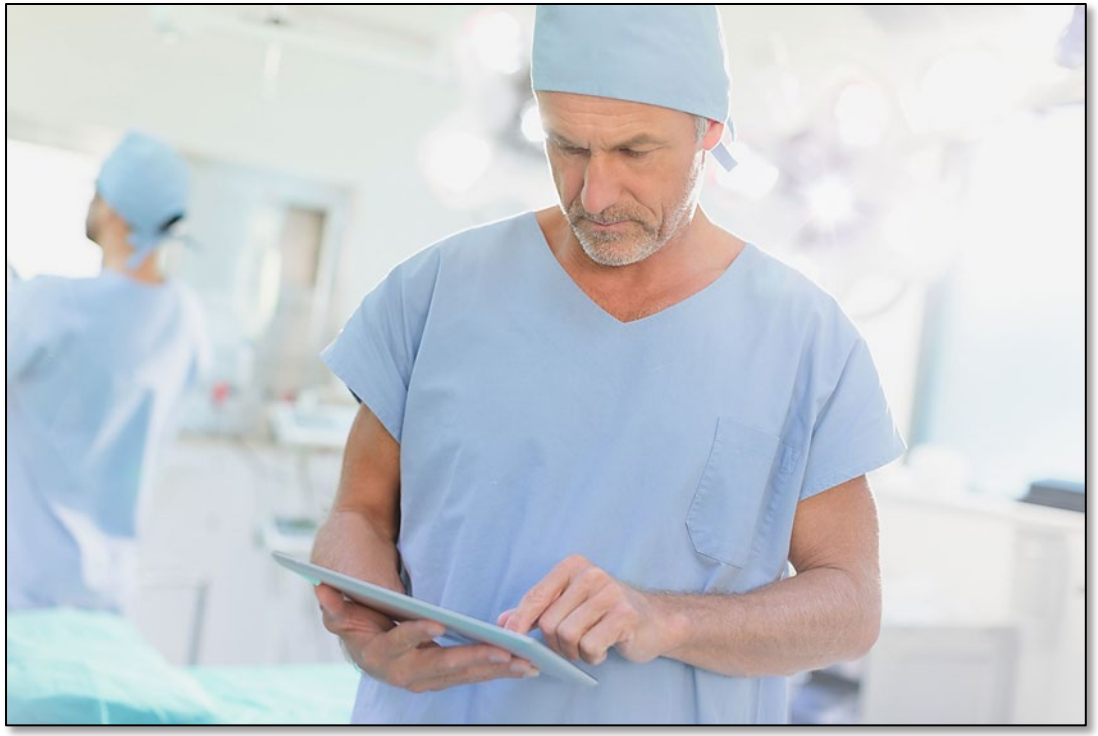
Wyoming Department of Health

Institutional Claims

Claim Submission

Course Content

- Institutional Claim Overview
- Institutional Claim Submissions
- Institutional Claim with Third-Party Liability (TPL)
- Institutional Claim with Tertiary Third-Party Liability (TPL)
- Institutional Claim Attachments



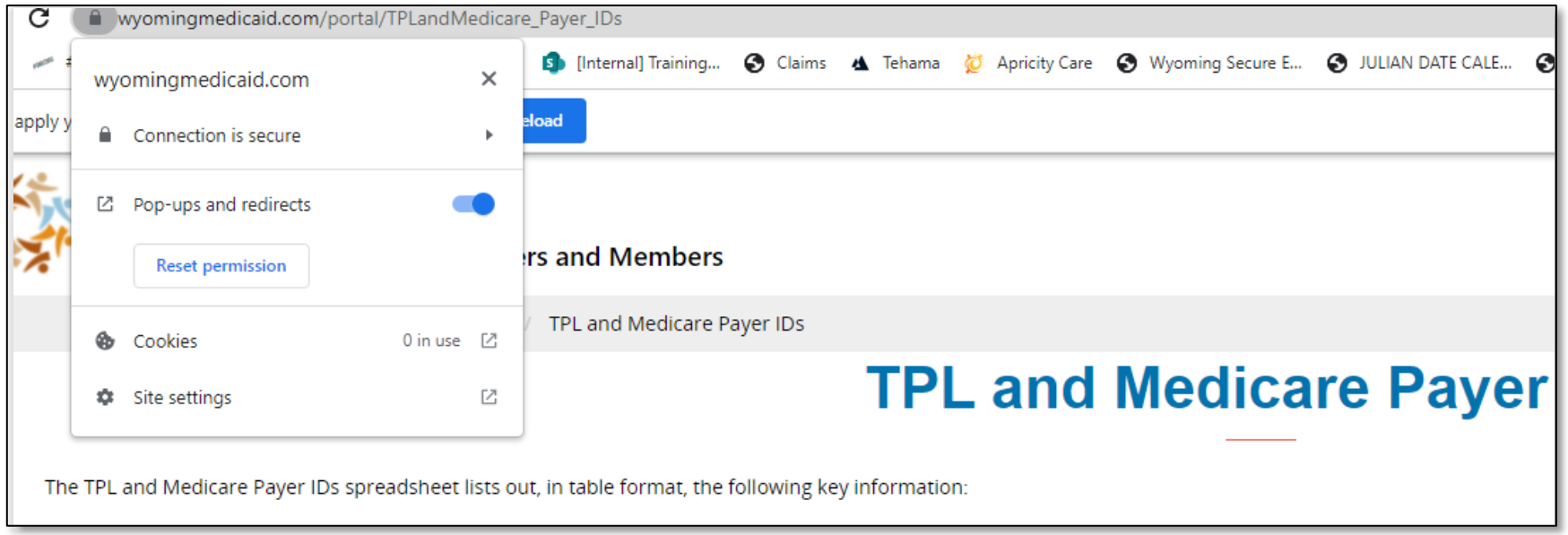
Institutional Claims Overview

- Institutional Claims are submitted by hospitals, nursing homes, and hospice
  - Member receives a service
  - Provider submits a claim
  - Claims include information about the Member, Provider, and service
  - The claim is submitted to the State Medicaid Agency
  - The claim is approved and paid or denied

Institutional Claims

How to enter an Institutional Claim

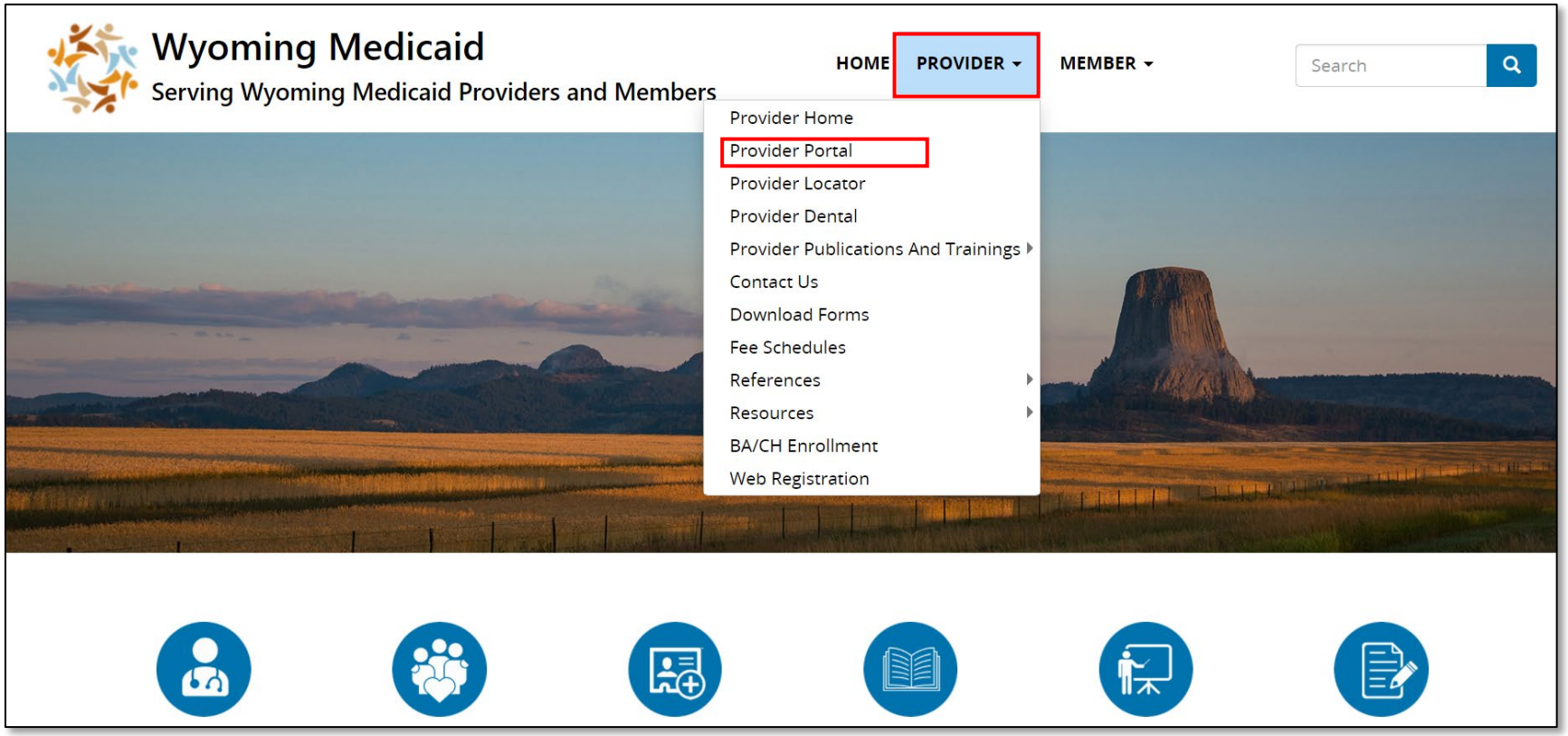
Institutional Claims Submission



Before Claim Submission Begins:

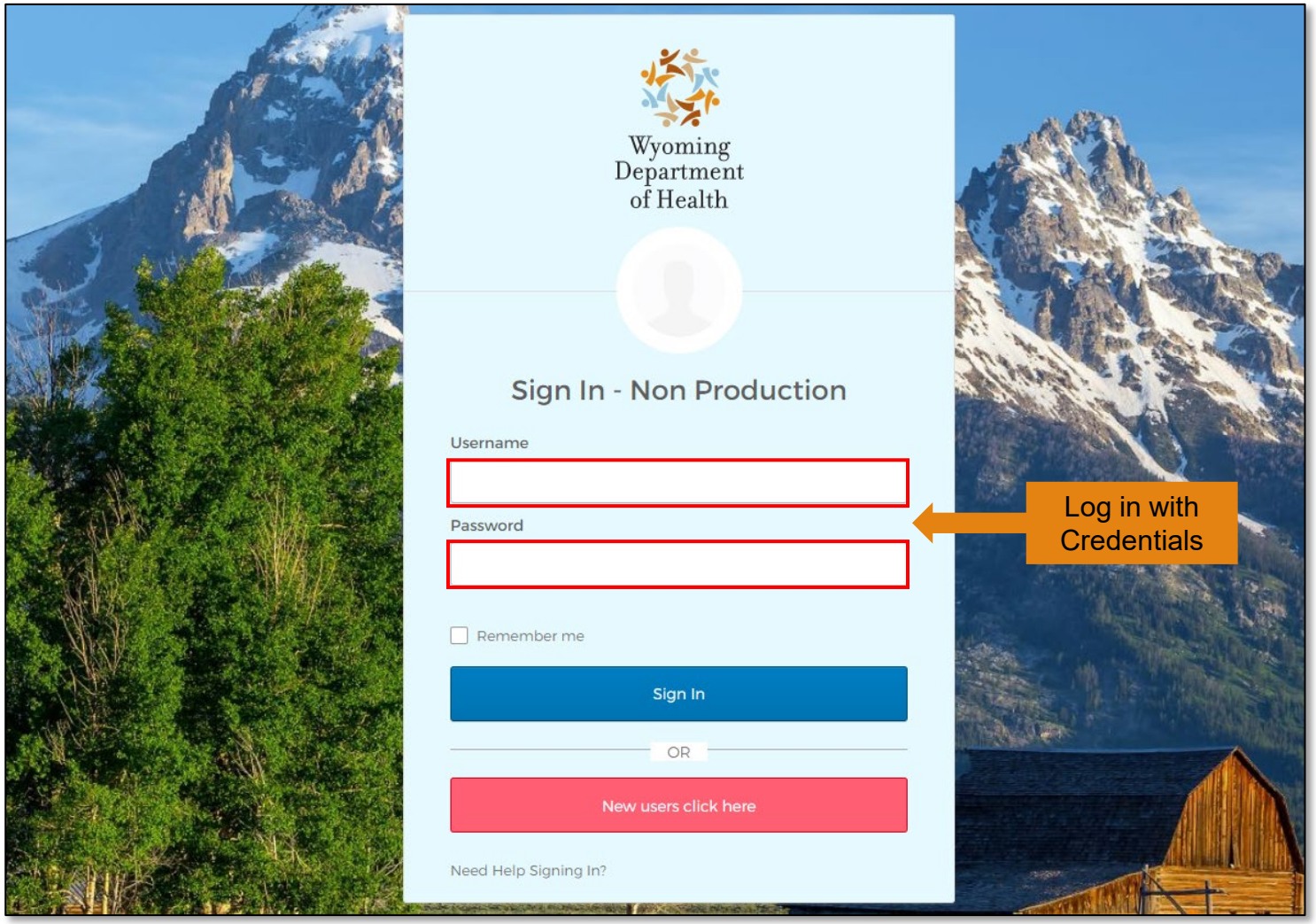
- Check that pop-up blocker will allow pop-ups from the BMS System
- Have all materials needed such as Explanation of Benefits (EOB), Claim Information, and Member Information

Institutional Claims Submission



- Access the Medicaid Website at: https://www.wyomingmedicaid.com/
- Select **Provider** at the top of the page. A drop-down list displays
- Select **Provider Portal**

Institutional Claims Submission

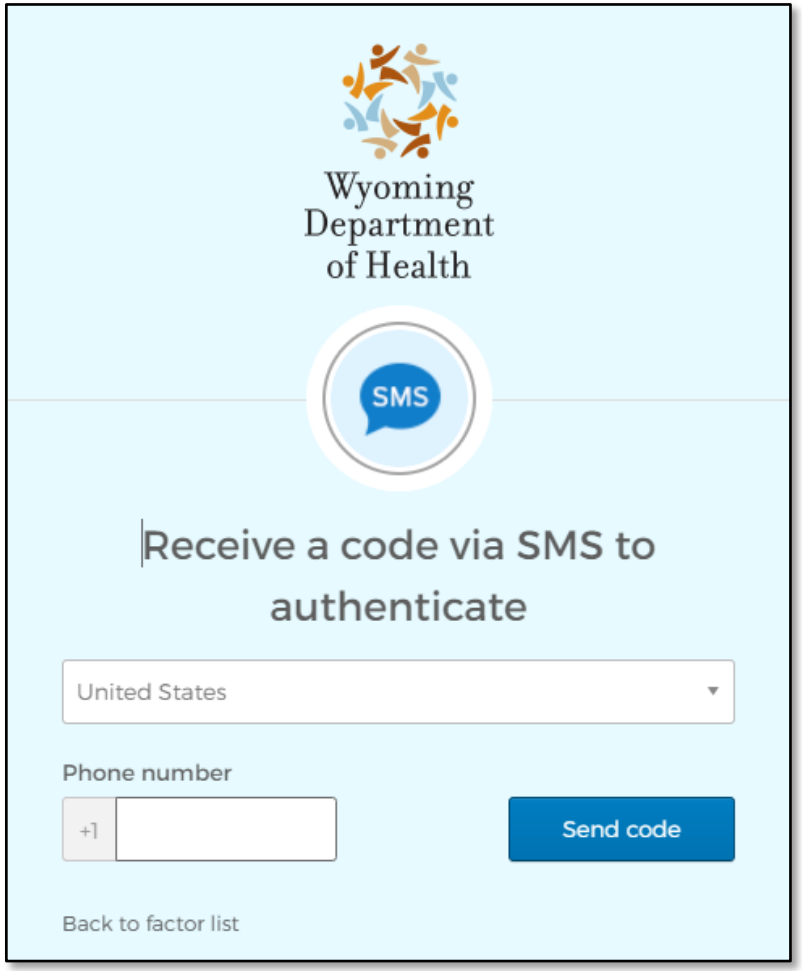


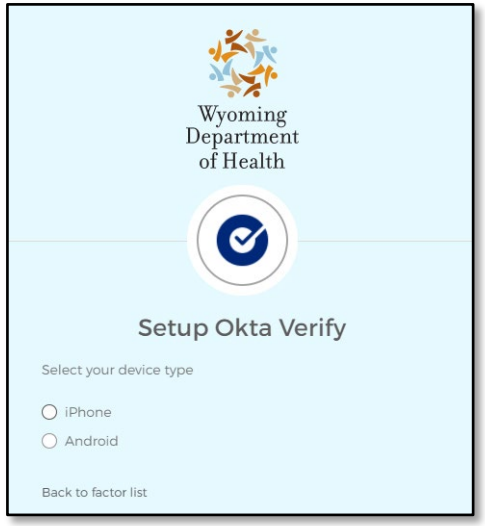
Log in to the BMS system:

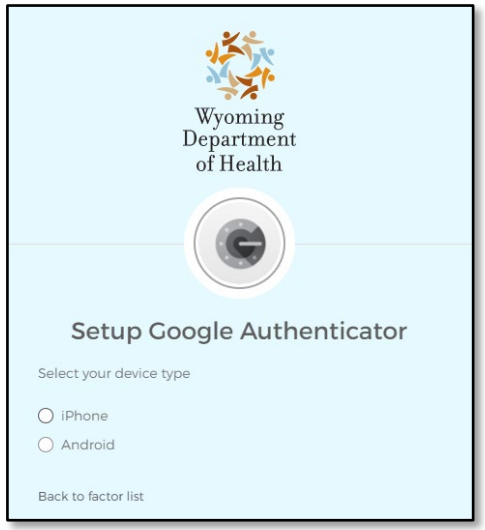
- Log in to the Provider Portal with your Single Sign-On (SSO) username and password

After logging in, an authentication screen displays to authenticate access to the system.

Institutional Claims Submission







After logging in, the Multi-Factor Authentication (MFA) appears to authenticate access to the system:

Verify authentication based on your setup selection:

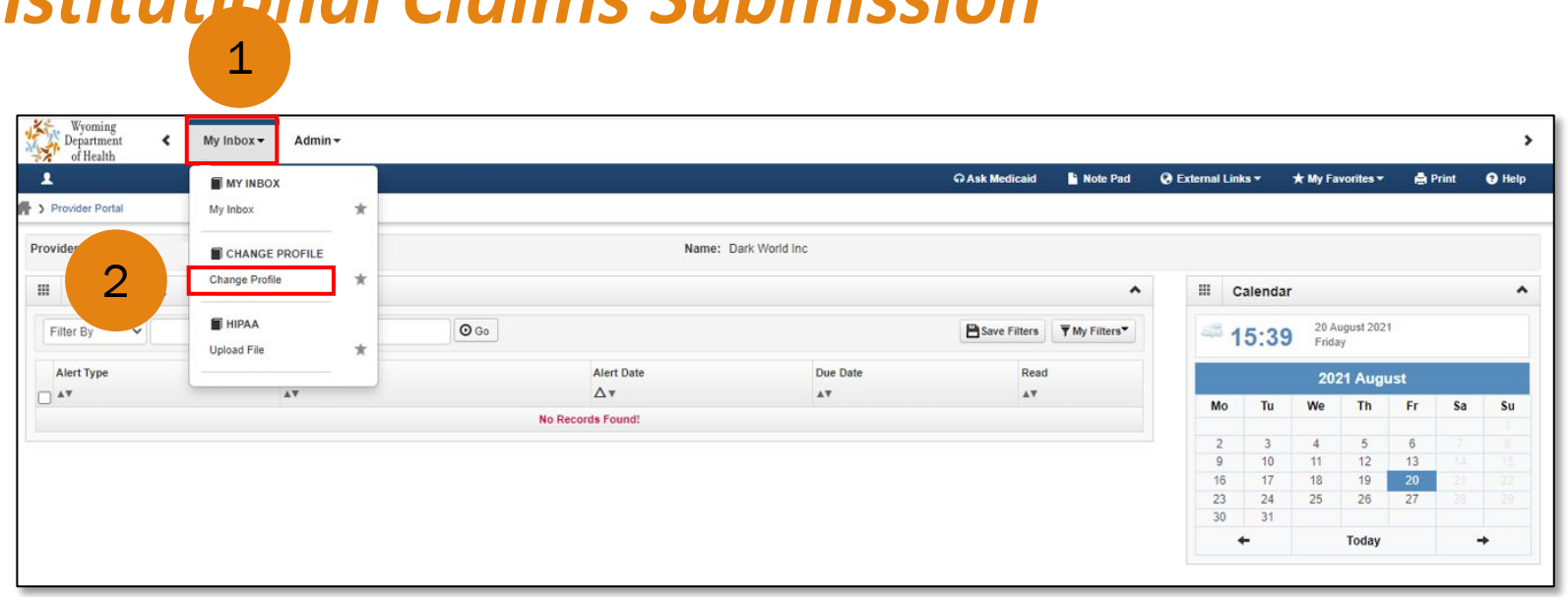
- Select **Send code** for SMS
- If you chose Google Authenticator, enter that code
- If you did an OKTA push, accept the push

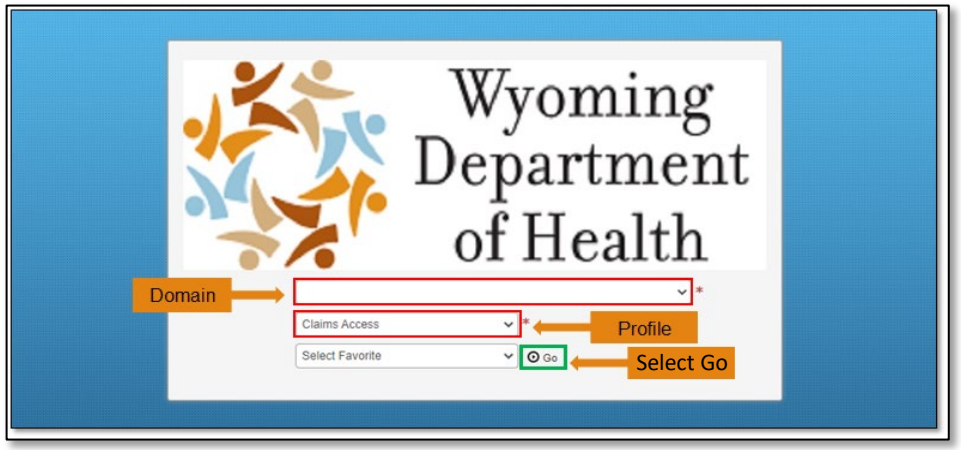
Institutional Claims Submission

Next, select the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**

Institutional Claims Submission





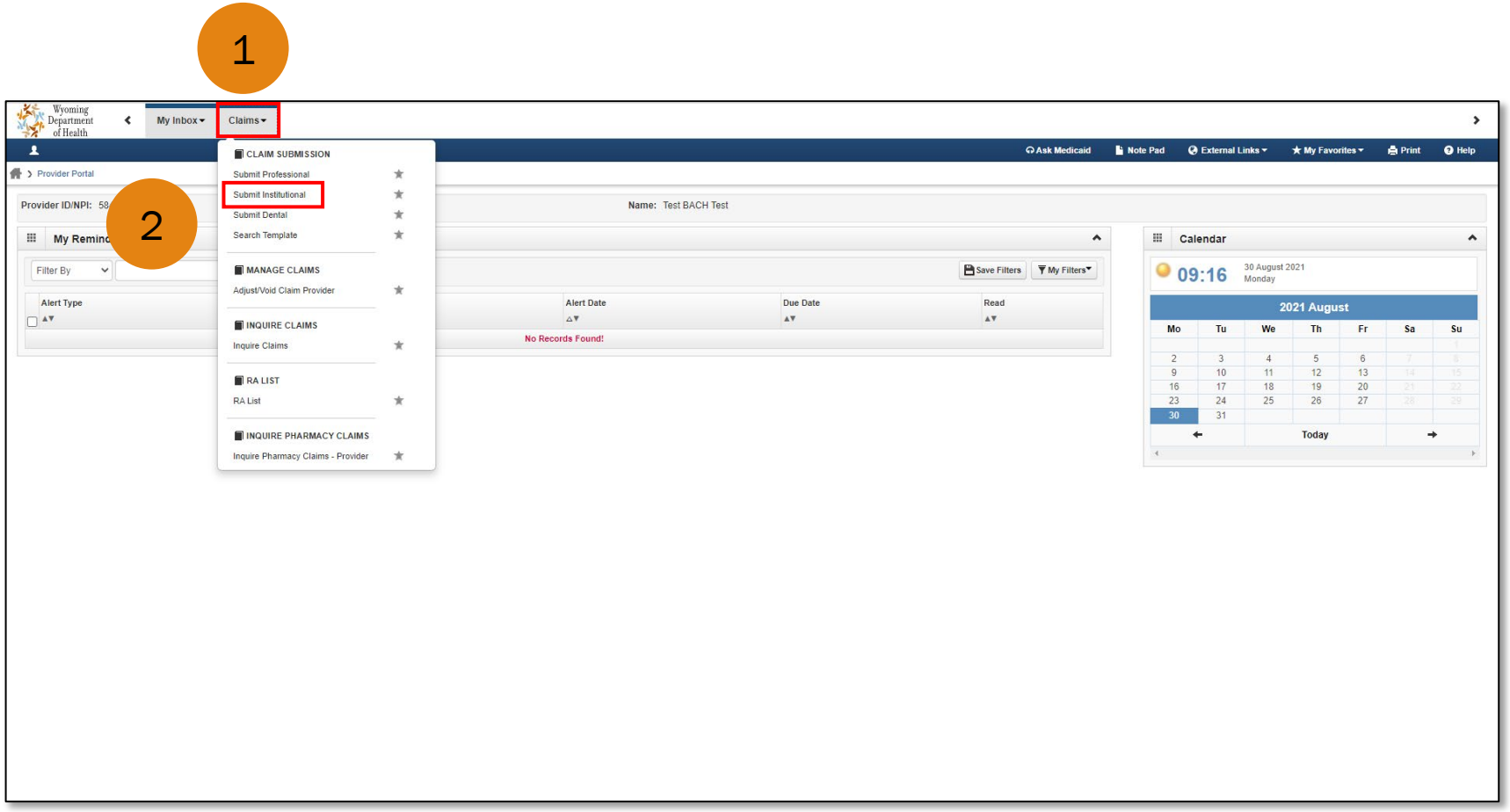
If you are already logged in to the Provider Portal, you can change your profile:

1. Select **My Inbox**.
2. Select **Change Profile**.

Next, select the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**

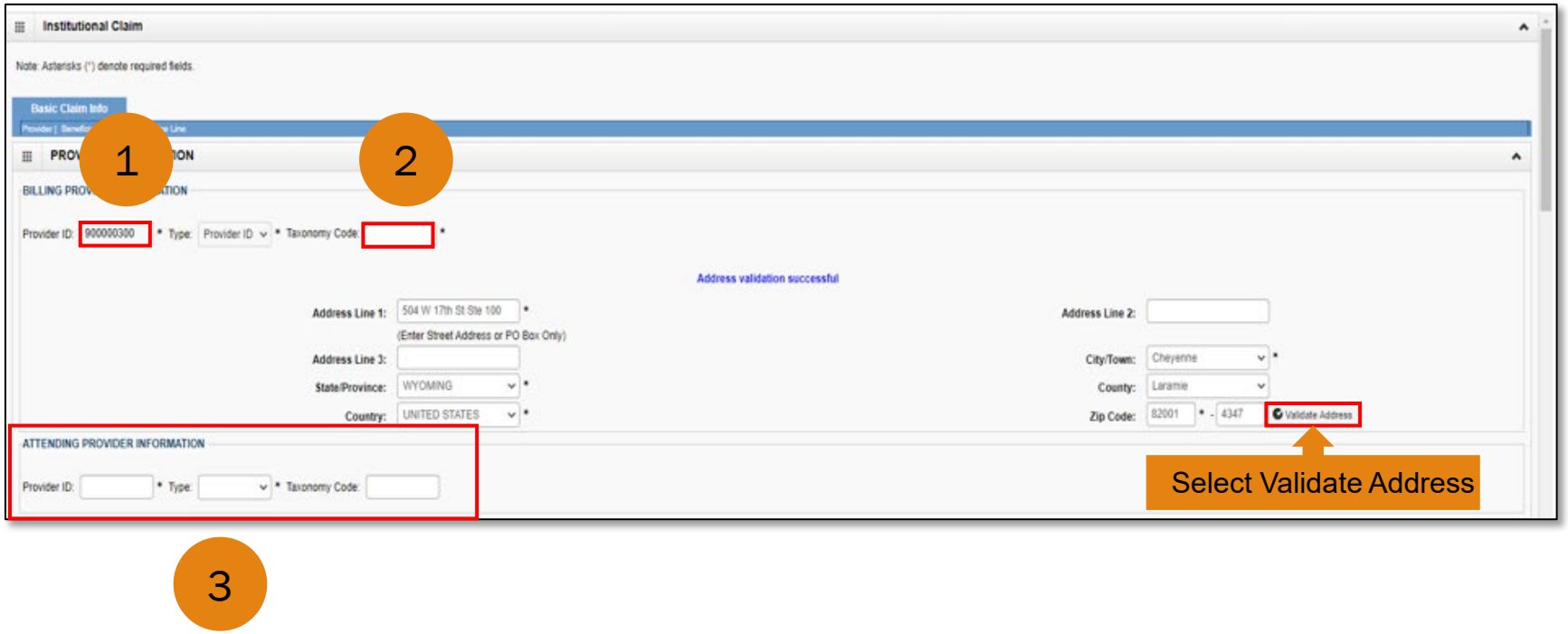
Institutional Claims Submission



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission



To enter Provider Information:

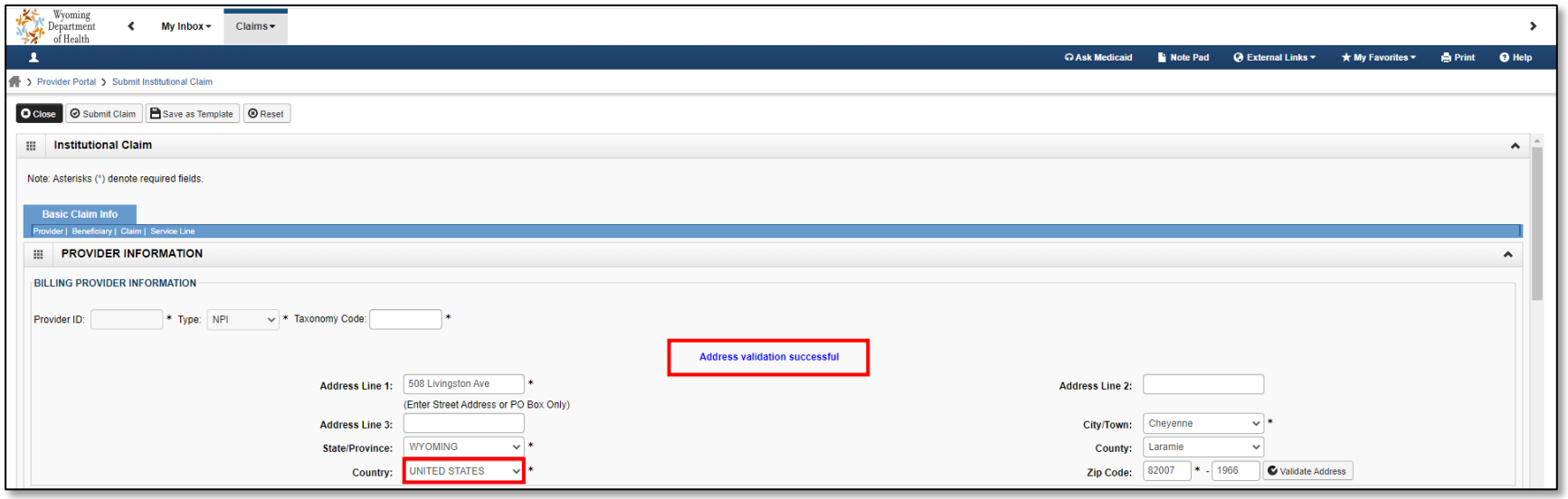
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

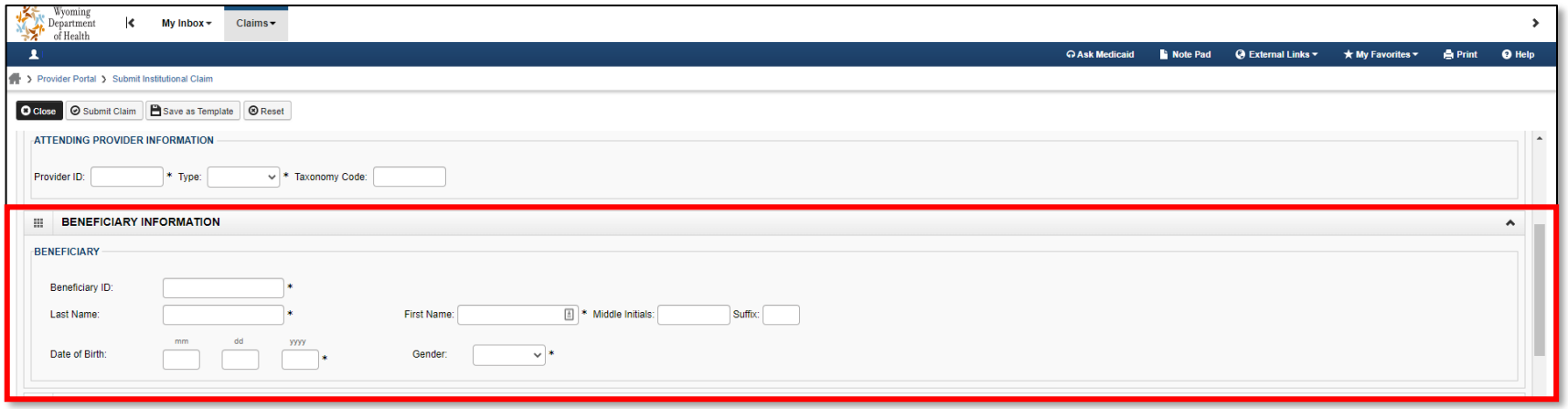
Institutional Claims Submission



BMS validates the address information and displays the following message “Address validation successful”

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

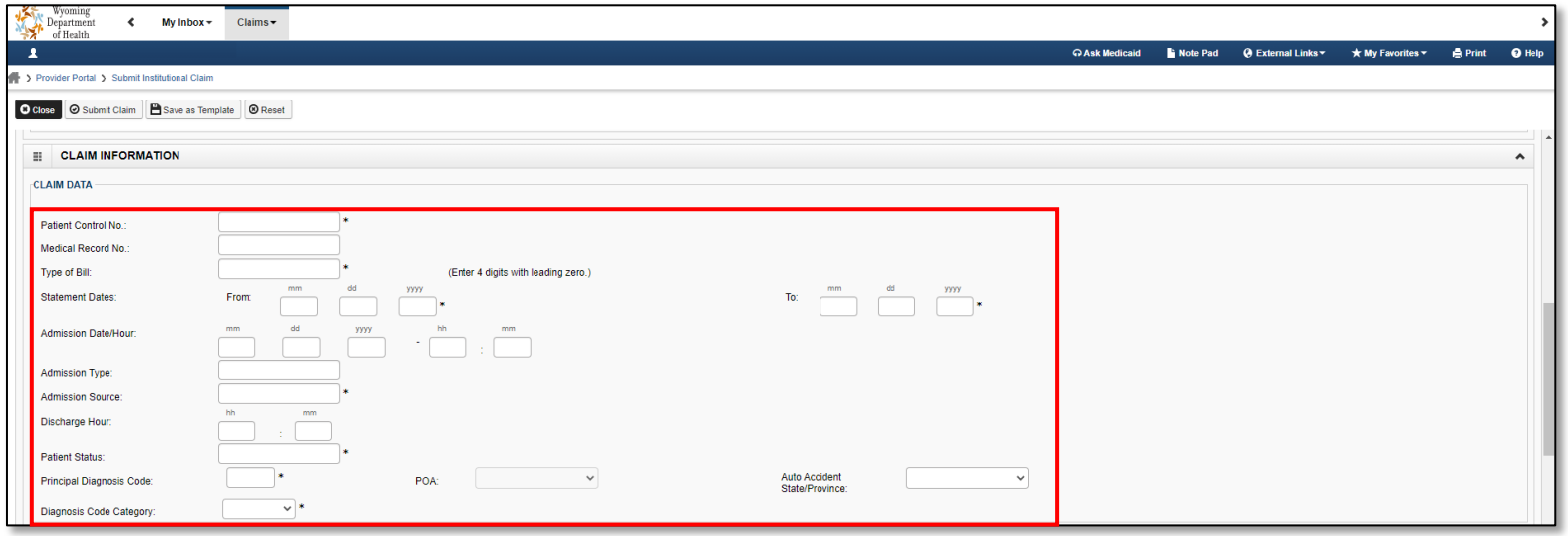


Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

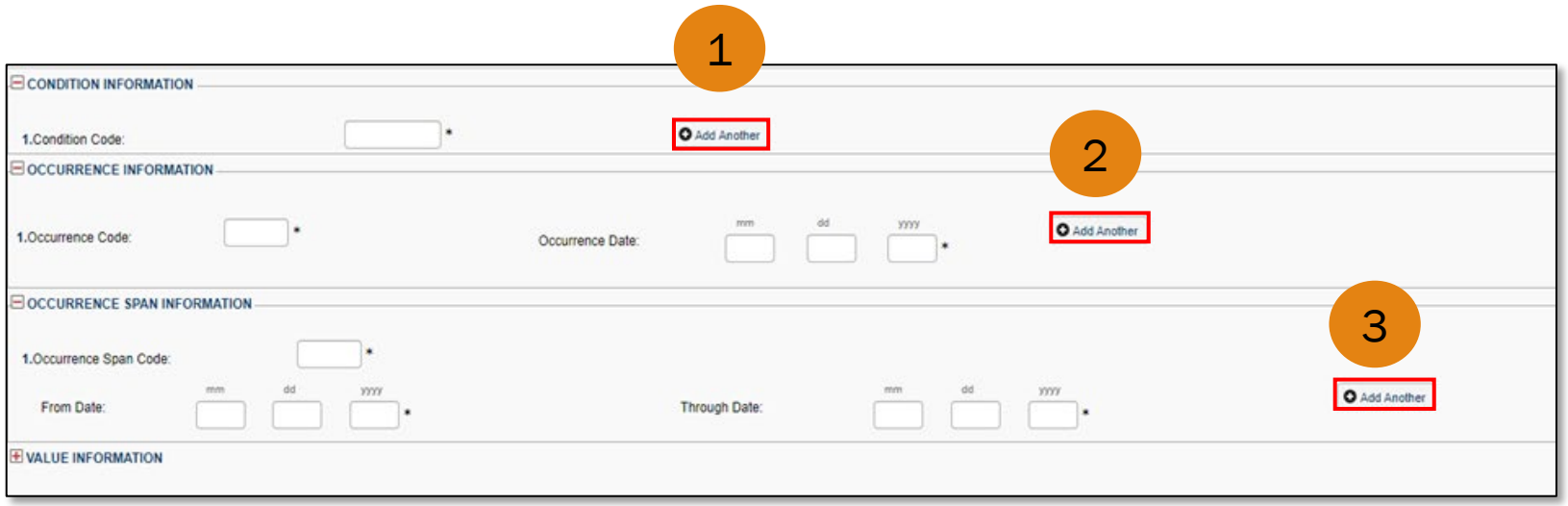
In order to process your claim, BMS also requires claim data about the patient.



Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start** and **End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

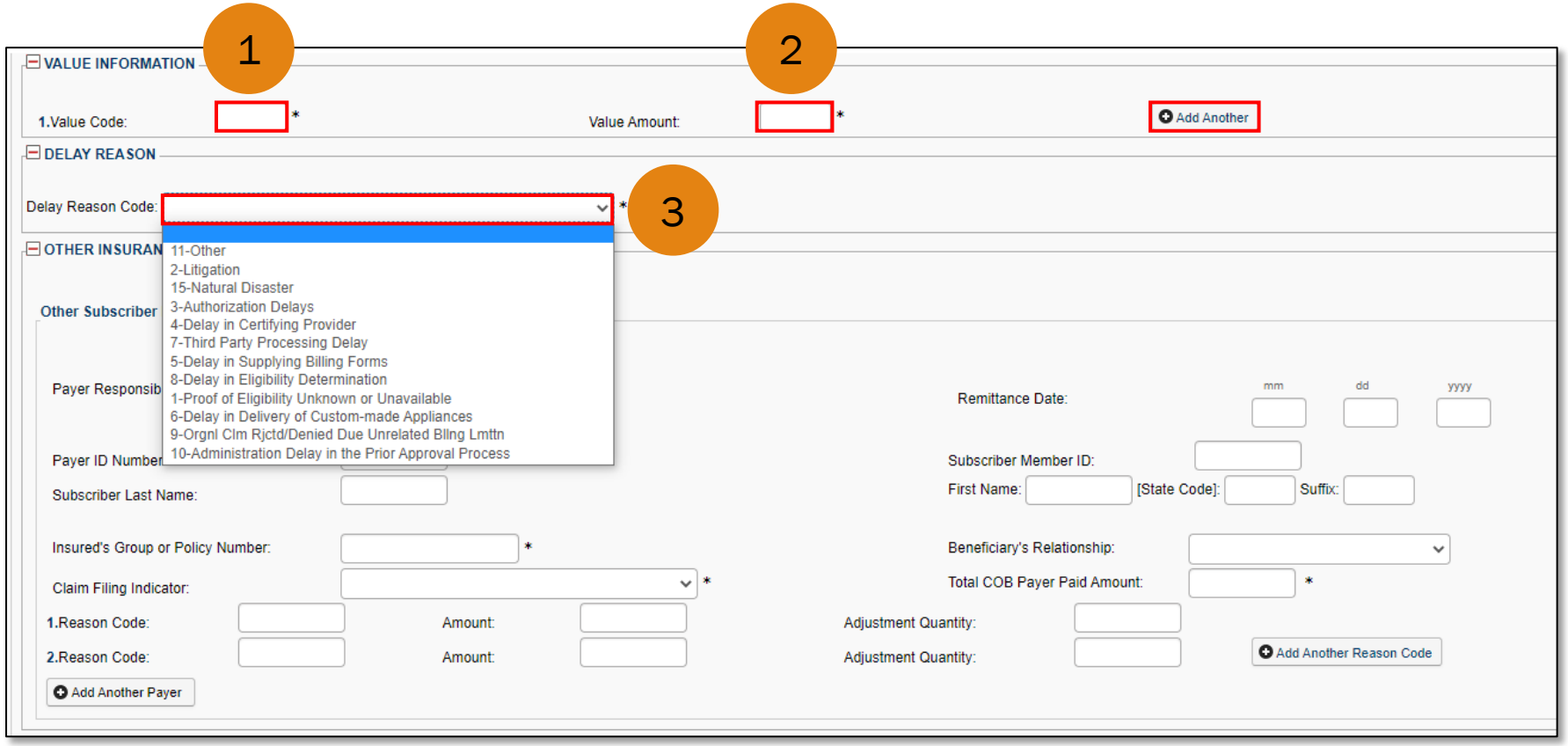
Institutional Claims Submission



Under **Condition Information**, **Occurrence Information**, and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

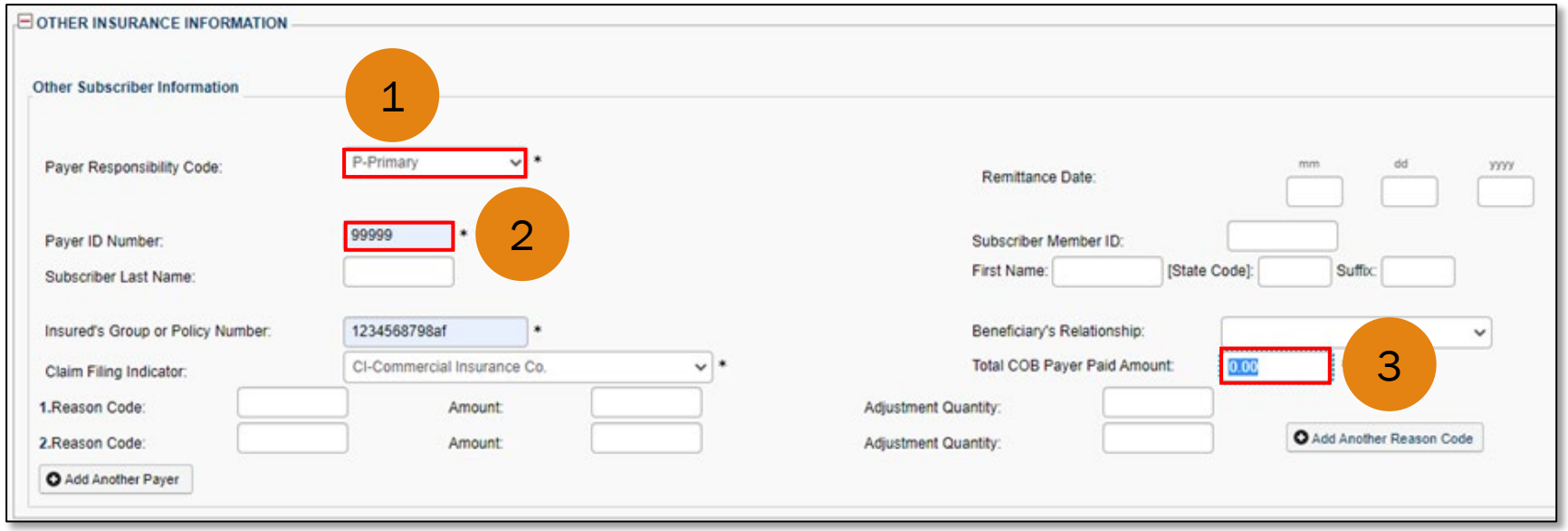
Institutional Claims Submission



Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

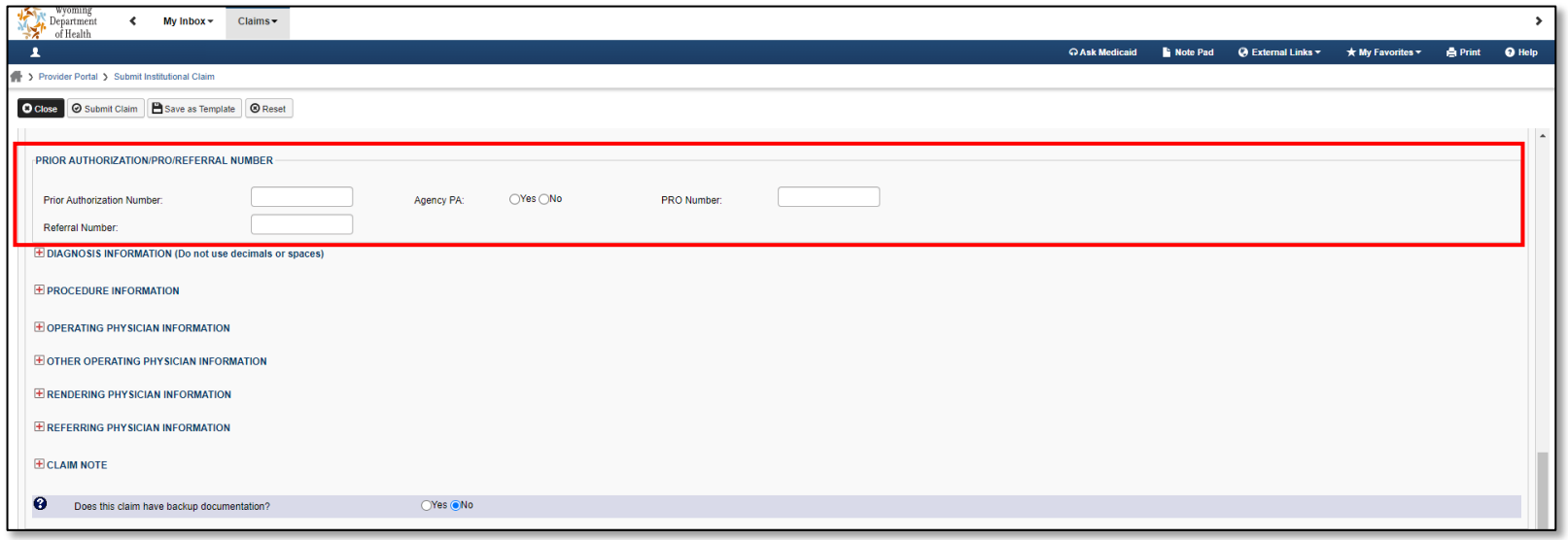
Institutional Claims Submission



If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

1. **Payer Responsibility** will be primary or secondary or tertiary in some cases.
2. **Payer ID Number** can default to 99999, or you can find the Payer ID Number at: Payer ID List.
3. Enter **Insured's Group or Policy number** and **Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission



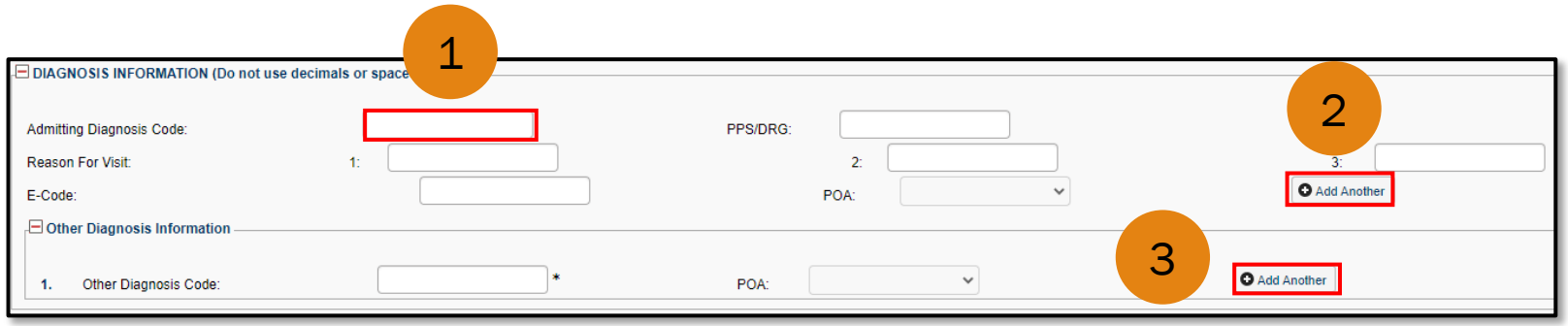
If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission



Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a "." when adding information, as the system will not recognize it.

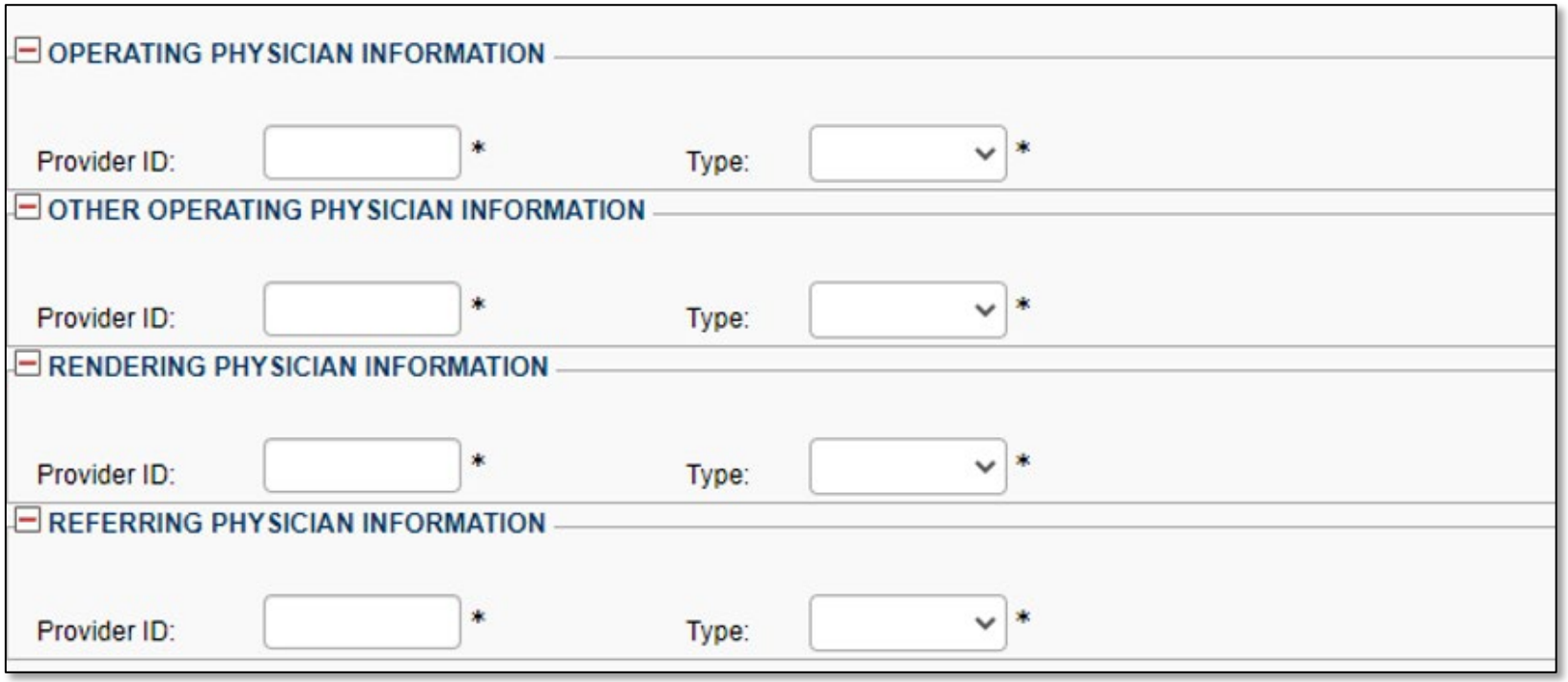
Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.

3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission



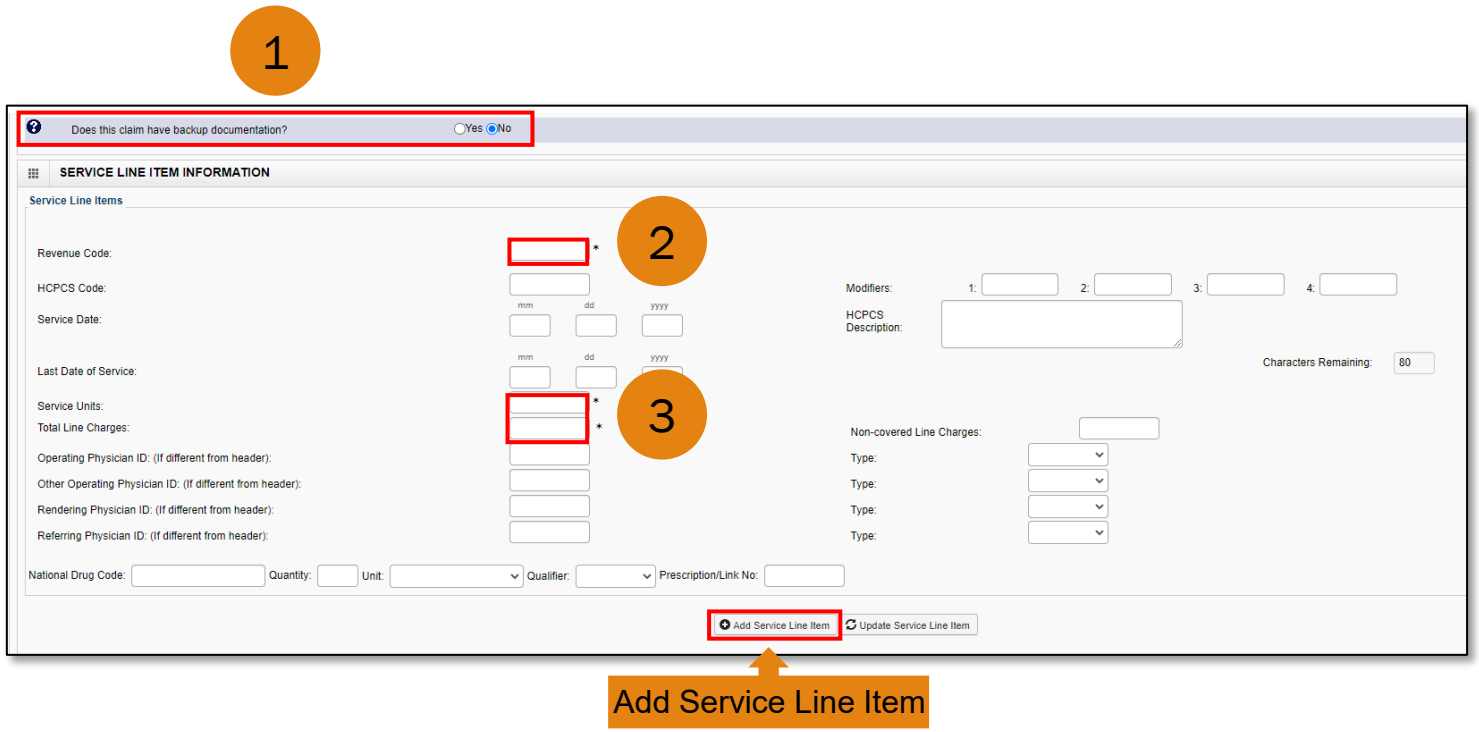
Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

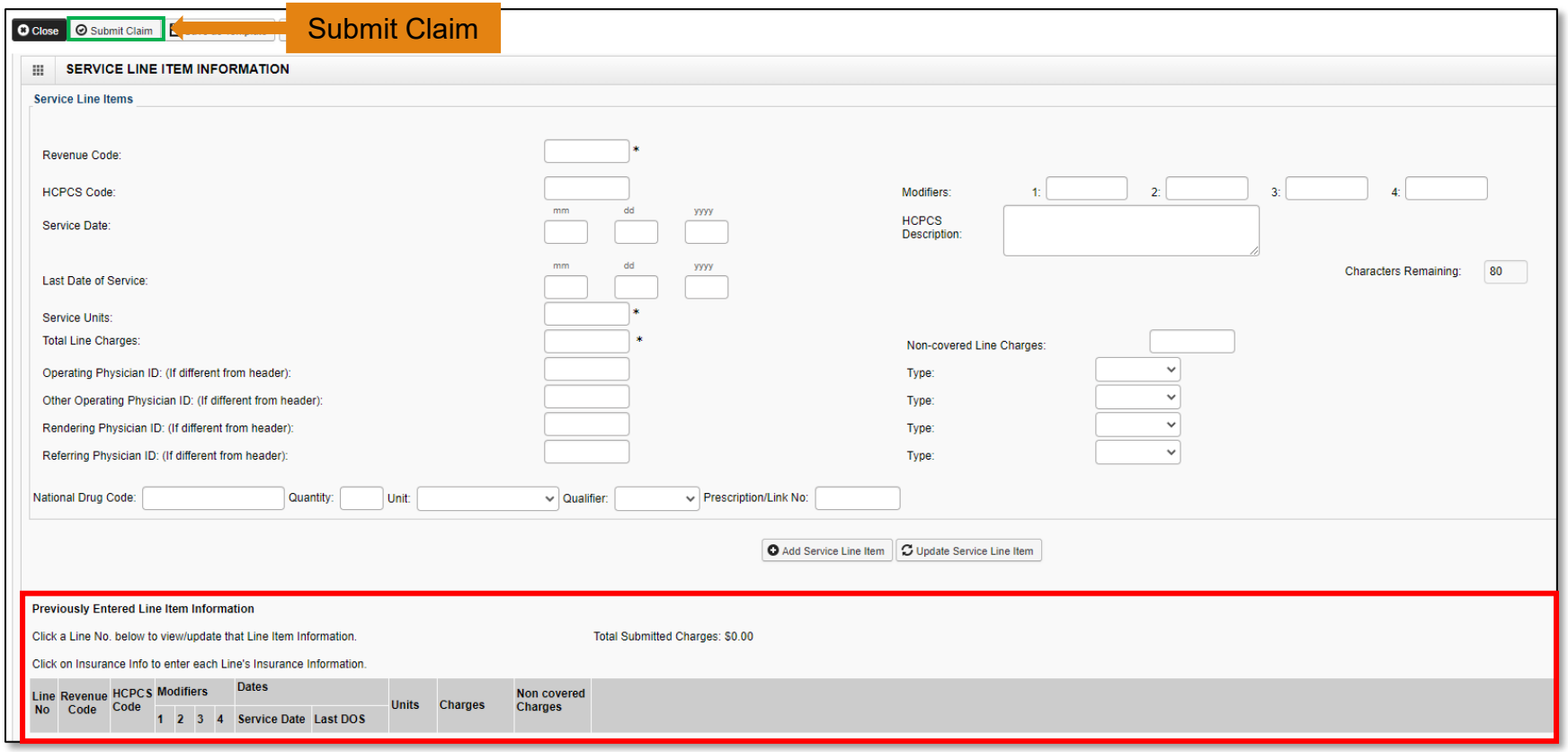
Institutional Claims Submission



Service Line Item Information is required to process the claim, all required fields are indicated with an *:

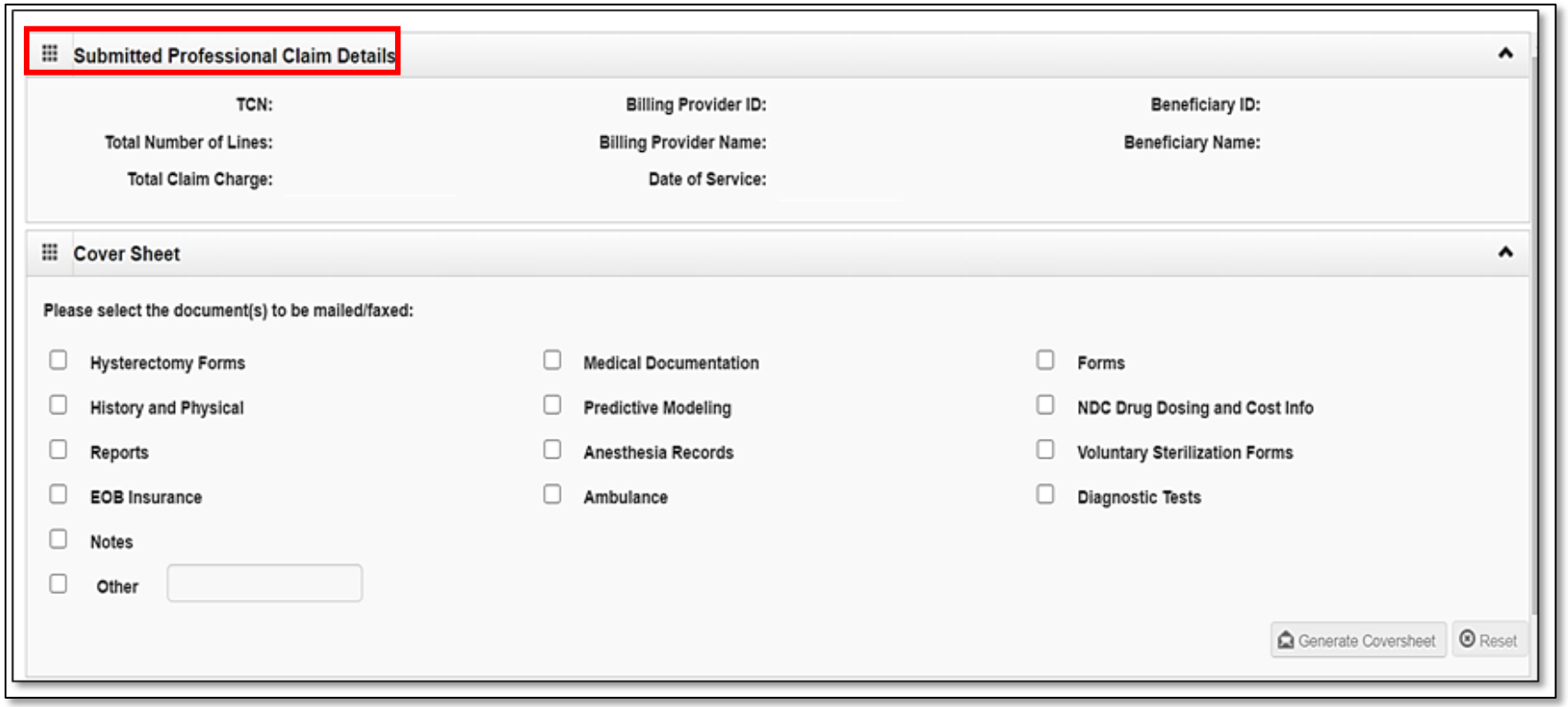
1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

Institutional Claims Submission



- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission.
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**.

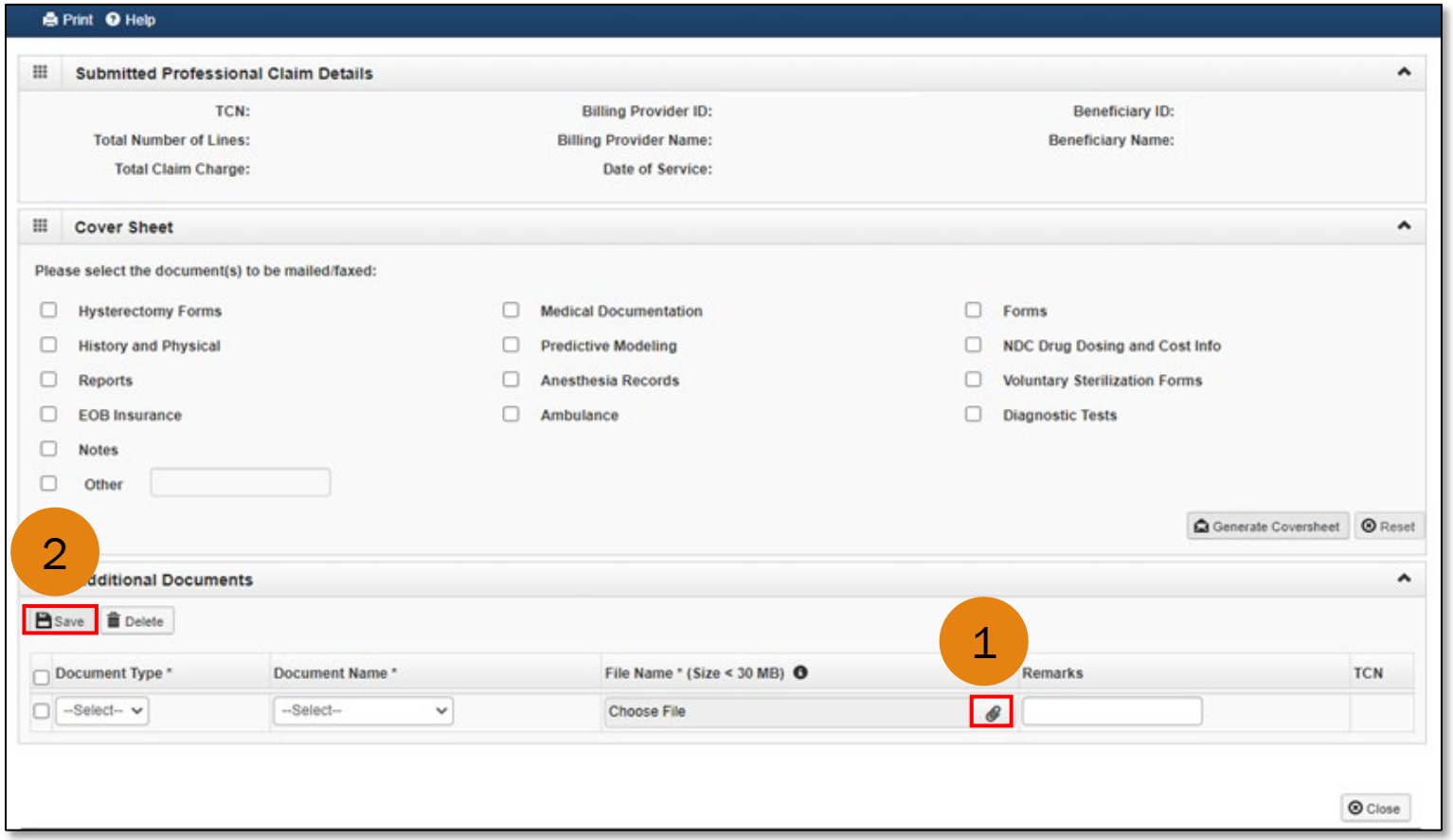
Institutional Claims Attachment



Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment



Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon to search for and select the file to upload from your computer.
2. Select **Save** to save the file. The message “File Uploaded Successfully” displays.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with TPL

How to bill Third-Party Liability (TPL) with an Institutional Claim

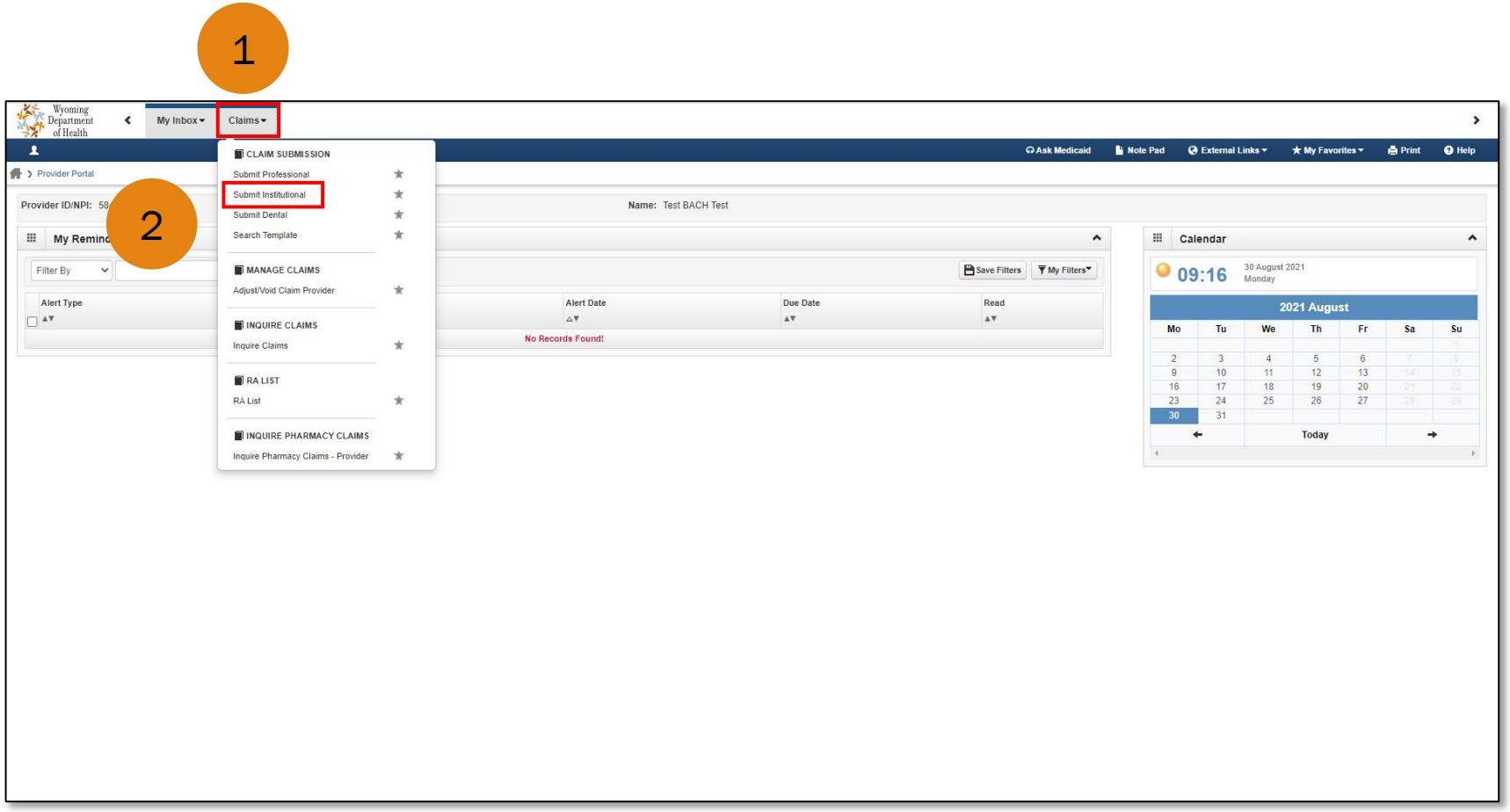
Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223

    - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.

- TPL can be direct billed, through a clearing house or from a Medicare if applicable
- An EOB or Explanation of Benefits is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the over all payment

Institutional Claims Submission



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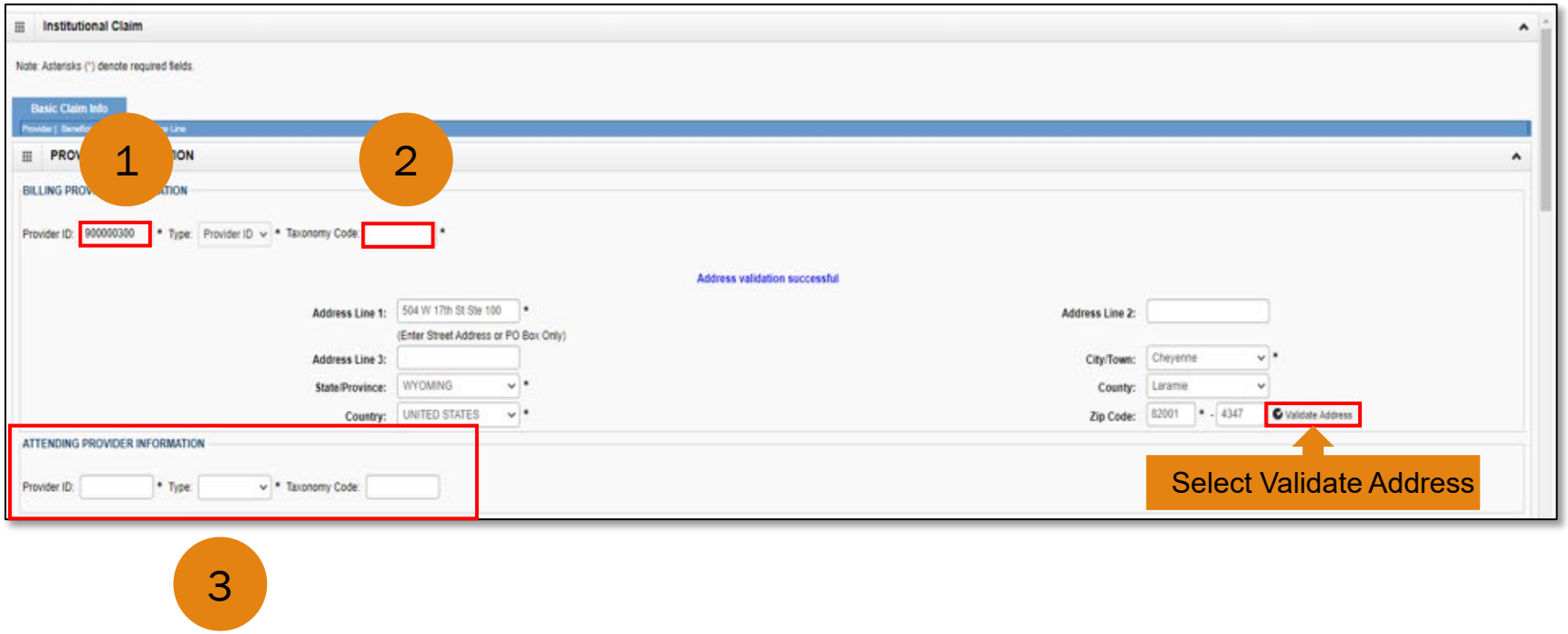

To enter Provider Information:

Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
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The address auto-populates.

- Select **Validate Address**
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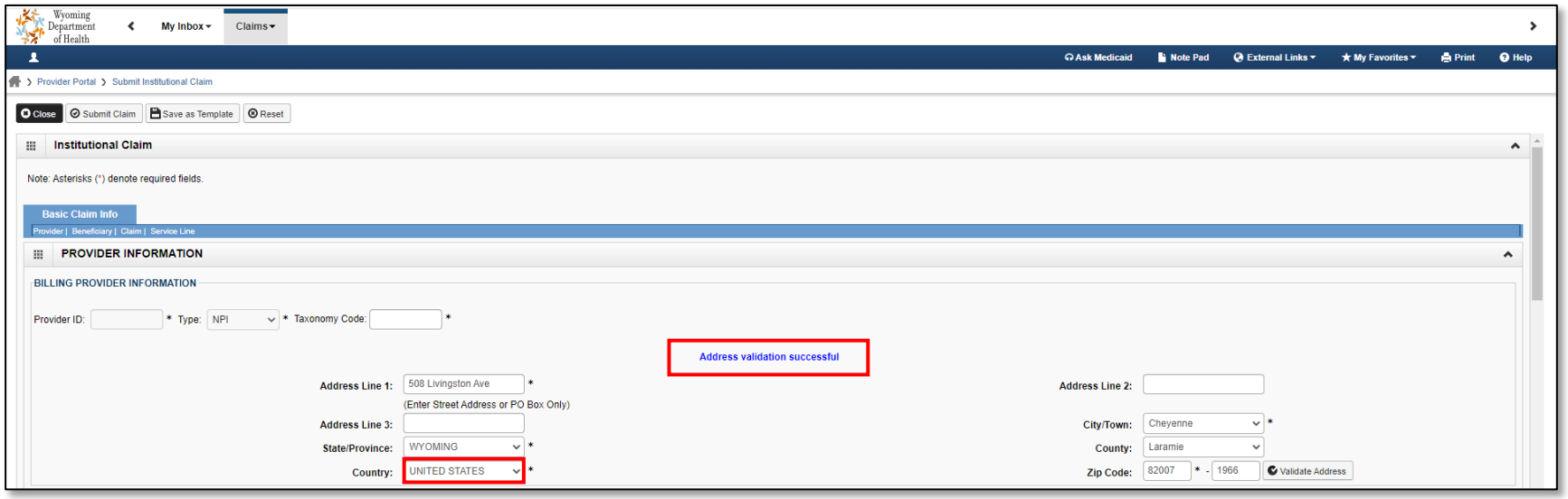

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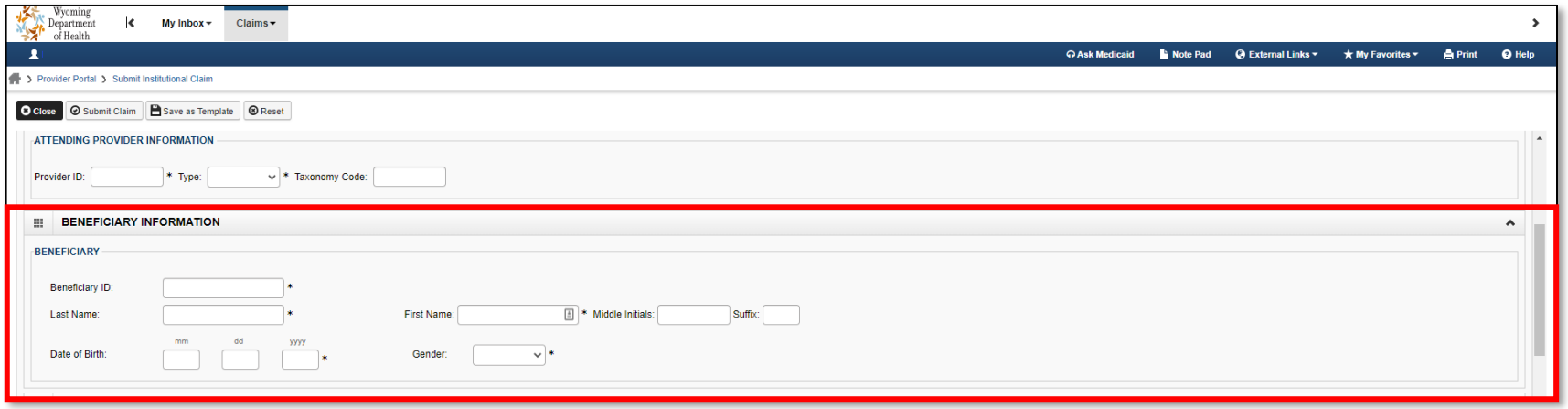

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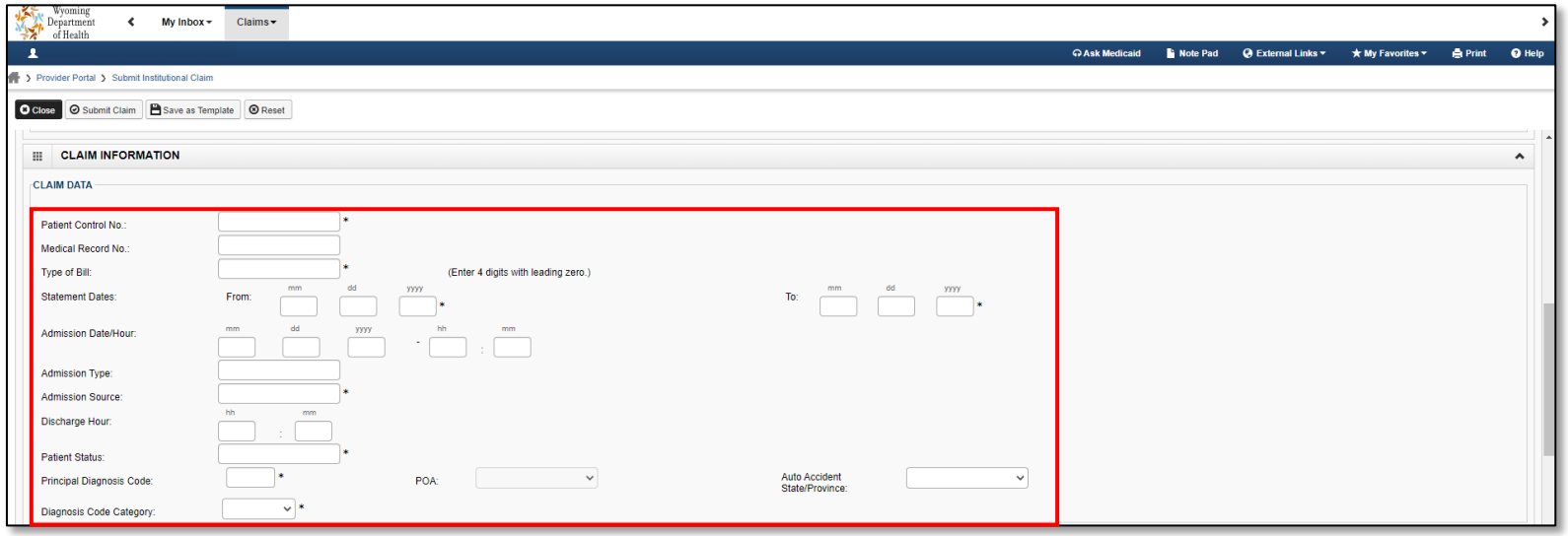
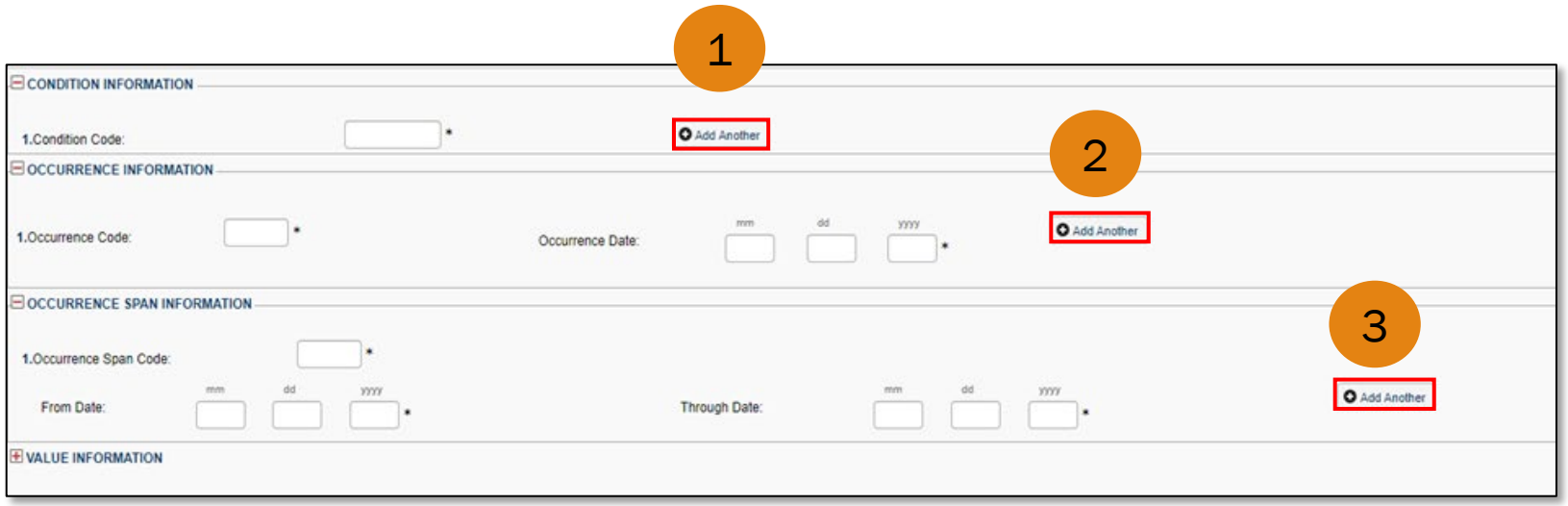


Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start** and **End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

Institutional Claims Submission



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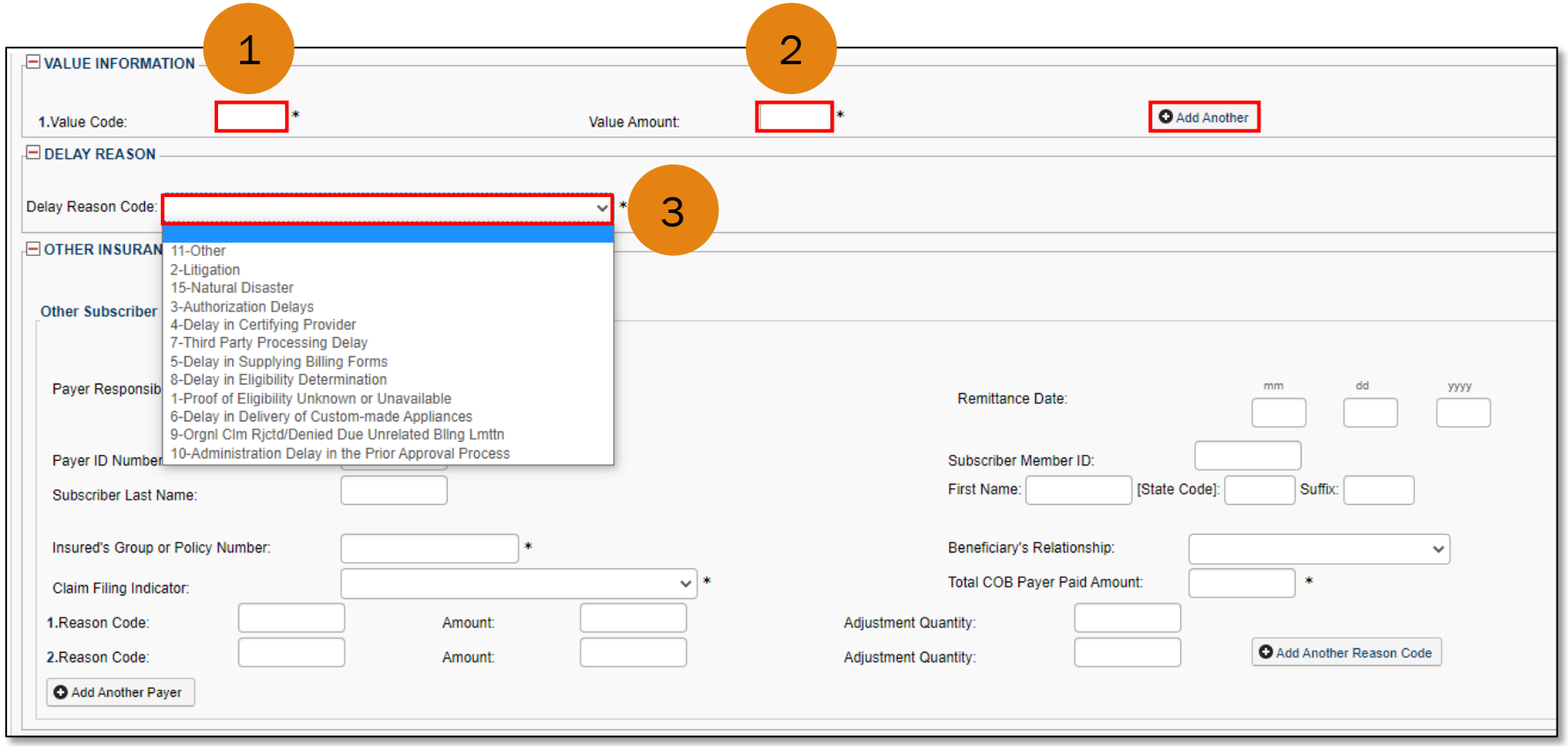

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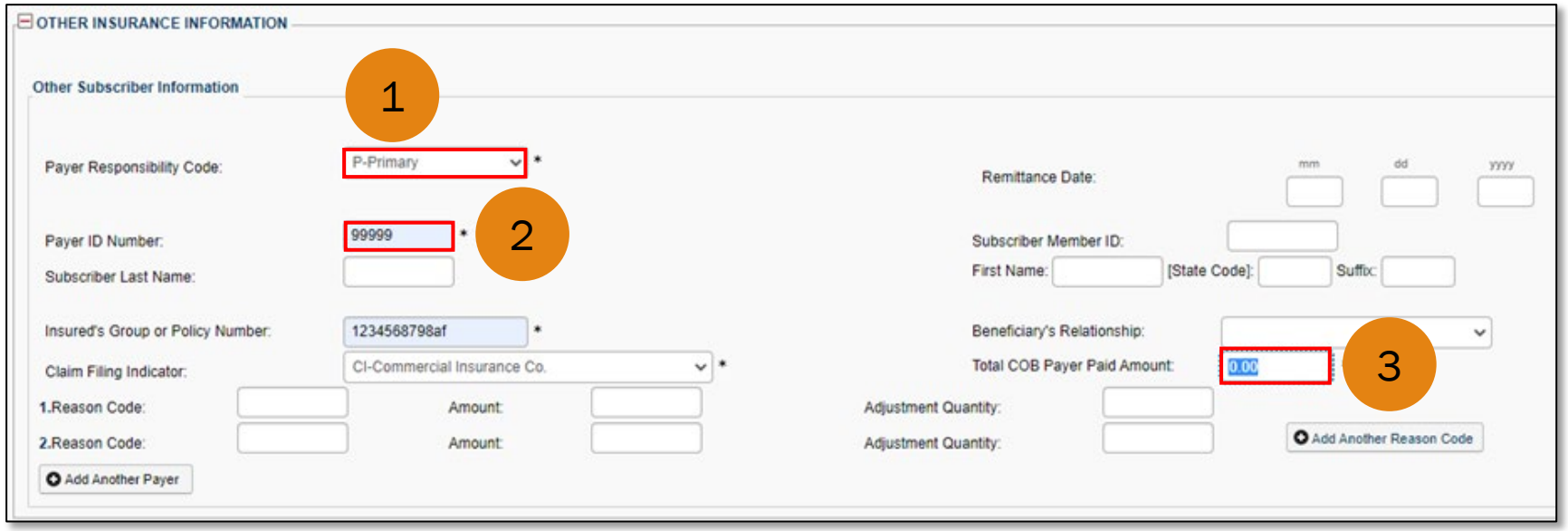

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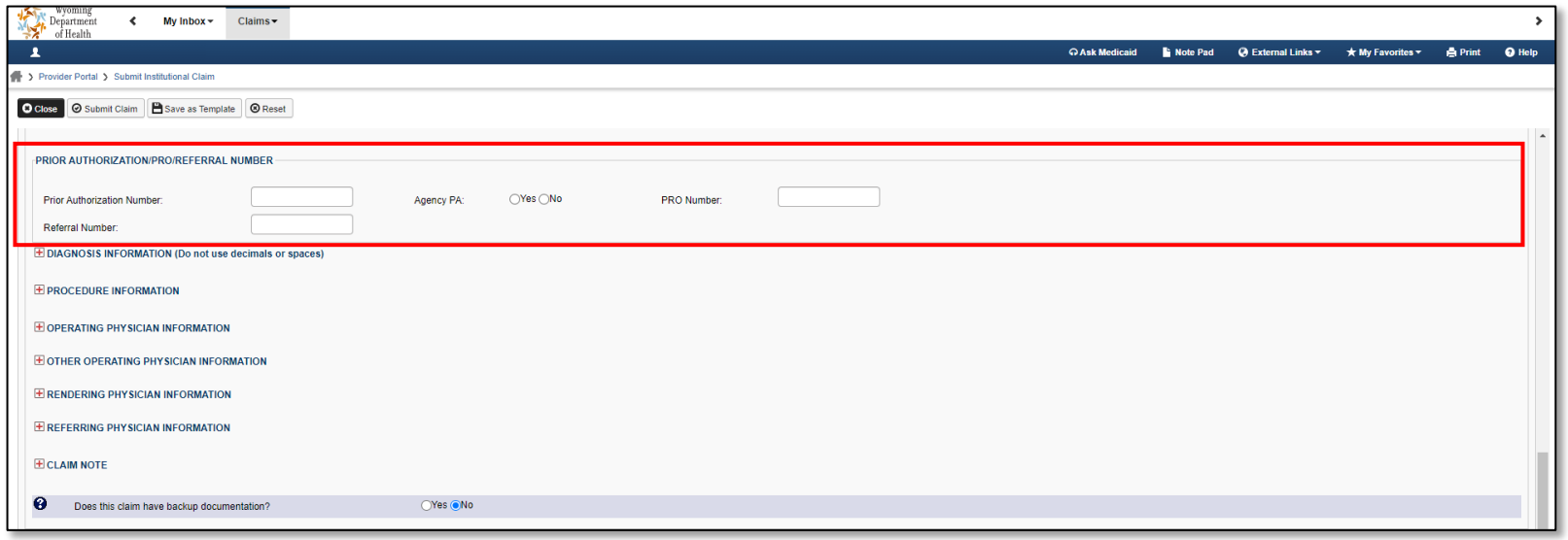

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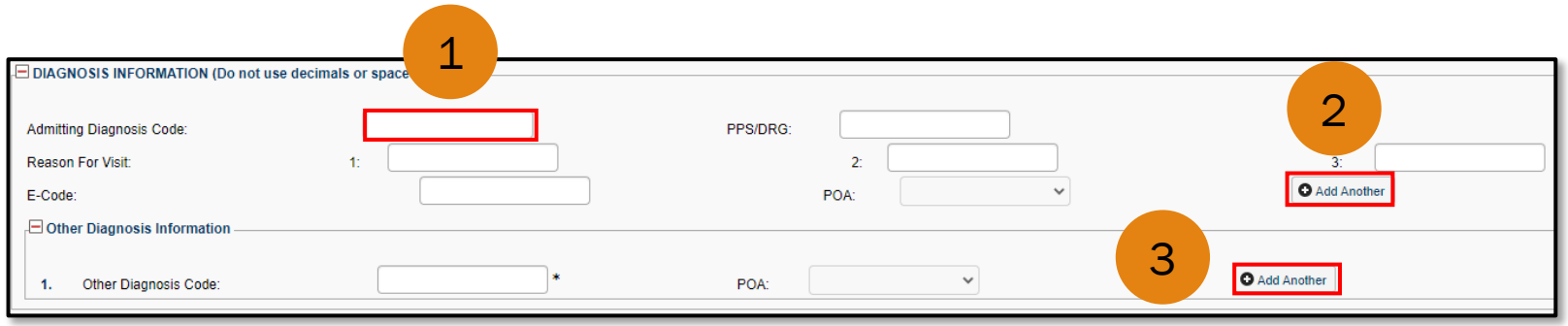

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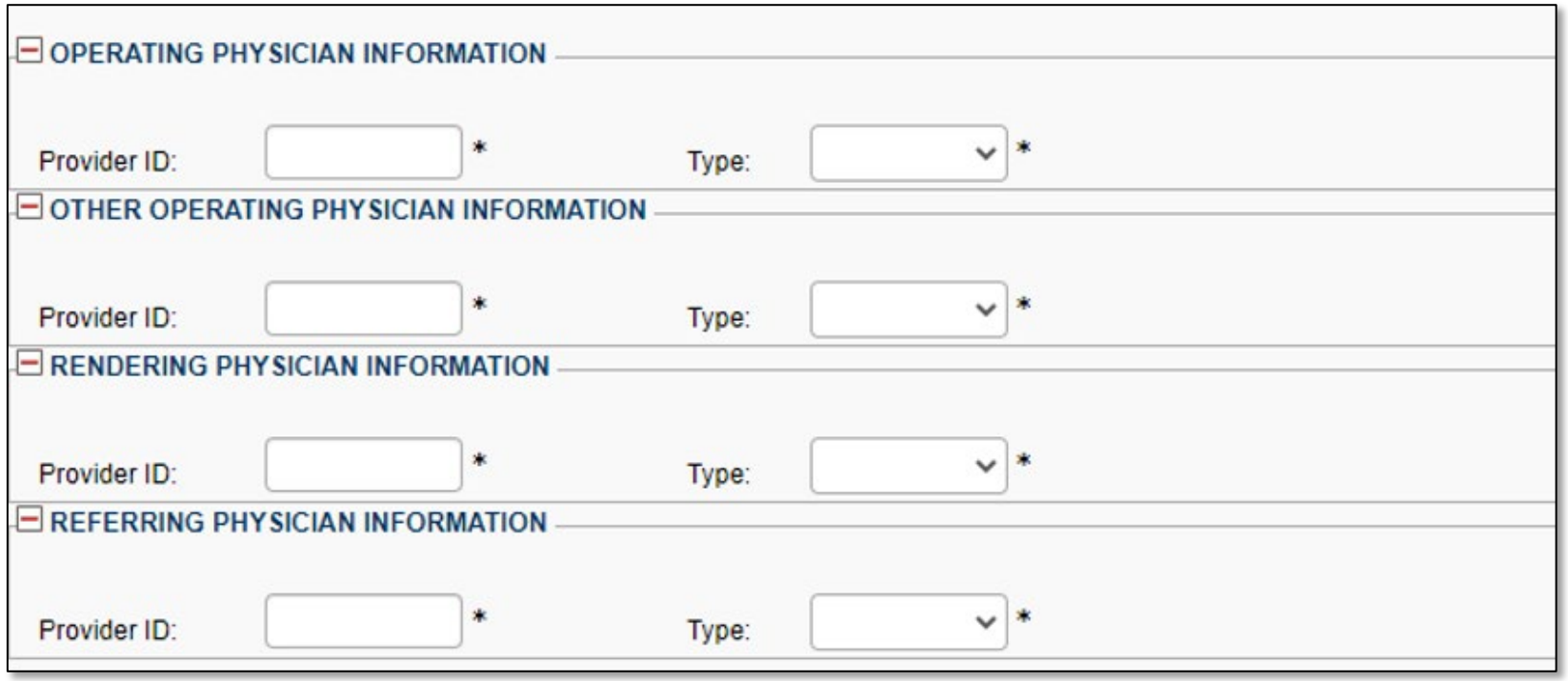

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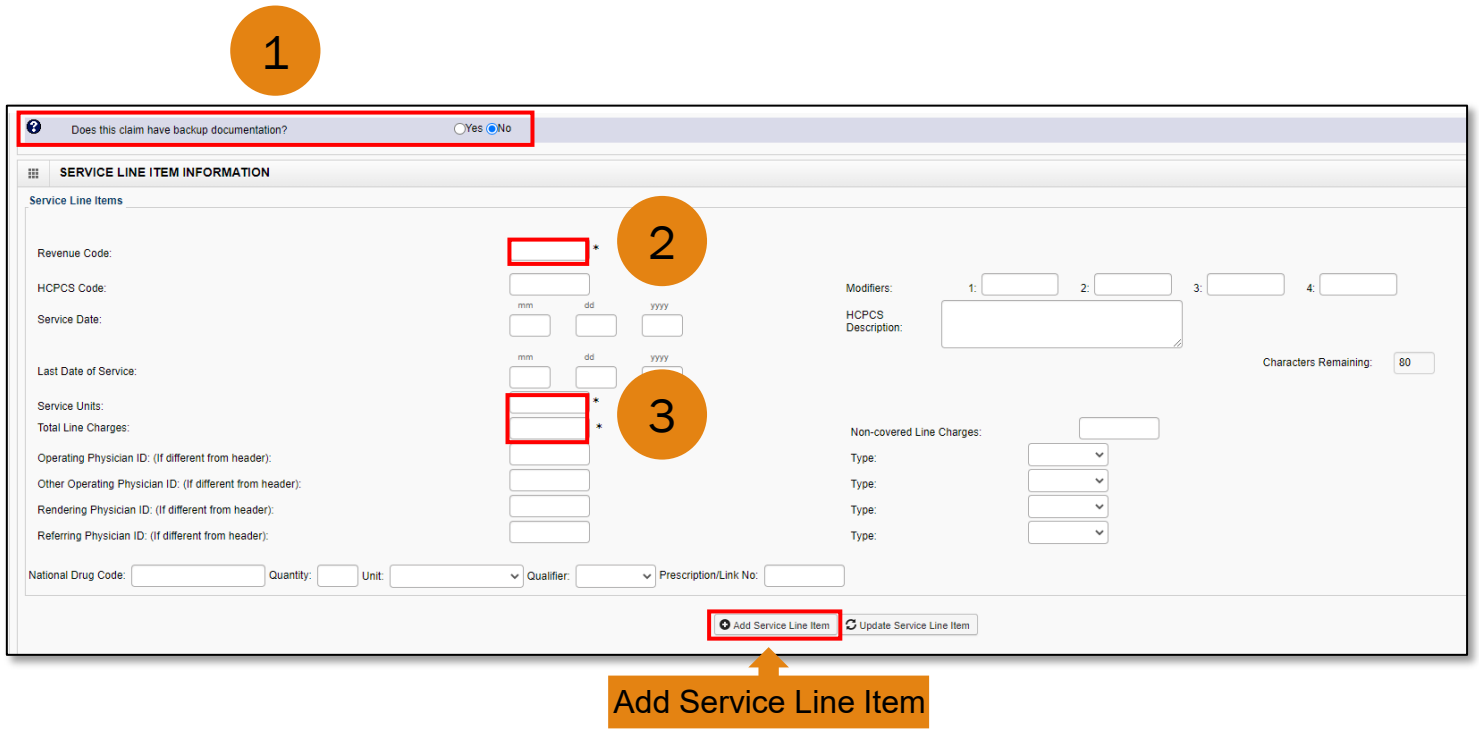

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2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

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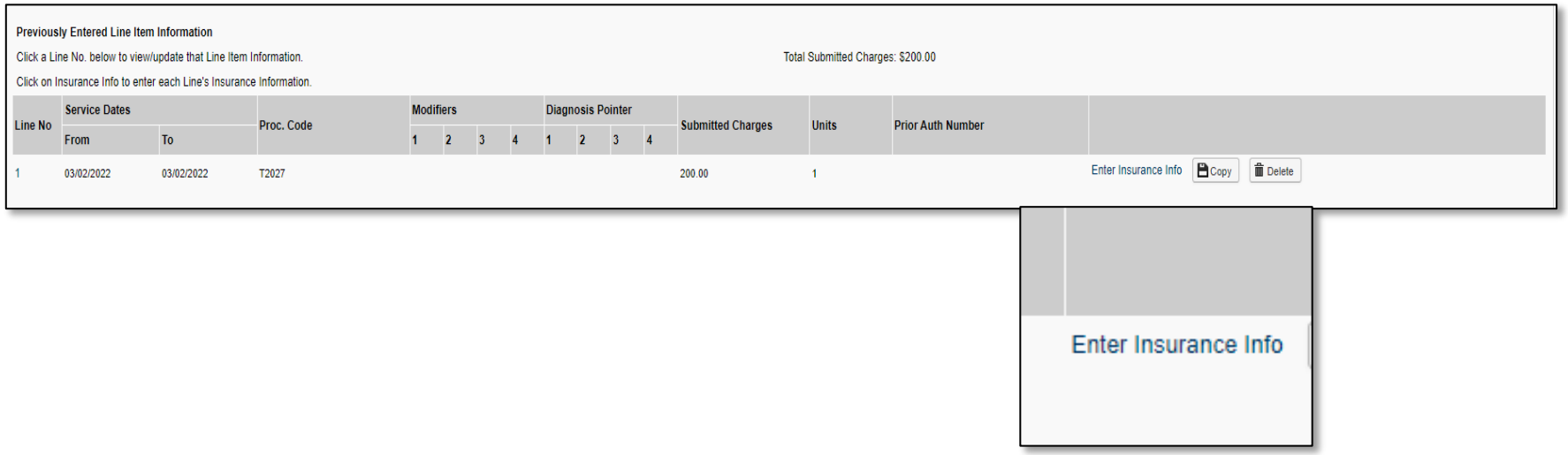
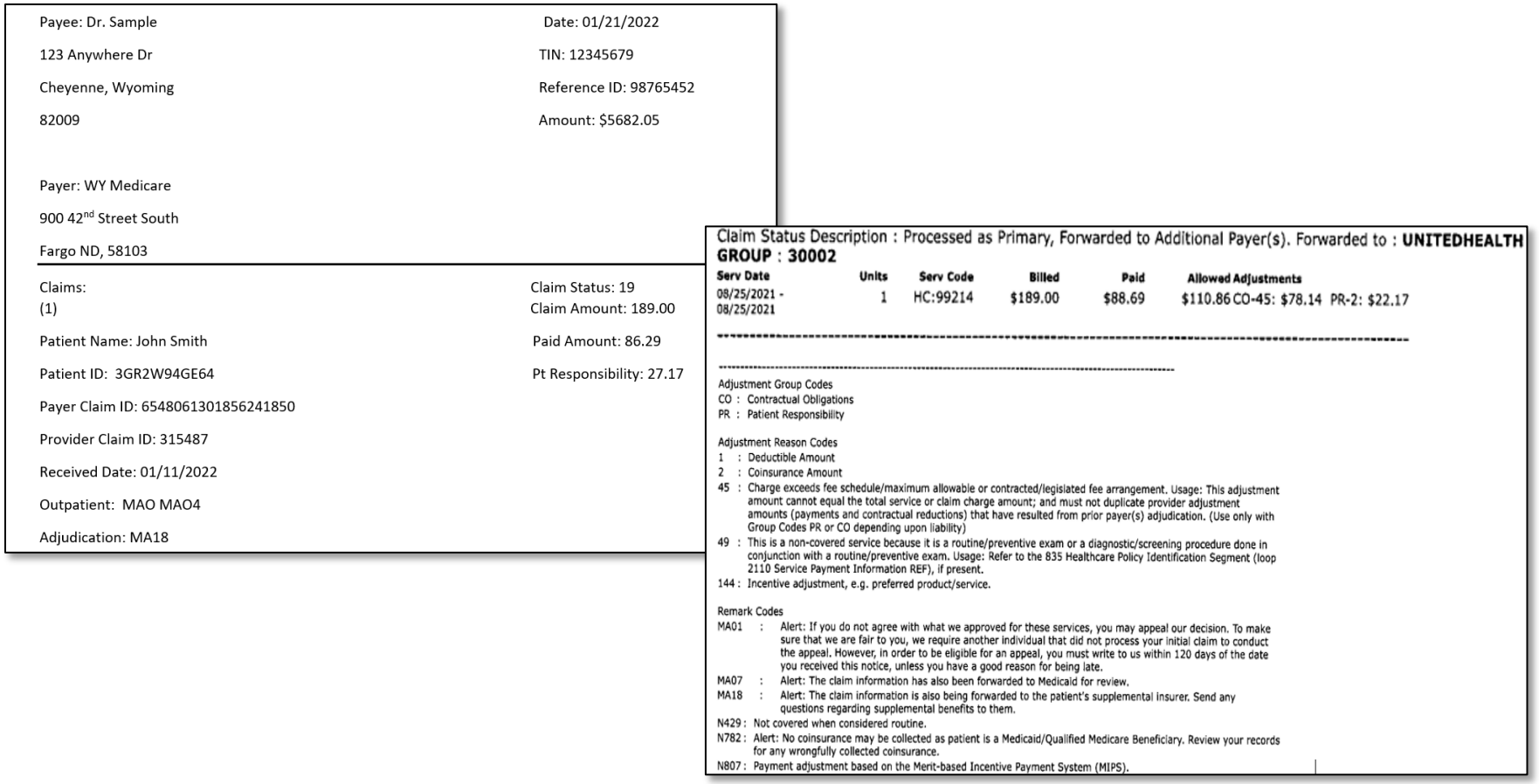


At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.

Institutional Claims Submission



Payee: Dr. Sample
123 Anywhere Dr
Cheyenne, Wyoming
82009

Date: 01/21/2022
TIN: 12345679
Reference ID: 98765452
Amount: $5682.05

Payer: WY Medicare
900 42nd Street South
Fargo ND, 58103

Claims:
(1)

Claim Status: 19
Claim Amount: 189.00
Paid Amount: 86.29
Pt Responsibility: 27.17

Patient Name: John Smith
Patient ID: 3GR2W94GE64
Payer Claim ID: 6548061301856241850
Provider Claim ID: 315487
Received Date: 01/11/2022
Outpatient: MAO MAO4
Adjudication: MA18

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **UNITEDHEALTH GROUP : 30002**

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	1	HC:99214	$189.00	$88.69	$110.86 CO-45: $78.14 PR-2: $22.17

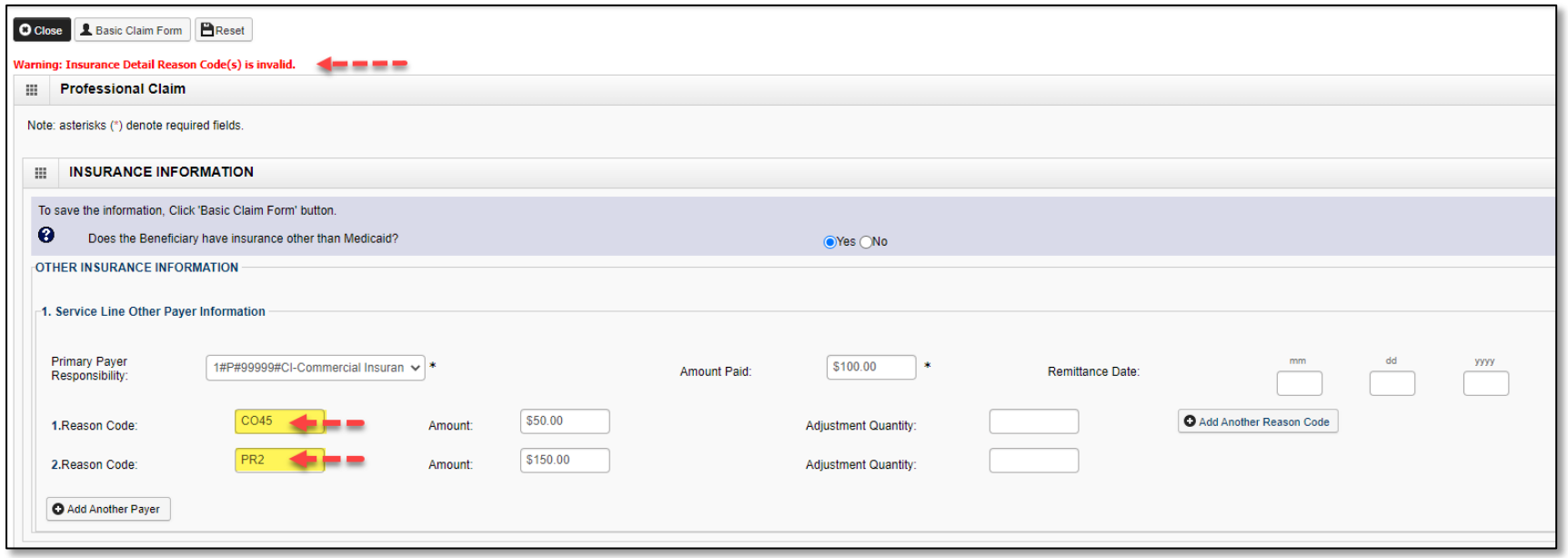
Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49 : This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
144 : Incentive adjustment, e.g. preferred product/service.

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07 : Alert: The claim information has also been forwarded to Medicaid for review.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N429 : Not covered when considered routine.
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).

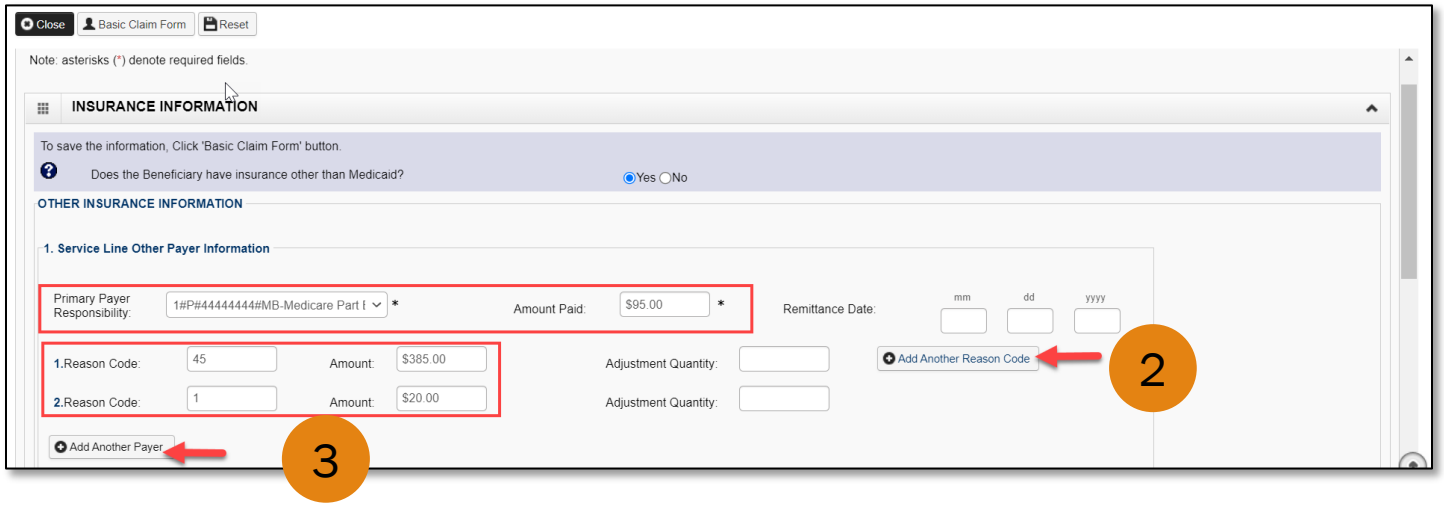
Proprietary codes and their descriptions are shown in this sample Explanation of Benefits (EOB), this is used for adjustment reasons. Also, what is shown on the EOBs.

Institutional Claims Submission



- If you see the error code “Warning: Insurance Detail Reason Code(s) is Invalid”
- Check to make sure you did not enter the letters of the reason code as shown in the example

Institutional Claims Submission



At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.

- Complete the required fields indicated with an *.

2. Select **Add Another Reason Code** to add additional reason code and amount.

3. Reason codes must be entered with only the number. Do not enter "PR" or "CO".

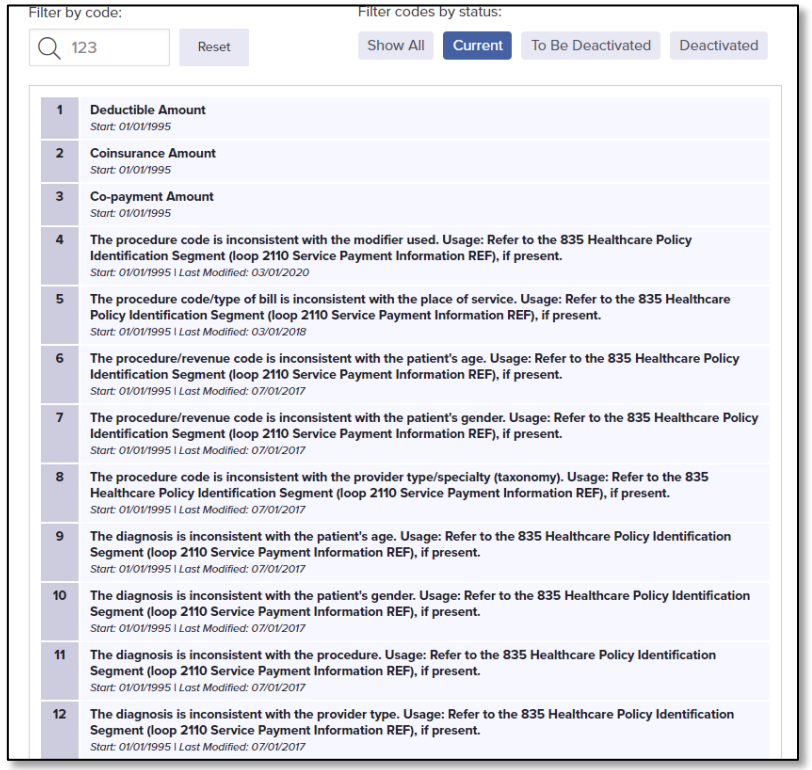
- Total + Adjustment Reason = Total amount billed to Medicaid.

4. After all primary insurance information is entered, select **Basic Claim Form** to return to the claim for submission.

Institutional Claims Submission

1

2

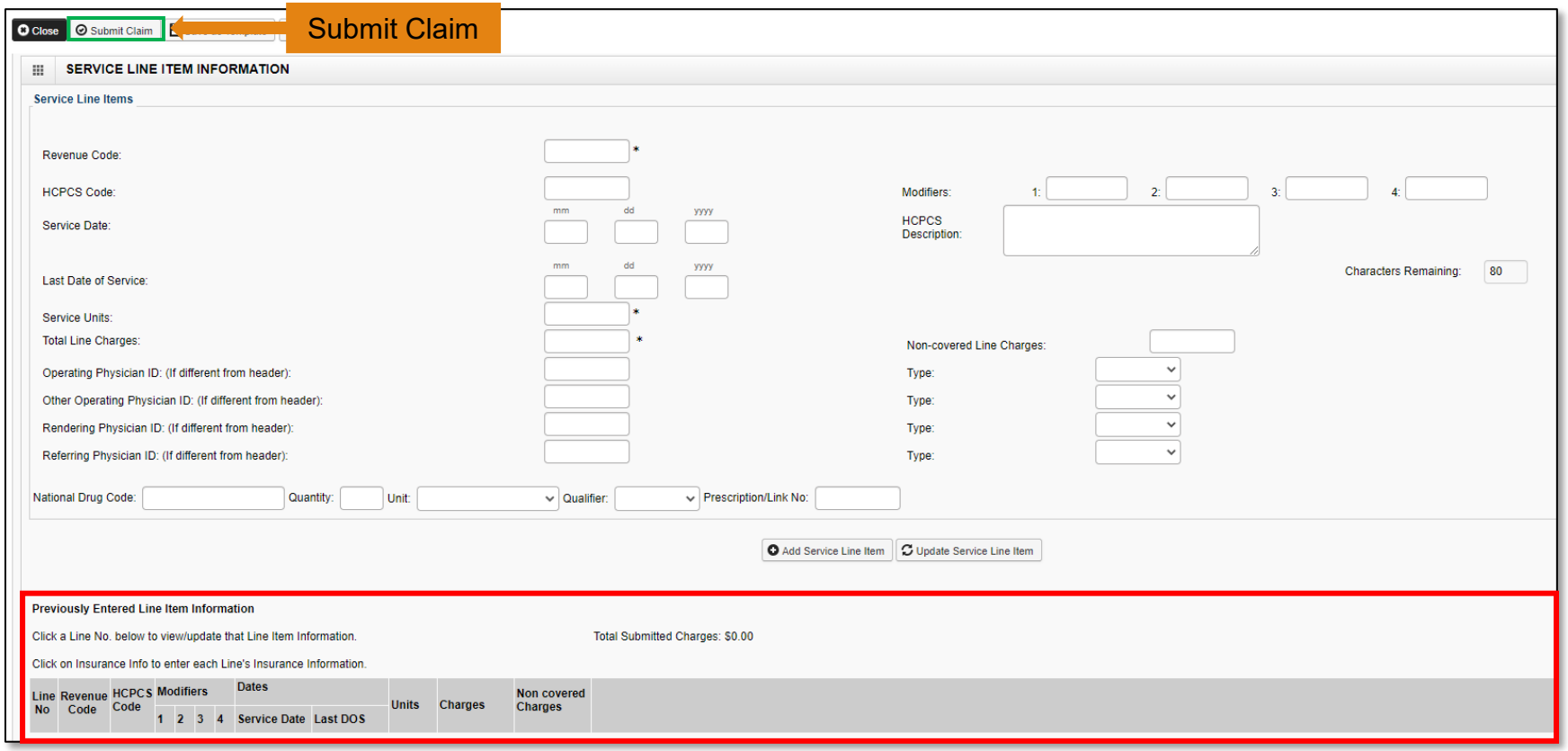


3

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

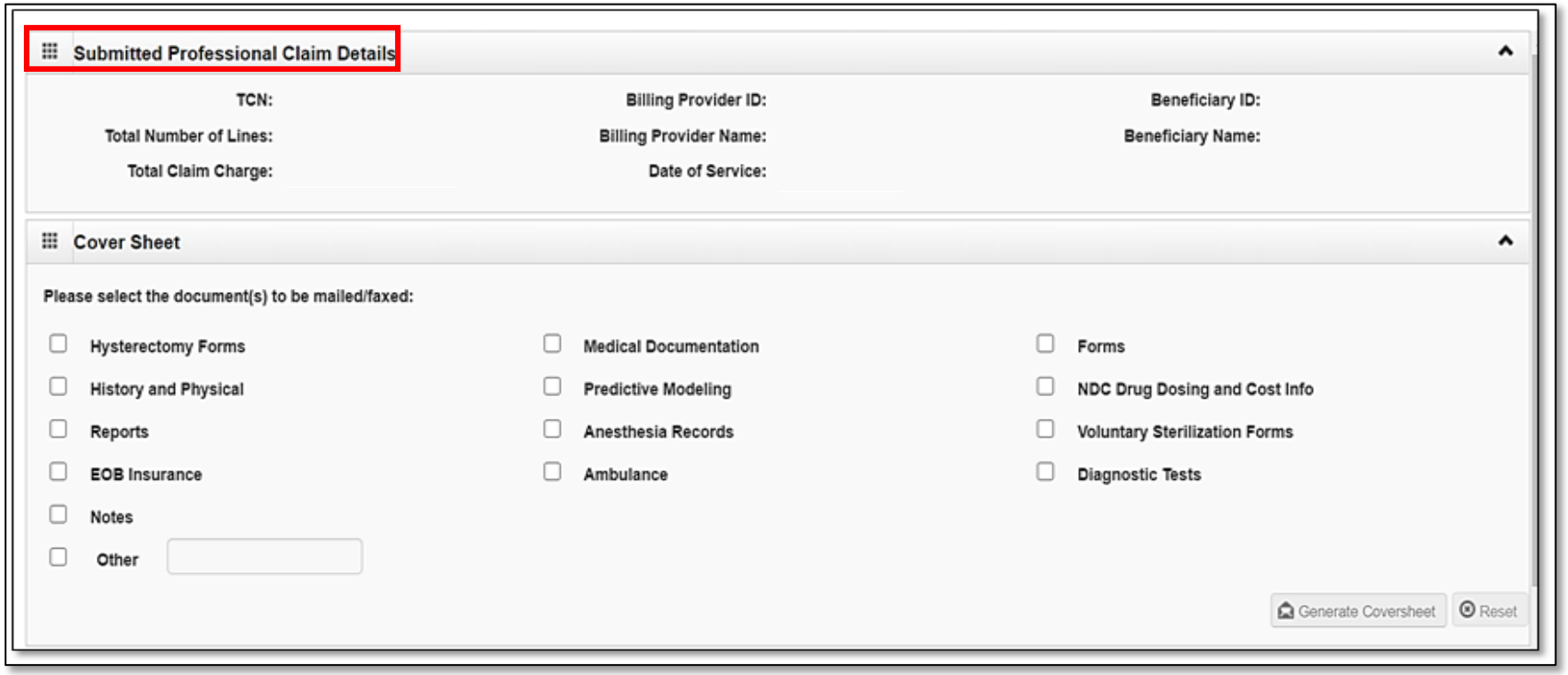
1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Institutional Claims Submission



- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**

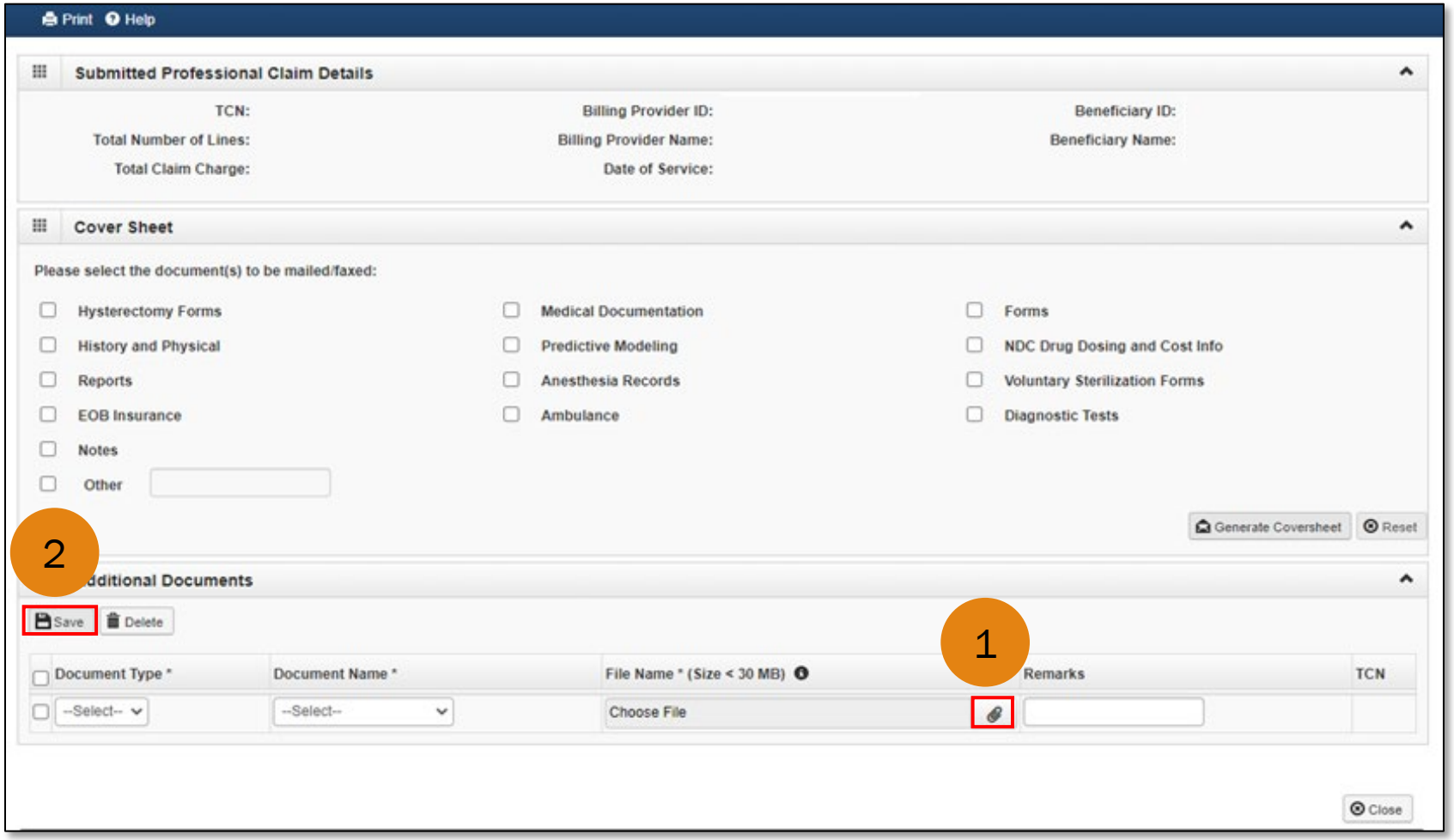
Institutional Claims Attachment



Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment



Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with Medicare Primary

How to bill a Medicare Primary Claim

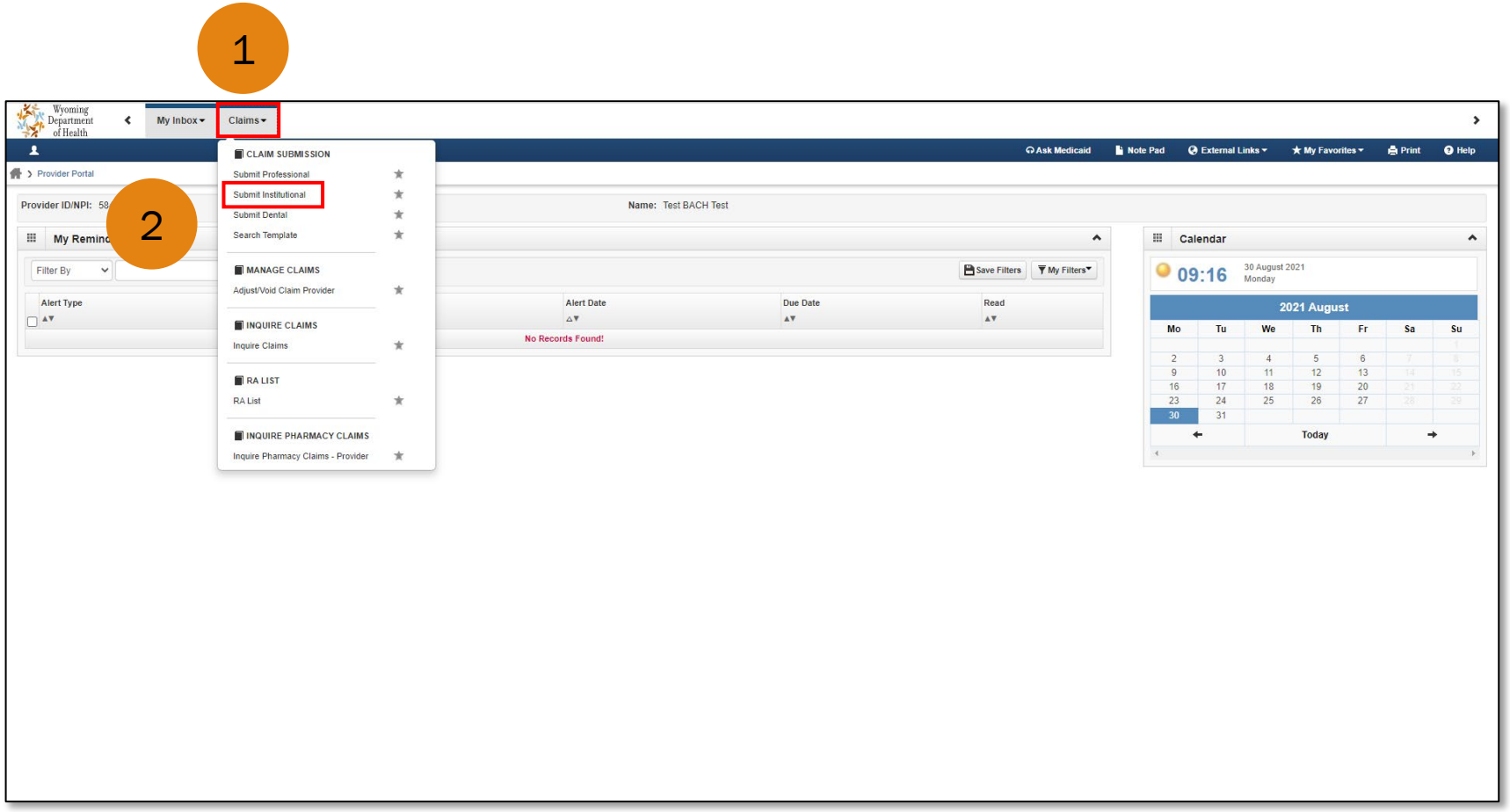
Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223

    - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.

- TPL can be direct billed, through a clearing house or from a Medicare if applicable
- An EOB or Explanation of Benefits is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the over all payment

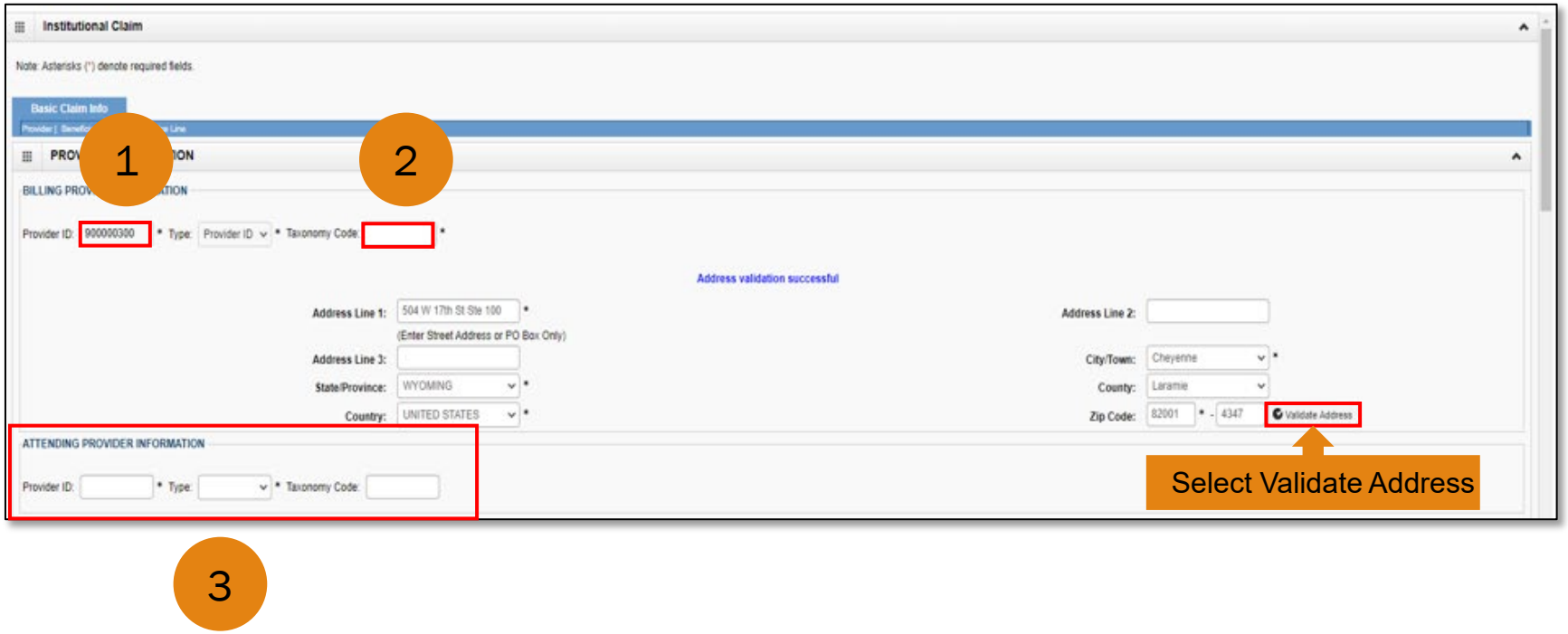
Institutional Claims Submission



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission



To enter Provider Information:

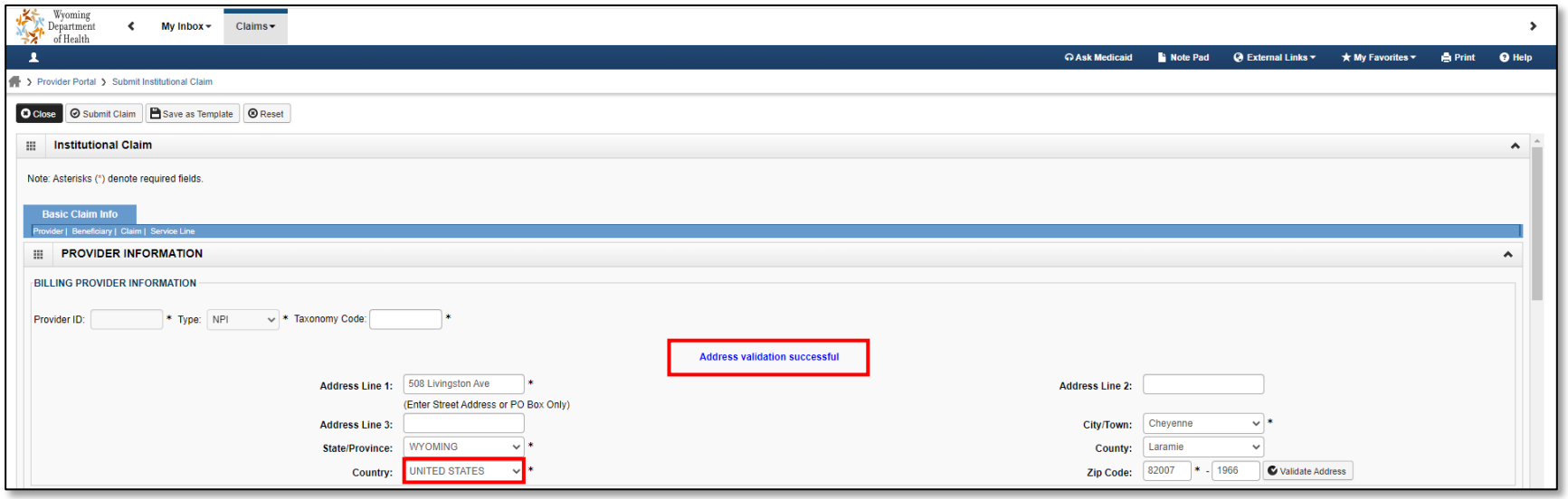
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

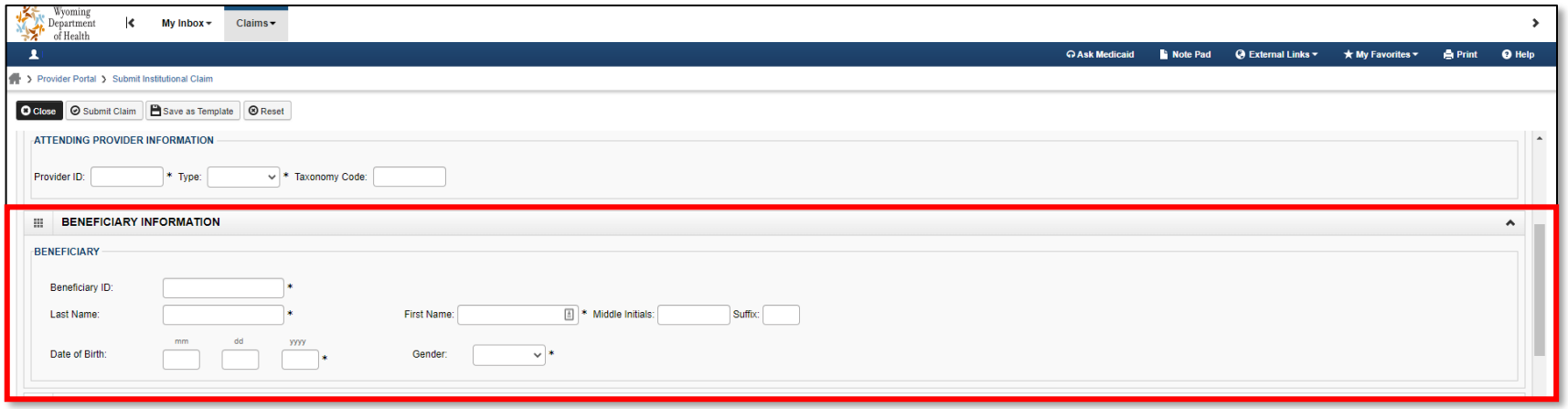
Institutional Claims Submission



BMS validates the address information and displays the following message “Address validation successful”.

- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission

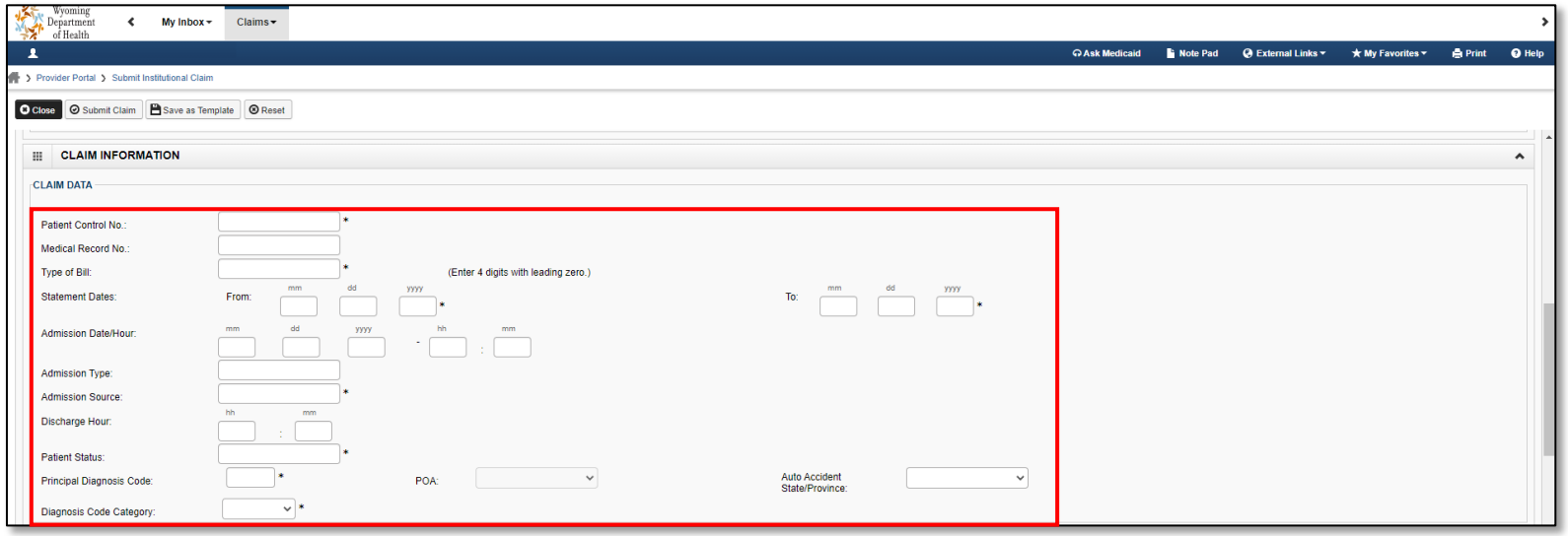


Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

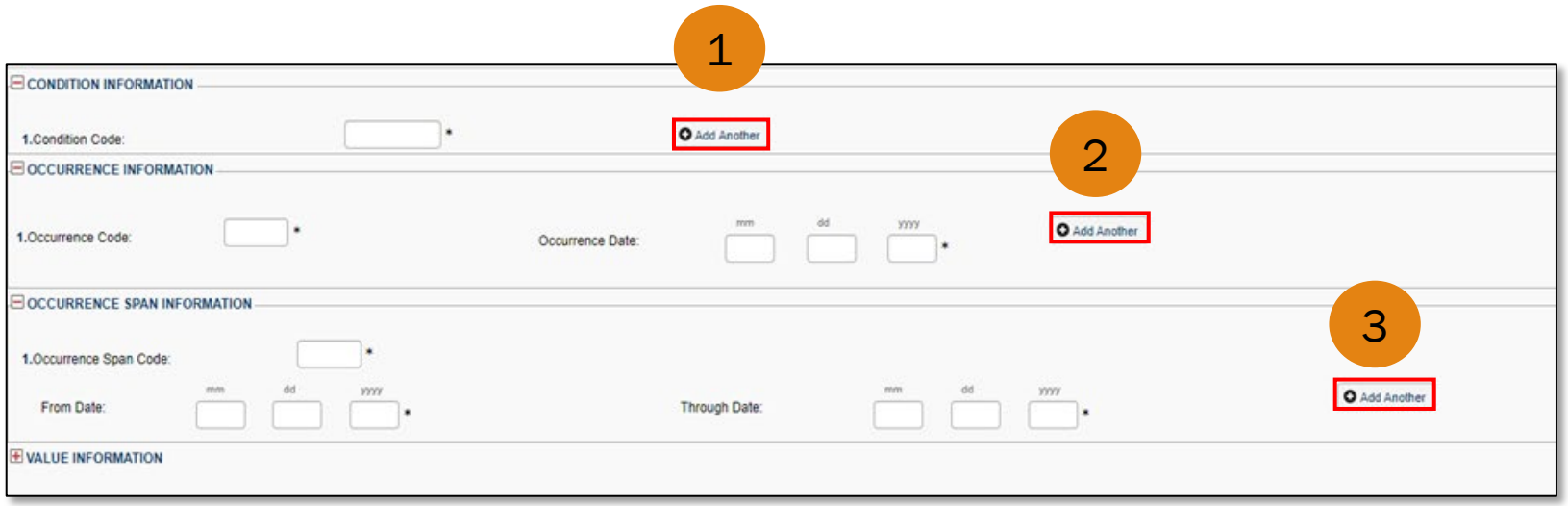
In order to process your claim, BMS also requires claim data about the patient.



Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start** and **End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

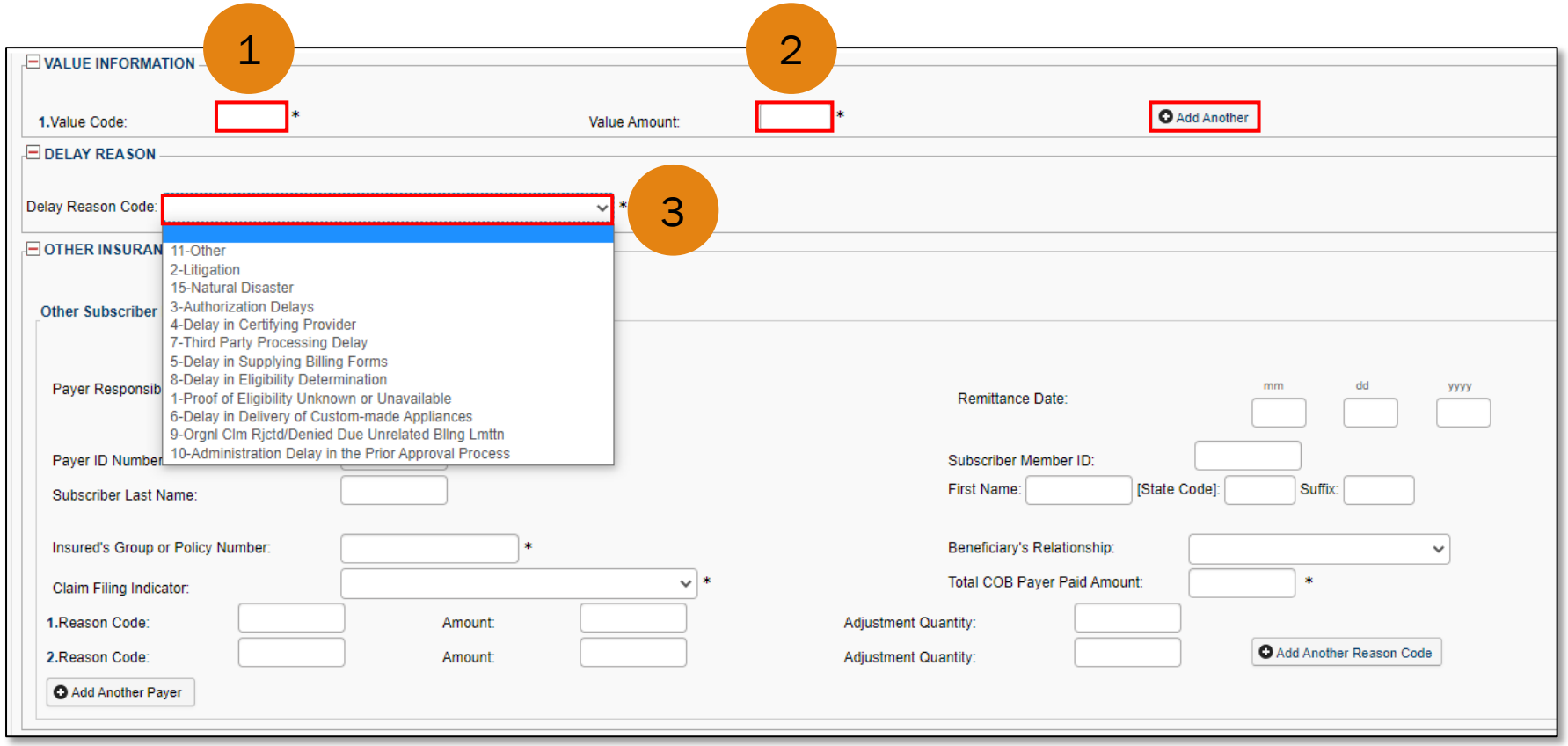
Institutional Claims Submission



Under **Condition Information**, **Occurrence Information** and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

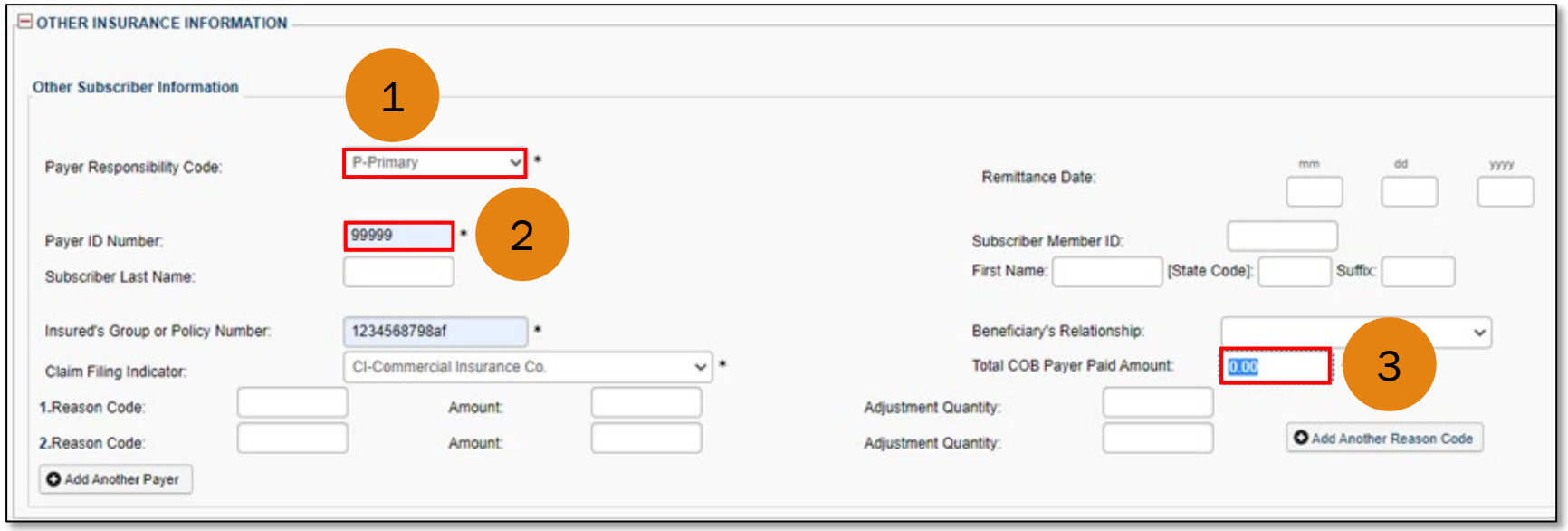
Institutional Claims Submission



Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

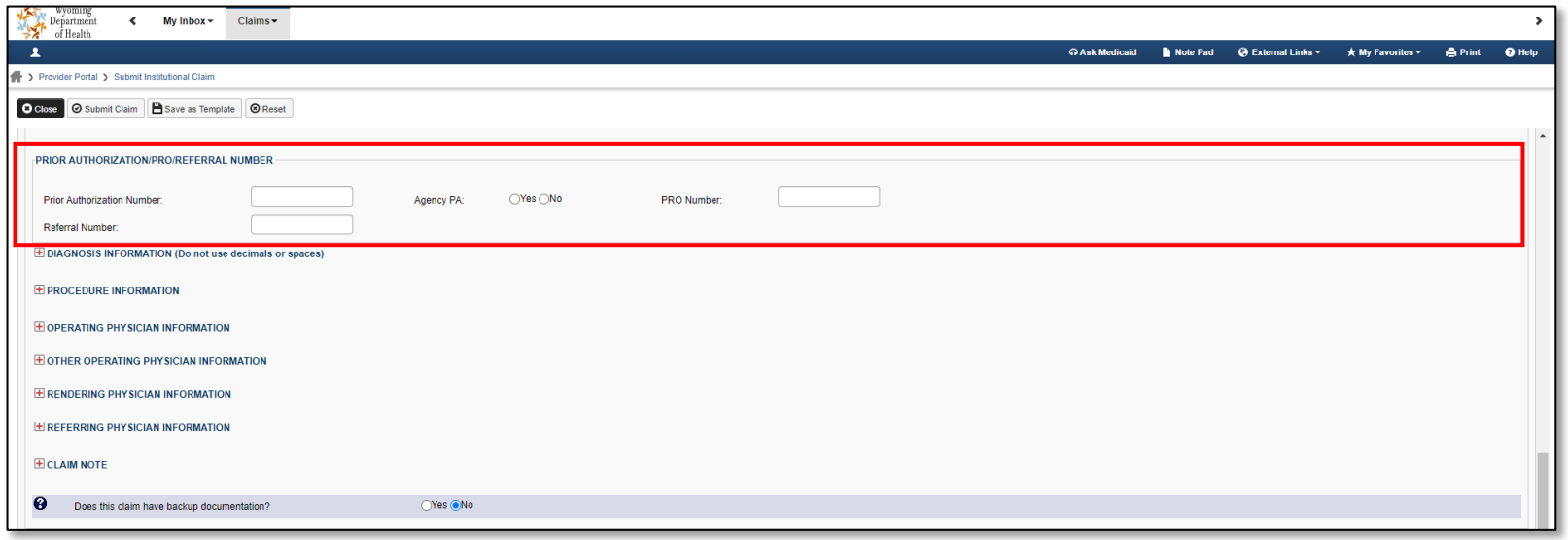
Institutional Claims Submission



If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

1. **Payer Responsibility** will be primary or secondary or tertiary in some cases.
2. **Payer ID Number** can default to 99999, or you can find the Payer ID Number at: Payer ID List.
3. Enter **Insured's Group or Policy number** and **Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission



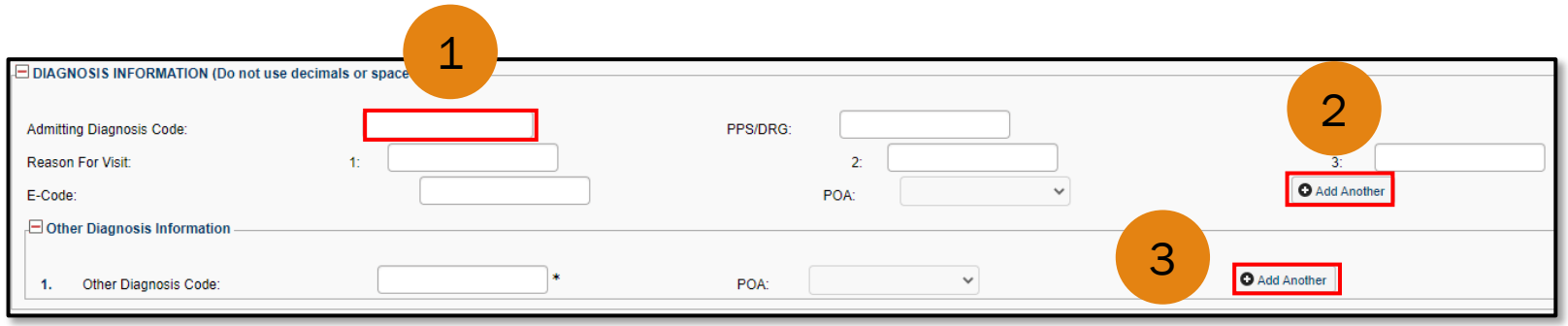
If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission



Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a "." when adding information, as the system will not recognize it.

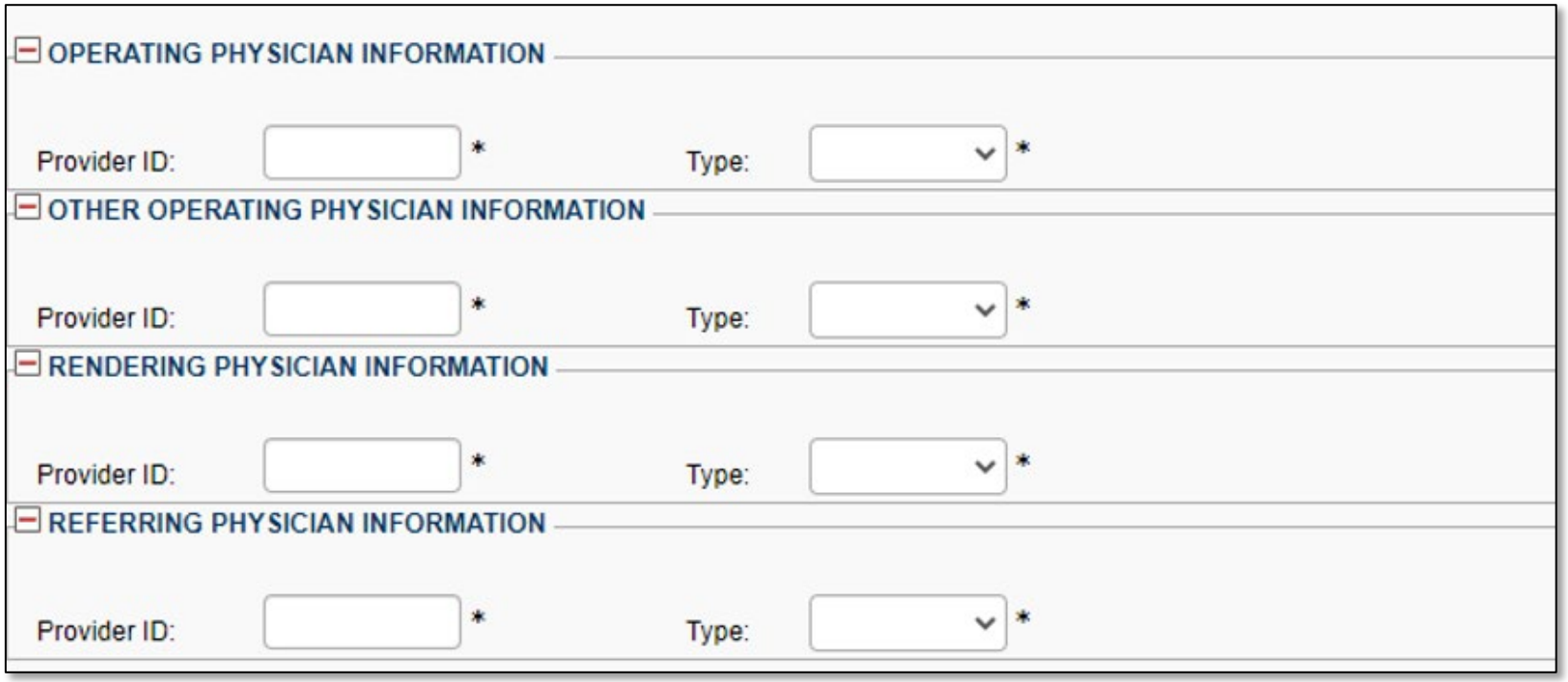
Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.

3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission



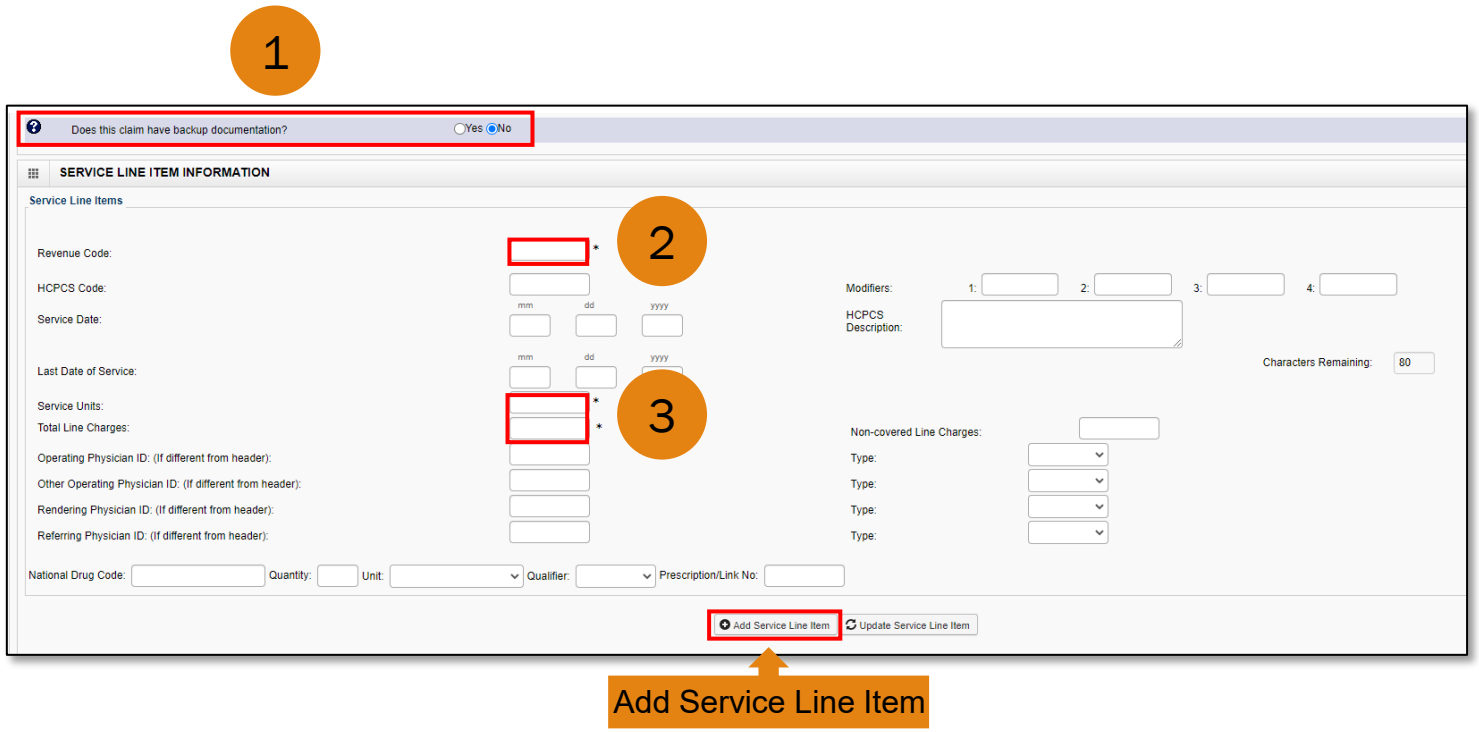
Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

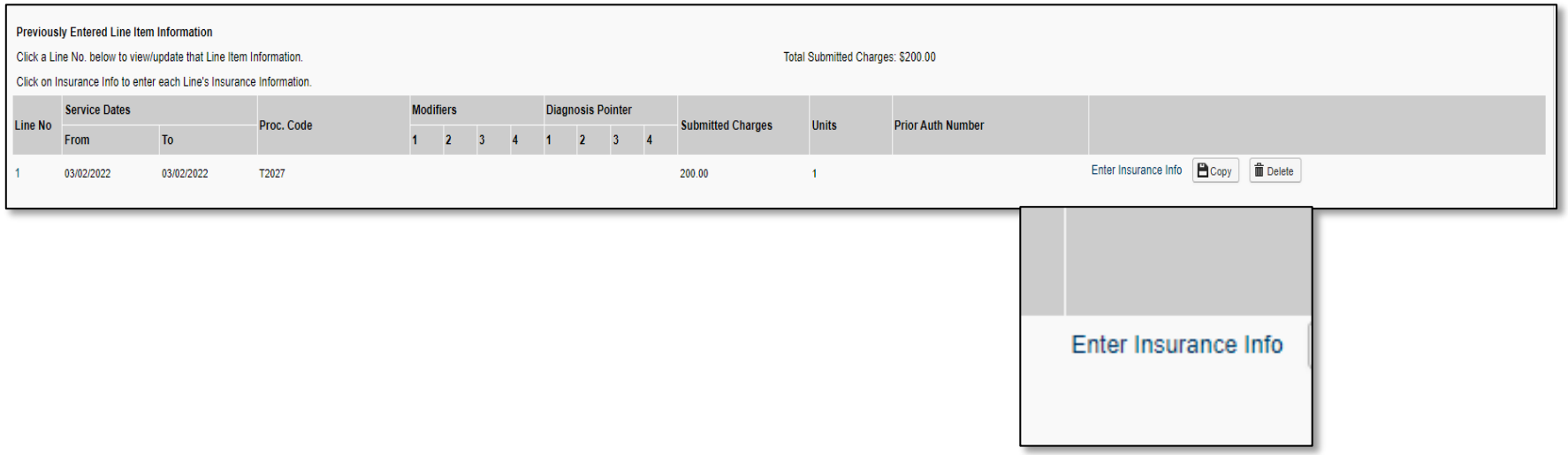
Institutional Claims Submission



Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.
5. Other fields can be completed, if applicable.

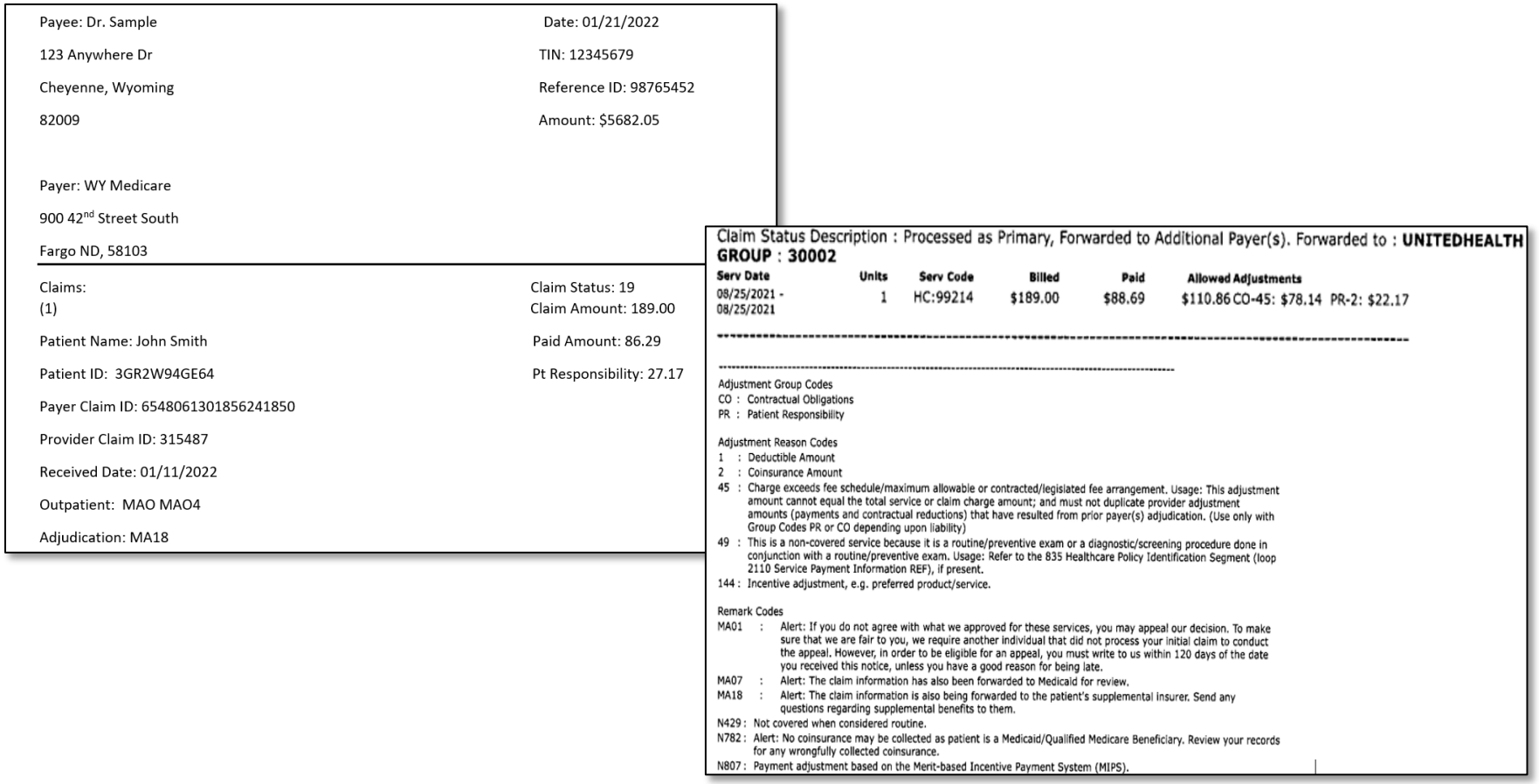
Institutional Claims Submission



At the bottom of the **Claims** page, enter each Claim Line's insurance information:

- Select **Insurance Info** to enter the other insurance payments and adjustments.

Institutional Claims Submission



Payee: Dr. Sample
123 Anywhere Dr
Cheyenne, Wyoming
82009

Date: 01/21/2022
TIN: 12345679
Reference ID: 98765452
Amount: $5682.05

Payer: WY Medicare
900 42nd Street South
Fargo ND, 58103

Claims:
(1)

Claim Status: 19
Claim Amount: 189.00

Patient Name: John Smith
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Received Date: 01/11/2022
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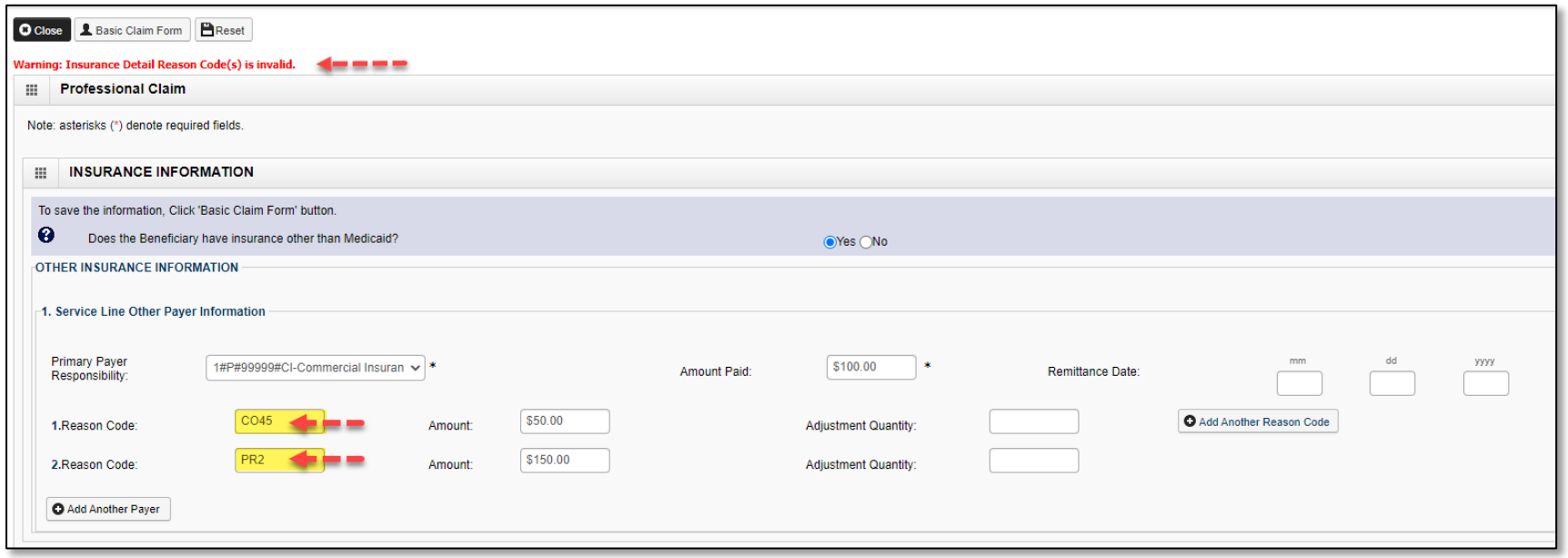
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).

This is an example of a Medicare EOB.

- Details on payment from Medicare
- Remark and Adjustment Codes
- Member information

Institutional Claims Submission



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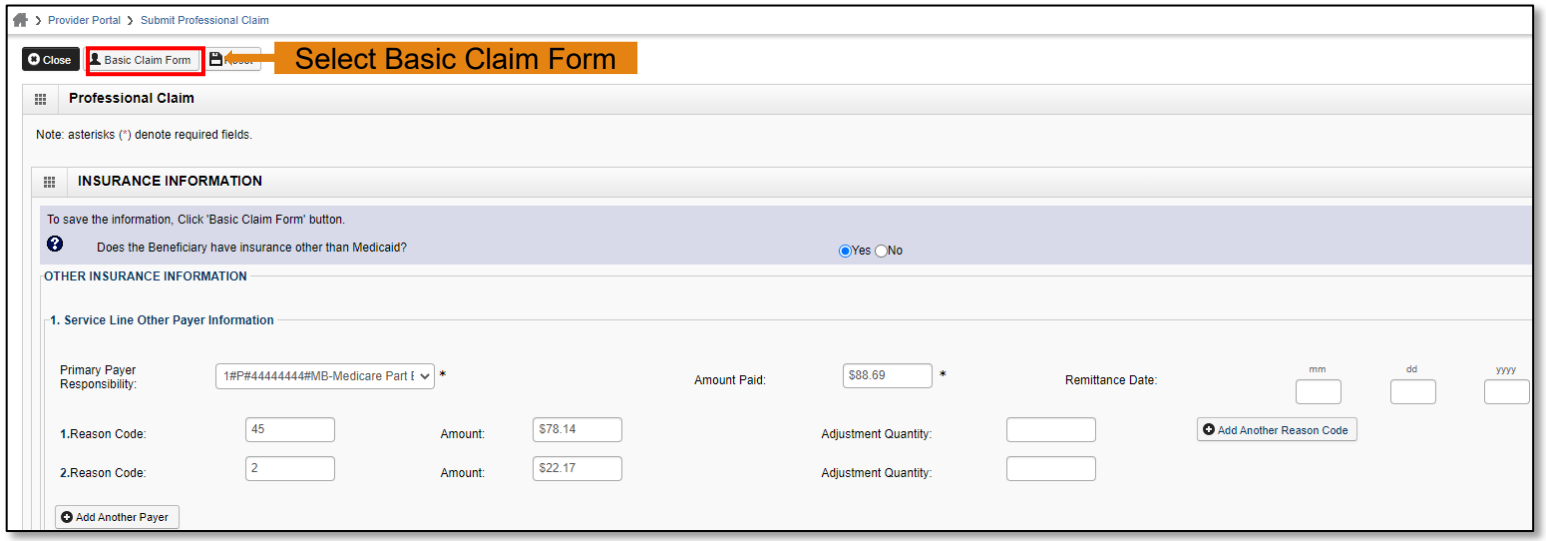
Institutional Claims Submission



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1. Select **Insurance Info** to enter the other insurance payments and adjustments.
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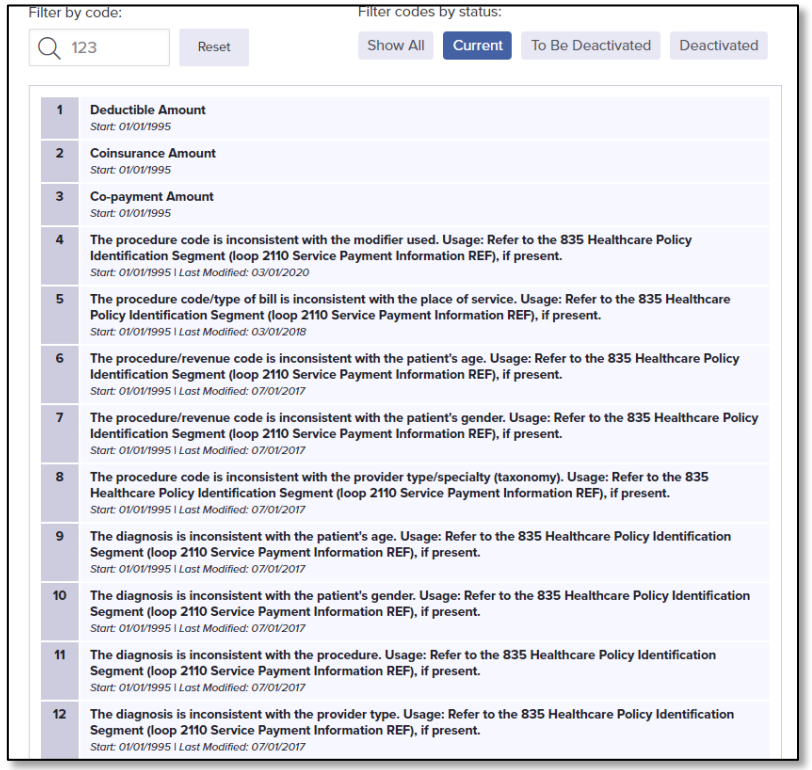
Institutional Claims Submission

1

2



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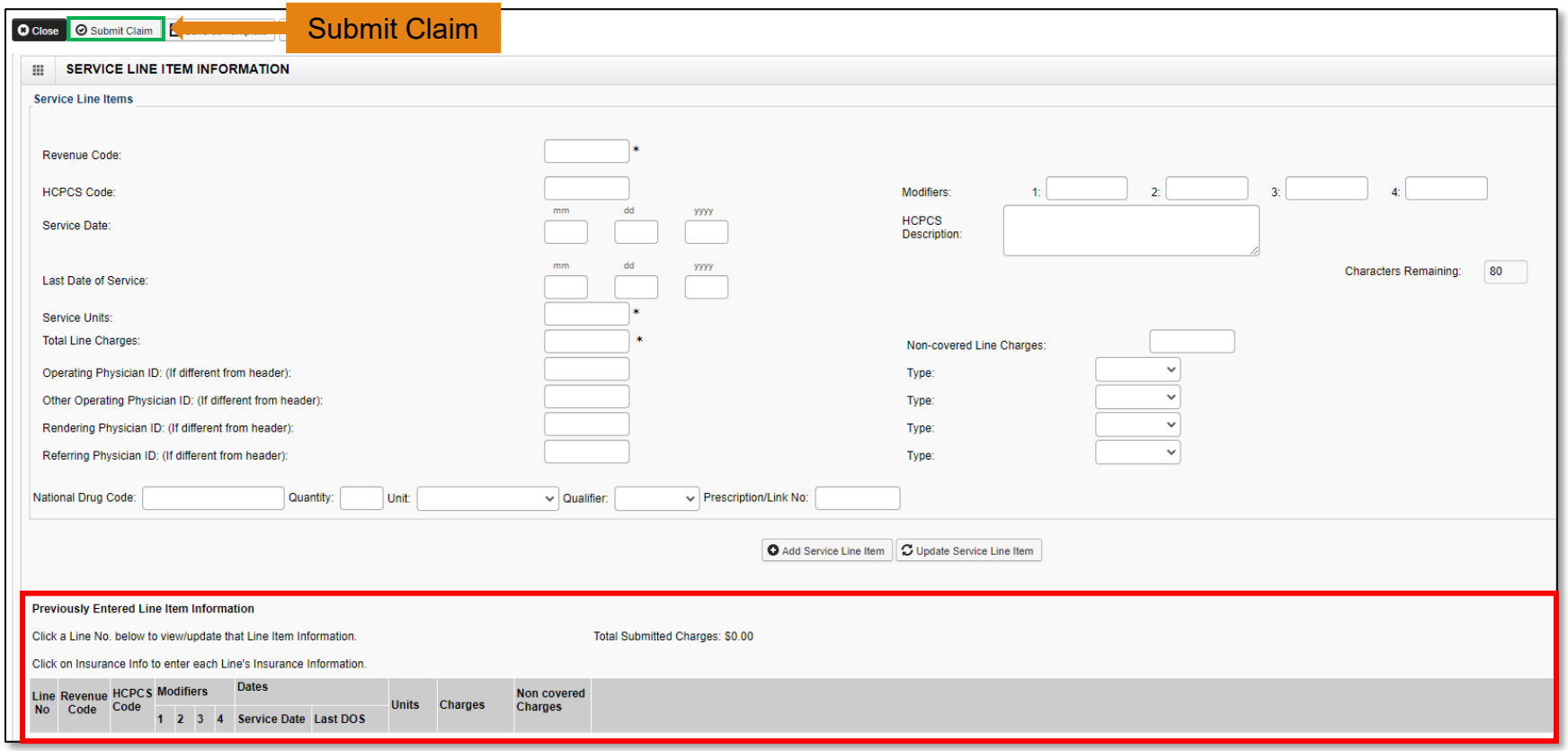

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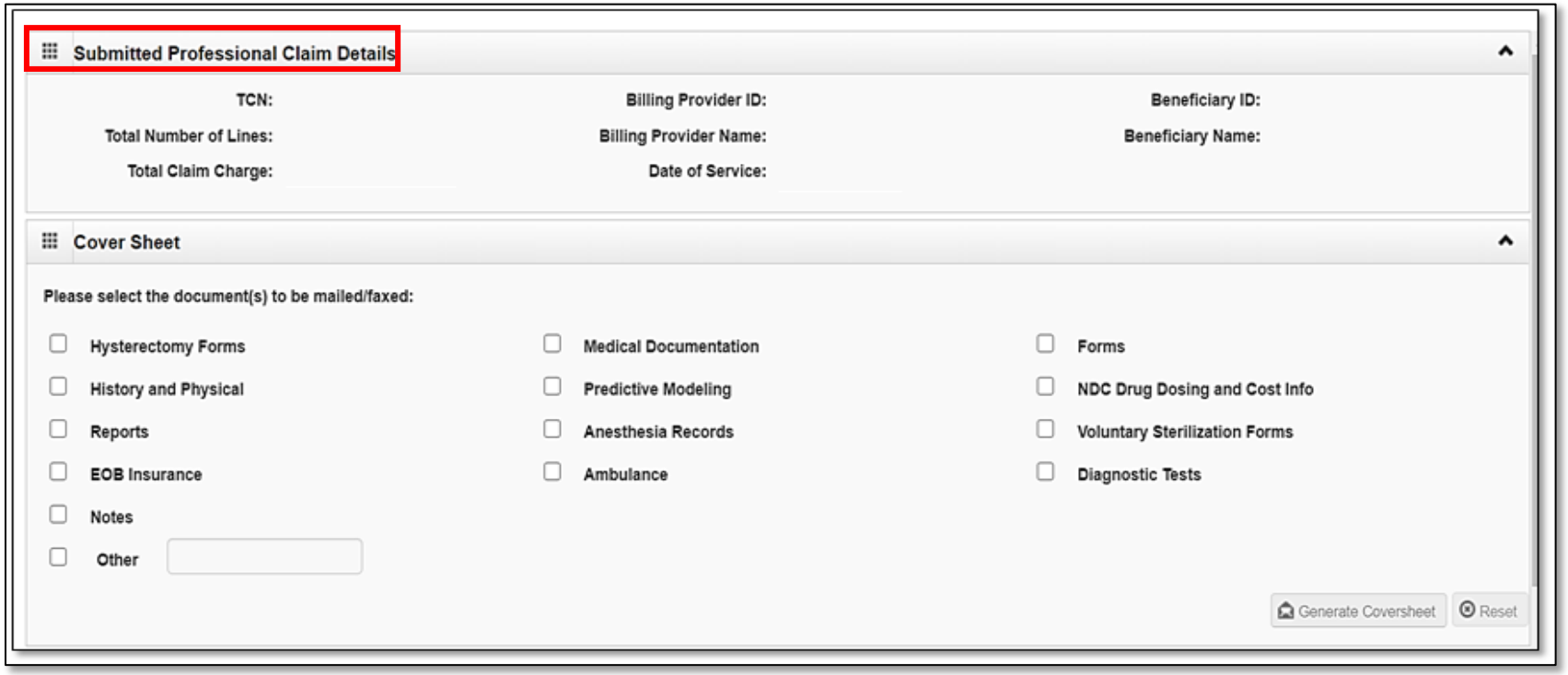
Institutional Claims Attachment



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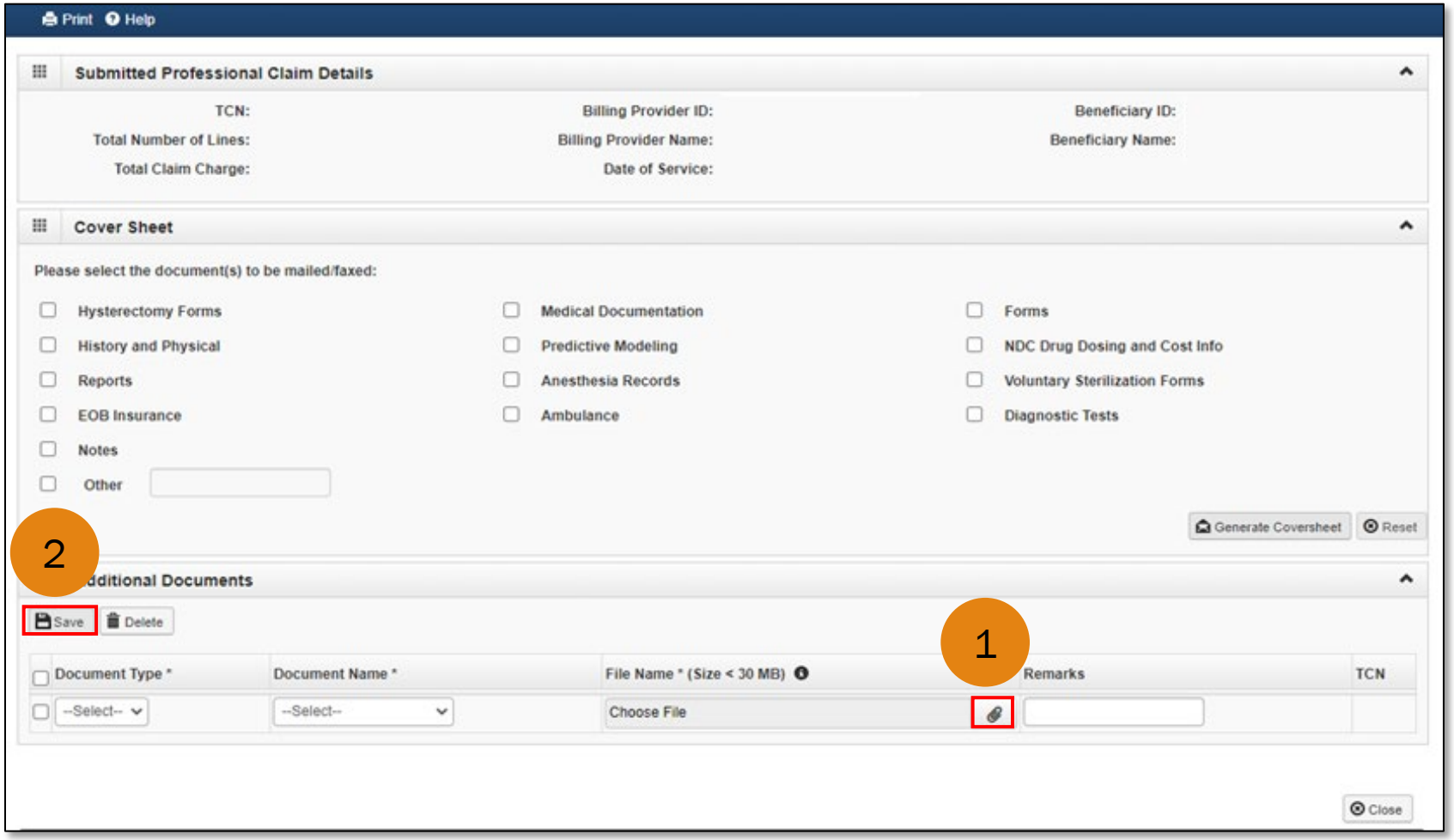
- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment



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2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Institutional Claims with Tertiary TPL

How to bill a Tertiary Third-Party Liability (TPL) Claim

Institutional Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability, and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223

    - Within the IVR say **Report TPL** or **Update insurance** to speak with someone.

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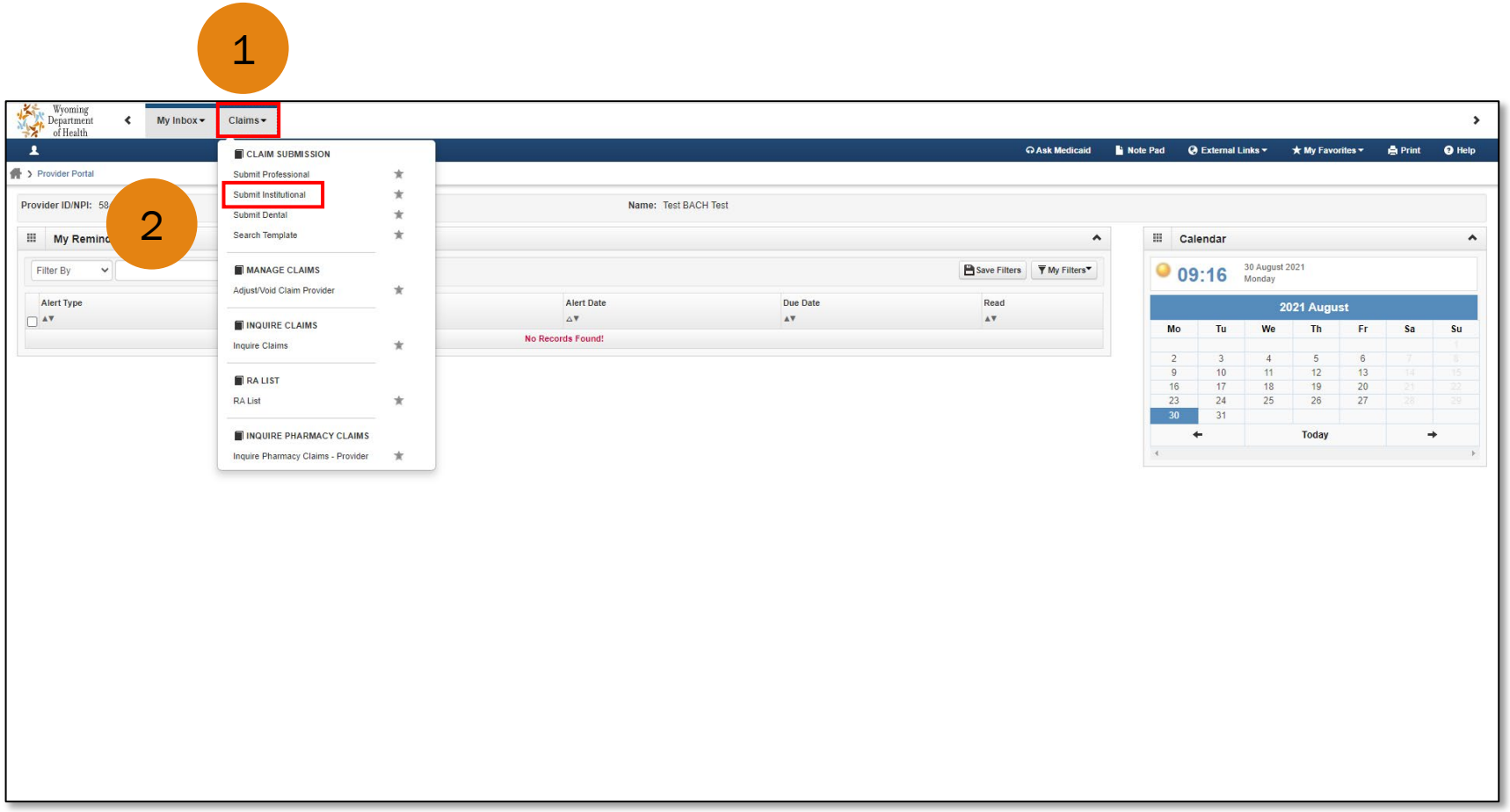
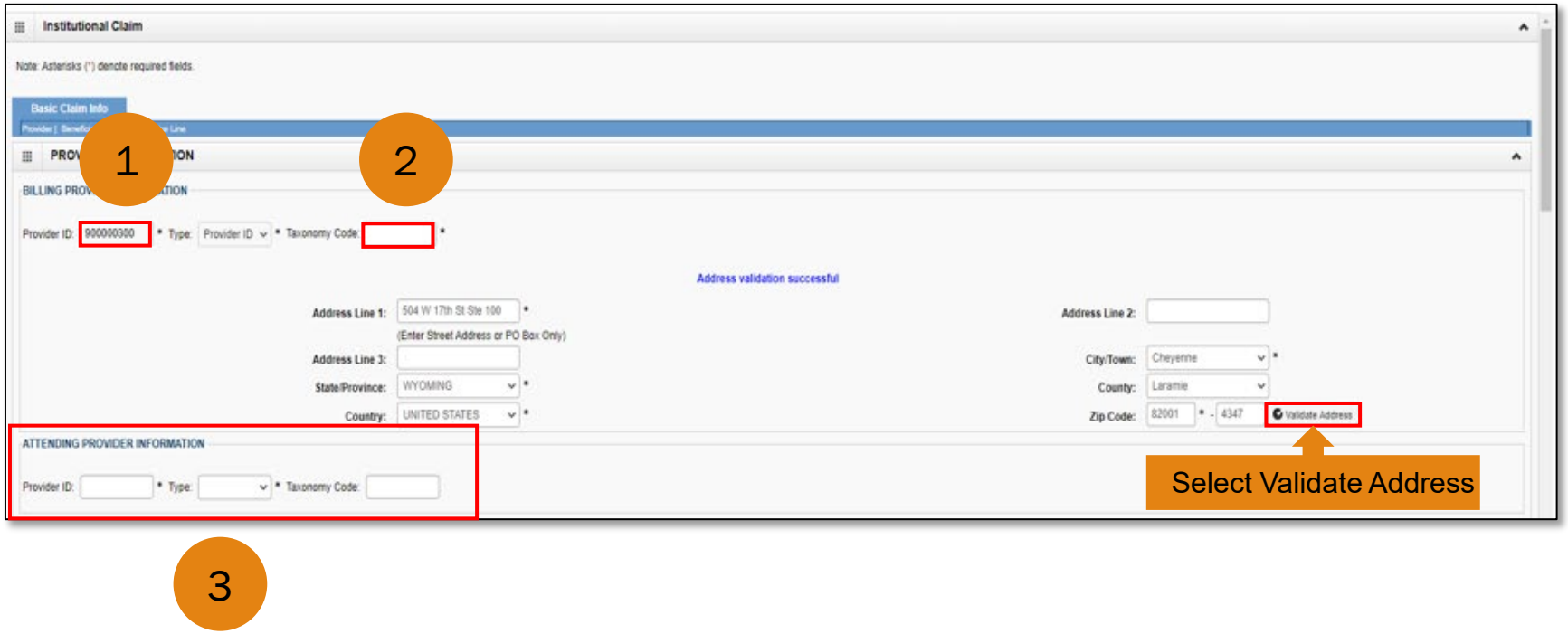
Institutional Claims Submission



To enter Institutional Claims in BMS:

1. Select **Claims**.
2. Select **Submit Institutional**.

Institutional Claims Submission



To enter Provider Information:

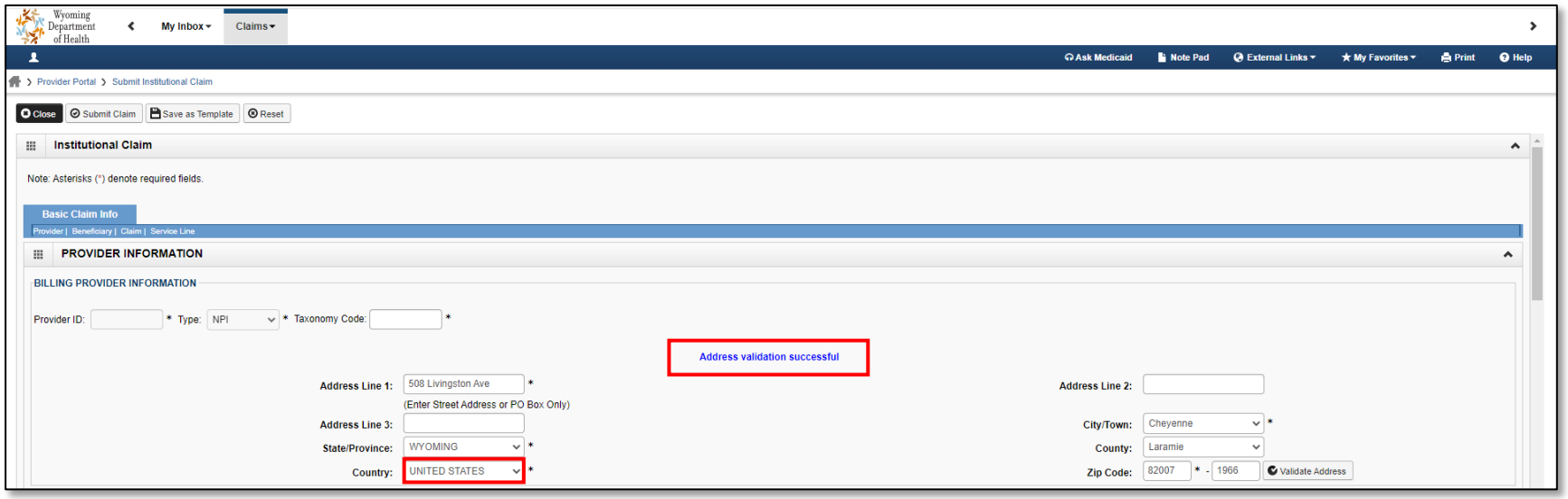
Required fields are indicated with an *.

1. National Provider Identifier (NPI) auto-populates in the **Provider ID** field. Confirm this is the correct NPI.
2. Enter in all caps the applicable **Taxonomy Code** associated with Provider.

The address auto-populates.

- Select **Validate Address**
3. Enter **Attending Provider Information**.

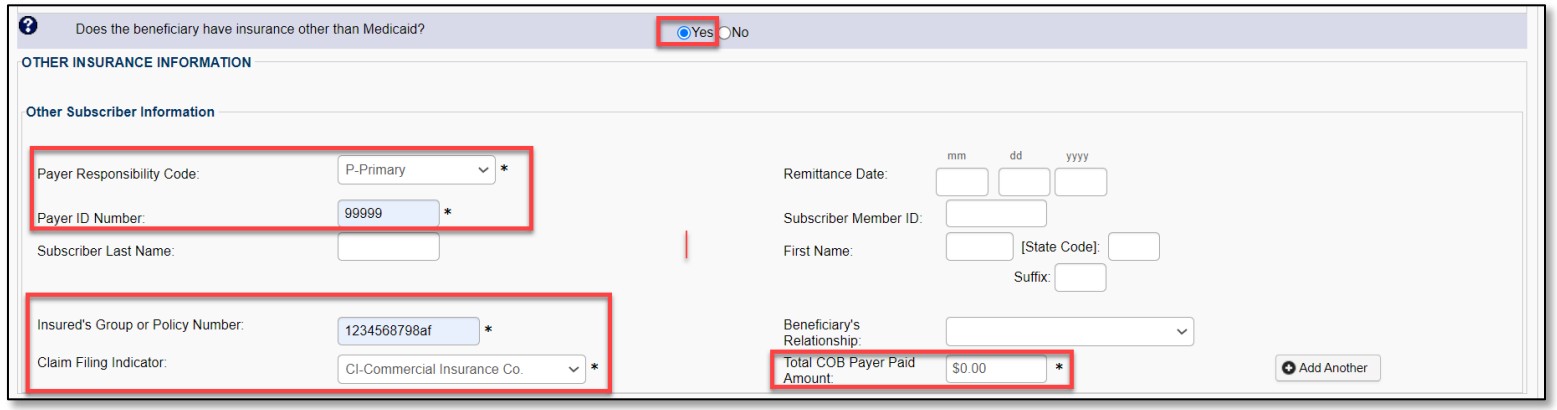
Institutional Claims Submission



BMS validates the address information and displays the following message “Address validation successful”

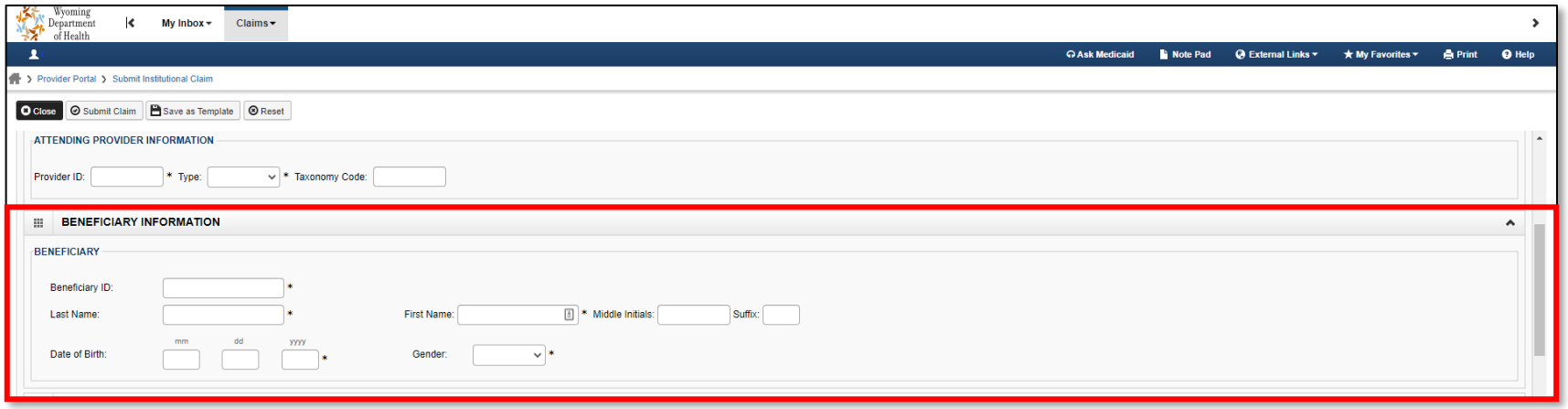
- If a message displays “International Address,” change **Country** to **United States** and re-validate

Institutional Claims Submission



- Select **Yes** to **Does the beneficiary have insurance other than Medicaid**
- **Payer Responsibility Code** for one TPL will be **Primary**
- **Payer ID** can be found at Primary Payer ID list
- **Insured's Group or Policy Number** is the Primary ID number
- **Claim Filing Indicator** is the type of insurance (such as Medicare or Commercial)
- **Total COB Payer Paid Amount** is the Total amount TPL paid

Institutional Claims Submission

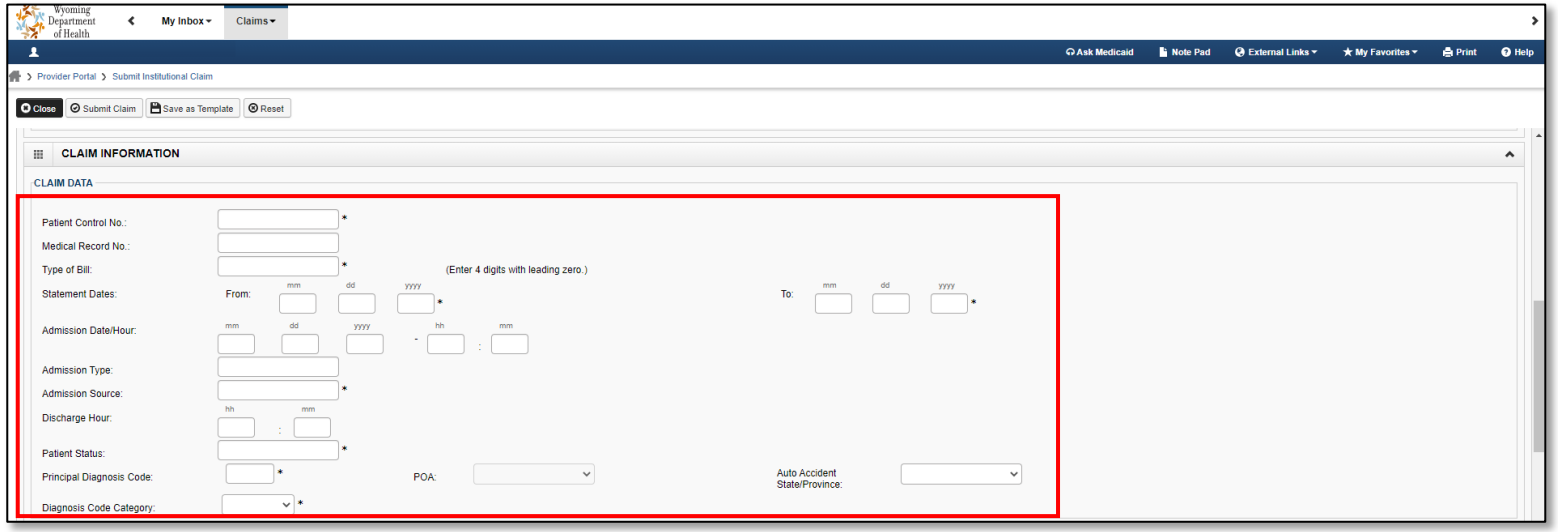


Complete the required **Beneficiary Information** (Member data), required fields are indicated with an asterisk *:

- Beneficiary (Member) ID
- Last Name
- First Name
- Date of Birth
- Gender

Institutional Claims Submission

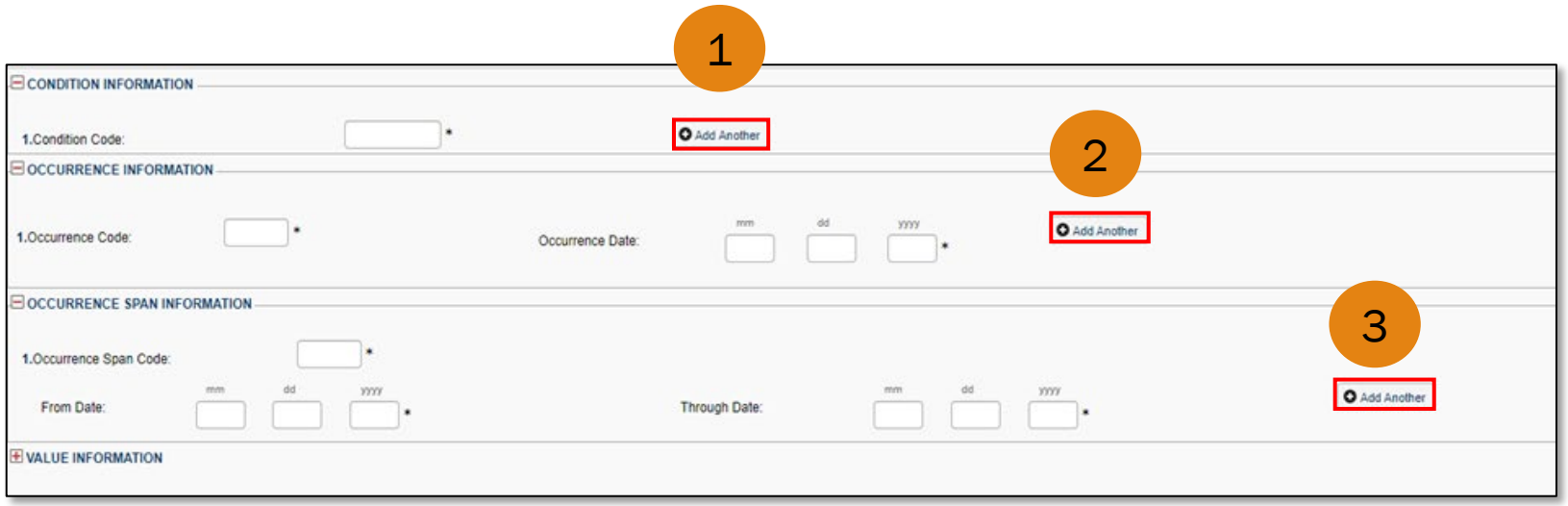
In order to process your claim, BMS also requires claim data about the patient.



Complete the required fields indicated with an *:

- **Patient Control No** identifies the Medicaid Member
- **Type of Bill** is a 4-digit number
- **Statement Start** and **End Dates**
- **Admission Source** is needed
- **Patient Status**
- **Principal Diagnosis Code**
- **Diagnosis Code Category** defaults to **ICD-10**

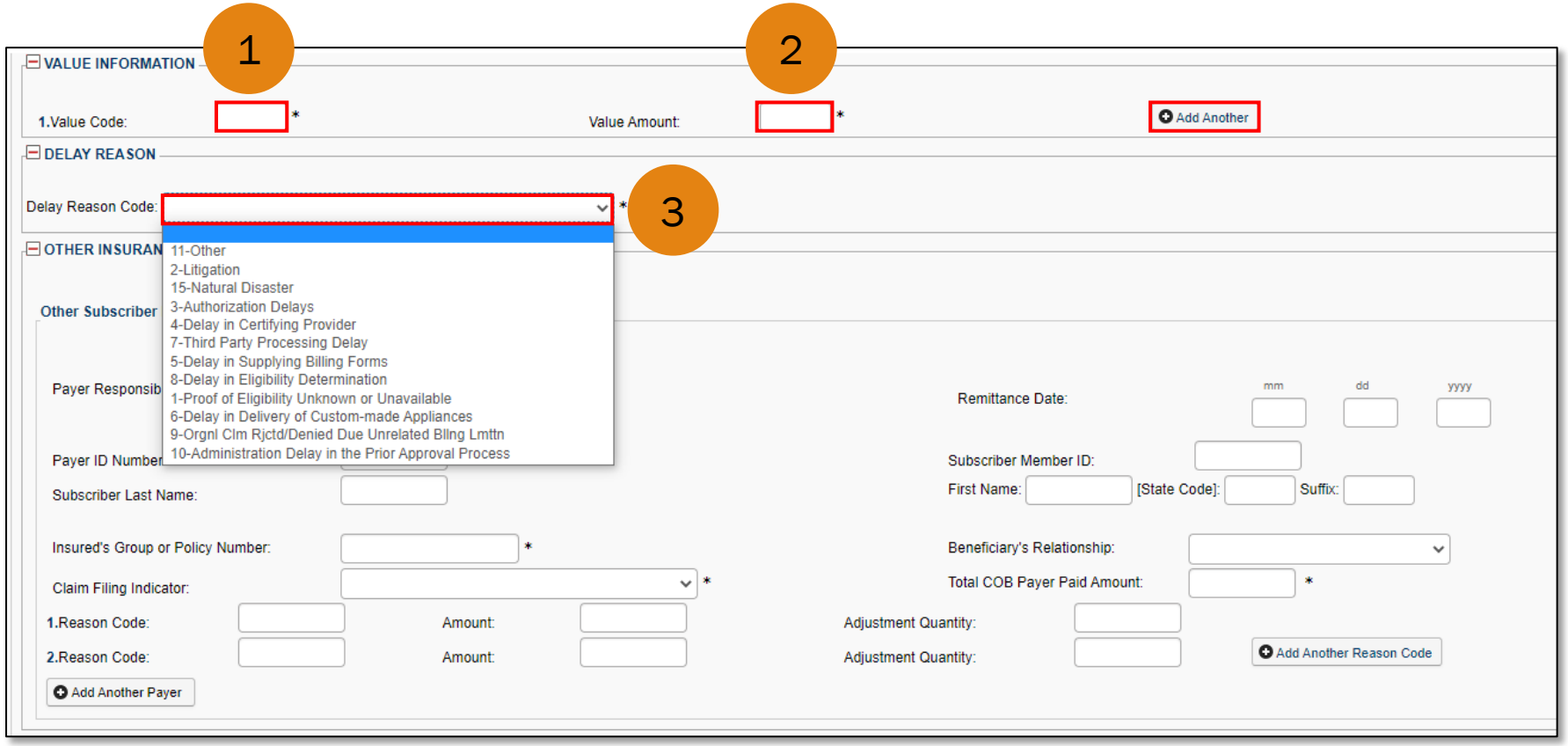
Institutional Claims Submission



Under **Condition Information**, **Occurrence Information**, and **Occurrence Span Information**, required fields are indicated with an *:

1. Enter **Condition Code**. If there is more than one, select **Add Another**.
2. Enter **Occurrence Code** and **Occurrence Date**. If there is another code, select **Add Another**.
3. Enter **Occurrence Span Information**. If there is another span, select **Add Another**.

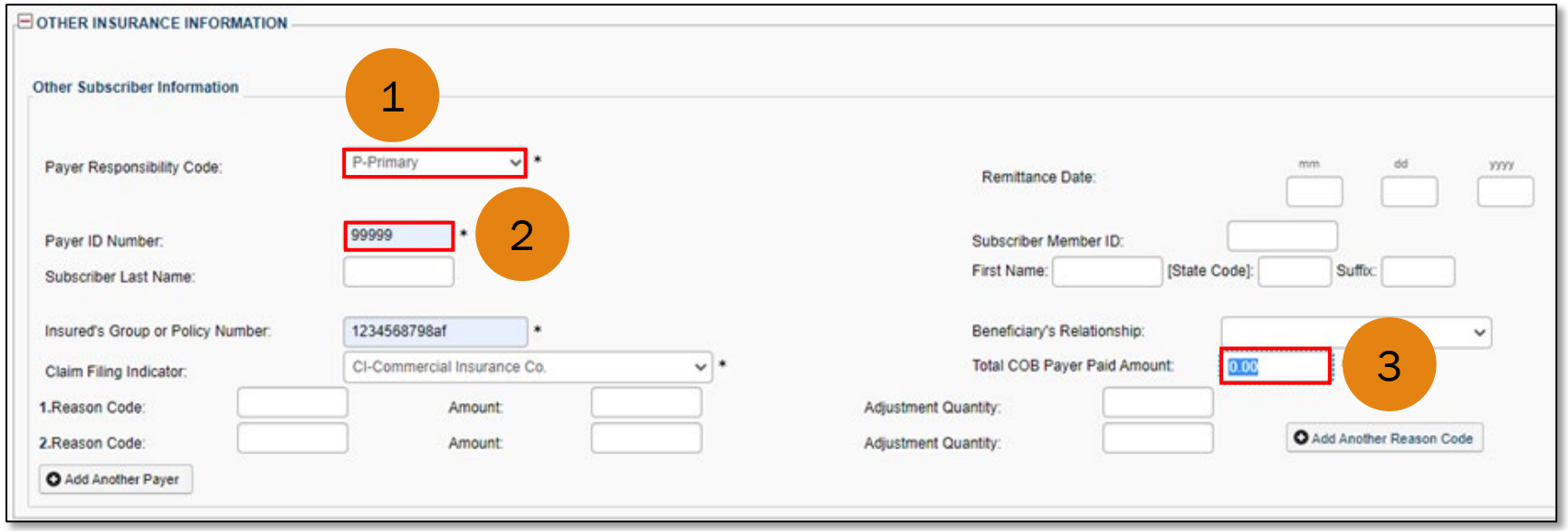
Institutional Claims Submission



Under **Value Code**, required fields are indicated with an *:

1. Enter **Value Code**.
2. Enter **Value Amount**. If there is another, select **Add Another**.
3. Select the applicable **Delay Reason**.

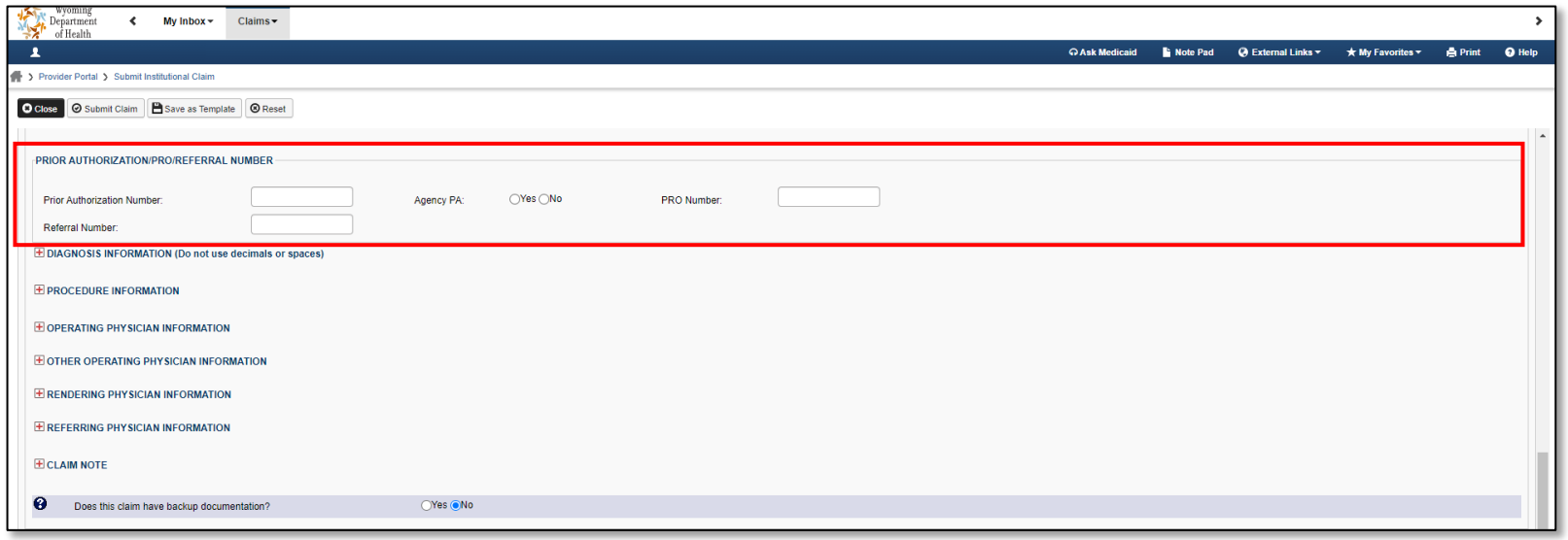
Institutional Claims Submission



If the Member has other insurance besides Medicaid, this can be Commercial or Medicare:

1. **Payer Responsibility** will be primary or secondary or tertiary in some cases.
2. **Payer ID Number** can default to 99999, or you can find the Payer ID Number at: Payer ID List.
3. Enter **Insured's Group or Policy number** and **Claim Filing Indicator**, along with **Total COB Payer Paid Amount**. This is the amount that the Primary Insurance paid.

Institutional Claims Submission



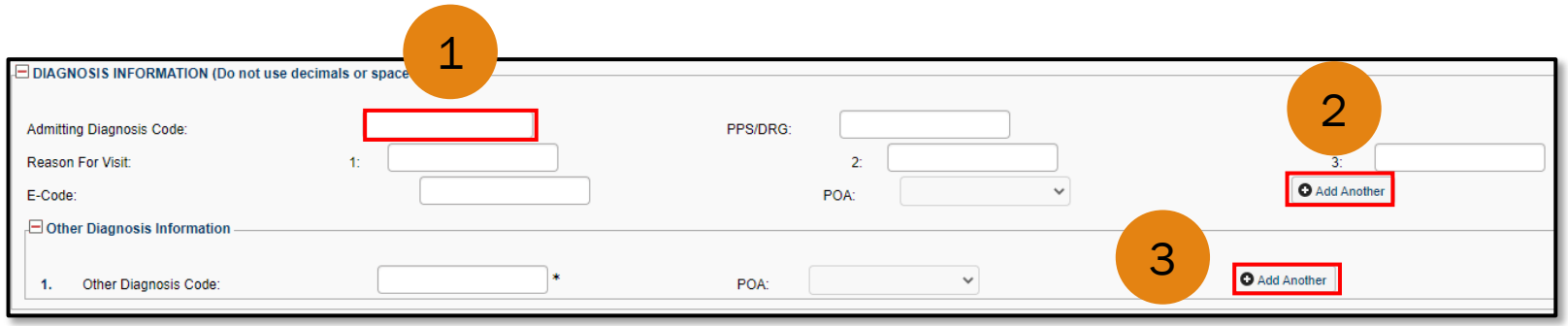
If your claim requires a Prior Authorization (PA), complete the fields for the **Prior Authorization/Pro/Referral Number**:

- **Prior Authorization Number**
- For **Agency PA**, select **Yes** or **No**.

This is all the information you will need. *PRO number and Referral number are not needed*

PAs are not needed for every claim.

Institutional Claims Submission



Under **Diagnosis Information**:

1. Enter **Admitting Diagnosis Code**.

Do not place a "." when adding information, as the system will not recognize it.

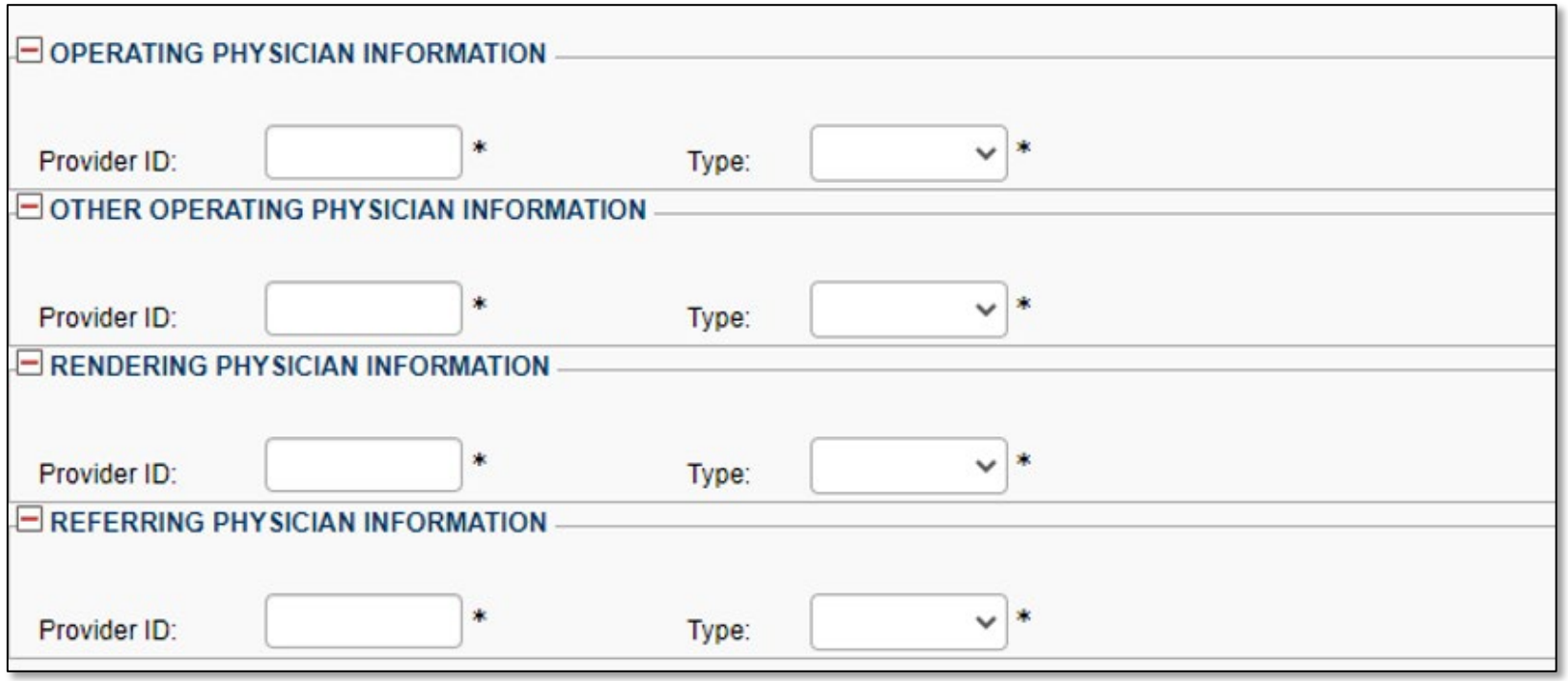
Example: Enter F402 instead of F4.20.

2. Select **Add Another** to add other diagnosis codes.

3. To add more of the Admitting or Other Diagnosis codes, select **Add Another**.

Diagnosis codes may not always be applicable.

Institutional Claims Submission



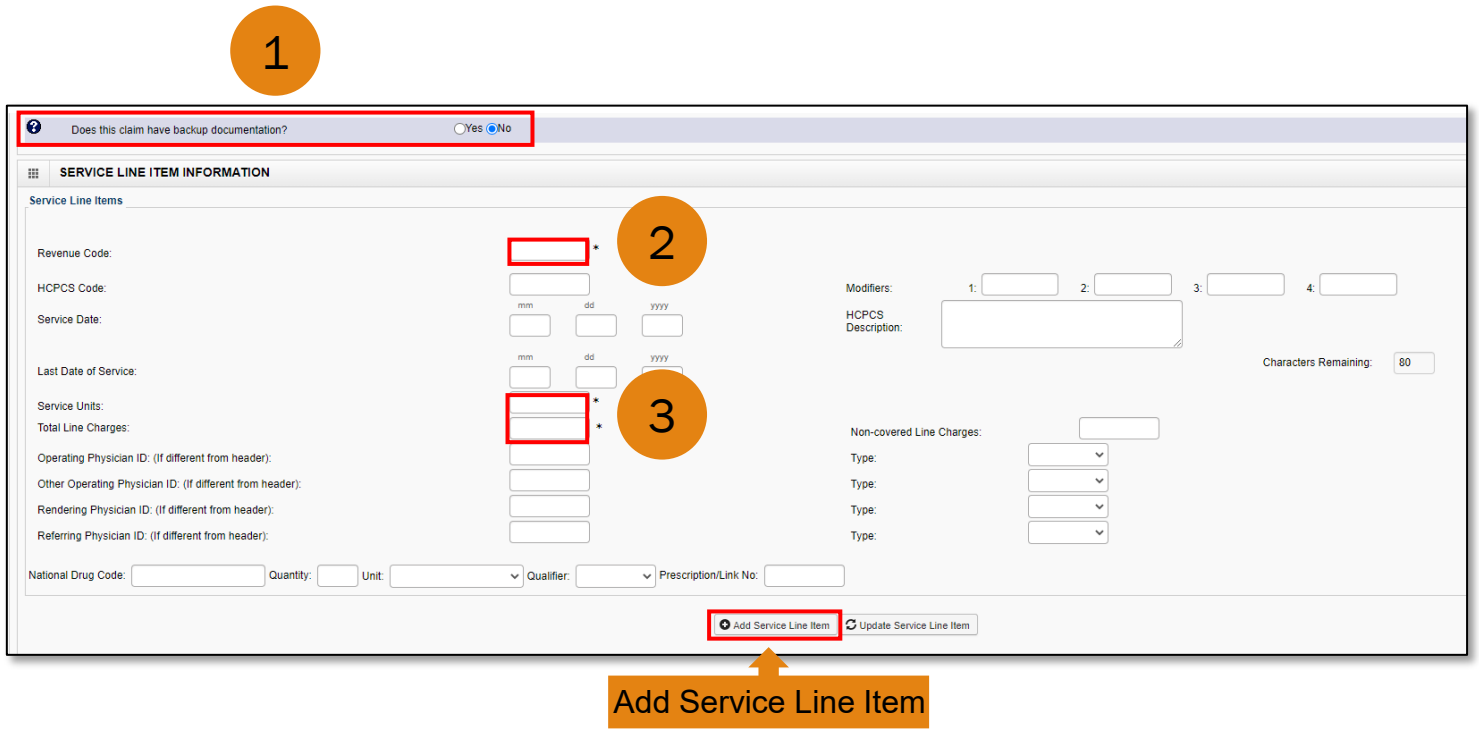
Operating, Rendering, and Referring Physician Information:

If applicable, complete the required fields indicated with an *.

In **Provider ID** field, use NPI or Provider ID for Identification Number.

Not all claims require this information.

Institutional Claims Submission

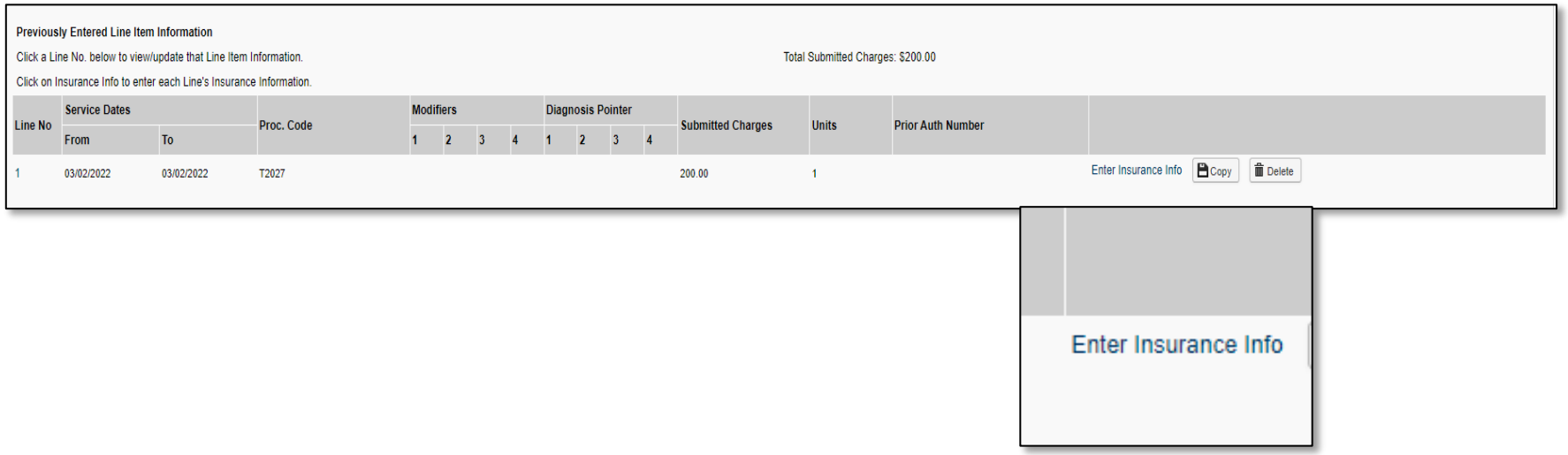


Service Line Item Information is required to process the claim, all required fields are indicated with an *:

1. Select **Yes** for **Does this claim have backup documentation** for items such as OP notes or sterilization forms. This suspends the claim for 30 days for processing attachments.
2. Enter **Revenue Code**.
3. Enter **Service Units** and **Total Line Charges**.
4. Select **Add Service Line Item**. Repeat for additional revenue codes.

- Other fields can be completed, if applicable.

Institutional Claims Submission



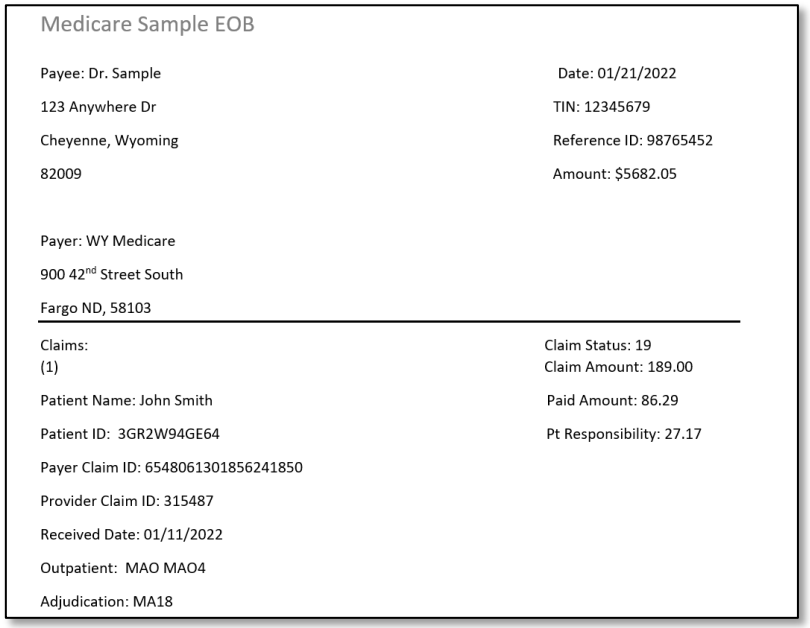
At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Edit Insurance Info** to enter the other insurance payments and adjustments.

- Complete all required fields indicated with an *.

2. Select **Add Another Reason Code** to add additional reason code and amount.
3. Select **Add Another Payer** to items for Secondary/Tertiary Payer.
4. The **Amount Paid** for this line + Reason Amounts must = Billed Amount.

Institutional Claims Submission



Medicare Sample EOB

Payee: Dr. Sample
123 Anywhere Dr
Cheyenne, Wyoming
82009

Date: 01/21/2022
TIN: 12345679
Reference ID: 98765452
Amount: $5682.05

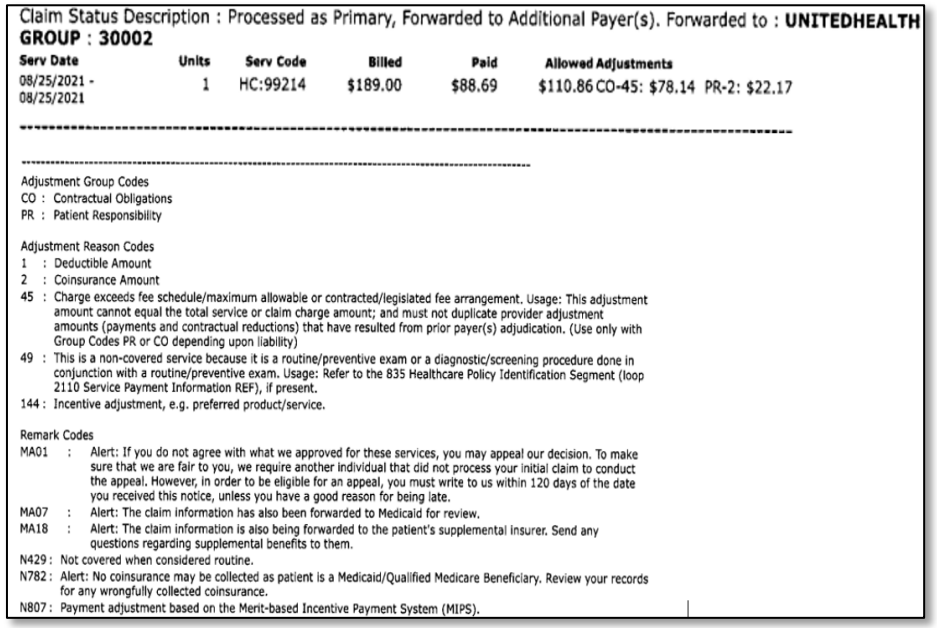
Payer: WY Medicare
900 42nd Street South
Fargo ND, 58103

Claims:
(1)

Claim Status: 19
Claim Amount: 189.00

Patient Name: John Smith
Patient ID: 3GR2W94GE64
Paid Amount: 86.29
Pt Responsibility: 27.17

Payer Claim ID: 6548061301856241850
Provider Claim ID: 315487
Received Date: 01/11/2022
Outpatient: MAO MAO4
Adjudication: MA18



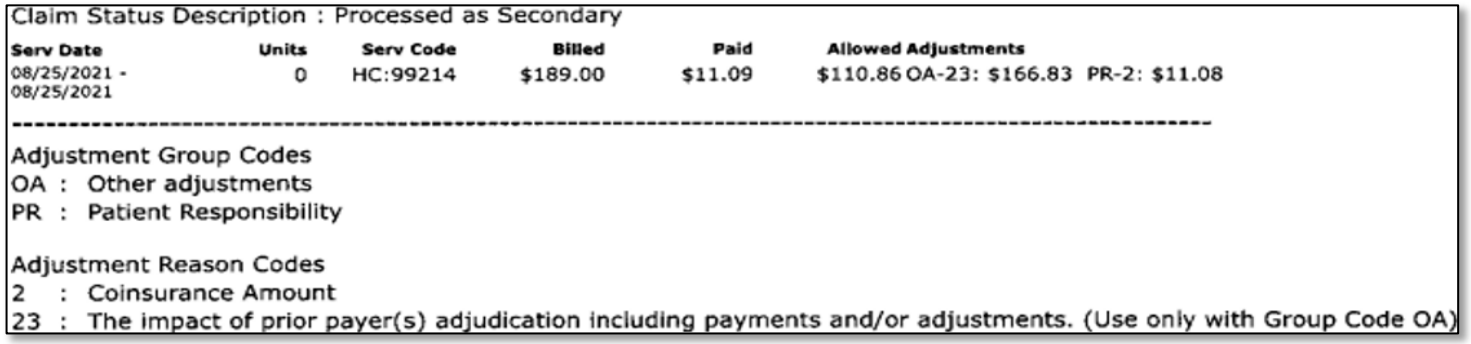
Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **UNITEDHEALTH GROUP : 30002**

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	1	HC:99214	$189.00	$88.69	$110.86 CO-45: $78.14 PR-2: $22.17

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49 : This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
144 : Incentive adjustment, e.g. preferred product/service.

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07 : Alert: The claim information has also been forwarded to Medicaid for review.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N429 : Not covered when considered routine.
N782 : Alert: No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.
N807 : Payment adjustment based on the Merit-based Incentive Payment System (MIPS).



Claim Status Description : Processed as Secondary

Serv Date	Units	Serv Code	Billed	Paid	Allowed Adjustments
08/25/2021 - 08/25/2021	0	HC:99214	$189.00	$11.09	$110.86 OA-23: $166.83 PR-2: $11.08

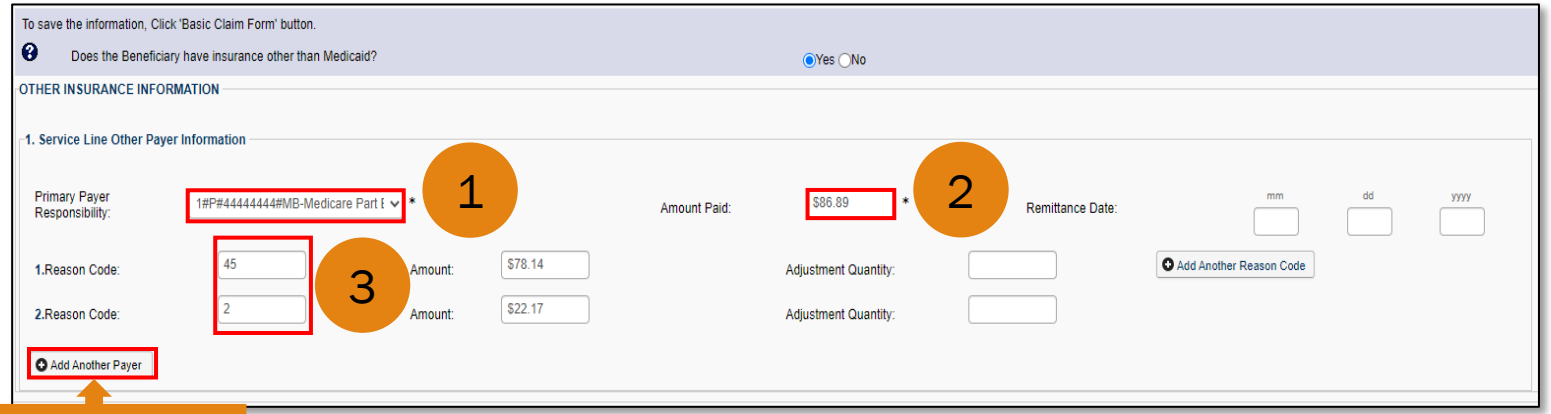
Adjustment Group Codes
OA : Other adjustments
PR : Patient Responsibility

Adjustment Reason Codes
2 : Coinsurance Amount
23 : The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

For a Tertiary Claim, you will have 2 EOBs:

- The secondary insurance will have an adjustment reason code of **23**. This is to signify payment of other payer
- Other payers' amount + adjustments will equal the total billed amount to Medicaid

Institutional Claims Submission



Add Another Payer

Enter information from the EOB:

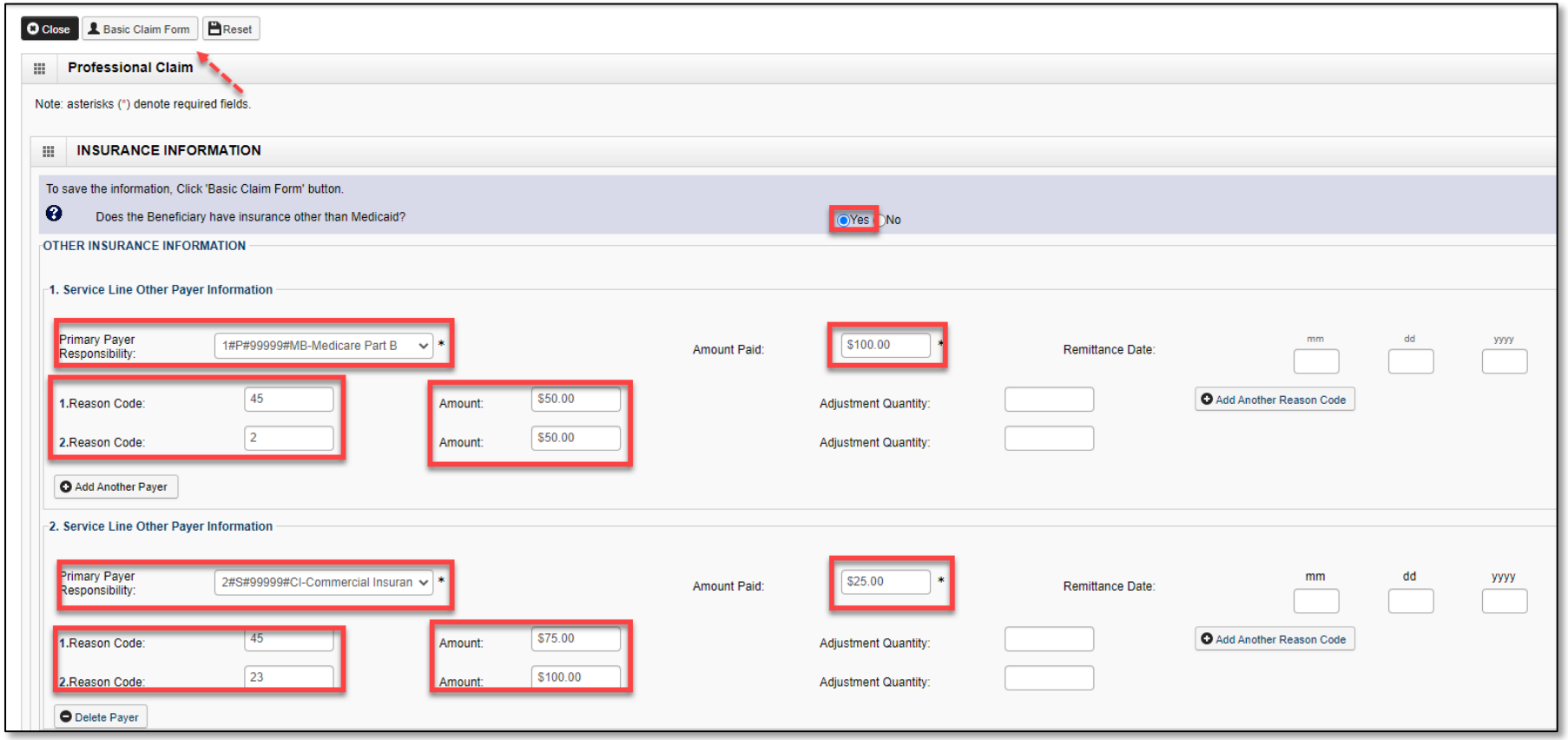
1. Enter your 1st insurance in **Primary Payer Information**.
2. Enter <u>total</u> **Amount Paid** by the first payer <u>only</u>.
3. Enter your reason codes from the EOB in **Reason Code** fields.

Your billed amount from Medicare must equal total amount billed to Medicaid.

In this example Total paid ($86.89) + Adjustment Reason ($78.17+22.17) =Total amount billed to Medicaid. $189.00. This will balance the first line

4. Select **Add Another Payer**.

Institutional Claims Submission

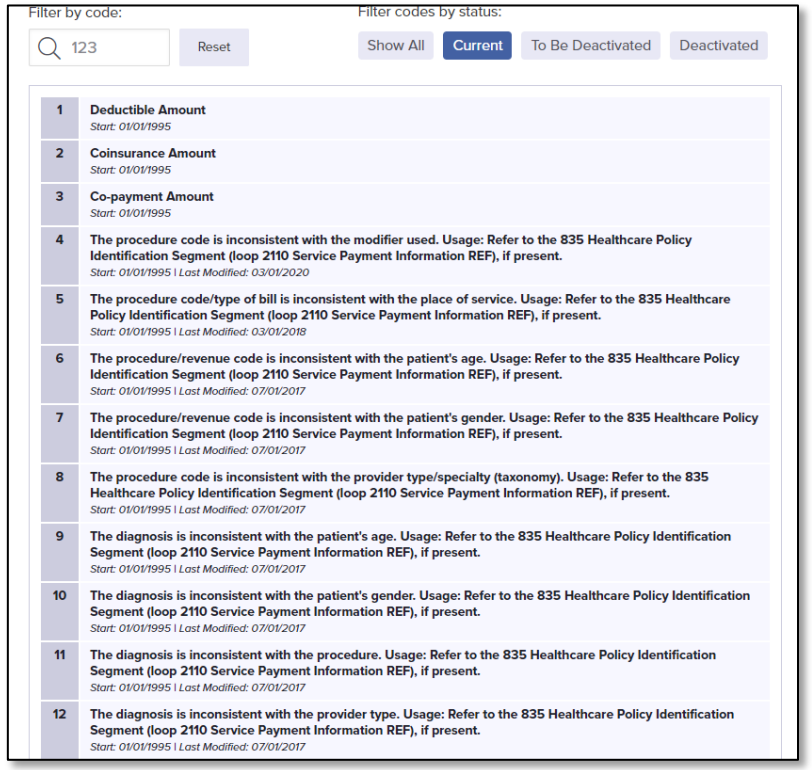


- Like your first line, the second line must balance.
- Your secondary insurance will have an adjustment code of **23** showing what the primary payer paid. <u>You must enter this</u>.
- Total + Adjustment Reason =Total amount billed to Medicaid.
- After all primary insurance information is entered, select **Basic Claim Form** to return to the claim for submission.

Institutional Claims Submission

1

2

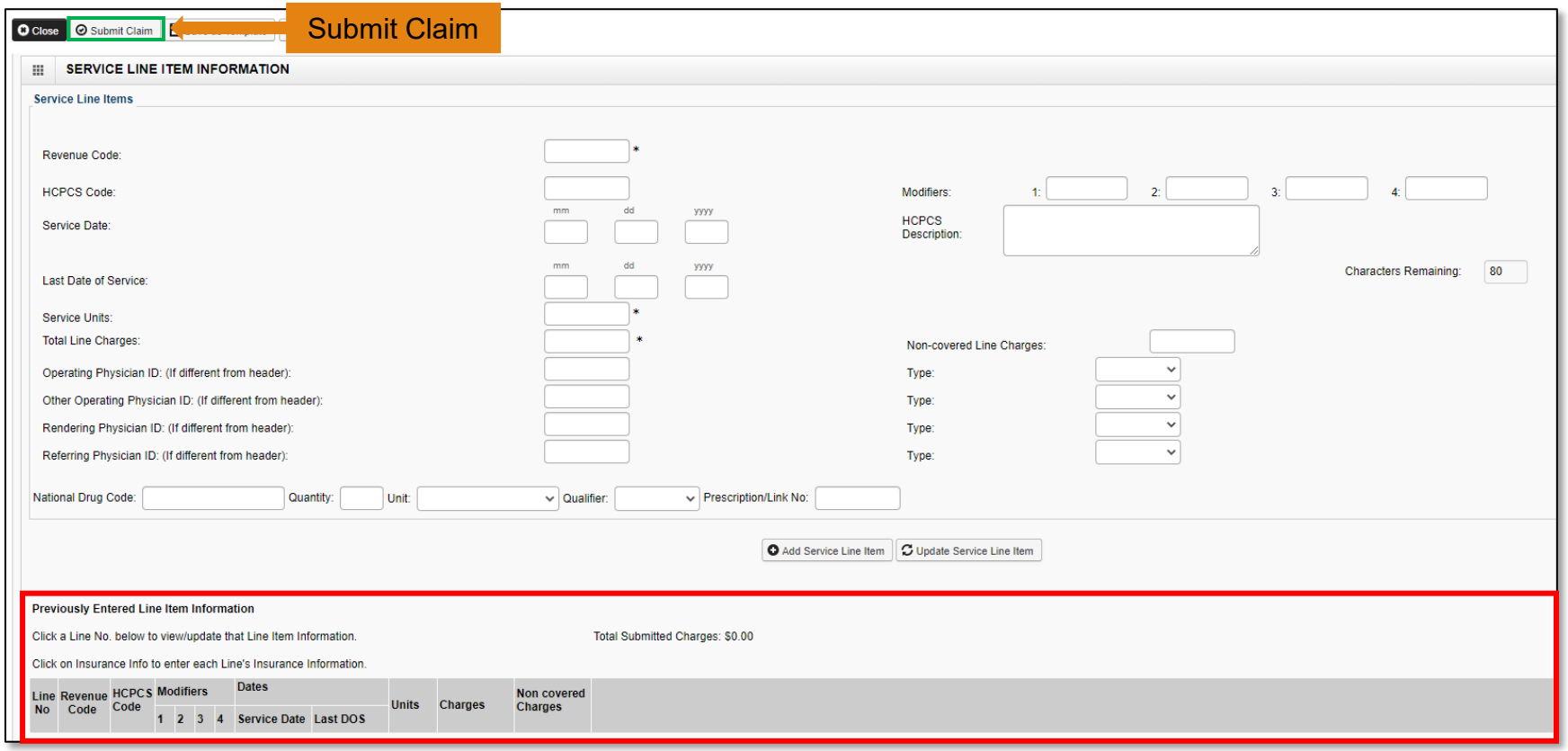


3

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

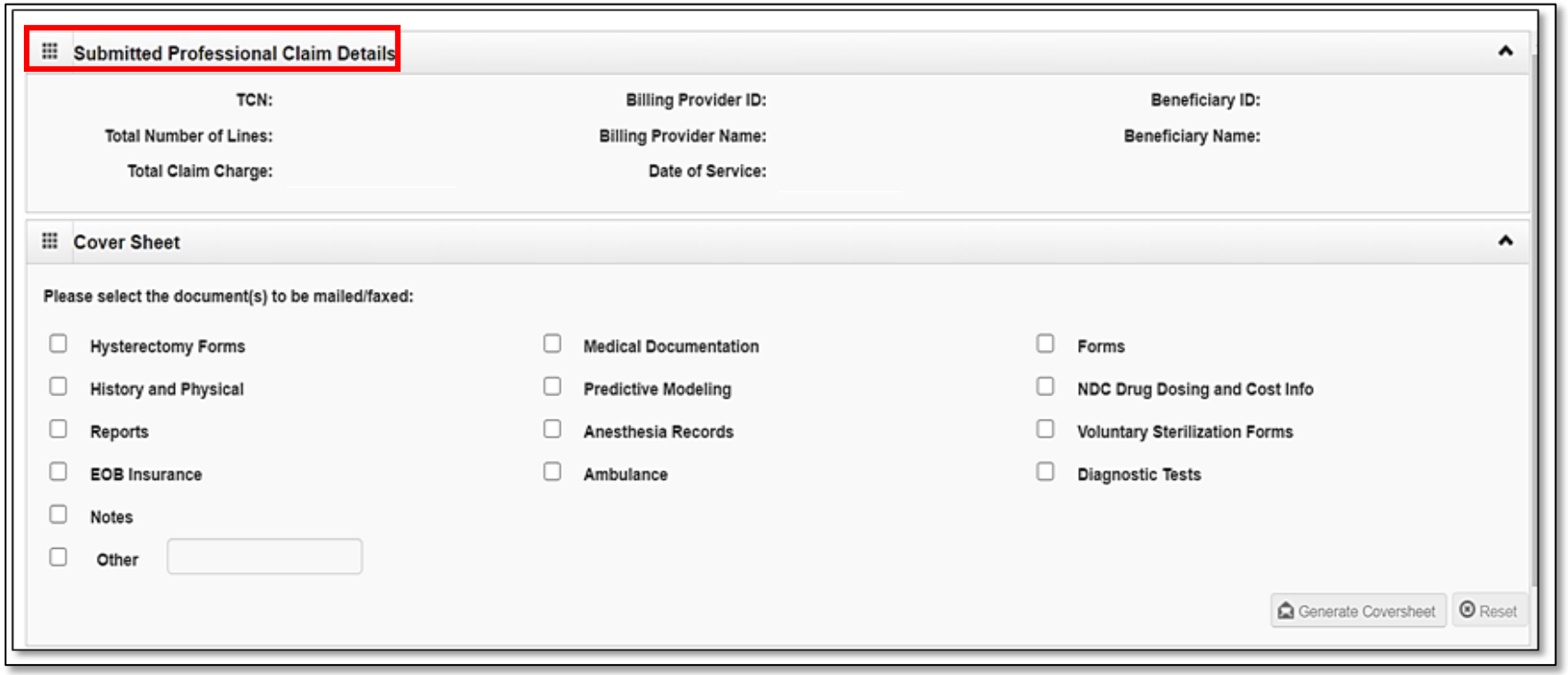
1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Institutional Claims Submission



- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**

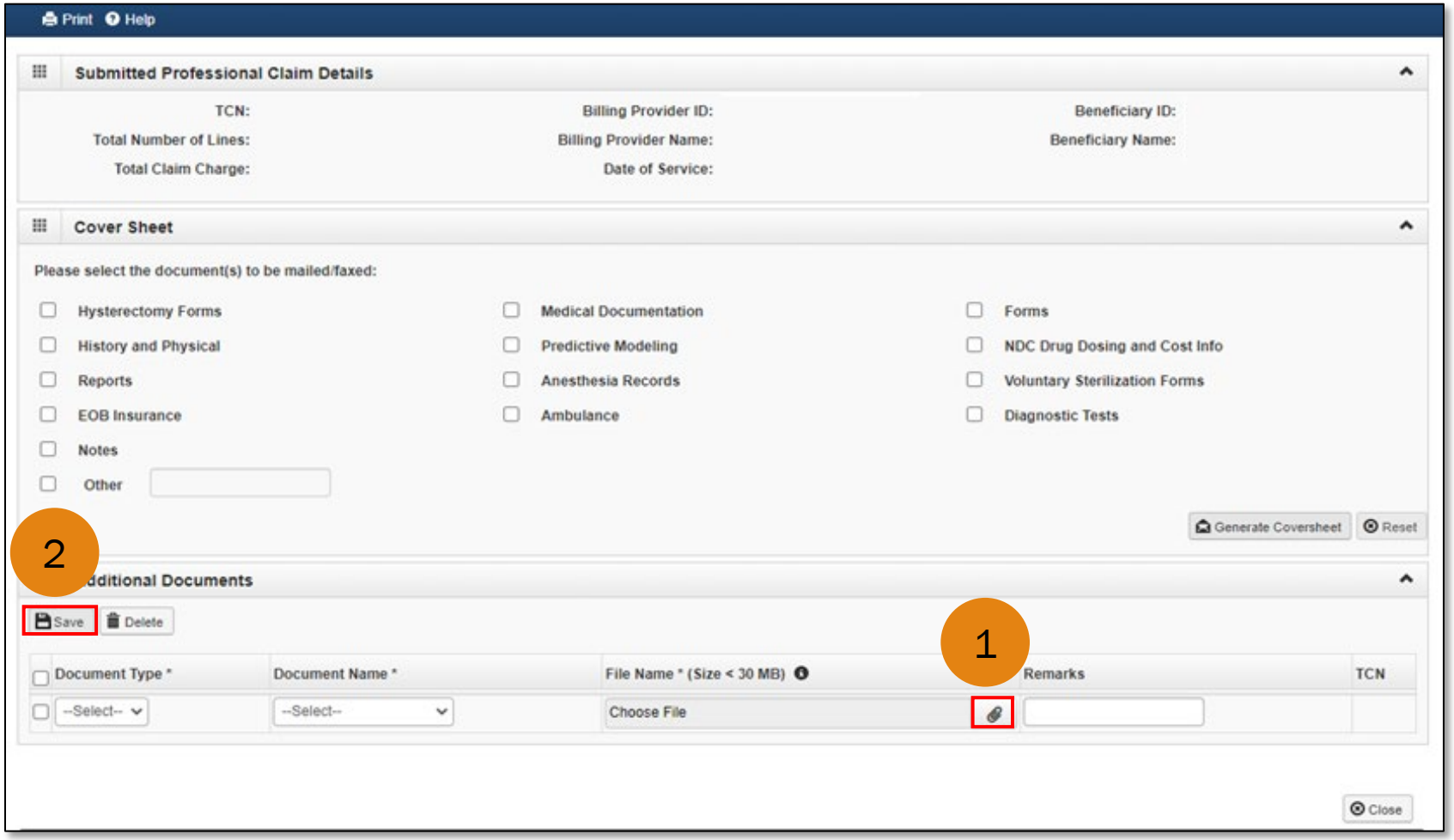
Institutional Claims Attachment



Once your claim is submitted, the BMS system displays the **Submitted Professional Claim Details**:

- Scroll down until you reach the **Additional Documents** section.

Institutional Claims Attachment



Select the type of electronic document to attach from the options listed or select a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the **paper clip** icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Course Review

- Institutional Claim Overview
- Institutional Claim Submissions
- Institutional Claim with Third-Party Liability (TPL)
- Institutional Claim with Tertiary Third-Party Liability (TPL)
- Institutional Claim Attachments

Wyoming Department of Health

Thank you

Claim Transaction