Private Duty Nursing Manual

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How to Search this manual:

This edition has three search options.

1. **Search the whole manual.** Open the Complete Manual pane. From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show all locations where denials discussed in the manual.
2. **Search by Chapter.** Open any Chapter tab (for example the "Billing Procedures" tab). From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show where denials discussed in just that chapter.
3. **Site Search**. Search the manual as well as other documents related to a particular search term on the Montana Healthcare Programs Site Specific Search page. Prior manuals may be located through the provider website archives.

Private Duty Nursing Manual

Updated 01/01/2020

This manual was updated 01/01/2020

Complete Private Duty Nursing Manual

Private Duty Nursing Manual

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Update Log

Publication History

This publication supersedes all previous Private Duty Nursing handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

Updated December 2015, June 2017, June 2018 and January 2020.

Update Log

01/01/2020

- Cost Share references removed from the Billing Procedures and How Payment is Calculated Chapters.
- Term "Medicaid" replaced with "Montana Healthcare Programs" throughout the manual.
- Terms "client" and "patient" replaced with "member".

06/04/2018

Removed commercial resource references.

06/16/2017

Private Duty Nursing Manual converted to an HTML format and adapted to 508 Accessibility Standards.

12/31/2015
Private Duty Nursing Services, January 2016: HELP Plan-Related Updates and Others

End of Update Log Chapter

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Key Contacts and Websites

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated only "In state" will not work outside Montana. For additional contacts and websites, choose the Contact Us link in the left menu on the Provider Information website.

Prior Authorization

For prior authorization requests or for authorization for private duty nursing services requests not included in the Montana Healthcare Programs fee schedule:

(800) 262-1545, X5850
(406) 443-4020 Helena

Mail backup documentation to:

Medicaid Utilization Review Department
Mountain-Pacific Quality Health
P.O. Box 6488
Helena, MT 59604-64882

Fax backup documentation to:

(877) 428-0684
(406) 513-1922 Helena

Private Duty Nursing Services

(406) 444-4189 Phone
(406) 444-1861 Fax

Send written inquiries to:

Program Officer
Private Duty Nursing Services
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

End of Key Contacts and Websites Chapter

Introduction

Thank you for your willingness to serve members of the Montana Healthcare Programs and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for providers of private duty nursing services. Additional essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.
A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. Each manual contains a list of *Key Contacts*. We have also included a space on the back of the front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

In order to remain accurate, manuals must be kept current. Changes to manuals are provided through notices and replacement pages, which are posted on the Provider Information website (see *Key Websites*). When replacing a page in a paper manual, file

the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Healthcare Programs. Provider manuals are to assist providers in billing Montana Healthcare Programs; they do not contain all Montana Healthcare Programs rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails**. Links to rules are available on the Provider Information website (see *Key Websites*). Paper copies of rules are available through the Secretary of State's office (see *Key Contacts*).
Providers are responsible for knowing and following current laws and regulations.

In addition to the general Montana Healthcare Programs rules outlined in the General Information for Providers manual, the following rules and regulations are also applicable to the private duty nursing services program:

- Code of Federal Regulations (CFR)
- 42 CFR 440.80 Private Duty Nursing Services
- Montana Code Annotated (MCA)
- MCA 53-6-101
- Administrative Rules of Montana (ARM)
- ARM 37.85.2701–37.86.2217 EPSDT Private Duty Nursing Services

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Montana Healthcare Programs providers' claims as quickly as possible. Montana Healthcare Programs claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. The Department performs periodic retrospective reviews, which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid, and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by Federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a prior authorization contractor or Provider Relations). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The Introduction chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Montana Healthcare Programs manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

Other Department Programs

The Montana Healthcare Programs private duty nursing services in this manual are not benefits of the Mental Health Services Plan (MHSP), so the information in this manual does not apply to MHSP. For more information on MHSP, see the mental health manual available on the Provider Information website (see *Key Websites*).
The Montana Healthcare Programs private duty nursing services in this manual are not covered benefits of Healthy Montana Kids (HMK). Additional information regarding HMK benefits is available by contacting Blue Cross and Blue Shield of Montana at 1-877-543-7669 (toll-free, follow menu) or 1 (855) 258-3489 (toll-free, direct), or by visiting the HMK website (see *Key Websites*).

End of Introduction Chapter

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services provided by private duty nursing services providers. Like all health care services received by Montana Healthcare Services members, services rendered by these providers must also meet the general requirements listed in the *General Information for Providers* manual, *Provider Requirements* chapter.
Services within scope of practice (ARM 37.85.401)
Services are covered only when they are within the scope of the provider's license. As a condition of participation in the Montana Healthcare Services program all providers must comply with all applicable state and Federal statutes, rules and regulations, including but not limited to Federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Montana

Healthcare Services program and all applicable Montana statutes and rules governing licensure and certification.

Licensing

Private duty nursing services providers must be registered nurses or licensed practical nurses.

Services for children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive approach to health care for Montana Healthcare Services members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Montana Healthcare Services-eligible children may receive any medically necessary covered service, including all private duty nursing services described in this manual. All applicable Passport to Health and prior authorization requirements apply. See the *Physician-Related Services* manual for more information on the EPSDT program.

Noncovered Services (ARM 37.85.207)

Montana Healthcare Services does not cover the following services:

- Services provided to Montana Healthcare Services members who are absent from the state, with the following exceptions:
- Medical emergency.
- Required medical services are not available in Montana. Prior authorization may be required; see the Prior Authorization chapter in this manual.
- If the Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
- When out-of-state medical services and all related expenses are less costly than in-state services.
- When Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.
- Private duty nursing services do not include psychological or mental health counseling; nurse supervision services including chart review, case discussion, or scheduling by a registered nurse; travel time to and/or from the member's place of service; or services provided to allow the member, family, or caregiver to work or go to school.
- Respite care is not a benefit of the private duty nursing program. If eligible, respite services may be covered through the Home- and Community-Based Services waiver program.

Coverage of Specific Services

Home Infusion Therapy Services

Home infusion therapy services are nursing services provided by a registered nurse

employed by a home infusion therapy agency. These nursing services are provided to all members who require home infusion therapy. See the Home Infusion Therapy Services manual for more information.

Home Health Nursing Services

Home health nursing services are provided by an enrolled Montana Healthcare Services home health agency. These nursing services are provided to members of all ages who require home health care. They must be billed by that agency in accordance with current home health program procedures and not under home infusion therapy or private duty nursing services. See the Home Health Services manual for more information.

Private Duty Nursing

Private duty nursing services are limited to skilled nursing services provided directly to a child under age 21 and member-specific training provided to a registered nurse or licensed practical nurse when a child is new to the nursing agency, when a change in the condition of a child requires additional training for the current nurse, or when a change in nursing personnel requires a new nurse to be trained to care for a child.

Private duty nursing services may be provided to a child without parents or guardians being present. However, providers may require a parent of guardian to be present while services are being provided. The issue of whether to require a parent or guardian to be present during private duty nursing services is between the provider and the member. Montana Healthcare Services will not dictate this policy.

Private duty nursing services must be authorized prior to the initial provision of services, and any time the condition of the member changes resulting in a change to the amount of skilled nursing services being provided. Authorization must be renewed with the Department or the Department's designated review agent every 90 days during the first 6 months of services, and every 6 months thereafter.

Authorization for private duty nursing services provided through school districts may be authorized for the duration of the regular school year. Services provided during the summer months are additional services that require separate prior authorization.

Authorization is based on approval of a plan of care by the Department or the Department's designated review agent.

A provider of private duty nursing services must be an incorporated entity meeting the legal criteria for independent contractor status that either employs or contracts with nurses for the provision of nursing services. The Department does not contract with or reimburse individual nurses as providers of private duty nursing services.

Private duty nursing services provided to an eligible member by a person who is the member's legally responsible person, as that term is used in this rule, must be prior authorized by the Department or its designee.

For purposes of this rule, "legally responsible person" means a person who has a legal obligation under the provisions of Montana law to care for another person. Legally responsible person includes the parents (natural, adoptive, or foster) of minor children, legally assigned caretaker relatives of minor children, and spouses.

For private duty nursing services provided to a Montana Healthcare Services member by a person who is legally responsible for the Montana Healthcare Services member, the Department will approve no more than 40 hours of services under the EPSDT program in a 7-day period. The legally responsible person must meet the Department's criteria for providing private duty nursing services. The individual must be a licensed RN or LPN and be employed by an agency enrolled to provide private duty nursing services.

Verifying Coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in this chapter and in the *General Information for Providers* manual, *Provider Requirements* chapter. **Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT and HCPCS Level II coding books. Use the fee schedule and coding books that pertain to the date of service.**
Current fee schedules are available on the Provider Information website (see *Key Websites*).

End of Covered Services Chapter

Passport to Health Program

For Passport to Health information, see the *Passport to Health* manual. The manual is available on the Passport to Health page and applicable provider type pages on the Provider Information website.

End of Passport to Health Program Chapter

Prior Authorization

Prior Authorization

All private duty nursing services must be prior authorized by the Department's designee (see *Key Contacts*). Prior authorization requests must be accompanied by a practitioner's prescription for the services.
The number of private duty nursing services units approved is based on the time required to perform a skilled nursing task. Montana Healthcare Programs authorizes a set number of private duty nursing hours based upon the needs of the individual child for a specific time period. How these hours are used is between the provider and the member and his/her parents. members may use their allotted number of hours for direct skilled care within the specific time period. The scheduling of the hours and how they are going to be used is between the provider, the member and his/her family; however, direct skilled care must be provided by the private duty nursing staff. **Additional hours will not be allowed if the family has used all allotted hours before the specified time period ends and wishes to have more to cover the rest of the time period unless there has been a medical change in the child. Unused hours for the specified time period do not carry forward.**
Private duty nursing services must be authorized prior to provision of the services and any time the plan of care is amended. Authorization must be renewed with the Department or Department's designated review agent (see *Key Contacts*) every 90 days during the first 6 months of service, and every 6 months thereafter.

Authorization is based on approval of a plan of care by the Department or Department's designated review agent.

Montana Healthcare Programs will not perform retrospective reviews of private duty nursing authorization requests for services that have already been provided to members and not authorized by the Department or its designee.

Private duty nursing hours for new members will be handled as requests are received from providers as members are discharged from the hospital or other medical setting. The prior authorization must be requested at the time of the initial submission of the plan of care.

For members currently receiving private duty nursing services, providers are required to renew prior authorization requests in 2 weeks before the end date on the current prior authorization request. Renewals of prior authorization requests must be made every 90 days during the first 6 months, and every 6 months after that. Prior authorization also must be requested any time the plan of care is amended.

To request a prior authorization, submit a completed Request for Authorization, Private Duty Nursing Services which can be found on the Provider Information website. Send it to the address listed in *Key Contacts*.

The Montana Healthcare Program uses an automated prior authorization system. A record of each authorization will be entered into the claims processing system. A prior authorization number will be assigned and notification of all prior authorization approvals and denials will appear on your remittance advice. This 10-digit number is specific to each prior authorization request and must be entered in Field 23 of the CMS-1500 claim form as proof of authorization.

If a provider receives prior authorization for a service, the Montana Healthcare Programs member must still be eligible for Montana Healthcare Programs at the time the service is provided. If the recipient is not eligible for Montana Healthcare Programs, payment will be denied based on member eligibility even if services were prior authorized.

You are requested to estimate the number of private duty nursing hours per day for each child. The number of hours authorized by the Department may be different than the number of hours the nursing firm requested. Federal regulations require Montana Healthcare Programs to authorize reimbursement only for the time required to perform a skilled nursing task. Therefore, units authorized may be different than units requested. Other services such as personal care attendants, home health care, etc. may be obtained under other programs if all program requirements are met.

End of Prior Authorization Chapter

Coordination of Benefits

When members Have Other Coverage

Montana Healthcare Programs members often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Montana Healthcare Programs, but there are some exceptions (see *Exceptions to billing third party first* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The member's Montana Healthcare Programs eligibility verification may identify other payers such as Medicare or other third party payers (see the General Information for

Providers manual, member Eligibility and Responsibilities). If a member has Medicare, the Medicare ID number is provided. If a member has additional coverage, the carrier is shown. Some examples of third party payers include:

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

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

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

When a member Has Medicare

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

Medicare Part B crossover claims
Private duty nursing services may be covered under Medicare Part B. The Department has an agreement with the Medicare Part B carrier for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with claims for members who have both Medicare and Montana Healthcare Programs coverage. Providers must tell Medicare that they want their claims sent to Montana Healthcare Programs automatically, and must have their Medicare provider number on file with Montana Healthcare Programs.
To avoid confusion and paperwork, submit Medicare Part B crossover claims to Montana Healthcare Programs only when necessary.

When members have both Medicare and Montana Healthcare Programs covered claims, and have made arrangements with both Medicare and Montana Healthcare Programs, Part B services need not be submitted to Montana Healthcare Programs. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Montana Healthcare Programs, and send the provider in Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the

claim has been referred to Montana Healthcare Programs for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Montana Healthcare Programs within the timely filing limit (see the Billing Procedures chapter in this manual).

Providers should submit Medicare crossover claims to Montana Healthcare Programs only when:

- The referral to Montana Healthcare Programs statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Montana Healthcare Programs for processing.
- The referral to Montana Healthcare Programs statement is present, but the provider does not hear from Montana Healthcare Programs within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Montana Healthcare Programs for processing.
- Medicare denies the claim, you may submit the claim to Montana Healthcare Programs with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

All Part B crossover claims submitted to Montana Healthcare Programs before the 45-day Medicare response time will be returned to the provider.
When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Submitting a Claim* chapter in this manual.
When submitting a claim with the Medicare EOMB, use Montana Healthcare Programs billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Montana Healthcare Programs's. The claim must also include the Montana Healthcare Programs provider number and Montana Healthcare Programs member ID number. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Montana Healthcare Programs within the timely filing limit (see the *Billing Procedures* chapter in this manual).
When submitting a Medicare crossover claim to Montana Healthcare Programs, use Montana Healthcare Programs billing instructions and codes; they may not be the same as Medicare's.

When a member Has TPL (ARM 37.85.407)

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

Providers are required to notify their members that any funds the member receives from third party payers (when the services were billed to Montana Healthcare Programs) must be turned over to the Department. The following words printed on the

member's statement will fulfill this obligation: *When services are covered by Montana Healthcare Programs and another source, any payment the member receives from the other source must be turned over to Montana Healthcare Programs.*

Exceptions to billing third party first

In a few cases, providers may bill Montana Healthcare Programs first:

- When a Montana Healthcare Programs member is also covered by Indian Health Services (IHS) or Crime Victim Compensation, providers must bill Montana Healthcare Programs first. These are not considered a third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Montana Healthcare Programs first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Third Party Liability Unit (see Key Contacts).

Requesting an exemption

Providers may request to bill Montana Healthcare Programs first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the Third Party Liability Unit (see *Key Contacts*).

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

When the third party pays or denies a service

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

- Pays the claim, indicate the amount paid when submitting the claim to Montana Healthcare Programs for processing.
- Allows the claim, and the allowed amount went toward the member's deductible, include the insurance explanation of benefits (EOB) when billing Montana Healthcare Programs.

- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Montana Healthcare Programs.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Montana Healthcare Programs. Include the EOB from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party does not respond

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

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

End of Coordination of Benefits Chapter

Billing Procedures

Claim Forms

Services provided by private duty nursing service providers must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Montana Healthcare Programs within:

- 12 months from the latest of:
- the date of service
- the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare EOMB approving the service (if the Medicare claim was timely filed and the member was eligible for Medicare at the time the Medicare claim was filed).

- 6 months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Montana Healthcare Programs does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Montana Healthcare Programs (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Montana Healthcare Programs crossover claims, see the *Coordination of Benefits* chapter in this manual.

When to Bill Montana Healthcare Programs Members (ARM 37.85.406)

In most circumstances, providers may not bill Montana Healthcare Programs members for services covered under Montana Healthcare Programs.

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Montana Healthcare Programs paid.
- When the provider bills Montana Healthcare Programs for a covered service, and Montana Healthcare Programs denies the claim because of billing errors.
-

Under certain circumstances, providers may need a signed agreement in order to bill a Montana Healthcare Programs member (see the following table).

When To Bill A Member (ARM 37.85.406)		
	Service Is Covered by Montana Healthcare Programs	**Service Is Not Covered by Montana Healthcare Programs**
Member is Montana Healthcare Programs Enrolled AND Provider has accepted Member as a Montana Healthcare Programs Member.	Provider cannot bill member.	Provider can bill member only if a custom agreement has been made between the member and provider BEFORE providing the service.
Member is Montana Healthcare Programs Enrolled AND Provider has not accepted Member as a Montana Healthcare Programs Member.	Provider can bill Montana Healthcare Programs member if the member has signed a private-pay agreement.	Provider can bill Montana Healthcare Programs member if the member has signed a private-pay agreement.
Individual is not Montana Healthcare Programs Enrolled	Provider can bill member.	Provider can bill member.

If a provider bills Montana Healthcare Programs and the claim is denied because the member is not eligible, the provider may bill the member directly.
Routine Agreement: This may be a routine agreement between the provider and member which states that the member is not accepted as a Montana Healthcare Programs member, and he/she must pay for the services received.
Custom Agreement: This agreement lists the service the member is receiving and states that the service is not covered by Montana Healthcare Programs and that the member will pay for it.

Member Co-Payments (ARM 37.85.204)

Effective for all claims paid on or after January 1, 2020 copayment will not be assessed.

When members Have Other Insurance

If a Montana Healthcare Programs member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible members

When a member becomes retroactively eligible for Montana Healthcare Programs, the provider has 12 months from the date retroactive eligibility was determined to bill for

those services. When submitting claims for retroactively eligible members, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

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

For more information on retroactive eligibility, see the General Information for Providers manual, *member Eligibility and Responsibilities* chapter.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Montana Healthcare Programs their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

Coding

Standard use of medical coding conventions is required when billing Montana Healthcare Programs. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

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

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

CPT

Description:
CPT codes and definitions.
Updated each January.

Contact:
American Medical Association
(800) 621-8335
https://commerce.ama-assn.org/store/

CPT Assistant

Description:
A newsletter on CPT coding issues.
Contacts:
American Medical Association
(800) 621-8335
https://commerce.ama-assn.org/store/

HCPCS Level II

Description:
HCPCS codes and definitions.
Updated each January and throughout the year.
Contact:
Available through various publishers and bookstores or from CMS at www.cms.gov.

ICD

Description:
ICD diagnosis and procedure code definitions.
Updated each October**.**
Contact:
Available through various publishers and bookstores.

Miscellaneous

Various newsletters and other coding resources are available in the commercial marketplace.

Using the Montana Healthcare Programs Fee Schedule

When billing Montana Healthcare Programs, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT and HCPCS Level II coding books.

In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers and prior authorization indicators. Department fee schedules are updated each January and July. Current fee schedules are available on the Provider Information website (see *Key Websites*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- The Montana Healthcare Programs claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Modifier 52 must be used when billing for a partial EPSDT well-child screen.

Billing Tips for Specific Providers

Private Duty Nursing Services
A provider of private duty nursing services must be an incorporated entity meeting the legal criteria for independent contractor status that either employs or contracts with nurses for the provision of nursing services. The Department does not contract with or reimburse individual nurses as providers or private duty nursing services.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double-check each claim to confirm the following items are included and are accurate.

Common Billing Errors

Reasons for Return or Denial:
Provider's NPI and/or taxonomy missing or invalid
Preventing Returned or Denied Claims:
Verify the correct NPI and taxonomy are on the claim.

Reasons for Return or Denial:
Authorized signature missing.
Preventing Returned or Denied Claims:
Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.

Reasons for Return or Denial:
Signature date missing.
Preventing Returned or Denied Claims:
Each claim must have a signature date.

Reasons for Return or Denial:
Incorrect claim form used.
Preventing Returned or Denied Claims:
The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic professional claim).

Reasons for Return or Denial:
Information on claim form not legible.
Preventing Returned or Denied Claims:
Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.

Reasons for Return or Denial:
Recipient number not on file, or recipient was not eligible on date of service.
Preventing Returned or Denied Claims:
Before providing services to the member:
View the member's eligibility information at each visit. Montana Healthcare Programs eligibility may change monthly.

Verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the General Information for Providers manual.

Reasons for Return or Denial:
Duplicate claim.
Preventing Returned or Denied Claims:
Please check all remittance advices for previously submitted claims before resubmitting.
When making changes to previously paid claims, submit an adjustment form rather than a new claim. (See Remittance Advices and Adjustments in this manual.)
Please allow 45 days for the Medicare/Montana Healthcare Programs Part B crossover claim to appear on the remittance advice before submitting the claim directly to Montana Healthcare Programs.

Reasons for Return or Denial:
Procedure requires Passport provider referral – No Passport provider number on claim.
Preventing Returned or Denied Claims:
A Passport provider number must be on the claim when such a referral is required. See the *Passport to Health* manual.

Reasons for Return or Denial:
TPL on file and no credit amount on claim.
Preventing Returned or Denied Claims:
If the member has other insurance (or Medicare), bill the other carrier before Montana Healthcare Programs. See Coordination of Benefits in this manual.
If the member's TPL coverage has changed, providers must notify Conduent TPL unit before submitting a claim.

Reasons for Return or Denial:
Claim past 365-day filing limit
Preventing Returned or Denied Claims:
The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.
To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.

Reasons for Return or Denial:
Missing Medicare EOMB
Preventing Returned or Denied Claims:
All Medicare crossover claims on CMS-1500 forms must have an EOMB attached.

Reasons for Return or Denial:
Provider is not eligible during dates of services, or provider number terminated
Preventing Returned or Denied Claims:
Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.
New providers cannot bill for services provided before Montana Healthcare Programs enrollment begins.
If a provider is terminated from the Montana Healthcare Programs, claims submitted with a date of service after the termination date will be denied.

Reasons for Return or Denial:
Type of service/procedure is not allowed for provider type
Preventing Returned or Denied Claims:
Provider is not allowed to perform the service.
Verify the procedure code is correct using current HCPCS and CPT billing manual.
Check the Montana Healthcare Programs fee schedule to verify the procedure code is valid for your provider type.

End of Billing Procedures Chapter

Submitting a Claim

Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience

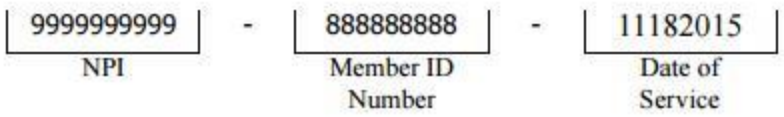
fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **Conduent WINASAP 5010**. Conduent makes available this free software, which providers can use to create and submit claims to Montana Healthcare Programs, MHSP, and HMK (dental and eyeglasses only), and FQHC and RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Conduent EDI Gateway**. Providers can send claims to the Conduent EDI Gateway in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the Conduent clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through Conduent EDI Gateway.
- **Clearinghouse**. Providers can contract with a clearinghouse so that the provider can send the claim to them in whatever format they accept. The provider's clearinghouse then sends the claim to Conduent in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Conduent. EDIFECS certification is completed through Conduent EDI Gateway. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see *Key Contacts*).
- **Montana Access to Health (MATH) web portal**. Providers can upload and download electronic transactions 7 days a week through the MATH web portal. This availability is subject to scheduled and unscheduled host downtime.
- Conduent B2B Gateway SFTP/FTPS Site. Providers can this method to send electronic transactions through this secure FTP process. This is typically encountered with high-volume/high-frequency submitters.
- Conduent MOVEit DMZ. Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between Trading Partners and Conduent. Its use is intended for those trading partners/ submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2MB.

Providers should be familiar with Federal rules and regulations and instructions on preparing electronic transactions.

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the Attachment Control Number field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Montana Healthcare Programs ID number followed by the member's ID number and the date of service, each separated by a dash:



The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet (on the Provider Information website and in Appendix A: Forms). The number in the paper Attachment Control Number field must match the number on the cover sheet. For information on attachment control numbers and submitting electronic claims, contact Provider Relations.

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the Billing Procedures chapter in this manual).

Claims are completed differently for the different types of coverage a member has. This chapter includes instructions and a sample claim for the following scenarios:

- member has Montana Healthcare Programs coverage only
- member has Montana Healthcare Programs and third party liability coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or member are indicated by "**".
- Field 24H, EPSDT/Family Planning, is used to override copayment and Passport authorization requirements for certain members or services.

EPSDT/ Family Planning Indicators

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

Code: 6 **Member/ Service:** Nursing facility member
Purpose: Used when providing services to nursing facility residents.

Unless otherwise stated, all paper claims are mailed to:

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

All Montana Healthcare Programs claims must be submitted on Department approved claim forms. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

member Has Montana Healthcare Programs Coverage Only

Field: 1 **Field Title:** Program
Instructions: Check Montana Healthcare Programs.
Field: 1a **Field Title:** Insured's ID number
Instructions: Leave this field blank for Montana Healthcare Programs only claims.
Field: 2* **Field Title:** member's name
Instructions: Enter the member's name as it appears on the Montana Healthcare Programs member's eligibility information.
Field: 3 **Field Title:** member's birth date and sex
Instructions: member's birth date in mm/dd/yyyy format. Check M (male) or F (female) box.
Field: 5 **Field Title:** Insured's address
Instructions: member's address.
Field: 10 **Field Title:** Is member's condition related to employment, auto accident, other accident?
Instructions: Check Yes or No to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Field 24. If you answered Yes to any of these, enter the two-letter state abbreviation on the Place line to indicate where the accident occurred.
Field: 10d* **Field Title:** Reserved for local use
Instructions: Enter the member's Montana Healthcare Programs ID number as it appears on the member's Montana Healthcare Programs eligibility information.
Field: 11d* **Field Title:** Is there another health benefit plan?
Instructions: Enter No, or if Yes, follow claim instructions for appropriate coverage later in this chapter.

Field: 14 **Field Title:** Date of current illness, injury, or pregnancy
Instructions: Enter date in mm/dd/yyyy format. This field is optional for Montana Healthcare Programs-only claims.
Field: 16 **Field Title:** Dates member unable to work in current occupation
Instructions: If applicable, enter date in mm/dd/yyyy format. This field is optional for Montana Healthcare Programs-only claims.
Field: 17 **Field Title:** Name of referring provider or other source
Instructions: Enter the name of the referring provider. For Passport members, the name of the member's Passport provider goes here.
Field: 17a** **Field Title:**NPI of referring provider
Instructions: Enter the referring or ordering physician's NPI. For Passport members, enter the member's Passport provider's Passport ID number.
Field: 18 **Field Title:** Hospitalization dates related to current service
Instructions: Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Montana Healthcare Programs only claims.
Field: 19 **Field Title:**Reserved for local use
Instructions: This field is used for any special messages regarding the claim or member.
Field: 20 **Field Title:**Outside lab?
Instructions: Check No. Montana Healthcare Programs requires all lab tests to be billed directly by the provider who performed them.
Field: 21* **Field Title:**Diagnosis or nature of illness or injury
Instructions: Enter the appropriate ICD diagnosis codes (up to 4 codes in priority order (primary, secondary)).
Field: 23** **Field Title:** Prior authorization number
Instructions: If the service requires prior authorization (PA), enter the PA number you received for this service.
Field: 24A* **Field Title:** Dates of service
Instructions: Enter date of service for each procedure, service, or supply.
Field: 24B* **Field Title:** Place of service
Instructions: Enter the appropriate two-digit place of service.
Field: 24C* **Field Title:** EMG (Emergency)
Instructions: Enter an X if this service was rendered in a hospital emergency room to override Montana Healthcare Programs cost share.
Field: 24D* **Field Title:** Procedures, services, or supplies
Instructions: Enter the appropriate CPT or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT/HCPCS modifier. Montana Healthcare Programs allows up to three modifiers per procedure code.
Field: 24E* **Field Title:** Diagnosis code
Instructions: Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.

Field: 24F* **Field Title:** Charges
Instructions: Enter provider's usual and customary charge for the procedure on this line.
Field: 24G* **Field Title:** Days or units
Instructions: Enter the number of units or days for the procedure and date of service billed on this line (see Billing Procedures, Coding for additional tips on days/units).
Field: 24H** **Field Title:** EPSDT/Family Plan(ning)
Instructions: If applicable, enter the appropriate code for the member/service: 1, 2, 3, 4 or 6 (see complete description in the EPSDT/Family Planning Overrides table in this chapter).
Field: 24I** **Field Title:** ID qualifier
Instructions:
Field: 28* **Field Title:** Total charge
Instructions: Enter the sum of all charges billed in Field 24F.
Field: 29 **Field Title:** Amount paid
Instructions: Leave blank or enter $0.00. Do not report member cost share or Montana Healthcare Programs payment amounts on this form.
Field: 30* **Field Title:** Balance due
Instructions: Enter the balance due as recorded in Field 28.
Field: 31* **Field Title:** Signature and date
Instructions: This field must contain an authorized signature of physician or supplier (include degree or credentials) which is either handwritten, stamped, or computer-generated, and a date.
Field: 32 **Field Title:** Service facility location
Instructions: Enter the name, address, city, state, and ZIP code of the person, organization, or facility performing the services if other than the member's home or physician's office.
Field: 33* **Field Title:** Billing provider info and phone
Instructions: Enter the name, address, city, state, ZIP code, and phone number and NPI of the provider or supplier who furnished the service.

* = Required field ** = Required, if applicable

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rhoads, Rock Y.

3. PATIENT'S BIRTH DATE MM DD YY: 02 28 11 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Harold Hunter, MD

17a.

17b. NPI 9989999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 783.3 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 999999

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 24 11	05 24 11	22	97802			179 00	4		NPI	9999999999
2	07 16 11	07 16 11	22	97803			79 00	2		NPI	9999999999
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN EIN [ ] [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 258 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 258 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Betty Biller 04/01/04

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406)555-5555

City Medical
P.O. Box 999
Anytown, MT 59999

a. 0000099999 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

member Has Montana Healthcare Programs and Third Party Liability Coverage

Field: 1 **Field Title:** Program
Instructions: Check Montana Healthcare Programs.
Field: 1a* **Field Title:** Insured's ID number
Instructions: Enter the member's ID number for the primary carrier.
Field: 2* **Field Title:** member's name
Instructions: Enter the member's name as it appears on the Montana Healthcare Programs member's eligibility information.
Field: 3 **Field Title:** member's birth date and sex
Instructions: member's birth date in mm/dd/yyyy format. Check male or female box.
Field: 4 **Field Title:** Insured's name
Instructions: Enter the name of the insured or SAME.
Field: 5 **Field Title:** member's address
Instructions: member's address.
Field: 7 **Field Title:** Insured's address
Instructions: Enter the insured's address and telephone number or SAME.
Field: 9–9d **Field Title:** Other insured's information
Instructions: Use these fields only if there are two or more third party insurance carriers (not including Montana Healthcare Programs and Medicare).
Field: 10 **Field Title:** Is member's condition related to:
Instructions: Check Yes or No to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Field 24. If you answered yes to any of these, enter the 2-letter state abbreviation on the Place line to indicate in which state the accident occurred**.**
Field: 10d* **Field Title:** Reserved for local use
Instructions: Enter the member's Montana Healthcare Programs ID number as it appears on the member's Montana Healthcare Programs eligibility information.
Field: 11 **Field Title:** Insured's policy group
Instructions: Leave this field blank, or enter the member's ID number for the primary payer.
Field: 11c* **Field Title:** Insurance plan or program
Instructions: Enter the name of the other insurance plan or program (e.g., BlueCross BlueShield, NewWest).
Field: 11d* **Field Title:** Is there another health benefit plan?
Instructions: Check "Yes."
Field: 14 **Field Title:** Date of current illness, injury, pregnancy
Instructions: Enter date in mm/dd/yyyy format.
Field: 16 **Field Title:** Dates member unable to work in current occupation
Instructions: If applicable, enter date in mm/dd/yyyy format.

Field: 17 **Field Title:** Name of referring provider
Instructions: Enter the name of the referring provider. For Passport members, the name of the member's Passport provider goes here.
Field: 17a** **Field Title:** NPI of referring provider
Instructions: Enter the referring or ordering provider's NPI. For Passport members, enter the member's Passport provider's Passport ID number.
Field: 18 **Field Title:** Hospitalization dates related to current service
Instructions: Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
Field: 19 **Field Title:** Reserved for local use
Instructions: This field is used for any special messages regarding the claim or member.
Field: 20 **Field Title:** Outside lab?
Instructions: Check No. Montana Healthcare Programs requires all lab tests to be billed directly by the provider who performed them.
Field: 21* **Field Title:** Diagnosis or nature of illness or injury
Instructions: Enter the appropriate ICD diagnosis codes. Enter up to four codes in priority order (primary, secondary).
Field: 23** **Field Title:** Prior authorization number
Instructions: If the service requires prior authorization (PA), enter the PA number you received for this service.
Field: 24A* **Field Title:** Date(s) of service
Instructions: Enter date of service for each procedure, service, or supply.
Field: 24B* **Field Title:** Place of service
Instructions: Enter the appropriate two-digit place of service.
Field: 24C* **Field Title:** EMG (Emergency)
Instructions: Enter an "X" if this service was rendered in a hospital emergency room to override Montana Healthcare Programs cost share.
Field: 24D* **Field Title:** Procedure, service, or supplies
Instructions: Enter the appropriate CPT or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Montana Healthcare Programs recognizes two pricing and one informational modifier per code.
Field: 24E* **Field Title:** Diagnosis code
Instructions: Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
Field: 24F* **Field Title:** Charges
Instructions: Enter your usual and customary charge for the procedure on this line.
Field: 24G* **Field Title:** Days or units
Instructions: Enter the number of units or days for the procedure and date of service billed on this line (see Billing Procedures, Coding for additional tips on days/units).
Field: 24H** **Field Title:** EPSDT/family planning
Instructions: If applicable, enter the appropriate code for the member/service: 1, 2, 3,

4 or 6 (see complete description in the EPSDT/Family Planning Overrides table earlier in this chapter).
Field: 24I** **Field Title:** ID qualifier
Instructions:
Field: 28* **Field Title:** Total charge
Instructions: Enter the sum of all charges billed in Field 24f.
Field: 29* **Field Title:** Amount paid
Instructions: Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
Field: 30* **Field Title:** Balance due
Instructions: Enter the balance due (the amount in Field 28 less the amount in Field 29).
Field: 31* **Field Title:** Signature and date
Instructions: This field must contain the date and the authorized signature of physician or supplier, which can be handwritten, stamped, or computer-generated.
Field: 32 **Field Title:** Service facility location information
Instructions: Enter the name, address, city, state, and ZIP code of the person, organization, or facility performing the services if other than the member's home or physician's office.
Field: 33* **Field Title:** Billing provider info and phone
Instructions: Enter the name, address, city, state, ZIP code, phone number, and NPI of the provider or supplier who furnished the service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): White, Snow

3. PATIENT'S BIRTH DATE MM DD YY: 02 26 11 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE:

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Smith, Steven R. MD

17a.

17b. NPI 9999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 783 xx 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 24 11	05 24 11	22		97802			179 00			NPI	9999999999
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 179 00

29. AMOUNT PAID $ 80 00

30. BALANCE DUE $ 99 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Betty Biller 05/01/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 999-9999

City Medical
P.O. Box 999
Anytown, MT 59999

a. 9999999999 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. Providers may also contact Provider Relations for questions regarding payments, denials, and other claim questions (see *Key Contacts*).
If you prefer to communicate with Provider Relations in writing, use the Montana Health Care Programs Claim Inquiry Form on the Provider Information website (see *Key Websites*). A copy of the form is also in *Appendix A: Forms*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 10 days. The response includes the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double-check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Claim Error: Required field is blank
Prevention: Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Claim Error: member ID number missing or invalid
Prevention: This is a required field (Field 10d); verify that the member's Montana Healthcare Programs ID number is listed as it appears on the member's eligibility information.
Claim Error: member name missing
Prevention: This is a required field (Field 2); check that it is correct.
Claim Error: NPI/API missing or invalid
Prevention: The NPI is a 10-digit number (API is a 7-digit) assigned to the provider. Verify the correct NPI/API is on the claim.
Claim Error: Referring or Passport provider name and ID number missing
Prevention: When a provider refers a member to another provider, include the

referring provider's name and ID number or Passport number (see the Passport chapter in this manual).
Claim Error: Prior authorization number missing
Prevention: When prior authorization (PA) is required for a service, the PA number must be on the claim (see the Prior Authorization chapter in this manual).
Claim Error: Not enough information regarding other coverage
Prevention: Fields 1a and 11d are required fields when a member has other coverage (see examples earlier in this chapter).
Claim Error: Authorized signature missing
Prevention: Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Claim Error: Signature date missing
Prevention: Each claim must have a signature date.
Claim Error: Incorrect claim form used
Prevention: Services covered in this manual require a CMS-1500 claim form.
Claim Error: Information on claim form not legible
Prevention: Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Claim Error: Medicare EOMB not attached
Prevention: When Medicare is involved in payment on a claim, the Medicare EOMB must be submitted with the claim or it will be denied.

End of Submitting a Claim Chapter

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers are paid on a one-week payment cycle (see Payment and the RA in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic Remittance Advice

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have Internet access, and be registered for the Montana Access to Health (MATH) web portal. You can

access your electronic RA through the web portal on the Internet by going to the Provider Information website (see Key Websites) and selecting the Log in to Montana Access to Health link. To access the MATH web portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

Electronic RAs are available for only 90 days on the web portal.

After these forms have been processed, you will receive a user ID and password that you can use to log onto the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

If a claim was denied, read the reason and remark code description before taking any action on the claim.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the MATH web portal home page. Due to space limitations, each RA is only available for 90 days.

The pending claims section of the paper RA is informational only. Do not take any action on claims shown here.

Paper Remittance Advice

The paper RA is divided into the following sections: RA Notice, Paid Claims, Denied Claims, Pending Claims, Credit Balance Claims, Gross Adjustments, and Reason and Remark Codes and Descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Sections of the Paper RA

Section: RA Notice

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

Section: Paid Claims

Description: This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Montana Healthcare Programs overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see Adjustments later in this chapter).

Section: Denied Claims

Description: This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 18). The reason and remark

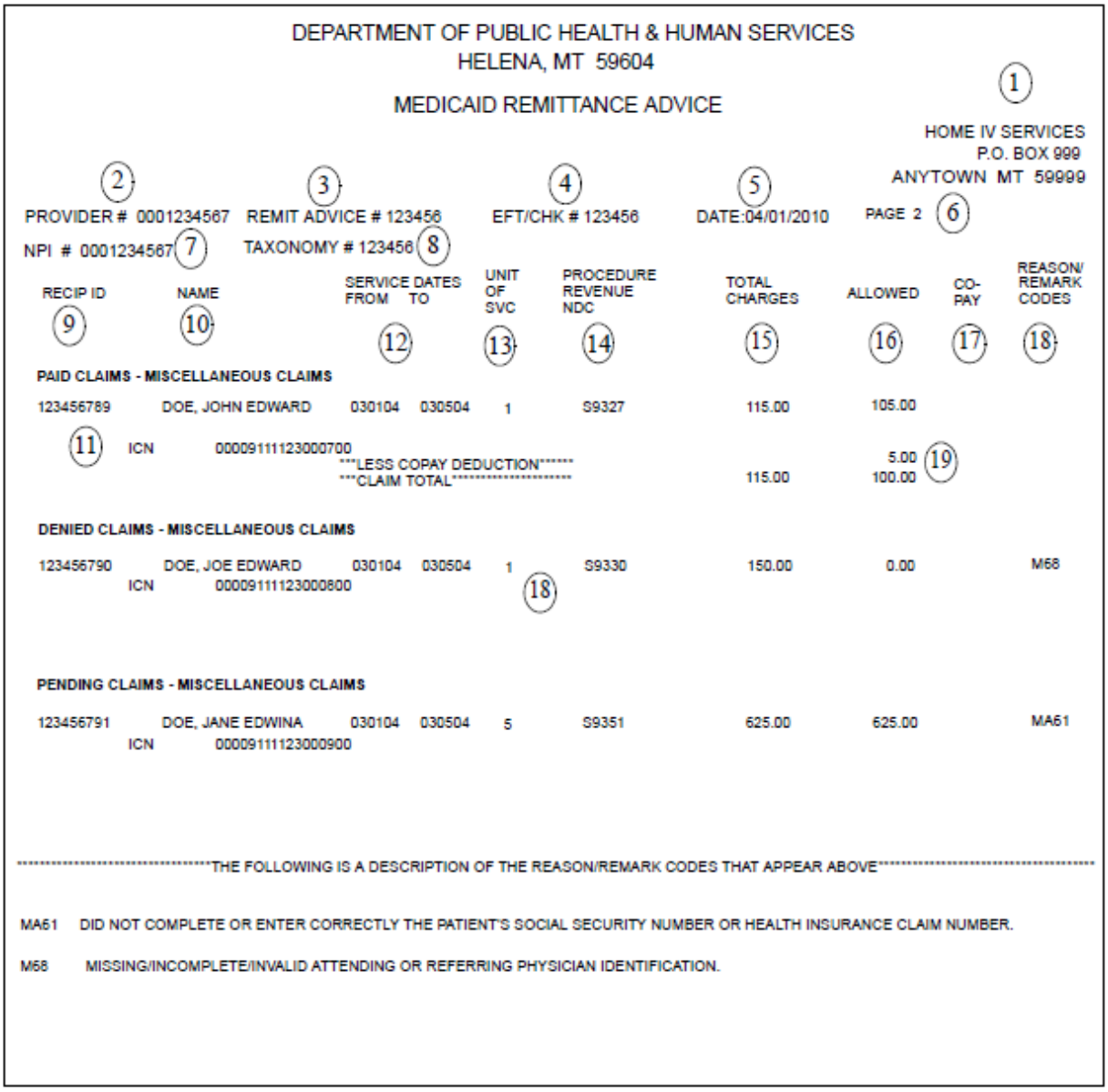
code description explains why the claim was denied and is located at the end of the RA. See The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter.

Section: Pending Claims
Description: All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 18). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

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

Section: Credit Balance Claims
Description: Credit balance claims are shown in this section until the credit has been satisfied.
Section: Gross Adjustments
Description: Any gross adjustments performed during the previous cycle are shown in this section.
Section: Reason and Remark Code Description
Description: This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Paper Remittance Advice



DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)
HOME IV SERVICES
P.O. BOX 999
ANYTOWN MT 59999

(2) PROVIDER # 0001234567 (3) REMIT ADVICE # 123456 (4) EFT/CHK # 123456 (5) DATE:04/01/2010 PAGE 2 (6)

NPI # 0001234567 (7) TAXONOMY # 123456 (8)

RECIP ID (9)	NAME (10)	SERVICE DATES FROM	TO (12)	UNIT OF SVC (13)	PROCEDURE REVENUE NDC (14)	TOTAL CHARGES (15)	ALLOWED (16)	CO-PAY (17)	REASON/ REMARK CODES (18)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	030104	030504	1	S9327	115.00	105.00		
(11) ICN	00009111123000700								
		LESS COPAY DEDUCTION***					5.00 (19)		
		CLAIM TOTAL*******				115.00	100.00		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456790	DOE, JOE EDWARD	030104	030504	1	S9330	150.00	0.00		M68
ICN	00009111123000800			(18)					
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456791	DOE, JANE EDWINA	030104	030504	5	S9351	625.00	625.00		MA61
ICN	00009111123000900								

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.

Key to the Paper RA

Field: 1. Provider name and address
Description: Provider's business name and address as recorded with the Department
Field: 2. Provider number
Description: The 7-digit number assigned to the provider when applying for Montana Healthcare Programs

Field: 3. Remittance advice number
Description: The remittance advice number
Field: 4. Warrant number
Description: Not used
Field: 5. Date
Description: The date the RA was issued
Field: 6. Page number
Description: The page number of the RA
Field: 7. NPI #
Description: NPI is a unique 10-digit identification number required by HIPAA for all health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA transactions.
Field: 8. Taxonomy #
Description: These are used to identify and code an external provider table that would be able to standardize provider types and provider areas of specialization for all medical-related providers.
Field: 9. Recipient ID
Description: The member's Montana Healthcare Programs ID number
Field: 10. Name
Description: The member's name
Field: 11. Internal control number (ICN)
Description: Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:
0 00111 11 123 000123
A B C D E
A = Claim medium

0 = Paper claim
2 = Electronic claim
3 = Encounter claim
4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim)
6 = Pharmacy

B = Julian date (e.g., April 1, 2010 was the 91st day of 2010)
C = Microfilm number
00 = Electronic claim
11 = Paper claim
D = Batch number
E = Claim number
If the first number is:
0 = Regular claim

1 = Negative side adjustment claim (Montana Healthcare Programs recovers payment)
2 = Positive side adjustment claim (Montana Healthcare Programs reprocesses)

Field: 12. Service dates
Description: Dates services were provided. If services were performed in a single day; the same date will appear in both columns
Field: 13. Unit of service
Description: The number of services rendered under this procedure or NDC code.
Field: 14. Procedure/revenue/NDC
Description: The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
Field: 15. Total charges
Description: The amount a provider billed for this service.
Field: 16. Allowed
Description: The Montana Healthcare Programs allowed amount.
Field: 17. Copay
Description: Y indicates cost sharing was deducted, and N indicates cost sharing was not deducted from the payment.
Field: 18. Reason/Remark Code
Description: A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
Field: 19. Deductions, Billed Amount, and Paid Amount
Description: Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Montana Healthcare Programs reimbursement.

Credit balance claims
Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.
The Credit Balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

- By working off the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Healthcare Programs. Attach a note stating that the check is to pay off a credit balance and include your provider

number. Send the check to the attention of the Third Party Liability address in *Key Contacts*.

Rebilling and Adjustments

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

Montana Healthcare Programs does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

How long do I have to rebill or adjust a claim?

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Rebilling Montana Healthcare Programs

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

Rebill denied claims only after appropriate corrections have been made.

When to rebill Montana Healthcare Programs

- *Claim Denied*. Providers may rebill Montana Healthcare Programs when a claim is denied. Check the Reason and Remark Codes, make the appropriate corrections, and resubmit the claim (do not use the adjustment form).
- *Line Denied*. When an individual line is denied on a multiple-line claim, correct any errors and submit only the denied line to Montana Healthcare Programs. For CMS-1500 claims, do not use an adjustment form.
- *Claim Returned*. Rebill Montana Healthcare Programs when the claim is returned under separate cover. Occasionally, Montana Healthcare Programs is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

- Check any Reason and Remark Code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.

- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Claim Inquiries* in the *Submitting a Claim* chapter of this manual). Once an incorrect payment has been verified, the provider should submit an Individual Adjustment Request form (see *Appendix A: Forms*) to Provider Relations. If incorrect payment was the result of a keying error, contact Provider Relations.

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

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).

How to request an adjustment

To request an adjustment, use the Montana Health Care Programs Individual Adjustment Request form in Appendix A: Forms. The requirements for adjusting a claim are as follows:

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

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website or copy it from Appendix A: Forms. Complete Section A first with provider and member information and the claim's ICN number (see following table).

2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):

a. Enter the date of service or the line number in the Date of Service or Line Number column.

b. Enter the information from the claim form that was incorrect in the Information on Statement column.

c. Enter the correct information in the column labeled Corrected Information.

3. Attach copies of the RA and a corrected claim if necessary.

. If the original claim was billed electronically, a copy of the RA will suffice.

a. If the RA is electronic, attach a screen print of the RA.

4. Verify the adjustment request has been signed and dated.

5. Send the adjustment request to Claims Processing (see Key Contacts).

Completing an Individual Adjustment Request Form

Section A
Field: 1. Provider Name and Address
Description: Provider's name and address (and mailing address if different).
Field: 2. Recipient Name
Description: The member's name.
Field: 3.* Internal Control Number (ICN)
Description: There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
Field: 4*. Provider number
Description: The provider's Montana Healthcare Programs ID number.
Field: 5*. Recipient Montana Healthcare Programs Number
Description: member's Montana Healthcare Programs ID number.
Field: 6. Date of Payment
Description: Date claim was paid found on Remittance Advice Field 5 (see the sample RA earlier in this chapter).
Field: 7. Amount of Payment
Description: The amount of payment from the Remittance Advice Field 19 (see the sample RA earlier in this chapter.).

Section B
Field: 1. Units of Service
Description: If a payment error was caused by an incorrect number of units, complete this line.

Field: 2. Procedure Code/NDC/Revenue Code
Description: If the procedure code, NDC, or revenue code are incorrect, complete this line.
Field: 3. Dates of Service (DOS)
Description: If the date of service is incorrect, complete this line.
Field: 4. Billed Amount
Description: If the billed amount is incorrect, complete this line.
Field: 5. Personal Resource (Nursing Facility)
Description: If the member's personal resource amount is incorrect, complete this line.
Field: 6. Insurance Credit Amount
Description: If the member's insurance credit amount is incorrect, complete this line.
Field: 7. Net (Billed - TPL or Medicare Paid)
Description: If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
Field: 8. Other/Remarks
Description: If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

*Indicates a required field

- If an original payment was an underpayment by Montana Healthcare Programs, the adjustment results in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Montana Healthcare Programs, the adjustment results in recovery of the overpaid amount from the provider. This can be done in 2 ways: by the provider issuing a check to the Department or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

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

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

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper newsletter, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with 4 (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and the RA

Providers may receive their Montana Healthcare Programs payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Weekly payments are available only to providers who receive both EFT and electronic RAs.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA. To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Montana Healthcare Programs payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

End of Remittance Advice and Adjustments Chapter

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. These examples are for August 2005 and these rates may not apply at other times.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Montana Healthcare Programs and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter in this manual), and Montana Healthcare Programs makes a payment as the secondary payer. For example, a member receives four 15-minute visits from an RN (T1002). The third party insurance is billed first and pays $15.00. The Montana Healthcare Programs allowed amount for this service totals

$22.64. The amount the insurance paid ($15.00) is subtracted from the Montana Healthcare Programs allowed amount ($22.64), leaving a balance of $7.64, which Montana Healthcare Programs will pay on this claim.

Many Montana Healthcare Programs payment methods are based on Medicare, but there are differences. In these cases, the Montana Healthcare Programs method prevails.

How Payment is Calculated on Medicare Crossover Claims

When a member has coverage from both Montana Healthcare Programs and Medicare, Medicare is the primary payer as described in the Coordination of Benefits chapter of this manual. Montana Healthcare Programs then makes a payment as the secondary payer. For the provider types covered in this manual, Montana Healthcare Programs's payment is calculated so that the total payment to the provider is either the Montana Healthcare Programs allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called 'lower of' pricing.

Other Factors That May Affect Payment

When Montana Healthcare Programs payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Montana Healthcare Programs fee or the provider's charge.
- The member may have an incurment amount that must be met before Montana Healthcare Programs will pay for services (see the General Information for Providers manual, member Eligibility and Responsibilities chapter, Coverage for the Medically Needy section.
- Date of service; fees for services may change over time.
- Medicare, and/or TPL payments, which are shown on the remittance advice.

End of How Payment is Calculated Chapter

Appendix A: Forms

For the forms listed below and others, see the Forms page on the Provider Information website.

- Montana Healthcare Programs Montana Healthcare Programs/MHSP/HMK Individual Adjustment Request
- Paperwork Attachment Cover Sheet

End of Appendix A: Forms Chapter

Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms page of the Provider Information website.

End of Definitions and Acronyms Chapter

Index

Previous editions of this manual contained an index.

This edition has three search options.

1.**Search the whole manual.** Open the Complete Manual pane. From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show all locations where denials discussed in the manual.
2.**Search by Chapter.** Open any Chapter tab (for example the "Billing Procedures" tab). From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show where denials discussed in just that chapter.
3.**Site Search.** Search the manual as well as other documents related to a particular search term on the Montana Healthcare Programs Site Specific Search page.

End of Index Chapter
End of Private Duty Nursing Manual