Billing 101 Training for Providers

Presented by Loma Romero, Provider Relations Field Representative

Conduent
Government Healthcare Solutions
Montana FAS January 2026

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 DATES FROM	TO
00[redacted]	[redacted]	10557[redacted]	021521	021521

REASON: 999

LINE ITEM	UNITS	MAXIMUM DOLLARS	FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG RANGE
01	1	0.00	021521	021521	A0430 A0430	
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

REASON: 999

LINE ITEM	UNITS	MAXIMUM DOLLARS	FR-DTE	TO-DTE	PROC RANGE / MOD	DIAG RANGE
01	1	0.00	021121	021121	A0430 A0430	
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.

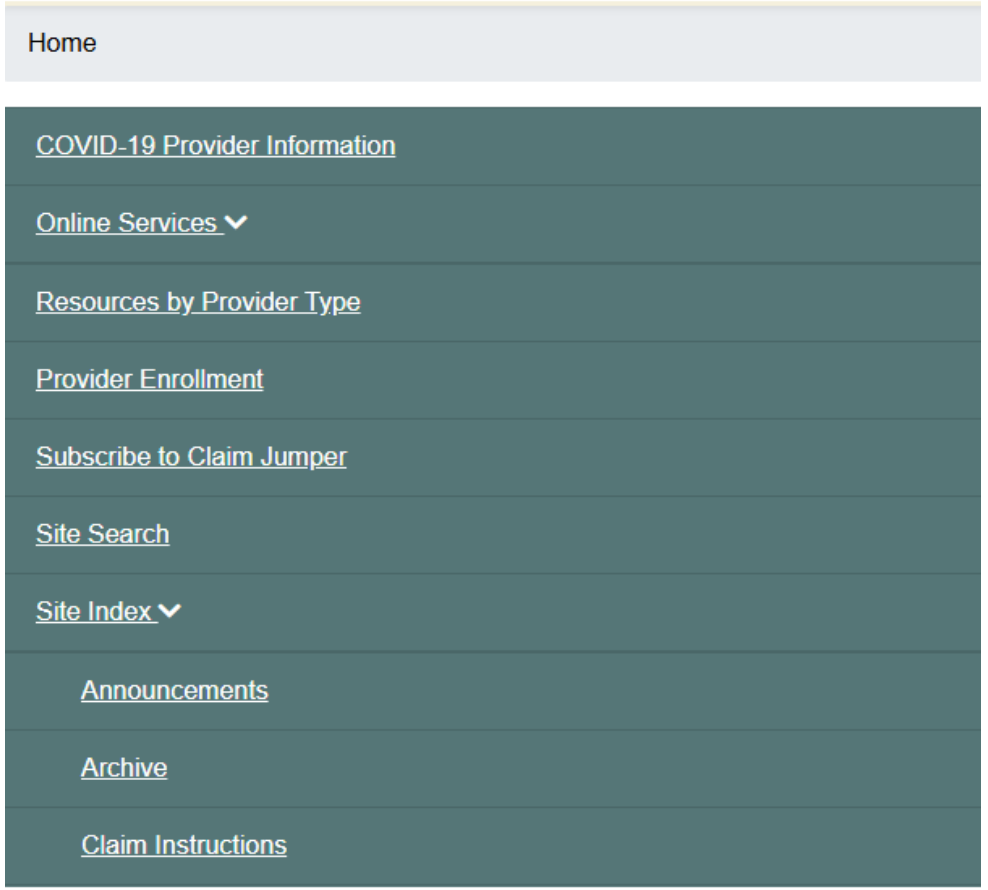
Claims Submission

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

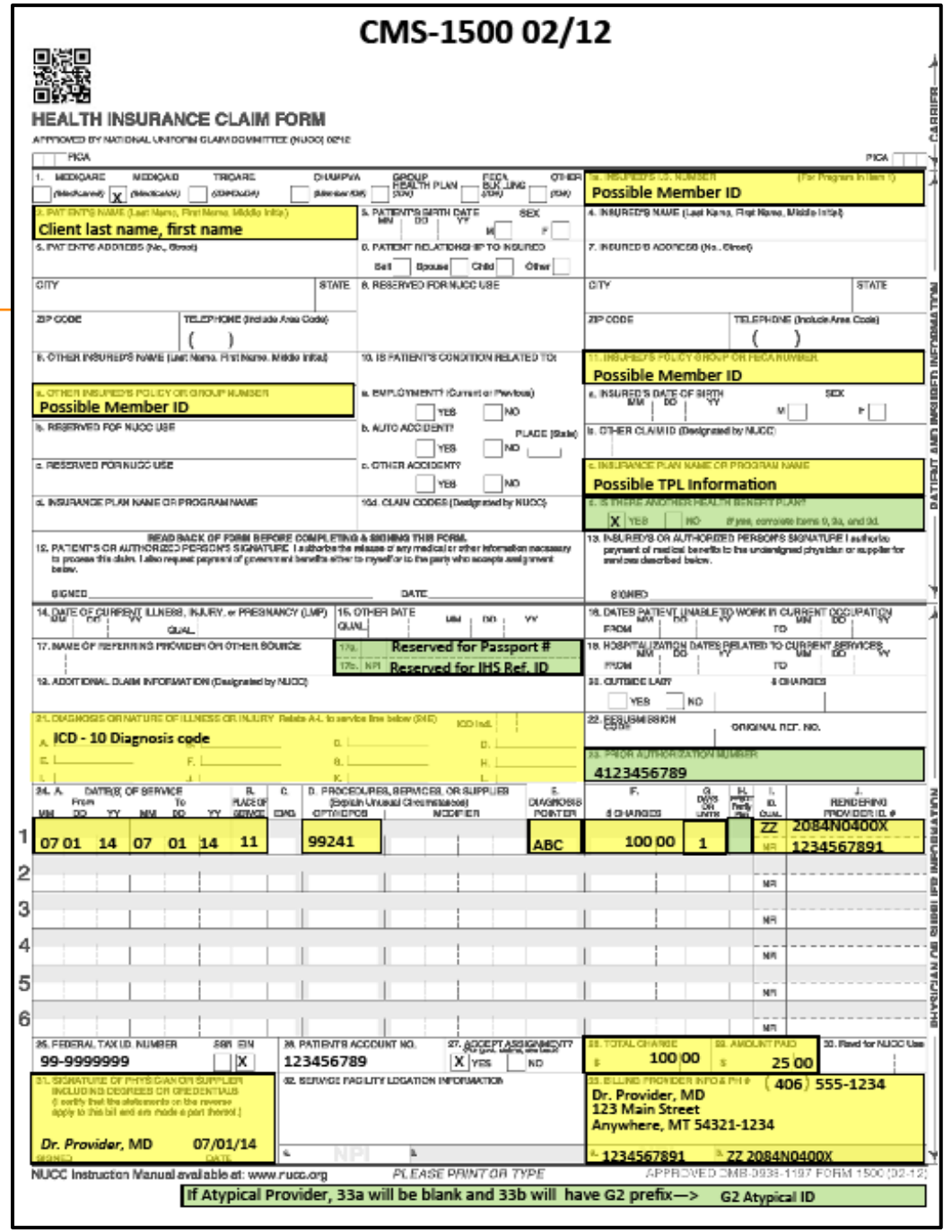
Paper Claim Submissions – CMS 1500

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



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.

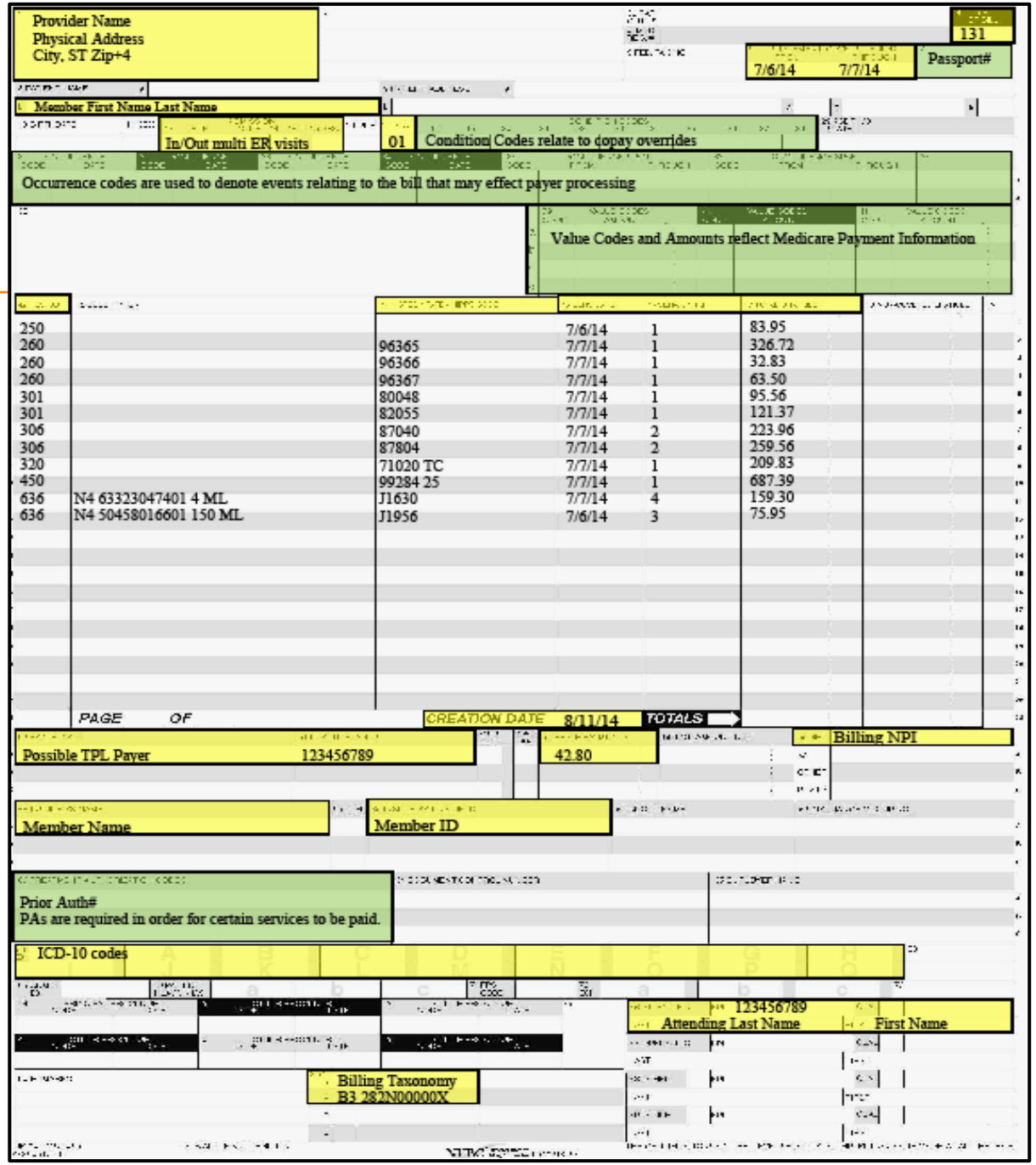
Paper Claim Submissions – UB-04

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



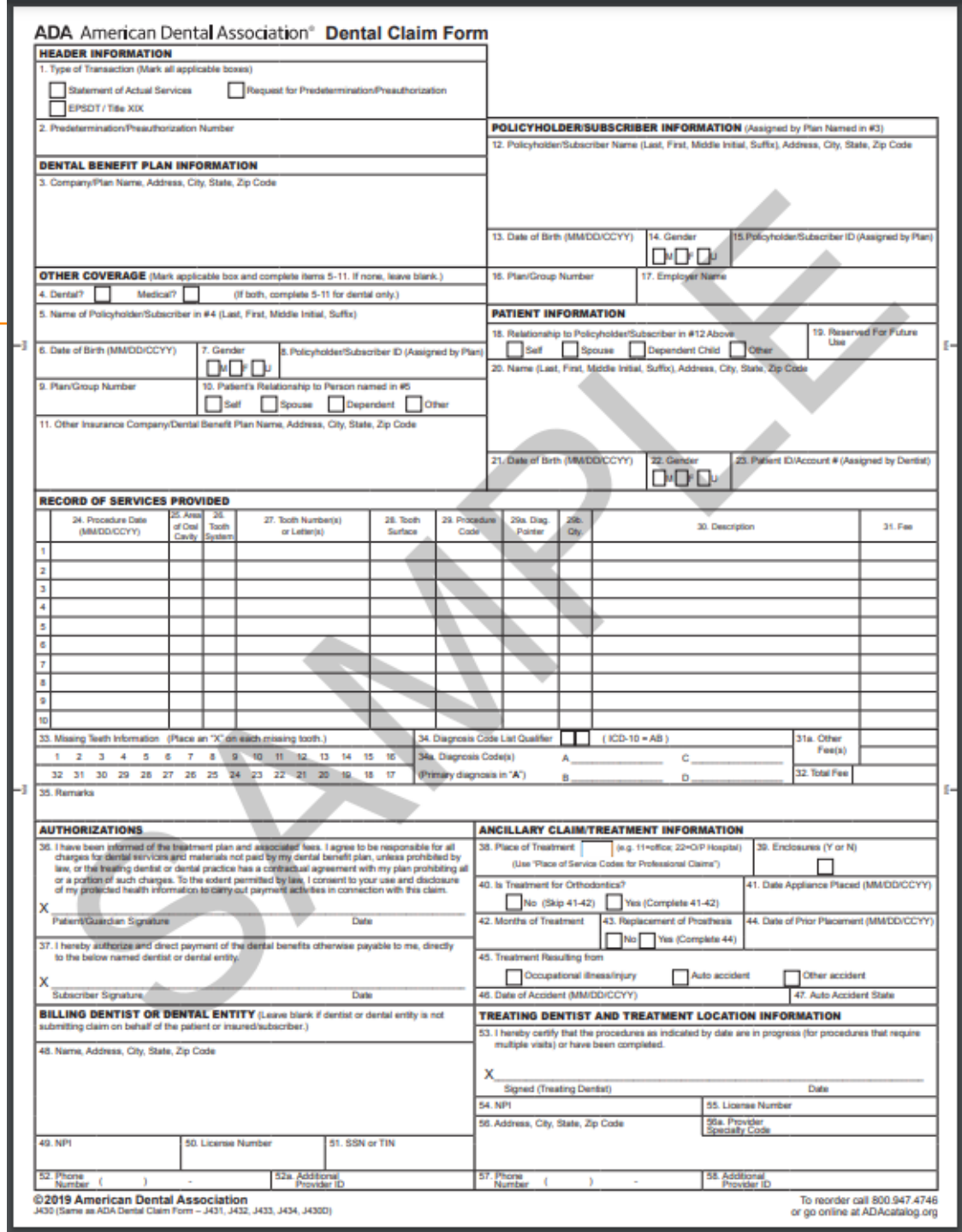
Paper Claim Submissions
ADA Dental

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)
Statement of Actual Services
Request for Predetermination/Preauthorization
EPSDT / Title XIX
2. Predetermination/Preauthorization Number

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 U
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

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 U
15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

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

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	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) (Primary diagnosis in "A") A B C D
31a. Other Fee(s)
32. Total Fee
35. Remarks

AUTHORIZATIONS

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P 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
43. Replacement of Prosthesis No Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from Occupational illness/injury Auto accident Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

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

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

SAMPLE

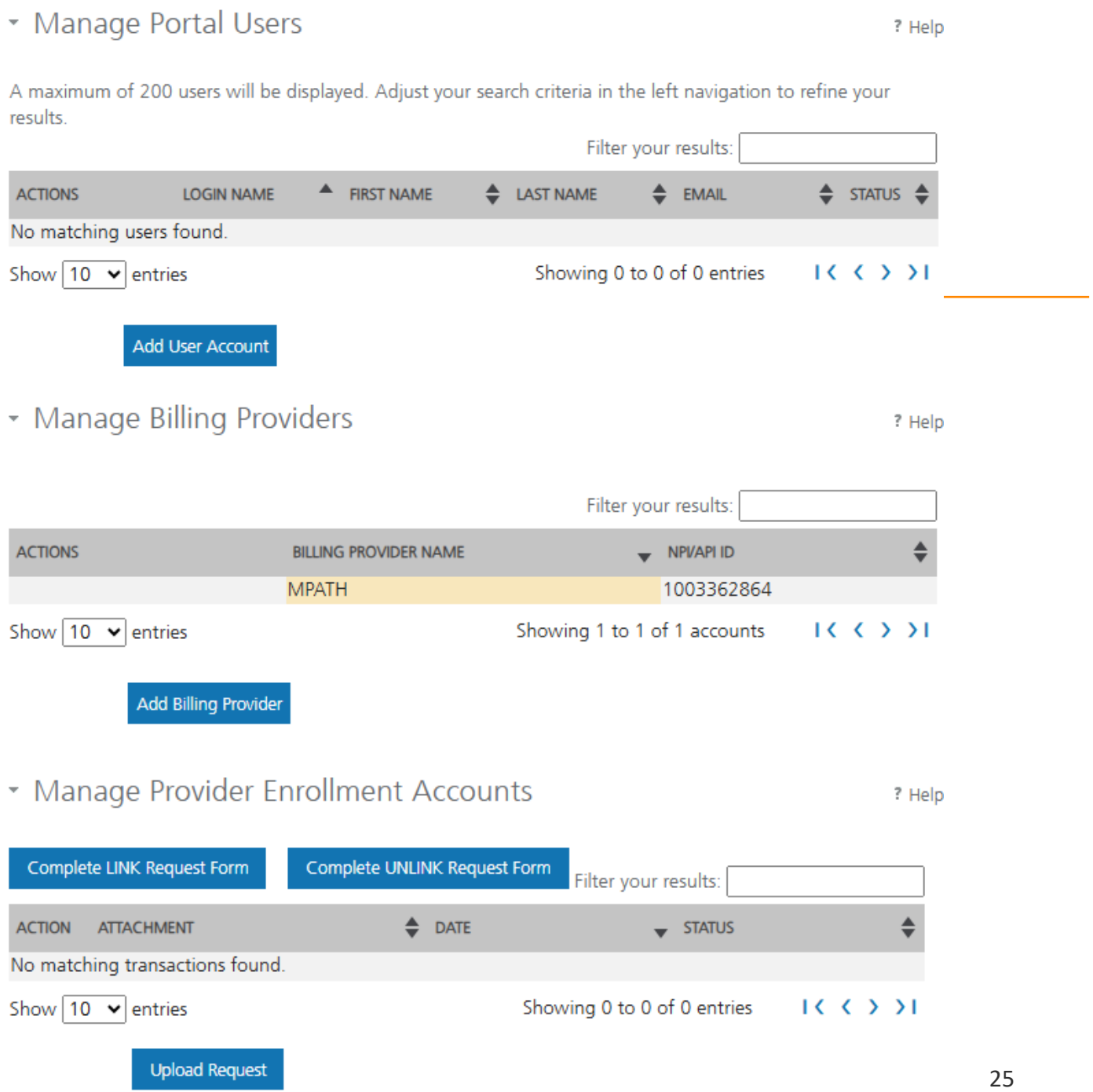
©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)
To reorder call 800.947.4746 or go online at ADAcatalog.org

MPATH Claims Setup

Account Administration

All 3 Account Administration functions are located on one screen.

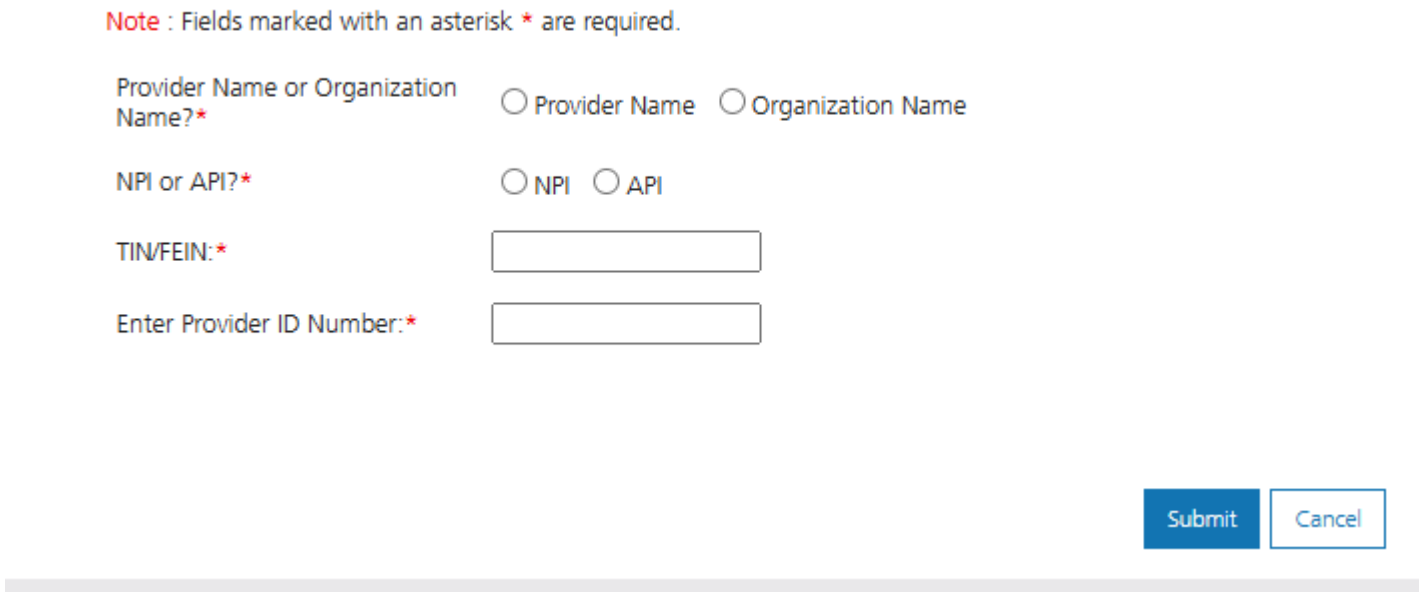
- Manage Portal Users
- Manage Billing Providers
- Manage Provider Enrollment Accounts



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.*

Manage Affiliations

Manage Affiliations

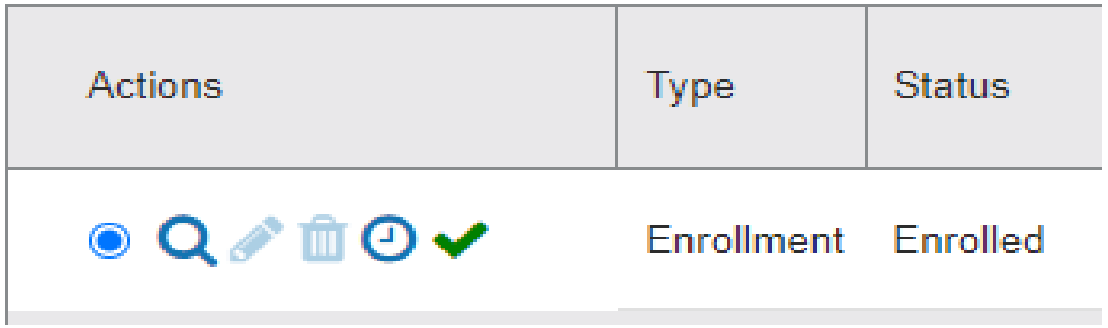
This action is **needed** if you are a facility that employs Rendering Providers and/or you are billing on the Provider Services Portal.

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

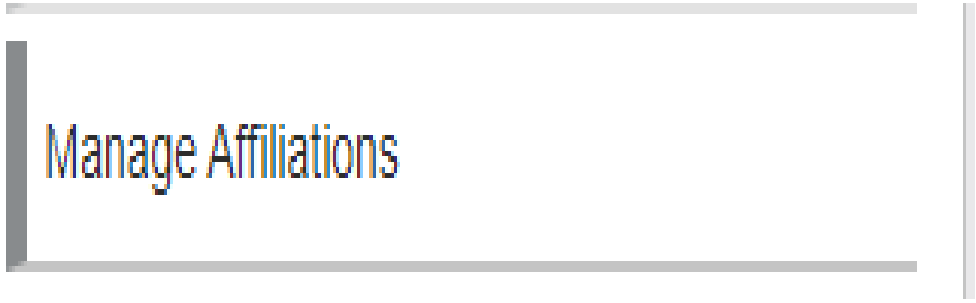
Add an Affiliation

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.



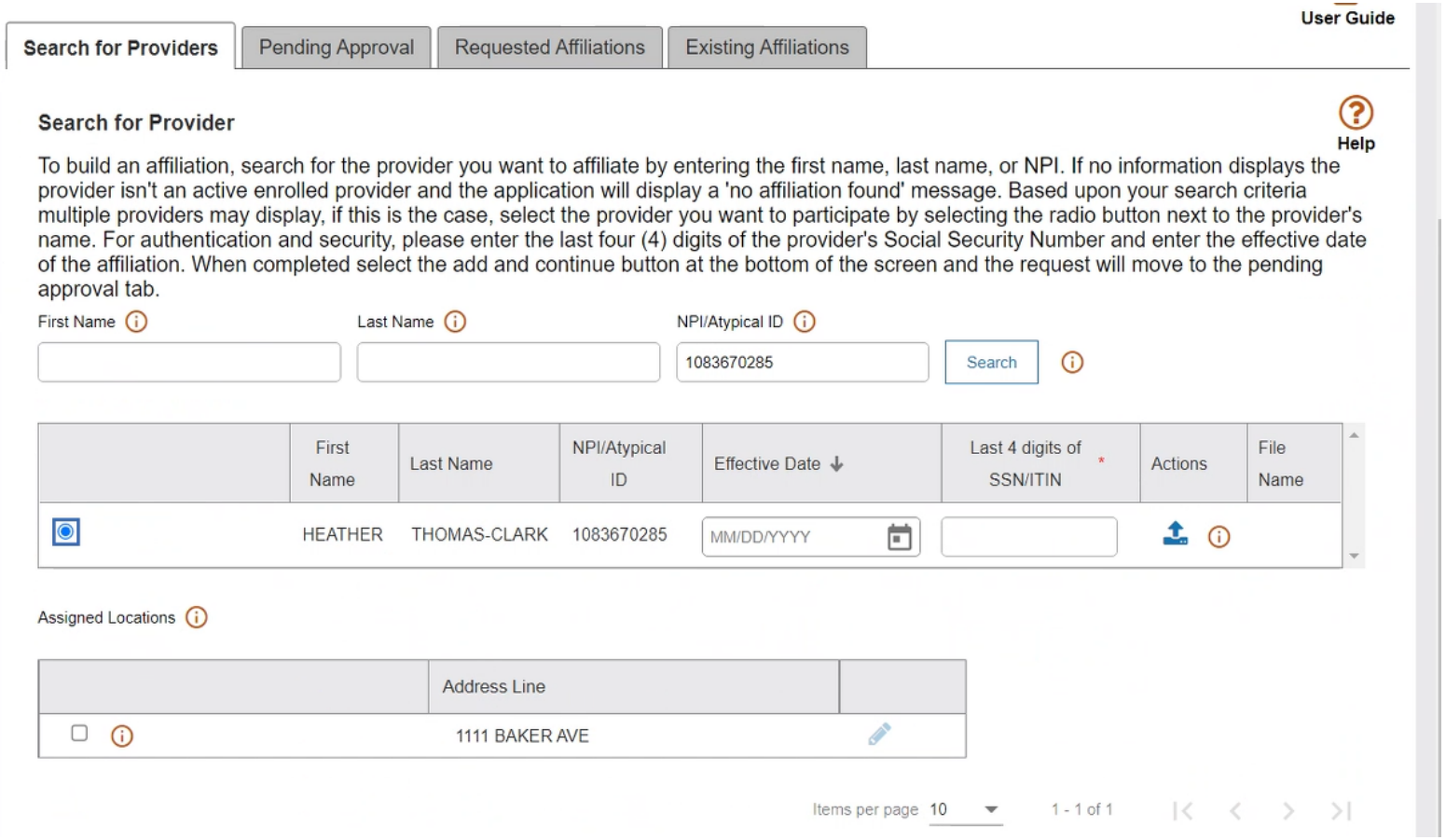
Add an Affiliation Cont.

Search for Providers tab.

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

Click Search.

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



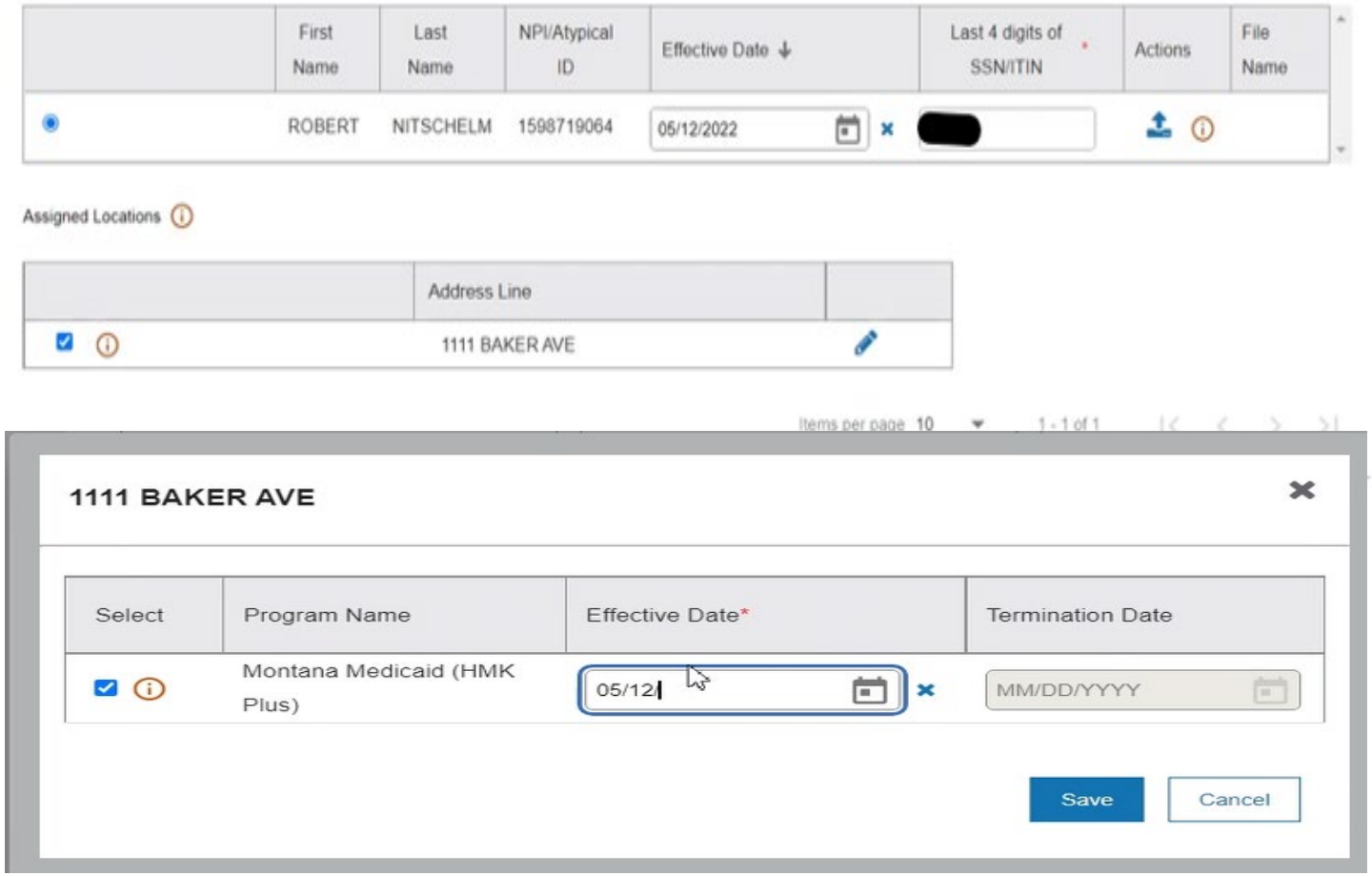
Add an Affiliation Cont.

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.**

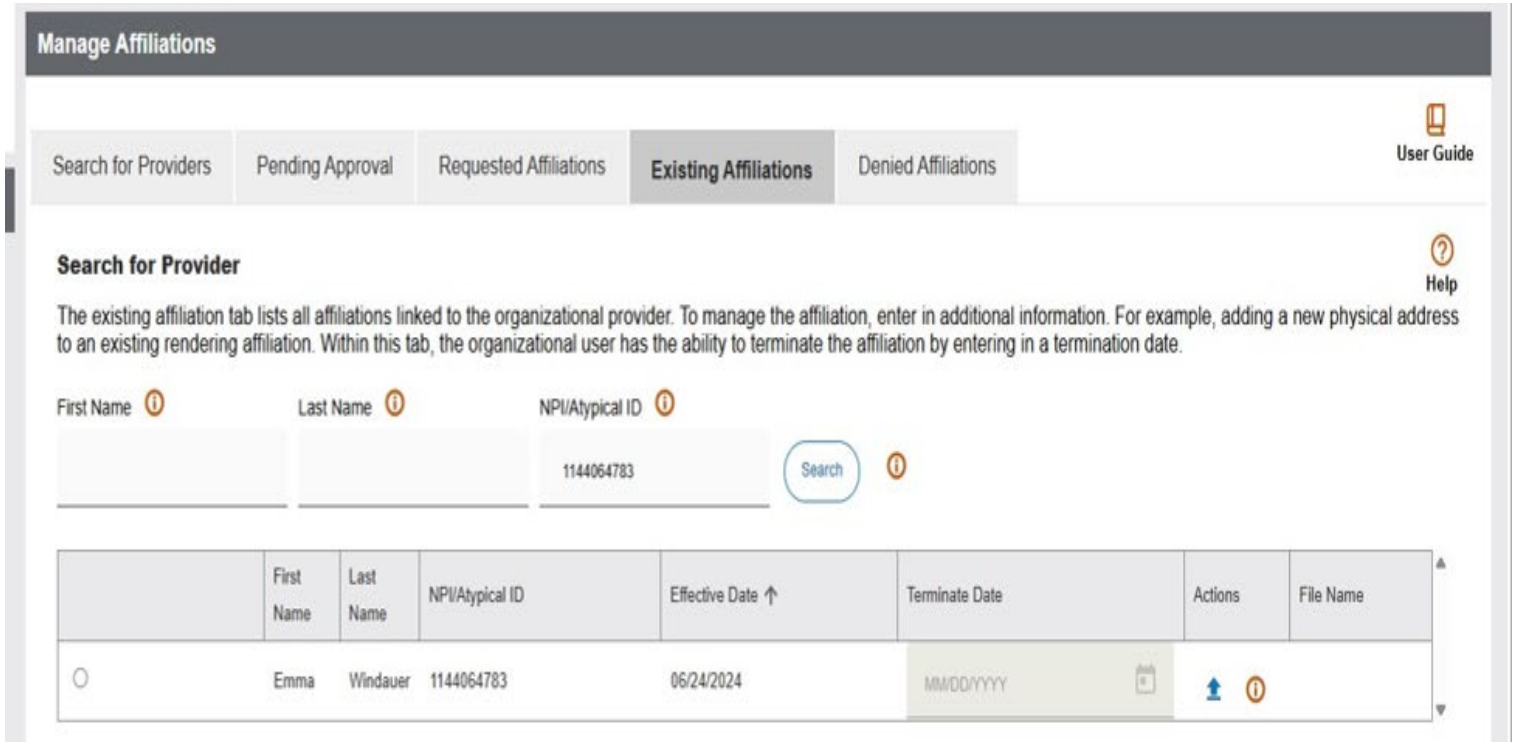


Manage Existing Affiliations

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.



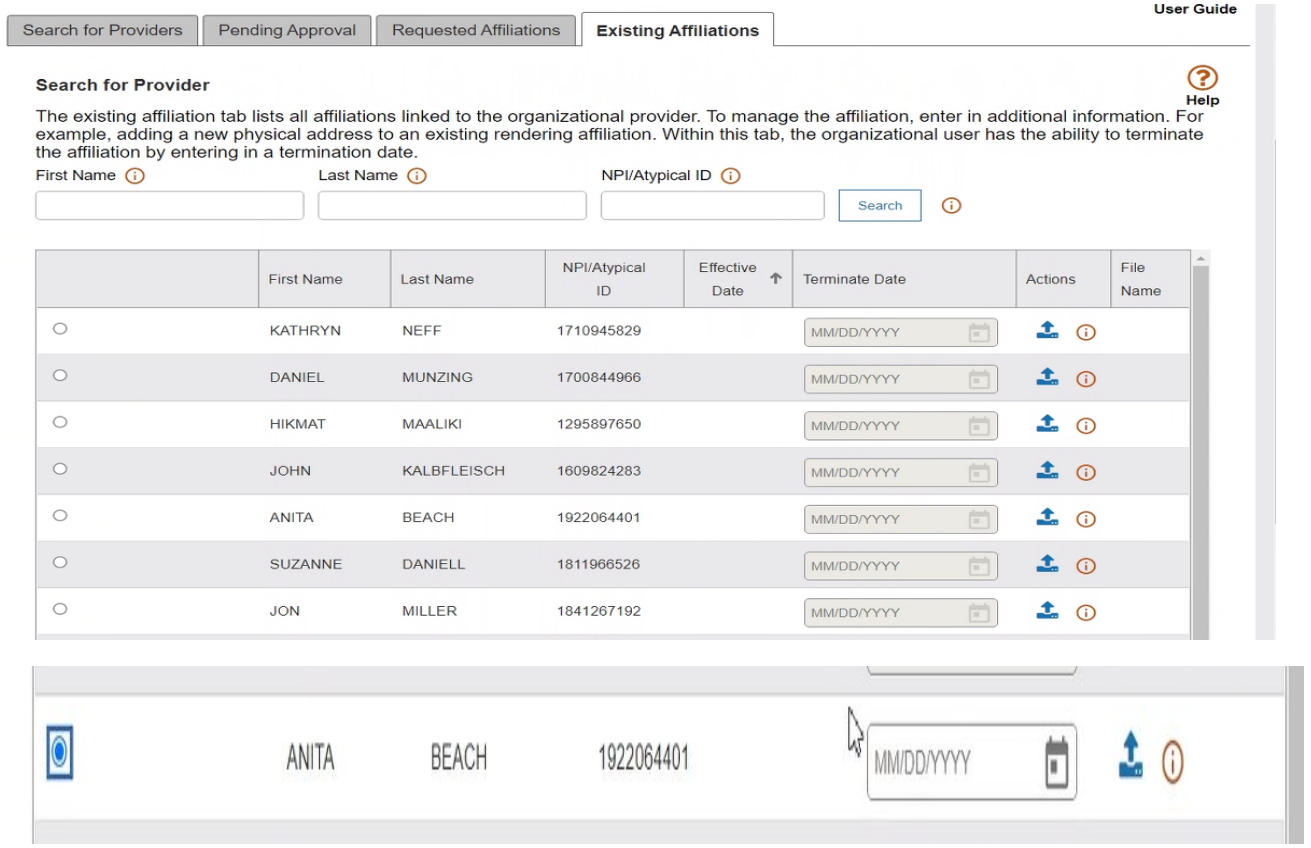
Ending Affiliations

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.



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.

Questions?

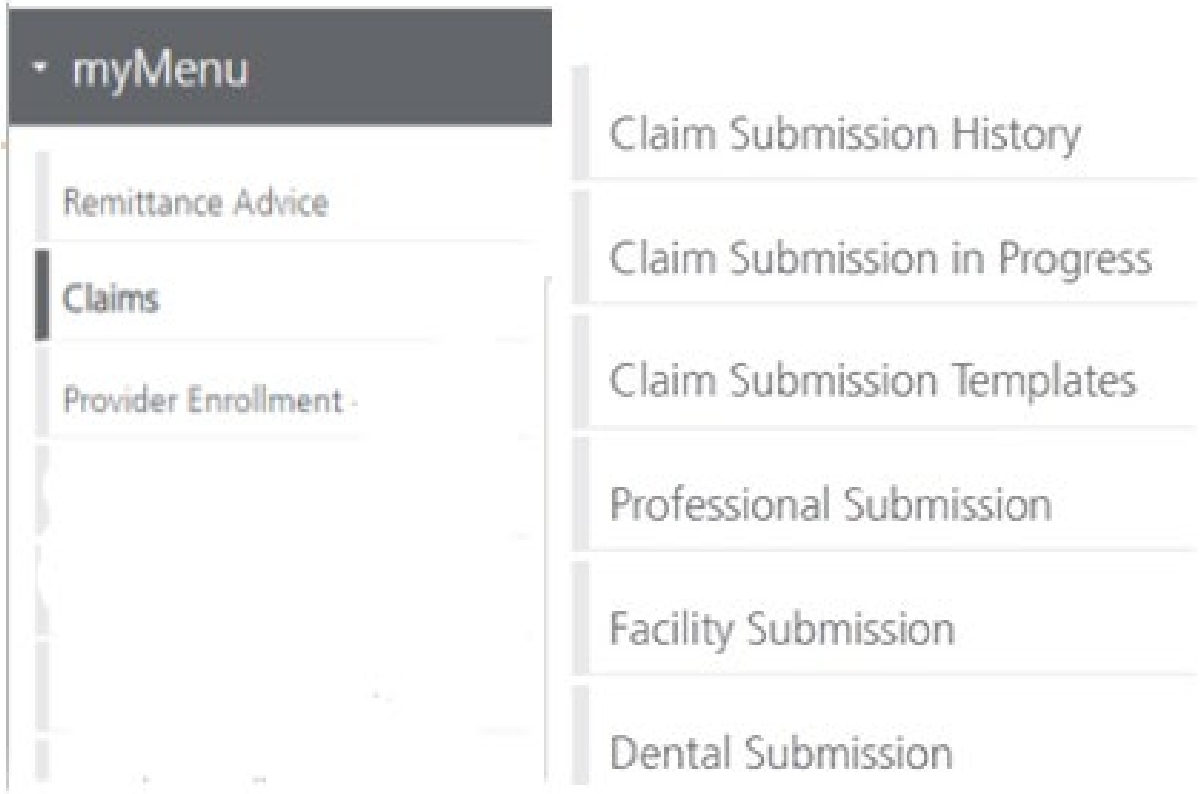
Provider Services Portal Claims Submission

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.

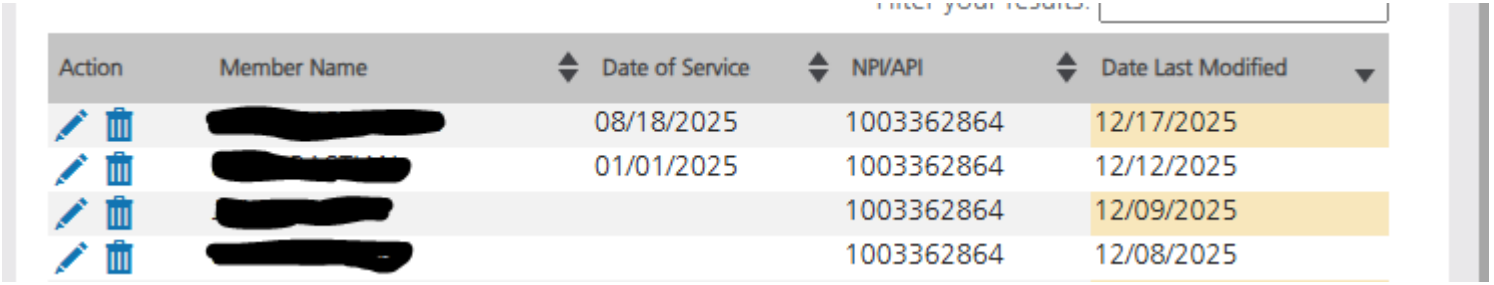
Claims Submission in Progress

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 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.

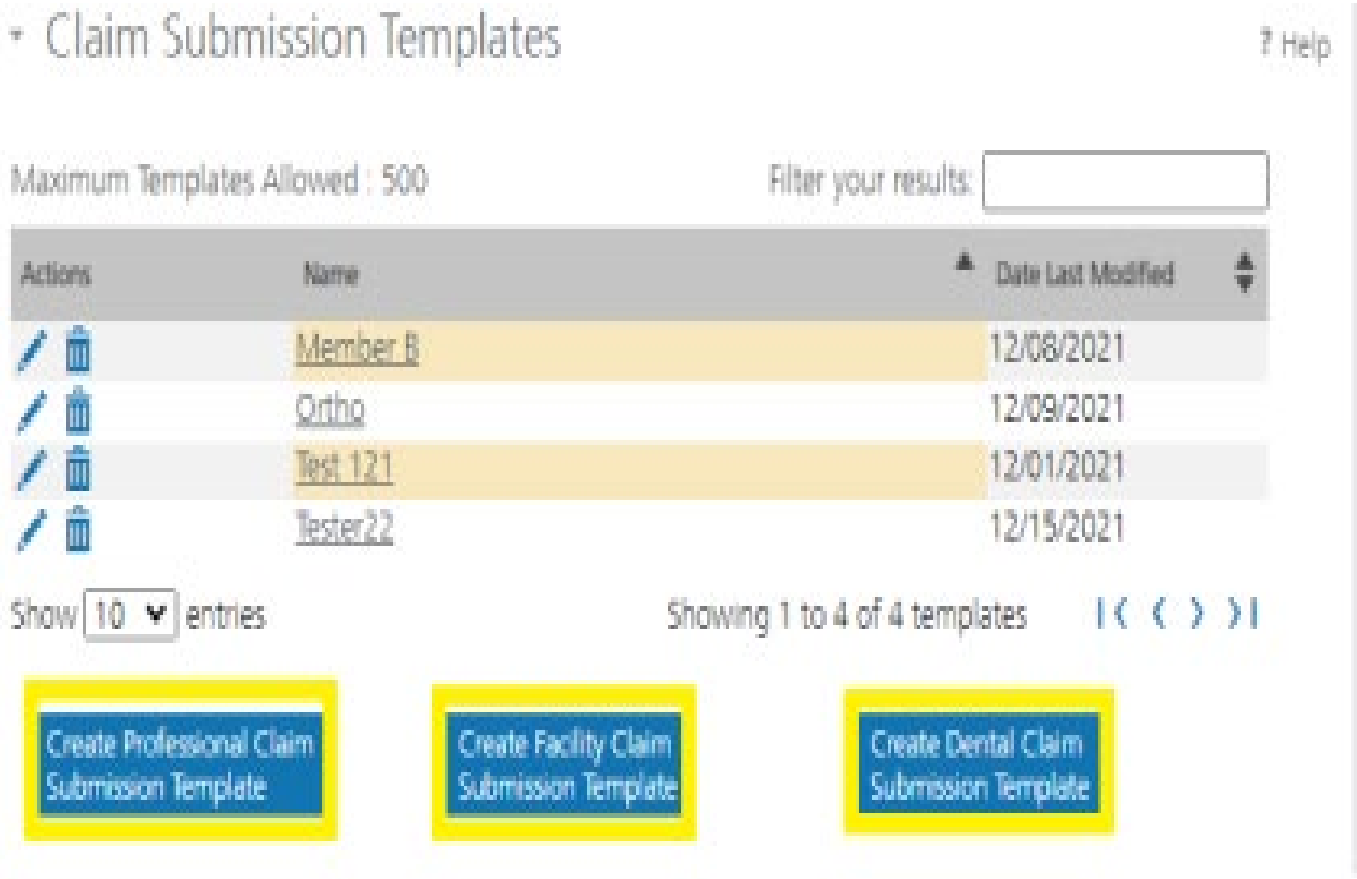
When it is time to submit the claim; select the billing provider NPI & Rendering Provider NPI (if applicable). Enter any additional required information on the Claim Information screen. Submit your claim.

Creating a Template

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

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

*Section 6, of the Provider Portal User Guide.



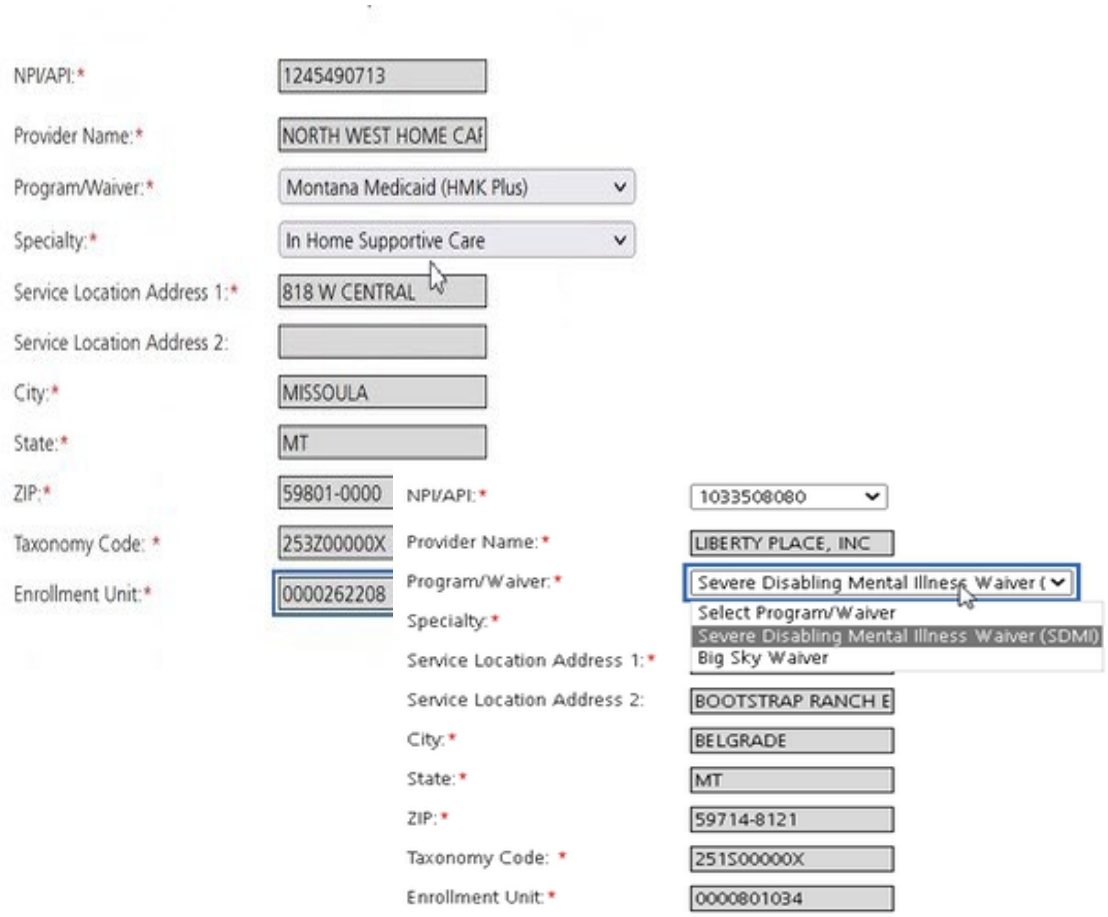
Creating a template cont.

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**.



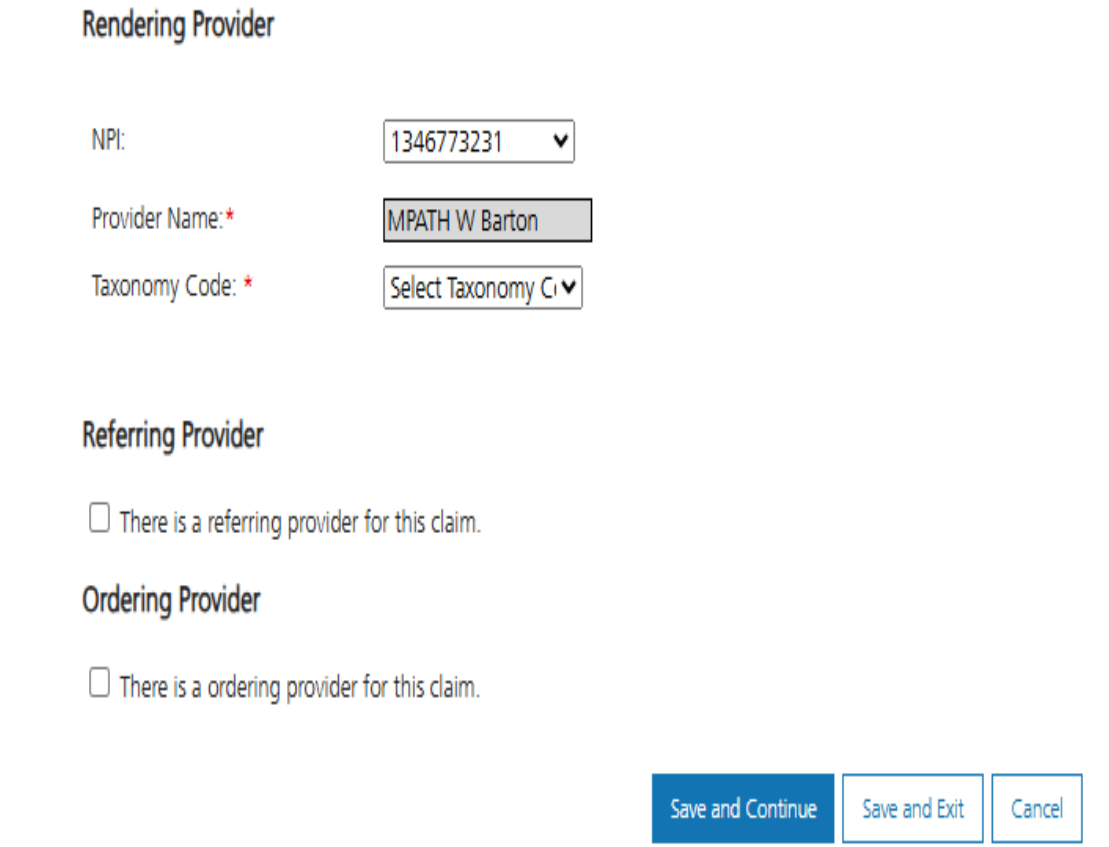
Creating a template cont.

Select the Rendering Provider file.

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

Select NPI.
Select Specialty.

Click **Save and Continue**.

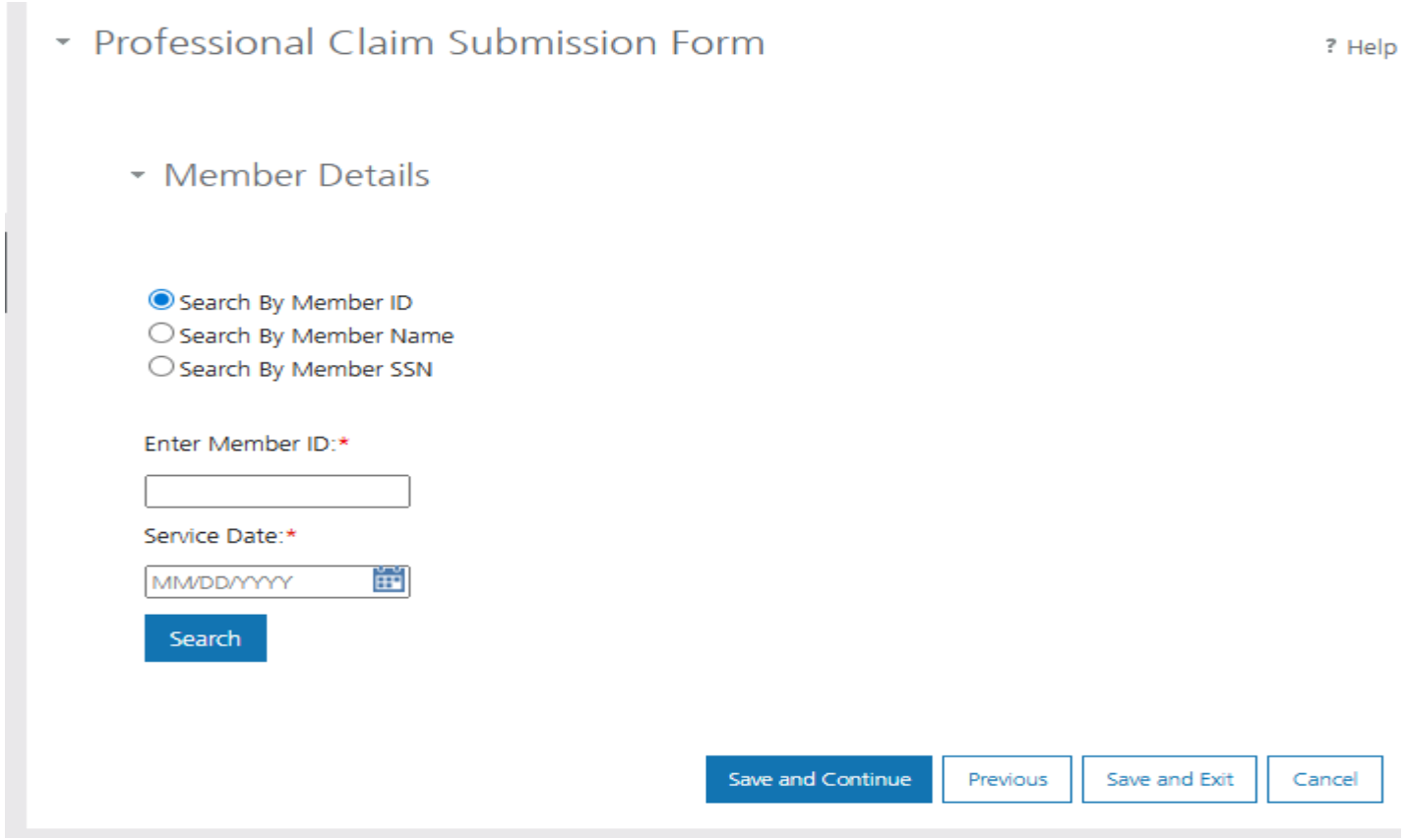


Creating a Template Cont.

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

Click **Search**.

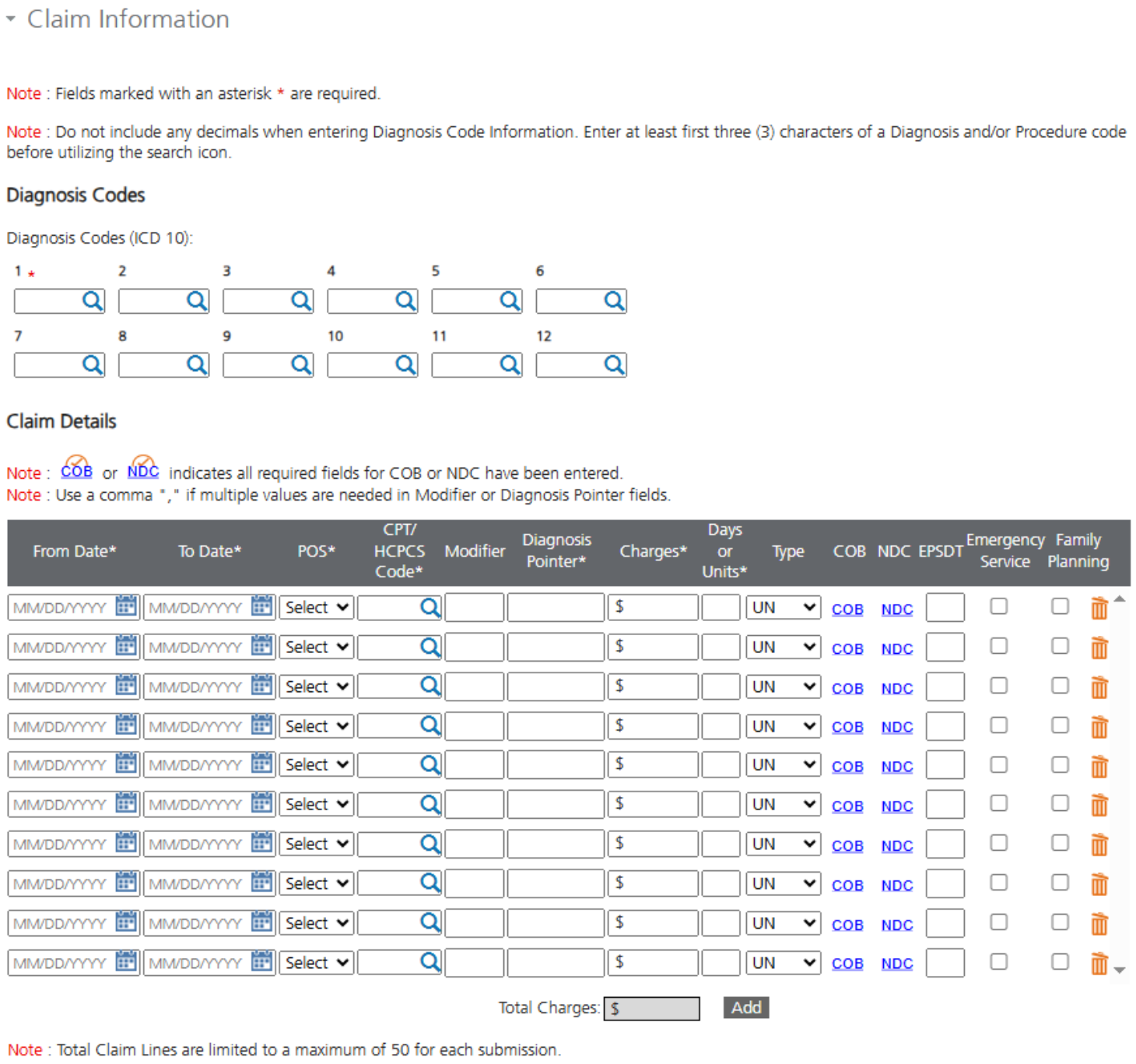
When the member information populates, verify and click **Save and Continue**.



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.

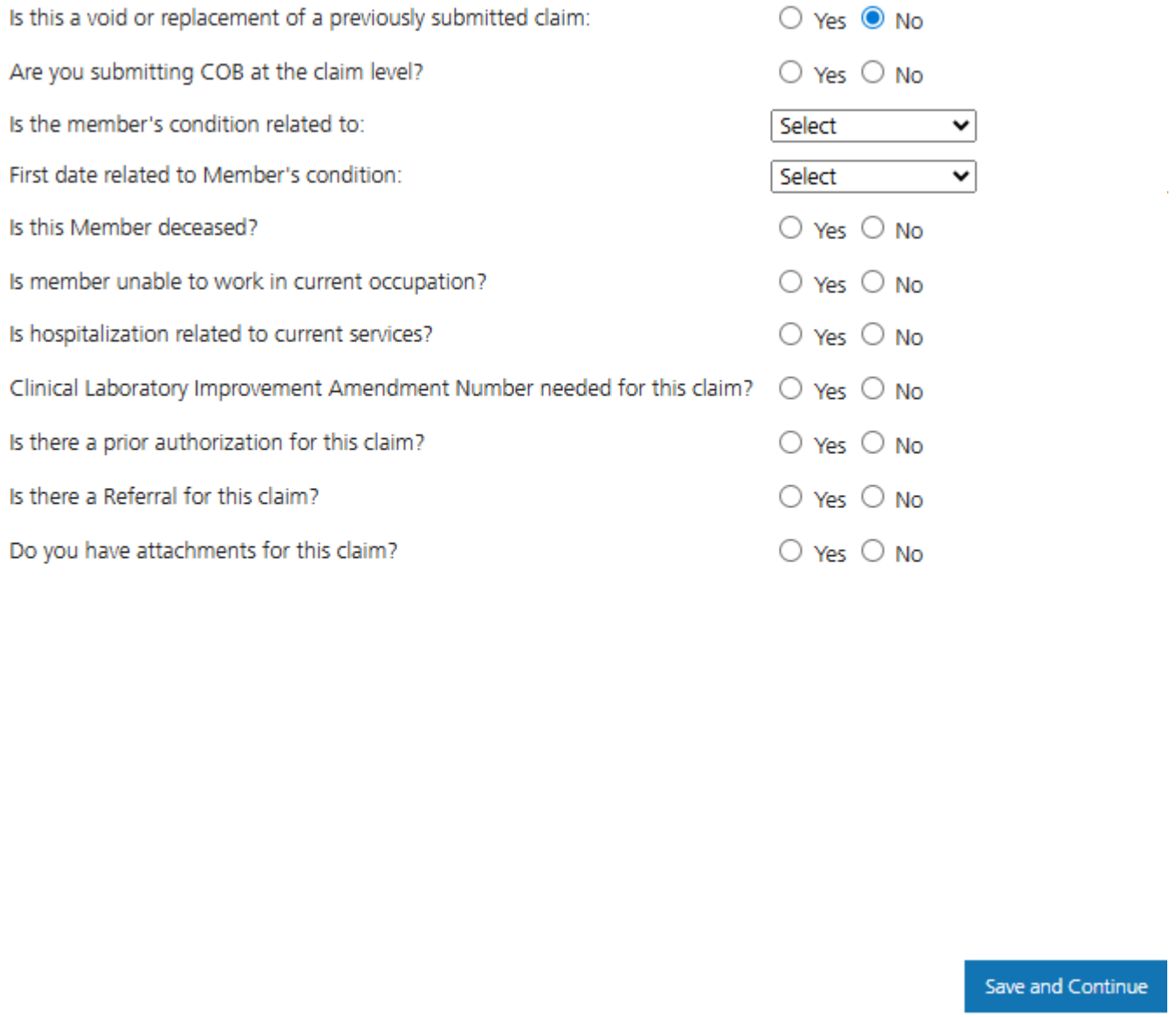


Creating a Template Cont.

Answer all the questions at the bottom of the screen.

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

Click **Save and Continue**.



Creating a Template Cont.

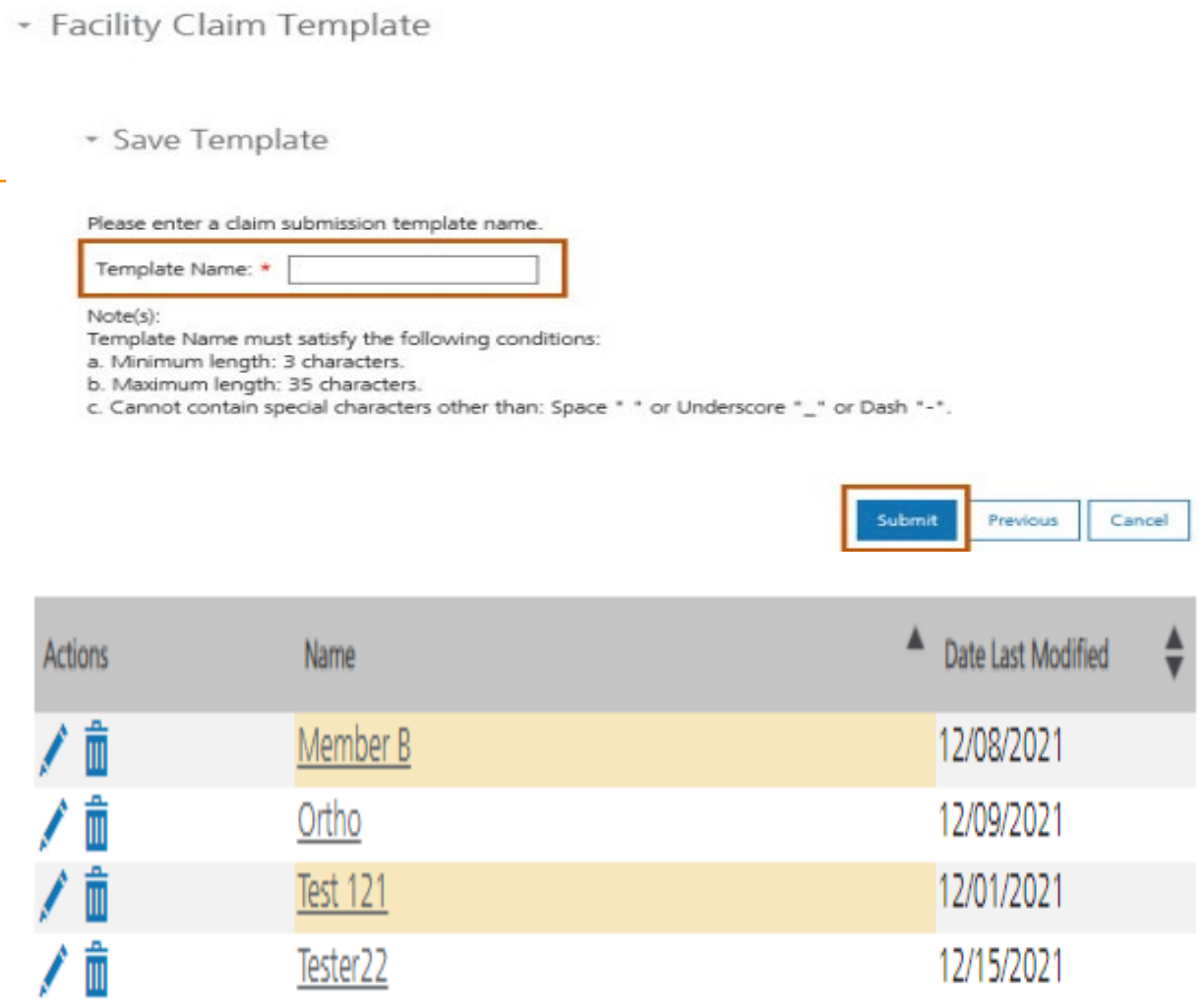
The last step is to name the template. Then click **Save/submit**.

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.



Questions?

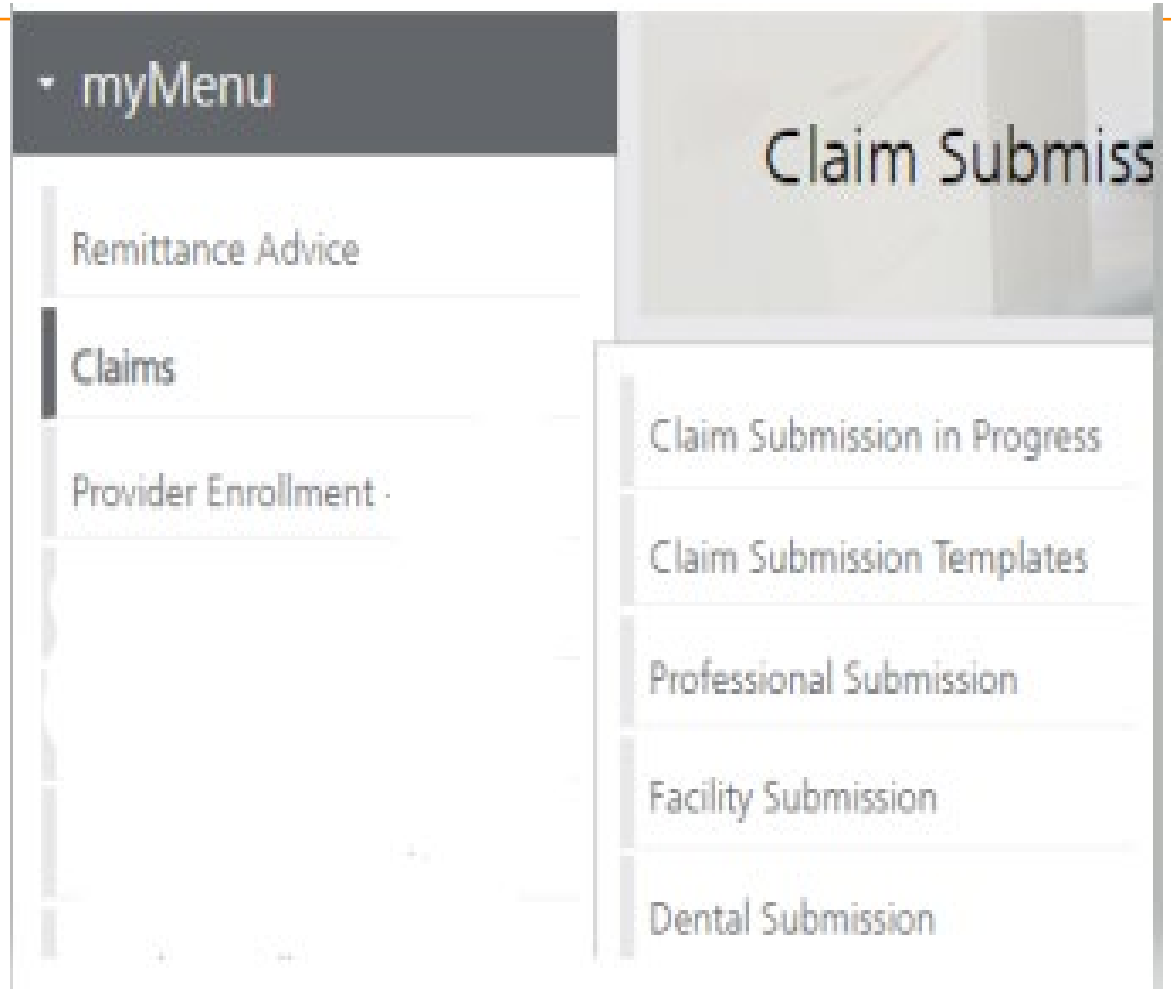
Claim Submission

Submitting a Claim

To submit a claim using a template, place your curser 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.



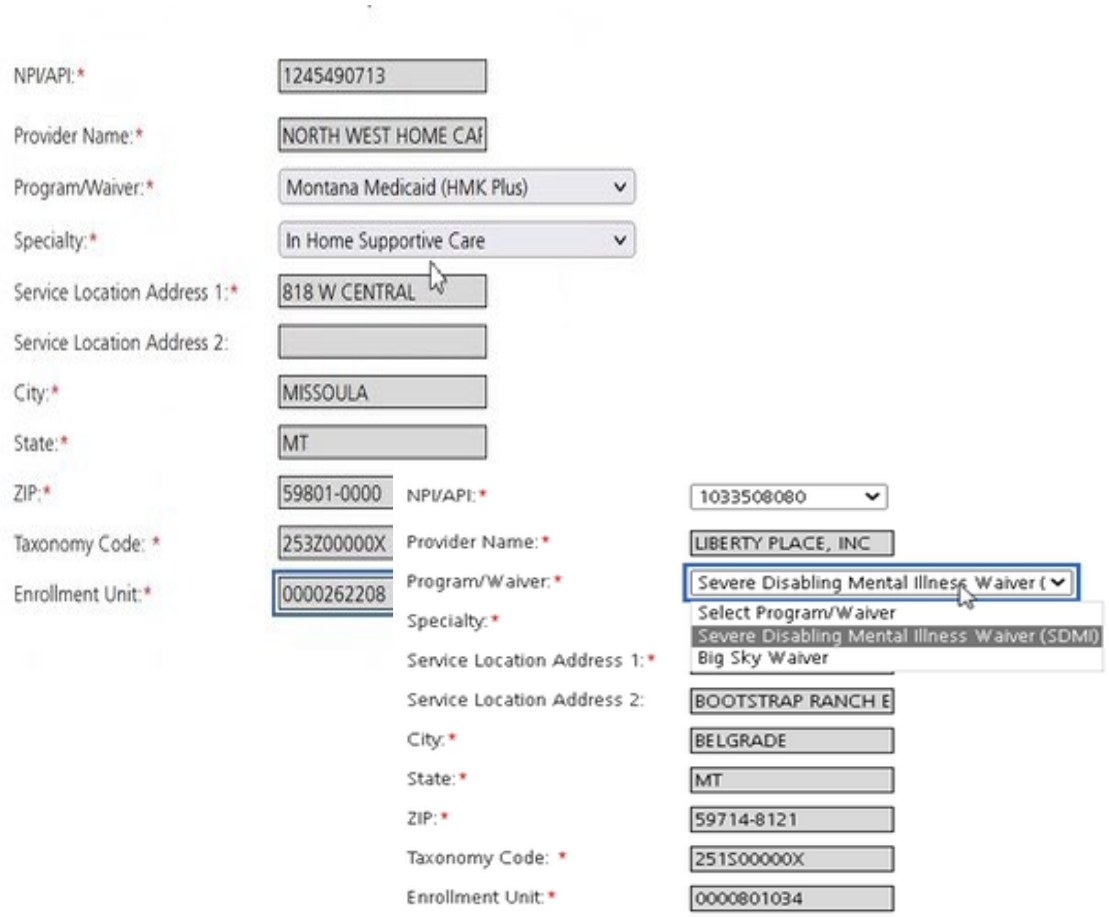
Billing Provider

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**.



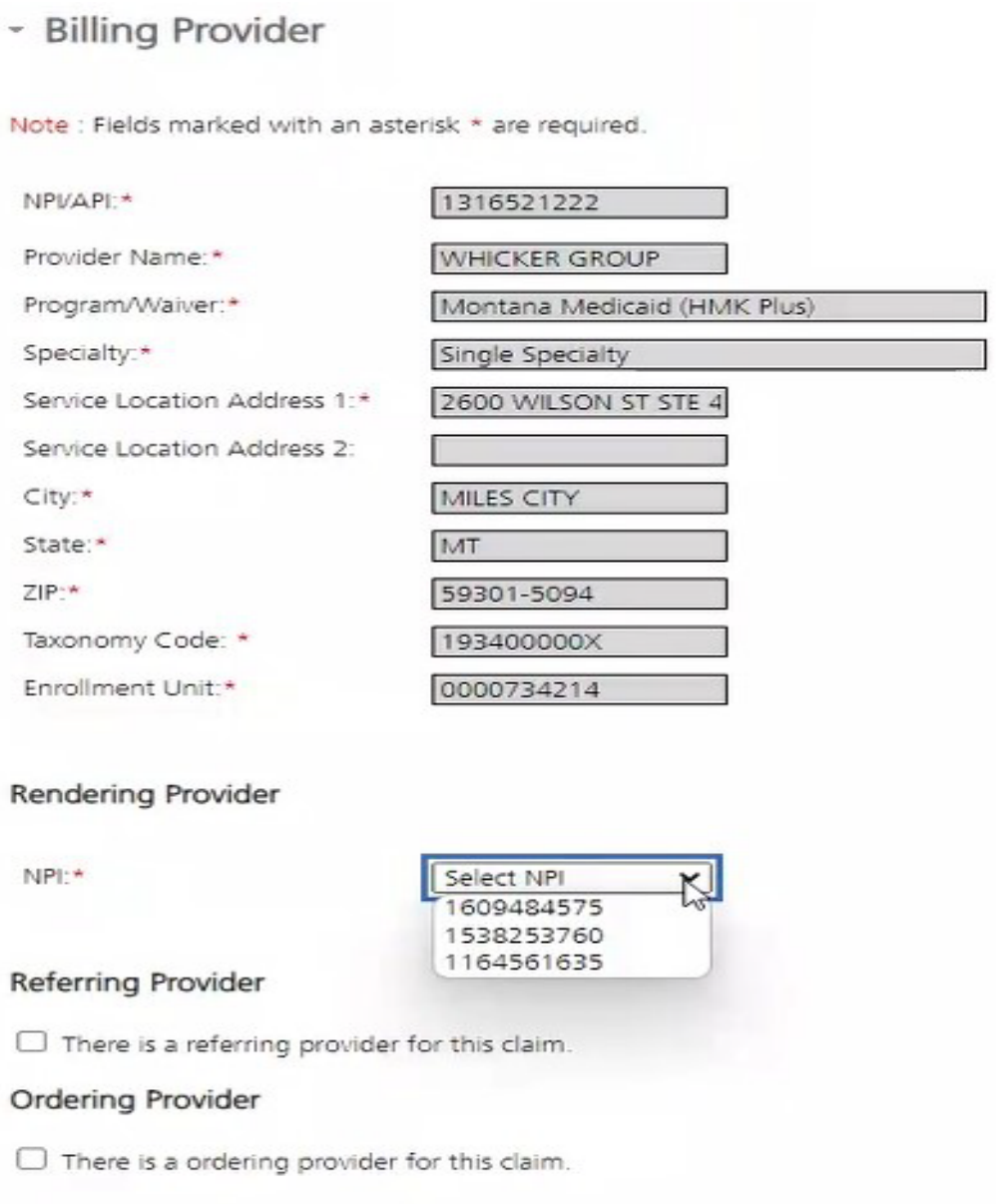
Billing Provider Cont.

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**.



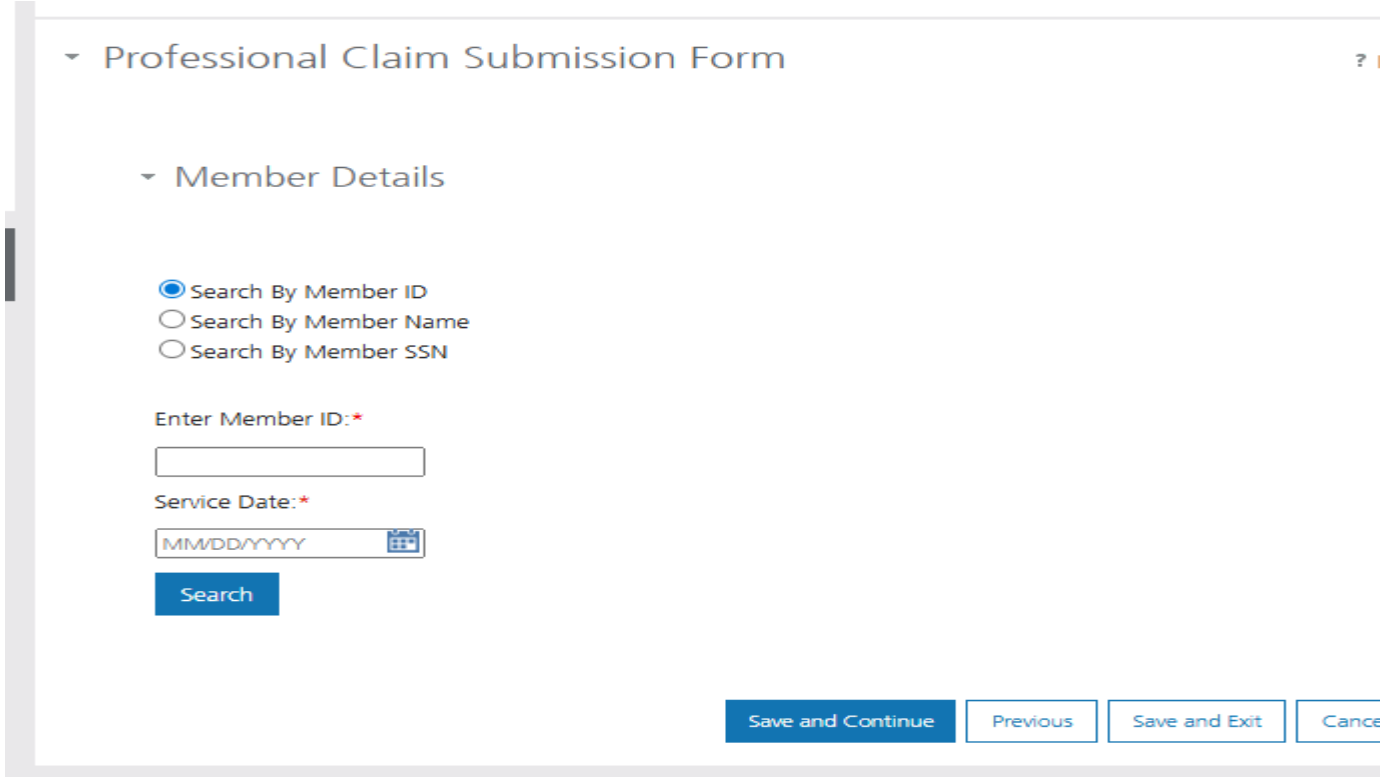
Member Details

Enter the member's MT Medicaid ID number.

Click **Search**.

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

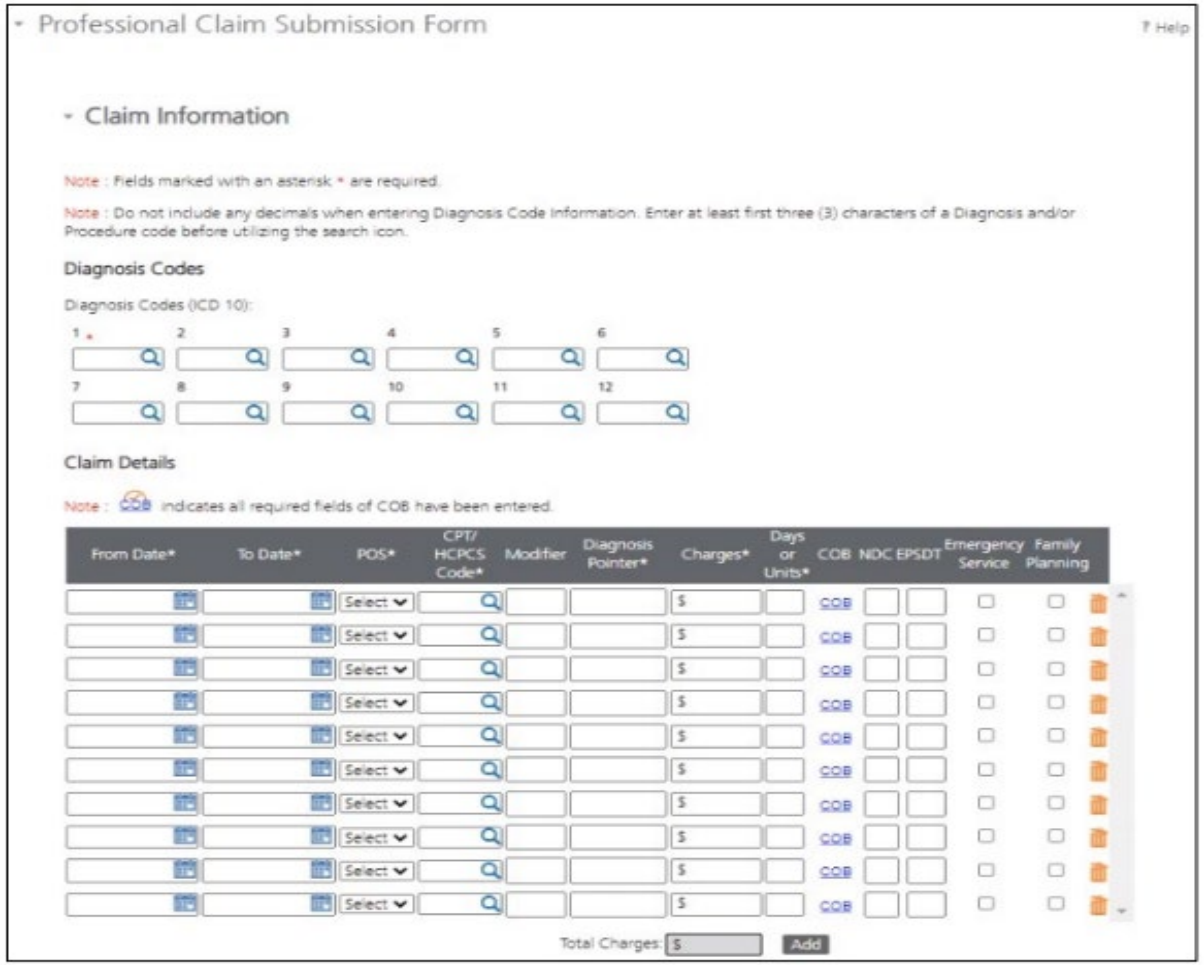
Click **Save and Continue**.



Claim Information

Complete all required fields and questions.

Required information is denoted with a red asterisk *

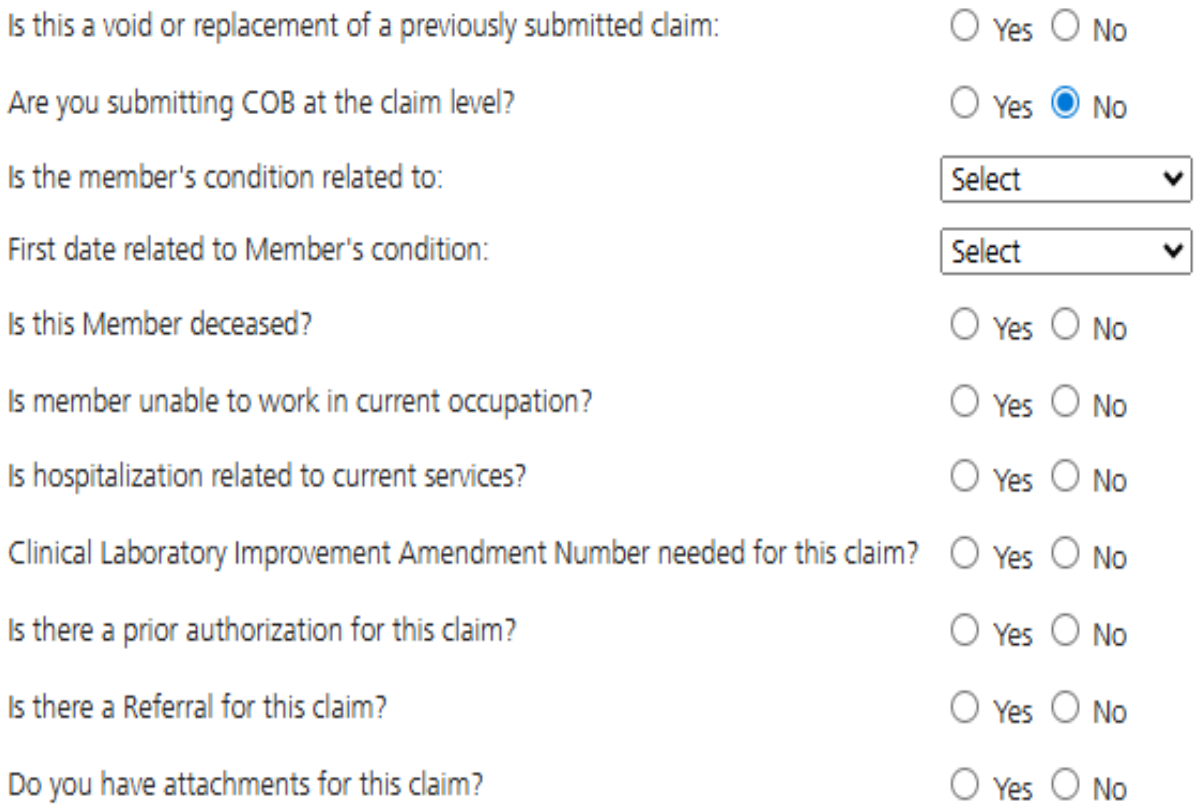


Claim Information Questions

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.

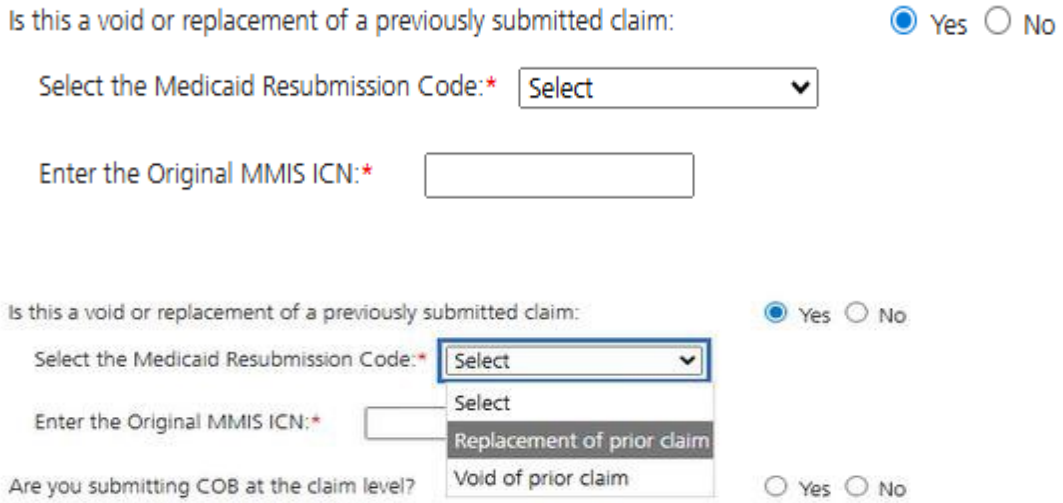


Claim Adjustment Question

Select Yes to complete a claim adjustment.

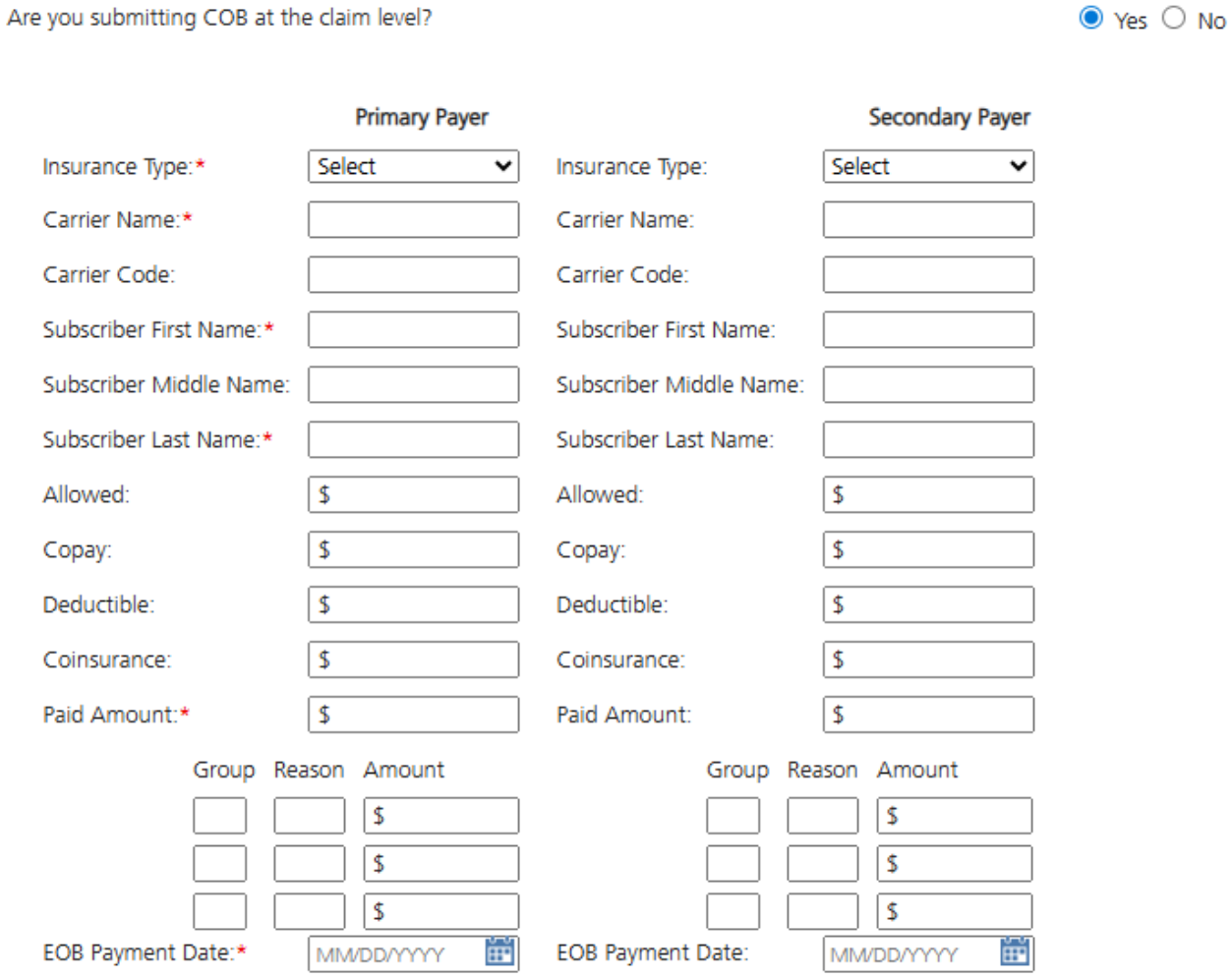
Select Replacement or Void claim.

Enter Original ICN.

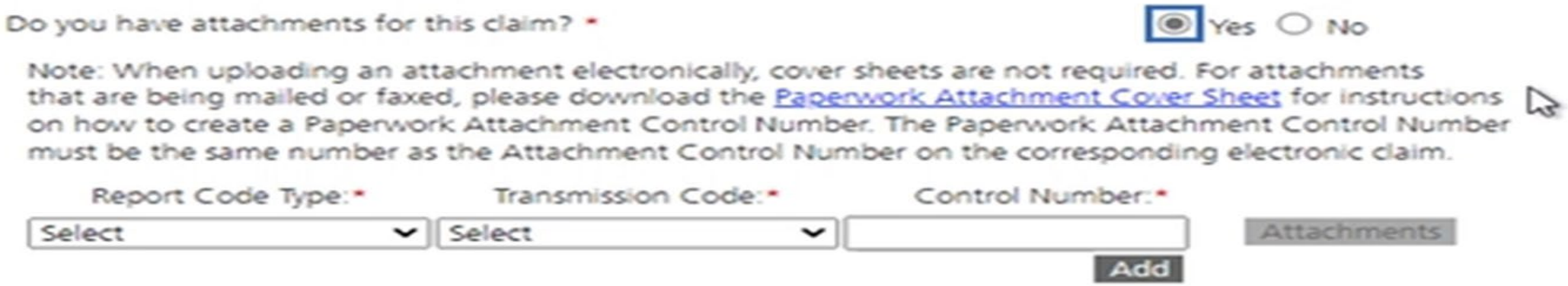


Primary Insurance EOB

- 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.



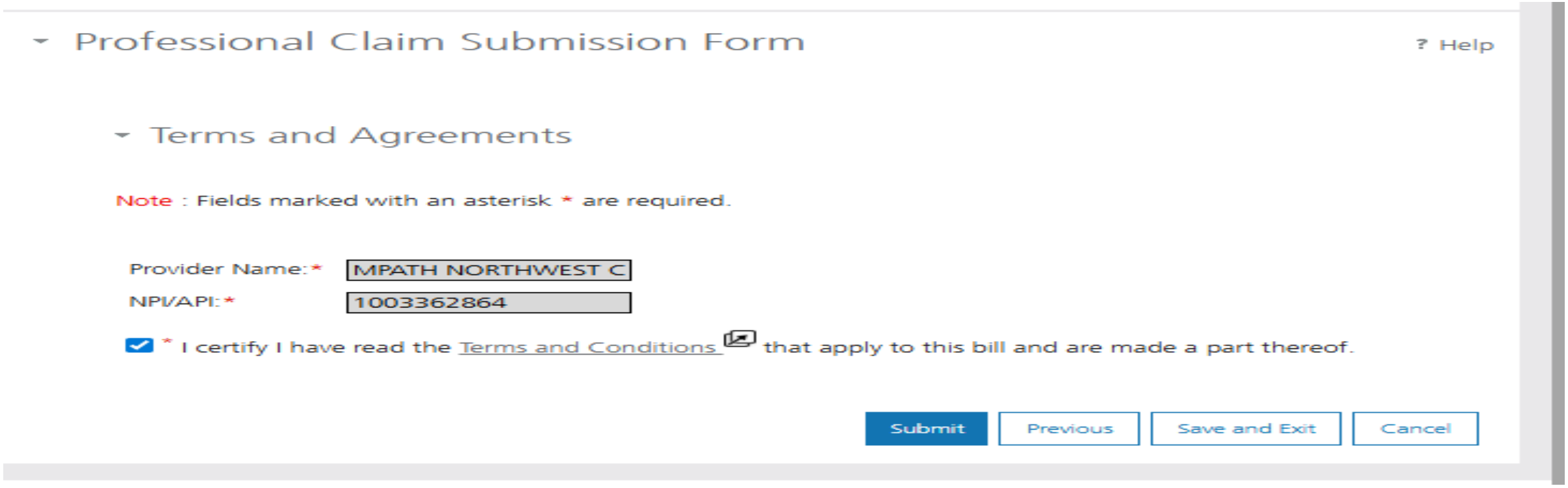
Electronic Claim Attachments



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.

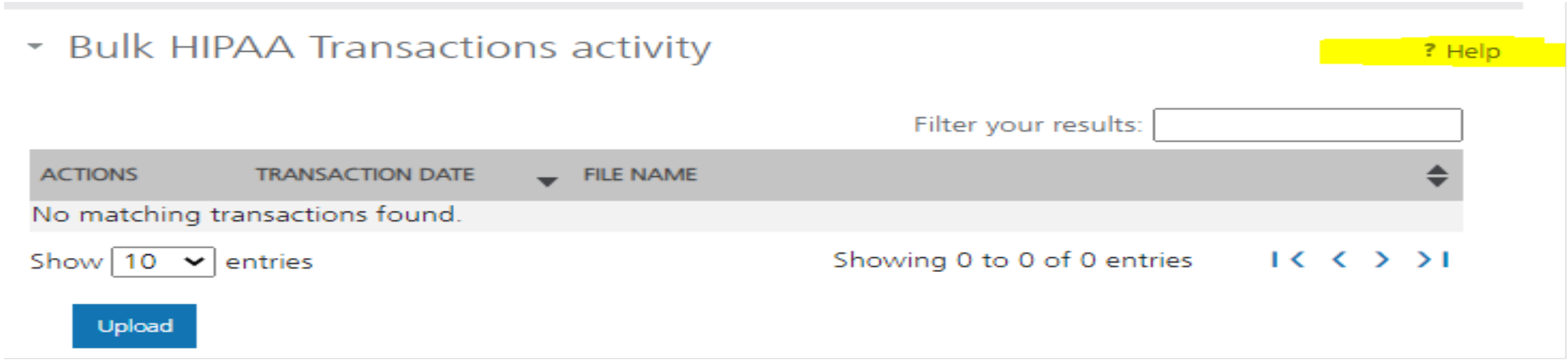
Final Submission

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

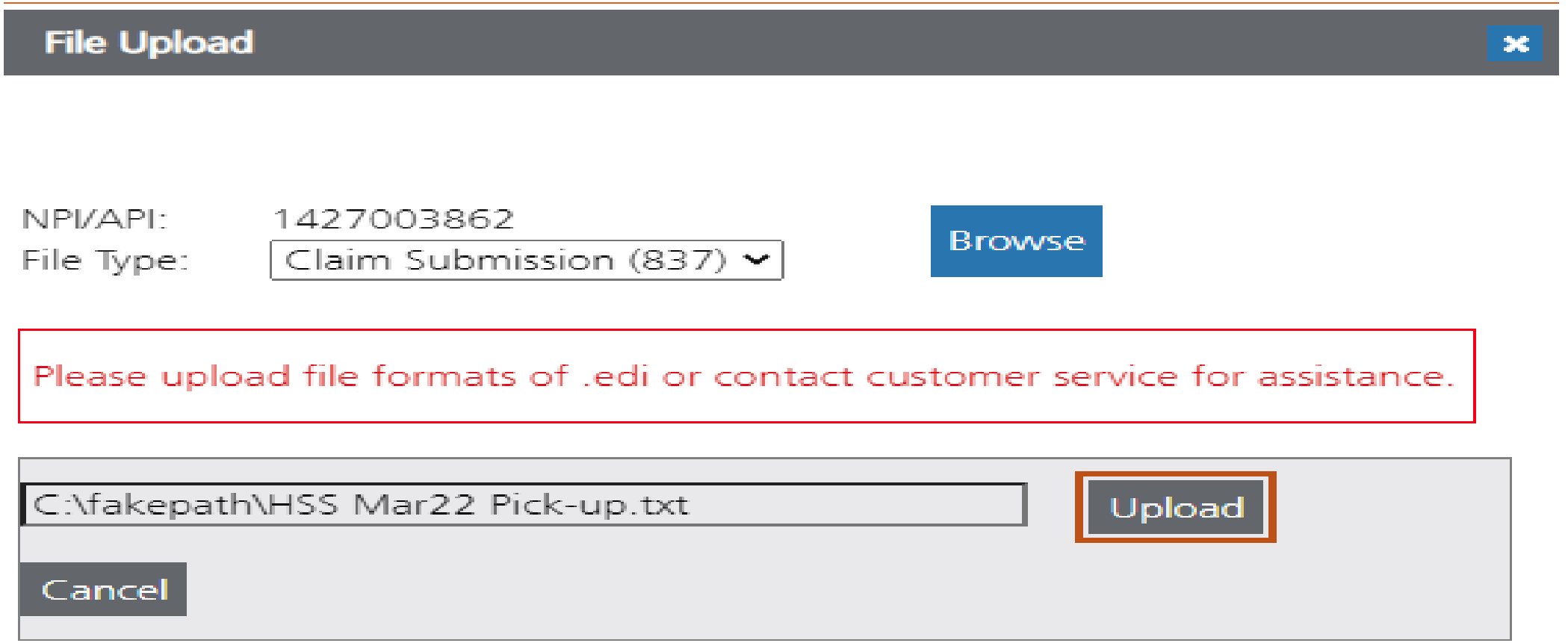


Bulk HIPAA Transactions

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



Bulk HIPAA Transactions Cont.



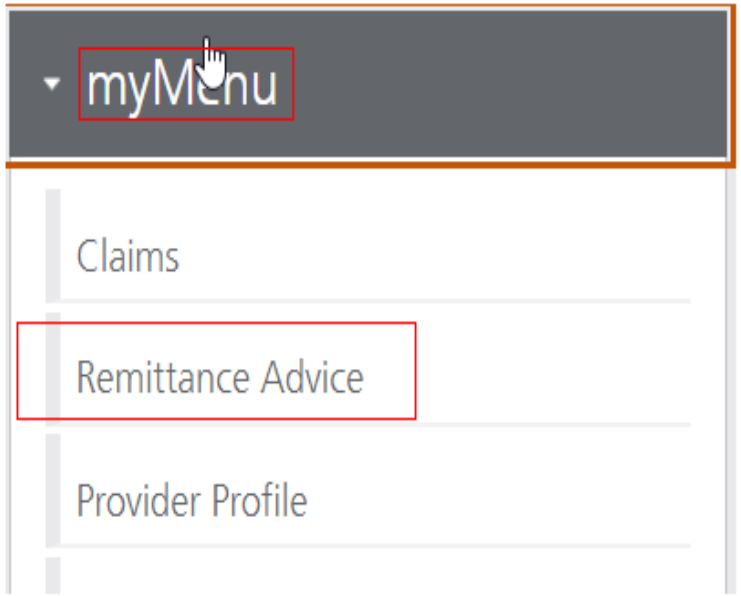
Questions?

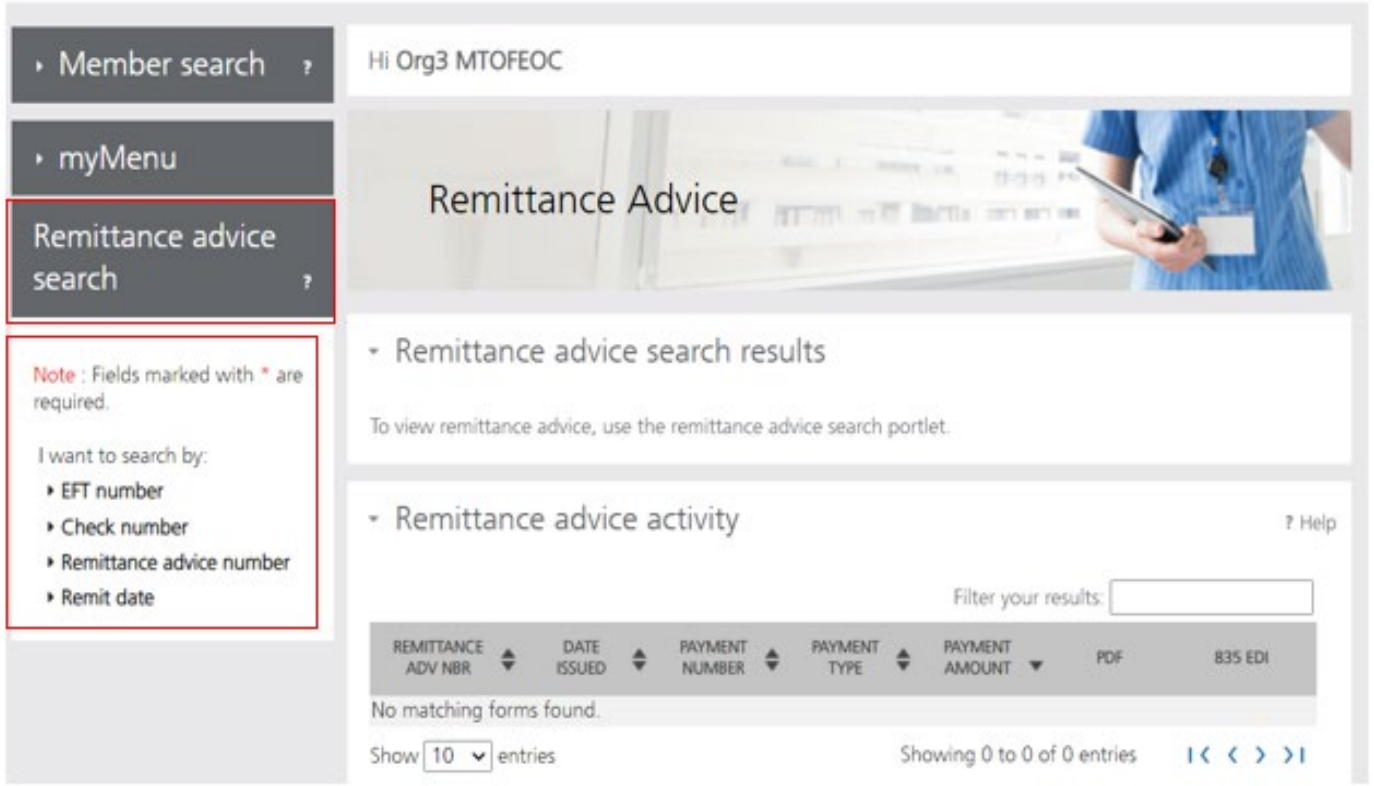
MPATH Portal Additional Features

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





Remits Search

Remits Results

Filter your results:

REMITTANCE ADV NBR	DATE ISSUED	PAYMENT NUMBER	PAYMENT TYPE	PAYMENT AMOUNT	PDF	835 EDI
C	09/27/2021	0	Check	$1150550.83	View	Download
O	09/27/2021	0	Check	$246077.51	View	Download
O	09/27/2021		Check	$94875.42	View	Download
	09/20/2021	01	Check	$14843.00	View	Download
0	09/27/2021	0	Check	$7195.51	View	Download
0	09/06/2021	0	Check	$1572.51	View	Download
0	09/13/2021	01	Check	$520.36	View	Download

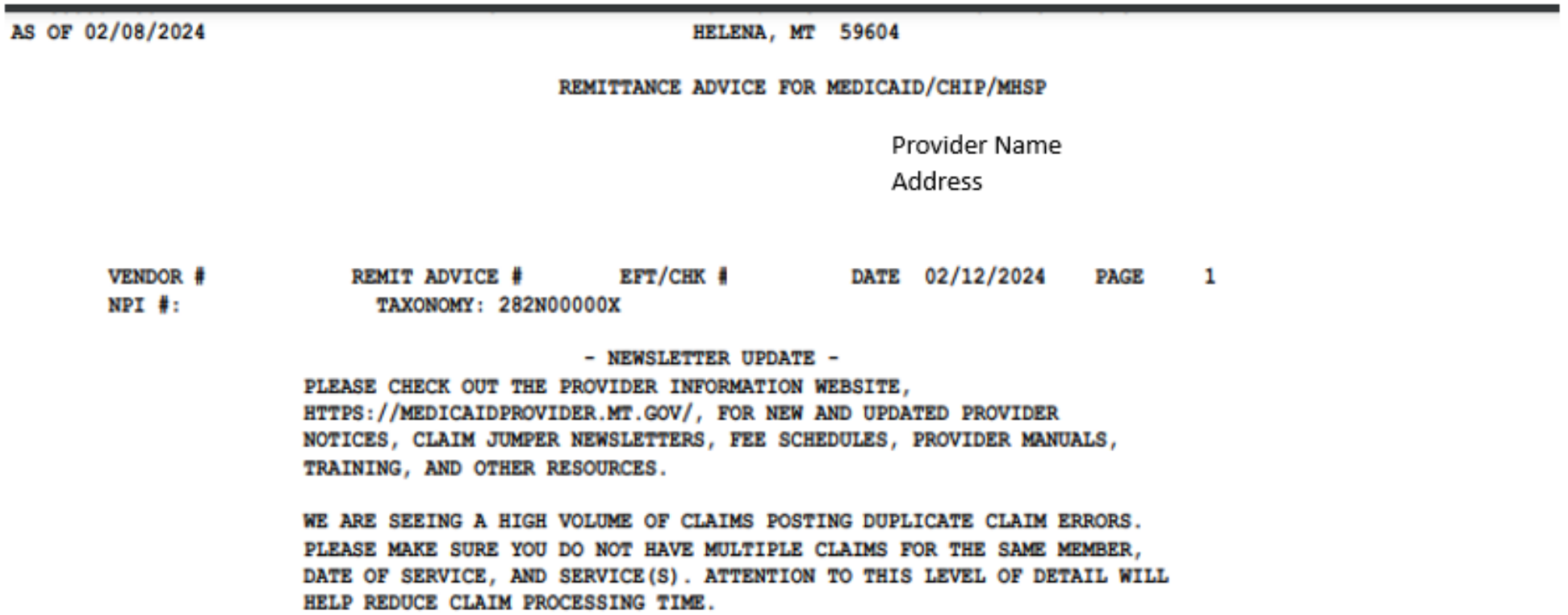
Show 10 entries

Showing 1 to 7 of 7 forms

VENDOR # 000 REMIT ADVICE # 8 EFT/CHK #0 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 22 PATIENT	07012021	07312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01								
	07012021	07312021	5.000	S5135	115.50	115.50		
	CLAIM TOTAL				883.20	883.20		
ICN 221 PATIENT	08012021	08312021	1.000	T2032	767.70	767.70		
TEAM NUMBER 01								
	08012021	08312021	5.000	S5135	115.50	115.50		
	CLAIM TOTAL				883.20	883.20		
ICN 2212 PATIENT	07012021	07312021	8.000	T2021	782.48	782.48		
TEAM NUMBER 01								

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/, 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
PAID CLAIMS - INPATIENT CLAIM									
		01042024	01252024	6.000	124	17359.50	0.00		
ICN	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 REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
CLAIMS PENDING:	INPATIENT CLAIM								
		10172023	10222023	1.000	120	2038.50	0.00		
ICN	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 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 #            REMIT ADVICE #        EFT/CHK #          DATE  02/12/2024     PAGE   631
        NPI #:                TAXONOMY: 282N00000X

                                                          UNIT   PROCEDURE
                                    SERVICE   DATES       OF      REVENUE          TOTAL                CO-
RECIP ID        NAME                  FROM    TO        SVC          NDC        CHARGES    ALLOWED    PAY  REASON & REMARK CODES

 CLAIMS PENDING:      MEDICARE OUTPATIENT CROSSOVER

                                 06192023 06192023     1.000     300           27.00        0.00
   ICN                     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:

                                 11102023 11102023     1.000     510          129.44        0.00          133
   ICN                     PATIENT NUMBER=

                                    *** MEDICARE PAYMENT*****                              101.47
                                    ***CLAIM TOTAL***************          129.44        0.00          133

                                 01092024 01092024     1.000     300           67.25        0.00
   ICN                     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

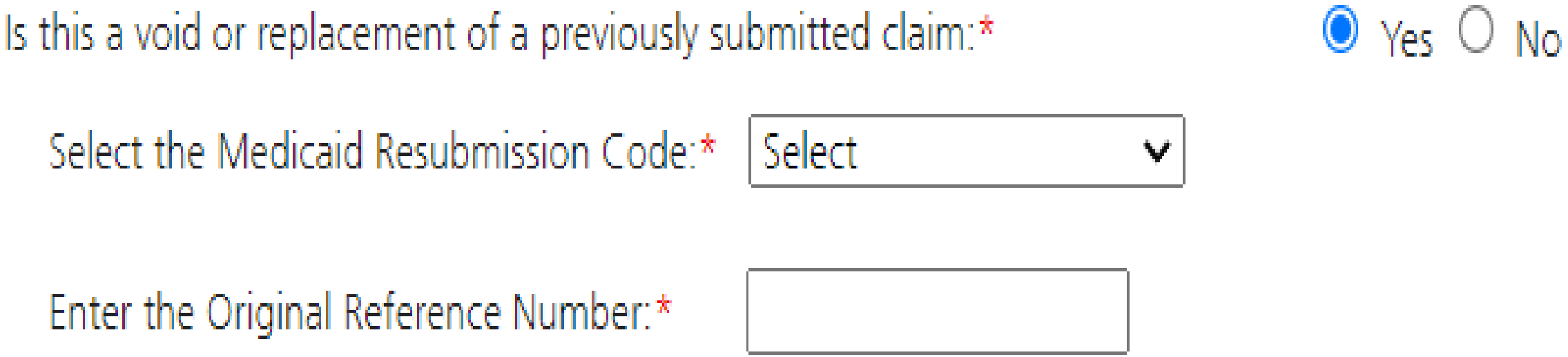
Answer YES, to the first question at the bottom of the claim entry screen. The next two fields are now visible.

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.

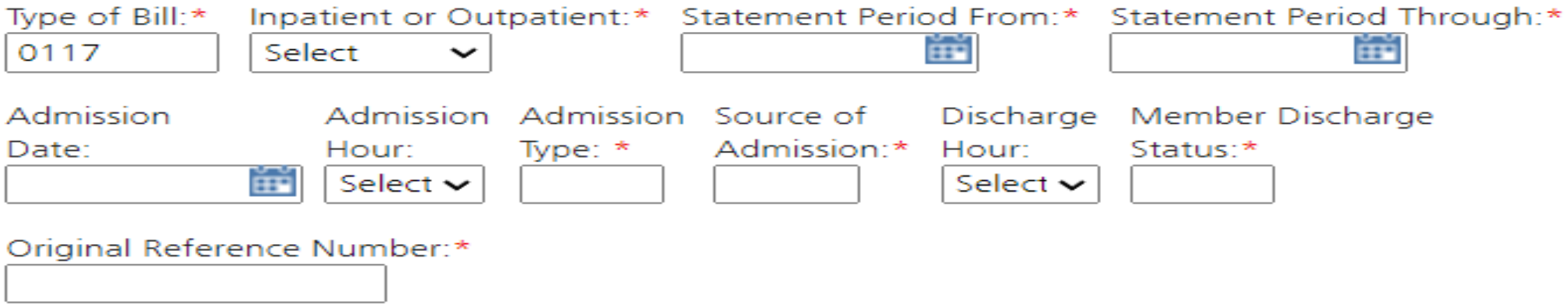


Claim Adjustments for Institutional Claims

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.



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!