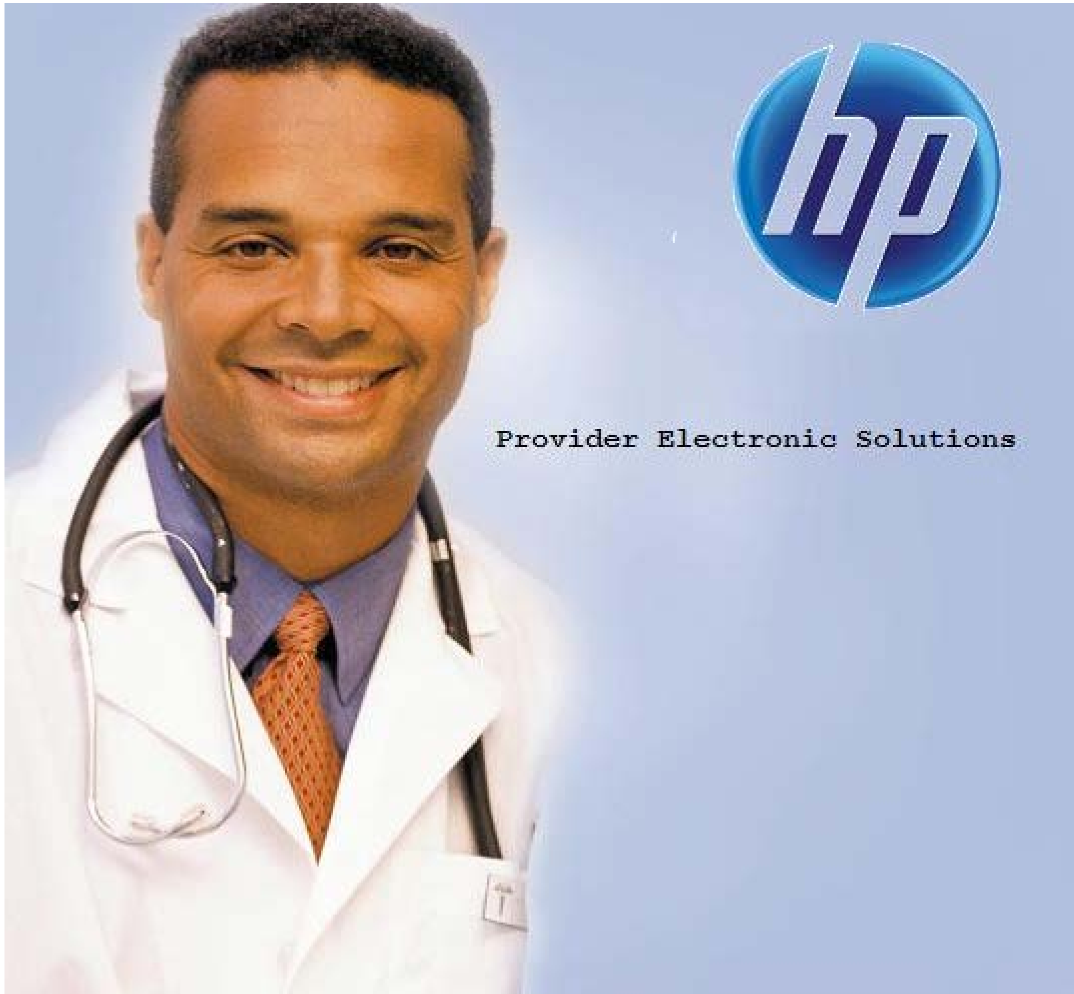
HP Provider Electronic Solutions

Billing Instructions



Outpatient Claims

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INTRODUCTION

Now that you have installed and become familiar with the functionality of the HP PROVIDER ELECTRONIC SOLUTIONS software, it's time to begin claims data entry.

The claim entry screen consists of eight sections: Five Header, One Service, Other Insurance, and Crossover screens.

The following instructions detail requirements and general information for each section of your claim.

In the following sections, each data entry field is defined with the appropriate requirements. Edits have been built into the software to assist you in correct data entry, however, READ THESE SECTIONS CAREFULLY. Payment or denial of your claims depends on the data you supply to HP.

Please reference your billing manual for detailed Connecticut Medical Assistance Program billing requirements unique to your provider type.

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit forms. For example, you can enter lists of common diagnosis codes, procedure codes, types of bill and admission sources and types. All of the lists are available from the data entry section as a drop down list where you can select previously entered data to speed the data entry process and help ensure accuracy of the form.

There are several lists that you are required to complete prior to entering a transaction. Because this software uses the HIPAA compliant transaction format, there is certain information, which is required for each transaction. To assist you in making sure that all required information is included, some of the lists are required. These lists are:

- Client
- Billing Provider
- Other Provider
- Taxonomy
- Policy Holder

If these lists are not completed prior to keying your transaction, the list will open in the transaction form.

Some of the lists contain preloaded information that is available for auto-plugging as soon as you install Provider Electronic Solutions. Other lists require you to enter the information you will use for auto-plugging. You should enter your data in these lists soon after you set up Provider Electronic Solutions to take advantage of the auto-plug feature. To create or edit a list, select List from the Main Menu and then select the appropriate item.

Working with Lists

From the Lists option on the menu bar, select the list you want to work with.

Perform one of the following:

- To add a new entry, select Add.
- To edit an existing entry, select the entry and then enter your changes.
- The command buttons for Delete, Undo All, Find, Print, and Close work as titled.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

CLIENT SCREEN

Client

Client ID 001000002 | ID Qualifier MI | Issue Date 00/00/0000 | Add
Account # | Client SSN 345-67-8901 | Delete
Last Name ROBERT | First Name SMITH | MI B | Undo All
Client DOB 12/01/1975 | Gender M | Save
Subscriber Address
Line 1 150 EAST STREET | Line 2 APT 3 | Find...
City GRANBY | State CT | Zip 06050-6451 | Print...

Client ID	Last Name	First Name
001000000	JOHN	DOE
001000001	JANE	DOE
001000002	ROBERT	SMITH
001000003	JENNIFER	JOHNSON

Close

The Client list requires you to collect detailed information about your clients, which are then automatically entered into forms. All of the fields are required except Issue Date, Account #, Middle Initial and Subscriber Address Line 2.

CLIENT ENTRY INSTRUCTIONS

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

ID Qualifier:
This field has been preloaded with the information that identifies the type of client. This field will be by-passed.

Issue Date:
Enter the issue date found on the patient's Medical Assistance Program Identification Card.

Account #:
Enter the unique number assigned by your facility to identify a client.

Client SSN:
Enter the client's social security number.

Last Name:
Enter the last name of the client who received services.

First Name:
Enter the first name of the client who received services.

MI:
Enter the middle initial of the client who received services.

Client DOB:
Enter the date the client was born.

Gender:
Select the appropriate value from the drop down list to enter the client's gender.

Code	Description
F	Female
M	Male
U	Unknown

Subscriber Address Line 1:
Enter the street address that is on file with CT Medicaid of the client being referenced. The address is required for providers, clients and policyholders.

Line 2:
Enter additional address information of the client being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the client being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the client being referenced. The address is required for providers, clients and policyholders.

Zip:
Enter the 9 digit zip code of the client being referenced. The address is required for providers, clients and policyholders.

BILLING PROVIDER SCREEN

Billing Provider

Provider ID 1000000002 | Provider ID Code Qualifier XX
Taxonomy Code 314000000X | Entity Type Qualifier 2
Last/Org Name LONG TERM CARE | First Name
SSN / Tax ID 234567890 | SSN / Tax ID Qualifier 24

Provider Address
Line 1 100 EAST STREET | Line 2
City BRIDGEPORT | State CT | Zip 06060-1234

Add | Delete | Undo All | Save | Find... | Print... | Close

Provider ID	Taxonomy	Last/Org Name	Type Qualifier
1000000000	314000000X	TEST FACILITY	2
1000000001	314000000X	GENERIC FACILITY	2
1000000002	314000000X	LONG TERM CARE	2
1000000003	314000000X	EXTENDED CARE	2
1000000004	314000000X	SKILLED NURSING	2

The Provider list requires you to collect information about service providers, which is then automatically entered into forms. These can be individual providers or organizations. Use this list to enter all billing provider, and Medicare rendering Medical Assistance Provider numbers. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

BILLING PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

The taxonomy code entered in this field must be among the list of taxonomy codes submitted to the Connecticut Medical Assistance Program by the provider via the provider enrollment application.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:
Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Facility Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address that is on file of the provider being referenced. The address is required for providers, subscribers and policyholders.

Line 2:
Enter additional address information of the provider being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the provider being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the provider being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9 digit zip code of the provider being referenced. The address is required for providers, clients and policyholders.

OTHER PROVIDER SCREEN

Other Provider

Provider ID 1111122223 | Provider ID Code Qualifier XX
Taxonomy Code 208000000X | Entity Type Qualifier 1
Last/Org Name SMITH | First Name ROBERT
SSN / Tax ID 234567890 | SSN / Tax ID Qualifier 34
Provider Address
Line 1 250 PARK PLACE | Line 2
City WETHERSFIELD | State CT | Zip 06240-1234

Add | Delete | Undo All | Save | Find... | Print... | Close

Provider ID	Taxonomy	Last/Org Name	Type Qualifier
1000000001	207N00000X	GENERIC	1
1111122222	204F00000X	DOE	1
1111122223	208000000X	SMITH	1
1111122224	207N00000X	JOHNSON	1
1111122225	2084P0800X	MARTINEZ	1

The Other Provider list requires you to collect information about non-billing providers, which are then automatically entered into forms. Enter the attending, operating and other Medical Assistance provider numbers in this list. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

OTHER PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:

Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Facility Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address that is on file with CT Medicaid of the provider being referenced. The address is required for providers, subscribers and policyholders.

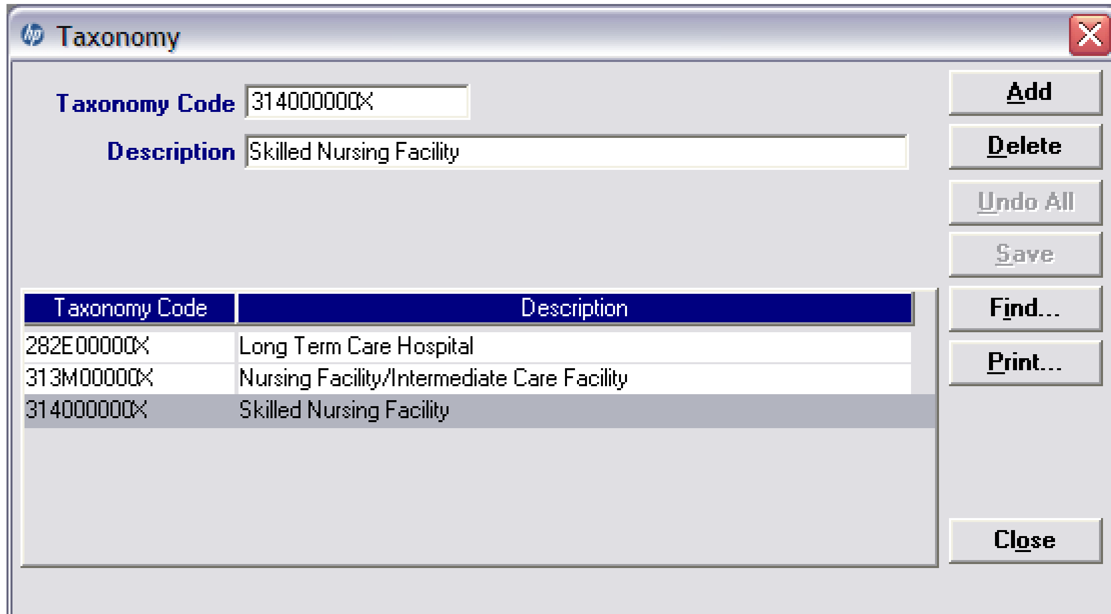
Line 2:
Enter additional address information of the provider being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the provider being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the provider being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9 digit zip code of the provider being referenced. The address is required for providers, clients and policyholders.

TAXONOMY SCREEN



The Taxonomy list allows you to list the taxonomy code, which is then automatically entered into the Provider List. All fields are required.

TAXONOMY ENTRY INSTRUCTIONS

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Description:

Enter the description of the code listed.

POLICY HOLDER SCREEN

Policy Holder

Client ID 001000001 Group # ABC0000123D Carrier Code 901

Carrier Name BEST PLAN Other Insurance Group Name ABCCORPORATION

Relationship to Insured 18

Policy Holder Information

Last Name DOE First Name JANE

ID Code XYZ0000123AA ID Qualifier MI

Date Of Birth 01/01/1965 Gender F

Policy Holder Address

Line 1 100 MAIN STREET Line 2 SUITE 2A

City SPRINGFIELD State CT Zip 06000-1234

Patient Information

Patient ID 001000001 ID Qualifier 23

Add Delete Undo All Save Find... Print... Close

Client ID	Group #	Carrier Code	Last Name	First Name
001000001	ABC0000123D	901	DOE	JANE
001000000	CTMEDJDOE	MDCR	DOE	JOHN

The Policy Holder list requires you to list the information for the policyholder of the other insurance policies and Medicare policies. As with the provider and client lists, this list must be completed before completing a claim with other insurance or Medicare. Complete a separate list for each policy when a client has both other insurance and Medicare. Like the other lists, once the code is entered into the list, it may be accessed by the drop down window and will automatically populate into the claim. All fields are required except Policy Holder Address Line 2.

POLICY HOLDER ENTRY INSTRUCTIONS

This list is required if an indicator of Y is entered in the other insurance indicator field on the Header Three screen. The information on this screen must be entered before you enter the Group Number located on the Other Insurance screen.

Client ID:

Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

Group Number:

Enter group number for other insurance or Medicare. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Carrier Code:

Select the three digit other insurance carrier code from the drop down box.

Note: Provider must maintain an Explanation of Benefit (EOB) on file for audit purposes.

Carrier Name:

This field is auto-plugged by the system once the carrier code is entered and contains the name of the other insurance company listed for the client.

Other Insurance Group Name:
Enter the name of the group that the other insurance is listed under and coincides with group number.

Relationship to Insured:
Select the appropriate value from the drop down box that identifies the client's relationship to the policy-holder for the other insurance or Medicare listed. If the client is the policyholder, self will be listed.

Last Name:
Enter the last name of the policyholder of the other insurance or Medicare. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

First Name:
Enter the first name of the policyholder of the other insurance or Medicare.

ID Code:
Enter the policyholder's identification number assigned by the other insurance company or Medicare.

ID Qualifier:
Select the appropriate value from the drop down box that identifies the type of ID that is being used.

Date of Birth:
Enter the date the policyholder was born.

Gender:
Select the appropriate value from the drop down box that identifies the sex of the individual.

Policy Holder Address Line 1:
Enter the street address of the policy holder being referenced. The address is required for providers, clients and policyholders.

Line 2:
Enter additional address information of the policy holder being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the policy holder being referenced.

State:
Enter the state of the address of the policy holder being referenced.

Zip Code:
Enter the 9 digit zip code of the policy holder being referenced.

Patient ID:
Enter the other insurance identification number of the Medical Assistance Program client being billed.

ID Qualifier:
Select the appropriate value from the drop down box that identifies the type of ID that is being used.

CLAIM ENTRY INSTRUCTIONS

Use the following instructions to complete the claim screens. When data entry is complete, click **SAVE.** The saved claim will appear in the list below the data entry screen. If the claim data hits edits, a message window will appear with error messages. Click **SELECT** to move to the highlighted error and correct the data. Once all error messages have been resolved, you can save the claim.

Newly saved claims are in Status R (Ready). Status R claims can be edited and saved multiple times prior to submission. Be sure to click **ADD** before beginning to enter the data for each new claim.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

OUTPATIENT HEADER ONE

HEADER ONE SCREEN

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header5 | Service

Type Of Bill | Original Claim #

Provider ID | Taxonomy Code

Last/Org Name

Client ID | Account #

Last Name | First Name | MI

Patient Status | Medical Record #

From DOS 00/00/0000 To DOS 00/00/0000

Release of Medical Data Y | Benefits Assignment Y | Report Type Code

Report Transmission Code | Attachment Ctl

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
TYPE OF BILL	3	R	N
ORIGINAL CLAIM #	13	S	N
PROVIDER ID	9	R	N
TAXONOMY CODE	10	R	X
LAST/ORG NAME	35	R	A
CLIENT ID	16	R	X
ACCOUNT NUMBER #	38	R	X
LAST NAME	35	R	A
FIRST NAME	25	R	A
MI	1	O	A
PATIENT STATUS	2	R	N
MEDICAL RECORD #	30	O	X
FROM DOS	8	R	N
TO DOS	8	R	N
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
REPORT TYPE CODE	2	O	X
REPORT TRANSMISSION CODE	2	O	A
ATTACHMENT CTL	30	S	X

HEADER ONE ENTRY INSTRUCTIONS

Special Note: All data entry will default to capital letters.

Header Field Definition

$$ = Dollars
cc = Cents
A = Alpha
N = Numeric
X = Alphanumeric

Type of Bill:

Enter the 3-digit code that identifies the type of bill. The code identifies the type of facility and the bill classification.

First digit indicates facility.

Code	Description
1	Hospital
3	Home Health
8	Hospice

Second Digit indicates the Bill Classification.

Code	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)

Third Digit indicates the Frequency.

Code	Description
0	Non-payment / Zero Claim
1	Admit through discharge date
2	First interim claim
3	Continuing Interim claim
4	Last interim claim
7	Replacement of prior claim (designates electronic adjustment)
8	Void/Cancel of prior claim (designates electronic adjustment)

Note: If the third digit is a “7” or “8”, the Original Claim field will be required.

Remarks: Required
Format: NNN

Original Claim #:
This field is populated when the last digit on the Type of Bill is a “7” or “8”. When a claim is replaced or voided, indicate the original Internal Control Number as it appears on the remittance advice.

Remarks: Situational
Format: NNNNNNNNNNNNNN

Provider ID:
Enter the NPI or Connecticut Medical Assistance Program's Provider number with two leading zeros.

Remarks: Required
Format: NNNNNNNNNN

Taxonomy Code:
This field will be auto plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Last/Org Name:
This field will be auto plugged once you enter your provider number and contains the provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Programs.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
or AA

Client ID:
Enter the client's nine-digit Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: NNNNNNNNNN

Account #:
Enter the patient's account number. Provider assigned, this field may be alphabetic or numeric and is used for the provider's own accounting purposes.

Remarks: Required
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Name:
This field is auto plugged when the client ID is entered and contains the client's last name or the first two characters of the client's last name.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
or AA

First Name:

This field is auto plugged when the client ID is entered and contains the client's first name or the first character of the client's first name. There are no spaces allowed in this field.

Example: JOHN or 'J'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAA or A

MI:

This field is auto plugged when the client ID is entered and contains the first character of the client's middle name.

Example: 'J'
Remarks: Optional
Format: A

Patient Status:

Enter the appropriate patient status code as of the through date from the table below:

Code	Description
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital
03	Discharged/transferred to a skilled nursing facility
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home, under care of organized home health service organization
07	Left against medical advice
20	Expired or did not recover
30	Still a patient
40	Expired at home
41	Expired in medical facility
42	Expired – place unknown
50	Hospice – home
51	Hospice – medical facility
61	Discharge/transferred within this institution to hospital-based Medicare approved swing bed
72	Discharged/transferred/referred/to this institution for outpatient services as specified by the discharge plan of care

Remarks: Required
Format: NN

Medical Record #:

Enter the number assigned to the patient's record.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

From DOS:

Enter the first date of service on which services were provided for this claim

Remarks: Required
Format: MM/DD/CCYY

To DOS:

Enter the last date of service on which services were provided for this claim.

Remarks: Required
Format: MM/DD/CCYY

Release of Medical Data:

This code indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. Enter the value that corresponds to the release of the medical data:

Code	Description
I	Informed consent to release medical information. For conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Remarks: Required
Format: A

Benefits Assignment:

Code identifying that the client, or authorized person, authorizes benefits to be assigned to the provider.
Enter one of the values below to indicate assignment of benefits.

Y - Yes
N – No
W – Not Applicable

Remarks: Required
Format: A

Report Type Code:

Code indicating the title or contents of a document report or supporting item for this claim
Enter the two-digit value that corresponds to the report type.

Code	Description
03	Report Justifying Treatment beyond Utilization Guidelines
04	Drugs Administered
05	Treatment Diagnosis

06 Initial Assessment
07 Functional Goals
08 Plan of Treatment
09 Progress Report
10 Continued Treatment
11 Chemical Analysis
13 Certified Test Report
15 Justification for Admission
21 Recovery Plan
A3 Allergies/Sensitivities Document
A4 Autopsy Report
AM Ambulance Certification
AS Admission Summary
B2 Prescription
B3 Physician Order
B4 Referral Form
BR Benchmark Testing Results
BS Baseline
BT Blanket Test Results
CB Chiropractic Justification
CK Consent Form(s)
CT Certification
D2 Drug Profile Document
DA Dental Models
DB Durable Medical Equipment Prescription
DG Diagnostic Report
DJ Discharge Monitoring Report
DS Discharge Summary
EB Explanation of Benefits
HC Health Certificate
HR Health Clinic Records
I5 Immunization Record
IR State School Immunization Records
LA Laboratory Results
M1 Medical Record Attachment
MT Models
NN Nursing Notes
OB Operative Notes
OC Oxygen Content Averaging Report
OD Orders and Treatment Document
OE Objective Physical Examination
OX Oxygen Therapy Certification
OZ Support Data for Claim
P4 Pathology Report
P5 Patient Medical History Document
PE Parenteral or Enteral Certification
PN Physical Therapy Notes
PO Prosthetics or Orthotic Certification
PQ Paramedical Results
PY Physician's Report
PZ Physical Therapy Certification
RB Radiology Films
RR Radiology Reports
RT Report of Tests and Analysis Report
RX Renewable Oxygen Content Averaging Report
SG Symptoms Document
V5 Death Notification
XP Photographs

Remarks: Optional
Format: XX

Report Transmission Code:

Code defining timing, transmission method or format by which reports are to be sent. Enter the two digit value that defines the transmission method reports will be sent:

Code	Description
AA	Available on Request at Providers Site
BM	By mail
EL	Electronically only
EM	E-mail
FT	File transfer
FX	By fax

Note: If the values BM, EL, EM, FT or FX are used, the Attachment Control field will be required.

Attachment CTL:

This field is enabled when the Report Transmission Code is a “BM”, “EL”, “EM”, “FT”, or “FX”. Enter the control number of the attachment.

Remarks: Situational
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

OUTPATIENT HEADER TWO

HEADER TWO SCREEN

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header5 | Service

Diagnosis Codes
Primary Other: 1 2 3 4
5 6 7 8
E-Code E-Code: 2 3
Patient Reason: 1 2 3

Attending
Provider ID Taxonomy Code
Last/Org Name First Name

Surgical Procedure Qualifiers/Codes/Dates
1 00/00/0000 2 00/00/0000
3 00/00/0000 4 00/00/0000
5 00/00/0000

OUTPATIENT CLAIMS BILLING INSTRUCTIONS

DESCRIPTION	**LENGTH**	**OPTIONAL (O) SITUATIONAL (S)**	**NUMERIC (N) ALPHANUMERIC (X)**
DIAGNOSIS CODES PRIMARY	5	R	X
DIAGNOSIS CODES OTHER 1-8	5	O	X
DIAGNOSIS CODES E-CODE 1-3	5	O	X
PATIENT REASON 1-3	5	O	X
ATTENDING PROVIDER ID	9	R	X
ATTENDING TAXONOMY CODE	10	R	X
ATTENDING LAST/ORG NAME	35	R	A
ATTENDING FIRST NAME	25	R	A
SURGICAL QUALIFIERS 1-5	2	S	X
SURGICAL CODES 1-5	5	S	A
SURGICAL DATES 1-5	8	S	N

HEADER TWO ENTRY INSTRUCTIONS

Diagnosis Codes Primary:

Enter the primary diagnosis code from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) manual.

Note: DO NOT key the decimal point. It is assumed.

Remarks: Required
Format: XXXXX

Diagnosis Codes Other 1-8:

Enter up to 8 ICD-9-CM three, four or five digit diagnosis code for a diagnosis other than the principal diagnosis.

Note: DO NOT key the decimal point. It is assumed.

Remarks: Optional
Format: XXXXX

Diagnosis Codes E-Code 1-3:

Enter the appropriate diagnosis code, beginning with “E” whenever there is a diagnosis of an injury, poisoning, or adverse effect.

Remarks: Optional
Format: XXXXX

Patient Reason 1-3

Enter the ICD-9 diagnosis code that identifies the reason for the patient visit.

Remarks: Optional
Format: XXXXX

Attending Provider ID

Select the Connecticut Medical Assistance Program attending provider number or the HIPAA NPI from the drop down window.

Note: Once you have entered the Provider ID number the Taxonomy Code, Last/Org Name and First Name will be populated automatically.

Remarks: Required
Format: XXXXXXXXXX

Attending Taxonomy Code:

This field will be auto plugged once you enter the attending provider ID and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

OUTPATIENT HEADER THREE

HEADER THREE SCREEN

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
OCCURRENCE CODES 1-8	2	S	N
OCCURRENCE CODE DATES	8	S	N
OCCURRENCE SPAN CODES 1-2	2	O	N
OCCURRENCE SPAN DATES	8	O	N
CONIDITON CODES 1-7	2	S	X

HEADER THREE ENTRY INSTRUCTIONS

Occurrence Codes 1-8:
Enter the applicable code that identifies a significant event relating to this stay. Up to eight occurrence codes can be entered with a corresponding date.

Code	Description
01	Auto Accident (out of state accident)
02	Auto Accident (used for no fault)
03	Accident Tort Liability – if known
04	Accident Employment Related
05	Type of Accident Other than 01 - 04
06	Crime Victim
11	Onset of Symptoms/Illness
21	Administratively Necessary Days
42	Discharge date

Remarks: Situational
Format: NN

Occurrence Code Date:
Enter the date associated with the code listed.

Remarks: Situational
Format: MM/DD/CCYY

Occurrence Span Codes 1-2:
Enter the Occurrence span code.

Remarks: Optional
Format: NN

Occurrence Span Date:
Enter the date associated with the code listed.

Remarks: Optional
Format: MM/DD/CCYY

Condition Codes 1-7:
Enter the appropriate condition codes to identify conditions that determine eligibility and establish primary and/or secondary responsibility. The following codes are applicable to the Connecticut Medical Assistance Program.

Code	Description
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Shown on Claim
05	Lien Has Been Filed
A1	EPSDT
A4	Family Planning

Note: The condition codes listed below should only be used if an abortion was performed due to rape, incest or life endangerment.

Code	**Description**
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AD	Abortion performed due to a life endangering physical condition caused by or arising from pregnancy itself
A7	Induced abortion endangerment to life
A8	Induced abortion victim of rape/incest

Remarks: Situational
Format: XX

OUTPATIENT HEADER FOUR

HEADER FOUR SCREEN

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
VALUE CODES 1-12	2	S	X
VALUE CODE AMOUNTS 1-12	9	S	N
OTHER PHYSICIAN PROVIDER ID	9	S	X
OTHER PHYSICIAN TAXONOMY CODE	10	S	X
OTHER PHYSICIAN LAST/ORG NAME	35	S	A
OTHER PHYSICIAN FIRST NAME	25	S	A

HEADER FOUR ENTRY INSTRUCTIONS

Value Codes 1-12:

Enter the applicable code that identifies a significant event relating to this stay. Up to twelve value codes can be entered with a corresponding amount.

Institutional Part A Deductible

Code	Description
A1	Deductible payer A
B1	Deductible payer B
C1	Deductible payer C

Institutional Part A Coinsurance

Code	Description
A2	Coinsurance payer A
B2	Coinsurance payer B
C2	Coinsurance payer C
08	Medicare lifetime reserve coinsurance amount in first calendar year
09	Medicare coinsurance amount in first calendar year
10	Medicare lifetime reserve coinsurance amount in second calendar year
11	Medicare coinsurance amount in second calendar year

Professional Part B Deductible

Code	Description
A1	Deductible payer A
B1	Deductible payer B
C1	Deductible payer C

Professional Part B Coinsurance

Code	Description
A2	Coinsurance payer A
B2	Coinsurance payer B
C2	Coinsurance payer C

Covered Days

Code	Description
80	Covered Days

Newborn Birth Weight

Code	Description
54	Newborn Birth Weight in Grams

Remarks: Situational
Format: XX

Value Code Amounts 1-12:

Enter the corresponding value code amount.

Remarks: Situational
Format: $$$$$$$cc

Other Physician Provider ID:

Select the Connecticut Medical Assistance Program provider number or the HIPAA NPI from the drop down window.

Note: Once you have entered the Provider ID number the Taxonomy Code, Last/Org Name and First Name will be populated automatically.

Remarks: Required
Format: XXXXXXXXX

Other Physician Taxonomy Code:

This field will be auto plugged once you enter the other physician provider ID and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Situational
Format: NNNANNNNNA

Other Physician Last/Org Name:

This field will be auto plugged once you enter the other physician provider ID and contains the last name of an individual provider, or the business name of a group or facility.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Other Physician First Name:

This field will be auto plugged once you enter the other physician provider ID and contains the first name of the provider when they are an individual.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAA

OUTPATIENT HEADER FIVE

HEADER FIVE SCREEN

Total Charge 250.00 OI Amount .00 Billed Amount 250.00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header5 | Service

Admission Type

Admit Source

Facility ID 1000000000

Other Insurance Indicator N

Crossover Indicator N

Delay Reason Code

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
ADMISSION TYPE	1	R	X
ADMIT SOURCE	1	R	X
FACILITY ID	10	O	N
OTHER INSURANCE INDICATOR	1	S	A
CROSSOVER INDICATOR	1	S	A
DELAY REASON CODE	1	O	N

HEADER FIVE ENTRY INSTRUCTIONS

Admission Type:

Enter the corresponding code from the primary admission reason list below:

Code	Description
1	Emergency
2	Urgent
3	Elective
5	Trauma Center
6	Re-Admission
9	Information Not Available

Remarks: Required
Format: X

Admit Source:

Select the appropriate value that corresponds to the source of admission.

Code	Description
1	Physician referral
2	Clinic referral
3	HMO
4	Transfer from hospital
5	Transfer from SNF
6	Transfer from another health facility
7	Emergency room
8	Court, Law
A	Transfer from a critical hospital

New Born (If the admission type has a value of 4)

Code	Description
1	Normal delivery
2	Premature delivery
3	Sick baby
4	Extramural birth
5	Born inside hospital
6	Born outside hospital

Remarks: Required
Format: X

Facility ID:

Select the Connecticut Medical Assistance Program provider number from the drop down box that identifies the facility where services were performed.

Remarks: Optional
Format: NNNNNNNNNN

Other Insurance Indicator:

This field indicates whether the client has other insurance or when Medicare does not pay any portion of the claim. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Other Insurance Tab is added to the claim form for entry.

Y – Yes
N – No (default)

Remarks: Situational
Format: A

Crossover Indicator:

This field should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Crossover Tab is added to the claim form for entry. Use this field for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

Note: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Remarks: Situational
Format: A

Delay Reason Code:

Select the appropriate code from the drop down list that identifies the reason for delay in submitting the claim.

Code	Description
1	Proof of eligibility unknown or unavailable
2	Litigation
3	Authorization delays
4	Delay in certifying provider
5	Delay in supplying billing forms
6	Delay in delivery of custom-made appliances
7	Third party processing delay
8	Delay in eligibility determination
9	Original claim rejected or denied due to a reason unrelated to the billing limitation rules
10	Administration delay in the prior approval process
11	Other
15	Natural disaster

Remarks: Optional
Format: N

OUTPATIENT SERVICE

SERVICE SCREEN

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header5 | OI | Crossover | Service

Date Of Service 00/00/0000 Revenue Code Billed Amount .00

Units .0 Basis of Measurement UN

Procedure Modifiers: 1 2 3 4

Pharmaceutical

NDC Units .000 Basis for Measurement

Add Srv

Copy Srv

Delete Srv

Srv #	Date Of Service	Revenue Code	Units	Billed Amount
1			.0	.00

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
DATE OF SERVICE	8	R	N
REVENUE CODE	3	R	N
BILLED AMOUNT	9	R	N
UNITS	5	R	N
BASIS OF MEASUREMENT	2	R	A
PROCEDURE	5	S	X
MODIFIERS 1-4	2	S	X
PHARMACEUTICAL NDC	11	S	N
PHARMACEUTICAL UNITS	8	S	N
PHARMACEUTICAL BASIS FOR MEASUREMENT	2	S	A

SERVICE ENTRY INSTRUCTIONS

Please NOTE: If the intent for this claim is to obtain coinsurance and deductible payments form a claim paid by Medicare, please complete this section as though you were submitting this claim to Medicare:

Date of Service:

Enter the date on which service(s) were provided for this claim in MM/DD/CCYY format.

Remarks: Required
Format: MM/DD/CCYY

Revenue Code:

Enter the revenue code for the appropriate accommodation and/or ancillary services provided. Each specific revenue center code for outpatient services must have a single date of service. Span dating is not permitted in the detail section for outpatient claim submission.

Outpatient Revenue center codes 300-309 must be accompanied by the corresponding HCPCS code for laboratory services.

Outpatient Revenue center codes 250-253, 258-260, 273, and 634-637 must be accompanied by the corresponding HCPCS code for physician administered pharmaceuticals.

Home Health Revenue center codes 500-599 must be accompanied by the corresponding HCPCS code for home health claims.

Revenue center codes 657 and 659 must be accompanied by the corresponding HCPCS code for hospice claims.

Outpatient and Home Health claims must be billed with the RCCs for which DSS has assigned rates.

Remarks: Required
Format: NNN

Billed Amount:

Enter the total amount for the services performed for this procedure. This should include the charge for all units listed.

Remarks: Required
Format: $$$$$$$cc

Units:

Enter the number of days or units of service for which services were provided.

Note: For accommodation days, the sum of all the detail days must equal the days indicated.

Remarks: Required
Format: NNNNN

Basis of Measurement:
Enter the code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken. This field defaults to 'UN'.

Code	Description
DA	Days
UN	Units (default)

Remarks: Required
Format: AA

Procedure:
Enter the appropriate procedure code when submitting revenue center codes for Laboratory, Physician Administered Pharmaceutical, Home Health, or Hospice services. Please refer to the relevant Connecticut Medicaid Provider Billing Manual Chapter 8 for provider-specific claims submission instructions.

Remarks: Situational
Format: XXXXX

Modifiers 1-4:
Enter the modifier, if applicable. Up to four (4) modifiers may be entered for each detail.

Remarks: Situational
Format: XX

Note: When physician administered drugs are being billed the Pharmaceutical section should also be used.

Pharmaceutical NDC:
Enter the 11 digit National Drug Code (NDC).

Remarks: Situational required if physician administered drug is billed
Format: NNNNNNNNNNN

Pharmaceutical Units:
Enter the number of units for the drug that was dispensed.

Remarks: Situational, required if NDC present
Format: NNNNNNNN

Pharmaceutical Basis for Measurement:
Select the appropriate value from the drop-down lists that specifies the units in which a value is being expressed, or the manner in which a measurement has been taken. This field defaults to 'UN'.

Code	Description
GR	Grams
ME	Milligram
ML	Milliliters
UN	Units (default)

Remarks: Situational, required if NDC present
Format: AA

OUTPATIENT OTHER INSURANCE

OTHER INSURANCE SCREEN

Total Charge 12,000.00 OI Amount .00 Billed Amount 12,000.00 Services 3

Header 1 | Header 2 | Header 3 | Header 4 | Header 5 | OI | Crossover | Service

Release of Medical Data Y Benefits Assignment Y ICN

Claim Filing Ind Code Adjustment Group Cd Payer Responsibility

Reason Codes/Amts:1 .00 2 .00

Paid Date/Amount 00/00/0000 .00 3 .00

Policy Holder

Group # CTMEDJDOE Group Name FEDMEDICARE Carrier Code MPA

Last Name DOE First Name JOHN

Add OI

Copy OI

Delete OI

Srv #	Carrier Code	Group #	Group Name	Last Name
1	MPA	CTMEDJDOE	FEDMEDICARE	DOE

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
ICN	30	O	X
CLAIM FILING IND CODE	2	R	X
ADJUSTMENT GROUP CD	2	R	X
PAYER RESPONSIBILITY	1	R	A
REASON CODES 1-3	5	R	X
REASON AMTS 1-3	9	R	N
PAID DATE	8	R	N
PAID AMOUNT	9	R	N
POLICY HOLDER GROUP #	17	O	X
POLICY HOLDER GROUP NAME	14	R	A
POLICY HOLDER CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

OTHER INSURANCE ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim. This tab should also be used when Medicare does not pay any portion of the claim and all dollar fields below will contain zero amounts. Please use the crossover tab when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare.

The following fields are required when a "Y" is indicated in the other insurance indicator field on the Header Five Screen.

Release of Medical Data:

Select the appropriate value from the drop down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

ICN:

Enter the claim number from the claim processed by the other insurance.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Claim Filing Ind Code:

Select the appropriate value from the drop down box that identifies the type of other insurance claim that is being submitted Select MA or M when the denial is from Medicare.

Remarks: Required
Format: XX

Adjustment Group Cd:

Select the appropriate value from the drop down box that identifies the general category of payment adjustment by the other insurance company.

Remarks: Required
Format: XX

Payer Responsibility:

Select the code that describes the order of insurance carrier's level of responsibility for a payment of a claim.

Remarks: Required
Format: A

Reason Codes:

Enter the code identifying the reason the adjustment was made by the other insurance carrier or use this field to indicate the reason Medicare denied the claim. The reason code can be found in the Implementation Guide by clicking on the following site**:** http://www.wpc-edi.com. Follow these instructions to retrieve the reason codes:

- Click on *HIPAA*
- Click on *Code Lists*
- Click on *Claim Adjustment Reason Codes*

Use this list of codes to indicate if a payment was made by OI or denied by OI.

Remarks: Required
Format: XXXXX

Reason Amounts:

Enter the amount associated with the reason code.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date on the other insurance voucher or explanation of benefits. Use this field to enter the date Medicare denied the claim.

Remarks: Required
Format: MM/DD/CCYY

Paid Amount:

Enter the amount paid by the other insurance carrier. An amount of zero (0) may be entered. This field is required if a value is entered in the Reason Code field on the other insurance screen and a payment has been received towards the claim from a third party.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Group #:

Select the group number for the other insurance from the drop down list. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXX

Policy Holder Group Name:

This field is auto-plugged when a group number is entered and contains the name of the group that the other insurance is listed under and coincides with the Group number.

Remarks: Required
Format: AAAAAAAAAAAAAA

Policy Holder Carrier Code:

This field is auto-plugged when a group number is entered and contains the carrier code identifying the Other Insurance carrier from the drop down list.

Remarks: Required
Format: XXX

Policy Holder Last Name:

This field is auto-plugged when a group number is entered and contains the client's Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:

This field is auto-plugged when a group number is entered and contains the client's Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAA

OUTPATIENT CROSSOVER

CROSSOVER SCREEN

Total Charge .00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header 5 | OI | Crossover | Service

Release of Medical Data Y Benefits Assignment Y Claim Filing Ind Code MB

Medicare Providers

Rendering ID 1000000000 Last/Org Name TEST FACILITY

Medicare ICN Paid Amount .00 Paid Date 00/00/0000

Amounts

Deductible .00 Coinsurance .00

Policy Holder

Carrier Code MPA

Last Name DOE First Name JOHN

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
CLAIM FILING IND CODE	2	R	X
MEDICARE PROVIDERS RENDERING ID	9	O	N
MEDICARE PROVIDERS LAST/ORG NAME	16	O	A
MEDICARE ICN	14	R	X
PAID AMOUNT	9	R	N
PAID DATE	8	R	N
AMOUNTS DEDUCTIBLE	9	R	N
AMOUNTS COINSURANCE	9	R	N
POLICY HOLDER CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

CROSSOVER ENTRY INSTRUCTIONS

The following fields are required when a "Y" is indicated in the Crossover Indicator field on the Header Three Screen. These fields should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. Please see the instructions on the Other Insurance tab if Medicare did not pay any portion of the claim. Use these fields for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

Note: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Release of Medical Data:

Select the appropriate value from the drop down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

Claim Filing Ind Code:

Select the appropriate code from the drop-down box that identifies the type of other insurance claim that is being submitted.

Remarks: Required
Format: XX

Medicare Providers Rendering ID:

Select the appropriate identification number of the Medicare attending provider from the billing provider list.

Remarks: Optional
Format: NNNNNNNNNN

Medicare Providers Last/Org Name:

This field is auto-plugged once you select the Rendering provider identification number.

Remarks: Optional
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Medicare ICN:

Enter the claim number assigned to the claim by Medicare.

Remarks: Required
Format: XXXXXXXXXXXXXXX

Paid Amount:
Enter the dollar amount paid by Medicare for the service or claim.

Remarks: Required
Format: $$$$$$$cc

Paid Date:
Enter the date on the Explanation of Medicare Benefits (EOMB) on which these services are listed.

Remarks: Required
Format: MM/DD/CCYY

Amounts Deductible:
Enter the amount of the deductible that applies to the claim or detail identified by Medicare.

Remarks: Required
Format: $$$$$$$cc

Amounts Coinsurance:
Enter the amount of coinsurance applied to the claim or detail identified by Medicare.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Carrier Code:
Select the carrier code that corresponds to the policyholder for this claim.

Remarks: Required
Format: XXX

Policy Holder Last Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAA