WPS Government Health Administrators Portal User Manual

WPS Government Health Administrators http://www.wpsgha.com

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

September 2023

WPS GOVERNMENT HEALTH ADMINISTRATORS

Introduction

WPS Government Health Administrators Portal Overview

The WPS Government Health Administrators Portal ("the portal") is a comprehensive and secure alternative to obtain Medicare patient eligibility and claim status and perform various claim-related transactions. Partnered with the Centers for Medicare & Medicaid Services (CMS), which governs the security regulations and policies of the portal, WPS Government Health Administrators is pleased to be able to provide this convenient and efficient tool to our Medicare providers.

The portal is available to Medicare Part A and Part B providers and their staffs operating within Medicare Jurisdiction 5 (J5) and Jurisdiction 8 (J8). These jurisdictions are comprised of providers in the states of Indiana, Iowa, Kansas, Michigan, Missouri, and Nebraska, as well as a small number of Part A providers in other parts of the country. Providers who do not submit Medicare claims to WPS Government Health Administrators should contact their own Medicare Administrative Contractor (MAC) for information about registering for their MAC's portal.

The portal offers many functions including the functions listed below. The most frequently accessed functions are eligibility and claim status. The portal uses the CMS HIPAA Eligibility Transaction System (HETS) 270/271 transaction to obtain the most current patient eligibility, while the claim status function uses the Claims Processing Shared Systems. In addition, the portal offers the ability to do the following:

- Send secure messages to Customer Service staff
- Register to receive the Electronic Remittance Advice (ERA)
- Submit redetermination requests and supporting documentation
- Check status on any redetermination submitted to WPS Government Health Administrators
- Enter a Part B claim (Paper billers who are not already submitting electronic data interchange (EDI) claims only)
- Submit a Part B clerical error reopening
- Submit a Part B overpayment claim adjustment
- Submit medical documentation for pre- and post-payment reviews
- Request duplicate remittances
- Submit Prior Authorization Requests (Part A providers only, and only for the following types of service: blepharoplasty, botulinum toxin injections, cervical fusion with disc removal, implanted spinal neurostimulators, panniculectomy, rhinoplasty, and vein ablation)
- Submit electronic refunds
- Receive and respond to Additional Documentation Requests (ADRs) and Demand Letters

The portal is available 24 hours a day, 7 days a week, with limited functionality outside of normal business hours. Weekly maintenance is scheduled from Saturday at 11:00 PM CT (12:00 AM ET) through Sunday at 5:00 AM CT (6:00 AM ET). See the System Status alerts (https://www.wpsgha.com/wps/portal/mac/site/home/system-statuses) for information about

maintenance scheduled outside of the usual times. These alerts are also available on the portal's home page.

User Responsibilities

All portal users must agree to abide by the Terms of Use for Transactional Areas when registering for portal access. Due to the sensitive nature of the information available in the portal, failure to abide by the terms of use may result in the immediate termination of your account and could result in civil and criminal penalties.

Our General Terms of Use (https://www.wpsgha.com/wps/portal/mac/site/home/footer-resources/general-terms-of-use) are available on our website.

Use of Automated Programs with the Portal

Users are strictly prohibited from using automated programs, macros, etc. to access the features of the WPS Government Health Administrators Portal. Users found to be accessing the portal in any manner other than the process described in the Logging In and Logging Out section of this manual will have their access revoked. In addition, the use of such tools will result in the suspension of all accounts associated with the NPI(s) of that user's organization(s).

Required Browser Settings to Access the Portal

The portal requires the user's browser to use Transport Layer Security (TLS) settings of 1.2 or higher to secure and protect the information it contains. The browser may display the message ""This page cannot be displayed" if the TLS settings are insufficient.

A user can update the TLS settings for their preferred browser by following the instructions below. Some users may need to contact their company's technology department to make these changes.

Updating TLS Settings in Microsoft Internet Explorer (IE)

1. Go to 'Tools' in your top toolbar
2. Select Internet Options
3. Click on the Advanced tab
4. Scroll to the Security section and then find 'Use TLS 1.2' and check the box
5. Click Apply
6. Click OK

Updating TLS Settings in Mozilla FireFox

Current versions of Firefox automatically use TLS 1.2. If you are using an older version of Firefox, follow these steps:

1. In a new Firefox browser type about:config in the address bar
2. In the address bar type in: security.tls.version.max
3. Replace the '1' with '3' to enable TLS 1.2

Updating TLS Settings in Google Chrome

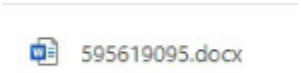
Current versions of Chrome use TLS 1.2. If you are using an older version of Chrome, follow these steps:

1. Open Google Chrome
2. Click Alt F and select Settings
3. Scroll down and select Show advanced settings
4. Scroll down to the Network section and click Change proxy settings
5. Select Advanced tab
6. Scroll down to Security category and check 'Use TLS 1.2'
7. Click OK

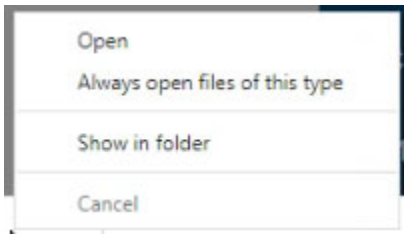
Updating Chrome Settings to View vs Save a Document

Are you are getting a message to save a letter or attachment in the portal when using Chrome? If yes, and you do not want to save it, you can update your settings by using the steps below. This only affects the Chrome browser. This will need to be done for each type of document (i.e. word, excel, pdf, etc.)

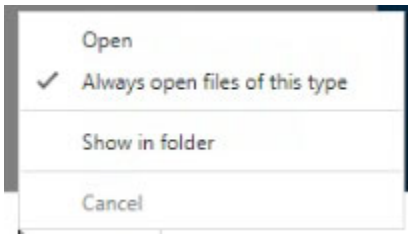
1. Click on the letter or document, a dialog box asking you to save the file will appear. Save the file, and a small box will appear in the lower left-hand corner of your screen as shown below.



2. Right click on the box and you will get options as shown below



3. Click on the second option, "Always open files of this type," to update your setting so that the next time you open the document type in Chrome it will automatically open instead of asking you to save it. You may have to repeat this action if you clear cache or cookies.



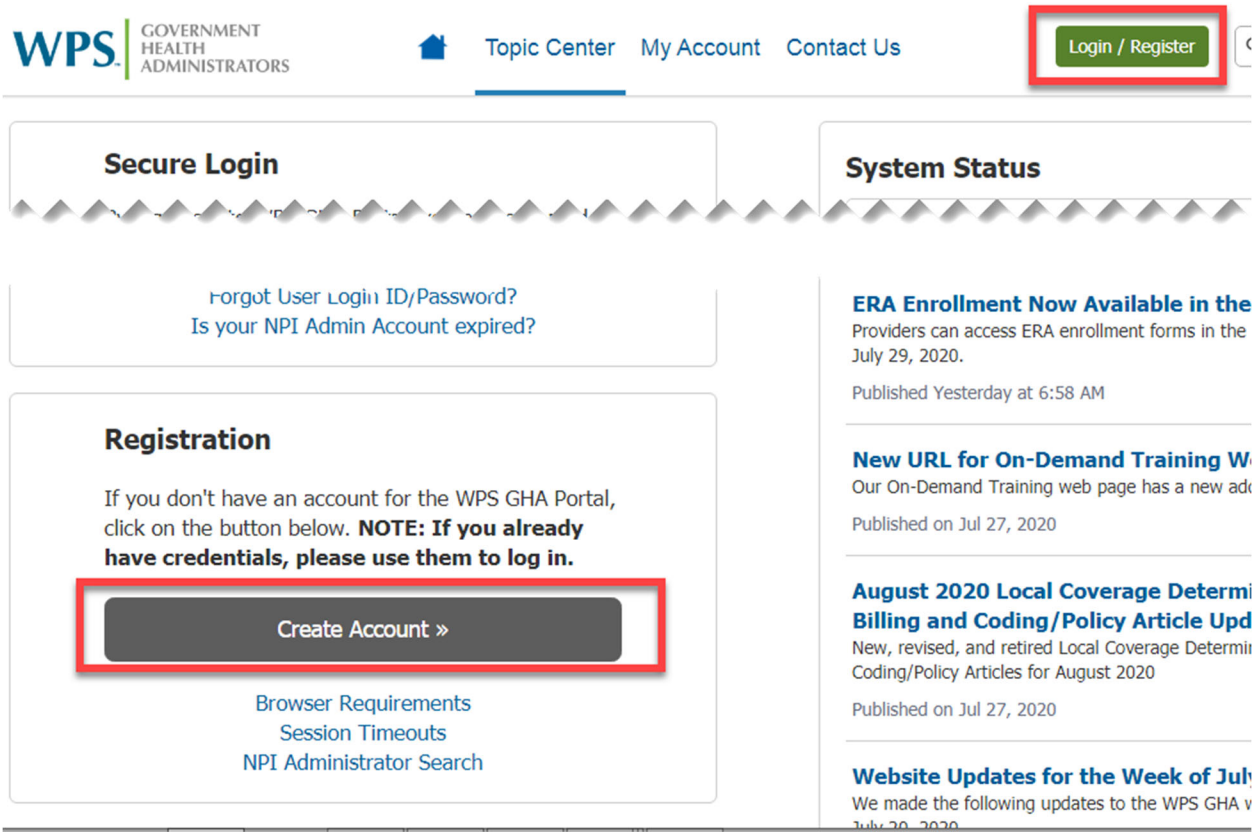
Registration, Account Management, and Recertification

Registering for Initial Access to the Portal

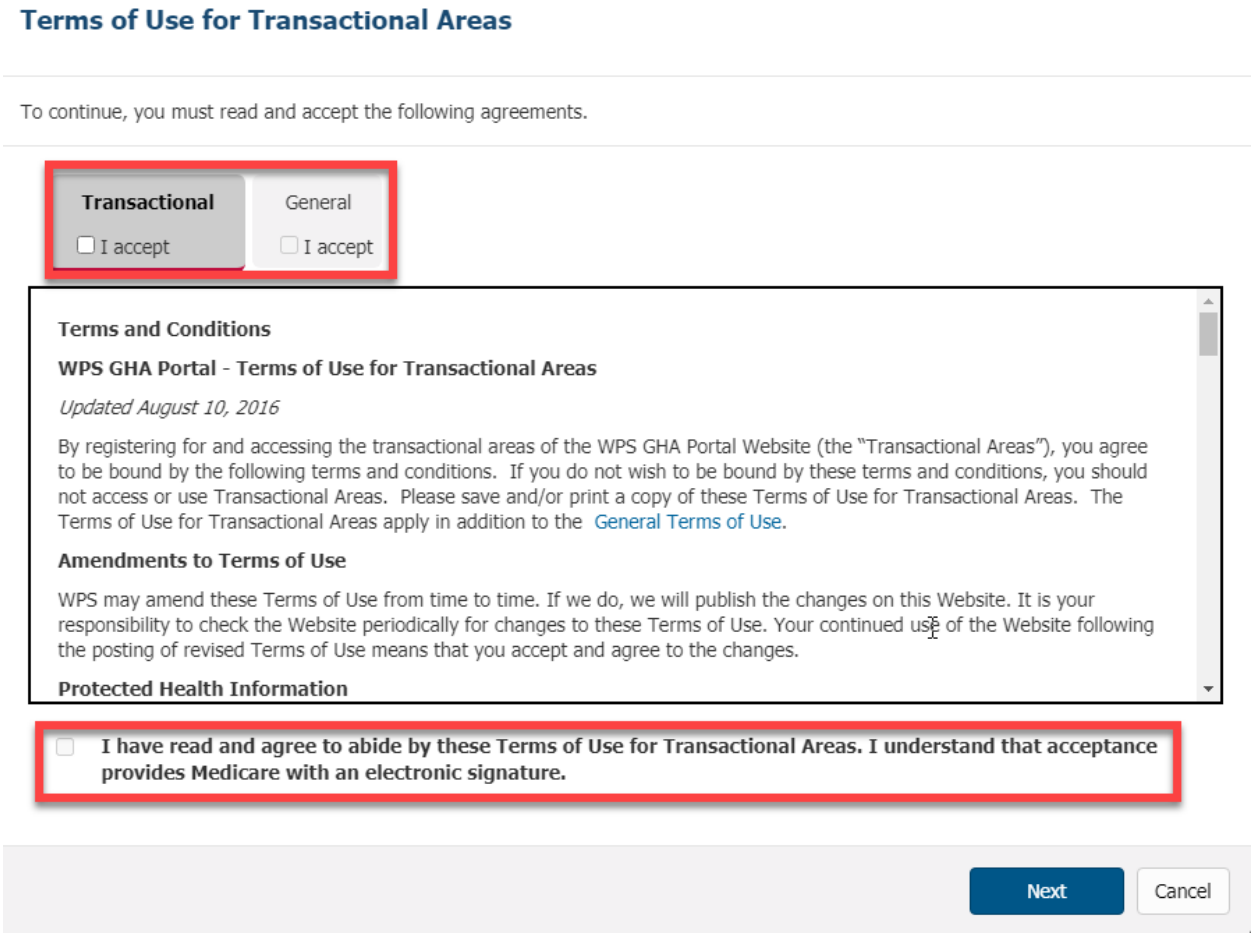
If you do not have a WPS Government Health Administrators Portal account, follow the steps below to register for access. An NPI Administrator must approve all users' access (or the user must self-register as an NPI Administrator, if applicable) before accessing any protected information in the portal.

1. Access the portal at: http://www.wpsgha.com

2. Select the "Login/Register" button at the top right side of the page, then choose "Create Account" on the left-hand side.

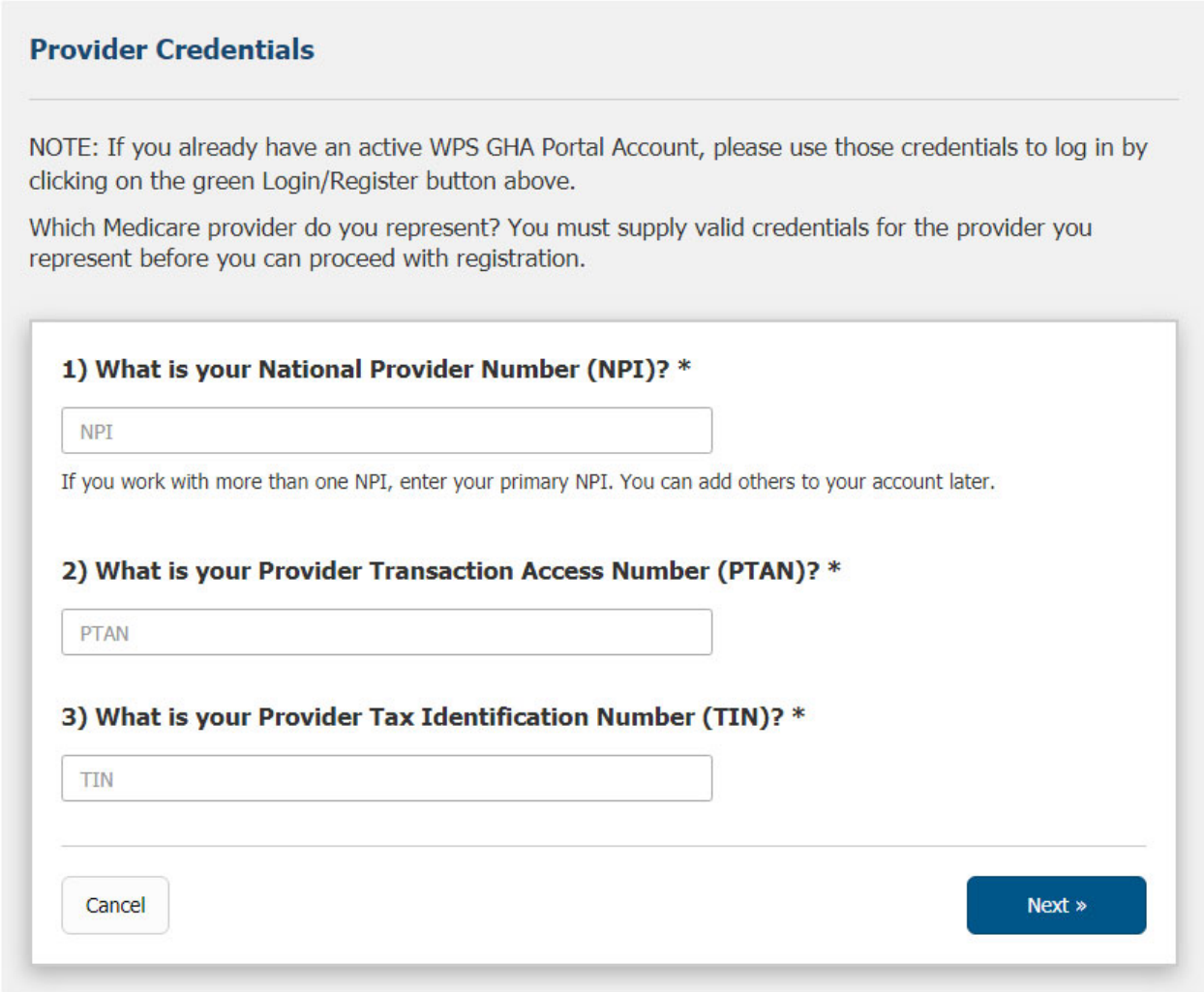


3. Read the details of the Transactional and General Areas of the User Agreement and select "I Accept." Select the "I have read…" statement to continue the registration process, then select "Next." Selecting "Cancel" terminates the registration process and reverts to the Home Page.



4. On the “Provider Credentials” page, enter the National Provider Number (NPI), Provider Transaction Access Number (PTAN) and Provider Tax Identification Number (TIN/EIN) for the NPI to which you are requesting access. When done, select “Next.”

   NOTE: If you are part of a provider group/clinic, you must use your GROUP NPI and PTAN to register for the portal. You cannot register using an individual provider’s NPI and PTAN.

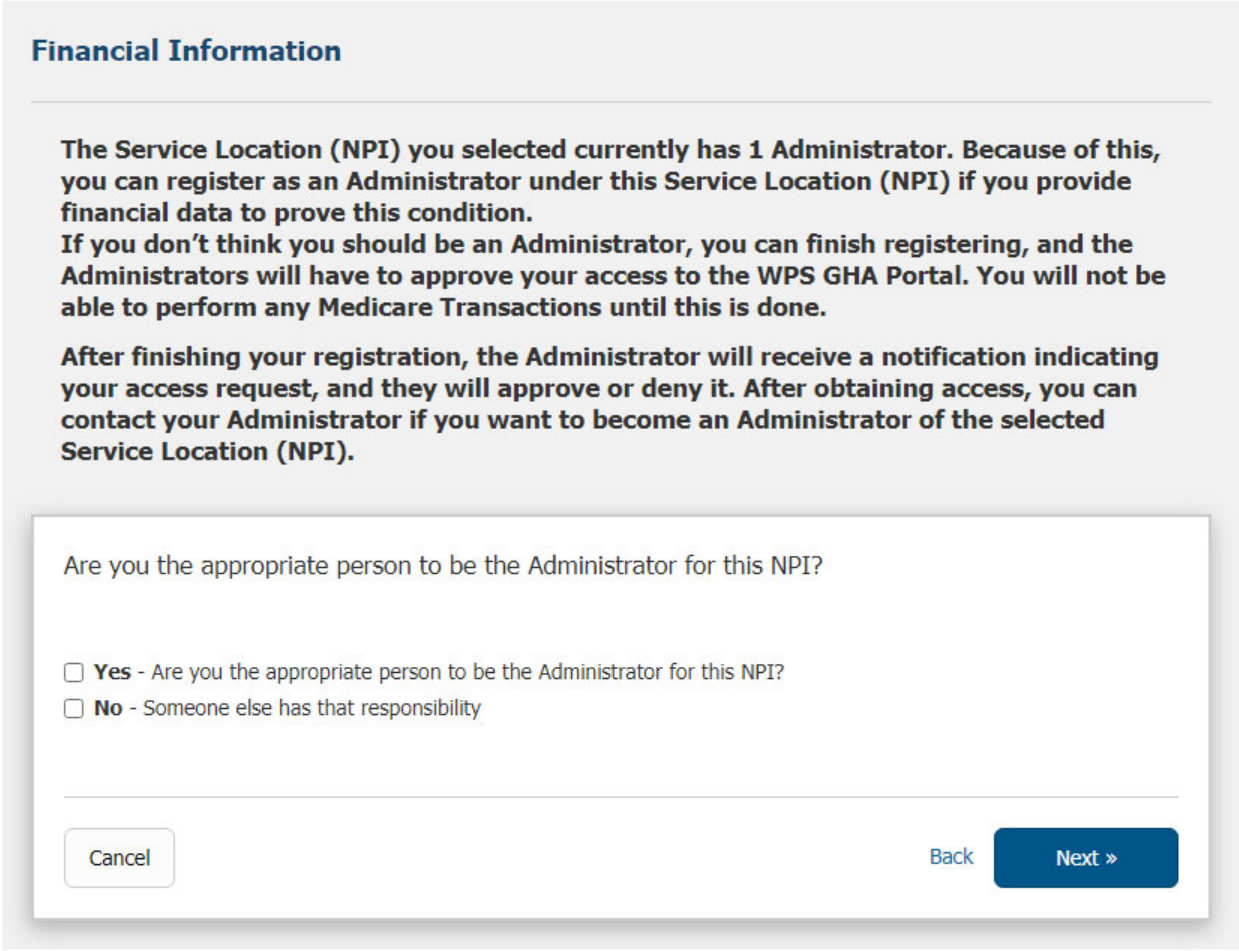


5. Once you enter your provider credentials, the portal will verify the current number of administrators for that NPI. Depending on the number of administrators the NPI already has, you may have the option to self-register as an administrator.

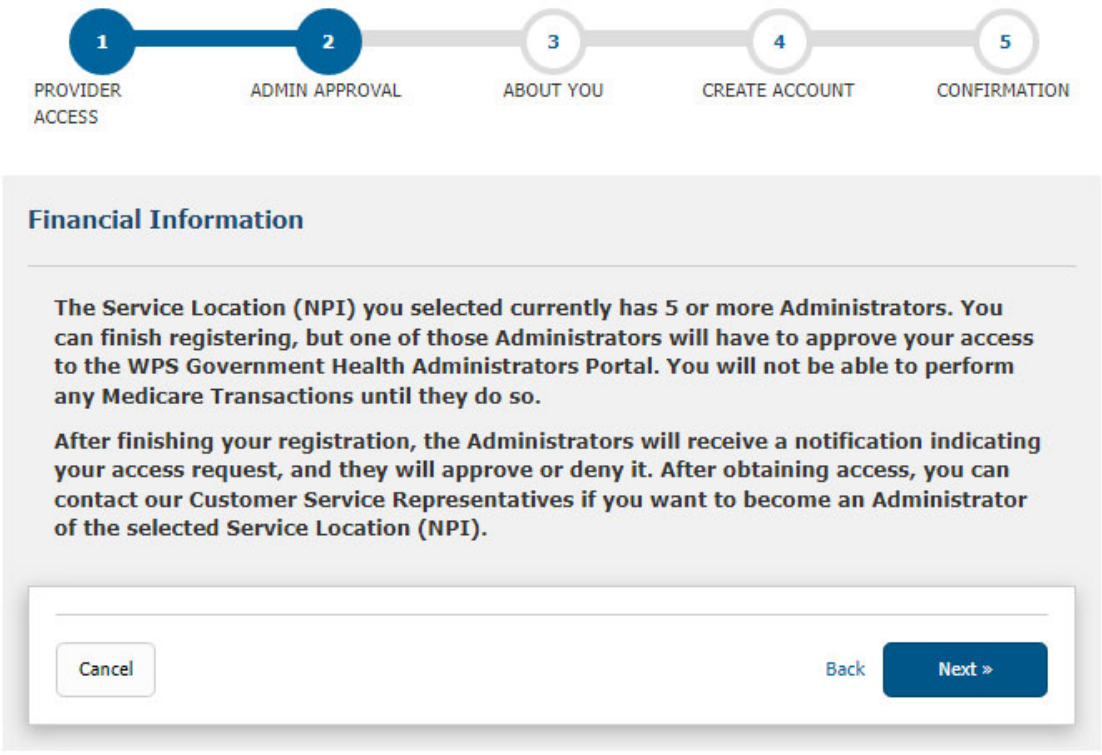
   - If the NPI currently has fewer than five administrators, it will give you the option to register as an NPI Administrator for that NPI. You may accept or reject the role of NPI

Administrator. If you accept the role, you must agree to the NPI Administrator responsibilities.

NOTE: If there are currently no NPI Administrators, and you are not an appropriate person to become the administrator, your account access will not be approved until someone else registers as the NPI Administrator and approves your access.



- If the NPI already has five NPI Administrators, you will not have the option to register as an administrator. You can continue to create your account, but a current NPI Administrator must approve your account before you can access information in the portal.



6. On the “About You” page, enter all required data and then select “Next” to continue the registration process. You will create your User Login ID and password during the next step.

About you

You may NOT share accounts. Every user must have their own unique account.

Provider Name *

Provider Name

Your Name *

First | MI | Last | Suf

Email Address *

Enter email

Confirm email *

Enter email

Phone Number *

Area Code* | Local Phone* | Ext.

Work Location Name *

Location Name

Work Location Address (Must be a street address, not a P.O. Box) *

Line 1

Line 2

City

-- Please select a State -- | Zip code

Cancel | Back | Next »

User Login ID and Password Setup and Management

Creating Your User Login ID and Initial Password during Registration

User Login IDs

User Login IDs are 5-16 characters in length. Spaces are not allowed. Your User Login ID can contain the following characters:

- A-Z
- 0-9
- Dollar ($)
- Underscore (_)
- Hyphen (-)

Your User Login ID is permanent and cannot be changed later.

Passwords

Your password must meet several requirements. Be sure to review the password requirements below prior to creating the password:

- Passwords must be 8 - 20 characters in length
- Passwords **must contain** at least:
    - One upper case alphabetic letter: A - Z
    - One lower case alphabetic letter: a - z
    - One numeric digit: 0 - 9
    - One special character (only the characters listed below are valid):
        - Hashtag (#)
        - Dollar ($)
        - Percent (%)
        - Ampersand (&)
- Passwords **cannot contain**:
    - Your first or last name
    - Any special characters that are not listed above
    - User Login ID
    - Security question answers
    - Words found in a dictionary (four or more letters)

Some helpful suggestions to assist you in the creation of your new password:

- Choose a smaller password and repeat it: Ab#1Ab#1
- Use the $ sign in place of the letter “S”: Pa$$1Pa$$1
- Use the number zero in place of the letter “O”: w0rd1w0rd1
- Use the number one in place of the letter “I”: Wh1te$Wh1te$

In addition, remember the following password rules:

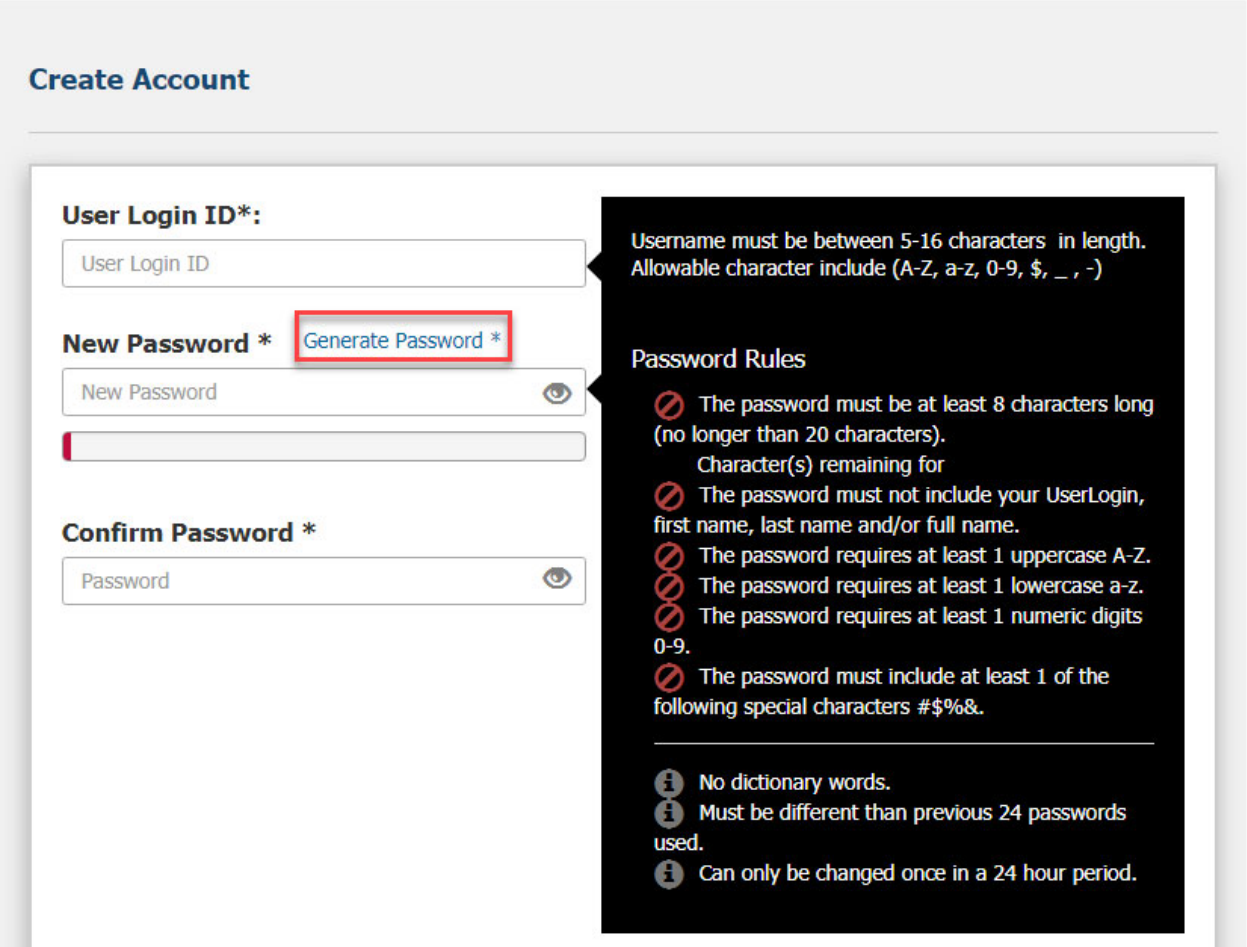
- Passwords can only be changed once in a 24-hour period
- Newly created passwords must be different from the previous 24 passwords used.
- Newly created passwords must differ from the previous password by at least four characters.

Once you choose your password, enter it in the “New Password” field, and then reenter the same password in the “Confirm Password” field.

Auto-Generated Passwords

If you are having trouble creating your own password, you can have the portal auto-generate a password for you. Select the “Generate Password” link and the portal will generate a password that meets the password requirements. It will autofill the generated password in the “New Password” and “Confirm Password” fields.

NOTE: Please remember the auto-generated password. You will need to enter the password the next time you log in.



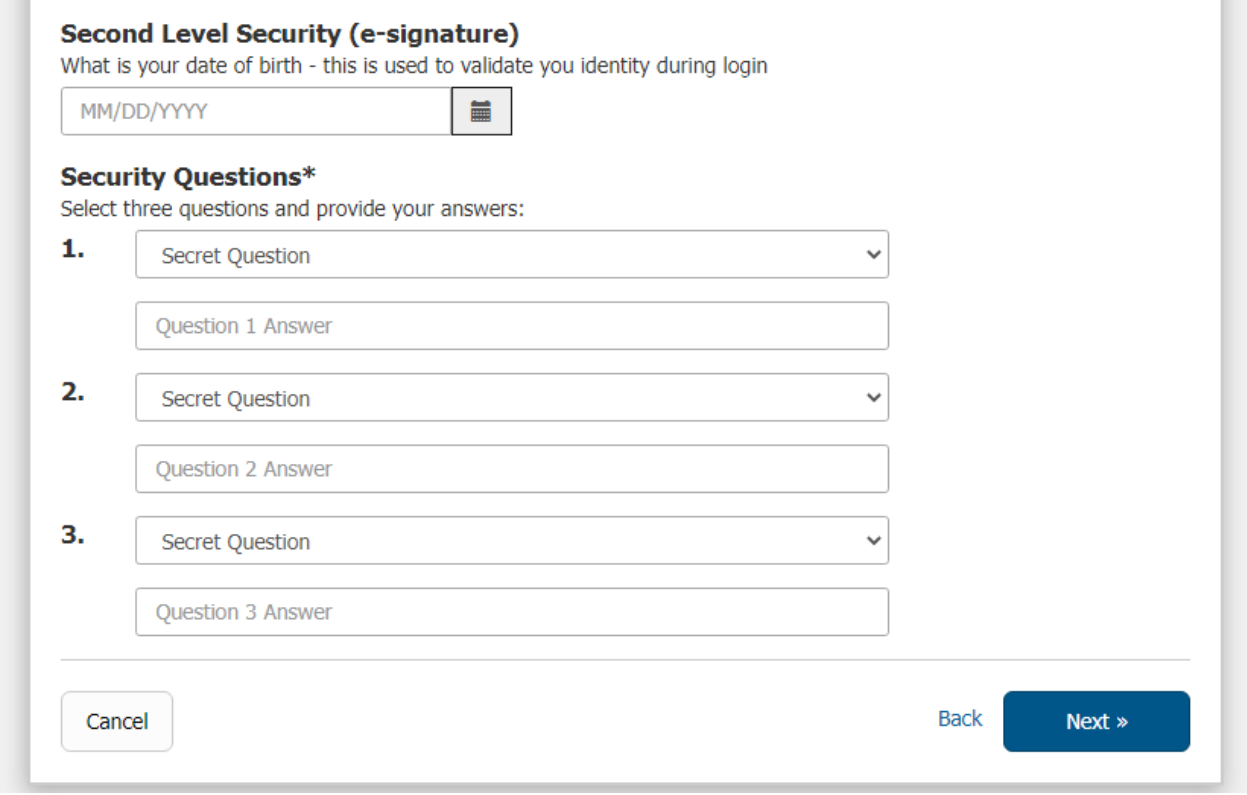
Create your E-Signature (Date of Birth and Secret Questions and Answers)

During the registration process, you will also create your e-signature. The only times you will use this second level of security is if you forget your User Login ID or password and for recertification of your portal account.

To create your e-signature, enter your date of birth and choose three security questions. It is very important to enter your correct date of birth, as you cannot change this information later.

Be sure to note the format of your answers to your security questions. (For example, if you select a question that has a date for an answer, make sure to note if you spell out the date or use numerals. The portal would consider “January 1, 2020,” “01/01/20,” and “01/01/2020” to be completely different answers.)

NOTE: No one has access to your e-signature information except you. Neither an NPI Administrator nor Medicare staff can see or update your e-signature answers or date of birth in the portal.



Password Expiration

- User-created and auto-generated passwords expire every 60 days.
- Temporary passwords expire after a single use. In addition, temporary passwords must be used within 21 days. (**NOTE:** If a new user does not enter their temporary password within 21 days, their account will need to be recreated.)

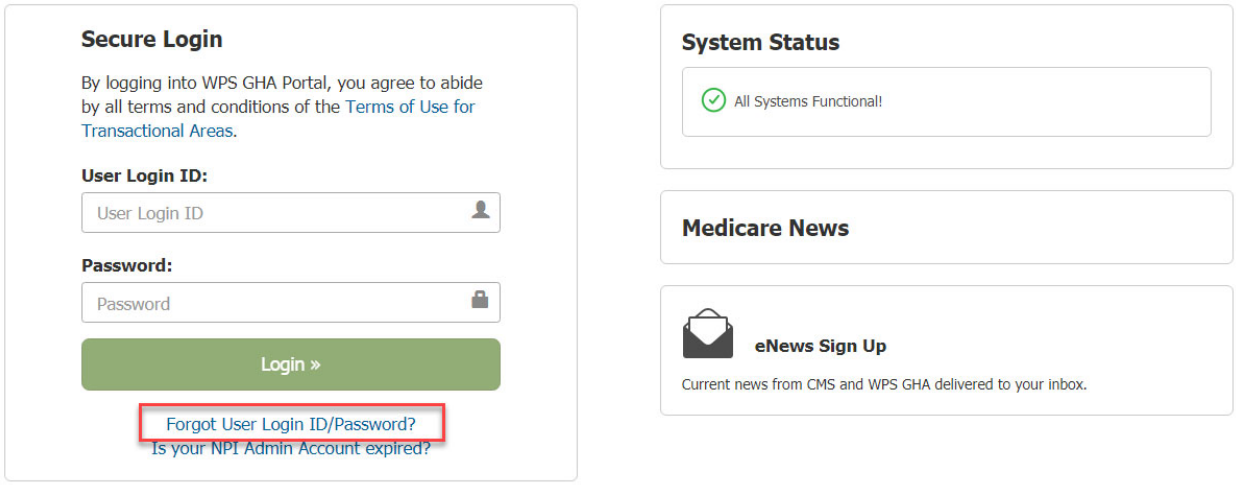
Once a password expires, the portal will display the “Password Expired” page when you log in. You will need to change your password before continuing.

- Enter the expired password in the “Current Password” field.
- Enter a newly created password in the “New Password” field. (The portal automatically completes this field if you auto-generate the password.)
- Enter the newly created password again in the “Confirm Password” field. (The portal automatically completes this field if you auto-generate the password.)
- Select “Save my password” to change your password.

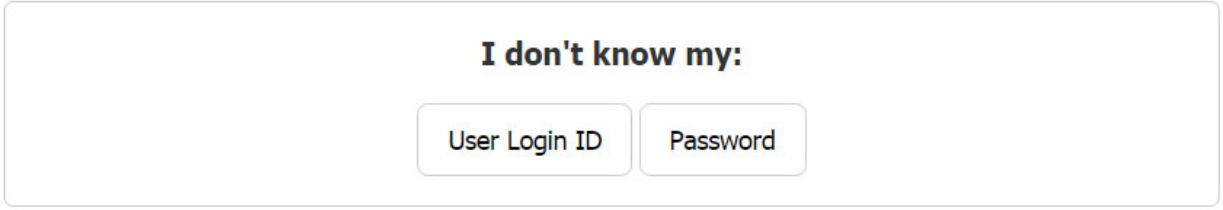
Forgot User Login ID or Password

Follow the steps below if you forget your User Login ID or your password:

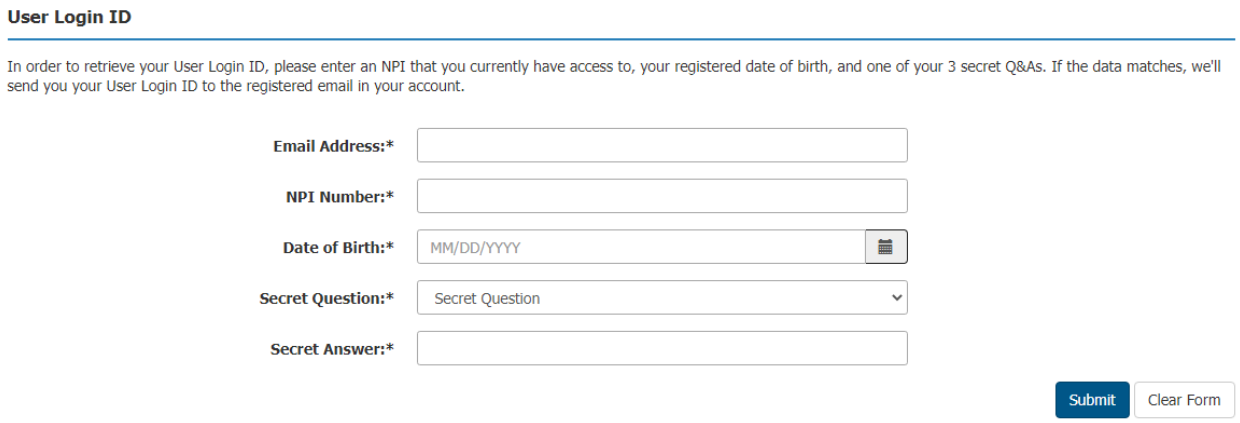
1. On the initial Login page, select the “Forgot User Login ID/Password?” link beneath the area where you would normally enter your ID and password.



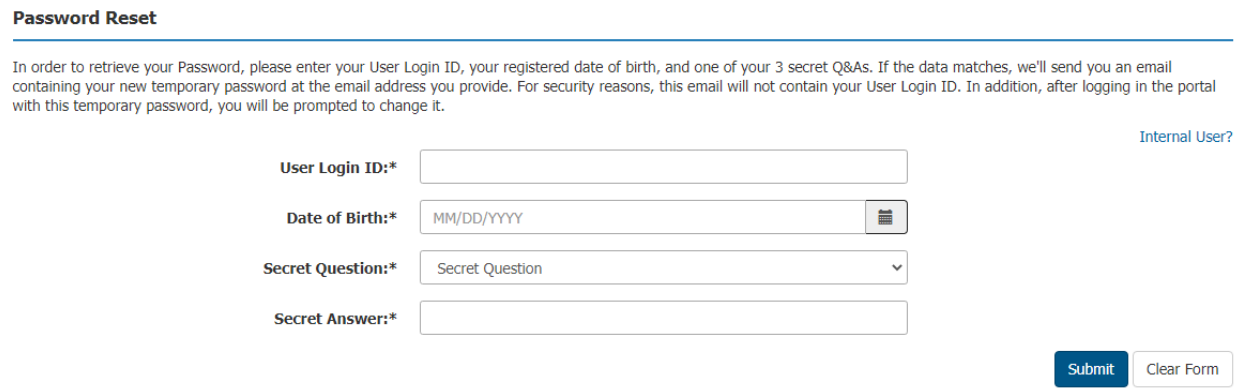
2. Select “I don’t know my User Login ID” or “I don’t know my Password” depending on which item you have forgotten.



3. If you do not remember your **User Login ID**, the portal will ask you to enter the following items:
   - Email Address
   - NPI number
   - Date of Birth
   - Secret Question
   - Secret Answer (Enter your answer in the same format as you originally answered. "January 1, 2020," "01/01/20," and "Jan 1, 2020" would be different answers.)



   If you do not remember your **password**, the portal will ask you to enter the following items:
   - User Login ID
   - Date of Birth
   - Secret Question
   - Secret Answer



4. Once you click Submit, the portal will display the message, "Please check your email for your User Login and/or temporary password." The portal will send the email to the email address currently listed on your account. Check your spam or junk folders if you do not see the email in your inbox.

5. Return to the portal and log in with your User login ID or the temporary password from the email.

6. If you reset your password, the portal will display the Password Expired page when you log in with the temporary password from the email. You will need to change your password before continuing. See the Password Expiration section above for information about changing your password. Remember to use the temporary password from the email in the Current Password field when changing your password.

Password and User Login ID Tips and Troubleshooting

- Passwords are case-sensitive, but User Login IDs are not.

- If you forget your password, you can:
  - Use the "Forgot User Login ID/Password?" to reset your password
  - Contact your NPI administrator to reset your password
  - NPI Administrators may contact the Provider Contact Center to reset their password

- If you enter the incorrect password three times, the portal will lock your account. A Standard and Eligibility user must contact their NPI Administrator to reset their password and unlock their account. An NPI Administrator must contact the Provider Contact Center during normal business hours to reset their password and unlock their account.

- If you receive the error message, "**The client supplied invalid authentication information**," when changing your password, it means you entered the wrong information in the Current Password field. (**NOTE:** If the Current Password field displays all asterisks (*****), delete them and enter the temporary password from the password reset email. Do not allow your browser to save your password for the portal.)

- If you receive the error message, "**New password verification failed. Make sure the new password fields contain the same data**," when changing your password, it means the new password and confirm new password fields do not match.

- If you receive the error message, "**Password rejected due to policy violation**," when changing your password, it means the new password does not meet all the password requirements. Verify you are not using dictionary words. Also verify your password contains one of the four special characters (# $ % &).

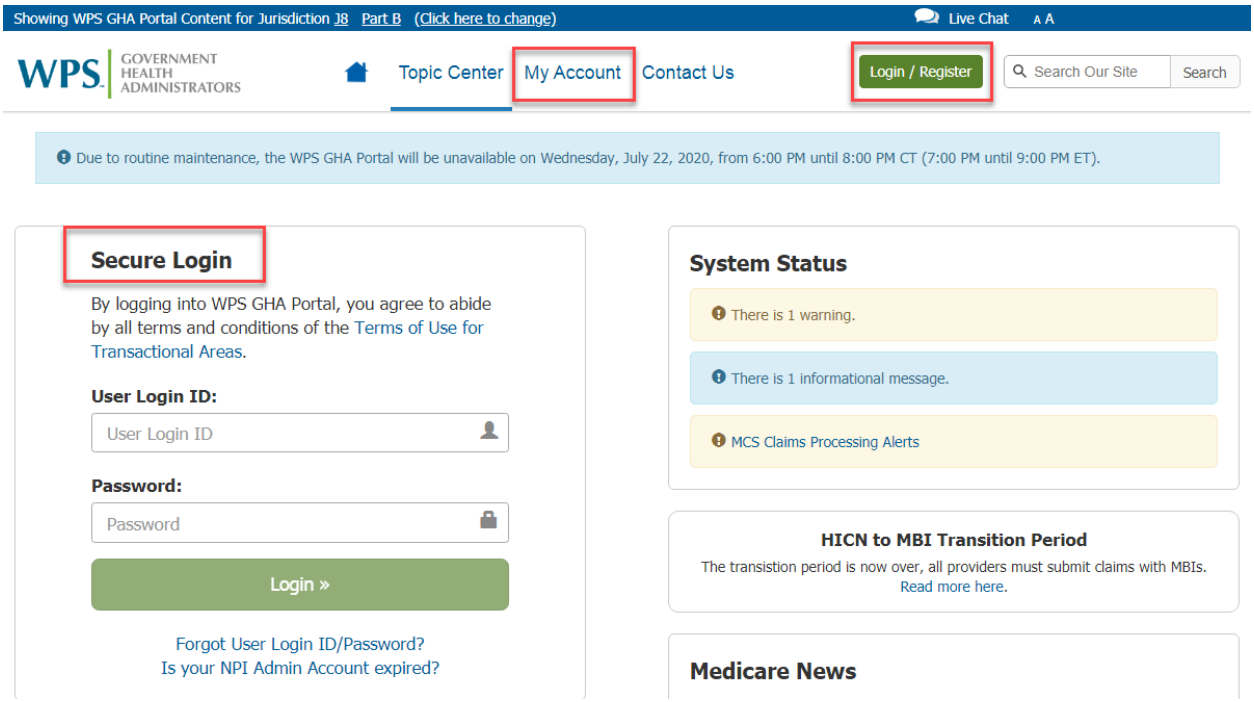
Logging In and Logging Out

Logging into the Portal

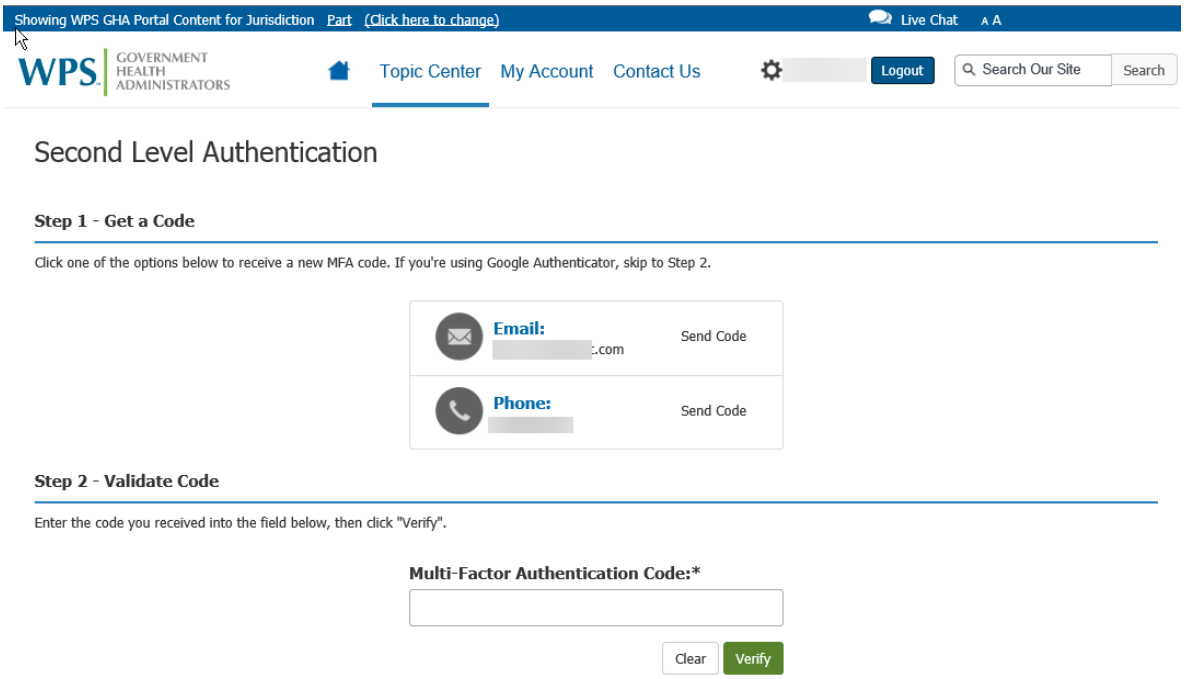
IMPORTANT: All users must log into the WPS Government Health Administrators Portal at least once every 30 days to keep their account active. If a user fails to log in at least once during a 30-day period, the portal will disable the user's account.

To log into your account:

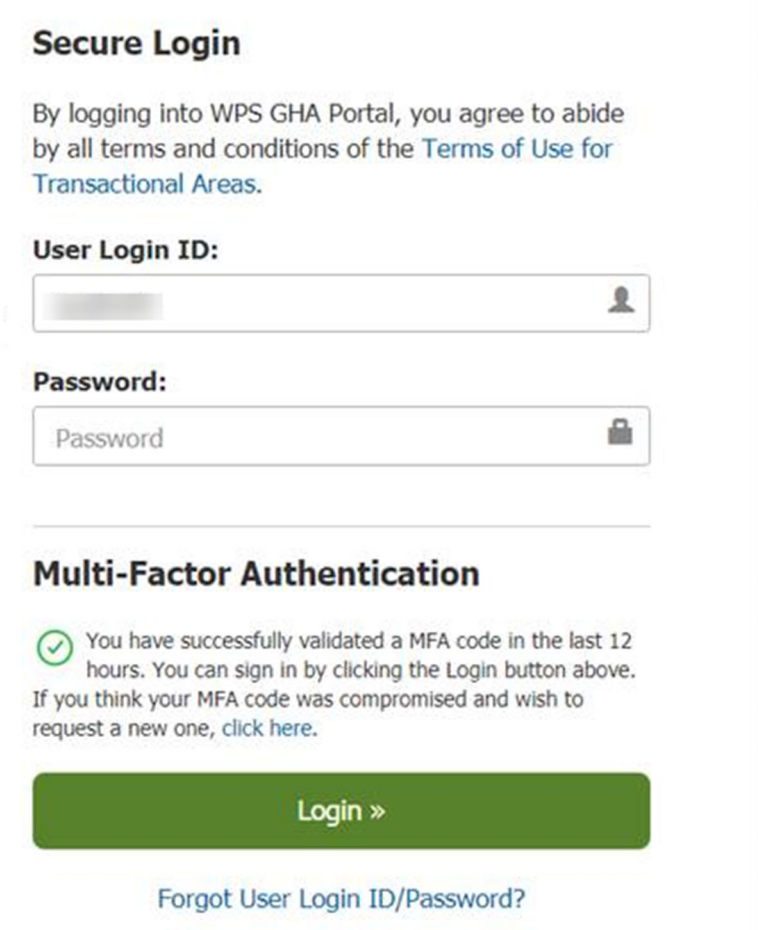
1. Access the portal at http://www.wpsgha.com and click on the "My Account" link or the "Login/Register" button at the top of the page
2. Enter your User Login ID and password in the Secure Login box and click the "Login" button



3. Once you successfully enter your User Login ID and password, you will reach the Second Level Authentication screen. You will need to request a Multi-Factor Authentication (MFA) code by email or phone or through the Google Authenticator app to proceed.



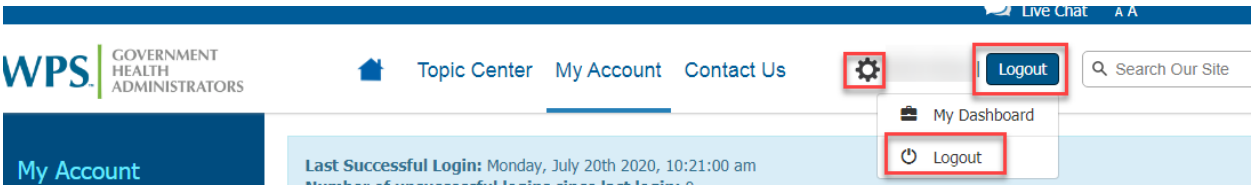
4. You only need to validate an MFA code once every 12 hours if you log into the same computer with a static IP address. If you log in again on the same computer within 12 hours of validating an MFA code, you will see the message below. (**NOTE:** This does not apply if you log into multiple computers or if your computer has a dynamic IP address. You need to request an MFA code each time in these situations.)



Logging Out

To avoid potential issues when you need to log in again, be sure to log out using the following methods:

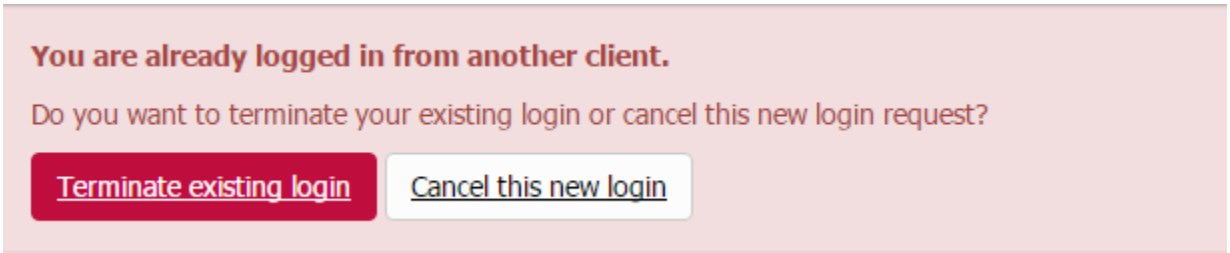
- Click the blue “Logout button in the upper right corner of the screen near your name, OR
- Click the gear icon in the upper right corner, then click “Logout” in the dropdown box.



Login Tips and Troubleshooting

Logging in After "X-ing out" Versus Selecting "Logout"

If you close your browser window ("X out") to leave the portal instead of properly logging out, you may see the following error message when trying to log back in:



If you receive this error, select "Terminate existing login" to log back into the portal. This terminates the previous session that did not log out properly and allows you to sign in again.

To log out properly, use the "Logout" button (or click the gear icon and select "Logout" from the dropdown list).

Logging in After Timing Out

Users who are logged out after 15 minutes of inactivity sometimes encounter issues when logging back in. Try these steps if you have difficulties log in:

1. Close ALL open website browser windows (not just the window containing the WPS Government Health Administrators Portal site).
2. Reopen the website browser and manually enter https://www.wpsgha.com (Do not let your browser autofill the website address.)
3. If you still cannot log in, and there is no "Logout" button or link available, see the section below for information about clearing your browser's cache and cookies (browsing data or history).
4. You can also try logging in using a different browser. (i.e., If you were previously using Internet Explorer, try logging in using Google Chrome or Firefox.)

Lock Out After Three Failed Login Attempts

The portal will lock a user's account if they enter their password incorrectly three times. Standard and Eligibility users must contact their NPI Administrator to reset their password, which will immediately unlock the account.

If an NPI Administrator gets locked out of their account, the NPI Administrator must contact our Customer Service department to have their password reset and their account unlocked.

Clearing Cache and Internet Cookies

As a rule, a portal user should never save the portal's URL (website address) as a favorite. When we make updates to the portal, the browser's saved version is not up to date, which can cause issues with logging in or changing your password. Always access the WPS Government Health Administrator Portal by typing https://www.wpsgha.com in your browser's address field.

If you have problems accessing the portal or changing your password, or if you are locked out for unknown reasons, try clearing your browser's cache and Internet cookies. The steps for clearing your cache and cookies vary depending on the browser you are using. In general, follow these steps:

1. Look for a Tools or Settings menu within your browser. You can often access the Tools or Setting menu through an icon in the upper right corner of the browser.
2. Locate the browsing data or history section of the menu and clear your temporary files and cookies.
3. Choose how far back to clear your data.
4. If you continue to have difficulty, contact your company's IT department for assistance.

Multi-Factor Authentication – Initial Setup for Email and Telephone

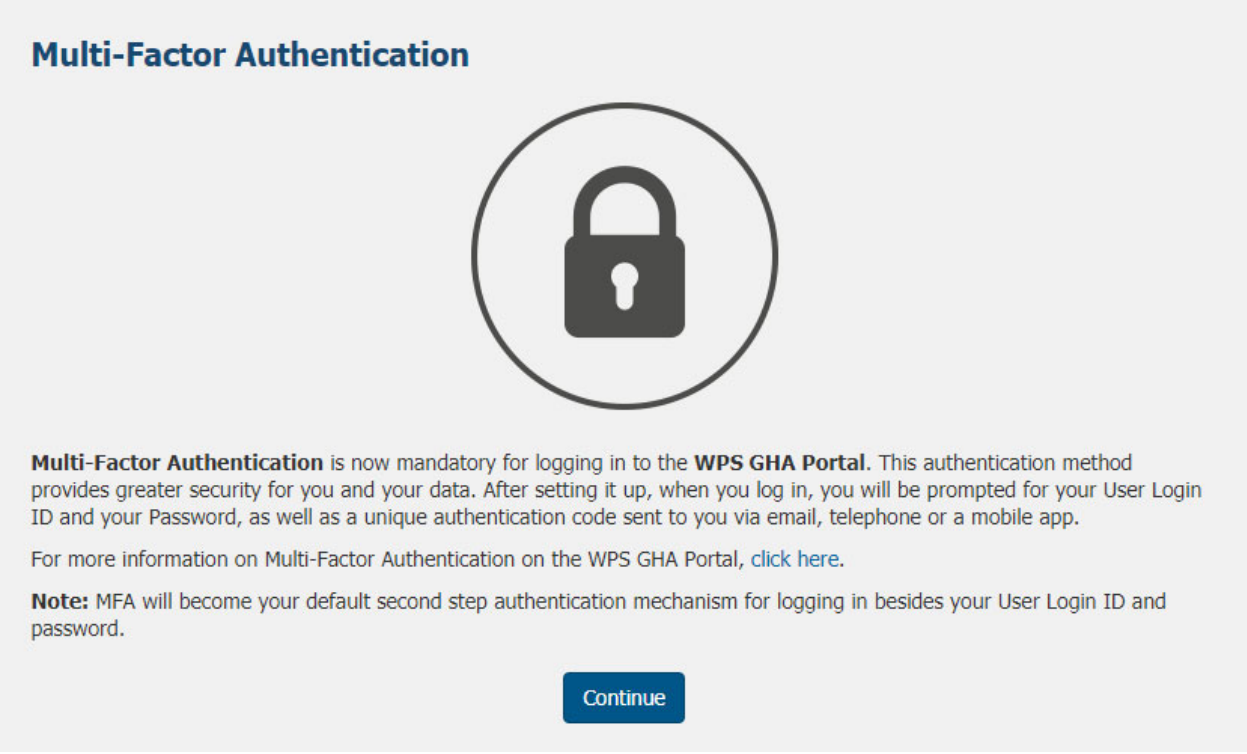
CMS requires Medicare contractors to use Multi-Factor Authentication (MFA) in the secure areas of their websites. MFA provides two layers of security to safeguard both patient and provider information.

Users set up MFA when registering for the access to the WPS Government Health Administrators Portal. You can receive an MFA verification code in three ways:

- Email
- Telephone call (for direct lines only)
- Google Authenticator mobile app

An MFA code will usually be valid for 12 hours once you enter it during the login process. However, if you log into the portal from different computers during the day, or if you have a dynamic IP (Internet Protocol) address, you may need to request a new MFA code each time you log in. (Contact your company's IT department if you have questions about static and dynamic IP addresses.)

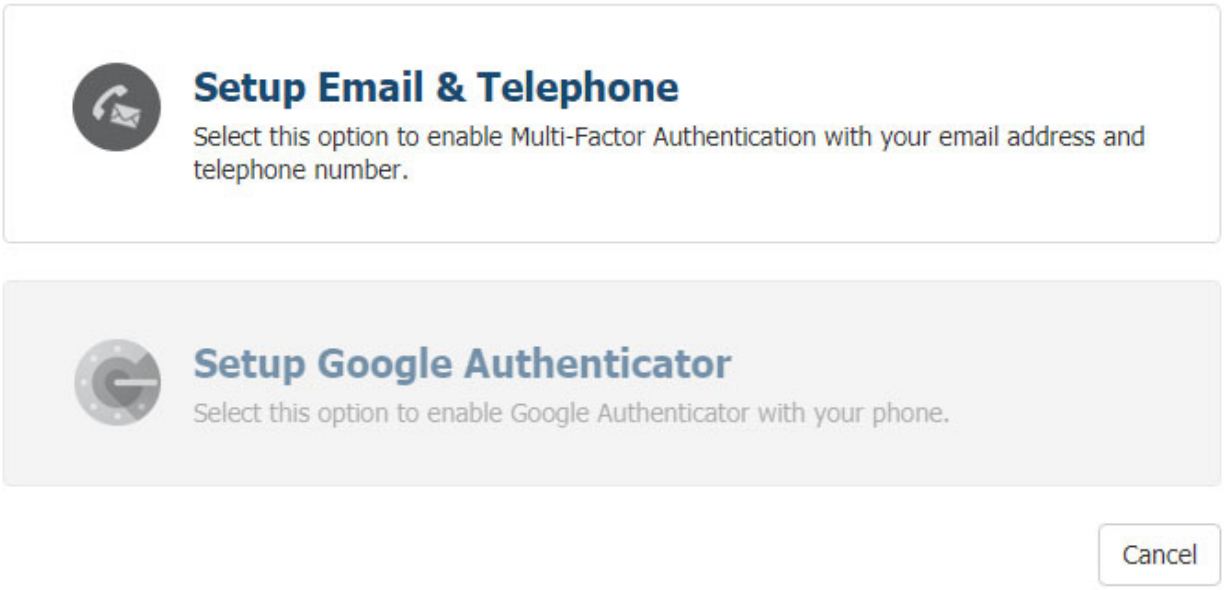
New users will see the screen below when accessing the portal for the first time:



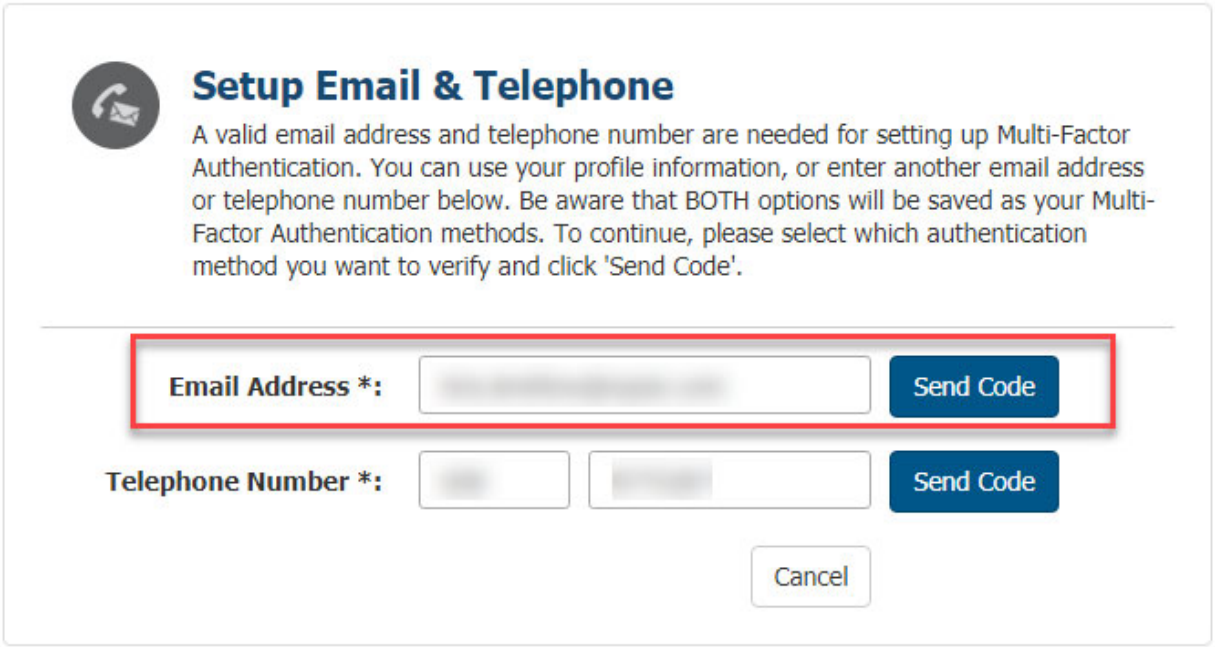
Click "Continue" to begin the setup process. Initially, you will provide your email address and/or direct telephone number to allow you to receive the MFA verification code. While you are only required to set up one option, we recommend users set up both the email and telephone options. Setting up both options allow you to have a backup method of receiving your MFA code if your primary method is not working.

Setup MFA by Email

1. Click the Setup Email & Telephone button

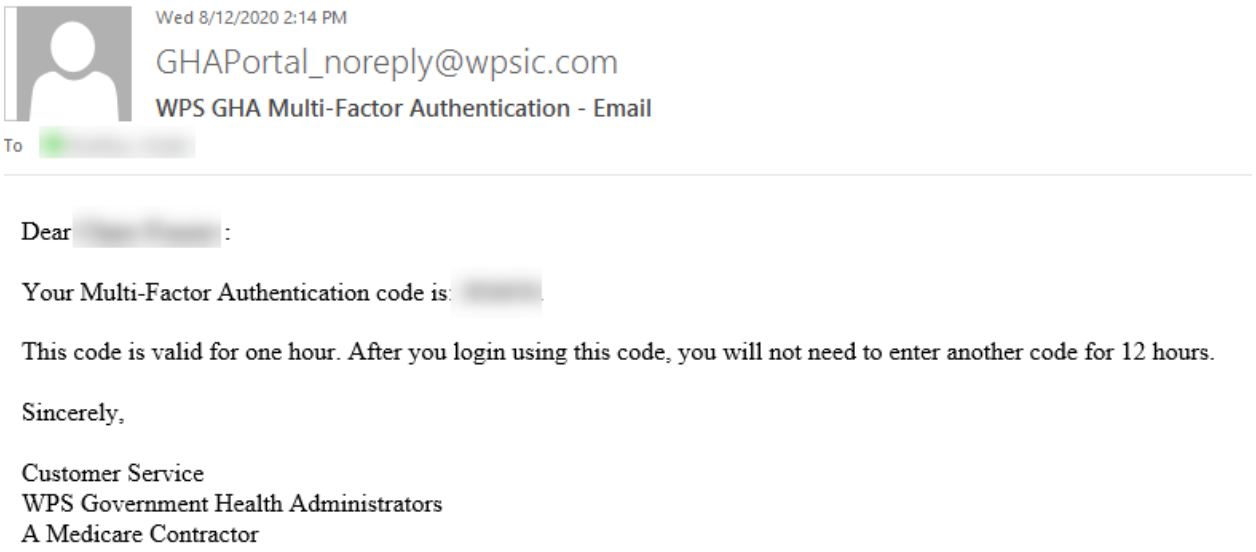


2. Enter your email address in the appropriate box (or, if your email address is pre-populated, verify the email address is the one you want to use to receive the MFA code) and click the Send Code button.



3. Check your email for an automated message from GHAPortal_noreply@wpsic.com. We send the email immediately, but it may take several minutes for the email to appear in your inbox. Remember to check your Spam or Junk folder for the email if you do not receive the email immediately.

   NOTE: If you have trouble receiving our emails, contact your company's IT department or system administrator to ask them to whitelist the email address or domain name.



Wed 8/12/2020 2:14 PM

GHAPortal_noreply@wpsic.com

WPS GHA Multi-Factor Authentication - Email

To [redacted]

Dear [redacted] :

Your Multi-Factor Authentication code is: [redacted]

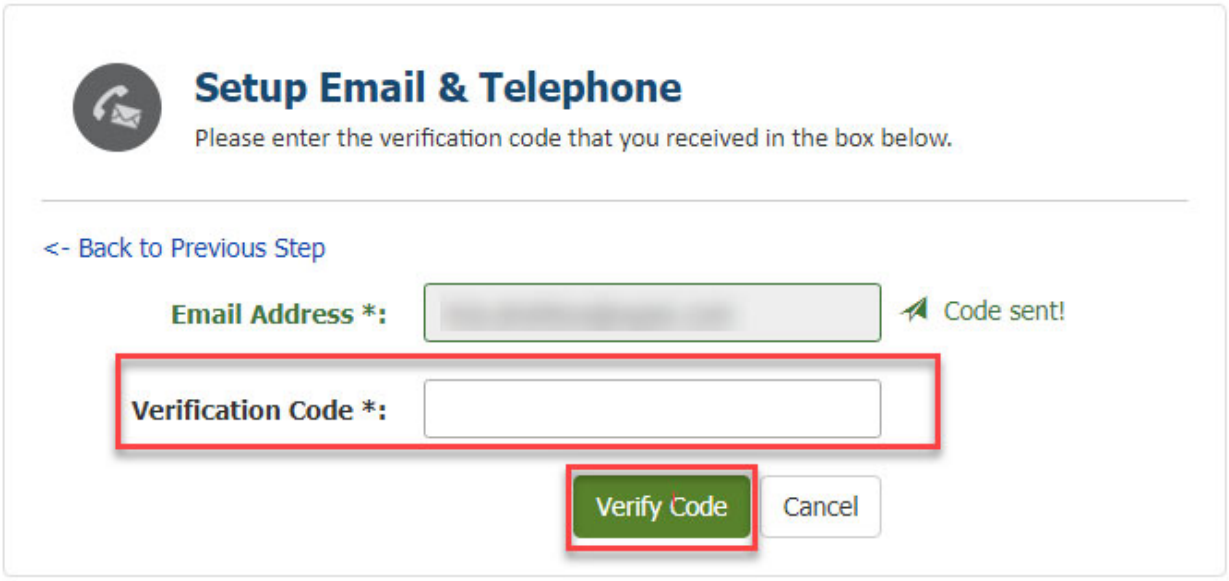
This code is valid for one hour. After you login using this code, you will not need to enter another code for 12 hours.

Sincerely,

Customer Service
WPS Government Health Administrators
A Medicare Contractor

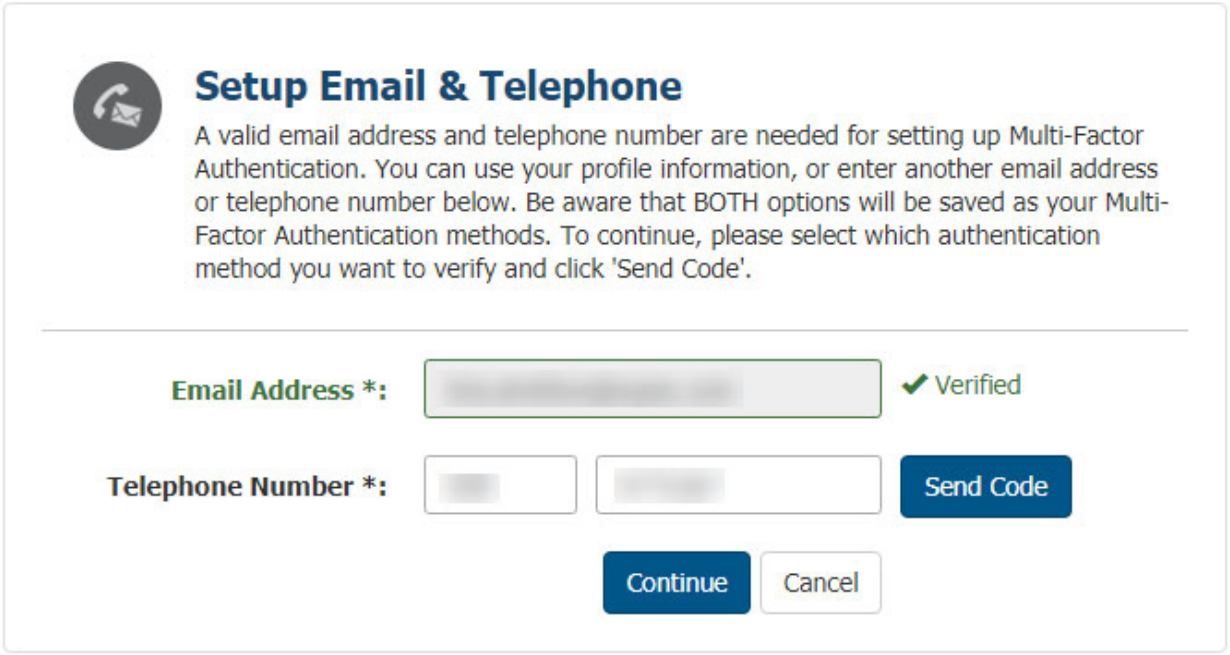
4. Once you receive the email, enter the MFA code from the email in the Verification Code field and click the Verify Code button.

   NOTE: You must enter the MFA code into the Verification Code field within one hour of receiving it or it will expire. If your code expires, you will need to request a new code.



5. If you do not receive the email containing the MFA code, or if the code does not work, click on the “Back to Previous Step” link to request a new code.

6. Once you successfully verify your email address using the MFA code you received, you will see a green check mark with the word “Verified” next to it.



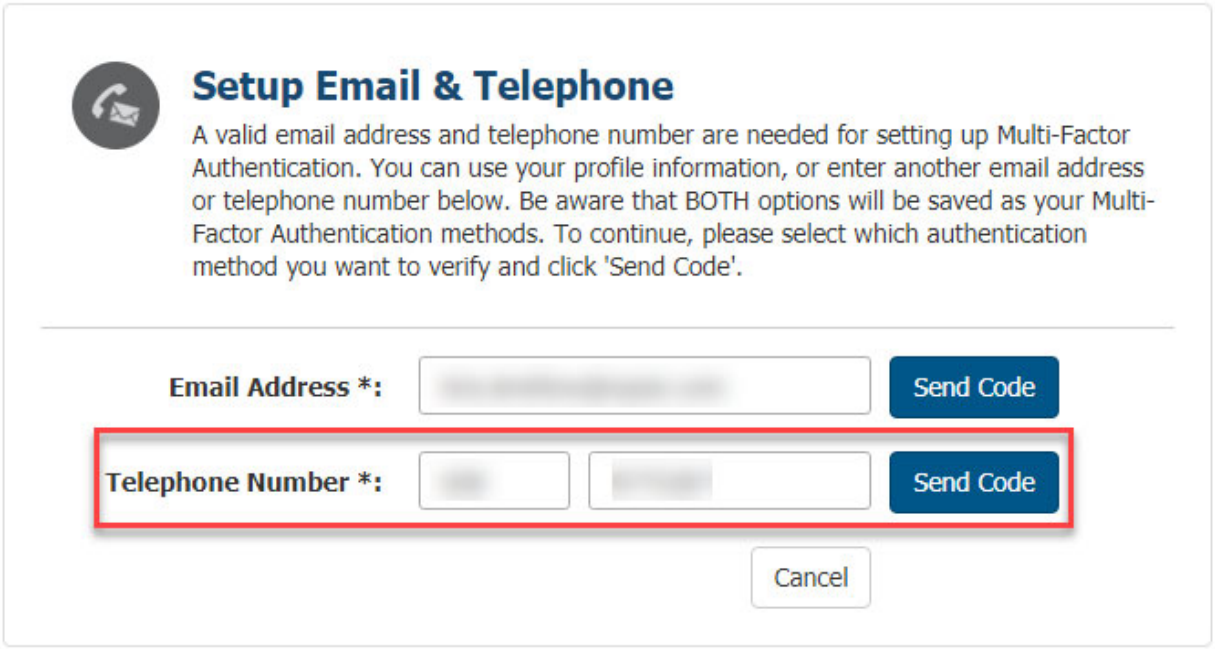
7. Follow the steps below to set up MFA by telephone or click “Continue” to go to the Dashboard.

Setup MFA by Telephone

1. Enter your telephone number in the appropriate box (or, if your telephone number is pre-populated, verify the telephone number is the one you want to use to receive the MFA code).

   NOTE: The telephone number must be a **direct line** (landline or mobile). It cannot be a telephone number that requires the caller to enter an extension or select a routing option from a menu.

2. Click the Send Code button.

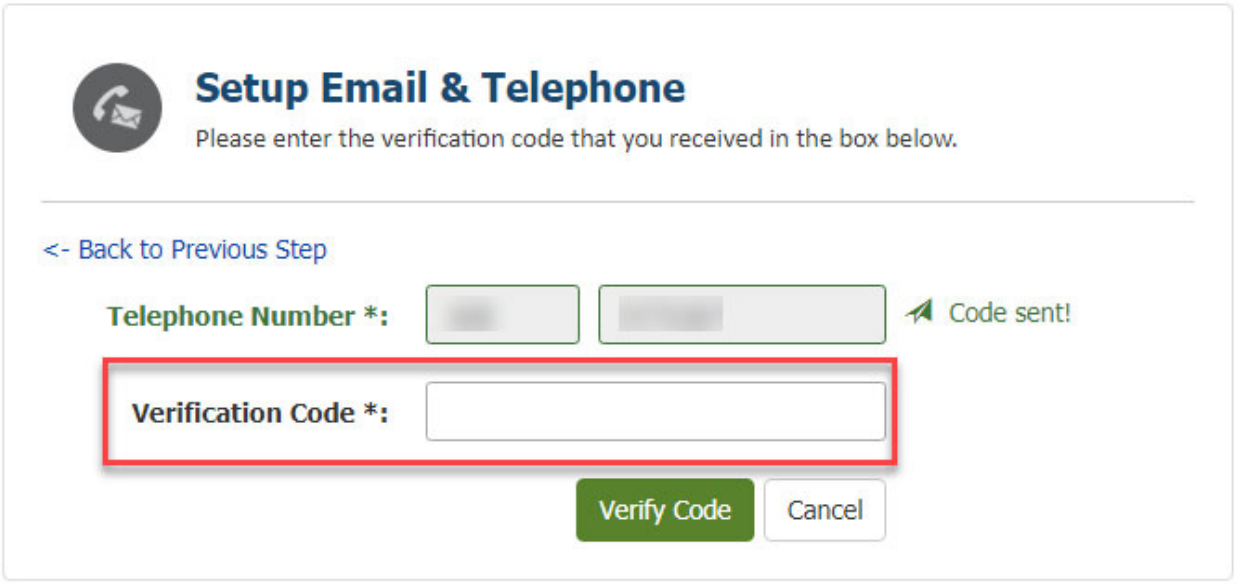


3. You will receive an automated telephone call from WPS with the following message:

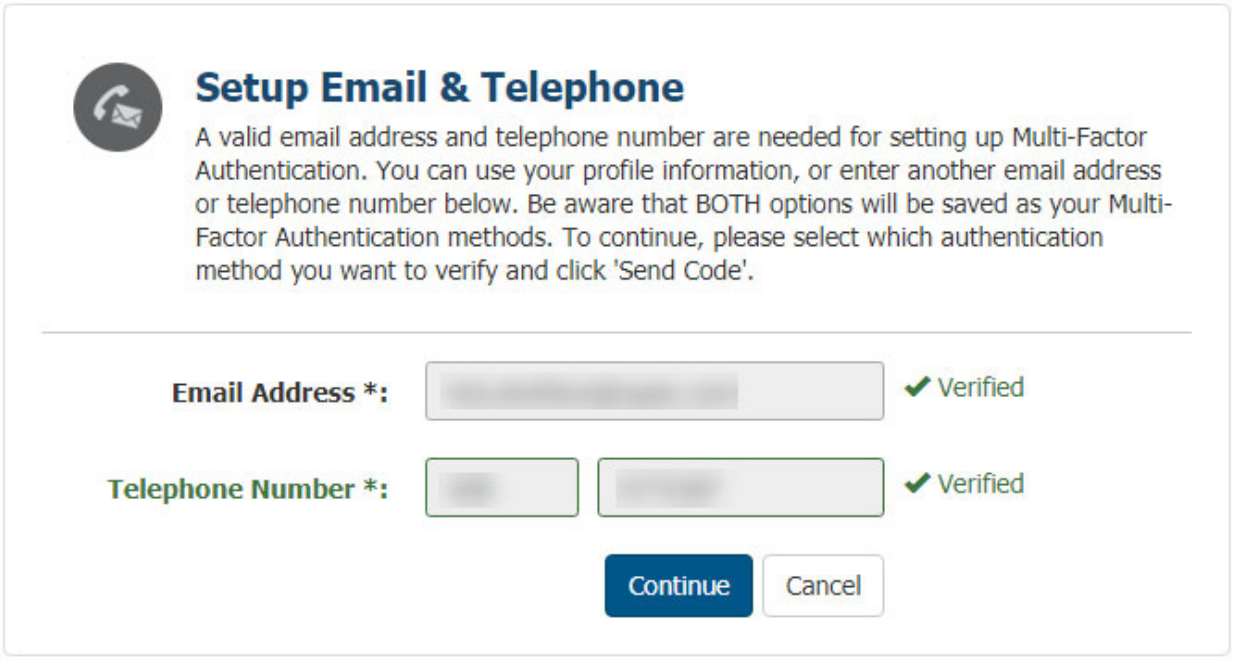
   "Hello. Thank you for using the WPS GHA Multi-Factor Authentication phone verification option. Your code is: [randomly generated six-digit number]. Again, your code is: [repeat of six-digit number]. Remember, you should not share this code with anyone else, and no one from WPS GHA will ever ask for this code. Goodbye."

4. Enter the MFA code from the telephone call in the Verification Code field and click the Verify Code button.

   NOTE: You must enter the MFA code into the Verification Code field within one hour of receiving it or it will expire. If your code expires, you will need to request a new code.



5. Once you successfully verify your telephone number using the MFA code you received, you will see a green check mark with the word “Verified” next to it.

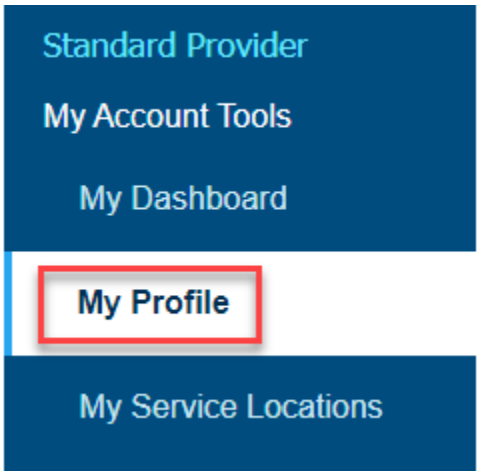


6. Click “Continue” to proceed to the next step.

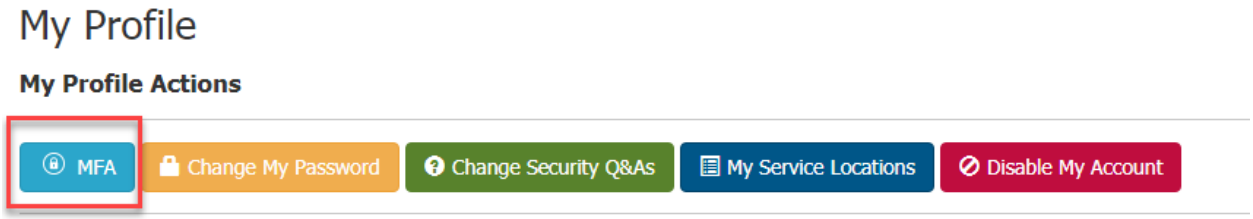
Updating your Email Address or Telephone Number for MFA

If the email address or phone number you use to receive your MFA codes changes, follow the steps below to update them. Changing the information on your account profile DOES NOT change your email address or phone number for MFA (or vice versa).

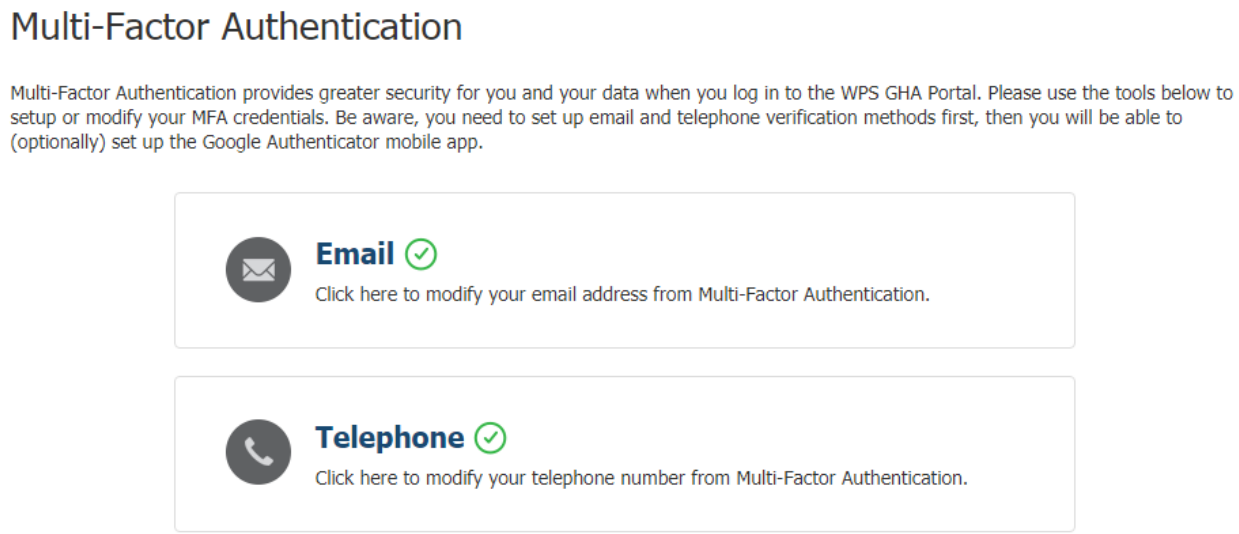
1. Log into the portal and click on the “My Profile” link in the left-hand navigation



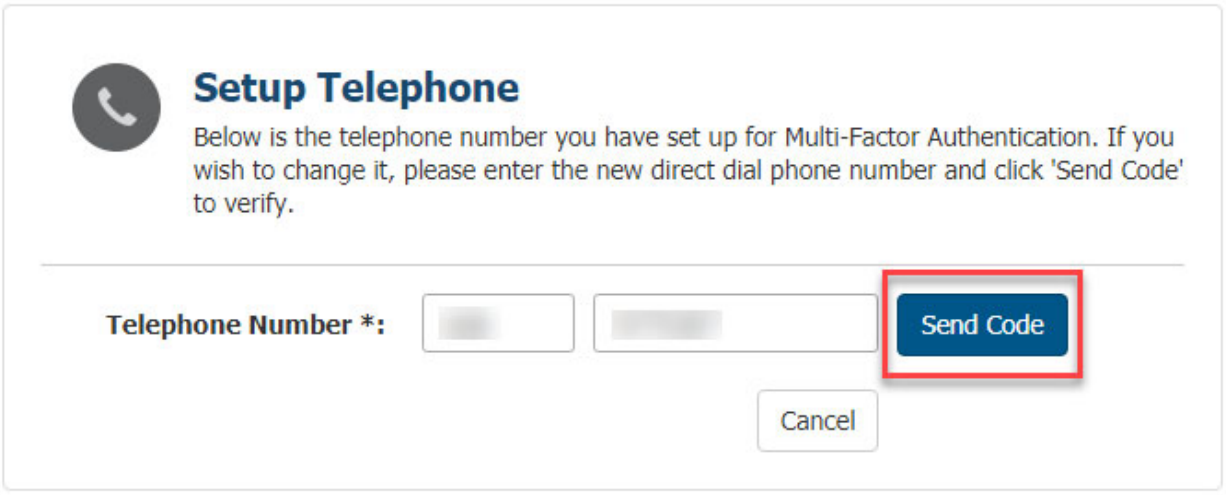
2. Click on the MFA tab at the top of the screen



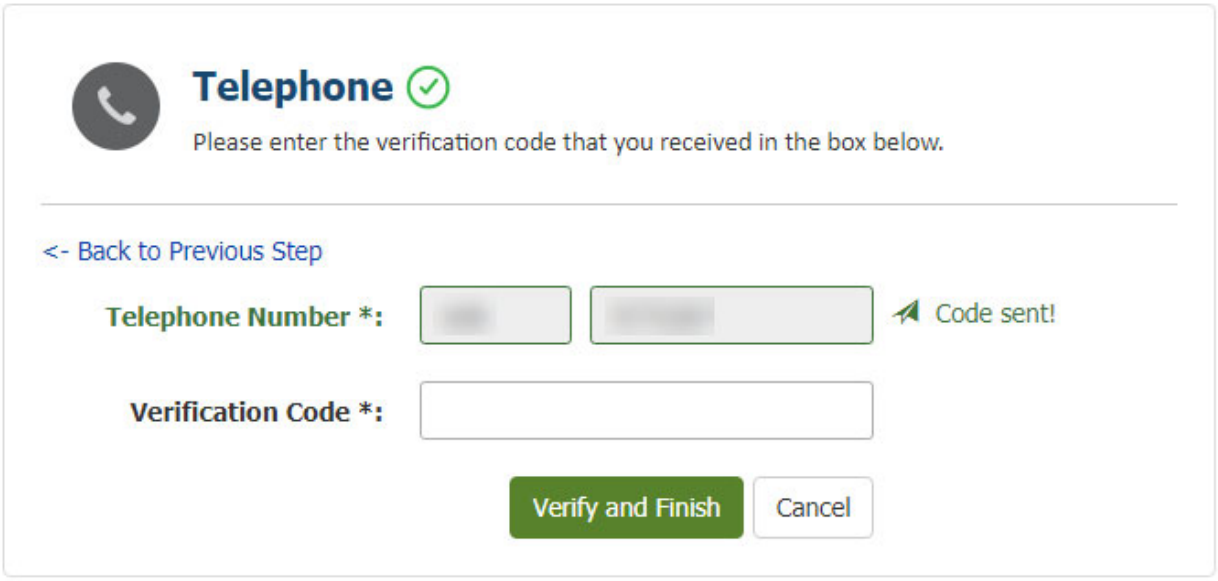
3. Select the option you are changing (email address or telephone number) and enter in the correct information



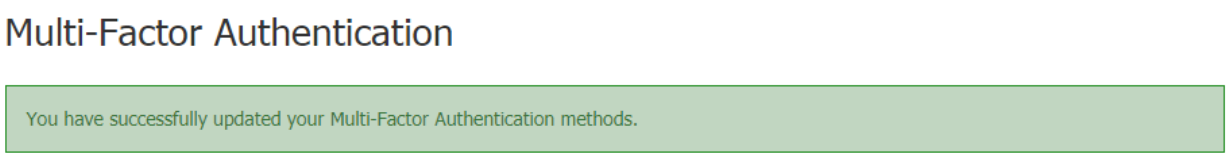
4. Click “Send Code” to send an MFA verification code to the new email address or telephone number



5. Once you receive the code, enter it in the appropriate box and click “Verify and Finish”



6. The message at the top of the page will indicate, “You have successfully updated your Multi-Factor Authentication methods.”

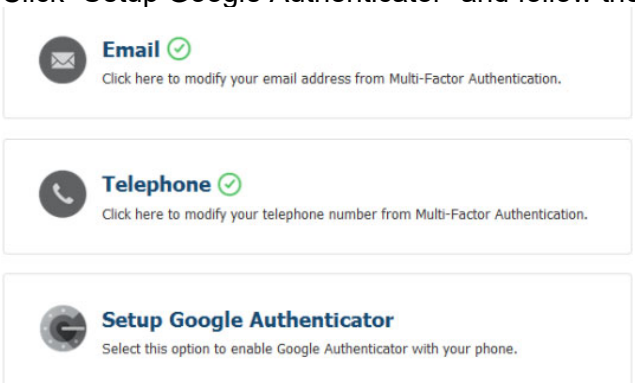


Multi-Factor Authentication (MFA) – Google Authenticator

Once you set up the email and/or telephone options for receiving the MFA code, you have the option of using Google Authenticator to receive your MFA code. Google Authenticator is an application typically installed on a smart phone. You are not required to install or set up Google Authenticator, but you can avoid some common obstacles by using it. Since you immediately receive an MFA code on your own mobile device, you do not need to wait to receive an email containing the verification code. It is also a good secondary authentication option if you cannot set up MFA for telephone because you do not have a direct phone line.

Setting Up Google Authenticator

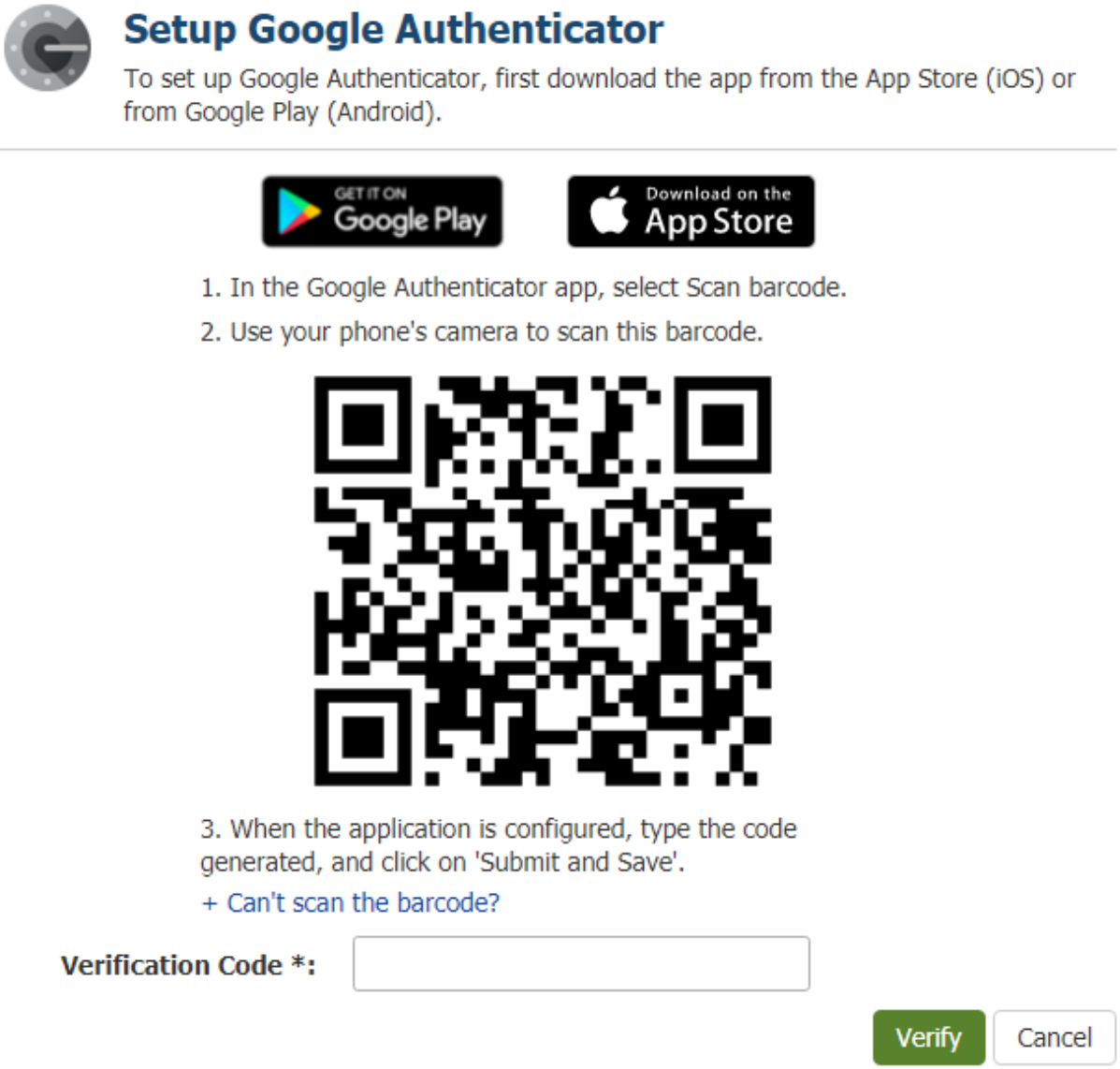
1. Click “Setup Google Authenticator” and follow the on-screen instructions.



2. Download the Google Authenticator app using Google Play (Android devices) or the App Store (iOS devices). Follow the instructions in the app to install it on your mobile device.

3. Once installed on your mobile device, follow the instructions in the app for scanning the QR code displayed in the WPS Government Health Administrators Portal (shown below). If your mobile device cannot scan a QR code, click the “Can’t scan the barcode?” link to use the manual entry option.

   NOTE: The QR code displayed below is an example of what your personalized QR will look like. It is not a working code.



4. The Google Authenticator app will display an MFA code on your mobile device.

5. Enter the MFA code in the Verification Code box located below the QR code and click “Verify.”

   NOTE: The verification code displayed in the Google Authenticator app changes every 30 seconds.

6. The portal will display a message indicating you have successfully enabled Google Authenticator and take you to your Dashboard.

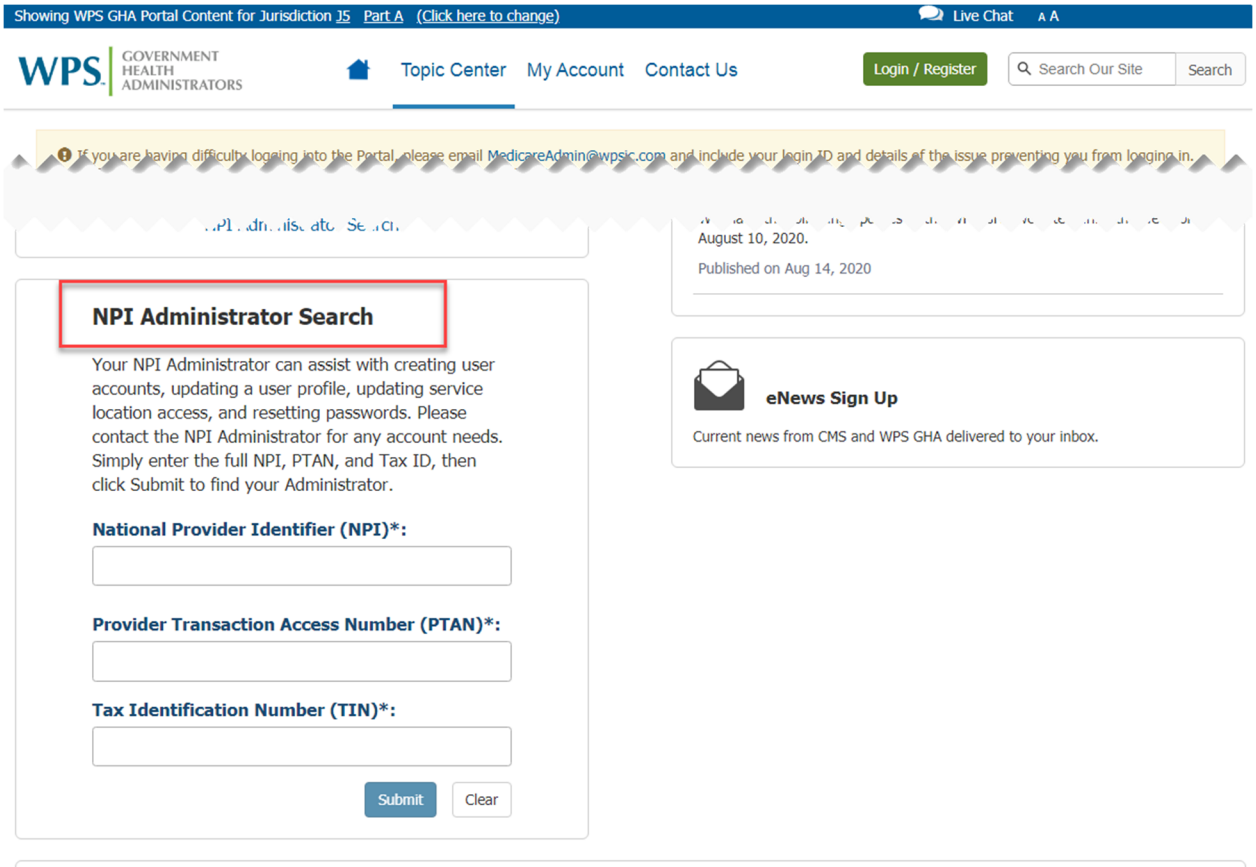
Locating Your NPI Administrator

Your NPI Administrator should be your first point of contact if you have any issues with your account. NPI Administrators can perform most tasks associated with account maintenance, such as resetting passwords and security questions. In addition, NPI Administrators are the only individuals who can grant access to an NPI or change your level of access. If you need to contact your NPI Administrator, but do not know who it is, you can use the NPI Administrator Search to look up their name and contact information.

Locating Your NPI Administrator without Logging In

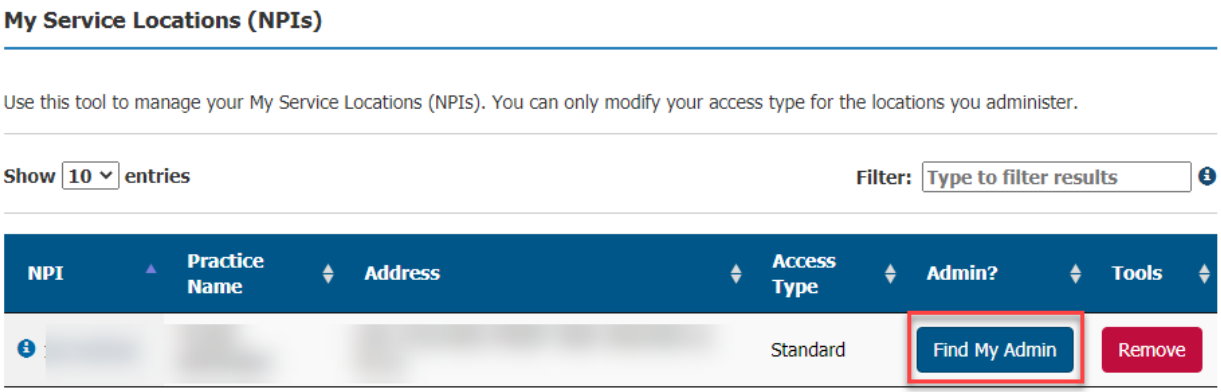
If you are not able to log into your account, you can search for your NPI Administrator on the Login page.

1. Locate the NPI Administrator Search box near the bottom of the Login screen.
2. Enter your NPI, PTAN, and Tax ID (TIN) in the designated fields and click the “Submit” button.
3. If the information is valid, the portal will return a list of all active NPI Administrators for the NPI you entered. The information will include their name, phone number, and email address on file.



Locating Your NPI Administrator after Logging In

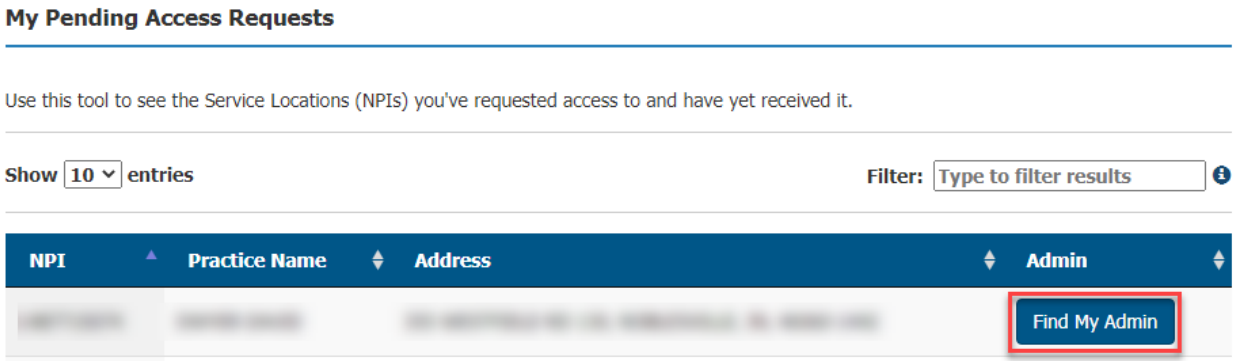
1. Click on the “My Service Locations” link in the blue left navigation menu.
2. Scroll to the “My Service Locations (NPIs)” section.
3. Click on the blue “Find My Admin” button located next to the NPI.
4. The portal will display a pop-up with the NPI, PTAN, and TIN, along with the name, phone number, and email address for the NPI Administrator.



Locating Your NPI Administrator for a Pending Access Request

When you request access to a new NPI, only an administrator for that NPI can grant you access to the NPI. If you have questions about the status of your pending access to an NPI, you must contact that NPI’s administrator.

1. Click on the “My Service Locations” link in the blue left navigation menu.
2. Scroll to the “My Pending Access Requests” section.
3. Click on the blue “Find My Admin” button located next to the NPI.
4. The portal will display a pop-up with the NPI, PTAN, and TIN, along with the name, phone number, and email address for the NPI Administrator.



Recertification of Portal Users

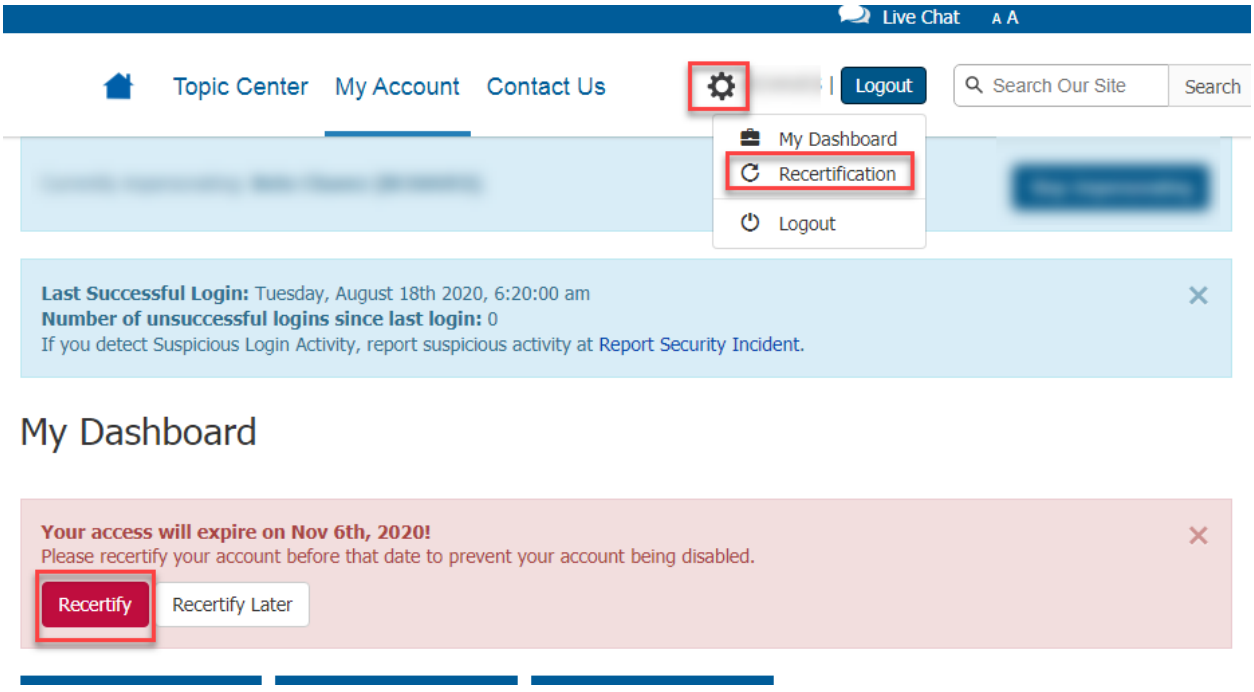
All users must recertify their accounts annually. Recertification helps to protect patient and provider data by ensuring those individuals who need access to the data will access it properly and use the information for legitimate purposes. The process is very similar to the initial registration process. Users who fail to recertify their accounts by the recertification deadline, or who do not agree to abide by all the portal's terms of use will have their accounts deactivated.

Recertification Notification

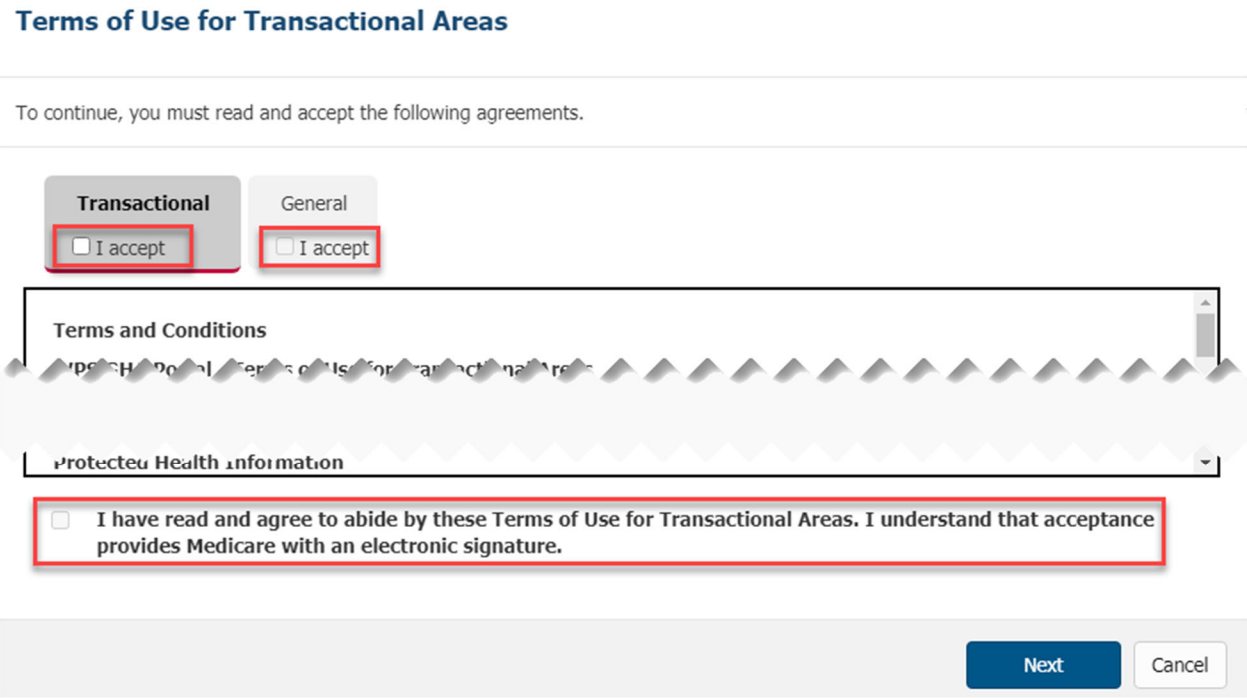
The portal notifies users they are due for recertification 90 days prior to the deadline to allow adequate time to complete the recertification steps. The portal notifies users they are within the recertification window by placing a message on the user's Dashboard. Users will NOT receive an email notifying them they are due for recertification. This helps to ensure that only active users have active portal accounts.

Recertification Process

1. Once you are within the recertification window, you can begin the recertification process in two ways:
   - On your "My Dashboard" page, click the "Recertify" button in the red banner window.
     - **NOTE:** The date listed in pop-up window is the date on which you will lose access if you do not recertify your account. You must complete recertification **BEFORE** the date in the banner window.
   - Click on the gear icon next to your username in the top right corner of the page. If you are due for recertification, there will be an option for "Recertification."



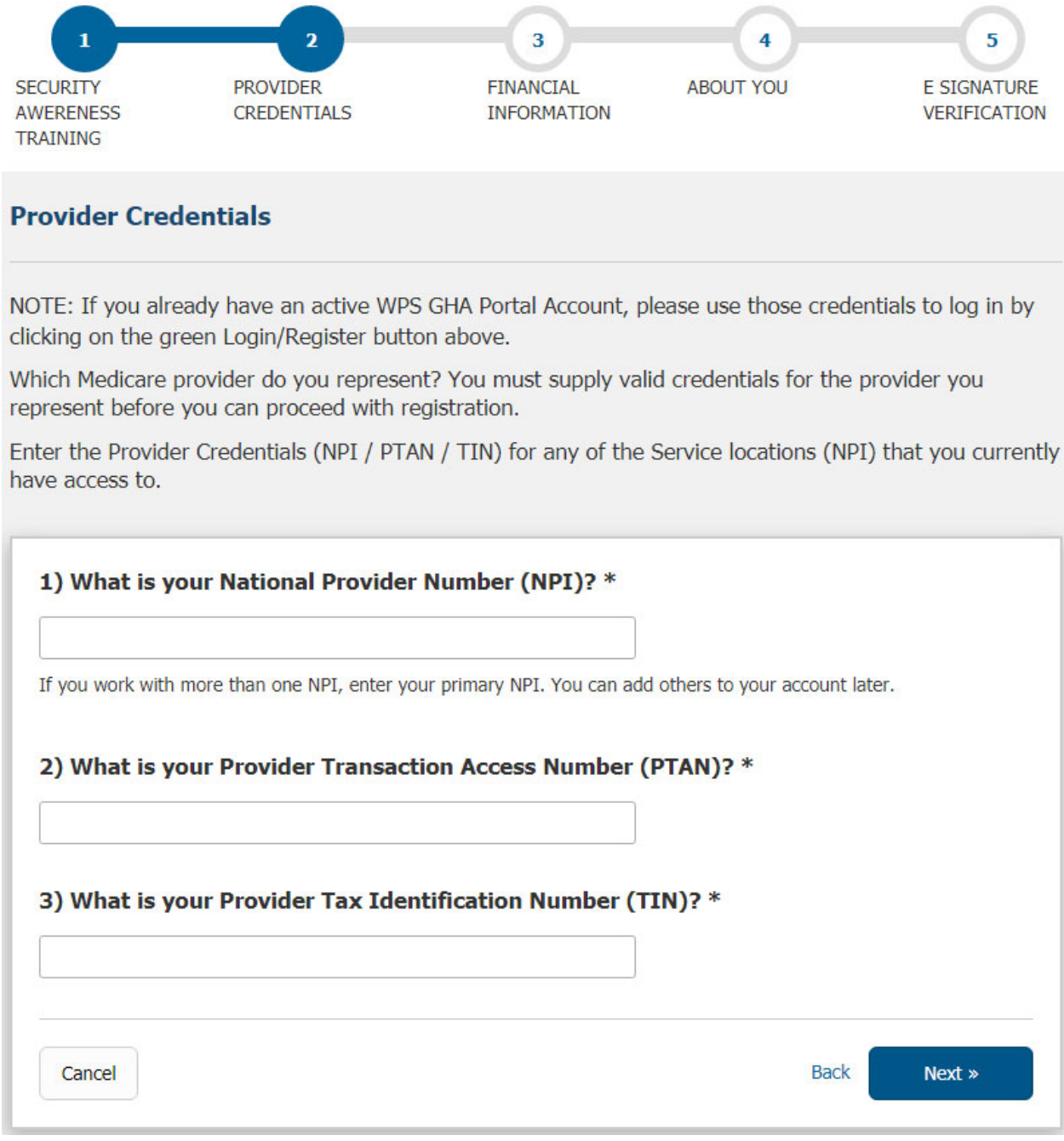
2. Read and accept the transactional and general terms of use.
   - If you decline either user agreement, the portal will immediately disable your account access.
   - To accept the terms of the agreements, you must click “I accept” in both the Transactional and General boxes, and then check the box for the statement, “I have read and agree to abide by these Terms of Use for Transactional Areas. I understand that acceptance provides Medicare with an electronic signature.”
   - Click the “Next” button to continue.



3. Attest that you have completed (or will complete) your company’s annual security awareness training.
   - WPS Government Health Administrators does not mandate what must be included in your company’s security training, nor do we offer a security awareness training course. Your company must determine how to protect itself and your patients from cybersecurity threats (such as phishing) and other fraudulent activity. The content should provide a basic explanation of the need for information security and the need for operations security.
   - Select “Yes” to confirm you have completed or will be completing annual training.

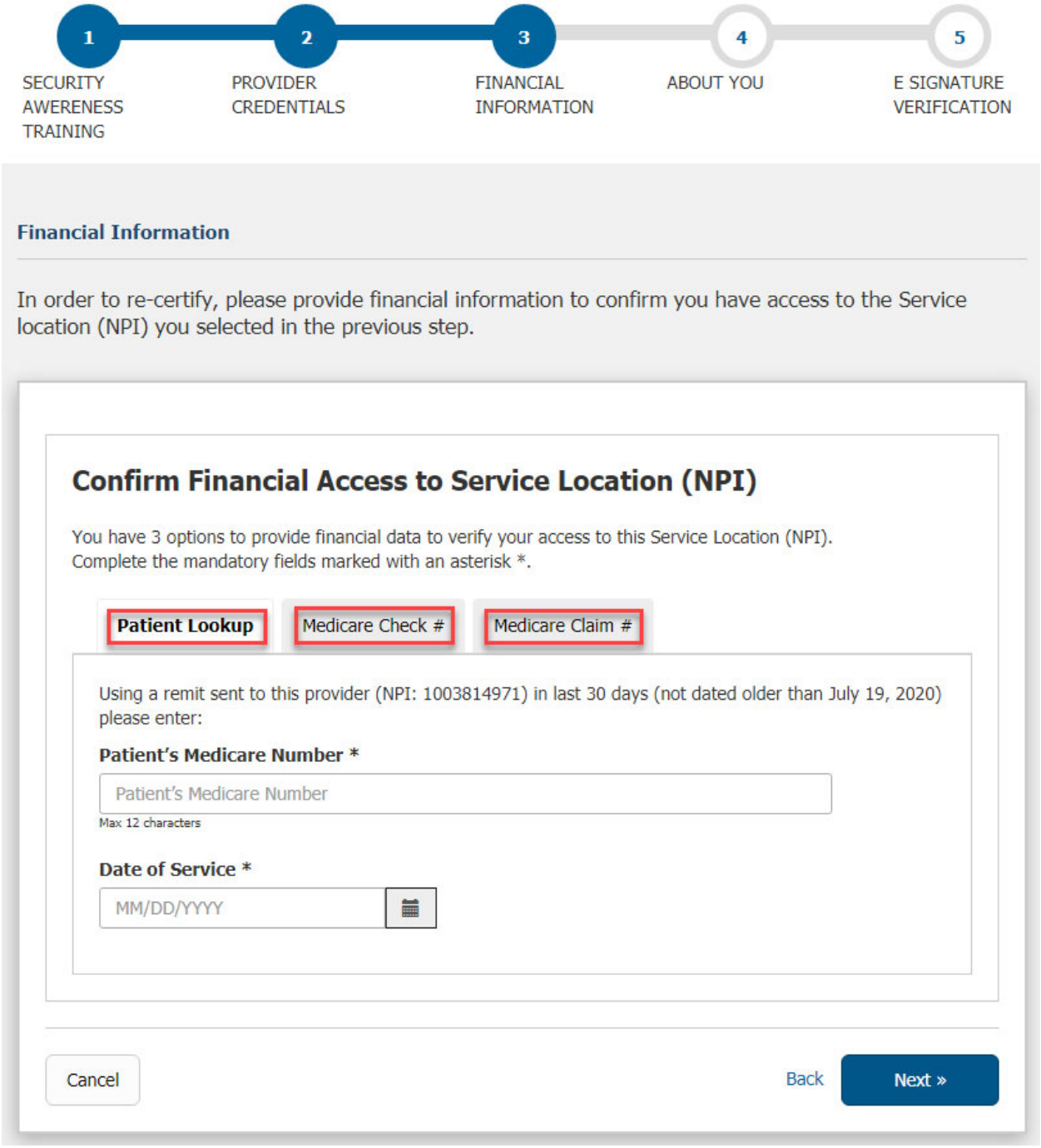
     NOTE: If you select “No,” the portal will disable your account.

4. Enter the provider credentials for any one of the Service Locations (NPIs) to which you currently have access. Then choose “Next.”



5. Enter your choice of financial information appearing on a recent remittance advice, and then click “Next.” The remittance advice must be no more than 30 days old. You can enter:
   - Patient Medicare number and date of service
   - Medicare check number
   - Medicare claim number

   NOTE: If you have access to more than one NPI, verify that the financial data you are entering belongs to the NPI you entered in the Provider Credentials step.



6. Review, update, and confirm your personal information. Ensure all required fields are complete, and then select "Next." The portal will display an error message next to each empty or invalid field if you select "Next" before entering the required information.

About you

You may NOT share accounts. Every user must have their own unique account.

Please verify the information we have on your profile below. For security reasons, we require you to re-enter and confirm your email address.

Provider Name *

- This is required.

Your Name *

Email Address *

Confirm email *

- This is required.
- error-mismatch-email

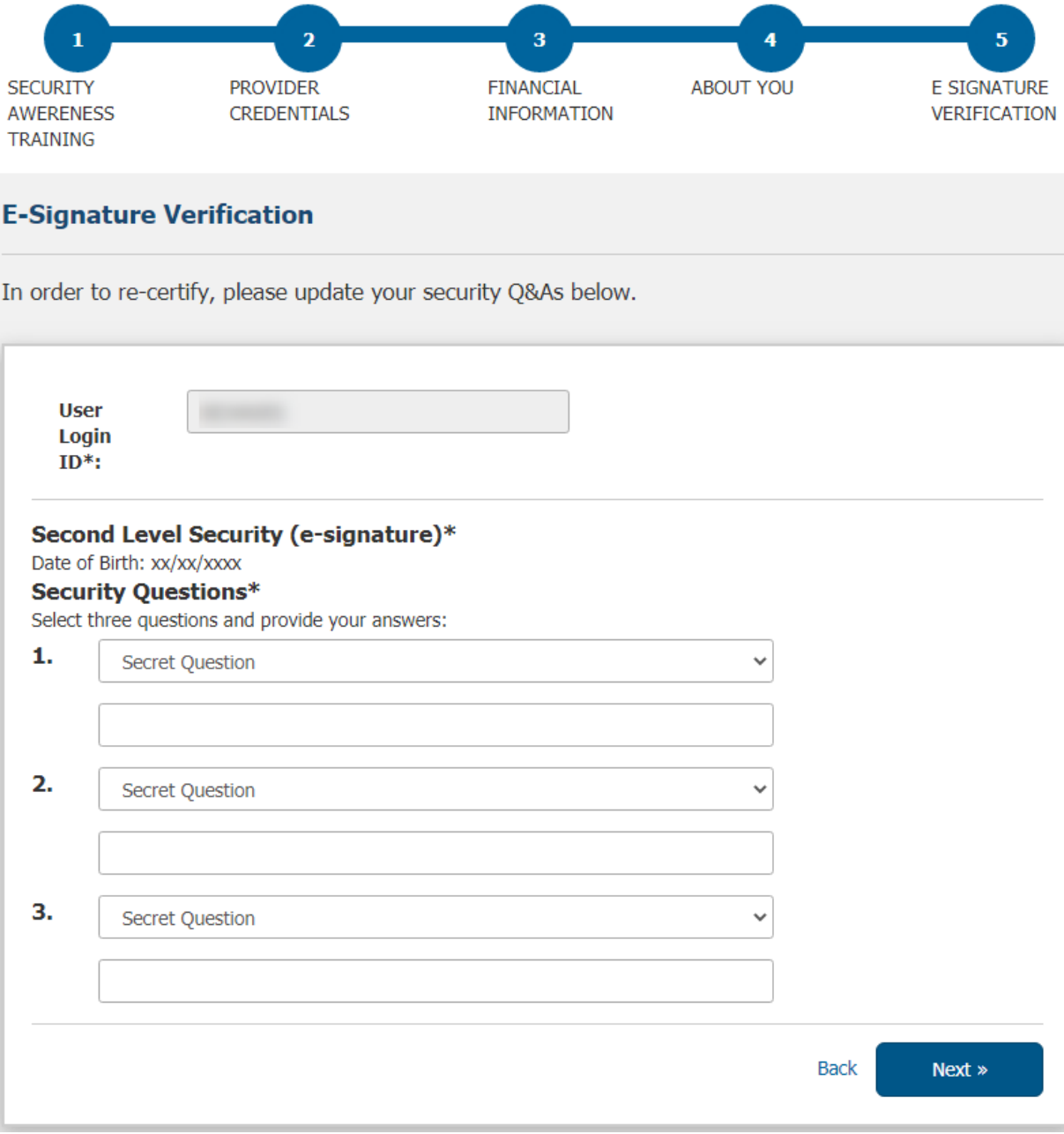
Phone Number *

Work Location Name *

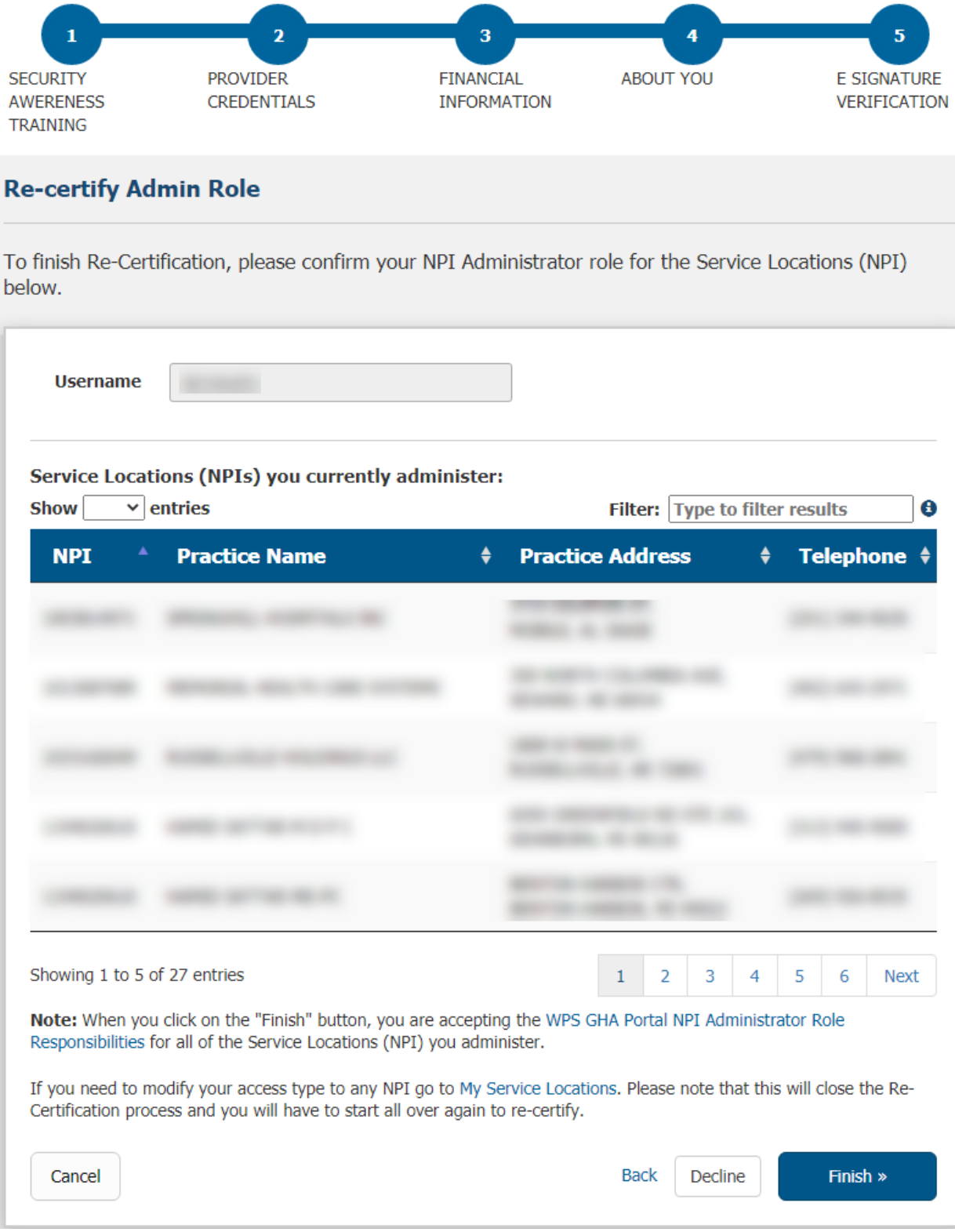
Work Location Address (Must be a street address, not a P.O. Box) *

Cancel Back Next »

7. Select and answer three new security questions for your E-Signature Verification, and then select “Next.



8. (**NPI Administrators Only)** Recertify and accept the NPI Administrator Role Responsibilities.
   - Verify the listed NPIs and review the Administrator responsibilities.
   - Select “Reaccept Admin Role” to continue recertification.
   - If you choose to modify your access to any NPI, go to “My Service Locations.” Once this is done, you will need to complete the recertification process again.
   - Select “Finish” when the NPI Administrator Recertification steps are complete.



9. You will receive a confirmation message indicating your recertification is complete.

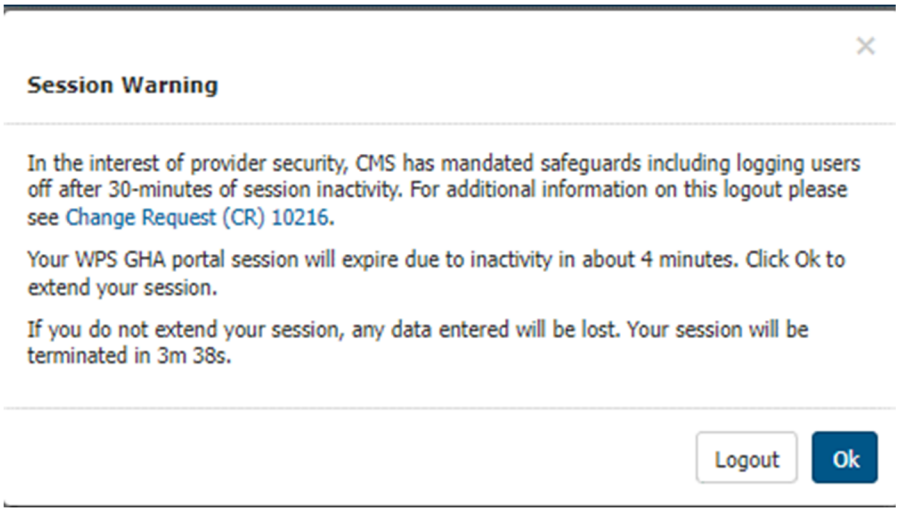
Portal Security and Loss of Account Access

CMS mandates that Medicare Administrative Contractors (MACs) follow a set of Acceptable Risk Safeguards (ARS) to protect both providers' and beneficiaries' sensitive information. CMS continually updates ARS standards to stay ahead of constantly advancing technology that could be used to steal personal data. For more information about ARS standards, see CMS Change Request (CR) 10216 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R13SS.pdf).

Account Timeout

One of the many safeguards CMS mandates is Session Lock. This rule requires all users to be actively working in the portal, which helps ensure that protected information is only displayed when a user is at their workstation. If a user is inactive for 30 minutes, the portal automatically logs the user out. The session remains locked until the user logs in again.

The portal will display a warning message with a countdown timer about five minutes before logging a user out due to inactivity. If you are still working in the portal, click the OK button to stay logged in. If you are no longer actively using the portal, you can click the Logout button to be logged out immediately. If you do nothing, the portal will automatically log you out of the portal when the timer runs out.



Losing Access to Your Account

In some cases, you may lose access to your WPS Government Health Administrators Portal account. See below for the main reasons that users lose access to their accounts and for information about resolving each situation.

Disabled Accounts

If your user account is disabled, it means the portal does not recognize your account as a valid, active account. Your user account can be disabled for several different reasons, including:

- Not signing into the account at least once every 30 days
- Not completing the annual recertification before the deadline
- Indicating you will not abide by the Terms of Use during recertification
- Not attesting to completing your company's annual security awareness training
- Clicking on the "Disable My Account" button on your My Profile page

If your account is disabled, you can register for a new account. However, if your account has been disabled for less than a year, the easier option is to reactivate your account. NPI Administrators can reactivate your account if you are a Standard or Eligibility user. If you are an NPI Administrator, you can reactivate your own account. NPI Administrators should review the Account Reactivation section of this manual for instructions on reactivating accounts.

If your account has been disabled for more than one year, it cannot be reactivated. Your only option is to register for a new account.

NOTE: WPS staff cannot reactivate any user's account. Only NPI Administrators can perform this function.

Blackout NPIs

Every NPI used to access the WPS Government Health Administrators Portal requires at least one person to accept the responsibility for the administration of the NPI's users. Like Standard and Eligibility users, an NPI Administrator will lose access to their account if they fail to log in at least once every 30 days, or if they fail to complete their annual account recertification.

If all the administrators for an NPI lose (or remove) their access, the NPI moves into "blackout" status. Other users may continue to access information in the portal using the blackout NPI for 30 days. This allows time for the previous NPI Administrator to regain access to their account, or for a new person to self-register as an administrator. If the Blackout NPI remains without an administrator after 30 days, all users lose access to that NPI.

The portal will notify you that your NPI is in blackout status on your dashboard. If you are willing and able to become the NPI Administrator, you can click on the link in your dashboard window. See the information, see the Blackout NPIs section of this manual for instructions on self-registering as an NPI Administrator for a blackout NPI.

Replicated Accounts

The WPS Government Health Administrators Portal does not allow users to have more than one account for the same NPI. If you create two accounts for the same NPIs using the same contact information, the portal will consider the accounts to be replicated. You will not be able to access either account until you contact Customer Service to remove one of the accounts and fix the replication error. You **cannot** fix a replication error just by removing one of the accounts.

NOTE: NPI Administrators do **not** have the ability to fix replicated accounts. You must contact Customer Service for help with this issue.

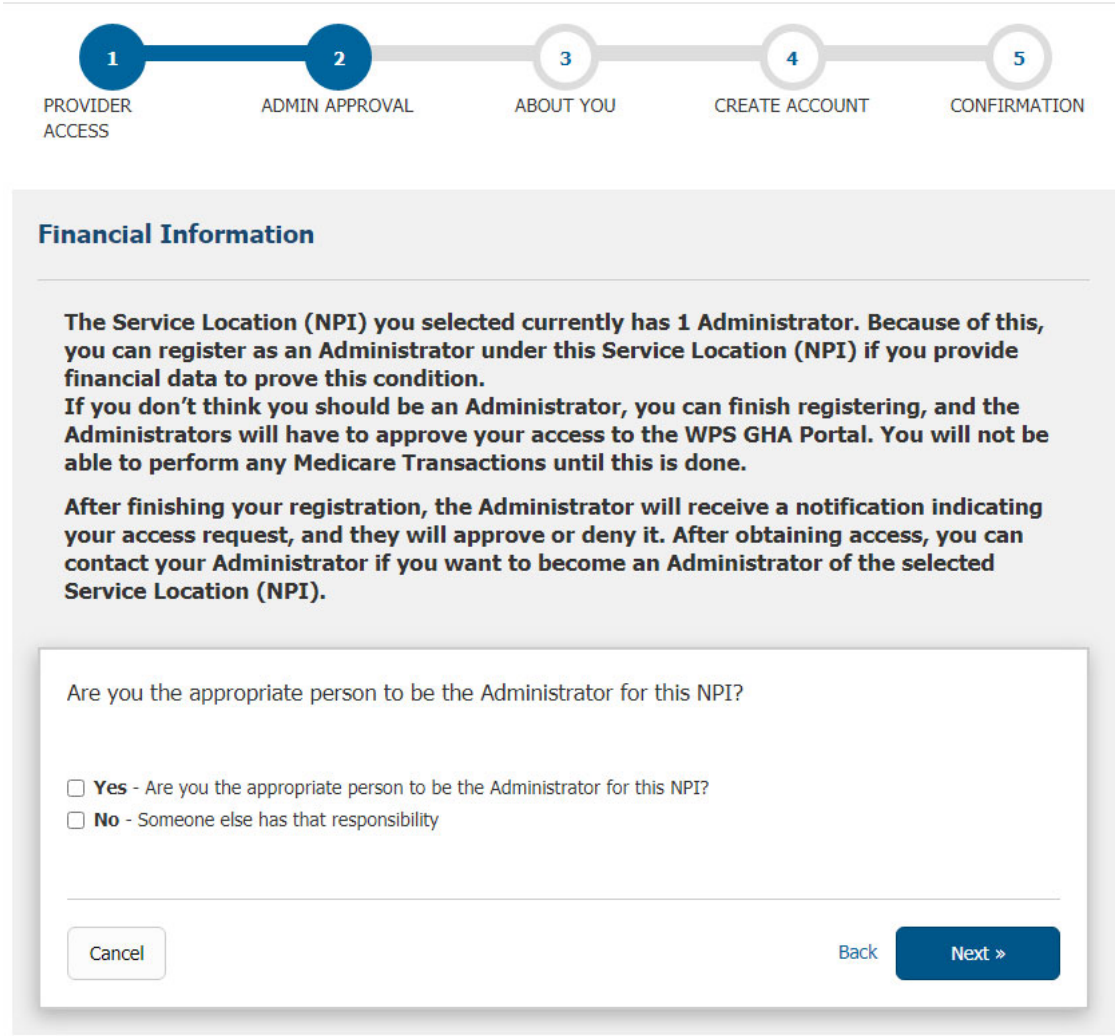
NPI Administrator Functions

Registering as an NPI Administrator

Any NPI used to perform transactions in the WPS Government Health Administrators Portal must have at least one user who agrees to manage all users' access to the portal using that NPI. When requesting access to an NPI you may have the option to accept the role of NPI Administrator. You should only accept the role of NPI Administrator if you are willing and able to fulfill the NPI Administrator responsibilities.

Accepting the Administrator Role during Initial Account Setup

When setting up a portal account for the first time, you must enter your provider credentials (NPI, PTAN, and Tax ID) as part of the registration process. If the portal determines that your NPI does not already have five or more NPI Administrators, it will you give you to option to accept the role.

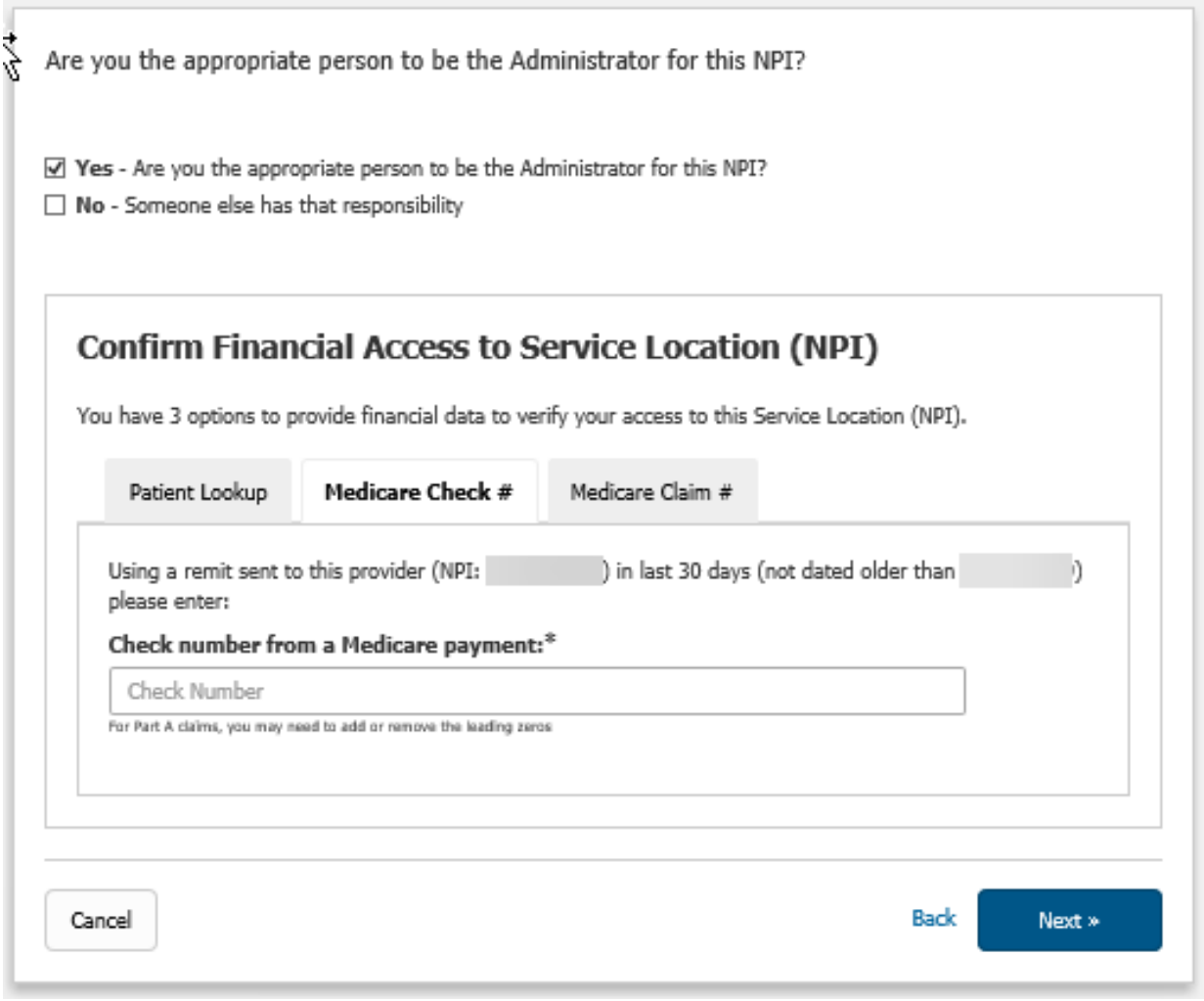


7. On the Financial Information screen, read the details and answer whether you are the appropriate person to be the Administrator for this NPI. If you ARE an appropriate person to be the administrator, select “Yes,” then click the “Next,” button. A pop-up box with the Administrator Role Responsibilities will display.

8. Review the pop-up window listing the NPI Administrator Responsibilities and select “Accept” or “Decline.”
   - Selecting “Accept” will take you to the Financial Information screen to enter data to confirm authorized access to a Service Location.
   - Selecting “Decline” will revert back to the Financial Information page to allow you to select “No” and continue with the registration process as a non-administrator user.

NOTE: Selecting the “Back” button will revert to the Provider Credentials page; selecting “Cancel” will cancel out the entire registration process and revert to the Login/Registration page.

NOTE: Make sure that you verify that the NPI you are using for registration matches the financial information needed to complete the step below.



9. To register as an administrator for an NPI, you must confirm you have access to recent

financial (claim) data for that NPI (service location). You must be able to provide information that would appear on a remittance advice issued within the last 30 days.

- Select one of the three tabs to verify your access to the service location.
- Enter the required data of your choosing (Patient Lookup, Medicare Check # or Medicare Claim #), then select “Next.”

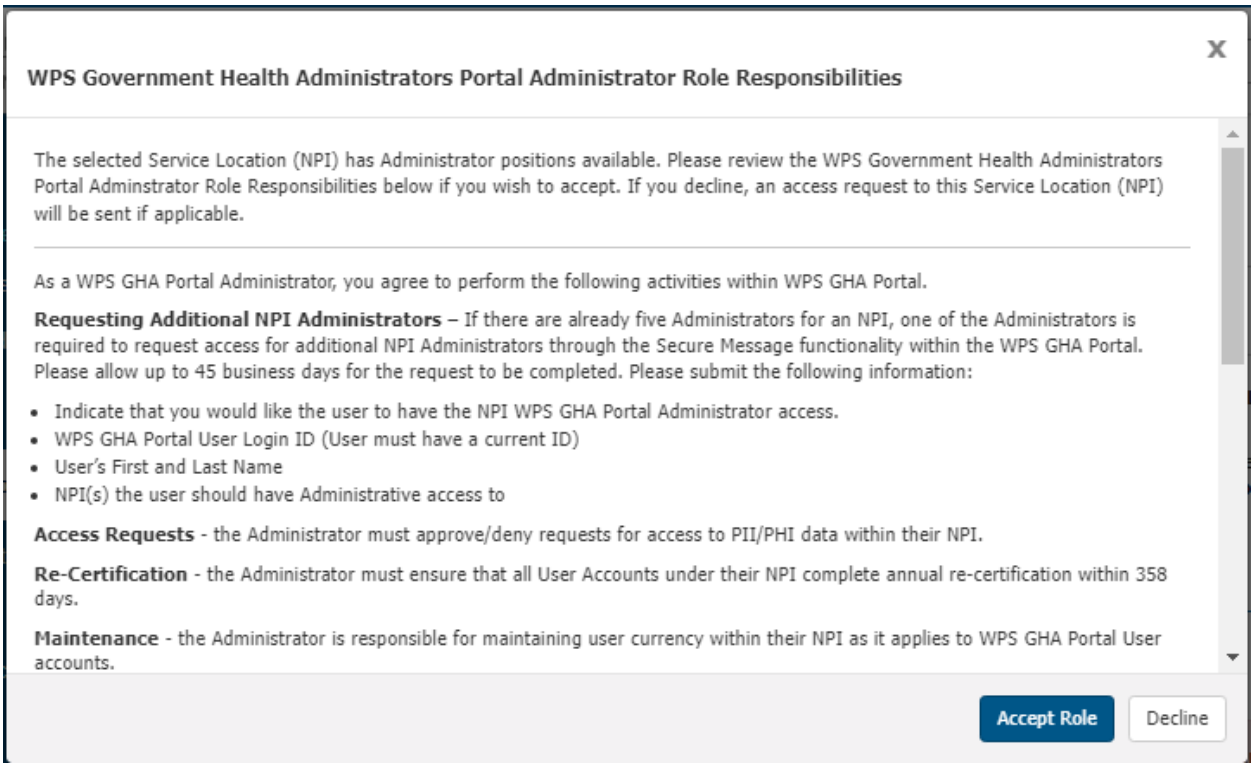
10. After successfully verifying your access to the NPI and accepting the responsibility of being the NPI administrator, you will create your personal account. For more information about creating your personal account, see the User Login ID and Password Setup and Management section of this manual.

Accepting the Role of Administrator When Requesting Access to Another NPI

After initially creating your portal account, you can request access to additional NPIs on your My Service Locations page. Once you enter the NPI, PTAN, and TIN of the new NPI, the portal will determine if there are fewer than five current NPI Administrators. If there are, the portal will offer you the opportunity to accept the role. The process is similar to accepting the NPI Administrator role during initial registration.

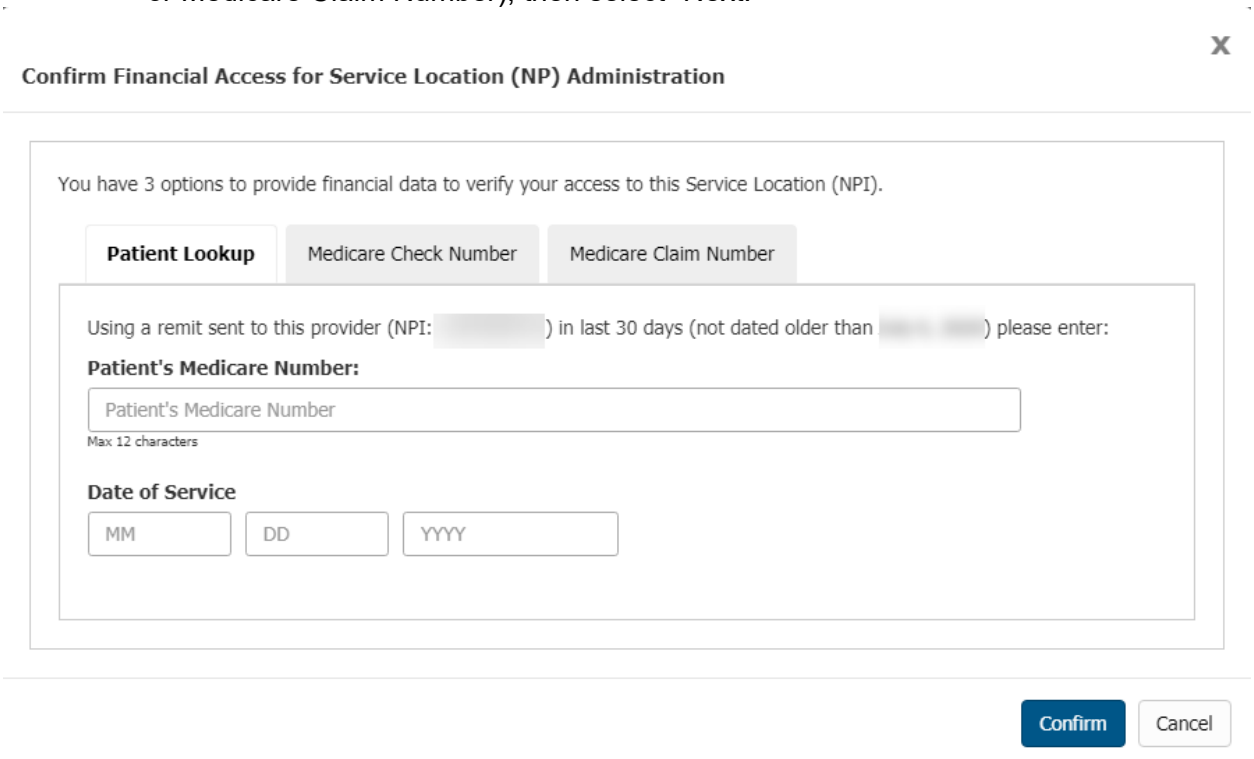
- Review the Portal Administrator Role Responsibilities in the pop-up window. Click “Accept Role” if you agree to accept the administrator role and responsibilities.

  NOTE: If you decline the role, the portal will immediately send your request for access to the NPI to the existing NPI Administrator for approval of Standard or Eligibility access. If there is no existing NPI Administrator, your access request cannot be approved until someone else accepts the role and approves your request.



After accepting the role, you must confirm you have access to recent financial (claim) data for that NPI (service location). You must be able to provide information that would appear on a remittance advice issued within the last 30 days.

- Select one of the three tabs to verify your access to the service location.
- Enter the required data of your choosing (Patient Lookup, Medicare Check Number or Medicare Claim Number), then select "Next."



Becoming an Administrator When You Already Have Standard or Eligibility Access to the NPI

Users with Standard or Eligibility access to an NPI may need to assume the role of NPI Administrator. This most often occurs when a current administrator changes jobs or otherwise can no longer perform the duties of the NPI Administrator. The process for becoming an NPI Administrator for an NPI to which you already have access differs depending on the number of current NPI Administrators.

Becoming an Administrator When There Are Fewer than Five Current NPI Administrators

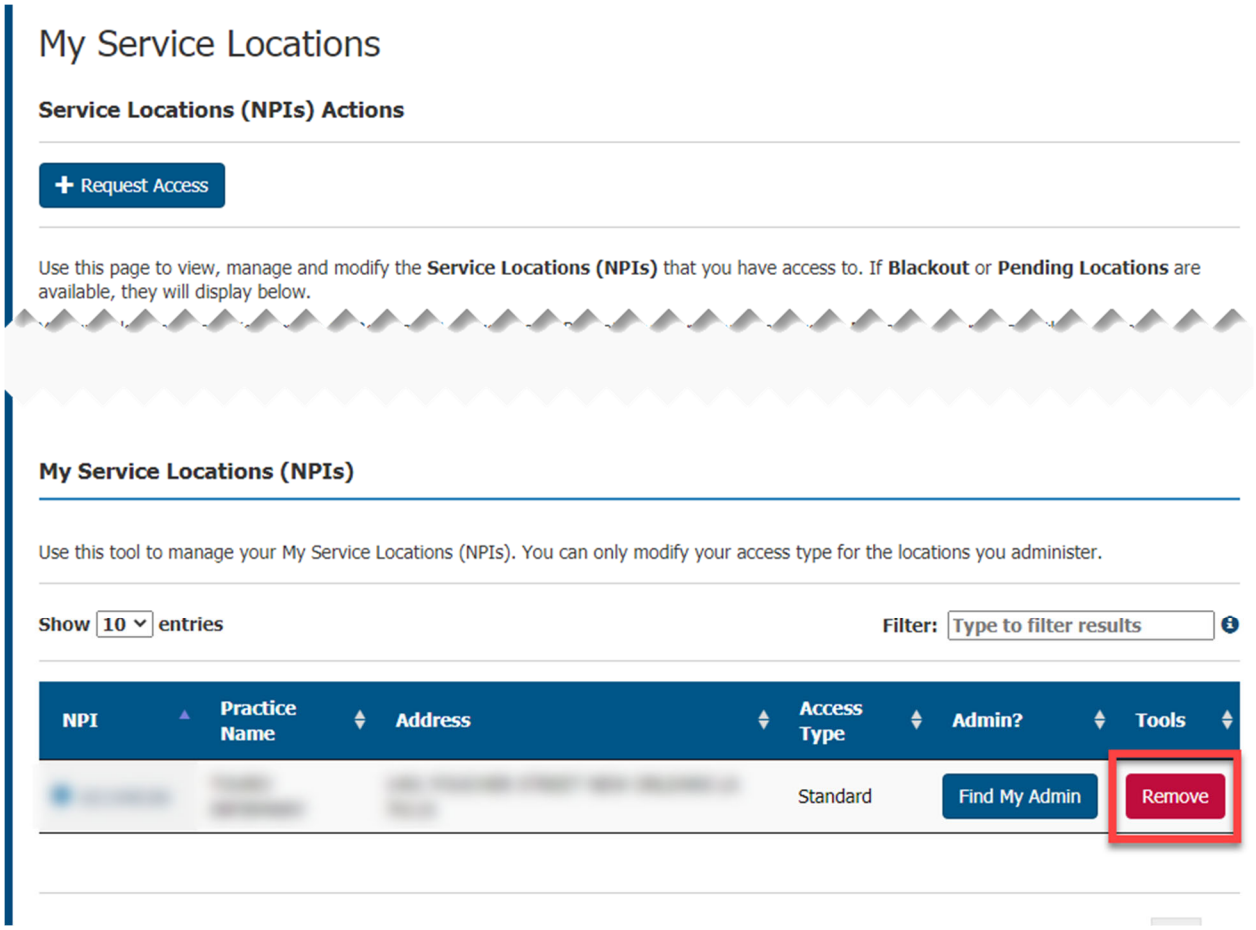
If you already have Standard or Eligibility access to the NPI for you want to become the administrator, you must first remove your access to the NPI. As soon as you remove your access, you can immediately request access to the NPI again. This is the only way to trigger the self-registration process to become an NPI Administrator.

Follow these steps to remove your access and request administrator access:

1. Log into your account and navigate to the My Service Location page.

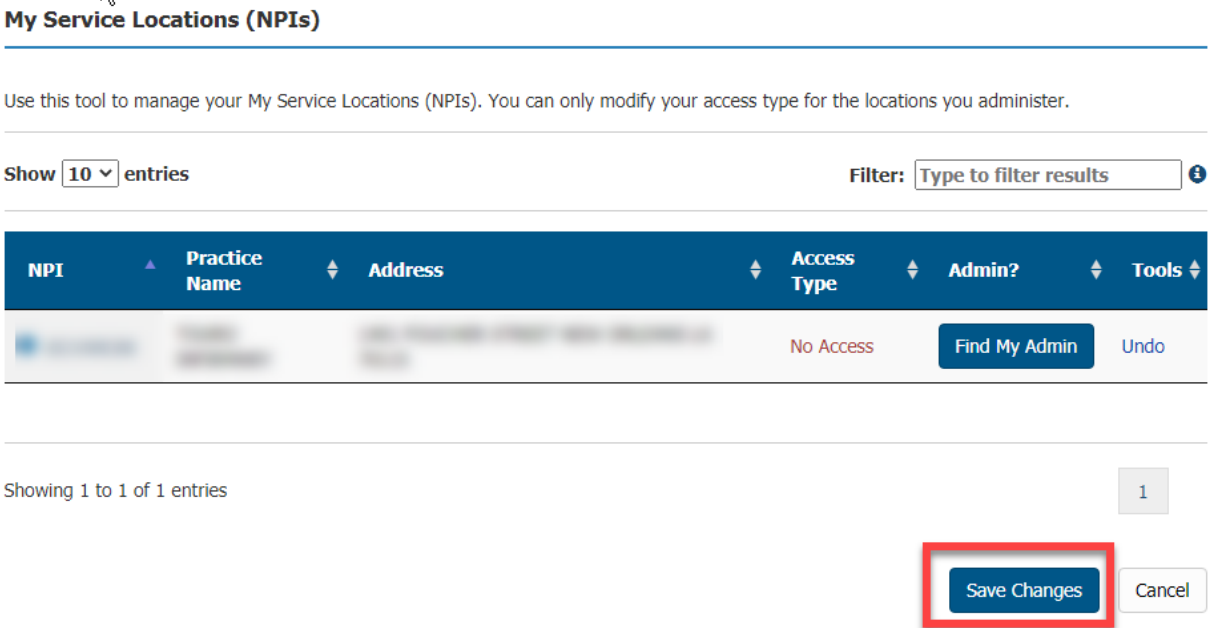
2. Scroll down the page to the My Service Locations (NPIs) section to locate the list of the NPIs to which you have access.

3. Locate the NPI to which you will be requesting administrative access. Click the Remove button next to that NPI.

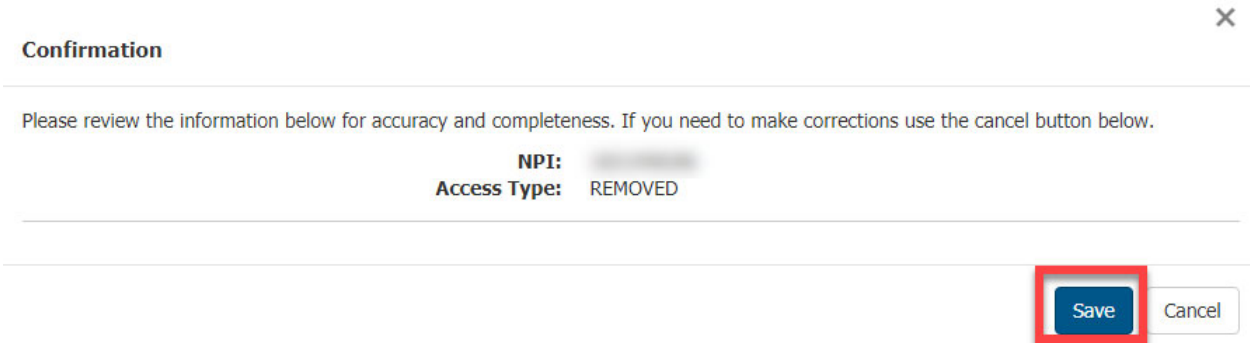


4. Click “Save Changes” to remove your access to the NPI.

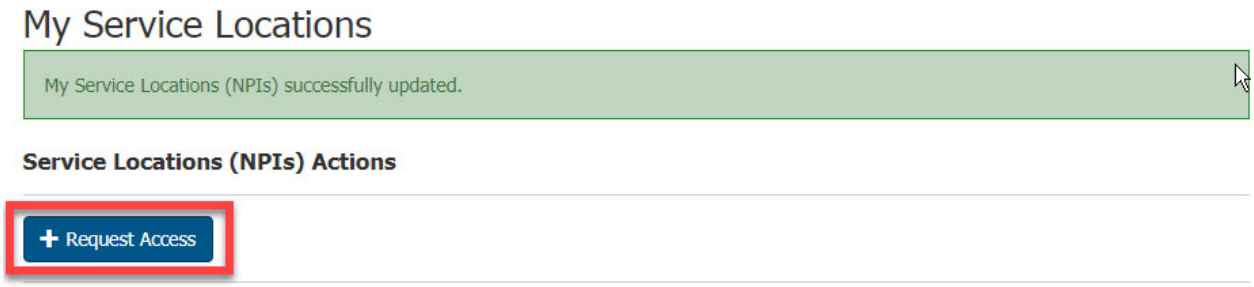
NOTE: If you inadvertently click the Remove button next to the wrong NPI, you may click “Undo” before saving your changes to keep your access to that NPI.



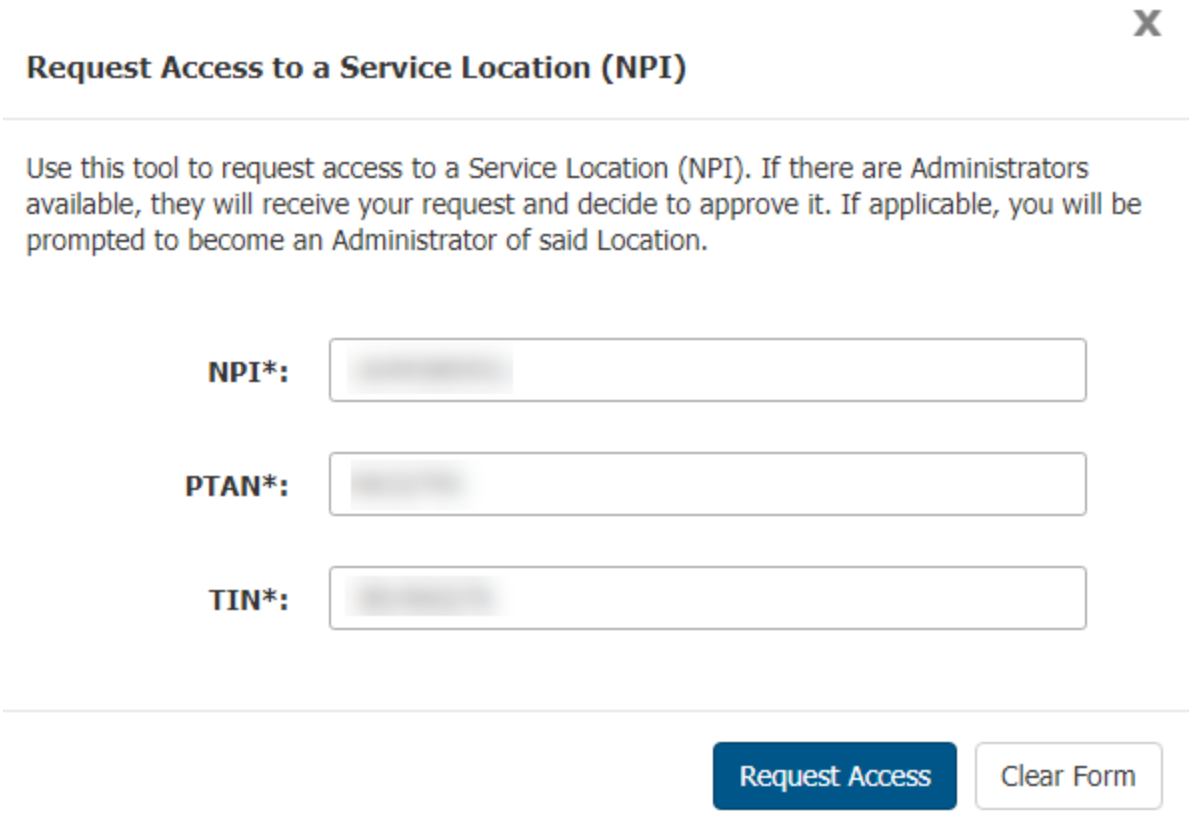
5. In the Confirmation pop-up window, click “Save” to confirm you are removing access to the NPI.



6. After removing your access to the NPI, return to the top of the My Service Location page. You will see both a confirmation message and the Request Access button. Click “Request Access” to request access to the same NPI you just removed.



7. Enter your NPI, PTAN, and TIN information in the pop-up box.



8. If the NPI has fewer than five administrators, the portal will offer you to option to accept the role of the NPI Administrator. Follow the instructions above in the “Accepting the Role of Administrator When Requesting Access to another NPI” section to complete your self-registration.

NOTE: If the portal does NOT offer you the option to accept the administrator role, it means the NPI already has five or more administrators, and you will not be able to self-register as a new administrator. Continue to request Standard or Eligibility access to the NPI. Once a current administrator grants your access, follow the instructions below to request administrative access when there are five or more current administrators.

Becoming an Administrator When There Are Five or More Current NPI Administrators

If the NPI currently has five or more administrators, a current NPI must send a Secure Message to our Customer Service staff requesting your level of access be changed to NPI Administrator. The portal does not offer an option to self-register as an NPI Administrator if there are already five or more NPI Administrators.

1. Contact a current NPI Administrator for the NPI to let them know you would like administrative access. If you do not know who the administrators are for the NPI, see the Locating Your NPI Administrator in this manual for instructions on identifying an administrator.

2. Ask the current NPI Administrator to send a Secure Message to Customer Service requesting a change to your level of access. The message must contain:

    - Your user login ID
    - Your first and last name
    - A list of the NPIs to which you should have administrative access

3. Allow up to 45 business days for Customer Service to process the request, though most requests are processed in significantly less time.

NOTE: Please be sure the NPI Administrator requesting the change to your level of access is an administrator for every NPI listed in the request. Our Customer Service staff cannot change your level of access if the request is submitted by an individual who is not currently an NPI Administrator for that NPI.

NPI Administrator Responsibilities

Anyone who accepts the role of NPI Administrator for their NPI agrees to perform certain functions on behalf of their NPI group or facility. NPI Administrators not only facilitate access to the portal for the other users in their group, but also ensure those users abide by the WPS Government Health Administrators Portal General Terms of Use and Transactional Terms and Conditions.

When registering as an NPI Administrator, you agree to be responsible for the following functions for your NPI group:

Access Requests
An NPI Administrator must approve or deny requests for access to protected data within the portal for their NPI.

Account Reactivation and Self-Reactivation
An NPI Administrator is responsible for reactivating other users' portal accounts if the account becomes disabled. An NPI Administrator is also responsible for reactivating their own account if it is disabled. This only applies to accounts that have been disabled for less than one year.

Account Review
An NPI Administrator is responsible for completing a thorough user review every 90 days to assure all active accounts are in compliance. The NPI Administrator's user review shall include the following steps:

- Verifying all active user accounts under the NPI(s) are held by current employees or contractors with the NPI organization and confirming those users should still have access to the portal under the NPI(s).
    - If a user is no longer associated with an NPI, the NPI Administrator must remove the user's access to the NPI location access immediately. Do not disable the user's account as the user may have valid access to the portal under other NPIs you do not administer.
- Verifying all active users have the appropriate level of portal access and correcting it, if necessary.

Identity Proofing
The NPI Administrator must verify the identity of all portal user account registrants under their NPI using a government-issued identification document containing a photograph (e.g., driver license, passport, state ID card, etc.)

Recertification
The NPI Administrator should remind users under their NPI to complete annual recertification within 358 days of their previous certification/recertification.

Requesting Additional NPI Administrators (When the NPI Already Has Five or More Administrators)
If an organization determines it needs more than five NPI Administrators to manage its WPS Government Health Administrators Portal users, one of the existing NPI Administrators must request access for any additional NPI Administrators by sending a secure message to Customer Service through the Message Center in the portal. The request must include the following:

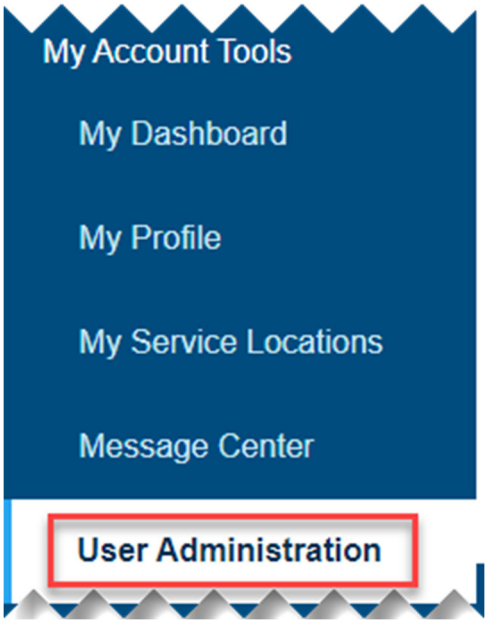
- The new administrator's User Login ID (The new administrator must already have an active user account.)

- The user's first and last names
- The NPI(s) to which the user should have administrative access (The new administrator must already have Standard or Eligibility access to the NPI(s). The NPI Administrator making the request must be the administrator for all NPIs in the request.)
- A statement indicating you would like the user to have NPI Administrator access.

Please allow up to 45 business days for the request to be completed.

User Administration

NPI Administrators have a link to the User Administration page in the left side navigation menu. This link does not appear for Standard or Eligibility users.

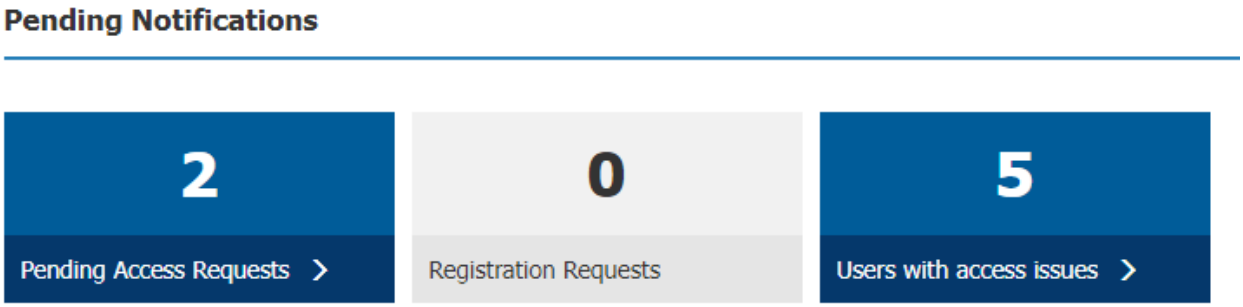


From the User Administration page, an NPI Administrator can access most administrative functions including:

- Approving new access requests
- Adding a new user
- Editing a current user's information or level of access
- Resetting a user's password or secret questions
- Reactivating a user's disabled account
- Unlocking a user's account

Pending Notifications

If you have any pending access or approval requests that need attention, you will see them at the top of the User Administration page. The requests on this page also appear on your My Dashboard page; this is just another way to access the requests. Click on the notification to review and act on the request.



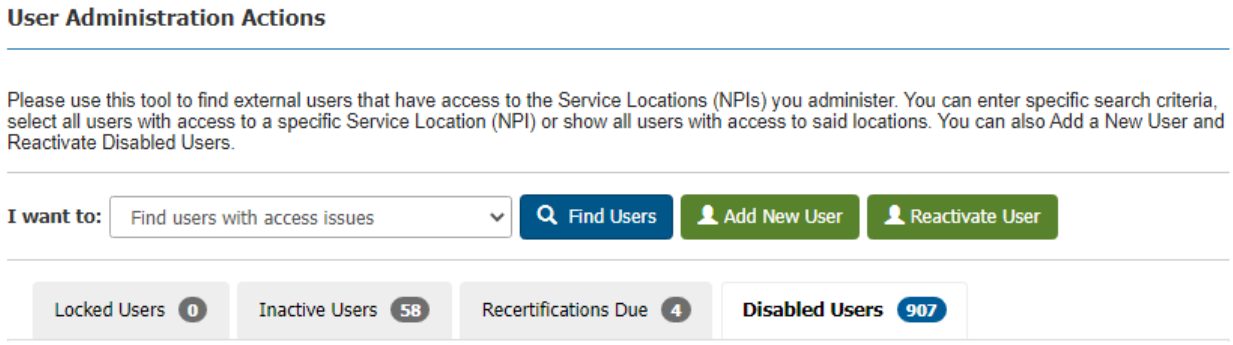
You can find more information about these functions in the following sections of this manual:

- Pending Access Requests
- Registration Approvals

User Administration Actions

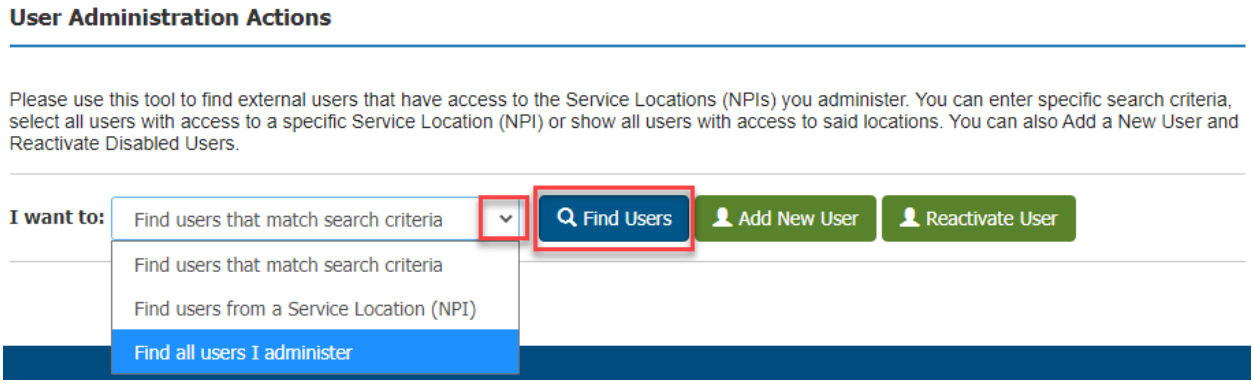
The User Administration Actions area allows NPI Administrators to perform all other administrative functions other than processing access or approval requests. NPI Administrators can access these functions by clicking on one of the following buttons:

- Find Users
- Adding a New User by the NPI Administrator
- Reactivate User
- Locked Users
- Inactive Users
- Recertifications Due
- Disabled Users



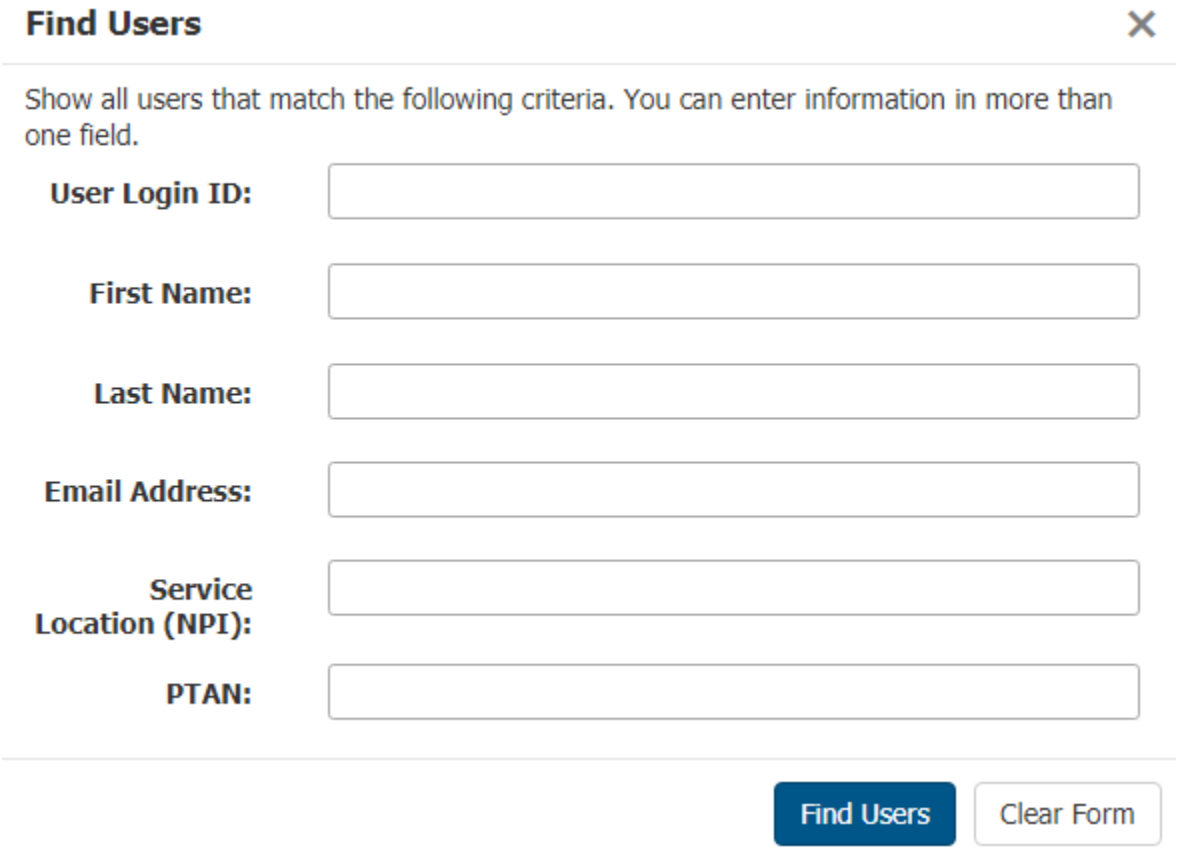
Finding Users

NPI Administrators have three search options to locate the accounts of users they administer. To select a search method, click the down arrow at the end of the dropdown box and select the search method you want to use, then click “Find Users.” Once you locate a user, you can click on their username to update or delete their account.



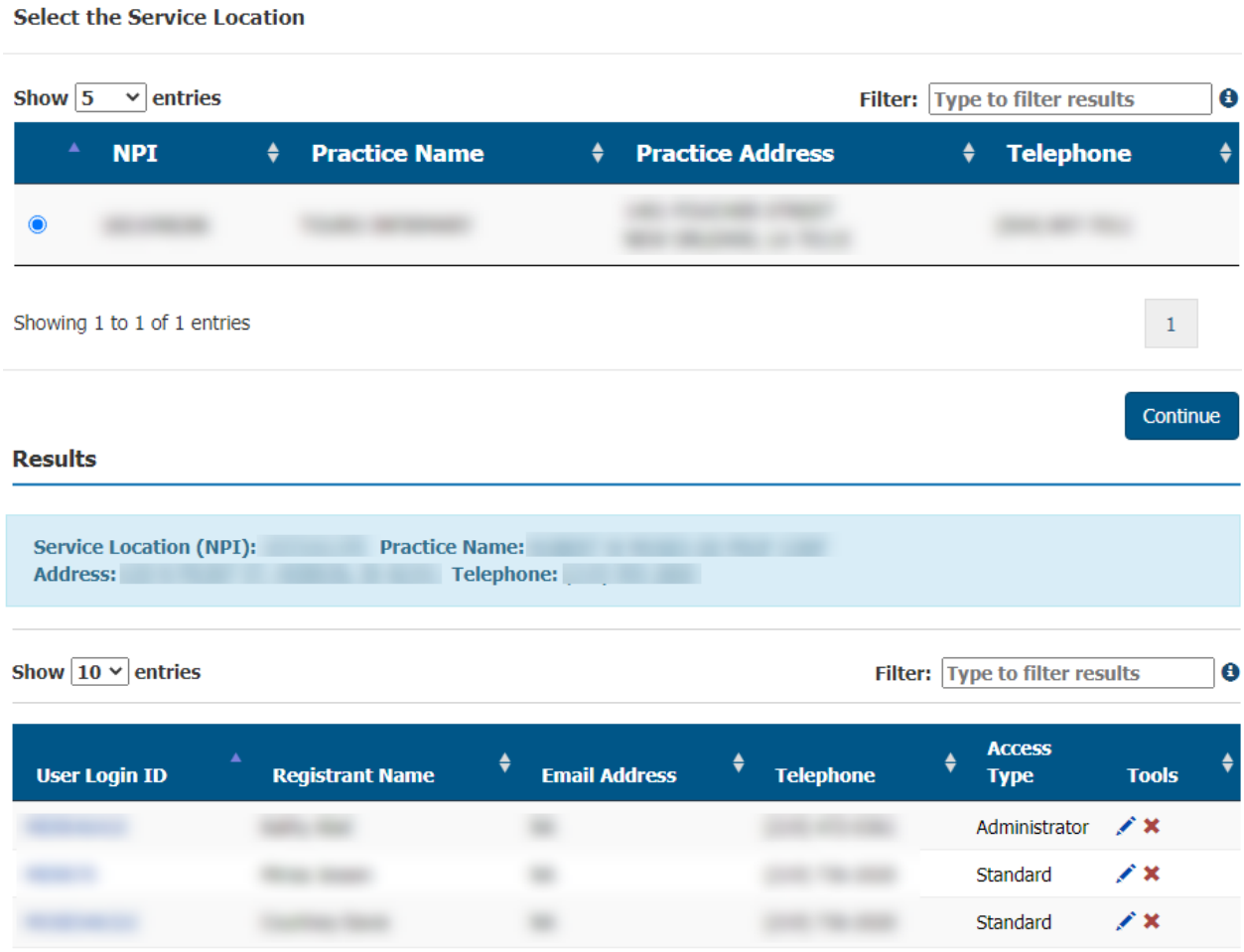
Find Users that Match Search Criteria

This search option allows the administrator to search by User Login ID, first name, last name, email address, NPI, and/or PTAN. This option is useful if you need to locate a specific user’s account.



Find Users from a Service Location (NPI)

This search option allows the administrator to search by NPI. This option is useful for identifying all users who have access to an NPI, including their levels of access.



Find All Users I Administer

This search option shows an alphabetical list of every user whose account you fully or partially administer.

NOTE: Users may have access to additional NPIs that you do not administer. You cannot update or remove a user's access to an NPI if you are not the administrator for that NPI.

Results

0-9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

B

- [redacted]
- [redacted]

G

- [redacted]

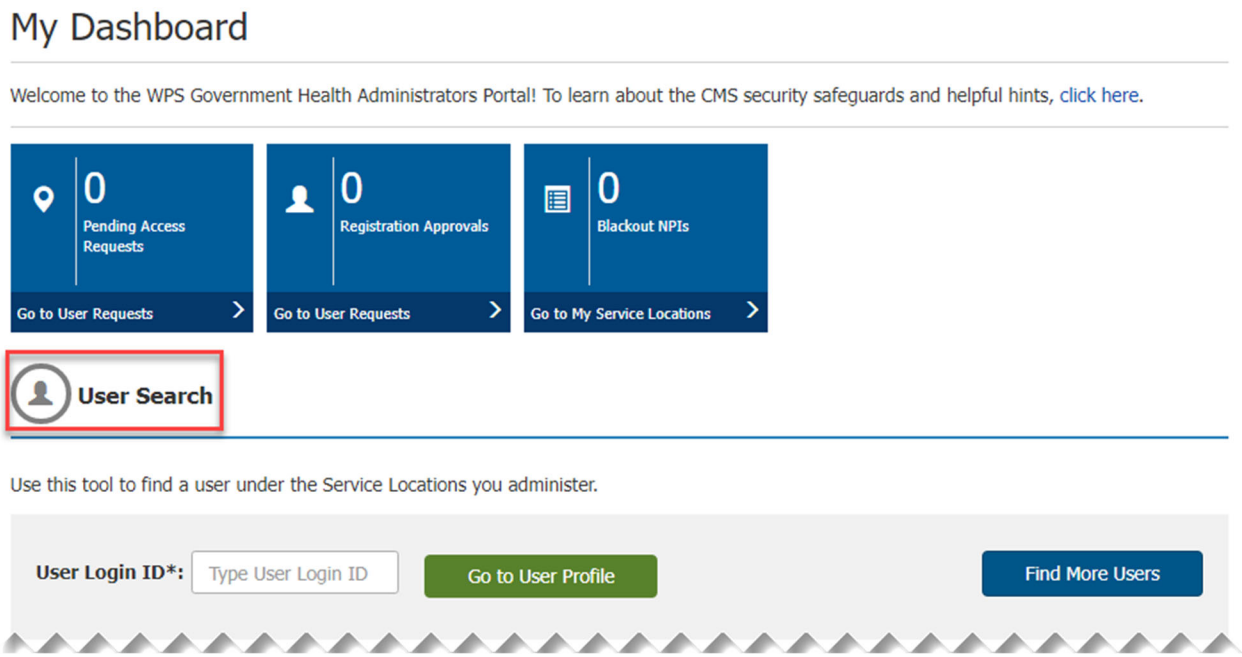
Editing User Accounts

NPI Administrators are responsible for the users under their account. This includes resetting users' passwords and secret questions and removing access when a user no longer needs access to the portal.

Locating a User's Account

NPI Administrators can locate the account of a user they administer in two ways:

From My Dashboard:
If you know the user's Login ID, you can use the User Search function on My Dashboard to go directly to the user's account edit page. If you don't know the user's Login ID, you can also use the Find More Users button to go to the User Administration page to search for them.

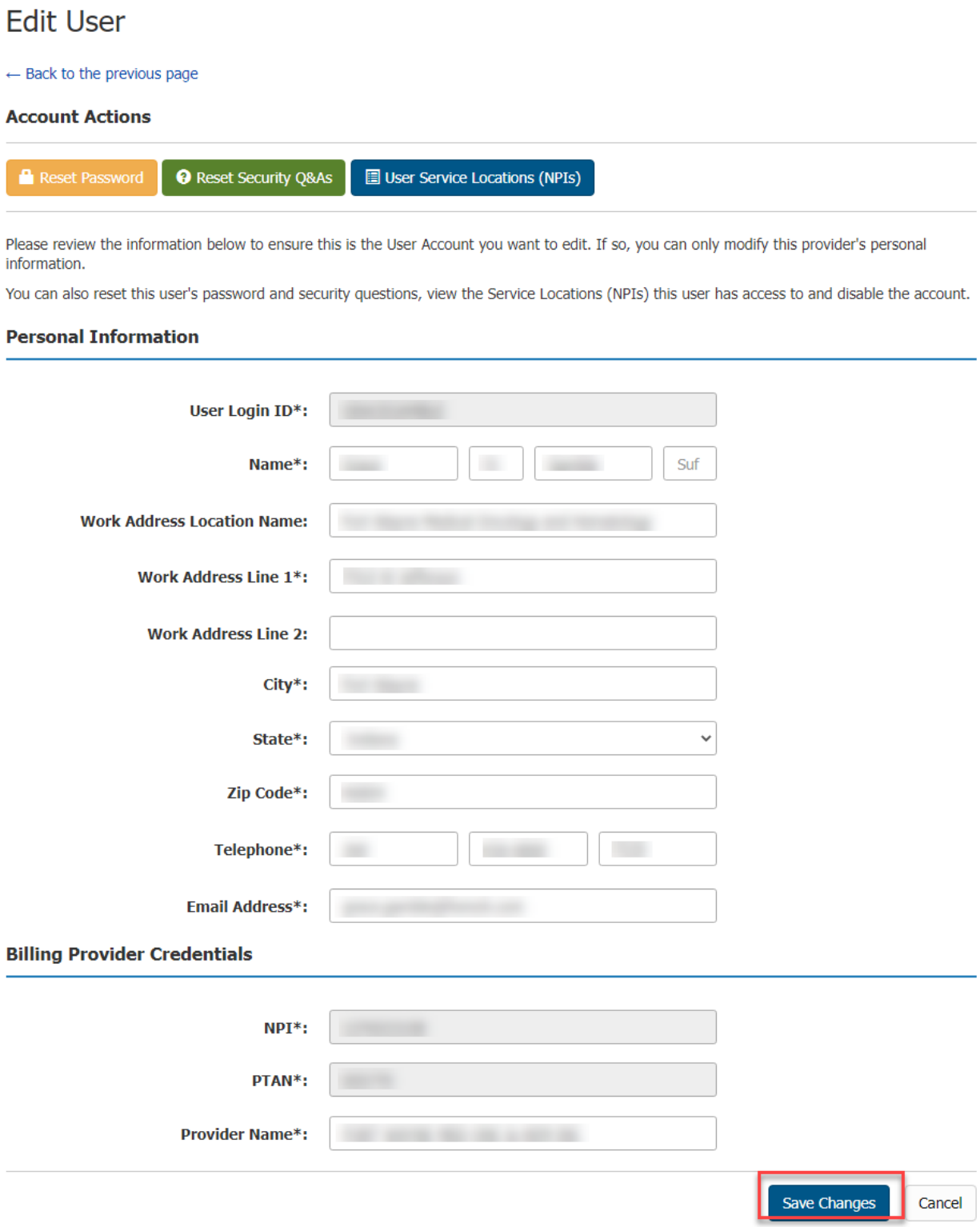


From the User Administration page:
If you don't know the user's Login ID, you can use the Find Users function to locate them. See the "Finding Users" section of this manual for more information.

Updating a User's Information

After locating the user's account, you will enter the Edit User page where you can update the user's personal information, reset their password or security Q&As (i.e., secret questions and answers), or update their service locations (NPIs). Use the buttons at the top of the page under Account Actions to access the password, security questions, and NPI functions. See below for additional information.

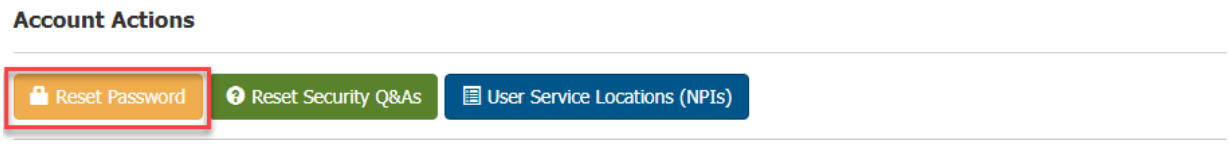
If you need to make changes to the user's personal information, update the information in the Personal Information section and click the Save Changes button to make the update.



Resetting a User's Password

One of the most common tasks an NPI Administrator will need to perform is resetting user's password. NPI Administrators are the only users who can reset a Standard or Eligibility user's password if they get locked out of the portal due to too many failed login attempts. Customer Service cannot reset passwords for Standard and Eligibility users.

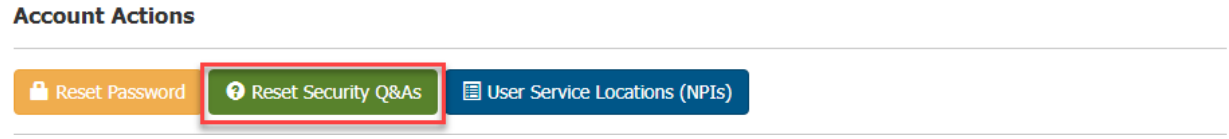
To reset a user's password, click the Reset Password button under Account Actions. A confirmation pop-up will appear confirming that you want to perform the action.



Resetting a User's Security Q&As

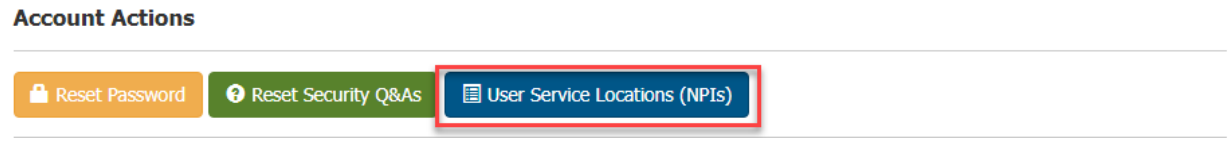
Users rarely need to answer their Security Q&As (sometimes called the secret questions and answers) when using the portal. In some cases, a user may forget their questions and answers (or the format of their answers) when the portal does require the additional layer of security. NPI Administrators can clear the questions and answers for Standard and Eligibility users to allow them to access their account. The user will then select new questions and answers once they can access their account.

To reset a user's security Q&As, select the Reset Security Q&As button under Account Actions. A confirmation pop-up will appear confirming that you want to perform the action.



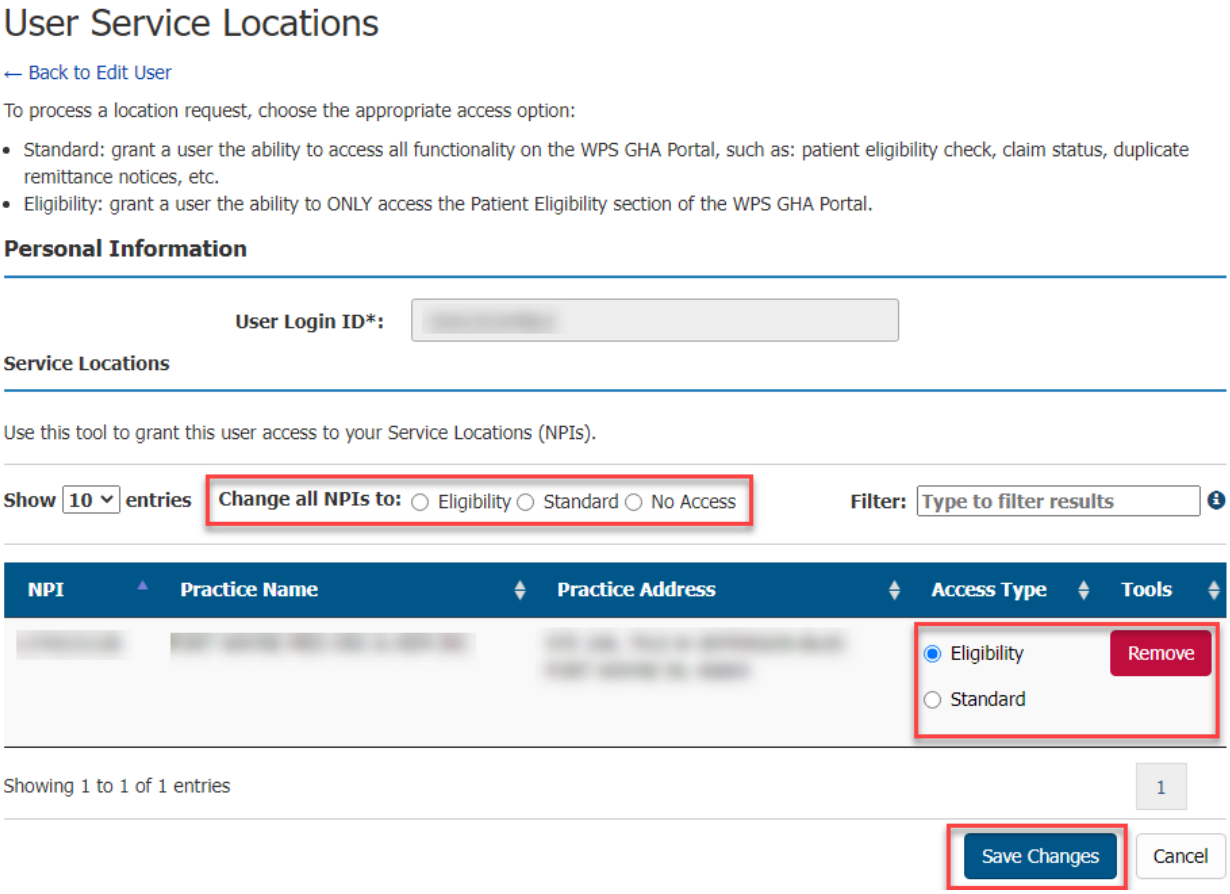
Updating a User's Service Locations (NPIs)

NPI Administrators are responsible for determining the level of access Standard or Eligibility user should have to portal based on their job duties. NPI Administrators are also responsible for removing a user's access to an NPI if they no longer need it due to a change in job duties or termination of employment. Use the User Service Locations (NPIs) button under Account Actions to make changes to a user's NPI access.



On the User Service Location screen, you can select what level of access the user should have for each NPI listed by selecting the appropriate radio button next to the NPI or by clicking the Remove button if the user should have no access to the NPI. If the user has access to multiple NPIs, and you need to make the same change to all of them, you can use the radio buttons

above the list of NPIs to make the same change to all of them at once. Click the Save Changes button to confirm your update.

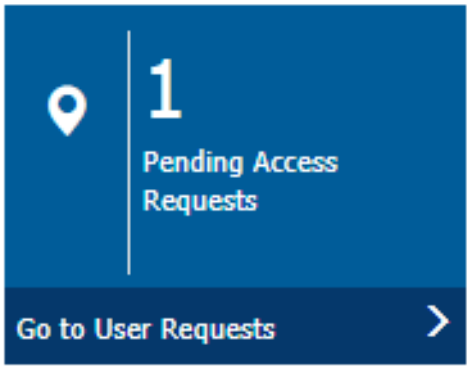


Pending Access Requests

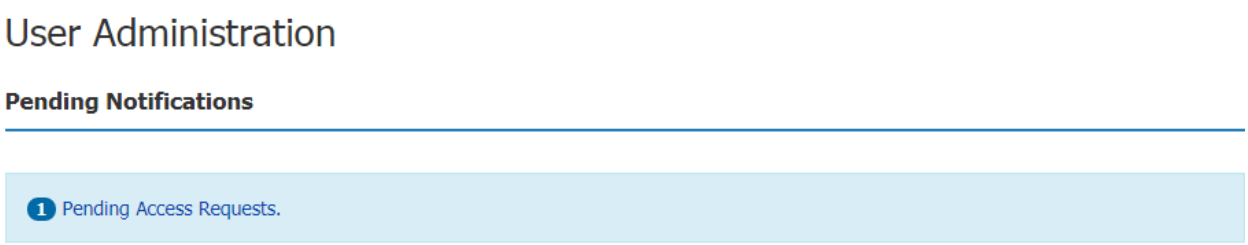
When an existing user requests access to additional NPI locations in the portal, an NPI Administrator must approve the access request before the user can access any protected information under that NPI.

Notification of Pending Access Requests

The NPI Administrator's dashboard shows the number of pending access requests. The administrator will see this window on the My Dashboard page when logging into the portal.

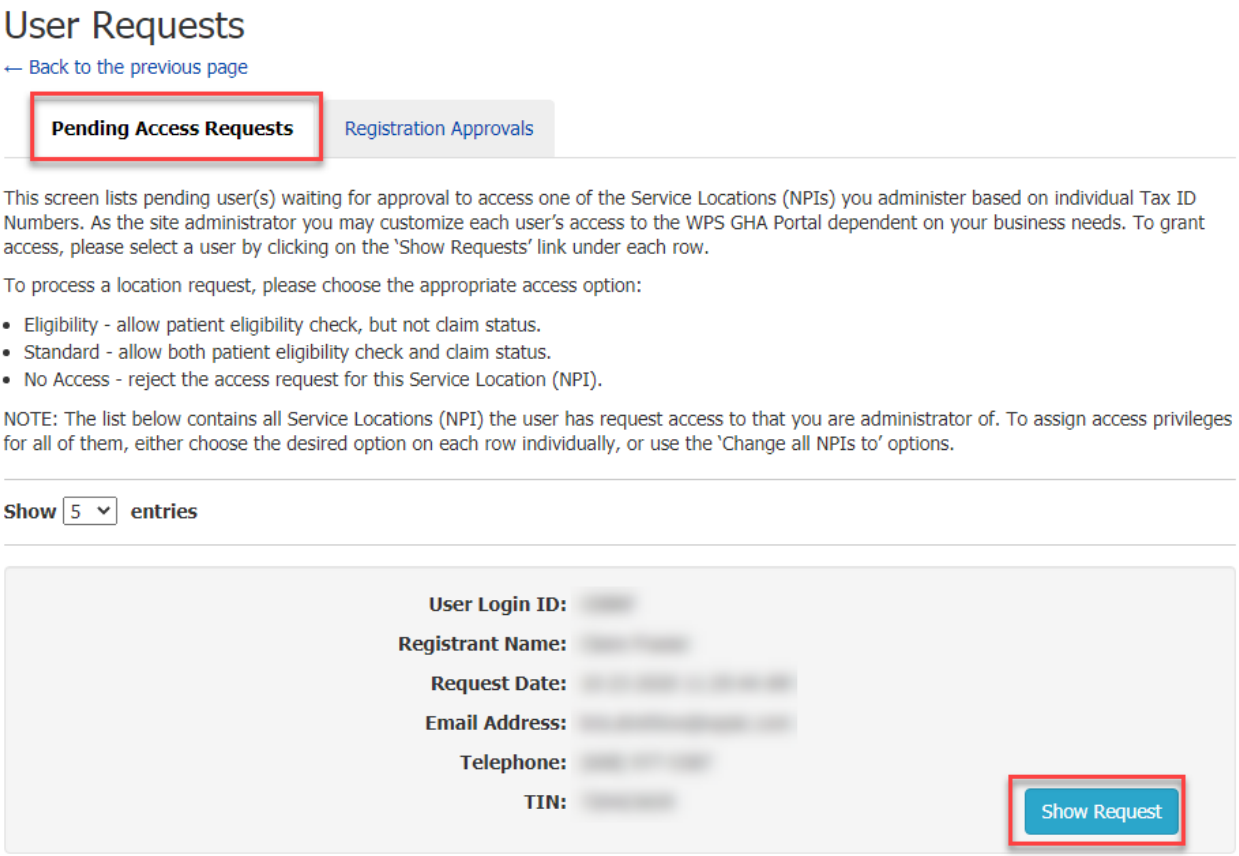


The NPI Administrator will also see this message on their User Administration page if there is a pending registration approval:

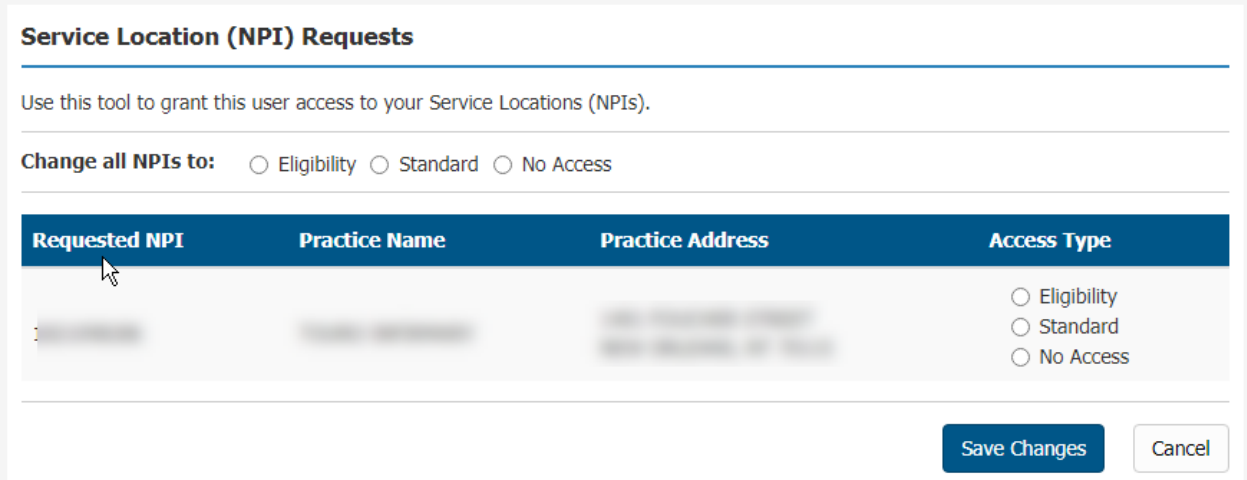


Approving Pending Access Requests

1. To review the request, click on the dashboard window on your My Dashboard page, or click on the notification message on the User Administration page. Both ways will take you to the User Requests page where you can access the request(s) under the Pending Access Requests tab.



2. Click on the Show Request button to see the NPIs the new user requests to access.



3. Click the radio button next to the level of access the user should have for each NPI. Or, if the user should have the same access for all NPIs, select the appropriate radio button next to "Change all NPIs to." A description of each level of access is at the top of the page. Click the Save Changes button when you're finished.

   NOTE: You cannot give a user NPI Administrator access on this page. If the user should be an NPI Administrator, follow the applicable instructions in the Registering as an NPI Administrator section of this manual to get the user NPI Administrator access.

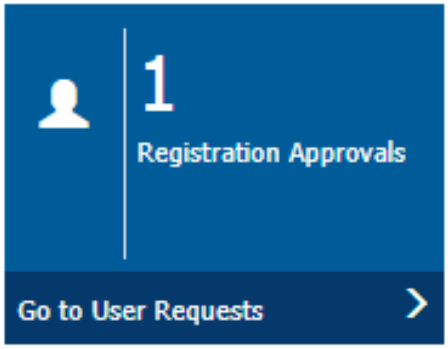
4. Review the changes in the confirmation message for accuracy, and then click the Save button to complete the update. You will see a message stating, “Service Locations (NPIs) successfully updated” at the top of the screen if the approval is successful.

Registration Approvals

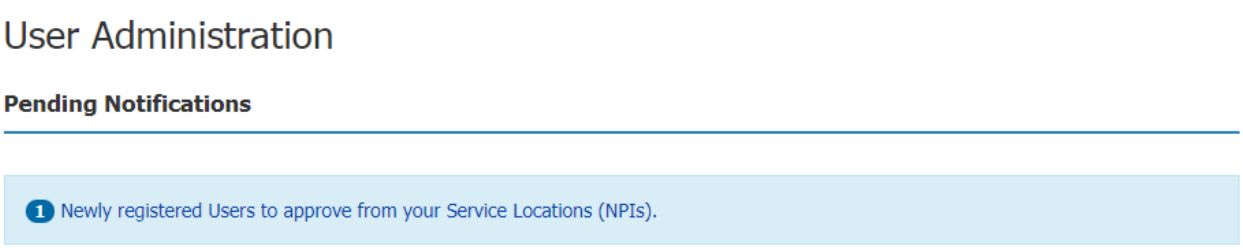
When a new user registers for an account in the WPS Government Health Administrators Portal, an NPI Administrator must approve the registration request before the new user can access any protected information.

Notification of Pending Registration Approvals

The NPI Administrator's dashboard shows the number of registration approval requests. The administrator will see this window on the My Dashboard page when logging into the portal.

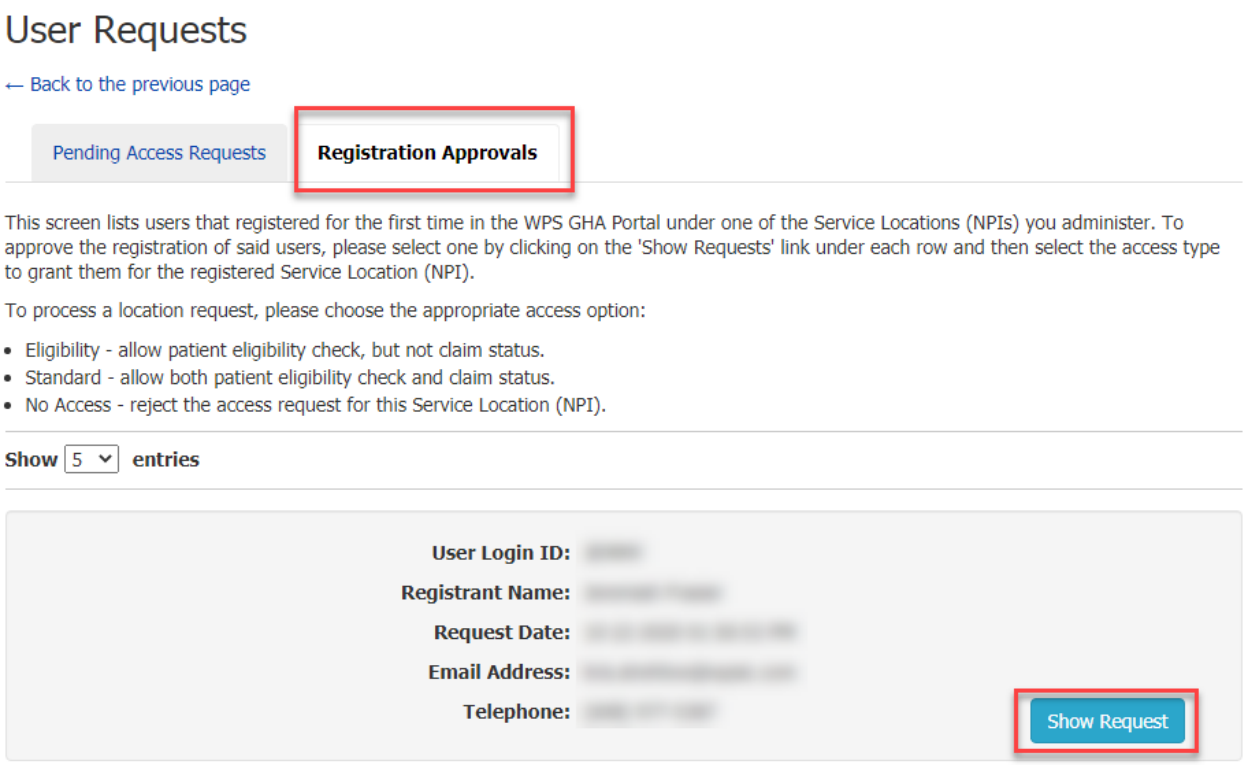


The NPI Administrator will also see this message on their User Administration page if there is a pending registration approval:

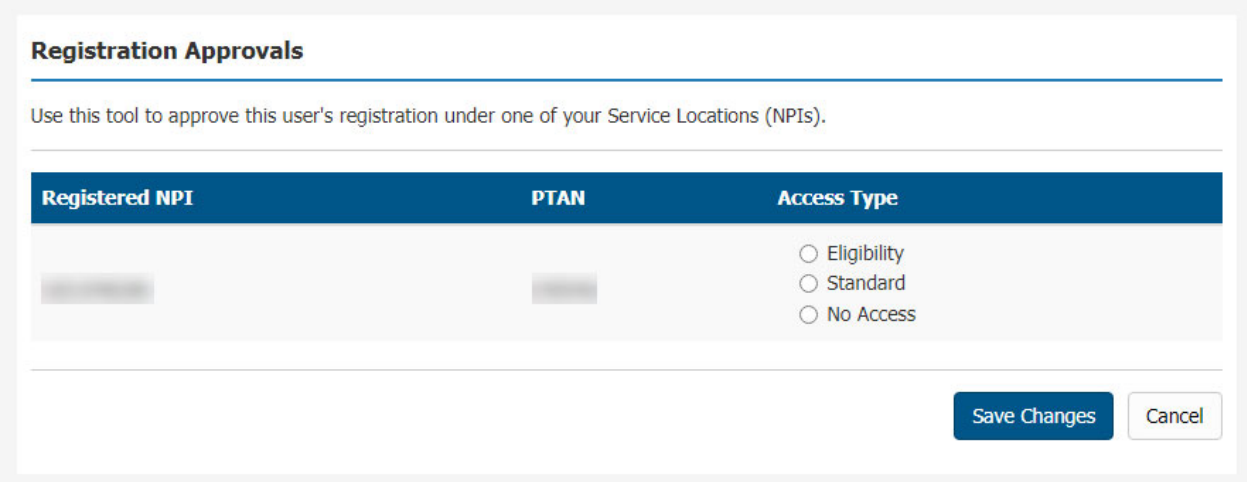


Approving a Pending Registration Request

1. To review the request, click on the dashboard window on your My Dashboard page, or click on the notification message on the User Administration page. Both ways will take you to the User Requests page where you can access the request(s) under the Registration Approvals tab.



2. Click on the Show Request button to see the NPIs the new user requested access to.



3. Click the radio button next to the level of access the new user should have for each NPI. A description of each level of access is at the top of the page. When you're done, click the Save Changes button.

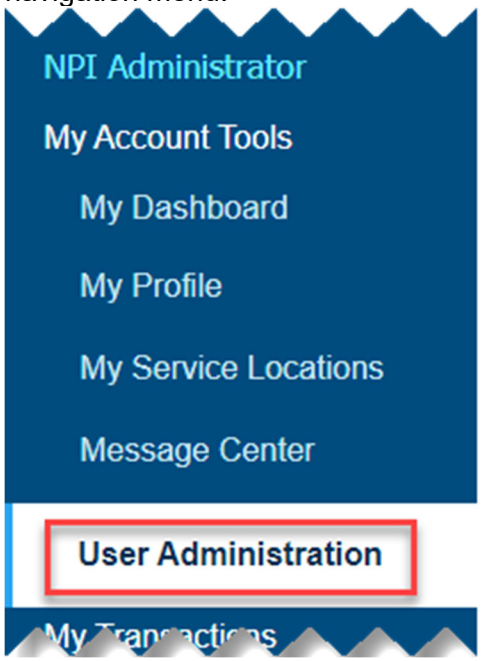
   NOTE: You cannot give a user NPI Administrator access on this page. If the new user should be an NPI Administrator, follow the applicable instructions in the Registering as an NPI Administrator section of this manual to get the new user NPI Administrator access.

4. Review the changes in the confirmation message for accuracy, and then click the Save button to complete the update.

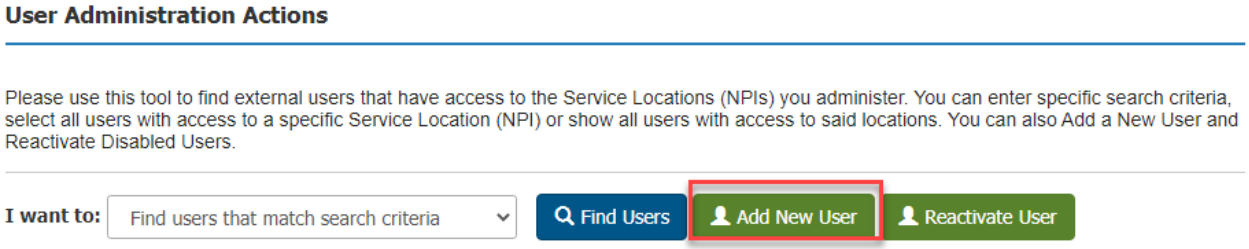
Adding a New User by the NPI Administrator

NPI Administrators can create accounts for new users. When the NPI Administrator creates a new account, they set up the account with minimal information and grant the new user access to their NPI(s). The portal then sends the new user a temporary password, which they use to set up their account, password, and secret questions.

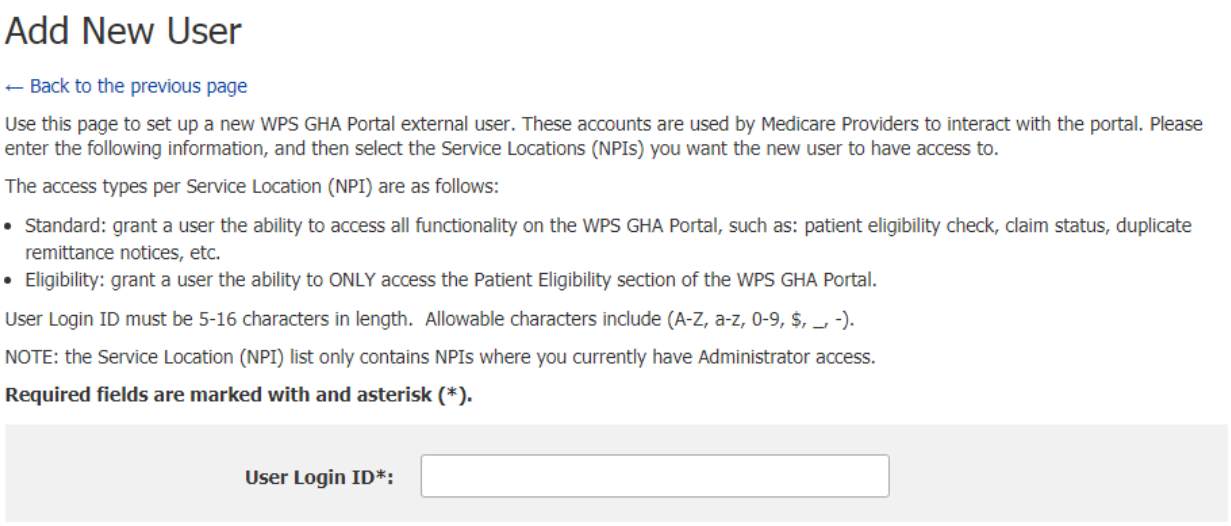
To create an account for a new user, begin by clicking on the User Administration link in the left navigation menu.



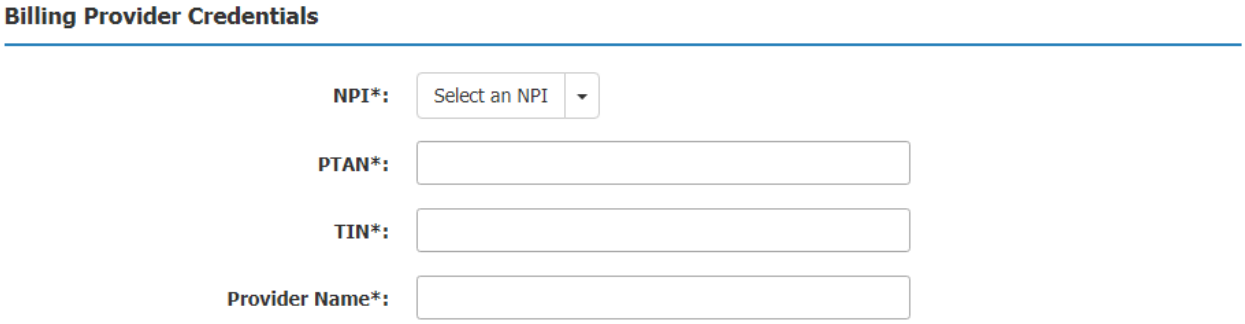
1. In the User Administration Actions section, click the Add New User button.



2. Create the new user's User Login ID.

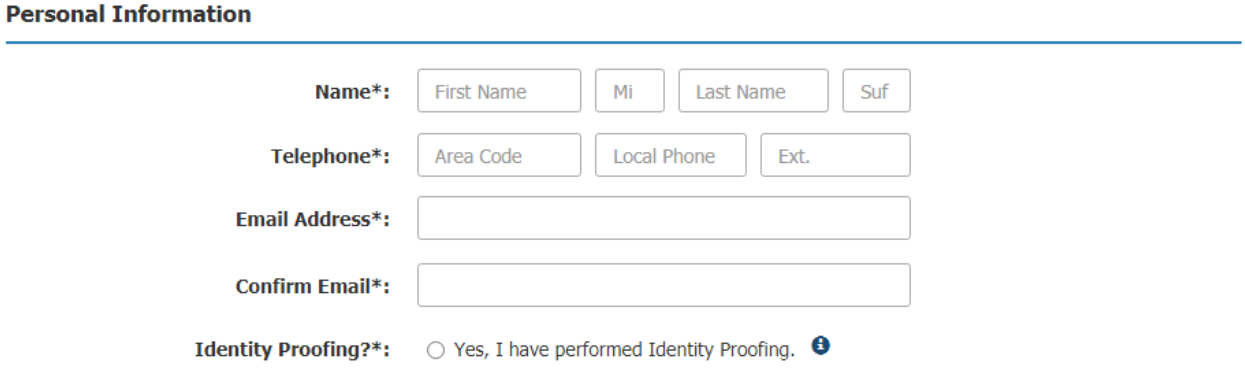


3. Enter the new user's billing provider credentials. You must select an NPI from the dropdown list and enter the corresponding PTAN, TIN, and provider name.



4. Enter the new user's name, telephone number, and email address. Make sure the user's email address is correct so they can receive the email with the instructions for finishing the account setup.

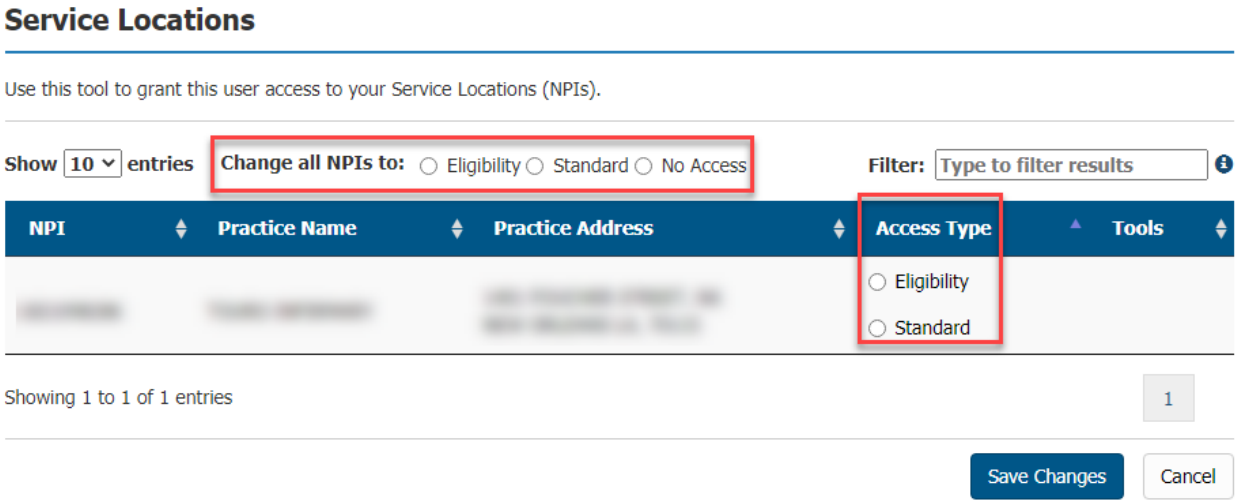
   As the NPI Administrator, you are also responsible for confirming the identity of the new user (identity proofing) using a government-issued identification document containing a photograph (e.g., driver license, passport, state ID card, etc.). Do not create an account for anyone whose identity you have not confirmed.



5. Select the service locations (NPIs) you want the new user to be able to access. The portal will automatically select the NPI you listed as the new user's billing credentials, but you can grant the user access to any additional NPIs that you also administer.

   You will also need to select the level of access the user should have for each NPI by selecting either the Eligibility or Standard radio button next to the NPI. You can also change all NPIs to the same level of access by selecting the appropriate radio button above the list of NPIs.

   If the new user needs access to additional NPIs that you do NOT administer, they can request access to those NPIs once they set up their account.



6. Click the Save Changes button to create the account. The new user will receive an email with a temporary (single use) password that allows them to finish setting up their account. The new user will need to use the temporary password to set up the account within 21 days or the account will be deleted.

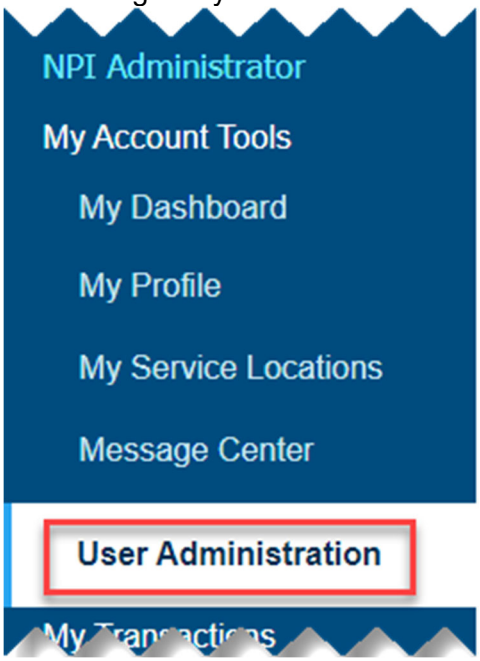
Account Reactivation

An NPI Administrator can reactivate a user's account (including their own account) if the account has been disabled for less than one year. User accounts deactivated for a year or more cannot be reactivated. If an account cannot be reactivated, the user can register for a new account.

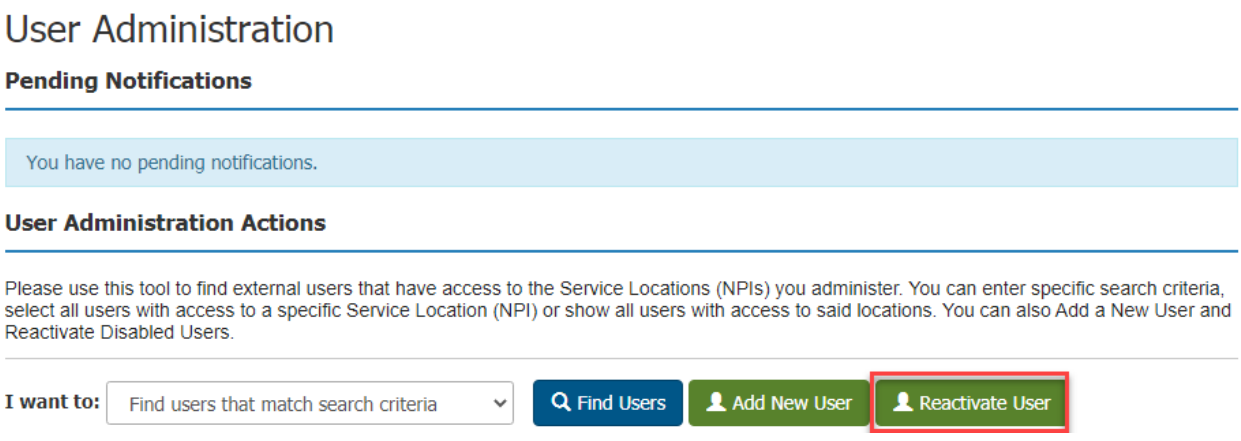
WPS staff cannot reactivate user accounts.

Reactivating Standard and Eligibility Accounts

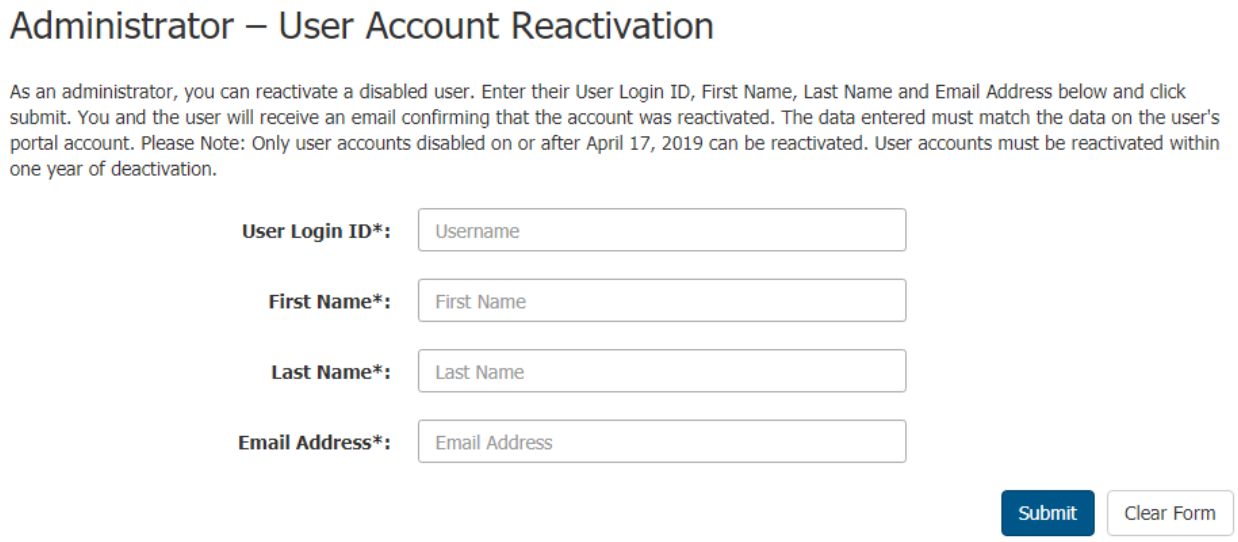
- Log into your account and select User Administration from the left navigation menu.



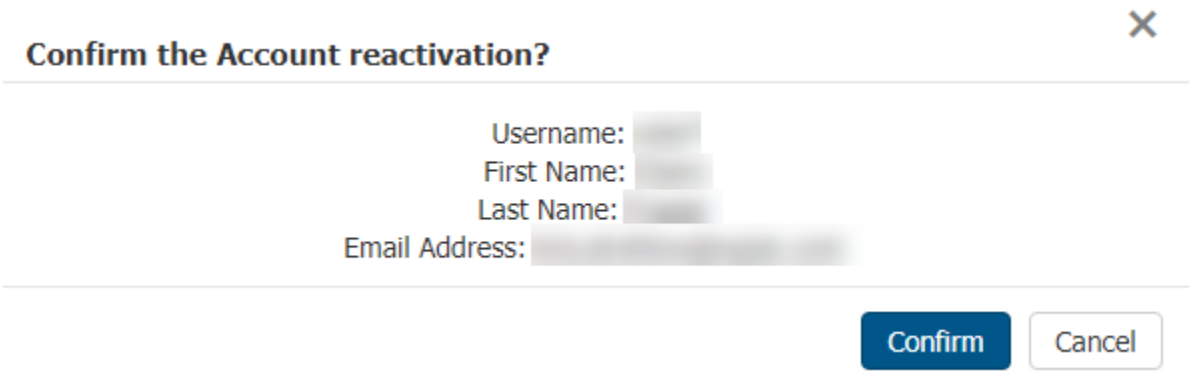
- Click on the Reactivate User button in the User Administration Actions section.



- Enter the following information and then click “Submit” (**NOTE:** The information must match what is on the user’s account.):
  - User Login ID
  - User First Name
  - User Last Name
  - User’s Email Address

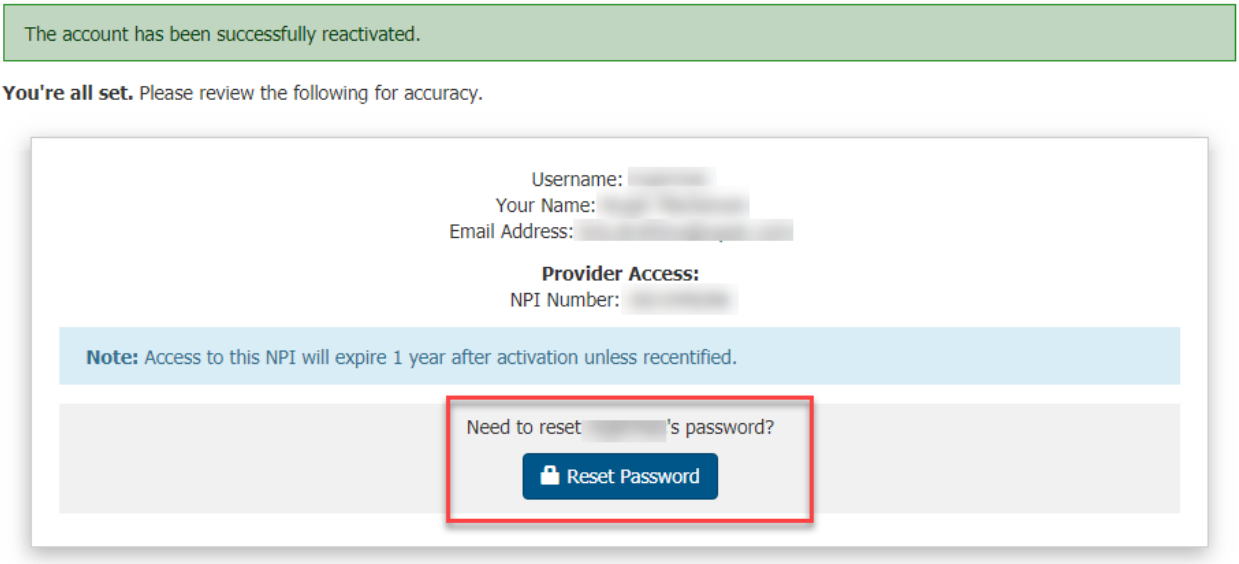


- Click “Confirm” on the confirmation pop-up box



- The NPI Administrator will see the message below.

  NOTE: If the reactivated user does not remember their password, the NPI Administrator can reset the password by clicking the Reset Password button at the bottom of the pop-up box.

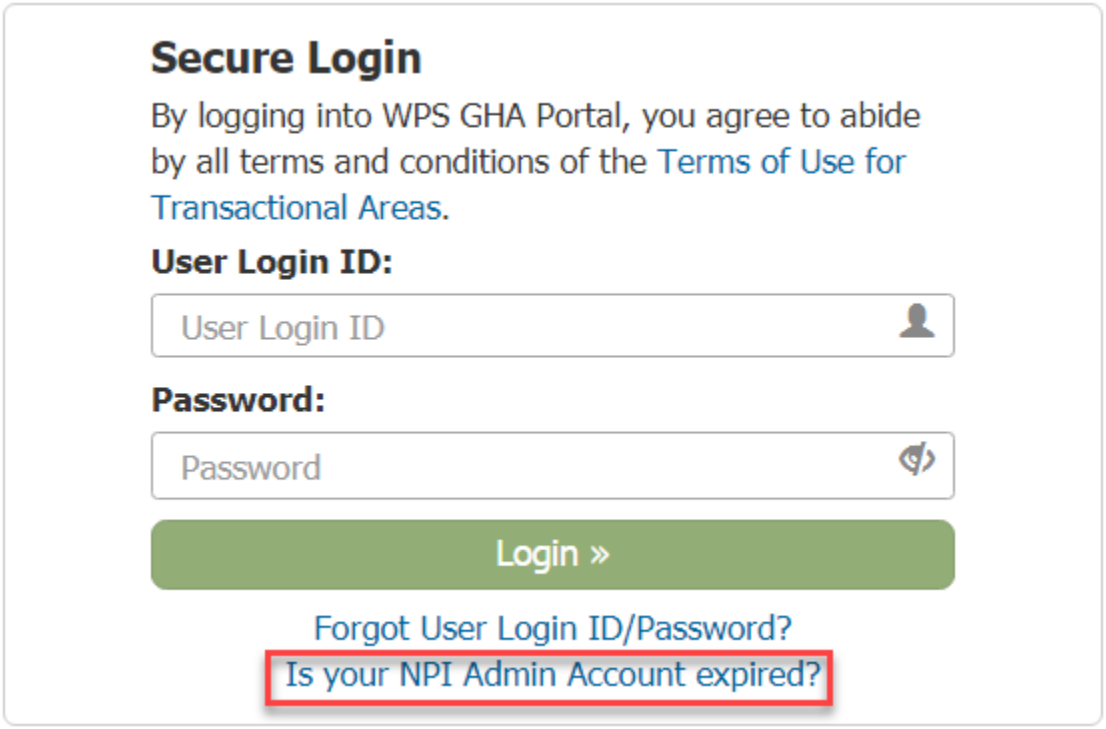


- Both the NPI Administrator and the reactivated user will receive an email confirming the account reactivation.

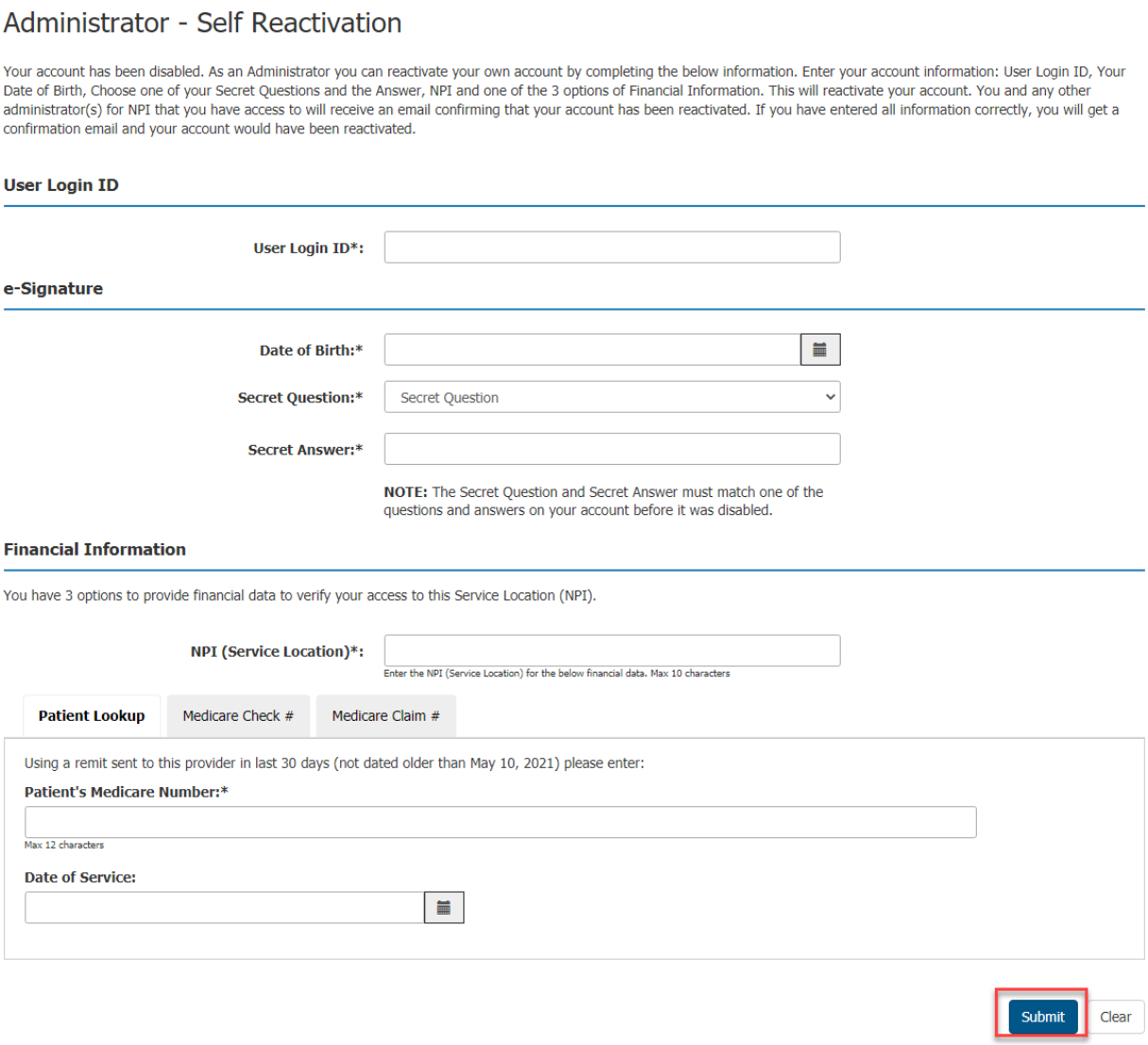
Reactivating an NPI Administrator Account

NPI Administrators can reactivate their own accounts if the account has been disabled for less than one year. NPI Administrators should follow these steps to reactivate their own disabled account:

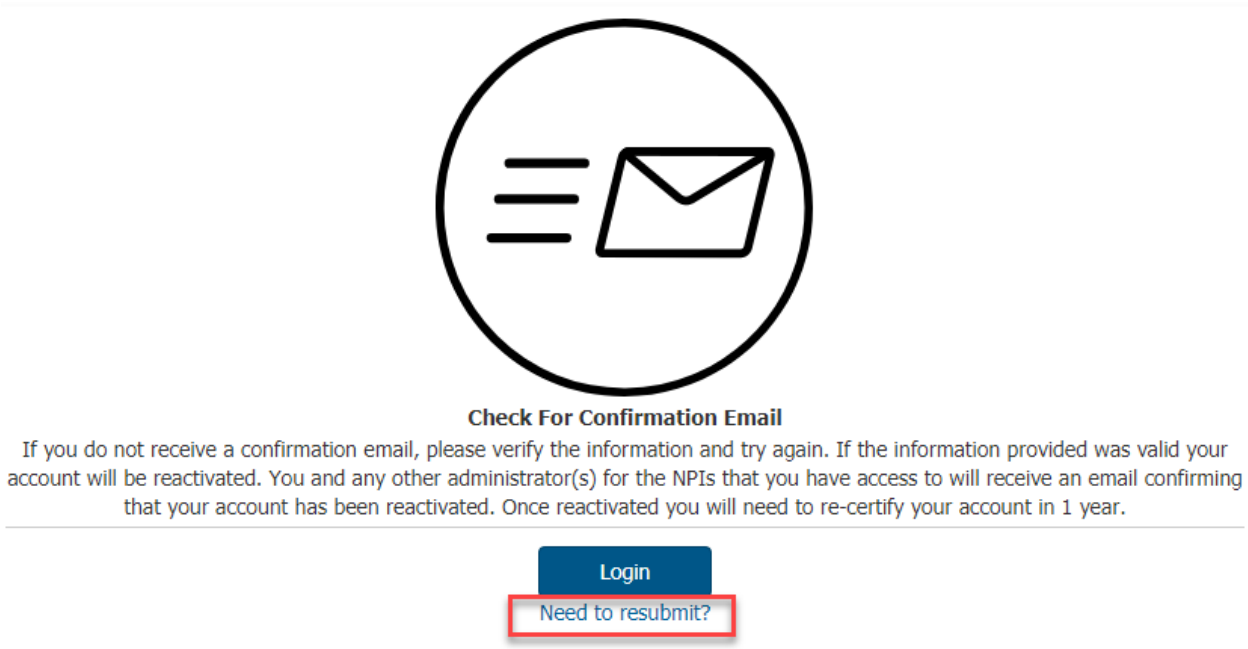
- On the Login screen, click “Is your NPI Admin Account expired?” in the Secure Login box.



- Enter the following information and click Submit (**NOTE:** This information must match what is on your account):
  - User Login ID
  - Date of Birth
  - Select one of your Secret Questions from the drop down
  - Secret Answer
  - NPI for the financial data
  - Financial Data for one of the tabs; Patient Lookup, Medicare Check # or Medicare Claim # that matches the NPI you entered


Administrator - Self Reactivation
Your account has been disabled. As an Administrator you can reactivate your own account by completing the below information. Enter your account information: User Login ID, Your Date of Birth, Choose one of your Secret Questions and the Answer, NPI and one of the 3 options of Financial Information. This will reactivate your account. You and any other administrator(s) for NPI that you have access to will receive an email confirming that your account has been reactivated. If you have entered all information correctly, you will get a confirmation email and your account would have been reactivated.
User Login ID
User Login ID*:
e-Signature
Date of Birth:*
Secret Question:*
Secret Question
Secret Answer:*
NOTE: The Secret Question and Secret Answer must match one of the questions and answers on your account before it was disabled.
Financial Information
You have 3 options to provide financial data to verify your access to this Service Location (NPI).
NPI (Service Location)*:
Enter the NPI (Service Location) for the below financial data. Max 10 characters
Patient Lookup
Medicare Check #
Medicare Claim #
Using a remit sent to this provider in last 30 days (not dated older than May 10, 2021) please enter:
Patient's Medicare Number:*
Max 12 characters
Date of Service:
Submit
Clear

- Once you enter your information and click Submit, you will see the following pop-up box.

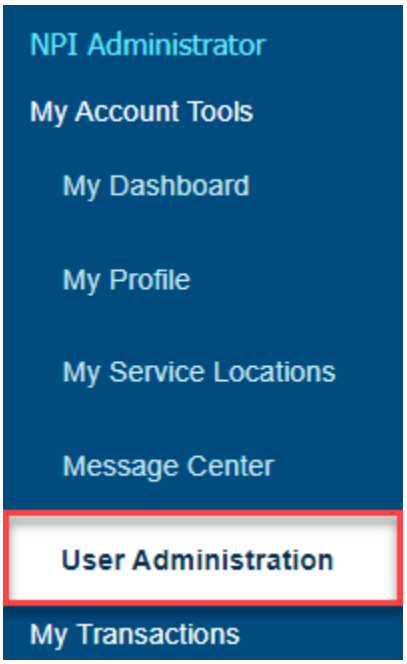


- Check your email for confirmation that you reactivated your account.
- If you do not receive an email, it means you entered at least one piece of incorrect data. You can try to reactivate your account again by clicking on the “Need to Resubmit?” link in the pop-up box.

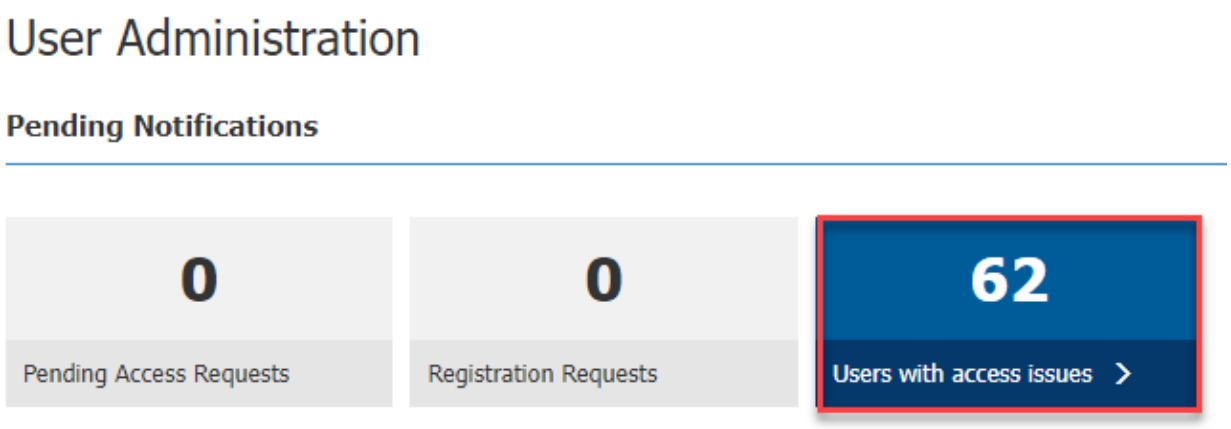
NOTE: If you successfully reactivate your account, all other NPI Administrators for that NPI will receive an email stating that you have access.

Locked Users

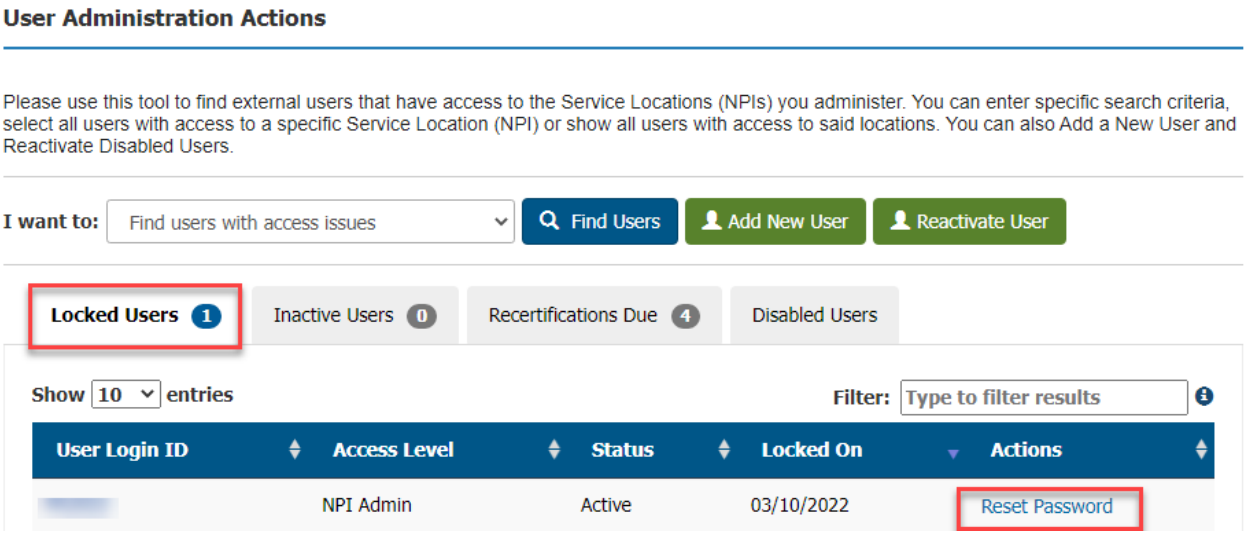
From My Dashboard click on the User Administration link in the left navigation.



Once on the User Administration page, click on the Users with access issues box.

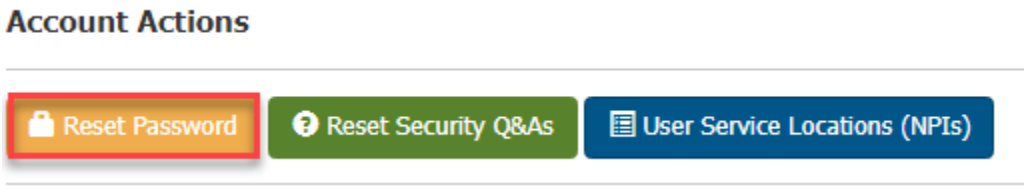


On the Locked Users tab, there will be a number indicating how many users need their account unlocked. The Administrator will click on the Locked Users tab and the page will expand with the User Login IDs that requires a password reset to unlock their account. Click on the link under Actions indicating ‘Reset Password’.



Resetting a User's Password

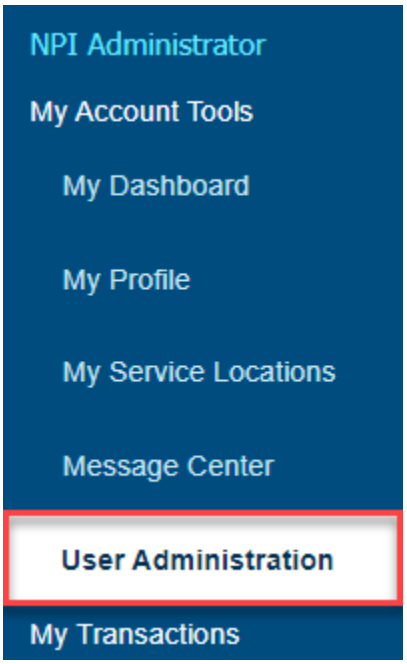
NPI Administrators are the only users who can reset a Standard or Eligibility user's password if they get locked out of the portal due to too many failed login attempts. Customer Service cannot reset passwords for Standard and Eligibility users.



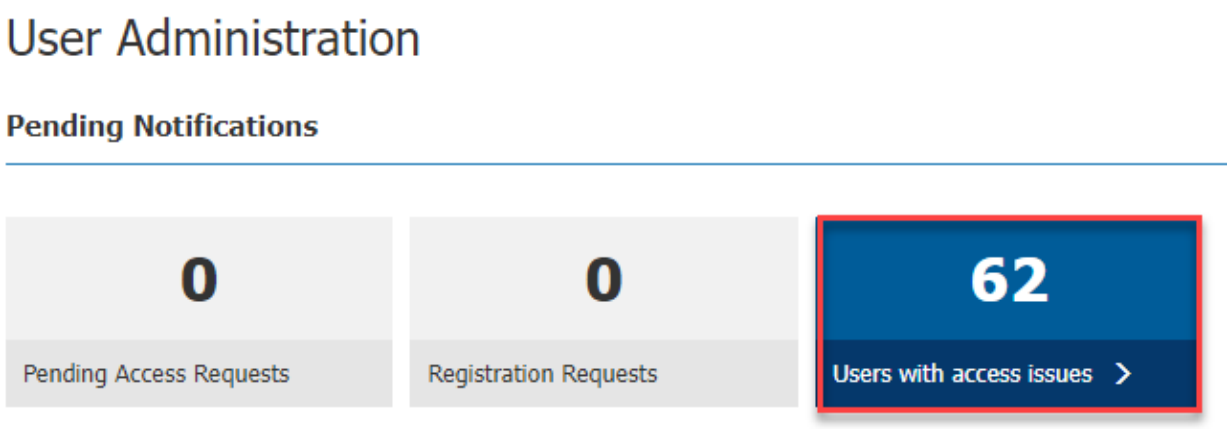
One the Reset Password is clicked, a temporary password will be emailed to the user and the email address on their profile.

Inactive Users

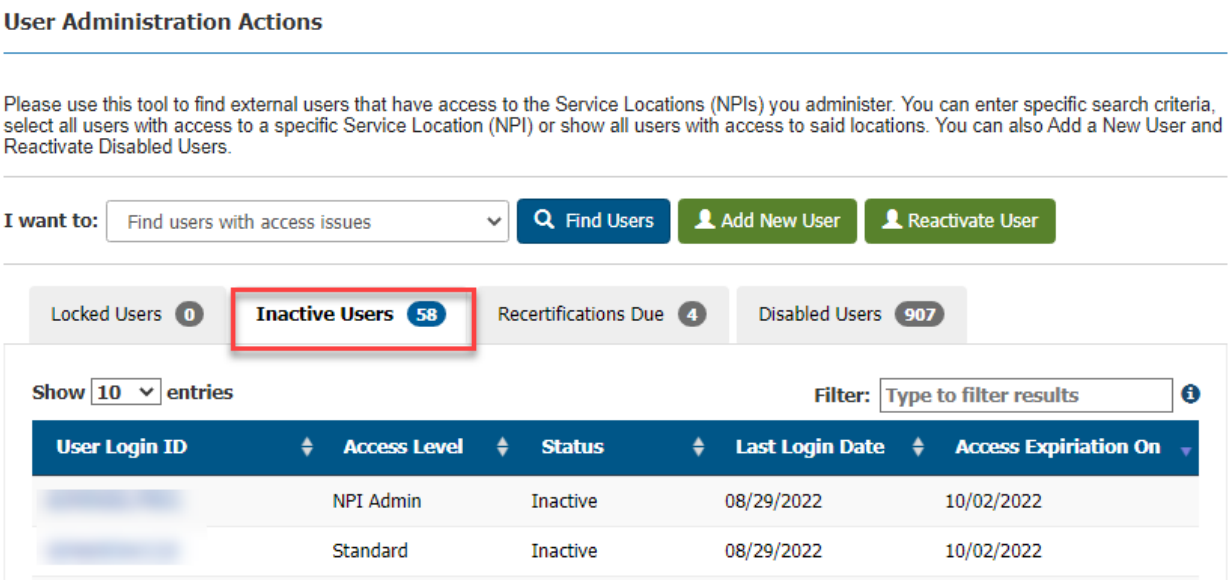
From My Dashboard click on the User Administration link in the left navigation.



Once on the User Administration page, click on the Users with access issues box.



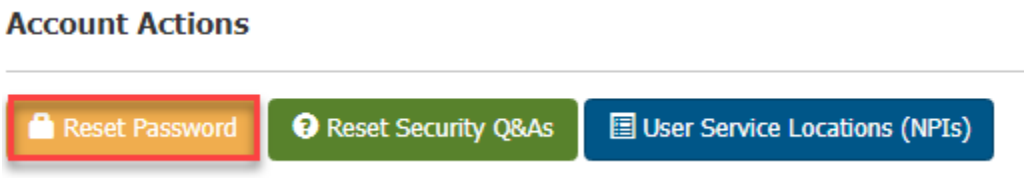
On the Inactive Users tab, there will be a number indicating how many users need their account activated. The Administrator will click on the Inactive Users tab and the page will expand with the User Login ID's that are inactive. Click on the link with the User Login ID.



The Administrator will be taken to the Edit User page for the user where they can do a Reset Password to activate the user's account.

Resetting a User's Password

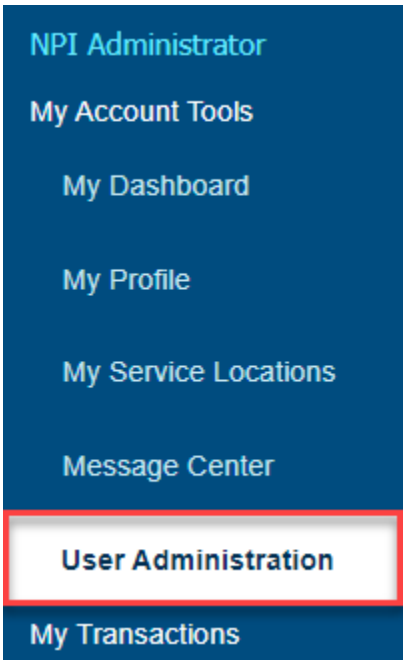
NPI Administrators are the only users who can reset a Standard or Eligibility user's password if their account becomes inactive. Customer Service cannot reset passwords for Standard and Eligibility users.



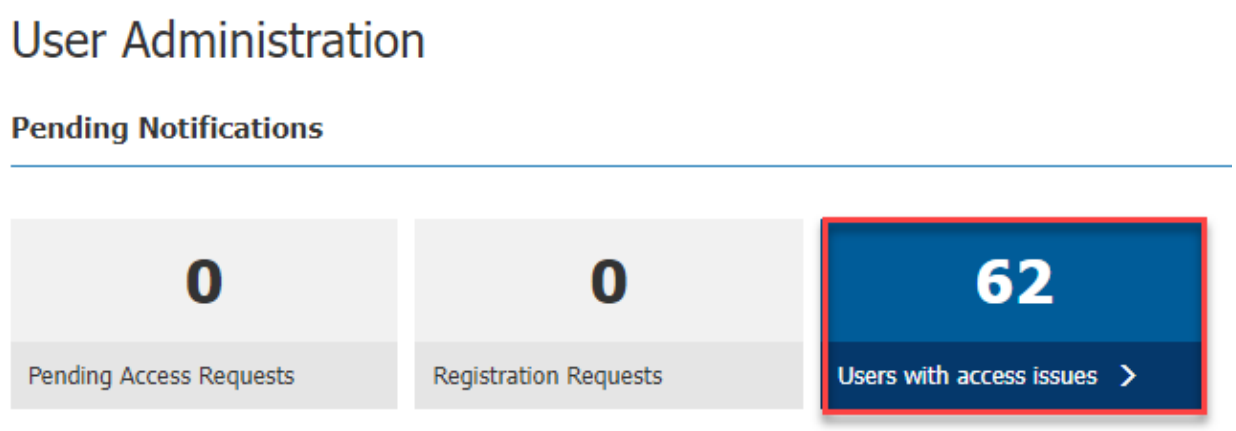
One the Reset Password is clicked, a temporary password will be emailed to the user and the email address on their profile.

Recertifications Due

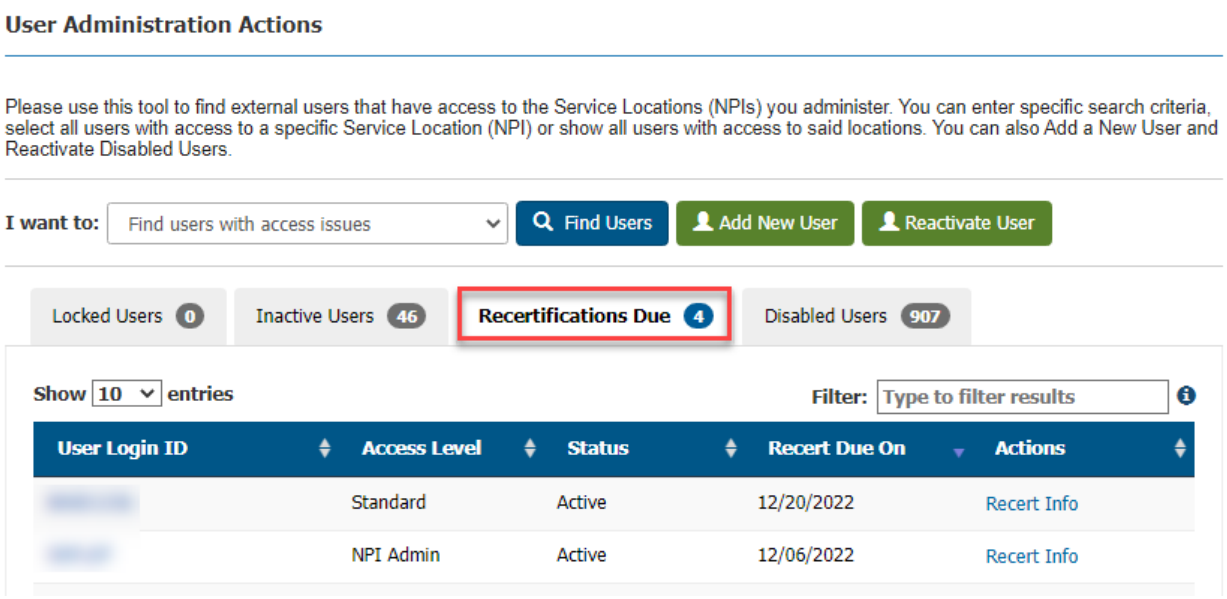
From My Dashboard click on the User Administration link in the left navigation.



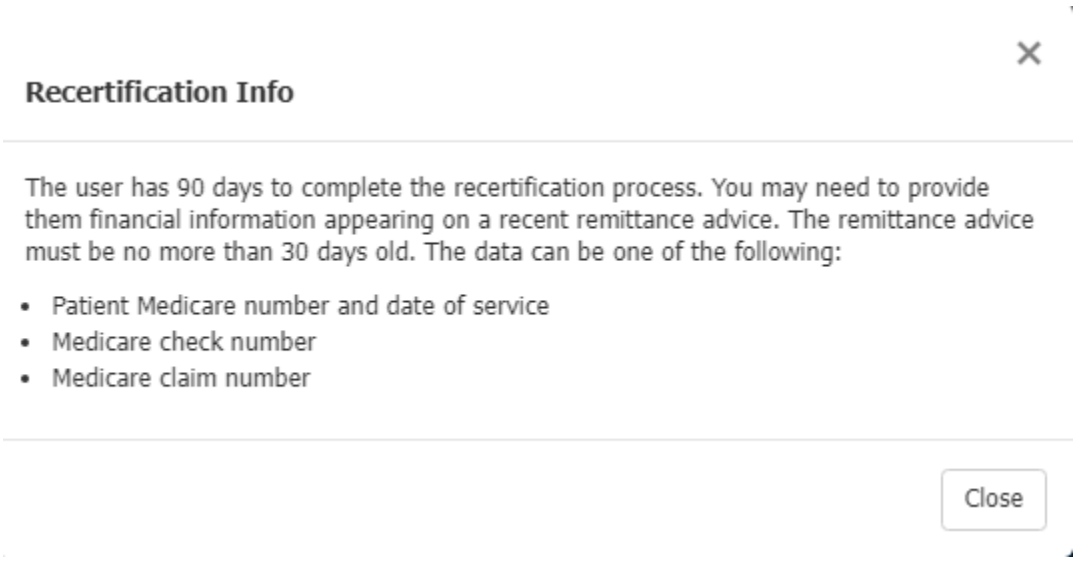
Once on the User Administration page, click on the Users with access issues box.



On the Recertifications Due tab, there will be a number indicating how many users are within the 90 day recertification timeframe. The Administrator can click on the tab and a listing of all users that are due for recertification will display.

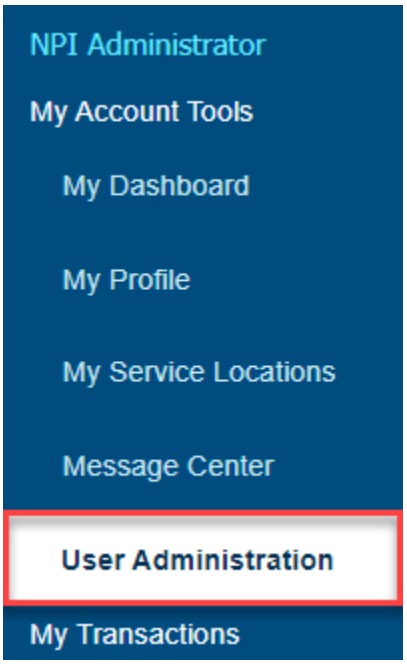


The Administrator cannot do the recertification but can provide the user with information needed to complete it. By clicking on the 'Recert Info' a popup will display indicating what the user will need to recertify.

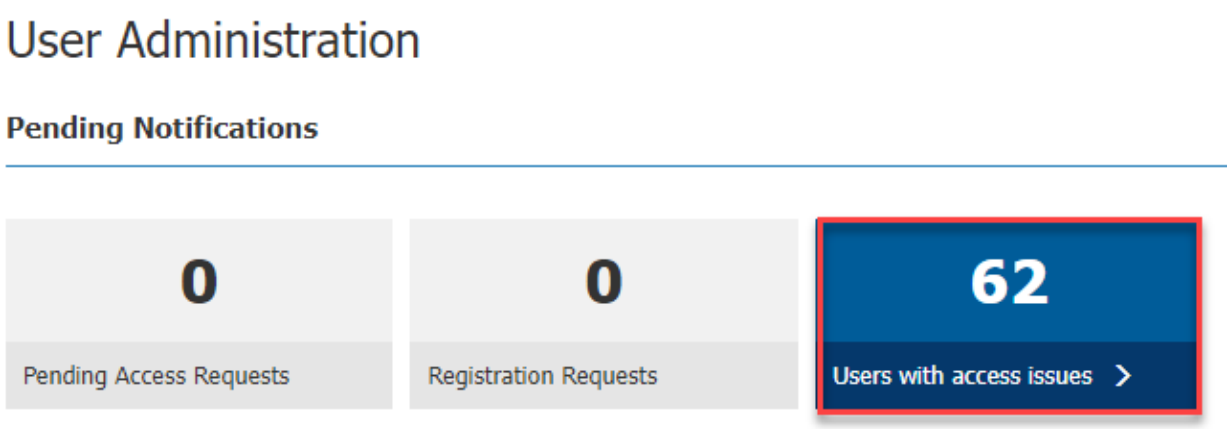


Disabled Users

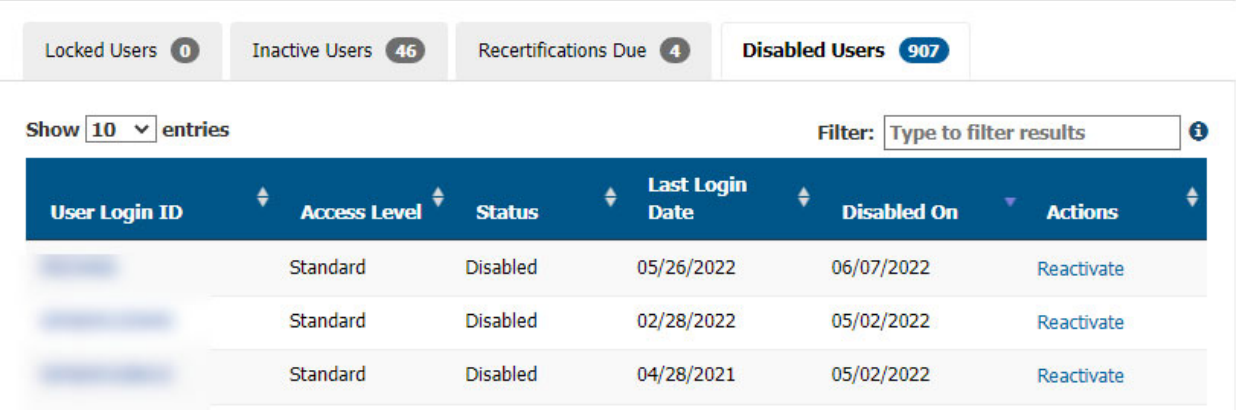
From My Dashboard click on the User Administration link in the left navigation.



Once on the User Administration page, click on the box for Users with access issues.



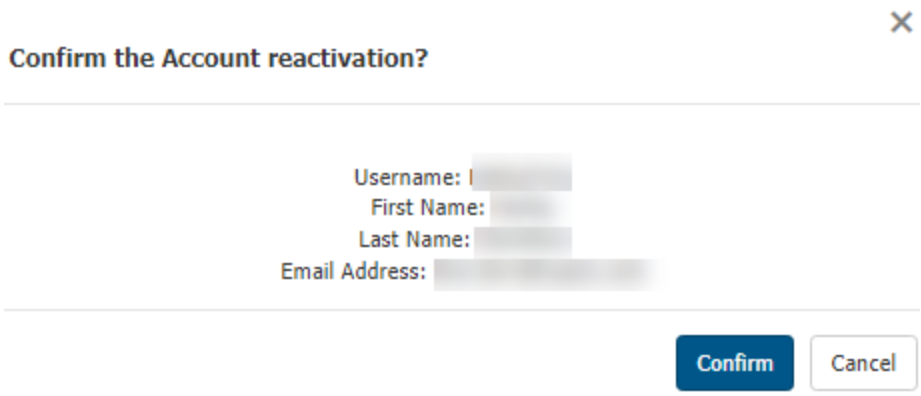
On the Disabled Users tab, there will be a number indicating how many users need their account reactivated. The Administrator will click on the Disabled Users tab and the page will expand with the User Login ID's that are currently disabled. Click on the link with the User Login ID.



Enter the following information and then click “Submit” (**NOTE:** The information must match what is on the user’s account.):

- User Login ID
- User First Name
- User Last Name
- User’s Email Address

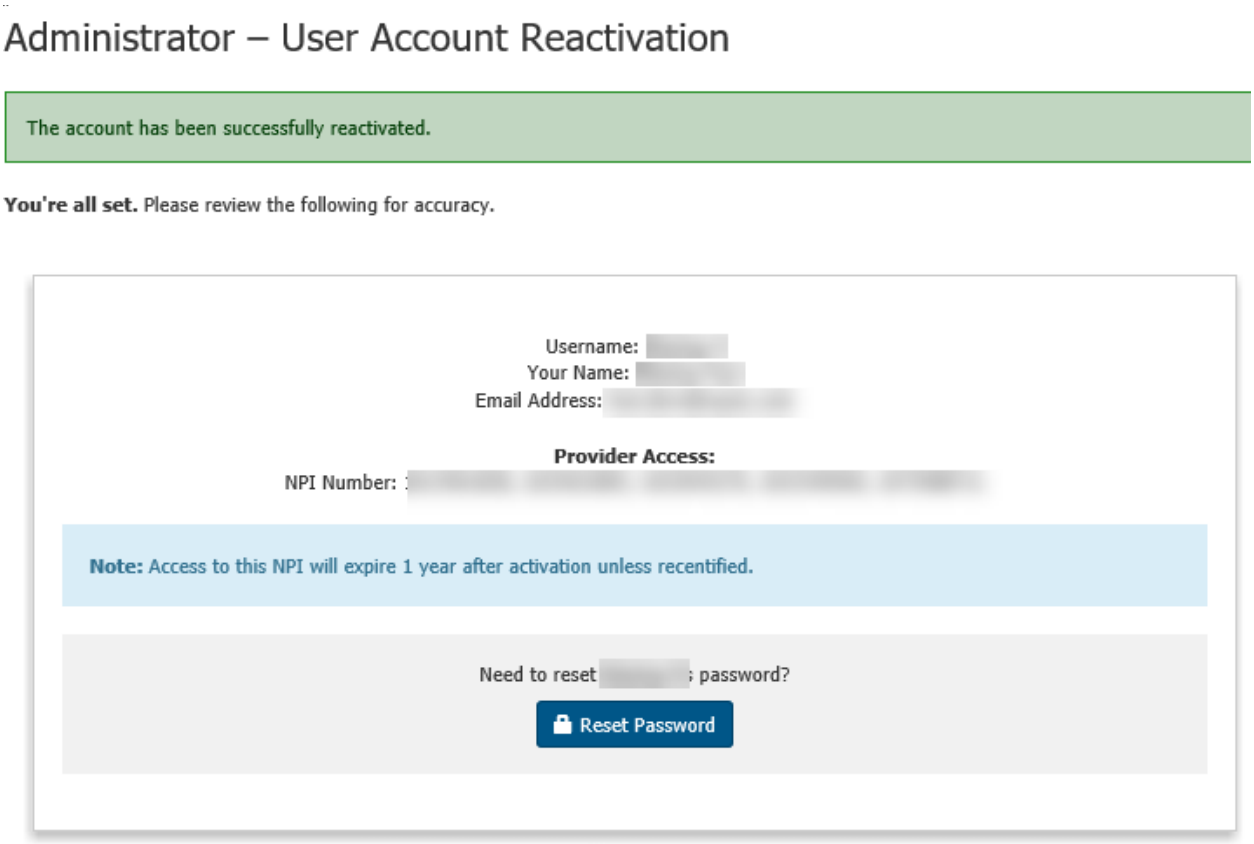
Click “Confirm” on the confirmation pop-up box.



The NPI Administrator will see the message below.

NOTE: If the reactivated user does not remember their password, the NPI Administrator can reset the password by clicking the Reset Password button at the bottom of the pop-up box.

Both the NPI Administrator and the reactivated user will receive an email confirming the account reactivation.


Administrator – User Account Reactivation
The account has been successfully reactivated.
You're all set. Please review the following for accuracy.
Username:
Your Name:
Email Address:
Provider Access:
NPI Number:
Note: Access to this NPI will expire 1 year after activation unless recentified.
Need to reset ; password?
Reset Password

Account Tools

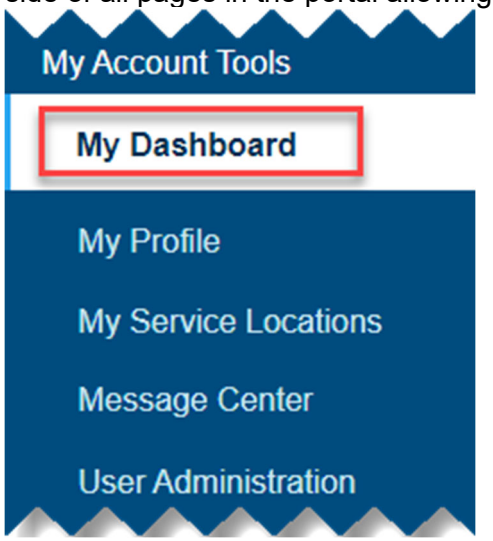
My Dashboard

After logging in, you will land on the “My Dashboard” page. “My Dashboard” provides important notifications about your account, alerts, and links to the portal functions available to you based on your level of access.

- Eligibility users have access to their own account details and the Eligibility Check, MBI Lookup, and Message Center functions
- Standard users have access to all Eligibility user functions, plus access to all the non-administrative functions (e.g., Claim Inquiry, Remittance Advice, eRefunds, etc.)
- NPI Administrators have access to all Standard user functions, plus the ability to manage other users’ accounts

Left Navigation Menu

All users have access to the left navigation menu, which allows you to navigate to all parts of the transactional portal to which you have access. The left navigation menu appears on the left side of all pages in the portal allowing you to move easily between tasks.

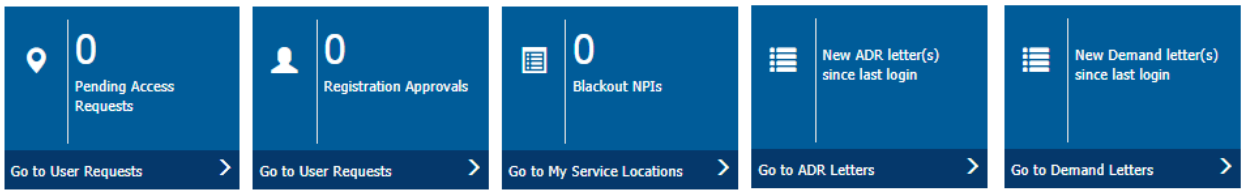


User Dashboard Windows

User Dashboard Windows notify users of any pending tasks that need attention. Clicking in the window will take you to the area where you can research or resolve it. Depending on your level of access, you will see the following windows on your dashboard:

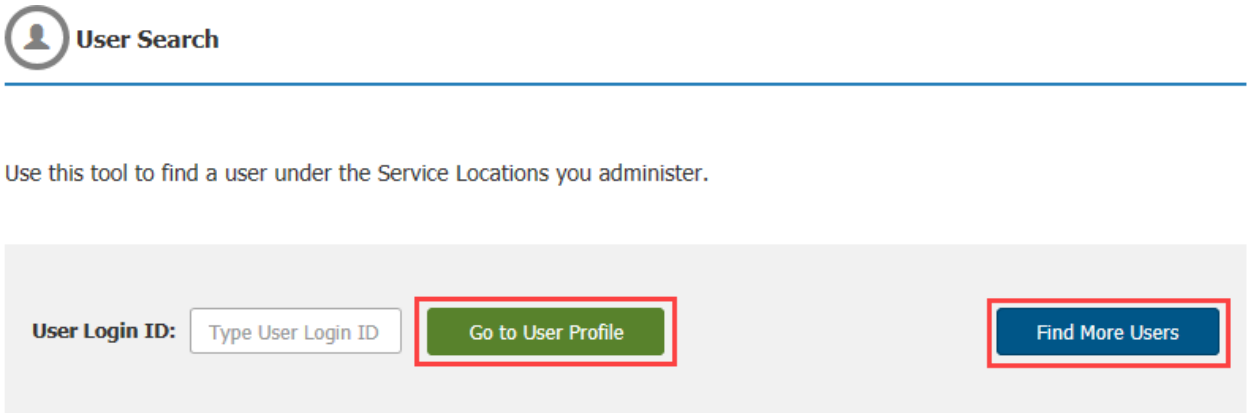
- Pending Access Requests (NPI Administrators only)
- Registration Approvals (NPI Administrators only)
- Blackout NPIs (All users)
- New ADR Letter(s) Since Last Login (NPI Administrators and Standard users)
- New Demand Letter(s) Since Last Login (NPI Administrators and Standard users)

NOTE: The new ADR and new Demand Letter windows only appear if new letters are available in the portal.



User Search (NPI Administrators Only)

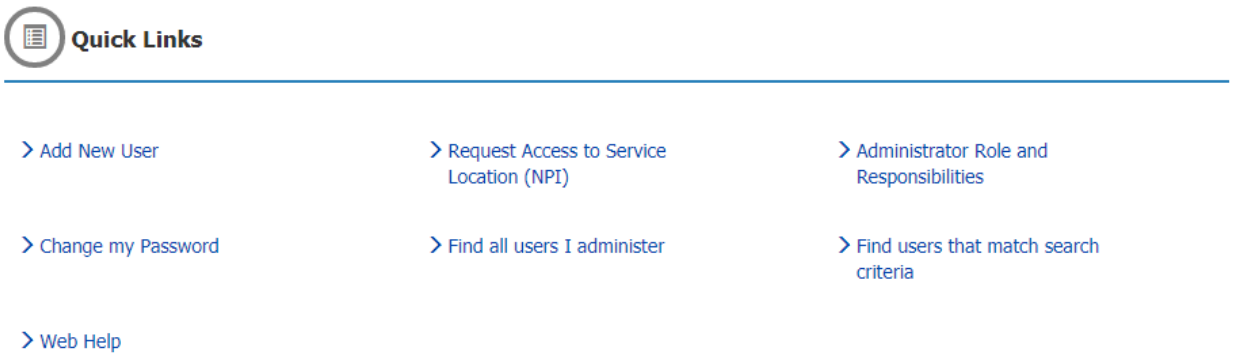
NPI Administrators can search for the users they administer by User Login ID using the User Search. If you know the User Login ID for the user, enter it in the User Login ID box and select "Go to User Profile" to go to the user's profile page. If you do not know the User Login ID, select "Find More Users" to bring up additional options for searching.



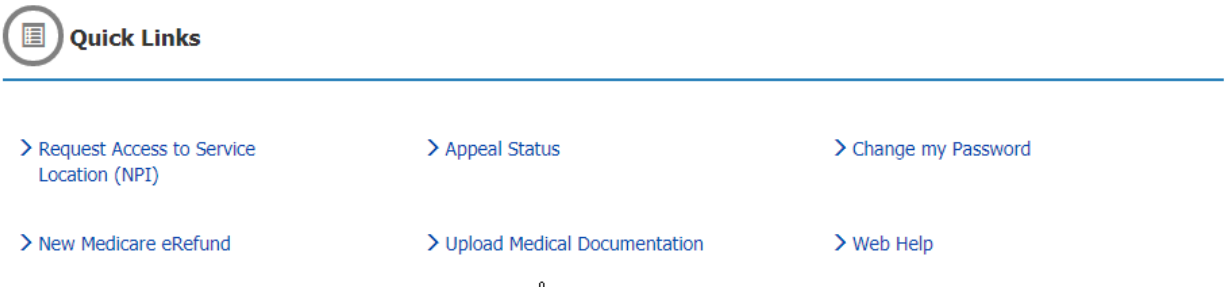
Quick Links

The Quick Links take you directly to some of the more common tasks in the portal. The links you see in Quick Links vary depending on your level of access.

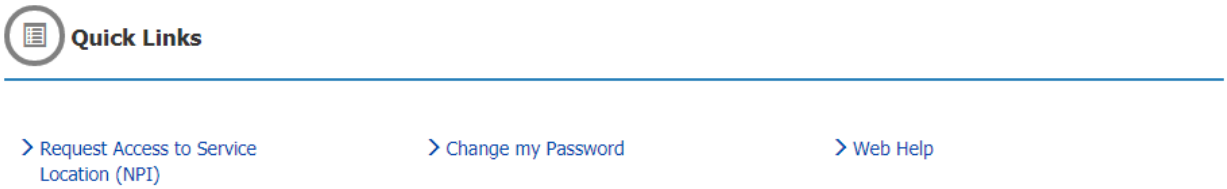
NPI Administrator Quick Links:



Standard User Quick Links:

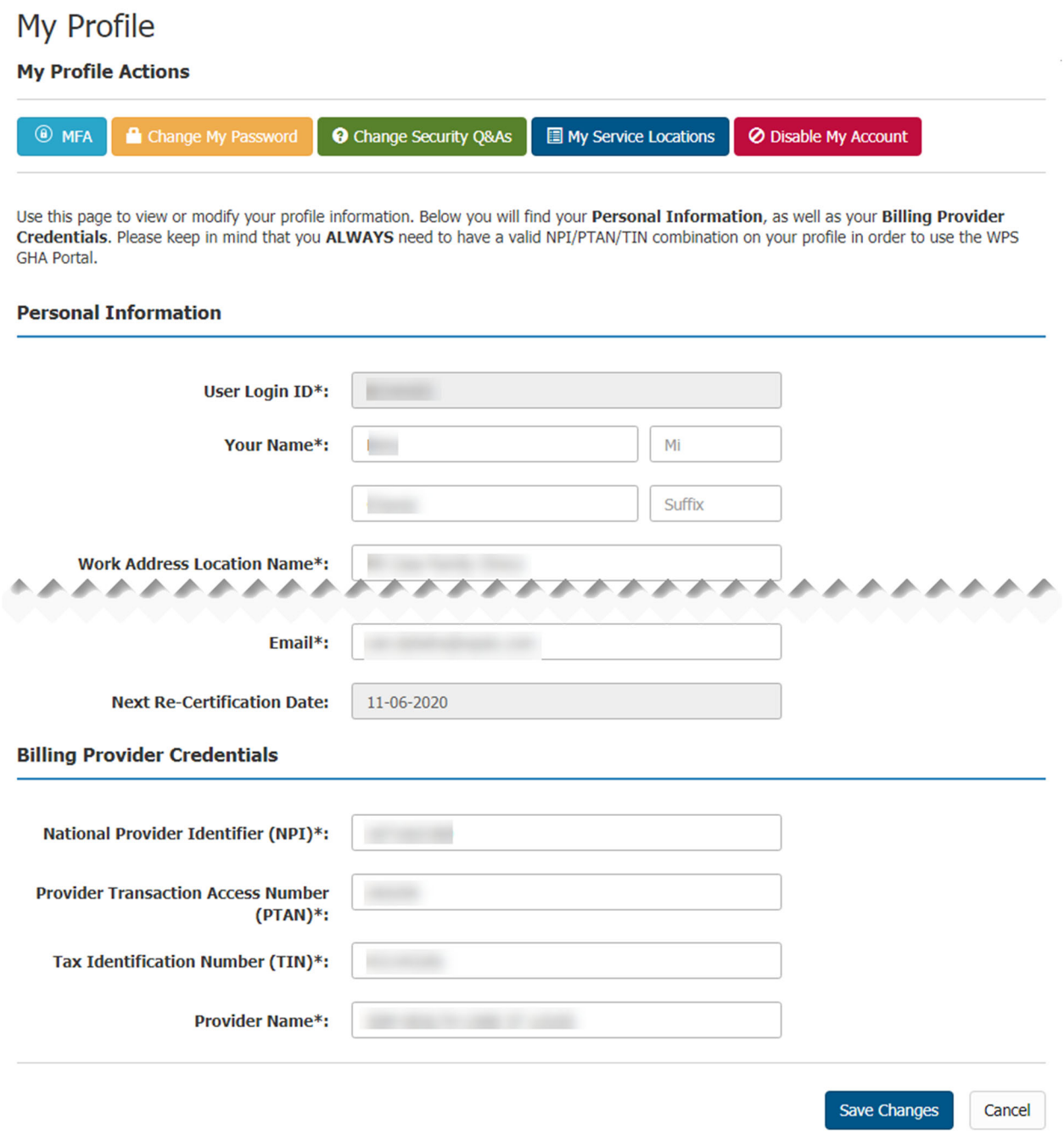


Eligibility User Quick Links:



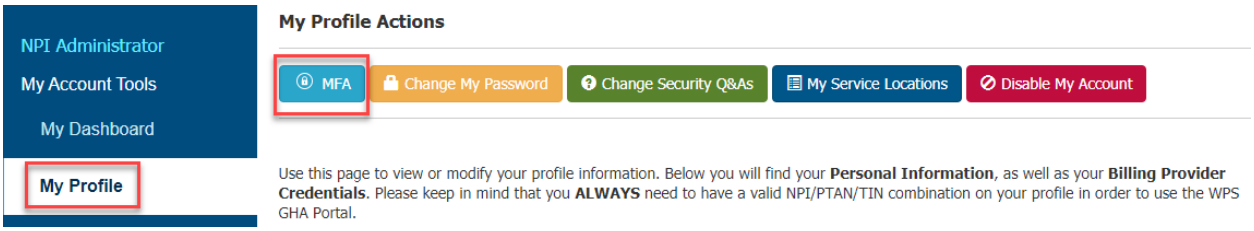
My Profile

The My Profile page allows you to review and update your profile information, such as your personal information (name, work address, email, etc.) or your billing provider credentials. You can also find the next recertification date for your account access.



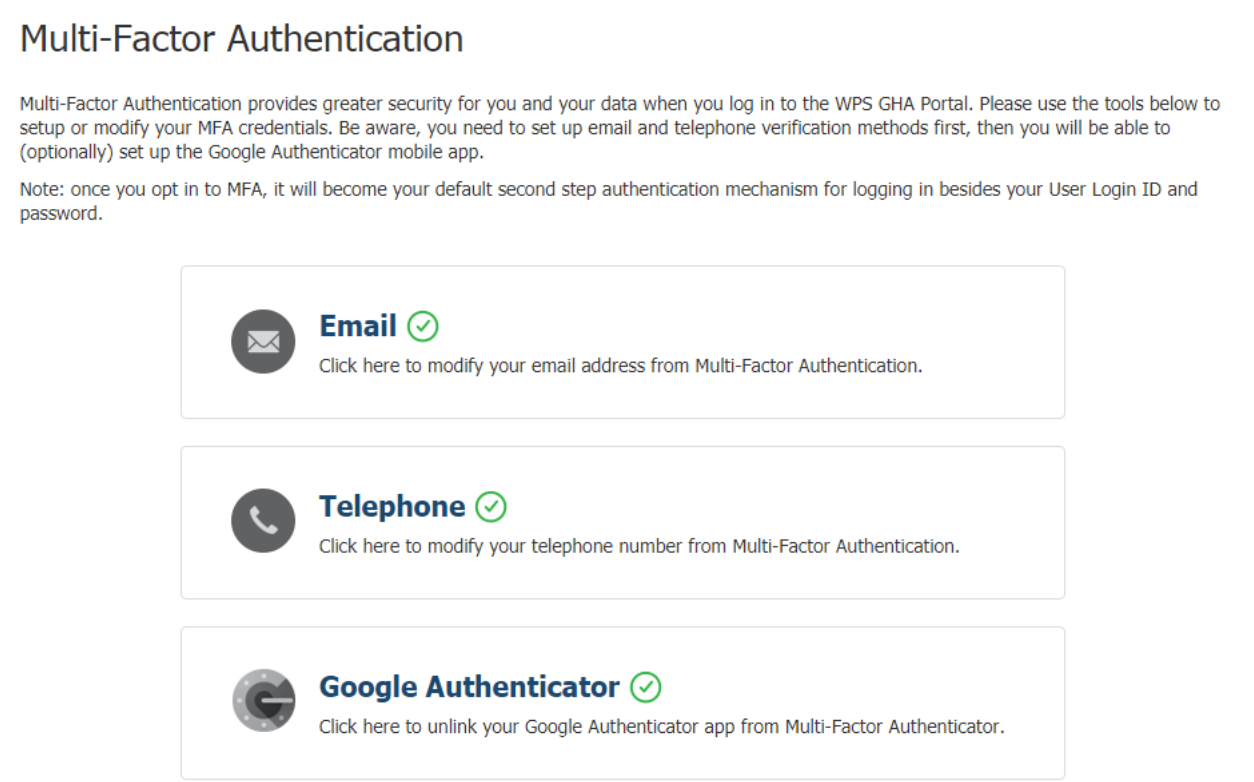
In addition, the My Profile Actions buttons below allow you to make additional changes related to your account.

MFA

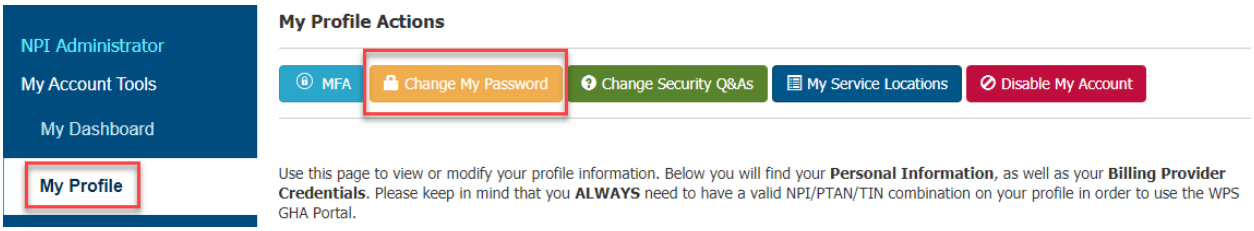


Click the MFA button to review your contact information for Multi-Factor Authentication. You can update the telephone number or email address you use to receive your MFA codes, or you can set up or unlink Google Authenticator.

NOTE: Updating your contact information on your My Profile page **does not** update your email address or phone number for MFA. You must use the MFA button to update your email address or phone number for your MFA codes.



Change My Password

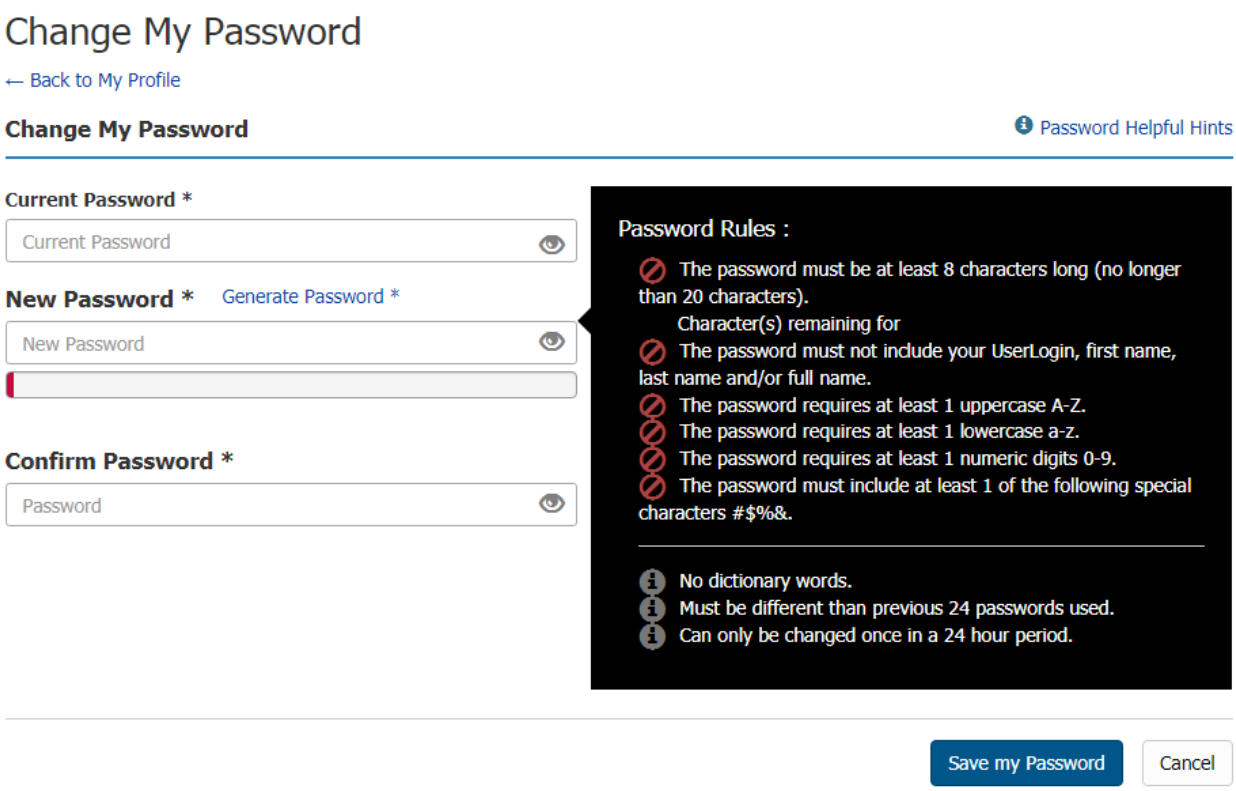


Click the “Change My Password” button to change your password. You can update your password once every 24 hours.

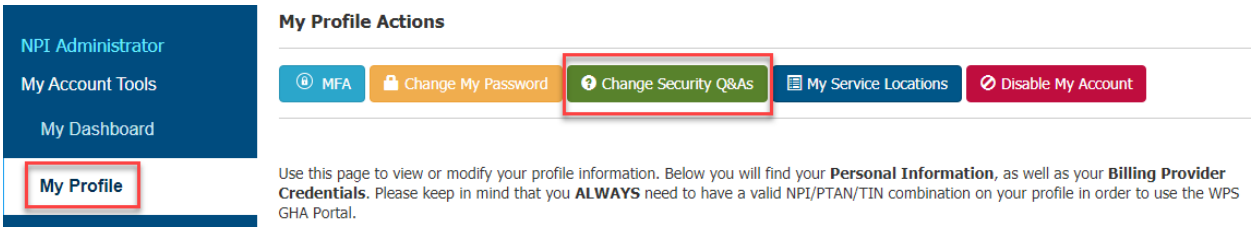
Follow these steps to update your password:

1. Enter your current password in the “Current Password” field.
2. Select a new password that meets all password requirements and enter it in the “New Password” field. See the User Login ID and Password Setup and Management section of this manual for password requirements. If you prefer, select “Generate Password” to have the portal auto-generate a new password for you. Please remember the password.
3. Re-enter your new password in the “Confirm Password” field.
4. By default, the portal will mask the information you type. Click the eye icon at the end of each field to show what you typed.
5. Click the “Save my Password” button to save your new password or “Cancel” to keep your existing password.

NOTE: The red symbols in the black Password Rules box will turn to green check marks when the criterion is met. However, the portal does not check for dictionary words, previous passwords, or the time between password changes until you click “Save my Password.” These rules will not have a green check mark if the criterion is met.

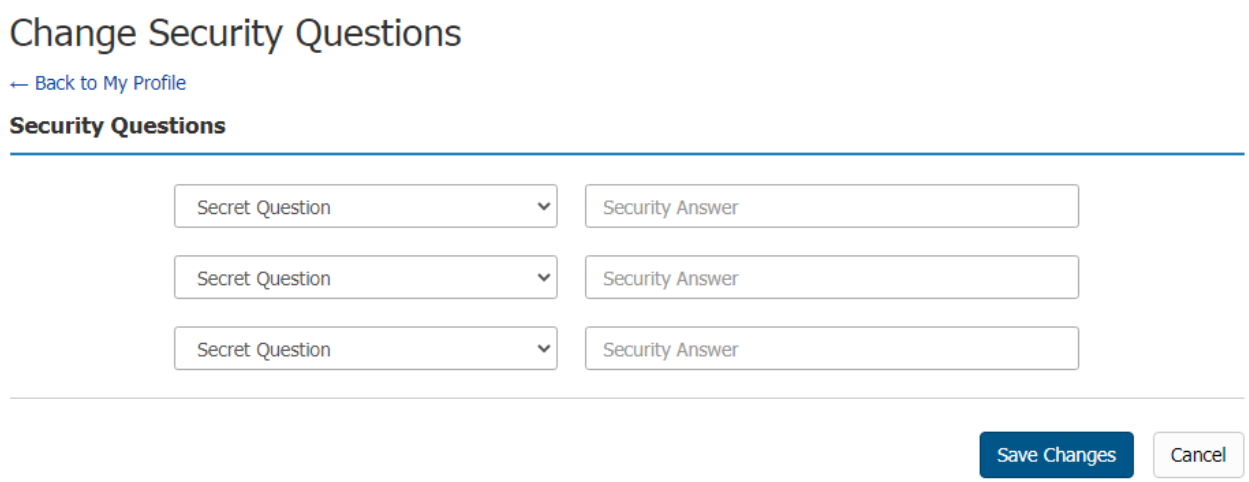


Change Security Q&As

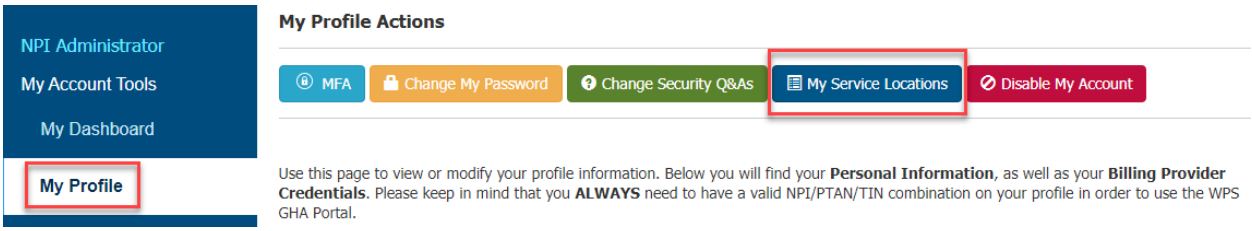


You are required to change your security questions during your annual recertification period, but you can also change your security questions at any time by following these steps:

1. Select “Change Security Q&As”
2. Choose and answer three new questions
3. Select “Save Changes”
4. After you save the changes, you will see the message, “Your security questions have been successfully updated.”

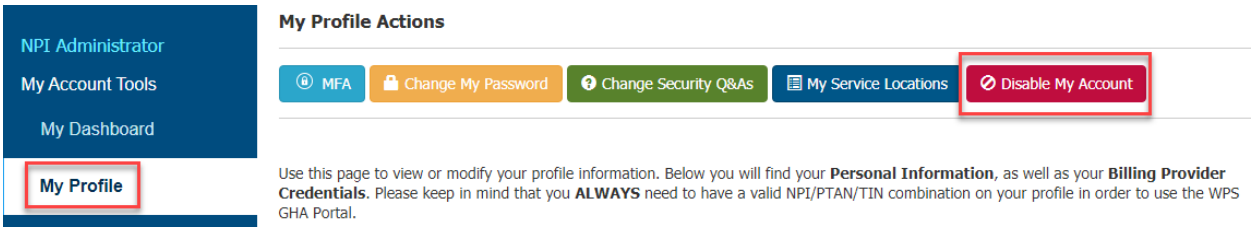


My Service Locations



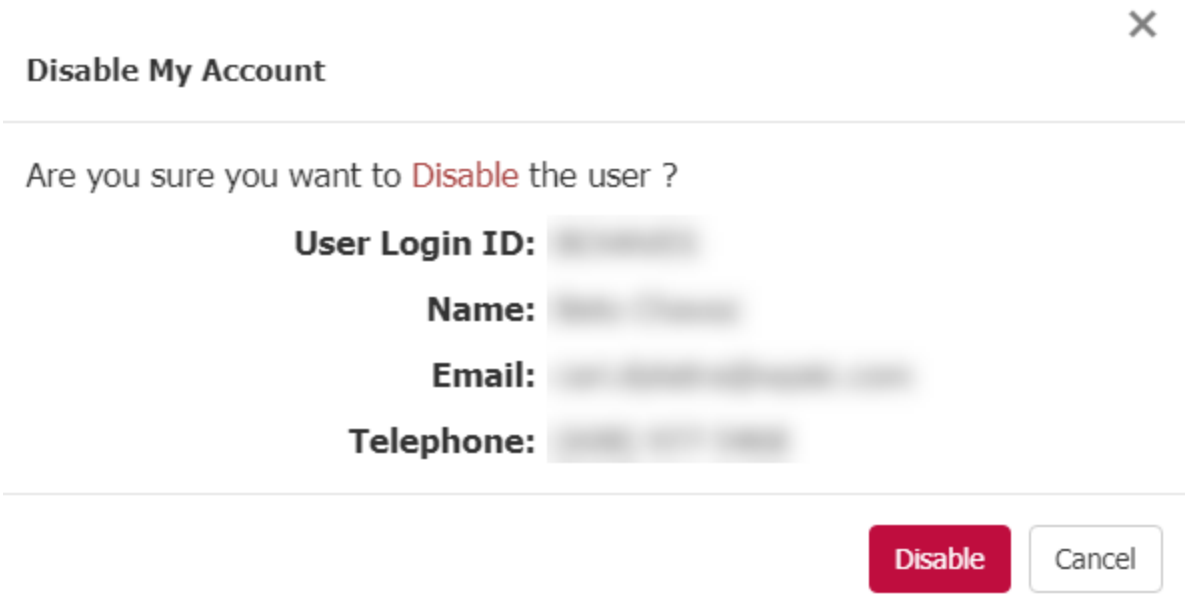
You can view, manage, and modify your Service Locations (NPIs) on the My Service Location page. You can access the My Service Locations page by clicking on the My Service Locations button under My Profile Actions, or by clicking on the My Service Locations link in the left navigation menu. For more information, see the My Service Locations section of this manual.

Disable My Account



If your job changes and you no longer need access to patient eligibility and/or claim information, you should disable your portal account.

1. Select the “Disable My Account” button
2. In the pop-up box, select “Disable.” (Select “Cancel” to return to your “My Profile” page.)
3. The portal will immediately disable your account and display a message indicating the account has been disabled successfully.



Combining Multiple Accounts into One Account

WPS Government Health Administrators strongly urges users maintain only one user account per person unless there is a business need to have separate accounts for each NPI. It is easier to remember your password when you only have one account, and you only need to complete the annual recertification once a year with a single account.

If you have multiple active accounts that you would like to combine, follow the steps below **in order**. Since the portal does not permit users to have more than one account for the same NPI, you may temporarily lose access to all your accounts if you reverse the order of the steps. (See the Portal Security and Loss of Account Access section of this manual and follow the instructions under Replicated Accounts to regain portal access in this situation.)

To combine multiple accounts into one account:

1. Log into the account you will no longer use and navigate to the My Profile page.
2. Click on the My Service Locations button and make note of all the NPIs listed.
3. Click the Disable My Account button and follow the instructions above to disable your account. (Repeat steps 1 through 3 for every account you will no longer be using.)
4. Log into the account you are keeping and navigate to the My Profile page.
5. Click on the My Service Locations button.
6. Click the Request Access button and follow the instructions for requesting access to each NPI that was listed under your now disable account(s). (**NOTE:** The NPI Administrator will need to grant access to the NPI before you can access information under that NPI.)

My Service Locations

Use this page to view, manage, and modify your service locations (NPIs), including performing the following tasks:

- Request access to additional NPIs
- View your Primary Service Location
- Determine which NPIs still require approval by an NPI Administrator (Pending Locations)
- Resolve blackout NPIs by self-registering as a new NPI Administrator
- Remove your access to an NPI
- Modify your level of access to an NPI (current NPI Administrators only)

NOTE: The practice addresses used in the WPS Government Health Administrators Portal come directly from Medicare's enrollment records. You **cannot** update your group's practice address in the portal. If you believe your group's address is incorrect, log into the Provider Enrollment, Chain, and Owner System (PECOS) (https://pecos.cms.hhs.gov/) to verify the address on file for your group. (You must be the Practitioner, the Authorized or Designated Official for the provider organization, or the official contact person to access PECOS.)

Requesting Access to Additional NPIs

Follow these steps to request access to additional service locations.

1. Click the "Request Access" button at the top of the My Service Locations page.

2. Enter the NPI, PTAN, and TIN of the location you want to access and then click "Request Access."

3. Depending on the number of NPI Administrator the NPI already has, the portal may give you the option of registering as an NPI Administrator, or you may need to wait for an administrator to approve your access request.
   - **If the NPI currently has no NPI Administrators**, the portal will ask you to accept the role and complete the self-registration process. (**NOTE:** If you are unwilling or unable to accept the role of the administrator, your access to the NPI will remain pending until another person becomes the administrator.)
   - **If there is currently only one NPI Administrator**, you will have the choice to accept or decline the administrator role.
   - **If the NPI already has two or more NPI Administrators**, the portal will notify them of your pending request. The current administrators will approve or deny your request and determine your level of access (Standard or Eligibility).

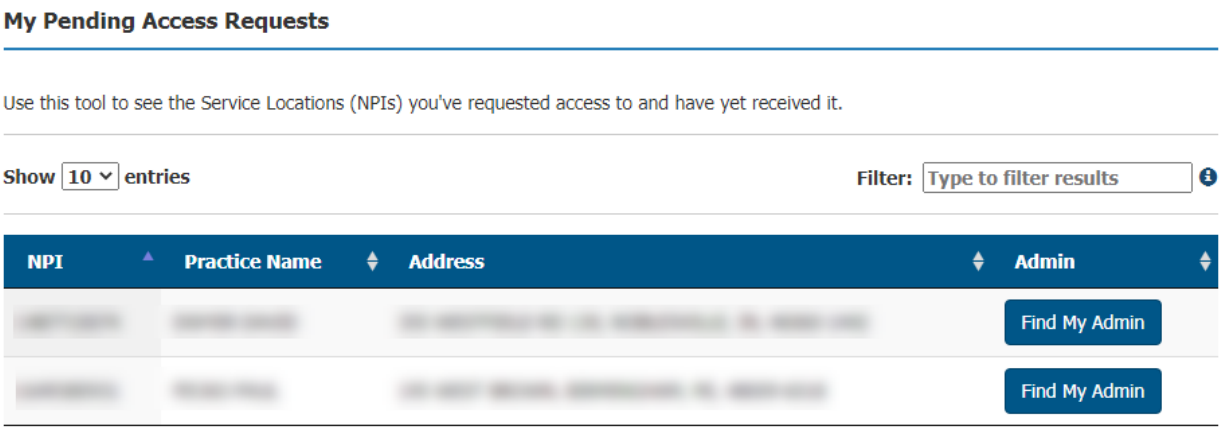
My Primary Service Location

Your Primary Service Location is generally the NPI you use most often to look up information in the portal. By default, it is the first NPI you used to register for portal access. If you would like to change the NPI listed as your Primary Service Location, you may do so by updating your Provider Billing Credentials on your My Profile page.

Pending Service Locations

If you have any access requests waiting for approval by an NPI Administrator, you can find a list of them in the Pending Service Locations section. You will only see this section if you have a pending request.

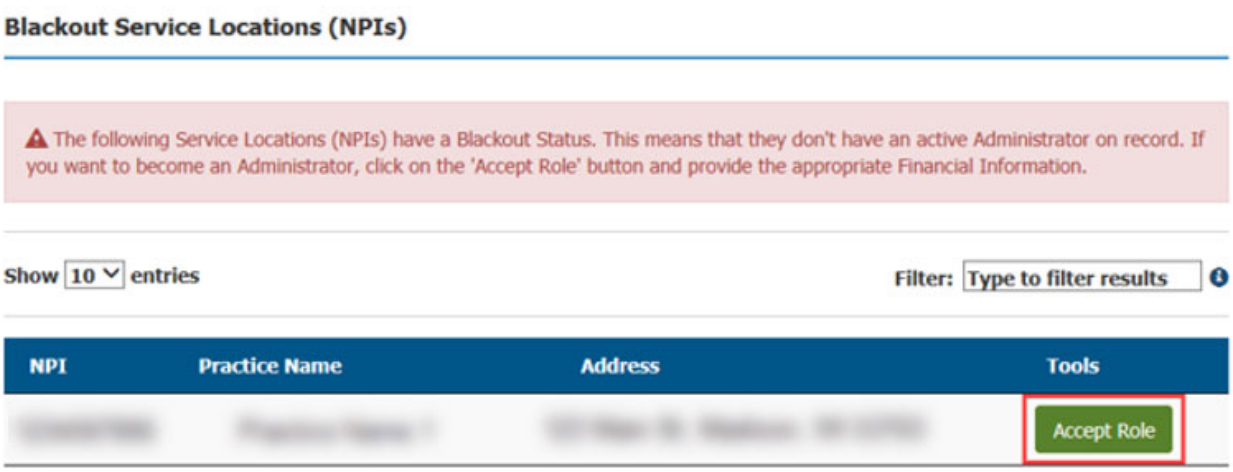
Please remember that WPS staff cannot grant access to an NPI. If you have any questions about the status of an access request, contact the NPI Administrator for the NPI. Click the Find My Admin button to locate the contact information for each NPI's administrator(s).



Blackout Service Locations (NPIs)

All Blackout Service Locations are NPIs that do not currently have an NPI Administrator. You will only see this section if you have blackout NPIs.

If you are willing and able to become the NPI Administrator for the blackout NPI, click the Accept Role button to begin the process of registering as an NPI Administrator.

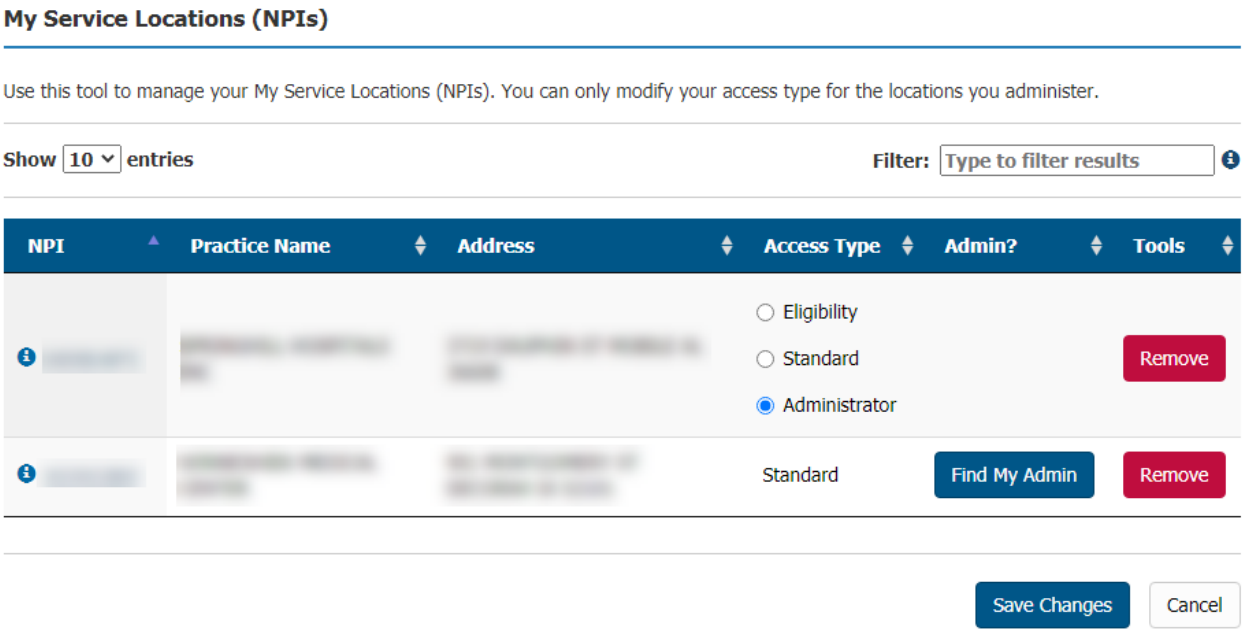


My Service Locations

This section shows a list of all the NPIs to which you have access. If you have access to multiple NPIs, you can click on the column headings to sort the data by that column.

The actions available for each NPI differ depending on your level of access to the NPI. NPI Administrators can modify their level of access for the NPIs they administer. Standard and Eligibility users can view their level of access and lookup their NPI Administrators. See below for details about the information available in each column.

NOTE: In the example below, the user is an NPI Administrator for the first NPI and a Standard user for the second NPI. The portal displays the appropriate actions available to the user for each NPI.



NPI Column

Clicking an NPI in the NPI column will show additional information about the NPI. If you are the NPI Administrator, will also have a “View Users for this NPI” link that allows you to view and manage the other users registered under the NPI.

Access Type Column

This column shows the type of access you have for each NPI. Depending on your level of access, you can perform different tasks related to each service location.

- If you have Standard or Eligibility Access, you can locate your NPI Administrator by clicking the Find My Admin button.
- If you are an NPI Administrator, you have the option to reduce your level of access. Click the radio button next to your level of access, and then click “Save Changes” at the bottom of the page. (**NOTE:** Once you save your changes, you will not be able to change your level of access because you are no longer an administrator.)

Tools Column

The Tools column contains a Remove button for each NPI to allow you to completely remove your access to that Service Location. If you no longer need access to an NPI, you should remove your access to ensure you are compliant with HIPAA standards. Click “Save Changes” to remove your access effective immediately.

NOTE: If you click the Remove button by accident, click “Cancel” or “Undo” to back out without saving the changes.

Blackout NPIs

If an NPI has no administrators for more than 30 days, no other users can access information in the WPS Government Health Administrators Portal using that NPI. These are known as "blackout NPIs."

The Cause of Blackout NPIs

Every NPI used to access the portal requires at least one person to accept the responsibility for the administration of the NPI's users. Like Standard and Eligibility users, an NPI Administrator will lose access to their account if they fail to log in at least once every 30 days, or if they fail to complete their annual account recertification.

If all administrators for an NPI lose (or remove) their access, the portal moves the NPI into Blackout status.

When an NPI is in Blackout status, Standard and Eligibility users registered under that NPI may continue to access information in the portal using the Blackout NPI for 30 days. This allows time for the previous NPI Administrator to regain access to their account, or for a new person to self-register as an administrator. If the Blackout NPI remains without an administrator after 30 days, all users lose access to the NPI.

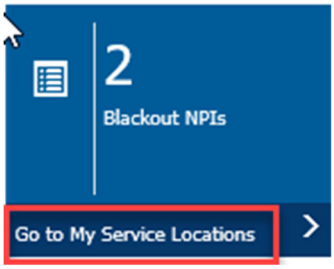
Fixing Blackout NPIs

To fix a Blackout NPI, someone who is willing and able to be the NPI Administrator must self-register as the administrator. The NPI Administrator can be someone who was previously the administrator, or it can be a new individual.

Accepting the Administrator Role during the Blackout Period

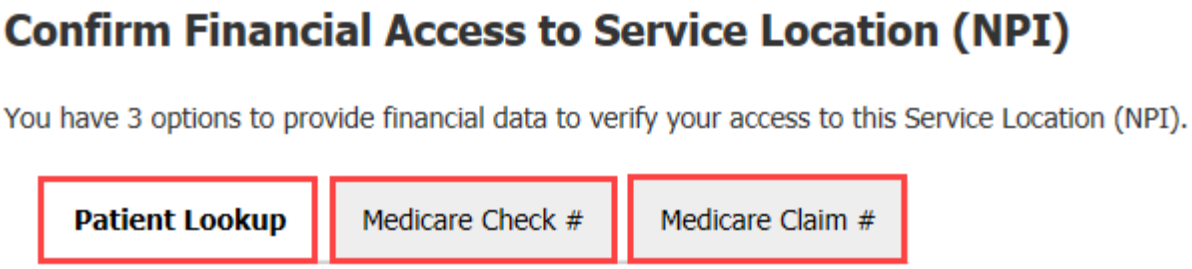
A window on your dashboard will display the number of NPIs in Blackout status. If you are willing to become the administrator for the NPI and have access to the required financial information, follow the instruction below to self-register:

1. If the dashboard window indicates there are any Blackout NPIs, select the "Go to My Service Locations" link. (You can also access this information by selecting "My Service Locations" from the left navigation menu.)



2. In the Blackout Service Locations (NPIs) section, you will see a list of the Blackout NPIs. Scroll to the NPI that does not have an administrator and select “Accept Role.”

3. Read and accept the Administrator Role Responsibilities.
4. In the “Confirm Financial Access for Service Location (NPI) Administration” section, select one of the three options for providing financial data.



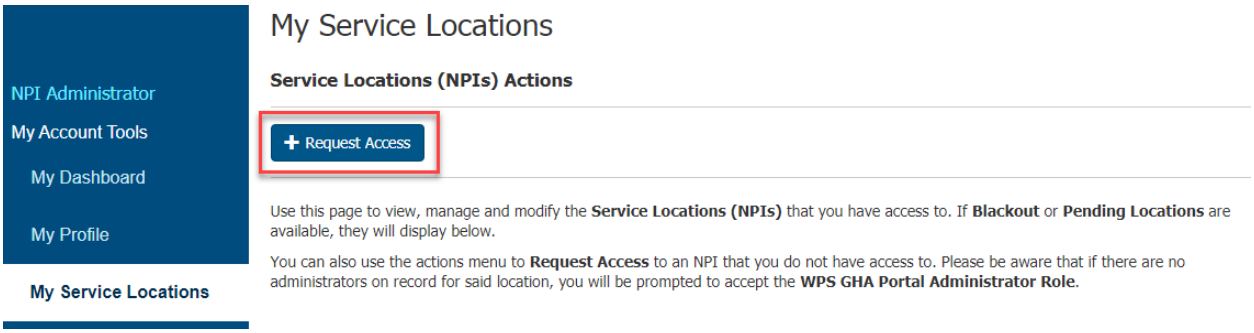
5. After entering the financial data, click “Confirm” to become the NPI Administrator. The NPI will no longer be in Blackout status, and other users will no longer see the information on their dashboard.

Accepting the Administrator Role after the Blackout Period Expires

If no one accepts the role of NPI Administrator during the 30-day Blackout period, all users lose their access to the NPI.

To regain access, all users need to follow the normal process for requesting access to an NPI by clicking on the “Request Access” button on the “My Service Locations” page. At least one user must agree to become the NPI Administrator.

Once the new NPI Administrator completes the self-registration process, they can approve the other users’ requests for access to the NPI. See the My Service Locations section of this manual for more information about requesting access to an NPI.


NPI Administrator
My Account Tools
My Dashboard
My Profile
My Service Locations
My Service Locations
Service Locations (NPIs) Actions
+ Request Access
Use this page to view, manage and modify the Service Locations (NPIs) that you have access to. If Blackout or Pending Locations are available, they will display below.
You can also use the actions menu to Request Access to an NPI that you do not have access to. Please be aware that if there are no administrators on record for said location, you will be prompted to accept the WPS GHA Portal Administrator Role.

My Correspondence

Message Center Overview

The Message Center allows users to send messages to the following departments for the following purposes:

- Customer Service for general inquiries about Medicare and the WPS Government Health Administrators Portal
- Electronic Data Interchange (EDI) for Electronic Remittance Advice (ERA) enrollment and change requests

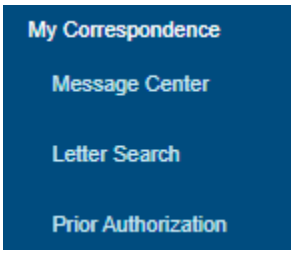
Since the portal is a secure site, messages and responses sent through the Message Center can include protected health information (PHI) and personally identifiable information (PII). This allows users to include claim-specific, patient-specific, and provider-specific questions and information in messages.

In addition, we house the outcome of portal-submitted appeals (redeterminations) in the Message Center. For information about this function, see the Checking the Status of Appeals Submitted Via the Portal section of this manual.

NOTE: Users cannot send inquiries or messages to the Appeals department through the Message Center.

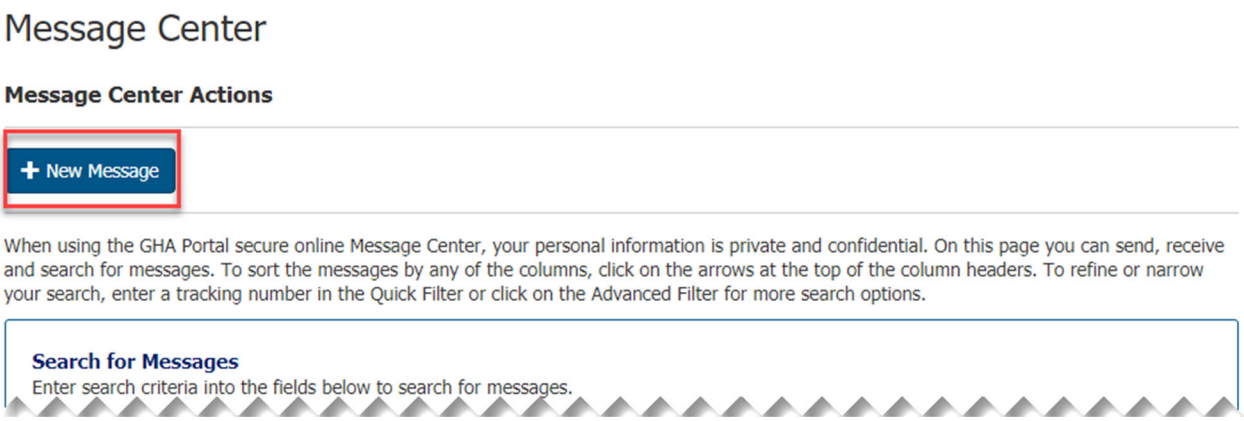
Accessing the Message Center

Access the Message Center by clicking on the Message Center link in the left navigation menu.

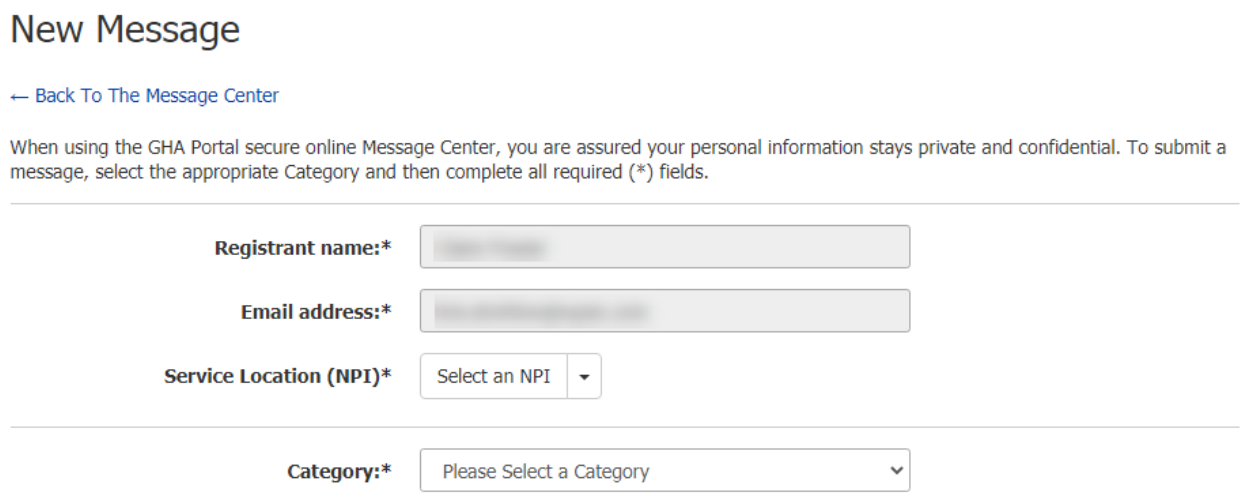


Sending a New Message through the Message Center

Click the New Message button to send a new message to Customer Service, EDI department, or Financial department. (The Appeals department does not accept incoming messages through the Message Center.)



This will open the New Message screen where your name and email address will be pre-populated.



You will need to select the service location (NPI) that pertains to your inquiry. Note that the drop-down box may default to an NPI you previously selected. If it does not default to your NPI, or if it defaults to the incorrect NPI for your inquiry, click the down arrow and select the applicable NPI.

Next, select the category (department) for your inquiry. Currently, our Customer Service, EDI, and Financial departments are the only departments that accept messages through the Message Center. Depending on the category you select, you will see additional fields that you must complete.

Searching for Messages in the Message Center

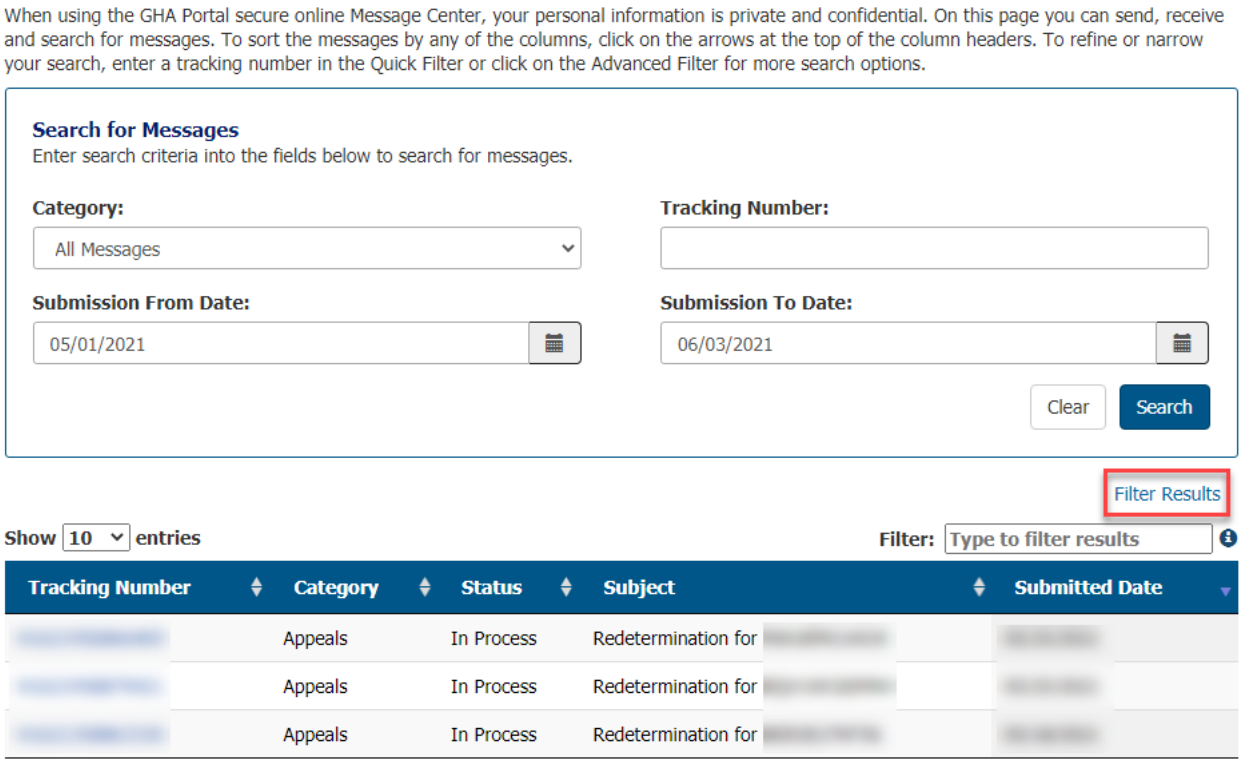
The Message Center Actions section includes a search function allowing you to search for messages and appeals previously submitted. The portal displays the message history below the search area. It includes the following information for each message or appeal:

- Tracking number
- Category (department)
- Message/appeal status
- Message subject
- Submission date

Use the arrows next to each column header to sort messages by that column. Click on the tracking number to view the message or appeal.

When you enter the Message Center, the portal will display all messages and appeals submitted within the previous week by default. You can use the drop-down boxes in the search area to search by category (department), tracking number, and/or a different date range.

If you need to perform a more detailed search, you can find additional search options by clicking on the Filter Results link below the search area. Depending on the type of message and your level of access, you may also be able to see messages submitted by other users at your service location in your message history.



Message Center Statuses

The Customer Service, EDI, Appeals, and Financial departments classify the status of their messages differently. See below for the message status definitions for each department.

Customer Service Message Statuses

- Sent – The message has been sent to Customer Service.
- Received – Customer Service has responded to your message.
- Deleted – Customer Service responded to your question by telephone. (You will not see a response in the portal.)

EDI Message Statuses

- Sent – Your ERA enrollment request was sent to EDI for processing.
- Not Accepted – The EDI staff did not accept your request. Contact them for more details

Appeals Message Statuses

- Submitted – Your appeal has been submitted.
- In Process – The Appeals department acknowledges they received your Part B appeal.
- Open – The Appeals department acknowledges they received your Part A appeal.
- Closed – The Appeals department made a redetermination decision.
- Not Accepted – The Appeals department was not able to accept your appeal.

Financial Message Statuses

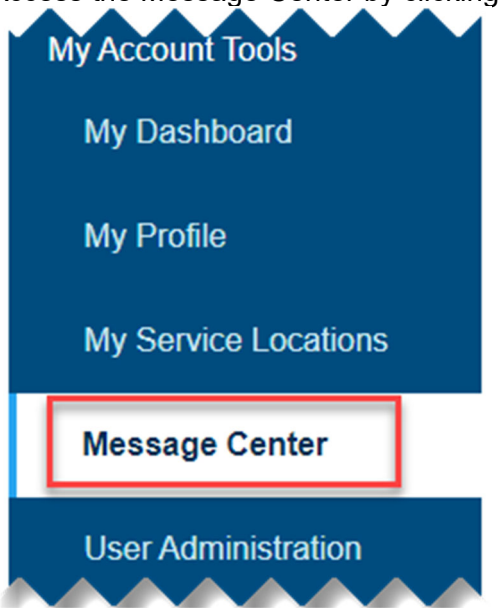
- Sent – Your Credit Balance Report was sent to Financial.
- Closed – Closure Message received in the portal.

Customer Service Inquiries

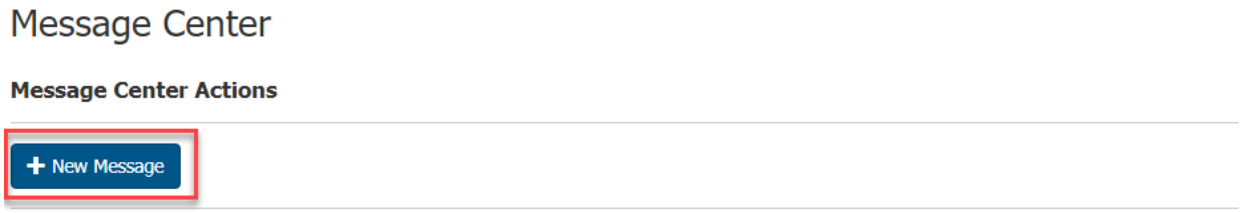
Steps to Submit a Customer Service Inquiry in the Message Center

You can send an inquiry to the Customer Service department through the Message Center by following these steps:

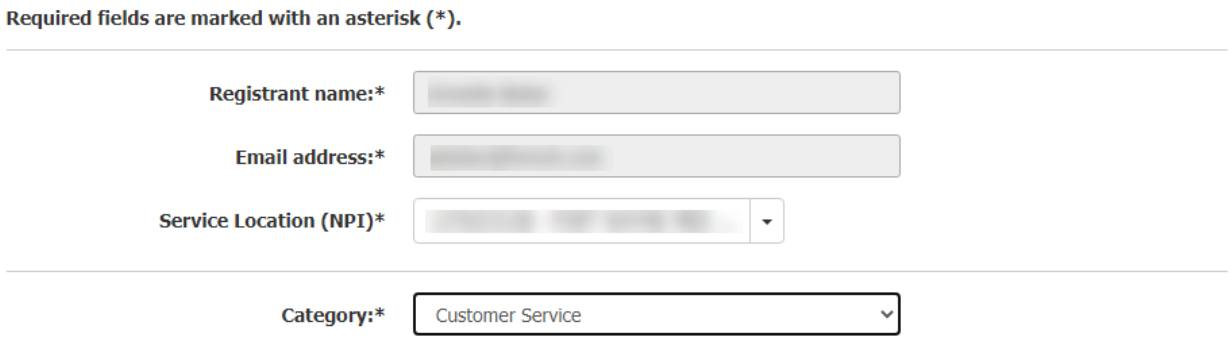
1. Access the Message Center by clicking on the link in the left navigation menu.



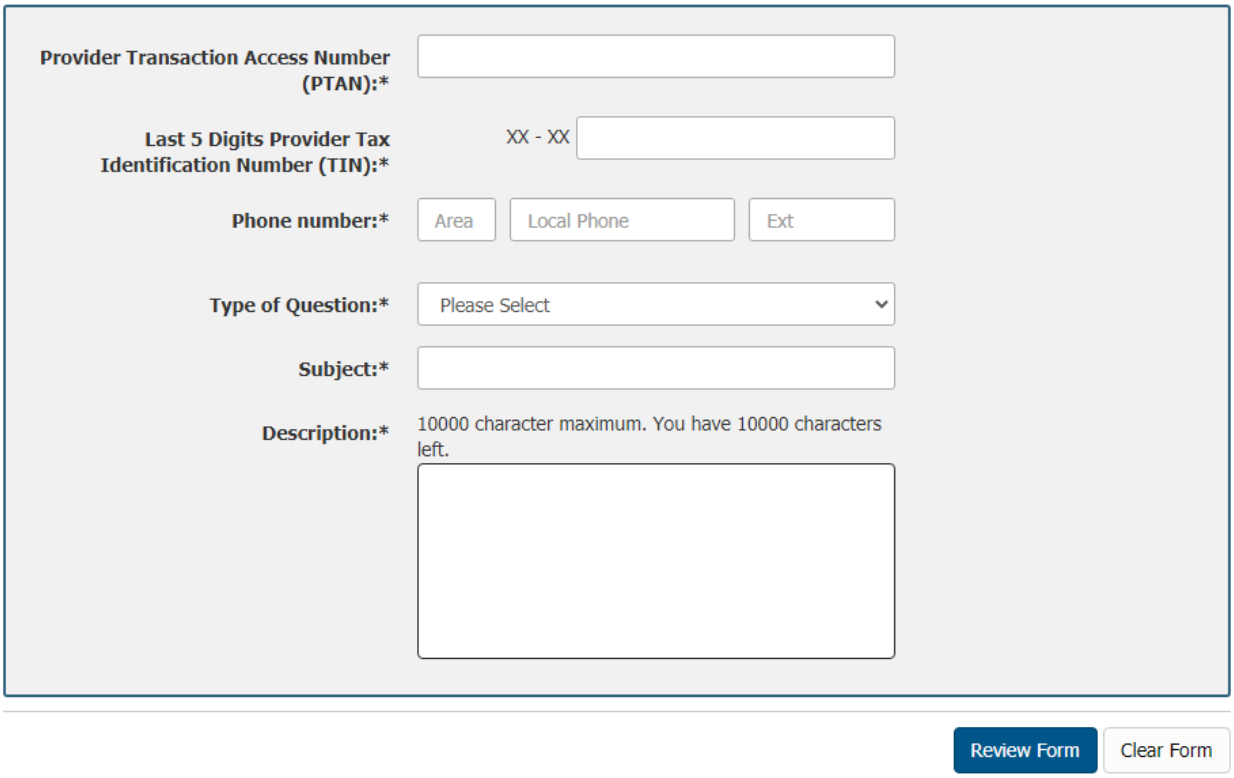
2. Click the New Message button.



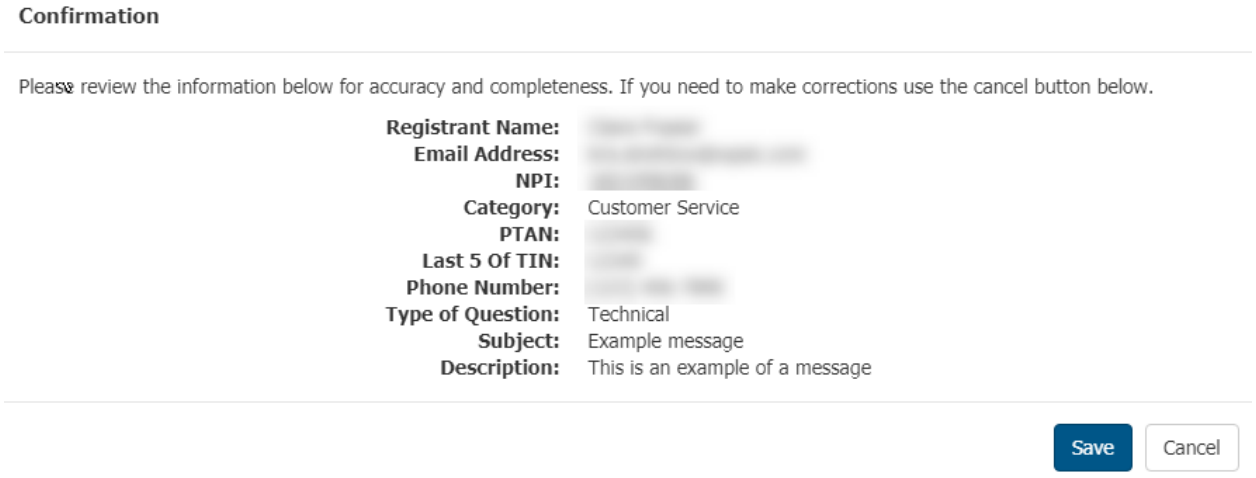
3. Select the applicable NPI from the drop-down box if it is not already filled in (Your name and email address will be pre-populated.) and select Customer Service from the Category drop-down box to open the message form.



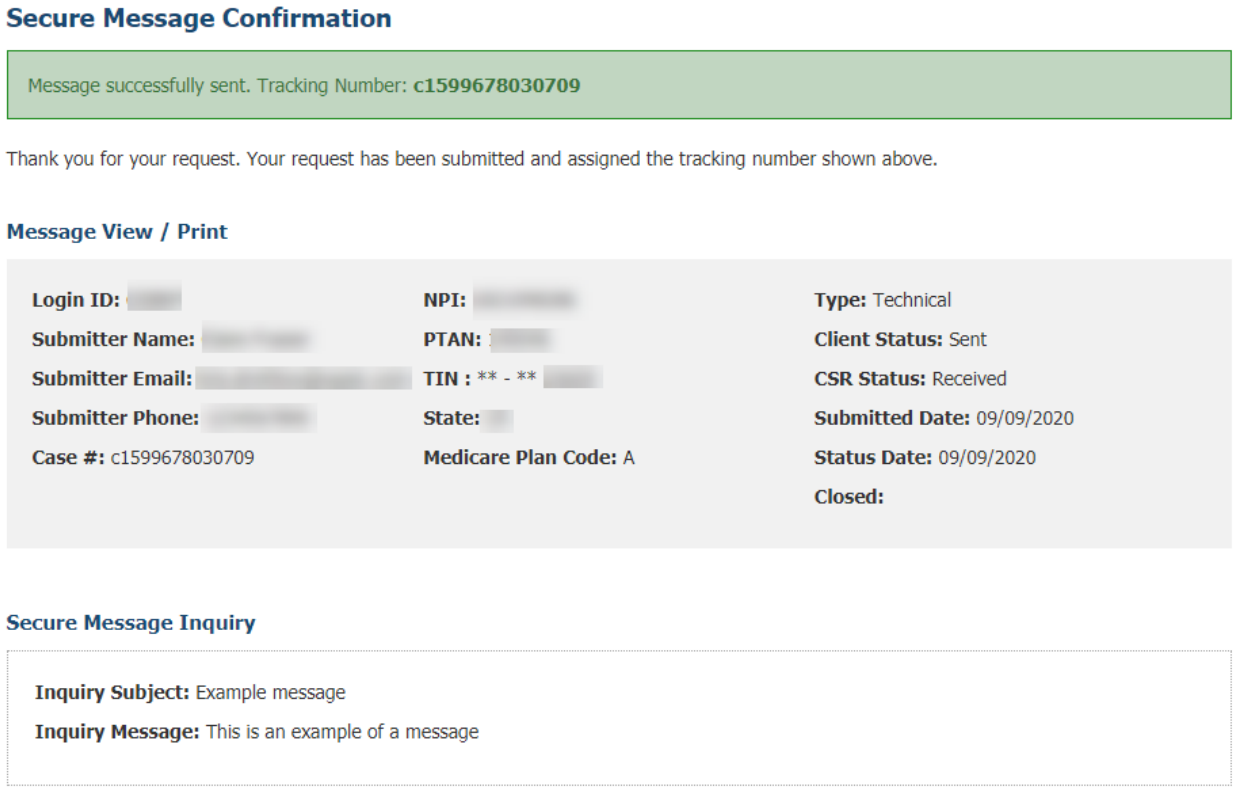
4. Complete the following fields and click the Review Form button to review the details of your inquiry:



5. If you are satisfied with your inquiry, click the Save button to submit your inquiry to Customer Service. Click the Clear Form button if you would like to make any corrections.



6. Once you submit your inquiry, you will see a confirmation message with the details of your inquiry. You will also see the Tracking Number assigned to your message. The Tracking Number will also appear in your message history so you can monitor the status of your inquiry.



Customer Service Inquiry Submission Guidelines

Our Customer Service staff must follow the same rules regarding the release of information for messages sent through the Message Center as they do for telephone calls. This means:

- You must provide your **NPI, Provider Transaction Access Number (PTAN) and the last five digits of your Tax ID (TIN)** when submitting your inquiry.
- Our staff is not permitted to release claim status or eligibility information if the information is available in the portal or the Interactive Voice Response (IVR) system.
- CMS allows Medicare contractors up to **45 business days** to respond to written inquiries, including inquiries submitted through the portal.

To help us respond to your inquiry as quickly as possible, please complete all fields accurately and provide as much detail as possible in your inquiry.

Customer Service Portal Question Types

When submitting your question, you will need to select the type of question (technical or non-technical) that you are submitting. This helps us route your question to the appropriate staff to assist you.

- **Technical** questions pertain directly to the use or functionality of the WPS Government Health Administrators Portal, including questions about:
    - Adding or removing service locations
    - Adding or removing users' portal access
    - Site navigation
    - Requesting administrative access for a third (or subsequent) NPI Administrator (Current NPI Administrators only)
- **Non-Technical** questions involve any issue other than use of functionality of the portal, including:
    - Policy questions or clarification
    - Claim submission questions
    - Claim payment or denial explanations

If your question is claim-specific or patient-specific, you must include the following details in the description field:

- Patient's name
- Patient's Medicare Beneficiary Identifier (MBI)
- Date of service (for claim-specific questions)
- Patient's date of birth (for patient-specific (eligibility) questions)

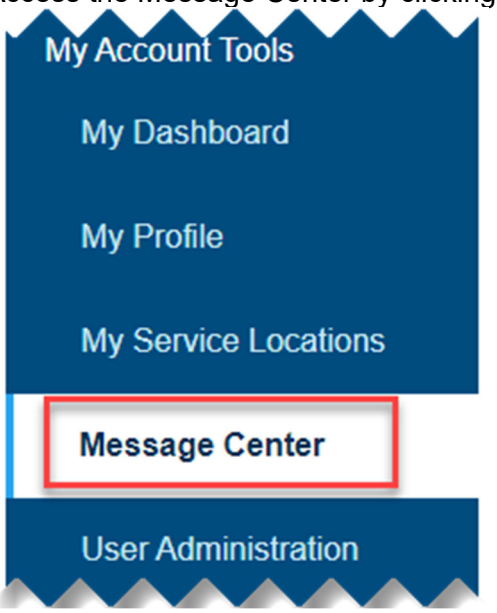
NOTE: The portal does not allow for special formatting in messages. Please avoid creating tables or using special characters in the description field as it can make your message difficult to understand.

ERA Enrollment Requests or Changes

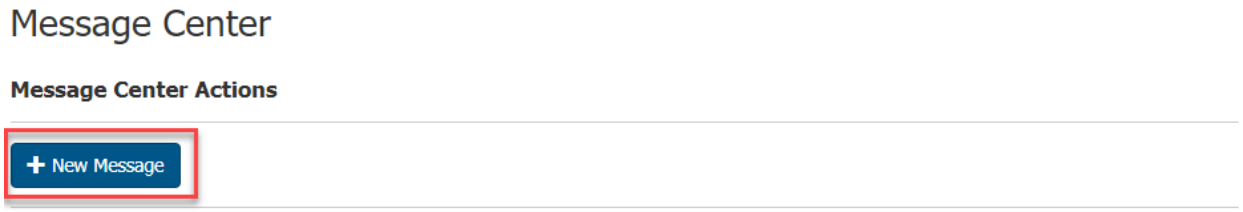
Providers must use the Message Center to submit an ERA enrollment application or change request to the EDI department. This is also known as the 835 transaction set or Health Care Claim Payment and Remittance Advice.

Steps to Submit an ERA Enrollment Request or Change in the Message Center

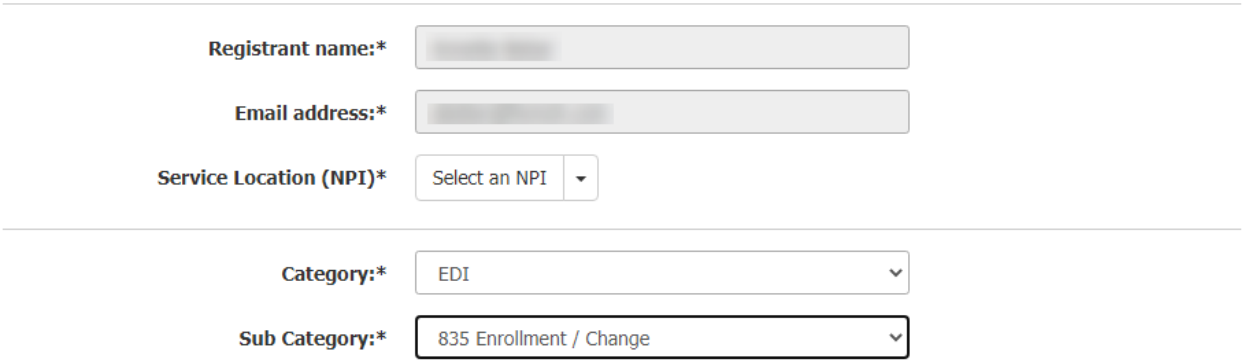
1. Access the Message Center by clicking on the link in the left navigation menu.



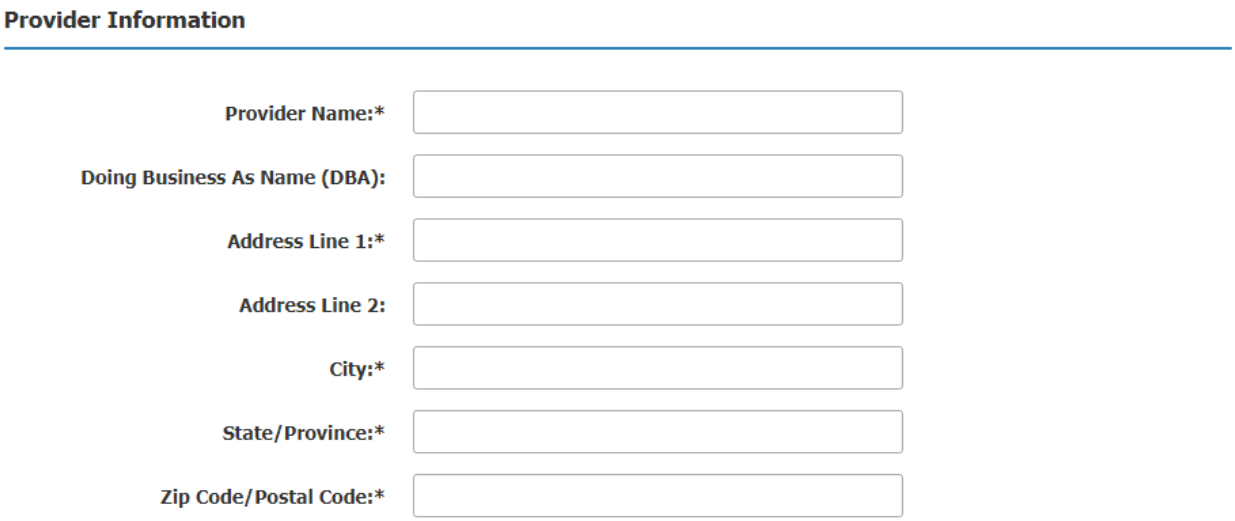
2. Click the New Message button.

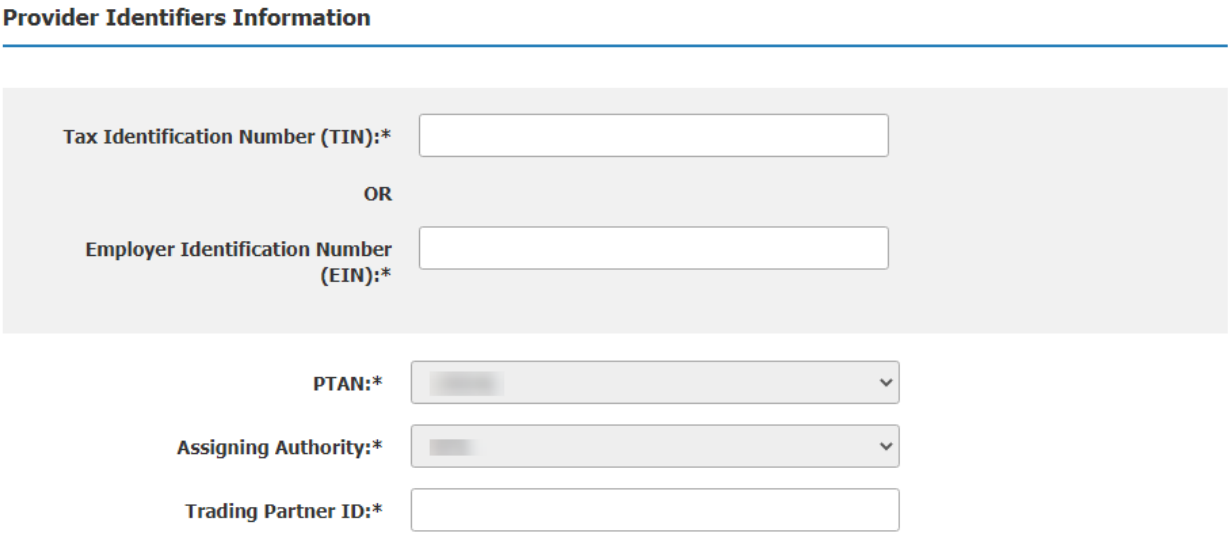


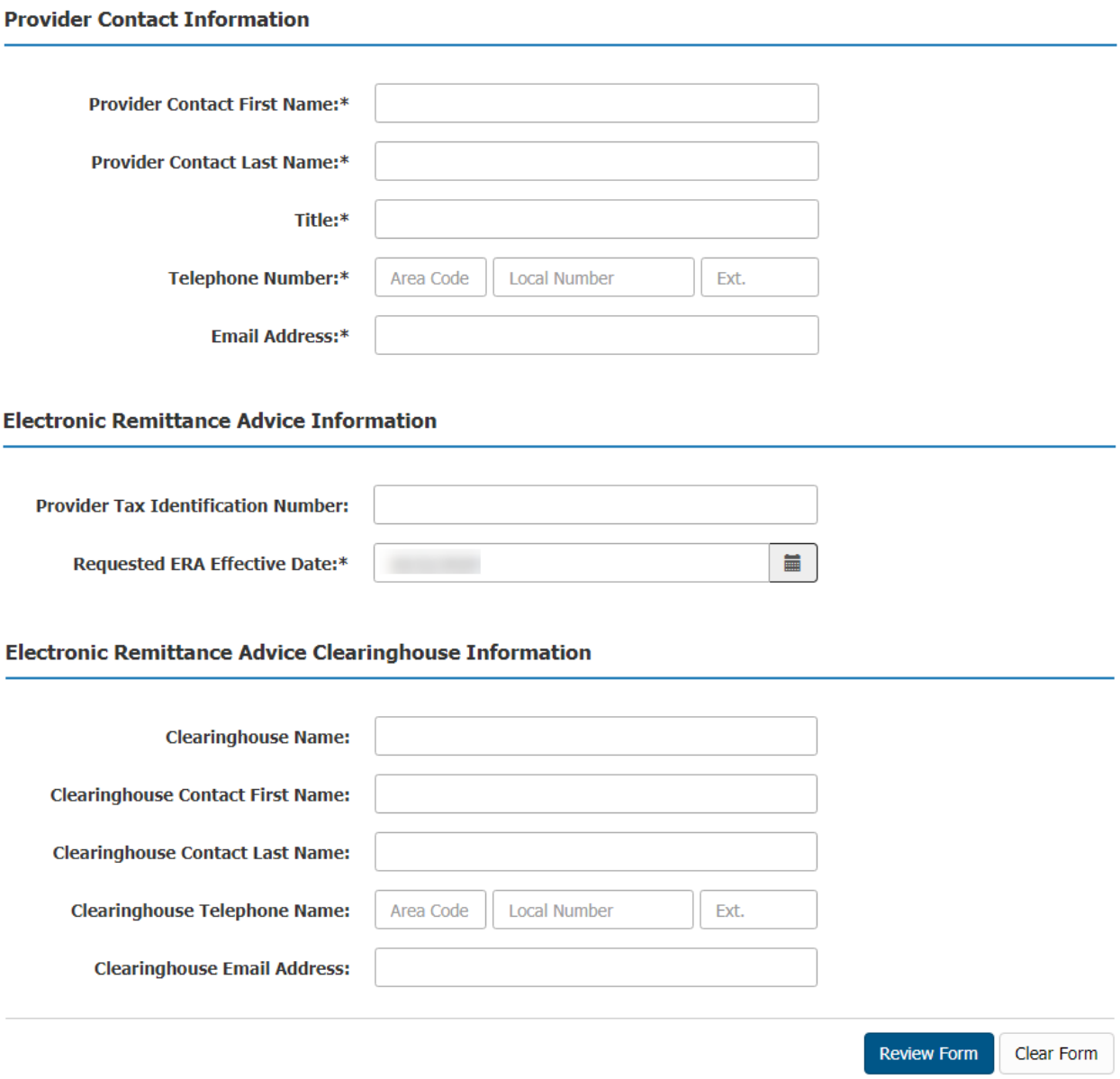
3. Select the applicable NPI from the drop-down box if it is not already filled in (Your name and email address will be pre-populated.) and select EDI from the Category drop-down box to open the message form. This will automatically open and populate a sub-category field with “835 Enrollment/Change.”



4. Complete all the required fields designated with an asterisk (*) and any optional fields, as appropriate:







If you need assistance completing the ERA enrollment/change request, contact the EDI department for assistance:

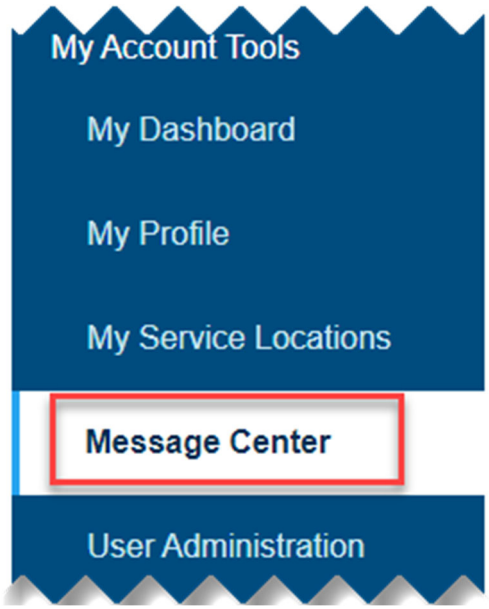
By telephone:
J5 Providers: (866) 518-3285
J8 Providers: (866) 234-7331

By email:
Part A Providers: EDIMedicareA@wpsic.com
Part B Providers: EDIMedicareB@wpsic.com

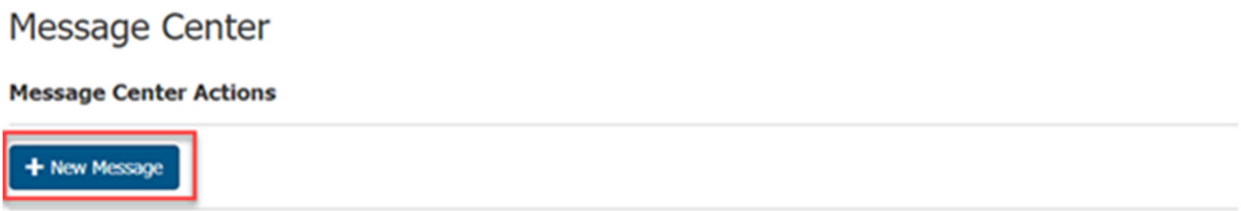
Credit Balance Reporting

Steps to Submit a Credit Balance Report in the Message Center

Step 1: Access the Message Center by clicking on the link in the left navigation menu.

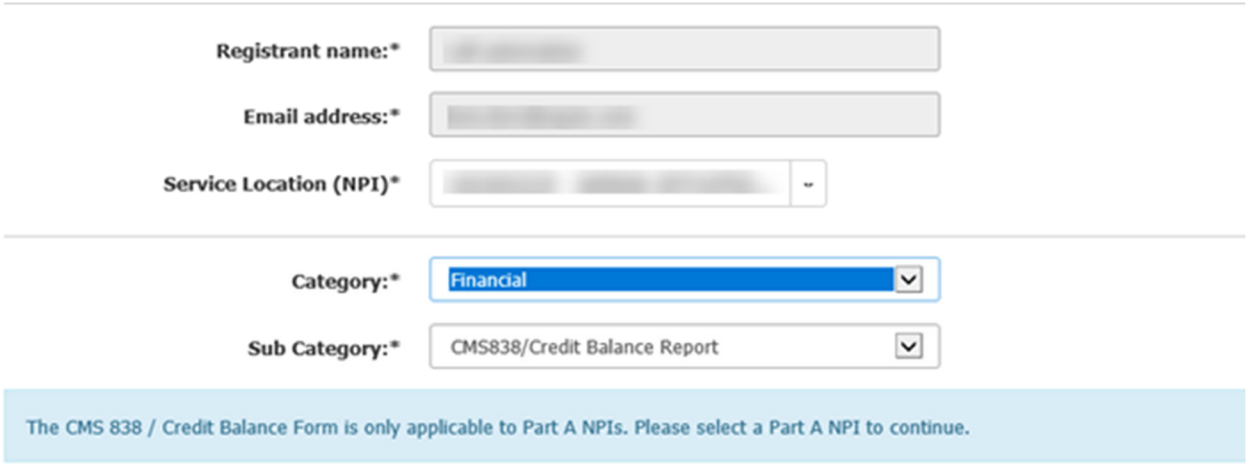


Step 2: Click the New Message button.



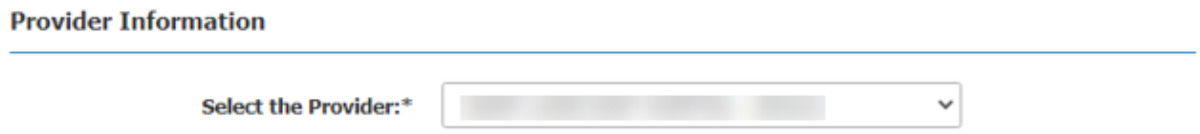
Step 3: The Registrant name and email address will be pre-populated. Select the appropriate NPI from the Service Location (NPI) dropdown.

Select Financial from the Category drop-down box to open the message form. This will automatically open and populate a sub-category field with "CMS838/Credit Balance Report."

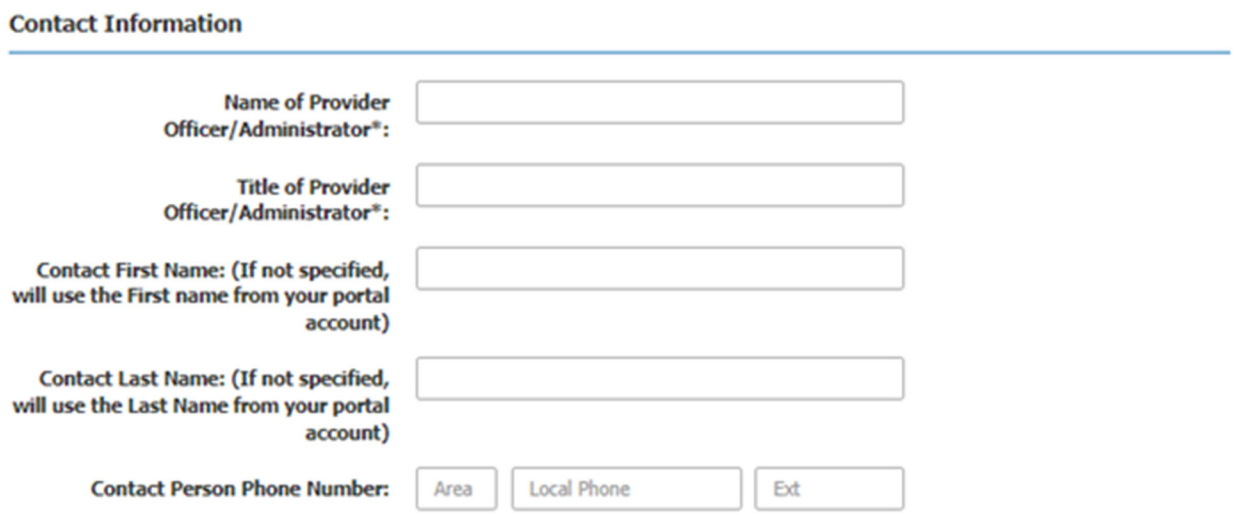


The Credit Balance feature is only available for Part A providers. If you select a Part B NPI, you will receive the above message.

Step 4: Select the appropriate Provider Transaction Access Number (PTAN) from the provider dropdown selector.



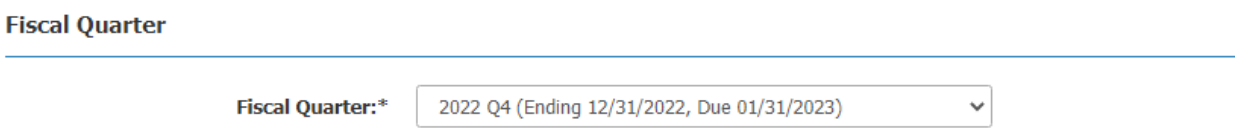
Step 5: Enter the Name and Title of Provider Officer/Administrator. When submitting the credit balance report, the contact information will populate with what is on the user's My Profile page. If it should be someone else, enter the contact information in the appropriate fields.



Step 6: CMS requires Credit Balance Reports to be submitted within 30 days after the close of each calendar quarter. As an example, Quarter 4 ends on December 31 so the report cannot be submitted until January 1. Reports can be submitted for the previous 2 quarters via the portal. If submitting a report older than this, submit the report to the Financial.Reporting.Inquiry@wpsic.com email address. You can also fax your report to (608) 223-7560.

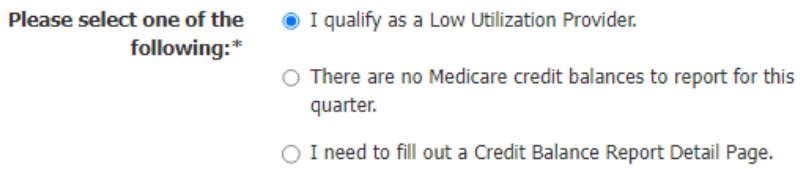
Select the Fiscal Quarter End period based on the CMS Credit Balance Report Due Dates.

Quarter Ending	Due Date
March 31	April 30
June 30	July 30
September 30	October 30
December 31	January 30

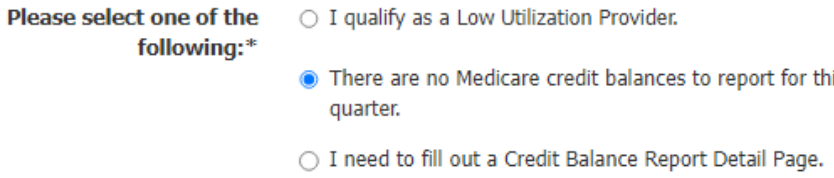


Step 7: Select the action that you need to take. Based on your selection, additional fields will display.

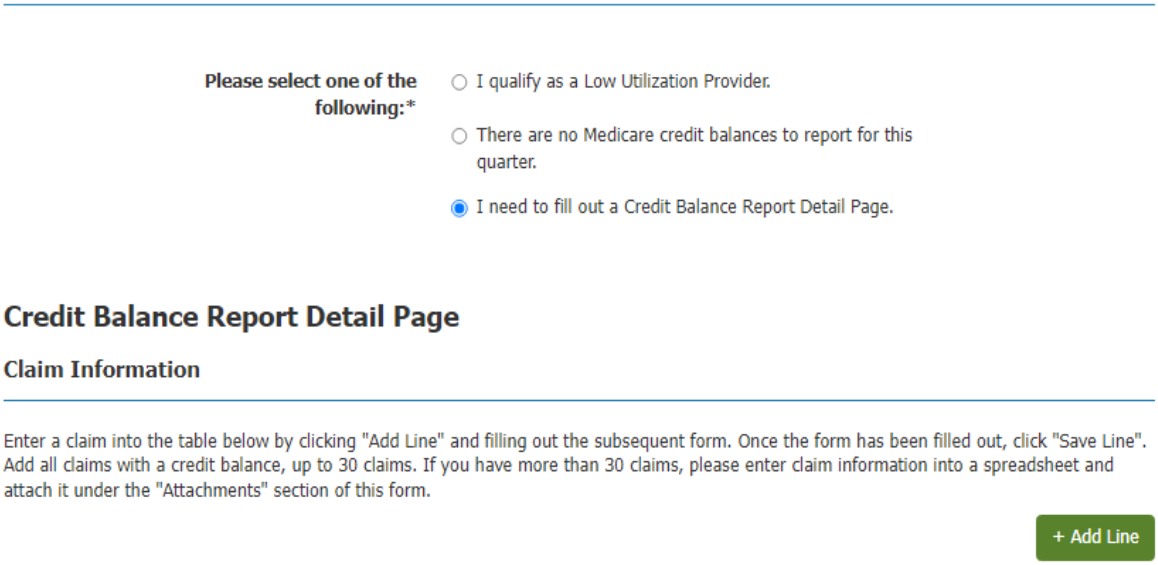
- I qualify as a Low Utilization Provider:



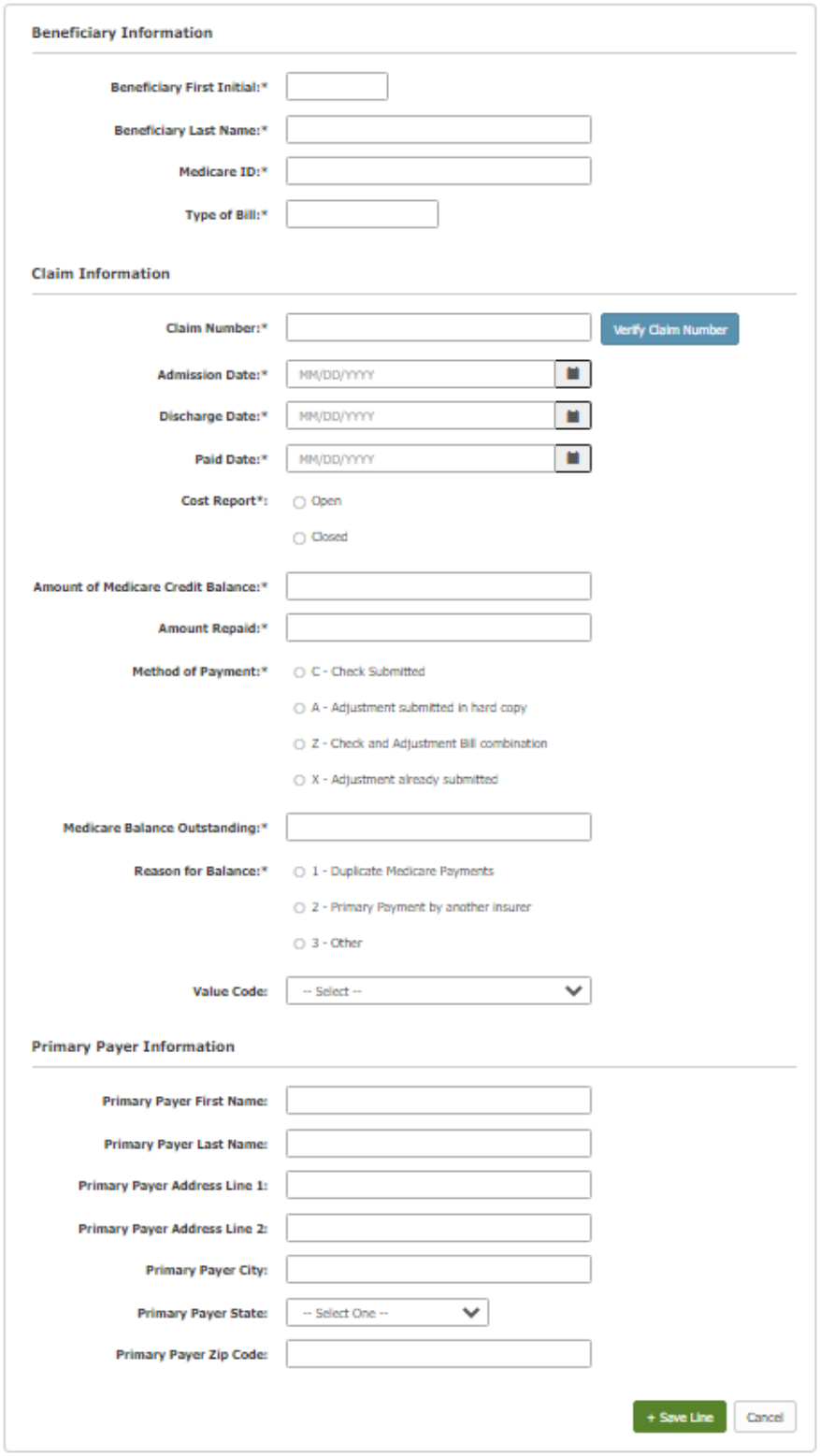
- There are no Medicare credit balances to report for this quarter.



- I need to fill out a Credit Balance Report Detail Page

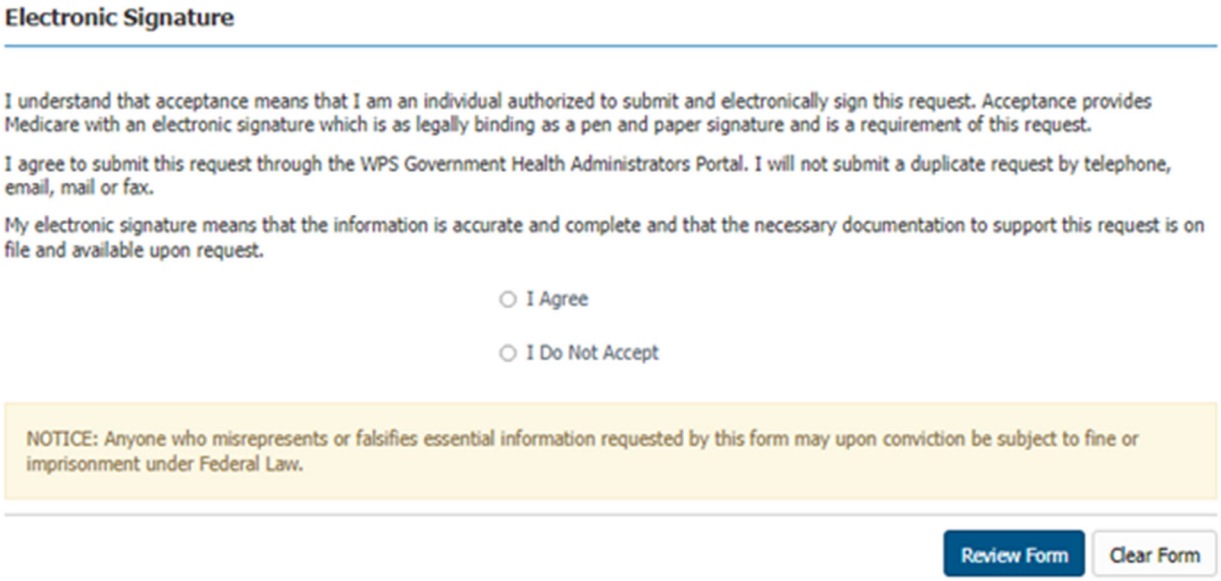


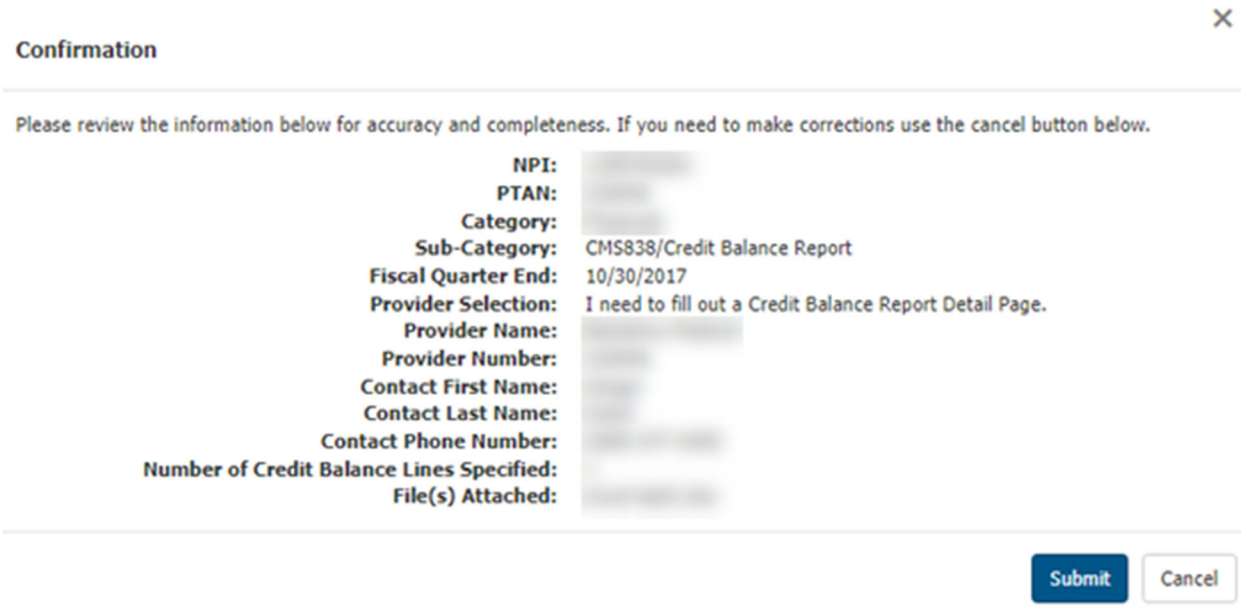
Step 8: To add your claim information, click on the + Add Line button and the page will expand with additional fields to complete. Once all required information is entered, click + Save Line.



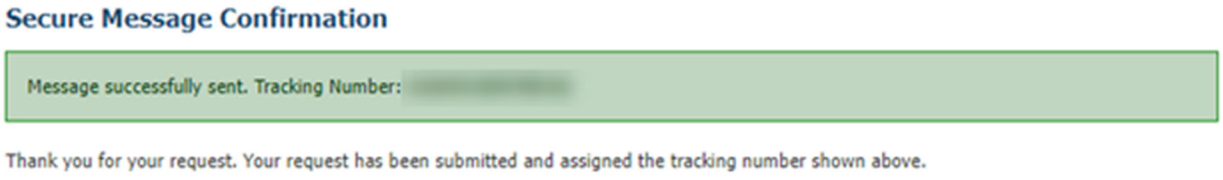
Step 9: Find and upload your attachment.

Step 10: Complete the Electronic Signature and then click "Review Form." You will receive a Confirmation page, if everything is correct, click "Submit." If changes are needed, click "Cancel" to start over.





Step 11: The page will refresh and will display with a message indicating "Message successfully sent" along with the Tracking Number.



Letter Search Overview

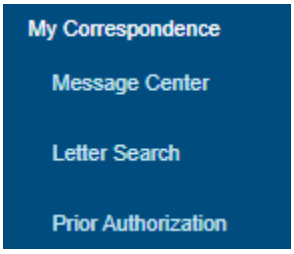
Letter Search allows users to view the following types of letters within the WPS Government Health Administrators Portal:

- Additional Documentation Request (ADR) letters – Sent when Medicare needs additional information to process a claim (i.e., pre-payment review)
- Demand letters – Send when Medicare needs to recoup money due to an overpayment

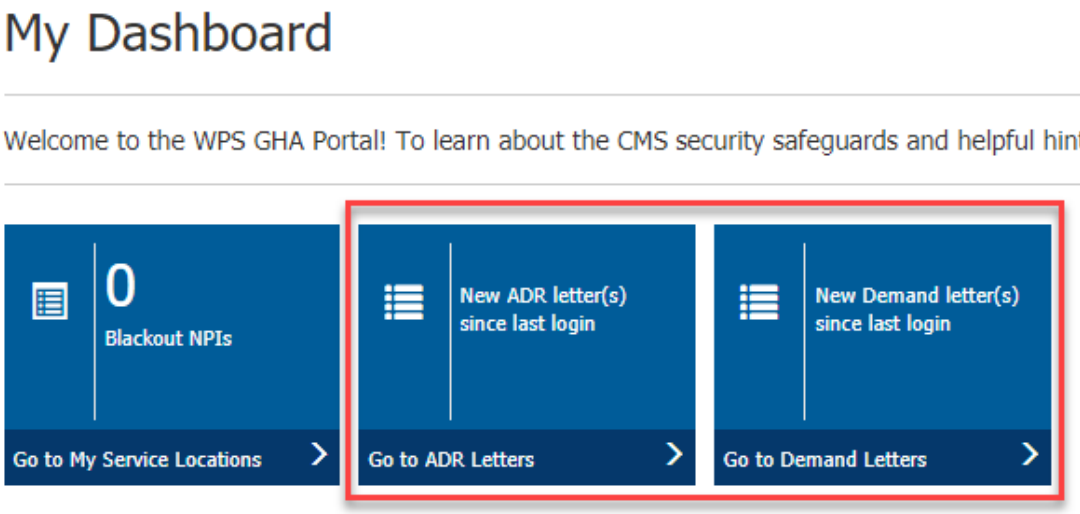
In addition, users can use the Overpayment Search function (located within Letter Search) to find more information about the overpayments included in demand letters.

Accessing Letter Search

You can access the Letter Search function by selecting the Letter Search link under the My Correspondence heading in the left navigation menu. (If you do not see the Letter Search link, click the arrow next to the My Correspondence heading to open the My Correspondence menu.)



You can also access the Letter Search feature from your My Dashboard page. Note that this option is only available if there is a dashboard window indicating you have a new ADR and/or demand letter available since the last time you logged into the portal.



For more information about the Letter Search functions see the following sections in this manual:

- ADR and Demand Letters
- Overpayment Details

ADR and Demand Letters

Providers can use the portal to view Additional Documentation Request (ADR) letters and demand letters for up to 90 days after WPS Government Health Administrators issues them. While not required, providers can also respond to ADR and demand letters via the portal.

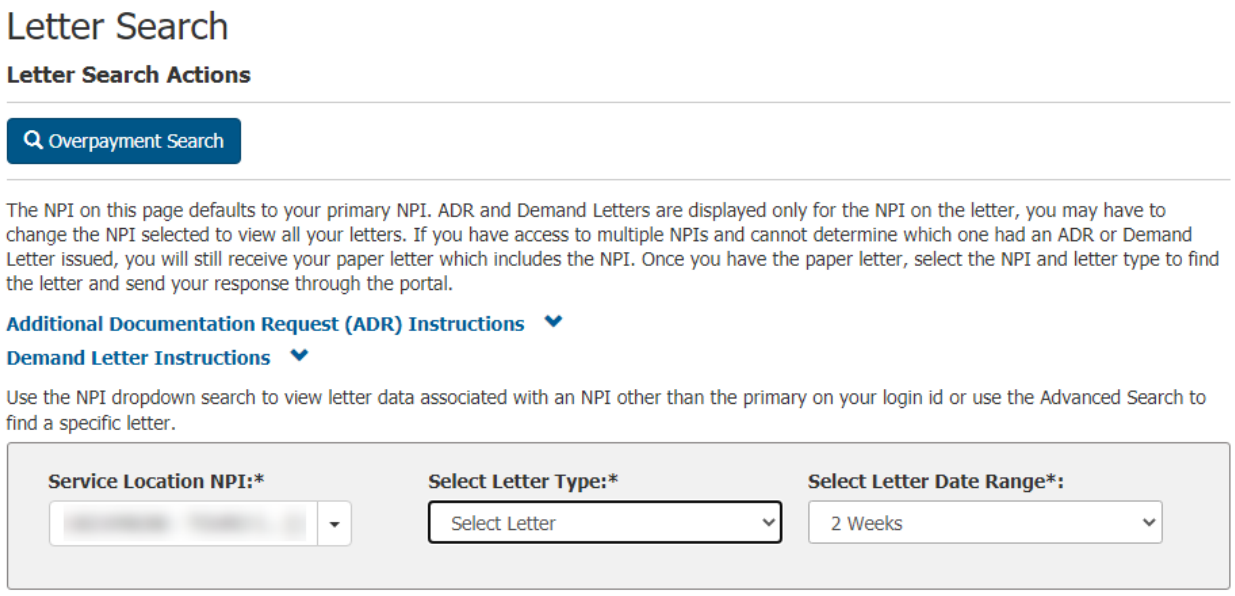
See the preceding Letter Search Overview section of this manual for information about accessing Letter Search.

Performing a Letter Search

After accessing the Letter Search page, use the dropdown boxes to enter the following information:

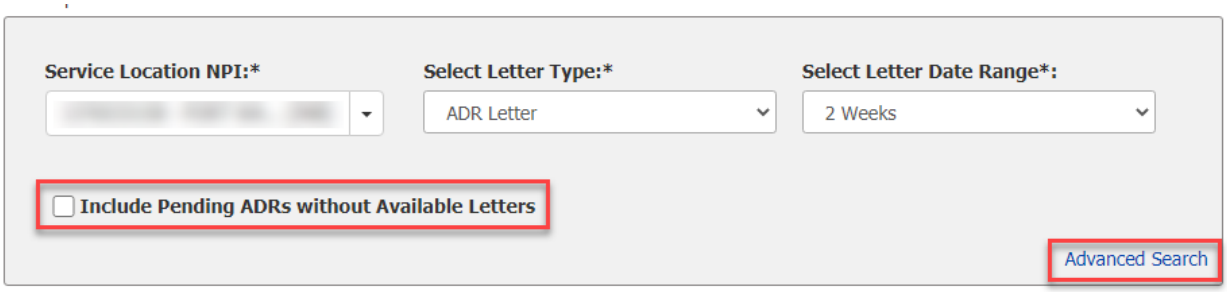
- Service location NPI (The portal will default to your primary NPI in the Service Location NPI, but you can select a different NPI in the dropdown box.)
- Type of letter (ADR or demand letter)
- Date range (between 2 weeks and 3 months)

NOTE: If you access Letter Search using your My Dashboard windows, the portal will automatically select the appropriate type of letter and date range; however, you may need to select a different NPI from the dropdown box if the letter is for a location other than your primary service location.



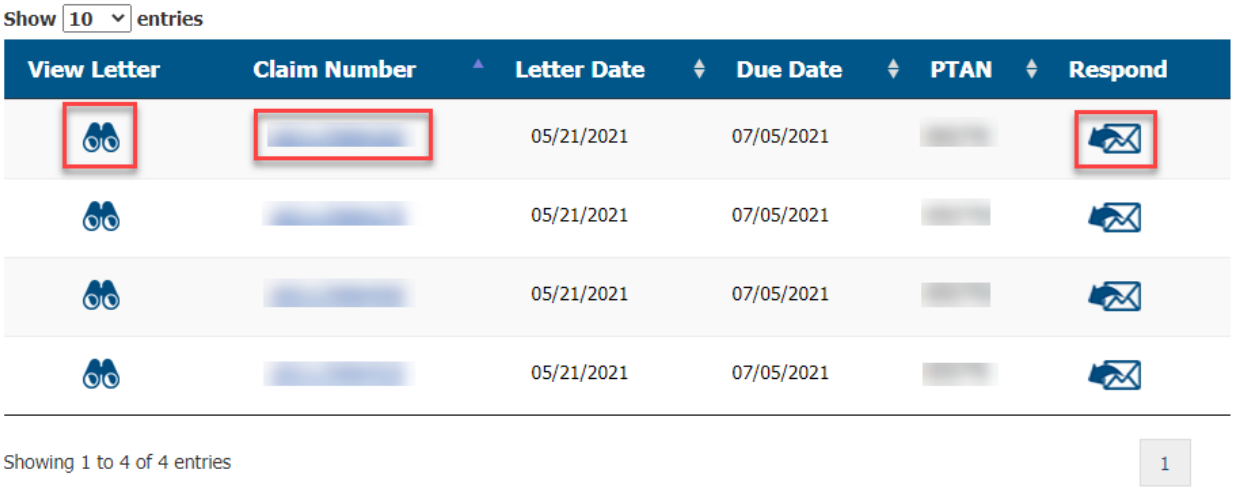
After the portal displays the initial results, you can narrow the results further by selecting the Advanced Search link in the lower right corner of the selection box.

For ADR letters, you can also expand the results to include pending ADR that do not have letters available for viewing in the portal. Check this box if the if your My Dashboard window indicates you have a new ADR letter available, but no letter is found.



ADR Letter Search Results

When selecting ADR Letter as the letter type, the portal will display the ADR letters that match your search criteria.



There are several actions you can take from the list of ADR letter search results.

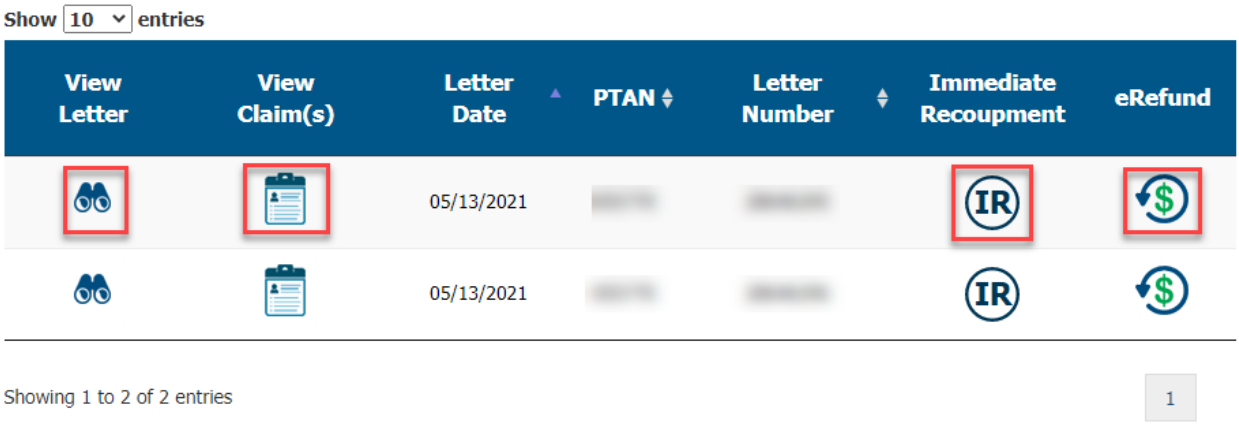
- Click the **binoculars icon** in the View Letter column to view the ADR letter in a PDF format.
- Click the **claim number link** in the Claim Number column to view the claim using the Claim Inquiry function.
- Click the **envelope icon** in the Respond column to respond to the documentation request using the Medical Documentation function.

NOTE: If the binoculars icon is grayed out, it means the letter is not currently available in the portal. Some letters may become available for viewing within a few days. In other cases, the portal may be unable to capture the letter image. If you are a DDE provider and have elected to view ADRs in DDE only, the letter will not be available in the portal, and you will not receive a paper letter. If the ADR letter is not available for viewing in the portal, you can still respond through the portal once you receive the paper letter by mail or review the letter in DDE.

NOTE: Providers are not required to respond to ADR letters through the portal. Providers can view and respond to ADR letters using the method that best meets their business needs. Click the Additional Documentation Request (ADR) Instructions link on the Letter Search page for more information about the options for responding to ADR letters.

Demand Letter Search Results

When selecting Demand Letter as the letter type, the portal will display the demand letters that match your search criteria.



There are several actions you can take from the list of demand letter search results.

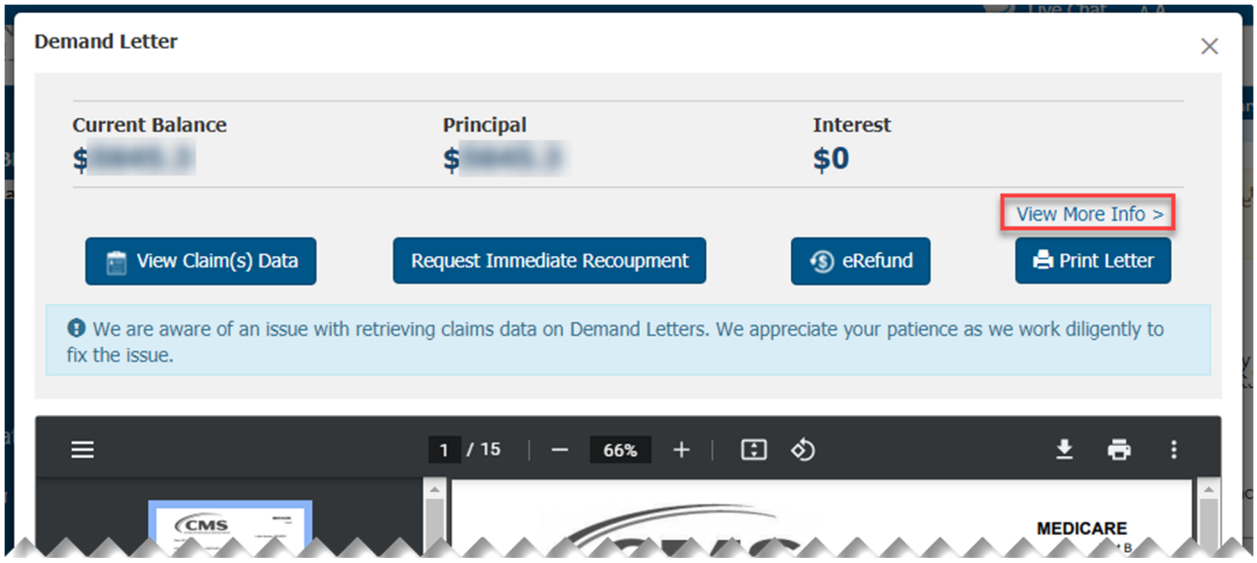
- Click the **binoculars icon** in the View Letter column to view the demand letter. See below for more information about the additional demand letter details available in the portal.)
- Click the **clipboard icon** in the View Claim(s) column to view the list of claims included in the demand letter. (You can click a claim number link in the list of claims to view details of the claim using the Claim Inquiry function.)
- Click the **IR icon** in the Immediate Recoupment column to access the Immediate Recoupment Request Form.
- Click the **dollar sign icon** in the eRefund column to submit a refund using the eRefund function.

NOTE: Providers are not required to respond to demand letters using eRefund. Providers can view and respond to demand letters using the method that best meets their business needs. Click the Demand Letter Instructions link on the Letter Search page for more information about the options for responding to demand letters.

Additional Demand Letter Details

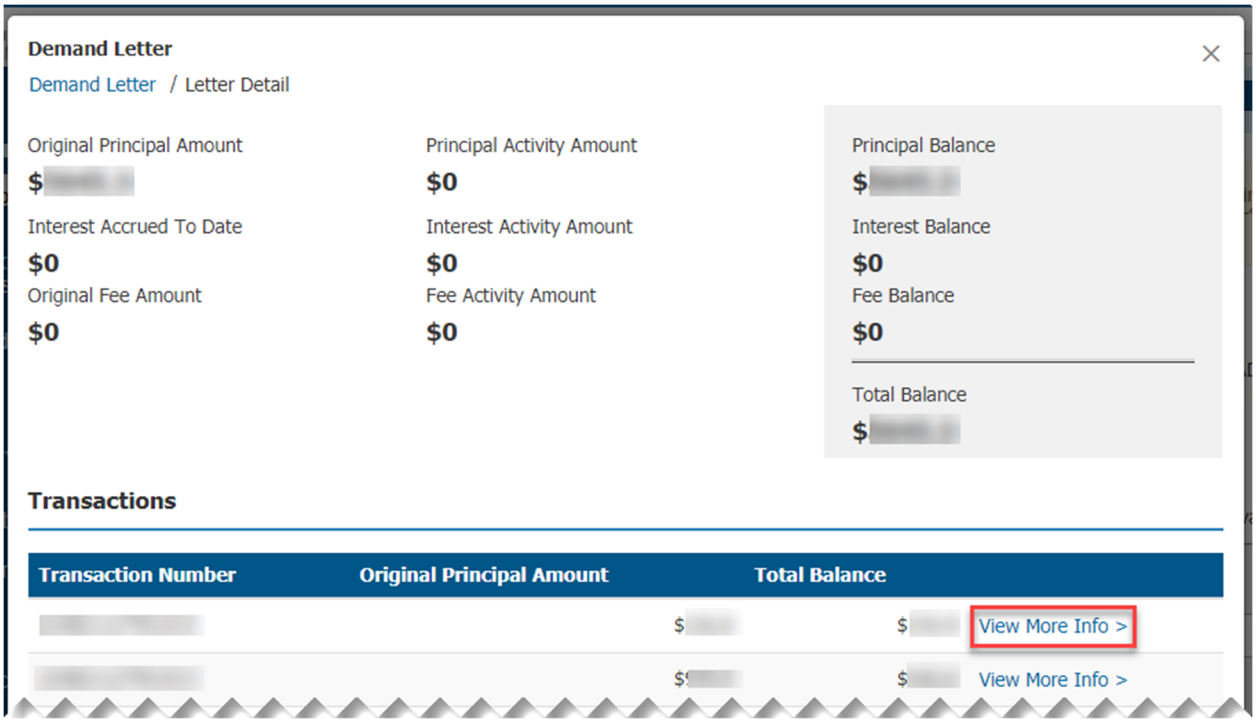
When viewing a demand letter in the portal, providers have access to additional information not normally provided with a paper copy of the letter. Click the View More Info link to access the additional details.

You can easily access additional details about the overpayment(s) included a demand letter by clicking the View More Info link when you open the letter. The information is the same as you will find using the Overpayment Search function. See the Overpayment Details section of this manual for more information about the details available.



The information available includes:

- Original principal amount
- Principal activity amount
- Principal balance
- Interest accrued to date
- Interest activity amount
- Interest balance
- Original fee amount
- Fee activity amount
- Fee balance
- Total balance



You can find additional claim-specific information by clicking the View More Info button next to each claim in the Transactions section. The information available includes the following:

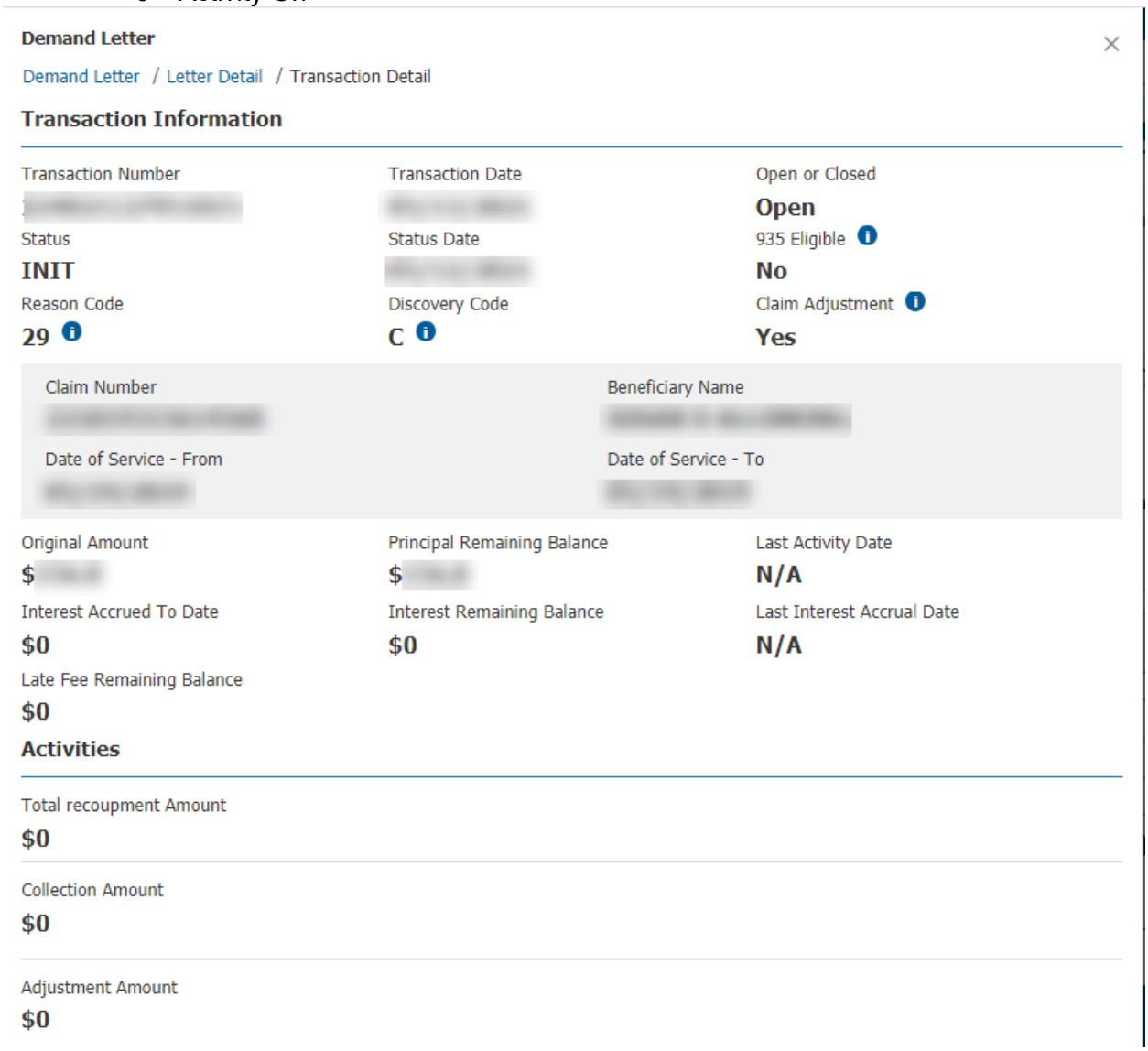
Transaction Information:

- Transaction Number
- Transaction Date
- Open or Closed
- Status
- Status Date
- 935 Indicator
- Reason Code
- Discovery Code
- Interfaced AR
- Claim Number
- Bene Name
- DOS From
- DOS To
- Original Amount
- Principal Remaining Balance
- Last Activity Date
- Interest Accrued to Date
- Interest Remaining Balance
- Last Interest Accrual Date
- Late Fee Remaining Balance

Activities:

- Total Recoupment Amount
    - Activity Number

  - Activity Date
  - Activity Amount
  - Total Activity Amount
  - Activity On
- Collection Amount
  - Activity Number
  - Activity Date
  - Activity Amount
  - Total Activity Amount
  - Activity On
- Adjustment Amount
  - Activity Number
  - Activity Date
  - Activity Amount
  - Total Activity Amount
  - Activity On



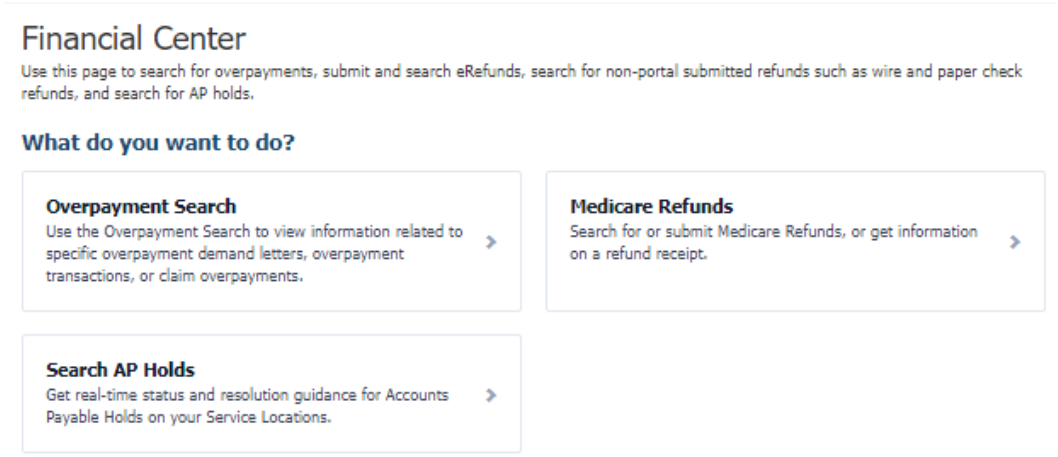
Overpayment Search

The Overpayment Search allows you to access the claim and overpayment information. You can search for a Medicare overpayment by the demand letter number, transaction number, or claim number.

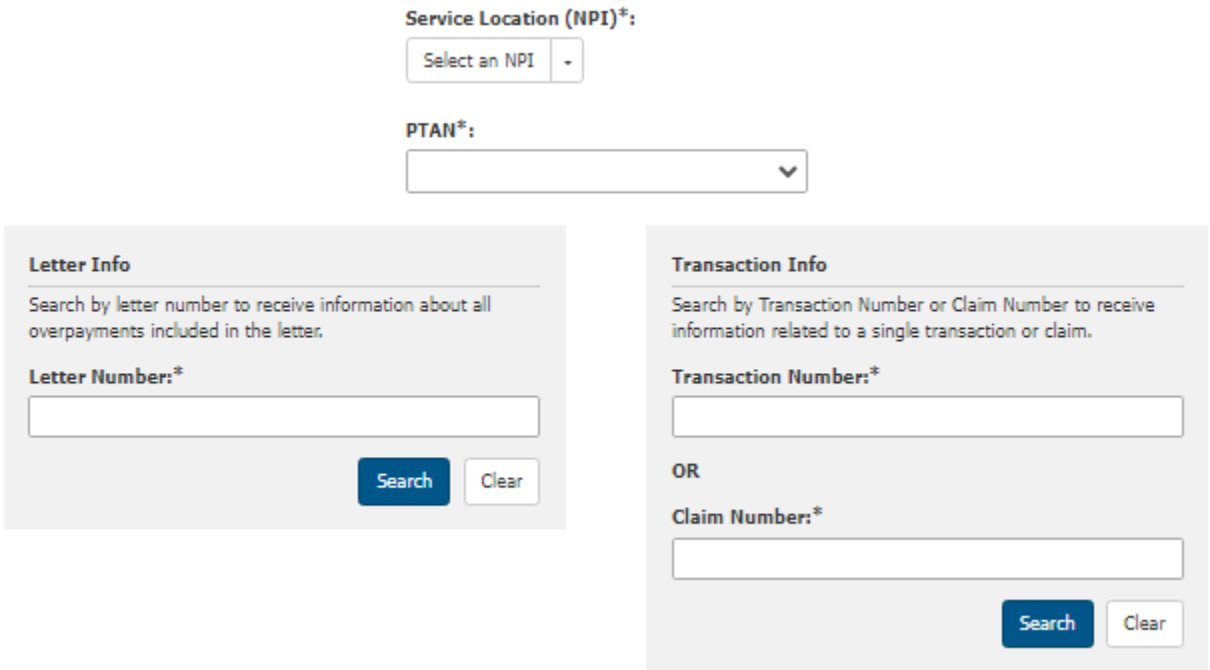
You can access the Overpayment Search via the Financial Center or via the Letter Search. To access through the Financial Center, select the Financial Center link in the left navigation.

Accessing Overpayment Search

From the Financial Center page, click on the Overpayment Search box.



From Letter Search, click the Overpayment Search button.

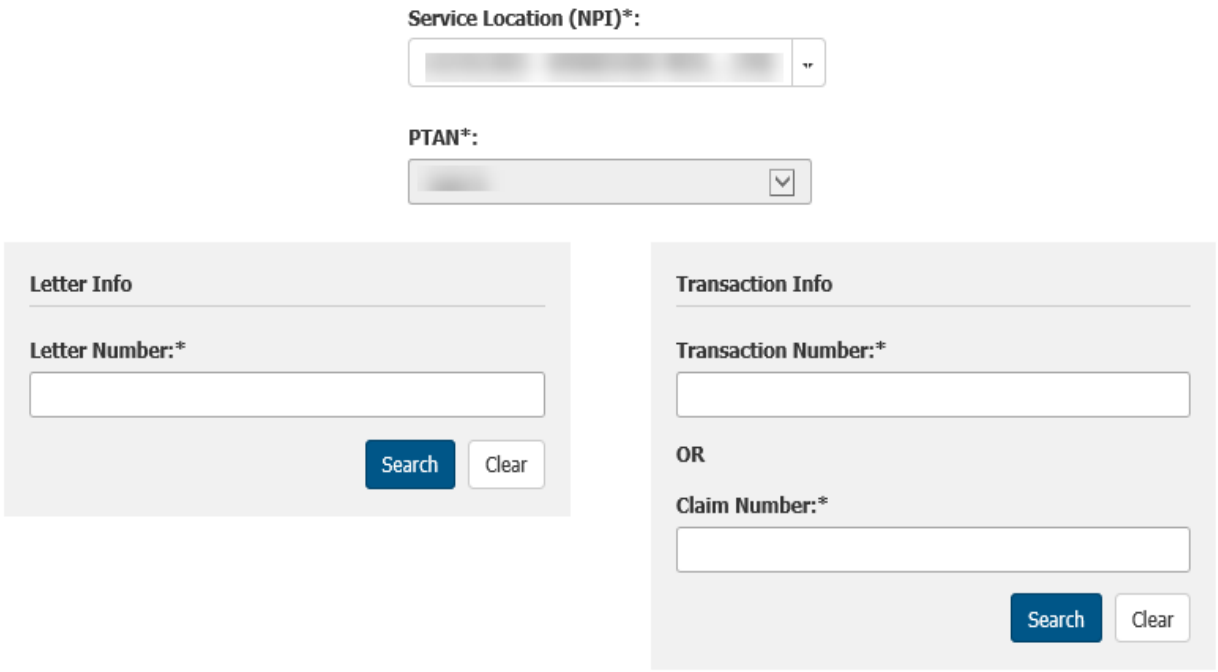


Once on the Overpayment Search page, select your Service Location (NPI) and PTAN from the dropdown boxes. Depending on the number of NPI you have access to, these options may be pre-selected.

Next, enter your search criterion for the overpayment. You must select **one** of the following options:

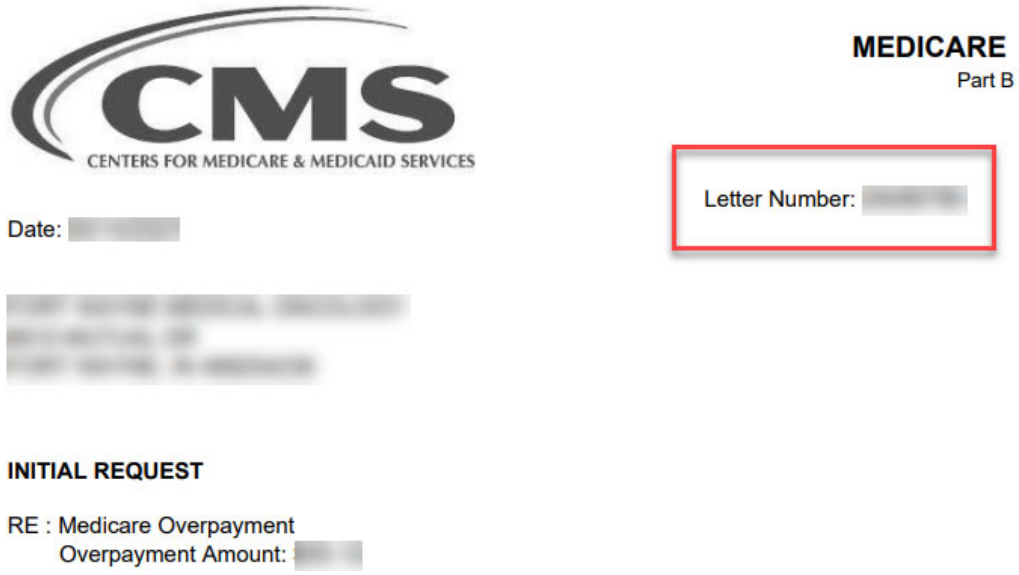
- Letter Number
- Transaction Number (Invoice Number)
- Claim Number

Searching by the letter number will information for all overpayments included in the demand letter, searching by the Transaction or Claim number will return information for the single transaction.



Overpayment Search Using the Letter Number

You can perform an overpayment search using the letter number listed on your demand letter.


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE
Part B

Letter Number:

Date:

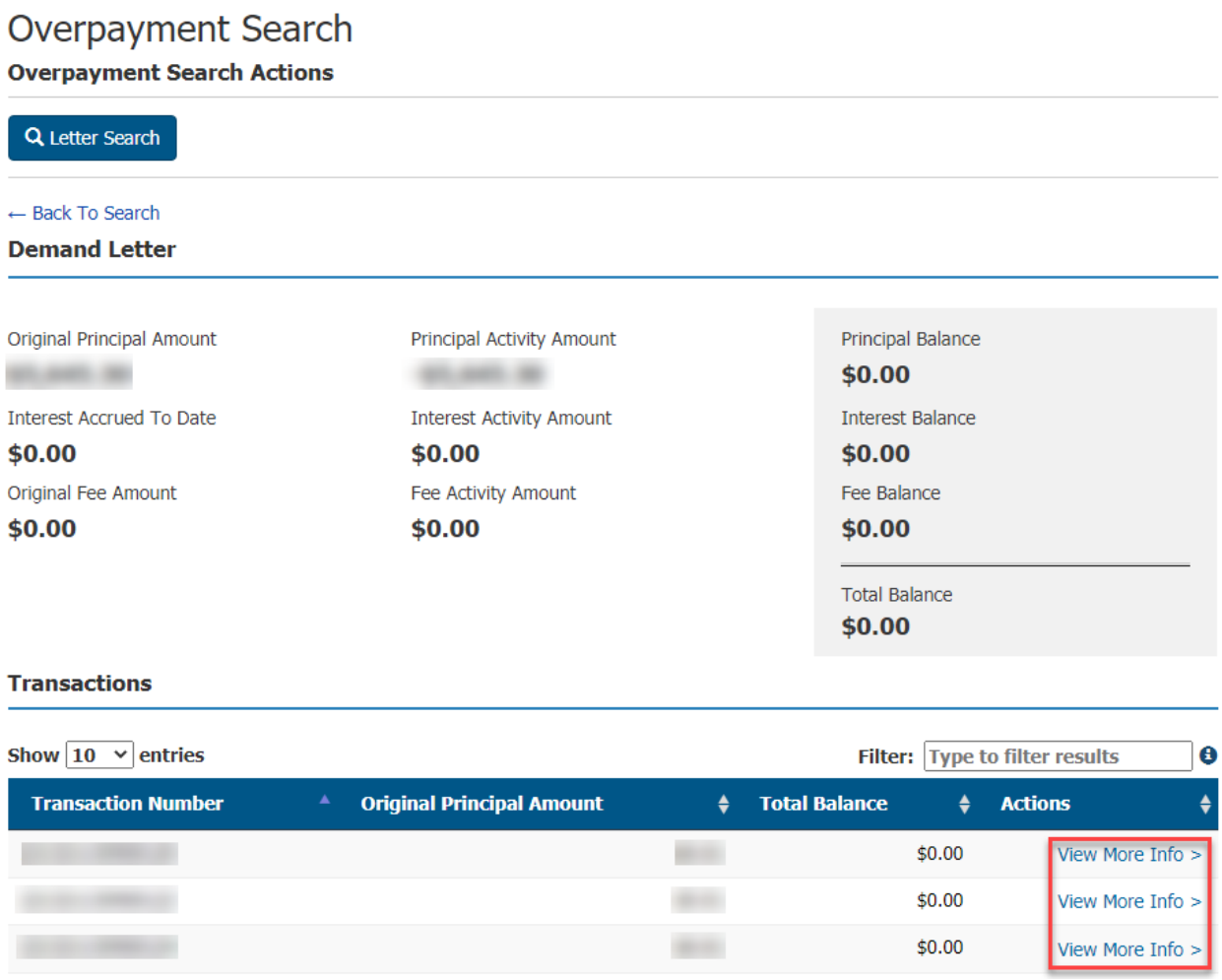
INITIAL REQUEST

RE : Medicare Overpayment
Overpayment Amount:

A demand letter may include multiple overpayments and searching by the letter number will return details about all the overpayments included in the demand letter. The information returned includes:

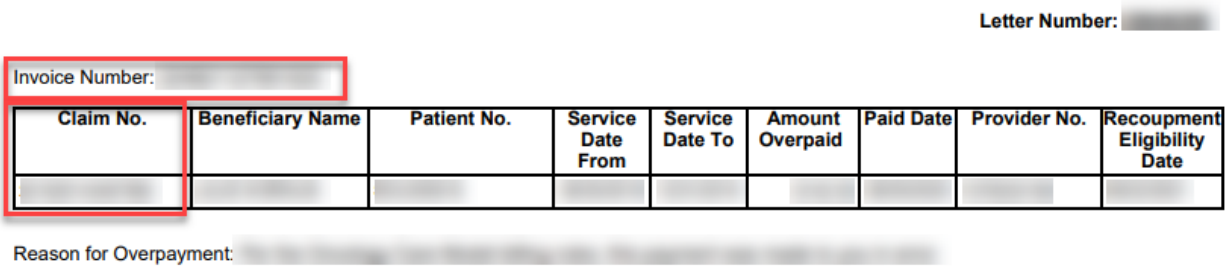
- Original Principal Amount
- Principal Activity Amount
- Principal Balance
- Interest Accrued to Date
- Interest Activity Amount
- Interest Balance
- Original Fee Amount
- Fee Activity
- Fee Balance
- Total Balance

Individual overpayment (transaction) information is located below the demand letter details. Click the View More Info link in the Actions column to see details about each overpayment. See the Overpayment Search by Transaction Number or Claim Number in the section below for more information about the details available.


Overpayment Search
Overpayment Search Actions
Letter Search
← Back To Search
Demand Letter
Original Principal Amount
Principal Activity Amount
Principal Balance
$0.00
Interest Accrued To Date
$0.00
Interest Activity Amount
$0.00
Interest Balance
$0.00
Original Fee Amount
$0.00
Fee Activity Amount
$0.00
Fee Balance
$0.00
Total Balance
$0.00
Transactions
Show 10 entries
Filter: Type to filter results
Transaction Number
Original Principal Amount
Total Balance
Actions
$0.00
View More Info >
$0.00
View More Info >
$0.00
View More Info >

Overpayment Search by Transaction Number or Claim Number

You can perform an overpayment search by the transaction number (invoice number) or claim number. You can locate these numbers in the final page(s) of the demand letter.


Letter Number:

Invoice Number:

Claim No.	Beneficiary Name	Patient No.	Service Date From	Service Date To	Amount Overpaid	Paid Date	Provider No.	Recoupment Eligibility Date

Reason for Overpayment:

NOTE: Medicare uses some terms interchangeably on the demand letter and in financial transactions. Both of the following terms are types of Financial Control Numbers (FCNs):

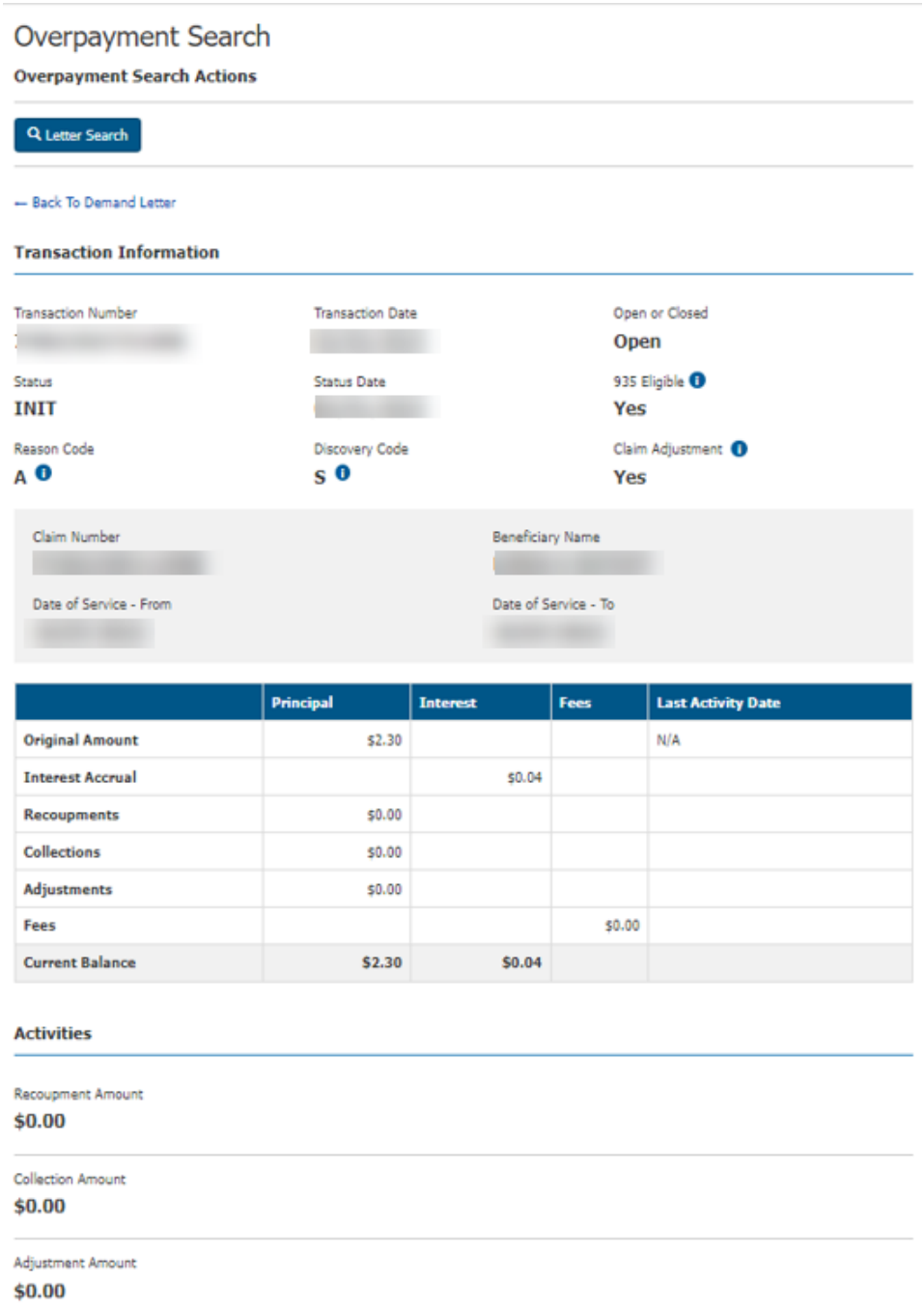
- A “claim number” (claim no.) is based on the **original** claim’s Internal Control Number (ICN) or Document Control Number (DCN) (or, if the claim has been adjusted multiple times, the claim that was adjusted to create the overpayment).
    - The Part A claim number may be the same as the DCN, or it could be the same DCN number followed by different letters.
    - The Part B claim number is a 15-digit number consisting of a two-digit code followed by the 13-digit ICN.
- “Transaction number” is used interchangeably with “invoice number.” It is based on the ICN/DCN of the **adjusted** claim that resulted in the current overpayment.
    - The Part A transaction number is like the original DCN but followed by different letters.
    - The Part B transaction number/invoice number is a 15-digit number consisting of a two-digit code followed by the 13-digit adjusted ICN.

Searching by the transaction number or claim number, or clicking the View More Info link when viewing the demand letter details, will return the following information:

- Transaction Number
- Transaction Date
- Open or Closed
- Status
- Status Date
- 935 Eligible – Yes or No*
- Reason Code*
- Discovery Code*
- Claim Adjustment – Yes or No*
- Claim Number
- Beneficiary Name
- Date of Service – From
- Date of Service – To
- Original Amount (Principal, Interest, Fees, Last Activity)
- Interest Accrual (Principal, Interest, Fees, Last Activity)
- Recoupments (Principal, Interest, Fees, Last Activity)

- Adjustments (Principal, Interest, Fees, Last Activity)
- Fees (Principal, Interest, Fees, Last Activity)
- Activities
    - Recoupment Amount
    - Collection Amount
    - Adjustment Amount

Additional information is available for the items marked with an asterisk (*) by hovering your mouse over the blue “i” information icon next to the item.



Prior Authorization

CMS established a prior authorization (PA) program for a limited number of services. For Medicare Part A, the PA program applies only to the following services when they are performed in a hospital outpatient department (HOPD) and submitted on a 13x type of bill:

- Blepharoplasty
- Botulinum toxin injections
- Cervical fusion with disc removal
- Facet joint interventions
- Implanted spinal neurostimulators
- Panniculectomy
- Rhinoplasty
- Vein ablation

See Prior Authorization for Hospital Outpatient Department Services (HOPD) Overview (https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/prior-authorization-for-hopd-overview) for an overview of the process. (You will need to select J5A or J8A at the top of the page to view the full article.)

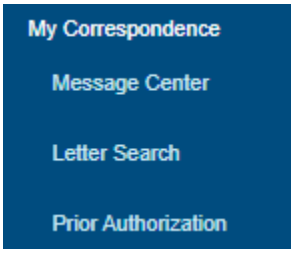
CMS established a PA program for Medicare Part B Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT). Procedure codes for the RSNAT program are:

- A0426 - Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
- A0428 - Ambulance service, basic life support (BLS), non-emergency transport
- Associated Service A0425 - Ground mileage, per statute mile

Procedure codes A0426 and A0428 require prior authorization; A0425 does not require prior authorization. See Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) (https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/prior-authorization-rsnat) for more information. (You will need to select J5B or J8B at the top of the page to view the full article.)

Submitting a Prior Authorization Request

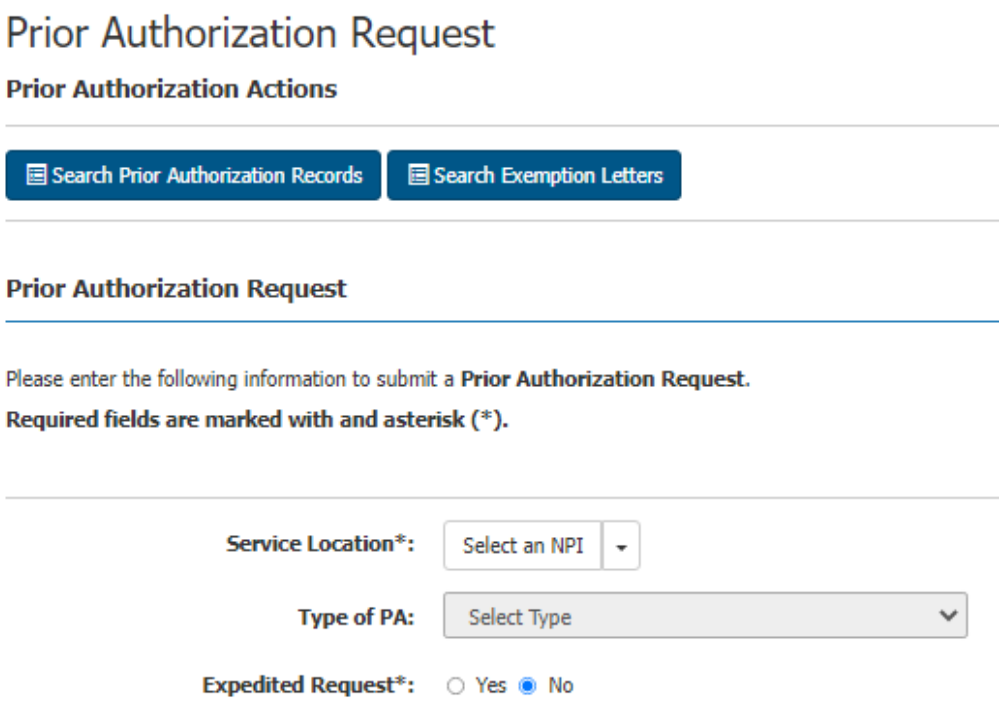
HOPDs and Ambulance Suppliers can use the WPS Government Health Administrators Portal to submit PA requests and supporting documentation to our Medical Review department. To access the Prior Authorization area of the portal, click on the Prior Authorization link under the My Correspondence heading in the left navigation menu.



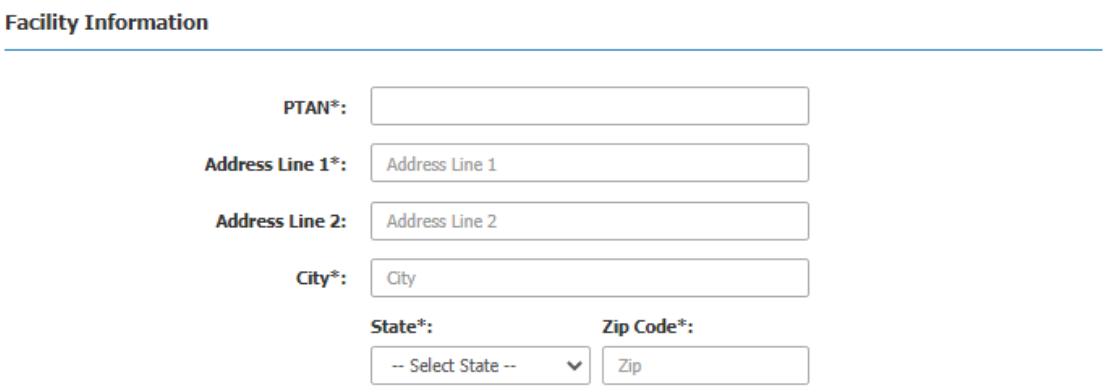
For OPD Prior Authorization Requests:

Step 1: Begin by selecting the NPI service location for the facility. Select the type of service you are providing from the drop-down box. Also, select the appropriate radio button to indicate whether the request needs to be expedited. Providers may only submit expedited requests if the standard timeframe for making a decision could seriously jeopardize the life or health of the patient.

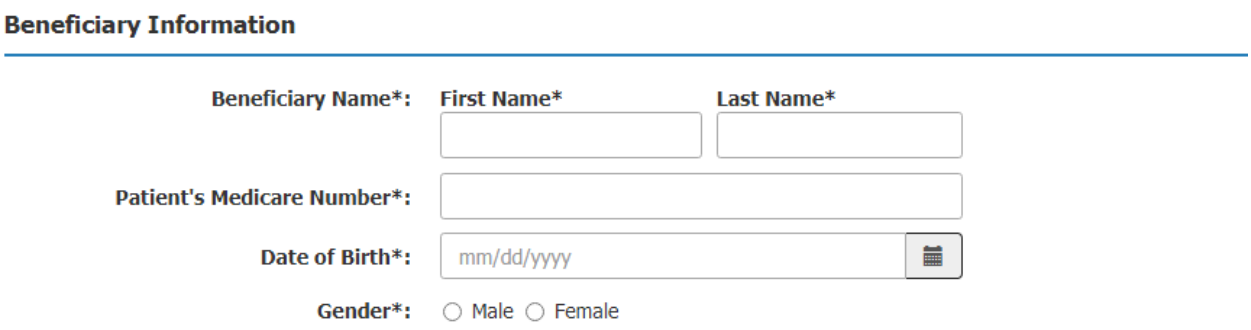
NOTE: If the supplier or facility's NPI does not appear in the drop-down list, you will need to request access to the NPI under My Service Locations (https://www.wpsgha.com/wps/portal/mac/site/self-service/guides-and-resources/my-service-locations) before submitting your prior authorization request through the portal.



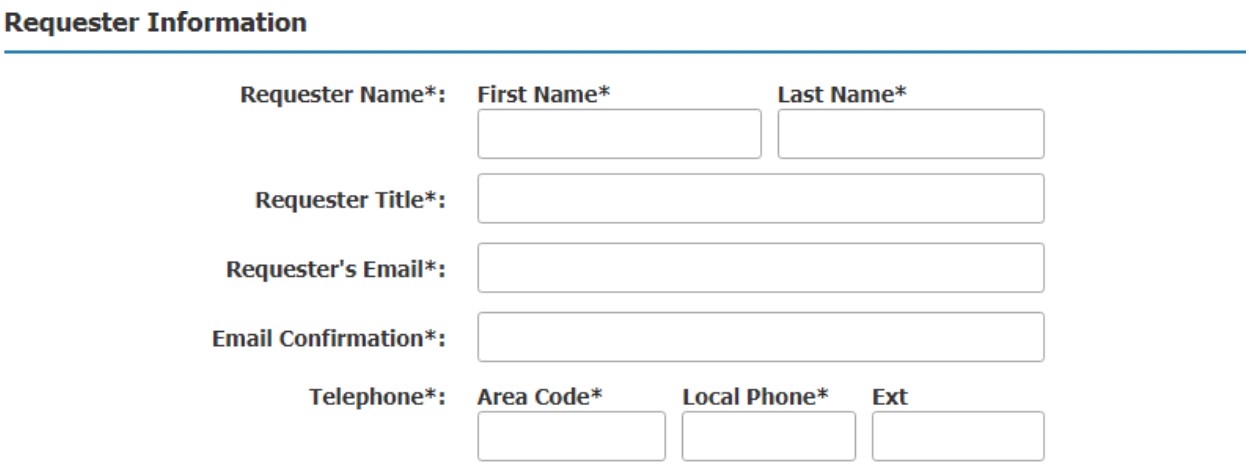
Step 2: Next, enter the PTAN and address for the facility where the service will be performed.



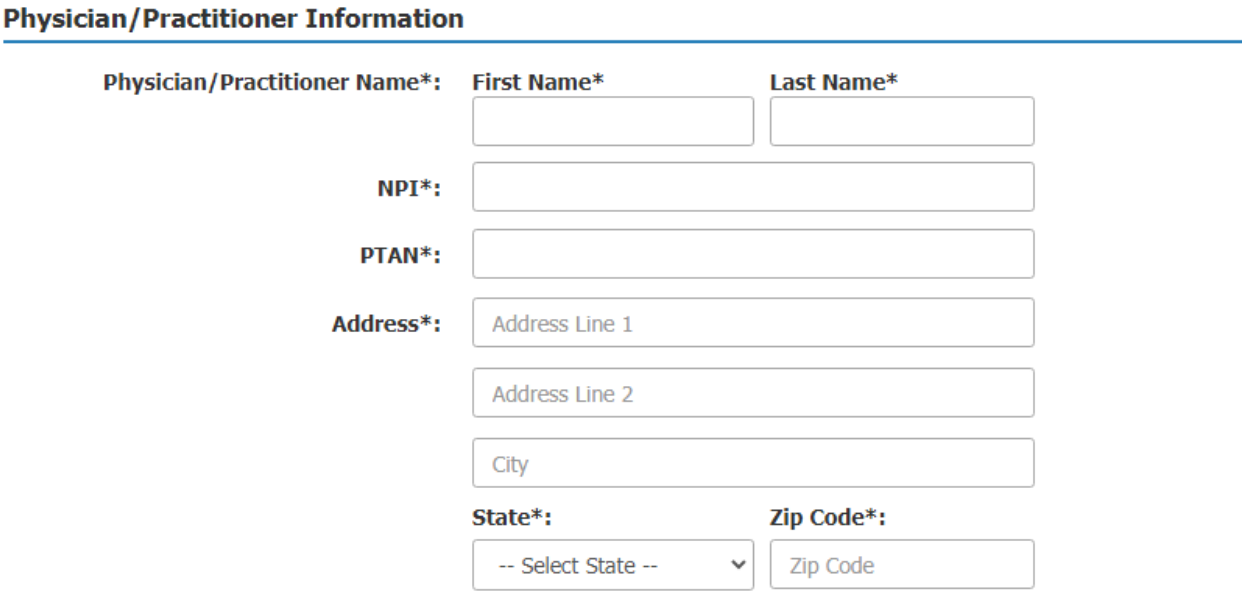
Step 3: Enter the patient's name, Medicare number, date of birth, and gender.



Step 4: Enter the requester's name, title, and contact information.

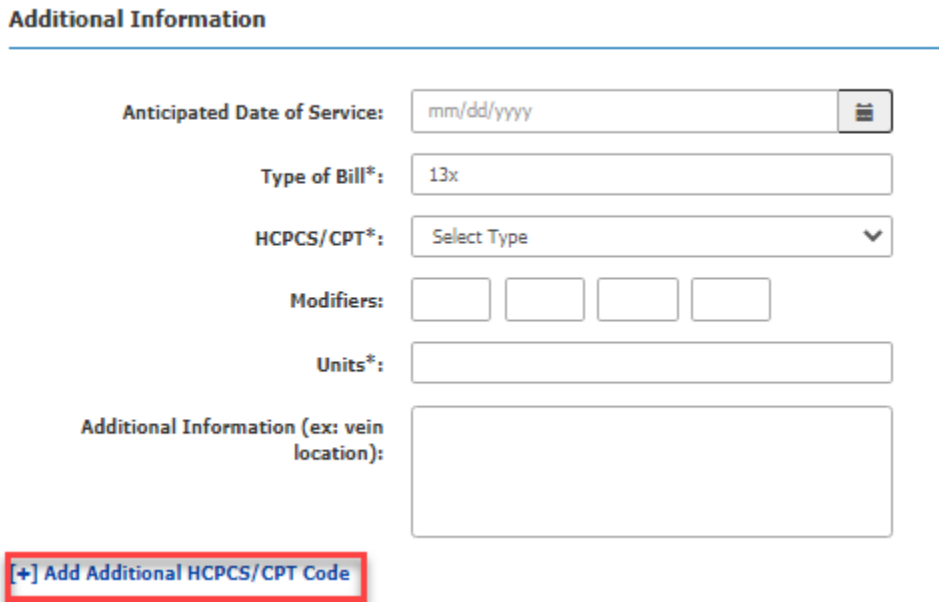


Step 5: Enter the physician/practitioner's name, NPI, PTAN, and address.



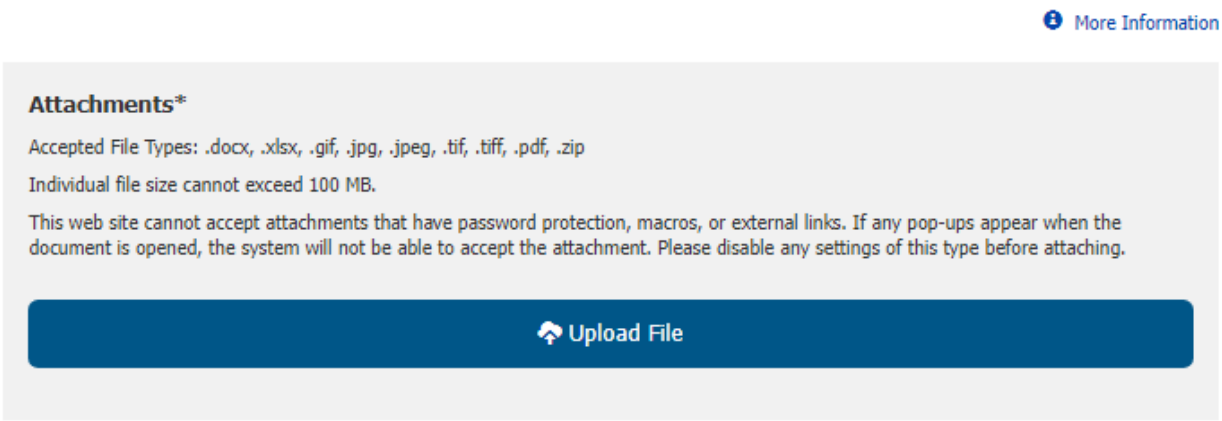
Step 6: Enter details about the procedure that will be performed, including the anticipated date of service, procedure code (CPT or HCPCS code), modifiers, and any additional pertinent information.

NOTE: If approved, the prior authorization is valid for 120 days. If the actual date of service will differ from the anticipated date of service, you do not need to submit a new request if the procedure is performed within 120 days of the prior authorization decision.



NOTE: If the provider will be performing more than one procedure that requires prior authorization, or if the provider may change the procedure intraoperatively, click the “Add Additional HCPCS/CPT Code” link to provide information about the additional procedures. It may be best to submit a prior authorization request with several potential service codes to avoid a claim denial due to no prior authorization.

Step 7: Upload documentation that supports the medical necessity for the procedure(s). Click the “More Information” link (also located near the top of the page) to see the documentation that should be provided for each type of service.



Documentation cannot be password protected, contain macros, or have external links. We accept documentation in the following file formats:

- .tif
- .tiff
- .doc
- .docx
- .pdf
- .xls
- .xlsx
- .jpg
- .jpeg
- .gif
- .zip

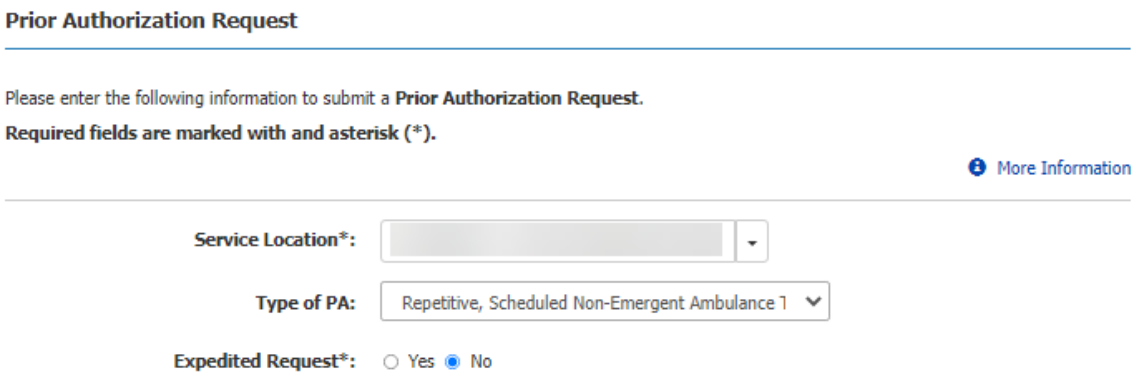
The uploaded file must be smaller than 100 MB. If you need to attach multiple files, you must put them into a single .zip file containing no more than 60 individual files. The files in the .zip file must be in one of the formats listed above.

Step 8: After entering the required information and uploading the supporting documentation, click the Continue button at the bottom of the page. Correct any errors, then click Submit to submit your prior authorization request to Medicare. If your submission is successful, you will see a confirmation page containing a confirmation number.

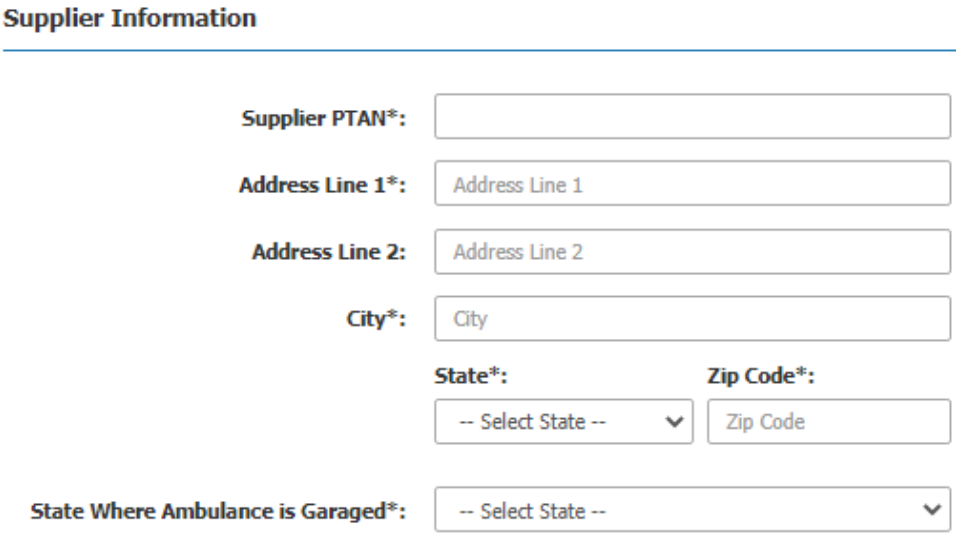
For RSNAT Prior Authorization Requests:

Step 1: Begin by selecting the NPI service location for the facility. Select the type of service you are providing from the drop-down box. Repetitive, Scheduled Non-Emergent Ambulance Transport will be selected. Select the appropriate radio button to indicate whether the request needs to be expedited. Providers may only submit expedited requests if the standard timeframe for making a decision could seriously jeopardize the life or health of the patient.

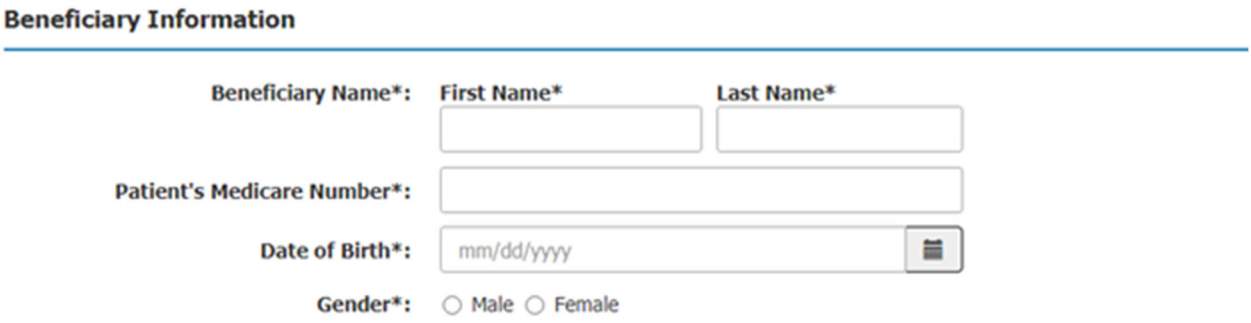
NOTE: If the supplier or facility's NPI does not appear in the drop-down list, you will need to request access to the NPI under My Service Locations (https://www.wpsgha.com/wps/portal/mac/site/self-service/guides-and-resources/my-service-locations) before submitting your prior authorization request through the portal.



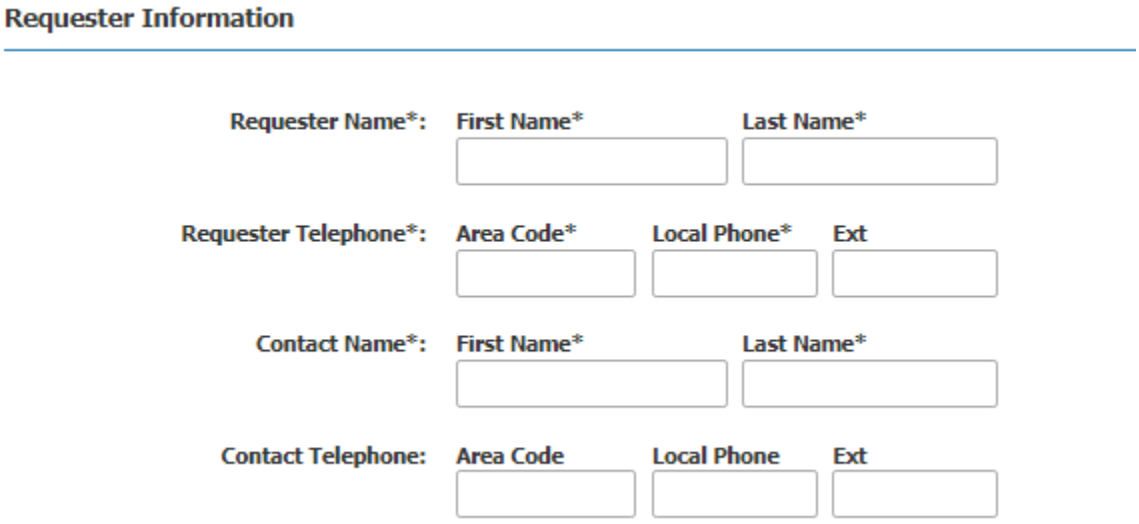
Step 2: In the Supplier Information section, enter the PTAN and address. Select the state where the ambulance is garaged.



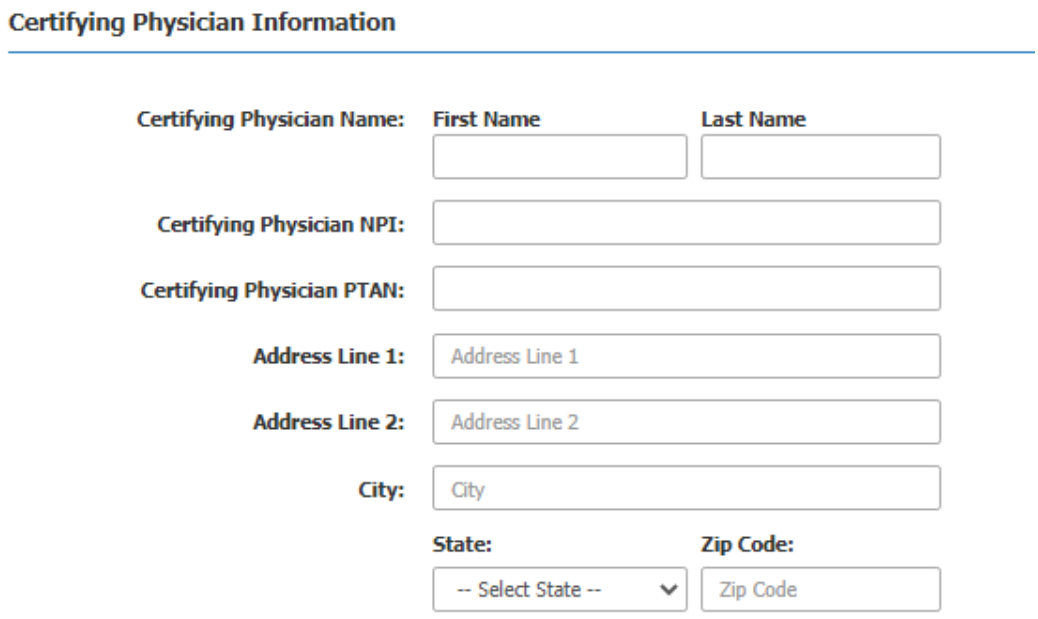
Step 3: Enter the patient's name, Medicare number, date of birth, and gender.



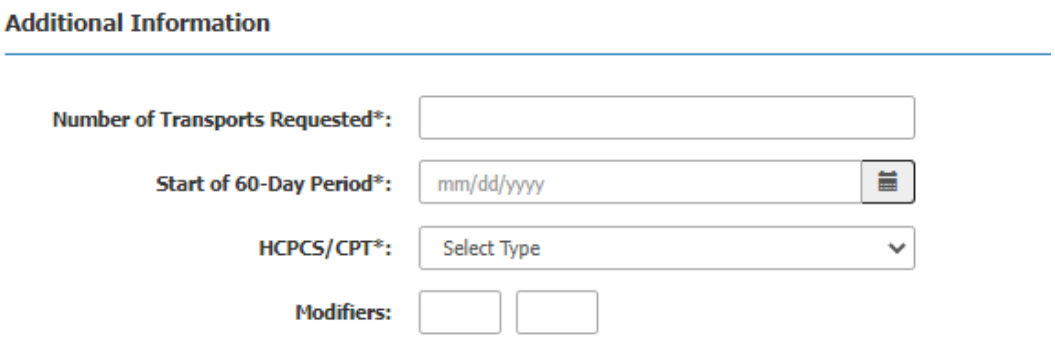
Step 4: Enter the Requester and Contact information.



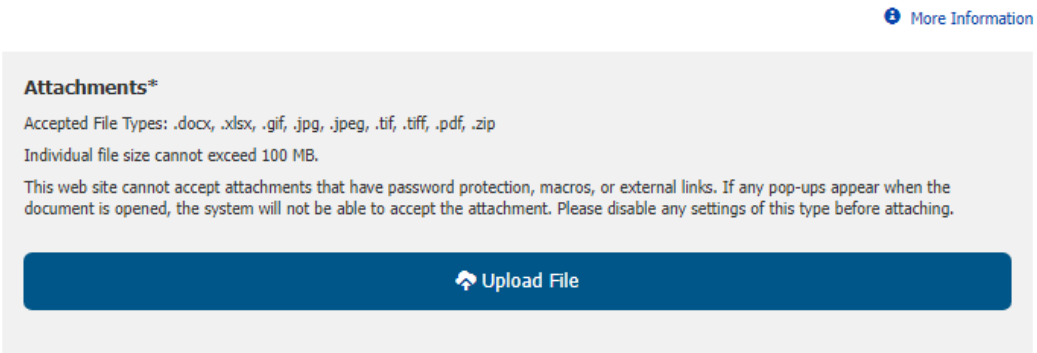
Step 5: Enter the Certifying Physician information



Step 6: Enter the number of transports requested, start of the 60-day period, select the HCPCS, modifiers are optional.



Step 7: Upload documentation that supports the medical necessity for the procedure(s). Click the “More Information” link (also located near the top of the page) to see the documentation that should be provided for each type of service.



Documentation cannot be password protected, contain macros, or have external links. We accept documentation in the following file formats:

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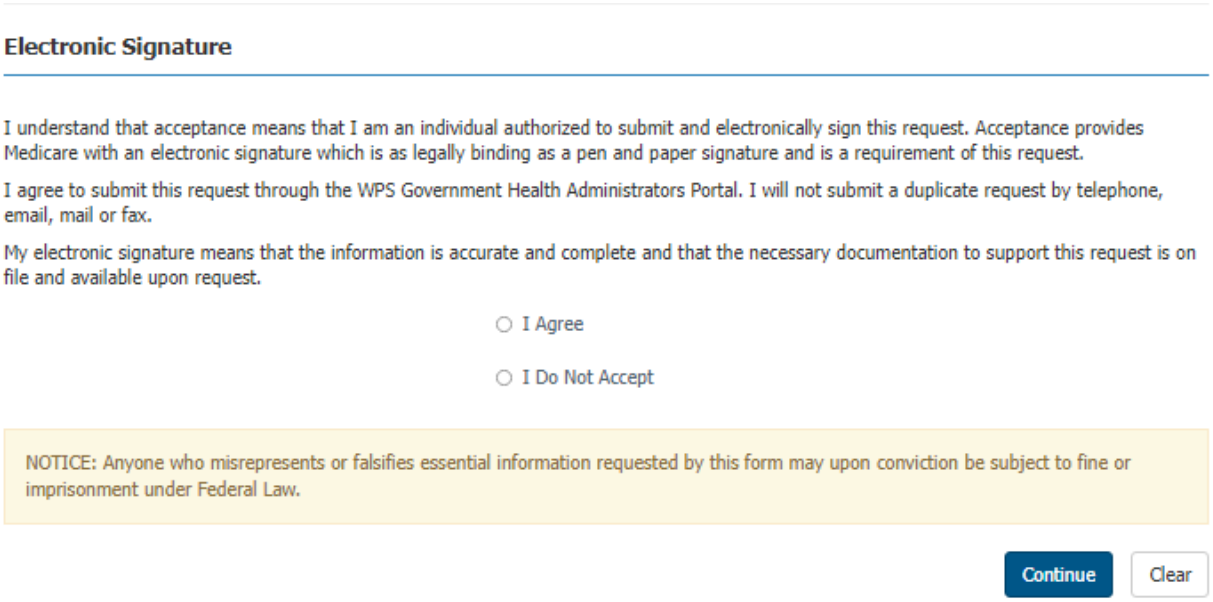
- .xlsx
- .jpg
- .jpeg
- .gif
- .zip

The uploaded file must be smaller than 100 MB. If you need attach multiple files, you must put them into a single .zip file containing no more than 60 individual files. The files in the .zip file must be in one of the formats listed above.

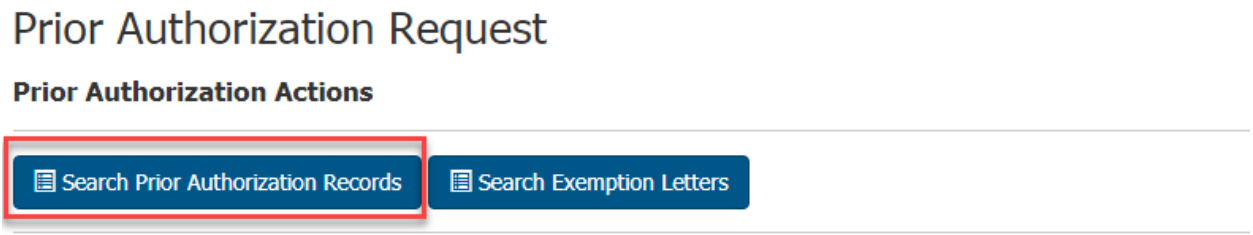
Step 8: You must provide an electronic signature by marking I Agree. If you do not accept, you will not be able to submit the Prior Authorization in the portal.



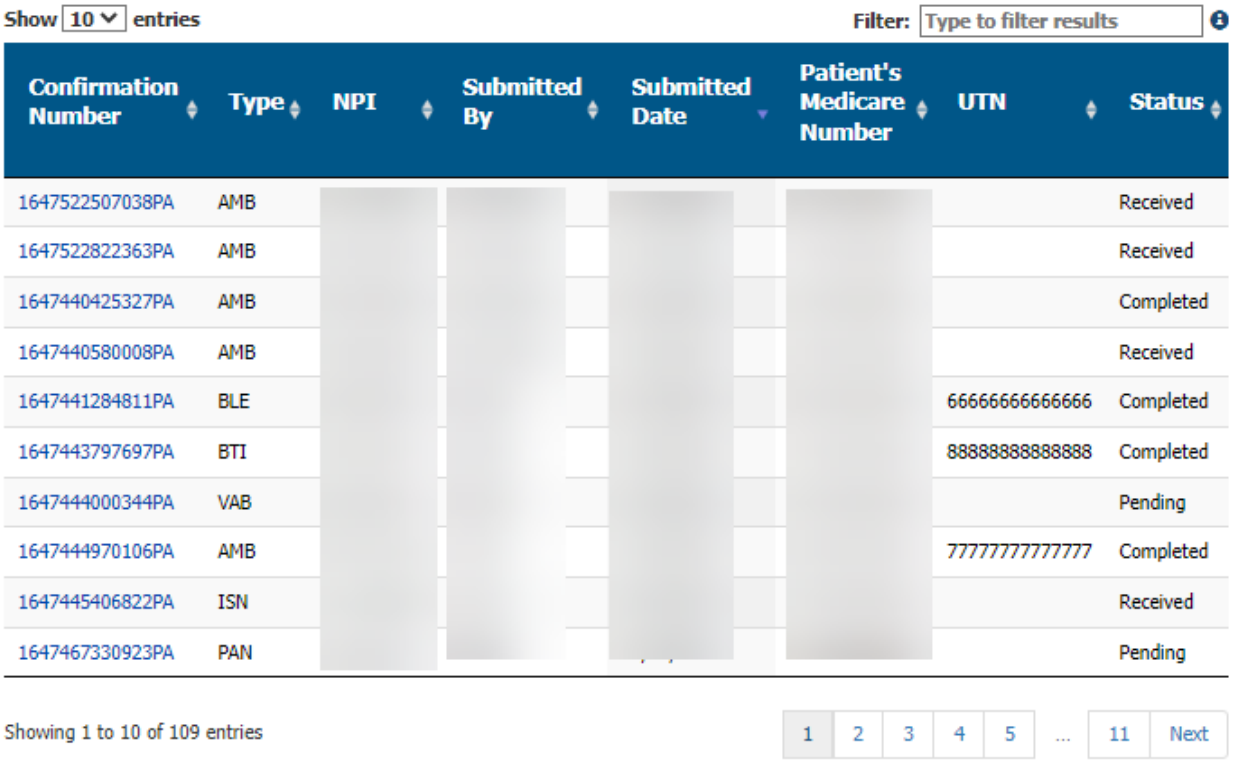
Step 9: After entering the required information and uploading the supporting documentation, click the Continue button at the bottom of the page. Correct any errors, then click Submit to submit your prior authorization request to Medicare. If your submission is successful, you will see a confirmation page containing a confirmation number.

Searching for Prior Authorization Requests and Decisions

After submitting a prior authorization request through the portal, you can monitor its status and view the decision letter within the portal. Begin by clicking on the Prior Authorization link in the left navigation menu to enter the Prior Authorization section of the portal. Click the Search Prior Authorization Records button at the top of the page to begin the search.



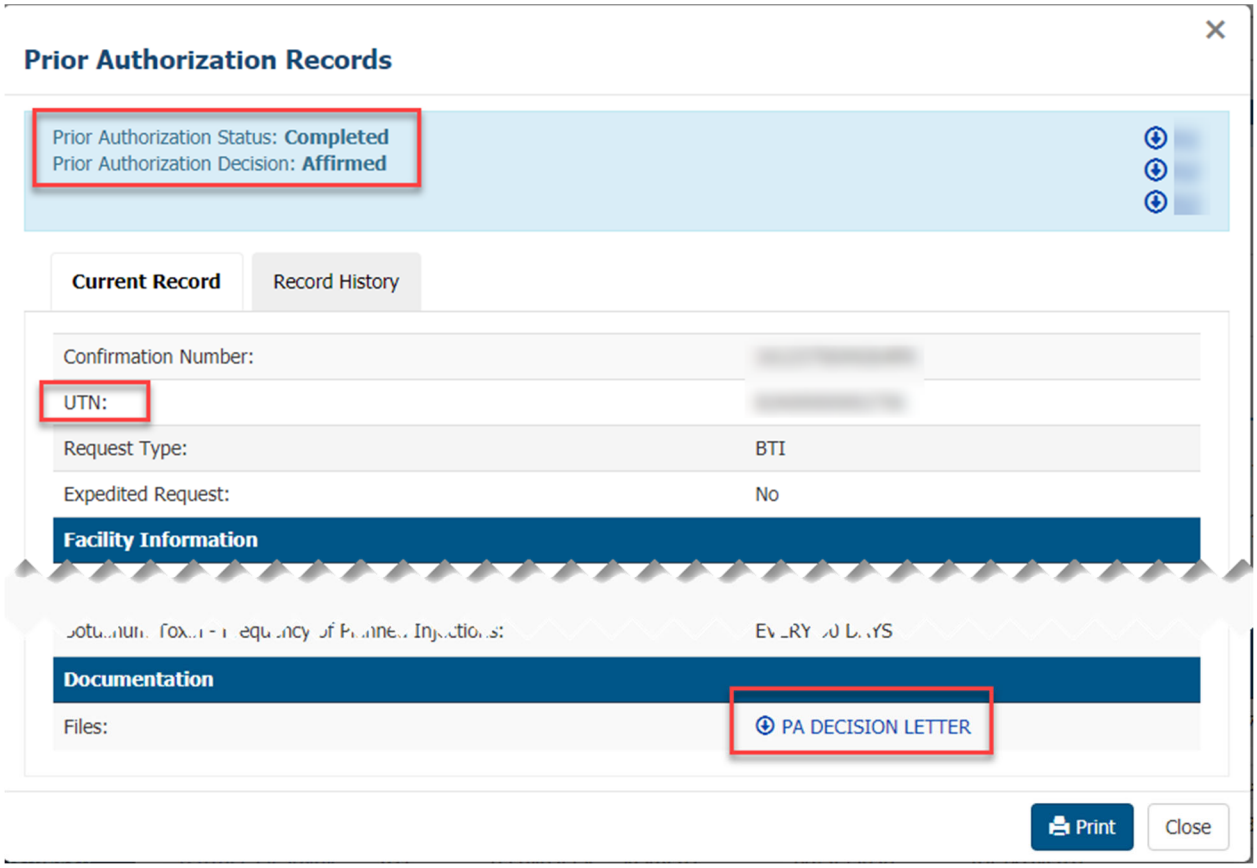
This will show a table containing all the prior authorization requests you are able to view. You can click the column headings to sort the results by that column. You can also narrow the results to see only a certain type of prior authorization or only those requests you submitted yourself. You can also use the filter to search for specific information in the table, such as a specific Medicare number. Click on the Confirmation Number to view a record.



Status Codes:
Received – The attachment has been submitted and is waiting for virus scanning.
Pending – The request has been received by the Medical Review department.
Completed – A decision letter is available to view.
Not Accepted – The file was invalid or corrupt. Review the accepted file types and resubmit.

Once you open a record, you will find:

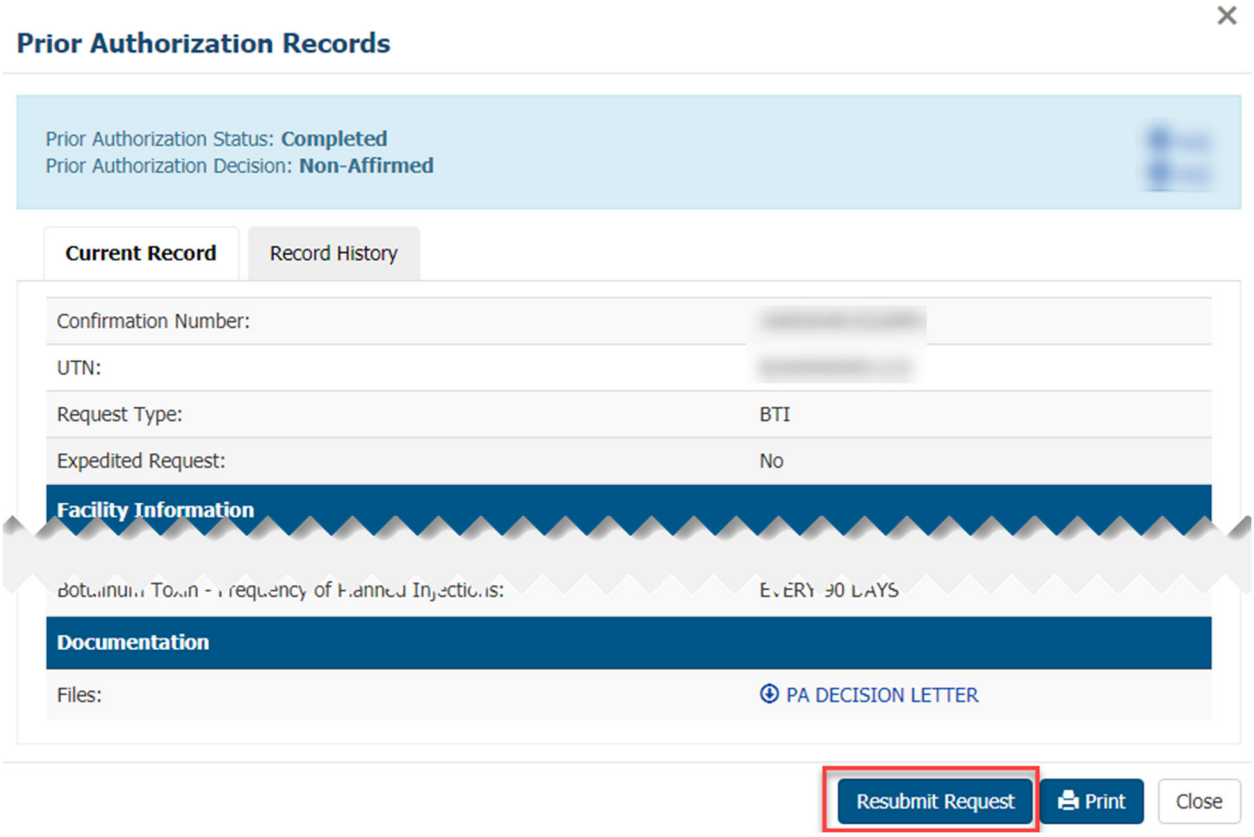
- The status of the request and the prior authorization decision at the top of the record
- The details of the request (on the Current Record tab)
- The Unique Tracking Number (UTN) (if the request is affirmed or non-affirmed)
- The decision letter that provides full details about the completed request (affirmed, non-affirmed, or rejected)



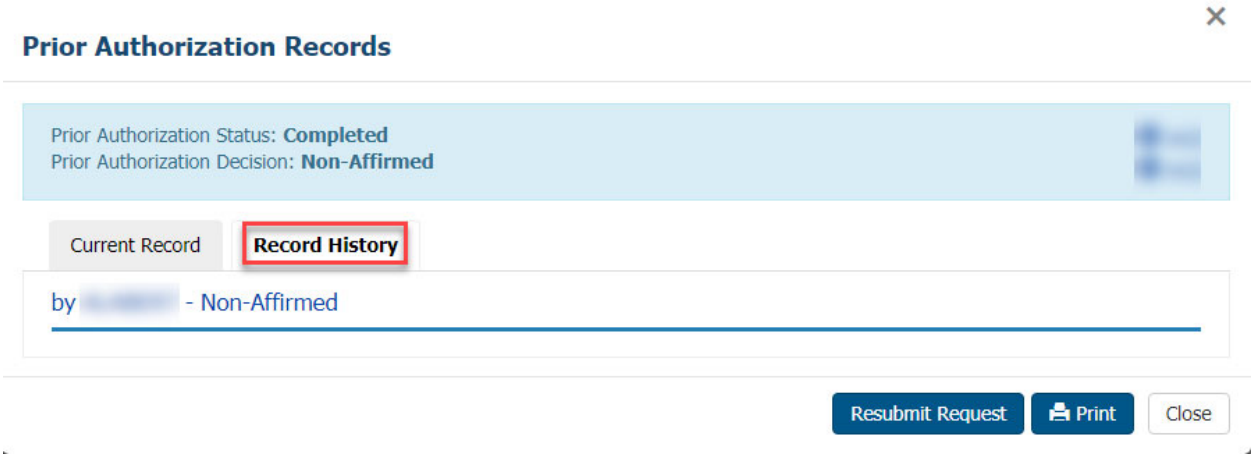
Subsequent Requests

If the request is non-affirmed, you can resubmit the request to provide additional information. Click the Resubmit Request button at the bottom of the page, which will open the prior authorization request form prepopulated with the details from the previous request.

NOTE: You will not see the Resubmit Request button if the decision is affirmed or rejected.

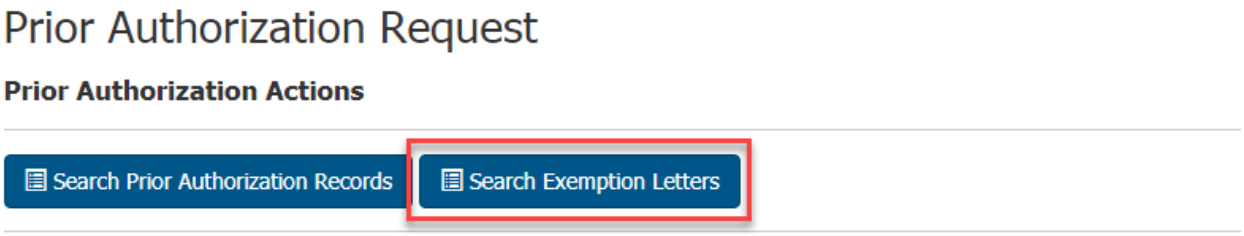


The Record History tab will show the history of your previous requests.

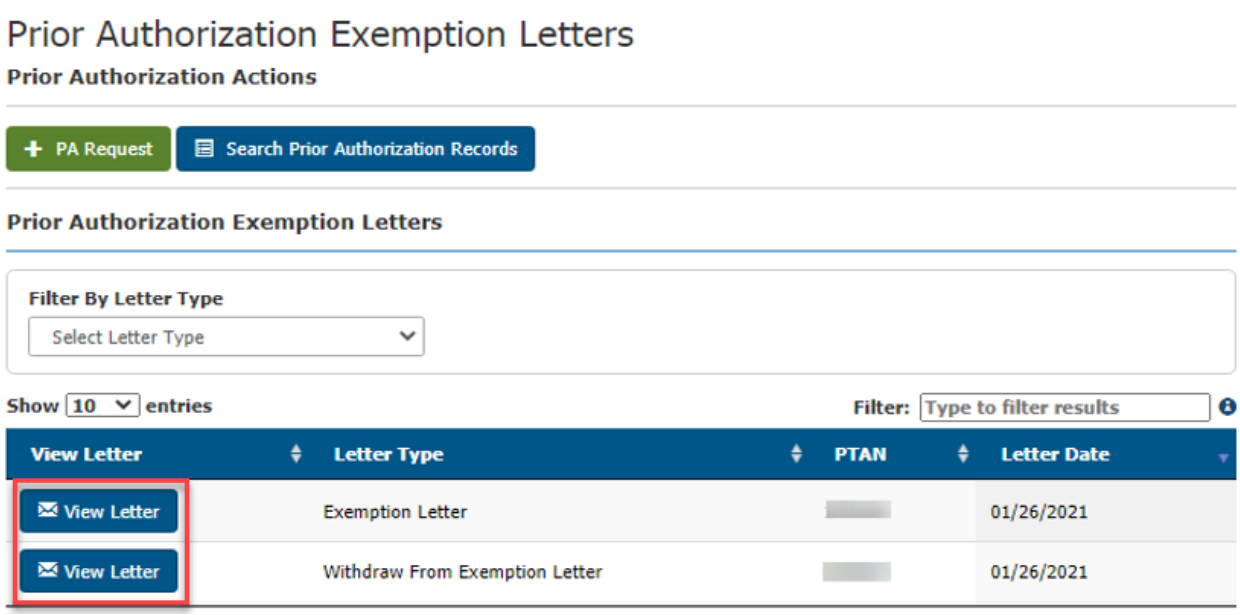


Searching for Prior Authorization Exemption Letters

CMS has the authority to exempt a provider from the prior authorization process if the provider demonstrates compliance with Medicare coverage, coding, and payment requirements. CMS also has the authority to withdraw such an exemption. WPS Government Health Administrators will notify a provider by letter if they are exempt from the prior authorization process or if their exemption is withdrawn. Providers can locate their exemption letters in the portal by clicking on the Search Exemption Letters button.



Click on the View Letter button to see the letter. You can also sort the letters by letter type or filter the results to find a specific letter.



Claim Transactions and Searches

Eligibility Check

Eligibility Check allows providers to verify certain information Medicare has on file for Medicare beneficiaries. This information helps providers bill Medicare correctly. Information is generally available 24 hours a day but may be temporarily unavailable due to scheduled or unscheduled maintenance.

Sources of Eligibility Data

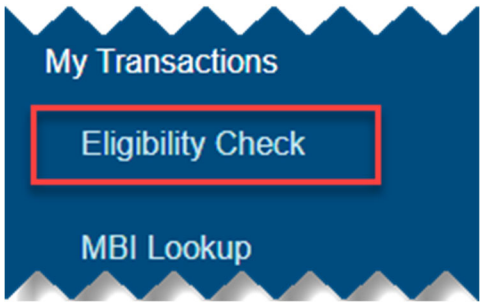
The eligibility information available in the WPS Government Health Administrators Portal comes from the HIPAA Eligibility Transaction System (HETS) 270/271 eligibility transaction. The information available in the portal is the same information provided by the Interactive Voice Response (IVR). It is important to understand that while eligibility information is accurate at the time it is given, the information may change if Medicare (or any of the Federal agencies that supply data to HETS, such as the Social Security Administration) receives additional information. Although the data from HETS is updated in real time, the data comes from many different sources that may take up to two weeks to update. Medicare contractors process claims based on the information on Medicare's files at the time the claim is processed.

If you have a question about a patient's eligibility information, you or the patient should contact the entity responsible for providing the data to Medicare:

- Contact the Social Security Administration (https://www.ssa.gov/) for questions about Medicare entitlement or benefit dates.
- Contact the Benefits Coordination and Recovery Center (BCRC) (https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page) for Medicare Secondary Payer (MSP) questions. The BCRC can also assist with some issues involving Medigap or supplemental insurance (i.e., insurance that pays after Medicare).
- Contact the Medicare Advantage (MA) plan (i.e., Managed Care Organization or Medicare replacement plan) directly for all questions involving MA plans.
- Contact your state's Medicaid agency for questions about the Qualified Medicare Beneficiary (QMB) program (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB).

Accessing Eligibility Check

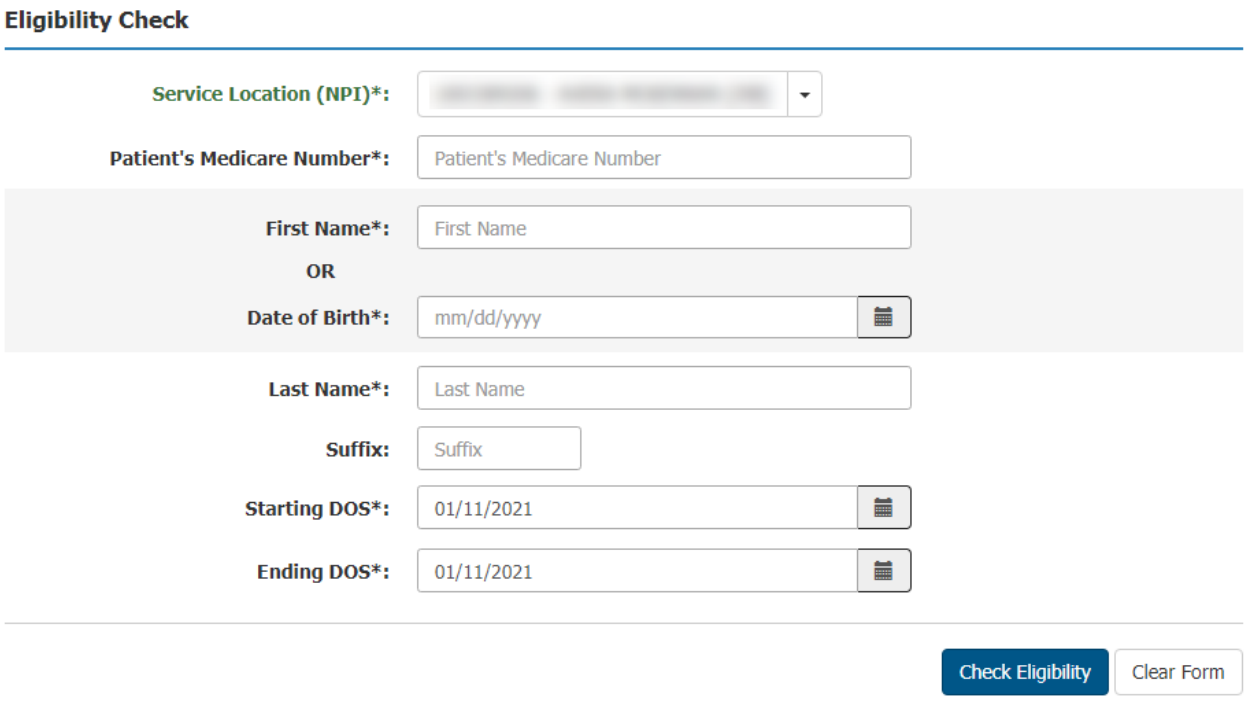
You can access Eligibility Check by clicking on the link under the My Transactions heading in the left navigation menu.



After clicking the link, select your service location (if it is not already prepopulated) and enter the following information about your patient:

- Medicare number (i.e., the Medicare Beneficiary Identifier (MBI))
- First name **-OR-** Date of birth
- Last name
- Suffix, if applicable (e.g., Jr., Sr., III, etc.)
- Starting and ending dates of service (DOS)

NOTE: The eligibility information provided corresponds to the starting and ending dates of service you enter on the search screen. You can search for eligibility information up to four years in the past or 4 months in the future by changing the dates in the Starting DOS and Ending DOS fields.

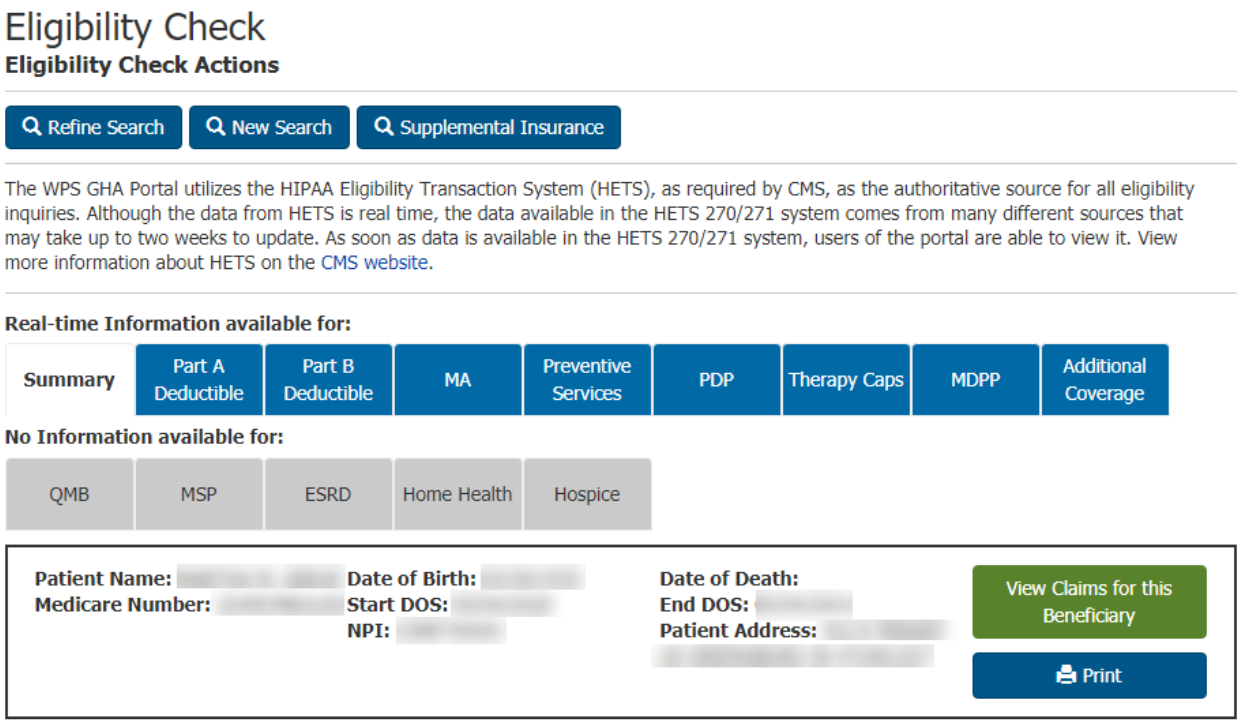


Click the Check Eligibility button to start the search. If any of the information you entered is incorrect, you will see an error message.

If the information you entered is valid, the portal will display the beneficiary's basic details along with links to additional eligibility categories.

- The category box is blue if eligibility information is available.
- The category box is gray if no eligibility information is available in that category.

You can also refine your search or start a new one, jump to the Claim Inquiry page (which will be prepopulated with the beneficiary's Medicare number), or print the beneficiary's eligibility details from this screen.



Available Eligibility Information

Use the tabs located above the patient's details to see additional eligibility information for your patient. The tabs highlighted in blue contain additional information for your patient. The order of the tabs will vary depending on the eligibility information available. The information available includes:

- Eligibility summary
- Part A deductible
- Part B deductible
- Medicare Advantage (MA) plan enrollment
- Preventive services eligibility
- Prescription drug plan (PDP) information
- Therapy cap (threshold) information
- Medicare Diabetes Prevention Program (MDPP) eligibility
- Acupuncture eligibility (on the Additional Coverage tab)
- Cognitive Assessment and Care Plan Services (on the Additional Coverage tab)
- Qualified Medicare Beneficiary (QMB) program eligibility
- Medicare Secondary Payer (MSP) information
- End stage renal disease (ESRD) eligibility

- Home health eligibility
- Hospice eligibility
- Part B Immunosuppressant Drug (PBID)
- Supplemental insurance information

NOTE: Medicare Diabetes Prevention Program (MDPP) suppliers have limited access to eligibility information. The data available is limited to the information an MDPP supplier would need to bill for MDPP services: Part B eligibility date, managed care organization (MCO) data, Medicare secondary payer (MSP) data, and end-stage renal disease (ESRD) data

Summary

The Summary tab provides the following entitlement and benefit information:

- Part A and Part B entitlement dates
- Part A and Part B entitlement reason codes (Hover your mouse over the code to display the definition of the reason code.)
- Previous Part A and Part B entitlement dates
- Part A and Part B ineligible dates (A beneficiary may have periods of ineligibility during their Medicare entitlement. The portal will show periods of ineligibility occurring within your search parameters.)
- Part A benefit data:
    - Lifetime reserve days
    - Lifetime reserve co-payment amount
    - Lifetime psychiatric days
    - Hospital days
    - Hospital co-payment days and amount
    - Skilled nursing facility (SNF) days
    - Skilled nursing facility (SNF) co-payment days and amount
- Part B benefit data:
    - Pulmonary rehabilitation sessions
    - Blood deductible
    - Smoking cessation sessions
    - Cardiac rehabilitation sessions
    - Intensive cardiac rehabilitation sessions
- Link to a list of procedure codes that require Prior Authorization

Part A Deductible

The Part A Deductible tab provides the following information:

- Coverage time span (year)
- Part A deductible amount
- Hospital spell dates (earliest/latest billing date and days remaining) and deductible remaining
- Hospital co-payment amount and days remaining
- Hospital stay dates and billing NPI
- SNF spell dates (earliest/latest billing date and days remaining) and deductible remaining
- SNF co-payment amount and days remaining
- SNF stay dates and billing NPI

Part B Deductible

The Part B Deductible tab provides the following information:

- Coverage time span (year)
- Part B deductible amount
- Part B deductible remaining

Medicare Advantage (MA)

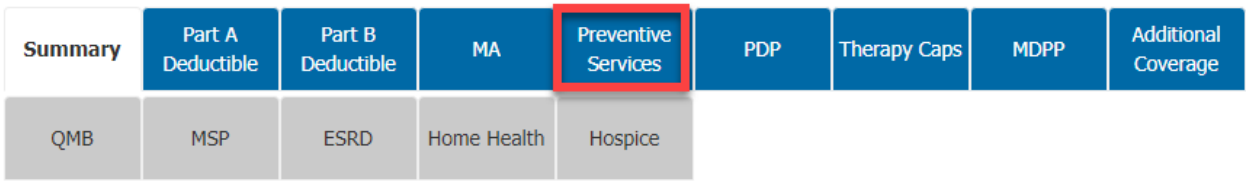
The MA tab provides information about insurance that pays INSTEAD of Medicare. This type of insurance is known by many names, including Medicare Part C, Medicare HMO, Medicare managed care organization, Medicare health plan, or Medicare replacement plan. When a beneficiary enrolls in a Medicare Advantage plan, they remain enrolled in Medicare, but they

elect to have their Medicare-covered services processed and paid by another insurer. In exchange for allowing the other insurer to manage their care (which usually includes limiting the beneficiary to a network of providers), the beneficiary may receive additional benefits that aren't covered under Original Medicare. In most cases, the provider submits a claim only to the MA plan. Though uncommon, some MA plan options allow beneficiaries to see out-of-network providers and have those services processed by Original Medicare instead of by the MA plan.

The MA tab provides the following information:

- MA plan enrollment and termination dates
- MA contract and plan
- MA name, address, telephone number, and website (if available)
- MA enrollment plan type
- Bill option code
- MA and plan benefit package (PBP) information are displayed on separate lines

Preventive Services



The Preventive Services tab provides the following information about the preventive services Medicare covers subject to specific frequency limitations (e.g., repeat preventive services covered only after a set amount of time has passed):

- Procedure code (with professional/technical modifier, if applicable)
- Next eligible date
- Pneumococcal pneumonia vaccination history (procedure code, rendering provider's NPI, and date of service)
- Influenza (procedure code, rendering provider's NPI, and date of service)
- COVID-19 Immunization Data (procedure code, immunization date, and rendering provider's NPI)

The portal displays current eligibility data only. You should not infer historic eligibility or prior services rendered based on the next eligible date. (For example, do not infer that the patient previously received a colonoscopy based on the date the patient is next eligible for a colonoscopy.)

If a procedure code has different next eligible dates for the professional and technical components, the portal will display different eligibility dates for each component.

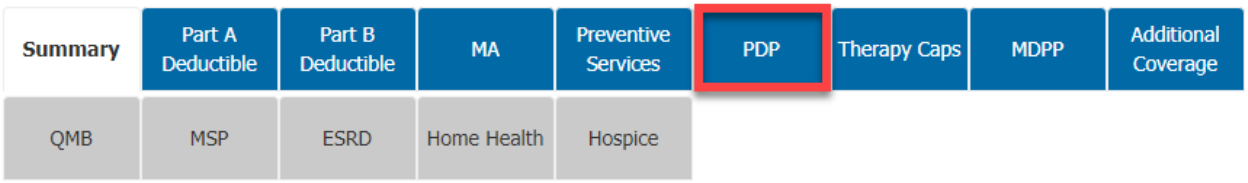
The portal displays the procedure codes that may be used to bill for preventive services that have a specific frequency limitation, including:

- Alcohol misuse screening and counseling (G0442 and G0443)
- Annual Wellness Visit (AWV) (G0438 and G0439)

- Audiology Screening (92550, 92552, 92553, 92555, 92556, 92557, 92562, 92563, 92565, 92567,92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 92651, 92652, and 92653)
- Bone mass measurement (76977, 77078, 77080, 77081, and G0130)
- Cardiovascular disease screening (80061, 82465, 83718, and 84478)
- Colorectal cancer screening (G0104, G0105, G0106, G0120, G0121, G0327, G0328, and 82270)
- Depression screening (G0444)
- Diabetes screening (82947, 82950, and 82951)
- Glaucoma screening (G0117 and G0118)
- Hepatitis B screening (G0499)
- Hepatitis C screening (G0472)
- Human Immunodeficiency Virus (HIV) screening (G0475)
- Intensive behavioral therapy (IBT) for cardiovascular disease (CVD) (G0446)
- Intensive behavioral therapy for obesity (G0447)
- Initial Preventive Physical Examination (IPPE) (G0402, G0403, G0404, and G0405)
- Prostate cancer screening (G0102 and G0103) (males only)
- Screening for cervical cancer with human papillomavirus (HPV) (G0476) (females only)
- Screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs (G0445)
- Screening mammography (77067)
- Screening Pap tests (G0123, G0143, G0144, G0145, G0147, G0148, P3000, and Q0091)
- Screening pelvic exam (G0101)
- Ultrasound screening for abdominal aortic aneurysm (AAA) (76706)

For more information about preventive services, including those services that are not included on the Preventive Services tab, see the Medicare Preventive Services (https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html) tool on the CMS website.

Prescription Drug Plan (PDP)



The PDP tab provides information about any Medicare Part D prescription drug plans the beneficiary has enrolled in. While these plans are called Medicare Part D, they are stand-alone prescription drug plans offered by private insurers, not Original Medicare. Providers who have questions about a patient's PDP should contact the PDP insurer directly. The PDP tab provides the following information:

- PDP enrollment and termination dates
- PDP contract and plan numbers
- Part D insurer's contact information, including:
    - Insurer's name

- Insurer's address
- Insurer's telephone number
- Insurer's website (if available)

- PDP plan name

Therapy Caps

The Therapy Caps tab provides information about the annual per-beneficiary threshold limitations on physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. In previous years, Medicare set financial limitations on the therapy services beneficiaries could receive in a calendar year. The Bipartisan Budget Act (BBA) of 2018 repealed those caps and added a limitation to ensure beneficiaries receive appropriate therapy. Though it is more accurate to refer to the limitations as per-beneficiary thresholds or KX modifier thresholds, they are commonly called "therapy caps."

There are two separate thresholds for therapy services: One for PT and SLP services combined and another for OT services. The Therapy Caps tab provides the following information:

- Type of therapy (**NOTE:** While the types of therapy are labeled either occupational therapy or physical therapy on this screen, remember physical therapy also includes speech-language pathology services)
- Deductible year
- Amount applied toward threshold (labeled "Part B Therapy Cap Used")

Medicare Diabetes Prevention Program (MDPP)

The MDPP tab provides information about Medicare Diabetes Prevention Program (MDPP) eligibility. The MDPP is a once in a lifetime benefit for eligible beneficiaries at risk of developing type 2 diabetes. Medicare Part B covers an initial 12-month period (six months of weekly sessions followed by six additional months of monthly sessions). Medicare can also cover a second 12-month period of maintenance sessions if the beneficiary meets certain criteria.

The MDPP tab provides the following information:

- MDPP effective and termination dates
- Inactive coverage
- Active coverage
- MDPP HCPCS codes billed

- Billing Provider NPI
- Date of Service for each HCPCS code
- MDPP Period 2 End Date

NOTE: The effective date for active coverage only displays the starting date of service you submitted on your eligibility request. It is NOT the actual start date for the beneficiary's MDPP. If the beneficiary's MDPP enrollment is not active, it will display the starting date of service submitted on your eligibility request on the Inactive Coverage line.

Additional Coverage

The Additional Coverage tab provides information about Medicare's coverage of acupuncture for chronic low back pain. Medicare Part B covers up to 12 acupuncture visits in 90 days to treat low back pain. Medicare can also cover 8 additional sessions if the initial sessions improve the beneficiary's low back pain. No more than 20 acupuncture treatments are covered annually.

Also found on the Additional Coverage tab is Cognitive Assessment and Care Plan services data provided there is not a recorded date of death prior to or equal to the requested date(s) of service. If there are no services provided during the request date(s) of service but there is prior usage, the portal will include the most recent service occurrence.

The Additional Coverage tag provides the following information:

Acupuncture:
- Technical sessions remaining
- Next technical date
- Professional sessions remaining
- Next professional date

Cognitive Assessment and Care Plan:
- HCPCS 99483
- Date of service
- Rendering provider NPI

Qualified Medicare Beneficiary (QMB)

The QMB tab provides information Qualified Medicare Beneficiary (QMB) eligibility. A QMB is eligible for both Medicare and Medicaid. Medicare providers and suppliers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays. Providers may be eligible to bill state Medicaid programs for those costs. People in the QMB program have no legal obligation to pay Medicare providers for Medicare Part A or Part B cost-sharing amounts even if the provider is not enrolled in the state's Medicaid program. For more information, see the CMS website (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB).

The QMB tab provides the following information:

- QMB enrollment period

NOTE: State Medicaid agencies determine QMB eligibility monthly, but they may not update the systems that supply eligibility data to Medicare by the first day of each month.

Medicare Secondary Payer (MSP)

The MSP tab provides information about insurance that pays BEFORE Medicare pays. When a beneficiary has two or more insurers, there are rules that determine which insurer pays first. Some types of primary insurance, such as employer group health plans, pay before Medicare for all types of services. Other types of primary insurance, such as worker's compensation or liability insurance, only pay before Medicare for services related to an accident or injury. In most cases, the provider submits a claim to the MSP insurer first and then submits a claim to Medicare. For more information, see the CMS website (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MSP_Fact_Sheet.pdf).

See our Medicare Secondary Payer (MSP) Fact Sheet (https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/msp-fact-sheet) for information on determining who is Primary to Medicare.

The MSP tab provides the following information:

- Enrollment and termination dates
- Insurer name and address
- Insurance type code and description
- Policy ID
- Group Number
- Last MSP Maintenance Date
- Patient Relationship Code
- MSP Source Code

- Diagnosis codes associated with the beneficiary's accident or injury
- ORM Indicator

End Stage Renal Disease (ESRD)

The ESRD tab provides eligibility information for beneficiaries eligible for Medicare due to their end stage renal disease. Medicare eligibility due to ESRD works differently than other types of Medicare eligibility. Medicare's coverage depends on when the beneficiary begins or ends regular dialysis treatments or receives a kidney transplant. For more information about Medicare eligibility due to ESRD, see the CMS website (https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD).

The ESRD tab provides the following information:

- ESRD coverage period effective date and end date
- Dialysis start and end date (if applicable)
- Kidney transplant date (if applicable)

Home Health

The Home Health tab provides information about home health periods of care. Home health agencies (HHAs) submit a consolidated bill to Medicare for the home health services a beneficiary receives during a home health episode of care. With limited exceptions, Medicare will only pay the HHA for the home health services and medical supplies a beneficiary receives during each 30-day period of care. For more information, see the CMS website (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf).

The Home Health tab provides the following information:

- Home health period start and end dates
- Date of earliest and latest billing activity
- HHA provider NPI
- Contractor number and name

- Patient status code (indicating whether the beneficiary is actively receiving services)
- Notice of Admissions (NOA) Indicator
    - 1 – NOA Received without condition code 47
    - 2 – NOA received with condition code 47

Hospice

The Hospice tab provides information about benefit periods once a beneficiary elects to receive hospice care. When a beneficiary elects to receive hospice care, they agree to receive palliative care instead of treatment to cure their terminal illness. Hospice care is available for two periods of 90 days and an unlimited number of subsequent 60-day periods. For more information, see the CMS website (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice).

The Hospice tab provides the following information:

Hospice Election Period Information (The Hospice Election Revocation Indicator will now be sourced from the specific Hospice Election record instead of the Hospice Period record):

- Hospice provider NPI
- Start date
- Receipt date
- Revocation date
- Revocation code

Hospice Benefit Period Information:

- Benefit period provider NPI
- Start and end date
- Dates of earliest and latest billing activity
- Number of hospice days used

Part B Immunosuppressant Drug (PBID)

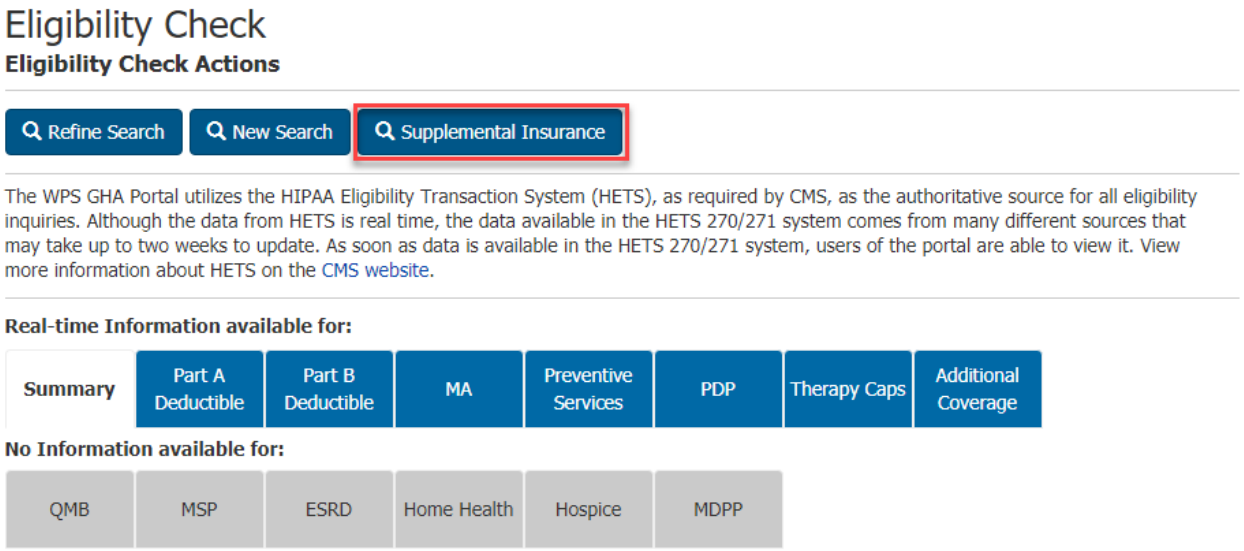
The PBID tab provides Enrollment information for Medicare beneficiaries following a kidney transplant. This benefit provides coverage for immunosuppressant drugs beyond the 36 months following a kidney transplant. This will only cover immunosuppressive drugs and no other services or items. The HETS response will return up to ten (10) Part B-ID enrollment periods within the requested date(s) of service. The HETS response for Part B-ID will never include Medicare Advantage (MA) or Medicare Secondary Payer (MSP) data.

The PBID tab provides the following information:

- Enrollment Reason Code
- Coverage Time Span
- Deductible Base
- Deductible Remaining
- Coinsurance

Supplemental Insurance

The Supplemental Insurance button provides information about insurance that may pay for services after Medicare processes the claim. Unlike the other eligibility information, the supplemental insurance information is available by clicking a button located above the row of eligibility information tabs.



The supplemental insurance information available is for informational purposes only. It may not be a comprehensive list of any or all the supplemental insurance a beneficiary may have. Medicare's information is limited to Medicare Crossover trading partners that sign trading partner agreements with Medicare. A trading partner agreement allows Medicare to send claim information to the supplemental insurer after Medicare processes the claim. Beneficiaries may have other insurance that would require the provider to file a claim directly with the insurer. Providers should obtain supplemental insurance information from the beneficiary.

The Supplemental Insurance tab provides the following information:

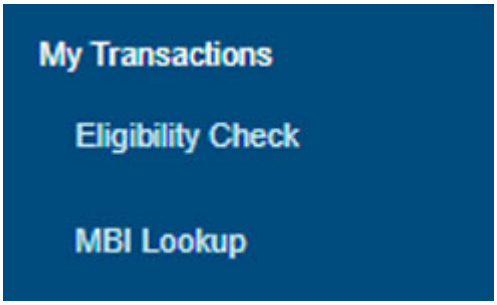
- Supplemental insurer's name and address
- Supplemental insurance effective and termination date
- Coordination of benefits agreement (COBA) number

Medicare Beneficiary Identifier (MBI) Lookup

Providers should obtain their patients' Medicare billing information directly from their patients. However, when a patient is unable to give you their Medicare Beneficiary Identifier (MBI), you can use the MBI Lookup.

The MBI is confidential, personally identifiable information (PII) about your patient, and you must protect it like you would any other PII or protected health information (PHI). You may only use the MBI for Medicare-related business. The MBI Lookup is protected by reCAPTCHA and subject to the Google Privacy Policy and Terms of Service.

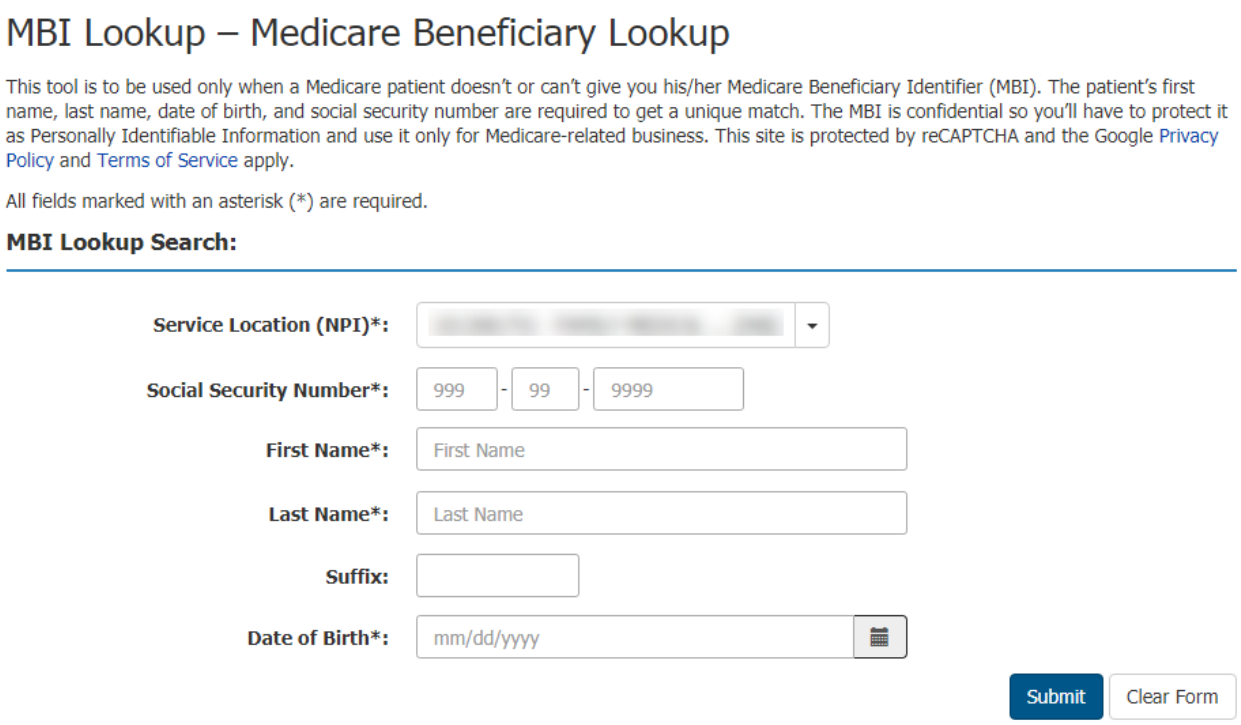
To use this tool, select "MBI Lookup" from the left navigation menu.



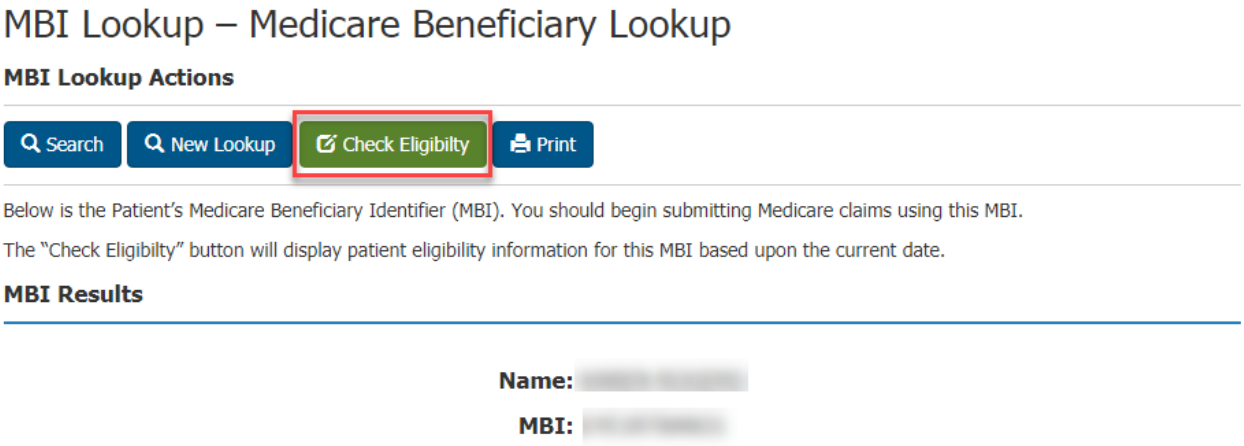
1. Select a Service Location (NPI) from the drop-down box to begin search. If you only have access to one NPI, it will be prepopulated in the box.

2. Enter the following patient information and click the Submit button:

    - Social Security number
    - First name
    - Last name
    - Suffix, if applicable (e.g., Jr., Sr., III, etc.)
    - Date of birth



3. If the data you entered is valid, the portal will supply you with the patient's MBI. You can also easily jump to the patient's Medicare eligibility information by clicking the green Check Eligibility button above the results.



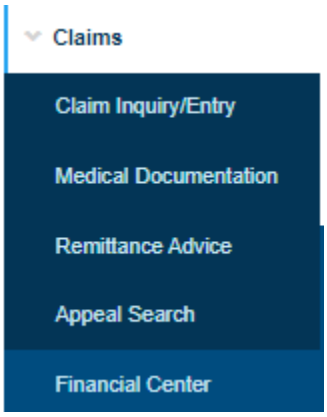
NOTE: If the patient has been deceased for more than 48 months, the portal will display the message, "Date of Death exceeds four years."

Claim Transactions Overview

The Claims area of the WPS Government Health Administrators Portal contains all the functions related to the submission, processing, and payment of Medicare claims. This includes the following tasks:

- Claim status inquiries
- Part B claim entry
- Clerical Error Reopenings
- Overpayment Claim Adjustments
- Prepayment and post-payment review of claims
- Duplicate remittance advice statements
- Medicare refunds
- Claim development and overpayment demand letter search

Users with Standard or NPI Administrator access have access to the Claims functions in the portal. Users who have Eligibility access only do not have access to the Claims transactions, and they will not have a link to the Claims area. You can access the Claims functions by clicking the appropriate link under the Claims heading in the left navigation menu.



NOTE: If you are a Standard or NPI Administrator and you do not see the links below the Claims heading, click the arrow next to “Claims” to open the menu.

Claim Status

The Claim Inquiry function allows Standard users and NPI Administrators users to check the status of pending and processed claims. It is also the starting point for several other claim-related transactions in the portal.

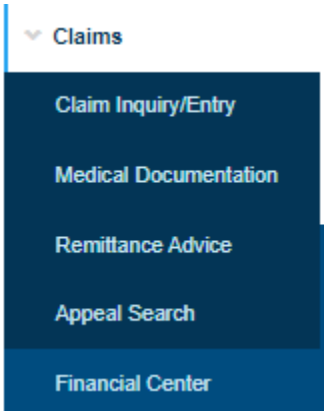
Claim status is available only when the claims processing system is available. Both the FISS (Part A/facilities) and MCS (Part B/practitioners and suppliers) claims processing systems go offline around 7:00 PM CT (8:00 PM ET) nightly. They generally come back online at the following times:

FISS (Part A)
J5 (IA, KS, MO, NE) 6:00 AM CT (7:00 AM ET)
J5 National 7:00 AM CT (8:00 AM ET)
J8 (IN, MI) 5:00 AM CT (6:00 AM ET)

MCS (Part B)
J5 (IA, KS, MO, NE) 7:00 AM CT (8:00 AM ET)
J8 (IN, MI) 5:00 AM CT (6:00 AM ET)

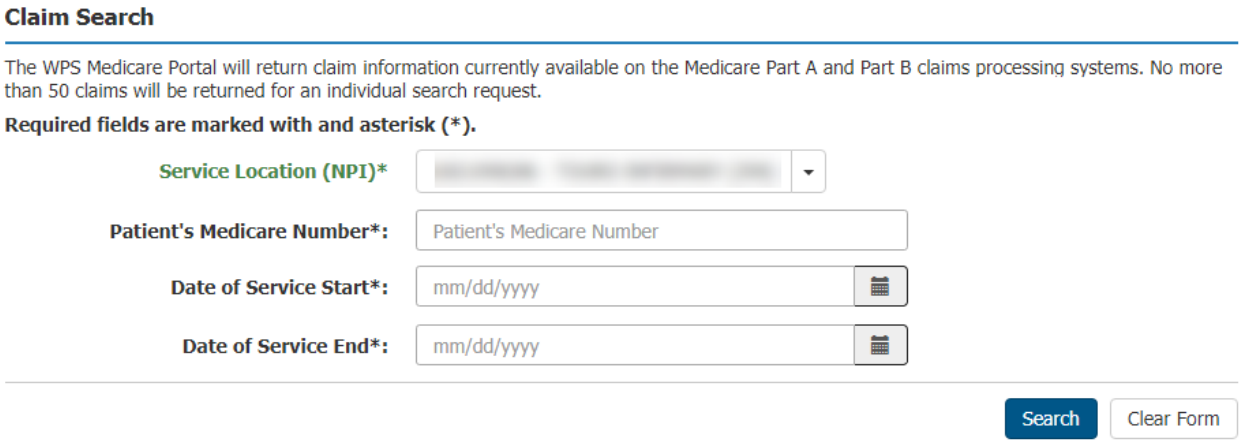
Claim Search

To check the status of a claim, begin by selecting the Claim Inquiry/Entry link under the Claims heading in the left navigation menu. (If you do not see the Claim Inquiry/Entry link, click the arrow next to Claims to open the Claims menu.)



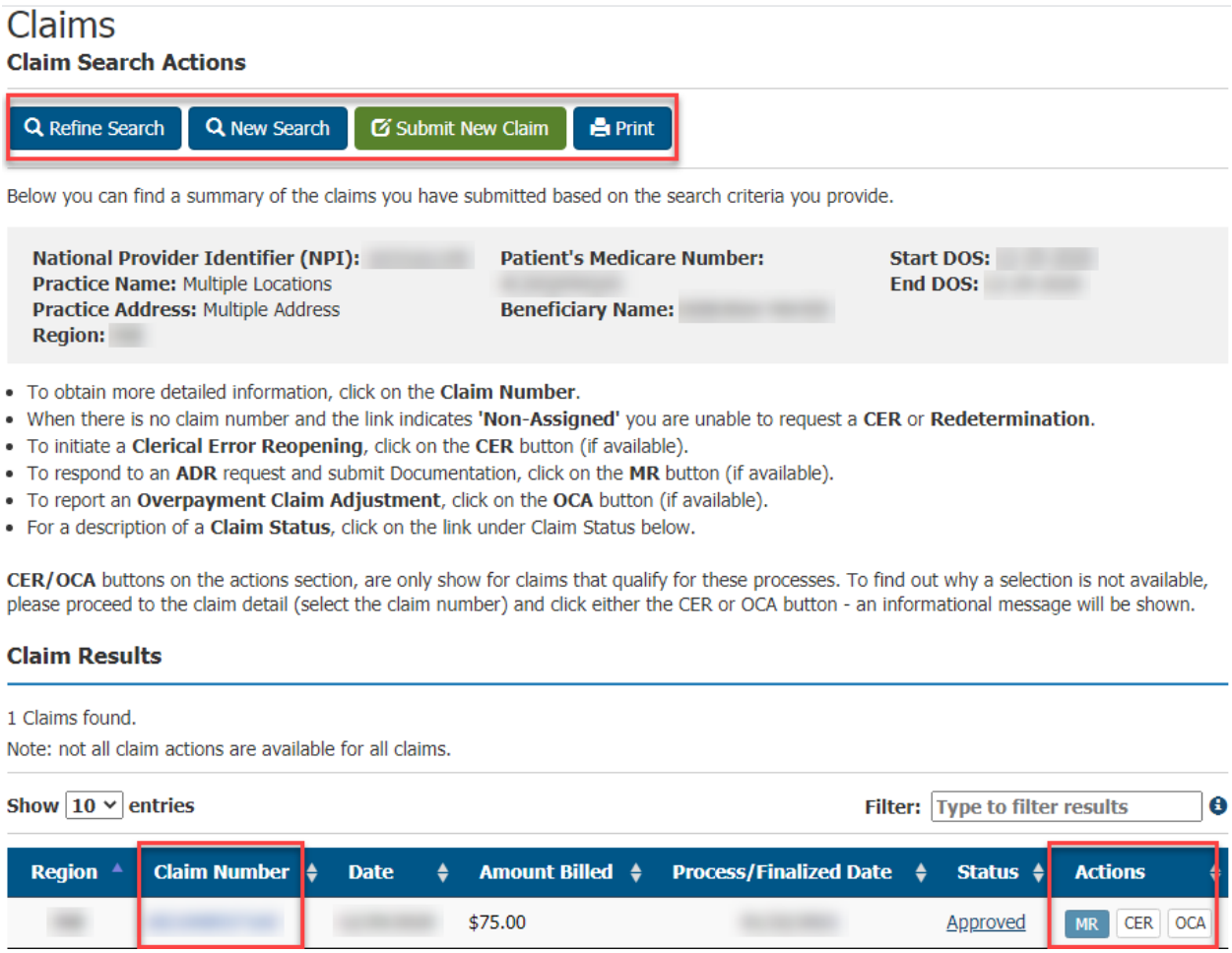
On the Claim Search screen, enter the following, then click the Search button to locate any claims meeting the criteria:

- Service location (NPI)
- Patient's Medicare number
- Start and end dates of service



The portal will display your search criteria near at the top of the page. A list of claims meeting the search criteria appears at the bottom of the page.

Click the buttons at the top of the page to refine your current search, start a new search, submit a new claim (if you are registered to submit Part B claims through the WPS Government Health Administrators Portal), or print the information on the page.



The claim results provide high-level information about the claim. Click the claim number to view more details about the claim or perform additional claim actions.

You may also be able to access the following claim actions directly from the claim results page, depending on the type of claim submitted. You will only be able to select a button if your claim qualifies for that action.

- MR: Respond to an Additional Development Request (ADR) letter sent by Medical Review (pending claims only)
- CER: Perform a Clerical Error Reopening to correct minor errors or omissions (finalized claims only)
- OCA: Perform an Overpayment Claim Adjustment to report an overpayment (finalized claims only)

NOTE: Older Part A claims may be archived. Archived claims appear in the claim results, but claim details are not available. Please contact our Provider Contact Center for help if you receive a message stating a claim is archived.

Claim Details

Clicking the claim number shows addition details and actions for the claim. The information displayed varies depending on if the claim is an institutional (i.e., Part A) claim or a professional (i.e., Part B) claim.

Institutional and professional claim details include the following information:

- Date(s) of service
- Patient's name and Medicare number
- Claim number (DCN/ICN)
- Claim status (i.e., Adjusted/Replaced, Processed, Finalized/Paid, In Process, Denied, Cancelled, Approved, etc.)
- Processed date
- Check/EFT number
- Check or paid date (RA date)
- Billed amount
- Allowed amount
- Paid amount
- Deductible applied
- Lines of service and their details (HCPCS/CPT codes, modifiers, revenue codes, units, etc.)
- Reason and/or remark codes

Institutional claims may also include:

- Type of bill
- Status/Location
- Blood deductible
- Discharge facility type

NOTE: In the Claim Details table, you can click on an underlined code for a definition of that code.

Claim Actions

The Claim Actions section (located toward the top of the page) shows actions you can take from this page. Not all actions are available for every claim. Actions available may include:

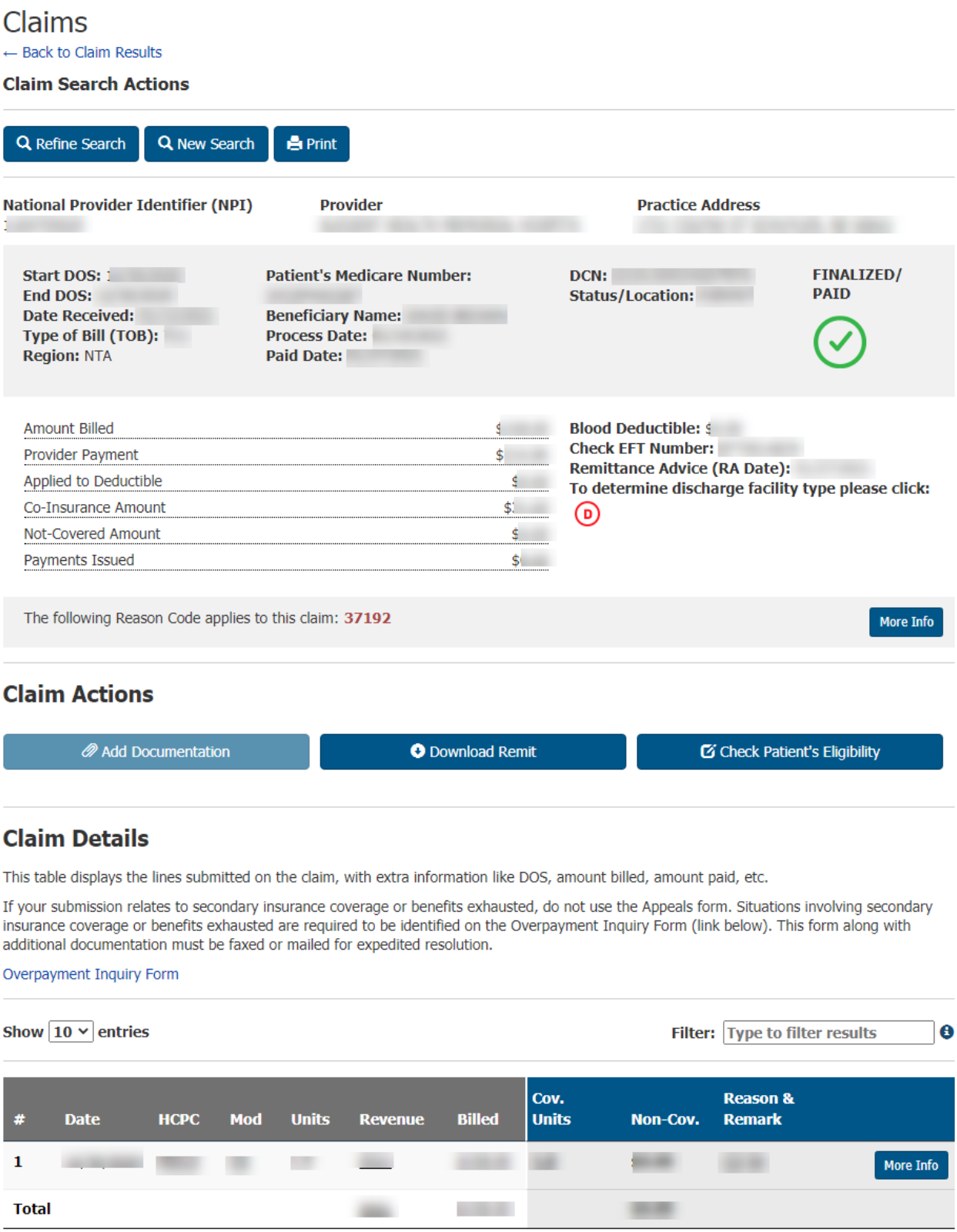
- Refine Search
- New Search
- Print
- Print Finalized Claim Summary (Part B claims only)

The Claim Actions section (located in the middle of the claim details) shows actions you can take on the claim. Not all actions are available for every claim. Actions available may include:

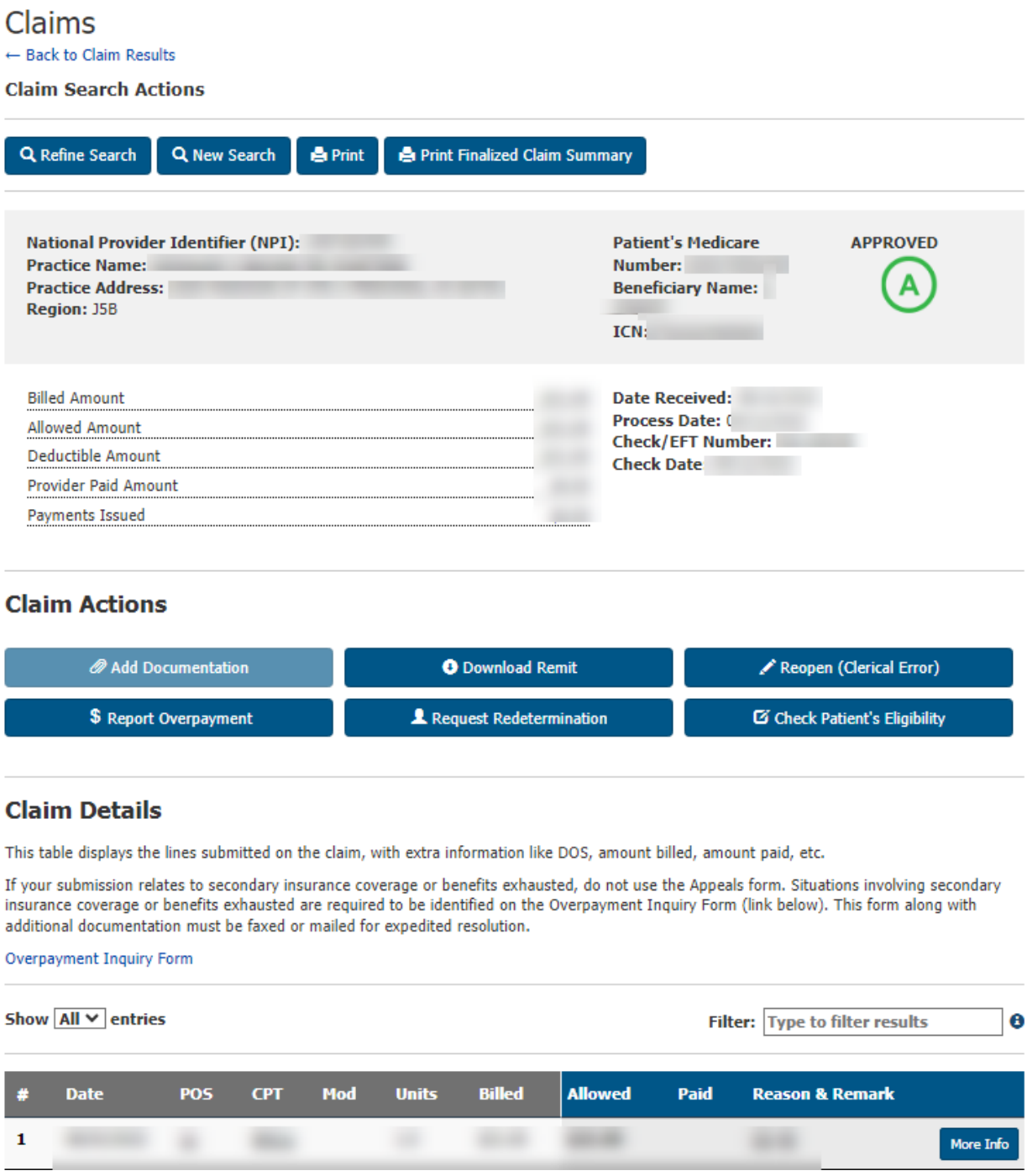
- Add Documentation [ADR or MR] (to upload documentation requested by the Medical Review department for a pre- or post-pay review; do not use this option to appeal a claim determination)

- Download Remit
- Reopen (Clerical Error) [CER] (to correct minor errors or omissions)
- Report Overpayment [OCA]
- Request Redetermination (to appeal Medicare's claim decision)
- Check Patient's Eligibility

Example of an institutional claim's details page:



Example of a professional claim's details page:



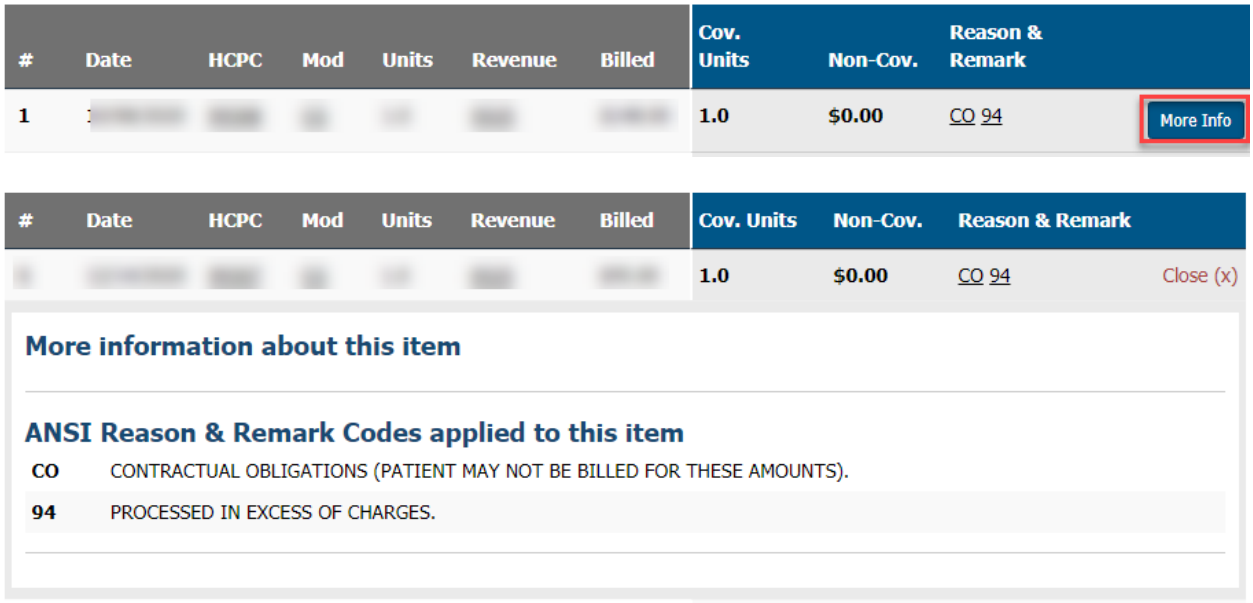
The Claim Actions section (located toward the top of the page) shows actions you can take from this page. Not all actions are available for every claim. Actions available may include:

- Refine Search
- New Search
- Print
- Print Finalized Claim Summary (Part B claims only)

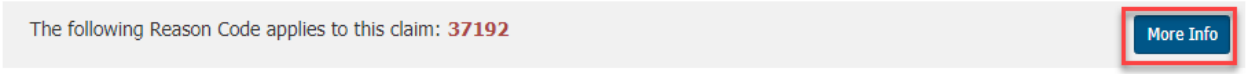
More Info Button

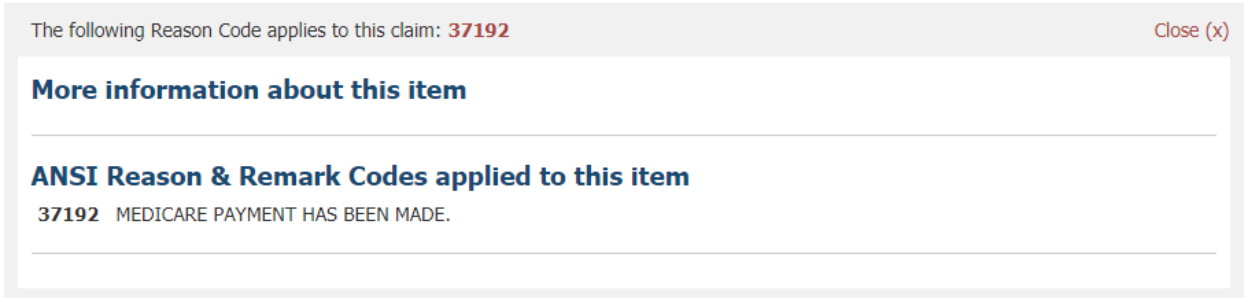
The More Info button provides additional details about the claim. On institutional and professional claims, you may see the More Info button next to each claim detail line. When the button appears next to the claim line, the information may include:

- Rendering provider name
- Rendering provider NPI
- ANSI reason and remarks codes
- Related claim link (a claim that may be duplicative of your claim)
- Patient eligibility information



Institutional claims may also include a More Info button next to a claim level reason code (i.e., a reason code that applies to the entire claim).





Enhanced Denial Information

Enhanced denial information is available for some denials. If enhanced denial information is available, it may provide:

- Additional information explaining the denial
- Guidance for correcting the claim
- Links to web pages containing information applicable to your claim
- Claim action buttons for correcting the denial (may not be available for all denials)

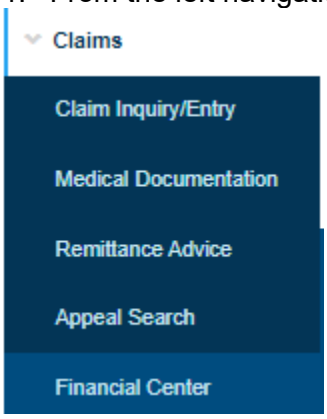
You can find more information about the enhanced denial information available in our article, "Self Service Denial Assistance is Available with the More Info Button." (https://www.wpsgha.com/wps/portal/mac/site/self-service/guides-and-resources/self-service-denial-assistance-more-info-button)

Part B Claim Submission Through the Portal

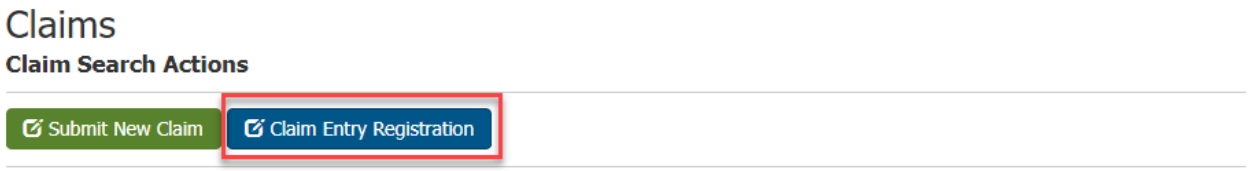
Part B providers who submit paper claims using the CMS-1500 claim form can register to submit claims through the portal. Since portal claims are processed as electronic claims, paper billers can receive many of the same benefits of electronic claim submission, including quicker payment of claims. This option is only available to Part B providers who are not already registered to submit electronic claims through traditional electronic data interchange (EDI) methods.

Registering for Claim Entry Through the Portal

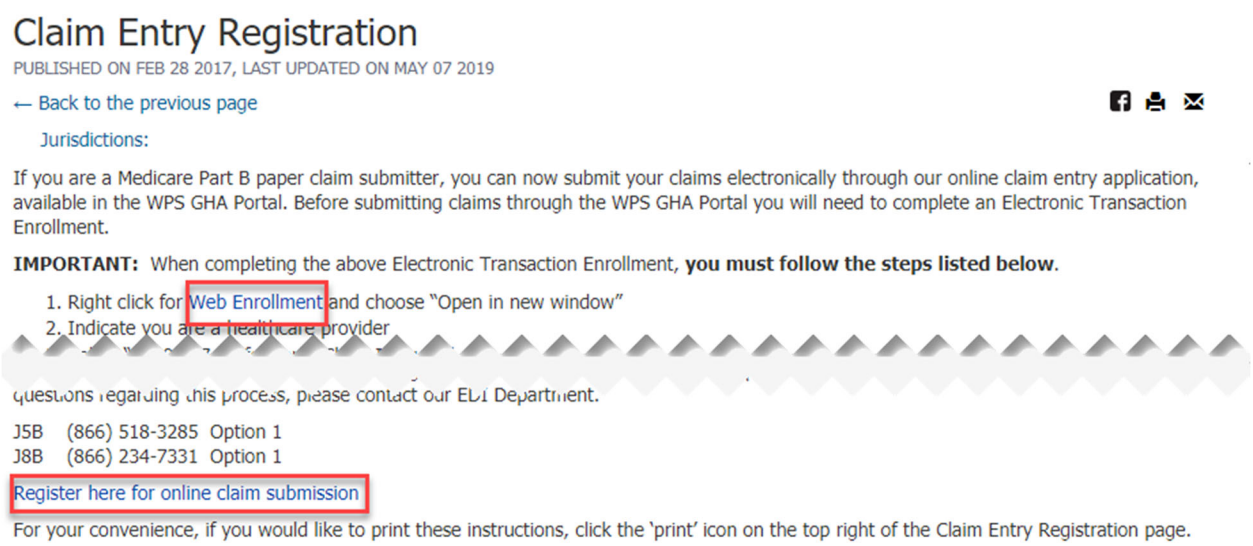
1. From the left navigation menu, select the Claim Inquiry/Entry link from the Claims menu.



2. Click the Claim Entry Registration button to open the registration instructions.



3. Click one of the links to the registration form in the instructions. We recommend printing the instructions or opening the form in a separate window to ensure you complete the registration form correctly.


Claim Entry Registration

PUBLISHED ON FEB 28 2017, LAST UPDATED ON MAY 07 2019

← Back to the previous page

Jurisdictions:

If you are a Medicare Part B paper claim submitter, you can now submit your claims electronically through our online claim entry application, available in the WPS GHA Portal. Before submitting claims through the WPS GHA Portal you will need to complete an Electronic Transaction Enrollment.

IMPORTANT: When completing the above Electronic Transaction Enrollment, **you must follow the steps listed below.**

1. Right click for Web Enrollment and choose "Open in new window"
2. Indicate you are a healthcare provider

questions regarding this process, please contact our EDI Department.

J5B (866) 518-3285 Option 1
J8B (866) 234-7331 Option 1

Register here for online claim submission

For your convenience, if you would like to print these instructions, click the 'print' icon on the top right of the Claim Entry Registration page.

4. Use the data in the instructions to complete the EDI Express Enrollment form. If you have any questions about the enrollment process or the form, contact the WPS Electronic Data Interchange (EDI) department for assistance.

5. The WPS EDI staff will send an email notifying you when your enrollment is complete. Please allow up to 30 days to process your request.

NOTE: Your ability to submit claims through the portal is tied to your User ID. If your User ID is ever disabled, be sure to reactivate your existing User ID instead of creating a new one. If you create a new User ID, you will need to re-enroll to continue submitting claims through the portal under your new username.

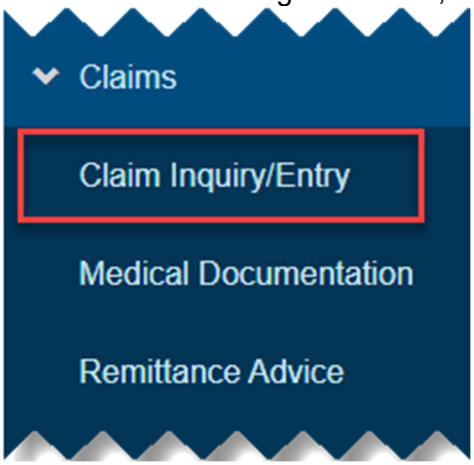
Submitting Part B Claims Through the Portal

Providers enrolled and approved to submit claims through the portal can submit most types of Part B claims through the portal. The following types of claims CANNOT be submitted through the WPS Government Health Administrators Portal:

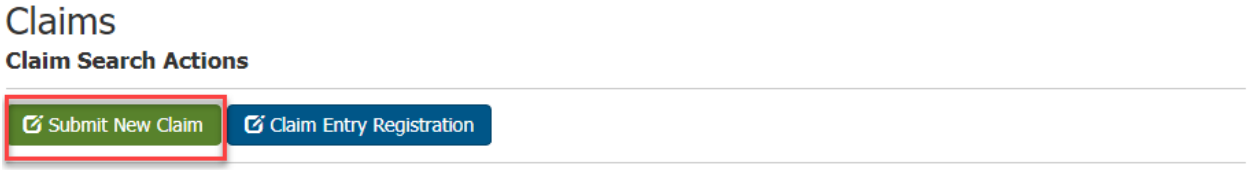
- Medicare Secondary Payer (MSP)
- Medigap (i.e., claims that require the provider to enter the supplemental insurer's information in Item 9 of the CMS-1500 claim forms)
- Hospice (i.e., place of service 34)
- Purchased services (i.e., anti-markup tests, formerly known as purchased diagnostic tests)

General Instructions for Portal Claim Entry

1. From the left navigation menu, select the Claim Inquiry/Entry link from the Claims menu.



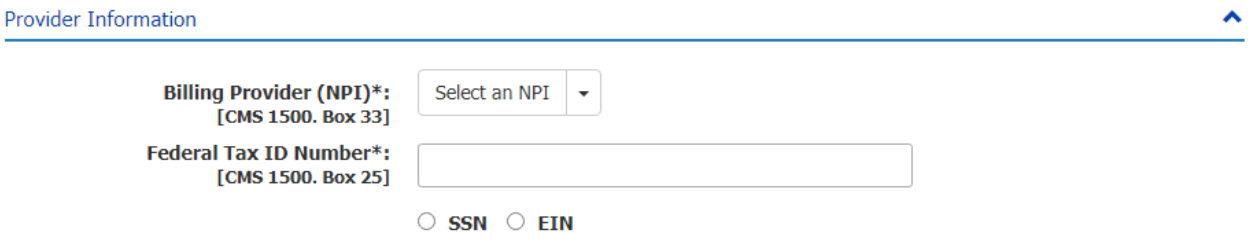
2. Click the Submit New Claim button to open the claim form.



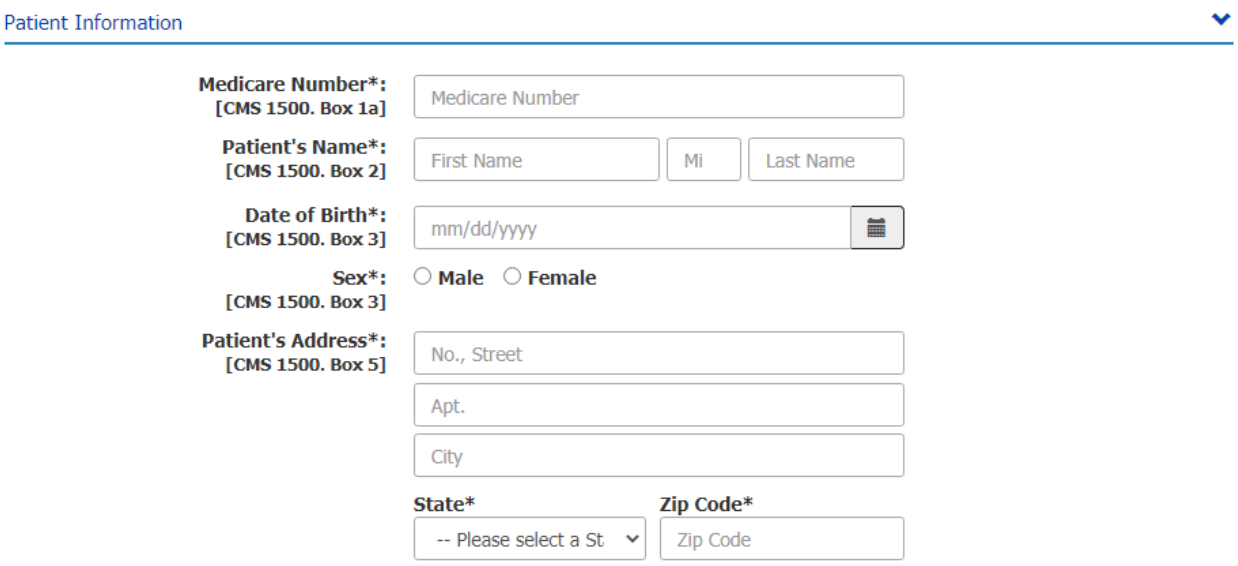
3. You will enter information into the portal claim form in a different order than you do on the paper CMS 1500 claim form. For your convenience, most fields refer to where the information appears on the CMS 1500 claim form.

4. Complete all fields marked with an asterisk (*) in each section. Depending on the type of service you are billing, you may also be required to complete some fields that are not marked with an asterisk.

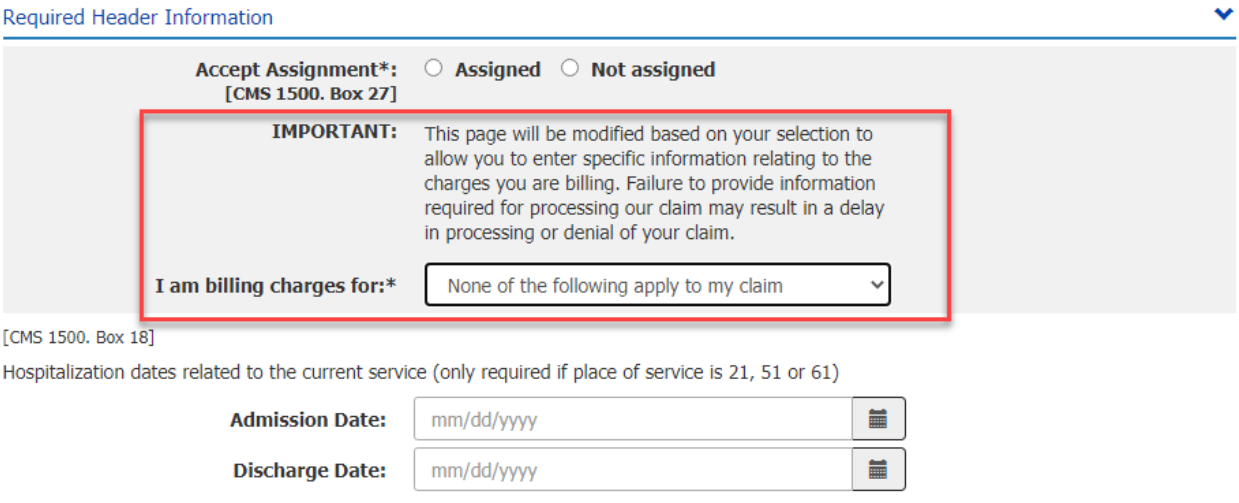
5. Enter the billing provider's information. Below the Federal Tax ID Number field, be sure to indicate what type of tax ID number is entered (e.g., SSN for Social Security Number or EIN for Employer Identification Number).



6. Enter the patient's information. The patient's name should match the information on their Medicare card.

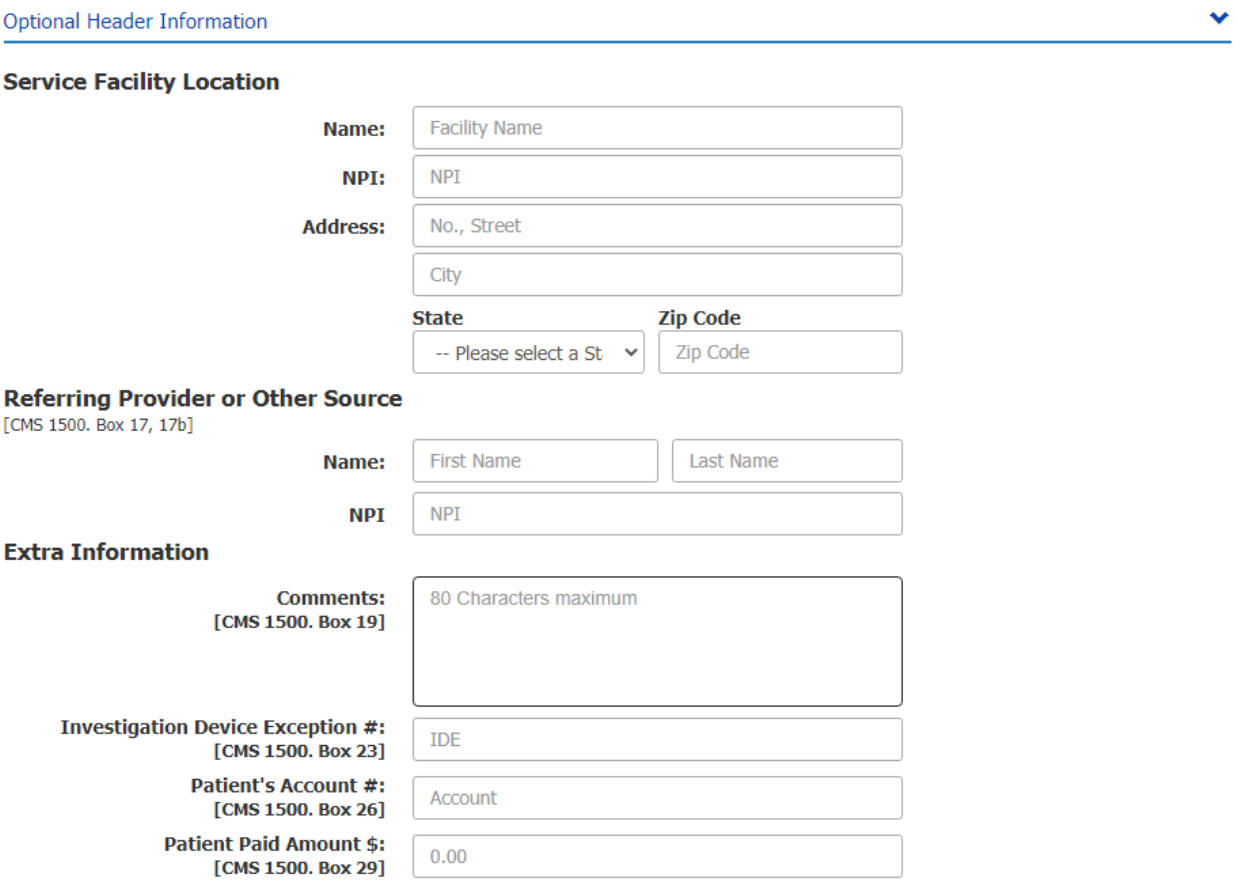


7. Enter the required header information.
   - **NOTE:** You must select one of the following options in the drop-down box shown below:
     - None of the following apply to my claim (Select if you are billing for services other than the ones listed.)
     - Ambulance Service
     - Global Surgery
     - Laboratory
     - Chiropractic Service
     - OT/PT
     - Inpatient Services
     - Mammography
   - Depending on the type of service selected, the portal claim form will display additional claim fields that must be completed for Medicare to process your claim. See the Claim Entry Instructions for Specific Claims section below for more information.

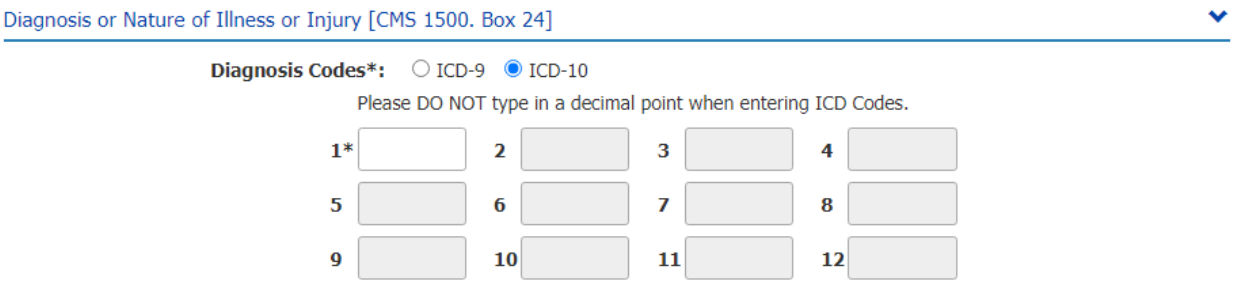


8. Enter the optional header information. which includes the service facility information (name, NPI, and full address), the referring provider information (name and NPI), and other miscellaneous data.

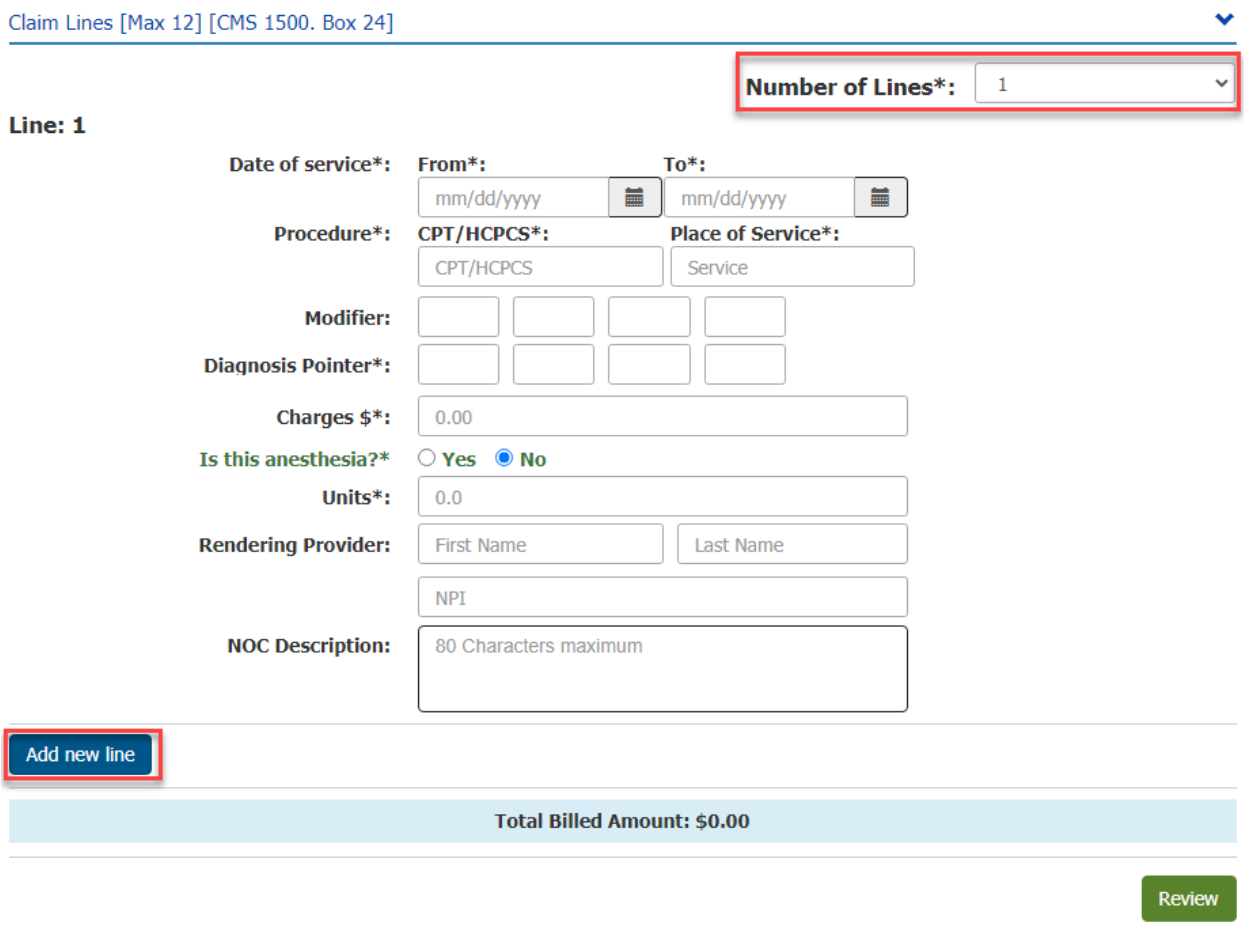
   NOTE: "Optional" in this section means the information is not required for all claims. Depending on the type of service you are billing, the information in this section **may be required** to process your claim. Failure to include the information may make your claim unprocessable or result in an overpayment or underpayment.
   - Do not list more than one ordering/referring provider per claim. Submit separate claims for each ordering/referring provider.
   - The Comments field (i.e., Item 19 on the CMS 1500 claim form) allows up to 80 characters.
   - Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an approved IDE clinical study. (See (https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies) for more information about IDEs.)
   - The Patient Account number field is for the provider's tracking purposes. It will appear on the remittance advice. Medicare does not use this information to process the claim.
   - The Patient Paid Amount field is only used to report payments your **patient** made out-of-pocket. Do not use this field to report a primary payment by another insurer or your claim will not be paid correctly.



9. Enter the diagnosis codes that apply to the claim.
    - Enter the primary diagnosis in the first position.
    - Enter any additional diagnosis codes that apply to the claim in the remaining fields.
    - Leave the fields blank if they do not apply.
    - Do not enter decimal points.



10. Enter claim line details.
    - Modifier: List modifiers that affect payment before modifiers that are informational only.
    - Diagnosis Pointer: Enter the number corresponding to the diagnosis codes listed in the Diagnosis Codes section (i.e., numbers 1-12) of the claim. Do not enter the full diagnosis code.
    - Anesthesia: If you indicate the line item is for anesthesia, the Units field will change to Minutes to allow you to enter the number of anesthesia minutes.
    - NOC Description: If you enter a “not otherwise classified” (NOC) or unlisted code, enter a description of the code. The description can be up to 80 characters. Do not use an NOC code if a valid true code exists.



11. To add additional lines of service to the claim, select the total number of lines from the drop-down box in the upper right corner of Line 1, or click “Add new line” at the bottom of each claim line to add lines one at a time.

12. Click the Delete Line button that appears next to the second and subsequent lines if you accidentally add too many lines of service to the claim.

13. Once you enter all claim lines, click the Review button to review the claim. After clicking the Review button, an Edit button and a Submit button will also appear.

14. The portal will review your claim for errors and display a message at the top of the Claims page indicating what needs to be corrected. Click the Edit button to correct errors or make other changes. (NOTE: The portal does not perform front end editing of your claim. The claims processing system could still reject your claim for incomplete or invalid information after it is submitted.)

15. When you are satisfied the claim is entered correctly, click the Submit button to submit your claim to Medicare and receive a confirmation number. You can print the confirmation page for your records. If Medicare’s claims processing system rejects your claim, the confirmation number will be referenced in your educational material.

16. Allow three business days before checking the status of your claim in the WPS Government Health Administrators Portal or the Interactive Voice Response (IVR) system.

Claim Entry Instructions for Specific Claims

Some commonly rendered services require providers to include additional information on their claims for payment. When selecting one of the services below from the drop-down box in the Required Header Information section, the portal will provide additional fields that must be completed:

- **Ambulance Services**
  - Pick up Location Address: Enter the complete address where the patient was picked up.
  - Drop-off Location Name and Address: Enter name of the facility and the complete address where the patient was dropped off.
  - Reason for Transport: Select the main reason for the transport.
  - Purpose of Round Trip: Explain the reason for a round trip, if appropriate.
  - Stretcher Purpose Description: Explain the reason the patient needed to be transported by stretcher.
  - Transport Distance in Miles: The transport distance is required when a reason for transport is selected.
  - Condition of patient: Select all conditions that apply to the ambulance service.

- **Chiropractic Service**
  - Initial Treatment Date: Enter the date the chiropractor initiated the course of treatment.

- **Global Surgery**
  - Assumed Care Date: Enter the date the provider assumed post-operative care of the patient (if post-operative care was shared with another provider)
  - Relinquished Care Date: Enter the date the provider relinquished post-operative care of the patient.

- **Inpatient Services**
  - Admit Date: Enter the date the patient was admitted to the facility.
  - Discharge Date: Enter the date the patient was discharged from the facility, if known.

- **Laboratory**
  - CLIA#: Enter the 10-digit Clinical Laboratory Improvement Amendments (CLIA) number of the laboratory that performed the lab procedure(s).
  - Referring CLIA#: Enter the 10-digit CLIA number for the referring laboratory if the lab specimen was referred to another laboratory for testing.

- **Mammography**
  - Mammography Certification #: Enter the six-digit FDA certified Mammography Certification number.

- **Occupational Therapy/Physical Therapy (OT/PT)**
  - Date Last Seen: Enter the date the patient last saw the supervising provider
  - Supervising Physician Name: Enter the first and last name of the attending physician/non-physician practitioner (NPP)
  - Supervising Physician NPI: Enter the NPI of the attending physician/NPP
  - NOTE: The supervising physician’s name and NPI are optional; however, if you enter information in one of these fields, you must complete them all.

- **Routine Foot Care**
  - Date Last Seen: Enter the date the patient last saw their attending physician.
  - Supervising Physician Name: Enter the attending physician's name.
  - Supervising Physician NPI: Enter the attending physician's NPI.

Clerical Error Reopenings (CER)

The Clerical Error Reopening (CER) process allows Part B providers to correct minor errors or omissions on claims processed in the Multi-Carrier System (MCS). The WPS Government Health Administrators Portal allows providers to make changes to certain claim information on a processed claim and receive immediate notification that the claim adjustment has been accepted into MCS.

Situations that Can Be Handled as a Clerical Error Reopening

In most cases, the following situations can be processed as a CER:

- Increase number of services or units (without an increase in the billed amount)
- Add/Change/Delete modifiers such as 24, 25, 54, 57, 58, 59, 76, 78, 79, 80, 95, AS, AQ or GA (Note: Post operative modifiers 24, 25, 57, 58, 78 and 79 can be added to a paid claim so the provider can submit a procedure code without having it reduced by the unrelated visit.)
    - Excluded modifiers: 22, 23, 53, 55, 62, 66, 74, and CR present on the claim, even if this is not the line being adjusted.
- Procedure Codes
    - Excluded: Not Otherwise Classified codes and drug codes present on the claim, even if this is not the line being adjusted
- Place of service
- Add or change a diagnosis.
- Billed amounts (without an increase in the number of units billed)
- Change Rendering Provider National Provider Identifier (NPI)
- Date of service. The date of service change must be within the same year

Situations that Cannot Be Handled as a Clerical Error Reopening

CMS regulations do not allow a Medicare contractor to process a claim reopening if the change would require Medicare to make a new claim determination. If the change would require a new claim determination, providers should usually request a redetermination (appeal) instead of performing a reopening. Situations that cannot be handled as a CER in the portal:

- Adding lines of service not submitted on the original claim (Medicare would have to make a new (initial) claim determination on the additional services.)
- Increasing both the number of services **and** the billed amount (In effect, this would be adding services to the claim.)
- Reopening an unprocessable (rejected) claim (Unprocessable claims have not had an initial claim determination, so they would require a new claim determination. Submit a new claim to correct an unprocessable claim.)
- Comprehensive Error Rate Testing (CERT) issues
- Provider Enrollment issues
- Claim denial due to no response to a development request

- Wrong payee situations
- Complex claim situations (Not Otherwise Classified codes, claims with modifiers 22, 23, 53, 55, 62, 66, 74, or CR.)
- Claims that require analysis of documentation
- Issues that require CMS input (e.g., services after date of death)
- Adjusting a previously adjusted claim

In addition, providers can only reopen a claim once via the WPS Government Health Administrators Portal, so it is important to update all applicable fields before submitting the CER. (For example, you cannot submit a CER to change the date of service and then submit another CER to correct the diagnosis code once the adjustment is finalized.)

Time Limit for Requesting a Clerical Error Reopening (H2)

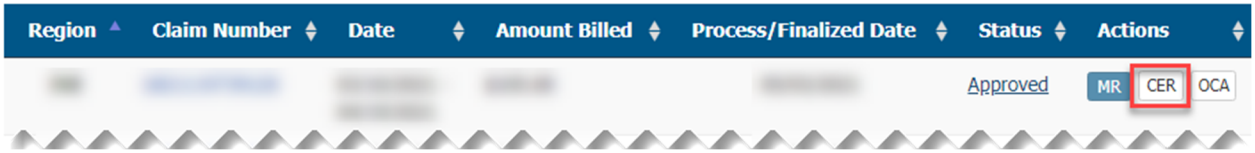
A provider, physician, or supplier may request a reopening up to one year from the receipt of the initial Remittance Notice. If the provider, physician, or supplier would like to request a reopening after the one-year time limit has expired, they may request the reopening in writing.
You must include documentation supporting good cause to waive the timeliness requirement. See the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 34 - *Reopening and Revision of Claim Determinations and Decisions* (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf), section 10.11 for information regarding good cause.

You can use our Reopening Calculator (https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/reopening-calculator) to find the deadline for submitting a reopening request.

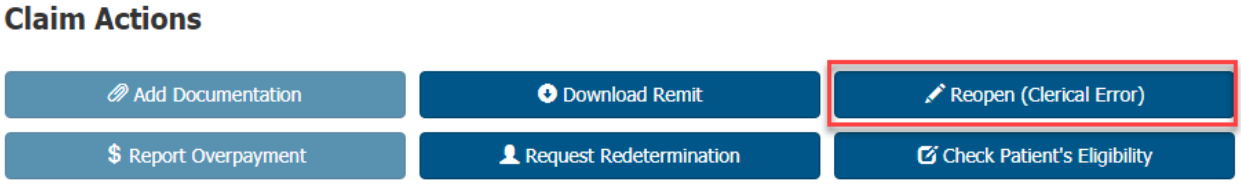
Submitting a CER through the WPS Government Health Administrators Portal

Step 1: All CERs begin by locating the claim in the portal using the Claim Inquiry function. Once you locate the claim, start the reopening by clicking on the CER or Reopen (Clerical Error) button. You can find these buttons in the following places:

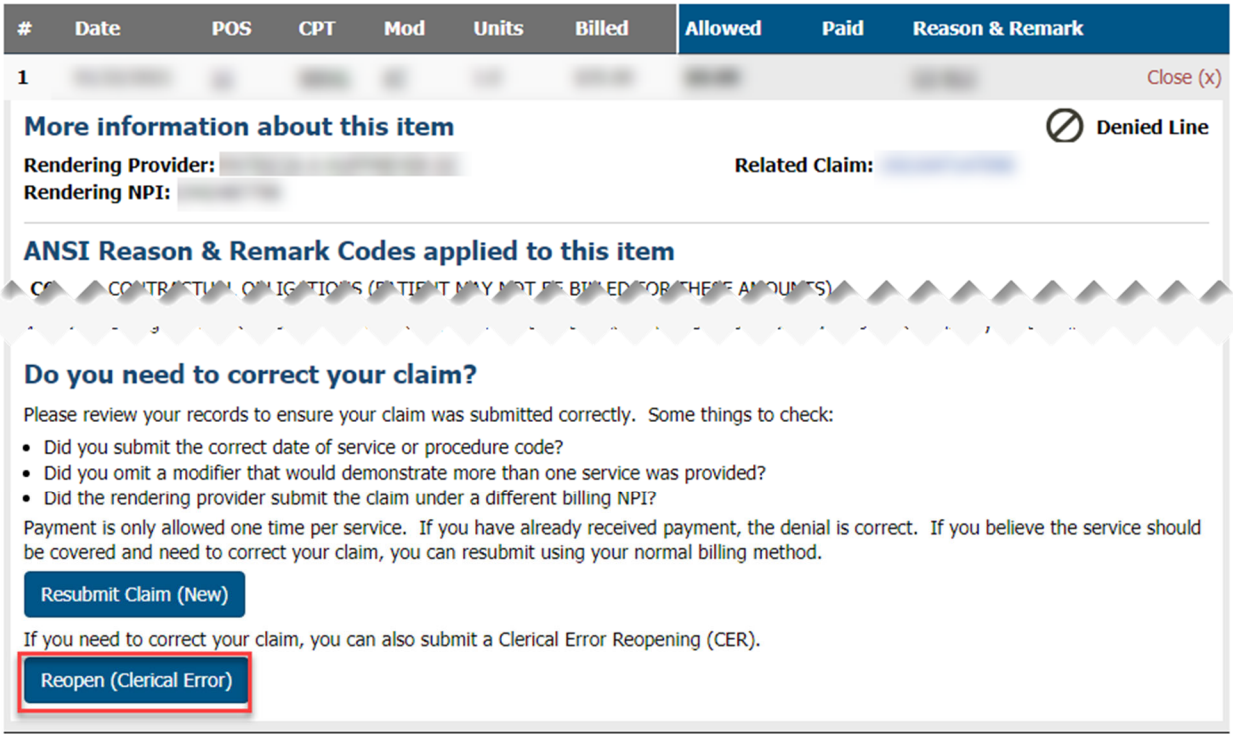
- On the Claim Results page after searching for the claim using the Claim Inquiry function



- In the Claim Actions area after selecting the claim in the Claim Results



- In the Claim Details section of a denied claim after clicking on the More Info button

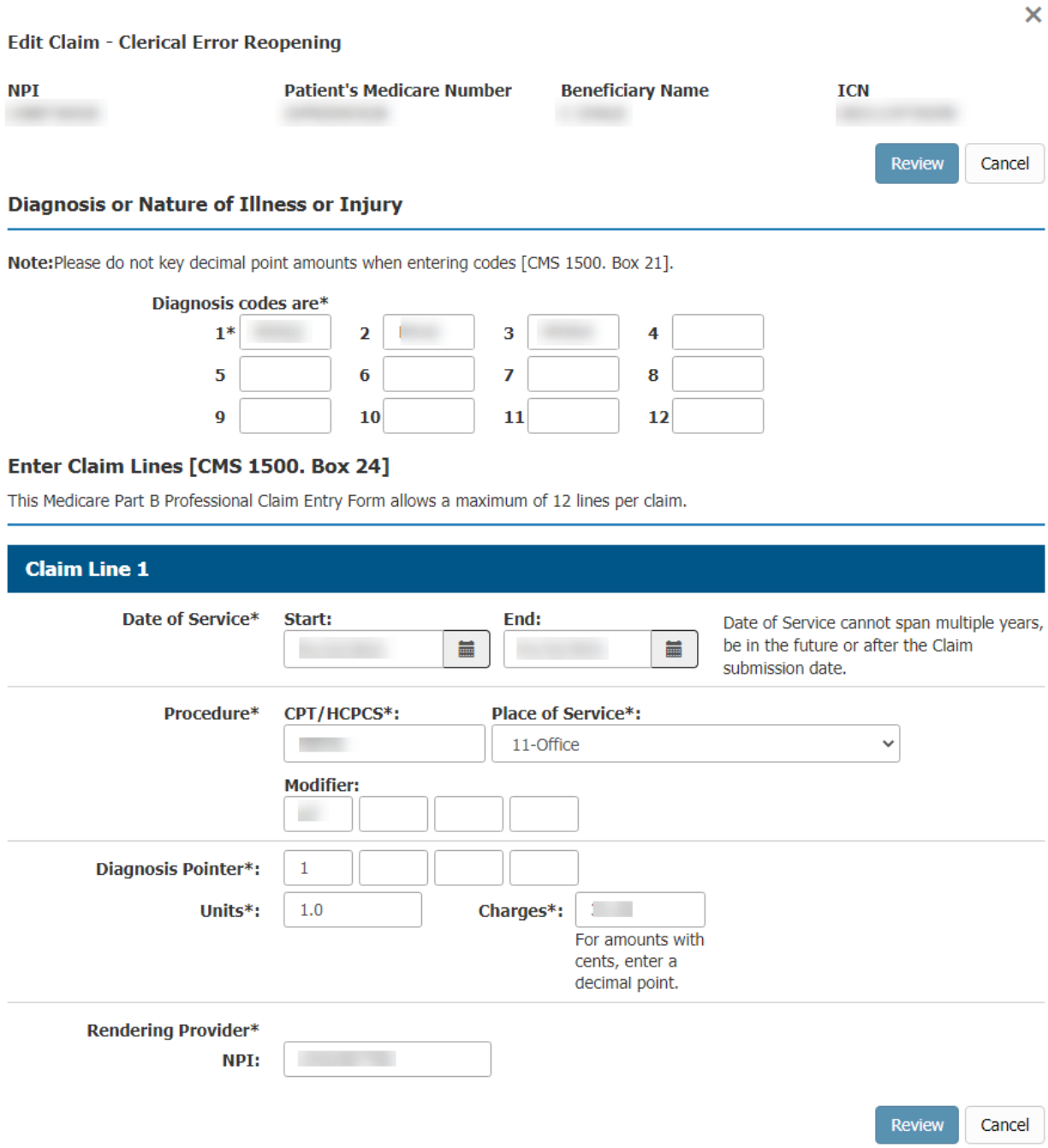


NOTE: If the claim is not eligible for a Clerical Error Reopening, the CER/Reopen (Clerical Error) button will not be active, and you will not be able to select it.

Step 2: The CER/Reopen (Clerical Error) button opens the Edit Claim – Clerical Error Reopening form. Make all necessary changes to the claim.

- If you update the billed amount, the portal will ask if the if the change is a “Fee Schedule Change.”

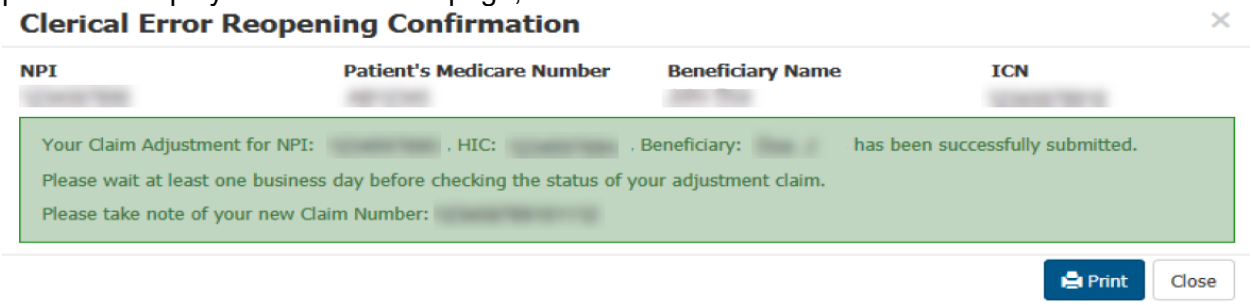
- Select Yes if the change is due to Medicare updating the amount it allows for the procedure code.
- Select No if you are updating the billed amount for any other reason.



Step 3: Click the Review button to have portal review the claim for errors. If the changes pass the review, the portal will display the message, “Your information has been successfully reviewed, to finalize your adjustment request, click the Submit button.” (See below for errors that may cause the claim to fail the review.)

If you need to make corrections, click the Edit button to make changes, or click the Cancel button to cancel the reopening request.

Step 4: Once you are satisfied with the updates to your claim, click the Submit button. The portal will display the confirmation page, which contains the new claim number.



Common CER Error Messages and Their Causes

Claim processed more than 1 year ago. Reopening not allowed unless good cause can be established. Please see IOM 100-4 Chapter 34 Section 10.11 to determine if good cause exists. If so, submit request in writing with good cause documentation.
Cause: Medicare allows claim reopenings within one year of the initial claim determination for any reason. Medicare can also allow claim reopenings within four years but only if good cause exists (as defined by CMS) to perform the reopening. For reopenings requested more than one year after the initial determination, providers must submit the request in writing to provide documentation proving the good cause requirement is met.

Claim has been previously adjusted, please submit a redetermination request.
Cause: Claim has been previously adjusted due to a reopening or a previous redetermination. Proceed to the next appropriate level of appeal to request an adjustment to the claim.

Procedure code not valid or Place of Service not valid for Procedure code - reopening not allowed for this change.
Cause: The place of service does not match the procedure code billed, or the procedure code is not valid. Since the information would cause the claim to deny again, a reopening cannot be completed.

Requested diagnosis code is invalid, please recheck diagnosis code. No reopening allowed for invalid diagnosis code.
Cause: An invalid diagnosis code will cause the adjustment to deny.

Claim cannot be reopened because there is no initial determination for this claim. Please submit a new corrected claim or wait until the claim in process has finalized.
Cause: Medicare can only reopen a claim with an initial determination that has finalized. If the claim was rejected as unprocessable (i.e., the remittance advice shows remark code MA-130), it has never had an initial determination, and you should submit a new claim with the necessary corrections. If the claim is still in a pending status, it has not finalized, you will need to wait to request a reopening until the claim finishes processing to request a reopening. (You can use the claim status feature to determine the status of the claim preventing you from requesting the reopening.)

Due to complex nature of the requested change this request cannot be handled as a reopening. Please submit redetermination request.
Cause: A claim adjustment that requires Medicare to review documentation is not considered a minor error or omission. Adjustments involving modifiers 22, 23, 53, 55 62, 66, 74, and CR require Medicare to review documentation and are therefore too complex to process as a clerical error reopening. You will need to resubmit a redetermination request with the appropriate documentation.

Due to the complex nature of this claim, you must submit a redetermination request.
Cause: The claim is for a CPT procedure code ending with a “99” (e.g., 01999, 33999, 99499, etc.). These codes are generally “not otherwise classified” (NOC) or unlisted procedure codes. Since Medicare needs to review documentation to determine the procedure performed, as well as determine Medicare’s coverage and payment, adjustments to these codes cannot be done as a reopening.

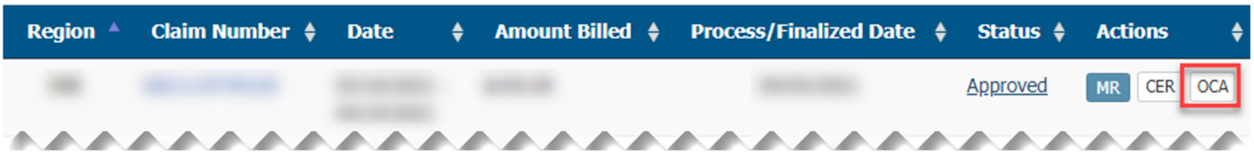
Overpayment Claim Adjustments (OCA)

Providers are required to notify Medicare of overpayments and repaying Medicare in a timely manner. Medicare Part B providers can notify Medicare of an overpayment by performing an Overpayment Claims Adjustment (OCA) in the WPS Government Health Administrators Portal. Providers can report both Medicare Secondary Payer (MSP) related overpayments and non-MSP related overpayments using the OCA process.

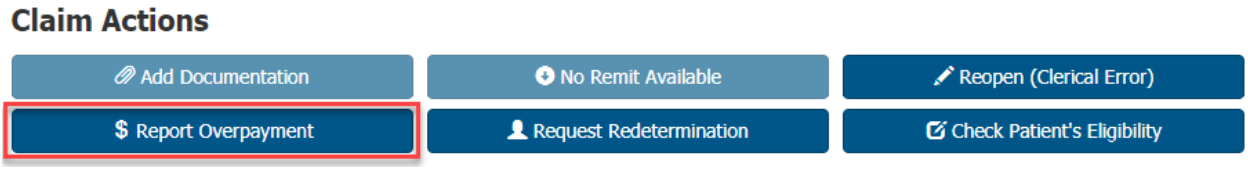
Submitting an OCA through the WPS Government Health Administrators Portal

Step 1: All OCAs begin by locating the claim in the portal using the Claim Inquiry function. Once you locate the claim, start the adjustment process by clicking on the OCA or Report Overpayment button. You can find these buttons in the following places:

- On the Claim Results page after searching for the claim using the Claim Inquiry function



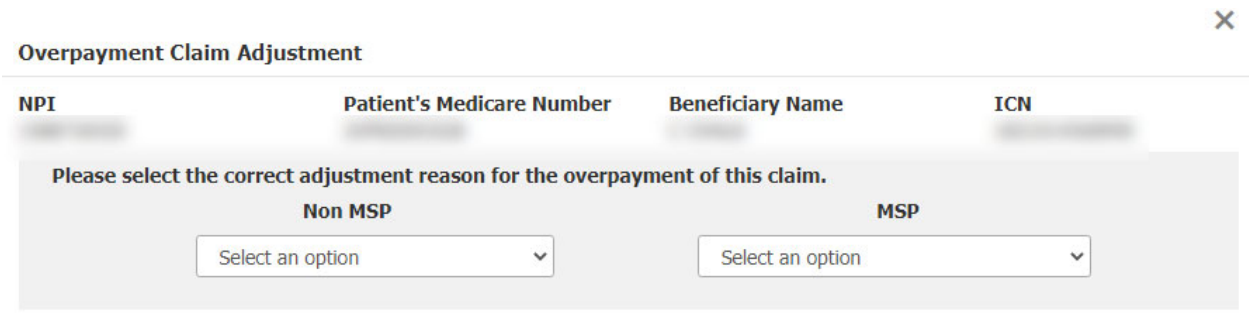
- In the Claim Actions area after selecting the claim in the Claim Results



NOTE: If the claim is not eligible for an Overpayment Claim Adjustment, the OCA/Report Overpayment button will not be active, and you will not be able to select it.

Step 2: The OCA/Report Overpayment button opens the Overpayment Claim Adjustment form where you need to indicate the reason for the overpayment.

- If the overpayment was not related to a Medicare Secondary Payer (MSP) situation, select the reason for the adjustment from the dropdown box under the Non MSP heading.
- If the overpayment was related to an MSP situation, you need to select the type of primary insurance (working aged, liability/no-fault, workers' compensation, etc.) from the dropdown box under the MSP heading. If you are unsure of the primary insurance type, use Eligibility Check to confirm.



NOTE: If you select an MSP option, but the patient does not have that type of primary payer on file, you will not be able to complete your OCA. You or your patient should contact the Benefits Coordination and Recovery Center (https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page) to update the patient's records. Once the patient's eligibility record is updated, you can submit your OCA.

In addition, if you select one of the non-MSP options below, but Medicare's eligibility records do not have a record of the corresponding information, you will not be able to complete the OCA. Contact the applicable insurer/facility/provider to update the patient's records or to clarify the patient's status.

- Patient enrolled in HMO/MCO (i.e., a Medicare Advantage plan)
- Patient enrolled in SNF
- Home Health
- Hospice

Step 3: Make the appropriate adjustments to the line(s) of service you are correcting. Note that the types of adjustments you can make on an OCA are limited.

- On non-MSP OCAs, you can only correct the number of units billed and/or change the billed amount. For all other non-MSP adjustment, you can only deny the lines of service that processed incorrectly. After the OCA is processed, you can resubmit those service(s) correctly.
- On MSP OCAs, you can only add the primary payer's processed claim information.

Step 4: Click the Review button to have portal review the claim for errors. If the changes pass the review, the portal will display the message, "Your information has been successfully reviewed, to finalize your adjustment request, click the Submit button."

If you need to make corrections, click the Edit button to make changes, or click the Cancel button to cancel the adjustment request.

Step 5: Once you are satisfied with the updates to your claim, click the Submit button. The portal will display the confirmation page, which contains the new claim number.

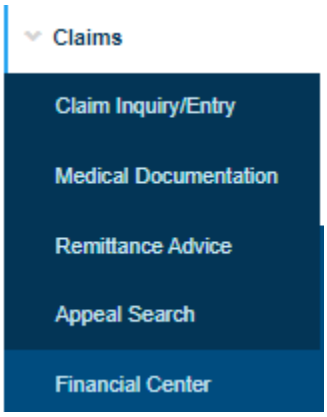
Medical Documentation Requests

Providers can use the WPS Government Health Administrators Portal to submit medical documentation for pre- and post-payment reviews. These are the reviews initiated by the Medical Review department.

Providers can also use the portal to search for documentation previously submitted for a pre- or post-payment review.

Please note, documentation for PWK or in response to Fiscal Intermediary Standard System (FISS) reason code U5601, should not be uploaded via the portal.

You can access the Medical Documentation function by selecting the Medical Documentation link under the Claims heading in the left navigation menu. (If you do not see the Medical Documentation link, click the arrow next to the Claims heading to open the Claims menu.)



NOTE: Providers who disagree with a claim determination and want to submit supporting documentation should not follow the instruction in this section. See the Appeal Submission section of this manual for information about requesting a redetermination.

Determining the Type of Medical Review

Before uploading your documentation, you need to determine if Medicare is conducting a prepayment review or a post-payment review. To avoid processing delays or possible claim denials, you must select the correct type of review when uploading your documentation.

You will find the information in the letter Medicare sent you requesting the documentation.

- If your letter indicates it is an Additional Documentation Request (ADR), Medicare is conducting a **prepayment** review.
- If your letter indicates Medicare is conducting Post Pay Review and contains a list of the selected claims, Medicare is conducting a **post-payment** review.

Documentation Requirements in the Portal

The portal accepts the following file types:

- .docx

- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip

Additional documentation tips:

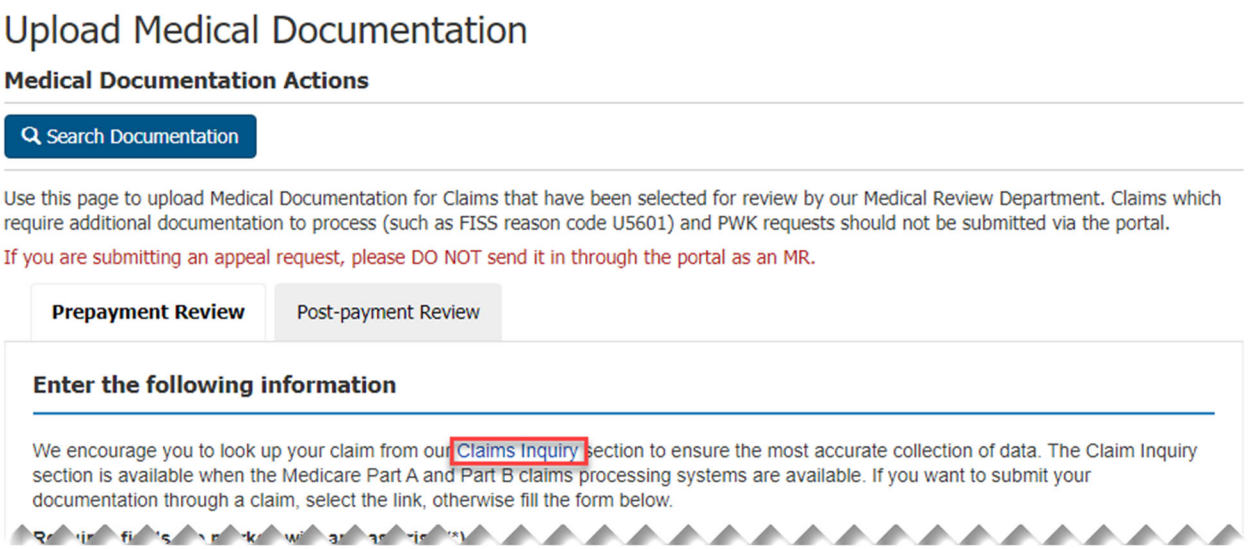
- You can only upload one file per claim. The file size cannot be larger than 100 MB.
- If you have multiple files to provide, all files must be included in a single .zip file.
- If you submit a .zip file, it shall contain no more than 60 files, and all files within the .zip file must be in one of the formats listed above.
- We cannot accept documents that have password protection, macros, or external links.

Uploading Documentation for a Prepayment Medical Review (ADR Response)

There are two methods for uploading documentation for a prepayment review. The more accurate method uses the Claim Inquiry function. However, this method is only available when the claims processing system is online. If you need to respond to an ADR letter when the claims processing system is offline, portal users can upload documentation using the prepayment review tab.

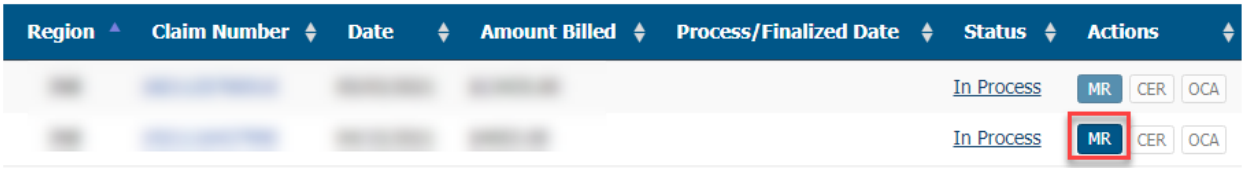
Uploading Documentation for a Prepayment Medical Review Using Claim Inquiry

The most accurate way to submit documentation in response to an ADR letter is to begin by locating the claim using the Claim Inquiry function. You can access the Claim Inquiry function by selecting the link in the left navigation menu or by using the link located on the Medical Documentation page:

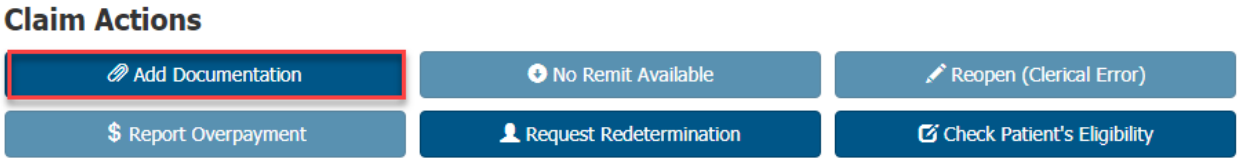


Step 1: Once you locate the claim using the Claim Inquiry function, you can start the upload by clicking on either the MR button or the Add Documentation button. You can find these buttons in the following places:

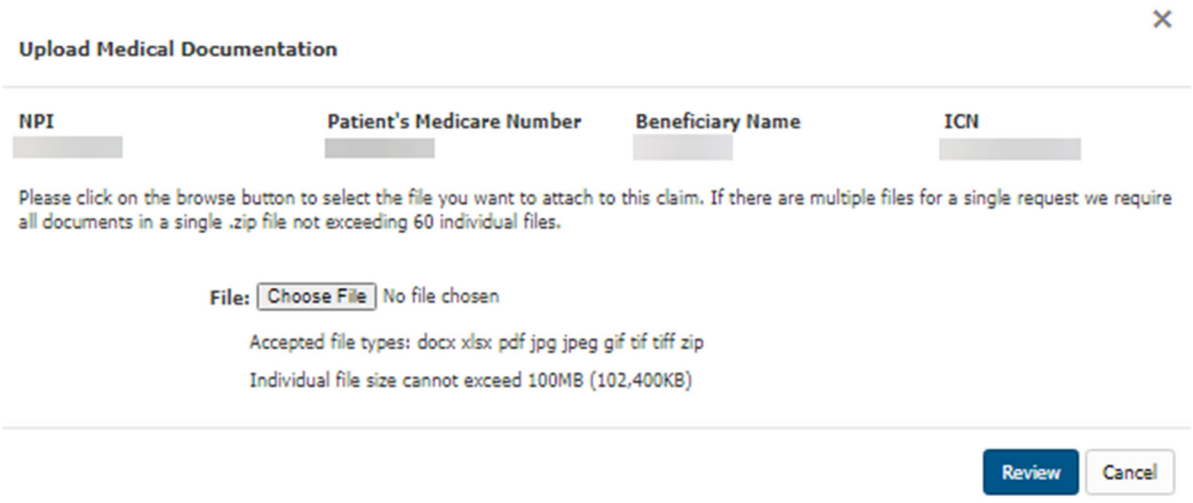
- On the Claim Results page after searching for the claim using the Claim Inquiry function (**NOTE:** The MR button will be dark blue if it is available. If the button is light blue, you cannot upload documentation for that claim.)



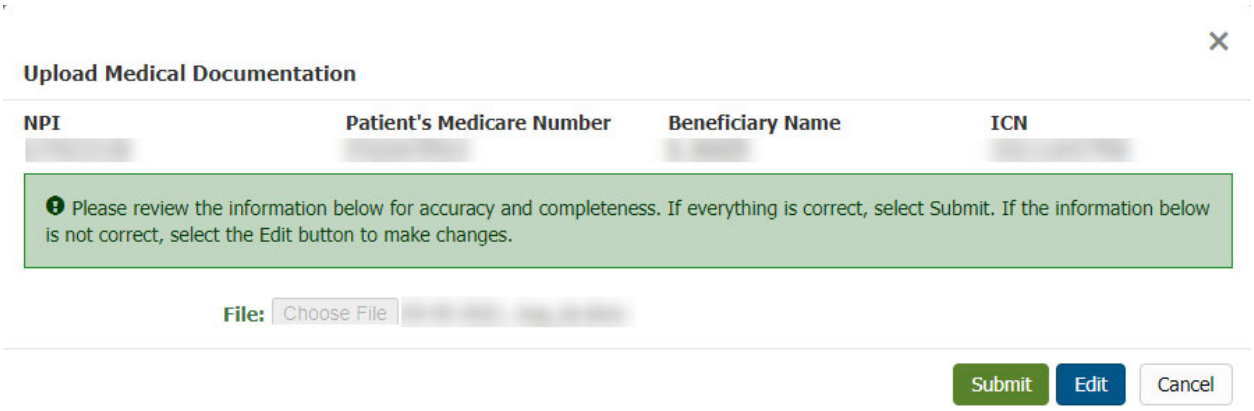
- In the Claim Actions area after selecting the claim in the Claim Results (**NOTE:** The Add Documentation button will be dark blue if it is available. If the button is light blue, you cannot upload documentation for that claim.)



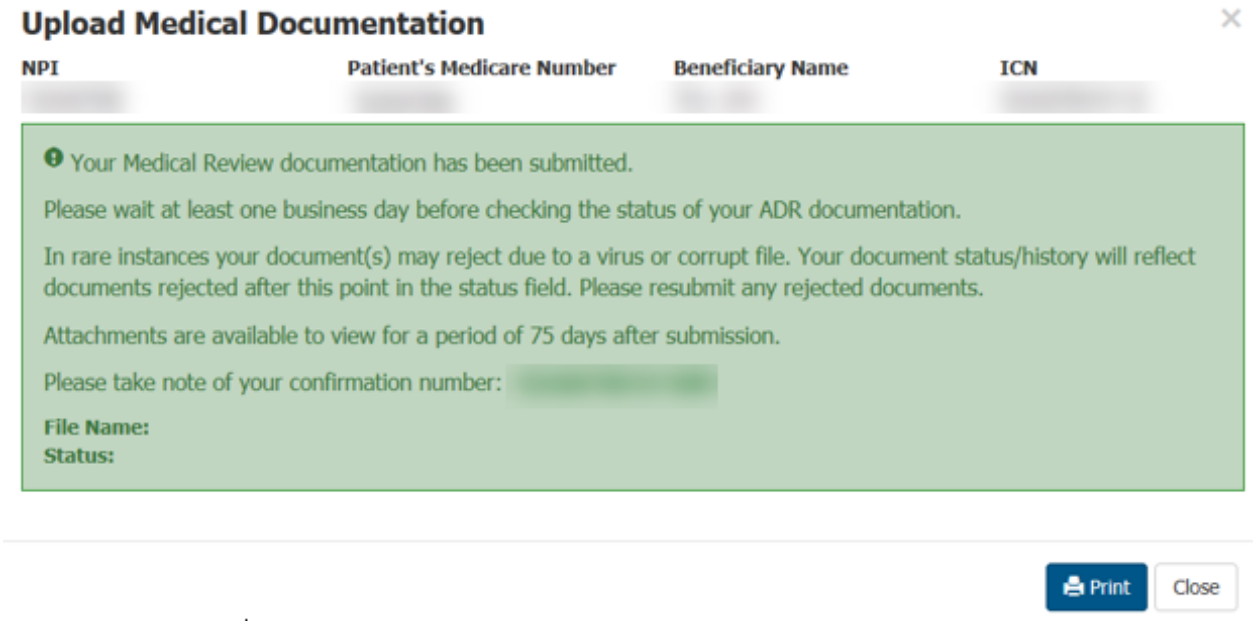
Step 2: After clicking the MR/Add Documentation button, a pop-up box will open allowing you to upload your documentation. Click the Choose File button to select a file from your computer to upload. After selecting the file to upload, click the Review button to review your information for accuracy and completeness.



Step 3: Choose the Submit button to upload the documentation, the Edit button to make changes, or the Cancel button to end the process.



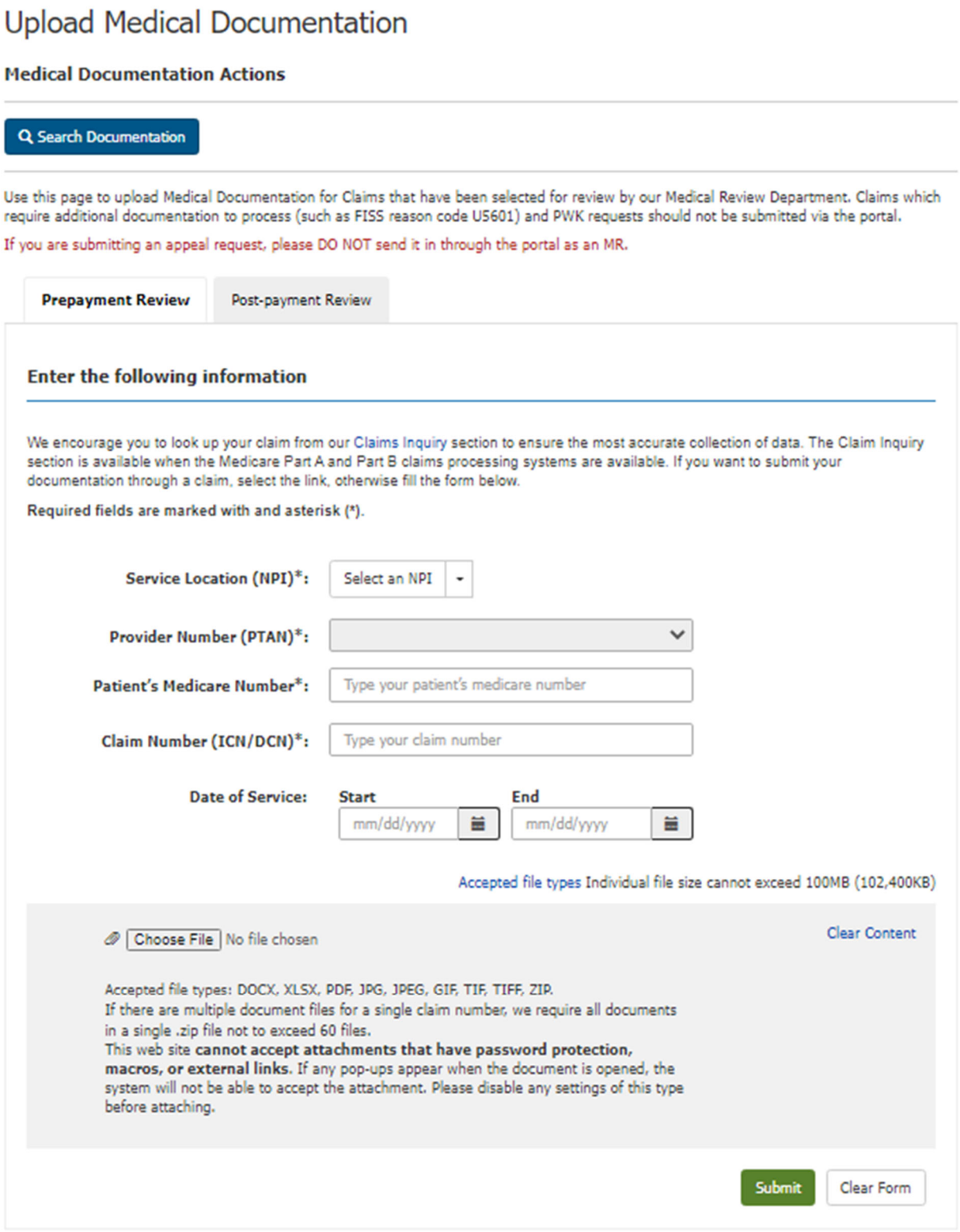
Step 4: After uploading your documentation, you will receive a confirmation message containing a confirmation number. Select the Print button to print the page or the Close button to return to the claim detail page.



Uploading Documentation Using the Prepayment Review Tab

If you are unable or choose not to use the Claim Inquiry function to locate your claim before uploading documentation, you can use the Prepayment Review tab. You will need to supply additional information to use the Prepayment Review tab to upload documentation.

Step 1: Access the Medical Documentation function by clicking the link in the left navigation menu, then click the Prepayment Review tab.



Step 2: Enter the following information in the available fields:

- Service Location (NPI)
- Provider Number (PTAN)
- Patient's Medicare Number

- Claim Number (ICN/DCN)
- Date of Service

Be sure to verify the information you entered is accurate to avoid unnecessary delays or denials.

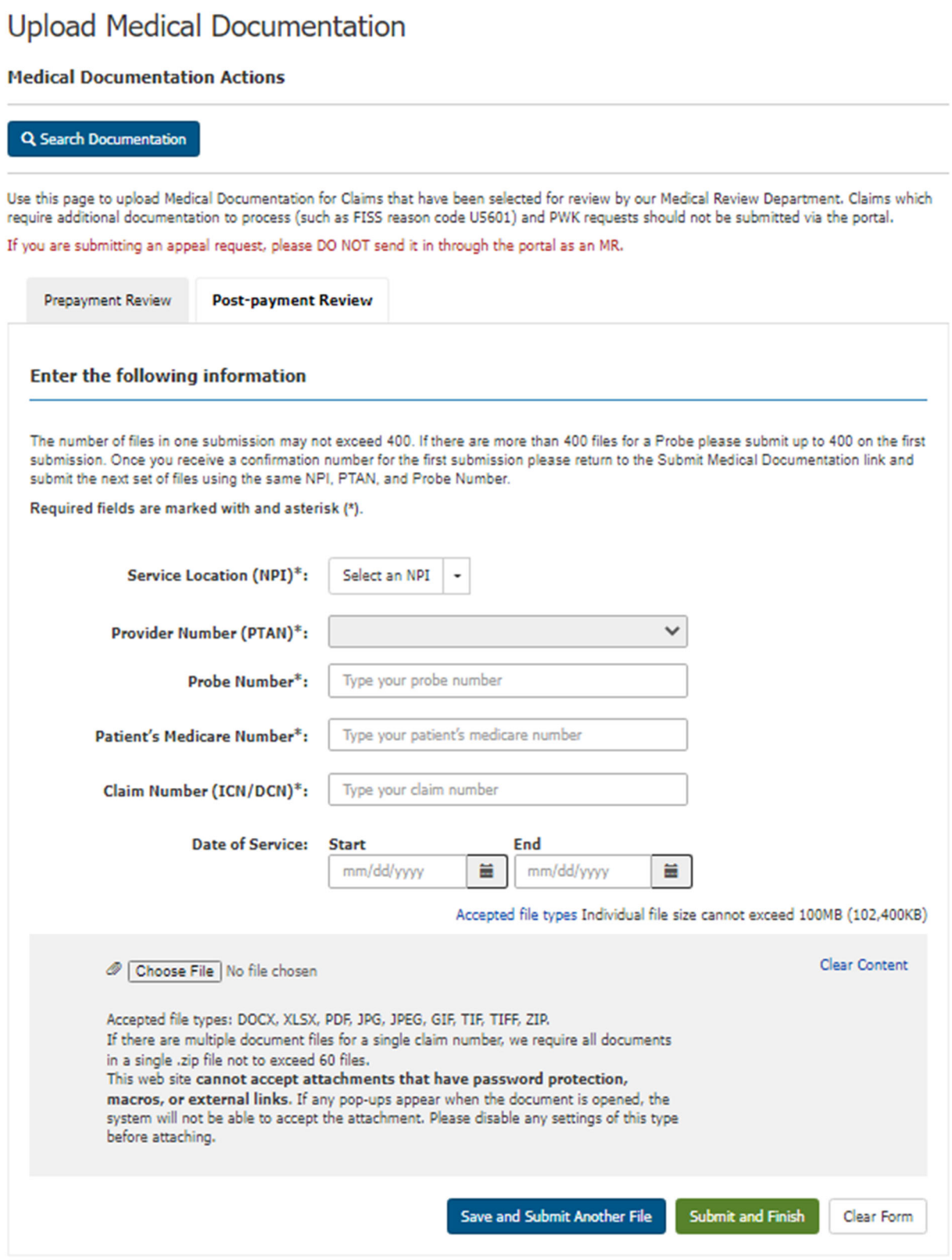
Step 3: Click the Choose File button and select the file you want to upload from your computer.

Step 4: Confirm the information you entered is accurate and click the Submit button to upload the documentation. Once you successfully upload the documentation, you will see a confirmation message with a confirmation number. You can print the information for your record or click OK to return to the previous screen.

Uploading Documentation Using the Post-Payment Review Tab

Unlike prepayment reviews, which apply to a single, specific claim, post-payment reviews (probes) may involve multiple claims. For this reason, you cannot use the Claim Inquiry function to start submitting documentation for a post-payment review.

Step 1: Access the Medical Documentation function by clicking the link in the left navigation menu, then click the Post-payment Review tab.



Step 2: Enter the following information in the available fields:

- Service Location (NPI)

- Provider Number (PTAN)
- Probe Number
- Patient's Medicare Number
- Claim Number (ICN/DCN)
- Date of Service

Be sure to verify the information you entered is accurate to avoid unnecessary delays or denials.

Step 3: Click the Choose File button and select the file you want to upload from your computer.

Step 4: After confirming everything is correct, click the appropriate button depending on if there are additional claims included in the probe.

- If you have additional documentation to submit for the same probe (for different claim numbers), click Save and Submit Another File.
- If you are done submitting documentation for the probe, click Submit and Finish.

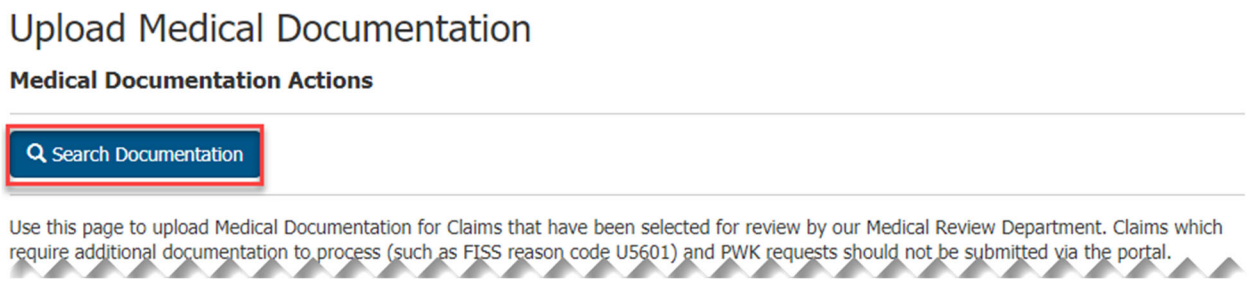
Once you successfully upload the documentation for the probe, you will see a confirmation message with a confirmation number. You can print the information for your record or click OK to return to the previous screen.

NOTE: You can submit documentation for up to 400 claims in one submission. If you have more than 400 claims included in a single probe, submit the documentation for the first 400 claims and receive your confirmation number. You can then repeat the same steps with the remaining claims in the probe. Please be sure to enter the same NPI, PTAN, and probe number.

Searching for Medical Documentation in the Portal

You can search for medical documentation submitted by your service location. This may be helpful several reasons, including if you are unsure if your group has already responded to a medical documentation request.

To search for documentation, navigate to the Medical Documentation page and click the Search Documentation button near the top of the page.



On the Medical Documentation Search page, you can view medical documentation submitted for your service locations (NPIs) and for Medical Review findings. By default, the results will be listed in the order we received them with the most recent listed first. You can click on the column headings to sort by each of the columns.

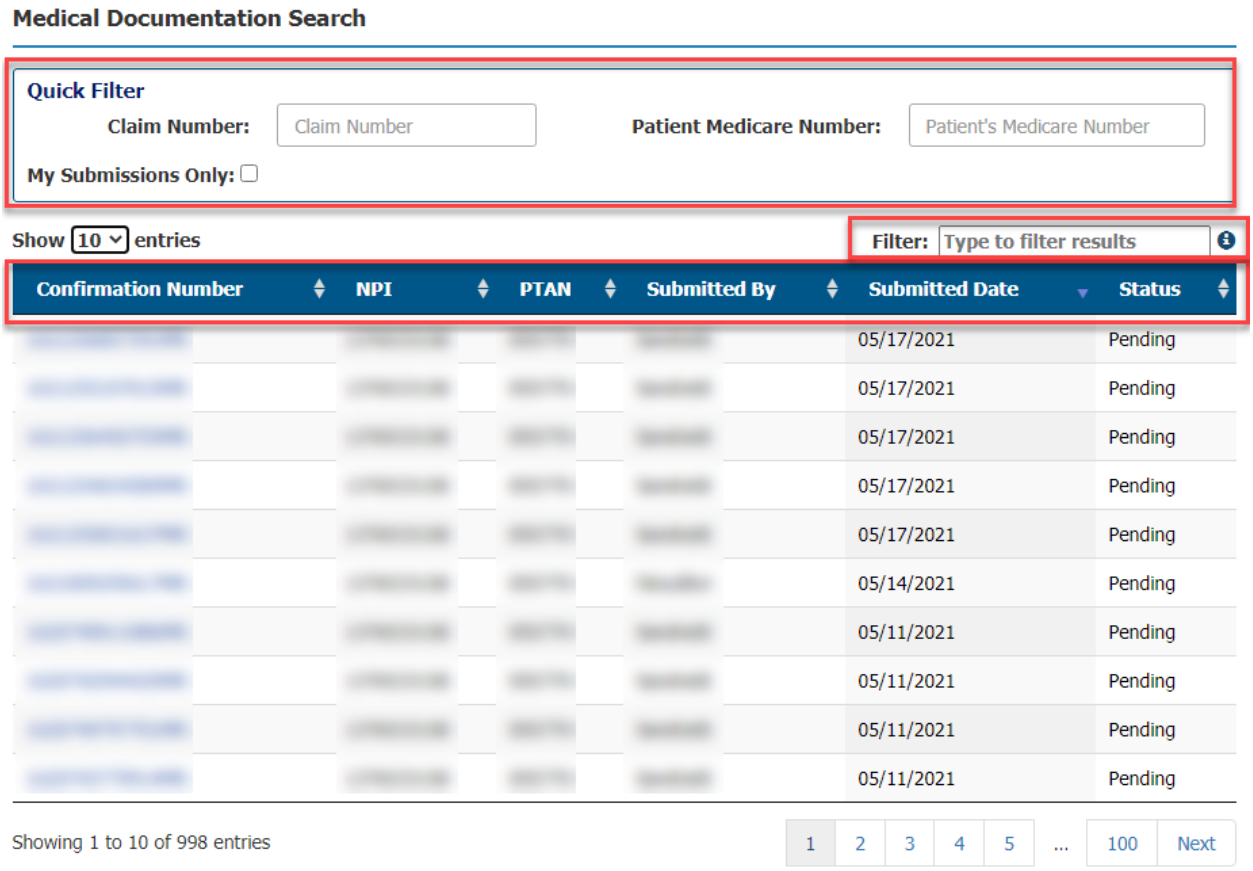
You can search and sort the documentation in the following ways:

- Use the Quick Filter and enter the Claim Number (ICN/DCN)
- Use the Quick Filter and enter the Patient Medicare Number. You will need to search using the MBI if you submitted the documentation with the MBI or the HICN if you submitted the documentation with the HICN.
- Use the “My Submissions Only” button to show only documents you have submitted.
- Use the “Show entries” dropdown to increase the results per page.
- Sort by using the arrows next to the column headings.
- Filter using the “Filter” box. (You can search for any information appearing in the table, such as Confirmation Number or Submitted Date.)

Status Codes:

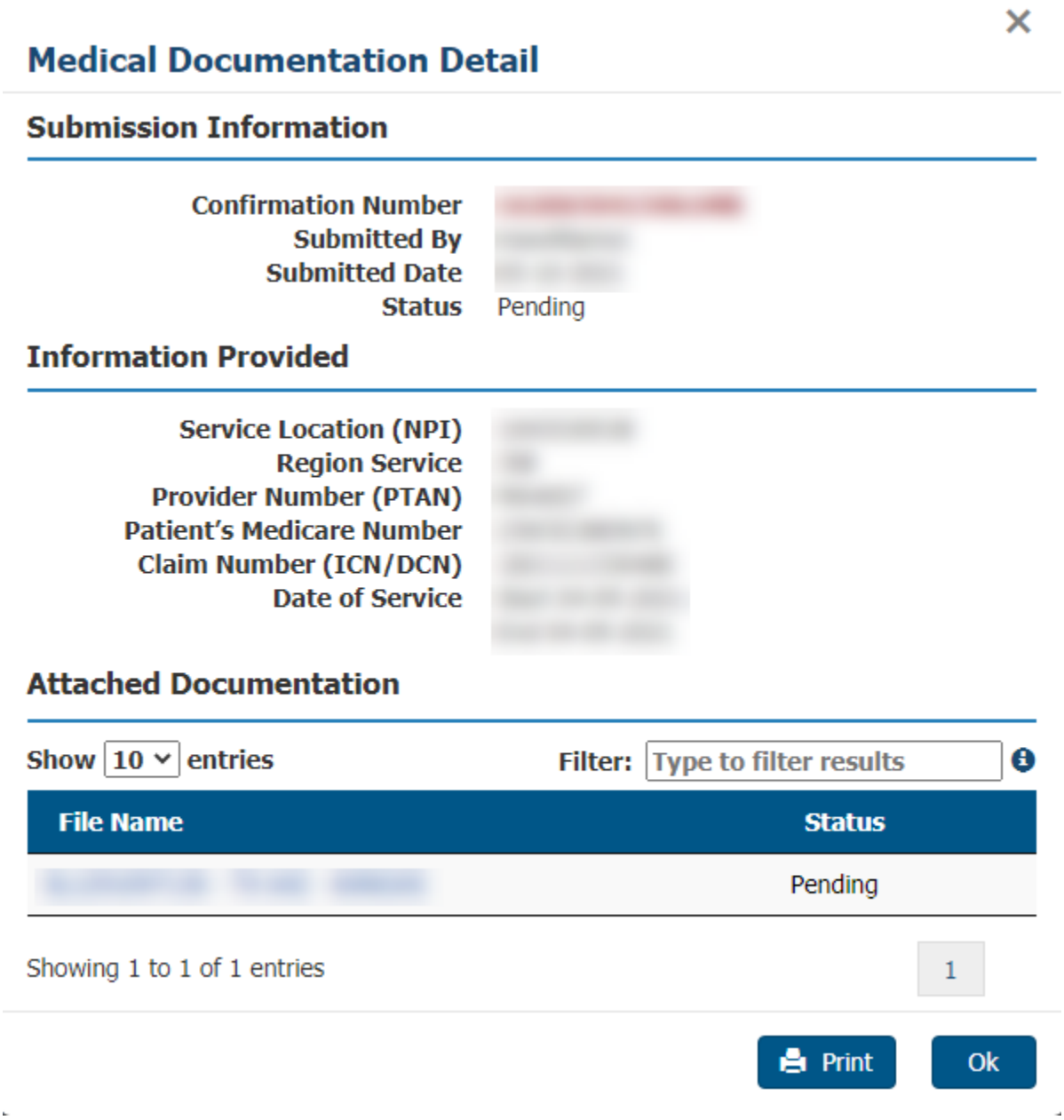
- Received – The attachment has been submitted and is waiting for virus scanning.
- Pending – The Medical Documentation has been received. Medical Documentation submissions will remain in Pending status. The Medical Review Targeted Probe and Educate (TPE) findings will be returned on a new tracking number.
- Completed – The Medical Review findings are available to view.
- Not Accepted – The file was invalid or corrupt. Review the accepted file types and resubmit.

NOTE: Documentation remains in pending status even after our Medical Review staff has reviewed it. For regular claim development responses, you will see the decision on your remittance advice when the claim finalizes. To find the TPE decision, filter on Completed. You will need to search for decisions rendered after you submitted the documentation. A decision is normally rendered within 30 days after documentation is submitted. The response will be from OBUSER in the Submitted By column. You will need to make sure the My Submissions Only box is not checked when searching for a decision.



Once you locate the record you wish to view, click the Confirmation Number link to view the details.

You may also be able to view the documentation submitted by clicking the link under File Name. (This option may not be available for some claims, especially those that are older.)


Medical Documentation Detail
Submission Information
Confirmation Number
Submitted By
Submitted Date
Status
Pending
Information Provided
Service Location (NPI)
Region Service
Provider Number (PTAN)
Patient's Medicare Number
Claim Number (ICN/DCN)
Date of Service
Attached Documentation
Show 10 entries
Filter: Type to filter results
File Name
Status
Pending
Showing 1 to 1 of 1 entries
1
Print
Ok

Remittance Advice and Payment Offset Searches

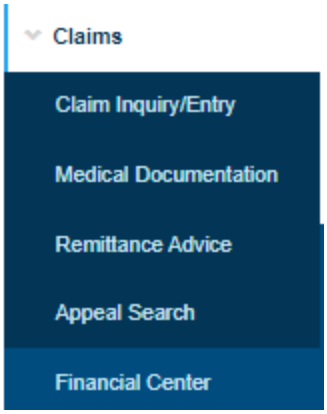
Providers can use the portal to view and print most regular remittance advices. To be available in the portal, the remittance advices must be:

- Issued within the past 13 months
- Not be larger than 150 pages
- Not be for an incentive or bonus payment

NOTE: The portal provides full remittance advices only. You cannot use the portal to obtain a remittance advice for a single claim.

Locating a Remittance Advice Using the Remittance Advice Search

You can access the Remittance Advice function by selecting the Remittance Advice link under the Claims heading in the left navigation menu. (If you do not see the Remittance Advice link, click the arrow next to the Claims heading to open the Claims menu.)

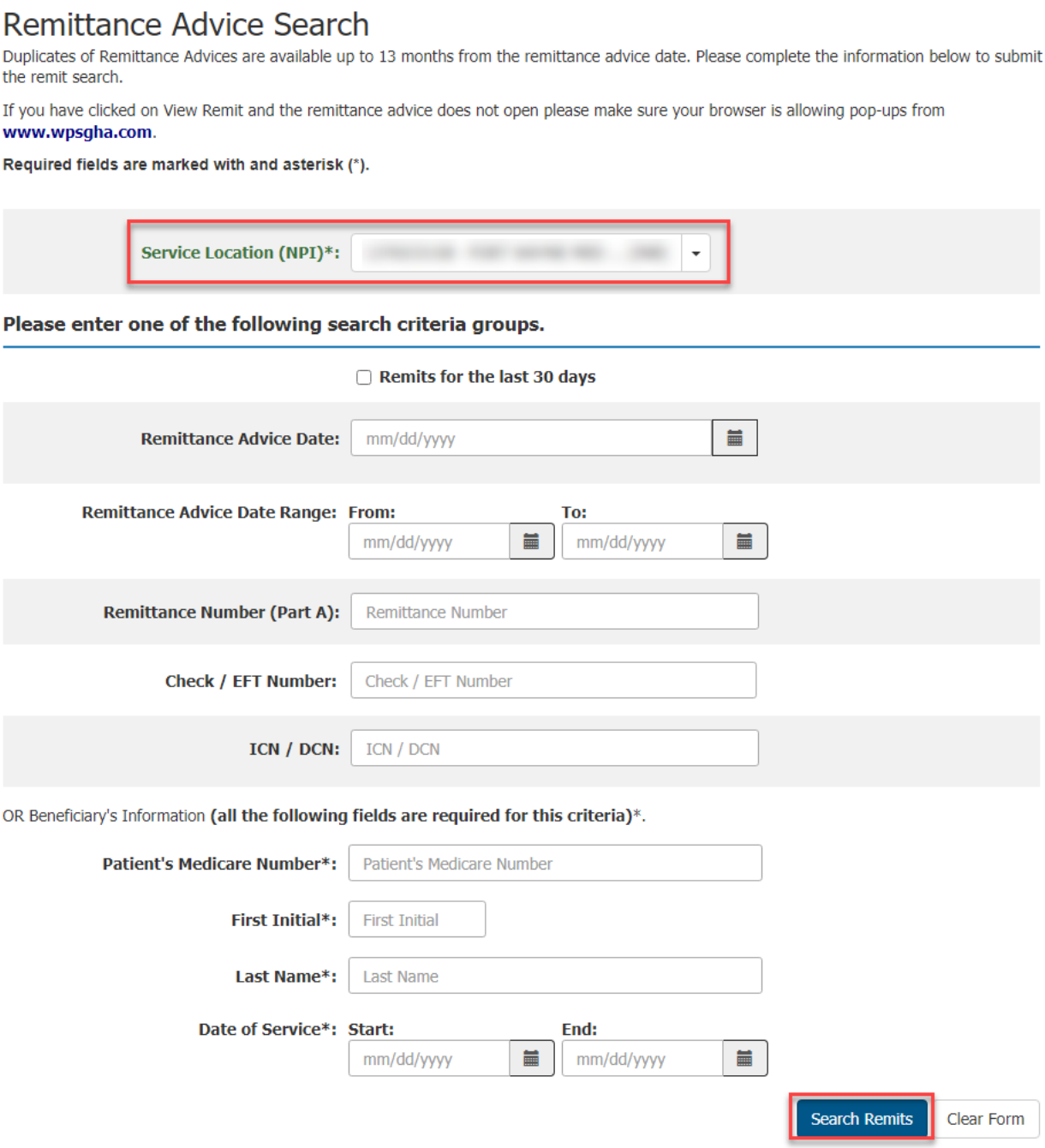


Step 1: Open the Remittance Advice Search and select your service location (NPI) from the dropdown list near the top of the page. If you only have access to one service location, the portal will automatically select it for you.

Step 2: Select your search criteria.

- To view all remittance advices issued within the last 30 days, check the box next to "Remits for the last 30 days."
- To search for a specific remittance advice or one issued more than 30 days in the past, narrow your search using one of these options:
  - Remittance advice date
  - Remittance advice date range
  - Part A remittance number
  - Check/EFT number
  - ICN/DCN
  - Beneficiary and claim information (i.e., patient's Medicare number, first initial and last name, and start/end dates of service)

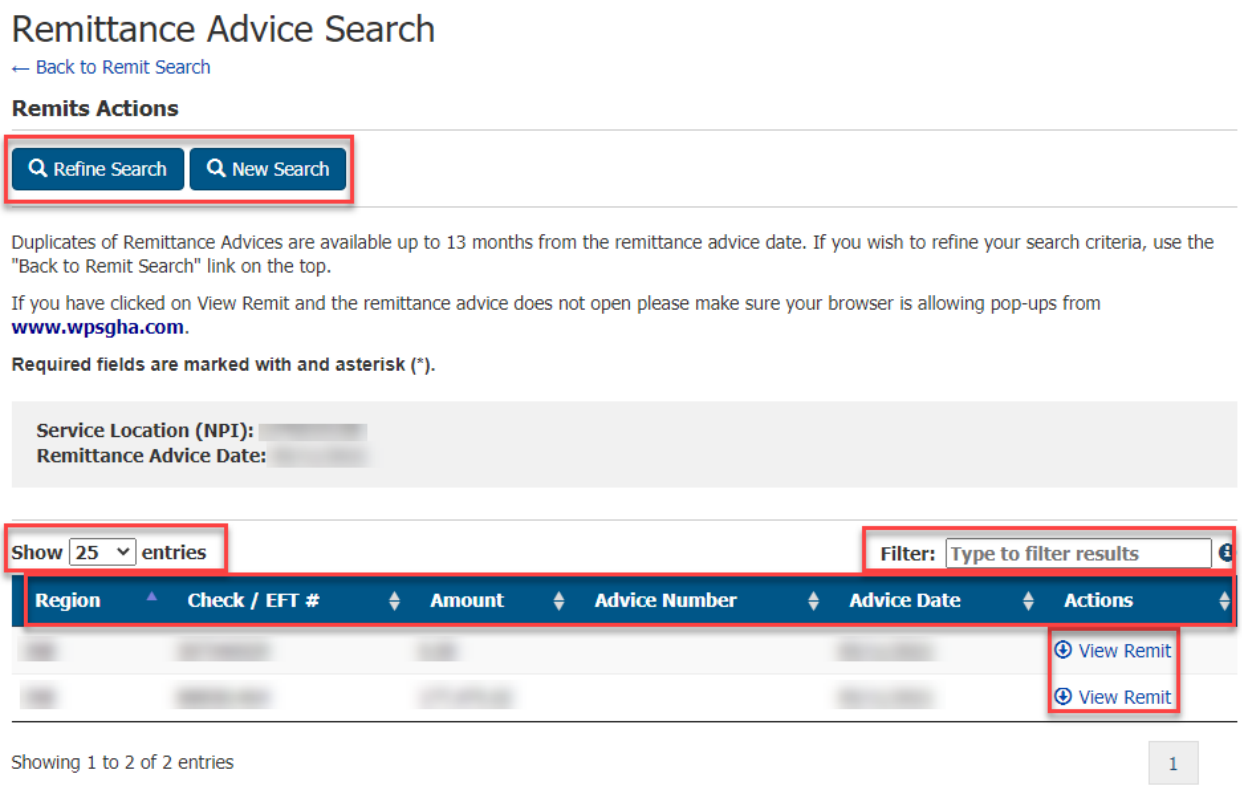
Step 3: Click the Search Remits button at the bottom of the page to locate the remittance advice(s) that meet the criteria you entered.



Step 4: The portal will display any remittance advices that meet your search criteria. For each remittance advice, it will also display the region (i.e., jurisdiction and Part A/Part B), check/EFT number, check amount, remittance advice number (Part A only), and remittance advice date. From the Remits Actions page, you can:

- Choose the View Remit link under the actions heading to view a copy of the remittance advice. **To view a remittance advice, your browser must allow pop-ups from www.wpsgha.com. If your browser blocks pop-ups, right-click on the View Remit link and select "Open Link in New Tab (or Window)" or "Open in New Browser."**
- Select the Refine Search button to refine the current search or the New Search button to start a new search.
- Use the Show Entries dropdown box to change the number of rows viewable on-screen.

- Use the Filter box to filter the results.
- Use the arrows next to the column headings to sort the fields.

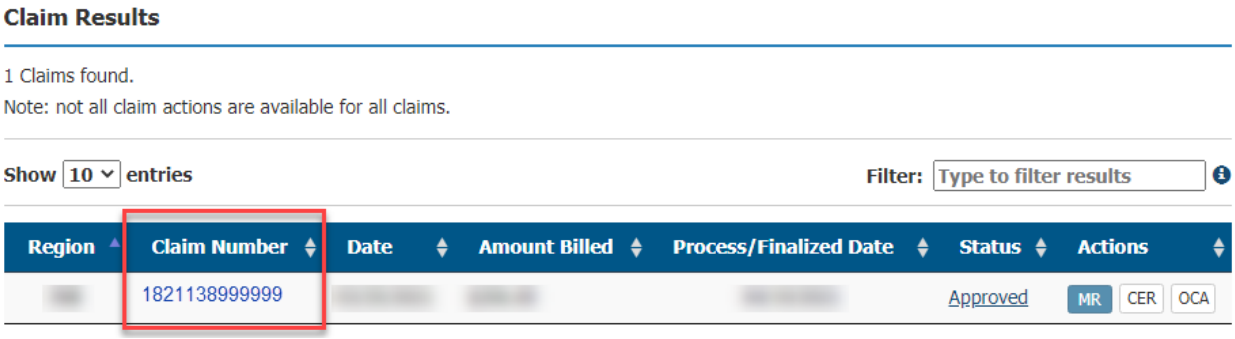


Locating a Remittance Advice Using Claim Inquiry

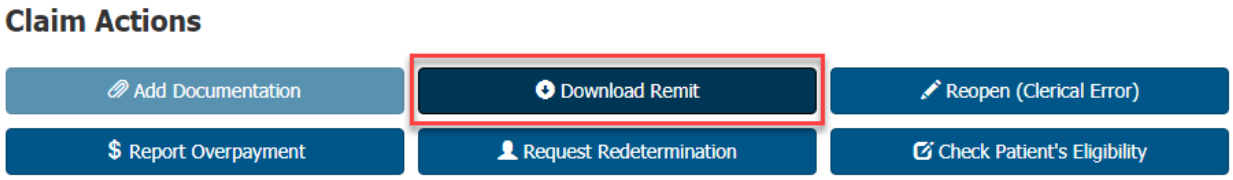
You can use the Claim Inquiry function to view and print the remittance advice issued for a specific claim. Please note that any remittance advice retrieved through the Claim Inquiry function will be the full remittance advice and will contain the same information as the original remittance advice. The portal does not provide remittance advices for individual claims.

Step 1: Locate the claim using the Claim Inquiry function.

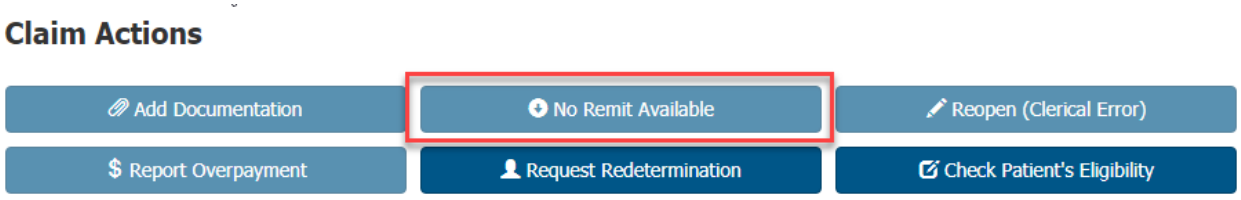
Step 2: On the Claim Results page, click on the claim number to open the claim details.



Step 3: In the Claim Actions section, click Download Remit to open a PDF version of the original remittance advice in a separate browser tab or window. (If your browser blocks pop-ups, right-click on the Download Remit button and select “Open Link in New Tab (or Window)” or “Open in New Browser.”)



If the button is labeled “No Remit Available” instead of “Download Remit,” you cannot download a remittance advice. In most cases, this indicates the claim has not yet finalized or the remittance advice is too large to be displayed.



Locating an Offset Using the Remittance Advice Search

An offset occurs when Medicare recoups an overpayment by withholding payment from a future remittance. Providers can request an immediate offset when learning of an overpayment, or Medicare can initiate an offset if a provider does not refund payment by the due date.

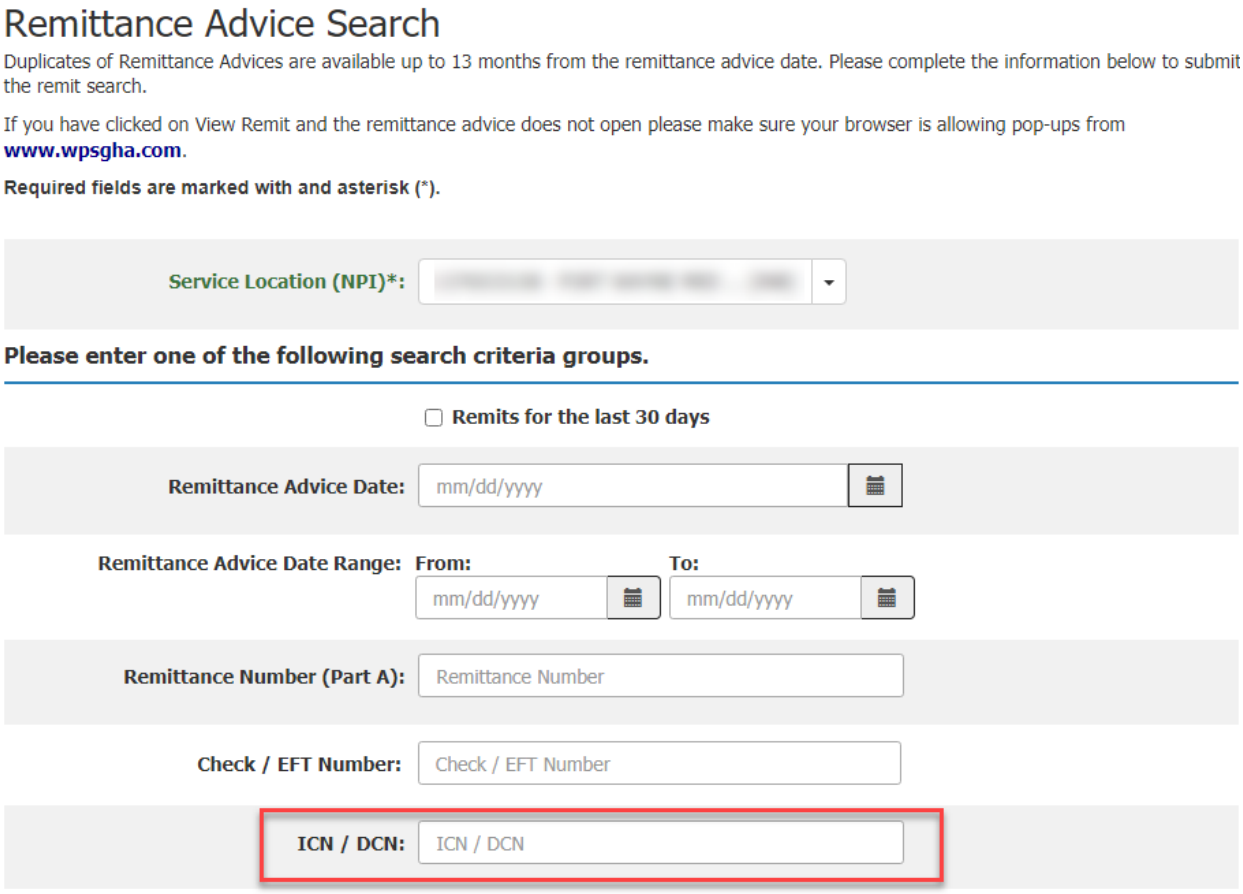
On a Medicare Part B remittance advice, an offset is shown near the end of the remittance advice and can be identified with the PLB reason code “WO.”

You can use the Remittance Advice Search function to identify most Medicare Part B claims Medicare is recouping, as long as **the FCN is 15 digits in length**. The Remittance Advice Search function **cannot** be used to find claims if the FCN ends with the letters “AG.” (These are aggregated offsets involving multiple claims. Contact Payment Recovery for information.)

To determine which claim Medicare is recouping, locate the 15-digit FCN on the remittance advice containing the offset.

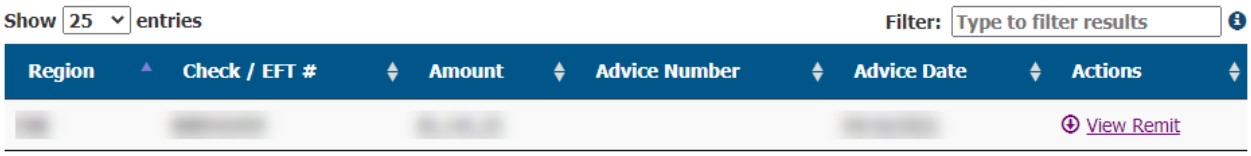
Step 1: Drop the first two digits of the FCN. The resulting 13-digit number is the ICN (claim number) of the adjusted claim that resulted in the overpayment. (For example, if the FCN is 221321140999999, remove the first two digits (22). The remaining 13-digit number, 1321140999999, is the ICN of the adjusted claim.)

Step 2: On the Remittance Advice Search page, enter the 13-digit ICN in the ICN/DCN field and click the Search Remits button at the bottom of the page.



Step 3: If the ICN is valid and processed within the previous 13 months, the portal will provide a link to the remittance advice containing the adjusted claim. Click the View Remit link to open the remittance advice. (If your browser blocks pop-ups, right-click on the Download Remit button and select “Open Link in New Tab (or Window)” or “Open in New Browser.”)

NOTE: Medicare offsets payments based on the EIN/TIN, not the NPI or PTAN. If your organization has multiple NPIs associated with the same EIN/TIN, Medicare may collect the debt under any NPI associated with the EIN/TIN. You must have access to the NPI (service location) the adjusted claim was processed under to view the remittance advice in the portal.



Step 4: Locate the ICN on the remittance advice. You can use Ctrl+F to open a search box to help you find the ICN on document. The remittance advice provides the claim details including the patient’s name, the date of service, and an explanation of how the claim processed. If you need more information about the claim, you can use the Claim Inquiry function to locate the claim shown on the remittance advice.

Appeal Submission and Search Overview

Providers who disagree with a Medicare claim determination generally have the right to appeal Medicare's decision on the claim. Information about the five levels of appeal and their respective requirements is available in our article, "How to Appeal a Claim Determination." (https://www.wpsgha.com/wps/portal/mac/site/appeals/guides-and-resources/how-to-appeal-claim)

Providers can use the WPS Government Health Administrators Portal to submit first and second level appeals. A redetermination is the first level of Medicare appeal and is performed by the Medicare Administrative Contractor (MAC) that made the initial claim determination. A reconsideration is the second level of Medicare appeal and is performed by contractors and entities that were not involved in the initial claim determination or appeal. For claims processed by WPS Government Health Administrators, providers can use the portal to:

- Submit a redetermination request
- Submit a Part A reconsideration request
- Check the status and outcome of a portal-submitted redetermination
- Track a redetermination request submitted by mail or by fax

NOTE: In the WPS Government Health Administrators Portal User Manual, the terms "appeal" and "redetermination" are used interchangeably to refer to the first level appeal. The terms "reconsideration" and "second level appeal" are used interchangeably to refer to the second level appeal.

Appeal Submission

All portal appeals begin by locating the claim in the portal using the Claim Inquiry function.

Requesting a Part A Redetermination in the Portal

Before submitting a Part A appeal, review the following guidelines to ensure an appeal is available to you and is appropriate for your situation:

- Claims must be in a finalized location: PB9997, DB9997, RB9997, and MSP finalized locations with PB75XX.
- You must retrieve claims in an offline location (O9998) before you can submit an appeal. Offline retrieval takes a weekend cycle before the claim is online again.
- Appeals submitted beyond the timely filing limit (within 120 days of the initial determination) require an explanation for filing the appeal late. Please review the acceptable reasons for filing a late appeal before submitting one.
    - Appeals submitted after 4:30 PM CT (5:30 PM ET) are considered to be submitted the following business day.
- Timely appeals for reason codes 56900, 7RAC1, 5RACG, 5RACH, 5RACK, and 5RACL (claim or line level) will be forwarded to the Medical Review department to be complete as a claim reopening. (Submitting as an appeal first is the correct action.)
- You must bill all claim lines before submitting your appeal. You cannot add lines to a claim after it has been reviewed and adjusted due to on a medical review.
- If you have claim level denials that are also missing charges that need to be appealed, include corrected UB claim form and a clear statement of what is exactly being added within your appeal request details. The appeal statement should state what is being appealed and why, as well as provide the detail of what is being added.
- Claims or claim lines without an MR indicator that were denied due to missing information or incorrect billing can be adjusted instead of being appealed. (When available, it is to the provider's benefit to adjust or resubmit a claim instead of appealing it.)
- If your claim was rejected (status location of RB9997) with an X in the tape-to-tape indicator, you can resubmit your claim. This should be considered when missing or incorrect billing caused the claim to reject.

Part A Claim Situations That Cannot Be Appealed in the Portal

The following types of claims cannot be appealed through the WPS Government Health Administrators Portal or can only be appealed in limited situations:

- You cannot appeal a claim with a cancel date.
- Claims denied because they were not submitted timely (reason codes 39011 and 39012) cannot be appealed. If you meet CMS' definition of "good cause" for filing a late claim, please work with the Claims department to have your claim processed.
- Claims denied for reason code 30801 can only be appealed to the MAC if they are an 11X bill type and related to the two-midnight rule. Any other bill type and reason must be appealed through the QIO (Quality Improvement Organization) that denied the claim.
- Claims or line level denials with reason codes 7SMR0, 7SMR1, 7SMR4, and 7SMR6 cannot be appealed to the MAC. You must complete your reopening request with the

Supplemental Medical Review Contractor (SMRC) that denied the line/claim for records not being received.

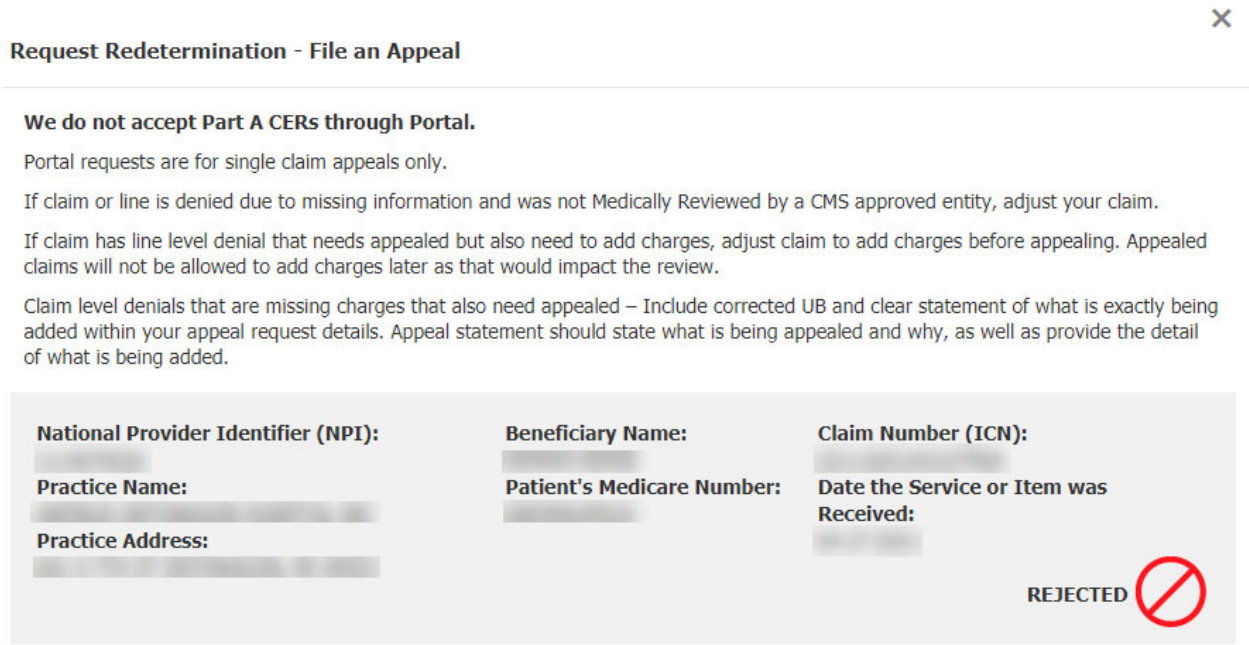
- Claims with a status of T or S are not finalized claims and cannot be appealed.
  - If the claim is in status of T, make your corrections to the claim so it can continue processing.
  - If the claim is in status of S, the MAC is working the edits internally and will continue processing the claim after working the edits.

Steps for Submitting a Part A Portal Appeal

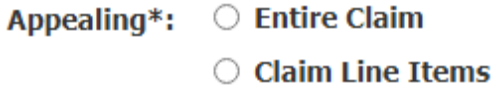
Once you confirm an appeal is appropriate, follow the steps below to submit your Part A appeal:

Step 1: Locate the claim you want to appeal and navigate to the Claim Actions section of the claim details. Click the Request Redetermination button to begin the appeal.

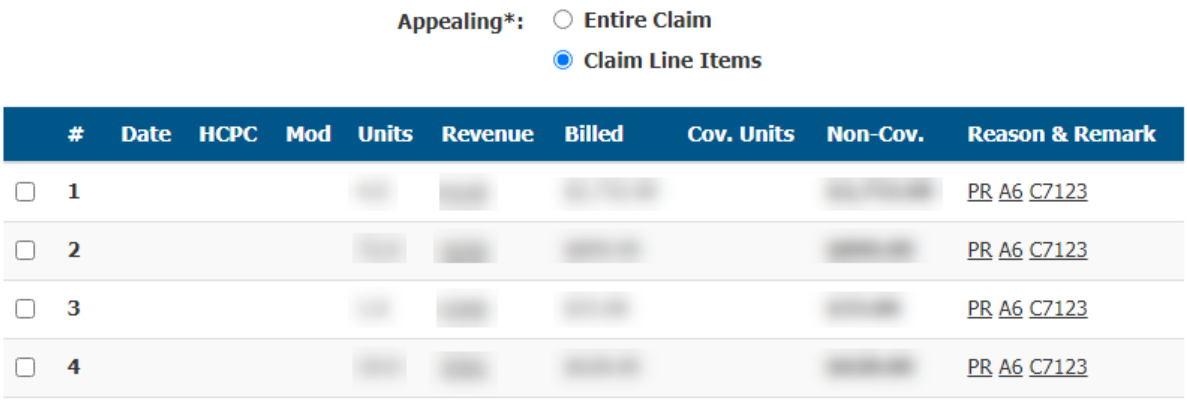
Step 2: Review the claim information to verify you are appealing the correct claim.



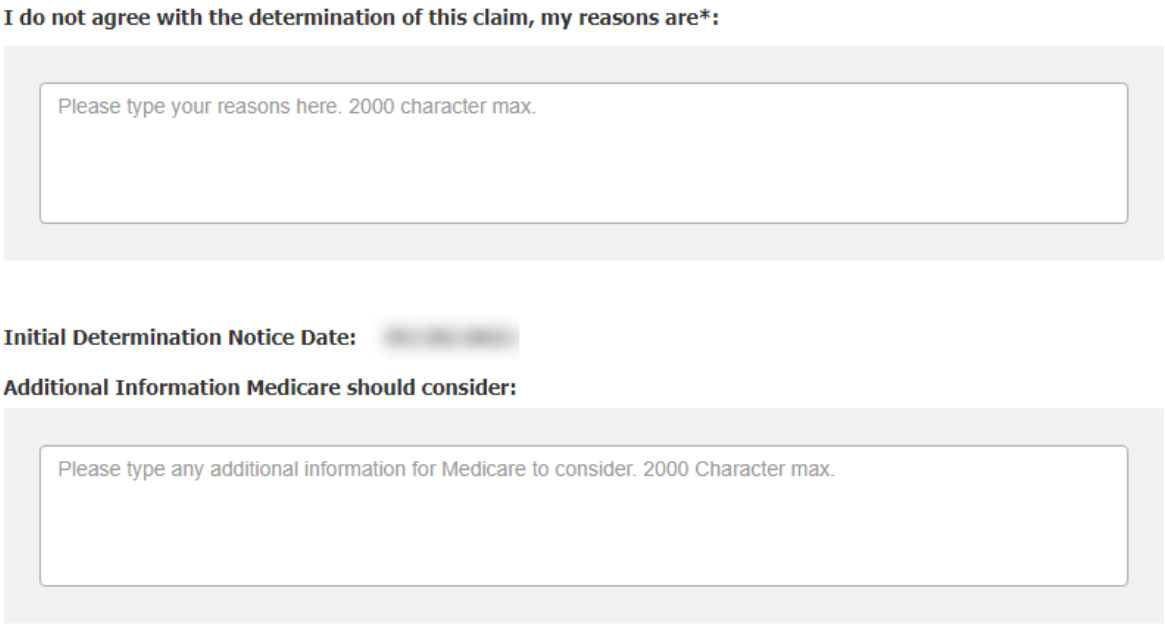
Step 3: Indicate whether you are appealing the entire claim or certain line items.



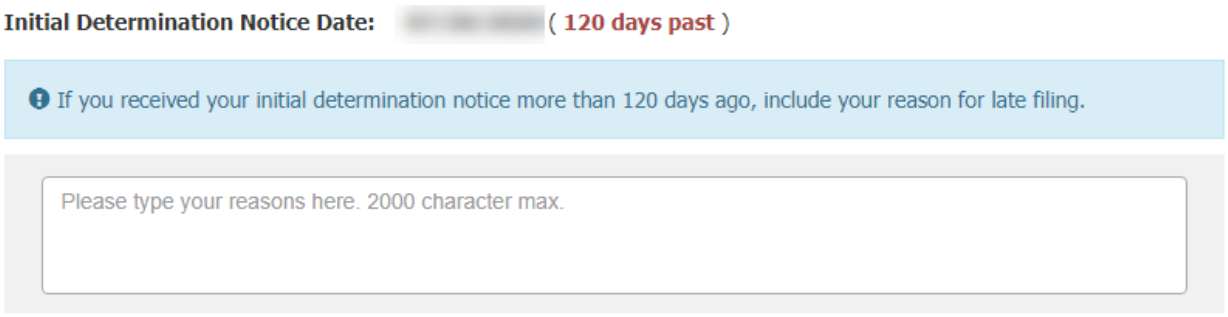
If you are appealing certain claim line items, place a check mark next to the lines you are appealing.



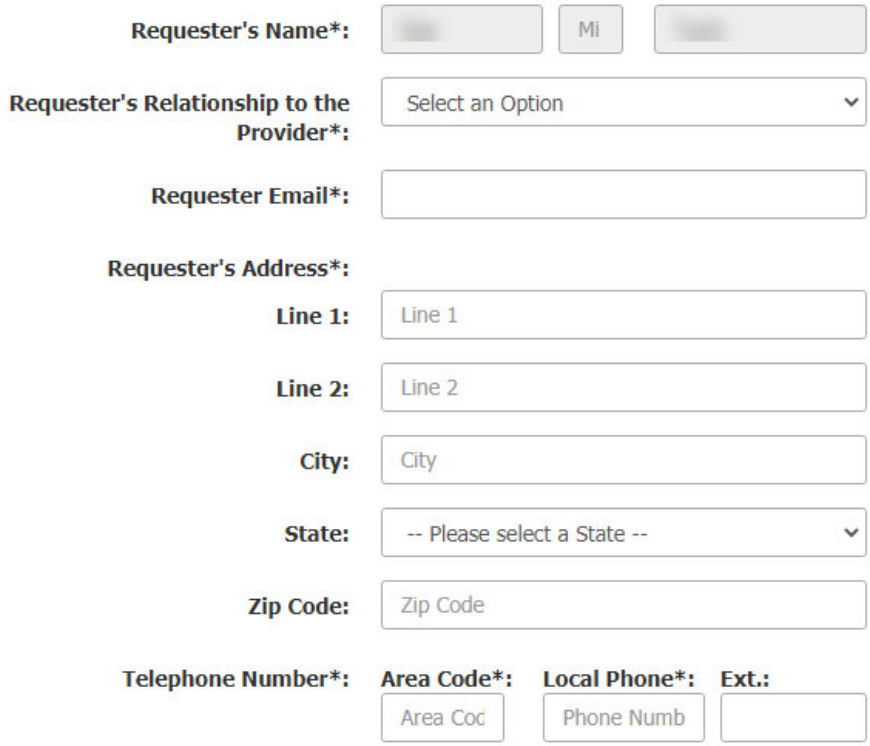
Step 4: Indicate why you disagree with Medicare's initial claim determination. You can also provide additional information you want Medicare to consider when making the redetermination.



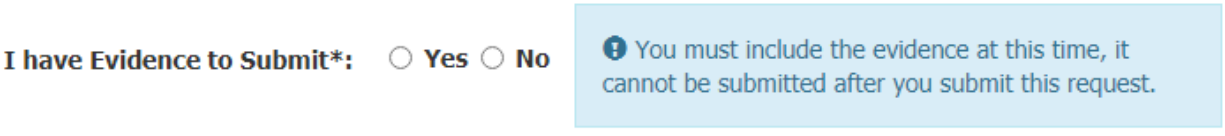
NOTE: If you are submitting your redetermination late (i.e., more than 120 days after the initial determination), the portal will alert you that your appeal is late. It will also provide an additional field where you can indicate your reason for filing a late appeal. You will only see this additional field if it has been more than 120 since the initial determination.



Step 5: Provide your contact information. Note that your name will be prepopulated from your portal account.



Step 6: Indicate whether you have documentation to submit with your appeal. It must be included with the redetermination request; you cannot submit it after you submit the request.

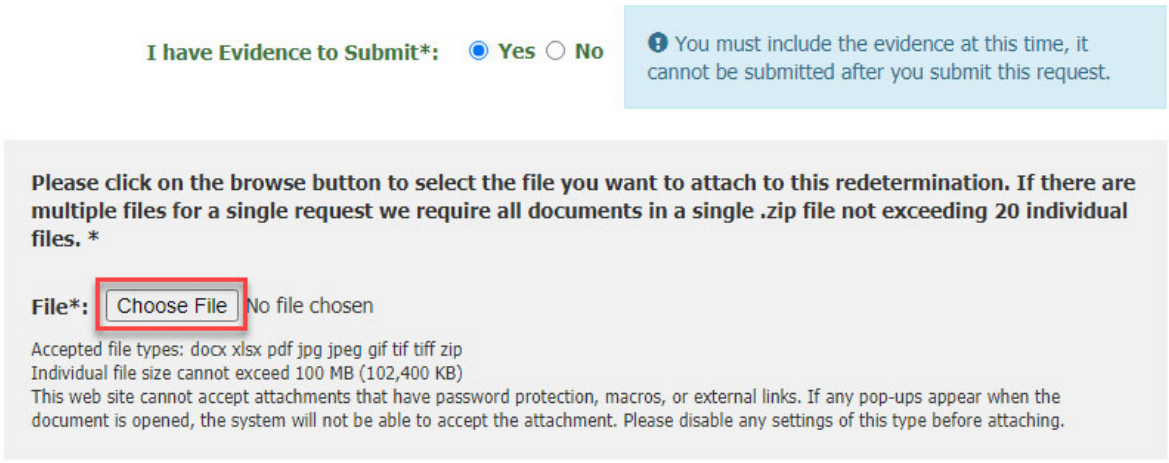


If you do have documentation to submit, click the Choose File button to upload it from your computer. The file size cannot exceed 100 MB (102,400 KB) for Part A appeals. The portal accepts the following document types:

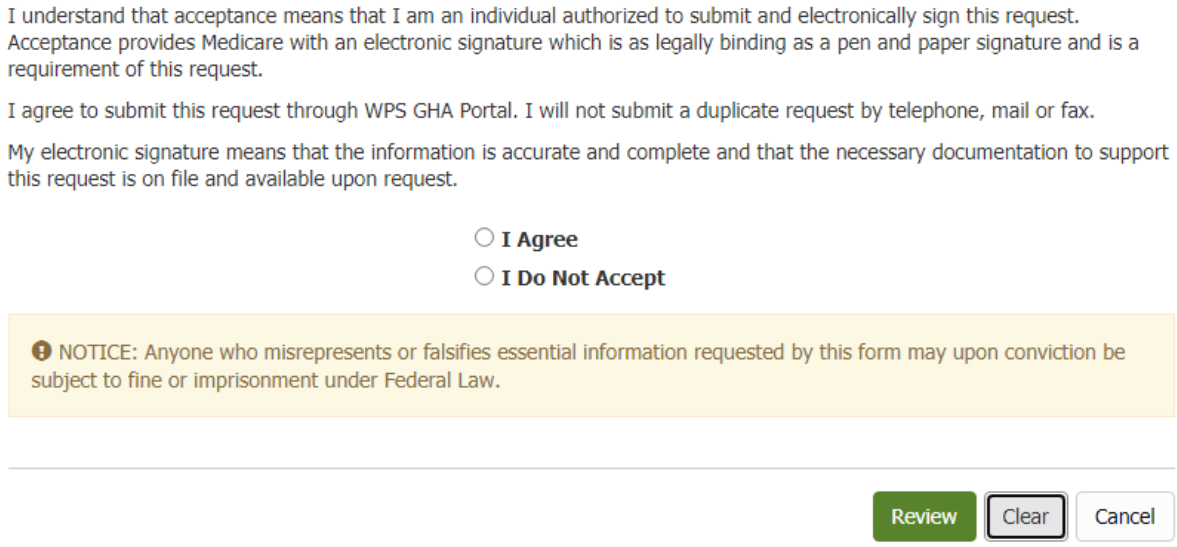
- .docx

- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip

If you have multiple documents to submit (up to 20 files), place them all in a single .zip file. Remember to disable all password protection, macros, and external links before submitting the documentation.

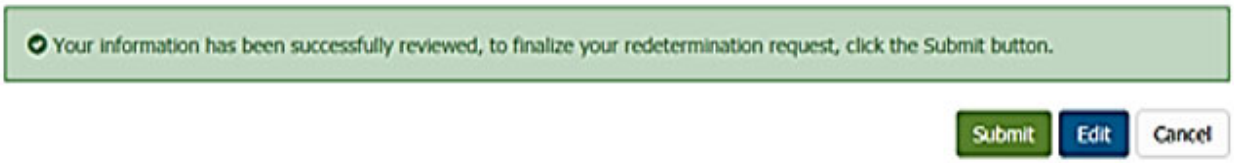


Step 7: Review the disclosure statement and indicate if you agree to the terms. If you agree, click the Review button to have the portal check your appeal for missing items. You can click the Clear button to clear the information on the form or the Cancel button to exit the appeal without submitting it.

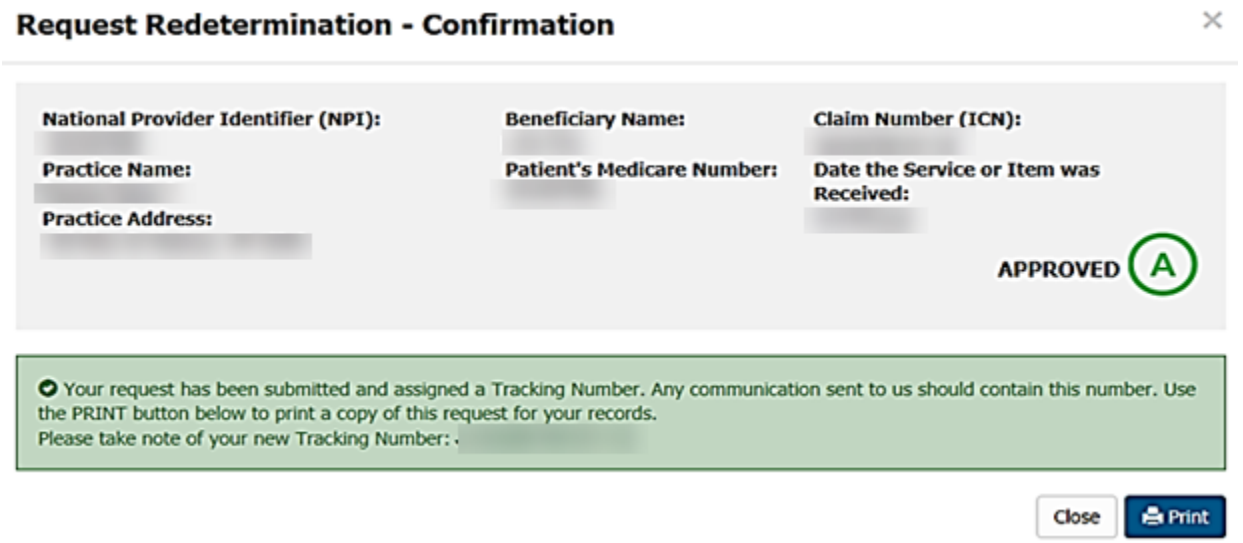


Step 8: Once portal reviews your appeal for missing items, click the Submit button to submit your redetermination, the Edit button to make changes, or the Cancel button to exit the request without submitting it.

NOTE: You cannot make any changes to your appeal once you submit it.



Step 9: The portal will display a confirmation message along with a tracking number. You can print the information for your records or close the window.



Once we complete our redetermination, the portal will be able to provide the appeal decision, but we will continue to mail your appeal decision letter.

Requesting a Part B Redetermination in the Portal

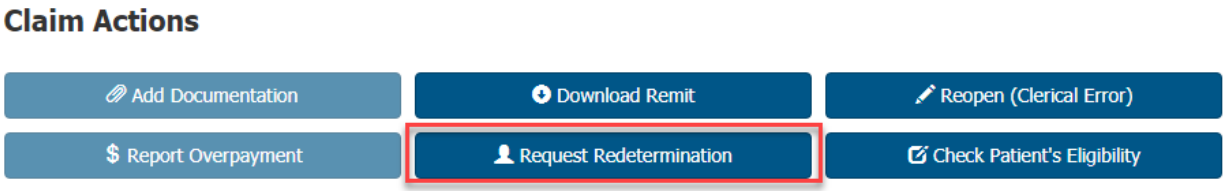
The process for submitting a Part B redetermination is very similar to the Part A process of appealing a claim.

- The claim must be finalized to request a redetermination. If a claim is approved to pay, but not yet finalized, you must wait until Medicare issues a remittance advice (i.e., the Claim Search shows a Check/EFT Number other than 000000000) to appeal any lines of service on the claim.
- If a claim is denied because requested documentation was not returned, Medicare may forward the documentation to the appropriate department for handling. Medicare will reopen the claim instead of processing a redetermination.
- You cannot appeal an unprocessable (rejected) claim. (Submit a new claim instead.)
- You cannot appeal a claim determination if you do not accept assignment on the claim.

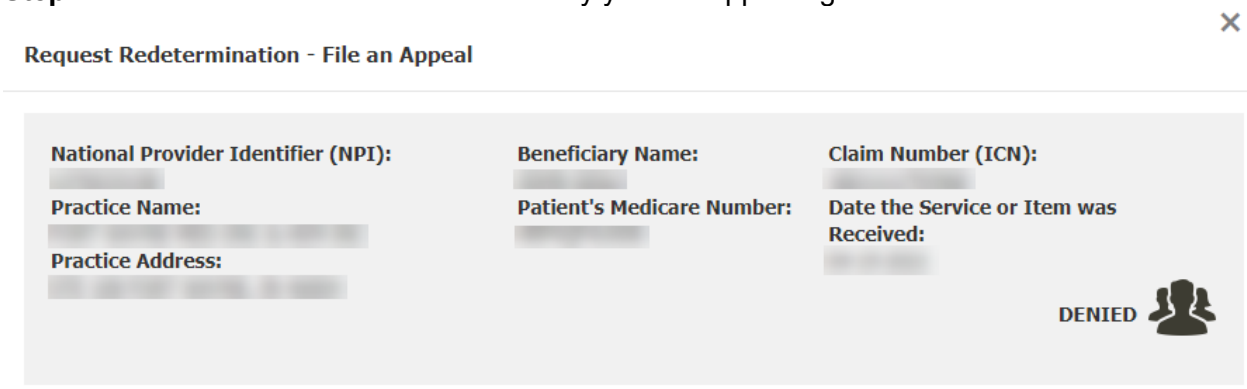
- Claims that are W status or have been denied with EDIT 119D will either be rejected by the portal or dismissed when the appeal is worked. See How to Appeal a Claim Determination (https://www.wpsgha.com/wps/portal/mac/site/appeals/guides-and-resources/how-to-appeal-claim) for more information on unprocessable (rejected) claims,

Steps for Submitting a Part B Portal Appeal

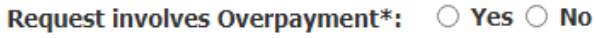
Step 1: Locate the claim you want to appeal and navigate to the Claim Actions section. Click the Request Redetermination button to begin the appeal.



Step 2: Review the claim information to verify you are appealing the correct claim.

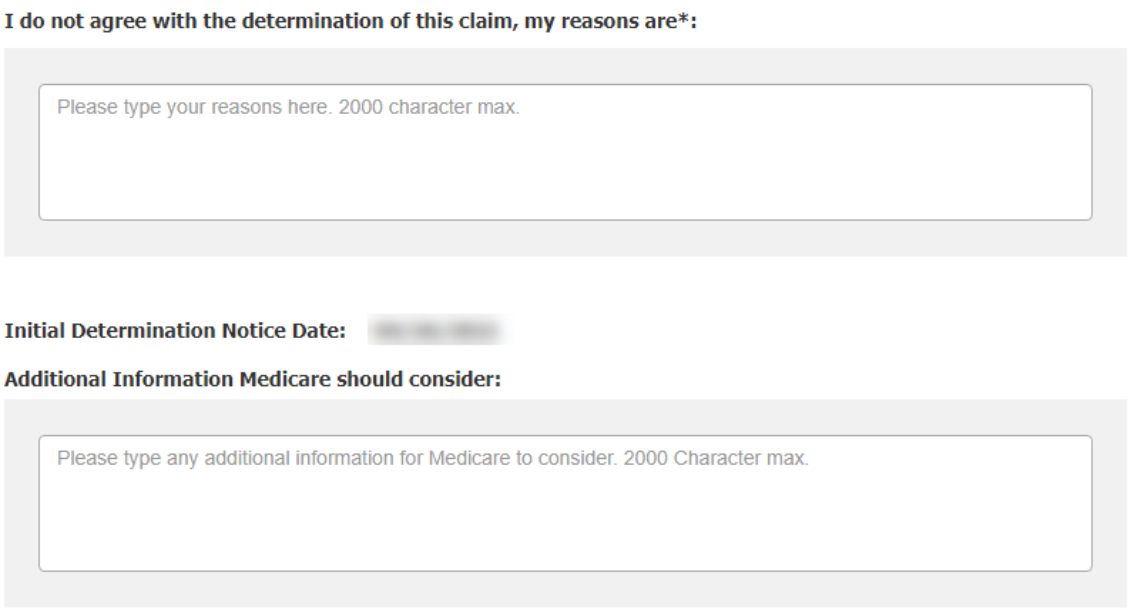


Step 3: Indicate if you are appealing an overpayment decision. Section 935 of the Medicare Modernization Act (MMA) requires Medicare contractors to halt overpayment recoupment if the provider appeals the decision. Clicking Yes notifies Medicare to pause pending collection activities until the redetermination is complete.

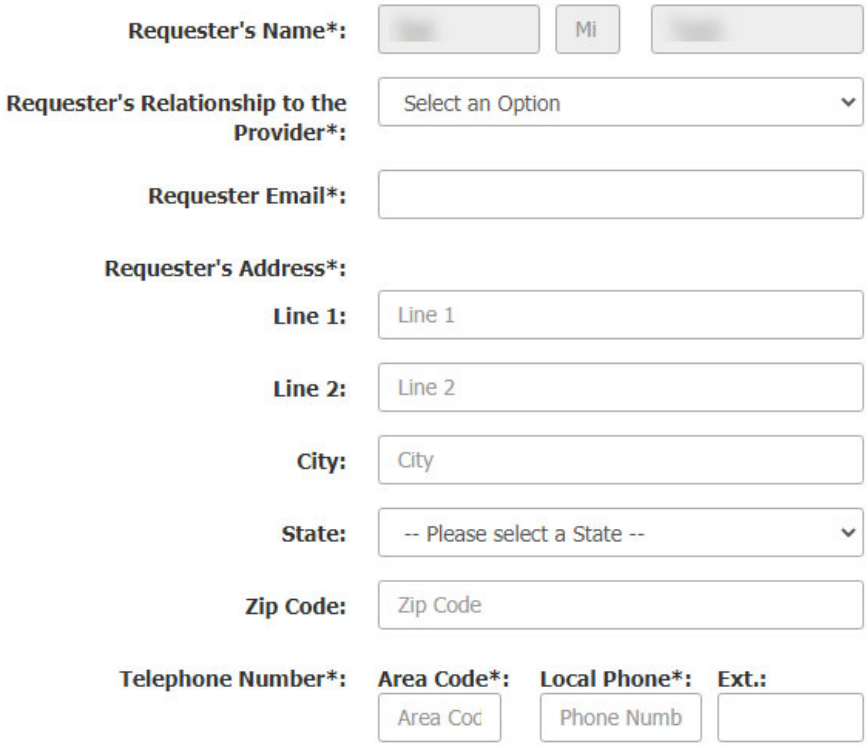


Step 4: Select the lines of service you are appealing. The procedure codes are listed in the order they appear on your remittance advice. If your claim has repeated procedure codes, confirm you are appealing the correct lines of service.

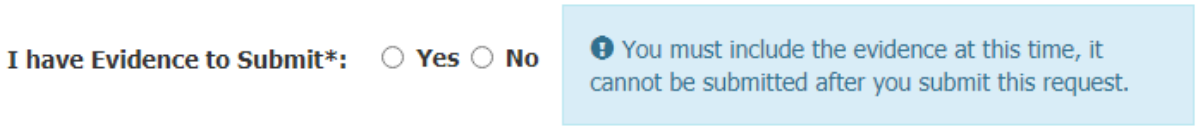
Step 5: Indicate why you disagree with Medicare's initial claim determination. You can also provide additional information you want Medicare to consider when making the redetermination, such as your reasons for filing a late redetermination request.



Step 6: Provide your contact information. Note that your name will be prepopulated from your portal account.



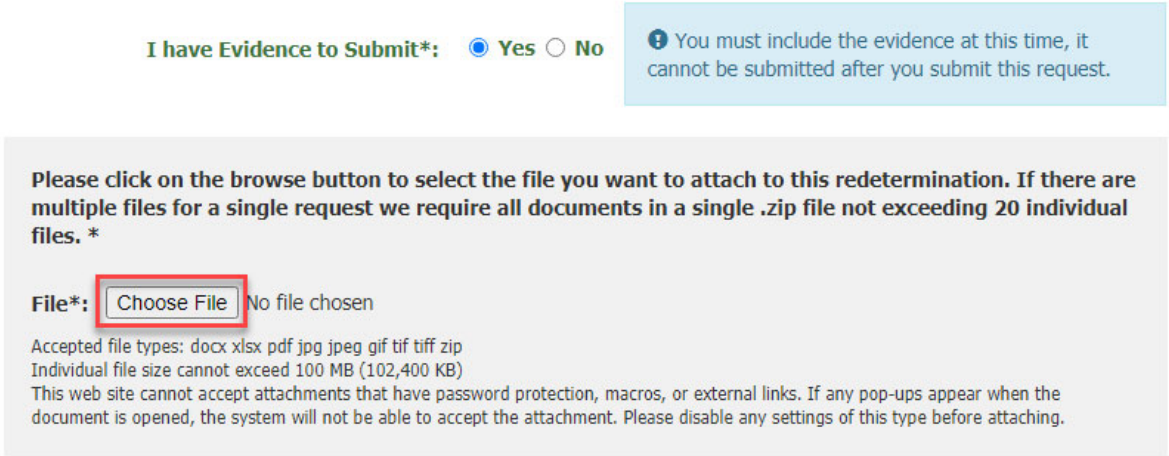
Step 7: Indicate whether you have documentation to submit with your appeal. It must be included with the redetermination request; you cannot submit it after you submit the request.



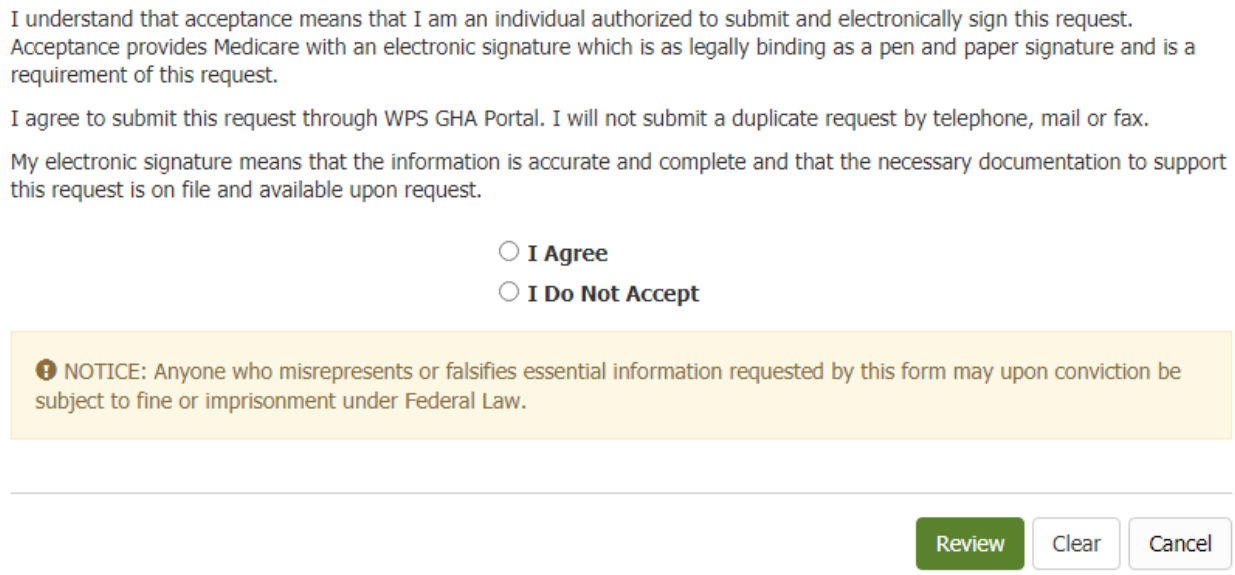
If you do have documentation to submit, click the Choose File button to upload it from your computer. The file size cannot exceed 100 MB (102,400 KB) for Part B redeterminations. The portal accepts the following document types:

- .docx
- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip

If you have multiple documents to submit (up to 20 files), place them all in a single .zip file. Remember to disable all password protection, macros, and external links before submitting the documentation.

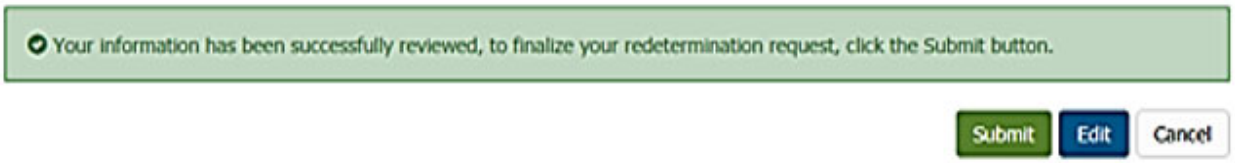


Step 8: Review the disclosure statement and indicate if you agree to the terms. If you agree, click the Review button to have the portal check your request for missing items. You can click the Clear button to clear the information on the form or the Cancel button to exit the appeal without submitting it.

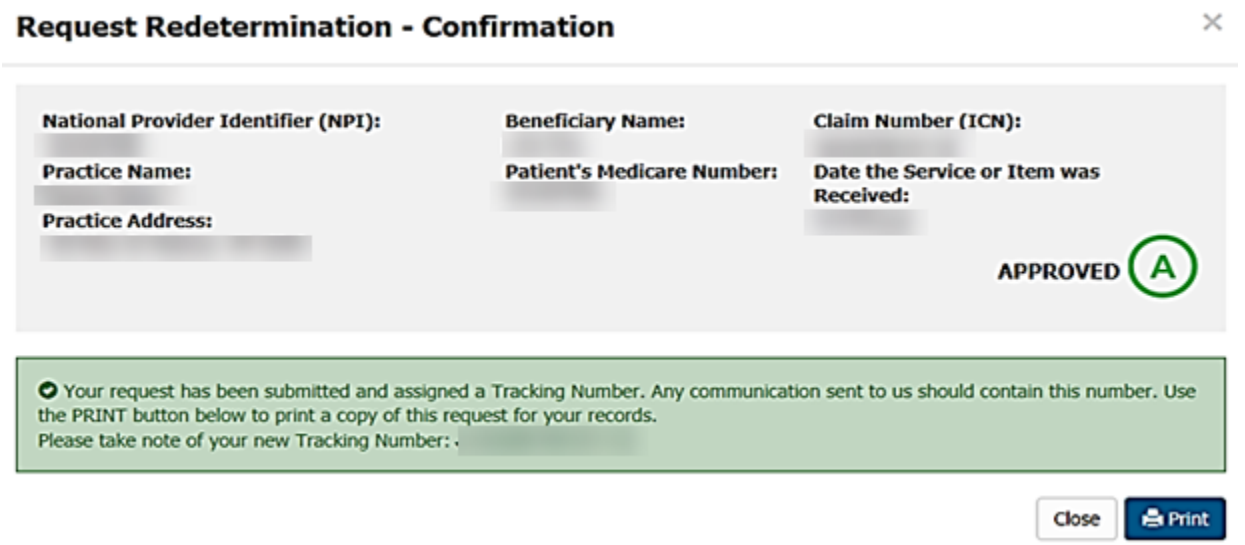


Step 9: Once portal reviews your appeal for missing items, click the Submit button to submit your redetermination, the Edit button to make changes, or the Cancel button to exit the request without submitting it.

NOTE: You cannot make any changes to your appeal once you submit it.

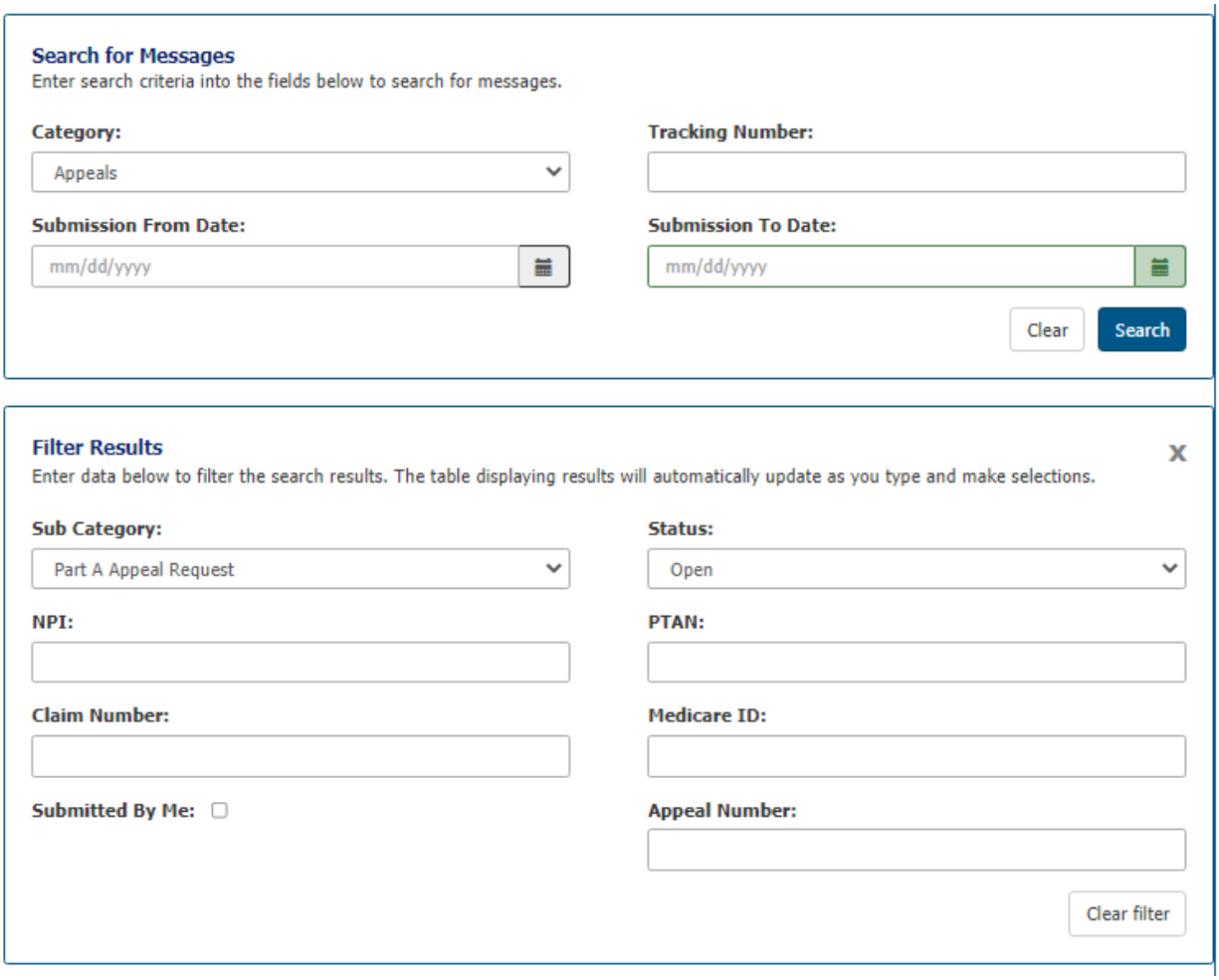


Step 10: The portal will display a confirmation message along with a tracking number. You can print the information for your records or close the window.

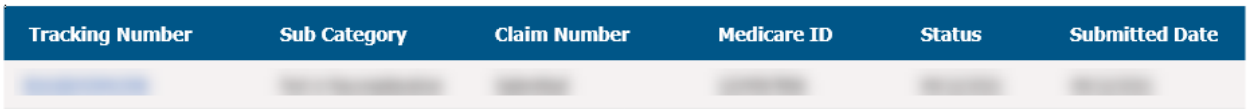


Submitting Additional Documentation for a Part A Redetermination via the Message Center

Step 1: Locate the Part A redetermination by using the below search criteria:



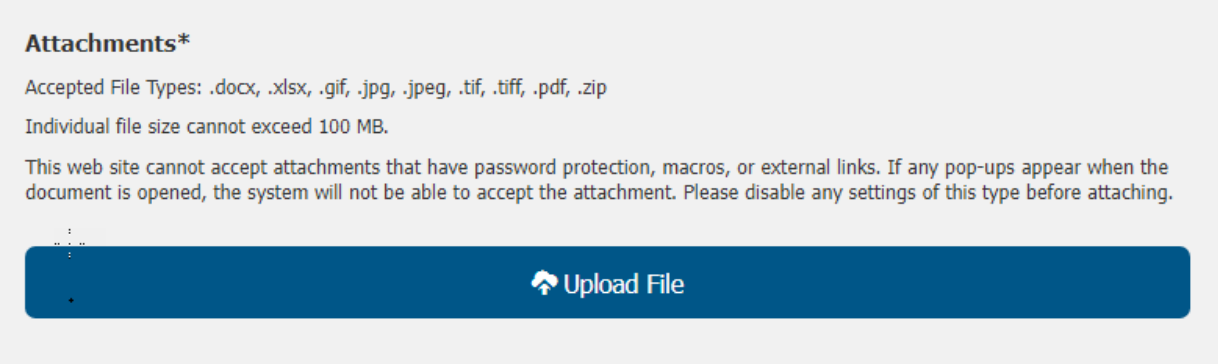
Step 2: Once the Redetermination is found, click on the Tracking Number link to go to the Level 1 appeal.



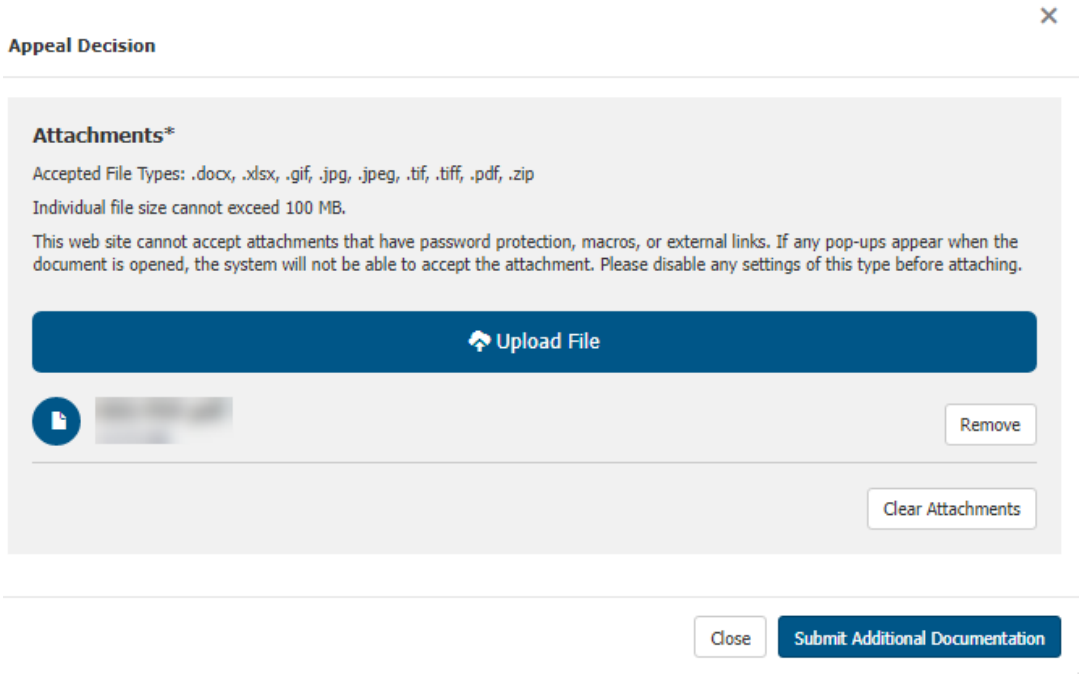
Step 3: The redetermination will display, and you will need to scroll to the bottom of the page and click the Attach Additional Documentation button.

Step 4: To upload your additional documentation, click on the Upload Files bar to locate your files on your computer. The file size cannot exceed 100 MB (102,400 KB) for Part A appeals. The portal accepts the following document types:

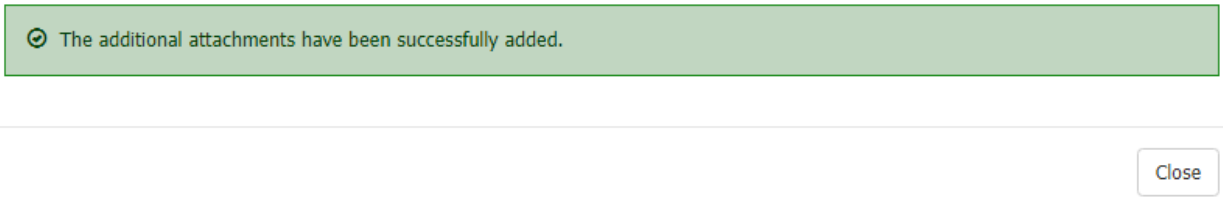
- .docx
- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip



Step 5: Once your Files have been uploaded, they will display for your verification. Once all new files have been uploaded click the Submit Additional Documentation button.



Step 6: You will receive a message that the documents have been successfully attached.



Checking the Status of Appeals Submitted Via the Portal

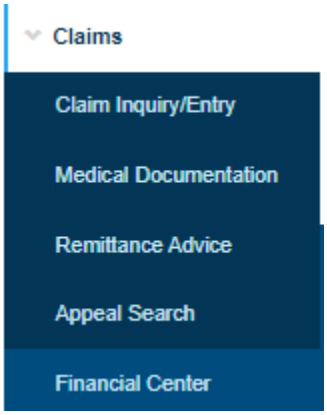
Providers can find the status and outcome of appeals (redeterminations) submitted through the portal using the Message Center. The Message Center does not provide information about appeals submitted outside the portal (i.e., by mail or fax).

Accessing the Message Center to View a Portal-Submitted Appeal

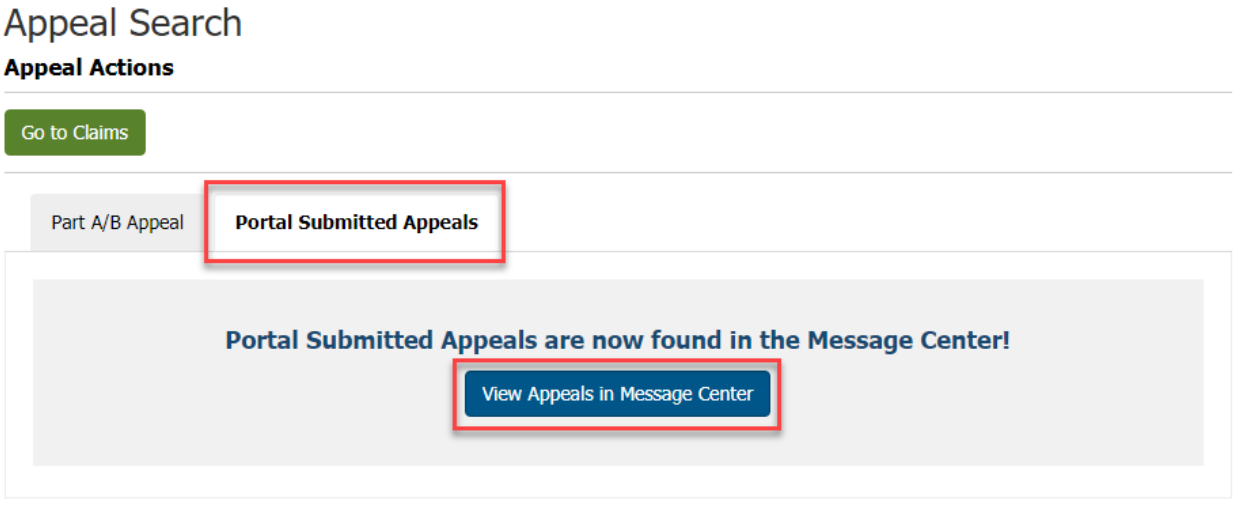
There are two methods to access appeal information in the Message Center. You will arrive in the same place using either method.

Using Appeal Search:

Navigate to Appeal Search by clicking the Appeal Search link in the left navigation menu. The link is located under the Claims section.

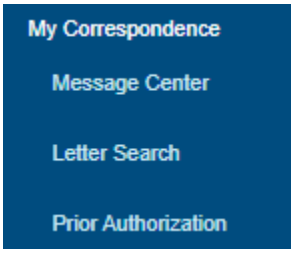


On the Appeal Search page, click the Portal Submitted Appeals tab, then click the View Appeals in Message Center button. The portal will automatically select the Appeals category in the Message Center search using this method.



Using the Message Center

Navigate to the Message Center by clicking on the Message Center link in the My Correspondence area of left navigation menu. You will need to select the Appeals category in the Message Center search.

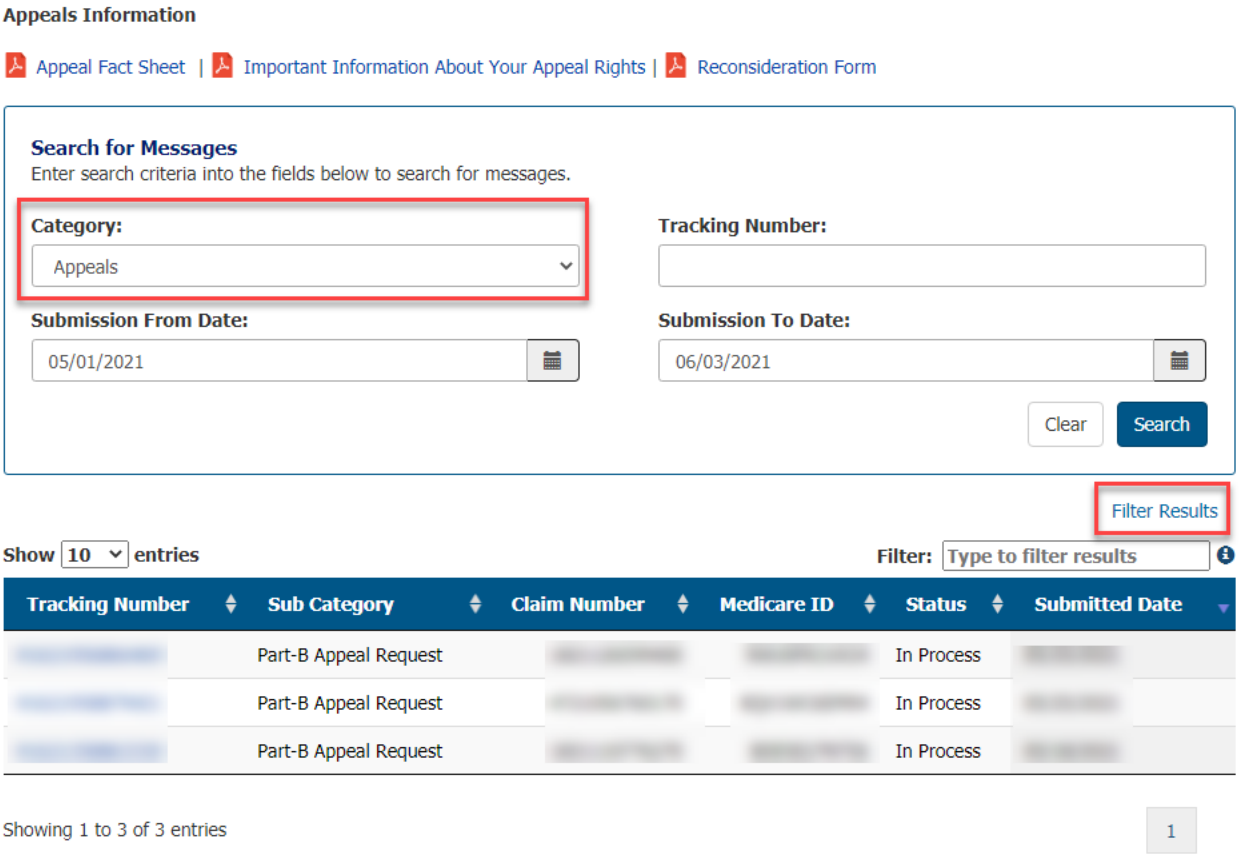


Searching for a Portal-Submitted Appeal

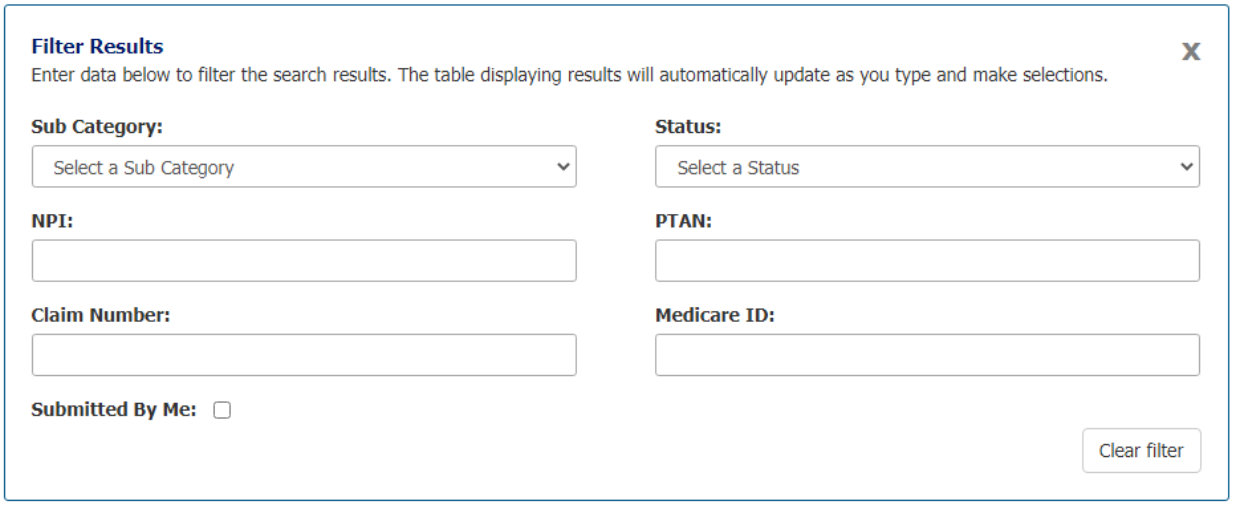
Once you are in the Message Center, follow these steps to locate the details about a portal-submitted appeal:

1. By default, the portal will display all messages submitted within the last week at the bottom of the Message Center Actions screen. (If you navigated to the Message Center using Appeal Search, you will only see the portal-submitted appeals submitted within the last week.)

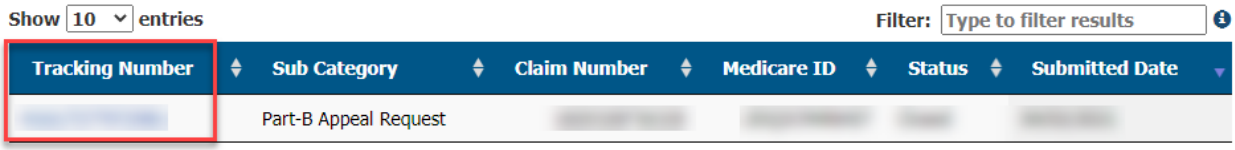
   Narrow your search by selecting Appeals in the drop-down box in the Category field (if it was not automatically selected). You can also search by tracking number and/or a submission date range. Click the Search button to search by the criteria you selected.



2. To search for a specific appeal by Medicare number, claim number, etc., or to narrow the search results, click the Filter Results link. (Note that you must perform an initial Category search before you can select the Sub-Category and Status fields.)



3. Once you locate your appeal, click the tracking number to see more details about the appeal.

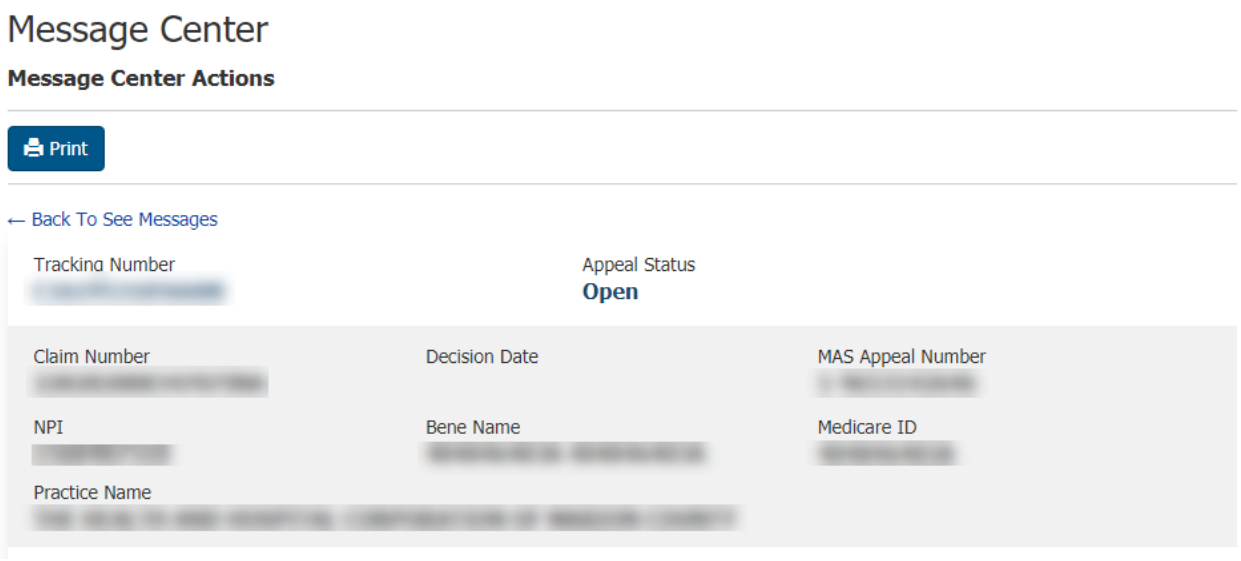


Information Available for a Portal-Submitted Appeal

After clicking the tracking number, the top section of the page will provide details about your claim and the appeal. Due to the differences between Part A and Part B appeals, the information provided in this section will differ depending on if the appeal is for a Part A or Part B claim. The information available includes the following:

- Tracking number – This number is used to track the case within the portal
- Appeal status – The status of the appeal
- Claim number – The claim number (ICN/DCN) of the claim you appealed
- CCN (Correspondence Control Number) – The tracking number used to identify the appeal request in the claims processing system (Part B only)
- Decision date – The date we made our decision on the redetermination, if the redetermination is complete
- MAS (Medicare Appeals System) Appeal Number – The number used to identify the appeal within the MAS system (Part A only)
- NPI – The billing provider's NPI
- Bene name – The name of the patient
- Medicare ID – The patient's Medicare Beneficiary Identifier (MBI) or Health Insurance Claim Number (HICN)
- Practice name – The name of the billing provider or facility

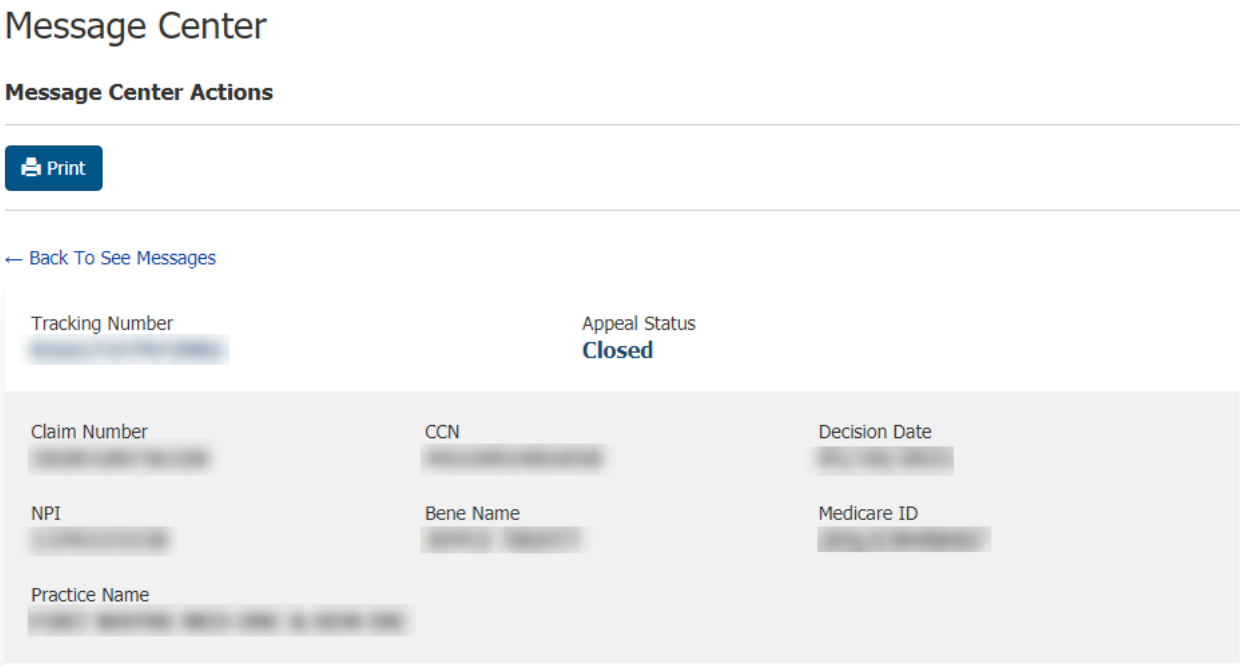
Part A Appeal Information:



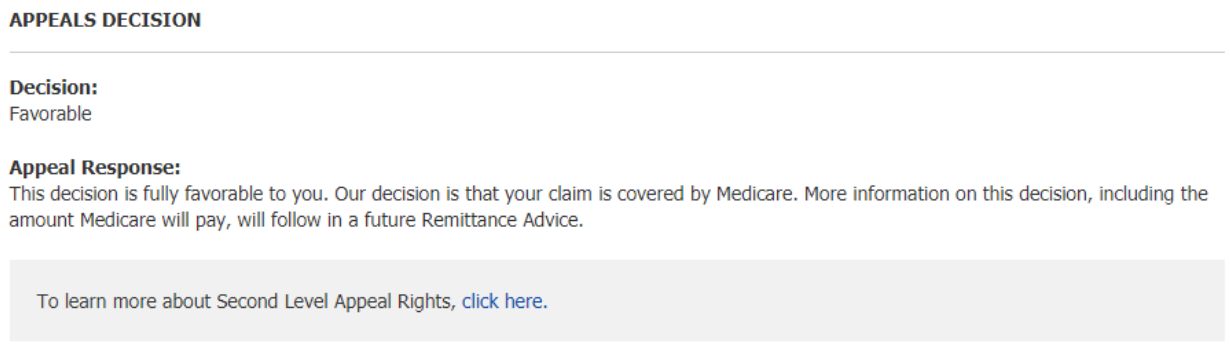
Note: The Part A Redetermination letter retrieval pulls letters back from a CMS third party source. If you see the below error message when attempting to review a letter, it is not an error. The letter that was created has an error in the file and is not viewable in the portal, decision letters are still being mailed to the address we have on file.

MAS-S-ERR-183 – "Your Appeal Number" does not contain a completed decision letter."

Part B Appeal Information:



The appeals decision (if the appeal is complete) is below the details. It may also include links to other important information related to your appeal, such as information about further appeal rights.

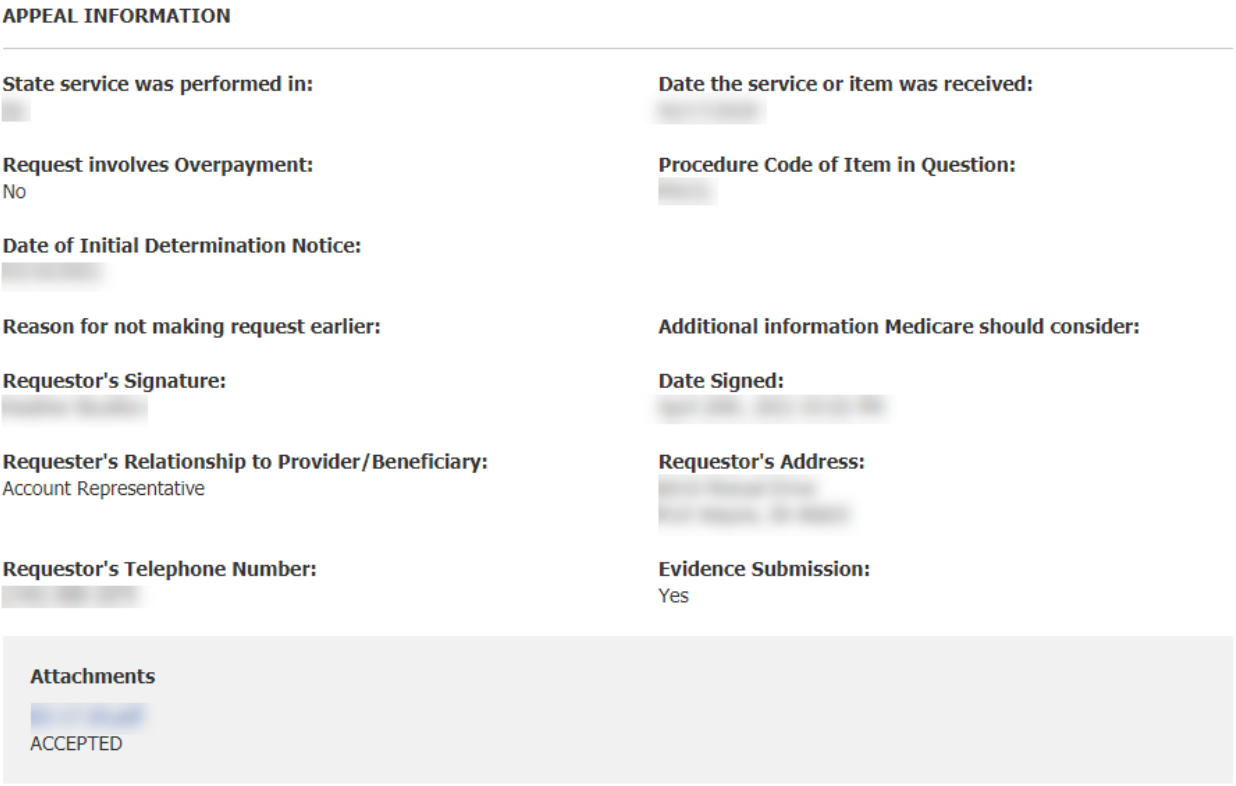

APPEALS DECISION

Decision:
Favorable

Appeal Response:
This decision is fully favorable to you. Our decision is that your claim is covered by Medicare. More information on this decision, including the amount Medicare will pay, will follow in a future Remittance Advice.

To learn more about Second Level Appeal Rights, click here.

Additional information about the appeal is located below the decision. If you submitted documentation to support your appeal, you can view the file that was submitted by clicking the link in the Attachments section at the bottom.


APPEAL INFORMATION

State service was performed in:

Date the service or item was received:

Request involves Overpayment:
No

Procedure Code of Item in Question:

Date of Initial Determination Notice:

Reason for not making request earlier:

Additional information Medicare should consider:

Requestor's Signature:

Date Signed:

Requester's Relationship to Provider/Beneficiary:
Account Representative

Requestor's Address:

Requestor's Telephone Number:

Evidence Submission:
Yes

Attachments

ACCEPTED

An important note about Part B dismissal letters: To determine the reason a Part B redetermination was dismissed, look for the statement, “Your request has been dismissed because,” which will be followed by the reason your appeal was dismissed.

APPEALS DECISION

Decision:
Dismissal

Appeal Response:
This letter is in response to your appeal request (also known as a redetermination) that was received in our office on . The redetermination was requested for the following date(s) of service: . Your redetermination request has been dismissed because it did not form a valid request for redetermination. In order to process a redetermination request, we need the following item(s) to be addressed: Missing Information * The beneficiary's name; * The Medicare health insurance claim number of the beneficiary; * The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service; * The name and signature of the person filing the redetermination request. Invalid Request * The requestor is not a proper party; * Defective Appointment of Representation (AOR); * No initial determination on the claim(s) appealed * Beneficiary is deceased with no remaining party or appointed representative with financial interest Your request has been dismissed because: No initial determination on the claim(s) appealed. You may file your request again if it has been 120 days or less since the date of receipt of the initial determination notice. When you file your request, please make sure you have addressed all of the above listed items and send your request to our office at the address noted below. If you disagree with this dismissal, you have two additional options: 1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate that you have good and sufficient cause for failing to submit a valid request. Your request to vacate this dismissal must be received at the address below within 6 months of the date of receipt this notice. Please send your request to: Wisconsin Physicians Service Medicare Part B ATTN: Redeterminations P.O. Box 8580 Madison, WI 53708-8580 2. If you think we have incorrectly dismissed your request (that is, you believe you did address all of the above listed items in your request), you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. The QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to: C2C Innovative Solutions, Inc. QIC Part B North Reconsiderations P.O. Box 45208 Jacksonville, FL 32232-5208

A copy of this letter was sent to the beneficiary noted in this appeal.

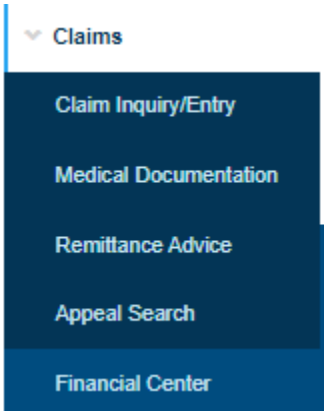
To learn more about Second Level Appeal Rights, click here.

Checking the Status of Appeals Submitted by Mail or Fax

Providers can use the WPS Government Health Administrators Portal to check the status of a redetermination request even if the request was not submitted through the portal. Status information is usually available within 15 days of the day we receive the redetermination request.

Checking the Status of Appeals Submitted Outside the Portal

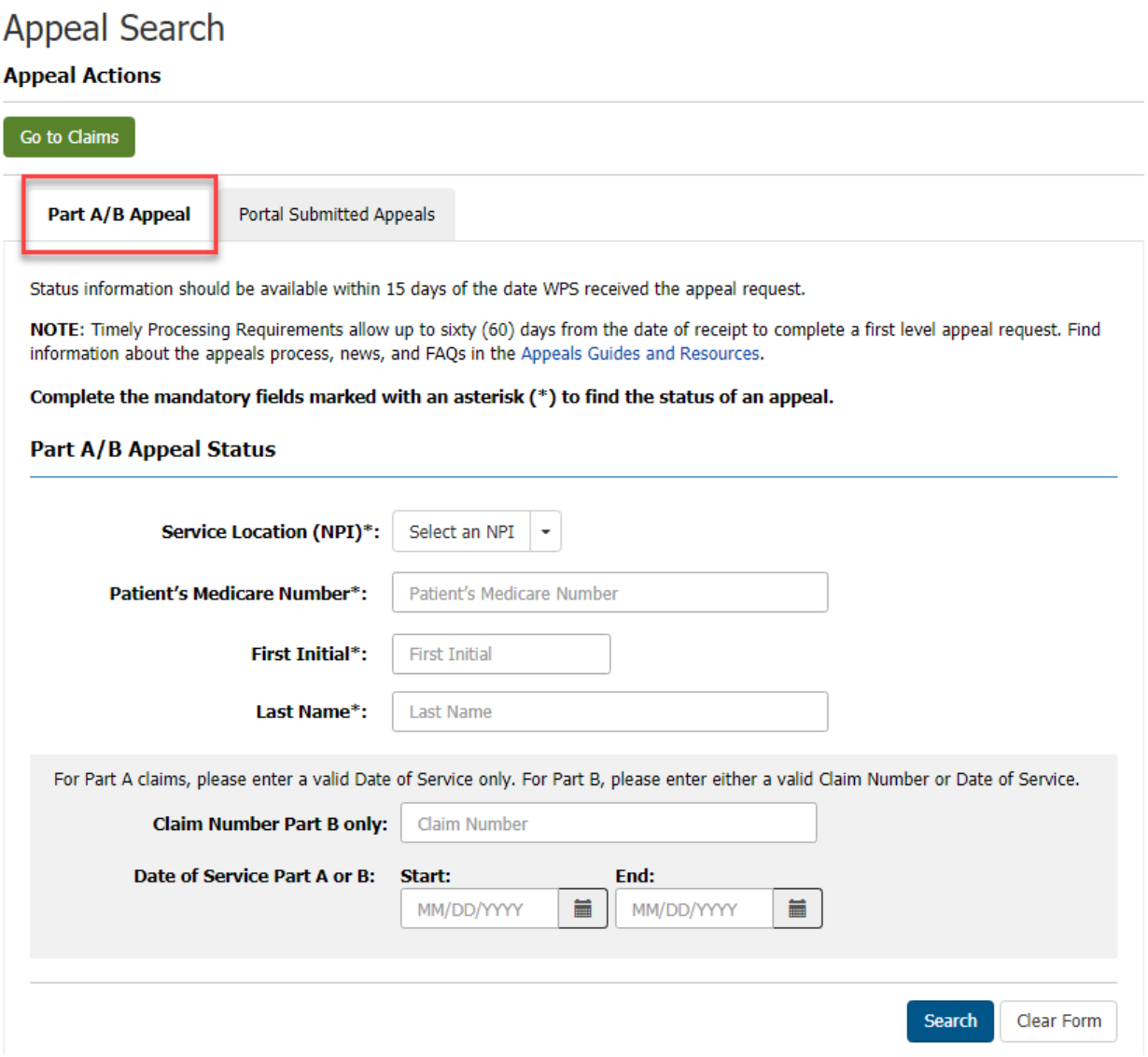
For redeterminations submitted outside the portal (i.e., by mail or fax), providers can use the Appeal Search function to check the status of an appeal. Access Appeal Search by clicking on the link in the left navigation menu.



On the Appeal Search screen, select the Part A/Part B Appeal tab and enter the following details about the claim you appealed:

- Patient's Medicare number
- Patient's first initial and last name
- Claim number (Part B claims only) **OR** date of service (Part A or Part B claims)

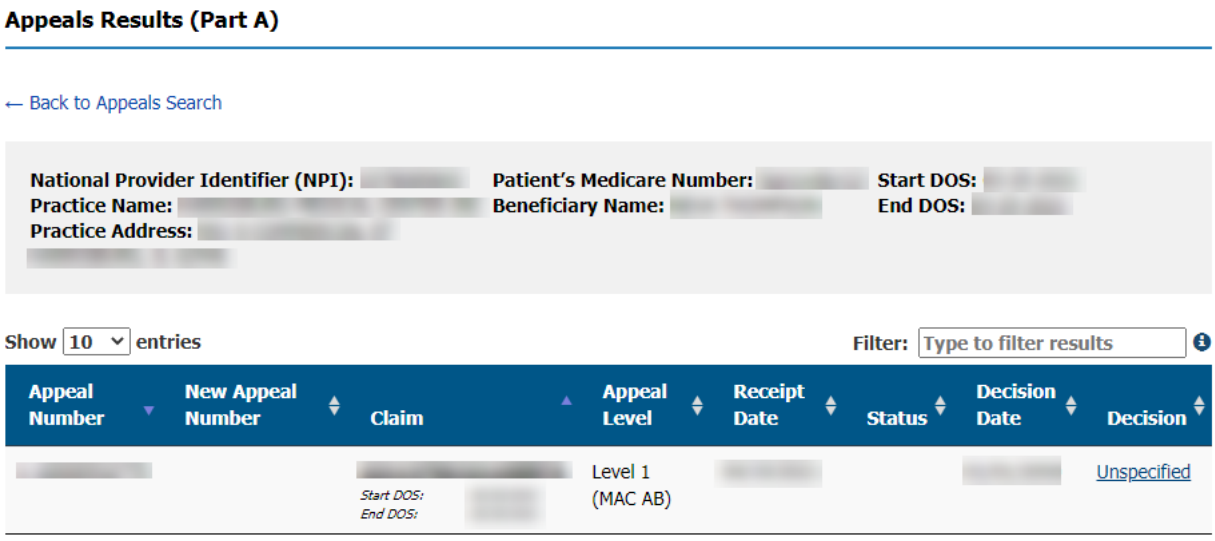
Depending on the service locations you have access to, the fields on the Part A/Part B Appeal tab may appear slightly differently than the screen below.



Click the Search button to search for the claim(s) meeting the selected criteria. The results appear on the Appeal Results page. Note that the portal displays Part A and Part B results differently.

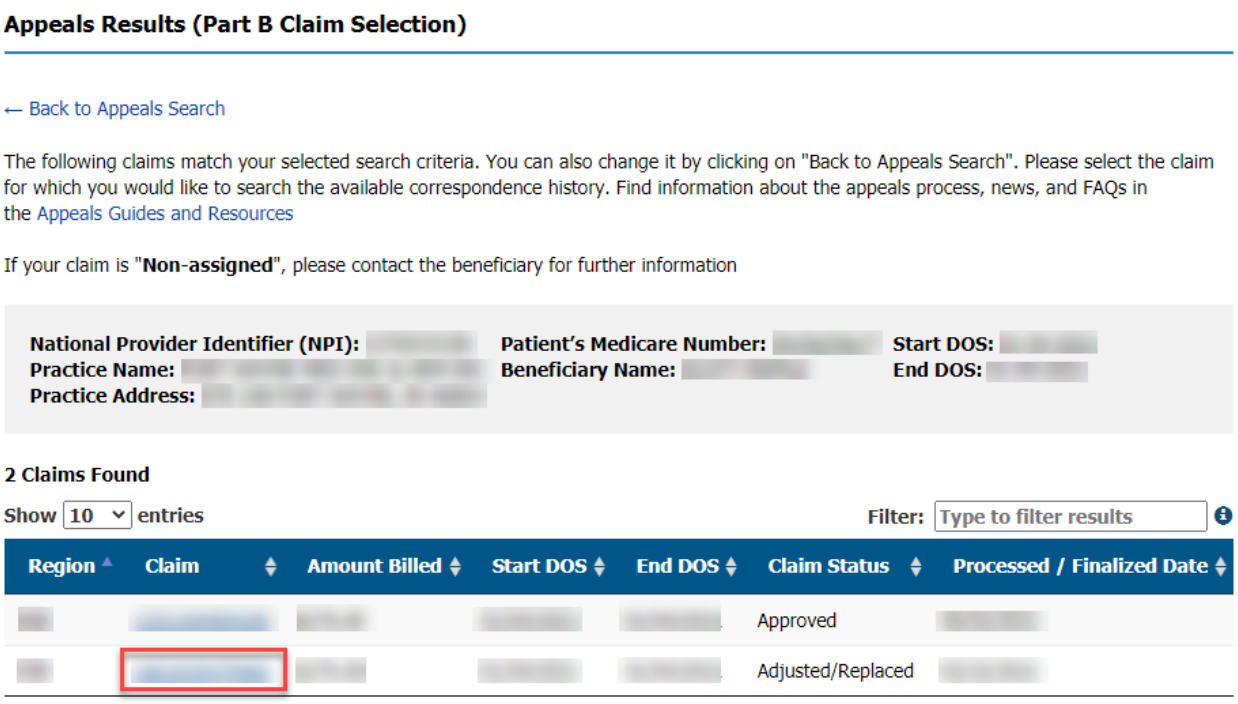
Search Results for Part A Mail/Fax Appeals

For Part A appeals, the portal will display any available information on the Appeal Results page. For further information about the appeal, see the redetermination outcome letter that Medicare will mail to your office.



Search Results for Part B Mail/Fax Appeals

For Part B claims, the portal will display information like claim inquiry results. If you searched using the date of service, you may see multiple claims listed in the results. Click on the claim number you appealed to see any available appeal details.

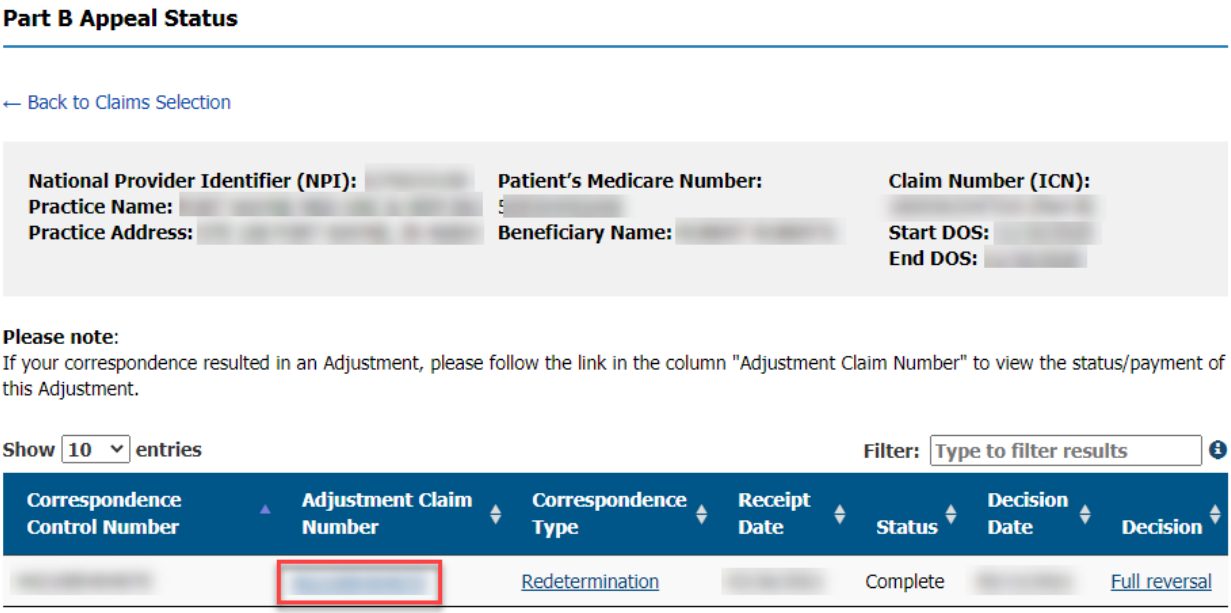


Part B Redetermination Request Received

If Medicare has a record of receiving a redetermination request on the claim you selected, the portal will provide the following additional details:

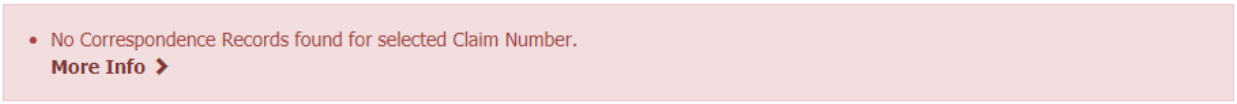
- Correspondence Control Number (CCN)
- Adjustment claim number (if the claim was adjusted)
- Correspondence type
- Receipt date of the redetermination
- Status of redetermination
- Decision date
- Decision

If Medicare adjusted the claim because of the redetermination decision, click the adjustment claim number to check the status of the adjusted claim.



No Part B Redetermination Request Received

If Medicare has no record of receiving a redetermination request on the claim number, the portal will display a message stating there are no correspondence records for the selected claim number:



It is important to remember that this message only applies to the specific claim selected. If you are unable to locate an appeal you've submitted, be sure to search using the date of service and check for duplicate claims. Occasionally, we may link a redetermination request to a different claim number than the one listed in your request. Medicare will process the redetermination on the appropriate claim according to Medicare guidelines.

Using the Part A/B Appeal Tab to Check the Status of Portal-Submitted Appeals

Users can use the Part A/B Appeal tab to locate basic information about any redetermination submitted to WPS Government Health Administrators. However, users will find detailed information about portal-submitted appeals in the Message Center.

Users can use the Part A/B Appeal tab to locate basic information about any redetermination submitted to WPS Government Health Administrators, including appeals submitted via the portal. However, the information available using the Part A/B Appeal tab is limited.

For appeals submitted through the portal (not by mail or fax), users can find detailed information about portal-submitted appeals in the Message Center. See the Checking the Status of Appeals Submitted Via the Portal section of this manual for complete details about using the Message Center to lookup portal-submitted appeal information.

Requesting a Part A Reconsideration from a Level 1 Appeal (Redetermination)

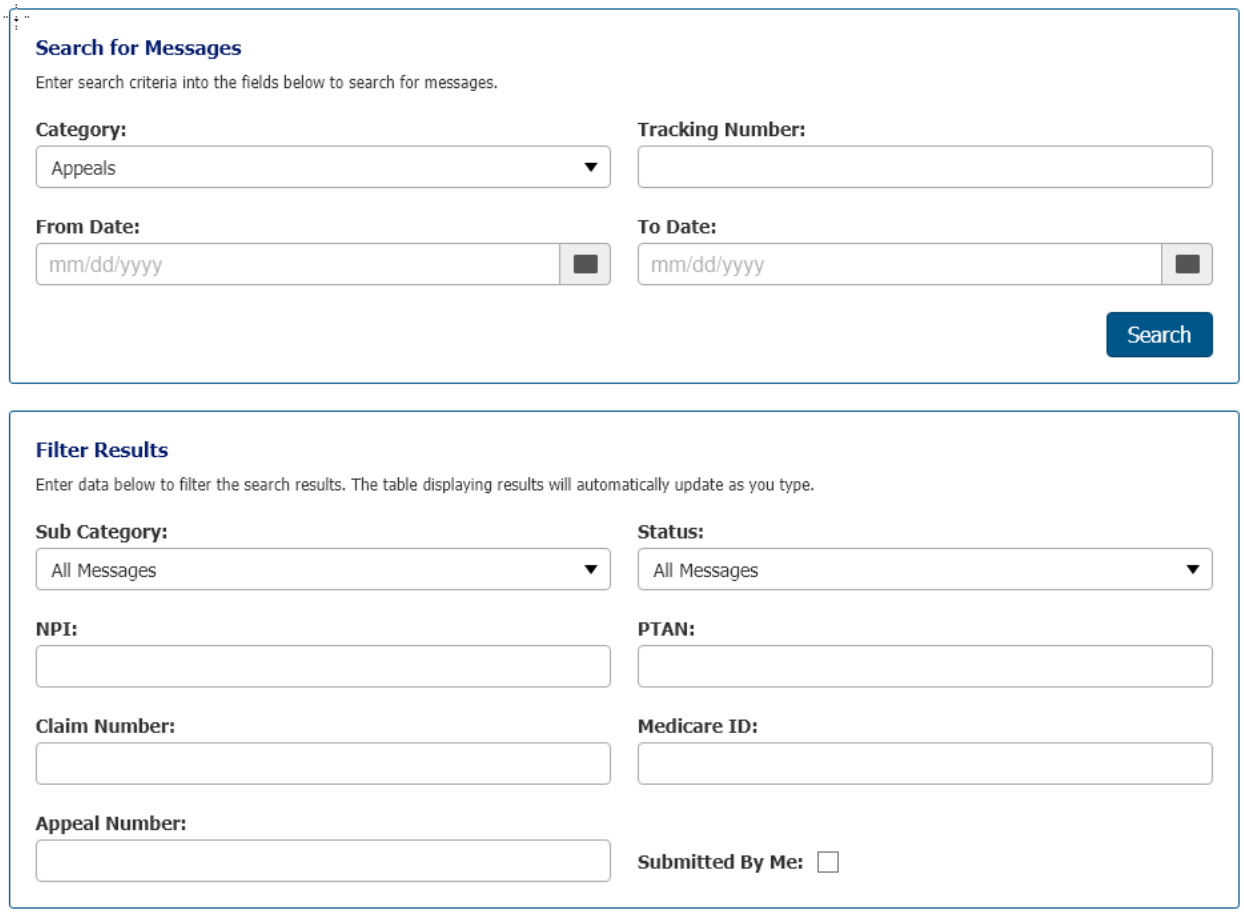
The following types of redeterminations are not available for a reconsideration through the WPS Government Health Administrators Portal:

- Favorable redetermination.
- Closed as misrouted
- Any claim that **has not** had a completed Level 1 Appeal done on it.

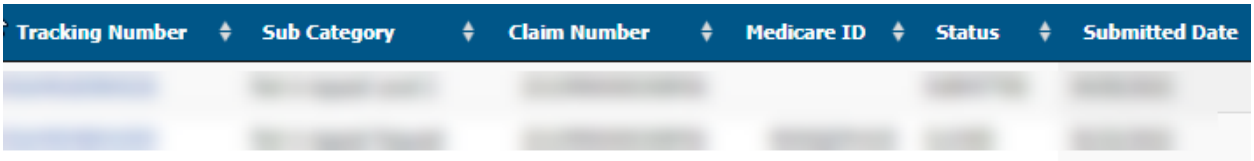
Steps for Submitting a Part A Reconsideration via the Message Center from a Level 1 Appeal

Once you confirm your Level 1 Appeal fits the criteria for a Reconsideration:

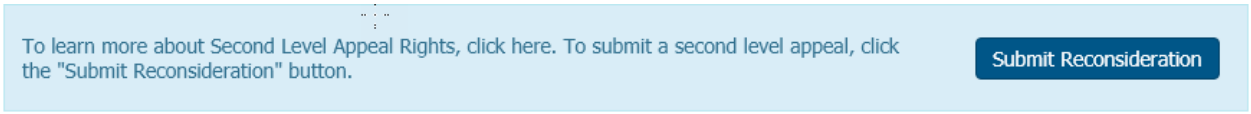
Step 1: Locate the Part A redetermination by using the below search criteria:



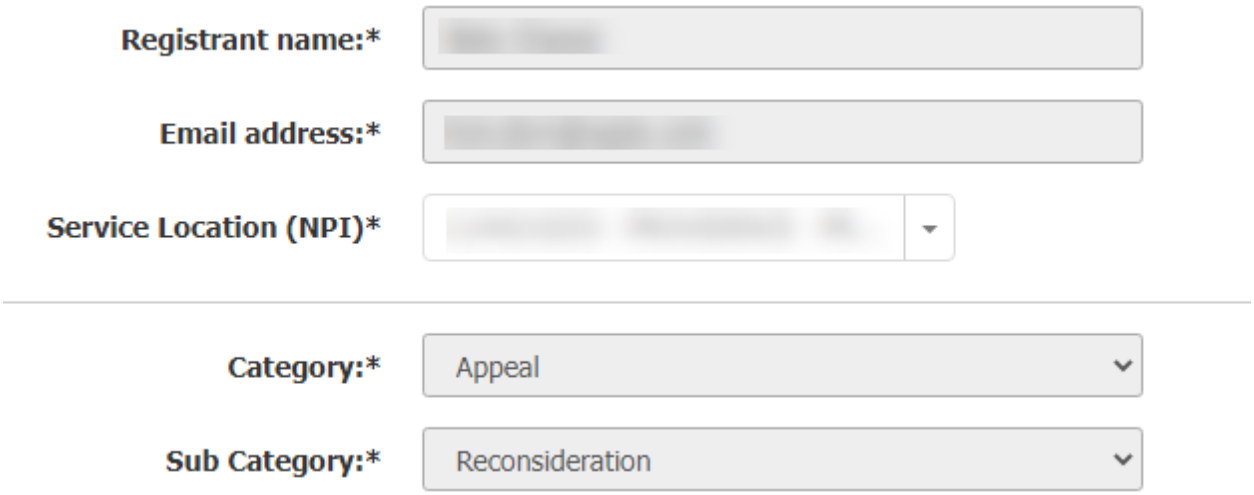
Step 2: Once the Redetermination is found, click on the Tracking Number link to go to the Level 1 appeal.



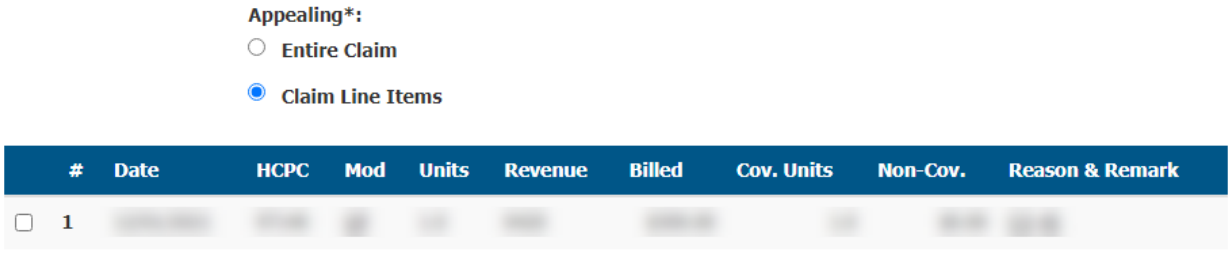
Step 3: Click on the Submit Reconsideration button to bring up the form.



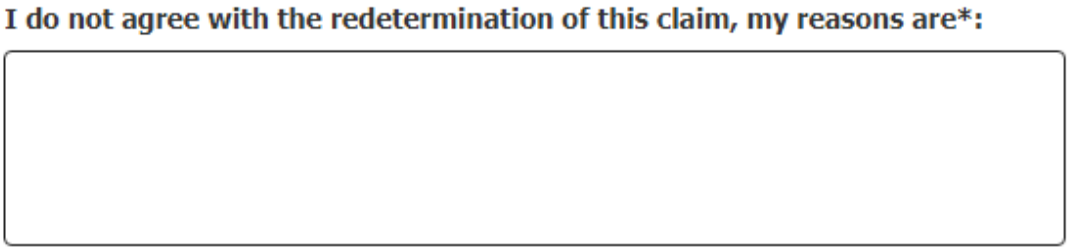
The Registrant name, Email address, Service Location (NPI), Category, and Sub Category will auto-populate.



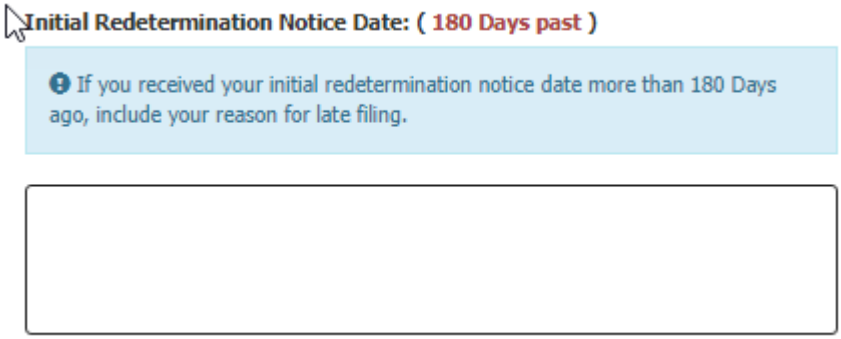
Step 4: If you are appealing certain claim line items, place a check mark next to the lines you are appealing.



Step 5: Indicate why you disagree with Medicare's initial claim determination. You can also provide additional information you want Medicare to consider when making the reconsideration.



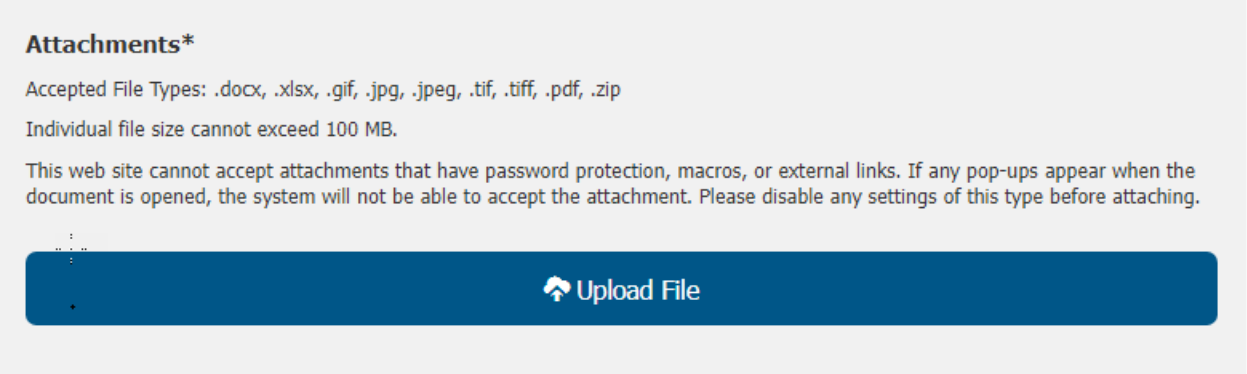
NOTE: If you are submitting your reconsideration late (i.e., more than 180 days after the initial determination), the portal will alert you that your appeal is late. It will also provide an additional field where you can indicate your reason for filing a late appeal. You will only see this additional field if it has been more than 180 days since the initial redetermination.



Step 6: Provide your contact information. Note that your name will be prepopulated from your portal account.

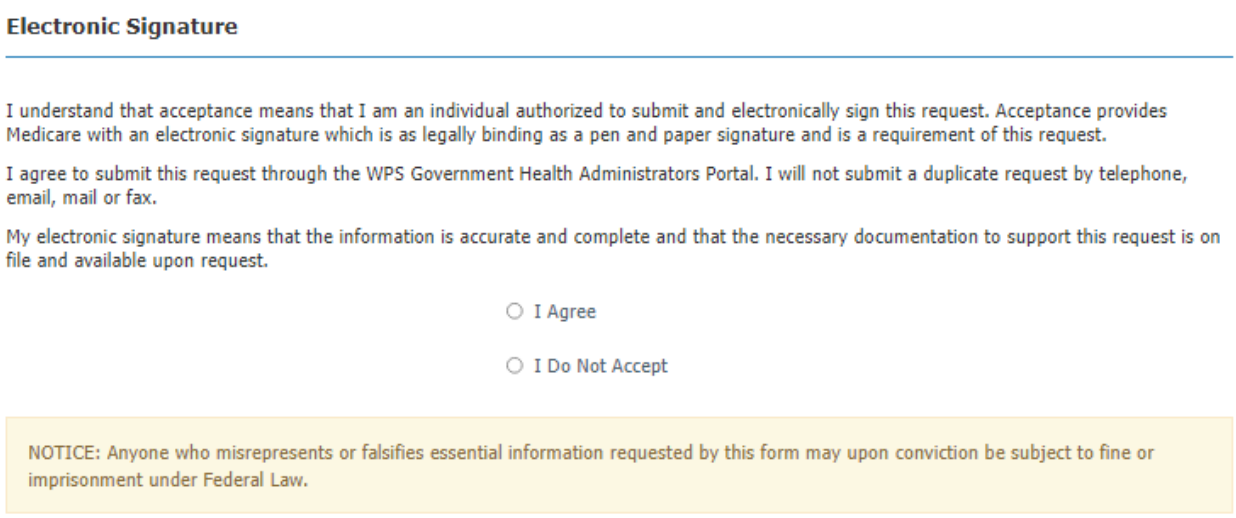
Step 7: If you have documentation to submit, click the Upload Files button to upload it from your computer. The file size cannot exceed 100 MB (102,400 KB) for Part A appeals. The portal accepts the following document types:

- .docx
- .xlsx
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .pdf
- .zip



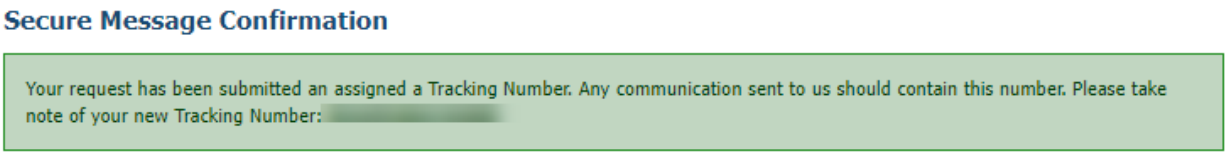
If you have multiple documents to submit (up to 20 files), place them all in a single .zip file. Remember to disable all password protection, macros, and external links before submitting the documentation.

Step 8: Review the disclosure statement and indicate if you agree to the terms. If you agree, click the Review button to have the portal check your appeal for missing items. You can click the Clear button to clear the information on the form or the Cancel button to exit the appeal without submitting it.



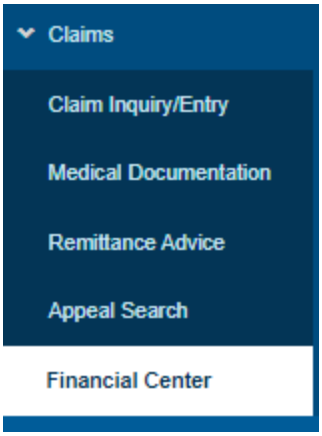
Step 9: Once the portal reviews your appeal for missing items, click the Submit button to submit your reconsideration, or click the Cancel button to make changes before submitting it.

NOTE: You cannot make any changes to your appeal once you submit it.



Steps for Submitting a Part A Reconsideration via the Appeal Search Link

A Part A reconsiderations can also be submitted by going through the Appeal Search function when checking the status of an appeal. Access Appeal Search by clicking on the link near the bottom of the left navigation menu.

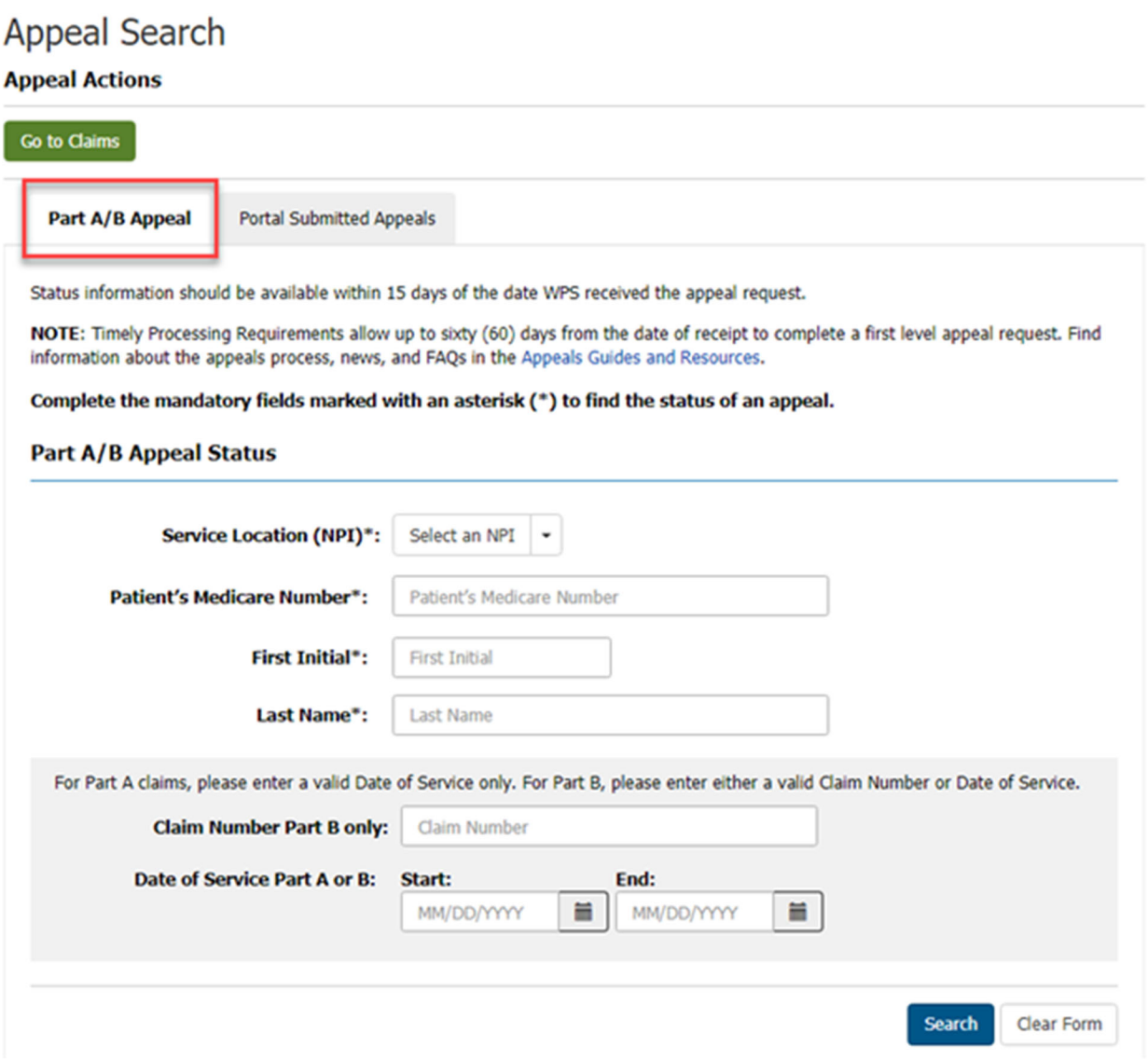


Step 1: Once on the Appeal Search screen, select the Part A/Part B Appeal tab and enter the following details about the claim you appealed:

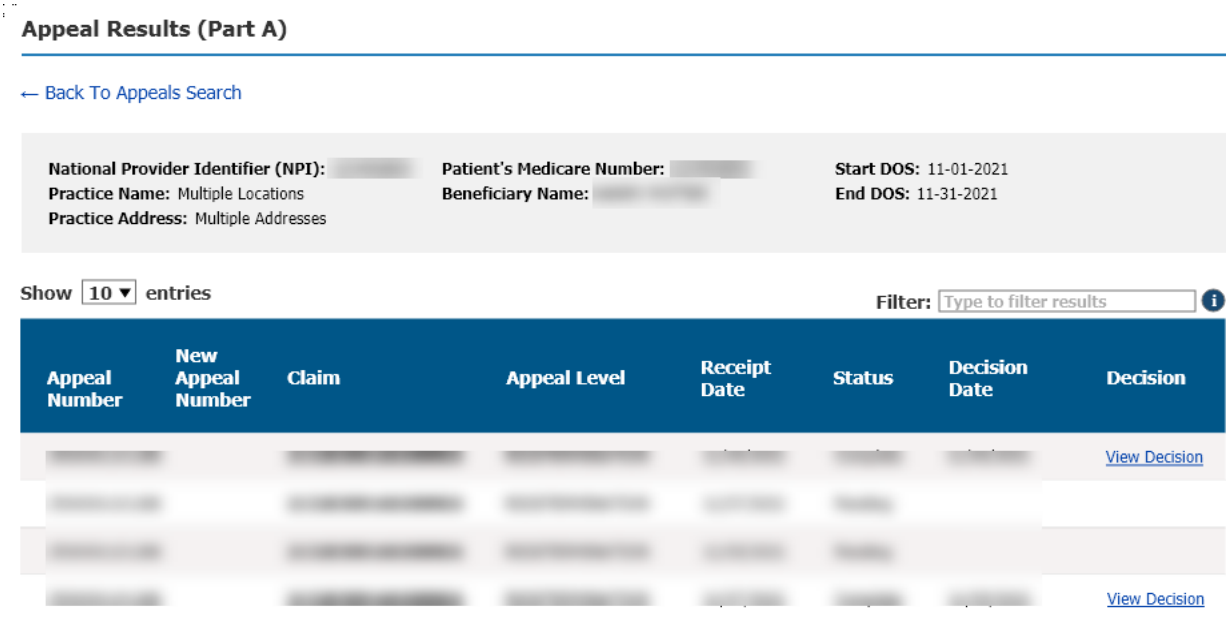
- Patient's Medicare number
- Patient's first initial and last name
- Date of service

Depending on the service locations you have access to, the fields on the Part A/Part B Appeal tab may appear slightly differently than the screen below.

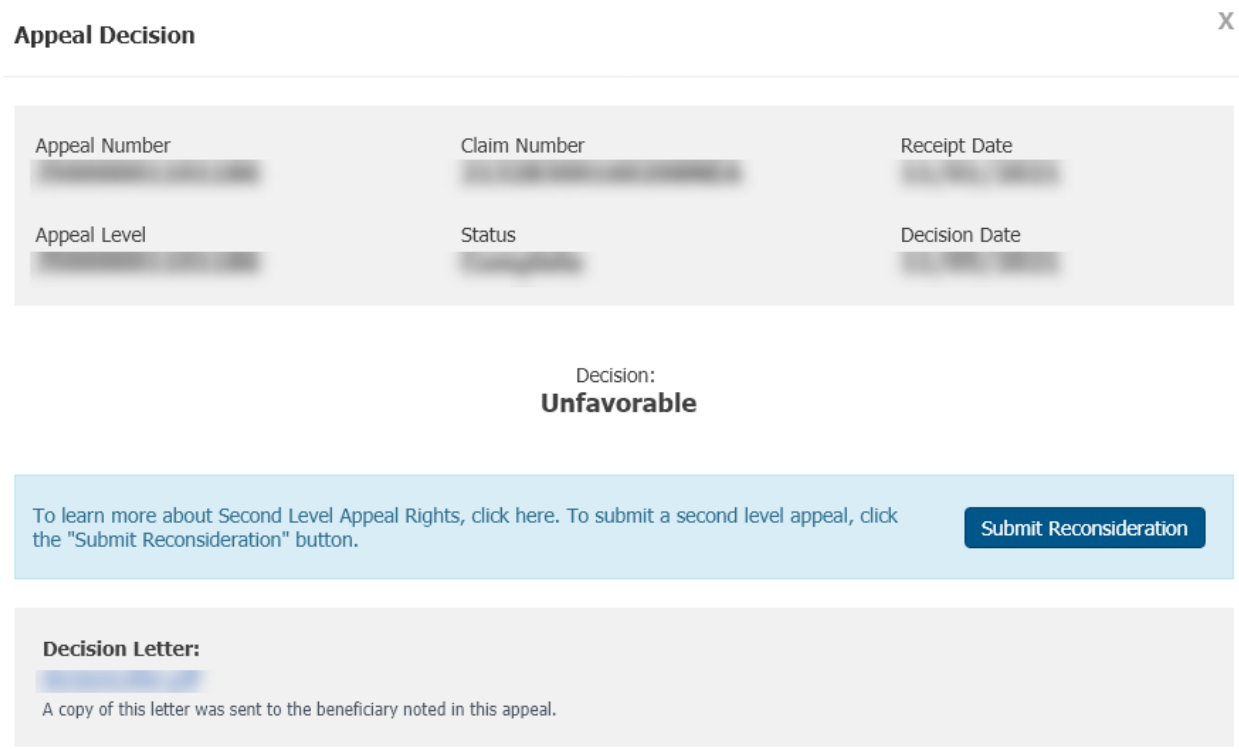
Step 2: Click the Search button to search for the claim(s) meeting the selected criteria. The results appear on the Appeal Results page. Note that the portal displays Part A and Part B results differently.


Appeal Search
Appeal Actions
Go to Claims
Part A/B Appeal
Portal Submitted Appeals
Status information should be available within 15 days of the date WPS received the appeal request.
NOTE: Timely Processing Requirements allow up to sixty (60) days from the date of receipt to complete a first level appeal request. Find information about the appeals process, news, and FAQs in the Appeals Guides and Resources.
Complete the mandatory fields marked with an asterisk (*) to find the status of an appeal.
Part A/B Appeal Status
Service Location (NPI)*:
Select an NPI
Patient's Medicare Number*:
Patient's Medicare Number
First Initial*:
First Initial
Last Name*:
Last Name
For Part A claims, please enter a valid Date of Service only. For Part B, please enter either a valid Claim Number or Date of Service.
Claim Number Part B only:
Claim Number
Date of Service Part A or B:
Start:
End:
MM/DD/YYYY
MM/DD/YYYY
Search
Clear Form

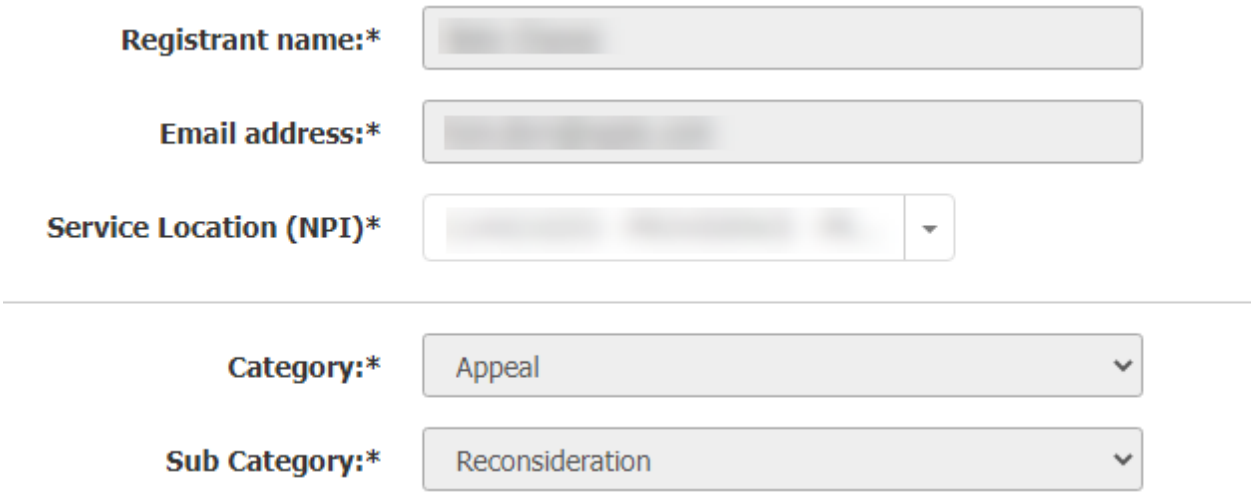
Step 3: Click on the View Decision link and you will be taken to the Appeal Decision.



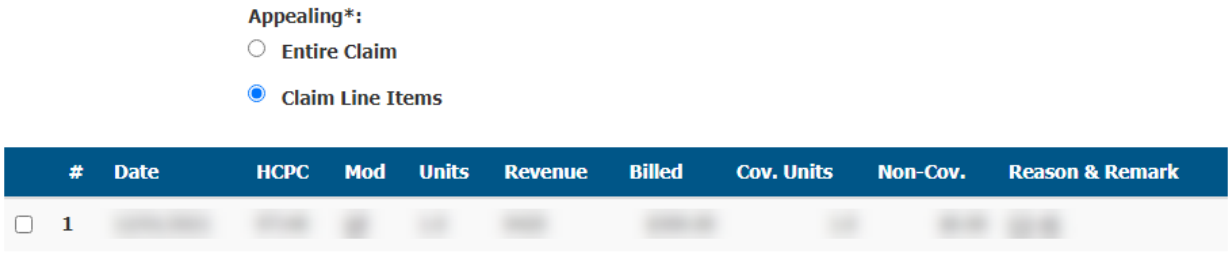
Step 4: Click on the Submit Reconsideration button to bring up the Reconsideration form. You will also find a link to a copy of the Decision letter.



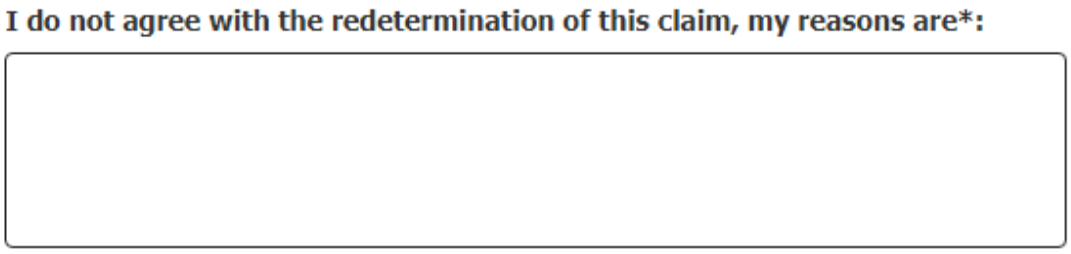
The Registrant name, Email address, Service Location (NPI), Category, and Sub Category will auto-populate.



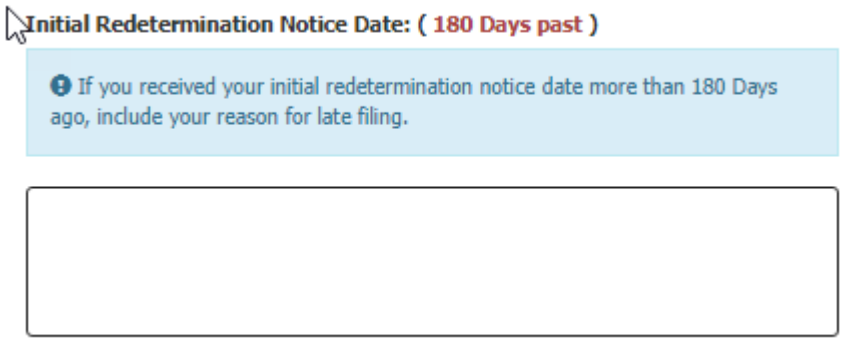
Step 5: If you are appealing certain claim line items, place a check mark next to the lines you are appealing.



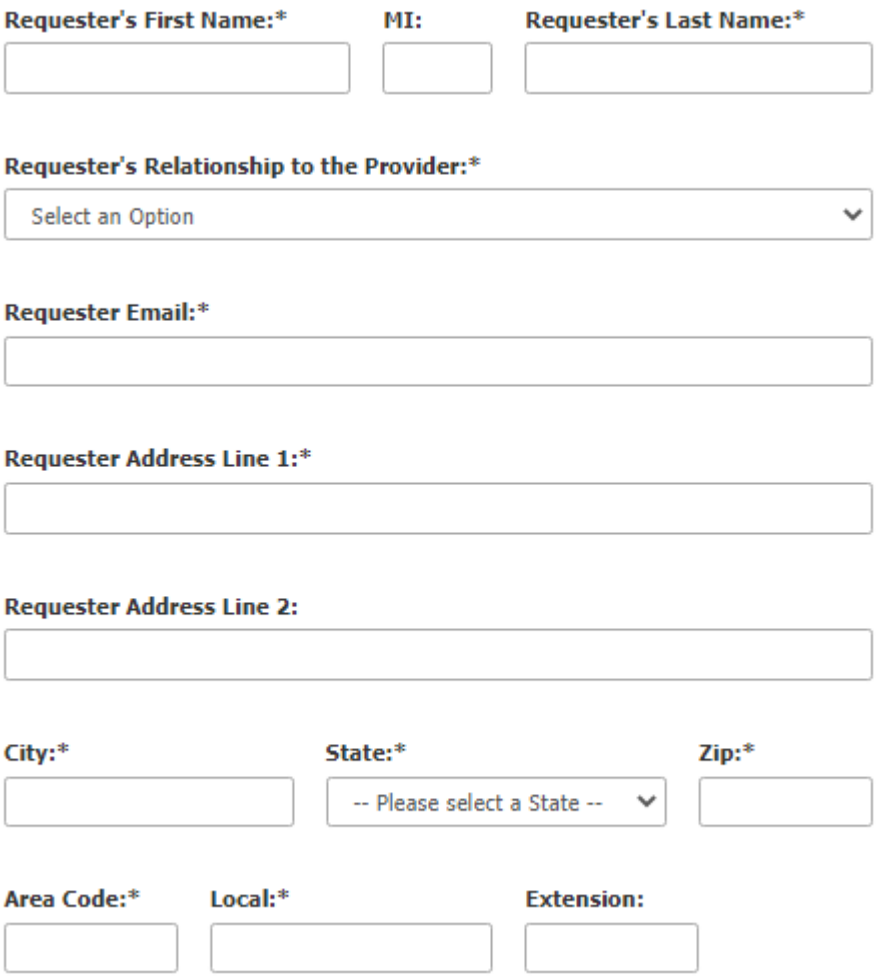
Step 6: Indicate why you disagree with Medicare's initial claim determination. You can also provide additional information you want Medicare to consider when making the reconsideration.



NOTE: If you are submitting your reconsideration late (i.e., more than 180 days after the initial determination), the portal will alert you that your appeal is late. It will also provide an additional field where you can indicate your reason for filing a late appeal. You will only see this additional field if it has been more than 180 days since the initial redetermination.

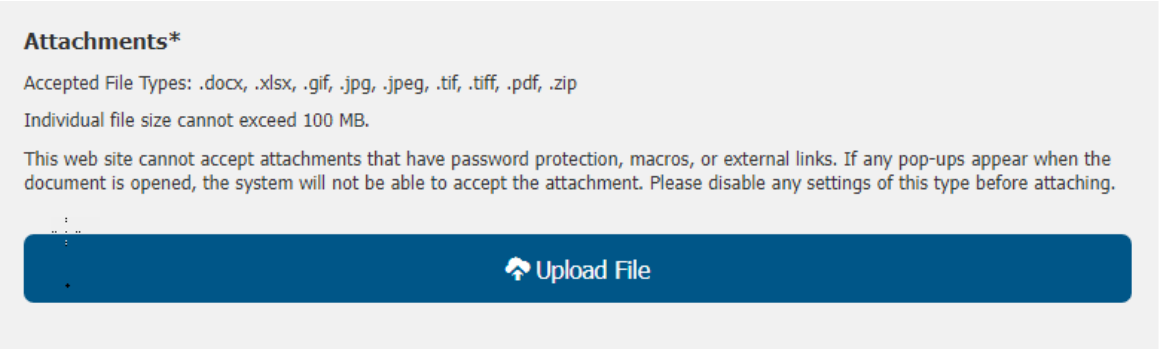


Step 7: Provide your contact information. Note that your name will be prepopulated from your portal account.



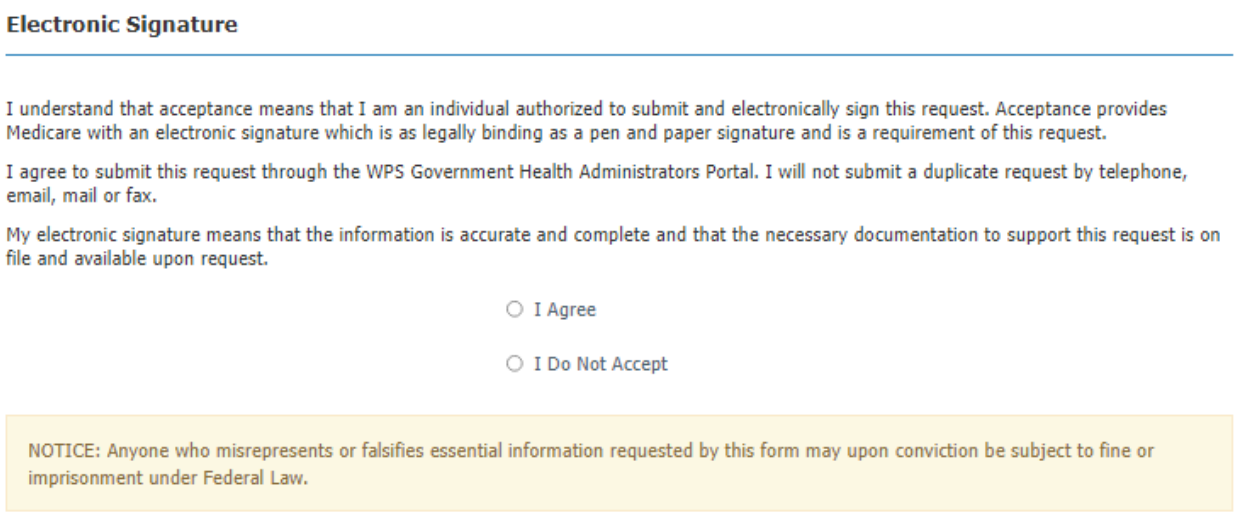
Step 8: If you do have documentation to submit, click the Upload Files button to upload it from your computer. The file size cannot exceed 100 MB (102,400 KB) for Part A appeals. The portal accepts the following document types:

- .docx
- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip



If you have multiple documents to submit (up to 20 files), place them all in a single .zip file. Remember to disable all password protection, macros, and external links before submitting the documentation.

Step 9: Review the disclosure statement and indicate if you agree to the terms. If you agree, click the Review button to have the portal check your appeal for missing items. You can click the Clear button to clear the information on the form or the Cancel button to exit the appeal without submitting it.

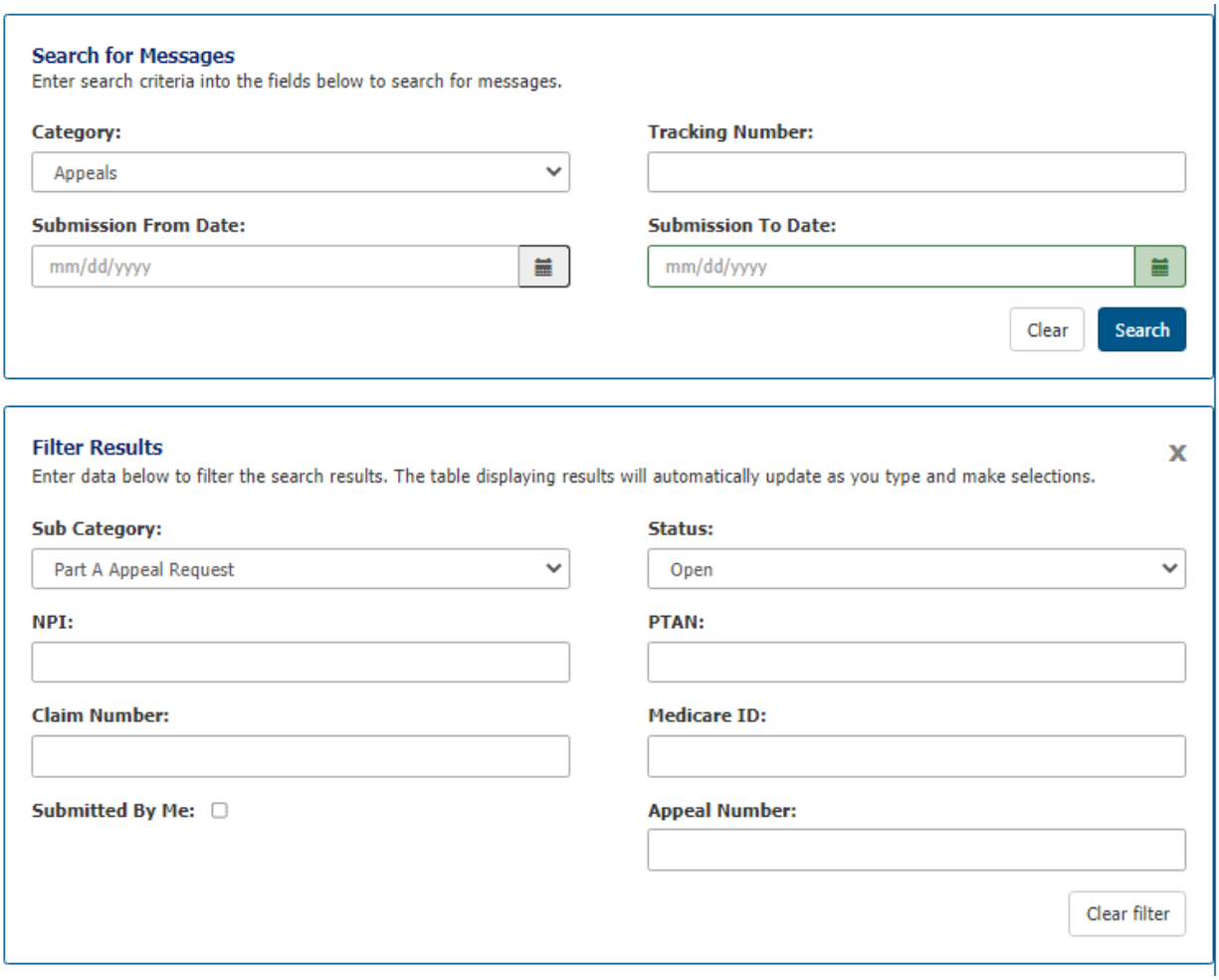


Step 10: Once portal reviews your appeal for missing items, click the Submit button to submit your reconsideration or click the Cancel button to make changes before submitting it.

NOTE: You cannot make any changes to your appeal once you submit it.

Steps for Submitting Additional Documentation for a Part A Reconsideration via the Message Center

Step 1: Locate the Part A reconsideration by using the below search criteria:

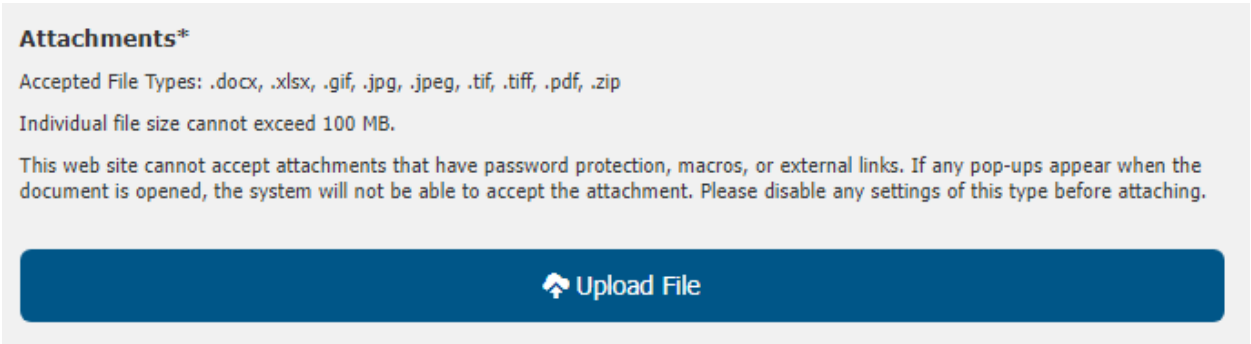


Step 2: Once the Reconsideration is found, click on the Tracking Number link to go to bring up the Reconsideration.

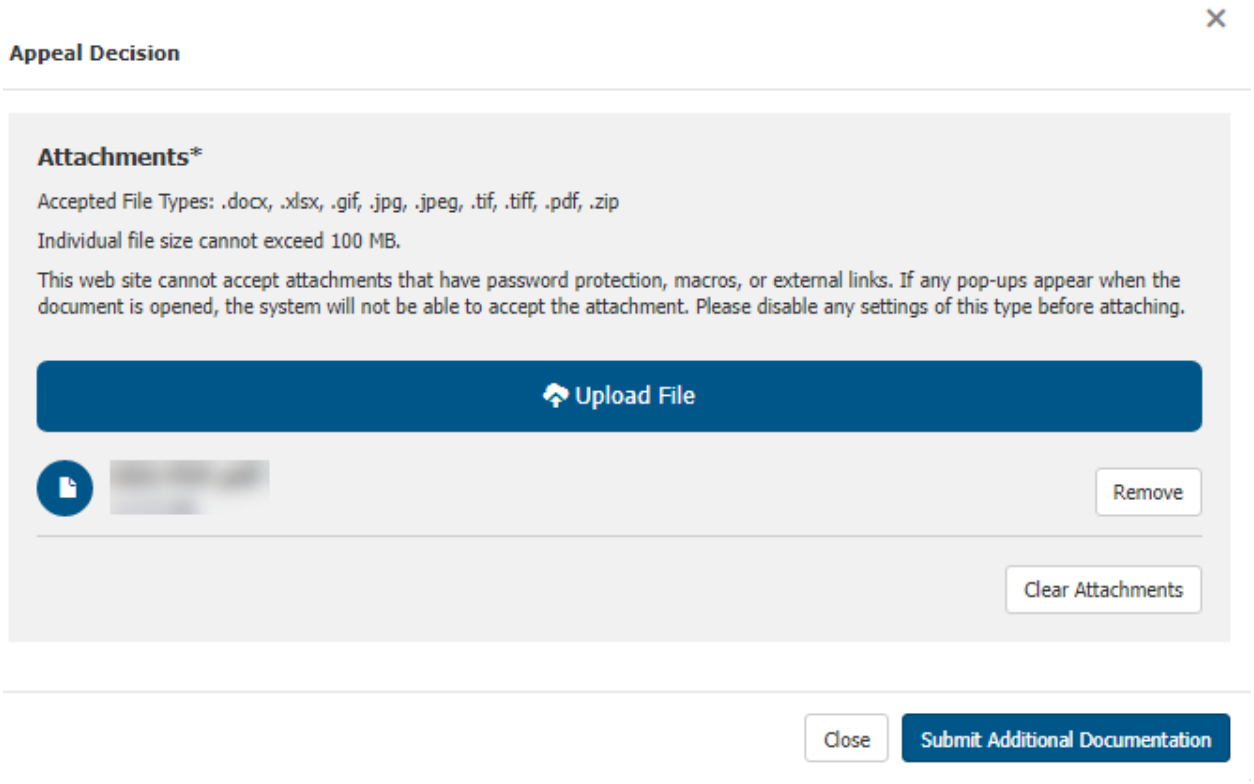
Step 3: The reconsideration will display, and you will need to scroll to the bottom of the page and click the Attach Additional Documentation button.

Step 4: To upload your additional documentation, click on the Upload Files bar to locate your files on your computer. The file size cannot exceed 100 MB (102,400 KB) for Part A appeals. The portal accepts the following document types:

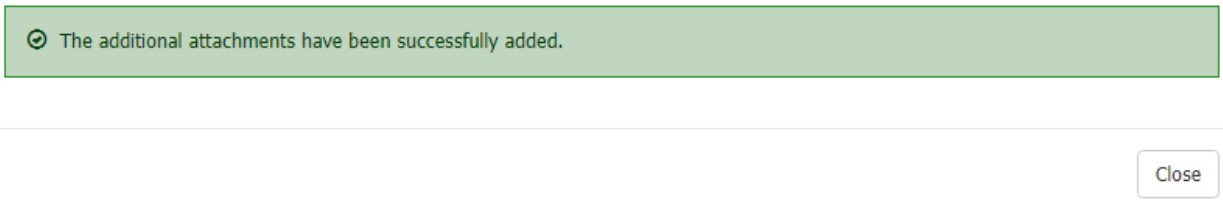
- .docx
- .xlsx
- .pdf
- .jpg
- .jpeg
- .gif
- .tif
- .tiff
- .zip



Step 5: Once your Files have been uploaded, they will display for your verification. Once all new files have been uploaded click the Submit Additional Documentation button.



Step 6: You will receive a message that the documents have been successfully attached.

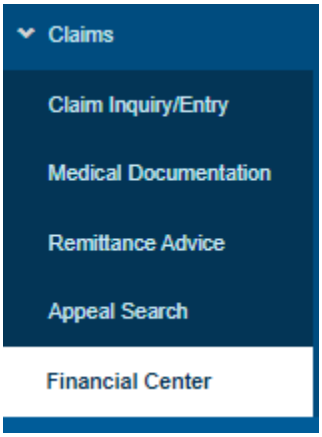


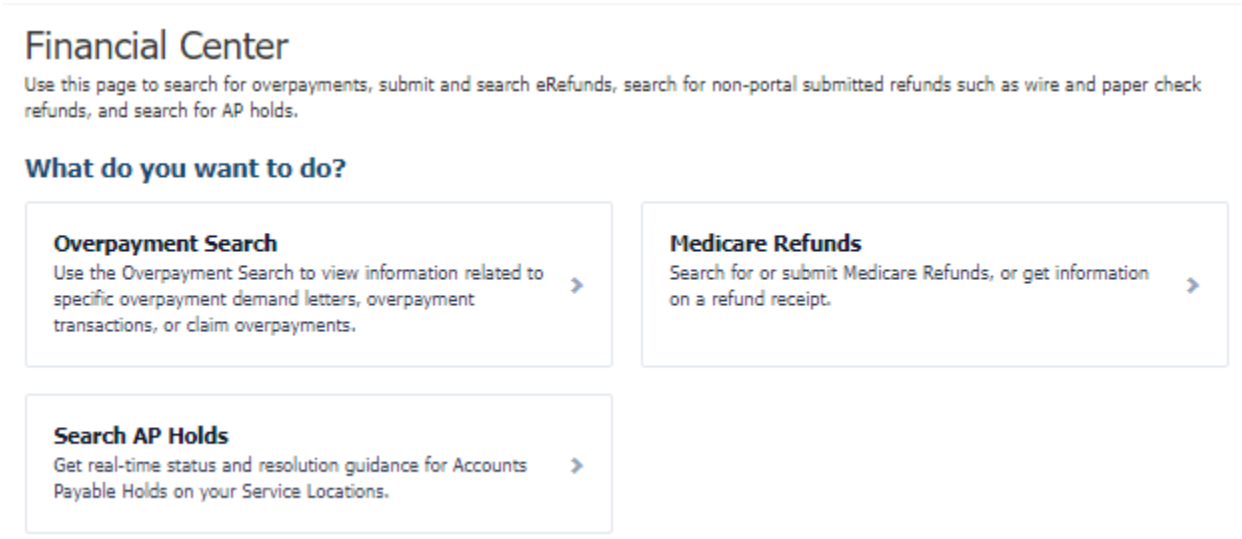
Financial Center Overview

Providers can use the Financial Center as a starting place to do an Overpayment Search, search for or submit Medicare Refunds, or search for active or inactive AP Holds.

- Overpayment Search
- Medicare Refunds
- Receipt Search
- Search AP Holds

Accessing the Financial Center
You can access the Financial Center by selecting the Financial Center link under the Claims heading in the left navigation menu. (If you do not see the Financial Center link, click the arrow next to the Claims heading to open the Claims menu.)





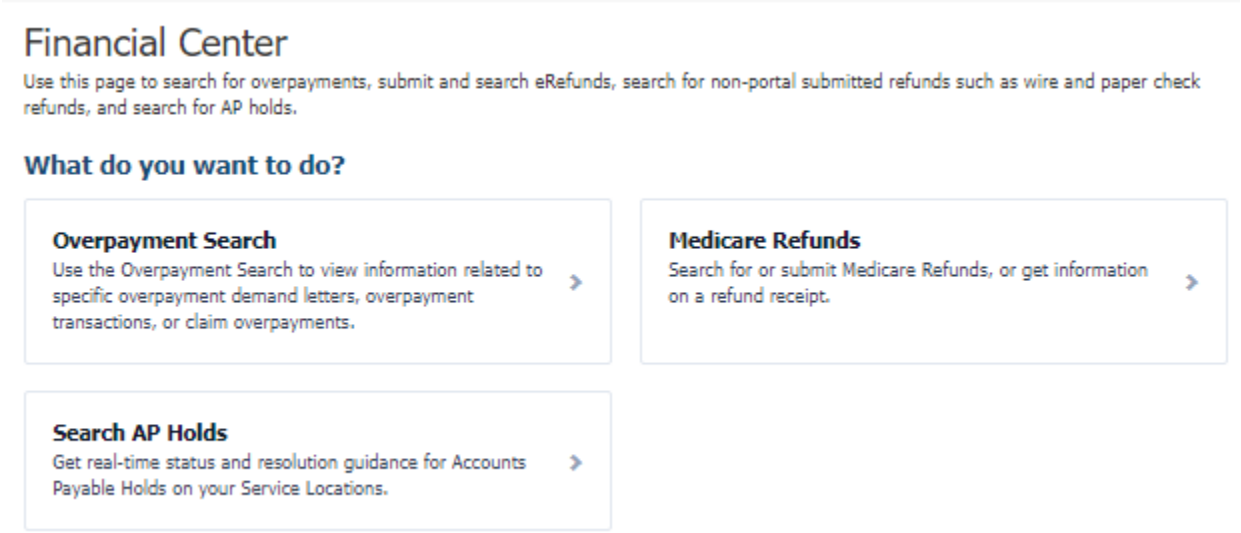
Overpayment Search

The Overpayment Search allows you to access the claim and overpayment information. You can search for a Medicare overpayment by the demand letter number, transaction number, or claim number.

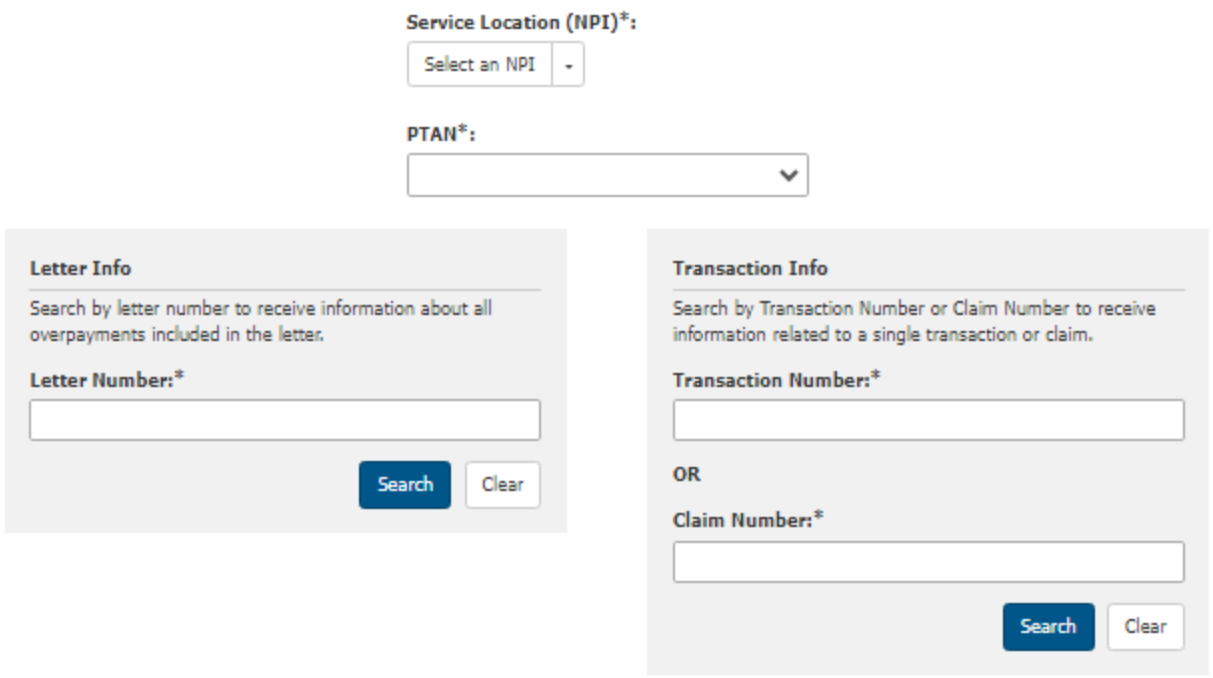
You can access the Overpayment Search via the Financial Center or via the Letter Search. To access through the Financial Center, select the Financial Center link in th e left navigation.

Accessing Overpayment Search

From the Financial Center page, click on the Overpayment Search box.



From Letter Search, click the Overpayment Search button.

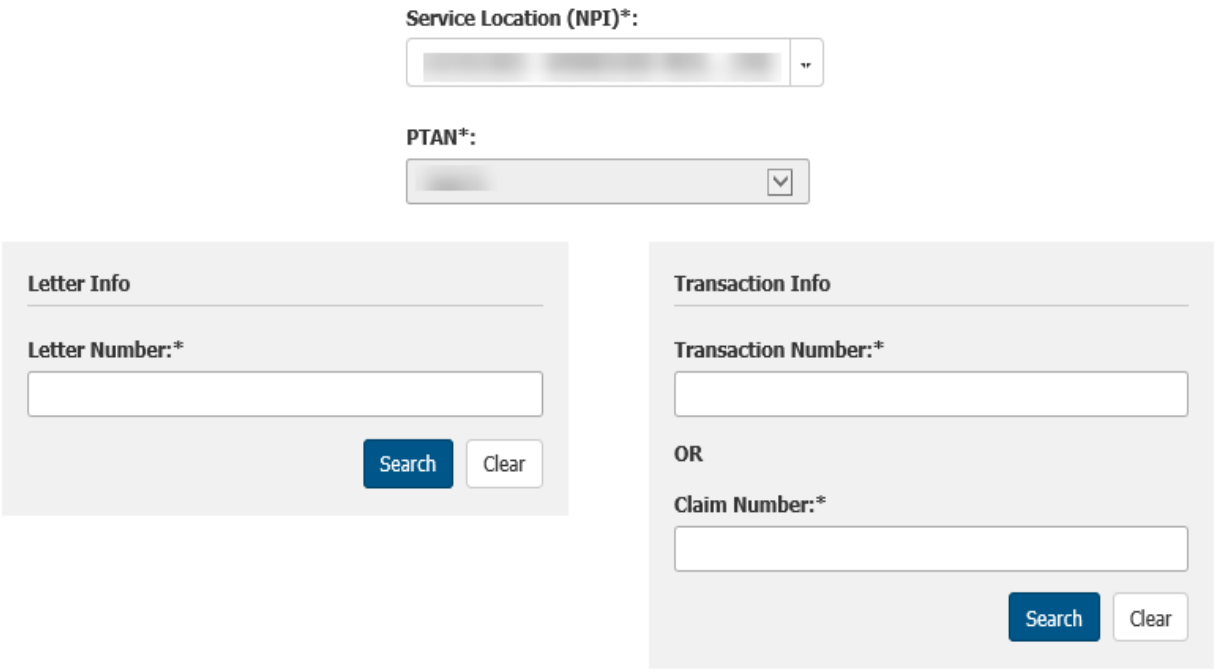


Once on the Overpayment Search page, select your Service Location (NPI) and PTAN from the dropdown boxes. Depending on the number of NPI you have access to, these options may be pre-selected.

Next, enter your search criterion for the overpayment. You must select **one** of the following options:

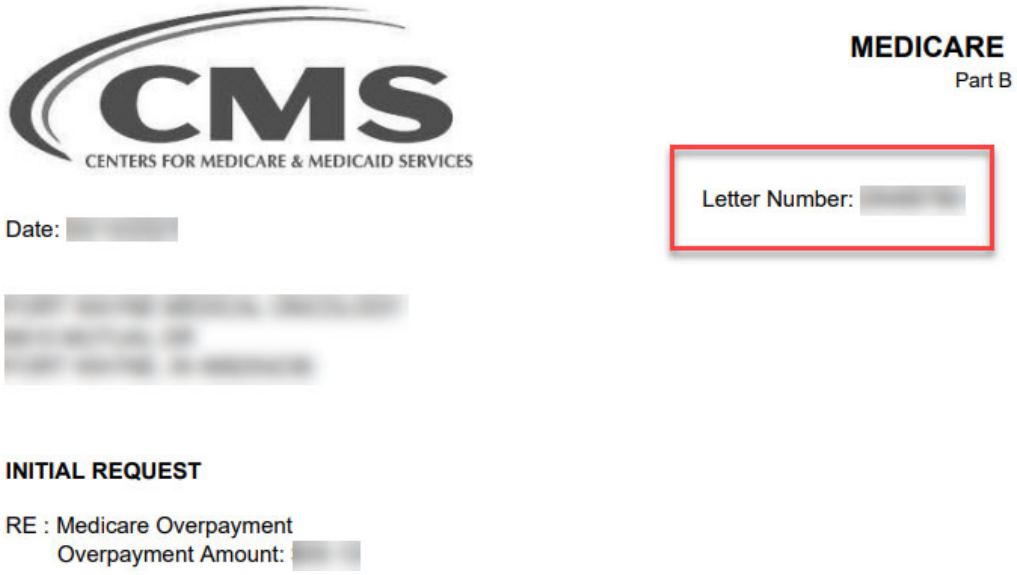
- Letter Number
- Transaction Number (Invoice Number)
- Claim Number

Searching by the letter number will information for all overpayments included in the demand letter, searching by the Transaction or Claim number will return information for the single transaction.



Overpayment Search Using the Letter Number (H2)

You can perform an overpayment search using the letter number listed on your demand letter.

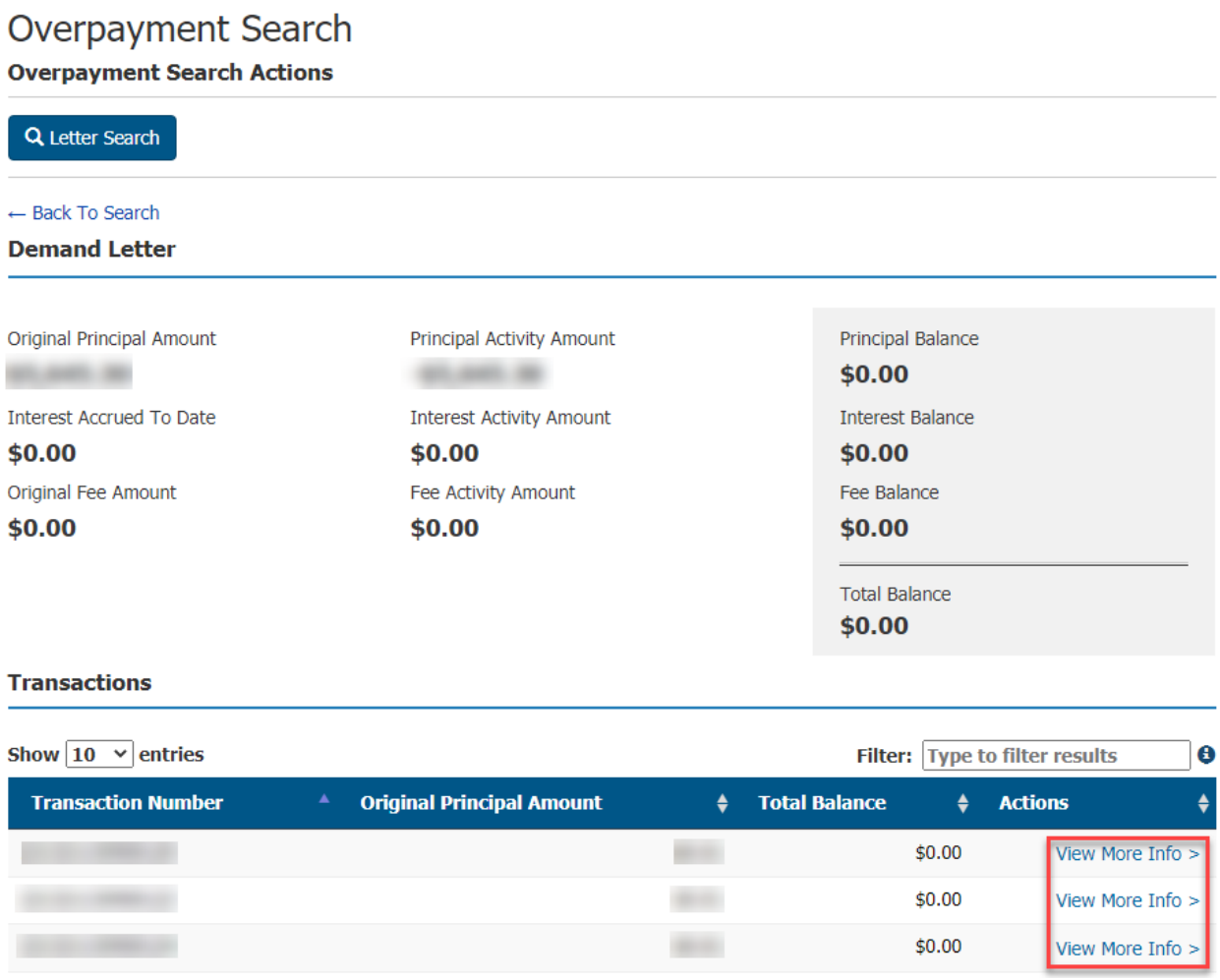


A demand letter may include multiple overpayments and searching by the letter number will return details about all the overpayments included in the demand letter. The information returned includes:

- Original Principal Amount
- Principal Activity Amount
- Principal Balance

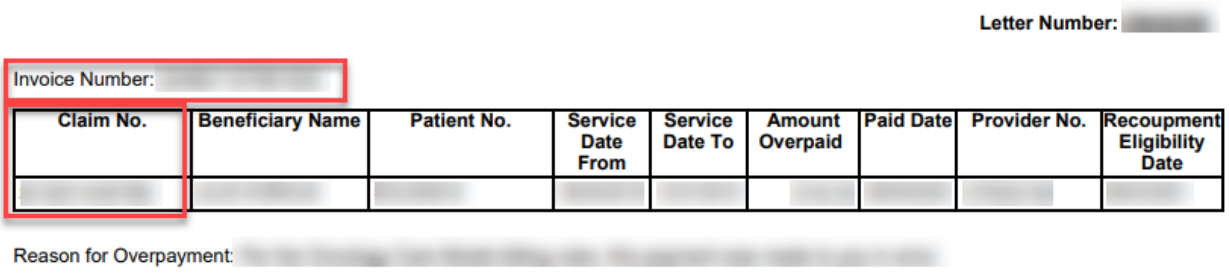
- Interest Accrued to Date
- Interest Activity Amount
- Interest Balance
- Original Fee Amount
- Fee Activity
- Fee Balance
- Total Balance

Individual overpayment (transaction) information is located below the demand letter details. Click the View More Info link in the Actions column to see details about each overpayment. See the Overpayment Search by Transaction Number or Claim Number in the section below for more information about the details available.



Overpayment Search by Transaction Number or Claim Number (H2)

You can perform an overpayment search by the transaction number (invoice number) or claim number. You can locate these numbers in the final page(s) of the demand letter.



Letter Number:

Invoice Number:

Claim No.	Beneficiary Name	Patient No.	Service Date From	Service Date To	Amount Overpaid	Paid Date	Provider No.	Recoupment Eligibility Date

Reason for Overpayment:

NOTE: Medicare uses some terms interchangeably on the demand letter and in financial transactions. Both of the following terms are types of Financial Control Numbers (FCNs):

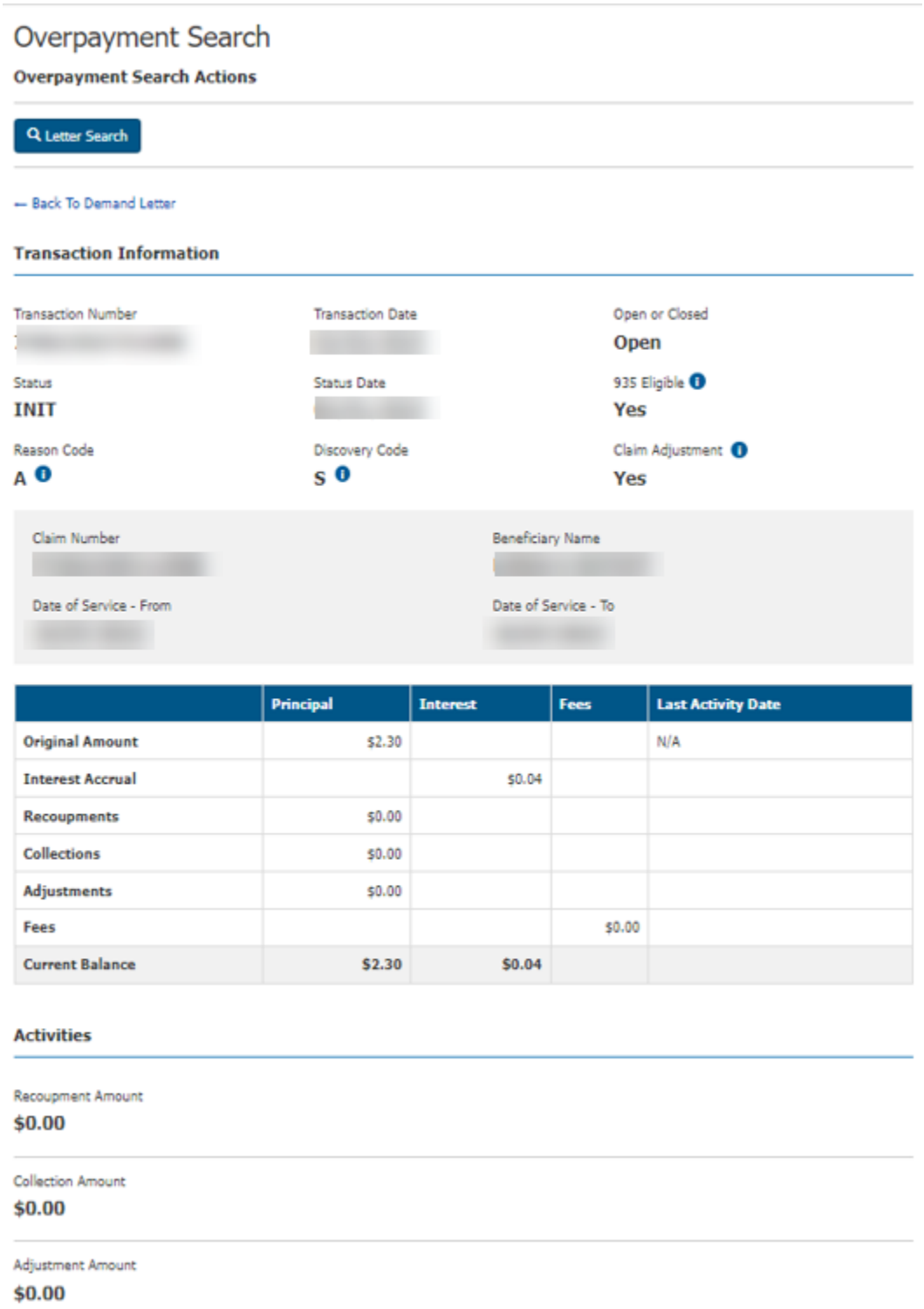
- A "claim number" (claim no.) is based on the **original** claim's Internal Control Number (ICN) or Document Control Number (DCN) (or, if the claim has been adjusted multiple times, the claim that was adjusted to create the overpayment).
    - The Part A claim number may be the same as the DCN, or it could be the same DCN number followed by different letters.
    - The Part B claim number is a 15-digit number consisting of a two-digit code followed by the 13-digit ICN.
- "Transaction number" is used interchangeably with "invoice number." It is based on the ICN/DCN of the **adjusted** claim that resulted in the current overpayment.
    - The Part A transaction number is like the original DCN but followed by different letters.
    - The Part B transaction number/invoice number is a 15-digit number consisting of a two-digit code followed by the 13-digit adjusted ICN.

Searching by the transaction number or claim number, or clicking the View More Info link when viewing the demand letter details, will return the following information:

- Transaction Number
- Transaction Date
- Open or Closed
- Status
- Status Date
- 935 Eligible – Yes or No*
- Reason Code*
- Discovery Code*
- Claim Adjustment – Yes or No*
- Claim Number
- Beneficiary Name
- Date of Service – From
- Date of Service – To
- Original Amount (Principal, Interest, Fees, Last Activity)
- Interest Accrual (Principal, Interest, Fees, Last Activity)
- Recoupments (Principal, Interest, Fees, Last Activity)
- Adjustments (Principal, Interest, Fees, Last Activity)
- Fees (Principal, Interest, Fees, Last Activity)
- Activities
    - Recoupment Amount
    - Collection Amount

- Adjustment Amount

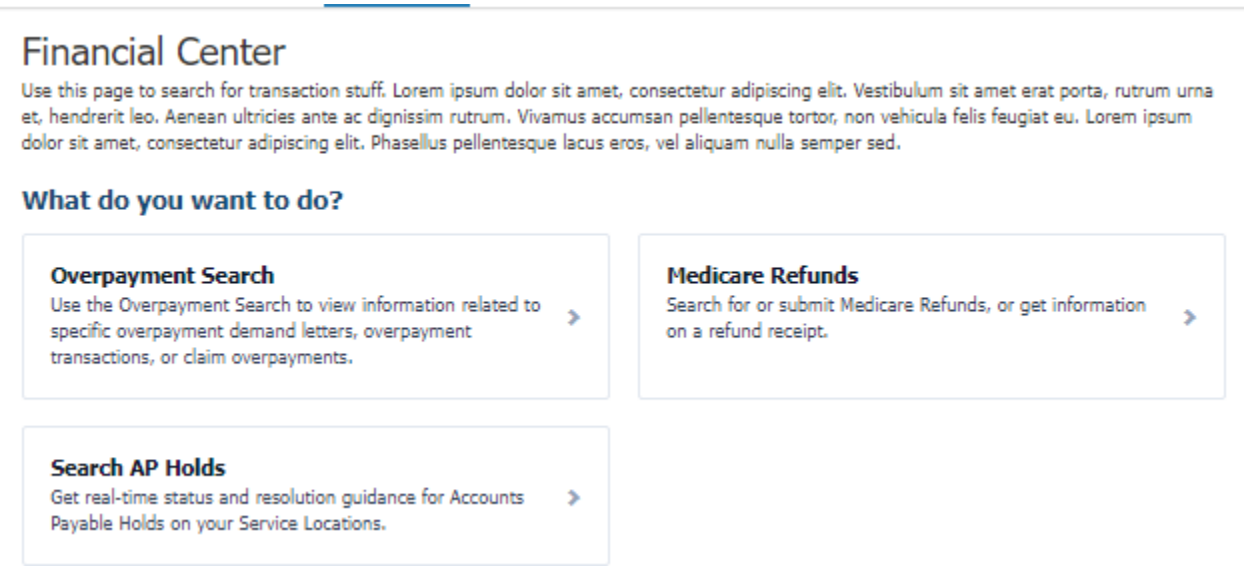
Additional information is available for the items marked with an asterisk (*) by hovering your mouse over the blue “i” information icon next to the item.



Medicare Refunds

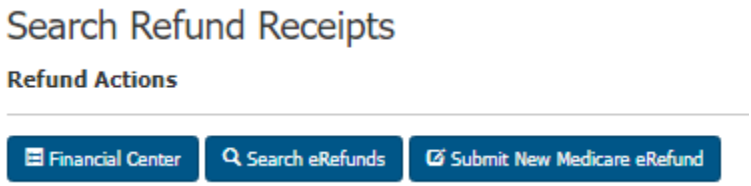
Providers who owe refunds to Medicare can return the money electronically through the portal, which can save time, money, and resources. You can access Medicare Refunds via the Financial Center by selecting the Financial Center link in the left navigation.

On the Financial Center page, click on the Medicare Refunds box.



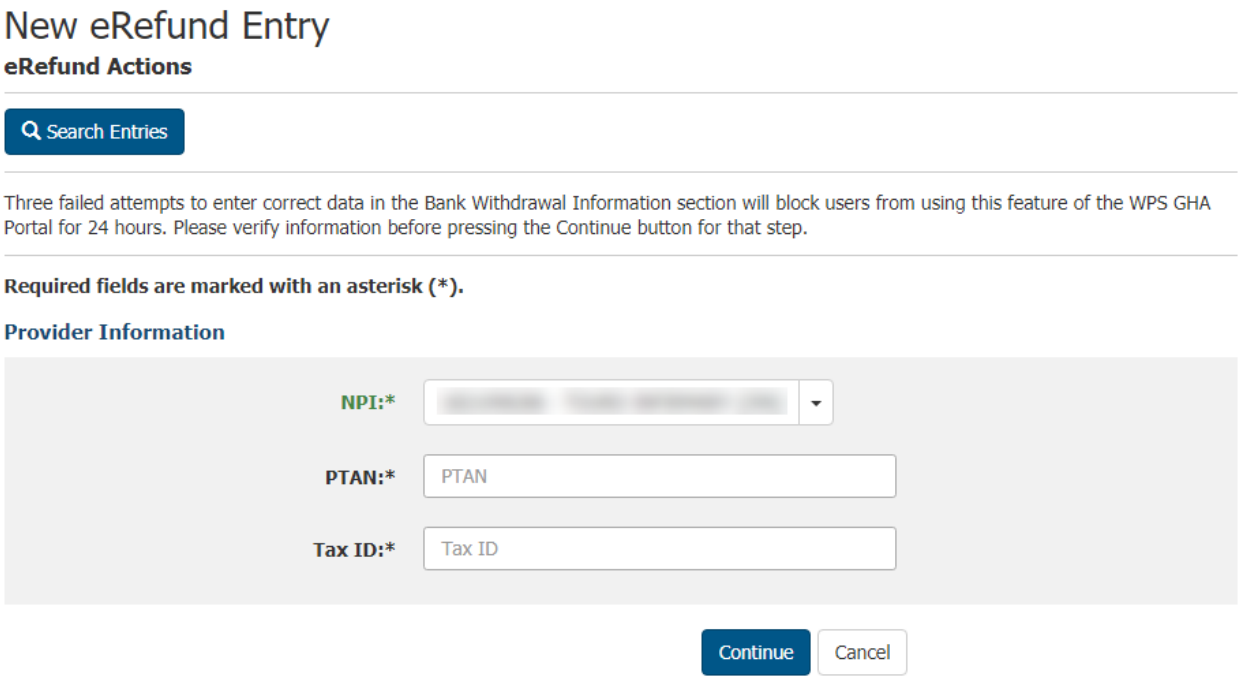
Submitting an eRefund

To submit an eRefund, from the Search Refund Receipts page, click the Submit New Medicare eRefund button.

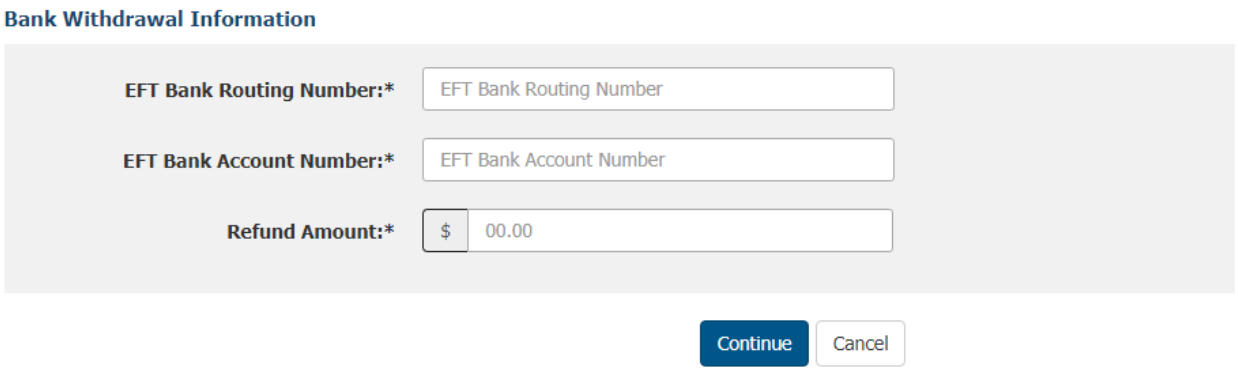


Before submitting an eRefund, you will need to gather your group's banking information. The information must match the banking information on your group's CMS-588 form (Electronic Funds Transfer Authorization Agreement). You cannot submit alternate banking information when completing an eRefund.

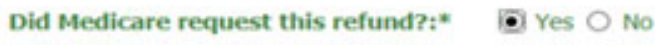
Step 1: Open the Medicare eRefunds function and enter your NPI, PTAN, and TIN information. Click the Continue button.



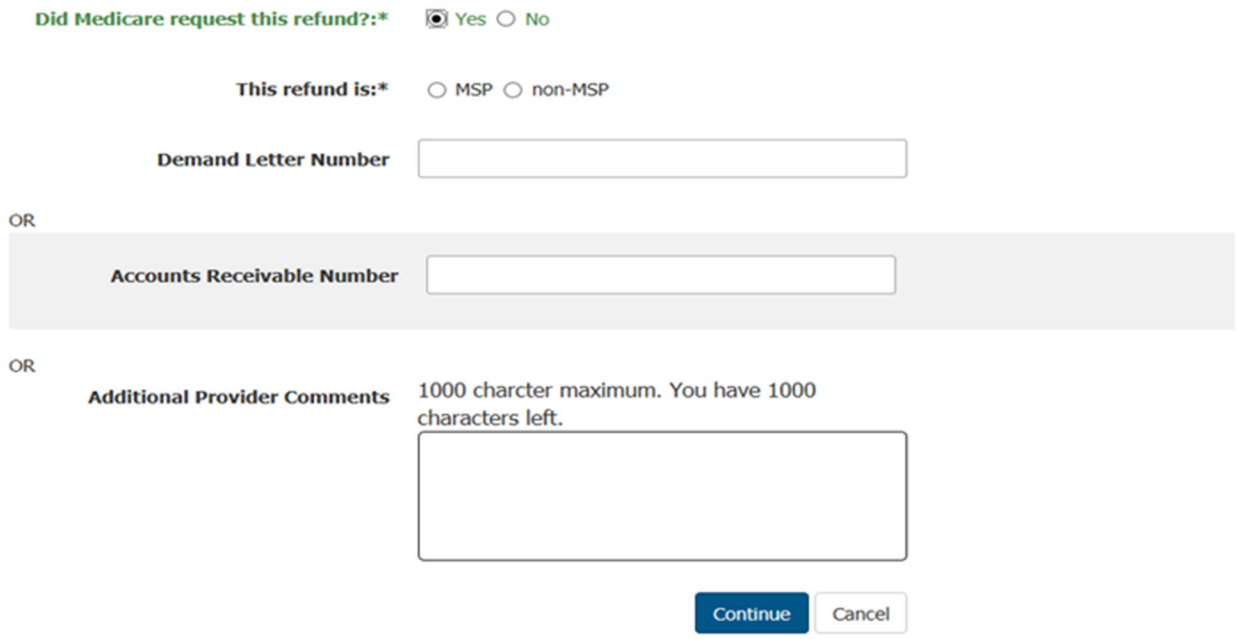
Step 2: Enter your banking information. The information must match the information on the CMS-588 form filed with Medicare. Also enter the amount you are refunding to Medicare.



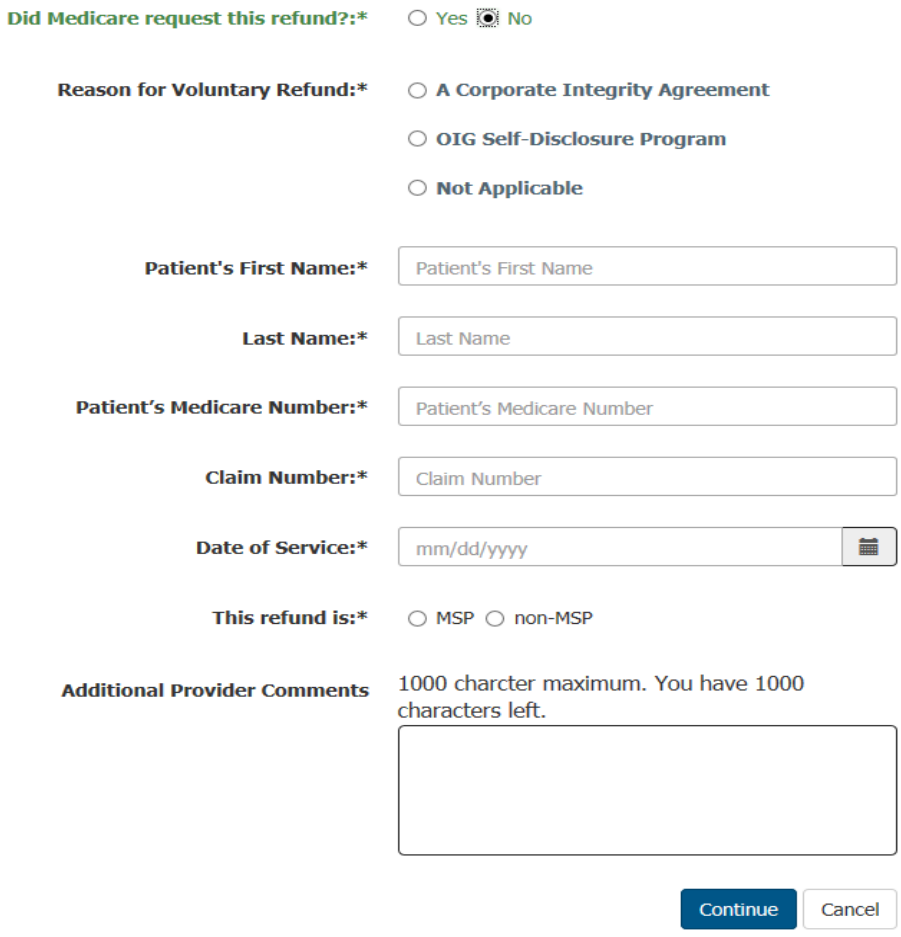
Step 3: Indicate if Medicare requested the refund. Depending on your answer, you will need to provide additional details about the refund.



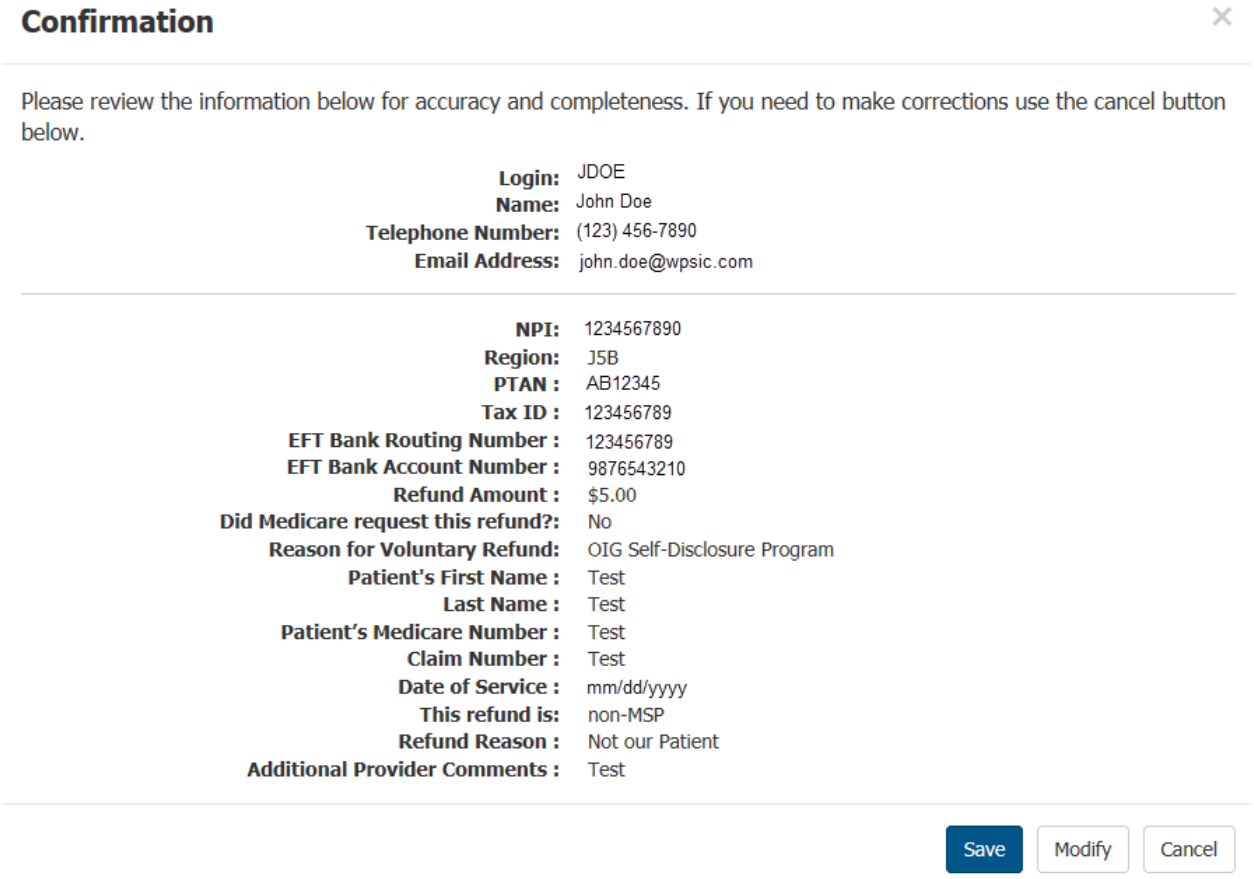
If you answered "Yes," meaning Medicare did request the refund, you will need to indicate if the refund is related to a Medicare Secondary Payer (MSP) issue. You will also need to provide the demand letter number, the accounts receivable (A/R) number, or other details to allow Medicare to match your eRefund to the overpayment in Medicare's records.



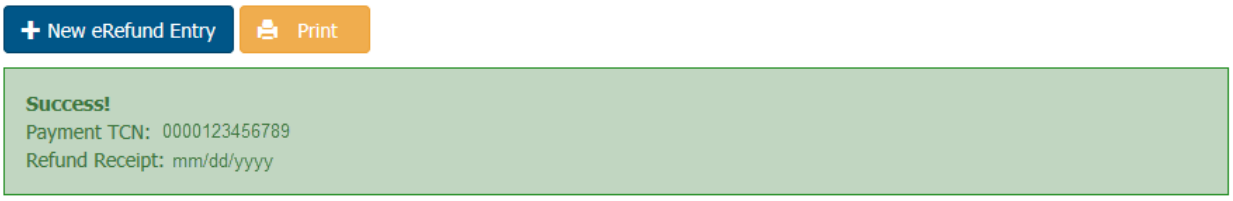
If you answered "No," meaning you are submitting a voluntary refund, you need to indicate the reason for the refund, the patient and claim information, and whether the refund is related to an MSP issue. You can also provide additional comments, if necessary.



Step 4: After clicking the Continue button, you will see a confirmation pop-up window. Verify the information is accurate and complete, then choose the Save button to submit the eRefund, the Modify button to go back and make changes, or the Cancel button to exit the eRefund process.



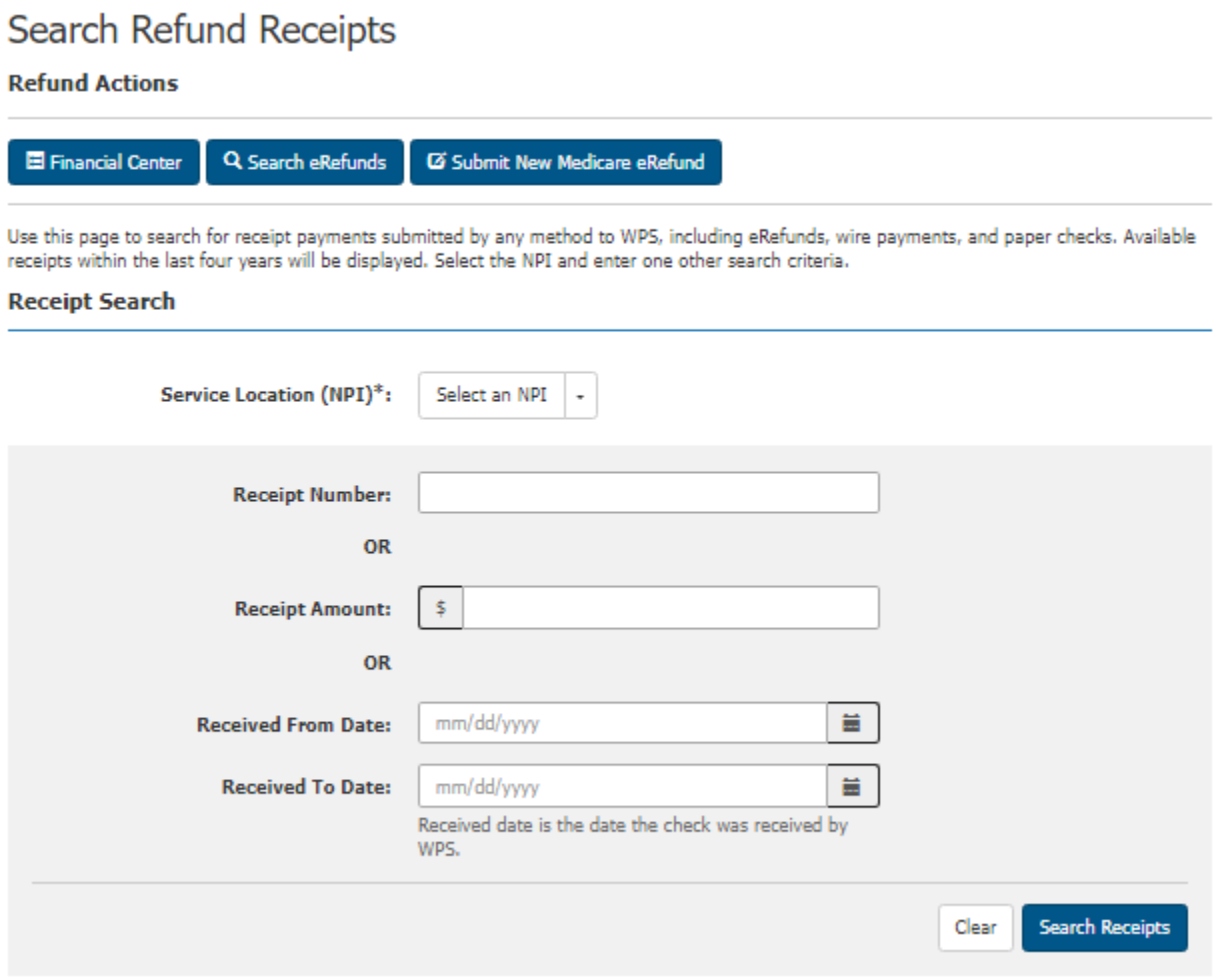
Once you successfully submit your eRefund, the portal will provide a tracking control number (TCN) and the refund receipt date. (You can use this information if you need to search for your eRefund later.) You can select the New eRefund Entry button if you need to submit another eRefund or the Print button to print the details.



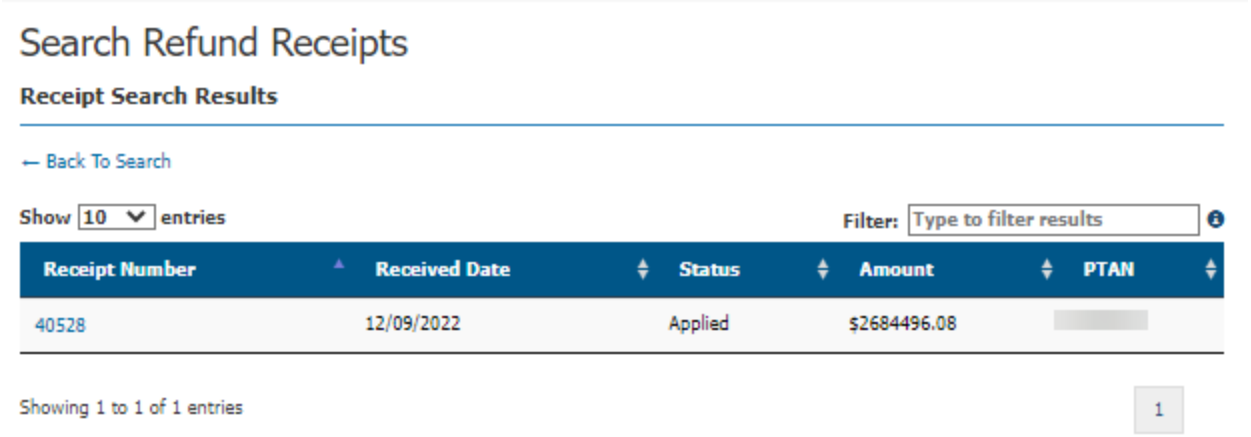
Refund Receipt Search

On the Search Refund Receipts page, you can search for receipts submitted by any method (eRefund, wire payment, paper check); search for eRefunds submitted in the portal or submit a new eRefund.

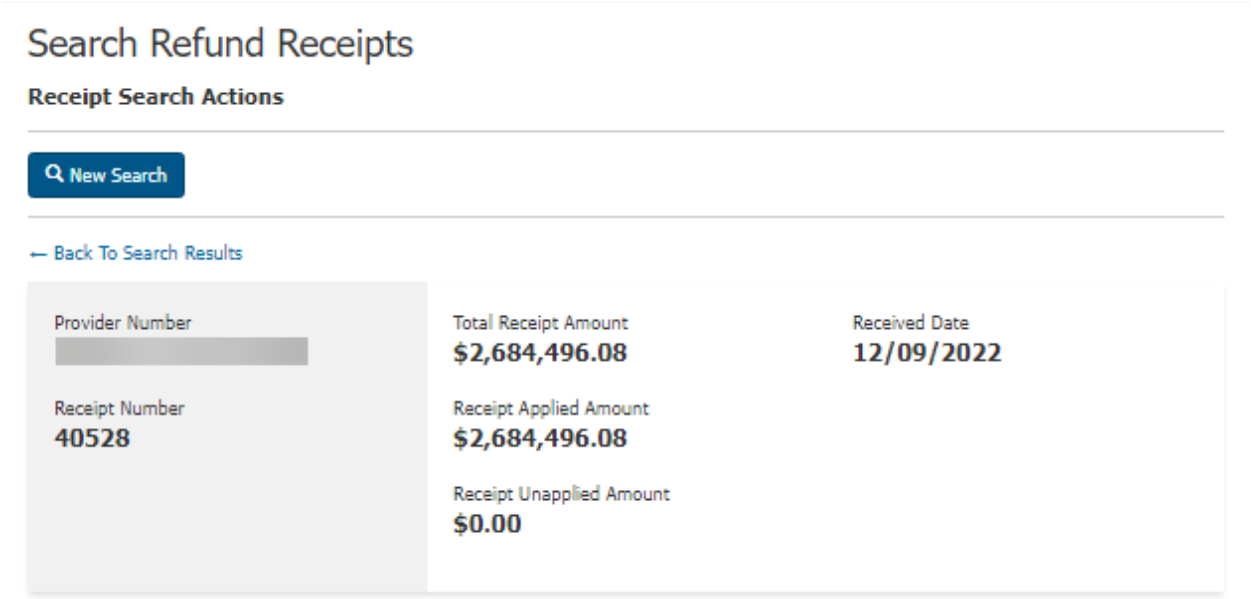
To search a receipt of any type, select your NPI and one criterion: the Receipt Number, the Receipt Amount, or the Received date range. The Received date is the date the check was received by WPS.



On the search results page click the Receipt Number link to view the receipt details.



The Receipt Details will provide the Total Receipt Amount, Applied Amount, Unapplied Amount, and the date the receipt was received.

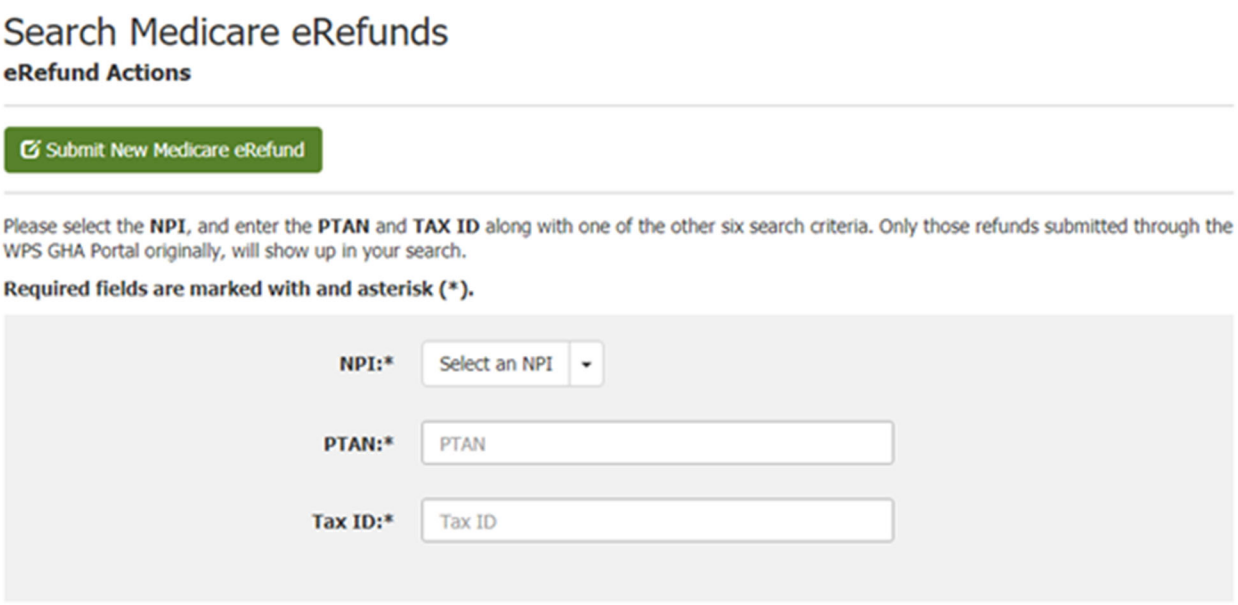


Searching for an eRefund

You can use the portal to search for refunds previously submitted in the portal.

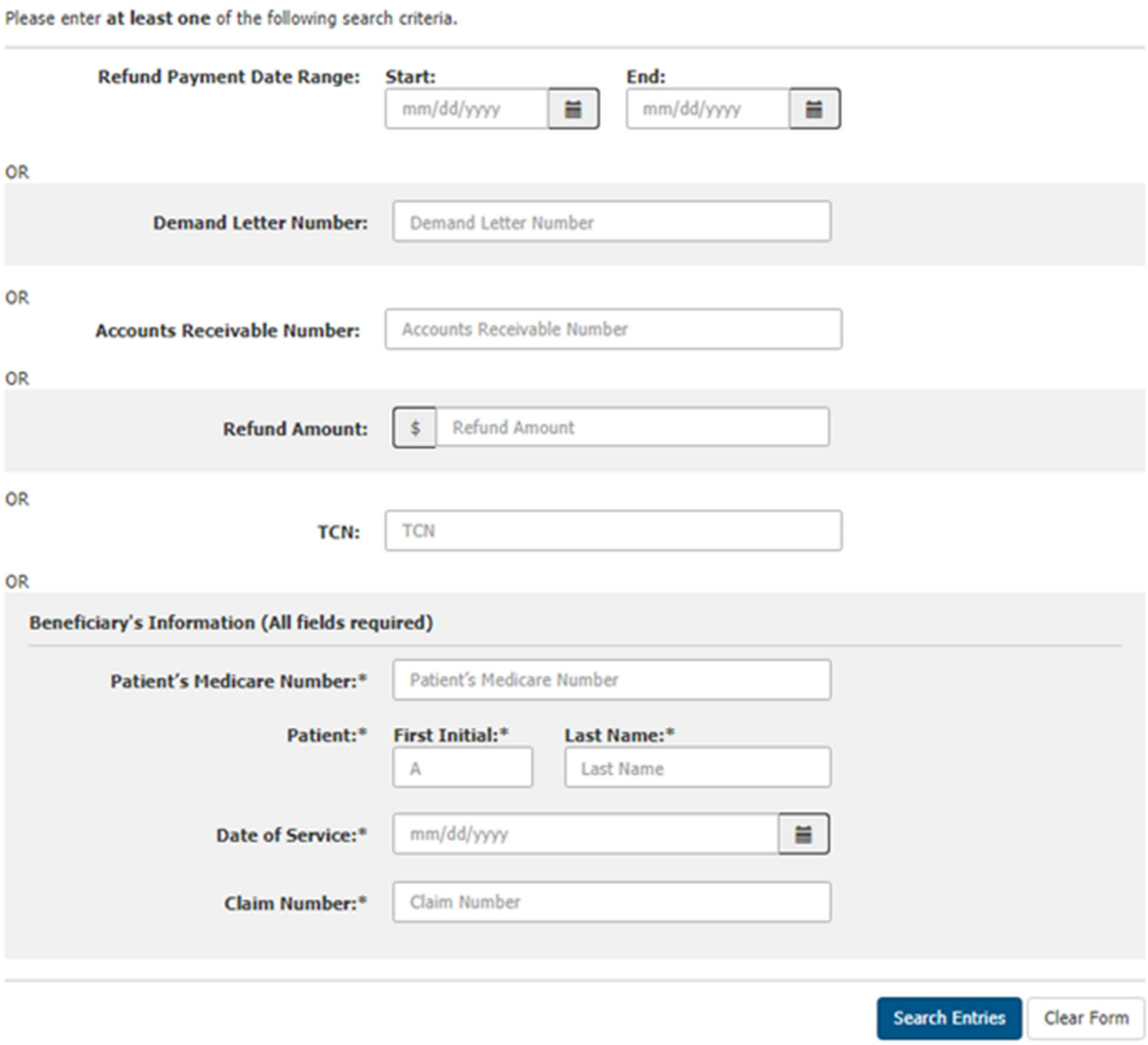
Step 1: Select Medicare eRefunds from the left navigation menu, then select the Search Refunds button near the top of the page.

Step 2: Enter your group's NPI, PTAN, and Tax ID (TIN) on the Search Medicare eRefunds page.



After entering your group's information, enter one or more search criteria:

- Refund payment date range
- Demand letter number
- Accounts receivable number
- Refund amount
- TCN
- Beneficiary and claim information, which requires all the following items:
    - Patient's Medicare number
    - Patient's first initial and last name
    - Date of Service
    - Claim number



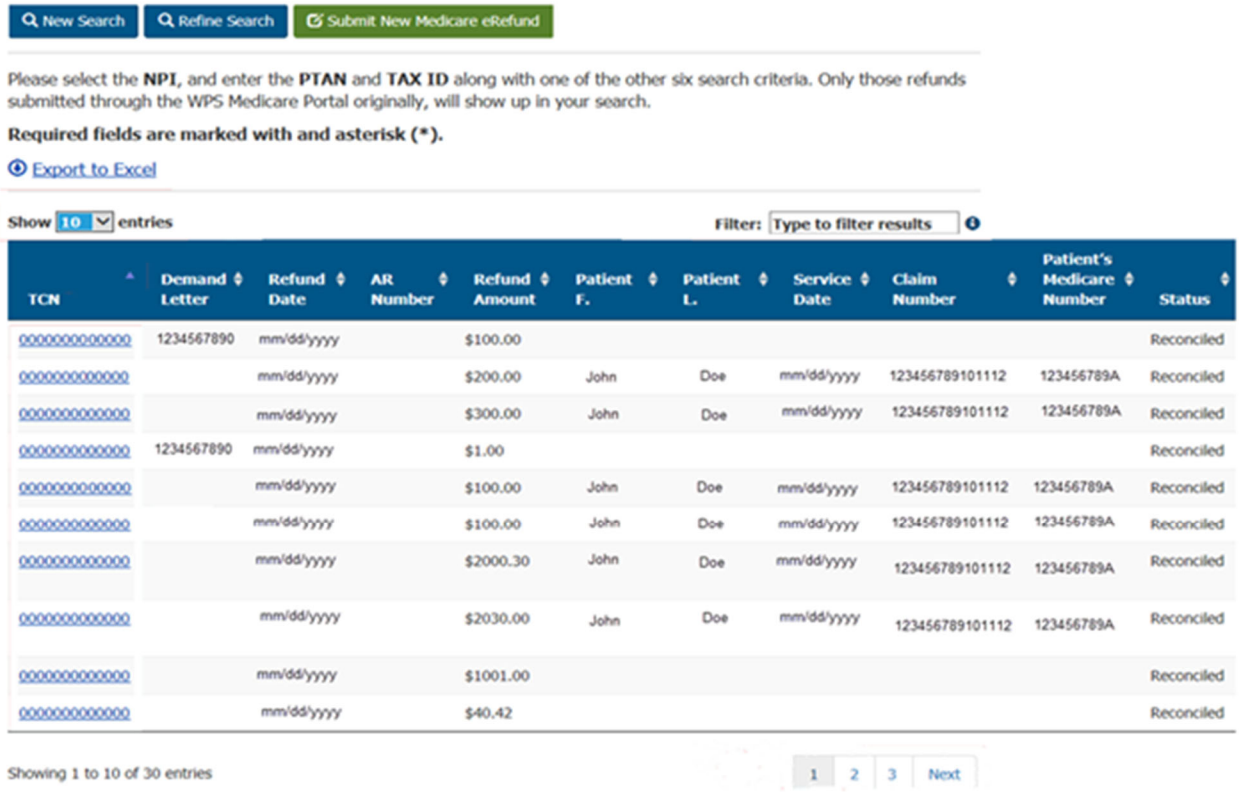
Step 3: After clicking the Search Entries button, the results page will load showing any results that matched the search. The list of results will always display the following:

- TCN
- Refund date
- Refund Amount
- Status

If applicable, the results will also display:

- Demand letter
- Accounts Receivable (A/R) number
- Patient's name
- Service date

- Claim number
- Patient's Medicare number



From the results page, you can:

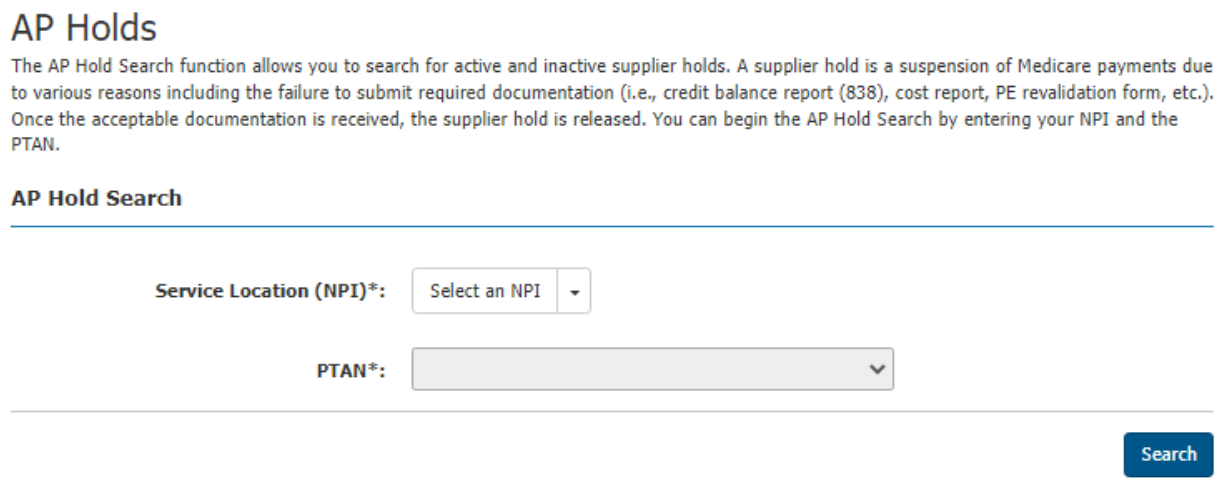
- Choose the New Search button to start a new search, the Refine Search button to refine the current search, or the Submit New Medicare eRefund to submit a new eRefund.
- Choose the Export to Excel link to export the list to Excel for saving.
- Use the Show Entries dropdown box to expand the number of eRefunds showing on-screen.
- Use the arrows at the top of a column to sort the results by that column.
- Use the Filter box to filter the results.
- Click on a TCN number link in the list to see additional details about the eRefund in a pop-up box.

Accessing AP Hold Search

The AP Hold Search function is an extension of the Financial Center in the portal. You can get real-time status and resolution guidance for Accounts Payable holds on your service locations that you have access to. You can search for an AP Hold by NPI and PTAN.

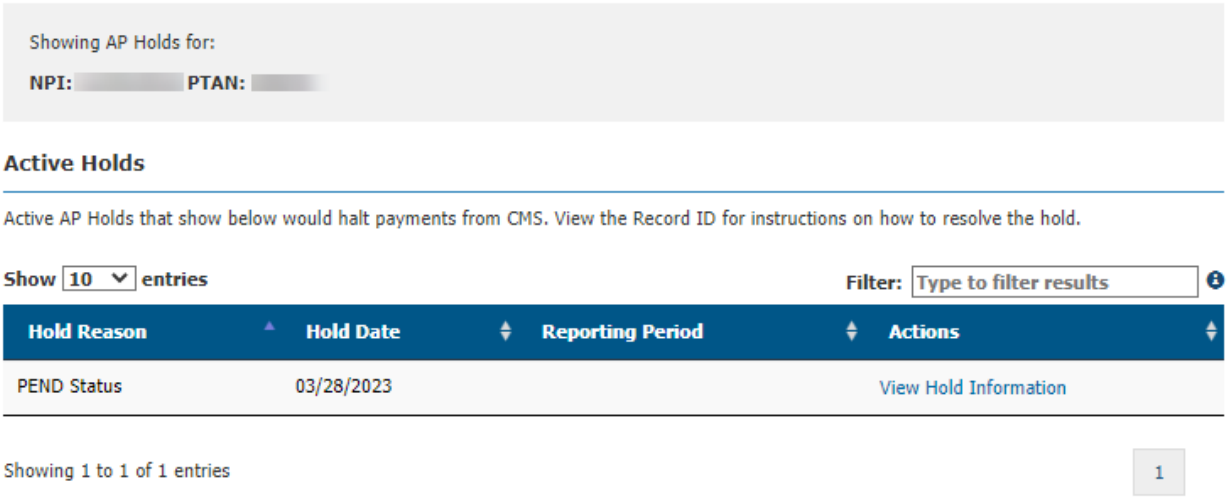
Active Holds

Step 1: On the AP Hold Search page, select your Service Location (NPI) and Provider Transaction Access Number (PTAN) from the dropdown boxes. Depending on the number of NPI you have access to, these options may be pre-selected. If there are multiple PTANs for the NPI, you will need to select the appropriate PTAN. Click the Search button.



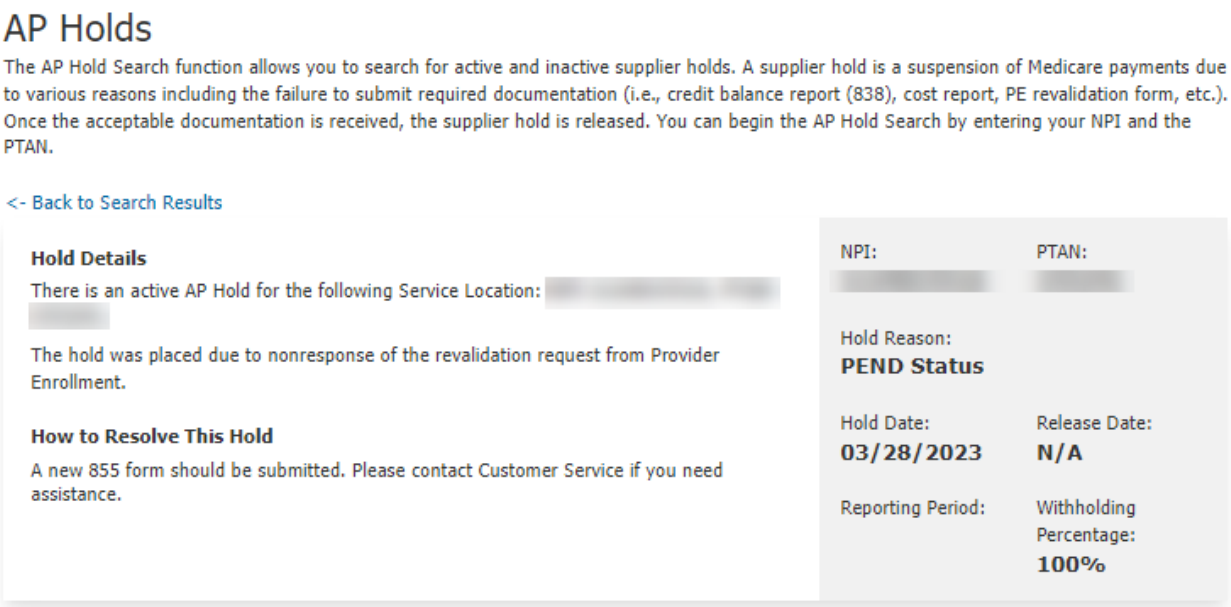
Step 2: The search will return all active holds for the NPI. The data displayed will be:

- Hold Reason
- Hold Date
- Reporting Period
- Actions



Step 3: Under the actions, click on the 'View Hold Information' link to obtain additional details on the active hold.

- Holds Details
- NPI
- PTAN
- Hold Reason
- Hold Date
- Release Date
- Reporting Period
- Withholding Percentage
- How to Resolve This Hold

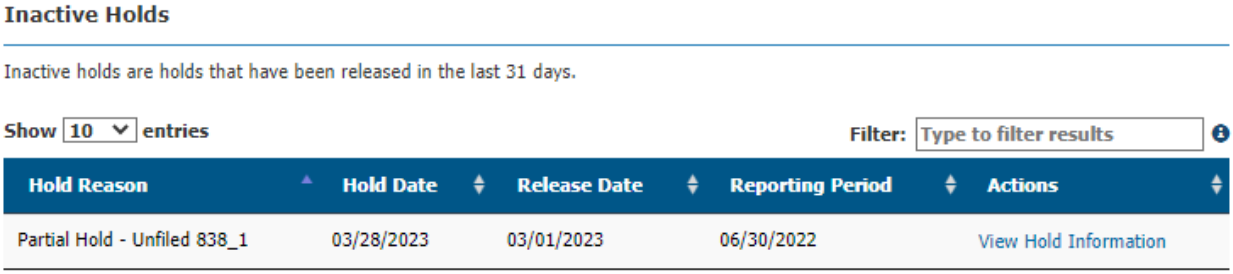


Inactive Holds

Step 1: On the AP Hold Search page, select your Service Location (NPI) and Provider Transaction Access Number (PTAN) from the dropdown boxes. Depending on the number of NPI you have access to, these options may be pre-selected. If there are multiple PTANs for the NPI, you will need to select the appropriate PTAN. Click the Search button.

Step 2: The search will return all inactive holds for the NPI. The data displayed will be:

- Hold Reason
- Hold Date
- Release Date
- Reporting Period
- Actions



Step 3: Under the actions, click on the 'View Hold Information' link to obtain additional details on the active hold.

- NPI
- PTAN
- Hold Reason
- Hold Date
- Release Date
- Reporting Period
- Withholding Percentage

AP Holds

The AP Hold Search function allows you to search for active and inactive supplier holds. A supplier hold is a suspension of Medicare payments due to various reasons including the failure to submit required documentation (i.e., credit balance report (838), cost report, PE revalidation form, etc.). Once the acceptable documentation is received, the supplier hold is released. You can begin the AP Hold Search by entering your NPI and the PTAN.

<- Back to Search Results

NPI:	PTAN:	Hold Reason:	
[redacted]	[redacted]	**Partial Hold - Unfiled 838_1**	
Hold Date:	Release Date:	Reporting Period:	Withholding Percentage:
03/28/2023	**01-MAR-2023**	**06/30/2022**	**50%**

Revision History

Version	Date	Description of Changes
1.0	12/29/2016	Added new manual with Revision History page.
2.0	03/24/2017	Added text to password 21-day rule. Added text for Administrator disabling accounts. Changed screens with Appeal Status tab order. Removed G0389 and replace with 76706 in Preventive Services for eligibility. Added Multi-Factor Authentication section.
3.0	05/24/2017	Updated “Request Submitter ID” section to be “Register for Online Claim Entry.” There is a new process for user to enroll in online claim entry using the portal. Updated screen shots and text to explain the new process
4.0	07/18/2017	Added information to the MFA section concerning the roll-out and updates that were not made on 05/24/2017.
5.0	09/05/2017	Added new screens for new claim inquiry features. Updated MFA showing code is now valid for 4 hours and on how to change default to Google Authenticator. Added new screens for new Provider Self Service Denial tool.
6.0	10/02/2017	Corrected some MFA screens.
7.0	01/26/2018	Replaced the entire MFA section. Code is now valid for 8 hours and screens changed.
8.0	03/09/2018	Updated Administrator Roles, QMB information, added FAQs. New screens showing the new Appeals Tabs.
9.0	04/01/2018	Added MBI information.

Version	Date	Description of Changes
10.0	04/23/2018	Changed the name of the MBI section.
11.0	06/15/2018	Added Easier Remittance Advice lookup, Who is My Admin feature, new NPI Admin Lookup on login page, and MDPP information.
12.0	08/31/2018	Updated Message Center to add Audit.
13.0	11/02/2018	Modified the Clerical Error Reopening (CER) section. Renamed to match Link in Footer of Portal.
14.0	11/15/2018	Added section to remove access for Standard and Eligibility Users.
15.0	11/20/2018	Removed numbered lists and replaced with bulleted lists for easier formatting.
16.0	03/30/2019	Added Account Reactivation section and updated eligibility section with HETS Q100 changes.
17.0	04/22/2019	Updated Financial data timeframe from 90 to 30. Added a note to the account reactivation section.
18.0	08/08/2019	Added CER over 6 line claim ability. Updated Admin Responsibilities on Reactivation. Added instruction on Admin Self Reactivation process. Added Letter Search for ADR and Demand Letters.
19.0	11/11/2019	Changed MFA code to last 12 hours. Updated Eligibility information available. Added Letter Search. Updated Appeals tab names and screens.
20.0	12/30/2019	Added the new information for Supplemental Insurance under Eligibility.
21.0	04/06/2020	Added new PPV information under Preventives Service in Eligibility. Update Offset information. Removed Post Payment Review information and added new screens to

Version	Date	Description of Changes
		the MR section
22.0	04/23/2020	Updated the login process. Q&A Update for being locked out and having a password reset.
23.0	06/15/2020	Added new SNF/Hospital data, Patient Status Code, Preventive Code G0476, Date of Death changed to last 4 years for MBI.
24.0	07/24/2020	Added ERA Enrollment section.
25.0	10/19/2020	Updated Hospice Information. Added prior Authorization.
26.0	11/06/2020	Removed instructions to submit Audit message in the portal.
27.0	01/21/2021	Added Password Reset to the Reactivation process for Administrators. Added New Claim Search screen.
28.0	02/08/2021	Added Prior Authorization Exemption Letter screen.
29.0	03/05/2021	Demand Letter Enhancement features. Claim Entry POS clarification and added information to the Q&As.
30.0	4/2/2021	Adding Part A Appeal submission, changes to the location of the Part B Appeal Search, adding new eligibility features; COVID-19 vaccines, Acupuncture Benefits, MCO name change to MA, adding Beneficiary Entitlement Reason Codes. Added information to Ineligible Dates.
31.0	5/6/2021	Add Pre-Payment Review Tab and Post-Payment Review tab instructions for Medical Documentation section. Changes to the Message Center search
32.0	6/17/2021	Updated Prior Authorization to add Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators. Updated fields in the

Version	Date	Description of Changes
		Additional Information section.
33.0	6/24/2021	Added the new Overpayment Search section.
34.0	7/2/2021	File attachment size for appeals is changed to 100 MB. Removed MFA Default option section.
35.0	9/13/2021	Revised format of manual. Updated screenshots and corrected minor typographical errors.
36.0	10/29/2021	Added information about Transportation Layer Security (TLS) settings. Added additional instructions for account lockouts due to three failed login attempts.
37.0	11/04/2021	Added Editing Users section.
38.0	01/11/2022	Updated step 5 in Recertification Process.
39.0	02/09/2022	Added note about DDE users in ADR Letter Search Results sections
40.0	03/14/2022	Updated Available Eligibility Information (Additional Coverage and Preventive Services tabs).
41.0	03/18/2022	Added Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) information to Prior Authorization section.
42.0	05/05/2022	Multiple sections updated with new Level 2 Submission via the Message Center and Appeal Search. Adding steps to upload additional documentation to a Level 1 and Level 2 Appeal.
43.0	05/12/2022	Adding Chrome setting for View vs Save of Documents.
44.0	06/20/2022	Adding Notice of Admissions (NOA) Indicator to Home Health page
45.0	07/18/2022	Changed inactivity timeout from 15 to 30 minutes.
46.0	10/04/2022	Added new sections to the Updated Appeal FAQs, updated Appeal information

Version	Date	Description of Changes
		for W status claims denied with EDIT 119D.
47.0	10/14/2022	Added new sections to the User Admin Dashboard, CERs can now be performed on claims that contain J codes.
48.0	12/12/2022	Added PBID to the Eligibility section of the manual and notice that financial data will be returned for Codes G0117, G0118, G0403, G0404, G0405 and G0102. Updated Medical Documentation Requests section to indicate the MR file size is up to 100 MB.
49.0	12/20/2022	Added new section for Credit Balance Reporting.
50.0	01/17/2023	Changed the format of the Credit Balance Message form.
51.0	02/01/2023	Updated number of User Administrators that can self-register to five.
52.0	03/13/2023	Updated Eligibility data for Hospice.
53.0	05/26/2023	Updated Clerical Error Reopening (CER) section to provide more details on what can and cannot be submitted as a CER.
54.0	06/05/2023	Added new Financial Center (Overpayment Search, Medicare Refunds, eRefund Submission, Receipt Search) section to the manual. Message Center, Letter Search Overview and Prior Authorization information moved under My Correspondence.
55.0	06/15/2023	Added Facet Joint Interventions to the Prior Authorization section of the manual.
56.0	06/19/2023	Added new fields to the MSP eligibility sections (Group Number, Last Maintenance Date, Patient Relationship

Version	Date	Description of Changes
		Code, MSP Source Code)
57.0	07/17/2023	Updated the email address to submit older Credit Balance Reports and added Fax number.
58.0	07/20/2023	Clarified the search instructions and status code information for Medical Documentation and Prior Authorization. Updated a screen shot to add text for Overpayment Search.
59.0	09/18/2023	Added Print Finalized Claim Summary to the Claim Status section.
60.0	09/23/2023	In the Eligibility Check section, updated information available from Summary tab, added audiology screening HCPCS codes under Preventive Services, and added ORM Indicator to the list of information available from the MSP tab.

Medicare eNews Messages

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