

# Those Pesky Claims!

**Proper Claim Submission Guidelines  
(Paper and Electronic)**

# 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

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- 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

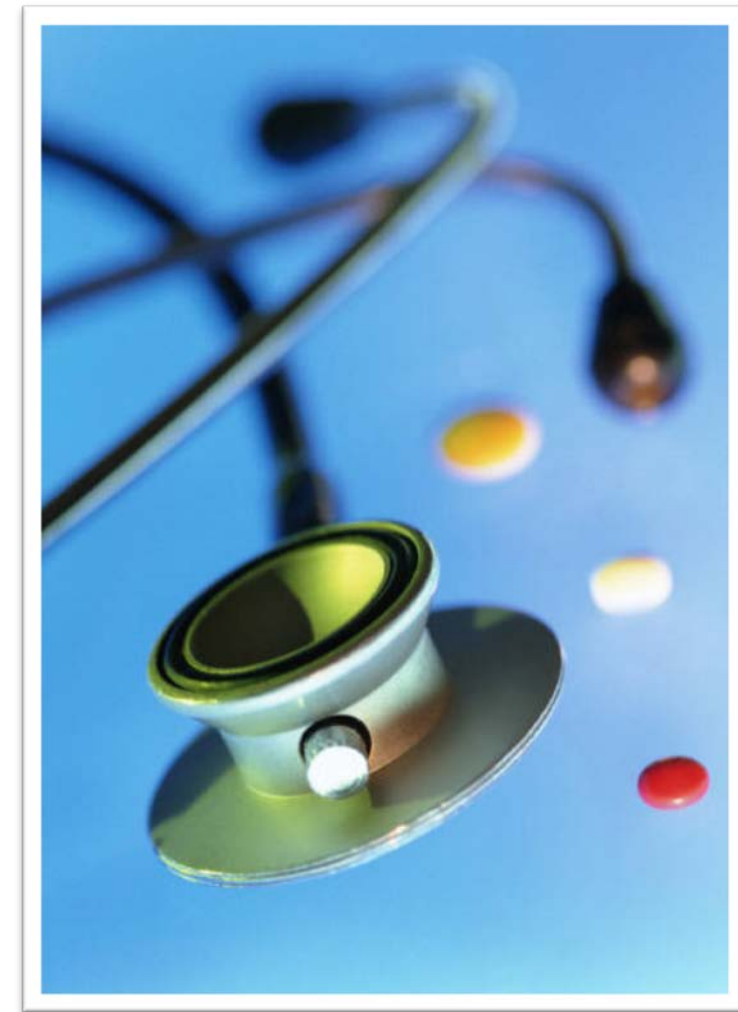
- Usually a large business specifically setup to handle mass electronic billing transactions.

## Billing Agent

- Individuals who handle the electronic billing directly for providers.

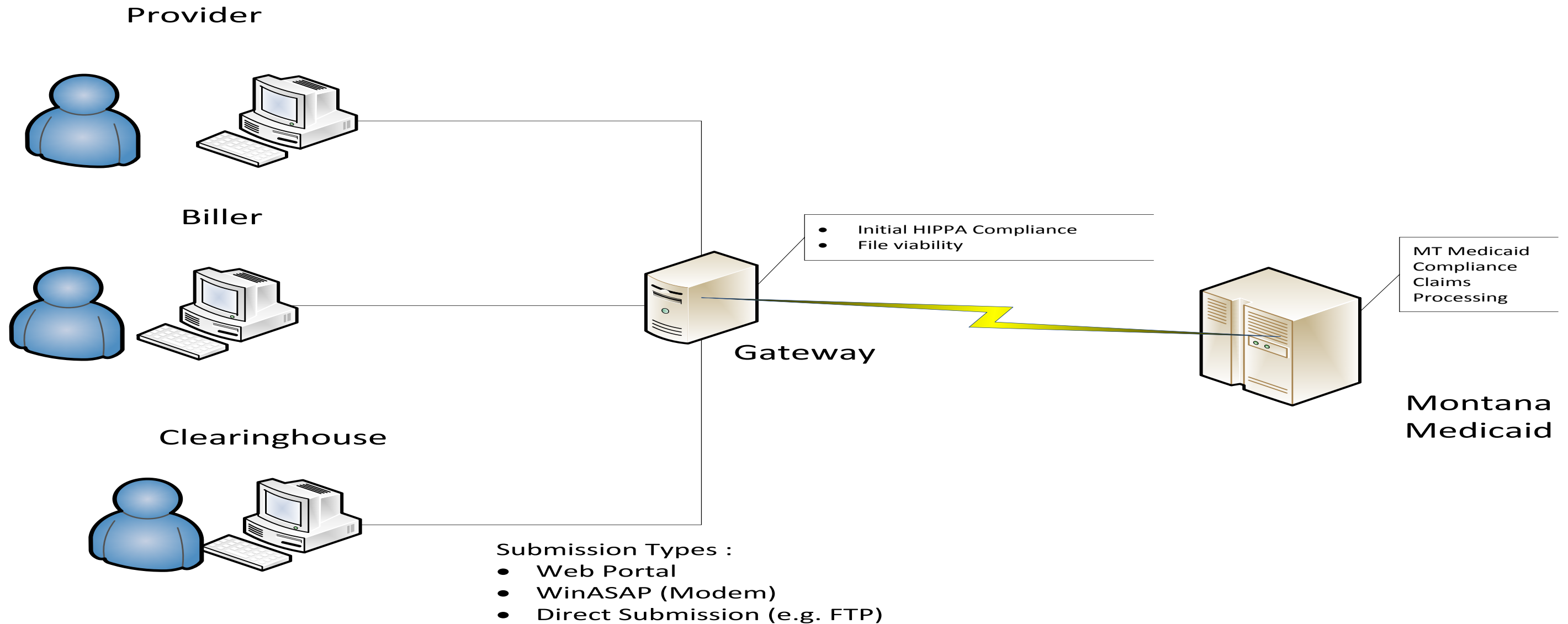
## Providers

- 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.

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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 NUCCC 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

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- 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

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- 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

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- 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 HIPAA 5010:**
  - [http://medicaidprovider.mt.gov/Portals/68/docs/hipaa5010/electronictransactioninstructionshipaa5010\\_01132014.pdf](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](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

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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



**CMS-1500 02/12**

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BOX LING OT-ER  
 (MEDICARE)  (MEDICAID)  (TRICARE)  (CHAMPVA)  (GROUP HEALTH PLAN)  (FECA BOX LING)  (OT-ER)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
**Client last name, first name**

3. PATIENT'S ADDRESS (No. Street)  
 CITY STATE ZIP CODE TELEPHONE (Include Area Code)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)  
**Possible Member ID**

5. INSURED'S ADDRESS (No. Street)  
 CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  
**Possible Member ID**

7. INSURED'S POLICY GROUP OR FECA NUMBER  
**Possible TPL Information**

8. INSURED'S DATE OF BIRTH MM DD YY SEX  
**Possible Member ID**

9. OTHER CLAIM ID (Designated by NUCC)

10. INSURANCE PLAN NAME OR PROGRAM NAME  
**Possible TPL Information**

11. CLAIM CODES (Designated by NUCC)

12. ICD-10 Diagnosis code  
**ICD - 10 Diagnosis code**

13. DATE OF SERVICE FROM TO PLACE OF SERVICE  
**07 01 14 07 01 14 11 99241 ABC 100 00 1 ZZ 2084N0400X 1234567891**

14. FEDERAL TAX ID NUMBER 99-9999999

15. PATIENT'S ACCOUNT NO. 123456789

16. ACCEPT ASSIGNMENT?  YES  NO

17. TOTAL CHARGE \$ 100.00 AMOUNT PAID \$ 25.00

18. BILLING PROVIDER INFO & PII #  
 Dr. Provider, MD  
 123 Main Street  
 Anywhere, MT 54321-1234  
 1234567891 77 2084N0400X

19. SIGNATURE OF PHYSICIAN OR SUPPLIER  
 Dr. Provider, MD 07/01/14

20. SERVICE FACILITY LOCATION INFORMATION

21. BILLING TAXONOMY  
 B3 282N00000X

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED CMB-9839-1197 FORM 1500 (02-12)

Provider Name  
 Physical Address  
 City, ST Zip+4

7/6/14 7/7/14 131 Passport#

Member First Name Last Name  
 In/Out multi ER visits 01 Condition Codes relate to copay overrides

Occurrence codes are used to denote events relating to the bill that may affect payer processing

Value Codes and Amounts reflect Medicare Payment Information

DATE	ICD-10 CODE	QUANTITY	UNIT	UNIT PRICE	TOTAL
7/6/14	96365	1		83.95	
7/7/14	96366	1		326.72	
7/7/14	96367	1		32.83	
7/7/14	96368	1		63.50	
7/7/14	80048	1		95.56	
7/7/14	82055	1		121.37	
7/7/14	87040	2		223.96	
7/7/14	87804	2		259.56	
7/7/14	71020 TC	1		209.83	
7/7/14	99284 25	1		687.39	
7/7/14	J1630	4		159.30	
7/6/14	J1956	3		75.95	

PAGE OF CREATION DATE 8/11/14 TOTALS

Possible TPL Payer 123456789 42.80 Billing NPI

Member Name Member ID

Prior Auth#  
 PAs are required in order for certain services to be paid.

ICD-10 codes

Billing Taxonomy  
 B3 282N00000X

Attending Last Name First Name



# Specific Field Requirements

Instructions can be found at:

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## 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](http://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](http://www.nucc.org)
- Information for the UB-04 can be found at. [www.nubc.org](http://www.nubc.org)

# Specific Field Requirements

## CMS-1500

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

1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BLK LUNG <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID NUMBER (For Program in item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM   DD   YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>		PATIENT AND INSURED INFORMATION
5. PATIENT'S ADDRESS (No., Street)		
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
7. INSURED'S ADDRESS (No., Street)		
CITY _____ STATE _____	8. RESERVED FOR NUCC USE	CITY _____ STATE _____
ZIP CODE _____ TELEPHONE (Include Area Code) ( )	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	11. INSURED'S POLICY GROUP OR FECA NUMBER
9a. OTHER INSURED'S POLICY OR GROUP NUMBER		
10. IS PATIENT'S CONDITION RELATED TO:	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____	DATE _____	SIGNED _____

# 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.**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
				17b. NPI								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.							22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____							23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To											
MM DD YY	MM DD YY											
										NPI		
										NPI		
										NPI		

# 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)

19. ADDITIONAL CLAIM INFORMATION (Designated by NCCC)										20. OUTSIDE BILLING <input type="checkbox"/> YES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE			
A. _____		B. _____			C. _____			D. _____			23. PRIOR AUTHORITY		
E. _____		F. _____			G. _____			H. _____					
I. _____		J. _____			K. _____			L. _____					
24. A. DATE(S) OF SERVICE										E. DIAGNOSIS POINTER		F. \$ CHARGE	
From		To		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER				

# 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

25. FEDERAL TAX I.D. NUMBER 99-9999999	88N EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 123456789	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 100 00	29. AMOUNT PAID \$ 25 00	30. Rcvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  Dr. Provider, MD SIGNED		32. SERVICE FACILITY LOCATION INFORMATION  a. NPI		33. BILLING PROVIDER INFO & PH # (406) 555-1234 Dr. Provider, MD 123 Main Street Anywhere, MT 54321-1234 b.		
07/01/14 DATE				1234567891	ZZ 2084N0400X	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

If Atypical Provider, 33a will be blank and 33b will have G2 prefix—> G2 Atypical ID

# Box 29 additional info

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TPL and Medicare for Medicaid are treated different. Box 29 is for 3<sup>rd</sup> 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

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Field 6	-Beginning and ending service dates included on form.	Field 58	-Insured Name
Field 7	-Passport referral number or exempt indicator.	Field 60	-Members Medicaid Number
Field 8b	-Medicaid Members Name Last, First and Middle Initial	Field 63	-Prior Authorization number (if applicable)
Fields 12-15	-Inpatient: admissions date, hour, type and Source	Field 66	-Diagnosis codes, ICD-10
Field 17	-Patient Status code	Field 76	-Attending NPI, ZZ + Taxonomy code, Last Name and First Name
Field 42	-Revenue Code	Field 81	-Pay-to Taxonomy and appropriate Qualifier
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		

# Common Billing Errors

Provider's National Provider Identifier (NPI) and/or Taxonomy is missing or invalid	<ul style="list-style-type: none"><li>• The provider NPI is a 10-digit number assigned to the provider by the national plan and provider enumerator system.</li><li>• Verify the correct NPI and Taxonomy are on the claim.</li></ul>
Member ID number not on file, or member was not eligible on date of service	<ul style="list-style-type: none"><li>• 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.</li></ul>
Procedure requires Passport provider referral – No Passport provider number on claim	<ul style="list-style-type: none"><li>• A Passport provider number must be on the claim form when a referral is required. Passport approval is different from prior authorization. See the <i>Passport to Health</i> provider manual.</li></ul>
Prior authorization does not match current information	<ul style="list-style-type: none"><li>• 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</li></ul>

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



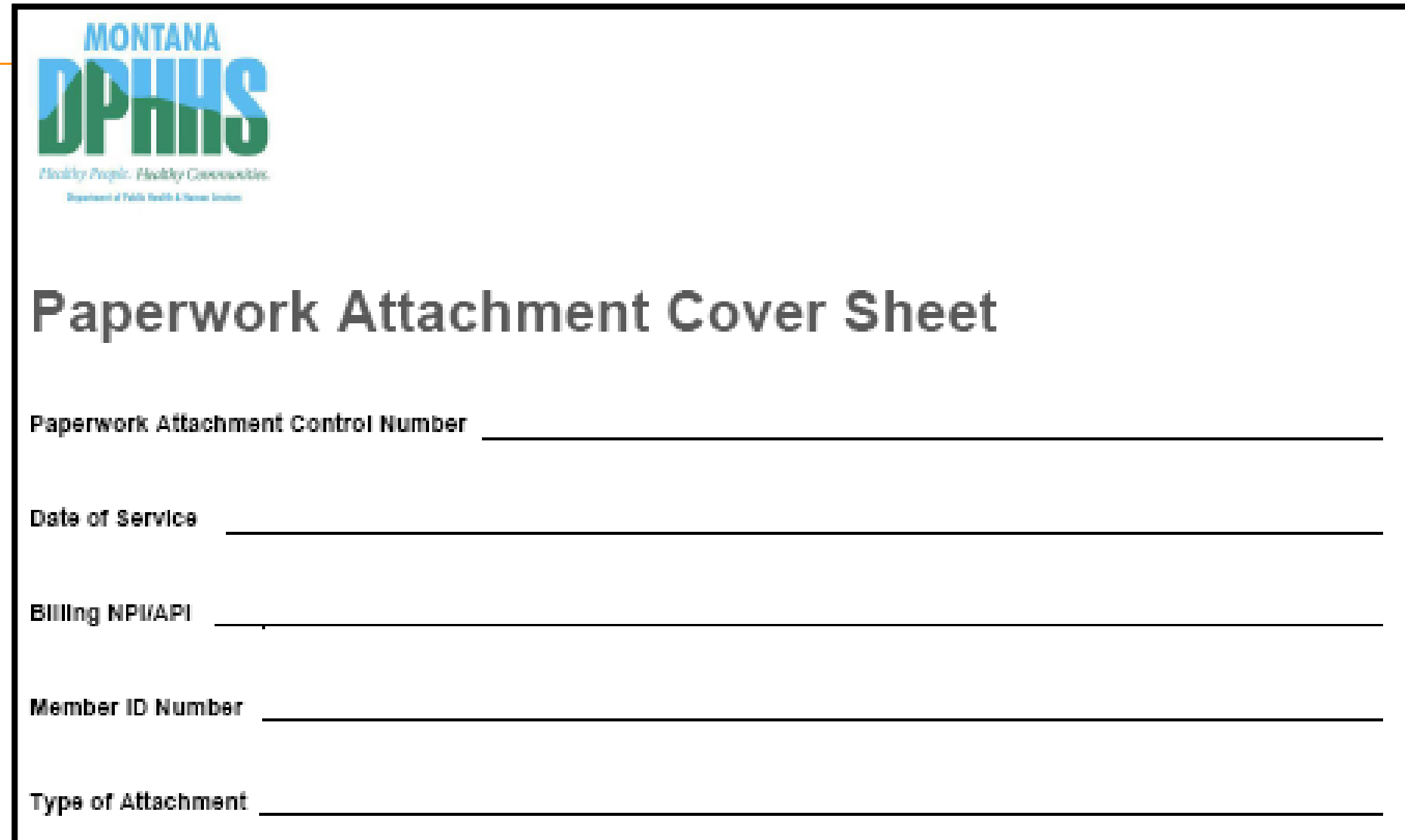
# Electronic with Paper Attachments

- 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.

9999999999	-	8888888888	-	11182015
NPI		Member ID Number		Date of Service

# 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



The form is titled "Paperwork Attachment Cover Sheet" and features the Montana DPHHS logo at the top left. The logo includes the text "MONTANA DPHHS" and the tagline "Healthy People. Healthy Communities." Below the logo, the form contains five fields for data entry, each with a horizontal line for text:

- 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?

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- 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

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- 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.

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- 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 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	3. Internal Control Number (ICN)
Name	
Street or P.O. Box	4. NPI/API
City State ZIP	
Telephone Number	5. Member ID Number
2. Member Name	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

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- 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

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## 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

**CONDUENT**

