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## **Medicaid Management Information Systems**

*Maine Integrated Health Management Solution*

*Health PAS Online: Dental Claim Submission*

*and Claim Status User Guide*

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## 1. Introduction

Using My Health PAS Online, MaineCare providers can quickly and easily enter professional, institutional, and dental claims. This guide will walk you through the process of entering a dental claim and modifying it as necessary.

***HINT:** If you are not already a registered Trading Partner, click this link to the Trading Partner User Guides for more information:*

<https://mainecare.maine.gov/Trading%20Partner%20Guides/Forms/Publication.aspx>

## 2. Information You Will Need

Before you begin the claims submission process, it will be useful to have the following information, forms, and other documents on hand:

- Verify that the recipient is eligible on the date of service for the services rendered.
- Medicaid is always the payer of last resort. If the member has Medicare or third party insurance, bill them first before billing Medicaid.
- Gather complete member, provider, and service information associated with the claim.

## 3. System Requirements

To successfully use all features of the Health PAS Online Portal, ensure that your computer system meets the following minimum requirements:

- Reliable online connection
- Web browser- The latest version of Microsoft Internet Explorer is recommended. As versions of Internet Explorer become available, it is recommended that these versions are used.
- The latest version of Adobe Acrobat Reader

## 4. Form Entry: Claim Submission

To begin a claim submission, click the **Claim Submission** link located below the Form Entry heading on the portal links, as shown in Figure 4-1: Claim Submission. Now the Submit Claim– Find Member screen will display.

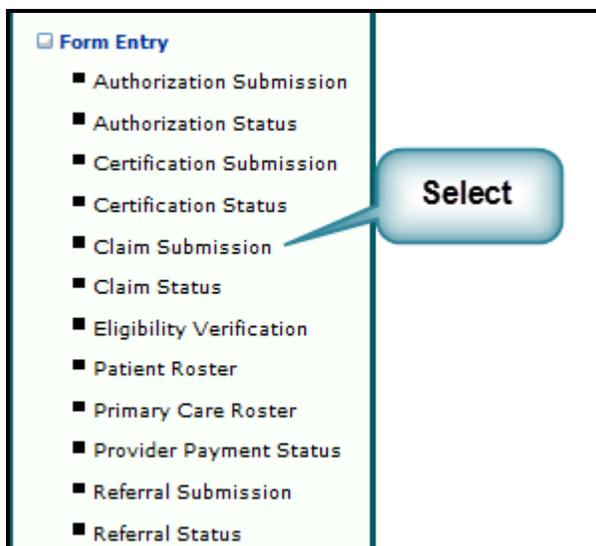


Figure 4-1: Claim Submission

The **Submit Claim** button is also available directly from the Eligibility Verification, Patient Roster, and Primary Care Roster screens.

The Submit Claim function uses a wizard to guide you through the steps of the process. The wizard starts with Find Member.

#### 4.1 Step 1– Find Member

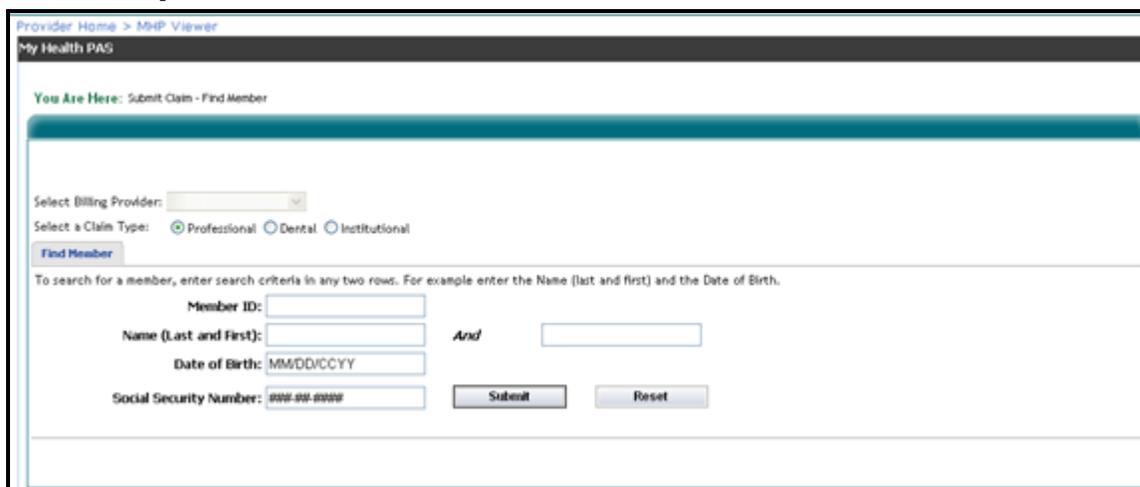


Figure 4-2: Find Member

Use the instructions below to execute a member search associated with a claim submission.

1. If there is more than one **Billing Provider** associated with the Trading Partner ID, click the drop-down menu to select the proper Billing Provider from the pre-determined list. An example of the Select Billing Provider drop-down is shown in Figure 4-3: Select Billing Provider.



Figure 4-3: Billing Provider

1. Select the proper claim type by clicking the radio button next to the “Dental” option.
2. Enter member search criteria. Two of the four available search criteria fields must be filled for a successful member search:
  - Member ID
  - Name (Last and First)
  - Date of Birth
  - Social Security Number

**Additional details on entering search criteria for the member search:**

- The **Last Name** and **First Name** count as one search criterion.
  - On the search screen, enter the Last Name in the first field and the First Name in the second field. See Figure 4-2: Find Member.
  - Names must match exactly for the first five (5) letters of the last name and the first three (3) letters of the first name.

***HINT:** If no match is found, try less criteria. For example: Jane Example-Member could be entered as Examp for the last name and Jan as the first name. Alternatively, do not use the name criteria, but MaineCare ID and Date of Birth.*

- The **Date of Birth** must be entered in the MM/DD/CCYY format.
  - For example, February 14<sup>th</sup>, 2008 would be entered as “02/14/2008”.
- The **Social Security Number** should be entered without any dashes.

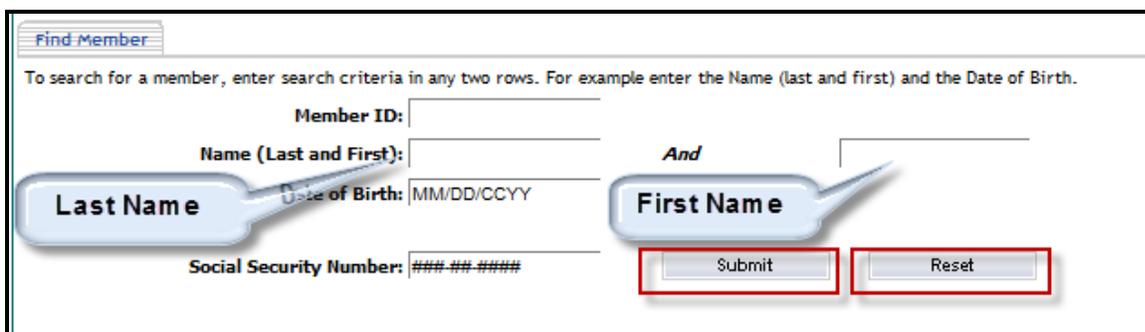


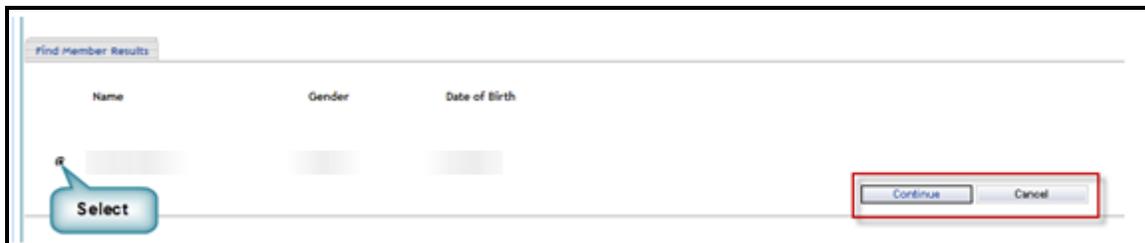
Figure 4-4: Member Search

3. Select the **Submit** button to perform your search.
  - a. To start your search over, select the **Reset** button to clear all the values entered in the Find Member search fields. See Figure 4-4: Member Search.

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4. The search results are returned under the Find Member Results tab, as depicted in Figure 4-5: Member Search Results. The results will include a list of all the members that meet the search criteria. It will display their Name, Gender, and Date of Birth.
  - a. **If your search returns multiple results**, select the correct member by clicking the checkbox in front of that member's name as shown in Figure 4-5: Member Search Results. Click **Continue**.
  - b. **If the member is not returned in the search**, click the **Cancel** button to reset and clear all the values entered in the find member search. Try your search again. See the hint under Step 3.



**Figure 4-5: Member Search Results**

## 4.2 Step 2 – Dental Claim Submission

The Dental claim type is used to submit claims rendered by dental providers (ADA2006). There are four different parts to this claim, as shown in Figure 4-6: Dental Claim: **Claim Information**, **Diagnosis**, **Services**, and **Additional Information**.

Enter information in the fields provided below and click the Submit button.

**Claim Information**

Billing Provider: [text field]  
Member Name: [text field] Patient Account #: [text field]  
Date of Birth: [text field] Medical Record #: [text field]  
Member ID: [text field] EPSDT/Title XXX:  YES  NO  
Referring Provider: [text field]  
Rendering Provider: [dropdown menu]  
Service Location: [dropdown menu]

**Diagnosis**

Code Version:  ICD-9  ICD-10 CMS claims guidelines for implementing ICD-10  
**NOTE: Diagnosis code entry is optional.**

Line #	Code	Description	Type	ICD Version
1				

**Services**

Line#	DOS From	DOS To	Place of Service	Code	Related Diagnosis	Tooth	Area	Surface	Quantity	Fee	Auth #	Rendering Provider
1												

Service Code Description: [text field] Total: 50.0 Units: 0

**Additional Information**

Is Patient Condition Related To:  
 Employment  Auto Accident  Other Accident  
State: [dropdown menu]  
Date of Accident: [text field]  
Miscellaneous  
 Is Orthodontics  
Date Appliance Placed: [text field] No. of Months Remaining: [text field]  
 Initial Prosthesis  
Prior Prosthesis Date: [text field]

Figure 4-6: Dental Claim

Input fields with a red asterisk (\*) are required. An error message will be displayed if these values are left blank.

**NOTE:** Always tab through fields on a single line (such as in the Services Section) to ensure proper completion.

Proceed through the sections below to complete this screen:

### 4.2.1 Complete the Claim Information Section

**Figure 4-7: Dental Claim Information Section**

Figure 4-7: Dental Claim Information Section shows the fields for the Claim Information section for Direct Data Entry (DDE) Dental Claims.

Table 1: Claim Information supplies descriptions and instructions for to each field. Use it to complete this section:

**Table 1: Claim Information**

Field Name	Field Description
<b>Referring Provider</b>	<b>Not required.</b> Leave this field blank.
<b>Rendering Provider</b>	<b>This field is required.</b>  Enter the rendering provider by selecting the drop-down arrow and clicking on the appropriate option.  The drop-down selection for this field will show a list of providers if there is more than one rendering provider option.
<b>Service Location</b>	<b>This field is required if the provider is enrolled with more than one service location.</b>  Enter the billing provider service location by selecting the drop-down arrow and clicking on the appropriate option.  The drop-down selection for this field will show a list of locations if the provider has more than one service location.
<b>Patient Account #</b>	<b>This field is required.</b>  The alpha numeric information assigned by the Provider that is returned on any Remittance Advice (RA).
<b>Medical Record #</b>	The alpha numeric information assigned by the Provider.

## 4.2.2 Complete the Diagnosis Section

Diagnosis code entry for dental claims is optional. If desired, populate the Diagnosis section by utilizing the search function, or by entering the correct diagnosis code in the code section. See Figure 4-8: Diagnosis Section. For more information on utilizing the search function, see Section 4.2.3.1: CDT or Diagnosis Search Function.

**NOTE:** Effective on 10/1/2015, providers will be able to enter both ICD-9 and ICD-10 based claims. The following changes to the portal will be available:

- ICD-9 and ICD-10 radio buttons will be provided in diagnosis code session. Selection of one radio button will be required to differentiate between ICD-9 and ICD-10 based claims. A diagnosis code cannot be entered before one of the ICD radio buttons is selected. After a diagnosis code is entered, the ICD radio button selection cannot be changed.
- A link called 'CMS Claims Guidelines for Implementing ICD-10' will be available to the right of the ICD radio button selection if additional ICD-10 information is needed.

Line #	Code	Description	Type	ICD Version
1				

**Figure 4-8: Diagnosis Section**

**Note:** Claims for procedure code D4341:

- must have a diagnosis for patients whose diagnosis is ICD-9 code 101 (ANUG) or ICD-10 code A69.0 (necrotizing ulcerative stomatitis) or A69.1 (other Vincent's infections).
- For patients who have no ICD-9 code 101 or ICD-10 code A69.0 or A69.1 diagnosis, claims for this procedure code require Prior Authorization.

**NOTE:** Effective on October 1, 2015, the Code ID displayed in the search field will be based on the ICD-radio button selection made as part of the steps listed in section 4.2.2. For example, if a user chose the ICD-10 radio button, only ICD-10 codes will display in the Code ID field.

### 4.2.3 Complete the Services Section

Complete the Services Section as depicted in Figure 4-9: Dental Services Section.

**Figure 4-9: Dental Services Section**

This section of the claims screen is used to enter all the Services rendered to the member that will be included in the claim submission. Modifiers are not used for dental claim submissions. The fields and links associated with this section are summarized in Table 2: Service Line Detail:

***NOTE:** Additional information on covered services can be found in the MaineCare Benefits Manual.*

*If a member has a coverage code of “Spend Down”, the Spend Down letter must be obtained and attached to the claim. Please see Section 4.3.4: Upload Attachments for more information. Spend Down claims are entered via Direct Data Entry (DDE) according to the usual Dental Claim entry instructions in this guide in Section 4: Form Entry: Claim Submission.*

**Table 2: Service Line Detail**

Field Name	Field Description
	Click this icon to delete a service line.
<b>Line #</b>	This is a system-generated field used to number each service line added by the user.  To add a new service line, hit tab at the end of the last line and a new line will appear.
<b>DOS From/DOS To</b>	<b>This field is required.</b>  Enter the beginning and ending dates of the period in which the service was provided.  Dates must be entered in MM/DD/CCYY format. For example, February 14 <sup>th</sup> , 2008 would be entered as “02/14/2008”.
<b>Place of Service</b>	<b>This field is required.</b>  Identify the location for each item used or service performed using one of the following place of service codes: <ul style="list-style-type: none"> <li>• 11– Office</li> <li>• 22– Hospital</li> <li>• 31– Skilled Nursing Facility</li> <li>• 99– Other</li> </ul>

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Field Name	Field Description
<b>Code</b>	<p><b>This field is required.</b></p> <p>Enter the CDT code for the service in this field if known. If not known, use the  link to perform a code search as described in Section 4.2.3.1: CDT or Diagnosis Search Function.</p> <p><b>Note:</b> Claims with anesthesia services beyond 45 minutes may list each additional 15 minutes distinctly during claim entry.</p>
<b>Related Diagnosis</b>	<p><b>This field is optional.</b></p> <p>Enter the Related Diagnosis code in this field if known.</p>
<b>Tooth</b>	<p><b>This field is required if the procedure directly involves a tooth.</b></p> <p>Entry must be no more than two (2) characters.</p> <p>Enter the tooth number (1–32 for permanent teeth) or the tooth letter (A–T for primary teeth).</p> <p><b>NOTE:</b> For tooth numbers 1–9, do not put a zero before the tooth number.</p> <p>For supernumerary tooth designation, use the following:</p> <ul style="list-style-type: none"> <li>• <b>Permanent dentition:</b> Supernumerary teeth are identified by the numbers 51–82 (add 50 to each tooth number). <i>Example:</i> Tooth 32 would be entered as supernumerary tooth “82”</li> <li>• <b>Primary dentition:</b> For supernumerary teeth (A–T), place the letter S after the letter of the primary tooth. <i>Examples:</i> tooth A would be entered as “AS”. Tooth Q would be entered as “QS”.</li> </ul>

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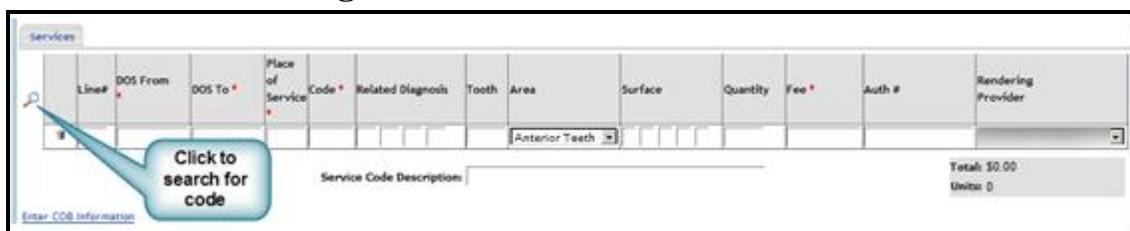
Field Name	Field Description
<b>Area</b>	<p><b>This field is required if the procedure is related to the oral cavity.</b></p> <p>Indicate the area of the procedure by selecting one of the options from the drop-down:</p> <ul style="list-style-type: none"> <li>• Anterior Teeth- Permanent</li> <li>• Anterior Teeth- Primary</li> <li>• Left Hemisphere</li> <li>• Lower (paper claim option listed as Mandibular Arch)</li> <li>• Lower Left (paper claim option listed as Lower Left Quadrant)</li> <li>• Lower Right (paper claim option listed as Lower Right Quadrant)</li> <li>• Oral Cavity</li> <li>• Permanent Teeth</li> <li>• Primary Teeth</li> <li>• Right Hemisphere</li> <li>• Upper (paper claim option listed as Maxillary Arch)</li> <li>• Upper Left (paper claim option listed as Upper Left Quadrant)</li> <li>• Upper Right (paper claim option listed as Upper Right Quadrant)</li> </ul>
<b>Surface</b>	<p><b>This field is required if the procedure directly involves one or more tooth surfaces (e.g. restorations).</b></p> <p>Enter the appropriate letter indicating the surface of the tooth that was restored:</p> <ul style="list-style-type: none"> <li>• O: occlusal</li> <li>• M: mesial</li> <li>• D: distal</li> <li>• B: buccal</li> <li>• L: lingual</li> <li>• F: facial</li> <li>• I: incisal</li> </ul>
<b>Quantity</b>	<p><b>This field will automatically populate and may be changed.</b></p> <p>Enter the number of units billed for the service.</p>
<b>Fee</b>	<p><b>This field is required.</b></p> <p>Enter the total dollar amount charged for the service.</p> <p>The system will add the dollar sign (\$) and will assume 2 decimal places unless specifically entered by the user.</p>

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Field Name	Field Description
<b>Auth #</b>	Enter the prior authorization number, if applicable. Required for services where multiple prior authorizations exist for the same date, service, member and provider.
<b>Rendering Provider</b>	<b>This field will automatically populate and may be changed.</b> This field captures the provider that rendered the service for which the claim is being submitted. Select the provider that performed the service by clicking the drop-down menu and making a selection from the list.
<b>Service Code Description</b>	<b>This field will automatically populate.</b> Shows the description of the service code entered for the specified service line.
<b>Totals</b>	<b>This field will automatically populate.</b> This field displays the total charges from all service lines entered.
<b>Units</b>	<b>This field will automatically populate.</b> This field displays the total units/quantity from all service lines entered.

**NOTE:** When a service code is entered, the description will appear below in, *Current Dental Terminology*, in the **Service Code Description** box. The **Total Price** and **Total Units** will be totaled in the grey area next to the **Service Code Description** box. For location of Service Code Description box and location of Total Price and Total Units, see Figure 4-10: CDT Search Function Icon.

### 4.2.3.1 CDT or Diagnosis Search Function



**Figure 4-10: CDT Search Function Icon**

To search for a **Service Code** or **Diagnosis Code**, click the  button next to the **Line #**, as shown in Figure 4-10: CDT Search Function or Figure 4-11: Diagnosis Search Function Icon and a new search window will open.

**NOTE:** Effective on 10/01/2015, the Code ID displayed in the search field will be based on the ICD-radio button selection made as part of the steps listed in section [Error! Reference source not found.](#) For example, if a user chose the ICD-10 radio button, only ICD-10 codes will display in the Code ID field.

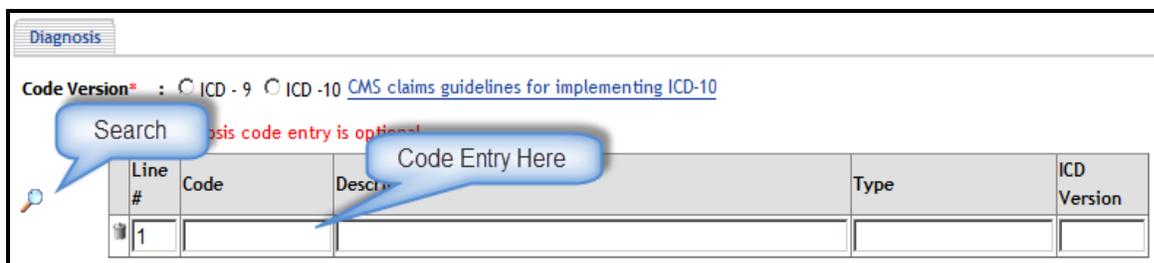


Figure 4-11: Diagnosis Search Function Icon

1. Enter any part of the description of the code in the **Description** field. Figure 4-12: CDT Search Function provides an example of the Search Function while searching for CDT codes.

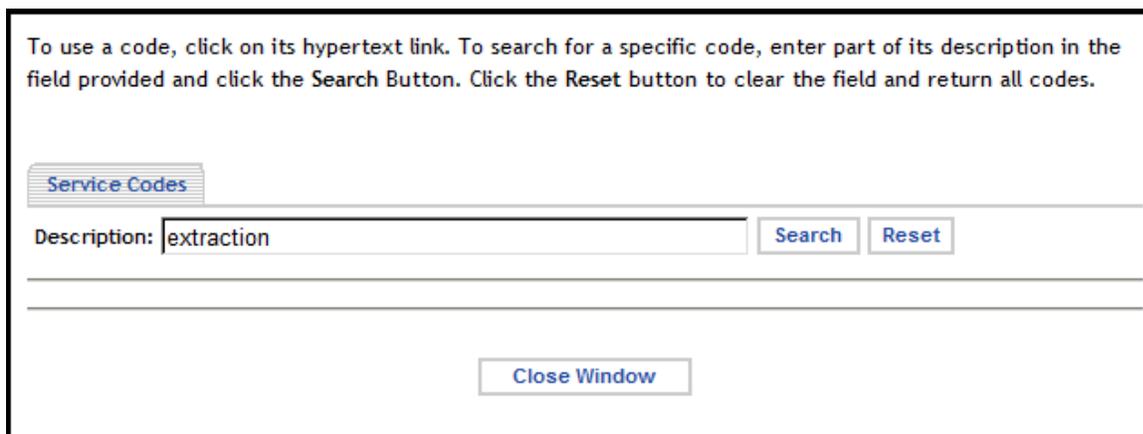


Figure 4-12: CDT Search Function

**HINT:** MIHMS will match exactly the sequence of characters entered in the search criteria. For example: If nothing is found for “periodontal disease” try just “periodontal”. Conversely, using just the word “tooth” may be too broad and result in a longer list.

2. Click the **Search** button to retrieve a list of results. The system will look for your entry regardless of where it falls in the description.
  - a. To start over, click the **Reset** button to clear the **Description** field.
3. The search will return a list of **Service Codes** or **Diagnosis Codes**, their **Descriptions**, and **Effective** and **Term Dates**. Single-click any **Service ID Code** or **Diagnosis Code** link to populate it to the appropriate field on the service line. Figure 4-13: CDT Search Function Results provides an example of selecting a Service Code.

**NOTE:** Clicking the CDT search icon shown in Figure 4-10: CDT Search Function Icon will only provide CDT search results. Clicking the Diagnosis search icon shown in Figure 4-11: Diagnosis Search Function Icon will only provide diagnosis search results.

Service Code	Description	Effective Date	Term Date
<a href="#">D9974</a>	Internal bleaching, per tooth	1/1/2000	
<a href="#">D9973</a>	External bleaching, per tooth	1/1/2000	
<a href="#">D9911</a>	App resin, per tooth	1/1/2000	
<a href="#">D7560</a>	Prep, rmv tooth fragment/FB	1/1/1982	
<a href="#">D7283</a>	Platilitate impacted tooth	1/1/2005	
<a href="#">D7282</a>	Mobilization, erupted/malposition tooth	1/1/2003	

**Click  
Code ID**

**Figure 4-13: CDT Search Function Results**

#### 4.2.4 Enter COB (Coordination of Benefits) Information

You may enter more information for the COB by selecting the **Enter COB Information** link below.

- The COB information may be entered either by Claim or by Service Line for any external totals to be applied as COB. Information must be entered at the Service Line level when available on the Explanation of Benefits (EOB). When possible, enter detail at the Line Level for more accurate claims processing. See Figure 4-14: COB Information by Service Line.

To enter COB information, select the Enter Method (by Claim or by Service Line); then enter the information in the fields provided.

**COB Information**

Enter External Totals to be applied as COB

Enter Commercial:  by Claim  by Service line

Line #/Total	Service Code	DOS	Allowed Amt	Paid Amt	Deductible Amt	Coinsurance Amt	Paid Date
Total Commercial							
1	D7320	09/20/2013-09/20/2013					

**Figure 4-14: COB Information by Service Line**

- The allowed amount should equal the sum of paid, deductible, and coinsurance amounts for TPL (Third Party Liability). The coinsurance amount will include copays.
- The Paid Date must be entered on the Coordination of Benefits screen when the claim is submitted as a secondary claim to MaineCare. Claims with no Paid Date will be denied.

**NOTE: Enter detail at the line level for more accurate claims processing.**

*If entering COB information, the **Paid Amt**, **Deductible Amt**, and **Coinsurance Amt** fields must be populated. If the paid, deductible, or coinsurance amount is \$0.00, enter a "0" or "0.00" into the field. The online portal will not allow the manual entry of the "\$" symbol when entering dollar amounts. Alternately, the provider may "tab through" the fields, and they will automatically populate with \$0.00.*

*When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.*

## 4.2.5 Complete the Additional Information Section

Complete the Additional Information section for the claim submission, shown in Figure 4-15: Dental Additional Information, if applicable. The Additional Information section is used to enter information related to any third party liability and orthodontic services associated with the claim.

**Additional Information**

**Is Patient Condition Related To**

Employment  Auto Accident  Other Accident

State:

Date of Accident:

**Complete if applicable**

**Miscellaneous**

Is Orthodontics

Date Appliance Placed:  No. of Months Remaining:

Initial Prosthesis

Prior Prosthesis Date:

**Submit**

Figure 4-15: Dental Additional Information

- If applicable, under the heading for **Is Patient Condition Related To**, select the check box next to the correct type of accident associated with the claim: **Employment**, **Auto Accident** or **Other Accident**. If a check box is selected, enter the two-letter abbreviation of the state in which the accident took place. Enter the date of the accident in eight-digit format (MM/DD/YYYY).
- If the claim is for orthodontic services, complete the fields under the heading for **Miscellaneous**. Select the **Is Orthodontics** check box and populate the **Date Appliance Placed** field and the **Number of Months Remaining** field.
- If the prosthetic device associated with the orthodontic claim is the initial device, select the check box next to **Initial Prosthesis**. If this check box is not checked, fill in the **Prior Prosthesis Date** field in eight-digit format (MM/DD/YYYY).

## 4.2.6 Submit the Claim

When all the claim information has been entered, click **Submit** to submit the claim. Any errors in your application will be indicated at the top of the page in red text and must be corrected before the claim can be submitted.

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate.

### 4.3 Step 3 – The Claim Wizard Confirmation Screen

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate as shown in Figure 4-16: Claim Confirmation Screen.



Figure 4-16: Claim Confirmation Screen

The **Claim ID** is automatically displayed on the confirmation screen. The Claim Wizard Confirmation screen also presents the following options:

- **Claim View:** Used to view a summary of the information that was entered into the claim (claim summary).
- **Adjudicate Claim:** Processes the submitted claim against the business rules to ready it for finalization.
- **Edit Claim:** Used to **change** claim information.
- **Upload Attachments:** Used to **attach** any **additional information** that is required to support the claim submission. Uploaded documents must be uniquely named. Without a unique name, the document will not overwrite another document of the same name; the result is the original attachment will now be inappropriately attached to the current claim.
  - Claims with COB information must have a corresponding EOB attached.
  - Spend Down letters should be attached for each claim where the member has a coverage code of “Spend Down” for that particular date of service. Please see Section 4.3.4: Upload Attachments for more information. *Note: Spend Down claims are entered via Direct Data Entry (DDE) according to the usual Dental Claim entry instructions in this guide in Section 4: Form Entry: Claim Submission.*
- **Print Attachment Cover Sheet:** Select to print a cover sheet for your attachment.
- **New Claim:** Used to create a new claim.

### 4.3.1 Claim View

Clicking the **Claim View** hyperlink reveals the original claim. Figure 4-17: Claim View is an example of a claim view:

Details for the selected claim appear below:

**Claim Summary:**

Claim Type: DENTAL      Status: OPEN

Claim #: [REDACTED]      Patient Account #: [REDACTED]

Member ID: [REDACTED]      Medical Record #: [REDACTED]

Member Name: [REDACTED]      Service Provider: [REDACTED]

Address: [REDACTED]      Pay To Provider: [REDACTED]

Dates of Service: [REDACTED]      Check #: [REDACTED]

Date Processed: [REDACTED]      Check Date: [REDACTED]

Service Location: [REDACTED]

**Reimbursement Detail:**

Claim Total: \$180.00	Copy Applied: \$0.00
Allowed Amt: \$0.00	Deductible Applied: \$0.00
Eligible Amt: \$0.00	Coinsurance Applied: \$0.00
Paid Amt: \$0.00	Disallowed: \$0.00
Interest Days: 0	Cost of Care: \$0.00
Withhold Amt: \$0.00	Adm Responsibility: \$0.00
Paid(net Withhold) Amt: \$0.00	Total Patient Responsibility: \$0.00
COB Allowed: \$180.00	
COB Paid: \$0.00	
Refund Amt: \$0.00	

**Diagnosis Codes:**

No Diagnosis codes were found for this claim.

**Services:**

Service Line	Dates of Service	Service Location	Billed Service	Approved Service	Billed Units	Billed Amount	Paid Amount	Detail
1	[REDACTED]	22	D7140	D7140	1.00	\$180.00	\$0.00	<a href="#">Details</a>

**Remittance Comments:**

No comments were found for this claim.

**Claim Edits:**

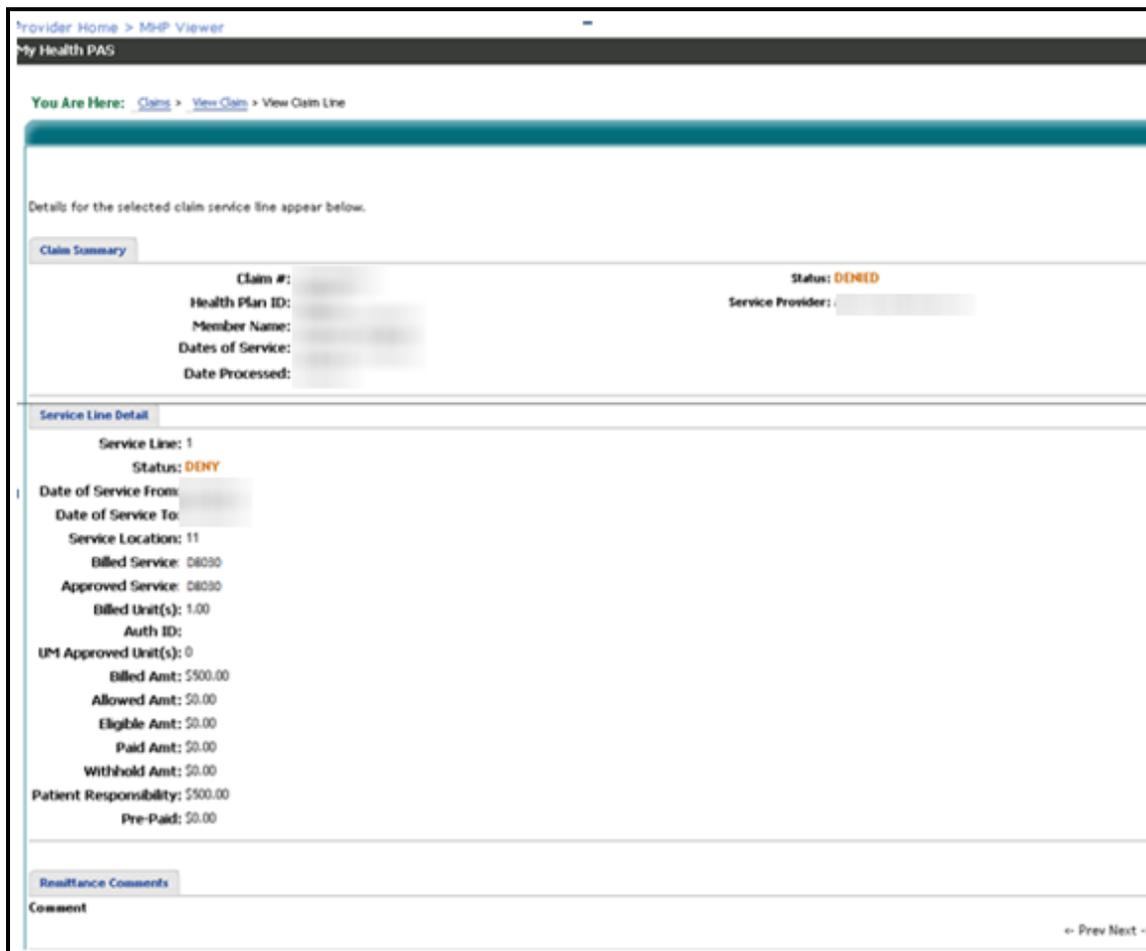
No Edits were found for this claim.

**Details Link**

Buttons at the bottom: [Return to Claim Status](#), [Adjustable Claims](#), [Reverse](#), [Add Attachments](#)

**Figure 4-17: Claim View**

View the details of a specific service line by clicking on the **Details** link at the end of that service line as shown in Figure 4-17: Claim View. An example of the service line detail is depicted in Figure 4-18: Service Line Details.



**Figure 4-18: Service Line Details**

After viewing the claim, you may Adjudicate or Reverse it, Add Attachments, or Return to Claim Status by using the buttons at the bottom of the screen as shown in Figure 4-19: Claim Functions.



**Figure 4-19: Claim Functions**

**NOTE:** If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.

### 4.3.2 Adjudicate Claim

The **Adjudicate Claim** button on the confirmation page initiates the claim adjudication process and sends the claim through predefined edits for real-time claims processing.

By viewing the status of the adjudication, you can see if a claim has been successfully processed. If the claim fails to adjudicate, you will see an error message that reads, “Warning: There are Outstanding Edits.” The edits that caused the claim to fail adjudication will display under the Outstanding Edits

header, as shown in Figure 4-20: Adjudicate Claim. See Table 3: Claim Statuses for a list of Claim Statuses.

A claim on the portal can be adjudicated up to 10 times. The message at the top of the screen reading "Number of online adjudication attempts: x" keeps a running count.

Claims may have edits posted that indicate if the edit is a warning, denial, or pend. **A warn edit does not prevent a claim from paying.**

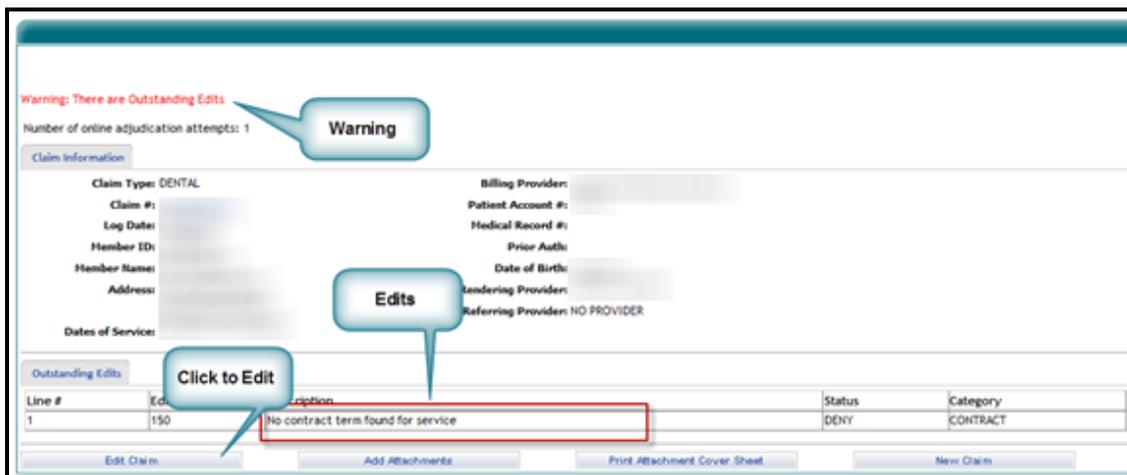


Figure 4-20: Adjudicate Claim

### 4.3.3 Edit Claim

Clicking the **Edit Claim** button opens the claim that was just submitted and offers the option to edit the claim and add or delete parts of the claim as needed before adjudicating the claim again.

Upon completion, three buttons offer further options: **Back, Save, Adjudicate**, as shown in Figure 4-21: Back, Save, Adjudicate Buttons.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.

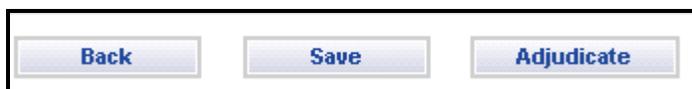


Figure 4-21: Back, Save, Adjudicate Buttons

### 4.3.4 Upload Attachments

Attachments may be uploaded from the Claims Status window by clicking the **Add Attachments** button as shown in Figure 4-19: Claim Functions. A new window will appear as shown in Figure 4-22: Upload Attachments.

The screenshot shows a web-based interface for uploading attachments. At the top, there are fields for Claim Number, Provider Name, Member Name, and Date of Service. To the right, it indicates 'Type: DENTAL' and 'Claim Status: DENY'. A tab labeled 'Attachments' is active. Below this, there is a 'Type of Attachment' dropdown menu with 'X-ray' selected. A callout bubble labeled 'Drop Down Menu' points to this dropdown. Underneath is a 'File Format' section with the text 'Valid file formats are: GIF, JPEG, MS Excel, MS Word, PDF, TIFF'. Below this is a text input field and a 'Browse...' button. A callout bubble labeled 'Browse Computer' points to the 'Browse...' button. At the bottom of the window are 'Attach' and 'Cancel' buttons.

Figure 4-22: Upload Attachments

Claim information is pre-populated on the top of the page. To add an attachment, follow the steps below:

1. Click the drop-down menu to select the **Type of Attachment** that will be added.
2. Select the **Browse** button to locate the file on your local computer. All supporting document files must be in one of these formats: GIF, JPEG, MS Excel (.xls), MS Word (.doc), PDF, or TIFF.
3. Click the **Attach** button when the file to upload is listed in the **Browse** field.
4. Attachments may be uploaded through the portal for claims previously submitted via EDI or paper by searching for the matching claim in Claim Status and uploading a scanned document directly to the claim. See Section 5: Claim Status for more information on searching for claims by claim status. Attachments should be submitted on the same day. If appropriate attachment is not present when a claim is being reviewed, it will deny.
  - If you are unable to upload required attachments, claims should then be submitted on paper with the appropriate attachment.

**NOTE:** If you are unable to upload electronic copies of attachments, fill out the **Cover Sheet for Claims** found on the Provider Page>Provider Documents>Forms> Claims. Be sure to include the **Claim number** provided to you on the confirmation screen. Send the cover sheet along with all mailed documents. If the appropriate attachment is not present when the claim is reviewed, the claim will deny.

**Mail to:**

Claims Unit- Attachments  
Office of MaineCare Services  
11 State House Station  
Augusta ME 04333-0011

## 5. Claim Status

To check the status of a claim, follow the steps below:

1. Select the **Claim Status** link under the **Form Entry** heading to access the claim status screen. See Figure 5-1: Form Entry.

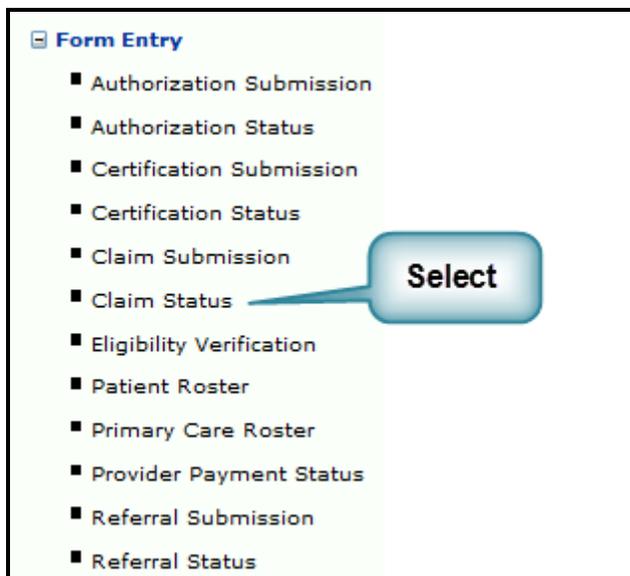


Figure 5-1: Form Entry

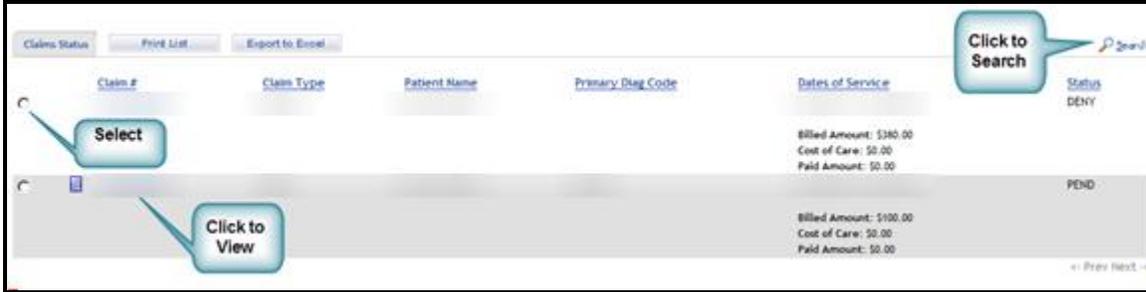
2. Select the proper provider from the **Billing Providers** drop-down menu. See Figure 5-2: Select Provider. The most current claims submitted for that provider will show beneath the drop-down menu, under claim status.



Figure 5-2: Select Provider

3. The search results for that Billing Provider are shown in the order of the newest to the oldest claims. Clicking on any underlined column heading will sort the lines according to the values in that column. To view claims in greater detail, click the **Claim #** link. See Figure 5-3: Claim Status Screen.

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**Figure 5-3: Claim Status Screen**

- Claim status identifies the processing stage of the claim. Table 3: Claim Statuses groups the statuses into three categories: **Initial**, **Awaiting Payment**, and **Finalized**. Claims with an initial status of “Rev” or “Rev Synch” may not be edited. Claims with any other initial status may be edited by the provider. Claims in Finalized status of Paid may be Reversed or Replaced.

***NOTE:** If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.*

See Table 3: Claim Statuses for more detailed explanations of the claims statuses.

**Table 3: Claim Statuses**

Claim Statuses	
<b>Initial Claim Statuses</b>	
Open	The claim has been entered with the required fields for submission.
Adjudicated	The claim has been processed against the business rules of the system.
Deny	The claim has failed the adjudication process.
Pay	The claim has passed the adjudication process and is ready to be submitted for payment.
Pend	The claim has been set aside for review to determine if it should be paid or denied.
Rev	The claim is an inverse of a previously paid claim that is created to take away any payment error.
Rev synch	The REV claim is held in this status until the companion replacement claim moves to Pay or Deny.
<b>Awaiting Payment Claim Statuses</b>	
Wait deny	Awaiting the finalization of the claim denial for inclusion on the remittance advice.
Wait pay	Awaiting the finalization of the claim payment submitted to AdvantageME for inclusion on the check and remittance advice.
Wait rev	Awaiting the finalization of the claim reversal for inclusion on the check and remittance advice.
<b>Finalized Claim Statuses</b>	

Claim Statuses	
Paid	The payment process is complete and is included in a Remittance Advice.
Denied	The claim has failed the adjudication process, has been denied, and is included in a Remittance Advice.
Reversed	The negative claim has been finalized and is included in a Remittance Advice.
Void	May be created as part of a mass adjustment (reversal and replacement) to void the replacement (adjustment) claim when only a reversal should have occurred. These transactions do not appear on a remittance advice or in an 835. They are administrative transactions only.

5. You can perform the following actions on selected claims: Edit, Adjudicate, Add Attachments, Reverse, Print, or Print Attachment Cover Sheet. See Figure 5-4: Claim Standard Buttons.



**Figure 5-4: Claim Standard Buttons**

## **5.1 View a Claim**

To view a claim, see Section 4.3.1.

## **5.2 Search Claim**

To search for a specific claim:

1. Click the  icon as shown in Figure 5-3: Claim Status Screen.
2. Searches may be performed on any of the fields available. See Figure 5-5: Claim Search.
  - a. The dates entered in the **Date of Service From** and **To** fields must be fewer than 90 days apart.
  - b. The Search button finds the claim(s).
  - c. The **Reset** button clears all the values.
  - d. The **Close** button closes the search area.

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Date of Service:	<input type="text" value="5/24/2009"/>	To	<input type="text" value="8/22/2009"/>	<i>(MM/DD/YYYY)</i>
Claim #:	<input type="text"/>			
Patient Account Number:	<input type="text"/>	Medical Record Number:	<input type="text"/>	
Patient Last Name:	<input type="text"/>	First Name:	<input type="text"/>	
Date of Birth:	<input type="text"/>			
Social Security Number:	<input type="text"/>			
Member ID:	<input type="text"/>			
Status:	<input type="text" value="ALL"/>			
<div style="border: 2px solid red; border-radius: 15px; padding: 10px; display: inline-block; background-color: #ffe6e6;"><b>Warning: Entering too many search criteria may prevent you from finding the claim</b></div>				
<input type="button" value="Search"/> <input type="button" value="Reset"/> <input type="button" value="Close"/>				

**Figure 5-5: Claim Search**

### 5.3 Edit Claim

Claims with an initial status of “Rev” or “Rev Synch” **may not be edited**. Claims with any other initial status may be edited. Refer to Table 3: Claim Statuses for the list of initial statuses. Claims with a finalized status of “Reversed” or “Void” cannot be reversed or replaced. **“Denied” claims cannot be reversed and should be rebilled**.

- Claims listed as "Open", "Adjudicated", "Pay", "Pend", “ Rev”, or "Deny" have not been finalized.
- Claims listed as "Paid", “Reversed”, or "Denied" have been finalized (processed through the payment cycle).

Click the option button in front of the claim to select it for editing, as shown in Figure 5-6: Edit Claim. Click **Edit** to edit the claim.

For additional information about editing a claim see Section 4.3.3.

**NOTE:** If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.

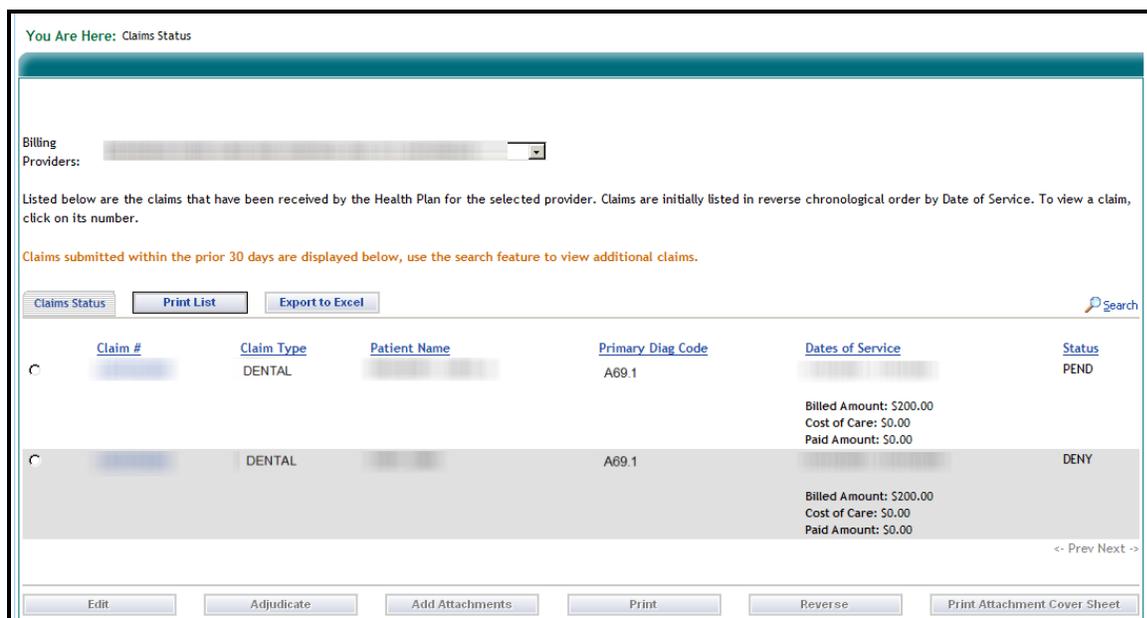


Figure 5-6: Edit Claim

Upon completion, three buttons offer further options: **Back, Save, Adjudicate**, as shown in Figure 5-7: Claim Edit Options.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.

- Click **Adjudicate** to adjudicate the edited claim.



Figure 5-7: Claim Edits Options.

## 5.4 Adjudicate Claim

To adjudicate a claim, see Section 4.3.2.

## 5.5 Reversing a Paid Claim

You may reverse and replace any finalized **Paid** claim. You may also simply reverse the claim.

- A **Reverse** transaction reverses everything on the claim; the charged amount, payment and the units/visits, etc. are negated.
- During the **Replace**, the claim data will be pre-populated. You will have the option of changing the data prior to resubmission. **Note:** When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

**Note:** When a reversal claim is submitted, and is in a status of “Rev” or “Rev Synch”, the **Edit** and **Adjudicate** buttons at the bottom of the Claim Status screen will be greyed out.

- The Original Claim, the Reversal Claim and/or the Replacement Claim will be visible in the system. This is for accounting purposes and will show on the next Remittance Advice.

To reverse or reverse and replace a claim, follow these steps:

1. Search for a claim by clicking the  icon, as shown in Figure 5-3: Claim Status Screen.
2. Select a claim.
3. Select **Reverse** on the claim status page, as shown in Figure 5-8: Reverse a Claim.

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You Are Here: Claims Status

Billing Providers:

Listed below are the claims that have been received by the Health Plan for the selected provider. Claims are initially listed in reverse chronological order by Date of Service. To view a claim, click on its number.

Claims submitted within the prior 30 days are displayed below, use the search feature to view additional claims.

[Claims Status](#) [Print List](#) [Export to Excel](#) [Search](#)

Claim #	Claim Type	Patient Name	Primary Diag Code	Dates of Service	Status
6	DENTAL		A69.1		PAID
Billed Amount: \$200.00 Cost of Care: \$0.00 Paid Amount: \$0.00					
C	DENTAL		A69.1		DENY
Billed Amount: \$200.00 Cost of Care: \$0.00 Paid Amount: \$0.00					

<- Prev Next ->

[Edit](#) [Adjudicate](#) [Add Attachments](#) [Print](#) [Reverse](#) [Print Attachment Cover Sheet](#)

**Reverse Claim**

Figure 5-8: Reverse a Claim

4. On the next screen, select the option to **Reverse this claim and create a new claim**. **Note:** to reverse a claim without creating a replacement claim, select the option to **Reverse this claim only**.
5. Preserve the existing date by checking the box next to **Use the data from this claim as basis for the new claim**, as shown in Figure 5-9: Claim Status- Reverse Claim. The new claim will have all applicable data copied over.

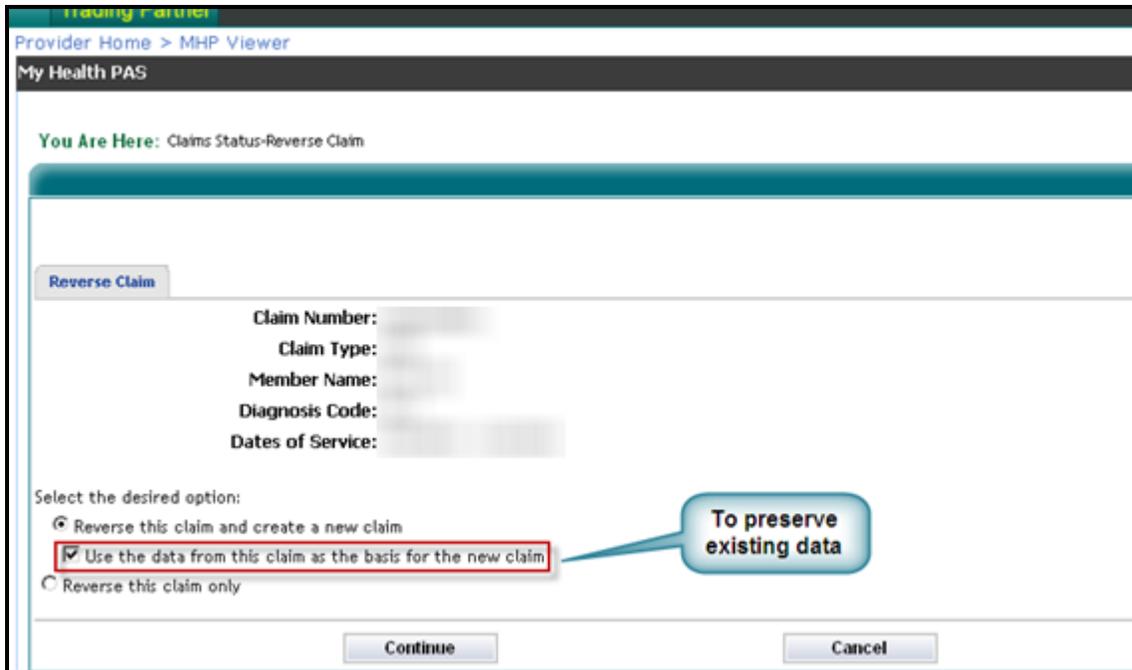


Figure 5-9: Claim Status-Reverse Claim

6. Click **OK** when the verification question pops up. See Figure 5-10: Verification Question.

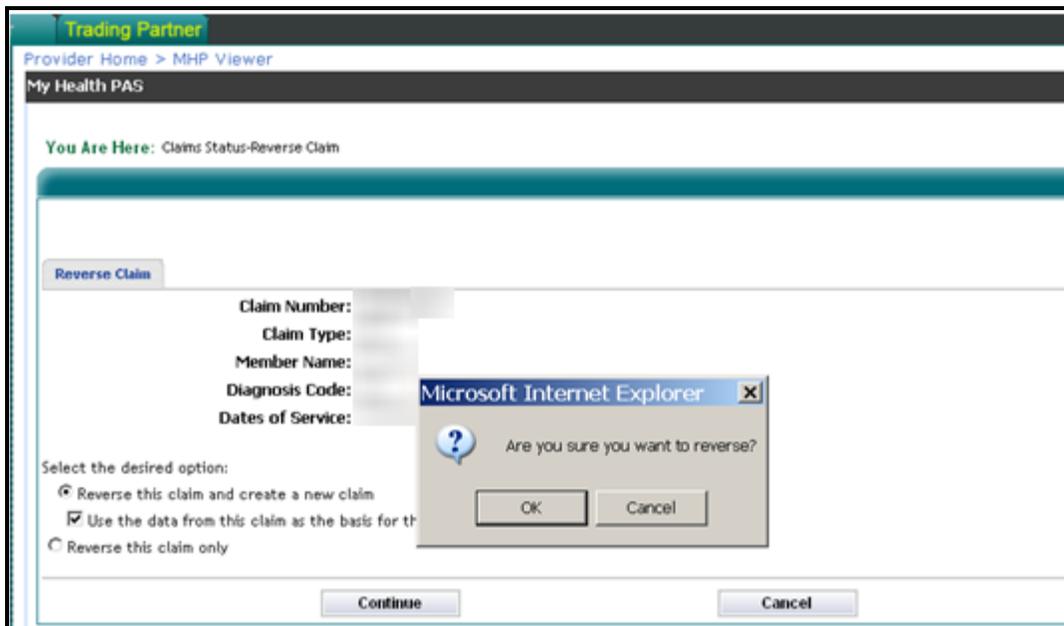


Figure 5-10: Verification Question

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- If reversing and replacing the claim, the portal will automatically navigate to a claim edit screen where the replacement claim information may be updated. Figure 5-11: Replacement Claim Edit Screen shows an example of this screen.

Claim is successfully Reversed and Replaced **Reversal Claim ID is** R1

**Claim Information**

Claim Type: DENTAL  
 Status: OPEN  
 Claim #:   
 Log Date: 2/26/2014  
 Member ID:   
 Member Name:   
 Address:   
 Dates of Service: 2/25/2014 - 2/25/2014

Billing Provider:   
 Patient Account # :   
 Medical Record #:   
 EPSDT/Title XIX :  YES  NO  
 Date of Birth:   
 Rendering Provider :   
 Referring Provider:   
 Service Location:

**Diagnosis**

Code Version\* :  ICD - 9  ICD - 10 [CMS claims guidelines for implementing ICD-10](#)

Line #	Code	Description	Type	ICD Version
1				

**Services**

Line#	DOS From	DOS To	Place of Service	Code	Related Diagnosis	Tooth	Area	Surface	Quantity	Fee	Auth #	Rendering Provider
1	2/25/2014	2/25/2014		D1208					1	\$36.00		
2	2/25/2014	2/25/2014		D0330					1	\$106.00		
3	2/25/2014	2/25/2014		D0120					1	\$44.00		
4	2/25/2014	2/25/2014		D1110					1	\$85.00		
5	2/25/2014	2/25/2014										

Service Code Description:  **Total: \$271.00**  
**Units: 4**

**Enter COB Information**

**Additional Information**

Is Patient Condition Related To  
 Employment  Auto Accident  Other Accident  
 State:   
 Date of Accident:

**Miscellaneous**

Is Orthodontics  
 Date Appliance Placed:  No. of Months Remaining:   
 Initial Prosthesis  
 Prior Prosthesis Date:

**Figure 5-11: Replacement Claim Edit Screen**

8. After the revisions are completed, the new replacement claim can be adjudicated with the updated data. **Note:** the updated information must be saved by selecting Save, as shown in Figure 5-12: Save Updated Information, before the claim can be adjudicated.

Additional Information

Is Patient Condition Related To

Employment  Auto Accident  Other Accident

State:

Date of Accident:

Miscellaneous

Is Orthodontics

Date Appliance Placed:  No. of Months Remaining:

Initial Prosthesis

Prior Prosthesis Date:

Back Save Adjudicate

**Figure 5-12: Save Updated Information**

**Note:** When a reversal claim is submitted, and is in a status of “Rev” or “Rev Synch”, the **Edit** and **Adjudicate** buttons at the bottom of the Claim Status screen will be greyed out.

- A Reversed Claim will have an R1 (or sequential number) at the end of the Claim number.
- A Replaced Claim will have an A1 (or sequential number) at the end of the Claim number.
  - The Replaced Claim will require a new Patient Account # since it is a new claim.

Figure 5-13: Successfully Reversed and Replaced Claim Screen provides an example of a successfully reversed and replaced claim.

Trading Partner

Provider Home > MHP Viewer

My Health PAS

You Are Here: Claim Edit

Claim is successfully Reversed and Replaced Reversal Claim ID is

Claim Information

Claim Type:		Billing Provider:	
Status:		Patient Account # * :	
Claim #:		Medical Record #:	
Log Date:		Prior Auth:	
Member ID:		Date of Birth:	
Member Name:		Rendering Provider * :	
Address:		Referring Provider:	NO PROVIDER
Dates of Service:		Service Location * :	

Figure 5-13: Successfully Reversed and Replaced Claim Screen

You may also choose **to reverse a claim without creating a replacement claim**, by selecting the **Reverse this Claim Only** option in step 3.

- A Reversal transaction reverses everything on the claim. The charged amount, the payment and the units/visits, etc. will be negated.
- A Reversed Claim will have an R1 (or sequential number) at the end of the Claim number.

Figure 5-14: Successfully Reversed Claim Screen provides an example of a successfully reversed claim.

*Note: It is not necessary to click on **Continue** once you receive this reversal confirmation screen. Clicking on **Cancel** will bring you back to the Claim Status page.*

**Reverse Claim**

**Claim Number:** [REDACTED]

**Claim Type:** DENTAL

**Member Name:** [REDACTED]

**Diagnosis Code:**

**Dates of Service:** [REDACTED]

Select the desired option:

- Reverse this claim and create a new claim
- Use the data from this claim as the basis for the new claim
- Reverse this claim only

**Reversal ClaimId :** [REDACTED] **R1**

**Claim is successfully Reversed**

**Continue** **Cancel**

Figure 5-14: Successfully Reversed Claim Screen

## Appendix A: Claim Cover Sheet

Claims Supporting Documents Cover Sheet	
<i>DO NOT SEND CLAIMS TO BE PROCESSED TO THIS ADDRESS- THIS IS FOR SUPPORTING DOCUMENTS ONLY</i>	
<i>These fields below are required and must match the original claim.</i>	
<b>Information for Processing:</b>	
1. Provider NPI or API	<input type="text"/>
2. Provider Name	<input type="text"/>
3. Member ID	<input type="text"/>
4. Member Name	<input type="text"/>
5. Claim ID number	<input type="text"/>
<b>Purpose:</b>	
This form <b>MUST</b> be used when <b>mailing</b> the claim supporting documents request. Submission of this completed form along with any required attachments will allow the appropriate review process to be conducted by the Claims unit.	
<b>Instructions:</b>	
1. In box 1, fill in Provider NPI or Atypical Provider ID	
2. In box 2, fill in the Provider Name	
3. In box 3, fill in the nine-digit Member identification number that is used on the claim	
4. In box 4, fill in the Member Name	
5. In box 5, fill in the Claim ID that the attachment corresponds with.	
Place this completed form on top of the attachment(s) to expedite the processing of your claim.	
Mail to: Claims Unit Office of <u>MaineCare Services</u> 11 State House Station Augusta ME 04333	

Figure A- 1: Claim Cover Sheet

## Appendix B: Resolutions for Claim Edits found in Adjudication

**Table 4: Resolutions for Claim Edits**

Edit Number	Description	Instructions
107	Negative charge on claim line	Negative charges not allowed; please correct
204	Invalid accommodation days	Must ensure accommodation days billed match date span
219	Provider overlap of global days period	Global days in effect for prior services billed
311	Claim Submission Window Exceeded [All Claims, header date]	Verify date entries are correct
329	Invalid Patient status for bill type	Must bill valid CMS patient status code + bill type combinations
360	DRG is NOT in the selected DRG Group	DRG is not to be submitted on claim
515	Invalid HCPCS for Revenue Code	Must bill valid CMS HCPC + Revenue code combinations
530	Insufficient units for date span	Check number units billed with dates billed
541	Claim Line Submission Window Exceeded	Correct date entries
542	Claim Line Submission Window Overlap	Correct date entries
543	Inpatient Claim Submission Window Exceeded [header to date]	Correct date entries
662	Contract for service location on claim was not found	Validate the service location is correct with your initial provider registration record

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<b>Edit Number</b>	<b>Description</b>	<b>Instructions</b>
990	Missing Claim Information	Required entry missing