Montana Healthcare Programs Provider Claim Entry Solution Training

Q: What is MPATH?

A: MPATH stands for the Montana Program for Automating and Transforming Healthcare. MPATH is the Department of Public Health and Human Services initiative to modernize all of the computer systems and services that support the administration of Montana Healthcare Programs including Medicaid and Developmental Disability Services.

Q: What is the MPATH Provider Services claim entry solution?

A: The Department contracted with OptumInsight to implement a new Provider Services solution that will include provider enrollment, revalidation, and maintenance. In addition, it will include enhanced web portal capabilities such as provider claim entry, checking member eligibility, and viewing remittance advices. The Provider Claims Entry solution is the Department's first component implementation of Provider Services module. The Department expects to implement additional Provider Service module components near the end of 2019.

Q: How can I find out more information about claim billing?

A: There will be a training session on claim billing in the coming weeks, check the DDP MMIS Transition page https://dphhs.mt.gov/dsd/developmentaldisabilities/mmistransition website by Friday, July 19, 2019 for details. Also, the following URL has additional provider training resources: https://medicaidprovider.mt.gov/training

Q: Are there handouts that we can print out for this presentation?

A: A copy of the presentation will be posted on the medicaidprovider.mt.gov website by Friday July 19, 2019. Click the link below for the location where the presentation will be posted:

https://medicaidprovider.mt.gov/82

Q: What is the link or where do we go to get to the sign in page for the Optum program,

A: On August 5th, a link for the MPATH Provider Claims Entry Tool will be posted on the medicaidprovider.mt.gov website.

Q: When will the live system be available to start billing?

A: The link is not currently available. The website will be available for registration and billing starting on August 5th at 8:00am.

Q: What is the provider website?

A: The Provider website provides comprehensive resource information for Montana Healthcare Programs Providers. The Provider website contains Resources by provider type (Manuals, notices, and fee schedules), the Claim Jumper newsletter, Provider Notices, upcoming training events and historical training information, and claims/billing information. The Provider website can be located at: http://www.medicaidprovider.mt.gov

Q: Where do we find our consumer's member ID?

A: The consumers member ID can be found on the member's Montana Access to Health ID card. The member ID is also included in the Prior Authorization notification letter.

Q: Do I need to submit a claim line for every day or one claim for the month with 30 units?

A: The Provider can decide their preferred method of billing. A claim can be built using span billing (i.e. to submit one claim line with "To" date span with the appropriate number of units for the time period) or you can create a discrete claim line for each day with the appropriate number of units for each day.

Q: Where do we get the diagnosis codes?

A: In healthcare, diagnosis codes are used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for a patient encounters with healthcare services. Diagnostic coding is the translation of written descriptions of diseases, illnesses and injuries into codes from a particular classification.

All standardized healthcare claims have required fields that must be included on the claim in order for billed services to be paid. Diagnosis codes are one of those required fields. For the new DDP claims processing requirements, providers must determine a diagnosis code that best describes the patient's condition, reason or need for the service being rendered. The selection of the diagnosis code comes from documentation found typically in the member's medical record but can also be found in assessments or plans of care or provider referrals and so forth. Classifying statements found within the member's medical record, assessments, or plans of care may describe the member's primary condition in the following terms: Autism Disorder, Borderline Personality Disorder, Schizoaffective Disorder, Other Conduct Disorders. These terms are used to identify a diagnosis code to be placed on the claim, which is a required field.

The diagnosis code can be found in the International Classification of Diseases, 10th Revision book. This book contains the description of the condition (reason or need for the services being rendered) with its corresponding ICD-10 diagnosis code. This coding book is updated annually to incorporate new, revised and deleted codes. Providers can order this book through a vendor or they can get a complete list of the codes on the Centers for Medicare and Medicaid Services (CMS) website: https://www.cms.gov/Medicare/Coding/ICD10/index.html

This site contains the current and past ICD codes sets as well as Frequently Asked Questions (FAQs), tips and tools. The current ICD-10 code set,*2019 ICD-10-CM*, is effective for dates-of-service October 1, 2018 – September 30, 2019. For services provided beginning October 1, 2019-September 30, 2020, providers can use the 2020 ICD-10-CM.

As previously mentioned, the diagnosis is statement describing the patient's condition. Reviewing the documentation on hand or making an inquiry to a referring provider, case manager, etc. is necessary to determine the diagnosis; the Fiscal Agent, aka Conduent, will not be able to make that determination. Chapters 5, *Mental, Behavioral and Neurodevelopmental disorders (F01 – F99),* of the ICD-10 manual will contain the diagnosis codes most relevant to the DDP population. If a condition is not stated or cannot be determined a non-specific code from this chapter may be appropriate, such as Unspecified Intellectual Disabilities, codes F71 – F79. Codes in this range should only be used if there is no other documentation that supports the use of a different diagnosis.

Q: Where can we find which POS (Place of Service) codes are valid for the DDP services provided, or can we always use 99?

A: A list of the available codes for place of service will be posted to the Department's Developmental Disabilities Program website at the following link: https://medicaidprovider.mt.gov/82

Q: What is a Carrier Name and Carrier Code and where do we find these?

A: Carrier Name is the name of the member's primary insurance payer (e.g. Blue Cross Blue Shield, Cigna). This information can be found on the Explanation of Benefits provided after the primary insurance has paid on your members services. The Carrier Code is not required.

Q: Will our Prior Authorizations include Medicaid numbers, diagnosis codes and CPT codes?

A: The Prior Authorizations will include the member number, the CPT codes authorized for your member, the dates that the authorization is approved for as well as approved units. Diagnosis codes will not appear on the Prior Authorization.

Q: Can we create these templates prior to the first of August?

A: No, the website will be available for providers to create templates and begin billing on August 5, 2019.

Q: Do we have to create a Template for each type of service we provide for the person or can we add all the services to one template?

A: Templates can be developed based on the provider's preference. One approach is to set up templates with reoccurring services for the same member. This approach allows providers to reduce the amount of member information updated for each claim submission. A limited set of information would require review and entry including; dates of service, units (if variable for the service) and validation of the prior authorization number). Templates can also be set up for specific services without member information. This approach allows providers who provide a standard set of services to a number of members to reduce the number of templates that need to be created for billing. Providers can develop templates that include the services they will bill regularly, when submitting claims, the information requiring update would be member specific, e.g., member ID and demographics, member diagnosis code, prior authorization number, dates of service, and units of service. There are advantages to either approach and providers are encouraged to select the approach that is most efficient for their circumstances.

Q: Since most of my consumers/patients have the same services/diagnosis codes each month, can I create a template that saves the service and each line under it for the consumers/patients? Or if I set the template by service, do I need to enter the consumer/patient each time?

A: Providers can set up the templates based on their preference, while being sure that the appropriate information is updated depending on your template set up such as updating the member for the claim and dates of service.

Q: When can we expect to start getting the prior authorizations in the mail from Conduent?

A: Once the prior authorizations are sent to the claims processing system, a letter is generated and will be mailed. The letters are expected to be sent to providers by the end of July. If you haven't received your letter by August 2, 2019, please contact Provider Relations at 1-800-624-3958.

Q: We have only a couple of days to load about 132 client templates before we can bill?

A: There are no time constraints on the provider for setting up the templates. Taking the time to setup the templates in the early August should improve your billing efficiency in the future. If the provider submits the claim for each template after the template is created, the claim will be submitted and processed during the next payment cycle of the claims processing system.

Q: How many templates can each provider have?

A: On August 5th, providers will have the ability to save up to 200 claim templates. By early October, the number of claim templates per provider will be increased from 200 to 500 claim templates.

Q: If an error is made on an initial claim, how we rebill or resubmit a correct claim?

A: If the claim was submitted in error and the claim was either paid or partially paid, the provider must submit a claim adjustment request using the claim adjustment for found on the following location on the Provider website: https://medicaidprovider.mt.gov/Portals/68/docs/forms/adjustmentrequestindividual12192017.pdf

If the claim that was submitted in error was denied, the provider can submit a new claim with the corrected information using one of their templates claims submission tool. Future enhancements to the claims submission tool will allow the provider to submit claim adjustments online. The Department will post notices to providers when this functionality is available.

Q: Where are the prior authorization letters being mailed, to the client or the provider?

A: The prior authorization letters will be mailed to the provider using the mailing address specified on the provider's enrollment.

Q: Is there a plan in the future to make individual adjustment available electronically?

A: Yes. Future enhancements to the claims submission tool will allow the provider to submit claim adjustments online. The Department will post notices to providers when this functionality is available.

Q: Are Remittance Advice submitted to providers individually by member name and ID?

A: No. The remittance will contain information for all your claims processed by the claims processing system for that week. The member name and ID are included with the specific claim you submitted for them.

Q: When will the portal for remittance be available?

A: Remittance Advice is currently available on the Montana Access to Health web site.

Q: Can partial units be billed? One service has an hourly rate and we are currently allowed to bill partial units. Must we bill whole units?

A: No. Providers must bill in whole units. However, different services can be billed at varying time increments (i.e. 15 minutes, 30 minutes, hourly). Below is a link to the Developmental Disabilities Program Services manual:

https://medicaidprovider.mt.gov/Portals/68/docs/manuals/DRAFTDDProgramServicesManual507162019.pdf

This manual includes information on billing units (see page 5) including definitions of what constitutes a "15 minute", hourly, daily, and month increments.

Q: What is the email address for the provider helpdesk?

A: MTPRHelpdesk@conduent.com

Q: How are prior authorizations for DDP services created?

A: The prior authorizations are created based on the services approved in the members cost plans.

Q: What is the confirmation number used for?

A: The confirmation number is for your records that the claim was submitted and accepted by the MPATH system. You can also use this confirmation number for follow-up questions to reference the specific claim submission.

Q: The log-in for Optum requires an SSN?

A: No. The log-in does not require you to enter a social security number. However, during the registration process, you may be required to enter a social security number if you are registering for an individual provider if that provider enrolled with a social security number as their tax ID.

Q: If there are two shifts in the day, can you bill the two episodes within the same day?

A: Yes, if you provide a service two or more times in the same day, you can enter the number of units on one line in the claim.

Q: Do authorizations get mailed or delivered electronically?

A: Currently, prior authorizations are mailed directly to the provider through the US postal service.

Q: The system goes live 8/5 - is that for claims for dates of service on or after 7/1 or 8/1?

A: You will be able to start submitting claims with dates of service from July 1, 2019 forward.

Q: How do we enroll to get to this system?

A: When the MPATH online claims submission tool is available, you will be able to create your own Optum Gov ID and register with your existing provider information in the tool. Instructions will be made available prior to August 5, 2018 on the provider resource page at https://medicaidprovider.mt.gov/82

Q: How many lines are on the claim submission form?

A: The MPATH Provider Services claim entry allows up to 99 lines per claim.

Q: Will there be a point when we are able to go back in and view submitted claims?

A: Yes, in the future you will be able to view submitted claims on the MPATH Provider Services claim entry tool.

Q: If we call the help line would you use the confirmation number from MPATH?

A: Provider Relations will not be able to use the confirmation number to locate your claim in MMIS. They can easily find a specific claim with the dates of service and member information that was submitted on the claim.

Q: Are the trainings recorded?

A: Trainings will be recorded and available at the www.medicaidprovider.mt.gov.

Q: If I want to submit claims electronically or use a clearinghouse, where can I get that information?

A: Please see the information on the website at https://medicaidprovider.mt.gov/claims#la-515376129-electronic-submission-setup for instructions on how to complete the electronic billing requirements.

Q: When will be the first payout?

A: Any claims that you submit between August 5th and the afternoon of August 7th will process for payment the following Monday, August 12, 2019.

Q: Will you please give the 30,000-foot view of how MMIS, MPATH, Conduent, and Optum all fit together? Who does what?

A: The Medicaid Management Information System (MMIS) is the mechanized claims processing and information retrieval system that all states are required to have according to section 1903(a)(3) of the Social Security Act and defined in regulation at 42 CFR 433.111. All states operate an MMIS to support Medicaid business functions and maintain information in such areas as provider enrollment; clienteligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

MPATH stands for the Montana Program for Automating and Transforming Healthcare. MPATH is the Department of Public Health and Human Services initiative to modernize all of the computer systems and services that support the administration of Montana Healthcare Programs including Medicaid and Developmental Disability Services.

Conduent is the Department's current contracted fiscal agent responsible for the operation of the MMIS. Conduent manages the member and provider call centers, provider enrollment and maintenance, claims processing, provider training, and many other responsibilities on behalf of DPHHS Montana Healthcare Programs.

The Department contracted with OptumInsight to implement a new Provider Services solution that will include provider enrollment, revalidation, and maintenance. In addition, it will include enhanced web portal capabilities such as provider claim entry, checking member eligibility, and viewing remittance advices. The Provider Claims Entry solution is the Department's first component implementation of Provider Services module. The Department expects to implement additional Provider Service module components near the end of 2019.

Q: Is there a list of links / URL's for provider information?

A: Please see the links below:

Montana Healthcare Programs Provider Information Website:	https://medicaidprovider.mt.gov/
Developmental Disabilities Program Providers:	https://medicaidprovider.mt.gov/82
Developmental Disabilities Program Services manual:	https://medicaidprovider.mt.gov/Portals/68/docs/manuals/DRAFTDDProgramServicesManual507162019.pdf
CMS ICD-10 Website:	https://www.cms.gov/Medicare/Coding/ICD10/index.html
Provider Training Website	https://medicaidprovider.mt.gov/training
Claim Billing Basics Training Material	https://medicaidprovider.mt.gov/Portals/68/docs/training/2018/ClaimsBasicsWebEx07192018.pdf
Manual Claim Adjustment Request Form	https://medicaidprovider.mt.gov/Portals/68/docs/forms/adjustmentrequestindividual12192017.pdf
Provider Relations Email	MTPRHelpdesk@conduent.com