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

• 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.

Submission Types:
- Web Portal
- WinASAP (Modem)
- Direct Submission (e.g. FTP)

Provider

Biller

Clearinghouse

Gateway

MT Medicaid

Compliance Claims Processing

• Initial HIPPA Compliance
• File viability
Electronic Claims

837 Transactions and the related Paper Claim.

<table>
<thead>
<tr>
<th>Transaction Type</th>
<th>Related Paper Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>837P</td>
<td>Professional claim (CMS-1500)</td>
</tr>
<tr>
<td>837I</td>
<td>Institutional claim (UB-04)</td>
</tr>
<tr>
<td>837D</td>
<td>Dental Claim (ADA 2012)</td>
</tr>
</tbody>
</table>

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

## Transaction Descriptions

<table>
<thead>
<tr>
<th>Transaction Descriptions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>270/271</td>
<td>Eligibility inquiry</td>
</tr>
<tr>
<td>277</td>
<td>Claim status inquiry</td>
</tr>
<tr>
<td>277CA</td>
<td>Claim acknowledgement</td>
</tr>
<tr>
<td>999</td>
<td>Implementation acknowledgement</td>
</tr>
<tr>
<td>835</td>
<td>Electronic Remittance Advice (ERA)</td>
</tr>
</tbody>
</table>
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 it's required electronically.
Resources for Electronic Billing

• Electronic Transaction Instructions for HIPPA 5010:
  • A copy of link is on your flash drive.

• Crosswalk for the CMS-1500 to 837p on the NUCC website.
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

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

All paper claims must be mailed to:
Claims Processing
P. O. Box 8000
Helena, MT 59604
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

- 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

Montana specific information can be found under the forms section of the medicaidprovider.mt.gov.
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.
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 waiver needs to have “G2” then your ID number

Dr. Provider, MD          07/01/14

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

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Additional Information</th>
</tr>
</thead>
</table>
| 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.

| 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
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
## Adjustment Request Form - Section A

### Completing an Individual Adjustment Request Form – Section A

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provider Name and Address</td>
<td>Provider’s name and address (and mailing address if different).</td>
</tr>
<tr>
<td>2. Name</td>
<td>The member’s name</td>
</tr>
<tr>
<td>3. Internal Control Number (ICN)</td>
<td>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.</td>
</tr>
<tr>
<td>4. Provider number</td>
<td>The provider’s NPI/API.</td>
</tr>
<tr>
<td>5. Member Medicaid Number</td>
<td>Member’s Medicaid ID number.</td>
</tr>
<tr>
<td>6. Date of Payment</td>
<td>Date claim was paid.</td>
</tr>
<tr>
<td>7. Amount of Payment</td>
<td>The amount of payment from the remittance advice.</td>
</tr>
</tbody>
</table>
Adjustment Request Form - Section B

### Completing an Individual Adjustment Request Form – Section B

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