

2014 Fall Training

October 2014



CMS-1500

October 2014



CMS-1500 (02/12) Claim Form

As of April 1, 2014, only the CMS-1500 (02/12) version is accepted. If the 08/05 claim form is used after April 1, the claim will be returned to the provider.

If rebilling a claim after April 1, 2014, providers must use the 02/12 version even though the 08/05 version was used to bill the claim.

A sample CMS-1500 (02/12) is on the Forms page; however, claim forms must be ordered from an authorized vendor.

CMS-1500 professional claim form
www.nucc.org

02/12
Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (TRICARE) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA (BULKING) <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		3a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 11. INSURED'S POLICY GROUP OR FECA NUMBER: a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 5, 6a, and 9d.	
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 _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) (MM DD YY) QUAL. _____		15. OTHER DATE (MM DD YY) QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. _____ 17b. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY) (FROM TO) (MM DD YY)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM) (ICD-10)		22. RE-Submission CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE (From To) (MM DD YY MM DD YY) B. PLACE OF SERVICE (EMG) C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OF SERVICE (MM DD YY) H. POLY (Y/N) I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Need for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE



New Form

- Quick Recognition is QR Code in top left.
- Form also indicates approval date of 02/12



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Important Changes to Note

Box 10d Claim Codes

This box is no longer scanned for the member ID.

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 I.D. NUMBER (For Program in Item 1)		
2. PATIENT'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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
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) ()				ZIP CODE		TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY		
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			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>		
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.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
SIGNED _____			DATE _____			SIGNED _____		

Items to Note

- **Box 17 Name of Referring Provider or Other Source.**
 - Montana Medicaid continues to accept for the referring provider's name.
- **Box 17a Unlabeled**
 - Montana Medicaid reserves for Passport to Health referral number.
- **Box 17b NPI and Unlabeled Field**
 - Montana Medicaid reserves 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) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						22. RESUBMISSION CODE ORIGINAL REF. NO.								
						23. PRIOR AUTHORIZATION NUMBER								
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		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. #			
									NPI					
									NPI					
									NPI					

Items to Note

- **Box 21 Diagnosis or Nature of Illness or Injury**
 - Numeric Diagnosis Code Pointers are not allowed (e.g., 1, 2) on the line items; use alpha characters (e.g., A, B)
 - The State will accept only 4 diagnosis codes when processing claims; use Boxes A–D until further notice.
 - Once ICD-10 is implemented, the State will begin accepting diagnosis codes A–L and the corresponding Diagnosis Code Pointers (A–L).

19. ADDITIONAL CLAIM INFORMATION (Designated by HICRY)										20. OUTSIDE L <input type="checkbox"/> YES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMIS- CODE		
A. _____		B. _____			C. _____			D. _____			23. PRIOR AUT	
E. _____		F. _____			G. _____			H. _____				
I. _____		J. _____			K. _____			L. _____				
24. A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.			
From		TO		PLACE OF	(Explain unusual circumstances)				DIAGNOSIS			
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER	POINTER	\$ CHARGE	
1												

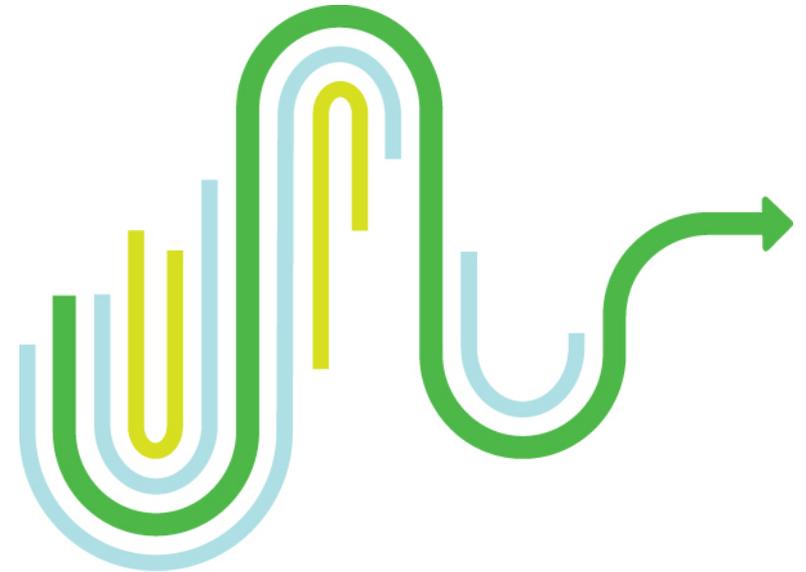
Remittance Advice

October 2014



Ways to Receive Remittance Advice (RAs)

- Web Portal: Download
- 835 Transactions



Remittance Advice

First Page: Important Information

- NEWSLETTER UPDATE -

PROVIDERS ARE REMINDED TO USE THE MEDICAID MEMBER ID NUMBER, NOT THE MEMBER'S SSN, FOR BILLING PURPOSES AND CHECKING ELIGIBILITY TO ENSURE THE EXPENDITURES ARE APPLIED TO THE CORRECT AND ANY QUERY INFORMATION IS FOR THE CORRECT MEMBER. ERRORS CAN OCCUR USING THE SSN FOR EITHER BILLING/REQUESTING ELIGIBILITY INFORMATION. CONTACT PROVIDER RELATIONS AT 1.800.624.3958. (PSTD 01/08/14)

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THE 2014 SPRING PROVIDER FAIR IS BEING HELD MAY 20-21 IN HELENA, MT AT THE GREAT NORTHERN HOTEL. VISIT THE TRAINING PAGE ON THE MONTANA MEDICAID PROVIDER INFORMATION WEBSITE TO REGISTER, VIEW THE AGENDA, AND TO GET UP-TO-DATE INFORMATION ABOUT THE PROVIDER FAIR. (PSTD 03/05/14)

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IMPORTANT: FOR INFORMATION ABOUT MEDICAID AND G-CODES, SEE THE PROVIDER INFORMATION WEBSITE, [HTTP://MEDICAIDPROVIDER.HHS.MT.GOV/](http://MEDICAIDPROVIDER.HHS.MT.GOV/). (PSTD 01/15/14)

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A PROVIDER WHO BILLS MEDICAID FOR SERVICES RENDERED TO AN ELIGIBLE MEDICAID MEMBER WILL BE DEEMED TO HAVE ACCEPTED THE PATIENT AS A MEDICAID MEMBER AND MAY NOT BILL THE MEMBER FOR THE SERVICES. (PSTD 11/26/12)

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AS OF APRIL 1, 2014, THE CMS-1500 (08/05) FORM WILL NO LONGER BE A VALID FORM FOR THE SUBMISSION OF PROFESSIONAL CLAIMS. YOU MUST USE THE CMS-1500 (02/12) CLAIM FORM FOR SUBMISSION OF MEDICAID CLAIMS FOR PAYMENT. CMS-1500 (08/05) CLAIMS ARRIVING AFTER THAT DATE WILL BE RETURNED TO THE PROVIDER. SEE THE APRIL 2014 ISSUE OF THE CLAIM JUMPER FOR MORE INFORMATION ABOUT BILLING WITH THE 02/12 VERSION. FOR INFORMATION ON THE 02/12 VERSION, YOU MAY ALSO VISIT WWW.NUCC.ORG. (PSTD 03/17/14)

Tips

- Grouped by status.
- ICN located under member's name
- Do not resubmit a claim in PENDED (133) status.
- Work all denial reasons before resubmitting.
- Always contact Provider Relations if you have questions.

Remittance Advice

AS OF 08/08/2013

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

THE CLINIC
123 MAIN STREET
ANYWHERE, MT 59999

VENDOR # REMIT ADVICE # 228928 EFT/CHK # DATE 08/12/2013 PAGE 2

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	CO-PAID ALLOWED	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM								
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	1878.90	
	PATIENT NUMBER=							
CLAIM TOTAL**						1878.90	1878.90	
PAID CLAIM TOTALS - MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1	1878.90	1878.90		
CLAIMS PENDING: MISCELLANEOUS CLAIM								
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	0.00	133
	PATIENT NUMBER=							
CLAIMS PENDING TOTALS -MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1	1878.90	0.00		
TOTAL WARRANT AMOUNT							1878.90	

Reason and Remark Codes

HOpR: Standardized codes.

See R&R EOB Crosswalk for further explanation.

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE *****

- B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
- B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
- B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.
- M57 MISSING/INCOMPLETE/INVALID PROVIDER IDENTIFIER.
- M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.
- M77 MISSING/INCOMPLETE/INVALID PLACE OF SERVICE.
- M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
- N30 PATIENT INELIGIBLE FOR THIS SERVICE.
- 125 PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
- 22 PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
- 29 THE TIME LIMIT FOR FILING HAS EXPIRED.
- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

Gross Adjustment

Listed as:

- Paid claims – Gross Adjustment
- History only – Gross Adjustment

Lists provider, facility, or member for which the adjustment belongs.

PAID CLAIMS - GROSS ADJUSTMENT				
ICN 00000000000000000000	08062004 03302005	0.000	346.42-	346.42-
	MOVE CREDIT BALANCE FROM 12345			
ICN 00000000000000000000	11142007 11142007	0.000	45.74-	45.74-
	MOVE CREDIT BALANCE FROM 54321			
ICN 00000000000000000000	11142007 11142007	0.000	30.15-	30.15-
	MOVE CREDIT BALANCE FROM 11111			

Credit Balance

- Under member ID, the status of the claim is listed.
- Do not post a credit balance.
- The Internal Control Number (ICN) of a credit balance does not change.

```
CREDIT-BALANCE-CLAIMS - GROSS ADJUSTMENT
                                07122007 07242007      0.000      8.40-      8.40-
ICN 00000000000000000000
TEAM NUMBER 02
                                MOVE CREDIT BALANCE FROM 123456
**CR BAL CLAIM TOTALS - GROSS ADJUSTMENT      **NUMBER OF CLAIMS- 1**      8.40-      8.40-
```

Adjustment Requests

October 2014



MONTANA DPHHS Public Health and Human Services
Healthy People. Healthy Communities.

Welcome to the Montana Department of Public Health and Human Services
Richard H. Opper, Director

DPHHS Home About Us Contact Us News & Events

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Electronic Billing
Electronic Health Records
Incentives
Emergency Services
Enhanced Payment
FAOs
Forms
Health Improvement Program
ICD-10 Information
Medicaid Fraud and Abuse
Medicaid Information
National Provider Identifier
Nurse First

You must use Medicaid claim after that date

See the April 2013 billing with the new rules. You may also visit [www.mtmedicaid.org](#)

2014 Spring Meeting
Plan to attend the meeting on May 20-21, 2014 in Helena, MT.

For information on the meeting, visit [www.mtmedicaid.org](#)

Retroactive Effective January 1, 2014

Forms

Forms are listed alphabetically by form name.

A - C	D - F	G - K	L - O	P - Q	R - Z
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Forms A-C (09/2013)

[Abortion Form \(09/2013\)](#)

[Address Correction Form \(03/2013\)](#)

Physical address change must be accompanied by a completed W-9 form.

[Adjustment Request Form \(03/2013\)](#)

[Ambulance Trip Log \(01/2008\)](#)

[Attachment Cover Sheet for Paperwork \(03/2013\)](#)

[Authorization for Health Disclosure \(03/2003\)](#)

[Blanket Denial Request for TPL \(07/2012\)](#)

Adjustment Request Form

- ✓ Complete all required sections.
- ✓ Make sure the information is legible.
- ✓ Double-check that your adjustments are correct.
- ✓ Attach a copy of the remittance advice with Reason and Remark Codes.
- ✓ Do not adjust a denied claim.

Montana Health Care 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 statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advice and Adjustments chapter in your program manual or 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 (RA) for information.

1. Provider Name and Address Name _____ Street or P.O. Box _____ City _____ State _____ ZIP _____	3. Internal Control Number (ICN) _____
2. Member Name _____	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 complete, attach a copy of the RA and a copy of the corrected claim, and mail to:
Claims
P.O. Box 8000
Helena, MT 59604

Section A



Montana Health Care 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 statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or 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 (RA) for information.	
1. Provider Name and Address The Clinic Name	3. Internal Control Number (ICN) 214010001200000
123 Main Street Street or P.O. Box	4. NPI/API 1234567891
Anywhere MT 59991 City State ZIP	5. Member ID Number 1133111
2. Member Name John Doe	6. Date of Payment 01/01/2013
	7. Amount of Payment \$ 558.86



Section B

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	Line 3	4	2
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 John R. Smith, M.D. Date 02/02/2014

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims
P.O. Box 8000
Helena, MT 59604



Updated 03/2013



Remittance Advice

Must Be Attached to Request

AS OF 08/08/2013

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

THE CLINIC
123 MAIN STREET
ANYWHERE, MT 59999

VENDOR # 0000121754 REMIT ADVICE # 228928 EFT/CHK # DATE 08/12/2013 PAGE 2

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM									
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	1878.90		
	PATIENT NUMBER=								
CLAIM TOTAL**						1878.90	1878.90		
PAID CLAIM TOTALS - MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	1878.90		
CLAIMS PENDING: MISCELLANEOUS CLAIM									
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	0.00		133
	PATIENT NUMBER=								
CLAIMS PENDING TOTALS -MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1		1878.90	0.00		
TOTAL WARRANT AMOUNT							1878.90		

Reason and Remark Codes

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- M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
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Electronic Billing

October 2014



Website Electronic Billing Page

www.mtmedicaid.org

5010 HIPAA Information
Claim Instructions
Claim Jumper Newsletter
Contact Us
Definitions and Acronyms
Early and Periodic Screening,
Diagnosis and Treatment
Electronic Billing
Electronic Health Records
Incentives
Emergency Services
Enhanced Payment
FAQs
Forms
Health Improvement Program
ICD-10 Information

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Montana Medicaid

**New or Existing
Provider Enrollment**

**Log in to Montana
Access to Health**

Member Information Provider Information

5010 HIPAA Information
Claim Instructions
Claim Jumper Newsletter
Contact Us
Definitions and Acronyms
Early and Periodic Screening,
Diagnosis and Treatment
Electronic Billing

Electronic Billing

Electronic Billing

Whether you submit one claim a month, or hundreds, any provider can benefit from switching from paper to electronic billing. Whether by using the free WINASAP5010 software or by using a clearinghouse to submit claims, electronic billing is faster, more accurate, and more secure.

Electronic claims can be processed for payment in as little as a week versus 3 to 4 weeks to process a paper claim. You need a personal computer with Windows 98 and above and a standard phone line to submit electronically via WINASAP5010.

See Electronic Submission Setup below to begin the process. For information about HIPAA 5010, [click here](#).

Electronic Submission Setup

Follow the steps below to submit your Medicaid claims electronically.

EDI Transaction Descriptions

- ✓ 270 / 271 – Eligibility inquiry
- ✓ 277 – Claim status inquiry
- ✓ 277CA – Claim acknowledgment
- ✓ 999 – Implementation acknowledgment
 - Contains accept or reject information
- ✓ 835 – Electronic Remittance Advice (ERA)

EDI Transactions – 837

- ✓ See the Electronic Transaction Instructions for HIPAA 5010 on the website: www.mtmedicaid.org
 - 837P – Professional claim (CMS-1500)
 - 837I – Institutional claim (UB-04)
 - 837D – Dental claim (ADA)

5010 HIPAA Information

www.mtmedicaid.org

5010 HIPAA Information
Claim Instructions
Claim Jumper Newsletter
Contact Us
Definitions and Acronyms
Early and Periodic Screening,
Diagnosis and Treatment
Electronic Billing
Electronic Health Records
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Montana Medicaid

New or Existing Provider Enrollment

Log in to Montana Access to Health

Member Information

Provider Information

5010 HIPAA Information
Claim Instructions
Claim Jumper Newsletter
Contact Us
Definitions and Acronyms
Early and Periodic Screening,
Diagnosis and Treatment
Electronic Billing
Electronic Health Records
Incentives
Emergency Services

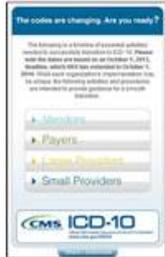
HIPAA 5010

Announcements

Meeting Timelines for ICD-10 and HIPAA 5010

For detailed timelines of activities that providers, payers, and vendors need to undertake to prepare for Version 5010 and ICD-10, download the [timeline widget](#) to your desktop or mobile device.

Printer-friendly versions of the Version 5010 and ICD-10 widget compliance timelines are available for [large providers](#), [small providers](#), [payers](#) and [vendor](#).



The widget and timelines are public domain. CMS encourages organizations to distribute them widely through posting to websites and other channels.

Frequently Asked Questions (11/07/2011)

11/07/2011 [HIPAA 5010 FAQs](#)

837P – General Montana Submission Rules

- ✓ To indicate Prior Authorization, use 'G1' in Loop 2300, REF01 at the header.
- ✓ To indicate a Passport Referral Number, use '9F' in Loop 2300, REF01 at the header.
- ✓ If the billing provider is an atypical provider, the 10-digit Montana Provider ID must be submitted in Loop 2010BB, segment REF with qualifier G2 Provider Commercial Number.

837 – Montana Specific Submission Rules

- ✓ Montana processes 4 diagnoses only.
- ✓ See the Electronic Transaction Instructions for HIPAA 5010 on the website(www.mtmedicaid.org) for details regarding:
 - Comprehensive School and Community Treatment
 - Indian Health Service (IHS) (CSR 6440 was implemented and now does an automatic co-pay override if the race is Native American)
 - Pregnancy
 - Family Planning

837 – Paperwork Attachment Requirements

- ✓ Use Loop 2300, PWK segment to indicate paperwork is being sent.
- ✓ Use the Paperwork Attachment Cover Sheet located on the Forms page of the website (www.mtmedicaid.org).
- ✓ Detailed instructions are included on the Paperwork Attachment Cover Sheet.
- ✓ The claim will pend for 30 days awaiting receipt of the paperwork.

Common Errors and Rejections

- ✓ Missing or invalid taxonomy code
- ✓ Non-matched ZIP + 4
- ✓ Missing Team Number
- ✓ National Provider Identification (NPI) not enrolled
- ✓ Rendering provider
- ✓ Clearinghouse not sending Montana specific requirements

WINASAP 5010

- ✓ Free software offered by Xerox
 - Submission to Montana Health Care Programs only
 - Requires EDI enrollment.
 - Requires basic Web navigation and computer skills.
 - Detailed instruction manual available on the Electronic Billing page.
 - WebEx presentation posted on Training page
 - Support is limited. Troubleshooting for modem, computer hardware, and software is not offered.



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