

ND MMIS INSTITUTIONAL WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION



Health & Human Services

ND MMIS Web Portal Institutional Claim Form Submission Instructions



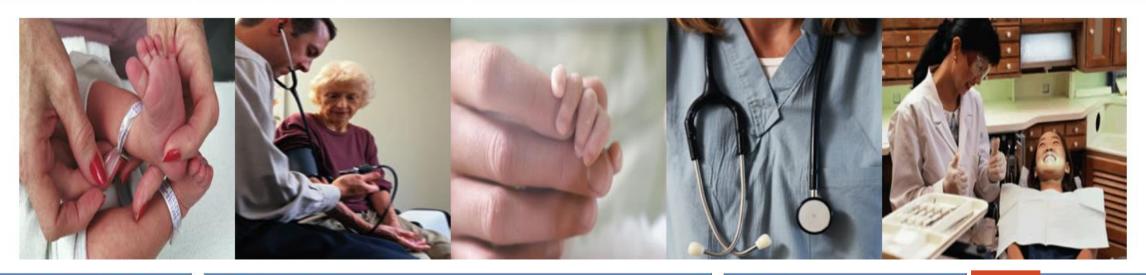
Go to https://mmis.nd.gov/portals/wps/portal/EnterpriseHome



Home

Program >

Member ▶ Provider ▶ Documentation ▶ Directories ▶



Welcome

Print | - -

Welcome to the North Dakota MMIS Web Portal.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the

Provider Registration

To obtain a user id and password, Providers and Trading Partners must have an approved enrollment with North Dakota and have received their Provider or Trading Partner ID.

Register

Quick Links

- FAQ
- Find a Healthcare Provider
- Benefits Overview
- Provider Enrollment
- Report Fraud & Abuse

Sign In

_ 0

Log into the system based upon your role:

Providers

Internal Users

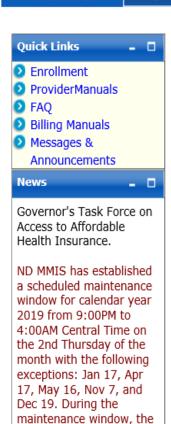




Home

Program >

Member ▶ Provider ▶ Documentation ▶ Directories ▶



system may not be

accessible.

Provider

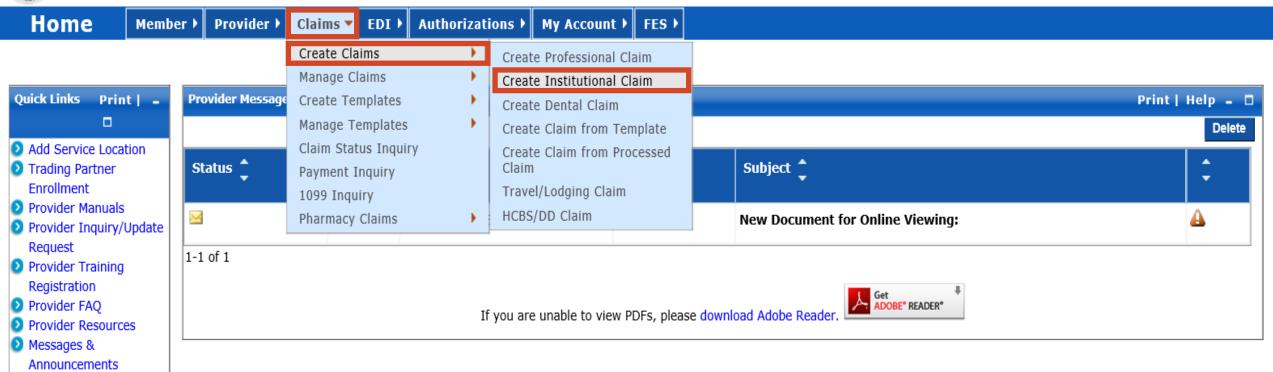
The Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

	ı	
ProviderLogin	- 0	
log in by entering your User ID and Password.		
* User ID:		
* Password:		
Forgot User Name or Password ?		
	Login Reset	

> Provider Login

USER ID and **Password**





> Submit a Claim

Claims

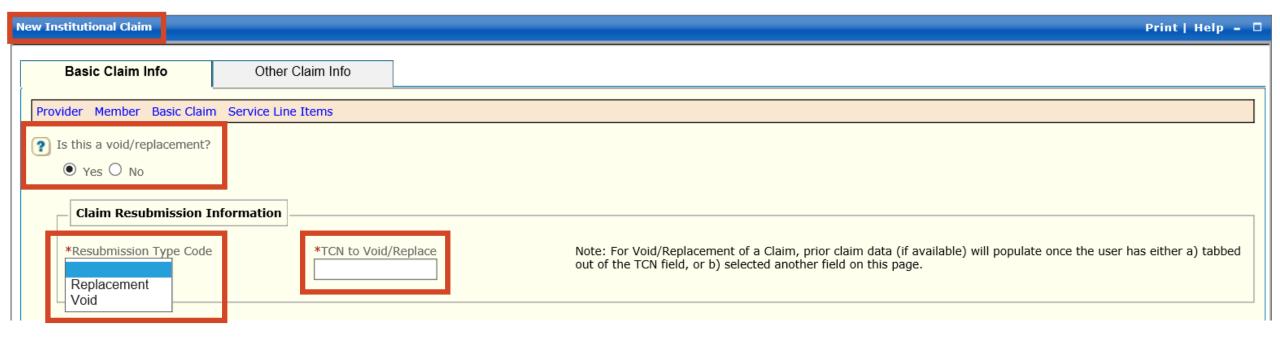
EFT EnrollmentERA Enrollment

- Create Claims
- Create Institutional Claim



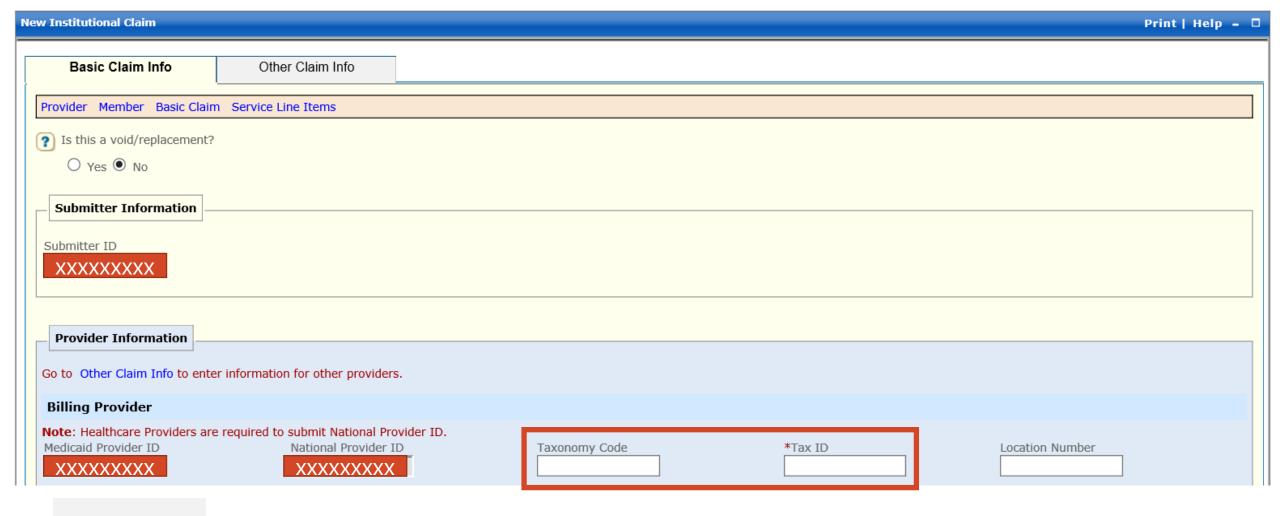
> New Institutional Claim

- Is this a void/replacement?
 - ✓ Defaults to "No."
 - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.

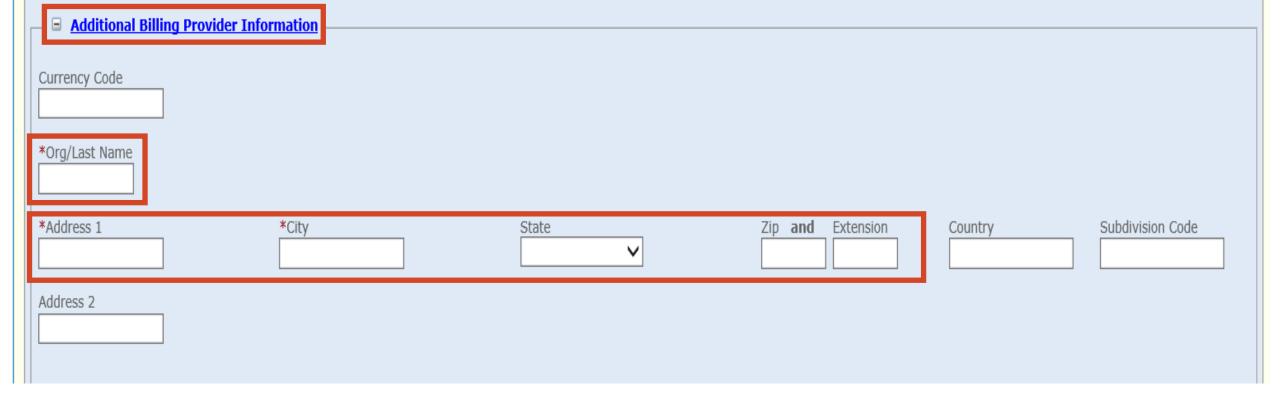


> New Institutional Claim

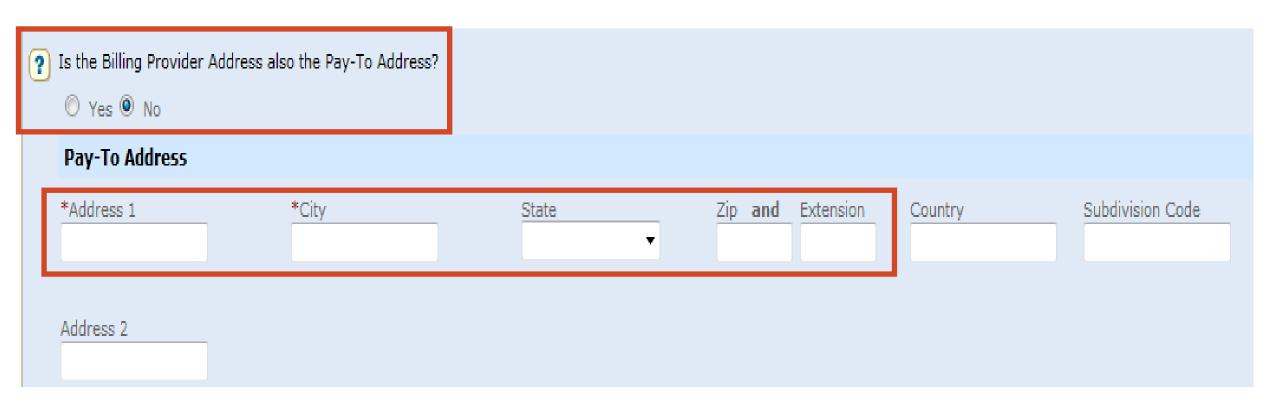
- Is this a void/replacement?
 - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
 - ✓ Resubmission Type Code Replacement or Void
 - ✓ TCN to Void/Replace



- **Enter** Billing Provider Taxonomy Code
- **Enter** Billing Provider Tax ID or SSN Number

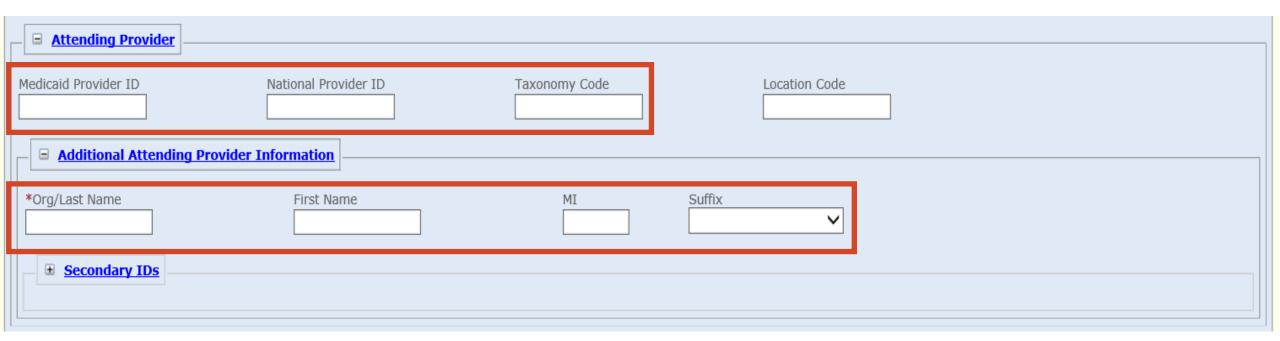


- > Additional Billing Provider Information
 - REQUIRED
 - Enter Org/Last Name, Address, City, State and Zip Code



> Is the Billing Provider also the Pay-To Address?

- Required Defaults to "Yes"
- Pay-To Address is different, select "No"
 - ✓ Complete the Pay-To Address section with the Address, City, State and Zip Code



- > Attending Provider
 - Required
 - Medicaid Provider ID, National Provider ID and Taxonomy
- > Additional Attending Provider Information
 - Required
 - Org/Last Name, First Name, MI and Suffix



Member Information

- REQUIRED
- Enter Member's 9-digit ID number
- Enter Member's Last Name
- Enter Member's First Name
- Enter Member's Date of Birth
 - ✓ Use format: MM/DD/YYYY
- Enter Member's Gender
 - ✓ F = Female
 - \checkmark M = Male

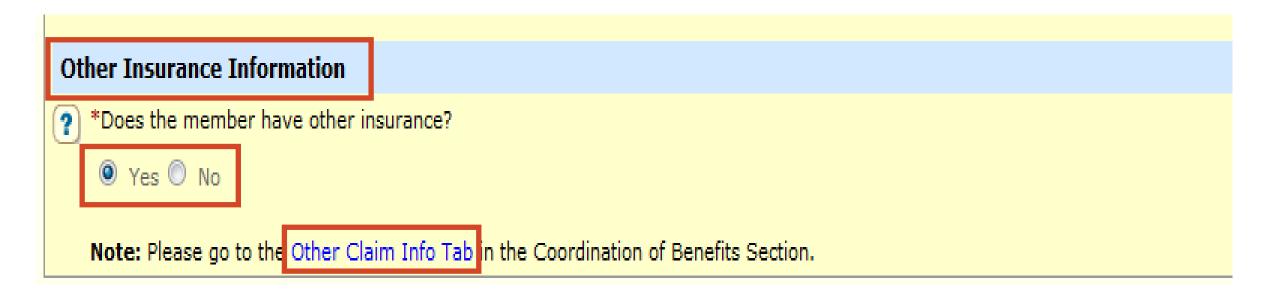


> Member Address

- REQUIRED
- Enter Member's Address, City, State and Zip Code

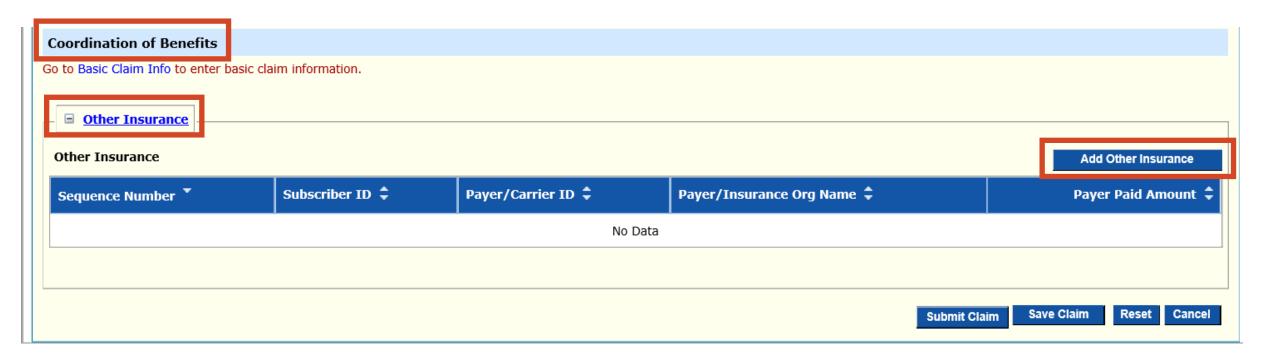


- > Does the member have other insurance?
 - Yes or No
- ➢ If "No" member does not have other insurance proceed to slide 28
- > If "Yes" member has other insurance proceed to slide 15



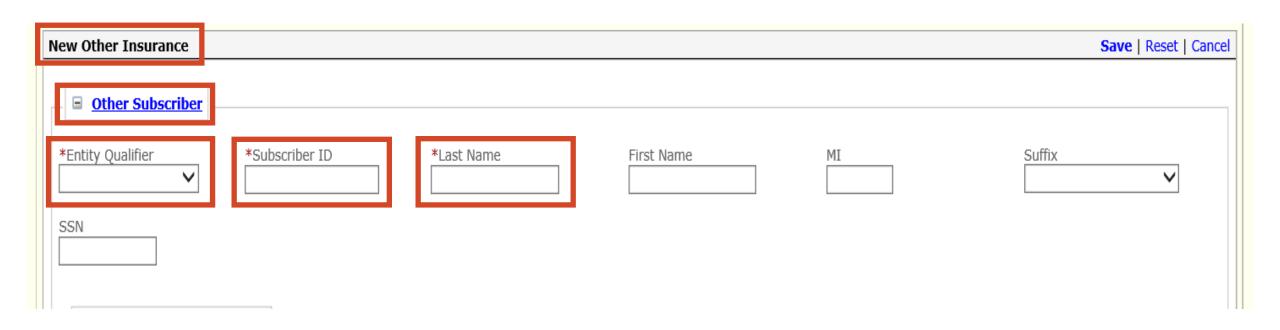
> Other Insurance Information

- REQUIRED
- Does the member have other insurance?
- Select "Yes"
- Click and complete the Other Claim Info Tab with the Other Insurance information



> Coordination of Benefits

- REQUIRED
- Other Insurance
- Add Other Insurance



> New Other Insurance

- REQUIRED
- Other Subscriber
- Entity Qualifier Non-Person
- Subscriber ID Member's Primary Insurance ID number
- Last Name Member's Last Name



> Other Subscriber Information

- REQUIRED
- Relation to Individual
- Claim Filing Code
- Group or Policy number

Disability

Exclusive Provider Organization (EPO) Federal Employee Program

Health Maint Org (HMO) Medicare Risk

Health Maintenance Organization

Indemnity Insurance

Liability

Liability Medical

Medicaid

Medicare Part A

Medicare Pt B

Mutually Defined/Unknown

Other Federal Program

Other Non-Federal Programs

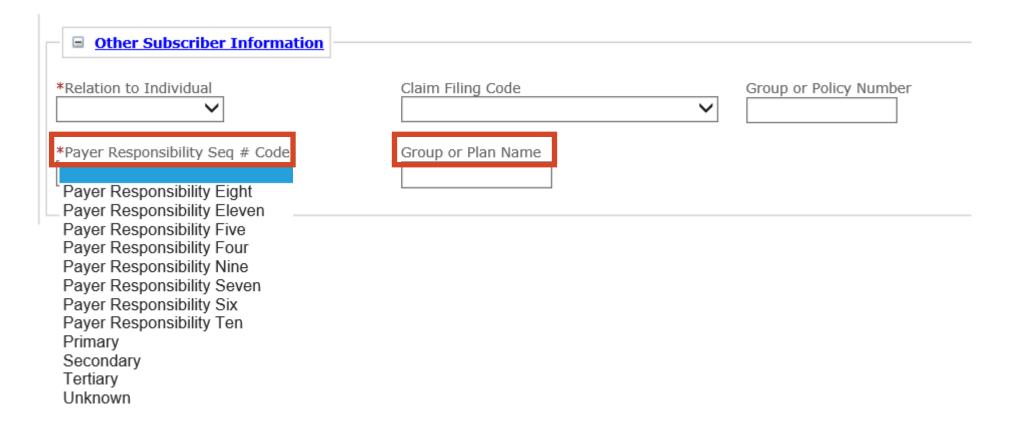
Point of Service (POS)

Preferred Provider Organization (PPO)

Title V

Veteran Administration Plan

Workers' Compensation Health Clm



> Other Subscriber Information Cont.

- REQUIRED
- Payer Responsibility Seq # Code
- Group or Plan Name

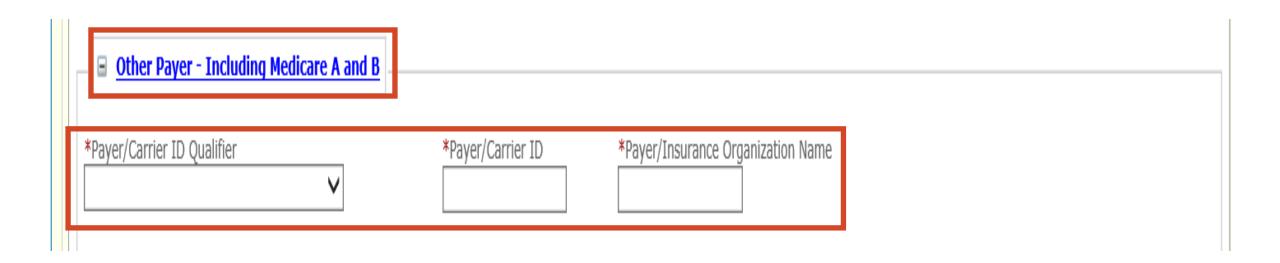


> Other Insurance Coverage

- REQUIRED
- Release of Information Code
- Select appropriate value

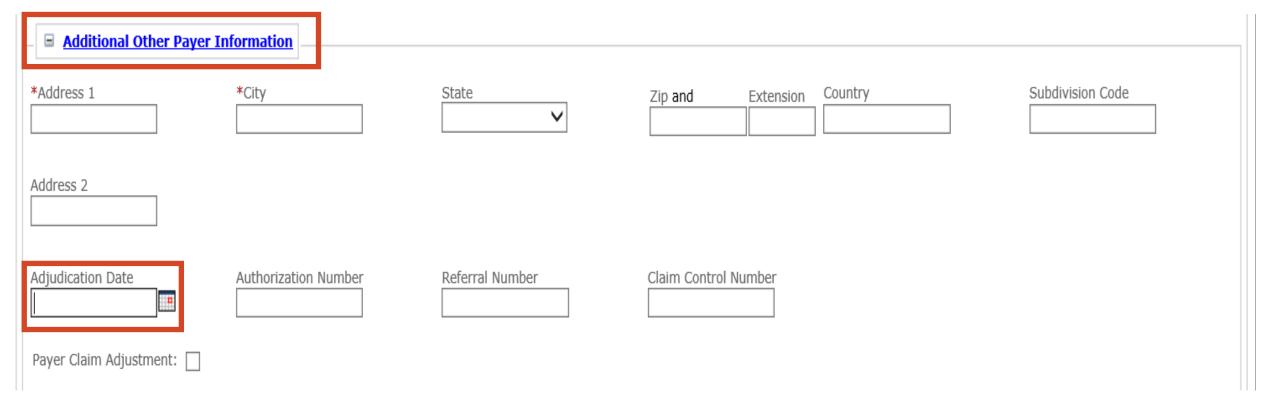
Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim



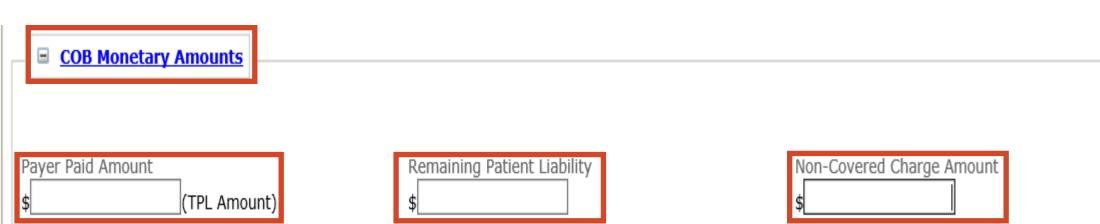
> Other Payer - Including Medicare A and B

- Payer/Carrier ID Qualifier Select Payer Identification
- Payer/Carrier ID Insurance Payer/Carrier ID number
 - Medicare and Medicare Advantage plans need to use Payer/Carrier ID of 0000003302
- Payer/Insurance Organization Name Insurance Name



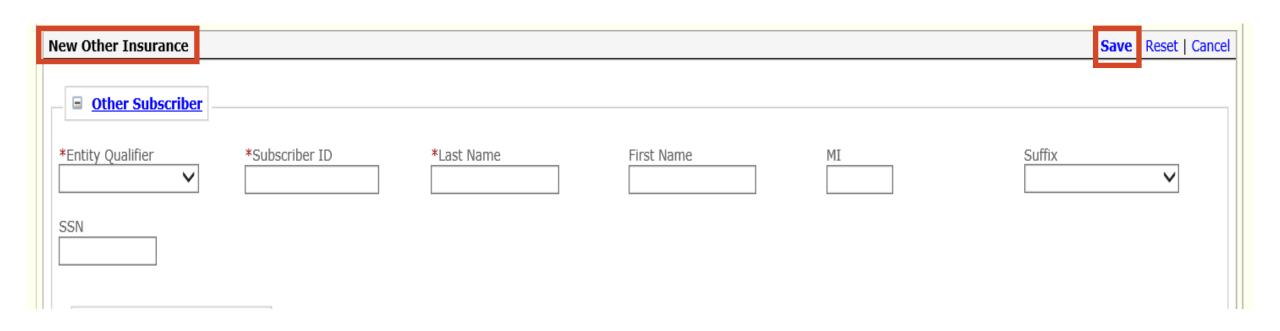
> Additional Other Payer Information

Adjudication Date



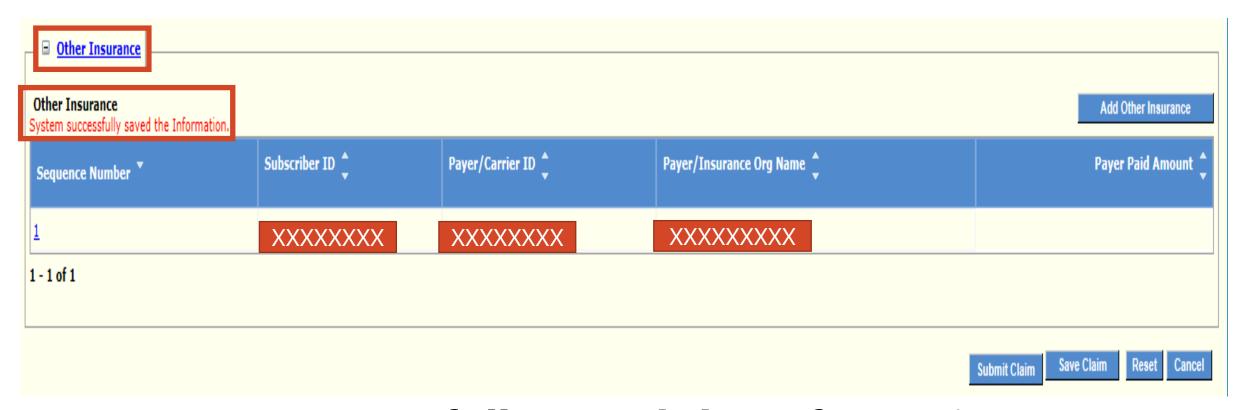
> COB Monetary Amounts

- Payer Paid Amount
- Remaining Patient Liability
- Non-Covered Charge Amount



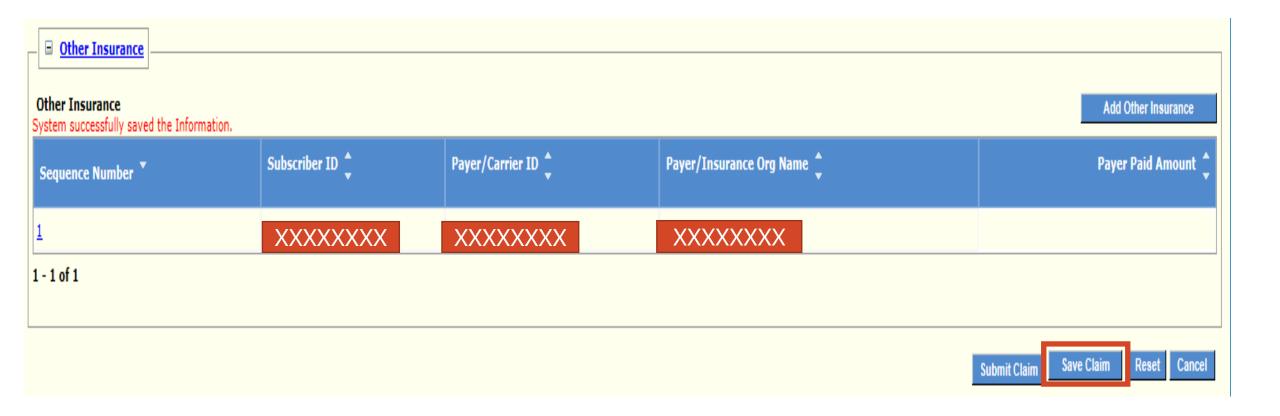
> New Other Insurance

- REQUIRED
- Scroll to the top of New Other Insurance section
- > SAVE



System successfully saved the Information

- Verify the Insurance was added
- Sequence Number
- Subscriber ID
- Payer/Carrier ID
- Payer/Insurance Org Name
- Repeat slides 16 24 if member has more than 1 payer



> Save Claim



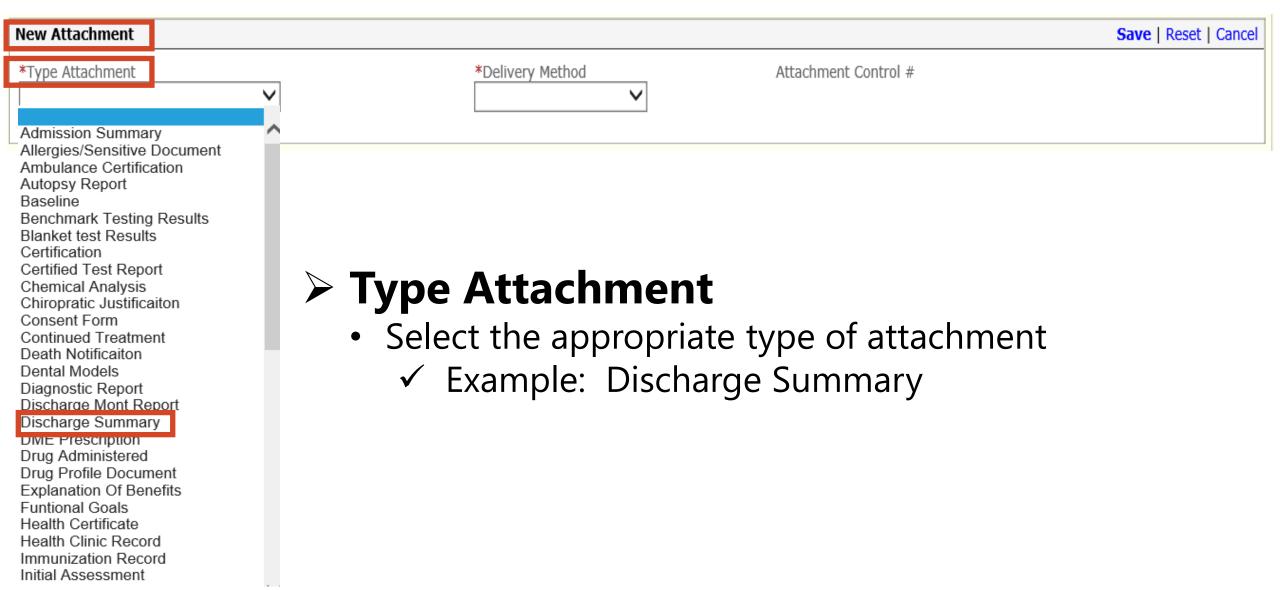
> Navigate to the Basic Claim Info Tab

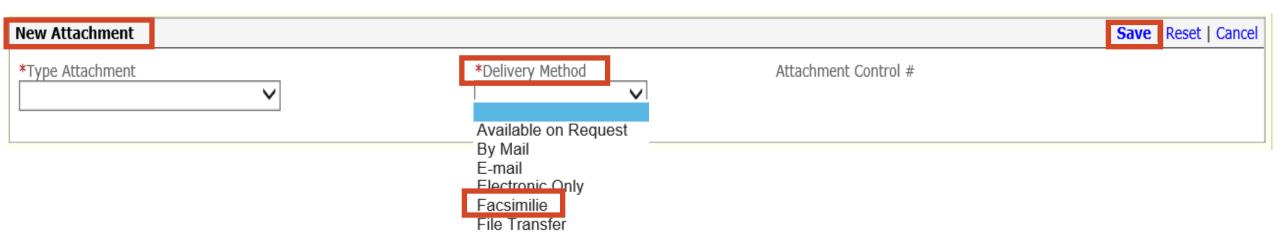
Faxing in an Attachments



> Does this claim have Attachments?

- Yes or No
 - ✓ Yes
 - ✓ Add Attachment





Delivery Method

- Select the Facsimilie
- Faxed documentation needs to have a SFN177 cover form
- SFN 177 link: https://www.nd.gov/eforms/Doc/sfn00177.pdf
- > SAVE
- Claim Submitted Confirmation Page may be substituted for the SFN 177

MMIS ATTACHMENT COVER SHEET – SFN 177





Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Corresponding Record Number	
oresponding Necord Number	
pe of Attachment (select only one)	
Claim	
Transaction Control Number (TCN)	Fax To:
	701-328-0374
Service Authorization (SA)	
Service Authorization (SA) Number	Fax To:
	701-328-1544
Referral	
Referral Number	Fax To:
	701-328-1544
Other	
Description	Fax To:
	701-328-1544

Required

- Provider NPI or Medicaid Number
- Member Medicaid Number
- Type of Attachment Select only one
 - ✓ Claim Transaction Control Number (TCN)
 - ✓ Service Authorization (SA) SA Number
 - ✓ Referral Referral Number
 - ✓ Other Description

Mail to:

North Dakota Department of Human Services MMIS Attachments 600 East Blvd Ave. Bismarck, ND 58505

Telephone Number: 1-877-328-7098

Provider NPI or Medicaid Number

Member Medicald Number

Electronic Only in an Attachment



> Does this claim have Attachments?

- Yes or No
 - ✓ Yes
 - ✓ Add Attachment



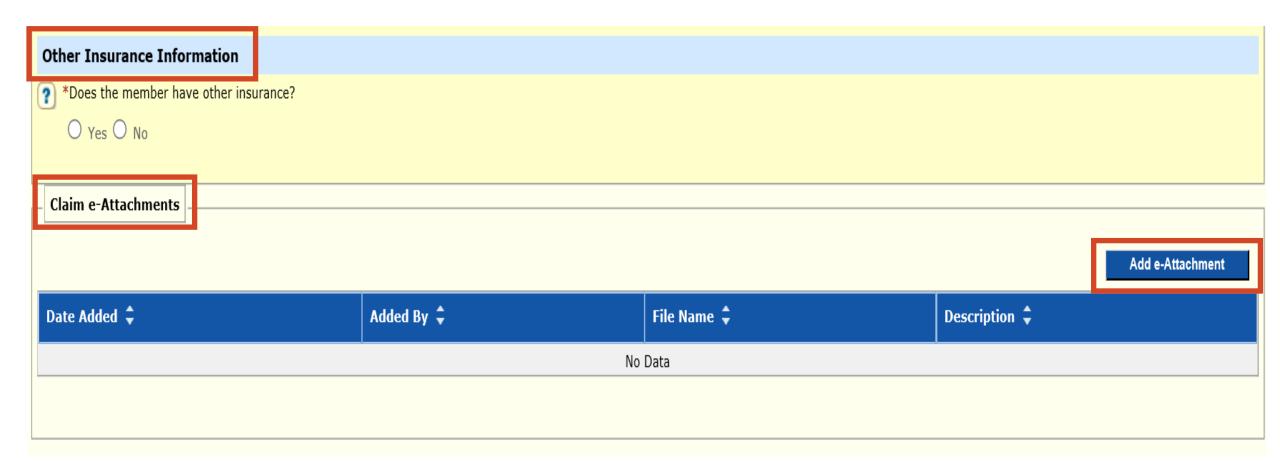


- Delivery Method
 - Select the Electronic Only
- > Save

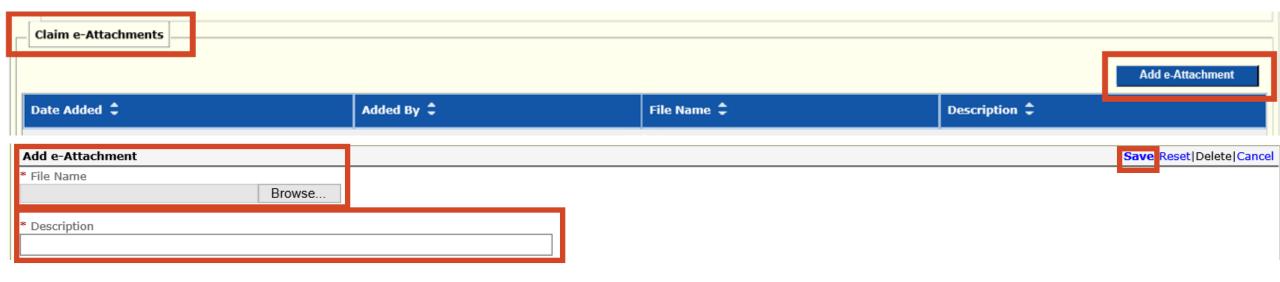


- > Save System successfully saved the Information
- > Scroll down to Other Insurance Information





- > Claim e-Attachment
 - Add e-Attachment



> File Name

- **Cannot** be more than 55 characters
- Cannot have special characters: example !@#\$

Select Browse

Insert/select file that is saved to your computer

Description

• Content of attachment: example Periodontal Chart

> SAVE



> File Name

- Cannot be more than 55 characters
- Cannot have special characters: example !@#\$

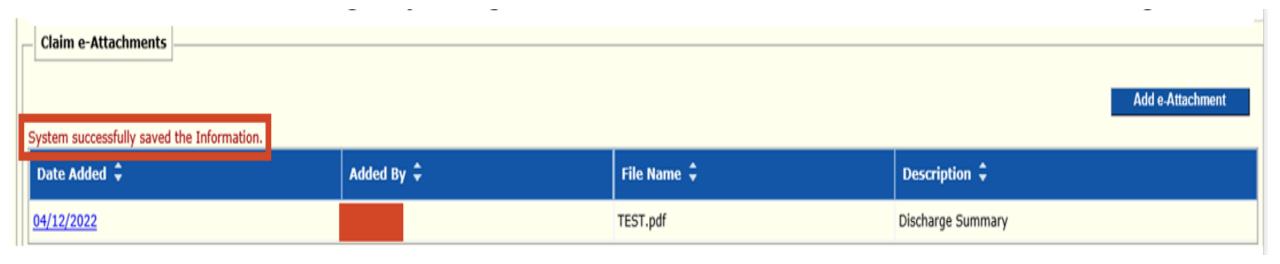
Select Browse

Insert/select file that is saved to your computer

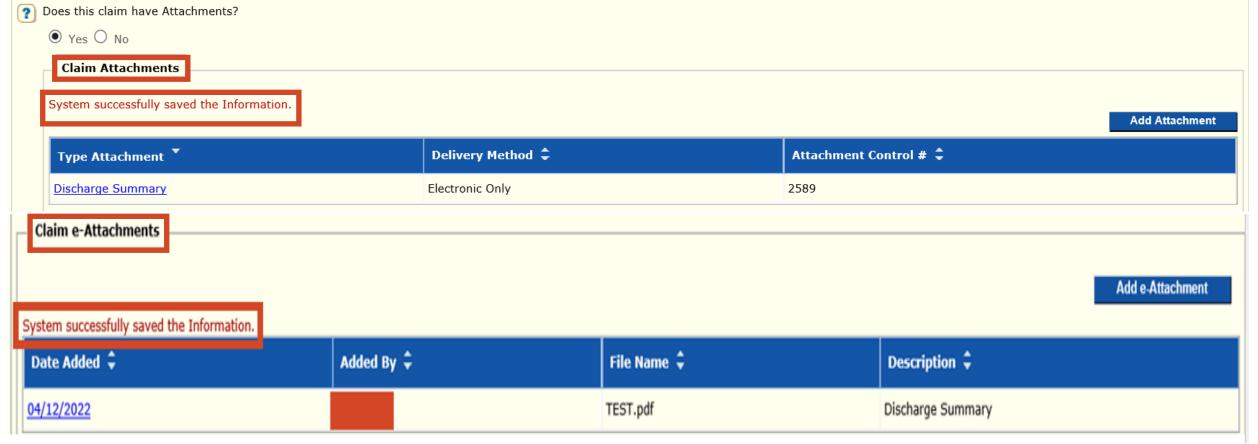
> Description

Content of attachment: example Periodontal Chart

> SAVE

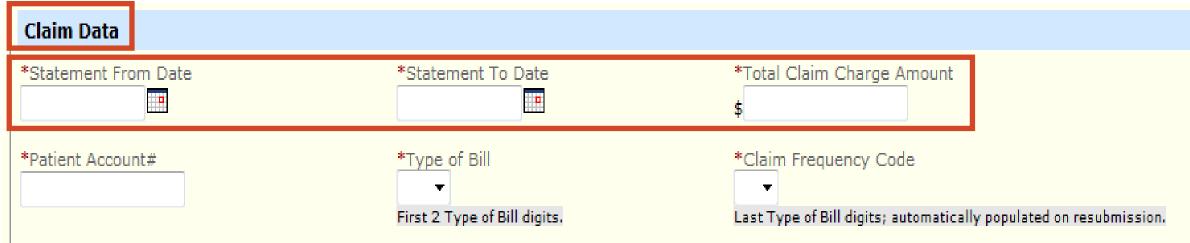


- > Save System successfully saved the Information
- > Note: If resubmitting/adjusting a claim, all documents need to be attached again.



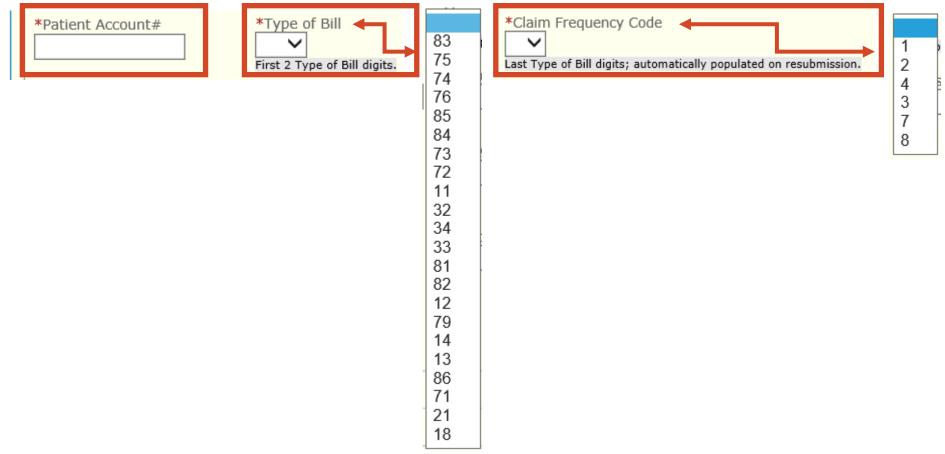
- Save System successfully saved the Information
- > Claim Attachment and Claim e-Attachment must be completed
- > Note: If resubmitting/adjusting a claim, all documents need to be attached again.



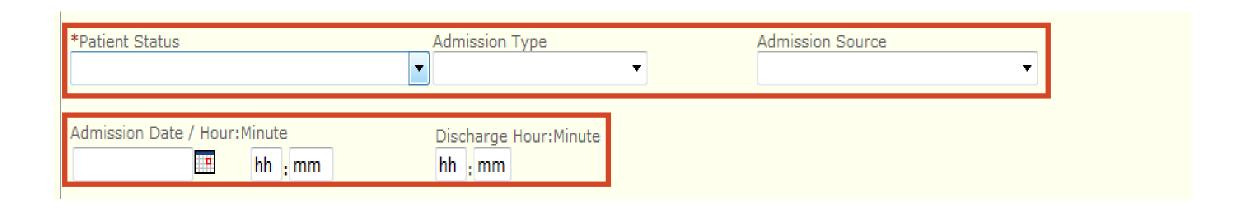


>Claim Data

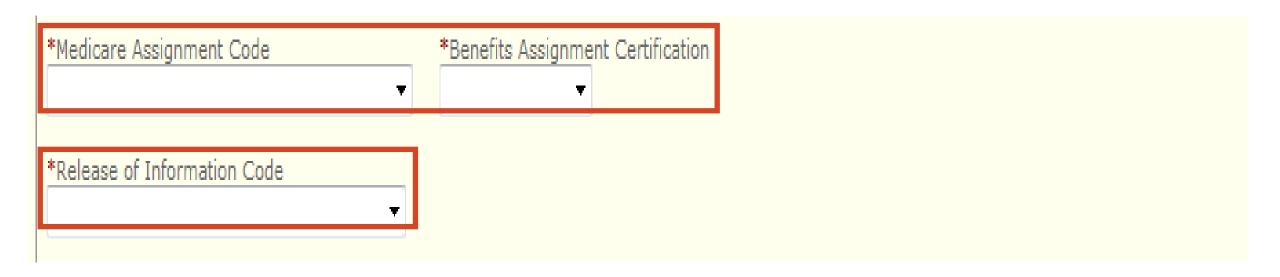
- REQUIRED regardless if there is a red asterisk by the field
- Statement From Date and Statement To Date
 - ✓ Use format: MM/DD/YYYY
- Total Claim Charge Amount
 - ✓ Enter the total amount billed



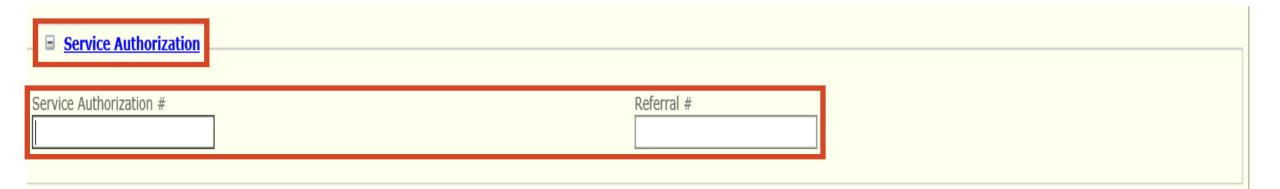
- Patient Account # Enter the internal patient account number will print on remittance advice
- Type of Bill First 2 digits of the Type of Bill
- Claim Frequency Code last digit of the Type of Bill



- REQUIRED regardless if there is a red asterisk by the field
- Patient Status
- Admission Type
- Admission Source
- Admission Date/Hour:Minute
 - ✓ Use date format: MM/DD/YYYY. Use military format: HH:MM
- SITUATIONAL Discharge Hour:Minute
 - ✓ If patient is other than "Still a Patient" you must enter the hour:minute the member was discharged. Use military format: HH:MM

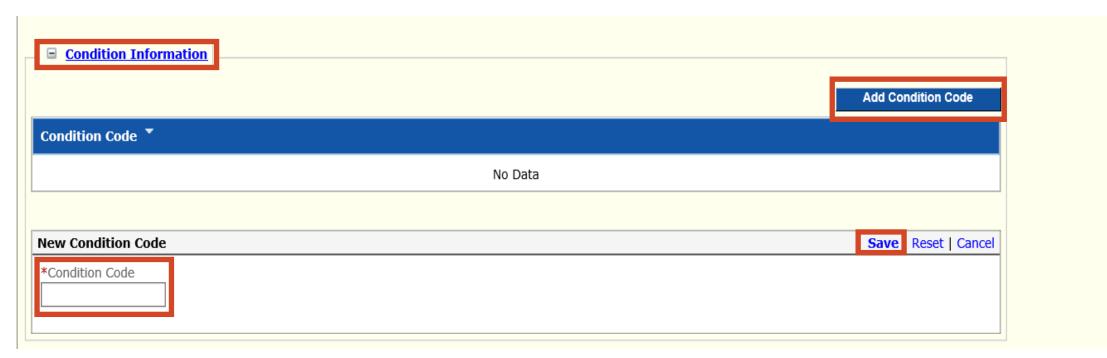


- REQUIRED
- Medicare Assignment Code
- Benefits Assignment Certification
- Release of Information Code

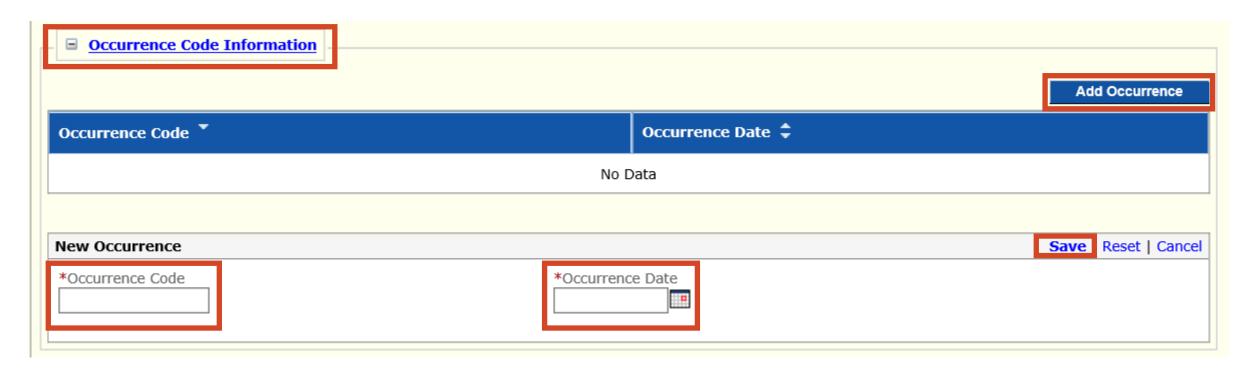


> Service Authorization

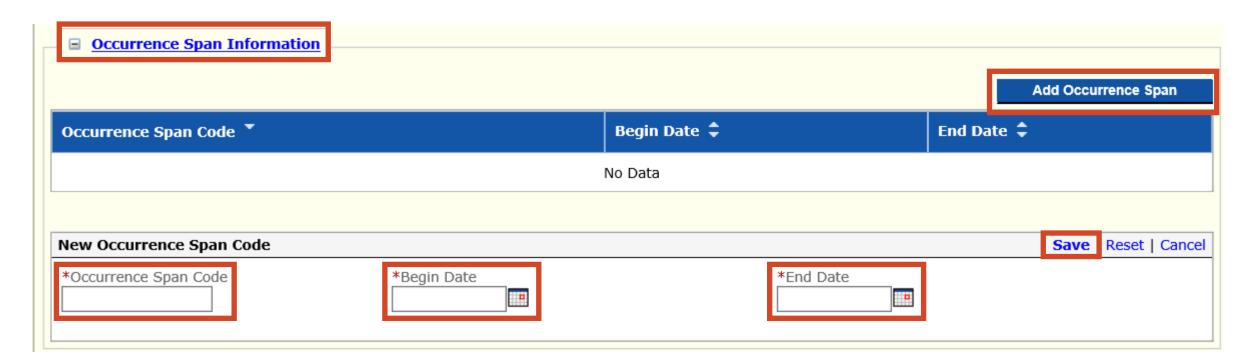
- REQUIRED if applicable
- Service Authorization Number
- Referral Number



- > Condition Information
- > Add Condition Code
 - REQUIRED if applicable
 - Condition Code
 - Save



- Occurrence Code Information
- > Add Occurrence
 - Required if applicable
 - Occurrence Code
 - Occurrence Date
 - Save

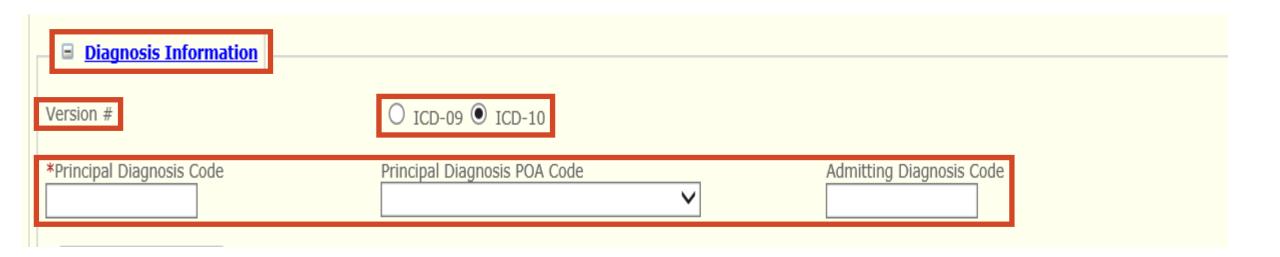


- > Occurrence Span Information
- > Add Occurrence Span
 - Required if applicable
 - Occurrence Span Code
 - Begin Date
 - End Date
 - Save



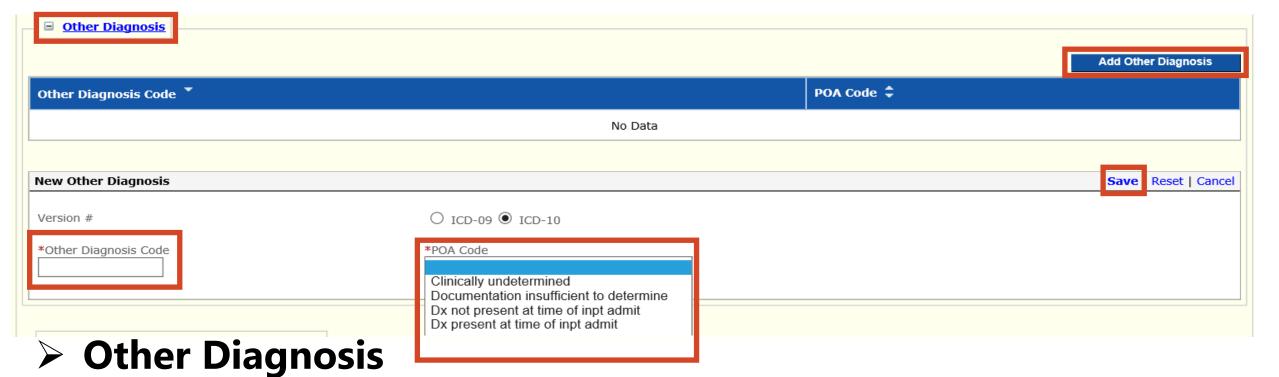
> Value Information

- > Add Value
 - REQUIRED if applicable
 - Value Code 80 = Covered Days
 - Value Amount Value Amount should be entered as a dollar amount
 ✓ Example: 30 days = 30.00
 - Save

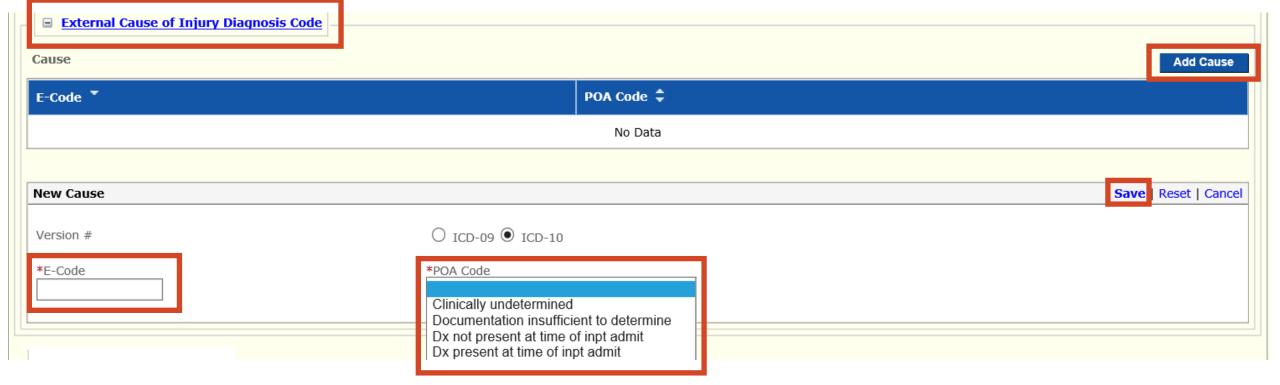


Diagnosis Information

- REQUIRED
- Version # Defaults to ICD-10 Select appropriate version based on date of service
- Principal Diagnosis Code
 - ✓ Enter the diagnosis code for the member's primary diagnosis
- Principal Diagnosis POA Code if applicable
- Admitting Diagnosis Code if applicable



- > Add Other Diagnosis
 - REQUIRED if applicable
 - Version # Defaults to ICD-10 Select appropriate version based on date of service
 - Other Diagnosis Code Additional Diagnosis Codes
 - ✓ Enter the diagnosis code for the member's additional diagnosis's
 - POA Code if not applicable select Clinically undetermined
 - Save

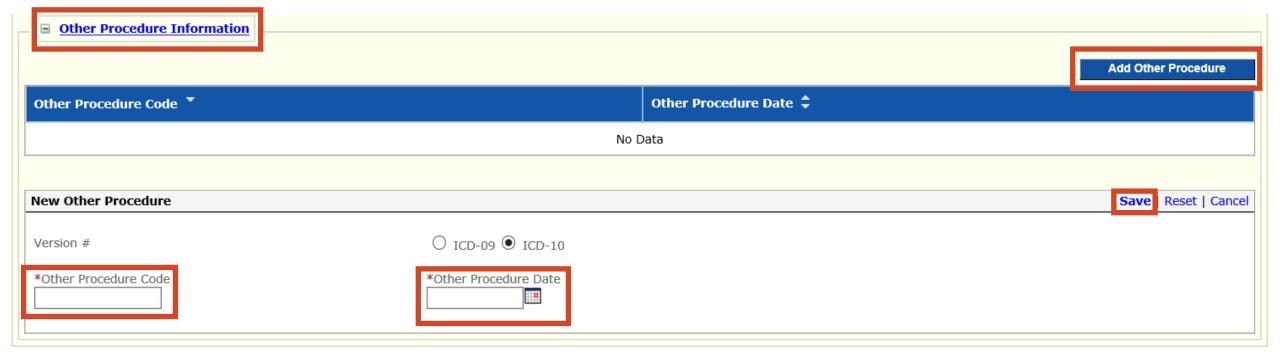


- > External Cause of Injury Diagnosis Code
- > Add Cause
 - Version # Defaults to ICD-10 Select appropriate version based on date of service
 - Enter E-Code
 - POA Code
 - Save



Procedure Information

- Version # Defaults to ICD-10 Select appropriate version based on date of service
- Principal Procedure Code
- Procedure Date

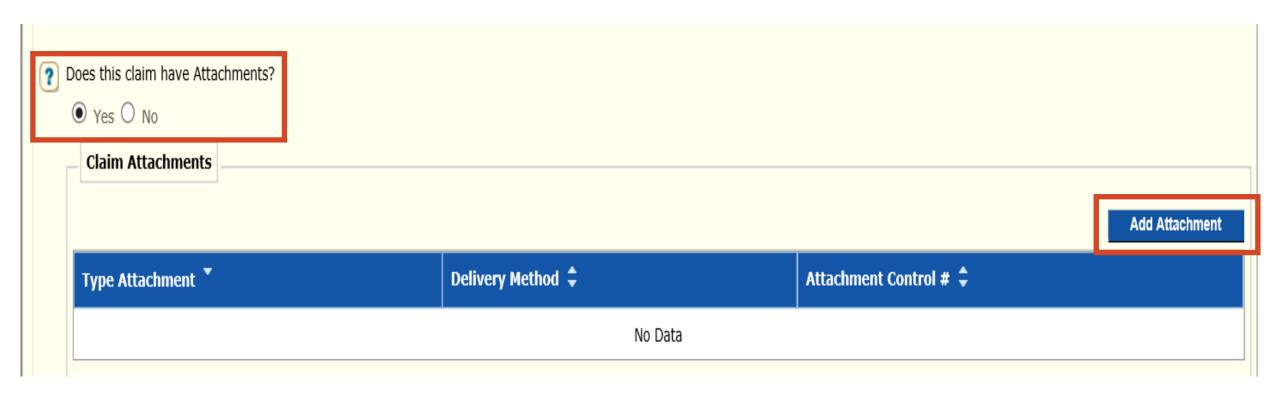


- > Other Procedure Information
- > Add Other Procedure
 - Version # Defaults to ICD-10 Select appropriate version based on date of service
 - Other Procedure Code
 - Other Procedure Date
 - Save

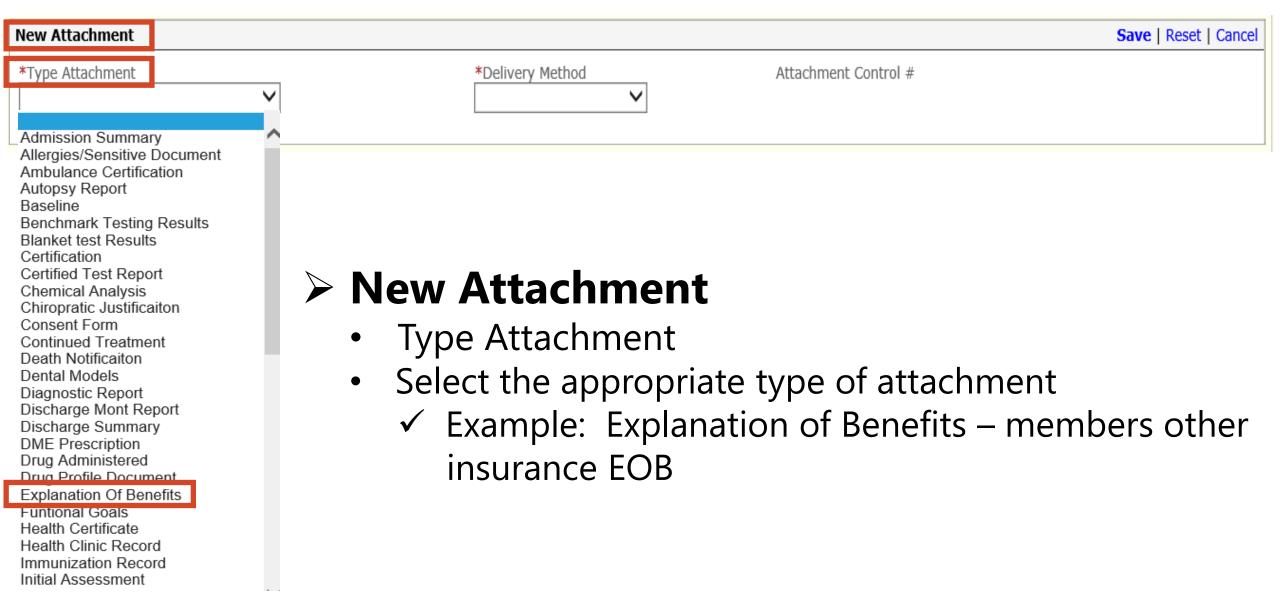


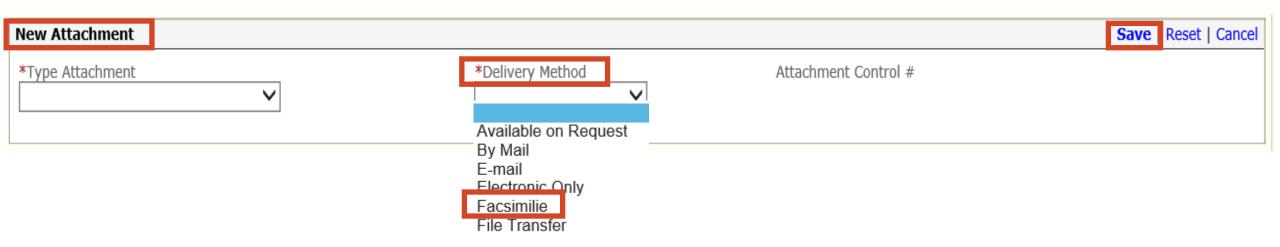
> Billing Note

- Add any pertinent information
 - ✓ Example Note: Proving the One-Year Timely Filing Limit Policy Remittance Advice (RA) Date and TCN Number



- > Does this claim have Attachments?
 - Yes
- > Add Attachment
 - Add Attachment





> New Attachment

- Delivery Method
- Select the Facsimilie fax into the appropriate number
- Faxed documentation needs to have a SFN177 cover form
- SFN 177 link: https://www.nd.gov/eforms/Doc/sfn00177.pdf
- > SAVE
- Claim Submitted Confirmation Page may be substituted for the SFN 177

MMIS ATTACHMENT COVER SHEET – SFN 177





Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Provider NPI or Medicaid Number
Member Medicald Number
Corresponding Record Number

pe of Attachment (select only one)		
Claim		
Transaction Control Number (TCN)	Fax To:	
	701-328-0374	
Service Authorization (SA)		
Service Authorization (SA) Number	Fax To:	
	701-328-1544	
Referral		
Referral Number	Fax To:	
	701-328-1544	
	701-328-1544	
Other	701-328-1544	
	701-328-1544 Fax To:	

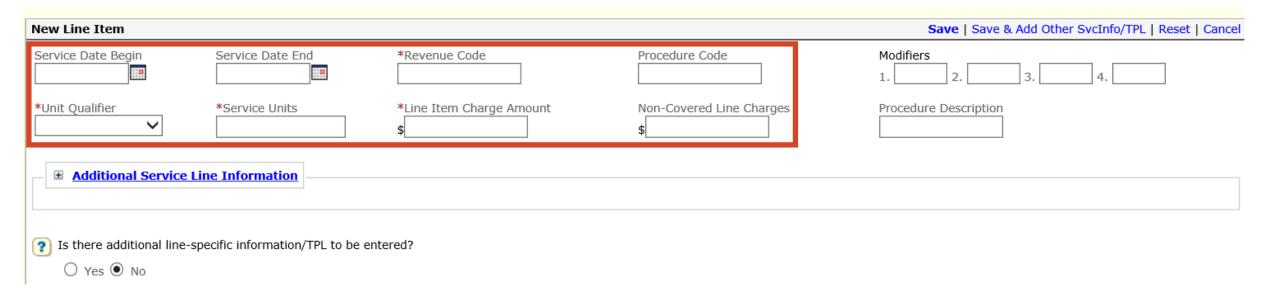
Required

- Provider NPI or Medicaid Number
- Member Medicaid Number
- Type of Attachment Select only one
 - ✓ Claim Transaction Control Number (TCN)
 - ✓ Service Authorization (SA) SA Number
 - ✓ Referral Referral Number
 - ✓ Other Description
 - ✓ Fax to the appropriate phone number

Mail to

North Dakota Department of Human Services MMIS Attachments 600 East Blvd Ave. Bismarck, ND 58505

Telephone Number: 1-877-328-7098



New Line Item

- Service Date Begin Use Format: MM/DD/YYYY
- Service Date End Use format: MM/DD/YYYY
- Revenue Code
- Procedure Code if applicable
- Unit Qualifier
- Service Units
- Line Item Charge Amount
- Non-Covered Line Charges if applicable



- > Is there Additional line-specific information/TPL to be entered?
 - No member does not have other insurance
 - Save New Line Item
 - SAVE CLAIM
 - SUBMIT CLAIM



- > Is there Additional line-specific information/TPL to be entered?
 - Yes Member has Other Insurance proceed to <u>Slide 63</u> for instructions
 - Save & Add Other Svc Info/TPL

TCN:

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

Date of Service: 03/20/2020 - 03/20/2020

Provider #: Member ID:

Claim Status: C - To Be Dnd

Total Charge: \$500.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.

Adjustment Reason Codes

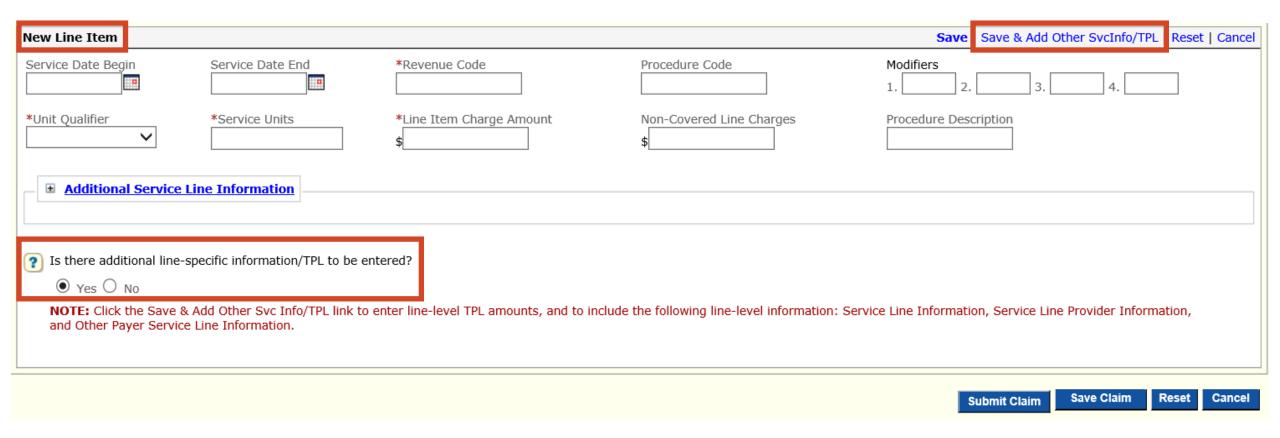
Line #	Adjustment Reason Code	Description
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
0	В7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
0	N253	Missing/incomplete/invalid attending provider primary identifier.



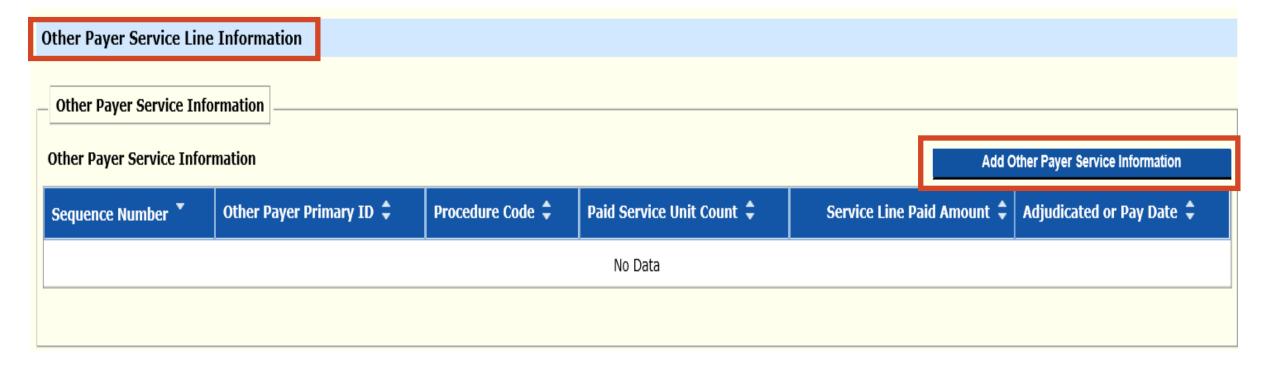


- > Is there Additional line-specific information/TPL to be entered?
 - **Yes** Member has Other Insurance
 - Save & Add Other Svc Info/TPL



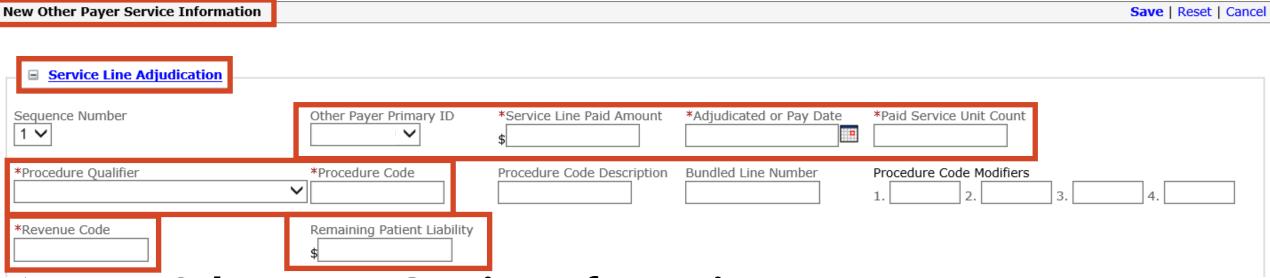
> New Institutional Claim

- System successfully saved the Information
 - ✓ Line # 1

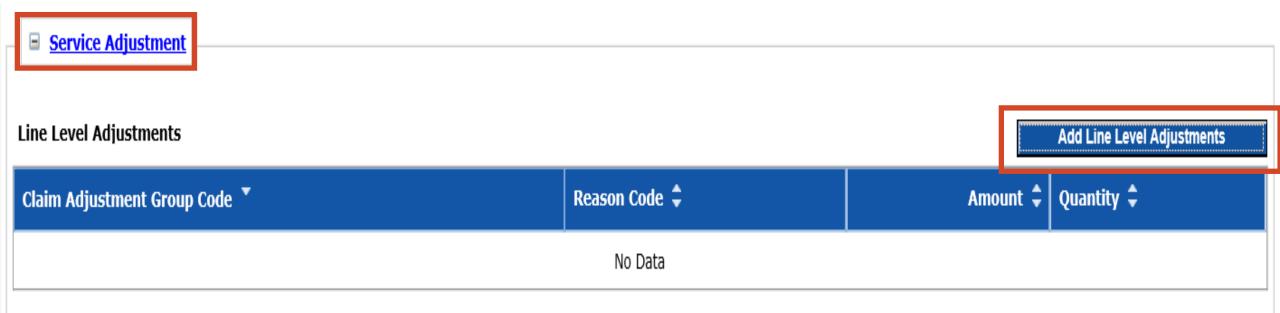


> Other Payer Service Line Information

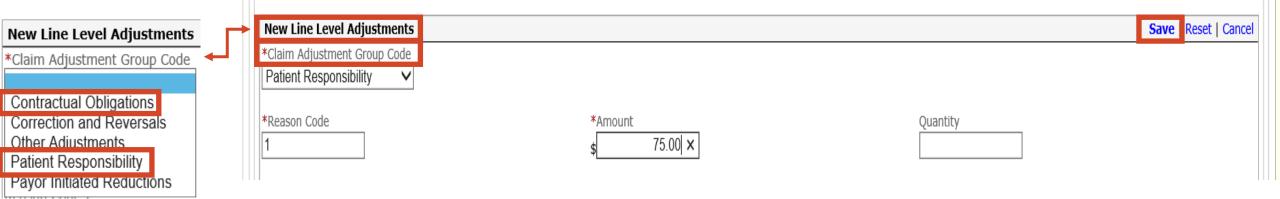
Add Other Payer Service Information



- New Other Payer Service Information
- > Service Line Adjudication
 - **✓** REQUIRED
 - ✓ Other Payer Primary ID
 - ✓ Service Line Paid Amount
 - ✓ Adjudicated or Pay Date
 - ✓ Paid Service unit Count
 - ✓ Procedure Qualifier ABC
 - ✓ Procedure Code
 - ✓ Revenue Code
 - ✓ Remaining Patient Liability

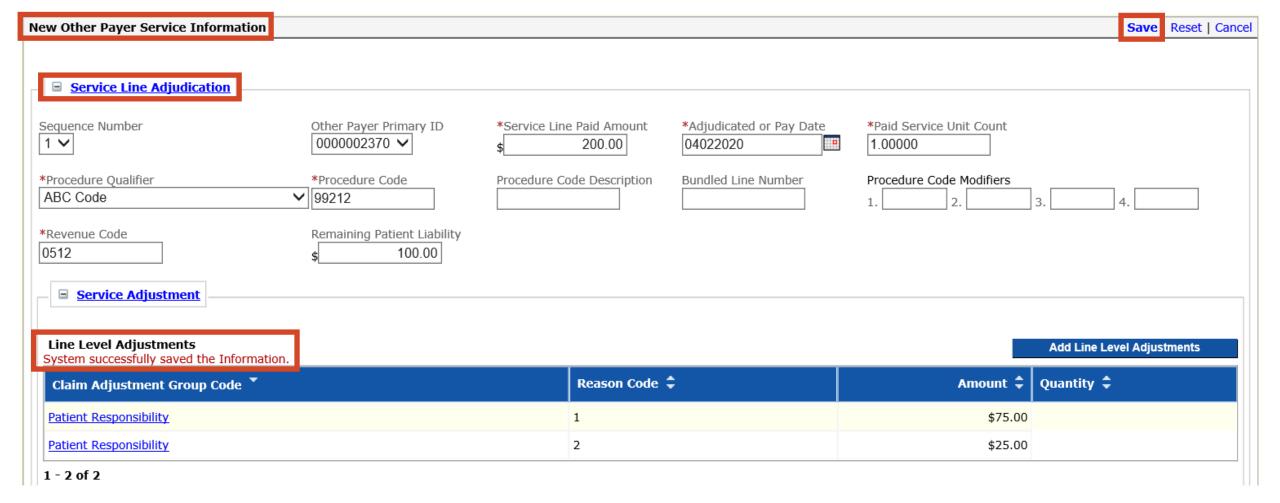


- > Service Adjustment
- > Add Line Level Adjustments



New Line Level Adjustments

- Claim Adjustment Group Code Patient Responsibility or Contractual Obligation
 - ✓ Only 1 Claim Adjustment Group Code may be selected at a time
- Reason Code and Amount (Do Not enter PR or CO in front of Reason Code)
 - ✓ Patient Responsibility add reason code and amount
 - ✓ Save
 - ✓ Contractual Obligations add reason code and amount
 - ✓ Save
- Add new Line Level Adjustments for each Reason Codes per detail line



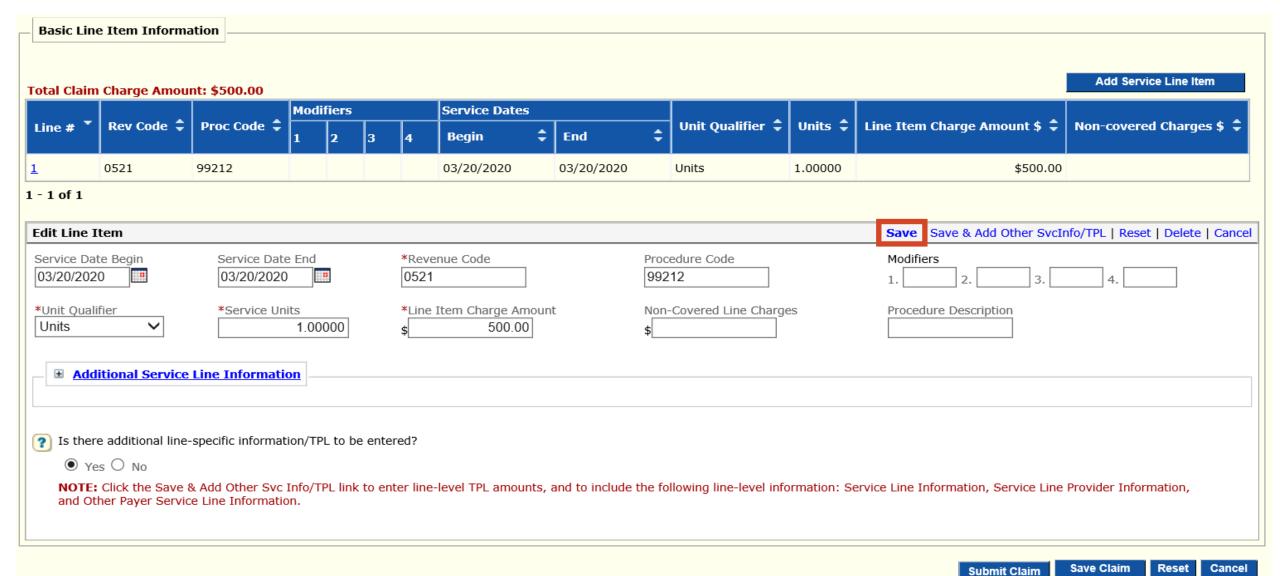
New Other Payer Service Information

- Additional Adjustments Add Line Level Adjustments if applicable
- Verify Line Level Adjustments saved
- Save New Other Payer Service Information

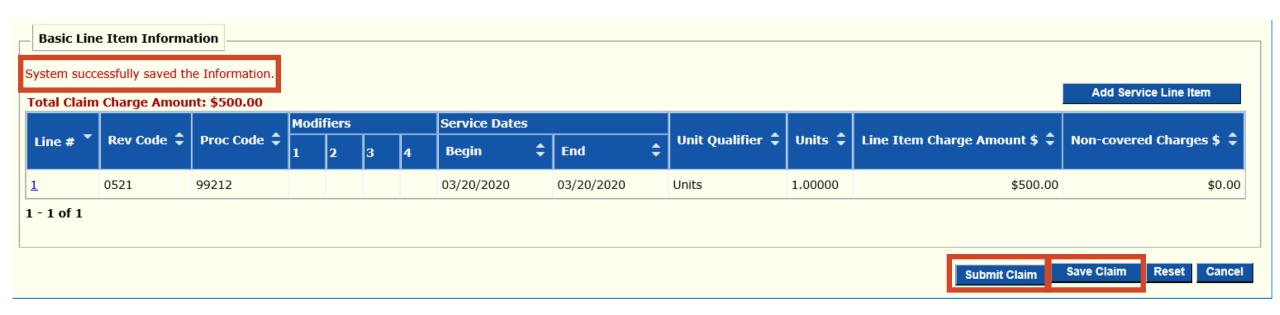


> If the member has 2 Insurance Policies

- Add Other Payer Service Information
 - ✓ Complete a 2nd Sequence Number Repeat slides 49 53
 - ✓ Primary is Sequence Number #1
 - ✓ Secondary is Sequence Number #2
- > If the member has 1 insurance
- > Save & Return to Basic Service Line Item



> Save Line



- > System successfully saved the Information
- > Save Claim Needs to be done before submitting the claim
 - In order to re-submit the claim from a processed claim if need be
- > Submit Claim

TCN:

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

Date of Service: 03/20/2020 - 03/20/2020

Provider #: Member ID:

Claim Status: C - To Be Dnd

Total Charge: \$500.00

*To Be Paid Amount: \$0.00

*Co-Payment: \$0.00

*Total Recipient Liability: \$0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

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Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
0	В7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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Remark Codes

Line #	Remark Code	Description
0	N253	Missing/incomplete/invalid attending provider primary identifier.

