

Several state and federal programs are available to help the uninsured; see the Subsidized Health Insurance Programs in Montana table at the end of this chapter.

Member Responsibilities

Medicaid members are required to:

- Know if they have Full or Basic benefits and understand what these benefits include.
- Notify providers that they have Medicaid coverage.
- Present a valid Montana Access to Health (MATH) or Healthy Montana Kids (HMK) *Plus* card at each visit.
- Pay Medicaid cost sharing amounts; see the Billing Procedures chapter in this manual.
- Notify providers of any other coverage, such as Medicare or private insurance.
- Notify providers of any change in coverage.
- Forward any money received from other insurance payers to the provider.
- Inform their local office of public assistance about any changes in address, income, etc.

Medicaid members may see any Medicaid-enrolled provider as long as Passport to Health and prior authorization guidelines are followed, and as long as they are not enrolled in Team Care.

Other Programs

Member eligibility provisions also apply to Department of Public Health and Human Services programs other than Medicaid. The information covered in this chapter applies to members enrolled in the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) dental services and eyeglasses only.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program (CDB-SPSDATP)

Members in this program are not issued a Montana Access to Health card. Members should apply for services directly from the state-approved programs. For a list of these programs, call 406-444-9408. Services require prior authorization and authorization for continued stay review.

Healthy Montana Kids (HMK)

Few children are eligible for both Medicaid and HMK simultaneously. If a patient presents both cards, check the dates of Medicaid eligibility and the child's HMK enrollment. If both cards are valid, treat the patient as an HMK patient. Services not covered by HMK may be covered by Medicaid.

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If a member presents an HMK card for dental services, the provider should refer to the HMK dental services manual for information about coverage and billing. If a member presents an HMK card for eyeglasses, the card is valid only with the HMK program's designated supplier. (See the HMK section of the *Optometric and Eyeglass Services* manual.) If a member presents an HMK card for any other service, see the HMK provider manual published by Blue Cross and Blue Shield of Montana. Call 1-800-447-7828 for more information.

Mental Health Services Plan (MHSP)

MHSP members will present a hard white plastic card. Their MHSP card makes them eligible only for those services covered by MHSP, which are described in the mental health and prescription drug manuals. Medicaid members do not need an MHSP card to receive mental health services.

Plan First

If a member loses Medicaid, he/she may get family planning services paid by Plan First, which is a separate Medicaid program that covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of STDs. Visit http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst.

Subsidized Health Insurance Programs in Montana

Providers may refer member to the following programs.

Program	Administered by	Target Populations	For Information on Eligibility
Children's Special Health Services	Montana DPHHS	Children with special healthcare needs.	800-762-9891 406-444-3622
Crime Victim Compensation Program	Montana Department of Justice	Crime victims and their dependents and relatives.	406-444-3653 Helena 800-498-6455 https://dojmt.gov/victims/crime-victim-compensation/
Indian Health Service	Billings Area Indian Health Service	All enrolled members of federally recognized tribes.	406-247-7107 www.ihs.gov/
Medicaid	Montana DPHHS	Low-income children and their family members, and disabled individuals.	Local Office of Public Assistance http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance
Medicare	Centers for Medicare and Medicaid Services	People who are age 65 and over, have a disability, or have end-stage renal disease.	U.S. Social Security Administration office www.medicare.gov/
Mental Health Services Plan (MHSP)	Montana DPHHS	Individuals with a qualifying mental health diagnosis who are ineligible for Medicaid.	Community Mental Health Center
Workers' Compensation	State Fund and independent workers' compensation insurers	People with injuries or illnesses related to their work.	406-444-6543 Workers

Note: Eligibility rules are complex; members and providers should check with the program administrator for specifics.

Surveillance and Utilization Review

Surveillance and Utilization Review (42 CFR 456)

The Department's Surveillance and Utilization Review Section (SURS) performs federally mandated retrospective reviews of paid claims (42 CFR 456). SURS is required to safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments. If the Department pays a claim, but subsequently discovers that the provider was not entitled to payment for any reasons, the Department is entitled to recover the resulting overpayment (ARM 37.85.406).

SURS monitors compliance with state and federal rules, laws, and policies in several ways:

1. **New Provider Audits**. SURS reviews the billing data of newly enrolled providers and may also review documentation.

2. **Provider Self-Audits**. A self-audit is an opportunity for the provider to perform an audit and self-disclose errors to SURS. Providers may access the website for Office of Inspector General (OIG) provider self-disclosure protocol resources at http://oig.hhs.gov/compliance/self-disclosure-info/index.asp.

3. **Individual Audits**. An individual audit is conducted by the Program Integrity Auditor in charge of reviewing the provider type being audited.

4. **Team Audits**. Team audits are conducted by a team of Program Integrity Auditors whose individual expertise contributes to the review of the issue being audited.

5. **Data Mining Audits**. An audit conducted by data mining which reviews the appropriateness of the data submitted on the claim, such as dates of service, procedure code, units, etc.

6. **Statistical Sampling**. When a provider is audited, claims data is gathered for the audit time frame. If a provider has a large number of claims for which records collection and submission for a complete review would be burdensome to the provider, a statistical sample of the claims may be reviewed at the option of the Department. SURS uses a program called RAT-STATS to pull a random subset (sample) of the total claims under review (universe). The audit is then completed on the sample of claims. The determination made on the sample is then extrapolated to the entire universe. If a provider disagrees with the final determination, a 100% review of claims may be requested by the provider. More information about the statistical sampling process can be found in ARM 37.85.416.

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During an audit, SURS personnel send a spreadsheet to the provider with paid claims data. The provider is required to send supporting documentation for the items listed on the spreadsheet. A SURS Program Integrity Auditor reviews the documentation and/or data submitted by the provider.

If SURS determines an overpayment that exceeds $5,000, the audit is presented to the Medicaid Review Committee for review and approval. With the approval of the committee, an overpayment letter will be sent to the provider.

If SURS determines an overpayment that is less than $5,000, the case is reviewed by the associated program bureau chief, program officer, SURS supervisor, and Program Compliance bureau chief. Their approval will initiate an overpayment letter to the provider.

The overpayment letter specifies the amount of the overpayment, the date the funds are due, how to appeal the Department's decision, and the appropriate contact person.

Key Points

- The SURS unit encourages providers to call with any questions or concerns regarding the audit of paid claims.
- The Department is entitled to recover payment made to providers when a claim was paid incorrectly for any reason. (MCA 53-6-111, ARM 37.85.406)
- The Department may charge interest on recovered funds. (MCA 53-6-111)
- When an inappropriate payment has been identified, the Department may recover the overpayment by any legal means, including withholding of provider payments on subsequent claims. (MCA 53-6-111)
- The Department may sanction a provider, including suspension or termination of Medicaid enrollment, if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and/or policies. (MCA 53-6-111, ARM 37.85.501–502, ARM 37.85.513)
- Prior authorization does not guarantee payment; a claim may be denied or money paid to providers may be recovered if the claim is found to be inappropriate. (MCA 53-6-111, ARM 37.85.406, ARM 37.85.410)
- The provider must upon request provide to the Department or its designated review organization without charge any records related to services or items provided to a member. The provider shall submit a true and accurate copy of each record of the service or item being reviewed as it existed within 90 days after the date on which the claim was submitted to Medicaid. (ARM 37.85.410, ARM 37.85.414)

Billing Tips

The following suggestions may help reduce billing errors but are not inclusive of all possible errors and recoupment scenarios.

1. Be familiar with the Medicaid provider manuals, fee schedules, and provider notices that are in effect for the claim dates of service. Read the *Claim Jumper* provider newsletter. These are available on the Provider Information website.

2. Comply with applicable state and federal regulations, including but not limited to the Administrative Rules of Montana. (ARM 37.85.401)

3. Use CPT, HCPCS, and ICD coding books that are in effect for the claim dates of service, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing. Additional coding resources such as those noted in CPT are also recommended.

4. All providers of services must maintain complete records which fully demonstrate the extent, nature, and medical necessity of services and items provided to Montana Medicaid members. Information regarding the minimum requirements for records are found in ARM 37.85.414. In addition to complying with these minimum requirements, providers must also comply with any specific recordkeeping requirements applicable to the type of services the provider furnishes. See the Record Keeping section in the Provider Requirements chapter in this manual.

5. When reimbursement is based on the length of time spent providing the service, the records must specify the time spent or the time treatment began and ended for each procedure. (ARM 37.85.414)

6. Attend classes on coding offered by certified coding specialists.

7. Avoid billing for the same service/supply twice. Contact Provider Relations for the status of submitted claims.

8. Use specific codes rather than miscellaneous codes. For example, Code 99213 is more specific (problem-focused visit) than Code 99499 (unlisted evaluation and management service).

9. Verify that the item/service meets criteria for payment by the Department. (See current fee schedule, provider manuals, and Administrative Rules of Montana.)

10. Bill only under your own provider number.

11. Bill only for services you provided.

12. Bill for the appropriate level of service provided. For example, the CPT coding book contains detailed descriptions and examples of what differentiates a level 1 office visit (Code 99201) from a level 5 office visit (Code 99205).

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13. Services covered within "global periods" for certain CPT procedures are not paid separately and should not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT service.

14. Pay close attention to modifiers used with CPT and HCPCS codes on both CMS-1500 bills and UB-04 bills. Modifiers are becoming more prevalent in healthcare billing, and they often affect payment calculations.

15. Choose the least costly alternative. For example, if a member is able to operate a standard wheelchair, then a motorized wheelchair should not be prescribed or provided.

16. For repeat members, use an established patient code (e.g., Code 99213) instead of a first time patient code (e.g., Code 99203).

17. Use the correct units measurement on CMS-1500 and UB-04 bills. In general, Medicaid follows the definitions in the CPT and HCPCS coding books. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.

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Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual may be billed electronically or on paper claim forms, which are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- Six months from the date on the Medicare explanation of benefits approving the service.
- Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

For claims involving Medicare or TPL, if the 12-month time limit has passed, providers must submit clean claims to Medicaid within:

- **Medicare Crossover Claims**. Six months from the date on the Medicare explanation of benefits, if the Medicare claim was timely filed and the member eligible for Medicare at the time the Medicare claim was filed.
- **Claims Involving Other Third Party Payers (excluding Medicare)**. Six months from the date on an adjustment notice from a third party payer who 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 that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status.
- If another insurer has been billed and 90 days have passed with no response, a provider can bill Medicaid. (See the Member Eligibility and Responsibilities chapter in this manual for more information.)

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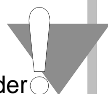
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Member Eligibility and Responsibilities chapter in this manual and the Coordination of Benefits chapter in your provider type manual.

When to Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid. The main exception is that providers may collect cost sharing from members.



If a provider bills Medicaid and the claim is denied because the member is not eligible, the provider may bill the member directly.

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third party payer 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 covered individuals, such as in a public health clinic.

Under certain circumstances, providers may need a signed agreement to bill a patient.

Billing a Patient (ARM 37.85.406)

Service	Patient is Medicaid-enrolled and provider accepts patient as a Medicaid member	Patient is Medicaid-enrolled and provider does not accept patient as a Medicaid member
Is covered by Medicaid	Provider can bill patient **only** for cost sharing.	Provider can bill Medicaid patient if patient has signed a private pay agreement.
Is not covered by Medicaid	Provider can bill patient **only** if custom agreement has been made between patient and provider before he/she provides the service.	Provider can bill patient if patient has signed a custom agreement.

Private-Pay Agreement. A nonspecific private-pay agreement between the provider and member stating that the patient is not accepted as a Medicaid member, and that he/she must pay for the services received.

Custom Agreement. A specific agreement that includes the dates of service, actual services or procedures, and the cost to the patient. It states the services are not covered by Medicaid and the member will pay for them.

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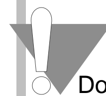
Member Cost Sharing (ARM 37.85.204)

Cost sharing fees are a set dollar amount per visit based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice.

The following members are exempt from cost sharing:

- An Indian who has ever been seen at an Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U).
- Members under 21 years of age (i.e., EPSDT services).
- Pregnant women, until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed.
- Institutionalized individuals for services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility or other medical institution if such individual is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.



Do not show cost sharing as a credit on the claim; it is automatically deducted.

Cost sharing may not be charged for the following services:

- Emergencies
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services
- Family planning
- Home and community-based waiver services
- Home dialysis attendant services
- Hospice
- Independent laboratory and x-ray services
- Medicare crossover claim services where Medicaid is the secondary payer under ARM 37.85.406(18). If a service is not covered by Medicare but is covered by Medicaid, cost sharing will be applied.
- Nonemergency medical transportation services
- Personal assistance/Community First Choice services
- TPL claim services where Medicaid is the secondary payer under ARM 37.85.407. If a service is not covered by TPL but is covered by Medicaid, cost sharing is applied.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. A provider's policy on collecting delinquent payment from non-Medicaid members (if there is one) may be used for Medicaid members.

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Billing for Members with Other Insurance

A Medicaid member may also be covered by Medicare or have other insurance, or some other third party is responsible for the cost of the member's healthcare,

When completing a claim for members with Medicare and Medicaid, Medicare coinsurance and deductible amounts must correspond with the payer listed. For example, if the member has Medicare and Medicaid, any Medicare deductible and coinsurance amounts must be listed and preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare must be listed in the corresponding field. (See the Submitting a Claim section in this manual.)

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the hospital provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.

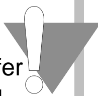
When the provider accepts the member's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date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

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

Coding Tips

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. See the Coding Resources table.

The following may reduce coding errors and unnecessary claim denials:



Always refer to the long descriptions in coding books.

- Use current CPT, CDT, HCPCS, and ICD diagnosis coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.

- Use specific codes rather than unlisted codes.
- Bill for the appropriate level of service provided. Evaluation and management services have 3 to 5 levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to but not over the time spent.
- Revenue Codes 25X and 27X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be underpaid.
- Take care to use the correct units measurement. In general, Medicaid follows the definitions in the CPT and HCPCS coding books. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes." Always check the long text of the code description published in the CPT or HCPCS coding books.

Coding Resources

The Department does not endorse the products of any particular publisher.

Resource	Description	Contact
CDT	The CDT is the official coding used by dentists.	American Dental Association 312-440-2500 http://www.ada.org/en/publications/
CPT	CPT codes and definitions Updated each January	American Medical Association 800-621-8335 https://commerce.ama-assn.org/store/
CPT Assistant	A newsletter on CPT coding issues	American Medical Association 800-621-8335 https://commerce.ama-assn.org/store/
HCPCS	HCPCS codes and definitions Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov/.
ICD	ICD diagnosis and procedure codes definitions Updated each October	Available through various publishers and bookstores.
Miscellaneous Resources	Various newsletters and other coding resources.	Optum360 800-464-3649 www.optumcoding.com/
NCCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service 800-363-2068/703-605-6060 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html
UB-04 National Uniform Billing Expert	National UB-04 billing instructions	Available through various publishers and editors.

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Number of Lines on Claim

The Montana claims processing system supports 40 lines on a UB-04 claim, 21 lines on a CMS-1500, and 21 lines on a dental claim.

Multiple Services on Same Date

Outpatient hospital providers must submit a single claim for all services provided to the same member on the same day. If services are repeated on the same day, use appropriate modifiers. The only exception to this is if the member has multiple emergency room visits on the same date. Two or more emergency room visits on the same day must be billed on separate claims with the correct admission hour on each claim.

Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, so long as the service is paid by fee schedule (e.g., partial hospitalization, therapies) and the date is shown on the line. However, the Outpatient Code Editor (OCE) will not price APC procedures when more than one date of service appears at the line level, so we recommend billing for only one date at a time when APC services are involved.

Reporting Service Dates

All line items must have a valid date of service. The revenue codes on the following page require a separate line for each date of service and a valid CPT or HCPCS code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis – Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis – Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD – Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

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Using Modifiers

- Review the guidelines for using modifiers in the most current CPT book, HCPCS book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter, and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- Medicaid accepts most of the same modifiers as Medicare, but not all.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line on the CMS-1500. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Discontinued or reduced service modifiers must be listed before other pricing modifiers on the CMS-1500. For a list of modifiers that change pricing, see the How Payment Is Calculated chapter in this manual.

Hospitals should put the most important modifiers in the first position.

Billing Tips for Specific Services

Prior authorization is required for some services. Passport and prior authorization are different; some services may require both. Different numbers are issued for each type of approval and must be included on the claim form.

Abortions

A completed Montana Healthcare Programs Physician Certification for Abortion Services (MA-37) form must be attached to every abortion claim or payment will be denied. **Complete only one section of this form.** This is the only form Medicaid accepts for abortions.

Drugs and Biologicals

While most drugs are bundled, there are some items that have a fixed payment amount and some that are designated as transitional pass-through items. (See the Pass-Through section in the How Payment Is Calculated chapter of this manual.) Bundled drugs and biologicals have their costs included as part of the service with which they are billed. The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs
- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

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Lab Services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day) bill the panel code with units corresponding to the number of times the panel was performed.

Outpatient Clinic Services

When Medicaid pays a hospital for outpatient clinic or provider-based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., POS 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must bill only for the professional component if the hospital is going to bill Medicaid for the technical component. Refer to the *Physician-Related Services* manual and the Billing Procedures chapter in this manual for more information. Provider type manuals are located on the provider type pages of the Provider Information website.

Partial Hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization		
Code	**Modifier**	**Service Level**
H0035	—	Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

Sterilization/Hysterectomy (ARM 37.86.104)

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when **all** of the following requirements are met:

1. Member must complete and sign the Informed Consent to Sterilization (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the only form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied.

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The 30-day waiting period may be waived for either of the following:

- **Premature Delivery**. The Informed Consent to Sterilization must be completed and signed by the member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- **Emergency Abdominal Surgery**. The Informed Consent to Sterilization form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.

2. Member must be at least 21 years of age when signing the form.
3. Member must not have been declared mentally incompetent by a federal, state, or local court, unless the member has been declared competent to specifically consent to sterilization.
4. Member must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The member must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The member must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The member must be made aware of available alternatives of birth control and family planning.
- The member must understand the sterilization procedure being considered is irreversible.
- The member must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The member must be informed of the benefits and advantages of the sterilization procedure.
- The member must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for members who are blind or deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the member is in labor or childbirth.
- If the member is seeking or obtaining an abortion.
- If the member is under the influence of alcohol or other substance which affects his/her awareness.

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For elective sterilizations, a completed Informed Consent to Sterilization (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

For medically necessary sterilizations, including hysterectomies, oophorectomies, salpingectomies, and orchiectomies, one of the following must be attached to the claim, or payment will be denied:

- A completed Medicaid Hysterectomy Acknowledgement form (MA-39) for each provider submitting a claim. It is the billing provider's responsibility to obtain a copy of the form from the primary or attending physician. **Complete only one section of this form.** When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member (or representative, if any) and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.) Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used.
- For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
  - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
  - The reason for the hysterectomy was a life-threatening emergency.
  - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible members, for which the date of service is more than 12 months earlier than the date the claim is submitted, contact the member's local Office of Public Assistance and request a Notice of Retroactive Eligibility (160-M). Attach the form to the claim.

Supplies

Supplies are generally bundled, so they usually do not need to be billed individually. A few supplies are paid separately by Medicaid. The fee schedules on the website lists the supply codes that may be separately payable.

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Submitting a Claim – Paper

Unless otherwise stated, all **paper claims** must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

On the CMS-1500, EPSDT/Family Planning, is used as an indicator to specify additional details for certain members or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	**Member/Service**	**Purpose**
1	EPSDT	Used when the member is under age 21
2	Family planning	Used when providing family planning services
3	EPSDT and family planning	Used when the member is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	Used when providing services to pregnant women
6	Nursing facility member	Used when providing services to nursing facility residents

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 HIPAA 5010 page of the website.

- **WINASAP 5010**. Xerox makes this free software available to providers for submitting electronic claims via telephone modem or MATH web portal upload for Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department. **Separate EDI enrollment is required.**
- **Xerox EDI Solutions**. Providers can send claims to the Xerox clearinghouse (EDI Solutions) in X12 837 format using a dial-up connection or MATH web portal upload. **Separate EDI enrollment is required.** Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **Clearinghouses**. Providers can contract with a clearinghouse to send claims in whatever format the clearinghouse accepts. The provider's clearinghouse sends the claims to EDI Solutions in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Xerox. EDIFECS certification is completed through EDI Solutions.

- **Montana Access to Health (MATH) Web Portal**. A secure website on which providers may view members' medical history, verify member eligibility, check claim status, verify payment status, upload 5010 X12 files, and download remittance advices.
- **B2B Gateway SFTP/FTPS Site**. Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high frequency submitters.
- **MOVEit DMZ**. Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.

Claim Inquiries

Contact Provider Relations for general claim questions and questions regarding payments, denials, member eligibility.

The Most Common Billing Errors and How to Avoid Them

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.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider's National Provider Identifier (NPI) and/or Taxonomy is missing or invalid	• The provider NPI is a 10-digit number assigned to the provider by the national plan and provider enumerator system. Verify the correct NPI and Taxonomy are on the claim.
Authorized signature missing	• Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer-generated.
Signature date missing	• Each claim must have a signature date.
Incorrect claim form used	• The claim must be the correct form for the provider type.
Information on claim form not legible	• Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Member ID number not on file, or member was not eligible on date of service	• Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of this manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider referral – No Passport provider number on claim	• A Passport provider number must be on the claim form when a referral is required. Passport approval is different from prior authorization. See the *Passport to Health* provider manual.

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Common Billing Errors (Continued)

	How to Prevent Returned or Denied Claims
	• Prior authorization is required for certain services, and the prior authorization number must be on the claim form. Prior authorization is different from Passport. See the Prior Authorization chapter in this manual.
	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
	• Check all remittance advices for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form. (See Remittance Advices and Adjustments in this manual.)
	• If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. • If the member's TPL coverage has changed, providers must notify the TPL unit before submitting a claim.
	• The Claims Processing unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing.
	• All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied. • After updating his/her license, the claims that have been denied must be resubmitted by the provider.
	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT coding books. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The information in this chapter also applies to those services covered under the Mental Health Services Plan (MHSP).

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Remittance Advices and Adjustments

The Remittance Advice

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany payment for services rendered. The remittance advice provides details of all transactions that have occurred during the previous remittance advice cycle. Each line represents all or part of a claim and explains whether the claim or service has been paid, denied, or suspended/pending. If the claim was suspended or denied, the remittance advice also shows the reason.

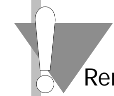
Remittance advices are available electronically through the Montana Access to Health (MATH) web portal. To access the web portal and receive electronic remittance advices, providers must first complete an EDI Provider Enrollment Form and an EDI Trading Partner Agreement, and then register for the web portal.

Each provider must complete an EDI Trading Partner Agreement, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

After the forms have been processed, the provider receives a user ID and password to use to log into the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number.

Access the MATH web portal directly at https://mtaccesstohealth.acs-shc.com. or through the MATH web portal link on the Provider Information website.

Remittance advices are available in PDF format. Providers can read, print, or download PDF files using PDF reader software available online. Due to space limitations, each remittance advice is only available for 90 days. The remittance is divided into the following sections:



Remittance advices are available for only 90 days on the web portal.

Remittance Advice Notice

This section is on the first page of the remittance advice. It contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.

Paid Claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the pro-

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vider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted. (See the Adjustments section later in this chapter.)

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column. The Reason and Remark Code description explains why the claim was denied and is located at the end of the remittance advice. See the section titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter.

Pending Claims

All claims that have not reached final disposition will appear in this area of the remittance advice (pended claims are not available on X12 835 transactions). The remittance advice uses *suspended* and *pending* interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column. The Reason and Remark Code description located at the end of the remittance advice explains why the claim is suspended. This section is informational only and no action should be taken on claims displayed here. Processing continues until each claim is paid or denied.

Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for member eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balance Claims

Credit balance claims are shown in this section until the credit has been satisfied.

Gross Adjustments

Any gross adjustments performed during the previous cycle are shown in this section.

Reason and Remark Code Description

This section lists the reason and remark codes that appear throughout the remittance advice with a brief description of each.

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Credit Balance Claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied. Credit balances can be resolved in two ways:

- **By working off the credit balance**. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive remittance advices until the credit has been paid.
- **By sending a check payable to DPHHS for the amount owed**. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the Third Party Liability unit.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Timeframe for Rebilling or Adjusting a Claim

Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter.

The time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting a gross adjustment be made.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures chapter in this manual.

When to Rebill Medicaid

- **Claim Denied**. Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim. **Do not attempt to adjust denied claims.**

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- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. For CMS-1500 claims, do not use an adjustment form. In the case of a UB-04, the line should be adjusted rather than rebilled. (See the Adjustments section.)
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to Rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations. Once an incorrect payment has been verified, the provider should submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's remittance advice as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same remittance as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as claims.

When to Request an Adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- Request an adjustment when an individual line is denied on a multiple-line UB-04 claim. The denied service must be submitted as an adjustment rather than a rebill.

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form available on the Forms page of the website. Requirements for adjusting a claim are:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service. (See the Timely Filing section in the Billing Procedures chapter in this manual.) After this time, gross adjustments are required.
- Use a separate adjustment request form for each ICN.
- If correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section.

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website. Complete Section A with provider and member information and the claim's ICN number (see following table).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the Date of Service or Line Number column.
   - Enter the information from the claim form that was incorrect in the Information on Statement column.
   - Enter the correct information in the Corrected Information column.
3. Attach copies of the remittance advice and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the remittance advice will suffice.
   - If the remittance advice is electronic, attach a screen print of it.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing.
   - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
   - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims. (See Credit Balance earlier in this chapter.)
   - Direct questions regarding claims or adjustments to Provider Relations.

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Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Name	The member's name
3. Internal Control Number (ICN)	There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim.
4. Provider number	The provider's NPI/API.
5. Member Medicaid Number	Member's Medicaid ID number.
6. Date of Payment	Date claim was paid.
7. Amount of Payment	The amount of payment from the remittance advice.
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/NDC Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if unsure what caused the payment error, complete this line.

Mass Adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice, the monthly *Claim Jumper*, or provider notices. Mass adjustment claims shown on the remittance advice have an ICN that begins with a 4.

Payment and the Remittance Advice

Medicaid payment and remittance advices are available weekly. Payment is via electronic funds transfer (EFT). Direct deposit is another name for EFT. The electronic remittance advices (ERAs) are available on the web portal for 90 days.

With EFT, the Department deposits the funds directly to the provider's financial institution account. Holidays may delay payments until the next business day.

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP), and Healthy Montana Kids (HMK) dental and eyeglasses benefits.

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Appendix A: Forms

The forms listed below and others are available on the Forms page of the Montana Healthcare Programs Provider Information website.

- Presumptive Eligibility Notice of Decision
- Medicaid Incurment Notice
- Medicaid Form Order
- Individual Adjustment Request Form
- Paperwork Attachment Cover Sheet
- Provider Address Correction Form
- Blanket Denial

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Appendix B: Place of Service Codes

For a list of place of service (POS) codes, corresponding names, and a brief description of each, see the CMS website.

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Appendix C: Local Offices of Public Assistance

See the DPHHS webpage http://www.dphhs.mt.gov/hcsd/OfficeofPublicAssistance

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Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms link on the Montana Healthcare Programs Provider Information website.

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