

# Billing 101 Training for Providers

Presented by Jennifer Stirling, Provider Enrollment Supervisor

# In this training...

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- Claim preparation
- Claims submissions
- MPATH Claims Setup
- MPATH Claims Solution
- MPATH Additional Portal Features
- Adjustments
- Most common billing errors
- Where do I go for help

# Email Assistance

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- The [MTPRhelpdesk@Conduent.com](mailto:MTPRhelpdesk@Conduent.com) can be used for generic questions. Questions related to specific member information or specific claims must be directed to the Call Center. Emails must not contain PHI.
- If you have specific questions regarding an enrollment in process or to follow up on missing documentation, please email [MTEnrollment@conduent.com](mailto:MTEnrollment@conduent.com). Make sure to include the NPI, name, and confirmation number of the enrollment in question.
- Secured emails are not accepted.

# Automated System Information

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The MATH/MPATH portals and the IVR do not give services limits.

Always contact the Call Center to confirm service limits.

The verbiage on the IVR can be confusing when it comes to covered services.

It may say the member is eligible for eye exam & glasses. That only means that the member's coverage allows for this service.

It may say that the member is eligible for vision or dental services when the member only has QMB. This is because Medicare may cover some services in medical setting.

Inconsistent waiver information on MATH portal.

# MPATH Portal Help

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For technical assistance with the Provider Services portal (MPATH)

Email the following to [MTPRhelpdesk@conduent.com](mailto:MTPRhelpdesk@conduent.com) so we can submit a help ticket to our Tech Team.

**GovID:**

**Name:**

**Email registered:**

**NPI used to register:**

**Phone number:**

**A full screen, screen shot of the error:**

For issues registering, please provide screen shots of both the Details tab and Review tab showing all information entered and any error messages.

**\*Include the issue and function you're are attempting.**

# Preparation for submitting claims

# What order should information be gathered?

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1. Verify member eligibility & service limits (if applicable)
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) & modifier
6. Verify Fee Schedule
7. EOB from primary insurance (if applicable)

# Prior Authorizations

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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

DATE 02/25/21

RECIP ID	NAME	PRIOR AUTH NUMBER	AUTHORIZE FROM	DATES TO
00 [REDACTED]	[REDACTED]	10557 [REDACTED]	021521	021521

REASON: 999

LINE	----MAXIMUM----		FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
ITEM	UNITS	DOLLARS			A0430 A0430		
01	1	0.00	021521	021521			
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED		
REASON:							
02	106	0.00	021521	021521	A0435 A0435		
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED		
REASON:							

RECIP ID	NAME	NUMBER	FROM	TO
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00 [REDACTED]	[REDACTED]	10557 [REDACTED]	021121	021121
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REASON: 999

LINE	----MAXIMUM----		FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG	RANGE
ITEM	UNITS	DOLLARS			A0430 A0430		
01	1	0.00	021121	021121			
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED		
REASON:							
02	182	0.00	021121	021121	A0435 A0435		
TOOTH NUM / SURFACE:			THERA CLASS:		STATUS: APPROVED		
REASON:							

# Diagnosis Codes

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ICD-10 is short for *International Classification of Diseases, 10<sup>th</sup> Revision.*

There are many websites out there to obtain this information. This is a very user-friendly site.

<https://icd10coded.com>

# Place of Service

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The Place of Service List is in Appendix B, of the General Information for Providers manual, located on every Provider Type page of the Provider Information website.

<https://medicaidprovider.mt.gov/manuals/generalinformationforprovidersmanual>

# CPT Code

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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>

Correct Procedural Coding Manual. Also contains modifier information.

# Rev Codes

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

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

# Modifiers & Other Coding Resources

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***Resources for coders*** – coding manuals, diagnosis code ICD-10 book & websites, provider manuals, general manual, & provider notices.

Modifier info – CMS newsletter, provider notices, Correct Procedural Coding Manual (appendix A = modifiers).

Montana Medicaid only accepts one modifier on the UB – 04 – use billing modifier first.

Montana Medicaid only accepts up to 3 modifiers on the CMS-1500.

Conduent is not allowed to give billing advice.

# EOB for Primary Insurance

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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 Reason and Remark Code explanations for the codes listed on the EOB.
- If there is more than one patient on the page, please cross out the information for other patients.

# Claims Submission

# Electronic Claim Submission Setup

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You must submit a Montana DPHHS EDI Provider Enrollment Form. This allows your Submitter ID to transmit claims. (Unless using MPATH)

The form can be found on the [Claims page of the Provider Information Website.](#)

# Electronic Claim Submission

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We currently support one free billing program. The MPATH claims solution is a function on the Provider Services Portal.

The MPATH system is a web-based program. Therefore, it can be used on any computer.

The Provider Portal User Guide is available under the Claims Page of the Provider Information Website.

The Call Center can only assist with submission questions on the EDI line. They are not available to walk you through the entire process.

Please send an email to [MTPRHelpdesk@Conduent.com](mailto:MTPRHelpdesk@Conduent.com) if you have set up questions.

# Electronic Claims Submission Cont.

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- Electronic claims must be submitted by 2pm MST on Wednesdays in order process during that claim cycle.
- Electronic claims process faster than paper claims.
- Electronic claims can also be submitted through a Billing Agency or a Clearing House.

# Paper Claim Submissions

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- Paper claims can only be submitted via fax or US Mail.
- Claims may not be emailed.
- Paper claims can take several weeks longer to process than electronic claims as these claims must be manually keyed into our system.
- Claim forms can be purchased through most office supply stores and through Amazon.
- Information must be legible and in the correct fields. Please avoid using copies of copies.
- Instructions can also be found at [www.nucc.org](http://www.nucc.org) and [www.nubc.org](http://www.nubc.org)

# Paper Claim Submissions – CMS 1500

## Required Fields:

- Box 1a Member ID
- Box 2 Member Name
- Box 21 Diagnosis Codes
- Box 24 Lines of Service
- Box 28 Total Charges
- Box 31 Provider’s signature and date
- Box 33 Billing Provider Information
- Box 33a Billing NPI
- Box 33b Billing taxonomy

## Optional fields as applicable:

- Box 11 TPL information
- Box 17a Passport number
- Box 23 Prior Authorization
- Box 29 TPL Payment amount

CMS-1500 02/12

# Additional Montana Medicaid CMS-1500 Info

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- Box 17a Passport referral and Box 23 Prior Authorization are different. The boxes they belong in are not interchangeable.
- Box 24J is for the rendering provider. The NPI and taxonomy must match an active provider file on the DOS.
- Box 29 is for TPL payment amounts except Medicare. When Medicare made a payment, submit the Medicare EOB with the claim without entering any Medicare payment information on the claim.
- Box 33 Billing provider information must match the physical location on file for the Billing NPI listed in box 33a and the Billing taxonomy listed in box 33b. Montana Medicaid does not edit on box 32 for servicing location.

# Paper Claim Submissions – UB-04

## Required Fields:

- Box 1 Billing provider name and address
- Box 4 Type of Bill
- Box 6 Covered Days
- Box 8b Member Name
- Box 12 Admit Date
- Box 17 Discharge Status
- Box 42 Revenue Code
- Box 44 HCPCS code
- Box 45 Service date
- Box 46 Units of Service
- Box 45 total Charges
- Creation Date

- Box 56 Billing NPI
- Box 60 Member ID
- Box 56 Diagnosis Codes
- Box 76 Attending Provider
- Box 81 Billing NPI Taxonomy

## Optional fields:

- Boxes 18-26 Condition Codes
- Box 43 Description – Can be used for NDCs
- Box 50 TPL Payer Name
- Box 51 TPL Member ID
- Box 54 TPL payment amount
- Box 63 Prior Authorization
- Box 74 Surgical procedure Codes

Provider Name Physical Address City, ST Zip+4	131																																															
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ICD-10 codes																																																
Billing Taxonomy B3 282N0000X																																																

# Paper Claim Submissions

## ADA Dental

### Required Fields:

- Box 12 Member Name
- Box 15 Member ID
- Box 29 Procedure Code
- Box 29a Diagnosis Pointer
- Box 29b Unit of Service
- Box 31 Fee
- Box 32 Total Charge
- Box 48 Billing provider Name and Address
- Box 49 Billing NPI
- Box 52a Billing Taxonomy
- Box 54 Rendering NPI
- Box 58 Rendering Taxonomy

### Optional Fields:

- Box 2 Prior Authorization
- Boxes 5-11 TPL Information
- Box 25-28 Tooth Number and Surfaces
- Box 33 Missing Teeth
- Box 35 Remarks (Used to indicate disabled members needing additional services)

ADA American Dental Association® Dental Claim Form																			
<b>HEADER INFORMATION</b>																			
1. Type of Transaction (Mark all applicable boxes)																			
<input type="checkbox"/> Statement of Actual Services		<input type="checkbox"/> Request for Predetermination/Prior Authorization																	
<input type="checkbox"/> EPSDT / Title XIX																			
2. Predetermination/Prior Authorization Number																			
<b>DENTAL BENEFIT PLAN INFORMATION</b>																			
3. Company/Plan Name, Address, City, State, Zip Code																			
4. Other Insurance Company/Plan Name, Address, City, State, Zip Code																			
<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)																			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																			
6. Date of Birth (MM/DD/CCYY)		7. Gender		8. Policyholder/Subscriber ID (Assigned by Plan)															
<input type="checkbox"/> M		<input type="checkbox"/> F		<input type="checkbox"/> U															
9. Plan/Group Number		10. Patient's Relationship to Person named in #8																	
<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Dependent		<input type="checkbox"/> Child		<input type="checkbox"/> Other											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																			
<b>PATIENT INFORMATION</b>																			
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																			
13. Date of Birth (MM/DD/CCYY)		14. Gender		15. Policyholder/Subscriber ID (Assigned by Plan)															
<input type="checkbox"/> M		<input type="checkbox"/> F		<input type="checkbox"/> U															
16. Plan/Group Number		17. Employee Name																	
18. Relationship to Policyholder/Subscriber in #12 Above																			
<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Dependent Child		<input type="checkbox"/> 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		23. Patient ID/Account # (Assigned by Dental)															
<input type="checkbox"/> M		<input type="checkbox"/> F		<input type="checkbox"/> U															
<b>RECORD OF SERVICES PROVIDED</b>																			
24. Procedure Code (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diagnosis	29b. Date	30. Description	31. Fee										
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33. Missing Teeth Information (Place an 'X' on each missing tooth.)																			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34. Diagnosis Code List Qualifier <input type="checkbox"/> ( ICD-10 = AB )		31a. Other Fee(s)	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee	
35. Remarks																			
<b>AUTHORIZATIONS</b>												<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>							
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 dental 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.												38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")							
X												39. Enclosures (Y or N) <input type="checkbox"/>							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dental or dental entity.												40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)							
X												41. Date Appliance Placed (MM/DD/CCYY)							
38. Patient/Guardian Signature _____ Date _____												42. Months of Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)							
39. Subscriber Signature _____ Date _____												43. Replacement of Prosthetic <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)							
40. Billing Dentist or Dental Entity (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)												44. Date of Prior Placement (MM/DD/CCYY)							
41. Name, Address, City, State, Zip Code												45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident							
42. Name, Address, City, State, Zip Code												46. Date of Accident (MM/DD/CCYY) <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)							
47. Auto Accident State																			
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)												48. Signed (Treating Dental) _____ Date _____							
49. NPI												50. License Number							
51. SSN or TIN												52. Additional Provider ID							
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																			
54. NPI												55. License Number							
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455. Phone Number ( ) -												456. Additional Provider ID							
4																			

# MPATH Claims Setup

# Manage Billing Providers

Add Billing NPIs to this section  
ONLY if,

- You will be submitting claims through MPATH
- You need access to the weekly Remittances for this NPI

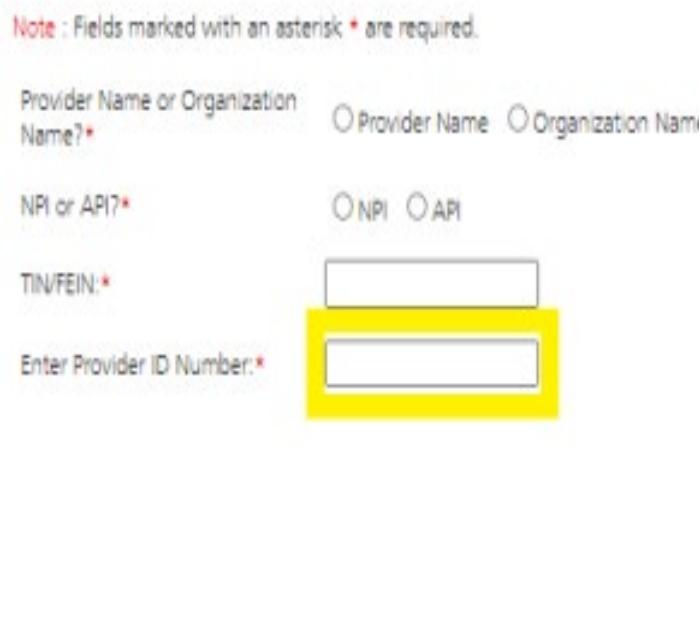
**Note :** Fields marked with an asterisk \* are required.

Provider Name or Organization Name?\*  Provider Name  Organization Name

NPI or API?\*  NPI  API

TIN/FEIN:\*

Enter Provider ID Number:\*



**This is the Optum assigned Provider ID number. *Not the PID from MT Medicaid.* You will need to contact the PR Call Center for this information.**

# Manage Affiliations

---

This function is **NOT** required for facilities or billing providers submitting claims through any other avenue than the MPATH system.

This function adds Rendering providers to the drop-down list, in the MPATH claims entry system.

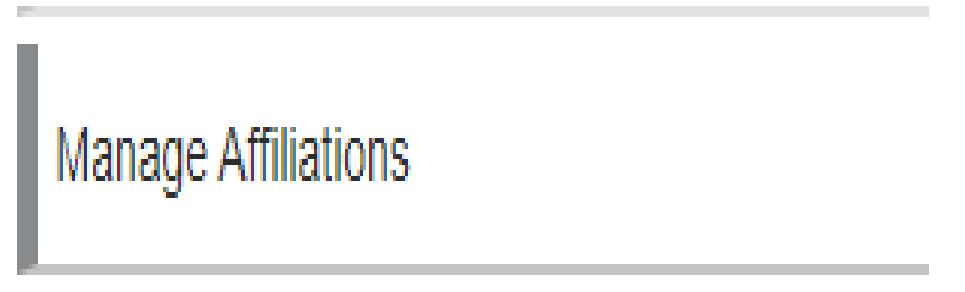
# Add an Affiliation

Click the **Provider Enrollment** tab under myMenu.

Click the **Radio button** on the Enrollment line of the facility.

Click the **Manage Affiliations** tab now visible under the Enrollment Menu.

Actions	Type	Status
<input checked="" type="radio"/>     	Enrollment	Enrolled



# Add an Affiliation Cont.

**Search for Providers tab.**

**Enter Provider's NPI or name.**

**Click Search.**

**Click the Radio button on the provider line now visible.**

**Assigned Locations line is now visible.**

User Guide 

Search for Providers Pending Approval Requested Affiliations Existing Affiliations

**Search for Provider**

To build an affiliation, search for the provider you want to affiliate by entering the first name, last name, or NPI. If no information displays the provider isn't an active enrolled provider and the application will display a 'no affiliation found' message. Based upon your search criteria multiple providers may display, if this is the case, select the provider you want to participate by selecting the radio button next to the provider's name. For authentication and security, please enter the last four (4) digits of the provider's Social Security Number and enter the effective date of the affiliation. When completed select the add and continue button at the bottom of the screen and the request will move to the pending approval tab.

First Name  Last Name  NPI/Atypical ID   
    

	First Name	Last Name	NPI/Atypical ID	Effective Date 	Last 4 digits of SSN/ITIN 	Actions	File Name
<input checked="" type="radio"/>	HEATHER	THOMAS-CLARK	1083670285	MM/DD/YYYY 	<input type="text"/>	 	

Assigned Locations 

	Address Line	
<input type="checkbox"/> 	1111 BAKER AVE	

Items per page 10  1 - 1 of 1    

# Add an Affiliation Cont.

Enter **Effective Date & last 4 digits of the provider's SS#**.

Click the **box** under Assigned Locations for all where the provider will be practicing. Then click the **Pencil** icon.

In the Pop-up box, enter **Effective Date** again. Click **Save**.

Click **Add and Continue**.

	First Name	Last Name	NPI/Atypical ID	Effective Date	Last 4 digits of SSN/ITIN	Actions	File Name
<input checked="" type="radio"/>	ROBERT	NITSCHLME	1598719064	05/12/2022			

Assigned Locations

	Address Line	
<input checked="" type="checkbox"/>	1111 BAKER AVE	

1111 BAKER AVE

Select	Program Name	Effective Date*	Termination Date
<input checked="" type="checkbox"/>	Montana Medicaid (HMK Plus)	05/12/2022	MM/DD/YYYY

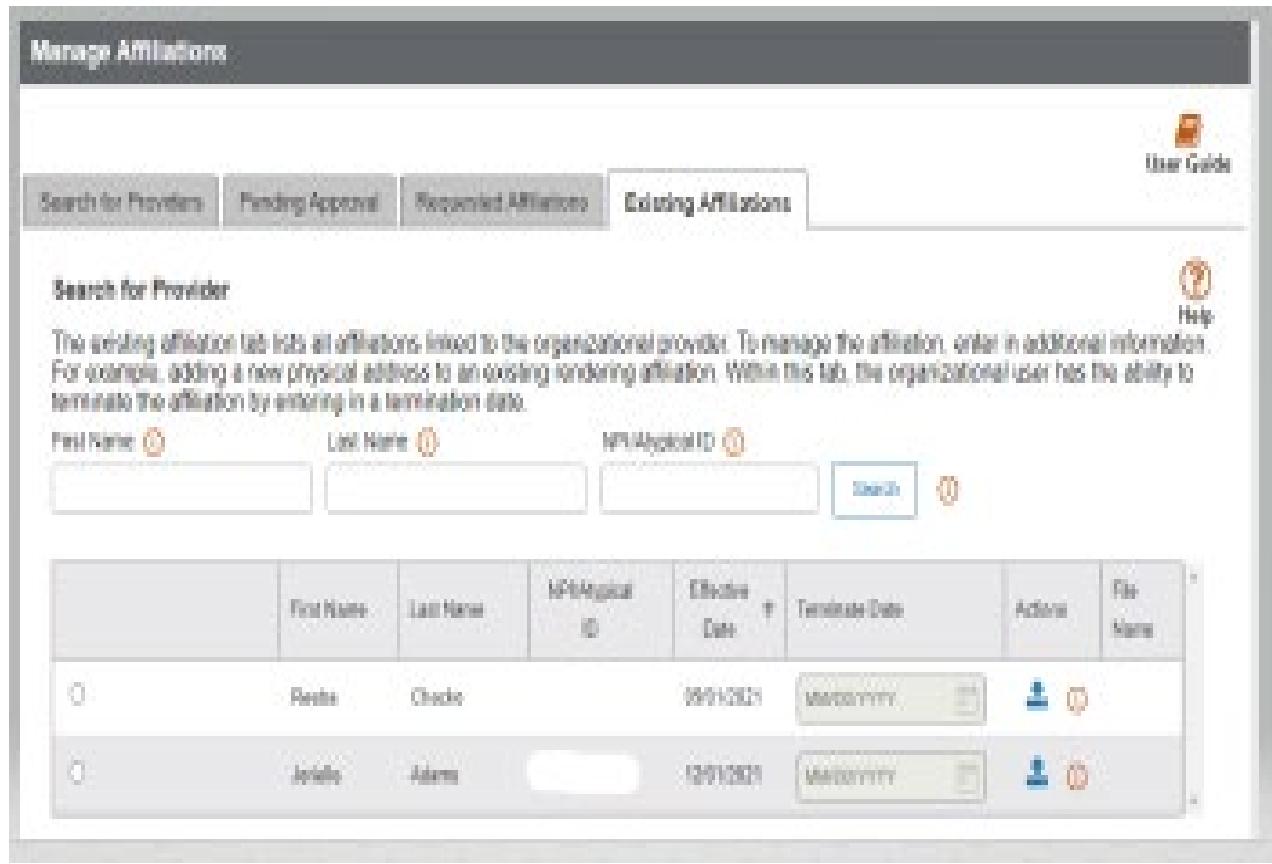
**Save** **Cancel**

# Manage Existing Affiliations

**Pending Approval** tab will show any providers you have submitted to be affiliated.

**Requested Affiliations** are providers who are requesting affiliation.

Approved affiliations can be searched under the **Existing Affiliations** tab.



The screenshot shows a software application window titled "Manage Affiliations". At the top, there is a navigation bar with four tabs: "Search for Provider", "Pending Approval", "Requested Affiliations", and "Existing Affiliations". The "Existing Affiliations" tab is currently selected, indicated by a blue border. In the top right corner, there are "User Guide" and "Help" buttons. Below the tabs, there is a search section titled "Search for Provider" with fields for "First Name", "Last Name", and "NPI/RegID", each with a magnifying glass icon. There is also a "Search" button and a "Help" icon. The main area of the screen displays a table of existing affiliations. The table has columns: First Name, Last Name, NPI/RegID, Effective Date, Termination Date, Actions, and File Name. Two rows of data are visible. The first row shows "Pete" and "Check" in the First Name and Last Name columns respectively, with an NPI/RegID of "1234567890", an Effective Date of "09/01/2021", and a Termination Date of "09/01/2021". The second row shows "John" and "Adam" in the First Name and Last Name columns respectively, with an NPI/RegID of "9876543210", an Effective Date of "12/01/2021", and a Termination Date of "12/01/2021". Each row has an "Actions" column with a blue person icon and an orange person icon, and a "File Name" column.

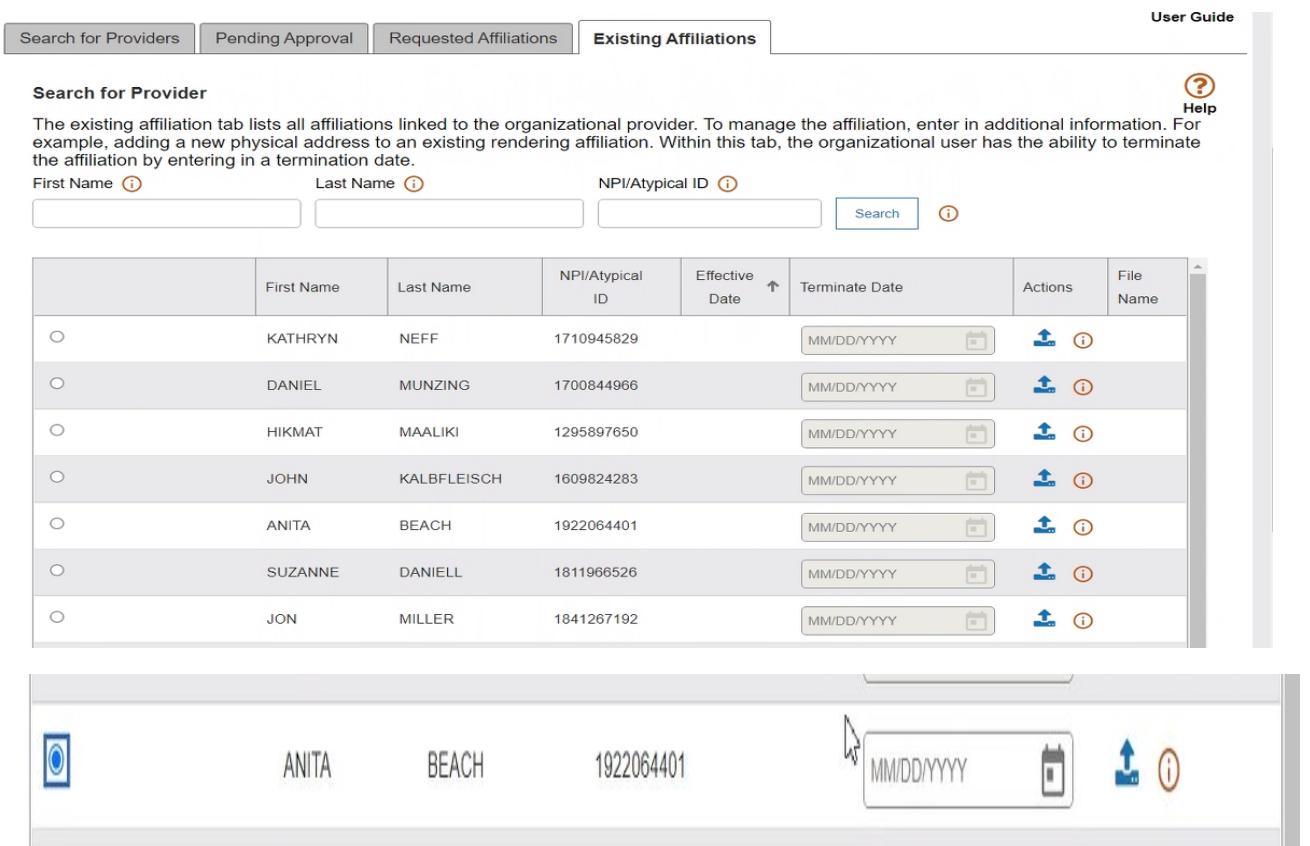
# Ending Affiliations

Click the **Existing Providers** tab.

Click the **Search** button.

This will bring up a list of the providers affiliated to this NPI.

Click the **Radio button** for the provider you wish to terminate.



The screenshot shows a software interface for managing provider affiliations. At the top, there are tabs: 'Search for Providers', 'Pending Approval', 'Requested Affiliations', and 'Existing Affiliations'. The 'Existing Affiliations' tab is selected. To the right of the tabs is a 'User Guide' link and a 'Help' button. Below the tabs is a section titled 'Search for Provider' with three input fields: 'First Name' (with an info icon), 'Last Name' (with an info icon), and 'NPI/Atypical ID' (with an info icon). There is also a 'Search' button and an info icon. Below this is a table listing providers. The table has columns: First Name, Last Name, NPI/Atypical ID, Effective Date (with an info icon), Terminate Date (with an info icon), Actions, and File Name. Each provider row contains a radio button, the provider's name, their NPI/Atypical ID, and a date input field for termination. The 'Actions' column contains icons for edit and delete. The 'Terminate Date' column for each provider has an info icon. The table is scrollable. At the bottom of the screenshot, a zoomed-in view shows the 'Terminate Date' input field for the provider 'ANITA BEACH' with the value '1922064401'. To the right of the input field are icons for edit, delete, and info.

	First Name	Last Name	NPI/Atypical ID	Effective Date ↑	Terminate Date	Actions	File Name
<input type="radio"/>	KATHRYN	NEFF	1710945829	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	DANIEL	MUNZING	1700844966	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	HIKMAT	MAALIKI	1295897650	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	JOHN	KALBFLEISCH	1609824283	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	ANITA	BEACH	1922064401	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	SUZANNE	DANIELL	1811966526	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		
<input type="radio"/>	JON	MILLER	1841267192	MM/DD/YYYY <input type="button" value="Calendar"/>	<input style="margin-right: 10px;" type="button" value="Up"/> <input style="margin-right: 10px;" type="button" value="Delete"/> <input type="button" value="Info"/>		

# Ending Affiliations Cont.

---

The **Assign Locations** box is now visible.

Click the **radio button** under **Deactivate**.  
Enter the **termination date**.

Click the **Save and Continue** button.

The provider will remain on your Affiliations list. However, it will not appear in the claims drop down.

Address Line	Active	Deactivate	Effective Date	Terminate Date	
1111 BAKER AVE	<input type="radio"/>	<input checked="" type="radio"/>	01/01/2006	05/11/2022	

Questions?

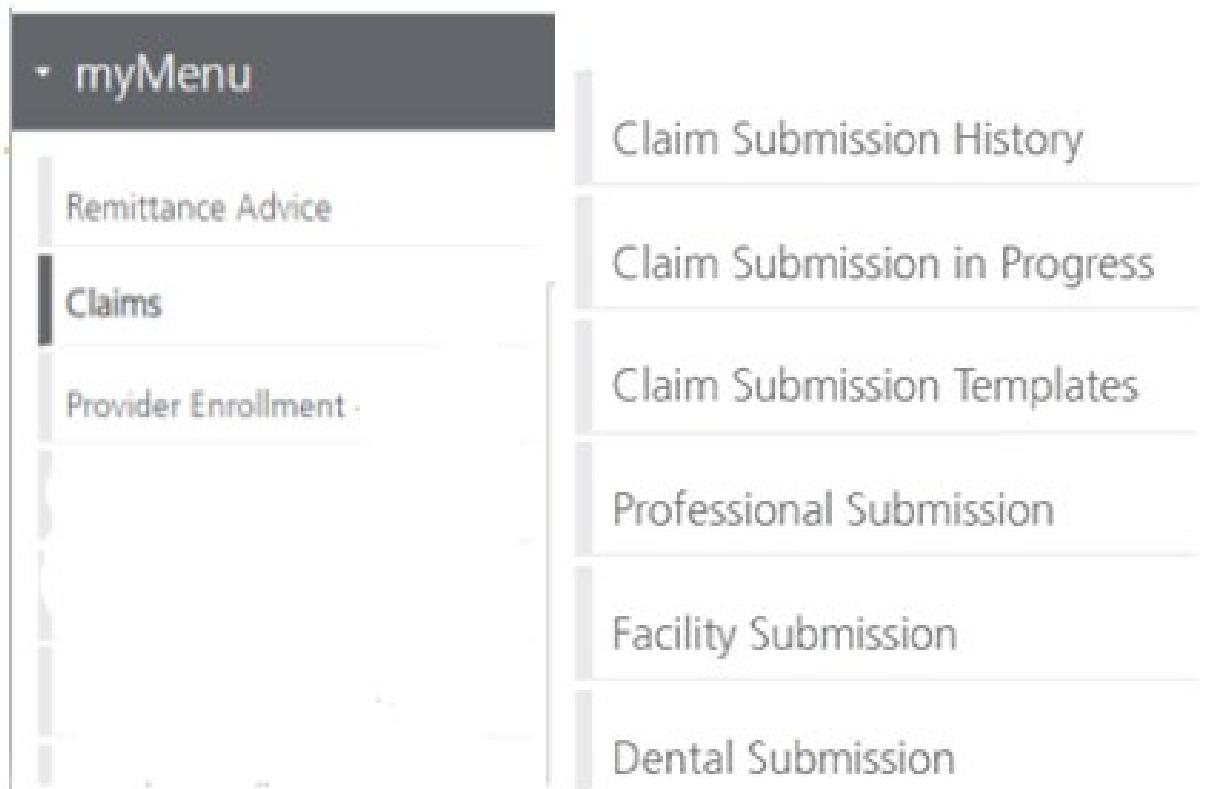
# MPATH Claims Solution

# Claim Submission Menu

Under myMenu, without clicking, place your cursor on the **Claims** tab.

A side menu with submission options will appear.

The following slides will describe each function.



# Claims Submission History

---

This option will show you the most recent claims SUBMITTED to Montana Medicaid for processing.

This function comes in handy if you have a big batch of claims to submit and lose track of who you have completed.

This section will not give you any charge line details or adjudication information.

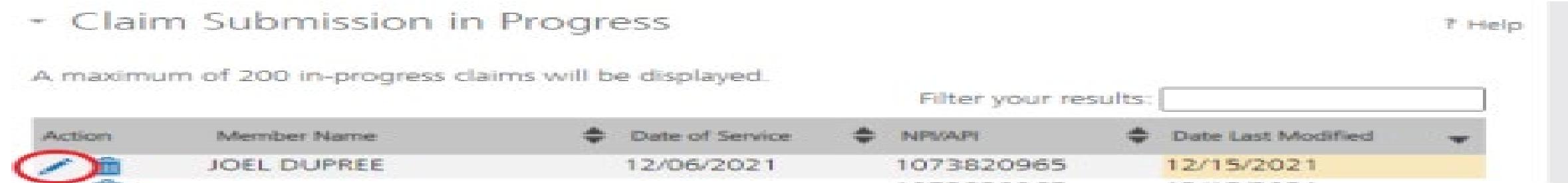
# Claims Submission in Progress

**This function is for claims started but not submitted.**

Example:

You begin to complete the information for claim. You are interrupted and need to exit the system. When you click Save and Exit at the bottom of the current claim screen; your claim moves to this section.

When you return, click Claims Submission in Progress. Click the **Pencil** icon to pick up where you left off on that claim.



The screenshot shows a software interface for managing claims. At the top, there is a navigation bar with the title 'Claim Submission in Progress' and a 'Help' link. Below the title, a message states 'A maximum of 200 in-progress claims will be displayed.' A 'Filter your results:' input field is also present. The main area is a table with the following columns: 'Action', 'Member Name', 'Date of Service', 'INPA/PI', and 'Date Last Modified'. The table contains one row of data for 'JOEL DUPREE', with the 'Date of Service' listed as '12/06/2021', 'INPA/PI' as '1073820965', and 'Date Last Modified' as '12/15/2021'. The 'Action' column for this row features a blue pencil icon inside a red circle, which is highlighted with a red oval.

Action	Member Name	Date of Service	INPA/PI	Date Last Modified
	JOEL DUPREE	12/06/2021	1073820965	12/15/2021

# Claim Submission Templates

---

**This function is a time saving tool for reoccurring claims.**

**Example:**

You see the same member for the same service on a consistent basis. You can create a template for that member with all the claim information except the date of service, and maybe the units & billed amount.

When it is time to submit their claim; select the billing provider NPI & Rendering Provider NPI (if applicable). Enter any additional required information on the Claim Information screen. Submit your claim.

# Creating a Template

To create a template, select the **Claims Submission Templates** tab.

Click the **blue button** for the claim form required.

Claim Submission Templates			?	Help
Maximum Templates Allowed : 500			Filter your results: <input type="text"/>	
Actions	Name	Date Last Modified		
 	Member.B	12/08/2021		
 	Ortho	12/09/2021		
 	Test.121	12/01/2021		
 	Tester22	12/15/2021		

Show  entries      Showing 1 to 4 of 4 templates         

\*Section 6, of the Provider Portal User Guide.

# Creating a Template Cont.

Enter the member's MT  
Medicaid ID number.

**Click Search.**

When the member information  
populates, verify and click  
**Save and Continue.**

- Professional Claim Template
- Member Details

The image shows a search interface with the following elements:

- A text input field labeled "Enter Member Card ID:" with a yellow border.
- A blue "Search" button with a red circle around it, positioned to the right of the input field.
- A "Save and Continue" button with a red oval around it, located at the bottom right of the interface.
- A "Cancel" button located next to the "Save and Continue" button.

# Creating a Template Cont.

Complete the fields that will not change.

For instance, the diagnosis code, place of service, CPT code, modifier & diagnosis point fields will most likely not change for reoccurring visits.

- Professional Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk \* are required.

Note : Do not include any decimals when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note : indicates all required fields of COB have been entered.

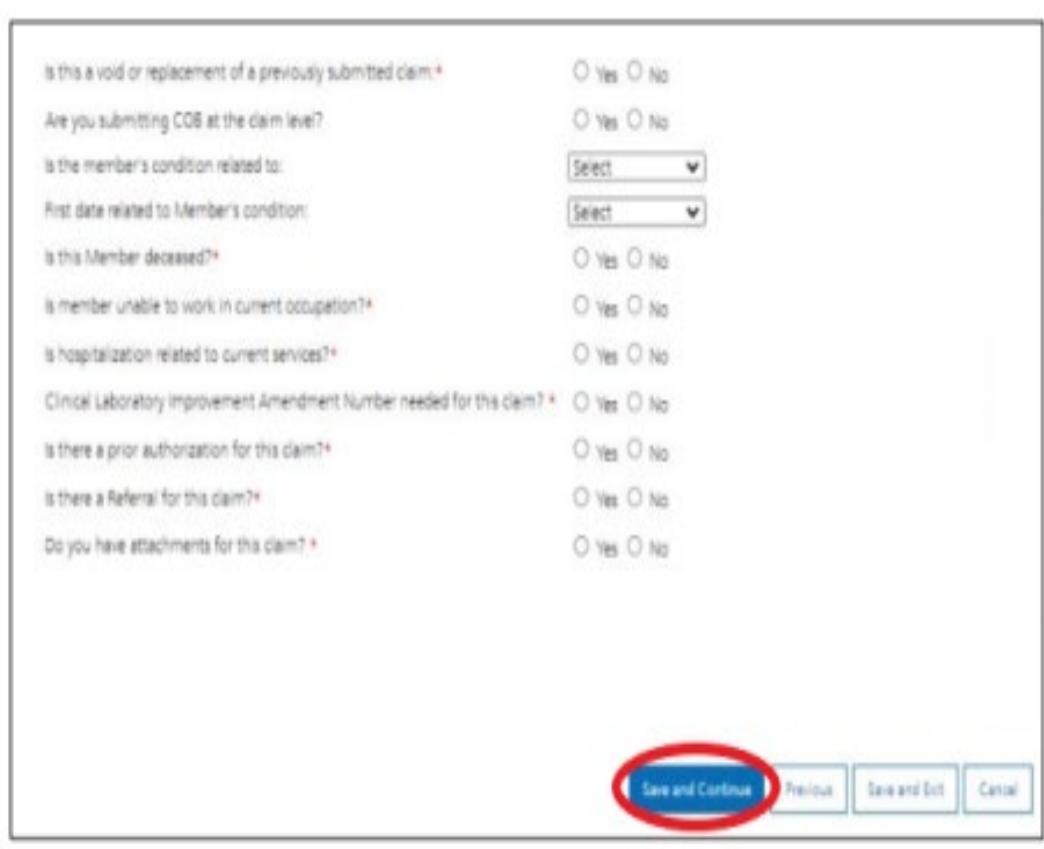
From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>				
<small>Total Charges: <input type="text"/> <input type="button" value="Add"/></small>												

# Creating a Template Cont.

Answer all the questions at the bottom of the screen.

If your claim requires a Prior Authorization, make sure to add that number to your template.

Click **Save and Continue**.



Is this a void or replacement of a previously submitted claim? \*  Yes  No

Are you submitting COB at the claim level?  Yes  No

Is the member's condition related to:  Select

First date related to Member's condition:  Select

Is this Member deceased? \*  Yes  No

Is member unable to work in current occupation? \*  Yes  No

Is hospitalization related to current services? \*  Yes  No

Clinical Laboratory Improvement Amendment Number needed for this claim? \*  Yes  No

Is there a prior authorization for this claim? \*  Yes  No

Is there a Referral for this claim? \*  Yes  No

Do you have attachments for this claim? \*  Yes  No

**Save and Continue**

# Creating a Template

The last step is to name the template. Then click **Save**.

Your template is now visible.

To submit a claim, click on the **Name**.

To edit a template, click on the **Pencil** icon.

To delete a template, click on the **Garbage can** icon.

Facility Claim Template

Save Template

Please enter a claim submission template name.

Template Name: \*

Note(s):

Template Name must satisfy the following conditions:

- a. Minimum length: 3 characters.
- b. Maximum length: 35 characters.
- c. Cannot contain special characters other than: Space " " or Underscore "\_" or Dash "-".

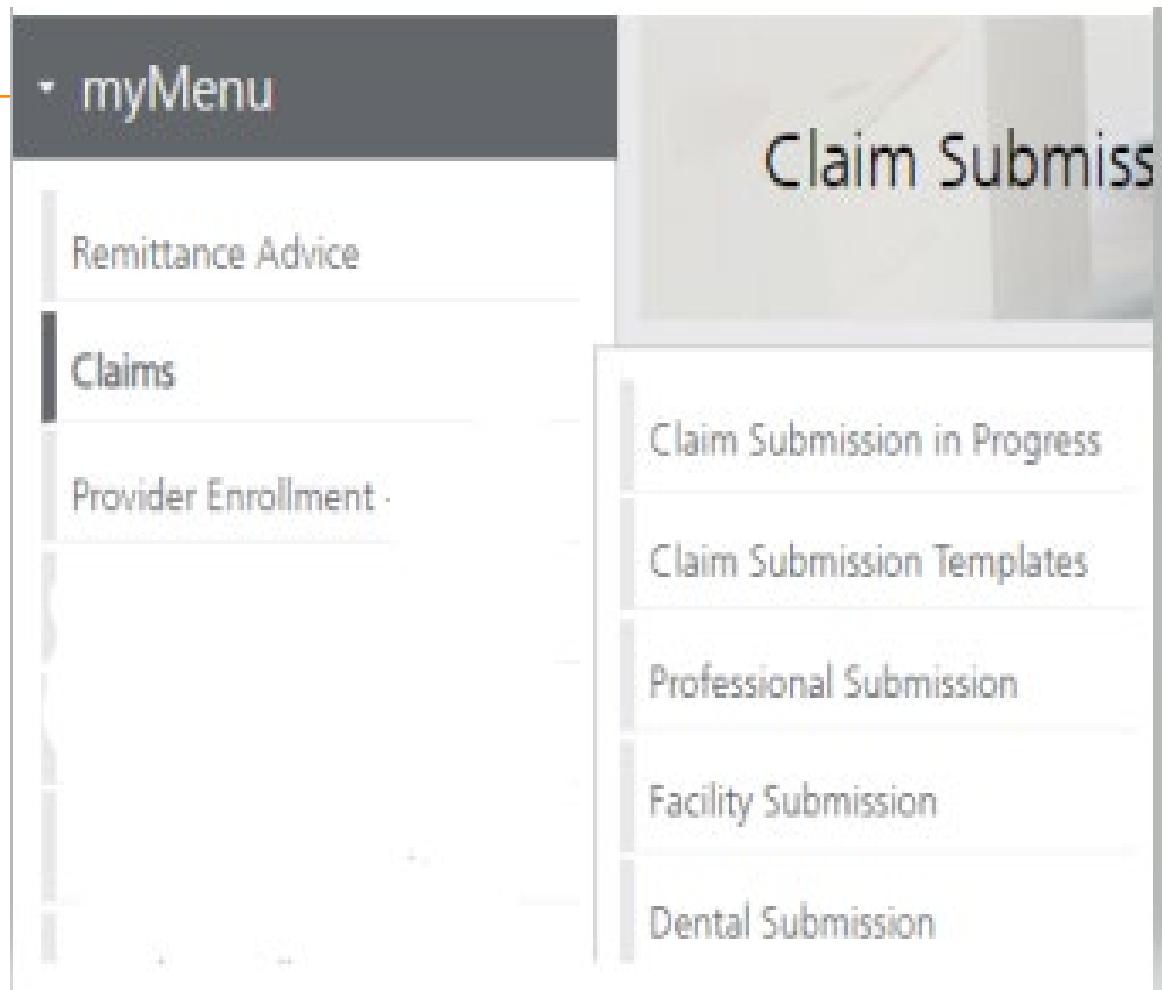
**Submit** Previous Cancel

Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

# Submitting a Claim

To submit a claim using a template, place your cursor on the **Claims** tab.

Select **Claim Submission type** for one-time claims or **Claim Submission Templates** to submit a claim from a template.



\*Section 6, of the Provider Portal User Guide.

# Billing Provider

Select the Billing Provider file.

If you have multiple NPIs listed under Manage Billing Providers, The NPI/API field will have a drop down.

Select NPI.

Select Program/Waiver.

Select Specialty.

Click Save and Continue.

NPI/API:*	1245490713		
Provider Name:*	NORTH WEST HOME CAF		
Program/Waiver:*	Montana Medicaid (HMK Plus)		
Specialty:*	In Home Supportive Care		
Service Location Address 1:*	818 W CENTRAL		
Service Location Address 2:			
City:*	MISSOULA		
State:*	MT		
ZIP:*	59801-0000	NPI/API:*	1033508080
Taxonomy Code: *	253Z00000X	Provider Name:*	LIBERTY PLACE, INC
Enrollment Unit:*	0000262208	Program/Waiver:*	Severe Disabling Mental Illness Waiver (SDMI)
		Specialty:*	Select Program/Waiver
		Service Location Address 1:*	Severe Disabling Mental Illness Waiver (SDMI)
		Service Location Address 2:	Big Sky Waiver
		City:*	BOOTSTRAP RANCH E
		State:*	BELGRADE
		ZIP:*	MT
		Taxonomy Code: *	59714-8121
		Enrollment Unit:*	251S00000X
			0000801034

# Billing Provider Cont.

If the Billing file you chose, requires a Rendering provider.

The Rendering Provider drop down will appear.

Select your rendering NPI from the drop down.

Click **Save and Continue**.

## Billing Provider

**Note :** Fields marked with an asterisk \* are required.

NPI/API:*	1316521222
Provider Name:*	WHICKER GROUP
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Single Specialty
Service Location Address 1:*	2600 WILSON ST STE 4
Service Location Address 2:	
City:*	MILES CITY
State:*	MT
ZIP:*	59301-5094
Taxonomy Code: *	193400000X
Enrollment Unit:*	0000734214

## Rendering Provider

NPI:*	<input type="button" value="Select NPI"/> 1609484575 1538253760 1164561635
-------	---

## Referring Provider

There is a referring provider for this claim.

## Ordering Provider

There is a ordering provider for this claim.

# Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

When the member information populates, verify you have the correct member.

- Professional Claim Template
- Member Details

Enter Member Card ID:



Search

Save and Continue Cancel

Click **Save and Continue**.

# Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk \*

- Professional Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk \* are required.

Note : Do not include any decimal's when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note :  indicates all required fields of COB have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											
<input type="text"/>	<input type="checkbox"/>											

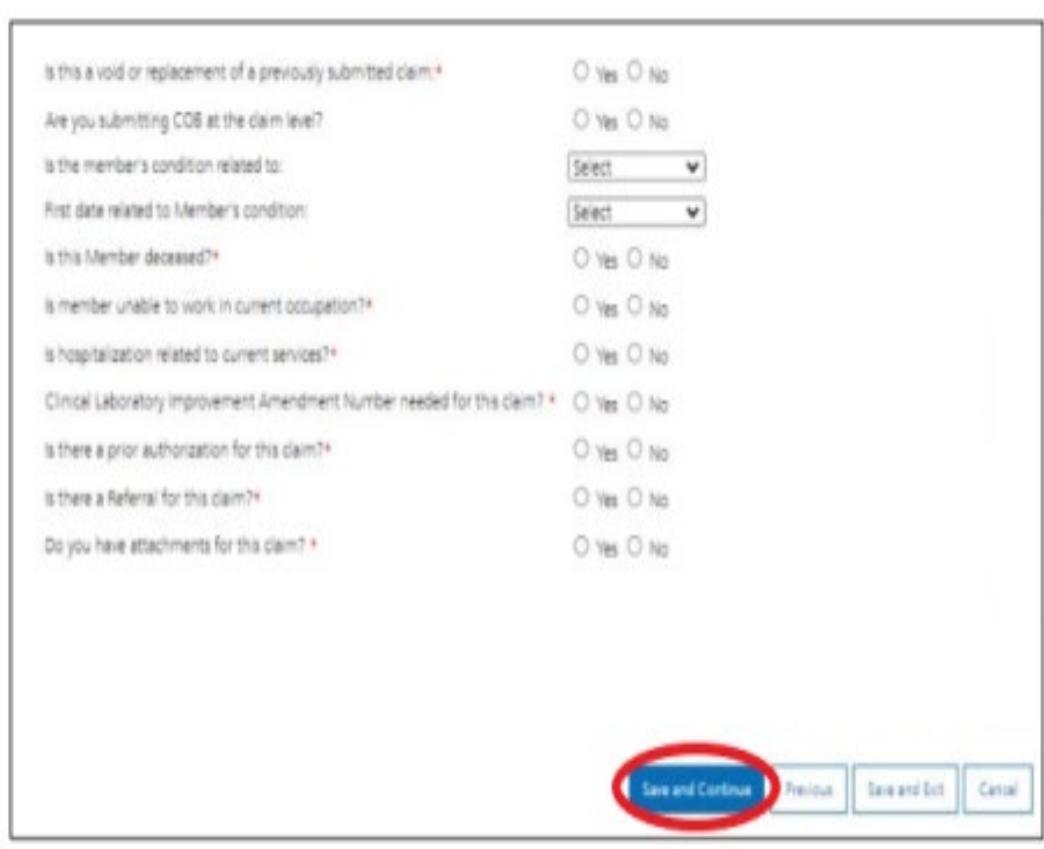
Total Charges:

# Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk \*

Click **Save and Continue**.



Is this a void or replacement of a previously submitted claim?\*  Yes  No

Are you submitting COB at the claim level?  Yes  No

Is the member's condition related to:  Select

First date related to Member's condition:  Select

Is this Member deceased?\*  Yes  No

Is member unable to work in current occupation?\*  Yes  No

Is hospitalization related to current services?\*  Yes  No

Clinical Laboratory Improvement Amendment Number needed for this claim?\*  Yes  No

Is there a prior authorization for this claim?\*  Yes  No

Is there a Referral for this claim?\*  Yes  No

Do you have attachments for this claim?\*  Yes  No

**Save and Continue**

# Primary Insurance EOB

---

Are you submitting COB at the claim level?

Yes  No

<b>Insurance Type:</b> *	<b>Primary Payer</b>	<b>Secondary Payer</b>
Carrier Name:	<input type="text"/>	<input type="text"/>
Carrier Code:	<input type="text"/>	<input type="text"/>
Subscriber First Name:	<input type="text"/>	<input type="text"/>
Subscriber Middle Name:	<input type="text"/>	<input type="text"/>
Subscriber Last Name:	<input type="text"/>	<input type="text"/>
Allowed:	<input type="text"/>	<input type="text"/>
Copay:	<input type="text"/>	<input type="text"/>
Deductible:	<input type="text"/>	<input type="text"/>
Coinsurance:	<input type="text"/>	<input type="text"/>
Paid Amount:	<input type="text"/>	<input type="text"/>
	<b>Group</b> <b>Reason</b> <b>Amount</b>	<b>Group</b> <b>Reason</b> <b>Amount</b>
	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
EOB Payment Date:	<input type="text"/>	<input type="text"/>

Answer Yes to this question, only if you have received payment from a primary insurance. Do not use for Medicare payments.

If you have a primary EOB but they did not pay, do not use this screen.

For Medicare payments or Zero payment EOBS, skip this step and proceed to the attachment question.

# Electronic Claim Attachments

Do you have attachments for this claim? \*

Yes  No

Note: When uploading an attachment electronically, cover sheets are not required. For attachments that are being mailed or faxed, please download the [Paperwork Attachment Cover Sheets](#) for instructions on how to create a Paperwork Attachment Control Number. The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim.

Report Code Type: *	Transmission Code: *	Control Number: *
<input type="button" value="Select"/>	<input type="button" value="Select"/>	<input type="text"/>
<input type="button" value="Attachments"/> <input type="button" value="Add"/>		

**Report Code Type:** Select what type of document you are attaching.

**Transmission Code:** Select Electronic submission.

**Control Number:** The control number will auto-generate once the attachment is uploaded.

**Add:** Click add if you have more than one attachment type.

Report Code Type: *	Transmission Code: *	Control Number: *
<input type="button" value="EB-Explanation of Benefit"/>	<input type="button" value="FT-Electronic Attachmen"/>	<input type="text"/>
		<input type="button" value="Attachments"/> <input type="button" value="Add"/>

# Bulk HIPAA Transactions

Your file must be in an accepted format of either .edi or .bil.

▼ Bulk HIPAA Transactions activity ? Help

ACTIONS	TRANSACTION DATE	FILE NAME
No matching transactions found.		

Filter your results:

Show 10 entries Showing 0 to 0 of 0 entries 1 < < > > 1

[Upload](#)

Click the “Help” link and you’ll be taken to that section of the manual

# Bulk HIPAA Transactions Cont.

**File Upload** X

**Note:** Only .edi formats are supported for uploading

NPI/API: 1427003862

File Type:

**Browse**

Please upload file formats of .edi or contact customer service for assistance.

**Upload**

**Cancel**

Questions?

# MPATH Portal Additional Features

# Claims Inquiry

Member search ?

Find everything you need to know about a member with just one search!

Member search

Enter Member Card ID \*

Go

Member search ?

Member found!

You are currently viewing:

Member's Name

[Clear Search](#)

Claims Inquiry  
 Eligibility

Search

# Claims Inquiry Cont.

Member search

myMenu

Claim search ?

I want to view:  
Claims for

Time period  
From Date: 09/01/2021   
To Date: 12/01/2021

Claim number

Patient account number

Search

Hi Org3 MTOFEOC

Claims Detail 

Claim search results

Member:   
You are viewing: Claims for NPI/API 1 and time period from 09/01/2021 to 12/01/2021.

Claim activity

Filter your results:

ICN	OPTUM CLAIM NUMBER	SERVICE DATE	MEMBER NAME	PROVIDER	STATUS	BILLED AMOUNT	PLAN PAYS
221	221	09/01/21	INC	F1		\$177.44	\$177.44

Show 10 entries  Showing 1 to 1 of 1 Claims

# Claims Inquiry Results

I want to view:  
Claims for

Time period  
From Date:   To Date:

Claim number   
Patient account number

**Claim search results**

Member: You are viewing: Claims for NPI/API 1 and time period from 09/01/2021 to 12/01/2021.

**Claim activity**

ICN: 221 Optum Claim number:

Member: <input type="text"/>	Date of service: 09/01/21-09/30/21	Total amount billed: \$177.44
Patient account: <input type="text"/>	Date processed: 10/04/21	Total amount paid: \$177.44
Member: <input type="text"/>	Member ID: <input type="text"/>	<b>Payment details</b>
Claim status: F1:Finalized/Payment	Payment number: 00000261657	Payment date: 10/11/21
	Payment amount: \$177.44	

**Line 1**

Provider name: <input type="text"/>	Provider NPI/API: <input type="text"/>	INC	Cost for this service	Amount billed: \$177.44
Date of service: 09/01/21-09/30/21	Procedure code: T2041			Amount paid by plan: \$177.44

# Remittance Advice

The screenshot shows a web-based application interface. At the top left is a 'myMenu' button with a dropdown menu. The main content area has a 'Remittance Advice' search portlet. The search portlet includes fields for EFT number, Check number, Remittance advice number, and Remit date. It also features a 'Remittance advice search results' section with a note about required fields and a 'Remittance advice activity' section with a table header and a message about no matching forms found.

myMenu

Claims

Remittance Advice

Provider Profile

Member search

myMenu

Remittance advice search

**Note:** Fields marked with \* are required.

I want to search by:

- EFT number
- Check number
- Remittance advice number
- Remit date

Hi Org3 MTOFEOC

Remittance Advice

Remittance advice search results

To view remittance advice, use the remittance advice search portlet.

Remittance advice activity

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
--------------------	-------------	----------------	--------------	----------------	-----	---------

No matching forms found.

Show 10 entries

Showing 0 to 0 of 0 entries

# Remits Search

---

I want to search by:

**▼ EFT number**

Enter EFT number:\*

**▼ Check number**

Enter check number:\*

**▼ Remittance advice number**

Enter remittance advice number:\*

**▼ Remit date**

From Date(mm/dd/yyyy):\*

09/02/2021 

To Date(mm/dd/yyyy):\*

12/01/2021 

**Search**

# Remits Results

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
C	09/27/2021	01	Check	\$1150550.83	<a href="#">View</a>	<a href="#">Download</a>
O	09/27/2021	01	Check	\$246077.51	<a href="#">View</a>	<a href="#">Download</a>
O	09/27/2021	01	Check	\$94875.42	<a href="#">View</a>	<a href="#">Download</a>
V	09/20/2021	01	Check	\$14843.00	<a href="#">View</a>	<a href="#">Download</a>
OL	09/27/2021	01	Check	\$7195.51	<a href="#">View</a>	<a href="#">Download</a>
OE	09/06/2021	01	Check	\$1572.51	<a href="#">View</a>	<a href="#">Download</a>
OT	09/13/2021	01	Check	\$520.36	<a href="#">View</a>	<a href="#">Download</a>

Show  entries

Showing 1 to 7 of 7 forms [|<](#) [<](#) [>](#) [>|](#)

VENDOR # 0001 REMIT ADVICE # 81 EFT/CHK #01 DATE 09/27/2021 PAGE 2  
NPI #: 12-  
TAXONOMY:

RECIPI ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
<b>PAID CLAIMS - MISCELLANEOUS CLAIM</b>									
ICN 221	TEAM NUMBER 01		07012021 07312021	1.000	S5141	2453.93	2453.93		
			PATIENT NUMBER=001						
***** <b>CLAIM TOTAL*****</b>									
ICN 221	TEAM NUMBER 01		08012021 08312021	1.000	S5141	2453.93	2453.93		
			PATIENT NUMBER=001						
***** <b>CLAIM TOTAL*****</b>									
ICN 221	TEAM NUMBER 01		07012021 07312021	1.000	T2032	767.70	767.70		
			PATIENT NUMBER=001						
***** <b>CLAIM TOTAL*****</b>									
ICN 221	TEAM NUMBER 01		07012021 07312021	5.000	S5135	115.50	115.50		
			PATIENT NUMBER=001						
***** <b>CLAIM TOTAL*****</b>									
ICN 221	TEAM NUMBER 01		08012021 08312021	1.000	T2032	767.70	767.70		
			PATIENT NUMBER=001						
***** <b>CLAIM TOTAL*****</b>									
ICN 2212	TEAM NUMBER 01		07012021 07312021	8.000	T2021	782.48	782.48		
			PATIENT NUMBER=001						

# Adjustments

# Electronic vs Paper Claim Adjustments

---

When you submit a paper Individual Adjustment Request (IAR) form:

<https://medicaidprovider.mt.gov/docs/forms/adjustmentrequestindividual12192017.pdf>

1. Provide only the corrections needed.
2. Must attach the remittance advice showing the paid claim.
3. Call Center can see who submitted & any reason listed.

When submitting an electronic replacement claim:

1. Include all charge lines, including lines that paid correctly.
2. No additional paperwork is required.
3. Call Center can NOT see who submitted & why.

# Adjustment Tips

---

- Cannot adjust denied claims.
- Claims cannot be electronically adjusted more than 12 months from the paid date. These will reject. Claims needing to be adjusted past this time frame must be sent via a paper IAR form.
- If a claim was previously adjusted, you must use the most recent paid ICN.

# Electronic Claim Adjustments

---

Electronic Adjustments are now accepted by Montana Medicaid. There will be 2 options for submitting an electronic adjustment.

## Acceptable frequency codes:

- 1 Indicates the claim is an original claim.
- 7 Indicates the new claim is a replacement or corrected claim – the information present on this claim represents a complete replacement of the previously issued claim.
- 8 Indicates the claim is a voided/canceled claim

\*Modifiers may also be used for electronic adjustments.

## *All claim types*

Loop 2300 - (CLM05-3) is the Claim Frequency Code. Enter 7 or 8.

REF\*F8\* - Enter the original ICN.

# Electronic Claim Adjustments Cont.

---

## **MPATH Claims Solutions**

Create a new claim with the corrected information. If you are voiding the claim, claim information must match original claim.

## ***Professional Claims (CMS-1500) & Dental Claims***

Answer YES, to the first question at the bottom of the claim entry screen. The next two fields are now visible.

Select either ***Replacement of prior claim*** or ***Void of prior claim*** from the Medicaid Resubmission drop down.

Enter the Paid ICN of the claim being adjusted in the Original Reference Number field.

# Claim Adjustments Cont.

---

- Original Reference Number must be a valid paid claim ICN.
- Cannot adjust denied claims.

Is this a void or replacement of a previously submitted claim:\*

Yes  No

Select the Medicaid Resubmission Code:\*

Select

Enter the Original Reference Number:\*

# Claim Adjustments

## ***Institutional Claims (UB-04)***

When recreating the claim, change the last digit of the Type of Bill code to either **7 for replacement** or **8 for void**.

The Original Reference Number filed is now visible. Enter the Paid ICN of the claim being adjusted in the Original Reference Number field.

Type of Bill:*	Inpatient or Outpatient:*	Statement Period From:*	Statement Period Through:*		
<input type="text" value="0117"/>	<input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>		
Admission Date:	Admission Hour:	Admission Type: *	Source of Admission:*	Discharge Hour:	Member Discharge Status:*
<input type="text"/>	<input type="button" value="Select"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Select"/>	<input type="text"/>
Original Reference Number:*					
<input type="text"/>					

# Claim Adjustment ICNs

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The claim numbers (ICN) look different for electronic adjustments.

Paper Adjustment ICNs

ICN: 2 22035 00 255 **1**01500 (recoupment)

ICN: 2 22035 00 255 **2**01500 (adjustment)

Electronic Adjustment ICNs

ICN: 2 22035 00 **960** 100013 (recoupment)

ICN: 2 22035 00 **960** 001234 (replacement)

*The highlighted section of the ICN would be **960 – 969** if the claim is an electronic adjustment.  
The rest of the ICN can be anything.*

Questions?

# Common Billing Errors

# Common Billing Errors

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- Missing/Invalid Information
- Prior Authorization Number Missing or Invalid
- Exact Duplicate
- Proc. Code or Rev Code Not Covered/Not Allowed for Provider Type
- Recipient Not Eligible DOS
- Missing primary EOB
- Using the incorrect modifier for a provider type (HCBS vs SDMI)

# If You Have Questions

# Need Help with MPATH?

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At the top of each screen is a **User Guide** icon.



When you click on the icon, the user guide will open to the section matching the screen you are on.

# Online Resources

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<https://medicaidprovider.mt.gov>

## Claims Information Page

- Electronic Submission Setup
- Electronic Submission Resources and User Guides
- Claim instructions
- Adjustment instructions

## Other Pages

- FAQs
- Provider Type pages (Provider notices, Provider manuals, Fee Schedules)
- Claim Jumper Newsletters

# Provider Relations Contact Information

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Provider Relations Call Center:

(800) 624-3958

Monday through Friday

8 AM to 5 PM Mountain Time

[MTPRHelpdesk@conduent.com](mailto:MTPRHelpdesk@conduent.com)

Questions?

# Thank you!