

Windows Accelerated Submission and Processing WINASAP 5010

Montana Medicaid, Healthy
Montana Kids (HMK) and Mental
Health Services Plan (MHSP)

August 2017

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Important Information

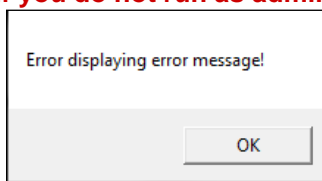
The software does not run consistently on tablets or Windows-based Macs. See [Troubleshooting Tips](#) for information. Users running Windows Vista and Windows 7, must right-click on the WINASAP icon and select "Run as administrator" every time the program is opened. **Failure to do so will result in all data deleted upon exit!**

Windows 8 must follow the instructions below to modify the shortcut. **Failure to do so will result in all data deleted upon exit!**

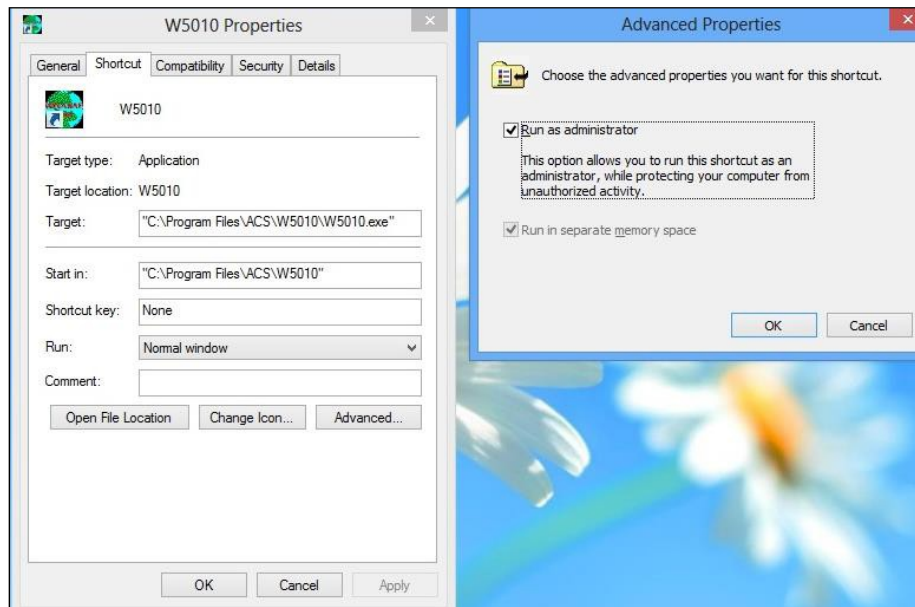
Prior to contacting the EDI Support Unit, consult this guide for solutions.

Hardware/System Requirements for WINASAP Use

- Windows Accelerated Submission and Processing (WINASAP 5010) is Windows-based (Windows 98, NT, 2000, XP, Vista, Windows 7, and Windows 8) software application developed by Conduent. WINASAP 5010 allows users to submit claim data electronically from their personal computer to EDI Solutions.
- WINASAP supports dial-up modem and high-speed transmissions. See [Submitting Claims through the MATH Web Portal](#).
- [Software updates can be downloaded from http://medicaidprovider.mt.gov](http://medicaidprovider.mt.gov).
- If you do not run as administrator, the following error message appears:**



- Windows 8 requires that you right-click on the WINASAP icon and click the Advanced button and select the Run as administrator. If you do not do this, your *.bil file will not be exported to the correct file location as indicated in the web portal instructions.

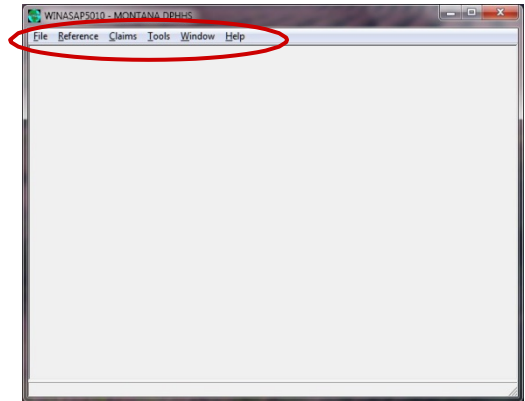


- Due to recent security updates, Windows 10 is no longer compatible with WINASAP.

Navigating in WINASAP

WINASAP opens as a mostly gray screen. The menu options are listed across the top: File, Reference, Claims, Tools, Window, and Help.

- WINASAP is not case-sensitive.
- Most Windows-based keyboard commands are available in WINASAP:
 - Tab key moves cursor from field to field.
 - Shift + Tab moves cursor back by field.
 - Control + C is a copy command.
 - Control + V is a paste command.
 - F5 enters the current date in a date field.
- WINASAP does not allow users to save an incomplete provider, patient, or claim entry. A claim must be placed in Hold status to save an entry.
- It is recommended that providers regularly back up their WINASAP database to prevent loss of data and to be able to recall data.



Claims

- We cannot offer coding advice including diagnosis and HCPCS codes.
- To submit electronic claim data to EDI Solutions, users must be enrolled as either a provider or an authorized billing agent for actively enrolled providers. This varies by payer; contact your Medicaid office for more information.
- **WINASAP does not automatically prompt a user to save the claim.** Canceling or exiting a claim prior to saving loses the claim.
- Keep claim lists short by deleting old claims on a regular basis. Large claim lists adversely affect software performance and increases error messages.
- Individual claims can be printed by selecting File/Print while the claim is open; however, printed claims **are not** valid for submission.

Enrollment

[Users must complete the EDI Provider Enrollment Packet to submit claims electronically.](#) EDI Solutions assigns a Trading Partner ID, User Name, and User ID. If you have registration questions or need technical support, contact the EDI Support Unit.

Provider/Patient Information

- Provider and patient information must be entered in the reference database prior to incorporating it into the electronic claim. Procedure, diagnosis, and revenue codes can be entered into reference databases, but do not have to be entered prior to building a claim; they can be entered directly from the Claim screen.
- Required fields are underlined on Entry screens; however, a claim may require additional information (e.g., prior authorization number, Passport referral number). This guide identifies all required fields.

Contact Information

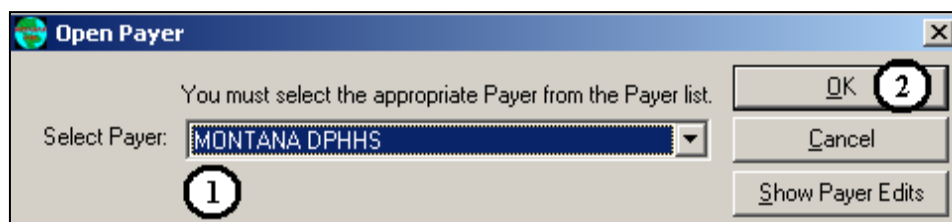
Prior to contacting the EDI Support Unit, refer to Troubleshooting Tips for solutions. Call the EDI Support Unit at 1-800-987-6719 for WINASAP technical issues, electronic claims submission, rejects, and enrollment. Call Provider Relations at 1-800-624-3958 or 406-442-1837 with other claim questions.

Initial Setup

- Enter the default password “asap” (not case-sensitive).
- Click OK.

At initial setup, WINASAP prompts users to Select Payer.

- On the pull-down menu, select Montana DPHHS. **This is the only payer for which WINASAP allows submission.**
- Click OK.



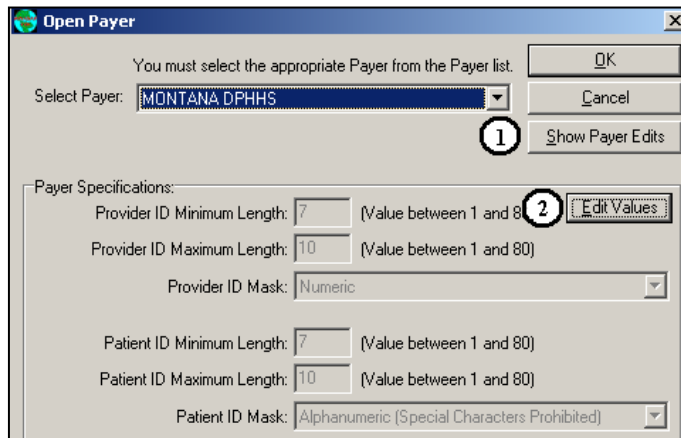
This is a one-time-only setup. Subsequently, each time WINASAP is opened, Montana DPHHS will be set as the payer.

Setting Provider ID and Patient ID Character Length

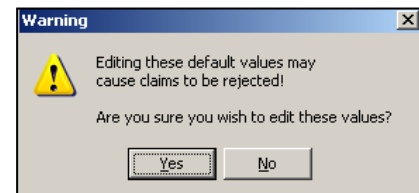
This step must be completed before patients can be entered in the patient list with a card number.

Note: Some Montana Healthcare Programs do use SSNs; however, that is subject to change.

Under File, select Open Payer.

The 'Open Payer' dialog box is shown. It has a title bar with a green icon and the text 'Open Payer'. The main area contains the text 'You must select the appropriate Payer from the Payer list.' Below this is a 'Select Payer:' label followed by a dropdown menu showing 'MONTANA DPHHS'. To the right of the dropdown are 'OK', 'Cancel', and 'Show Payer Edits' buttons. A circled '1' is next to the 'Show Payer Edits' button. Below the dropdown is a section titled 'Payer Specifications:'. It contains four rows of input fields: 'Provider ID Minimum Length' (7), 'Provider ID Maximum Length' (10), 'Patient ID Minimum Length' (7), and 'Patient ID Maximum Length' (10). Each field has a small text box to its right indicating a range: '(Value between 1 and 8)' for Provider ID Minimum, '(Value between 1 and 80)' for Provider ID Maximum, '(Value between 1 and 80)' for Patient ID Minimum, and '(Value between 1 and 80)' for Patient ID Maximum. A circled '2' is next to the 'Edit Values' button next to the Provider ID Maximum Length field. Below these fields are two dropdown menus for 'Provider ID Mask' (set to 'Numeric') and 'Patient ID Mask' (set to 'Alphanumeric (Special Characters Prohibited)').

1. Click the Show Payer Edits button.
2. Click Edit Values. A warning appears; click Yes.
3. Enter “7” in the **Provider** ID Minimum Length field and “10” in the **Provider** ID maximum Length field.
4. Enter “7” in the **Patient** ID Minimum Length field and “9” in the **Patient** ID Maximum Length field.
5. Click OK.



Trading Partner/Submitter Setup

The communications settings for Fields 1, 2, 10, 11, and 12 below can be found on the Welcome Letter sent by EDI. Under the File pull-down menu at the top of the screen, select Trading Partner.

The screenshot shows a software window titled "Trading Partner Information". It contains several sections with input fields and a pull-down menu, each marked with a circled number from 1 to 13:

- Trading Partner Identification:**
 - Primary Identification: [7777777] (1)
 - Secondary Identification: [7777777] (2)
- Trading Partner Name:**
 - Entity Type: [Non-Person] (3)
 - Organization Name: [Provider Name] (4)
 - Last Name: []
 - First Name: []
 - Middle Name: []
- Contact Information:**
 - Contact Name: [Contact Name] (5)
 - Telephone #: [(000)000-0000] Ext. [] (6)
 - FAX #: [() -] (7)
 - Email: [] (8)
- Additional Contact Information:**
 - Contact Name: [Additional Contact Name] (9)
 - Telephone #: [(000)000-0000] Ext. []
 - Fax #: [() -]
 - Email: []
- WINASAP5010 Communications:**
 - Host Telephone #: [18003344650] (10)
 - User ID #: [User ID] (11)
 - User Name: [User Name] (12)
- At the bottom right are buttons for "Save" (13) and "Cancel".

1. Under Primary Identification, enter your 7-digit Trading Partner/Submitter ID Number assigned by EDI. (Hint: It always begins with 7.)
2. Under Secondary Identification, enter your Trading Partner/Submitter ID Number again.
3. On the pull-down menu, select Entity Type, either Person or Non-Person.
4. Enter Organization Name. If Person is selected under Entity Type, enter last name and first name in the appropriate fields. Middle name is optional.
5. Enter the Contact Name (name of billing person).
6. Enter the Telephone Number.
7. Enter the Fax Number (optional).
8. Enter the E-Mail address.
9. Enter Additional (secondary) Contact Information (optional).
10. Enter the Host Telephone Number without dashes. Due to submission activity, you may get a busy signal when dialing the first number below. You may want to try one of the other lines.

1-800-334-2832

1-800-334-4650

1-800-335-6165

1-800-335-6171

If you need to dial a number to connect to an outside line, enter that number followed by a comma before dialing the rest of the number (e.g., 8,18003342832). **If uploading to the MATH web portal, leave this field blank.**

11. Enter the User ID # assigned by EDI as Password/User ID.
12. Enter the User Name assigned by EDI.
13. When completed, click Save.

Entering Taxonomy Codes

Does not apply to Waiver/Atypical providers.

You must create your taxonomy codes here. You may enter more than one taxonomy code. They are identified by descriptions.

If you do not add here, the drop down menu will not be populated when you enter provider data.

Under Reference, select Taxonomy Code. This opens the Taxonomy Code List. Click Add to add a taxonomy code to the list.

The screenshot shows a 'Taxonomy Code List' window. Inside is a 'Taxonomy Code Data' section. It has two input fields: 'Taxonomy Code' containing '193400000X' and 'Taxonomy Code Description' containing 'Group Taxonomy'. At the bottom right are 'Save' and 'Cancel' buttons. Three numbered circles are overlaid on the image: circle 1 is next to the 'Taxonomy Code' field, circle 2 is next to the 'Taxonomy Code Description' field, and circle 3 is next to the 'Save' button.

1. Enter the 10-digit alphanumeric Taxonomy Code.
2. Enter a brief description of the Taxonomy Code.
3. Click Save.

Entering Provider Data (NPI)

Does not apply to Waiver/Atypical providers.

Under the Reference pull-down menu at the top of the screen, select Provider. This opens the Provider list. Click Add to add a provider to the list. **Important:** If you make changes to your provider file, you must open each claim and reselect the provider from the drop-down menu.

The screenshot shows the 'Provider Data' window with two tabs: 'Provider Data' and 'Secondary Identification'. The 'Provider Data' tab is active. The form is divided into several sections: 'Provider Identification', 'Provider Name', 'Provider Address', 'Provider Tax Identification Number', 'Contact Information', and 'Additional Contact Information'. Numbered callouts (1-13) point to specific fields: 1. NPI Number; 2. Provider Taxonomy Code; 3. Entity Type; 4. Organization Name; 5. Address; 6. ID Type; 7. ID Number; 8. Contact Name; 9. Telephone #; 10. Fax #; 11. Email; 12. Additional Contact Information; 13. Save button.

1. Enter the provider's NPI.
2. In the pull-down menu select the correct provider taxonomy code from the Taxonomy Code Data pull-down menu.
3. On the pull-down menu, select Entity Type, either Person or Non-Person.
4. Enter Organization Name. If Person is selected under Entity Type, enter the Last Name and First Name in the appropriate fields. Middle Name and Suffix are optional.
5. Enter Provider Address (must be physical address, **no post office boxes**) including City, State, and ZIP code (ZIP + 4). If the +4 digits are unknown, contact EDI to verify the ZIP code on file.
6. Select ID Type for Provider Tax Identification Number.
7. Enter the provider's Tax ID Number.
8. Enter the Contact Name (name of billing person/provider).
9. Enter the contact Telephone Number.
10. Enter the contact Fax Number (optional).
11. Enter the contact E-mail address (optional).
12. Enter Additional Contact Information (optional).
13. Click Save. The provider now appears in the provider list. To add additional provider numbers, follow the same instructions.

Entering Provider Data (Waiver/Atypical)

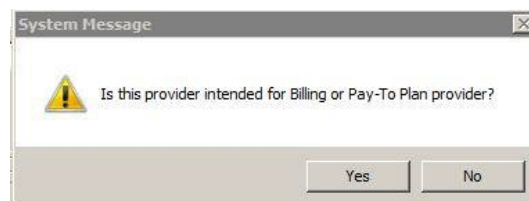
Under the Reference pull-down menu at the top of the screen, select Provider. This opens the Provider List. Click Add to add a provider to the list. **Important:** If you make changes to your provider file, you must open each claim and reselect the provider from the drop-down menu.

The screenshot shows the 'Provider Data' window with two tabs: 'Provider Data' and 'Secondary Identification'. The 'Provider Data' tab is active. The form is divided into several sections:

- Provider Identification:** Includes fields for 'NPI Number' and 'Provider Taxonomy Code'.
- Provider Name:** Includes a dropdown for 'Entity Type' (callout 1), and text fields for 'Organization Name' (callout 2), 'Last Name', 'First Name', 'Middle Name', and 'Suffix'.
- Provider Address:** Includes a text field for 'Address' (callout 3), 'Address (cont'd)', 'City', 'State' (dropdown), and 'Zip Code'. A note states: 'Billing and Service Facility Provider Zip MUST be 9 digits'.
- Provider Tax Identification Number:** Includes a dropdown for 'ID Type' (callout 4) and a text field for 'ID Number' (callout 5).
- Contact Information:** Includes a text field for 'Contact Name' (callout 6), and telephone/fax fields with area codes (callouts 7, 8, 9).
- Additional Contact Information:** Includes a text field for 'Contact Name', and telephone/fax fields with area codes (callout 10).

At the bottom, there are buttons for 'Next Page' (callout 11), 'Save', and 'Cancel'.

1. On the pull-down menu, select Entity Type, either Person or Non-Person.
2. Enter Organization Name. If Person is selected under Entity Type, enter the Last Name and First Name in the appropriate fields. Middle Name and Suffix are optional.
3. Enter the Provider Address (must be physical address, **no post office boxes**), including City, State, and ZIP Code (ZIP + 4). If the +4 digits are unknown, contact EDI to verify the ZIP code on file.
4. Select ID Type for Provider Tax Identification Number.
5. Enter the provider's Tax ID Number.
6. Enter the Contact Name (name of billing person/provider).
7. Enter contact Telephone Number.
8. Enter contact Fax Number (optional).
9. Enter contact E-mail address (optional).
10. Enter Additional Contact Information (optional).
11. Click Next Page.
12. Choose Yes when this System Message appears: *Is this provider intended for Billing or Pay-to Plan provider?*



Secondary Identification

The screenshot shows the 'Provider Data' window with the 'Secondary Identification' tab selected. There are five identical identification entry sections. The first section has 'Provider Commercial Number' selected in the 'Identification Type' dropdown (marked with a circled 1) and '#####' entered in the 'Identification Number' field (marked with a circled 2). The 'Payer ID #' field is empty. The other four sections are empty. At the bottom of the window are three buttons: 'Prev Page', 'Save' (marked with a circled 3), and 'Cancel'.

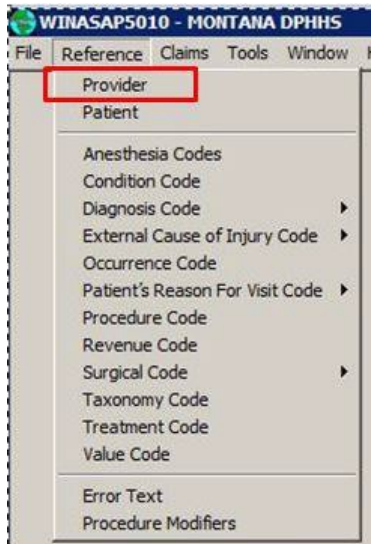
1. Under Identification Type, select Provider Commercial Number.
2. In the Identification Number field, enter the provider's **7-digit** Montana Medicaid ProviderNumber. **You must include the leading zero (e.g., 0123456).**
3. Click Save. The provider appears in the list. Repeat above steps to add additional provider numbers.
4. A System Message appears. Click Yes to save the atypical provider number.

The screenshot shows a 'System Message' dialog box. It has a yellow warning triangle icon on the left. The text inside reads: "You did not set any value in the NPI Number. Are you sure the provider is not a mandated HIPAA National Provider Identifier (NPI)?". At the bottom, there are two buttons: 'Yes' and 'No'.

Identification of Referring Providers

You must add the provider in order for it to appear on the drop-down. See [Entering Provider Data \(NPI\)](#).

1. Click Reference >> Provider.



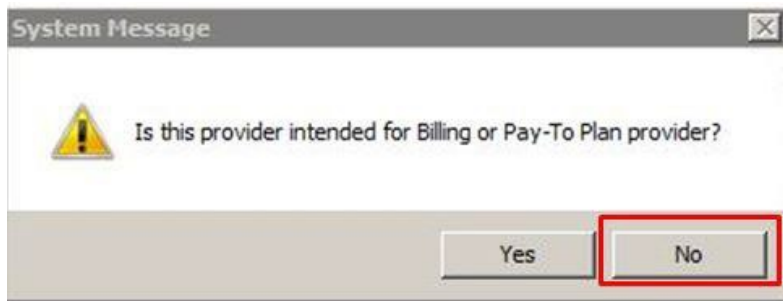
2. Click Add.



3. Leave TIN blank.

The screenshot shows the 'Provider Data' form with the 'Secondary Identification' tab selected. The form is divided into several sections: 'Provider Identification' (with NPI Number and Provider Taxonomy Code fields), 'Provider Name' (with Entity Type, Organization Name, Last Name, First Name, Middle Name, and Suffix fields), 'Provider Address' (with Address, Address (cont'd), City, State, and Zip Code fields), 'Provider Tax Identification Number' (with ID Type and ID Number fields, highlighted with a red box), 'Contact Information' (with Contact Name, Telephone #, Fax #, and Email fields), and 'Additional Contact Information' (with Contact Name, Telephone #, Fax #, and Email fields). At the bottom, there are 'Next Page', 'Save', and 'Cancel' buttons.

4. When prompted with the System Message: Is this provider intended for Billing to Pay To Plan provider, choose No.



For additional information, refer to the applicable provider notice.

- [Identification of Ordering and Referring Providers on UB-04 and 837I X12 Transactions](#)
- [Identification of Ordering and Referring Providers on CMS-1500 and 837P X12 Transactions](#)
- [Identification of Referring Providers on ADA Claim Form and 837D X12 Transactions](#)

Entering Patient Data

Under the Reference pull-down menu at the top of the screen, select Patient. This opens the Patient List. Click Add to add a patient to the list.

Patient Data

The screenshot shows the 'Patient Data' form with the following fields and callouts:

- 1**: Patient ID #
- 2**: Patient Account #
- 3**: Last Name
- 4**: Date of Birth
- 5**: Sex
- 6**: Address
- 7**: Insurance button

A red box highlights the 'Medicare Recipient?' checkbox. A separate window shows the expanded Sex dropdown menu with options for Male, Female, and Is Patient Pregnant?.

1. Enter the Patient ID Number. This is a 7- or 9-digit number.
2. Enter the Patient Account Number. If users do not assign patient account numbers, enter the member ID number. **Do not leave blank. If billing HMK/CHIP Dental, do not include the YDA prefix.**
3. Enter the patient's last name and first name in appropriate fields. Middle Name/Initial and Suffix are optional.
4. Enter patient's Date of Birth (mm/dd/ccyy).
On the pull-down menu, select the patient's Sex (once Female is selected, the option for indicating patient pregnancy is generated). **If you are not billing Medicare primary, do not select the Medicare Recipient option.**
5. Enter patient's address, including City, State, and ZIP Code (ZIP + 4). If the +4 digits are unknown, enter 4 zeroes. Telephone Number is not required.
6. Click Insurance to go to the second screen.

Insured's Data

Patient Data

Patient Data | Insured's Data

Insured's Information

Patient ID #: 1234567 Insured's SSN:

Patient Relationship to Insured: 1 Insured's Primary ID:

Entity Type: Insured's Group or Plan Name:

Organization Name: Insured's Group or Policy #:

Last Name: Insured's Address:

First Name: Insured's Address (cont):

Middle Name/Initial: Insured's City:

Suffix: Insured's State: Insured's Zip Code:

Date of Birth: / / Sex:

Property and Casualty Information

Contact Name: Telephone #: () - Ext. Property and Casual Claim #:

Payer Information

Payer Name: MONTANA DPHHS Payer Primary ID: 77039

Payer Address: Payer Responsibility Sequence Code: 2

Address (cont): Insurance Type:

City: Payer Secondary ID:

State: Zip:

Patient Data 3 Save Cancel

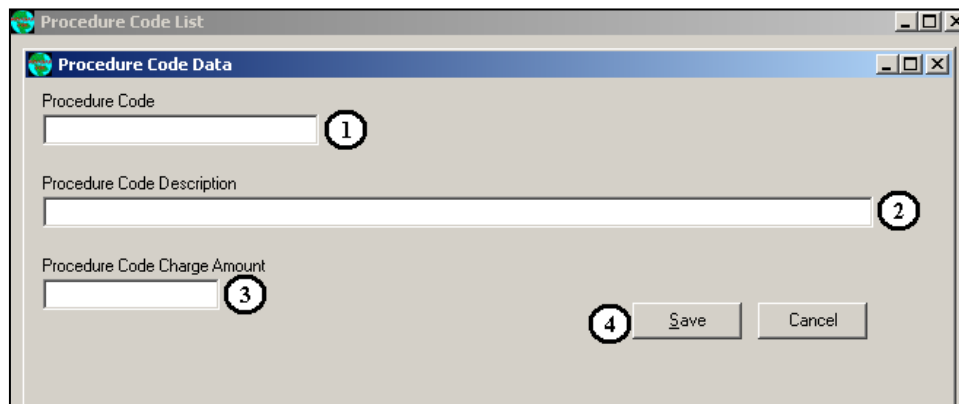
1. In the pull-down menu, select Self. This automatically populates the appropriate fields in the upper section of the screen. **DPHHS members are always Self.**
2. In the Payer Responsibility Sequence Code pull-down menu, indicate whether Medicaid is primary, secondary, or tertiary.
3. Click Save. The patient now appears on the patient list and will be available when building a claim. Add additional patients using these same instructions.

Entering Procedure, Diagnosis, and Revenue Codes

Unlike provider and patient data, procedure codes, diagnosis codes, and revenue codes do not have to be entered into the reference databases prior to incorporating them into a claim. These codes can be entered directly into the Claim Entry screen.

Under the Reference pull-down menu at the top of the screen, select Procedure Code. This opens the Procedure Code List. Click Add to add a procedure code to the list.

Procedure Code Data



1. Enter the HCPCS code. Do not add code modifiers here.
2. Enter a description of the procedure/service.
3. Enter the usual and customary charge amount with 2-digit decimal. If your charge amount changes, you must update the charge. Only one charge can be entered for each code. Charges can be entered manually in the Claim Entry screen.
4. Click Save.

The procedure code now appears on the Procedure List. Add additional procedure codes using the same instructions.

Under the Reference pull-down menu at the top of the screen, select Diagnosis. This opens the Diagnosis Code List. Click Add to add a diagnosis code to the list. Enter ICD-10.

Diagnosis Code Data

1. Enter the Diagnosis Code with or without the decimal. It is recognized to follow after the third digit (e.g., 12310 = 123.10) if left blank.
2. Enter a Diagnosis Code Description.
3. Click Save. The diagnosis code now appears on the Diagnosis Code List. Add additional diagnosis codes using the same instructions.

Under the Reference pull-down menu at top of screen, select Revenue Code. This opens the Revenue Code List. Click Add to add a revenue code to the list.

Revenue Code Data

1. Enter the Revenue Code.
2. Enter the Revenue Code Description.
3. Enter the Revenue Code Charge Amount with a 2-digit decimal. If your usual and customary charge changes, you must update the charge. Charges can be entered manually in the Claim Entry screen.
4. Click Save. The revenue code now appears on the Revenue Code List. Add additional revenue codes using the same instructions.

Creating a Professional Claim (CMS-1500)

Under the Claims pull-down menu at the top of the screen, select Professional. This opens the Professional Claim List. Click Add to add a professional claim to the list. **For existing claims, if any changes are made to provider, facility, or patient, you must open the claim and reselect the items changed.**

Claim Data

The screenshot shows the 'Professional Claim Data' window with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy)
- 2**: Patient ID (pull-down menu)
- 3**: Billing Provider (pull-down menu)
- 4**: Signature on File (radio buttons: No, Yes)
- 5**: Diagnosis Type Code (pull-down menu)
- 6**: Principal Diagnosis (pull-down menu)
- 7**: Place of Service (pull-down menu)
- 8**: Claim Frequency Type Code (pull-down menu)
- 9**: Next Page button

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date. Must be on or after last date of service.
2. Use the pull-down menu to access the Patient List; select Patient ID Number. For new patients, use the member card ID. For existing patients, if you have updated the Patient ID Number to the member ID number, be sure to select the correct entry.
3. Use the pull-down menu to access the Provider List; select the Billing Provider ID Number. The Pay-to Address is not needed. The Rendering Provider may or may not apply.
 - a. If applicable, select referring provider here.
4. In the Signature on File field, choose the Yes option. This is mandatory.
5. Select Diagnosis Type Code ICD-10.
6. Enter the diagnosis code bykeying in the diagnosis code or accessing the Diagnosis Code List using the pull-down menu. When keying diagnosis codes, the decimal point is not visible, but WINASAP recognizes it between the third and fourth digits based on the expanded length of ICD-10 codes. For diagnosis codes, the decimal point is not visible, but WINASAP recognizes it between the third and fourth digits based on the expanded length of ICD-10 codes. To enter additional diagnosis codes, click Other Diagnosis Codes.
7. Under the pull-down menu, select the Place of Service.
8. Under the pull-down menu, **always** select 1: Original (Admit thru Discharge Claim).
9. Click Next Page. Claim Status automatically defaults to Keyed.

Modem Only

This status changes once the claim is successfully submitted. If billing a Rendering Provider, add the Provider Data in the Provider List following the previously stated instructions and select the

appropriate Provider from the pull-down menu. Waiver providers do not need to enter a Rendering Provider.

Claim Codes

The screenshot shows the 'Professional Claim Data' application window with the 'Claim Codes' tab selected. The interface is organized into several sections:

- Claim Codes:** A group of six pull-down menus for selecting codes: Medicare Assignment Code, Release of Information Code, Patient Signature Source Code, Special Program Indicator Code, Delay Reason Code, and Claim Filing Indicator.
- Claim Indicators:** Includes a 'Homebound Indicator' with a 'Yes' checkbox and a 'Benefits Assignment Certification Indicator' pull-down menu.
- Claim Amounts:** A text field for 'Patient Amount Paid'.
- Claim Numbers:** A group of text fields for 'Mammogram Certification Number', 'Medical Record Number', 'CLIA Number', 'Referral Number', and 'Prior Authorization'. There is also a button for 'Other Claim Level Numbers'.

At the bottom of the window, there are four buttons: 'Next Page', 'Previous Page', 'Save', and 'Cancel'.

1. If known, select the appropriate Medicare Assignment Code from the pull-down menu. If you do not bill Medicare, select Not Assigned. This is the recommended default. **This is a HIPAA-required field.**
2. Under Release of Information, users select the entry from the pull-down menu that best reflects their office protocol regarding release of information. **This is a HIPAA-required field.**
3. For Claim Filing Indicator **always** select Medicaid from the pull-down menu.
4. For the Benefits Assignment Certification Indicator, select Yes from the pull-down menu.
5. If the claim requires a Passport Referral Number, enter it here.
6. If the claim requires a Prior Authorization Number, enter it here. The prior authorization number may change due to various reasons (e.g., funds exhausted, service date changes, authorized codes). Update here when the prior authorization number changes.
7. Click Next Page.

Claim Information

In most cases, there are no required fields on this screen; however, there are two fields that *may* be required for the claim.

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Ambulance Transport Info	Other Subscriber Info (2)
Claim Note (1)	Spinal Manipulation Info (3)
Claim Price/Reprice Information	Supplemental Info
Contract Info	Related Causes Info
EPSDT Info (4)	Service Facility Info
File Info	Vision Info
Miscellaneous Dates	

(5) Next Page Previous Page Save Cancel

Specialized instructions for these fields can be found in Appendices A, B, and C.

- To enter the 2-digit **CSCT** team code, click Claim Note. **The team code must be entered as a 2-digit numeric code.** If you do not enter the team code as 2 digits, the claim will ultimately fail, although no error indication will be generated in this window.
- To enter **TPL** information, click Other Subscriber Info. Other Subscriber Info (2) can be entered if the patient has additional insurance (TPL) that pays primary to Medicaid. **Do not enter \$0 Pay.**
- To enter paperwork attachment information, click Supplemental Info. Supplemental Info (3) can be used to indicate that a paperwork attachment to the electronic claim has been sent by mail/fax, or to reference a blanket denial letter on file in the Third Party Liability Unit. **Paperwork attachment information must be entered here.**
- Click on **EPSDT** Info and select Yes for Certification Condition Indicator. In the Conditions drop-down, choose New Service Requested.
- Click Next Page.

Claim Level Note

Note Reference Code: Additional Information

Note Text 1: 01

Delete Data

OK Cancel

EPSDT Information

Certification Condition Indicator:

☒ Yes ☐ No

Conditions

1: New Service Requested

2:

3:

Delete Data

OK Cancel

Claim Line Items

The number in the upper right corner of this screen indicates which line is being entered. As each line is added, this number changes. The total claim charges appear in the box on the lower left. Although WINASAP can accommodate 15 items in a single claim, the recommended maximum is 10.

The screenshot shows the 'Professional Claim Data' application window, specifically the 'Claim Line Items' tab. The interface includes several input fields and a table for entering claim line items. The fields are numbered 1 through 10, corresponding to the steps in the instructions below. The table at the bottom has columns for line number, service dates, procedure code, modifiers, units, and charges. A 'Total Claim Charges' box is located on the right side of the table. The screen also includes navigation buttons like 'First', 'Previous', 'Next', 'Last', 'Delete', 'Copy', 'Save', and 'Cancel'.

1. Enter the Service Dates (mm/dd/ccyy). If a single date of service, enter the date in both fields.
2. Under the pull-down menu, **always** select HCPCS.
3. Enter the HCPCS procedure/service code. Either key in the code or access the Procedure Codelist using the pull-down menu.
4. Enter up to four Procedure Modifiers.
5. Under the pull-down menu, **always** select Unit.
6. Enter the number of units being billed.
7. Enter the Charges. If the procedure code was previously entered into the Reference database with the corresponding per unit charge, WINASAP automatically calculates the charge.
8. Enter the Diagnosis Code Pointers. If there is only one diagnosis, then enter 1 in the first box.
9. Click Add Line Item. At this point, the claim line data moves to the box below. Repeat steps above to add additional lines.
10. When all line items have been entered, click Save.

Creating an Institutional Claim (UB-04)

Under the Claims pull-down menu at the top of the screen, select Institutional. This opens the Institutional Claim List. Click Add to add a new claim to the list.

Claim Data

The screenshot shows the 'Institutional Claim Data' form with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy) with a calendar icon.
- 2**: Patient ID pull-down menu.
- 3**: Billing Provider pull-down menu.
- 4**: Admission Date (mm/dd/ccyy) with a calendar icon.
- 5**: Admission Type pull-down menu.
- 6**: Discharge Status pull-down menu.
- 7**: Statement Coverage Period (From/Through dates) with calendar icons.
- 8**: Prior Authorization #.
- 9**: Type of Bill pull-down menu.
- 10**: Next Page button.

Other fields include: User Batch #, Claim Number, Claim Status (Keyed), Transaction Type (Chargeable), Patient Account #, Date of Birth, Sex, Last Name, First Name, Middle Name/Initial, Pay-to Address, Service Facility Location, Tax ID, Taxonomy Code, Attending Provider, Operating Physician, Other Operating Physician, Rendering Provider, Referring Provider, Pay To Plan, Referral #, Auto Accident State, Medical Record #, and Repricer Received Date.

*Claim Status automatically defaults to Keyed. This status changes once the claim is successfully submitted.

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date.
2. Use the pull-down menu to access the Patient list; select the Patient ID Number.
3. Use the pull-down menu to access the Provider list; select the Billing Provider ID Number.
4. Enter the Admission Date.
5. Enter the Admission Type.
6. Enter the Discharge Status. Refer to the UB-04 Instructions for valid status codes.
7. Enter the Statement Coverage Period dates.
8. If required, enter the Prior Authorization Number.
9. Enter the Type of Bill.
10. Click Next Page.

Claim Codes

The screenshot shows the 'Institutional Claim Data' window with the 'Claim Codes' tab selected. The form contains several sections with numbered callouts:

- 1**: Principal Diagnosis Code Qualifier dropdown.
- 2**: Principal Diagnosis Code dropdown.
- 3**: Admitting Diagnosis Code Qualifier dropdown.
- 4**: Admitting Diagnosis Code dropdown.
- 5**: Assignment or Plan Participation Code dropdown.
- 6**: Release of Information Code dropdown.
- 7**: Claim Filing Indicator Code dropdown.
- 8**: Assignment of Benefits Indicator dropdown.
- 9**: Other Subscriber Info button.
- 10**: Supplemental Info button.
- 11**: Next Page button.

Other visible fields include: Principal Procedure Code Qualifier, Principal Procedure Code, Principal Procedure Date, Present on Admission Indicator, DRG Code, Patient Reason for Visit Codes, External Cause of Injury Codes, Occurrence Span Codes, Occurrence Codes, Value Codes, Condition Codes, Treatment Codes, and Claim Pricing / Repricing Info.

* **Personal Resource Amounts can be entered in Patient Responsibility Amount.**

1. Select the Principal Diagnosis Code Qualifier from the pull-down menu. Choose ICD-10.
2. Enter the Principal Diagnosis Code either manually or from the pull-down menu (if previously saved in WINASAP 5010). When keying diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP recognizes it between the third and fourth digits.
3. Select the Admitting Diagnosis Code Qualifier from the pull-down menu. Choose ICD-10.
4. Enter the Admitting Diagnosis Code either from the pull-down menu (if previously saved in WINASAP 5010) or enter it manually. When keying diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP recognizes it between the third and fourth digits.
5. If known, select the appropriate Assignment or Plan Participation Code from the pull-down menu. If unknown, select Not Assigned. This is the recommended default.
6. Under the pull-down menu, users select the entry that best reflects their office protocol regarding Release of Information.
7. Under the Claim Filing Indicator Code pull-down menu, **always** select Medicaid.
8. Under the Assignment of Benefits Indicator, select Yes from the pull-down menu. This is mandatory.
9. If there is TPL that pays primary to Medicaid, click Other Subscriber Info to enter the TPL information (See Appendix A).
10. Click Supplemental Info to indicate that a paperwork attachment to the electronic claim has been sent by mail or fax, or to reference a blanket denial letter on file with the Third Party Liability Unit (See Appendix B).
11. Click Next Page.

Claim Line Items

The screenshot shows the 'Institutional Claim Data' window with the 'Claim Line Items' tab selected. The form includes the following fields and controls:

- Service Line Revenue Code:** Field with a pull-down menu (circled 1).
- Product / Service ID Qualifier:** Field with a pull-down menu (circled 2).
- Procedure Code:** Field with a pull-down menu (circled 3).
- Procedure Modifiers:** Four fields with pull-down menus (circled 4).
- Description:** Text field (circled 1).
- Line Item Charge Amount:** Field (circled 5).
- Unit or Basis for Measurement Code:** Field with a pull-down menu (circled 6).
- Service Units Count:** Field (circled 7).
- Non-Covered Charge Amount:** Field.
- Service Date(s):** Field with a date picker (circled 8).
- Line Item Control#:** Field.
- Repriced Line Item Ref #:** Field.
- Adjusted Repriced Line Item Ref #:** Field.
- Service Tax Amount:** Field.
- Facility Tax Amount:** Field.
- Operating Physician:** Field with a pull-down menu.
- Other Operating Physician:** Field with a pull-down menu.
- Rendering Provider:** Field with a pull-down menu.
- Referring Provider:** Field with a pull-down menu.
- Add Line Item:** Button (circled 9).
- Additional Line Item Information:** Section with tabs for Drug Information, Paperwork, Adjudication Information, and Line Pricing / Repricing Info.
- Navigation Buttons:** Delete, Copy, First, Previous, Next, Last.
- Table:** A table with columns for #, Service Dates From, Service Dates To, Revenue Code, HCPCS Code, Modifiers 1, 2, 3, 4, Service Units Count, and Line Item Charge Amount. It contains 5 rows.
- Total Claim Charges:** Field (circled 10).
- Page Navigation:** First Page, Previous Page, Save, Cancel.

1. Enter the Service Line Revenue Code or select it from the pull-down menu if it has been previously saved in WINASAP.
2. Select HCPCS from the Product/Service ID Qualifier pull-down menu.
3. Enter the Procedure Code or select it from the pull-down menu if it has been previously saved in WINASAP.
4. Enter up to four Procedure Modifiers.
5. Enter the Line Item Charge Amount.
6. Under the Unit or Basis of Measurement Code pull-down menu, **always** select Unit.
7. In the Service Units Count field, enter the number of units being billed.
8. Enter the Service Dates.
9. Click Add Line Item. Repeat these steps for additional line charges.
10. When all the lines have been entered, click Save.

The claim now appears in the Institutional Claim List window. Add additional claims using these same instructions.

Creating a Dental Claim

Under the Claims pull-down menu at the top of the screen, select Dental. This opens the Dental Claim List. Click Add to add a dental claim to the list.

Claim Data

The screenshot shows the 'Dental Claim Data' form with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy)
- 2**: Patient ID (pull-down menu)
- 3**: Billing Provider (pull-down menu)
- 4**: Signature on File (radio buttons: No, Yes)
- 4a**: Rendering Provider (pull-down menu)
- 5**: Place of Service (pull-down menu)
- 6**: Claim Frequency Type Code (pull-down menu)
- 7**: Principal Diagnosis (pull-down menu)
- 8**: Principal Diagnosis (pull-down menu)
- 9**: Next Page button

A red box highlights the 'Claim or Encounter Identifier' field, which is set to 'Chargeable'. A callout points to this field with the text: 'Do not change the Claim or Encounter Identifier field.'

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date. **Do not change the Claim or Encounter Identifier.**
2. Use the pull-down menu to access the Patient list; select Patient IDNumber.
3. Use the pull-down menu to access the Provider list; select the Billing Provider IDNumber.
4. In the Signature on File field, choose Yes.
 - a. If applicable, select referring provider here.
5. Under the Place of Service pull-down menu, select the place of service.
6. Under the Claim Frequency Type Code pull-down menu, **always** select 1: Original (Admit thru Discharge Claim).
7. Under the Principal Diagnosis pull-down menu, select the principal diagnosis code qualifier. Choose ICD-10. **Montana does not currently required diagnosis codes on dental claims.**
8. Enter the principal diagnosis code either manually or from the pull-down menu if previously saved in WINASA P5010). When keying diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP recognizes it between the third and fourth digits. **Montana does not currently required diagnosis codes on dental claims.**
9. Click Next Page.

Claim Information

The screenshot shows the 'Dental Claim Data' application window with the 'Claim Information' tab selected. The form contains the following elements:

- Release of Information Code:** A pull-down menu (1).
- Special Program Indicator:** A pull-down menu (2).
- Delay Reason Code:** A pull-down menu (3).
- Claim Filing Indicator Code:** A pull-down menu (3).
- Accident Date:** A date field (// / /) (4).
- Repricer Received Date:** A date field (// / /) (4).
- Date of Service:** A date field (// / /) (4).
- Patient Amount Paid:** A text input field (4).
- Service Authorization Exception Code:** A pull-down menu (5).
- Predetermination of Benefits Indicator:** A checkbox (5).
- Benefits Assignment Certification Indicator:** A pull-down menu (5).
- Additional Claim Level Information:** A grid with the following cells:

Related Causes Info	Service Facility Info	Predetermination Identification	Contract Info
Claim Notes	Supplemental Info	Tooth Status Info	Referral #
Prior Authorization	Other Subscriber Info (6)	Orthodontic Info	File Info
- Buttons:** Repriced Claim, Adjusted Repriced Claim, Claim Pricing/Repricing, Next Page (7), Previous Page, Save, Cancel.

1. **This is a HIPAA-required field.** Under the pull-down menu, users select the entry that best reflects their office protocol regarding release of information.
2. This is optional. To indicate EPSDT at the claim level, select EPSDT on the pull-down menu.
3. Under the pull-down menu, **always** select Medicaid.
4. Enter the first Date of Service.
5. From the Benefits Assignment Certification Indicator pull-down menu, select Yes. This is mandatory.
6. If COB, click Other Subscriber Info, and follow instructions in Appendix A.
7. Click Next Page.

Claim Line Items

1. If you have another Date of Service (a date that differs from the Date of Service entered on the previous page) enter the Date of Service (mm/dd/ccyy). If the Date of Service is the same as the previous page, leave this space blank.
2. Enter the CDT Procedure/Service Code. Either key in the code or access the Procedure Code List using the pull-down menu.
3. Enter up to 4 Procedure Modifiers.
4. Enter the number of Units being billed.
5. Enter the Charges. If the procedure code was previously entered into the Reference database with the corresponding per unit charge, WINASAP will automatically calculate the charge.
6. If applicable, click Tooth Information to enter the tooth information related to the line charge. See below for Tooth Information data entry instructions.
7. Click Add Line Item. Repeat steps above to add additional lines.
8. When all line items have been entered, click Save.

The claim now appears on the Dental Claim List. Add additional claims using the same instructions.

Tooth Information

1. Under the Tooth Code pull-down menu, select the code.
2. Under the Tooth Surface Codes pull-down menus, select the codes/quadrants.
3. When completed, click OK.

Creating a Nursing Facility Claim Template (UB-04)

Nursing facility claims use a template to expedite ongoing monthly billing. Once a template is created for each resident, subsequent claims are created by entering the billing month. WINASAP automatically generates a new claim for each resident. **If any changes are made to provider, facility, or patient, you must open the template and reselect the items changed.**

Under the Claims pull-down menu at the top of the screen, select Nursing Facility, then Nursing Facility Template. This opens the Nursing Facility Template List. Click Add to add a template to the list. Like all WINASAP electronic claims, patient and provider data must be entered prior to creating a template or claim. Since this a claim template, many of the date fields are left blank, but will be filled automatically when creating claims.

Template Data

The screenshot shows the 'Nursing Facility Template Data' window. It contains several sections: 'Template Data' (Bill Date, User Batch #, Claim Number, Claim Status), 'Patient Information' (Patient ID, Patient Account #, Date of Birth, Sex, Last Name, First Name, Middle Name/Initial), 'Provider Information' (Billing Provider, Pay-to Address, Service Facility Location, Taxonomy Code, Attending Provider, Operating Physician, Other Operating Physician, Rendering Provider, Referring Provider, Pay To Plan, Tax ID), 'Claim Data' (Admission Date, Type, SRC, Discharge Status, Statement Coverage Period), and 'Other Data' (Referral #, Prior Authorization #, Medical Record #, Type of Bill, Reprinter Received Date). Numbered callouts 1 through 10 point to specific fields: 1. Bill Date, 2. Patient ID, 3. Billing Provider, 4. Admission Date, 5. Admission Type, 6. SRC, 7. Discharge Status, 8. Statement Coverage From Date, 9. Type of Bill, 10. Next Page button.

1. Select the Bill Date. Press the F5 key to enter the current date.
- * Claim Status reads as Template.
2. Select the Patient ID from the Patient ID pull-down menu.
3. Select the Provider ID from the Billing Provider pull-down menu.
4. Enter the Admission Date (mm/dd/ccyy).
5. Enter the Admission Type Code. See the UB-04 manual.
6. Enter the Admission Source Code. See the UB-04 manual.
7. Enter the Discharge Status (Default is 30).
8. Enter the Statement Coverage from Date (enter Admission Date mm/dd/ccyy).
9. Enter the Type of Bill (Default is 213).
10. Click Next Page.

Template Codes

The screenshot shows the 'Nursing Facility Template Data' window with the 'Template Codes' tab selected. The window contains several sections for entering codes and information:

- Procedure Codes:** Includes fields for Principal Procedure Code Qualifier (1), Principal Procedure Code (2), Principal Procedure Date, and Other Procedure Codes.
- Diagnosis Codes:** Includes fields for Principal Diagnosis Code Qualifier (1), Principal Diagnosis Code (2), Present on Admission Indicator, Admitting Diagnosis Code Qualifier (3), and Admitting Diagnosis Code (4).
- Additional Claim Codes:** Includes Assignment or Plan Participation Code (5), Release of Information Code (6), Delay Reason Code, Claim Filing Indicator Code (7), and Assignment of Benefits Indicator (8).
- Buttons:** Includes Patient Reason for Visit Codes, External Cause of Injury Codes, Occurrence Span Codes (9), Occurrence Codes, Value Codes, Condition Codes, Treatment Codes, and Claim Pricing / Repricing Info.
- Additional Claim Information:** Includes Patient Responsibility Amount (10), Claim Notes, Billing Notes, Other Subscriber Info, Other Reference Info, Supplemental Info, Contract Info, File Info, and EPSDT Info.
- Navigation:** Includes Next Page (11), Previous Page, Save, and Cancel buttons.

1. Enter the Principal Diagnosis Code Qualifier.
2. Enter the Principal Diagnosis Code. When keying a diagnosis, users will not see the decimal; however, it is recognized to follow after the third digit (e.g., 12310 = 123.10).
3. Enter the Admitting Diagnosis Code Qualifier. Choose ICD-10.
4. Enter Admitting Diagnosis Code. Users will not see the decimal, but it is recognized to follow after the third digit (e.g., 12310 = 123.10).
5. If known, select the appropriate Medicare Assignment Code from the pull-down menu. If unknown, select Not Assigned. This is the recommended default. **This is a HIPAA-required field.**
6. Select the Release of Information Code from the pull-down menu.
7. Under Claim Filing Indicator Code, select Medicaid from the pull-down menu.
8. Select an Assignment of Benefits Indicator. Yes is required.
9. Click the Occurrence Span Codes button to change level of care from 2 (intermediate) to 1 (skilled). See the following page.
10. Enter the personal resources amount in the Patient Responsibility Amount field.
11. Click Next Page.

Template Line Items

1. In the Service Line Revenue Code field enter 160. Either key in the amount or access the Revenue Code List using the pull-down menu.
2. In the Unit or Basis for Measurement Code field, select Days from the pull-down menu.
3. Enter the Daily Rate.
4. Click Save.

There are no required fields on the Claim Home Health Data screen. The claim now appears on the Nursing Facility Template List. Add additional templates using the same instructions.

Occurrence Codes

The levels of care are Level of Care 1 = Skilled and Level of Care 2 = Intermediate. The default level of care is Level 2 – No action necessary.

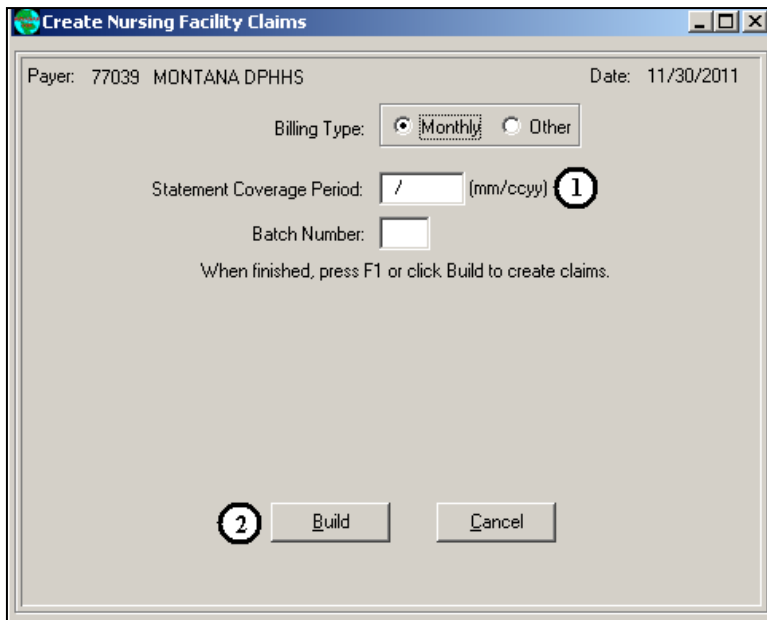
To indicate Level of Care 1:

1. Enter 70 in the Code field.
2. Enter the Date.
3. Click OK.

Creating a Nursing Home Claim from the Template List

Under the Tools pull-down menu, select Create Nursing Facility Claims.

Create Nursing Facility Claims



1. Enter month and year (mm/ccyy) in the Statement Coverage Period field.
2. Click the Build button.

WINASAP generates a claim for each Nursing Facility template for the month entered.

To make changes to claims, open the Nursing Facility Claims List under the Claims pull-down menu. Users select the claim they wish to change, make any changes, and click Save.

Submitting Claims

Under the Tools pull-down menu at the top of the screen, select Send Claim File. It is not necessary for users to select by claim type unless they wish to send different claim types in separate batches.

All Claim Lists must be closed.

To test the process before submitting claims for processing, use the Test indicator. **Claims submitted under the Test indicator will not be processed for payment.**

Send Claims

Modem Only

The default is set at Send Keyed Claims. (Claims that have not been billed.)

1. Click Production. Subsequently each time this screen is opened, it will be set to Production.
2. **Click Send. Failure to click Send results in duplicate files being submitted and processed.**

Once Send is clicked, the System Message appears indicating how many claims will be generated within this submission or batch. Click OK to send the claims. WINASAP begins the submission process.

System Message

6 claims will be generated.
Do you wish to proceed?

OK Cancel

Transmission Confirmation – Modem Only

Following transmission, users receive a confirmation message similar to the one below.

The screenshot shows a window titled "Transmission Confirmation" with a blue title bar. The window contains the following text:

```

Date: 11/30/11          ACS Host System          Time: 18:10
User Name: MTTEST3      User Number: *****

File Number  Payor  Frmt  Type  Ver  Claims  Batches  Tot. Charges  Status  Msg
-----
11300307.G09  77039  X12  837I  5010  ① 2  ② 1  ③ 1120.00  Test  001
11300308.G09  77039  X12  837D  5010  ① 2  ② 1  ③ 600.00  Test  001
11300309.G09  77039  X12  837P  5010  2  2  1  1300.00  Test  001

Messages
001 - File received, will not be processed for payment.

                ** End of Report **
  
```

The Receipt Complete screen gives the submitter feedback regarding the submission.

1. The number of Claims submitted within the batch.
2. The total number of Batches.
3. The total amount of Charges.

This screen can be printed and saved for verification purposes.

Submitting Claims through the MATH Web Portal

For a number of reasons (e.g., no internal modem in the computer, having a digital phone line instead of an analog phone line) users may not be able to submit claims through WINASAP using an analog phone or fax line. Instead, they use the Montana Access to Health web portal to submit claims. **However, if users do submit claims through the web portal, the Receive Response File and the automatic changing of the status of submitted claims is not available.**

Users must register to use the MATH web portal before being able to use it to submit claims. If users do not have access, they should visit the MATH web portal, and follow the instructions to register (see your EDI Welcome Letter for necessary information.). Users need to assign their Security Privileges to include Upload Files. This must be selected before uploading the WINASAP claims.

Security Privileges		
<input type="checkbox"/> Verify Eligibility	<input type="checkbox"/> Check Claim Status	<input type="checkbox"/> View Provider Payment
<input checked="" type="checkbox"/> Upload Files	<input type="checkbox"/> Download Files	<input type="checkbox"/> Office Administrator
<input type="checkbox"/> View eISOR Reports	<input type="checkbox"/> View Medical History	<input type="checkbox"/> View Electronic Health Record
<input type="checkbox"/> Prescriber Privileges		

The setup of WINASAP5010 is similar to that of previous versions. .

The screenshot shows the 'Trading Partner Information' window. It has a title bar and standard window controls. The main area is divided into several sections:

- Trading Partner Identification:** Fields for Primary Identification (7777777) and Secondary Identification (7777777).
- Trading Partner Name:** Fields for Entity Type (Non-Person), Organization Name (Provider Name), Last Name, First Name, and Middle Name.
- Contact Information:** Fields for Contact Name, Telephone # (000)000-0000, Ext., FAX #, and Email.
- Additional Contact Information:** Fields for Contact Name, Telephone #, Fax #, and Email.
- WINASAP5010 Communications:** Fields for Host Telephone # (circled), User ID # (MTTEST300), and User Name (MTTEST3).

At the bottom right, there are 'Save' and 'Cancel' buttons.

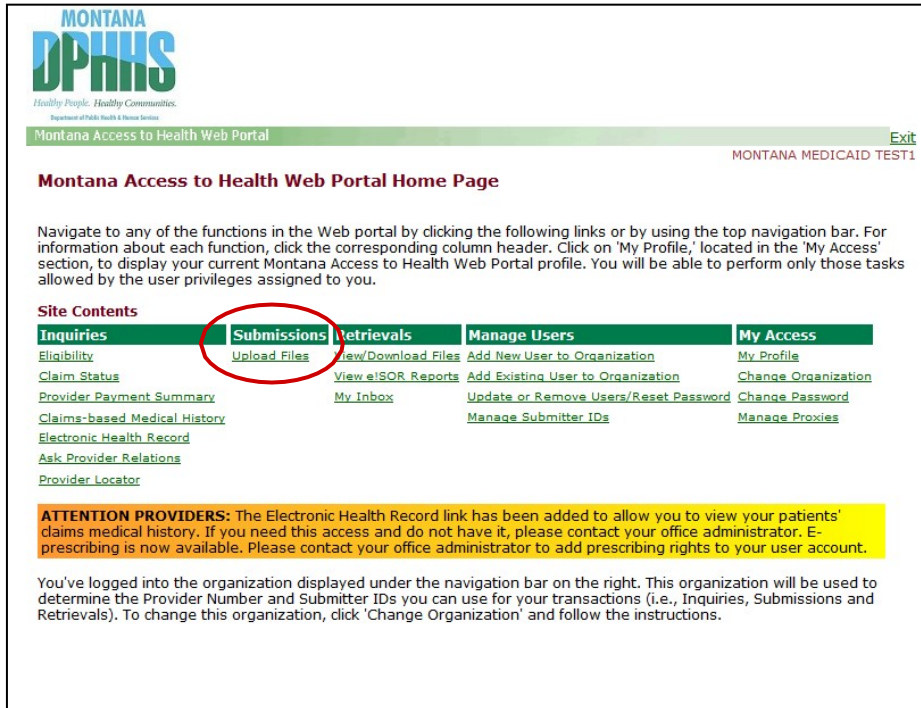
1. Users enter their Trading Partner information as described earlier, leave the Host Telephone Number field blank, and click Save.
2. Enter the provider information, the member information, and the diagnosis codes. Create the claims, save them as described in this guide, and submit them following the steps described earlier.
3. After doing so, users receive a Transmission Claims message. This indicates that the claim file has been saved to their computer.
4. Click Cancel.



5. [Log into the MATH web portal, https://mtaccessstohealth.portal.conduent.com/mt/general/home.do.](https://mtaccessstohealth.portal.conduent.com/mt/general/home.do) You may also go to <http://medicaidprovider.mt.gov> and click the Log in to Montana Access to Health link in the gray box on the left side near the top.

MATH Home Page

- Once logged in, select the Upload Files option in the Submissions column.



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Department of Public Health & Human Services

Montana Access to Health Web Portal Exit

MONTANA MEDICAID TEST1

Montana Access to Health Web Portal Home Page

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

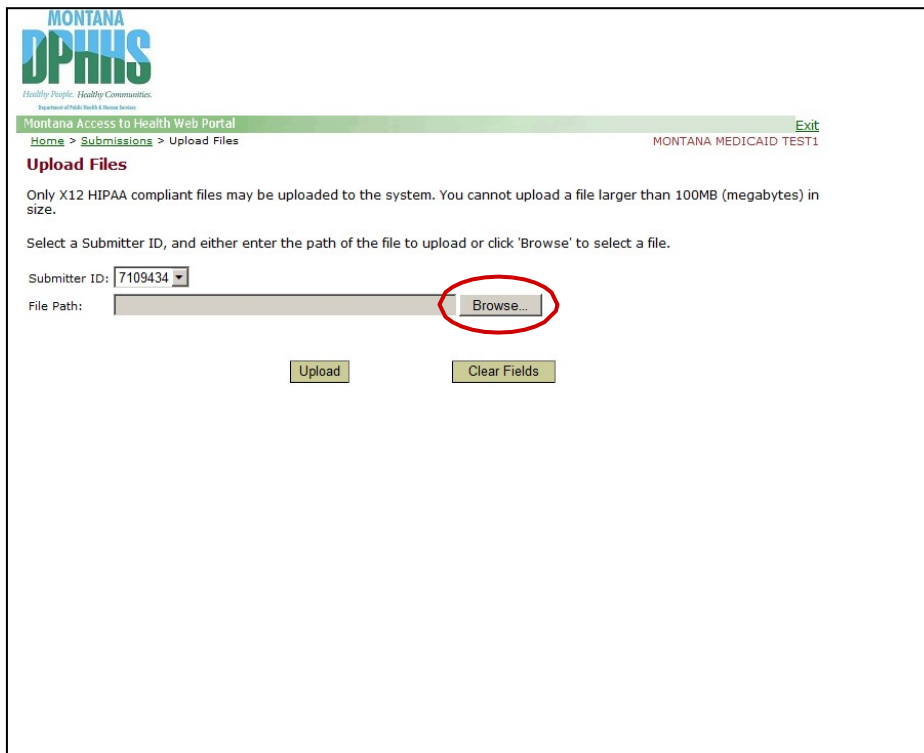
Site Contents

Inquiries	Submissions	Retrievals	Manage Users	My Access
Eligibility	Upload Files	View/Download Files	Add New User to Organization	My Profile
Claim Status		View e!SOR Reports	Add Existing User to Organization	Change Organization
Provider Payment Summary		My Inbox	Update or Remove Users/Reset Password	Change Password
Claims-based Medical History			Manage Submitter IDs	Manage Proxies
Electronic Health Record				
Ask Provider Relations				
Provider Locator				

ATTENTION PROVIDERS: The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

- Click the Browse button. This opens a Choose File window where users select their filepath.
Note: This option may be labeled differently depending on browser used.



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Montana Access to Health Web Portal Exit

Home > Submissions > Upload Files MONTANA MEDICAID TEST1

Upload Files

Only X12 HIPAA compliant files may be uploaded to the system. You cannot upload a file larger than 100MB (megabytes) in size.

Select a Submitter ID, and either enter the path of the file to upload or click 'Browse' to select a file.

Submitter ID:

File Path: Browse...

3. Select the files in the order shown below by double-clicking the files.
 - a. Local Disk (C :)
 - b. Program Files
 - c. Conduent (Previously ACS)
 - d. W5010
 - e. db
 - f. 77039
 - g. 77039.bil. This is the file location users' claims are saved on their computer. The file path is C:\Program Files\Conduent\W5010\db\77039\77039.bil. The file *name* never changes. Users may verify the current file by the date changed.
4. Click the Upload button. Users should receive a message stating their file was successfully uploaded.
5. Users must now manually change the status of the claims they have just submitted through the MATH web portal. Users may call EDI one hour after upload to verify that the files have been received.

Manually Changing Claim Status

To manually change the status of claims, users must open the Claims List, select the type of claim (professional, institutional, dental, or nursing facility) they want to change, select the specific claim, and open the claim.

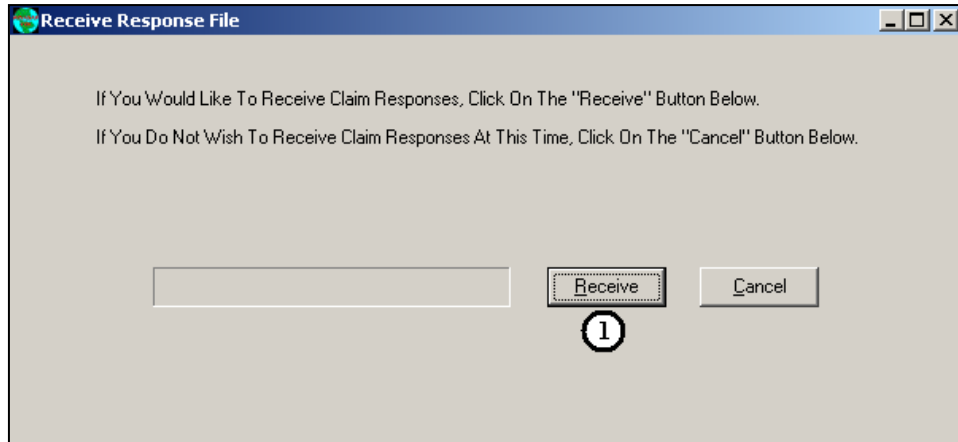
The screenshot shows the 'Professional Claim Data' window with the following sections:

- Claim Data:** Includes fields for Bill Date, User Batch #, User Claim Number, Claim Status (dropdown menu open showing options: Keyed, Hold, Billed, Accepted, Rejected, Paid, Denied, Errored), and Encounter (Chargeable).
- Patient Information:** Includes Patient ID, Patient Account #, Last Name, First Name, Sex, and me/Initial.
- Provider Information:** Includes Billing Provider, Pay-to-Address, Rendering Provider, Tax ID, Taxonomy Code, Signature on File (radio buttons for No/Yes), Referring Provider 1, Referring Provider 2, Supervising Provider, and Pay-to Plan.
- Claim Data:** Includes Health Care Diagnosis Codes (Diagnosis Type Code, Principal Diagnosis, Other Diagnosis Codes), Anesthesia Related Procedure (Anesthesia Related Procedure Code 1, Anesthesia Related Procedure Code 2), and Condition Information (Condition Code List, Condition Codes).
- Place of Service:** A dropdown menu.
- Claim Frequency:** A dropdown menu.
- Buttons:** Next Page, Save (circled 2), and Cancel.

1. Click the pull-down menu next to Claim Status and select Hold.
Note: The list is alphabetical; therefore, you must arrow up to locate Hold.
2. Click Save. This prevents the claim from being resubmitted with the next batch of claims if users choose to keep their submitted claims in the Claims List.

Running a Receive Response File

Wait a minimum of one hour before running this. Under the Tools pull-down menu, select Receive Response File.



**Modem
Only**

1. Click Receive.
2. WINASAP connects to the host and updates the status of sent claims on Claims Lists. Unsent claims are in Keyed status. Sent claims default to Billed status.

Following the Receive Response File, sent claims are either accepted or rejected. If a claim is marked as rejected, contact EDI Gateway at 800-987-6719 or Provider Relations at 800-624-3958 for an explanation and for steps that are needed to correct rejected claims.

Reports, Backing up a Database, and Other Features

Under the Tools pull-down menu, select Reports. WINASAP can generate a variety of reports. Select the report type and criteria and click Run in the lower right of the screen. Other items of interest under the Tools menu are:

**Modem
Only**

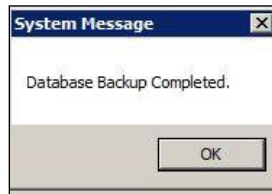
1. Back-Up Database

- a. By backing up a database, users ensure that data can be recalled in the event of dataloss.
- b. A backup is recommended on a regular basis. Data can be backed up to the WINASAP database folders, your Desktop, a jump drive, or CD.

1.) Select Tools >> Backup Database



- 2.) When the **Confirm window** appears asking if you want to **Backup Database**, click **Yes**.
The default save path is C:\Program Files\Conduent\W5010\db\backup. If you wish to save to a flash drive, CD, or your Desktop, select the path.
- 3.) The backup process will run. When completed, a System Message appears.

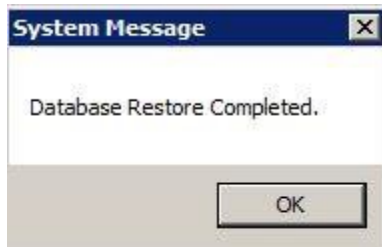


- c. To recall a backup, use the Restore Database option under the Tools menu.

- 1.) To restore the database, select Tools >> Restore Database

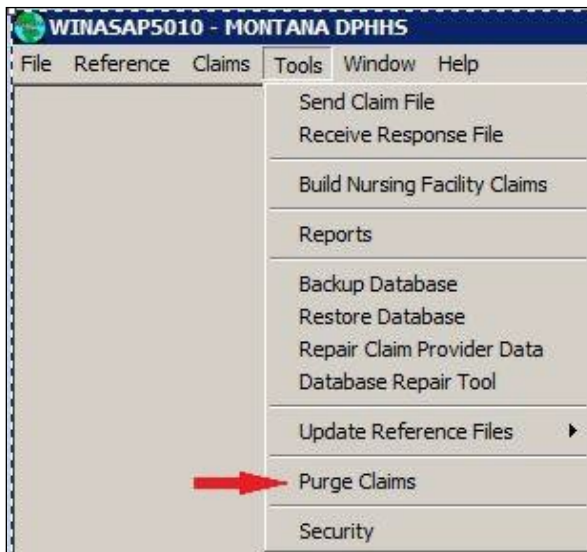


- 2.) When the Confirm window appears asking if you want to Restore Database, click Yes.
The default save path remains the same (C:\Program Files\Conduent\W5010\db\backup).
If you wish to save to a flash drive, CD, or your Desktop, select the path.
- 3.) When the Confirm window appears asking if you want to include the Payor Table, click Yes.
- 4.) The Database Restore process will run. When completed, a System Message appears.

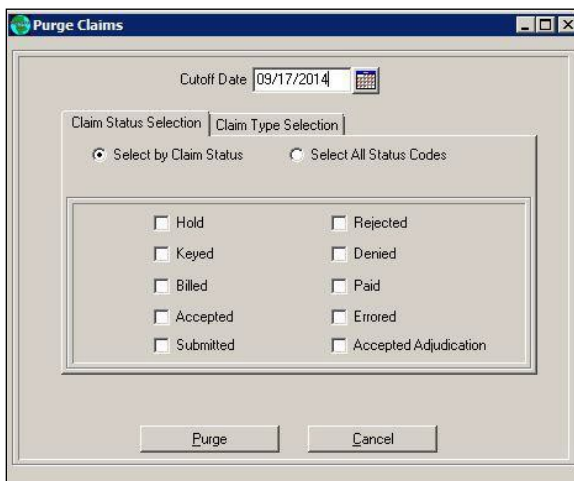


2. Purge Claims

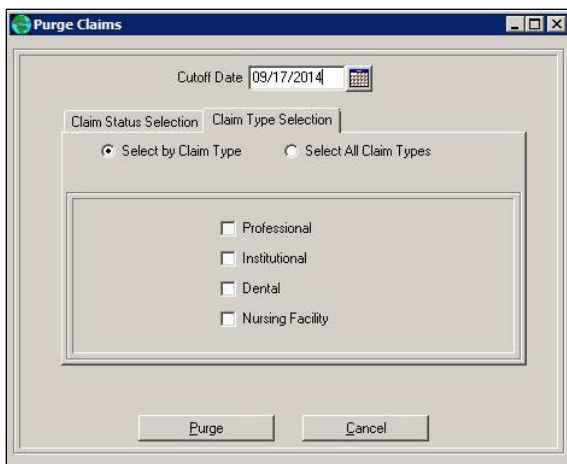
- a. Select Tools >>Purge Claims to remove them from the Claim List.



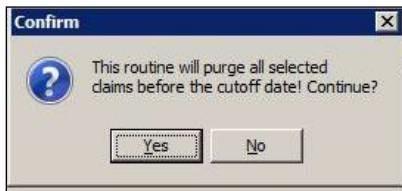
- b. Select the Cutoff Date. Claims transmitted before this date will purge. You may choose Claim Status Selection or Claim Type Selection. If you choose Status and upload to the MATH portal only, Hold and Keyed status are available options).



- c. You may also choose Claim Type Selection and either Select by Claim Type or Select All Claim Types.



- d. When the Confirm window appears asking if you want to purge selected claims, choose Yes.

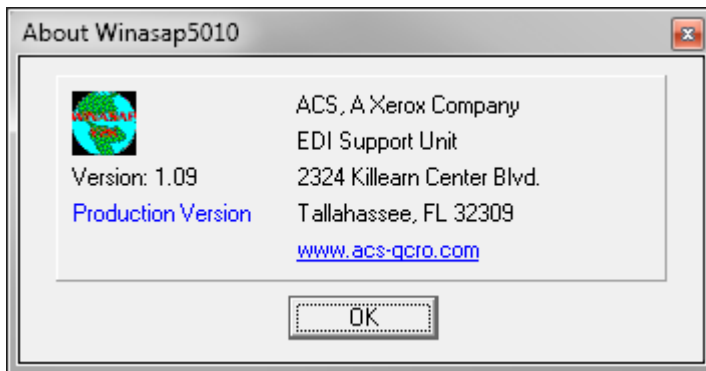


- e. You will be prompted to make a backup before the purge begins. The default save path is C:\Program Files\Conduent\W5010\db\backup. To point to a flash drive/CD/desktop select the path.
- f. Once removed, purged claims can be found in the WINASAP Database File.

3. Security

- a. Passwords may be changed, and users can be added through the Security option. This is not recommended. If you forget the username or password, EDI Support cannot provide this information to you.

4. To view the version of WINASAP being used, choose Help >> About. A screen appears indicating the version being used (e.g., Version 1.09).

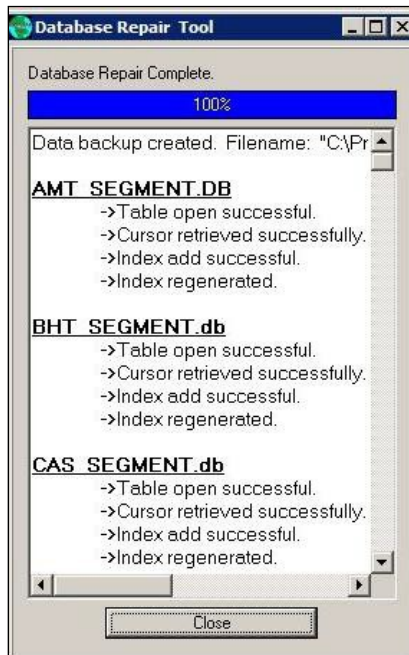


5. Database Repair Tool. This item can be used to troubleshoot minor glitches or errors that are experienced within the software.

- a. Select Tools >> Database Repair Tool.



- b. The database repair process will run.



Once the Database Repair Tool is complete, restart computer before proceeding.

Troubleshooting Tips

1. **Claims, Denied; the Receive Response File Shows as Accepted.** When claims are submitted electronically, they are screened for validity of data and HIPAA compliancy. If the submitted claims fail to meet these criteria, they are rejected from processing. If all criteria are met, the electronic claim gets accepted; however, this status means that the claim was *received* by Medicaid for processing. A claim can still be denied for many reasons. **Note:** When uploading through the web portal, all Receive Response options are disabled. To confirm submission, contact the EDI Support Unit at least 1 hour after submission.
2. **Claims, Same Patient Same Codes.** Use the Copy feature in the Claim List to copy the claim and allow updates to it. This saves data entry time because updates can be done to the data that changes (e.g., bill dates, services dates) and the rest is already entered.
3. **Database, Backup.** We recommend backing up data on a flash drive to store at an alternative location in the event that something happens to the computer on which WINASAP is installed.
4. **Database, Restoring.** Restoring a database will overwrite current data. There is no function to combine parts of multiple databases.
5. **Downloading WINASAP Software.** Available at <http://medicaidprovider.mt.gov/claims>
[When downloading WINASAP, save it to the computer Desktop and install the program from there.](#)
 The installation software looks like a red box. Once installed, the actual WINASAP application resembles a globe with red writing on it. To determine what version you are running, click Help > About...
 Once WINASAP is successfully installed, delete the installation box to prevent from installing the software again. If the database is not backed up to an external location and WINASAP is installed over the top, all previously entered data will be lost.
6. **E-101 System Error.** Check that you are running as administrator and restart computer.
7. **Modem Not Accessible.** Choose device. WINASAP is direct submission software; therefore, a direct submission method must be reflected. The system that best reflects that is a dial-up modem and phone line. Many computers have internal modems and can simply have a phone or fax line plugged directly into the computer to resemble direct submission compliance. To find an active modem on the computer, access the Control Panel.
8. **Payer.** Ensure the right payer (Montana DPHHS) is selected **before** submitting claims. The payer is indicated in the blue bar at the top of the screen.
9. **User Not Approved for Payer/Format/Type.** This error occurs on the Receipt Complete screen. To resolve this issue, contact the EDI Support Unit at 800.987.6719.
10. **User Unable to Submit Claims (Option Is Not Available).** Close all data entry screens before submitting claims so only the gray WINASAP screen shows.
11. **Screen That Was Open Has Disappeared.** Multiple screens can get concealed behind one another. Minimize the open screens to determine whether a screen is hidden behind it. The minimized screens can be maximized again.
12. **Patient or Provider ID is not the right length.** Manually modify the length allowed for the patient or provider data ID under File/Open Payer/Show Payer Edits.
13. **Receive Response File.** It is beneficial to know if claims are rejecting on the electronic submission. If nothing comes through on the remittance advice, this is an indicator of claims rejecting.
14. **Running WINASAP on a Mac.** Users attempting to run WINASAP on a Mac may find the program does not work to its full extent. WINASAP has run successfully on a Mac, but overall its functionality does not operate well. Users do need a Windows parallel because WINASAP is Windows-based. Support for this is limited.
15. **WINASAP on CD.** Users who wish to have a CD sent to them instead of downloading WINASAP from the website should call Provider Relations at 1.800.624.3958 or the EDI Support Unit at 800.987.6719.

Appendix A – Indicating TPL Payments in a WINASAP Claim

If users need to indicate that Medicaid is not primary on a patient, access the patient data through Reference/Patient. Once the Patient List comes up, users can either double-click the patient to access or select the Change tab.

For WINASAP professional claims in which Medicaid pays secondary or tertiary to another insurer (TPL), providers should follow these instructions to enter the TPL paid amount and other TPL information.

Claims indicating a TPL payment (not including Medicare) do not require attached paper documentation. However, an attachment is required if the TPL denies payment for noncovered services, exceeded benefits, etc. **Do not enter \$0 Pay.**

The numbers on the screen shot below indicate the fields required to indicate Medicaid as secondary or tertiary.

The screenshot shows the 'Patient Data' window with the 'Insured's Data' tab selected. The 'Insured's Information' section contains fields for Patient ID #, Insured's SSN, Patient Relationship to Insured (highlighted with a circled '1'), Insured's Primary ID, Entity Type, Insured's Group or Plan Name, Organization Name, Insured's Group or Policy #, Last Name, Insured's Address, First Name, Insured's Address (cont), Middle Name/Initial, Insured's City, Suffix, Insured's State, and Insured's Zip Code. The 'Property and Casualty Information' section includes Contact Name, Telephone #, Ext, and Property and Casual Claim #. The 'Payer Information' section includes Payer Name (MONTANA DPHHS), Payer Primary ID (77039), Payer Address, Payer Responsibility Sequence Code (highlighted with a circled '2'), Address (cont), Insurance Type, City, Payer Secondary ID, State, and Zip. At the bottom, there are buttons for Patient Data, Save (highlighted with a circled '3'), and Cancel.

1. In the Patient Reference Database, on the Insured's Data tab, under Patient Relationship to Insured, be sure that Self is entered.
2. Under Payer Responsibility Sequence Code, select Medicaid as Secondary (or Tertiary, if applicable).
3. Click Save to exit the screen.

On the Professional Claim Data screen, **Claim Information tab**, click Other Subscriber Info.

The screenshot shows the 'Professional Claim Data' application window. The 'Claim Information' tab is selected. Inside the window, there is a section titled 'Additional Claim Level Information' which contains a grid of buttons. The buttons are arranged in two columns. The first column includes: Ambulance Transport Info, Claim Note, Claim Price/Reprice Information, Contract Info, EPSDT Info, File Info, and Miscellaneous Dates. The second column includes: Other Subscriber Info, Spinal Manipulation Info, Supplemental Info, Related Causes Info, Service Facility Info, and Vision Info. The 'Other Subscriber Info' button is circled with a red 'X'. At the bottom of the window, there are four buttons: Next Page, Previous Page, Save, and Cancel.

Other subscriber information allows the entry of many different aspects of third party payers, including Medicare.

- For Professional claims, Other Subscriber Info is located on the Claim Information tab.
- For Institutional claims, Other Subscriber Info is located on the Claim Codes tab in the bottom row of tabs.
- For Dental claims, Other Subscriber Info is located on the Claim Information tab near the bottom.
- For Nursing Facility claims, Other Subscriber Info is located on the Claim Codes tab in the bottom row of tabs.

Other Subscriber Page 1

Complete the following fields on page 1 of this screen.

Other Subscriber Information

Other Subscriber Page 1 | Other Subscriber Page 2 | 1

Insured's Name

Patient Relationship To Insured: Entity Type:

Organization Name:

Last Name: First Name: Middle Name/Initial: Suffix:

Insured's Address

Address: Address (cont):

City: State:

Zip Code:

Insured's Identification

Insured's Primary ID Type: Insured's Primary ID:

Secondary Identification

Delete First Previous Next Last

OK Cancel

1. Patient Relationship to Insured.
2. Entity Type.
3. Last Name and First Name.
4. Insured's Primary ID Type.
5. Insured's Primary ID.
6. Click OK or the Other Subscriber Page 2 tab at the top to move to the second page.

Other Subscriber Page 2

Complete the following fields on page 2 of this screen.

1. Group or Policy Number.
2. Group or Plan Name.
3. Insurance Type Code.
4. Claim Filing Indicator.
5. Release of Information Code.
6. Patient Signature Source Code.
7. Payer Name.
8. Payer Responsibility Sequence Code (enter Primary).
9. Payer Primary ID Type.
10. Payer Primary ID.
11. Claim Check or Remittance Date.
12. Click COB Amounts.

COB Information

1. Enter the Paid Amount (TPL payment). Be sure to indicate payment with a 2-digit decimal to ensure the amount comes across correctly (e.g., 100.00 not 100).
2. Click OK. Repeat the process for other TPL payments on the claim.

Appendix B – Indicating Medicare Part B for a Professional Claim

Follow the same procedures to indicate in the patient's data that Medicaid is either Secondary or Tertiary. (See the Running a Response File instructions on page 35.)

When entering the Professional Claim, on the Claim Codes tab, enter Assigned for the Medicare Assignment Code.

The screenshot shows the 'Professional Claim Data' window with the 'Claim Codes' tab selected. The 'Claim Codes' section contains several dropdown menus: 'Medicare Assignment Code' is set to 'Assigned' (marked with a circled 1), 'Release of Information Code' is 'Informed Consent to Release Medical Information for Conditions or Diagnosis Regulated by Federal Statutes', 'Patient Signature Source Code' is 'Signature generated by provider because the patient was not physically present for Services', 'Special Program Indicator Code' is empty, 'Delay Reason Code' is empty, and 'Claim Filing Indicator' is 'Medicaid'. Below this, the 'Claim Indicators' section has 'Homebound Indicator' (checkbox) and 'Benefits Assignment Certification Indicator' (dropdown set to 'NA'). The 'Claim Amounts' section has a 'Patient Amount Paid' field. The 'Claim Numbers' section has fields for 'Mammogram Certification Number', 'Medical Record Number', 'CLIA Number', 'Referral Number', 'Prior Authorization', and 'Other Claim Level Numbers'. At the bottom are 'Next Page', 'Previous Page', 'Save', and 'Cancel' buttons.

Proceed to follow normal claim billing procedures.

Other Subscriber Page 1

On the third page of data within a Professional Claim, select Other Subscriber Information.

Complete the following fields on page 1 of this screen.

The screenshot shows a window titled "Other Subscriber Information" with two tabs: "Other Subscriber Page 1" and "Other Subscriber Page 2". The "Other Subscriber Page 1" tab is active. The form contains the following fields:

- Insured's Name:**
 - Patient Relationship To Insured:** A dropdown menu (callout 1).
 - Entity Type:** A dropdown menu (callout 2).
 - Organization Name:** A text box.
 - Last Name:** A text box (callout 3).
 - First Name:** A text box (callout 3).
 - Middle Name/Initial:** A text box (callout 3).
 - Suffix:** A text box.
- Insured's Address:**
 - Address:** A text box.
 - Address (con't):** A text box.
 - City:** A text box.
 - State:** A dropdown menu.
 - Zip Code:** A text box.
- Insured's Identification:**
 - Insured's Primary ID Type:** A dropdown menu (callout 4).
 - Insured's Primary ID:** A text box (callout 5).
 - Secondary Identification:** A button.

At the bottom of the form are navigation buttons: "Delete", "First", "Previous", "Next", "Last", "OK", and "Cancel".

1. Patient Relationship to Insured: Self.
2. Entity Type: Person.
3. Last Name and First Name.
4. Insured's Primary ID Type: Select Member Identification Number. Insured's Address is not required.
5. Insured's Primary ID: Enter patient's Medicare IDNumber.
6. Click the Other Subscriber Page 2 tab at top to move to the second page.

Other Subscriber Page 2

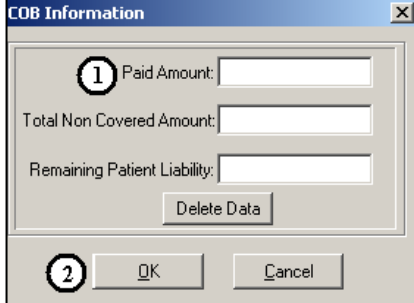
Complete the following fields on page 2 of this screen.

The screenshot shows the 'Other Subscriber Information' form, Page 2. The form is divided into two main sections: 'Insurance Information' and 'Other Payer Information'. The 'Insurance Information' section includes fields for Group or Policy # (1), Group or Plan Name (2), Insurance Type Code (3), Claim Filing Indicator (4), Release of Information Code (5), Patient Signature Source Code (6), and Benefits Assignment Certification Indicator (12). The 'Other Payer Information' section includes fields for Payer Name (7), Payer Responsibility Sequence Code (8), Payer Primary ID Type (9), Payer Primary ID (10), Payer Address, Payer City, Payer State, Payer Zip Code, Claim Check or Remittance Date (11), and Claim Control Number. At the bottom, there are buttons for 'Delete', 'First', 'Previous', 'Next', 'Last', 'OK', and 'Cancel'.

1. Group or Policy Number.
2. Group or Plan Name.
3. Insurance Type Code: Medicare Part B.
4. Claim Filing Indicator: Medicare Part B.
5. Release of Information Code: Select the first option.
6. Patient Signature Source Code: Select the first option.
7. Payer Name: Noridian Medicare.
8. Payer Responsibility Sequence Code: Enter Primary.
9. Payer Primary ID Type.
10. Payer Primary ID: Enter MCARE PART B for Noridian Medicare.
11. Claim Adjudication Date: The date the claim processed in Medicare.
12. Click COB Amounts.

COB Information

1. Enter the paid amount to indicate the total amount paid by Medicare on this claim. Indicate the payment with a 2-digit decimal to ensure the correct amount comes across (100.00 not 100).
2. Click OK. Repeat this process to add any additional payments.



COB Information

1 Paid Amount:

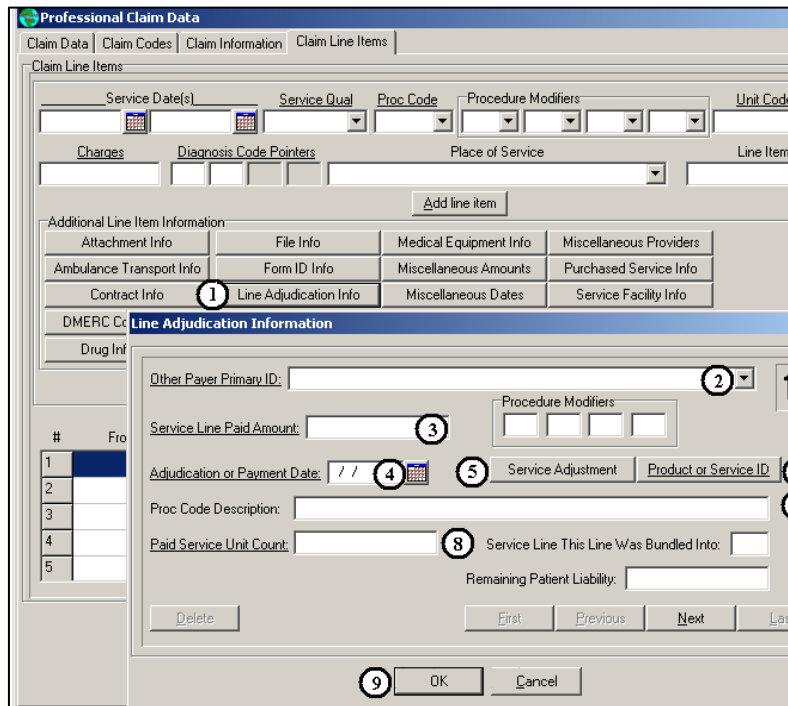
Total Non Covered Amount:

Remaining Patient Liability:

Delete Data

2 OK Cancel

Claim Line Items



Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Line Items

Service Date(s) Service Qual Proc Code Procedure Modifiers Unit Code

Charges Diagnosis Code Pointers Place of Service Line Item

Add line item

Additional Line Item Information

Attachment Info	File Info	Medical Equipment Info	Miscellaneous Providers
Ambulance Transport Info	Form ID Info	Miscellaneous Amounts	Purchased Service Info
Contract Info	1 Line Adjudication Info	Miscellaneous Dates	Service Facility Info

DMERC Co Drug Inf

Line Adjudication Information

Other Payer Primary ID: 2

Service Line Paid Amount: 3

Adjudication or Payment Date: / / 4 5 Service Adjustment Product or Service ID

Proc Code Description:

Paid Service Unit Count: 8 Service Line This Line Was Bundled Into:

Remaining Patient Liability:

Delete First Previous Next Last

9 OK Cancel

1. Under Additional Line Item Information, select the Line Adjudication Info button.
2. For Other Payer Primary ID, select the pull-down menu, and indicate the same Payer PrimaryID entered previously (MCARE PART B).
3. Enter the paid amount in the Service Line Paid Amount field.
4. In the Adjudication or Payment Date field, enter the adjudication date of the claim.
5. Select the Service Adjustment button.
 - a. Group Code – Select the appropriate code identifying the general category from the pull-down list.
 - b. Reason Code – Select either 1 Deductible Amount or 2 Coinsurance Amount from the pull-down list.
 - c. Adjusted Amount – Enter the amount of the deductible or coinsurance.

6. Select Product or Service ID.
 - a. Identification Type – **Always** select **HCPCS** from the pull-down list.
 - b. Identification Number – Enter the appropriate procedure code from the corresponding line item.
7. In the Proc Code Description field, enter the procedure code description.
8. In the Paid Service Unit Count field, enter the number of paid units.
9. Click OK.

If there are additional service dates that need to be billed, click the Add Line Item button and repeat the steps for each additional line items.

Appendix C – Paperwork Attachments / Blanket Denial Letters

For WINASAP claims in which a provider must indicate that a separate paperwork attachment has been sent, or to reference a blanket denial letter on file in the TPL Unit, click the Supplemental Info button.

The screenshot shows the 'Professional Claim Data' application window. The 'Claim Information' tab is selected. Inside the window, there is a section titled 'Additional Claim Level Information' which contains a grid of buttons. The buttons are arranged in two columns. The first column includes: Ambulance Transport Info, Claim Note, Claim Price/Reprice Information, Contract Info, EPSDT Info, File Info, and Miscellaneous Dates. The second column includes: Other Subscriber Info, Spinal Manipulation Info, Supplemental Info (which is highlighted with a circled '1'), Related Causes Info, Service Facility Info, and Vision Info. At the bottom of the window, there are four buttons: Next Page, Previous Page, Save, and Cancel.

Additional Claim Level Information	
Ambulance Transport Info	Other Subscriber Info
Claim Note	Spinal Manipulation Info
Claim Price/Reprice Information	Supplemental Info ①
Contract Info	Related Causes Info
EPSDT Info	Service Facility Info
File Info	Vision Info
Miscellaneous Dates	

Next Page Previous Page Save Cancel

Supplemental Information

The black numbers on the screen images indicate required fields.

Supplemental Information

	Report Code	Transmission Code	Identification Code
1:	1	2	3
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			
10:			

Delete Data

4 OK Cancel

1. Under the Report Code pull-down menu, select the type of attachment (e.g., EOB). If the exact definition is not listed, select Support Data for Claim.
2. Under the Transmission Code pull-down menu, select the appropriate code (e.g., By Mail for attachments sent by mail with the Paperwork Attachment Cover Sheet; Electronically Only to reference a Blanket Denial Letter on file in the TPL Unit).
3. In the Identification Code field, enter the Attachment Control Number for attachments sent by mail with the Paperwork Attachment Cover Sheet. This number consists of the provider's NPI, member's ID number, and date of service (mmddccyy) each separated by a hyphen. This number must match the Paperwork Attachment Control Number entered on the Paperwork Attachment Cover Sheet.

For claims referencing a blanket denial letter on file in the TPL Unit, enter the reference number assigned by the TPL Unit. The format of this number is TPL + Member ID Number + Carrier Code with no hyphens between the three elements.

4. When completed, click OK.