ND MMIS DENTAL WEB PORTAL TRAINING

LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH Dakota | Health & Human Services
Be Legendary.

ND MMIS Web Portal Dental 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 Dental Claim

* Required Field

Basic Claim Info   Other Claim Info

Provider   Member   Claim   Basic Line Items

? Is this a Service Authorization?

◉ Yes ○ No

NOTE: Please use the Service Authorization form.

➢ **New Dental Claim**
- Is this a Service Authorization
  - ✓ Defaults to "No"
  - ✓ Select "Yes" if you are submitting a Service Authorization – click on the link **Service Authorization** form

➢ **Service Authorization Instructions**
http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dental-training-materials.pdf

Is this a void/replacement?

☑ Yes ○ No

Claim Resubmission Information

*Resubmission Type Code
Replacement
Void

*TCN to Void/Replace

Note: For Void/Replacement of a Claim, prior claim data (if available) will populate once the user has either a) tabbed out of the TCN field, or b) selected another field on this page.

➢ **New Dental Claim**
- Is this a void/replacement?
- Defaults to "No"
  - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
  - ✓ Resubmission Type Code – Replacement or Void
  - ✓ TCN to Void/Replace

Submitter Information

Submitter ID

Provider Information

Go to Other Claim Info to enter information for other providers.

Billing Provider

NOTE: Healthcare Providers are required to submit National Provider ID

Medicaid Provider ID	National Provider ID	Taxonomy Code	Tax ID	SSN	Location Number

➢**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

➢ **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

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

Other Insurance Information

? *Does the member have other insurance?

◯ Yes ⦿ No

> **Does the member have other insurance?**
>   - **Yes or No**

> **If "No" - member does not have other insurance – proceed to slide 22**

> **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 Insurance Coverage
> - **REQUIRED**
> - Release of Information Code
> - Select appropriate value

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

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

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

- ➢ **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
>   - **Save Claim – System will take you back to the Basic Claim Info Tab**

Claim Information
- Is this claim accident related?
  - ✓ Yes or No

> **Claim Data**
> - Patient Account # - Acct # will print on remittance advice
> - Service Date
> - Place of Service - Office
> - Benefits Assignment Certification – No, Not Applicable or Yes
> - Assignment Code – Assigned or Not Assigned
> - Release of Information Code – Informed Consent to Release Information or Yes, provider has signed statement

> **Service Authorization**
> - Enter Service Authorization number if applicable

> **Referral Number**
> - Enter Referral number 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

Save | Reset | Cancel

*Type Attachment

*Delivery Method

Attachment Control #

*Type Attachment

Dental Models
Diagnostic Report
Explanation Of Benefits
Periodontal Charts
Radiology Films
Radiology Reports
Referral Form
Support Data for Claim

➢ **Type Attachment**
- Select the appropriate type of attachment
  - ✓ Example: Periodontal Charts

➢ **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
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
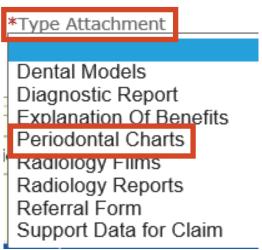 - ✓ Other - Description

Electronic Only in an e-Attachment
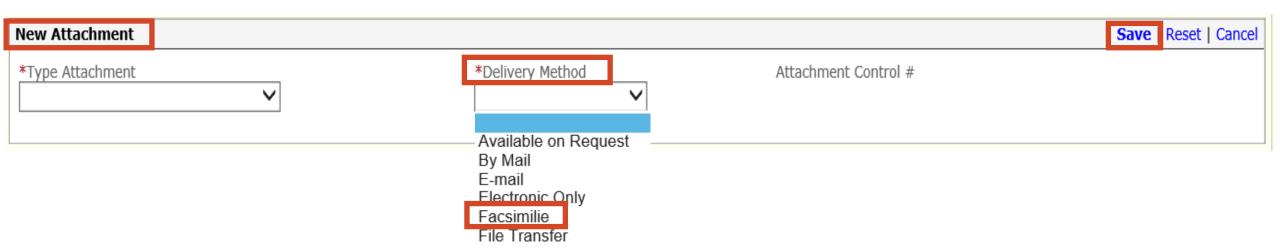

> **Does this claim have Attachments?**
> - Yes or No
>   - ✓ Yes
>   - ✓ Add Attachment

> **Type Attachment**
> - Select the appropriate type of attachment
>   - ✓ Example: Periodontal Charts

New Attachment   Save Reset | Cancel

*Type Attachment   *Delivery Method   Attachment Control #

Available on Request
By Mail
E-mail
Electronic Only
Facsimilie
File Transfer

➢ **Delivery Method**
  • Select the Electronic Only

➢**Save**

Does the claim have Attachments?

◉ Yes ○ No

Claim Attachments

System successfully saved the Information.

Add Attachment

Type Attachment ▼	Delivery Method ⬍	Attachment Control # ⬍
Periodontal Charts	Electronic Only	9972

1 - 1 of 1

➢ **System successfully saved the Information**

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

Add e-Attachment | Save | Reset | Delete | Cancel

* File Name [Browse...]

* Description [   ]

Please upload your file, enter a Description, and click the Save link; repeat this for as many attachments as needed. Once all e-Attachments have been Saved, ensure you click the Submit button.

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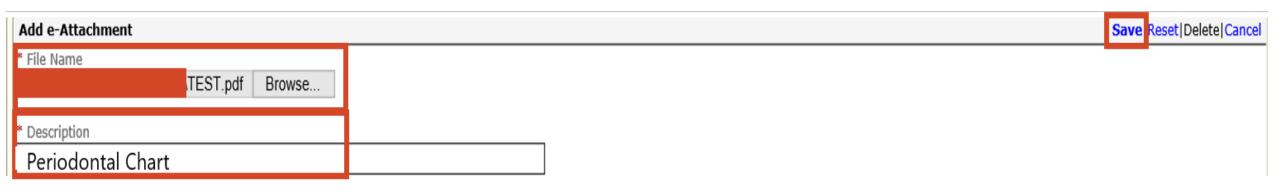- **Cannot** have special characters: example !@#$

➢ **Select Browse**
- Insert/select file that is saved to your computer

➢ **Description**
- Content of attachment: example Periodontal Chart

➢ **SAVE**

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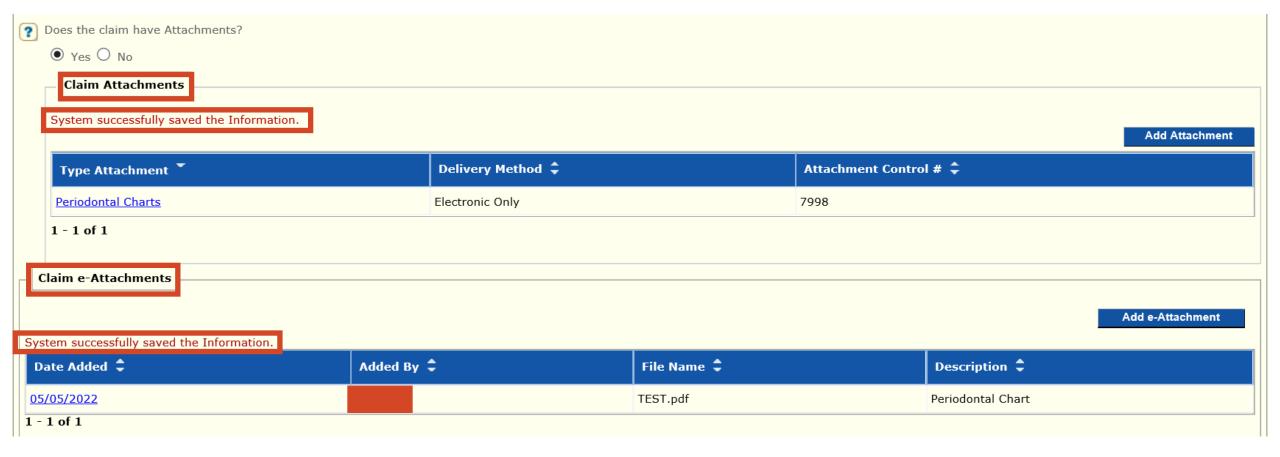- **Cannot** have special characters: example !@#$

➢ **Select Browse**
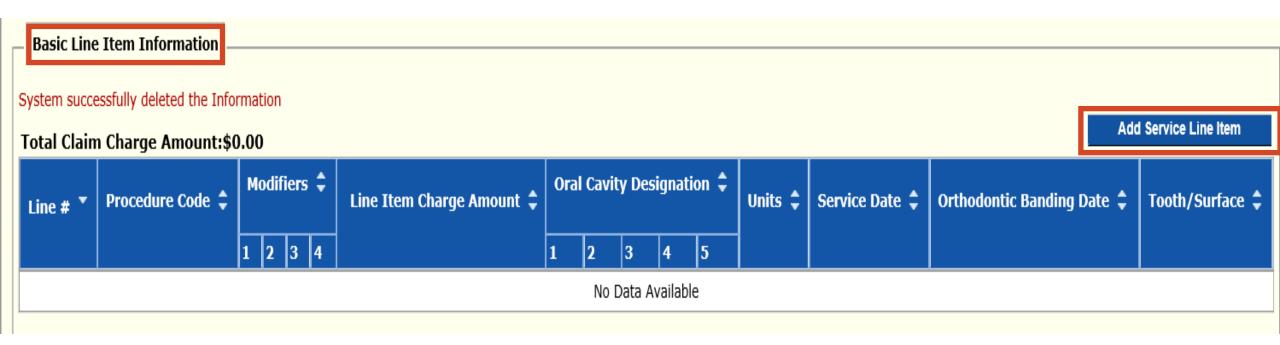- Insert/select file that is saved to your computer

➢ **Description**
- Content of attachment: example Periodontal Chart

➢ **SAVE**

> **SAVE – System successfully saved the Information**

> **Claim Attachments and Claim e-Attachments must be completed**

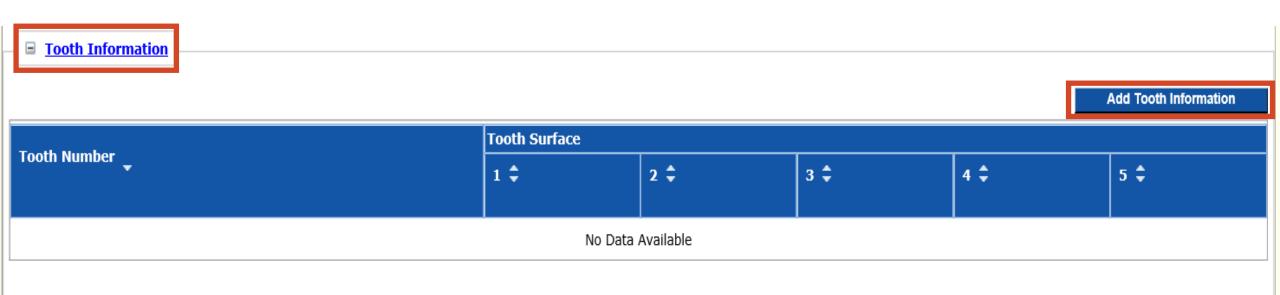> **NOTE:** If resubmitting/adjusting a claim, all documents need to be attached again

> **Basic Line Item Information**
> - Add Service Line Item
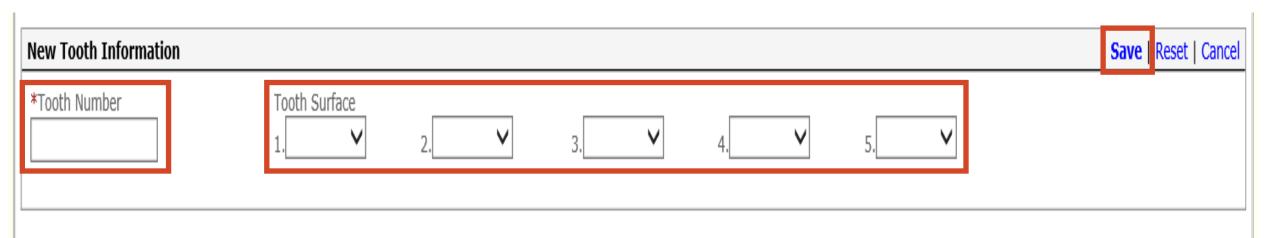
New Line Item

- Procedure Code
- Line Item Charge Amount
- Place of Service – Office
- Oral Cavity Designation – if applicable
- Procedure Count - Unit
- Service Date
- Orthodontic Banding Date – if applicable

> **Tooth Information**
> - Add Tooth Information
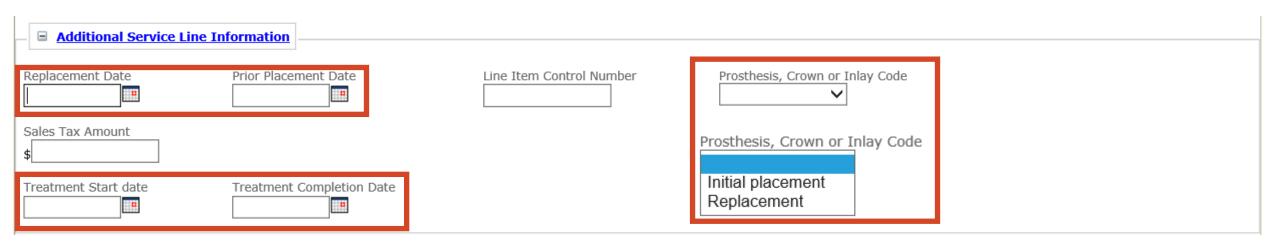
➤ **Tooth Information**
- Tooth Number
- Tooth Surface – if applicable - enter all applicable surfaces
- **SAVE**

Service Authorization – if applicable

- Service Authorization #
- Referral #

> **Additional Service Line Information – if applicable**
> - Replacement Date
> - Prior Placement Date
> - Prosthesis, Crown or Inlay Code
> - Treatment Start Date
> - Treatment Completion Date

New Line Item | **Save** Save & Add Other Svc Info/TPL | Reset | Cancel

? Is there additional line-specific information/TPL to be entered?

○ Yes ◉ No

Submit Claim | Save Claim | Reset | Cancel

➢ **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**

New Line Item | Save Save & Add Other Svc Info/TPL Reset | Cancel

? Is there additional line-specific information/TPL to be entered?

◉ Yes ○ No

NOTE: Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information: Service Line Information, Service Line Provider Information and Other Payer Service Line Information

➢ **Is there Additional line-specific information/TPL to be entered?**

- **Yes** – Member has Other Insurance – proceed to **Slide 46** for instructions
- **Save & Add Other Svc Info/TPL**

> **Print and Save for your records**

New Line Item

Save | **Save & Add Other Svc Info/TPL** | Reset | Cancel

*Procedure Code

Procedure Description

*Line Item Charge Amount $

Place of Service

Modifiers
1. 2. 3. 4.

Oral Cavity Designation
1. 2. 3. 4. 5.

Procedure Count

Service Date

Orthodontic Banding Date

⊞ **Tooth Information**

⊞ **Service Authorization**

⊞ **Additional Service Line Information**

? Is there additional line-specific information/TPL to be entered?
● Yes ○ No

NOTE: Click the Save & Add Other Svc Info/TPL link to enter line-level TPL amounts, and to include the following line-level information:Service Line Information,Service Line Provider Information and Other Payer Service Line Information
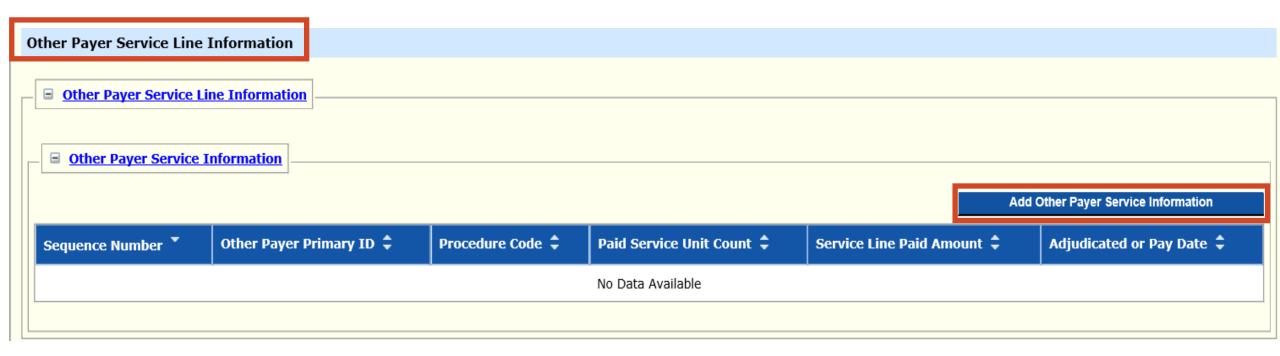
➢ **Is there Additional line-specific information/TPL to be entered?**
- **Yes** – Member has Other Insurance
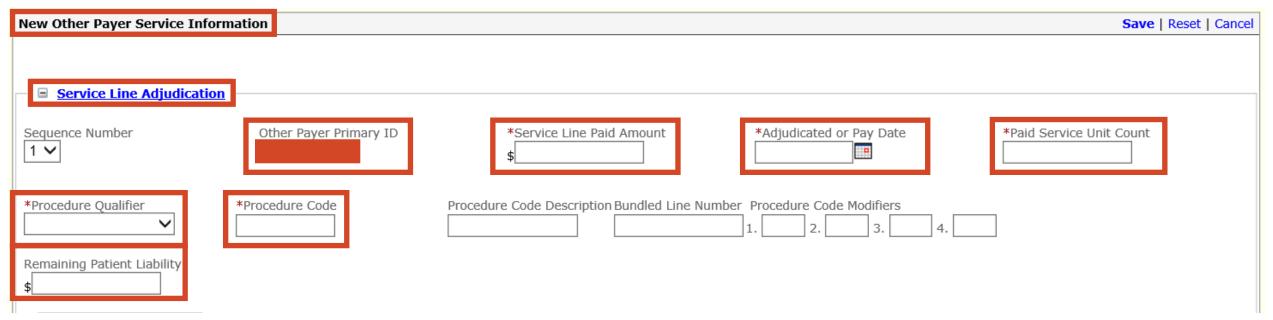- **Save & Add Other Svc Info/TPL**

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> **New Dental Claim**
> - System successfully saved the Information
>   - ✓ Line # 1
>   - ✓ **Scroll down to the bottom of page - Other Payer Service Line Information section**

➢ **Other Payer Service Line Information**
- Add Other Payer Service Information

New Other Payer Service Information — Save | Reset | Cancel

Service Line Adjudication

| Sequence Number | Other Payer Primary ID | *Service Line Paid Amount | *Adjudicated or Pay Date | *Paid Service Unit Count |

*Procedure Qualifier | *Procedure Code | Procedure Code Description | Bundled Line Number | Procedure Code Modifiers 1. 2. 3. 4.
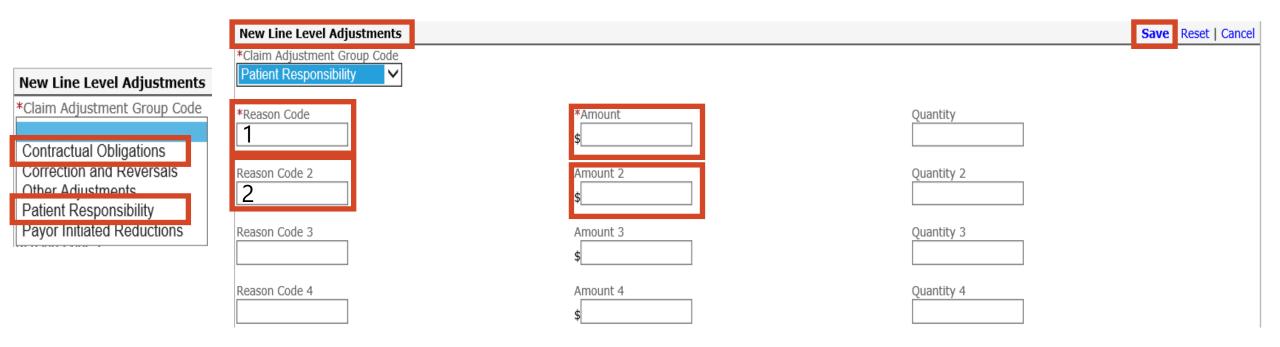
Remaining Patient Liability $

➢ **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 - ADA
    - ✓ Procedure Code
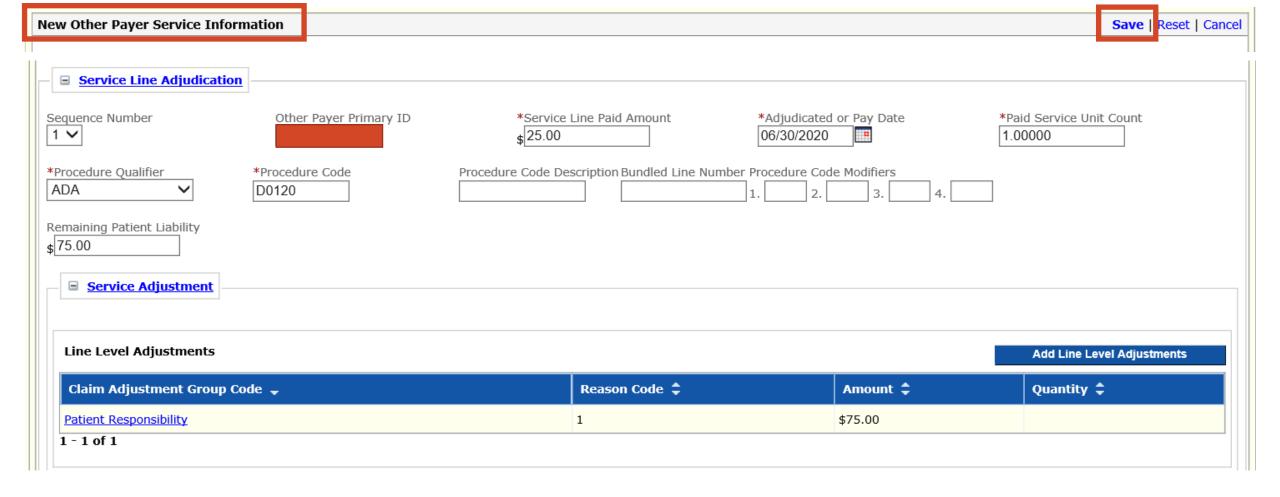   - ✓ Remaining Patient Liability

> **Service Adjustment**
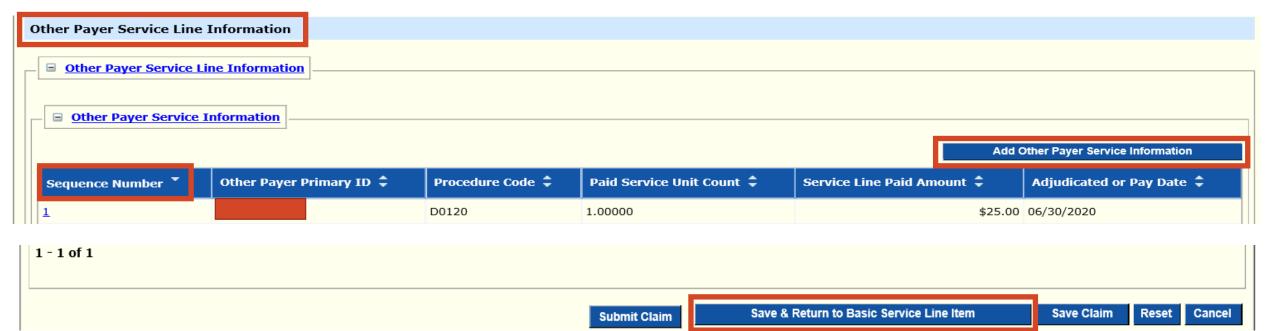> • Add line Level Adjustments

> # **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**
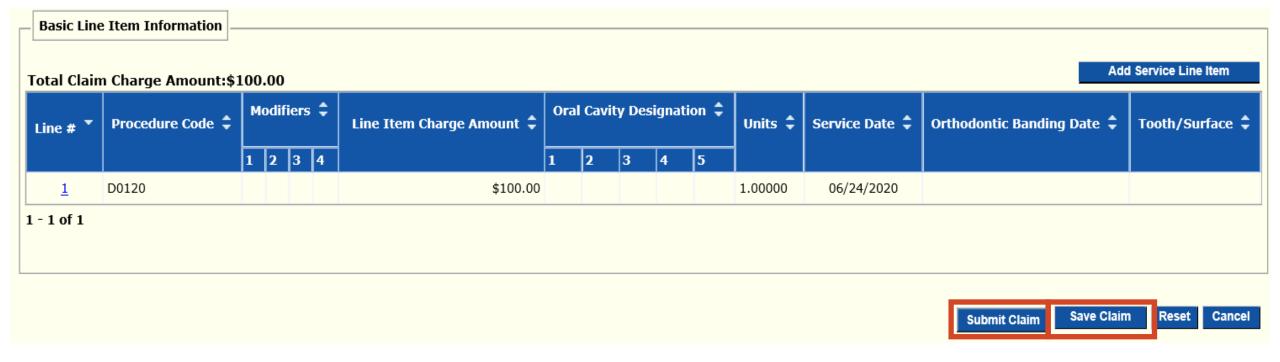>   - ✓ **Contractual Obligations** – up to 4 Reason Codes per detail line - **Save**

> # **New Other Payer Service Information**
> - Additional Adjustments - Add Line Level Adjustments – if applicable
> - Verify Line Level Adjustments
> - **Save – New Other Payer Service Information**

> ## If the member has 2 Insurance Policies
> - ## Add Other Payer Service Information
>   - ✓ Complete a 2nd Sequence Number – Repeat slides 40 – 45
>   - ✓ Primary is Sequence Number #1
>   - ✓ Secondary is Sequence Number #2
>
> ## If the member has 1 insurance
> ## Save & Return to Basic Service Line Item

> **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

Adjustment Reason Codes

TCN: [REDACTED]
Date of Service: 06/24/2020 - 06/24/2020
Provider #: [REDACTED]
Member ID: [REDACTED]

Claim Status: C - To Be Dnd
Total Charge: $100.00
*To Be Paid Amount: $0.00
*Co-Payment: $0.00
*Total Recipient Liability: $0.00
Submission Date/Time: Mon Jul 20 14:39:13 CDT 2020

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

Line #	Adjustment Reason Code	Description
0	B7	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	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
1	170	Payment is denied when performed/billed by

➤ **Print and Save for your records**