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

Claim Jumper

Montana Healthcare Programs Claim Jumper January 2021 Volume XXXVI, Issue 1

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Have Feedback? Have Questions?

Take The Survey!

Upcoming Training

Targeted Case Management for Youth with Serious Emotional Disturbance
January 21, 2021

Hospitals Training
February 18, 2021

Register Now

PERM Medical Review Process Has Started

NCI, Inc. is the Federal contractor for the Payment Error Rate Measurement (PERM) medical record reviews. PERM participation is required under the Federal Improper Payments Elimination and Recovery Act (IPERA) of 2010. NCI will began contacting providers for CHIP and Medicaid claims that have been sampled for review. Providers must to respond to NCI within the given timeframe, submit all requested documentation, and return the documentation with the claim-specific cover letter for each claim pulled for review. If no documentation or incomplete records are provided to NCI, the claim will be considered in error and the State will seek an overpayment recovery.

Please contact Heather Smith with DPHHS Program Compliance Bureau for any PERM questions by email HeatherSmith@mt.gov or telephone (406) 444-4171,

Providers may also visit the CMS Providers and PERM Provider Training webpages at any time to become familiar with the entire PERM Process.

CMS Providers Webpage
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html

PERM Provider Training
https://medicaidprovider.mt.gov/Portals/68/docs/training/2020training/PaymentErrorRateMeasurementPERMProviderTrainingConduent06192020.pdf

Submitted by Heather Smith
PERM / MEQC / IPV Supervisor
DPHHS Quality Assurance Division

Provider Relations wants your feedback!

Send comments, general questions, suggestions, or compliments to the Provider Survey.

The National Diabetes Prevention Program in Montana

Montana healthcare providers have a fresh way to help Montanans prevent type 2 diabetes. One proven way to delay or prevent type 2 diabetes is to join the **National Diabetes Prevention Program (DPP)**. The National DPP is a proven lifestyle change program. Class members learn to eat healthfully and increase exercise habits to help them lose weight. The program is:

- 12 months long – weekly sessions the first 6 months of the program and monthly sessions the second 6 months of the program.
- A group-based program which provides support and accountability to all class members.
- A trained lifestyle coach leads all classes.
- Classes are delivered in-person as well as virtual (online, distance learning)

For more information about the National Diabetes Prevention Program, visit their website.

Qualifications
Patients qualify for the National DPP with a diagnosis of prediabetes **or** by meeting the program eligibility requirements below:

- Adults 18 years or older with a body mass index (BMI) of 25 or greater (23 or greater if Asian) **plus one or more** of the following risk factors for heart disease and type 2 diabetes:
    - Fasting glucose of 100-125 mg/dL
    - A1C between 5.7% and 6.4%
    - Blood pressure of at least 130/80 mmHg or treatment
    - Triglycerides greater than 150 mg/dL
    - LDL cholesterol greaterthan130 mg/dL or treatment
    - HDL cholesterol less than 40 mg/dL for men, less than 50 mg/dL for women
    - History of gestational diabetes mellitus
    - Score 5 or more on the Prediabetes Risk Test.

Watch a short video about Taking the Prediabetes Risk Test.

Providers who would like to learn more about the National Diabetes Prevention Program can find program locations on their website or by calling Sonja Tysk at (406) 444-0593.

For Medicaid members who qualify, the National DPP is a covered service.

Field Rep Corner

Top 15 Denial Reason Codes

We have some new denial codes that have reached our Top 15 denied reason codes. The Top 15 Claim Denial list can be found on page 4 of this month's issue. The list, which is updated monthly, provides most frequent reasons claims are denied. The codes may be found on your remit advice in the MATH web portal. Below are some of the codes that are now appearing in the Top 15, an explanation of what each reason code means and how to prevent it.

Procedure/Age Mismatch
Reason: The code on the claim has age limitations and the age of the member does not fall within that range. Most fee schedules containing codes with age limitations will show age range information.
Prevention: Review your fee schedule before providing the service. If your fee schedule does not show an age range and you receive this reason code, please contact the Call Center for assistance at (800) 624-3958.

Provider Type/Procedure Mismatch
Reason: The code on the claim is not allowed for the provider billing the code. The fee schedule associated with your provider type will show the codes you can bill.
Prevention: Review your fee schedule before providing services.

SLMB or QI-1 Eligibility Only
Reason: The member only has Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) coverage.

- SLMB ***only*** covers the member's Medicare premiums.
- Without Medicaid coverage, QMB services are limited.
- Reminder: The MATH portal and the IVR do not give service limits. Examples:
    - The MATH portal or IVR may state the member is eligible for eye exam & glasses. That only means that the member's coverage allows for this service.
    - The MATH portal or IVR may state the member is eligible for vision or dental services when the member only has QMB. This is because Medicare may cover some services in medical setting.

Prevention: Always contact the Call Center at (800) 624-3958 to confirm service limits or coverage when in question.

Deprivation Code Restricted
Reason: The code on the claim is not billable under the member's coverage. This is different from the reason code Procedure Not Allowed, which may be shown on a remit advice as Proc. Fact. Code. Montana Medicaid has very few coverage types that do not cover all services.

- Plan First, also referred to as Family Planning, is the most common. Plan First is very limited on the services covered. Review the current Plan First covered codes on the Plan First page of the provider website.
- Less common is HMK/CHIP dental which has its own list of covered services. Review the HMK/CHIP dental codes on the Dental page of the provider website.
- This denial reason code can also be generated by submitting the charge on the incorrect claim form.

Prevention: It is always good practice to verify a member's coverage type using the MATH provider portal or contacting the Call Center at (800) 624-3958 before providing services. This can also be caused by submitting the charge on the incorrect claim form.

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PPS Hospitals – Inpatient Bundled Services

All PPS inpatient and outpatient hospital services that occur during an inpatient stay are included in the APR-DRG grouper except dialysis services and long-acting reversible contraceptive (LARCs) inserted at the time of delivery.

Services that are included in the APR-DRG payment are considered bundled and include the following:

- Services provided on the day of admission or on the day preceding admission.
- All routine services.
- All diagnostic services (e.g., radiology). This includes diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., CT scan) as well as transportation between the two hospitals.
- Donor/Harvesting.
- All ancillary services provided by the hospital or performed by another entity under contract with the hospital (e.g., hospital has a contractual agreement with an enrolled independent laboratory).

Submitted by Val St. Clair
Hospitals Program Officer
DPHHS

Top 15 Claim Denials

Claim Denial Reason	NOVEMBER 2020	OCTOBER 2020
MISSING/INVALID INFORMATION	1	1
PA MISSING OR INVALID	2	2
EXACT DUPLICATE	3	3
RATE TIMES DAYS NOT = CHARGE	4	5
RECIPIENT NOT ELIGIBLE DOS	5	4
PROC. CODE NOT COVERED	6	6
RECIPIENT COVERED BY PART B	7	7
PROC. NOT ALLOWED	8	8
PROVIDER TYPE/PROCEDURE MISMAT	9	11
PROCEDURE/AGE MISMATCH	10	10
CLAIM INDICATES TPL	11	9
SUSPECT DUPLICATE	12	16
SLMB OR QI-1 ELIGIBILITY ONLY	13	12
REV CODE INVALID FOR PROV TYPE	14	15
SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER	15	14

Recent Website Posts

Below is a list of recently published Montana Healthcare Programs information and updates available on the provider information website. On the website, select "Resources by Provider Type" in the left menu to locate information specific to your provider type. If you cannot locate the information below, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena.

PROVIDER NOTICES Date Posted	Provider Types	Provider Notice Title
11/24/2020	CAH, Hospital Outpatient, Mid-Levels, Physician	Physician Administered Drug (PAD) Prior Authorization Requests Revised
12/01/2020	ASC, CAH, Family Planning Clinic, FQHC, Hospital Inpatient, Hospital Outpatient, Pharmacy, IHS, Mid-Levels, Physician, Plan First Public Health Clinic	Changes in Application Process for Plan First
12/07/2020	All Providers	Medicaid Expansion Extended Through December 31, 2020

FEE SCHEDULES

Revised July 2020

DME

Manuals

DME

FORMS

EPSDT Prior Authorization Form

Prior Authorization Criteria for Physician Administered Drugs

- CINQUAIR® (reslizumab)
- ENTYVIO® (vedolizumab)
- EVENITY™ (romosozumab-aqqg)
- EXONDYS 51® (eteplirsen)
- FASENRA® (benralizumab)
- KRYSTEXXA® (pegloticase)
- NUCALA® (mepolizumab)
- OCREVUS® (ocrelizumab)
- PROLIA® (denosumab)
- SIMPONI ARIA® (golimumab)
- SPINRAZA® (nusinersen)
- SPRAVATO™ (esketamine)
- SUBLOCADE™ (buprenorphine extended-release)
- SUPPRELIN® (histrelin acetate)
- VIVITROL® (naltrexone)
- XGEVA® (denosumab)
- XOLAIR® (omalizumab)
- ZINPLAVA® (bezlotoxumab)
- ZOLGENSMA® (onasemnogene abeparvovec-xioi)
- ZULRESSO™ (brexanolone)

ADDITIONAL DOCUMENTS POSTED

- DUR B Agenda for December 2020

SURS Review Revelations

Peer Support Services

A recent SURS review found Peer Support services being utilized incorrectly. The provider of these services must be certified by the Board of Behavioral Health, prior to providing Peer Support services. Transportation of a member solely is not a covered service. While the Peer Support Specialist may transport the member to and from an activity, there must be some sort of therapeutic intervention to be a billable service. Such therapeutic interventions may include coaching or relapse support. These services must be documented in the notes.

The member receiving these services must have a Severe Disabling Mental Illness (SDMI) or Substance Use Disorder (SUD) diagnosis. The Individual Treatment Plan must include goals that address the member's primary behavioral health needs. These services are provided one-on-one in individual settings utilized to promote healthy coping skills through mentoring. When utilized appropriately, these remarkable services help members navigate a healthier lifestyle and embrace recovery.

Summer Roberts
Program Integrity Compliance Specialist
Quality Assurance Division
DPHHS

Wishing You and Your Staff a Healthy and Successful 2021.

2020 *was a challenging year for everyone and Montana Healthcare Programs recognizes the extraordinary efforts our providers and billers made to keep Montanans safe while keeping up with the changes in policies and procedures made to support those efforts.*

2021 *brings some familiar favorites: a reliable Provider Relations Call Center with short wait times, an easy-to-access and current Provider Website, and customer service designed to support claims paid on the first try.*

Our 2021 New Year's Resolution is *to keep you up-to-date through provider notices, website announcements, and the Claim Jumper with the most recent and important information needed to stay current and submit clean claims.*

We look forward to another year together with you serving Montana Healthcare Program Members.

Field Rep
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Submit Bill to Other Processor or Primary Payer
Reason: The claims system reflects that the member on the claim has another insurance. Montana Medicaid is last source of payment. All other insurance policies held by the member must be billed prior to billing Montana Medicaid.
Prevention: Provide the paid or denied Explanation of Benefits (EOB) from the other insurance company when submitting your claim to Montana Healthcare Programs.

Rev Code Invalid for Provider Type
Reason: The revenue (Rev) code on the claim is not allowed for the provider billing the code.
Prevention: Review one of the following ensure you are billing the correct codes:

- The UB-04 information in the CMS manual; or
- The provider type manual found on the appropriate provider type page on the provider website; or
- The provider's UB-04 manual if one is used.

If you have questions about denial reason codes found on your remit advice, please contact the Provider Relations Call Center at (800) 624-3958, Monday – Friday, 8:00 AM – 5:00 PM Mountain Time for assistance. Provider Relations agents are here to assist providers and billers with information on the remit advice and other Montana Healthcare Programs documents.

Submitted by Deb Braga
Field Rep
Montana Provider Relations

Upcoming Monthly Online Trainings

Register and find more information on the Online Registration Page

Targeted Case Management for Youth with Serious Emotional Disturbance
Presented by Renae Huffman, Children's Mental Health Bureau Program Officer, DPHHS, January 21, 2021
Hospitals Training
Presented by Val St. Clair, Hospitals Program Officer, DPHHS, February 18, 2021
FQHC/RHC Training
Presented by Alyssa Clark, FQHC and RHC Program Officer, DPHHS, March 18, 2021

Key Contacts
Montana Healthcare Programs

Provider Relations
General Email:
MTPRHelpdesk@conduent.com
Enrollment Email:
[redacted]
P.O. Box 4936
Helena, MT 59602
(800) 624-3958 In/Out of state
(406) 442-1837 Helena
(406) 442-4402 or (888) 772-2341 Fax

Conduent EDI Solutions
https://edisolutionsmmis.portal.conduent.com/gcro/

Third Party Liability
P.O. Box 5838
Helena, MT 59604
(800) 624-3958 In/Out of state
(406) 443-1365 Helena
(406) 442-0357 Fax

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

EFT and ERA
Fax completed documentation to Provider Relations (406) 442-4402.

Verify Member Eligibility
FaxBack (800) 714-0075 or
Voice Response (800) 714-0060

POS Help Desk for Pharmacy
(800) 365-4944

Passport
(406) 457-9542

PERM Contact Information
Email: HeatherSmith@mt.gov
Telephone: (406) 444-9365

Prior Authorization
OOS Acute & Behavioral Health
Hospital, Transplant, Rehab, PDN,
DMEPOS/Medical,
& Behavioral Health Reviews
(406) 443-0320 (Helena) or
(800) 219-7035 (Toll Free)