ND MMIS INSTITUTIONAL WEB PORTAL TRAINING

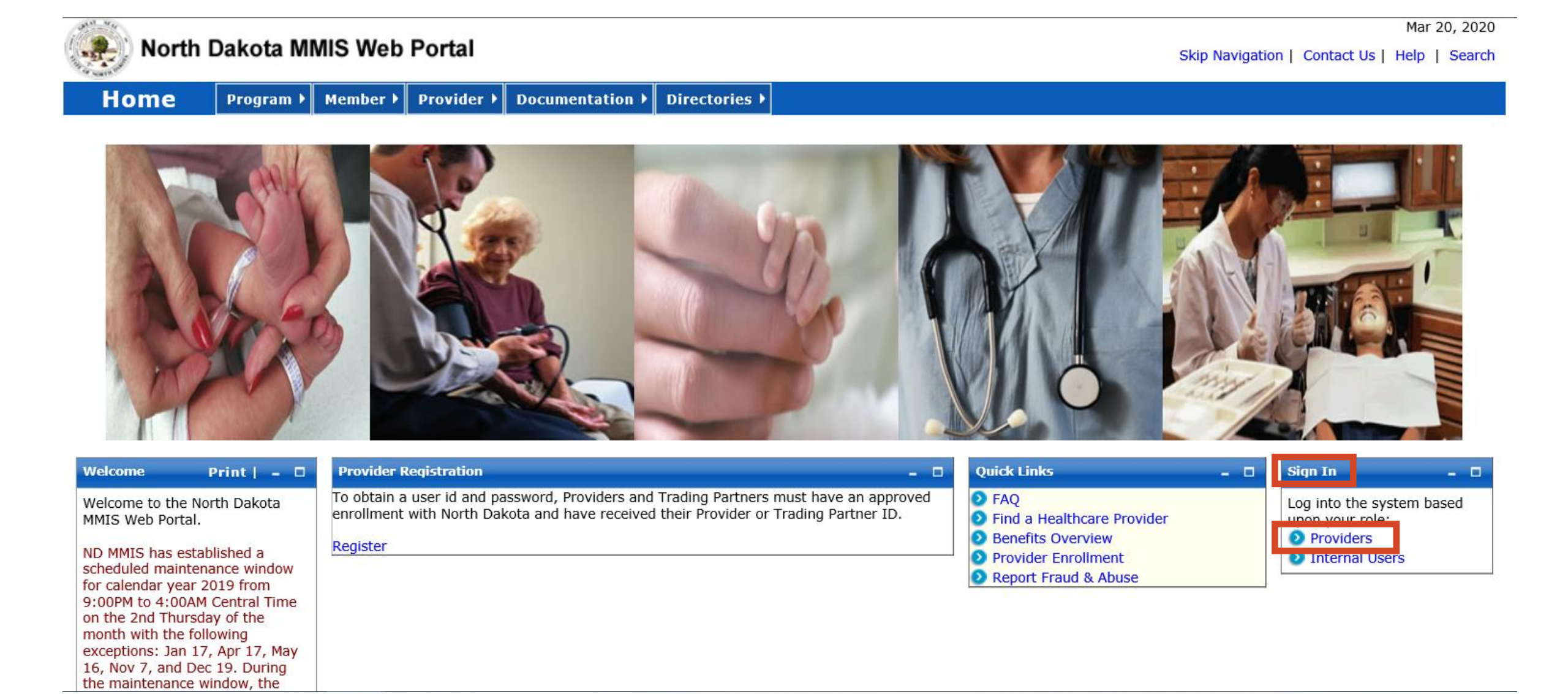
LAURA HOLZWORTH, MEDICAL SERVICES DIVISION

NORTH Dakota | Health & Human Services

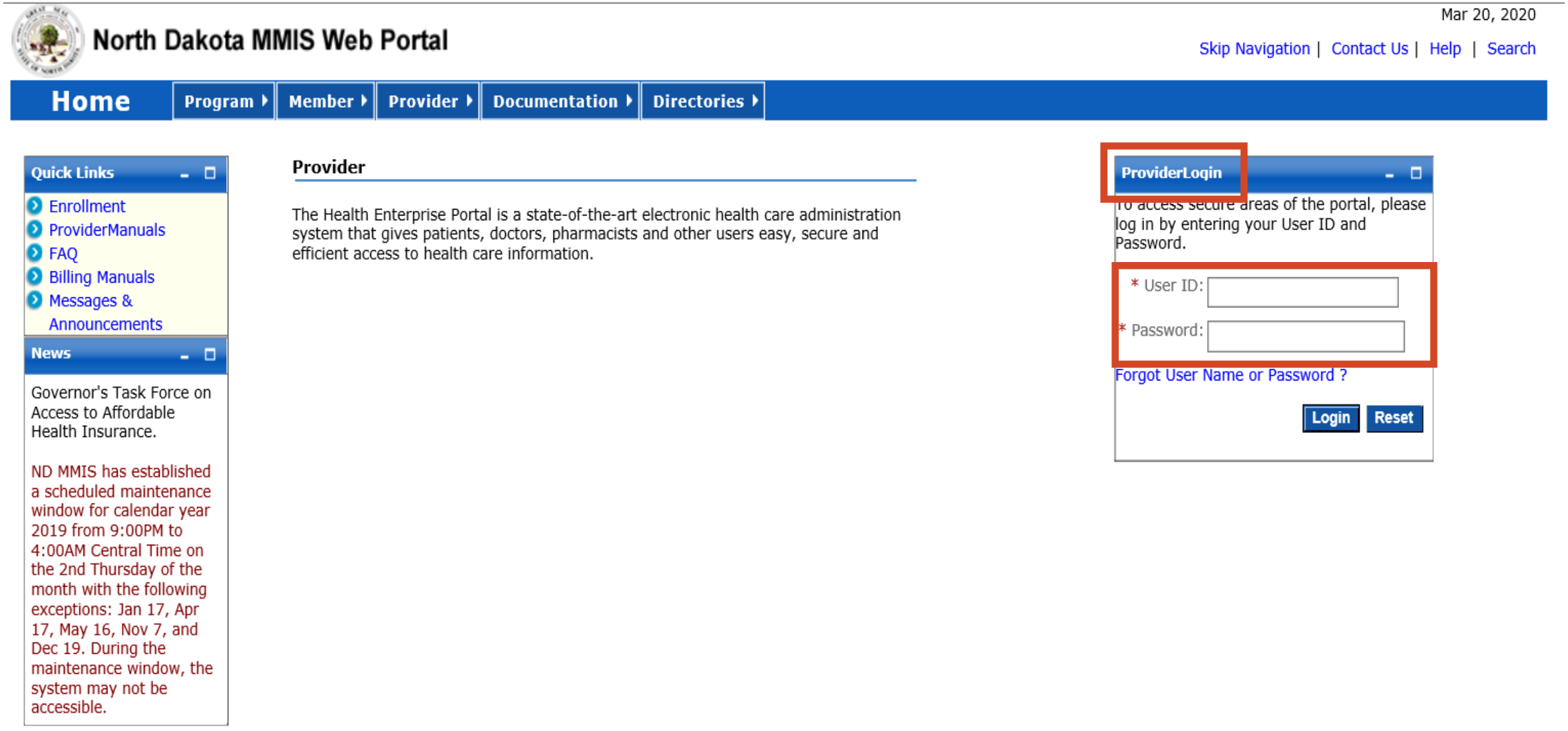
Be Legendary.

ND MMIS Web Portal Institutional Claim Form Submission Instructions

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

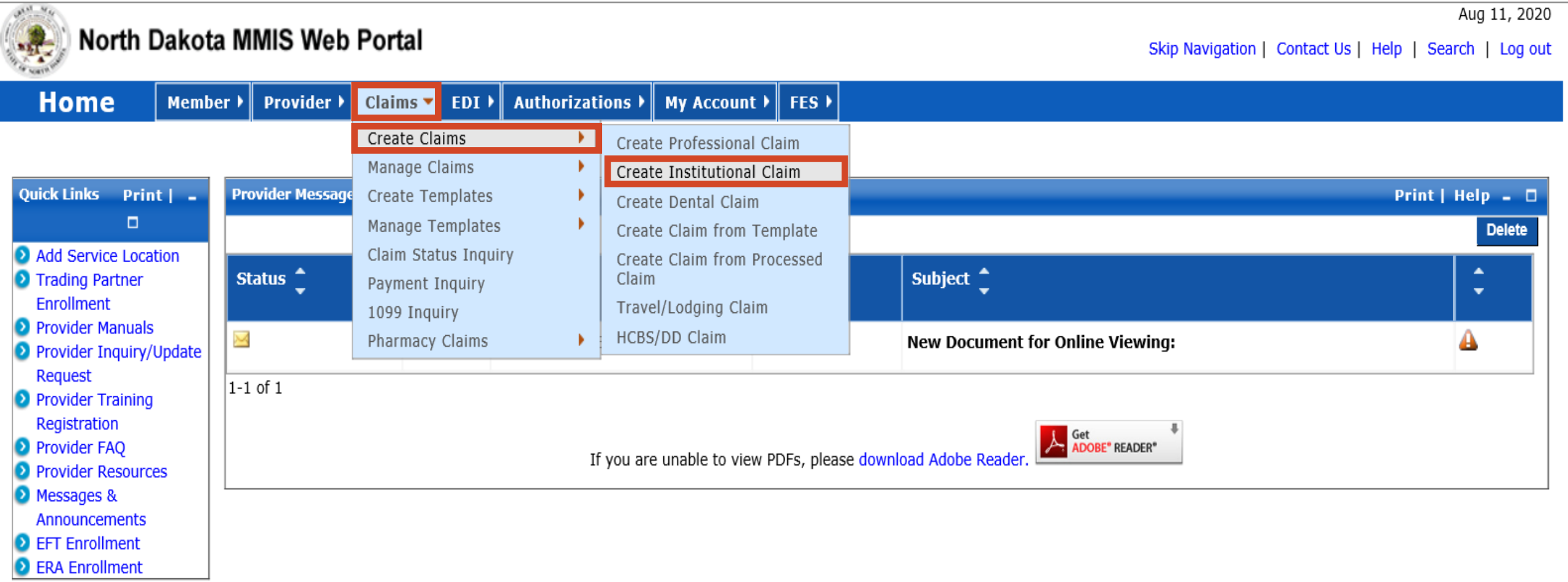


➢ Sign In - Provider



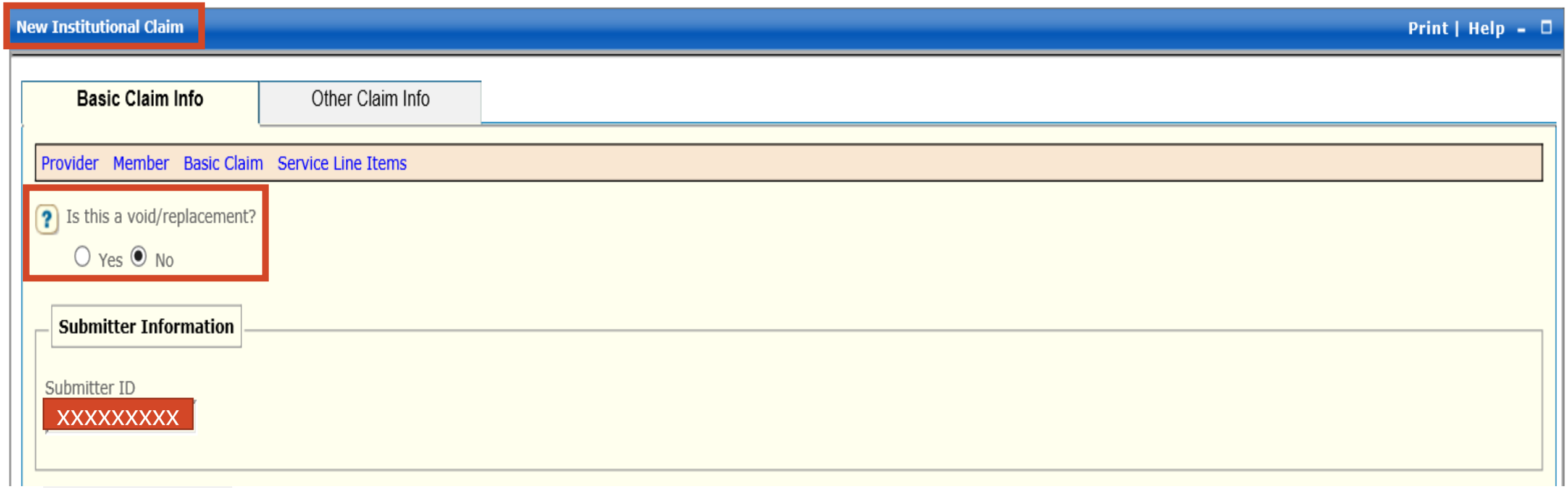
➢ Provider Login

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



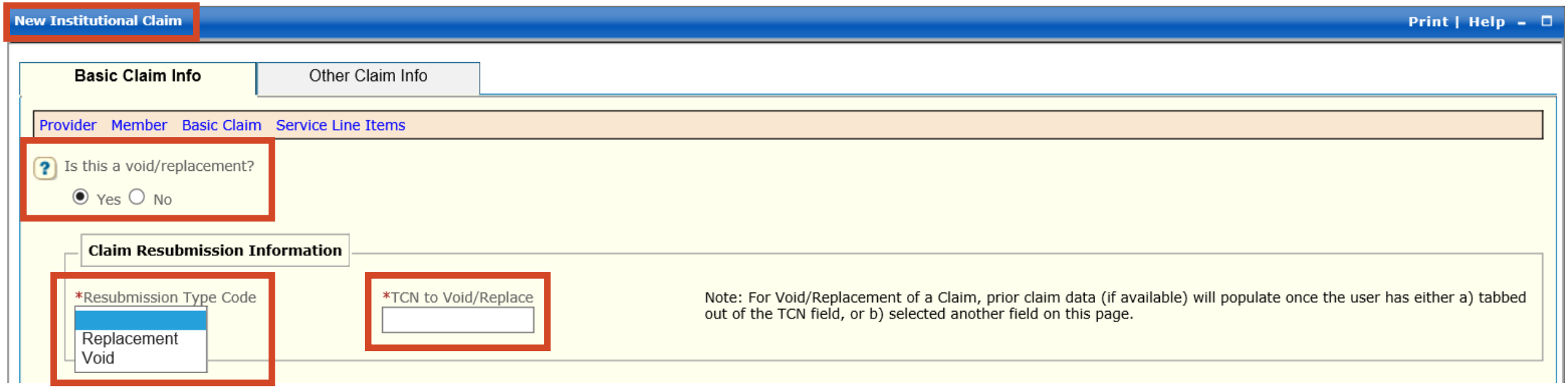
➢ Submit a Claim

- Claims
- Create Claims
- Create Institutional Claim



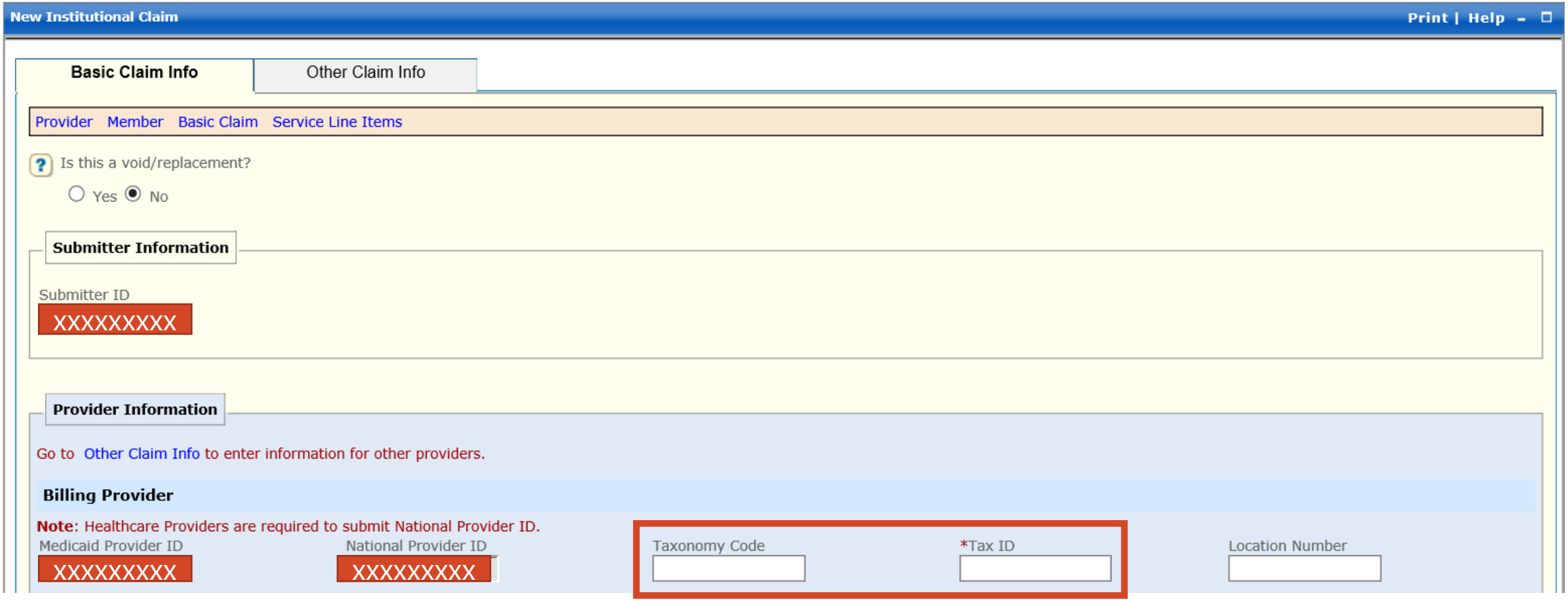
➢New Institutional Claim

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

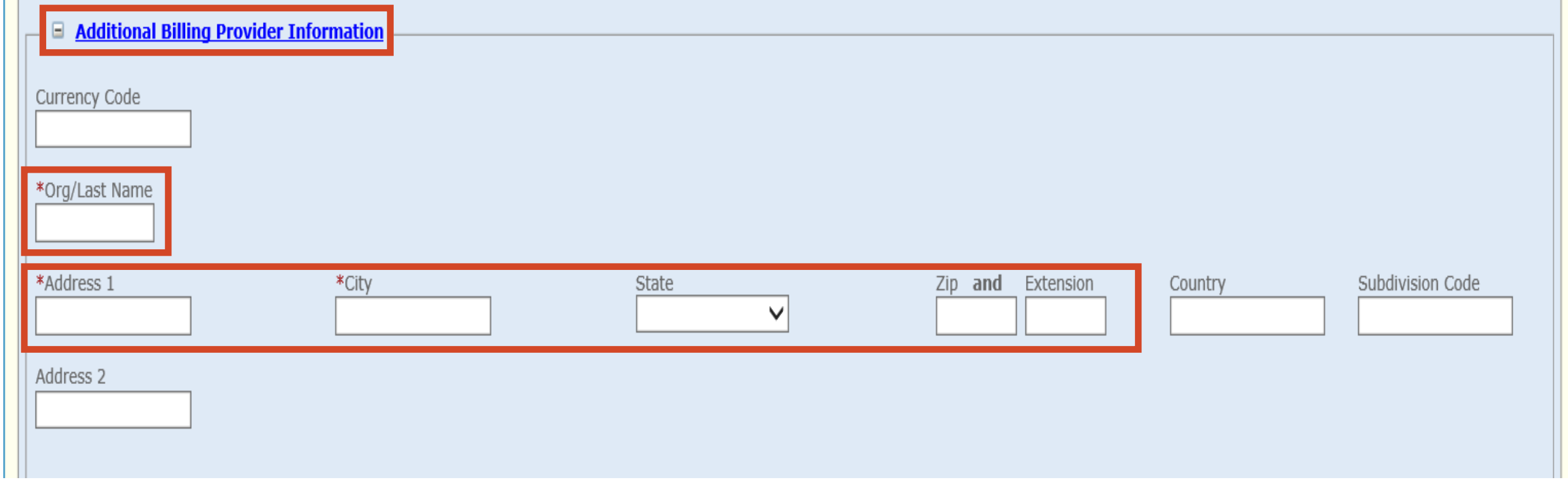


➢New Institutional Claim

- 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

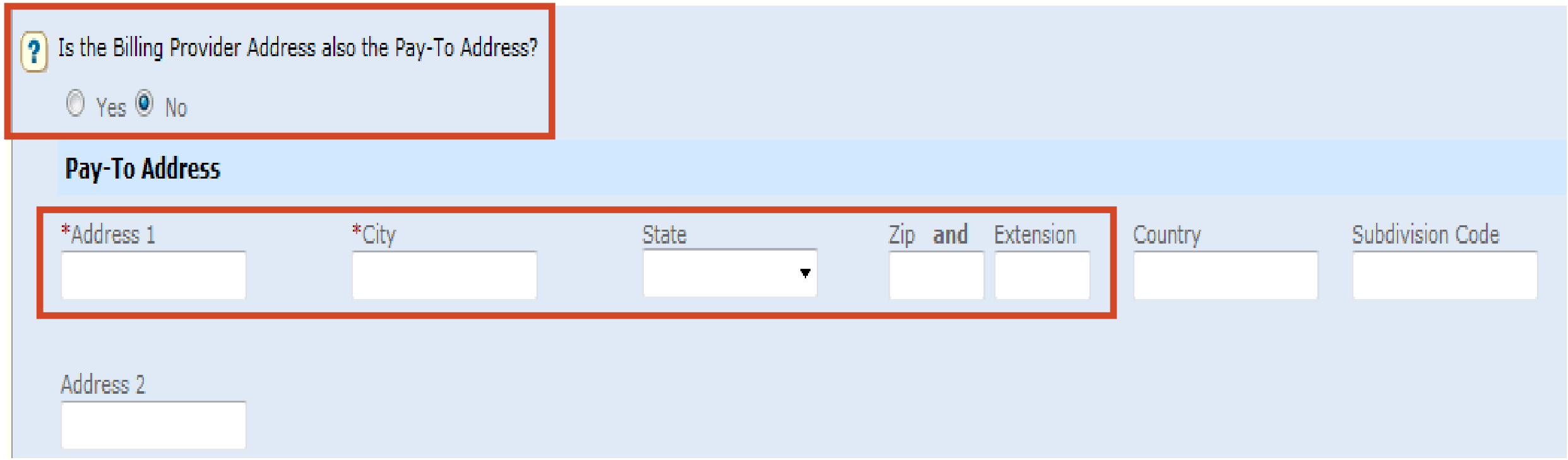


- **Enter** - Billing Provider Taxonomy Code
- **Enter** - Billing Provider Tax ID or SSN Number



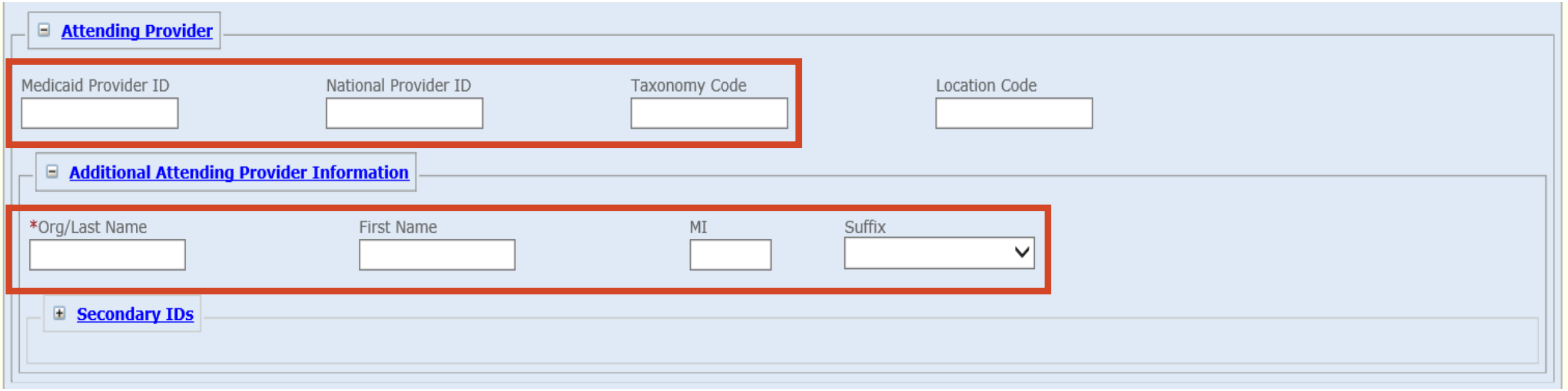
➢ Additional Billing Provider Information

- **REQUIRED**
- **Enter** – Org/Last Name, Address, City, State and Zip Code



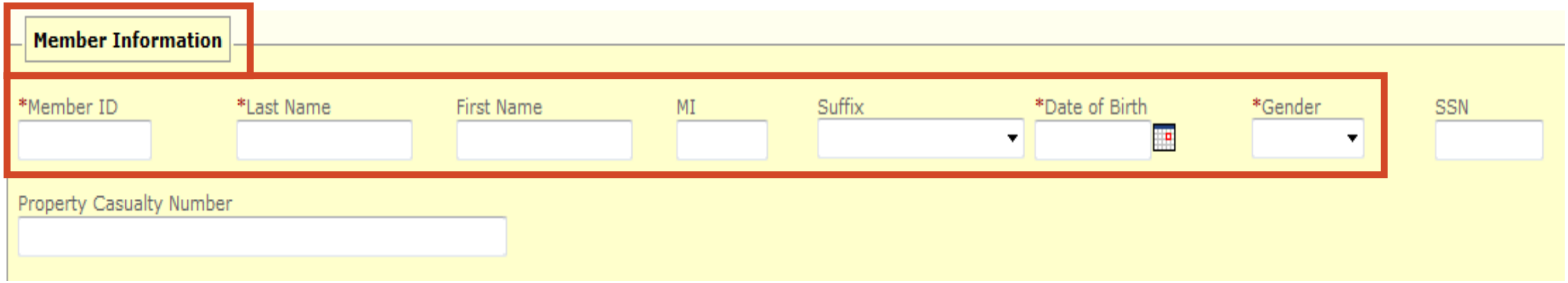
➢ Is the Billing Provider also the Pay-To Address?

- **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



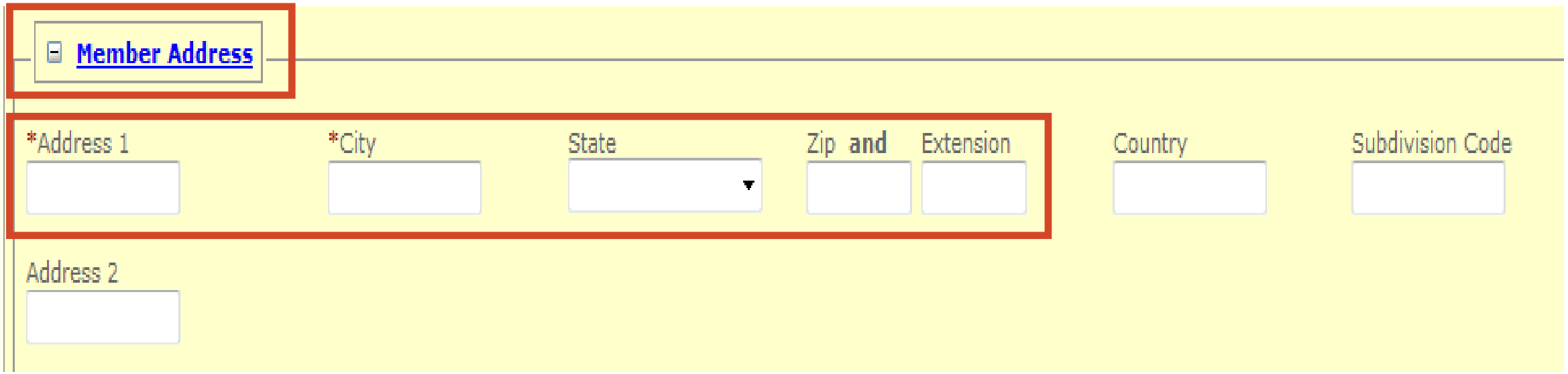
- **Attending Provider**
  - **Required**
  - Medicaid Provider ID, National Provider ID and Taxonomy

- **Additional Attending Provider Information**
  - **Required**
  - Org/Last Name, First Name, MI and Suffix



➢ Member Information

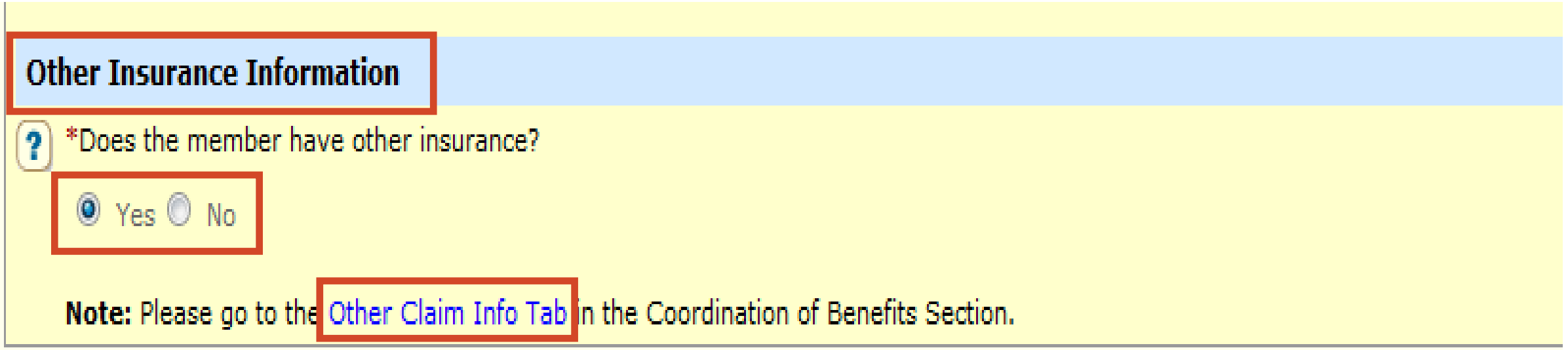
- **REQUIRED**
- **Enter -** Member's 9-digit ID number
- **Enter** - Member's Last Name
- **Enter -** Member's First Name
- **Enter -** Member's Date of Birth
  - ✓ Use format: MM/DD/YYYY
- **Enter -** Member's Gender
  - ✓ F = Female
  - ✓ M = Male



➢ Member Address

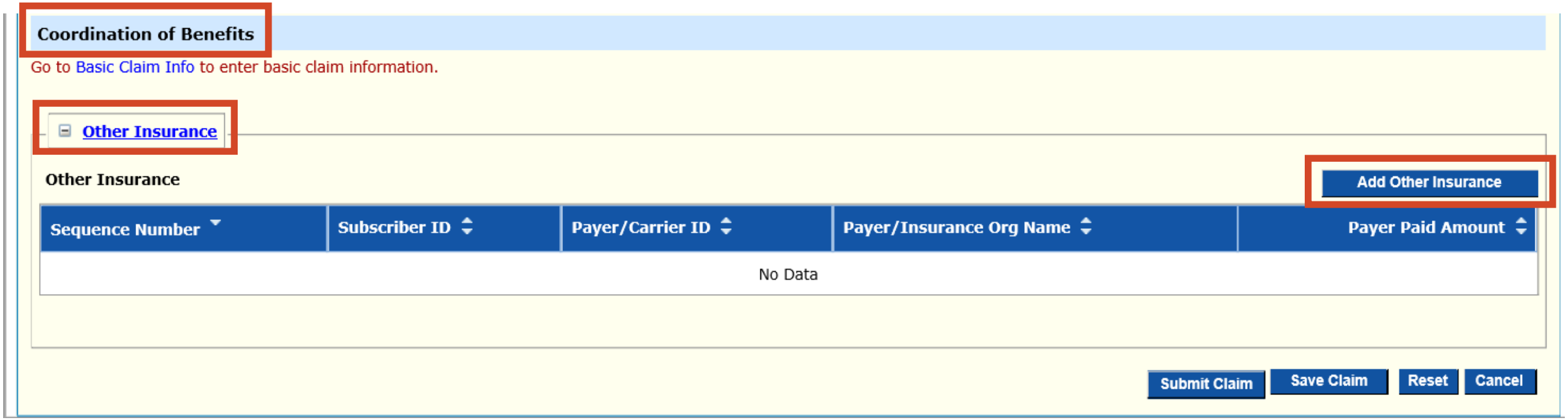
- **REQUIRED**
- **Enter** - Member's Address, City, State and Zip Code

- **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**



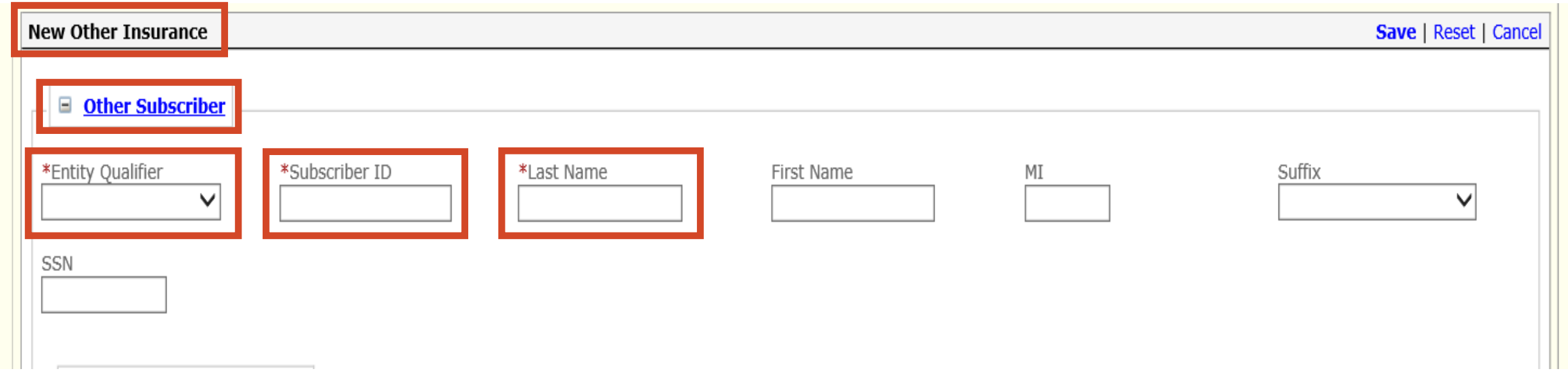
➢ Other Insurance Information

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



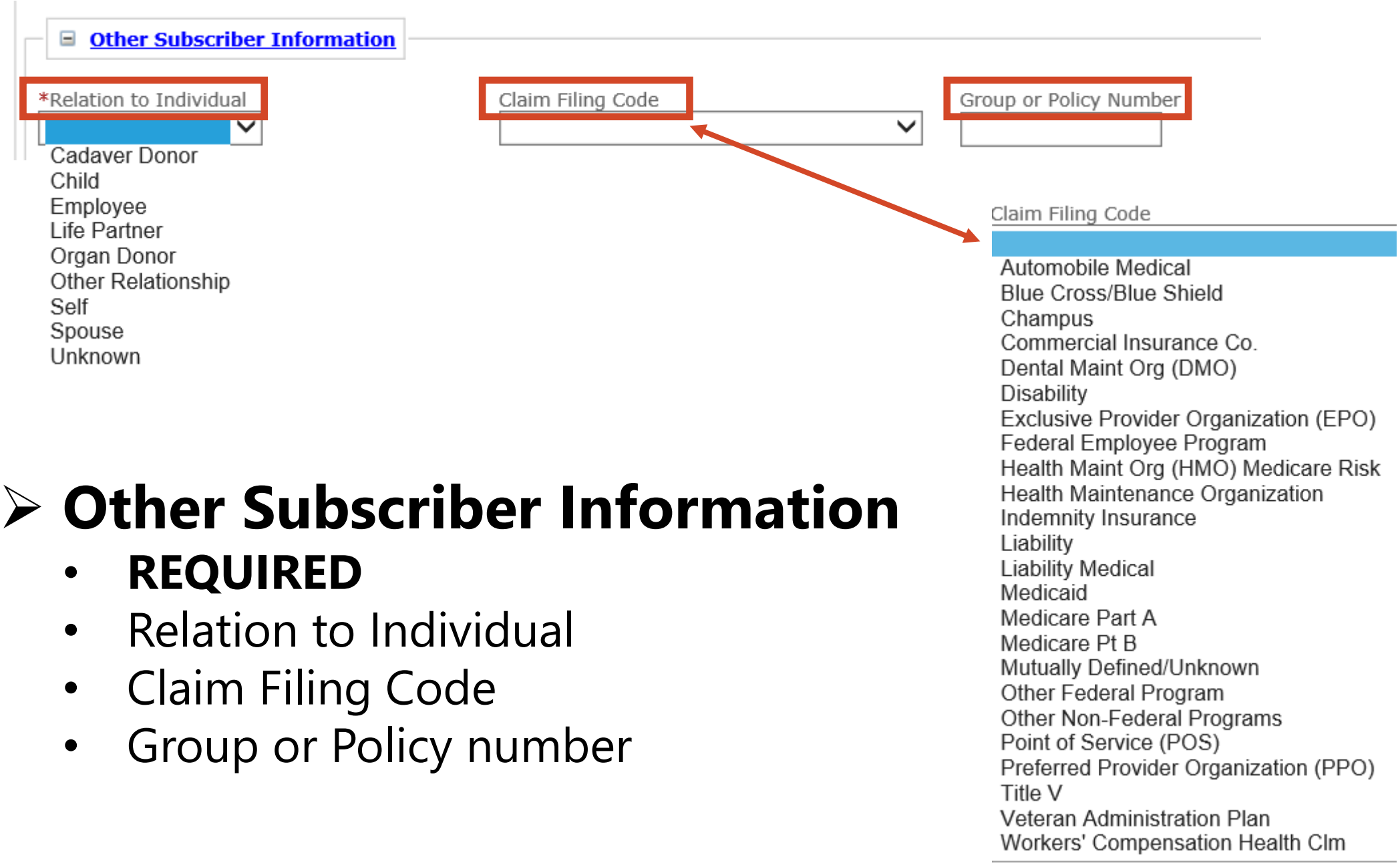
➢ Coordination of Benefits

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



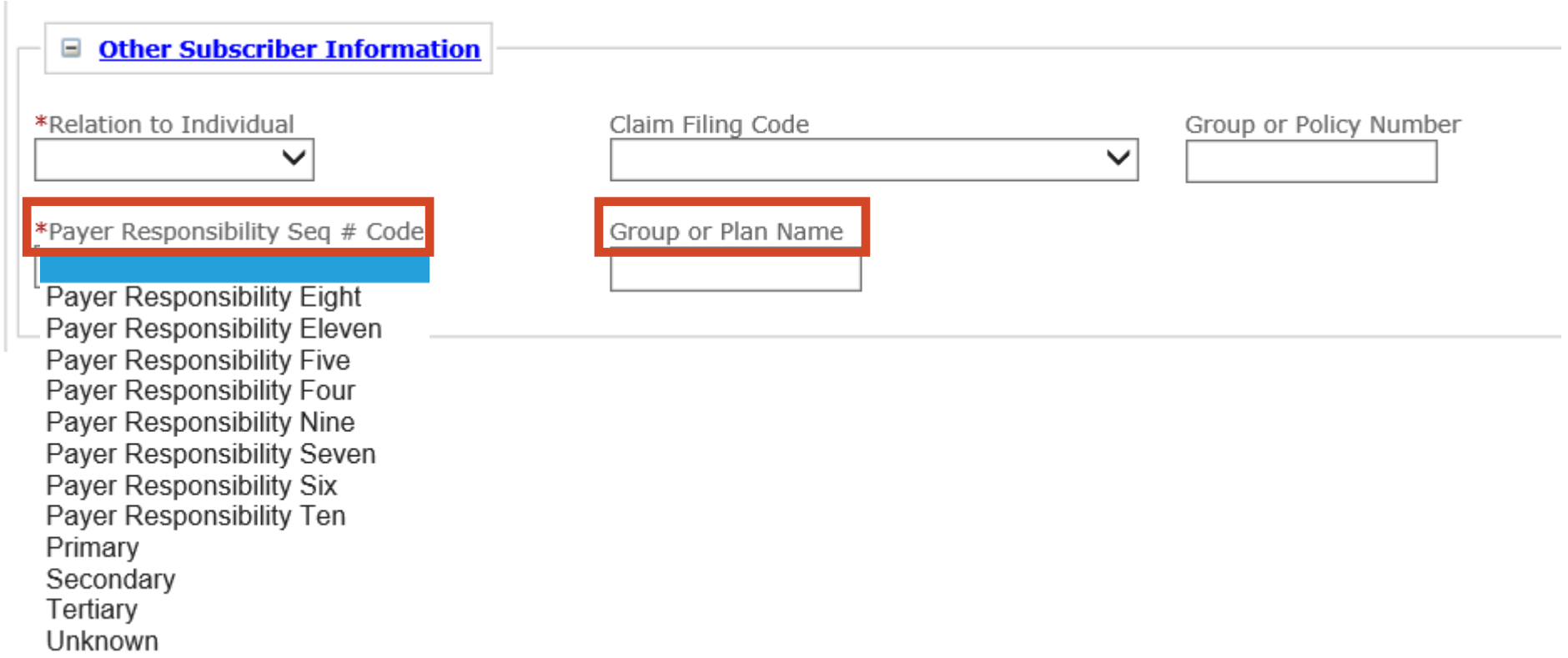
➢ New Other Insurance

- **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



➢ Other Subscriber Information Cont.

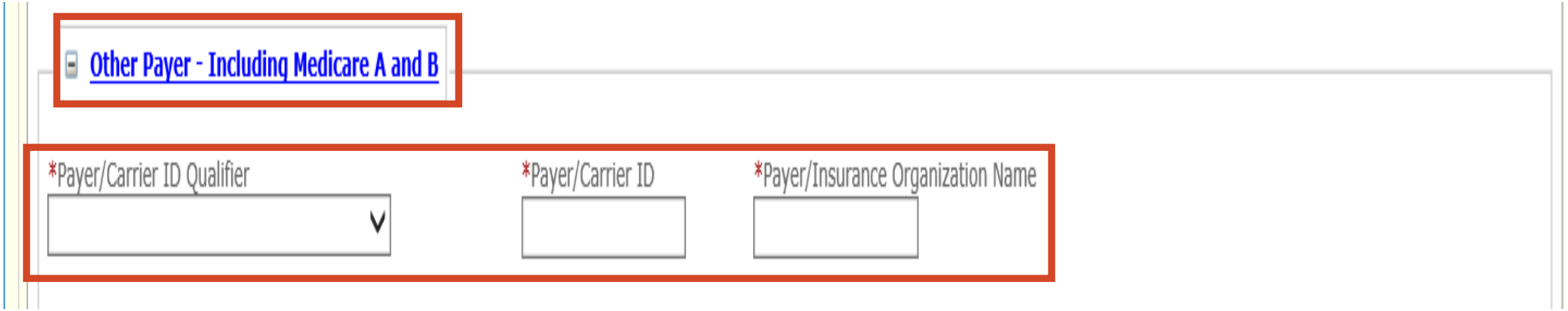
- **REQUIRED**
- Payer Responsibility Seq # Code
- Group or Plan Name

➢ Other Insurance Coverage

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

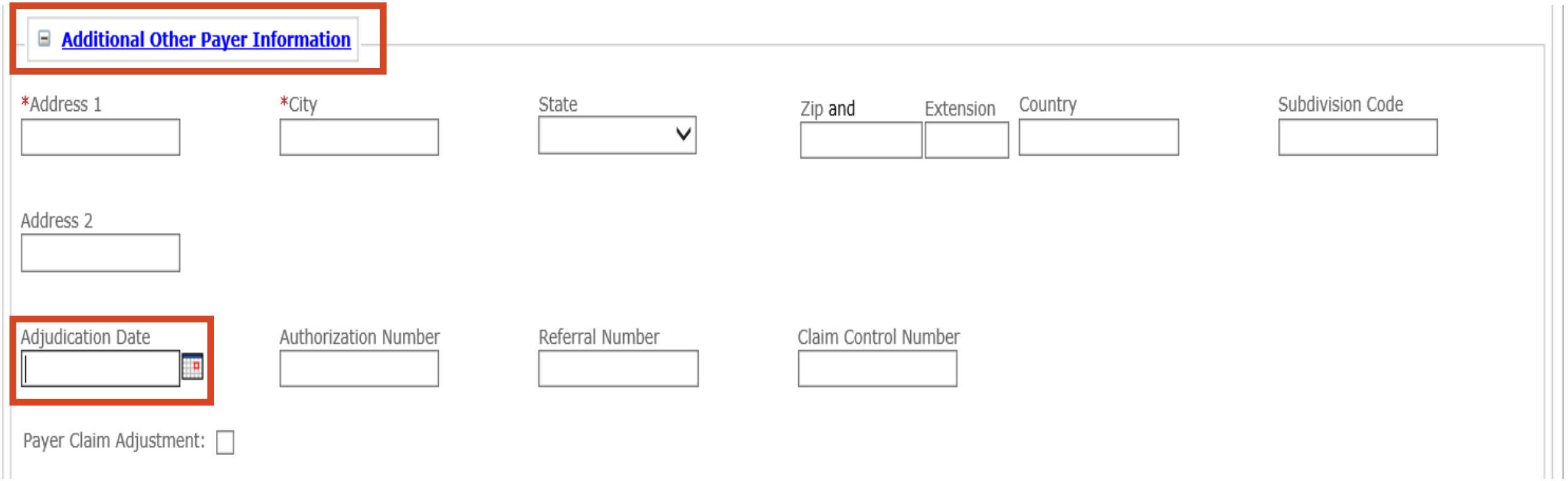
Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

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



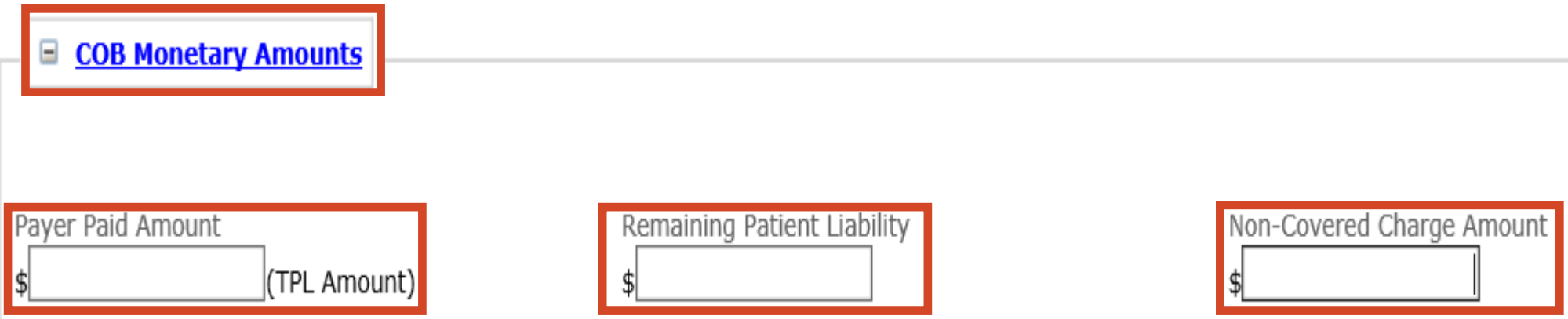
➢ Other Payer – Including Medicare A and B

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



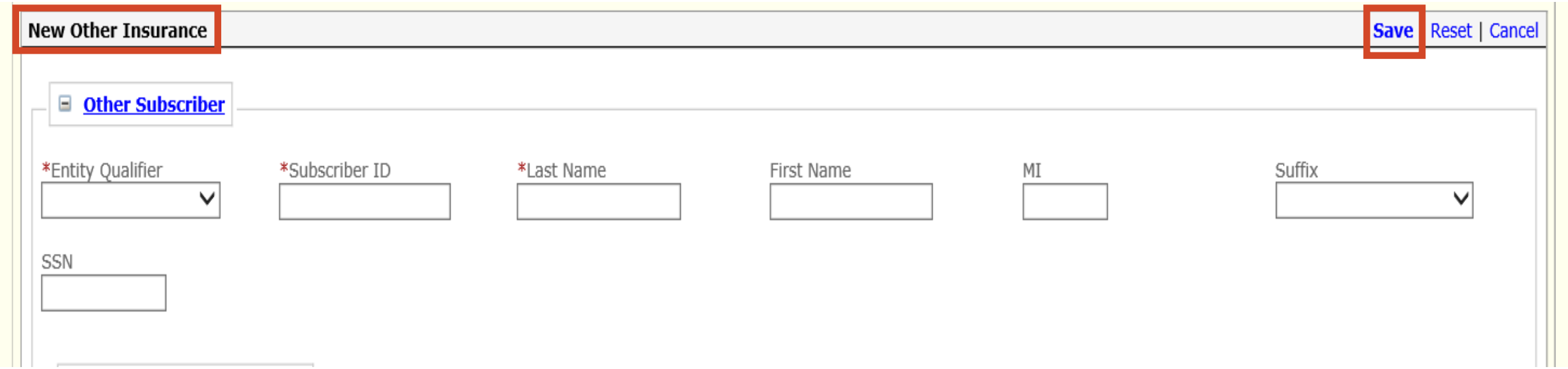
➢ Additional Other Payer Information

- Adjudication Date

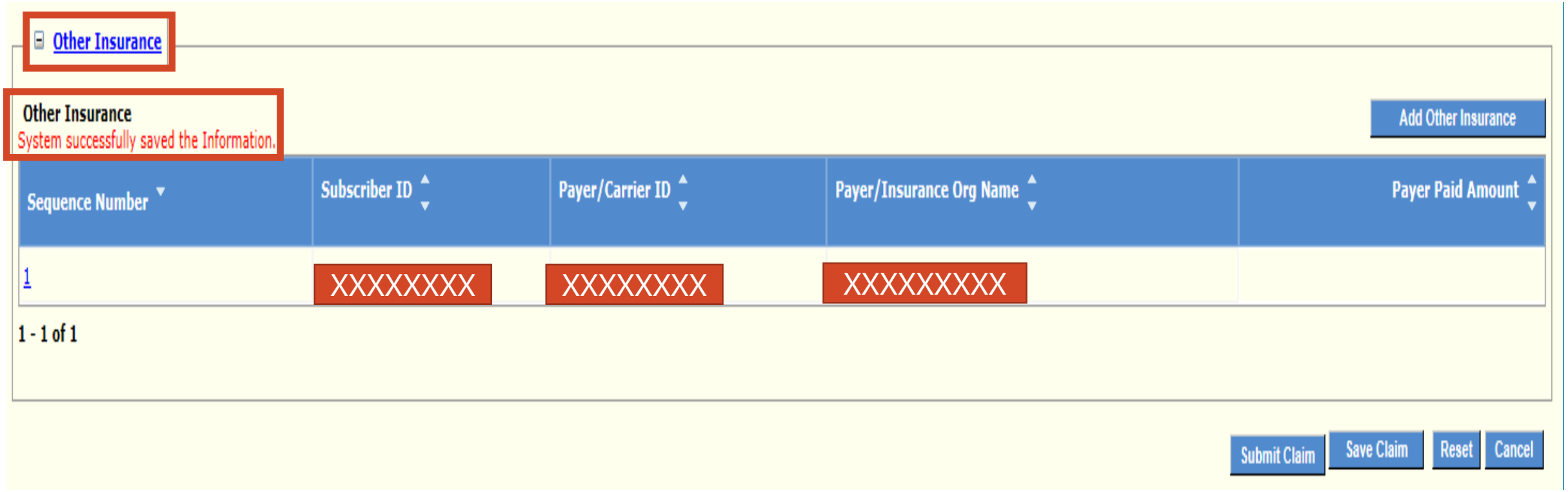


➢ COB Monetary Amounts

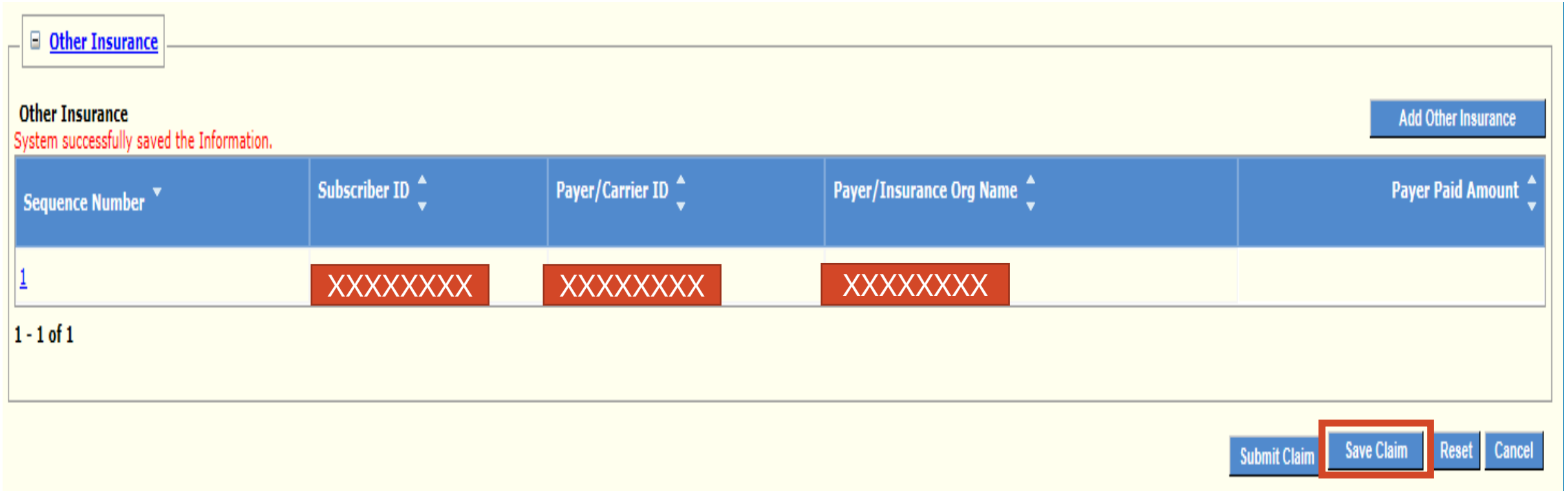
- Payer Paid Amount
- Remaining Patient Liability
- Non-Covered Charge Amount



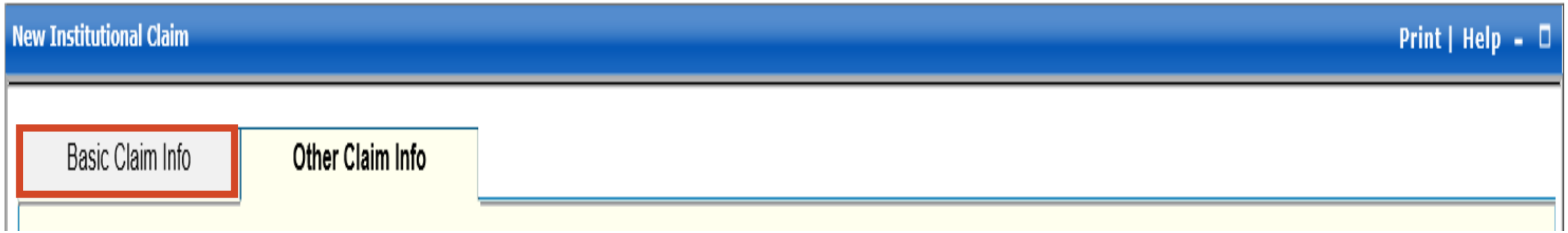
- **New Other Insurance**
  - **REQUIRED**
  - Scroll to the top of **New Other Insurance** section
- **SAVE**



- **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

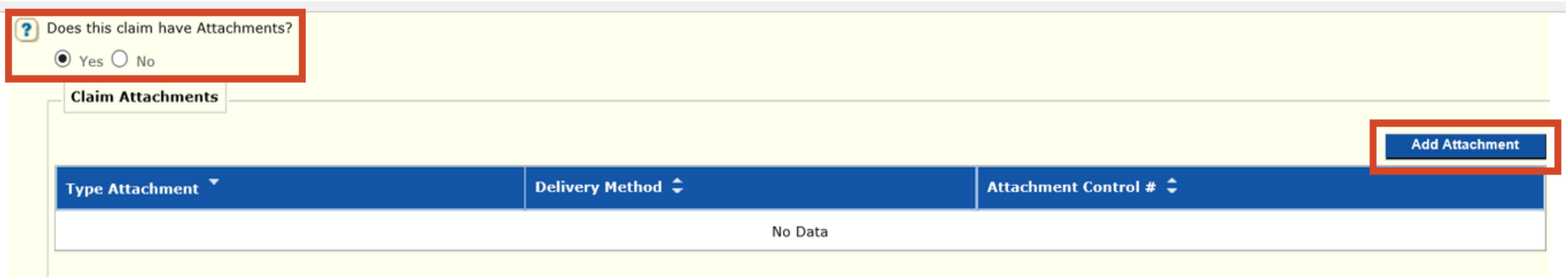

Other Insurance
Other Insurance
System successfully saved the Information.
Add Other Insurance
Sequence Number
Subscriber ID
Payer/Carrier ID
Payer/Insurance Org Name
Payer Paid Amount
1
XXXXXXXX
XXXXXXXX
XXXXXXXX
1 - 1 of 1
Submit Claim
Save Claim
Reset
Cancel

- **Save Claim**

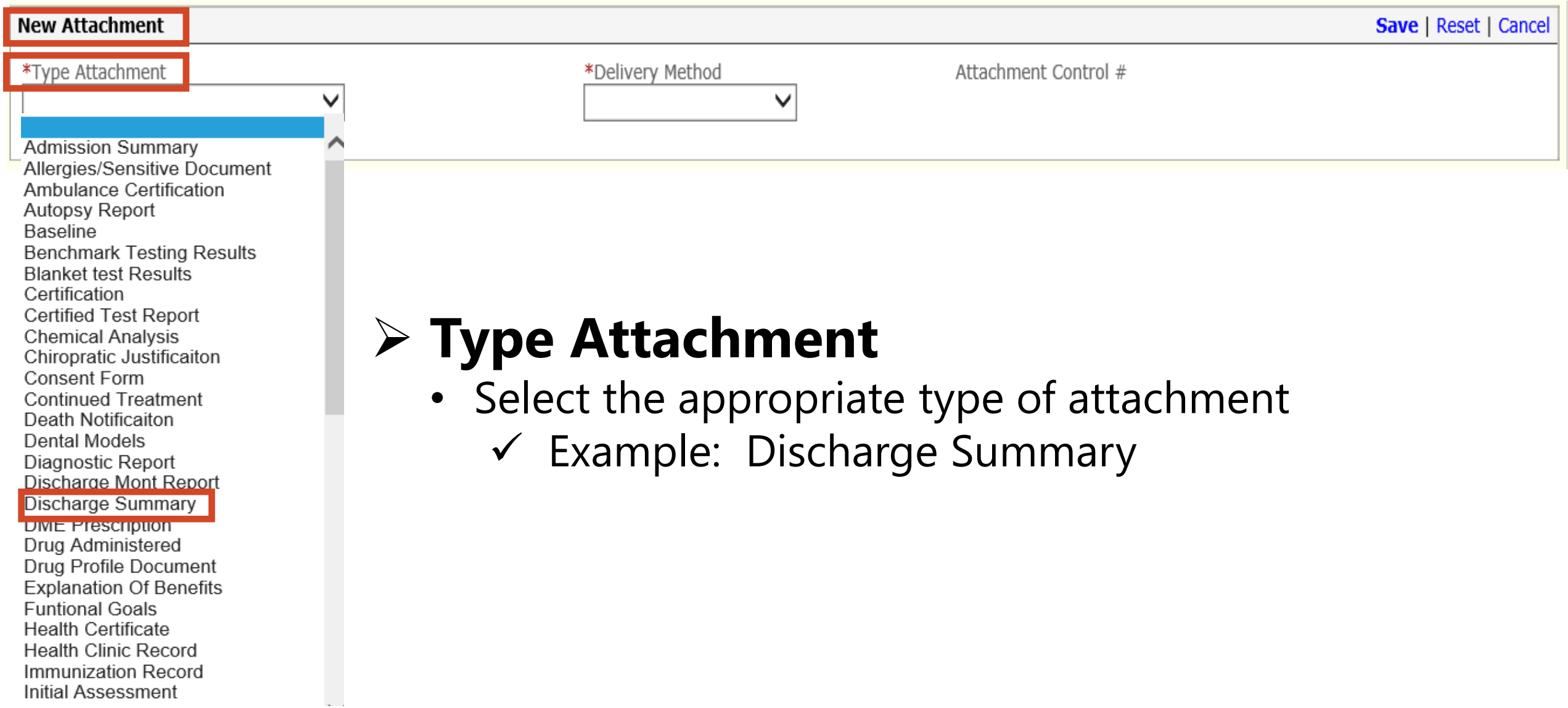


- **Navigate** to the **Basic Claim Info Tab**

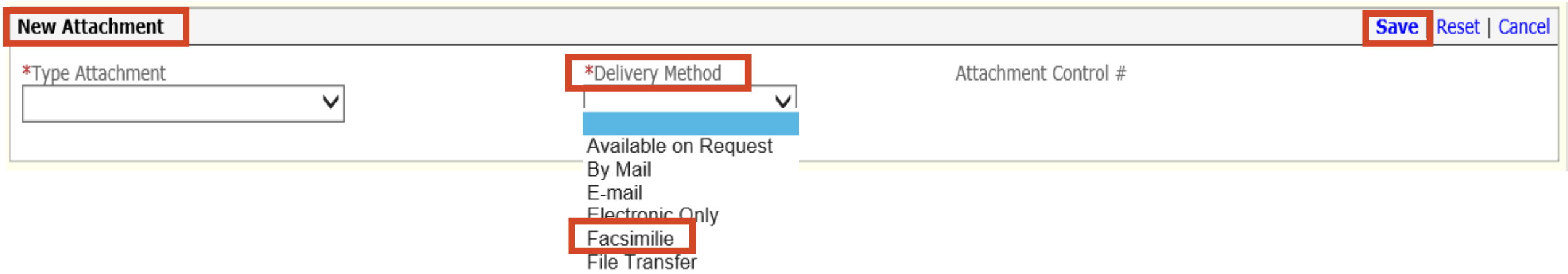
Faxing in an Attachments



- **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

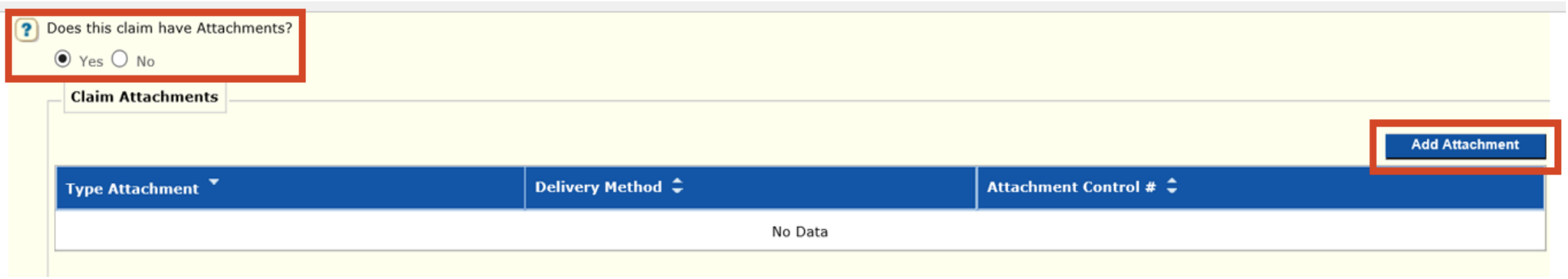
Telephone Number: 1-877-328-7098

Required

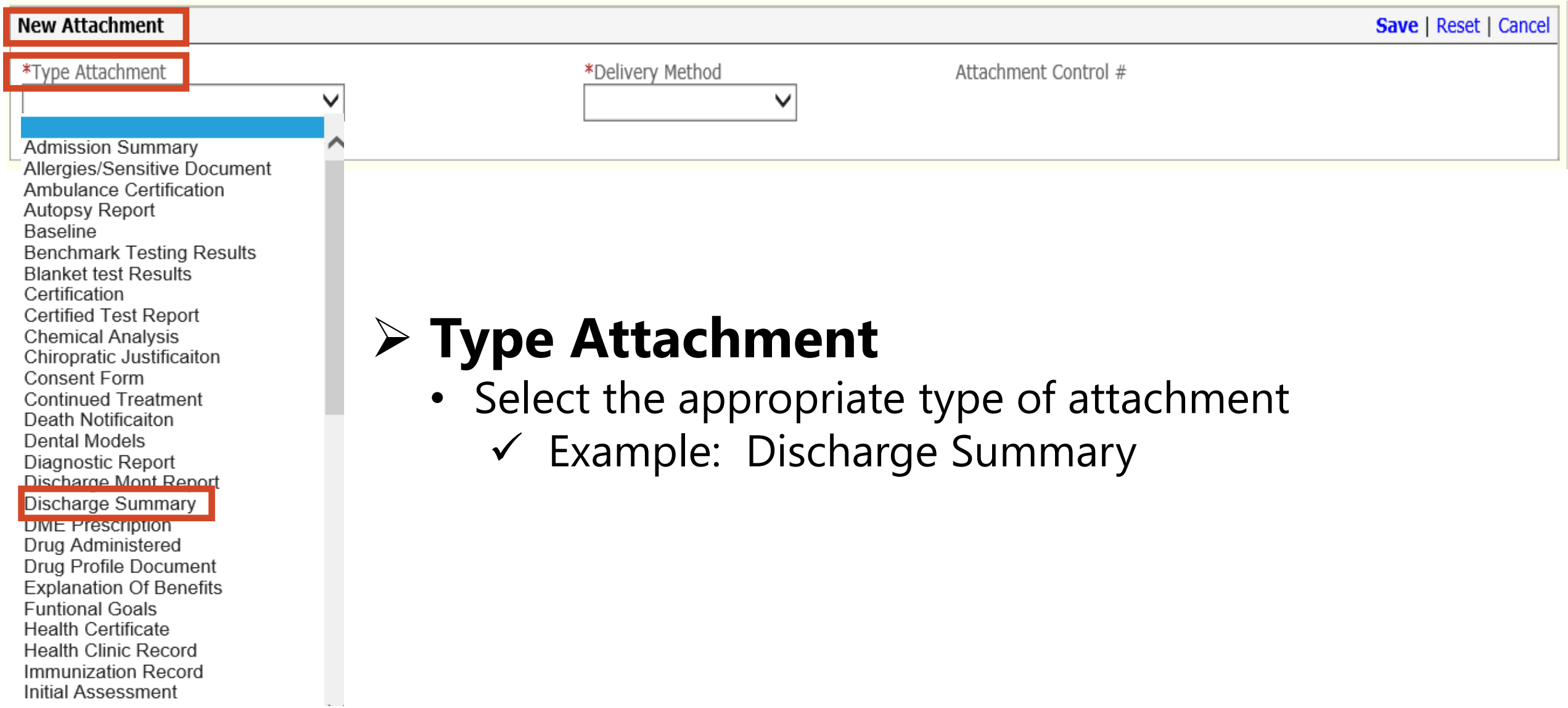
- Provider NPI or Medicaid Number
- Member Medicaid Number

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

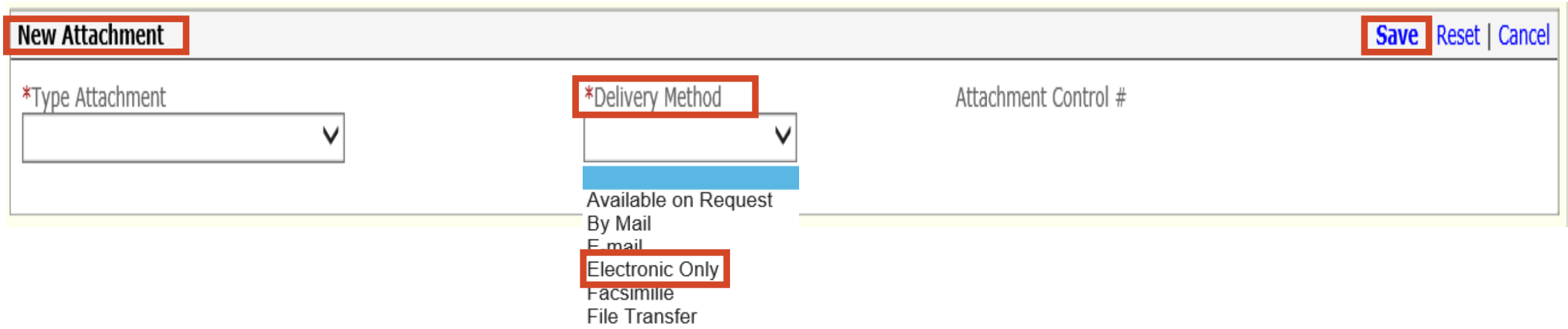
Electronic Only in an Attachment



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

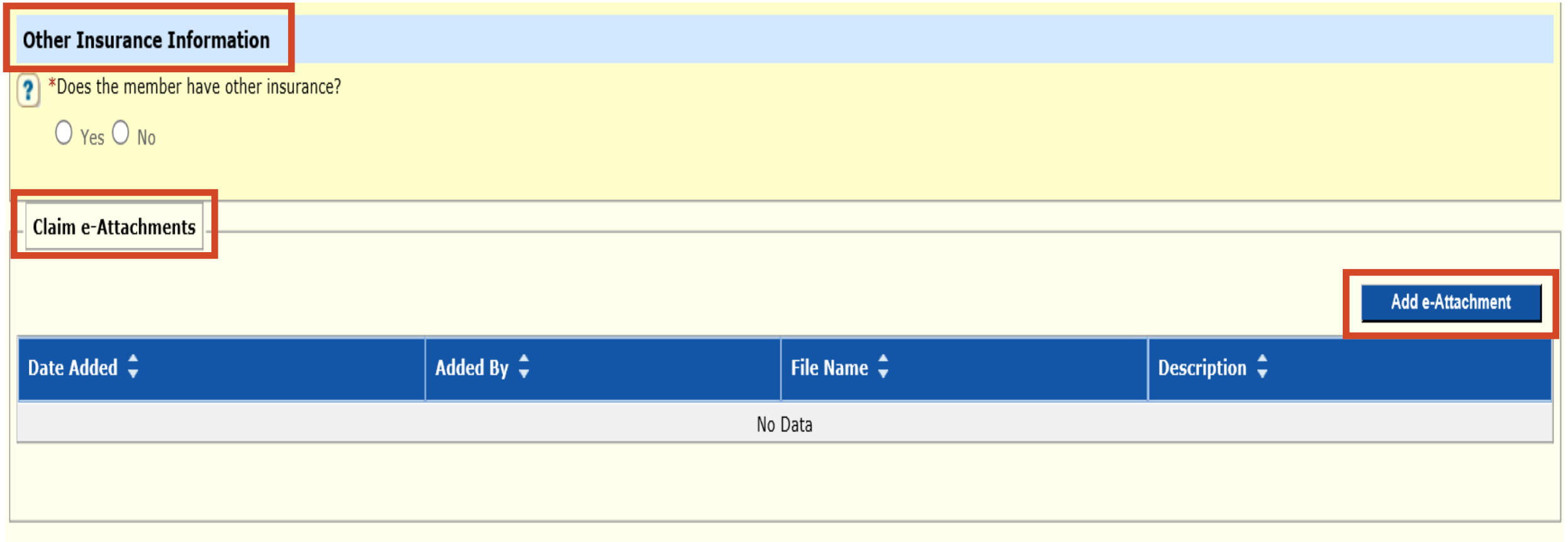


- **Type Attachment**
  - Select the appropriate type of attachment
    - ✓ Example: Discharge Summary

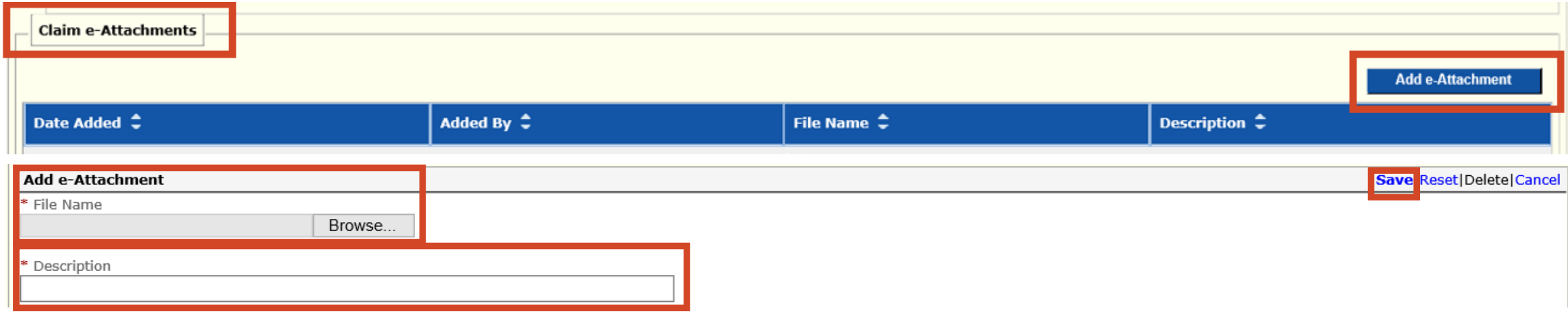


- **Delivery Method**
  - Select the Electronic Only
- **Save**

- **Save – System successfully saved the Information**
- **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 !@#$

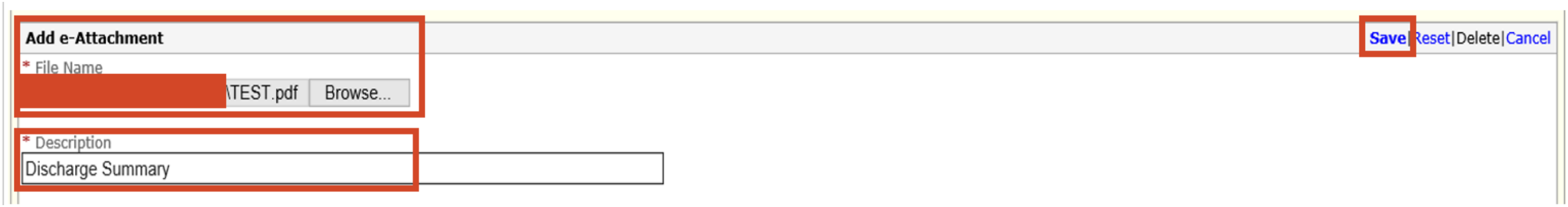
➢ Select Browse

- 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 !@#$

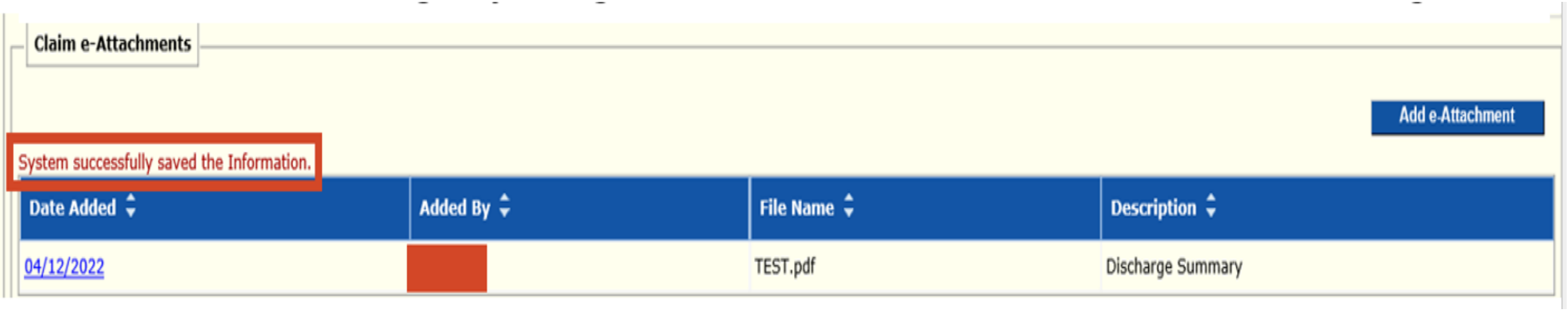
➢ Select Browse

- Insert/select file that is saved to your computer

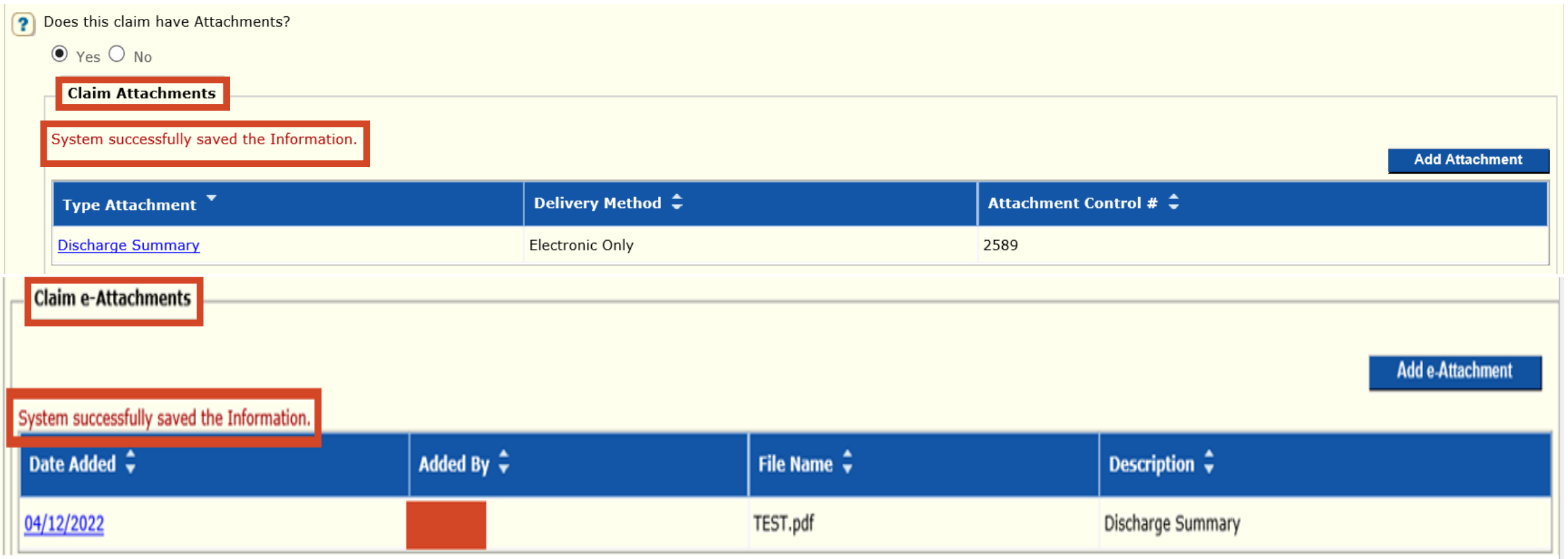
➢ Description

- Content of attachment: example Periodontal Chart

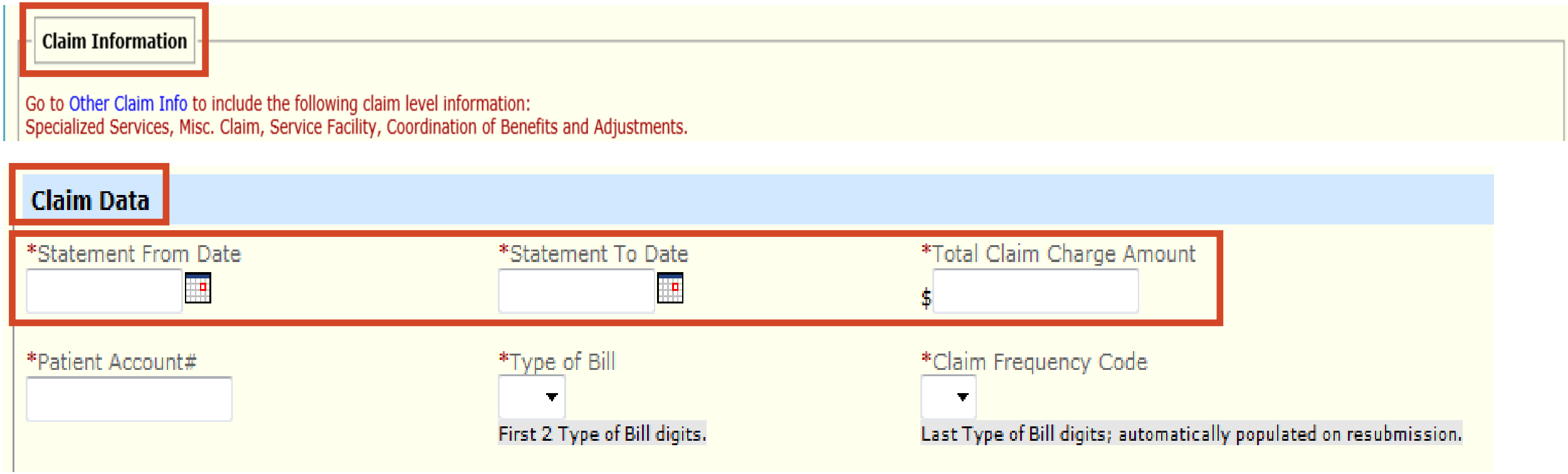
➢ SAVE



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



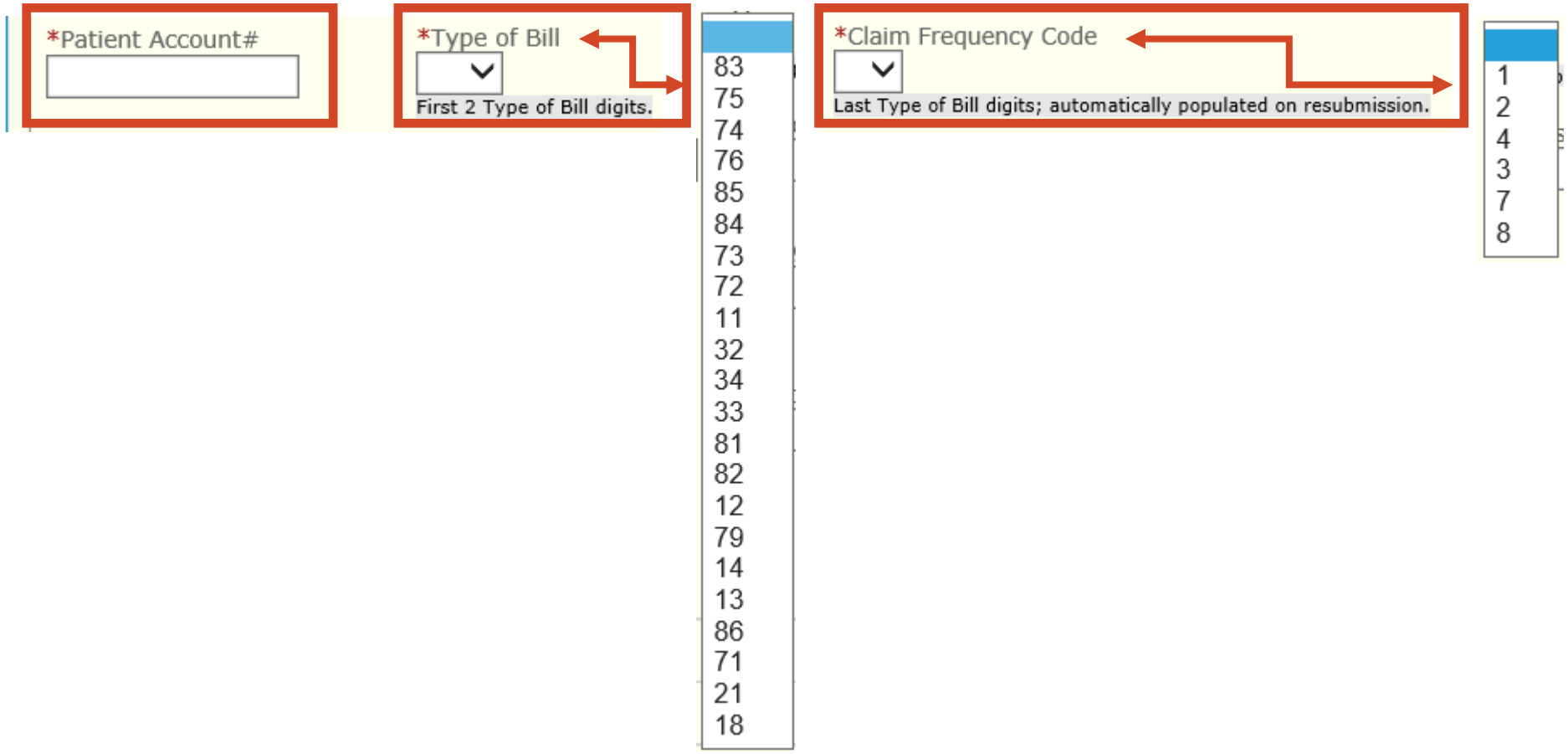
- **Save – System successfully saved the Information**
- **Claim Attachment and Claim e-Attachment must be completed**
- **Note:** If resubmitting/adjusting a claim, all documents need to be attached again.



➢ Claim Data Information

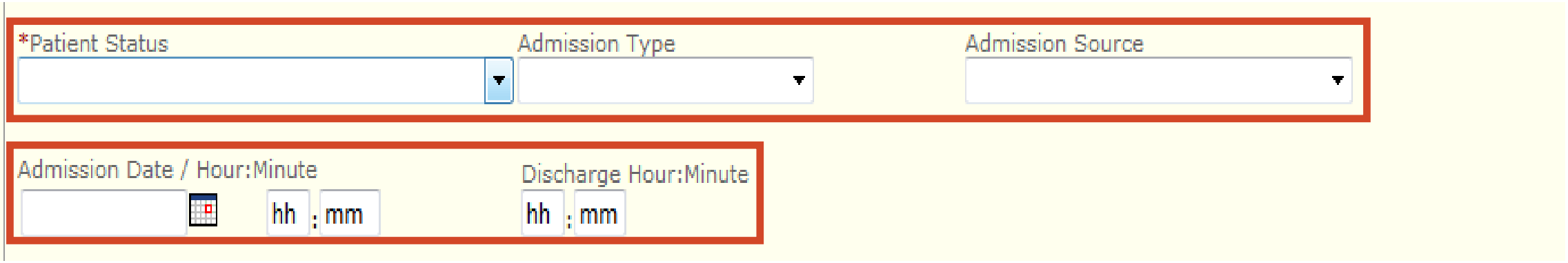
➢ Claim Data

- **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



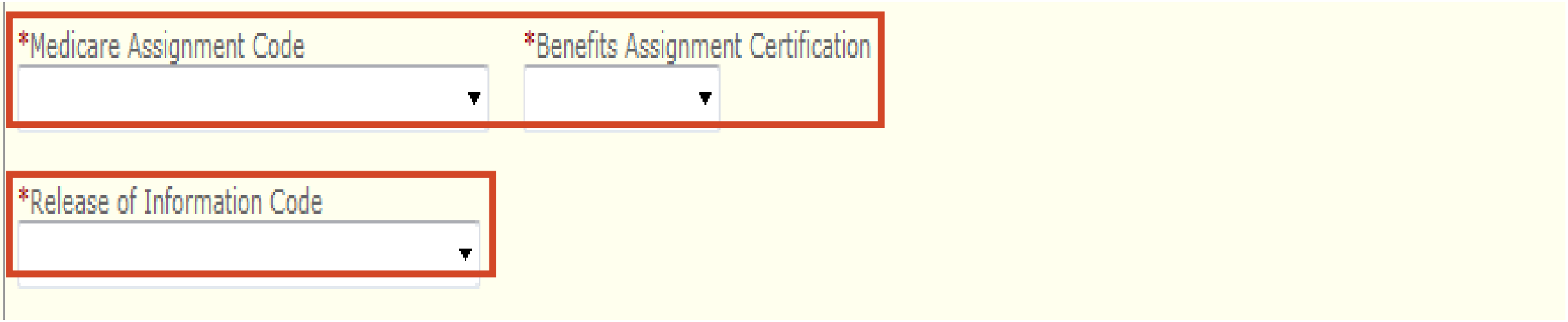
➢ Claim Data Information

- 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



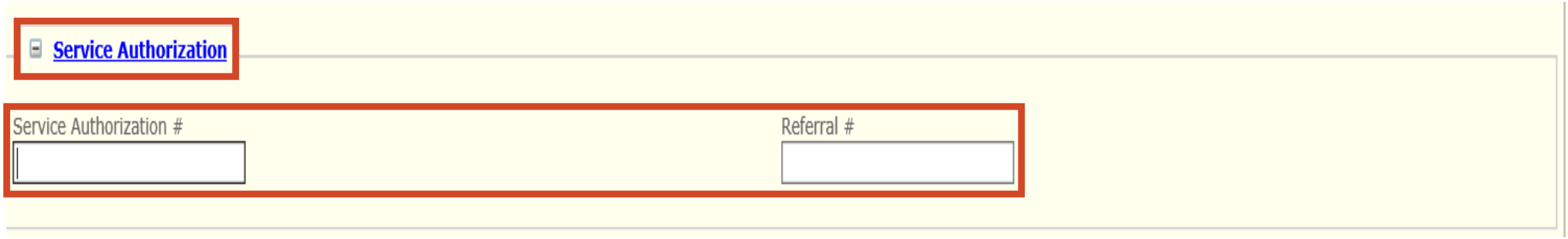
➢ Claim Data Information

- **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



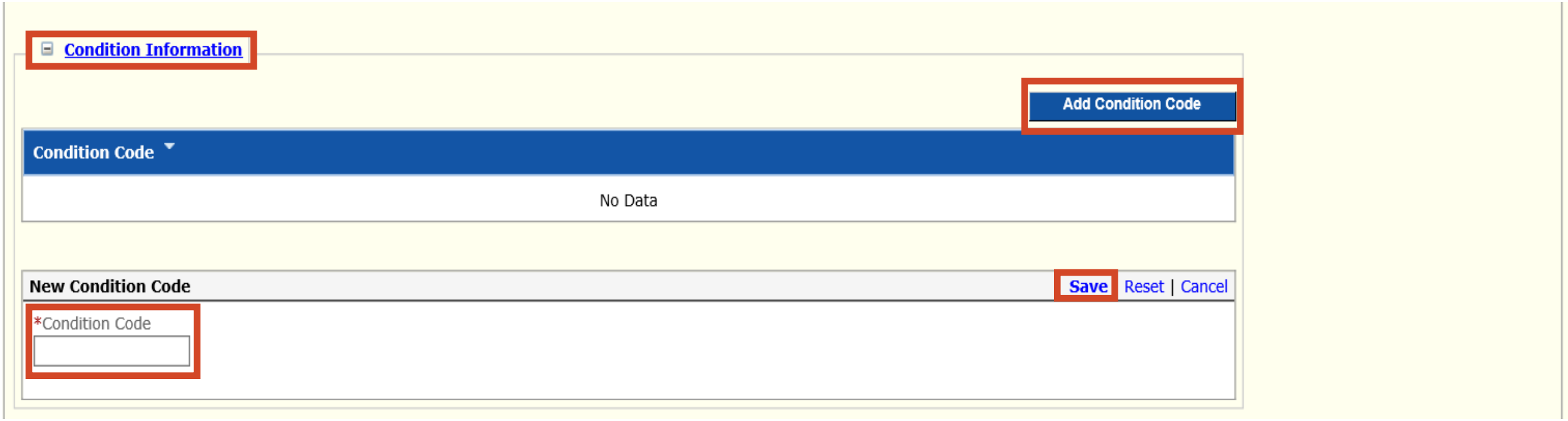
➢ Claim Data Information

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

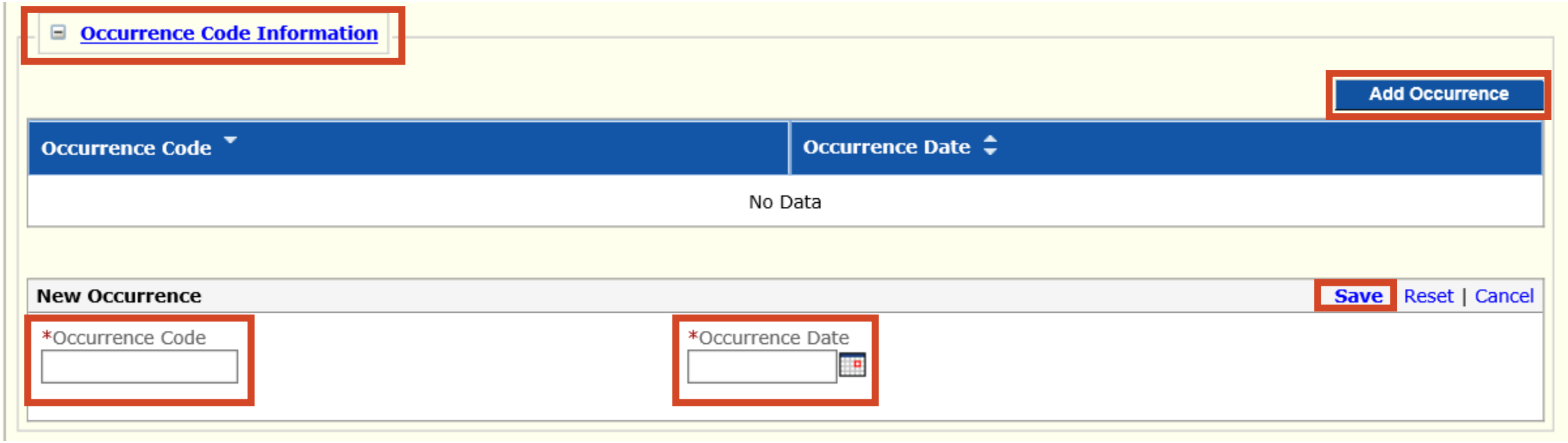


➢ Service Authorization

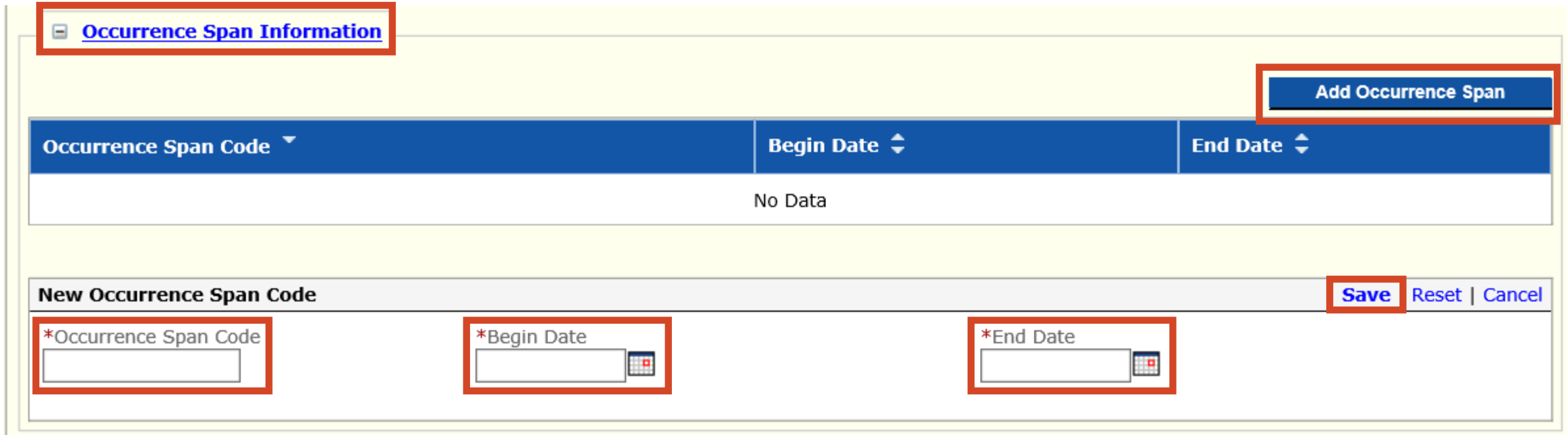
- **REQUIRED – if applicable**
- Service Authorization Number
- Referral Number



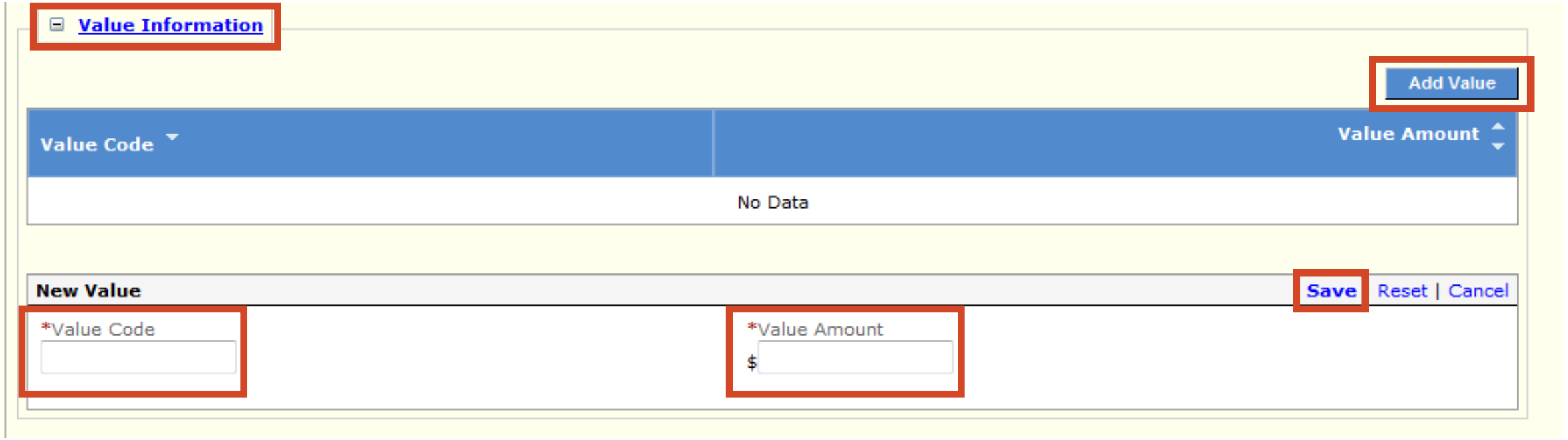
- **Condition Information**
- **Add Condition Code**
  - **REQUIRED – if applicable**
  - Condition Code
  - **Save**



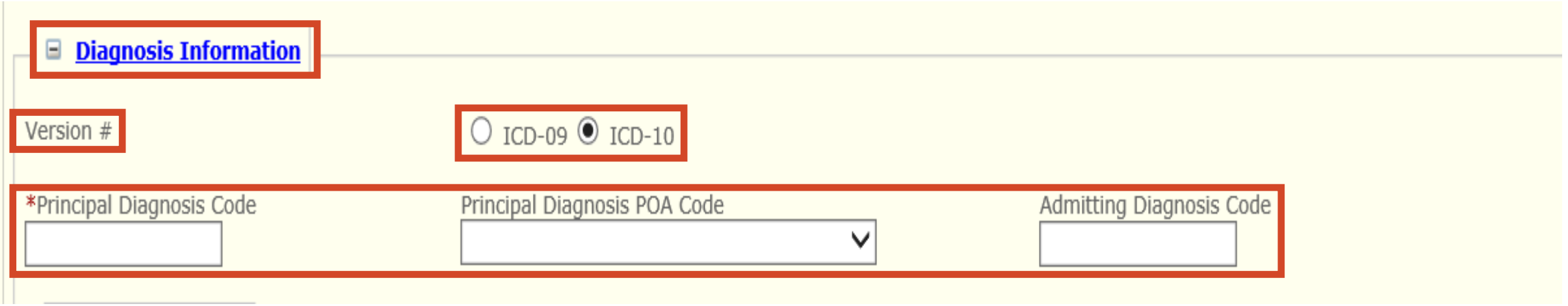
- **Occurrence Code Information**
- **Add Occurrence**
  - **Required – if applicable**
  - Occurrence Code
  - Occurrence Date
  - **Save**



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

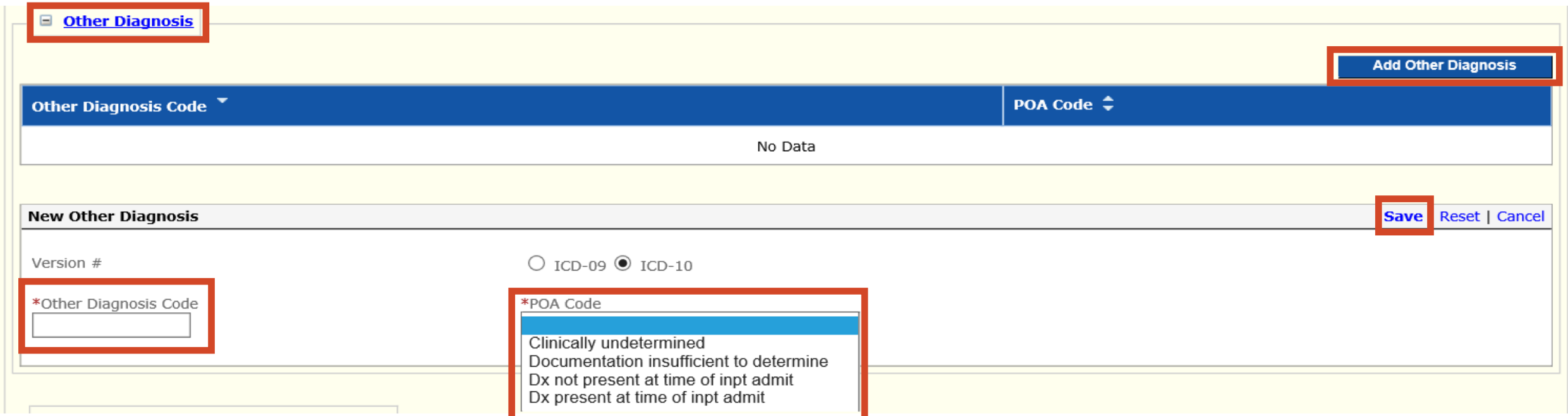


- **Value Information**
- **Add Value**
  - **REQUIRED – if applicable**
  - Value Code - 80 = Covered Days
  - Value Amount - Value Amount should be entered as a dollar amount
    - ✓ Example: 30 days = 30.00
  - **Save**

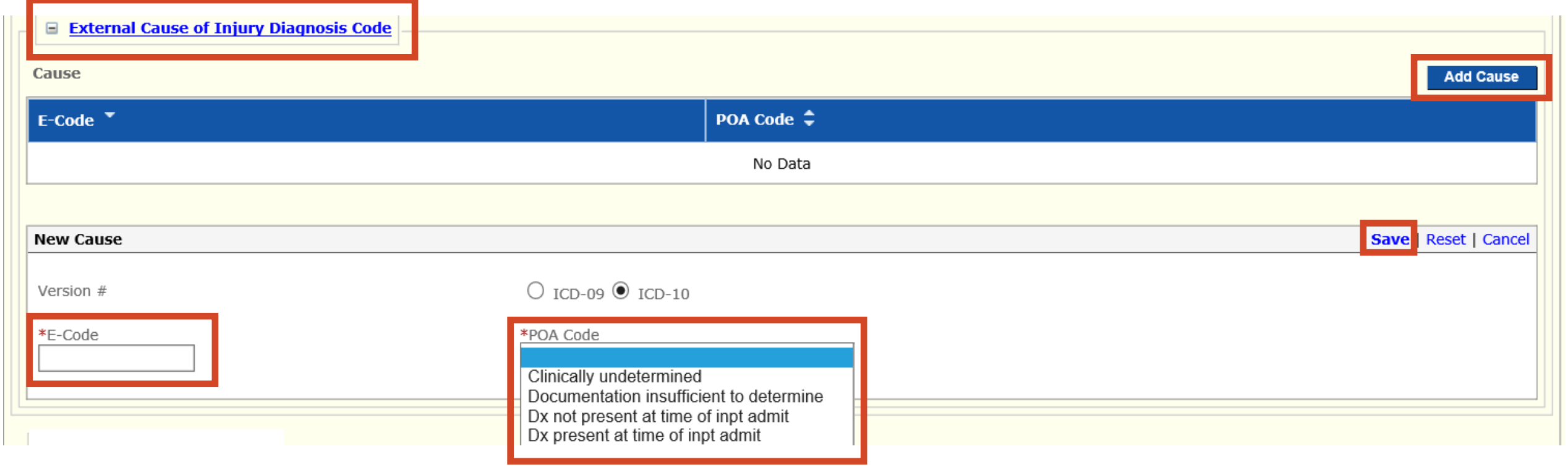


➢ Diagnosis Information

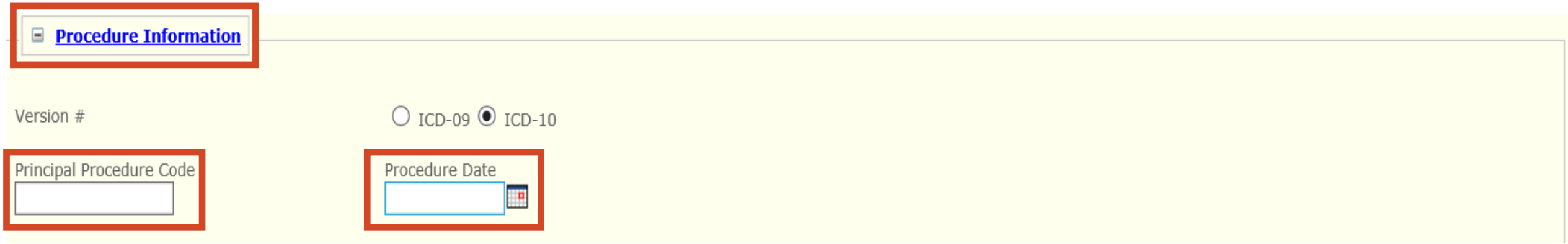
- **REQUIRED**
- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- **Principal Diagnosis Code**
  - ✓ Enter the diagnosis code for the member's primary diagnosis
- **Principal Diagnosis POA Code – if applicable**
- **Admitting Diagnosis Code – if applicable**



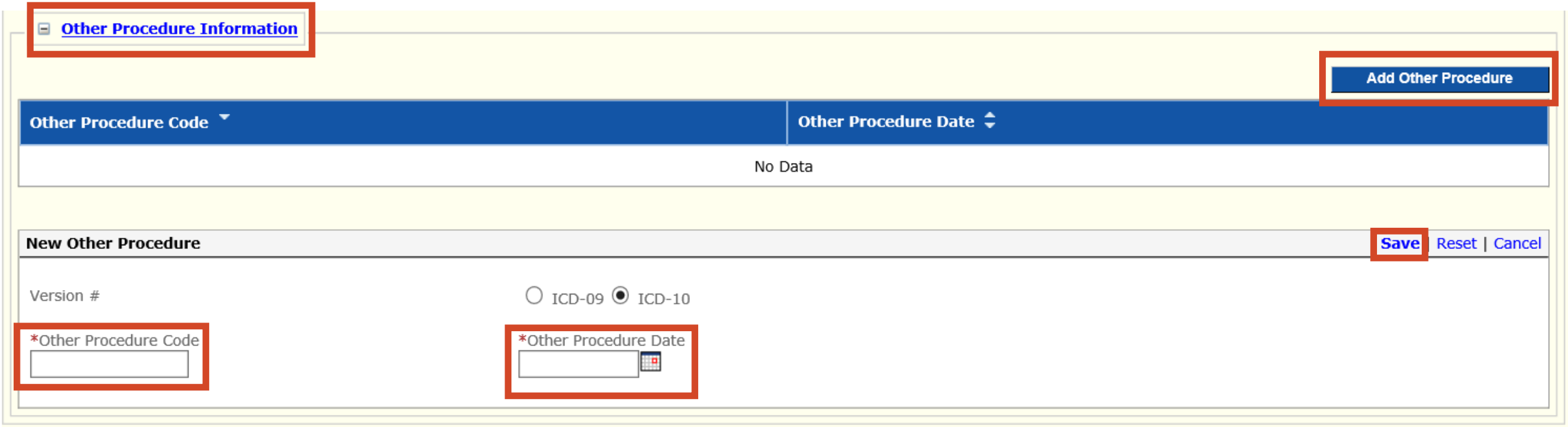
- **Other Diagnosis**
- **Add Other Diagnosis**
  - **REQUIRED – if applicable**
  - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
  - **Other Diagnosis Code - Additional Diagnosis Codes**
    - ✓ Enter the diagnosis code for the member's additional diagnosis's
  - **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**



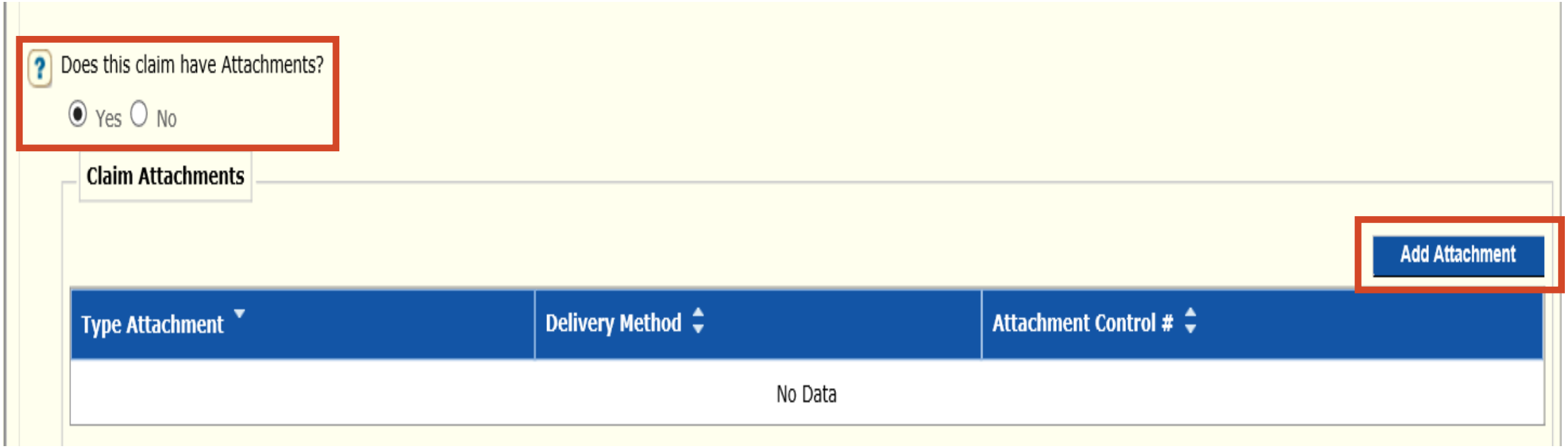
- **Procedure Information**
  - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
  - Principal Procedure Code
  - Procedure Date



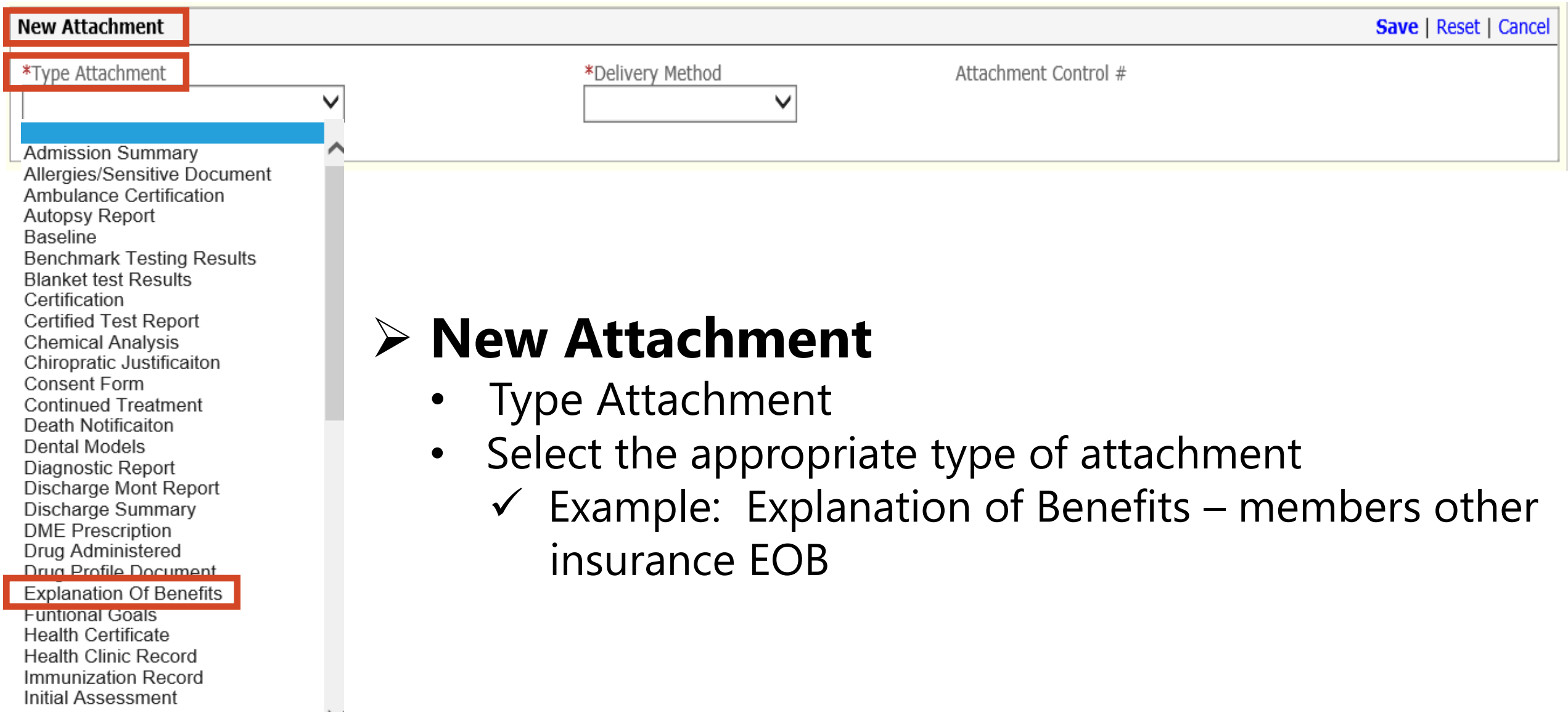
- **Other Procedure Information**
- **Add Other Procedure**
  - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
  - Other Procedure Code
  - Other Procedure Date
  - **Save**

➢ Billing Note

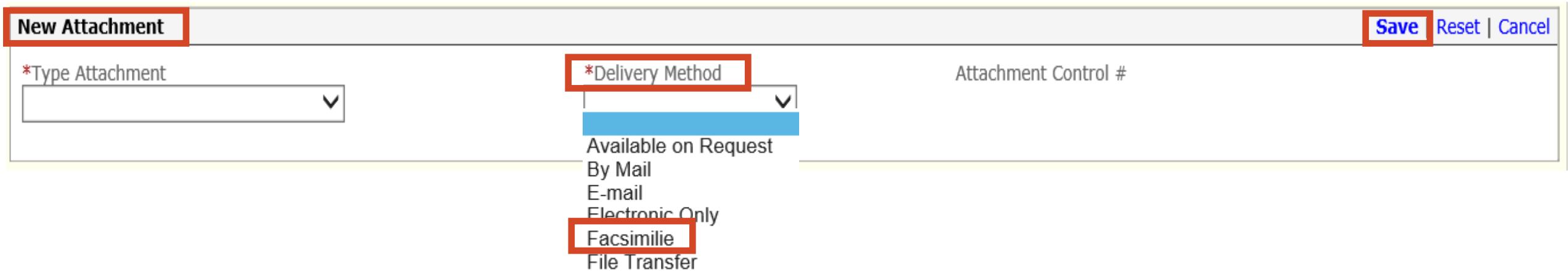
- Add any pertinent information
  - ✓ Example Note: Proving the One-Year Timely Filing Limit Policy Remittance Advice (RA) Date and TCN Number



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



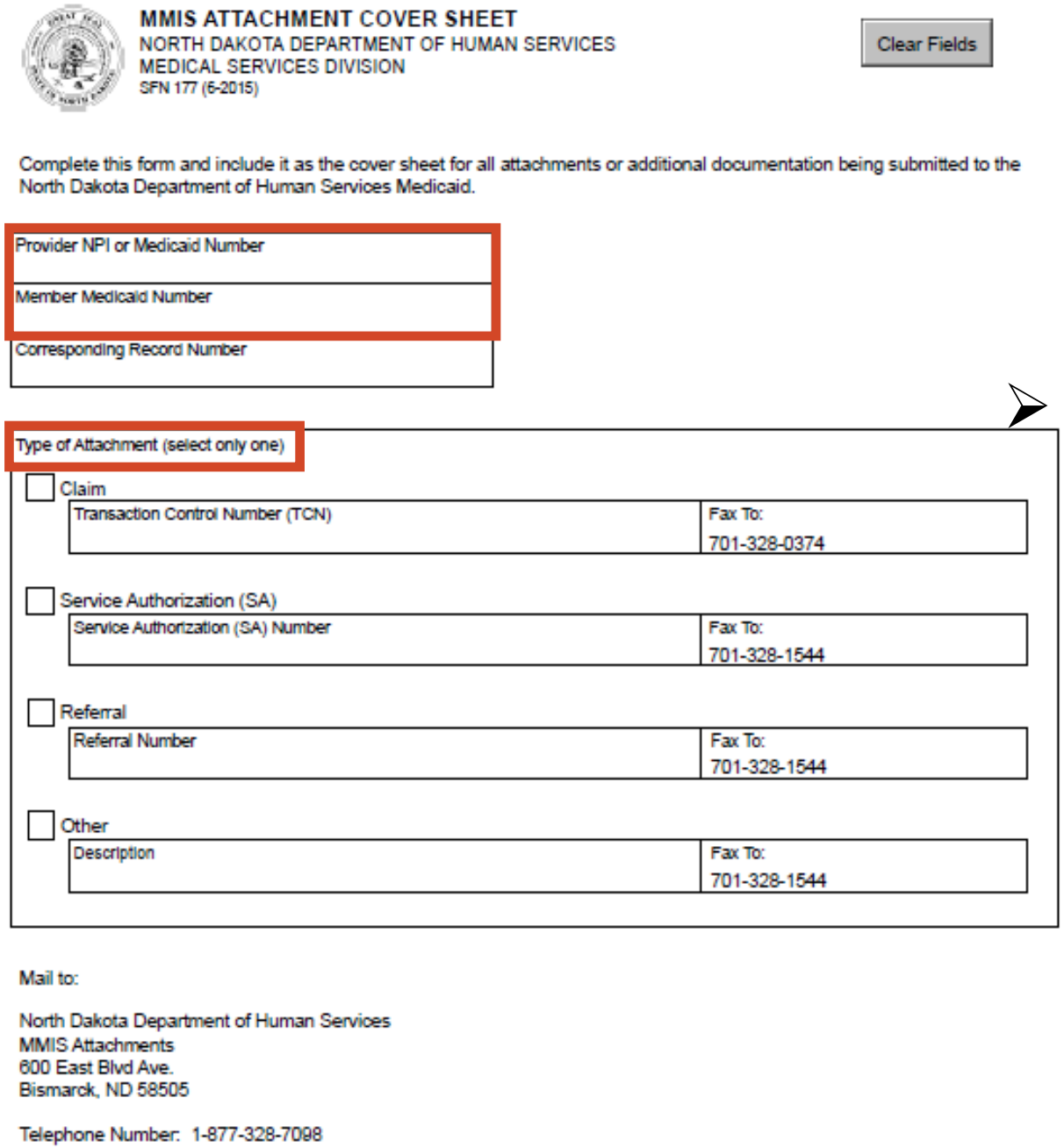
- **New Attachment**
  - Type Attachment
  - Select the appropriate type of attachment
    - ✓ Example: Explanation of Benefits – members other insurance EOB



- **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



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:

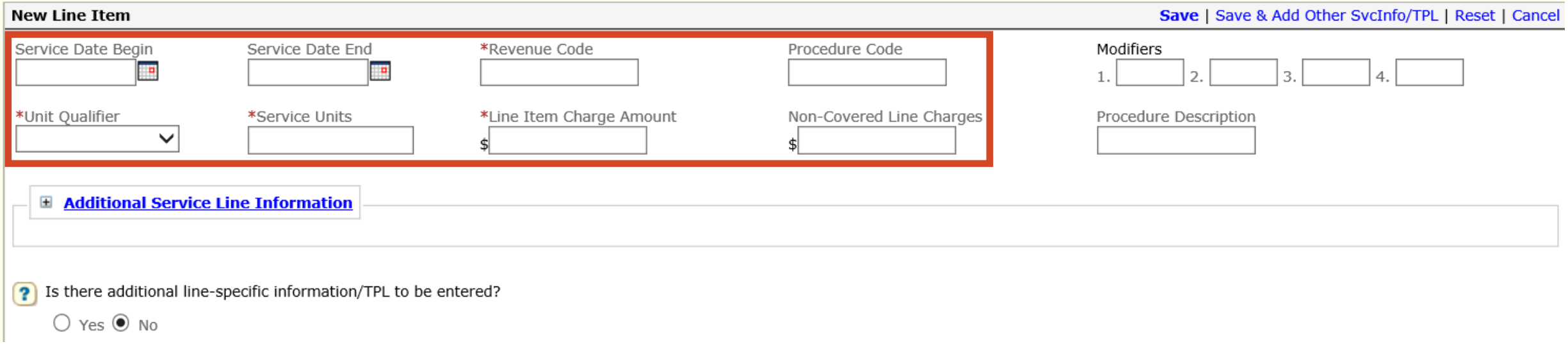
North Dakota Department of Human Services
MMIS Attachments
600 East Blvd Ave.
Bismarck, ND 58505

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
  - ✓ Fax to the appropriate phone number



- **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 **Slide 63** for instructions
  - **Save & Add Other Svc Info/TPL**

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: $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

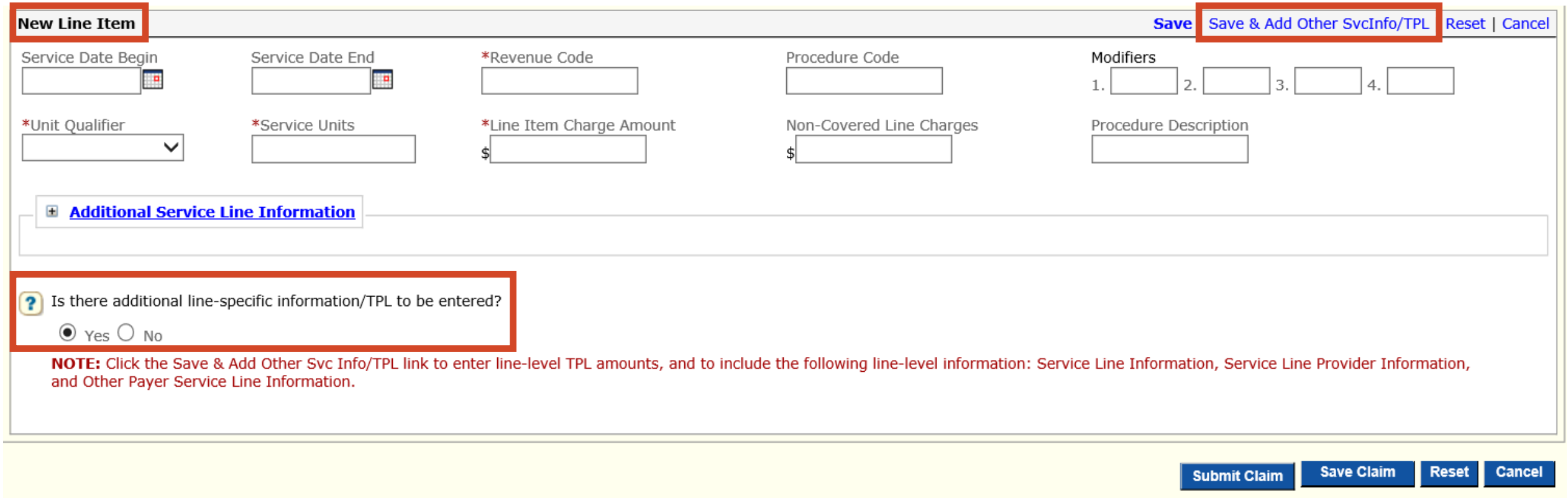
Line #	Adjustment Reason Code	Description
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance 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	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 - 2 of 2

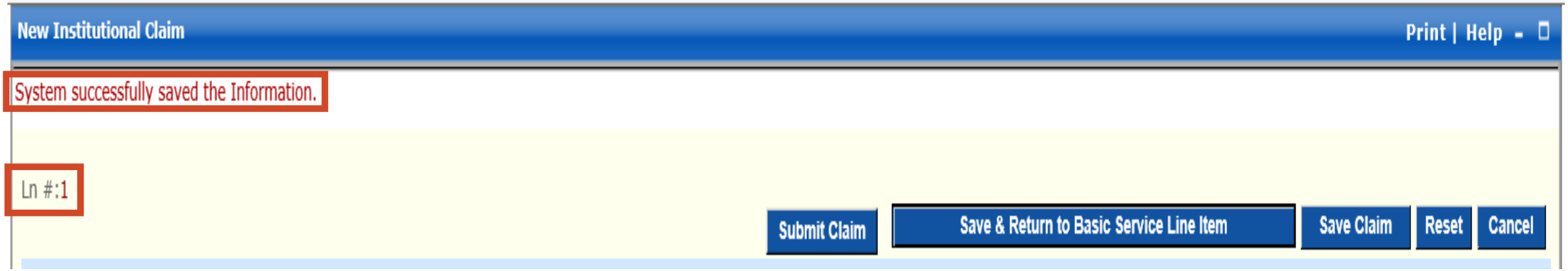
Remark Codes

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

- **Print and Save for your records**

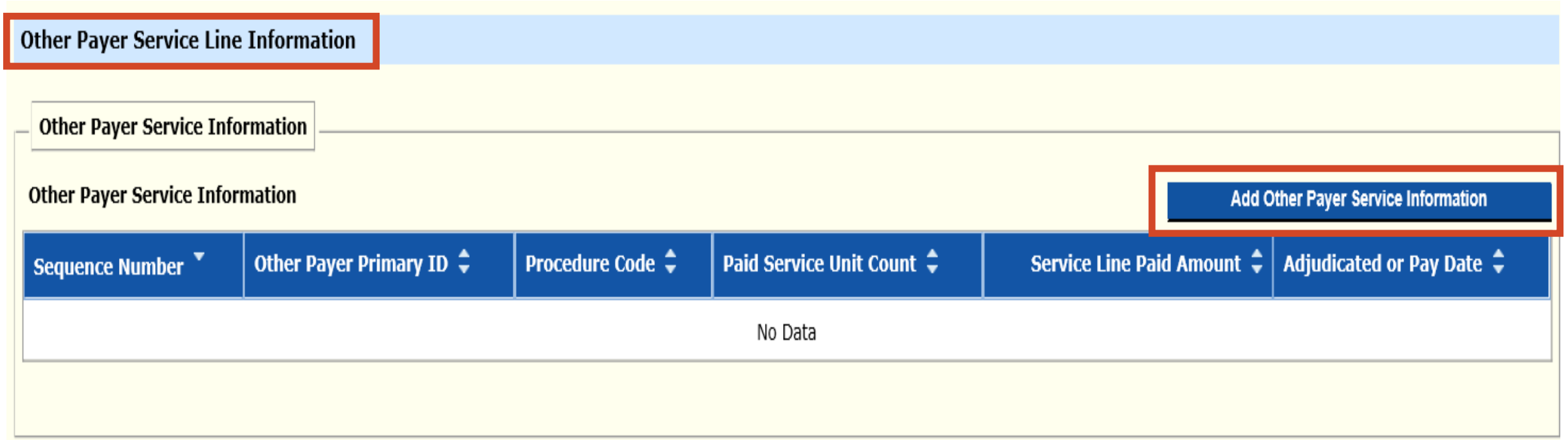


- **Is there Additional line-specific information/TPL to be entered?**
  - **Yes** – Member has Other Insurance
  - **Save & Add Other Svc Info/TPL**



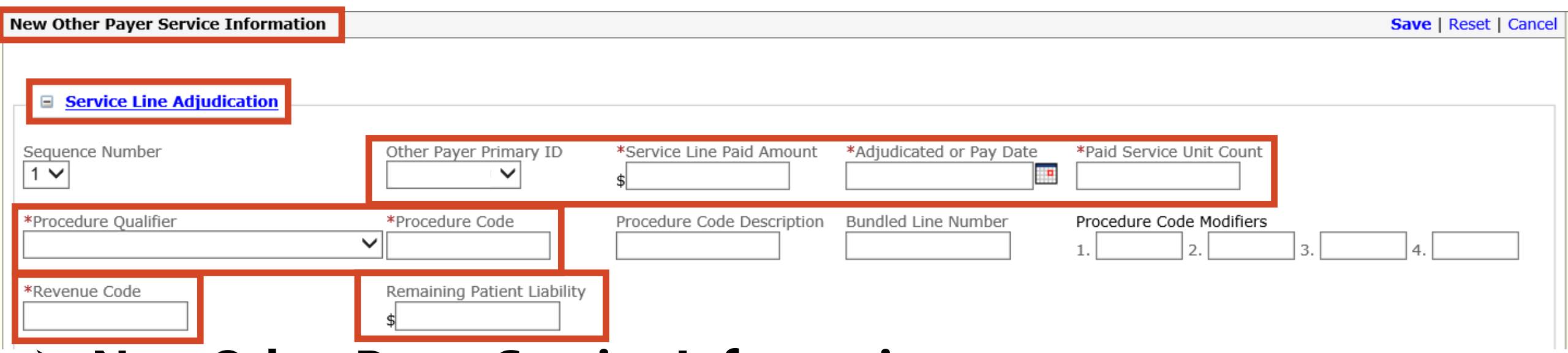
➢ New Institutional Claim

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

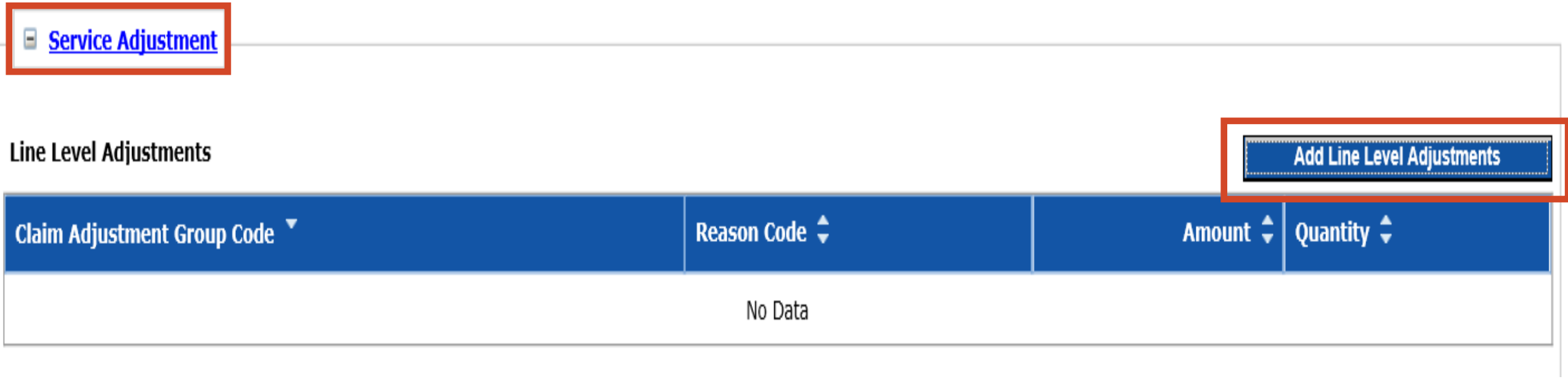


➢ Other Payer Service Line Information

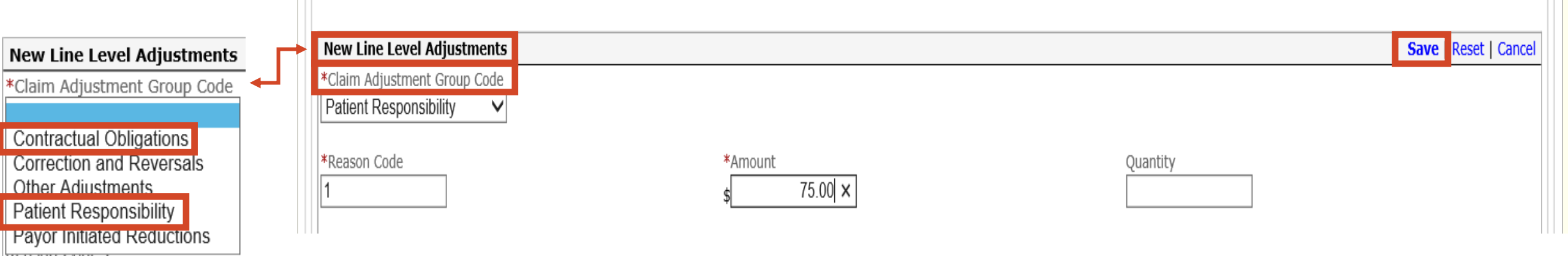
- Add Other Payer Service Information



- **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



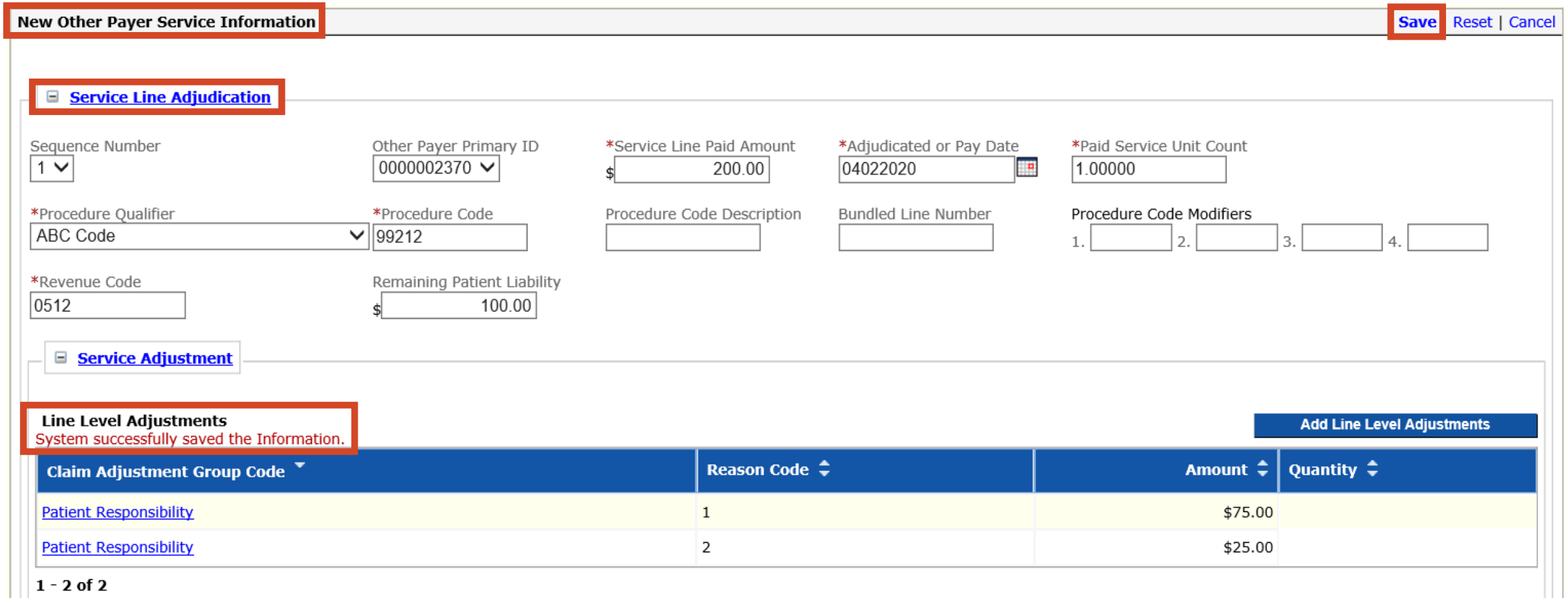
- **Service Adjustment**
- **Add Line Level Adjustments**



➢ 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**

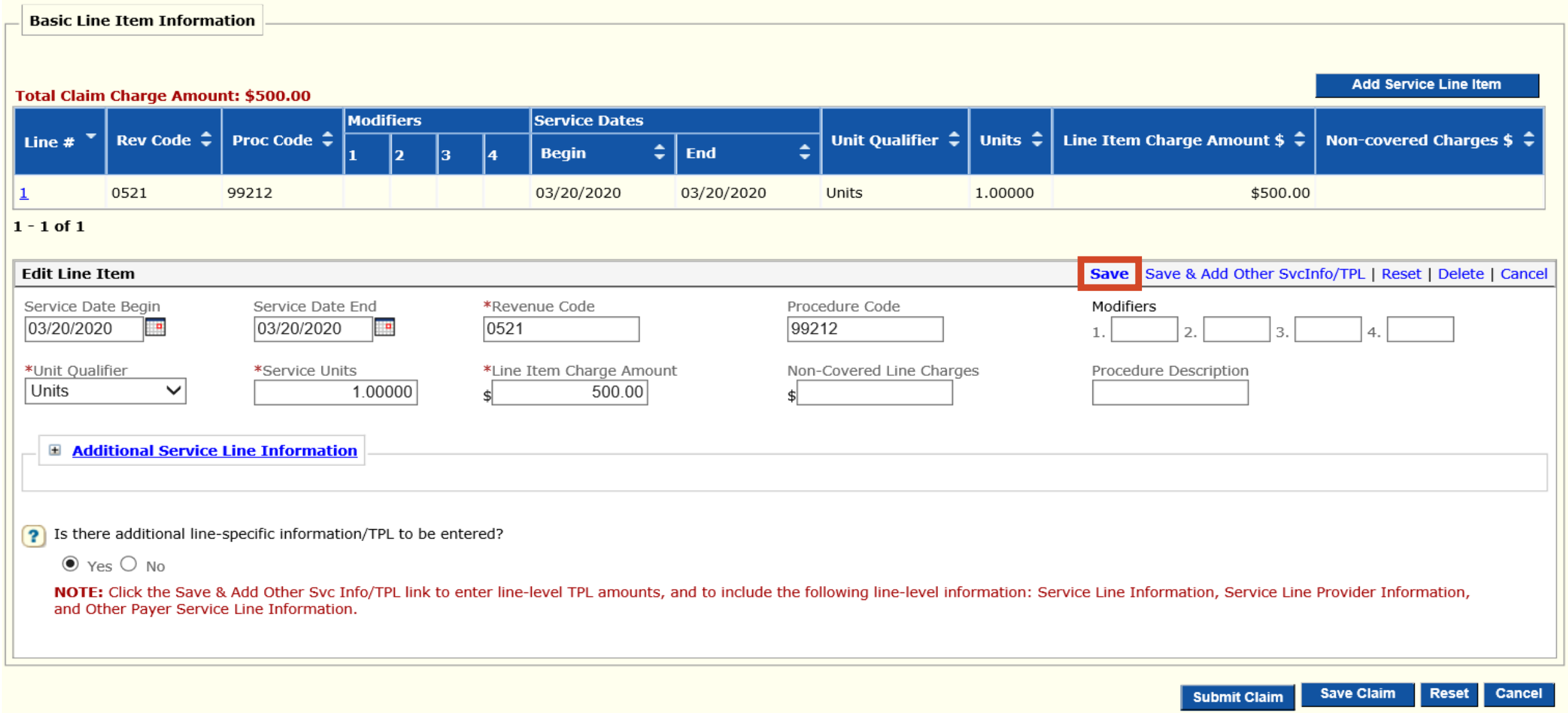


➢ New Other Payer Service Information

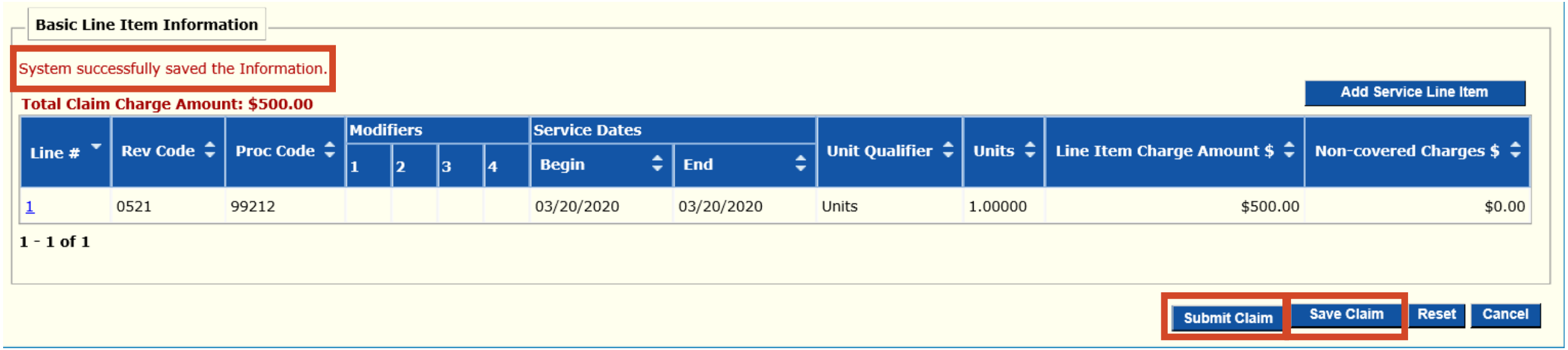
- Additional Adjustments - Add Line Level Adjustments – if applicable
- Verify Line Level Adjustments saved
- **Save – New Other Payer Service Information**

- **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**


Basic Line Item Information
Total Claim Charge Amount: $500.00
Add Service Line Item
Line # | Rev Code | Proc Code | Modifiers 1 2 3 4 | Service Dates Begin End | Unit Qualifier | Units | Line Item Charge Amount $ | Non-covered Charges $
1 | 0521 | 99212 | | | | | 03/20/2020 | 03/20/2020 | Units | 1.00000 | $500.00 |
1 - 1 of 1
Edit Line Item
Save | Save & Add Other SvcInfo/TPL | Reset | Delete | Cancel
Service Date Begin 03/20/2020
Service Date End 03/20/2020
*Revenue Code 0521
Procedure Code 99212
Modifiers 1. 2. 3. 4.
*Unit Qualifier Units
*Service Units 1.00000
*Line Item Charge Amount $ 500.00
Non-Covered Line Charges $
Procedure Description
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.
Submit Claim
Save Claim
Reset
Cancel

➢ 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**

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: $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.

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1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
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- **Print and Save for your records**