Direct Data Entry (DDE) Manual

Wisconsin Physicians Service Insurance Corporation https://www.wpsgha.com

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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WPS A HEALTH SOLUTIONS COMPANY

Introduction

The Fiscal Intermediary Shared System (FISS) is the processing system designated by the Centers for Medicare & Medicaid (CMS) to be used for Medicare Part A claims and Part B facility claims. DDE is a real-time FISS application giving providers access for inquiries, claims entry, and correction purposes. It also is a valuable resource for providers who use batch submissions to transmit electronic claims, monitor claims and requested documentation, manage claim errors and check beneficiary information.

This manual is designed to help DDE users understand the information available within the DDE system, provide an overview of the DDE menu options, and instructions for entering and correcting claims.

Chapter 1: Overview

What is the DDE System?

The DDE system was designed as an integral part of FISS. DDE offers various tools to help providers obtain answers to many questions and provide another method for electronically submitting claims to the Medicare Administrative Contractor (MAC). Medicare Part A providers can use DDE to enter claims electronically, on-line and in real time

FISS Availability

Production times-all in Central Standard Time (CST)

Region	On-Line up	Down Time
J5- (05)	6:00 AM	9:00 PM
J8-MI (81)	5:00 AM	8:00 PM
J8-IN (82)	5:00 AM	8:00 PM
J5N (LW)	7:00 AM	9:30 PM Mon – Thu 10:00 PM Fri

Note: Depending on the time it takes the nightly system cycle to run, FISS may not always be available at 5:00 a.m. CST. In addition, FISS system releases may affect availability over weekends. FISS is not available on Sunday or on national holidays.

DDE Capabilities and Benefits

Providers can access eligibility data on the Common Working File (CWF). This file shows eligibility data, utilization information, deductible status, health maintenance organization (HMO) enrollment/disenrollment data, and Medicare Secondary Payer (MSP) information.

DDE allows providers that currently do not have another way to submit electronic claims to enter initial claims. Providers will be able to enter claims directly FISS and receive the identical edits received by the MAC when hard copy claims are entered. This helps ensure clean, error-free submissions

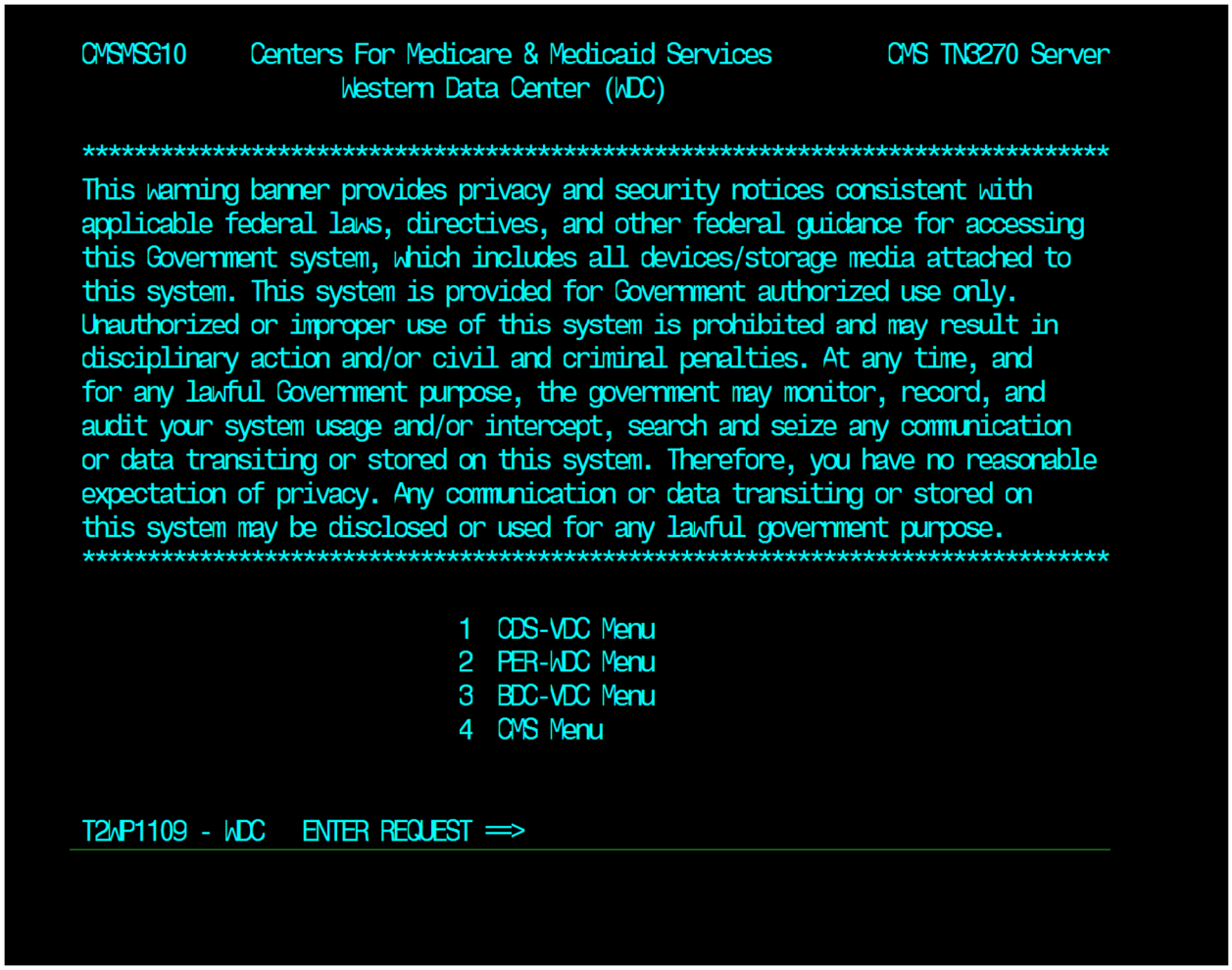
Providers can electronically resubmit claims previously returned for billing errors. Providers may continue to submit claims using existing electronic means, e.g., system-to-system, tape-to-tape, etc.… Since editing of claims submitted via other electronic avenues is not as intense as the FISS on-line editing, providers generally realize some portion of their electronically submitted claims will be returned for billing errors. All claims returned for correction, whether they were originally submitted electronically or paper form, may be resubmitted in DDE and edited with the same intensity as a new claim.

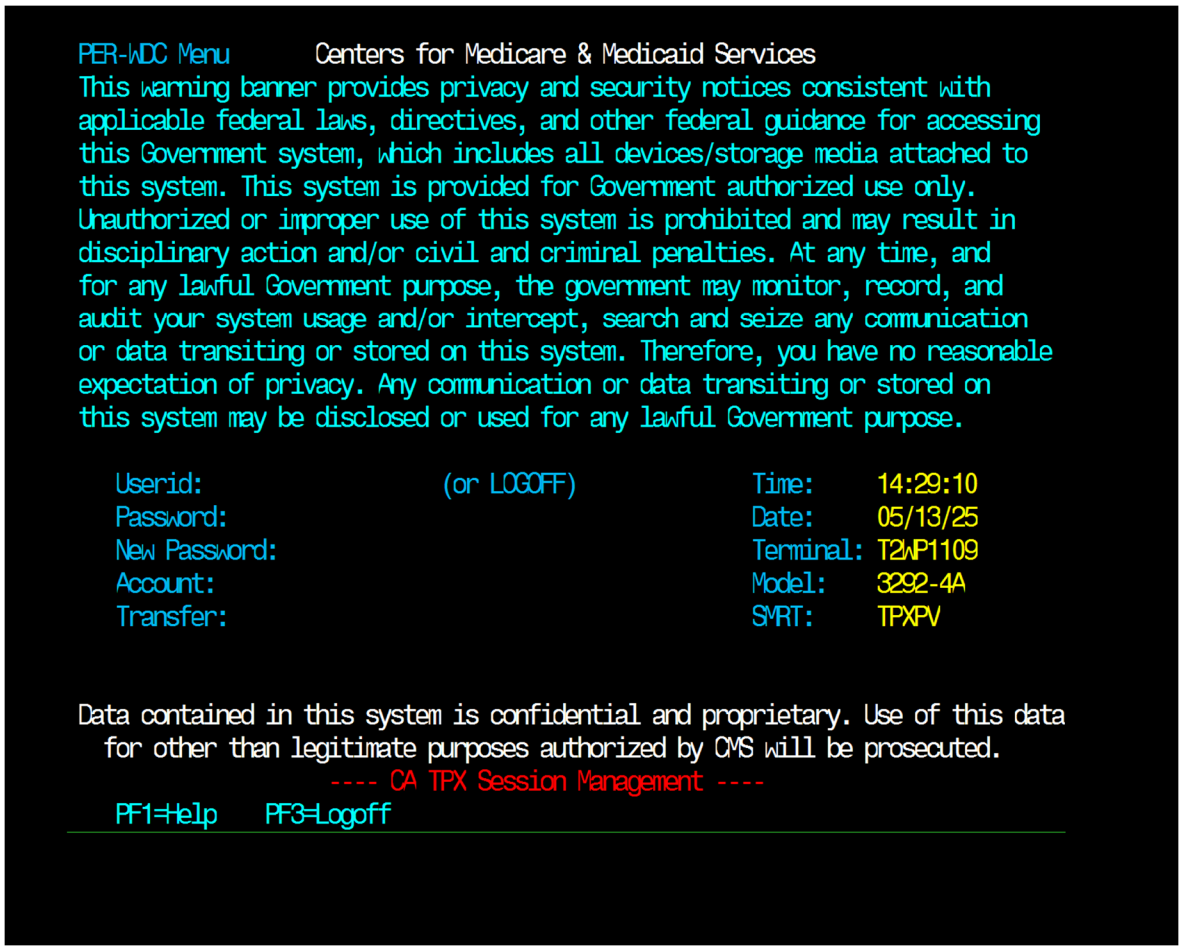
DDE provides on-line access to MAC Files (Revenue Codes, Health Care Procedure Coding System (HCPCS) and the Reason Codes Files). This will help providers know immediately what codes are acceptable on any given billing date. In addition, providers will be able to determine what specific fee schedule amounts are in effect on any given date. DDE also allows on-line claim status inquiry to determine when a claim was processed.

Sign ON/OFF Procedures

Before accessing the FISS System, you must first connect through your Network Service Vendor.

Once you have made a successful connection, you will see the Centers for Medicare & Medicaid Services Western Data Center (WDC) menu.


CMSMSG10 Centers For Medicare & Medicaid Services CMS TN3270 Server
Western Data Center (WDC)
****
This warning banner provides privacy and security notices consistent with
applicable federal laws, directives, and other federal guidance for accessing
this Government system, which includes all devices/storage media attached to
this system. This system is provided for Government authorized use only.
Unauthorized or improper use of this system is prohibited and may result in
disciplinary action and/or civil and criminal penalties. At any time, and
for any lawful Government purpose, the government may monitor, record, and
audit your system usage and/or intercept, search and seize any communication
or data transiting or stored on this system. Therefore, you have no reasonable
expectation of privacy. Any communication or data transiting or stored on
this system may be disclosed or used for any lawful government purpose.
****
1 CDS-VDC Menu
2 PER-WDC Menu
3 BDC-VDC Menu
4 CMS Menu
T2WP1109 - WDC ENTER REQUEST ==>



Type your DDE User ID and press **<TAB>.** Note: DDE User ID numbers are assigned to every individual that utilizes the DDE system.

Type in your password and then press **<ENTER>.**

If this is the first time logging on using your new DDE User ID, use the default password that was included in your DDE confirmation. As you enter your default password, nothing will show on the screen, but you will see the cursor move to the right. After you press **<ENTER>,** the system will prompt you to change the password.

Follow the directions noted on the screen regarding password requirements when changing your password. Note: Your password will expire every 30 days, and you must make at least 12 password changes before you can repeat a previously used password.

If you receive notice that your password has expired, please follow the directions noted on the screen when changing your password. If you have not signed into DDE for 30 days, your ID will automatically revoke, and you will have to call in to get a new password. If you have issues creating a new password, contact the DDE Navigation & Password Reset Line J5 (866) 518-3251 or J8 (866)-580-5986.

If you have not signed in within 90 days, your ID will be deactivated or deleted. If your ID is deactivated or deleted, contact the DDE Systems department at Medicare.DDE.Analysts@wpsic.com.

Guidelines for New Passwords

1. The user's name cannot be contained in the password.
2. Only 3 consecutive characters of the user's name are allowed.
3. The user ID cannot be contained in the password.
4. Only 3 consecutive characters of the user ID are allowed. No repeating characters are allowed. This is not case sensitive. (e.g., "Ggep78c#" would not be allowed. However, "Gpeg78c#" would be allowed.)
5. The password length is 8 positions.
6. At least 1 upper case, 1 lower case, 1 number, and 1 special character must be used.
7. The password cannot begin with a number.
8. The special character must be a $, #, or @. The password cannot start with a special character.
9. You must change at least 5 characters from the previous password.
10. Passwords may not be reused for 12 iterations.
11. The following character strings are not allowed: [APPL APR AUG ASDF BASIC
    CADAM DEC DEMO FEB FOCUS GAME IBM JAN JUL JUN LOG MAR
    MAYNET NEW NOV OCT PASS ROS SEP SIGN SYS TEST TSO VALID VTAM
    XXX 1234]

User IDs or passwords should never be shared between users. The user is responsible for all activity conducted under their User ID.

Once you are logged in, select which session you would like to access. Type an S in front of the correct session and press <ENTER>.

Type FSS0 and press <ENTER> to access DDE.

To exit the system, press <F4> until you see the message "SESSION SUCCESSFULLY TERMINATED," then type LOGOFF and press <ENTER>. When you are back on the TPX Menu Screen, type K in the Command ===> field and press <ENTER>.

DDE Menu Selections

MAIN MENU

1-INQUIRES
2-CLAIMS/ATTACHMENTS
3-CLAIMS CORRECTION
4-ON-LINE REPORTS VIEW

INQUIRY MENU

10- BENEFICIARY/CWF
11-DRG (PRICER/GROUPER)
12-CLAIM SUMMARY
13-REVENUE CODES

15-DX/PROC CODES ICD-9
16-ADJUSTMENT REASON CODES
17-REASON CODES
19-ZIP CODE FILE
56-CLAIM COUNT SUMMARY
67-HOME HEALTH PYMT TOTALS
68-ANSI REASON CODES
88-INVOICE NO/DCN TRANS
1A-OSC REPOSITORY INQUIRY
1B-DX/PROC CODES ICD-10
1C-CMHC PAYMENT TOTALS
1D-PROV PRACTICE ADDR QUER
1E-NEW HCPC SCREEN
1F-OUD DEMO 99
FI-CHECK HISTORY

CLAIMS ENTRY

20-INPATIENT
22-OUTPATIENT
24-SNF
26- HOME HEALTH
28-HOSPICE
49-NOE/NOA

CLAIMS CORRECTION

21-INPATIENT
23-OUTPATIENT
25-SNF
27-HOME HEALTH
29-HOSPICE

CLAIM ADJUSTMENT

30-INPATIENT
31-OUTPATIENT
32-SNF
33-HOME HEALTH

35-HOSPICE

Claim Cancels

50-INPATIENT
51-OUPATIENT
52-SNF
53-HOME HEALTH
55-HOSPICE

ATTACHMENT CORRECTION

42-PACEMAKER
43-AMBULANCE
44-THERAPY
45-HOME HEALTH

87-ROSTER BILL ENTRY

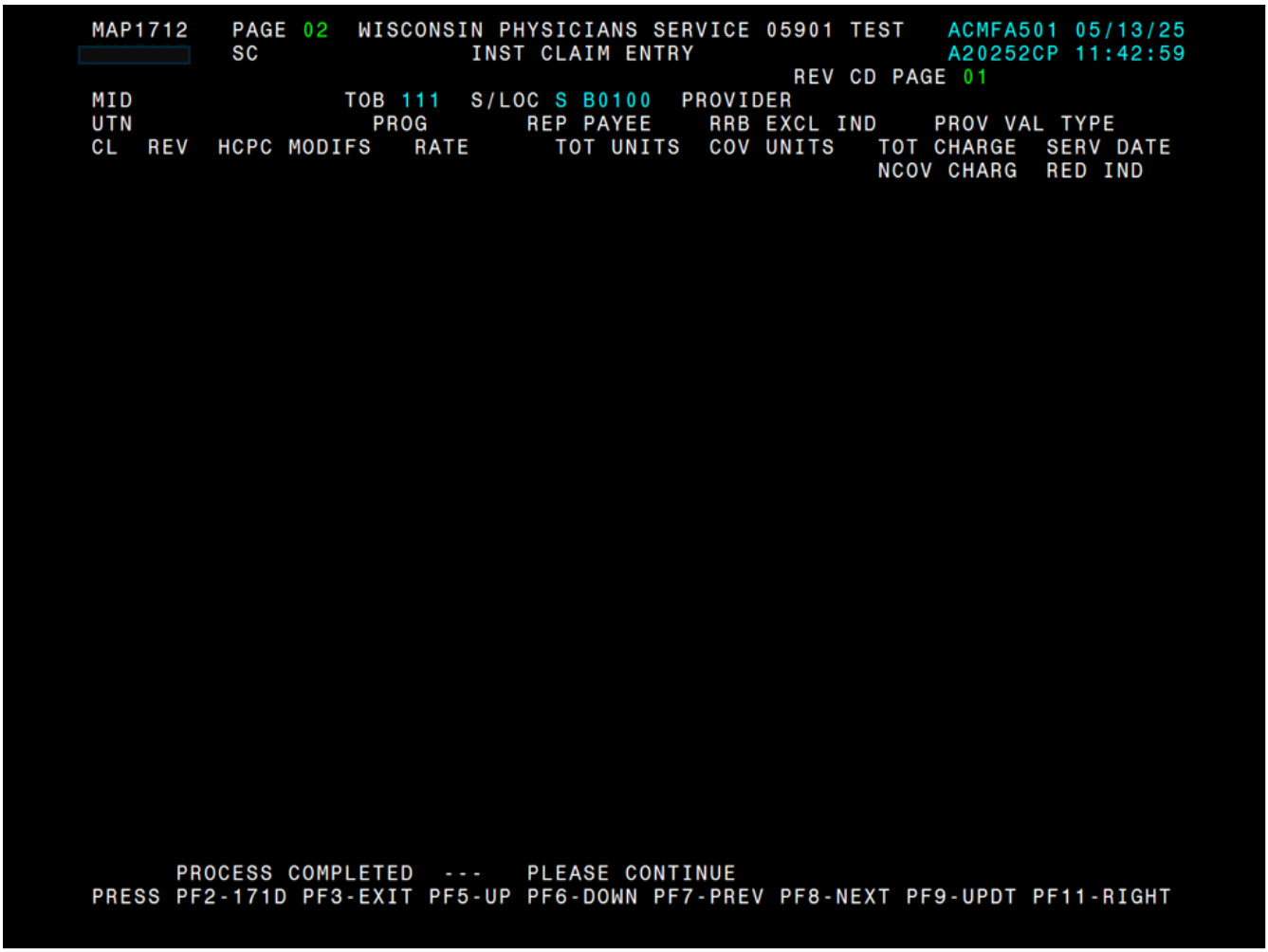
ATTACHMENT ENTRY	ON-LINE REPORTS VIEW
41-HOME HEALTH	R1-SUMMARY OF REPORTS
54-DME HISTORY	R2-VIEW A REPORT
57-ESRD CMS-382 FORM	R3-CREDIT BALANCE REPORT-CMS 838

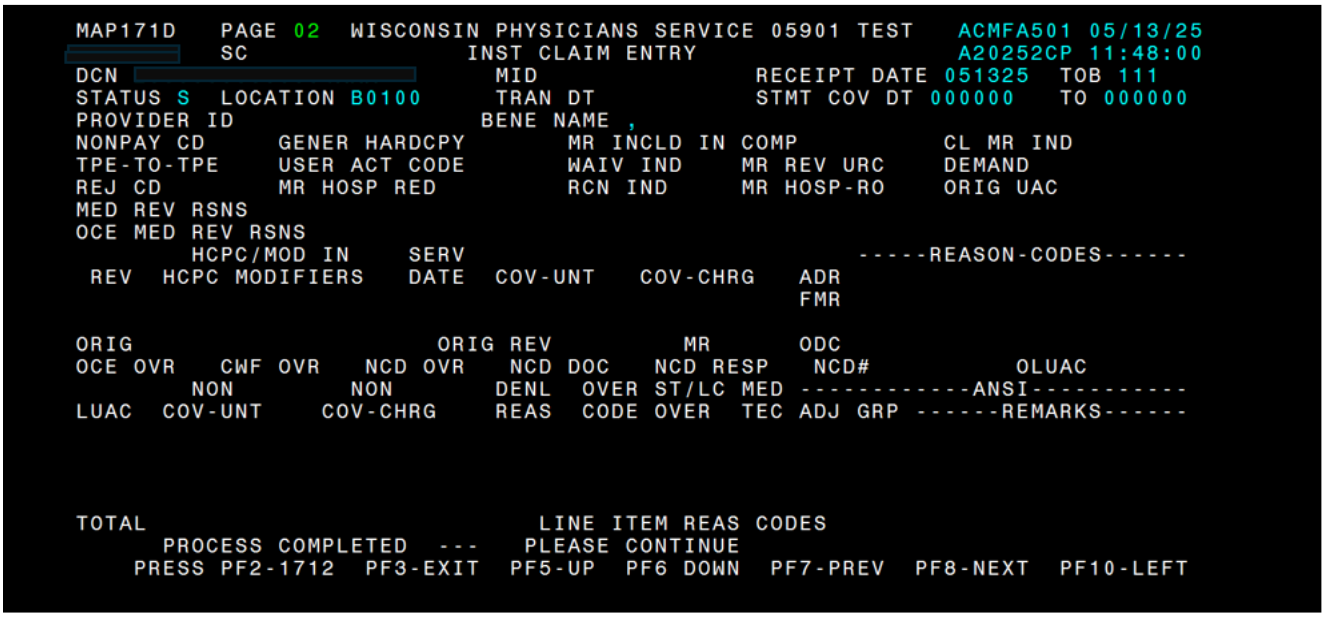
Program Function Keys

The provider can perform specific processes within the system utilizing the program function keys. The correct function keys for each MAP will be displayed at the bottom of the screen. The table below identifies those keys used in FISS.

F1-Help key allows access to specific Reason Code File information about the error received.

F2- Jumps the user from claim to (MAP1712) for the first revenue code in error; or, when placed on a specific revenue code line on claim page 2, the system will automatically go to the same revenue code on (MAP171D).


MAP1712 PAGE 02 WISCONSIN PHYSICIANS SERVICE 05901 TEST ACMFA501 05/13/25
SC INST CLAIM ENTRY A20252CP 11:42:59
REV CD PAGE 01
MID TOB 111 S/LOC S B0100 PROVIDER
UTN PROG REP PAYEE RRB EXCL IND PROV VAL TYPE
CL REV HCPC MODIFS RATE TOT UNITS COV UNITS TOT CHARGE SERV DATE
NCOV CHARG RED IND
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT


MAP171D PAGE 02 WISCONSIN PHYSICIANS SERVICE 05901 TEST ACMFA501 05/13/25
SC INST CLAIM ENTRY A20252CP 11:48:00
DCN MID RECEIPT DATE 051325 TOB 111
STATUS S LOCATION B0100 TRAN DT STMT COV DT 000000 TO 000000
PROVIDER ID BENE NAME ,
NONPAY CD GENER HARDCPY MR INCLD IN COMP CL MR IND
TPE-TO-TPE USER ACT CODE WAIV IND MR REV URC DEMAND
REJ CD MR HOSP RED RCN IND MR HOSP-RO ORIG UAC
MED REV RSNS
OCE MED REV RSNS
HCPC/MOD IN SERV -----REASON-CODES------
REV HCPC MODIFIERS DATE COV-UNT COV-CHRG ADR
FMR
ORIG ORIG REV MR ODC
OCE OVR CWF OVR NCD OVR NCD DOC NCD RESP NCD# OLUAC
NON NON DENL OVER ST/LC MED -------------ANSI-----------
LUAC COV-UNT COV-CHRG REAS CODE OVER TEC ADJ GRP ------REMARKS------
TOTAL LINE ITEM REAS CODES
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF2-1712 PF3-EXIT PF5-UP PF6 DOWN PF7-PREV PF8-NEXT PF10-LEFT

F3-Exits to the first previous menu or sub-menu. When in a roll-out screen, brings the user back to the original screen.

Note: Use caution before pressing F3 because it will take you back to the previous screen and could cause you to lose your work. For example, if you are entering a billing transaction into FISS and accidentally press *F3*, you will be returned to the Claim and Attachments Entry Menu and the information you enter on the billing transaction will be lost.

F4-Exits the entire system by terminating the session.

Note: Use caution before pressing F4 because it will exit the system and you could lose your work.

F5-Scrolls backward within a page of screen data.
F6-Scrolls forward within a page of screen data.
F7-Moves back a page, one page at a time.
F8-Moves forward a page, one page at a time.
F9-Stores or updates claim.
F10-Moves left to columns 1-80 within a claim record. In addition, allows access to the last page of beneficiary history when in claim summary by MBI.
F11-Moves right to columns 81-132.
F12-No Function

Standards and Conventions

ARROWS-Use the arrow keys to move one character at a time in any direction within a field. See the “TAB KEYS" section for information regarding moving between fields.

TAB-Press <TAB> to move forward between fields. Press <SHIFT>+<TAB> to move backward between fields. Tabbing backwards is helpful if the cursor is at the top of the screen, and you need to move the bottom of the screen. Some keyboards may be equipped with a <Back Tab> key.

CURSOR-The cursor is the flashing underline or "block" that shows you where you are on the screen.

NUMBERS-In the examples in this manual, an "X" indicates any number from 0-9. Sometimes only one number is a variable, e.g., 72X. "X" represents 720-729.

X -When this symbol displays at the bottom of the screen, the system is processing your request. Do not press keys until the X goes away.

END KEY-To field exit or clear field. In FISS it is important that you not use the Space Bar to clear fields. Space can be recognized as a character to FISS.

If your screen freezes or locks, press the <ESC> key to reset your session.

ACRONYMS AND ABBREVIATIONS

Below is a list of the acronyms and abbreviations found in this manual.

Acronym/Abbreviation	Definition
ACS	Automated Claims Systems
Adj. Orbit	Rankings that the computer uses to determine what activity a claim should perform next
ADR	Additional Development Request
ALJ	Administrative Law Judge
ANSI	American National Standards Institute
APC	Ambulatory Patient Classification
ASC	Ambulatory Surgical Center
BCBS	Blue Cross Blue Shield
CAH	Critical Access Hospital
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARC	Claims Adjustment Reason Code
CBSA	Core Based Statistical Area
CERT	Comprehensive Error Rate Testing
CCPD	Continuous Cycling Peritoneal Dialysis
CICS	Customer Information Control System
CMG	Case Mix Group
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CR	Change Request
CWF	Common Working File
DCN	Document Control Number
DDE	Direct Data Entry
DGME	Direct Graduate Medical Education
DME	Durable Medical Equipment
DRG	Diagnostic Related Grouping
EGHP	Employer Group Health Plan
EMC	Electronic Media Claim
EPO	Epoetin Alfa
EPSDT/CHAP	Early & Periodic Screening, Diagnosis & Treatment Program (or Services)/Community Health Accreditation Program
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Center
HCPCS	Health Care Procedure Coding System
HH PPS	Home Health Prospective Payment System
HHA	Home Health Agency
HHRG	Home Health Resource Group
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System
HIQA	Health Insurance Query Access
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
ICD-9-CM	Internal Classification of Diseases-9th Edition-Coding Manual
ICF	Intermediate Care Facility

Acronym/Abbreviation	Definition
ICN	Internal Control Number
IDE	Investigational Device Exemption
IME	Indirect Medical Education
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IV	Intravenous
LCD	Local Coverage Determination
LGHP	Large Group Health Plan
LMRP	Local Coverage Determination
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MCCD	Medicare Coordinated Care Demo
MPPR	Multiple Procedure Payment Reduction
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N&A	Nursing and Allied Health
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NDC	National Drug Code
NIF	Not In File
NIH	National Institutes of Health
NLM	National Library of Medicine
NOA	Notice of Admission
NOE	Notice of Election
NPI	National Provider Identifier
NRS	Non-Routine Supply
OASIS	Outcome Assessment Information Set
OCE	Outpatient Code Editor
OIG	Office of Inspector General
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSC	Occurrence Span Code
ORF	Outpatient Rehabilitation Facility
PC	Professional Component
PCA	Progressive Correction Action
PE RVU	Practice Expense Relative Value Unit
PHS	Public Health Service
PIMR	Program Integrity Management Reporting
PIP	Periodic Interim Payment
POA	Present On Admission
PPS	Prospective Payment System
PPV	Pneumococcal Pneumonia Vaccine
PRO	Peer Review Organization
PT	Physical Therapy
PTAN	Provider Transaction Access Number
QIO	Quality Improvement Organization
RA	Recovery Auditor
RAP	Request for Anticipated Payment
RHC	Rural Health Clinic
RO	Regional Office

Acronym/Abbreviation	Definition
RTP	Return to Provider
RUG	Resource Utilization Group
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
TC	Technical Component
TOB	Type of Bill
TPL	Third Party Liability
UBC	Uniform Bill Code
UPIN	Unique Physician Identification
UR	Utilization Review
URC	Utilization Review Committee
VA	Veterans Administration

Reason Code File

FISS uses reason codes to direct the outcome of an edit or process within the system. Each reason code points to a status and location code. Each site determines the status and location code required for each reason. The status code alerts the system whether the claim should continue processing. The location code instructs the system to forward the claim to a specific site before any further claim activity occurs.

The assignment of a reason code (with an associated status/location) overrides the normal processing sequence of the claim path. When the system assigns multiple reason codes, it uses a hierarchical ranking to determine which status and location to assign to the claim.

Status

Hierarchy Table

The Status is a one-position field, which defines the condition of the claim (good, suspended, inactive, etc.). The system then determines which activity the claim should perform. This determination process uses a "Ranking Table" that lists that priority of each system status code in order of preference. The following table defines the valid values for status codes in the appropriate hierarchy listing.

Priority	Status Code	Definition	Condition
1	**F** (**F**orce)	Suspended on-line; system will add the claim record to the file with active errors.	Pending
2	**T** (Re**t**urn to Provider) OR **U** (Re**t**urn to PRO)	Claim has reached final disposition with no reimbursement and has been returned to the provider with billing errors. Claim has reached final Disposition and has been returned to the Peer Review Organization (PRO) for corrections.	Finalized Finalized
3	**I** (**I**nactive)	Claim moves from the active processing file to the inactive file.	Finalized
4	**R** (**R**eject)	Claim has reached final disposition with no reimbursement (non-medical reject).	Finalized
5	**D** (**D**eny)	Claim has reached final disposition with no reimbursement (medical denial).	Finalized
6	**M** (**M**anual Move)	Designated a manual claim move to another department, employee, desk, etc. **Note:** Once an **M** value is inserted in the status field, the system changes the status to an **S** for suspense after the move.	Pending
7	**S** (**S**uspense)	A manual update is needed before claim processing can continue.	Pending
8	**P** (**P**aid)	Claim has reached final disposition with reimbursement.	Finalized
9	**A** (Take NO **A**ction)	No processing error; claim continues to the next processing location. (Only seen on the Reason Code File.)	NA

Location

Highlights:

- Location – Five-position field which specifies where claim resides
- Status/Location routes claim through FISS
- Pre-defines system functional areas and manual work areas
- Status/Location may be system set or established by the user
- Status/Location audit trails are maintained
- Status/Locations reside on Reason Code File or may be system set
- System prioritizes Status/Location via an internal Ranking Table

Document Control Number Structure

Highlights

- Unique 23-position number assigned to all claims
- Provides a reference number for control and monitoring of specific claims
- Includes the actual date the claim is entered into the system

Field Position	Field	Definition
1	CENTURY CODE:	Code used to indicate the century the Document Control Number (DCN) was established. **Valid values:** **1** - 1900-1999 **2** - 2000>
2-3	YEAR:	The last two digits of the year during which the claim was entered.
4-6	JULIAN DATE:	Julian days corresponding to the calendar entry date of the claim.
7-10	BATCH SEQUENCE	Primary sequencing field, beginning with 0000 and ending with 9999.
11-12	CLAIM SEQUENCE:	Secondary sequencing field, beginning with 00 and ending with 99.
13	SPLIT/DEMO INDICATOR:	**C** - Medicare Choices claim **E** - ESRD Managed Care **V**- Veterans Administration (VA) Demo **P** - Encounter Claims System filled with **0** when not used at site.
14	ORIGIN:	Code designating claim origin. **Valid values:** **0** - Unknown **1** - EMC/UB-04/CMS Format **2** - EMC Tape/UB-04/Other Format **3** - EMC Tape/Other (Other is defined as PRO automated adjustment for FISS) **4** - EMC Telecom/UB-04 (DDE Claim) **5** - EMC Telecom/Not UB-04

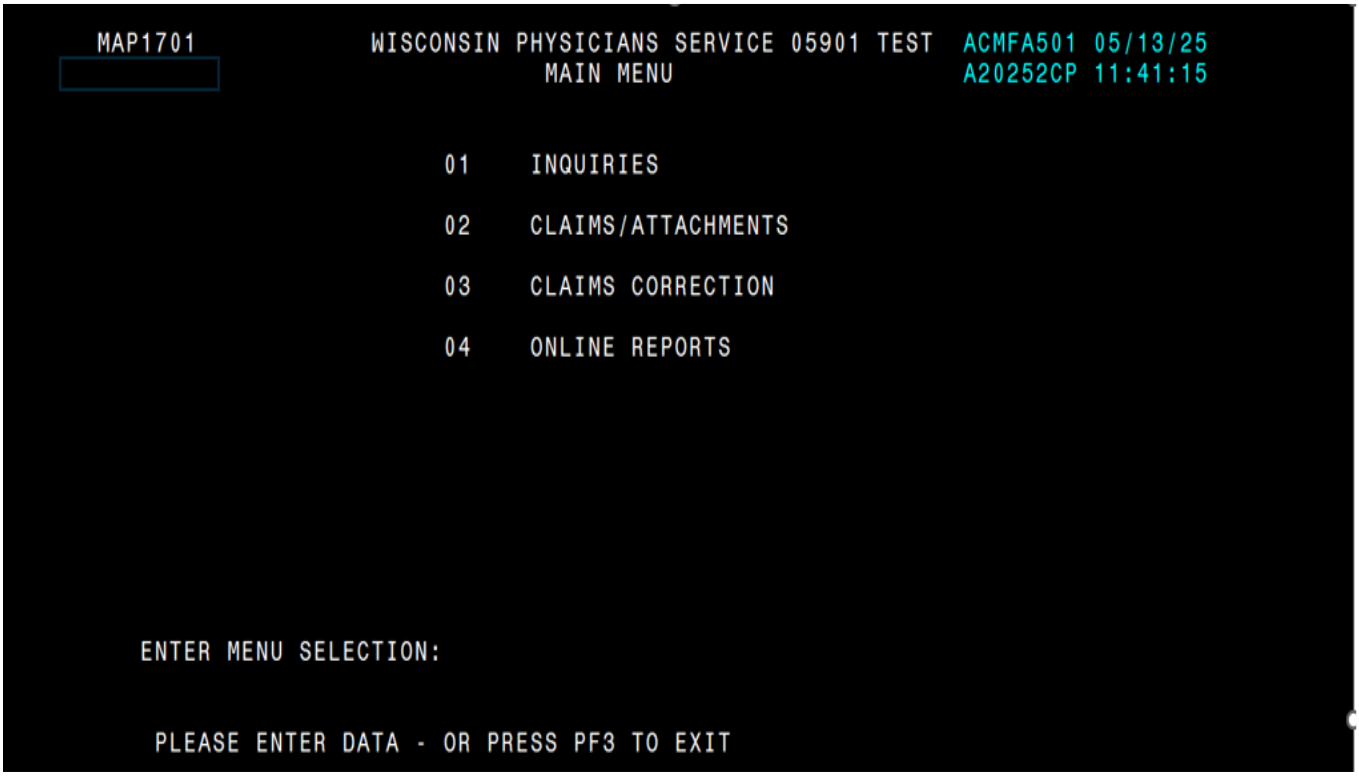
Field Position	Field	Definition
		6 - Other EMC/UB-04 **7** - Other EMC/Not UB-04 **8** - UB-04 Hard copy **9** - Other Hard copy
15-21	RESERVED:	First position of "reserved" area is being used in the Home Health A/B shift automated adjustment. **Valid values:** **H** - In 1st position indicates a system generated Trailer 16 adjustment **P** - In 2nd position indicates a system generated Trailer 15 adjustment **Blank** - In position 15-21 indicates reserved for future use
22-23	SITE CODE:	When "Use Site Processing" on the Site Control record is set to **Y**, these positions of the DCN will coincide with the value indicated in the SITE field on the Operator Control File.

Chapter 2: Inquiries Menu Introduction

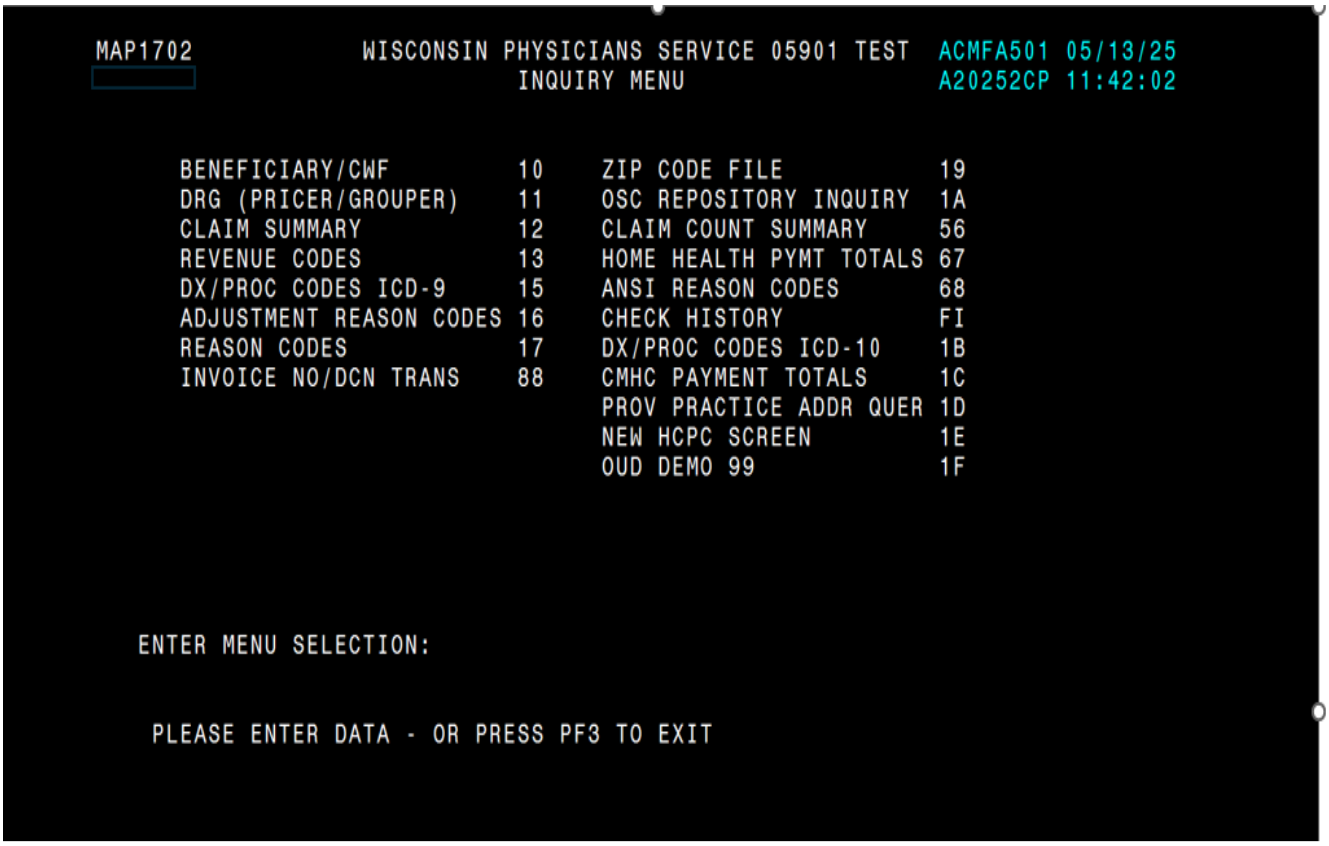
Purpose

The Inquiries Menu Option 01 (MAP1701) allows providers to research certain system files in an inquiry mode. There are nineteen (19) inquiry sub-menus available to the provider.
The Inquiries option allows you to:

- Check the status of submitted billing transactions
- Locate claims in an ADR (Additional Development Request) status
- View a summary of all claims currently being processed in the system
- Verify revenue codes, diagnosis codes, HCPCS codes, adjustment reason codes, reason codes, and ANSI (American National Standards Institute) codes
- View the amount and payment date of the last three checks issued to your facility
- Monitor total Home Health Prospective Payment System (HH PPS) payments and outlier payments made in a calendar year



From the Main Menu, In the Enter Menu Selection field: Type 1 (the leading zero is not necessary) Press **<ENTER>** to go to (MAP1702).



Medicare Care Choices Model (MCCM) Auxiliary Information Screen

- The Common Working File (CWF) is the source of eligibility and entitlement information for Medicare beneficiaries.

- CWF is comprised of nine databases throughout the United States called “Hosts.” The Hosts maintain the CWF databases.

- At the point of payment or denial, a detailed claim record is submitted to the Host. The Host uses the CWF data to determine the beneficiary’s most recent utilization and entitlement status and uses that information to decide if the claim should be approved for payment.

- Claims are processed by CWF in the order they are received, regardless of the dates of service incurred. This first-in, first-out method of processing requests facilitates prompt handling. Most claims are expedited quickly though CWF. However, sometimes there are delays. Below is an example of a circumstance that can delay payments.

Not in File (NIF) Error

- This response on the reply record indicates that the beneficiary record for which the Fiscal Intermediary submitted a claim is not in the CWF region being accessed by your Intermediary. Further research may be needed throughout the CWF Hosts to locate the information. Sometimes, because of the complexity of the CWF, it may take extra time to locate the records of the beneficiary. The claim will ‘loop’ until all hosts have been polled and, if the information is not found successfully, a CWF error message will be received.

Beneficiary Not Found

If the Eligibility detail inquiry screen reports that the Medicare ID number you keyed in is "Not Found," you may want to check the additional eligibility information, which is contained in CMS's national database, the Common Working File (CWF). The cursor will automatically position itself in the LN (Last Name) field.

COMMON WORKING FILE (CWF) HOST SITE SECTORS

CWF Host	States Processed
Great Western (GW)	Washington, Oregon, Idaho, Montana, Wyoming, Utah, North Dakota, South Dakota, Nebraska, Kansas, Missouri, Alaska, Iowa
Great Lakes (GL)	Minnesota, Wisconsin, Illinois, Michigan
Pacific (PA)	California, Nevada, Arizona, Hawaii, American Samoa, Guam
Southwest (SW)	Colorado, New Mexico, Oklahoma, Texas, Arkansas, Louisiana
Northeast (NE)	Maine, Vermont, New Hampshire, Massachusetts, Connecticut, New York, Rhode Island
Keystone (KS)	Pennsylvania, New Jersey, Delaware
Mid-Atlantic (MA)	Indiana, Ohio, West Virginia, Maryland, Washington DC, Virginia
Southeast (SE)	Kentucky, Tennessee, North Carolina, South Carolina, Mississippi, Alabama, Puerto Rico, Virgin Islands
Southern (SO)	Georgia, Florida, Railroad Board (RRB)

You do not need to enter the HOST ID character. However, if you receive the message, BENE-ERROR, BENEFICIARY RECORD NOT FOUND, and the beneficiary resides in another state, enter the host site where the beneficiary resides.

Diagnostic Related Grouping (DRG)/Prospective Payment System (PPS) (Option 11) MAP1781

Purpose

The purpose of the DRG Pricer/Grouper screen will be to research PPS information as it pertains to an inpatient stay.

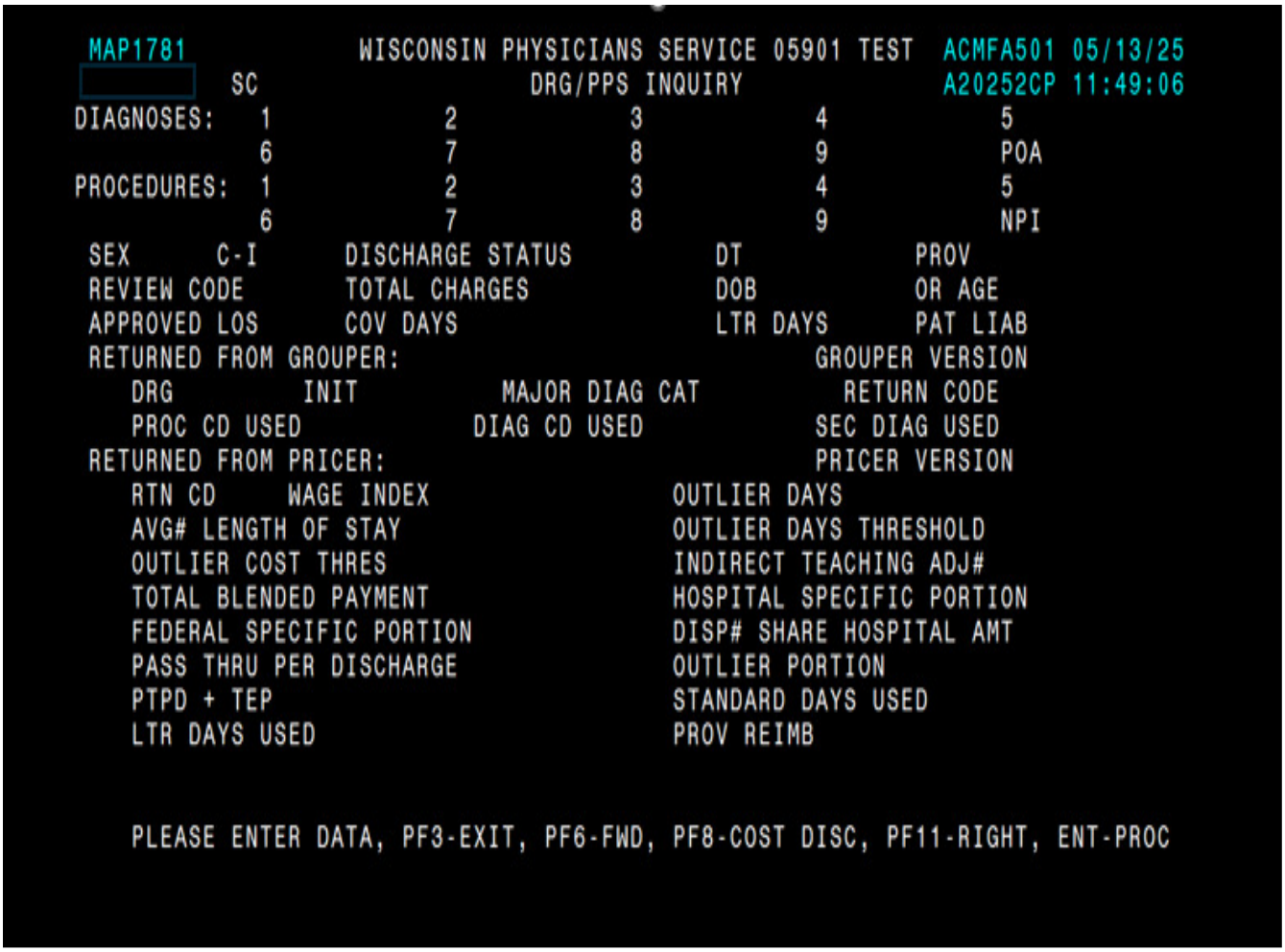
Access

From the Inquiry Menu, to access the DRG (Pricer/Grouper) sub-menu:
In the Enter Menu Selection Field, Type 11 Press <ENTER>

The DRG/PPS inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs.

The only function of the DRG/PPS inquiry is to provide specific Diagnostic Related Grouping (DRG) assignment/PPS payment calculations. This inquiry displays the DRG and Pricer calculation information. Search keys control choice of display.

- To bring up the information, you must first input all the diagnosis codes, procedure codes, discharge status, date, total charges, and date of birth or age.
  - Adding additional ICD-1 other (secondary) diagnosis codes (from 1 code to 24 codes) as well as additional associated present on admission (POA) codes; and
  - Adding additional ICD-9 other (secondary) procedure codes (from 5 codes to 24 codes).



Field Name	Description
DIAG CD	**Internal Classification of Diseases-9th Edition-Coding Manual (ICD-9CM) Diagnosis Codes** - Six-digit alphanumeric fields that identify up to nine ICD-9-CM codes for coexisting conditions on a particular claim. The admitting diagnosis is not entered. (From one code to 24 codes)
PROC CD	**Procedure Codes** - Seven-digit field that identifies the principal procedure (From 1 code to 24 codes) Required for inpatient claims.
SEX	**Beneficiary's Sex** - One-digit alphanumeric field that identifies the sex of the beneficiary. **Valid values:** **M** – Male **F** - Female
C-I	**Century Indicator** - One-digit numeric field that identifies the correct century for beneficiary's date of birth. **Valid values:** **8** - 18XX Beneficiary born in the 1800s **9** - 19XX Beneficiary born in the 1900s

DISCHARGE STATUS	**Patient's Discharge Status Code** – Identifies the status of the patient at the statement through date. **Valid values:** **01** - Discharged to home or self-care (routine discharge) **02** - Discharged/Transferred to another short-term general hospital **03** - Discharged/transferred to SNF **04** - Discharged/transferred to an Intermediate Care Facility (ICF) **05** - Discharged/transferred to a designated cancer center or childrens hospital **06** - Discharged/transferred to home under care of organized home health service organization **07** - Left against medical advice **09** - Discharged from outpatient care to be admitted to the same hospital from which the patient received outpatient services **20** – Expired **30** - Still a patient **43** - Discharged/transferred to a federal hospital **50** - Hospice - home **51** - Hospice - medical facility **61** - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed **62** - Discharged/transferred to an inpatient rehabilitation facility (IRF) including distinct part units of a hospital **63** - Discharged/transferred to a long-term care hospital **65** - Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital **66** - Discharged/transferred to a Critical Access Hospital **70** - Discharge/transfer to another type of health care institution not defined elsewhere in the code list
DT	**Discharge Date** - Six-digit numeric field that indicates the date the patient was discharged from the type of care in MMDDYY format.
PROV	**Provider Transaction Access Number (PTAN)** - 13-digit alphanumeric field that identifies the institution which rendered services pre-filled by the system for external operators directly associated with one provider. This number is assigned by the Centers for Medicare & Medicaid Services (CMS).
REVIEW CODE	**Review Code** - Indicates the code used in calculating the standard payment. **Valid values:** **00** - Pay with outlier - use of this code calculates the standard payment and attempts to pay only cost outliers (day outliers expired 10/01/97). **01** - Pay days outlier – use of this code calculates the standard payment and calculates the day outlier portion of the payment if the covered days exceed the outlier cutoff for the DRG. **02** - Pay cost outlier – use of this code calculates the standard payment and calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold. If the length of stay exceeds the outlier cutoff, no payment is made and a return code of "60" is returned. **03** - Pay per diem days – use of this code calculates a per diem payment based on the standard payment if the covered days are less than the

	average length of stay for the DRG. If the covered days equal or exceed the average length of stay, the standard payment is calculated. It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold. **04** - Pay average stay only – use of this code calculates the standard payment, but it does not test for days or cost outliers. **05** - Pay transfer with cost – use of this code pays transfer with cost outlier approved. **06** - Pay transfer no cost – use of this code calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG. If the covered days equal or exceed the average length of stay, the standard payment is calculated. It will not calculate any cost outlier portion of the payment. **07** - Pay without cost – use of this code calculates the standard payment without cost portion. **09** - Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – use of this code calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG. If the covered days equal or exceed the average length of stay, the standard payment is calculated. It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold. **11** - Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – use of this code calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG. If covered days equal or exceed the average length of stay, the standard payment is calculated. It will not calculate the cost outlier portion of the payment.
TOTAL CHARGES	**Total Covered Charges** -Ten-digit numeric field that identifies the total charges submitted on the claim in 99999999.99 format.
D.O.B	**Beneficiary's Date of Birth** - Eight-digit numeric field the date of birth for the beneficiary in MMDDYYYY format.
OR AGE	**Beneficiary's Age** - Three-digit numeric field to identify the age of the beneficiary
APPROVED LOS	**Approved Length of Stay (LOS)** - Three-digit numeric field that identifies the approved number of days for treatment. Approved LOS is necessary for Pricer to determine whether day outlier status is applicable in non-transfer cases, and, in transfer cases, to determine the number of days to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.
COV DAYS	**Covered Medicare Days** - Three-digit numeric field that identifies the number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct

	utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary.
LTR DAYS	**Lifetime Reserve Days** - Two-digit numeric field that identifies the number of Lifetime Reserve Days used for a particular claim. This field may be left blank.
PAT LIAB	**Patient Liability Due** - Eight-digit numeric field that identifies the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges in 999999.99 format.
NA	After the DRG has been assigned by the system and the PPS payment has been determined, the following information will be displayed on the screen under RETURNED FROM GROUPER or RETURNED FROM PRICER
D.R.G.	**Diagnostic Related Grouping (DRG)** - Three-digit alphanumeric field that identifies the code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data, and total charges.
MAJOR DIAG CAT	**Major Diagnostic Category** - Identifies the category in w the DRG resides. **Valid values:** **01** - Diseases and Disorders of the Nervous System **02** - Diseases and Disorders of the Eye **03** - Diseases and Disorders of the Ear, Nose, Mouth and Throat **04** - Diseases and Disorders of the Respiratory System **05** - Diseases and Disorders of the Circulatory System **06** - Diseases and Disorders of the Digestive System **07** - Diseases and Disorders of the Hepatobiliary System and Pancreas **08** - Diseases and Disorders of the Musculoskeletal System and Connective Tissue **09** - Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast **10** - Endocrine, Nutritional, and Metabolic Diseases and Disorders **11** - Diseases and Disorders of the Kidney and Urinary Tract **12** - Diseases and Disorders of the Male Reproductive System **13** - Diseases and Disorders of the Female Reproductive System **14** - Pregnancy, Childbirth, and the Puerperium **15** - Newborns and Other Neonates with Conditions Originating in the Prenatal Period **16** - Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders **17** - Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasm **18** - Infectious and Parasitic Diseases (Systemic or Unspecified Sites) **19** - Mental

RTN CD	**Return Code** - reflects the status of the claim when it has returned from the Grouper Program. Return codes **00-49** describe how the bill was priced. **00** - Priced standard DRG payment **01** - Paid as day outlier/send to PRO for post payment review **02** - Paid as cost outlier/send to PRO for post payment review **03** - Paid as per diem/not potentially eligible for cost outlier **04** - Standard DRG, covered days indicate day outlier, but day or cost outlier status was ignored **05** - Pay per diem days plus cost outlier for transfers with an approved cost outlier **06** - Pay per diem days for transfers without an approved outlier **10** - Bad state code for Skilled Nursing Facility (SNF) Resource Utilization Group (RUG) Demo or Post-Acute Transfer for Inpatient Prospective Payment System (PPS) Pricer DRG is 209, 210 or 211 **12** - Post acute transfer with specific DRGs of 14, 113, 236, 263, 264, 429, 483 **14** - Paid normal DRG payment with per diem days - or > average length of stay **16** - Paid as a cost outlier with per diem days - or > average length of stay **30** - Bad Metropolitan Statistical Area (MSA) Code Return codes **50-99** describe why the bill was not priced: **51** - No provider-specific information found **52** - Invalid CBSA in provider file **53** - Waiver State - not calculated by PPS **54** - DRG is not less than 001 or greater than 559; or equals 004, 005, 107, 109, 112, 115, 116, 209, 214, 215, 221, 222, 231, 400, 434, 435, 436, 437, 438, 456, 457, 458, 459, 460, 469, 470, 472, 474, 478, 483, 514, 516, 517, 526, 527. **55** - Discharge date is earlier than provider's PPS start date or later than the provider's PPS termination date **56** - Invalid length of stay **57** - Review Code invalid **58** - Charges not numeric **59** - Possible day outlier candidate **61** - Lifetime reserve days are not numeric **62** - Invalid number of covered days (e.g., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) **63** - Review code of **00** or **03** and bill is cost outlier candidate **64** - Disproportionate share percentage and bed size conflict on Provider Specific File **98** - Cannot process bill older than 5 years
PROC CD USED	**Procedure Code Used** – ICD-10 code(s) that identifies the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	**Diagnosis Code Used** - Identifies the primary ICD-10-CM diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	**Secondary Diagnosis Code Used** - The secondary ICD-10- CM diagnosis code used by the Grouper program for calculation.

GROUPER VER	**Grouper Version** - Four-digit numeric field for the program identification number for the Grouper program used.
RTN CD	**Return Code** - reflects the status of the claim when it has returned from the Grouper Program. Return codes **00-49** describe how the bill was priced. **00** - Priced standard DRG payment **01** - Paid as day outlier/send to PRO for post payment review **02** - Paid as cost outlier/send to PRO for post payment review **03** - Paid as per diem/not potentially eligible for cost outlier **04** - Standard DRG, covered days indicate day outlier, but day or cost outlier status was ignored **05** - Pay per diem days plus cost outlier for transfers with an approved cost outlier **06** - Pay per diem days for transfers without an approved outlier **10** - Bad state code for Skilled Nursing Facility (SNF) Resource Utilization Group (RUG) Demo or Post-Acute Transfer for Inpatient Prospective Payment System (PPS) Pricer DRG is 209, 210 or 211 **12** - Post acute transfer with specific DRGs of 14, 113, 236, 263, 264, 429, 483 **14** - Paid normal DRG payment with per diem days - or > average length of stay **16** - Paid as a cost outlier with per diem days - or > average length of stay **30** - Bad Metropolitan Statistical Area (MSA) Code Return codes **50-99** describe why the bill was not priced: **51** - No provider-specific information found **52** - Invalid CBSA in provider file **53** - Waiver State - not calculated by PPS **54** - DRG is not less than 001 or greater than 559; or equals 004, 005, 107, 109, 112, 115, 116, 209, 214, 215, 221, 222, 231, 400, 434, 435, 436, 437, 438, 456, 457, 458, 459, 460, 469, 470, 472, 474, 478, 483, 514, 516, 517, 526, 527. **55** - Discharge date is earlier than provider's PPS start date or later than the provider's PPS termination date **56** - Invalid length of stay **57** - Review Code invalid **58** - Charges not numeric **59** - Possible day outlier candidate **61** - Lifetime reserve days are not numeric **62** - Invalid number of covered days (e.g., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) **63** - Review code of **00** or **03** and bill is cost outlier candidate **64** - Disproportionate share percentage and bed size conflict on Provider Specific File **98** - Cannot process bill older than 5 years
WAGE INDEX	**Wage Index** – Six-digit field that identifies the wage index, as supplied by CMS, for the state where the services were provided to determine reimbursement rates for the services rendered in 99.9999 format.
OUTLIER DAYS	**Outlier Days** – Three-digit field that identifies the number of days beyond the cutoff point for the applicable DRG.

AVE # LENGTH OF STAY	**Average Length of Stay**-Four-digit field that identifies the CMS predetermined length of stay based on certain claim data in 99.99 format.
OUTLIER DAYS THRESHOLD	**Outlier Days Threshold-**Four-digit field identifies the number of days of utilization permissible for the DRG code in this claim. Day outlier payment is made when the length of stay (including days for a beneficiary awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation in 99.99 format.
OUTLIER COST THRESHOLD	**Outlier Cost Threshold-**Nine-digit numeric field used if the claim has extraordinarily high charges and does not qualify as a day outlier, then the claim may qualify as a cost outlier. Payment is based on the applicable Federal rate percentage times 75% of the difference between the hospital's cost for the discharge and the threshold established for the DRG in 9999999.99 format.
INDIRECT TEACHING ADJ#	**Indirect Teaching Adjustment Number** - Eight-digit numeric field that identifies the amount of the adjustment calculated by the Pricer for teaching hospitals in 999999.99 format.
TOTAL BLENDED PAYMENT	**Total Blended Payment** – Eight-digit numeric field that identifies the total PPS payment amount consisting of the Federal, hospital, outlier and indirect teaching reductions (such as Gramm Rudman) or additions (such as interest) in 999999.99 format
HOSPITAL SPECIFIC PORTION	**Hospital Specific Portion** - Eight-digit numeric field that identifies the hospital portion of the total blended payment used in reimbursing this PPS claim in 999999.99 format.
FEDERAL SPECIFIC PORTION	**Federal Specific Portion** – Eight-digit field that identifies the Federal portion of the total blended payment used in reimbursing this PPS claim in 999999.99 format.
DISP# SHARE HOSPITAL AMT	**Disproportionate Share Hospital Amount** - Nine-digit field defined as the percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also Supplemental Security Income (SSI) (this percentage will be supplied by CMS) in 9999999.99 format. Medicaid days and total days are available on the hospital's cost reports.
PASS THRU PER DISCHARGE	**Pass Thru Per Discharge** - Eight-digit numeric field that identifies the pass-through discharge cost in 999999.99 format.
OUTLIER PORTION	**Outlier Portion** - Eight-digit numeric field identifying the dollar amount calculated that reflects the outlier portion of the charges in 999999.99 format.
PTPD + TEP	**Pass Through Per Discharge Plus Total Blended Payment** -Eight-digit numeric field that reflects the sum of the pass through per discharge cost plus the total blended payment amount in 999999.99 format.
STANDARD DAYS USED	**Standard Days Used** - Three-digit numeric field that identifies the number or regular Medicare Part A days covered for this claim.
LTR DAYS USED	**Lifetime Reserve Days Used** - Two-digit numeric field that identifies the number of lifetime Reserve Days used during this benefit period.
PROV REIM	**Provider Reimbursement Amount** - Eight-digit numeric field that identifies the actual payment amount to the provider for this claim in 999999.99 format. This will be the amount on the Remittance Advice/Voucher.
PRICER VER	**Pricer Version** - Four-digit numeric field that identifies the program version number for the Pricer program used.

Claims Summary (Option 12) MAP1741

Purpose

The Claims Summary Inquiry screen displays specific claim history information for all pending and processed claims. The screen will show the condition of claim and where it is located in the system, based on the Medicare Beneficiary Identification number and dates of service selected. The claim status information is available online for viewing immediately after the claim is updated/entered on DDE. The entire claim can be viewed on-line through claim inquiry function but cannot be updated.

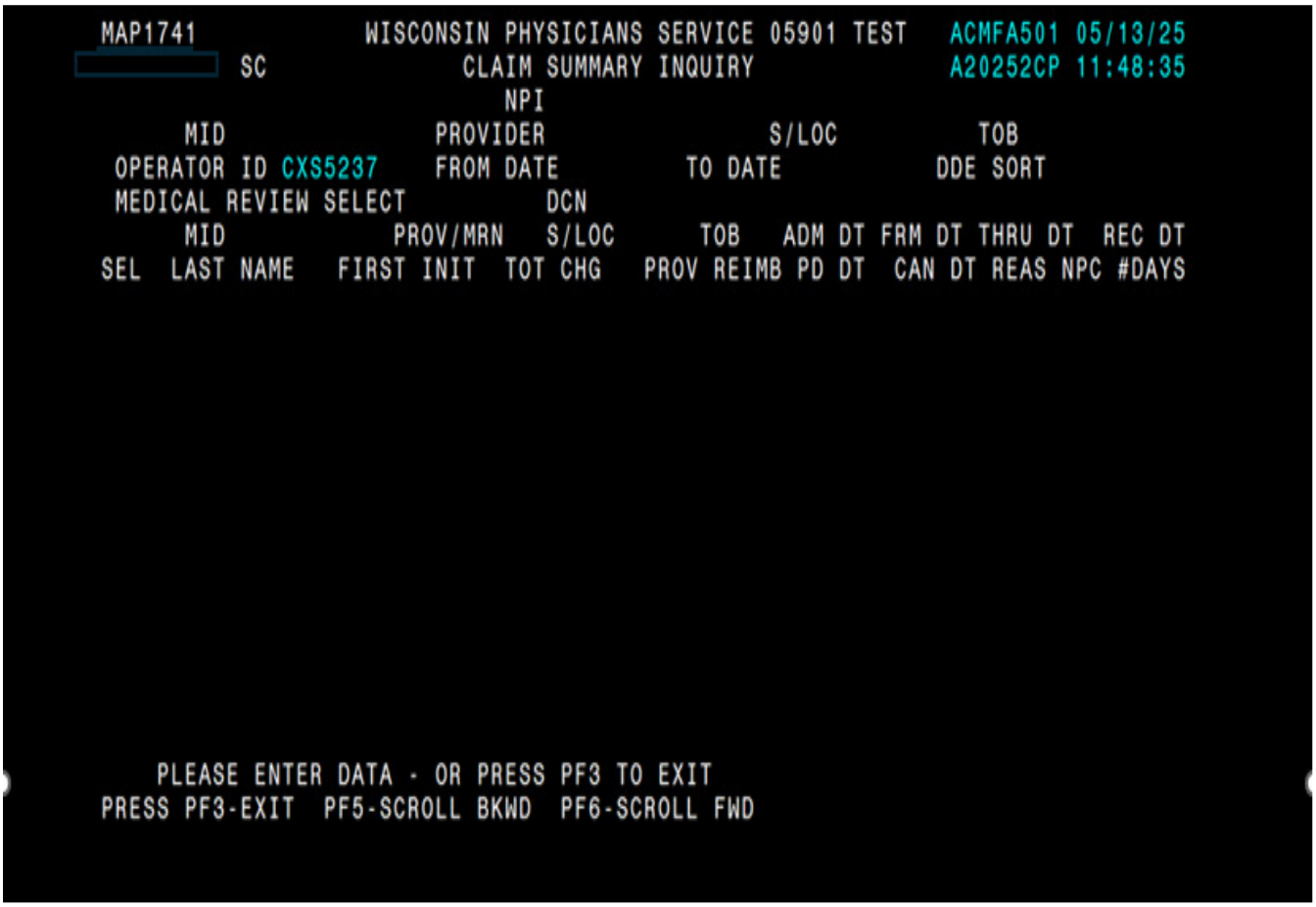
Access

From the Inquiry Menu, Type 12 in the "Enter Menu Selection", Press **<ENTER>.**

To start the Claims Summary inquiry process, enter the National Provider Identifier (NPI) number, patient's MBI number and the type of bill (TOB) code for the claim you wish to see and press **<ENTER>.**

DDE will display a list of all claims of that bill type for the patient.

You can customize your search by entering the Medicare Beneficiary Identifier (MBI) in combination with any of the following fields: TOB, STATUS, LOCATION, STATUS/LOCATION, and FROM/TO DATE before pressing **<ENTER>.**



The denial claim inquiry screen displays specific claim history for all pending and processed claims. The claim status information available is updated for viewing immediately after the claim is updated/entered in DDE.

- Select the claim to be viewed in detail by pressing <**TAB**> until the cursor is in the **SEL** field on the first line of the claim to be viewed. Type an **S** to select the claim and press <**ENTER**>.
- When you select a claim inquiry, you will automatically see MAP1711, which is the first page of the claim. To access the rest of the claim pages, press <**F8**> until all pages are viewed.
- To make multiple inquiries, key over the MBI and TOB code with the next patient's data and press <**ENTER**>.

To exit the detail claim inquiry screen, press <**F3**>. This will return you to the Claim Summary screen.

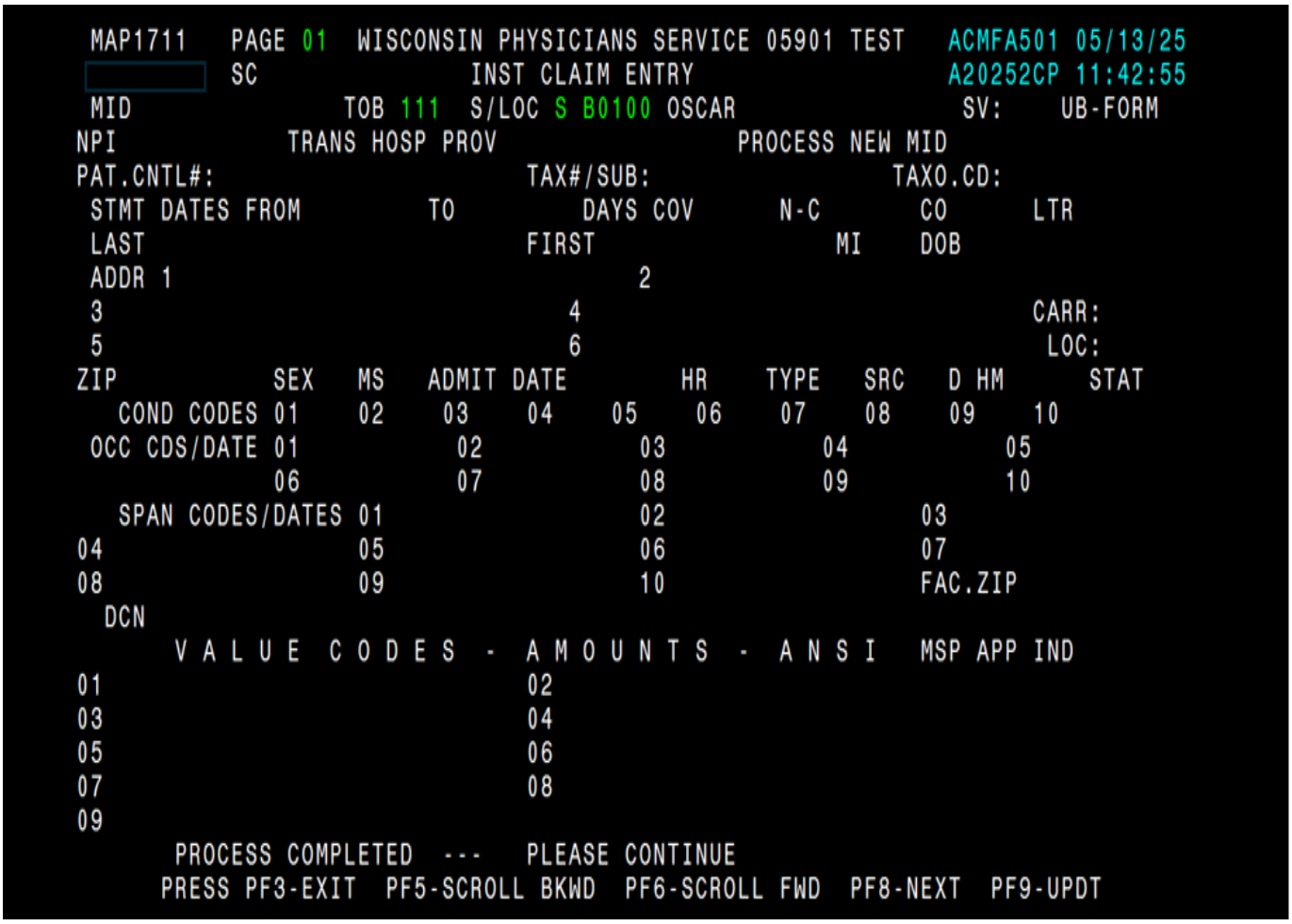
- To exit the claim summary inquiry screen, press <**F3**>. DDE will return you to the Inquiry sub-menu.
- Use this sub-menu to view newly entered claims in S/LOC S B9000.

Field Name	Description
NPI	**National Provider Identifier (NPI) –** Ten-digit unique provider identifier.
MID	**MID also known as Medicare Beneficiary Identifier (MBI)** - Type the beneficiary's identifier to view a particular beneficiary's claims data.
PROVIDER	**PTAN** - Your Medicare ID number will appear automatically.
S/LOC	**Status and Location** - Allows you to type a particular status and location you want to view.
TOB	**Type of Bill** - Three-digit alphanumeric field that identifies the type of facility, type of care source and frequency of this claim in a particular period of care. Created as follows: **1st position**-Type of facility (e.g., hospital, SNF) **2nd position**-Type of care (e.g., inpatient, outpatient) **3rd position**-Bill frequency (e.g., full period of care, first bill for multiple, adjustment, replacement, source). **Note:** The first two positions are required for a search. The third position is optional.
OPERATOR ID	**Operator Identification Number** - 13-digit alphanumeric field that identifies the individual who accesses the screen. Generally, this is the ID used when signing into the DDE System and is systematically filled.
FROM DATE	**From Date** -Six-digit numeric field that allows you to type (in MMDDYY format) the "From Date" of service you want to view.
TO DATE	**To Date** - Six-digit numeric field that allows you to type (in MMDDYY format) the "To Date" of service you want to view.
DDE SORT	**DDE Sort** - Not available in Inquiry Mode.
MEDICAL REVIEW SELECT	**Medical Review Select** - Not available in Inquiry Mode.
MID	**Known as Medicare Beneficiary Identifier (MBI)** -As it was originally keyed.
PROV/MRN	**PTAN/Medical Record Number** -Assigned to the facility.
S/LOC	**Status and Location** - Code assigned to the claim by the Fiscal Intermediary Standard System.
TOB	**Type of Bill –** Identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
ADM DT	**Admission Date** -Admission date of service.
FRM DT	**From Date -**From date of service.
THRU DT	**Through Date -** Through date of service.
REC DT	**Received Date -** Date claim was received in the FISS.

SEL	**Select -** Two-digit alphanumeric field used to select a specific claim. <TAB> down to the desired claim. Type an S and press <ENTER> to display detailed claim information for the claim you selected.
LAST NAME	**Last Name** -Patient's last name.
FIRST INIT	**First Initial -** Patient's first initial.
TOT CHG	**Total Charges -** Ten-digit numeric field that identified total charges billed on the UB-04 claim form in 99999999.99 format.
PROV REIMB	**Provider Reimbursement -** Ten-digit numeric field for amount of actual provider's reimbursement in 99999999.99 format. This is a "signed" field and displays as positive or negative as appropriate.
PD DT	**Paid Date -** Six-digit numeric field that identifies the date (in MMDDYY format) the claim was paid or written to the Remittance Advice.
CAN DT	**Cancel Date -** Six-digit numeric field that identifies the date (in MMDDYY format) of cancellation of original payment when an adjustment/cancel has been processed through the system.
REAS	**Reason Code -** Five-digit numeric field that identifies the Reason code assigned by FISS and the process being performed.
NPC	**Non-payment code –** Identifies the reason for Medicare's decision not to make payment. Valid values: B - Benefits exhausted C - Non-covered Care (discontinued) E - First Claim Development (Contractor 11107) F - Trauma code Development (Contractor 11108) G - Secondary Claims Investigation (Contractor 11109) H - Self Reports (Contractor 11110) J - 411.25 (Contractor 11111) K - Insurer Voluntary Reporting (Contractor 11106) N - All other reasons for non-payment P - Payment requested Q - MSP Voluntary Agreements (Contractor 88888) Q - Employer Voluntary Reporting (Contractor 11105) R - Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, or waiver of liability T - MSP Initial Enrollment Questionnaire (Contractor 99999) T - MSP Initial Enrollment Questionnaire (Contractor 11101) U - MSP HMO Cell Rate Adjustment (Contractor 55555) U - HMO/Rate Cell (Contractor 11103) V - MSP Litigation Settlement (Contractor 33333) W - Workers' Compensation X - MSP cost avoided Y - Internal Revenue Service (IRS)/ Social Security Administration (SSA) data match project, MSP cost avoided (Contractor 77777) Y - IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) Z - System set for types of bill 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed 00 - Coordination of Benefits (COB) Contractor (Contractor 11100) 12 - Blue Cross Blue Shield Voluntary Agreements Contractor 11112) 13 - Office of Personnel Management (OPM) Data Match (Contractor 11113) 14 - Workers' Compensation (WC) Data Contractor 11114)
#DAYS	**Number of Days –** Not available in Inquiry Mode.

Claim Page 1 (1 of 7) MAP1711

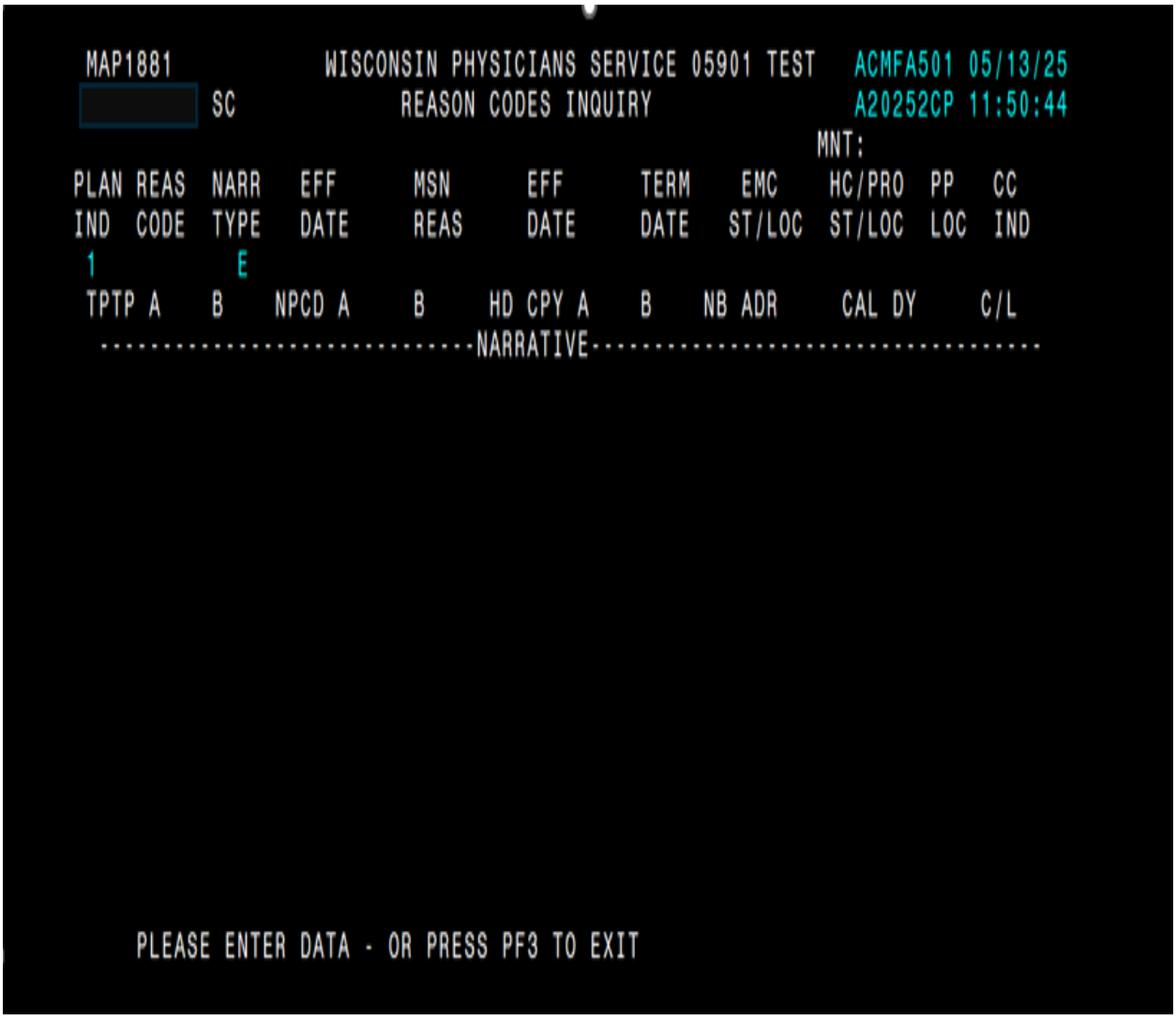
The purpose of the claim's inquiry process is to allow claim information, submitted by the provider, to be viewed online.



Reason Codes establish and maintain information needed to control automated and manual handling of system identified conditions/edits.

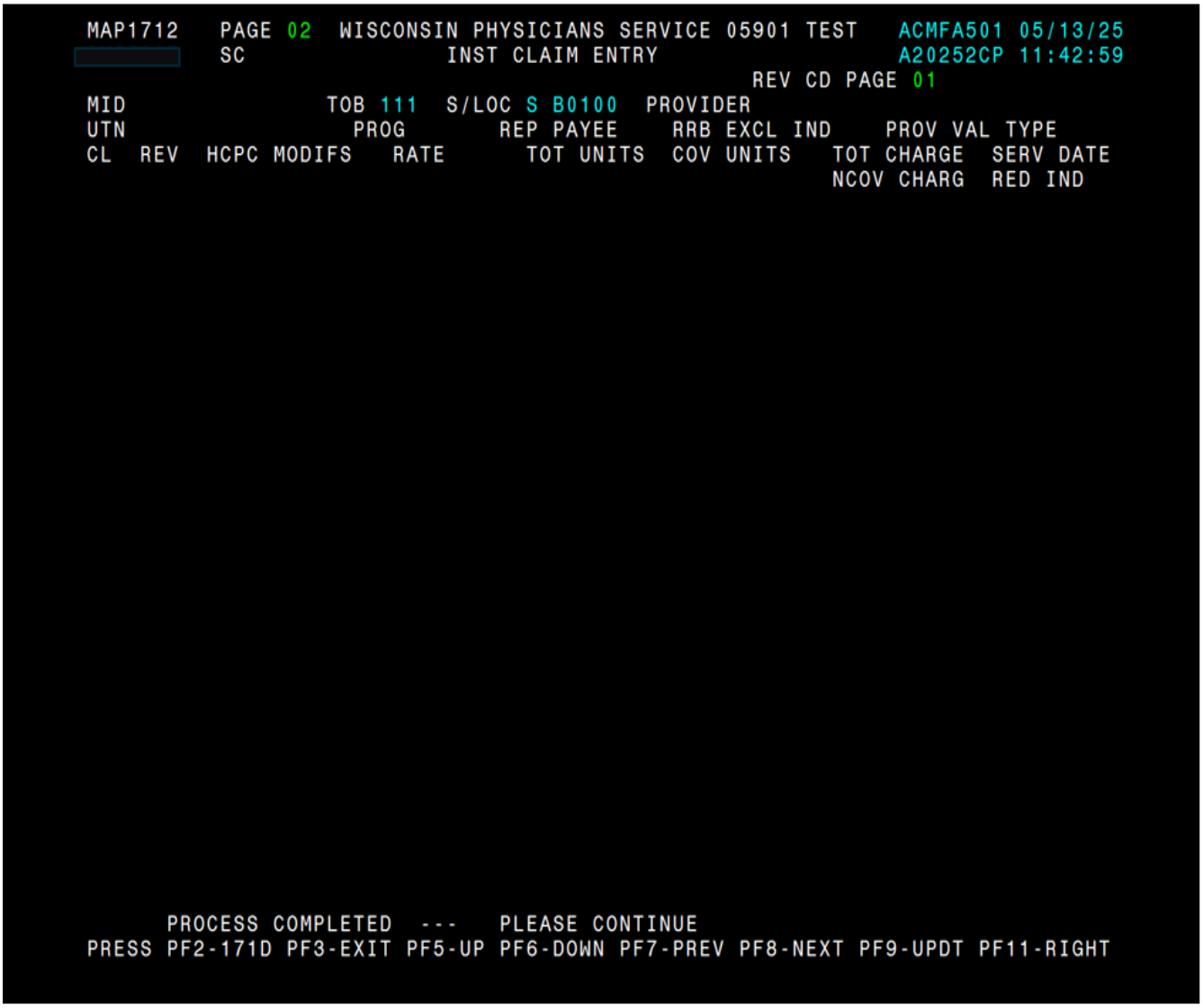
- To view a Reason Code from inside the claim, press <**F1**>
- To view additional Reason Codes, move cursor over directly under the first
- number of the next Reason Code, press <**F1**>

To return to the claim, press <**F3**>


MAP1881 WISCONSIN PHYSICIANS SERVICE 05901 TEST ACMFA501 05/13/25
SC REASON CODES INQUIRY A20252CP 11:50:44
MNT:
PLAN REAS NARR EFF MSN EFF TERM EMC HC/PRO PP CC
IND CODE TYPE DATE REAS DATE DATE ST/LOC ST/LOC LOC IND
1 E
TPTP A B NPCD A B HD CPY A B NB ADR CAL DY C/L
NARRATIVE
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

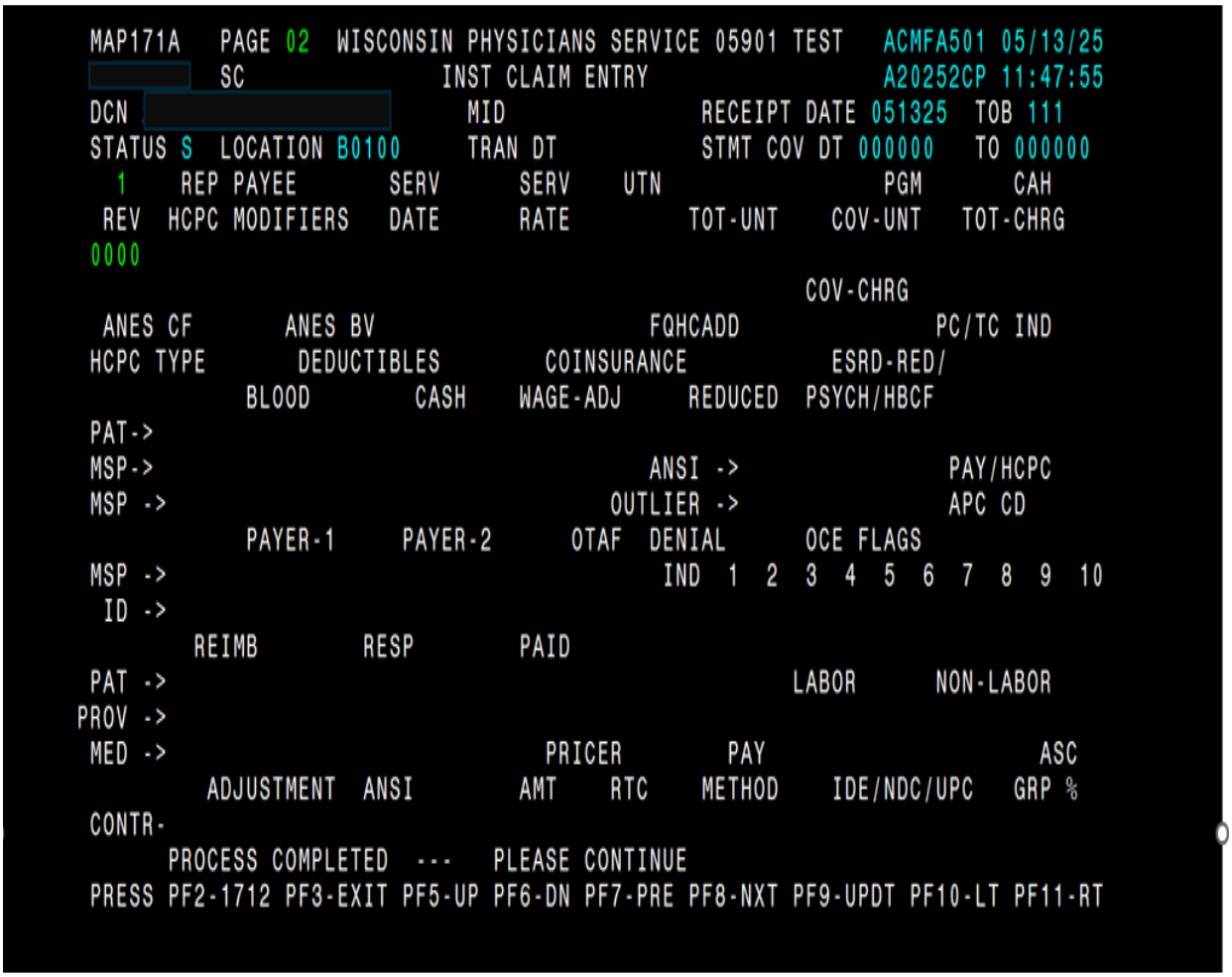
Claim Page 2 (2 of 7) MAP1712

This screen allows the provider to view covered and non-covered charges as submitted on the claim. There are three iterations of Page 2 (MAP1712, MAP171A, and MAP171D). To view other iterations, press <**F11**> twice. **Note:** If you do not see the 0001 Revenue Code – Total Charges, <**F6**> page down to see additional revenue lines.



Claim Inquiry – Page 2 (MAP171A)

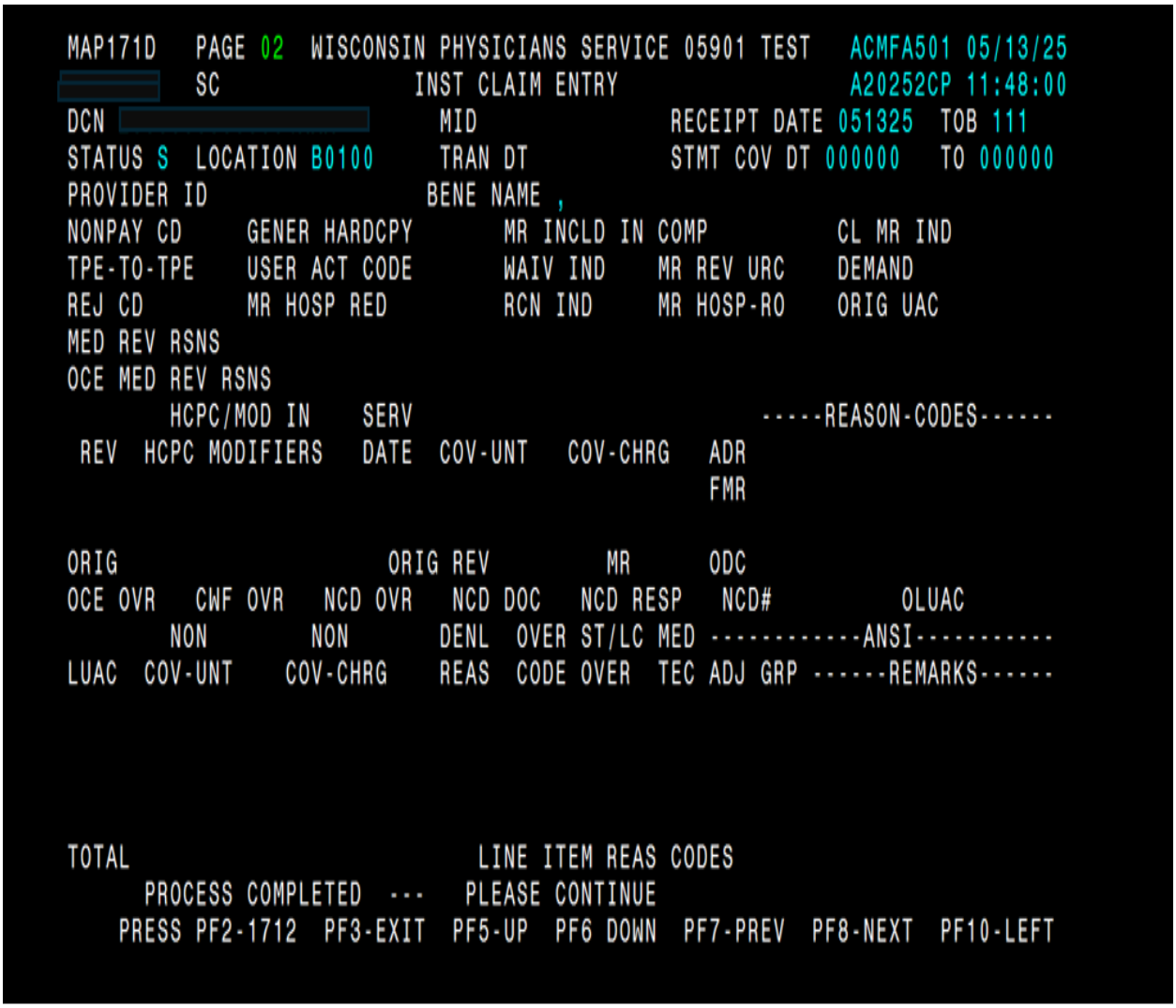
This screen was designed to allow viewing of line-item payment information.



Claim Inquiry - Page 2 (MAP171D)

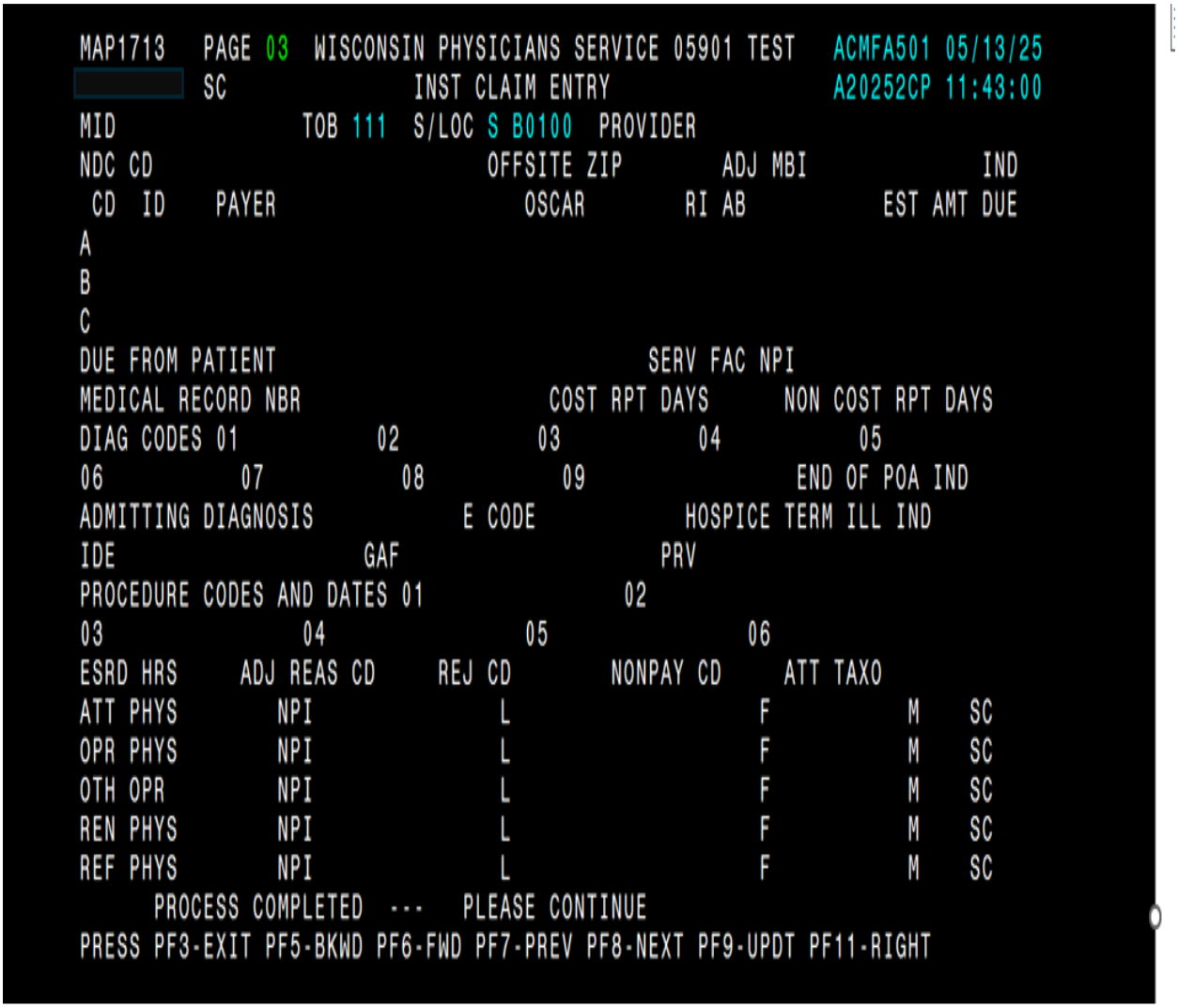
This screen was designed to allow viewing of line level Reason Codes.

Note: To move back to MAP171A, press <**F10**> twice.

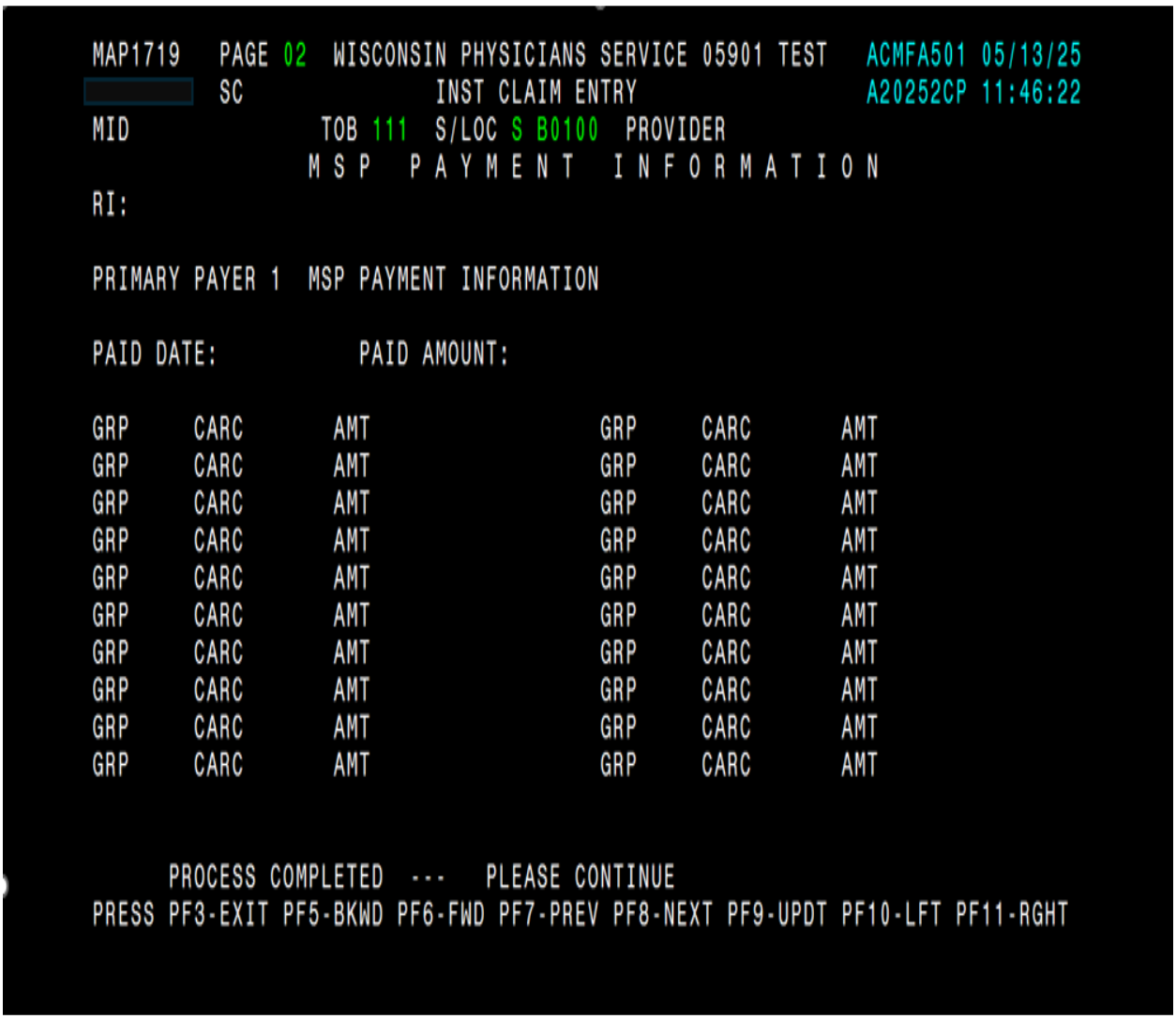


Claim Inquiry – Page 3 (3 of 7) MAP1713

This screen was designed to allow viewing MSP Inquiry, Diagnosis Codes, Procedure Codes, Adjustment Reason Codes, etc.

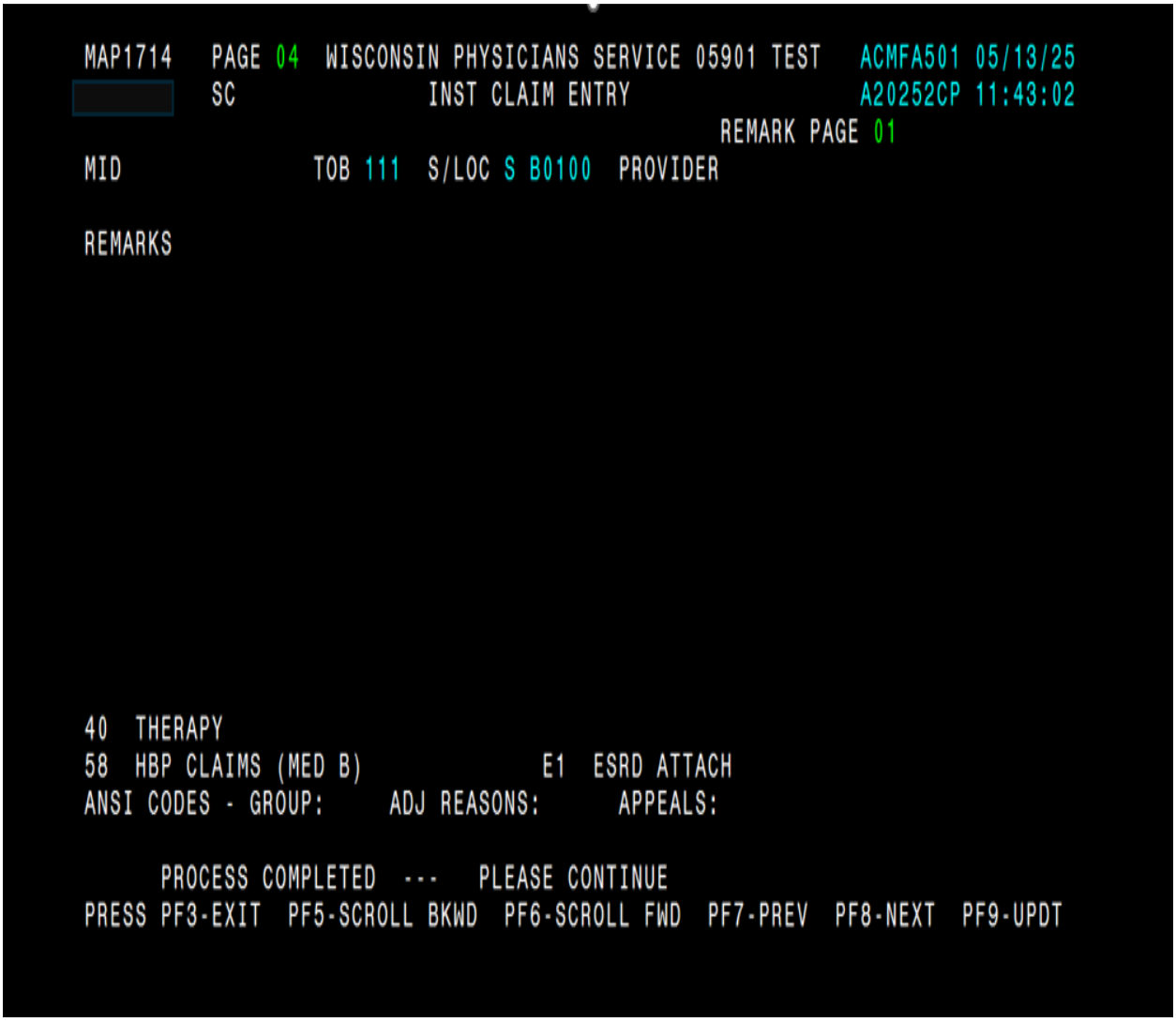


Claim Inquiry – Page 3 (3 of 7) MAP1719



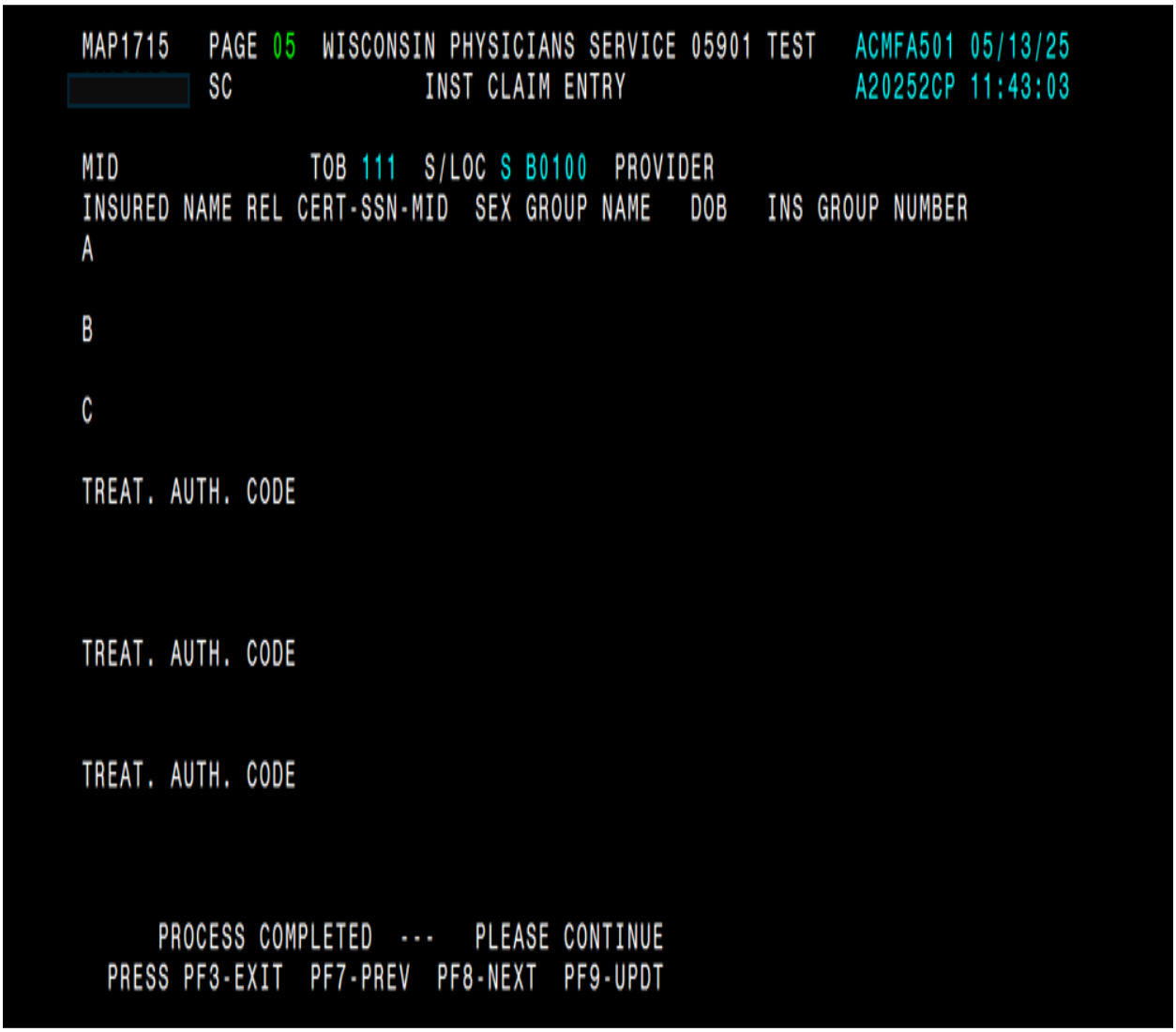
Claim Inquiry – Page 4 (4 of 7) MAP1714

This screen was designed to allow viewing of Remarks and Attachment Inquiry. **Note:** Attachments are no longer required by CMS.



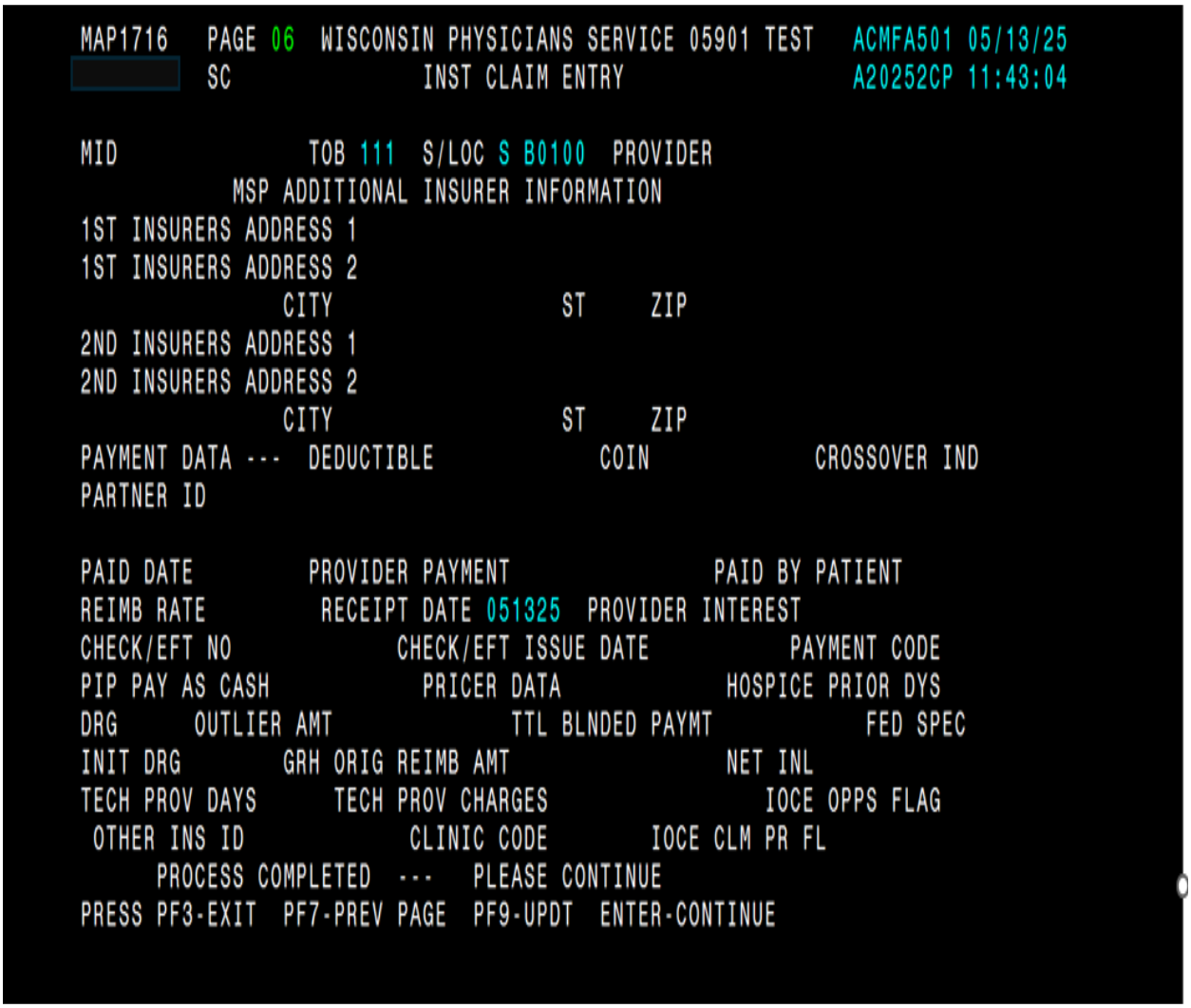
Claim Inquiry – Page 5 (5 of 7) MAP1715

This screen was designed to allow viewing of insurance and employer information.



Claim Inquiry – Page 6 (6 of 7) MAP1716

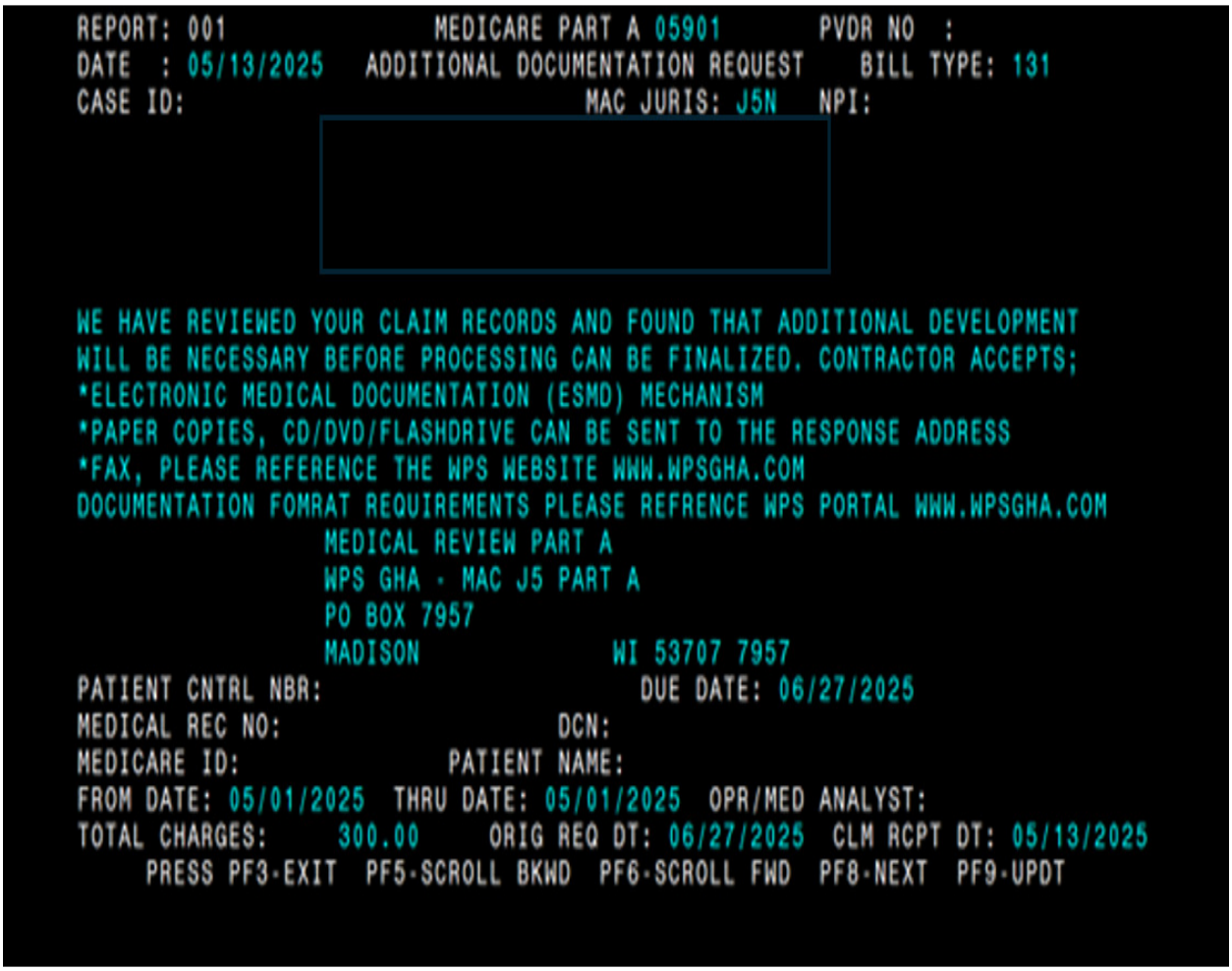
This screen was designed to allow viewing of MSP additional insurance and Payment/Pricer Data Inquiry.



Claim Inquiry – Page 7- ADR (page 1 of 2)

This screen was designed to allow on-line viewing of an Additional Development Request (ADR).
To immediately view the ADR:

- Access the claim
- Type **07** in Page Field
- To view Page 2 of the ADR, press <**F8**>
- ADR Status/Locations will be S B6000 – S B6999



The Additional Development Request process uses the FISS Operator Control File to determine whether to allow on-line viewing of ADRs via DDE. It is important to note that the 'ADR TYPE' is the sole control used in the determination of whether the operator is allowed to view ADRs on-line. The "DDE ADR TYPE" in the Provider File and the "ADR TYPE" in the Operator Control File are not compared when viewing on-line ADRs.

Valid values:
Y- Yes, this operator is authorized to view ADRs on-line.
N- No, this operator is not authorized to view ADRs on-line. It is expected that ADRs be generated hardcopy.

B-Yes, this operator is authorized to view ADRs on-line, and it is also expected that ADRs will be generated hardcopy.

Blank- Defaults to **N**. No, this operator is not authorized to view ADRs on-line. It is expected that ADRs will generate hardcopy.

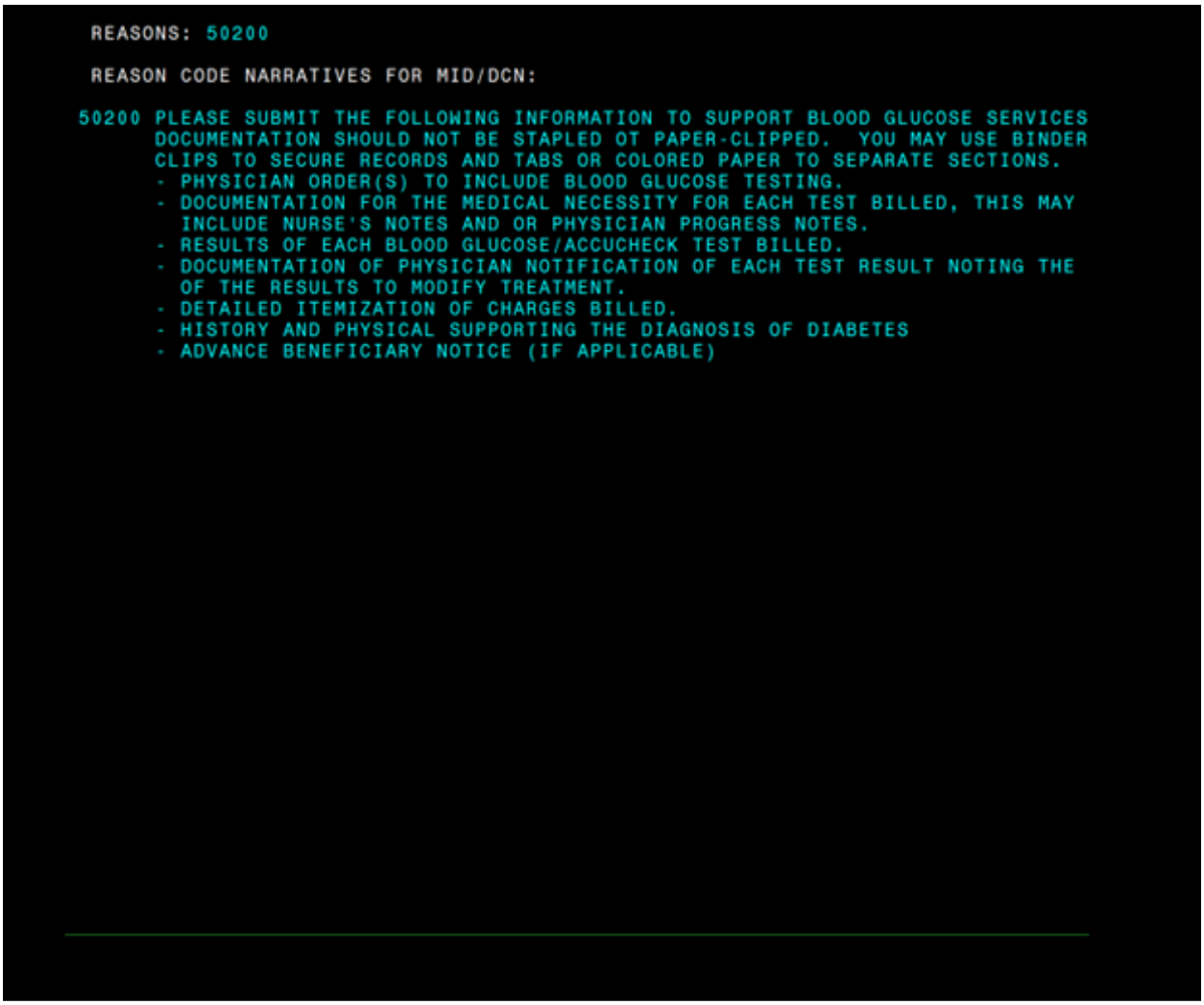
If the Intermediary is not careful in coordinating the updating of the Provider File DDE ADR TYPE field with the updating of the Operator Control File ADR TYPE field, it is possible to prevent the provider from receiving any ADRs at all. This could occur if the Provider File is updated to reflect that a provider should only receive on-line ADRs when the provider does not have DDE capability (or doesn't have an operator authorized to view the ADRs on-line).

Field Name	Description
REPORT	**Report Number** - This field identifies the standard FISS report number for Additional Development Requests.
PVDE NO	**PTAN/National Provider Identifier** - Ten-digit unique provider identifier.
DATE	**Date** – Eight-digit numeric field that identifies the system date on which the ADR is being viewed.
BILL TYPE	**Bill Type** - Three-digit numeric field that identifies the type of facility, type of care, and sequence of this bill in a particular period of care.
PATIENT CNTRL NBR	**Patient Control Number** - This field identifies the patient account number assigned to the beneficiary by the provider.
MEDICAL REC NO	**Medical Record Number** - This field identifies the provider's identification number for the claim.
DCN	**Document Control Number (DCN)** - This field identifies the internal control number of the claim assigned by the system.
MBI	**Medicare Beneficiary Identifier** - 11-digit alphanumeric field that identifies the Medicare identifier assigned to the beneficiary by CMS.
PATIENT NAME	**Patient Name** - Full name of the beneficiary/patient.
FROM DATE	**From Date** - Beginning date of service on the claim.
THRU DATE	**Thru Date** - Ending date of service on the claim.
OPR/MED ANALYST	**Operator** / **Medical Analyst** - Unique ID code assigned to the operator or medical analyst who requested the additional development.
TOTAL CHARGES	**Total Charges** - This field identifies the total charges from revenue code 0001 on the claim record.
ORIG REQ DT	**Original Request Date** -The date the original ADR was generated for this claim.
CLM RCPT DT	**Claim Receipt Date** - This field contains the date on which the Intermediary received the claim.

Claim Inquiry – Page 7- ADR (page 2)
This screen was designed to allow on-line viewing of the Additional Development Request (ADR) External Reason Code narratives.

- For Reason Codes to display in ADRs, an External Narrative must be set up in the Reason Code file.
- To view reason code narrative press <**F8**>.

To return to claim press <**F8**> again



Revenue Code Inquiry (Option 13) MAP1761

Purpose

This screen will display data needed for revenue code processing.

Access

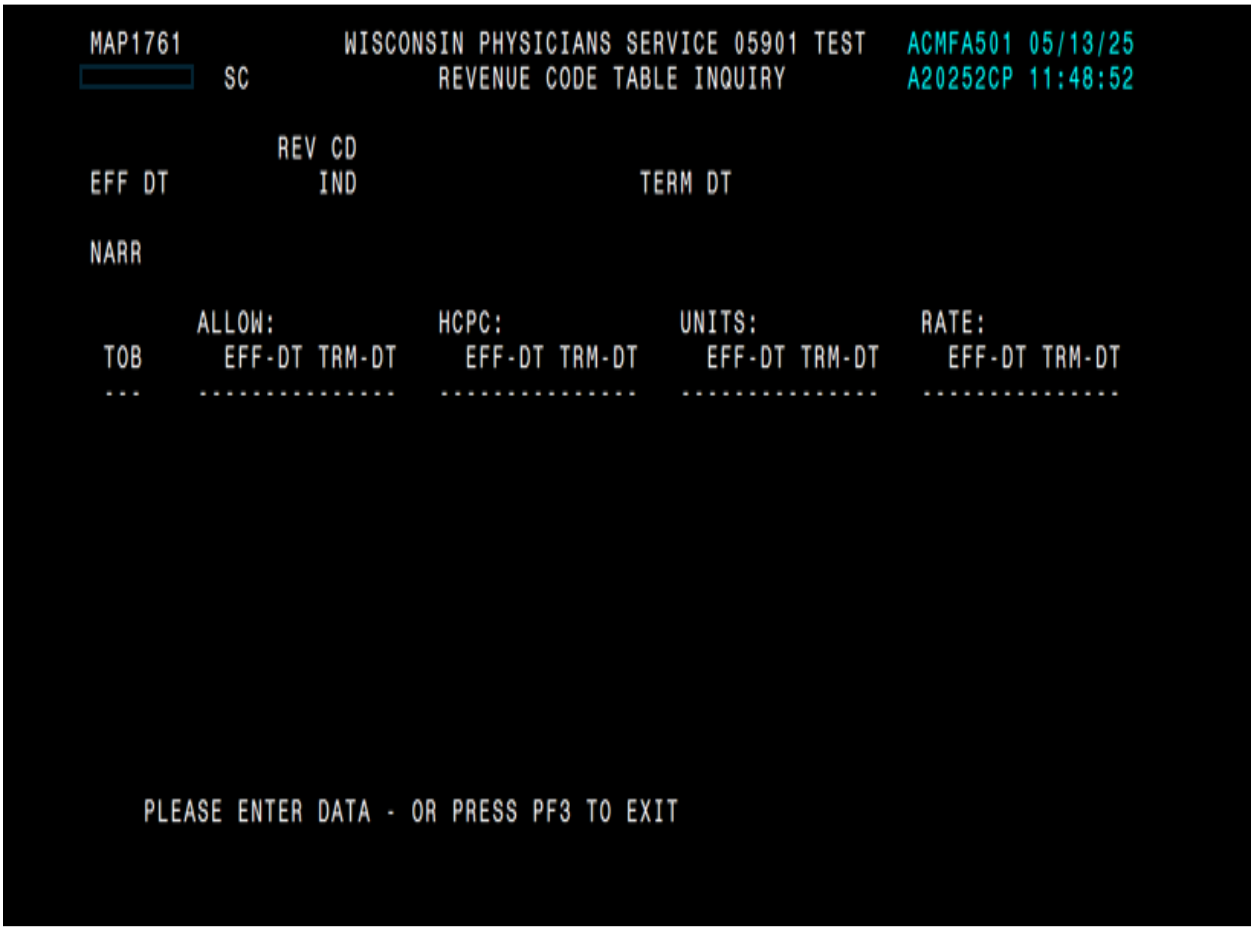
From the Inquiry Menu, to access the Revenue Code sub-menu:

In the Enter Menu Selection Field, Type **13** Press <**ENTER**>

The Revenue Code Table provides information regarding revenue codes that are billable for certain types of bills within the FISS system. Reference this file to determine which revenue codes are allowable for certain types of bills and whether they require a HCPCS, unit, or rate. The effective date and the date of termination (if applicable, for the Revenue Code will also be displayed.

Type the four (4)-digit Revenue Code you wish to view in the REV CD field.

Revenue Code Table Inquiry



Field Name	Description
REV CD	**Revenue Code -** Four-digit numeric field that identifies a specific accommodation, ancillary service, or billing calculation. **Valid values: 0001-9999**
EFF DT	**Effective Date** - Six-digit numeric field that identifies the date the code became effective/active in MMDDYY format.
IND	**Effective Date Indicator** -One-digit alphanumeric field instructs the system to either use the FROM date on the claim or to use the System Run Date to perform edits for this particular revenue code. **Valid values:** **F** - Claim from date **R** - Claim receipt date **D** - Claim discharge date
TERM DT	**Termination Date** - Six-digit numeric field that identifies the date the code was terminated/no longer active in MMDDYY format**.**
NARR	**Narrative** - 77-digit alphanumeric field that identifies the English-language description of the code.
TOB	**Type of Bill** - This field identifies all types of bill codes within the Medicare Part A system that are allowed by Medicare.

07/ALLOW EFF-DT TRM –DT	**Allowable -**This code identifies whether or not the revenue code is currently valid for a specific type of bill. Valid values: Y - Yes N – No
HCPC EFF-DT TRM-DT	**Health Care Procedure Code System (HCPCS)** – One-digit field that identifies whether a HCPCS code is required from specific types of providers for this Revenue Code by type of bill. Valid values: Y - HCPCS is required for all providers N - HCPCS not required V - Validation of HCPCS is required F - HCPCS required only for claims from free standing ESRD facility H - HCPCS required only for claims from hospital based ESRD facility
UNITS EFF-DT TRM-DT	**Units -** Identifies if the revenue code requires units to be present for a specific type of bill. Valid values: Y - Yes N – No
RATE EFF-DT TRM-DT	**Rate** - Identifies if the revenue codes require a rate to be present for a specific type of bill. Valid values: Y - Yes N - No

Diagnosis and Procedure Code (Option 15) MAP1731

Purpose

This file is for inquiry only; updates are not permitted (all fields are protected). The file provides a reference of ICD-9-CM code(s) used to identify specific diagnosis(es) or inpatient surgical procedure(s) relating to the bill, which may be used to calculate payment, e.g., DRG or make medical determinations relating to the claim.

Access

From the Inquiry Menu, to access the DX/PROC Codes sub-menu:
In the Enter Menu Selection field
Type 15
Press **<ENTER>**

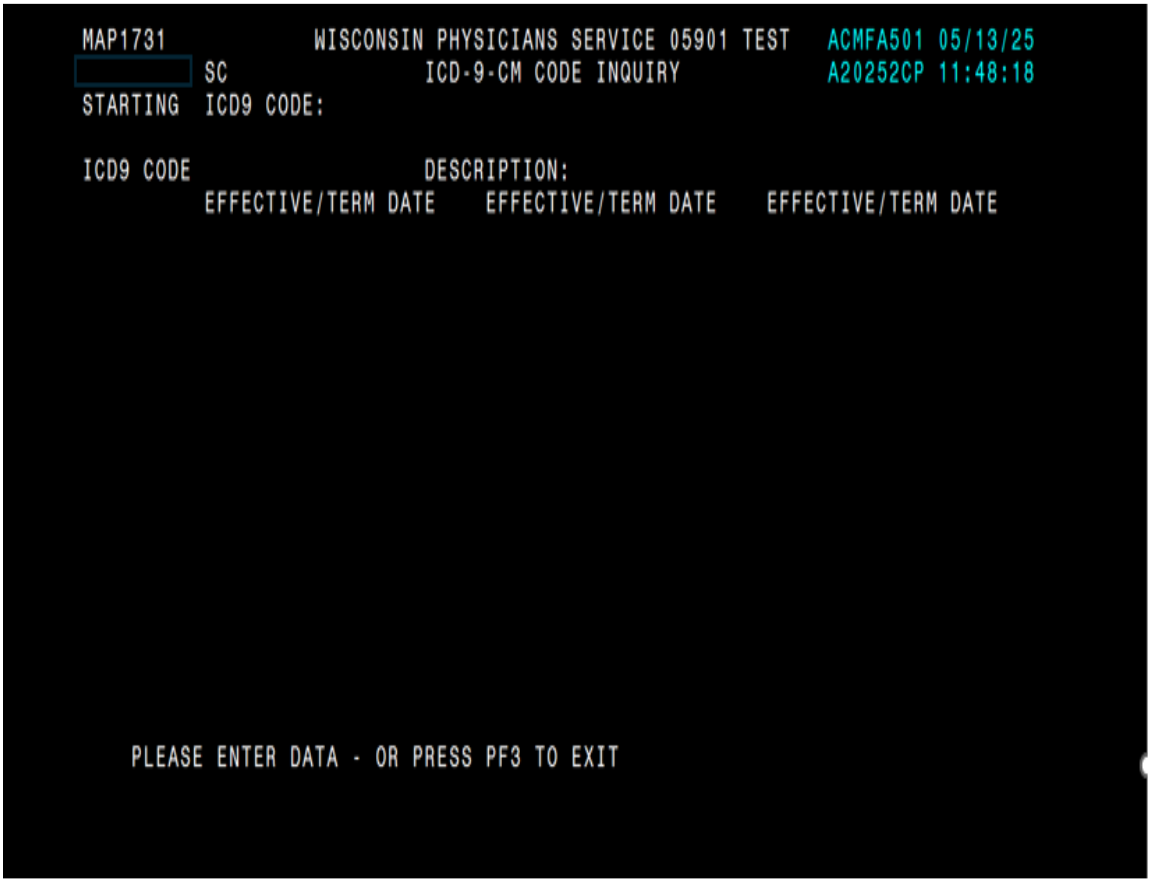
Diagnosis & Procedure Code Table

The diagnosis or procedure code screens display the description for the ICD-9-CM code. These screens are used for inquiry only and provide a reference of ICD-9-CM codes to identify specific diagnoses or inpatient surgical procedures relating to the bill. After one code is entered, the screen will also display other codes in sequential order. By using the scroll keys, you may also view previous or remaining codes on the system.

- Type the first ICD-9-CM code desired and press <**ENTER**>. The system will display all ICD-9-CM code from that code forward.

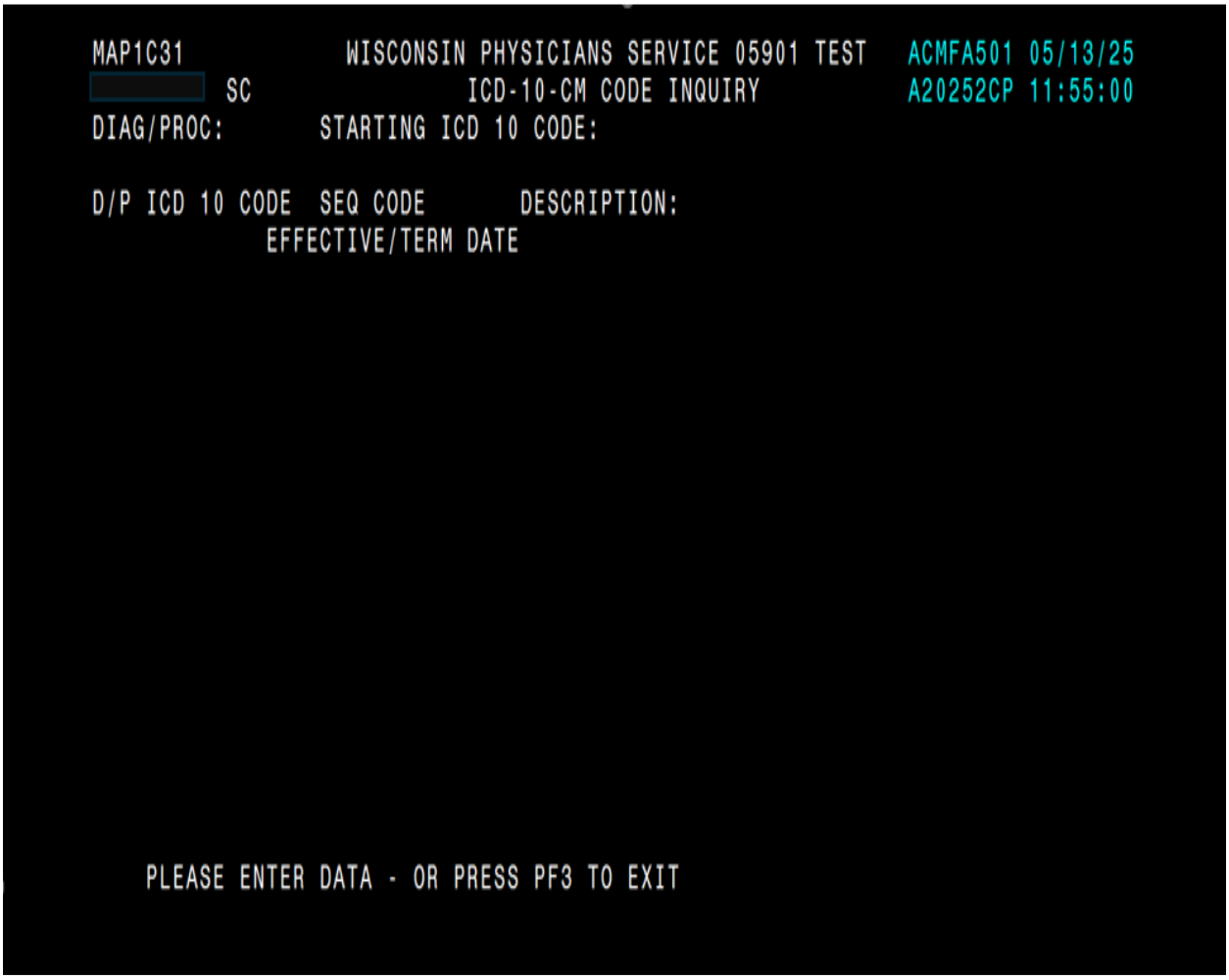
• To enter a procedure code, you must **first type an alpha P,** then the three or four digits of the procedure code. When entering a diagnosis code, do not precede the code with an alpha **P**. If you enter an invalid code, the system will try to select the nearest code. Do not key codes with decimal or zero fill.

ICD-9-CM Code Inquiry Screen (MAP1731)



Field Name	Description
STARTING ICD9 CODE	**Starting ICD-9 Code** - To view all ICD-9-CM codes, press the <**ENTER**> key at this field. The ICD-9-CM code is used to identify a specific diagnosis(es) or inpatient surgical procedure(s) relating to a bill, which may be used to calculate payment (i.e., DRG) or make medical determination relating to a claim.
ICD9 CODE	**ICD-9 Code** - Specific ICD-9 code to be viewed.
DESCRIPTION	**Description** - 77-digit alphanumeric field displaying the description of ICD-9 code.
EFFECTIVE DATE	**Effective Date** - Six-digit numeric field that displays the effective date of the program in MMDDYY format. There are three (3) occurrences of this field.
TERM DATE	**Termination Date** - Six-digit alphanumeric field displaying the program ending date in MMDDYY format. There are three (3) occurrences of this field.

ICD-10-CM Code Inquiry Screen (MAP1C31)



Adjustment Reason Code Inquiry (Option 16) MAP1821

Purpose
This screen provides an on-line method to identify the two-digit adjustment reason code and narrative for a particular type of adjustment. This file is also used to validate the adjustment reason code entered on the adjustment.

Access
From the Inquiry Menu, to access the Adjustment Reason Code sub-menu: In the Enter Menu Selection field, Type 16, Press **<ENTER>.**

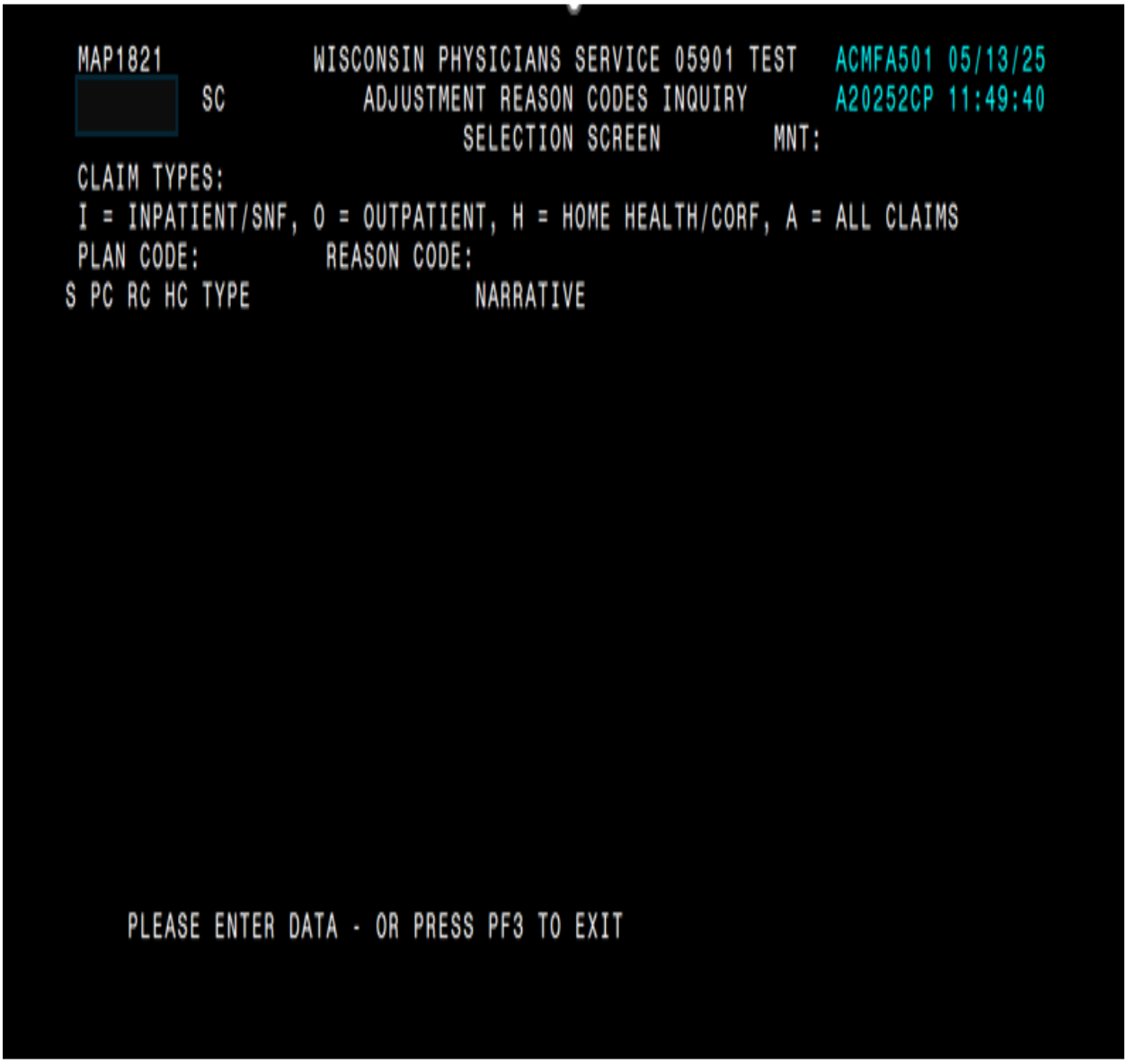
The adjustment reason code file contains the adjustment narrative description and associated two-digit adjustment codes, which define, by type of bill, the reason an adjustment is being processed.

Adjustment reason codes are required any time you make an adjustment to a processed claim (XX7).

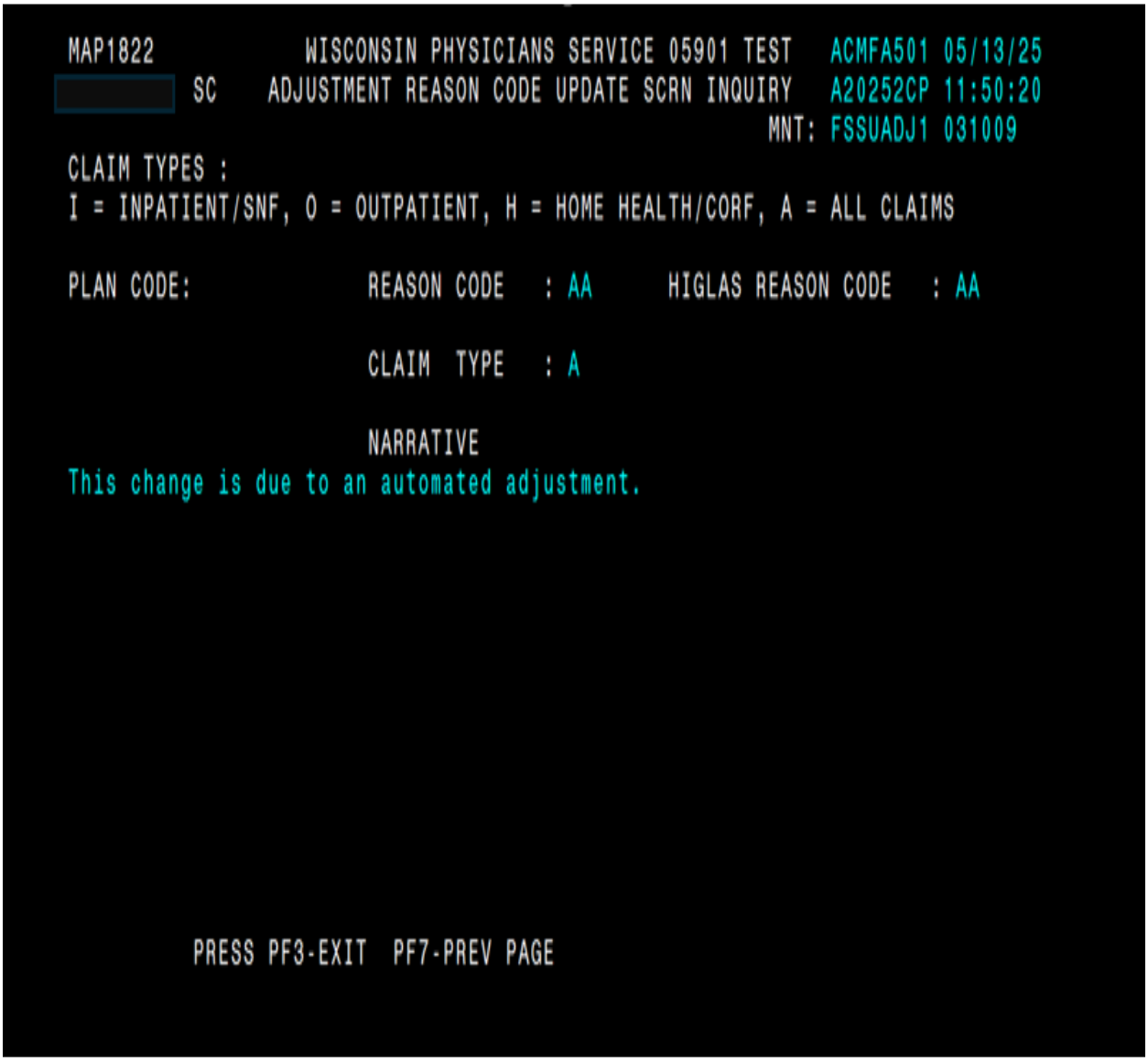
Key the two-digit adjustment reason code in the reason code field to view the narrative or press **<ENTER>** twice to view all adjustment reason code narratives.

The adjustment reason code file may contain user defined adjustment reason code, but the original code cannot be altered, e.g., DP's description cannot be changed to Deranged Patient. DP must remain Diagnosis and Procedure changes.

To view the detail for an Adjustment Reason Code, from the Selection Screen position the cursor in the **S** field and type **S** beside the desired code.



Adjustment Reason Code Update-Screen Inquiry (MAP1822)



Field Name	Description
CLAIM TYPES	**Claim Types** - This field describes the claim types identified for each adjustment reason code. This field is not accessible.
PLAN CODE	**Plan Code -** This field differentiates between plans (Intermediaries), which share a processing site. The home or host site is considered **1** by the system. It is the number assigned to the site on the System Control file. **Valid values: 1-9**
REASON CODE	**Reason Code** - Two-digit alphanumeric field. To view a specific adjustment reason code, enter the value in this field. To view all Adjustment reason codes, press the <**ENTER**> key in this field. There are hard coded and user defined Adjustment Reason Codes. **Note:** PRO Review Code letters are indicated in parentheses. **Valid values:**

	AA - Automated adjustment **AD** - Admission denial - technical denial (A) **AM** - Admission denial - no payment (medical denial) (A) **AR**- Admission Reversal **AU** - Automobile **AW-** Admission Denial-Payable Per Waiver **BB** - Same Day Transfer **BC** - Adjustment due to Common Working File (CWF) beneficiary overlay problem **BL** - Black lung **CC** - SNF PPS Demand bill appeals determination decision **CD** -Covered days charges (B) **CO** -Cost outlier - no payment (E) **CP** - Cost outlier partial approved **CR** -Claim reconsideration **DB** -Disability **DC** -Diagnosis changes **DD** -Discharge destination code changes **DG** -DRG change & day outlier denial (G) **DH** -DRG change & cost outlier denial (H) **DI** - DRG & Beneficiary liability change (I) **DO** -Day outlier denial - no payment (D) **DP** - Diagnosis and procedure changes **DS** - Discharge status changes **DV** - DRG validation **ES** – ESRD **FB** - Beneficiary liability change (F) **FD** - Full denial - (A) **FF** - Ban on payment rescinded **FR** - Full reversal (N) **FT** - Full denial - Technical denial (A) **GG** - Ban on payment **HH** - SNF Recon **HP** - Claim cancelled due to HMO or hospice enrollment **IB** - PPS interim bill **IC** - Non-billable revenue codes/invalid revenue codes **ID** - Inpatient or blood deductible **II** - CERT **JJ** - Probes **JP** - Deemed Admission – input PRO code 1J or 5J **KB** -Deemed admission/diagnosis and procedure code (J) **KD** -Deemed admission/diagnosis code change (K) **KK** - Appeals Outpatient **KP** - Deemed admission/procedure code change (K) **LD** - Deemed admission/day outlier denial (L) **LI** - Liability **LL** - Sanctioned Unique Physician Identification (UPIN) **MA** - Mass Adjustment – CMS mandated **MC** - deemed admission/cost outlier denial - input pro code 1m **MM** - Administrative Law Judge , or ALJ **MR** - Non appeal Medical review adjustment **NN** - Fair Hearing **OC** - Procedure codes changed, denied or added **OO** - Part B Review **OP** - Day outlier partially approved **OR** - Outpatient Redetermination

	OT - Other change **PC** - Procedure changes (C) **PH** - Public Health Service (PHS) MSP value code 16 **PI** - Program Integrity **PN** - PTAN change **PP** - Discharge status change (P) **R1**- For re-openings performed within 1 year of the date of the initial Determination **R2- For** re-openings performed greater than 1 year and up to 4 years from the date of the initial determination **R3** - For re-openings performed greater than 4 years of the date of the initial determination **PR** - Previous adjustment modified (modifies the PRO's last action (O) **PT** - Admission denial and DRG change (T) **QC** - Procedure codes (HCPCS) changed/deleted/added (R) **QD** - Ancillary services denied or approved (Q) **QQ** - Update Timely Filing **QR** -HCPCS add/delete/change with ancillary change (S) **RP** - Partial reversal of previous adjustment (O) **RR** - Change patient status **SA** - Increase in covered services **SB** - Decrease in covered services **SC** - Change in professional component amount **SD** - Change in patients' paid amount **SE** - PRO-related Utilization adjustment **SG** - Services not provided/billed in error/duplicate **SI** - Change in dates of service or admission **SL** - Inpatient/outpatient claim service dates duplicate or overlap **SO** - Change due to Part A to B or Part B to A coverage change **SP** - Reopen **SR** - Special project – provider initiated **SS** - Change/add occurrence span code **SV** - Adjustment to "spin-off" claim **SW** -Adjustment to correct reimbursement, or provider-initiated DRG change **SZ** - Special Project – intermediary initiated **TA** - Change from untimely to timely **TB** - Change Medicare Secondary to Medicare Primary **TL** - Adjustment/claim processed due to telephone review decision **TT** - change/add diagnosis **UU** - change HCPCS code **VA** - Veterans Administration **VV** - Recalculate payment **WC** - Workers' compensation **WE** - Working elderly **WW** - Change dates of service **XX** - Decrease in charges **YY** - Change/add modifiers **ZA** - Office of Inspector General (OIG) PPS transfer recovery project **ZB** - OIG duplicate payment recovery project **ZW** - Adjustment being processed for Medicare Administrative Contractor (MAC)/Provider and initial bill is being processed to CWF **ZZ** - increase in charges

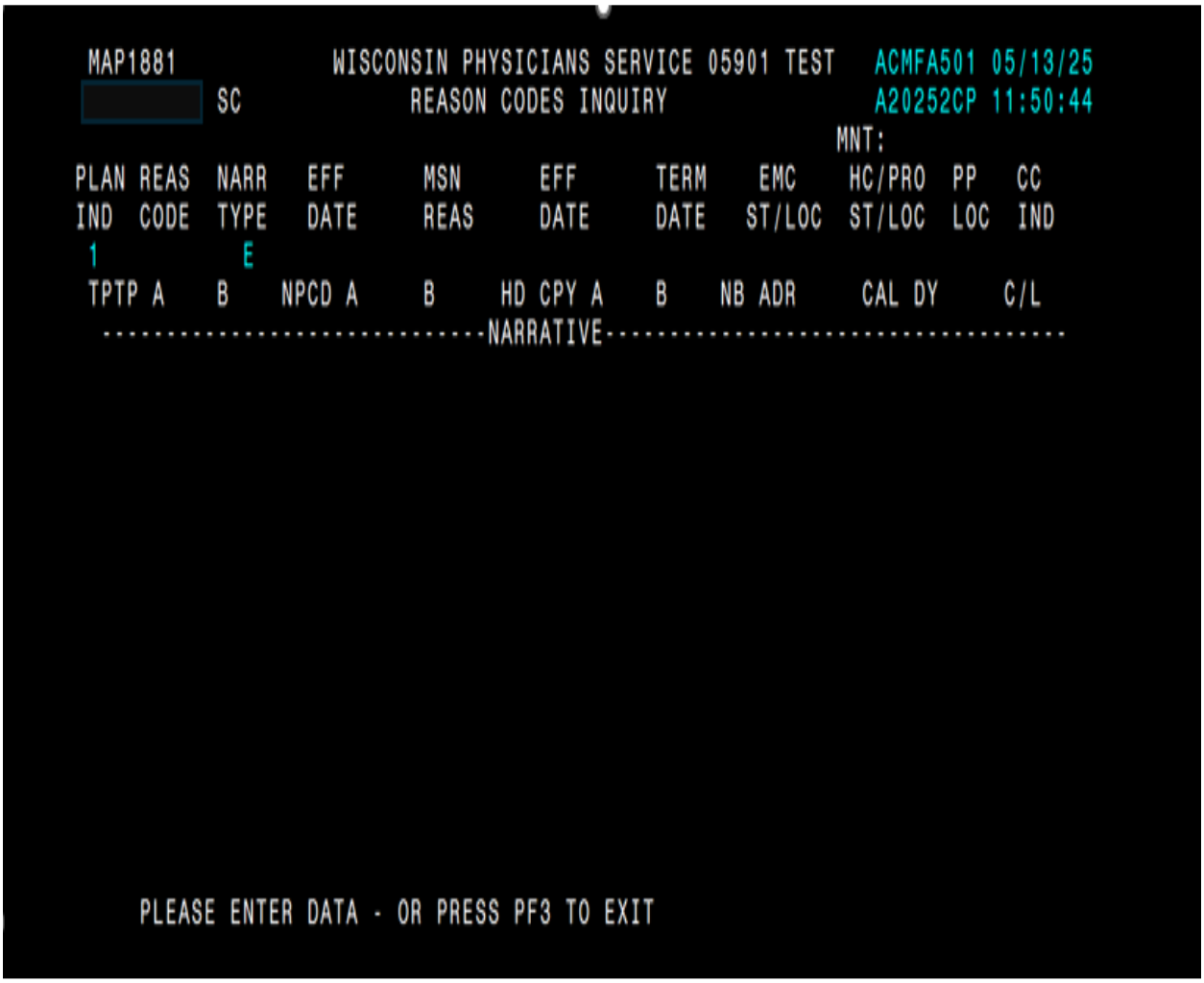
S	Type **S** in the field to make a selection.
PC	**Plan Code -** This field differentiates between plans (Intermediaries), which share a processing site. The home or host site is considered **1** by the system. It is the number assigned to the site on the System Control file. **Valid values: 1-9**
RC	**Reason Code** - Two-digit alphanumeric field that displays the adjustment reason code.
TYPE	**Type** - One-digit alphanumeric field displaying the type of claim associated with this reason code. **Valid values:** **I** - Inpatient/SNF **O** – Outpatient **H** - Home Health/CORF **A** -All claims
NARRATIVE	**Narrative** - 69-digit alphanumeric field displaying a short description for the adjustment reason code.

Reason Codes (Option 17) MAP1881

This screen provides a reason code narrative used to explain/describe the reason code. In addition, it identifies data, such as status and location and how the claim will be adjudicated.

To start the inquiry process, type the five-position reason code and press **<ENTER>.** To make additional inquiries, key over the reason code with the next reason code and press **<ENTER>** to repeat the process**.**

Reason Code Inquiry Screen (1 of 2)

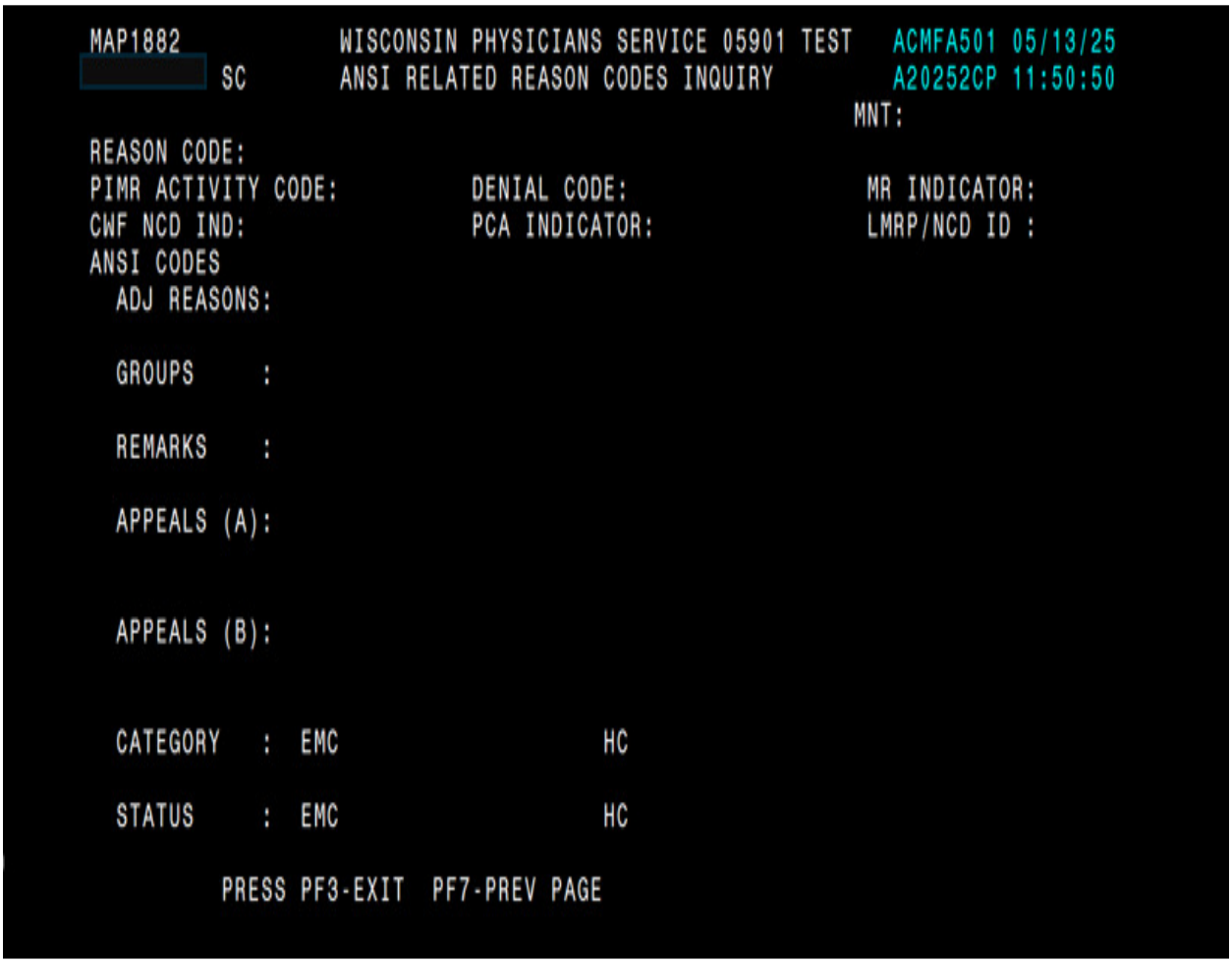


Field Name	Description
OP	**Operator Code** - Identifies the last operator who created or revised the reason code.
DT	**Date** – Identifies the date that this code was last saved.
PLAN IND	**Plan Indicator -** All FISS shared maintenance customers will be 1; the value for FISS shared processing customers will be determined at a later date.
REAS CODE	**Reason Code -** Five-digit alphanumeric field that identifies a specific condition detected during the processing of a record.
NARR TYPE	**Narrative Type -** This field identifies the "type" of reason code narrative provided. This field will default to an E - external message for DDE providers.

EFF DATE	**Effective Date -** Identifies the effective date for the reason code or condition.
MSN REAS	**Medicare Summary Notice (MSN) Reason -** field no longer used/valid.
EFF DATE	**Effective Date -** Effective date for the alternate reason code.
TERM DATE	**Termination Date -**Alternate reason code termination date.
EMC ST/LOC	**Electronic Media Claims (EMC) Status and Location –** Identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. If the ST/LOC is the same for both hard copy and EMC claims, the data will only appear in the hard copy category and the system will default to the hard copy claims for action on EMC claims
HC/PRO ST/LOC	**Hard Copy/Peer Review Organization (PRO) Status and Location Codes -** Status and location code for hard copy (paper) and peer review organization claims. This is the path DDE will follow.

To view ANSI Related Reason Codes inquiry narrative associated with Remarks or Appeals A and B, from the Reason Code Inquiry press <F8>.

ANSI Related Reason Code Screen (2 of 2)

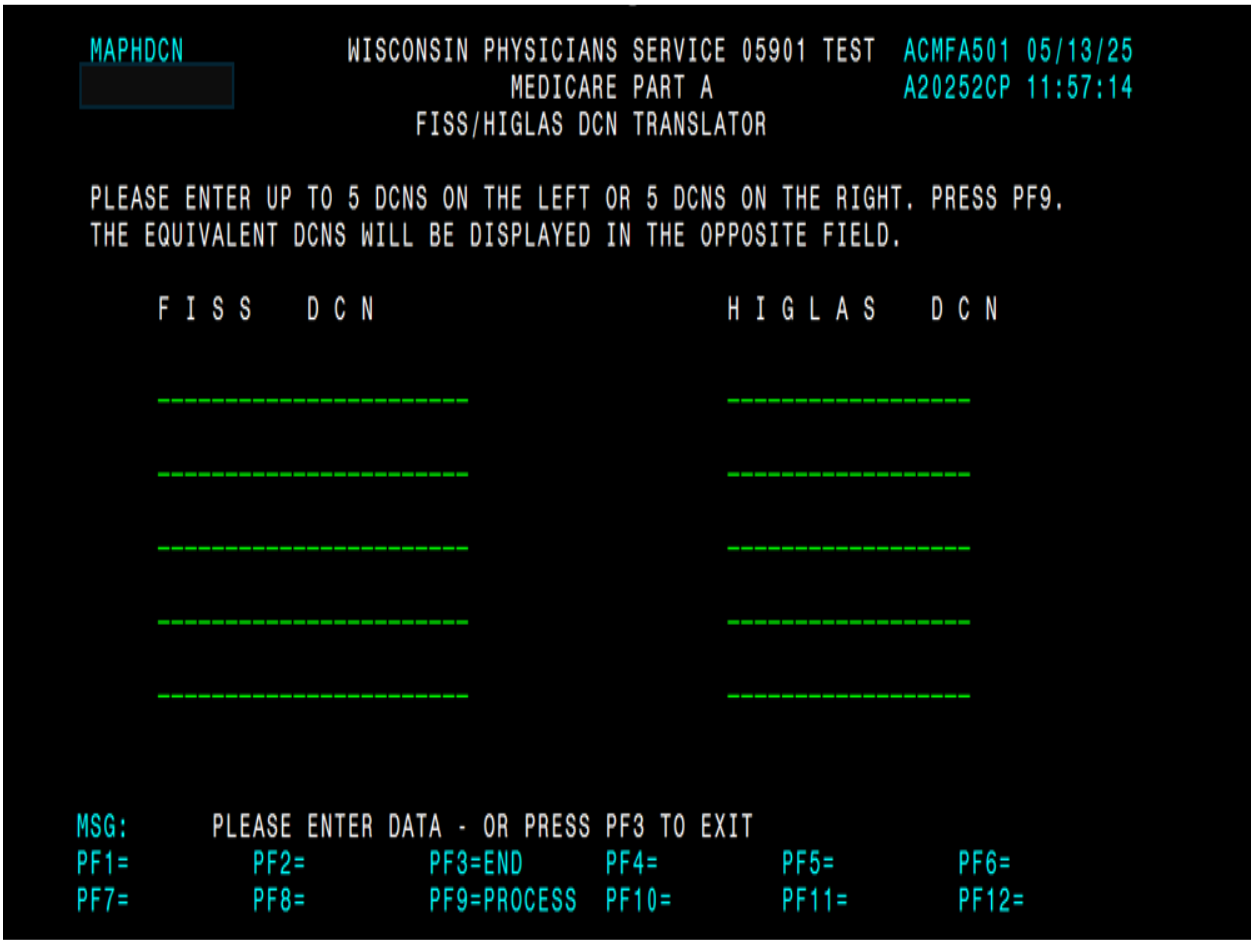


Field Name	Description
OP	**Operator Code** - Identifies the last operator who created or revised the reason code**.**
DT	**Date** - Identifies the date that this code was last saved.
REAS CODE	**Reason Code -** Five-digit alphanumeric field that pulls from the previous screen.
PIMR ACTIVITY CODE	**Program Integrity Management Reporting (PIMR) Activity Code -** Two-digit field that identifies the PIMR Code for which the reason code was categorized. Valid values: AI - Automated National Correct Coding Initiative (NCCI) Edit AL - Automated Locally Developed Edit AN - Automated National Edit CP - Prepay Complex Probe Review DB - Third Party Liability (TPL) or Demand Bill Claim Review MR - Manual Routine Review PS - Prepay Complex Provider Specific Review RO -Reopening SS - Prepay Complex Service Specific Review
DENIAL CODE	**Denial Code –** Six-digit field that identifies the Program Integrity Management Reporting System (PIMR) denial reason code that is being categorized. Valid values: NOPIMR -Default 100001-Documentation does not support service 100002-Investigation/experimental 100003-Item/services excluded from Medicare coverage 100004-Requested information not received 100005-Services not billed under the appropriate revenue or procedure code (include denials due to unbundling in this category) 100006-Services not documented in record 100007-Services not medically reasonable and necessary 100008-Skilled nursing facility demand bills 100009-Daily nursing visits are not intermittent/ part time 100010-Specific visits did not include personal care service 100011-Home Health demand bills 100012-Ability to leave home unrestricted 100013-Physicians order not timely 100014-Service not ordered/not included in treatment plan 100015-Services not included in plan of care 100016-No physician certification, e.g., Home Health 100017-Incomplete physician order 100018-No individual treatment plan 100019-Other Valid values: NOPIMR -Default 100001-Documentation does not support service 100002-Investigation/experimental 100003-Item/services excluded from Medicare coverage 100004-Requested information not received 100005-Services not billed under the appropriate revenue or procedure code (include denials due to unbundling in

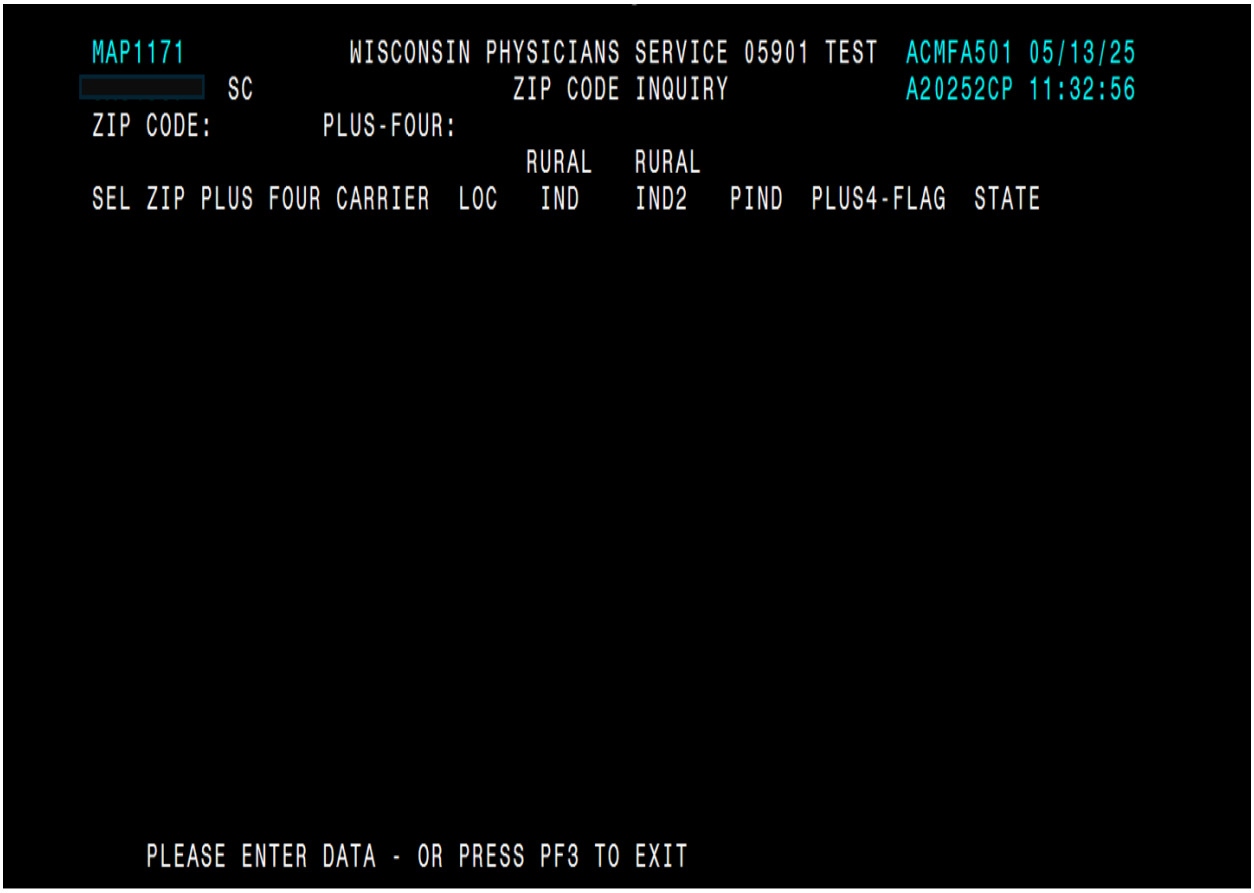
	this category) 100006-Services not documented in record 100007-Services not medically reasonable and necessary 100008-Skilled nursing facility demand bills 100009-Daily nursing visits are not intermittent/ part time 100010-Specific visits did not include personal care service 100011-Home Health demand bills 100012-Ability to leave home unrestricted 100013-Physicians order not timely 100014-Service not ordered/not included in treatment plan 100015-Services not included in plan of care 100016-No physician certification, e.g., Home Health 100017-Incomplete physician order 100018-No individual treatment plan 100019-Other
MR INDICATOR	**Complex Manual Medical Review (MR) –** This field identifies whether or not the service received complex manual medical review. This is a one-position alphanumeric field. Valid values: Blank - The services did not receive manual medical review (default value). Y - Medical records received. This service received complex manual medical review. N - Medical records were not received. This service received a routine manual medical review.
PCA INDICATOR	**Progressive Correction Action (PCA) -** This field identifies the progressive correction action indicator. This is a one-position alphanumeric field. Valid values: Blank - The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. Y - The Medical Policy Parameter is PCA-related and is included in the PCA transfer files. N - The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID#:	**Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) identification number -**This field identifies the LCD/NCD identification numbers, which are assigned to the FMR reason code for reporting on the beneficiary's Medicare Summary Notice (MSN). This is an eleven-position alphanumeric field, with five occurrences. The values for the LCD are user defined and the NCD is CMS defined.
ADJ REASONS	**Adjustment Reason Codes -** Three-digit field with ten (10) occurrences that identifies the ANSI reason code that is related to the FISS reason code.
GROUPS	**ANSI Group Codes -** Two-digit field with four (4) occurrences.
REMARKS	**Remarks-Five**-digit alphanumeric code with four (4) occurrences associated with the ANSI codes, which further describes the reason for nonpayment.
APPEALS (A)	**ANSI Appeal-A Codes -** Five-digit field with 20 occurrences. These codes are used for inpatient only.
APPEALS (B)	**ANSI Appeal-B Codes -** Five-digit field with 20 occurrences. These codes are used for outpatient only.
EMC	**Electronic Media Claim (EMC) Category Code -**Three-digit field that identifies the EMC category of the claim that is returned on a 277-claim response.
HC	**Hard Copy Claim Category Code -** Three-digit field that identifies the Hard Copy category of the claim that is returned on a 277-claim response.
EMC	**Electronic Media Claim (EMC) Status Code -** Four-digit field that identifies the EMC status of the claim that is returned on a 277-claim response.
HC	**Hard Copy Claim Status -**Four-digit field that identifies the Hard Copy status of the claims that is returned on a 277 claim response.

Invoice Number DCN Translator (Option 88) MAPHDCN

Access
From the Inquiry Menu, Type 88, in the Enter Menu Selection field, Press **<ENTER>.**



Zip Code File (Option 19) MAP1171



(OSC) Repository Inquiry (Option 1A) MAP11A1

Purpose
For use by Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) providers.

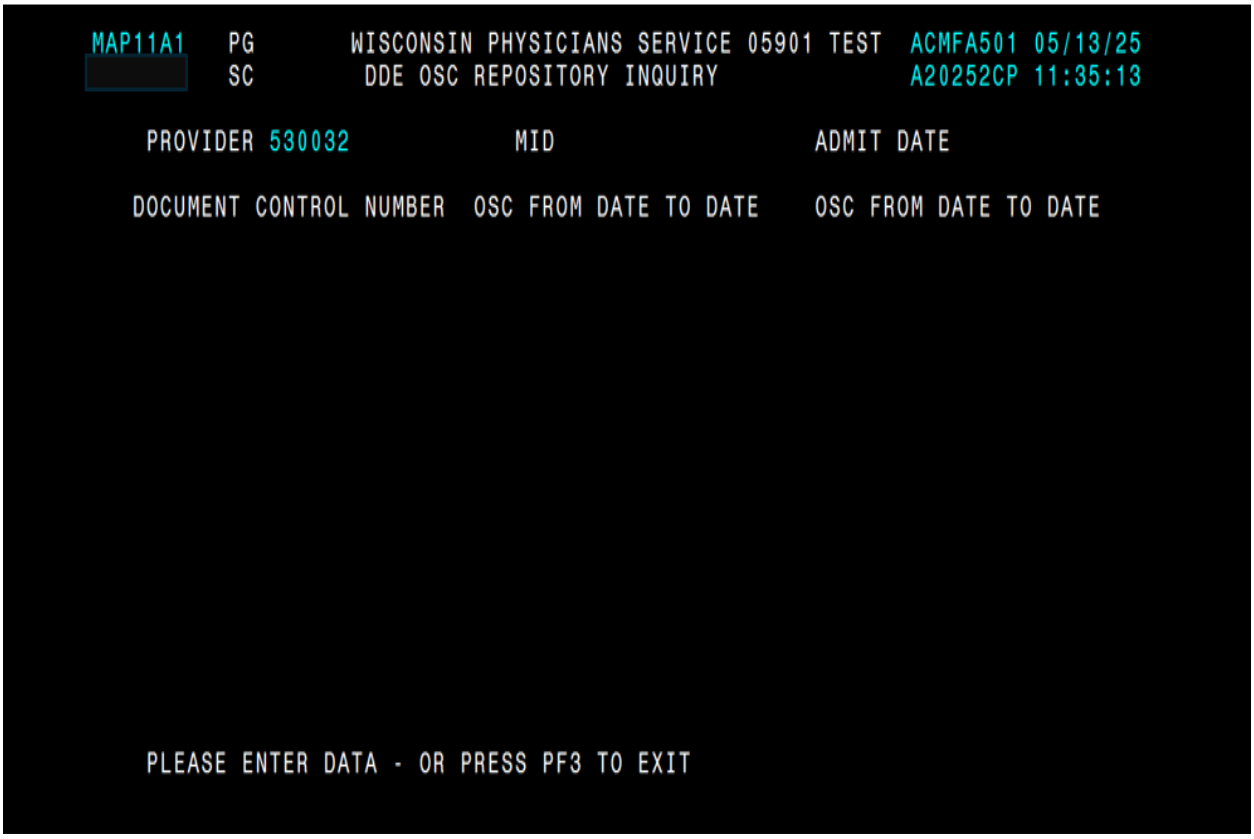
This screen allows access to the Occurrence Span Codes (OSC) that were previously “stored” on the earlier version of long-term claims that qualify for interim billing (TOB 112) and contain more than ten Occurrence Span codes over the course of the claim.

Access
From the Inquiry Menu:
Type 1A in the Enter Menu Selection field
Press **<ENTER>**

Allows access to the **Occurrence Span Codes (OSC)** that were previously stored on the earlier version of long-term claims that qualify for interim billing (TOB 112) and contain more than ten Occurrence Span Codes over the course of the claim.

Providers can access the list of previously stored OSC, type the Provider Number in the PROVIDER field, type the MBI number in the MBI field, and type the Admit date in the ADMIT Field. Press <**ENTER**>.

OSC Repository Inquiry Screen



Field Name	Description
PROVIDER	**PTAN -**13-position alphanumeric field systematically filled, but accessible if the provider is authorized to view other PTANs.
DCN	**Document Control Number -** Unique 23-digit number assigned to all claims
OSC	**Occurrence Span Code (OSC)** - Two-digit alphanumeric code, defines a specific event relating to this billing. See page 104 for the list of OSCs.
FROM DATE	**Beginning date of OSC –** Six-digit field in MMDDYY format.
TO DATE	**Ending Date of OSC –** Six-digit field in MMDDYY format.

Claim Count Summary (Option 56) MAP1371

Purpose
The purpose of the Claim Count Summary screens is to provide a mechanism for the DDE provider to view a total claim count and total dollar amount by status and location.

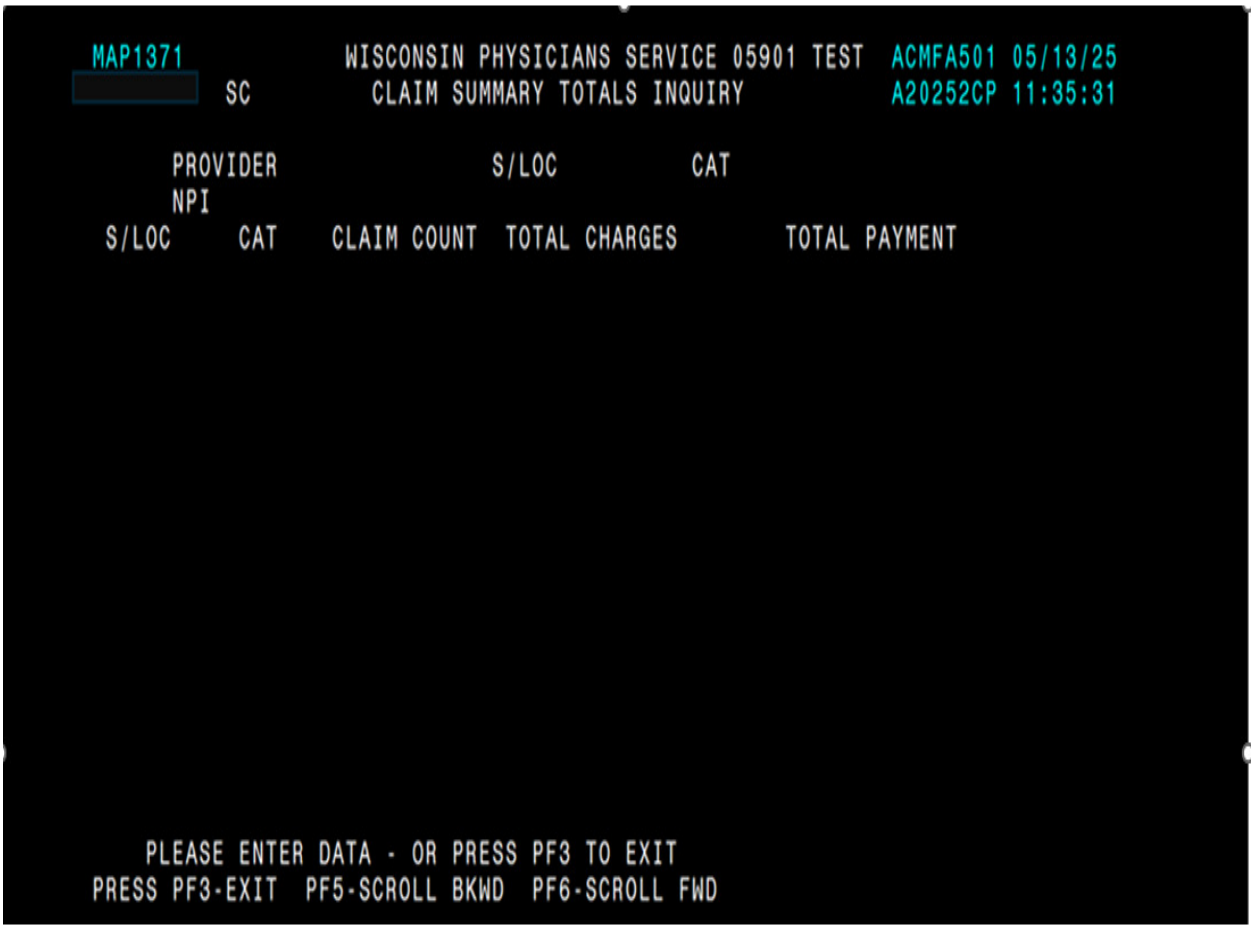
Access
From the Inquiry Menu, to access the Claim Count Summary sub-menu:
In the Enter Menu Selection Field, Type **56** Press <**ENTER**>

This screen allows the provider to monitor where claims are in the FISS system by dollar amounts. The "picture" may change daily as issues are worked, Session Term runs, and claims move on through the system.

Providers should be cautioned not to try to use Claim Summary to determine reimbursement. Remittance Advice should be the only tool for determining reimbursement. The fields in Claims Summary are not signed.

PTAN will default. S/LOC and CAT can be used as search criteria to narrow the search to display specific information.

Claim Summary Totals Inquiry



Field Name	Description
PROVIDER	**PTAN -** 13-position alphanumeric field systematically filled, but accessible if the provider is authorized to view other PTANs.
S/LOC	**Status and Location** - This field can be used as search criteria to narrow the search. The provider can request claims summary by Status and/or Location.
CAT	**Category -** This field can be used as search criteria to narrow the search. The provider can request claims summary by Category.
S/LOC	**Status and Location -** Six-digit alphanumeric field that identifies the condition of the claim and/or location of the claim.
CAT	**Bill Category -** Two-digit alphanumeric field that identifies the type of claims in specific locations by type of bill. In addition, a value that identifies the total claim number or each status/location. **Valid values:** First two digits of any TOB appropriate to the provider, e.g., 11, 13, 32, 72, etc. **MP - Medical Policy -** Medical policy applies to claims in a status of **T** and a location of **B9997** only. It identifies RTP'd claims where the first digit of the primary reason code is a **5**. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. **NM - Non-Medical Policy -** Applies to claims in a status of **T** and a location of **B9997** only. It identifies RTP'd claims where the first digit of the primary reason code is not a **5**. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. **AD - Adjustments -** Within each status/location. Claims in this category are also counted under the standard bill category. Therefore, claims in this category are not included in the total count (TC). **TC - Total Count -** Is the total within each status/location excluding claims with a category of AD, MN, or MP. **GT - Grand Total -** For the provider of all categories in all status/locations. This total will be printed at the beginning of the listing and associated status/locations will be blank. The grand total is displayed only when the total by provider is requested.
CLAIM COUNT	**Claim Count -** Total claim count for each specific status/location.
TOTAL CHARGES	**Total Charges -** Total dollar amount accumulated for the total number of claims identified in the claim count.
TOTAL PAYMENT	**Total Payment -** Total dollar payment amount that has been calculated by the system. This is an accumulated dollar amount for the total number of claims identified in the claim count. For those claims suspended in locations prior to payment calculations, the total payment will equal zeros.

Home Health Payment Totals (Option 67) MAP1B41

Purpose
This screen will display data needed for Home Health Payment Totals.

Access
From the Inquiry Menu, to access the Home Health Payment Totals sub-menu:

In the Enter Menu Selection Field, Type **67** Press <**ENTER**>

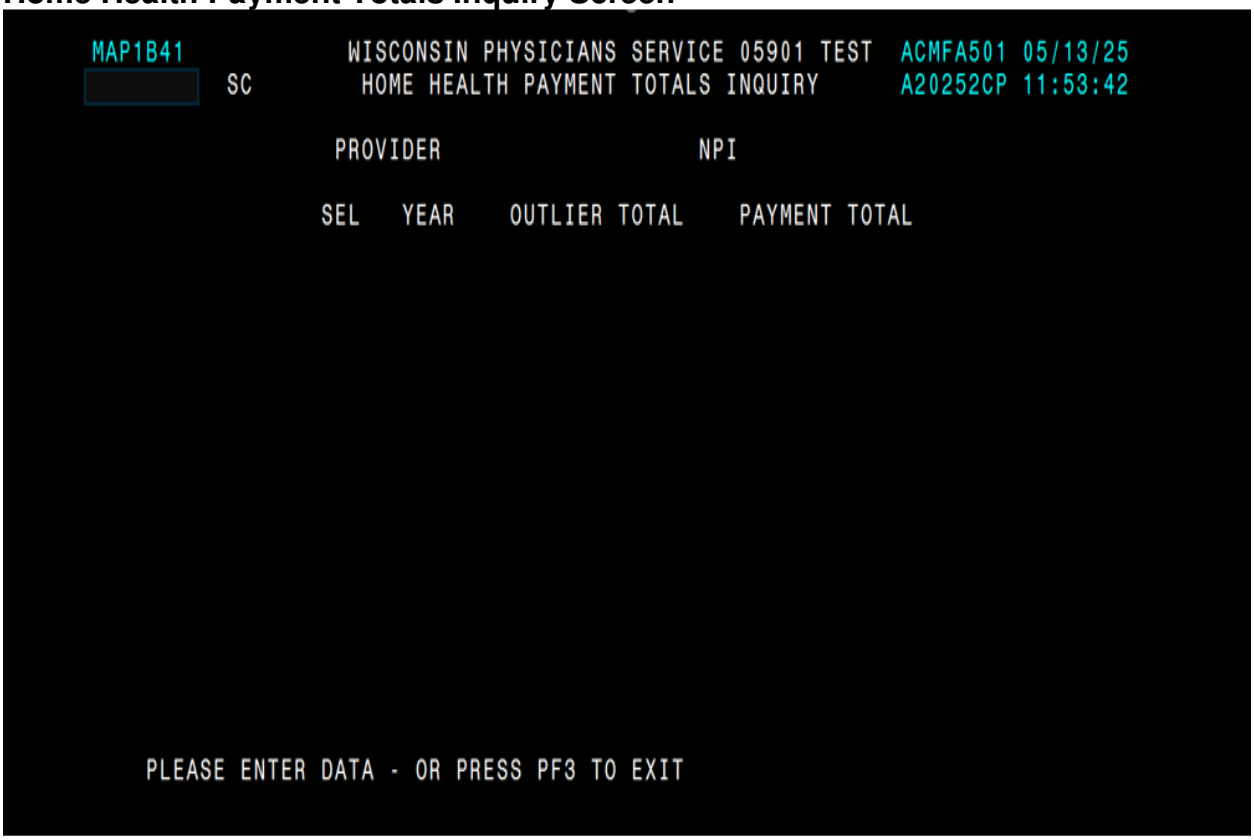
Effective January 1, 2010, the outlier payments made to each home health agency will be subject to an annual limitation. The Home Health Payment Totals (MAP 1B41) screen will track your outlier payment and Home Health Prospective Payment System (HH PPS) payment totals. Data for up to three years will be available, beginning with calendar year 2010 HH PPS payment totals and outlier payments. Once the HH PPS claim (3X9 TOB) or adjustment (3X7, 3XG, 3XH, or 3XI TOB) has processed (FISS S/LOC P B9997), they are available to view using this inquiry option.

Type your facility's Provider Transaction Access Number (PTAN) (also known as your on-line Survey, Certification and Reporting (OSCAR)/Legacy provider number) in the PROVIDER field.

Tab to the NPI field, type your facility's National Provider Identifier (NPI), and press <**ENTER**>.

The Home Health Payment Totals Inquiry (MAP1B42) screen displays the total home health payment and outlier totals for up to three years beginning with calendar year 2010 HH PPS payments.

Home Health Payment Totals Inquiry Screen



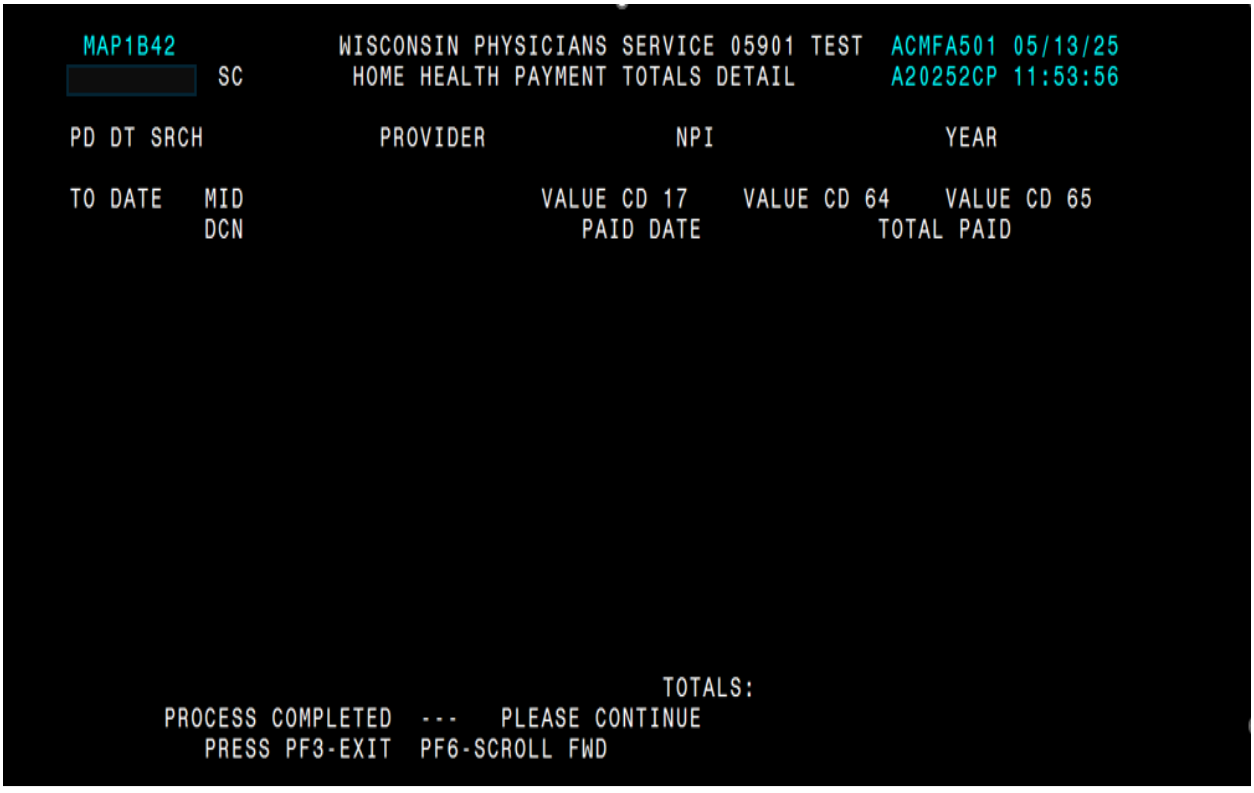
Note: The payment information is updated only after HH PPS claims/adjustments are in FISS ST/LOC P B9997 (Paid). HH PPS claims with **TO** dates on or after January 1, 2010, are included in the data currently available.

To display a list of claims that comprise the outlier and payment totals for a specific year, type **S** in the SEL field next to that year. Press <**ENTER**>.

Field Name	Description
PROVIDER	**PTAN -** 13-position alphanumeric field that identifies the Medicare-assigned PTAN.
NPI	**National Provider Identifier -** Ten-digit unique provider identifier.
SEL	**Selection -** This field is used to view claim data for a particular year.
YEAR	The calendar year in which the outlier and payment totals are comprised.
OUTLIER TOTAL	The total outlier payments made on HH PPS home health claims for a calendar year. Note that Requests for Anticipated Payment (RAPs) (type of bill 322 or 332) are excluded from this total. The **TO** date on the HH PPS claim determines the calendar year in which the outlier is applied.
PAYMENT TOTAL	The total HH PPS payment made on home health claims for a calendar year. Note that Requests for Anticipated Payment (RAPs) (type of bill 322 or 332) are excluded from this total. The **TO** date on the HH PPS claim determines the calendar year in which the outlier is applied.

The Home Health Payment Totals Detail (MAP1B42) screen appears with individual claim data and the value code amount listed under the corresponding value code. Providers may need to press <**F6**> to scroll forward to view the entire listing of claims data available on the Detail screen.

Home Health Payment Totals Detail Screen



To return to the Home Health Payment Totals Inquiry (MAP 1B42) screen, press <**F7**>. To return to the Inquiry Menu, press <**F3**>.

Field Name	Description
PROVIDER	**PTAN -** 13-position alphanumeric field that identifies the Medicare assigned PTAN.
NPI	**National Provider Identifier -** Ten-digit unique provider identifier.
YEAR	The calendar year that was selected to view the claim detail data.
DATE	The month and day of the "through" date of the claim.
MBI NUMBER	The beneficiary's Medicare Identifier (MBI) on the claim.
DCN	The document control number of the claim.
VALUE CD 17	The dollar amount associated with the outlier payment on the claim.
VALUE CD 64	The dollar amount associated with the HH PPS payment from the Part A trust fund. For more information regarding the Medicare Part A trust fund, see the CMS Internet-Only Manual (IOM) *Medicare Claims Processing Manual* Publication 100-04, Chapter 10 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf).
VALUE CD 65	The dollar amount associated with the HH PPS payment from the Part B trust fund. For more information regarding the Medicare Part B trust fund, see the CMS Internet-Only Manual (IOM) *Medicare Claims Processing Manual* Publication 100-04, Chapter 10 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf).

ANSI Standard Codes Inquiry (Option 68) MAP1581

Purpose
The American National Standards Institute (ANSI) reason code file establishes and maintains the ANSI reason codes used to standardize the current FISS reason codes. These codes are used to communicate to the provider all financial changes made to the claim by the payer.

Access
From the Inquiry Menu, to access the ANSI Standard Codes sub-menu:
In the Enter Menu Selection field
Type 68
Press **<ENTER>**

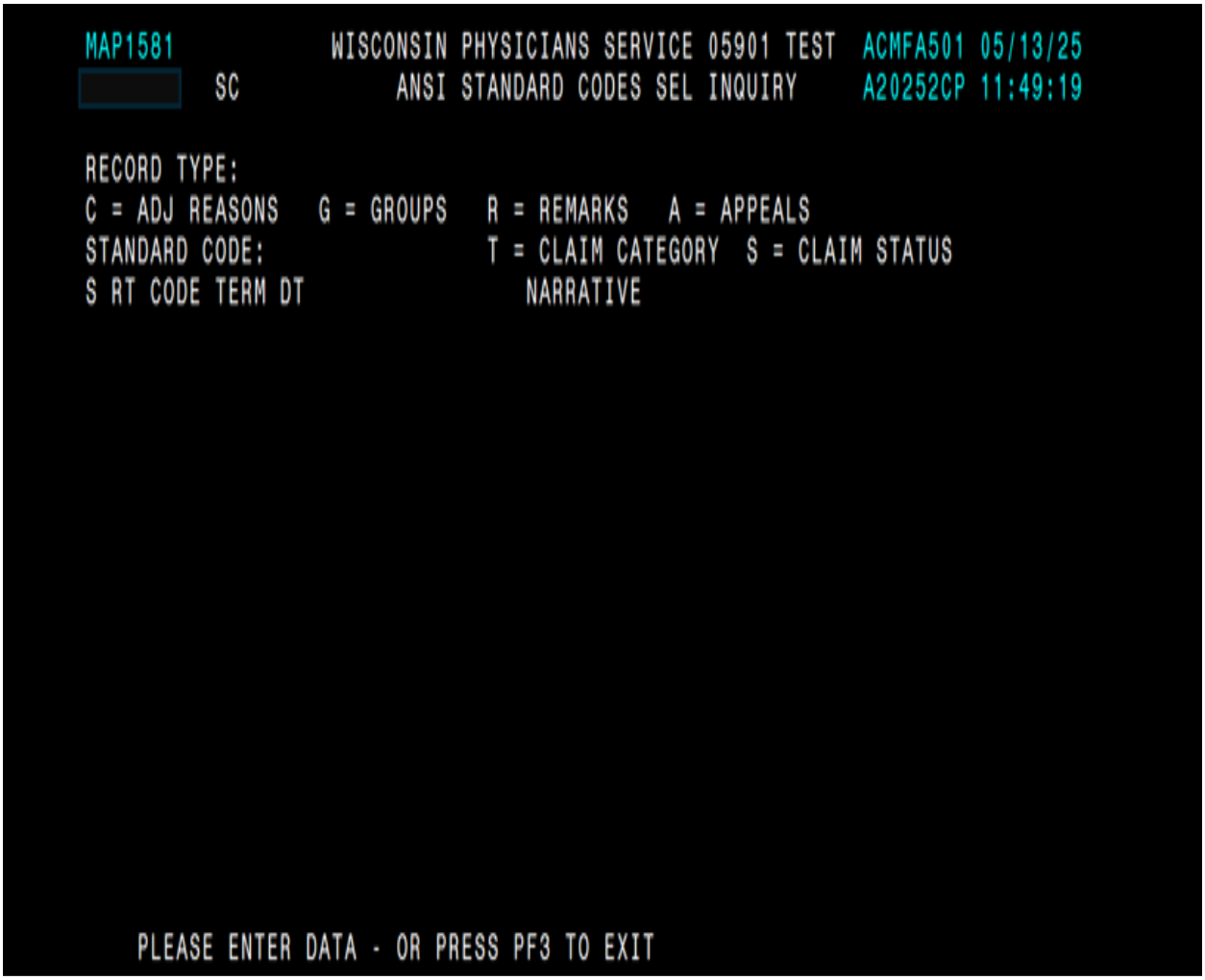
ANSI reason codes appear on Remittance Notices and therefore, are not routinely discussed as a part of DDE. Although, the Inquiry menu allows research for narratives associated with the various ANSI codes appearing on Remittance Notices.

To view ANSI codes, position the cursor in the Record Type field and press **<ENTER>** to display various ANSI Reason Codes and place an S in the selection field to view the specific narrative related to the code.

From the Selection screen type in the desired Record Type and Standard Code, then press **<ENTER>** to view the related information.

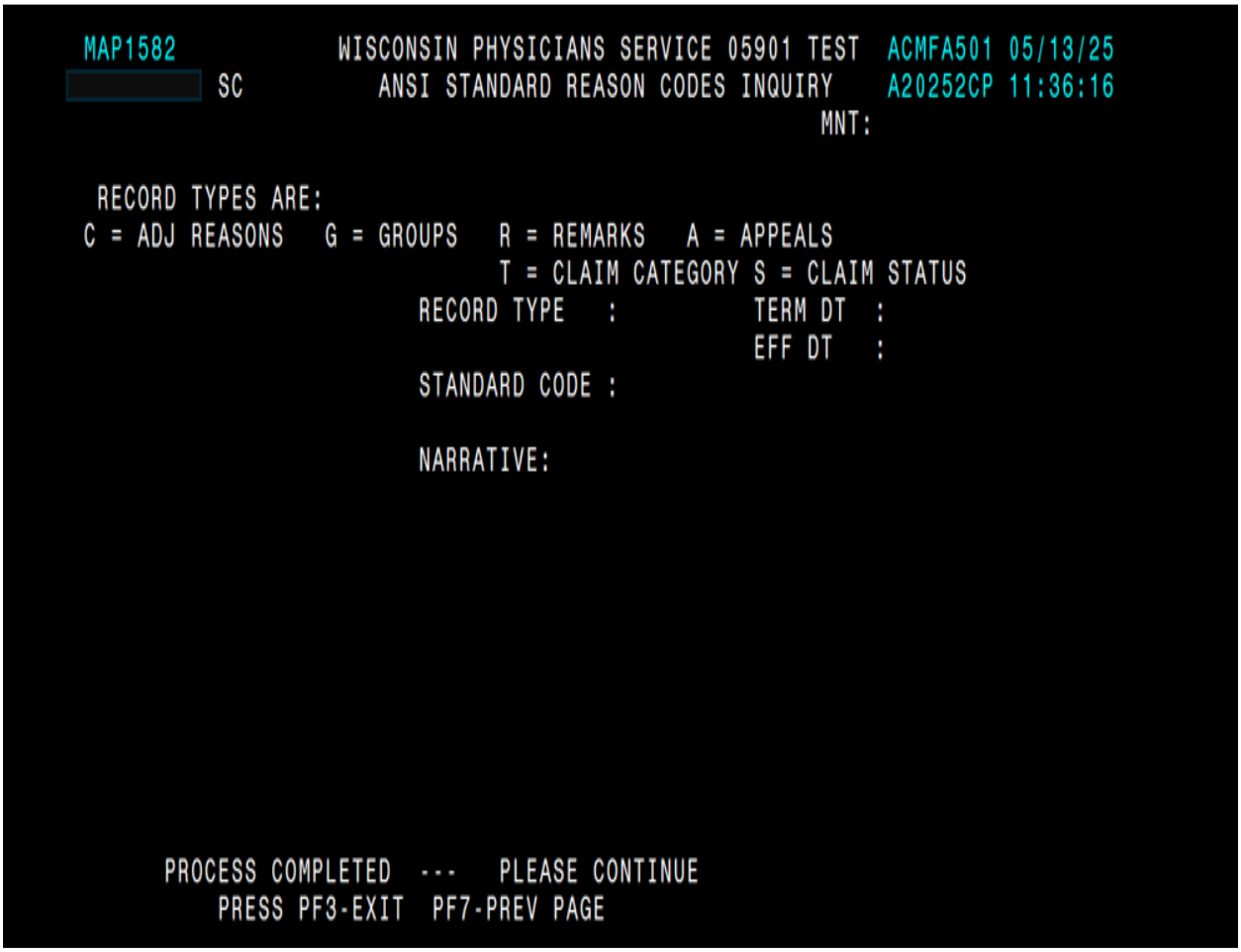
Record Type	Description	Positions
A	**Appeals**	**5**
C	**Adjustment reason**	**3**
G	**Groups**	**2**
R	**Reference remarks**	**4**
S	**Claim Status**	**4**
T	**Claim category**	**3**

ANSI Standard Codes Inquiry – Selection Screen



Field Name	Description
RECORD TYPE	**Record Type** - Identifies the record type for the standard code (**A**, **C**, **G**, **R**, **S**, or **T**) for inquiry or updating.
STANDARD CODE	**Standard Code** - Identifies the standard code within the above record type for inquiry or updating. If the record code is present and no standard code is shown, all standard codes for the record type will display. If both record and standard codes are present, the standard codes are shown. All ANSI codes will be displayed in record type/standard code sequence.
S	**Selection** - This field is used to select a specific code from the listing.
RT	**Record Type** - The record type selected
CODE	**Standard Code** -The standard code selected.
NARRATIVE	The description of the standard code. This is the only field that can be updated for a standard code.

ANSI Standard Codes Inquiry Screen



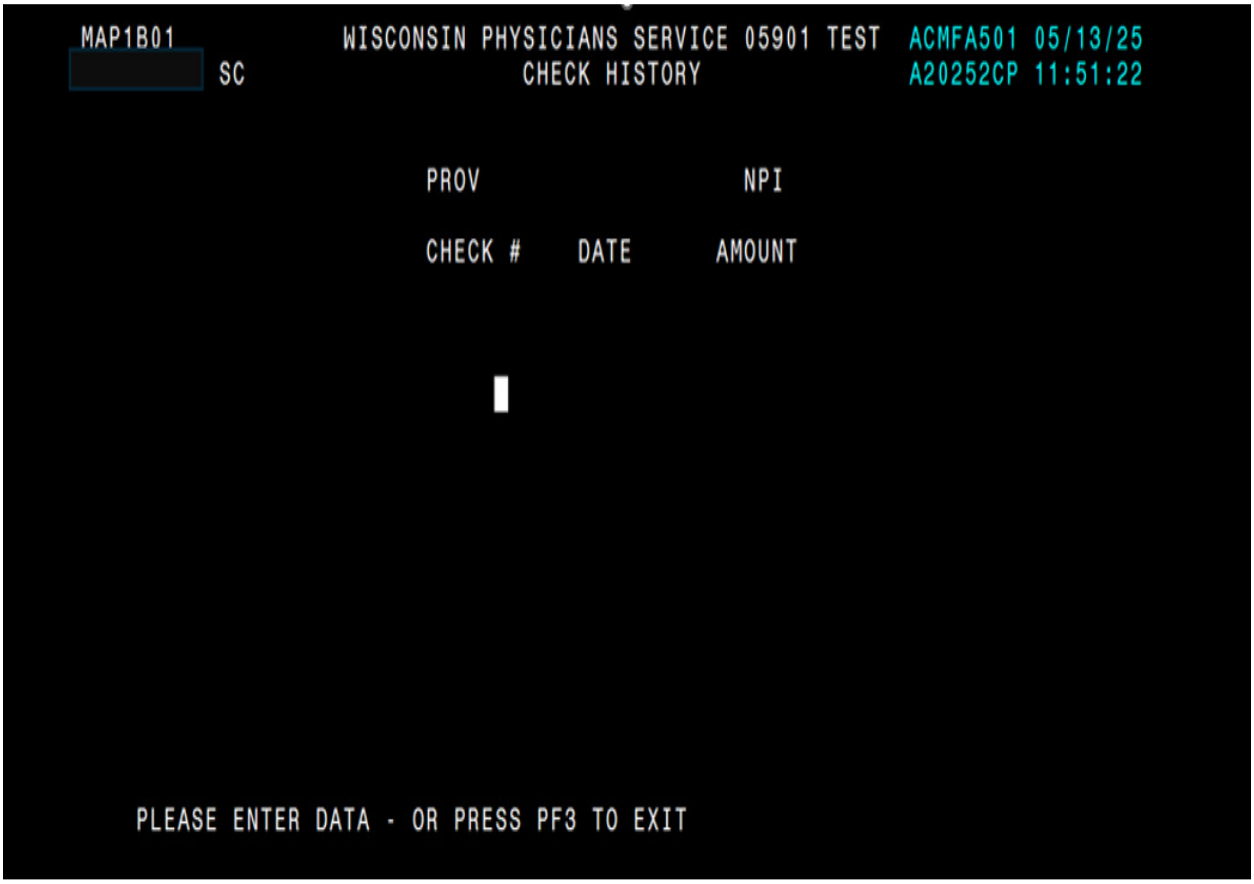
Field Name	Description
RECORD TYPE	**ANSI Record Type -** Identifies the record type for the standard code (**A**, **C**, **G**, **R**, **S**, or **T**).
STANDARD CODE	**Standard Code** - Identifies the standard code within the above record type.
NARRATIVE	**Narrative** -A description of the standard code

Check History Screen

Purpose
The purpose of the check history screen is to provide a mechanism for the provider to view funds reflected on their Remittance Advice whether payment is by check or electronic fund transfer.

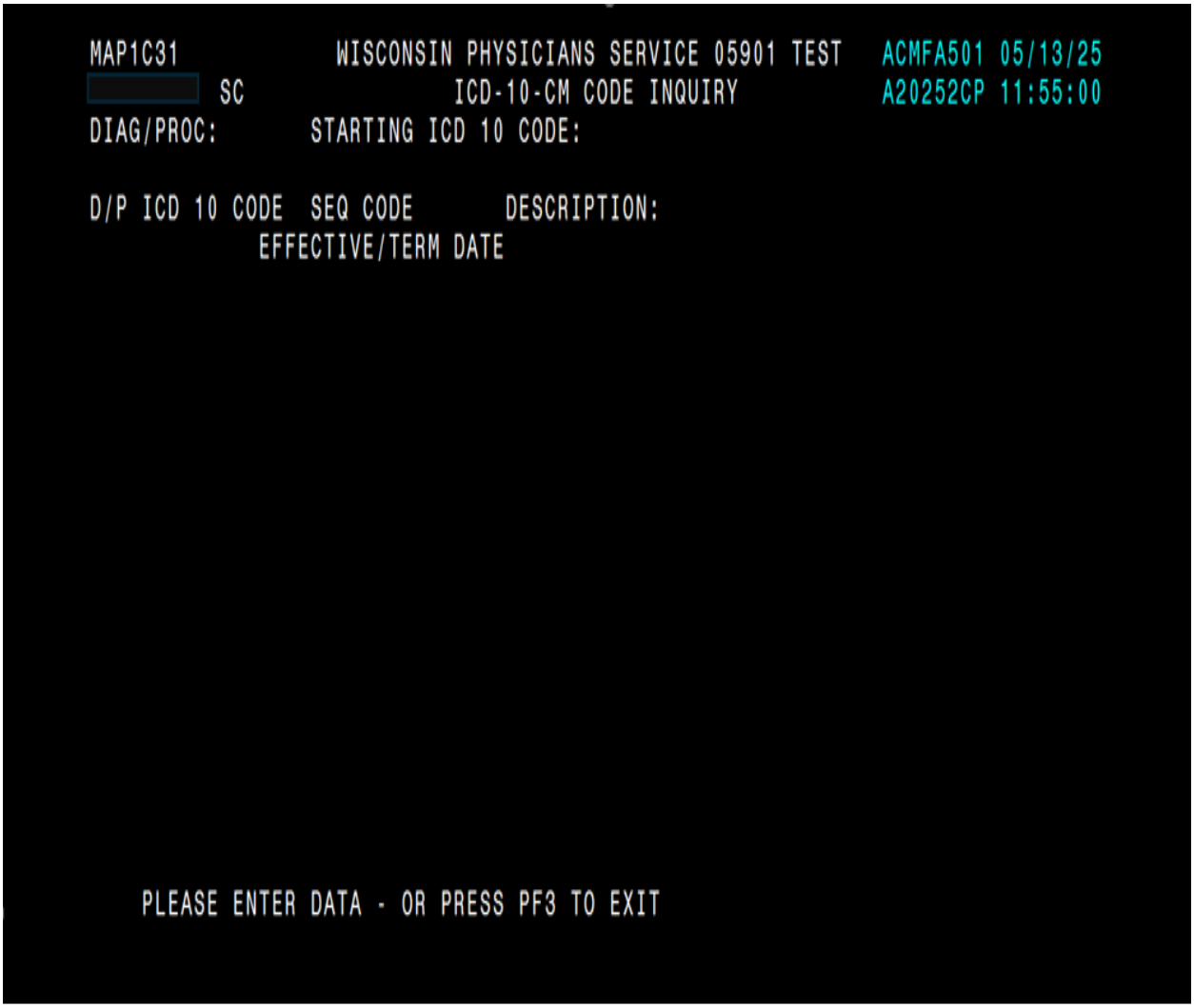
Access
From the Inquiry Menu, to access the Check History sub-menu:
In the Enter Menu Selection Field, Type **FI** Press <**ENTER**>

This screen allows the viewing of most current three (3) payments whether by check or electronic fund transfer. PTAN will default. Press <**ENTER**> to view payment history.

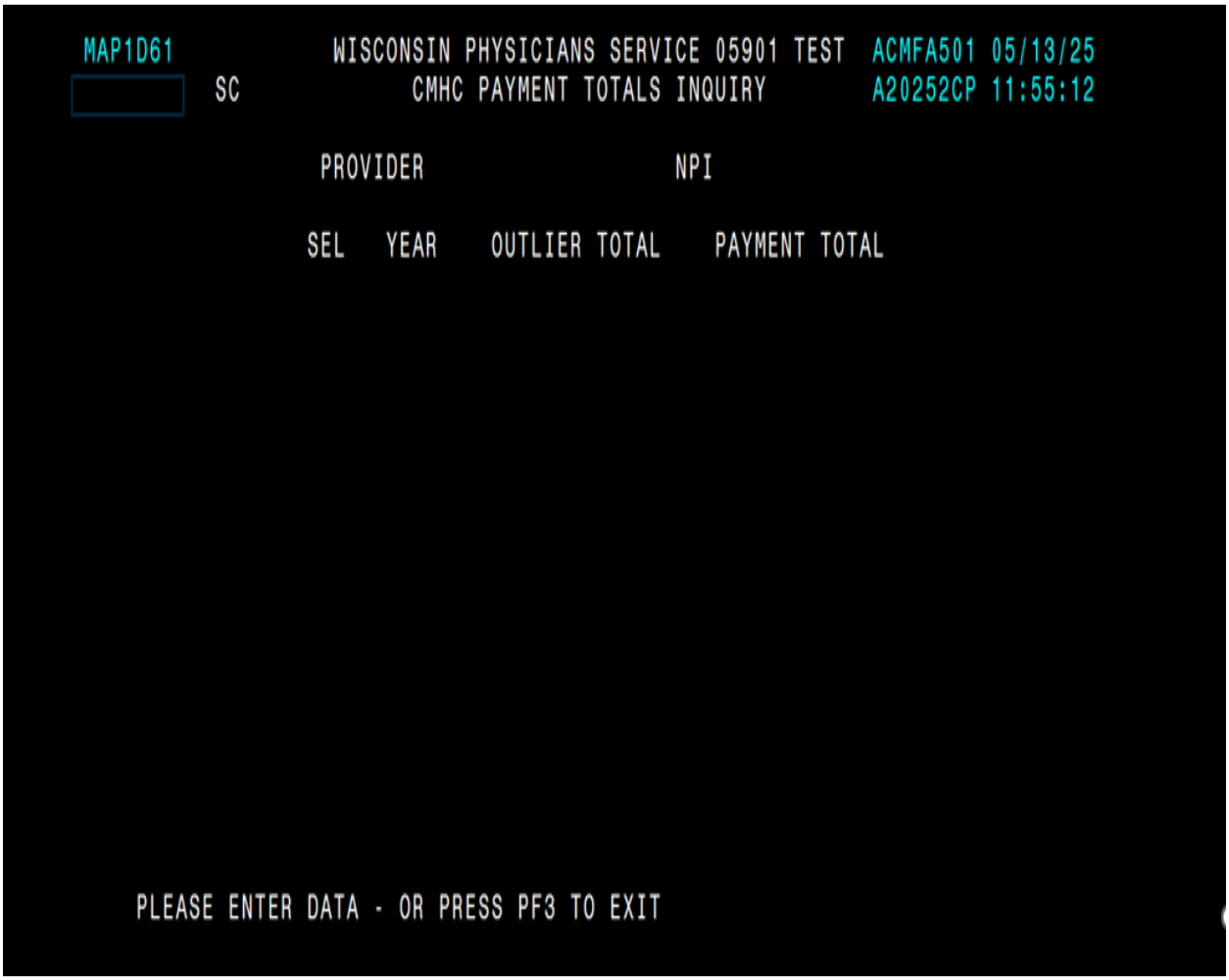


Field name	Description
PROV	**PTAN –** 13-position alphanumeric field that identifies the Medicare assigned PTAN.
NPI	**National Provider Identifier -** Ten-digit unique provider identifier.
CHECK #	**Check -** The last three (3) payments issued to the provider by Medicare. Leading zeros indicate a check; **eft** indicates electronic fund transfer.
DATE	**Date -** The date when the payments were issued to the provider.
AMOUNT	**Amount -** The dollar amount of the last three (3) payments issued to the provider by Medicare.

DX/PROC Codes ICD-10 (Option 1B) MAP1C31



CMHC Payment Total Inquiry (Option 1C) MAP1D61

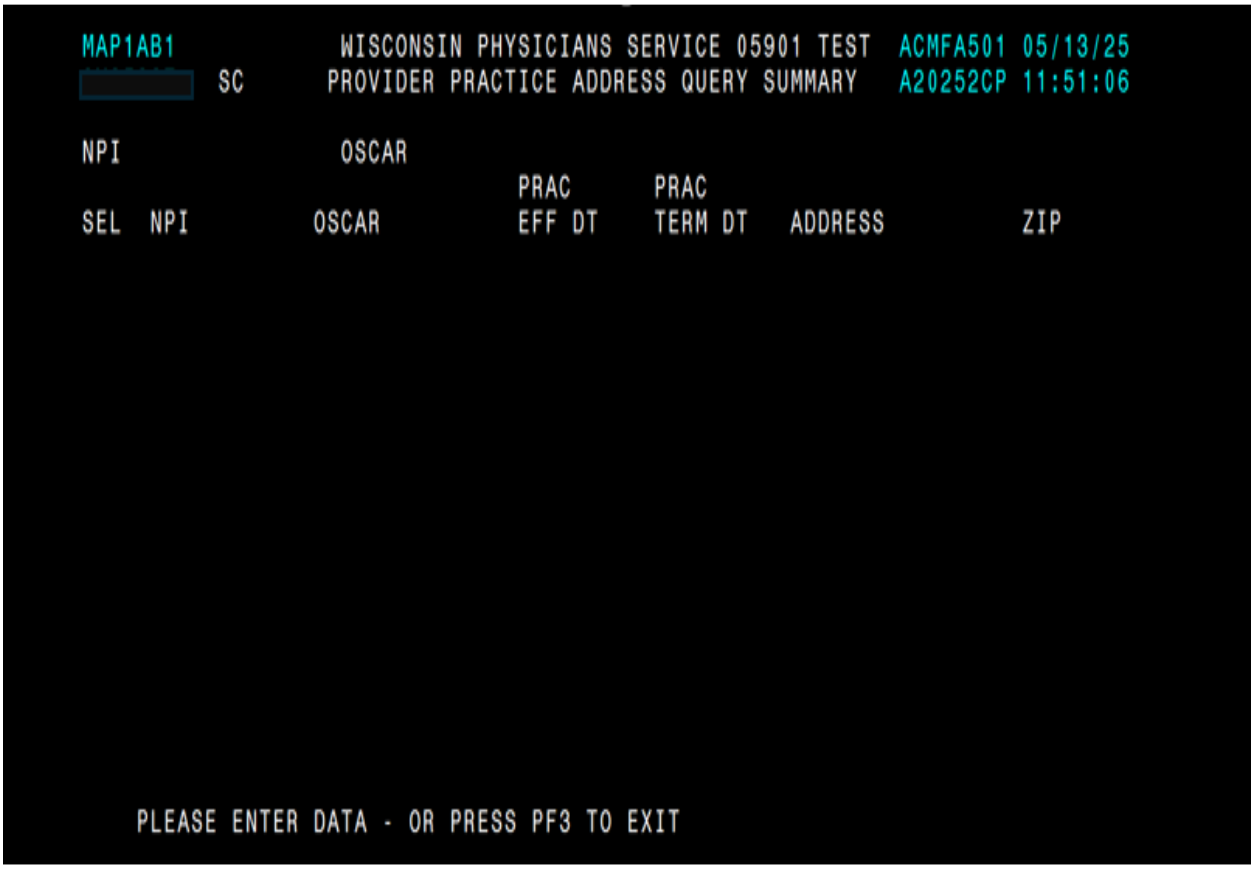


Provider Practice Address Query (Option 1D) MAP1AB1

Access
From the Inquiry Menu, type **1D,** Press <**ENTER**>

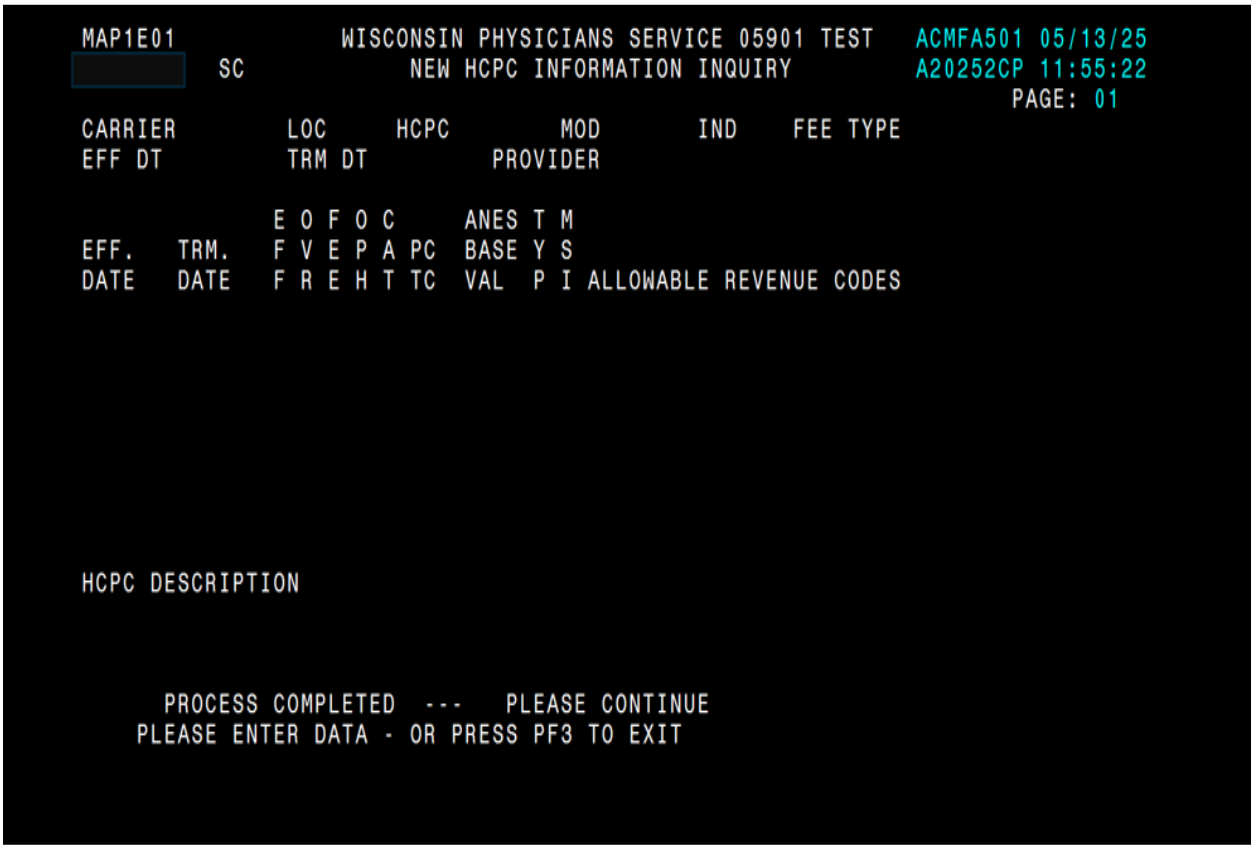
The Provider Practice Address inquiry screens display the additional practice addresses for a facility.

To access the information, enter the NPI and/or OSCAR, press the **<ENTER>** key and a list of addresses will be displayed. To view, the full practice address information, tab to the specific code, enter "S" and press **<ENTER>.**

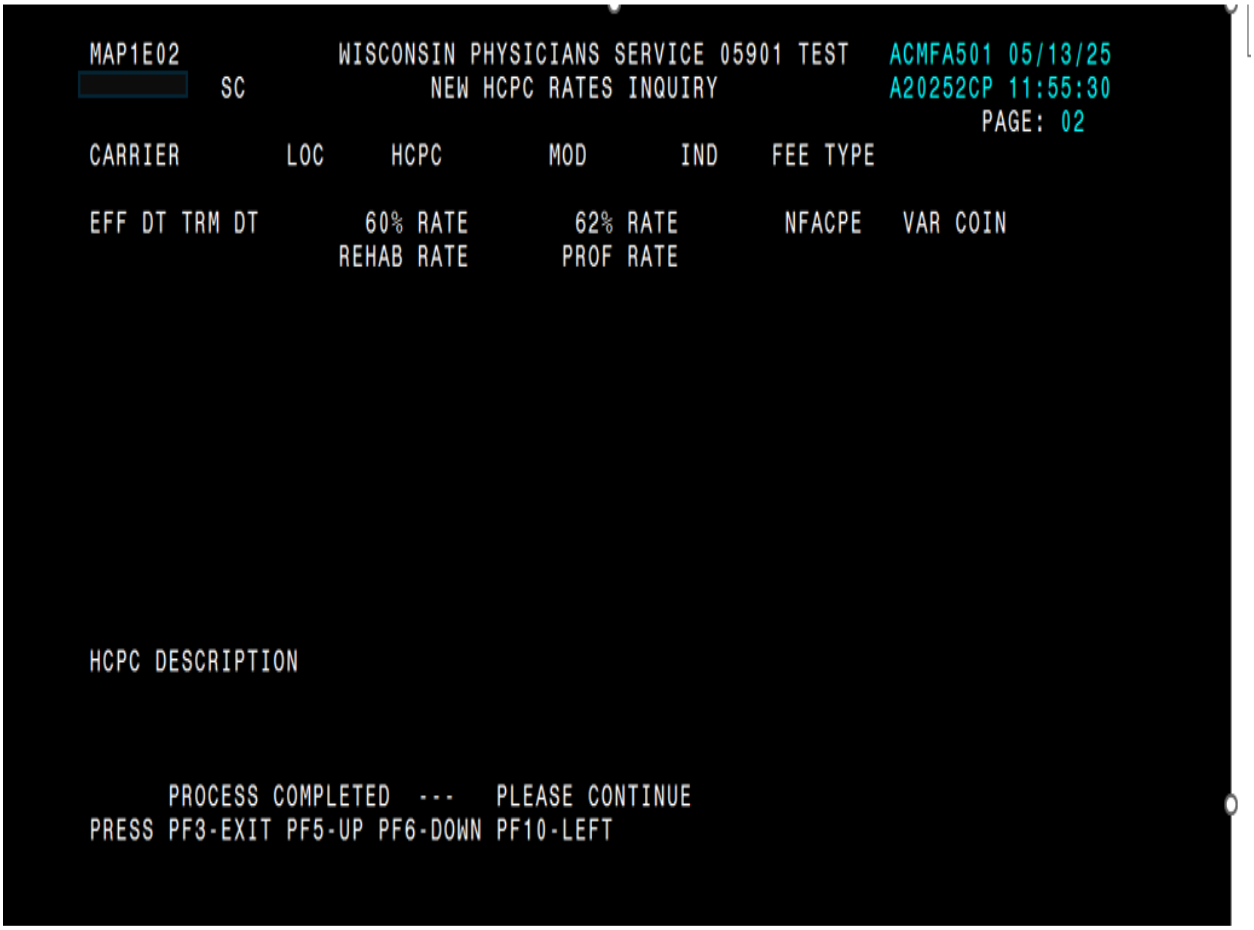


NEW HCPC Information Inquiry (Option 1E) MAP1E01

Access
From the Inquiry Menu, type **1E,** Press <**ENTER**>

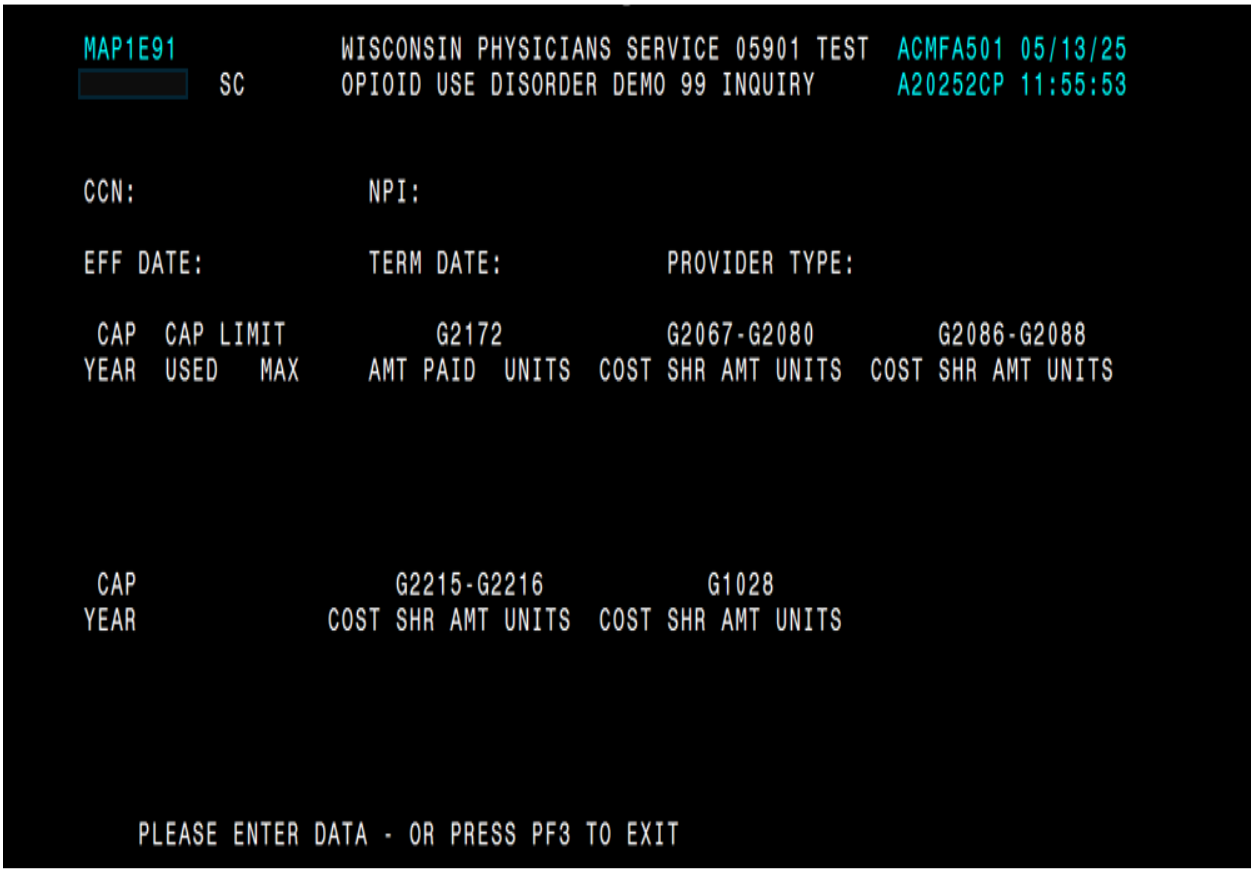


New HCPC Rates Inquiry Screen (MAP1E02)



NEW OUD DEMO 99 (Option 1F) MAP1E91

Access
From the Inquiry Menu, type **1E,** Press <**ENTER**>

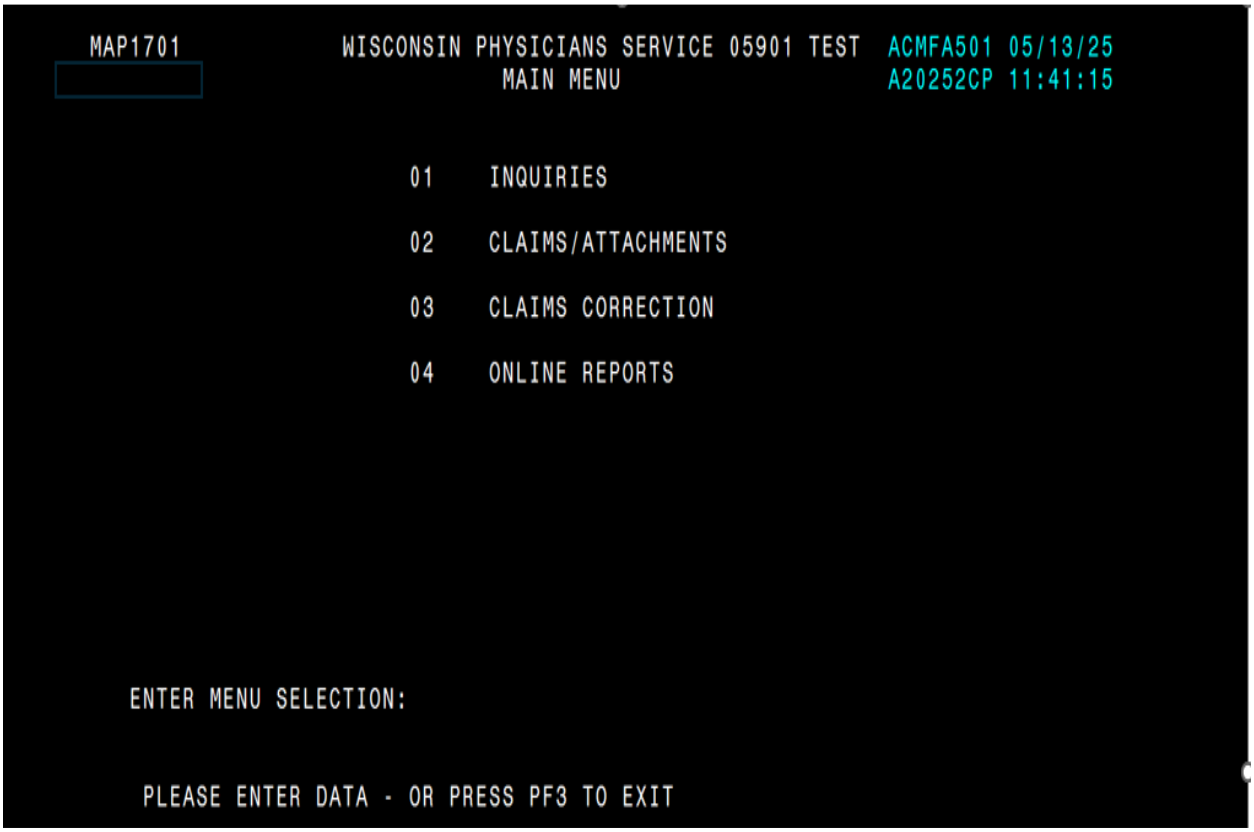


Chapter 3: Claims and Attachments Entry Introduction

Purpose
Allows claim information to be submitted by the provider into the Fiscal Intermediary Standard System

Access
From the FISS Main Menu, type 2 in the Enter Menu Selection field and press **<Enter>.**

DDE Main Menu



Use the following keys to move around the FISS claim pages:
Tab – Moves your cursor from left to right, placing it in a valid field
Shift + Tab – Moves your cursor from right to left, placing it in a valid field

F3 – Exits the entry process and returns to the Claims/Attachments Menu (note that you will lose your work if you press **<F3>** during claim entry)
F5 – Scrolls back through a list (billing transactions, revenue codes, diagnosis and procedure codes, charges, etc.)
F6 – Scrolls forward through a list
F7 – Moves backward one page (e.g., FISS Page 03 to FISS Page 02)
F8 – Moves forward one page (e.g., FISS Page 01 to FISS Page 02)
F9 – Updates/submits the claim into FISS
F10 – Moves to the left
F11 – Moves to the right

After you've entered your appropriate type of bill, and before you begin to enter your claim information, press **<Enter>.** This allows you access to all of the fields required for your bill type.

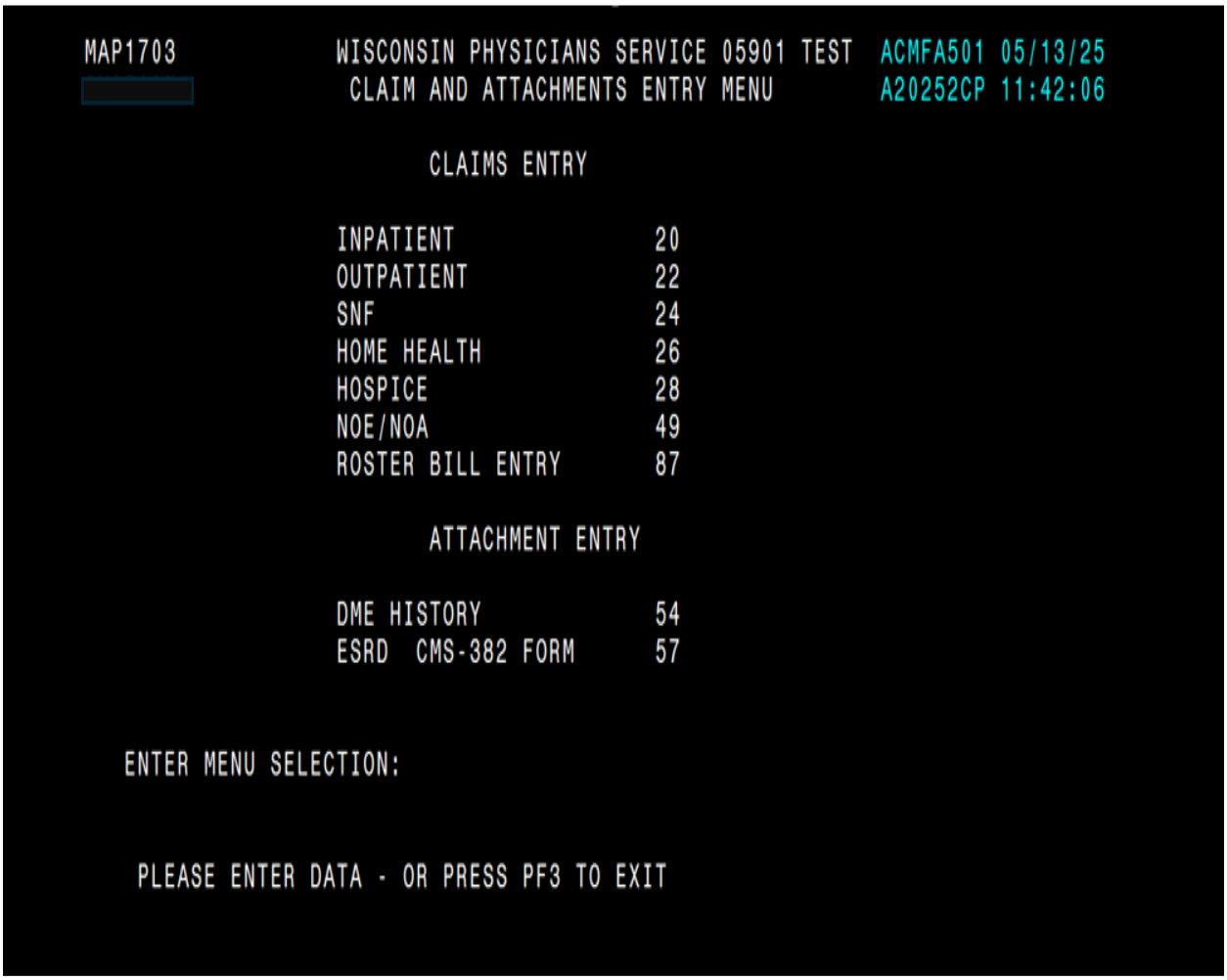
Claims Entry

Purpose

This screen allows the entry of claim information in a UB-04 compliant format
From the Claim and Attachments Entry Menu (MAP1703), enter the appropriate claims entry option in the Enter Menu Selection field and press **<Enter>.**

- Inpatient (20) – used to enter inpatient (11X type of bills)
- Outpatient (22) – used to enter outpatient (13X, 14X type of bills)
- Home Health (26) – used to enter home health RAPs (322 type of bill) and final claims (329 type of bill). This option is also used to enter individual vaccine claims, outpatient therapy services and other types of services billed by home health providers on 34X type of bills.
- Hospice (28) – use to enter hospice claims (81X or 82X type of bills).
- NOE/NOA (49) – use to enter hospice notices of election (NOEs) (8XA type of bill), notices of election termination/revocation (NOTRs) (8XB type of bill) or to cancel an NOE (8XD type of bill)
- Roster Bill Entry (87) – use to enter flu and pneumonia roster bills.

Claims and Attachments Entry Menu



UB-04 Claim Entry-General Information

The claim entry screens (pages 01-06) allow on-line entry of all patient billing information from the UB-04 form. To make it easier, the screens are in the same order as the UB-04 form. There is also a series of menus that will allow you to choose the claim type (e.g., Inpatient, Outpatient, SNF, etc.).

The DDE claim consists of six (6) screens/pages:

- **Page 01** (MAP1711) contains general patient information, condition codes, occurrence codes, occurrence span codes, and value codes.
- **Page 02** (MAP1712) contains revenue code information, HCPCS codes, charges and service dates.
- **Page 03** (MAP1713) contains payer information, diagnosis/procedure code information, and physician information.
    - MAP1719 Press **<F11>** one time from Page 03 contains Claim Adjustment Segment (CAS) information, required on all Medicare Secondary Payer (MSP) claims.
- **Page 04** (MAP1714) contains space for remarks.

- **Page 05** (MAP1715) contains insured information.
- **Page 06** (MAP1716) contains Medicare payment information upon processing of the claim.

When entering information remember to **<TAB>** among the fields until you have completed the screen. To move on to the next screen/page, press **<F8>.** Depending on the TOB, the cursor will skip fields that are not required. If you press **<F3>** while you are in the middle of keying data into your claim before you have 'stored' the claim, you will lose all the information you have keyed.

IF, AT ANY TIME, YOU PRESS <F4>, THIS WILL EXIT YOU OUT OF THE SYSTEM.
The on-line system defaults to bill type **111** for **inpatient**, **131** for **outpatient,** and **211** for **SNF**. If you are data entering a different bill type, then you must type over the default with the correct type of bill.

- On the bottom of each screen is a list of the available function keys for that screen and what functions they perform.
- Field names within DDE will not always follow the same order as found on the UB-04 claim form. To help alleviate confusion, the UB-04 X-REF field on each page of field descriptions will help direct you to the UB-04 form locator number.

Cancel Method

If, after beginning to enter claim data, you decide that you do not wish to continue keying the claim information, press **<F3>.** This action will delete the claim transmission from DDE and will return you to the Claims and Attachments Entry sub-menu.

Transmitting Data

When you have completed the UB-04 claim screens, press **<F9>** to update the claim and transmit the data. If any information is missing or entered incorrectly, the DDE system will display reason codes at the bottom of the claim screen so that you can correct the errors. The claim will not transmit until it is free of front-end edit errors.

Correcting Reason Codes

If reason codes are encountered, you must view the reason code narrative to determine how to correct the error. Press **<F1>** to see an explanation of the reason code. After reviewing the explanation, press **<F3>** to return to your claim and make the necessary corrections. If more than one reason code appears, continue this process until all reason codes are resolved and the claim successfully stores when you press **<F9>.**

If more than one reason code is present, pressing the **<F1>** key will always bring up the explanation of the first reason code **unless** the cursor is positioned over one of the other reason codes. To view the reason code narrative for any displayed reason code, position the cursor over the desired reason code and press **<F1>.** Reason codes may be **viewed** from any screen and in any mode. Reason codes may be **resolved** from any screen and in update and entry mode.

Working through the reason codes in the order they are listed is recommended. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected, as well.

Type of Bill

When Page 01 of the claim appears, FISS automatically inserts default information into the type of bill (**TOB**) field and the status/location (**S**/**LOC**) field. You may need to change this information to reflect the most appropriate bill type. Do not change the default S/LOC field.

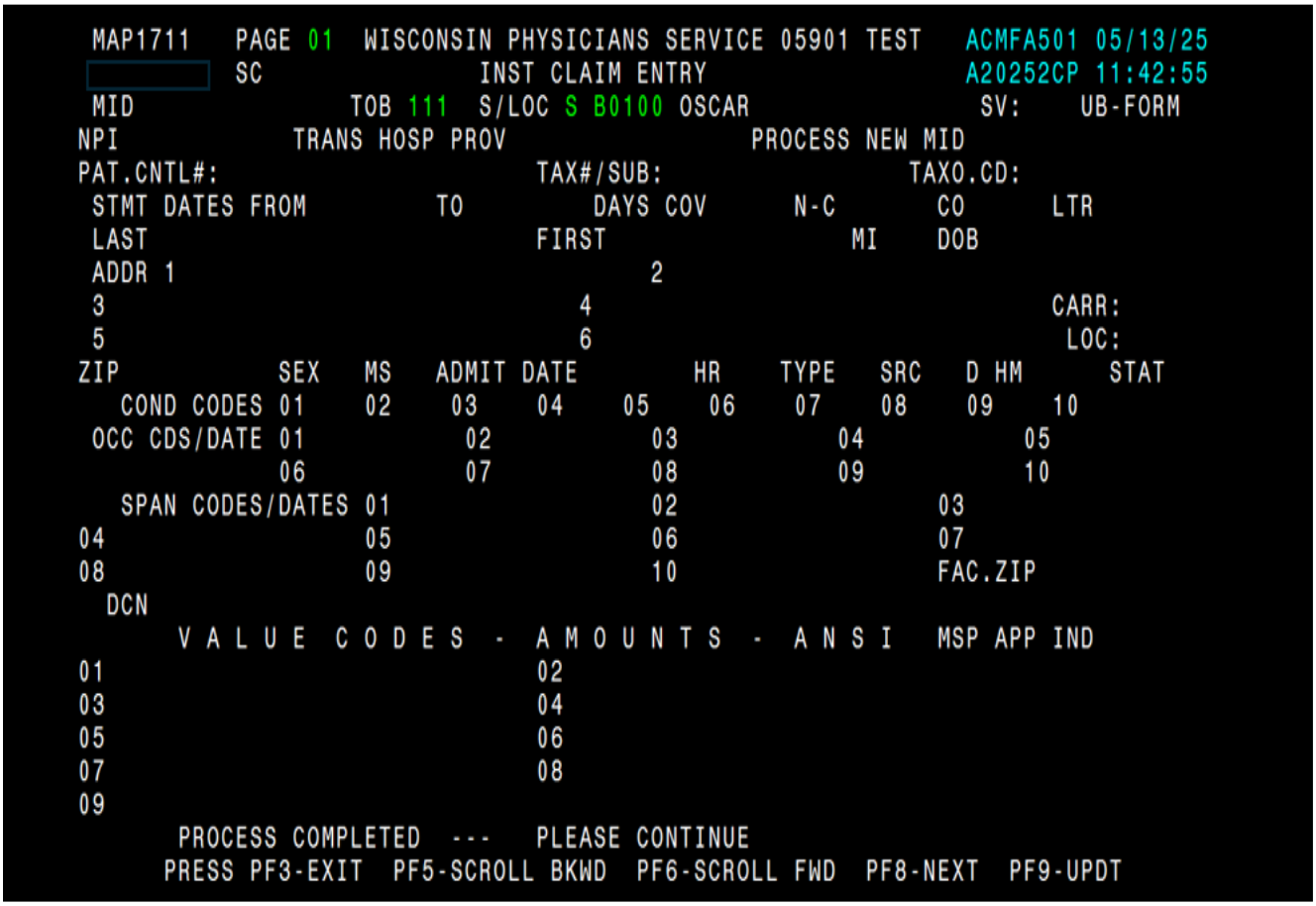
The three-digit **type of bill** of a Medicare claim actually determines how the claim is processed in the FISS System. The FISS system has many edits to determine how the claim is processed. These edits or claim path control the flow of the claim by type of bill.

1st DIGIT	TYPE OF FACILITY
1	Hospital
2	Skilled Nursing Facility
3	Home Health
4	Religious Non-Medical Healthcare Institution (Hospital)
5	Religious Non-Medical Healthcare Institution (Extended Care)
6	Intermediate Care
7	Clinic or Hospital Based ESRD Facility (requires special second digit – see below)
8	Special Facility or Hospital ASC Surgery (requires special second digit – see below)
2nd DIGIT (EXCEPT CLINICS AND SPECIAL FACILITIES)	**BILL CLASSIFICATION**
1	Inpatient Part A
2	Inpatient Part B (includes Part B plant of treatment)
3	Outpatient (includes Part B plan of treatment)
4	Other (includes home health agency (HHA) medical and other health services not under a plan of treatment –also hospital laboratory services to non-patients).
5	Intermediate Care – Level I
6	Intermediate Care – Level II
7	Subacute Inpatient (Revenue Code 19X required)
8	Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9	Reserved for National Assignment
2ND DIGIT (CLINICS ONLY)	**BILL CLASSIFICATION**
1	Rural Health Facility (RHC)
2	Hospital-based or freestanding renal dialysis center
3	Free-standing Provider-based Federally Qualified Health Center (FQHC)
4	Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Community Mental Health Center (CMHC)
7	Opioid Treatment Program (OTP)
8	Reserved for National Assignment
9	Other
2ND DIGIT (SPECIAL FACILITIES ONLY)	**BILL CLASSIFICATION**
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgical Center (ASC) services to outpatient
4	Free standing birthing center
5	Critical Access Hospitals (CAH)
9	Other
3RD DIGIT	**INITIAL – BILL FREQUENCIES**
0	Non-payment / Zero claim
1	Admit through discharge claim
2	Interim – first claim
3	Interim – second claim
4	Interim – last claim

7	Replacement of Prior Claim (See Adjustment third digit)
8	Void/Cancel of Prior Claim (See Adjustment third digit)
9	Home Health PPS Final Claim
A	Admission Notice for Hospice (CMS1450) / Notice of Admission (NOA) (UB-04)
B	Hospice Termination / Revocation Notice
C	Hospice Change of Provider Notice
D	Hospice Election Void / Cancel or NOA Cancel (UB-04)
E	Hospice Change Of Ownership
F-P	Adjustment Claims (for internal use only)
Q	Reopening
Z	Temporary for Encounter Claims (Only applicable to 11 TOB)

Inpatient Claim Entry (MAP1711)

From the Claims Entry, to access the Inpatient Claims Entry: In the Enter Menu Selection Field, Type **20** Press <**ENTER**>.



The Claim Entry screen contains general patient information, condition codes, occurrence codes, occurrence span codes, and value codes.

Note: This screen is no longer unprotected. PAR FL2031 has changed this field to be protected, we are not able to update or change it.

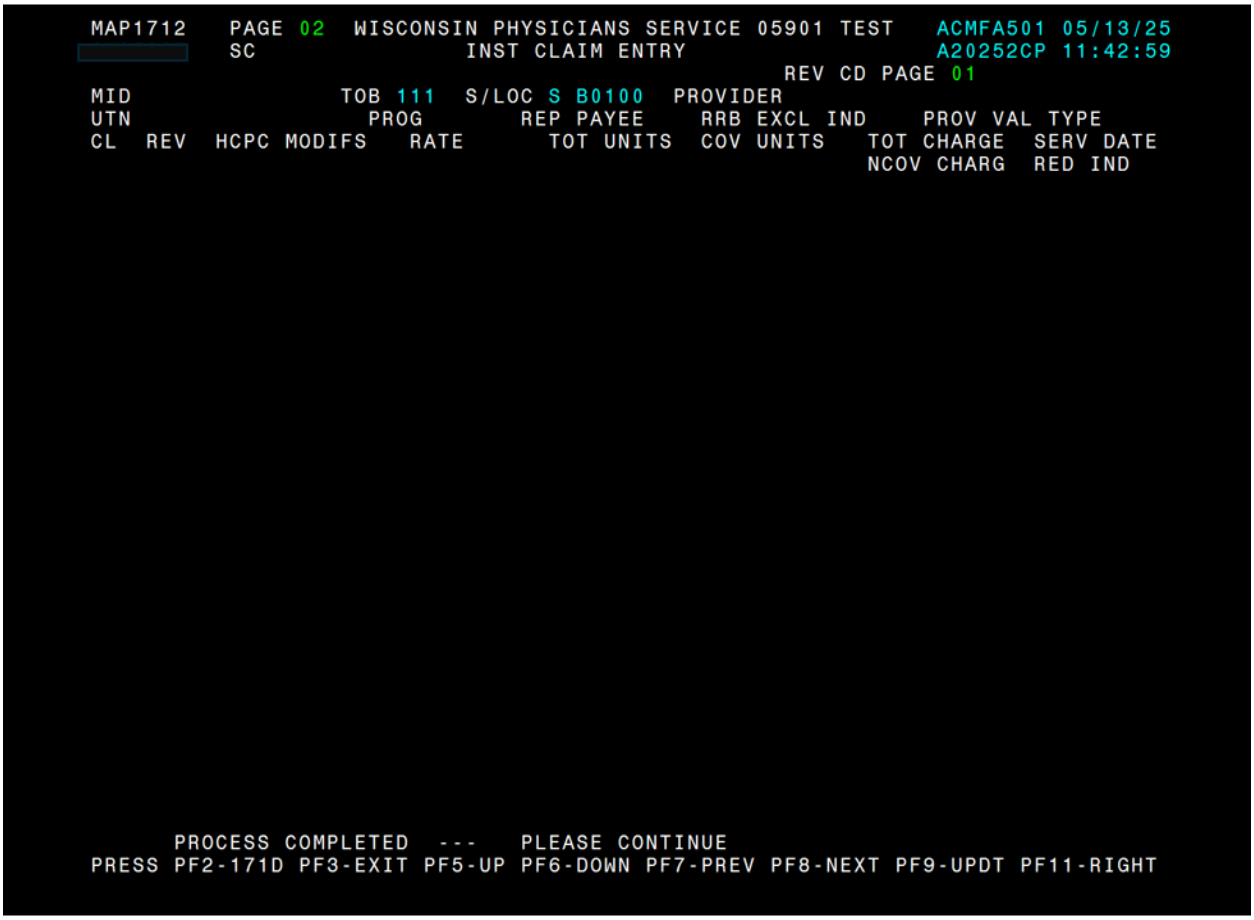
TOB, S/LOC and PTAN fields will be systematically filled after selecting the appropriate claim entry bill type.

Begin entering data on Page 01 of the claim and continue until the appropriate fields are completed. The easiest way to move from field to field is to use your Tab key.

- When keying dollar amounts in the VALUE CODES – AMOUNTS fields, you may type or omit the decimal point as you choose (i.e., $45.92 can be keyed as 45.92 or 4592; $1500.00 can be keyed as 1500.00 or 150000). However, it is important to ensure that the appropriate cents value is entered, regardless of whether the decimal point is used.
- For home health and hospice providers, when a five-digit core based statistical area (CBSA) code is entered in the VALUE CODE AND AMOUNTS field (value code 61 or G8). Two zeroes must be added behind the CBSA code (i.e., CBSA code 19000 must be entered as 1900000 or 19000.00). If you do not add two zeroes, the CBSA code will be incorrect (i.e., entering the CBSA code as 19000 instead of 1900000 will result in FISS reading the code as 190 instead of 19000).
- Page 01 of the claim allows space for ten condition codes, ten occurrence codes/dates, and nine values codes/amounts. However, you can enter up to 30 condition codes, 30 occurrence codes/dates, and up to 36 value codes/amounts. To access the additional space for these fields, press *F6* to scroll forward.

Field Name	Description	UB-04 Form Locator (FL)
SC	Screen control. Used to access the Inquiry screens while entering a claim.	N/A
MID	The beneficiary's Medicare ID number.	FL 60
TOB	Type of Bill (system generated; you may need to change this depending on the TOB you are entering).	FL 4
S/LOC	Status/location code (system generated).	N/A
OSCAR	Online Survey Certification and Reporting System (OSCAR). Not used during claim entry.	FL 51
SV	Suppress View. Only used from the Claims Correction menu. Not used during claim entry.	N/A
NPI	National Provider Identifier.	FL 56
TRANS HOSP PROV	Medicare number of transferring provider.	N/A
PROCESS NEW MID	Corrected Medicare ID number. Only used from the Claims Correction menu. Not used during claim entry.	N/A
PAT CNTL #	Patient Control Number.	FL 3a
TAX # / SUB	Federal Tax Number (subsidiary) (do not enter).	FL 5
TAXO. CD	Taxonomy code. Not required by home health and hospice providers.	FL 81
STMT DATES FROM/TO	Statement covers period.	FL 6
DAYS COV	Number of covered days billed. Not applicable to home health and hospice claims.	N/A
N-C	Number of noncovered days billed. Not applicable to home health and hospice claims.	N/A
CO	Number of coinsurance days used. Not applicable to home health and hospice claims.	N/A
LTR	Number of lifetime reserve days used. Not applicable to home health and hospice claims.	N/A
LAST	Beneficiary's last name.	FL 8
FIRST	Beneficiary's first name.	FL 8
MI	Beneficiary's middle initial.	FL 8
DOB	Beneficiary's date of birth (MMDDCCYY).	FL 10
ADDR 1-6	Beneficiary's street address, city and state.	FL 9
CARR	Carrier number associated with the nine-digit service facility zip code. Not applicable to home health and hospice claims.	N/A
LOC:	Locality code associated with the nine-digit service facility zip code. Not applicable to home health and hospice claims.	N/A
ZIP	Beneficiary's zip code (5- or 9-digit).	FL 9
SEX	Beneficiary's sex (M or F).	FL 11
MS	Beneficiary's marital status.	N/A
ADMIT DATE	Admission date.	FL 12
HR	Admission hour.	FL 13
TYPE	Priority (type) of admission.	FL 14
SRC	Point of Origin (previously known as source of admission).	FL 15
D HM	Discharge hour and minutes. Not applicable to home health and hospice claims.	FL 16
STAT	Beneficiary's status code.	FL 17
COND CODES	Condition codes.	FL 18-28
OCC CDS/DATES	Occurrence codes and dates.	FL 31-34
SPAN CODES/ DATES	Occurrence span codes and dates.	FL 35-36
FAC ZIP	Facility zip code of the provider or the subpart (5- or 9- digit field)	FL 1
DCN	Document Control Number. Not used on claims entry – for adjustments/cancellations only.	N/A
VALUE CODES – AMOUNTS	Value codes and amounts.	FL 39-41
ANSI	ANSI codes (system generated after claim is processed).	N/A
MSP APP IND	MSP Apportion Indicator – No longer used.	N/A

Inpatient Claim Entry-Page 2 (MAP1712)



The Inpatient Claim Entry (page 02) screen contains revenue code information, HCPCS codes, charges and service dates.

Type in the dollar amounts, with or without the decimal for example, 47.50 or 4700.

Revenue Code 0001 should always be the final Revenue Code entry and correspond with the totals for 'Total Charges' AND 'Non-Covered Charges.'

There are additional revenue lines available. Press **<F6>** to scroll down and **<F5>** to scroll up.

To delete a Revenue Code line, type four (4) zeros over the Revenue Code to be deleted and press **<HOME>** (this will position the cursor in CLAIM PAGE 02) and press

<ENTER> OR type D in the first position of the Revenue Code to be deleted and press **<HOME>** (this will position the cursor in CLAIM PAGE 02) and press **<ENTER>.**

- Be sure to adjust your Total Charges to reflect any deletions.

To insert a Revenue Code line, type the appropriate information after the 0001 line. Once you have typed all the information, press **<HOME>** (this will position the cursor in CLAIM PAGE 02) and press **<ENTER>.** DDE will resort to the Revenue Code lines.

- Be sure to adjust your Total Charges to reflect any additions.

Field Descriptions for Page 02

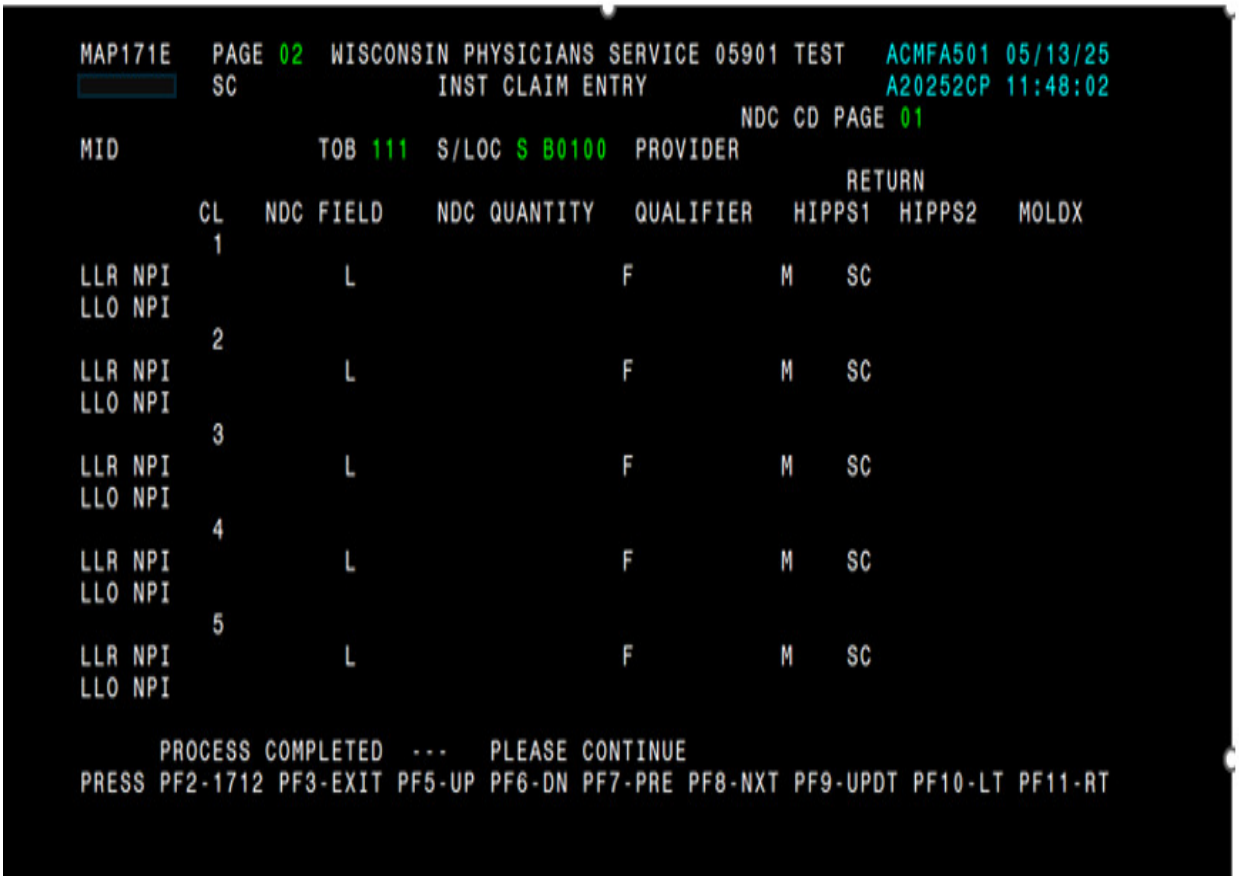
Field Name	Description	UB-04 Form Locator (FL)
UTN	Unique Tracking Number	N/A
PROG	Prior Authorization Program Indicator	N/A
REP PAYEE	Identifies a Medicare beneficiary with a Rep Payee. Valid values are: **R** – Bypass Rep Payee ' ' Blank	N/A
RRB EXCL IND	Railroad Board (RRB) Exclusion Indicator. Valid values are: Y – Exclude RRB beneficiary services from the prior authorization program Blank – Subject RRB beneficiary services to prior authorization	N/A
PROV VAL TYPE	Provider validation type. Valid values are: RP (Rendering Provider) RP (Rendering Provider) OP (Operating Physician) CP (Ordering / Referring Physician) CP (Ordering / Referring Physician) FA (Facility)	N/A
CL	Claim line item number (1 – 450).	N/A
REV	Revenue code.	FL 42
HCPC	Healthcare Common PrHealthcare Common Procedure Coding System	FL 44
MODIFS	Modifiers.	FL 44
RATE	Per unit raPer unit rate for revenue code line item service. Not used for claim entry.	FL 44
TOT UNT	Total units.	FL 46
COV UNT	Covered units.	FL 46
TOT CHARGE	Total charges per revenue code line.	FL 47
NCOV CHARGE	Noncovered charges billed per revenue code line.	FL 48
SERV DATE	Date service was provided.	FL 45
RED IND	Therapy Reduction Indicator. Valid values: **P** = partial (if all units except 1 were reduced) **R** = all units were reduced. **M** = multiple surgery reduction Not used for claim entry.	N/A

Claims Entry Screen 2B – National Drug Code (NDC) Information MAP171E

Hospitals subject to OPPS must include NDC information for drugs coded with HCPCS code C9399, and all hospital outpatient departments who serve patients who are dually eligible for Medicare and Medicare need to include the NDC, corresponding amounts and qualifiers on crossover claims.

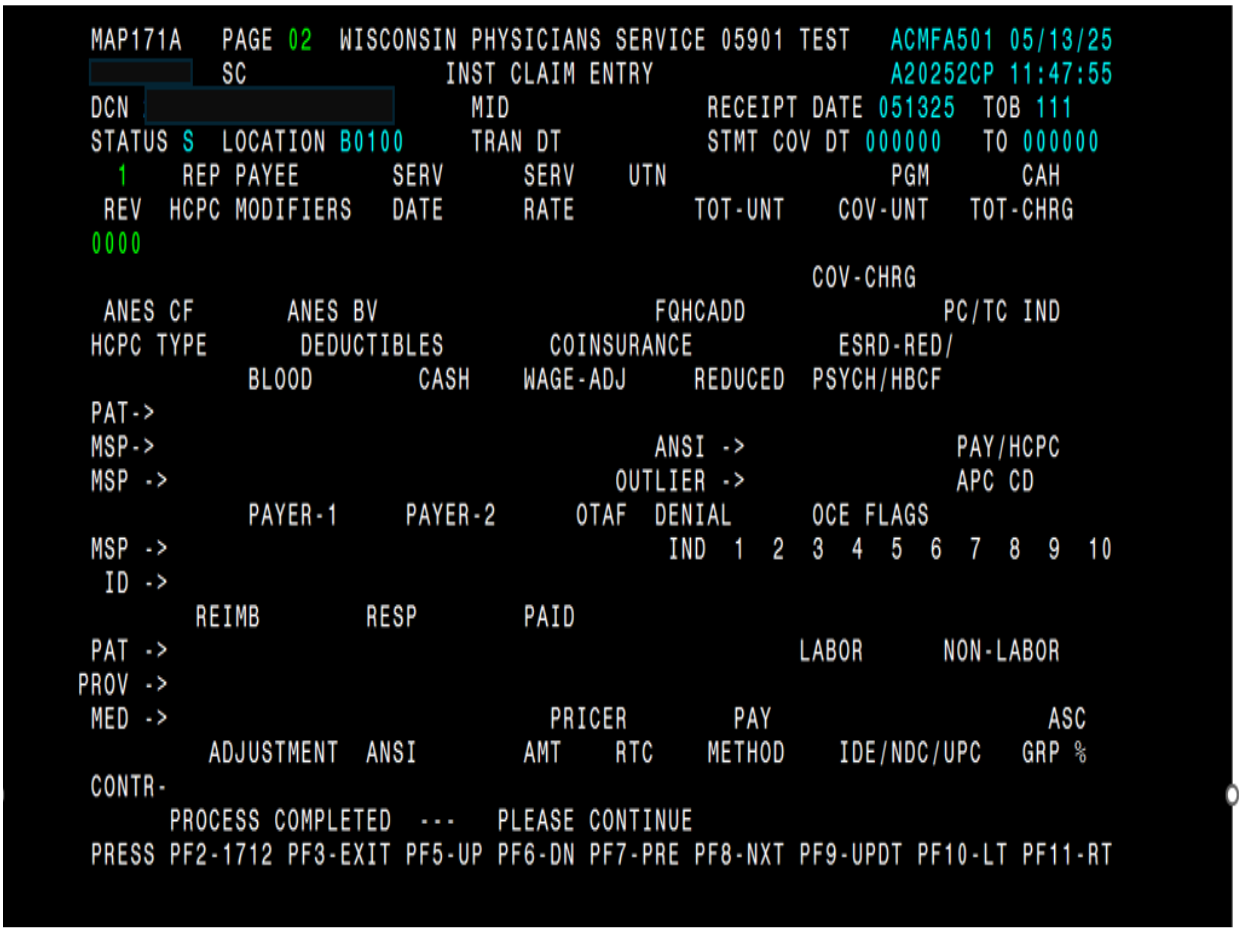
This information is added on MAP171E in the corresponding line item of the drug code, which can be accessed from the charge screen, MAP1217, by pressing [F11], or from MAP171A by pressing [F10]. To return to the charge screen, press [F10]. The newest addition to this screen is the LLO NPI field, which displays the NPI of the Ordering physician.

Inpatient Claim Entry-Page 2 (MAP171E)



Field Name	UB-04 X-Ref	Description
LLR NPI	NA	Line Level Rendering Physician NPI
L	NA	Last Name of Rendering Physician
F	NA	First Name of Rendering Physician
M	NA	Middle initial of Rendering Physician
SC	NA	Specialty Code - This is a protected field that is filled in by the system once the rendering physician NPI, last name, first name, and middle initial have been entered.
NDC FIELD	NA	This field identifies the National Drug Code.
NDC QUANTITY	NA	The quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological.
QUALIFIER	NA	The unit of measurement qualifiers are: F2 - International Unit GR - Gram ML - Milliliter UN - Unit

Inpatient Claim Entry-Page 2 (MAP171A)



Most of the fields on this screen are systematically filled.

- Pressing <**F11**> twice while on claim page 02 will take the provider to MAP171A to allow entry of more than two modifiers. Pressing <**F6**> while on MAP171A allows the provider to scroll to the line requiring the additional modifier. <**F5**> will allow you to scroll backward.
- Claim line number was added above the Rev Code field to allow immediate movement to the desired Revenue Code line
- Entry of appropriate information was allowed in the Denial IND

Field Name	UB-04 X-Ref	Description
UNTITLED	NA	**Claim Line Number -** Three-digit numeric field that identifies the line number of the revenue code. There are 14 revenue code lines per page with a total of 450 revenue code lines per claim. In entry mode this field is systematically filled when the claim is processed. The line number will be present for update and inquiry.
REV	NA	**Revenue Code -** Four-digit numeric field that displays the code for a specific accommodation or services that was billed on the claim. This will be the revenue code selected on MAP1712.

HCPC	NA	**Health Care Procedure Coding [System] (HCPCS) -** Five- digit alphanumeric field that identifies certain medical procedures or equipment for special pricing, assigned by CMS.
MODIFIERS	NA	**Health Care Procedure Coding System (HCPCS) Modifier-** Ten-digit alphanumeric field that will contain five two-character modifiers. The two modifiers entered on MAP1712 will be displayed and the user can enter any remaining modifiers.
SERV DATE	NA	**Service Date -** Six-digit field in MMDDYY format. This is the date of service that is required for many outpatient bills and will be the same as the line item selected on MAP1712.
SERV RATE	NA	**Rate -** Fourteen-digit field in 999999999999.99 format that identifies per unit cost for a particular line item. This is the rate that was entered on MAP1712.
TOT-UNT	NA	**Total Units -** Ten-digit field that displays units of service, a quantitative measure of services rendered by revenue category. The total units displayed on this screen are the same as was entered on MAP1712.
COV-UNT	NA	**Covered Units** - Ten-digit field that displays units of service, a quantitative measure of services rendered by revenue category. The covered units displayed on this screen are the same as was entered on MAP1712.
TOT-CHRG	NA	**Total Charges -** Twelve-digit numeric field in 9999999999.99 format. The total charges displayed on this page are the same as was entered on MAP1712.
PC/TC	NA	**Professional Component/Technical Component -** This field identifies the PC/TC indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) services Supplemental Fee Schedule. This is used to identify professional services eligible for the Health Professional Shortage Area (HPSA) bonus payments. This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. 0-Physician Service Code-Identifies codes that describe physician services. 1-Diagnostic Tests For Radiology Services- Identifies codes that describe diagnostic tests. 2- Professional Component Only Codes- Identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only, and another associated code that describes the global test. 3- Technical Component Only Codes-Identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only

		4- Global Test Only Codes- Identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe: • Professional component of the test only • Technical component of the test only 5- Incident To Codes- Identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. 6- Laboratory Physician Interpretation Codes- Identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made 7-Physical Therapy Service, For Which Payment May Not Be Made- Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. 8-Physician Interpretation Codes- Identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient 9-Concept of a professional/technical component does not apply.
ANES CF	NA	**Anesthesia Conversion Factor -** This field identifies the anesthesia conversion factor. This is a five-digit field in 999.99 format.
ANES BV	NA	**Anesthesia Base Units Value -**This field identifies the anesthesia base values. This is a three-digit field.
COV/CHRG	NA	**Covered Charges -**Twelve-digit numeric field in 9999999999.99 format. The covered charges displayed on this page are the same as was entered on MAP1712.
PAT BLOOD DEDUCTIBLE	NA	**Patient Blood Deductible -** The amount of Medicare blood deductible applied to the line item. Blood deductible will be applied at the line level on revenue codes 380, 381, and 382. This field will systematically fill.
PAT CASH DEDUCTIBLE	NA	**Patient Cash Deductible -** The amount of Medicare cash deductible applied to the line item. This field will systematically fill.
PAT WAGE ADJ COINSURANCE	NA	**Patient Wage Adjustment Coinsurance -** The amount of coinsurance applicable to the line based on the particular service rendered. The revenue and HCPCS code submitted define the service. For services subject to Outpatient Prospective Payment System (OPPS) in hospitals (TOB 12X, 13X and 14X) and in community mental health centers (TOB 76X), the applicable coinsurance is wage adjusted. Therefore, this field will have either

		a zero (for the services without applicable coinsurance) or a regular coinsurance amount (calculated on either charges or a fee schedule), unless the service is subject to OPPS. If the service is subject to PPS, the national coinsurance amount will be wage adjusted, based on the MSA where the provider is located or assigned as the result of a reclassification. CMS supplies the national coinsurance amount to the MACs, as well as the MSA by the provider. This field will systematically fill.
PAT REDUCED COINSURANCE	NA	**Patient Reduced Coinsurance -** For all services subject to OPPS (TOB 12X, 13X, 14X, and 76X) the amount of coinsurance applicable to the line for a particular coinsurance amount. Note: Providers are only permitted to reduce the coinsurance amount due from the beneficiary for services paid under OPPS, and the reduced amount cannot be lower than 20% of the payment rate for the line. If the provider does not elect to reduce the coinsurance amount, the field will contain zeros.
PAT ESRD-RED/PSYCH/HBCF	NA	**Patient End Stage Renal Disease Reduction/ Psychiatric Reduction/Hemophilia Blood Clotting Factor** - This field will house one of these three values: ESRD reduction amount, Psychiatric reduction, or hemophilia blood clotting factor amounts. ESRD reduction refers to the ESRD network reduction found on Claim Page 1 in Value Code 71. Psychiatric reduction applies to line items that have a P pricing indicator. The amount represents the psychiatric coinsurance amount (37.5% of the covered charges). Hemophilia Blood Clotting Factor represents an additional payment to the DRG payment for hemophilia. The additional payment is based on the applicable HCPCS. This payment add-on applies to inpatient claims.
VALCD-05/ OTHER	NA	**Value Code-05/Other** - If value code 05 is present on the claim, this field will contain the portion of the value code 05 amounts that is applicable to this line item. The value code 05 amount is applied to revenue codes 96X, 97X, and 98X first and then applied to revenue code lines in numeric order that are subject to deductible and/or coinsurance.
MSP BLOOD DEDUCTIBLE	NA	**Medicare Secondary Payer Blood Deductible -** This field identifies the blood deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP CASH DEDUCTIBLE	NA	**Medicare Secondary Payer Cash Deductible -** This field identifies the cash deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP WAGE-ADJ COINSURANCE	NA	**Medicare Secondary Payer Coinsurance -** This field identifies the coinsurance amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
ANSI ESRD-RED/PSYCH/HBCF	NA	**ANSI End Stage Renal Disease Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor -** This field is the two-character Group Code and three-character Reason (Adjustment) Code. This will be used for sending ANSI information to the Financial System for reporting on the remittance advice for the ESRD Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor.

ANSI VALCD-05/OTHER	NA	**ANSI Value Code-05/Other -** This field is the two-character Group Code and three-character Reason (Adjustment) Code. This will be used for sending ANSI information for the value code 05 to the financial system for reporting on the remittance advice for the value code 05/other amount.
MSP PAYER-1	NA	**Medicare Secondary Payer Payer-1** -The amount entered by the user (if available) or apportioned by MSPPAY as payment from the primary payer. The MSPPAY module based on the amount in the value code for the primary payer apportions this amount.
MSP PAYER-2	NA	**Medicare Secondary Payer Payer-2** – The amount entered by the user (if available) or apportioned by MSPPAY as payment from the secondary payer. The MSPPAY module based on the amount in the value code for the secondary payer apportions this amount.
OTAF	NA	**Obligated to Accept in Full -** This field contains the line item apportioned amount entered by the user (if available) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full. This field will be populated when value code 44 is present.
MSP DENIAL IND	NA	**Medicare Secondary Payer Denial Indicator -** This field will provide the user an opportunity to tell the MSPPAY module that an insurer primary to Medicare has denied this line item. Valid values: Blank - Blank D - Denied
OCE FLAGS	NA	**Outpatient Code Editor (OCE) -** One-digit alphanumeric field that identifies nine fields that are returned by the OCE module via the APC return buffer. **OCE flags:** **Flag 1** - Service **Flag 2** – Payment **Flag 3** - Discounting Factor **Flag 4** - Line Item Denial or Rejection **Flag 5** -Packing **Flag 6** - Payment Adjustment **Flag 7** - Payment Method **Flag 8** - Line Item Action **Flag 9**-Composite Adjustment
PAY/HCPC APC CD	NA	**Payment Ambulatory Patient Classification (APC) Code or HCPCS Ambulatory Patient Classification Code -** Five-digit field that identifies the APC group number by line item. Payment for services under the OPPS is calculated based on grouping outpatient services into APC groups. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. Both APC codes appear on the claims file, but only one appears on the screen. If their values are different, this indicates a partial hospitalization item. In this case the payment APC code is displayed. When the item is not a partial hospitalization, the HCPCS APC code is displayed. This data is read from the claims file. If an APC is not found, the value will default to 00000.

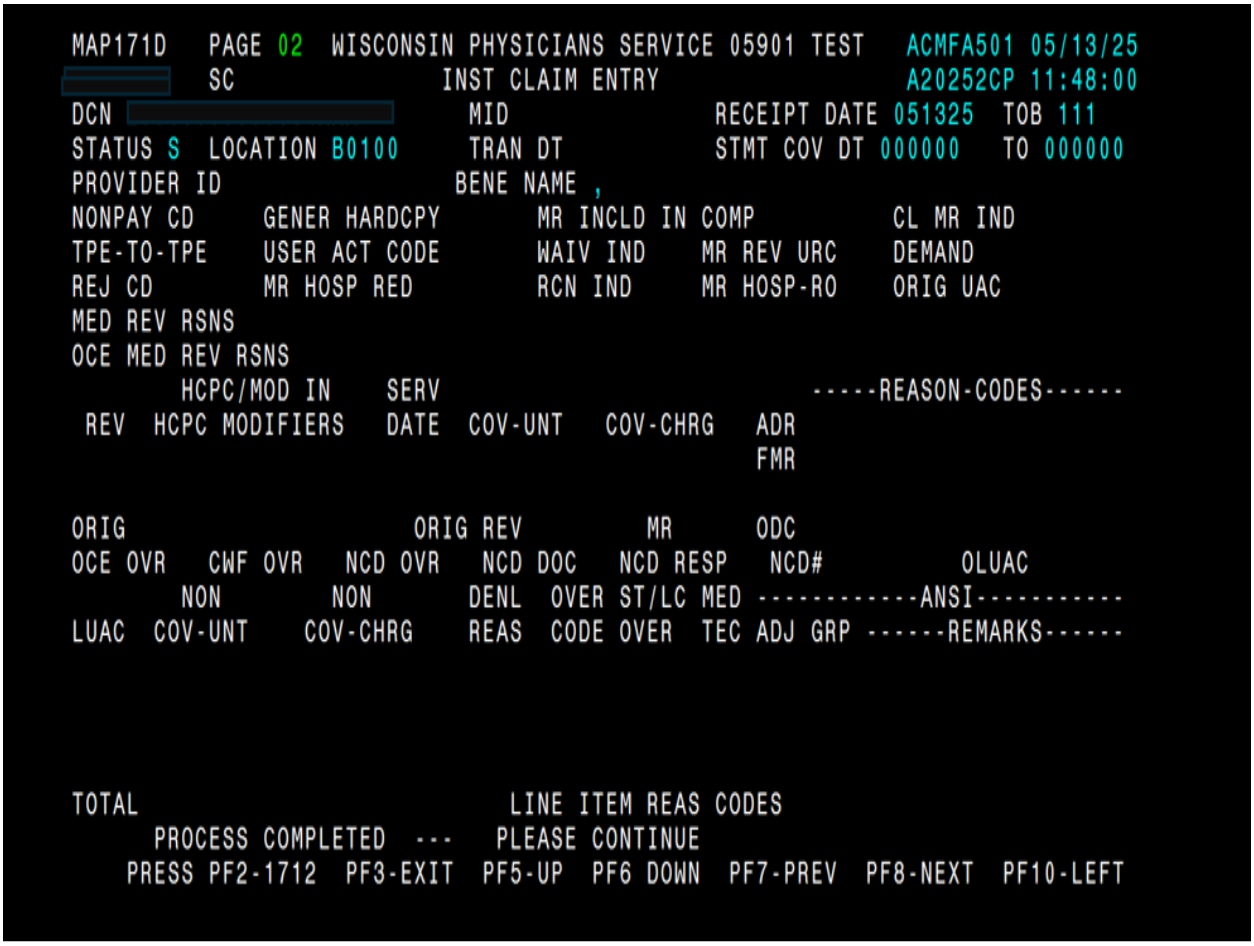
		• Claim page 31 displays the HIPPS code if different from what is billed. If medical changes the code, the new HIPPS code is displayed in the PAY/HCPC APC CD field and a value of M is in the OCE flag 1 field. When a value of M is in the OCE flag 1 field, the MR IND field is automatically populated with a Y. If Pricer changes the code, the new Home Health Resource Group (HHRG) is displayed in the PAY/HCPC APC CD field and a value of P is in the OCE flag 1 field. If the HIPPS code was not changed, fields PAY/HCPC APC CD and OCE flag 1 are blank. • For Home Health PPS claims, claim page 31 displays the HIPPS code if different from what is billed. • For Inpatient Rehabilitation Facility (IRF) PPS claims: if the IRF PPS Pricer returns a HIPPS/CMG code different from what was billed, the new HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field and a value of I is displayed in the OCE FLAG 1 field. If the IRF PPS pricer does not change the HIPPS/CMG code, these fields are blank.
MSP PAYER-1 ID	NA	**Medicare Secondary Payer Payer-1 ID -** This is a one-digit alphanumeric code identifying the specific payer. If Medicare is primary, this field will be blank. Valid values: 1- Medicaid 2- Blue Cross 3- Other 4- None A - Working Aged B - End Stage Renal Disease (ESRD) Beneficiary in 12- month coordination period with an employer group health plan C - Conditional Payment D - Auto No-Fault E - Workers' Compensation F - Public Health Service or other Federal Agency G - Disabled H - Black Lung I - Veterans Administration L – Liability Z-Medicare
MSP PAYER-2 ID	NA	**Medicare Secondary Payer Payer-2 ID -** This is a one-digit alphanumeric code identifying the specific payer. If Medicare is secondary, this field will be blank. Valid values: 1- Medicaid 2- Blue Cross 3- Other 4- None A - Working Aged

		B - End Stage Renal Disease (ESRD) Beneficiary in 12-month coordination period with an employer group health plan C - Conditional Payment D - Auto No-Fault E - Workers' Compensation F - Public Health Service or other Federal Agency G - Disabled H - Black Lung I - Veterans Administration L – Liability Z-Medicare
PAT REIM	NA	**Patient Reimbursement -** This amount is determined by the system to be paid to the patient based on the amount entered by the provider on claim page 3, in the Due from Pat field. This amount is the calculated line-item amount.
PAT RESP	NA	**Patient Responsibility -** This field identifies the amount the individual receiving services is responsible. The amount is calculated as follows: • If Payer-1 indicator is C or Z, then the amount will equal: Cash Deductible + Coinsurance + Blood Deductible • If Payer-1 indicator is not C or Z, then the amount will equal MSP Blood + MSP Cash Deductible + MSP Coinsurance
PAT PAID	NA	**Patient Paid -** This is the line item patient paid amount calculated by the system. This amount is the lower (Patient Reimbursement + Patient Responsibility) or the remaining Patient Paid (after the preceding lines have reduced the amount entered on Page 3).
PROV REIMB	NA	**Provider Reimbursement -** The amount determined by the system to be paid to the provider. This amount is the calculated line item amount.
LABOR	NA	**Labor -** This field identifies the labor amount of the payment as calculated by the Pricer.
NON-LABOR	NA	**Non-Labor -** This field identifies the non-labor amount of the payment as calculated by the Pricer.
MED REIMB	NA	**Medicare Reimbursement -** This field is the total Medicare reimbursement for the line item. It will be the sum of the patient reimbursement and the provider reimbursement.
CONTR	NA	**Contractual Adjustment -** The following calculation will be performed to obtain the total contractual adjustment
ADJUSTMENT		Submitted Charges minus Deductible minus Wage Adjusted Coinsurance minus Blood Deductible minus Value Code 71 minus Psychiatric Reduction minus Value Code 05/Other minus Reimbursement Amount. For MSP claims, the MSP deductible, MSP blood deductible and MSP coinsurance is used in the above calculation in place of the deductible, blood deductible and coinsurance amounts.

REDUCT-AMT	NA	From DDE claim page 02, press <F11> twice to reach MAP171A. MAP171A now shows the REDUCT-AMT field which displays the 10% reduction and the ANSI field which displays the group code and Claims Adjustment Reason Code (CARC).
ANSI	NA	**ANSI Group-ANSI Adjustment Code -** This field is the two-character group code and three-character reason (adjustment) code. This will be used to send ANSI information to the Financial System for reporting on the remittance advice.
OUTLIER AMOUNT	NA	**Outlier Amount -** This field identifies the apportioned line level outlier amount returned from MSPPAYOL. This is a Ten-digit field in 99999999.99 format.
PRICER AMT	NA	**Pricer Amount -** This field provides the line item reimbursement received from a Pricer.
PRICER RTC	NA	**Pricer Return Code -** Two-digit field that identifies the return code from OPPS. Valid values: Describes how the bill was paid. 00-Priced standard DRG payment 01- Paid as day outlier/send to PRO for post payment review 02- Paid as cost outlier/send to PRO for post payment review 03- Paid as per diem/not potentially eligible for cost outlier 04- Standard DRG, but covered days indicate day outlier but day or cost outlier status was ignored 05- Pay per diem days plus cost outlier for transfers with an approved cost outlier 06- Pay per diem days only for transfers without an approved outlier 10 - Bad state code for SNF RUG Demo or Post-Acute Transfer for Inpatient PPS Pricer DRG is 209, 210, or 211 12 - Post acute transfer with specific DRGs of 14, 113, 236, 263, 264, 429, 483 14 - Paid normal DRG payment with per diem days = or > average length of stay 16 - Paid as a Cost Outlier with per diem days = or > average length of stay 20 - Bad revenue code for SNF RUG Demo or invalid HIPPS code for SNF PPS Pricer 30 - Bad Metropolitan Statistical Area (MSA) Code 51- No provider specific information found. 52- Invalid MSA in provider file 53- Waiver State - not calculated by PPS 54- DRG not 001-468 or 471-910 55- Discharge date is earlier than provider's PPS start date 56- Invalid length of stay 57- Review code not 00-07 58- Charges not numeric 59- Possible day outlier candidate 60- Review code 01 and length of stay indicates day outlier. Bill is not eligible as cost outlier 61- Lifetime reserve days not numeric 62- Invalid number of covered days (e.g., more than approved length of stay, non-numeric or lifetime reserve days greater than covered days) 63- Review code of 00 or 03, and bill is cost outlier candidate 64- Disproportionate share percentage and bed size conflict on

		provider specific file 98 - Cannot process bill older than 10/01/87
PAY METHOD	NA	**Payment Method -** This field identifies the method of payment (e.g., OPPS, LAB fee schedule, etc.) returned from OCE. Valid values: 0- OPPS PRICER determines payment for service 1- Based on OPPS coverage, or billing rules, the service is not paid 2- Service is not subject to OPPS 3- Service is not subject to OPPS, and has an OCE line item denial or rejection 4- Line item is denied or rejected by you; OCE not applied to line item 5- Payment for service determined under FQHC PPS 6- CMHC outlier limitation reached 7- Section 603 service with no reduction in OPPS PRICER 8- Section 603 service with PFS reduction applied in OPPS PRICER 9- CMHC outlier limitation bypassed 10- Transferred from input for PRICER; COBOL pic 9(8)v99 A-Payment reduction for off-campus clinic visit Z- Contractor bypass determines payment for services
IDE/NDC/UPC	NA	This field identifies the IDE (Investigational Device Exemption), NDC, or UPC authorization number assigned by the FDA. This is a 15-position alphanumeric field.
ASC GRP	NA	**Ambulatory Surgical Center (ASC) Group -** This field identifies the ASC group code for the indicated revenue code.
ASC%	NA	**Ambulatory Surgical Center Percentage -** This field identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code.

Inpatient Claim Entry – Page 2 (MAP171D)



MAP171D is a copy of core claim MAP103I, claim page 32. (Claim page 32 is an internal screen.) However, providers may only view this map. They may not add, modify, or delete any information.

Press **<F2>** (Jump Key) while on claim page 02 (MAP1712) to take provider to MAP171D to view line denials. Press **<F11>** once to take provider to MSP171A.

A place was added for three (3) additional two-digit modifiers (total of five) on MAP171D. Additional modifiers may be added, deleted, or modified from MAP171A.

Jump key, when placed on a revenue code on MAP1712, allows the user to scroll to the same revenue code line on MAP171D.

The provider can view Line Item Reason Codes - the reason code(s) that is/are assigned out of the system for suspending the line item.

Claim line number was added above the Rev Code field to allow immediate movement to the desired Revenue Code line.

Field Name	UB-04 X-Ref	Description
PROVIDER ID	NA	**Provider Identification Number** - 13-digit field that identifies the identification number of the provider submitting the claim.
BENE NAME	NA	**Beneficiary Name** - 30-digit field that identifies the name of the Beneficiary in a sequence of two alphanumeric sub-fields, 20 positions for the last name, and ten positions for the first name.
NON PAY CD	NA	**Non-Pay Code** - Two-digit field that identifies the reason for Medicare's decision not to make payment. **Valid values:** **B** - Benefits exhausted **C** - Non-Covered Care (Discontinued) **E** - First Claim Development (Contractor 11107) **F** - Trauma Code Development (Contractor 11108) **G** - Secondary Claims Investigation (Contractor 11109) **H** - Self Reports (Contractor 11110) **J** - 411.25 (Contractor 11111) **K** - Insurer Voluntary Reporting (Contractor 11106) **N** - All other reasons for non-payment **P** - Payment requested **Q** - MSP Voluntary Agreements (Contractor 88888) **Q** - Employer Voluntary Reporting (Contractor 11105) **R** - Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely or Waiver of Liability **T** - MSP Initial Enrollment Questionnaire (Contractor 99999) **T** - MSP Initial Enrollment questionnaire (contractor 11101) **U** - MSP HMO Cell Rate Adjustment (Contractor 55555) **U** - HMO/Rate Cell (Contractor 11103) **V** - MSP Litigation Settlement (Contractor 33333) **V** - Litigation Settlement (Contractor 11104) **W** - Workers' Compensation **X** - MSP cost avoided **Y** - IRS/SSA Data Match Project MSP Cost Avoided (Contractor 77777) **Y** - IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) **Z** - System set for types of bill 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed. **00** - Coordination of Benefits (COB) Contractor (Contractor 11100) **12**- Blue Cross Blue Shield Voluntary Agreements (Contractor 11112) **13**- Office of Personnel Management (OPM) Data Match (Contractor 11113) **14**- Workers' Compensation (WC) Data Match (Contractor 11114)
GENER HARDCPY	NA	Generate Hard Copy - One-digit field instructs the system to generate a specific type of hard copy document. Valid values: **2**- Medical ADR **3**- Non-Medical ADR **4**- MSP ADR **5** - MSP Cost Avoidance ADR **7** - ADR to Beneficiary **8** - MSN (Line Item) or Partial Benefit Denial Letter

		9 - MSN (Claim Level) or Benefit Denial Letter
MR INCLD IN COMP	NA	**Composite Medical Review Included in the Composite Rate -** One-digit alphanumeric field that identifies (for ESRD bills) if the claim has been denied because the service should have been included in the Comp Rate. Valid value: Y - The claim has been denied
CL MR IND	NA	**Complex Manual Medical Review Indicator –** One-digit field that identifies if all services on the claim received complex manual medical review. The value entered in this field auto populates the MR IND field for all revenue code lines on the claim. Valid values: Blank - The services did not receive manual medical review (default) Y - Medical records received. This service received complex manual medical review N - Medical records were not received. This service received routine manual medical review
TPE-TO-TPE	NA	Tape-to-Tape Flag - One-digit alphanumeric field that identifies the tape-to-tape flag (if applicable). Valid values: The flag indicators across the top of the chart. Each indicator instructs the system to either perform or skip each of the four functions listed on the left of the chart. The first indicator column represents a blank. If this field is blank, all functions are performed (as indicated on the chart below).

Function	Blank	A	B	J	O	Q	S	T	U	W	X	Z
Transmit To CWF	Y	Y	Y	N	N	N	Y	Y	Y	Y	N	N
Print On Remittance	Y	Y	Y	Y	N	Y	Y	N	N	N	Y	N
Include On PS & R	Y	Y	N	Y	Y	N	N	N	N	Y	Y	N
Include On Workload	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	N
Bypass All Duplicate Edits	N	N	N	Y	N	N	N	N	Y	N	Y	N

USER ACT CODE	NA	**User Action Code -** Two-digit User Action Code is to be used for medical review and reconsideration only. First position: User Action Code, Second position: Reconsideration Code. The reconsideration user action code will always be R. When a recon is performed on the claim, the user should enter an R in the second position of the claim user action code, or in the line user action code field. This tells the system that reconsideration has been performed. Valid values: Medical Review A - Pay per waiver - full technical. B - Pay per waiver - full medical. C - Provider liability - full medical - subject to waiver provisions. D - Beneficiary liability - full - subject to waiver provisions. E - Pay claim - line full. F - Pay claim - partial - claim must be updated to reflect liability. G - Provider liability - full technical - subject to waiver provisions. H - Full or partial denial with multiple liabilities. Claim must be updated to reflect liability. I - Full provider liability - medical - not subject to waiver provisions. J - Full provider liability - technical - not subject to waiver provisions. K - Full provider liability - not subject to waiver provisions. M - Pay per waiver - line or partial line. N - Provider liability - line or partial line. O - Beneficiary liability - line or partial line. P - Open biopsy changed to closed biopsy. Q - Release with no medical review performed. R - CWF (Common Working File) denied but medical review was performed. Z - Force claim to be re-edited by Medical Policy. Special Screening 5 - Generates systematically from the reason code file to identify claims for which special processing is required. 7 - Force claim to be re-edited by Medical Policy edits in the 5XXXX range but not the 7XXXX range. 8 - A claim was suspended via an OCE MED review reason. 9 - Claim has been identified as "First Claim Review."
WAIV IND	NA	**Waiver Indicator -** One-digit field that identifies whether the provider has their presumptive waiver status. Valid values: Y - The provider does have their waiver status N - The provider does not have their waiver status
MR REV URC	NA	**Medical Review Utilization Review Committee (URC) Reversal -** One-digit alphanumeric field that identifies whether a SNF URC Claim has been reversed. This indicator can be used for a partial or a full reversal. Valid values: P - Partial reversal F - Full reversal, the system reverses all charges and days
DEMAND	NA	**Medical Review Demand Reversal -** One-digit alphanumeric field that identifies a SNF demand claim has been reversed. Valid values: P - Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal.

		F - Full reversal, the system reverses all charges and days.
REJ CD	NA	**Reject Code -** Five-digit alphanumeric field that identifies the reason code for which the claim is being denied.
MR HOSP RED	NA	**Medical Review Hospice Reduced –** One-digit field that identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. Valid values: Blank - Not reduced Y - Reduced
RCN IND	NA	**Reconsideration Indicator -** This field is used only for home health claims. Valid values: A - Finalized count affirmed B - Finalized no adjustment count (pay per waiver) R - Finalized count reversal (adjustment) U - Reconsideration
MR HOSP-RO	NA	**Medical Review Regional Office (RO) Referred -** One-digit alphanumeric field that identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. Valid values: Blank-Not related Y-Referred
MED REV RSNS	NA	**Medical Review Reasons -** Five-digit alphanumeric field that identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field displays medical review reasons specific to claim level. The system determines this by a 'C' in the claim/line indicator on the reason code file. The medical review reasons must contain a "5" in the first position.
OCE MED REV RSNS	NA	**OCE Medical Review Reasons -** Three-digit field displays the edit returned from the OPPS version of OCE. Valid values: • - Non-covered service submitted for review (condition code 11,12,30,31,32, and 33). • - Questionable covered service. • - Insufficient services on day of partialization. • - Partial hospitalization on same day as electroconvulsive therapy or type T procedure. • - Partial hospitalization claim spans three or less days with insufficient services, or electro convulsive therapy or significant procedure on at least one of the days. • - Partial hospitalization claim spans more than three days with insufficient number of days having mental health services.

UNTITLED	NA	**Claim Line Number -** Three-digit field that identifies the line number of the revenue code. The line number is located above the revenue code on this map. To move to another revenue code, enter the new line number and press **<ENTER>**.
REV	NA	**Revenue Code -** Four-digit numeric field that identifies the code for a specific accommodation or service that was billed on the claim. This information was entered on MAP1712. Valid values: 01 – 9999 Note: To move to the next Revenue Code with a line level reason code, position the cursor in the page number field, press **<F2>.**
HCPC/MOD IN	NA	**HCPCS Code/Modifier -** One-digit field that identifies whether the HCPCS Code, Modifier or the REV Code were changed. Valid values: U - Up coding D - Down coding Blank – Blank Note: A U or D in this field opens the REV Code and HCPC/Mod fields to accept the changed code. Enter U or D, <Tab> down to the REV Code and HCPC/ MOD fields. After the new code is entered, the original Rev Code and HCPC/MOD fields move down to the ORIG REV or ORIG HCPC/MOD field.
HCPC	NA	**HCFA (CMS) Common Procedure Code -** Five-digit alphanumeric field that identifies the HCPCS code that further defines the revenue code being submitted. The information on this field was entered on MAP1712.
MODIFIERS	NA	**HCPCS Modifiers -** Ten-digit alphanumeric field that identifies the HCPCS modifier codes for claim processing. This field may contain five two-position modifiers.
SERV DATE	NA	**Service Date -** Six-digit field that identifies the line item date of service, in MMDDYY format, and is required for many outpatient bills. This information was entered on MAP1712.
COV-UNT	NA	**Covered Units -** This field identifies the number of covered units associated with the revenue code line item being denied.
COV-CHRG	NA	**Covered Charges -** This field identifies the number of covered charges associated with the revenue code line item being denied.
ADR REASON CODES	NA	**Additional Development Reason Codes -** This field identifies the ADR reason codes that are present on the screen and allows the user to manually enter up to four (4) occurrences to be used when an ADR letter is to be sent. The system reads the ADR code narrative to print the letter. The letter prints the reason code narrative as they appear on each revenue code line.

FMR REASON CODES	NA	**Focused Medical Review Suspense Codes -** This field identifies when a claim is edited in the system, based on a parameter in the Medical Policy Parameter file. There are four (4) five-position alphanumeric fields to store the medical review suspense codes. Note: The system generates the Medical Review code for the corresponding line item on the second page of the Denial/Non-Covered/Charges screen. The system assigns the same Focused Medical Review ID edits on lines that are duplicated for multiple denial reasons. The user may enter or overlay any existing Medical Review suspense codes. Claim level suspense codes should not apply to the line level. The Medical Policy reasons are defined by a 5 or 7 in the first position of the reason code.
MR IND	NA	**Complex Manual Medical Review Indicator -** One-digit field that identifies if all services on the claim received complex manual medical review. The value entered in this field auto populates the MR IND field for all revenue code lines on the claim. Valid values: Blank - The services did not receive manual medical review (default) Y - Medical records received. This service received complex manual medical review N - Medical records were not received. This service received routine manual medical review
ODC	NA	**Original Denial Reason Codes -** Five-digit alphanumeric field with four occurrences that identifies the original denial reason codes.
ORIG	NA	**Original HCPCS and Modifiers Billed -** This field identifies the original HCPCS billed and modifiers billed. This field accommodates a five-digit HCPCS and up to five two-digit modifiers.
ORIG REV CD	NA	**Original Revenue Code -** Four-digit field that identifies the revenue code billed.
OCE OVR	NA	**OCE Override -** One-digit alphanumeric field used to override the way the OCE module controls the line item. Valid Values: 0- OCE line item denial or rejection is not ignored 1- OCE line item denial or rejection is ignored 2- External line item denial. Line item is denied even if no OCE edits 3- External line item rejection. Line item is rejected even if no OCE edits 4- External line item adjustment. Technical charge rules apply.
CWF OVR	NA	**CWF Home Health Override -** One-digit alphanumeric field that overrides the way the OCE module controls the line item.
NCD OVR	NA	**National Coverage Determination Override Indicator -** This field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. Valid values:

		Blank - Default value. The NCD edits are not bypassed. A blank in this field is set on all lines for resubmitted RTP'd claims. Y - The line has been reviewed for medical necessity and bypasses the NCD edits. D - The line has no covered charges and bypasses the NCD edits.
NCD DOC	NA	**National Coverage Determination (NCD) Documentation Indicator -** This field identifies whether the documentation was received for the necessary medical service. This indicator will not be reset on resubmitted RTP'd claims. Valid values: Y - The documentation supporting the medical necessity was received. N - Default Value. The documentation supporting the medical necessity was not received.
NCD RESP	NA	**NCD RESP National Coverage Determination Response Code –** This field identifies the response code that is returned from the NCD edits. Valid values: Blank - Set to space for all lines on resubmitted RTP'd claims (default value.) 0-The HCPCS/Diagnosis code matched the NCD edit table "pass" criteria. The line continues through the system's internal local medical necessity edits. 1-The line continues through the system's internal local medical necessity edits, because: the HCPCS code was not applicable to the NCD edit table process, the date of service was not within the range of the effective dates for the codes, the override indicator is set to Y or D, or the HCPCS code field is blank. 2- None of the diagnoses supported the medical necessity of the claim (list three codes), but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. 3- The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list two codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to non-coverage by statute. 4- None of the diagnosis codes on the claim support the medical necessity for the procedure (list three codes) and no additional documentation is provided. This line suspends as not medically necessary and will be denied. 5- Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the MAC will RTP the claim.

OLUAC	NA	**Original Line User Action Code -** Two-digit alphanumeric field that identifies the original line user action code. It is only populated when there is a line user action code and a corresponding denial reason code in the Benefits Savings portion of claim page 32.
LUAC	NA	**Line User Action Code (LUAC) -** Two-digit alphanumeric field that identifies the cause of denial for the revenue line, and a reconsideration code. The denial code (1st position) must be present in the system and pre-defined in order to capture the correct denial reason. The values are equal to the values listed for User Action Codes. The reconsideration code (2nd position) has a value equal to R indicating to the system that reconsideration has been performed. LUAC - Revenue Code Total Line - For the total revenue code line 0001, the system generates a value in the first two line occurrences of the LUAC field. These values indicate the type of total amount displayed on the total non-covered units and non-covered charges for the revenue code line 0001, only on MAP171D. These values do not apply to this field for any other revenue code line other than 0001. Valid values: 1- LUAC lines present on MAP171D 2- Non-LUAC lines present on MAP171D
NON COV- UNT	NA	**Non-Covered Units -** Ten-digit field that identifies the number of days/visits that are being denied. Denied days/visits are required for those revenue codes that require units on Revenue Code file. The first line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines not containing a LUAC on MAP171D.
NON COV-CHRG	NA	**Non-Covered Charges** - Twelve-digit field in 9999999999.99 format identifies the total number of denied/ rejected/non-covered charges for each line item being denied. The first line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines not containing a LUAC on MAP171D.
DENIAL REAS	NA	**Denial Reason -** Five-digit alphanumeric field that identifies the cause of denial for the revenue code line. The denial code must be present in the system and pre-defined in order to capture the correct denial reason
OVER CODE	NA	**Override Code -** This field identifies the override code that allows the operator to manually override the system generated ANSI codes taken from the Denial Reason Code file. Valid values: Blank - Default to system generated A - Override system generated ANSI Codes

ST/LC OVER	NA	**Status Location Override - One**-digit alphanumeric field that identifies the override of the reason code file status when a line item has been suspended. Valid values: Blank - Process claim with no override code D - Denied, for the reason code on the line R - Rejected, for the reason code on the line
MED TEC	NA	**Medical Technical Denial Indicator -** This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. Valid values: A - Home Health only - not intermittent care - technical and waiver was applied B - Home Health only - not homebound - technical and waiver was applied C - Home Health only - lack of physicians orders – technical deletion and waiver was not applied D - Home Health only - Records not submitted after the request-technical deletion and waiver was not applied M - Medical denial and waiver was applied S - Medical denial and waiver was not applied T - Technical denial and waiver was applied U - Technical denial and waiver was not applied
ANSI ADJ	NA	**ANSI Adjustment Reason Code –** Three-digit field that identifies the ANSI Adjustment Reason Code. The data for this field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the Reason Code file to assign the ANSI code to the denial screen. This code will occur once for each line item.
ANSI GRP	NA	**ANSI Group Code -** Four-digit field that identifies the ANSI Group Code. The data for this field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
ANSI REMARKS	NA	**ANSI Remarks Code -** Four-digit field that identifies the ANSI Remarks codes. The data for this field is taken from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
TOTAL	NA	**Total -** This field identifies the total of all revenue code non- covered units and charges present on MAP171D.

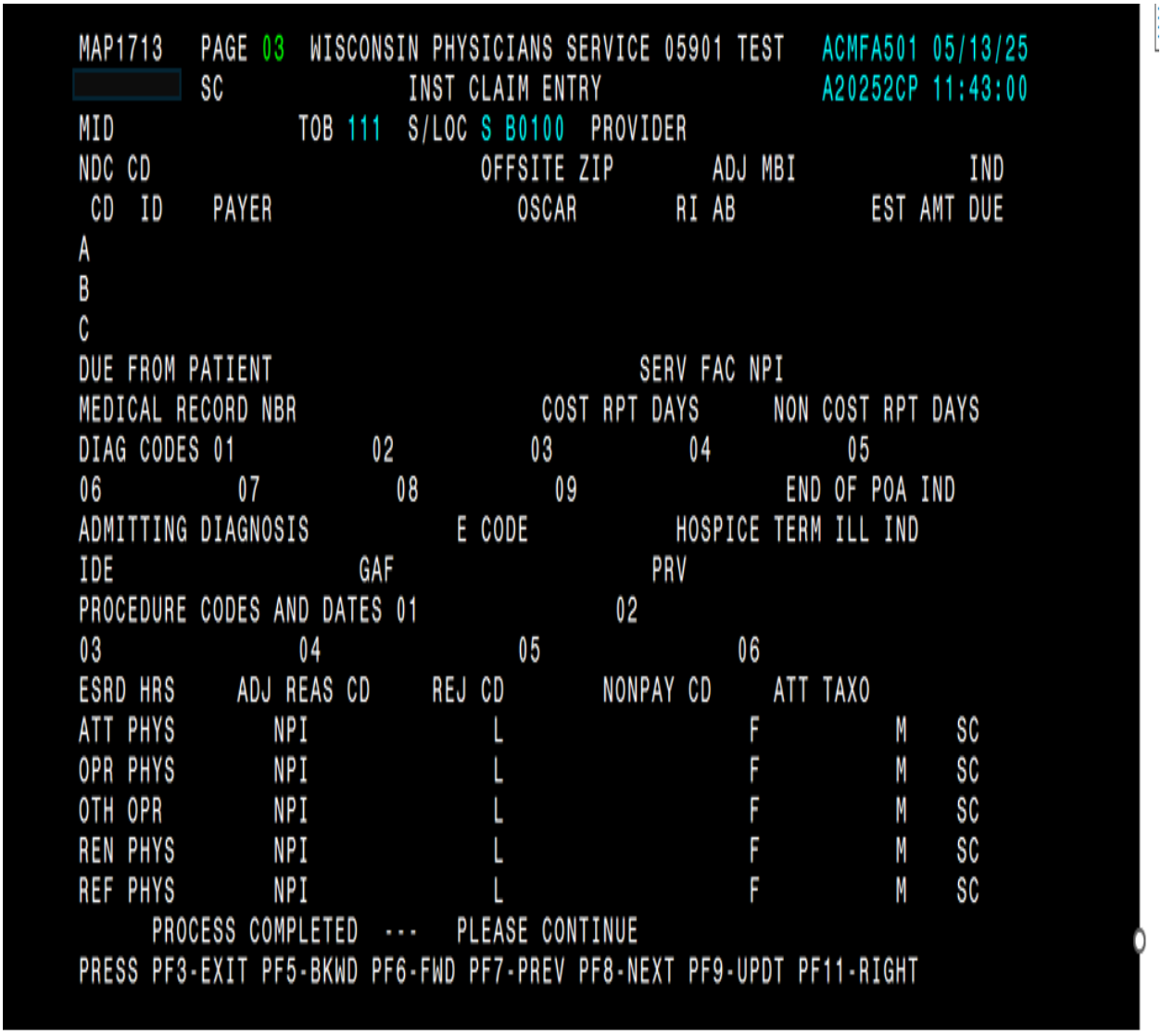
LINE ITEM REASON CODES	NA	**Line Item Reason Codes -** Five-digit field that identifies the reason code that is assigned out of the system for suspending the line item. There are a maximum of four (4) FISS reason codes that can be assigned to the line level.

Inpatient Claim Entry-Page 3 (MAP1713)

Use this screen to enter diagnosis codes, procedure codes, attending physician information, etc.

Note: We are not able to accept MSP claims (including conditional payment claims) that are submitted via Fiscal Intermediary Standard System/Direct Data Entry (FISS/DDE). All MSP claim submissions will need to be submitted either electronically hardcopy submission on a UB-04 (CMS-1450) claim form*, or through PC-ACE. MSP adjustments must be submitted via EMC, hardcopy or through PC-ACE.

Note: DDE MAP1719 has been created to house payment information for up to 2 payers primary to Medicare. This CR is **also** making system changes that will allow providers to key MSP claims via DDE.



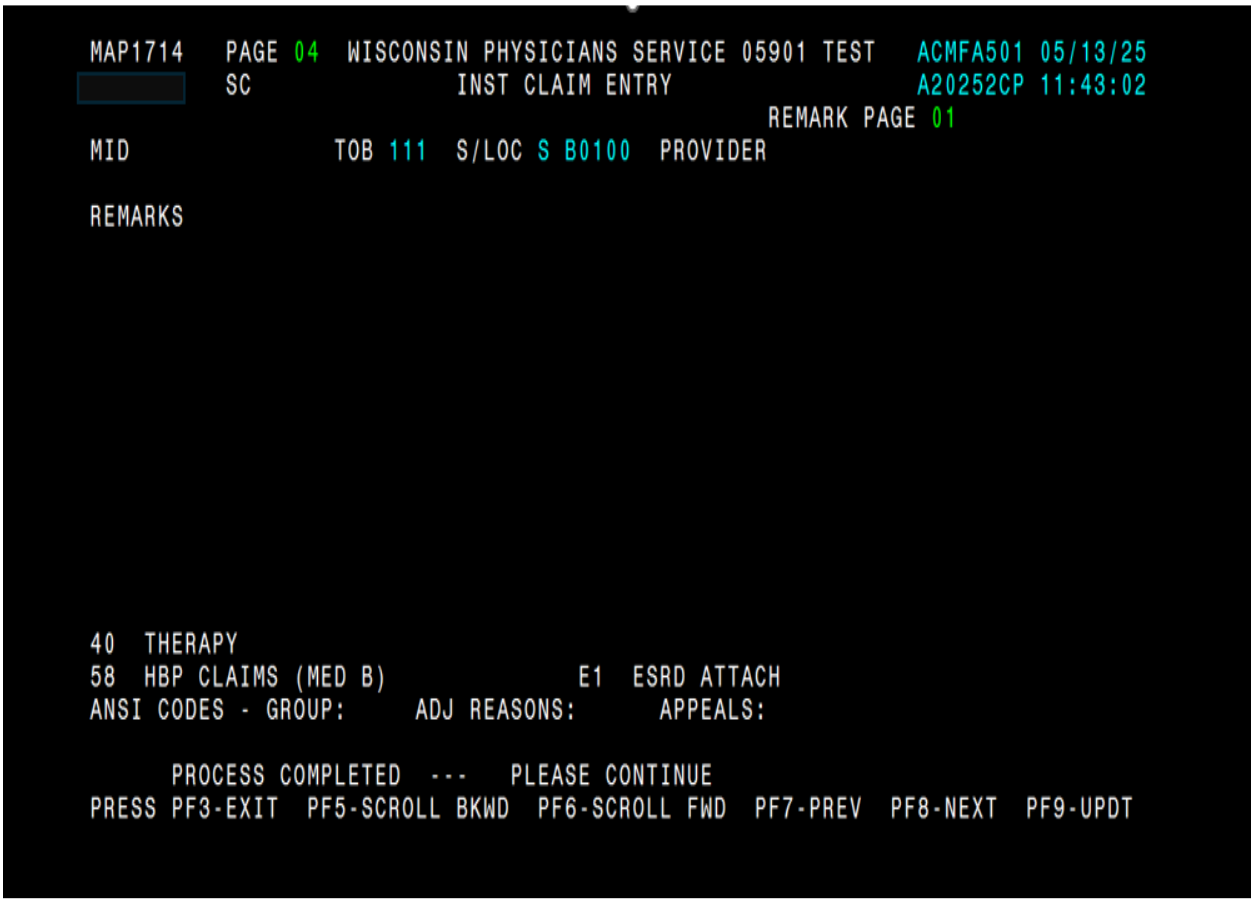
Field Name	UB-04 X-Ref	Description
CD	50 A, B, C	**Primary Payer Code** - Use the following list of codes when submitting electronic claims for payer identification. **Note:** The codes listed in the following table are for Medicare requirements only. Other payers require codes not reflected. **Valid values:** **1** – Medicaid **2** - Blue Cross **3** - Other **4** - None **A** - Working-aged - Employer Group Health Plan (EGHP) B - End Stage Renal Disease (ESRD) beneficiary in 1month coordinated period with an Employer Group Health Plan (EGHP) C - Conditional payment D - Automobile no-fault E - Workers' compensation F - Public Health Service (PHS) or other federal agency G - Disabled - Large Group Health Plan (LGHP) H - Black lung (federal black lung program) I - Veterans administration L - Liability Z - Medicare A
ID	NA	(Not required)
PAYER	50 A, B, C	**Payer Identification –** A. Primary Payer – If Medicare is the primary payer, enter "Medicare" on line A. Entering Medicare indicates that the hospital developed for other insurance and determined that Medicare is the primary payer. If there are payer(s) of higher priority than Medicare, enter the name of the higher priority payer on line B. Secondary Payer - If Medicare is the secondary payer, identify the primary payer on line A and enter "Medicare" on line B. C. Tertiary Payer - If Medicare is the tertiary payer, identify the primary payer on line A, the secondary payer on line B and enter "Medicare" on line C.
OSCAR	51 A, B, C	**PTAN** - Maximum of 13 digits. Enter the number assigned to the provider by the payer indicated in Form Locator 50 A, B, C.

RI	52 A, B, C	**Release of Information Certification Indicator** - Maximum of one digit. Enter the code indicating whether the provider has a signed statement on file permitting the provider to release data to other organizations in order to adjudicate the claim. Valid values: Y - Yes R - Restricted or modified release N - No release
AB	53 A, B, C	**Assignment of Benefits Certification Indicator** - One-digit code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Valid values: Y - Yes, Benefits assigned N - No, Benefits not assigned
EST AMT DUE	55 A, B, C	**Estimated Amount Due** - Twelve-digit numeric field in 9999999999.99 format. Not applicable.
DUE FROM PATIENT	NA	**Due From Patient -** Ten-digit numeric field for outpatient services only. Enter the amount the provider has received from the patient toward payment, if applicable in 99999999.99 format.
MEDICAL RECORD NBR	3b	**Medical Record Number** - 17-digit alphanumeric field used to enter patient's medical record number.
COST RPT DAYS	NA	**Cost Report Days** - Three-digit field that identifies the number of days claimable as Medicare patient days for inpatient and SNF types of bills (11X, 41X, 18X, 21X, 28X, and 51X) on the cost report. The system calculates this field and inserts the applicable data.
NON COST RPT DAYS	NA	**Non-Cost Report Days –** Three-digit field that identifies the number of days not claimable as Medicare patient days for inpatient and SNF types of bills (11X, 18X, 21X, 28X, 41X, and 51X) on the cost report.
DIAGNOSIS CODE	66	**Diagnosis Code -** Six-digit alphanumeric field used to enter the full ICD-9-CM codes for the principal diagnosis code (first code) and up to 24 additional conditions coexisting at the time of admission or which developed subsequently, and which had an effect upon the treatment given or the length of stay. Note: Decimal points are not required and should not be entered.
POA	NA	**POA Indicators** - Present On Admission (POA) Indicator for every diagnosis on your inpatient acute care hospital claims. Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement. (From 1 code to 24 codes). The POA data element on your electronic claims must contain the letters POA, followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after POA, and (when applicable) the POA indicators for secondary diagnoses would follow.

		Reporting Options and Definitions. Y - Yes (present at the time of inpatient admission) N - No (not present at the time of inpatient admission) U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission) W- Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not) 1 - Unreported/Not used – Exempt from POA reporting. (This code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1.)
END OF POA IND	NA	**End of Present On Admission Indicator -** The last POA indicator must be followed by the letter Z to indicate the end of the data element (or MACs and A/B MACs will allow the letter X, which CMS may use to identify special data processing situations in the future) Blank-Not acute care, POA's do not apply.
ADMITTING DIAGNOSIS	69	**Admitting Diagnosis** - Maximum of seven digits. For inpatients, enter the full ICD-10-CM code for the principal diagnosis relating to the condition established after study to be chiefly responsible for the admission. Note: Decimal points are not required and should not be entered.
E CODE	72	**External Cause of Injury Code -** Seven-digit alphanumeric field used for E-codes should be reported in the second diagnosis field Form Locator 68.
HOSPICE TERM ILL IND	NA	**Hospice Terminal Illness Indicator -** Not required.
IDE	NA	**Investigational Device Exemption (IDE) Number** - This field identifies the IDE authorization number assigned by the FDA. This is a 15-position alphanumeric field.
GAF	NA	Geographic Adjustment Factor
PRV	NA	**Patient Reason for Visit -** Diagnosis codes get placed in this field. This field is for 13x and 85x TOBs for unscheduled outpatient visits with type of admission codes 1, 2, or 5 and revenue codes 045x, 0516, or 0762.
PROCEDURE CODES AND DATES	74 A, B, C, D, E, F	**Procedure Codes and Date -** Six-digit date. Enter the full ICD-10-CM, Vol. 3, code, including all four-digit codes where applicable, for the principal procedure (first code). Enter the date (in MMDDYY format) that the procedure was performed during the billing period (within the from and through dates of services in Form Locator 6). (From 1 code to 24 codes)
NDC CODE	NA	National Drug Code (NDC) - Maximum of 24 digits. The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA.

ESRD HOURS	NA	**End Stage Renal Disease (ESRD) -** Maximum of two digits. Enter the number of hours a patient dialyzed on peritoneal dialysis.
ADJUSTMENT REASON CODE	NA	**Adjustment Reason Code -** Not required for new claim entry. Adjustment reason codes are applicable only on adjustments TOBs XX7 or XX8. For a list of Adjustment reason codes go to SC16.
REJECT CODE	NA	**Reject Code -** Not required by provider. For MAC use only.
NON PAY CODE	NA	**Non-Pay Code** - Not required by provider. For MAC use only.
ATTENDING PHYS	76	**Attending Physician ID -** Enter the National Provider Identifier Number (NPI) and name of the attending physician for inpatient bills or the physician that requested the outpatient services. Inpatient Part A - Enter the NPI and name of the clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. Enter the NPI in the first ten digits, followed by, the last name, the first name, and middle initial. Outpatient and Other Part B - Enter the NPI of the physician who requested the surgery, therapy, diagnostic tests, or the physician who has ordered Home Health, Hospice, or a Skilled Nursing Facility admission in the first ten digits followed by, the physician's last name, first name, and middle initial. **Attending Physician ID** - All Medicare claims require NPIs, including cases when there is a private primary insurer involved. Physicians not participating in the Medicare program may obtain NPIs. Additionally, for outpatient and other Part B, if there is more than one referring physician, enter the NPI of the physician requesting the service with the highest charge.
OPERATING/OTHER	77 A, B	**Operating/Other Physician ID –** Inpatient Part A Hospital - Enter the NPI and name of the physician who performed the principal procedure. If no principal procedure is performed, leave blank. Outpatient Hospital - Enter the NPI and name of the physician who performed the principal procedure. If there is no principal procedure, enter the NPI and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. Use the format for inpatient. **Other bill types -** Not required. Please note that if a surgical procedure is performed, and entry is necessary, even if the performing physician is the same as the admitting/attending physician.
SC	NA	**Specialty Code-** will only populate if the physician NPI, last name, and first name on the claim match the record on the Physician/Non-Physician File.

Inpatient Claim Entry-Page 4 (MAP1714)



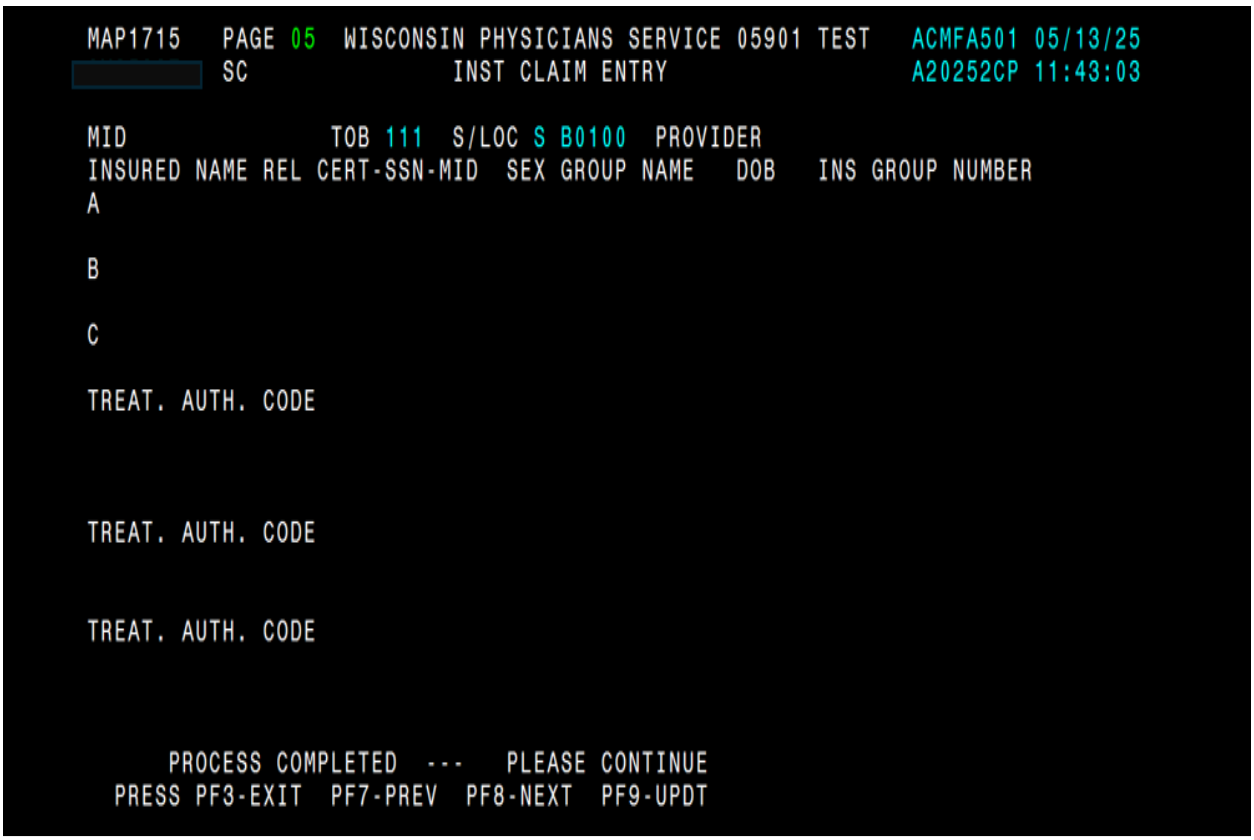
Use to enter remarks. WPS Government Health Administrators does not use the Attachment portion of this page.

There are up to three (3) additional remarks screens. Press **<F6>** to see additional pages and **<F5>** to page back to Remarks Page 01.

Field Name	UB-04 X-Ref	Description
REMARKS	80	**Remarks -** Maximum of 711 positions. Enter any remarks needed to provide information that is not reported elsewhere on the bill and may be necessary to ensure proper Medicare payment. This field carries the remarks information as submitted on automated claims, as well as provides internal staff with a mechanism to provide permanent comments regarding special considerations that played a part in adjudicating the claim, e.g., the Medical Review Department may use this area to document their rationale for the final medical determination or to provide additional information to the Waiver Employee to assist that individual with claim finalization. The remarks field is also used for providers to furnish justification of late filed claims that override the Intermediary's existing reason code for timeliness. The

		following information must be entered on the first line. Additional information may be entered on the second and subsequent lines of the remarks section for further justification. Select one of the following reasons and enter the information exactly as it appears below: Justify: MSP involvement Justify: SSA involvement Justify: PRO Review involved Justify: Other involvement.

Inpatient Claim Entry-Page 5 (MAP1715)



Use this screen to enter insured and employer information and treatment authorization number and code.

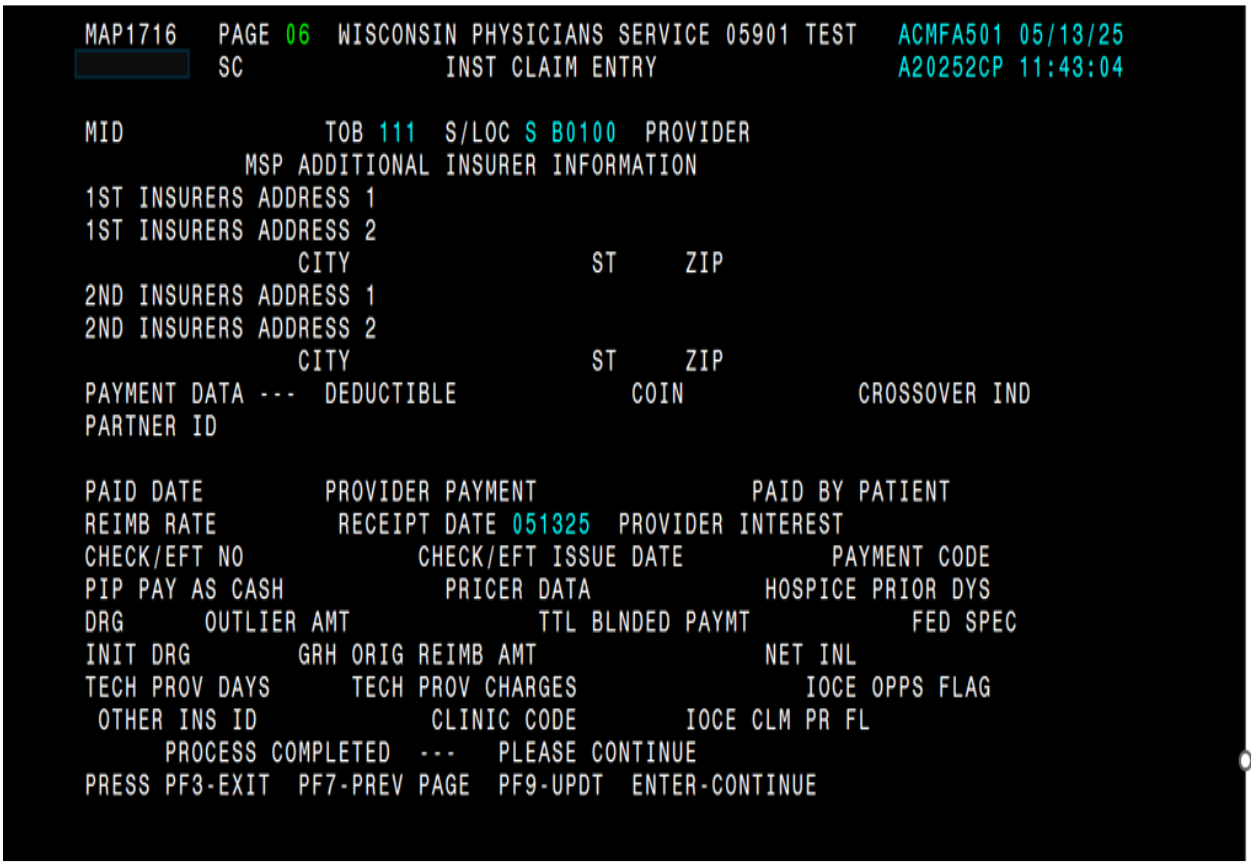
This screen has been unprotected for TOBs 81A, 81C, 81D, 82A, 82C, and 82D.

Field Name	UB-04 X-Ref	Description
INSURED NAME	58 A, B, C	**Insured's Name** - Maximum of 25 digits; Last Name, First Name. On the same line that corresponds to the line on which Medicare payer information is reported, enter the patient's name as reported on his/her Medicare health insurance card. If billing supplemental insurance, enter the name of the individual insured under Medicare on line A and enter the name of the individual insured under a supplemental policy on line B. Complete this section by entering the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and the provider is requesting payment because: A. Another payer paid some of the charges and Medicare is secondarily liable for the remainder; B. Another payer denied the claim; or C. The provider is requesting conditional payment.
REL	59 A, B, C	**Patient's Relationship To Insured** - Maximum of two digits On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is reported, enter the code indicating the relationship of the patient to the identified insured. The codes listed below are for Medicare requirements only. Other payers may require codes not reflected. **Valid values:** 00- Default 01- Patient is insured 02- Spouse 03- Natural child/insured has financial Responsibility 04- Natural child, insured does not have financial responsibility 05- Step child 06- Foster child 07- Ward of the court 08- Employee 09- Unknown 10- Handicapped dependent 11- Organ donor 12- Cadaver donor 13- Grandchild 14- Niece/nephew 15- Injured plaintiff 16- Sponsored dependent 17- Minor dependent of a minor dependent 18- Parent 19– Grandparent 20- Life Partner 21-99 - Reserved for National Assignment

CERT-SSN-MBI ID	60 A, B, C	**Certification-Social Security Number – Medicare Beneficiary Identifier (MBI)** - Maximum of 19 digits. The insurer-assigned Medicare Beneficiary Identifier used in all correspondence and to facilitate the payment of claims. Enter the patient's Medicare Beneficiary Identifier (MBI) if Medicare is the primary payer.
SEX	NA	**Sex Code -** This field identifies the sex of the beneficiary/patient. This is a one-position alphanumeric field. **Valid values:** **F** – Female **M** - Male **U** - Unknown
GROUP NAME	61 A, B, C	**Group Name** - Maximum of 18 digits. Enter the name of the group or plan of provided insurance. Entry required, if applicable.
DOB		**Date of Birth –** This field identifies the insured's date of birth. This is an eight-digit field in MMDDCCYY format.
INS GROUP NUMBER	62 A, B, C	**Insurance Group Number** - Maximum of 17 digits. Enter the identification number, control number or code assigned by that health insurance company to identify the group that covers the insured individual is covered. Entry required, if applicable. Enter the code that indicates whether the employment information given on the same line in items 72-75 applies to the insured, the patient, or the patient's spouse.
TREAT AUTH CODE	63 A, B, C	**HH PPS Treatment Authorization Code** - Maximum of 18 digits that identifies a matching key to the OASIS (Outcome Assessment information Set) of the patient. This field is 2 8-digit dates (MMDDCCYYMMDDCCYY) followed by a 2-digit code (01-10). The first date comes from M0030 that is the Start of Care Date; the second date is from M0090 that is the Date Assessment Completed. The codes are from M0100 that is for the assessment currently being completed for the following reasons: **01**- Start of care – further visits planned **02**- State of care – no further visits planned **03**- Resumption of care (after inpatient stay) **04**- Rectification (follow-up) reassessment **05**- Other follow-up **06**- Transferred to an inpatient facility – patient not discharged from agency **07**- Transferred to an inpatient facility – patient discharged from agency **08**- Death at home **09**- Discharge from agency **10** - Discharge from agency – no visits completed after start/resumption of care assessment Entry required, if applicable.

Inpatient Claim Entry- Page 6 (MAP1716)

Use this screen to enter MSP information for viewing Payment/Pricer data.



Field Name	UB-04 X-Ref	Description
INSURER'S ADDRESS 1st AND 2nd	NA	**Insurance Company's Address** - Maximum of 32 digits. Enter the address of the insurance company that corresponds to the line on which Medicare payer information is reported Form Locator **58 A,B,C**.
CITY 1 AND 2	NA	**Insurance Company's City** - Maximum of 15 digits. Enter the specific city of the insurance company.
ST 1 AND 2	NA	**Insurance Company's State** - Maximum of two digits. Enter the specific state of the insurance company.
ZIP 1 AND 2	NA	**Insurance Company's ZIP Code** - Maximum of nine digits. Enter the specific ZIP code of the insurance company.

Field Name	PAYMENT DATA
DEDUCTIBLE	**Deductible** - Amount applied to the beneficiary's deductible payment. When the claim has processed to finalization, this field is systematically generated.
COIN	**Coinsurance** - Amount applied to the beneficiary's coinsurance payment. When the claim has processed to finalization, this field is systematically generated.

CROSSOVER IND	**Crossover Indicator** - This field identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. **Valid values:** **1-Primary** **2-Secondary** **3-Tertiary**
PARTNER ID	**Trading Partner ID** - Identifies the Trading Partner number.
PAID DATE	**Paid Date -** Identifies the scheduled payment date of the claim or the date the provider is actually reimbursed.
PROVIDER PAYMENT	**Provider Payment -** Actual amount that provider was reimbursed for services.
PAID BY PATIENT	**Paid By Patient -** Actual amount reimbursed to the beneficiary. Not utilized in DDE.
REIMB RATE	**Reimbursement Rate -** Identifies the per diem amount to be paid for an individual claim for those providers reimbursed on per diem reimbursement or percentage of reimbursement if the provider's type of reimbursement is based on a percentage of charges.
RECEIPT DATE	**Receipt Date -** Date claim was first received in the FISS system.
PROVIDER INTEREST	**Provider Interest** - Interest paid to the provider for late payment on clean claims.
CHECK/EFF NO	**Check/Electronic Funds Transfer Number** - Displays the identification number of the check or electronic funds transfers.
CHECK/EFT ISSUE DATE	**Check/Electronic Funds Transfer Issue Date** - Displays the date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE	**Payment Code –** Displays the payment method of the check or electronic funds transfer. Valid values: ACH - Automated Clearing House or Electronic Funds Transfer CHK - Check NON - Non-payment data
DRG	**Diagnostic Related Grouping Code -** Code assigned by the Pricer's calculation.
OUTLIER AMOUNT	**Capital Outlier Payment -** Amount qualified for outlier reimbursement.

TTL BLNDED PAYMENT	**Dollar amount -** Not used in DDE.
FED SPEC	**Dollar amount -** Not used in DDE.
GRH ORIG REIMB AMT	**Gramm Rudman Original Reimbursement Amount -** Identifies the amount reduced from the provider's reimbursement as mandated by Gramm/Rudman/Hollings legislation Note: For IRF PPS claims, the IRF PPS Pricer populates this field if a late assessment penalty has been applied to the claim. If populated, the field contains the dollar amount of the penalty applied.
NET INL	**Dollar amount -** Not used in DDE.
TECHNICAL PROV DAYS	**Technical Provider Liable Days** - The number of days the provider is liable.
TECHNICAL PROV CHARGES	**Technical Provider Charges -** The dollar amount the provider is liable.
OTHER INS ID	**Other insurance indicator** - Not used in DDE
CLINIC CODE	**HMO Clinic Identification Number** - Not used in DDE.

Outpatient Claim Entry

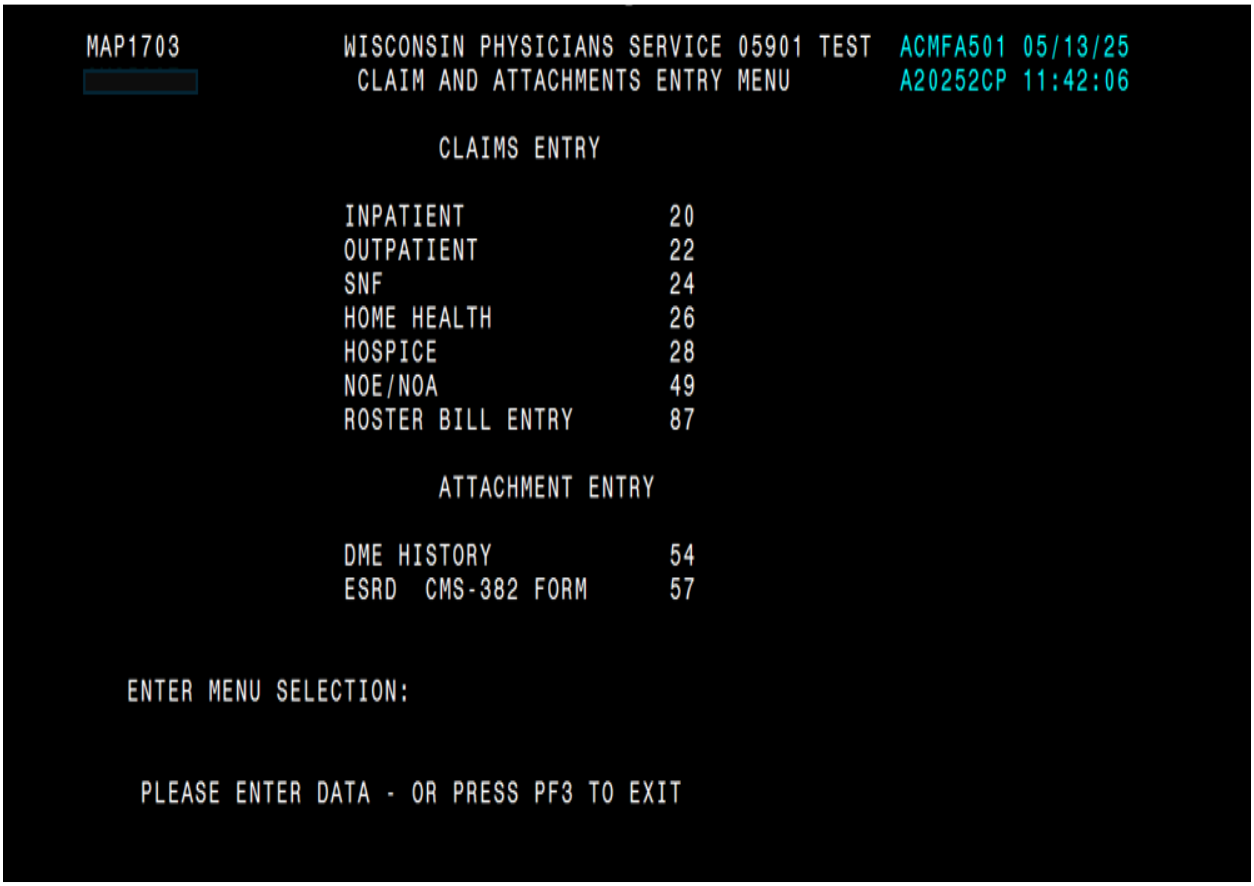
Purpose

This screen allows entry of new Outpatient claim from UB-04 compliant format.

Access

From the Claims Entry, to access the Outpatient Claims Entry: the Enter Menu Selection field Type 22 Press <ENTER>

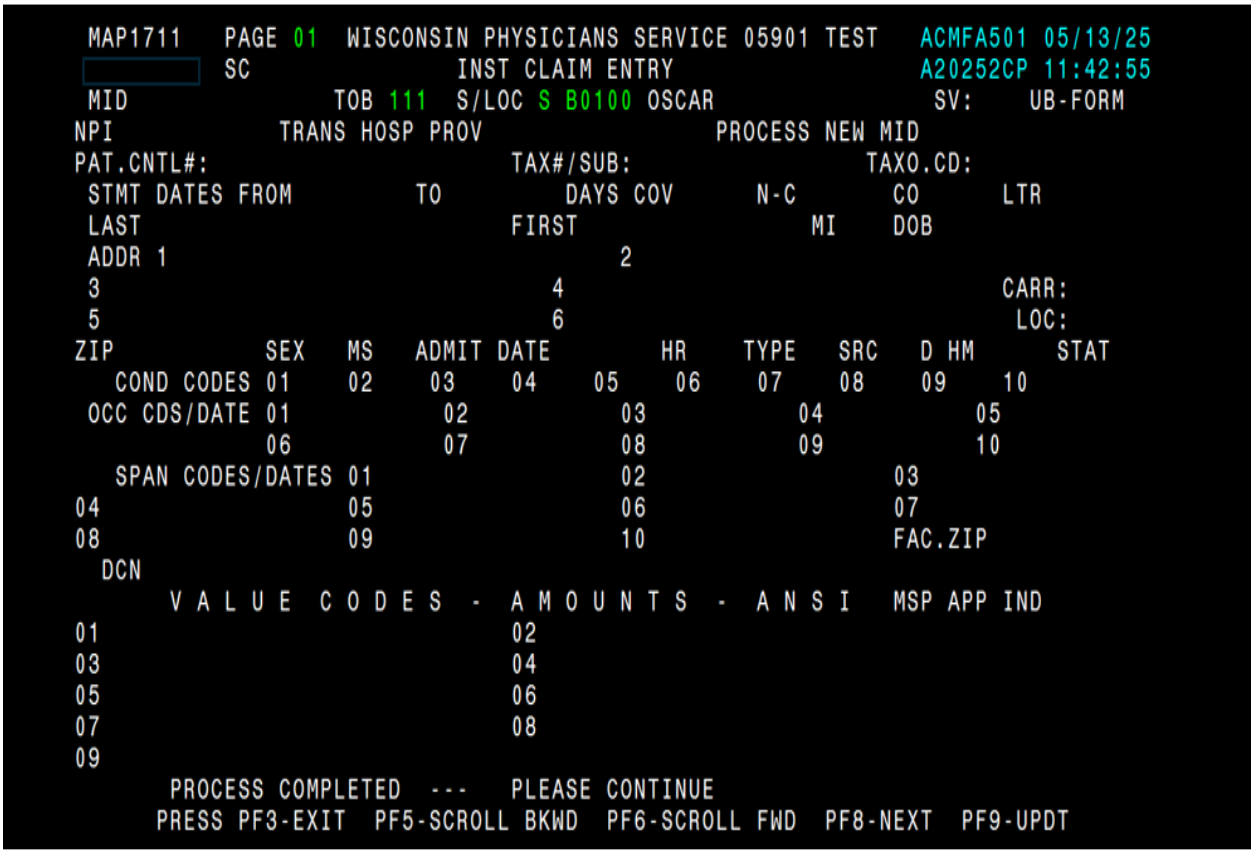
Claims and Attachments Entry Menu-(MAP1703)



Outpatient Claims Entry

This screen allows entry of new Outpatient claim from UB-04.

For Outpatient-22, SNF-24, Home Health-26, Hospice-28, and Notice of Election (NOE)/NOA-49 the claims entry screens are the same. The differences are where the cursor stops and the required fields. By not changing to a different type of claim on the claims and attachment entry menu, you will get edits/reason codes for missing information.



Hint: For DDE providers, when keying in an outpatient claim, it will automatically default to a **13x** TOB, which does not require the admission type. The provider will need to key the correct bill type (**22x** or **12x**), press <**Enter**>, then continue to key their claims. This will open the field, allowing the provider to enter it. The provider should be able to correct any that were already RTP'd to the provider since they stored it originally with the **22x** bill type.

Home Health Entry or Request for Anticipated Payment (RAP)

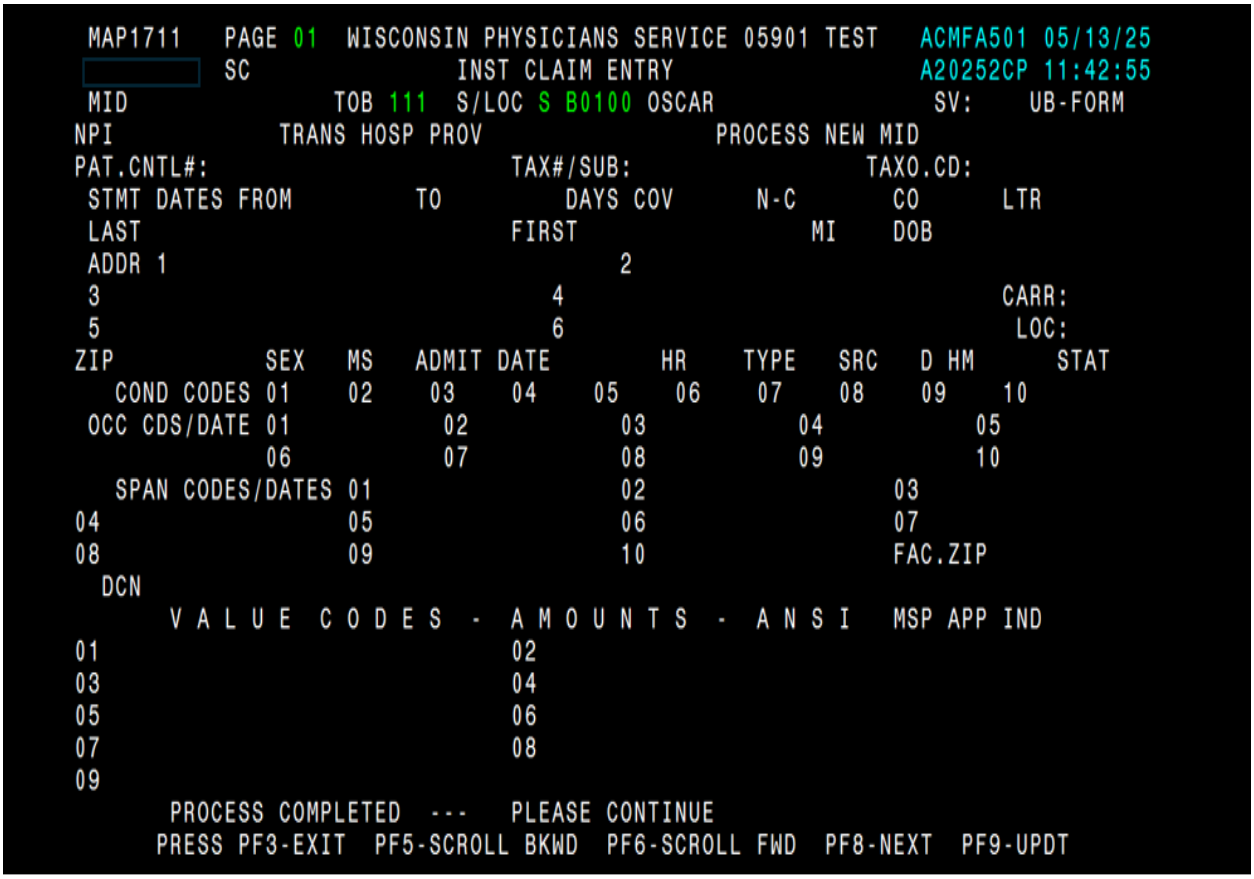
Purpose

This allows entry of a Home Health Claim or Request for Anticipated Payment (RAP).

Access

From the Attachment Entry, to access the Home Health Entry:
In the Enter Menu Selection field:
Type **41**
Press <**ENTER**>

Home Health Claim Entry or (RAP) – Page 1 (MAP1711)



This allows for entry of new Home Health Claim from UB-04.

- Required information for entry is MBI, TOB, NPI, STMT DATES FROM AND TO, LAST NAME, FIRST NAME, DOB, ADDRESS, ZIP, SEX, ADMIT DATE, HR SRC, STAT, FAC. ZIP AND VALUE CODES.
- Optional information for entry is PAT. CNTL #, MI, and MS.
- Conditionally Required fields, depending on the type of claim would be COND CODES, OCC CDS/DATE, and SPAN CODES/DATES.

- The system generates field S/LOC.

Field Name	Description
MBI Required	Key the beneficiary's Medicare Beneficiary Identifier (MBI)
TOB Required	**Type of Bill -** Three-digit numeric field that identifies the type of facility, type of care, source, and frequency of this claim in a particular period of care. Defaults to TOB 322; you may need to change this depending on the TOB you are entering. Valid values: 320 - Nonpayment claim 322 - Request for Anticipated Payment (RAP) 323 - Subsequential (RAP) 324 - Final claim for RAP 329 - Final claim for HH episode 34X - HHA visits provided on an outpatient basis (X denotes the frequency of bill. Refer to Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 25, Section 75.1 to determine the correct frequency).
NPI Required	**National Provider Identifier –** Ten-digit unique provider identifier
PATIENT Control Number Optional	**Patient Control Number** - Maximum of 20 digits. Patient's unique number assigned by the provider to facilitate retrieval of individual patient records and posting of the payment.
STMT DATES Required	**Statement Covers Period -** Key the beginning and ending dates for this billing period. A. RAPs: use the same date for both the from and to dates. On the first RAP in an admission, the from and to date must be the date of the first Medicare billable service. On RAPs for subsequent episodes, the from and to date must be the first calendar day of the subsequent episode (day 61, 121, etc.). B. For all HH PPS claims (including No-RAP-LUPAs): enter the 60th day of the episode or the date of discharge, death, or transfer if prior to the 60th day in the to field. When billing subsequent episodes, there should not be a break in service dates between the STMT DATES FROM date of the prior final claim and the STMT DATES FROM and TO dates of the subsequent RAP. You may submit claims or No-RAP-LUPA claims for payment immediately after the last billable service date has been provided and signed orders have been obtained.
LAST Required	**Last Name -** Key the beneficiary's last name exactly as it appears on the Medicare card or HIQA page 1.
FIRST Required	**First Name -** Key the beneficiary's first name exactly as it appears on the Medicare card or HIQA page 1.
MI Optional	**Middle Initial -** Key the beneficiary's middle initial.
DOB Required	**Date of Birth -** Key the beneficiary's date of birth (MMDDCCYY).

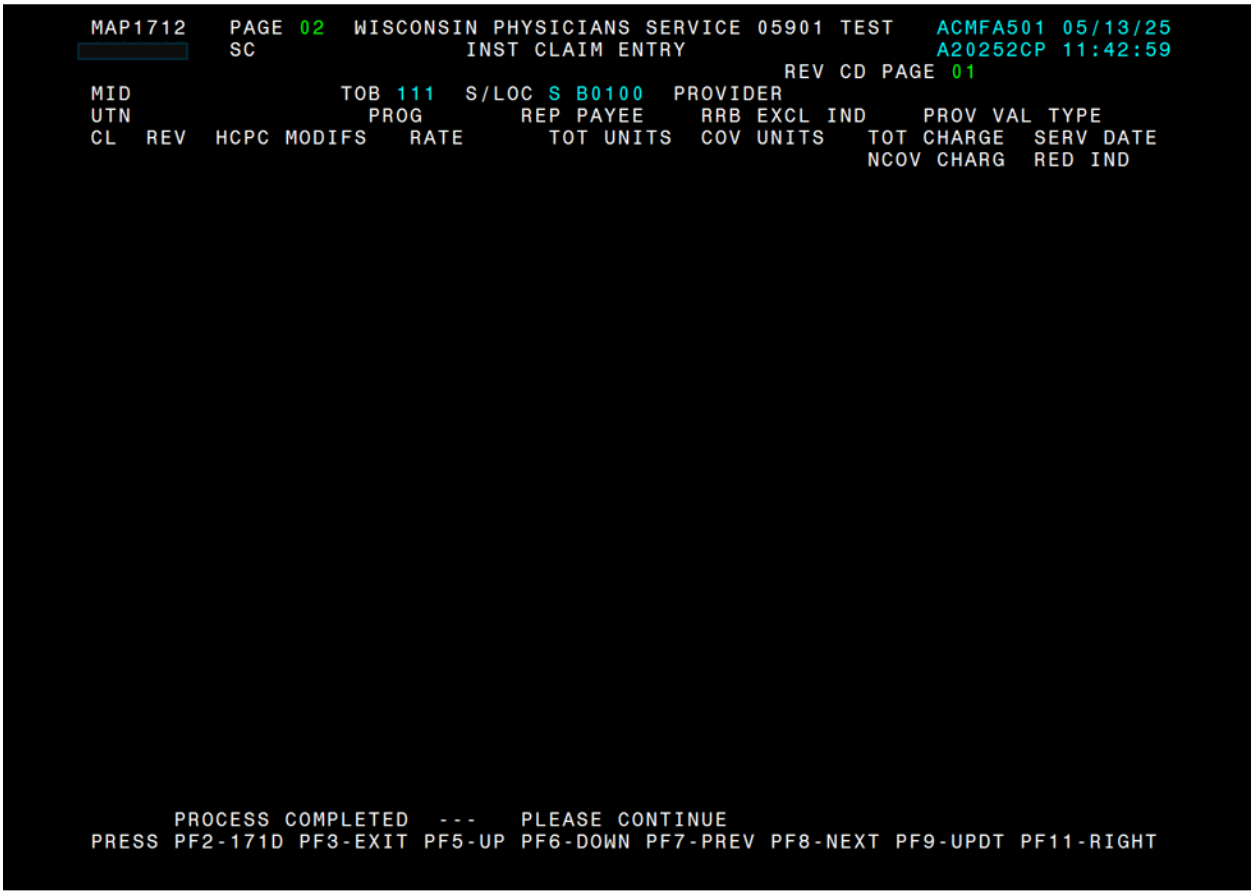
ADDR 1, 2, 3, 4, 5, 6 Required	**Street Address** - Patient's street address including house number, post office box number and/or apartment number, patient's city and state address abbreviation, as recognized by the US Postal Service.
ZIP Required	**ZIP Code -** Valid ZIP code (minimum of five digits).
SEX Required	**Sex (Patient) -** Maximum of one digit. Valid values: F – Female M - Male U - Unknown
MS Optional	**Patient Marital Status -** Maximum of one digit. Valid values: S - Single M - Married X - Legally separated D - Divorced W - Widowed U - Unknown
ADMIT DATE Required	**Admission Date -** Key the start of care date on which the Medicare covered home health services began. This date should reflect the first Medicare billable service of the initial episode and correspond with the start of care date on the Plan of Care.
HR Required	**Admission Hour and Minutes -** Key the two-digit hour of admission using the 24-hour clock. For example, if the patient was admitted at 8:00 am, key 08. If their hour of admission was 2:00 pm, enter 14. If the exact hour is not known, enter 01.
SRC Required	**Source of Admission -** Key the code indicating the beneficiary's point of origin (formerly the source of admission).
STAT Required	**Patient Status -** Key the beneficiary's status code. Key the beneficiary's status code. C. RAPs: key 30 as the patient status code. D. Final and No-RAP-LUPA claims: key the appropriate patient status code listed to reflect the patient's status as of the TO date of the episode.
COND CODES Conditionally Required	**Condition Codes -** Condition codes. Note: Claim Page 01 displays space for ten condition codes. However, FISS allows you to enter up to 30 condition codes by pressing <F6> to scroll forward.
OCC CDS / DATES Conditionally Required	**Occurrence Codes and Dates** - Occurrence codes and dates.
SPAN CODES / DATES Conditionally Required	**Occurrence Span and Date** - Occurrence span codes and dates.
FAC ZIP Required	**Facility Zip -** Five- or nine-digit field. The billing provider or the Subpart ZIP Code.

VALUE CDS and AMOUNTS Required	**Value Codes and Amounts -** The *Core Based Statistical Area (CBSA)* code should be used on all 32X and 33X types of bill. Record value code 61 and the *CBSA* code that corresponds with the location where the service is provided. Multiple occurrences of value code 61 are not allowed. In situations where the beneficiary's site of service changes from one *CBSA* to another within the episode period, submit the *CBSA* code corresponding to the site of service at the end of the episode. CBSA codes are published annually in the Federal Register. Access the Home Health. Prospective Payment System (HH PPS) Rates web page for these calendar year codes.

Home Health Claim Entry or (RAP) – Page 2 (MAP1712)

This screen is used for posting Revenue Codes and charges. Type in the dollar amounts, with or without the decimal, for example, 47.50 or 4750.

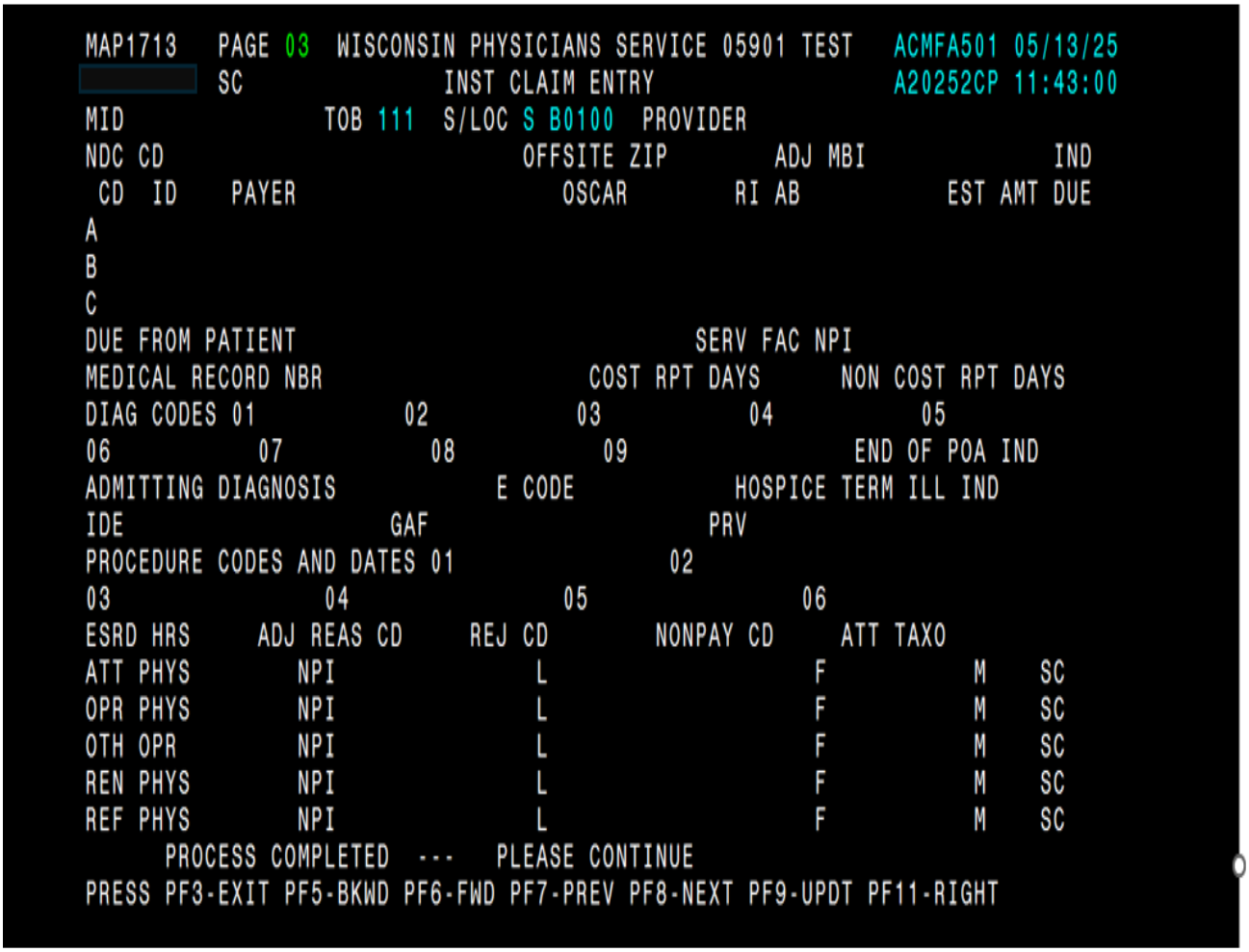
Note: To view all Claim Entry functions, see Chapter 3, Inpatient Claim Entry.



Field Name	Description
REV Required	**REV -** This is a four-position field. You may key a **0** before the revenue code (e.g., 0420) or key the three-digit code (e.g., 420) and then use your <**Tab**> key to go to the next field. This page will hold up to 14 revenue code lines. To enter additional revenue code lines, press <**F6**> to scroll down. There are 33 revenue code pages and 450 total revenue code lines available. **Note:** All **32X** and **33X** bill types must include revenue code 0023 with the appropriate Health Insurance Prospective Payment System (HIPPS) code. **RAPs** - Enter the 0023 line with the HIPPS code in the HCPC field. Revenue code 0001 is entered on the second revenue code line. No other revenue code lines are required on a RAP. If additional revenue codes are submitted, FISS will ignore them. **Claims** - Revenue code 0023 with a Health Insurance Prospective Payment System (HIPPS) code matching the RAP must be present on all **3X9** types of bill. Services billed on **3X9** and **34X** types of bill must be line item billed. Do not combine two visits that are performed on the same day as a single line item. Revenue code 0001 is entered on the last revenue code line of the claim.
HCPC Required	**Health Care Procedure Coding System (HCPCS)** - Key the appropriate HCPCS code that corresponds with the service(s) being billed and the HIPPS code on the 0023-revenue code line. Appropriate HCPCS codes can be found in the CPT coding book. See the Home Health Revenue Code Listing below to determine the appropriate HCPCS used when billing therapies, skilled nursing, medical social services, and home health aide visits on home health claims. **Note:** Effective 10/2009, FISS will edit changes to the fifth position of the HIPPS code to ensure the letter or number submitted does not change the non-routine supply (NRS) severity level between the RAP/claim for the same episode of care.
MODIFS Conditionally Required	**Modifier** - Modifiers. Use the appropriate modifier on home health outpatient therapy claims (type of bill **34X**). **GN** - Services personally provided by a speech therapist **GO** - Services personally provided by an occupational therapist **GP** - Services personally provided by a physical therapist **KX** - Outpatient therapy service when the beneficiary is qualified for exception to the therapy caps.
TOTAL UNT Required	**Total Units of Service** - Key the corresponding units for the services billed. Units can reflect the number of 15-minute increments, oxygen feet or pounds, units of service, DME items supplied per month, units of medication, visits, and drugs and biologicals. Revenue code 0023 does not require units to be reported. On a **34X** type of bill, report the units as the number of times the procedure was performed.
COV UNIT Required	**Units of Service** - Key the number of units covered for the services billed. Ensure the appropriate increment is reflected for the type of service or supply billed. 0023 no units required.
TOT CHARGES Required	**Total Charges** - Twelve-digit numeric field in 9999999999.99 format. Report on the total charge pertaining to the related revenue code for the current billing period as entered in the statement covers period. 0023 no charges required.

NCOV CHARGES Conditionally Required	**Non-Covered Charges** – Twelve-digit numeric field in 9999999999.99 format. Report on the non-covered charges for the primary payer pertaining to the related revenue code. Submission of bills by providers for all stays, including those for which no payment can be made, is required to enable the Intermediary and CMS to maintain utilization records and determine eligibility on subsequent claims. When non-covered charges are present on the bill, remarks are required in UB-04 X-REF 84.
SERV DT Required	**Service Date** - Key the date the service was provided. Line item dates of service are required on all claims paid under the Home Health Prospective Payment System (HH PPS) and home health outpatient therapy claims (**34X** type of bill). The service dates on the 0023 revenue code line for both the RAP and claim reflects the date of the first billable visit in the episode. The service date reported must fall within the **from**/**to** date reported on the claim. Service dates billed for visits should reflect the date the visit occurred.

Home Health Entry or (RAP) – Page 3 (MAP1713)
This screen is used for posting payer information, diagnosis/procedure code information and physician information.
Note: To view all Claim Entry functions, see Chapter 3, Inpatient Claim Entry.



Field Name	Description
CD Required	**Primary Payer Code** – Primary payer code. **Valid values:** **Z** - Medicare **C** - Conditionally Required Payment We are not able to accept MSP claims (including conditional payment claims) that are submitted via Fiscal Intermediary Standard System Direct Data Entry (FISS/DDE). All MSP claim submissions will need to be submitted either electronically hardcopy submission on a UB-04 (CMS- 1450) claim form*, or through PC-ACE. MSP adjustments must be submitted via EMC, hardcopy or through PC-ACE. **Note**: Per CR 8486 dated 11/24/15 new screen DDE MAP1719 has been created to house payment information for up to 2 payers primary to Medicare. This CR is also making system changes that will allow providers to key MSP claims via DDE. The following payer codes are only used on lines B (secondary payer) and C (tertiary payer) to identify supplemental insurance payers: 1- Medicaid 2- Blue Cross 3- Other **Note:** providers should submit RAPs showing Medicare as primary payer, regardless of any MSP involvement.
PAYER Required	**Payer Identification -** Payer name. FISS will automatically insert the payer's name "Medicare" in this field when the payer code (CD field) for this line is a **Z**. If a supplemental insurer is listed, or when billing Medicare conditionally, you must enter the name of the other insurer on the corresponding A, B or C line.
OSCAR Conditionally Required	**PTAN** - Maximum of 13 digits. Enter the number assigned to the provider by the payer indicated in Form Locator 50 A,B,C.
RI Required	**Release of Information Certification Indicator** - Maximum of one digit. Enter the code indicating whether the provider has a signed statement on file permitting the provider to release data to other organizations in order to adjudicate the claim. **Valid values:** **Y** - Yes **R** - Restricted or modified release **N** - No release
MEDICAL RECORD NBR Optional	**Medical Record Number** – 17-digit alphanumeric field used to enter patient's medical record number.

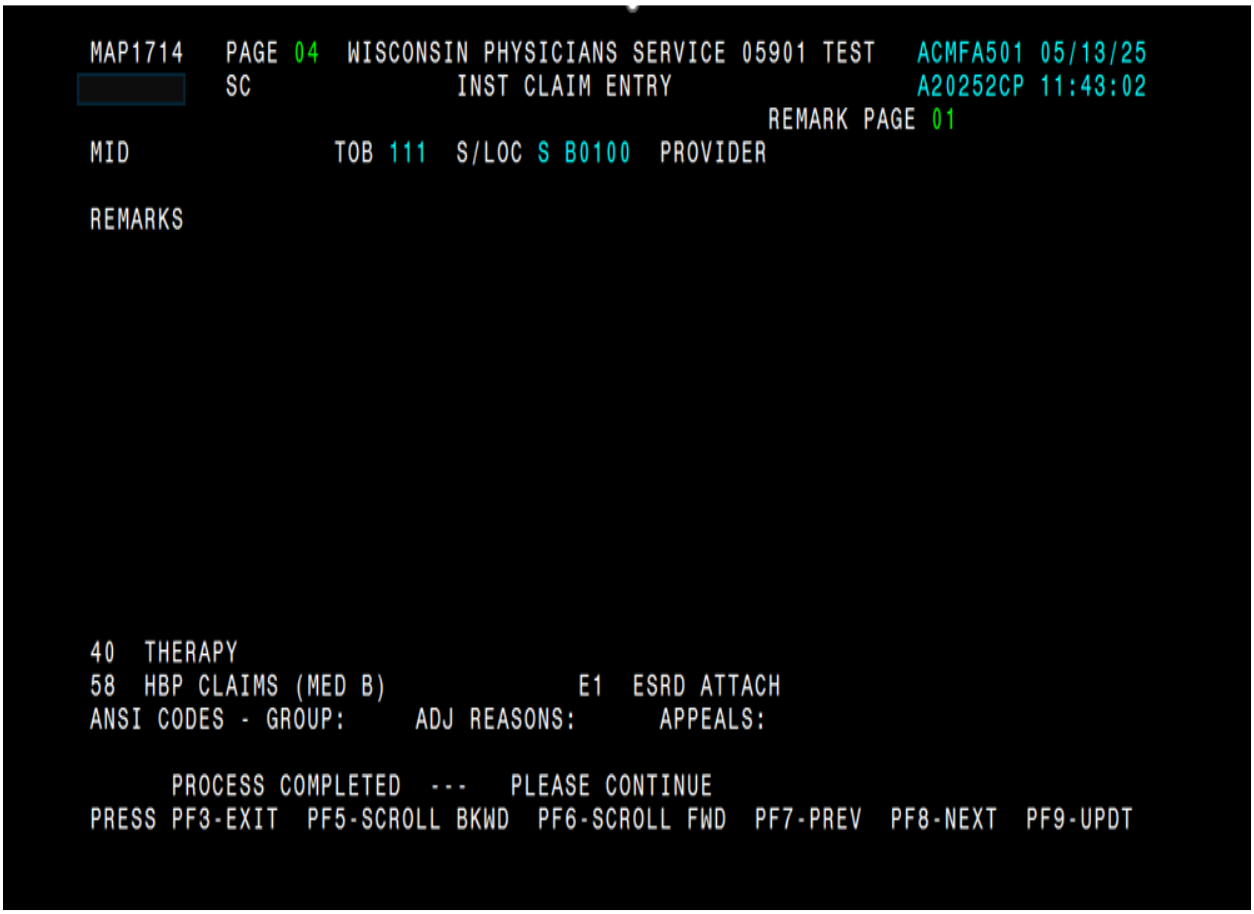
DIAGNOSIS CODE Required	**Diagnosis Code** - Six-digit alphanumeric field used to enter the full ICD-10-CM codes for the principal diagnosis code (first code) and up to eight additional conditions coexisting at the time of admission or which developed subsequently, and which had an effect upon the treatment given or the length of stay. A. Decimal points are not required. B. POA Indicators
ATTENDING PHYS Required	**Attending Physician ID -** Enter the National Provider Identifier Number (NPI) and name of the attending physician for inpatient bills or the physician that requested the outpatient services. **Inpatient Part A** - Enter the NPI and name of the clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. Enter the NPI in the first ten digits, followed by, the last name, the first name, and middle initial. **Outpatient and Other Part B** - Enter the NPI of the physician who requested the surgery, therapy, diagnostic tests, or the physician who has ordered Home Health, Hospice, or a Skilled Nursing Facility admission in the first ten digits followed by, the physician's last name, first name, and middle initial. **Attending Physician ID** - All Medicare claims require NPIs, e.g., including cases when there is a private primary insurer involved. Physicians not participating in the Medicare program may obtain NPIs. Additionally, for outpatient and other Part B, if there is more than one referring physician, enter the NPI of the physician requesting the service with the highest charge.
OPERATING/OTHER Optional	**Operating/Other Physician ID –** **Inpatient Part A Hospital** - Enter the NPI and name of the physician who performed the principal procedure. If no principal procedure is performed, leave blank. **Outpatient Hospital** - Enter the NPI and name of the physician who performed the principal procedure. If there is no principal procedure, enter the NPI and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. Use the format for inpatient. **Other bill types** - Not required. Please note that if a surgical procedure is performed, and entry is necessary, even if the performing physician is the same as the admitting/attending physician.
REN PHYS	**Rendering Physician-**The claim level rendering provider NPI is required when the rendering provider is different from the attending provider.
REF PHYS	**Referring Physician-**The Referring Physician information can be entered per line of charges.
SC	The Specialty Code (SC) field is a protected field and can only be updated by the system. For more information please refer to Change Request (CR) 7755 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2448CP.pdf).

Home Health Claim Entry or (RAP) – Page 4 (MAP1714)

Use to enter remarks. WPS Government Health Administrators does not use the Attachment portion of this page.

There are up to three (3) additional remarks screens. Press **<F6>** to see additional pages and **<F5>** to page back to Remarks Page 01.

Note: To view all Claim Entry functions, see Chapter 3, Inpatient Claim Entry

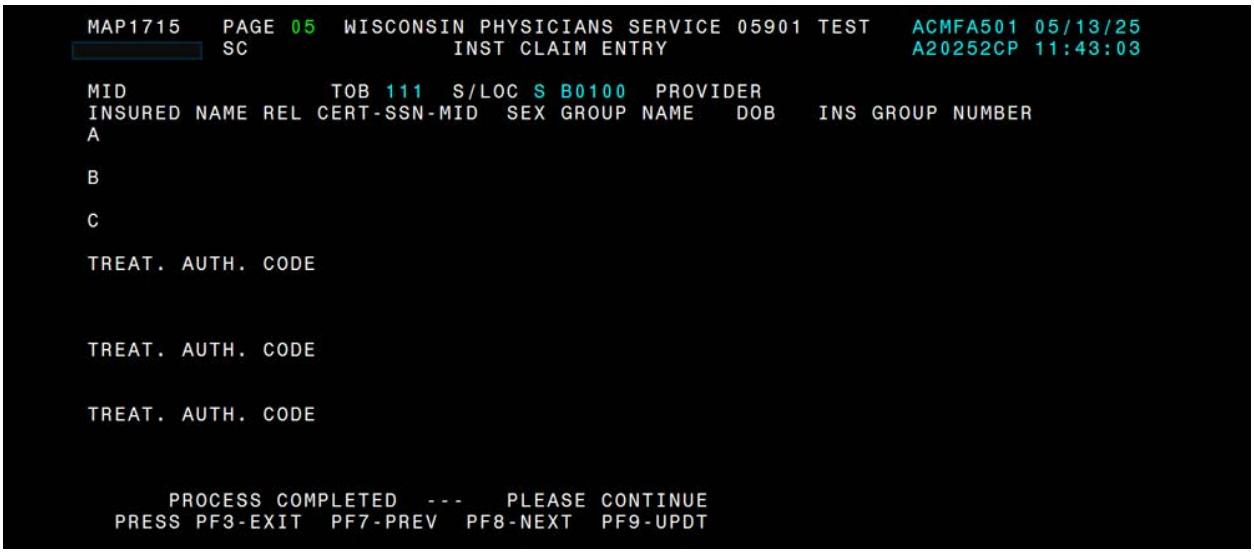


Field Name	Description
REMARKS Conditionally Required	**Remarks** - Key any additional pertinent information to assist the processing of the claim. Include the date of the remark and your initials. Three pages are available to make remarks. Each page holds 10 lines of remarks. Press <**F6**> to scroll forward to the next remark page. Please note: We may also use this field to relay information back to the provider when the claim is in process or processed. Providers are encouraged to add remarks to MSP claims, claim adjustments, and cancellations. Please be aware that remarks may be required on the claim, adjustment, or cancellation.

Home Health Claim Entry or (RAP) – Page 5 (MAP1715)

Use this screen to enter insured and employer information and treatment authorization number and code. The MBI, TOB, S/LOC, and PROVIDER fields are systems generated from the information on Claim Page 1.

Note: To view all Claim Entry functions, see Chapter 3, Inpatient Claim Entry.



Field Name	Description
INSURED NAME Conditionally Required	**Insured's Name** - Name of policyholder, last name and first name. **Medicare is primary:** insured's information is not to be entered on Line A. However, if the beneficiary has supplemental insurance, key the insured's supplemental insurance information on Line B. **Medicare is not primary:** Medicare secondary payer (MSP) claims and adjustments can only be submitted via Direct Data Entry (DDE) using FISS in limited situations. Refer to the Submission of Medicare Secondary Payer (MSP) Claims on the Claims Submission page of the WPS Government Health Administrators website for more information regarding claims containing Medicare Secondary Payer (MSP) information.

REL Conditionally Required	**Patient's Relationship To Insured** - Maximum of two digits On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is reported, enter the code indicating the relationship of the patient to the identified insured. The codes listed below are for Medicare requirements only. Other payers may require codes not reflected. *For list of codes see Chapter 3, Inpatient Claim Entry.
CERT-SSN-MBI Required	**Certification-**Social Security Number (SSN) - Health Insurance **Claim** - Maximum of 19 digits. The insurer-assigned Medicare Beneficiary Identifier used in all correspondence and to facilitate the payment of claims. Enter the patient's Medicare Beneficiary Identifier (MBI) if Medicare is the primary payer.
SEX Required	**Sex Code -** This field identifies the sex of the beneficiary/patient. This is a one-position alphanumeric field. **Valid values:** **F** – Female **M** - Male **U** - Unknown
GROUP NAME Conditionally Required	**Group Name** - Maximum of 14 digits. Enter the name of the group or plan of provided insurance. Entry required, if applicable.
DOB Required	**Date of Birth –** This field identifies the insured's date of birth. This is an eight-digit field in MMDDCCYY format.
INS GROUP NUMBER Conditionally Required	**Insurance Group Number** - Maximum of 17 digits. Enter the identification number, control number or code assigned by that health insurance company to identify the group that covers the insured individual is covered. Entry required, if applicable. Enter the code that indicates whether the employment information given on the same line in items 72-75 applies to the insured, the patient, or the patient's spouse.
TREAT AUTH CODE Required	**HH PPS Treatment Authorization Code** - Key the billing transaction's 18-position Claim-OASIS Matching Key output from the Grouper software on all RAPs and HH PPS claims. This code contains the start of care date, the date the assessment was completed, the reason for the assessment, whether the episode was "early" or "late" and the clinical and functional domain points under the four-equation model of the refined HH PPS case mix system. The format of the code is made up of numeric and alpha character calculated by the Grouper software: 99XX99XX99XXXXXXXX (e.g., 09JK10AA41GBMDCDLG). If Medicare is the primary payer, the Claim-OASIS matching key must be entered in the first TREAT. AUTH. CODE field immediately under Line C. If Medicare is the secondary payer, enter the Claim-OASIS matching key in the second TREAT. AUTH. CODE field. If Medicare is the tertiary payer, the Claim-OASIS matching key must be typed in the third TREAT. AUTH. CODE field.

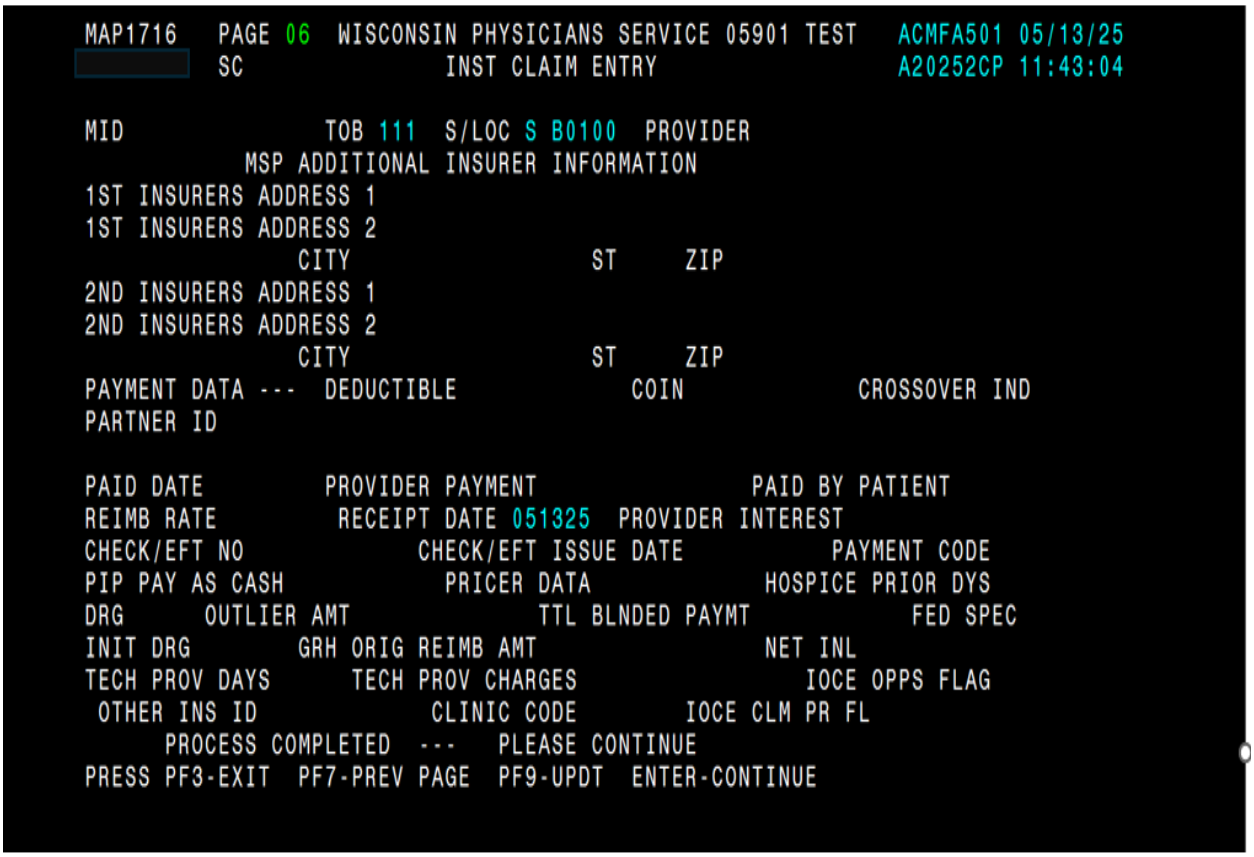
Home Health Claim Entry or (RAP) – Page 6 (MAP1716)

Use this screen to enter MSP information for viewing Payment/Pricer data.

We are not able to accept MSP claims (including conditional payment claims) that are submitted via Fiscal Intermediary Standard System Direct Data Entry (FISS/DDE). All MSP claim submissions will need to be submitted either electronically hardcopy submission on a UB-04 (CMS-1450) claim form*, or through PC-ACE. MSP adjustments must be submitted via EMC, hardcopy or through PC-ACE.

Note: DDE MAP1719 was created to house payment information for up to 2 payers primary to Medicare.

Note: To view all Claim Entry functions, see Chapter 3, Inpatient Claim Entry.



Field Name	Description
INSURER'S ADDRESS 1st AND 2nd Conditionally Required	**Insurance Company's Address** - Maximum of 32 digits. Enter the address of the insurance company that corresponds to the line on which Medicare payer information is reported Form Locator 58 A, B, C.
CITY 1 AND 2 Conditionally Required	**Insurance Company's City** - Maximum of 15 digits. Enter the specific city of the insurance company.
ST 1 AND 2 Conditionally Required	**Insurance Company's State** - Maximum of two digits. Enter the specific state of the insurance company.

ZIP 1 AND 2 Conditionally Required	**Insurance Company's ZIP Code -** Maximum of nine digits. Enter the specific ZIP code of the insurance company**.**

Roster Bill Entry

Purpose

This allows input of influenza vaccine claim information.

Access

From the Claims Entry, to access the Roster Bill Entry (MAP1681):

In the Enter Menu Selection field Type **87** Press <**ENTER**>

To use the Roster bill function, type the information in the following fields: NPI, TAXO.CD, FAC.ZIP, REVENUE CODE, HCPC, and CHARGES PER BENEFICIARY. Press the <**ENTER**> key. (This unlocks the Patient Information fields.)

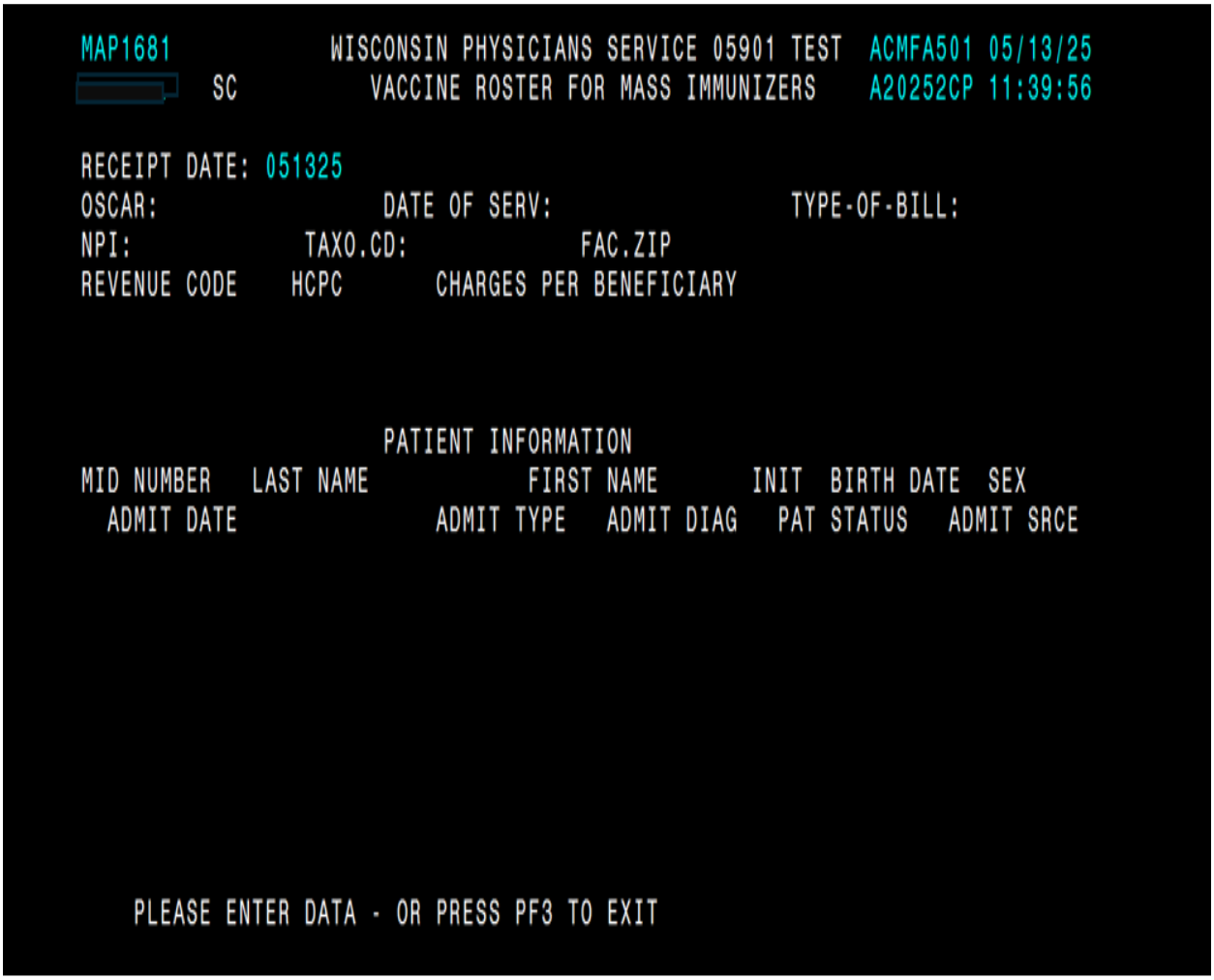
Tab down to MBI field and type the information for all fields on that line.

Tab to move down to the ADMIT DATE field and type the information for that line.

After keying the Roster billing information, press the **<F9>** key to transmit the claim to Medicare Part A.

- Only one date of service per Roster Bill
- A maximum of ten (10) patients per page may be reported on a DDE Roster page
- If using a 23X type of bill, the **ADMIT DATE** line fields will not open, as they are not required.
- Effective October 1, 2010, **ADMIT TYPE** is required on Flu Roster entry.

Vaccine Roster for Mass Immunizers



Field Name	Description
RECEIPT DATE	**Receipt Date** - This field displays the system date the claim was received by the Intermediary.
PROVIDER NUMBER	**PTAN** - Displays the identification number of the institution, which rendered services to the beneficiary/patient. The field will systematically fill with the Medicare PTAN used when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, HOME HEALTH, INPATIENT, ETC.) the Medicare PTAN must be changed to reflect the PTAN you wish to submit claims for. If the Medicare PTAN is not changed for your sub-units, the claims will be processed under the incorrect PTAN.
NPI NUMBER	**Provider Identification number** - Ten-digit number: National Provider Identifier
TAXO. CD	**Taxonomy code** - Ten-digit field that identifies the facility/unit type within a single NPI
FAC. ZIP	**Facility ZIP Code** – Five- or nine-digit field that identifies ZIP code of facility billing the service.

DATE OF SERV	**Date of Service** - The date the service was rendered to the beneficiary. This field should be keyed in MMDDYY format.
TYPE-OF-BILL	**Type of Bill** - Key the type of bill for the roster bill being submitted. (This is only a two-digit field.)
REVENUE CODE	**Revenue Code** - Enter the specific accommodation or service that was billed on the claim. This should be done by line item. **Valid values: 0636** or **0771**
HCPC	**Health Care Procedure Coding System (HCPCS)** - Coding system applicable to ancillary services. **Valid values: G0008 Q0124 90724** *Effective October 1, 2010: 90658, Q2035, Q2036, Q2037, Q2038, and Q2039 replace 90658.*
CHARGES PER BENEFICIARY	**Changes per Beneficiary** - Enter the charges per Revenue Code being charged to the beneficiary.
MBI	**Medicare Beneficiary Identifier** - Number assigned when a beneficiary becomes eligible for Medicare.
LAST NAME	**Patient Last Name** - Enter the last name of the patient as it appears on the patient's Health Insurance Card or other Medicare notice.
FIRST NAME	**Patient First Name** - Enter the first name of the patient as it appears on the patient's Health Insurance Card or other Medicare Notice.
INIT	**Patient Middle Initial** - Enter the middle initial of the patient.
BIRTHDATE	**Birth Date** - Enter the date in MMDDYYYY format.
SEX	**Sex** - Enter the sex of the patient. **Valid values:** **F** – Female **M** - Male
ADMIT DATE	**Admission Date** - Maximum of six digits. Enter date (MMDDYY) services were received.
ADMIT TYPE	**Type of Admission** - Maximum of one digit. Enter the appropriate inpatient code, which indicates the priority of the admission. **Valid values:** 1-Emergency - The patient required immediate medical intervention because of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room. 2-Urgent - The patient required immediate attention for the care and treatment of physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodations. 3-Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodation. 4-Newborn 5-Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation. 6-8-Reserved for National Assignment 9- Information Not Available

ADMIT DIAG	**Admitting Diagnosis** - Maximum of six digits. For inpatients, enter the full ICD-9-CM code for the principal diagnosis relating to the condition established after study to be chiefly responsible for the admission. **Note:** Decimal points are not required.
PAT STATUS	**Patient Status** - if using **12x** or **22x** type of bill, use **30**.
ADMIT SRCE	**Source of Admission** - Maximum of one digit. Enter appropriate code indicating the source of the referral. **Valid values:** 1-Physician referral 2-Clinic referral 3-HMO referral 4-Transfer from a hospital 5-Transfer from a SNF 6-Transfer from another health care facility 7-Emergency room 8- Court/law enforcement 9- Information not available A-Transfer from a Critical Access Hospital B-Transfer from another Home Health Agency (HHA) C-Readmission to the same Home Health Agency D-Transfers from hospital inpatient in the same facility E-Z-Reserved for National Assignment

End Stage Renal Disease (ESRD) CMS-382 Method Selection Form

Purpose
Allow the entry, inquiry or updating of the ESRD CMS-382 attachment.

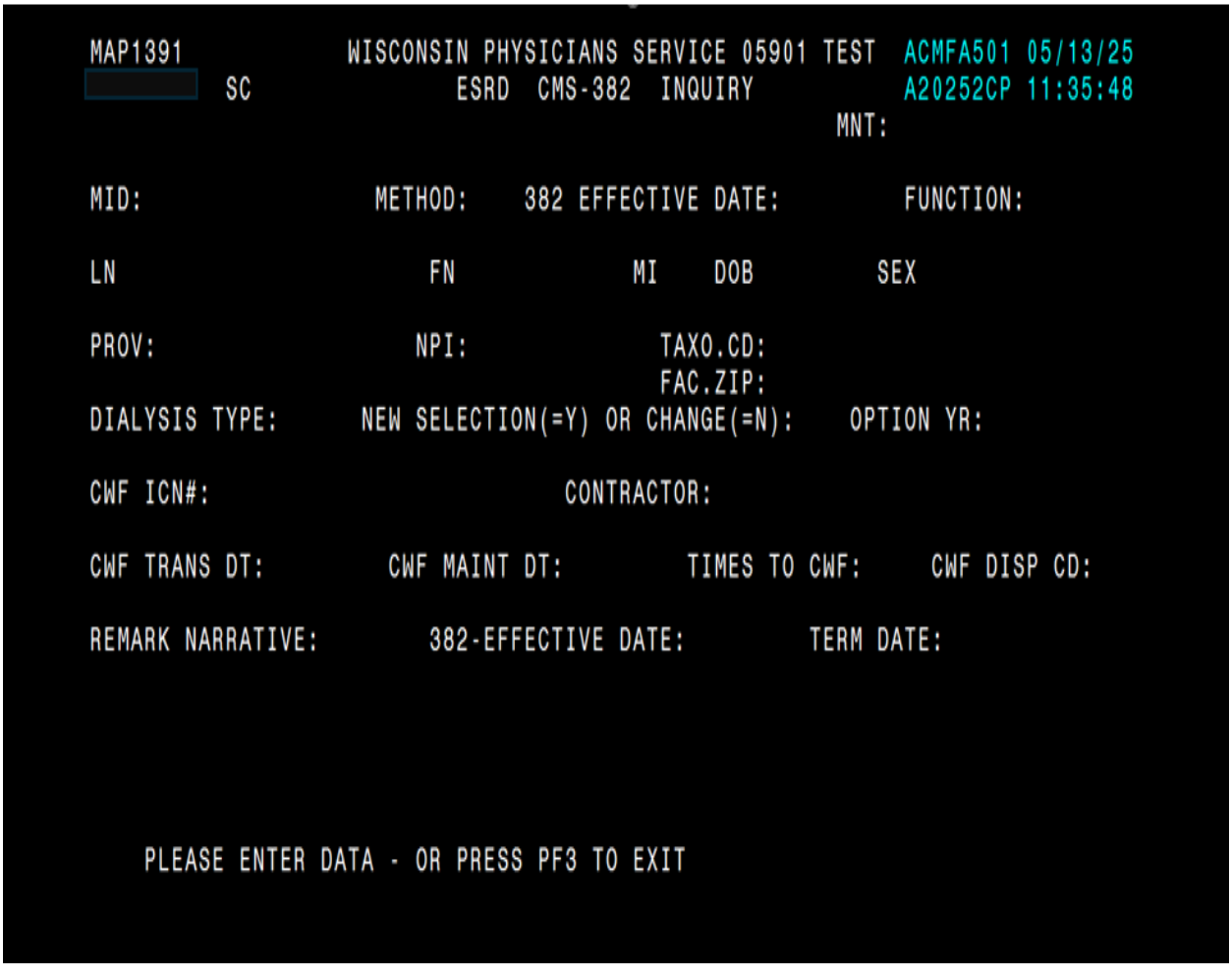
Access
From the Claims Entry, to access the ESRD CMS-382 (MAP1391):
In the Enter Menu Selection Field, Type **57** Press <**ENTER**>

The ESRD CMS-382 attachment will allow ESRD providers to inquire, update, and enter ESRD method selection data. Available **functions** are **I**, **U**, and **E**. After deciding on the function, press <**ENTER**> to access additional fields for typing the data.

Type the MBI, METHOD, and 382 EFFECTIVE DATE. Type an **E** for FUNCTION and press <**ENTER**>. If the beneficiary is on file, the system will automatically enter the beneficiary's last name, first name, middle initial, date of birth and sex based on the information stored on the beneficiary file. In addition, the system should allow access to the PTAN (Prov), dialysis type, and selection or change fields.

Next enter the PROV, NPI, TAXO. CD, FAC. ZIP, DIALYSIS TYPE, NEW SELECTION, OPTION YR and press **<F9>** to store.

ESRD CMS-382 Attachment



Field Name	Description
OP	**Operator Code** - This field identifies the last operator to update this record.
DT	**Date** - This field indicates the last date this record was processed.
MBI	**Medicare Beneficiary Identifier (MBI)** - of the beneficiary.
METHOD	**Method Selection** - Identifies the method of home dialysis selected by the beneficiary. **Valid values:** 1- Method I - Beneficiary receives all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claims for their services 2**-** Method II - Beneficiary deals directly with one supplier and is responsible for submitting their own claim
382 EFFECTIVE DATE	**382 Effective Date –** Identifies the date the Beneficiary's ESRD Method Selection becomes effective on the (CMS- 382) form.
FUNCTION	**Function** - Three possible functions: **E** – Entry **U** – Update **I** - Inquiry

LN	**Last Name** - Last name of the beneficiary at the time the method selection occurs.
FN	**First Name** - First name of the beneficiary.
MI	**Middle Initial** - Middle initial of the beneficiary.
DOB	**Date of Birth** - Beneficiary's date of birth.
SEX	**Sex** - Sex of the beneficiary **Valid values:** **F** – Female **M** - Male **U** - Unknown
PROV	**PTAN** - Enter the ESRD PTAN or the facility you are keying the ESRD attachment for. The Medicare PTAN will systematically fill with the PTAN you logged on to the DDE system with, but if you have sub-units (multiple ESRD facilities) you will need to change the PTAN to reflect the ESRD facility the attachment information is being keyed for.
NPI NUMBER	**National Provider Identifier (NPI)** – Ten-digit unique provider identifier
TAXO.CD	**Taxonomy code** - Ten-digit field that identifies the facility/unit type within a single NPI.
FAC.ZIP	**Facility ZIP -** Five- or nine-digit field. The billing provider or the Subpart ZIP Code.
DIALYSIS TYPE	**Dialysis Type** - The types are as follows: 1- Hemodialysis 2- Continuous ambulatory peritoneal dialysis (CAPD) 3- Continuous cycling peritoneal dialysis (CCPD)
NEW SELECTION OR CHANGE	**New Selection or Change** – This field indicates an exception to other ESRD data. **Valid values:** **Y** - Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date **N** - Entered for a change in selection, e.g., optional year is one year greater than the year of select date.
OPTION YR	**Option Year** - Identifies the year that a beneficiary selection or change is effective. A selection change becomes effective on January 1st of the year following the year the ESRD beneficiary signed the selection form.
CWF ICN#	**CWF Internal Control Number** - Common Working File (CWF) Internal Control Number (ICN). FISS inserts this number on the ESRD Remarks screen to ensure the correction is being made to the appropriate ESRD Remark segment.
CONTRACTOR	**Contractor -** Identifies the carrier or Intermediary responsible for a particular ESRD maintenance file.
CWF TRANS DT	**CWF Transmit Date** - Date information was transmitted to the Common Working File (CWF).
CWF MAINT DT	**CWF Maintenance Date** - Identifies the date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	**Times to CWF** - Number of times the record was transmitted to the CWF.

CWF DISP CD	**CWF Disposition Code -** Received from CWF **Valid values:** **01-** Debit accepted, no automated adjustment **02**- Debit accepted, automated adjustment **03**- Cancel accepted **04**- Outpatient history only accepted **50** - Not in file (NIF) **51** - True NIF on CMS Batch System **52** - Master record housed at another CWF site **53** - Record in CMS alpha match **55** - Name/personal character mismatch **57** - Beneficiary record archived, only skeleton exists **58** - Beneficiary record blocked for cross reference **59** - Beneficiary record frozen for clerical correction **60** - Input/output error on data **61** - Cross-reference database problem **AB** - Transaction caused CICS abnormal end of job (abend) **BT** - History claim not present to support spell **CI** - CICS processing error **CR** -Crossover reject **ER** - Consistency edit reject **UR** -Utilization reject **RD** - Transaction Error
REMARKS NARRATIVE	**Remark Narrative** - The types are as follows: M1 - Method I M2 - Method II These numeric values will systematically fill.
382 EFFECTIVE DATE	**382 Effective Date -** Method effective date – Valid values: Y - The 382 effective date is equal to the 382-signature date N - The 382 effective date will be January 1 of the following year
TERM DATE	**Termination Date** - Projected date of termination of dialysis coverage.

Chapter 4: Claims Corrections

- Correct claims in the return to provider (RTP) status/location (T B9997)
- Adjust paid or rejected claims
- Cancel paid claims

When a claim is submitted, it goes through two levels of editing to determine whether it can be processed. The front-end edits catch errors before the claim is transmitted and results in reason codes. The back-end edits look for additional problems after the claim has been transmitted and may result in an RTP if an error exists.

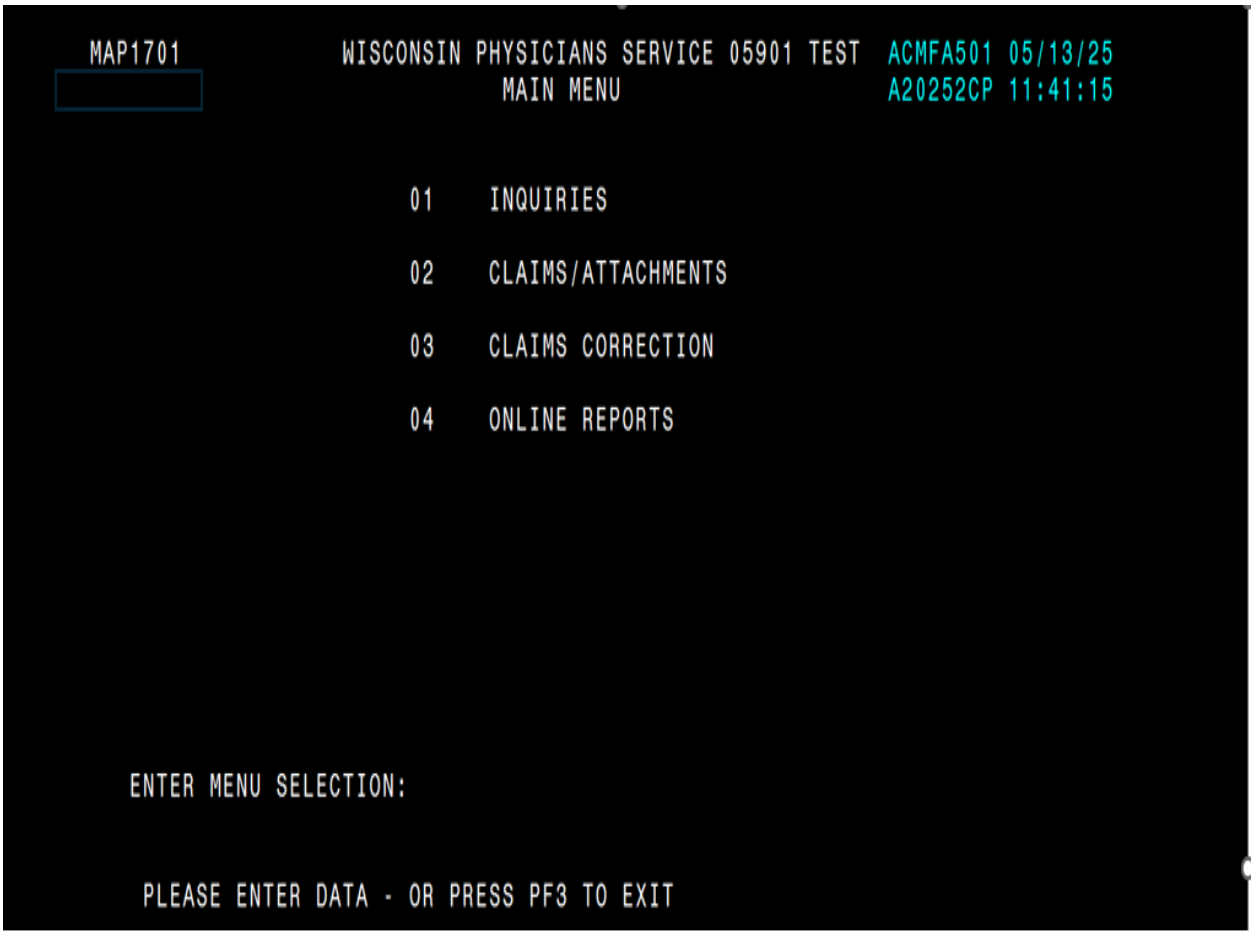
RTPs are claims that error after transmission and are "Returned to Provider" for provider-correctable problems. Providers need to correct and reactivate these claims.

When the back-end edits determine that a claim requires correction, the claim is given a status/location code beginning with the letter **T** and routed to the claim summary inquiry screen. Claims requiring correction appear on the claim summary screen the day after claim entry.

It is not possible to correct a claim until it appears on the summary screen. Providers are permitted to correct only those claims appearing on the summary screen in status **T**. Claims that have been given **T** status have not yet been processed for payment consideration, so it is important to **review your claims daily and correct them to avoid delays in payment.**

- When correcting a claim, the correct NPI number for the facility's claims you wish to access must be keyed in the NPI field. If the correct NPI associated with the claim is not entered, the system will give you an error message that it cannot locate the claim. If you receive an error message, verify that the correct Medicare NPI number is shown in the NPI field. To do so, simply <**TAB**> to the NPI field and type in the correct NPI number.
- End Stage Renal Facilities (ESRD), Comprehensive Outpatient Rehab. Facilities (CORF) and Outpatient Rehab. Facilities (ORF) will need to select the Outpatient option and then change the TOB to reflect the TOB used for that specific facility. By doing this, returned claims for your facility will appear.

FISS Main Menu, type **03** in the Enter Menu Selection field and press **Enter**



Claims and Attachment Corrections

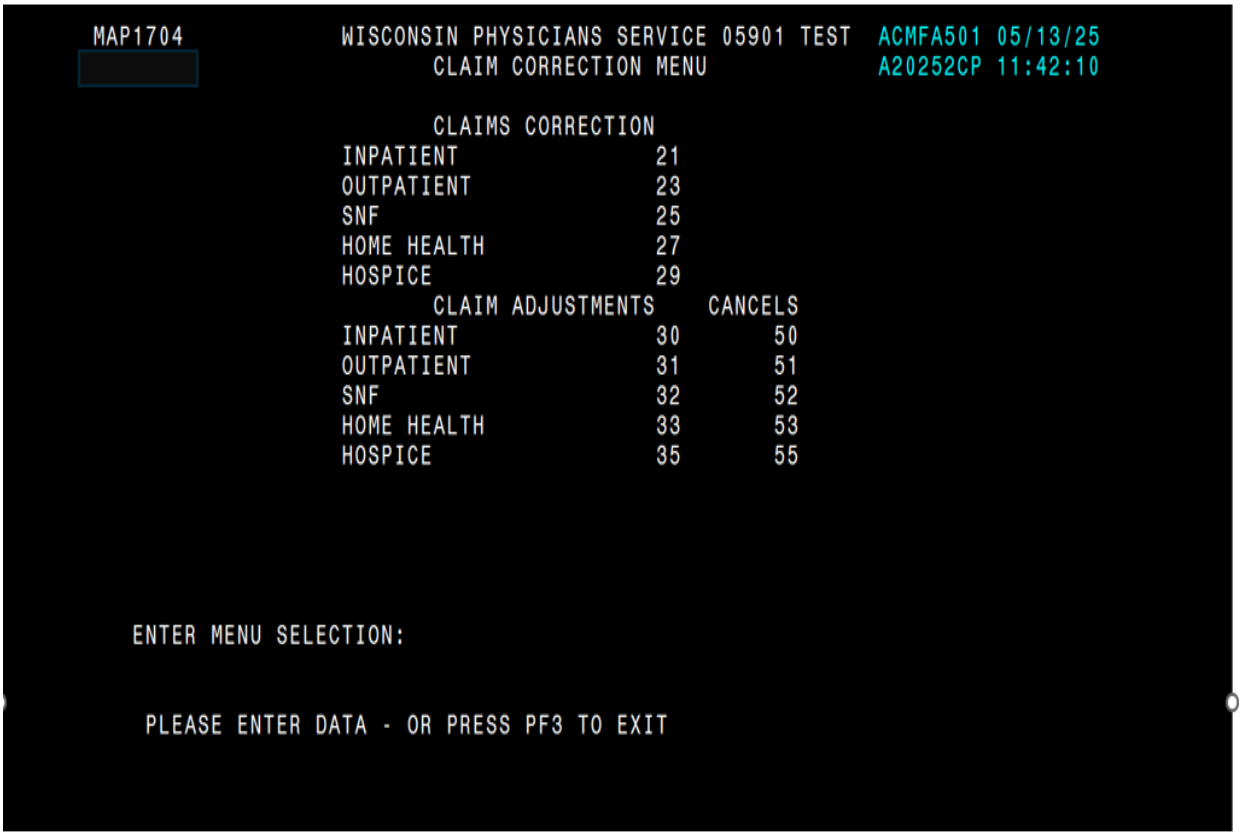
Purpose

This screen displays subsequent menu options for correct DDE claims that have been returned due to errors, entry of adjustment claims, and entry of attachments for suspended claims. Allows for selection by Type of Claim for correction, adjustment, or cancellation.

Access

From the Claims and Attachments Correction Menu, to access the Inpatient Claims Correction:
In the Enter Menu Selection field, type **21,** Press <**ENTER**>.

Claim and Attachments Correction Menu-(MAP1704)



Corrections

This screen provides a summary of specific claim data and will allow selection of a particular claim for correction.

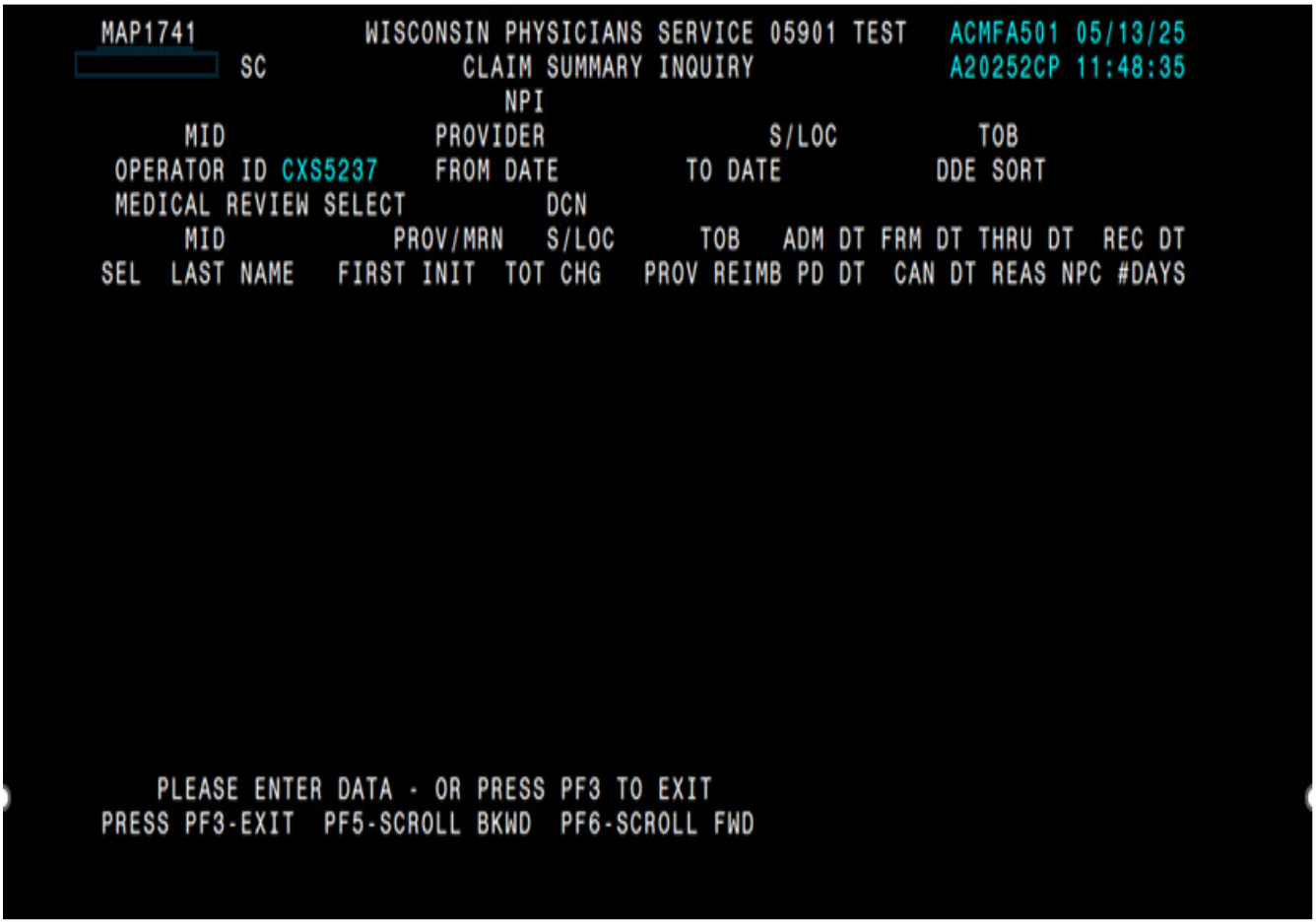
Use any of the following criteria to narrow your search:

- MBI
- STATUS/LOCATION (S/LOC)
- TYPE OF BILL (TOB)
- NPI Number

Be sure to change NPI number, if necessary, to view claims for other than default NPI.

You may select a DDE SORT criteria, e.g., M, R, H, etc.

Claim Summary Inquiry-(MAP1741)



Field Name	Description
DDE SORT	**DDE Sort -** Allows multiple sorting of displayed information. **Valid values:** **Blank** - TOB/DCN (Current default sorting process, S/LOC, Name) **M** - Medical Record number sort (Ascending order, MBI) **N** - Name sort (Alphabetical by last name, first initial, Receipt Date, MR#, MBI) **H** –Medicare Beneficiary Identifier sort (Ascending order, Receipt Date, MR#) **R** - Reason Code sort (Ascending Order, Receipt Date, MR#, MBI) **D** - Receipt Date sort (Oldest Date displaying first, MR#, MBI)

MEDICAL REVIEW SELECT	**Medical Review Selection -** One-digit alphanumeric field used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. **Valid values:** **Blank** - Selects all claims 1- Selects all claims 2- Selects all claims excluding Medical Review 3- Selects Medical Review only

On-Line Claims Correction

Claim Summary Inquiry

Certain information is already filled in: provider number (PTAN), the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter a particular type of bill.

To see a list of the claims which require correction, press <**ENTER**> twice. The selection screen will then display all claims that have been returned for correction (status/ location **T change to T B9997**). On the claims correction screen, the system will only display five claims to a page. To view additional claims, use <**F6**> to scroll forwarding the list of claims.

To narrow the scope of the claims viewed, enter one of the following selection criteria:

- type of bill
- From date
- To date
- MBI

If the claim you are looking for does not appear on the screen, do the following:

- Verify the MBI that you typed
- Verify the from and through dates
- Verify that the TOB (type of bill) is the same TOB on the claim you originally submitted. If not, <**TAB**> to the TOB field and enter the first two digits of the TOB for the claim you are trying to retrieve.
- If you still cannot find the claim, back out of claims correction <**F3**> to the Main Menu. Choose Inquiry (Option 01) and Claims (Option 12) and select the claim. Check the Status/Location (S/LOC). Only claims in status location T B9997 can be corrected. Status locations that cannot be corrected or may require adjustment include:
  - **P B9997** - This claim has been paid. An adjustment is required to change paid claim.
  - **P 09998** - This claim was paid, but due to its age, it has been moved to off-line history. An adjustment is required to change a paid claim.
  - **P B9996** - This claim is waiting to be released from the 14-day payment floor (not shown on the RA). No correction allowed.
  - **R B9997** - This claim was rejected. Submit a new claim or an adjustment.
  - **D B9997** - This claim was denied and may not be corrected or adjusted.
  - Status locations that begin with an **S** are internal locations that can only be corrected by Medicare staff.

Claims Correction Processing Tips

Key Information:

- The Revenue Code screen has multiple sub-screens. If you have more Revenue Codes that can fit on one screen, press <**F6**> to go to the next sub-screen. Press <**F5**> to go back to the first screen.
- You can also get from page to page by entering the page number in the top right-hand corner of the screen (Claim Page).
- Reason codes will appear at the bottom of the screen to explain why the claim was returned. **Up to 10 reason codes** can appear on a claim.
  - Press <**F1**> to access the reason code file.
  - Press <**F3**> to return to the claim.
  - The reason codes can be accessed from any claim screen.
  - The inquiry screen can be accessed by typing the option number in the **SC** field in the upper left-hand corner of the screen, for instance **10** for Beneficiary information. Press <**F3**> to return to the claim.

Correcting Revenue Code Lines

Adding and Deleting Line Items- (The only correction that can be made on claim page 2 is to delete the incorrect line and re-enter the line correctly on the line(s) below the total.)

- **To delete an entire Revenue Code line:**
  - Type four (4) zeros over the Revenue Code to be deleted and press <**HOME**> (this will position the cursor in CLAIM PAGE 02) and press <**ENTER**> **or** type **D** in the first position of the Revenue Code to be deleted and press <**HOME**> (this will position the cursor in CLAIM PAGE 02) and press <**ENTER**>. This will delete your line.
  - Next, add up the individual line items and correct the total charge amount on Revenue Code line (0001).

- **To add a Revenue Code line:**
  - Tab to the line below the total line (0001 Revenue Code).
  - Type the new Revenue Code information.
  - Press <**HOME**> to go to the **Page Number** field. Press <**ENTER**>. The system will resort the Revenue Codes into numerical order.
  - Correct the total charge amount of Revenue Code line (0001).

- To exit without transmitting any corrections, press <**F3**> to return to the selection screen. Any changes made to the screen will not be updated.

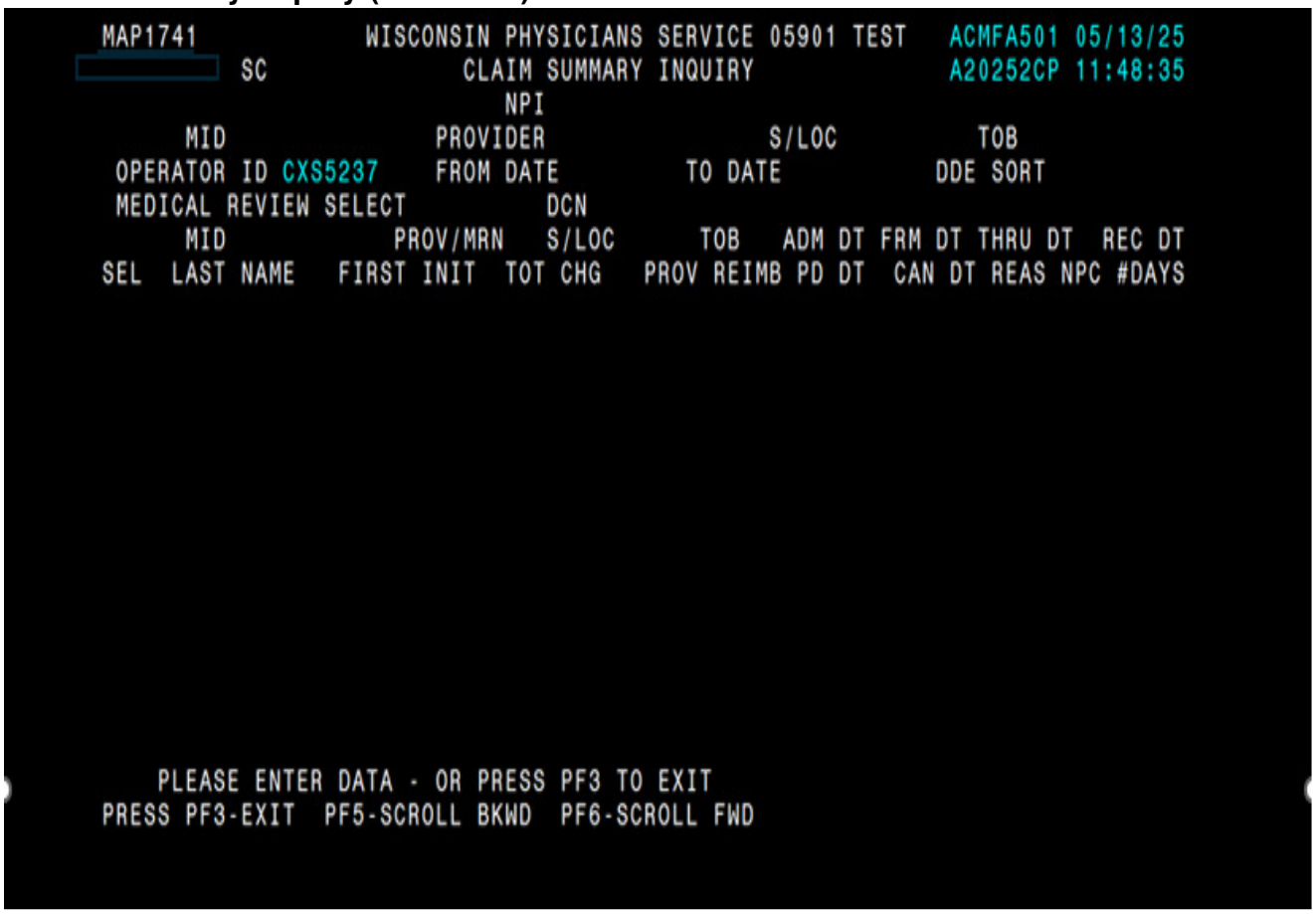
- Press <**F9**> to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the claim correction summary.
  - The on-line system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check (S B9000, unless otherwise set in the System Control file). The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: "PROCESS COMPLETED – ENTER NEXT DATA."

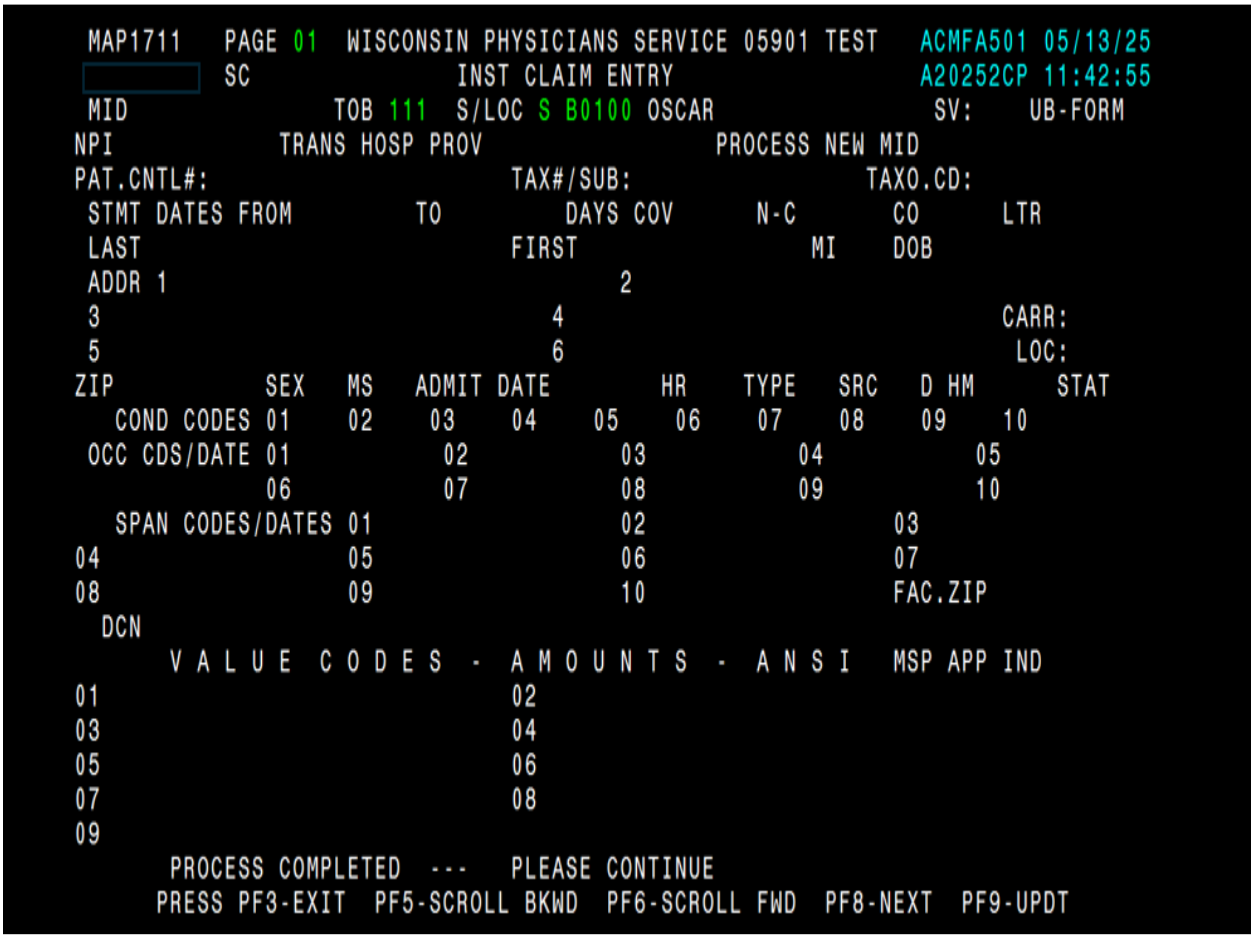
RTP Correction Tips

- It is recommended that RTPs be worked daily.
- EMC/DDE providers do not have to wait for a hard copy RTP report before entering corrections on-line or before submitting a new hard copy claim(s). on-line corrections can be entered when the RTP status/location is **T B9997**.
- Claims resubmitted that are re-keyed do not duplicate against RTP claims.
- Medical review RTPs (reason code range **5XXXX**) cannot be corrected on-line. Records requested must be submitted hard copy for review. The medical review RTPs will continue to show as pending on the RTP file until the file is purged.
- The status/location **T B9900** is designated for the day the RTP letter is generated. The next day the claim will be in status/location **T B9997** and, at this point, can be accessed through DDE on-line claim correction option.
- The on-line 201 and 050 reports will reflect weekly RTP'd claims.
    - Each report will contain the necessary information to identify a bill for corrections including the beneficiary's last name, first initial, and patient control number, type of bill, DCN, primary payer code, and the code(s). If the beneficiary's name and/or first initial do not match the beneficiary file for the Medicare beneficiary identifier, the FISS system will update the claim to reflect the beneficiary's name that is on the file and not the name that was submitted by the provider.
    - An RTP (**T** status) claim is not active in the system, so it cannot be adjusted or voided.
- If the RTP letter is 180 days or older, it will be purged when the system purges the file every 180 days (User controlled). Resubmit the claim as a new bill. Medical review RTPs are also suspended for 60 days and can be identified by reason code(s) in the 5XXXX. The initial request is an additional development request (ADR) letter to the provider, requesting information, is sent with 45 days. If the information is not received, the claim will suspend to the RTP location for 60 days. This enables providers to have access to the original bill for a total of 105 days on all Medicare record requests.

Claim Summary Inquiry (MAP1741)



Claim Summary Inquiry (MAP1711)

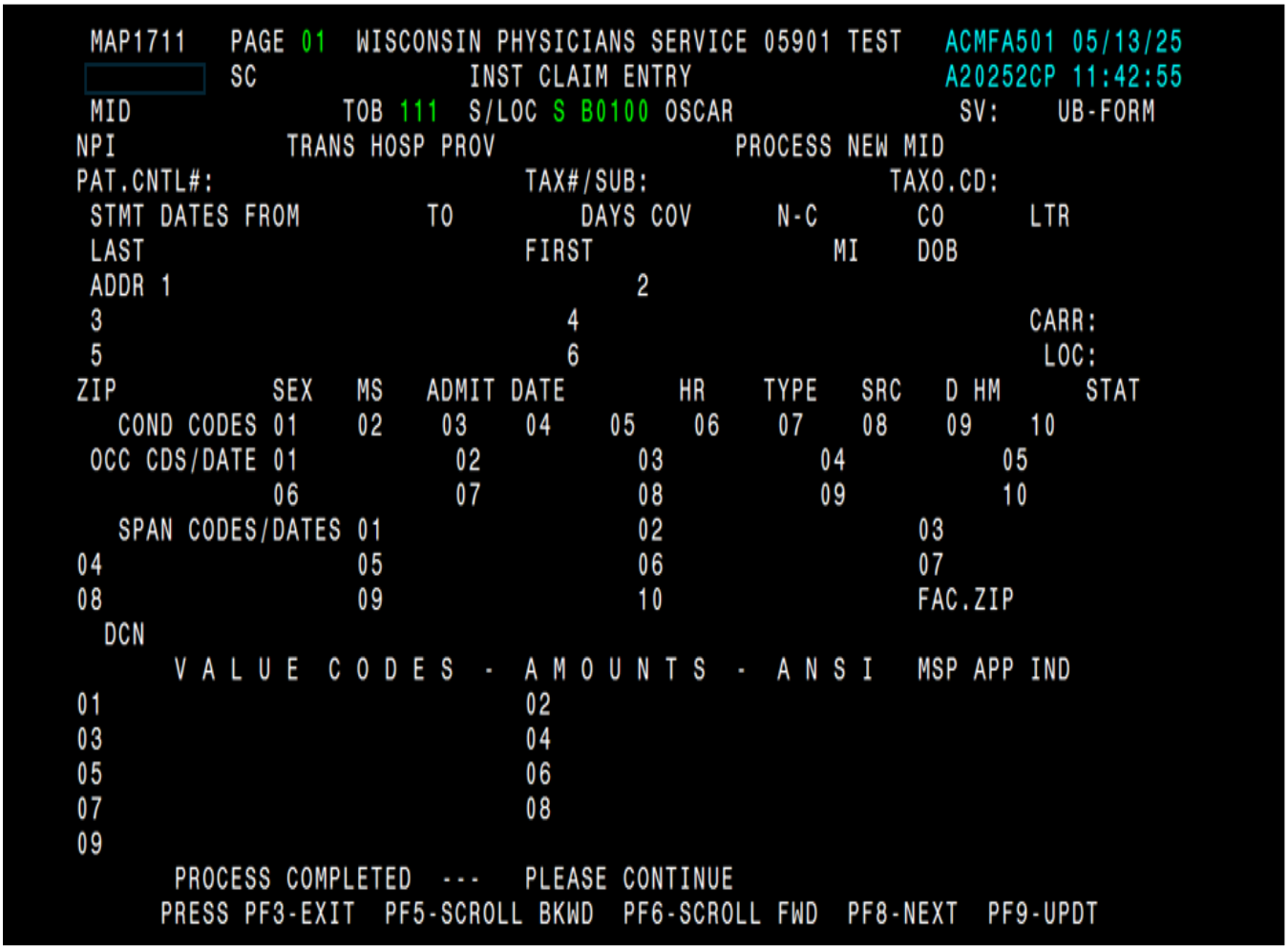


Suppressing RTP Claims

Since RTP claims do not purge from the system for 180 days (User controlled), a feature exists within the FISS system that allows a claim to be suppressed. This is helpful for RTP claims that do not need to be resubmitted and are filling up unnecessary space under the Claim Correction Menu option**;** however, all claims will continue to display through the Inquiry Menu option until they purge from the system. Select the option under CLAIMS CORRECTION for the type of claim to be corrected and press <**ENTER**>. Select the claim you wish to suppress by putting an **S** next to the claim under the **SEL** field.

DANGER - THIS ACTION CANNOT BE REVERSED

Suppressing an RTP Claim (MAP1711)



Field Name	Description
SV	**Suppressing the RTP Claim –** Type a **Y** in the **SV** field, which is located in the upper right hand corner of Page 1, then press <**F9**>. The system will return to the Claim Summary Inquiry (MAP1741) screen and the suppressed claim will no longer be displayed.

Adjustments

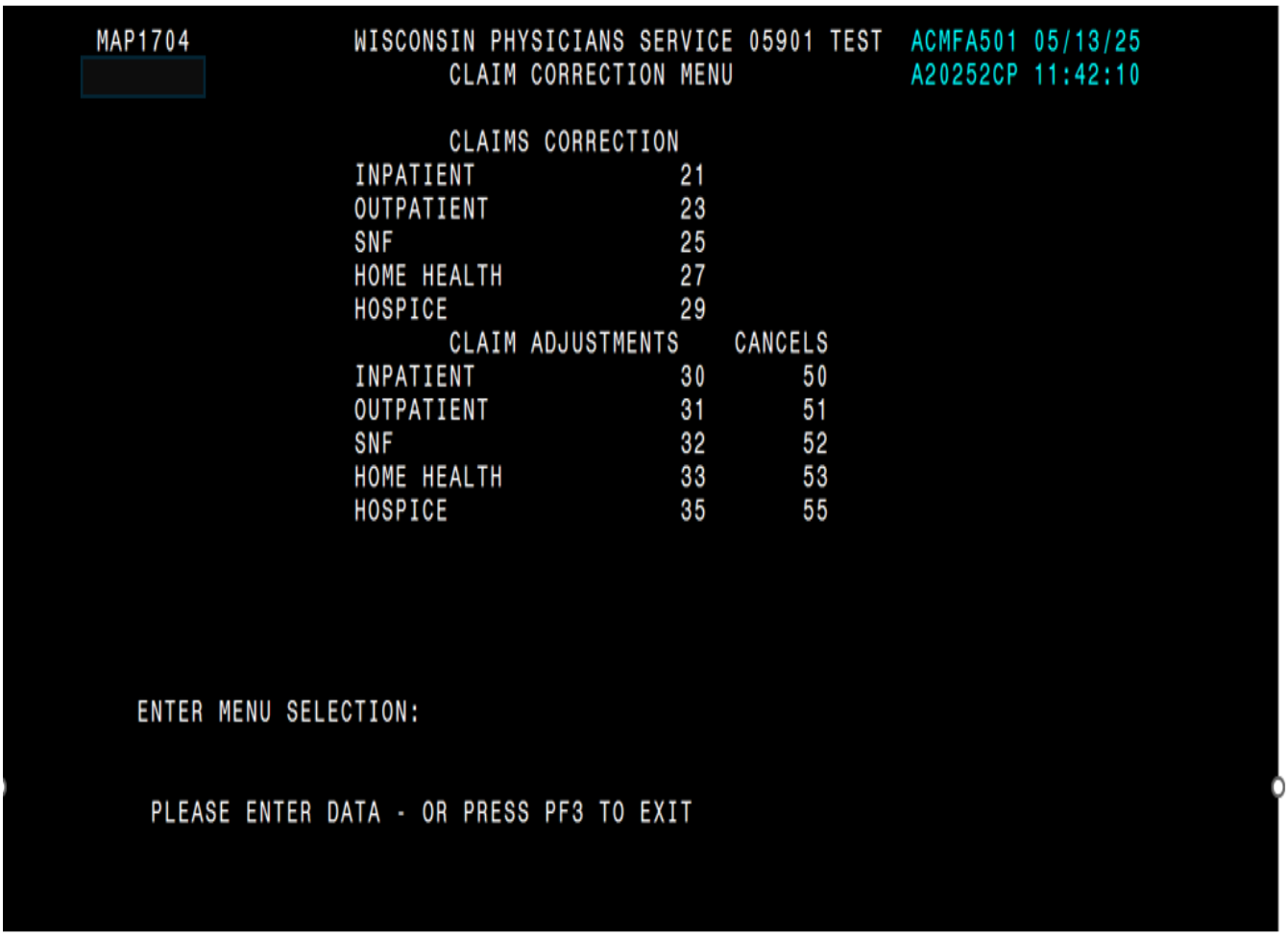
Purpose

This screen displays subsequent menu options for correcting DDE claims that have been returned due to errors, for entry of adjustment claims and entry of attachments for suspended claims.

Access

From the Claims Correction Menu, to access the Inpatient Claims Adjustments: In the Enter Menu Selection field Type **30** Press **<ENTER>.**

Claim Correction Menu-(MAP1704)



Using the Claim Adjustment option, providers can submit adjustments for previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letters **D**, **P** or **R** and is recorded on the claim status inquiry screen.

A claim cannot be adjusted unless it has been finalized and is reflected on the remittance advice. Providers must be very careful when creating adjustments. If you go into the adjustment system and update a claim without making the right corrections, the adjustment will still be created and process through the system. Errors could cause payment to be taken back unnecessarily.

No adjustments can be made on the following claims:

- **T** Status/RTP;
- **D** Status/Medically Denied; or
- Type of bill **XXP** (QIO Adjustment), **XXI** (Intermediary Adjustment), **XXK** (OIG Adjustment), or **XXH** (Comprehensive Error Rate Testing (CERT) or Recovery Auditor (RA) Adjustments).

If a claim has been denied with a full or partial medical denial, the provider cannot submit an adjustment. Any attempted adjustments will reject with Reason Code 30904 (a provider is not permitted to adjust a partially or fully medically denied claim).

If claim is in status location R B9997 with an **X** in TPE-TO-TPE it **may not** be adjusted. Follow steps below to verify if there is an **X** in TPE-TO-TPE.

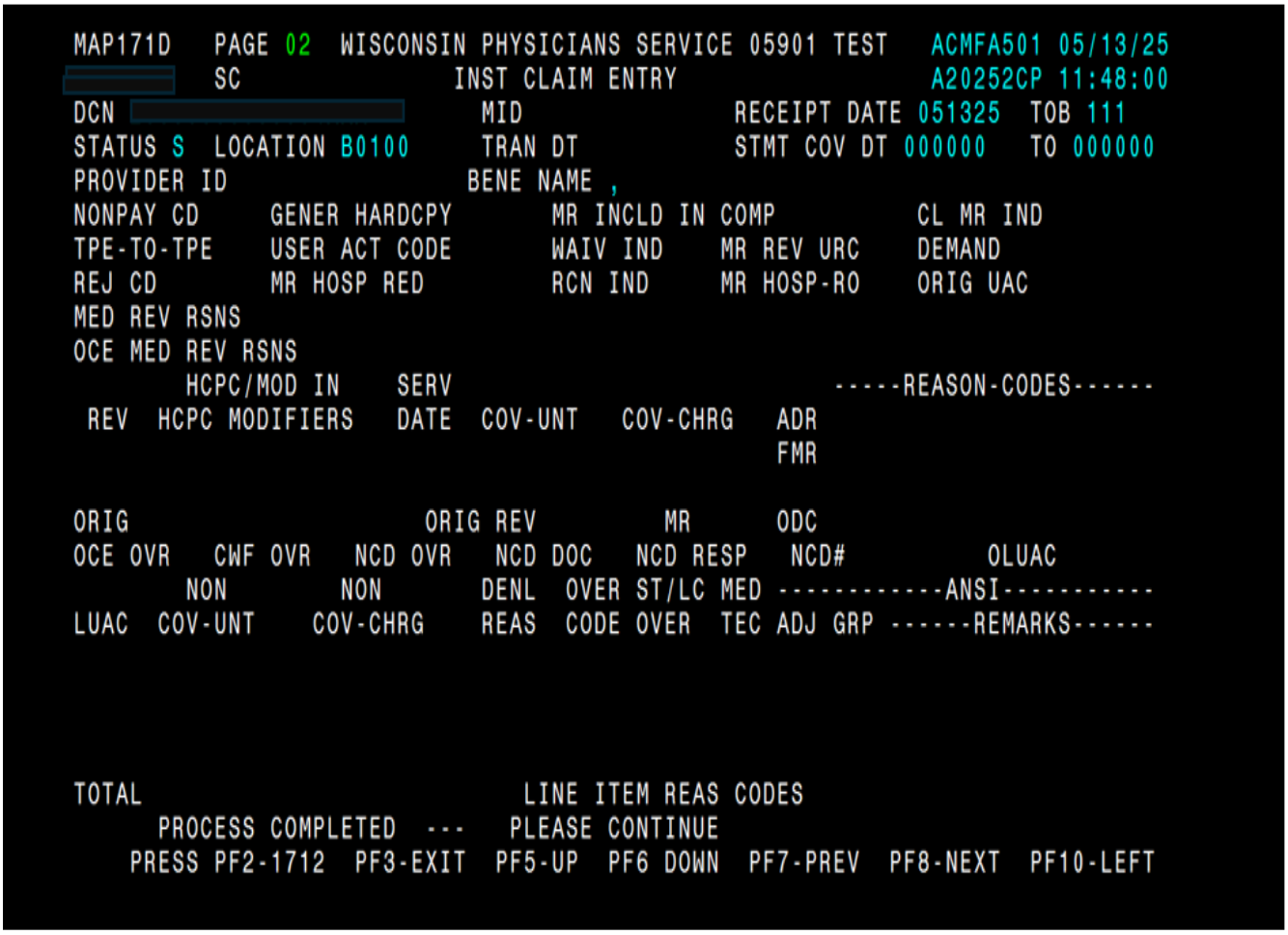
1. Select Inquiries (01) from the Main Menu.
2. Select Claims (12).
3. Key in NPI, MBI, and Dates of Service, change the S/LOC to an **R** as it automatically populates a **P** and press <**ENTER**>.
4. Select the claim you need to adjust, <**F8**> to get to page 2 and press <**F2**>.
5. See highlighted section below to view TPE-TO-TPE field in screen print of MAP171D.

Note: If claim **does** have **X** in TPE-TO-TPE field, you will need to **resubmit as new claim**. No adjustment can be made.

Note: We are not able to accept MSP claims (including conditional payment claims) that are submitted via Fiscal Intermediary Standard System Direct Data Entry (FISS/DDE). All MSP claim submissions will need to be submitted either electronically hardcopy, submission on a UB-04 (CMS-1450) claim form*, or through PC-ACE.

Note: DDE MAP1719 has been created to house payment information for up to 2 payers primary to Medicare. This CR is also making system changes that will allow providers to key MSP claims via DDE.

MAP171D

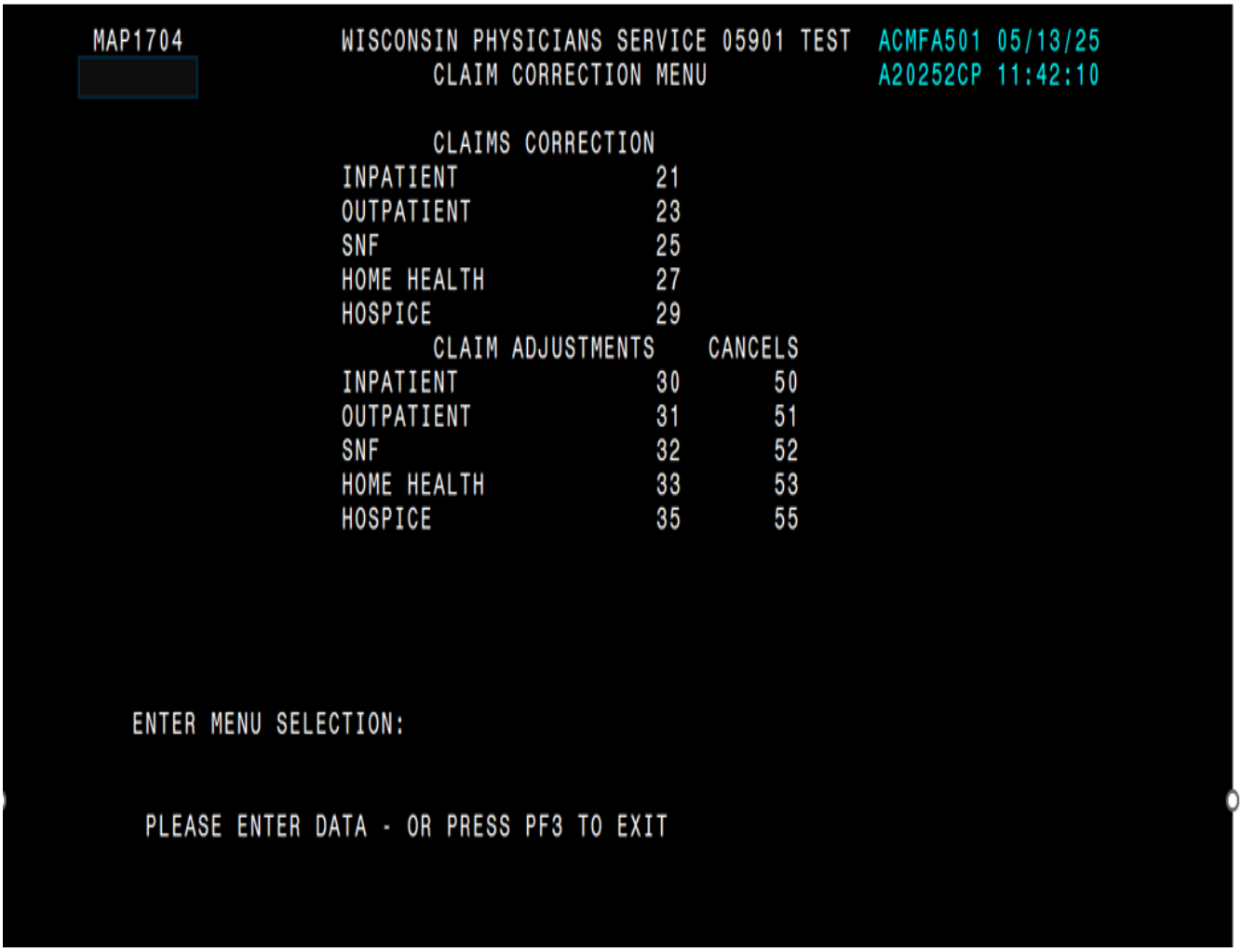


On-Line Claims Adjustments (Type of Bill XX7)- Processing Tips

When claims are keyed and submitted through DDE for payment consideration, the user can sometimes make entry mistakes that are not errors to the DDE/FISS system. As a result, the claim is processed through the system to a final disposition and payment. To change this situation, the on-line claim adjustment option can be used.

Select the option under CLAIM ADJUSTMENTS for the type of claim to be adjusted and press **<ENTER>.**

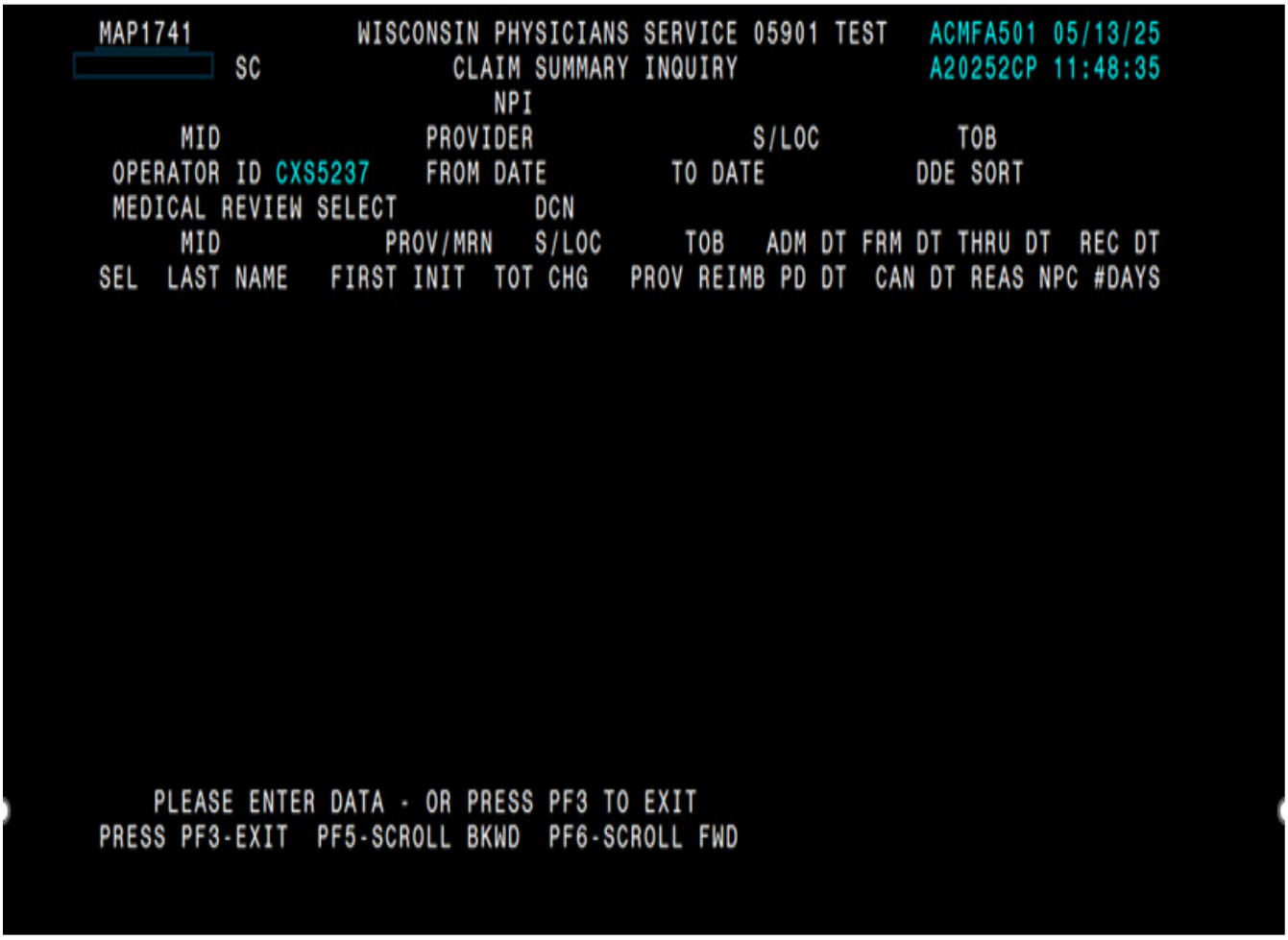
Claim and Attachments Correction Menu (MAP1704)



End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB. By doing this, paid claims for your particular facility will appear.

- Once you have selected the type of adjustment you need to set up to access the claim to be adjusted, key in the NPI, MBI, and Dates of Service. The S/LOC automatically populates the letter **P**. If your claim was rejected, you will need to change the S/LOC to an **R**. The TOB automatically populates **11** (INPATIENT), **13** (OUTPATIENT), **21** (SNF), **and 32** (HOME HEALTH). If the TOB is anything other than those listed, you will need to change. Then press <**ENTER**>.
- Place an **S** in front of the claim you would like to adjust, then press <**ENTER**>.

Claim Summary Inquiry (MAP1741)



- The system will automatically default the TOB frequency to an XX7.
  - The MBI field is now protected and may no longer be changed.
- Indicate why you are adjusting the claim by entering the claim change condition code on Page 01 of the claim. (See list below.)

Claim Change Condition Codes

Adjustment condition code will be needed to indicate the primary reason for initiating an on-line claim adjustment or cancel.

Valid values:

D0 Changes to service dates
D1 Changes to covered charges
D2 Changes to Revenue Codes/HCPCS
D3 Second or subsequent interim PPS bill
D4 Change in diagnosis and/or procedure codes
D5*Cancel only to correct a MBI or provider identification number (**cancels only**)
D6* Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.) (**cancels only**)
D7 Change to make Medicare the secondary payer

D8 Change to make Medicare the primary payer
D9 Any other change
E0 Change in patient status

- Enter a Valid Adjustment Reason Code on Page 03. Valid Adjustment Reason Codes can be found by going to the **SC** field in the upper right hand corner of the screen, typing **16,** and pressing <**ENTER**>. This brings up the Adjustment Reason Code table.
- Give a short explanation of the reason for the adjustment in the remarks section on Page 04 of the claim.
- To exit without transmitting the adjustment, press <**F3**> (exit). Any changes made to the screens will not be updated.
- Press <**F9**> to update/enter the claim into DDE for reprocessing and payment consideration. Claims being adjusted will still show on the claim summary screen. Always check the inquiry claim summary screen (#12) to affirm location of the claim being adjusted.
- It is possible to do multiple adjustments (an adjustment to an adjustment).
- Check the remittance advice to assure that the claim adjusted properly.

Procedures for Claim Retrieval

Purpose

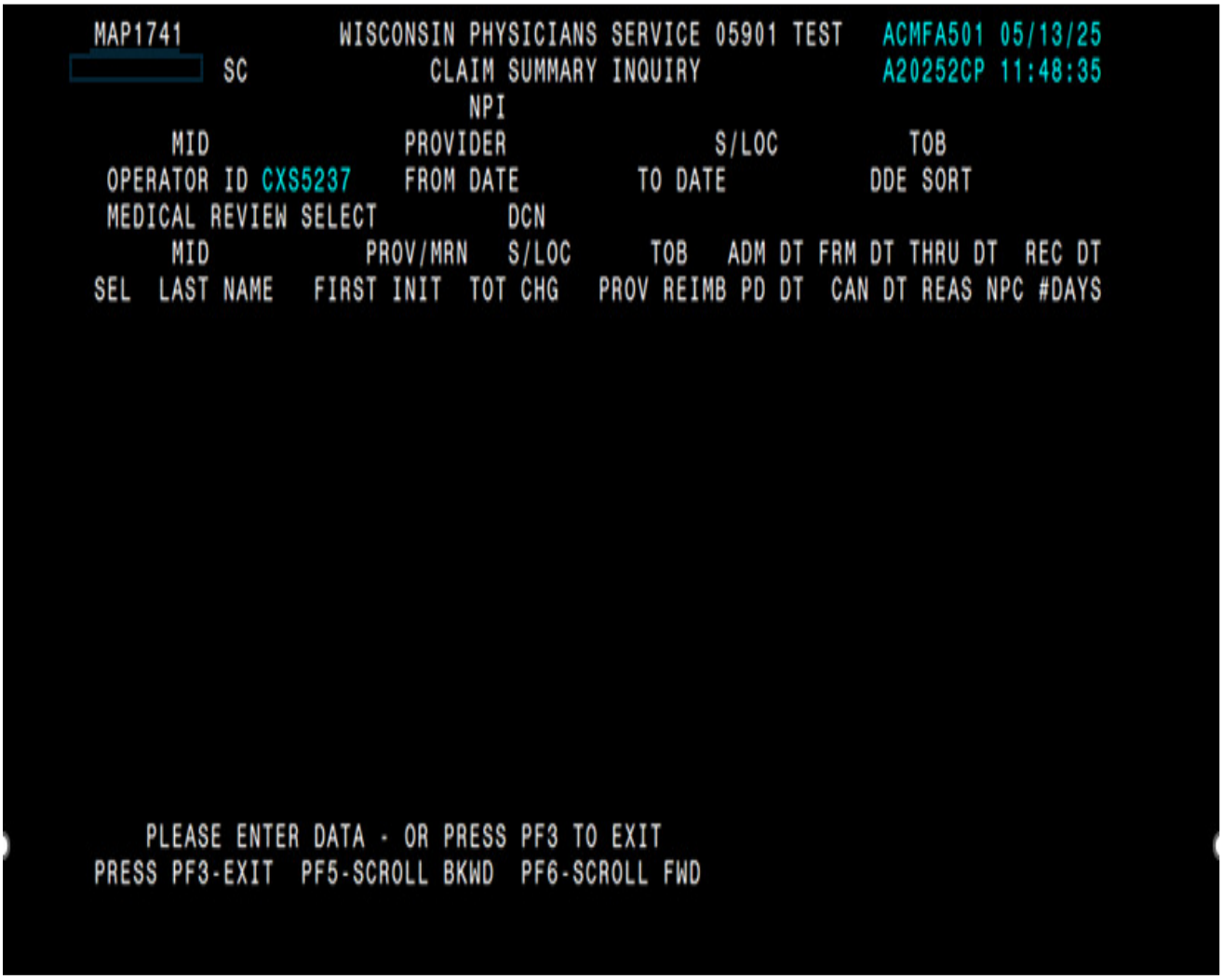
To give the provider a method to retrieve offline claims electronically, through the DDE process, to create adjustments and/or cancels.

Access

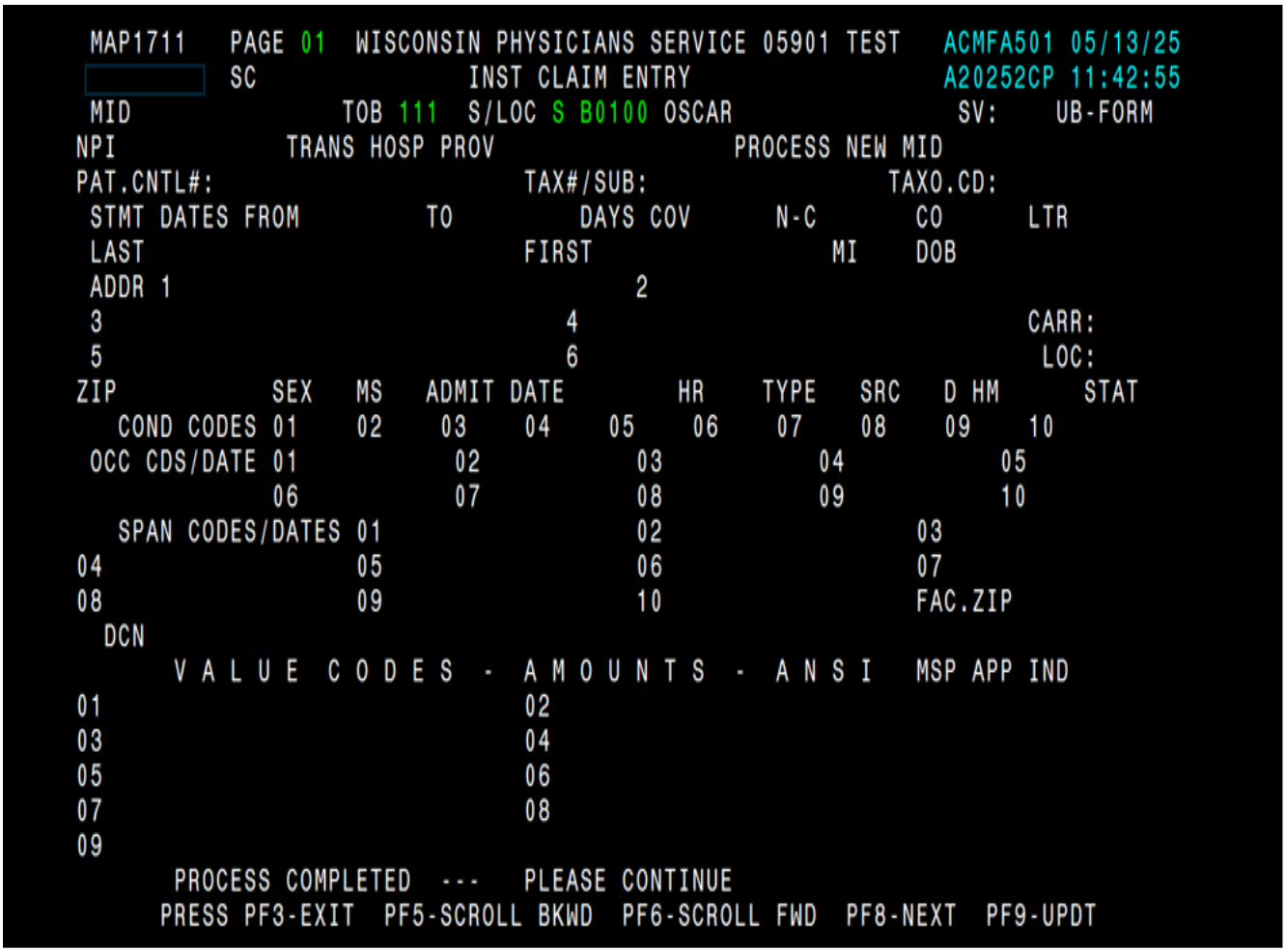
From the DDE Main Menu, to access the Claims Corrections Sub-Menu:
In the Enter Menu Selection field Type **3** Press <**ENTER**>

Note: The MBI is required for the claim to be marked for retrieval.

Claim Summary Inquiry (MAP1741)



UB04 Claim Adjustment: The above message will appear at the bottom of Claim Page 01 and instructs the user to press <**F10**> to MAP1711.



Once **<F10>** is pressed, the above message will appear at the bottom of claim page 01, stating "the offline claim will be retrieved within 7 days." Press **<F3>** to return to the claim summary inquiry screen. A weekend cycle must run before the claim will appear on the system. Claims retrieved from offline status should appear the Monday following the retrieval request. The claim will be restored and available through the claim and attachment correction menu, claims summary inquiry for subsequent adjustment and/or cancellation.

Procedure for Adjusting Claims in RB9997

Purpose

Allow DDE providers to submit an adjustment on a rejected claim with non-covered charges.

- The claim being adjusted must have posted to CWF.
- The beneficiary MBI must be known.
- Providers cannot adjust a claim with an **X** in TPE-TO-TPE field. They will have to resubmit as new claim. See ADJUSTMENTS section above for steps to verify if there is an **X** in the TPE-TO-TPE FIELD.

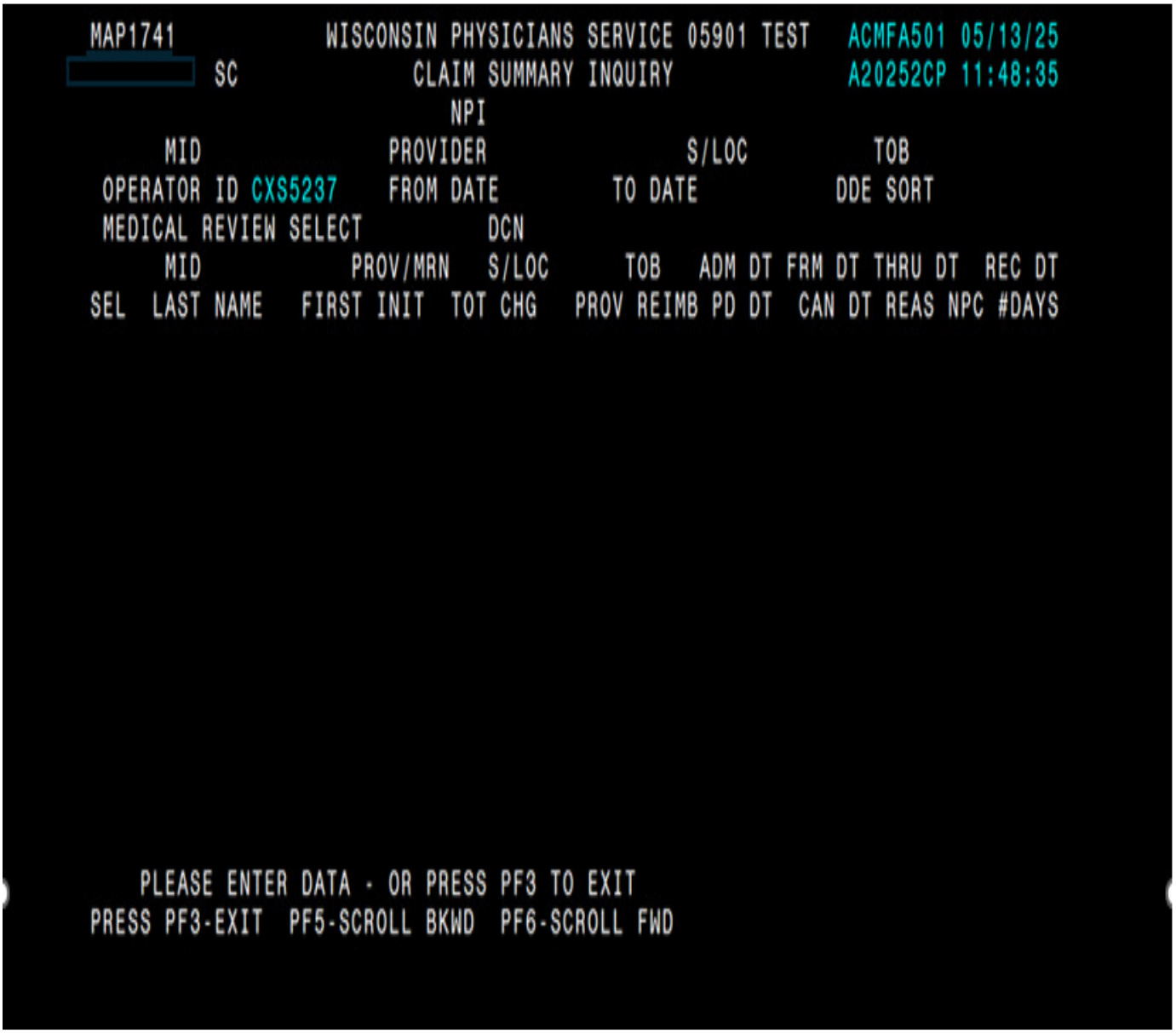
Access

From the Claims and Attachments Correction Menu, to access the Outpatient Claim Adjustments or the correct type of claim:

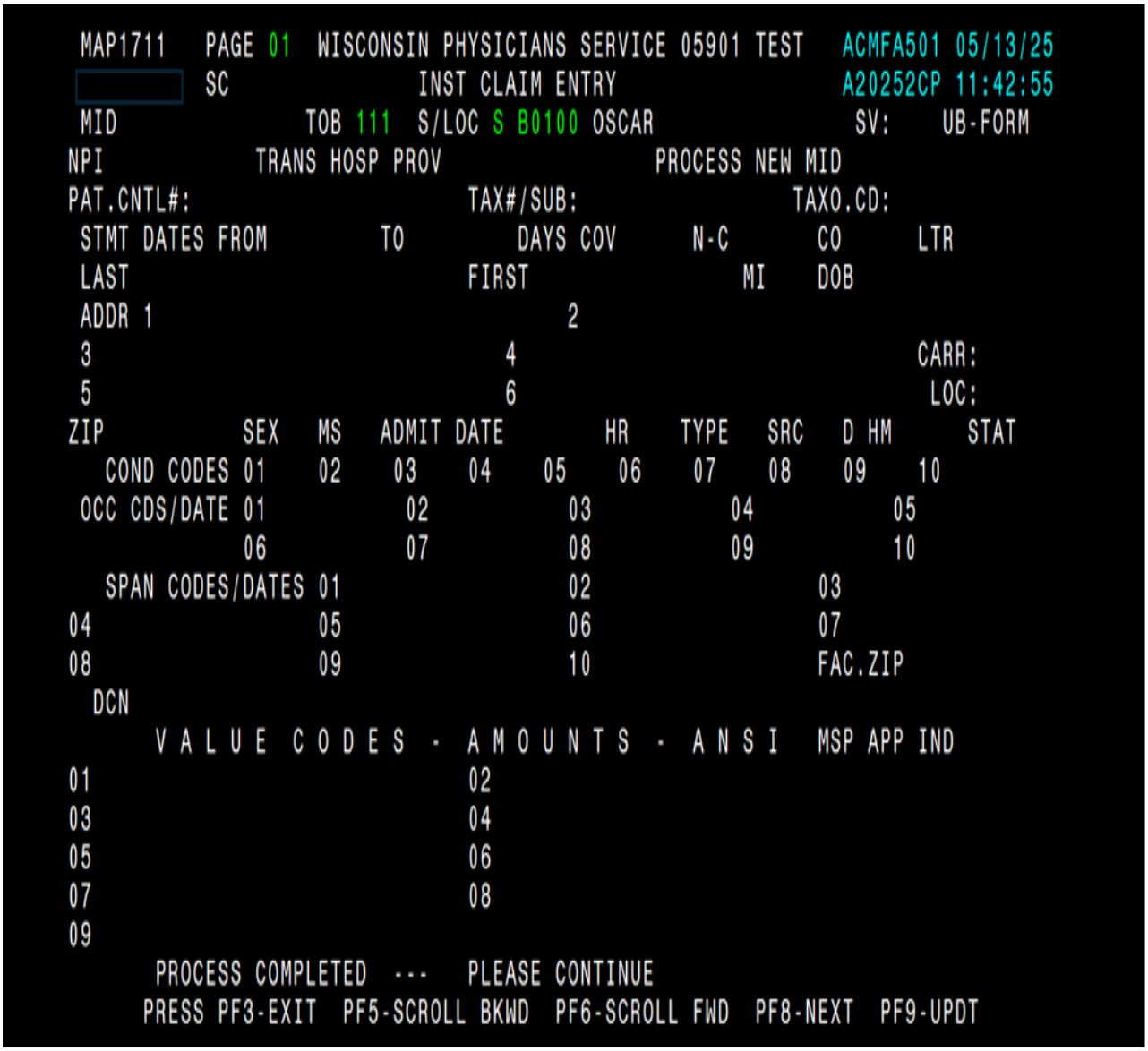
In the Enter Menu Selection field Type **31** Press <**ENTER**>.

Make the following changes on the Claim Summary Inquiry Screen:
1. Type the beneficiary MBI number
2. Type the PTAN if it is a chained provider situation.
3. Type an **R** over the **P** in the S/LOC field
4. Correct the TOB if necessary.
5. Press <**ENTER**>
   - The displayed list of claims should all be associated to the entered MBI and in RB9997 status/location.
6. Select the claim to be adjusted.
7. Proceed to adjust the claim in the normal way.

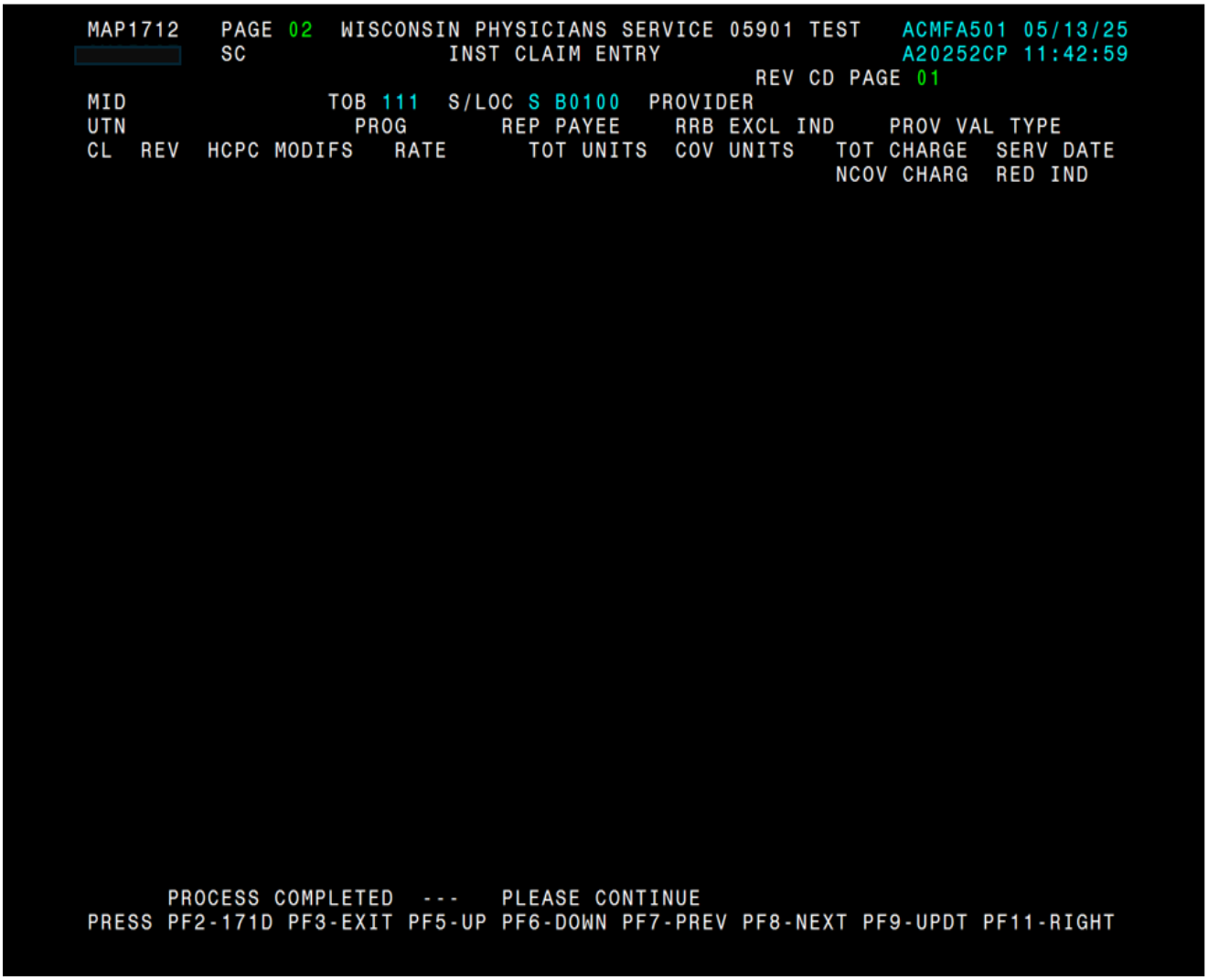
Claim Summary Inquiry (MAP1741)



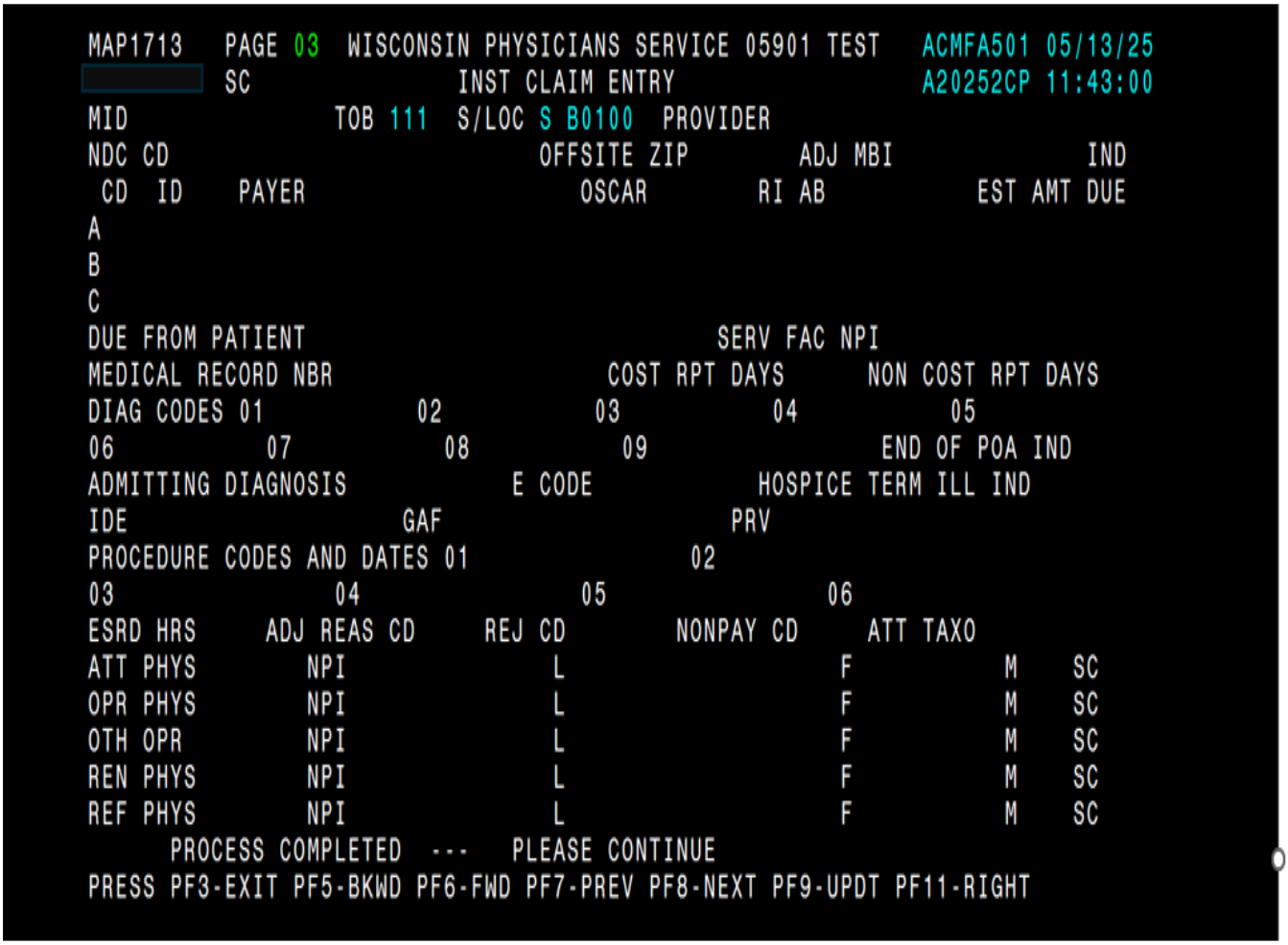
Claim Page 01



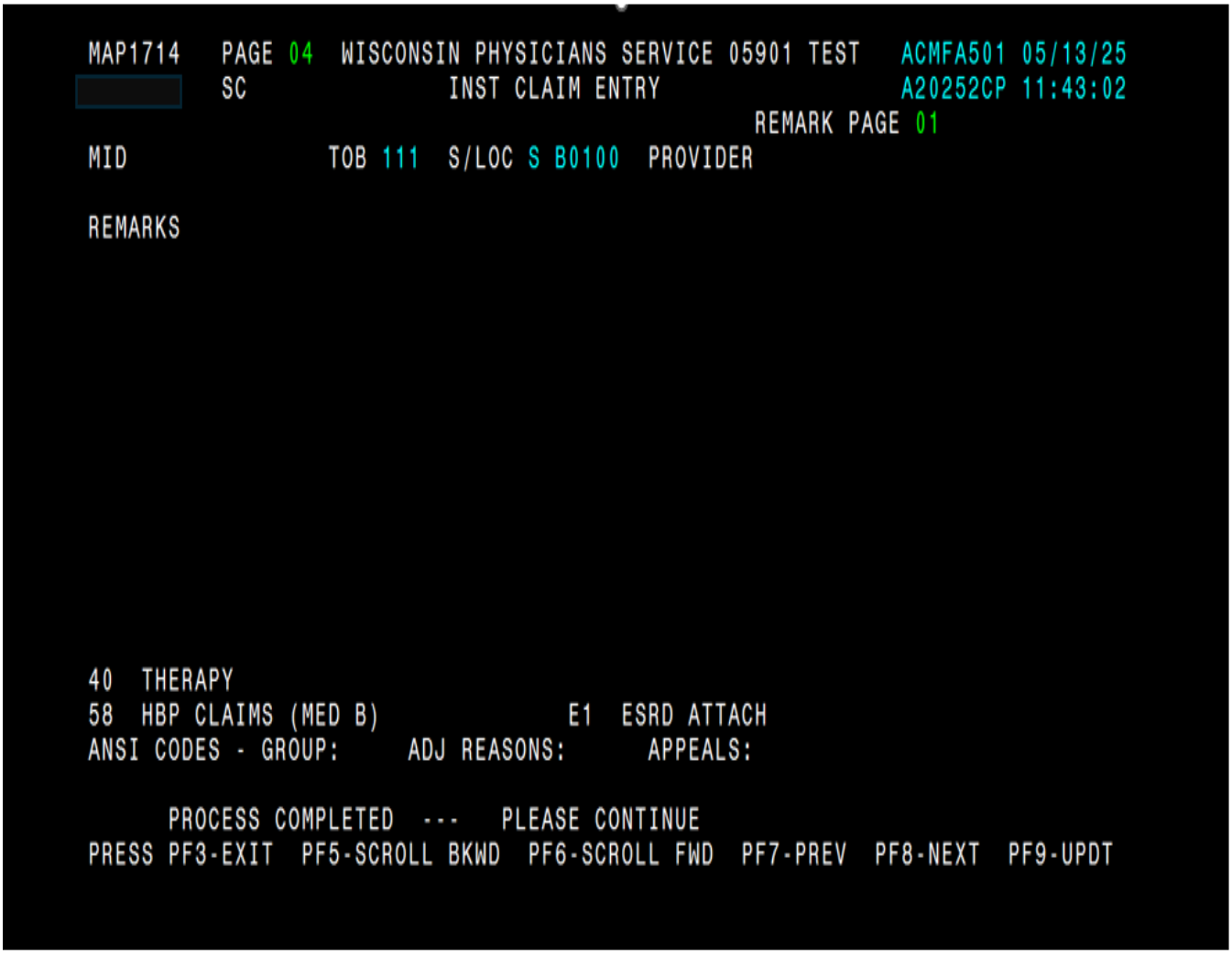
Claim Page 02



Claim Page 03



Claim Page 04



- Press **<F9>** to process the adjustment.
- The original claim (the claim you just adjusted) will no longer be available. If you attempt to retrieve the original claim, there will be a message at the bottom of the screen: "ADJUSTMENT CLAIM IS PRESENTLY CANCELED."

Cancels

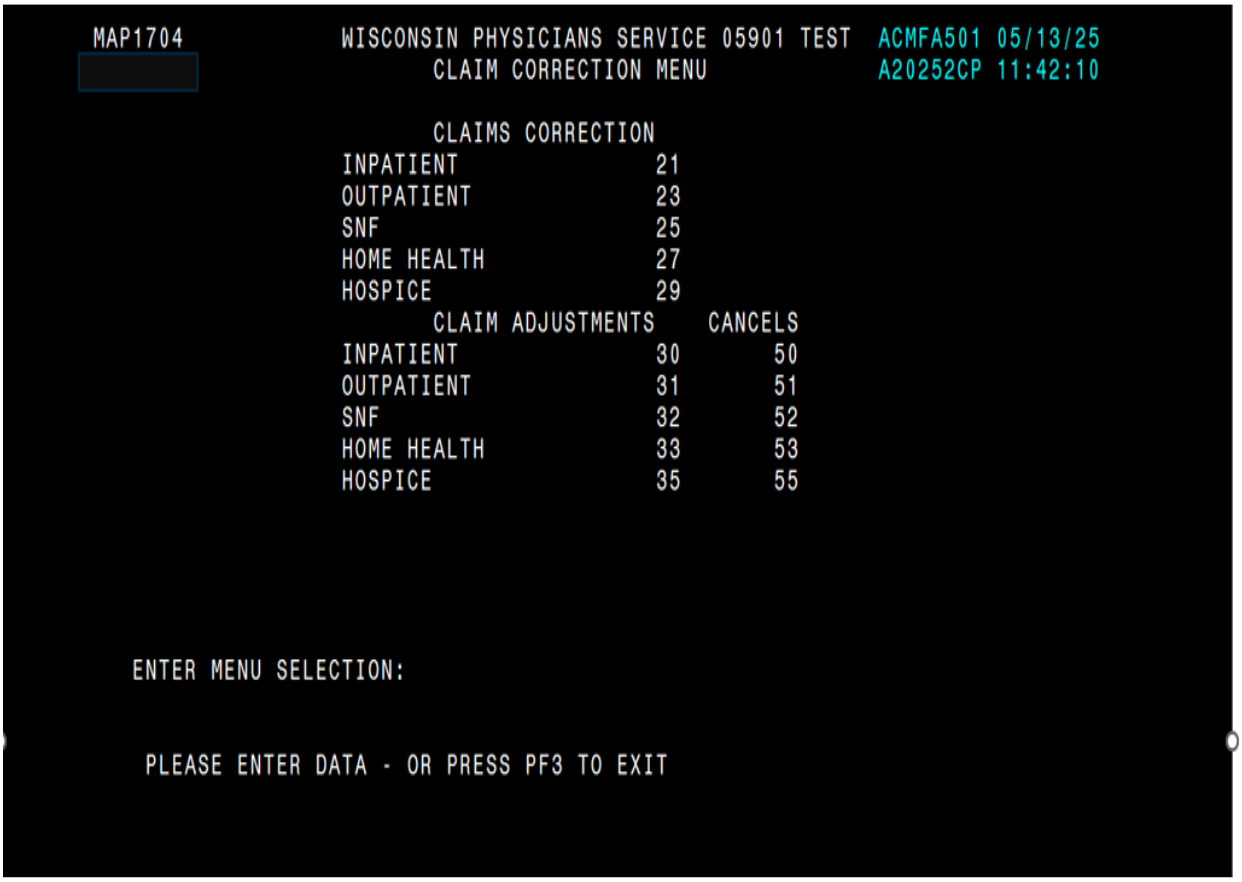
Purpose

This screen displays subsequent menu options for correcting DDE claims that have been returned due to errors, for entry of adjustment claims and entry of attachments for suspended claims.

Access

From the Claims and Attachments Correction Menu, to access the Inpatient Claims Cancels: In the Enter Menu Selection field, Type **50,** Press <**ENTER**>.

Claim and Attachments Correction Menu (MAP1704)



Using the Claim Cancels option, providers can cancel previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter **P** and is recorded on the claim status inquiry screen. Providers need to follow the guidelines of timely filing.

A claim cannot be canceled unless it has been finalized and is reflected on the remittance advice. The claim must be in a status location of P B9997 or P 09998. Claims that are in status location P B9996 should not be canceled.

Providers must be very careful when creating cancel claims. If you go into the adjustment system and update a claim without making the right corrections, the cancel will still be created and process through the system. Errors could cause payment to be taken back unnecessarily.

In addition, once a claim has been canceled, no other processing can occur on that bill.

- All bill types can be canceled except one that has been denied with full or partial medical denial.
- Do not cancel TOBs **XXP** (QIO adjustments), **XXI** (Intermediary Adjustments), **XXK** (OIG Adjustments), or **XXH** (CERT or RA adjustments).
- Do not cancel claims involving MSP; these claims have to be adjusted as an **XX7**.

Claim Change Condition Codes
An Adjustment condition code is needed to indicate the primary reason for initiating an on-line claim cancel.

D5 ***Cancel only to correct an MBI or provider identification number **D6* Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).

On-Line Claims Cancels (Type of Bill XX8) – Processing Tips
Select the option under Claim Cancel for the type of claim to be canceled and press <**ENTER**>.

INPATIENT 50
OUTPATIENT 51
SNF 52
HOME HEALTH 53
HOSPICE 55

End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Outpatient Rehabilitation Facilities (ORFs) will need to select the outpatient option and then change the TOB. By doing this, paid claims for your particular facility will appear.

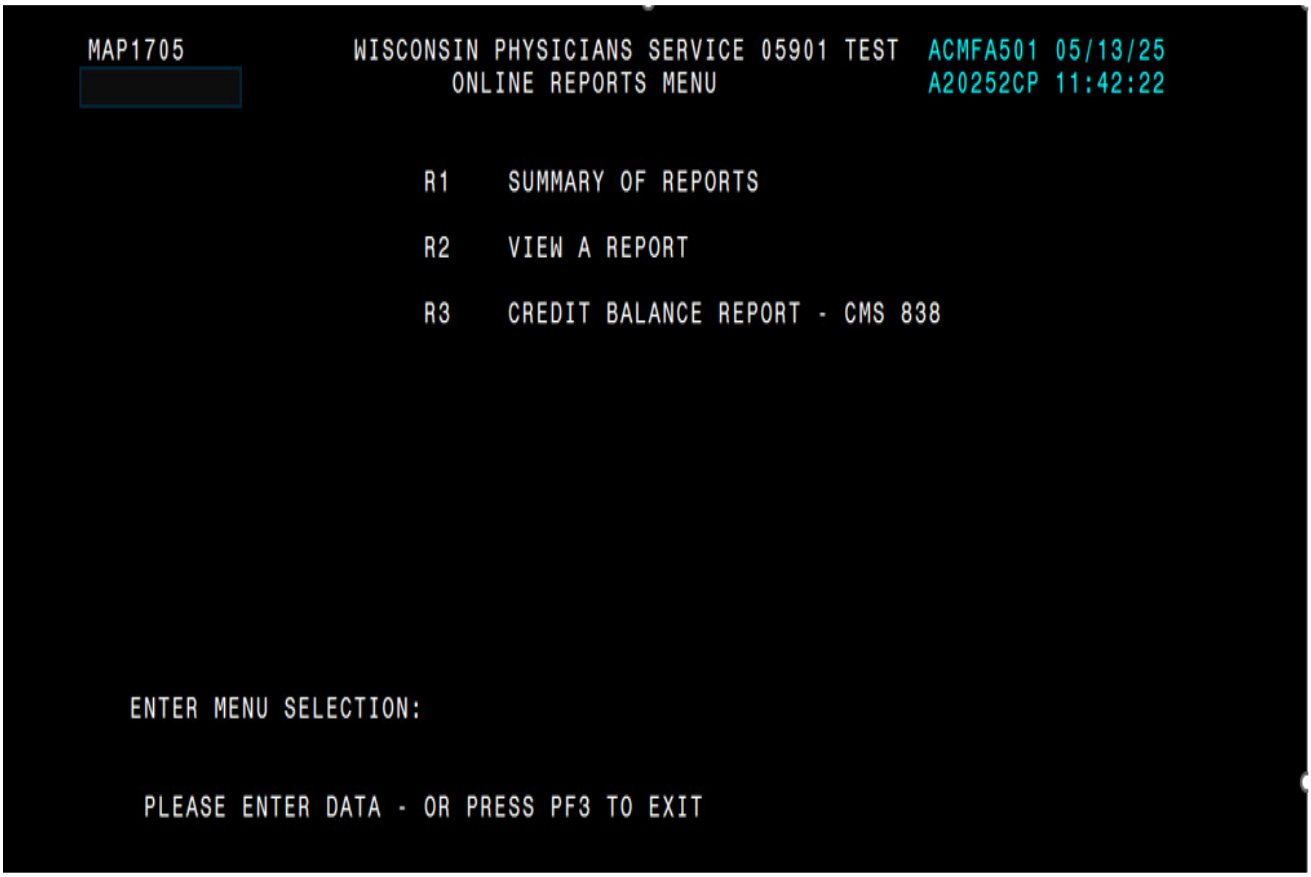
Claim Summary Inquiry

- To access the claim to be canceled, key the NPI, MBI and the From and To dates of service and press <**ENTER**>.
- Select the claim to be canceled by moving the cursor to the **SEL** field beside the first line of the claim. Type an **S** and press <**ENTER**>.
- Indicate why you are canceling the claim by entering the claim change condition code, on Page 01 of the claim.
  - The MBI number field is now protected and may no longer be changed.
- Indicate the reason for the cancel in the remarks section on Page 04 of the claim.
- To exit without transmitting the adjustment, press <**F3**>.
- Press <**F9**> to update/enter the cancel claim into DDE for reprocessing and payment retraction.

Claim Cancel Action/Recourse

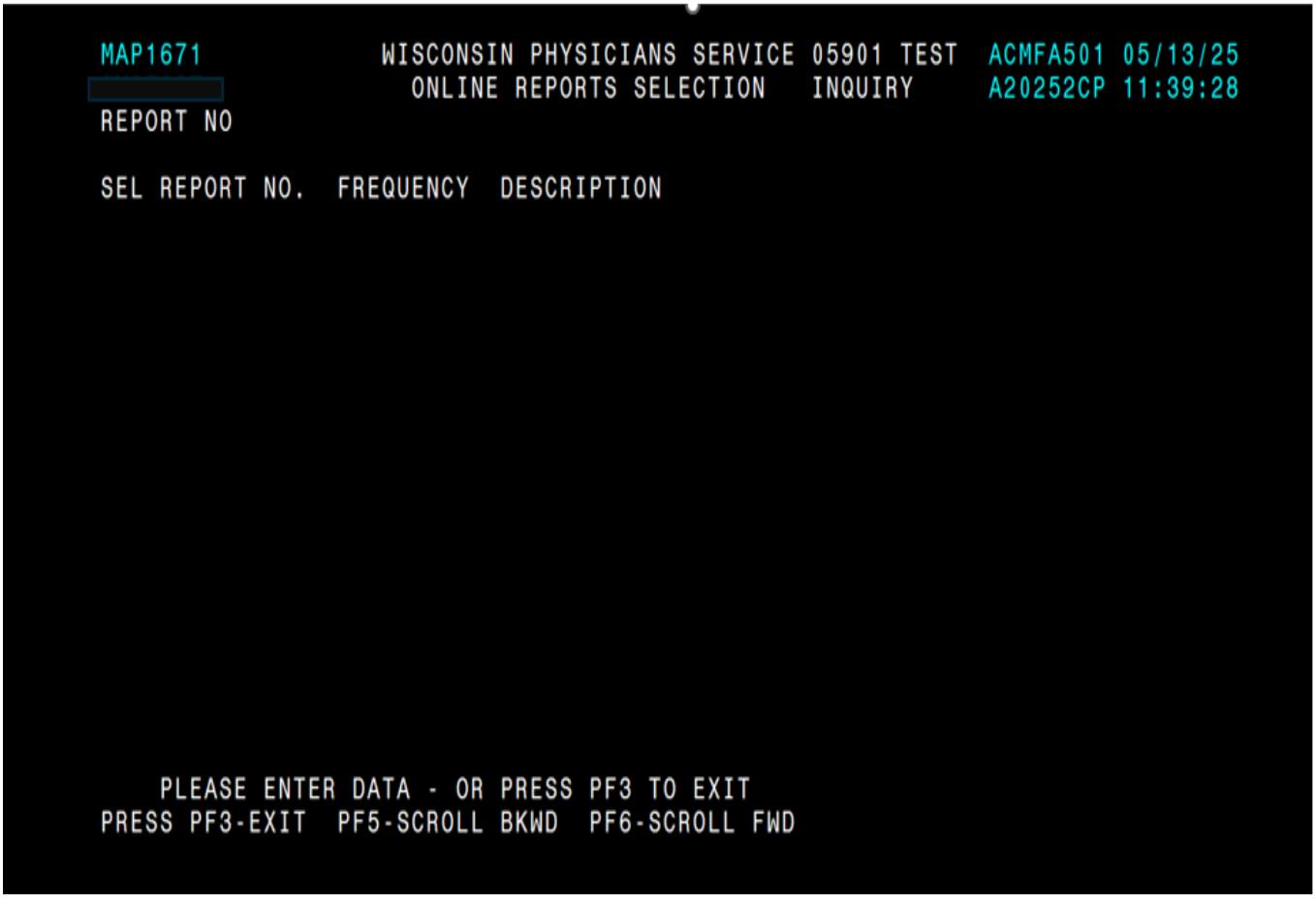
- Providers may not reverse a cancel. Errors will cause payment to be taken back by the MAC..
- Providers cannot cancel an MSP claim.
- Providers should add Remarks, Claim Page 04, to document the reason for the cancel.
- Cancels do not appear on provider weekly monitoring reports; therefore, use the Claim Summary Inquiry to follow the status/location of a cancel.
- The provider should check the remittance advice to assure the claim canceled properly.
- Providers should not cancel a claim that is in **P B9996**, as the claim has not been reflected on the Remittance advice. Doing so will delay the processing of the cancel.

Chapter 5: On-Line Reports View



Summary of Reports-R1

Select R1 from the On-Line Reports Menu and **<ENTER>** and MAP1671 will appear



The most frequently viewed provider reports are the 028, 050, 201, and 316.

028- Provider Submission Reports – daily and monthly summary of submitted claims by type of bill.

050 -The Claims Returned to Provider Report lists the claims that are being returned to the provider for correction. The claims on the report are in status/location **T B9997**. The main difference between this report and the 201 is it contains the **description** of the Reason Code(s) for the claim being returned.

201 -The Pending, Processed, and Returned Claims Report lists claims that are pending claims returned to the provider for correction and claims processed, but not necessarily shown as paid on a remittance advice. This report will **exclude** Medicare Choices, ESRD Managed Care and plan submitted HMO (Encounter) claims.

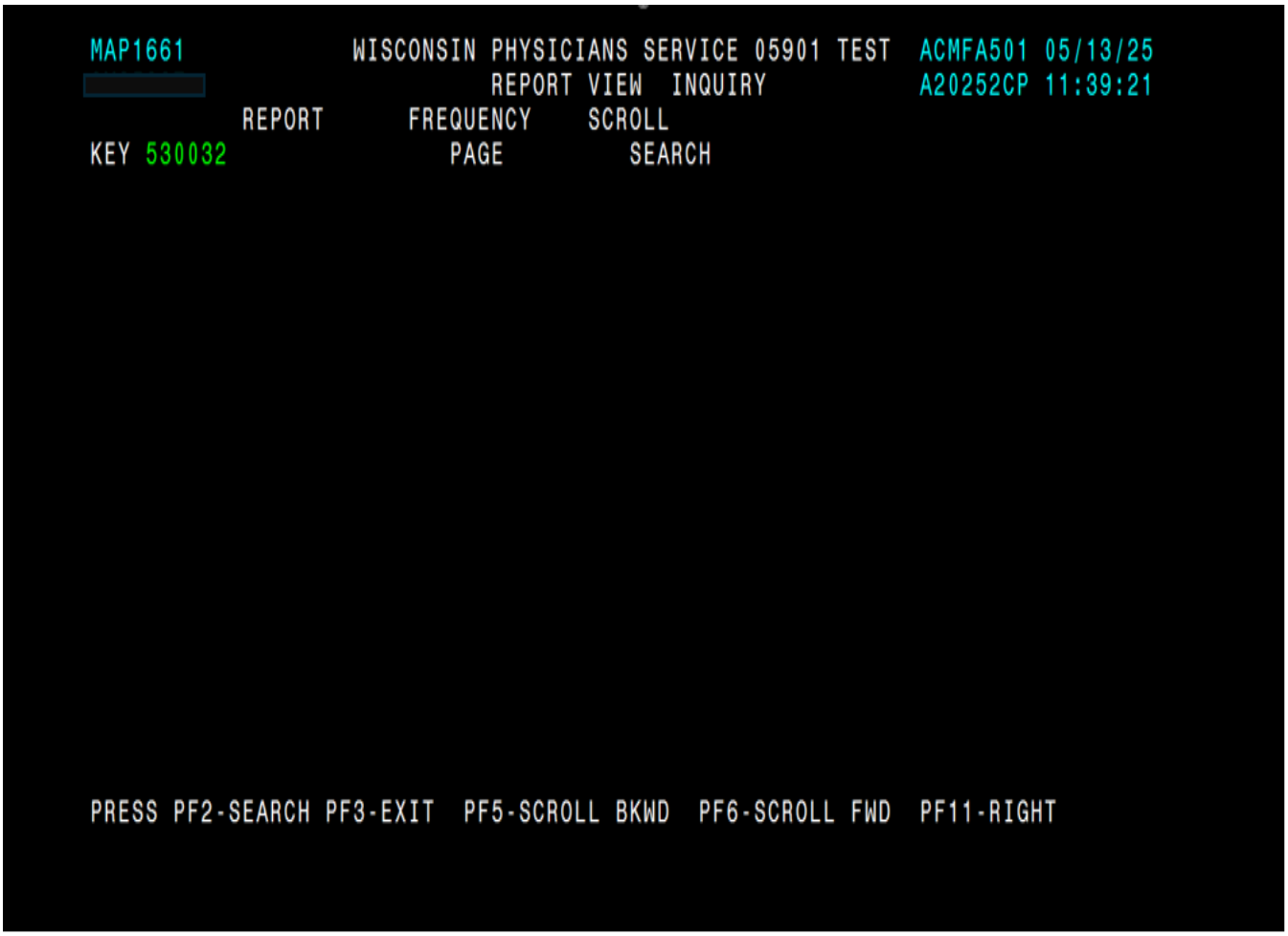
316 -The Errors on Initial Bills Report is a listing, by provider, of errors received on new claims (claims which were entered into the system for the present cycle.)

Field Name	Description
REPORT NO	**Report Number -** Type in the desired report to view on-line.
SEL	**Selection -** This field is used to select the report to be viewed. Type an S before the desired report to be viewed.
REPORT NO	**Report Number -** Three-digit alphanumeric field indicating the report number.
FREQUENCY	**Frequency -** Nine-digit alphanumeric field reflecting the frequency of the report. Valid values: Daily Weekly Monthly
DESCRIPTION	**Description -** This field identifies the name or title of the report.

View A Report Inquiry Screen-R2

Reports 028, 050, 201 and 316 appear on the MAP1661. Type in selection criteria and press **<ENTER>.** This information will be the same information that would have appeared if the report had been selected through MAP1671.

REPORT-This field identifies the number of the report. Type in the desired report to view on-line.
FREQUENCY-Reflects how often the report is generated. Valid values are: 'D' = Daily 'W' = Weekly 'M' = Monthly.
SCROLL- This field is used to scroll to the left or right sides of the report.
KEY-This field reflects the key or sort field for the selected report.
PAGE-This field identifies the page number of the report being viewed.
SEARCH- This field searches for a specific field name or value



The following Header Record fields appear on every page of the reports

Field	Description
REPORT	**Report Number -** Three-digit numeric field that identifies the unique number assigned to the Claims Returned to Provider report.
SCROLL	**Scroll -** Used to move left or right in the on-line report by using <F11> to move right and <F10> to move left.
KEY	**Key -** PTAN.
SEARCH	**Search -** Allows searching for specific information contained in report fields by using <F2>.
REPORT	**Report Number -** Three-digit numeric field that identifies the unique number assigned to the Claims Returned to Provider report.

PAGE	**Page Number -** Three-digit numeric field that identifies the specific page within the report.
CYCLE DATE	**Cycle Date -** Six-digit numeric field that identifies the production cycle date in MMDDYY format.
FREQUENCY	**Frequency -** Nine-digit alphanumeric field that identified the frequency the report is run.
PROVIDER	**PTAN -** 13-digit alphanumeric field that identifies the facility that rendered services for the claims being returned.
NPI	**NPI Number –** Ten-digit unique provider identifier

050 Report-Claims Returned to Provider

This report lists the claims that are being returned to the provider for correction. The claims on the report are in status/location **T B9997**. Primarily used by providers who are not on DDE to identify the Reason Code(s) for the returned claims. This report includes the Reason Code(s) by number and narrative.

RUN TIME	**Run Time -** Four-digit field that identifies the time of the production cycle that produced the reports.
FOR PROVIDER	**For Provider -** 31-digit alphanumeric field that identifies the provider name and address for report remittance. This information is taken from the Provider File and is a total of four lines of 31 characters each.
MBI/CERT/SSNO	Medicare Beneficiary Identifier (MBI) - 11-digit alphanumeric field that identifies the MBI submitted by the provider for the beneficiary listed in the name field.
PCN/DCN	**Document Control Number** - 23-digit alphanumeric field that identifies the returned claim.
TYPE OF BILL	**Type of Bill -** Three-digit numeric field that identifies the type of facility, type of care, source, and frequency of this claim in a particular period of care.
PROVIDER	**PTAN -** 13-digit alphanumeric field that identifies the facility listed on the claim.
NAME	**Beneficiary Name -** 31-digit alphanumeric field that lists the last and first name as submitted by the provider of the patient who received the services.
ADMIT DATE	**Admit Date** - Six-digit numeric field that identifies the date (in MMDDYY format) the beneficiary was admitted for inpatient services or the beginning of the outpatient, home health, or hospice services.
COV FM	**Covered From Date** - Six-digit numeric field that identifies the beginning date (in MMDDYY format) of services rendered to the beneficiary as indicated on the claim.
COV TO	**Covered To Date** - Six-digit numeric field (in MMDDYY format) that identifies the ending date of services rendered to the beneficiary as indicated on the claim.
TOTAL CHGS	**Total Charges** - Nine-digit field that displays the total charges as submitted by the provider in X,XXX,XXX.XX format.
REASON CODE	**Reason Code** - Five-digit alphanumeric field that displays the reason code(s) for the returned claim.
REASON CODE NARRATIVE	**Reason Code Narrative** - 77-digit alphanumeric field that displays the reason code(s) narrative for the returned claim. There is a maximum of 150 occurrences for each reason code/narrative.
TOTAL RETURNED CLAIMS	**Total Returned Claims** - Seven-digit field that identifies the total number of reported claims being returned to the provider listed in the provider field in X,XXX,XXXX format.
TOTAL RETURNED CHARGES	**Total Returned Charges -** 11-digit field that identifies the total amount of charges for claims returned to the provider listed in the PTAN field in XXX,XXX,XXX.XX format.

201 Report-Pended, Processed and Returned Claims

Users may search for specific detail from the **Search** field, <F2>. Search criteria can include name (last or first), MBI, dates, type of claim, etc.

The search takes place from the current cursor position down.

201 Summary of Pended Inpatient Claims

Field	Description
TITLE OF REPORT	**Title of Report** - Report title changes as the user cycles through the available types of bill (e.g., Pending, Processed, or Returned).
BLUE CROSS	**Blue Cross Code** - 13-digit field that identifies the Blue Cross Blue Shield (BCBS) identification number assigned to a particular provider/ facility.
TYPE OF CLAIM	**Type of Claim** - This field identifies the type of claim being reflected on the report, e.g., Inpatient/Outpatient/Lab/Other.
NAME	**Name -** Beneficiary's Last Name/First Name.
MED REC NUMBER	**Medical Record Number** - Unique number assigned to the beneficiary at the medical facility.
MBI	**Medicare Beneficiary Identifier** - 11-digit alphanumeric field that identifies the unique number assigned to the beneficiary by CMS. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	**Received Date** - Six-digit numeric field in MMDDYY format that identifies the date on which the Intermediary received the claim from the provider.
ADMIT DATE	**Admit Date** - Six-digit numeric field that identifies the date the patient was admitted to the provider for inpatient care, outpatient service, or start of care in MMDDYY format.
PROVIDER NUMBER	**PTAN** - 6-digit numeric field that identifies the Medicare provider rendering services to the beneficiary.
FROM DATE	**From Date** - Six-digit numeric field that identifies the beginning date of service for the period included on the claim in MMDDYY format.
THRU DATE	**Thru Date** - Six-digit numeric field that identifies the ending date of service for the period included on the claim in MMDDYY format.
ADJ IND	**Adjustment Indicator** - This field indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank. TOB frequency code, Description, FISS Transaction Type (FTT) and Record sent to Financial (RF) 7-Provider Submitted Debit FTT-D RF-7-Debit, 8-Credit 8-Provider Submitted Cancel FTT-C RF- 8-Credit 9- System Generated Debit (HHPPS) FTT-D RF-9-Debit/Credit F-Intermediary Submitted Bene Debit/Credit FTT- D,C RF-F-Debit, 8-Credit, F-Cancel G-Intermediary Submitted CWF Debit/Credit FTT-D,C RF-G-Debit, 8-Credit, G-Cancel H-Intermediary Submitted HCFA Debit/Credi FTT-D,C RF-H-Debit, 8-Credit, H-Cancel

	I-Intermediary Submitted Intermediary Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, I-Cancel J- Intermediary Submitted Other Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, J-Cancel K- Intermediary Submitted OIG Debit/Credit FTT-D,C RF-K-Debit, 8-Credit, K-Cancel M- Intermediary or Provider Submitted MSP Debit/Credit FTT-D,C RF-M-Debit, 8-Credit, M-Cancel Q-Provider Submitted Debit (Request for Reopening) FTT-D RF-7-Debit, 8-Credit
LAST TRAN	**Last Transaction** - Six-digit numeric field that identifies the date of the most recent transaction on this claim in MMDDYY format.
SUB IND	**Submission Indicator** - One-digit alphanumeric field that identifies the mode of submission of the claim. If the Uniform Bill Code (UBC) is a 7 or 8 (hard copy indicator), this will be a P (paper claim); otherwise, it will contain an A (automated claim).
SUSP TYPE	**Suspense Type** - Four-digit alphanumeric field that identifies the suspense location where the claim resides within the system. Valid values: **MED (Medical) - Location code positions 2 & 3 is 50 MSP (MSP)** - Location code positions 2 & 3 is 80 or 85 CWFR - Location code positions 2 & 3 is 90 (CWF Regular) - Location code position 4 IS NOT B, F, J, L, or M CWFD - Location code positions 2 & 3 is 90 (CWF Delayed) Location code position 4 is B, F, J, L, or M SUSP (Suspense) Any suspended claim (Status S) that does not fall into any of the categories listed above.
TOTAL CHARGES	**Total Charges** - This field reflects total charges by beneficiary line item.
ADS	**Addition Development System** - This field identifies if the claim has been to or currently resides in ADR. If Location code positions 2 & 3 have ever equaled 60, this field will contain a Y; otherwise, it will be blank.
PAT CONTROL NBR	**Patient Control Number** - Unique number assigned to the beneficiary at the medical facility.
ADS REASON CODES	**ADS Reason Codes** - This field identifies contains up to ten five-digit reason codes requesting specific information from the provider on claims for which the ADS indicator is Y.
(MED) MEDICAL	**Medical -** This field identifies the total charges of the medical suspense category. Location code positions 2 & 3 is 50.
(MSP) MSP	**Medicare Secondary Payer** - This field identifies the category heading identifying counts, by type of bill, of adjustment records meeting the following criteria: Adjustment requester ID – H (hospital) or F (Fiscal Intermediary), and the adjustment reason code – AU, BL, DB, ES, LI, VA, WC, or WE. Location code positions 2 & 3 is 80 or 85.
(CWFR) CWF REFULAR	**CWF Regular** - This field identifies the total charges of the CWF category. Location code positions 2 & 3 is 90. Location code position 4 IS NOT B, F, J, L, or M.
(CWFR) CWF DELAYED	**CWF Delayed** - This field identifies the total charges of the CWF category. Location code positions 2 & 3 is 90, Location code position 4 IS B, F, J, L, or M.

(SUSP) SUSPENSE	**Suspense** - This field identifies the total charges of all suspended claims (Status – S), which do not fall into any of the other listed categories, e.g., MED, MSP, CWFR, CWFD.
CLAIMS COUNT	**Claims Count** - This field identifies the total number of claims pending (not processed) at the end of the processing cycle for this provider.
TOTAL CHARGES	**Total Charges** - This field identifies the total charges by suspense category for pending claims or adjustments at the end of the processing cycle.
ADJUSTMENTS COUNT	**Adjustments Count** - This field identifies by suspense category the total number of adjustments pending (not processed) at the end of the processing cycle for this provider.
TOTAL CHARGES	**Total Charges** - This field identifies by suspense category the total charges for pending claims or adjustments at the end of the processing cycle.

Screen 201 Summary of Processed Inpatient Claims

Field Name	Description
TITLE OF REPORT	**Title of Report** - Report title changes as the user cycles through the available types of bill (e.g., Pending, Processed, or Returned.)
BLUE CROSS CODE	**Blue Cross Code** - 13-digit field that identifies the Blue Cross Blue Shield (BCBS) identification number assigned to a particular provider/facility.
TYPE OF CLAIM	**Type of Claim** - This field identifies the type of claim being reflected on the report, e.g., Inpatient/Outpatient/Lab/Other.
NAME	**Name** - Beneficiary's Last Name/First Name.
MED REC NUMBER	**Medical Record Number** - Unique number assigned to the beneficiary at the medical facility.
MBI	**Medicare Beneficiary Identifier** - 11-digit alphanumeric field that identifies the unique number assigned to the beneficiary by CMS. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	**Received Date** - Six-digit numeric field that identifies the date on which the Intermediary received the claim from the provider.
ADMIT DATE	**Admit Date** - Six-digit numeric field that identifies the date the patient was admitted to the provider for inpatient care, outpatient service, or start of care (in MMDDYY format).
PROVIDER NUMBER	**PTAN** - Six-digit numeric field that identifies the Medicare provider rendering services to the beneficiary.
FROM DATE	**From Date** - Six-digit numeric field that identifies the beginning date of service (in MMDDYY format) for the period included on the claim.
THRU DATE	**Thru Date** - Six-digit numeric field that identifies the ending date of service (in MMDDYY format) for the period included on the claim.
ADJ IND	**Adjustment Indicator** - This field indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank. TOB frequency code, Description, FISS Transaction Type (FTT) and Record sent to Financial (RF) 7-Provider Submitted Debit FTT-D RF-7-Debit, 8-Credit

	8-Provider Submitted Cancel FTT-C RF- 8-Credit 9- System Generated Debit (HHPPS) FTT-D RF-9-Debit/Credit F-Intermediary Submitted Bene Debit/Credit FTT- D,C RF-F-Debit, 8-Credit, F-Cancel G-Intermediary Submitted CWF Debit/Credit FTT-D,C RF-G-Debit, 8-Credit, G-Cancel H-Intermediary Submitted HCFA Debit/Credi FTT-D,C RF-H-Debit, 8-Credit, H-Cancel I-Intermediary Submitted Intermediary Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, I-Cancel J- Intermediary Submitted Other Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, J-Cancel K- Intermediary Submitted OIG Debit/Credit FTT-D,C RF-K-Debit, 8-Credit, K-Cancel M- Intermediary or Provider Submitted MSP Debit/Credit FTT-D,C RF-M-Debit, 8-Credit, M-Cancel Q-Provider Submitted Debit (Request for Reopening) FTT-D RF-7-Debit, 8-Credit
PAID	**Paid Date** – Six-digit numeric field that identifies the date (in MMDDYY format) the claim was paid or rejected.
CLEAN IND	**Clean Indicator** - One-digit alphanumeric field that identifies whether or not the processed claim was clean. Valid values: A - PIP other B - PIP clean C - Non-PIP other D - Non-PIP clean E - Additional information was requested (Non-PIP reimbursement) F - Additional information was requested (PIP reimbursement) G - A reply has been received from CWF providing a date of death. The date of death is prior to or overlaps the dates of service on the claim; therefore, development was required in order to process the claim (Non-PIP reimbursement). I - A non-definitive response was received from CWF requiring development (Non-PIP reimbursement). J - A non-definitive response was received from CWF requiring development (PIP reimbursement). K - A definitive response was not received from CWF within seven days (delayed response, Non-PIP reimbursement). L - A definitive response was not received from CWF within seven days (delayed response, PIP reimbursement).

	M - The claim was manually set to Non-Clean (non-PIP). This will only occur in rare situations such as a claim-required development external to the Intermediary's operation (Non-PIP reimbursement). N - The claim was manually set to Non-Clean (PIP).This will only occur in rare situations such as a claim-required development external to the Intermediary's operation (PIP reimbursement). O - The claim is a sequential claim in which the prior claim was pending and was determined "other" (Non-PIP reimbursement). P - The claim is a sequential claim in which the prior claim was pending and was determined "other" (PIP reimbursement).
REJECT CODE	**Reject Code** – Five-position alphanumeric field that identifies the reason code, for a specific error reason condition, existing. The first position indicates the type and location of the reason code. Valid values: A- Consistency Edits B- Reserved for future use C- Fiscal Intermediary Standard System D- File maintenance E- Medical Review F- Post payment 7-Site Specific (non-medical) A-Z – CWF (except W) W- OCE/MCE and Grouper Positions 2-5 indicate either a file or application error. If position 2 contains an alpha character, it is file related; otherwise, it is application related.
PAT CONTROL NBR	**Patient Control Number** - Unique number assigned to the beneficiary at the medical facility.
TOTALS	**Totals** - This field identifies the total counts of claims paid, rejected, and adjusted.
PAID CLAIMS	**Paid Claims** - Identifies the total number of claims paid (claim status of (P) during this reporting period.
REJECTED CLAIMS	**Rejected Claims** - This field identifies the number of finalized claims rejected (claim status is not equal to P) due to non-covered services, duplicates, etc., during this report period.
PAID ADJUSTMENTS	**Adjustments Paid** - This field identifies the total number of adjustments paid during this reporting period for records with an adjustment status of P.
REJECTED ADJUSTMENTS	**Adjustments Rejected** - This field identifies the total number of adjustments rejected (adjustment status is not P) during this reporting period for finalized records.
PROCESSED	**Processed** - This field identifies the total number of claims and adjustments processed by type of bill category.
INP	**Inpatient Claims** - This field identifies the number of final pending inpatient Claims/adjustments with a type of bill 11X or 41X.
OTP	**Outpatient Claims** - This field identifies the number of final pending outpatient claims/ adjustments with a type of bill 13X, 23X, 43X, 53X, 73X, or 83X.
SNF	**Skilled Nursing Facility Claims** - This field identifies the number of final processed SNF claims/adjustments with a type of bill 18X, 21X, 28X, or 51X.

HHA	**Home Health Claims** - This field identifies the number of final processed HHA claims/adjustments with a type of bill 32X, 33X, or 34X**.**
HOSPICE	**Hospice Claims** - This field identifies the number of final processed Hospice claims/adjustments with a type of bill 81X or 82X.
CORF	**Comprehensive Outpatient Rehabilitation Facility** - This field identifies the number of final processed CORF claims/adjustments with a type of bill 75X.
ESRD	**End Stage Renal Disease Attachment -** This field identifies the number of final processed ESRD claims/adjustments with a type of bill of 72X.
LAB	**Laboratory** - This field identifies the number of final processed laboratory claims/adjustments with type of bill 14X or 24X.
OTHER	**Other** - This field identifies the number of processed claims/adjustments for all types of bill except: 11X, 13X, 14X, 18X, 21X, 23X, 24X, 28X, 32X, 33X, 34X, 41X, 43X, 51X, 53X, 72X, 73X, 75X, 81X, 82X, or 83X.
TOTAL	**Total** - This field identifies the combined total count of claims and adjustment counts by type of bill.
CLAIMS PAID	**Claims Paid** - This field identifies the number of claims paid (claim status is P) during this reporting period, within the indicated category.
CLAIMS REJECTED	**Claims Rejected** - This field identifies the number of claims rejected (claim status is not P) due to non-covered services, duplicates, etc., during this report period within the indicated category.
ADJUSTMENTS PAID	**Adjustments Paid** - This field identifies the number of adjustments paid (adjustment status is P) during this reporting period, within the indicated category.
ADJUSTMENTS REJECTED	**Adjustments Rejected** - This field identifies the number of adjustments rejected (adjustment status is not P) during this reporting period, within the indicated category.

Screen 201-Summary of Returned Inpatient Claims

Field Name	Description
TITLE OF REPORT	**Title of Report** - Report title changes as the user cycles through the available types of bill (e.g., Pending, Processed, or Returned.)
BLUE CROSS CODE	**Blue Cross Code -** 13-digit field that identifies the BCBS identification number assigned to a particular provider/facility.

TYPE OF CLAIM	**Type of Claim** - This field identifies the type of claim being reflected on the report, e.g., Inpatient/Outpatient/Lab/Other.
NAME	**Name** - Beneficiary's Last Name/First Name.
MED REC NUMBER	**Medical Record Number** - Unique number assigned to the beneficiary at the medical facility.
MBI	**Medicare Beneficiary Identifier** - 11-digit alphanumeric field that identifies the unique number assigned to the beneficiary by CMS. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	**Received Date** - Six-digit numeric field that identifies the date on which the Intermediary received the claim from the provider.
ADMIT DATE	**Admit Date** - Six-digit numeric field that identifies the date the patient was admitted to the provider for inpatient care, outpatient service, or start of care (in MMDDYY format).
PROVIDER NUMBER	**PTAN** - Six-digit numeric field that identifies the Medicare provider rendering services to the beneficiary.
FROM DATE	**From Date** - Six-digit numeric field that identifies the beginning date of service (in MMDDYY format) for the period included on the claim.
THRU DATE	**Thru Date** - Six-digit numeric field that identifies the ending date of service (in MMDDYY format) for the period included on the claim.

ADJ IND	**Adjustment Indicator** - This field indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain and asterisk, otherwise it will be blank. **Adjustment Indicator** - This field indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank. TOB frequency code, Description, FISS Transaction Type (FTT) and Record sent to Financial (RF) 7-Provider Submitted Debit FTT-D RF-7-Debit, 8-Credit 8-Provider Submitted Cancel FTT-C RF- 8-Credit 9- System Generated Debit (HHPPS) FTT-D RF-9-Debit/Credit F-Intermediary Submitted Bene Debit/Credit FTT- D,C RF-F-Debit, 8-Credit, F-Cancel G-Intermediary Submitted CWF Debit/Credit FTT-D,C RF-G-Debit, 8-Credit, G-Cancel H-Intermediary Submitted HCFA Debit/Credi FTT-D,C RF-H-Debit, 8-Credit, H-Cancel I-Intermediary Submitted Intermediary Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, I-Cancel J- Intermediary Submitted Other Debit/Credit FTT-D,C RF-I-Debit, 8-Credit, J-Cancel K- Intermediary Submitted OIG Debit/Credit FTT-D,C RF-K-Debit, 8-Credit, K-Cancel M- Intermediary or Provider Submitted MSP Debit/Credit FTT-D,C RF-M-Debit, 8-Credit, M-Cancel
RTP DATE	**Returned to Provider Date -** Six-digit numeric field that identifies the date the claim or adjustment was returned to the provider, in MMDDYY format.
PAT CONTROL NBR	**Patient Control Number** - Unique number assigned to the beneficiary at the medical facility.
REASON CODES	**Returned to Provider Reason Codes** - This field identifies the return reason codes from the claim record. There will be up to ten five-position codes per claim reported.

TOTALS	**Totals** - This field identifies the total counts of claims paid, rejected, and adjusted returned to the provider.
CLAIMS	**Claims Count** - This field identifies the count of claims returned to the provider.
ADJUSTMENTS	**Adjustments** - This field identifies the count of adjustments returned to the provider.

Screen 201-Claims Summary Totals

Field Name	Description
TITLE OF REPORT	**Title of Report** - Report title changes as the user cycles through the available types of bill (e.g., Pending, Processed, or Returned).
BLUE CROSS CODE	**Blue Cross Code** – 13-digit field that identifies the BCBS identification number assigned to a particular provider/facility.
PROVIDER NUMBER	**PTAN** - Six-digit numeric field that identifies the Medicare provider rendering services to the beneficiary.
INP	**Inpatient Claims** - This field identifies the number of combined pended, processed, or returned inpatient claims/adjustments with a type of bill 11X or 41X.
OTP	**Outpatient Claims** - This field identifies the number of combined pended, processed or returned outpatient claims/adjustments with a type of bill 13X, 23X, 43X, 53X, 73X, or 83X.
SNF	**Skilled Nursing Facility (SNF) Claims** - This field identifies the number of combined pended, processed, or returned SNF claims/adjustments with a type of bill 18X, 21X, 28X, or 51X.
HHA	**Home Health Agency (HHA) Claims** - This field identifies the number of combined pended, processed, or returned HHA claims/adjustments with a type of bill 32X, 33X, or 34X.
HOSPICE	**Hospice Claims** - This field identifies the number of combined pended, processed, or returned Hospice claims/adjustments with a type of bill 81X or 82X.
CORF	**Comprehensive Outpatient Rehabilitation Facility (CORF)** - This field identifies the number of combined pended, processed, or returned CORF claims/adjustments with a type of bill 75X.
ESRD	**End Stage Renal Disease (ESRD) Attachment** - This field identifies the number of combined pended, processed, or returned ESRD claims/adjustments with a type of bill of 72X.

LAB	**Laboratory** - This field identifies the number of combined pended, processed, or returned laboratory claims/adjustments with type of bill 14X or 24X.
OTHER	**Other** - This field identifies the number of combined pended, processed or returned claims/ adjustments for all types of bill except the following: 11X, 13X, 14X, 18X, 21X, 23X, 24X, 28X, 32X, 33X, 34X, 41X, 43X, 51X, 53X,72X, 73X, 75X, 81X, 82X, or 83X.
TOTAL	**Total** - This field identifies the combined recap count of claims and adjustment pended, processed, or returned to the provider during the reporting period (for all types of bills).
PENDING	**Pending** - These fields are a recap count of claims and adjustments pending at the end of this reporting period for this provider by type of bill category.
CLAIMS	**Claims** - These fields identify the count of claims pending within the indicated category.
ADJUSTMENTS	**Adjustments** - These fields identify the count of adjustments pending within the indicated category.
PROCESSED	**Processed** - These fields are a recap count of claims and adjustments processed during this reporting period, for this provider by type of bill category and by PAID/REJECTED status.
CLAIMS PAID	**Claims Paid** - These fields identify the number of processed claims paid (claim status is P) during this reporting period, within the indicated category.
CLAIMS REJECTED	**Claims Rejected** - These fields identify the number of processed claims rejected (claim status is not P) due to non-covered services, duplicates, etc., during this reporting period, within the indicated category.
ADJUSTMENTS PAID	**Adjustments Paid** - These fields identify the number of processed adjustments paid (adjustment status is P) during this reporting period, within the indicated category.
ADJUSTMENTS REJECTED	**Adjustments Rejected** - These fields identify the number of processed adjustments rejected (adjustment status is not P) during this reporting period, within the indicated category.
RETURNED	**Returned** - These fields are a recap count of claims and adjustments returned to the provider during this reporting period, for this provider by type of bill category.
CLAIMS	**Claims** - These fields identify the count of claims returned to the provider, within the indicated category.

ADJUSTMENTS	**Adjustments** - These fields identify the count of adjustments returned to the provider within the indicated category.

316 Report-Errors on Initial Bills

This report lists (by provider) errors received on new claims (claims entered into the system for the present cycle). The purpose of this report is to provide a monitoring mechanism for claims management and customer service to use in determining problem areas for providers during their claim submission process.

Field Name	Description
TITLE OF REPORT	**Title of Report** - Report title changes as the user cycles through the available types of bill (e.g., Pending, Processed, or Returned).
PROVIDER	**PTAN** - Six-digit numeric field that identifies the Medicare provider rendering services to the beneficiary.
NPI	**NPI number** - Ten-digit unique provider identifier
REASON CODE	**Reason Code** – Five Position alphanumeric field that identifies the reason code for a specific error reason condition, existing. The first position indicates the type and location of the reason code. Valid values: 1 – Consistency Edits 2 - Reserved for future use 3 - Fiscal Intermediary Standard System 4 - File maintenance 5 – Medical Review 6- Post payment 7-Site Specific (non-medical) A-Z – CWF (except W) W- OCE/MCE and Grouper Positions 2-5 indicate either a file or application error. If position 2 contains an alpha character, it is file related; otherwise, it is application related.
INPAT	**Inpatient Claims** – This column will reflect all claims/adjustments with a type of bill 11X or 41X.
SNF	**Skilled Nursing Facility Claims** - This column will reflect all SNF claims/adjustments with a type of bill 18X, 21X, 28X, or 51X.
HHA	**Home Health Claims** - This column will reflect all HHA claims/adjustments with a type of bill 32X, 33X, or 34X.
OUTPAT	**Outpatient Claims** - This column will reflect all outpatient claims/ adjustments with a type of bill 13X, 23X, 43X, 53X, 73X, or 83X.
HOSP-ESRD	**Hospital End Stage Renal Disease** - This column will reflect all claims with a type of bill 72X.
LCF-ESRD	**Long Term Care Facility End Stage Renal Disease** - This column will reflect all claims with a type of bill 72X and a PTAN greater than XX299 and less than XX2500 (XX represents the state code).
CORF	**Comprehensive Outpatient Rehabilitation Facility** – This column will reflect all CORF claims/adjustments with a type of bill 75X.
HOSPICE	**Hospice Claims** - This column will reflect all Hospice claims/ adjustments with a type of bill 81X or 82X.
ANC/OTHER	**Ancillary and Other Claims** - This column will reflect all claims with a type of bill 12X, 14X, 22X, 24X, 42X, 44X, 52X, 54X, 71X, 74X, or 79X.

TOTAL	**Total** - This column will reflect the total of all claims printed on this report for each specific Reason Code.
H/C	**Hard Copy Claims** - This column will reflect claims by bill type, which are produced on paper and submitted to the Intermediary designated by a Uniform Bill Code less than 8.
AUTO	**Automated Claims** - This column will reflect claims by bill type, which are submitted to the Intermediary in an electronic mode, designated by a Uniform Bill Code greater than 7.

Credit Balance Report Form 838-R3

Select R3 from the On-Line Reports Menu and **<ENTER>**. MAP1B21 will appear.

PROVIDER- This field displays the six-digit provider number issued by CMS.

STARTING MID- This field identifies the beneficiary/patient's Medicare number as shown on the Medicare card.
838 ENTRY- This field identifies the 838 Entry field. Valid values are: 'Y' = Yes 'N' = No Note: When this field is populated with a 'Y' the credit balance entry screen is displayed and allows the provider to enter a new record.

MID NUMBER-This field identifies the beneficiary/patient's Medicare number as shown the Medicare card.

BENEFICIARY NAME LAST FI- This field displays the beneficiary/patient's last name and the initial of the first name.

TOB- This field displays the Type of Bill for a particular period of care.

FROM DATE- Statement From Date – This field identifies the beginning date of service for the period included on the claim in MMDDYY format.

THRU DATE- Statement Through Date – This field identifies the ending date of service for the period included on the claim in MMDDYY format.

QUARTER ENDING- This field identifies the quarter ending date in CCYYMM format

Medicare eNews

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