School-Based Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

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My Medicaid Provider ID Number:

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When a Client Has TPL (ARM 37.85.407)

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

If a parent determines that billing their insurance would cause a financial hardship (e.g., decrease lifetime coverage or increase premiums), and refuses to let the school bill the insurance plan, the school cannot bill Medicaid for these services based on requirements of IDEA.

If a parent refuses to let the school bill their insurance plan, Medicaid cannot be billed either.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

CSCT services

Procedure H0036 is a Medicaid-only code and other insurances do not recognize it as a valid procedure code. Providers of CSCT services must bill the appropriate CPT-4 code(s) to other payers, as those payers require (i.e. licensed staff may provide an individual therapy to a child in CSCT, bill CPT code that best describes service provided). When billing Medicaid after TPL, submit total charges/units for that date under the H0036 code and enter the amount paid by the other insurance on the claim. Do not bill CSCT services under any other code than H0036 to Medicaid.

Billing for Medicaid covered services when no IEP exists

In order to bill for Medicaid covered services that are not in the client's IEP, the school must meet all the following requirements:

- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

If the school bills private pay clients, then they must bill as follows for the services provided:

Client Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid*	Bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Billing for Medicaid covered services under an IEP

If a child is covered by both Medicaid and private insurance, and the services are provided under an IEP, providers must bill as follows:

Client Insurance Status	Billing Process
Medicaid only*	Bill Medicaid
Private pay, no Medicaid	Not required to bill family
Private insurance/Medicaid*	Bill private insurance before Medicaid
Private insurance, no Medicaid	Not required to bill private insurance

*Note: Under FERPA, schools must have written parental permission for release of information before billing Medicaid. For billing third party insurances, schools must have written permission for billing and written permission for release of information.

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Children's Mental Health Services Plan (CMHSP) eligibility for the same month, Medicaid must be billed before CMHSP.
- When a child is covered under BlueCross BlueShield or CHIP, providers may bill Medicaid first since these insurances do not cover services provided in a school setting.
- Medicaid must be billed before IDEA funds are used.

Requesting an exemption

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

- If another insurance has been billed, and 90 days have passed with no response, include a note with the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

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

When the third party pays or denies a service

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

- Pays the claim, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance EOB when billing Medicaid.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim and submit to Medicaid. If a "blanket" denial is provided, the Department will accept and allow this denial for a period of no more than two years. The school must include a copy of this "blanket" denial with each submission for health-related services for each client. The "blanket" denial must be specific to the provider, client, and health-related services provided to the client. Blanket denials issued to schools without a client's name will not be accepted.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

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

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

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