Objective	Completing a MN–ITS Professional (837P) claim with ICF-DD variable rate charges
Performed by	MN–ITS Interactive Users
Background	This User Guide lists which MN-ITS fields you must complete when requesting MHCP reimbursement for ICF-DD with variable rate charges
Claim Form	MN-ITS Professional (837P)

Using MN–ITS Interactive

- Complete all **bolded** (required) fields
- Complete other (non-bolded, situational) fields as appropriate for your claim
- Underlined items are linked to definitions and additional information, including completing a field, code definitions for fields, or instructional information
- Some fields are grouped together in boxes of associated information. Field titles with an asterisk (*) indicate that the information is situational. If you complete one asterisked field within a boxed section of a screen, you must complete all asterisked fields in that section of the screen
- MHCP requires only a limited number of claim attachments. Refer to Electronic Claim Attachments

Entering an Online Claim

1. Login to MN–ITS (refer to the Login process, if necessary).
2. From the left menu:
   - Select MN–ITS
   - Select Submit Interactive Claims (837)
   - Select Professional (837P)
3. The MN-ITS Interactive Professional claim contains the following five tabs:
   - Subscriber
   - Providers
   - COB
   - Claim Information
   - Services

Completing the Subscriber Tab

1. Enter recipient (member) information on the Subscriber tab.
2. Enter the 8 digit member number for the recipient's MHCP identification card in the **Subscriber ID** field.
3. Enter the recipient's birth date in the **Birth Date** field. The birth date must match the birth date on the MHCP file. The format for entering the birth date is 2-digit month, 2-digit day, and 4-digit year (MMDDYYYY).
4. Enter the recipient's last name in the **Last Name** field.
5. Enter the recipient's first name in the **First Name** field.
6. Click the down-arrow in the **Gender** field to select appropriate option.
7. Enter the recipient's street address in the **Address** field.
8. Enter the city/town where the recipient lives in the **City** field.
9. Enter the state where the recipient resides in the **State** field (this should be "MN").
10. Enter the recipient's zip code in the **Zip Code** field.
    The Address, City, State and Zip Code fields can be the recipient's current address, last known address or Post Office box. The zip code must be a valid zip code.

Select the Providers tab.

Completing the Providers Tab

This tab contains two main sections:

1. **Billing Provider**
   MN–ITS Interactive auto-populates the required fields in the Billing Provider section with data on file. The Address fields auto-populate information in either Line 1, Line 2 or both. If you see the LOOK UP button, refer to the 837P Consolidated Provider user guide for further instructions.
2. **Other Provider Type**
   ICF-DD Providers billing variable rates do not need to complete the OTHER PROVIDER TYPES section.

Complete all other fields as needed and select the COB tab.

Completing the COB Tab

When no other payers exist, proceed to the Claim Information tab.

The COB tab requires information about third party liability (TPL) or other. You will need the EOB (explanation of benefits) from the TPL/other payer to complete this tab.

For additional assistance completing the COB tab refer to the COB Field Completion Guide to determine the minimum required fields for each payer type, or click on COB Help in the upper right hand corner of the COB tab and a pop up screen will display with additional information and a link to the COB Field Completion Guide.

When reporting TPL or other insurance coverage in addition to MHCP

1. Enter the name of the payer or other insurance in the **Payer Name** field.

2. Enter the carrier ID of the TPL or other insurance in the **Primary ID** field**.** This information is provided on the MN-ITS Interactive Eligibility Response (271 transaction).
3. Scroll down to the **PAID AMOUNTS** section on the left hand side of the screen.
   a. Click the drop down arrow in the **Type** field and select **Payer Amount Paid**.
   b. Enter the total amount paid by the other payer in the **Amount** field, even if the other payer paid $0.00.
   c. Click the **A** button to add the information, which will appear in the third field. Scroll down to the **Claim Adjustment Amounts** section to report all adjustments made to your submitted charge.

      Note: If the EOB you received from the other insurance does not supply HIPAA compliant group or reason codes, go to the Washington Publishing Company to determine the most appropriate codes to enter on this claim.
4. Click the down arrow in the **Group Code** field to select the claim level adjustment type. Claim level adjustment types include:
   - CO (Contractual obligation)
   - CR (Corrections and reversals)
   - OA (Other adjustments)
   - PI (Payer-initiated reductions)
   - PR (Patient responsibility)

Refer to the Billing Policy section of the MHCP Provider Manual for different methods of submitting contractual obligations or reduced rates.

   a. Enter the appropriate HIPAA compliant reason code in the **Reason Code** field.
   b. Enter the dollar amount of the adjustment (using a decimal point) in the **Amount** field.
   c. Click the **A** button to add the adjustment amount to the claim.
   d Repeat steps a-d until all adjustments are added.

Scroll down to the **OTHER PAYER SUBSCRIBER** section. This section is specific to the person who actually holds the insurance policy. Complete all asterisked (*) fields in the OTHER PAYER SUBSCRIBER information.

1. Enter the identification number of the policy holder for this insurance in the **Insured ID** field.
2. Enter the policy holder's birth date in the **Birth Date** field. The birth date must match the birth date on the MHCP file. The format for entering the birth date is 2-digit month, 2-digit day, and 4-digit year (MMDDYYYY).
3. Enter the policy holder's last name in the **Last Name** field.
4. Click the down arrow in the **Insurance Type** field to select the appropriate insurance type. (Click the field title to display the codes with corresponding definitions).
5. Click the down arrow in the Insured **Gender** field to indicate the policy holder's gender.
6. Click the down arrow in the **Relationship** field to select "18" for self or the correct code to indicate the relationship of the recipient of this service to the policyholder.
7. Click the **Benefits Assignment** field to indicate a yes/no response that a third party payer authorization is on file in your office allowing you to bill for the recipient.

8. Enter the appropriate code in the **Release of Information** field to indicate whether or not you have a release of information on file from the recipient.
9. The **Payer Responsibility** field identifies the insurance carrier's level of responsibility for payment of the claim. Click the down arrow to select the appropriate response: primary, secondary or tertiary.
10. Click the down arrow in the **Claim Filing Indicator** field to select the appropriate code for the type of insurance coverage being reported.
11. Complete the remaining fields in this section if the information is available.
12. Move to the top of the screen and review to ensure you have completed all required fields.
13. Click the **Save** button located near the top of the COB tab to save the information that appears next to the blue dot.

    Note: If reporting more than one TPL or other insurance, click on **New** and repeat steps.

Select the 

tab to continue.

Completing the Claim Information Tab

The Claim Information tab contains claim level information. Many of the required fields on this tab are defaulted to the most common responses. The **Total Submitted Charges** field is displayed but cannot be altered. That field will populate after you enter the line information on the Services tab.

1. The **Place of Service** field is defaulted to 11 (office) and can be changed as needed to reflect the most appropriate Place of Service code that applies to the claim (click the down arrow and select the appropriate code).
2. Enter the unique 1-38 character alpha/numeric code you assign to this claim in the **Patient Account Number** field of the same name. This number will appear on your RA.
3. The following are required fields with generally accepted defaults. Review each defaulted section for accuracy and adjust as needed.
   a. **Medicare Assignment** field indicates whether or not you accept assignment. The default is Option A, because MHCP requires you to accept assignment.
   b. **Submission Code** indicates if you are filing an original (1) or replacement (7) claim. The default is 1 – original.
   c. **Benefits Assignment** field indicates whether or not you have a third party payer authorization on file allowing you to bill for the recipient. The default is Yes.
   d. **Release of Information** field indicates whether or not you have a release of information on file from the recipient. The default is A for appropriate release of information is on file.
   e. **Provider Signature** on File field indicates whether or not you have a signature on file acknowledging the performance of the service and authorizing you to bill for those services. The default is Yes.
4. Enter the highest level of specificity ICD-CM-9 code in the **Diagnosis Code** field.
5. Click the **A** button to add the diagnosis code. Codes will not be visible unless you click the down arrow in the second diagnosis code field to see your entry.
6. Add any additional diagnosis codes in order of importance, up to eight diagnosis codes.

7. Enter the service agreement or authorization number in the **Authorization Number** field, as appropriate.
8. The **Claim Notes** field is situational. Use this field only when required for claim adjudication to report claim information about the product or service provided for the entire claim (up to 80 characters.)

9. When a claim requires an attachment:

   a. Enter the **Attachment Control Number**
   b. Click the drop down arrow in the **Type** field and select the appropriate type.
   c. Click the **A** button to add the information, which will appear in the box below.
   d. Repeat steps a-c to report additional attachments you are submitting with this claim.

Select the 

tab.

Completing the Services Tab

The Services tab contains the line item information.

1. Enter the actual date services were provided in the **From Date** field in MMDDYYYY format. The To Date is only required if you are billing consecutive days. You may bill only for services provided within the same calendar month.
2. Complete the **Place of Service** field on the service line to indicate a different place of service than indicated on the Claim information tab.
3. Enter the appropriate code in the **Procedure** field.
4. Enter the appropriate modifiers when necessary in the **Modifiers** field. If you have a service agreement or authorization, the modifiers on the service line must match your service agreement or authorization.
4. Complete the **Diagnosis Pointers** field by relating the diagnosis to the procedure code with a Diagnosis Pointer when appropriate. This enables MN–ITS to read the diagnosis code that was entered on the Claim Information tab. The Diagnosis pointer reflects the order of the diagnosis codes on the Claim Information tab. If you entered multiple codes, select the appropriate pointer here. You may have more than one Diagnosis Pointer per entry. Enter the most relevant diagnosis first in the Diagnosis Pointers field.

   a. Click the down-arrow in the Diagnosis Pointers field.
   b. Select the appropriate pointer number (1-8).
   c. Click the A button to add the pointer number. The pointer number is not visible unless you select the down arrow in the second Diagnosis Pointer field.

6. Enter the total dollar amount you are billing for this month in the **Charge** field. The decimal point will right-justify after the number you enter. For example, if you enter “10” the charge would be $10.00; if you enter 1000 the charge would be $1,000.
7. Enter the number of units charged in the first **Units** field just below the field title. For variable rate charges you should enter 1 here.
8. Move to the top of the screen and review this tab to ensure that you have completed all required fields.

9. Click the **Save** button to save the line item. Saved line information is visible next to the blue dot (P1). You may enter a maximum of 50 lines of service per professional claim transaction.
    - To add additional lines: click the New button to add an additional line (P2) and clear the fields on the screen
    - To delete a line: select the line to be deleted and click the Delete button. The line item next to the blue dot will delete.
10. Repeat Steps 1 – 9 for each item you wish to bill on this claim.

Validating and Submitting Your Claim

Validate your claim after completing the necessary tabs to:

- Ensure that you have completed all required HIPAA-compliant fields
- Verify with DHS that your claim information will be submitted and returned to you with the appropriate edits

To Validate Your Claim

1. Click the **Validate** button.
2. Review the validate response to ensure the claim information is correct. Check the Claim Status Category Codes and Claim Status Codes for edits, which will determine if any corrections may be needed.
3. Close the validate response and make any necessary changes based on your validation response and click on Save.
4. If you made changes, click the Validate button again for your new validate response. Repeat the above steps as necessary.

To Submit Your Claim to DHS

1. Close the validate response.
2. Click the **Submit** button. Within seconds, you will receive a Claim Response similar to the Validate with the claims Payer Claim Control (PCN) number at the top.

Your claim is now complete. You have the option of copying the claim, beginning a new claim or logging out of MN–ITS.

Copying a Claim

After you submit a claim, you may choose to copy a portion or an entire claim. This can save you time if you have multiple claims for the same individual or the same claim for multiple recipients.

1. Click the **Copy Claim** button from the Claim Detail or Claim Response screen.
2. Select the appropriate button to select which screens you want to copy. You may choose all tab screens or individual tab screens to copy.
3. Click the **Submit** button at the bottom of the Copy Claim Options screen to return to the Subscriber tab to begin your next claim.
4. Complete all updates to the claim, then repeat the validate and submit process.