Member Guide

Montana Medicaid and HEALTHY MONTANA Kids Plus

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

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Welcome

Medicaid's Mission

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

You Matter

Being a member of the Montana Medicaid or Healthy Montana Kids *Plus* (Medicaid for children) programs is great. It means you'll be able to get help with most health matters. Getting or keeping you healthy is important to us. Medicaid has a number of staff and programs to meet your healthcare needs.

This guide is for people who are eligible for Montana Medicaid/Health Montana Kids *Plus* and receive the Standard Medicaid benefit. This guide will help to explain coverage, benefits, copayments, and rights and responsibilities.

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About Montana Medicaid and Healthy Montana Kids *Plus*

Montana Medicaid and Healthy Montana Kids *Plus*

Montana Medicaid is healthcare coverage for some low-income Montanans. Medicaid is run by the Montana Department of Public Health and Human Services (DPHHS).

Healthy Montana Kids *Plus* (HMK *Plus*) is Meadicaid health coverage for low-income children in Montana and is also run by DPHHS.

The State of Montana pays about one-third of the cost of Medicaid and HMK *Plus* and the federal government pays the rest.

Medicaid and HMK *Plus* do not pay money to you. Instead, payments for healthcare services are sent directly to your healthcare providers.

If Medicaid and HMK *Plus* pay for healthcare:

- services must be medically necessary;
- services must be provided by a healthcare provider who is a Montana Medicaid or HMK *Plus* provider; and
- services must be Medicaid or HMK *Plus* covered services (See Section 4, Covered Services).

Did You Get a Medicaid or HMK *Plus* Card?

Adults with Medicaid will get a plastic "Montana Access to Health" card in the mail. Kids with HMK *Plus* will get a plastic "Healthy Montana Kids *Plus*" card in the mail. Each person will get his or her own card. Keep your card in a safe place. **Always take your card with you to your appointments and show it when you check in.**

If the information on your card is not right, tell your case manager at the Office of Public Assistance (OPA) right away. If you haven't gotten your health coverage card before you need medical care, contact your case manager at the **Montana Pubic Assistance Helpline at 1-888-706-1535**.

Keep your card, even if your Medicaid or HMK *Plus* ends. If you get Medicaid or HMK ***Plus*** again in the future, you will use the same card.
The front of your card has your name, your member number, and your birth date. The member number is a unique identifier that is not your Social Security Number.

The back of your card has information about using the card and the **Medicaid/HMK *Plus* Member Help Line phone number, 1-800-362-8312**. The back of the card also has information for your provider.

Here is what a Montana Access to Health card looks like.

Here is what a Healthy Montana Kids *Plus* card looks like.

If you lose your card contact the Office of Public Assistance.

If You Move, Get Married, Have a Baby or Have Other Changes

Tell your case manager within 10 days if you have changes in your household. Some examples are if you have:

- changed your address;
- changed your phone number;
- gotten married or divorced;
- moved to a nursing home;
- become pregnant;
- had a baby;
- changed jobs;
- gotten other insurance; or
- had changes in your assets or income.

The case manager will tell you if you are still eligible for Medicaid or HMK *Plus*.

How Does Medicaid or HMK *Plus* Work, and How do You Use Your Healthcare Coverage?

The programs or services you will read about on the next few pages can help you learn to make the most of your coverage.

Nurse First Advice Line

Nurse First is a **free telephone nurse advice line** you can call when you are sick, hurt, or have health questions. Call the **Nurse First Advice Line at 1-800-330-7847** and talk with a registered nurse **24 hours a day, 7 days a week**. Nurse First is for members with Medicaid, HMK *Plus* or Mental Health Services Plan (MHSP) health coverage.

Before you go to your provider or the emergency room, call Nurse First. You may be able to treat the problem at home. Nurses licensed in the State of Montana at Nurse First can help you by guiding you to the right care, at the right place, and at the right time.

Nurses at Nurse First can help you with problems like:

- fever;
- earache and headache;
- flu and sore throat;
- skin rash;
- vomiting or upset stomach;
- colds and coughing; and
- back pain.

If you have just found out you have diabetes, heart disease, high cholesterol, or any other health issue, the Nurse First Advice Line may be able to give you some information and help answer your questions.

Don't call Nurse First when:

- You have a health concern you are sure is life threatening. In this case, **call 911** or go directly to the emergency room;
- It's time for your child's next well-child checkup or immunizations (shots). Call your provider's office directly to schedule an appointment;
- You've seen your provider for a specific health problem and a follow-up appointment is needed. Call the office directly to schedule the appointment;
- You've seen your provider for a specific health problem, and they refer you to a specialist. Call the specialist's office directly to set up an appointment; or
- You, or your child, need regular services such as transfusions or dialysis. Make the series of appointments directly with your provider's office.

Remember, if you are not sure you should go to the emergency room, call the **Nurse First Advice Line at 1-800-330-7847.** The **call is free**. Registered nurses are available **24 hours a day, 7 days a week** to help you.

Montana Health and Wellness Website

The Montana Health and Wellness website has information on thousands of health topics such as diseases, symptoms, medical tests, medications and much more. Use this site to check on a topic of personal interest or learn more about health and wellness. You can find the Montana Health and Wellness website by going to **http://dphhs.mt.gov/MontanaHealthcarePrograms/NurseFirst** and clicking on the ***"Additional Montana Health and Wellness Information"*** link.

Mental Health Services Plan (MHSP)

Mental Health Services Plan (MHSP) covers mental health services for adults, who are not on Medicaid, with severe and disabling mental illness.

The services are provided through mental health centers and prescribers that have contracts with DPHHS. The drug coverage of $425 a month is to be used for only prescribed psychotropic medications. For more information on MHSP contact 1-406-444-9530.

72 Hour Presumptive Eligibility Program

The 72 Hour Presumptive Eligibility program is funded through the Addictive and Mental Disorders Division. The purpose for the program is to provide mental health crisis services to individuals not currently enrolled in Medicaid. For more information on the 72 hour program, contact 1-406-444-9530.

Presumptive Eligibility Program

Presumptive eligibility is short term coverage, available once every 12 months (or, once per pregnancy) and lasts from the date of determination until a determination of Medicaid program eligibility is made, or until the last day of the month following the month of determination, whichever is earlier.

Hospitals and other designated facilities participating in Montana Medicaid are able to make presumptive eligibility determinations for the following groups:

- Children (HMK *Plus* and HMK (CHIP));
- Pregnant women (Ambulatory Prenatal Care);
- Parent/Caretaker Relative Medicaid;
- Former Foster Care Children (ages 18 up to 26); and
- Breast and Cervical Cancer.

If You have Other Questions or Concerns

What if you get a bill?

If you sign an Advanced Beneficiary Notice (private pay agreement) before receiving services, providers may bill you for:

- non-covered services;
- experimental services;
- unapproved services;
- covered but medically unnecessary services,
- unapproved services that require referral from your Passport to Health provider;
- services performed in an inappropriate setting;
- services received when you are not accepted as Medicaid; and
- investigational services.

You are responsible to pay for the service if you signed an agreement. If you think a provider is billing both you and Medicaid or HMK *Plus* for the same service, or is charging Medicaid, HMK *Plus*, or you for services you did not receive, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

Medicaid and HMK *Plus* usually do not pay your provider the full amount the provider charges for services. Your provider has agreed to accept the lower payment amount. You do not pay the amount Medicaid or HMK *Plus* does not pay.

If you have questions about a bill from your provider, try to work with your provider's office to get an answer. If you still need help, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362- 8312**.

Can you get help getting to your appointment?

Medicaid and HMK *Plus* may pay for you to get to your healthcare provider or other healthcare service, if the service is covered by Medicaid or HMK *Plus*, and if you have no other way to get there. See page 36 for details about transportation coverage.

Do you need an interpreter?

If English is not your first language, or you have trouble understanding English, please ask your case manager or Medicaid or HMK *Plus* provider for an interpreter who speaks or signs your language. The interpreter can explain Medicaid or HMK *Plus* to you. Interpreters are free and available, including sign language.

If you have trouble hearing.

If you are hard of hearing or have a speech disability, call the **Montana Telecommunications Access Program (MTAP) at 1-800-833-8503**. They will give you more information about amplified telephones, captioned telephones, and hands free devices.

If you are deaf or hard of hearing and want direct call relay service, the Montana Relay call service will relay your phone calls – just call **711 or 1-800-253-4091**. The Montana Relay customer service number is **1-800-833-8503.**

What can you do to get the most from your healthcare and to stay healthy?

As a partner in your healthcare and the healthcare of your family, it is up to you to help keep healthcare costs as low as possible. Go to the Montana Health and Wellness website, **http://dphhs.mt.gov/MontanaHealthcarePrograms**, and click on the "Additional Montana Health and Wellness Information" link to find information on healthy eating and exercise.

If you have not had Medicaid for months.

To reapply for Medicaid, HMK *Plus*, or HMK (CHIP) complete an online Medicaid application at **http://apply.mt.gov**, or complete a paper application and give it to any county OPA, either in person or by mail. To find the location of your local OPA call the **Montana Public Assistance Helpline at 1-888-706-1535** or the **Montana Citizens' Advocate Office at 1-800-332-2272.**

Offices of Public Assistance (OPA)

To find the location of your local OPA call the Montana Public Assistance Helpline at **1-888-706-1535**, or the Montana Citizens' Advocate Office at **1-800-332-2272**.

Your Passport to Health

Passport to Health

Passport to Health (Passport) is a medical home program.

What is a medical home?

A medical home is when you choose one provider and ideally one pharmacy that will coordinate most all of your health care needs.

That means any time you are sick, hurt, need medicine or need to see your doctor for an exam, you see the same provider. You work together to know your health status, any medications you may take, and your health history. This helps you and your provider make good decisions so you get the best healthcare possible.

Most members who have Medicaid or HMK *Plus* must participate in the Passport program.

Your Passport Provider

You will choose a dedicated Montana Medicaid Passport provider such as a physician, nurse practitioner, physician assistant, community health center, tribal health, Indian Health Service (IHS), or a primary care clinic. Your Passport provider will take care of most of your medical needs, make referrals to other providers as necessary, and keep your medical records up to date and in one place. With some exceptions, all medical appointments must be provided or approved by your Passport provider.

What to Expect from Your Passport Provider

Your Passport provider has agreed to several requirements to help coordinate your care. Your Passport provider should:

- provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordinate your access to specialty care by providing referrals;
- work with Health Improvement Program (HIP) care managers to coordinate your care (see page 14);
- assist you with finding services;
- provide or arrange for well-child checkups; children's healthcare (EPSDT) services, lead screenings, and immunizations (shots) (see pages 19, 31, and 37-38); and
- offer interpreter services covered by Medicaid.

Who is Ineligible for Passport?

All Medicaid members are in Passport with some exceptions. You are not eligible for Passport if you are:

- eligible for spend down (medically needy),
- living in a nursing home or other institutional setting;
- receiving Medicaid for less than three (3) months;
- eligible for Medicare;
- eligible for Medicaid adoption assistance or guardianship;
- eligible for foster care;
- receiving retroactive Medicaid eligibility,
- receiving Medicaid home and community based services;
- eligible for a non-Medicaid plan like HMK (CHIP), MHSP, or Plan First;
- enrolled in Medicaid funded third party administrator services;
- receiving Medicaid under a presumptive eligible program; and
- residing out of the State of Montana.

Choosing Your Passport Provider

You choose your Passport provider. You can choose the same provider for everyone in your family, or each person can have a different provider according to their healthcare needs. For example, parents may choose a pediatrician for their child, and a family doctor or nurse practitioner for themselves.
If you want to keep seeing your current provider, ask if they are a Passport provider. If they are, you can choose them.

Need Help Choosing?

Call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm. The Help Line staff can tell you about Passport providers near you.

You can also choose your Passport provider anytime online by going to **http://mtpassport.com/**.

If you do not choose a Passport provider, one will be chosen for you. It's best if you choose because you know what's right for you and your family.

After you choose or are assigned your Passport provider, you will get a confirmation letter in the mail with the name of the provider you chose. The letter will also tell you how to contact your provider during normal work hours and after normal work hours.

American Indians and Passport

If you are American Indian, you can choose an IHS or any other Passport provider. If you choose a Passport provider who is not IHS, you can still go to an IHS for health services without a referral from your Passport provider. However, if IHS refers you to someone who is not with IHS, you must get a referral from your Passport provider before you go. **Medicaid and HMK *Plus*** may not pay the bill if you do not get a referral from your Passport provider before seeing another provider. When in doubt, contact your Passport provider.

Changing Your Passport Provider

If you need to change your Passport provider, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm, or log onto **http://mtpassport.com/**. If you change your provider, you will get a letter in the mail confirming the change.

The change usually happens at the beginning of the next month, depending on when the change is requested.

Passport Referrals

Your Passport provider will provide most of your healthcare needs, but sometimes you may need to see a specialist or go to urgent care. Your Passport provider will be asked to give the specialist or urgent care a referral. The specialist or urgent care must make sure they have a referral from your Passport provider before they see you.

You don't need a referral from your Passport provider for all services. See the Covered and Non-Covered Services section beginning on page 17 for services that don't need Passport referrals.

To be Removed from Passport

Most members with Medicaid or HMK *Plus* must choose a Passport provider. Sometimes choosing one provider may make it hard to get healthcare when you need it. In some circumstances an exemption from enrolling in Passport will be approved. Reasons to be exempt from Passport include if you are:

- enrolled with a case management program through another payer;
- unable to find a primary care provider willing to provide case management;
- residing in a county in which there are not enough primary care providers; or
- participating in Passport would be a hardship.

At the discretion of DPHHS, eligible members who are exempt from participating in the Passport program may choose to enroll in Passport. The Passport program has the discretion to determine hardship and to place time limits on all exemptions. If you would like to voluntarily enroll or request an exemption from the Passport to Health program. **Call the Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm.

Pregnancy and Passport

Pregnant women may get pregnancy related care from any provider who takes Medicaid or HMK *Plus*. If you are pregnant, you do not need a referral for pregnancy related care. Your Passport provider must provide most other healthcare that is not pregnancy related.

Getting Passport Medical Care

Checkups, exams, sick, or hurt

Always go to your Passport provider for exams and when you are sick or hurt.

Emergency room care

A medical emergency is when you are sick or hurt and you need medical care right away. Examples of emergencies are if you are bleeding a lot, or having trouble breathing.

You can get emergency treatment without a referral from your Passport provider. If emergency treatment has been done and you still need more care, like getting stitches out, you should go to your Passport provider for that care.

What if you have an emergency?

Call **911** or go to the nearest emergency room.

When should you go to the emergency room?

Go to the emergency room only when you have a medical or behavioral health emergency. See the definition of an emergency on page 33.

Urgent care

Urgent care clinics do not provide the same services as a Passport provider and some do not accept Medicaid. If you go to an urgent care clinic when your Passport provider is not in the office, make sure the urgent care takes Medicaid. Then be sure to ask your Passport provider to give a referral to the urgent care clinic.

Not sure where to go?

If you are not sure if you have an emergency or need to get care right away, you should **call Nurse First at 1-800-330-7847**. There is more information about Nurse First on pages 5 and 6.

Concerns with Your Passport Provider

If you have concerns with your Passport provider, here are some things you can do:

- Talk to your provider, explain what the problem is and try to work it out;
- Choose a new Passport provider;
- Call the Member Help Line. Tell the person who answers that you are having a problem with your Passport provider; or
- You have the right to file a complaint. To do this, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm.

If You do not Have Passport

You can get healthcare from any provider who is a Medicaid or HMK *Plus* provider.

Be sure to ask if the provider is a Medicaid or HMK *Plus* provider before you make an appointment. Here are some common kinds of providers you might see to get healthcare:

- Physicians (doctors), such as internists; pediatricians, obstetricians, gynecologists;
- Mid-level practitioners, such as physician assistants, nurse midwives and nurse practitioners;
- IHS, tribal health, community health center, or a clinic;
- Ambulatory surgical center;
- FQHCs (Federally Qualified Health Centers);
- RHCs (rural health clinics); or
- County or city-county health departments.

To find providers or places to get healthcare that are Medicaid or HMK *Plus* providers, go to **http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices** and click on the "Find a Montana Medicaid Provider" link. Once there, you can search by provider type, provider specialty, name, zip code or even county.

Health Improvement Program

If you have Passport, you are enrolled in the Health Improvement Program (HIP). This program can provide extra help for members with serious health issues through care coordination and management. This program can also help you prevent serious illness, prolong life, and promote better physical and behavioral health.

A care manager, like a nurse or health coach, will contact you by letter and then by phone if you need extra help.

Services that may be offered are:

- Health assessment (questions asked by a nurse or health coach to see what your needs are);
- A written plan to help you manage your health;
- Help with scheduling tests and follow-up care;
- Help with finding care you need before or after a hospital stay;
- Help with questions about medications you are taking;
- Help with finding other services that may help you take care of yourself (such as transportation and community resources);
- Education about how to help yourself with diet, exercise, or medications;
- Reminders to make appointments or schedule other services you may need;
- Keeping a record of your progress; and
- More information about your health condition.

The nurses and health coaches work at health centers across Montana. They will work with your Passport provider to help you get the care you need. If you receive a letter and phone call from a care manager, you will be asked to answer questions about your health and can learn about extra services they offer. You can choose any of the services offered or you can choose not to get the services.

Your Rights and Responsibilities

Your Rights as a Member with Medicaid or HMK *Plus*

A person who is eligible for Medicaid or HMK *Plus* has the right to be treated fairly and with courtesy and respect.

- You have the right to have your privacy protected and to be treated with dignity by providers and their staff;
- You have the right to get medical care no matter your race, color, nationality, sex, religion, age, creed, disability, marital status, or political belief;
- You have the right to know if the medical services you need are paid for by Medicaid or HMK *Plus*;
- You have the right to discuss all information on available treatment options and possible results with your provider before accepting or refusing treatment;
- You have the right to use the services of an interpreter, if necessary, at no cost to you;
- You have the right to make a complaint about Medicaid or HMK *Plus* and to receive an answer;
- You have the right to choose your provider; and
- You have the right to receive information and instructional materials; and the right to request additional information and materials.

Your Responsibilities as a Medicaid or HMK *Plus* Member

You and your healthcare provider are a team. Your job is to help your healthcare provider give you the best healthcare. Here's what you can do:

- Know if you are eligible and understand what benefits are available to you;
- Treat your healthcare providers with respect, just as you like to be treated;
- Call the Nurse First Advice Line – first. Nurses are there every day, 24 hours a day to help you decide if you should see your provider, go to the emergency room, or take care of the problem at home. **Call 1-800-330-7847**;
- Don't use an ambulance or go to an emergency room if you do not have a medical emergency;
- Follow Montana Medicaid's policies and procedures;
- Receive most of your care through your primary care provider;
- Keep your appointments and call your provider in advance if you cannot make it to your appointment;
- Carry your Montana Medicaid/HMK *Plus* ID card with you and show it at every appointment;
- Contact the OPA about any changes in your case;
- Ask all providers if they are Medicaid or HMK *Plus* providers;
- Help your provider get your last medical records;
- Tell your provider about signs of trouble, such as pain, allergies, or changes you've noticed;
- Get complete directions about drugs, treatments, or tests. Write down directions or ask your provider to write them down;
- Make a list of questions before your appointment. Ask about risks, choices, and cost before getting treatments or prescriptions. If you don't understand what you need to do to get better, ask more questions;
- Take time to make a decision about treatment. Think about your choices and discuss them with your provider. For some treatments, your provider will need prior authorization or Passport referral before the treatment is done;
- Go to the same pharmacy to get all your prescriptions. The pharmacist will tell you if different drugs together will give you problems or if a drug has side effects. The pharmacist can also answer questions about your prescription drugs;
- Don't sign anything you don't understand;
- Pay your copayments. If you do not know your copayment amount, ask your healthcare provider;
- Use Medicaid and HMK *Plus* wisely – only when you are sick or for exams and regular checkups to help prevent sickness; and
- If Medicaid or HMK *Plus* paid or may pay for medical care for damages caused by another person, you must give DPHHS the names and addresses of the person or insurance company responsible. **Call DPHHS at 1-800-694-3084**.

Covered and Non-covered Services

This section tells you if a service is covered by Medicaid and HMK *Plus*. For more details on these covered services, turn to page 30. There may be other services that Medicaid and HMK *Plus* will pay for that are not listed. Ask your provider if you're not sure if something is covered, has limits, or requires prior authorization by Medicaid or HMK *Plus*, or call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

All Medicaid and HMK *Plus* services must be medically necessary. The services must be provided by a Montana Medicaid provider.

Passport Referral

Some Medicaid and HMK *Plus* services will need a referral from your Passport provider to see other healthcare providers before Medicaid or HMK *Plus* will pay for services.

Copayments

Some members with Medicaid make a copayment to the provider when they receive services or prescriptions. Members who do not have copayments are:

- Under age 21;
- American Indians/Alaska Natives who are eligible and have ever received a service from a tribal health, Urban Indian clinic, or IHS provider;
- Inpatient in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the member is required to spend for the cost of care all but their personal needs allowance;
- Pregnant women;
- Terminally ill members receiving hospice services; and
- Members who are receiving services under the Medicaid breast and cervical cancer treatment category.

Copayments may not be charged to you until the healthcare provider's claim has been processed, your provider has been notified of payment, and the amount you owe. Be sure to get a receipt for any copayments paid. Providers cannot deny services if you are below 100% of the Federal Poverty Level (FPL) and are unable to pay copayments.

The chart of covered services tells you which services will have a copayment, including the specific copayment amount. Here is a list of Medicaid services that do not require copayments:

- Emergency;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT);
- Family planning;
- Eyeglasses purchased by Medicaid through a volume purchasing agreement;
- Hospice;
- Transportation;
- Home and Community Based Waiver;
- Provider preventable healthcare acquired conditions;
- Generic drugs;
- Approved preventive; and
- Services where Medicaid is the secondary payer. If the service is not covered by the primary payer but is covered by Medicaid, copayment will be applied.

For more information regarding copayments visit **http://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices** or, contact the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

Members with income at or above 100% of the Federal Poverty Level are responsible for a 10% copayment of the provider reimbursed amount for any Medicaid covered service. Except for outpatient pharmacy services where the member will be responsible for:

- a $4 copayment for preferred brand drugs; and
- an $8 copayment for non-preferred brand drugs.

The total of the Medicaid copayments incurred by a Medicaid household may not exceed five (5) percent of the family's income applied quarterly. Copayment may not be applied to the household members in a quarter once the household has met the quarterly cap.

Note: You may need to pay more than one copayment amount, depending on the Medicaid services received. For example, a visit may result in the following copayments, $4 for x-rays, $4 for lab work, $4 for a doctor visit, and $4 for a facility fee (depending on the place of service) for a total copayment amount of $16. Ask your provider's office if you have copayment questions.

Prior Authorization

Some Medicaid and HMK *Plus* services require authorization before Medicaid or HMK *Plus* will pay for the services. For transportation services call **1-800-292-7114**.

For other services, talk to your Passport provider or other provider of service. You may also call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312.**

***For more information regarding benefits, limits, or copayments contact the Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312.**

Montana Medicaid and HMK Plus make every effort to have a complete set of medical policies in place. However, due to the fast pace of medical changes and new medical procedures, Medicaid and HMK Plus may not have a policy to address every service. In those cases, Medicaid and HMK Plus may review other information including current medical literature and other medical resources, and consult with healthcare providers.

The description of Medicaid and HMK Plus covered and non-covered services presented in this chapter is a guide and not a contract to provide medical care. Administrative Rules of Montana, Title 37, Chapters 81 through 88 and 90, govern access and payment of services.

Standard Medicaid Benefit Chart

Hospital, Clinic, and Physician Related Services

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Ambulatory Surgery Center	Surgical procedures performed at a licensed outpatient/same day surgery facility.	$4	10% not to exceed 5% of family income quarterly.	Limited to covered surgical procedures that do not generally last longer than 90 minutes operating time.	Yes, for some services.	Yes, for some services.
Children's Healthcare/ Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Aids families in early identification and treatment of medical, dental, vision, mental health, and developmental screenings or problems for children. For more information see explanation of services in this section, or visit http://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild.aspx.	None	None	Limited to children ages 20 and under.	Yes, for some services.	Yes, for some services.

Hospital, Clinic, and Physician Related Services Continued						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Federally Qualified Health Center/Community Health Center	Health centers that offer sliding fee scales and provide comprehensive services (dental, behavioral health, and primary care).	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.
Hospital: Inpatient	Services for members formally admitted as inpatient and the expected hospital stay is more than 24 hours.	$75 per discharge.	10% not to exceed 5% of family income quarterly.	N/A	Yes, unless pregnancy related.	Yes, for some services.
Hospital: Outpatient	Hospital stays that are expected to last less than 24 hours.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.
Indian Health Services/Tribal Health Centers	Federal healthcare provider and health advocate for American Indians and Alaska Natives.	None	None	Limited to members of federally recognized Indian tribes and their descendants.	No	Yes, for some services.
Mid-Level Practitioners	Services provided by Physician Assistants and Advanced Practice Registered Nurses (Nurse Anesthetists, Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives). See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	Lay mid-wife services are not covered.	Yes, for some services.	Yes for some services.
Physicians/ Specialists	Services provided by physicians for treatment of illness, injury, primary care, preventive care, and health maintenance. See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.
Podiatry	Routine podiatric care when a medical condition (such as diabetes) affecting the legs or feet requires treatment. See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.

Hospital, Clinic, and Physician Related Services Continued

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Public Health Clinic	Physician and mid-level practitioner services provided by a DPHHS designated Public Health Clinic.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.
Rural Health Clinics	Health clinics in rural areas that offer outpatient primary care services and basic laboratory services.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	Yes, for some services.

Senior and Long Term Care Services

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Home Health	Home health services provided by a licensed and certified agency. See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	180 visits per year. Services exceeding the limit must be prior authorized by DPHHS or its designee. Home Health services do not include personal assistance services. Therapy services must be provided by a licensed therapist.	No	Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.
Personal Assistance	Hands-on assistance with activities of daily living.	None	None	There must be a medical or functional need for hands on assistance with an activity of daily living to qualify for services. Limit 80 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.

Senior and Long Term Care Services continued						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Community First Choice	Hands-on attendant based services for member's needing additional help in their home.	None	None	Must meet level of care criteria and have a medical or functional need for hands on assistance with an activity of daily living to qualify for services. Limit of 86 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific Quality Health at 1-800-219-7035.
Home Dialysis Attendants	Attendants who perform home dialysis.	None	None	Must be diagnosed by a healthcare provider as suffering from chronic end stage renal disease. When possible, a household member shall be trained as the attendant. Attendant must be trained with the member at a certified dialysis center. Training and travel time is not reimbursed by Medicaid.	No	Contact DPHHS at 1-406-444-4564 for medical necessity determination.

Behavioral Health Related Services						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Children's Mental Health	Mental health services provided by: • Licensed Professional Counselor (LCPC); • Licensed Clinical Social Worker (LCSW); • Psychiatrists; • Psychologist; • Mental Health Center; • Therapeutic group home; • Residential treatment; and • Hospital. See explanation of services in this section.	None	None	See link to Children's Mental Health Bureau website http://dphhs.mt.gov/dsd/CMB.aspx.	No	Yes, for some services.
Adult Mental Health	Mental health services provided by: • Licensed Professional Counselor (LCPC); • Licensed Clinical Social Worker (LCSW); • Psychiatrists; • Mid-Levels; • Psychologist; • Hospital; and • Mental Health Center. See explanation of services in this section or visit http://dphhs.mt.gov/amdd/Mentalhealthservices.aspx.	$4 $4 $4 $4 $4 $4 $4	10% not to exceed 5% of family income quarterly.	N/A	No	Yes, for some services.
Substance Abuse Disorder Treatment	Substance Use Disorder Treatment services include early intervention, diagnosis, treatment, and recovery support for substance use disorders through outpatient, residential treatment, and non-hospital inpatient treatment. See explanation of services in this section or visit http://dphhs.mt.gov/amdd/SubstanceAbuse.aspx.	$4	10% not to exceed 5% of family income quarterly.	N/A	No	No

Transportation Related Services						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Ambulance	Emergency ground or air transport. See the definition of emergency services in this section. If you are not sure if you should go to the emergency room, call the Nurse First Advice Line at 1-800-330-7847, call 911, or call the local emergency number for services.	None	None	If the transport is denied as not medically necessary you will be responsible for the bill.	No	No
Non-Emergency Transportation (NEMT)	Scheduled non-emergency use of ambulance, wheelchair-lift equipped vans, taxicabs, and buses. See explanation of services in this section.	None	None	N/A	No	Yes, call 1-800-292-7114 before travel takes place.
Transportation	Reimbursement for personal vehicle mileage or bus ticket to travel to a healthcare provider or other Medicaid covered healthcare service. See explanation of services in this section.	None	None	N/A	No	Yes, call 1-800-292-7114 before travel takes place.

Dental Related Services

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Dental	Dental services (exams, cleanings, X-rays, fillings, crowns, orthodontia). See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	Effective July 1, 2016, adults ages 21 and over will be limited to $1,125 of dental treatment benefits annually (July-June). Dentures, anesthesia, diagnostic and covered preventative services do not count towards the annual dental limit. Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.	No	Yes, for some services.
Denturists	Removable artificial teeth. See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	Partial dentures may be replaced every 5 years. Full dentures may be replaced every 10 years.	No	Yes, for some services.

Vision Related Services

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Optometric/ Opticians	Eye exams or diagnosis and treatment of eye diseases. See explanation of services in this section.	$4	10% not to exceed 5% of family income quarterly.	One eye exam every 12 months.	No	No

Vision Related Services Continued

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Eyeglasses	Corrective lenses and/or frames to aid and improve vision. See explanation of services in this section.	None, if received through the Medicaid eyeglass contractor.	None, if received through the Medicaid eyeglass contractor.	One pair of glasses every 12 months. Frames must be Medicaid approved frames. Medicaid will not pay for most add-ons such as photo-grey or transition lenses, progressive or no line bifocal lenses, round bifocals, tints other than rose 1 or 2, polycarbonate or shatter resistant material in lenses, scratch-resistant coating and ultra-violet coating. Contact lenses are covered only when medically necessary and not for cosmetic reasons.	No	Some features may require authorization.

Miscellaneous Services

Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Audiology/ Hearing Aids	Hearing aids, evaluations, and basic hearing assessments for members with hearing disorders.	$4	10% not to exceed 5% of family income quarterly.	Hearing aids must be ordered by a medical provider.	No	Yes, for some services.
Durable Medical Equipment (DME)	Equipment or supplies to treat a health problem or a physical condition.	$4	10% not to exceed 5% of family income quarterly.	Equipment or supplies must be ordered by a medical provider.	No	Yes, for some equipment. Call 1-877-443-4021.
Dialysis Clinic	Outpatient dialysis services provided to members who have been diagnosed with end-stage renal disease.	$4	10% not to exceed 5% of family income quarterly.	Must be diagnosed by a provider as suffering from chronic end stage renal disease.	No	No

Miscellaneous Services Continued						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Habilitative Care	Habiliative services when you require help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. Services may be provided in a variety of inpatient and/or outpatient settings.	$4	10% not to exceed 5% of family income quarterly.	Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.	Yes, for some services.	Yes, for some services.
Home Infusion Therapy	Comprehensive treatment program of pharmaceutical products and clinical support services provided to members who are living in their home, a nursing facility, or any setting other than a hospital. See explanation of services in this section.	$4 per therapy span. No copayment for home infusion nursing services.	10% not to exceed 5% of family income quarterly.	Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation. Drug products that are not FDA-approved or whose use in the non-hospital setting present an unreasonable health risk are not covered.	No	Yes, for most services.
Independent Diagnostic Testing Facility (IDTF)	Diagnostic testing services provided under supervision of a physician independent of a hospital.	$4	10% not to exceed 5% of family income quarterly.	Lab is not covered under IDTF. The provider must enroll as an independent lab to bill lab procedures.	No	No

Miscellaneous Services Continued						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Independent Lab and X-Ray	Tests and imaging provided by an independent (non-hospital) lab or imaging facility.	$4	10% not to exceed 5% of family income quarterly.	N/A	Yes, for some services.	No
Nutrition	Nutritionist or dietician services.	None	None	Limited to children ages 20 and under and adults with diabetes. Services must be ordered by a healthcare provider.	Yes, for some services.	No
Pharmacy	Prescribed medications (prescription or over the counter). See explanation of services in this section.	Generics - None Preferred Brand - $4 Non-preferred brand drugs - $8	Generics - None Preferred Brand - $4 Non-preferred brand drugs - $8	Generic drugs are required when possible. Drugs prescribed: • To promote fertility; • For erectile dysfunction; • For weight reduction; and • For cosmetic purposes or hair growth are not covered.	No	Yes, for some medications.
Private Duty Nursing	Skilled nursing services for children with severe medical problems who are not in a hospital.	None	None	Limited to children ages 20 and under. Services must be ordered by a healthcare provider. Services do not include taking care of a child to give the regular caretaker a break (respite care).	Yes	Yes

Miscellaneous Services Continued						
Benefit	Description	Member Copayments		Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
		Under 100% FPL	Over 100% FPL			
Rehabilitative Care	Services when you need help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because the member was sick, hurt, or disabled. Services may be provided in a variety of inpatient and/or outpatient settings.	$4	10% not to exceed 5% of family income quarterly.	Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.	Yes, for some services.	Yes, for some services.

Non-covered Services

The following are examples of medical and non-medical services that are not covered:

- Chiropractic;
- Acupuncture;
- Naturopathic;
- Dietician;
- Surgical technicians who are not physicians or mid-level practitioners;
- Nutritional;
- Masseur or masseuse;
- Dietary supplements;
- Homemaker;
- Telephone services in home, remodeling of home, plumbing, car repair, and/or modification of automobile;
- Delivery services not provided in a licensed healthcare facility or nationally accredited birthing center, unless as an emergency service;
- Infertility or sterilization reversals;
- Experimental, unproven, investigational, and services in an inappropriate setting;
- Invasive medical procedures for the purpose of weight reduction (gastric bypass, gastric banding, or bariatric surgery); and
- Unauthorized circumcisions.

This is not a complete list.

More Information About Standard Medicaid

This section includes examples of Standard Medicaid. If you are on Medicaid or HMK *Plus* you receive the Standard Medicaid benefit. Not all services are listed, and not all details about a service are shown. Ask your Passport provider or healthcare provider for more information. You can also call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312** for more information.

All covered treatments and services must be medically necessary.

Alcohol and Other Drug Treatment (Substance Use Disorder)

There are several different kinds of alcohol and drug treatment services. Services must be ordered by a licensed healthcare professional trained in substance use disorder treatment services provided by a substance abuse disorder program approved by Medicaid. Treatment must be medically necessary.

- Hospital Inpatient;
- Day treatment;
- Non-hospital inpatient treatment; and
- Non-hospital outpatient treatment.

The following outpatient services are covered:

- Screening and assessment to find out if you have an alcohol or drug problem;
- Individual, group or family counseling;
- Multi-family counseling; and
- Targeted case management for youth.

Autism Services

The Children's Autism Waiver program provides up to 3 years of service for children from 15 months through 7 years of age. Services are designed to improve communication, social, and daily living skills.

Contact the **Children's Autism Waiver Program at 1-406-444-6047** for more information.

Birth Control

Pills, condoms, shots, and most other types of birth control and family planning supplies are covered. Birth control must be prescribed by a healthcare provider.

Blood Lead Testing

Blood lead testing is covered by Medicaid and HMK *Plus*. The symptoms of lead poisoning can be difficult or impossible to recognize, making blood lead testing the only way to confirm exposure.

Case Management (Targeted)

The cost of targeted case management may be covered. You may be able to receive targeted case management if you fall into one of the following groups:

- High-risk pregnant women up to sixty days postpartum and babies of high risk pregnant women up to one year of age;
- Members 18 years and older with severe disabling mental illness;
- Members 16 years and older with developmental disabilities or who reside in a children's developmental disabilities group home;
- Children and youth ages 5-17 or to the age of 20 if the youth is still in secondary school with serious emotional disturbance;
- Children and youth between the ages of birth and 18 with special healthcare needs;
- Children age 20 and under with substance use related disorders;
- Adults 21 years and older with substance use related disorders; and
- Children and youth under age 18 with serious emotional disturbance in an out-of-state psychiatric treatment facility.

Children's Healthcare (EPSDT)

If you take your child to a provider for a well-child checkup or because they are feeling sick, this is the "Early and Periodic Screening" part of EPSDT. Children need regular visits to a provider to make sure that they are growing and are healthy. It's also important to catch problems early so they can be treated. You can read more about well-child checkups on pages 37-38.

If your child's provider finds something that needs to be treated or looked into further, this is the "Diagnosis and Treatment" part of EPSDT. As long as the treatment is ordered by a provider and is medically necessary, it is covered.

If you feel that your child is not receiving what they need, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

Chiropractic Services

Chiropractic services for children ages 20 and under are covered. Adults with Medicare and Medicaid may receive copayment, coinsurance, and deductible reimbursement for limited chiropractic services.

Chiropractic services for children ages 20 and under include:

- Spine adjustment;
- X-rays; and
- Evaluation and management.

Circumcision

Circumcision may be covered if medically necessary and must be prior authorized.

Community First Choice (CFC)

The type of care authorized is developed with each member in a person centered manner and is dependent upon specific needs and living situation. Services available through the CFC program include:

- Assistance with activities of daily living: bathing, dressing, grooming, toileting, eating, medication assistance, ambulation, and exercising;
- Limited assistance with instrumental activities of daily living: grocery shopping, housekeeping, laundry, community integration, yard hazard removal for the purpose of providing safe access and entry to the home, and correspondence assistance;
- Personal emergency response system monitoring; and
- Medical escort.

Services may not be provided in a hospital, a hospital providing long term care, a nursing home, an assisted living facility, or group homes.

Dental Braces (Orthodontia)

Non-cosmetic braces may be covered for children ages 20 and under and must be prior authorized.

Dental Services

Most routine dental services are covered for members with Standard Medicaid and HMK *Plus*.

Children 20 and under

- Can get dental exams and cleanings as often as necessary;
- Should visit a dentist by their first birthday, and then at least once every six months after the first tooth comes in;
- During a well-child checkup, providers should do an oral exam, including the application of fluoride varnish if needed;
- Bridges and tooth-colored crowns are available; and
- Dentures are covered.

Adults with Standard Medicaid benefits

- Effective July 1, 2016, adults ages 21 and over will be limited to $1,125 of dental treatment benefits annually (July-June);
  - Dentures, anesthesia, diagnostic and covered preventative services do not count towards the annual dental limit.
  - Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.
- Can have dental exams and cleanings every six months;
- Can get two porcelain crowns per calendar year; and
- Dentures (see next column).

Dentures for adults

- Dentures are covered for adults;
- Partial dentures may be replaced if the dentures are 5 years old or older;
- Full dentures may be replaced if the dentures are 10 years old or older; and
- One lost pair of dentures in a person's life time is covered.

Dialysis

Services covered at dialysis clinics include outpatient dialysis and training for self-dialysis.

Drugs (Prescriptions)

To find out if a drug you need is covered or to find out if a drug needs prior authorization, talk to your pharmacist or your healthcare provider.

Medicaid usually pays for a 34-day supply. You may get a 90-day supply of some drugs taken all the time, such as drugs for heart disease, high blood pressure, diabetes, thyroid conditions, and birth control. Your pharmacist can tell you if you can get a 90-day supply.

Drugs (Over-the-counter)

The following over-the-counter drugs are covered if they are prescribed for you by your healthcare provider:

- Aspirin;
- Insulin;
- Laxatives, antacids, head lice treatment;
- Stomach products such as Zantac® and Prilosec OTC®;
- Allergy products such as Claritin®;
- Bronchosaline;
- Levonorgestre;
- Ketotifin ophthalmic solution;
- Pyridoxine;
- Doxylamine;
- Oxybutynin; and
- Steroid nasal sprays.

Nursing homes pay for over-the-counter laxatives, antacids, and aspirin for their residents.

Emergency Services

Emergency services are covered. An emergency means the symptoms or a medical or behavioral health condition are severe enough that a person with an average knowledge of health and medicine would expect there might be danger to the health or cause serious harm to any body part of the person or unborn child if the person is not treated right away.

Family Planning Services

Most family planning services are covered, including, but not limited to:

- Physical exams, with breast exams;
- Pap test (to test for pre-cancerous conditions);
- Pregnancy tests;
- Birth control;
- Testing and treatment for sexually transmitted infections;
- Shots for German measles;
- Shots for Human papillomavirus (HPV); and
- Sterilization information and counseling.

Sterilization is covered for members who are mentally competent and 21 years old or older at the time the consent form is signed. The consent form must be signed by the member at least 30 days before the scheduled sterilization.

Infertility services and paternity tests are not covered.

Foot Care (Podiatry)

Covered services include:

- Cutting or removing corns or calluses;
- Trimming nails;
- Applying skin creams;
- Measuring and fitting foot or ankle devices;
- Lab services and supplies; and
- Orthopedic shoes are covered if:
  - you are age 20 or under; or
  - you have a brace or a device attached to your shoe.

Group Medical Visits

A provider may see many patients at the same time for follow-up or routine care. This is a group visit. Group visits are covered. Your provider can let you know if he or she offers group visits.

Home and Community-Based Waiver Services (HCBS)

You must live in a county that has waiver services. Members who may be eligible for HCBS waivers:

- Children with autism, some restrictions apply;
- Children with severe emotional disturbance (SED), 5-17 years old or to the age of 20 if the youth is still in secondary school and consents to participation;
- Physically disabled;
- Elderly;
- Members with a brain injury;
- Members with severe disabling mental illness (SDMI); and
- Members with developmental disabilities.

Services are different in each HCBS waiver and are determined by your needs. Here is a partial list of HCBS services:

- Case management;
- Personal assistance for supervision and socialization;
- Modifications to home or vehicle;
- Supported living and assisted living;
- Clinical and therapy services;
- Substance use disorder treatment;
- Communication and social interaction skill building;
- Homemaking;
- Private nursing;
- Adult day care;
- Adult group and foster home;
- Community-based psychiatric rehabilitation and support;
- Specially trained attendant care;
- Service dogs;
- Home delivered meals;
- Respite care;
- Non-medical transportation;
- Illness management and recovery;
- Health and wellness;
- Pain and symptom management;
- Peer support services; and
- Other services defined under a waiver.

For more information about these HCBS waiver programs, call:

- Physically disabled and elderly waivers **1-406-444-4077**;
- SED for children waiver **1-406-444-1460**;
- SDMI waiver **1-406-444-3964**;
- Developmentally disabled waivers **1-406-444-2995**; and
- Children's Autism waiver **1-406-444-6047**.

Home Health Services

Covered services include:

- Part-time care in your home from a skilled nurse;
- Home health aide care – services for a short, definite period of time to assist in the activities of daily living and care of the household to keep you in your home. This is only available when personal assistance services are not available;
- Physical therapy, occupational therapy or speech therapy by a licensed therapist; and
- Non-routine medical supplies suitable for home use.

Home Infusion Therapy

Some drug treatments must be given in your veins (intravenously). For some members, these treatments may be given in their homes. Home infusion therapy in your home is covered, along with the cost of the person who comes to your home to give you the drug treatments. Services must be prior authorized.

Hospice

Hospice manages all care related to a terminal illness. Grief counseling is also available for the family. Hospice is provided by a licensed and certified agency.

Hospital Services

Services you get in a hospital, whether you stay in the hospital overnight or not, are covered. Some examples of services you might get in a hospital are:

- Emergency room services;
- Medical services for which your provider admits you to the hospital;
- Physical therapy;
- Lab services;
- X-rays;
- Cardiac rehabilitation; and
- Pulmonary rehabilitation.

Many hospital services must be prior authorized before you go to the hospital. For more information about hospital services, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312.**

Interpreter Services

Interpreter services will be provided if you do not speak fluent English. Interpreter services are covered if you get a covered service. Your provider or case manager can help arrange for a qualified interpreter to provide services. You may request a friend or family member to be your interpreter. There is no cost to you for using interpreter services.

Lead Screening

HMK *Plus* children should be tested for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before should also be tested. All HMK *Plus* children at other ages should be screened for risk of lead poisoning.

Mental Health Services for Adults

Medicaid covers these mental health services for all adults:

- Crisis and emergency services;
- Individual, group, and family counseling;
- Inpatient and outpatient therapy;
- Medication management; and
- Psychological testing.

Medicaid also covers these services for adults with Severe Disabling Mental Illness (SDMI):

- Adult group and foster home;
- Community-based psychiatric rehabilitation and support;
- Illness management and recovery;
- Dialectical behavior therapy;
- Assertive community treatment;
- Crisis intervention facility;
- Targeted case management;
- Partial hospitalization;
- Day treatment half day; and
- Intensive community based rehabilitation.

Mental Health Services for Children

HMK *Plus* covers these mental health services:

- Individual, group, and family counseling;
- Outpatient mental health assessments; and
- Acute inpatient hospital services.

HMK *Plus* also covers these services for children with Severe Emotional Disturbance:

- Individual and family counseling;
- Targeted case management;
- Day treatment services;
- Psychological testing;
- Community-based psychiatric rehabilitation and support;
- Comprehensive school and community treatment;
- Therapeutic youth group home;
- Therapeutic family and foster care; and
- Psychiatric residential treatment facility.

Most services must be prior authorized.

Nursing Homes

Covered services include a double room (or a private room if your provider says it's medically necessary), laundry service, travel for medical appointments, meals, minor medical or surgical supplies, nursing services, social services, and activity programs. The nursing home will provide you with a list of other services you will get and will know which services need prior authorization.

OB (Obstetric) Services

Prenatal visits, delivery, and checkups for the mother after she gives birth are covered. A baby's delivery must be in a licensed hospital or birthing center to be covered.

Out-of-State Services

You may need to get medical services outside of Montana.

- If you have an accident, crisis or something that cannot wait until you're back in Montana, seek help at a hospital. The out-of-state hospital must become a Montana Medicaid or HMK *Plus* provider in order to get paid;
- A hospital provider 100 miles or less outside the Montana border is considered an in-state provider and Medicaid or HMK *Plus* will pay for services if the provider is enrolled in Montana Medicaid or HMK *Plus*;
- All out-of-state hospital inpatient services need prior authorization before you get services unless you have an emergency; and
- Services received outside the United States, including Canada or Mexico, are not covered.

Respiratory Therapy

Respiratory therapy is covered for children ages 20 and under, and includes treatment by a licensed respiratory therapist. Services are ordered by your child's healthcare provider. If your child has Passport, your Passport provider must approve the service.

School-Based Services

Children can get some HMK *Plus* services at school. These services are called school-based services. If your child has Passport, their Passport provider may need to approve some services. Examples of services your child may get at school are:

- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Private duty nursing;
- Help with daily living activities;
- Specialized transportation;
- Mental health; and
- Orientation and mobility services for blind or low vision.

Tobacco and Smoking

Everyone in Montana can get help to stop smoking or chewing by calling the **Tobacco Quit Line at 1-800-QUIT-NOW or 1-800-784-8669**.

Stop-smoking products and counseling are covered. Talk to your healthcare provider or call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312** for more information.

Transplants

Most transplants are covered. All transplant services, with the exception of corneal transplants, require prior authorization.

Transportation

The following are the rules used to decide if travel funds will be given:

- You must use the least costly way to travel that still meets your needs;
- All transportation must be approved before you go, and if your appointment is changed, you must get your transportation approved again. The number to call for approval is **1-800-292-7114**;
- Medicaid will reimburse for travel to your Passport provider or to the closest, approved provider of other medical services;
- Travel funds can be provided for out-of-town or out-of-state if the service is not available near you. Advance payment will be on a case-by-case basis; and
- You must be eligible for Medicaid or HMK *Plus* on the date of the medical appointment.

If you used a personal vehicle for emergency travel you must call **1-800-292-7114** within 30 days of the emergency in order to be considered for payment.

There are different rules for different kinds of transportation, such as taxicabs, buses, wheelchair-accessible vans, and non- emergency ambulances. Sometimes friends or family members can get paid for using their cars to take you to Medicaid covered appointments. Be sure to call the Medicaid Transportation Center at

1-800-292-7114 before you arrange travel. You will be paid after you travel, if you have followed the above steps. The transportation center will contact your provider's office to make sure you went to your appointment before paying.

Well-Child Checkups

All members ages 20 and under should have well-child services or visits.
When you make an appointment for a well-child visit, be sure to say that it is a well-child visit so enough time will be scheduled.

Your child, age 20 and under, should receive the following during a well-child visit:

- Head-to-toe unclothed physical exam;
- Eye check;
- Oral check by provider, including application of fluoride varnish if needed;
- Hearing check;
- Nutrition check-up;
- Growth and development check-up;
- Blood and urine tests;
- Immunizations (shots), if needed (see Bright Futures Periodicity Schedule on page 38);
- Speech and language checkup; and
- Lead screening at ages 1 and 2, or up to 6 years if not previously tested.

During the well-child visit, you will also receive health education. If problems or concerns are found during the well-child visit, your child may be referred to another provider for more exams and treatment.

Your child should visit a dentist by their first birthday and at least once every six months after the first tooth comes in.

Every child's visit is covered whether the visit falls within the ages listed on the chart to the right or not. You can request that your child get a well-child screen during any visit for an illness or injury.

Immunizations (shots)

It's important for a child to visit a provider, Community Health Center, or Public Health Clinic to get the right immunizations (shots). Getting shots not only protects the child, but also the anyone the child comes in contact with. A child's provider will know which shots the child should get. Shots protect against a number of diseases including:

- Hepatitis A and B;
- Diphtheria;
- Tetanus;
- Pertussis (whooping cough);
- Polio;
- Pneumococcal disease;
- MMR (measles-mumps-rubella);
- Varicella (Chicken pox);
- Influenza (flu);
- Hib (Haemophilus Influenzae Type B);
- HPV (Human papillomavirus);
- Meningococcal disease; and
- Rotavirus.

If a child misses a shot, he or she should get the shot from the provider as soon as possible. Keep a shot record filled out by the healthcare provider. You will need this record when a child starts day care, school, and college.

Medicaid has adopted the American Academy of Pediatrics Bright Futures Periodicity Schedule. The full national schedule can be found at **http://brightfutures.aap.org/.**

Age	Well-Child Visit	Immunizations (Shots)
Birth	*	*
3-5 days	*	*
1 month	*	
2 months	*	*
4 months	*	*
6 months	*	*
9 months	*	
12 months	*	*
15 months	*	*
18 months	*	*
24 months	*	
30 months	*	
3 years	*	
4 years	*	*
5 years	*	
6 years	*	
7 years	*	
8 years	*	
9 years	*	
10 years	*	
11 years	*	*
12 years	*	
13 years	*	
14 years	*	
15 years	*	
16 years	*	
17 years	*	*
18 years	*	
19 years	*	
20 years	*	

*Means that it is time to receive care

More Helpful Programs

Plan First

If you lose, or are not eligible for Medicaid or HMK *Plus*, family planning services may be paid by Plan First. Plan First 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).

Eligibility Criteria:

- Montana resident;
- Female 19 through 44;
- Able to bear children and not presently pregnant;
- Annual household income up to and including 211% FPL; and
- Applicant cannot be enrolled in Medicaid.

To Apply or For More Information

visit the Plan First Website at **http://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst.**

To speak with Plan First staff

call **1-855-854-1399** or **1-406-444- 6446,** or email ***planfirst@mt.gov.***

Health Insurance Premium Payment (HIPP) Program

HIPP may pay health insurance premiums for members with Medicaid or HMK *Plus* who also have other health insurance coverage. Here are some ways you may be eligible for HIPP:

- You have insurance either through your job or through an individual healthcare policy;
- Your job offers insurance, but you haven't signed up because it costs too much; or
- You had insurance through your job but you are no longer working and can't pay the COBRA continuation coverage premiums.

For more information **about HIPP, call 1-800-694-3084** and press 1 when prompted.

Waiver for Additional Services and Populations

This waiver covers members age 18 or older, with SDMI, who are otherwise ineligible for Medicaid benefits. Members receive Standard Medicaid benefits.

To Apply or For More Information

contact the Addictive & Mental Disorders Division at **1-406-444-2878, hhsamddmhspwaiver@mt.gov**, or visit the Basic Medicaid Waiver website at **http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Medicad1115Waver.**

Assistance for Members with Medicare

If you have Medicare and Medicaid, most of your healthcare costs are paid by Medicare. Medicaid will help with healthcare costs Medicare doesn't pay.

Members who have Medicare with incomes too high to get Medicaid may be able to get Medicare monthly premiums paid. There are three programs called Medicare Savings Programs you may apply for at the OPA. For Medicaid members who qualify, Medicaid will pay:

- Coinsurance and deductibles for the Qualified Medicare Beneficiary program;
- Monthly premiums, deductibles, and copayments for Part B (and Part A if necessary);
- Medicare Part B monthly premiums for the Specified Low-Income Medicare Beneficiary and Qualifying Individual programs; and
- All or part of your Medicare drug plan monthly premium for the Big Sky Rx program. Big Sky Rx is run by DPHHS. Big Sky Rx is for people who have Medicare and don't qualify for Medicaid or the Medicare Savings Programs listed above.

For more information about Big Sky Rx, call **1-866-369-1233** or visit **http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky**.

You can get more information about Medicare and related services from SHIP (State Health Insurance Assistance Program) at **1-800-555-3191.**

Resources

Organization or Service	Website	Phone Number
Aging Services	www.dphhs.mt.gov/sltc/aging.aspx	1-800-551-3191
AIDS or Sexually Transmitted Diseases	www.dphhs.mt.gov/publichealth/hivstd/	1-406-444-3565
Child Abuse and Neglect	http://dphhs.mt.gov/CFSD.aspx	1-866-820-5437
Child Support Customer Service	http://dphhs.mt.gov/CSED/CONTACTS.aspx	1-800-346-5437
Childhood Lead Poison Prevention Information	www.lead.mt.gov/	1-406-444-0340
Children's Special Health Services	www.cshs.mt.gov/	1-800-762-9891
Citizen's Advocate (Governor's Office)	www.citizensadvocate.mt.gov/	1-800-332-2272
Elder Abuse Information (Aging Services)	http://dphhs.mt.gov/SLTC/APS.aspx	1-800-551-3191
Healthy Montana Kids (CHIP)	www.hmk.mt.gov	1-877-543-7669
Legal Services	www.montanalawhelp.org	1-800-666-6124
Medicaid Fraud Line	https://dphhs.mt.gov/MontanaHealthcarePrograms/fraudandabuse.aspx	1-800-201-6308
Medicaid/HMK *Plus* Member Help Line	http://dphhs.mt.gov/MontanaHealthcarePrograms	1-800-362-8312
Montana Citizens Advocate	http://citizensadvocate.mt.gov	1-800-332-2272 Advocate)
Montana Public Assistance Help Line (OPA)	www.dphhs.mt.gov/contact/hotlinenumbers.aspx	1-888-706-1535
Medicaid Transportation Center	http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/MontanaHealthcareTransportation	1-800-292-7114
Medicare	www.mymedicare.gov	1-800-633-4227
Mental Health Ombudsman	www.mhombudsman.mt.gov/	1-888-444-9669
National Alliance on Mental Illness-Montana	www.namimt.org/	1-406-443-7871
National Domestic Violence Hotline	www.thehotline.org/	1-800-799-7233
Poison Control	http://dphhs.mt.gov/publichealth/EMSTS/prevention/poison.aspx	1-800-222-1222
Prescription Assistance Programs	www.bigskyrx.mt.gov	1-866-369-1233
Social Security	www.ssa.gov/	1-800-273-8255
Substance Abuse Treatment	www.dphhs.mt.gov/amdd/substanceabuse	1-406-444-3964
Suicide Prevention	http://dphhs.mt.gov/amdd/suicide	1-800-273-8255
Teen Dating Abuse Helpline	http://www.loveisrespect.org/	1-866-331-9474
Tobacco Quit Line	http://dphhs.mt.gov/publichealth/mtupp/quitline	1-800-784-8669
WIC Nutrition Information	www.dphhs.mt.gov/publichealth/wic	1-800-433-4298

Grievances and Appeals

If You Experience Discrimination

DPHHS may not exclude, deny benefits to, or otherwise discriminate against any person because of race, color, national origin, age, physical or mental disability, marital status, religion, creed, gender, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry.

Discrimination may not occur regarding admission, participation, or receipt of services or benefits of any programs, activities, or employment, whether carried out by the DPHHS through a contractor or other entity.

To file a complaint for discrimination, forms are available by request at **Medicaid/HMK *Plus* Member Help Line** at **1-800-362-8312** or go to **http://dphhs.mt.gov/NondiscriminationPolicy** or contact:
Complaint Coordinator
Phone: 1-406-444-4211
V/TTY: 1-866-735-2968

You can file a complaint with the federal Office of Civil Rights. To file a complaint with the federal Office of Civil Rights contact:

Office of Civil Rights
US Department of Health and Human Services
1961 Stout Street, Room 1426
Denver, CO 80294
Phone: 1-303-844-2024
TDD: 1-303-844-3439

If You Disagree with a Decision by Medicaid or HMK *Plus*

You can take action for yourself or for someone else for one of the reasons listed below.

If you are denied Medicaid or HMK *Plus* eligibility: There is a form you may use for requesting a fair hearing on the back of the notices that are sent out by the Office of Public Assistance. You may also call the **Montana Public Assistance Helpline at 1-888-706-1535** to find out why you were denied eligibility.

If Medicaid or HMK *Plus* won't pay the healthcare bill or you disagree with a decision: If Medicaid or HMK *Plus* didn't pay for a service you think they should pay, or you disagree with any decision, you can call the **Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312**.

You can always request a fair hearing with the DPHHS Office of Fair Hearings if you disagree with a decision on eligibility, payment of your bill, or any other adverse action taken against you. A fair hearing is an impartial administrative hearing. For information on how to request a hearing or to file a request, contact:

Department of Public Health and Human Services
Office of Fair Hearings
PO Box 202953
2401 Colonial Drive, Third Floor
Helena, MT 59620
406-444-2470
Fax: 406-444-3980
E-mail: hhsofh@mt.gov

Let Us Know How Medicaid is Working for You

We want you to be happy with your Medicaid coverage. To let us know how we are doing call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**. We are here to help you with questions or problems. Talking about a problem or filing a complaint or an appeal will not affect your coverage or benefits.

Protected Health Information

The Notice of Protected Health Information is available upon request through the **Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312** or go to **http://dphhs.mt.gov/**.

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Submit questions about this Member Guide to:

Montana Department of Public Health and Human Services
Member Health Management Bureau
PO Box 202951, Helena, MT 59620-2951

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