BlueCross BlueShield of Montana

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

# HELP PLAN PROVIDER MANUAL

January 2016

This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services.
The statements herein do not necessarily reflect the opinion of the Department.



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# Contents

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# Chapter 1: CONTACT INFORMATION

## BCBSMT Overview

Blue Cross and Blue Shield of Montana (BCBSMT) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

## HELP Plan Overview

During the 2015 Legislative session, the Montana Legislature enacted Senate Bill 405, the Montana Health and Economic Livelihood Partnership (HELP) Act, which expands health care services for state residents between the ages of 19 and 64, whose household income is 138% or less of the federal poverty level (FPL). This Medicaid expansion program is referred to as the "HELP Plan." The HELP Plan creates affordable health plan coverage and access to providers for this segment of the State's population. THE HELP Plan is sponsored by the Montana Department of Public Health and Human Services (DPHHS). Blue Cross and Blue Shield of Montana was selected as the third-party administrator (TPA) of the HELP Plan for HELP Plan participants whose household income is 51%-138% of the FPL.

## HELP Plan Benefits

The HELP Plan is effective January 1, 2016. There are no retroactive benefits prior to this date.

Benefits are only available for medically necessary services provided by a HELP in-network provider, with the exception of urgent, emergent or preauthorized services.

Eligibility is dependent upon the participant's income.

Premiums and copayments are dependent upon the participant's income.

BCBSMT, as the TPA of the HELP Plan, contracts with health care providers for the HELP Plan provider network and processes claims for specific services, while XEROX/DPHHS processes claims for specific services. The directions of which services are processed by each entity are defined in Chapter 2 - General Information Professional Claims.

## Introduction

The Blue Cross and Blue Shield of Montana HELP Plan provider manual is updated quarterly and contains information to assist your office with day-to-day business operations involving BCBSMT and its Participants. Your office will be notified of changes in the Blue Review℠ quarterly newsletter and/or by direct mail.

If you have questions regarding this manual or updates, contact your Provider Network Representatives at **1-800-447-7828**, Extension 6100, or by e-mail at **hcs-x6100@bcbsmt.com**.

## BCBSMT Support Areas

BCBSMT provides support to its physicians, professional providers and institutional/facility providers through:

- Provider Customer Service
- Provider Network Representatives
- Medical Directors
- Utilization Management Department

Providers and their staff are encouraged to contact these sources when they have questions and/or need assistance.

## BCBSMT Geographical Regions

The Network Management Department is organized into three geographical regions to provide local service to our customers.

Central Region:

- Floyd Khumalo, **406-437-5248**, **thamsanqa_F_khumalo@bcbsmt.com**

Eastern Region:

- Susan Lasich, **406-437-6223**, **Susan_Lasich@bcbsmt.com**
- Troy Smith, **406-437-5214**, **Troy_Smith@bcbsmt.com**

Western Region:

- Christy McCauley, **406-437-6068**, **Christy_McCauley@bcbsmt.com**
- Leah Martin, **406-437-6162**, **Leah_Martin@bcbsmt.com**

The regions are staffed with Directors and Provider Network Representatives dedicated to each region.

## Network Management Department (Provider Relations)

Network Management, commonly known as provider relations, is the department responsible for issues beyond the scope of the BCBSMT Customer Service Department, such as:

- Provider network development, HELP enrollment screening, credentialing and provider data maintenance
- Provider compensation analysis, methodologies, and implementation
- Provider database maintenance

E-mail Network Management at **HCS-X6100@bcbsmt.com** or call **1-800-447-7828**, Extension 6100, for new provider contracts and provider contract questions, NPI questions, credentialing and re-credentialing status, provider workshops, and complex claims issues beyond the scope of Customer Service. If the Provider Network Representatives are unavailable at the time of your call, your message will be returned within 24 hours. Or refer to the provider section of the BCBSMT web portal at **www.bcbsmt.com/provider**. A provider can submit an update to your clinic location or other information from this page or request new provider contracts.

Continue to contact Provider Customer Service at the number on the back of the Participant's ID card, for routine benefits, eligibility, and claims questions. You may also register at **www.bcbsmt.com** to view benefits, claims, and eligibility information online.

## XEROX HELP Plan Contacts

XEROX processes claims on behalf of DPHHS. Contact XEROX using the following methods:

- Provider Services **1-800-624-3958**
- Visit the Montana Healthcare Programs Provider Information website at **http://medicaidprovider.mt.gov/**
- Claims questions or other questions contact Provider Relations at:
  - **1-800-624-3958** ( In/out of state)
  - **406-442-1837** (Helena) or;

**MTPRHelpdeak@xerox.com**

| HELP Plan Contacts | |
|---|---|
| Health-e-Web (HEW) | **1-877-565-5454 http://www.hewedi.com/** |
| Behavioral Health | **1-877-296-8206** |
| BCBSMT Claims Address (Submission of Paper Claims) | BCBSMT HELP Claims<br>Po Box 3387<br>Scranton, PA 18505 |
| DPHHS (Submission of Paper Claims) | Claims Processing<br>Po Box 8000<br>Helena MT 59604 |
| Health Care Management | **1-877-296-8206** |
| Dental Services | **1-800-362-8312** |
| Electronic Claim Questions or Problems | **1-800-447-7828**, Extension **6100** |
| Fraud Hotline BCBSMT Special Investigations Department (to report suspected fraud and abuse) | **1-800-543-0867**, TTY/TOD **711** |
| Language Interpreter Line | **1-800-225-5254** |
| Relay (TTY Deaf, hearing, and/or speech impaired) | **1-800-833-8503** Voice, **406-444-1335** Voice TTY |
| Bilingual (English-Spanish) Customer Service | **1-877-233-7055** TTY/TDD **711** |
| Transportation Services | **1-800-292-7114** |
| BCBSMT Network Service Representatives | **1-800-447-7828**, Extension **6100** |
| BCBSMT Provider Resources | **https://www.bcbsmt.com/provider/network-participation/the-help-plan** |
| Utilization Management (UM) | **1-877-296-8206** |
| Utilization Management Member Appeals | **1-877-233-7055** |
| Pharmacy @ DPHHS | **1-800-362-8312** |
| Provider Customer Service (Claims, benefits, etc) | **1-877-296-8206** |
| DPHHS/XEROX | **1-800-624-3958**<br>**MTPRHelpdesk@xerox.com**<br>**http://medicaidprovider.mt.gov/** |

# Chapter 2: GENERAL INFORMATION

# PARTICIPANT IDENTIFICATION (ID) CARDS

## Participant ID Numbers

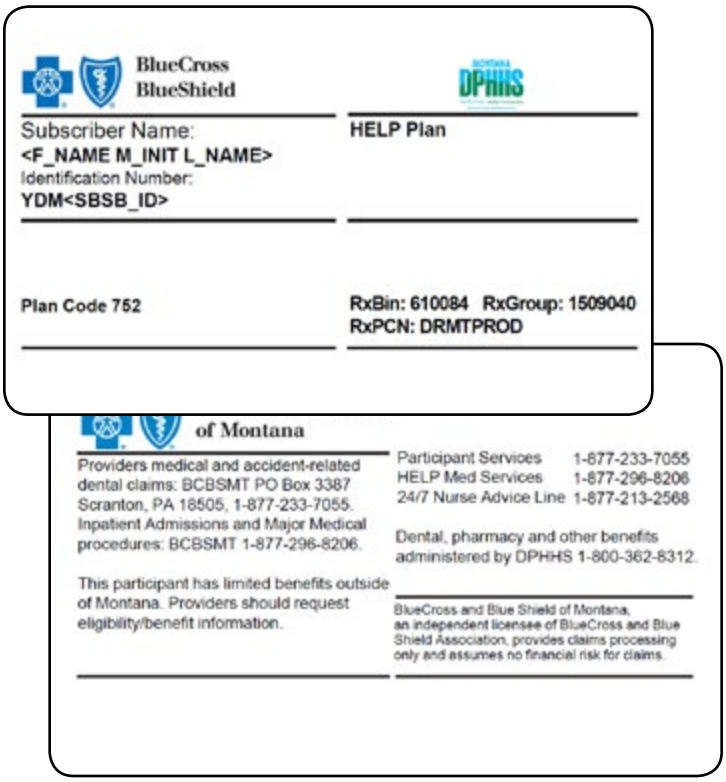
The HELP Plan Alpha Prefix is YDM.

## Participant Verification

Verification of HELP participant eligibility is available from several sources:

- Membership Identification (ID) card
- Register or log into the BCBSMT Secure Provider Portal at **www.bcbsmt.com** for eligibility, benefits and claims information.
- Provider service line for the HELP Plan: **1-877-296-8206**

Although each participant should present a membership card upon request for service, this card cannot fully ensure current eligibility, so providers are encouraged to obtain verification via the BCBSMT Secured Services provider portal. Moreover, given how often a participant's coverage can change, it is highly recommended a copy of the participant's ID card be taken each time a participant visits.



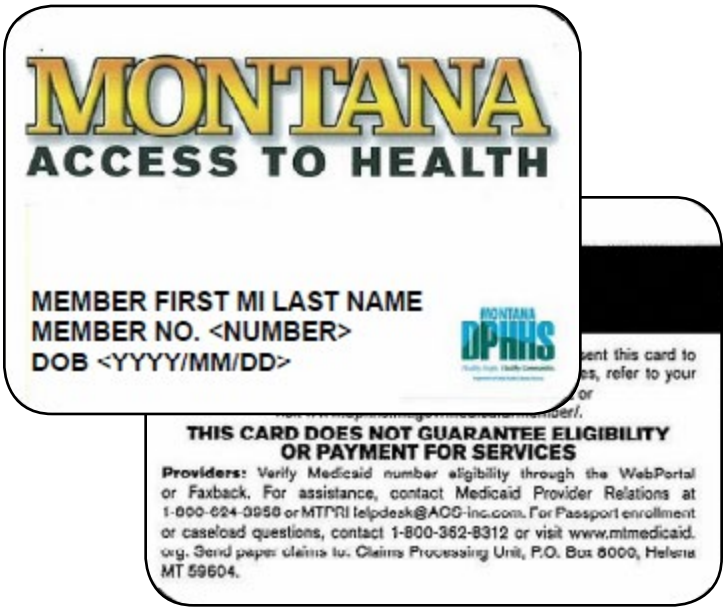

## HELP Plan Identification Card

An example of the identification card provided to each HELP Plan participant is shown below. Remember that not all membership ID cards are alike, so read the front and back carefully for any special information about the participant's plan.

- The HELP Plan ID card contains both BCBSMT's and DPHHS's logos.
- The HELP Plan is specified
- The Alpha Prefix is YDM
- HELP participants have a 7-digit Medicaid CHIMES identification number, in comparison to the usual 9-digit BCBSMT member ID. When using the BCBSMT Secure Provider Portal, two (2) leading zeros will auto populate.
- The HELP Plan ID Card does not contain a group number. A group ID number is not required to submit HELP Plan claims.
- For ease of searching in the BCBSMT Secure Provider Portal, use the Group ID MCAID1.
- Hard copy claims are submitted to Scranton, PA

## Differentiating a HELP Plan Participant from a Medicaid Participant:

If a member presents with a Standard Medicaid card as shown below, all services are processed by Xerox.



## HELP Plan Participant Registration

Inasmuch as DPHHS intends to reallocate additional and supplemental payments over Medicaid and HELP Plan inpatient days, which were previously solely dependent on Medicaid inpatient days, it is recommended that the facility establish a separate payor category for the HELP Plan, so it might easily identify its participants and their charges, allowances, and utilization as well as to accurately support additional and supplemental payments. Having these patients classified under the HELP Plan may also assist the provider to track copayment collection and bad debt/write-offs.

## BCBSMT Secure Provider Portal

Eligibility, benefits, and finalized claims may be viewed for HELP Plan participants on the BCBSMT Secure Provider Portal.

Eligibility:

- Eligibility may be searched by first name, last name and date of birth, or by the HELP participant's ID number.
- HELP participants have a 7-digit Medicaid CHIMES identification number, in comparison to the usual 9-digit BCBSMT member ID. When using the BCBSMT Secure Provider Portal, two (2) leading zeros will auto populate.
- Searches within the provider portal may be performed with or without the leading zeros.
- The HELP Plan ID Card does not contain a group number. A group ID number is not required to submit HELP Plan claims.
  - For ease of searching in the BCBSMT Secure Provider Portal, use the Group ID MCAID1.

### Benefits:

HELP Participant Benefits are provided via the HELP Plan Participant Guide, which is displayed on the Provider Section of the BCBSMT public website, under the Network Participation Tab, and the HELP Plan Tab or via the BCBSMT Secure Provider Portal.

- At the inception of the program, the Maximum Out- of-Pocket amounts will not display.
- Please refer to the copayment table in the Participant Guide for copayment information
- Providers may not collect a copayment until the claim has finalized and the PCR reflects the participant's responsibility amount.

### Claims:

HELP Participant Claims Status may be verified through the BCBSMT Secure Provider Portal.

- At the inception of the program, finalized claims only will display.
- The HELP Plan ID Card does not contain a group number. A group ID number is not required to submit HELP Plan claims.
- For ease of searching for claims in the BCBSMT Secure Provider Portal, use the Group ID MCAID1
- HELP Participant eligibility, benefits and claims status may also be verified by calling **1-877-296-8206**.

BlueCard® Program (out-of-state claims)

In regard to the HELP Plan, the BlueCard program only applies to urgent/emergent services or services that have been preauthorized. Otherwise, there is no access to the Blue Card Network.

To determine where to send claims, please refer to the following table:

| Service/ Benefit | Claims Processed by BCBSMT | Claims Processed by DPHHS |
|---|---|---|
| **Ambulatory Patient Services** | | |
| Primary Care | X | |
| Specialists | X | |
| Other Practitioner (APRN, Physician Assistant) | X | |
| Hospice | X | |
| Adult Dental Preventive Services | | X |
| Urgent Care | X | |
| Home Health Care - Limit 180 Annual Visits | X | |
| FQHC/RHC Services | | X |
| Family Planning Services and Supplies | X | |
| Adult Dental Treatment Services (Includes TMJ Services) | | X |
| Routine Eye Exams – Limit 1 Exam Every 2 Years for Adults | X | |
| Hearing Aid | | X |
| Dialysis | X | |
| Allergy Treatment | X | |
| Telehealth Services (Type of Service Delivery) | X | |
| Indian Health Service (IHS) and Tribal Health Services | | X |
| Outpatient Surgery Facility | X | |
| Audiology | | X |
| Outpatient Hospital | X | |
| Adult Eye Glasses - Limit One Pair Every 12 Months | | X |
| Accident Related Dental Surgery and Services | X | |
| Other Individualized Education Services (Related to a Medical Condition Other Than Diabetes) | X | |
| Non-Emergency Transportation Services (Includes: Personal Per Diem for Mileage; Including Taxis if Trip is >16 Miles, In-Town Bus Rates; Meals; Lodging; Non-Emergency Wheelchair; and Adult Companion for Children Under Age 21) | | X |

| Service/ Benefit | Claims Processed by BCBSMT | Claims Processed by DPHHS |
|---|---|---|
| **Emergency Services** | | |
| ER Department Services | X | |
| Air & Ground Ambulance | | X |
| **Hospitalization** | | |
| Observation/Anesthesia | X | |
| Inpatient Services (Includes: Transplant, Physicians, and Surgical) | X | |
| Cosmetic Surgery (Condition Severe Detrimental Effect) | X | |
| Transplant and Donor Services (Excludes: Donor Searches and Experimental Treatments) | X | |
| Blood Transfusions | X | |
| Reconstructive Breast Surgery | X | |
| **Maternal and Newborn Care (pre and post)** | | |
| Prenatal and Postnatal Care | X | |
| Delivery and All Inpatient Services for Maternity | X | |
| Long Acting Reversible Contraceptives Inserted at Time of Delivery (LARC) | X | |
| **Mental Health and Substance Use Disorder Including Behavioral Health** | | |
| Mental/Behavioral Health Outpatient Services (Not provided in an IMD) | X | |
| Mental/Behavioral Health Inpatient Services (Not provided in an IMD) | X | |
| Substance Use Outpatient Services (Not provided in an IMD) | X | |
| Substance Use Inpatient Services (Not provided in an IMD) | X | |
| **Pharmacy Distributed/ Prescription Drugs (Identical coverage as existing Medicaid)** | | |
| Home Infusion | | X |
| Tobacco Cessation | | X |
| OTCs | | X |
| Vaccines | | X |
| Contraceptives | | X |
| Physician Administered Medications | X | |

| Service/ Benefit | Claims Processed by BCBSMT | Claims Processed by DPHHS |
|---|---|---|
| **Rehabilitative and Habilitative Services and Devices** | | |
| Outpatient Rehabilitative - No Limits (Including: Services Provided for Physical Therapy; Speech Therapy; Occupational Therapy and Cardiac Therapy) | X | |
| Habilitative Services | X | |
| Prostheses (Included: to replace a body part missing due to accident, illness, or injury) | X | |
| DME (Includes: blood glucose testing and supplies; spacers for metered dose inhalers; enteral solutions; syringes and needles) | X | |
| Skilled Nursing Services – 60 day annual limit (No custodial care) | X | |
| Cochlear Implants (All ages) | X | |
| Transitional Services (Includes: swing beds and short term rehabilitation) | X | |
| **Laboratory Services - Imaging, X-Ray, and Lab** | | |
| Diagnostic Test (X-Ray and Lab) | X | |
| Imaging (CT/PET Scans and MRI) | X | |
| **Preventive and Wellness Services and Chronic Disease Management** | | |
| Preventive Care, Screening, Immunizations | X | |
| Breast Pumps - Limit One Per Birth | X | |
| Preventive Health Services | X | |
| Diabetes Prevention Program | | X |
| Diabetes Self-Management Education | X | |
| Pediatric Services Including Oral and Vision Services (EPSDT: under age 21) | X | |

# Chapter 3: PROFESSIONAL CLAIMS

## National Provider Identifier (NPI) Number

The provider's NPI number is the key to prompt payment of claims. Always include this number when submitting claims for HELP participants; otherwise, the claims will be returned to the provider.

Providers must submit claims for services under the provider number assigned to them. Submitting claims for payment under another provider's number is considered fraud as defined under Montana Code Annotated 33-1-1202(1). A provider may not let another provider use his/her NPI number to submit claims except as described in the Locum Tenens Policy or Provider-in-Training Policy. Copies of these policies are available under Administrative policies.

For questions about the NPI number, contact your Network Management Provider Service Representative.

## Time Limitation for Filing Claims

BCBSMT requires that claims be submitted no later than one year following the date of service.

All claims must provide enough information about the services for the plan to determine whether or not they are a covered medical expense. Submission of such information is required before payment will be made. In certain instances, BCBSMT may require that additional documents or information including, but not limited to, accident reports, medical records, and/or information about other insurance coverage, claims, payments, and settlements, be submitted within the time frame requested for the additional documentation before payment will be made.

For questions, contact BCBSMT HELP Plan Provider Customer Service at **1-877-296-8206**.

## Claims Xten

BCBSMT uses McKesson ClaimsXten™ code auditing software in processing commercial business claims.

This software allows efficient, consistent claim review to evaluate the accuracy and adherence of reported services to accepted national reporting standards (i.e., unbundling, mutually exclusive, and incidental).

## Guidelines for Printing Claim Forms

Professional providers filing paper claims with BCBSMT must use the CMS-1500 claim form. For assistance with completing the CMS-1500 claim form, refer to the CMS-1500 User Guide in the Education and Reference Center of BCBSMT's provider website. Contact your print vendor to request a supply of paper claim forms. The form also may be ordered online at **http://bookstore.gpo.gov**, or by calling **202-512-1800**.

Please follow these guidelines when printing claim forms:

- Ensure the printed information on claim forms is in dark black print or type so the optical reader can recognize it accurately. Never use red ink for any claim-related information. The optical reader cannot read red ink
- Use high-quality, original CMS-1500 and UB 04 claim forms.
- Ensure the forms are aligned properly when printing so the claim information corresponds to the appropriate field.

## Where to Submit Paper Claims

BCBSMT encourages electronic submittal of claims. In the event you submit paper claims, they should be submitted to BCBSMT at:

**BCBSMT HELP Medicaid Claims Correspondence**
P.O. Box 3387
Scranton, PA 18505

Paper claims should be submitted to XEROX/DPHHS at:

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

Paper claims should be submitted on a CMS-1500 or UB 04 form using current:

- Diagnosis codes ICD-10
- AMA CPT procedure codes
- HCPCS codes for professional services, and
- ASA procedure codes for anesthesia services.

## Electronic Claims

HIPAA requires covered entities submitting electronic claims to use a HIPAA-compliant vendor. Health-e-Web (HeW) is the preferred data network that health care providers, financial institutions, employer groups, and payers use to ensure efficient claims submission and information sharing. Questions concerning electronic claims submission for the HELP Plan should be directed to:

**Health-e-Web**
P.O. Box 1540
Helena MT 59624

**http://www.hewedi.com**

**877-565-5457** Toll Free
**406-449-0190** Fax

HeW's Provider Electronic Payor ID- 66004

If using a clearinghouse other than HeW, we recommend you contact them for their Electronic Payor ID for HELP.

## Corrected Claims

### Electronic

Electronically submit claim with bill type ending in 5 or 7 to indicate a corrected claim.

### Paper

Clearly indicate on the claim Corrected Claim, Corrected Diagnosis, or some other indicator identifying the claim as corrected, and what is being corrected (e.g., procedure code, date of birth, etc.).

### Send all HELP Plan corrected claims to BCBSMT at :

**BCBSMT HELP Medicaid Claims Correspondence**
P.O. Box 3387
Scranton, PA 18505

### Send all HELP Plan corrected claims to XEROX/DPHHS at:

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

## CMS-1500 Form Required Fields

The CMS-1500 claim form is available at most office supply stores and accommodates NPI reporting. The form is also published at **www.bcbsmt.com** (click "Providers" and then "Forms"). See 'Guidelines for Printing Claim Forms' above for more details.

The following table explains the CMS-1500 form fields. The numbers in the left column correspond to the form in Appendix A. Fields not required by BCBSMT are labeled Not required.

| No. | Field Name | Explanation |
|---|---|---|
| 1 | Plan Type | Check the appropriate box. |
| 1a | Insured's ID Number | Enter the participant's BCBSMT ID number as it appears on the identification card. Be sure to include the alpha prefix. |
| 2 | Patient's Name | Enter the participant's given name. (LN, FN, MI) |
| 3 | Patient's Birth Date, Sex | Indicate the participant's month, day, and year of birth in numbers (e.g., 3-16-48). Select patient gender. |
| 4 | Insured's Name | Enter the participant's name as it appears on the BCBSMT identification card. |
| 5 | Patient's Address & Phone Number | Enter the patient's address and phone number. |
| 6 | Patient Relationship to Insured | Check appropriate box for relationship of the patient to the participant, if known. |
| 7 | Insured's Address | Enter the insured's address. |
| 8 | Patient Status | Check the appropriate box. |
| 9 | Other Insured's Name | Not required. |
| 10 | Is Patient's Condition Related to | Check the appropriate box if the participant's condition is related to employment or an auto accident, or check "other." |

| No. | Field Name | Explanation |
|---|---|---|
| 11a | Insured's DOB | Insured's date of birth. |
| 11b | Insured's Plan Name | Insured's plan name. |
| 11c | Other Health Plan | Enter information Y or N if there is another health plan. |
| 12 | Patient's or Authorized Person's Signature | Not required. |
| 13 | Insured's or Authorized Person's Signature | Not required. |
| 14 | Date of Current Illness/ Injury/Pregnancy | Enter the date (month, day, year) the participant became injured (e.g., 2-10-01). |
| 15 | If the Patient Has Had the Same or Similar Illness. Give First Date | Enter the date (e.g., 2-10-01). |
| 16 | Dates Patient Unable to Work in Current Occupation | Not required. |
| 17 | Name of Referring Physician or Other Source | Enter the name of the referring physician. 17a and 17b also must be completed when listing a referring physician. |
| | | For anesthesiology and assistant surgeon claims, use this space for the chief surgeon's name. |
| | | For laboratory and x-ray claims, enter the name of the physician who ordered the diagnostic services. |
| 17a | Other ID | Enter taxonomy code. |
| 17b | NPI | Enter the referring provider's NPI. |
| 18 | Hospitalization Dates Related to Current Services | If the patient was hospitalized when the services were rendered, enter the dates of hospitalization. |

| No. | Field Name | Explanation |
|---|---|---|
| 19 | Reserved for Local Use | See provider-in-training at the beginning of this section. Enter unlisted procedure codes. |
| 20 | Outside Lab? Charges | Enter Y or N if claim includes lab services provided outside of a provider's office. |
| 21 | Diagnosis or Nature of Illness or Injury | Specify ICD codes. Codes will be required on a per-procedure basis in Item 24D. Enter primary diagnosis code first. |
| 22 | Medicaid Resubmission Code | Not required. |
| 23 | Prior Authorization Number | Leave blank, or if applicable, enter the pre-service authorization number in its entirety given by BCBSMT or APS Healthcare. |
| 24a | Date(s) of Service | Enter the month, day, and year for each service. If you are providing the same level of medical care for consecutive days, include the "from/ to" dates and show the per-day charge in 24f. |
| 24b | Place of Service (POS) Code | Enter the appropriate place of service code. Refer to the Place of Service Compensation Policy published at www.bcbsmt.com for a list of place of service codes. |
| 24c | EMG | Enter Y for emergency or N for all others. |

| No. | Field Name | Explanation |
|---|---|---|
| 24d | Procedures, Services, or Supplies | Describe the services rendered or procedures performed using CPT-4, HCPCS, NDC, or ASA procedure codes and appropriate modifiers. Explain any unusual services or circumstances related to the procedure in the space provided. Attach reports to the claim form, if necessary. Refer to the Modifier Use When Coding Claims policy published at bcbsmt.com\ Providers (click Provider Policies). One code per line. |
| 24e | Diagnosis Pointer | Enter the diagnostic (ICD) code(s) per procedure or service represented in Box 21 with the numbers 1-4. One code per line. |
| 24f | Charges | Enter the amount billed for the procedures or services described in 24d. |
| 24g | Days or Units | Enter the number of times the procedure was performed. Indicate anesthesia time in number of minutes. |
| 24h | EPSDT Family Plan | Not required. |
| 24I | ID Qualifier | Not required. |
| 24J | Rendering Provider ID # | Rendering providers in a group practice should enter their individual NPI number in Box 24j as the rendering provider and then list the group's billing NPI number in Box 33a. |
| 25 | Federal Tax ID Number | Enter the provider's federal tax ID number. |

| No. | Field Name | Explanation |
|---|---|---|
| 26 | Patient's Account No. | Not required (However, BCBSMT suggests entering this number as a method to help balance the Provider Claims Register/ Remit to claims submitted). |
| 27 | Accept Assignment? | Enter Y if provider pay and N if participant pay. |
| 28 | Total Charge | Enter the total of all charges from 24f. |
| 29 | Amount Paid | Not required. |
| 30 | Balance Due | Not required. |
| 31 | Signature of Physician or Supplier Including Degrees or Credentials | Sign and date to certify services were rendered. The signature Box 31 certifies the information is true and does not affect claims processing, nor does it necessarily represent the treating or billing provider. |
| 32 | Service Facility Location | Enter complete address. |
| 32a | | Enter the provider's NPI. |
| 32b | | Enter the provider's NPI. |
| 33 | Billing Provider Info & Ph # | Enter required information. |
| 33a | NPI | Enter the billing provider's NPI. An individual provider rendering and billing for services should enter their NPI in Box 33a. |
| 33b | Other ID | Enter the provider's NPI. |

# Chapter 4: FACILITY CLAIMS

# FILING CLAIMS

## Introduction

This chapter applies to hospitals that submit claims to BCBSMT on behalf of their patients. Hospitals should submit claims according to UB-92 Editor and Medicare guidelines, and they will be compensated according to their established BCBSMT hospital contract(s).

## UB-04 Form Required Fields

Facility providers filing paper claims with BCBSMT must use the UB-04 claim form. For assistance with completing the UB-04 claim form, refer to the UB-04 User Guide in the Education and Reference Center of the BCBSMT Provider website. For additional information on the UB-04 claim form, visit the National Uniform Billing Committee (NUBC) website at **nubc.org**.

The form is also published at **www.bcbsmt.com**. If you use this form, print it in color, so our optical character reader can scan your claims into the system. Be sure to use dark type or print.

The following table explains the UB-04 form fields. The numbers in the left column correspond to the form in Appendix A. Fields not required by BCBSMT are labeled "Not required."

| No. | Field Name | Explanation |
|---|---|---|
| 1 | Billing provider name, address, and phone | Enter the full name, address, and phone |
| 2 | Pay to name and address | Enter the full name and address if different from number 1 |
| 3a | Pat. cntl. # | Enter the patient control number |
| 3b | Med. rec. # | Enter the medical record number, if necessary |
| 4 | Type of bill | Enter the 3- or 4-digit type of bill |
| 5 | Federal tax ID number | Enter the billing entity tax ID number |
| 6 | Statement covers period – from through | Enter the date span of services |
| 7 | Reserved for NUBC assignment | Not required |
| 8a | Patient name | Enter the participant's given name |
| 8b | Patient identifier | Enter the unique patient ID, if necessary |
| 9a | Patient address | Enter the patient's street address |
| 9b | Patient address | Enter the patient's city |
| 9c | Patient address | Enter the patient's state |
| 9d | Patient address | Enter the patient's zip code |
| 9e | Patient address | Enter the patient's two-letter country code |
| 10 | Birth date | Enter the participant's month, day, and year of birth numerically |
| | | (e.g., 3-16-48) |
| 11 | Sex | M for male and F for female |
| 12 | Admission – date | Enter the admission date for inpatient services |
| 13 | HR | Enter the hour of admission for inpatient services |
| 14 | Type | Enter the priority type for inpatient services |
| 15 | SRC | Enter the referral code, if necessary |
| 16 | DHR | Enter the discharge hour |
| 17 | Stat | Enter the patient's status |
| 18 | Condition codes | Enter the condition code for inpatient services |
| 19 | Condition codes | Enter the condition code for inpatient services |
| 20 | Condition codes | Enter the condition code for inpatient services |
| 21 | Condition codes | Enter the condition code for inpatient services |
| 22 | Condition codes | Enter the condition code for inpatient services |

| No. | Field Name | Explanation |
|---|---|---|
| 23 | Condition codes | Enter the condition code for inpatient services |
| 24 | Condition codes | Enter the condition code for inpatient services |
| 25 | Condition codes | Enter the condition code for inpatient services |
| 26 | Condition codes | Enter the condition code for inpatient services |
| 27 | Condition codes | Enter the condition code for inpatient services |
| 28 | Condition codes | Enter the condition code for inpatient services |
| 29 | Acc. state | Enter what state the accident occurred for other party liability purposes, if necessary |
| 30 | Reserved for NUBC | Not required |
| 31 | Occurrence – code/date | Enter the occurrence code and date for other party liability purposes, if necessary |
| 32 | Occurrence – code/date | Enter the occurrence code and date for other party liability purposes, if necessary |
| 33 | Occurrence – code/date | Enter the occurrence code and date for other party liability purposes, if necessary |
| 34 | Occurrence – code/date | Enter the occurrence code and date for other party liability purposes, if necessary |

| No. | Field Name | Explanation |
|---|---|---|
| 35 | Occurrence span – code/from/through | Enter the occurrence code and date span for other party liability purposes, if necessary |
| 36 | Occurrence span – code/from/through | Enter the occurrence code and date span for other party liability purposes, if necessary |
| 37 | Reserved for NUBC | Not required |
| 38 | Responsible party name and address | Enter the name and address for other party liability purposes, if necessary |
| 39 | Value codes – code/amount | Enter the code and amount, if necessary |
| 40 | Value codes – code/amount | Enter the code and amount |
| 41 | Value codes – code/amount | Enter the code and amount |
| 42 | Revenue code | Enter the appropriate revenue code(s) |
| 43 | Description | Enter the revenue codes description |
| 44 | HCPCS/rate/HIPPS code | Enter the codes for inpatient services |
| 45 | Service date | Enter the service date |
| 46 | Service units | Enter the service unit(s) |
| 47 | Total charges | Enter the total charges |
| 48 | Non-covered charges | Enter the non-covered items |
| 49 | Reserved for NUBC | Not required |
| 50 | Payer name | Enter the payer name |
| 51 | Health plan ID | Enter the participant's health plan ID number |

| No. | Field Name | Explanation |
|---|---|---|
| 52 | Relationship information | Enter the relationship information |
| 53 | Assignment benefits | Enter assignment of benefits |
| 54 | Prior payments | Enter prior payments |
| 55 | Est. amount due | Enter the estimated amount due |
| 56 | NPI | Enter the facility NPI |
| 57 | Other/prv. ID | Enter any other provider NPI |
| 58 | Insured's name | Enter patient name |
| 59 | Patient relation | Enter patient relation |
| 60 | Insured's unique ID | Enter the patient health plan ID number |
| 61 | Group name | Enter the group name |
| 62 | Insurance group number | Enter the group insurance number |
| 63 | Treatment authorization codes | Enter the prior authorization number assigned by BCBSMT or APS Healthcare |
| 64 | Document control number | Not required |
| 65 | Employer name | Not required |
| 66 | Diagnosis | Enter the diagnosis code(s) |
| 68 | Reserved for NUBC | Not required |
| 69 | Admit diagnosis | Enter the admitting diagnosis for inpatient services |
| 70 | Patient reason diagnosis | Enter the reason diagnosis |
| 71 | PPS. code | Enter the PPS code for DRG claims |
| 72 | ECI | Enter accident diagnosis code(s) |

| No. | Field Name | Explanation |
|---|---|---|
| 73 | Reserved for NUBC | Not required |
| 74 | Principal procedure code/date | Enter primary procedure code (required for inpatient and home IV services) |
| 74a | Other procedure code/date | Enter other procedure codes and date, if necessary |
| 74b | Other procedure code/date | Enter other procedure codes and date |
| 74c | Other procedure code/date | Enter other procedure codes and date |
| 74d | Other procedure code/date | Enter other procedure codes and date |
| 74e | Other procedure code/date | Enter other procedure codes and date |
| 75 | Reserved for NUBC | Not required |
| 76 | Attending – NPI/ qual./last/first | Enter the physician responsible for home health treatment plan when claim has services other than non-scheduled transport |
| 77 | Operating – NPI/ qual./last/first | Enter operating physician NPI |
| 78 | Other – NPI/qual./ last/first | Enter other physician/ provider NPI |
| 79 | Other – NPI/qual./ last/first | Enter other physician/ provider NPI |
| 80 | Remarks | Not required |
| 81 | CC – A/B/C/D | Not required |

# HOSPITAL BILLING PROCEDURES

## Billing Requirements

Hospital will submit charges on a CMS-1450 (UB-04) claim form, or its successor, and must follow generally accepted guidelines with the following clarifications and exceptions:

- Hospital will provide information needed for description of unlisted procedures
- Hospital will not submit $0 charges on lines
- Hospital will submit their claims with the appropriate provider identification number based on the services being rendered
- Hospital understands and agrees that prior to payment a clean claim must be submitted to BCBSMT for services provided to participant
- Hospital will be compensated for medically necessary observation and treatment room charges up to the semi-private room rate (private room rate if there is no semi-private room rate)
- Hospital cannot balance bill participant for services that are deemed "provider responsibility" on the provider claims summary, to the extent this clause is consistent with CMS regulations when applied to coordinating of benefits with a Medicare recipient and Montana law
- Based on changes to the facility UB-04 billing guideline requirements due to outpatient prospective payment system (OPPS). If hospital builds inclusive services into its APC charges, it cannot bill for these items separately (e.g., if supply charges are built into a surgical charge, these items may not be billed separately).
- Hospital will bill the appropriate units per the CPT / HCPCS coding requirements (For example: J2250 1 unit is equivalent to 1mg. If billing for 10 mg, then "10" will be in the units column (FL46) so the compensation will calculate accurately.)

## Exceptions to CMS Billing

Below is a list of revenue codes for which BCBSMT will require a CPT/HCPCS code:

275 Pacemaker

53X Osteopathic Services

63X Drugs requiring specific identification

77X Preventative care services

88X # Session Miscellaneous Dialysis

942 Other Therapeutic Services - Education / Training

946 Complex medical equipment - routine

947 Complex medical equipment - ancillary

96X Professional fees

97X Professional fees

98X Professional fees

# Chapter 5: BENEFIT MANAGEMENT

## PREAUTHORIZATION

Preauthorization is required in order to receive some Benefits provided under this EOC. Listed covered Benefits in this EOC that require Preauthorization arenoted under each covered Benefit. The appropriate Claim Administrator is identified for claim processingpurposes under each covered Benefit.

### BCBSMT Administered Claims

BCBSMT has designated certain covered services which require Preauthorization in order for the Participant to receive the maximum Benefits possible.

If the Participant uses a Participating Provider for covered services, the Participating Provider is responsible for satisfying the requirement for Preauthorization.

If the Participant uses a Non-Participating Provider for covered services, the Participant is responsible for satisfying the requirement for Preauthorization.

To request Preauthorization, the Participant or his/her Physician must call the Preauthorization number shown on the Participant's Identification Card before receiving treatment. BCBSMT will assist in coordination of the Participant's care so that his/her treatment is received in the most appropriate setting for his/her condition.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits.

## SECTION I: PREAUTHORIZATION PROCESS FOR INPATIENT SERVICES

Preauthorization must be requested before the Participant's scheduled Inpatient admission. BCBSMT will consult with the Participant's Physician, Hospital, or other facility to determine whether Inpatient level of care is required for the Participant's Illness or Injury. BCBSMT may decide that the treatment the Participant needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office).

If BCBSMT determines that the Participant's treatment does not require Inpatient level of care, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with an Inpatient stay without approval, the Participant may be responsible to pay the full cost of the services received, if an ABN has been signed.

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." If it is determined that the services were not Medically Necessary; were Experimental, Investigational, or Unproven; were not performed in the appropriate treatment setting; or did not otherwise meet the terms and conditions of the EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

# SECTION II: PREAUTHORIZATION PROCESS FOR MENTAL ILLNESS, SEVERE MENTAL ILLNESS AND CHEMICAL DEPENDENCY SERVICES

All Inpatient and partial hospitalization services related to treatment of Mental Illness, Severe Mental Illness, and Chemical Dependency must be preauthorized. Preauthorization is also required for the following Outpatient Services:

- Psychological Testing;
- Neuropsychological Testing;
- Electroconvulsive Therapy; and
- Intensive Outpatient Treatment.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform covered services. However, all services are subject to the provisions in the section entitled Concurrent Review.

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." If it is determined that the services were not Medically Necessary; were Experimental, Investigational, or Unproven; were not performed in the appropriate treatment setting; or did not otherwise meet the terms and conditions of the EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

## Care Coordination and Wellness Program

### Care Coordination

The BCBSMT HELP Plan provides Care Coordination services to your patients, and we encourage providers to reach out to our team to request these services when needed. Our trained care coordinators help participants manage chronic conditions and non-health-related issues. BCBSMT HELP Plan Care Coordinators, many of whom are registered nurses or social workers, are available to help participants navigate the health care system; including setting and keeping appointments, reviewing eligibility and benefits and connecting participants with social supports to improve health outcomes. To support a growing HELP Plan population, BCBSMT uses a combination of care coordination, community outreach and supplemental benefits to provide support and education to participants. We encourage our providers to contact our Care Coordination Department at **877-296-8206**, Monday – Friday from 8AM to 8PM MST.

### Wellness Program

The BCBSMT Health and Economic Livelihood Partnership (HELP Plan) is committed to stand beside participants by offering various Wellness Programs to assist them in achieving and maintaining a healthy life. The Health Assessment allows participants to work with an assigned Care Coordinator on available programs to meet Personal Wellness Goals. Available programs include Smoking Cessation, Diabetes Management, Asthma Management, Disease Prevention and more. The Program promotes healthy lifestyles, educates on chronic health conditions, directs the participant in locating accurate health information, and provides information on how to access plan benefits. If a participant is enrolled in a Wellness Program, the provider will be notified and provided the Care Coordinators contact information.

# SECTION III: PREAUTHORIZATION PROCESS FOR OTHER OUTPATIENT SERVICES

In addition to the Preauthorization requirements outlined above, BCBSMT also requires Preauthorization for certain Outpatient services. The following services and items require Preauthorization:

- Home Health Care and Hospice services, including Private Duty Nursing and Personal Care Services for EPSDT;
- Outpatient Therapies;
- Potentially experimental, investigational or cosmetic procedures;
- Transplant evaluations for the following transplant surgeries: heart, lung, heart/lung, liver, pancreas, kidney, bone marrow, corneal, and small bowel;
- Outpatient surgeries for dental anesthesia, dental trauma, termination of pregnancy, cochlear implants and uvulopalatopharyngoplasty (UPPP);
- Laminectomy;
- Genetic testing and/or counseling;
- DME, medical supplies, orthotics and prosthetics over $2,500 and including the following: diabetic shoes, power wheelchairs, diapers, under pads and incontinent supplies, specialty beds, and cochlear implant devices.
- Cardiac rehabilitation;
- MRIs, PET scans, GI radiology, and CT scans; and
- All services provided by a non-covered or non-participating provider, with the exception of Emergency Services.

For additional information on Preauthorization, the Participant or the Provider may call the Participant Services number on the Participant's identification card.

*It is NOT necessary to preauthorize standard x-ray and lab services or Routine office visits.*

If BCBSMT does not approve the Outpatient Service, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with the services without approval, the Participant may be responsible to pay the full cost of the services received, if an ABN has been signed.

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

The Benefits section of this EOC details the services that are subject to Preauthorization.

# SECTION IV: PREAUTHORIZATION REQUEST INVOLVING EMERGENCY CARE

If the Participant is admitted to the Hospital for Emergency Care and there is no time to obtain Preauthorization, the Participant's Provider must notify BCBSMT within two business days following the Participant's emergency admission.

# SECTION V: PREAUTHORIZATION REQUIRED FOR CERTAIN PRESCRIPTION DRUG PRODUCTS AND OTHER MEDICATIONS

Prescription Drug Products, which are self-administered, process under the Prescription Drug Program Benefit of this EOC. There are other medications that are administered by a Covered Provider, which process under the medical Benefits.

### 1. Prescription Drugs – Covered under the Prescription Drug Program Benefit administered by DPHHS.

Certain prescription drugs, which are self-administered, require Preauthorization. Please refer to the Prescription Drug Program section for complete information about the Prescription Drug Products that are subject to Preauthorization and quantity limits, the process for requesting Preauthorization and related information. Please refer to the Pharmacy provider manual located at the following website: **http://medicaidprovider.mt.gov/** or by calling **1-800-362-8312**.

### 2. Other Medications – Covered Under Medical Benefits

Medications that are administered by a Covered Provider will process under the medical Benefits of this EOC. Certain medications administered by a Covered Provider require Preauthorization. The medications that require Preauthorization are subject to change by BCBSMT.

To determine which medications are subject to Preauthorization, please refer to the Prescription Drug Program section for complete information.

# SECTION VI: GENERAL PROVISIONS APPLICABLE TO ALL REQUIRED PREAUTHORIZATIONS

### 1. No Guarantee of Payment

Preauthorization does not guarantee payment of Benefits. Even if the Benefit has been Preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date of service or the Participant's Benefits may have changed as of the date the service.

### 2. Request for Additional Information

The Preauthorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Preauthorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSMT to make a determination of coverage pursuant to the terms and conditions of this EOC.

### 3. Failure to Obtain Preauthorization

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." If it is determined that the services were not Medically Necessary; were Experimental, Investigational or Unproven; were not performed in the appropriate treatment setting; or did not otherwise meet the terms and conditions of the EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

*Any treatment the Participant receives that is not a covered service under this EOC; or is not determined to be Medically Necessary; or was Experimental, Investigational, Unproven; or is not performed in the appropriate setting will be excluded from the Participant's Benefits. This applies even if Preauthorization approval was requested or received. When a service is denied as non-covered, Participating Providers may not balance bill the Participant for the services, unless the Participant or the Participant's authorized representative has signed*

*an ABN. For non-covered services, providers may bill Participants only when providers and Participants have agreed in writing prior to the services being provided.*

DPHHS Administered Claims

A request for Preauthorization must be submitted for consideration in the following manner:

- A written request for Preauthorization must be submitted to DPHHS in writing by the Participating Provider.
- The written request should explain the proposed services being sought, the functional aspects of the service, and why it is being done.
- Any additional documentation such as study molds, x-rays, or photographs necessary for adetermination should be mailed to the address listed on the Participant's ID card. HELP Plan Participant's names, addresses, and Participant numbers must be included.

DPHHS will review the request and all necessary supporting documentation to determine whether the services are Medically Necessary. The decision will be made in accordance with the terms of this EOC. In no event shall a coverage determination be made more than 14 days following receipt of all documents.

A request for Preauthorization does not guarantee that Benefits are payable. Attending an appointment prior to receiving Preauthorization approval may result in the HELP Plan Participant paying costs of a service determined to not be Medically Necessary; not covered; Experimental, Investigational, Unproven; or performed in an inappropriate setting under this EOC.

Pharmacy Claims

Many drug products require Preauthorization before the pharmacist provides them to the Participant. For the Pharmacy drug Preauthorization process, please refer to the Pharmacy provider manual located at the following website: **http://medicaidprovider.mt.gov/** or by calling **1-800-362-8312**.

# SECTION VII: CONCURRENT REVIEW

Whenever it is determined by BCBSMT that Inpatient care or an ongoing course of treatment may no longer meet Medical Necessity criteria or is considered Experimental, Investigational, or Unproven, the Participant, Participant's Provider or the Participant's authorized representative may submit a request to BCBSMT for continued services.

## Medicaid Prior Authorization Requirements

With the exception of services provided in an emergency, the following services require a prior Authorization:

| Service | MT |
|---|---|
| Out of Network Provider Requests (All levels of care) | X |
| Inpatient facilities:<br>• Acute Care Facility/Hospital<br>• Post-Acute Facilities | X |
| OUTPATIENT SURGERIES<br>• Dental Anesthesia<br>• Dental Trauma<br>• Termination of Pregnancy<br>• UPPP<br>• Cochlear Implants | X |

| Service | MT |
|---|---|
| Experimental or Investigational Procedures<br>Potentially cosmetic procedures including (but not limited to):<br>• Varicose Vein Treatment<br>• Breast Reduction<br>• Surgery to treat Malocclusion<br>• Blepharoplasty<br>• Lipectomy<br>• Abdominoplasty<br>• Panniculectomy<br>• Rhinoplasty<br>• Septoplasty<br>Laminectomy (Except for Codes: 63030, 63056, 63057, 64999, 72275 which do not require auth)<br>Transplant Evaluation for the following transplant surgeries:<br>• Heart<br>• Lung<br>• Heart/Lung<br>• Liver<br>• Pancreas<br>• Kidney<br>• Bone Marrow<br>• Corneal Transplants<br>• Small Bowel | X |
| Genetic testing and/or counseling | X |
| Radiology<br>• MRIs, PET scans, GI Radiology, CT scans (listed codes only)<br>• 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816, 77058, 77059, 75571, 75572, 75573, 75574, 91110, 91111 | X |

| Service | MT |
|---|---|
| DME, Medical Supplies, Orthotics and Prosthetics > $2500 and including the following:<br>Diapers and Underpads<br>Diabetic Shoes<br>Power Wheelchairs<br>Specialty Beds<br>Cochlear Implant Devices<br>The Following Items:<br>A9276, A9277, A9278, E0181, E0184, E0185, E0271, E0637, E0641, E0642, E0651, E0652, E0660, E0667, E0668, E0700, E0705, E0935, E0936, G0151, G0248, G0249, L1904, L5629, L5631, L5637, L5645, L5647, L5649, L5650, L5652, L5661, L5665, L5666, L5668, L5670, L5671, L5700, L5701, L5781, L5785, L5910, L5920, L5940, L5950, L5962, L5968, L8400, L8410, L8420, L8430, L8440, L8460, L8470, L8480, V2623, V2627, V5130, V5140, V5160, V5180, V5200, V5220, V5240, V5241, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5264 A6199, , A6242, L2785, | X |
| Outpatient Therapies | X |
| Cardiac Rehabilitation | X |
| Home Health Care and Hospice (includes PDN and PCS for EPSDT) | X |
| Specialty Drugs - J1459, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, 90283, 90284, J2357, J1745, J0490, Q2043, J3262, J2323, J9035, C9257, J9310, J0585, J0587, J2505, J9228, C9027, C9453, J0881, J0882 | X |
| Behavioral Health | |
| Inpatient Acute | X |
| Residential Treatment Center | X |
| Mental Health Services (PHP, IOP) H0035, S9480 | X |
| Substance Abuse Services (PHP, IOP) S0201, H0015 | X |
| Outpatient Services –<br>Psychological Testing 96101, 96102, 96103 Neuropsychological Testing -, 96118, 96119, 96120,<br>ECT - 90870 | X |

# ADVANCE BENEFIT NOTIFICATION

## Overview

An Advance Benefit Notice (ABN) must be signed by the Montana Health and Economic Livelihood Partnership (HELP) Plan participants prior to the service being rendered and billed. The signed ABN signifies the participant understands and agrees that they will be responsible for the full payment of that particular service. If the participant is 19 or 20, any non-covered service requests must be reviewed through the EPSDT program.

Services that fall in this category have been categorized as experimental, investigational, or unproven by BCBSMT based on the predominate evidence-based opinion of independent experts; or the service is not deemed experimental or investigational in itself pursuant to the above criteria, but would otherwise not be medically necessary as provided in conjunction with the provision of a treatment, procedure, device, or drug that is experimental, investigational, or unproven, or it is not a benefit under the Evidence of Coverage (EOC).

Providers may only charge HELP Plan participants for the following services if an ABN is signed prior to service delivery:

a. Non-covered services;
b. Experimental services;
c. Unproven services;
d. Services performed in an inappropriate setting;
e. Services that are not medically necessary; or
f. Services that require prior authorization and are not prior authorized.

BCBSMT will comply with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for participants under the age of 21. EPSDT is federally mandated to meet the physical, emotional, medical, and developmental needs of children as early as possible. EPSDT provides preventive, well-child checks, immunizations, and access to medically necessary health care services that are not available to adults. Requests for medically necessary non-covered services will be reviewed and approved or denied by BCBSMT according to the EPSDT State Plan Amendment.

# COPAYMENTS

## HELP PLAN COPAYMENTS

1. Except as otherwise provided by state or federal laws or regulations, each participant in the HELP Plan must pay to the provider of service copayments as described below not to exceed the cost of service.
2. All HELP Plan participants receive a credit in the amount of their premium obligation toward the first copayments accrued up to two percent of household income.
3. Premiums and copayments combined may not exceed an aggregate limit of five percent of the annual family household income.
4. Participants with incomes at or below 100 percent of the FPL are responsible for the following copayments:
   - Inpatient hospital - $75 per discharge;
   - Nonemergency services provided in an emergency room - $8;
   - Pharmacy-preferred brand drugs - $4;
   - Pharmacy-non-preferred brand drugs, including specialty drugs - $8;
   - Professional services - $4;
   - Outpatient facility services - $4;
   - Durable medical equipment - $4; and
   - Lab and radiology - $4.
5. Participants with incomes above 100 percent of the FPL are responsible for the following copayments:
   - Inpatient hospital - 10 percent of provider reimbursed amount;
   - Nonemergency services provided in an emergency room - $8;
   - Pharmacy-preferred brand drugs - $4;
   - Pharmacy-non-preferred brand drugs, including specialty drugs - $8;
   - Professional services - 10 percent of provider reimbursed amount;
   - Outpatient facility services - 10 percent of provider reimbursed amount;
   - Durable medical equipment - 10 percent of provider reimbursed amount; and
   - Lab and radiology - 10 percent of provider reimbursed amount.
6. Copayments are subject to a quarterly aggregate cap of one-quarter of three percent of the annual household income. Copayments may not be charged in a quarter after a household has met the quarterly aggregate cap.
7. Copayments may not be charged for:
   - Preventive health care services;
   - Immunizations provided according to a schedule established by the department that reflects guidelines issued by the Centers for Disease Control and Prevention;
   - Medically necessary health screenings ordered by a health care provider;
   - Generic pharmaceutical drugs;
   - Eyeglasses purchased by the Medicaid program under a volume purchasing agreement; and
   - Other services exempt by applicable federal authority.
8. Copayments may not be charged for services rendered in circumstances of third party liability (TPL) claims where the HELP Plan is the secondary payor under ARM 37.85.407. If a service is not subject to TPL, but is covered by the HELP Plan, copayments are applied.
9. Copayments may not be charged to the participant until the claim has processed through the claims adjudication process and the provider has been notified of payment and amount owing.

## Uncollected Copayment Report

Participating Providers must compile, analyze, and provide an annual Uncollected Copayment Report for all services covered by the HELP Plan. The reports must include the following information:

- The total amount of copayments the providers were unable to collect from participants;
- The efforts providers made to collect the copayments; and

BCBSMT will collect this uncollected payment report from Participating Providers on an annual basis.

## Services Reimbursed Directly by Medicaid

1. Covered services for participants in the HELP Plan enrolled with the TPA, except as otherwise provided in (2), are reimbursed directly by the TPA according to the schedule found at **https://medicaidprovider.mt.gov**.
2. The following services received by participants enrolled with the TPA are reimbursed directly through the Department of Public Health and Human Services:
   - FQHC;
   - RHC;
   - Dental;
   - Eyeglasses;
   - Indian Health Services and tribal health services;
   - Diabetes prevention programs;
   - Transportation;
   - Prescription drugs;
   - Home infusion;
   - Hearing aids; and
   - Audiology.
3. The services specified in (2) are reimbursed at the established Medicaid reimbursement rates for those services.

## Physician Administered Drugs

BCBSMT requires providers to bill claims for physician-administered drugs and include valid and accurate NDCs and HCPCS codes in compliance with 42 CFR 447.520 and the Social Security Act, sections 1927(b)(2)(A) and 1903(m)(2)(A). This is standard billing practice and should be followed for the HELP Plan.

## Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

HELP Plan participants 19-20 years of age remain eligible for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefits.

Participation in the Diabetes and Asthma Education programs require a physician's order.

Diabetes and Asthma education provided to individual participants in the HELP Plan will be billed to the HELP Plan. HELP Plan participants wishing to participate in GROUP classes for Diabetes and Asthma programs will be billed to the Department of Health and Human Services (DPHHS).

# Chapter 6: PHARMACY

## HELP Plan Pharmacy Benefits

HELP Plan pharmacy benefits are processed by XEROX/ DPHHS.

For specific information regarding the pharmacy benefits, refer to the HELP Plan Evidence of Coverage at:

**http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/DraftEvidenceofCoverage102915.pdf**

For information regarding pharmacy benefits, call **1-800-362-8312**.

## Physician Administered Drugs

Physician administered drugs are processed by Blue Cross and Blue Shield of Montana.

Blue Cross and Blue Shield of Montana (BCBSMT) requires the use of National Drug Codes (NDCs) and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims. As of May 1, 2015, the NDC pricing effective date, professional/ancillary claims for drugs must include NDC data in order to be processed by BCBSMT.

Refer to the BCBSMT Provider Secure Provider Portal for NDC Billing Guidelines.

# Chapter 7: COORDINATION OF BENEFITS

# THIRD PARTY LIABILITY (TPL)

## When a Participant Has TPL (ARM 37.85.407)

A HELP participant may have insurance coverage in addition to the HELP Plan, but may not have dual coverage with standard Medicaid or Medicare.

When a HELP Participant has additional medical coverage, it is often referred to as third-party liability or TPL. In most cases, providers must bill other insurance carriers before billing the HELP Plan. When services are covered by the HELP Plan and another source, any payment the participant receives from the other source must be turned over to the Montana Department of Health and Human Services (DPHHS). Providers are required to notify HELP Plan participants of such.

## Exceptions to Billing Third-Party Liability Carrier First

In a few cases, providers may bill the HELP Plan first:

- When a HELP Plan participant is also covered by the Crime Victim Compensation Program, providers must bill the HELP Program first. These are not considered a third-party liability.
- When a member has HELP Plan eligibility and MHSP eligibility for the same month, the HELP Plan must be billed first.
- ICD prenatal and ICD preventive pediatric diagnosis conditions may be billed to the HELP Plan first. In these cases, the HELP Plan will pay and then recover payment directly from the third-party payor.

The following services may also be billed to the HELP Plan first. Refer to Chapter 2, General Information, to determine where to submit claims, BCBSMT or DPHHS.

- Nursing facility
- Audiology
- Dental and denturist
- Drugs
- Eyeglasses
- Hearing aids and batteries
- Home and community-based services
- Optometry
- Oxygen in a nursing facility
- Personal assistance/ Community First Choice
- Transportation (other than ambulance)

If the third party has only potential liability, the provider may bill the HELP Plan first. Do not indicate the potential third party on the claim. Instead, notify BCBSMT or DPHHS first, depending on the appropriate entity for claims processing.

## Requesting an Exemption

Providers may request to bill the HELP Plan first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the following addresses:

For claims processes by BCBSMT:

**BCBSMT HELP Medicaid Claims Correspondence**
P.O. Box 3387
Scranton, PA 18505

For claims processed by DPHHS/XEROX:

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

# Chapter 8: APPEALS

# HELP PLAN PARTICIPANT BENEFIT APPEALS

## Appeals for claims administered by BCBSMT

### First Level Appeal

If Participants do not agree with a denial or partial denial of a claim, Participants have 90 days from receipt of the denial to appeal the decision on the claim. Participants must write to BCBSMT and ask for a review of the claim denial. BCBSMT will acknowledge Participants' requests for appeals within 3 business days of receipt of requests.

To file a written appeal, Participants must state their issue and ask for a review of the denied claim and send it to:

**Blue Cross and Blue Shield of Montana**
Attention: Appeals Coordinator
P.O. Box 27838
Albuquerque, NM 87125-9705

Confidential Fax: **866-643-7069**

Participants will receive a written response to their appeal within 30 days of receipt. If Participants do not agree with the First Level determination, Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services.

### Second Level Appeal

If Participants do not agree with the First Level determination by BCBSMT, Participants may fax a Second Level appeal request to (406)-444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

**Office of Fair Hearings**
Montana Department of Public Health and Human Services
P.O. Box 202953
Helena, MT 59620-2953

The Office of Fair Hearings will contact Participants to conduct an impartial administrative hearing and/or a Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

## Appeals for claims administered by DPHHS

### First Level Appeal

If Participants do not agree with a denial or partial denial of a claim, Participants have 180 days from receipt of the denial to appeal the determination made. To request an Administrative Review, the request must be in writing, must state in detail all objections, and must include any substantiating documents and information that Participants wish the Department to consider in the Administrative Review. The request must be mailed or delivered to:

**Montana DPHHS**
Attn: Program Officer
1400 Broadway, Room A206
Helena, MT 59601

FAX: (406) 444-1861

Once the Administrative Review has been completed Participants will receive a letter outlining the Department's First Level decision. Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services Office of Fair Hearings.

### Second Level Appeal

If Participants do not agree with the First Level determination, Participants may fax their Second Level appeal request to (406)-444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

**Office of Fair Hearings**
Montana Department of Public Health and Human Services
P.O. Box 202953
Helena, MT 59620-2953

The Office of Fair Hearings will contact Participants to conduct an impartial Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, the Office of Fair Hearings issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

## Participating Provider Appeals

1. A HELP Participating Provider who is aggrieved by an adverse department action that directly affects the rights or entitlements of the provider under the Montana HELP Plan, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.
2. Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action affecting the participant's eligibility under the Montana HELP Plan, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.
3. This provision does not grant to providers any right to notice of actions affecting participants, including but not limited to eligibility determinations.

# Chapter 9:
# ADMINISTRATIVE POLICIES

# HIPAA INFORMATION

## Privacy

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, BCBSMT will only disclose the minimum necessary Protected Health Information (PHI) for treatment, payment, and BCBSMT health care operations on those participants with whom the health care provider has or had a relationship.

Any requests for information that pertain to the health care provider's health care operations other than those listed above will be directed to the BCBSMT Privacy Office at **1-800-447-7828**.

## Verification

BCBSMT must verify the identity of a caller requesting information concerning participant PHI. When calling BCBSMT, be prepared to give your National Provider Identifier (NPI), tax identification number (TIN), and your first name. A department and/or position title would also be helpful for BCBSMT Customer Service Representatives to accurately document the inquiry.

## Minimum Necessary

When sending printed documentation to BCBSMT for any reason, send only the minimum necessary information to complete the task, e.g., black out other patient information on your "Provider Claims Summary" that is not related to your inquiry.

## Authorization

BCBSMT may require written authorization from its participants to disclose information to covered entities under HIPAA for health information other than payment, treatment, or its own health care operations. Any requests for information other than payment, treatment, or health care operations will be directed to the BCBSMT Privacy Office at **1-800-447-7828**.

**Privacy Office**
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

## Notification of Changes

Immediately notify Network Management in writing when any change is made to the following:

- Name
- Credentials
- Address
- Phone number
- Specialty
- Tax ID or Social Security number
- Accepting/Not Accepting new patients
- On-call list
- Patient age restrictions
- Licensure
- Leave of absence or sabbatical

A "Provider Change of Status" form may be submitted electronically by logging into the Secure Provider Portal and selecting the "Update Office Info" tab, or a hard copy form may be downloaded. Click on "Provider", then "Forms & Documents", "Provider Change of Status" form.

E-mail the change form to **MTHCSSPEC@bcbsmt.com** or mail or fax all changes to:

**ATTN: Network Management**
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

FAX: **406-437-7879**

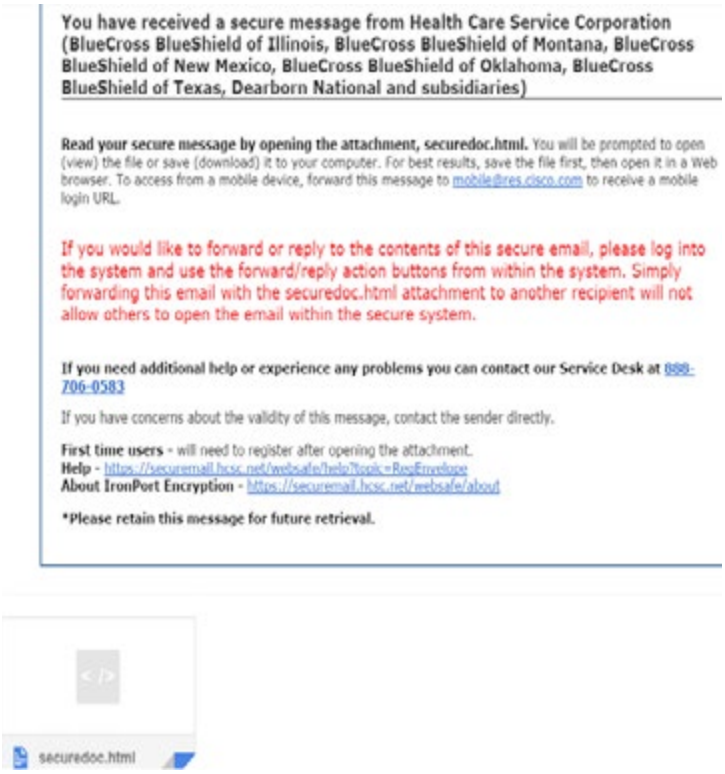
## E-Mail Security

BCBSMT uses e-mail software called "Cisco IronPort CRES" for secure messaging.

This message then gets encrypted using BCBSMT's Cisco appliance onsite, with the keys needed to decrypt the message stored in Cisco's cloud. When a recipient receives a message from HCSC that is encrypted he/she follows the instructions attached to open the message.

Opening a secure message using "Cisco Registered Envelope Service" (CRES) for the first time, as follows;

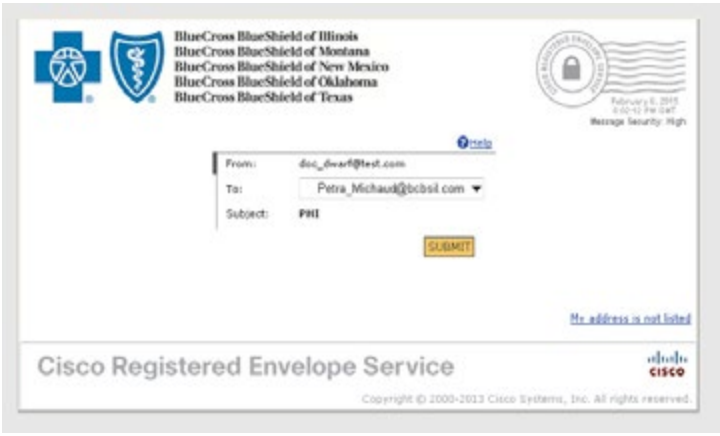
1. Click on the securedoc.html attachment at the bottom of your secure email to open it:



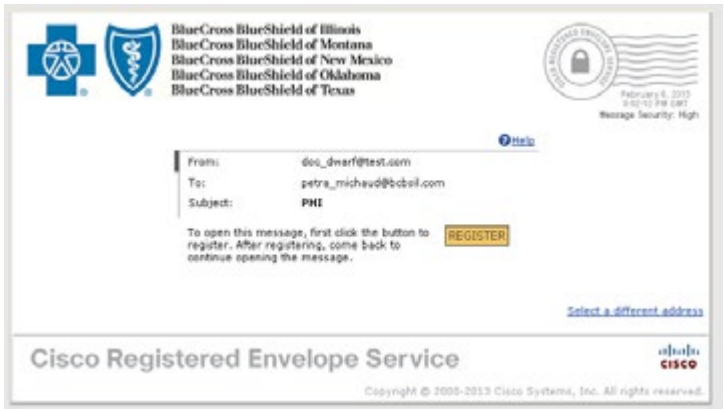




2. Confirm your email address and click "Submit":

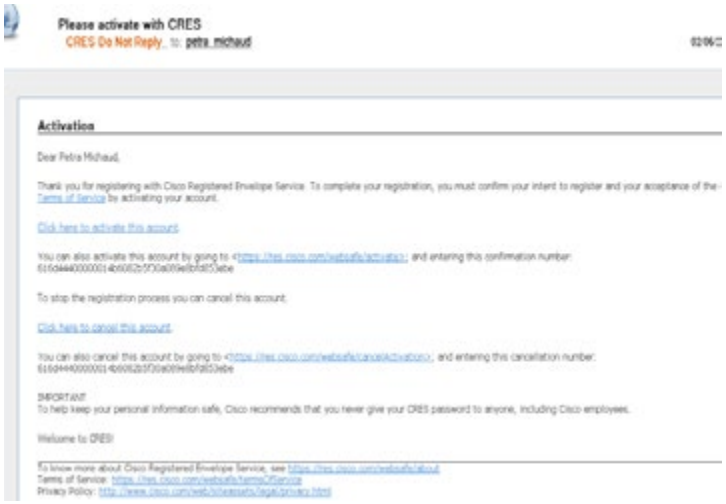



3. You will be taken to the registration window. Click Register:




4. You will get this message:

5. Check your email for the activation email. It will be similar to this:




6. Select "Click here to activate this account" and follow the prompt for creating a password and some security questions.


7. Upon completion of #6 you'll get the following window. Click Continue and enter the updated password:


8. Your email will open successfully:

The ZIX system uses three dictionaries that scan all messages and attachments to determine what will be encrypted. Messages must have a match with at least two lists before being encrypted. These dictionaries are:

1. HIPAA: The largest list that contains diagnosis and procedure codes and thousands of keywords, such as claims and prescription.
2. Relationships: Family relationship keywords, such as mother and father.
3. Identifiers: Unique combinations, such as member ID and Social Security number.

You will receive a message from ZIX informing you an encrypted e-mail has been sent to you from BCBSMT. If you currently use the ZIX system, you will receive encrypted e-mails directly; otherwise, you must click on the link to the ZIX message center and create a password before you can view the e-mail. If you have not used ZIX for 90 days, you will need to create a new password.

You may also download a free 30-day trial of ZixMail at **www.zixcorp.com** to receive BCBSMT correspondence directly without going to the ZIX message center. You will be able to send encrypted e-mails to any recipient without altering your current e-mail address or e-mail system.

If you have any questions, call Customer Service at **1-800-447-7828**.

### APPOINTMENT AVAILABILITY STANDARDS AND MEASURES

BCBSMT monitors provider availability through participant complaints tracking and responses to an annual participant satisfaction survey.

Montana HELP Plan Participating Providers agree to adhere to the following timely access to care standards:

- A maximum wait time for routine-care appointment with a primary care provider to be 45 days;
- A maximum wait time for urgent care with a primary provider to be two days;
- A maximum wait time for routine-care appointment with a specialist to be 60 days; and
- A maximum wait time for urgent care with a specialist to be four days.

## LOCUM TENENS PROVIDER POLICY

### Scope

This policy applies to all lines of Blue Cross and Blue Shield of Montana (BCBSMT) business except Medicare.

### Purpose

This policy documents BCBSMT administrative guidelines for a locum tenens provider's use of the BCBSMT provider identification number(s) (i.e., ID number(s)) assigned to a provider, who is on leave of absence ("provider on leave") from his/her practice.

Note: Copies of this specific policy can be located under "Administrative policies".

## PROVIDER IN TRAINING POLICY

### Scope

This policy applies to all lines of BCBSMT business with the exception of Medicare.

### Purpose

BCBSMT recognizes the value of services being provided to its participants by providers in training for their health care profession. This policy establishes billing guidelines for providers in training.

Note: Copies of this specific policy can be located under Administrative policies.

## PROVIDER NETWORK PARTICIPATION POLICY

### Scope

This policy applies to the following networks:

- BCBSMT traditional participating provider network
- BCBSMT managed care provider network
- Montana HealthLink (PPO) – includes HealthLink PPO network with the traditional provider network wrapped around it for the BlueCard program
- Healthy Montana Kids (HMK) Provider Network
- Blue Cross Medicare Advantage PPO℠ and Blue Cross Medicare Advantage (HMO)℠ provider networks
- HELP Plan PPO provider network.
- Blue Focus POS℠ provider network

## Purpose

The purpose of this policy is to document the types of professional and facility providers and specialties allowed to participate in the provider networks offered or administered by BCBSMT.

Note: Copies of this specific policy can be located under Administrative policies.

# PROVIDER REQUIREMENTS

## Written Participating Provider Agreement

All providers, including professional providers and institutional/facility providers, must enter into a written agreement with BCBSMT to participate in the BCBSMT provider networks. This written agreement obligates the provider to participate in the PPO and Traditional provider networks, which the Federal Employee Program (FEP) and Blue Card Program access. An additional amendment must be signed to participate in the BCBSMT HELP Plan and managed care provider networks. Standalone contracts exist for additional networks, including Healthy Montana Kids (HMK) and Medicare Advantage.

The participating provider and BCBSMT are independent parties contracting with each other solely for the purpose of effecting the provisions of the written agreement. The participating provider provides services to BCBSMT participants in the capacity of an independent contractor.

The participating provider is bound by the administrative policies, medical policies, provider manual rules, and regulations adopted or amended by BCBSMT.

When initially entering into an agreement, the participating provider must sign the BCBSMT "Participating Provider Agreement" the HELP Plan and any other amendments, and list all current individual providers on Attachment A of the contract. The participating provider may add individual providers to its group by completing the "Addition of Individual Provider" form (Attachment B).

Prior to participation, when a new provider joins the BCBSMT provider networks, the provider must successfully complete the credentialing process, if the provider is not already credentialed with BCBSMT. In addition, for participation in the HELP Plan provider network, the provider must complete the screening process required by 42 CFR 455 Subparts B and E. An individual provider will not be considered as participating until the date the provider is approved by the BCBSMT Credentialing Committee. BCBSMT will not retroactively credential a provider or the provider's effective/start date.

If the participating provider is comprised of a group of licensed health care providers, the participating provider represents and warrants that it is duly authorized to enter into the BCBSMT "Participating Provider Agreement" on behalf of such individual providers and has the authority to bind its individual providers.

## Requirements

### Conditions for Participation

Conditions for participation as a participating provider include the following:

- The participating provider agrees to cooperate and to require each individual provider to cooperate with BCBSMT in compliance with all applicable Credentialing Criteria established by the BCBSMT Credentialing Committee
- The provider is a fully licensed health care provider in the State of Montana
- The provider is practicing within the scope of such license
- The provider warrants that all information submitted for credentialing and re-credentialing is accurate and truthful
- The provider is not currently being sanctioned by any governmental agency for violation of any federal medical program rules or regulations including but not limited to Medicare and Medicaid
- The provider maintains malpractice liability insurance.

## Obligations and Responsibility

According to the written agreement, both the participating provider and BCBSMT agree to certain obligations and responsibilities, as defined below:

Each party agrees to notify the other party within five business days of receipt of notice of the following:

- Notice to the participating provider of any disciplinary proceeding reported to or initiated by the applicable board of examiners of any state in which the participating provider is licensed or any action that may be brought against the participating provider by any professional society or facility acting through its professional staff, directors, or trustees
- Notice to BCBSMT from the Montana Commissioner of Securities and Insurance that may affect BCBSMT's ability to perform its obligations under the agreement
- Any action taken against either party by any governmental agency that may affect the other party's ability to perform the obligations under the agreement
- Any action against or lapse of the participating provider's license, controlled substance permit, medical staff membership or clinical privileges
- Any felony arrest information or indictment or any criminal charge naming the participating provider
- Any cancellation or material modification of the participating provider's professional liability insurance or BCBSMT's industry standard insurance coverage
- Any judgment or finding against the participating provider that might materially impair his/her ability to perform under this agreement.

Upon reasonable request by either party, the other party agrees to provide copies of any documents filed or prepared in connection with any item identified above, unless such documents are deemed protected information.

The participating provider agrees to the following:

- As applicable, the participating provider will comply with all plan notification and prior authorization requirements.

The participating provider will promptly notify BCBSMT if he/she becomes aware that a Participant:

- Was hospitalized on the date the participant's initial enrollment under a Health Plan became effective;
- Has obtained other insurance coverage;
- Has committed acts of physical or verbal abuse that pose a threat to providers or other participants; or
- Has allowed a non-Participant to use the BCBSMT-issued identification card to obtain services.

The participating provider must notify BCBSMT in writing at least thirty (30) days prior to any change in business address, payment address, business telephone number, office hours, tax identification number, state license number, DEA registration number, and/or change in employment status.

The participating provider will cooperate with BCBSMT in matters relating to coordination of benefits with other carriers or responsible parties, to make inquiry regarding and provide BCBSMT relevant information relating to any other coverage held by a participant, and to abide by the BCBSMT coordination of benefits, subrogation, and duplicate coverage policies determinations procedures and rules, as well as with the applicable state and federal regulations.

## Cooperation

The participating provider will cooperate with BCBSMT in programs of utilization management, quality assurance, quality improvement, audits, peer review, and all internal and external grievance procedures. Each party agrees to use its best efforts to assure that activities conducted pursuant to any quality assurance program or utilization management plan will be conducted in such a manner as to be subject to and obtain the benefits of applicable laws conferring immunity on peer-review committees and their participants, and rendering peer-review documents and information confidential and non-discoverable.

## Access to Premises

The participating provider provides BCBSMT, or its authorized representatives, the right to enter at reasonable times the participating provider's premises or other places where services under this agreement are performed to inspect, monitor, or otherwise evaluate the services performed. The participating provider will provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties.

## Disclosures

The participating provider agrees that BCBSMT may list such information as the name, specialty, business address, business telephone number and board status in BCBSMT's provider directory.

## Transparency

The participating provider authorizes BCBSMT to publicly release general cost, utilization, and other information consistent with BCBSMT's consumer transparency programs.

## Prohibitions Regarding Discrimination

The participating provider will not refuse to accept a BCBSMT participant as a patient on the basis of race, color, religion, sex, age, veteran status, national origin, health status, medical condition of the patient, and/or participation in a health plan as a private purchaser or as a participant in a publicly financed program; provided, however, the participating provider should not render services because of lack of training, skill, or experience or because of licensure restrictions if failure to render the service would endanger the health, life, or safety of the patient because of the patient's health status or medical condition.

BCBSMT does not prohibit or discourage the participating provider from discussing with or communicating in good faith to a current, prospective, or former BCBSMT participant, or the participant's designee, information or opinions regarding:

- The participant's health care, including, but not limited to, the Participant's medical condition or treatment options, including alternative medications, regardless of BCBSMT coverage limitations; or
- The provisions, terms, requirements or services of BCBSMT as they relate to the medical needs of the BCBSMT participant.

## Access to Medical Records

Subject to any applicable disclosure and confidentiality laws, upon BCBSMT's request, the participating provider will provide BCBSMT, or its authorized third-party reviewer, with all records necessary to comply with BCBSMT's auditing programs, including but not limited to, utilization management, case management, disease management, fraud and abuse, claim reviews and audits, billing practices, and quality assurance programs.

## Confidentiality

Both BCBSMT and the participating provider agree that Private Health Information (PHI) to which it has access or receives pursuant to the agreement will be kept confidential and will not be disclosed to any person except as authorized by state law, by federal law and/or by a participant through an appropriate consent or authorization.

Each party is responsible for any breach of its confidentiality obligations, including any obligations each may have under state or federal law, both during the term of the agreement and after termination.

# Chapter 10: ENROLLMENT AND CREDENTIALLING

# CONTRACTING AND CREDENTIALING

## Overview

## Definitions

Prior to participation in the HELP Plan provider network, a provider must sign a HELP Plan contract amendment, successfully be credentialed by BCBSMT and complete the provider enrollment screening compliant with 42 CFR 455 Subparts B & E.

Each of these, contracting, credentialing and enrollment screenings are separate processes.

Contracting is two parties entering into an agreement voluntarily to create legal obligations between them.

Credentialing is the process by which Blue Cross and Blue Shield of Montana (BCBSMT) reviews and validates the professional qualifications of health care providers, both institutional and professional providers, who apply for participation with our health insurance organization, ensuring that they meet the required professional standards.

Provider enrollment screening is required by the Centers for Medicare and Medicaid (CMS), and is the process by which Blue Cross and Blue Shield of Montana (BCBSMT) reviews and validates the identity of providers, both institutional and professional providers, and ensures standards required by federal law are met.

## Apply in Advance of the Start of Practice

The BCBSMT provider contracts require successful completion of credentialing and enrollment screening prior to participation in the BCBSMT HELP Plan provider network.

Credentialing and re-credentialing criteria are the rules and regulations that govern BCBSMT's credentialing and re-credentialing process for the HELP Plan. The applicable HELP Plan screening criteria and credentialing and re-credentialing criteria are be consistent with the applicable Montana and federal statutes, rules and regulations, including, without limit, the Centers for Medicare and Medicaid Services (CMS) Medicaid requirements for provider screening and enrollment requirements as outlined under 42 Code of Federal Regulations 455 Subparts B and E, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes, site visits, criminal background checks, federal database checks, enrollment screening based on provider risk category (including unannounced pre and post site visits where applicable).

A provider should submit the completed credentialing application and provider enrollment application (as necessary) to BCBSMT at least 45 days prior to his/her starting date of practice to allow time for processing of the applications.

A provider's participation effective date is the credentialing approval date.

BCBSMT does not back date effective dates of participation.

## Provider Enrollment Screening (HELP/HMK)

According to the CMS Federal Regulations, BCBSMT should not duplicate provider enrollment screening efforts already performed by Medicare, Montana Medicaid, or another state's Medicaid or CHIP Program. Verification of participation in one of these programs meets the intent of the enrollment/screening process for participation in the HELP and HMK provider networks.

If the provider is not participating and, therefore, has not been screened by one of these agencies, the provider must complete and submit a complete provider enrollment screening application.

## Credentialing Applications

For professional providers, BCBSMT uses the Council for Affordable Quality Healthcare (CAQH) on-line credentialing application/data repository.

Providers already registered with CAQH must ensure their information is current and authorize BCBSMT to view their credentials.

Providers not previously registered may self-register and complete their information on-line any time and authorize BCBSMT to view their credentials.

For institutional/facility providers, BCBSMT uses a paper credentialing application.

## Prior to Applying for Participation

Before a provider can apply to join the BCBSMT provider networks, the provider must have a current, active, unrestricted Montana license. The provider may not have been sanctioned by or excluded from participating in government programs.

## Credentialing Committee

The BCBSMT Credentialing Committee consists of practicing physicians and non-physician health care providers representing multiple specialties from across Montana, and representatives from BCBSMT. Each applicant's credentials are reviewed by the Credentialing Committee for approval of participation in the BCBSMT provider networks.

## Provider Rights

Providers have the right to obtain information regarding their credentialing status upon request by e-mailing **MTHCSSPEC@bcbsmt.com** or calling **1-800-447-7828**, Extension 6100.

Prior to review, the provider has the right to correct incomplete, inaccurate, or conflicting credentialing information.

## Providers Requiring Credentialing

All professional and institutional providers must be credentialed prior to participation in all of the BCBSMT provider networks, with the exception of the Healthy Montana Kids (HMK) network. Only physicians must be credentialed for HMK.

## Licensing Requirements

The provider must have a valid and current license to practice in the state of Montana. Licensure is verified through the appropriate Montana State Licensing Board.

## Credentialing Process

| Step | Action |
|---|---|
| 1 | To begin the application process a provider must first request a BCBSMT provider record.<br>• Practices new to BCBSMT may access an on-line form on the BCBSMT website at **www.bcbsmt.com/provider/network-participation/contract-request** to complete and submit electronically.<br>• Individual professional providers joining an existing contracted practice must complete and submit the "Add Sheet"/ Exhibit B of the Professional Provider Agreement. And may skip Step 2. |
| 2 | After BCBSMT creates the required provider record, a contract is forwarded to the provider. The provider must complete the necessary information, sign, date, and return the contract. |
| 3 | BCBSMT then rosters the professional provider with CAQH. The system automatically searches for a completed CAQH application daily until one is found.<br>BCBSMT begins to process the institutional provider/ facility credentialing application. |
| 4 | The Credentialing Team reviews the application for completeness and may need to clarify application details with the provider. Three (3) attempts to obtain missing information or clarify details are made. After 3 attempts, application is administratively denied. |
| 5 | BCBSMT verifies the information supplied in the application with the primary sources of the information.<br>• BCBSMT is dependent upon timely response from those sources.<br>• The Credentialing Team reviews the information for any discrepancies and may need to clarify application details with the provider. |
| 6 | The application is presented to the BCBSMT Medical Director or the BCBSMT Credentialing Committee for consideration of participation in the BCBSMT provider networks.<br>Note: The Credentialing Committee meets twice monthly. |

| Step | Action |
|---|---|
| 7 | BCBSMT sends the provider notice of the credentialing outcome within ten (10) business days of the decision. |

| Step | Action |
|---|---|
| 8 | Once a provider is approved for network participation, BCBSMT executes the provider contract. A copy of the contract is sent to the provider with notification of the effective date of the provider networks. The provider database is updated with the effective date of the networks.<br>• The contract effective date is the credentialing approval date. Contracts are not backdated. |

# PROFESSIONAL PROVIDER- MINIMUM CREDENTIALING CRITERIA- EDUCATION & TRAINING

## Overview

To be eligible to apply for network participation, the professional providers outlined in this Education & Training section, must meet the following minimum requirements. The highest level of education is verified through the:

- Professional school and training programs
- Appropriate certification board

## Physicians (MD, DO & Oral and Maxillofacial Surgeons)

Eligibility for BCBSMT HELP and HMK Provider Networks

To be eligible to apply for participation in the traditional provider networks, physicians must meet the following requirements:

- Completed a medical degree or foreign equivalent, and;
- One year post graduate training in general medicine
- A physician who only completed one year of postgraduate training is approved as a General Practitioner.
- A physician must have completed a residency in a specialty in order to be considered a specialist.

Recognized Board Certification programs include those approved by the following:

| Abbreviation | Recognized Board |
|---|---|
| ABMS | American Board of Medical Specialties |
| AOA | American Osteopathic Association |
| ABMFS | American Board of Oral & Maxillofacial Surgeons |

## Podiatrists

### Eligibility for BCBSMT HELP and HMK Provider Networks

To be eligible to apply for network participation in the traditional networks, at a minimum, a podiatrist must have:

- Completed a podiatric medical degree or foreign equivalent, after June 30, 1982 and;
- Completed one year postgraduate training or has equivalent experience or training approved by the Credentialing Committee.

## Physician Assistants

To be eligible to apply for participation, physician assistants must have:

- Graduated from a physician assistant program approved by the American Medical Association Committee on Allied Health Education and Accreditation, or its successor and
- Maintained certification issued by the National Commission on Certification of Physician Assistants

## Advanced Practice Registered Nurses (NPs, CNMs, CRNAs and CNSs)

To be eligible to apply for participation, advanced practice registered nurses must have:

- Graduated from the advanced practice nursing education required to take the first national certification examination available from a board-approved national certifying body appropriate to the specific field of advanced practice registered nursing and
- A current certificate issued by a board-approved national certifying body appropriate to the specific field of advanced practice registered nursing

## Mental Health Providers

To be eligible to apply for participation, mental health providers must meet the following requirements:

### Psychologists

- Completed a doctoral degree in clinical psychology from an accredited college or university having an appropriate graduate program approved by the American Psychological Association; or
- Completed a doctoral degree in psychology from an accredited college or university not approved by the American Psychological Association and successfully completed a formal graduate retraining program in clinical psychology approved by the American Psychological Association; or
- Completed a doctoral degree in psychology from an accredited college or university and has completed a course of studies that meets minimum standards specified in rules by the board.

### Licensed addiction counselor

- Completed a master's degree in alcohol and drug studies, psychology, sociology, social work, or counseling, or a comparable master's degree from an accredited college or university.
- An LAC who has not completed as master's degree is required to complete a master's degree in alcohol and drug studies, psychology, sociology, social work, or counseling, or a comparable master's degree within 5 years of approval to the network.

### Licensed professional counselor

- Completed a planned graduate program of 60 semester hours, primarily counseling in nature, 6 semester hours of which were earned in an advanced counseling practicum that resulted in a graduate degree from an institution accredited to offer a graduate program in counseling.

### Licensed clinic social workers

- Completed a doctorate or master's degree in social work from a program accredited by the Council on Social Work Education or approved by the board.

## Optometrists

To be eligible to apply for participation, optometrists must have:

- Graduated from a school approved by the board, including schools of optometry accredited the International Association of Boards of Examiners in Optometry

## Physical and Occupational Therapists

To be eligible to apply for participation, physical and occupational therapists must have:

- Graduated from a physical or occupational therapy program approved by one of the following organizations:
  - Committee on Accreditation in Physical Therapy Education
  - Accreditation Council for Occupational Therapy Education

## Speech-Language Pathologists and Audiologists

To be eligible to apply for participation, speech-language pathologists and audiologists must have:

- Completed an academic, supervised clinical practicum and post-classroom sponsored employment requirements of the American Speech-Language and Hearing Association

## Certified Surgical Assistants

To be eligible to apply for participation, certified surgical assistants must have:

- Graduated from a National Surgical Assistant Association-approved program of surgical assisting

### Registered Dieticians

To be eligible to apply for participation, registered dieticians must have:

- Completed appropriate academic requirements for the field of dietetics and related disciplines, including;
- Baccalaureate and masters or a doctoral degree in the field of dietetics, food and nutrition, or public health nutrition conferred by an accredited college or university.
- Completed a program of supervised clinical experience of not less than 6 months in length that is designed to train entry-level dietitians through instruction and assignments in a clinical setting.

## PROFESSIONAL PROVIDER-OTHER MINIMUM CREDENTIALING REQUIREMENTS

### Malpractice Coverage

The provider must have current malpractice liability insurance coverage ($1,000,000 per occurrence and $3,000,000 in aggregate is encouraged). Coverage is verified through a:

- Copy of Malpractice Certificate of Insurance (COI)

For provider group malpractice policies, the individual professional provider's name must be listed on the COI, or the malpractice carrier must provide a list of the names of providers covered by the policy.

### Medicare/ Medicaid Sanctions

The provider is currently eligible to participate in Medicare and/ or Medicaid programs. A provider cannot have been sanctioned. Lack of sanctions is verified through the:

- Office of Inspector General Exclusions List
- Excluded Parties List System (EPLS)
- National Practitioner Data Bank

### Hospital Admitting Privileges

Physicians must maintain hospital admitting privileges at an acute care hospital, or have a formal written admit plan in place with another physician or physician group in the same community of practice to admit on his/her behalf. Privileges are verified with:

- The appropriate hospital's medical staff services office
- Formal admit plan

### Drug Enforcement Administration Certification (DEA)

Physicians, advanced practice nurses and physician assistants must maintain current DEA certification or provide a plan with how they will provide prescriptions to their patients requiring such. The DEA certification is verified through:

- A copy of a current DEA certificate
- Registration in the NTIS database

### Physician Assistants Only

Physician Assistants must have a supervising physician.

### Individual Criteria and Other Considerations

Other individual review criteria may include, but is not limited to:

- State board disciplinary action/license restrictions
- Hospital disciplinary action
- Drug Enforcement Agency certification disciplinary action/restrictions
- Criminal history
- Alcohol or drug abuse/provider impairment
- Malpractice suits/claims history
- Claims fraud or abuse
- Completeness of application
- Member complaints
- Quality of care issues

# INSTITUTIONAL PROVIDER CREDENTIALING CRITERIA

## Institutional/Facility Provider Credentialing

BCBMST requires all institutional/facility providers to submit a credentialing application. All locations for credentialed institutions/facilities are credentialed separately. Initial credentialing is conducted prior to the institution/entity contract being executed or being listed in the provider directory. Information collected and the standards for institutional providers are as follows:

| Application Requirement | Source of Information | Standard |
|---|---|---|
| Current valid State of Montana License | Copy of state license(s) | Valid, current license |
| Current professional liability coverage | Copy of malpractice certificate of insurance | Current professional liability insurance coverage |
| Medicare Certification | Verification of Medicare Certification with State | In good standing with Medicare |
| Survey results, as applicable | Copy of appropriate Accrediting Body, JCAHO, CHAP, AAHC or other recognized accrediting body, survey results | Based on the committee's judgment, the survey results do not indicate deficiencies that would pose unacceptable risk to the patients. |
| | state survey results | |
| Sleep medicine centers | Verification of accreditation with the American Academy of Sleep Medicine (AASM) | Accreditation by the American Academy of Sleep Medicine (AASM) is required within 12 months of approval to the network. |

If a quality issue is identified at any time, information regarding the issue is presented to the Credentialing Committee for review and action as needed.

# RE-CREDENTIALING

## Time Frame & Application

Re-credentialing is performed every three (3) years for both professional and institutional providers.

Professional providers have the ability to maintain current information in CAQH. If at the time of re-credentialing the information is not current, the provider is notified to update information in CAQH. BCBSMT requires an updated provider application and re-verification of all of the information, except the provider's initial education and training.

Facilities providers are sent paper applications and are required to update the information.

The BCBSMT Medical Director or Credentialing Committee reconsiders each provider's application for continued participation at re-credentialing.

If information is received that raises quality concerns prior to re-credentialing, the provider's participation may be reconsidered at that time.

Failure to comply with re-credentialing within the three-year time frame results in the provider's name being removed from the directory and/or termination of the provider contract.

## Re-credentialing Continuing Education Requirements

State licensing board continuing education requirements are followed for all professional providers with the exception of physicians (MDs, DOs, DPMs and oral & maxillofacial surgeons).

Physicians are required to complete 75 Category I continuing education credits every three (3) years between re-credentialing cycles.

The following websites offer free or low-cost continuing medical education credits:

**www.medscape.com** **www.medconnect.com**

**www.cmeweb.com** **www.medsitecme.com**

## BCBSMT Contacts

For questions regarding the provider enrollment process, contact BCBSMT at

**1-800-447-7828**, Extension 6100, or via e-mail to **HCSSPEC@bcbsmt.com**

## CAQH Resources

Explore the CAQH websit at **www.caqh.org** for more information about the CAQH ProView database and the application process.

CAQH Help Desk: **888-599-1771**

Help Desk Email Address: **providerhelp@solutions.caqh.org**

# HELP PLAN AND HMK PROVIDER ENROLLMENT SCREENING

## Policy

This policy defines the provider enrollment and screening process for providers prior to their participation in the HELP Plan and HMK networks.

## Purpose

This process ensures every provider participating in HELP Plan or HMK meet applicable Federal regulations or state requirements for the provider type prior to making an enrollment determination.

## Regulatory Requirements & References

This policy is compliant with 42 CFR Part 455 subparts B & E

## Provider Minimum Eligibility

To participate in the HELP Plan provider network, a provider:

- Must be a participating provider with BCBSMT
- Must sign a HELP Plan Amendment to the BCBSMT PPO Agreement Entity Agreement with BCBSMT
- Must have a valid National Provider Identifier (NPI)
- Must have a valid unrestricted Montana license
- Complete the BCBSMT credentialing process

To participate in the HMK provider network providers:

- Must sign an HMK Agreement with BCBSMT
- Must have a valid National Provider Identifier (NPI)
- Must have a valid unrestricted Montana license
- Physicians (MDs, DOs and DPMs) must complete the BCBSMT credentialing process

## Sanctions under Federal Health Programs and State Law

To participate in the HELP Plan and/or HMK provider network providers (professional providers and suppliers) or any person with an ownership or controlling interest or who is an agent or managing employee of the provider may not:

- Have had an imposition of a payment suspension within the previous 10 years
- Be terminated or otherwise precluded from billing Medicaid;
- Be excluded by the OIG
- Have had billing privileges revoked by a Medicare contractor within the previous 10 years and be attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establishing billing privileges for a new practice location;
- Be excluded from any federal health care program
- Have been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years; or
- Be a provider type or supplier that is prevented from enrolling based on a moratorium imposed by DPHHS.

## Definitions

Newly enrolling and revalidating providers are placed in one of three screening categories based upon assessment of fraud, waste and abuse risk of the provider. BCBSMT follows the categories as defined by CMS for Medicare. The providers are categorized as follows:

| Limited -Professional Providers | Limited- Facilities |
|---|---|
| • Medical Doctors (MDs)<br>• Doctors of Osteopathy (DOs)<br>• Doctors of Dental Surgery/ Oral Surgeons (DDS/DMDs)<br>• Doctors of Podiatric Medicine (DPMs)<br>• Doctors of Chiropractic (DCs)*<br>• Optometrists (ODs)<br>• Nurse Practitioners (NPs)<br>• Certified Nurse Midwives (CNMs)<br>• Certified Registered Nurse Anesthetists (CRNAs)<br>• Clinical Nurse Specialists (CNSs)<br>• Physician Assistants (PAs)<br>• Occupational Therapists (OT)<br>• Speech-Language Pathologists and Speech Therapists (SLPs and STs)<br>• Licensed Addiction Counselors (LACs)<br>• Licensed Clinical Professional Counselors (LCPCs)<br>• Licensed Clinical Social Workers (LCSWs)<br>• Psychologists (PhDs/ EdDs/PsyDs) | • Ambulatory Surgery Centers (ASC)<br>• Chemical Dependency Centers<br>• Dialysis Treatment Centers (ESRD)<br>• Hospitals (Acute Care & CAH)<br>• Inpatient Mental Health Facilities<br>• Laboratories<br>• Oxygen Suppliers<br>• Radiology Centers<br>• Psychiatric Residential Treatment Centers<br>• Skilled Nursing Facilities (SNF) |

* HMK Only

| Moderate | High |
|---|---|
| • Community Mental Health Centers<br>• Hospice Agencies<br>• Physical Therapists (PTs)<br>• Independent Labs<br>• Radiology Centers<br>• Revalidating DME (Durable Medical Equipment) | • Newly Enrolling DME (Durable Medical Equipment)<br>• Newly Enrolling Home Health Agencies |

## Existing Medicare/Medicaid Providers

According to the CMS Federal Regulations, BCBMST should not duplicate provider screening efforts already performed by Medicare, Montana Medicaid, or another state's Medicaid or CHIP Program. Verification of participation in one of these programs meets the intent of the enrollment/screening process for participation in the HELP provider network.

## Provider Application Process

As part of the contracting process, a provider is queried as to current participation in Medicare, Montana Medicaid, or another state's Medicaid or CHIP Program. If the provider is not participating and, therefore, has not been screened by one of these agencies, the provider must complete and submit a complete provider enrollment application.

## Performing the Screening Process

If the provider indicated current participation in the Medicare, Montana Medicaid, or another state's Medicaid or CHIP Program, the following sources are used to verify such:

| Montana Medicaid | Medicare | Other State's Medicaid/ CHIP Program |
|---|---|---|
| MT Medicaid Contractor - XEROX file | PECOS | Appropriate state's program |

Limited Risk- Professional Providers the following elements are verified:

| Element | Source |
|---|---|
| Current Unrestricted Montana License | Montana.gov Licensee Lookup |
| Current NPI | NPI Registry (NPPES) |
| Lack of OIG Sanctions | OIG/LEIE Federal Exclusion website: http://oig.hhs.gov/exclusions/index.asp |
| Lack of Exclusions from Federal Programs | System for Award Management/ Excluded Parties List System EPLS Web Site |
| Validate the Provider's Identity | SSN Master Death File |
| Other State's Licenses | Appropriate State's Licensing Board |

Limited Risk- Facility/Institutional Providers the following elements are verified:

| Element | Source |
|---|---|
| Current Unrestricted Montana License | Montana.gov Facility License Lists |
| Current NPI | NPI Registry (NPPES) |
| Lack of OIG Sanctions | OIG/LEIE Federal Exclusion website: **http://oig.hhs.gov/exclusions/index.asp** |
| Lack of Exclusions from Federal Programs | System for Award Management/ Excluded Parties List System EPLS Web Site |

## Denial or Termination of Enrollment

A provider, or any person with 5 percent or greater ownership in the provider, who fails to comply with the provider enrollment screening requirements may be denied or terminated accordingly. This includes, but is not limited to:

- Failure to submit timely and accurate information
- Provider is found to have been convicted of a crime with Medicare, Medicaid or the Title XXI program in the last 10 years.
- Failure to submit sets of fingerprints determined by BCBSMT within 30 days of request
- Failure to comply with site visit
- Provider is found to have falsified information on the application
- BCBSMT is unable to verify the identity of the applicant.

## Ongoing Monitoring

On at least a monthly basis, BCBSMT performs searches of federal databases to monitor for ongoing compliance with the provider enrollment requirements. In the event a provider is determined to no longer meet the requirements, BCBSMT will take immediate action to terminate the provider's contract.

## Revalidation Process

All providers must be revalidated every five years.

## Participating Provider Effective Date Requests

- No provider is considered to be a participating provider until they have completed the provider enrollment screening process and the BCBSMT credentialing process, including having been approved by BCBSMT (see the "Credentialing Standards" section for full requirements).
  - Effective dates are not made retroactive
- Claims received prior to credentialing/re-credentialing or enrollment screenings are treated as out-of-network until the provider has met all network requirements.
  - Note — Benefits are not available for HELP Participants for services provided by an out-of-network provider, with the exception of urgent/emergent or preauthorized services.
- Providers are strongly encouraged to submit all necessary documentation for participation at least 60 day prior to the intended effective date.
- Once approved, all providers are expected to comply with re-credentialing and revalidation standards.
- If a provider does not comply with re-credentialing or revalidation requirements before the current cycle ends, BCBSMT reserves the right to treat all such claims as out-of- network.
- If a provider is terminated for not meeting re-credentialing requirements, the provider will have thirty (30) days from the termination date to rectify and apply for reinstatement. Providers who remain terminated beyond thirty (30) days will have to reapply to the network under the normal course of business.

# Chapter 11:
# COMPENSATION POLICIES

## Overview

Provider compensation policies for HELP Plan covered benefits are located on the Department of Public Health and Human Services website at **http://medicaidprovider.mt.gov**. Refer to "Resources by Provider Type" and "RBRVS Fee Schedules" for specific provider manuals and fee schedules or call Provider Customer Service at **1-877-296-8206**.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

For questions about this guide, contact:

BCBSMT
560 North Park Avenue
Helena, MT 59602
**1-877-233-7055**



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