Montana Healthcare Programs Provider Notice
March 27, 2024

All Providers

Avoiding Claim Denials

This notice reviews common reasons for denials and provides guidance on avoiding claim denials.

Verify Member Eligibility
The main reason for a claim denial is member ineligibility. Because eligibility, TPL, and waiver statuses may change from month-to-month, providers should verify eligibility **before** providing a service. Check eligibility using:

- Integrated Voice Response (IVR) (800) 714-0060
- FaxBack (800) 714-0075
- The Montana Access to Health (MATH) web portal
- Provider Relations (800)624-3958

For specific instructions for the bulleted items listed above, see the Member Eligibility and Responsibilities section in the General Information for Providers Manual.

Duplicate or Suspect Duplicate Services
Claims are often suspended or denied because they are an exact duplicate or a suspected duplicate of another claim. To prevent duplicate claims:

- Do not resubmit a claim that is in a pending status. A claim that is in a pending status will have reason code 133 on the remittance advice.
- Before resubmitting a claim, call Provider Relations or use the Montana Access to Health (MATH) web portal to check the claim status if you are not sure if a claim was paid.
- Review claim details against previously submitted claims.
- If span billing, be sure the dates of service do not overlap between lines on the same claim or across claims.
- If dates must overlap, refer to the fee schedules for any necessary modifiers.

Provider Fee Schedules
To avoid billing errors, refer to your applicable Medicaid provider fee schedule and bill for items and services covered for your specific provider type using your coding book or billing code resources.

Fee schedules show covered service codes, associated billing modifiers, method of payment, effective dates, associated rates, and an indicator for prior authorization. Depending on the provider type, fee schedules may show global information, payment adjustors, and coverage limits.

Common denial reasons for invalid provider type for procedure code or no rate on file:

- Services denied for invalid provider type are associated with reason code 065.
- Service denied for invalid procedure code deny for reason code 96 and remark code MA66.
- Services denied for no rate on file are denied for reason code 87.

To avoid these claim denials, a few helpful hints:

- Use your coding books or billing code resources to ensure the code is still active nationally for the date of service.
- Use the Medicaid fee schedule to determine if Medicaid covers the service for your provider type.
- Codes not listed on your fee schedule may not be covered for your provider type. Contact your DPHHS Program Officer for coverage determinations. See the Contact Us page on the Provider Information website.
- Do not code from the Medicaid fee schedules. Use your coding books to identify the correct service to be billed. The fee schedule shows only the short description, and many codes share the same short description. Covered items and services are subject to change based on funding, legislative action, and administrative rule updates.

Prior Authorization

Each program has different prior authorization (PA) requirements. Refer to your Medicaid provider manual and fee schedule for those requirements. Services requiring PA must have a valid PA number submitted on the claim for processing.

A claim or service line associated with a PA may deny in the claim system for the following reasons:

- Claim is submitted with no PA number, or the PA submitted is not in the claim system. The entire claim will deny with reason code 198 and remark code M62.
- Claim is submitted and there is a mismatch on the rendering provider ID. The entire claim will deny with reason code 15.
- Claim is submitted and there is a mismatch on the member ID. The entire claim will deny for reason code 15 and remark code N54.
- Claim is submitted and there is a mismatch on authorization dates, service code, modifier, tooth number and/or surface. The service line will deny for reason code 15 and remark code N54.
- The authorized units or dollars have been exceeded. Service line will deny for reason code 198 and remark code N54.
- The authorized units or dollars have been used. Service line will deny for reason code 197.

Below are tips for providers:

- Validate that the services being rendered match the PA notification letter. If discrepancies occur, contact the approving agency, case manager, regional manager, or program for clarification and corrections.
- Submitting claims electronically may require that your billing system is updated annually with new PA numbers.
- Do not span bill a service where the To Date is authorized under a different PA number.
- Do not bill for more than what has been authorized.

Timely Filing Limits

- Providers must submit clean claims based on timelines addressed in ARM 37.85.406.
- Clean claims are claims that can be processed without additional information or action from the provider.
- The submission date is defined as the date that the claim was received by the Department or the claims processing contractor (ARM 37.85.406 (1)(c)). All problems with claims must be resolved within this 12-month period.
- See the Billing Procedures section in the General Information for Providers Manual for specific instructions on avoiding timely filing denials.

Supplement Information

Avoid claim denials for supplemental information by using the Paperwork Attachment Indicator (PWK) on electronic (837) claims. **Claim paperwork for electronic claims must be received within 8 calendar days from the claim submission**.

When submitting claims electronically via the MPATH Provider Services Portal, documents can be uploaded during claim entry and will be electronically delivered for processing or can be sent by mail or fax by following the instructions provided.

Electronic claims from other sources must use the PWK indicator to prompt the claim examiner to locate the supporting documentation.

The Paperwork Attachment Cover Sheet is available on the Forms page on the Provider Information website. Access the Forms page through the Site Index option in the left menu. Follow the instructions on the form to create the Paperwork Attachment Control Number for electronic claims.

When submitting **paper claims,** supplemental information must be attached to the claim. If it is not attached, the claim will be denied.

Review your remittance advice for pending claims.

Contact and Website Information

For claims questions or additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email Montana Provider Relations Helpdesk.

Visit the Montana Healthcare Programs Provider Information website to access your provider type page. Choose Resources by Provider Type in the left-hand menu.

Visit the Contact Us page on the Provider Information website for additional DPHHS contact numbers.