

Billing 101 Training for Providers

Presented by Jennifer Stirling, Provider Enrollment Supervisor

In this training...

- 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

- The 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. Make sure to include the NPI, name, and confirmation number of the enrollment in question.
- Secured emails are not accepted.

Automated System Information

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

For technical assistance with the Provider Services portal (MPATH)

Email the following to 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 attempting.

Preparation for submitting claims

What order should information be gathered?

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

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		10557	021521	021521
REASON: 999				
LINE ----MAXIMUM----				
ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE
01	1	0.00	021521	021521
TOOTH NUM / SURFACE:		PROC RANGE / MOD		
REASON:		DIAG RANGE		
02	106	0.00	021521	021521
TOOTH NUM / SURFACE:		THERA CLASS: STATUS: APPROVED		
REASON:		A0435 A0435		
RECIP ID	NAME	NUMBER	FROM	TO
00		10557	021121	021121
REASON: 999				
LINE ----MAXIMUM----				
ITEM	UNITS	DOLLARS	FR-DTE	TO-DTE
01	1	0.00	021121	021121
TOOTH NUM / SURFACE:		PROC RANGE / MOD		
REASON:		DIAG RANGE		
02	182	0.00	021121	021121
TOOTH NUM / SURFACE:		THERA CLASS: STATUS: APPROVED		
REASON:		A0435 A0435		

Diagnosis Codes

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

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

<https://icd10coded.com>

Place of Service

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

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

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

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

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

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

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 if you have set up questions.

Electronic Claims Submission Cont.

- 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

- 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 and 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



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

☐ FICA ☐ FICA

<p>1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> OTHER <input type="checkbox"/></p>		<p>2. INSURED'S POLICY OR GROUP NUMBER Possible Member ID</p>	
<p>3. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client last name, first name</p>		<p>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p>	
<p>5. PATIENT'S ADDRESS (No., Street)</p>		<p>6. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F</p>	
<p>7. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p>		<p>8. RESERVED FOR NUCC USE</p>	
<p>CITY STATE ZIP CODE (Include Area Code)</p>		<p>CITY STATE ZIP CODE (Include Area Code)</p>	
<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>		<p>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>11. OTHER INSURED'S POLICY OR GROUP NUMBER Possible Member ID</p>		<p>12. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F</p>	
<p>13. RESERVED FOR NUCC USE</p>		<p>14. OTHER CLAIM ID (Designated by NUCC)</p>	
<p>15. RESERVED FOR NUCC USE</p>		<p>16. INSURANCE PLAN NAME OR PROGRAM NAME Possible TPL Information</p>	
<p>17. INSURANCE PLAN NAME OR PROGRAM NAME</p>		<p>18. IS TRANSFERRED HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete items 19, 20, and 21.)</p>	
<p>19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts and I warrant below.)</p>		<p>20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)</p>	
<p>SIGNED _____ DATE _____</p>		<p>SIGNED _____</p>	
<p>21. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL</p>		<p>22. OTHER DATE MM DD YY QUAL</p>	
<p>23. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>		<p>24. RESERVED FOR PASSPORT #</p>	
<p>25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p>		<p>26. RESERVED FOR IHS Ref. ID</p>	
<p>27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (SAL))</p>		<p>28. PRIOR AUTHORIZATION NUMBER 4123456789</p>	
<p>A. ICD - 10 Diagnosis code</p>		<p>29. PRIOR AUTHORIZATION NUMBER</p>	
<p>B. ICD - 10 Procedure code</p>		<p>30. PRIOR AUTHORIZATION NUMBER</p>	
<p>C. ICD - 10 Procedure code</p>		<p>31. PRIOR AUTHORIZATION NUMBER</p>	
<p>D. ICD - 10 Procedure code</p>		<p>32. PRIOR AUTHORIZATION NUMBER</p>	
<p>33. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>34. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>35. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>36. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>37. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>38. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>39. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>40. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>41. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>42. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>43. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>44. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>45. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>46. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>47. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>48. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>49. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>50. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>51. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>52. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>53. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>54. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>55. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>56. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>57. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>58. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>59. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>60. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>61. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>62. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>63. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>64. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>65. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>66. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>67. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>68. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>69. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>70. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>71. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>72. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>73. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>74. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>75. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>76. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>77. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>78. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>79. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>80. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>81. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>82. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>83. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>84. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>85. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>86. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>87. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>88. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>89. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>90. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>91. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>92. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>93. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>94. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>95. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>96. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>97. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>98. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	
<p>99. DATE OF SERVICE FROM MM DD YY TO MM DD YY</p>		<p>100. PROCEDURE, SERVICE, OR SUPPLIER (Specify unusual circumstances)</p>	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB 0938-1197 FORM 1500 02-12

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

Additional Montana Medicaid CMS-1500 Info

- 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	
Member First Name Last Name		Passport#	
In/Out multi ER visits		01 Condition Codes relate to copy overrides	
Occurrence codes are used to denote events relating to the bill that may effect payer processing			
Value Codes and Amounts reflect Medicare Payment Information			
250		7/6/14	1
260		7/7/14	1
260		7/7/14	1
260		7/7/14	1
301		7/7/14	1
301		7/7/14	1
306		7/7/14	2
306		7/7/14	2
320		7/7/14	1
450		7/7/14	1
636	N4 63323047401 4 ML	7/7/14	4
636	N4 50458016601 150 ML	7/6/14	3
PAGE OF		CREATION DATE	8/11/14
Possible TPL Payer		123456789	42.80
Member Name		Member ID	
Prior Auth#		PAAs are required in order for certain services to be paid.	
ICD-10 codes			
Billing Taxonomy		B3 282N00000X	
Attending Last Name		First Name	

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐ J 15. Policyholder/Subscriber ID (Assigned by Plan)

DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

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 ☐ J 8. Policyholder/Subscriber ID (Assigned by Plan)
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
16. Plan/Group Number 17. Employer Name
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 ☐ J 23. Patient ID/Account # (Assigned by Dental)

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	29a. Diag. Pointer	29b. City	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

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
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
34b. Primary diagnosis in "A" B _____ 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 _____

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 _____

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment (e.g. 11=Office, 22=OP 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 ☐ No ☐ Yes (Complete 44) 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 _____

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 _____

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form - J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

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

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.*

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: *



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

Manage Affiliations

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.

Search for Providers

Pending Approval

Requested Affiliations

Existing Affiliations

User Guide

Search for Provider

Help

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

Search

	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			

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="checkbox"/>	ROBERT	NITSCHHELM	1598719064	05/12/2022  		 	

Assigned Locations 

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

Items per page: 10 1 - 1 of 1

1111 BAKER AVE 

Select	Program Name	Effective Date*	Termination Date
<input checked="" type="checkbox"/> 	Montana Medicaid (HMK Plus)	05/12  	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 displays the 'Manage Affiliations' interface. At the top, there's a header 'Manage Affiliations' and a 'User Guide' link. Below the header are four tabs: 'Search for Providers', 'Pending Approval', 'Requested Affiliations', and 'Existing Affiliations'. The 'Existing Affiliations' tab is active. Below the tabs, there's a 'Search for Provider' section with a text input field and a 'Search' button. To the right of the search section is a 'Help' icon. Below the search section is a table with the following columns: 'First Name', 'Last Name', 'NP/Physician ID', 'Effective Date', 'Termination Date', 'Actions', and 'File Name'. The table contains two rows of data. The first row shows 'Reels', 'Oleke', '00000000', '08/01/2021', '08/01/2021', and 'Actions'. The second row shows 'Jorillo', 'Adams', '00000000', '12/01/2021', '12/01/2021', and 'Actions'.

	First Name	Last Name	NP/Physician ID	Effective Date	Termination Date	Actions	File Name
0	Reels	Oleke	00000000	08/01/2021	08/01/2021	Actions	
0	Jorillo	Adams	00000000	12/01/2021	12/01/2021	Actions	

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.

Search for ProvidersPending ApprovalRequested AffiliationsExisting Affiliations

User Guide

Search for Provider

The existing affiliation tab lists all affiliations linked to the organizational provider. To manage the affiliation, enter in additional information. For example, adding a new physical address to an existing rendering affiliation. Within this tab, the organizational user has the ability to terminate the affiliation by entering in a termination date.

First Name ⓘ

Last Name ⓘ

NPI/Atypical ID ⓘ

Search ⓘ

	First Name	Last Name	NPI/Atypical ID	Effective Date ↑	Terminate Date	Actions	File Name
<input type="radio"/>	KATHRYN	NEFF	1710945829		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	DANIEL	MUNZING	1700844966		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	HIKMAT	MAALIKI	1295897650		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	JOHN	KALBFLEISCH	1609824283		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	ANITA	BEACH	1922064401		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	SUZANNE	DANIELL	1811966526		<input type="text" value="MM/DD/YYYY"/>	ⓘ	
<input type="radio"/>	JON	MILLER	1841267192		<input type="text" value="MM/DD/YYYY"/>	ⓘ	

ANITABEACH1922064401

ⓘ

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.

Assign Locations ⓘ

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?

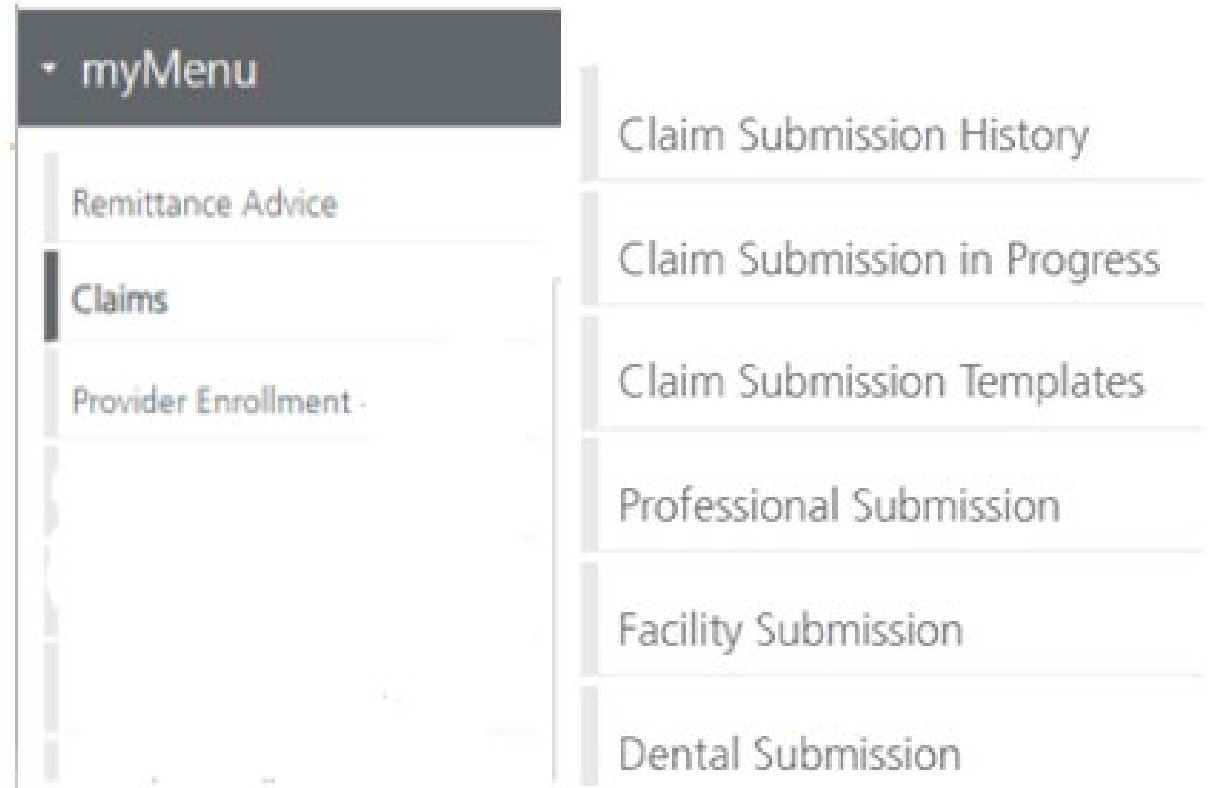
MPATH Claims Solution

Claim Submission Menu

Under myMenu, without clicking, place your curser 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.

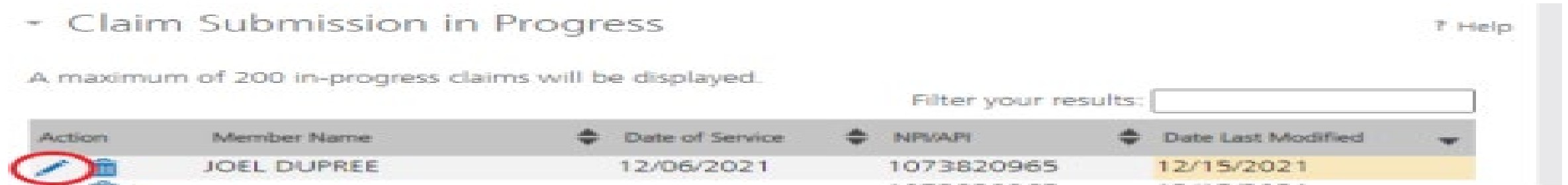
Claims Submission in Progress


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.



Claim Submission in Progress					Help
A maximum of 200 in-progress claims will be displayed.					
Filter your results:					
Action	Member Name	Date of Service	NPV/API	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.

*Section 6, of the Provider Portal User Guide.

The screenshot displays the 'Claim Submission Templates' section of a web application. At the top, there's a header with a plus icon and the text 'Claim Submission Templates', followed by a 'Help' link. Below this, a status bar indicates 'Maximum Templates Allowed : 500' and a search filter 'Filter your results:' with an input field. The main content is a table with four columns: 'Actions', 'Name', and 'Date Last Modified'. The table lists four templates: 'Member B' (modified 12/08/2021), 'Ortho' (modified 12/09/2021), 'Test 121' (modified 12/01/2021), and 'Tester22' (modified 12/15/2021). Each row has a blue pencil icon for editing and a blue trash can icon for deleting. Below the table, there's a 'Show 10 entries' dropdown and a pagination bar showing 'Showing 1 to 4 of 4 templates' with navigation arrows. At the bottom, three blue buttons are highlighted with yellow boxes: 'Create Professional Claim Submission Template', 'Create Facility Claim Submission Template', and 'Create Dental Claim Submission Template'.

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

Showing 1 to 4 of 4 templates

Create Professional Claim Submission Template Create Facility Claim Submission Template Create Dental Claim Submission Template

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

Help

Member Details

Enter Member Card ID:

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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	8	9	10	11	12
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

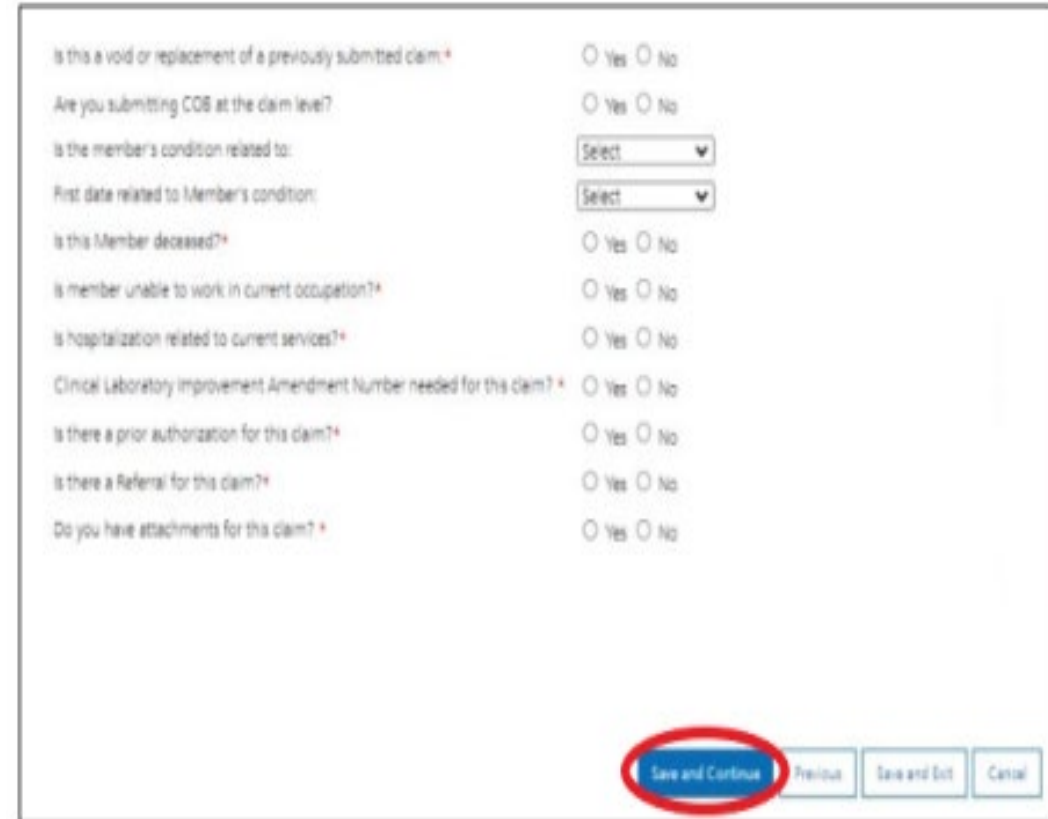
Total Charges: \$

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**.



The screenshot shows a web form for creating a template. It contains several questions with radio button or dropdown answers. The questions are:

- Is this a void or replacement of a previously submitted claim? * (Radio buttons: Yes, No)
- Are you submitting COB at the claim level? (Radio buttons: Yes, No)
- Is the member's condition related to: (Dropdown menu: Select)
- First date related to Member's condition: (Dropdown menu: Select)
- Is this Member deceased? * (Radio buttons: Yes, No)
- Is member unable to work in current occupation? * (Radio buttons: Yes, No)
- Is hospitalization related to current services? * (Radio buttons: Yes, No)
- Clinical Laboratory Improvement Amendment Number needed for this claim? * (Radio buttons: Yes, No)
- Is there a prior authorization for this claim? * (Radio buttons: Yes, No)
- Is there a Referral for this claim? * (Radio buttons: Yes, No)
- Do you have attachments for this claim? * (Radio buttons: Yes, No)

At the bottom right, there are four buttons: "Save and Continue" (highlighted with a red circle), "Previous", "Save and Exit", and "Cancel".

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 "-".

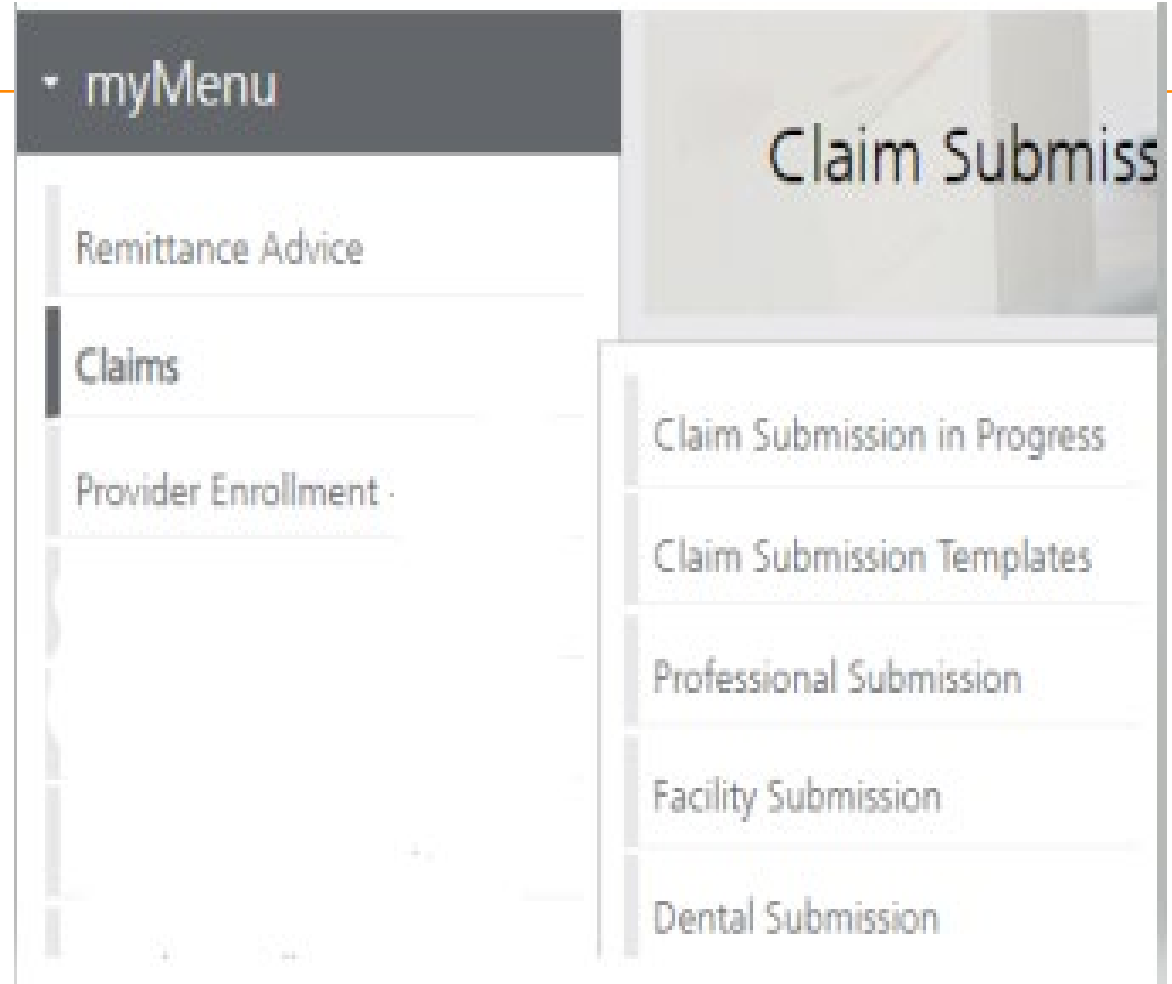
Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

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**.

Field	Value
NPI/API *	1245490713
Provider Name *	NORTH WEST HOME CARE
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
Taxonomy Code *	253Z00000X
Enrollment Unit *	0000262208

Field	Value
NPI/API *	1033508080
Provider Name *	LIBERTY PLACE, INC
Program/Waiver *	Severe Disabling Mental Illness Waiver (SDMI)
Specialty *	Severe Disabling Mental Illness Waiver (SDMI)
Service Location Address 1 *	Big Sky Waiver
Service Location Address 2 *	BOOTSTRAP RANCH E
City *	BELGRADE
State *	MT
ZIP *	59714-8121
Taxonomy Code *	251S00000X
Enrollment Unit *	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: *	<div>Select NPI 1609484575 1538253760 1164561635</div>
--------	--

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.

Click **Save and Continue**.

Professional Claim Template

Help

Member Details

Enter Member Card ID:

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 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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	8	9	10	11	12
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Claim Details

Note: COB 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	NOC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

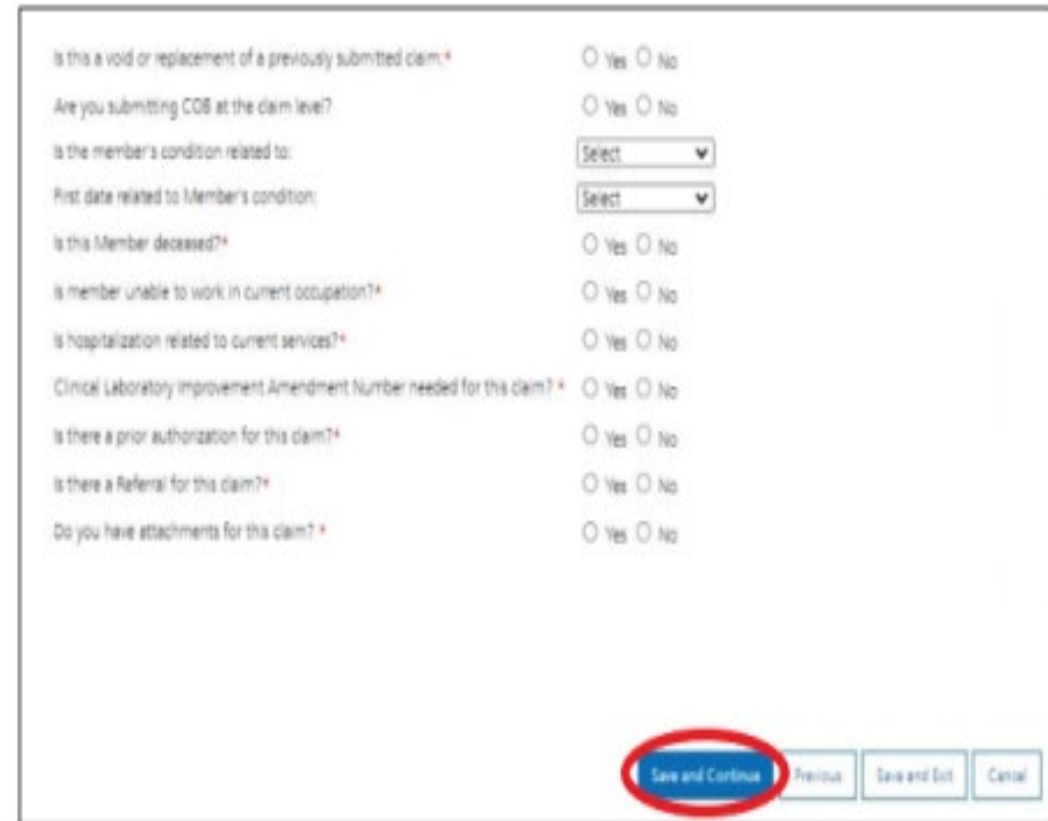
Total Charges: \$ Add

Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.



The screenshot shows a web form titled "Claim Information Questions". It contains several questions, each followed by radio buttons for "Yes" and "No", or a dropdown menu. The questions are:

- Is this a void or replacement of a previously submitted claim? *
- Are you submitting COB at the claim level?
- Is the member's condition related to: (dropdown menu)
- First date related to Member's condition: (dropdown menu)
- Is this Member deceased? *
- Is member unable to work in current occupation? *
- Is hospitalization related to current services? *
- Clinical Laboratory Improvement Amendment Number needed for this claim? *
- Is there a prior authorization for this claim? *
- Is there a Referral for this claim? *
- Do you have attachments for this claim? *

At the bottom right of the form, there are four buttons: "Save and Continue" (highlighted with a red circle), "Previous", "Save and Exit", and "Cancel".

Primary Insurance EOB

Are you submitting COB at the claim level?

☒ Yes ☐ No

Primary Payer				Secondary Payer			
Insurance Type: *	<input type="text" value="Select"/>			Insurance Type:	<input type="text" value="Select"/>		
Carrier Name: *	<input type="text"/>			Carrier Name:	<input type="text"/>		
Carrier Code:	<input type="text"/>			Carrier Code:	<input type="text"/>		
Subscriber First Name: *	<input type="text"/>			Subscriber First Name:	<input type="text"/>		
Subscriber Middle Name:	<input type="text"/>			Subscriber Middle Name:	<input type="text"/>		
Subscriber Last Name: *	<input type="text"/>			Subscriber Last Name:	<input type="text"/>		
Allowed:	<input type="text" value="\$"/>			Allowed:	<input type="text" value="\$"/>		
Copay:	<input type="text" value="\$"/>			Copay:	<input type="text" value="\$"/>		
Deductible:	<input type="text" value="\$"/>			Deductible:	<input type="text" value="\$"/>		
Coinurance:	<input type="text" value="\$"/>			Coinurance:	<input type="text" value="\$"/>		
Paid Amount: *	<input type="text" value="\$"/>			Paid Amount:	<input type="text" value="\$"/>		
Group	Reason	Amount		Group	Reason	Amount	
<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>	
<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>	
<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>		<input type="text"/>	<input type="text"/>	<input type="text" value="\$"/>	
EOB Payment Date: *	<input type="text"/>			EOB Payment Date:	<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 Sheet](#) 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: *

Select ▼

Select ▼

Attachments

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: *

EB-Explanation of Benefi ▼

FT-Electronic Attachmen ▼

Attachments



Add

Bulk HIPAA Transactions

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

Bulk HIPAA Transactions activity

[? Help](#)

Filter your results:

ACTIONS	TRANSACTION DATE	FILE NAME
No matching transactions found.		

Show entries

Showing 0 to 0 of 0 entries

[|](#) [<](#) [>](#) [|](#)

Upload

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

Bulk HIPAA Transactions Cont.

File Upload



Note: Only .edi formats are supported for uploading

NPI/API: 1427003862

File Type: Claim Submission (837) ▼

Browse

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

C:\fakepath\HSS Mar22 Pick-up.txt

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 *

0000001

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 NPV/API 12/01/2021 and time period from 09/01/2021 to 12/01/2021.

Claim activity

Download Print Help

Filter your results:

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

Showing 1 to 1 of 1 Claims

Claims Inquiry Results

I want to view:
Claims for

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

Claim number
Patient account number

Search

Claim search results

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

Claim activity

ICN: 221 Optum Claim number:

[Download](#) [Print](#) [Help](#)

[< Return to search](#)

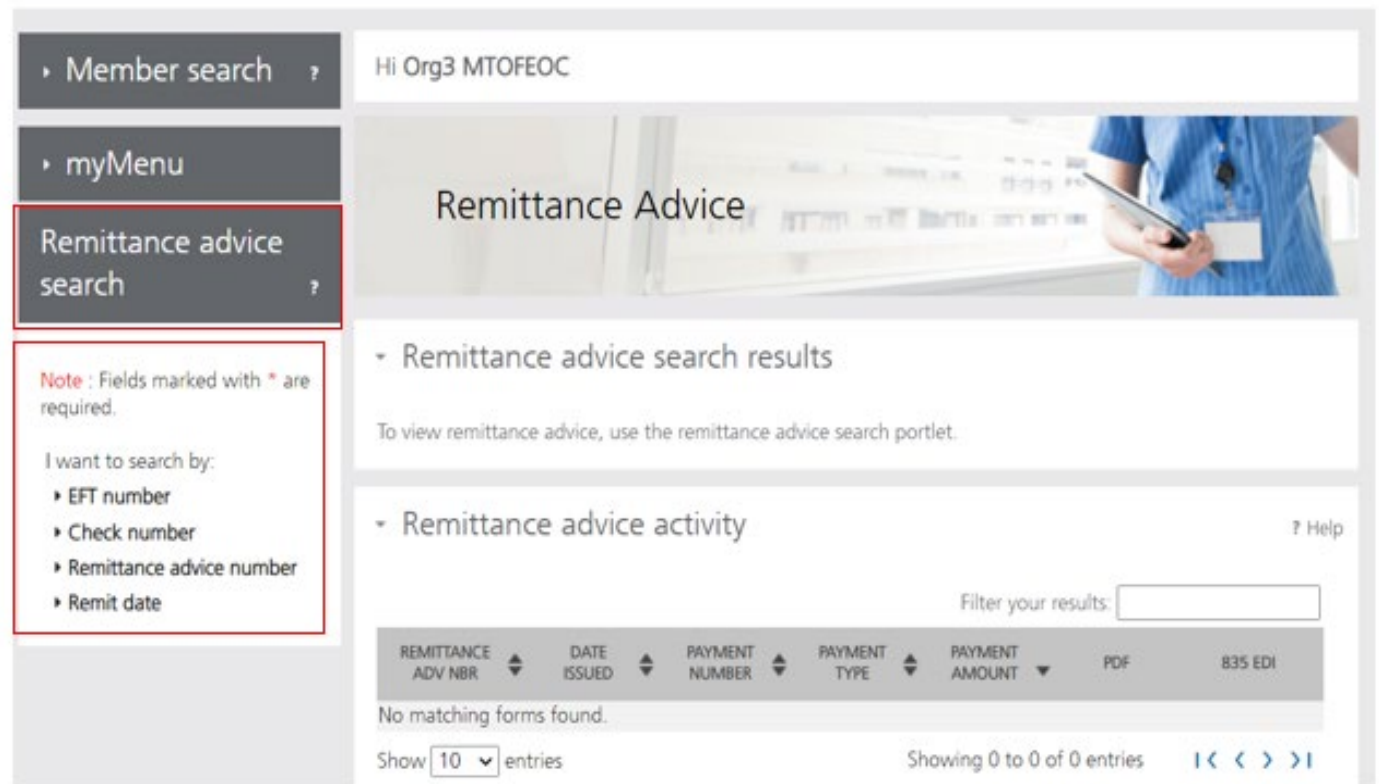
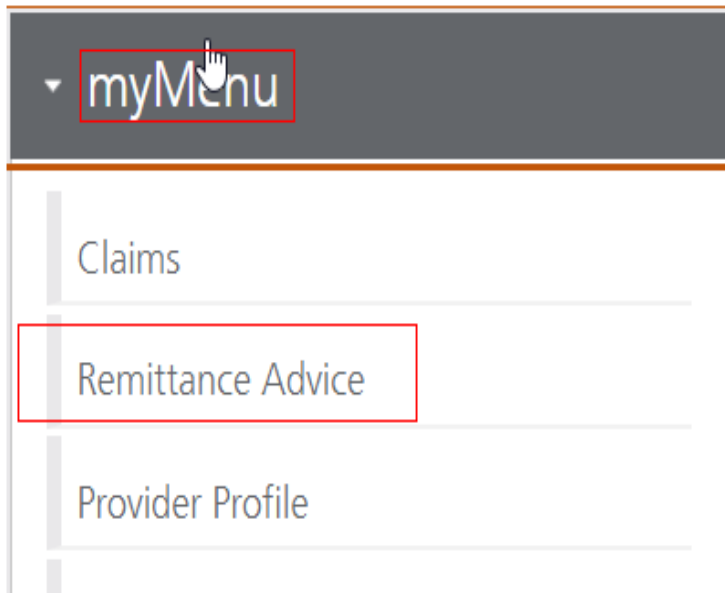
Member:		Total amount billed:	\$177.44
Date of service: 09/01/21-09/30/21		Total amount paid:	\$177.44
Patient account:	Date processed: 10/04/21		
Member:		Payment details	
Member ID:		Payment number:	00000261657
Claim status: F1:Finalized/Payment		Payment date:	10/11/21
		Payment amount:	\$177.44

Line 1

Provider name:	INC	Cost for this service	Amount billed:	\$177.44
Provider NP/API: 12			Amount paid by plan:	\$177.44
Date of service: 09/01/21-09/30/21				
Procedure code: T2041				

[< Return to search](#)

Remittance Advice



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	00	Check	\$1150550.83	View	Download
O	09/27/2021	00	Check	\$246077.51	View	Download
O	09/27/2021	00	Check	\$94875.42	View	Download
O	09/20/2021	01	Check	\$14843.00	View	Download
O	09/27/2021	00	Check	\$7195.51	View	Download
O	09/06/2021	00	Check	\$1572.51	View	Download
O	09/13/2021	01	Check	\$520.36	View	Download

Show entries

Showing 1 to 7 of 7 forms

[<](#) [<<](#) [>>](#) [>](#)

VENDOR # 0000 REMIT ADVISE # 81 EFT/CHK #01 DATE 09/27/2021 PAGE 2
NPI #: 12 TAXONOMY:

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									
ICN 22	PATIENT	07012021	07312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01									
CLAIM TOTAL**						2453.93	2453.93		
ICN 221	PATIENT	08012021	08312021	1.000	S5141	2453.93	2453.93		
TEAM NUMBER 01									
CLAIM TOTAL**						2453.93	2453.93		
ICN 221	PATIENT	07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01									
CLAIM TOTAL**						767.70	767.70		
ICN 221	PATIENT	07012021	07312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01						883.20	883.20		
CLAIM TOTAL**						883.20	883.20		
ICN 221	PATIENT	08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01									
CLAIM TOTAL**						767.70	767.70		
ICN 2212	PATIENT	08012021	08312021	5.000	S5135	115.50	115.50		
TEAM NUMBER 01						883.20	883.20		
CLAIM TOTAL**						883.20	883.20		
ICN 2212	PATIENT	07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01									
CLAIM TOTAL**						782.48	782.48		

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:*

 ▼

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="text" value="Select"/>	<input type="text" value=""/>	<input type="text" value=""/>		
Admission Date:	Admission Hour:	Admission Type:*	Source of Admission:*	Discharge Hour:	Member Discharge Status:*
<input type="text" value=""/>	<input type="text" value="Select"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="Select"/>	<input type="text" value=""/>
Original Reference Number:*					
<input type="text" value=""/>					

Claim Adjustment ICNs

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

- 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?

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

<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

Provider Relations Call Center:

(800) 624-3958

Monday through Friday

8 AM to 5 PM Mountain Time

MTPRHelpdesk@conduent.com

Questions?

Thank you!