

Billing 101 Training for Providers

Presented by Loma Romero, Provider Relations Field Representative

Roll Call

In chat, please share:

- Your name
- Company
- Who you are representing

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

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)

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.

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 [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
----------	------	--------	------	----

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

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 in the Provider manuals, 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>

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.

The Call Center 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 include 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.

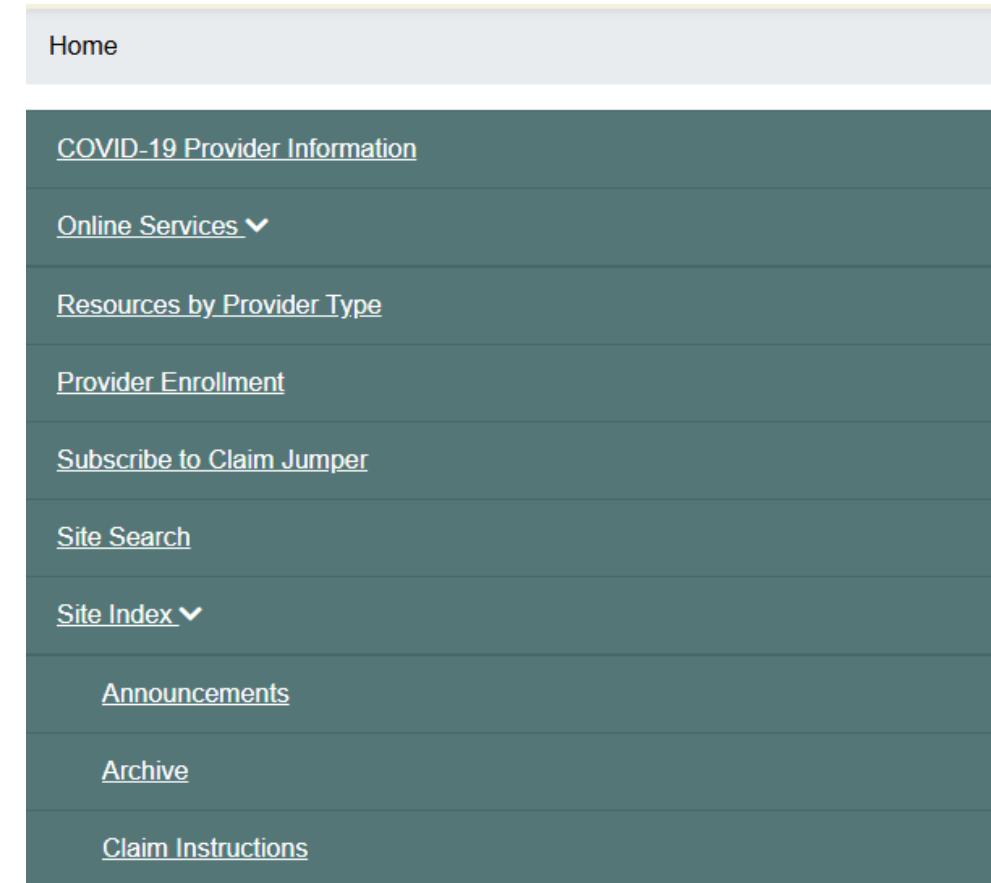
Claims Submission

Electronic Claim Submission Setup

A clearinghouse, software, or billing agent that is contracted to submit claims with MT Medicaid can assist with claims submission.

A Montana DPHHS EDI Provider Enrollment Form can be filled out if you have a company that is not contracted. (Unless using MPATH)

The form can be found on the [Claims Instruction 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. This is not a payment guarantee.
- 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

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 7 Passport Referral
- 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 66 Diagnosis Codes
- Box 76 Attending Provider
- Box 81 Billing NPI Taxonomy

Optional fields, as applicable:

- 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

Service Date	Quantity	Unit	Amount
7/6/14	1	83.95	
9/6365	1	326.72	
96366	1	32.83	
96367	1	63.50	
80048	1	95.56	
82055	1	121.37	
87040	2	223.96	
87804	2	259.56	
71020 TC	1	209.83	
99284 25	1	687.39	
J1630	4	159.30	
J1956	3	75.95	

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 56A Rendering Taxonomy

Optional Fields, as applicable:

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

ADA American Dental Association® Dental Claim Form																	
HEADER INFORMATION																	
1. Type of Transaction (Mark all applicable boxes)																	
<input type="checkbox"/> Statement of Actual Services		<input type="checkbox"/> Request for Predetermination/Priorauthorization															
<input type="checkbox"/> EPSDT / Title XIX																	
2. Predetermination/Priorauthorization Number																	
DENTAL BENEFIT PLAN INFORMATION																	
3. Company/Plan Name, Address, City, State, Zip Code																	
4. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																	
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"/> Other											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																	
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. Employer Name															
PATIENT INFORMATION																	
18. Relationship to Policyholder/Subscriber in #12 Above		19. Reserved For Future Use															
<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Dependent Child		<input type="checkbox"/> Other											
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													
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	34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-10 = AB)	31a. Other Fee(s) <input type="checkbox"/>
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 <input type="checkbox"/>
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 dental 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 () -	53. Additional Provider ID	57. Phone Number () -	58. Additional Provider ID														
ANCILLARY CLAIM/TREATMENT INFORMATION																	
38. Place of Treatment (e.g. 11=office; 22=O/P Hospital)		39. Enclosures (Y or N) <input type="checkbox"/>															
(Use "Place of Service Codes for Professional Claims")																	
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)																	
42. Months of Treatment		43. Replacement of Prosthetic		44. Date of Prior Placement (MM/DD/CCYY)													
<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																	
45. Treatment Resulting from																	
<input type="checkbox"/> Occupational illness/injury		<input type="checkbox"/> Auto accident		<input type="checkbox"/> 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		57. Provider Specialty Code															
© 2019 American Dental Association J430 (Same as ADA Dental Claim Form - J431, J432, J433, J434, J430)																	
To reorder call 800.947.4746 or go online at ADACatalog.org																	

MPATH Claims Setup

Account Administration

All 3 Account Administration functions are located on one screen.

- Manage Portal Users
- Manage Billing Providers
- Manage Provider Enrollment Accounts

Manage Portal Users [? Help](#)

A maximum of 200 users will be displayed. Adjust your search criteria in the left navigation to refine your results.

Filter your results:

ACTIONS	LOGIN NAME	FIRST NAME	LAST NAME	EMAIL	STATUS
No matching users found.					

Show entries Showing 0 to 0 of 0 entries [|<](#) [<](#) [>](#) [|>](#)

[Add User Account](#)

Manage Billing Providers [? Help](#)

Filter your results:

ACTIONS	BILLING PROVIDER NAME	NPI/API ID
	MPATH	1003362864

Show entries Showing 1 to 1 of 1 accounts [|<](#) [<](#) [>](#) [|>](#)

[Add Billing Provider](#)

Manage Provider Enrollment Accounts [? Help](#)

[Complete LINK Request Form](#) [Complete UNLINK Request Form](#) Filter your results:

ACTION	ATTACHMENT	DATE	STATUS
No matching transactions found.			

Show entries Showing 0 to 0 of 0 entries [|<](#) [<](#) [>](#) [|>](#)

[Upload Request](#)

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:*

Submit

Cancel

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

Manage Affiliations

This action is **needed** if you are a facility that employs Rendering Providers and/or you are billing on the Provider Services Portal.

The person completing this action will need the facility NPI on their Enrollment workbench.

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
	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.

User Guide 

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 	Search 
<input type="text"/>	<input type="text"/>	<input type="text" value="1083670285"/>	<input type="button" value="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	<input type="text" value="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 each location 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
1	ROBERT	NITSCHLME	1598719064	05/12/2022			

Assigned Locations

	Address Line	
	1111 BAKER AVE	

1111 BAKER AVE

Select	Program Name	Effective Date*	Termination Date
	Montana Medicaid (HMK Plus)	05/12	MM/DD/YYYY

Save **Cancel**

Manage Existing Affiliations

Pending Approval tab will show any providers that have submitted to be affiliated by your facility.

Requested Affiliations are providers who are requesting affiliation.

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

Manage Affiliations

User Guide 

Search for Providers Pending Approval Requested Affiliations **Existing Affiliations** Denied Affiliations

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 

1144064783  

	First Name	Last Name	NPI/Atypical ID	Effective Date ↑	Terminate Date	Actions	File Name
	Emma	Windauer	1144064783	06/24/2024	 	 	

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 Providers Pending Approval Requested Affiliations Existing Affiliations User Guide Help

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 i Last Name i NPI/Atypical ID i Search i

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

 ANITA BEACH 1922064401 MM/DD/YYYY calendar up i

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?

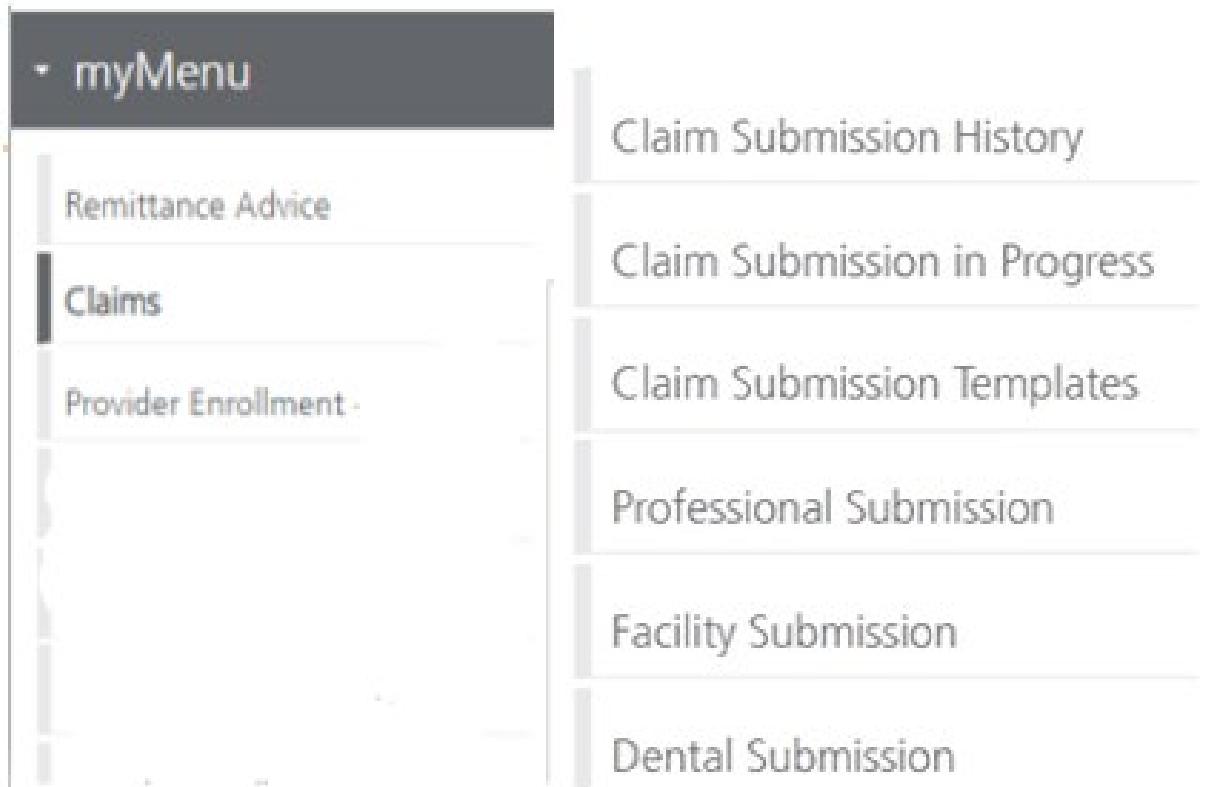
Provider Services Portal Claims Submission

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.

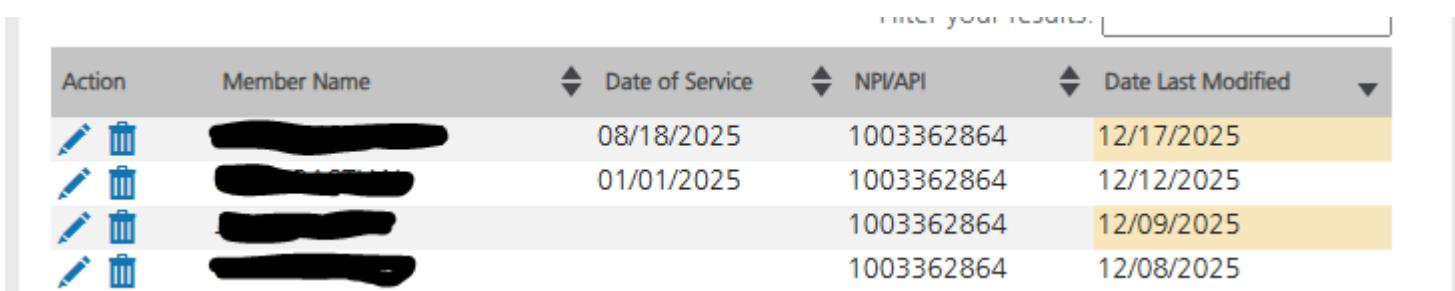
Claims Submission in Progress

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.



Enter your results.				
Action	Member Name	Date of Service	NPI/API	Date Last Modified
	[REDACTED]	08/18/2025	1003362864	12/17/2025
	[REDACTED]	01/01/2025	1003362864	12/12/2025
	[REDACTED]		1003362864	12/09/2025
	[REDACTED]		1003362864	12/08/2025

Claim Submission Templates

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 the 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 7 Help

Maximum Templates Allowed: 500 Filter your results:

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 1 2 3 4

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

*Section 6, of the Provider Portal User Guide.

Creating a template cont.

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

Creating a template cont.

Select the Rendering Provider file.

If you have multiple NPIs listed under Affiliations, The NPI field will have a drop down.

Select NPI.

Select Specialty.

Click **Save and Continue**.

Rendering Provider

NPI:	<input type="text" value="1346773231"/>
Provider Name:*	<input type="text" value="MPATH W Barton"/>
Taxonomy Code: *	<input type="text" value="Select Taxonomy C"/>

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Save and Continue

Save and Exit

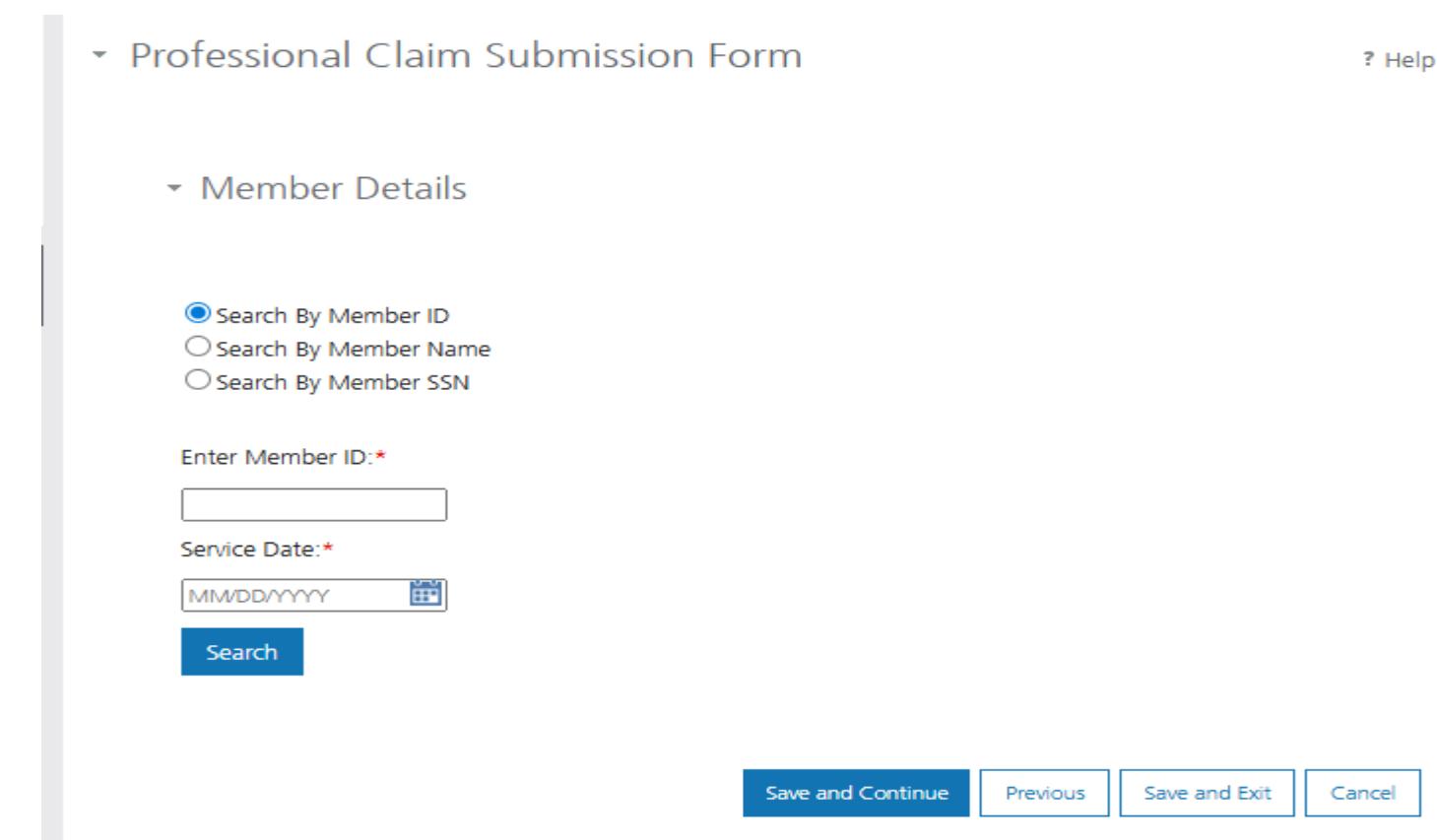
Cancel

Creating a Template Cont.

Enter the member's MT
Medicaid ID number and Date
of Service.

Click **Search**.

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



The screenshot shows a software interface for a 'Professional Claim Submission Form'. At the top right is a 'Help' link. Below it, a 'Member Details' section is expanded. It contains three radio buttons for search methods: 'Search By Member ID' (selected), 'Search By Member Name', and 'Search By Member SSN'. Below these are fields for 'Enter Member ID:' (a text input field) and 'Service Date:' (a date input field with a calendar icon). A 'Search' button is located below the date field. At the bottom of the interface are four buttons: 'Save and Continue' (highlighted in blue), 'Previous', 'Save and Exit', and 'Cancel'.

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.

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 :  or  indicates all required fields for COB or NDC have been entered.

Note : Use a comma ", " if multiple values are needed in Modifier or Diagnosis Pointer fields.

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

Total Charges: 

Note : Total Claim Lines are limited to a maximum of 50 for each submission.

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?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Are you submitting COB at the claim level?	<input type="radio"/> Yes <input type="radio"/> No
Is the member's condition related to:	<input type="radio"/> Select
First date related to Member's condition:	<input type="radio"/> Select
Is this Member deceased?	<input type="radio"/> Yes <input type="radio"/> No
Is member unable to work in current occupation?	<input type="radio"/> Yes <input type="radio"/> No
Is hospitalization related to current services?	<input type="radio"/> Yes <input type="radio"/> No
Clinical Laboratory Improvement Amendment Number needed for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Is there a prior authorization for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Is there a Referral for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Do you have attachments for this claim?	<input type="radio"/> Yes <input type="radio"/> No

Save and Continue

Creating a Template Cont.

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

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

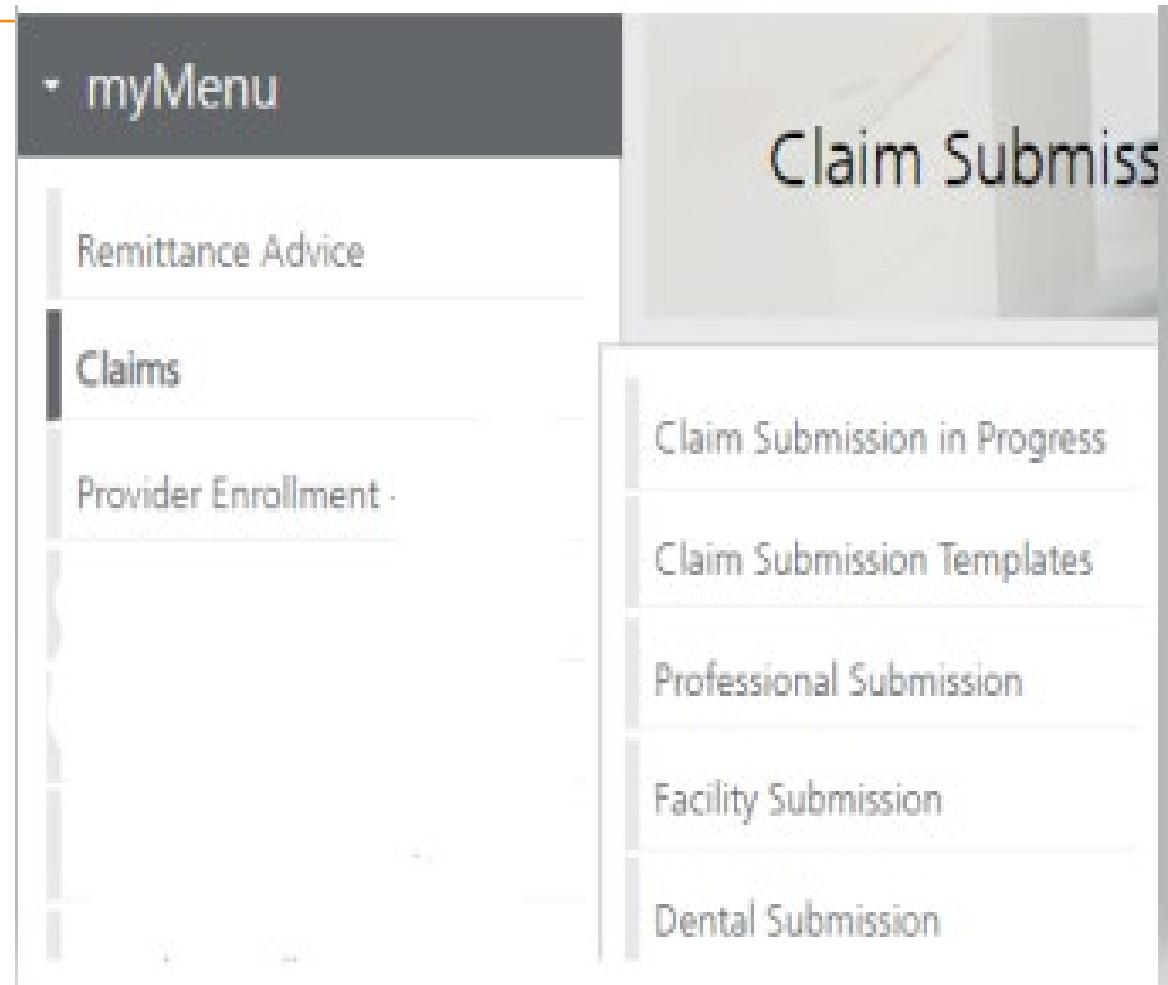
Questions?

Claim Submission

Submitting a Claim

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

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



*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:*

- 1609484575
- 1538253760
- 1164561635

Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

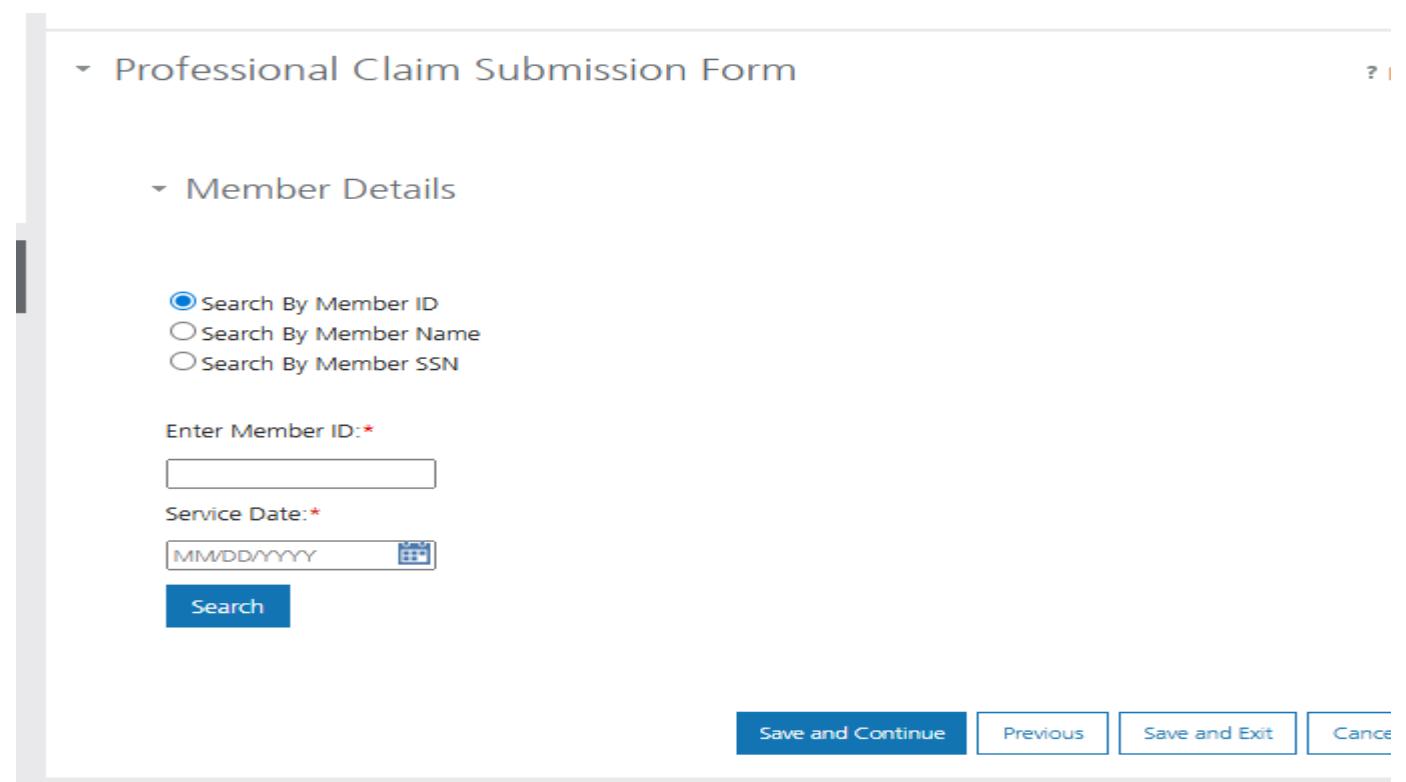
Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

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

Click **Save and Continue**.



The screenshot shows a software interface for a 'Professional Claim Submission Form'. At the top, there is a navigation bar with a question mark icon and a search bar. Below the navigation bar, the 'Member Details' section is expanded. It contains three search options: 'Search By Member ID' (selected), 'Search By Member Name', and 'Search By Member SSN'. Below these options is a field labeled 'Enter Member ID: *' with a red asterisk indicating it is required. A text input field is provided for this. Underneath the input field is a 'Service Date:' label with a red asterisk, followed by a date input field in 'MM/DD/YYYY' format with a calendar icon. A 'Search' button is located below the date field. At the bottom of the search panel, there are four buttons: 'Save and Continue' (blue), 'Previous' (light blue), 'Save and Exit' (light blue), and 'Cancel' (light blue).

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"/>					
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"/>	Select	<input type="text"/>	<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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <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"/>	\$ <input type="text"/>	COB <input type="checkbox"/>	<input type="checkbox"/>				
<input type="text"/> Total Charges: \$ <input type="text"/> <input type="button" value="Add"/>												

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:	<input type="radio"/> Yes <input type="radio"/> No
Are you submitting COB at the claim level?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Is the member's condition related to:	<input type="button" value="Select"/>
First date related to Member's condition:	<input type="button" value="Select"/>
Is this Member deceased?	<input type="radio"/> Yes <input type="radio"/> No
Is member unable to work in current occupation?	<input type="radio"/> Yes <input type="radio"/> No
Is hospitalization related to current services?	<input type="radio"/> Yes <input type="radio"/> No
Clinical Laboratory Improvement Amendment Number needed for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Is there a prior authorization for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Is there a Referral for this claim?	<input type="radio"/> Yes <input type="radio"/> No
Do you have attachments for this claim?	<input type="radio"/> Yes <input type="radio"/> No

Claim Adjustment Question

Select Yes to complete a claim adjustment.

Select Replacement or Void claim.

Enter Original ICN.

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

Yes No

Select the Medicaid Resubmission Code:*

Select

Enter the Original MMIS ICN:*

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

Yes No

Select the Medicaid Resubmission Code:*

Select

Enter the Original MMIS ICN:*

Select

Replacement of prior claim

Void of prior claim

Are you submitting COB at the claim level?

Yes No

Primary Insurance EOB

- 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.

Are you submitting COB at the claim level?

Yes No

Primary Payer			Secondary Payer				
Insurance Type: [*]	Select	Insurance Type:	Select	Carrier Name:	Carrier Name:		
Carrier Name: [*]		Carrier Code:		Carrier Code:			
Carrier Code:		Subscriber First Name: [*]		Subscriber First Name:			
Subscriber First Name: [*]		Subscriber Middle Name:		Subscriber Middle Name:			
Subscriber Middle Name:		Subscriber Last Name: [*]		Subscriber Last Name:			
Subscriber Last Name: [*]		Allowed:	\$	Allowed:	\$		
Allowed:	\$	Copay:	\$	Copay:	\$		
Copay:	\$	Deductible:	\$	Deductible:	\$		
Deductible:	\$	Coinsurance:	\$	Coinsurance:	\$		
Coinsurance:	\$	Paid Amount: [*]	\$	Paid Amount:	\$		
Paid Amount: [*]	\$	Group	Reason	Amount	Group	Reason	Amount
				\$			\$
				\$			\$
				\$			\$
EOB Payment Date: [*]	MM/DD/YYYY	<input type="button" value="Calendar"/>	EOB Payment Date:	MM/DD/YYYY	<input type="button" value="Calendar"/>		

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"/>
<input type="button" value="Delete"/>		

Final Submission

Check the box to certify that you have read the Terms and Conditions

▼ Professional Claim Submission Form ? Help

▼ Terms and Agreements

Note : Fields marked with an asterisk * are required.

Provider Name: *

NPI/API: *

* I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

[Submit](#)

[Previous](#)

[Save and Exit](#)

[Cancel](#)

Bulk HIPAA Transactions

Your file must be in 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

1 < < > > 1

Upload

Bulk HIPAA Transactions Cont.

File Upload X

NPI/API: 1427003862

File Type: Claim Submission (837) ▼

Browse

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

Upload

Cancel

Questions?

MPATH Portal Additional Features

Remittance Advice- e!Sor

- Remits can be found on the Provider Services Portal back rolling 12 month
- Information about upcoming events and provider type specific updates.
- Sections for paid claims, denied claims, and pending claims.
- Includes any adjusted claims, voids or credit balance claims.
- Includes the Internal Claim Number(ICN).

Remittance Advice

The screenshot shows a web-based application interface. At the top left is a 'myMenu' button with a dropdown menu. The 'Remittance Advice' option in the dropdown and the main content area are highlighted with a red box. The main content area shows a search interface for Remittance Advice, including search fields, a note about required fields, and a table of search results.

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

List of Remittance Advices							Filter your results: <input type="text"/>	
Remittance Adv Nbr.	Date Issued	Payment Number	Payment Type	Payment Amount	PDF	835 EDI		
0123456789	09/27/2021	01	Check	\$1150550.83	View	Download		
0123456789	09/27/2021	02	Check	\$246077.51	View	Download		
0123456789	09/27/2021	03	Check	\$94875.42	View	Download		
0123456789	09/20/2021	01	Check	\$14843.00	View	Download		
0123456789	09/27/2021	04	Check	\$7195.51	View	Download		
0123456789	09/06/2021	05	Check	\$1572.51	View	Download		
0123456789	09/13/2021	01	Check	\$520.36	View	Download		

Show 10 entries

Showing 1 to 7 of 7 forms

1 < < > > 1

VENDOR # 0001		REMIT ADVICE #	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
PAID CLAIMS - MISCELLANEOUS CLAIM								
ICN 22	TEAM NUMBER 01	07012021	07312021	1.000	S5141	2453.93	2453.93	
	PATIENT NUMBER=00				***CLAIM TOTAL*****	2453.93	2453.93	
ICN 221	TEAM NUMBER 01	08012021	08312021	1.000	S5141	2453.93	2453.93	
	PATIENT NUMBER=00				***CLAIM TOTAL*****	2453.93	2453.93	
ICN 221	TEAM NUMBER 01	07012021	07312021	1.000	T2032	767.70	767.70	
	PATIENT NUMBER=00				07012021 07312021 5.000 S5135	115.50	115.50	
					CLAIM TOTAL**	883.20	883.20	
ICN 221	TEAM NUMBER 01	08012021	08312021	1.000	T2032	767.70	767.70	
	PATIENT NUMBER=0				08012021 08312021 5.000 S5135	115.50	115.50	
					CLAIM TOTAL**	883.20	883.20	
ICN 2212	TEAM NUMBER 01	07012021	07312021	8.000	T2021	782.48	782.48	
	PATIENT NUMBER=00							

Remittance

AS OF 02/08/2024

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

Provider Name
Address

VENDOR #	REMIT ADVICE #	EFT/CHK #	DATE	PAGE	1
NPI #:			02/12/2024		
	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 # NPI #:		REMIT ADVICE # TAXONOMY: 282N00000X		EFT/CHK #018077531 DATE 02/12/2024		PAGE 2		
RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED CO-PAY	REASON & REMARK CODES
PAID CLAIMS - INPATIENT CLAIM								
ICN	PATIENT NUMBER=	01042024	01252024	6.000	124	17359.50	0.00	
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					
<hr/>						
RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES ALLOWED CO-PAY
						REASON & REMARK CODES
CLAIMS PENDING: INPATIENT CLAIM						
ICN	PATIENT NUMBER=	10172023	10222023	1.000	120	2038.50 0.00
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 REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
DENIED CLAIMS - OUTPATIENT CLAIM									
		12122022	12122022	2.000	259	40.00	0.00		
ICN 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	
		01212024	01212024	1.000	300	78.25	0.00		
ICN PATIENT NUMBER=									
OUTPATIENT GROUP 00									
		01212024	01212024	1.000	300	85.00	0.00		
		CLAIM TOTAL**				163.25	0.00	31	

Total Warrant Amount

VENDOR # NPI #:		REMIT ADVICE # TAXONOMY: 282N00000X		EFT/CHK #		DATE	02/12/2024	PAGE	631
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									
ICN	PATIENT NUMBER=	06192023	06192023	1.000	300	27.00	0.00		
		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									
ICN		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
*****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

Electronic vs Paper Claim Adjustments

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

<https://medicaidprovider.mt.gov/docs/forms/IndividualAdjustmentRequest.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.
- If you have a claim that is split, please use a Paper Adjustment form and put both ICN's on the adjustment form

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

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 to include the correctly paid lines. 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 for Institutional Claims

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

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)

Additional Resources

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

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.

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 are attempting.**

Questions?

Thank you!