Electronic Transactions

Instructions for HIPPA 5010

837 Professional, Institutional, and Dental Transaction Data

835 Health Care Payment Advice

270/271 Health Care Eligibility and Benefit Inquiry and Response

276/277 Health Care Claim Status Request and Response

March 1, 2018
Version 1

Update Log

Date of Change	Changed By	Changes Made
07/26/2011	Zoe Sandy	Entire Manual Updates to entire manual; addition of TOC and History Log, new format
08/10/2011	Zoe Sandy	Entire Manual Review with Department staff – minor spelling and grammatical updates
09/07/2011	Zoe Sandy	Updated Chapter 2 -Transmission Methods Removed NDM as a transmission method; ACS does not support it. Added MoveIt and SFTP as methods. Made miscellaneous verbiage updates
09/15/2011	Lisa Stimatz	Final review of document before publication Minor formatting changes; fixed web links and typos
05/15/2012	Lisa Stimatz	Chapter 7: 837 Transactions – Reject Information Chapter 8: 837 Transactions General Information Corrected the value for receiver ID to 100000 (it previously was 77039, same as Payer ID, which was incorrect). Corrected the loop/segment for pregnancy indicator to 2000B (it previously was 2400, which was incorrect). Chapter 1–6, 9, 11 Changed ACS references to Xerox throughout. All Applied updated Xerox template
01/13/2014	Tom Keith	Chapter 8: General Montana-Specific Submission Rules Corrected the bulleted text that indicates where a Passport and prior authorization number go.
05/17/2017	Ross Barnes	Updated to Conduent format. Reviewed and updated for 508 compliance. Changed Xerox references to Conduent references as appropriate. Corrected outdated and defunct web links.
5/25/2017	Ellie Kaplita	Conduent Rebranding
3/01/18	Dan Hickey	Updated URLs from ASC to Conduent

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Contents

1. Introduction

Conduent EDI Gateway, Inc., a leader in health care technology, provides electronic data interchange (EDI) gateway services to providers enrolled in contracted health care plans. This document outlines the procedures necessary for engaging in electronic data interchange with EDI Gateway, Inc., and supplies specific data clarifications where applicable. For information specifically regarding the electronic transactions, refer to the *5010 X12 Technical Report (TR3)* documents, available from [Washington Publishing Company at http://www.wpc-edi.com/](http://www.wpc-edi.com/).

Our electronic transaction acquisition services provide an array of tools that allow you to:

- Easily submit all of your transactions for Montana Department of Public Health and Human Services (DPHHS) to one source.
- Submit transactions 24 hours a day/7 days a week.
- Receive confirmation of receipt of each file transferred.
- Receive remittance notification from health care plans on a regular basis.
- Receive eligibility and benefit response.
- Receive claim status response.

Transactions are accepted electronically into our data center in Tallahassee, Florida, and are processed through the Conduent State Healthcare Clearinghouse (SHCH). As an EDI gateway service, we provide connectivity to various health care plans and states where EDI Gateway, Inc. is the fiscal agent, third party administrator, or contracted clearinghouse.

The Conduent SHCH provides connectivity for the flow of medical information and data between medical providers, facilities, vendors, claim payment agencies, and other clearinghouses. Beyond the receipt and delivery of this data, Conduent SHCH provides translation to and from ANSI ASC X12N standard formats.

The 837 Professional, Institutional, and Dental Health Care Claim transaction data, 270/271 Health Care Eligibility Benefit Inquiry and Response and 276/277 Health Care Claim Status Request and Response transactions, will be submitted to the Conduent SHCH for processing. Conduent SHCH validates submission of ANSI X12N formats. If the file contains syntactical errors, the segments and elements where the errors occurred will be reported in a 999 Implementation Acknowledgement. The TA1 report is used to report receipt of the individual interchange envelope that contains corrupt data or an invalid Trading Partner relationship. If the data fails payer-specific edits, it will be indicated in the 277CA Healthcare Claim Acknowledgement that will be returned to the submitter. The ANSI ASC X12N 835 Health Care Payment Advice can contain information related to payees, payers, dollar amount, and payments.

Provider Relations Unit

The Montana DPHHS provides support to all the providers through the Montana Provider Relations Unit. Contact Montana Provider Relations to establish yourself as a new Montana provider. To contact the Provider Relations Unit, use the following number:

In/Out of State: **1(800) 624-3958**

Helena: **1(406) 442-1837**

2. Transmission Methods

Conduent EDI Gateway provides several mechanisms for you to upload your files or retrieve response transactions (including 999, 835, etc.). Which method(s) is(are) used depends on your needs and preferences. With your Trading Partner/Submitter enrollment comes access to a bulletin board for asynchronous dial-up (typical for small providers). Coupled with that is automatic access to a small volume/small file website for direct submission and response retrieval. For large volume or large file submitters, we can provide access to two different sites: the Conduent MOVEit DMZ (with a web browser-based interface) and the Conduent B2B Gateway SFTP/FTPS site. The latter is ideal for those submitting via some type of scripted, secured FTP.

These various methods will be discussed in the following order:

- Montana Access to Health (MATH) Web Portal
- Conduent MOVEit DMZ*
- Conduent B2B GatewayMontana*
- Bulletin Board System (BBS)*

*These options for data receipt may involve connectivity issues and have additional cost factors that will need to be resolved prior to implementation.

Montana Access to Health (MATH) Web Portal

Transaction files can be uploaded and downloaded through the MATH web portal at https://mtaccesstohealth.portal.conduent.com/mt/general/home.do. Transaction transmission is available 24 hours a day, 7 days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventive maintenance periods on weekends whenever possible.

Conduent MOVEit DMZ

The Conduent MOVEit DMZ is a secured transmission protocol & secured storage landing zone (intermediate storage) for the exchange of files between Trading Partners and Conduent. Its use is intended for those Trading Partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2MB. ***Access to this site is not automatic; Trading Partners must contact their EDI representative to request set up on the site.***

If approved, a separate URL will be provided, along with new credentials, a welcome letter containing basic site navigation, restrictions on passwords, and other helpful information. ***Trading Partners approved for this site should note that files are retained only for 30 days, whether or not they have been retrieved.***

Conduent B2B Gateway SFTP/FTPS Site

The Conduent B2B Gateway SFTP/FTPS site is intended primarily for Those Trading Partners/Submitters who will be using secured FTP clients – over SSH or SSL – usually in some fashion of automated (scripted) mode. This is typically encountered with high volume/high frequency submitters.

Like the Bulletin Board System (BBS) website, a Trading Partner is automatically configured to use this site upon successful Trading Partner enrollment. The Trading Partner's credentials on this site are the same as for the BBS. Those details are provided once a Trading Partner is enrolled.

The Conduent B2B Gateway has separate sites for testing and for production:
- The testing site is at domain name: mft-uat.services.conduent.com. For an SSL connection, access the site on port 443. For an SSH connection, access the site on port 22.
- The production site is at domain name: mft.services.conduent.com. As with the test site, FTPS (SSL) connections should be to port 443, and SFTP (SSH) should be to port 22.

To avoid password issues/maintenance, Trading Partners may wish to exchange specific SSL certificates or SSH keys. If so, contact your EDI representative and make this known. Arrangements will be made to have the Trading Partner's technical staff work with Conduent B2B technical staff to accomplish this.

Bulletin Board System (BBS)

Conduent EDI Gateway provides an interactive, menu-driven bulletin board system that allows you to upload your transaction files and receive immediate confirmation of the status of your transfer. This Host Data Exchange system can be accessed using a standard modem and supports modem speeds of up to 56,000 BPS. Transaction transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible

Communication Protocols

Conduent currently supports the following communication options: XMODEM, YMODEM, ZMODEM, Kermit.

Teleprocessing Requirements

The general specifications for communication with Conduent are:

Telecommunications	Hayes-compatible 2400-56K BPS asynchronous modem.
File Format	ASCII text data.
Compression Techniques	PKZIP will compress one or more files into a single ZIP archive. WINZIP will compress one or more files into a single ZIP archive. Xerox accepts transmission with any of the above compression techniques, as well as non-compression files.
Data Format Transmission Protocol	8 data bit, 1 stop bit, no parity, full duplex. ZMODEM uses 128-byte to 1024-byte variable packets and a 16-bit or 32-bit Cyclical Redundancy Check (CRC). XMODEM uses 128-byte blocks and a 16-bit CRC. YMODEM uses 1024-byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software

Teleprocessing Settings

ASCII -	Sending Send line ends with line feeds (should not be set). Echo typed characters locally (should not be set). Line delay 0 milliseconds. Character delay 0 milliseconds.
ASCII Receiving	Append line feeds to incoming line ends should not be checked.
Terminal Emulation	Wrap lines that exceed terminal width. VT100 or Auto.

Transmission Procedures

Submitter	Host System
1. Dials Conduent Host 1(800) 334-2832 or 1(800) 334-4650	Answers call, negotiates a common baud rate, and sends to the Trading Partner: *Please enter your Logon=>"*
2. Enters Logon Name <CR>	Receives User Name (Logon Name) and sends to the Trading Partner: *Please enter your password=>"*
3. Enters Password <CR>	Receives Logon and verifies if Trading Partner is an authorized user. Sends HOST selection menu followed by a user prompt: *Please Select from the Menu Options Below=>*
4. Enters Desired Selection <CR>	#1. **Electronic File Submission:** Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the Trading Partner. #2. **View Submitter Profile.** #3. **Select File Transfer Protocol:** Allows you to change the protocol for the current submission only. The protocol may be changed to (k)Kermit, (x)Modem, (y)Modem, or (z)Modem. Enter selection [k, x, y, z]. #4. **Download Confirmation.** #5. **Exit & Disconnect:** Terminates connection.
5. Enters "1" to send file <CR>	Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=> *Please Select from the Menu Options Below=>*

3. Transmission Responses

HIPAA not only gave the health care community the ability to standardize transactions, but also the ability to standardize front-end edits and the acceptance/rejection reports associated with the edits. The acceptance/ rejection reports provide a method of reporting on the validity of EDI transaction format syntax and transaction implementation guide compliance. When a report is generated, the type of report returned is dependent on the edit level that is invalid. A transaction contains four levels where edits are present. The edit level in which the error occurs designates ejection of an entire batch or a single claim.

The four levels are:
- Interchange Level Errors
- Transaction Set Level Syntax Results
- Functional Group Level Results
- Implementation Guide Level Results

In the descriptions below, the four levels and their affiliated acceptance/rejection reports are discussed.

Interchange Level Errors and TA1 Rejection Report

This edit is enforced by interchange level problems. These edits check the ISA, GS, GE and IEA level segments and the data content within these segments, which consist of the header and footer batch information. Any X12N syntax error that occurs at this level will result in the entire transaction being rejected. These rejections are reported on a TA1.

TA1 – Interchange Acknowledgement

A TA1 is an ANSI ASC X12N Interchange Acknowledgement segment used to report receipt of individual interchange envelopes. An interchange envelope contains the sender, receiver, and data type information within the header. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (e.g., the data is corrupt or the Trading Partner relationship does not exist within the Conduent system) the interchange will reject and a TA1, along with the data, will be forwarded to the Conduent EDI call center for referencing purposes.

Transaction Set Level Syntax Results and 999 Implementation Acknowledgment

This edit is enforced by transaction set level syntax problems for all transactions within each functional group. These edits check the ST and SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12N syntax error that occurs at this level will result in the entire transaction being rejected. However, if the functional group consists of additional transactions without errors, these will be processed. The rejections are reported on a 999.

ANSI ASC X12N 999 – Implementation Acknowledgment

Conduent SHCH validates submission of ANSI ASC X12N format(s). An ANSI ASC X12N 999, or Implementation Acknowledgement, is generated when an EDI file (e.g. an ANSI ASC X12N file that has passed the header and trailer check, passes through the clearinghouse. The 999 contains **ACCEPT** or **REJECT** information; if the file contained syntactical errors, the segments and elements where the errors occurred will be reported). For an example of this report, see the *ANSI ASC X12N Technical Report Type 3 (TR3)*. This method of acknowledgement is required by the Trading Partner Agreement between Conduent EDI Gateway and the Trading Partners.

ANSI ASC X12 277CA – Health Care Claim Acknowledgment

A 277CA Health Care Claim Acknowledgement will be returned to the submitter when an 837 transaction has been successfully translated. This transaction will indicate whether individual claims passed the Montana-specific edits or not and is used to report errors outside of the scope of the 999. It will detail what errors are present, and if necessary, what action the submitter should take. For an example of this report, see the *227CA Technical Report Type 3 (TR3)*.

ANSI ASC X12N 835 – Health Care Payment Advice

An 835 Remittance Advice may be requested. After claim adjudication, an 835 Health Care Payment Advice will be delivered to the HDE for those Montana DPHHS submitters enrolled to receive an electronic remittance advice. For further information, see Chapter 4, Data Retrieval Methods. The ANSI ASC X12N 835 can contain information related to payees, payers, dollar amounts and payments. See the *ANSI ASC X12N 835 Technical Report Type 3 (TR3)* for details on the ANSI ASC X12N 835.

ANSI ASC X12N 271 – Health Care Eligibility Benefit Response

271 Health Care Eligibility Benefit Response will be delivered to the HDE. The ANSI ASC X12N 271 Response will contain information related to acceptance or rejection of the request. See the *ANSI ASC X12N 271 Technical Report Type 3 (TR3)* for details on the ANSI ASC X12N 271 Eligibility Response.

ANSI ASC X12N 277 – Health Care Claim Status

A 277 Health Care Claim Status Response will be delivered to the HDE. The ANSI ASC X12N 277 Response will contain information related to acceptance or rejection of the request. See the *ANSI ASC X12N 277 Technical Report Type 3 (TR3)* for details on the ANSI ASC X12N 277 Claims Inquiry Response.

Technical Report Type 3 (TR3) documents are available on the Washington Publishing Company website at http://www.wpc-edi.com/.

4. Data Retrieval Methods

Host Data Exchange (HDE)

The HDE allows all Trading Partners to retrieve data via asynchronous dial-up 24/7. Billing Agents and Clearinghouses will have the option of retrieving the transaction responses and reports themselves and/or allowing each individual provider the option of retrieval.

Contact the Conduent EDI Support Unit at **1(800) 987-6719** to receive manual specifications for this procedure. The Host Data Exchange manual is also available on the Conduent EDI Gateway website at https://edisolutionsmmis.portal.conduent.com/gcro/mt-home.

The Trading Partner will access the HDE using the logon and password assigned to them during the EDI enrollment process described in Chapter 6: Payer-Specific Data.

Montana Access to Health (MATH) Web Portal

Transaction files can be retrieved through the MATH web portal at https://mtaccesstohealth.portal.conduent.com/mt/general/home.do. Transaction retrieval is available 24 hours a day/7 days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

Retrieval of 835 Health Care Payment Advice

Providers will continue to be able to choose whether to receive remittance advices (RAs) electronically, in paper format, or both. If the RA is electronic, then it will be in the ANSI ASC X12N 835 format. Providers who choose to receive remittance advices in the 835 format will receive electronic RAs regardless of whether they submitted claims electronically or on paper.

If a provider is interested in receiving an electronic remittance advice transaction instead of a paper remittance advice, they need to complete the Electronic Remittance Advice and Payment Cycle Enrollment Form. Providers can either download this form from the Provider Information website ("http://medicaidprovider.mt.gov/claims") or contact the Conduent Provider Relations Unit in Montana at **1(800) 624-3958** (in- and out-of-state) and **1(406) 442-1837** (Helena) to have the form sent to them. Providers currently receiving electronic RAs will not need to complete these forms in order to receive their RAs in the X12N 835 format. Providers who currently receive paper RAs will continue to receive them in paper format. Providers requesting both electronic and paper RAs should contact the Conduent Provider Relations Unit.

Both electronic and paper remittance advices show standard claim adjustment reason and claim payment remark codes. The paper RA will show up to 5 standard reason codes and the related remark codes at both the claim and line levels. The X12N 835 transaction, however, will show only 1 reason code and 1 remark code at both the claim and line levels per the 835 Health Care Claim Payment/Advice Technical Report Type 3.

Pharmacy claims are received and processed through a Point of Sale (POS) system that passes claims directly into the Montana claims processing system. Pharmacy providers can choose to receive RAs electronically or on paper. Pharmacy remittance advices, both on paper and 835 forms, will report standard pharmacy reject/payment codes instead of claim payment remark codes.

Suspended claims will not be reported using the X12N 835 transaction for electronic RAs, but instead will be reported on the X12N 276/277 Health Care Claim Status Inquiry and Response transactions. Paper RAs, however, will continue to report suspended claims.

5. Testing

Completion of the testing process must occur prior to electronic submission to Conduent EDI Gateway. Assistance from Conduent EDI Business Analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real transmission data. The number of test transmissions required depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the Conduent system. Also, changes to the ANSI formats may require additional testing. The EDI Enrollment Form determines where reports and responses will be delivered.

Trading Partner Testing Procedures

Conduent EDI Gateway makes electronic transaction instructions and enrollment packages available for download at http://medicaidprovider.mt.gov/claims.

1. The Trading Partner completes the enrollment package and submits it to Conduent EDI Gateway.
2. The Trading Partner is assigned a Logon Name and Logon User ID.
3. The Trading Partner contacts the Conduent EDI Business Analyst at **1(800) 987- 6719** to arrange a testing schedule (EDIFECS, COMM, SHCH, and MMIS).
4. The Trading Partner is given access to the EDIFECS website, described in further detail on the next page, in order to submit X12N test files for analysis. Each test file is analyzed based on the 7 levels of testing defined by WEDI SNIP (Workgroup Electronic Data Interchange – Strategic National Implementation Process). At this time, the submitter is required to address any errors discovered by EDIFECS during the compliance analysis prior to moving on to the next stage of testing with Conduent EDI Gateway.
5. The Trading Partner executes test cases and data is sent to Conduent EDI Gateway, Inc.
6. The Business Analyst evaluates the flow of test data through the Conduent SHCH.
7. If test cases are completed successfully, the Business Analyst contacts the Trading Partner and the Trading Partner is approved for placement into production environment when available. If the testing entity is a software vendor, they will be required to provide a list of submitters using the approved software package.
8. If test cases are unsuccessful, the Business Analyst will contact the Trading Partner. The Trading Partner will remain in the testing environment until test cases are completed successfully.

EDIFECS – HIPAA DESK Online Testing Application

EDIFECS – HIPAA DESK is an online HIPAA testing application available to Montana providers submitting claims to Montana DPHHS. HIPAA DESK offers the following types of testing against the base HIPAA implementation guidelines.

- Test all 7 WEDI/SNIP types. HIPAA DESK provides all 7 types of WEDI/SNIP Testing for HIPAA including integrity testing, requirement testing, balancing testing, situational testing, code set testing, product or services testing, and guide-specific testing.
- Test the HIPAA Code Sets. Validate over 40 industry code tables and databases.

Get your answers fast. With HIPAA DESK, the results of your free compliance testing are typically available within seconds for small files and within minutes for files up to 10 megabytes and larger.

Pilot submitters must use this application to validate their test files for HIPAA compliancy before submitting for Communication and Client Integration testing.

The EDIFECS main website for Montana is https://sites.edifecs.com/?conduent.

To access the free HIPAA testing service, enter the username and password that is provided by the EDI Business Analyst after your EDIFECS enrollment, and then select the HIPAA DESK Community.

To receive a HIPAA DESK account, send an e-mail to: support@edifecs.com.

6. Payer-Specific Data

EDI Support

The Conduent EDI call center assists users with questions about electronic submission. The Conduent EDI call center is available to all Montana DPHHS providers Monday through Friday from 8:00 a.m. to 5:00 p.m. MST at **1(800) 987-6719**.

The Conduent EDI call center:
- Provides information on available services
- Enrolls users for claims submission
- Enrolls users for the MATH web portal
- Verifies receipt of electronic transmissions
- Provides technical assistance to users who are experiencing transmission difficulties
- Resets MATH web portal passwords

Enrollment Information

Any entity sending electronic claims to Conduent EDI Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This package provides Conduent EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an enrollment package by contacting the Conduent EDI call center or by downloading it from our website at http://medicaidprovider.mt.gov/claims.

Transmission Telephone Number

Conduent EDI Gateway provides availability for transmission 24/7. There are no restrictions on the number or frequency of transmissions. The same phone number will be used for transmitting test and production. The toll-free transmission telephone numbers are **1(800) 334-2832** or **1(800) 334-4650**.

Tracking Transmission/Production Problems

Have the following information available when calling the Conduent EDI call center regarding transmission and production issues.

Trading Partner ID: Your Trading Partner ID is our key to accessing your Trading Partner information. Please have this number available each time you contact the Conduent EDI call center.

Logon Name and Logon User ID: These allow asynchronous Trading Partners access to the host system for claims submission. The Conduent EDI call center uses this information to reference your submitted data.

7.   837 Transaction – Reject Information

General Montana specific 837 submission rules that will result in the rejection of a claim if not followed are listed below:

- Use your 7-digit Montana Submitter ID.
- The Receiver ID should be 100000 and the Payer ID for Montana Health Care Programs should be 77039. Transmissions without these values in the appropriate fields will not be processed.
- Montana Billing and Rendering Provider IDs must be a valid 10-digit NPI for health care providers and a valid 10-digit Montana Health Care Plan ID for atypical providers.
- Pay to provider will be ignored on all transactions and payment will be made to the payee that we have on file for the Billing Provider.
    - Billing Provider NPI is required for health care providers. If the billing provider is an atypical provider (a provider who does not meet the definition of health care provider) the 10-digit Montana Health Care Billing ID must be submitted in Loop 2010BB, segment REF (billing provider secondary identification) with qualifier G2 – Provider Commercial Number.
- Montana DPHHS Client ID (Recipient ID) should be:
    - 7 numeric; or
    - 9 numeric; or
    - 8 numeric characters followed by one alpha character.
- Valid codes are 0, 1, 2, 3 4 and 5 for the Claim Frequency Code in Loop 2300, CLM05-3.
- Patient Claims (Loop 2000C) should not be submitted with Subscriber Claims (Loop 2000B).
- The 277CA X12 transaction or an error report will indicate if any of the conditions mentioned above are violated.

8. 837 Transactions - General Information

General Montana-Specific Submission Rules

- To indicate Prior Authorization, use 'G1' in loop 2300, REF01 at the header or loop 2400, REF01 on the line.
- To indicate a Passport referral number, use '9F' in loop 2300, REF01 at the header or loop 2400, REF01 on the line.
- Other Subscriber Information (loop 2320) Claim Filing Indicator Code, use qualifier ZZ to identify the following other payers who pay after Medicaid:
  - Indian Health Service
  - Crime Victims Fund

837P Montana-Specific Submission Rules

- Montana processes four diagnoses only.
- To ensure correct claim processing of Comprehensive School and Community Treatment (CSCT) services, the CSCT team number must be sent in the loop 2300, NTE Note segment as the first two characters of the NTE02 Claim Note Text data element. The qualifier value in the NTE01 Note Reference Code data element should be ADD (Additional Information).
- To indicate the services were referred by an IHS facility, include the NPI of the referring facility in loop 2310A, NM109.
- If patient is pregnant, use "Y" to indicate pregnancy in loop 2000B, PAT09 to exempt from cost share.
- If service is family planning-related, use "Y" to indicate family planning in loop 2400, SV112 to exempt from cost share.

837I Montana-Specific Submission Rules

- If patient is pregnant, use condition code "**B3**" to indicate pregnancy in loop 2300, HI01-12 to exempt from cost share.
- If service is family planning-related, use condition code "**A4**" to indicate family planning in loop 2300, HI01-12 to exempt from cost share.
- Use qualifier "**F3**" to indicate a Nursing Facility Personal Resource amount in loop 2300, AMT01.
- To indicate the services were referred by an IHS facility, include the NPI of the referring facility in loop 2310F, NM109.
- Attending provider NPI should be submitted in loop 2310A, NM109; if the attending provider is required by Montana Health Care Programs and a valid 10-digit NPI is not sent, the claim will be accepted but will be denied in MMIS.

837D Montana-Specific Submission Rules

- To indicate the services were referred by an IHS facility, include the NPI of the referring facility in loop 2310A, NM109.

9. Additional Business Rule Clarifications

Splitting Claims Rules

The Montana claims processing system supports 40 line items per claim for institutional claims and 21 line items for professional and dental claims. Claims submitted on ANSI ASC X12N 837I, P and D transactions with more than the maximum supported line items may be split into multiple separate claims upon acceptance into the system. Providers may wish to submit claims with more than the maximum supported lines as separate claims in their practice management systems in order to facilitate reconciliation and posting of the 835 transaction to their claim billing information. If you are submitting a professional claim with Vaccines for Children (VFC) immunization codes that contain more than 21 line items, list the VFC administration code and VFC vaccines in the first 21 lines so that these are not split into separate claims and the provider is paid properly for the number of administrations.

Claims may also be split when a valid X12N 837 transaction contains data that must be processed as two or more independent claims.

The situations where claims must be processed independently are:

1. Under the X12 837P and D transactions, providers can list prior authorization (PA) numbers at the line level, so the potential exists for two or more distinct PA numbers on the same claim.
2. Under the X12 837P transaction, providers can list referral (Passport) numbers at the line level, so the potential exists for two or more distinct referral numbers on the same claim.
3. Under the X12 837P and D transactions, providers can list different rendering provider numbers at the line level, so the potential exists for two or more distinct rendering providers on the same claim

Split claims will be reported on the 835 transaction and the paper RA as separate, individual claims with a recalculated total submitted charge that will be different from the submitted charge on the ANSI ASC X12N 837I P or D transaction. Billers will be able to reconcile their split claims using their billing system's internal billing number or account number that will appear on any claims that have been split. This original internal billing number will be passed back as part of the 835 transaction.

Multiple Modifiers

Montana DPHHS has a hierarchy that determines which modifiers are used, and their order, for pricing a claim within the MMIS. Montana will reorder modifiers according to their importance in accurately processing claims.

Paperwork Attachment

If a provider chooses to submit claims electronically which require additional supporting documentation, providers should use loop 2300, PWK segment to indicate such paperwork is being sent.

Each paper attachment will require a cover sheet to allow the paperwork attachment to be associated with the appropriate electronically submitted claims. Providers should use the cover sheet on the Montana Provider Information website.

The format of the paper attachment tracking number, included in the PWK segment and on the cover sheet, may be either the preferred format that uses the provider number, client number and date of service, or a format designed by software vendors or clearinghouses as long as the client identifier on the cover sheet matches the client identifier on the 837 transaction.

10. 835 Transaction Information

The ANSI ASC X12N 835 contains information related to payees, payers, dollar amounts and payments. See the standard *ANSI ASC X12N 835 Technical Report Type 3 (TR3)* for further details about the ANSI ASC X12N 835 transaction.

If you wish to receive an electronic 835 remittance advice instead of or in addition to a paper one, contact Conduent Provider Relations.

In/Out of State: **1(800) 624-3958**

Helena: **1(406) 442-1837**

11. 270/271 Transaction Information

- As indicated in the *Technical Report Type 3 (TR3)*, real-time requests typically have a response time that ranges from a few seconds to around 30 seconds, usually not exceeding one minute. Responses to batch requests are typically completed within 24 hours.
- A maximum of 99 subscriber loops per transaction can be processed in batch mode.
- Loop 2110C, Segment EQ, data element 01, Service Type Code – Per the *Technical Report Type 3 (TR3)*, an information source may support the use of values other than "30" in this field. However, Montana Health Care Programs only support generic eligibility requests. If an inquiry is submitted with a Service Type Code other than "30"(Health Benefit Plan Coverage), a generic response will be returned.
- If a 270 Request comes in with no date (system assumes current date) or asks for eligibility on a single specific date, the 271 Response indicates the applicable types of coverage. If the client (recipient) is not eligible for any of the Montana Health Care Programs an 'inactive' response is returned.
- If a 270 Request comes in with a range of dates in the DTP segment of loop 2100C, all coverage types are compared to those dates.
- The 271 Response will always send back the client name stored on the MMIS client master file. This will overlay the name originally sent on the 270 Request. Before rendering any services, please check the client name returned to ensure it matches the Client ID used for inquiry. All other data provided on the 270 Request that is not retrieved from the client master file will be retained and reattached prior to sending out the 271 Response.

12. 276/277 Transaction Information

- Only individual claim inquiry requests can be accommodated in a real-time environment.
- Batch processing can accept the submission of multiple requests in a single transaction.
- The data submitted on the 276 claim inquiry request will be returned on the 277 response.
- Detail level information in the request transaction will not be processed.
- Montana supports claim level status inquiry. Any inquiry made at the service line level will return the status on the entire claim.
- If the claim inquiry request locates multiple matching claims, only header level data will be returned on the response transaction.
  - If more than one TCN/ICN is identified in an inquiry, the 277 response will report only claim summary information for all the claims identified by the inquiry. This will allow Conduent to maximize the number of returned claims for that inquiry.
  - The information reported on the claim level will include the adjudication/payment status, total charge amount, total payment amount, date paid, check/EFT information and service dates.
- If a single claim is returned, detail level information will be returned.
  - If only one TCN/ICN corresponds to an inquiry, the 277 response will report the detailed line items for the claim. This will allow the provider to see the status of all line items for a specific claim.
  - The information reported on a claim at the line level will include all claim header level information and also line item date of service, procedure codes and procedure modifiers, submitted charges, allowed amounts, units, revenue codes and line item status.
- The combination of above-mentioned reporting will allow the providers to get a full status of their submitted claims and minimize the number of phone inquiries.