

UTAH MEDICAID SPECIFIC PROFESSIONAL COB TEMPLATE

UHINt 2.5 Tool

All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at www.uhin.org or call 801-466-7705.

Telephone Number for Medicaid EDI customer support is 801-538-6155 or 800-662-9651 menu 3, menu 5. Hours of operation are Monday through Wednesday (7 am to 12 noon and 1 pm to 6 pm) and Thursday (11 am to 12 noon and 1 to 6 pm). Closed on Fridays.

UHINt 2.5 is an internet based product offered by UHIN that can be used to interface between a medical billing system and UHINet (UHIN's internet portal). It can also be used to directly type in claims, eligibility inquires, etc. This is not a Medicaid product. The user guide is on the internet https://www.uhinet.com/uhint/install/UHINt_2.5_User_Guide.pdf. For help installing, security, or any technical question contact UHIN.

Submitter Maintenance and Provider Maintenance will need to be set up to submit claims. Providers submitting to HT000004-001 or HT000004-005 need to be set up with NPI and (EIN) Tax ID. Atypical providers submitting to HT000004-801 need to be set up with Medicaid Provider Number and Tax ID (EIN).

Required fields by the UHINt tool are in **Red**. There are some Utah Medicaid specific fields in addition to those that will need to be filled out to process the claim.

Transmit claims for all Medicaid programs (Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc.) to Medicaid Fee-For-Service (FFS), HT000004-001. If a commercial plan is primary submit TPL (Third Party Information).

Transmit claims that have Medicare Coordination of Benefits to the Medicare/Medicaid Crossover Trading Partner Number HT000004-005.

If Medicaid denies a Medicaid FFS claim for TPL information then fax the primary EOB to ORS (801) 536-8513. If Medicaid denies a Medicare/Medicaid Crossover claim then fax the EOMB to Medicaid (801) 536-0481. Be sure to send the Medicaid TCN of the denied claim as a reference number.

For additional information please refer to the Utah Medicaid Companion Guides <http://health.utah.gov/hipaa/guides.htm>.

The screenshot shows the 'Professional' tab of the UHInt 2.5 form. Key elements include:

- Bill Type:** Original Claim (dropdown)
- * Payer:** (dropdown)
- Billing Form Option:** Regular, Ambulance, Home Health, Oxygen, Spinal Manip, Vision, **COB** (selected), P&C, Pwk(0)
- 1. * Claim Source:** MEDICAID (dropdown)
- 1a. * Insured's ID Number:** (text field)
- Patient Information:**
 - 2. * Last Name, Suffix, * First Name, MI:** (text fields)
 - 5. * Address:** (text field)
 - 3. * Birthdate (mmddccyy), * Sex:** (text and dropdown)
 - * City, * State, * Zip:** (text and dropdown)
 - 6. Patient's Relationship to Insured:** Self (dropdown)
- Insured's Information:**
 - 4. Last Name, Suffix, First Name, MI:** (text fields)
 - 7. Address:** (text field)
- 10. Is Patient's Condition Related To:**
 - a. Employment? (current or previous):** Yes, No (radio buttons)
 - b. Another Party Responsible?:** Yes, No (radio buttons)
 - c. Accident?:** Auto, Other Accident, No (radio buttons)
- 11. Policy Group or FECA Number:** (text field)
- 9. Last Name, Suffix, First Name, MI, Address, City, State, Zip:** (text fields)
- a. Policy or Group Number:** REQUIRED (text field)
- Member ID Number:** REQUIRED (text field)
- Patient Member ID Number:** REQUIRED (text field)
- Other Patient Member ID Number:** Member ID (dropdown), REQUIRED (text field)
- b. Date of Birth (mmddccyy), Sex:** REQUIRED (text and dropdown)
- Patient's Relationship to Other Insured:** (dropdown)
- d. Other Insurance Payer Name:** REQUIRED (text field)
- Insurance Type:** (dropdown)
- Payer ID Number:** REQUIRED (text field)
- Source:** (text field)
- 10. a, b and c Required:** (callout pointing to the relationship dropdown)
- Required:** (callouts pointing to the Member ID Number and Insurance Type dropdown)

- Patient Information auto populates when using Patient Demography Repository.
- If Bill Type is a Replacement or Cancel of a Prior Claim enter the TCN of the Original Medicaid Paid Claim in Box 22. Enter all 17 digits with no hyphens or spaces.

UHINT 2.5 File Tools View Help

Monitor Professional Institutional Dental

12. Patient or Authorized Person's Signature
 I authorize the release of any medical or other information necessary to process this claim. I also request payment for this claim be made either to myself or to the provider of my assignment below.

13. Insured's or Authorized Person's Signature
 I authorize payment of medical benefits to the undersigned physician or supplier below.

BOX 12 AND BOX 13 ALL FIELDS REQUIRED FOR COB

* Release of Information - Destination Payer
 Provider has Signed Statement [REQUIRED]

Release of Information - Other Payer [REQUIRED]

Benefits Assignment [Yes] Patient Signature Source [REQUIRED]

14. Date of Current: (mmddccyy) **Claim Service Date**

16. Date Patient Unable to Work in Current Occupation (mmddccyy)
 From To

17. Referring Physician or Other Source Provider List
 Last Name Suffix First Name MI
 17a. Referring Physician ID Number
 Secondary ID

18. Hospitalization Dates Related to Current Services (mmddccyy)
 From To

19. Reserved for Local Use - Other Date **Digits only- no decimal**

20. Outside Lab? **If billing replacement claim enter the TCN of the original paid claim**

21. Diagnosis or Nature of Illness or Injury. (Relate items 1, 2, 3, or 4 to item 24E by line).
 1. 2. 3. 4. 5. 6.

Change Place of Service if different than Office

22. Original Ref No

23. Prior Authorization Number
 Prior Auth Referral CLIA

24. **Enter Total charges for Dates of Service. No comma, enter decimal for cents.**

Add	* Date of Service: From (mmddccyy)	Date of Service: To (mmddccyy)	* P D S	T O S	* CPT / HCPCS	N D C	Mod 1	Mod 2	Mod 3	Mod 4	DX Code Pointer 1-8 (Max 4)	* \$ Charges	Days or Units	Unit Type	Famil Plan	E M G	C O B	Local Host	P W K	
Del			11	1		N														P

Production (Butch)

- **Box 14.** Enter the first Date of Service for the claim. Returned on the 277FE as Claim Service Date.
- **Box 24.** Click ADD for additional lines. For each line enter a Date of Service in the Date Field. Charges field cannot have a comma but can have a decimal.
- **Box 24.** Do not delete a line located in the middle of charges. Type over the line to correct the information. Only the last line can be deleted, otherwise it causes an error at Medicaid. The claim is rejected.

The screenshot displays the UHINT 2.5 software interface. At the top, there is a blue header with the logo and title 'UHINT 2.5'. Below this is a menu bar with 'File', 'Tools', 'View', and 'Help'. On the left side, there is a vertical navigation menu with buttons for 'Preferences', 'Submission', 'Queries', 'Files', and 'Reports'. A 'Production (Butch)' button is also visible on the left. The main area contains several sections of data entry forms:

- Monitor** section: Includes fields for 'COB Option', 'Prior Authorization Number', 'Claim Adjudication Date (mmddccyy)', and 'Referral Number'.
- Claim Amount Information** section: Includes fields for 'Payer Paid Amount', 'Approved Amount', 'Allowed Amount', 'Patient Responsibility Amount', 'Covered Amount', 'Discount Amount', 'Per Day Limit Amount', and 'Claim Total Before Taxes'.
- Claim Level Adjustment Information** section: Includes a table with columns for 'Group Code', 'Reason Code', 'Monetary Amount', and 'Adjustment Quantity'. The first row shows 'Contractual Obligations', '42', 'Amount', and '1'.
- Provider Information** section: Includes fields for 'Referring Provider', 'Rendering Provider', 'ID', and 'Purchased Service Provider'.
- Line Level Adjudication Information** section: Includes fields for 'Service Line Number' (1), 'Bundled Line Number', '* Line Adjudication Date', '* Service Line Paid Amount', '* Paid Service Unit Count', '* Product/Service ID', 'HCPCS Codes', 'CODE', 'Procedure Modifier', and 'Group Code'.

Three callout boxes provide additional instructions:

- Amounts Reported by Other Payer**: Points to the 'Allowed Amount' and 'Patient Responsibility Amount' fields.
- Write-off Amounts Reported by Other Payer**: Points to the 'Reason Code' field in the Claim Level Adjustment Information table.
- To add additional line information, type over Service Line Number and tab. This opens the fields to report TPL for the Line Number entered.**: Points to the 'Service Line Number' field.
- Patient Responsibility Must be Reported**: Points to the 'Patient Responsibility' group code in the Line Level Adjustment Information table.

- Patient Responsibility must be entered for both Claim Level and Line Level.
- The tool requires Line Level information. For crossover claims report all line level data the same as the Medicare EOMB.
- All other claims; claim level payment information can be reported on the first line. No other line level information needs to be submitted as Medicaid will pay based on claim level information. The claim will pay at the claim level. Patient Responsibility is what Medicaid reviews to pay the provider.

- **Box 25 is the National Provider ID (NPI), unless an Atypical provider. Atypical providers must enter the Tax ID no hyphen or spaces**
- **Box 31 needs to be filled out if Box 33 is a group or provider needs to submit the taxonomy code. Must set up a Rendering Provider in Provider Maintenance. If no rendering provider then create one by using the same information as the billing provider using only one word in first and last name fields. (Recommend using the taxonomy code as the Unique identifier for Rendering Provider set up when Billing and Rendering Provider are the same.)**
- **Box 32 is not needed.**
- **Box 33 is the Billing Provider. Select from the Provider Maintenance List.**
- **Box 33 Payer Assigned Provider ID select the (EIN) enter the Tax ID, no hyphen or spaces. Atypical Providers select Medicaid Provider Number and enter the 12 digit Medicaid Payment Contract Number.**
- **Click Submit when finished to send the claim.**
- **Watch for Window that indicates that transmission was completed.**