Billing 101 Training for Providers

Billing process start to finish

Conduent
Government Healthcare Solutions
Montana FAS March 2020

In this training…

- What order should things be done?
- Where to I go to get information, submit & reconcile claims?
- What access do I need before I can begin?
- What are my resources?
- Most common billing errors. Individual Adjustment forms.
- Questions?

What order should things be done?

What order should things be done?

1. Verify member eligibility.
2. Obtain & review member's prior authorization (if applicable).
3. Select the proper diagnosis code.
4. Select place of service.
5. Select the proper CPT code (service provided).
6. Verify Fee Schedule
7. Enter and submit claim
8. Verify claim status
9. Obtain eSor to reconcile claims/payments

Eligibility Verification with Portal

Verify Member's Eligibility

It is important to verify your member's eligibility each month.

MATH Provider Web Portal
https://mtaccesstohealth.portal.conduent.com/

Call Center
1800-624-3958 Opt. 7, Opt. 3.

MATH Portal Access

2/26/2020

CONDUENT

Montana Provider Relations
P O Box 4936
Helena, MT 59604

tel 800-624-3958 Opt3

Provider name
Address
City ST Zip

Dear Montana Submitter:

Welcome to Conduent EDI Solutions. Please find below the information necessary to submit electronic transactions, based on your enrollment selections. Carefully review all the items in this package. If you find any discrepancies, please call Montana Provider Relations at 1-800-624-3958.

Trading Partner Login Information

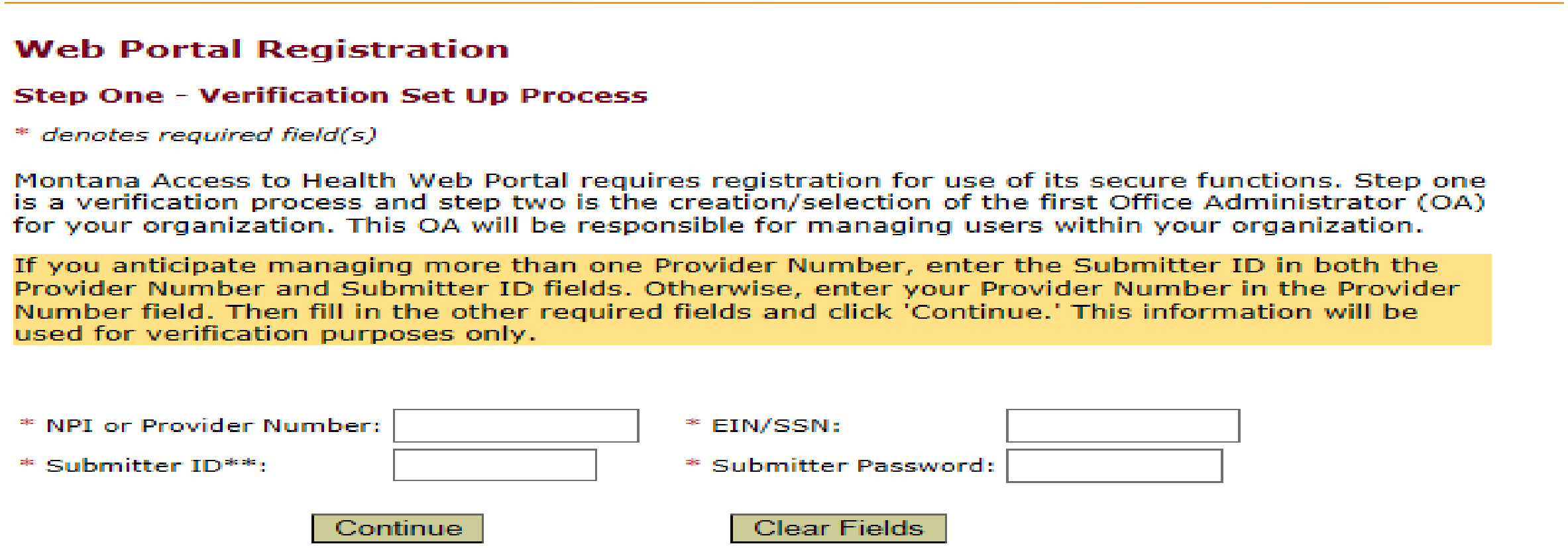
Trading Partner Category	
Trading Partner Name	**Provider name**
Trading Partner / Submitter ID	**7777777**
User Name	TMP: **123456**
Password/User ID	**Q9JJJOVF5**
Submission Telephone Number(s)	1-800-334-2832 or 1-800-334-4650

We recommended that all providers register for the Montana Access to Health Web Portal. To register, use the credentials in this letter. Visit the Provider Website (https://medicaidprovider.mt.gov) and select the MATH Web Portal link from the menu on the left. Or, go directly to the web portal (https://mtaccesstohealth.portal.conduent.com/mt/general/home.do) and choose Web Registration from the menu.

1. Enter the Submitter Number in both the NPI and Submitter fields.
2. Enter your Tax Identification Number and the password *from this letter*.
3. From the prompt, create your User ID that you will use to log in. Once the account is registered, an email will be generated with a temporary password.
4. Log in with the user ID you created and copy/paste the password *from the email*.
5. From the prompt, change your password. (Use the temporary password from the email as the old password.).
6. Once logged in to the MATH web portal, click Manage users and select Update or Remove Users to change access.

Note: All Vendors, Billing Agents, and Clearinghouses must enroll and test with Conduent EDI Solutions prior to submitting production transactions. If you are a provider, please check with your contracted Vendor, Billing Agent, or Clearinghouse

MATH Portal Access



Web Portal Registration

Step One – Verification Set Up Process

* *denotes required field(s)*

Montana Access to Health Web Portal requires registration for use of its secure functions. Step one is a verification process and step two is the creation/selection of the first Office Administrator (OA) for your organization. This OA will be responsible for managing users within your organization.

If you anticipate managing more than one Provider Number, enter the Submitter ID in both the Provider Number and Submitter ID fields. Otherwise, enter your Provider Number in the Provider Number field. Then fill in the other required fields and click 'Continue.' This information will be used for verification purposes only.

* NPI or Provider Number:

* EIN/SSN:

* Submitter ID**:

* Submitter Password:

Continue

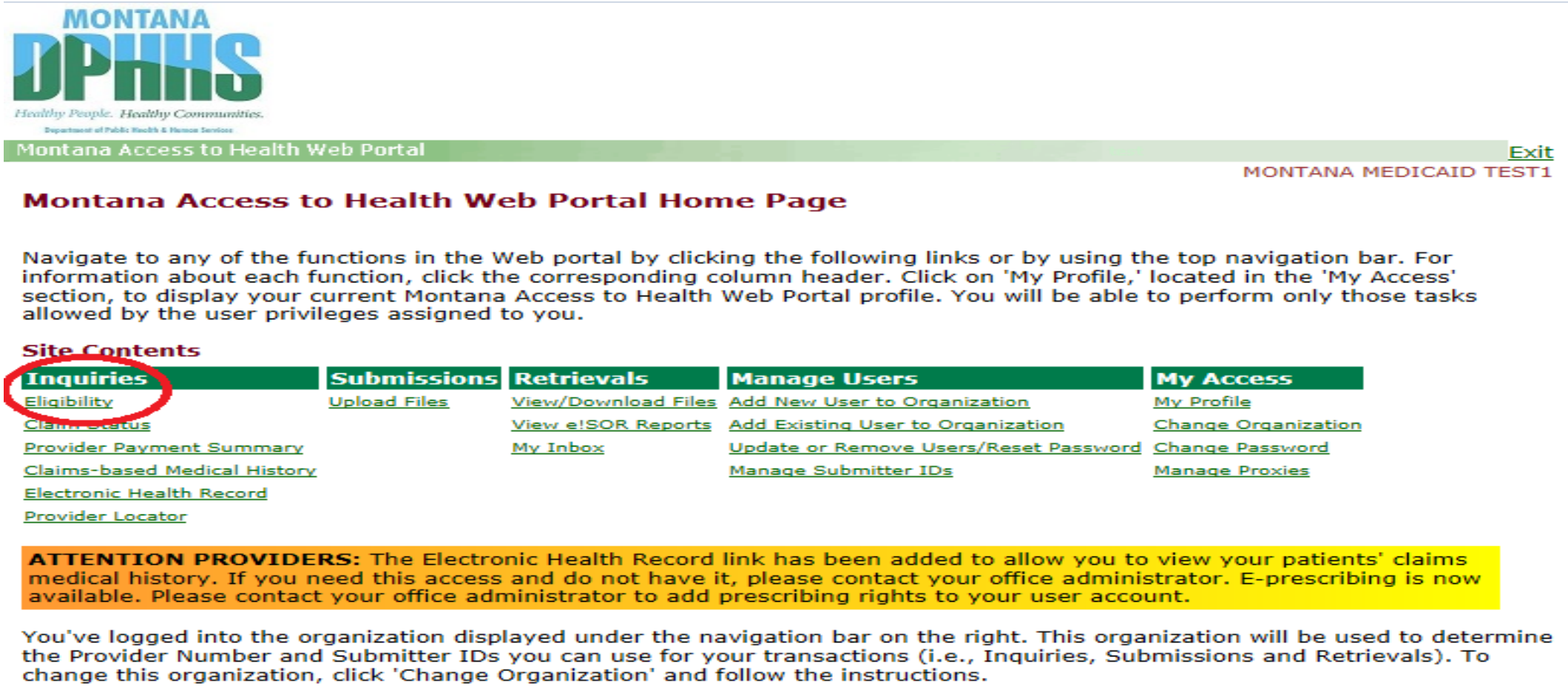
Clear Fields

** Submitter ID is the Trading Partner ID

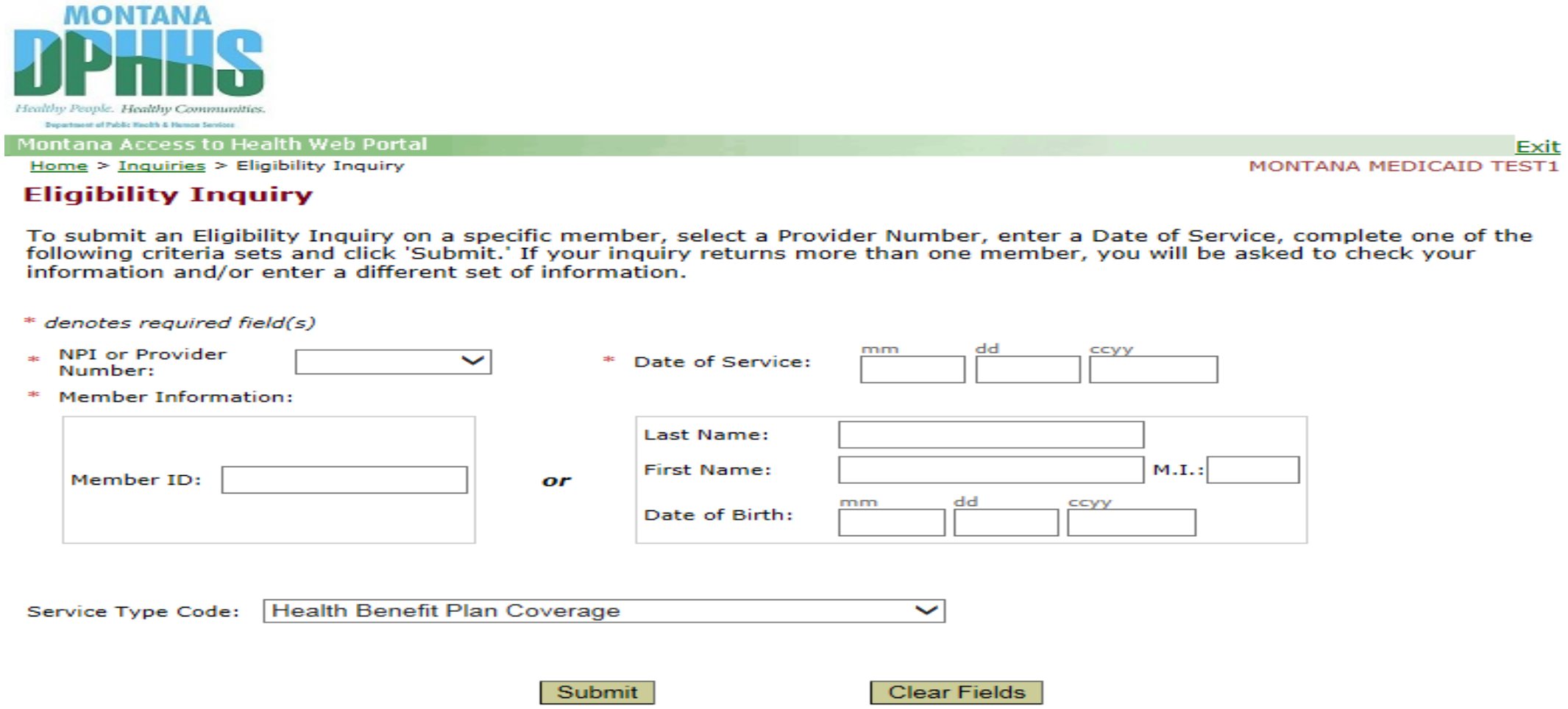
Log In


MONTANA
DPHHS
Healthy People. Healthy Communities.
Montana Access to Health Web Portal
Log In
Web Registration
Provider Enrollment
Provider Information Website
Electronic Billing
Provider Locator
Welcome to Montana Access to Health Web Portal!
Montana Access to Health Web Portal provides the tools and resources to help healthcare providers conduct business electronically. If you have already registered to use the Montana Access to Health Web Portal, Log In below. If you have already completed a Montana Enrollment Form, but have not yet registered to use the Montana Access to Health Web Portal, click the Web Registration button on the left side of this page to begin. If you are a new provider or have not already completed a Montana Enrollment Form, visit Provider Enrollment for step-by-step instructions.
Log In
Enter your User ID and Password and click 'Log In.' If you do not have a User ID and Password, contact your Office Administrator.
User ID:
Password:
Log In
Forgot Your Password?

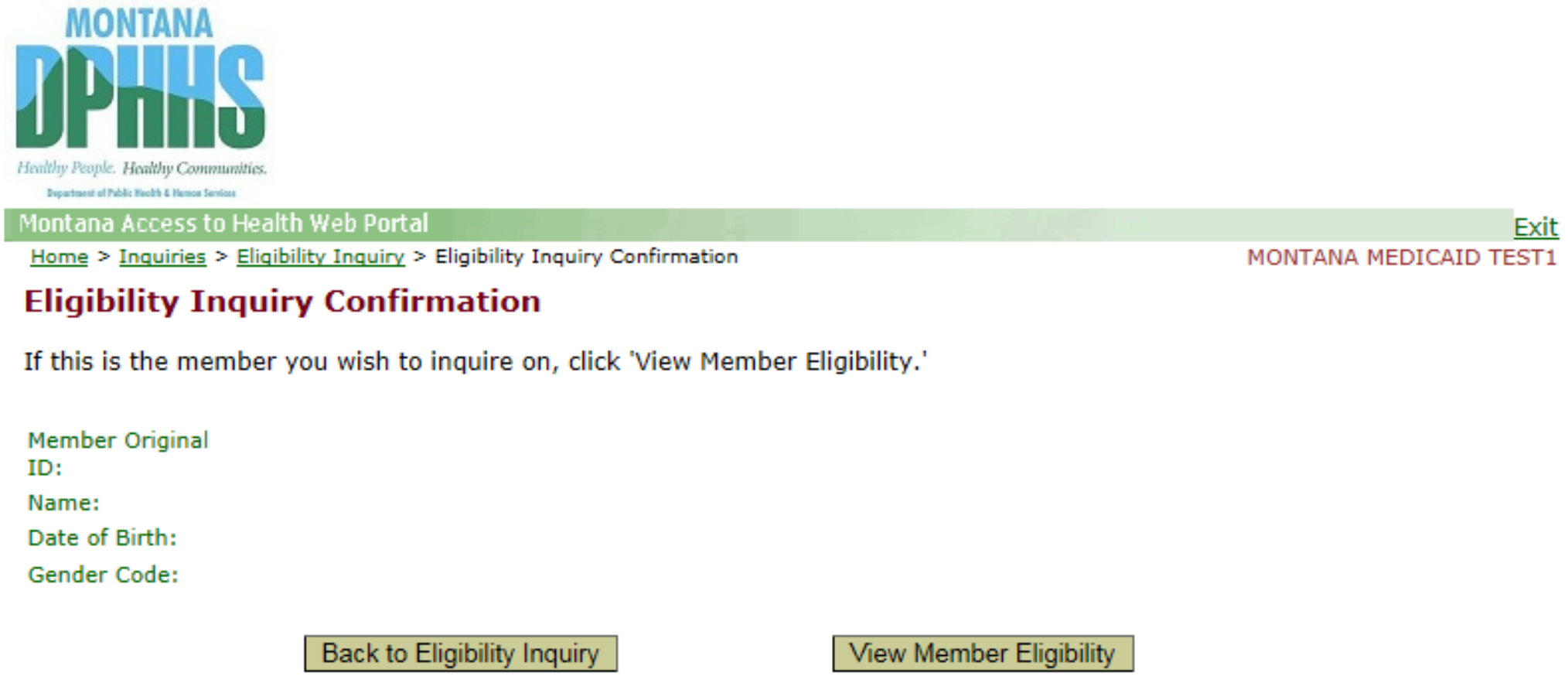
Eligibility Verification



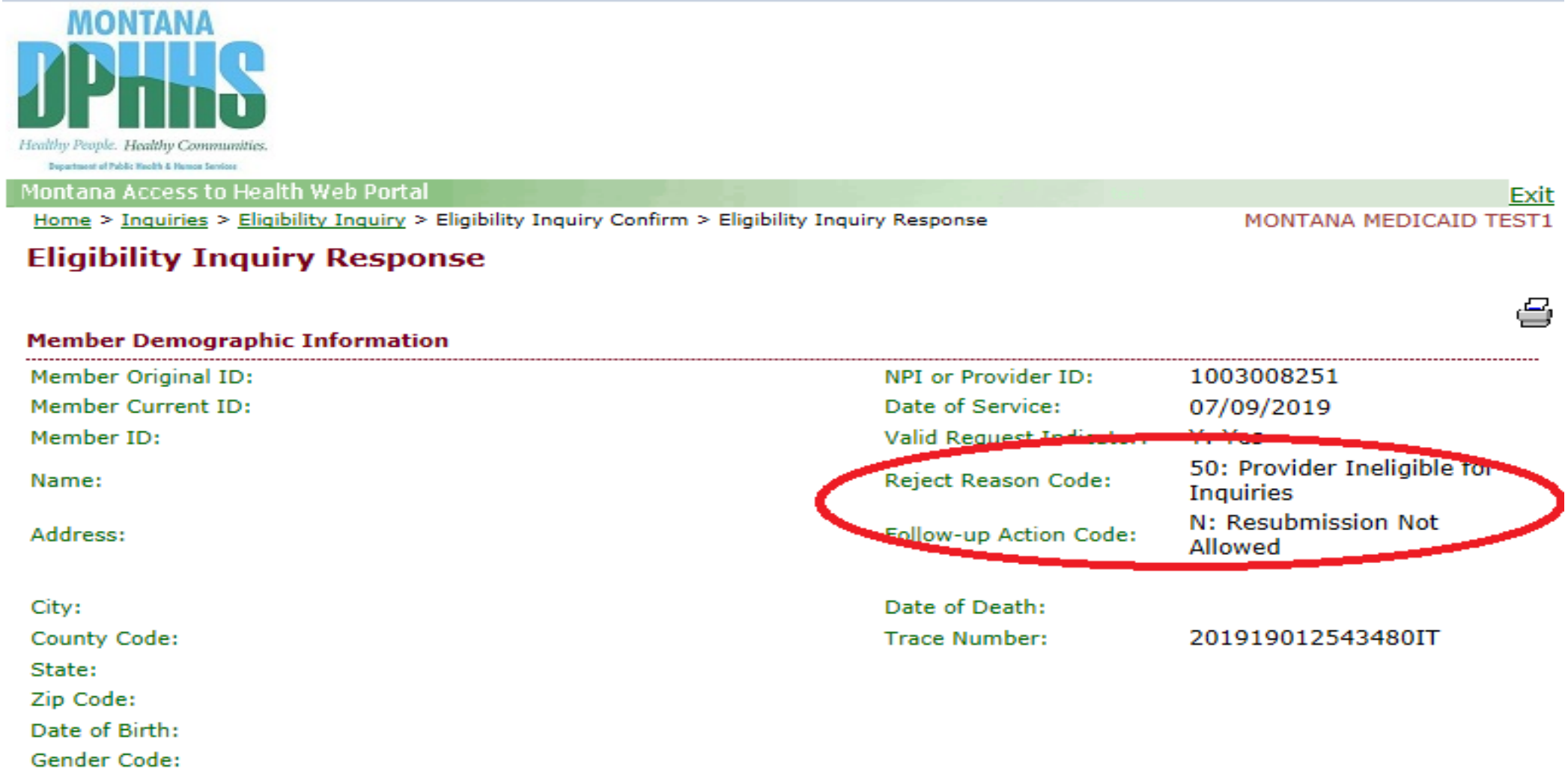
Member Information



Verify Member



Eligibility Response



Eligibility Response

Eligibility Spans About HMK/CHIP HELP Plan Standard Medicaid

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid	Standard Medicaid Plan	05/01/2019	07/31/2019

Managed Care Information

Plan Coverage Description	Plan/PCP Name	Plan/PCP Phone Number	Begin Date	End Date
Passport Provider	NORTHWEST COMMUNITY HEALTH CENT	4062836900	09/01/2018	07/31/2019

Dental Treatment Information

Dental Treatment Type	Treatment Limit	Used Amount	Remaining Reimbursement Balance	Effective Begin Date	Effective End Date
ADULT DENTAL TREATMENT LIMIT	$ 1,125.00	$ 0.00	$ 1,125.00	07/01/2019	06/30/2020

Please be advised that there may be other claims pending adjudication by the system which may be paid before your claim is submitted thereby reducing the available remaining balance from the amount reported above. Limits should be verified on each visit for the current date of service. The Treatment Limit amount shown is the amount Medicaid will reimburse for dental services.

Eligibility Response

Eligibility Spans About HMK/CHIP HELP Plan Standard Medicaid

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid	Standard Medicaid Plan	01/01/2019	07/31/2019
30: Health Benefit Plan Coverage	QM: Qualified Medicare Beneficiary	Medicaid/HMKPlus	Qualified Medicare Beneficiary	11/01/2009	07/31/2019
54: Long Term Care	LC: Long Term Care	Medicaid	Nursing Home	01/01/2011	07/31/2019

Medicare Information

Insurance Type Code	Member Policy ID	Eligibility Effective Date	Eligibility End Date
MA: Medicare Part A		08/01/2002	12/31/2099
MB: Medicare Part B		11/01/2009	12/31/2099

Questions?

Prior Authorizations

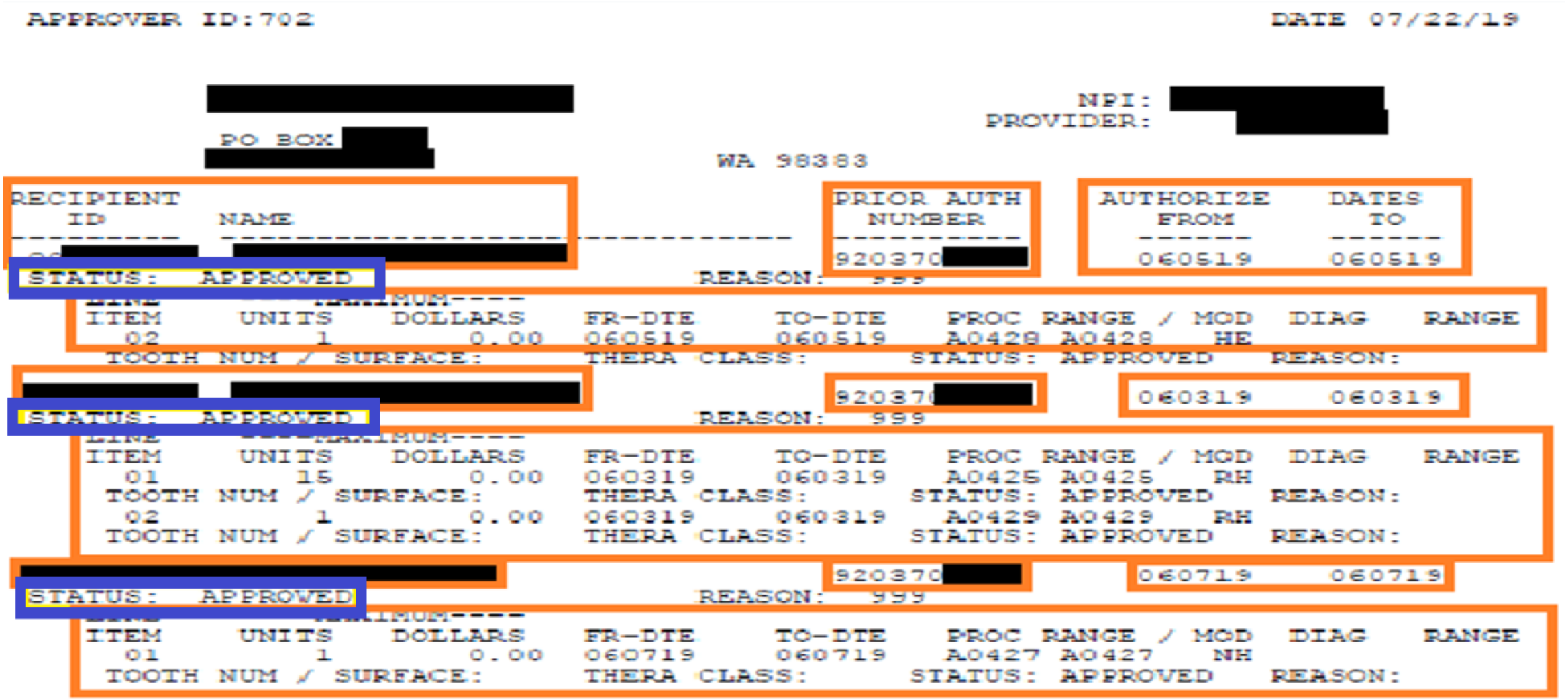
Prior Authorizations

Prior Authorization letters are mailed by Conduent any time a prior authorization has been entered into our system.

Letters may contain multiple members. Each member will have their own prior authorization number.

If you do not receive your prior authorizations in time for billing; contact the Call Center.

Prior Authorization Letter



APPROVER ID:702 DATE 07/22/19

[redacted]

NPI: [redacted]
PROVIDER: [redacted]

PO BOX [redacted]

WA 98383

RECIPIENT ID	NAME	PRIOR AUTH NUMBER	AUTHORIZE DATES FROM	TO
[redacted]	[redacted]	920370[redacted]	060519	060519

STATUS: APPROVED REASON: 999

ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE	PROC	RANGE	/ MOD	DIAG	RANGE
02	1	0.00	060519	060519	A0428	A0428	HE		

TOOTH NUM / SURFACE: THERA CLASS: STATUS: APPROVED REASON:

[redacted]	[redacted]	920370[redacted]	060319	060319

STATUS: APPROVED REASON: 999

ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE	PROC	RANGE	/ MOD	DIAG	RANGE
01	15	0.00	060319	060319	A0425	A0425	RH		
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED			REASON:	
02	1	0.00	060319	060319	A0429	A0429	RH		
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED			REASON:	

[redacted]	920370[redacted]	060719	060719

STATUS: APPROVED REASON: 999

ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE	PROC	RANGE	/ MOD	DIAG	RANGE
01	1	0.00	060719	060719	A0427	A0427	NH		
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED			REASON:	

Questions?

Diagnosis Codes (ICD-10)

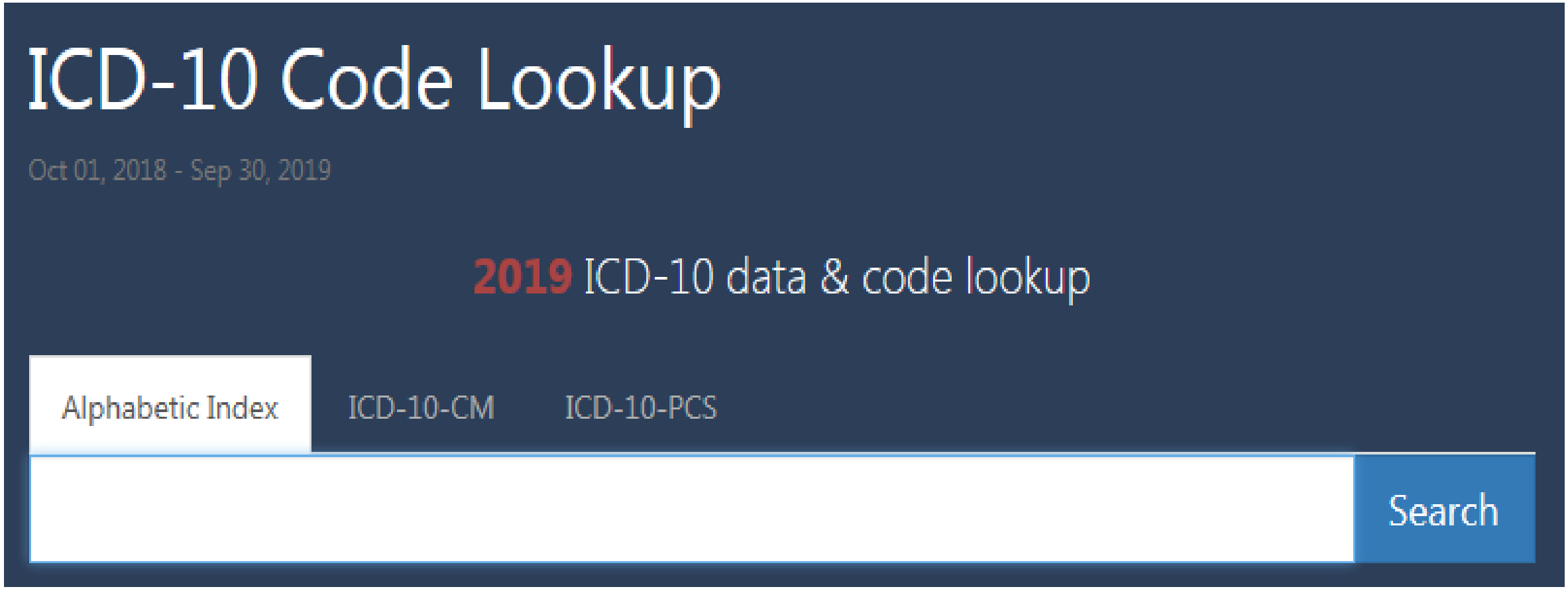
Diagnosis Codes

ICD-10 is short for *International Classification of Diseases, 10th Revision.*

There are many websites out there to obtain this information. Here is my favorite:

https://icd10coded.com/

Diagnosis Codes



Place of Service

Place of Service

Place of Service List:
https://dphhs.mt.gov/Portals/85/dsd/documents/DDP/MMIS%20Transition/PlaceofServicelist.pdf

This link will give you a list of acceptable place of service codes.

Place of Service

Place of Service list needed for claim submission.

01 Pharmacy
03 School
04 Homeless Shelter
05 IHS Freestanding Facility
06 IHS Provider-Based Facility
07 Tribal 638 Freestanding Facility
08 Tribal 638 Provider-Based Facility
11 Office
12 Home

Questions?

CPT Code (service provided)

Fee Schedule

CPT Code

Billable CPT Codes can be located on your provider page, under Fee Schedule.

Provider manuals should be reviewed for service specifics.

Check recent Provider Notices for any changes that may affect your claim.

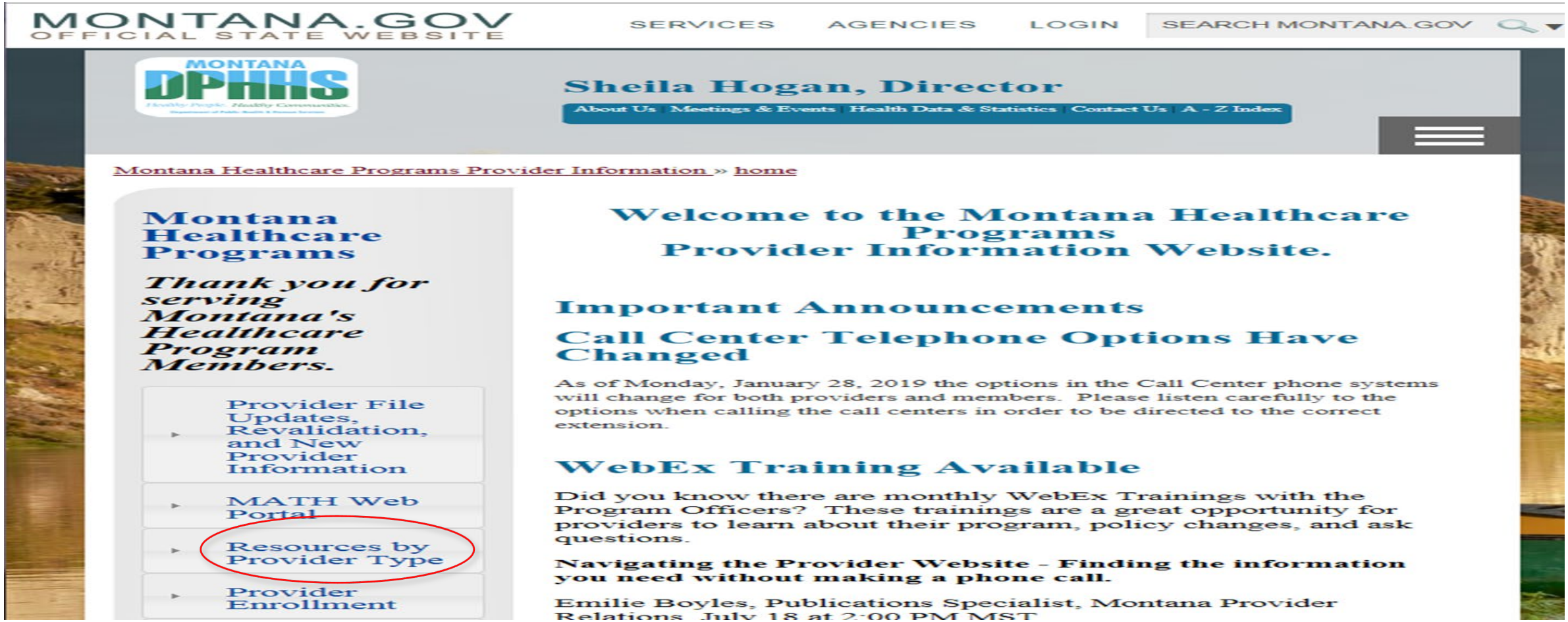
https://medicaidprovider.mt.gov

Rev Codes

In addition to CPT codes; Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services, Hospice and Critical Access Hospitals also use Rev Codes.

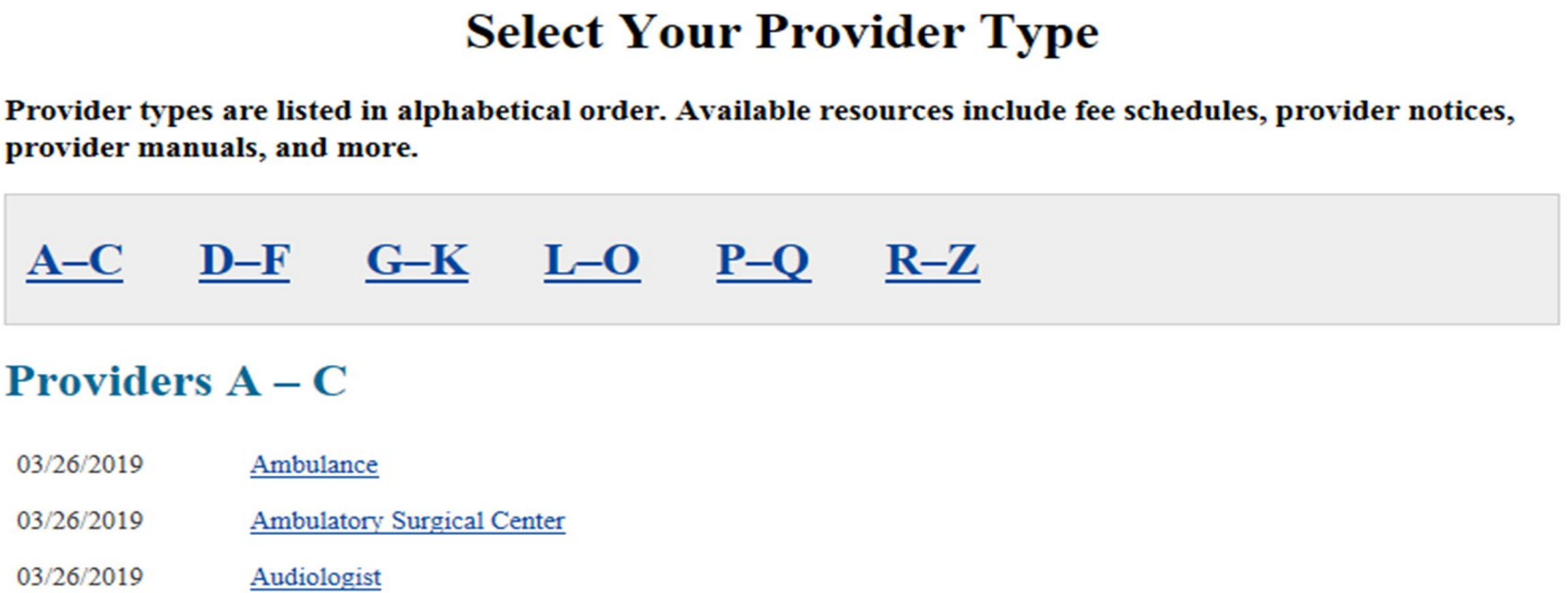
Rev Codes can be found in the UB-04 manual.

Locating your Provider Page



Resources by Provider Type

Providers are listed in alphabetical order



Select Your Provider Type

Provider types are listed in alphabetical order. Available resources include fee schedules, provider notices, provider manuals, and more.

A–C D–F G–K L–O P–Q R–Z

Providers A – C

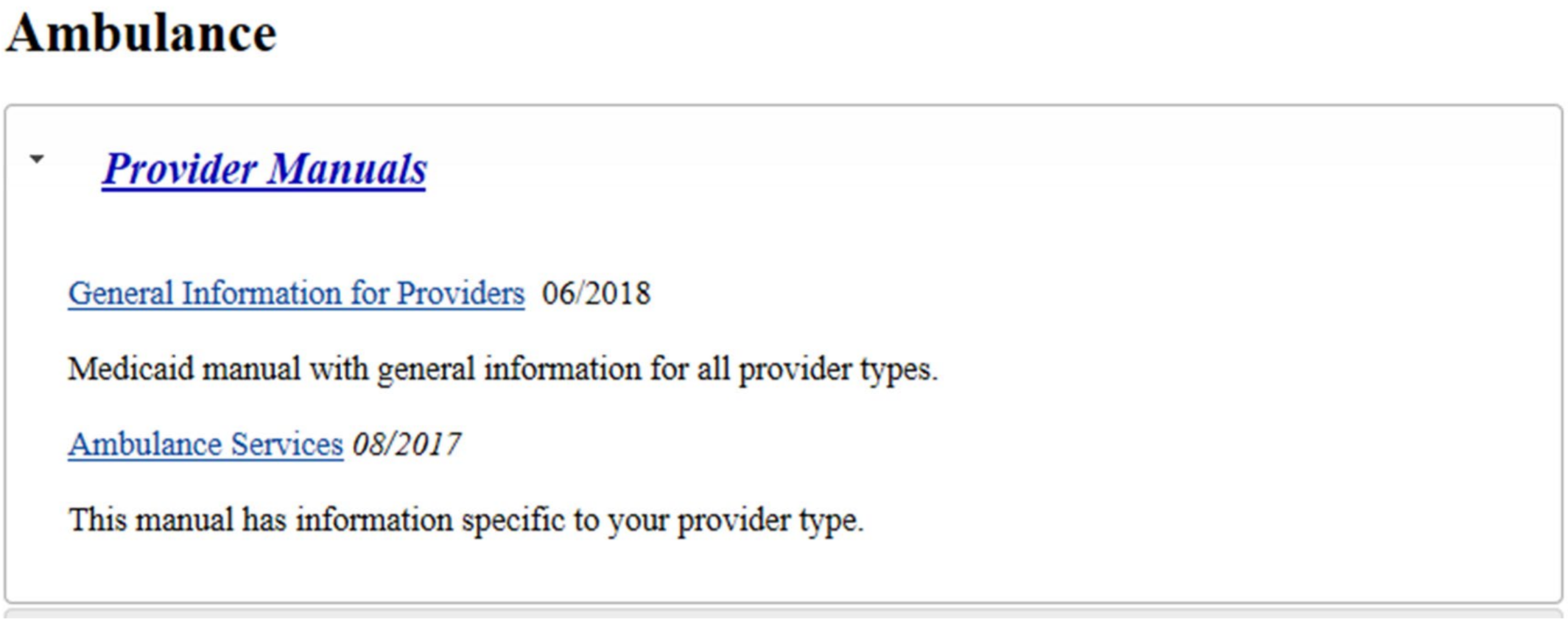
03/26/2019	Ambulance
03/26/2019	Ambulatory Surgical Center
03/26/2019	Audiologist

Resources Available on Your Page

All provider pages are set up the same.

Example: Ambulance

All provider type sections are set up in the same format



Fee Schedule: Ambulance

All provider type pages have this section

Fee Schedules – Ambulance

July 2018 Ambulance Coversheet Version 2
July 2018 Ambulance Fee Schedule Version 2 PDF
July 2018 Ambulance Fee Schedule Version 2 Excel

July 2018 Ambulance Coversheet
July 2018 Ambulance Fee Schedule PDF
July 2018 Ambulance Fee Schedule Excel

January 2018 Ambulance Cover Sheet
January 2018 Ambulance Fee Schedule PDF
January 2018 Ambulance Fee Schedule Excel

Coversheet: January 2017 Ambulance rev. 10/26/2017
PDF: January 2017 Ambulance rev. 10/26/2017
Excel: January 2017 Ambulance rev. 10/26/2017

Fee Schedule Example

Montana Healthcare Programs Fee Schedule
Ambulance Services
July 1, 2019

Proc	Mod	Description	Effective	Method	Fees	PA	Pass
A0021	-	OUTSIDE STATE AMBULANCE SERV	7/1/2019	FEE SCHED	$15,696.55	Y	-
A0380	-	BASIC LIFE SUPPORT MILEAGE	7/1/2019	FEE SCHED	$3.86	Y	-
A0382	-	BASIC SUPPORT ROUTINE SUPPLS	7/1/2018	MSRP	$0.00	-	-
A0384	-	BLS DEFIBRILLATION SUPPLIES	7/1/2018	MSRP	$0.00	-	-
A0390	-	ADVANCED LIFE SUPPORT MILEAG	7/1/2019	FEE SCHED	$3.86	Y	-
A0392	-	ALS DEFIBRILLATION SUPPLIES	7/1/2018	MSRP	$0.00	-	-
A0394	-	ALS IV DRUG THERAPY SUPPLIES	7/1/2018	MSRP	$0.00	-	-
A0396	-	ALS ESOPHAGEAL INTUB SUPPLS	7/1/2019	FEE SCHED	$12.70	-	-
A0398	-	ALS ROUTINE DISPOSBLE SUPPLS	7/1/2018	MSRP	$0.00	-	-
A0422	-	AMBULANCE 02 LIFE SUSTAINING	7/1/2019	FEE SCHED	$13.08	Y	-
A0425	-	GROUND MILEAGE	7/1/2019	FEE SCHED	$3.86	Y	-
A0426	-	ALS 1	7/1/2019	FEE SCHED	$164.22	Y	-
A0427	-	ALS1-EMERGENCY	7/1/2019	FEE SCHED	$260.05	Y	-
A0428	-	BLS	7/1/2019	FEE SCHED	$136.85	Y	-

Example: Ambulance

All provider type pages have this section.

Provider Notices

2019

03/20/2019 Prior Authorization Qualitrac Portal

2018

11/20/2018 Appropriate Billing Reminder
11/08/2018 Rate Updates Mass Adjustment
10/19/2018 Medicaid Fee Schedules
07/02/2018 Updated CLIA Claims Editing
06/04/2018 Coding Resources Change
04/04/2018 Updated Passport Eligible Populations & Reimbursement
02/26/2018 New Rendering Only Provider Enrollment Application

2017

12/20/2017 Ambulance Reimbursement Rate Changes
12/11/2017 Montana Plan First Procedure and Service Codes - Contraceptive (IUD) Update
12/01/2017 Montana Medicaid Expansion Prior Authorization Changes
11/20/2017 Qualified Medicare Beneficiary (QMB) Claim Adjustments
11/02/2017 New Medicare Card
10/02/2017 Montana Medicaid Expansion Changes
09/14/2017 Montana Plan First Anesthesia Update
08/21/2017 Clinical Pharmacist Practitioner
08/08/2017 HMK-CHIP Ambulance Claims Administration Change
08/01/2017 Telemedicine - Correction
05/26/2017 Federal Final Rule, "Nondiscrimination in Health Program and Activities" and Implication for Coverage of Services Related to Gender Transition
04/06/2017 New EPSDT Request Form

Questions?

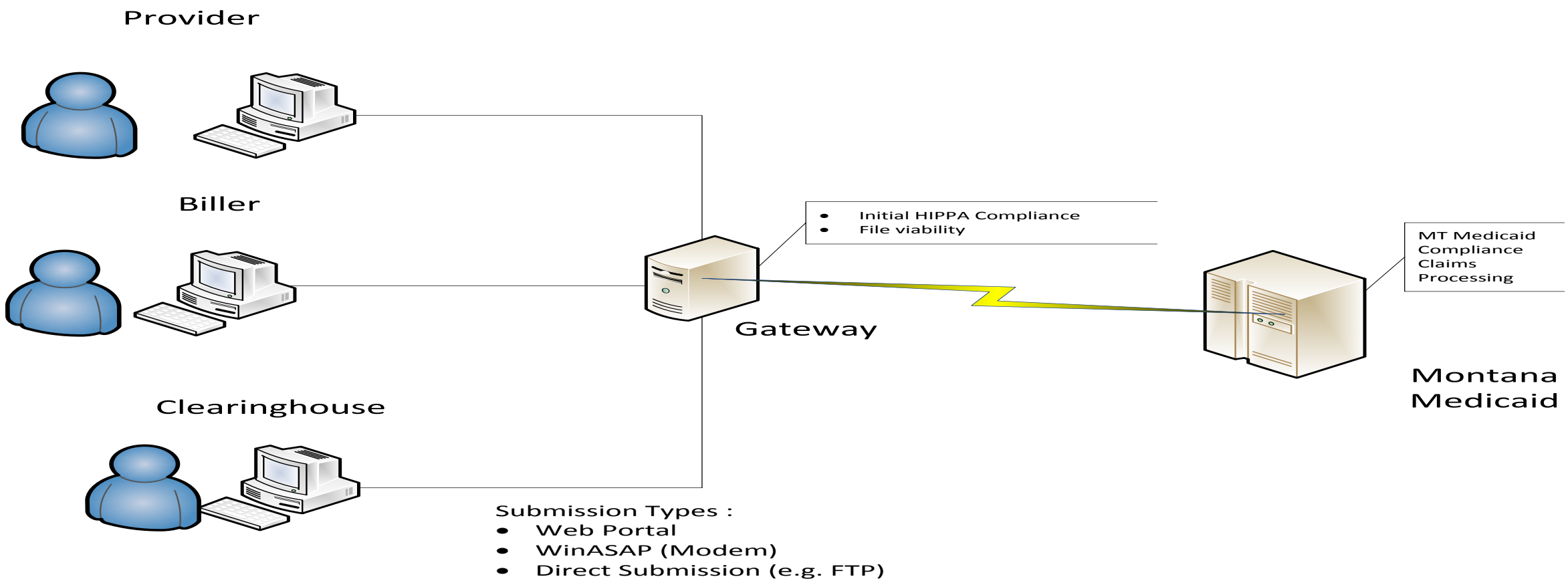
Claim Submission

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 us.



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.

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
- 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:

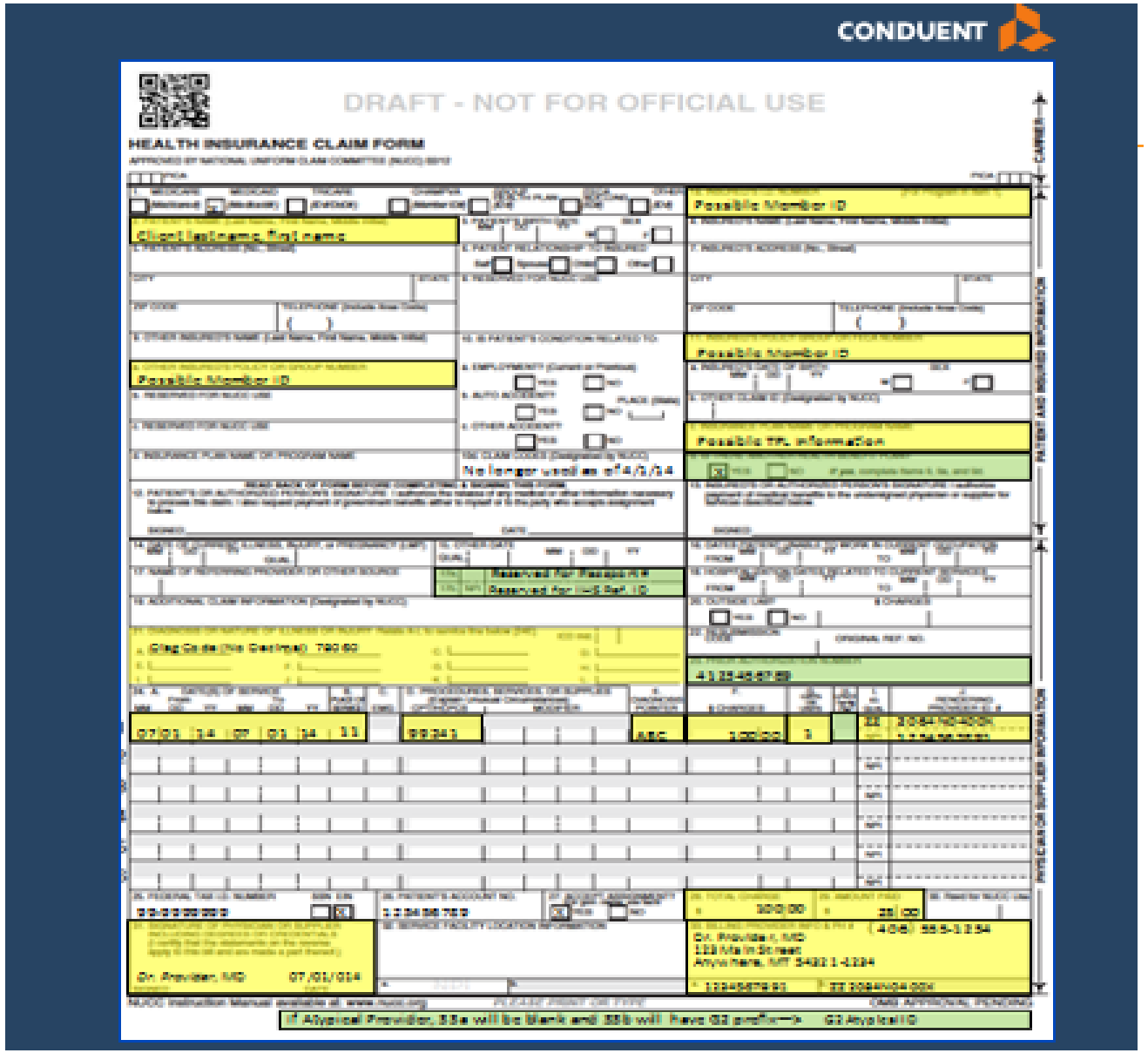
www.nubc.org

Required Fields

CMS 1500

Required Information:

- Members ID-box 1a
- Members Name- box 4
- DX-box 21
- DOS-box 24
- POS-box 24b
- Procedure code-box 24d
- DX pointer-box 24e
- Line Charge-box 24f
- Days/Units-box 24g
- Taxonomy & Qualifier
- NPI or Atypical PID –box 24j-(and qualifier)24i
- Total Charges-box 28
- Provider Signature and Date-31
- Billing Provider Name, Address, & Zip code +4-box 33
- NPI or Atypical PID (and qualifier)-box 33 a&b

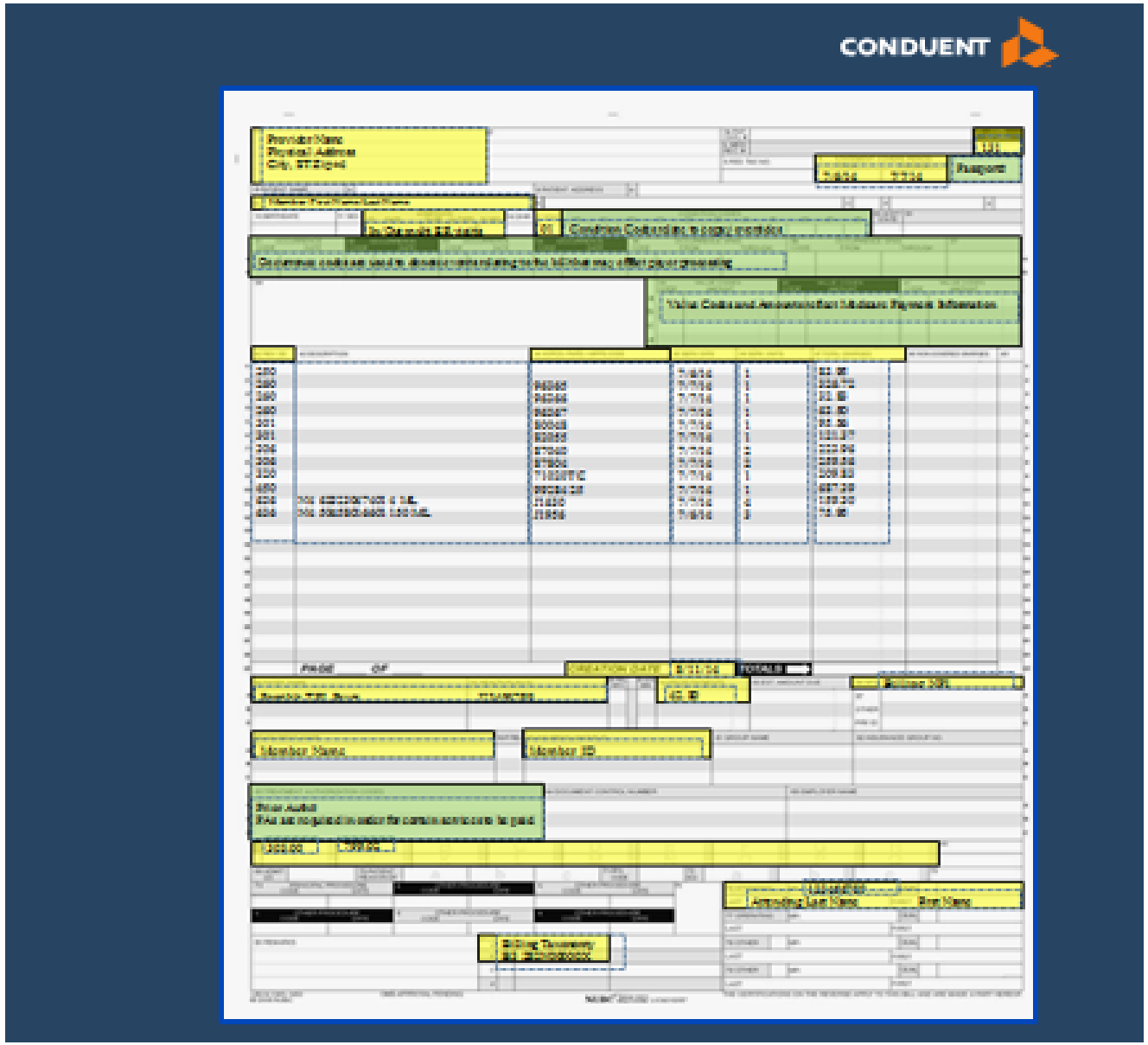


Required Fields

UB 04

Required Information:

- Providers Physical Address-field 1
- Bill Type-field 4
- Covered Dates-field 6
- Patient Name-field 8a
- Admit Date/hour-field 12
- Discharge Status-field 17
- Rev Codes-field 42
- HCPCS Codes field 44
- Service Dates-field 45
- Service units-field 46
- Charges-field 47
- Creation Date
- Payer Name-field 50
- Plan ID-field 51
- Prior Payments-field 54
- Billing Provider NPI-field 56
- Member Name-field 58
- Member ID-field 60
- DX Codes-field 66
- Attending Provider NPI-field 76
- Billing Provider Taxonomy (B3 Qualifier)-field 81



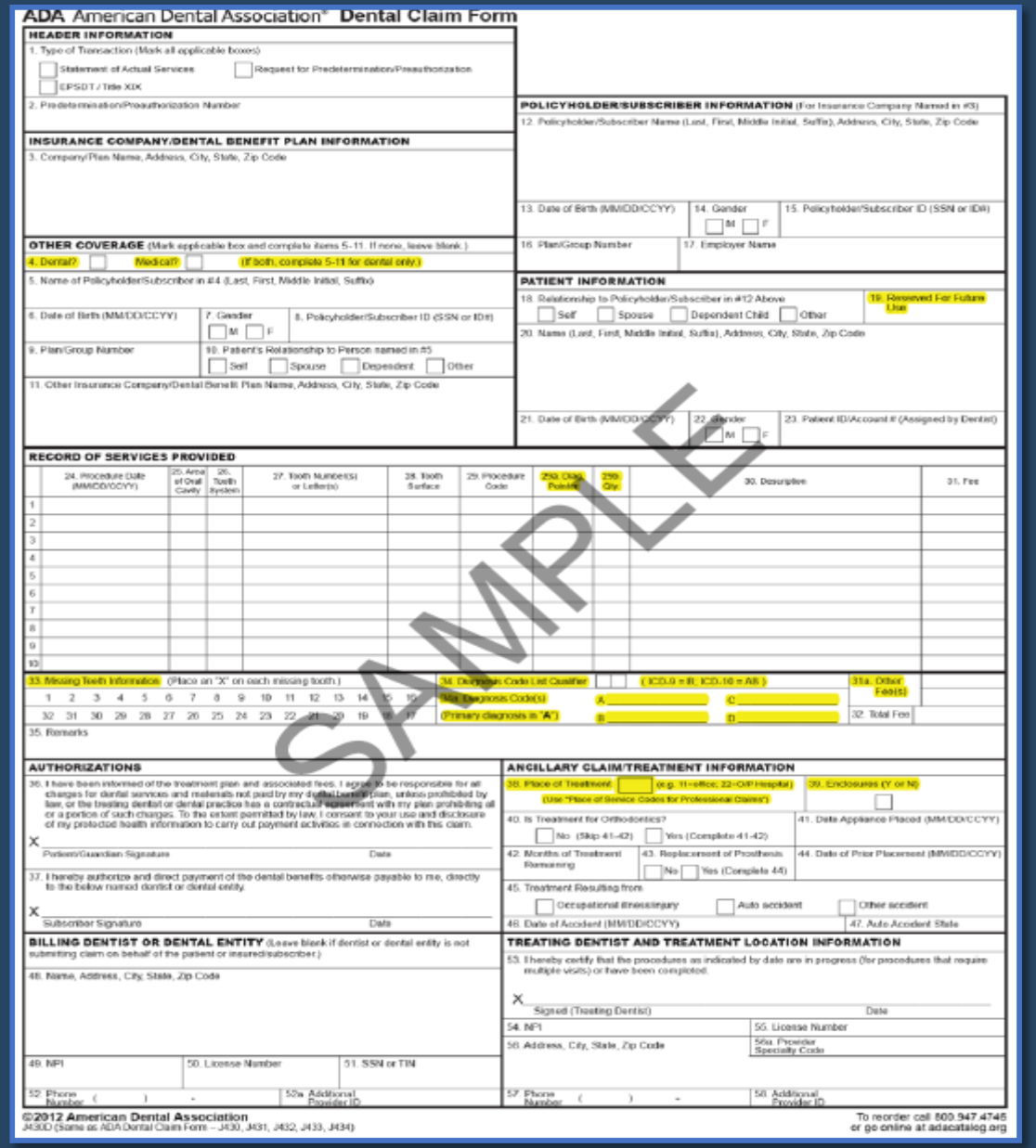
ADA Dental

Required Information:

- Member Name
- Member ID
- Provider Name
- Provider Taxonomy (No qualifier needed)
- Provider Signature
- Bill Date
- Line Date of Service
- Procedure Code
- Total Charge for Each Line

Billed by:

Dentists, Dental Hygienists, Denturists, and HMK Dentists


ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services
Request for Predetermination/Preauthorization
EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender M F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender M F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: Self Spouse Dependent Child Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender M F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29b. Diag. Pointer	29c. Qty.	30. Descriptive	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Tooth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
34. Diagnosis Code List Qualifier (ICD-9 = BI, ICD-10 = ABJ)
34a. Diagnosis Code(s) (Primary diagnosis in "A".) A B C D
31a. Other Fee(s)
32. Total Fee
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=Off Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N)
40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis No Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from: Occupational Illness/Injury Auto accident Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X
Signed (Treating Dentist) Date
54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)
To reorder call 800.947.4746 or go online at adacatalog.org

SAMPLE

MA-3 Claim Type Billers

Nursing Homes

*Each section is one claim

*One form can have 6 claims

ICF-Intermediate Care Facility

SNF-Skilled Nursing Facility

SNF/ICF Mental Aged

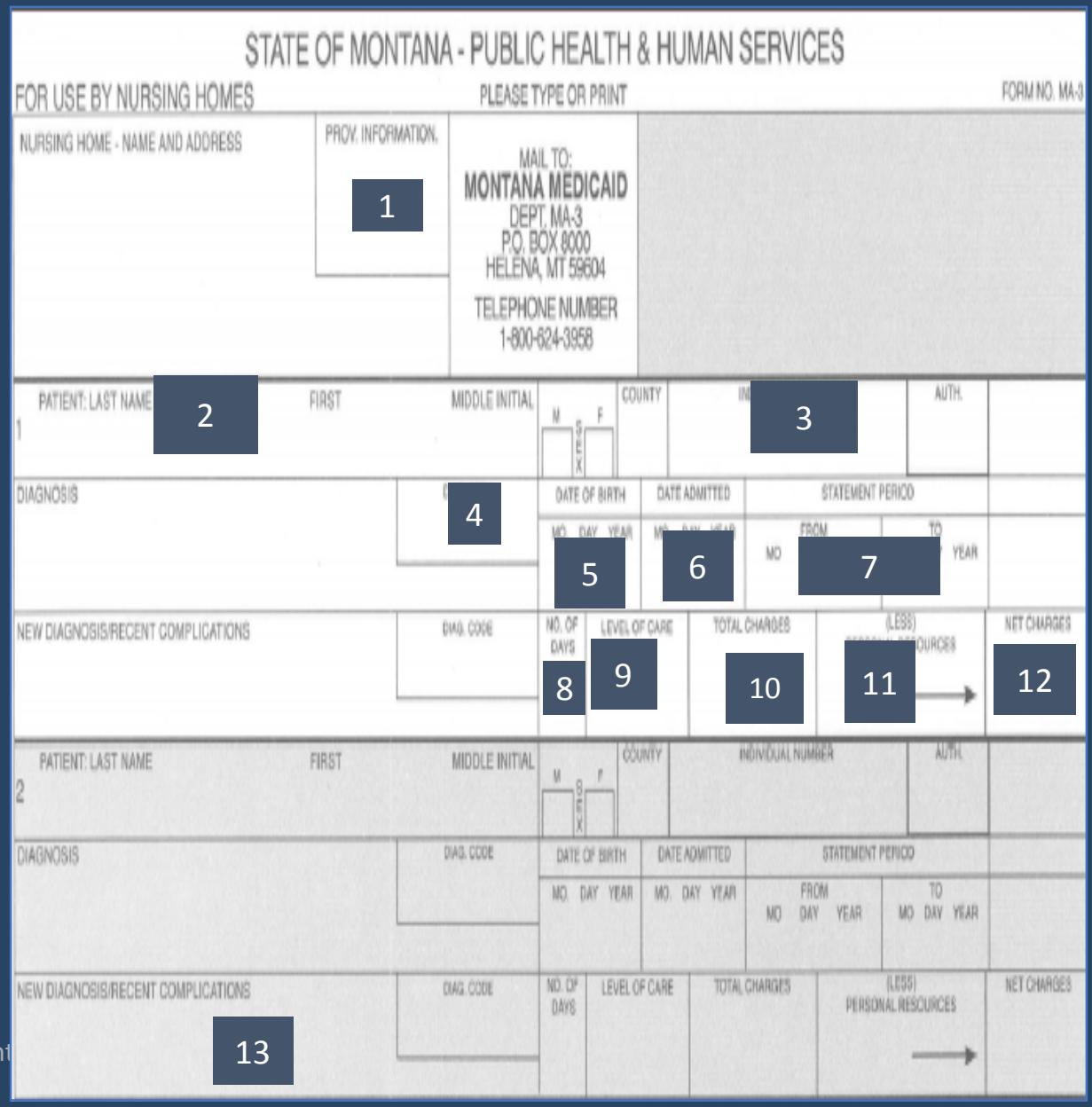
*Montana Mental Health Nursing Care Center

- Turn around documents (TADs) are MA-3 reports pre-completed with billing information for residents who were in the facility the previous month.
- These are generated and sent to facilities during the 3rd week of the month.
- Providers must make all the necessary changes to the TADs before returning them for processing.
- If there are changes, the provider must make out the No. of days, total charges, personal resources and/or net charges and enter the corrected information.
- Any new or additional information such as a new DX/recent complications may also e entered
- The authorized agent must sign, date and send in the reports after all changes are made and after the last billing date.

MA-3

Required Information:

1. NPI and taxonomy
2. Patient last and First Name
3. Member ID
4. DX Code
5. Date of Birth
6. Date of Admission
7. Statement Period
8. Number of Days
9. Level of Care
10. Total Charges
11. Personal Resource
12. Net Charges
13. Provider Signature and Date



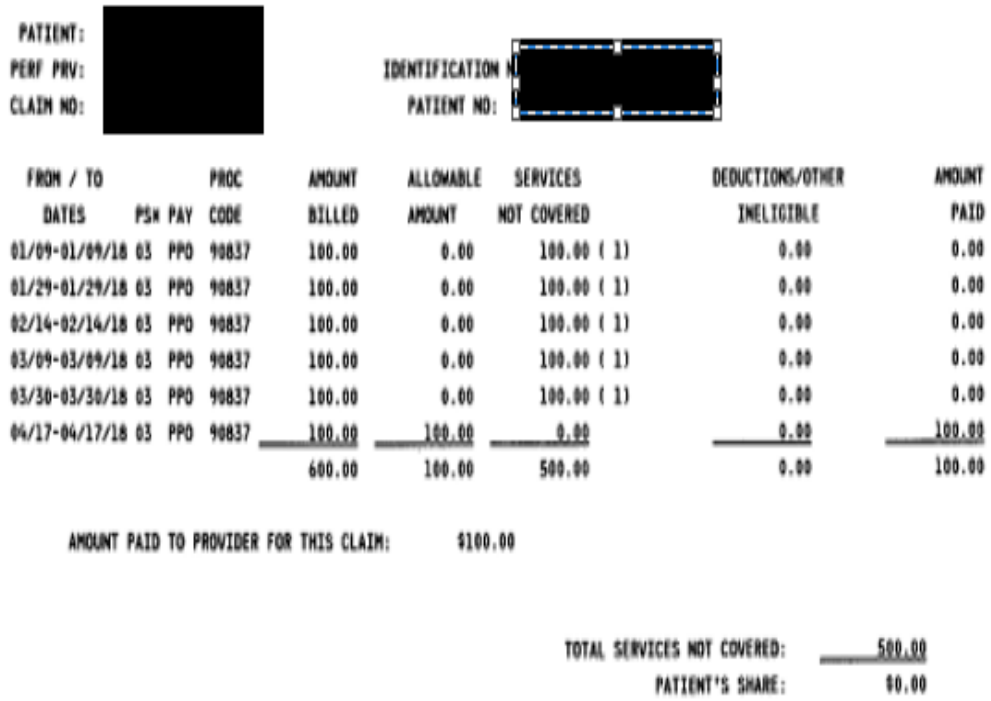
Paperwork Attachments and Electronic Claims

EOB for Primary Insurance

It is important that you send in all required information from the primary insurance's EOB.

- The page that shows the member and all their charges. Must show date of service, CPT codes, amount billed and amount paid by the primary insurance.
- The page that shows the "Key" to the codes listed on the EOB. This is normally the last page of the EOB.
- If there is more than one patient on the page, please cross out the information for other patients.

EOB Example - Incomplete



PATIENT: [redacted]
PERF PRV:
CLAIM NO:

IDENTIFICATION N [redacted]
PATIENT NO:

FROM / TO DATES	PS#	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
01/09-01/09/18	03	PPO	90837	100.00	0.00	100.00 (1)	0.00	0.00
01/29-01/29/18	03	PPO	90837	100.00	0.00	100.00 (1)	0.00	0.00
02/14-02/14/18	03	PPO	90837	100.00	0.00	100.00 (1)	0.00	0.00
03/09-03/09/18	03	PPO	90837	100.00	0.00	100.00 (1)	0.00	0.00
03/30-03/30/18	03	PPO	90837	100.00	0.00	100.00 (1)	0.00	0.00
04/17-04/17/18	03	PPO	90837	100.00	100.00	0.00	0.00	100.00
				600.00	100.00	500.00	0.00	100.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $100.00

TOTAL SERVICES NOT COVERED: 500.00
PATIENT'S SHARE: $0.00

PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	$0.00
AMOUNT BILLED:	$500.00	AMOUNT PAID TO PROVIDER:	$0.00
AMOUNT OVER MAXIMUM ALLOWANCE:	$0.00	RECOUPMENT AMOUNT:	$0.00
AMOUNT OF SERVICES NOT COVERED:	$500.00	NET AMOUNT PAID TO PROVIDER:	$0.00
AMOUNT PREVIOUSLY PAID:	$0.00	SUPPRESSED PAYMENT AMOUNT:	$0.00

* PLACE OF SERVICE (PS)

03. PHYSICIAN'S OFFICE.

MESSAGES:

(1). DUPLICATE BILLING, PREVIOUS CLAIM SUBMITTED.

EOB Example - Correct

[redacted]

SUBSCRIBER ID: [redacted]
CLAIM DATE:
REND PROV ID:

SUBSCRIBER NAME: [redacted]
DATE RECEIVED:
REND PROV:

CLAIM NUMBER:
PRODUCT: [redacted]

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
0077581935					$100.00				$0.00	$100.00

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
0602077S8 1925	11/11/19 - 11/11/19		90837			1		$100.00	$100.00	$100.00	PR	1	$0.00	W1
CLAIM# [redacted]							SUBTOTAL	$100.00	$100.00	$100.00			$0.00	

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

TOTAL PAYABLE TO PROVIDER	$0.00	

NOTES

PR1 PATIENT RESPONSIBILITY - DEDUCTIBLE AMOUNT

W1 BENEFITS FOR THIS SERVICE HAVE BEEN APPLIED TO YOUR DEDUCTIBLE. THE AMOUNT YOU OWE SHOWN ON THIS STATEMENT IS THE AMOUNT YOU MAY OWE YOUR PROVIDER.

Electronic with Paper Attachments

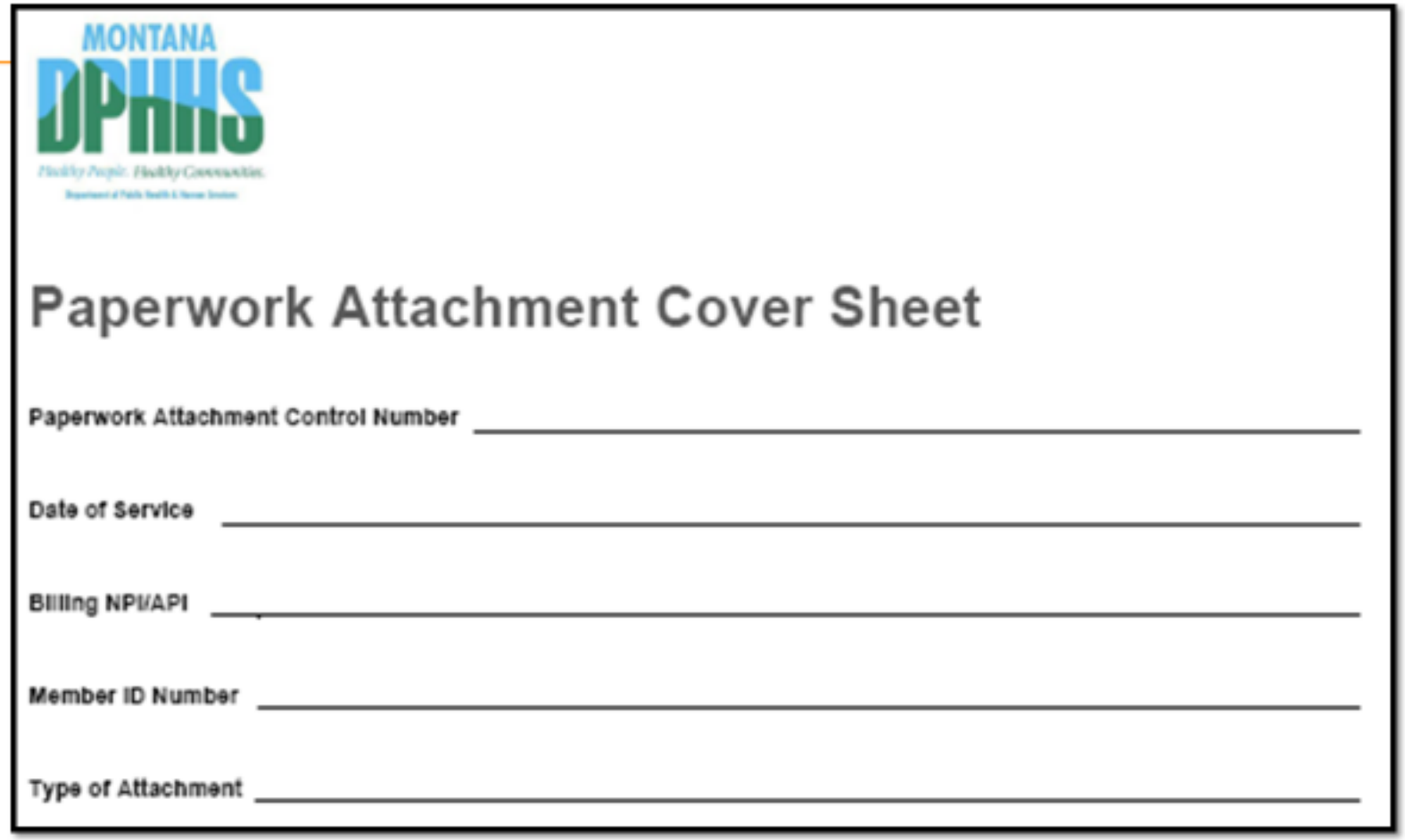
CONDUENT

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

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

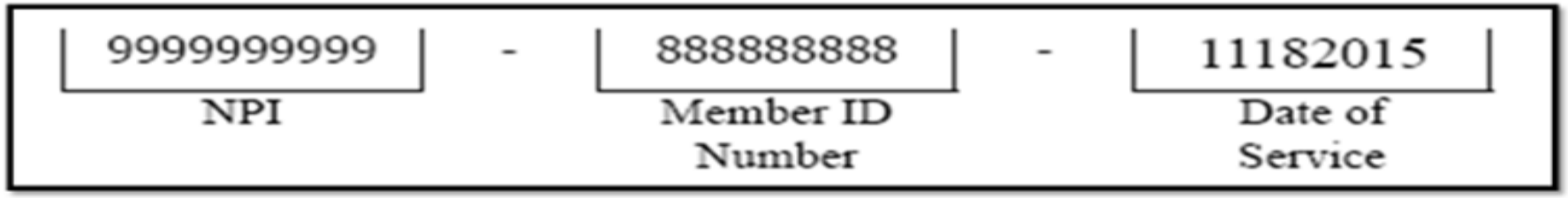
Billing NPI/API _____

Member ID Number _____

Type of Attachment _____

Electronic with Paper Attachments

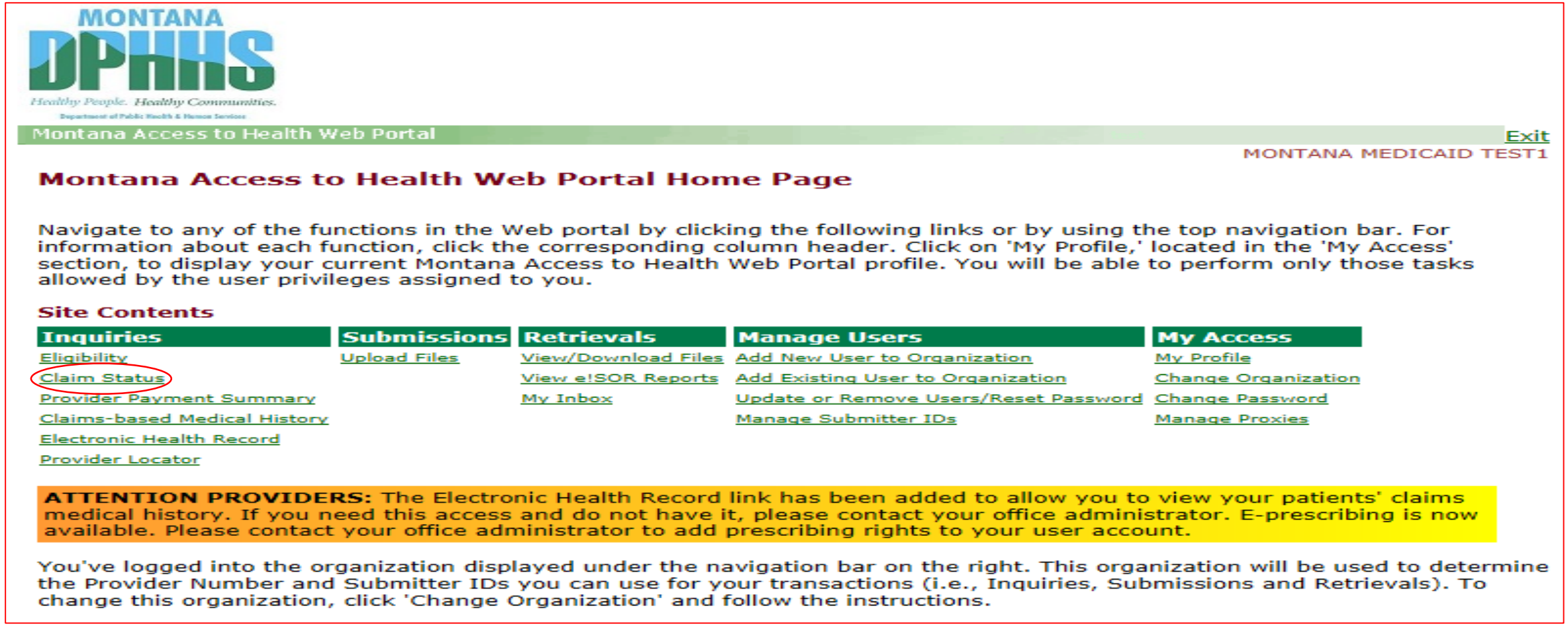
- Must indicate that Paperwork is being sent in the electronic claim file.
- Loop 2300, PWK segment
- Must be received by Claims Dept. within 30 days of electronic submittal.
- After 30 days, the claim will be denied and will need to be resubmitted with paper attachments.
- Must include Paperwork Attachment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



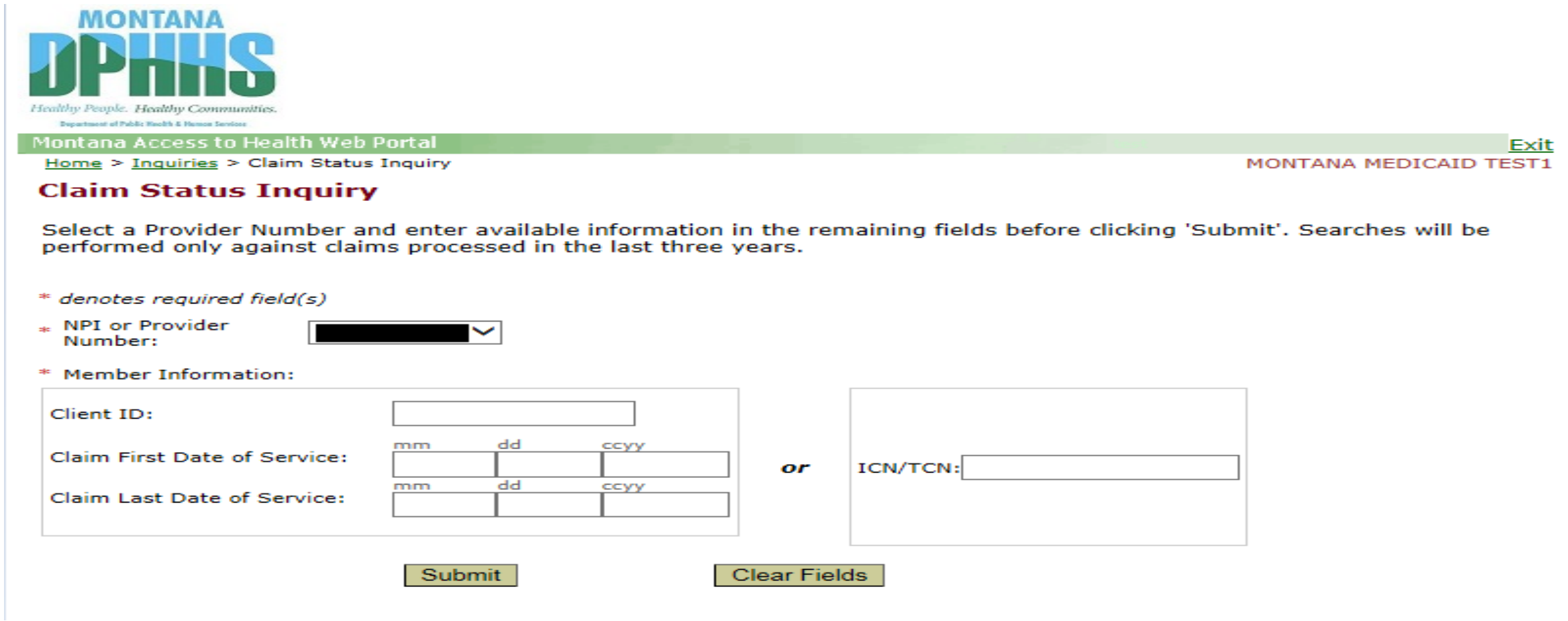
Questions?

Claim Status

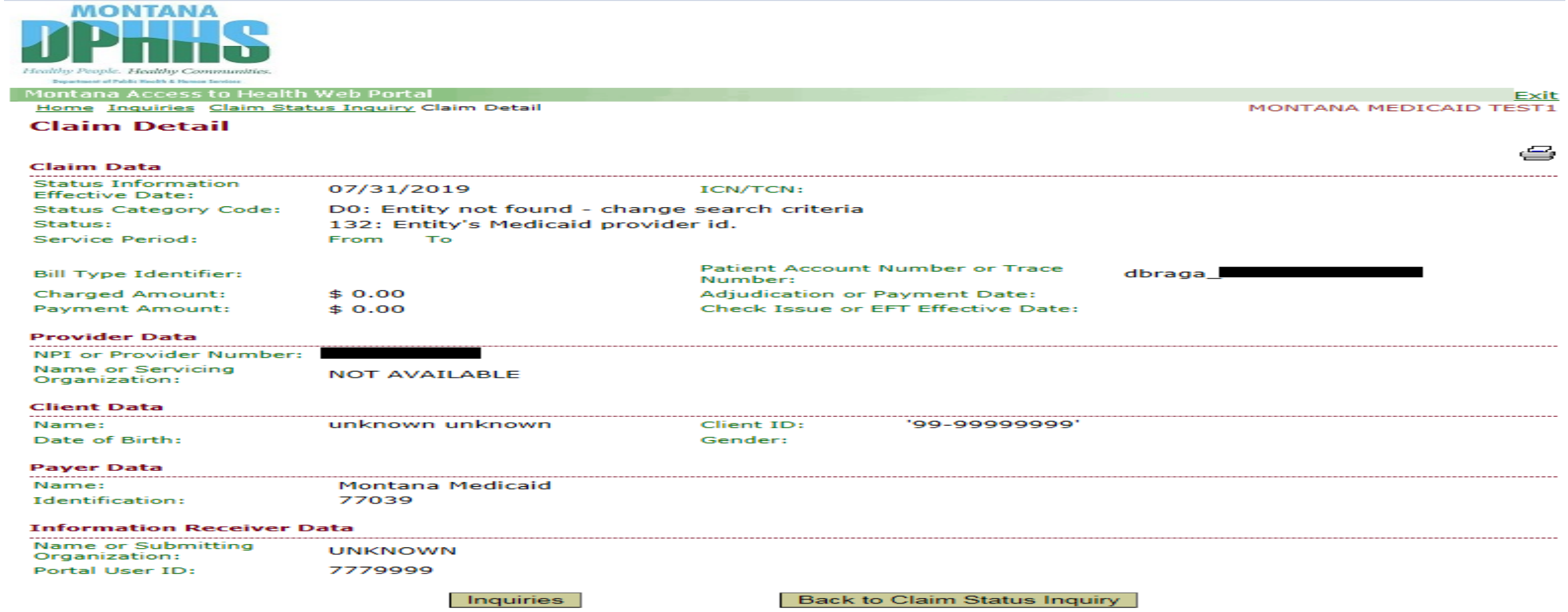
Claim Status



Claim Status Inquiry



Sample Claim Detail



MONTANA DPHHS
Healthy People. Healthy Communities.

Montana Access to Health Web Portal — Exit

Home Inquiries Claim Status Inquiry Claim Detail — MONTANA MEDICAID TEST1

Claim Detail

Claim Data

Status Information Effective Date:	07/31/2019	ICN/TCN:	
Status Category Code:	D0: Entity not found - change search criteria		
Status:	132: Entity's Medicaid provider id.		
Service Period:	From To		
Bill Type Identifier:		Patient Account Number or Trace Number:	dbraga_[redacted]
Charged Amount:	$ 0.00	Adjudication or Payment Date:	
Payment Amount:	$ 0.00	Check Issue or EFT Effective Date:	

Provider Data

NPI or Provider Number:	[redacted]
Name or Servicing Organization:	NOT AVAILABLE

Client Data

Name:	unknown unknown	Client ID:	'99-99999999'
Date of Birth:		Gender:	

Payer Data

Name:	Montana Medicaid
Identification:	77039

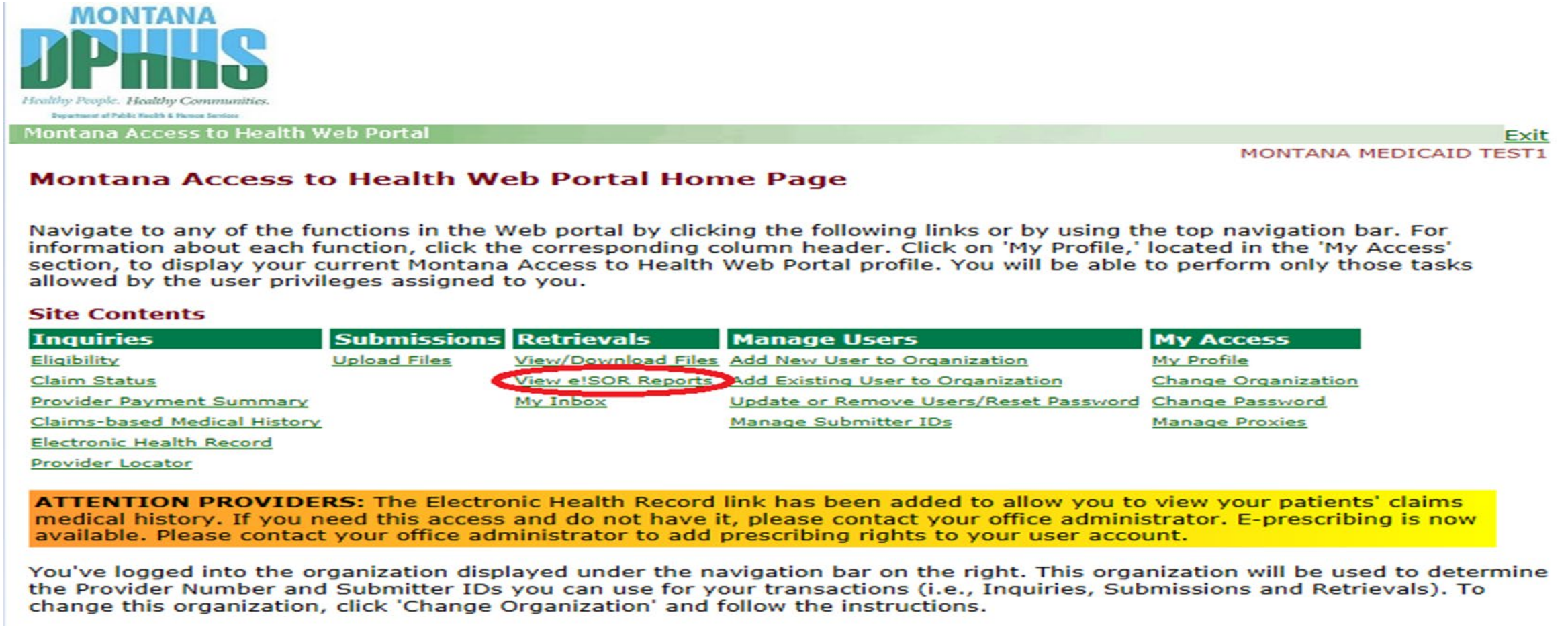
Information Receiver Data

Name or Submitting Organization:	UNKNOWN
Portal User ID:	7779999

Inquiries | Back to Claim Status Inquiry

Obtaining Statement of Remittance (eSors)

Obtaining your eSOR



Obtaining your eSOR

eSOR by Date

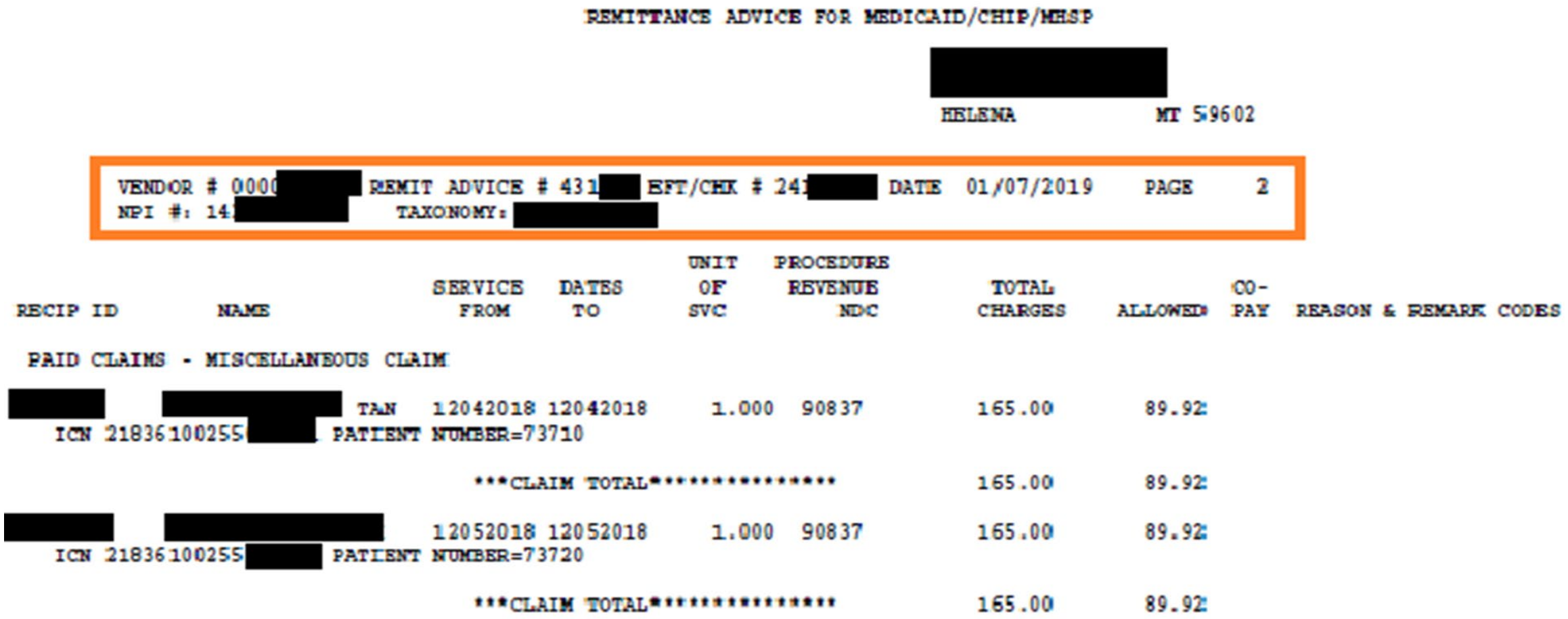
View/Download State of Remittance

A portion of this payment is made from American Recovery Investment Act funds. Go to http://recovery.mt.gov to follow how we are reinvesting and rebuilding Montana with funding from the Recovery and Reinvestment Act.

Report files will be stored for 90 days, after which time they will be deleted from the Web Portal.

Payment Date	File Name	File Size	Download Speed
05/27/2019	05272019_1003902909_01.pdf	68,369 bytes	Calculate
05/20/2019	05202019_1003902909_01.pdf	29,707 bytes	Calculate
05/13/2019	05132019_1003902909_01.pdf	39,367 bytes	Calculate
05/06/2019	05062019_1003902909_01.pdf	58,707 bytes	Calculate
04/29/2019	04292019_1003902909_01.pdf	39,373 bytes	Calculate
04/22/2019	04222019_1003902909_01.pdf	29,707 bytes	Calculate
04/15/2019	04152019_1003902909_01.pdf	39,371 bytes	Calculate
04/08/2019	04082019_1003902909_01.pdf	39,371 bytes	Calculate
04/01/2019	04012019_1003902909_01.pdf	39,375 bytes	Calculate
03/25/2019	03252019_1003902909_01.pdf	49,039 bytes	Calculate
03/18/2019	03182019_1003902909_01.pdf	58,701 bytes	Calculate
03/11/2019	03112019_1003902909_01.pdf	68,363 bytes	Calculate
03/04/2019	03042019_1003902909_01.pdf	87,695 bytes	Calculate
02/25/2019	02252019_1003902909_01.pdf	68,367 bytes	Calculate
02/18/2019	02182019_1003902909_01.pdf	126,352 bytes	Calculate

Remit Example



REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

[redacted]
HELENA MT 59602

VENDOR # 0000[redacted] REMIT ADVICE # 431[redacted] EFT/CHK # 241[redacted] DATE 01/07/2019 PAGE 2
NPI #: 14[redacted] TAXONOMY: [redacted]

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM									
[redacted]	[redacted] TAN	12042018	12042018	1.000	90837	165.00	89.92		
ICN 21836100255[redacted] PATIENT NUMBER=73710									
	CLAIM TOTAL					165.00	89.92		
[redacted]	[redacted]	12052018	12052018	1.000	90837	165.00	89.92		
ICN 21836100255[redacted] PATIENT NUMBER=73720									
	CLAIM TOTAL					165.00	89.92		

Example of Denial Reason Codes

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

N286 **Missing/incomplete/invalid referring provider primary identifier.**

133 **The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).**

15 **The authorization number is missing, invalid, or does not apply to the billed services or provider.**

Questions?

Common Billing Errors

Common Billing Errors

- Missing/Incorrect Passport number or in incorrect field. (17a for 1500/7 for UB)
- Missing PWK indicator on electronic claims.
- Incomplete primary EOB. Missing pages that contain code remarks.
- Member not eligible on date of service. Remember coverage could change monthly.
- Exact duplicates. Can be avoided by checking eSORs weekly or using IARs for claim corrections.
- Missing/incorrect Prior Authorization number or in incorrect field. (23 for 1500/63 for UB)

Submitting Individual Adjustment Requests

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 voided and reprocessed”. This has to be requested on the adjustment form and needs to include the corrected claim.

Adjustment Requirements

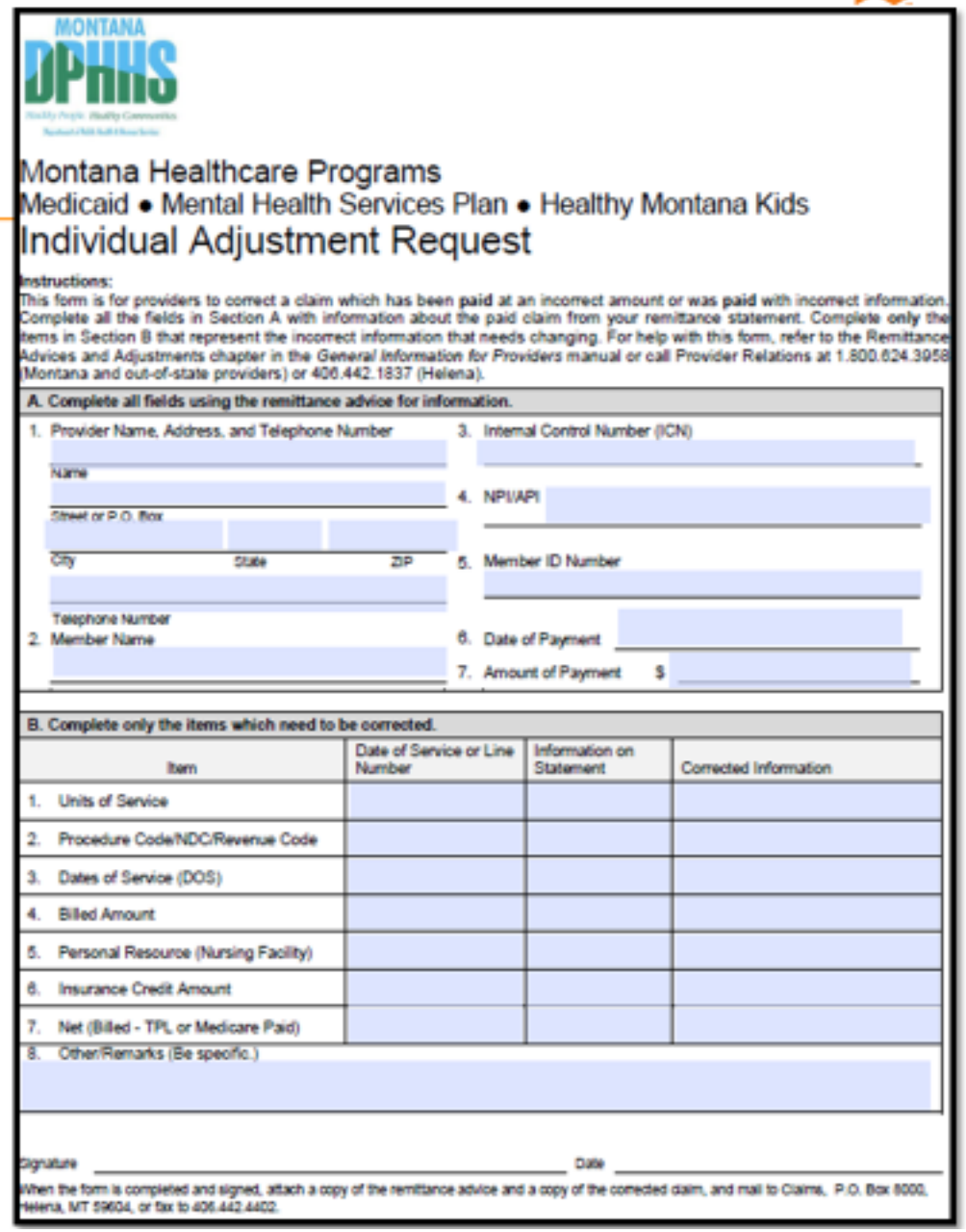
- Must be requested on the Individual Adjustment Request Form.
- Only be submitted on paid claims; denied claims cannot be adjusted.
- Always require a remit from the paid claim.
- Claims Processing must receive individual claim adjustments within 12 months from the date of Payment. After this time,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

Adjustment Request Form

One adjustment form per Internal Control Number

Section A – Must be completely filled out

Section B – Only the info that needs changing



MONTANA DPHHS

Montana Healthcare Programs
Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

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

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

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

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

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

Signature _____ Date _____

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

Adjustment Request Form - Section A

CONDUENT

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

CONDUENT

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.
2. 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.

Adjustment Form Examples

Example #1 – Incorrect units billed

Actual Claim

```
1541234 Mouse, Mickey        08012019 08312019  1.000 S0215   53.04 0.39
ICN 2192520025500l234 PATIENT NUMBER=1541234
TEAM NUMBER 01
                              ***CLAIM TOTAL*************** 53.04 0.39
```

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Examples

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

1. Provider Name, Address, and Telephone Number

DDP Provider
Name

123 Any Street
Street or P.O. Box

City | MT | 12345
City | State | ZIP

4065551212
Telephone Number

2. Member Name

Mickey Mouse

3. Internal Control Number (ICN)

21925200255001234

4. NPI/API 1010101010

5. Member ID Number

1541234

6. Date of Payment 09/09/2019

7. Amount of Payment $ 0.39

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	01	1	136

Adjustment Form Example #1

Adjustments – Two parts.

```
1541234 Mouse, Mickey     08012019 08312019       1.000 S0215       53.04- 0.39-
ICN 2192880025510170O PATIENT NUMBER=1541234
TEAM NUMBER 01
                                        ***CLAIM TOTAL*************** 53.04- 0.39-


1541234 Mouse, Mickey     08012019 08312019     136.000 S0215       53.04 53.04
ICN 2192880025520170O PATIENT NUMBER=1541234
TEAM NUMBER 01
                                        ***CLAIM TOTAL*************** 53.04 53.04
```

This is what the paid adjusted claim looks like on the eSOR.

Adjustment Form Example #2

Example #2 – Incorrect Units and Billed Amount

```
1123175 Duck, Donald      08012019 08312019     1.000 T2021     596.47 195.19
ICN 2192530025501356 7 PATIENT NUMBER=1123175
TEAM NUMBER 01
                          08012019 08312019     1.000 T2002     248.45 248.45
                                  ***CLAIM TOTAL*************** 844.92 443.64
```

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Example #2

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

1. Provider Name, Address, and Telephone Number

DDP Provider
Name

123 Any Street
Street or P.O. Box

City | MT | 12345
City | State | ZIP

4065551212
Telephone Number

2. Member Name

Donald Duck

3. Internal Control Number (ICN)

21925300255013567

4. NPI/API 1010101010

5. Member ID Number

1123175

6. Date of Payment 09/09/2019

7. Amount of Payment $ 443.64

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	01	1	18
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount	01	596.47	955.95

Adjustment Form Example #2

Adjustments – Two parts.

```
1123175 Duck, Donald       08012019 08312019      1.000 T2021    596.47- 195.19-
ICN 2192880025510250O PATIENT NUMBER=1123175
TEAM NUMBER 01
                           08012019 08312019      1.000 T2002    248.45- 248.45-
                                    ***CLAIM TOTAL************    844.92- 443.64-



1123175 Duck, Donald       08012019 08312019     18.000 T2021    955.95 995.95
ICN 2192880025520250O PATIENT NUMBER=1123175
TEAM NUMBER 01
                           08012019 08312019      1.000 T2002     248.45  248.45
                                    ***CLAIM TOTAL************ 1244.40 1244.40
```

This is what the paid adjusted claim looks like on the eSOR.

Adjustment Form Example #3

Example #3 – Multiple lines to correct

```
4054321 Doo, Scooby      08012019 08072019        60.000 S5135       331.35 331.35
ICN 21923800255069330 PATIENT NUMBER=4054321
TEAM NUMBER 01
                         08102019 08102019        12.000 S5135        66.27  66.27
                         08132019 08172019        60.000 S5135       331.35 331.35
                                        ***CLAIM TOTAL*************** 728.97 728.97
```

This is what the initial paid claim looks like on the eSOR.

Adjustment Form Example #3

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

1. Provider Name, Address, and Telephone Number

DDP Provider
Name

123 Any Street
Street or P.O. Box

City | MT | 12345
City | State | ZIP

4065551212
Telephone Number

2. Member Name

Scooby Doo

3. Internal Control Number (ICN)

21923800255069330

4. NPI/API 1010101010

5. Member ID Number

4054321

6. Date of Payment 09/02/2019

7. Amount of Payment $ 728.97

8. Other/Remarks (Be specific.)

Line 1 - decrease from 60 units to 15 units. Line 2 - decrease from 12 units to 3 units. Line 3 - decrease from 60 units to 15 units.

8. Other/Remarks (Be specific.)

Line 1 - Decrease from 15 units to 3 units & Decrease billed amount from $82.84 to $66.27
Line 2 - Decrease from 14 units to 4 units & Increase billed amount form $77.32 to $88.36

Adjustment Form Example #3

Adjustments – Two parts.

```
4054321 Doo, Scooby      08012019 08072019        60.000 S5135      331.35- 331.35-
ICN 2192880025510360O PATIENT NUMBER=4054321
TEAM NUMBER 01
                         08102019 08102019        12.000 S5135       66.27-  66.27-
                         08132019 08172019        60.000 S5135      331.35- 331.35-
                                     ***CLAIM TOTAL*************    728.97- 728.97-



4054321 Doo, Scooby      08012019 08072019        15.000 S5135      331.35 331.35
ICN 2192880025520360O PATIENT NUMBER=4054321
TEAM NUMBER 01
                         08102019 08102019         3.000 S5135       66.27  66.27
                         08132019 08172019        15.000 S5135      331.35 331.35
                                     ***CLAIM TOTAL*************    728.97 728.97
```

This is what the paid adjusted claim looks like on the eSOR.

Questions?

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

IVR - Automated system available 24/7:

- (800) 714-0060

Field Representative:

- Deb Braga (406) 457-9553

Conclusion