



ADMINISTRATIVE RULES OF MONTANA



37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT

- (1) Providers must submit clean claims to Medicaid within the latest of:
 - (a) 12 months from the latest of:
 - (i) the date of service;
 - (ii) the date retroactive eligibility is determined; or
 - (iii) the date disability was determined;
 - (b) six months from the date on the Medicare explanation of benefits approving the service, if the Medicare claim was timely filed and the member was Medicare eligible at the time the Medicare claim was filed; or
 - (c) six months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1)(a) and (b).
- (2) For purposes of this rule:
 - (a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;
 - (b) For inpatient hospital services, date of service is the date of discharge;
 - (c) The date of submission to the Medicaid program is the date the claim is stamped "received" by the department or its designee; and
 - (d) The claim submission deadline specified in (1) through (1)(c) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to Medicaid according to the requirements of ARM 37.85.407(6)(c) and subject to the claim submission deadline specified in (1) through (1)(c).
- (3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim. No further review or processing of a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

- (4) Except as provided in (7), all Medicaid claims submitted to the department are to be submitted on a state claim form which is:
- (a) personally signed by that provider;
 - (b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or
 - (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.
- (5) All Medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:
- (a) personally signed by the physician provider;
 - (b) personally signed by a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization; or
 - (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.
- (6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.
- (7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.
- (8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (5)(b).
- (a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.
 - (b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this rule, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.
- (9) If the department pays a claim but subsequently discovers that the provider was not entitled to payment for any reason, the department is entitled to recover the resulting overpayment as provided in (10).

- (10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all Medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations and rules. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made in accordance with ARM 37.85.512.
- (a) The department is entitled to recover under (10) any payment to which the provider was not entitled, regardless of whether the payment was the result of department or provider error, or other cause, and without proving that the provider submitted an improper or erroneous claim knowingly, intentionally, or with intent to defraud.
 - (b) The department is entitled to recover an overpayment from the provider in whose name the erroneous or improper claim was submitted, even if the provider was an employee of another individual or entity and was required as a condition of the provider's employment to turn over all fees received by the provider to the employer.
- (11) Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service or item provided to an eligible Medicaid member in accordance with the rules of the department. Providers must not seek any payment in addition to or in lieu of the amount paid by the Montana Medicaid program from a member or his representative, except as provided in these rules. A provider may bill a member for the copayments specified in ARM 37.83.826 and 37.85.204 and may bill certain members for amounts above the Medicare deductibles and coinsurance as allowed in ARM 37.83.825.
- (a) A provider may bill a member for noncovered services if the provider has informed the member in advance of providing the services that Medicaid will not cover the services and that the member will be required to pay privately for the services, and if the member has agreed to pay privately for the services. For purposes of (11)(a), noncovered services are services that may not be reimbursed for the particular member by the Montana Medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana Medicaid program for the particular member if all applicable requirements, including medical necessity, are met.
 - (b) Except as provided in this rule, a provider may not bill a member after Medicaid has denied payment for covered services because the services are not medically necessary for the member.
 - (i) A provider may bill a member for covered but medically unnecessary services, including services for which Medicaid has denied payment for lack of medical necessity, if the provider specifically informed the member in advance of providing the services that the services are not considered medically necessary under Medicaid criteria, that Medicaid will not pay for the services and that the member will be required to pay privately for the services, and the member has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the member indicating that the service will not be paid by Medicaid. The provider may not bill the member under this exception when the provider has informed the member only that Medicaid may not pay or where the agreement is contained in a form that the provider routinely requires members to sign.

- (ii) An ambulance service provider may bill a member after Medicaid has denied payment for lack of medical necessity.
 - (c) A provider may not bill a member for services as a private pay patient if, prior to provision of the services, the member informed the provider of Medicaid eligibility, unless, prior to provision of the services, the provider informed the member of its refusal to accept Medicaid and the member agreed to pay privately for the services.
 - (d) In service settings where the individual is accepted as a Medicaid member by an arranging provider including, but not limited to, a facility, institution, or other entity that arranges for provision of services by other providers, all other providers performing services for the individual in conjunction with the arranging provider will be deemed to have accepted the individual as a Medicaid member.
 - (i) The only exception to (d) is if the other provider, prior to providing services, informed the individual of their refusal to accept Medicaid and the individual agreed to pay privately for the services. The other provider may then bill the individual for services.
 - (e) The provider may not bill a member for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing, or other requirements necessary to obtain payment.
 - (f) Acceptance of an individual as a Medicaid member applies to all services provided by the provider to the member, except as provided in (11)(a) or (b). A provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid for other covered services. Subject to the requirements of ARM 37.85.402(4), a provider may terminate acceptance of Medicaid for a member in accordance with the provider's professional responsibility, by informing the member of the termination and the effect of the termination on provision of and payment for any further services.
 - (g) If an individual has agreed prior to receipt of services that payment will be made from a source other than Medicaid but later is determined retroactively eligible for Medicaid, the provider may choose to accept the individual as a Medicaid member with respect to the services or to seek payment in accordance with the original payment agreement.
 - (h) A provider that bills Medicaid for services rendered will be deemed to have accepted the individual as a Medicaid member.
 - (i) Nothing in this rule is intended to permit a provider to refuse to accept an individual as a Medicaid member where the provider is otherwise required by law to accept an individual as a Medicaid member.
- (12) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider must submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.
- (13) The Montana Medicaid program will make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.
- (a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a member to obtain medically appropriate services.

- (14) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.
- (15) A government agency may bill the Medicaid program for covered medical services under the following circumstances:
 - (a) The government agency has complied with all federal and state law governing the Medicaid program, and assures that the provider has complied with all state and federal law governing the Medicaid program, including reimbursement levels.
 - (b) The government agency accepts assignment from an eligible Medicaid provider for services provided prior to eligibility determination.
- (16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana Medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities, and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the Medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.
- (17) Medicaid coverage and reimbursement is available only for services or items that are provided in accordance with all applicable Medicaid requirements and within the scope of practice permitted under state licensure laws and other mandatory standards applicable to the provider.
- (18) Except as otherwise provided in the rules of the department which pertain to the method of determining payment rates for claims of recipients members who have Medicare and Medicaid coverage (cross-over claims), the Medicaid allowed amount for Medicare covered services is:
 - (a) for facility based providers who generally bill on the UB-04 billing form, for covered medical services the full Medicare coinsurance and deductible as defined by the Medicare carrier;
 - (i) there is an exception for inpatient ancillary services with Medicare Part B coverage only (no Medicare Part A) or FQHCs: Medicare payments for these services are treated as third party payments and are offset against the Medicaid payment;
 - (b) for medical providers who generally bill on the HCFA-1500 billing form, for covered medical services the lower of:
 - (i) the Medicare coinsurance and deductible (if not met); or
 - (ii) the Medicaid fee less the amount paid by Medicare for the same service, not to exceed the Medicaid fee for that service;
 - (c) for mental health services that are subject to the Medicare psychiatric reduction, the lower of:
 - (i) the Medicaid allowed amount; or
 - (ii) the Medicare allowed amount, less the Medicare paid amount;

- (d) for services to members eligible to receive both Medicare and Medicaid benefits, an amount not to exceed the Medicare allowed amount in instances where the Medicaid fee is higher than the Medicare allowable.
- (19) For all purposes of this rule, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged to all payers.
- (20) Reimbursement from Medicaid may not exceed an amount which would cause total payment to the provider from both Medicaid and all other payers to exceed the Medicaid fee.
- (21) Montana Medicaid does not reimburse for the facility component of a Provider Based entity service.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131, 53-6-149, MCA

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