

# Claims Basics

Proper Claim Submission Guidelines (Paper and Electronic)

**Presented by Dan Hickey – Field Representative**

# Objectives

- 
- Review paper claim submissions process for CMS 1500 and UB-04 forms and common errors
  - Review electronic claims submissions process and common errors
  - Review Paper Work Attachments and requirements
  - Review Individual Adjustment Requests and requirements
  - Review Remittance Advice/835 and importance of this

# 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

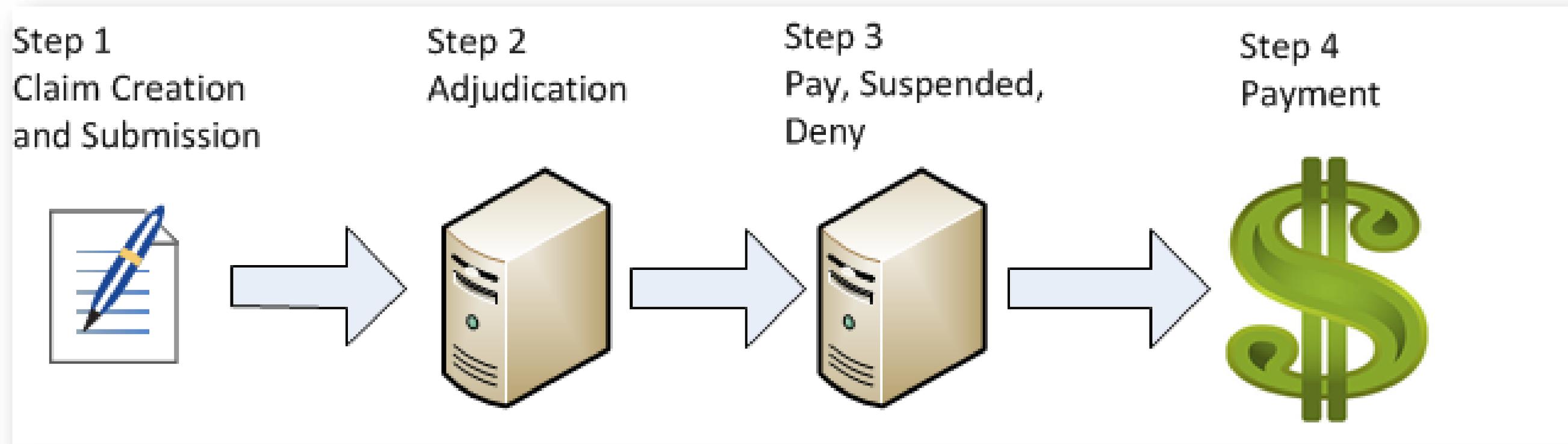
## **Please use original forms not copies.**

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

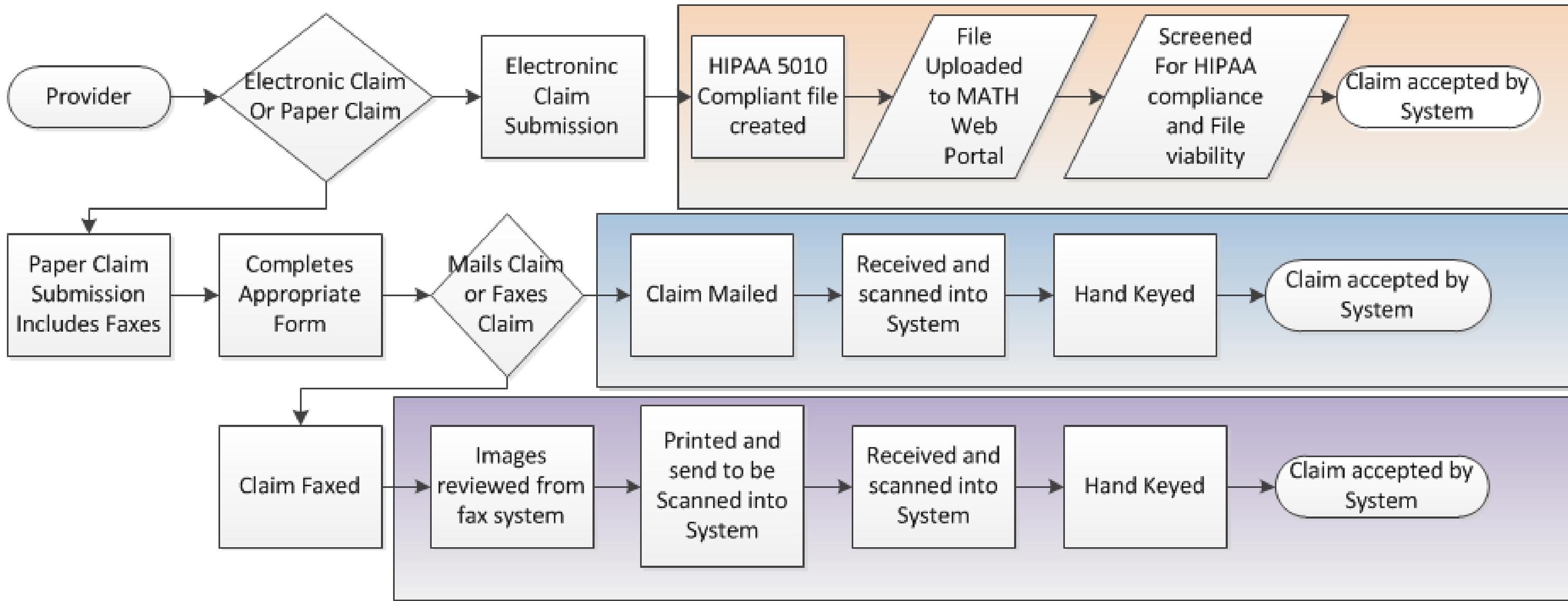
# Codes Used Are Important

- Providers are responsible for ensuring that coding is accurate, complete, and defensible.
- In general, Medicaid and fiscal agent staff should not recommend that Providers use specific codes in specific situations.
- At the national level, more and more guidance on how to code for services is available to Providers.

# Claim Submission Process



# Claim Submission Path





# Specific Field Requirements

Instructions can be found at:

---

## MT specific instructions for the CMS-1500 and the CMS-1450/UB-04

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"/>		7. INSURED'S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) ( )
5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) ( )		
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)
b. RESERVED FOR NUCC USE		
c. RESERVED FOR NUCC USE		
d. INSURANCE PLAN NAME OR PROGRAM NAME		
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 _____		b. OTHER CLAIM ID (Designated by NUCC) _____ c. INSURANCE PLAN NAME OR PROGRAM NAME _____ d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, complete items 9, 9a, and 9d.</i> 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 _____

# 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)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
From	To			CPT/HCPCS	MODIFIER							
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 NBOC)										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								
MM	DD	YY	MM	DD	YY	PLACE OF SERVICE	EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					
								CPT/HCPCS	MODIFIER				
1													

# 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

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. Rsvd 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 a. 1234567891		
07/01/14 DATE		b.		p. 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

---

TPL and Medicare for Medicaid are treated differently.

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

Box 4, 18- 28, 31-37, and 39-41. Have to be found from outside resources.

Passport goes in Box 7

1 Provider Name Physical Address City, ST Zip+4		2		3a PAT. CNTL.# b MED. REC.#		4 TYPE OF BILL 131	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 7/6/14 THROUGH: 7/7/14	
8 PATIENT NAME a		9 PATIENT ADDRESS a		b		c	
b Member First Name Last Name		c		d		e	
10 BIRTHDATE	11 SEX	12 DATE ADMISSION 13 HR 14 TYPE 15 SRC		16 DHR	17 STAT	18-28 CONDITION CODES	
		In/Out multi ER visits			01	Condition Codes relate to copay overrides	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE CODE DATE		36 OCCURRENCE CODE DATE		37		38	
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42	
a		b		c		d	
Value Codes and Amounts reflect Medicare Payment Information							



# Paper Claims – UB-04

Revenue codes go in Field 42, if the revenue code requires an NDC code the information needs to be in Field 43.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250			7/6/14	1	83.95		
260		96365	7/7/14	1	326.72		
260		96366	7/7/14	1	32.83		
260		96367	7/7/14	1	63.50		
301		80048	7/7/14	1	95.56		
301		82055	7/7/14	1	121.37		
306		87040	7/7/14	2	223.96		
306		87804	7/7/14	2	259.56		
320		71020 TC	7/7/14	1	209.83		
450		99284 25	7/7/14	1	687.39		
636	N4 63323047401 4 ML	J1630	7/7/14	4	159.30		
636	N4 50458016601 150 ML	J1956	7/6/14	3	75.95		

# Paper Claims – UB-04



Box 50, 51, & 54 - TPL

Prior Authorization -

Field 63 –

necessary for payment.

PAGE ____ OF ____		CREATION DATE 8/11/14		TOTALS →	
50 PAYER NAME Possible TPL Payer		51 HEALTH PLAN ID 123456789		54 PRIOR PAYMENTS 42.80	
58 INSURED'S NAME Member Name		60 INSURED'S UNIQUE ID Member ID		56 NPI Billing NPI	
63 TREATMENT AUTHORIZATION CODES Prior Auth# PAs are required in order for certain services to be paid.		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 ICD-10 codes					
74 PRINCIPAL PROCEDURE CODE DATE		a. OTHER PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE	
80 REMARKS		B1CC a Billing Taxonomy		76 ATTENDING NPI 123456789 LAST Attending Last Name FIRST First Name	
		b B3 282N00000X		77 OPERATING NPI LAST FIRST	
				78 OTHER NPI LAST FIRST	
				79 OTHER NPI LAST FIRST	

# Paper Claims – UB-04

---

## Resources Available

- NUBC manual – From [www.nubc.com](http://www.nubc.com) – updated annually in June
- CMS has info on the CMS 1450 or UB-04
- List of resources in the General Provider Manual
- Peer resources

# Remittance Advice(e!Sor) and 835 ERA

# 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).







\*\*\*TOTAL WARRANT AMOUNT\*\*\*

830.33

\*\*\*\*\*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.

# How do you get signed up to bill Electronically?

# Where to find the forms to E- Bill?

---

Information to electronically submit claims and the forms that are required can be found on the Medicaid Provider Web Site:

<http://medicaidprovider.mt.gov/claims#515376129-electronic-submission-setup>

# EDI Required Forms

## Trading Partner Agreement (TPA)

Establishes the basics.

- MATH Web portal access
- Access to e!Sor
- Creation of Trading Partner ID (TPID)
- Eligibility Verification

CONDUENT EDI SOLUTIONS, INC.  
TRADING PARTNER AGREEMENT

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between TRADING PARTNER ("Trading Partner") and CONDUENT EDI SOLUTIONS INC. ("EDI Gateway") collectively "the parties".

WHEREAS, Trading Partner desires to transmit Transactions to EDI Gateway for the purpose of submitting data to a Health Plan;

WHEREAS, EDI Gateway desires to receive such transactions for this purpose recognizing the EDI Gateway performs such services on behalf of the Health Plan; and

WHEREAS, Trading Partner is subject to the Transaction and Code Set Regulations with respect to the transmission of such transactions.

Now, therefore, the Parties agree as follows:

**1. Definitions**

EDI Gateway means Conduent EDI Solutions, Inc.

Trading Partner means the party identified as "Trading Partner" on the signature line of this Agreement who is a Health Care Provider or Health Care Clearinghouse as defined in 45 CFR 160.103.

Standard is defined in 45 CFR 160.103.

Transaction and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

**2. Obligations of the Parties Effective Upon Execution of this Agreement by Trading Partner**

A) The Parties agree, in regard to any electronic Transactions between them:

- 1) They will exchange data electronically using only those Transaction types as selected by Trading Partner on the Conduent EDI Solutions Trading Partner Enrollment Form (TPEF).

- 2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.
  - 3) They will not change any definition, data condition, or use of a data element or segment in a Standard transaction they exchange electronically.
  - 4) They will not add any data elements or segments to the Maximum Defined Data Set.
  - 5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.
  - 6) They will not change the meaning or intent of a Standard's implementation specification.
  - 7) EDI Gateway may reject a Transaction submitted by Trading Partner if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the TPEF. EDI Gateway may refuse to accept any claims from Trading Partner if Trading Partner repeatedly submits Transactions that do not meet the criteria set forth in TPEF or if Trading Partner repeatedly submits inaccurate or incomplete Transactions to EDI Gateway.
- B) Trading Partner understands that EDI Gateway or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Trading Partner will participate fully with EDI Gateway in the testing, verification, and implementation of the modification to a Transaction affected by the change.
- C) EDI Gateway understands that DHHS may modify the Transaction and Code Set Regulations. EDI Gateway will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Trading Partner and EDI Gateway.
- D) Neither Trading Partner nor EDI Gateway accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Trading Partner and EDI Gateway.

# EDI Required Forms

## X12N transaction paper work

### EDI Provider Enrollment Packet for X12N Transactions

- Clearinghouse and Billing Agents
- Individual provider requests to set up for self billing.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

 Please return to:  
Conduent EDI Solutions, Inc  
Attn: MT EDI  
PO Box 4936  
Helena, MT 59604  
Or fax to 406-442-4402

**CONDUENT** 

EDI SUBMITTER ENROLLMENT FORM. Please print or type. Complete all areas of the Submitter Enrollment Form, unless otherwise indicated.

**Section 1. Classification.** Please indicate your classification.

Software Vendor     Billing Agent     Clearinghouse

**Section 2. Submission Method.** Please indicate how you plan to submit your electronic transactions.

Asynchronous (Direct Submission to EDI)     WINASAP5010

**Section 3. Submitter Information.**

Business Name (if applicable) \_\_\_\_\_

Provider Name (Last, First, MI, and Suffix) \_\_\_\_\_

Business Street Address \_\_\_\_\_

City, State, and Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email Address \_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

**Section 4. Montana Submitter ID.**

If you are currently submitting electronic transactions directly to Montana FAS, please indicate your Montana 7-digit Submitter ID:  
NOTE: This is your Montana DPHHS Submitter ID Assigned by FAS.

**Section 4a. Submitter/Trading Partner ID Number.**

If you are currently submitting electronic transactions directly to EDI Solutions, please indicate your Conduent EDI Solutions 5-digit Submitter ID or 6-digit Trading Partner ID.  
NOTE: This is NOT your Montana submitter ID

**Section 5. Software Vendors Only**

If you have indicated that you are a Software Vendor in Section 1, please provide the following information:

1.800.987.6719 (phone) 1.406.442.4402 (fax)  
[edisolutions.mt.mhs.portal.conduent.com](http://edisolutions.mt.mhs.portal.conduent.com)

1 of 4

# EDI Required Forms

## MATH Link Request

Connection between multiple NPI's and a submitter ID for Web Portal

Applicable to group settings

Each NPI must have its own completed form.

Hint:

- Provider Name & NPI is who you want to link.
- Submitter ID is where you want the information to go.



### Montana Access to Health Web Portal Link Request

For multiple providers to appear on your drop-down list in the Montana Access to Health web portal, you must submit a Link Request.

Each National Provider Identifier (NPI) or Atypical Provider Identifier (API) used as the billing or pay-to provider will have an electronic statement of remittance (e!SOR) generated; therefore, it is important to have the NPI/API linked to the submitter/trading partner number for retrieval. You may verify your submitter number by selecting "My Profile" in the MATH web portal.

Complete the information below. Complete a separate form for each NPI/API you want linked. The form must be signed by the provider or an authorized representative. Mail or fax to Provider Relations, P.O. Box 8000, Helena, MT 59604, 406.442.4402.

**Allow up to 10 days for Provider Relations to process the request.**

Provider Name	<input type="text"/>
NPI/API	<input type="text"/>
<b>Complete a separate form for each NPI/API you want linked.</b>	
Submitter ID	<input type="text"/>
Printed Name	<input type="text"/>
Title	<input type="text"/>
Signature	_____ Date _____

# EDI Required Forms

## 835 request

- It can only be delivered to one place. Usually this is the clearinghouse.

Used for sending and Electronic Remittance Advice back to the requested submitter ID.

- Section A is info about the Provider.
- Section B is for the Clearinghouse information that is being sent the 835 electronic information.

Form located at:

<http://medicaidprovider.mt.gov/Portals/68/docs/forms/montanamedicaid835request.pdf>

**MONTANA DPHHS EDI 835 REQUEST FORM**



Healthy People. Healthier Communities.  
Department of Health, Behavior & Society

Please return to:  
Conduent EDI Solutions, Inc.  
Attn: MT EDI  
PO Box 4936  
Helena, MT 59604  
Or fax to 406-442-4402



---

**Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form**

**Section A. Provider Information.**

Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number	Federal Tax ID Number
Business Address	
City, State, and Zip	
Telephone Number	Fax Number
Contact Name	E-mail Address

**Section B. Authorization Signature (required).**

Provider, \_\_\_\_\_ hereby appoints  
Provider name /Provider Representative name (please print)

<small>Billing Agent/Clearinghouse name (please print)</small>	<small>Billing Agent/Clearinghouse Conduent Trading Partner/Submitter ID</small>
----------------------------------------------------------------	----------------------------------------------------------------------------------

to act as the authorized agent for the purpose of submitting health care transactions electronically to Conduent EDI Solutions, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

<input type="checkbox"/> 277-Claim Status Response	<input type="checkbox"/> 271-Eligibility Response
<input type="checkbox"/> 835-Healthcare Claims Payment Advice	<input type="checkbox"/> 278-Prior Authorization Response
<input type="checkbox"/> Exception Report (Print Image)	<input type="checkbox"/> 999-Implementation Acknowledgement
<input type="checkbox"/> 277CA-Healthcare Claim Acknowledgement	

\_\_\_\_\_  
Provider/Provider Representative name (Please print)

<small>Provider/Provider Representative Signature</small>	<small>Date</small>
-----------------------------------------------------------	---------------------

1.800.987.6719 (phone) 1.406.442.4402 (fax)  
 edisolutionsmmis.portal.conduent.com/gcro/

# Electronic Claim Submissions

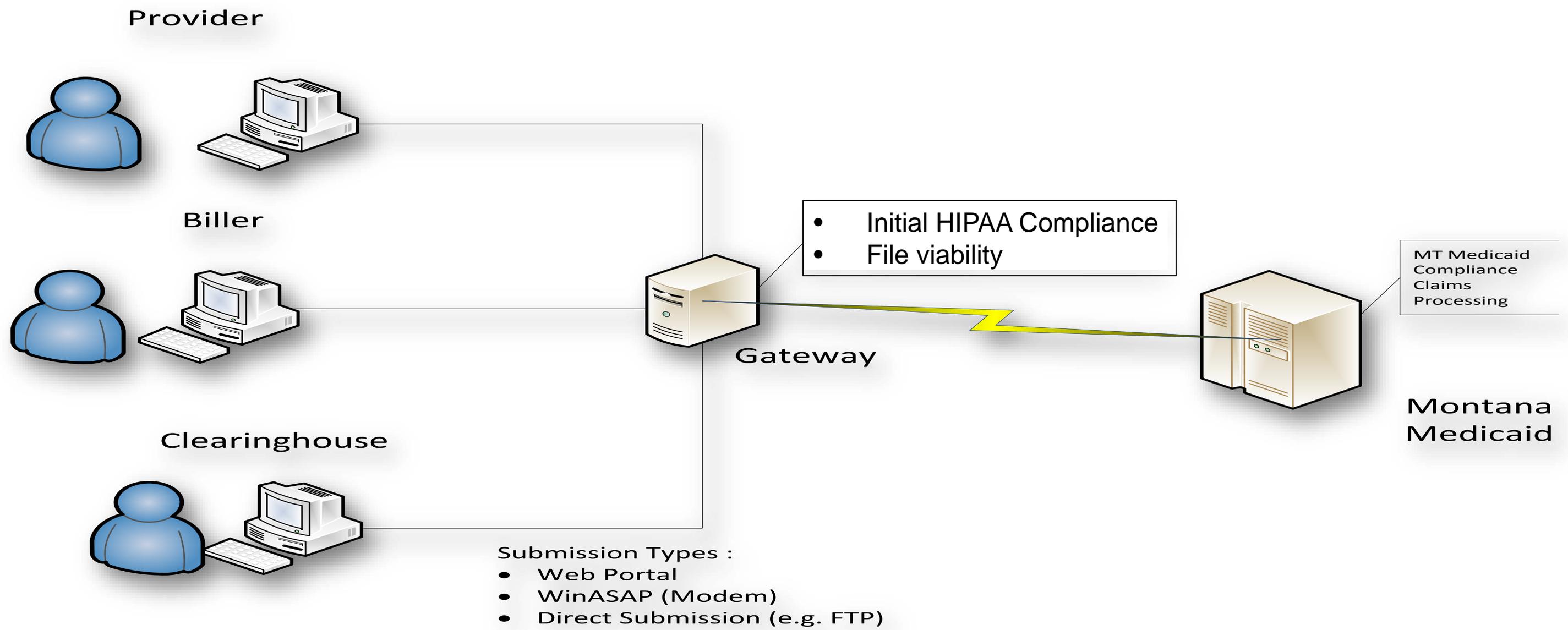
# Electronic Transactions

- 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 HIPAA in 1996.**

# Electronic Claims

## Different ways the claim files get to Conduent.



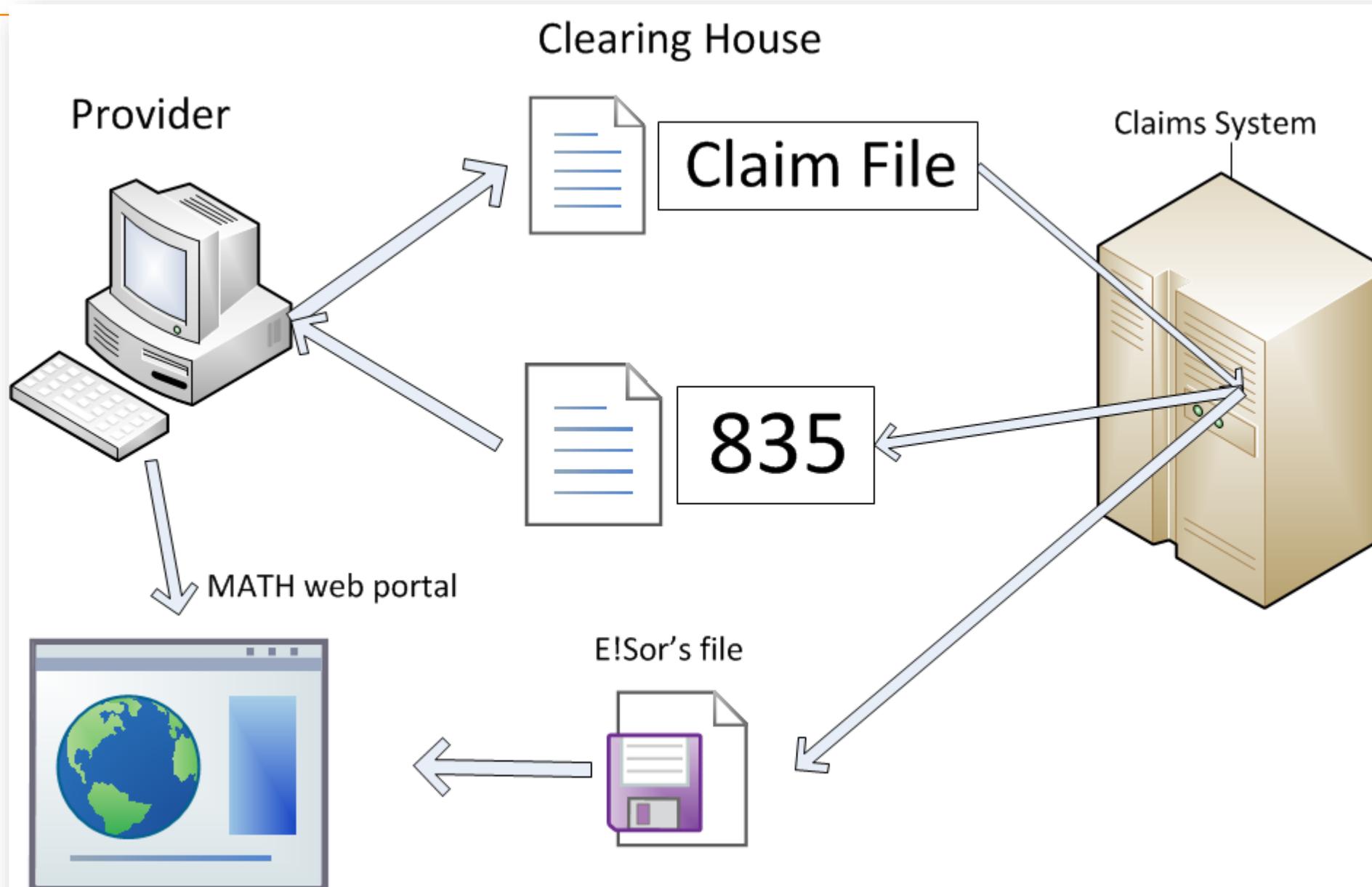
# Electronic Claims

## 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)

# Clearing House



# 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 enroll you for billing electronically. If you are using a clearing house, this step may already be done.
- Missing or invalid taxonomy codes
- Non-matched ZIP + 4

# Electronic Submissions

## Most common errors - How to fix them!

---

- 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 HIPAA 5010:**

[http://medicaidprovider.mt.gov/Portals/68/docs/EDI/Conduent\\_electronictransactioninstructionshipaa5010\\_03012018%20BR1290.pdf](http://medicaidprovider.mt.gov/Portals/68/docs/EDI/Conduent_electronictransactioninstructionshipaa5010_03012018%20BR1290.pdf)

# 835 or ERA file

---

- Can only be directed to one place - usually that's the clearing house
- Requires software to parse the contents of the 835 file into usable information.
- Does contain additional information that could show a different total than what was deposited or on the e!Sor PDF from the portal.

# Electronic Transaction Instructions for HIPAA 5010:

---

## General Montana-Specific Submission Rules:

- To indicate Prior Authorization, use 'G1' in loop 2300, REF01 at the header or loop 2400, REF01 on the line.
- To indicate a Passport referral number, use '9F' in loop 2300, REF01 at the header or loop 2400, REF01 on the line.

# Paperwork Attachments and Electronic Claims

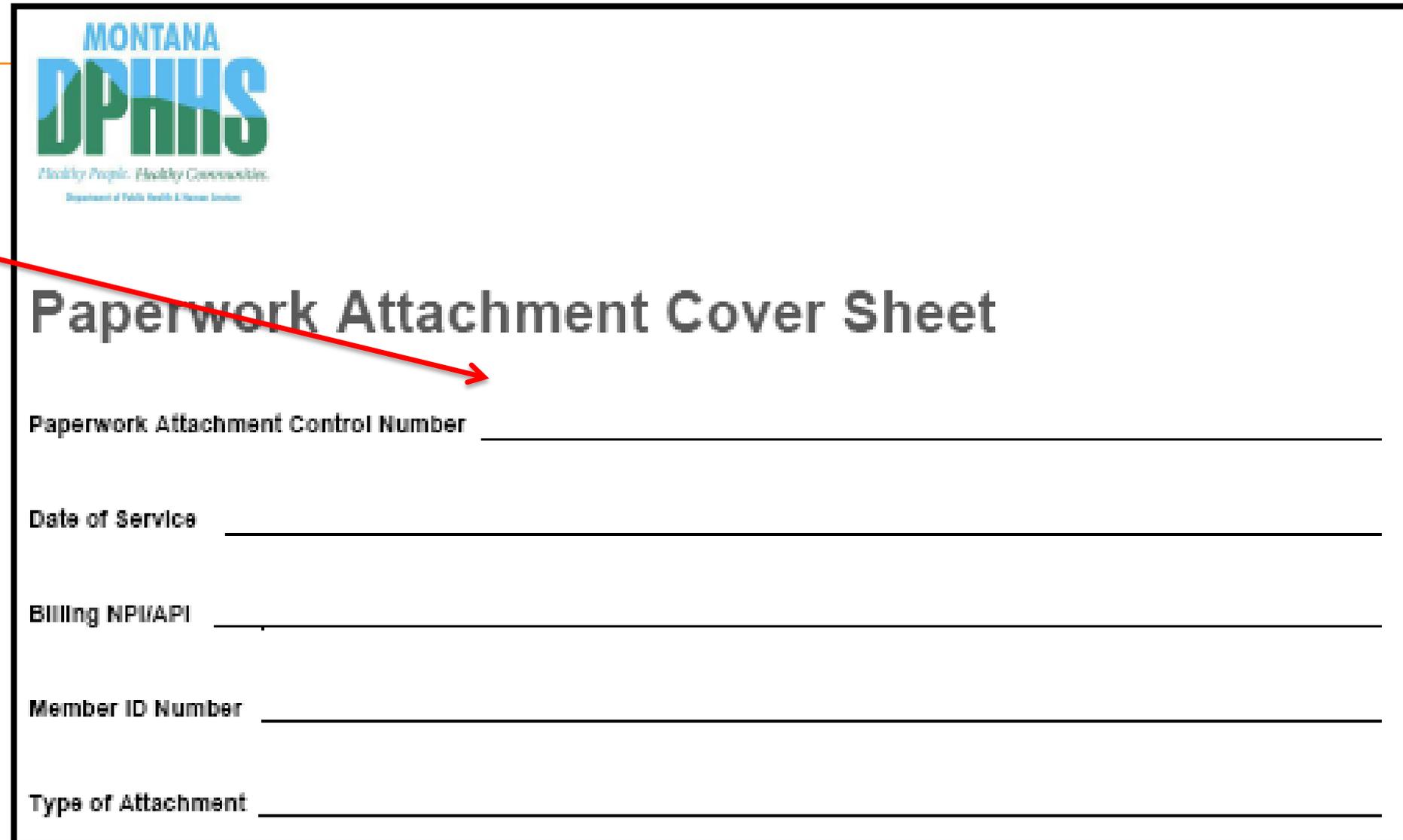
# Electronic with Paper Attachments

## 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.  
Department of Public Health & Human Services

### Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number \_\_\_\_\_

Date of Service \_\_\_\_\_

Billing NPI/API \_\_\_\_\_

Member ID Number \_\_\_\_\_

Type of Attachment \_\_\_\_\_

# 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 with 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 in this format:



# Individual Adjustment Requests

# Individual Adjustment Request Form

## Necessary information:

- Provider name & address
- Member name
- ICN #
- NPI/API #
- Member ID #
- Date of payment
- Amount of payment
- Corrected information
- Signature & date
- Medicaid remit from the paid claim



## 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. A copy of the corrected claim is optional. Mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to (406) 442-4402.

# Adjustment Request Form - Section A

## 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)
<b>The Clinic</b> <small>Name</small>	<b>214010001200000</b>
<b>123 Main Street</b> <small>Street or P.O. Box</small>	4. NPI/API
<b>Anywhere</b> <b>MT</b> <b>59991</b> <small>City State ZIP</small>	<b>1234567891</b>
<b>406-111-2222</b> <small>Telephone Number</small>	5. Member ID Number
2. Member Name	<b>1133111</b>
<b>John Doe</b>	6. Date of Payment <b>01/01/2013</b>
	7. Amount of Payment \$ <b>558.86</b>

# Adjustment Request Form - 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	<b>Line 3</b>	1 unit T1028	<b>2 Units T2028</b>
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount		<b>25.00</b>	<b>50.00</b>
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature  Date **02/02/2014**

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.

# 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.

# Submitting Adjustments

## When should I request an adjustment?

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. This needs to go in Box 8 of the Adjustment request.

5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

# Individual Adjustment Requests

## Things to remember

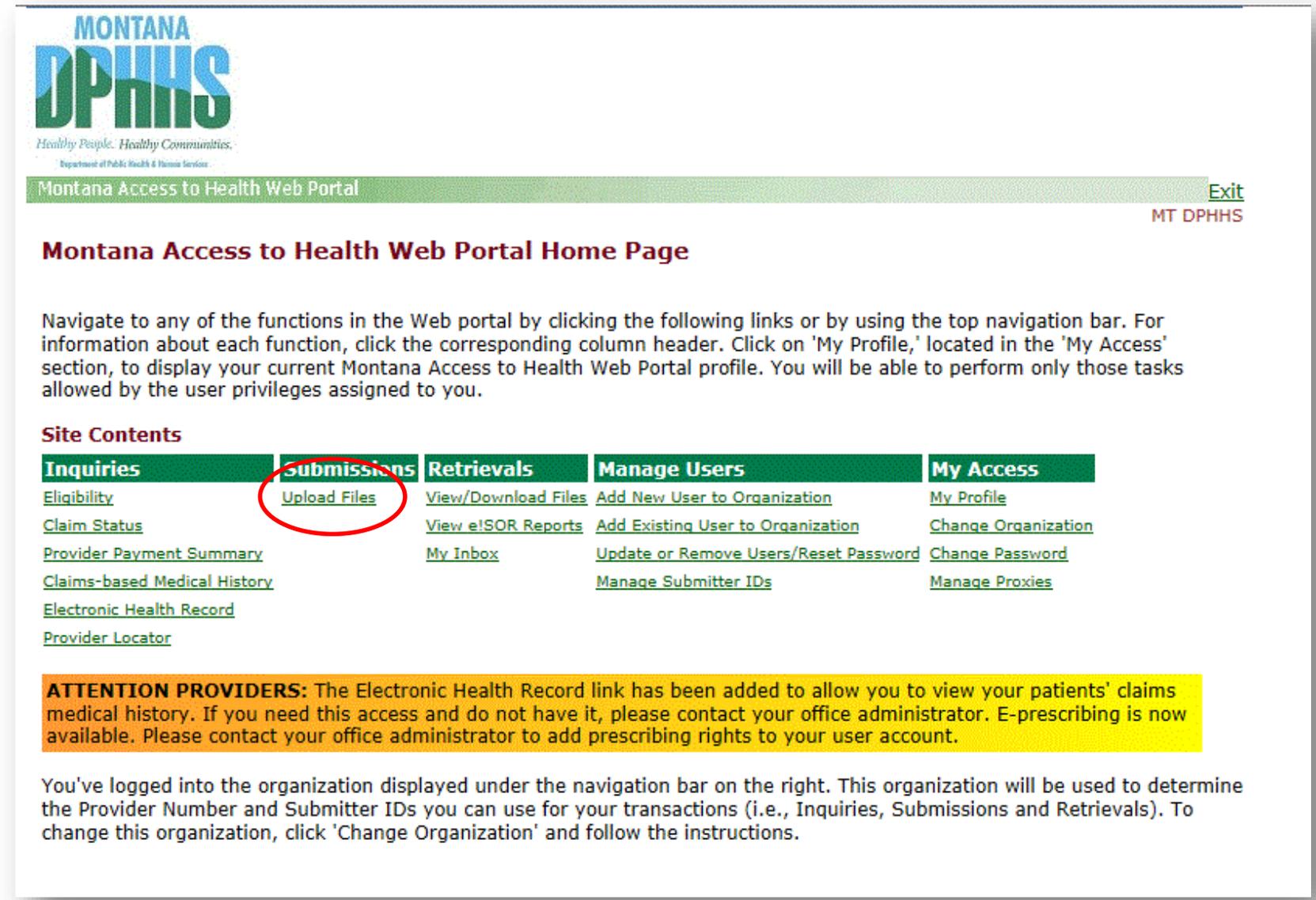
---

- The wording is very important - “corrected” or “new”
- A claim is not always necessary but the Medicaid remit is necessary.
- Adjusting a claim past timely (365 days from date of service)
- 1 adjustment per ICN unless the claim has been split then all ICNs are needed on line A3
- Adjusting the units
- Supporting documentation

# Montana Access to Health (MATH) Web Portal

# Upload Claim Files

- Chose the Upload files option under the Submissions tab.



**MONTANA DPHHS**  
Healthy People. Healthy Communities.  
Department of Public Health & Human Services

Montana Access to Health Web Portal [Exit](#)  
MT DPHHS

### Montana Access to Health Web Portal Home Page

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

**Site Contents**

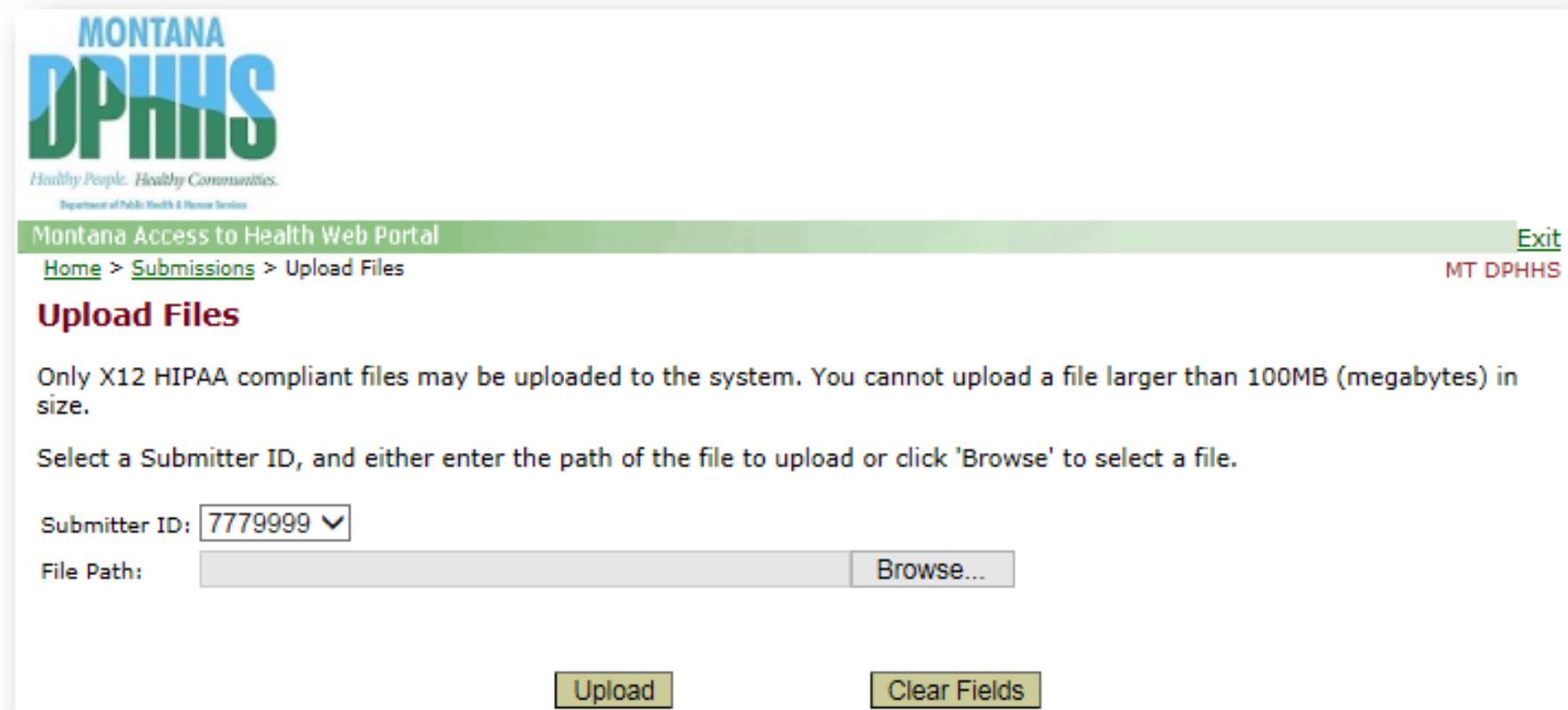
Inquiries	Submissions	Retrievals	Manage Users	My Access
<a href="#">Eligibility</a>	<a href="#">Upload Files</a>	<a href="#">View/Download Files</a>	<a href="#">Add New User to Organization</a>	<a href="#">My Profile</a>
<a href="#">Claim Status</a>		<a href="#">View e!SOR Reports</a>	<a href="#">Add Existing User to Organization</a>	<a href="#">Change Organization</a>
<a href="#">Provider Payment Summary</a>		<a href="#">My Inbox</a>	<a href="#">Update or Remove Users/Reset Password</a>	<a href="#">Change Password</a>
<a href="#">Claims-based Medical History</a>			<a href="#">Manage Submitter IDs</a>	<a href="#">Manage Proxies</a>
<a href="#">Electronic Health Record</a>				
<a href="#">Provider Locator</a>				

**ATTENTION PROVIDERS:** The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

# Choose the File to upload

- Click the “Browse” button and select the location and file to be uploaded.
- Click the “upload” button.
- Check your “View/Download Files” option in a few hours.



**MONTANA DPHHS**  
 Healthy People. Healthy Communities.  
 Department of Public Health & Human Services

Montana Access to Health Web Portal Exit

[Home](#) > [Submissions](#) > Upload Files MT DPHHS

### Upload Files

Only X12 HIPAA compliant files may be uploaded to the system. You cannot upload a file larger than 100MB (megabytes) in size.

Select a Submitter ID, and either enter the path of the file to upload or click 'Browse' to select a file.

Submitter ID:  ▼

File Path:

# Clearinghouse or Billing Agent

# Clearinghouse or Billing Agent

## Things to know

---

We can't tell you who to choose, you have to do your due diligence to choose the best fit for your practice.

How are issues going to be resolved?

- Will the clearinghouse or billing agent be reaching out for resolutions or issues? Or is that responsibility on you?

# Clearinghouse or Billing Agent

## Things to know

---

If your intent is to have your claims sent electronically, make sure that is how the company is submitting your claims.

- Be sure that they are not taking your information electronically and then filling out a form and mailing or faxing it to us.

Clearinghouse or billing agent need to be familiar with the Montana Specific Electronic Submission Standards.

- They have to make changes to get the claim into the system not Medicaid.

Know what the expectations are and what you are getting into.

# Practice Management Software

# Practice Management Software

---

- Scheduling
- Electronic Health Records
- Patient Roster
- May or may not have billing component for submitting claims
- Store claims data for comparison of billed vs paid
- Some have electronic reconciliation (835 files)

# Practice Management Software

## Things to know

---

We can't tell you what software to choose.

- You have to do your due diligence to choose the best software to fit for your practice.
- Some Clearinghouses will/can offer software, ask if it's available.
- WINASAP is not Practice Management Software.

# WINASAP

# WINASAP- What is it?

---

## Windows Accelerated Submission And Processing (WINASAP)

- It is **NOT** Practice Management Software. It **only** creates the claim file.

It creates an X12N HIPAA compliant electronic message that can be used to submit claims data.

**Free!!** but also has very limited technical support.

# WINASAP

## Known issue

---

Microsoft released a security patch in June, 2016 that is not compatible with WINASAP.

This security patch has made WINASAP incompatible with Windows 10.

At this time there is no available ETA on when or if this will be addressed.

- Please check the [medicaprovider.mt.gov](https://www.medicaprovider.mt.gov) website. Any changes in this status will be updated here.

# WINASAP-It can be found!

It's on the Medicaid Provider web page. Choose "Resources", then Electronic Billing. It can be found in Software Downloads and Users Guides.

<http://edisolutionsmmis.portal.conduent.com/gcro/winasap-software>

There is a User Guide:

- Very useful info about setting up the program.
- Most of the trouble shooting via the phone is from this guide.

<http://medicaidprovider.mt.gov/Portals/68/docs/manuals/montanawinasap5010guide.pdf>

Windows  
Accelerated  
Submission and  
Processing  
**WINASAP 5010**  
Montana Medicaid, Healthy  
Montana Kids (HMK) and Mental  
Health Services Plan (MHSP)

August 2017

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 Representative:

- Dan Hickey (406) 457-9553

**CONDUENT**

