ND MMIS PROFESSIONAL WEB PORTAL TRAINING

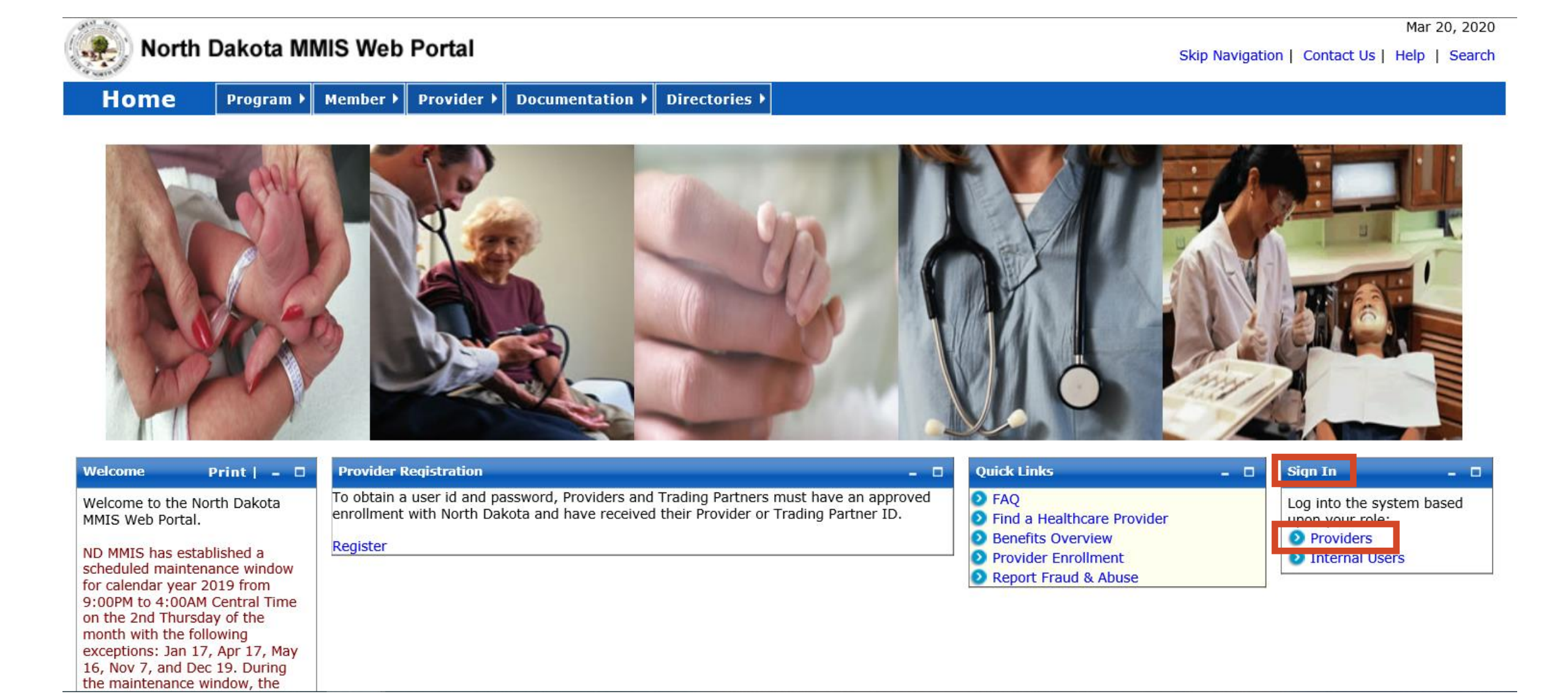
LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH Dakota | Health & Human Services

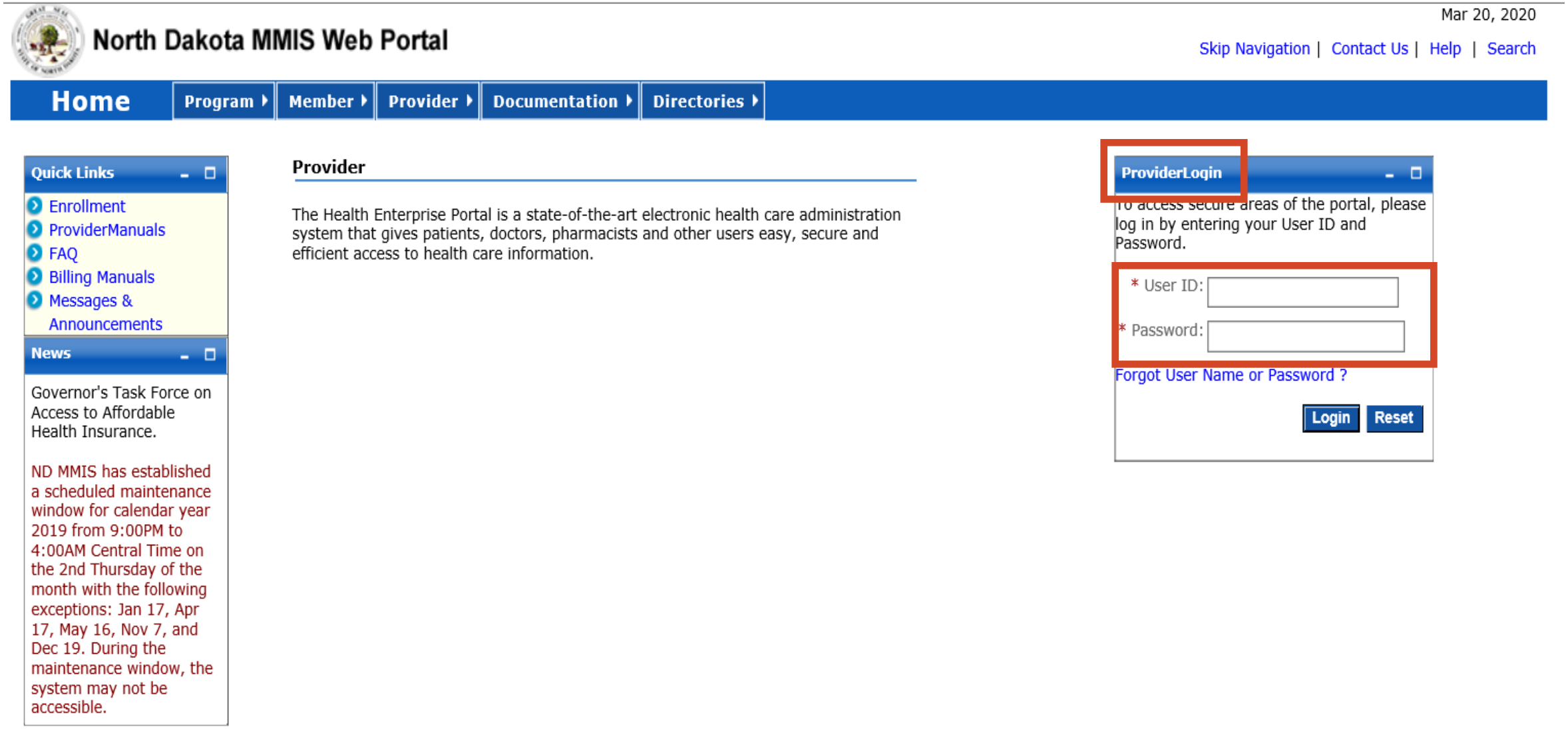
Be Legendary.

ND MMIS Web Portal Professional Claim Form Submission Instructions

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

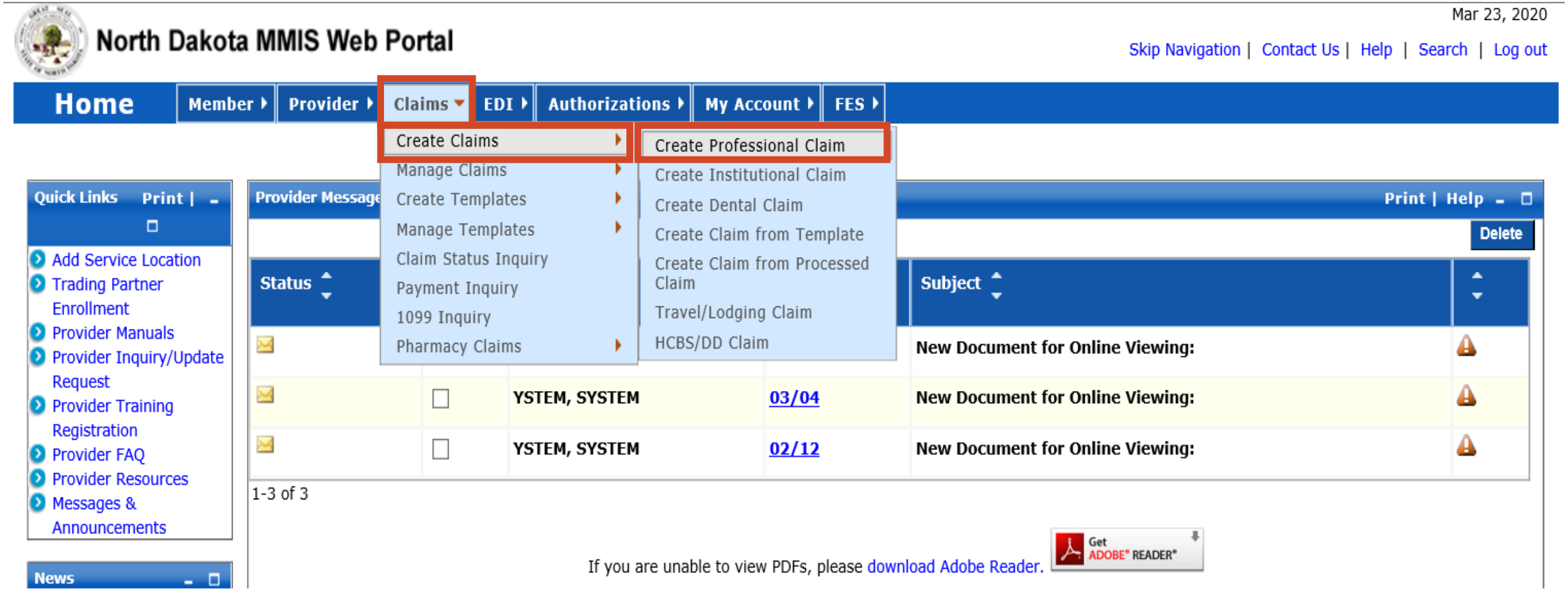


➢ Sign In - Provider



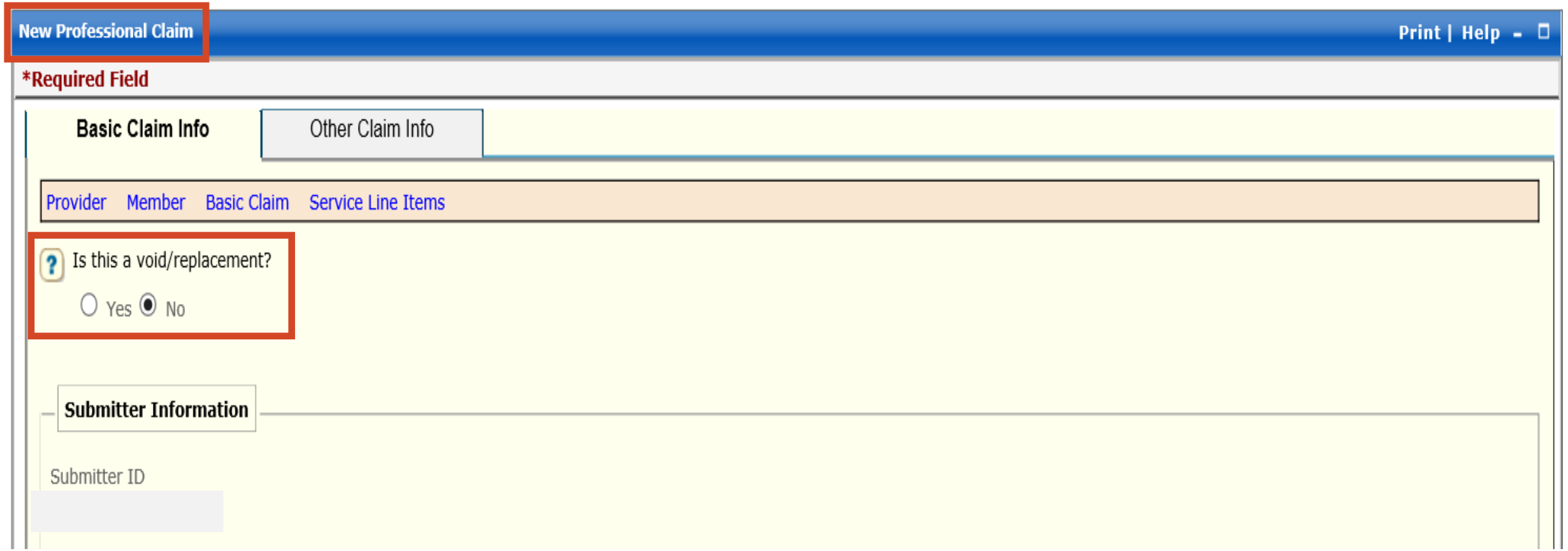
➢ Provider Login

- **USER ID** and **Password**



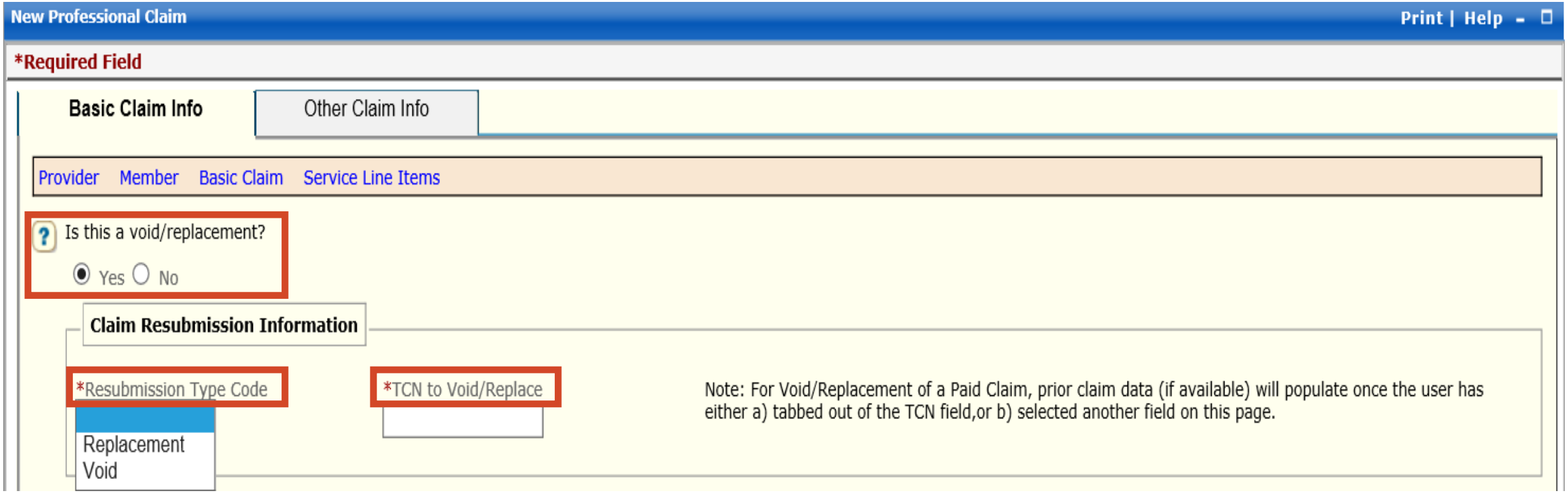
➢ Submit a Claim

- Claims
- Create Claims
- Create Professional Claim



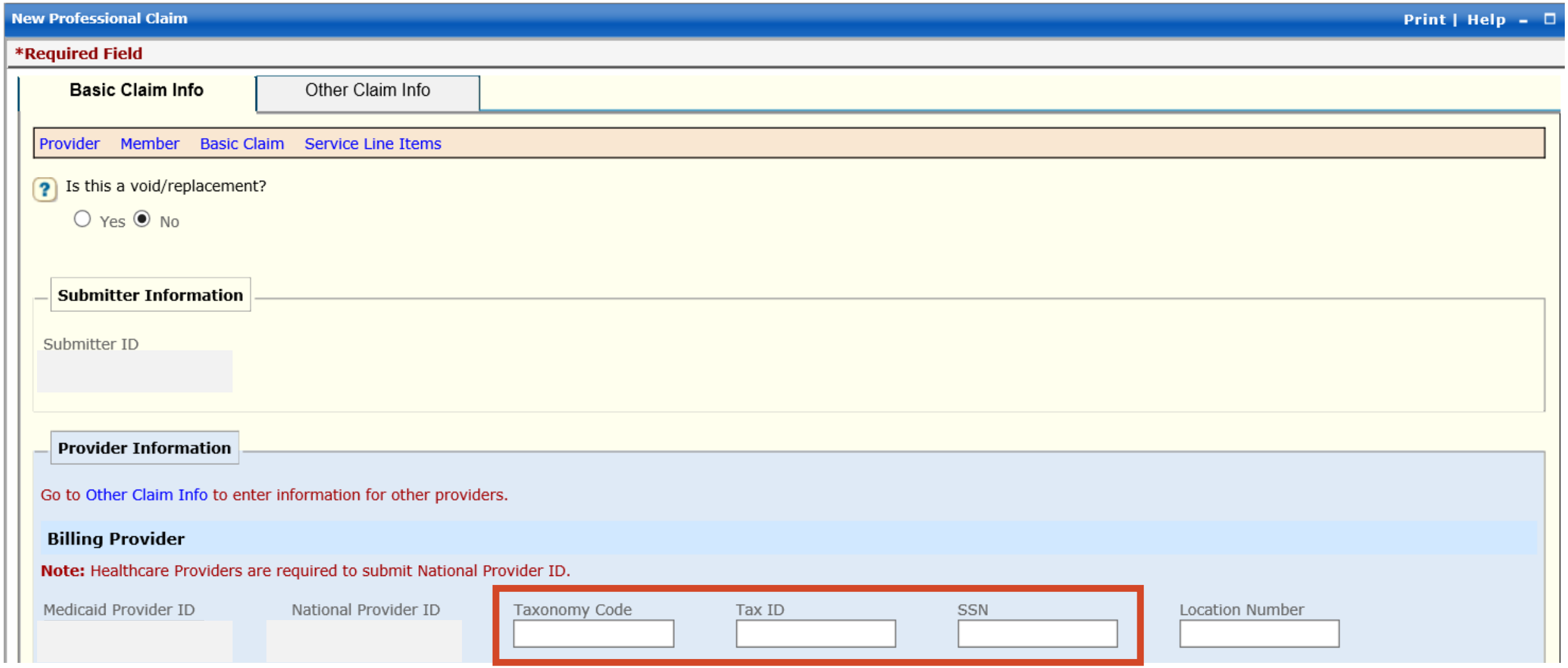
➢New Professional Claim

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

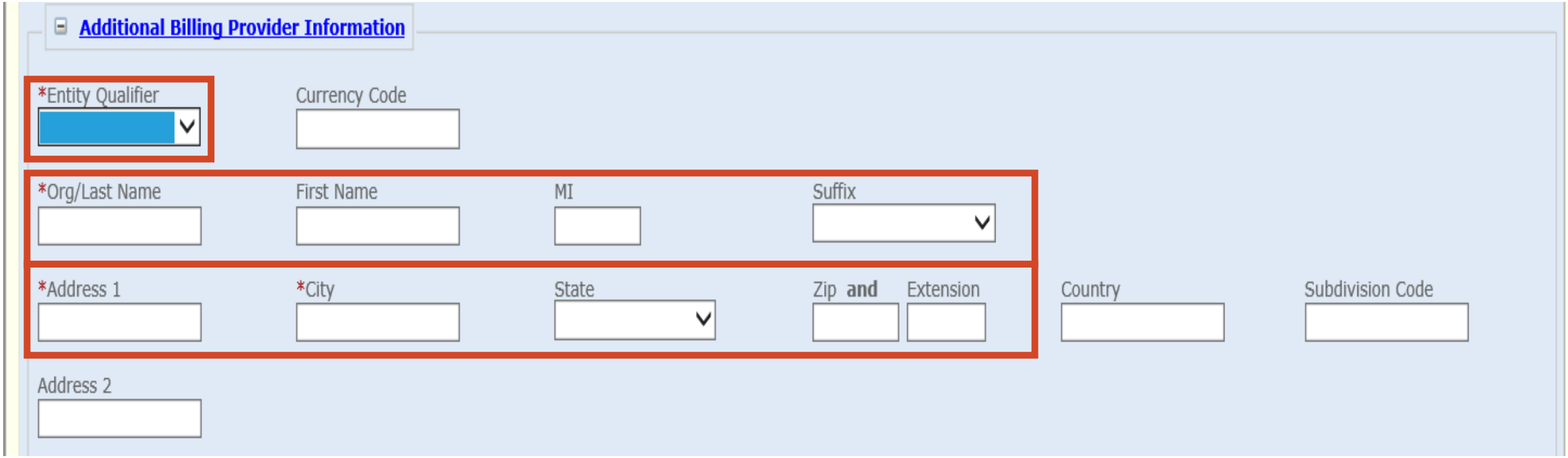


➢New Professional Claim

- 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

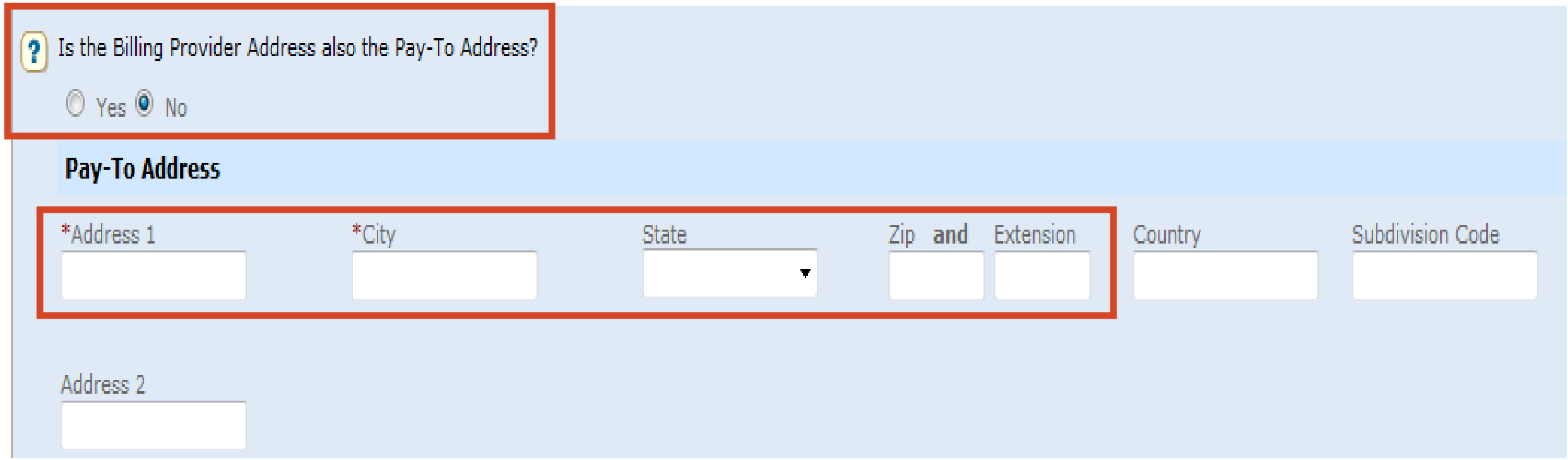


- **Enter** - Billing Provider Taxonomy Code
- **Enter** - Billing Provider Tax ID or SSN Number



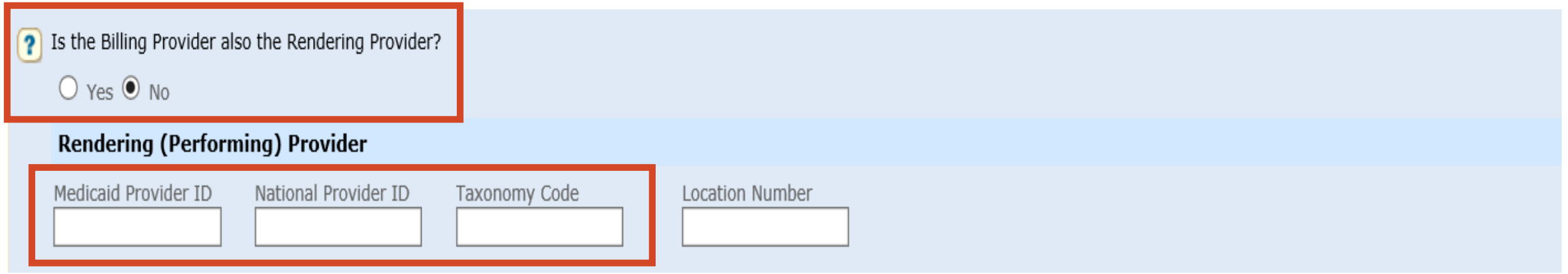
➢ Additional Billing Provider Information

- **REQUIRED**
- **Select** - Entity Qualifier – non-person or person
- **Enter** – Org/Last Name, Address, City, State and Zip Code

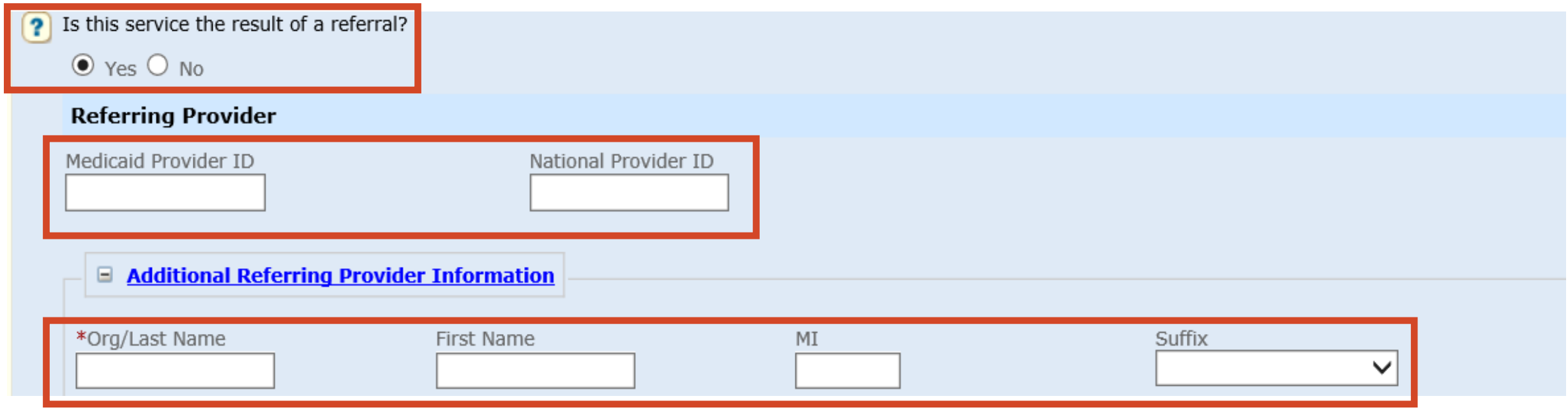


➢ Is the Billing Provider also the Pay-To Address?

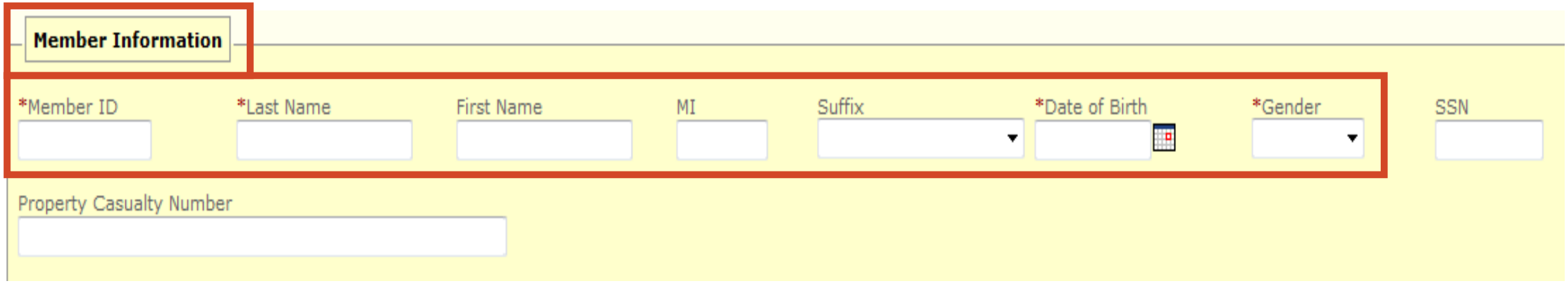
- **Required -** Defaults to "Yes"
- Pay-To Address is **different**, select "**No**"
  - ✓ Complete the Pay-To Address section with the Billing Provider Name, Address, City, State and Zip Code



- **Is the Billing Provider also the Rendering Provider?**
  - **Required** - Default to "Yes"
  - Rendering (Performing) Provider is **different** select "**No**"
    - ✓ **Enter –** Rendering (Performing) Provider Medicaid Provider ID
    - ✓ **Enter –** Rendering (Performing) Provider NPI Number
    - ✓ **Enter –** Rendering (Performing) Provider Taxonomy Code

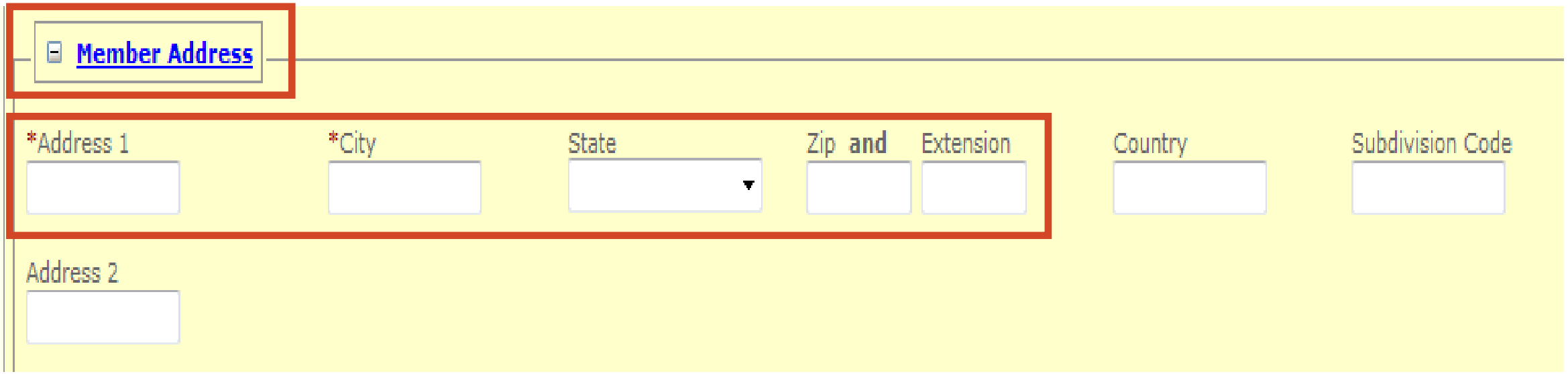


- **Is this service the result of a referral?**
  - **Defaults to "No"**
  - If "**Yes**" - Referring Provider Medicaid Provider ID and NPI (National Provider ID)
- **Additional Referring Provider Information**
  - Org/Last Name and First Name
  - MI and Suffix – if applicable



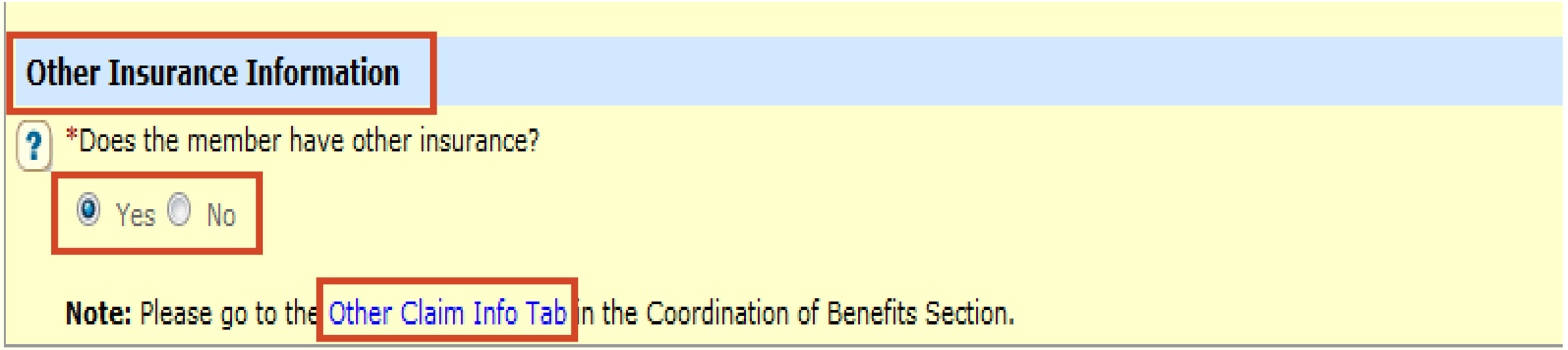
➢ Member Information

- **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
  - ✓ M = Male



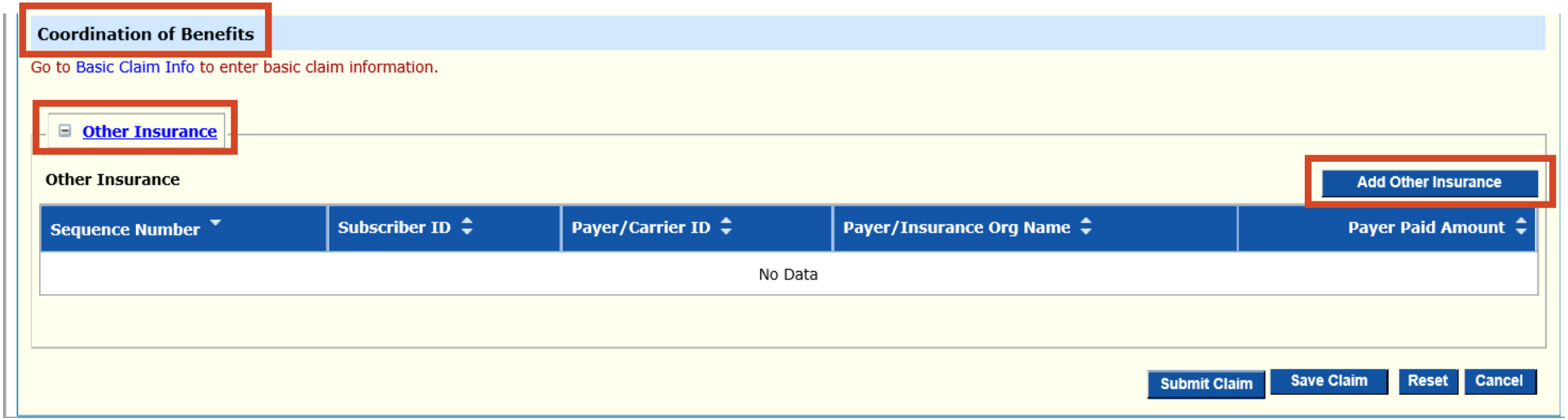
- **Member Address**
  - **REQUIRED**
  - **Enter** - Member's Address, City, State and Zip Code

- **Does the member have other insurance?**
  - **Yes or No**
- **If "No" - member does not have other insurance – proceed to slide 29**
- **If "Yes" - member has other insurance– proceed to slide 16**



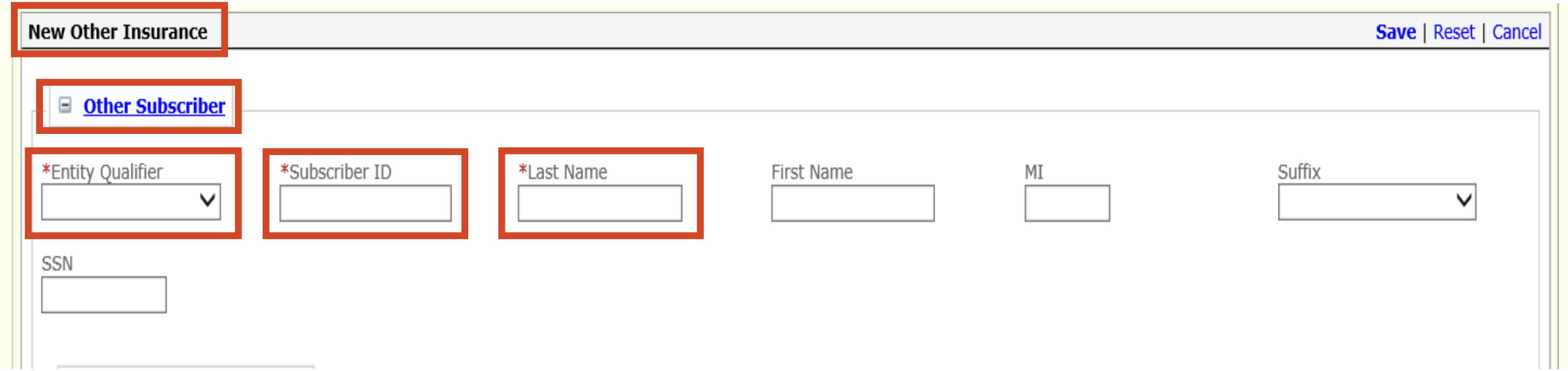
➢ Other Insurance Information

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



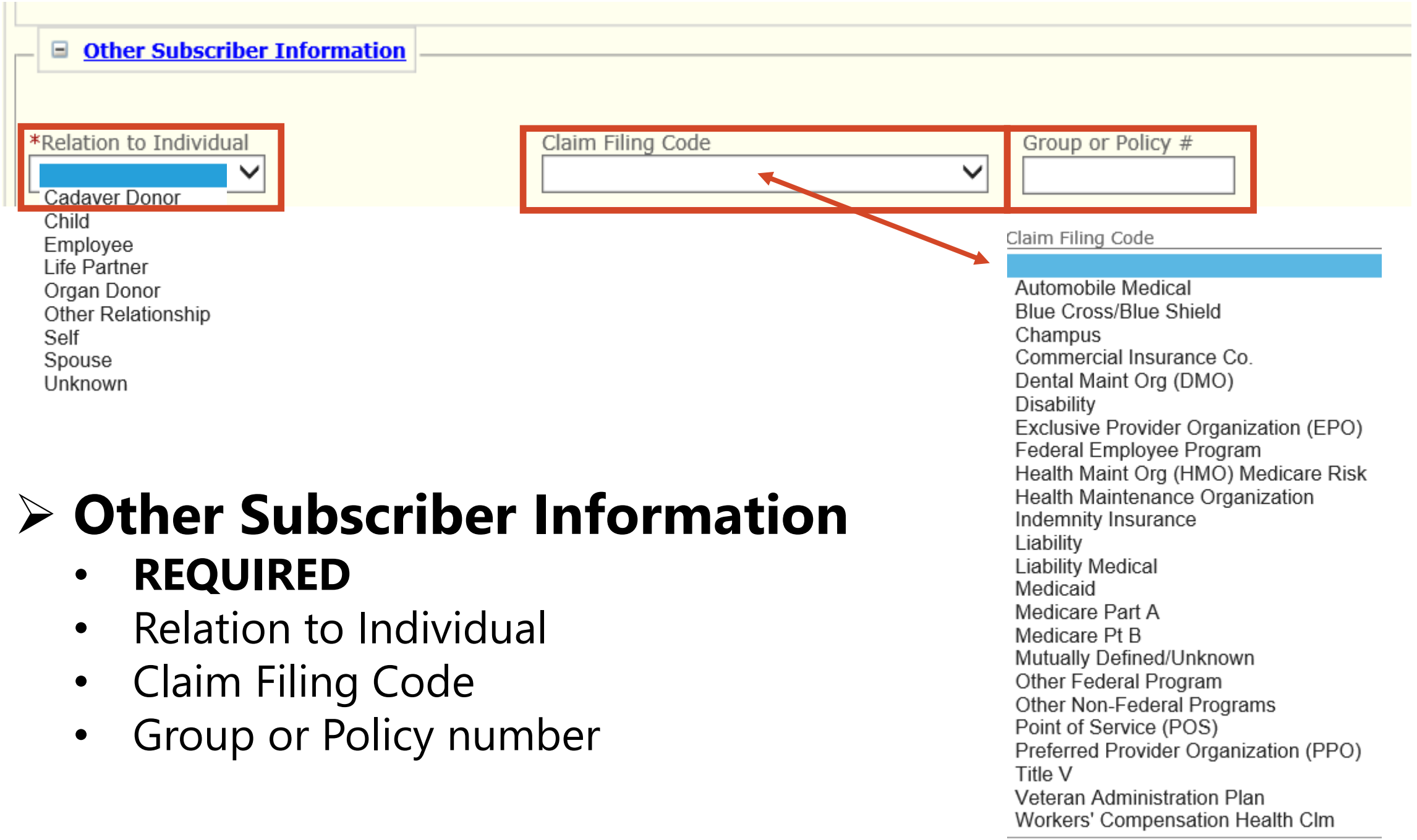
➢ Coordination of Benefits

- **REQUIRED**
- Other Insurance
- Add Other Insurance



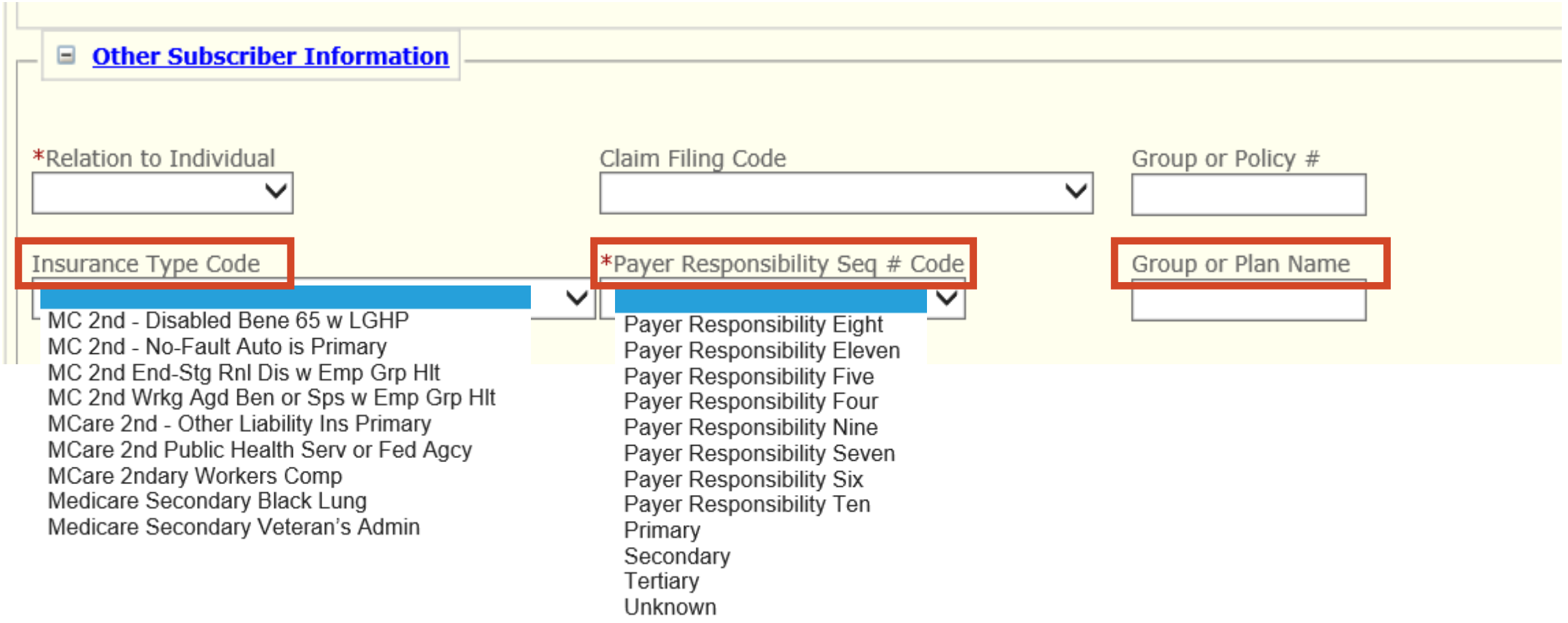
➢ New Other Insurance

- **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



➢ Other Subscriber Information

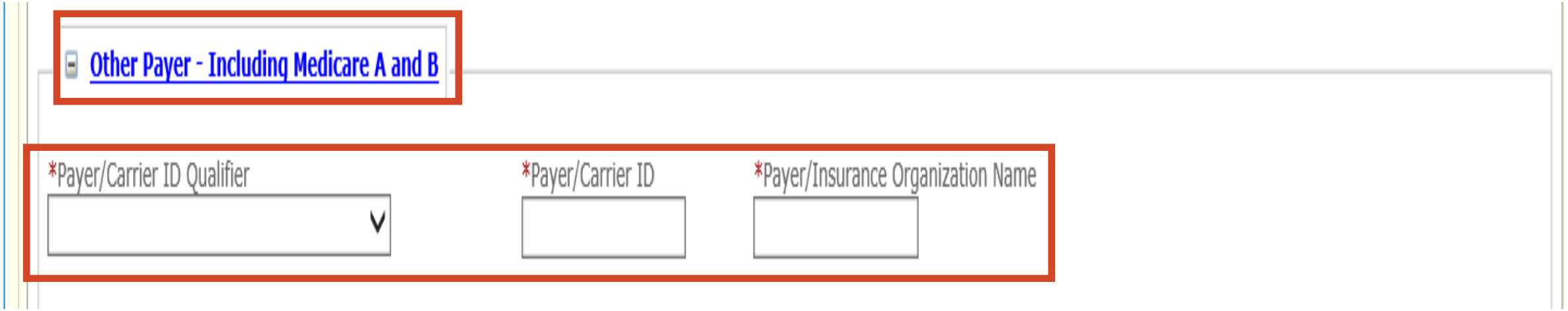
- **REQUIRED**
- Insurance Type Code
- Payer Responsibility Seq # Code
- Group or Plan Name

➢ Other Insurance Coverage

- **REQUIRED**
- Release of Information Code
- Select appropriate value

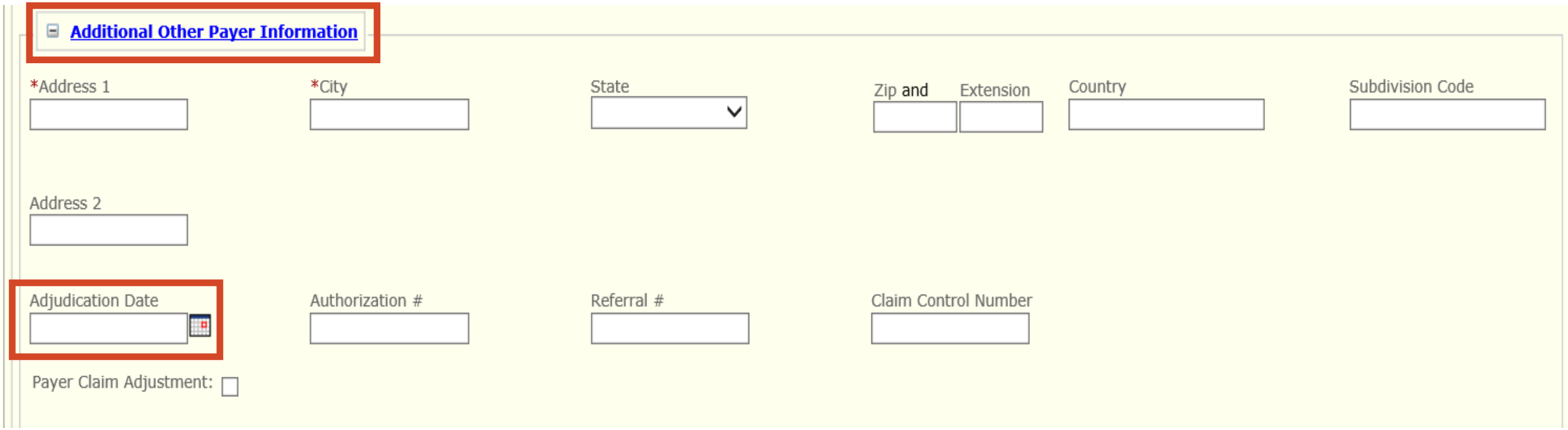
Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

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



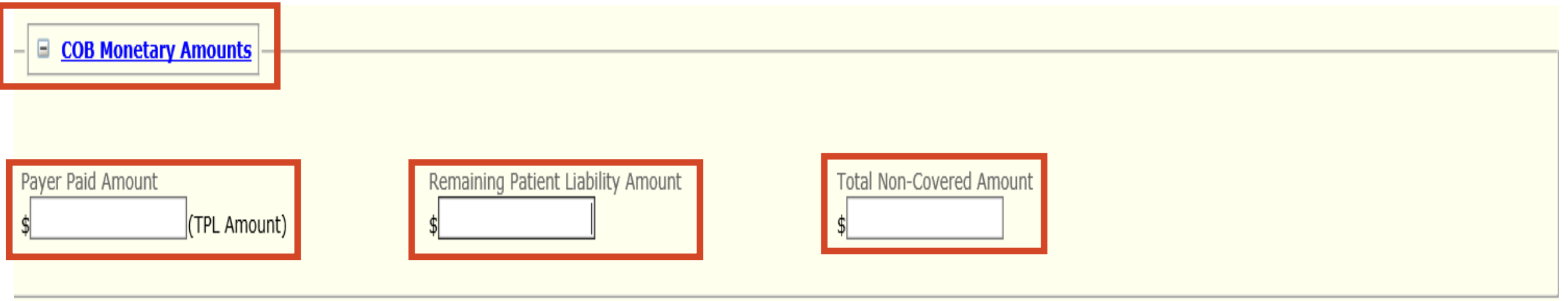
➢ Other Payer – Including Medicare A and B

- Payer/Carrier ID Qualifier – Select Payer Identification
- Payer/Carrier ID – Insurance Payer/Carrier ID number
- Payer/Insurance Organization Name – Insurance Name



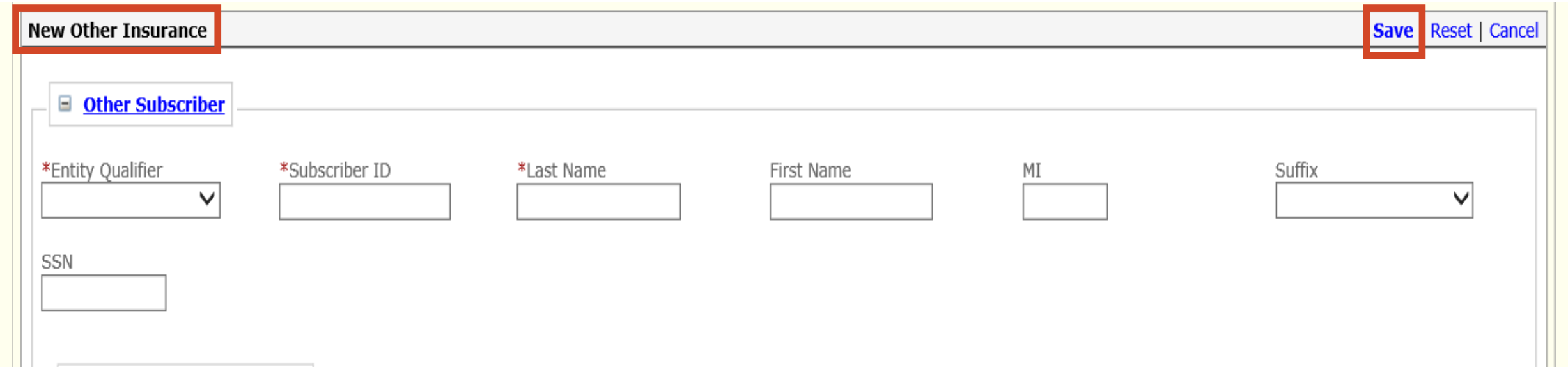
➢ Additional Other Payer Information

- Adjudication Date

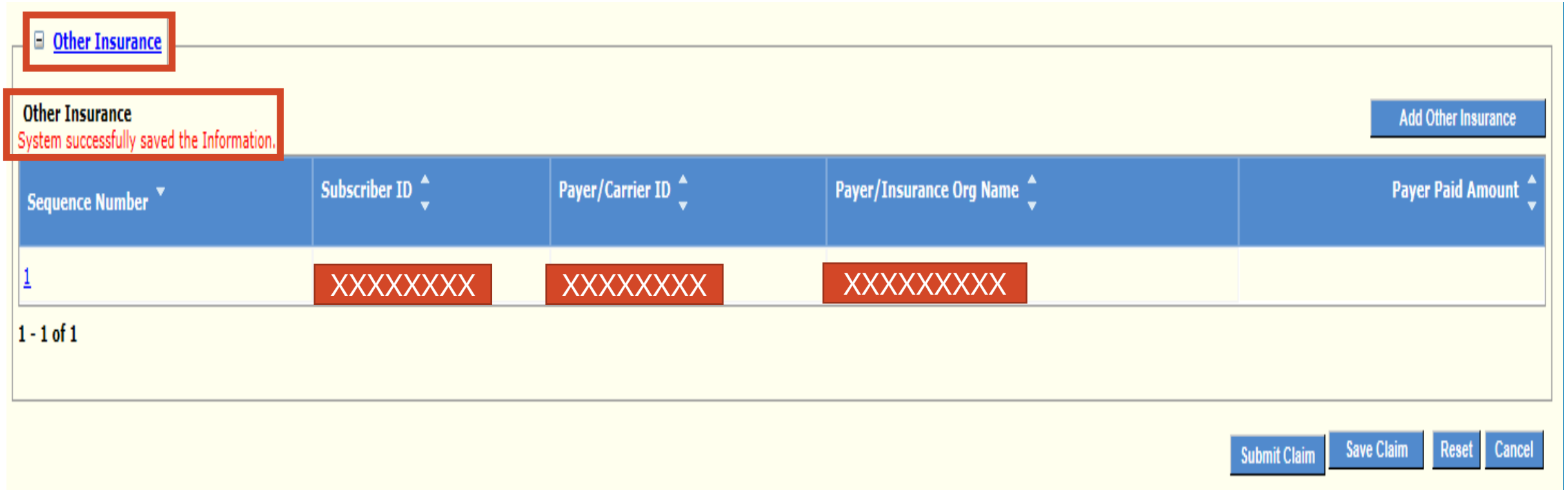


➢ COB Monetary Amounts

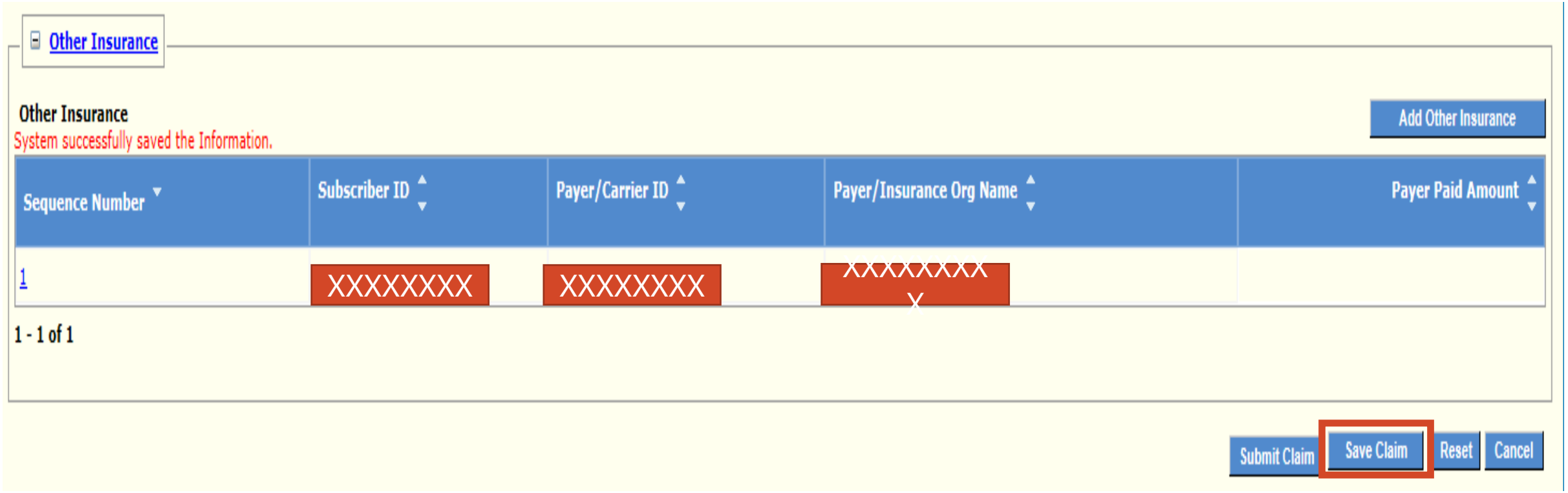
- Payer Paid Amount
- Remaining Patient Liability
- Total Non-Covered Charge Amount



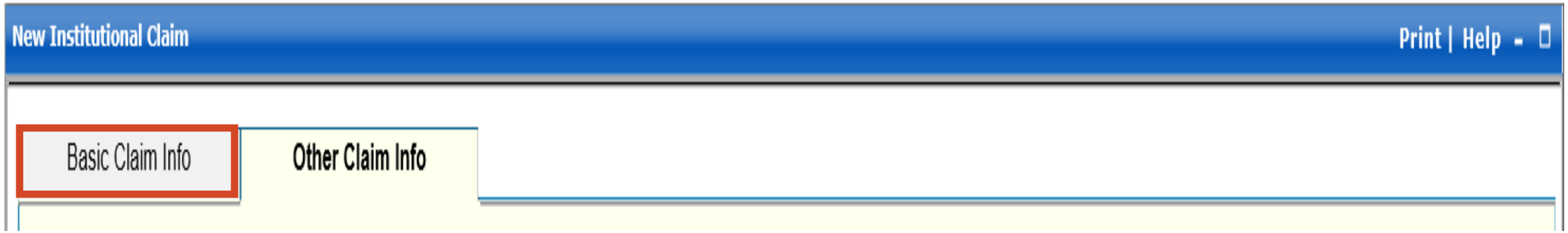
- **New Other Insurance**
  - **REQUIRED**
  - Scroll to the top of New Other Insurance section
- **SAVE**



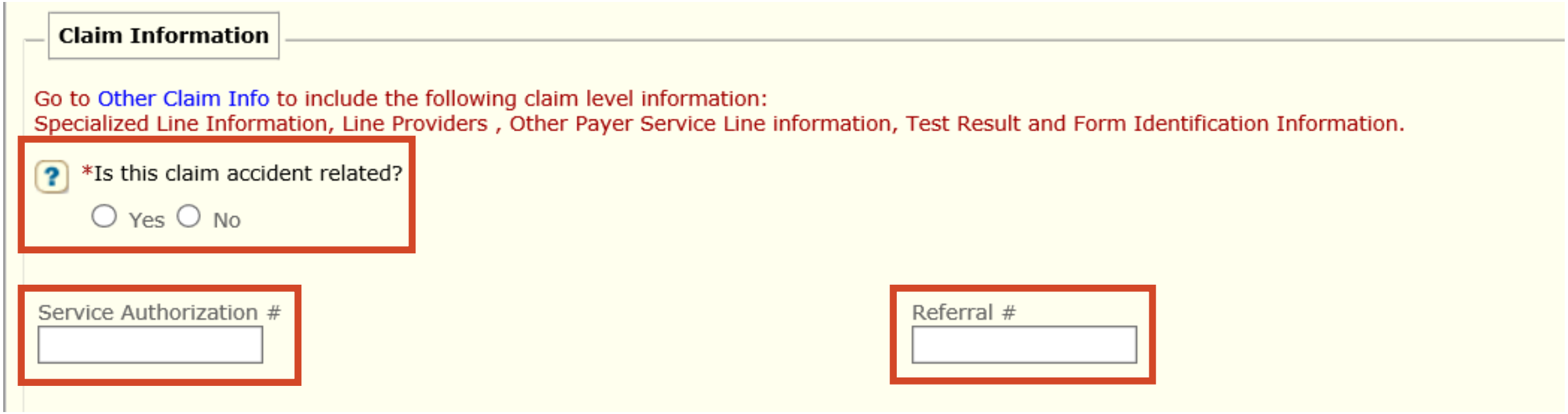
- **System successfully saved the Information**
  - Verify the Insurance was added
  - Sequence Number
  - Subscriber ID
  - Payer/Carrier ID
  - Payer/Insurance Org Name
  - Repeat slides 17 – 25 if member has more than 1 payer


Other Insurance
Other Insurance
System successfully saved the Information.
Add Other Insurance
Sequence Number
Subscriber ID
Payer/Carrier ID
Payer/Insurance Org Name
Payer Paid Amount
1
XXXXXXXX
XXXXXXXX
1 - 1 of 1
Submit Claim
Save Claim
Reset
Cancel

- **Save Claim**

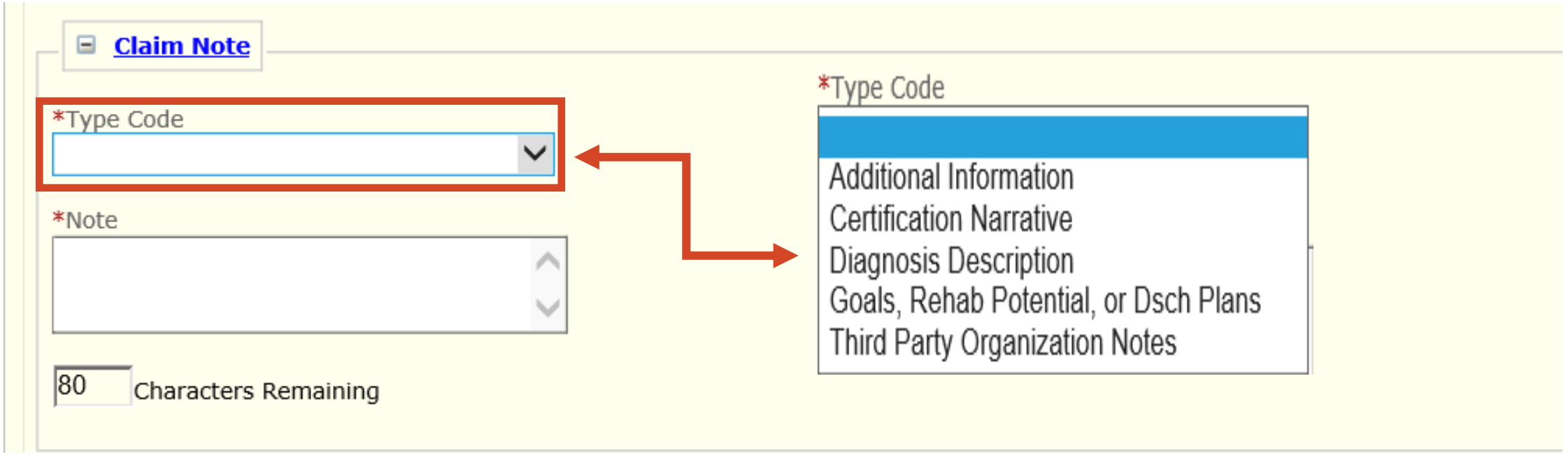


- **Navigate** to the **Basic Claim Info Tab**



➢ Claim Information

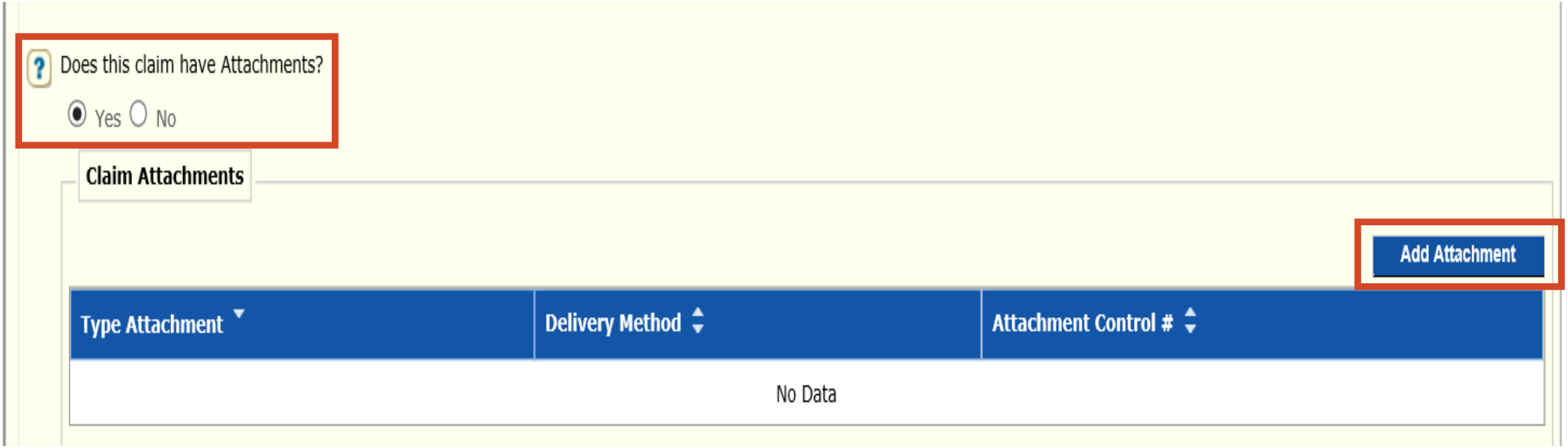
- Is this claim accident related?
  - ✓ Yes or No
- Service Authorization # - if applicable
- Referral # - if applicable



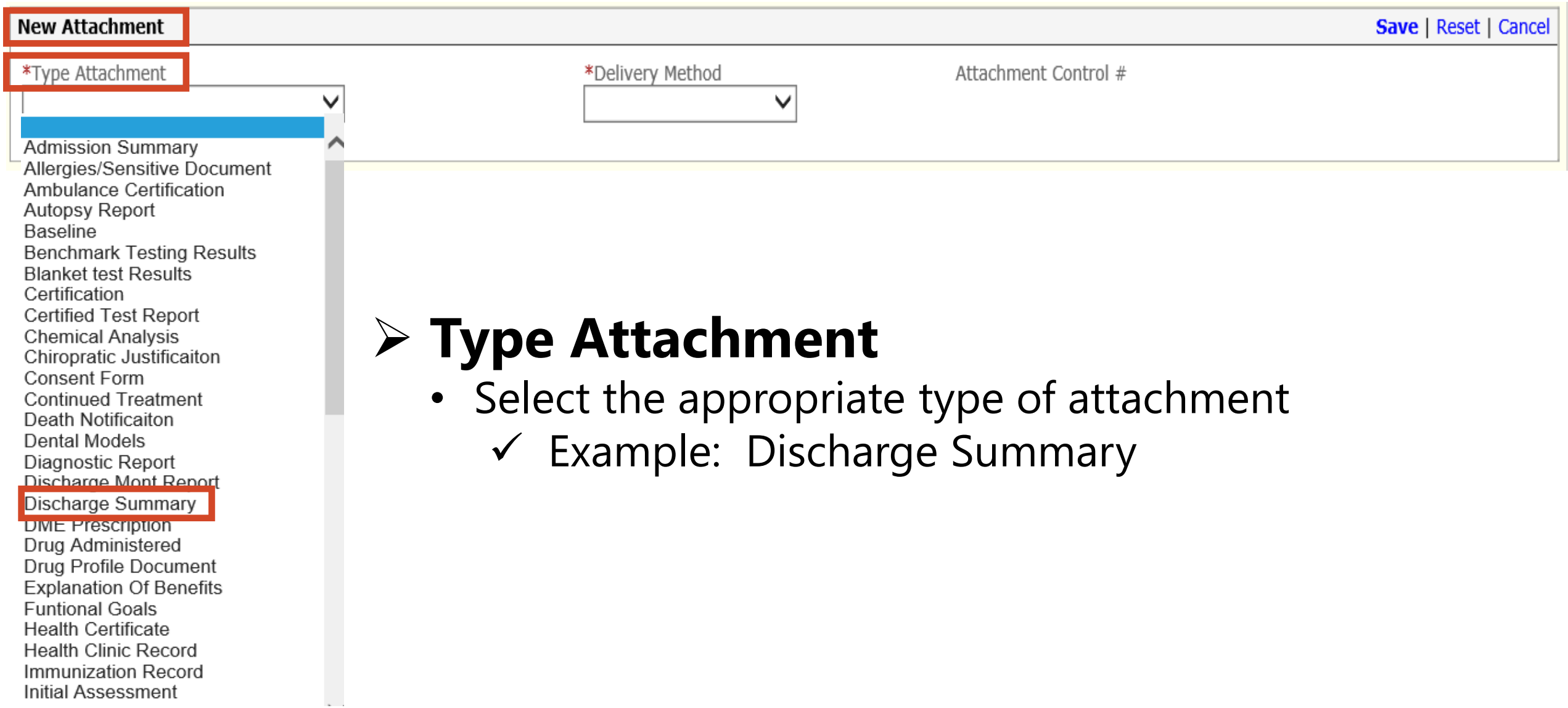
➢ Claim Note

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

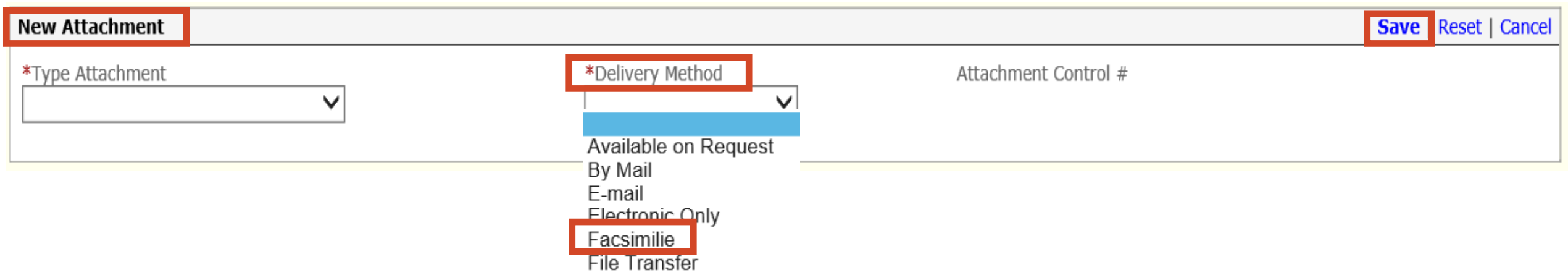
Faxing in an Attachment



- **Does this claim have Attachments?**
  - Yes or No
    - ✓ Yes
    - ✓ Add Attachment



- **Type Attachment**
  - Select the appropriate type of attachment
    - ✓ Example: Discharge Summary



➢ 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

MMIS ATTACHMENT COVER SHEET
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 177 (6-2015)

Clear Fields

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 Medicaid Number
Corresponding Record Number

Type 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

Mail to:

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

Telephone Number: 1-877-328-7098

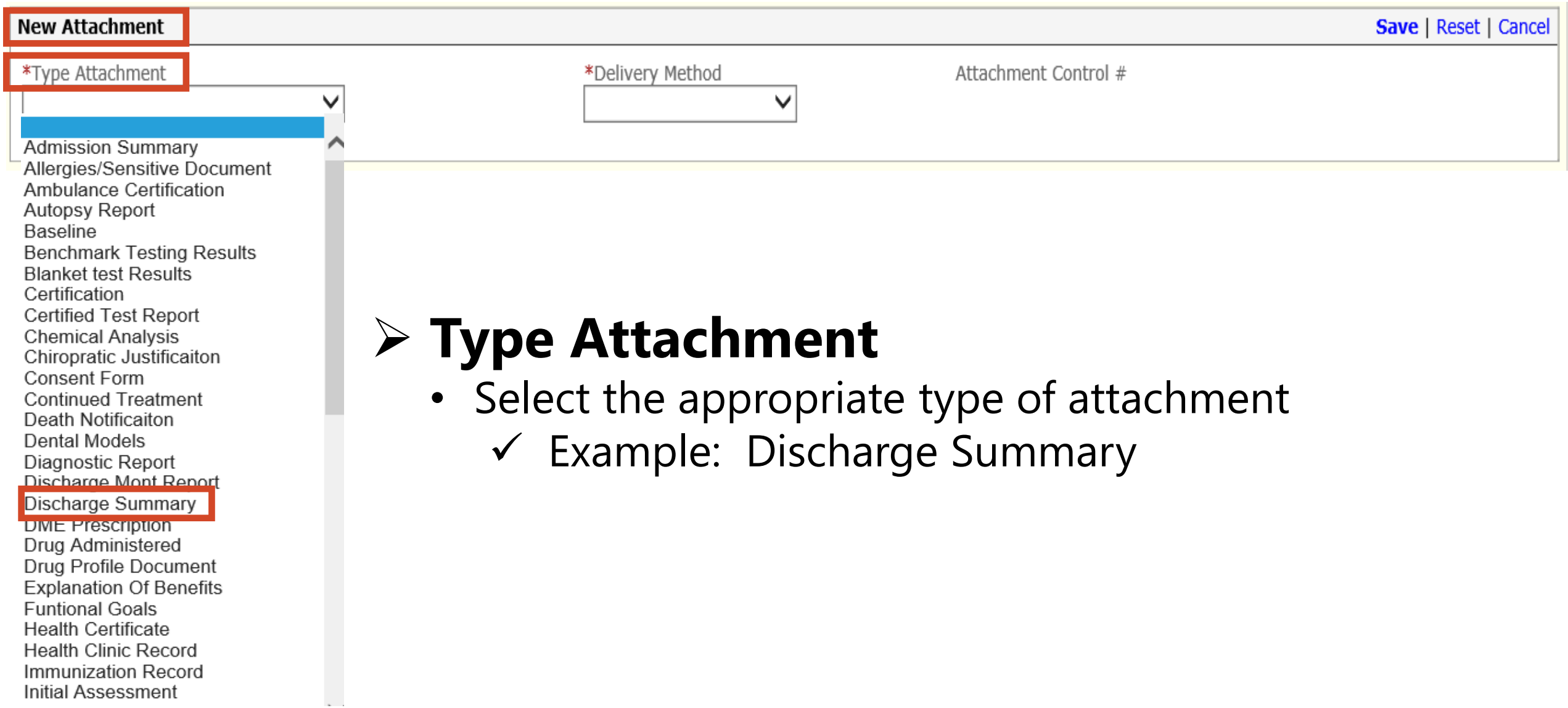
Required

- Provider NPI or Medicaid Number
- Member Medicaid Number

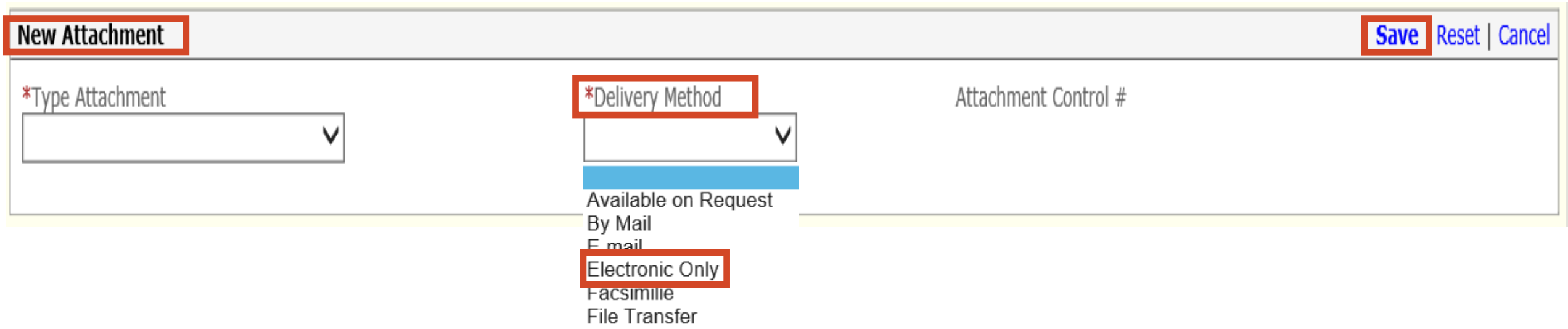
- Type of Attachment – **Select only one**
  - ✓ Claim - Transaction Control Number (TCN)
  - ✓ Service Authorization (SA) – SA Number
  - ✓ Referral – Referral Number
  - ✓ Other - Description

Electronic Only in an e-Attachment

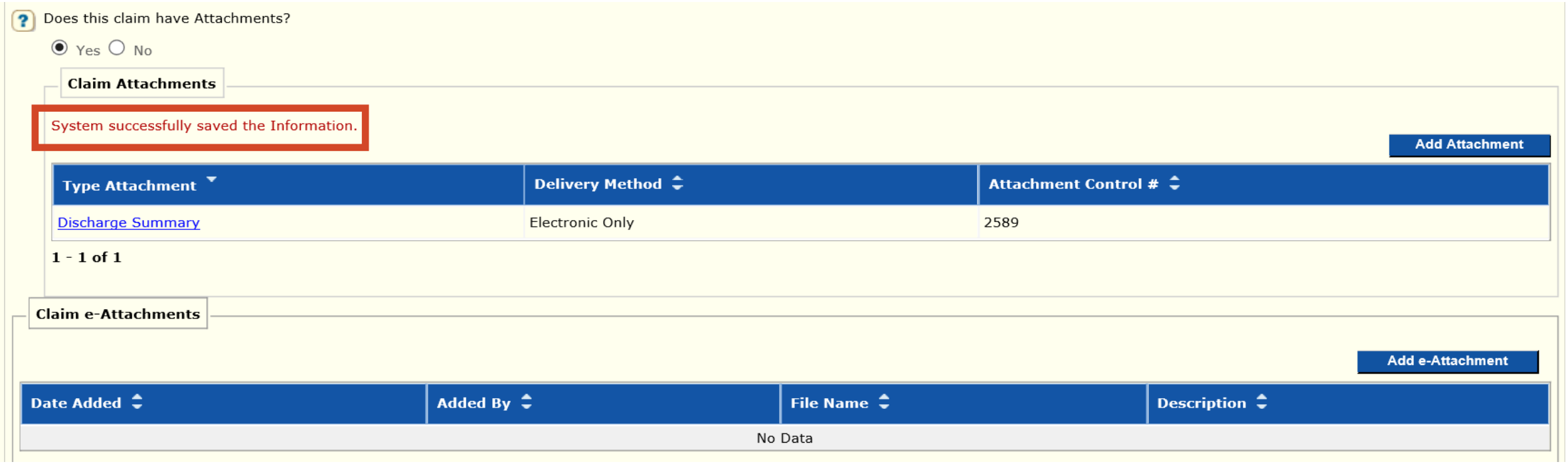
- **Does this claim have Attachments?**
  - Yes or No
    - ✓ Yes
    - ✓ Add Attachment



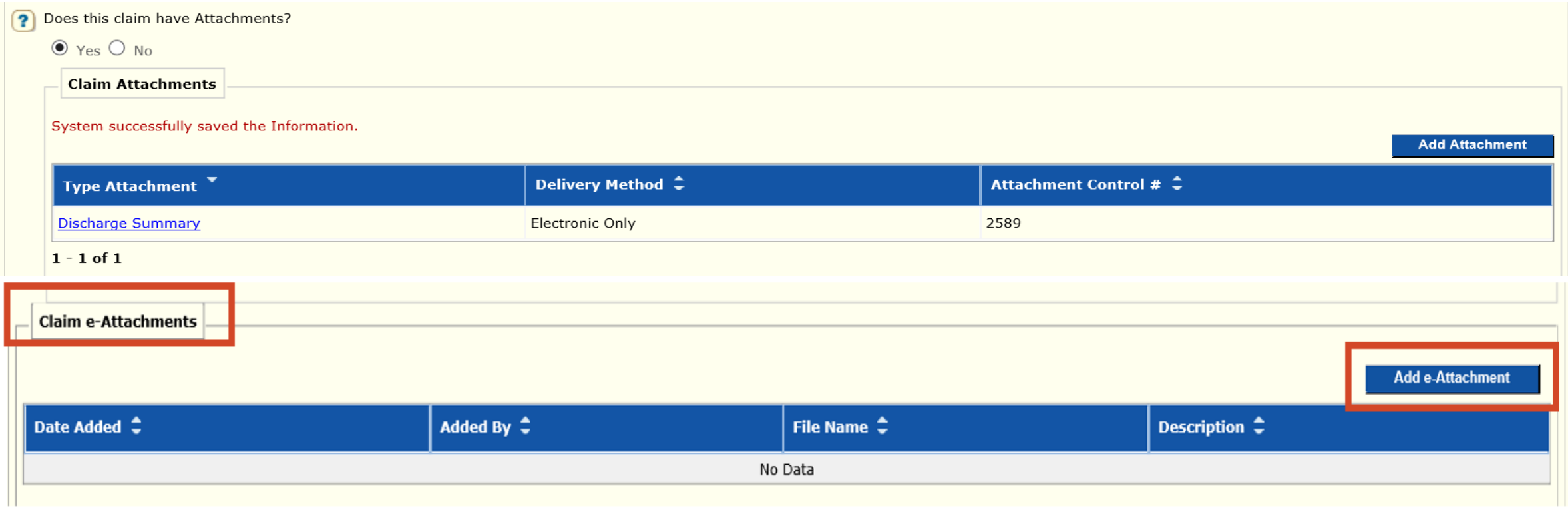
- **Type Attachment**
  - Select the appropriate type of attachment
    - ✓ Example: Discharge Summary



- **Delivery Method**
  - Select the Electronic Only
- **Save**

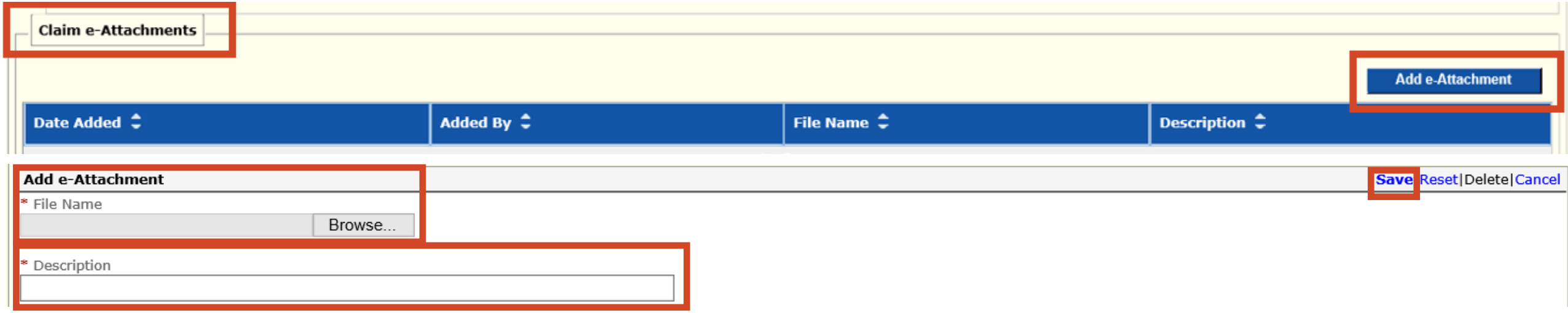


➢ Save – System successfully saved the Information

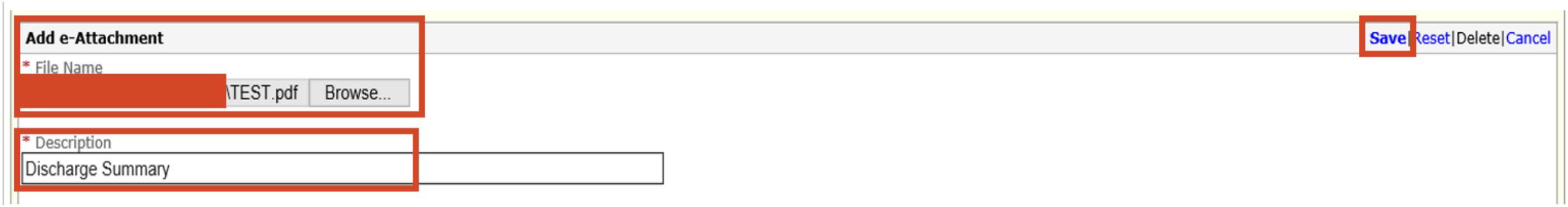


➢ Does this claim have Attachments?

- Yes or No
  - ✓ Yes
  - ✓ 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 !@#$

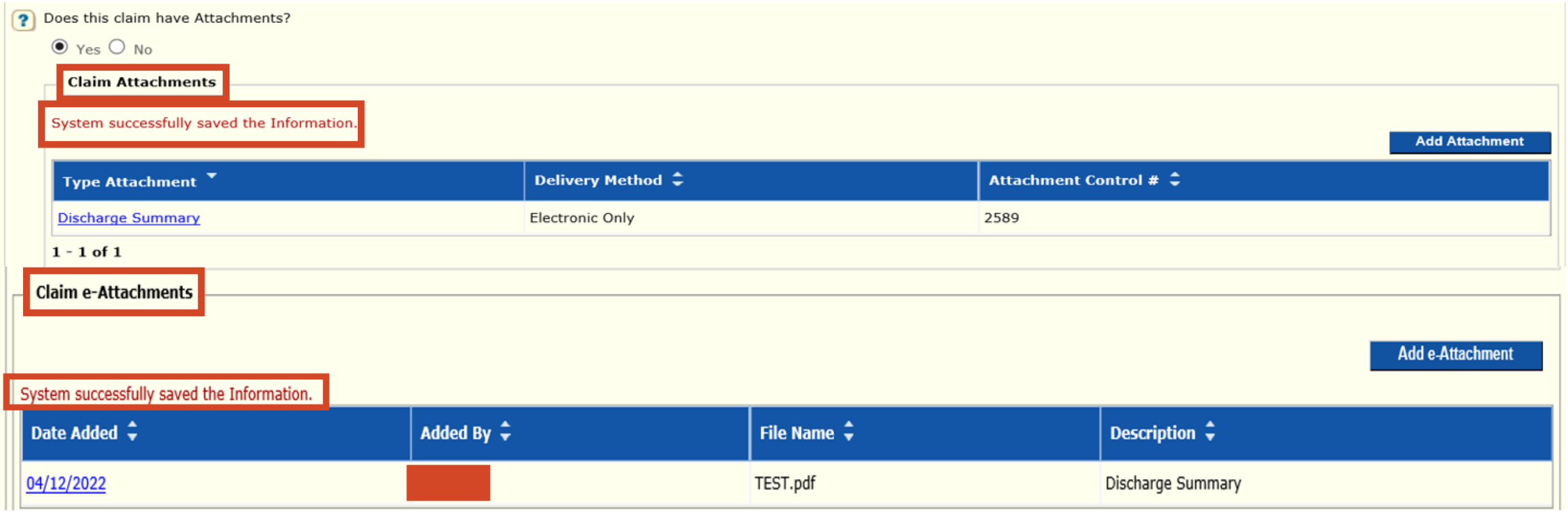
➢ Select Browse

- Insert/select file that is saved to your computer

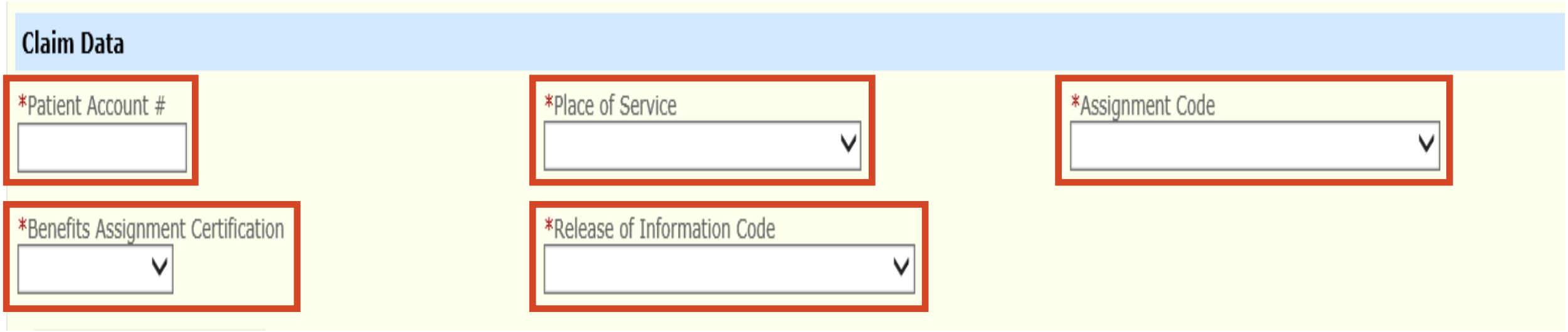
➢ Description

- Content of attachment: example Periodontal Chart

➢ SAVE

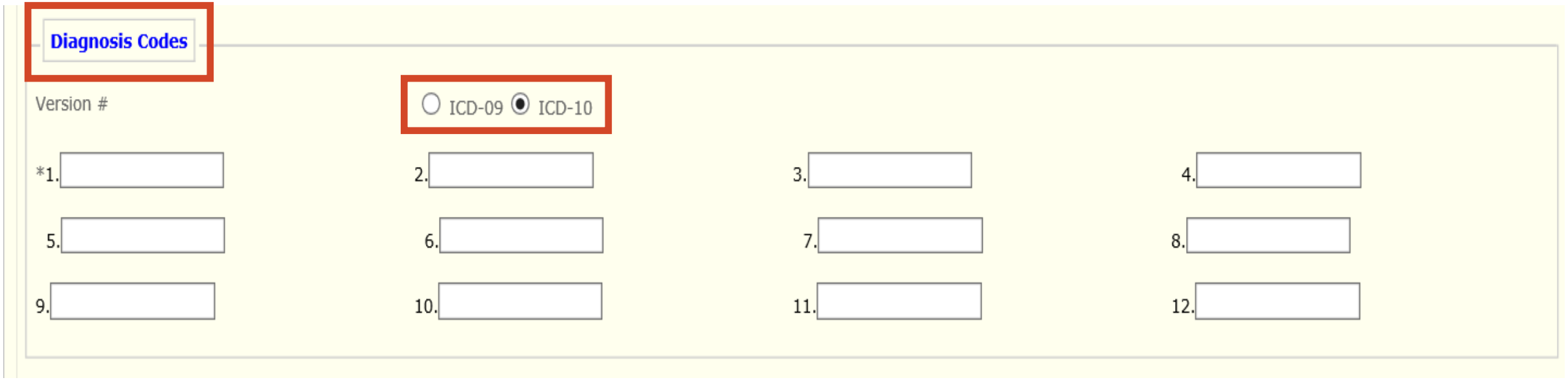


- **Save – System successfully saved the Information**
- **Claim Attachment and Claim e-Attachment must be completed**
- **Note:** If resubmitting/adjusting a claim, all documents need to be attached again.



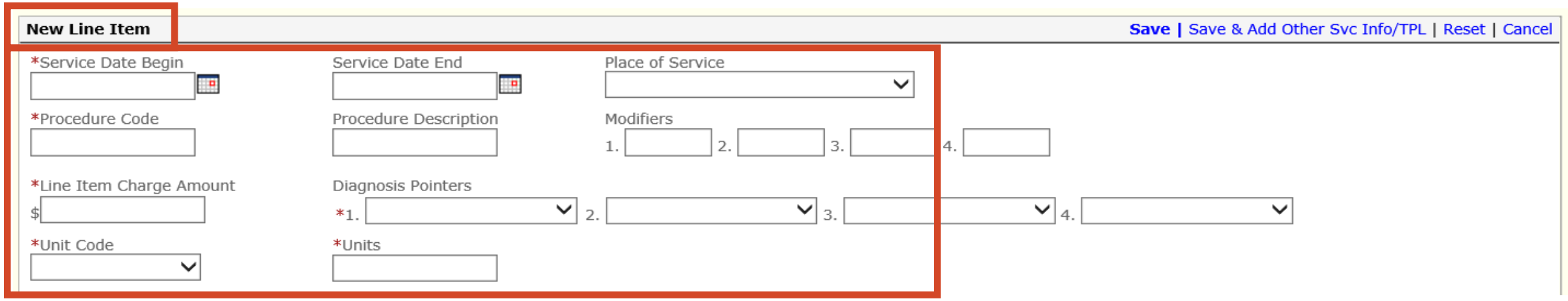
➢ Claim Data

- Patient Account #
- Place of Service
- Assignment Code
- Benefits Assignment Certification
- Release of Information Code

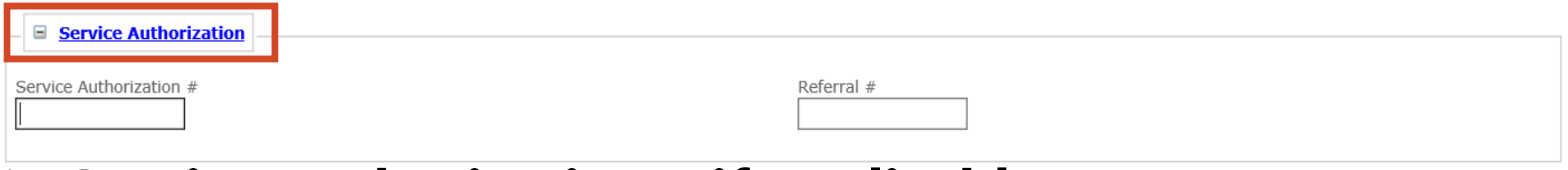


➢ Diagnosis Codes

- **REQUIRED**
- Version # - Defaults to ICD-10 - if Date of Service is older than 10/01/2015 select ICD-09
- Principal Diagnosis Code
  - ✓ Enter the Diagnosis Code for the Member's primary, secondary condition ect.

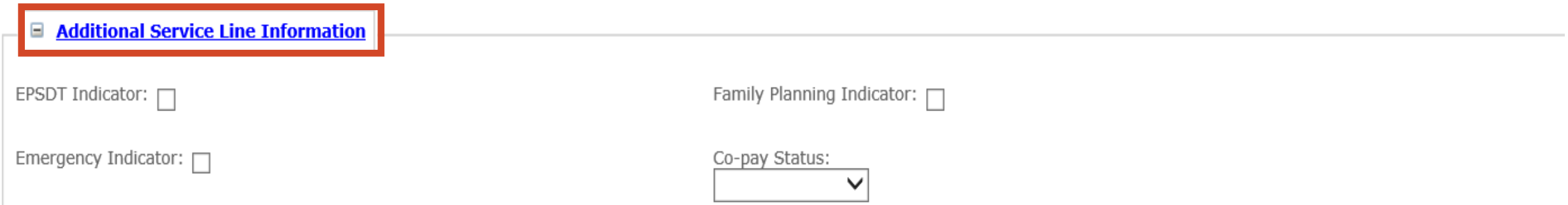


- **New Line Item**
  - Service Date Begin and Service Date End - Use format: MM/DD/YYYY
  - Place of Service
  - Procedure Code
  - Modifiers – if applicable
  - Line Item Charge Amount
  - Diagnosis Pointers – Primary, Secondary ect.
  - Unit Code and Units



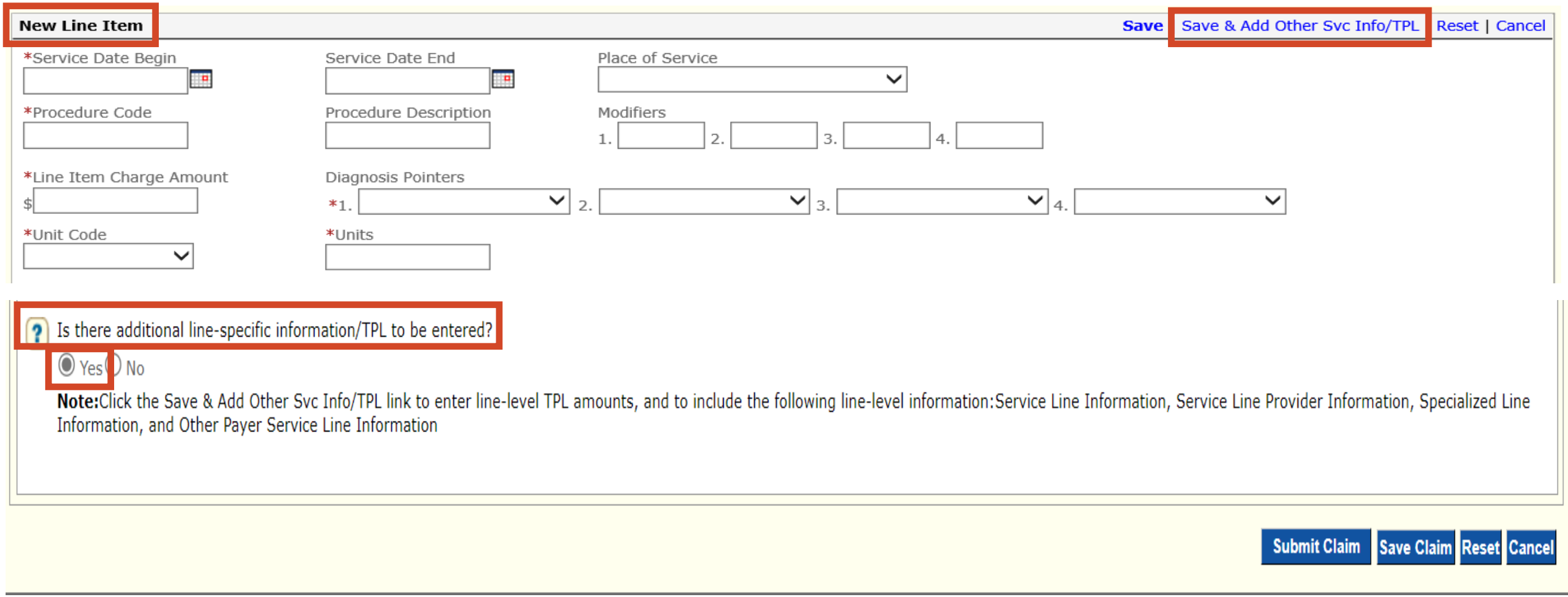
➢ Service Authorization – if applicable

- Service Authorization #
- Referral # - if applicable

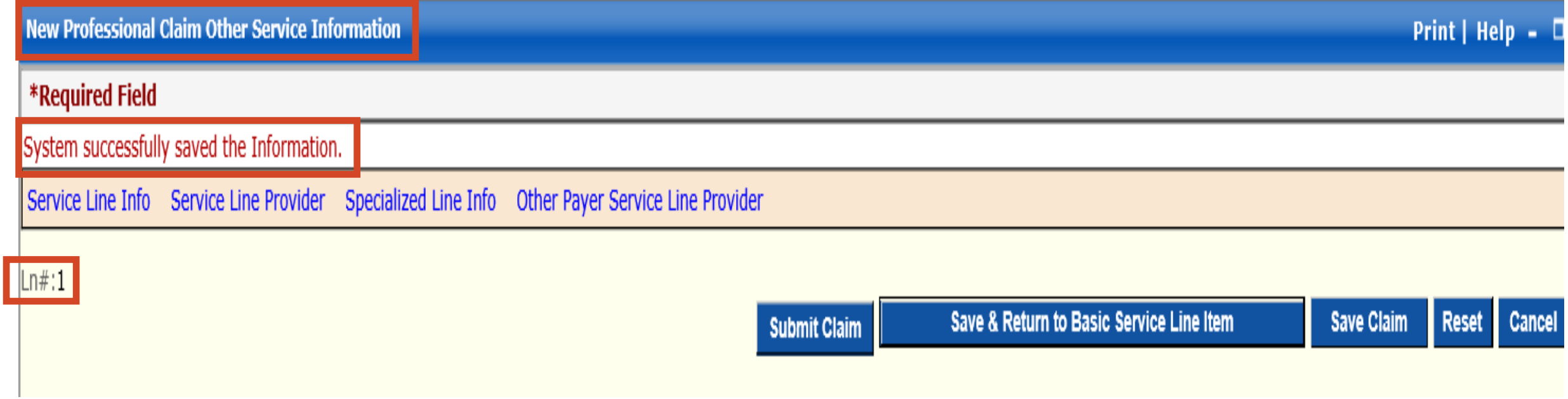


➢ Additional Service Line Information – if applicable

- EPSDT Indicator
- Family Planning Indicator
- Emergency Indicator
- Co-pay Status

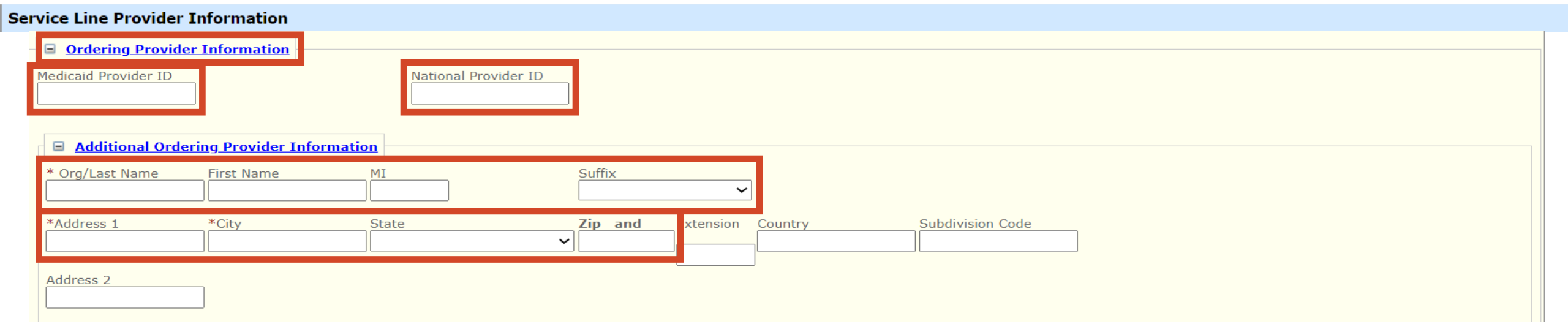


- **Is there Additional line-specific information/TPL to be entered?**
  - **Yes** – Enter **Ordering Provider** – repeat on each line entered
  - **Save & Add Other Svc Info/TPL**



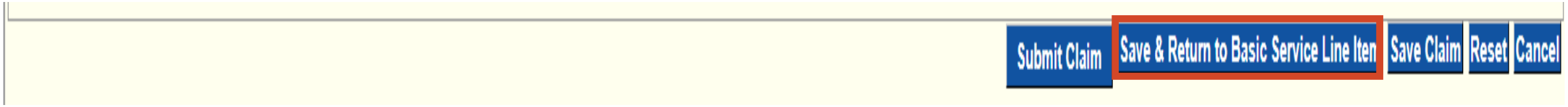
➢ New Professional Claim Other Service Information

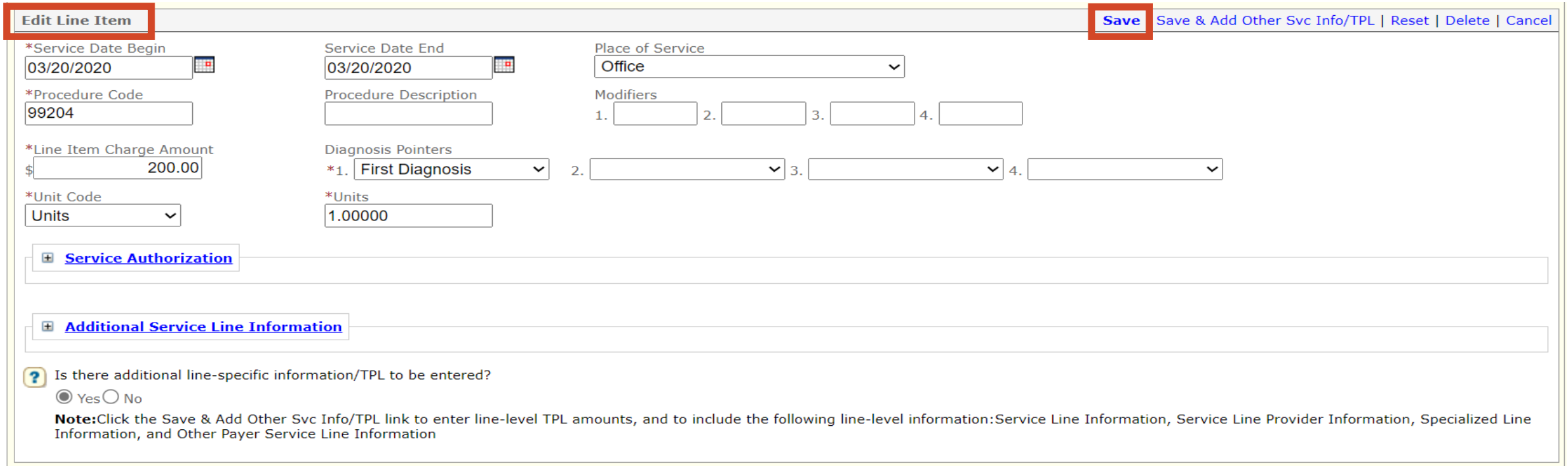
- System successfully saved the Information
  - ✓ **Line # 1**



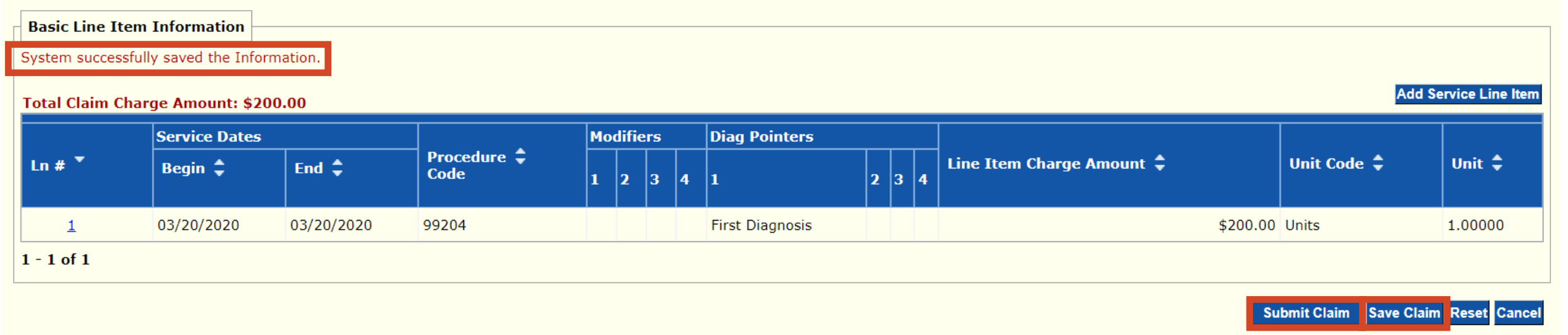
- **Ordering Provider Information – Repeat on each line**
  - **Scroll down to Service Line Provider Information**
  - Medicaid Provider ID
  - National Provider ID
  - Org/Last Name, First Name
  - MI and Suffix – if applicable
  - Address, City, State and Zip Code

- **Does the member have Other Insurance**
  - **No –** Member **does not** have Other Insurance
  - **Save & Return to Basic Service Line Item**





- **Edit Line Item**
  - **Save**



- **Basic Line Item Information**
  - **System successfully saved the Information**
  - **Save Claim**
  - **Submit Claim**

Claim Submitted

Print Help

TCN: [redacted]

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

Claim Information

TCN: [redacted]
Date of Service: 03/20/2020 - 03/20/2020
Provider #: [redacted]
Member ID: [redacted]

Claim Status: C - To Be Dnd
Total Charge: $200.00
*To Be Paid Amount: $0.00
*Co-Payment: $0.00
*Total Recipient Liability: $0.00
Submission Date/Time: Tue Mar 24 11:28:05 CDT 2020

*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	204	This service/equipment/drug is not covered under the patient?s current benefit plan
1	A1	Claim/Service denied. 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.)
1	26	Expenses incurred prior to coverage.
1	27	Expenses incurred after coverage terminated.

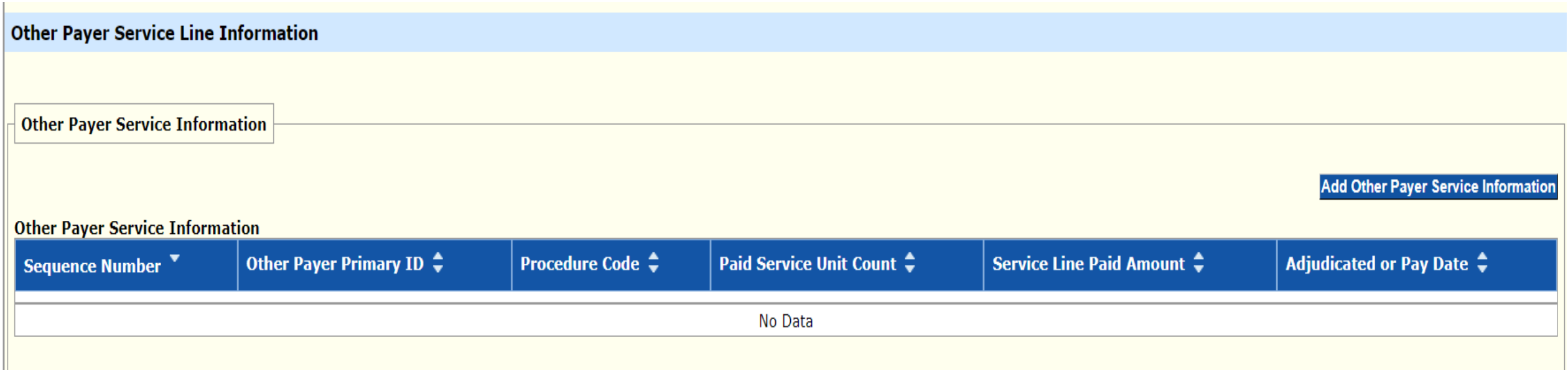
1 - 4 of 4

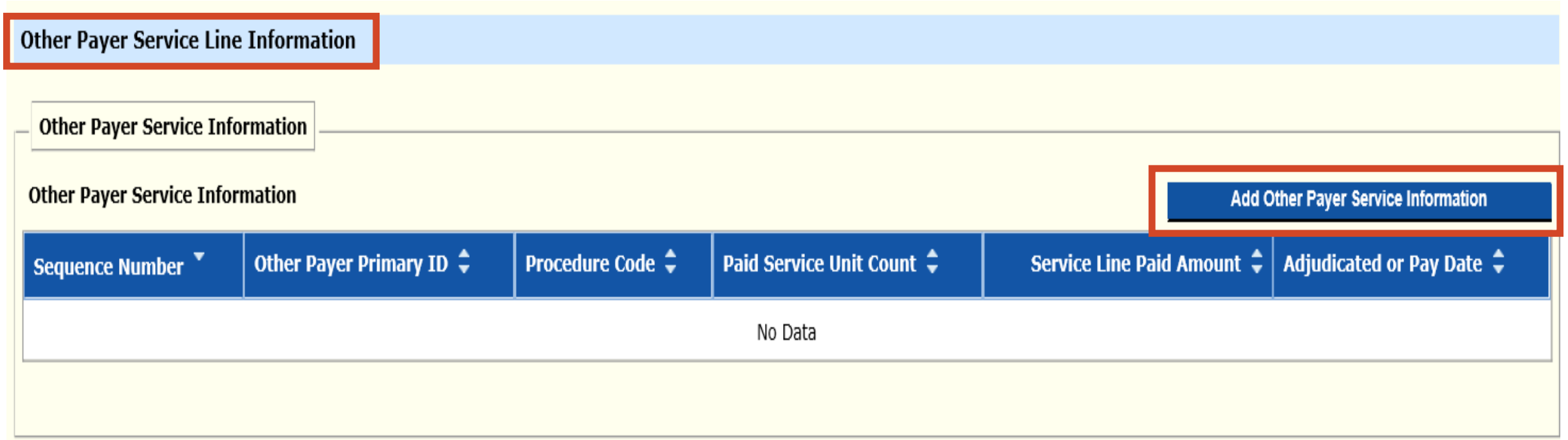
Remark Codes

Line #	Remark Code	Description
No Data		

- **Print and Save for your records**

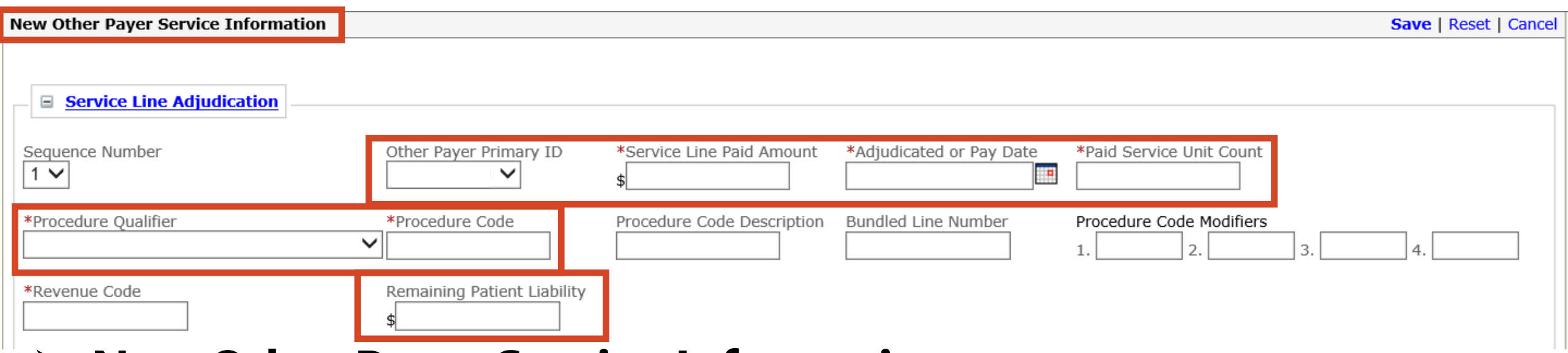
- **Does the member have Other Insurance– Repeat on each line**
  - **Yes** – Member has **Other Insurance** – proceed to **Slide 55** for instructions
  - Scroll down to **Other Payer Service Line Information**





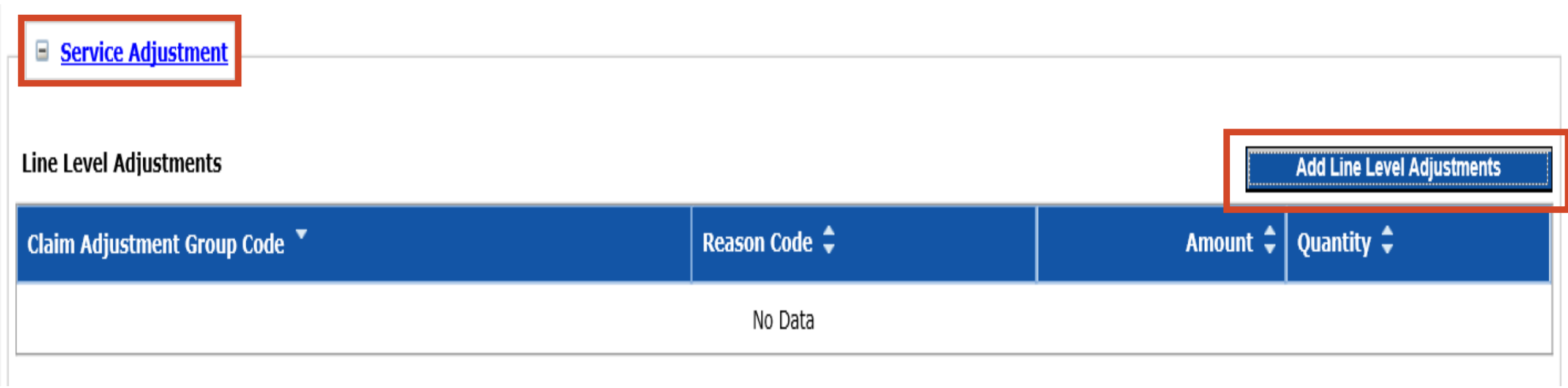
➢ Other Payer Service Line Information

- Add Other Payer Service Information



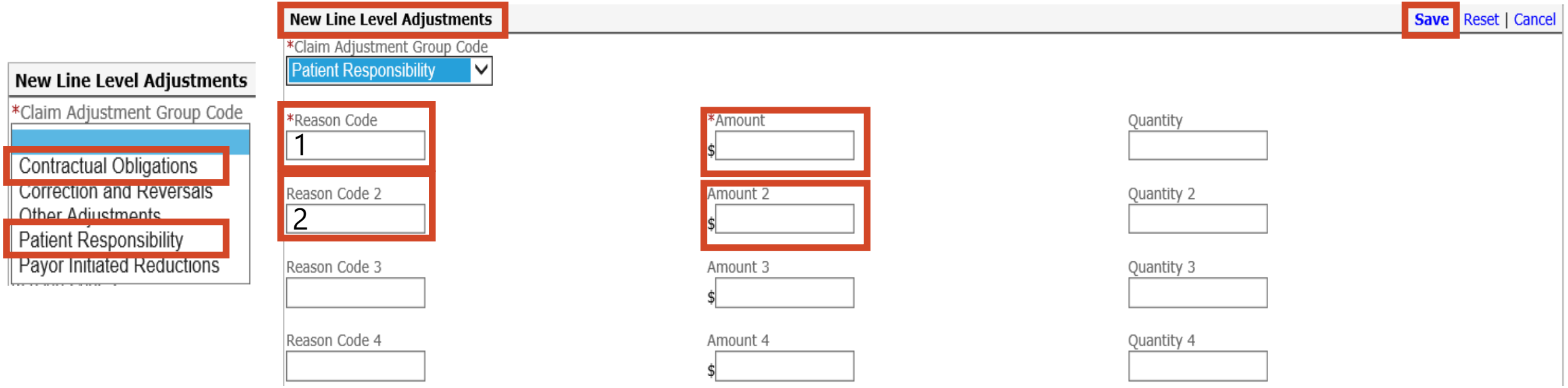
➢ New Other Payer Service Information

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



➢ Service Adjustment

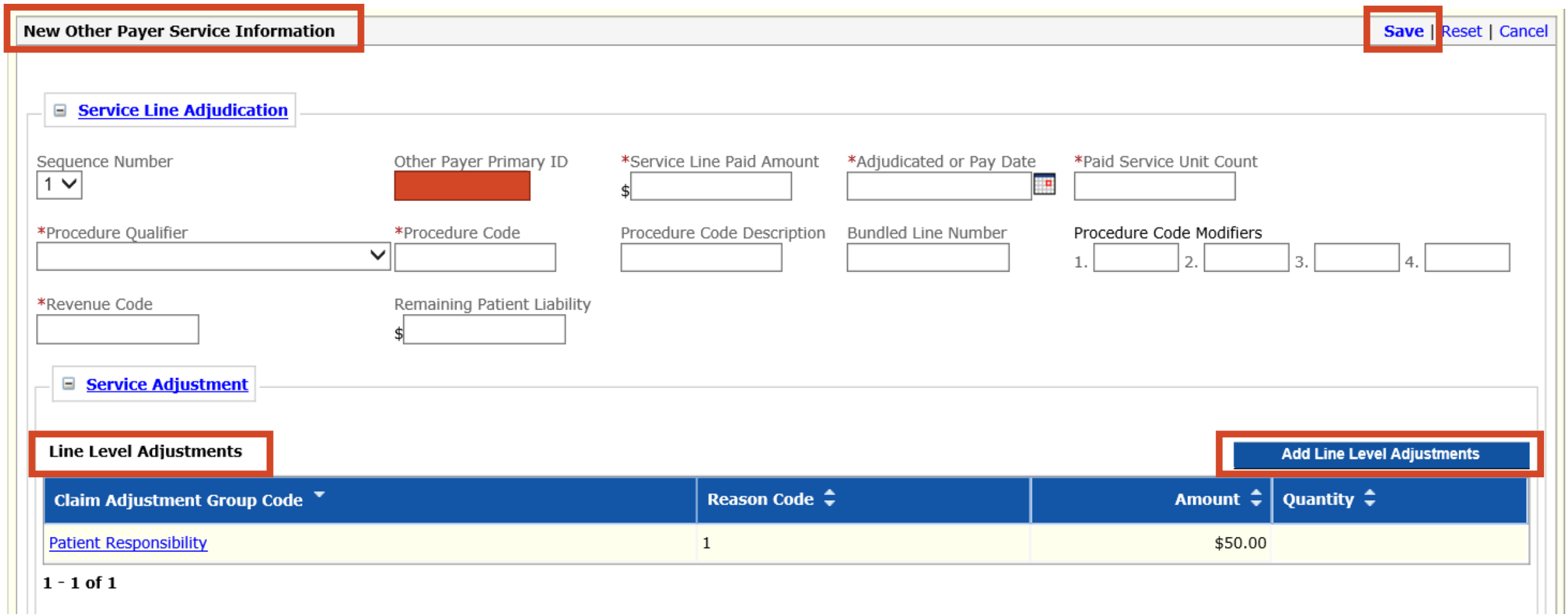
- Add line Level Adjustments



➢ New Line Level Adjustments

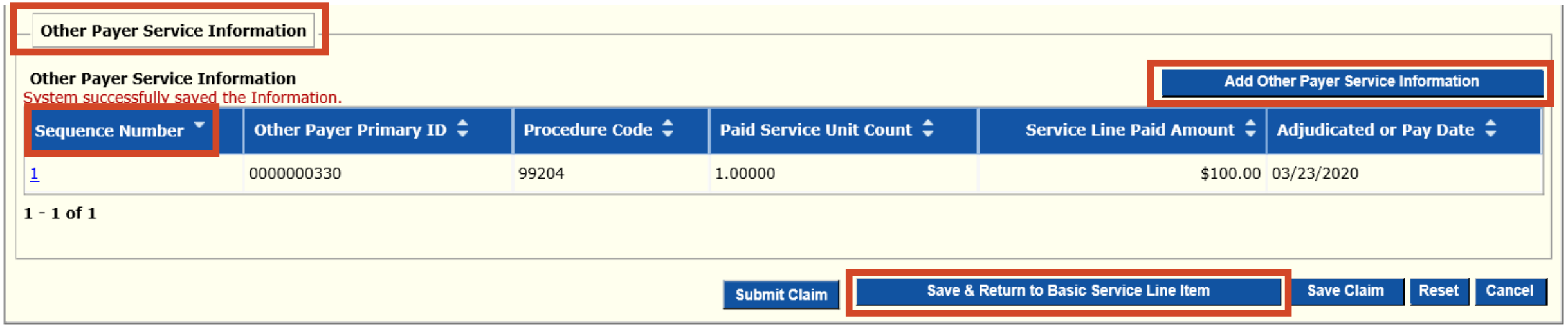
- Claim Adjustment Group Code – Patient Responsibility or Contractual Obligation
  - ✓ Only 1 Claim Adjustment Group Code may be selected at a time

- Reason Code and Amount - **(Do Not enter PR or CO in front of Reason Code)**
  - ✓ **Patient Responsibility** – up to 4 Reason Codes per detail line - **Save**
  - ✓ **Contractual Obligations** – up to 4 Reason Codes per detail line - **Save**

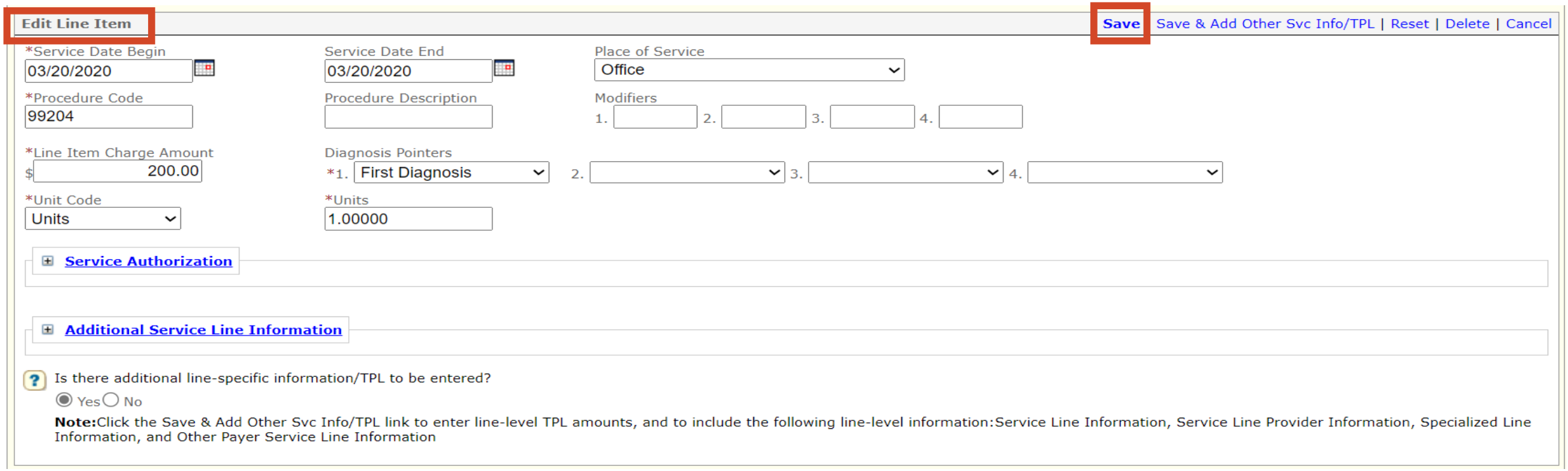


➢ New Other Payer Service Information

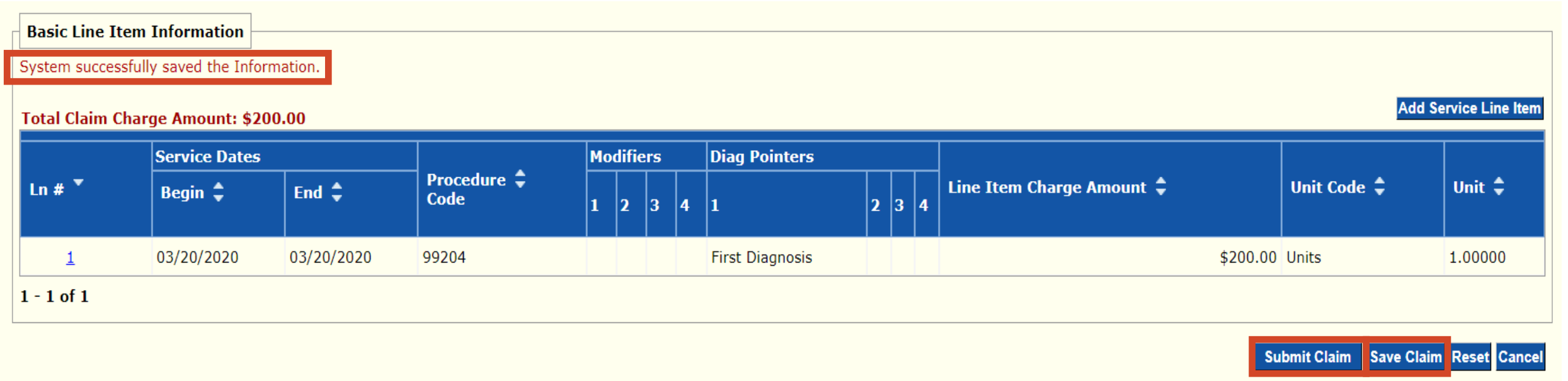
- Additional Adjustments - Add Line Level Adjustments – if applicable
- Verify Line Level Adjustments
- **Save**



- **If the member has 2 Insurance Policies**
  - **Add Other Payer Service Information**
    - ✓ Complete a 2nd Sequence Number – Repeat slides 55 – 59
    - ✓ Primary is Sequence Number #1
    - ✓ Secondary is Sequence Number #2
- **If the member has 1 insurance**
- **Save & Return to Basic Service Line Item**



- **Edit Line Item**
  - **Save**



- **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**

Claim Submitted

Print Help

TCN: [redacted]

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

Claim Information

TCN: [redacted]
Date of Service: 03/20/2020 - 03/20/2020
Provider #: [redacted]
Member ID: [redacted]

Claim Status: C - To Be Dnd
Total Charge: $200.00
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1 - 4 of 4

Remark Codes

Line #	Remark Code	Description
No Data		

- **Print and Save for your records**