Montana Healthcare Programs

Federally Qualified Health Center and Rural Health Clinic Provider Manual

Effective January 1, 2025

Federally Qualified Health Center and Rural Health Clinic Provider Manual

To print this manual, right-click your mouse and choose the Print option. **Printing the manual material found at this website for long-term use is not advisable.** Department of Public Health and Human Services (DPHHS) policy material is updated periodically, and users are responsible for ensuring that the policy they are researching or applying has the correct effective date for their circumstances.

Publication History

This publication supersedes all previous Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Provider Manuals, provider notices, or other communications concerning the content of this manual. Published by the Montana Department of Public Health and Human Services (DPHHS), 01/01/2025.

Montana Code Annotated (MCA) 53-6-1402 (3) (a) allows the Department or an auditor to request up to 6 months of records from a provider for claims paid by the Medicaid program up to 3 years before the request date.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Provider Manual updates include:

01/01/2025

- Entire manual reviewed.

11/01/2021 Update

- Entire manual reviewed.

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Provider Information and Documentation

How can I get necessary Montana Healthcare Programs provider information and documentation?

Visit the Montana Healthcare Programs Provider Information Website.

The Montana Healthcare Programs Provider Information website is where Montana Healthcare Programs posts provider notices, fee schedules, provider manuals, and forms. Most information can be located under the 'Resources by Provider Type' tab. Please note that it is a provider's responsibility to check provider notices and fee schedules on a frequent basis to ensure proper billing.

The Montana Healthcare Programs Provider Information Website is also where the General Information for Providers Manual is posted. The General Information for Providers Manual is the resource for information such as telemedicine, Passport, cost share, remittance advices, and adjustments.

For FQHC and RHC program contact information, access the Department of Public Health and Human Services (DPHHS) tab on the Contact Us page on the Montana Healthcare Programs Provider Information website.

Who do I contact for information such as claim denials, eligibility, and enrollment?

Access the Montana Provider Relations tab on the Contact Us page on the Montana Healthcare Programs Provider Information website.

Manual Maintenance

Changes to manuals are provided in the Publications History section. Policy changes are also updated through provider notices located on the FQHC and RHC provider type webpages.

Rule References

Providers must be familiar with all current rules and regulations governing Montana Healthcare Programs. Provider manuals are to assist providers in billing Montana Healthcare Programs; they do not contain all Montana Healthcare Programs rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule.

If a provider manual conflicts with a rule, the rule prevails. Providers are responsible for knowing and following current Montana Healthcare Programs rules and regulations.

Links to rules are available on the Provider Information website. Rules are available to print through the Secretary of State's website.

The following rules and regulations are applicable to FQHCs and RHCs:

- Code of Federal Regulations (CFR)
  - 42 CFR 405.2400–42 CFR 405.2472
- Montana Code Annotated (MCA)
  - MCA 53-2-201, MCA 53-6-101, 53-6-111, and MCA 53-6-113
- Administrative Rules of Montana (ARM)
  - ARM 37.86.4401–37.86.4420

Definitions and Acronyms

For general Montana Healthcare Programs definitions and acronyms, access the Definitions and Acronyms webpage from the Site Index entry in the left menu on the Provider Information website.

FQHC and RHC Reimbursement Methodology

All allowed FQHC and RHC services are reimbursed per visit. Services eligible for an encounter payment are reimbursed the facility-specific prospective payment system (PPS) rate. The PPS rate is a fixed, per-visit rate that reflects 100% of an FQHC's or RHC's reasonable costs to provide FQHC or RHC services.

Certain non-FQHC or non-RHC services are paid at the appropriate fee schedule amount. The Department determines which non-FQHC and non-RHC services are eligible for reimbursement outside of PPS reimbursement. Refer to the Services Reimbursed Outside the PPS Rate section in this manual for more information.

How is the PPS rate calculated?

Upon enrollment with Montana Healthcare Programs, an FQHC or RHC is issued an interim PPS rate for two complete fiscal years. After two complete fiscal years, a baseline PPS rate will be established.

Establishment of Interim PPS Rate (ARM 37.86.4413)

An interim PPS rate must be established for a newly enrolled FQHC or RHC, or for an enrolled FQHC or RHC that acquires ownership of an existing FQHC or RHC. The interim PPS rate can be set two ways:

1. One hundred percent (100%) of the average PPS rate of other FQHCs or RHCs located in the same or adjacent area with a similar caseload; or
2. If there is no FQHC or RHC located in the same or adjacent area with a similar caseload, the temporary PPS rate will be equal to the FQHC's or RHC's total projected allowable costs divided by the total projected allowable visits.

Establishment of Baseline PPS Rate (ARM 37.86.4413)

Two complete fiscal years after an FQHC or RHC has been enrolled with Montana Healthcare Programs, a baseline PPS rate will be established by the Department.

The baseline PPS rate is established using the FQHC's or RHC's first two complete as-filed Medicare cost reports. The cost reports are due six months after the end of the second complete fiscal year.

If the cost reports are not received **30 days prior** to the six-month deadline, the Department will send notification to the FQHC or RHC advising them payment will be suspended on all Montana Healthcare Programs claims if the cost reports are not received in a timely manner.

Within 90 days from receiving the cost reports (and any additional requested information) the Department will calculate the baseline PPS rate and send a letter to the FQHC or RHC.

The baseline PPS rate of a newly enrolled FQHC or RHC will be retroactive to the date that the FQHC or RHC was enrolled with Montana Healthcare Programs. A mass adjustment of claims will be submitted for any increase or decrease from the interim PPS rate.

Can the baseline PPS rate change?

The baseline PPS rate can change through two methods:

1. Annual Medicare Economic Index (MEI) changes – On the first day of each calendar year, the FQHC's or RHC's baseline PPS rate will be adjusted to factor in the MEI.
2. Change in scope of service – A change in scope of service can result in an incremental change to the baseline PPS rate; incremental changes can be either positive or negative. The baseline PPS rate may also remain the same after a change in scope of service calculation.

Change in Scope of Service

What is a change in scope of service?

A change in scope of service occurs when an FQHC or RHC has experienced a change in the type, intensity (quantity of labor and materials consumed), duration (length of encounter), or amount of a service.

The FQHC or RHC will submit a prospective change in scope of service, or retrospective change in scope of service, dependent on when the change in scope of service is implemented and documentation is received by the Department.

- ARM 37.86.4409 Prospective change – A change the FQHC or RHC plans to implement in the future.

- ARM 37.86.4410 Retrospective change – A change which took place in the past.

What formula is used to calculate the incremental change to the baseline PPS rate?

The Department uses the following formulas to determine the amount of an incremental change, if any, when an FQHC or RHC applies for a change in scope of service:

A/B = C
D/E = F
F-C = IC

Current baseline PPS rate + IC = New baseline PPS rate

A – represents allowable costs before the change in scope of service
B – represents total visits before the change in scope of service
C – represents the cost per visit before the change in scope of service
D – represents allowable costs after the change in scope of service
E – represents total visits after the change in scope of service
F – represents cost per visit after the change in scope of service
IC – represents the incremental change due to the change in scope of service. This value can be positive or negative.

What are examples of a change in scope of service?

- The addition or deletion of a service that was not originally calculated into the baseline PPS rate.
- The addition or deletion of a covered Medicaid FQHC or RHC service under the State Plan.
- A change necessary to maintain compliance with amended state or federal regulations.

- A change in applicable technology or medical practices used by the FQHC or RHC that is not funded by state or federal funds that is associated with a change in service.
- A change in the type of patients served, including but not limited to, populations with HIV/AIDS, other chronic diseases, homeless, elderly, migrant, or other special populations that require more intensive and frequent care.
- A change in operating costs attributable to capital expenditures corresponding to a change in the services provided by the FQHC or RHC.
- A change in the provider mix, including but not limited to:
    - A transition from mid-level providers to physicians with a corresponding change in services provided by the FQHC or RHC.
- The addition or removal of specialty providers with a corresponding change in services provided by the FQHC or RHC.

What are examples of situations not eligible for a change in scope of service?

- A change in ownership, including acquisition by another healthcare entity, FQHC, or RHC.
- A change in the number of staff furnishing an existing service.
- An increase or decrease in administrative staff.
- A change in the number of encounters.
- A change in the cost of supplies for existing services.
- A change in salaries and benefits not directly related to a change in scope of service.
- A change in patient type and/or volume without a corresponding change in the services provided by the FQHC or RHC.
- Capital expenditures for losses covered by insurance.
- A change in office location or office space.
- The addition of a new site or removal of an existing site, which offers the same FQHC or RHC services.
- Services paid at a fee-for-service rate.
    - Example: Peer support services

How does an FQHC or RHC apply for a change in scope of service?

All change in scope of service requests must be submitted directly to the Department in writing. Requests can either be emailed to the FQHC/RHC Program Officer or mailed to DPHHS, attention: FQHC/RHC Program Officer, P.O. Box 202951, Helena, MT 59620.

An FQHC or RHC must apply for a change in scope of service, even if it will not result in a positive incremental change to the baseline PPS rate.

What information is required to submit with a prospective change in scope of service?

The following information must be submitted to apply for a prospective change in scope of service:

- A narrative description of each change in scope of service.
- The date on which the change in scope of service is scheduled to occur.
- A description of each cost center(s) on the cost report that will be affected by the change in scope of service.
- The cost report for the fiscal year prior to the year in which the change in scope of service is scheduled to be implemented.
- A projected cost report for the fiscal year in which the change in scope of service is scheduled to be implemented which considers the change in scope of service.
    - If a projected cost report cannot be completed, the FQHC or RHC must provide sufficient cost and encounter information to establish a temporary rate.

What are the deadlines and effective dates associated with a prospective change in scope of service request?

- The completed application must be received no later than 120 days in advance of the prospective change in scope of service to be considered timely.
- For timely applications, the effective date of the temporary PPS rate will be the date that the change in scope of service is implemented.
- For untimely applications, the effective date of the temporary PPS rate is the later of:
    - The date that the Department receives the FQHC's or RHC's completed application materials; or
    - The date that the change in scope is implemented.

What is a temporary PPS rate?

A temporary PPS rate is established using the materials requested in ARM 37.86.4409. It is a rate assigned during the period between the change in scope of service and the establishment of the final incremental change to the baseline PPS rate. The Department will establish a temporary PPS rate within 90 days from receiving the completed application and notify the FQHC or RHC.

Once the change in scope of service is implemented, the FQHC or RHC must notify the Department, even if the change is implemented on the scheduled date.

What is required to submit to the Department to finalize the incremental change to the baseline PPS rate?

Six months after the close of the FQHC's or RHC's fiscal year in which the change in scope of service has ended the FQHC or RHC must supplement its application by submitting the following materials:

- A narrative description of each change in scope of service, including how the services were provided, both before and after the change
- The date that the change in scope of service was implemented
- The FQHC's or RHC's as-filed Medicare cost reports for the fiscal year prior to the change in scope of service and the year in which the change in scope of service occurred
- For Health Resources and Service Administration (HRSA) Health Center Program awardees and look-alikes, the Uniform Data System reports for the calendar year prior to the change in scope of service and the calendar year in which the change in scope of service occurred.
- A description of each cost center on the cost report affected by the change in scope of service
- An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC or RHC
- Any approved changes in scope of project as defined by HRSA

What if we are late in submitting our supplemental information?

If the supplemental material is not received 30 days prior to the six-month deadline, the Department will send notification to the FQHC or RHC advising them that payment for Montana Healthcare Programs claims will be suspended if the required documentation is not received in a timely manner.

When will the Department calculate the new baseline PPS rate for a prospective change in scope of service?

Once all the supplemental materials are received, the Department will calculate the incremental change to the baseline PPS rate and will notify the FQHC or RHC of the determination.

What will the effective date of the baseline PPS rate for a prospective change in scope of service be?

The effective date of the baseline PPS rate will be retroactive to the date that the change in scope was implemented.

What happens if the baseline PPS rate is different than the temporary PPS rate?

If your baseline PPS rate is greater than your temporary PPS rate, the Department will reimburse you the difference through a mass adjustment.

If your baseline PPS rate is less than your temporary PPS rate, the Department will recoup the difference through a mass adjustment.

How often can an FQHC or RHC submit a retrospective change in scope of service?

An FQHC or RHC may apply for a retrospective change in scope of service once per calendar year.

What information is required to submit with a retrospective change in scope of service?

The following information must be submitted to apply for a retrospective change in scope of services:

- A narrative description of each change in scope of service, including how services were provided before and after the change
- The FQHC's or RHC's as-filed Medicare cost reports for the fiscal year prior to the change in scope of service and the year in which the change in scope of service occurred
- For HRSA Health Center Program awardees and look-alikes, the Uniform Data System reports for the calendar year prior to the change in scope of service and the calendar year in which the change in scope of service occurred
- A description of each cost center on the cost report affected by the change in scope of service
- An attestation statement that certifies the truth, accuracy, and completeness of the information in the application signed by an officer or administrator
- Any approved changes in the scope of project as defined by HRSA

What effective date will be issued after the incremental change to the baseline PPS rate has been calculated for a retrospective change in scope of service?

The completed application must be received six months after the close of the FQHC's or RHC's fiscal year to receive a timely effective date (see below).

- For timely applications, the effective date of the incremental change to the baseline PPS rate is the beginning of the facility's fiscal year following the retrospective change in scope of service.

- For untimely applications, the effective date of the incremental change to the baseline PPS rate is the date that the Department received all required information

When will the Department calculate the incremental change to the baseline PPS rate for a retrospective change in scope of service?

The Department will notify the FQHC or RHC of the determination and any change to the PPS rate within 90 days from receiving the complete application and any requested information.

Claim Forms

FQHC and RHC services must be billed either electronically or on a paper UB-04 claim form. UB04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

FQHC and RHC services performed in a hospital setting must be billed on a CMS-1500 claim form. The FQHC or RHC NPI number must be submitted as the billing provider, and the individual provider that provided services must be submitted as the rendering provider on the CMS-1500 claim form.

Services submitted on a CMS-1500 claim form will be paid a fee for service rate, not the PPS rate.

Unless otherwise stated, all paper claims must be mailed to the following address:

Claims
P.O. Box 8000
Helena, MT 59604

Revenue Codes

The following revenue codes are reimbursable when billed by an FQHC or RHC with a valid, allowable procedure code:

- 0512 – Dental visit
- 0521 – FQHC/RHC clinic visit
- 0522 – FQHC/RHC home visit
- 0524 – Visit by FQHC/RHC practitioner to a member in a covered Part A stay at a skilled nursing facility
- 0525 – Visit by FQHC/RHC practitioner to a member in a skilled nursing facility (not in a covered Part A stay), a nursing facility or intermediate care facility for the MR, or other residential facility

- 0527 – FQHC/RHC visiting nurse services to a member's home when in a home health shortage area
- 0528 – Visit by an FQHC/RHC practitioner to other non-FQHC/RHC site (e.g., scene of accident)
- 0529 – Other freestanding clinic
- 0636 – HMK vaccine reimbursements and long-acting reversible contraceptives
- 0771 – Vaccine administration fee
- 0779 – Clinical Pharmacist Practitioner services
- 0780 – Telehealth originating site
- 0900 – Behavioral health services
- 0910 – Behavioral health peer support services
- 0911 – Substance use disorder peer support services
- 0942 – Health education
- 0944 – Substance use disorder services
- 0969 – Promising Pregnancy Care (group education session)
- 0982 – Professional fees outpatient services

Since FQHCs and RHCs are reimbursed at their PPS rate for most services, they do not have their own fee schedule. FQHCs and RHCs use the Outpatient Prospective Payment System (OPPS) fee schedule for reimbursable codes, including allowable dental service codes.

Please note, the OPPS fee schedule is for reference of Montana Medicaid allowable codes only. A code appearing on the OPPS fee schedule does not indicate if the code is an FQHC or RHC service, or if the code is considered an incident to a core provider encounter.

Number of Lines on Claim

Claims that are submitted with the same revenue code for the same date of service will bundle and be reimbursed at the PPS rate. Claims submitted with different revenue codes to distinguish distinct qualified encounters with core providers of differing specialties will be reimbursed at the PPS rate for each revenue code.

Multiple Services on Same Date (ARM 37.86.4402)

A visit is a face-to-face encounter between a patient and a health professional for the purpose of providing FQHC or RHC services. Mental health visits can be a face-to-face encounter or an encounter that meets the requirements under 42 CFR 405.2463 paragraph (b)(3).

Reimbursement is available for one encounter per day per eligible member unless it is necessary for the member:

- To be seen by different health professionals with different specialties; or
- To be seen multiple times per day due to unrelated diagnoses
    - When a member is seen by providers of the same specialty within the same visit, services rendered are reimbursable as one encounter

Span Billing

Span billing is not allowed for FQHCs and RHCs. Providers may bill for only one date of service per claim.

FQHC and RHC Limitations

Like all health care services received by Medicaid members, FQHC and RHC services must also meet the general requirements listed in the Provider Requirements chapter of the General Information for Providers Manual.

Although an FQHC or RHC receives a facility-specific PPS rate for most services they provide, the clinic is still obligated to follow the same limits on amount, scope, and duration of services covered by the Medicaid program. For example, if the clinic is providing dental services, the dental program limits still apply (e.g., an individual dental provider requiring an AbCd certification to submit claims with AbCd procedure codes).

As an FQHC or RHC, it is the responsibility of the provider to ensure that they comply with requirements disclosed in each program's provider manual.

Each clinic and individual provider rendering the service must maintain a current Medicaid provider enrollment. The enrollment link can be found on the Provider Information website.

Service Settings

Allowable services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office), or a member's place of residence. A member's place of residence may be a nursing facility or other institution used as the member's home.

Clinic services are covered off-site if the service is normally furnished within the scope of the clinic's professional services.

Satellite Clinics

Per 45 CFR 162.410, if the subparts are of the same legal entity as the parent company, a separate NPI number for each subpart is only required if the subpart would be a covered health care provider if it were a separate legal entity. If separate NPI numbers are obtained, each location must identify themselves with their assigned NPI numbers on all standard transactions that require the identifier.

Clinic Covered Core Services

The following are covered core services in FQHCs (F), RHCs (R), or both (B) and may be billed as a visit when there is a qualifying encounter with the member:

- B – Physician services
- B – Nurse practitioner, nurse specialist, certified nurse midwife, or physician's assistant services
- B – Clinical psychologist, clinical social worker, licensed professional counselor, licensed addiction counselor, licensed marriage & family therapist, or in-training mental health professional (as defined in ARM 37.85.213) services
- B – Dental services
- B – Visiting nurse services when provided in accordance with 42 CFR 405.2416
- B – Clinical Pharmacist Practitioner services
- F – Preventive primary services; does not include eyeglasses or hearing aids, but does include:
    - Perinatal care for high-risk members
    - Tuberculosis testing for high-risk members
    - Risk assessment and initial counseling regarding risks
    - Preventive Dental

Services and supplies furnished as incidental to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in the provider's rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B – Furnished as an incidental, although integral, part of the above provider's professional service (i.e., influenza vaccine/administration)
- B – Service commonly rendered without charge or included in the clinic's claim
- B – Service that is commonly furnished in a physician's office or a clinic
- B – Basic lab services essential to the immediate diagnosis and treatment of the member
- B – Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist, or social worker.
- B – In the case of a service, furnished by a member of the clinic's healthcare staff who is an employee of the clinic
- B – Drugs and biologicals that cannot be self-administered

- B – Radiology, including ultrasound
- B – Pharmacist-only visits of any kind
- B – Outreach
- B – Transportation

Care management services are only reimbursed through a primary care case management (PCCM) program. Detailed information about these programs is in the Passport to Health Manual on your provider type page on the Provider Information website, or on the Passport to Health webpage through the Site Index option in the left menu on the Provider Information website.

Dental Hygienist and Dental Hygienist with Limited Access Permit (LAP) Services

A billable dental encounter includes services performed by dental hygienists under the supervision of a licensed dentist and by LAP dental hygienists under public health supervision. LAP dental hygienists must ensure compliance in accordance with MCA 37-4-405. LAP dental hygienists must enroll in Montana Healthcare Programs and will use the rendering only provider application when employed by an FQHC or RHC.

Fluoride varnish application only encounters are included in the provider's PPS rate. This service is an incidental to the preventative screening or dental visit and is not billable as a stand-alone visit.

Ambulatory Services

Ambulatory services are services other than core services that would be covered under Montana Healthcare Programs, if provided by an individual or entity other than a clinic in accordance with Medicaid requirements.

Ambulatory services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program (e.g., medical necessity criteria).

Many services require Passport referral, and some services may require prior authorization.

Clinical Pharmacist Practitioner (CPP) Services

A change in scope of services request must be submitted and approved to receive reimbursement for CPP services. Members who have at least one chronic condition needing at least one maintenance medication are eligible for Collaborative Practice Drug Therapy Management. The CPP must be a pharmacist that meets the requirements as outlined in ARM 24.174.526, must be enrolled with Montana Medicaid, and must have a

collaborative practice agreement with the medical practitioner, as provided in ARM 24.174.524.

The legal basis for the Collaborative Practice Drug Therapy Management Program can be found in ARM 37.86.901, ARM 37.86.902, and ARM 37.86.905. The CPP must manage a member's drug therapy by providing face-to-face, direct care.

CPP services must be billed with revenue code 779 and procedure code 99605 or 99606 for each qualifying visit between a CPP and Montana Healthcare Programs member. Services will be reimbursed the PPS rate.

Substance Use Disorder (SUD) Services

A change in scope of service request is required to provide SUD services. Once approved, revenue code 944 should be billed using the following CPT codes:

- 90791
- 90832
- 90834
- 90837
- 90853

The rendering provider may only provide services if it is within their scope of licensure. Services are reimbursed the PPS rate. Refer to the Behavioral Health and Developmental Disabilities (BHDD) Division Program Manual on the BHDD webpage for service requirements.

Diabetes Self-Management Education Support (DSMES)

Eligible providers may be reimbursed for DSMES reimbursement if the service is rendered by a core FQHC or RHC provider, the code is allowed on the OPPS fee schedule, and it meets the definition of a visit. Eligibility requirements for providers and members can be found on the Montana Diabetes Program webpage.

Procedure code G0108 should be billed with Revenue code 942 and will be reimbursed the PPS rate.

Visiting Nurses (42 CFR 405.2416)

Part-time or intermittent nursing care and related medical services other than drugs and biologicals are covered if services meet all of the following:

- The FQHC or RHC is located in a geographic area designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services.
- The services are rendered to a homebound member only.

    - A homebound individual is a person who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long-term care facility.
- A registered nurse, licensed practical nurse, or licensed vocational nurse who is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either established and periodically reviewed (at least every 60 days) by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).
- During a Public Health Emergency (PHE), as defined in 42 CFR 400.200, an area typically served by the RHC, and an area that is included in the FQHC's service area plan, is determined to have a shortage of home health agencies; no request for this determination is required.

Vaccine Reimbursement

The Vaccines for Children (VFC) program makes selected vaccines available at no cost to providers for eligible children 18 years and under.

Vaccines and the administration of vaccines are not covered services in an FQHC or RHC setting and are not separately billable, except for services provided to children enrolled in Healthy Montana Kids (HMK). Vaccinations for Medicaid members are considered an incident to the face-to-face visit with the core provider.

Since HMK-enrolled children are not entitled to the VFC program, FQHC and RHC providers may bill Montana Healthcare Programs for vaccines using revenue code 0636 and the vaccine procedure code. A nurse-only administration visit for an HMK member is reimbursed with revenue code 0771. If the administration was part of a visit with a core provider, the administration will bundle with the revenue code submitted for the face-to-face visit.

HMK vaccine administration codes eligible for reimbursement to an FQHC or RHC are:

- 90471 – Immunization Admin
- 90472 – Immunization Admin Each Additional
- 90473 – Immunization Admin Oral/Nasal
- 90474 – Immunization Admin Oral/Nasal Additional
- 90480 – Covid Vaccine Administration

Nurse only vaccine administration visits are not reimbursable for Montana Medicaid members.

Non-Covered Services

Please refer to ARM 37.85.207 for a list of non-covered services.

Prior Authorization

For more information regarding prior authorization, refer to the Prior Authorization Information webpage or the General Information for Providers Manual found on your provider type page.

A few things to keep in mind:

- Refer to the most recent OPPS fee schedule to reference the code in question. The fee schedule will indicate if the code needs prior authorization.
- The referring provider should initiate all authorization requests.
- When prior authorization is granted, the provider will receive an authorization number that will be required on the claim. The prior authorization number and Passport number are two different numbers.
- For Passport information, refer to the Passport to Health Manual located on the Passport webpage or the FQHC and RHC provider type webpages on the Provider Information website.
- Providers must adhere to all prior authorization requirements to avoid claim denials

Services Reimbursed Outside the PPS Rate

Promising Pregnancy Care Group Education (ARM 37.86.4412, ARM 37.86.4501, ARM 37.86.4502, ARM 37.86.4503)

Promising Pregnancy Care (PPC) Program is a reimbursable group prenatal care program. To become a state-approved PPC program, providers must receive approval from the Department. The program must meet the education requirements of the Department or be licensed through the Centering Healthcare Institute. The obstetric visit will be reimbursed at the PPS rate, and the group educational component will be reimbursed at the OPPS fee schedule rate. The group educational component should be billed with revenue code 969 and the appropriate procedure code. Contact the Perinatal Health Program Officer for more information. Contact information can be found on the State of Montana Directory webpage under the Member Health Management Bureau of the Health Resources Division.

Long-Acting Reversible Contraceptive Devices (LARCs)

LARCs are defined as intrauterine devices and contraceptive implants that are effective as a long-acting reversible birth control.

Reimbursement for LARCs is the lower of submitted charges or the average acquisition cost (AAC) as defined in ARM 37.86.1106.

Claims should be submitted either electronically or on a UB-04 claim form using revenue code 636 with the allowed procedure code. Reimbursement will be made only on those drugs manufactured by companies that have a signed rebate agreement with CMS (ARM 37.85.905). Refer to the Medicaid Drug Rebate Program Data webpage to search for active Medicare Rebate Program drugs. Reminder, procedure code must also be an allowable code on the OPPS fee schedule.

The National Drug Code (NDC) is required on all claims submitted for physician administered drugs. The only exception is 340B providers. These providers must notify Montana Medicaid that they are a 340B provider and an NDC will not be required.

Certified Behavioral Health Peer Support Services

FQHC and RHC providers are eligible to be reimbursed for certified peer support specialist services. See the BHDD Division program manual located on the BHDD Manuals webpage for service requirements.

Certified Behavioral Health Peer Support Specialist services are reimbursed the lower of the provider's billed charges or the OPPS fee schedule rate.

Certified Behavioral Health Peer Support Services should be billed with revenue code 910 and procedure code H0038, and SUD Certified Behavioral Health Peer Support Services should be billed with revenue code 911 and procedure code H0038. Claims must have the supervising provider as the attending provider.

Telehealth Originating Site Fee

The originating site is the physical location of the member receiving services, including a member's home. Enrolled originating site providers should submit claims using Revenue code 780 with procedure code Q3014. This code is for reimbursement related to the use of a room and telecommunication equipment – note that when the member's home is the originating site, no one can bill Q3014. The claim must include the diagnosis provided by the distance provider. Reimbursement is the OPPS fee schedule rate for Q3014. Refer to the Telemedicine chapter of the General Information for Providers Manual for more information on providing telehealth services.

Medicare Claims

The Department's fiscal agent must have the provider's Medicare number on file to process claims, and providers should include their NPI/API on their Medicare claims.

FQHC and RHC claims automatically cross over from Medicare for dually eligible members, so providers do not need to send in their crossovers on paper. RHC claims that

cross over to Medicaid are paid the Medicare coinsurance and deductible less any TPL coverage. FQHC claims that cross over to Medicaid are paid the Medicaid allowed amount less the Medicare payment and any TPL coverage.

Members can be eligible for Qualified Medicare Beneficiary (QMB) Only, or QMB Plus. QMB Plus is dual eligibility, which includes QMB and a Medicaid policy.

- RHC QMB Reimbursement:
  - QMB Only and QMB Plus: Reimbursed for the full Medicare deductible and/or coinsurance.
- FQHC QMB Reimbursement:
  - QMB Only: Reimbursed the Medicare deductible and/or coinsurance
  - QMB Plus: Reimbursed the difference between the Medicare payment and the PPS rate.

When an FQHC or RHC provides services rendered by an LAC or CPP, the Medicare EOB is not required if the rendering provider is enrolled in Montana Healthcare Programs. A Medicare EOB is also not required for Certified Behavioral Health Peer Support Services or SUD Certified Behavioral Health Peer Support Services rendered by an LCPC. Montana Healthcare Programs recognizes these services are not covered by Medicare, so the denial for the Medicare EOB is bypassed.

Third Party Liability

When a member is eligible with Montana Healthcare Programs and another carrier, the other carrier is often referred to as third party liability (TPL). In these cases, the other carrier is typically considered the primary payer, and Medicaid will only reimburse the provider when the TPL payment is less than the Medicaid allowable amount.

For more information regarding TPL, refer to the General Information for Providers Manual posted on your provider type webpage.