

# Big Sky Waiver Training

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**Provider Relations Manager**

# Agenda

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- Enrollment Tips
  - How to find your PID/API
  - License Information
  - Adding Locations
  - IRS Letter
- Adjustment Tips
- How to read a remittance advice

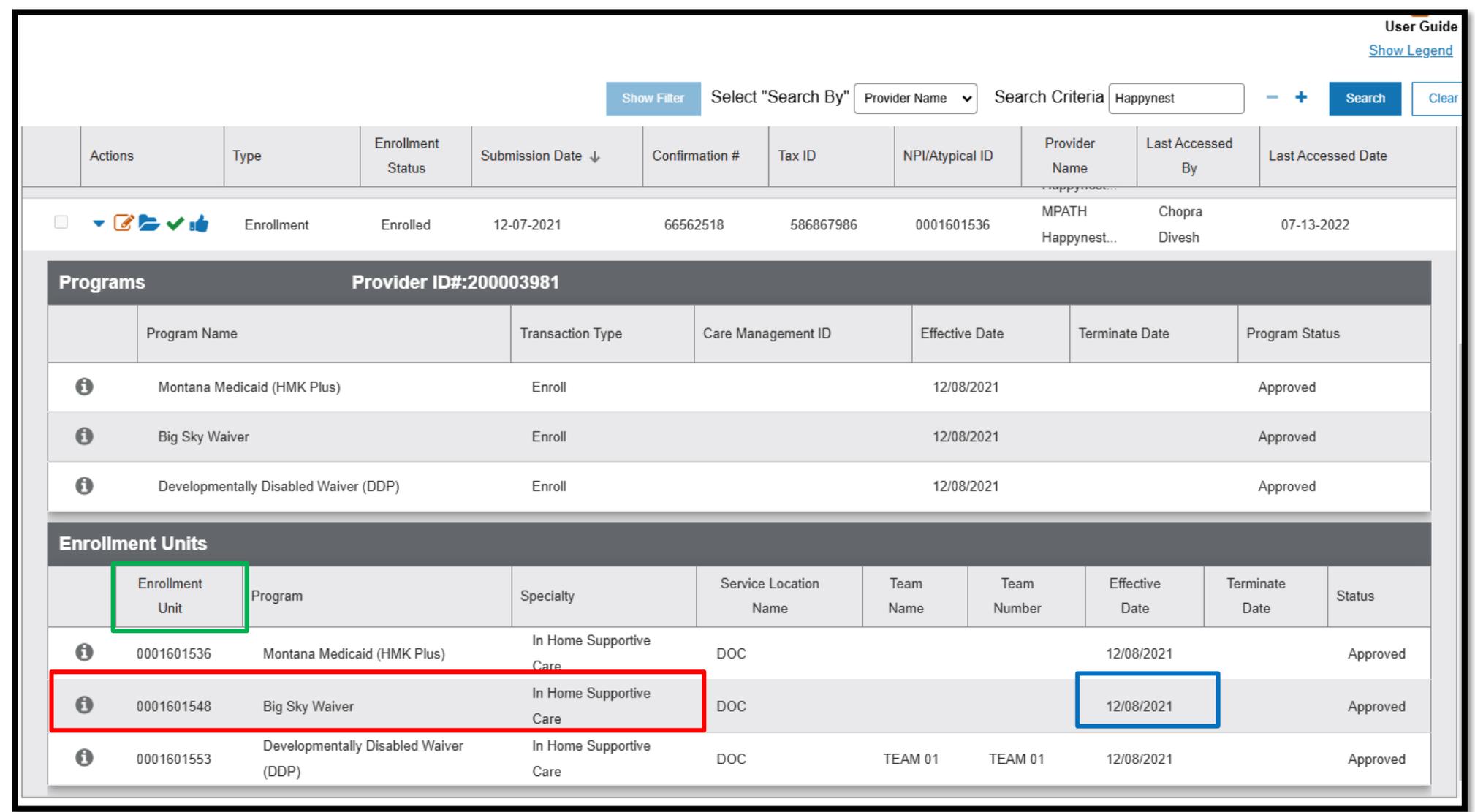
# Enrollment Tips



# Locating Your PID/API

To find your PID/API, you can check your enrollment workbench. Search for the name or NPI. Then, click the blue arrow to drop down your enrollment info. The Enrollment Units section is at the bottom where you can locate the needed information.

- API = Atypical Provider ID
- PID = Provider ID
- EU = Enrollment Unit



The screenshot shows a web application interface for managing enrollment. At the top right, there is a search bar with 'Show Filter', 'Select "Search By" Provider Name', 'Search Criteria Happynest', and 'Search' buttons. Below this is a table with columns: Actions, Type, Enrollment Status, Submission Date, Confirmation #, Tax ID, NPI/Atypical ID, Provider Name, Last Accessed By, and Last Accessed Date. A row shows 'Enrollment' with status 'Enrolled' and submission date '12-07-2021'. Below the main table is a section titled 'Programs' with a sub-header 'Provider ID#:200003981'. This section contains a table with columns: Program Name, Transaction Type, Care Management ID, Effective Date, Terminate Date, and Program Status. Three rows are listed: 'Montana Medicaid (HMK Plus)', 'Big Sky Waiver', and 'Developmentally Disabled Waiver (DDP)'. Below the programs is an 'Enrollment Units' section with a table containing columns: Enrollment Unit, Program, Specialty, Service Location Name, Team Name, Team Number, Effective Date, Terminate Date, and Status. The 'Enrollment Unit' column header is highlighted with a green box. The row for 'Big Sky Waiver' is highlighted with a red box, and its 'Effective Date' '12/08/2021' is highlighted with a blue box.

# License Information

- License information is required on the Credentials tab depending on the taxonomy selected on the Provider Information tab.
- If you have a license for the services you provide, click add and please enter the information as presented on your license and upload a copy.

**Licenses:** ⓘ  
Add ⓘ

License #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Other (Mail or Fax)	Actions
No Licenses found							

# License Information Cont.

- If you do not have a license and if being required to enter a license, please add the “dummy” info as listed below:
  - License #: BSW
  - State: MT
  - Issuing Party: Other
  - Effective Date: 01/01/2025
  - Expiration date: 12/31/2025
  - Check the box for Mail/Fax instead of uploading a document

### Add Licenses ✕

Required fields are marked with an asterisk (\*).

Provider Type: \* ⓘ

Specialty: \* ⓘ

License#: \* ⓘ  State: \* ⓘ

(Format: Universal)

Issuing Party Identifier: \* ⓘ

Effective Date: \* ⓘ   ✕ Expiration Date: \* ⓘ   ✕

License #	Specialty	State	Effective Date	Expiration Date	Issuing Party Identifier	Other (Mail or Fax)	Actions
BSW*	In Home Supportive Care	MT	01/01/2025	12/31/2025	Other	<input type="checkbox"/>	  

# Adding a Location

- On the Physical Location Tab of the Enrollment, click the Add Button.
  - Only add locations that have a unique Zip +4.



MPATH Happynes...  
Provider ID#:200003981

- Provider Information ○
- Credentials ○
- Financial Information ○
- Physical Location ○
- Enrollment Units ○
- Final Submission ○
- Summary
- Demographic Maintenance

### Physical Location

Users have the ability to enter multiple physical locations within a single enrollment application submission. After entering in all of the required information the user can select the "Add" button and the application will generate an additional physical location. Each physical location is identified by using the National Provider Identifier (NPI) or Atypical Provider Number plus a three digit extension. For example the first physical location number would be ex. 1234567891-001 and the additional locations would be -002, -003, etc. The information collected in each physical location will be utilized in the provider directory. The information disclosed will help the member population determine where to receive care and provider characteristics. Use the top ? to access User Documentation to help navigate each section of the Provider Enrollment application. The 'Help' symbol is also available for additional help or the (i) for hover field level help.

**Location**

Add \* ⓘ

Manage Affiliations ⓘ

ID	Address	City	State	County	Action	Progress
001	11 J Street	Helena	MT	Lewis And Clark		○
002	1233 Main	Helena	MT	Lewis and Clark		○

# Adding a Location Cont.

- Enter the required information denoted by a red asterisk.
- Once complete, click the Validate Address button. This verifies the address is valid per USPS.

Service Location Name: \* 

Physical Practice Location Address: \* 

Address Line 1: \* 

Address Line 2: 

City: \*  State: \*  Zip Code: \*  County: \*  Terminate Date: 

Select One ▼

Select One ▼

MM/DD/YYYY 

Phone Number: \*  Ext:  Fax Number:  Ext: 

Validate Address \* 

Be aware that by not selecting a US Postal Service validated address, this could affect but is not limited to the following:

- Credentialing Approval
- Ability for your practice to be accurately located in the Provider Directory or other search engines

Validate Address \*

# Adding a Location Cont.

- Check the specialties and programs that provide services at this location.
  - Do not enter terminate dates unless you are indicating the location no longer provides those services.

**Specialties \* **

	Type of Provider	Specialty	Taxonomy	Terminate Date
<input checked="" type="checkbox"/>	Agencies	In Home Supportive Care	253Z00000X	MM/DD/YYYY 

**Programs \* **

	Program Name	Care Management ID	Required Team Name	Terminate Date
<input type="checkbox"/>	Montana Medicaid (HMK Plus)			MM/DD/YYYY 
<input checked="" type="checkbox"/>	Big Sky Waiver			MM/DD/YYYY 
<input type="checkbox"/>	Developmentally Disabled Waiver (DDP)		<a href="#">Add Team</a> 	MM/DD/YYYY 

# IRS Letter

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- Effective 12/19/2024, a copy of the IRS Letter is required for all new enrollments and revalidations. The provider notice was posted on 12/19/2024 with more information.

## [IRS Tax Identification Letter Required for Pay-To Providers](#)

- The name on the IRS letter needs to match the Legal Entity name, name listed on the W9, and the DBA name.
- This can be uploaded in the W9 section of the enrollment or using the Additional Documents button after submission.

# How to Read a Remittance Advice



# Remittance Advice- e!Sor

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- Remits can be found on the MPATH portal for a rolling 12 months.
- Information about upcoming events and provider type specific updates.
- Sections for paid claims, denied claims, and pending claims.
- Includes any takebacks or credit balance claims.
- Includes the Internal Claim Number(ICN).

# Remittance

AS OF 02/08/2024

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

Provider Name  
Address

VENDOR #                      REMIT ADVICE #                      EFT/CHK #                      DATE 02/12/2024                      PAGE                      1  
NPI #:                              TAXONOMY: 282N00000X

- NEWSLETTER UPDATE -

PLEASE CHECK OUT THE PROVIDER INFORMATION WEBSITE,  
[HTTPS://MEDICAIDPROVIDER.MT.GOV/](https://MEDICAIDPROVIDER.MT.GOV/), FOR NEW AND UPDATED PROVIDER  
NOTICES, CLAIM JUMPER NEWSLETTERS, FEE SCHEDULES, PROVIDER MANUALS,  
TRAINING, AND OTHER RESOURCES.

WE ARE SEEING A HIGH VOLUME OF CLAIMS POSTING DUPLICATE CLAIM ERRORS.  
PLEASE MAKE SURE YOU DO NOT HAVE MULTIPLE CLAIMS FOR THE SAME MEMBER,  
DATE OF SERVICE, AND SERVICE(S). ATTENTION TO THIS LEVEL OF DETAIL WILL  
HELP REDUCE CLAIM PROCESSING TIME.

# Paid Claims

VENDOR # REMIT ADVICE # EFT/CHK #018077531 DATE 02/12/2024 PAGE 2  
 NPI #: TAXONOMY: 282N00000X

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES	
<b>PAID CLAIMS - INPATIENT CLAIM</b>										
		01042024	01252024	6.000	124	17359.50	0.00			
ICM		PATIENT NUMBER=								
		DRG CODE 0753-2 DRG								
		01042024	01252024	16.000	204	59332.00	0.00			
		01042024	01252024	347.000	259	3999.87	0.00			
		01042024	01252024	11.000	300	1817.75	0.00			
		01042024	01252024	1.000	306	112.00	0.00			
		01042024	01252024	1.000	450	1942.25	0.00			
		01042024	01252024	9.000	636	261.00	0.00			
		***CLAIM TOTAL*****				84824.37	5578.90			

# Claims Pending

VENDOR #                      REMIT ADVICE #                      EFT/CHK #                      DATE 02/12/2024                      PAGE 21  
 NPI #:                              TAXONOMY: 282N00000X

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES	
CLAIMS PENDING:              INPATIENT CLAIM										
ICN		10172023	10222023	1.000	120	2038.50	0.00			
		PATIENT NUMBER=								
		DRG CODE 0560-3 DRG								
		10172023	10222023	4.000	122	8154.00	0.00			
		10172023	10222023	72.000	259	1232.42	0.00			
		10172023	10222023	2.000	270	472.50	0.00			
		10172023	10222023	1.000	271	124.25	0.00			
		10172023	10222023	19.000	300	2229.00	0.00			
		10172023	10222023	1.000	351	2067.75	0.00			
		10172023	10222023	1.000	611	2341.25	0.00			
		10172023	10222023	1.000	615	2143.50	0.00			
		10172023	10222023	101.000	636	2125.94	0.00			
		10172023	10222023	1.000	720	4088.50	0.00			
		10172023	10222023	22.000	721	5263.50	0.00			
		***CLAIM TOTAL*****					32281.11	0.00		133

# Denied Claims

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
DENIED CLAIMS - OUTPATIENT CLAIM									
ICN		12122022	12122022	2.000	259	40.00	0.00		
	PATIENT NUMBER=								
	OUTPATIENT GROUP 00								
		12122022	12122022	4.000	310	1500.00	0.00		
		12122022	12122022	7.000	310	2625.00	0.00		119 M53
		12122022	12122022	1.000	312	290.50	0.00		
		12122022	12122022	6.000	312	1743.00	0.00		
		12122022	12122022	60.000	636	95.19	0.00		
		12122022	12122022	1.000	750	2273.00	0.00		
		***CLAIM TOTAL*****				8566.69	0.00		29
ICN		01212024	01212024	1.000	300	78.25	0.00		
	PATIENT NUMBER=								
	OUTPATIENT GROUP 00								
		01212024	01212024	1.000	300	85.00	0.00		
		***CLAIM TOTAL*****				163.25	0.00		31

# Total Warrant Amount

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
CLAIMS PENDING: MEDICARE OUTPATIENT CROSSOVER VENDOR # NPI #: REMIT ADVISE # TAXONOMY: 282N00000X EFT/CHK # DATE 02/12/2024 PAGE 631									
ICN		06192023	06192023	1.000	300	27.00	0.00		
	PATIENT NUMBER=								
		06192023	06192023	1.000	510	129.44	0.00		
		*** MEDICARE PAYMENT*****					101.47		
		***CLAIM TOTAL*****				156.44	0.00		133
OUR RECORDS INDICATE THAT THE RECIPIENT LISTED ABOVE HAS INSURANCE WITH UNITED HEALTHCARE SPRINGFIELD SERVICE CENTER P O BOX 740800 ATLANTA, GA 30374-0800 POLICY #: GROUP CERT #: SUBSCRIBER SSN: SUBSCRIBER NAME: SUBSCRIBER INITIAL:									
ICN		11102023	11102023	1.000	510	129.44	0.00		133
	PATIENT NUMBER=								
		*** MEDICARE PAYMENT*****					101.47		
		***CLAIM TOTAL*****				129.44	0.00		133
ICN		01092024	01092024	1.000	300	67.25	0.00		
	PATIENT NUMBER=								
		01092024	01092024	1.000	300	70.75	0.00		
		01092024	01092024	1.000	300	60.75	0.00		
		*** MEDICARE PAYMENT*****					31.23		
		***CLAIM TOTAL*****				198.75	0.00		133
**CLAIMS PENDING TOTALS -MEDICARE OUTPATIENT						**NUMBER OF CLAIMS-	47**	145357.81	0.00
***TOTAL WARRANT AMOUNT***							522768.96		

# Reason and Remark Codes

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
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\*\*\*\*\*THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE \*\*\*\*\*

- B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
- B5 Coverage/program guidelines were not met or were exceeded.
- MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
- MA30 Missing/incomplete/invalid type of bill.
- MA66 Missing/incomplete/invalid principal procedure code.
- M119 Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
- M123 Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
- M2 Not paid separately when the patient is an inpatient.
- M20 Missing/incomplete/invalid HCPCS.
- M50 Missing/incomplete/invalid revenue code(s).
- M53 Missing/incomplete/invalid days or units of service.
- M62 Missing/incomplete/invalid treatment authorization code.
- M67 Missing/incomplete/invalid other procedure code(s).
- M81 You are required to code to the highest level of specificity.
- M86 Service denied because payment already made for same/similar procedure within set time frame.
- N10 Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
- N192 Patient is a Medicaid/Qualified Medicare Beneficiary.
- N286 Missing/incomplete/invalid referring provider primary identifier.
- N3 Missing consent form.
- N30 Patient ineligible for this service.
- N378 Missing/incomplete/invalid prescription quantity.
- N45 Payment based on authorized amount.
- N54 Claim information is inconsistent with pre-certified/authorized services.
- 119 Benefit maximum for this time period or occurrence has been reached.
- 125 Submission/billing error(s). At least one Remark Code must be provided (

# Adjustments tips



# When should I request an adjustment?

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- Claim was overpaid or underpaid.
- Claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- When doing an adjustment for rate changes, bill for the new total amount – not the difference between prior payment and new rate amount.

# Adjustment Requirements

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- Adjustments may be submitted electronically or using Individual Adjustment Request (IAR) form. (Electronically is more efficient and reliable)
- Only be submitted on paid claims; denied claims cannot be adjusted.
- Always use most recent paid ICN on adjustments.
- Always require a remit from the paid claim.
- Claims Processing must receive individual claim adjustments within 15 months from the date of Payment. After this time, gross adjustments are required via DPHHS.

# Using the IAR form

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- Separate adjustment request form for each ICN.
- If correcting more than one error per ICN, use only one adjustment request form and include each error on the form.
- If there is not enough space on the form to detail the corrections needed, use box 8 to indicate “Please process attached claim” and attach a new claim with yioy corrections to the IAR form.

# Adjustment Request Form



One adjustment form per Internal Control Number

Section A – Must be completely filled out

Section B – Only the info that needs changing

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

**Montana Healthcare Programs**  
Medicaid • Mental Health Services Plan • Healthy Montana Kids

### Individual Adjustment Request

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

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

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

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

# Adjustment Request Form - Section A

## Completing an Individual Adjustment Request Form – Section A

Field	Description
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Name	The member's name
3. Internal Control Number (ICN)	There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim.
4. Provider number	The provider's NPI/API.
5. Member Medicaid Number	Member's Medicaid ID number.
6. Date of Payment	Date claim was paid.
7. Amount of Payment	The amount of payment from the remittance advice.

# Adjustment Request Form - Section B

## Completing an Individual Adjustment Request Form – Section B

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

If You Have Questions...



# Need Help?

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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.



**User Guide**

# Online Resources

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Provider Information Website:

<https://medicaidprovider.mt.gov>

- [Provider Enrollment Page](#)
- [Claims Page](#)
- Provider Services Module User Guides
- [Claim Jumper Newsletters](#)
- Previous training presentations and videos

# Provider Relations Contact Information

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Provider Relations Call Center:

(800) 624-3958

Monday through Friday

8 a.m. - 5 p.m. Mountain Time

General, Claims, TPL, and EDI questions:

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

Enrollment Questions and documents:

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

Note: the Conduent helpdesks cannot accept secured emails, claim forms, and cannot give claim status.

# Email Assistance

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When emailing the help desks, please provide the following so we can research & submit a help ticket to our Tech Team.

**GovID:**

**Name:**

**Email registered:**

**NPI attempting/registered:**

**Phone number:**

**A screen shot of the error:**

Please allow 2 - 5 business days for a response.

Thank you!