Those Pesky Claims!

Proper Claim Submission Guidelines
(Paper and Electronic)

Conduent Government Health Service
Presented on behalf of Montana DPHHS

Objectives

- Overview of the electronic claims submissions process and common errors
- Overview of the paper claim process including the CMS-1500 and UB-04 forms and common errors
- Paper Work Attachments
- Adjustment Requests
- Remittance Advice

Electronic Claim Submissions

Electronic Transactions

- EDI = Electronic Data Interchange
- ASC = Accredited Standards Committee is a subcommittee of American National Standards Institute (ANSI)
- X12N = Insurance format for the transfer of sensitive information

X12N became a requirement for insurance transactions with the passage of HIPPA in 1996

How are we receiving the files?

Clearinghouse

- Usually a large business specifically setup to handle mass electronic billing transactions.

Billing Agent

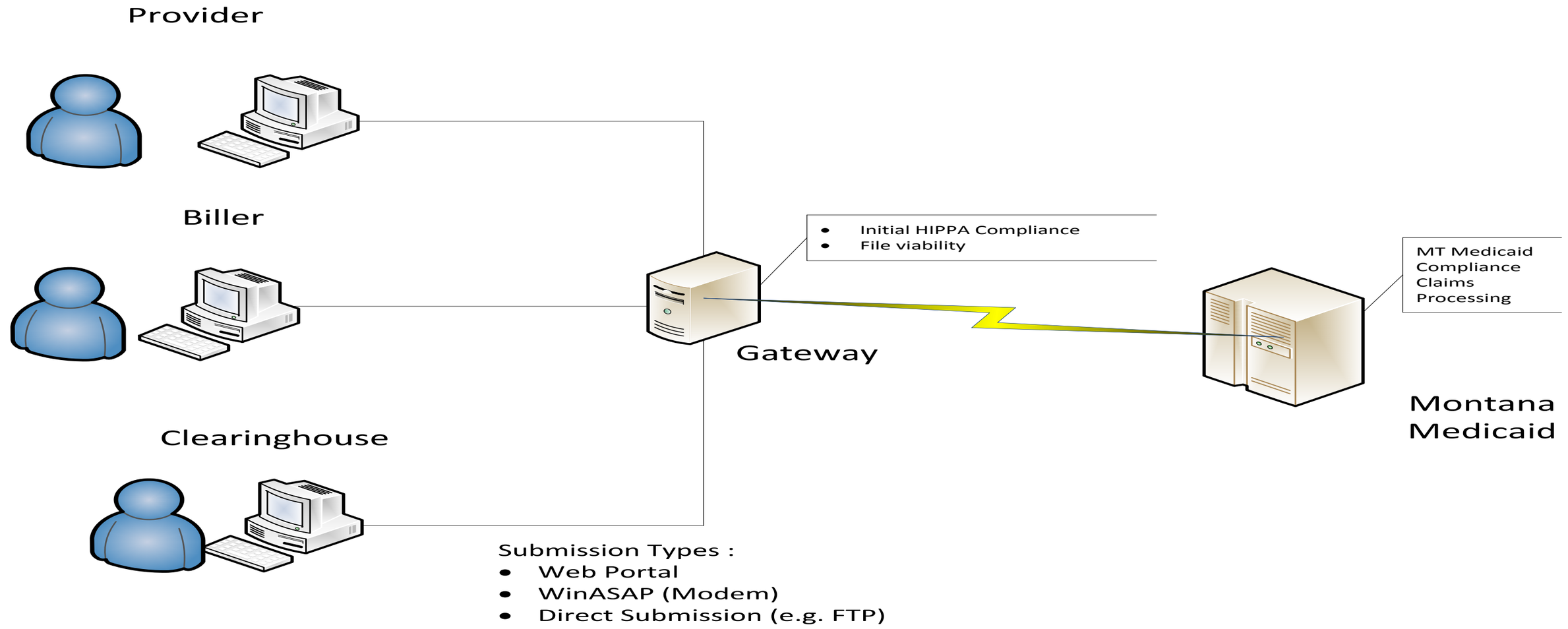
- Individuals who handle the electronic billing directly for providers.

Providers

- Medical provider facilities, most commonly in the form of eligibility or claim verification requests.

Electronic Claims-

Different ways the Claim Files get to us.



Electronic Claims

837 Transactions and the related Paper Claim.

Transaction Type	Related Paper Claim
837P	Professional claim (CMS-1500)
837I	Institutional claim (UB-04)
837D	Dental Claim (ADA 2012)

There is also a crosswalk for the CMS-1500 and 837P on the NUCC website.

Electronic Claims

Transaction Descriptions

Transaction Descriptions	
270/271	Eligibility inquiry
277	Claim status inquiry
277CA	Claim acknowledgement
999	Implementation acknowledgement
835	Electronic Remittance Advice (ERA)

Electronic Submissions

Most common errors

- Provider did not complete the EDI Enrollment (X12N) packet to enable electronic billing. Enrollment with Montana Healthcare Programs does not automatically set you up to bill electronically.
    - If you are using a Clearinghouse this step is already done.
- Missing or invalid taxonomy codes
- Non-matched ZIP +4

Electronic Submissions

Most common errors continued

- Missing Team Number (Schools)
- National Provider Identification (NPI) not enrolled
- Invalid/missing/unenrolled rendering provider
- Clearinghouse not sending Montana specific requirements For example, Electronically the Passport number is sent in the wrong place.

Electronic Submissions

Most common errors- How to fix

- Most important thing is make sure you are sending the most up to date information electronically.
- Make sure you are enrolled for electronic billing.
- If the information is required on paper its required electronically.

Resources for Electronic Billing

- **Electronic Transaction Instructions for HIPPA 5010:**
  - http://medicaidprovider.mt.gov/Portals/68/docs/hipaa5010/electronictransactioninstructionshipaa5010_01132014.pdf
  - A copy of link is on your flash drive.
- **Crosswalk for the CMS-1500 to 837p on the NUCC website.**
  - http://www.nucc.org/images/stories/PDF/1500_claim_form_map_to_837P_v3-2_2012_02.pdf

Paper Claim Submissions

Paper Claims

Paper Claims submitted for payment must be on

- CMS 1500 - For Professional Billing
- UB-04 - For Institutional Billing
- ADA 2012 - For Dental Billing
- MA-3 – Nursing Home

All paper claims must be mailed to:

Claims Processing

P. O. Box 8000

Helena, MT 59604

Please use original forms, not copies

- CMS requirement
- Forms can be purchased from most office supply stores
- Forms can speed up processing time, by allowing automated processes to read them

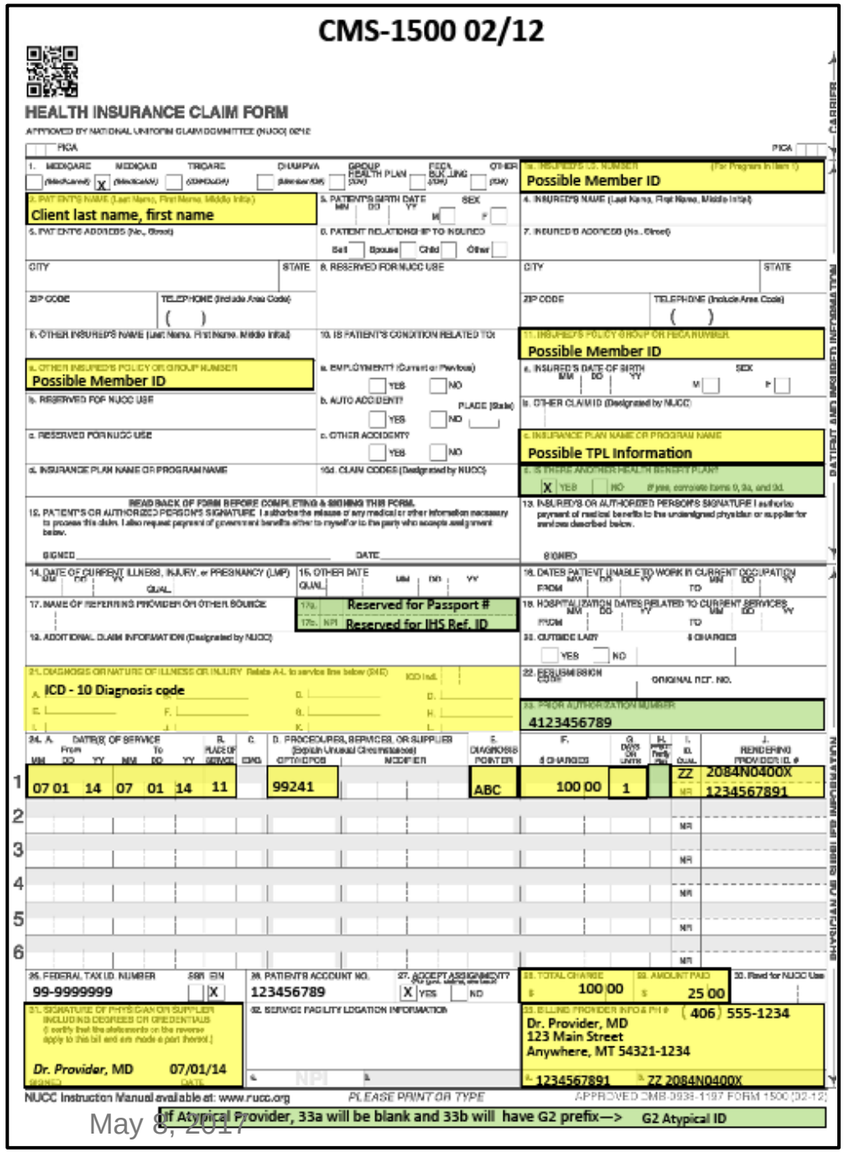
Paper Claims

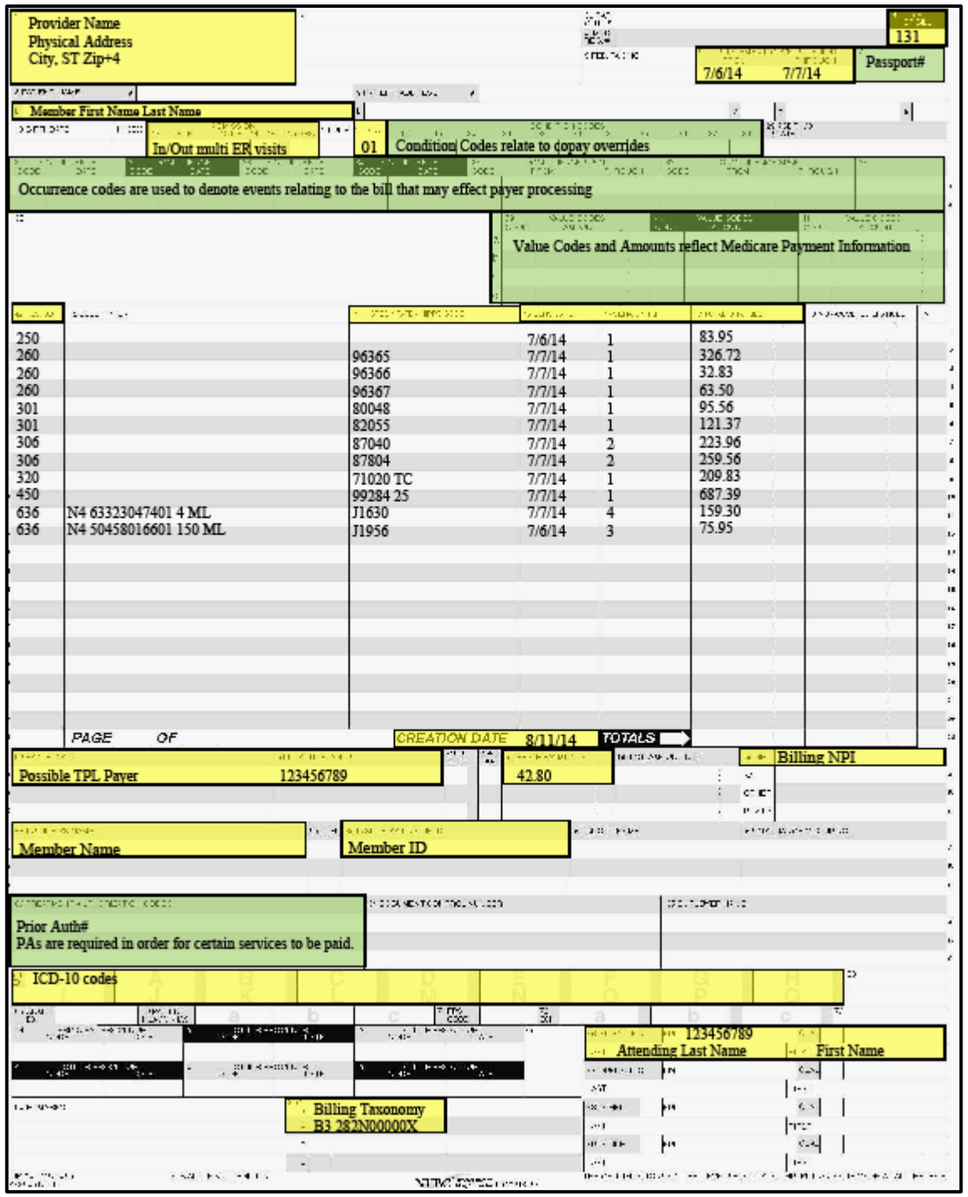
Suggested method for greatest efficiency and minimal delays in processing is electronic submission. Claims submitted electronically are processed an average of 14 days faster than paper claims.

- Paper claims submitted via mail are processed in an average 12 days.
    - Mailing a paper claim can be faster to get paid than paper claims submitted via fax.

FAX is not an Electronic Submission

Required Fields





Specific Field Requirements

Instructions can be found at:

MT specific instructions for the CMS-1500 and the CMS-1450/UB-4

Montana specific information can be found under the forms section of the medicaidprovider.mt.gov.

- Sample forms are detailed information for the individual box/field.

NUCC and NUBC

- The full instructions for the CMS-1500 can be found at.

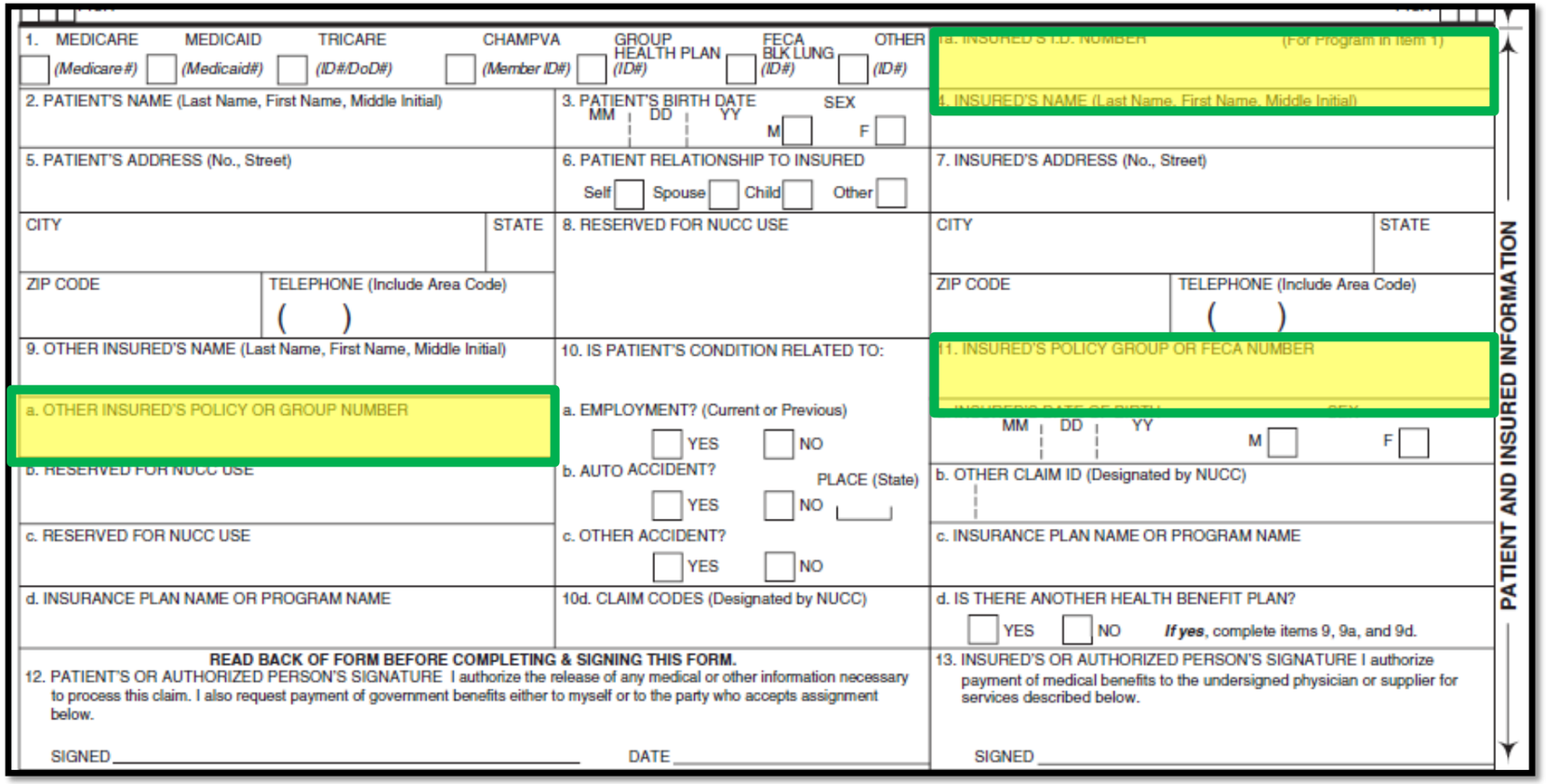
  www.nucc.org

- Information for the UB-04 can be found at.

  www.nubc.org

Specific Field Requirements
CMS-1500

The Medicaid system scans Boxes 1a, 9a, and 11 for the member ID.



Montana Specific Requirements 1500

Box 17 Name of Referring Provider or Other source.

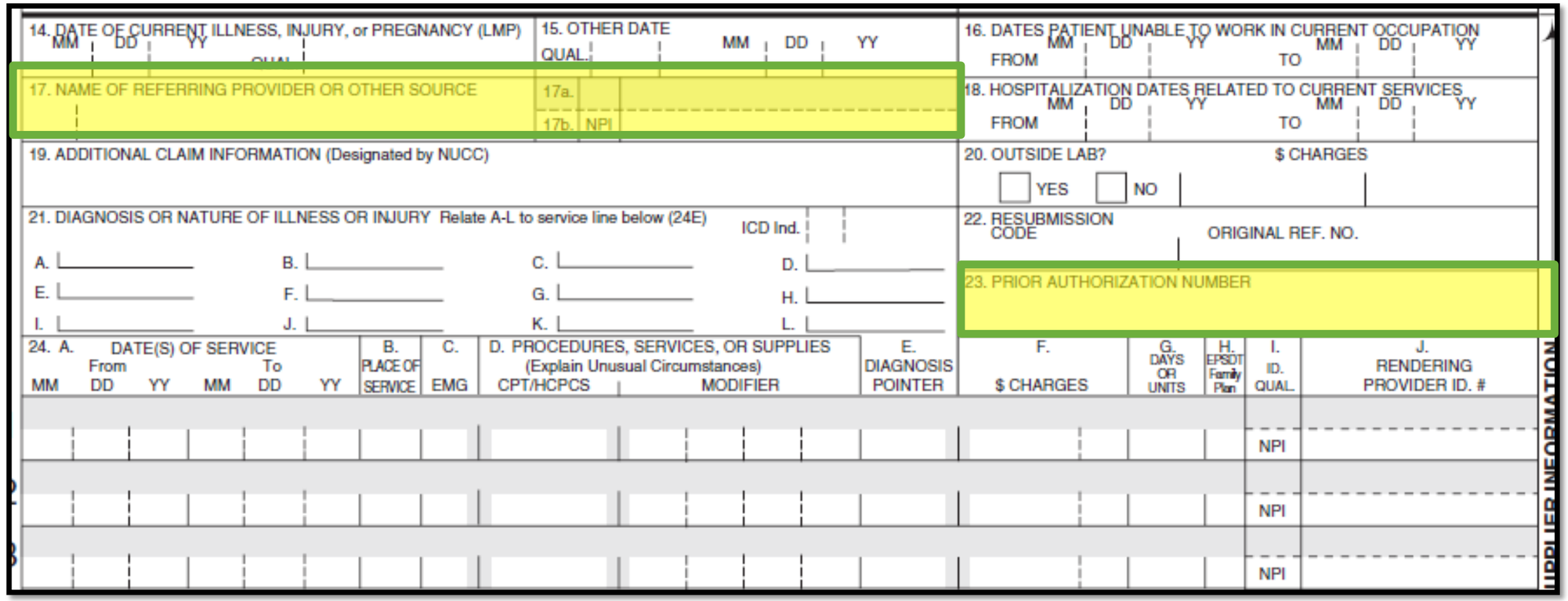
Box 17a Unlabeled

- MT Medicaid reserves this box for Passport referral number

Box 17b NPI and Unlabeled Field

- MT Medicaid reserves this for Indian Health Services Referral Number.

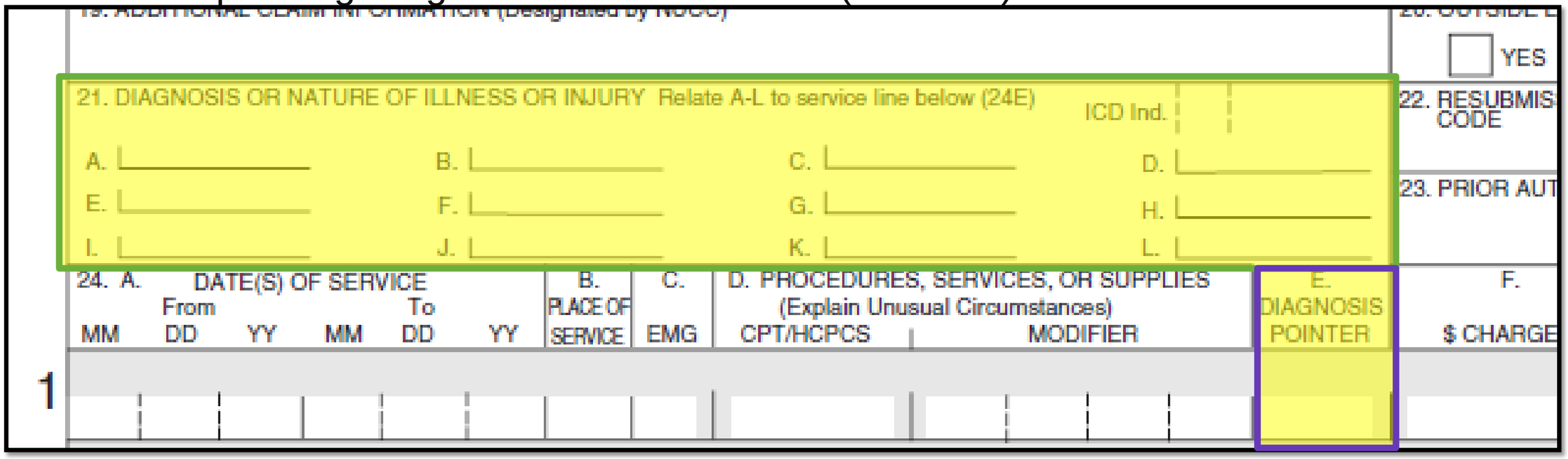
Box 23 Prior Authorization Number.



Montana Specific Requirements 1500

Box 21 Diagnosis or Nature of Illness or Injury

- With the adoption of ICD-10, the state accepts diagnosis codes A- L and the corresponding Diagnosis Pointer of A – L. (Box 24E)



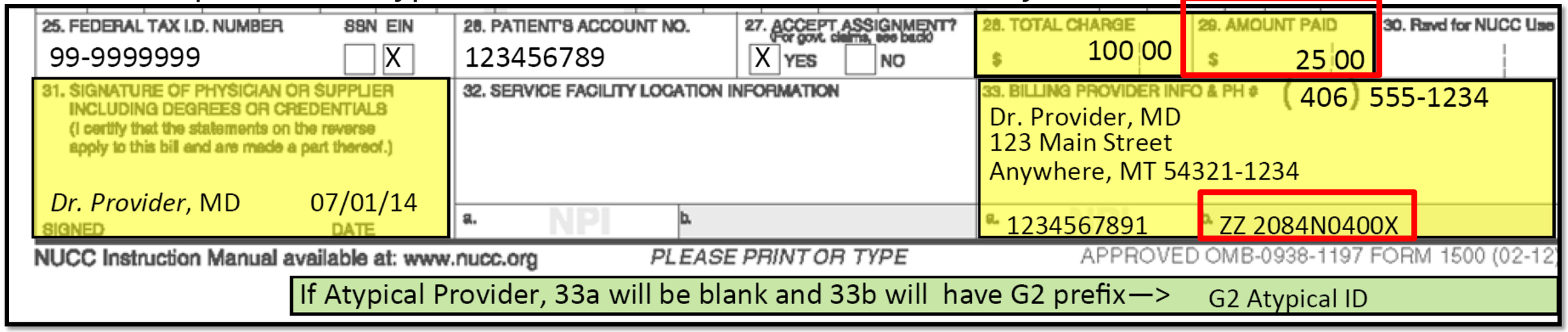
Montana Specific Requirements 1500

Box 29- Amount Paid

- Do NOT include Medicare Payment info here.

Box 33b – Taxonomy

- Must include “ZZ” modifier or the claim will be denied
  If the provider is atypical or waver needs to have “G2” then your ID number



Box 29 additional info

TPL and Medicare for Medicaid are treated different. Box 29 is for 3rd party payments already received.

- If a Member has both Medicare and Medicaid, don't put a yes in Box 11D and/or a dollar amount in Box 29. **LEAVE THEM BLANK**
- If you enter a yes in Box 11D or an amount in Box 29 the system will then see that amount as a payment against this claim and the payment will be reduced

Paper Claims – UB-04

Field 6 -Beginning and ending service dates included on form.
Field 7 -Passport referral number or exempt indicator.
Field 8b -Medicaid Members Name Last, First and Middle Initial
Fields 12-15 –Inpatient: admissions date, hour, type and Source
Field 17 -Patient Status code
Field 42 -Revenue Code
Field 44-47 -HCPCS codes, Service Date, Service Units, Total Charges
Line 23 -Creation Date
Field 50-51 -Medicaid, Health Plan ID
Field 54 -The amount the provider has received toward the payment of this bill
Field 56 -Billing providers NPI number

Field 58 -Insured Name
Field 60 -Members Medicaid Number
Field 63 -Prior Authorization number (if applicable)
Field 66 -Diagnosis codes, ICD-10
Field 76 -Attending NPI, ZZ + Taxonomy code, Last Name and First Name
Field 81 -Pay-to Taxonomy and appropriate Qualifier

Common Billing Errors

Provider's National Provider Identifier (NPI) and/or Taxonomy is missing or invalid	• The provider NPI is a 10-digit number assigned to the provider by the national plan and provider enumerator system. • Verify the correct NPI and Taxonomy are on the claim.
Member ID number not on file, or member was not eligible on date of service	• Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of this manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider referral – No Passport provider number on claim	• A Passport provider number must be on the claim form when a referral is required. Passport approval is different from prior authorization. See the *Passport to Health* provider manual.
Prior authorization does not match current information	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization

Additional common errors can be found in the General Provider Manual and the Top 15 for the month in the *Claim Jumper*

Paperwork Attachments and Electronic Claims

Electronic with Paper Attachments

- Must indicate that Paperwork is being sent in the electronic claim file.
    - Loop 2300, PWK segment
- Must be received by Claims dept. within 30 days of electronic submittal.
    - After 30 days the claim will be denied and will need to be resubmitted w/paper attachments
- Must include Paperwork Attachment Cover Sheet. (Copy Included on flash drive)
    - Can also be found on the website http://medicaidprovider.mt.gov/forms#240933498-forms-p--z
- Must include the Attachment Control Number.

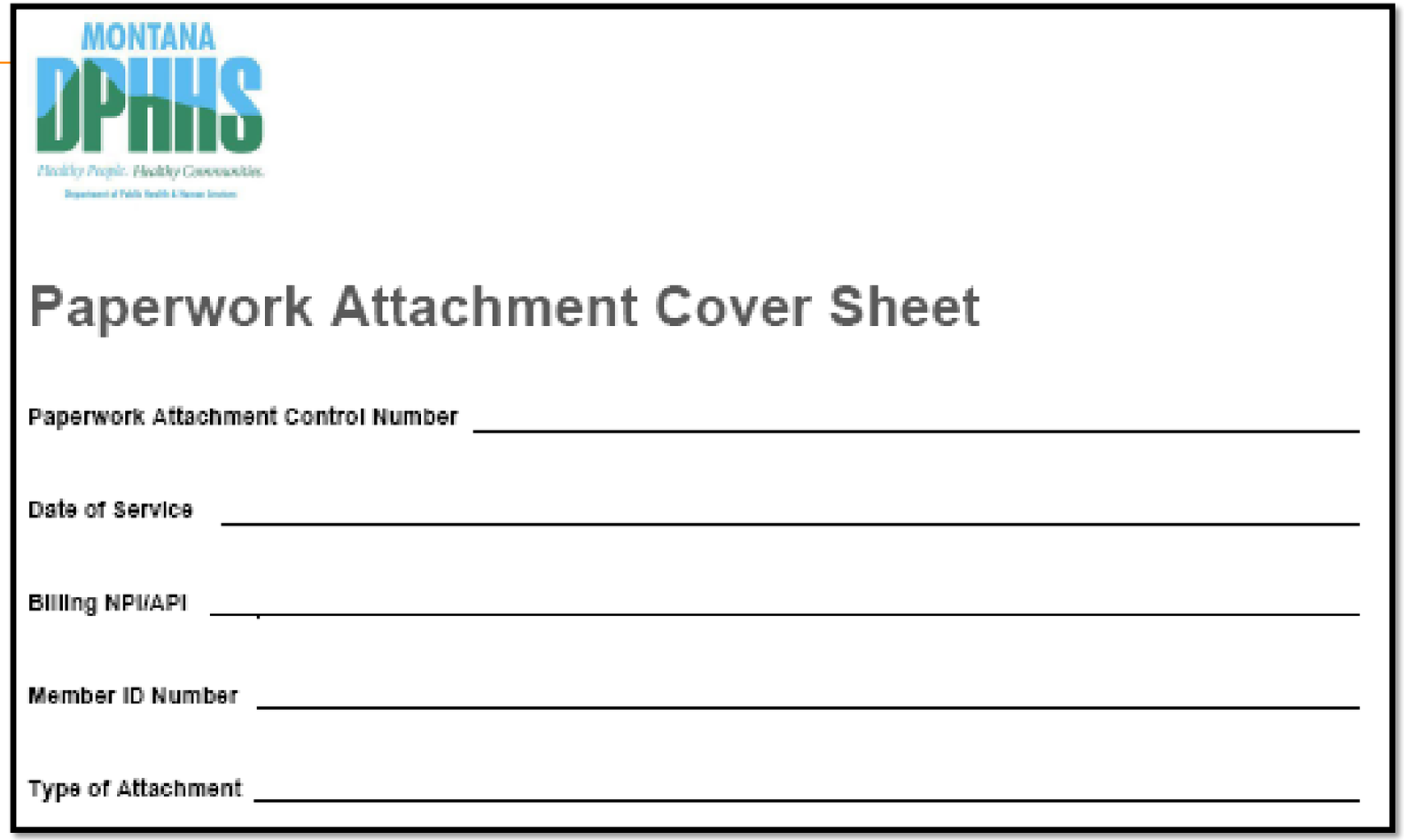
Electronic with Paper Attachments

- **Control Number =**

NPI/API – Members ID# -Date of Service

- **Completed forms should be Mailed or Faxed to:**

P.O. Box 8000
Helena, MT 59604
Fax: 406-442-4402



MONTANA DPHHS

Healthy People. Healthy Communities.

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

Billing NPI/API _____

Member ID Number _____

Type of Attachment _____

Submitting Adjustments

Submitting Adjustments

When should I request an adjustment?

- Claim was overpaid or underpaid.
- Claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- Individual line is denied on a multiple-line UB-04 claim. The denied service must be submitted as an adjustment rather than a rebill.

If there are a lot of corrections to make, you may want the “claim cleared and reprocessed”. This has to be requested and needs to also include the corrected claim.

Adjustment Requirements

- Must be requested on the Individual Adjustment Request Form.
- Only be submitted on paid claims; denied claims cannot be adjusted.
- Always require a remit from the paid claim.
- Claims Processing must receive individual claim adjustments within 12 months from the date of Payment. After this time, gross adjustments are required via DPHHS.

Adjustment Requirements – cont.

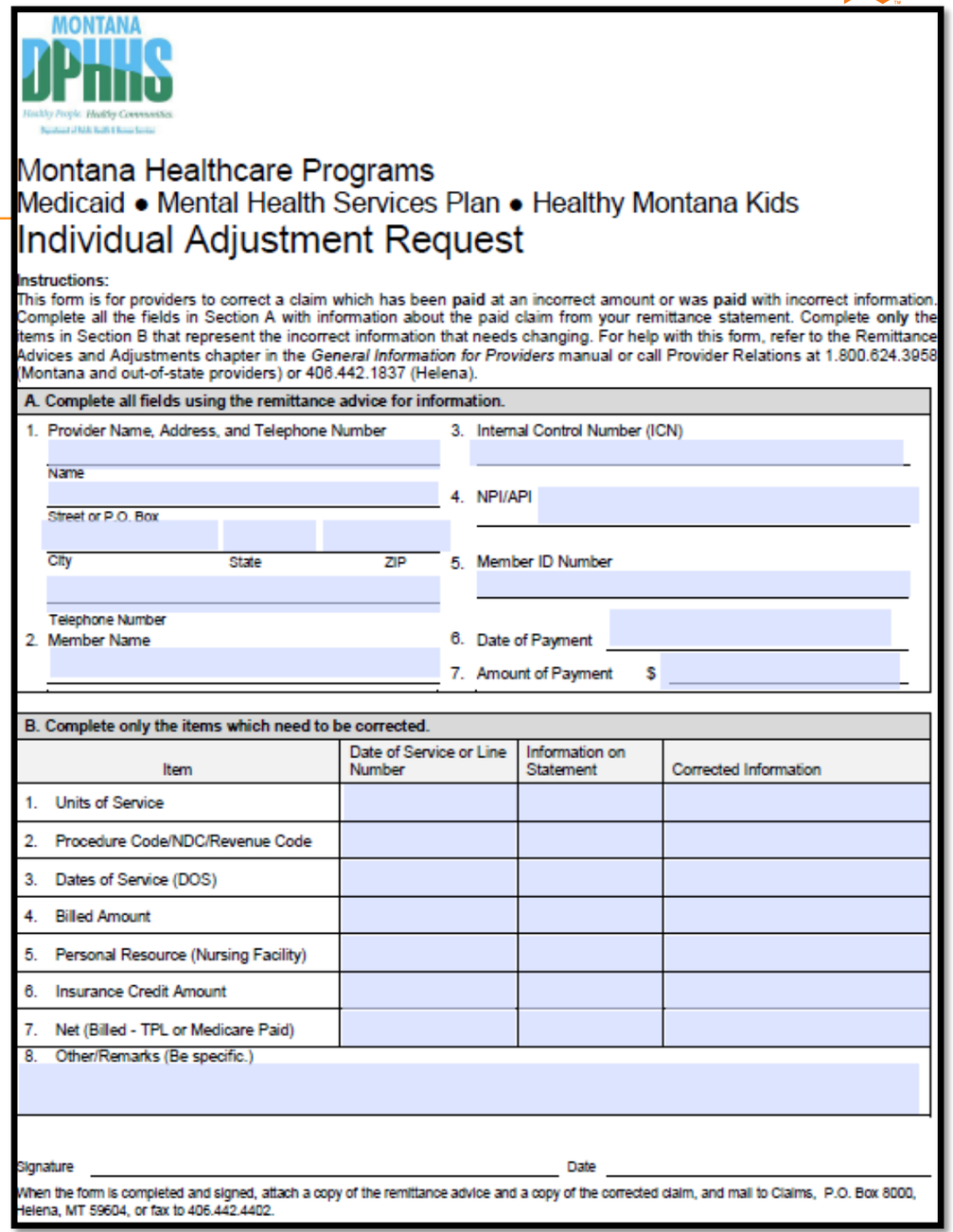
- Separate adjustment request form for each ICN.
- If correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the “Other/Remarks” section.

Adjustment Request Form

One adjustment form per Internal Control Number

Section A – Must be completely filled out

Section B – Only the info that needs changing



MONTANA DPHHS

Montana Healthcare Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your remittance statement. Complete **only** the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in the *General Information for Providers* manual or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice for information.

1. Provider Name, Address, and Telephone Number
   - Name
   - Street or P.O. Box
   - City / State / ZIP
   - Telephone Number
2. Member Name
3. Internal Control Number (ICN)
4. NPI/API
5. Member ID Number
6. Date of Payment
7. Amount of Payment $

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature _____ Date _____

When the form is completed and signed, attach a copy of the remittance advice and a copy of the corrected claim, and mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to 406.442.4402.

Adjustment Request Form - Section A

Completing an Individual Adjustment Request Form – Section A

Field	Description
1. Provider Name and Address	Provider’s name and address (and mailing address if different).
2. Name	The member’s name
3. Internal Control Number (ICN)	There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim.
4. Provider number	The provider’s NPI/API.
5. Member Medicaid Number	Member’s Medicaid ID number.
6. Date of Payment	Date claim was paid.
7. Amount of Payment	The amount of payment from the remittance advice.

Adjustment Request Form - Section B

Completing an Individual Adjustment Request Form – Section B

Field	Description
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
Procedure Code/NDC Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if unsure what caused the payment error, complete this line.

Remittance Advice- e!Sor

- Past 90 days can be found on the MATH Web Portal.
- Information about upcoming events on the first page.
- Sections for paid claims, denied claims, and pending claims.
- Includes any takebacks or credit balance claims
- Includes the Internal Claim Number(ICN).

Who to contact if you have questions.

Provider Relations Contact Information

Provider Relations Call Center:

- (800) 624-3958 or (406) 442-1837
- Monday through Friday
- 8 a.m. - 5 p.m. Mountain Time

Field Representatives:

- Dan Hickey (406) 457-9553
- Jason Armstrong (406) 457-9598