



Objective	Completing a MN-ITS Interactive Dental (837D) claim
Performed by	MN-ITS Interactive users with a Consolidated NPI
Background	This User Guide lists which MN-ITS Interactive fields you must complete when requesting MHCP reimbursement for Dental services.
Claim Form	MN-ITS Interactive Dental (837D)

Effective January 2, 2012, MN-ITS screens will reflect 5010 compliant field values. Non-compliant field values and certain sections of the screens have been removed. Continue to complete all bolded fields when completing the transaction.

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 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
- MHCP requires only a limited number of claim attachments. Refer to [Electronic Claim Attachments](#) for detailed instructions

Entering an Online Claim

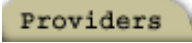
1. Log in to MN-ITS.
2. Select MN-ITS from the left-hand menu.
3. Select **Submit Interactive Claims** (837) on the left-hand menu to display the claim options menu.
4. Select Dental (837D)

The MN-ITS Interactive Dental claim contains the following five tabs:

- Subscriber
- Providers
- COB
- Claim Information
- Services

Completing the Subscriber Tab

1. Enter recipient (member) information on the  tab.

2. Enter the member number from 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. Select 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 lives 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.
11. Select the  tab.

Completing the Providers Tab

This tab contains your organization's provider information in two main sections:

- **BILLING PROVIDER:**

- Select the **LOOK UP** button to select the appropriate location and taxonomy code
- Select the **Show Taxonomy** link in the right column of the selected location. The circle will be auto selected for the location chosen.
- If the location contains more than one taxonomy code, select on the drop-down window and select the appropriate taxonomy code or description. **Note:** Not all providers will need to select a taxonomy. Only providers where the address information is the same will require a taxonomy to be selected
- Select the **Submit** button in the upper left hand corner of the pop-up screen. MN-ITS Interactive will auto-populate the required fields in the billing provider section

- **OTHER PROVIDER TYPES:**

Information from the OTHER PROVIDER TYPES section of the Providers tab is used to populate fields on the Claim Information and/or Services tabs. Dental providers must enter *rendering provider* information on all claims. To do this:

Scroll down to the **OTHER PROVIDER TYPES** section of the Providers tab.

1. Select **Rendering** from the **Provider Type** drop-down menu.
2. Enter the NPI for the rendering provider in the appropriate field.
3. After you tab out of the NPI field MN-ITS auto-populates the provider information for the entered NPI or UMPI. The auto-populated information in the Address field will appear in Line 1, Line 2 or both fields. The provider information will immediately appear to the right of the blue dot.

4. Verify the name and location of the other provider. (If the provider works from several locations the address may be different. This will not cause the claim to deny).
5. Select the **Save** button located at the top of the OTHER PROVIDER TYPES section to save the rendering provider information. If you do not save this information, it will be lost.

Adding Additional Entries

Select the **New** button to clear the fields and add additional other provider type information.

When you save the second entry, the blue dot will move to the second line and an underlined **P1** displays next to the first line of information.

If you enter a third other provider type, the blue dot moves down and the second entry displays an underlined P2 next to the second line of information. This process continues for each additional entry.

Deleting Entries

Select on the number of the line you want to delete. The blue dot will move to that line. Verify this is the information you want to delete, and then select the Delete button.

Complete all other fields as needed and select the  tab.

Completing the COB Tab

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

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

For additional assistance completing the COB tab refer to the 837D Dental Column of the [COB Field Completion Guide](#) to determine the minimum required fields for each payer type, or select 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. Select 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. Select 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. Select 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)

Note: The total paid amount, contractual obligation (CO) and patient responsibility (PR) must equal the usual and customary (U&C) total charge entered on the services tab for the claim to balance. The CO is no longer added to the paid amount, the claim is adjudicated using prorated amounts over all of the lines.

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. Select 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. Select the down arrow in the **Insurance Type** field to select the appropriate insurance type. (Select the field title to display the codes with corresponding definitions).
5. Select the down arrow in the Insured **Gender** field to indicate the policy holder’s gender.
6. Select 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. Select 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.

New value:	W–Not applicable, use when patient refused to assign benefits
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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. Select the down arrow in the **Claim Filing Indicator** field to select the appropriate code for the type of insurance coverage being reported.

New values:	AM–Automobile Medical 17–Dental Maintenance Organization FI– Federal Employees Program
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10. The **Payer Responsibility** field identifies the insurance carrier’s level of responsibility for payment of the claim. Select the down arrow to select the appropriate response: primary, secondary or tertiary.

New values:	A–Payer Responsibility Four B–Payer Responsibility Five C–Payer Responsibility Six D–Payer Responsibility Seven E–Payer Responsibility Eight F–Payer Responsibility Nine G–Payer Responsibility Ten H–Payer Responsibility Eleven U–Unknown
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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. Select 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, select on **New** and repeat steps.

Select the **Claim Information** 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 and cannot be altered. This field will populate after the submitted charge is entered on the Services tab.

1. The **Place of Service** field defaults to 11 (office) and can be changed as needed to reflect the appropriate Place of Service code that applies to the claim (select the down arrow and select the appropriate code). If you will be reporting multiple line items with different places of service, change the place of service code for a line item on the Services tab (select the down arrow and select the appropriate code).

New values:	01–Pharmacy 13–Assisted Living Facility 14–Group Home 16–Temporary Lodging 17–Walk–in Retail Health Clinic 49–Independent Clinic 57–Non Res Substance Abuse Facility
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2. Enter the date of service in the **Service Date** field. If there are multiple dates on the claim, enter the first date of service here. Additional dates may be added on the Services tab.

3. 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.
4. 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. Most dental providers select C to indicate that you do not accept assignment as most dental services are not covered by Medicare.
 - b. **Submission Code** indicates if you are filing an original (1) or replacement (7) claim. The default is 1 – original.
Note: If using a 7 or 8 submission code, you must enter your original payer claim number that you wish to replace or void in the **Original Reference Number** field.
 - 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.
Note: If using a 7 or 8 submission code, you must enter your original payer claim number that you wish to replace or void in the **Original Reference Number** field.
 - d. **Release of Information** field indicates whether or not you have a release of information on file from the recipient. The default is N. Enter the indicator that represents the appropriate release of information you have 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.
5. Additional fields may need to be completed for orthodontic services, or claims related to an accident.
6. Enter the prior authorization number in the **Authorization Number** field, as appropriate.
7. [When a claim requires an attachment:](#)
 - a. Enter the **Attachment Control Number**
 - b. Select the drop down arrow in the **Type field** and select the appropriate type.
 - c. Select 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.
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. Scroll down to the **CLAIM LEVEL PROVIDERS** section to add the rendering provider information to the entire claim.
10. Select the down-arrow in the **Rendering** field to select the rendering provider entered in the Other Provider Types field of the Provider tab.
11. Select on the name of the **Rendering** provider from the drop down list to report only one provider for all services on this claim.
Note: If reporting more than one rendering provider, you may select this information on the Services tab to report a specific rendering provider for each line item.

Select the **Services** tab.

Completing the Services Tab

The Services tab contains line item information.

1. Only enter the actual date service if different than the date entered on the Claims Information tab in the **Service Date** field in MMDDYYYY format. 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 CDT 2007 – 2008 code in the **Procedure** field.
4. Dental Providers do not currently use the **Modifiers** field.
5. Enter the number of units as “1” in the **Count** field. Only language interpreter services HCPCS code T1013 (15 minute interval) allows multiple units.
6. Enter the dollar amount for the line item in the **Charge** field. Multiply your usual and customary charge by the number of units if billing for multiple language interpreter service units. 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 \$1,000.00.
7. Complete the other fields if it is required by the procedure code entered in the service line.
 - TOOTH INFORMATION section:
 - Select the tooth number and all surfaces that pertain to the service
 - Select A to add this information to the field below
 - Placement Status: on dentures and partials
 - Oral Cavity Designation: on periodontal services only
 - Additional Dates: on dentures, partials, and orthodontics

New values:	Treatment Start and Treatment Completion. These fields are not used to adjudicate claims.
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8. When required, enter a statement of clarification for the line item in the **Notes** field (up to 80 characters).
9. If you are reporting more than one rendering provider on this claim, scroll down to the bottom of this tab to **Service Level Providers**:
 - a. Select the down-arrow of the **Rendering** provider field to display the list of rendering providers reported in the OTHER PROVIDER TYPES section of the Provider tab.
 - b. Select on the correct last name of the rendering provider for this line item so that name displays in the Rendering field.
 - c. Scroll back to the top of the screen and review to ensure you completed all required fields.
10. Select 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 dental claim transaction.
 - To add additional lines: Select 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 select the Delete button. The line item next to the blue dot will delete

11. Repeat Steps 1 – 10 for each line item you wish to bill for on this claim.

Validating and Submitting Your Claim

Validate your claim after completing the necessary tabs to:

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

To Validate Your Claim

1. Select 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 at the claim and service line levels to determine if any corrections are needed. Select on the underlined words Claim Status and Claim Status Category for definitions of the HIPAA compliant codes on the WPC Web site.
3. Close the validate response and make any necessary changes based on your validation response and select Save.
4. If you made changes, select 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. Select 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. Select the **Copy Claim** button from the Claim Detail or Claim Response screen.
2. Select the appropriate button to choose the screens you want to copy. You may choose all tab screens or individual tab screens to copy.
3. Select the **Submit button** at the bottom of the Copy Claim Options screen to return to the Subscriber tab to begin the next claim.
4. Complete all updates to the claim and select validate and review for errors before submitting the claim.