Alabama Medicaid Agency

Provider Electronic Solutions User Guide

HIPAA Compliant

May 2020

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1

1 Introducing Provider Electronic Solutions

Thank you for using Hewlett Packard Enterprise *Provider Electronic Solutions*. This software supports the processing of Health Insurance Portability and Accountability Act (HIPAA) ready transactions.

The HIPAA ready forms available for billing and inquiring Alabama Medicaid include the following: 837 Dental, 837 Institutional Inpatient/Outpatient, 837 Institutional Nursing Home, 837 Professional, 278 Prior Authorization, 270 Eligibility Request, 276 Claim Status Request, NCPDP Pharmacy and Pharmacy Reversal, and RX Eligibility. Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Provider Electronic Solutions is available at no charge to Alabama Medicaid providers. This user manual is designed to augment the online help that accompanies the *Provider Electronic Solutions* software. It also provides installation procedures and a contact number for the DXC Technology Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility verification, claim status inquiry, prior authorization request and claims submission.

Chapter 1, Introducing *Provider Electronic Solutions*, is comprised of three sections:

- *What You Need to Know to Use Provider Electronic Solutions*, provides definitions for important electronic claims submission, eligibility verification, prior authorization and claim status concepts.
- *How to Use this Manual*, describes the contents of the user manual.
- *Where to Get Help*, provides a contact list for the EMC Help Desk and other DXC Technology personnel who can assist you with claims-related questions.

1.1 What You Need to Know to Use *Provider Electronic Solutions*

Below are some terms and concepts that will enhance your ability to use *Provider Electronic Solutions*:

Submitting through Batch

Batch submission refers to sending groups of eligibility verification, claim status, prior authorization requests or claims to DXC Technology. A batch may contain one record or many records. These transactions are sent to the DXC Technology system via our public-Internet website. DXC Technology processes the batches of transactions and returns a response to the website. Providers may retrieve their responses through the *Provider Electronic Solutions* application.

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Using a Personal Computer

Provider Electronic Solutions operates in a Microsoft® Windows™ environment. The software is user-friendly and features point-and-click functionality and online help, just like other Windows applications.

To use *Provider Electronic Solutions*, you should have basic knowledge about personal computers (PC) and be able to navigate in Microsoft Windows. Specifically, you should know how to:

- Use a mouse, drop down menus, and navigation buttons.
- Toggle between open windows on your desktop.
- Determine some information about your PC's hard drive and be able to distinguish between a hard drive and a disk (or CD) drive. For instance, you should have a good idea about how much Random Access Memory (RAM) you have, and especially how much disk space (space available on your hard drive) you have. Chapter 2, 'Installing *Provider Electronic Solutions*', describes archiving, file retention, and other subjects that impact your PC's available space.
- Access the Windows Control Panel. Section 2.5, 'Setting up Personal Options', provides a brief description of how to use the Control Panel to research information about your modem.
- Determine a file and path name as necessary. The path name refers to a specific drive (for instance, your hard drive, CD-ROM drive, or USB drive) and folders within those drives, if applicable.

Your Microsoft Windows user guide should give you information about these topics if you aren't already familiar with them.

Internet Access

Since *Provider Electronic Solutions* submits batch transactions through the public Internet, your PC must have a method of connecting to the Web. An Internet Service Provider (ISP) can provide this connection through a dial-up modem, digital subscriber line (DSL) or a Cable link. Optionally, DXC Technology provides a Remote Access Server (RAS) to gain access to this web site only. Your computer can dial into the RAS using a Modem, RAS is now a toll-free service. An Internet browser will also be required to maintain your security identification number and password. The DXC Technology software is written to work best using the Internet Explorer Browser. This software is available to download from the Alabama Medicaid homepage at **http://www.medicaid.alabama.gov** and from the Help Option on the secure HIPAA web site.

Using a Modem

Your modem may be part of your PC, or attached to your PC. Regardless, it must also be attached to a working phone line. Section 2.5, Setting Up Personal Options, describes how to set up *Provider Electronic Solutions* with your modem information.

Provider Electronic Solutions User Manual versus the Alabama Medicaid Provider Manual

This user manual describes: how to install and set up *Provider Electronic Solutions*, how to navigate in *Provider Electronic Solutions*, how to establish lists to suit your business needs, how to complete the required and optional fields on the electronic forms, how to submit transactions, and how to produce reports. **It does not provide program-specific**

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information. The user manual describes how to complete the electronic claim forms correctly to enable you to submit claims that pay correctly.

Providers should review Part I of the *Alabama Medicaid Provider Manual*, plus the appropriate program chapter in Part II of the manual, for program-specific and claims filing instructions. For instance, the *Provider Electronic Solutions User Manual* will not provide instructions on submitting claims with third party denials, or inform the user which recipient aid categories allow for full Medicaid coverage, or whether a particular procedure code requires prior authorization. Refer to the *Alabama Medicaid Provider Manual* for this information.

NOTE:

If you did not receive a copy of the *Alabama Medicaid Provider Manual,* contact DXC Technology Provider Relations at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid homepage at **http://www.medicaid.alabama.gov/**

1.2 How to Use This Manual

This manual is comprised of the following chapters:

	Chapter Title	***Contents***
1.	Introducing *Provider Electronic Solutions*	Describes what you need to know to use *Provider Electronic Solutions*, how to use the user manual, and who to contact if you have questions.
2.	Installing *Provider Electronic Solutions*	Covers equipment requirements, getting a copy of PES, installation procedures, setting up personal options, installing software updates, and other maintenance options such as archiving and database recovery.
3.	Getting Around	Describes general navigation concepts and provides an overview of the online help feature.
4.	Customizing PES	Provides instructions on how to complete certain lists required for transmission, as well as how to use the lists options.
5.	Verifying Eligibility	Provides instructions for submitting batch eligibility verification requests.
6.	Submitting 837 Dental Claims	Provides instructions on entering claims in the electronic Dental Claim form and submitting the dental claims via a web server or diskette.
7.	Submitting NCPDP Pharmacy Claims	Provides instructions on entering Pharmacy claims in the electronic NCPDP Pharmacy form and submitting the NCPDP Pharmacy claims through web server or diskette.
8.	Submitting 837 Professional Claims	Provides instructions for entering claims in the electronic 837 Professional claim form and submitting the 837 Professional claims via a web server or diskette.
9.	Submitting 837 Institutional Inpatient Claims	Provides instructions for entering claims in the electronic 837 Institutional Inpatient claim form and submitting the 837 Institutional Inpatient claims via a web server or diskette.
10.	Submitting 837 Institutional Outpatient Claims	Provides instructions for entering claims in the electronic 837 Institutional Outpatient claim form and submitting the 837 Institutional Outpatient claims via a web server or diskette.
11.	Submitting 837 Institutional Nursing Home Claims	Provides instructions for entering claims in the electronic 837 Institutional Nursing Home claim form and submitting the 837 Institutional Nursing Home claims via a web server or diskette.
12.	Submitting Claim Reversals	Provides instructions for entering reversals or adjustments in the electronic claim forms and submitting the request via a web server or diskette.

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	Chapter Title	***Contents***
13.	Viewing Response files	Provides instructions on how to receive an electronic response to the claims submitted via web server or diskette.
14.	Generating Reports	Provides instructions on how to generate a summary or detailed report based on the options from the reports screen.
15.	Submitting 278 Prior Authorization request	Provides instructions for entering a request in the electronic 278 Prior Authorization request form and submitting the 278 Prior Authorization request via a web server or diskette.
16.	Submitting 276 Claim Status request	Provides instructions for entering a request in the electronic 276 Claim Status request form and submitting the 276 Claim Status request via a web server or diskette.
17.	Connecting to the Web Server	Provides instructions for connecting to the web server to keep your password updated accordingly. These instructions include connecting through an ISP (Internet Service Provider) or through RAS (Remote Access Server).

Many of the manual chapters feature step-by-step instructions accompanied by illustrations. Throughout the manual, note boxes are used to draw the reader's attention to important concepts.

1.3 Where to get Help

Provider Electronic Solutions features extensive, field-level online help available by pressing <F1>. Certain windows feature a **Help** button which accesses field level help. Field level help means that you can position your cursor in a field you are unfamiliar with, press <F1> or the **Help** button, if applicable, and read the online help to determine the usage of that field. DXC Technology provides a user manual on CD-ROM and online help to ensure access to as much information as possible about *Provider Electronic Solutions*.

If you still have questions, or if you encounter difficulty using *Provider Electronic Solutions* or dialing into the DXC Technology system, contact the Electronic Media Claims (EMC) Help Desk at 1 (800) 456-1242. The Help Desk staff is available from 7:00 a.m. to 8:00 p.m., Monday through Friday, excluding holidays. In addition, pharmacy providers may access the EMC Help Desk from 9:00 a.m. to 5:00 p.m. on Saturdays, including holidays.

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2

2 Installing HIPAA Provider Electronic Solutions

This chapter covers equipment requirements, instructions on obtaining a copy of *Provider Electronic Solutions*, installation procedures, setting up personal options, installing software upgrades, and other maintenance options such as archiving and database recovery.

2.1 Equipment Requirements

Before installing *Provider Electronic Solutions*, you must ensure you have the proper equipment. *Provider Electronic Solutions* is designed to operate on a personal computer with the following equipment requirements:

Minimum	Recommended
• Microsoft Internet Explorer Version 6.0	• Microsoft Internet Explorer Version 6.0
• Pentium III	• Pentium IV
• Windows 2000 (service pack 4 or higher)	• Windows XP
• 256 Megabytes RAM	• 512 Megabytes RAM
• 1024 x 768 Resolution	• 1024 x 768 Resolution
• 56K Baud Rate modem (required only for dial-up transmission)	• 56K+ Baud Rate modem (required only for dial-up transmission)
•	• Printer with 8pt MS Sans Serif font (Optional)
• 100 Megabytes free Hard Drive space	
• Dial-Up Networking (If user has no ISP, Internet Service Provider)	

NOTE:

Providers who wish to install *Provider Electronic Solutions* on a Local Area Network (LAN) or configuration other than a stand-alone personal computer should contact the DXC Electronic Media Claims (EMC) Help Desk at 1 (800) 456-1242 for instructions.

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2.2 Getting a Copy of *Provider Electronic Solutions*

The PES software may be downloaded from the Alabama Medicaid website at https://medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx. Please note that the downloading process may take a long time due to the size of the application file and your connection speed.

NOTE:

Please note that upgrade versions of the software, as described in Section 2.6, Installing Software Upgrades, do not replace a full installation. You must re-install *Provider Electronic Solutions* if the files or programs are damaged or deleted. Contact the EMC Help Desk at 1 (800) 456-1242 for assistance.

2.3 Installation Procedures

You should install your *Provider Electronic Solutions* software only once, unless the software is damaged while on your PC.

Updated versions of the software contain enhancements to the application. These updated releases may be downloaded from the Alabama Medicaid website at http://www.medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx. See Section 2.6, Installing Software Updates, for more information.

This section describes installation procedures from a Zip file (downloaded from the Web).

2.3.2 Installing from a Zip File

NOTE:

Providers are strongly encouraged to exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications.

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These instructions assume you are familiar with your Web browser and have used it to access the Internet to download information.

Access the Alabama Medicaid homepage at the following address:

http://www.medicaid.alabama.gov

Step 1 Click on the 'Providers' link

Step 2 Click on the Provider Electronic Solutions Software link. The *Provider Electronic Solutions* Software Specifications page displays.

Step 3 Review the information on the page. Use the scroll bar to move down the page, until you see the Provider Electronic Solutions Full Install.

Step 4 Your browser may ask you if you want to open the application or save it to disk. Choose "Save it to Disk" then click on 'OK' button to choose a directory on your hard drive. Please note this application is too large to fit on a 3.5" diskette. If you choose not to save it to your hard drive, you must have a Zip drive, CD/ROM Write-Once-Read-Many (WORM) recorder, or some other method for saving large files.

Step 5 Wait while the Zip file downloads. The download time varies depending on your Internet connection, your PC's processing speed, and other factors. When the download is complete, access the Zip file through Windows Explorer or File Manager if your download screen closes and continue to step 7, if not continue to step 6.

Step 6 After the download has completed, the download box will ask if you wish to OPEN, OPEN FOLDER, or CLOSE. Choose 'OPEN'. A new box will appear.

Step 7 Double click on "setup.exe" (a blue computer icon may be displayed.) Wait until the Setup Screen Welcome window displays.

Step 8 Click NEXT after reviewing the text in the window.

Step 9 Choose the default setup type (Typical) unless you have contacted the EMC Helpdesk for instructions on workstation setup. Click 'NEXT' to continue. The Choose Destination Location window should now be displayed.

NOTE:

Typical – Installs all the files, including the database. This installation is used to install the software to a stand-alone PC, or to initially install the software to a network server. Most installations will be typical installations.

Workstation – Used to add the software to additional PCs that are connected to a network server, where all users share a database. This installation type does not load the database files to the PC; however, it does allow for sharing the database files that were installed to the network.

Step 10 Click 'Next' to choose the default destination folder (recommended) or click Browse to select another destination folder. Then click 'Next' to advance the setup program. The following message displays:

Please note the database destination folder for future WORKSTATION setups.

Step 11 Click 'OK' to access the Setup Complete window. Click 'Finish' to complete setup.

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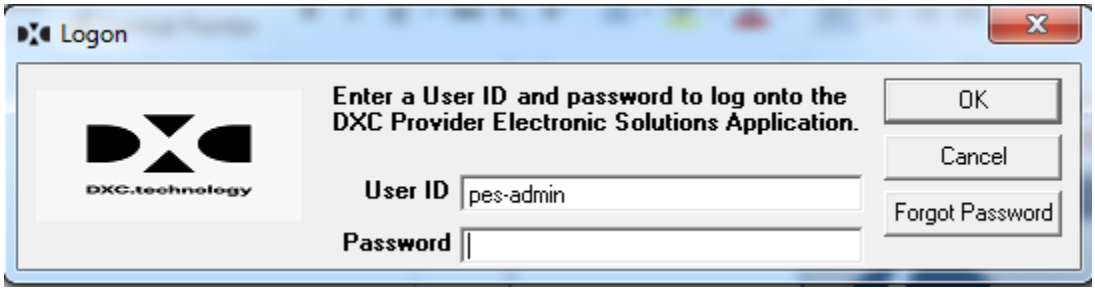
2.4 Accessing the Application

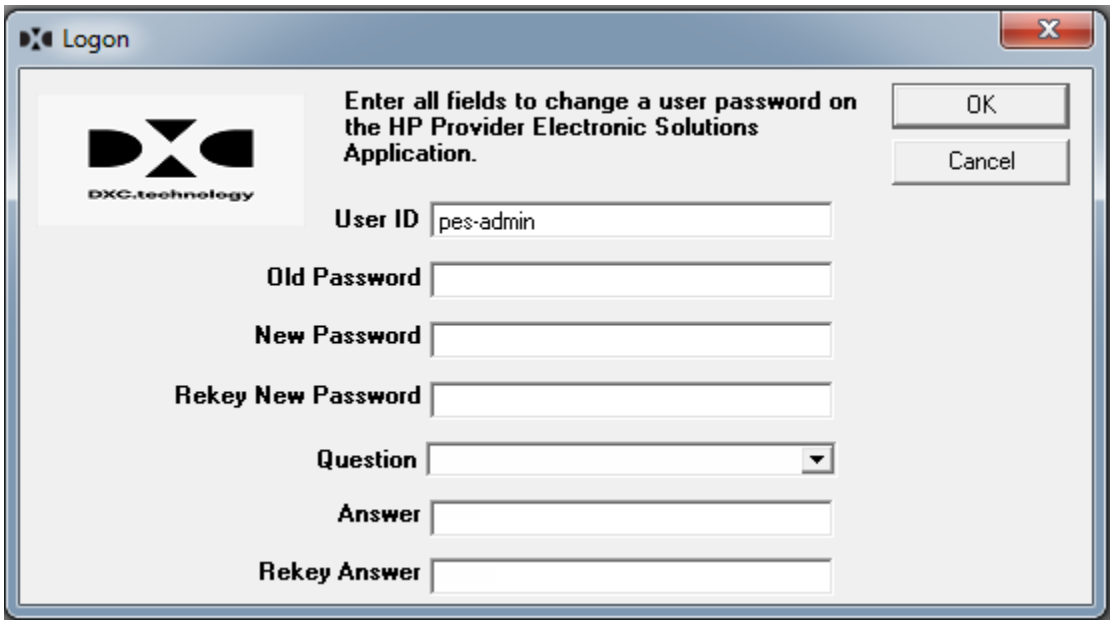
To access the application, perform the following steps:

Step 1 Double click the application folder from the desktop and then select *DXC Technology Provider Electronic Solutions* ***or*** Select the **Start** button on the bottom left-hand corner of your screen, then go to Programs and select AL *DXC Technology Provider Electronic Solutions*.



Step 2 Once the Logon Screen appears enter the default user password which is: **eds-pes** (The default user ID should remain as: pes-admin.) Click OK.

Step 3 The first time you log on, a Password Expired Box will appear, click 'OK'.



Step 4 The Logon Screen will prompt you to change your password. Fill in the information as stated below:

a. Type the old password, **eds-pes** in the Old Password field.

b. Type your new password in the New Password field. Your new password must be a minimum of five alphanumeric characters. **PLEASE STORE YOUR NEW PASSWORD IN A SAFE PLACE IN CASE IT IS FORGOTTEN**.

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c. Retype your new password in the Rekey New Password field.

d. Choose a question as your security question in the event you lose or misplace your new password.

e. Enter and re-enter the answer to your security question in the designated fields. Click 'OK' to continue.

Step 5 The Logon Status Box will appear, indicating that your password was successfully updated. Click 'OK'.

2.5 Setting Up Personal Options

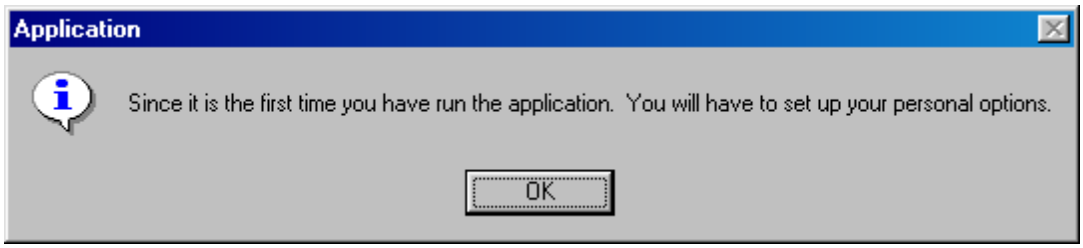
NOTE:

The *Provider Electronic Solutions* software requires that you have a trading partner and web ID in order to submit electronic claims to Alabama Medicaid. To obtain a trading partner ID, please complete the trading partner ID request form, which can be obtained from the AL Links page at https://www.medicaid.alabamaservices.org/ALPortal. If you need assistance, call 1 (800) 456-1242. **You will not be able to use *Provider Electronic Solutions* to submit batch transactions without this information**.

To use *Provider Electronic Solutions*, you must set up your personal options, including the following:

- Modem type and location (unless you use a separate connection device)
- If not connected through an ISP (Internet Service Provider) you must make modifications to install the RAS dial-up connection
- Logon IDs and passwords, as provided to you by the EMC Help Desk

When you access the *Provider Electronic Solutions* for the first time, the following message displays:



Click 'OK' to access the Options window. You can also access this window by selecting Tools>>Options from the menu bar at the top of the *Provider Electronic Solutions* application window.

The Options window contains seven tabs and four main buttons. These are described below:

Tabs

Tab	*Usage*
Batch	Use this tab to set up a trading partner ID, web logon ID, password to log onto the Medicaid website, and the requester's contact information.

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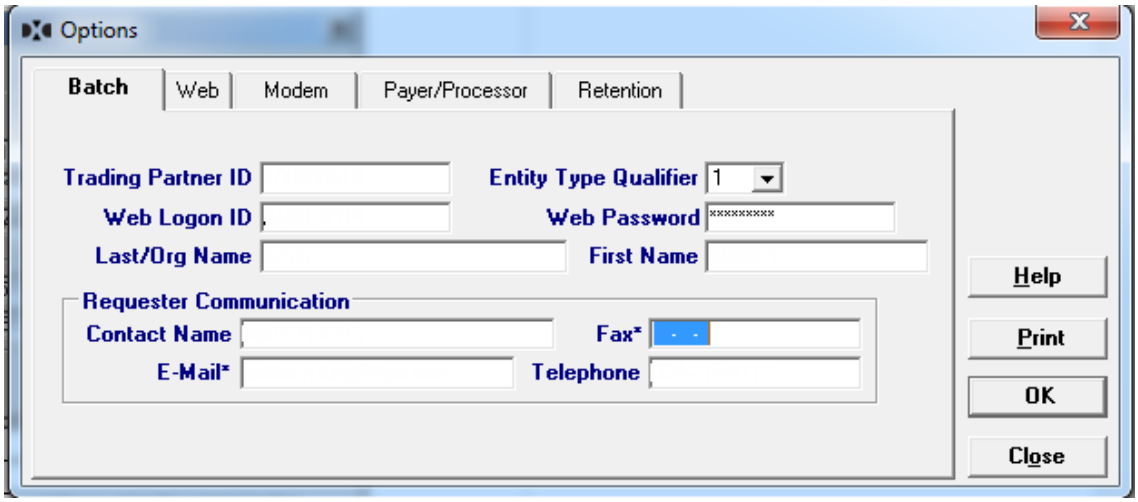
Tab	*Usage*
Web	Use this tab to configure how to connect to the Medicaid website for claim submission.
Modem	Use this tab to set up modem information, such as modem type and communication port.
Payer/Processor	Use this tab to access your system's payer/processor information.
Retention	Use this tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration.

Buttons

Button	*Usage*
Help	Use this button to access the online help for the field currently being accessed.
Print	Use this button to print options selected for all of the tabs.
OK	Use this button to save and close the information added or modified.
Close	Use this button to close the Options window.

2.5.1 Batch Tab

Users access the Batch tab to enter a trading partner ID, web logon ID, password and the requesters contact information. A sample Options window displaying the Batch tab is pictured below:



Field	*Guidelines*
Trading Partner ID	If you have used the software previously, continue using the same trading partner ID. If you need a new trading partner ID, complete the trading Partner request form, which can be obtained from the AL Links page at https://www.medicaid.alabamaservices.org/ALPortal or contact the EMC Helpdesk at 1 (800) 456-1242 for assistance.
Entity Type Qualifier	Choose the best value to indicate if this request comes from a person or non-person. A non-person would refer to a group or facility. A person would indicate an individual billing provider.
Web Logon ID	If you have used the software previously, continue using the same web logon ID. If you need a new web logon ID contact the EMC Helpdesk at 800-456-1242.
Web Password	Enter your password for your web logon ID. Please refer to chapter 17 on updating your password. You must complete that process before continuing.
Last/Org Name	If billing as an individual provider, enter the last name of the physician. If billing as an organization or group, enter the facility's name.

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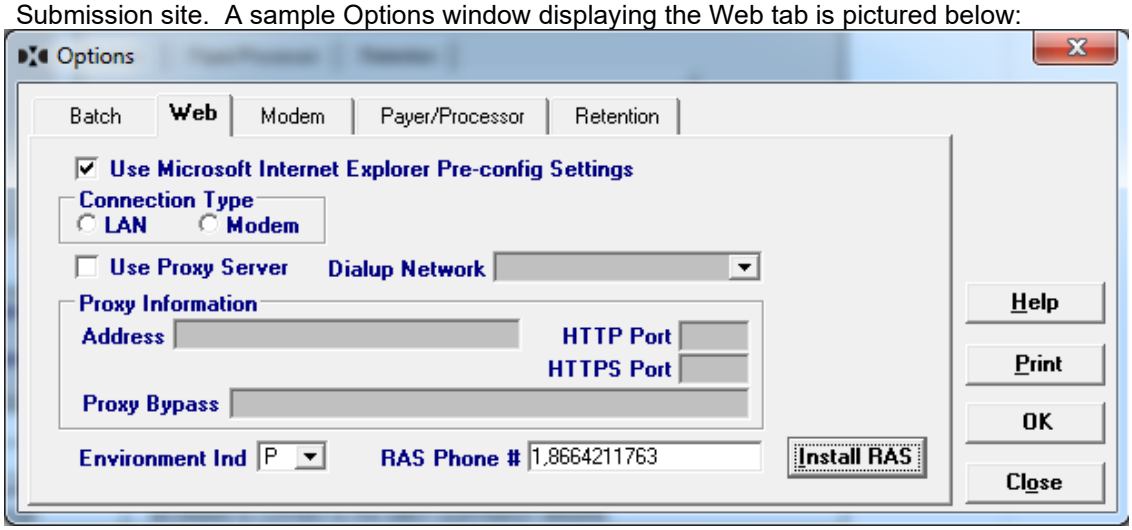
Field	*Guidelines*
First Name	If billing as an individual provider, enter the first name of the physician.
Requester – Contact Name	Enter the name of the software's user for contact purposes.
Requester – Fax	Enter the fax number of the software's user. This field is **optional**.
Requester – E-mail	Enter the e-mail address of the software's user. This field is **optional**.
Requester – Telephone	Enter the telephone number of the software's user.

2.5.2 Web Tab

Users access the Web tab to modify their method of connection to the Medicaid Submission site. A sample Options window displaying the Web tab is pictured below:



Field	*Guidelines*
Use Microsoft IE Pre-config Settings	If checked, the pre-config settings within your Internet Explorer will be accessed to connect to the batch submission website.
Connection Type	If the Internet Explorer Pre-config Settings option is **not** checked, you must choose either LAN or Modem to identify how the PC connects to the Internet.
Use Proxy Server	If the Internet Explorer Pre-config Settings option is **not** checked and your Internet access is filtered through a Proxy Server check this setting.
Dialup Network	If you choose the Modem Connection Type, you must select one of the Dialup Networks from the drop-down box. If you do not have an option listed, follow the instructions for the Install RAS button.
Proxy Information – Address	To obtain the address of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings to obtain the proxy address.
HTTP Port	To obtain the HTTP Port of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings. Click on Advanced and review the Port information for HTTP:
HTTPS Port	To obtain the HTTPS Port, follow the instructions above under HTTP Port and enter the Secure port number in this field.
Proxy Bypass	The Proxy Bypass information is found on the same window as the HTTP and HTTPS ports in the Exceptions text area.
Environment Ind	Choose the best value to indicate if the submission is Production or Test. Remember, if you have your indicator as Test your claims will not be paid.
RAS Phone #	If you use a dialup modem, enter 1,8664211763, If your phone service requires additional dialing features you may adjust this number to add those features. Such as dialing a '9' to get an outside line would be entered as: 9,1,8664211763.

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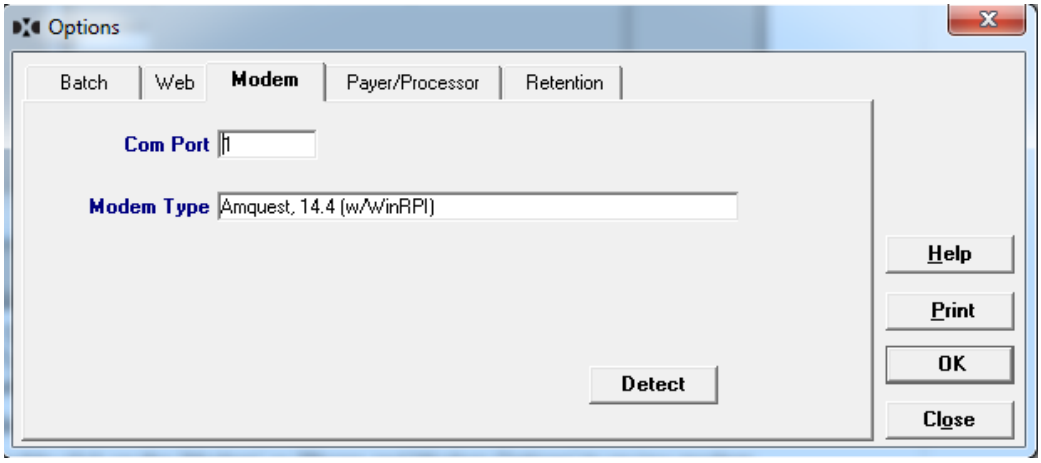
Field	*Guidelines*
Install RAS	If you choose to use a dial-up modem to connect to Medicaid, you must choose a Dialup Network option provided. If you have no option provided, press the Install RAS button and the option AL RAS will be available to you. **NOTE:** Due to a delay in installing RAS, the user may have to click on the 'LAN' option and then back to the 'Modem' option for the RAS Dial-up Network to display.

2.5.3 Modem Tab

Users access the Modem tab to establish connection between the modem and the *Provider Electronic Solutions* application. A sample Options window displaying the Modem tab is pictured below:



Click on the 'Detect' button to determine your modem type. The information displays in the Modem Type field. Perform the following to determine the communications port associated with your modem:

Step 1 Click on the 'Start' button, then choose Settings>>Control Panel.

Step 2 Double-click on the 'Modem' or 'Phone and Modem Options' to review modem information, including the communications port.

Step 3 Enter the communications port information in the Com Port field .

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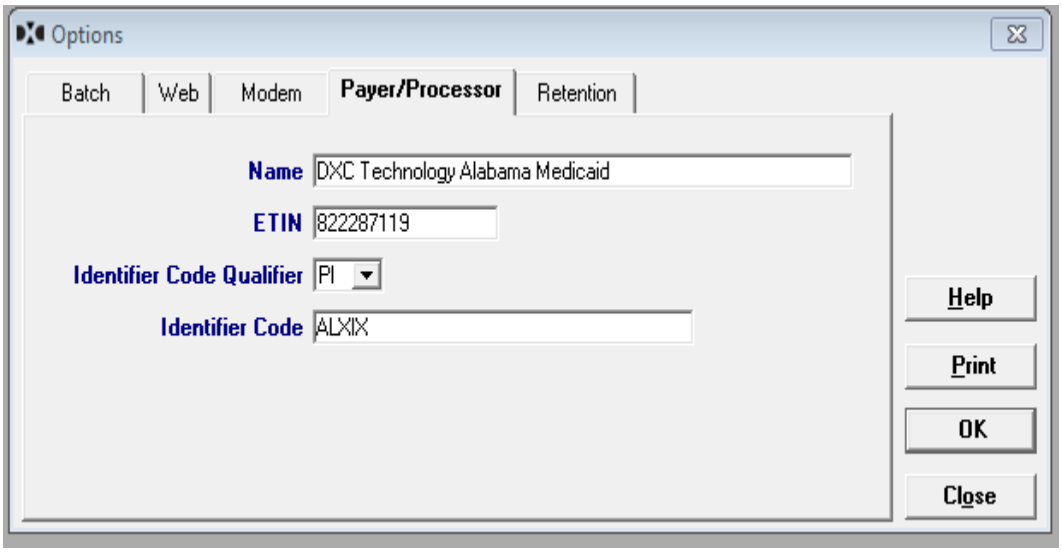
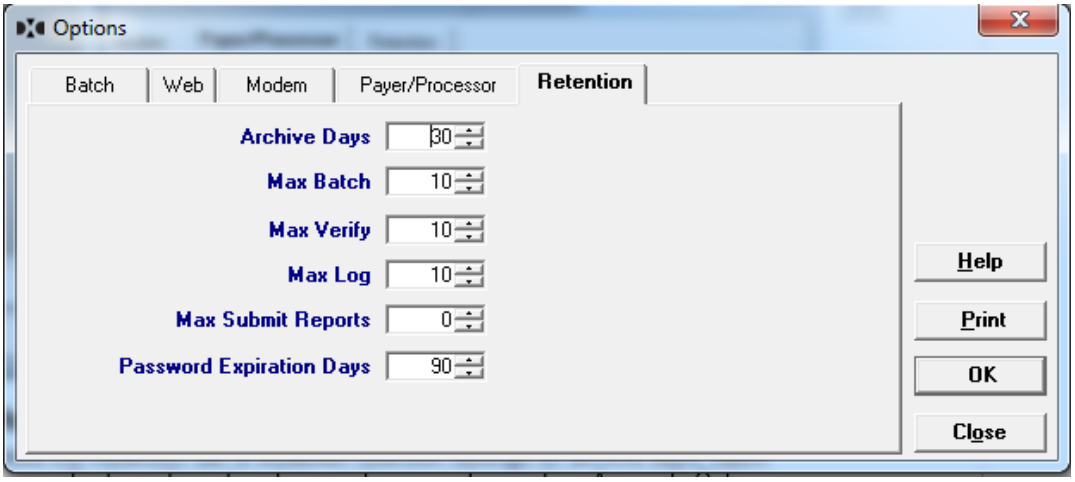
2.5.5 Payer/Processor Tab

This tab contains your system's payer/processor information. The fields on this screen will populate automatically and should not be altered unless directed by DXC Technology. A sample Options window displaying the Payer/Processor tab is pictured below:



2.5.6 Retention Tab

Users access the Retention tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration. A sample Options window displaying the Retention tab is pictured below:



Retention settings indicate the number of days worth of data the software should save. Users may set retention settings as required, or may retain the default settings. Click OK to save the information.

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NOTE:

Increasing the retention settings results in more data saved to your hard drive. *Provider Electronic Solutions* enables you to archive most types of data generated by the system. There may be a better alternative to increasing your retention settings. For more information, refer to Section 2.7, Other Maintenance Options.

2.6 Installing Software Updates

Occasionally, DXC Technology will release updates to *Provider Electronic Solutions*. Upgrading your software is quick and easy with the Get Upgrades option, available from the Tools menu option.

Receiving Notification of Upgrades

DXC Technology notifies providers of software updates in two ways:

- Update notices in the *Provider Insider,* the Alabama Medicaid bulletin
- "Mini-messages" on the Remittance Advice (RA) Banner Page.

You may also elect to use the Get Upgrades option if you unexpectedly experience difficulty in submitting claims, or if you have not used the software for an extended period of time. In this manner, you can be certain you are using the most current version of *Provider Electronic Solutions* even if you have not received an upgrade notification.

Upgrading *Provider Electronic Solutions*

Perform the following tasks to upgrade your *Provider Electronic Solutions* software:

Step 1 Select Tools>>Get Upgrades from the menu bar. Depending on the web connection options you have selected, *Provider Electronic Solutions* connects to the network and returns one of two actions:

If an upgrade is available, the system automatically downloads the upgrade to your PC. Proceed to Step 2.

If no upgrade is available, the system displays the message *No upgrades available to apply*. No further action is necessary.

Step 2 Close *Provider Electronic Solutions*. Access the Provider Electronic Solutions folder on your desktop and click on the Upgrade icon to upgrade the application.

NOTE:

Users must upgrade to version 2.16 before upgrading to the 3.0 version.

Before upgrading to version 3.0 users should submit all "R" status transactions currently in the Provider Electronic Solutions Software.

Once the version 3.0 upgrade has completed, users will not be able to change, copy, resubmit, or restore archived transactions that were entered in the previous versions of the Provider Electronic Solutions Software. The only option will be to delete these transactions.

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All transactions converted from previous versions to version 3.0 will be flagged with a new status based on the status the transaction was in at the time of the upgrade. The following new status codes will be used:

U - All transactions previously in an 'I' status at the time the upgrade is performed will have the status changed to 'U'. U = 4010 Unfinished/Incomplete.

B - All transactions previously in an 'A' status at the time the upgrade is performed will have the status changed to 'B'. B = 4010 Backup record/Archive.

C - All transactions previously in an 'R' status at the time the upgrade is performed will have the status changed to 'C'. C = 4010 Completed not yet Submitted/Ready.

S - All transactions previously in an 'F' status at the time the upgrade is performed will have the status changed to 'S'. S = 4010 Successfully Submitted/Finalized.

NOTE:

Providers are strongly encouraged to exit all other Windows programs before running the upgrade setup program. This includes MS Word, e-mail systems, or other applications.

Be sure to close *Provider Electronic Solutions.* Save any data currently being accessed on *Provider Electronic Solutions*, such as claims, lists, or eligibility verification responses before performing an upgrade on your software.

2.7 Other Maintenance Options

The Tools menu options enable users to archive data, recover the database, download upgrades, and set up options. Procedures for downloading upgrades are described in Section 2.6, Installing Software Upgrades. Set up options are covered in Section 2.5, Setting up Personal Options.

This section describes other maintenance options such as archiving and database recovery.

2.7.1 Archiving

Archiving data is the process used to keep the size of your data small enough for it to be useful, while maintaining historical records of the forms you have entered.

Archiving is designed to make management of forms easier and to keep the space on your hard drive used by the *Provider Electronic Solutions* application to a minimum.

One of the options available under Tools>>Archive>>Create is the setting that controls how many days of forms you wish to keep online on your PC. The standard setting is 30 days; however, you may select whatever setting best suits your needs. This means that when you select Tools>>Archive>>Create Archive from the menu bar, you will keep a copy of any form which was submitted more than 30 days ago. The form is copied to a compressed file and then deleted from your database. Forms submitted in the past 30 days are still accessible through the *Provider Electronic Solutions* database.

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You can store the compressed file on a diskette or leave it on your hard drive. Forms that are ready to be submitted (that have a status of ‘R') are not archived, but remain on your online database until you have submitted or deleted them. Forms that are incomplete (that have a status of ‘I’) and are older than the archived data are removed during the archive process and are not saved on the archived file.

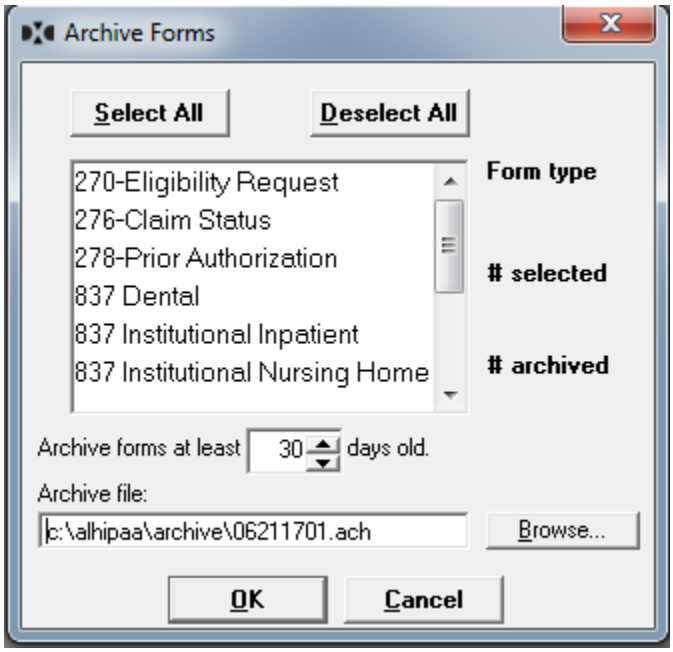
This section describes how to create an archive and how to restore archived files.

Create Archive

NOTE:

If running *Provider Electronic Solutions* on a network, other users must exit the application (must not be viewing, adding, or modifying any forms or lists) before you create an archive. The user creating the archive should have the only open copy of the software while the process runs.

To create an archive select Tools>>Archive>>Create from the menu bar. After verifying that all forms and lists are closed, click OK to proceed. The Archive Forms window displays:



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Using this window, you can:

- Select all the form types to archive by clicking on the 'Select All' button (click on 'Deselect All' to deselect). You may also select specific form types to archive by clicking on the form type.
- Change the default directory and the name of the file to archive by typing the path name in the Archive file field, or by clicking on the Browse button.
- Change the number of days used to archive the forms. (This change applies to the current session only. Select Tools>>Options>>Retention Tab to change the number of retention days for all future sessions.)

Select 'OK' to archive the selected forms. Select 'Cancel' to exit the archive function.

Once you select 'OK', the system archives the forms that match the selection criteria. *Provider Electronic Solutions* displays a confirmation message upon completion. Click 'OK' to exit the Create Archive process.

NOTE:

You can use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Restore Archive

The Restore Archive process enables users to recall forms from an archive file and put them back into the online database. For instance, if you elect to archive to diskette claims more than thirty days old, Restore Archive enables you to return them to the list that displays at the bottom of the *Provider Electronic Solutions* claim form.

Restored claims display with a status of 'A'. You cannot change information on these claim forms; however, you can use the restored forms to:

- Review them to confirm information
- Print them in a report
- Copy them to create a new claim form

NOTE:

5010

PES version 3.0 will not restore archived transactions originally submitted/archived with a previous version (2.16 and earlier).

Any attempt to restore archived transactions in HIPAA 4010 and NCPDP 1.1 format will receive the following error message:

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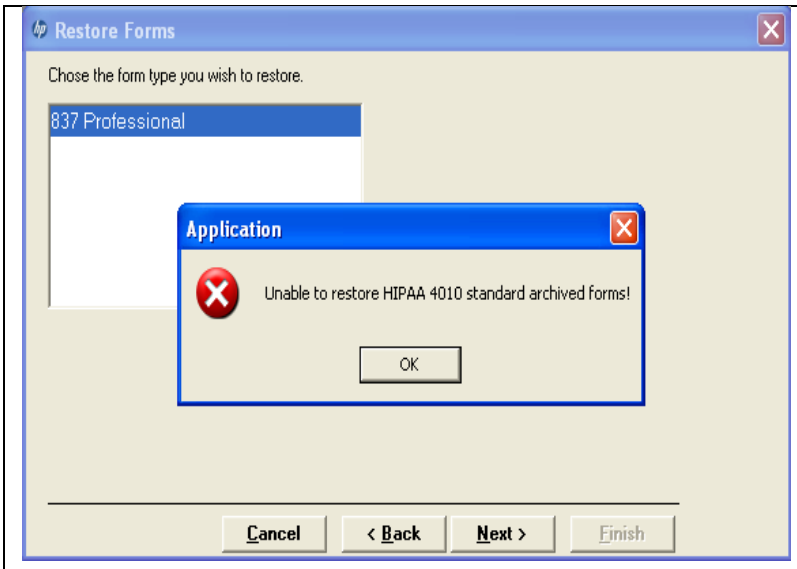
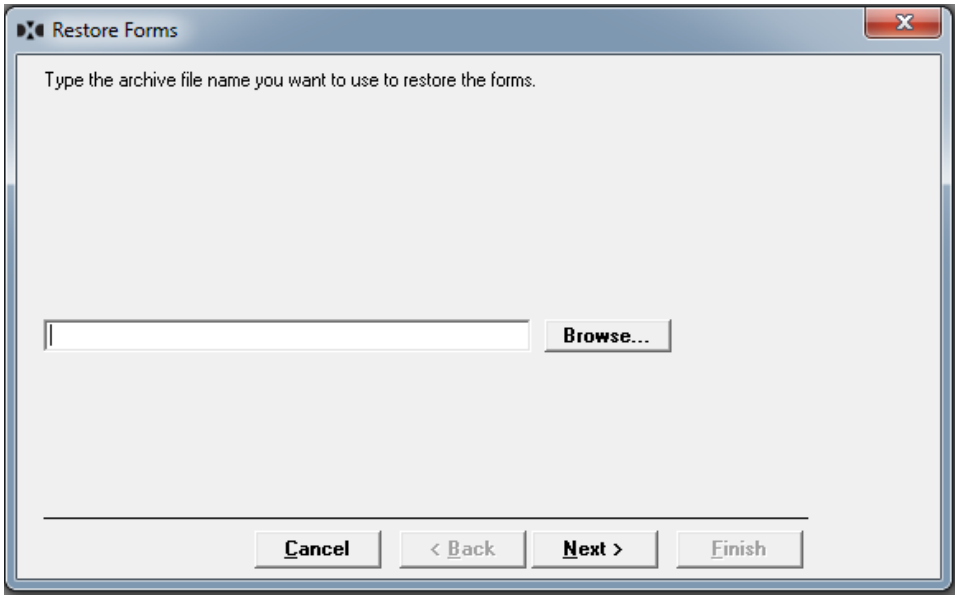


ICD-10

PES version 3.02 will not restore archived transactions originally submitted/archived with a previous version.

Perform the following to restore archived forms:

Step 1 Select Tools>>Archive>>Restore from the menu line. The Restore Forms window displays:



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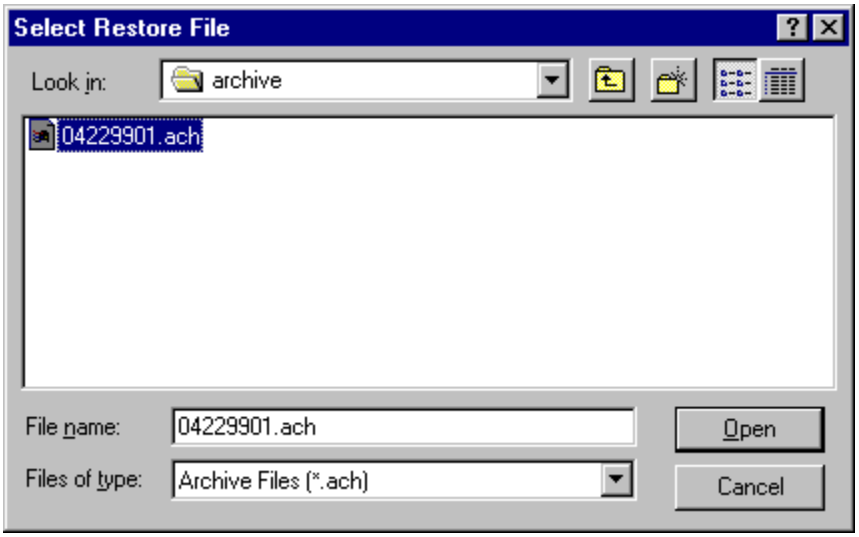
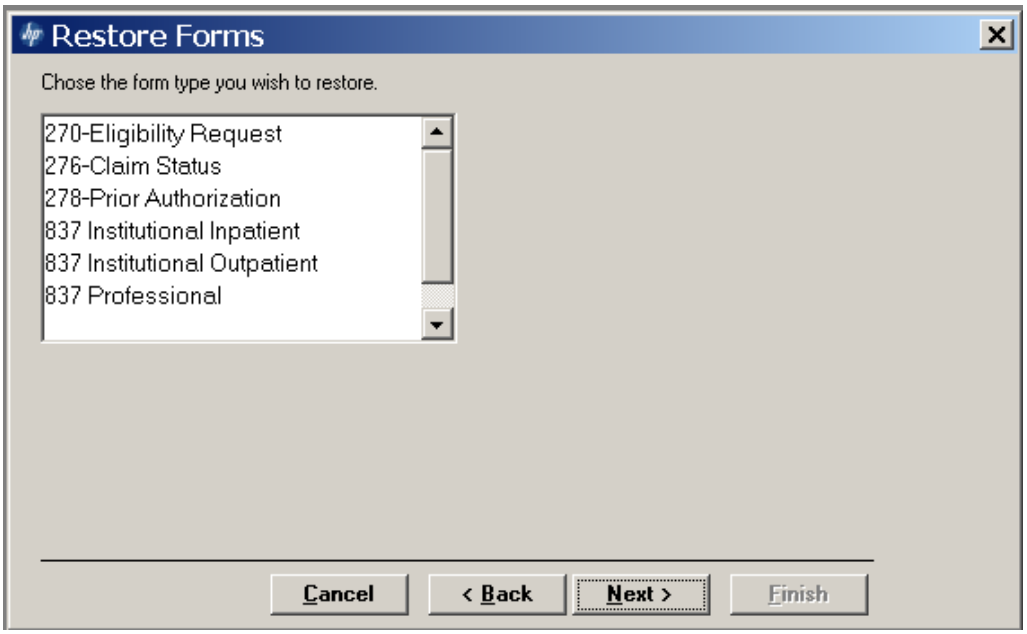
Step 2 Type in the path and file name of the file to restore and click the 'Next' button, or click on the 'Browse' button to search for the path and file name. The following window displays:



Step 3 Select the file and path name and click 'Open' button. Click 'Next' to display the Restore Forms window, pictured below:



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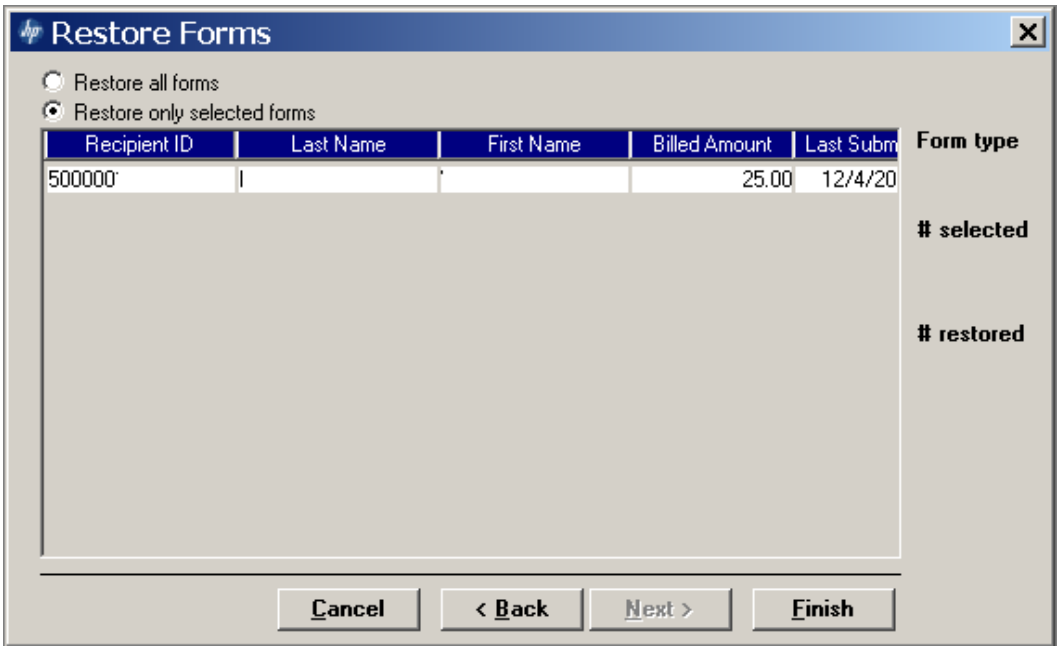
Step 4 Determine which form type(s) you want to restore. To select multiple form types, follow the procedures indicated in the note box under the Create Archive section. Click the 'Next' button to proceed.

Provider Electronic Solutions displays a message if it does not locate any forms matching the selection criteria for the file and path name you selected. When this occurs, you may select 'OK' to select another form type or 'Back' to go back and change the archive path and file name.

When *Provider Electronic Solutions* finds forms that match the selection criteria, the following displays:



Step 5 Select the restore option you want (all at once or only selected forms). To select multiple forms, follow the procedures indicated in the note box under the Create Archive section. The window displays forms by Insured ID (Recipient ID), Last Name, First Name, Billed Amt, and Last Submit Dt. Click the Finish button to proceed.

Provider Electronic Solutions displays a message upon successful restoration of the archived forms. Click 'OK' to exit the Restore Archive process.

2.7.2 Database Recovery

There may be times when there is a problem with your database. The Database Recovery option is designed to help you work with the Help Desk personnel to fix problems with your database.

Compact Database

Compact is used to make the database files smaller and better organized. When you delete a form, empty space is created in the database where that form used to be. Compact will release all the empty space so that it is available for you to use again.

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Repair Database

Repair will attempt to validate all system tables and all indexes. Generally, this feature is helpful when you are having trouble accessing your data. The Help Desk staff will let you know when this is necessary. You may use this feature any time you feel that it would be helpful. Compact is recommended after the Repair.

Unlock Database

Sometimes errors will cause database locks. The database may lock when you are submitting forms, archiving forms, restoring forms, and sometimes when you are adding or editing forms. Use the Unlock feature to unlock the database tables.

2.7.3 Changing Password

There may be times when you feel a need to change your password. The Change Password option is designed to allow you to do so. The password is defaulted to prompt its user to change the password every ninety days. This option may be adjusted, review Section 2.5.7 *Retention Tab* to do so.

Step 1 Go to Tools >> Change Password.

Step 2 Enter your old password in the **Old Password** field.

Step 3 Enter your new password in the **New Password** field.

Step 4 Re-enter your new password in the **Rekey New Password** field.

Step 5 Choose a security question, in the event you lose or misplace your password.

Step 6 Enter and re-enter the answer to your security question in the designated fields.

Step 7 Click OK to save your new Provider Electronic Solutions password.

2.7.4 Security Maintenance

There is an option to add users to access the Provider Electronic Solutions software without having to use the same logon ID. This also establishes certain users to have administrator versus non-administrator rights. This option may be accessed by going to Security >> Security Maintenance. Follow the steps below to add additional users to the *Provider Electronic Solutions* application.

Adding New Users

Step 1 Go to Security >> Security Maintenance to access the screen. You must be logged on as an administrator to complete this process. (The default administrator ID is pes-admin.)

Step 2 Enter a new User ID in the User ID field.

Step 3 Enter the new user's password in the Password field.

Step 4 Choose the new user's authorization level.

- User (Non-administrator) – This option allows the user to access the *Provider Electronic Solutions* software, create and save claims, submit electronic transactions and make the needed adjustments to the personal options menu. (This option only restricts users from adding or removing additional users.)

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- Administrator – This option allows the user to access the *Provider Electronic Solutions* software, create and save claims, submit electronic transactions, adjust their personal options, and create new users.

Step 5 Click on 'Save' once you have completed the above steps. And click on 'Close' to close the Security Maintenance screen.

Step 6 Once the new user logs on, they will be prompted to create a new password. Refer to *Section 2.4 Accessing the Application.*

NOTE:

Store your new user ID and password in a safe location for future use. If your password is lost or misplaced, have your administrator logon as pes-admin to assign your ID a new password.

Removing Users

Step 1 Go to Security >> Security Maintenance to access the screen. (You must be logged on as an administrator to complete this process. The default administrator ID is pes-admin.)

Step 2 Choose the user ID you wish to remove by clicking on it.

Step 3 Once highlighted, the information will auto-write into the fields.

Step 4 Click on 'Delete' to remove the user.

Step 5 Click on 'Close' once you have completed this process for each user you wanted to remove.

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3 Getting Around

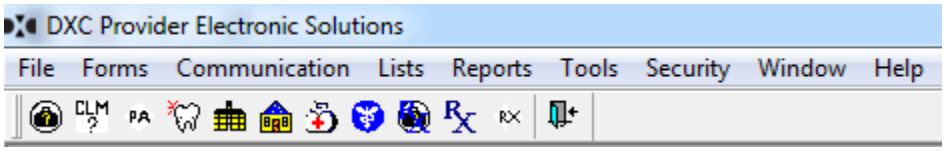
This chapter describes general navigation concepts and provides an overview of the online help feature.

3.1 Navigating in Provider Electronic Solutions

Before you begin using *Provider Electronic Solutions*, review the following section and learn how to navigate through the application with your keyboard and mouse.

Navigating through *Provider Electronic Solutions* is similar to other Windows-compatible applications. The navigation options available are menus, toolbars, and command buttons. Your mouse and keyboard enable you to access these navigation options. Use your mouse to point-and-click as a method for navigating through *Provider Electronic Solutions*.

Below are samples of the menu and icon toolbars that display on the *Provider Electronic Solutions* main window:



This section describes the menu and icon options available with *Provider Electronic Solutions.*

3.1.1 Menus

Provider Electronic Solutions uses menus to navigate throughout the application. The menu options change depending on what window you access. When you open *Provider Electronic Solutions* the main menu displays. You can access items on a menu using the mouse and clicking on their icon. The example below provides two methods for accessing the Eligibility form from the Forms menu option:

- Position your cursor over the Forms menu option and click the left mouse button to display the drop down menu. Scroll down to the Eligibility selection and click once with your left mouse button to display the Eligibility form
- Click on the 'Eligibility' icon

Refer to Section 3.1.2, Icons, for a listing of main menu icons.

The following options are accessible from the main menu:

This menu option…	***Allows you to…***
File	Exit the application.
Forms	Select the online form that you wish to work with.
Communication	Submit batches of forms and process batch responses. Resubmit batches of forms. View Communication Log files.
Lists	Add and edit reference lists, which allow you to collect information to be auto plugged in online forms.

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This menu option…	*Allows you to…*
Reports	Print summary or detail reports with information from forms or reference lists.
Tools	Create and work with archives, perform database maintenance, retrieve upgrades, and change your options. The Options selection allows you to set up communications options and determine retention settings.
Security	Add, delete and restrict users other than the administrator.
Window	Standard options available for most Windows compatible applications.
Help	Obtain help about *Provider Electronic Solutions* functions, screens, menus, and fields. Also view information about this application such as version and copyright.

3.1.2 Icons

The Icons toolbar displays below the menu bar on the main menu. The twelve icons displayed are:

- 270 Eligibility
- 276 Claim Status
- 278 Prior Authorization
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal
- Exit

Users can position the cursor over an icon to display a brief description.

When a form is opened, the toolbar display will change. After opening a specified form from the icon list above, the fifteen icons now displayed are:

- (Add) saves the existing form and calls up a new blank form.
- (Copy) makes a copy of the existing form.
- (Delete) deletes the existing form.
- (Undo) reverses all of the changes done to the existing form since the form was last saved.
- (Save) saves the existing form.
- (Print) can only be accessed from one of the various form screens. Selecting the print button will automatically create a report and allow you to print the report that was automatically created.
- (Cut) deletes the highlighted data and places a copy of the data on the clipboard so that it can be pasted into another field or software program.
- (Copy) copies the highlighted data to the clipboard so that it can be pasted into another field or software program.
- (Paste) inserts data from the clipboard to the selected data fields or another software program.

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- (Filter) allows you to define which forms are displayed at the bottom of the form screen by status, date submitted, name, amount billed, etc.
- (Find) allows you to search for a claim by recipient ID, last name, first name, and billed amount.
- (Sort) allows you to sort the claims that are displayed at the bottom of the form screen by recipient ID, last name, first name, billed amount, status and submit date.
- (Errors) allows you to view errors that have been detected on the current form.
- (Calculator) calls up the calculator.
- (Exit) allows you to exit the application.

3.1.3 Command Keys

Like most Windows applications, *Provider Electronic Solutions* provides the user with command keys. This enables the user to perform actions using either the mouse (point-and-click) or the keyboard. This section describes them.

Command Keys

The table below describes some standard navigation keys available with *Provider Electronic Solutions:*

To do this…	***Press this key…***
Go to the next field	<Tab> or <Enter>
Go to the previous field	<Shift>+<Tab>
Move backward within a field	Left Arrow
Move forward within a field	Right Arrow
Scroll up through a list	Up Arrow
Scroll down through a list	Down Arrow
Open online help for a field when the cursor is on a data entry field	<F1>

The list above includes function keys (usually located at the top of the keyboard and numbered ‘F1’ through ‘F12’), command keys (such as <Alt>, <Shift>, <Tab>, <Ctrl>, and <Enter>), and arrow keys. Depending on your keyboard, the arrow keys may be located on the numeric keypad, or in a separate section from the numeric keypad.

To use arrow keys on the numeric keypad, you will probably press the ‘Num Lock’ key. Press the 'Num Lock' key again to disable the arrow keys on the numeric keypad, making them display numbers instead.

3.2 Online Help

Accompanying the *Provider Electronic Solutions* software is context-sensitive, field-level online help. Context-sensitive and field-level refer to how the help is programmed. You can access help for any field in *Provider Electronic Solutions* simply by positioning your cursor in the field and pressing the <F1> function key usually located at the top of your keyboard.

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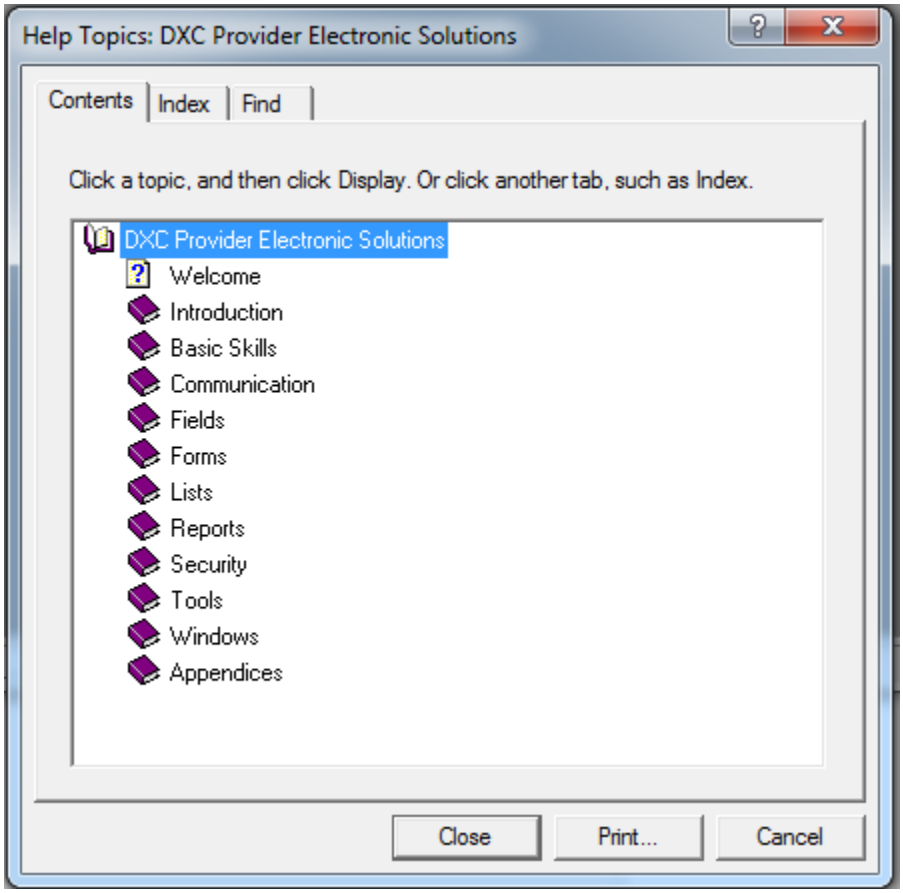
You can also access the online help document and search on specific information by selecting the Help menu option. To access the online help window select Help>>Contents and Index. The following pop-up window displays:



Enter keywords in the Help Topics window and press <Enter> to view information, or double click on topic name to view the information.

You can search by contents, by index (alphabetized), or by using the Find feature. Once you locate a specific topic, you can print the topic, or read it online, and then close the pop-up window.

To return to the list of topics once you've viewed information, click the Help Topics button.

NOTE:

The online help is not a substitute for the *Alabama Medicaid Provider Manual*. It merely provides general help regarding required fields and *Provider Electronic Solutions* functionality. It does not provide program-specific information. If you did not receive a copy of the *Alabama Medicaid Provider Manual,* contact DXC Technology Provider Relations at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid homepage at http://www.medicaid.alabama.gov

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4 Customizing Provider Electronic Solutions

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, provider numbers, or patient ID's. After saving the list information, the lists are available as a drop down list where you can select data to speed the data entry process and help ensure the accuracy of the form. Building a list can also increase your ability to submit correct claims quickly and efficiently.

To meet the standards set forth by the Health Insurance Portability Accountability Act (HIPAA), Provider and Recipient information is required to be entered into a list. You will no longer be able to enter the provider ID or recipient ID on the form manually.

This chapter describes two ways to build lists and how to use lists when filing claims, eligibility transactions, or claim status.

4.1 Building Lists

There are two ways to build lists with *Provider Electronic Solutions*:

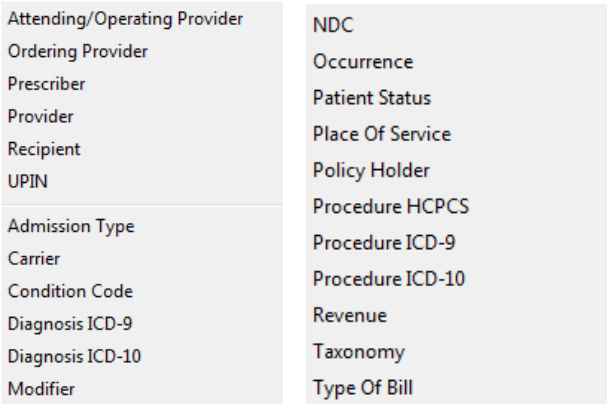
- Accessing list windows through the List menu.
- Double clicking on certain fields while you are completing a claim form or entering an eligibility verification transaction. Double clicking on these fields accesses the corresponding list window.

With *Provider Electronic Solutions*, you have the option of building lists as a separate task, or building (adding) to them as you submit claims.

NOTE:

To access a list window from a claim form, double-click in the field that corresponds to the list window. For example, while keying a claim, double click the Provider ID field to access the list window for providers. Enter information into the corresponding fields. Click the 'Save' button to add it to the list.

You can build the following lists using *Provider Electronic Solutions*:



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Each list type corresponds to a list window. Users may add, edit, or delete list records using list windows.

Below is a description of the buttons that display on each list window. The ‘copy’ button is not a feature on all list windows:

Button	***Usage***
Add	Pressing this button enables you to refresh the list screen so you may add a new record. Please note that if you key over data that already displays on the list window and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the list.
Select	Pressing this button enables you to select the current list record to add to the current transaction.
Help	Pressing this button enables a help screen to appear to answer any questions you may have.
Close	Pressing this button enables you to close the window.
Copy	Pressing this button enables you to build a new list from the current list record.

To Add a New Record to a List

Step 1 Click on the ‘List’ menu from the toolbar. To add a record, select the list by clicking on it.

Step 2 Key information into all required fields.

Step 3 You can enter information in any order, or may enter it in the order presented on the record, pressing the Tab key to move to the next field.

Step 4 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press ‘Save’.

Step 6 Press the ‘Add’ button to add another record.

To Modify a Record from the List

Step 1 Click on the ‘List’ menu from the toolbar. To modify, select the list by clicking on it.

Step 2 Scroll through the list of records that display at the bottom of the list window. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the record. Press ‘Undo All’ if you overwrite a record.

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- Press ‘Delete’ to delete an unwanted record.

To Find a Record in the List

Step 1 Select the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Step 2 Once you have entered the search criteria, click the ‘Find Next’ button with your mouse to search for the next record that matches the search criteria. Continue clicking ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Step 3 Press ‘Cancel’ when you have finished searching.

4.2 Completing the Provider List

The Provider list allows you to collect detailed information about providers that can then be automatically entered into forms. This includes such information as: Provider ID/NPI, last name, first name, address, and SSN/Tax ID.

To Add a New Provider

Step 1 Click on the ‘List’ menu from the toolbar. Select ‘Provider’ from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 3 A sample Provider list window is pictured below:

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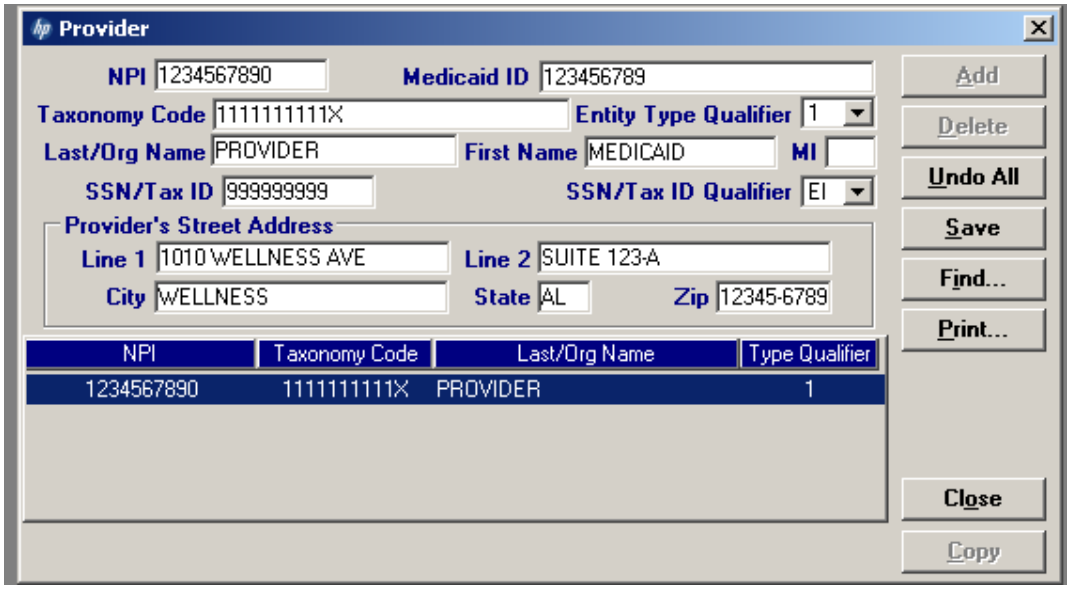

Field	*Guidelines*
Provider NPI	Enter the provider or prescriber's NPI according to the format in the Alabama Medicaid manual. A provider's NPI is 10 characters in length.
Medicaid ID	For providers with multiple service locations, enter the provider's Alabama Medicaid assigned ID as a secondary identifier. The Medicaid ID can be either 6, 8 or 9 characters in length.
Taxonomy Code	This field lists the code designating the provider type, classification and specialization. This field is optional for all claim types except Dental – it is a required field on Dental claims.
Entity Type Qualifier	Choose a value based on the information entered in the Provider ID/NPI field. 1 – Indicates the number entered in the field belongs to a Person. 2 – Indicates the number entered in the field belongs to a Non-Person.
Last/Org Name	Based on the information entered in the Provider ID/NPI field, enter the name of the facility or the provider's last name.
First Name	If a "1"' was chosen in the Entity Type Qualifier field, enter the provider's first name.
MI	If a "1" was chosen in the Entity Type Qualifier field, enter the provider's middle initial. This field is optional.
SSN/Tax ID	Enter the individual provider's 9-digit social security number or the Tax Identification number of the party being referenced. No hyphens, slashes, dashes or spaces should be used when completing this field. (If the Social Security Number or Tax ID is not known and cannot be obtained, please enter all 9's in this field and choose "SSN Number" from the SSN/Tax ID Qualifier.)
SSN/Tax ID Qualifier	Choose the best value to indicate if: **EI** – SSN/Tax ID entered is the employer's identification number (such as Tax ID) or **SY** - SSN/Tax ID entered is a SSN number.
Provider's Street Address – Line 1	Enter the facility or provider's primary street address. A Post Office Box address cannot be entered.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the facility or provider's City.
State	Enter the facility or provider's State.
Zip+4	Enter the facility or provider's Zip Code plus the 4-digit Zip Code extension.

Step 4 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll

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through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press ‘Save’.

Step 6 Press the ‘Add’ button to add another record.

NOTE:

The Provider List is also used to indicate referring physicians. If you are entering a referring physician, the same information that is entered for a billing provider is required for a referring provider.

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4.3 Completing the Recipient List

The Recipient list allows you to collect detailed information about recipients that can then be automatically entered into forms. This includes such information as: Recipient name, date of birth, address, social security number (SSN), and Recipient ID.

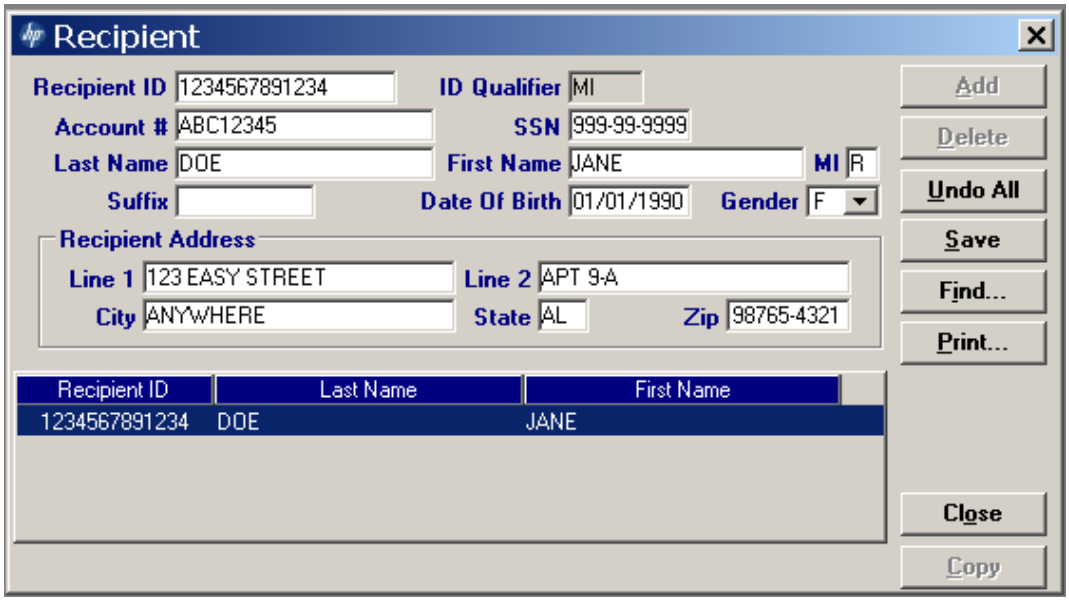
To Add a New Recipient

Step 1 Click on the 'List' menu from the toolbar. Select 'Recipient' from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 3 A sample Recipient list window is pictured below:



Field	*Guidelines*
Recipient ID	Enter the recipient's 13-digit Alabama Medicaid ID.
ID Qualifier	This field auto-defaults to its proper setting.
Account #	Enter the recipient's account number if your facility has assigned one. If no account number has been assigned enter a zero.
SSN	Enter the recipient's 9-digit Social Security Number.
Last Name	Enter the recipient's last name according to their eligibility verification.
First Name	Enter the recipient's first name according to their eligibility verification.
MI	Enter the recipient's middle initial according to their eligibility verification.
Suffix	If applicable, enter the recipient's suffix. Example JR or SR. This field is optional.
Date of Birth	Enter the recipient's date of Birth in MM/DD/CCYY format.
Gender	Choose the best value to indicate the recipient's gender.
Recipient Address – Line 1	Enter the recipient's primary street address.

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Field	Guidelines
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the recipient's city.
State	Enter the recipient's state.
Zip	Enter the recipient's Zip. Must be either 5 characters or 9 characters in length.

Step 4 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press 'Save'.

Step 6 Press the 'Add' button to add another record.

4.4 Completing the Policy Holder List

The Policy Holder list allows you to collect detailed information about a recipient's third party insurance that can then be automatically entered into forms. This includes such information as: Group #, Carrier Name, policy holder information, etc.

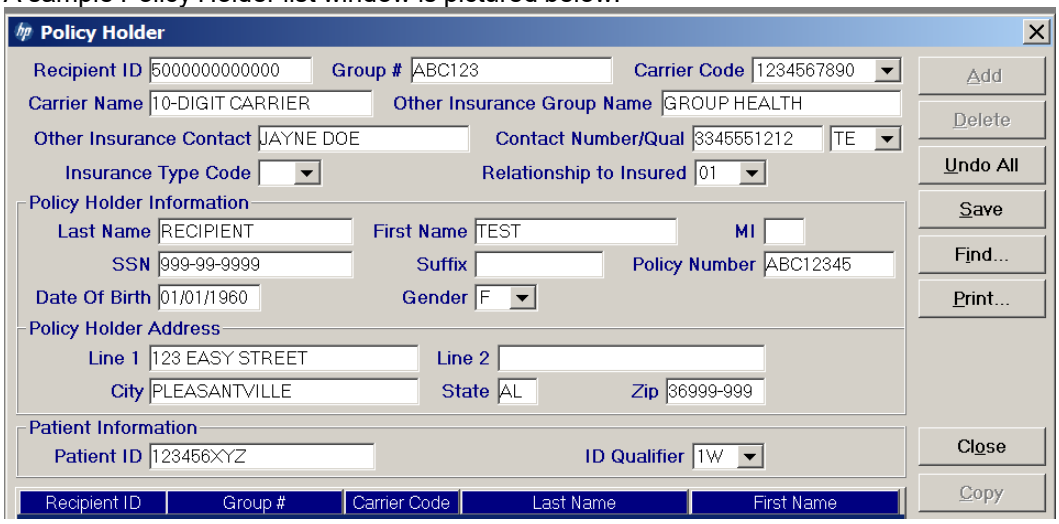
To Add a New Policy Holder

Step 1 Click on the 'List' menu from the toolbar. Select 'Recipient' from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

A sample Policy Holder list window is pictured below:



Field	Guidelines
Recipient ID	Enter the recipient's 13-digit Alabama Medicaid ID.

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Field	*Guidelines*
Group #	Enter the recipient's group number, assigned by the other insurance, if applicable.
Carrier Code	Choose a valid carrier code from the drop down box that identifies the recipient's health plan. If you are unable to make a choice based on the list provided, double-click on this field to add a new valid Carrier Code (up to 10 digits). (An expanded list of Carrier Codes can be found on Medicaid's website at http://www.medicaid.alabama.gov/. Select the most current version of the provider manual and navigate to appendix K: Top 200 Third Party Carrier Codes. FQHCs and RHCs can enter a carrier code equal to the NPI for the MCO plans to submit claims with MCO payment as other payers.
Carrier Name	This field auto-writes based on the information chosen in the Carrier Code field.
Other Insurance Group Name	Enter the Other Insurance's group (employer) name. This field is optional.
Other Insurance Contact	Enter the contact name of a valid representative from the other insurance. This field is optional.
Contact Number	Enter the other insurance representative's phone number. This field is optional.
Contact Qual	If applicable, choose the best value to indicate the type of number entered in the Contact Number field. ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone
Insurance Type Code	Choose the best value to indicate the type of policy entered. 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-stage Renal Disease Beneficiary in the mandated Coordination Period with an Employers Group Health Plan 14 Medicare Secondary, No-fault Insurance including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability insurance is Primary
Relationship to Insured	Choose the best value to indicate the relationship of the patient to the insured. 01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship
Last Name	Enter the last name of the policy holder.
First Name	Enter the first name of the policy holder.
MI	Enter the Middle Initial of the policy holder. This field is optional.
SSN Number	Enter the social security number of the policy holder. This field is optional.
Suffix	Enter the suffix of the recipient if applicable. Such as JR, SR, etc. This field is optional.
Policy Number	Enter the Policy Number of the policy holder.
Date of Birth	Enter the date of birth of the policy holder.
Gender	Choose the best value to indicate the gender of the policy holder.
Line 1	Enter the address of the policy holder.

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Field	*Guidelines*
Line 2	If applicable, enter the secondary address of the policy holder. Such as “Apt D or Ste 333”.
City	Enter the city of the policy holder.
State	Enter the state of the policy holder in an abbreviated format. EX Alabama = AL
Zip	Enter the zip code of the policy holder.
Patient ID	Enter the patient’s identification number; this may include the number assigned by the other insurance or their social security number. This field is optional.
ID Qualifier	Choose the best value to indicate the type of number entered in the Patient ID field. 1W Member ID Number IG Insurance Policy Number 23 Client Number

Step 3 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 4 Correct the mistake and press ‘Save’.

Step 5 Press the ‘Add’ button to add another record.

4.5 Completing the Provider UPIN List

The Provider UPIN list allows you to collect information about referring providers that can then be automatically entered into the professional claim form. This list contains the following information: the provider’s 6-digit unique identifier number, last name, first name.

To Add a New Provider UPIN

Step 1 Click on the ‘List’ menu from the toolbar. Select ‘Provider UPIN’ from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form.

A sample Provider UPIN list window is pictured below:

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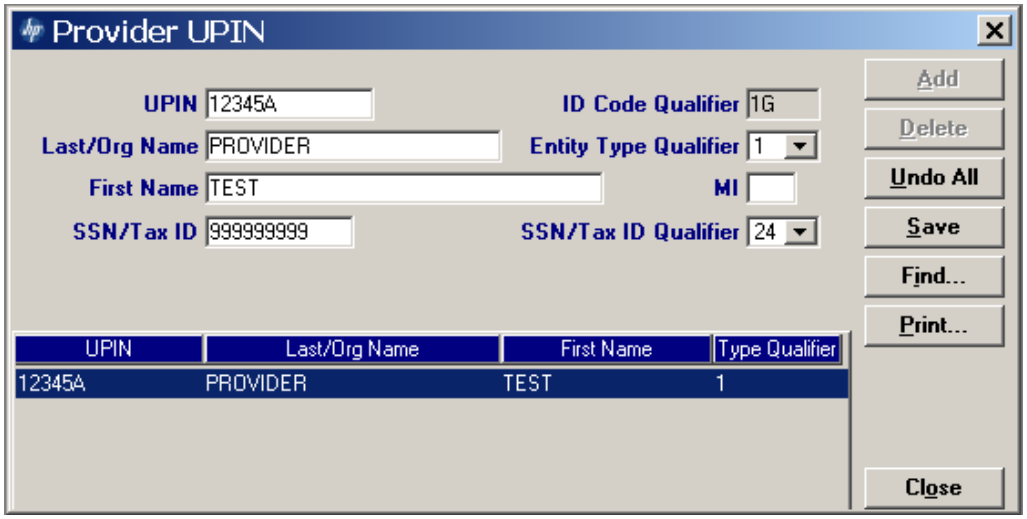

Field	*Guidelines*
UPIN	Enter the provider's 6-character unique provider identifier (ANNNNN or AAANNN characters).
Last/Org Name	Enter the name of the facility or the provider's/prescriber's name that corresponds to the number in the UPIN field.
ID Code Qualifier	Hard coded into the software
Entity Type Qualifier	Choose a value based on the information entered in the UPIN field. 1 – indicates the number entered in the UPIN field belongs to a person. 2 – indicates the number entered in the UPIN fields belongs to a non-person.
SSN/Tax ID	Enter the individual provider's 9-digit social security number or the Tax Identification number of the party being referenced. No hyphens, slashes, dashes or spaces should be used when completing this field. (If the Social Security Number or Tax ID is not known and cannot be obtained, please enter all 9's in this field and choose "SSN Number" from the SSN/Tax ID Qualifier.)
SSN/Tax ID Qualifier	Choose the best value to indicate if: 24 – SSN/Tax ID entered is the employer's identification number (such as Tax ID) or 34 - SSN/Tax ID entered is a SSN number.

Step 3 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 4 Correct the mistake and press 'Save'.

Step 5 Press the 'Add' button to add another record.

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4.6 Using Lists

The lists you maintain can speed up your claims filing process. When you are submitting a claim form and you access a field that corresponds to a list (for instance, the Recipient ID field), the system displays a drop down menu. This drop down list contains the records you have previously added to the list. Scroll through the records and select one. Tab through the field and the system populates the field (and any corresponding fields, such as Recipient Name) with the information from the list record.

Alternatively, you can double-click in any field that corresponds to a list to access the list window. From this window, you may search for a record, modify an existing record, or add a new record.

NOTE:

The system does not verify the accuracy of the data you maintain on lists, other than requiring data to be the correct field length, if applicable. If you key errors in your list file (for instance, if you transpose digits for a recipient ID), you may not know you have made an error until you submit the claim and the claim is rejected. If you use lists, please print and review the lists occasionally to ensure their accuracy.

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5

5 Verifying Eligibility

This chapter provides instructions for submitting eligibility verification requests. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

Version 3.09 of the Provider Electronic Solutions software includes MCO enrollment information on the eligibility response. Please contact the recipient's MCO for further benefit information.

Benefit limitations on eligibility responses are fee-for-service limits only.

EPSDT screening dates are both fee-for-service claim related and encounter claim related dates.

If a "partial" message is returned in a section of eligibility, this means the specific eligibility segment starts or ends within the requested date span and is not effective for the complete date span requested.

Users access the Eligibility Verification window using one of the following methods.

For a 270 request:

- Selecting the Eligibility icon from the toolbar
- Selecting Forms>>270 Eligibility Request

For a NCPDP Pharmacy request: (For Pharmacy's only)

- Selecting the NCPDP Pharmacy Eligibility icon from the toolbar
- Selecting Forms>> NCPDP Pharmacy Eligibility

The electronic form for the 270 Request displays with two tabs: Header 1 and Header 2

The electronic form for NCPDP Pharmacy Request displays with one Header tab.

5.1 Submitting a Request

The Eligibility window contains three main parts:

- Updateable fields used to enter eligibility data.
- Buttons to the right of the window used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several eligibility verification transactions. Users may highlight a row to delete, copy,

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print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Date of Service (DOS), and Status.

Below is a description of the buttons that display on the Eligibility window:

Button	***Usage***
Add	Pressing this button enables you to refresh the window so you may add a new record. Please note that if you key over data that already displays on the record and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record, or press Copy (see below) to build a new record from an existing record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new record from an existing record.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved record by status, DOS, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the record currently displayed.
Close	Pressing this button enables you to close the window.

To Add a New Record

Access the correct Eligibility form. Key information into all required fields, refer to Section *5.2 Completing the 270 Eligibility Form* **or** Section *5.3 Completing the NCPDP Pharmacy Eligibility Form.*

Step 1 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 2 Correct any mistakes and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete records (status ‘I’) cannot be submitted via batch

To Modify a Record from the List

Scroll through the list of records that display at the bottom of the form. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the record. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct record.
- Press ‘Copy’ to copy a verification request that closely matches the information you need to enter (for example, if you must enter an eligibility verification request for the same recipient on a different date of service) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Eligibility request created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option will be to delete these Eligibility request. All Eligibility request submitted using PES version 3.0 must be created in the 3.0 software as a new request.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

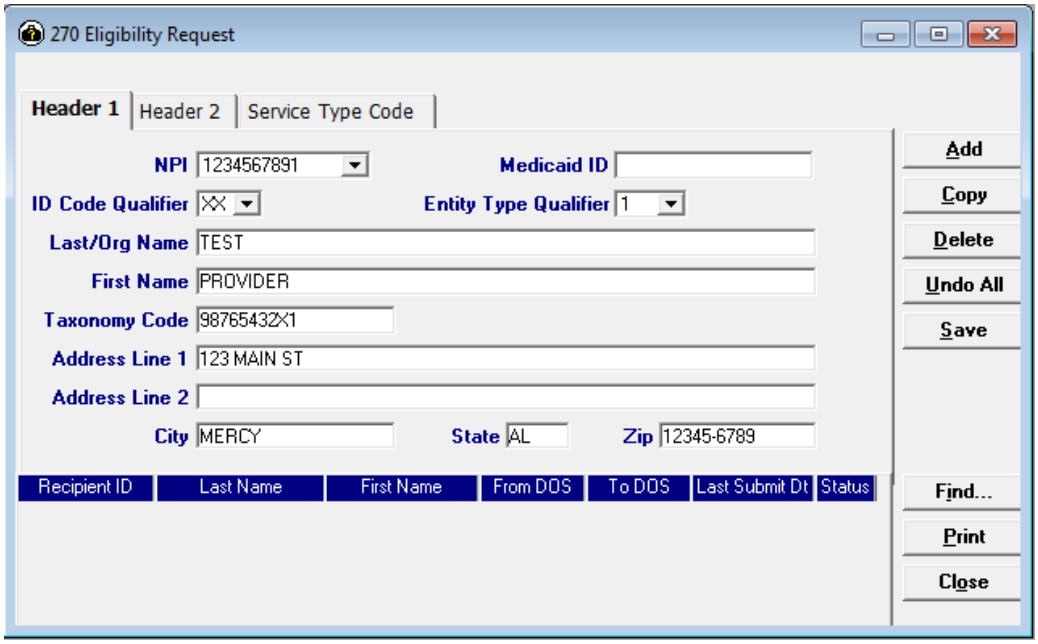
- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

5.2 Completing the 270 Eligibility form

The 270 Eligibility Request form is divided into three Headers. A sample of Header 1 is pictured below:



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Please complete the fields below in order to save and send your record:

Field	***Guidelines***
NPI	Choose the desired NPI from your Provider list. If you have not added the required NPI to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Medicaid ID	For providers with multiple service locations, enter the Alabama Medicaid ID number as a secondary identifier for the appropriate service location. For providers who do not have an NPI, enter the 9-digit Medicaid ID number. NOTE: If using only the 9-digit Medicaid ID number, the provider information must be manually entered. If using the NPI or NPI with Medicaid ID, the provider information can be populated from the Provider List.
ID Code Qualifier	Select the value that identifies the entity that assigned the ID.
Entity Type Qualifier	Choose a value based on the information entered in the Provider ID/NPI field. 1 – Indicates the number entered in the field belongs to a Person. 2 – Indicates the number entered in the field belongs to a Non-Person.
Last/Org Name	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. If using the 9-digit Medicaid ID, the information must be manually entered. Enter the name of the facility or the provider's last name.
First Name	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. If using the 9-digit Medicaid ID, the information must be manually entered. If a "1" was chosen in the Entity Type Qualifier field, enter the provider's first name.
Taxonomy Code	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. This field is optional.
Provider Address – Line 1	If using the NPI from the provider list, the provider address fields will auto-write based on the information placed in the Provider ID field or enter the facility or provider's primary street address.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the facility or provider's City.
State	Enter the facility or provider's State.
Zip+4	Enter the facility or provider's Zip Code plus the 4-digit Zip Code extension.

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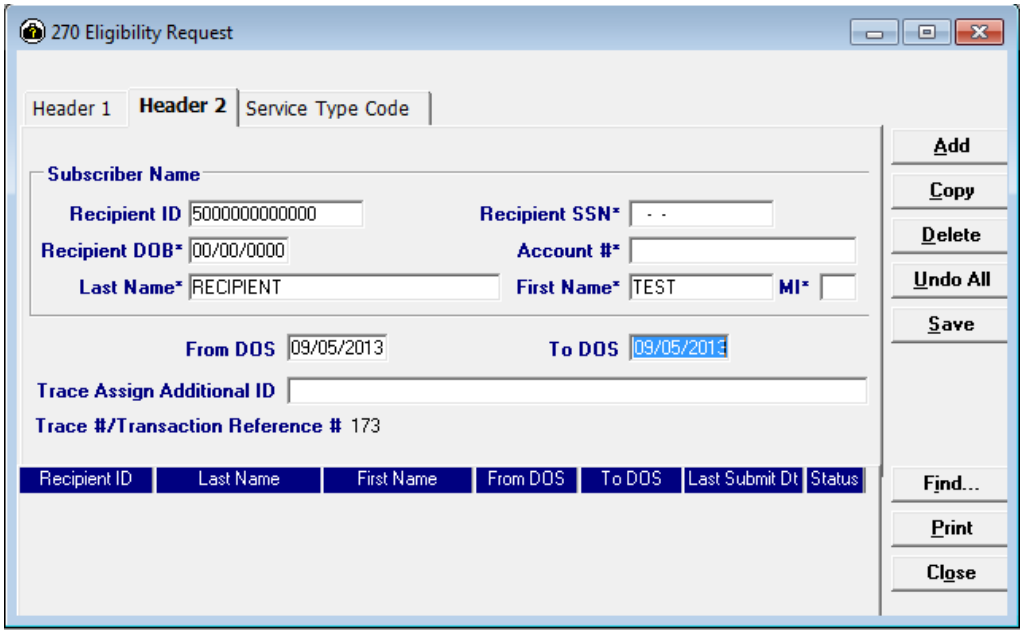
A sample of Header 2 is pictured below:



Please complete the fields below in order to save and send your record:

Field	***Guidelines***
Recipient ID	Enter the first 12 digits of the recipient number, the check digit will be returned in the eligibility verification response. Or select a recipient number from the recipient list. This field is optional if inquiring with the recipient's name, date of birth and or SSN.
Recipient SSN	Enter the Social Security Number of the person to which services are rendered. This field is optional if the Recipient ID number is entered.
Recipient DOB	Enter the date the Medicaid recipient was born in MMDDCCYY format. This field is optional if the Recipient ID number is entered.
Account #	Enter the patient account number for your records. This field is optional.
Last Name	Enter the recipient's last name. This field is optional if the Recipient ID number is entered.
First Name	Enter the recipient's first name. This field is optional if the Recipient ID number is entered.
MI	Enter the recipient's middle initial. This field is optional.
From DOS	The current days date will auto write within this field. If you do not wish to use the current date you may enter the start date in MM/DD/CCYY format.
To DOS	The current days date will auto write within this field. If you do not wish to use the current date you may enter the stop date in MM/DD/CCYY format.
Trace Assigning Additional ID	Identifies a further subdivision within the organization.
Trace #/Transaction Reference #	This field allows you to utilize the trace # that is also located on the 271 response to locate which request the response is referring to.

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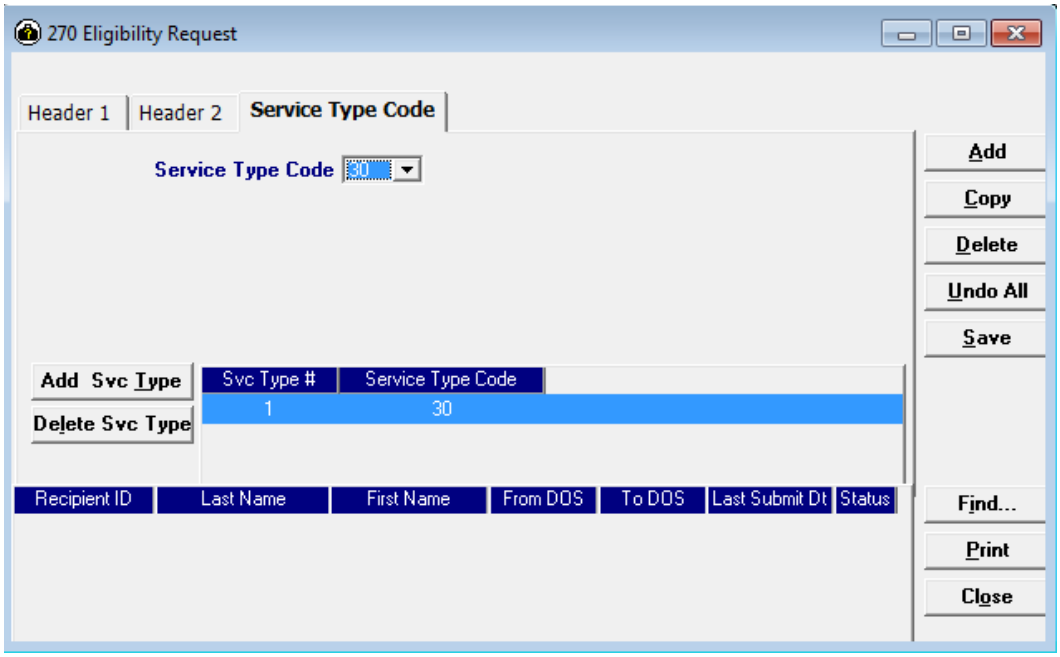
A sample of the Service Type Code tab is pictured below:



Please complete the fields below in order to save and send your record:

Field	***Guidelines***
Service Type Code	This drop down defaults to Service Type Code 30 – Health Benefit Plan Coverage. This is the same information that has been returned in the past for eligibility requests through Alabama Medicaid. You do not need to do anything on this tab if you wish to have just that information returned as before. If you wish to return a Service Type other than 30 click the dropdown to change the Service Type Code to the Service Type Code you want returned. If you wish to have additional Service Type Code information returned, click the 'Add Svc Type' button to the bottom left of the dropdown field and then change the Service Type Code dropdown to the code you want returned. The software will allow up to 99 Service Type Codes on one eligibility request.

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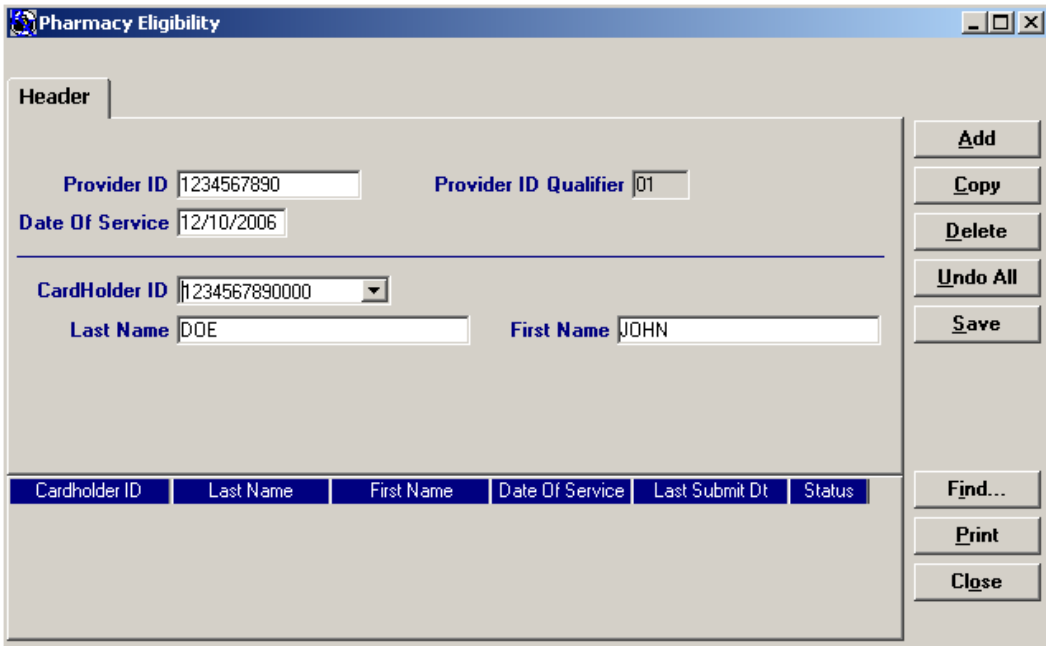
5.3 Completing the NCPDP Pharmacy Eligibility form

A sample of the Header for the request form is pictured below:



Please complete the fields below in order to save and send your record:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Code Qualifier	The value 01 will always be the default selection.
Date of Service	Change the date of service if the eligibility request is in regards to a dispense date other than the current date.
Cardholder ID	Enter the first 12 digits of the recipient number (the check digit will be returned in the eligibility verification response) from the Medicaid identification card.
Last Name	Enter the cardholder's last name. This field is optional if the cardholder ID is entered.
First Name	Enter the cardholder's first name. This field is optional if the cardholder ID is entered.

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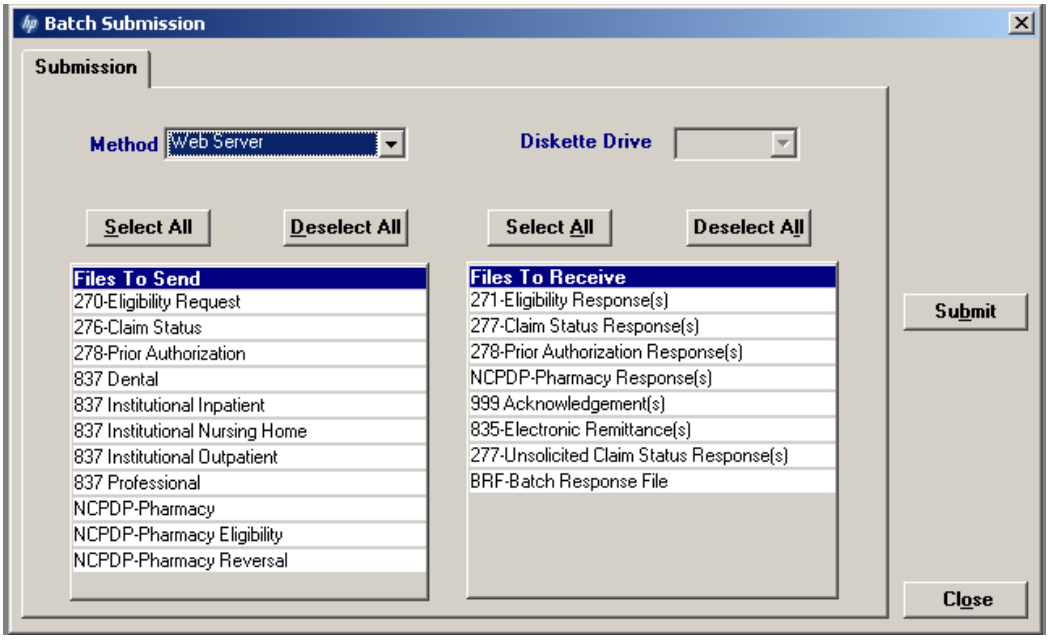
5.4 Submitting a 270 Batch Request

Review the steps for adding an eligibility verification record, modifying a record, and using the list feature as described in Section *5.1, Submitting a Request*. After all records have been entered and saved, submit the batch of 270 eligibility verification records using the procedures provided below.

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select ‘Web Server’ from the drop down next to Method.

Step 3 Determine which files you want to send from the Files to Send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the Files to Receive.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

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Step 5 Press the 'Submit' to submit (and receive) the files.
Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

To view Recipient Eligibility information, you must download the Batch Response File (BRF) using the Provider Electronic Solutions software.

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6

6 Submitting 837 Dental Claims

This chapter provides instructions for submitting electronic 837 Dental claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual, *Chapter 13*, for program-specific information.

Users access the Dental electronic claim form using one of the following methods:

- Selecting the Dental icon from the toolbar
- Selecting Forms>>837 Dental

The electronic form displays with three tabs: Header 1, Header 2, and Service. The additional tabs, if applicable are: OI (Other Insurance), OI Adj (Other Insurance Adjustment), and Service Adj (Service Adjustment.

6.1 Entering Claims in the Electronic Dental Form

Each tab on the Dental form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form in an "R" status.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.

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Button	*Usage*
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Dental form and key information into all required fields. (All fields are required unless indicated as optional.)

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the 'Save' button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct the mistake and press 'Save', or press 'Incomplete' to save the record with an incomplete status.

Incomplete claims (status 'I') are not submitted with the batch submission.

Step 4 Press the 'Add' button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. *You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).* Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients). Modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)

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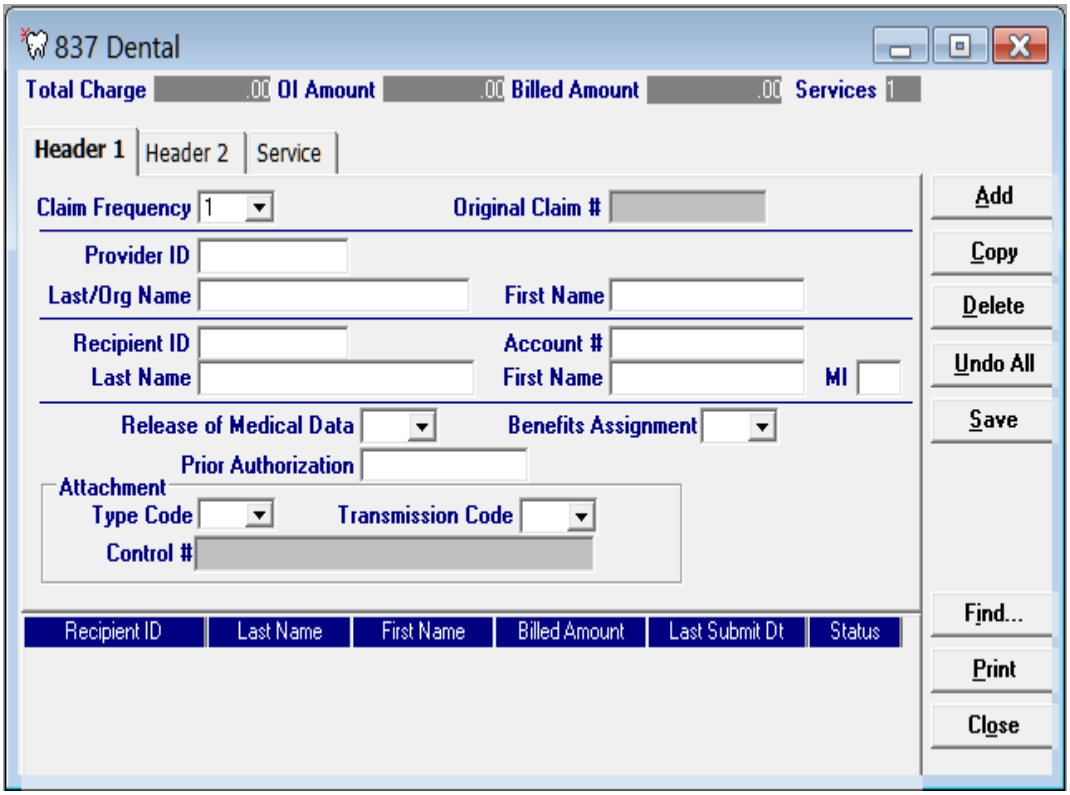
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria. Press 'Cancel' when you have finished searching.

6.2 Fields on the 837 Dental Claim Form

6.2.1 Header 1 Tab

Below is a sample electronic 837 Dental form displaying the Header 1 tab:



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Field	***Guidelines***
Claim Frequency	Choose the best value to indicate type of claim submission. 1 – Indicates this is an original claim (If you have billed this claim previously, but it denied you may still choose a 1 to indicate it is original). 7 – Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill. 8 – Void or reverse a prior claim. You must have the ICN number of the original paid claim in order to complete the claim reversal process.
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the ICN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Prior Authorization	If applicable, enter the Prior Authorization number issued by the Medicaid agency. **This field is optional**.
Attachment Type Code	If applicable, select the appropriate attachment type code from the drop-down-display menu.
Attachment Transmission Code	If applicable, select the appropriate transmission code from the drop-down-display menu.
Attachment Control #	If applicable, enter the Control Number of an electronic attachment.

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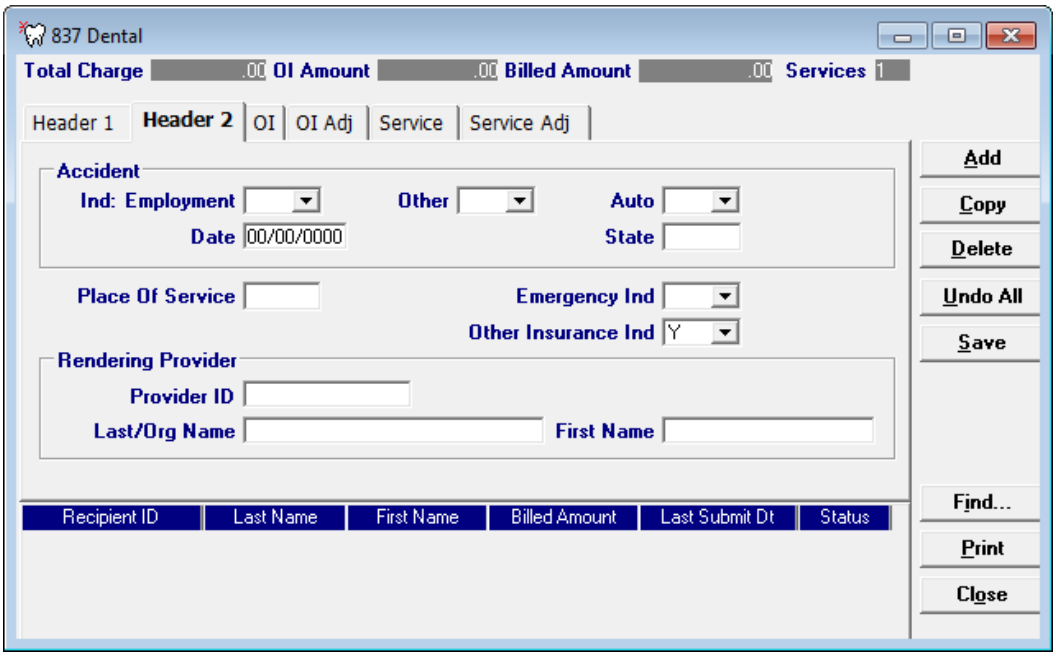
6.2.2 Header 2 Tab

Below is a sample electronic 837 Dental form displaying the Header 2 tab:



Field	*Guidelines*
Ind: Employment	Choose the best value to indicate if services were provided as a result of an on the job injury.
Other	Choose the best value to indicate if services were provided as a result of an injury (other than on the job injury or automobile accident).
Auto	Choose the best value to indicate if services were provided as a result of an automobile accident.
Date	Enter the date of the accident if services are the result of an accidental injury in MM/DD/CCYY format.
State	If applicable, enter the state that the accident occurred in an abbreviated format. For example, **AL** for Alabama.
Place of Service	Choose the best value to indicate where the service took place. • 11 – Dental Office • 21 – Inpatient Hospital • 22 – Outpatient Hospital • 31 – Nursing Facility
Emergency Ind	Choose the best value to indicate if this procedure was due to an emergency.
Other Insurance Ind	Choose the best value to indicate whether or not the recipient has other insurance besides Medicaid. An indication of 'Y' will put the "OI" tab and "OI Adj" tabs on your claim form.
Rendering Provider ID	Choose a provider ID from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions. **Also, if the provider entered here performed all services being billed on this claim, DO NOT enter a rendering provider ID on the Service tab.**
Last/Org Name	This field will auto-write based on the entry in the Rendering Provider ID field.
First Name	This field will auto-write based on the entry in the Rendering Provider ID field.

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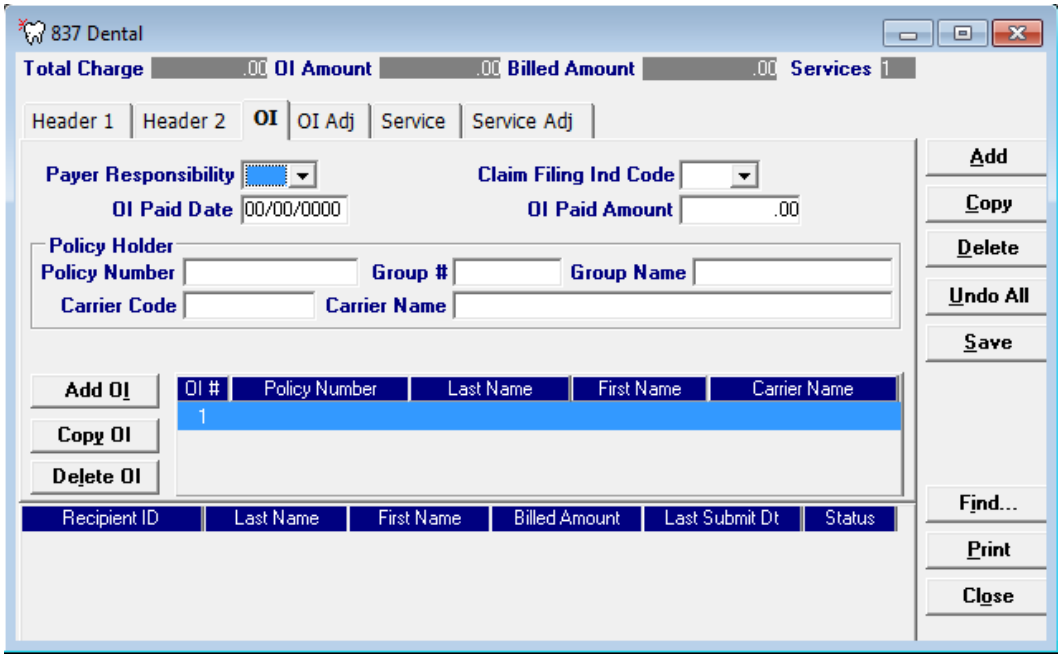
6.2.3 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Dental form displaying the OI tab.



Field	*Guidelines*
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's insurance coverage status to Medicaid. Do not enter 09 or Medicare-related codes 16 or MB on the OI tab. See Appendix B, section B-3 for specific codes in the dropdown list.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service(s) being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service(s) being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Group #	This field will auto-write based on the information chosen in the Policy Number field.
Group Name	This field will auto-write based on the information chosen in the Policy Number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy Number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy Number field.

Adding, Deleting, or Copying another insurance.

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more

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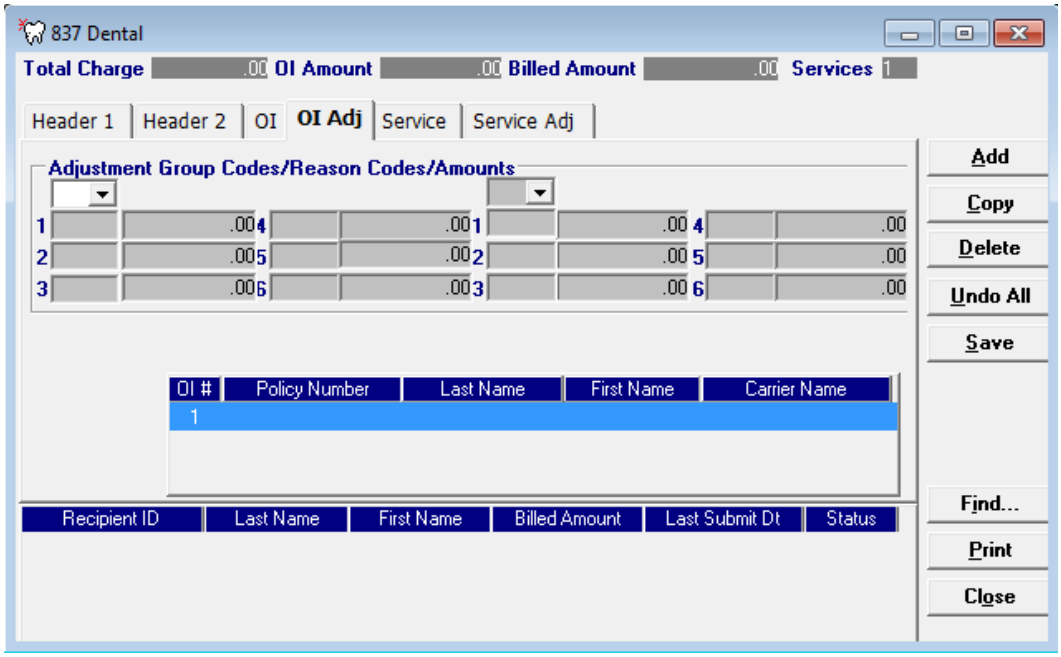
than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

6.2.4 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Dental form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

6.2.5 Service Tab

Below is a sample electronic 837 Dental form displaying the Service tab.

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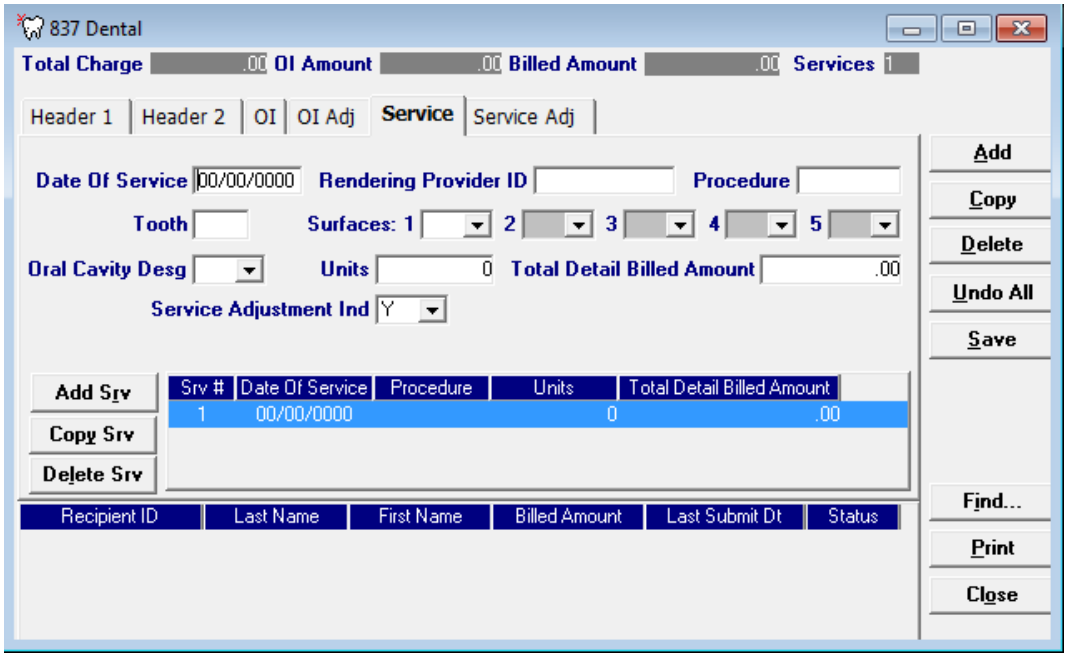

Field	*Guidelines*
Date of Service	Enter the Date of Service for the procedure being billed in MM/DD/CCYY format.
Rendering Provider ID	ENTER A RENDERING PROVIDER ID IN THIS FIELD **ONLY** IF ENTERING AN ID NUMBER THAT IS **DIFFERENT** FROM THE RENDERING PROVIDER ENTERED ON HEADER 2. Otherwise, choose a provider ID from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Procedure	Enter the appropriate ADA procedure code for the procedure being billed. (Such as D0230)
Tooth	If applicable to procedure billed, enter the appropriate tooth number for permanent teeth (01-32) or the appropriate letter for primary teeth (A-T). Medicaid recognizes supernumerary teeth for primary dentition as (AS – TS) and supernumerary teeth for permanent dentition as (51 – 82).
Surfaces	If applicable to procedure billed, choose the appropriate tooth surface of the tooth on which the service is performed (MBD, MOB, MODL). This field is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. B – Buccal D – Distal F – Facial I – Incisal L – Lingual M – Mesial O - Occlusal
Oral Cavity Designation	If applicable, choose the best value to indicate the area of the oral cavity (mouth) where treatment is being performed. 00 – Entire Oral Cavity 01 – Maxillary Area 02 – Mandibular Area 10 – Upper Right Quadrant 20 – Upper Left Quadrant 30 – Lower Left Quadrant 40 – Lower Right Quadrant
Units	Enter the amount of units/quantity being billed for the particular procedure code. If the procedure is performed on different teeth, a separate line of service must be entered.

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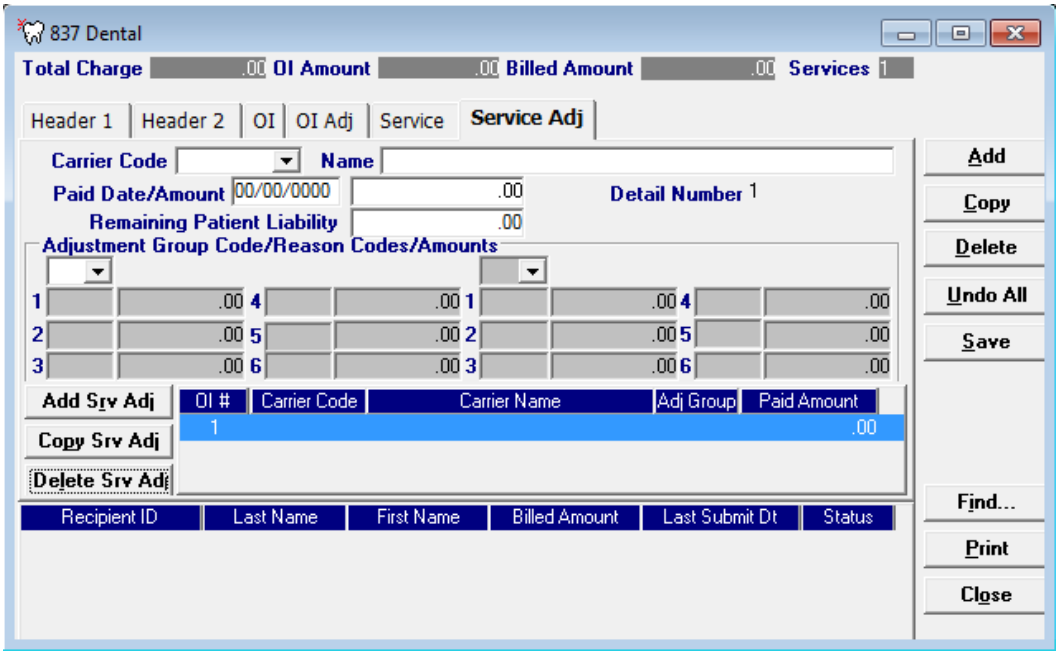
Field	*Guidelines*
Total Detail Billed Amount	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
Service Adjustment Ind	Select 'Y' to allow service adjustments to be entered on the service adjustment tab. If you have to enter adjustments for each detail you will need to select Y on this drop down for **EACH** detail line. Then you can go to the Service Adj tab to enter the information.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

6.2.6 Service Adj Tab

Below is a sample electronic 837 Dental form displaying the Service Adj tab.



Field	*Guidelines*
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.

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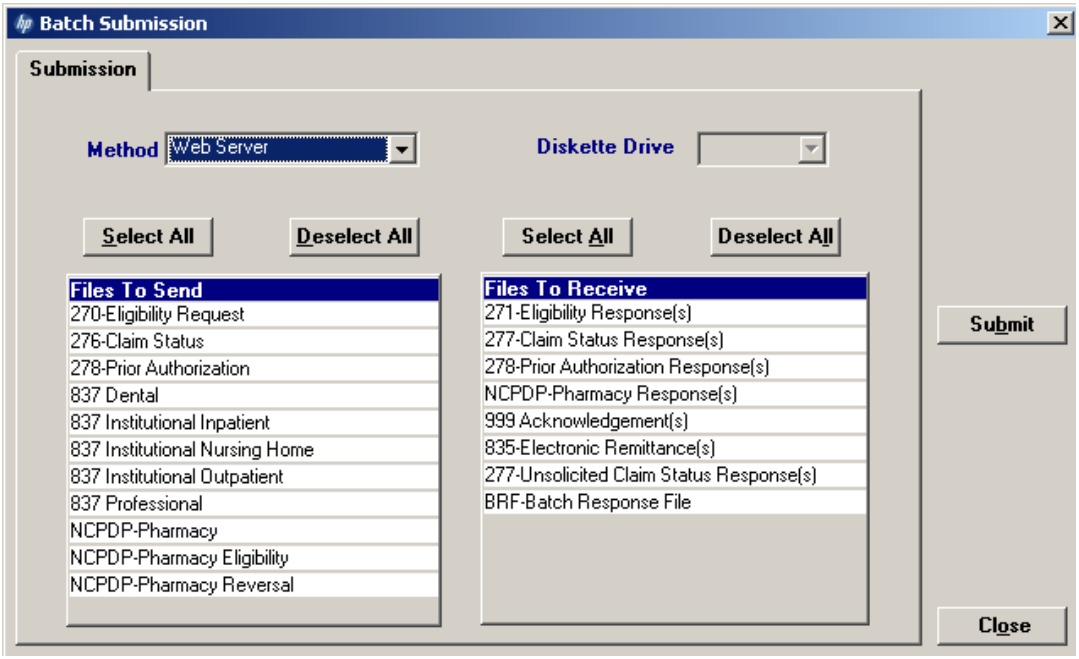
Field	*Guidelines*
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

6.3 Submitting Claims through the Web Server

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last* transmission, not the current transmission.

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the BRF using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and perform an online claim search.

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7 Submitting NCPDP Pharmacy Claims

This chapter provides instructions for submitting electronic Pharmacy claims. The interactive submission of pharmacy claims is no longer a feature of this software. Users must perform all interactive transactions using the Interactive Web Portal. For instructions to access the Interactive Web Portal, refer to Chapter 17. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the Pharmacy electronic claim form using one of the following methods:

- Selecting the NCPDP Pharmacy icon from the toolbar
- Selecting Forms>>NCPDP Pharmacy

The electronic form displays with three tabs: Header, Service 1 and Service 2.

7.1 Entering Claims in the Electronic NCPDP Pharmacy Form

Each tab on the Pharmacy form contains four main parts:

- Header line of fields that display the Provider and Recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is helpful if you routinely submit claims for the same procedure code, but different recipients, or when your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To submit pharmacy claims as a batch, refer to section *7.3 Submitting Claims through the Web Server or Diskette*.

DUR Alerts

Please refer to Chapter 27 of the Alabama Medicaid Provider Manual, Pharmacy, for a description of DUR alerts.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:

Pharmacy transactions created using 1.1 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using the 1.2 PES (version 3.0). The only option is to delete these Pharmacy transactions. All Pharmacy transactions submitted using PES version 3.0 must be created in the 3.0 software as a new Pharmacy transaction.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

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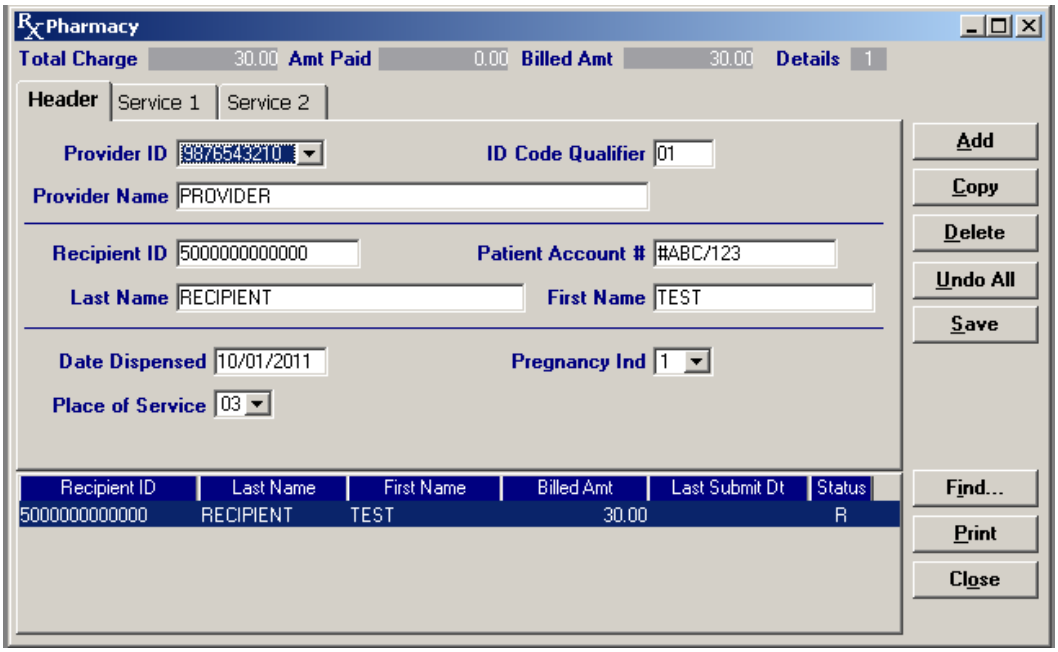
7.2 Fields on the NCPDP Pharmacy Claim Form

7.2.1 Header Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Header tab.



Complete the following fields under the Header tab to submit a pharmacy claim:

Field	*Guidelines*
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Qualifier	The value that identifies the entity that assigned the ID. 01 National Provider Identifier (NPI)
Provider Name	This field will auto-write based on the information placed in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Patient Account #	This field will auto-write based on the information placed in the Recipient ID field.
Last Name	This field will auto-write based on the information placed in the Recipient ID field.
First Name	This field will auto-write based on the information placed in the Recipient ID field.
Date Dispensed	Enter the date the prescription is dispensed to the recipient in MM/DD/CCYY format.
Pregnancy Ind	If applicable, choose the best value to indicate if the recipient is (1) not pregnant or (2) pregnant.
Place of Service	Select the best value from the drop-down-display menu box to indicate where the service was rendered.

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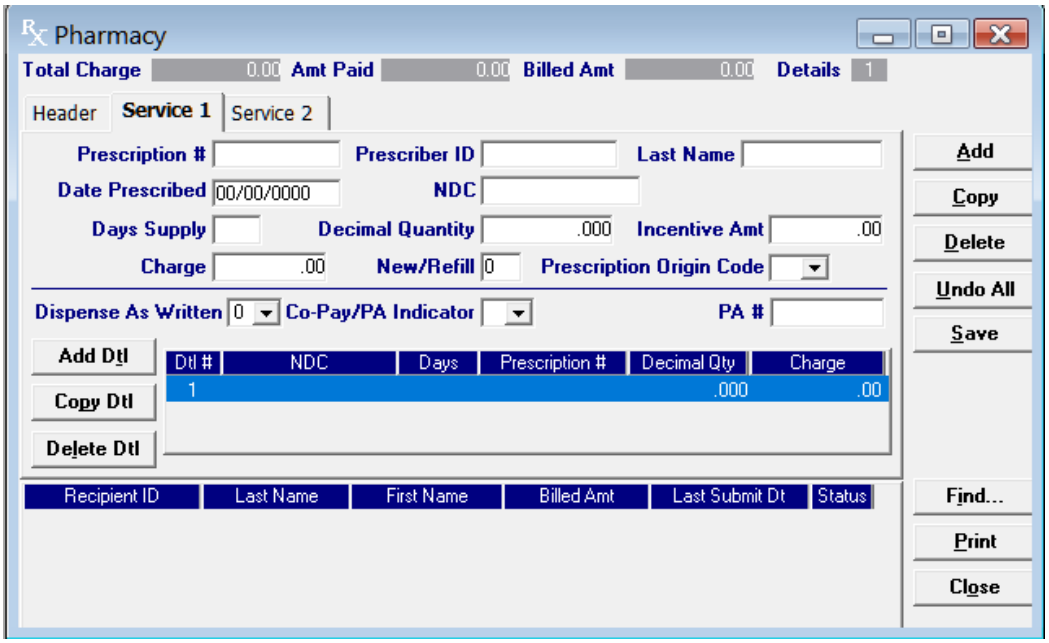
7.2.2 Service 1 Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Service 1 tab.



Complete the following fields under the Service 1 tab to submit a pharmacy claim.

Field	***Guidelines***
Prescription #	Enter the 7 to 12-digit prescription number.
Prescriber ID	Enter the prescriber's professional license number or NPI as it is displayed on the prescription.
Last Name	Enter the prescriber's last name as it is displayed on the prescription. This field will auto write if Provider ID field is populated with information from the prescriber list.
Date Prescribed	Enter the date the prescription was written in MM/DD/CCYY format.
NDC	Enter the 11-digit National Drug Code (NDC).
Days Supply	Enter the day supply according to the prescription. The day supply is limited to a maximum of 999 days.
Decimal Quantity	Enter the quantity or number of units or metric units of medication dispensed. The system displays quantities to the third decimal place. For example, if you enter 45, the system displays 45.000. There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5 ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45 gm tube of ointment should be coded as 00045. If a product is supplied in fractional units, you must key in the decimal as part of the quantity. For example, a 35.5 gm tube of ointment should be entered as 3–5–*decimal*–5 (35.500).
Incentive Amount	If applicable, enter the fee submitted by the pharmacy for contractually agreed upon services.

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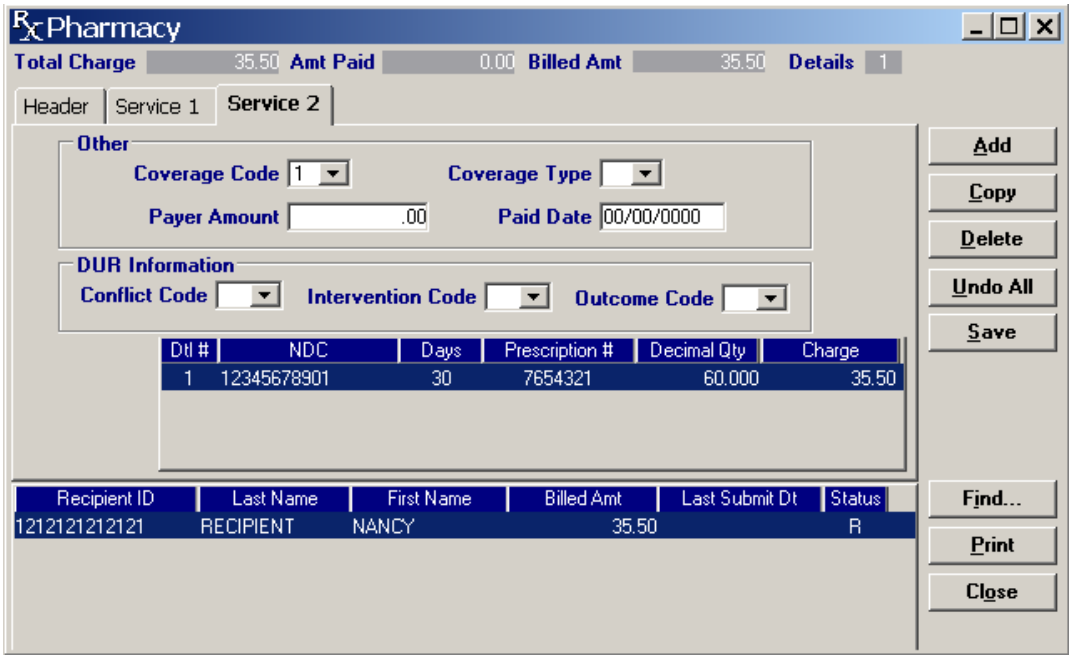
Field	Guidelines
Charge	Enter the amount (dollars and cents) of your customary charge.
New/Refill	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
Dispense as Written	Choose the best Dispense as Written (DAW) value from the drop-down-display menu box to indicate the reason if dispensing a brand name product.
Co-Pay/PA Indicator	If applicable, select the appropriate value from the drop down list box. Valid values are: 1 – Prior Authorization or 4 – Co-Pay Exempt. **This field is optional.**
PA #	If applicable, enter the 10-digit numeric Prior Authorization number. This field is optional.

7.2.3 Service 2 Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Service 2 tab.



Complete the following fields under the Service 2 tab to submit a pharmacy claim.

Field	Guidelines
Coverage Code	Choose the best coverage code that indicates the recipient's primary insurance coverage status on the particular prescription being filled. Valid values are 00 – 04.
Coverage Type	If the Coverage Code is a value of 02 - 04, then choose the correct value to categorize the other insurance as primary, secondary or tertiary to Medicaid.
Payer Amount	If applicable, enter any amount paid by an insurance company or other primary payers known at the time of submission. Do not enter Medicaid co-payment or patient payment in this block.
Paid Date	Enter the other insurance's paid date in MM/DD/CCYY format. This field is optional.

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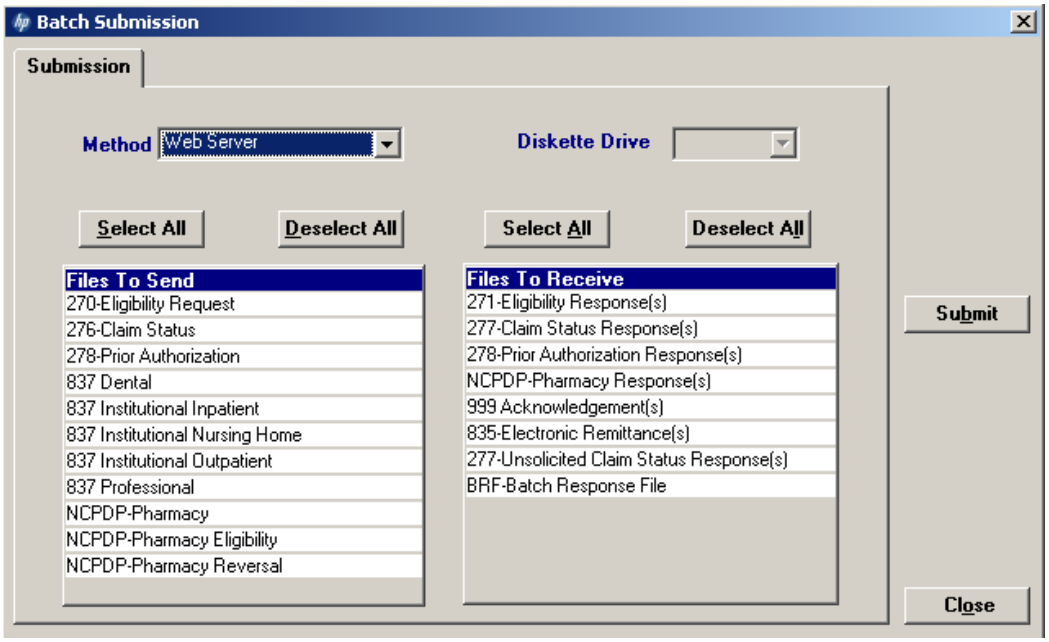
Field	*Guidelines*
Conflict Code	Choose the best value for a soft-edit prescription override. Conflict Codes are always system generated and are as follows: **DD** - Drug - Drug Interaction; **ER** - Overuse; **HD** - High Dose Alert; **LD** - Low Dose Alert; **LR** – Under-use Precaution; **PA** - Patient Age; **PS** - Product Selection; **TD** - Therapeutic Duplication, **ID – Ingredient Duplication**.
Intervention Code	Choose the best value for a soft-edit prescription override. The values are as follows: **OO(Zero + Zero)** - No intervention; **MO(M + Zero)** - Prescriber Consulted; **PO(P + Zero)** - Patient Consulted: **RO(R + Zero)** - Pharmacist Consulted Other Source:
Outcome Code	Choose the best value for a soft-edit prescription override. The values are as follows: **1A** - Filled as Is, False Positive; **1B** - Filled Prescription As Is; **1C** - Filled, With Different Dose; **1D** - Filled With Different Directions; **1E** - Filled With Different Drug; **1F** - Filled, With Different Quantity; **1G** - Filled with Prescription Approval; **2A** - Prescription Not Filled; **2B** - Not Filled, Directions Clarified.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, copy, or delete a service. Once you copy a service, you can modify it as necessary.

7.3 Submitting Claims through the Web Server

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

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Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

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8 Submitting 837 Professional

This chapter provides instructions for submitting electronic 837 Professional claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

8.1 General Instructions for Entering Electronic Claims

Users access the 837 Professional electronic claim form using one of the following methods:

- Selecting the 837 Professional icon from the toolbar
- Selecting Forms>>837 Professional

The electronic form displays with ten tabs: Header 1, Header 2, Header 3, Service 1 and Service 2. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustments), Crossover, Service Adj (Service Line Adjustments), and NDC.

8.1.1 Entering Claims in the Electronic 837 Professional Forms

Each tab on the 837 Professional form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record that has been submitted previously. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.

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Button	***Usage***
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Professional form. Key information into all required fields.

Field descriptions are provided in section *8.2 837 Professional form* in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.

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- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

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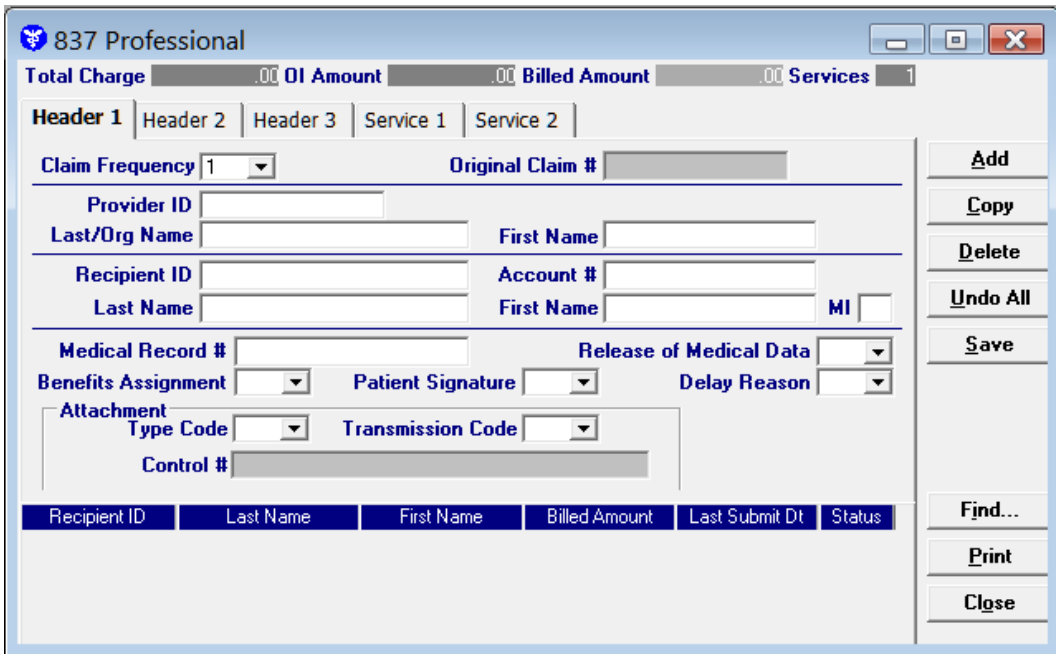
8.2 837 Professional Form *8.2.1*

Header 1 Tab

Below is a sample electronic 837 Professional form displaying the Header 1 tab.



Complete the following fields under the Header 1 tab to submit an 837 Professional claim:

Field	*Guidelines*
Claim Frequency	Choose the best value to indicate type of claim submission. 1 – Indicates this is an original claim (If you have billed this claim previously, but it denied you may still choose a 1 to indicate it is original). 7 – Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill. 8 – Void or reverse a prior claim. You must have the ICN of the original paid clam in order to complete this process.
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose the appropriate group/payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.

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Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Info for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Patient Signature	The default value is 'blank.' • **P** – Signature generated by provider because the patient was not physically present for service. • **'Blank'** - Signature generated by an entity other than the patient according to State or Federal law.
Delay Reason	Select the best value from the drop-down-display menu box to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. These delay reasons do <u>not</u> override claims over the year past filing limit. You must process such claims through the required process to receive payment considerations.
Attachment Type Code	If applicable, select the appropriate attachment type code from the drop-down-display menu.
Attachment Transmission Code	If applicable, select the appropriate transmission code from the drop-down-display menu.
Attachment Control #	If applicable, enter the Control Number of an electronic attachment.

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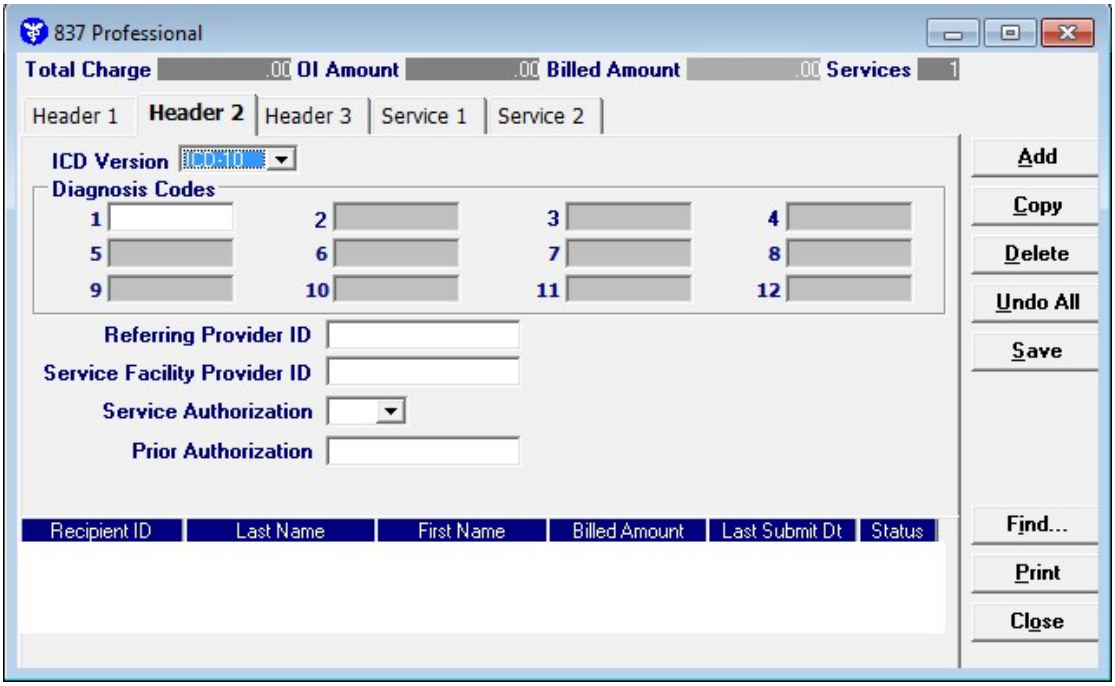
8.2.2 Header 2 Tab

Below is a sample electronic 837 Professional form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an 837 Professional claim:

Field	Guidelines
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Codes	Choose a proper diagnosis code from your diagnosis code list. These fields must be a minimum of 3-digits long and cannot contain decimals. Up to 12 diagnosis codes can be entered.
Referring Provider ID	Choose a provider ID from your provider ID list to indicate which provider referred the recipient to your facility. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Service Facility Provider ID	Select the provider NPI where the service was performed only if the service was provided at a location different than the billing provider location on Header 1 tab.
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. Immediate Urgent Care Services Rendered in a Retroactive Period Emergency Care Client has temporary Medicaid Bypass Provider Contract Check Claim exempt from Program edits Force into MAT Care Program
Prior Authorization	Enter the Prior Authorization number issued by the State Agency. This field is optional.

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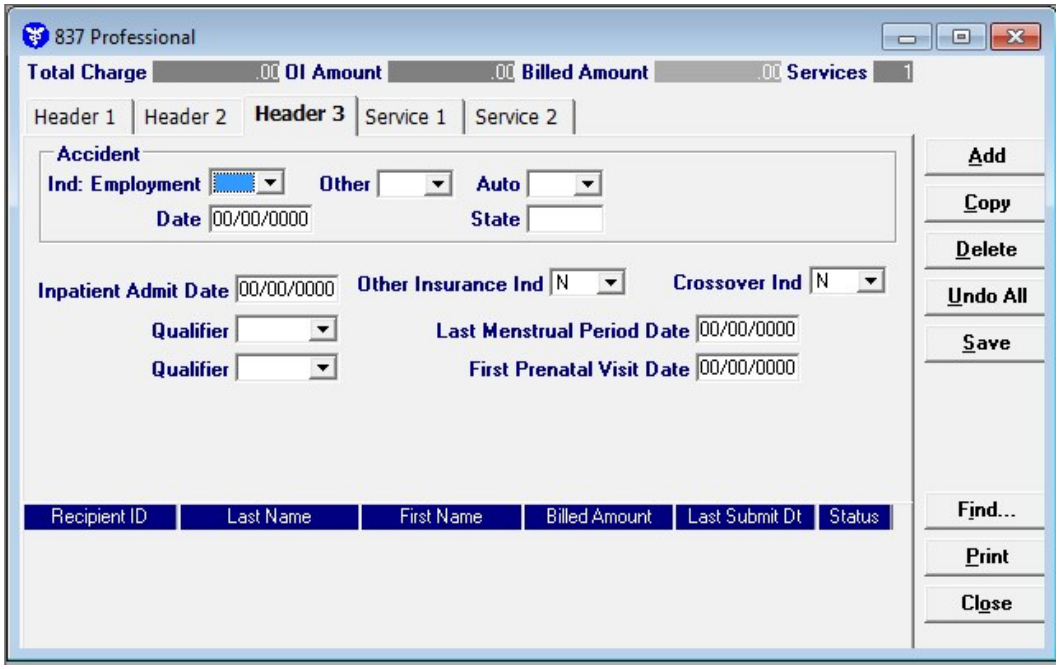
8.2.3 Header 3 Tab

Below is a sample electronic 837 Professional form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an 837 Professional claim:

Field	***Guidelines***
Ind: Employment	Choose the best value to indicate if services were provided as a result of an on the job injury.
Other	Choose the best value to indicate if services were provided as a result of an accident (other than on the job or automobile accident)
Auto	Choose the best value to indicate if services were provided as a result of an automobile accident.
Date	Enter the date of the accident if services were provided as a result of an accidental injury in MM/DD/CCYY format.
State	Enter the state that the accident occurred. The state should be abbreviated.
Inpatient Admit Date	If the recipient is currently admitted into the hospital as an inpatient stay, indicate the admission date in MM/DD/CCYY format.
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.
Qualifier	Choose the best value to indicate last menstrual period
Date	Enter the date of the last menstrual period if services are related in pregnancy in MM/DD/CCYY format.
Qualifier	Choose the best value to indicate first prenatal visit
Date	Enter the date of the first prenatal visit if services are related in pregnancy in MM/DD/CCYY format.

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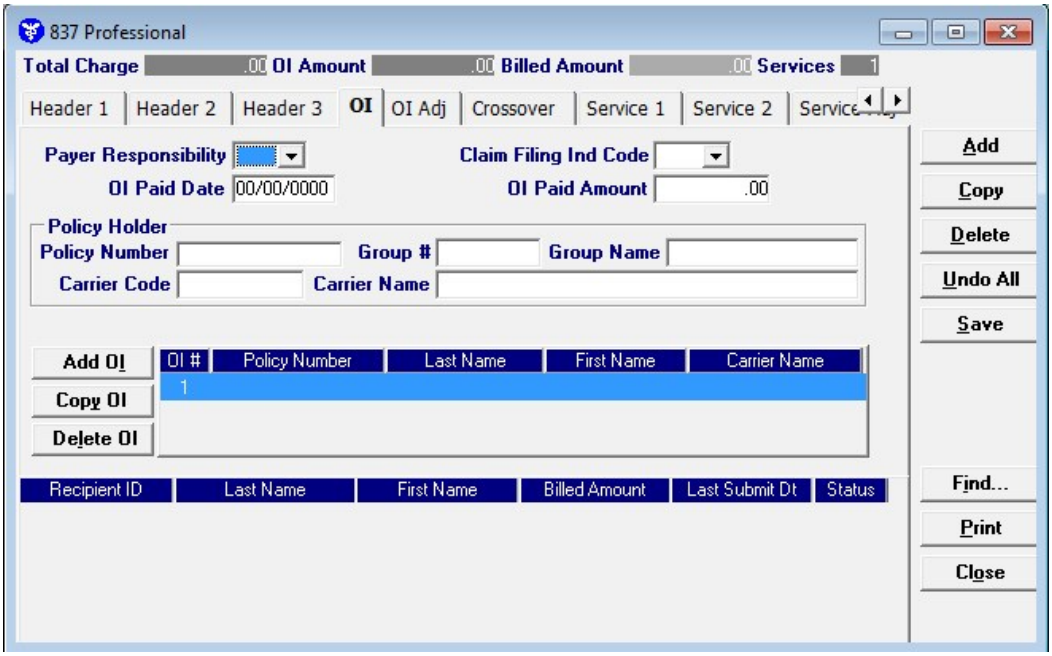
8.2.4 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Professional form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an 837 Professional claim:

Field	***Guidelines***
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the type of insurance the recipient has. (Do NOT select Selfpay or Medicare indicators for the OI tab). Note: For FQHC and Rural Health Clinics, if billing Alabama Medicaid as secondary to an MCO, use a claim filing indicator code of 14.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.

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Field	Guidelines
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

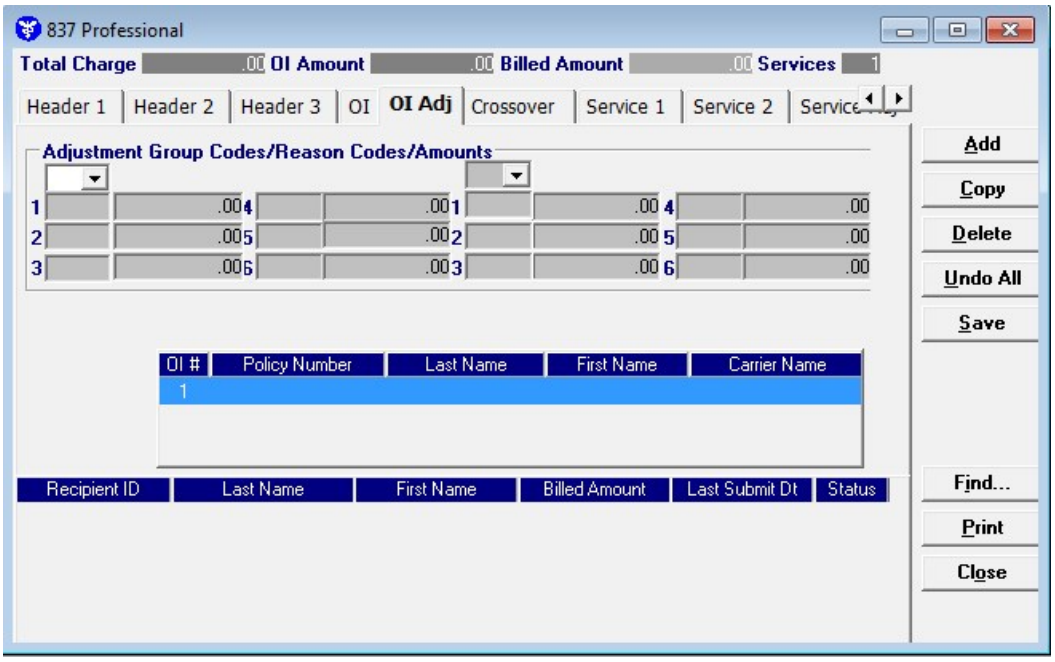
Adding, Deleting, or copying another insurance.

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient.

8.2.5 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Professional form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Complete the following fields under the OI Adj tab to submit an 837 Professional claim:

Field	Guidelines
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.

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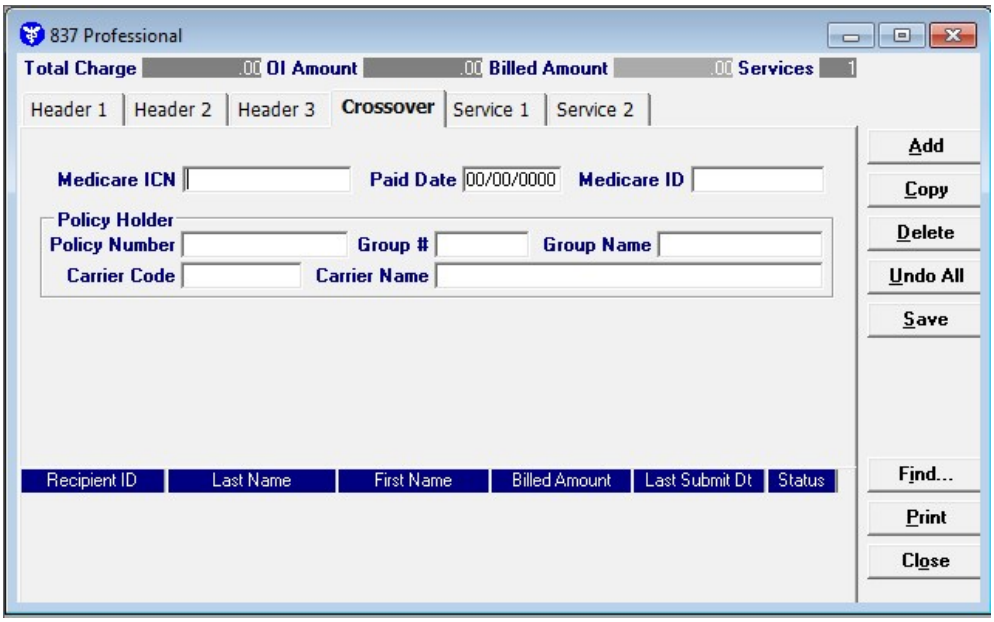
Field	*Guidelines*
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

8.2.6 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Professional form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an 837 Professional claim:

Field	*Guidelines*
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added a Medicare record for the recipient to the Policy Holder list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

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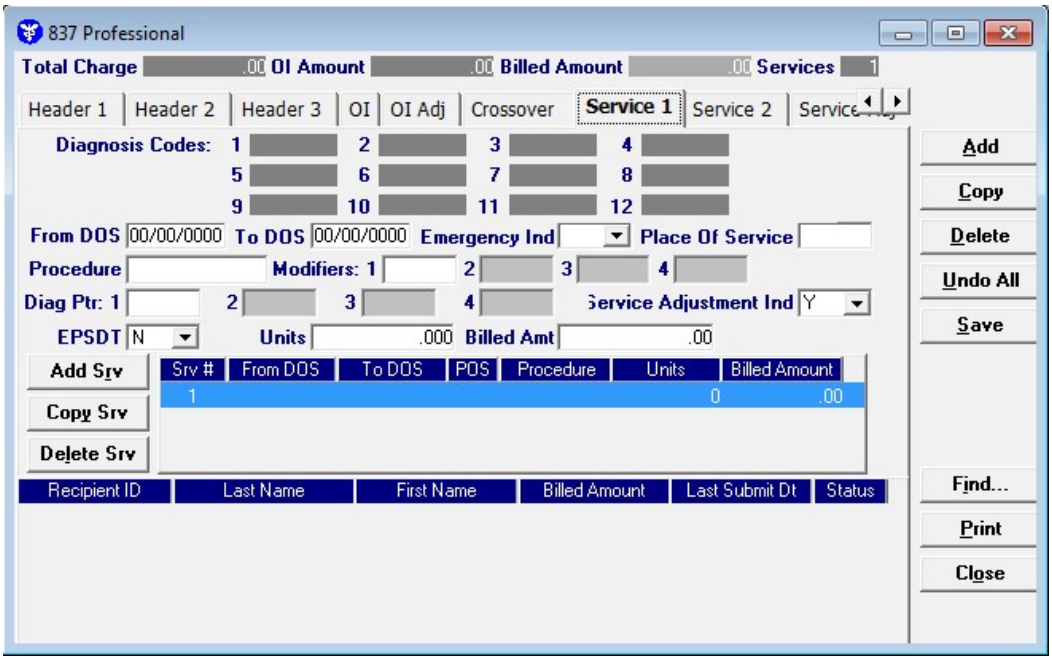
8.2.7 Service 1 Tab

Below is a sample electronic 837 Professional form displaying the Service 1 tab.



Complete the following fields under the Services 1 tab to submit an 837 Professional claim:

Field	***Guidelines***
From DOS	Enter the start date of service for each procedure provided in a MM/DD/CCYY format.
To DOS	Enter the stop date of service for each procedure provided in a MM/DD/CCYY format. If identical services (and charges) are performed on the same day, enter the same date of service in both 'from' and 'to' fields.
Emergency Ind	Choose the best value to indicate if this procedure was due to an emergency.
Place of Service	Choose the best value to indicate where the service/procedure was performed from the Place of Service list.
Procedure	Enter the appropriate five-digit procedure code for each procedure or service billed. Use the current CPT-4 book as a reference.
Modifiers	If applicable, enter the modifier for the procedure.
Diag Ptr	If a diagnosis code was entered, enter a value 1 – 12 to indicate which diagnosis the procedure is a result of.
EPSDT	Choose the best value to indicate if the procedure being billed is due to an EPSDT referral.
Units	Enter the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this block. Fractional units can be indicated – see Chapter 34 of the Provider Manual.
Billed Amount	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private pay patients.

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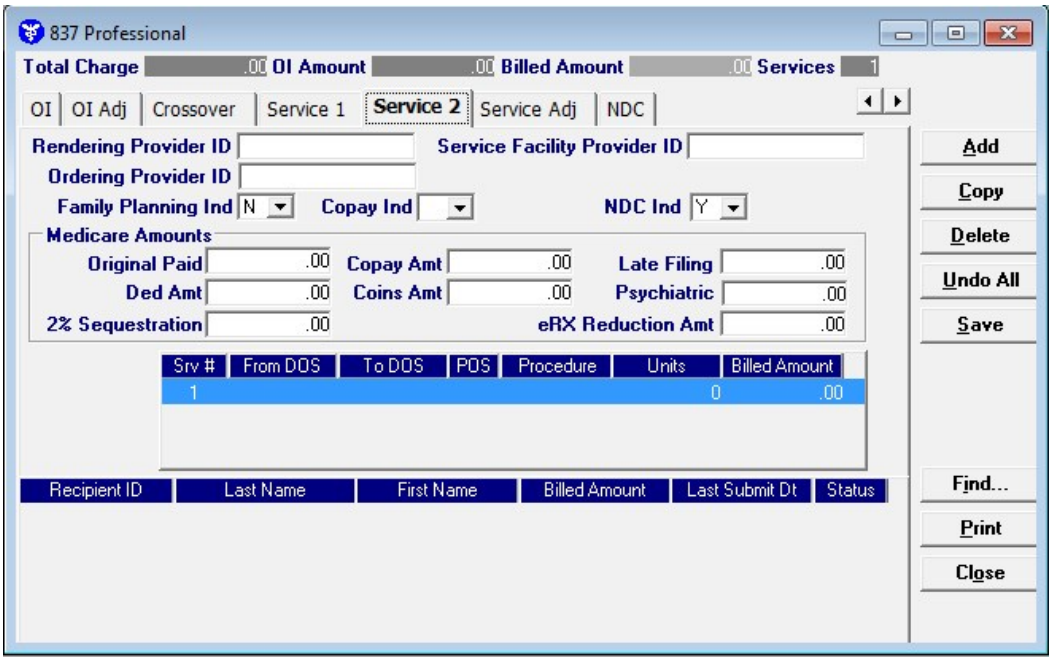
8.2.8 Service 2 Tab

Below is a sample electronic 837 Professional form displaying the Service 2 tab.



Complete the following fields under the Service 2 tab to submit an 837 Professional claim:

Field	***Guidelines***
Rendering Provider ID	Choose a provider ID from your provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.
Ordering Provider ID	Enter the ordering provider if the service or supply was ordered by a provider who is different than the rendering provider for this service line.
Copay Ind	Choose *0 - Co-pay Exempt* if the recipient is pregnant, if the recipient is a Native American with an Active User Letter issued by Indian Health Services, or if the service was due to an emergency.
Family Planning Ind	Choose the best value to indicate if the recipient's services were family planning related.
NDC Ind	Choose the best value to indicate if a National Drug Code (NDC) is being billed on the claim. If 'Y' is selected, the NDC tab will display, complete the information on the NDC Tab.
Medicare Amounts – Original Paid	If applicable, enter the paid amount issued by Medicare for the specific service currently being charge to Medicaid.
Co-pay Amount	If applicable, enter the amount determined by Medicare that the patient must pay for the service currently being submitted to Medicaid. This field is optional.
Late Filing	If applicable, enter the amount determined by Medicare that the patient must pay for late filing fees. This field is optional.
Ded Amt	If applicable, enter the deductible amount issued by Medicare for the specific service currently being charge to Medicaid.

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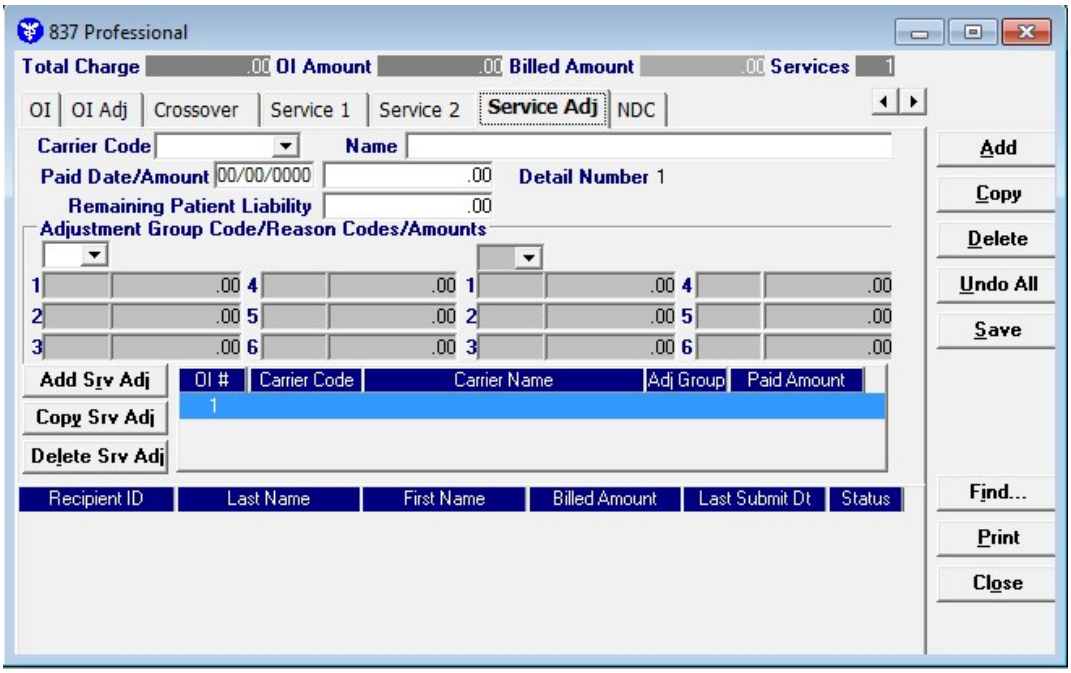
Field	Guidelines
Coins Amt	If applicable, enter the coinsurance amount issued by Medicare for the specific service currently being charge to Medicaid.
Psychiatric	If applicable, enter the amount determined by Medicare that the patient must pay for psychiatric procedures. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
eRX Reduction Amt	If applicable, enter the ERX Reduction Amount.

8.2.9 Service Ad Tab

Below is a sample electronic 837 Professional form displaying the Service Adj tab.



Complete the following fields under the Service Adj tab to submit an 837 Professional claim:

Field	Guidelines
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.

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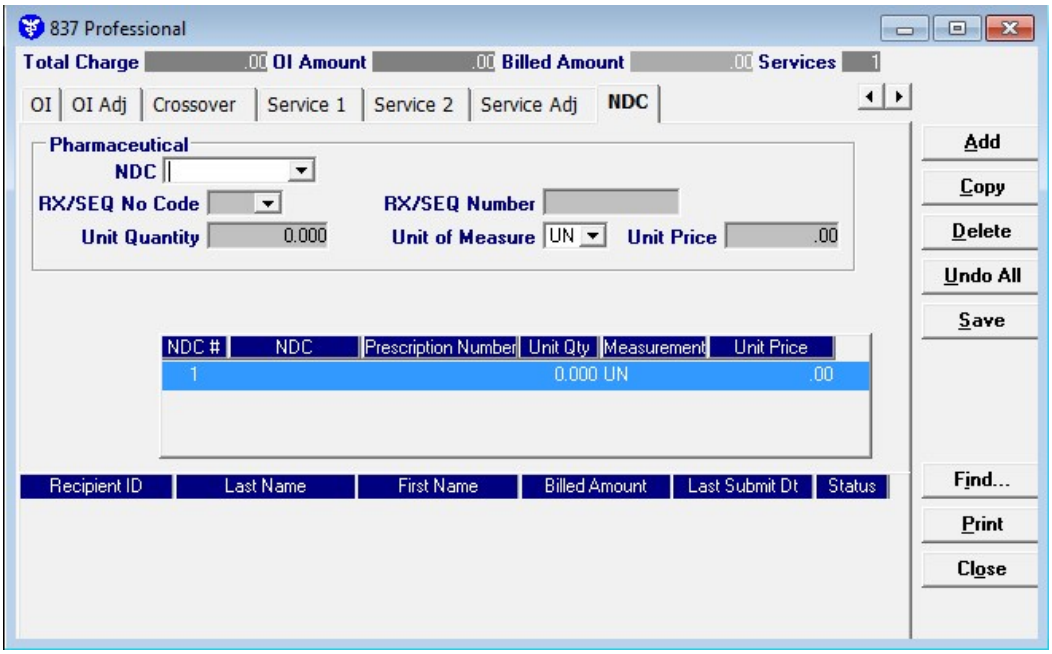
Field	Guidelines
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

8.2.10 NDC TAB

Completing the NDC tab is required if the NDC indicator on Service Tab 2 is 'Yes.' Below is a sample 837 Professional form displaying the NDC tab.



Complete the following fields under the NDC tab to submit a National Drug Code (NDC) on an 837 Professional claim:

Field	Guidelines
NDC	Enter the appropriate eleven-digit drug code for each drug billed. The NDC number submitted to Medicaid must be the NDC number on the package or container from which the medication was administered. This field is required if the NDC indicator on Service Tab 2 is 'Y.'
RX/SEQ No Code	Select the best value to indicate whether submitting the NDC with a prescription number or a Link Sequence Number. Default value is VY. **This field is optional.**
RX/SEQ Number	If applicable, enter the assigned prescription number or the sequence number when 2 or more drugs are compounded and there is no prescription number. **This field is optional**
Unit Quantity	Enter the number of units for the product billed.
Field	***Guidelines***

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Unit of Measure	Enter the type of units used for the product billed. Use the default value, UN, or select the best value from the drop down display window. Valid values are: F2 – International Unit GR – Gram ME - Milligram ML – Milliliter UN – Unit
Unit Price	Enter the price of the individual unit(s) billed. This field is optional unless more than one NDC is billed on each detail. It is a required field if multiple NDCs are billed on each detail.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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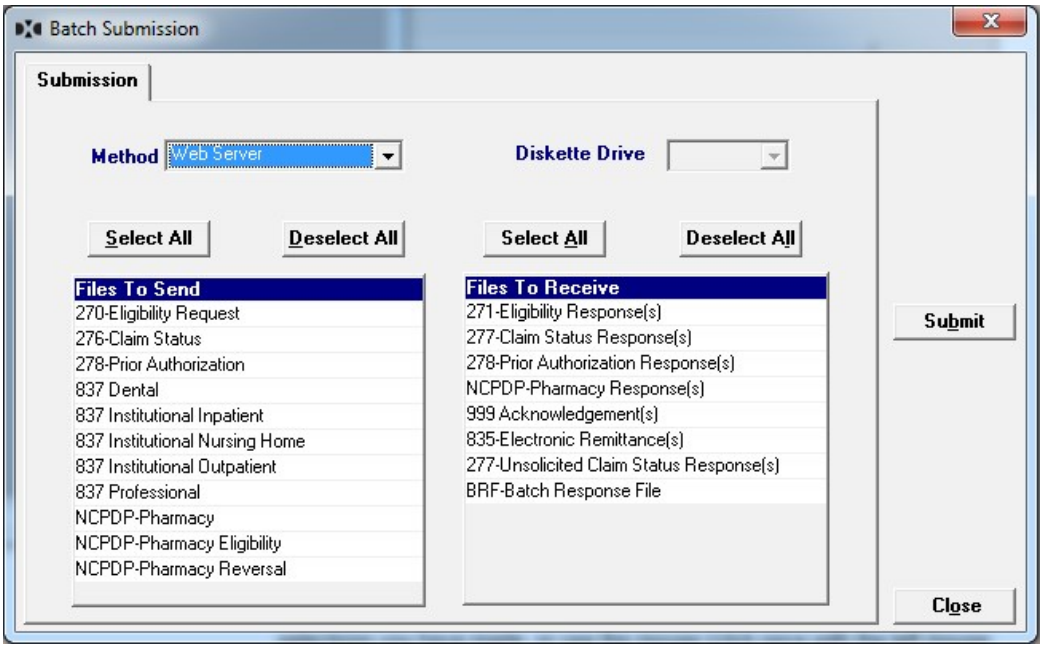
8.3 Submitting Claims through the Web Server

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

NOTE:

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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9 Submitting 837 Institutional Inpatient Claims

This chapter provides instructions for submitting electronic 837 inpatient claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Inpatient claim form using one of the following methods:

- Selecting the 837 Institutional Inpatient icon from the toolbar
- Selecting Forms>>837 Institutional Inpatient

The electronic form displays with seven tabs: Header 1, Header 2, Header 3, Header 4, Header 5, Header 6, and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustment, and Crossover.

9.1 Entering Claims in the 837 Institutional Inpatient Form

Each tab on the 837 Institutional Inpatient form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Inpatient form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the 'Save' button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press 'Save', or press Incomplete to save the record with an incomplete status.

Incomplete claims (status 'I') are not submitted with the batch submission.

Step 4 Press the 'Add' button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:
Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

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To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

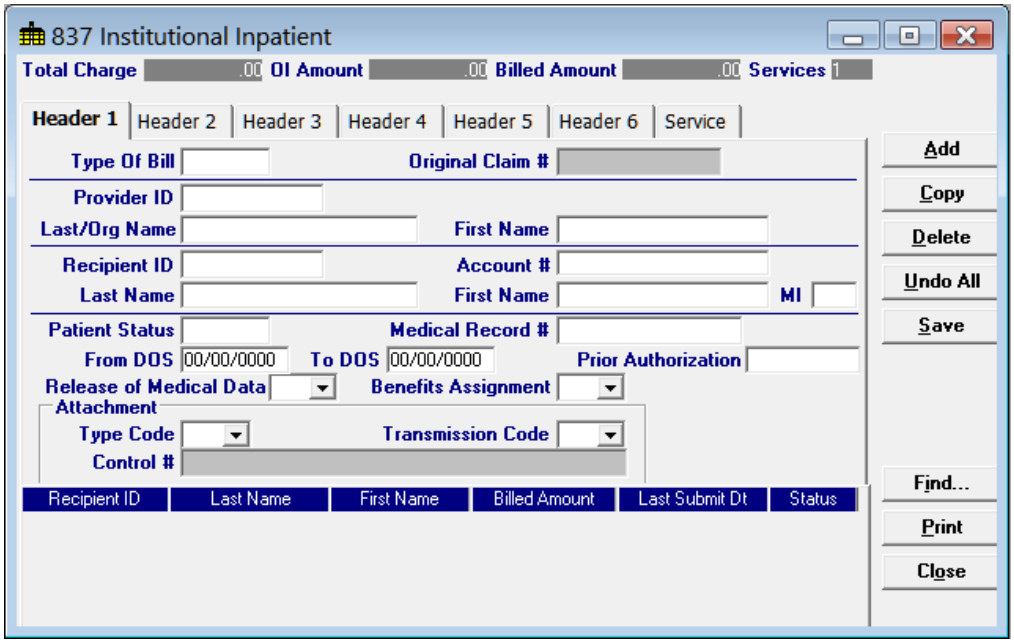
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

9.2 837 Institutional Inpatient Form

9.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Inpatient form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit an Inpatient claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.

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Field	***Guidelines***
Patient Status	Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period: 01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to NF 04 Discharged to ICF/MR 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an Inpatient to this hospital 20 Expired or did not recover 30 Still patient 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 50 Hospice, home 51 Hospice, medical facility 61 Discharged/Transferred within this institution 71 Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. 72 Discharge/transferred/referred to this institution for outpatient services as specified plan of care. If status code is 30, the total days in the covered and non-covered fields should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Prior Authorization	If applicable, enter the prior authorization number issued by the state. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Information for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Attachment Type Code	If applicable, select the appropriate attachment type code from the drop-down-display menu.
Attachment Transmission Code	If applicable, select the appropriate transmission code from the drop-down-display menu.
Attachment Control #	If applicable, enter the Control Number of an electronic attachment.

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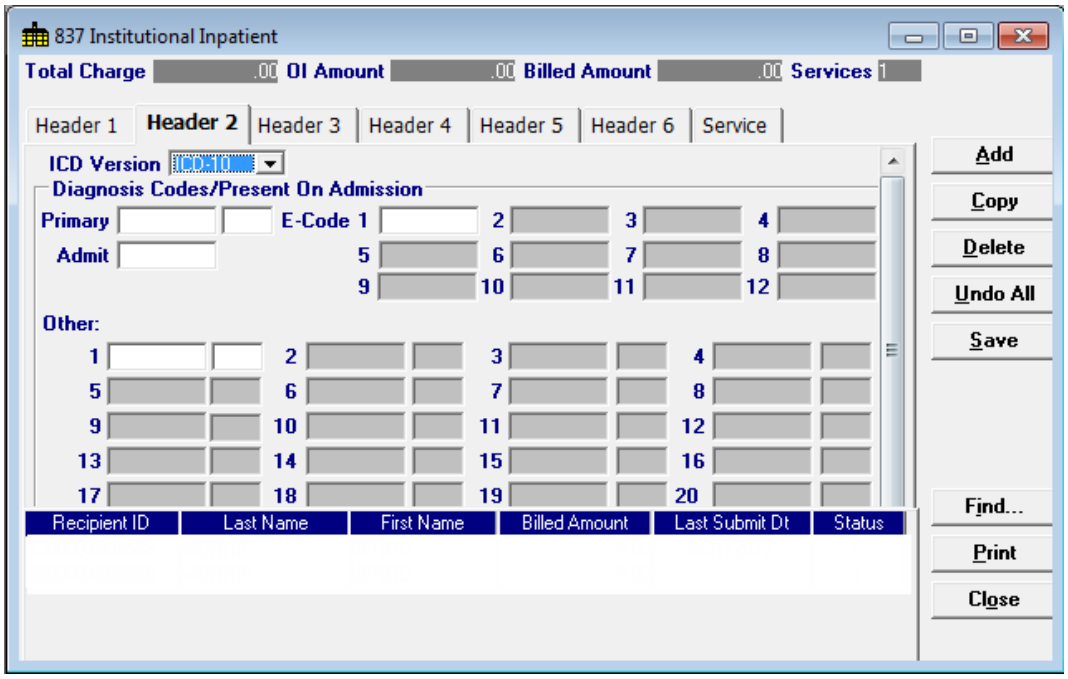
9.2.2 Header 2 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an inpatient claim:

Field	Guidelines
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Admit	Enter a proper admittance diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis – E-Code	Enter the diagnosis code(s) which describe the external cause of injury, poisoning or adverse effect. These fields must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code - Other	If applicable, enter any proper secondary diagnosis code(s). When used, these fields must contain a minimum of 3-digits and cannot contain a decimal.
Present on Admission (POA)	Choose the best value from the drop-down-display window to indicate whether the corresponding diagnosis was present on the patient's inpatient hospital admission. Valid values are: • Y – Yes • N – No • U – Unknown • W – Not Applicable • Blank – Exempt from POA reporting.

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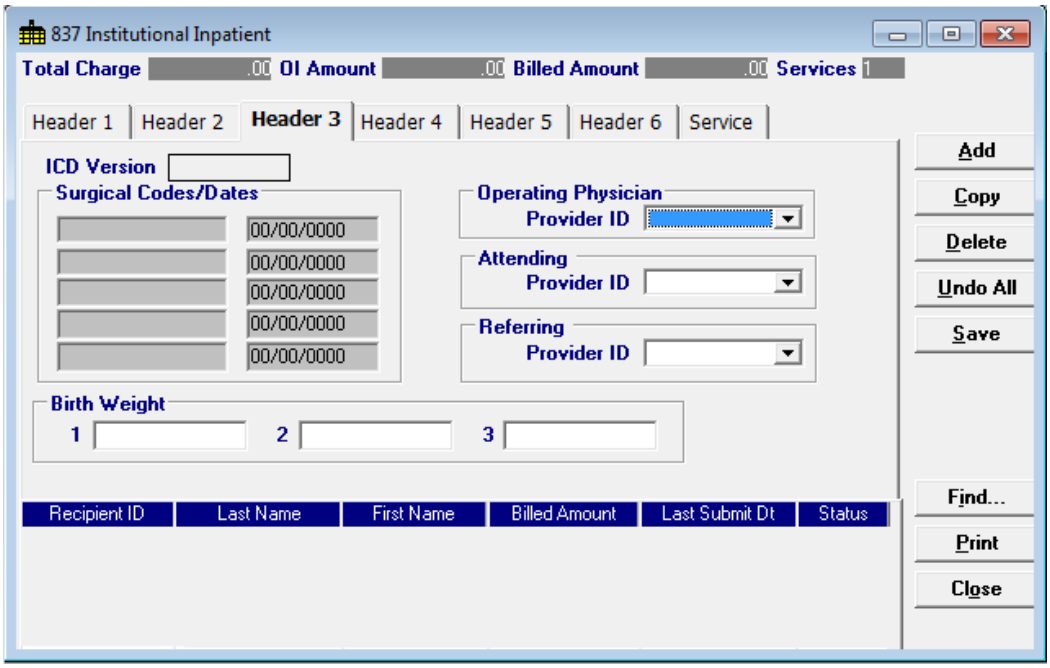
9.2.3 Header 3 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an inpatient claim:

Field	Guidelines
ICD Version (read only)	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10. Note: This field is read only. Go to Header 2 to change the ICD Version.
Surgical Codes – Principal	If revenue codes billed on this claim include 36X or 72X, enter the principal procedure code.
Surgical Dates	If a surgical code is entered, enter the surgery date in MM/DD/CCYY format.
Operating Physician ID	If a value was entered in the Surgical Code field, then choose a provider number from the corresponding Provider list to indicate which physician performed the operation. If you have not added the required ID to your list, double-click on this field to do so.
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Birth Weight	If applicable, enter a valid birthweight in this field.

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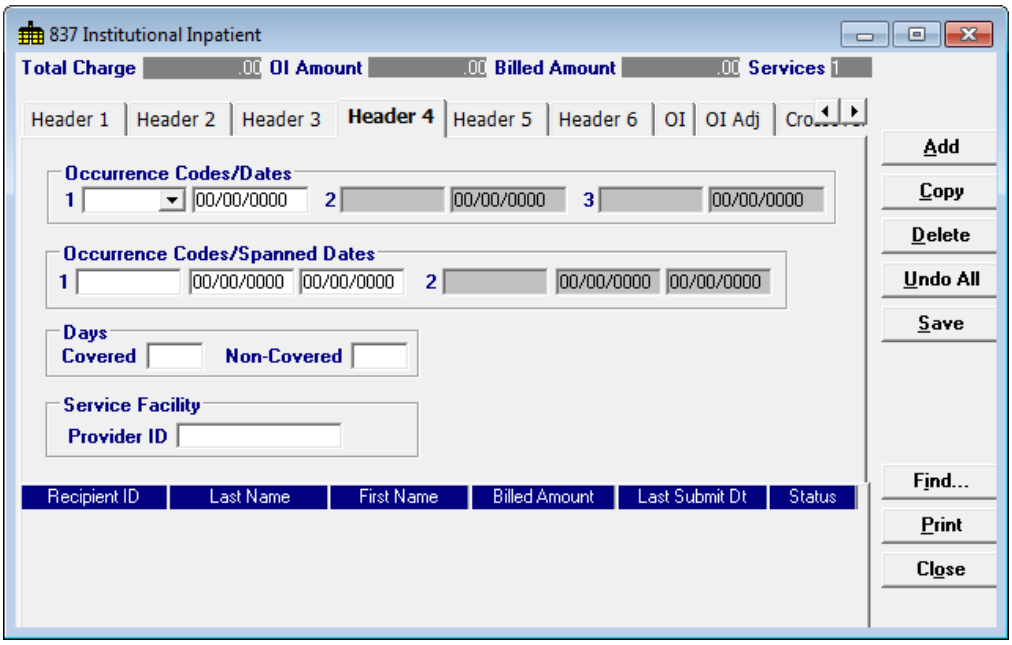
9.2.4 Header 4 Tab

Below is a sample 837 Inpatient form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit an inpatient claim:

Field	Guidelines
Occurrence Codes	Enter the Occurrence Code if applicable. For a full list of these codes see Appendix B Code Lists, Section B.1 Occurrence Codes.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.
Occurrence Code Spanned Dates	Enter the spanned from and to dates in MM/DD/CCYY format.
Days Covered	Enter the total days represented on this claim that are to be covered.
Days Non-Covered	Enter the total days represented on this claim that are not covered. The sum of covered and non-covered days equal the total days billed as reflected in units.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.

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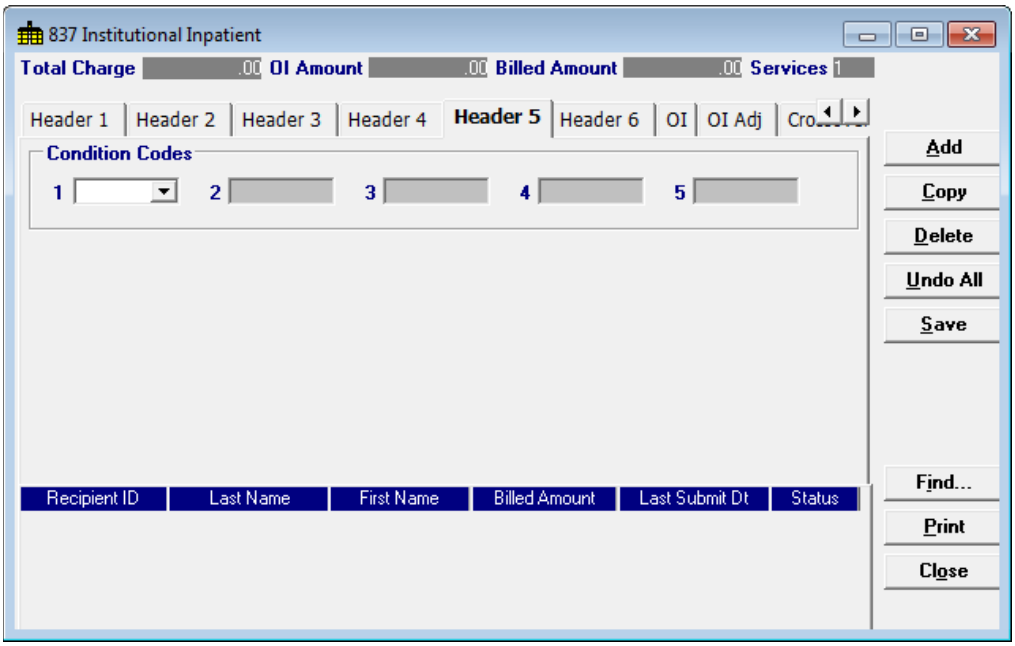
9.2.5 Header 5 Tab

Below is a sample 837 Inpatient form displaying the Header 5 tab.



Complete the following fields under the Header 5 tab to submit an inpatient claim:

Field	*Guidelines*
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. If A1 is entered here, a referring provider number must be indicated. To indicate the referring provider, choose an ID in the Referring Provider ID field on Header 2. For a full list of these codes see Appendix B Code Lists, Section B.2 Condition Codes.

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9.2.6 Header 6 Tab

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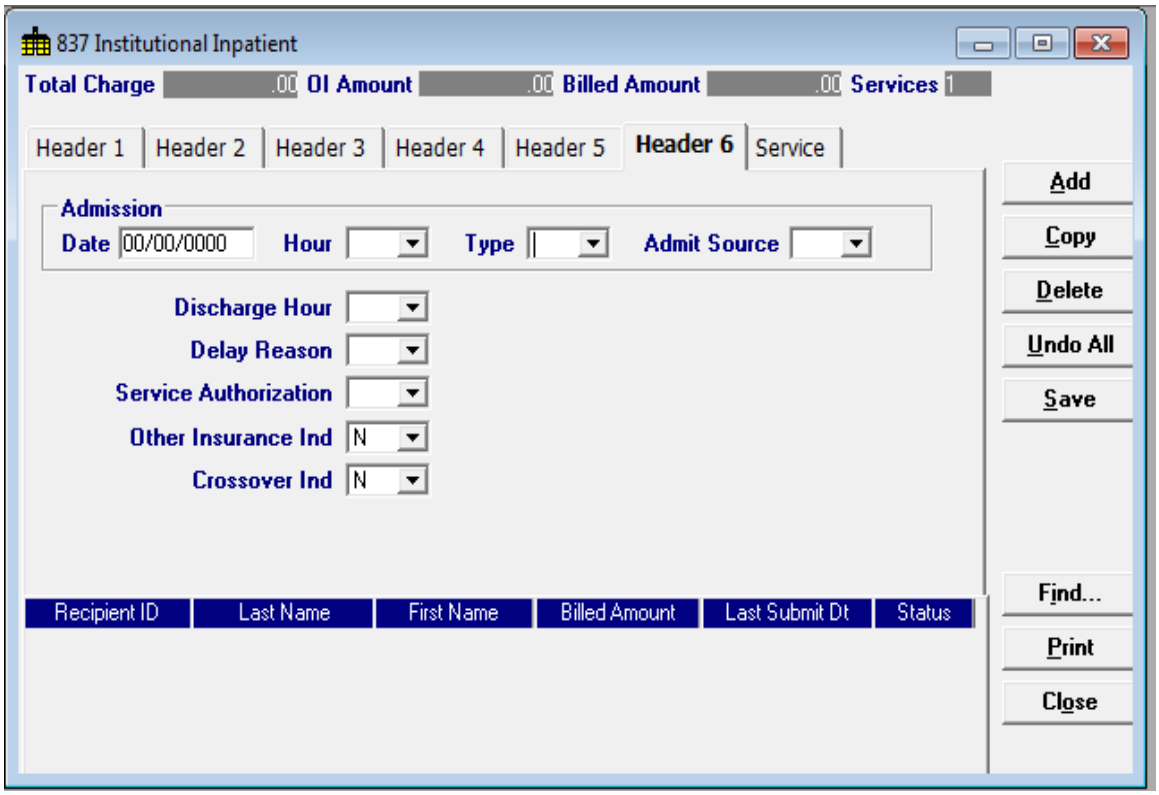

Complete the following fields under the Header 6 tab to submit an inpatient claim:

Field	***Guidelines***
Admission Date	Enter the date the recipient was admitted into your facility in MM/DD/CCYY format.
Admission Hour	Choose the best value to indicate the hour the recipient was admitted into your facility.
Admission Type	Choose a value from the Admission Type list.
Admit Source	Choose a value from the Admit Source list.
Discharge Hour	Choose the best value to indicate the hour the recipient was discharged from your facility.
Delay Reason	Choose a value to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. Note: This will not override claims that have fallen over a year past timely filing. You will need to proceed to file such claims to the Fair Hearing department.

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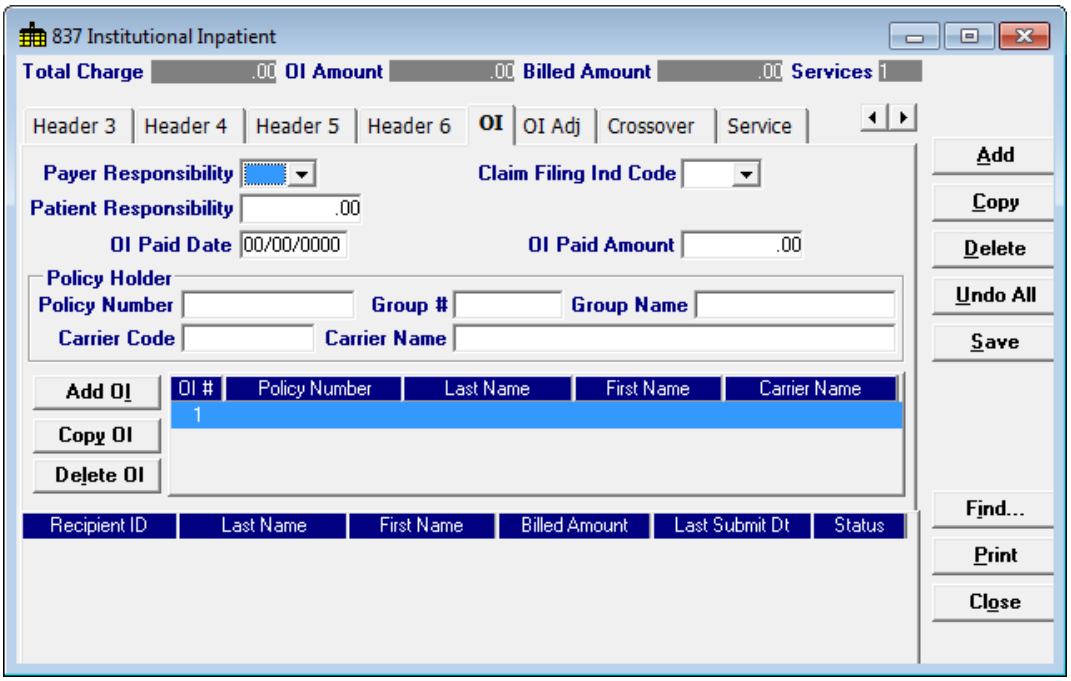
Field	*Guidelines*
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. 1 Immediate Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client has temporary Medicaid 5 Bypass Provider Contract Check 6 Claim exempt from Program edits 7 Force into MAT Care Program
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

9.2.7 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes.' Below is a sample electronic 837 Inpatient form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an inpatient claim:

Field	*Guidelines*
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance.
Patient Responsibility	Enter the amount the recipient will be responsible for paying. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.

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Field	*Guidelines*
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

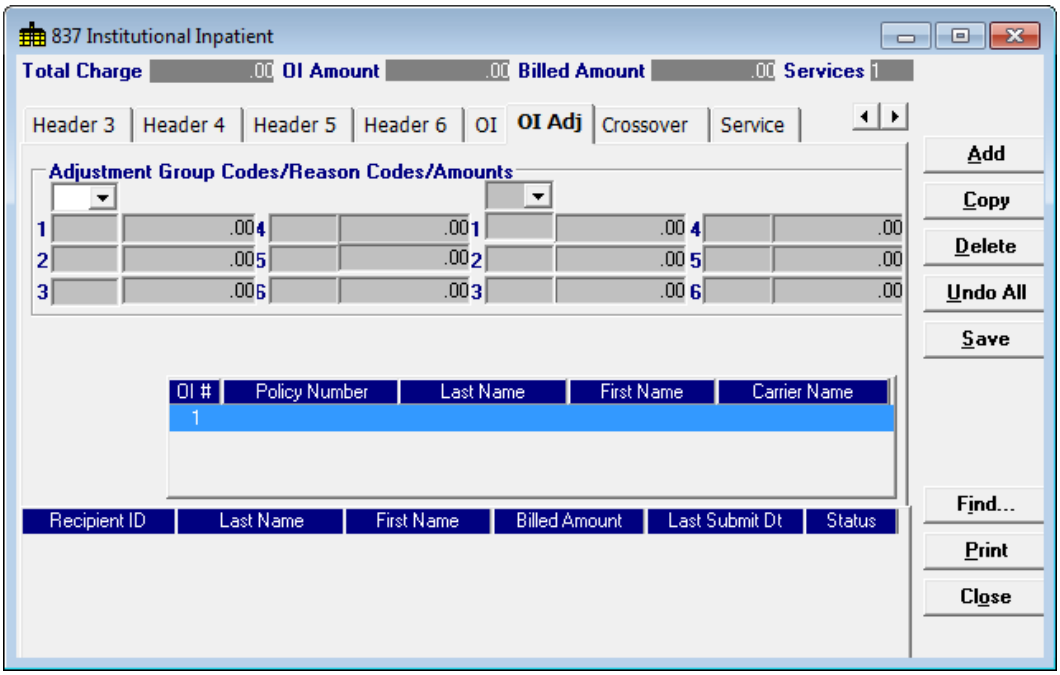
Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

9.2.8 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Institutional Inpatient form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



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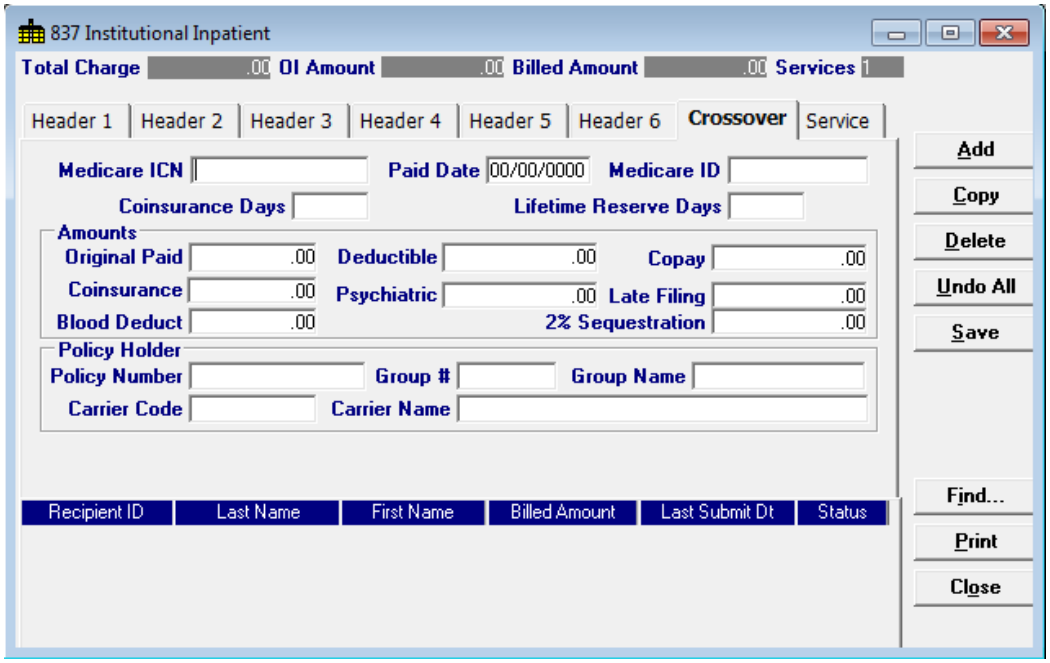
Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

9.2.9 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Inpatient form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an inpatient claim:

Field	**Guidelines**
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's policy number assigned by Medicare.
Coinsurance Days	Enter the amount of coinsurance days used during the inpatient stay on this claim. This field is optional.

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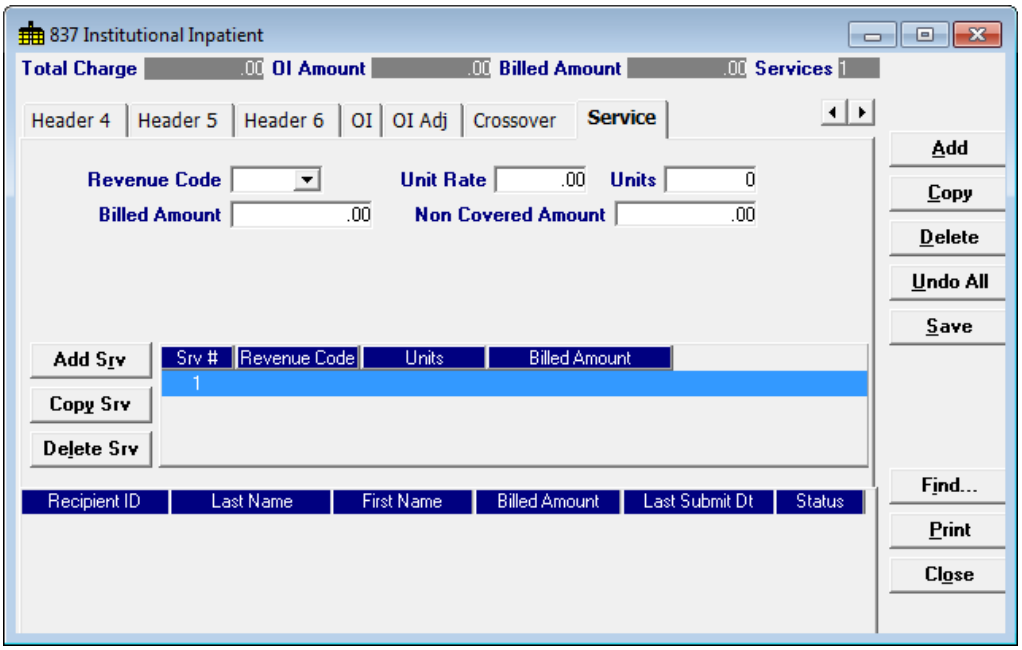
Field	Guidelines
Lifetime Reserve Days	Enter the amount of lifetime reserve days used during the inpatient stay on this claim. Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. This field is optional.
Amounts –Original Paid	Enter the actual amount paid by Medicare for the services being billed to Medicaid.
Deductible	Enter the deductible amount from Medicare. This field is optional.
Co-pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Psychiatric	If applicable, enter the amount Medicare determined the patient must pay for psychiatric services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined a recipient must pay for late filing fees. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined the patient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

9.2.10 Service Tab

Below is a sample 837 Inpatient form displaying the Service 1 tab.



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Complete the following fields under the Service 1 tab to submit an inpatient claim:

Field	***Guidelines***
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Unit Rate	If revenue code entered ranges from 100 – 219, enter the accommodation rate for the individual unit billed.
Units	Enter the unit(s) billed for the service.
Billed Amount	Enter the amount billed for the service.
Non Covered Amount	Enter the non covered amount. This field is optional.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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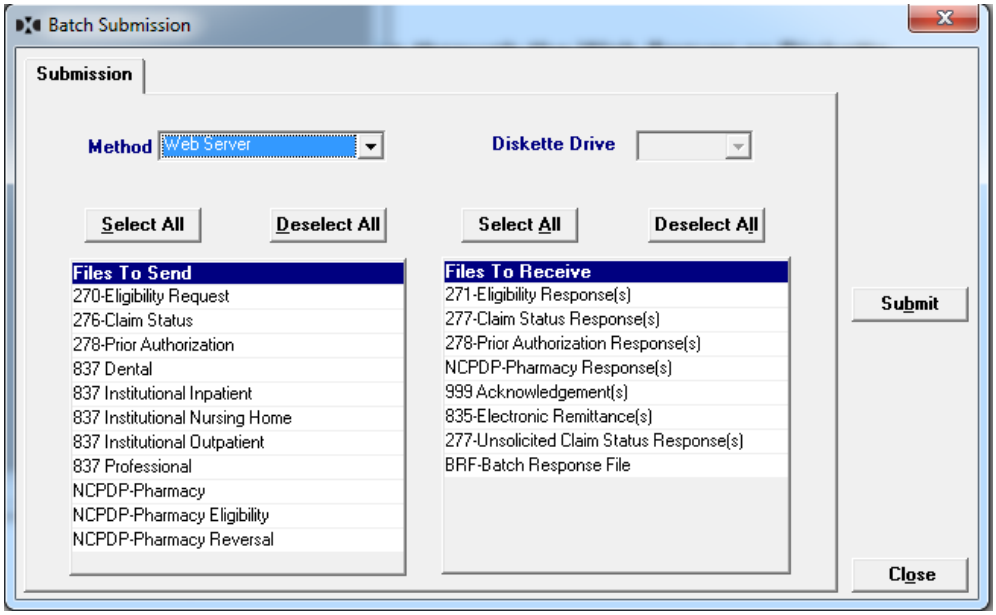
9.3 Submitting Claims through the Web Server

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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10

10 Submitting 837 Institutional Outpatient Claims

This chapter provides instructions for submitting electronic 837 outpatient claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Outpatient claim form using one of the following methods:

- Selecting the 837 Institutional Outpatient icon from the toolbar
- Selecting Forms>>837 Institutional Outpatient

The electronic form displays with ten tabs: Header 1, Header 2, Header 3, Header 4 and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (OI Adjustments), Crossover, Service Adj, and NDC.

10.1 Entering Claims in the 837 Institutional Outpatient Form

Each tab on the 837 Institutional Outpatient form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.

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Button	*Usage*
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Outpatient form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the 'Save' button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press 'Save', or press Incomplete to save the record with an incomplete status.

Incomplete claims (status 'I') are not submitted with the batch submission.

Step 4 Press the 'Add' button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press Undo All if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

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To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

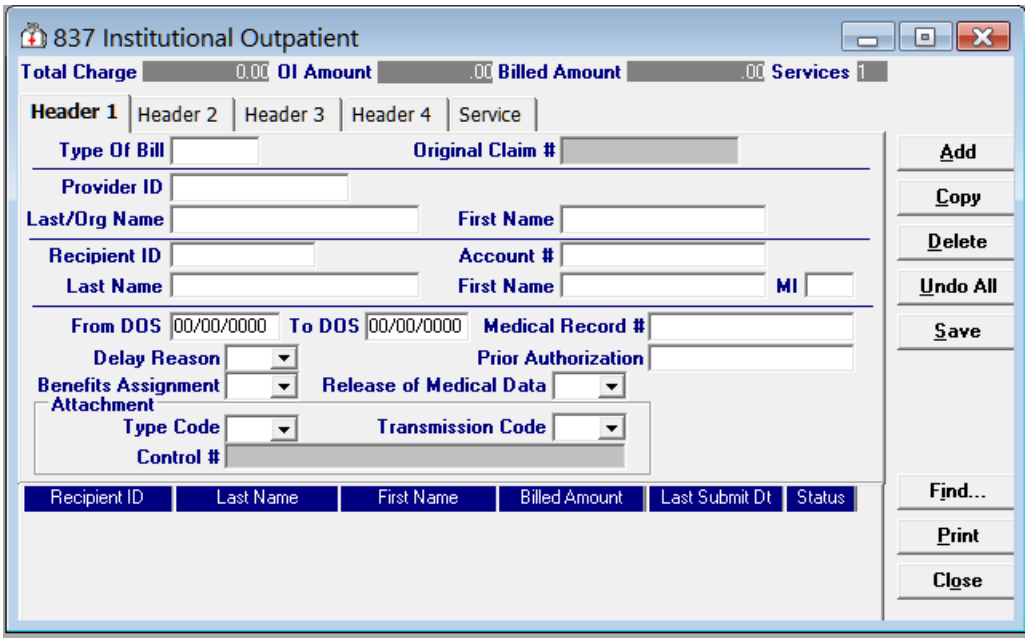
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

10.2 837 Institutional Outpatient Form

10.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Outpatient form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit an outpatient claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital 3 Home Health Agency 7 Clinic (RHC, FQHC) 8 Special Facility **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.

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Field	***Guidelines***
Delay Reason	Choose a value to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. Note: This will not override claims that have fallen over a year past timely filing. You will need to proceed to file such claims to the Fair Hearing department.
Prior Authorization	If applicable, enter the 10-digit prior authorization number issued by the Medicaid agency. This field is optional.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Information for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Attachment Type Code	If applicable, select the appropriate attachment type code from the drop-down-display menu.
Attachment Transmission Code	If applicable, select the appropriate transmission code from the drop-down-display menu.
Attachment Control #	If applicable, enter the Control Number of an electronic attachment.

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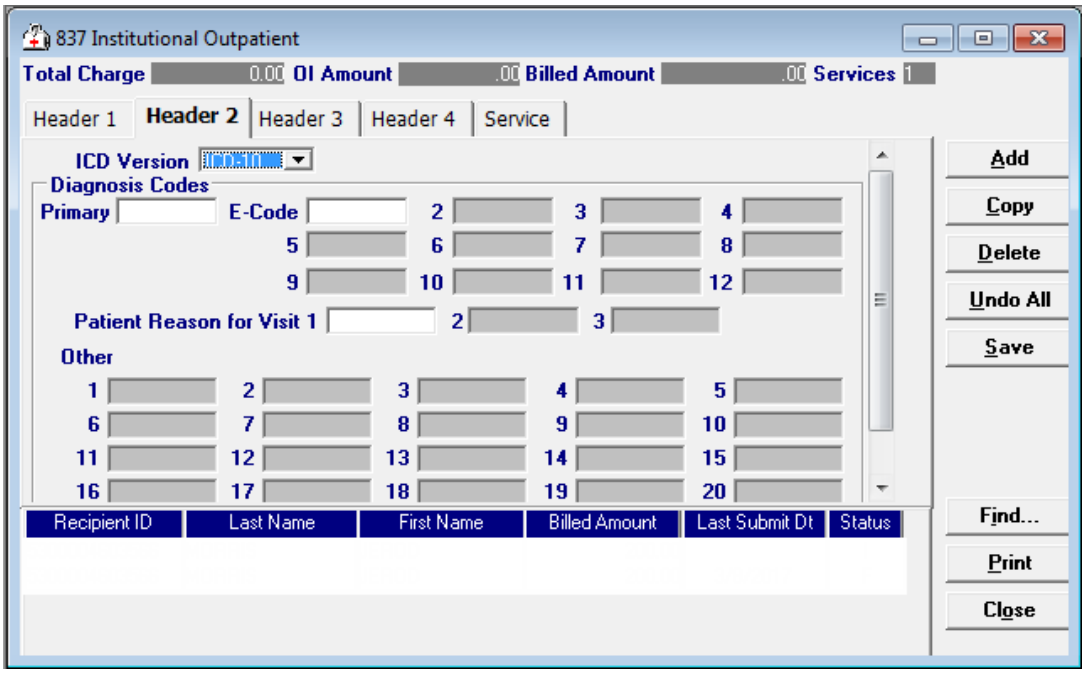
10.2.2 Header 2 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an outpatient claim:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must contain a minimum of 3-digits and cannot contain decimals.
Diagnosis Code - E-Code	Enter the diagnosis code(s) which describe the external cause of injury, poisoning or adverse effect. These fields must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Patient Reason for Visit	Enter a proper diagnosis code indicating the reason for the outpatient visit. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Other	If applicable, enter a proper diagnosis code. This field must contain a minimum of 3-digits and cannot contain decimals.

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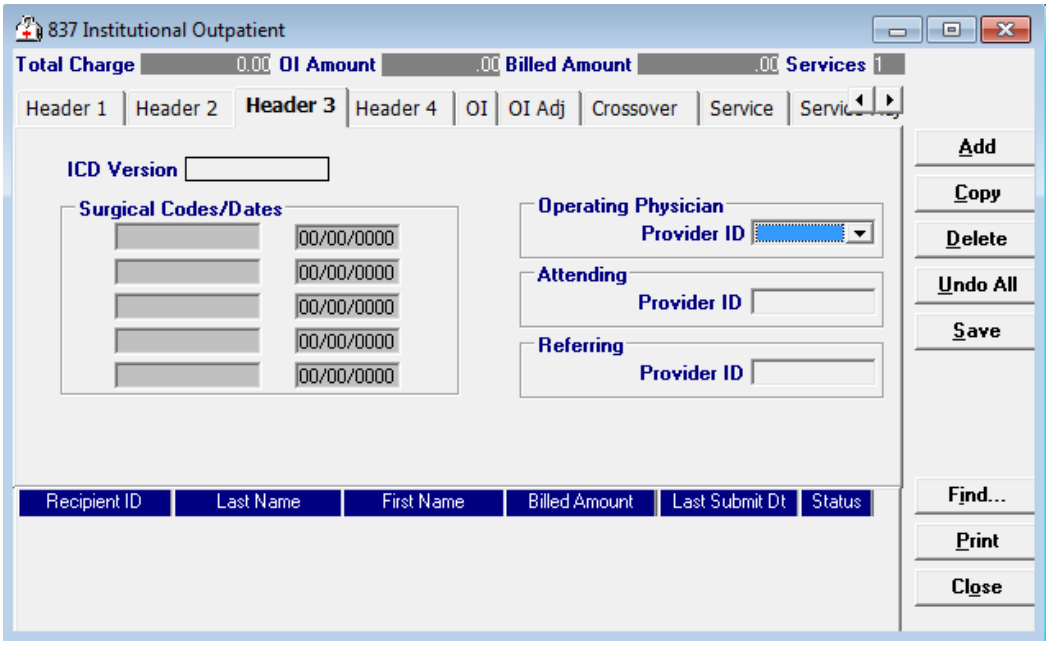
10.2.3 Header 3 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an outpatient claim:

Field	*Guidelines*
ICD Version (read only)	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10. Note: This field is read only. Go to Header 2 to change the ICD Version.
Surgical Codes	If revenue codes billed on this claim include 36X or 72X, enter the principal ICD-9 procedure code. This field is optional.
Surgical Dates	If a surgical code is entered, enter the surgery date in MM/DD/CCYY format. This field is optional.
Operating Physician Provider ID	If a value was entered in the Surgical Code field, then choose a provider number from the corresponding Provider list to indicate which physician performed the operation. If you have not added the required ID to your list, double-click on this field to do so.
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Referring Provider ID	If applicable, choose a referring provider number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.

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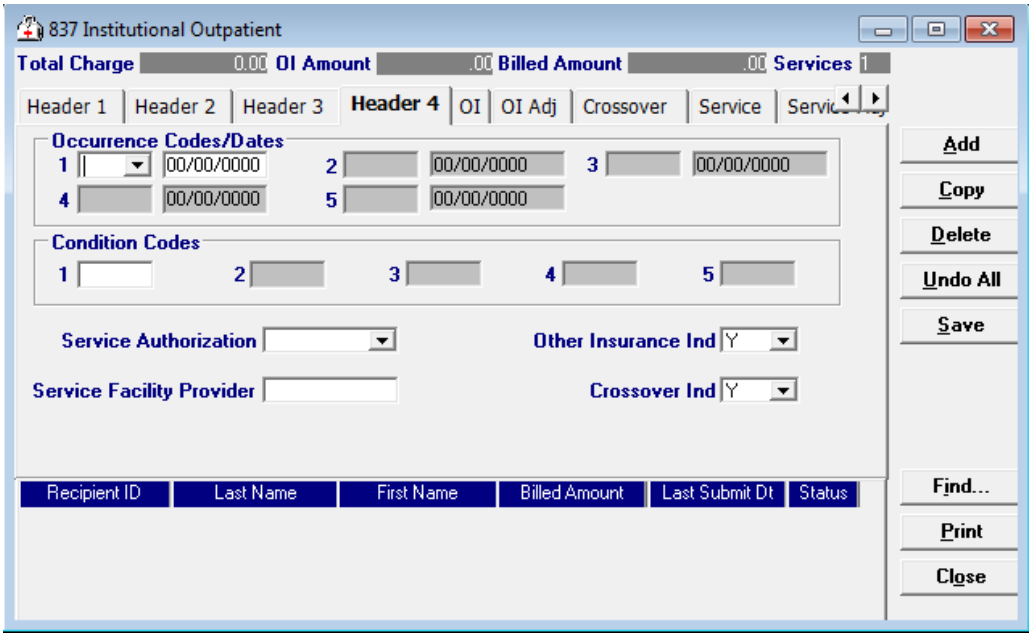
10.2.4 Header 4 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit an outpatient claim:

Field	*Guidelines*
Occurrence Codes	10.2.4.2 For a full list of these codes see Section B.1 Occurrence Codes in Appendix B Code Lists.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. If A1 is entered here, a referring provider number must be indicated. To indicate the referring provider, choose an ID in the Referring Provider ID field on Header 2. For a full list of these codes see Appendix B, Section B.2 Condition Codes.
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. 1 Immediate Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client has temporary Medicaid 5 Bypass Provider Contract Check 6 Claim exempt from Program edits 7 Force into MAT Care Program
Other Insurance Ind.	Choose the best value to indicate if the recipient has other insurance. Medicare is <u>not</u> considered other insurance.
Service Facility Provider	Select the provider NPI where the service was performed only if the service was provided at a location different than the billing provider location on Header 1 tab.

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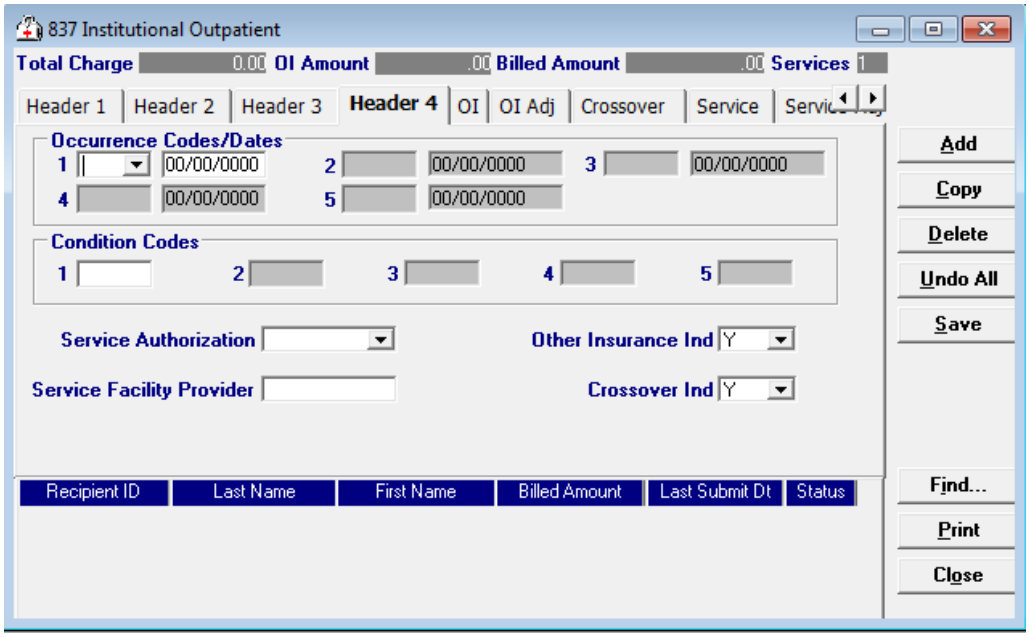
Field	Guidelines
ossover Ind.	hoose the best value to indicate if the claim is a crossover from Medicare.

10.2.5 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind.* field was marked as 'Yes'. Below is a sample electronic 837 Outpatient form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an outpatient claim:

Field	Guidelines
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's other insurance coverage status to Medicaid.
Claim Filing Ind. Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance. Do not use 09 (self-pay), 16 (Medicare HMO), MA (Part A Medicare) or MB (Part B Medicare) on the OI tab.
Patient Responsibility	Enter the amount of the other health plan's patient responsibility, i.e., deductible, coinsurance, co-pay, etc. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.

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Field	*Guidelines*
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

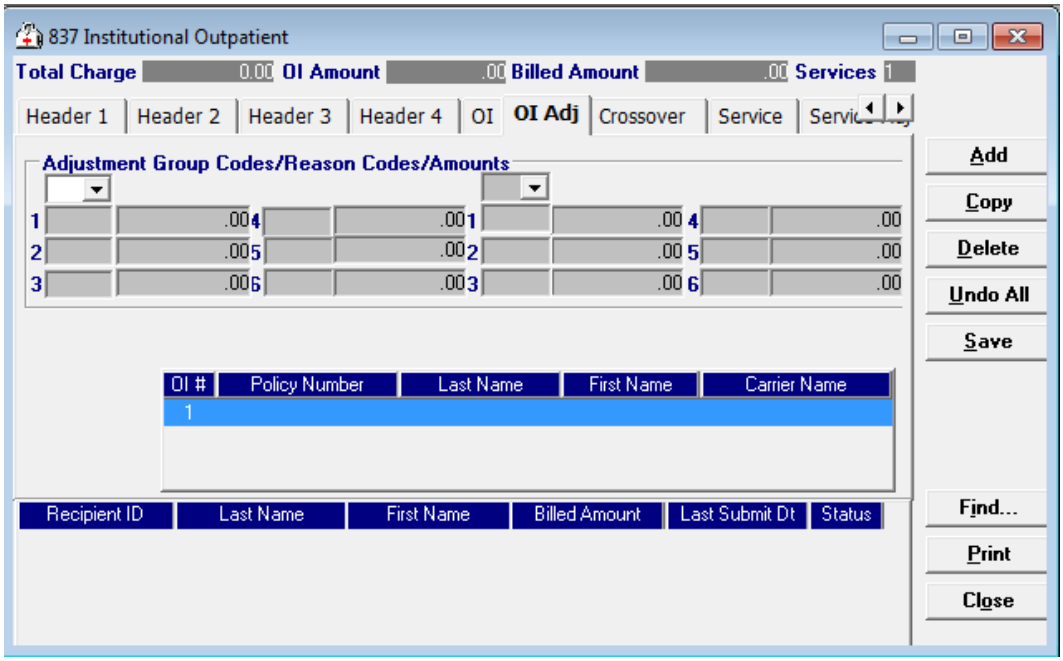
Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient.

10.2.6 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Outpatient form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

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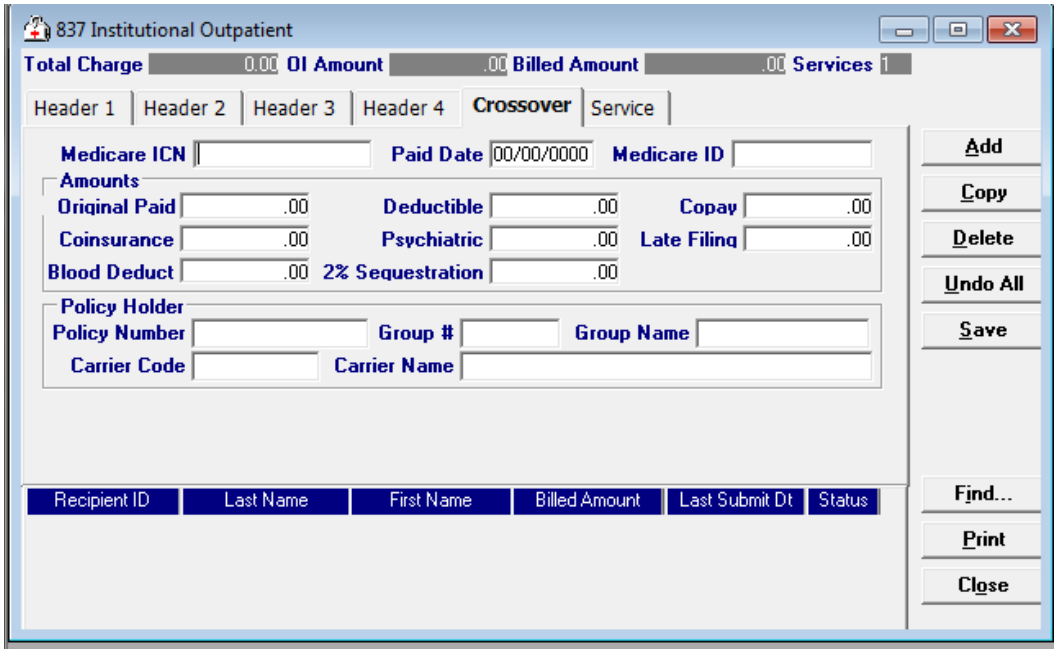
10.2.7 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Outpatient form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an outpatient claim:

Field	***Guidelines***
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID assigned by Medicare.
Amounts – Original Paid	If applicable, enter the paid amount issued by Medicare for the specific service currently being charged to Medicaid.
Deductible	Enter the deductible amount from Medicare. This field is optional.
Co-pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Policy Number	Choose the appropriate Medicare HIC # from the Policy Holder list. If you have not added a Medicare segment for this recipient to your list, double-click on this field. A screen will appear for you to do so.
Psychiatric	If applicable, enter the amount Medicare determined the patient must pay for psychiatric services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined the patient must pay for late filing fees. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined the patient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
Group #	This field will auto-write based on the information chosen in the Policy number field.

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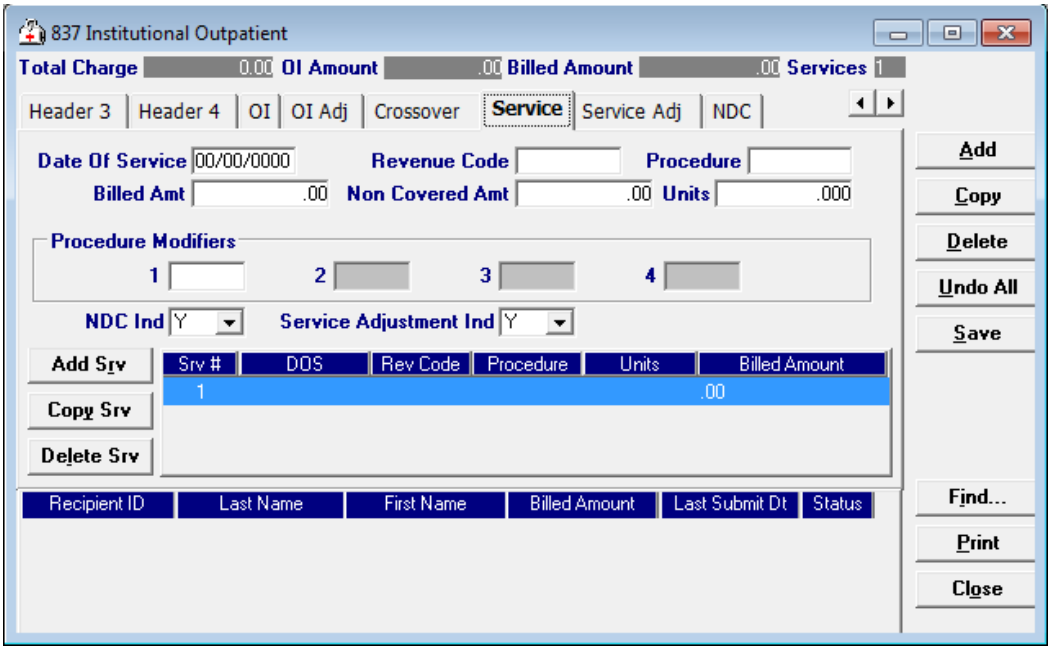
Field	*Guidelines*
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

Service Tab

Below is a sample 837 Outpatient form displaying the Service tab:



Complete the following fields under the Service 1 tab to submit an outpatient claim:

Field	*Guidelines*
Date of Service	Enter the date of service for each procedure provided in a MM/DD/CCYY format.
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Billed Amount	Enter the amount billed for the service.
Non Covered Amount	Enter the non covered amount. This field is optional.
Units	Enter the unit(s) billed for the service.
Procedure	Enter the appropriate five-digit procedure code for each procedure or service billed. Use the current CPT-4 book as a reference.
Procedure Modifiers	If applicable, enter the modifier for the procedure.
NDC Ind	Choose the best value to indicate if a National Drug Code (NDC) is being billed on the claim. If 'Y' is selected, the NDC tab will display, complete the information on the NDC Tab.

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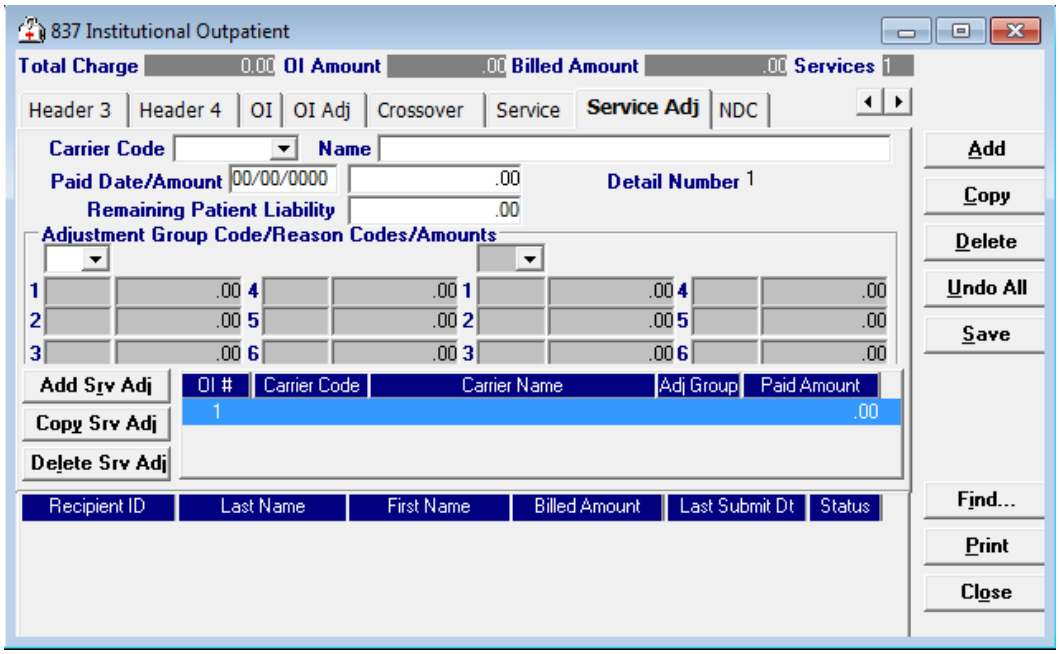
10.2.8 Service Adj Tab

Below is a sample electronic 837 Outpatient form displaying the Service Adj tab.



Field	*Guidelines*
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

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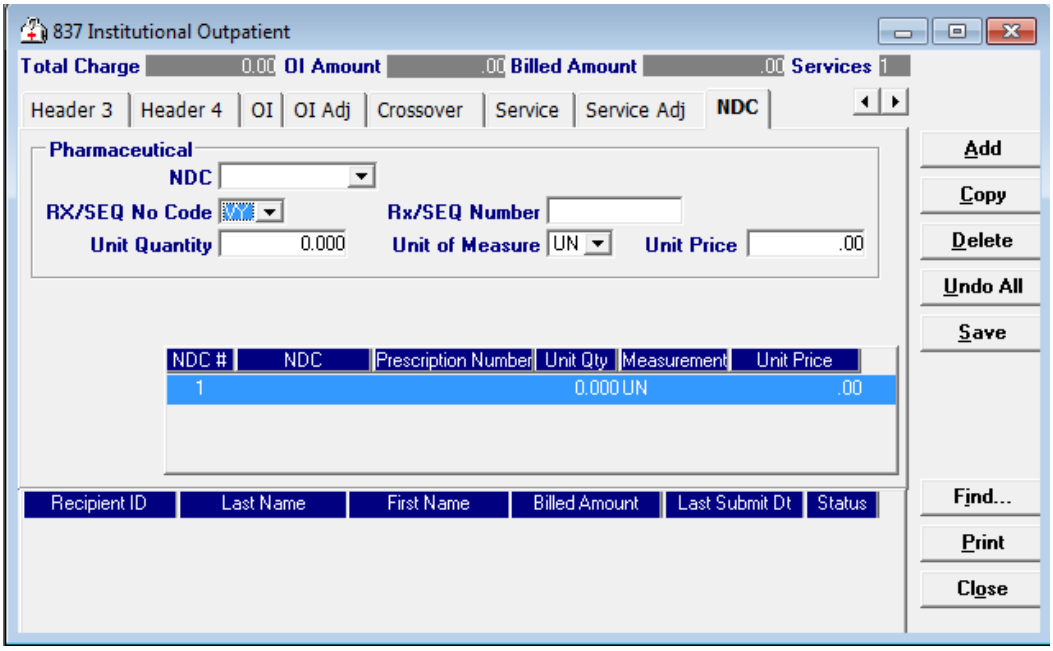
10.2.9 NDC Tab

Completing the NDC tab is required if the NDC indicator on the Service Tab is 'Yes.' Below is a sample 837 Outpatient form displaying the NDC tab:



Complete the following fields under the NDC tab to submit a National Drug Code (NDC) on an outpatient claim:

Field	*Guidelines*
Pharmaceutical - NDC	Enter the appropriate eleven-digit drug code for each drug billed. The NDC number submitted to Medicaid must be the NDC number on the package or container from which the medication was administered. This field is required if the NDC indicator on the Service Tab is 'Y.'
RX/SEQ No Code	Select the best value to indicate whether submitting the NDC with a prescription number or a Link Sequence Number. Default value is VY. **This field is optional.**
RX/SEQ Number	If applicable, enter the assigned prescription number or the sequence number when 2 or more drugs are compounded and there is no prescription number. **This field is optional.**
Unit Quantity	Enter the number of units for the product billed.
Unit of Measure	Enter the type of units used for the product billed. Use the default value, UN, or select the best value from the drop down display window. Valid values are: F2 – International Unit GR – Gram ME – Milligram ML – Milliliter UN – Unit
Drug Unit Price	Enter the price of the individual unit(s) billed. This field is optional unless more than one NDC is billed on each detail. It is a required field if multiple NDCs are billed on each detail.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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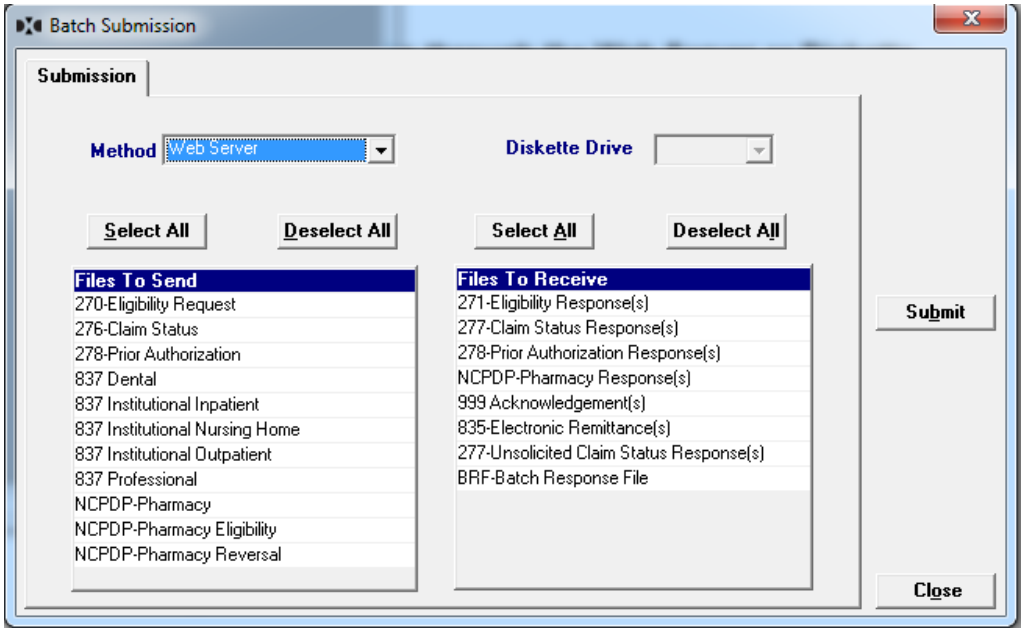
10.3 Submitting Claims through the Web Server

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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11

11 Submitting 837 Institutional Nursing Home Claims

This chapter provides instructions for submitting electronic 837 nursing home claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information

Users access the electronic 837 Institutional Nursing Home claim form using one of the following methods:

- Selecting the 837 Institutional Nursing Home icon from the toolbar
- Selecting Forms>>837 Institutional Outpatient

The electronic form displays with five tabs: Header 1, Header 2, Header 3, Header 4, and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustment), and Crossover.

11.1 Entering Claims in the 837 Institutional Nursing Home Form

Each tab on the 837 Institutional Nursing Home form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Nursing Home form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

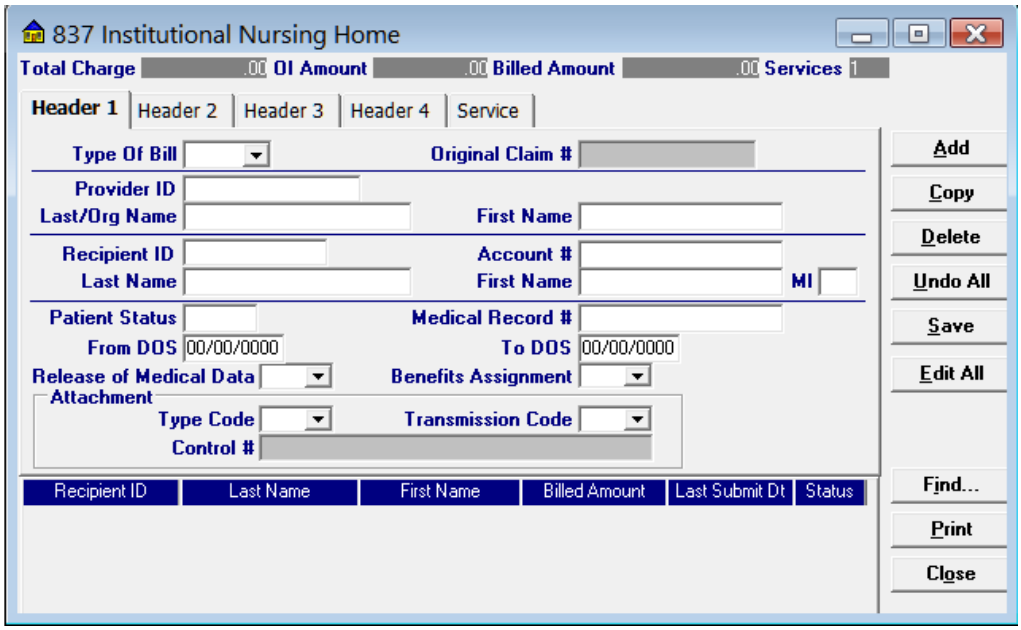
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

11.2 837 Institutional Nursing Home Form

11.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Nursing Home form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit a nursing home claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 3 Inpatient (Medicare Part B only) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.

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Field	***Guidelines***
Patient Status	Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period: 01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to NF 04 Discharged to ICF/MR 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an Inpatient to this hospital 20 Expired or did not recover 30 Still patient 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 50 Hospice, home 51 Hospice, medical facility 61 Discharged/Transferred within this institution 71 Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. 72 Discharge/transferred/referred to this institution for outpatient services as specified plan of care. If status code is 30, the total days in the covered and non-covered fields should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Info for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Attachment Type Code	If applicable, select the appropriate attachment type code from the drop-down-display menu.
Attachment Transmission Code	If applicable, select the appropriate transmission code from the drop-down-display menu.
Attachment Control #	If applicable, enter the Control Number of an electronic attachment.

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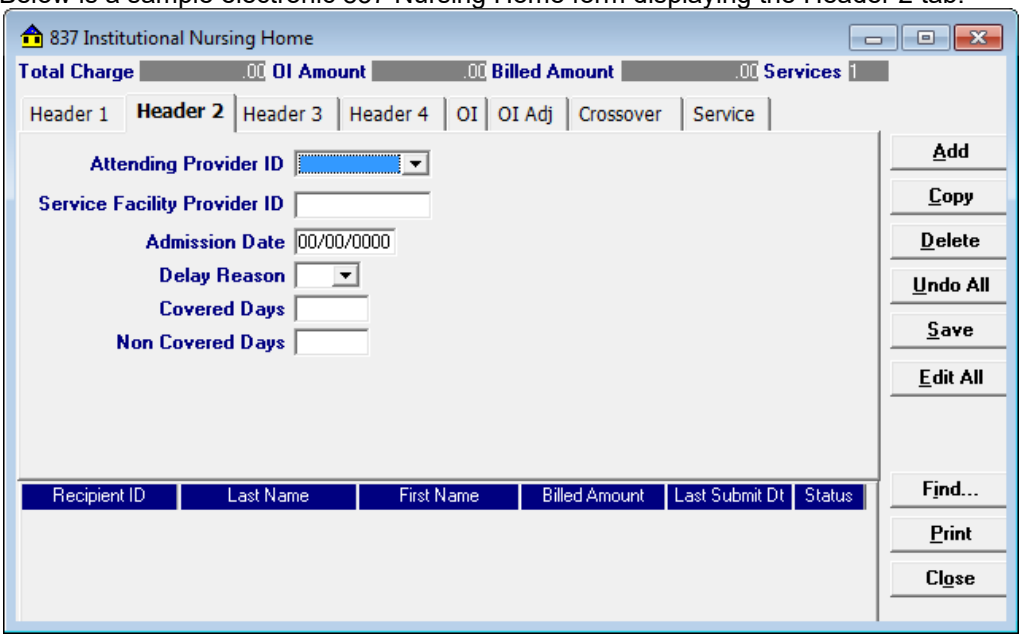
11.2.2 Header 2 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit a nursing home claim:

Field	***Guidelines***
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.
Admission Date	Enter the date the recipient was admitted into your facility in MM/DD/CCYY format.
Delay Reason	Select a value from the drop-down-display menu box to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional.
Covered Days	Enter the total days represented on this claim that are to be covered.
Non Covered Days	Enter the total days represented on this claim that are not covered. The sum of covered and non-covered days equal the total days billed as reflected in units.

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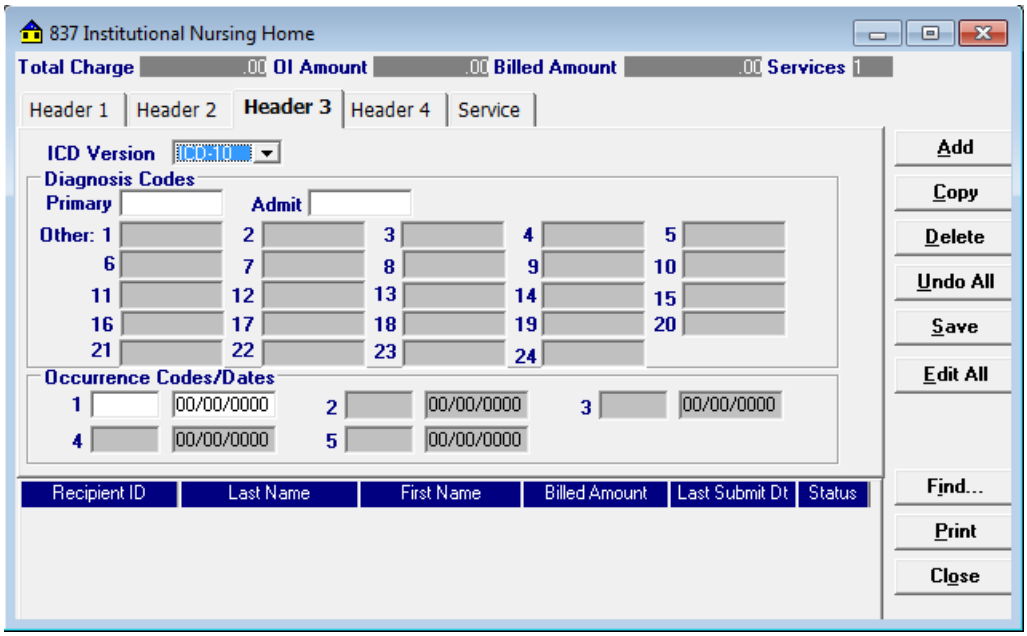
11.2.3 Header 3 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit a nursing home claim:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Other	If applicable, enter a proper diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Admit	Enter a proper admittance diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Occurrence Codes	See Chapter 5, section 5.4 of the Provider billing Manual for specific Occurrence code requirements. For a full list of these codes see Appendix B, Section B.1 Occurrence Codes in this Provider Electronic Solutions manual.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.

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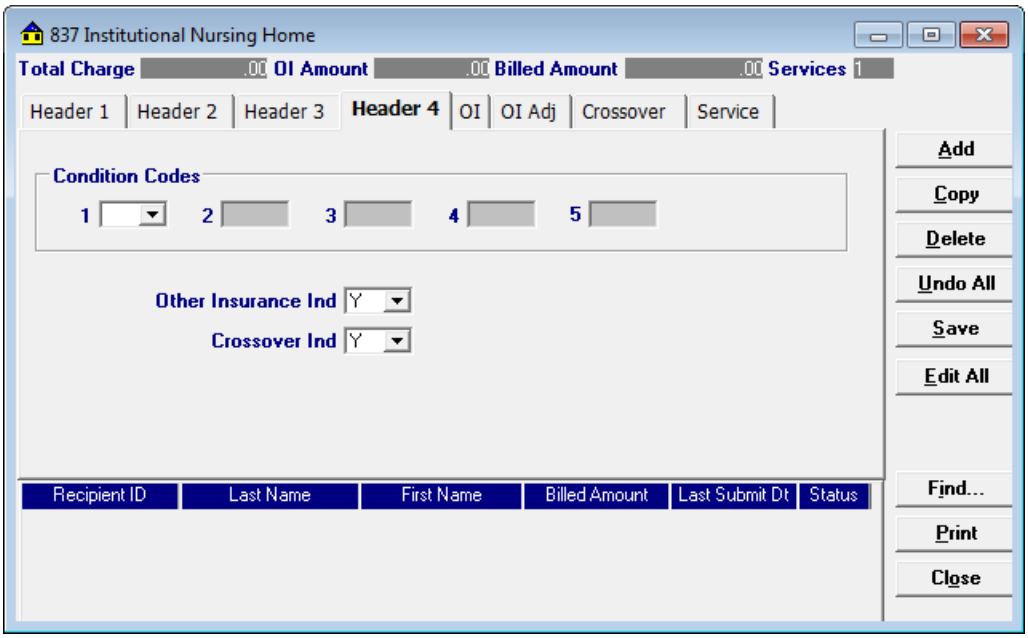
11.2.4 Header 4 Tab

Below is a sample 837 Nursing Home form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit a nursing home claim:

Field	Guidelines
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. For a full list of these codes see Appendix B, Section B.2 Condition Codes.
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

11.2.5 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Nursing Home form displaying the OI (Other Insurance) tab.

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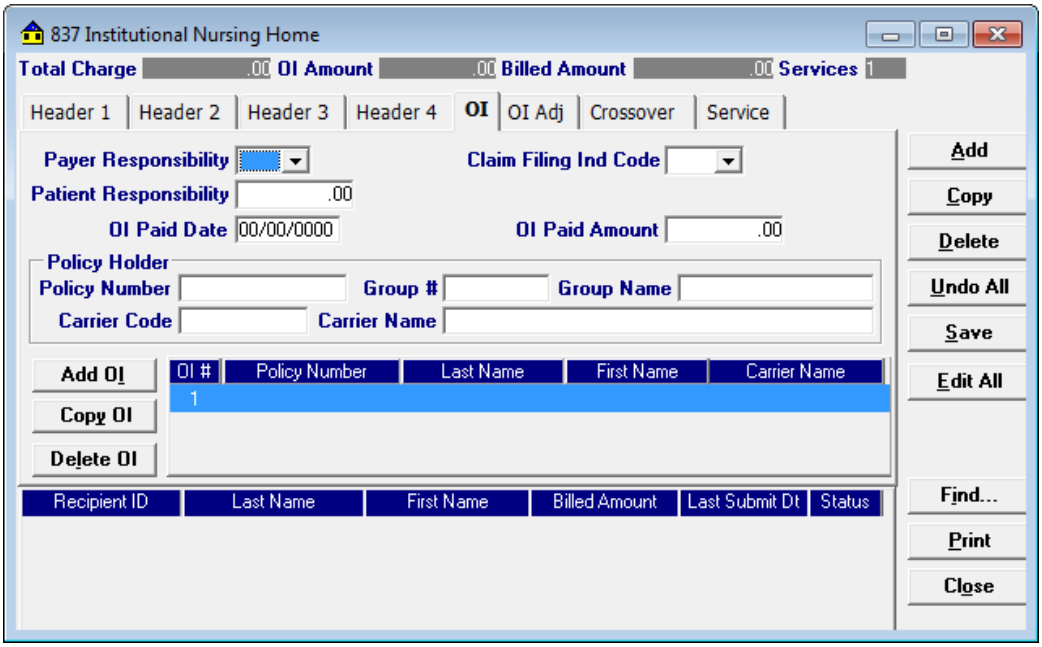

Complete the following fields under the Other Insurance tab to submit a nursing home claim:

Field	*Guidelines*
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance. Do not enter Medicare-related codes 09, 16, MA or MB on the OI tab.
Patient Responsibility	Enter the amount of the other insurance patient responsibility, i.e., deductible, coinsurance, co-pay, etc. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

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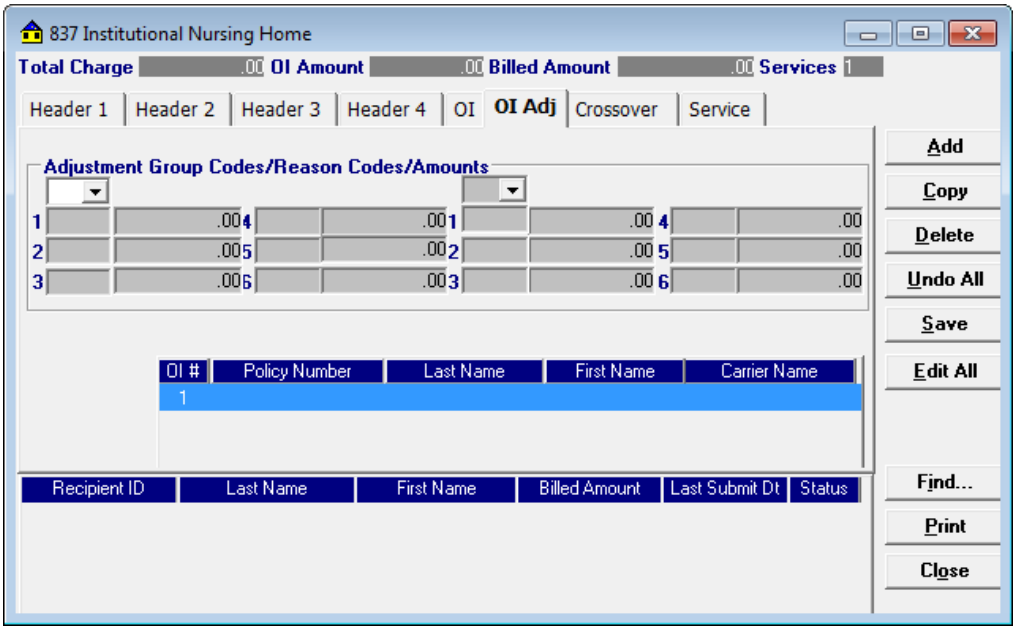
11.2.6 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Nursing Home form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

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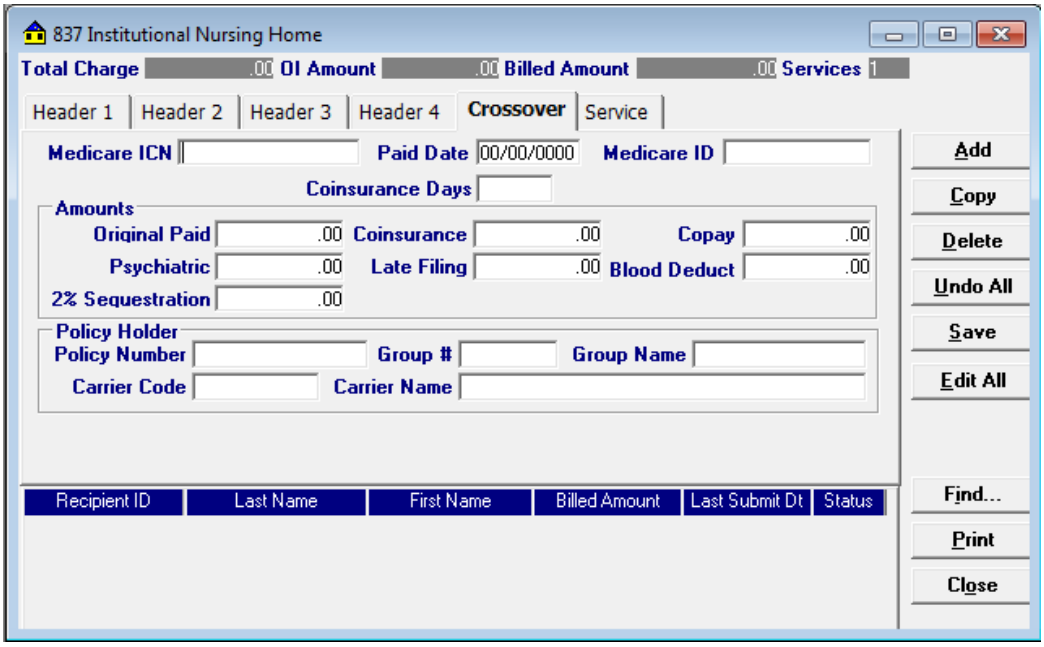
11.2.7 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Nursing Home form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit a nursing home claim:

Field	*Guidelines*
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID assigned by Medicare.
Coinsurance Days	Enter the amount of coinsurance days used during the inpatient stay on this claim. This field is optional.
Amounts – Original Paid	Enter the actual payment amount made my Medicare.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Co-Pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional
Psychiatric	If applicable, enter the amount Medicare determined a recipient must pay for psychiatric related services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined a recipient must pay for late filing. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined a recipient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
Policy Number	Choose the appropriate Medicare number from the Policy Holder list. If you have not added a Medicare segment for the recipient to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.

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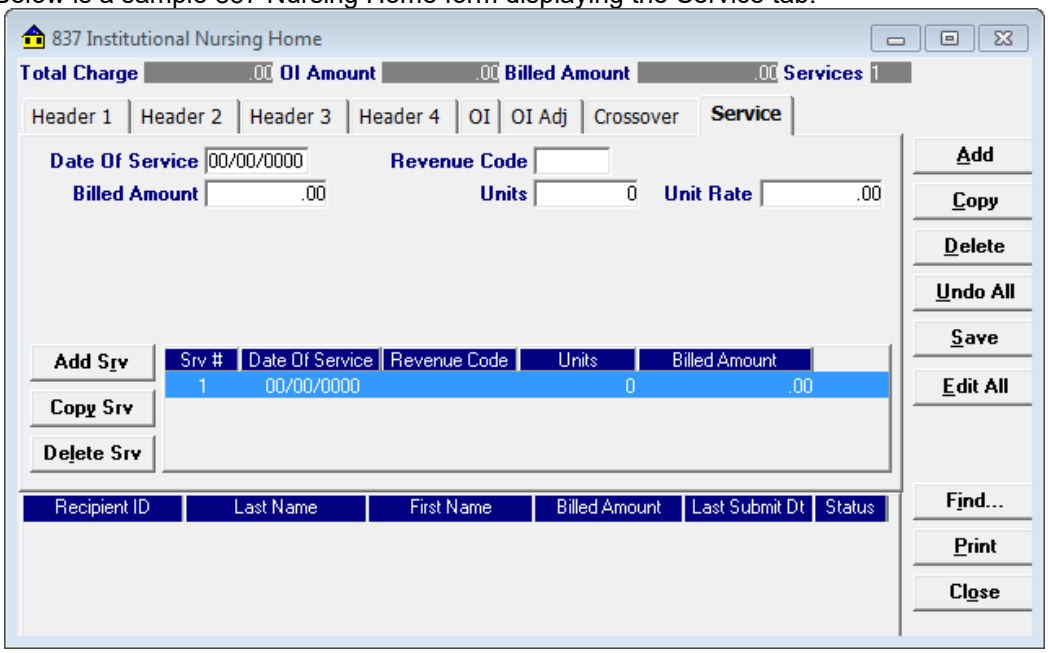
Field	*Guidelines*
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

11.2.8 Service Tab

Below is a sample 837 Nursing Home form displaying the Service tab.



Complete the following fields under the Service tab to submit a nursing home claim:

Field	*Guidelines*
Date of Service	Enter the date of service for each procedure provided in a MM/DD/CCYY format.
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Billed Amount	Enter the amount billed for the service.
Units	Enter the unit(s) billed for the service.
Unit Rate	If revenue code entered ranges from 100 – 219, enter the accommodation rate for the individual unit billed.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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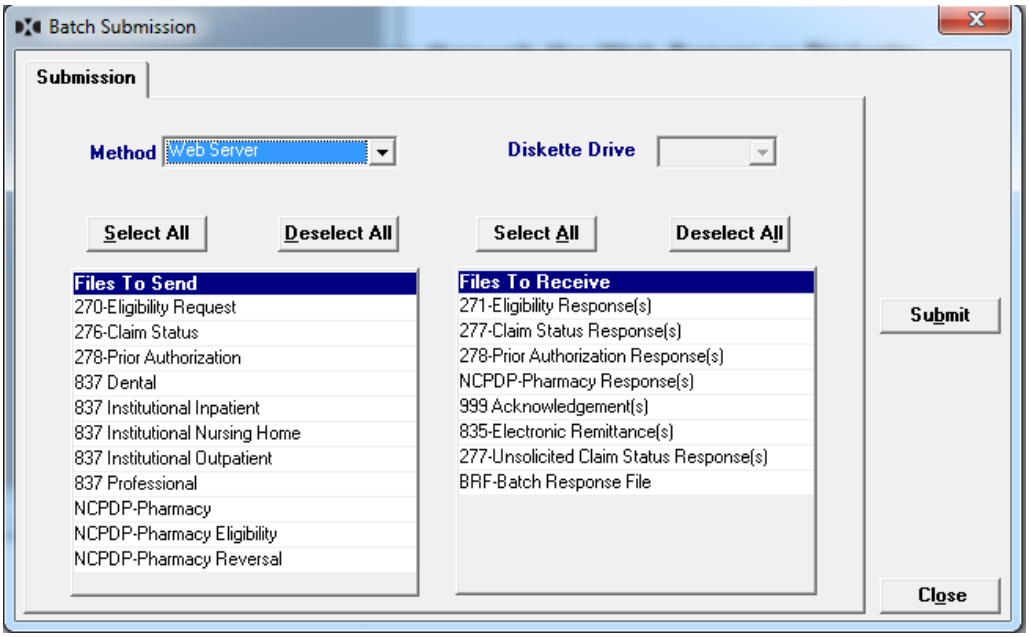
11.3 Submitting Claims through the Web Server

Step 1 Select Communication >> Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view t*he Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.*

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12

12 Submitting Claim Reversals and Adjusting Paid Claims

The new 5010 version of PES is now available in version 3.0. Users need to upgrade to PES version 2.16 before installing PES version 3.0 in order to preserve the PES database list. Once you upgrade to the new version of PES, you will no longer be able to submit, resubmit, copy, modify or restore HIPAA 4010 or NCPDP 1.1 transactions. After completing the upgrade to 3.0, all HIPAA 5010 and NCPDP 1.2 transactions will need to be entered in the software as a new claim.

This chapter provides instructions for submitting electronic pharmacy and non-pharmacy claim reversals. Claim reversals may be submitted by batch, or by diskette.

Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

12.1 General Instructions for Entering Reversals

Users access the NCPDP Pharmacy Claim Reversal window using one of the following methods:

- Selecting the NCPDP Pharmacy Claim Reversal icon from the toolbar
- Selecting Forms>> NCPDP Pharmacy Reversal

Users access the non-pharmacy claim reversal option using one of the following methods:

- Selecting the designated form that the claim was originally filed from the toolbar

  (Example: If the claim paid as an 837 Professional, choose the icon)
- Selecting Forms>> then choosing the designated form that the claim was originally filed on.

  (Example: If the claim paid as an 837 Professional, choose Forms>>837 Professional)

12.1.1 Entering Reversal/Adjustment Requests

The NCPDP Pharmacy Claim Reversal window contains three main parts:

- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form that enable users to view basic information about several reversal records. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Provider ID, Recipient ID, ICN, and Status.

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Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the window so you may add a new record. Please note that if you key over data that already displays on the record and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record, or press Copy (see below) to build a new record from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new record from an existing record. This feature is especially helpful if you are entering multiple batch reversals for batch submission.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved record by status, last provider ID, recipient ID, and ICN.
Print	Pressing this button enables you to print the record currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Record

Step 1 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the ‘Tab’ key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another record.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the window. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct record.
- Press ‘Copy’ to copy a record that closely matches the information you need to enter and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

12.2 Claim Adjustments/Reversals for Non-Institutional Claims

Step 1 Open the non-institutional form type that the original claim paid as.

If the claim was originally keyed into PES, you may locate that particular claim in an "F" status and press "Copy" to begin adjusting or reversing the claim.

Step 2 In the Claim Frequency field change the indicator to inform Medicaid if the request is an Adjustment or a Claim Reversal.

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.

8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.

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Step 3 In the Original Claim # field enter the ICN assigned by Medicaid once the claim was accepted and paid. This information can be located on your Batch Response report or *Explanation of Payment*.

Step 4 Fill out the form type according to how it was filed previously. Include the same Recipient ID, and Provider ID that was filed on the original claim.

- If the value '7' was chosen, enter the original claim exactly how it was filed except for the adjustments to be made to the claim. Whatever information is submitted on this claim will replace the claim with the ICN # from Step 3.
- If the value '8' was chosen, enter the original claim exactly how it was filed to complete the claim reversal. Once submitted, this reversal will cross-reference the provider ID and the recipient ID against the ICN # entered. If these fields do not match the information on the original claim, the reversal will be denied.

Step 5 Press 'Save' to save your claim, and follow Section 12.5, Submitting Reversals/Adjustments through Web Server or Diskette.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of payment; however, filing limits apply to claims re-filed as a result of an electronic adjustment or pharmacy reversal.

12.3 Claim Adjustments/Reversals for Institutional Claims

Step 1 Open the Institutional form type that the original claim paid as.

If the claim was originally keyed into PES, you may locate that particular claim in an "F" status and press 'Copy' to begin adjusting the claim.

Step 2 In the Type of Bill field the last digit of the three-digit code will inform Medicaid if the claim is a reversal or an adjustment. End the Type of Bill with a '7' or an '8' to indicate an adjustment or a reversal. See the NOTE below.

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.

8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.

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Step 3 In the Original Claim # field enter the ICN assigned by Medicaid once the claim was accepted and paid. This information can be located on your Batch Response report or *Explanation of Payment*.

Step 4 Fill out the form type according to how it was filed previously. Be sure to include the same Recipient ID, and Provider ID that was filed on the original claim.

- If the type of bill ended with a '7', enter the original claim exactly how it was filed except for the adjustments to be made to the claim. Whatever information is submitted on this claim will replace the claim with the ICN # from Step 3.
- If the type of bill ended with an '8', enter the original claim exactly how it was filed to complete the claim reversal. Once submitted, this reversal will cross-reference the provider ID and the recipient ID against the ICN # entered. If these fields do not match the information on the original claim, the reversal will be denied.

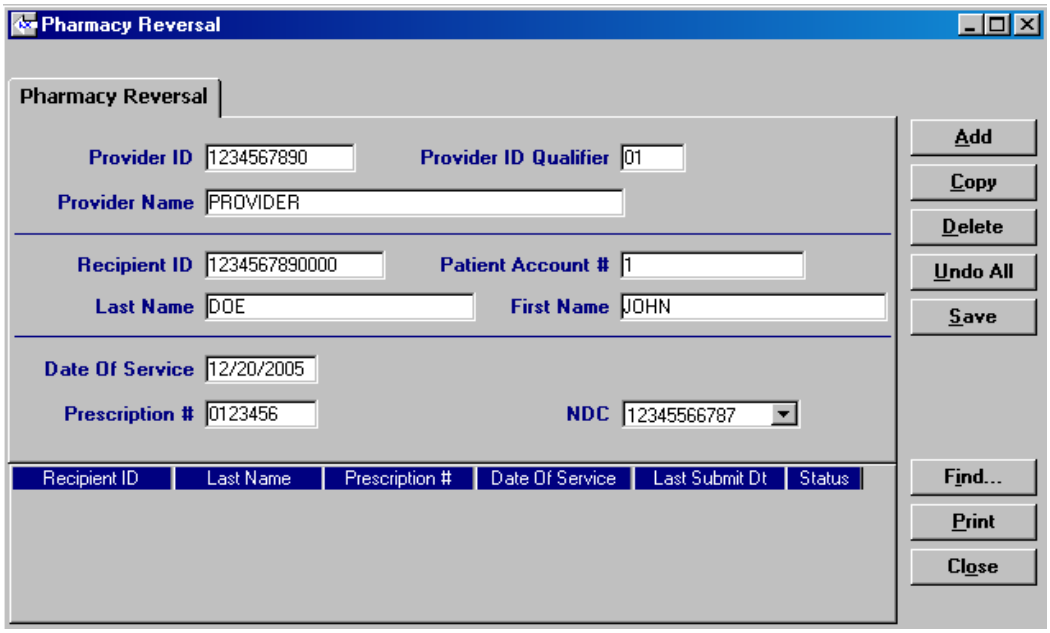
Step 5 Press 'Save' to save your claim, and follow Section 12.5, Submitting Reversals/Adjustments through Web Server or Diskette.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of payment; however, filing limits apply to claims re-filed as a result of an electronic adjustment or pharmacy reversal.

12.4 NCPDP Pharmacy Reversal Window

Below is a sample Pharmacy Reversal window:



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Complete the following fields under the NCPDP Pharmacy Reversal tab to submit a pharmacy claim reversal:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Qualifier	Select the value that identifies the entity that assigned the ID.
Provider Name	This field will auto-write based on the information placed in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Patient Account #	This field will auto-write based on the information placed in the Recipient ID field.
Last Name	This field will auto-write based on the information placed in the Recipient ID field.
First Name	This field will auto-write based on the information placed in the Recipient ID field.
Date of Service	Enter the date the prescription was dispensed to the recipient in MM/DD/CCYY format.
Prescription #	Enter the 7 to 12-digit prescription number.
NDC	Enter the 11-digit National Drug Code (NDC).

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

You can submit claim reversals for pharmacy claims up to 18 months after the claim was paid.

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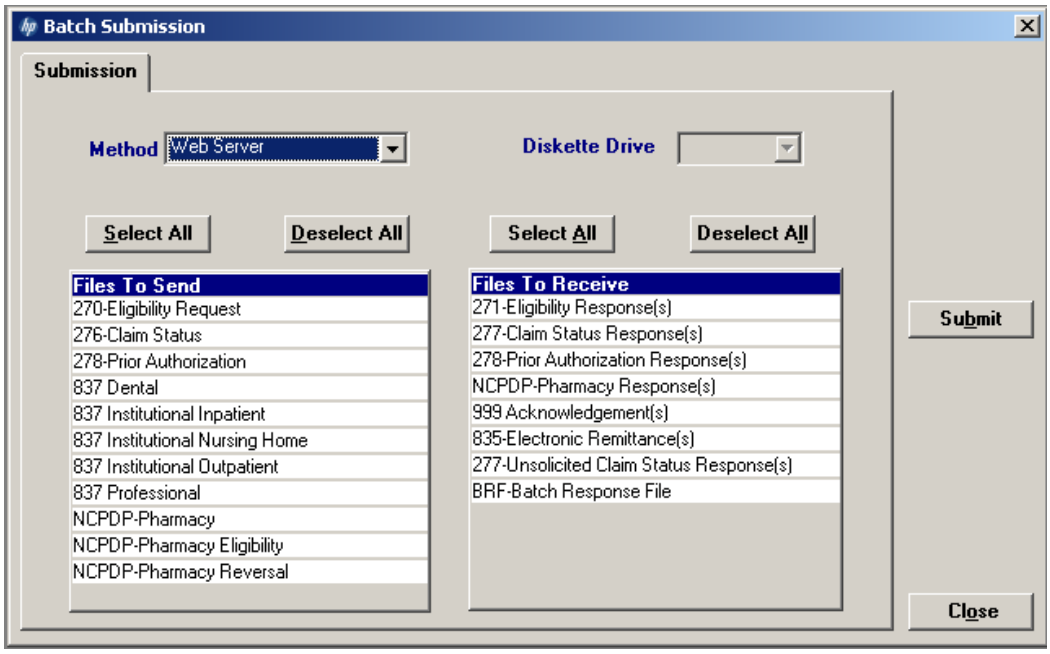
12.5 Submitting Reversals/Adjustments through the Web Server

Follow Steps 1-5 to receive the response from the Web Server.

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select ‘Web Server’ from the drop down next to Method..

Step 3 Determine which files you want to send from the Files to Send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

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Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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13

13 Receiving a Response

This chapter describes how to download a response, resubmit a batch, and understand the corresponding submission reports. It also discusses diskette and interactive submission and response.

Chapter 13, Receiving a Response, contains the following sections:

- Sending batch transactions to the Web Server
- Downloading responses from the Web Server
- Viewing batch responses
- Resubmitting batches
- Submitting batches by diskette

13.1 Sending Batch Transactions to the Web Server

Provider Electronic Solutions enables you to submit batch (groups of one or more records) transactions to the DXC Technology Web Server for all claim types, eligibility verification, claim status, prior authorization, and claim reversals. You can send batch transmissions for any combination of record types – for example, you can enter all your daily claims for 837 Professional and 276 Claim Status then submit them all in one batch transmission.

Likewise, you can submit eligibility verification and claim records together in the same batch transmission. *Provider Electronic Solutions* also enables you to upload responses while you are downloading batches to the Web Server.

NOTE:

You may download (receive) and upload (send) batches as often as you like.

Records that are ready for batch submission have a status of ‘R’. The status displays on the list field at the bottom of the claim, eligibility, claim status, or prior authorization form. Once you have added and saved all the records you want to include in your batch (see Chapters 5 -13 for instructions), perform the following steps to submit a batch transmission:

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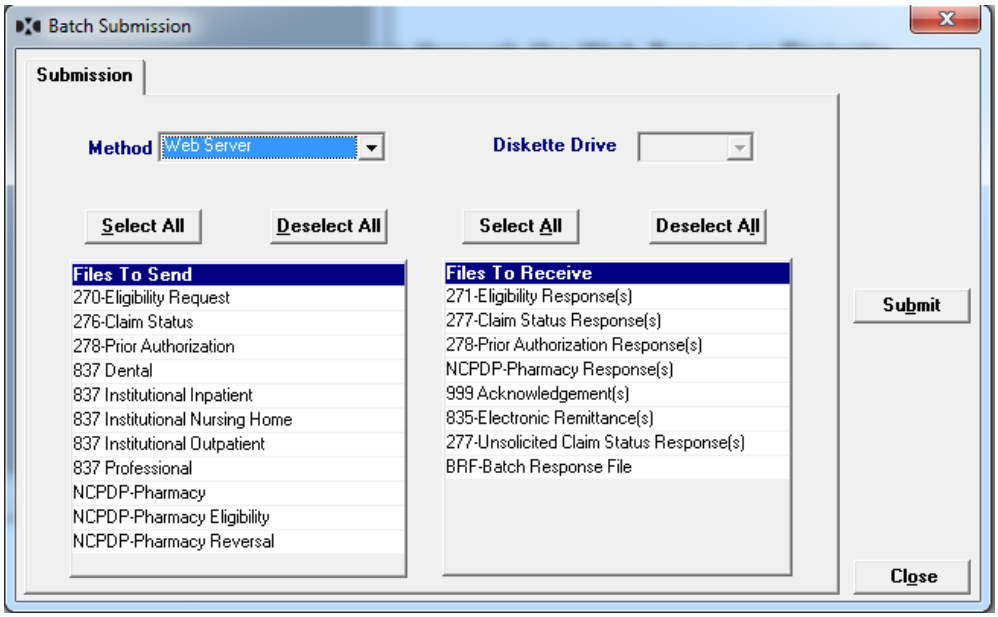
Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select ‘Web Server’ from the drop down next to Method.

Step 3 Determine which files you want to send from the ‘Files to Send’ list.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine the files you want to receive from the Files to Receive list.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

To download a response, follow the instructions provided in Section 13.1, Sending Batch Transactions to the Web Server. The system displays a 'Submission Successful' message when it successfully connects with the Web Server. This does not mean that your response file has been downloaded.

To determine whether a response has been downloaded, review the file name in the Communication Log or the Verification Log and search for that file name in the Response Log. You can also watch the system as it attempts to download a response. If *Provider Electronic Solutions* locates your response file on the Web Server, it will indicate the number of files downloaded in the lower left hand corner of your screen.

View the response by selecting the Communications>>View Batch Response menu option.

13.2 Viewing Responses

This section describes viewing the batch response, 999s, and communication log screens.

View Batch Response

This option enables the user to view a Batch Response File (BRF). The report shows whether or not claims were accepted or rejected as well as the batch identification number. The accepted and rejected claims will be in the order they were sent and will display the ICN and any applicable rejection codes and descriptions.

The 999-response informs the user if a transaction (270, 276, 278 or 837) was successfully uploaded to the web server and if the transaction was HIPAA compliant. *Provider Electronic Solutions* will not allow a user to send a Non-HIPAA compliant transaction, therefore all 999 responses should be sent back with an AK5 indicating the file was HIPAA compliant and will cycle to Medicaid for processing.

NOTE:

An electronic version of the EOP (835) is available if a request was signed and sent to the EMC Helpdesk. Although Provider Electronic Solutions has the ability to download the file, it does not allow the user to view it. Therefore, if an electronic version of the 835 report is desired, the user must contact an outside vendor for a program that is able to format the file into a report.

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View Communication Log

This option enables the user to view a log of each transaction that occurs between *Provider Electronic Solutions* and the Web Server (batch submission and software upgrades). Each occurrence is assigned a file name. Users scroll down the list of file names located at the top of the Communication Log window and click on a row to access the log associated with the file name.

13.3 Resubmitting Batches

Select Communication>>Resubmission to resubmit entire batches, resubmit records within batches, or to copy batches or records within batches for modification and resubmission. The Batch Resubmission window displays.

Users select from a list of previously submitted batches. The user highlights a particular batch to display all records stored within the batch. The user may perform any of the following:

- Click ‘Select All’ to select all records within a batch for resubmission, then press the ‘Resubmit’ button to resubmit the batch
- Click on one or more records for the batch displayed and press ‘Resubmit’
- Select the ‘Copy’ button to copy the entire batch
- Click on one or more records for the batch displayed and press ‘Copy’

To modify copied records, access the corresponding claim, eligibility, or claim status form and select the copied record from the list that displays at the bottom of the form. Modify and save the record, then submit according to the instructions in Section 13.1, Sending Batch Transactions to the Web Server.

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14

14 Producing Reports

This chapter describes how to select and produce detail, summary, and list reports. It contains the following sections:

- Detail and Summary Reports
- Other Reports

14.1 Detail and Summary Reports

Provider Electronic Solutions enables you to print detail and summary reports for your claims, eligibility verification requests, pharmacy reversals, claim status and prior authorization requests.

Selecting Reports>>Detail Forms enables you to produce a detail report that shows the claim in its entirety.

Selecting Reports>>Summary Forms enables you to produce summary reports such as the basic recipient information, billed amount, the date the claim was last submitted, claim status and the service (claim) lines.

When you select either the detail or summary menu options, you must also select a form. The Detail or Summary Reports window displays accordingly. To customize the report, enter information into at least one of the following fields and press 'Enter':

- Batch Number
- Recipient ID
- Form Status
- Submit Date

The system displays a print preview of the report and populates the Records Selected field with the number of records included on the report. Send the report to your printer as required.

Generating a Detail Form Report

You may select any option available on the Detail Form screen. Choosing this option will allow you to generate a detailed report for any claim type, eligibility request, claim status, or prior authorization request. Follow the step-by-step procedures below to complete this process:

Step 1 Click on Reports >> Detail Forms >> and choose the desired report. The available list includes:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient

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- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal

NOTE:

Creating these detailed reports will not include the responses created upon transmission. The only claim status you will receive on this report is the status of the claim within the Provider Electronic Solutions software. The status indicators include F (Finished/or successfully sent to Medicaid), A (Archived), I (Incomplete Transmission), P (Pending) and R (Ready to send).

These reports are to be used as a form of proof of filing, claim entry and internal usage.

Step 2 Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	Usage
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Recipient ID	To limit the detail report to request for a certain recipient, enter the appropriate 12-digit recipient ID in this field.
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's pull-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

Step 3 Click 'OK' after entering or choosing a value in one of the option screens as listed in Step 2.

Step 4 Click on 'Print' if you wish to print a copy of the report listed on your screen.

Step 5 Click on 'Close' to exit the Detail Report screen.

14.1.1 Generating a Summary Report

You may select any option available on the Summary Form screen. Choosing this option will allow you to generate a basic report for any claim type, eligibility request, claim status, or prior authorization request. Follow the step-by-step procedures below to complete this process:

Step 1 Click on Reports >> Summary Forms >> and choose the desired report. The available list includes:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy

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- NCPDP Pharmacy Reversal

Step 2 Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	*Usage*
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Recipient ID	To limit the detail report to request for a certain recipient, enter the appropriate 12-digit recipient ID in this field.
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's pull-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

Step 3 Click OK after entering or choosing a value in one of the option screens as listed in Step 2.

Step 4 Click on 'Print' if you wish to print a copy of the report listed on your screen.

Step 5 Click on 'Close' to exit the Detail Report screen.

14.2 Other Reports

Provider Electronic Solutions enables you to print reports of all you have stored in your list screens. Select the Reports menu option, then choose from the following:

- Attending/Operating Provider
- Ordering Provider
- Prescriber
- Provider
- Recipient
- UPIN
- Admission Type
- Carrier
- Condition Code
- Diagnosis ICD-9
- Diagnosis ICD-10
- Modifier
- NDC
- Occurrence
- Patient Status
- Place Of Service
- Policy Holder
- Procedure/HCPCS
- Procedure ICD-9
- Procedure ICD-10
- Revenue
- Taxonomy
- Type Of Bill

NOTE:

You may print from any of these reports as you so choose. Please be advised that the information displayed within the report is based on your List screens. The Place of Service and Carrier lists have already been populated by DXC Technology. The remainders of your list screen are only populated if the user so chooses to enter and save such information.

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15

15 Submitting 278 Prior Authorization Requests

This chapter provides instructions for submitting electronic requests for the 278 Prior Authorization form, which is available for Medical and Dental requests. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

278 prior authorization requests through Provider Electronic Solutions should only be used to submit fee-for-service requests to Alabama Medicaid. Contact MCOs for their process to submit prior authorizations to them.

Users access the 278 Prior Authorization request form using one of the following methods:

- Selecting the Prior Authorization Request icon from the toolbar called “Prior Auth”
- Selecting Forms>>278 Prior Authorization Request

The electronic form displays with eight tabs: Header 1, Header 2, Header 3, Header 4, Header 5, Header 6, Header 7, and Service 1.

15.1 Entering Requests Using the 278 Prior Authorization Form

Each tab on the 278 Prior Authorization form contains three main parts:

- Updateable fields used to enter PA request data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several PA requests. Users may highlight a row to modify, copy, or print a PA request record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

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Below is a description of the buttons that display on the PA request form:

Button	***Usage***
Add	Pressing this button enables you to refresh the PA request screen so you may add a new record. Please note that if you key over data that already displays on the PA request form and press Save, you will overwrite the previous PA request. Be sure to press Add before entering a new PA request, or press Copy (see below) to build a new PA request from an existing PA request record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new PA request from an existing PA request record. This feature is especially helpful if you routinely submit PA request for the same procedure code for different recipients or for other instances where your PA request may be similar to one another.
Delete	Pressing this button enables you to delete the PA request currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the PA request currently being displayed.
Save	Pressing this button enables you to save the PA request you just added or modified. The saved PA request displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved PA request by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the PA request currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New PA request

Step 1 Access the 278 Prior Authorization form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the PA request contains errors. Scroll through the error messages and double-click on each error to access the field on the PA request that contains the error.

Step 3 Correct each mistake and press ‘Save,’ or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete PA requests (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another PA request.

To Modify a PA request from the List

Scroll through the list of PA request that display at the bottom of the form. Highlight the PA request you wish to modify, and perform one of the following:

- Key over incorrect data on the PA request form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct PA request.

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- Press ‘Copy’ to copy a PA request that closely matches the information you need to enter (for instance, if you must enter PA request for identical services, but different recipients) and modify the new record accordingly. Press ‘Save” to save the new record.
- Press ’Delete’ to delete an unwanted record.

NOTE:
Prior Authorization transaction created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these Prior Authorization transactions. All Prior Authorizations submitted using PES version 3.0 must be created in the 3.0 software as a new Prior Authorization transaction.

To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

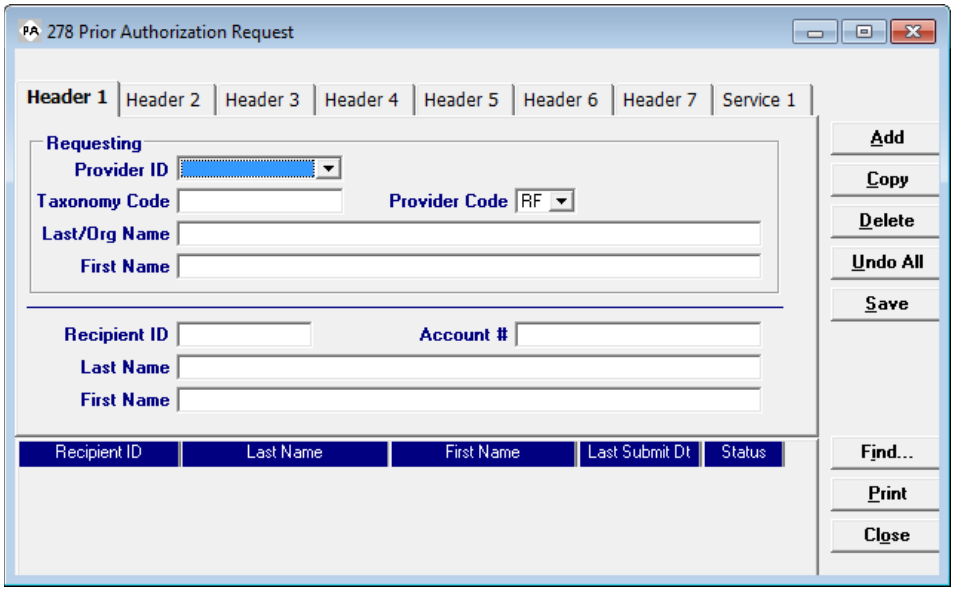
Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

15.2 Fields on the Prior Authorization Form

Header 1 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 1 tab.



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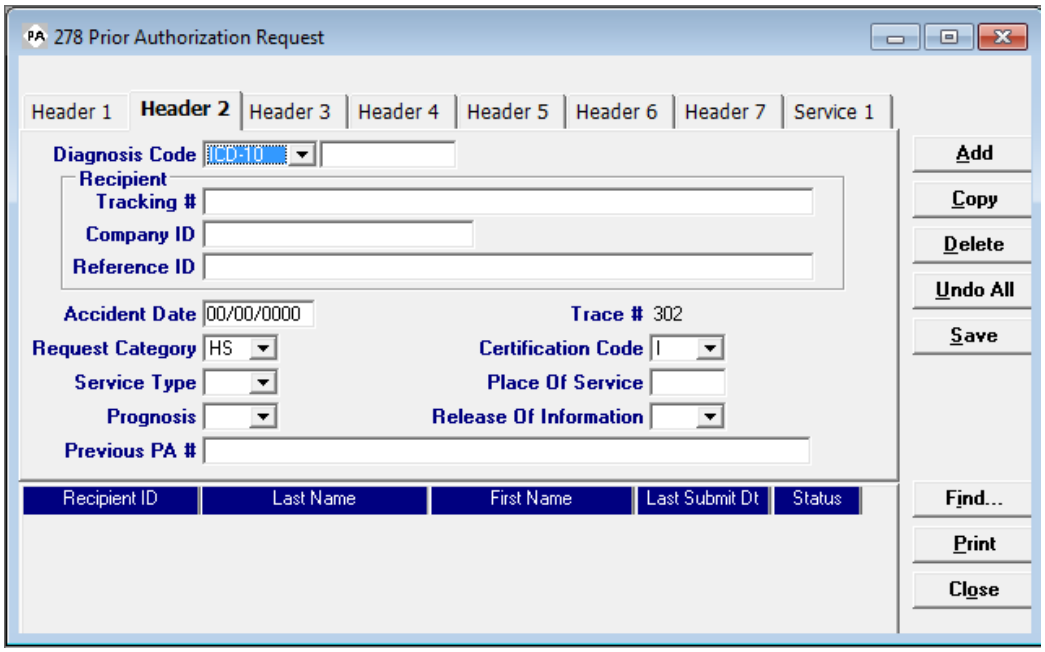
Complete the following fields under the Header 1 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Taxonomy Code	This field will auto-write based on your choice in the Provider ID field. This field is not currently used.
Provider Code	Choose the best value to indicate the type of provider indicated in the Provider ID field. If no value is indicated, the field will auto-plug 'RF'. AD Admitting AS Assistant Surgeon AT Attending OP Operating OR Ordering OT Other Physician PC Primary Care Physician PE Performing RF Referring
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.

Header 2 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 2 tab.



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Complete the following fields under the Header 2 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the PA request. ICD-9 or ICD-10.
Diagnosis Code	Choose a proper diagnosis code from your diagnosis code list or enter a valid diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Tracking #	Enter the recipient's tracking number. The requester assigns a unique trace number to the PA request, or enters the system assigned Trace # located under Header Tab 2 on the 278 request form.
Company ID	Enter the **Requester's** 10-digit Company ID. '1' plus EIN, '3' plus DUNS, or '9' plus nine user-assigned numbers.
Reference ID	Enter the recipient's reference ID to further identify a specific division or group of the company identified in the Company ID field. **This field is optional**.
Accident Date	If applicable, enter the date of the accident in a MM/DD/CCYY format.
Trace #	This field allows you to utilize the trace # that is also located on the 278 response to locate which request the response is referring to.
Request Category	Choose the best value to indicate the review type that resulted in the specific request. AR Admission Review HS Health Services Review IN Individual SC Special Care Review
Certification Code	Choose the best value to indicate the originality or follow-up status of the current Prior Authorization. If any value other than 'I' is chosen, enter the previous PA number into the Previous PA # field. I Initial N Reconsideration R Renewal S Revised
Service Type	Choose the best value to indicate the type of service to be performed. 01 – Medical Care 02 – Surgical 12 – DME – Purchase 18 – DME – Rental 35 – Dental Care 40 – Oral Surgery 42 – Home Health Care 44 – Home Health Visits 54 – LTC Waiver 56 – Medically Related Transportation 69 – Maternity 72 – Inhalation Therapy 74 – Private Duty Nursing 75 – Prosthetic Devices A4 - Psychiatric AD – Occupational Therapy AE – Physical Medicine AF – Speech Therapy AL – Vision – Optometry CQ - Case Management
Place of Service	Choose the best value to indicate where the service/procedure was performed from the Place of Service list.

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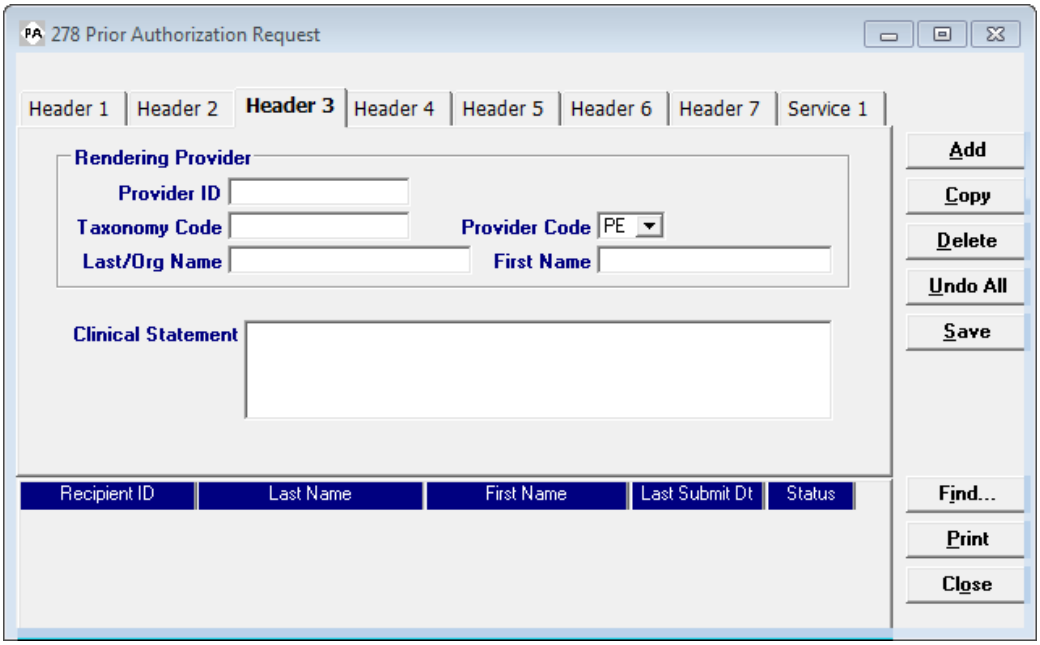
Field	*Guidelines*
Prognosis	Choose the best value to indicate the recipient's current health prognosis. This field is optional. 1 Poor 2 Guarded 3 Fair 4 Good 5 Very Good 6 Excellent 7 Less than 6 Months to Live 8 Terminal
Release of Information	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. M - Provider has limited or restricted ability to release data related to a claim Y - Yes, Provider has signed statement permitting release of medical billing data related to a claim
Previous PA#	If applicable, enter the previous PA number that applies to the services being requested on this PA.

Header 3 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit a 278 Prior Authorization request:

Field	*Guidelines*
Rendering Provider ID	Choose a provider ID from your provider ID list to indicate which provider will bill the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Taxonomy Code	This field will auto-write based on your choice in the Provider ID field.

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Field	***Guidelines***
Provider Code	Choose the best value to indicate the type of provider indicated in the Provider ID field. If no value is indicated, the field will auto-plug 'PE'. AD Admitting AS Assistant Surgeon AT Attending OP Operating OR Ordering OT Other Physician PC Primary Care Physician PE Performing RF Referring
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Clinical Statement	If a procedure code requires a modifier for non-transportation PA's, enter the modifier into this field immediately after the associated procedure code. For example, procedure code 19318 may require the modifier 50 to indicate 'Bilateral'. Enter this as '19318-50' so the PA clerk at the State agency may review this accordingly. Please enter a clinical statement, regarding the recipient, when you feel it may help the approval process. Refer to the Provider Manual for required information.

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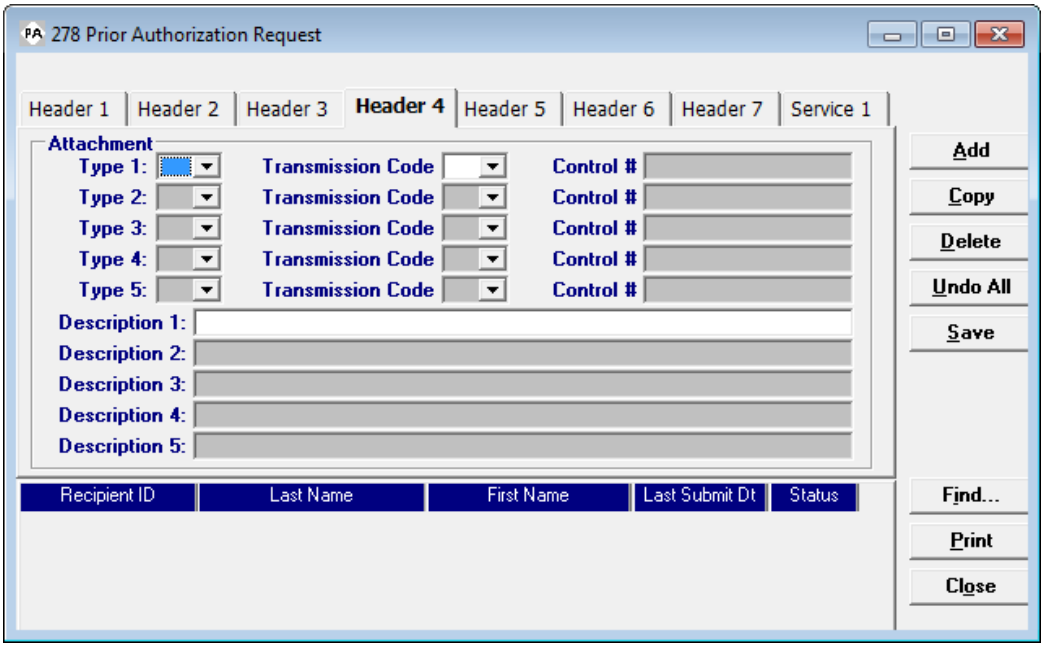
Header 4 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit a 278 Prior Authorization request with attachments:

Field	***Guidelines***
Attachment Type	If required for PA review, indicate the type of attachment.
Transmission Code	If a value was entered in the Attachment Type field, choose the best value to indicate the method or format, which the reports are to be sent. The only valid values processed by Alabama Medicaid are as indicated: AA Available on Request at Provider Site BM By Mail EL Electronically Only EM E-mail FX By Fax VO Voice
Control #	Enter the attachments control number. This number is based on your internal filing system, and will not be reviewed by Alabama Medicaid. NOTE: Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. Fax them to 334-215-4140, Attn: PA Unit, or mail the attachments to: DXC Technology Attn: PA Unit PO Box 244032 Montgomery, AL 36124
Description	Enter the attachments description. This field is optional.

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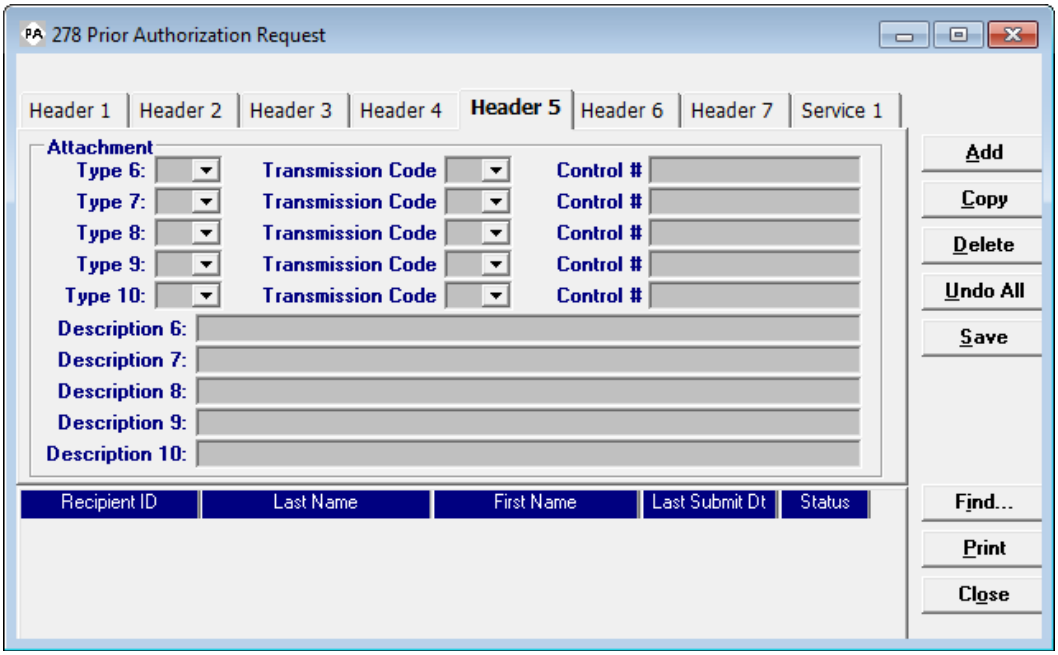
Header 5 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 5 tab.



Complete the following fields under the Header 5 tab to submit a 278 Prior Authorization request with attachments:

Field	***Guidelines***
Attachment Type	If required for PA review, indicate the type of attachment.
Transmission Code	If a value was entered in the Attachment Type field, choose the best value to indicate the method or format, which the reports are to be sent. The only valid values processed by Alabama Medicaid are as indicated: AA Available on Request at Provider Site BM By Mail EL Electronically Only EM E-mail FX By Fax VO Voice
Control #	Enter the attachments control number. This number is based on your internal filing system, and will not be reviewed by Alabama Medicaid. NOTE: Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. Fax them to 334-215-4140, Attn: PA Unit, or mail the attachments to: DXC Technology Attn: PA Unit PO Box 244032 Montgomery, AL 36124
Description	Enter the attachments description. This field is optional.

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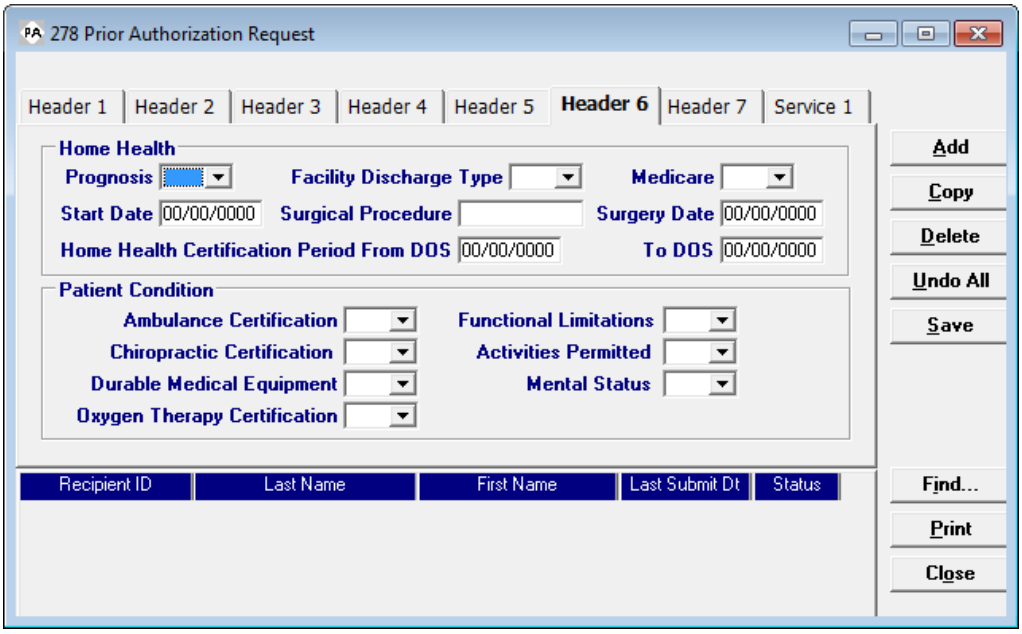
Header 6 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 6 tab.



Complete the following fields under the Header 6 tab to submit a 278 Prior Authorization request:

Field	Guidelines
Home Health Prognosis	Choose the best value to indicate the patient's current home health prognosis. 1 Poor 2 Guarded 3 Fair 4 Good 5 Very Good 6 Excellent 7 Less than 6 Months to Live 8 Terminal
Facility Discharge Type	If a value was indicated in the Home Health Prognosis field, choose the best value to indicate where the recipient was discharged. A Acute Care Facility B Boarding Home C Hospice D Intermediate Care Facility E Long-term or Extended Care Facility F Not Specified G Nursing Home H Sub-acute Care Facility L Other Location M Rehabilitation Facility O Outpatient Facility P Private Home R Residential Treatment Facility S Skilled Nursing Home T Rest Home
Medicare	If a value was indicated in the Home Health Prognosis field, choose the best to value indicate if the patient currently has Medicare
Start Date	The date covered home health services began

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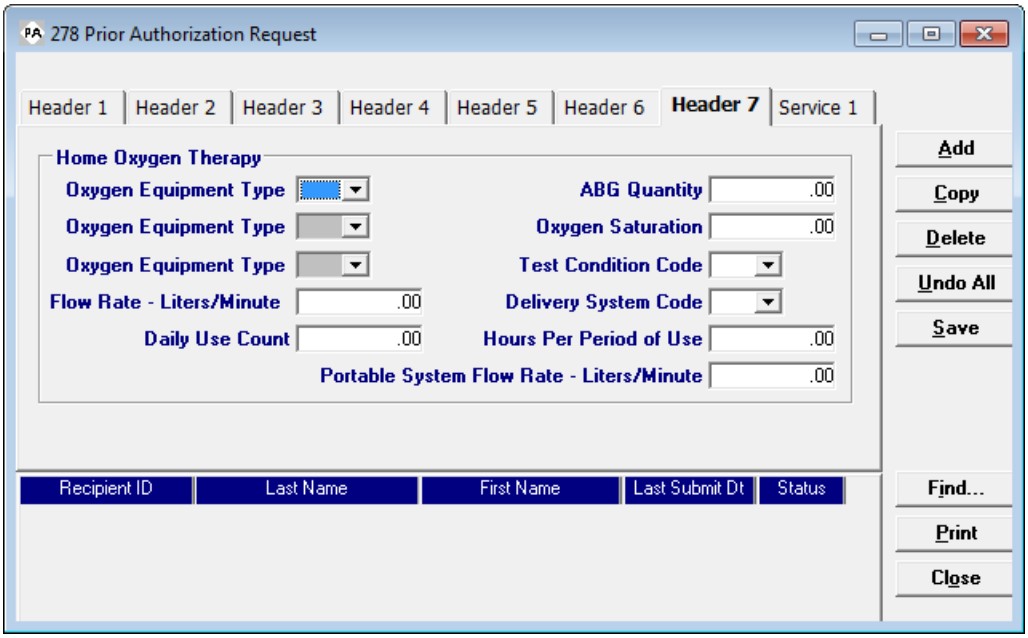
Field	Guidelines
Surgical Procedure	Code value for describing the surgical procedure code. Must be used with Surgery Date.
Surgical Date	The date of the Surgery. Must be used with Surgical Procedure.
Home Health Certification Period from DOS	Starting date of the plan of treatment.
To DOS	Through date of the plan of treatment.
Ambulance Certification	Choose the best value to indicate the correct condition code.
Functional Limitations	Choose the best value to indicate the correct condition code.
Chiropractic Certification	Choose the best value to indicate the correct condition code.
Activities Permitted	Choose the best value to indicate the correct condition code.
Durable Medical Equipment	Choose the best value to indicate the correct condition code.
Mental Status	Choose the best value to indicate the correct condition code.
Oxygen Therapy Certification	Choose the best value to indicate the correct condition code.

Header 7 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 7 tab.



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Complete the following fields under the Header 7 tab to submit a 278 Prior Authorization request for Home Oxygen Therapy:

Field	***Guidelines***
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Flow Rate – Liters/Minute	Enter the flow rate of the oxygen as will be used. Enter the value as liters per minute. Ex. If 1/4 liters per minute, enter .25.
Daily Use Count	Enter a value to indicate how many days the requested oxygen should last.
ABG Quantity	Enter the Arterial Blood Gas Quantity.
Oxygen Saturation	Enter the Oxygen Saturation Quantity.
Test Condition Code	Select the code indicating the conditions under which a patient was tested. E Exercising N No special conditions for test O On oxygen R At rest on room air S Sleeping W Walking X Other
Delivery System Code	Choose the best value to indicate the delivery of the oxygen into the recipient.
Hours Per Period of Use	Enter a value to indicate number of hours per period of oxygen use
Portable System Flow Rate – Liters/Minute	Enter the flow rate of the oxygen as will be used through a portable system. Enter a value as liters per minute.

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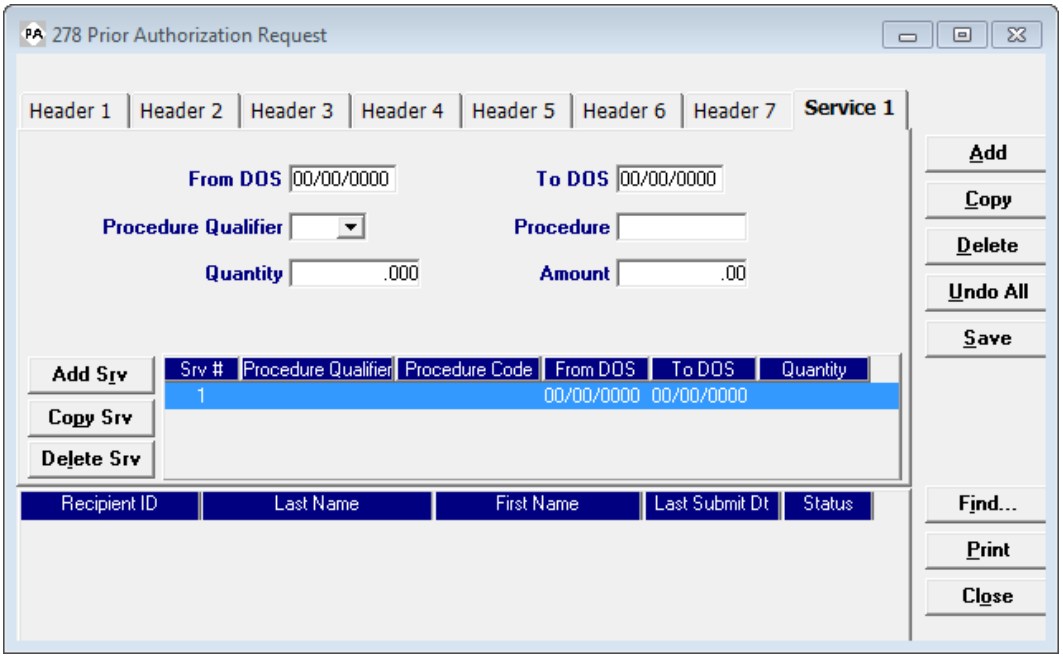
Service 1 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Service 1 tab.



Complete the following fields under the Service 1 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
From DOS	Enter the start date of service for each procedure requested in a MM/DD/CCYY format.
To DOS	Enter the stop date of service for each procedure requested in a MM/DD/CCYY format. If identical services (and charges) will be performed on the same day, enter the same date of service in both 'from' and 'to' fields.
Procedure Qualifier	Choose the best value to represent the origin of the procedure being billed. NOTE: When the PA is Inpatient or Psychiatric related, enter a valid revenue code into the procedure code field and chose 'HC' as the procedure qualifier. HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes AD American Dental Association Codes JP Universal National Tooth Designation System
Procedure	Choose the procedure being billed from the Procedure/HCPCS list. For Dental Providers: If a procedure code needs to be associated with a tooth number, first key a valid 5-digit procedure code. Press 'Copy Srv' to add a second detail line. On the newly copied detail line, choose JP in the Procedure Qualifier field and enter a valid 2-digit tooth number in the Procedure field. Repeat this for each procedure code which requires a corresponding tooth number. NOTE: Always file the procedure code first, and follow it with the tooth number. For multiple procedure codes, be sure to key in the next procedure code after the tooth numbers have been properly associated with the previous procedure code. For Inpatient/Psychiatric request: Instead of a procedure code, enter a valid revenue code.
Quantity	Enter the quantity being billed.

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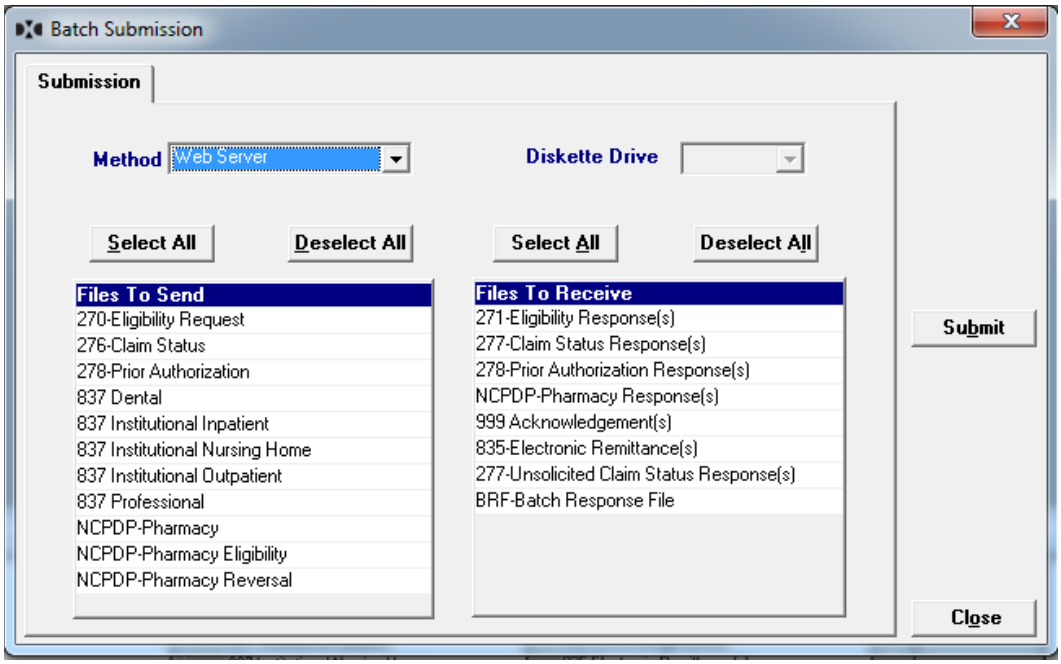
Field	*Guidelines*
Amount	If a quantity was not entered, then enter the amount (dollars and cents) of your customary charge.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

15.3 Submitting PA Request through Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select ‘Web Server’ from the drop down next to Method.

Step 3 Determine which files you want to send from the Files to send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the ‘Files to Receive’ list.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the ‘Submit’ to submit (and receive) the files.

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Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

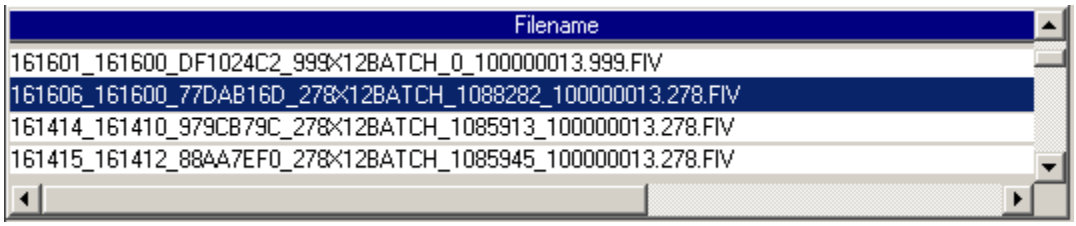
The batch number received is confirmation that your Prior Authorization Request has been received. It does not denote approval or denial of the requested service. After the Medicaid Agency reviews and approves or denies the request, a decision letter will be mailed to the rendering provider.

15.4 Reviewing a 278 Response

A response will be created in less than two hours after your submission. To download the response, please refer to *Section 15.3* and follow steps 4 – 5. Once this step has been completed, you may view the 278 response by going to Communication >> View Batch Response.

15.4.1 Reviewing a 278 Rejected Response

An example of the 278 rejected response is given below:



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Prior Authorization Request Batch Response 1

***** T R A N S A C T I O N I N F O R M A T I O N *****

Transaction Set Creation Date: 10/03/2011 2

Transaction Set Creation Time: 1420 3

***** P R O V I D E R I N F O R M A T I O N *****

Requesting Provider ID: 1234567890 4

***** R E C I P I E N T I N F O R M A T I O N *****

Recipient ID: 500000000000 5

Recipient Account #: #ABC/123 6

Yes/No Condition or Response: N 7

Reject Reason Code: C Please Correct and Resubmit 8

Follow-up Action Code: R Resubmission Allowed 9

***** S E R V I C E P R O V I D E R I N F O R M A T I O N *****

Trace Type Code: 1 10

Trace Number: 214 11

Trace Assigning Entity ID: 9111111111 12

Request Category Code: HS 13

PA Certification Type Code: I 14

Service Type Code: 18 15

Place Of Service: 12 16

Diagnosis Type 1: BK 17

Diagnosis Code 1: 25000 18

Request Status: Recipient Not on File 19

Rendering Provider ID: [illegible] 20

***** S E R V I C E L E V E L I N F O R M A T I O N *****

Service Date: 11/01/2011-11/30/2011 21

Procedure Qualifier: HC 22

Procedure Code: E0250 23

Procedure Amount: No Data 24

Quantity: 1.000 25

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The 278 Response fields are defined below:

Field #	Field	Guidelines
1	Prior Authorization Request Batch Response	This is the heading of your Prior Authorization response report.
2	Transaction Set Creation Date	This indicates the date in MM/DD/CCYY format of when the PA request was transmitted to Alabama Medicaid.
3	Transaction Set Creation Time:	This indicates the time when the PA request was transmitted to Alabama Medicaid in the military time format.
4	Requesting Provider ID	This reflects the requesting provider ID filed on Header 1 of the PA request form.
5	Recipient ID	This reflects the recipient ID entered on the PA request form on Header 1 tab.
6	Recipient Account Number	This reflects the recipient's account number entered on the PA request form.
7	Yes/No Condition or Response	This field is only available when the recipient's ID contains a rejection. This is represented by a value of 'N'.
8	Reject Reason Code	This field is only available when a request is rejected. HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
9	Follow-up Action Code	This field is only available when a request is rejected. This indicates the user to correct and resubmit the PA request. To do so, please refer to Section 15.1 on modifying a PA request.
10	Trace Type Code	Code identifying which transaction is being referenced.
11	Trace Number	Code that uniquely associates a request to a transaction.
12	Trace Assigning Entity ID	A unique identifier used to further track reference identification.
13	Request Category Code	This reflects the value chosen in the Request Category Code field on Service 1 of the PA request form.
14	PA Certification Type Code	This reflects the value chosen in the PA Certification Type Code field on Service 1 of the PA request form.
15	Service Type Code	This field is only available when a request is rejected. HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
16	Place of Service	This reflects the value chosen in the Place of Service field on Service 1 of the PA request form.
17	Diagnosis Type	Code indicating whether an ICD-9 diagnosis code or ICD-10 diagnosis code is entered on Header 2 of the PA request form. BK = ICD-9 ABK = ICD-10
18	Diagnosis Code	This reflects the diagnosis code entered on Header 2 of the PA request.
19	Request Status	This indicates whether the PA request was "Accepted – Pending Further Review" or "Rejected". If the PA request is rejected, an additional message will follow indicating the rejected reason. Once the Medicaid Agency reviews and approves or denies the request, an electronic response will be received with the "Approved" or "Denied" status. This information will also be mailed to the provider.
20	Rendering Provider ID	This reflects rendering provider ID entered in Header 3 of the PA request form.
21	Service Date	This reflects the date entered in the From DOS and To DOS fields on the Service Tab of the PA request form.
22	Procedure Qualifier	This reflects the value chosen in the Procedure Qualifier field on Service 1 of the PA request form.
23	Procedure Code	This reflects the value entered in the Procedure Code field on Service 1 of the PA request form.
24	Procedure Amount	This reflects the dollar amount entered in the 'Amount' field on the Service 1 tab of the PA request form.

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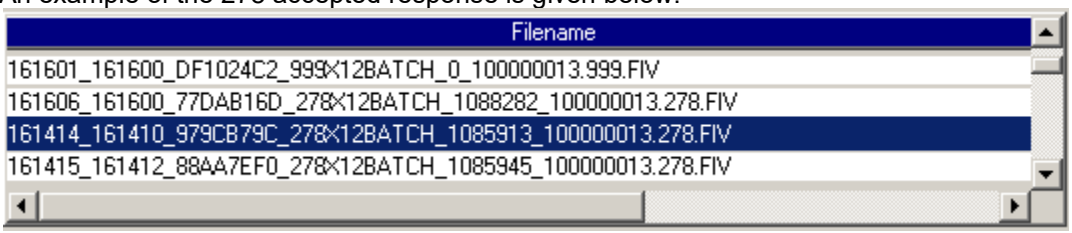
Field #	Field	Guidelines
25	Quantity	This reflects the number of units entered in the 'Quantity' field on the Service 1 tab of the PA request form.

NOTE:

If a PA request is accepted, the request will be forwarded to Alabama Medicaid's PA department for further review. Once the PA clerk approves or denies a Prior Authorization request, a letter of notification will be mailed to the provider's office. An electronic denial or acceptance response will also be available to the provider. This response may be received by performing steps 4 – 5 in Section 15.3 periodically. Please be aware that this approval or denial process can take up to 7-10 business days when all required information is available for review. For a PA status, you may contact provider assistance at 800-688-7989 and provide them with the PA number located on your original 278 response.

15.4.2 Reviewing a 278 Accepted Response

An example of the 278 accepted response is given below:



The 278 Response fields are defined below:

Field #	Field	Guidelines
1	Prior Authorization Request Batch Response	This is the heading of your Prior Authorization response report.
2	Transaction Set Creation Date	This indicates the date in MM/DD/CCYY format of when the PA request was transmitted to Alabama Medicaid.
3	Transaction Set Creation Time	This indicates the time when the PA request was transmitted to Alabama Medicaid in the military time format.
4	Requesting Provider ID	This reflects the requesting provider ID filed on Header 1 of the PA request.
5	Recipient ID	This reflects the recipient ID filed on the PA request.
6	Recipient Account #	This reflects the recipient account number indicated on Header 1 of the PA request.
7	Trace Type Code	Code identifying which transaction is being referenced.
8	Trace Number	Code that uniquely associates a request to a transaction.
9	Entity ID	Code identifying an organizational entity, a physical location, property or an individual.
10	Request Category Code	This code reflects the value chosen in the Request Category Code field on Header 2 of the PA request form.
11	PA Certification Type Code	This code reflects the value chosen in the PA Certification Type Code field on Header 2 of the PA request form.
12	Service Type Code	This code reflects the value entered in the Service Type Code on Header 2 of the PA request form.
13	Place of Service	This code reflects the value entered in the Place of Service field on Header 2 of the PA request form.
14	Certification Action Code	Displays the type of action taken toward the PA request or HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.

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15	PA Number	Prior Authorization Requ ***** T R A N S A C T I O N I N F O R Transaction Set Creation Date: 10/01/2011 2 Transaction Set Creation Time: 1720 3 ***** P R O V I D E R I N F O R M A T Requesting Provider ID: [redacted] 4 ***** R E C I P I E N T I N F O R M A Recipient ID: [redacted] 5 Recipient Account #: TEST FOR DF 9431 6 ***** S E R V I C E P R O V I D E R Trace Type Code: 1 7 Trace Number: 210 8 Trace Assigning Entity ID: 1111111111 9 Request Category Code: HS 10 PA Certification Type Code: I 11 Service Type Code: 18 12 Place Of Service: 12 13 Certification Action Code: Pending 14 PA Number: [redacted] 15 Reason Code: OV 16 Diagnosis Type 1: BK 17 Diagnosis Code 1: 4350 18 Request Status: ACCEPTED - PENDING F Rendering Provider ID: [redacted] 20 ***** S E R V I C E L E V E L I N F Service Date: 10/01/2011-12/31/201 Procedure Qualifier: HC 22 Procedure Code: E1150 23 Procedure Amount: No Data 24 Quantity: 1.000 25

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Field #	***Field***	***Guidelines***
		Once the pending PA is approved or denied, a response will be mailed and provided electronically. Please refer to the NOTE in Section 15.4.1 for further information.
16	Reason Code	HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
17	Diagnosis Type	Code indicating whether an ICD-9 diagnosis code or ICD-10 diagnosis code is entered on Header 2 of the PA request form. BK = ICD-9 ABK = ICD-10
18	Diagnosis Code	This reflects the diagnosis code entered on Header 2 of the PA request.
19	Request Status	This indicates whether the PA request was "Accepted – Pending Further Review" or "Rejected." If the PA request was rejected, an additional message will follow indicating the rejected reason. Once the Medicaid Agency reviews and approves or denies the request, an electronic response will be received with the "Approved" or "Denied" status. This information will also be mailed to the provider.
20	Rendering Provider ID	This reflects rendering provider ID entered in Header 3 of the PA request form.
21	Service Date	This reflects the value entered in the From and To Date of Service fields on Service 1 of the PA request form.
22	Procedure Qualifier	This reflects the value chosen in the Procedure Qualifier field on Service 1 of the PA request form.
23	Procedure Code	This reflects the value entered in the Procedure Code field on Service 1 of the PA request form.
24	Procedure Amount	This reflects the value entered in the Amount field on Service 1 of the PA request form.
25	Quantity	This reflects the value entered in the Quantity field on Service 1 of the PA request form.

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16

16 Submitting 276 Claim Status Request

This chapter provides instructions for submitting electronic requests for 276 Claim Status. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

276 Claim status requests through the Provider Electronic Solutions will only return claim status on Alabama Medicaid fee-for-service claims.

Users access the 276 Claim Status form using one of the following methods:

- Selecting the 276 Claim Status icon from the toolbar called 'Claim Status'
- Selecting Forms>>276 Claim Status Request

The electronic form displays with two tabs: Header 1 and Header 2.

16.1 Entering Requests Using the 276 Claim Status Request Form

Each tab on the 276 Claim Status Request form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code for different recipients or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.

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Button	*Usage*
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 276 Claim Status Request form. Key information into all required fields. (All fields are required unless indicated as optional.)

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct the mistake(s) and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. *You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete*). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Be sure to save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claim status requests created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claim status request. All requests submitted using PES version 3.0 must be created in the 3.0 software as a new request.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

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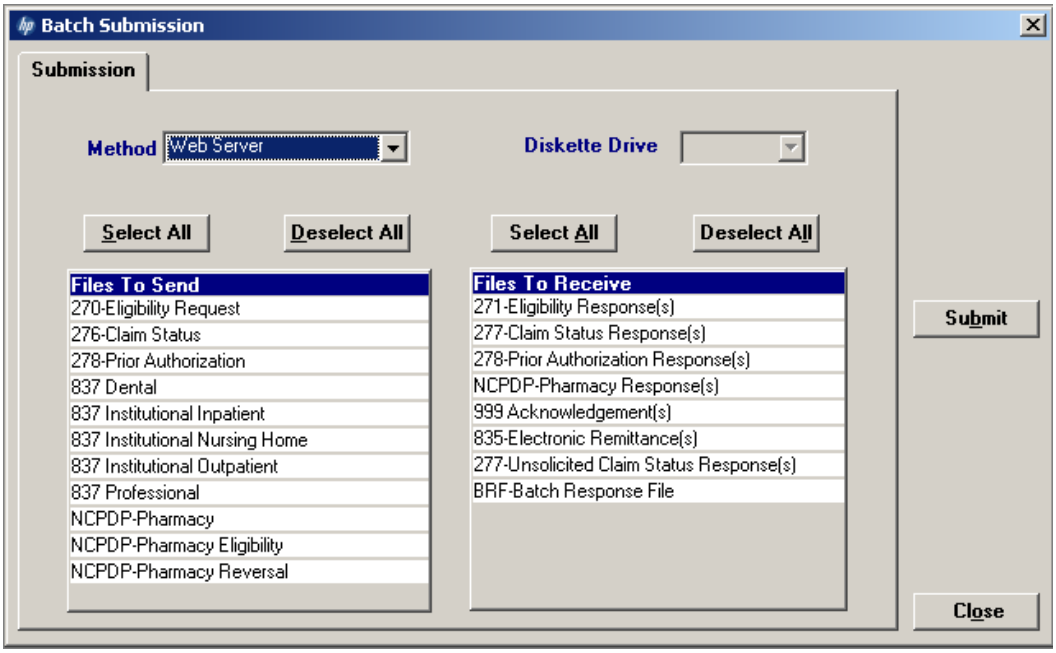
16.2 Submitting Claims through Batch

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Select 'Web Server' from the drop down next to Method.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine the files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 5 Press the 'Submit' button to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Step 6

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Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

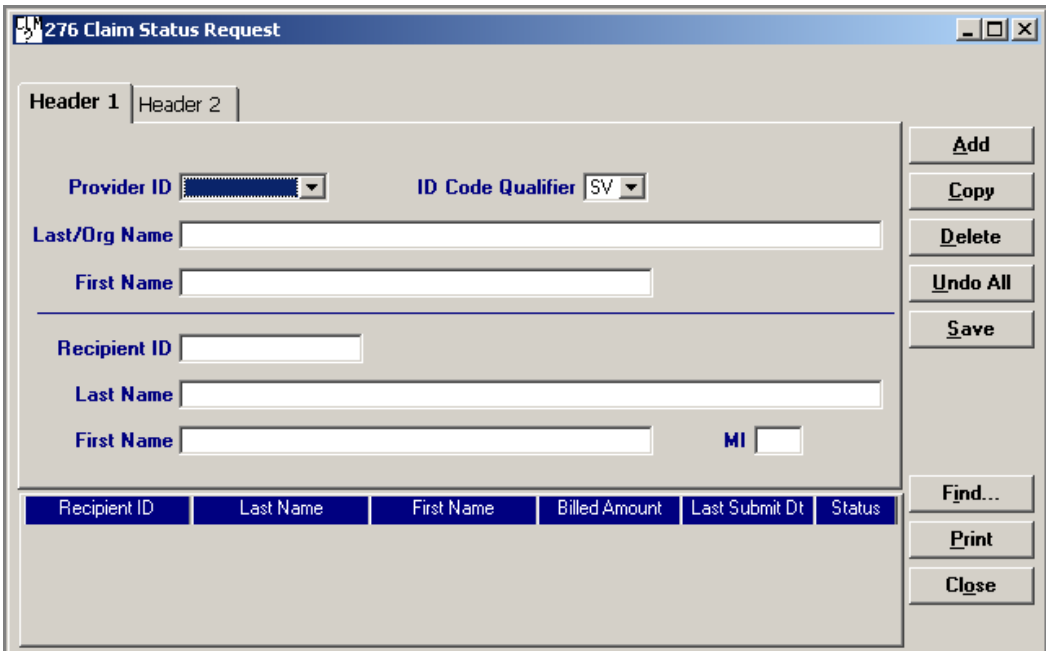
When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.* If you have questions regarding the claim status response codes that accompany your response, refer to Appendix A, Rejection Codes, to get a listing of all Claim Status Codes and definitions.

A NOTE on the Claim Status Response: When checking Claim Status, Providers will now see '19000101' displayed in the paid date field if a claim(s) has been adjudicated but has not gone through a check-write cycle. Once the claim(s) process through the check-write cycle, it will display the appropriate check-write date.

16.3 Completing the 276 Claim Status Request Form

16.3.1 Header 1 Tab

Below is a sample electronic 276 Claim Status Request form displaying the Header 1 tab.



Complete the fields described below for the Header 1 tab:

Field	*Guidelines*
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Code Qualifier	Select the value that identifies the entity that assigned the ID.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.

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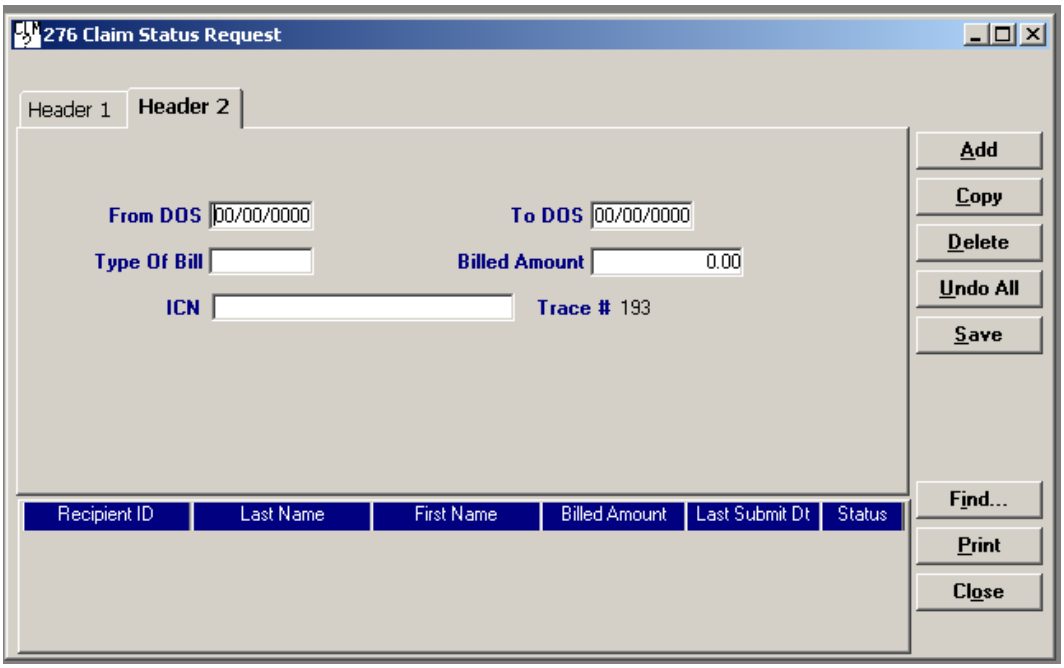
Field	*Guidelines*
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.
MI	If a middle initial entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.

16.3.2 Header 2 Tab

Below is a sample electronic 276 Claim Status Request form displaying the Header 2 tab.



Complete the fields described below for the Header 2 tab:

Field	*Guidelines*
From DOS	Enter the start date filed on the claim in MM/DD/CCYY format.
To DOS	Enter the stop date filed on the claim in MM/DD/CCYY format.
Type of Bill	Enter the code specifying the type of facility where the medical service was performed. This only applies to Institutional claim form types. This field is optional.
Billed Amount	Enter the amount you have billed Medicaid on the requested claim. *Do Not* enter the amount Medicaid is scheduled to pay.
ICN	Enter the Internal Control Number, or claims tracking Identification number. This field is optional.
Trace #	This field allows you to utilize the trace # that is also located on the 276 response to locate which request the response is referring to.

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17

17 The Web Server

This chapter provides instructions on what steps to take when connecting to the web Server to update your passwords according to the logon ID's provided to you by the EMC Helpdesk.

Users access the Web Server by the following methods:

- Connecting through an ISP (Internet Service Provider)
- Connecting through the RAS (an option provided by the *Provider Electronic Solutions* software)

17.1 Updating and Maintaining your Web Server Password

Now that you have your Provider Electronic Solutions software, a representative needs to contact one of the following telephone numbers to request a logon ID and password to connect to the Web Server:

- Providers located in Alabama: Contact the EMC Helpdesk at 1-800-456-1242.
- Providers located outside the state of Alabama: Dial (334) 215-0111 and ask for the EMC Helpdesk.

You may connect to the Web Server either through an ISP (Internet Service Provider) or through Remote Access Server (RAS).

17.1.1 Connecting through an ISP (Internet Service Provider)

This section will inform you how to logon to the Web Server through an ISP (Internet Service Provider), such as AOL, NetZero, etc.

Step 1 Open your ISP application and connect to the Internet accordingly.

Step 2 Once properly logged onto the World Wide Web, type in the following URL:

Step 3 https://www.medicaid.alabamaservices.org/ALPortalContinue to **Step 3** in section 17.1.3 Updating your Password for further instructions.

17.1.2 Connecting through RAS

Connecting through RAS (Remote Access Server) is an option created by the *Provider Electronic Solutions* software. This section will inform you how to logon to the Web Server through RAS if you do not have an ISP.

This method requires you to have Internet Explorer version 5.5 and a dial-up modem. If you do not have one or the other, you will need to contact your computer administrator to have it set up for you.

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NOTE:

Before beginning this process, you should have followed the instructions outlined in section 2.5.2 Web Tab. If you have not, please refer to the instructions to set up your connection method through 'modem'. You will need to follow the instructions described in the 'Install RAS' and the 'Dialup Network' fields.

Step 1 Open your AL RAS connection. To do so, click on Start >> Settings >> Control Panel >> 'Network and Dial-Up Connections' and open the 'AL RAS' option.

Step 2 Once opened, a screen should appear as shown below: (If you have completed these steps you may continue to **Step 3** in section 17.1.3 Updating your Password for further instructions.)

NOTE:

Enter your Trading Partner ID in the User Name and password fields. Contact the EMC Helpdesk at 800-456-1242 to give them your Trading partner ID so that dial-up permissions can be granted to you.

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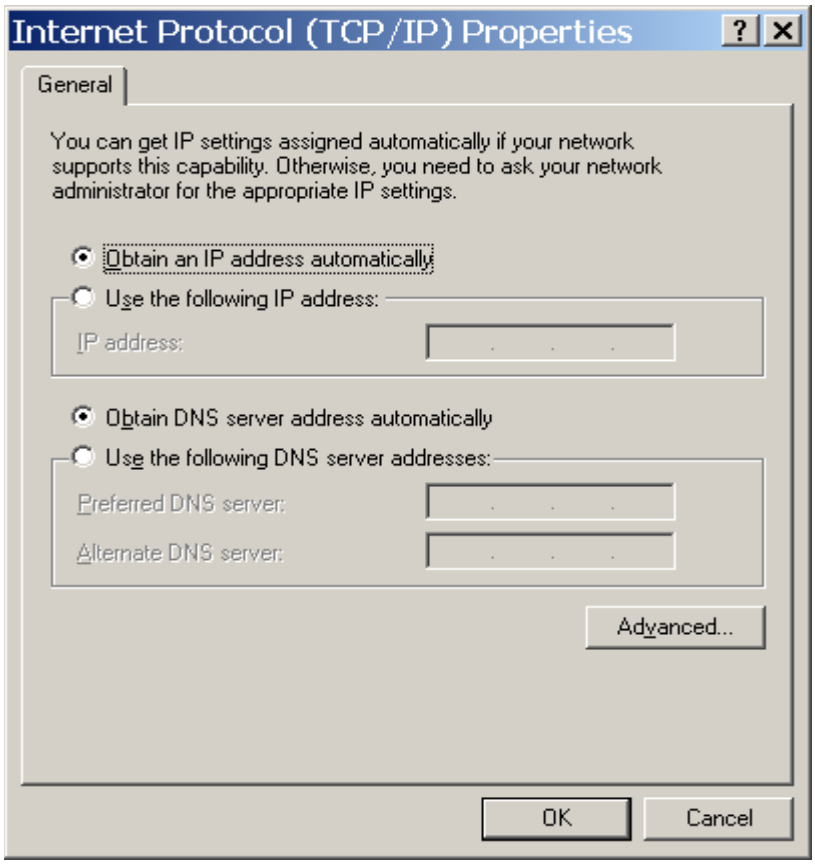
Step 3 Click on ‘Properties’ and click on the ‘Networking’ tab. A sample screen is pictured below:



Step 4 Make sure the Internet Protocol (TCP/IP) option is highlighted and click on ‘Properties’.

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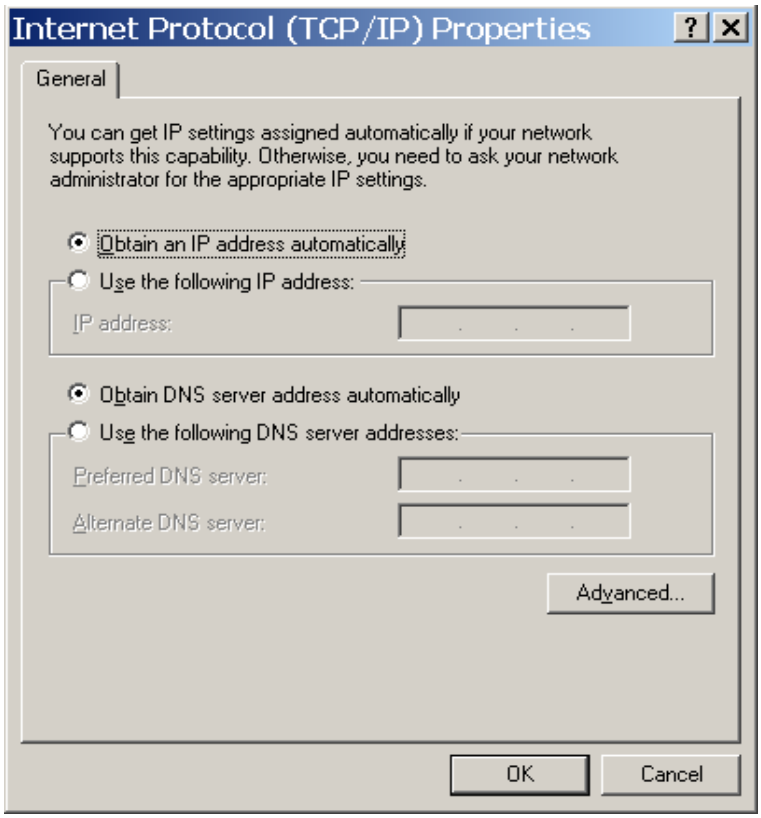
Step 5 Make sure the option for '**Obtain DNS server address automatically**' has been chosen.



Step 6 Click 'OK' to save your changes. Click on 'OK' to exit the Networking tab.

Step 7 Click 'DIAL' to continue to connect through RAS. This will begin the dial-up process according to the number you entered in the web tab. Refer to section 2.5.2 Web Tab.

Step 8 Once connected you may open your Internet Explorer browser.

Step 9 The options for accessing your Internet Explorer browser are described below:

- Go to your Internet Explorer icon located on your desktop.

Click on Start >> Programs >> Internet Explorer. In the browser address bar, enter https://www.medicaid.alabamaservices.org/ALPortal; and then press the **Enter** key on your keyboard."

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NOTE:

If you have a default home page within your IE browser, a message may appear that it was unable to connect. Ignore this message and in https://www.medicaid.alabamaservices.org/ALPortal

Step 10 Continue to **Step 3** in section 17.1.3 Updating your Password for further instructions.

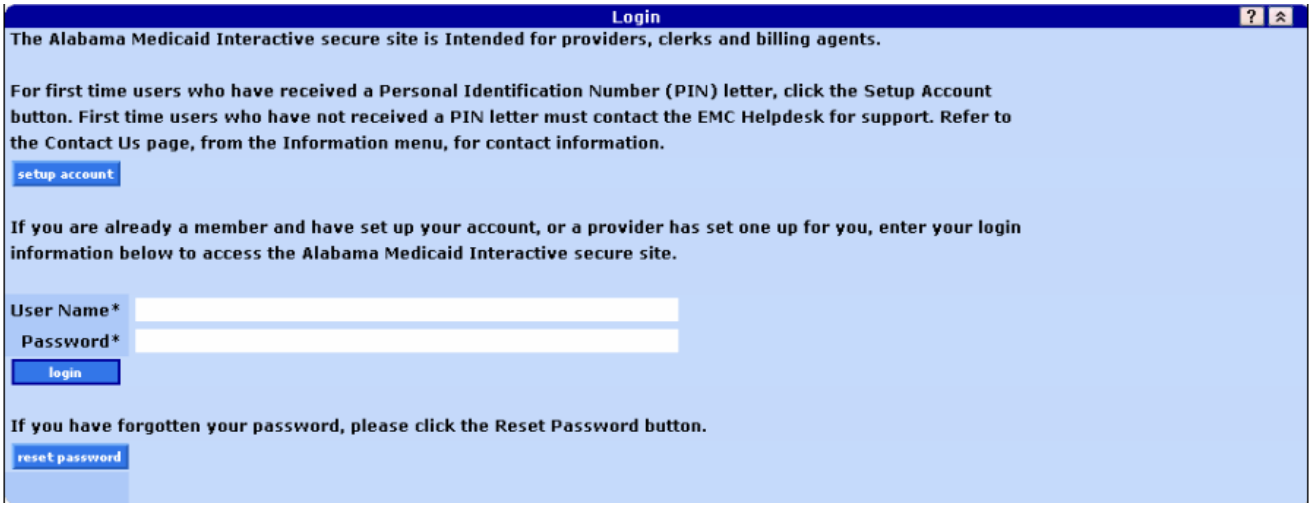
17.1.3 Updating your Password

Your password will need to be updated before a transmission can be attempted through the software. As a security measure, this password will need to be updated every 60 days. Follow the steps below to complete this process according to the method you use to connect to the Internet.

Step 1 Connect to the Web Server using either method as outlined above. Click 'Account' then 'Secure Site' to reach the Logon page.

Step 2 To change your password, follow steps 3 through 9.

Step 3 The main logon screen will look as follows:



Step 4 Type in the Web Logon ID and Web password you have keyed within your Tools >> Options screen. (Refer to section *2.5.1 Batch Tab)*

Step 5 Press the 'Login' button to continue.

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Step 6 A screen should appear as follows:

Step 7 Enter your current and new password in the designated fields. Press the 'change password' button to continue.

Step 8 You will be notified if you have completed this update successfully.

Step 9 Go to Account>>Logoff and proceed to your Tools >> Options screen to enter your updated password. (Refer to section 2.5.1 Batch Tab).

Providers that use the Provider Electronic Software to submit claims to Alabama Medicaid are required to use their new web user ID and password after creating one on the new Interactive Services website. In addition, Provider Electronic Software users are required to request a new Trading Partner ID.

NOTE:

To update the Provider Electronic Software with the new user ID and password, click on Tools >> Options within the Provider Electronic Software. Select the Batch Tab. Enter the new web user ID and password in the corresponding fields displayed.

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A Health Care Claim Status Code

This appendix lists codes that may appear on a Claim Status response. Section A.1, Health Care Claim Status Codes, lists codes that display on the Claim Status response.

A.1 Health Care Claim Status Codes

Below is a list of all Claim Status Codes (CSC) and Descriptions.

CSC	Description
0	Cannot provide further status electronically.
1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
8	No payment due to contract/plan provisions.
9	No payment will be made for this claim.
10	All originally submitted procedure codes have been combined.
11	Some originally submitted procedure codes have been combined.
12	One or more originally submitted procedure codes have been combined.
13	All originally submitted procedure codes have been modified.
14	Some originally submitted procedure codes have been modified.
15	One or more originally submitted procedure codes have been modified.
16	Claim/encounter has been forwarded to entity.
17	Claim/encounter has been forwarded by third party entity to entity.
18	Entity received claim/encounter, but returned invalid status.
19	Entity acknowledges receipt of claim/encounter.
20	Accepted for processing.
21	Missing or invalid information.
22	... before entering the adjudication system.

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CSC	Description
23	Returned to Entity.
24	Entity not approved as an electronic submitter.
25	Entity not approved.
26	Entity not found.
27	Policy canceled.
28	Claim submitted to wrong payer.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber ID mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber ID not found.
34	Subscriber and policyholder name not found.
35	Claim/encounter not found.
37	Predetermination is on file, awaiting completion of services.
38	Awaiting next periodic adjudication cycle.
39	Charges for pregnancy deferred until delivery.
40	Waiting for final approval.
41	Special handling required at payer site.
42	Awaiting related charges.
44	Charges pending provider audit.
45	Awaiting benefit determination.
46	Internal review/audit.
47	Internal review/audit - partial payment made.
48	Referral/authorization.
49	Pending provider accreditation review.
50	Claim waiting for internal provider verification.
51	Investigating occupational illness/accident.
52	Investigating existence of other insurance coverage.
53	Claim being researched for Insured ID/Group Policy Number error.
54	Duplicate of a previously processed claim/line.
55	Claim assigned to an approver/analyst.
56	Awaiting eligibility determination.
57	Pending COBRA information requested.
59	Non-electronic request for information.
60	Electronic request for information.

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CSC	Description
61	Eligibility for extended benefits.
64	Re-pricing information.
65	Claim/line has been paid.
66	Payment reflects usual and customary charges.
67	Payment made in full.
68	Partial payment made for this claim.
69	Payment reflects plan provisions.
70	Payment reflects contract provisions.
71	Periodic installment released.
72	Claim contains split payment.
73	Payment made to entity, assignment of benefits not on file.
78	Duplicate of an existing claim/line, awaiting processing.
81	Contract/plan does not cover pre-existing conditions.
83	No coverage for newborns.
84	Service not authorized.
85	Entity not primary.
86	Diagnosis and patient gender mismatch.
87	Denied: Entity not found.
88	Entity not eligible for benefits for submitted dates of service.
89	Entity not eligible for dental benefits for submitted dates of service.
90	Entity not eligible for medical benefits for submitted dates of service.
91	Entity not eligible/not approved for dates of service.
92	Entity does not meet dependent or student qualification.
93	Entity is not selected primary care provider.
94	Entity not referred by selected primary care provider.
95	Requested additional information not received.
96	No agreement with entity.
97	Patient eligibility not found with entity.
98	Charges applied to deductible.
99	Pre-treatment review.
100	Pre-certification penalty taken.
101	Claim was processed as adjustment to previous claim.
102	Newborn's charges processed on mother's claim.
103	Claim combined with other claim(s).
104	Processed according to plan provisions.

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CSC	Description
105	Claim/line is capitated.
106	This amount is not entity's responsibility.
107	Processed according to contract/plan provisions.
108	Coverage has been canceled for this entity.
109	Entity not eligible.
110	Claim requires pricing information.
111	At the policyholder's request these claims cannot be submitted electronically.
112	Policyholder processes their own claims.
113	Cannot process individual insurance policy claims.
114	Should be handled by entity.
115	Cannot process HMO claims.
116	Claim submitted to incorrect payer.
117	Claim requires signature-on-file indicator.
118	TPO rejected claim/line because payer name is missing.
119	TPO rejected claim/line because certification information is missing.
120	TPO rejected claim/line because claim does not contain enough information.
121	Service line number greater than maximum allowable for payer.
122	Missing/invalid data prevents payer from processing claim.
123	Additional information requested from entity.
124	Entity's name, address, phone and ID number.
125	Entity's name.
126	Entity's address.
127	Entity's phone number.
128	Entity's tax ID.
129	Entity's Blue Cross provider ID.
130	Entity's Blue Shield provider ID.
131	Entity's Medicare provider ID.
132	Entity's Medicaid provider ID.
133	Entity's UPIN.
134	Entity's CHAMPUS provider ID.
135	Entity's commercial provider ID.
136	Entity's health industry ID number.
137	Entity's plan network ID.

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CSC	Description
138	Entity's site ID.
139	Entity's health maintenance provider ID (HMO).
140	Entity's preferred provider organization ID (PPO).
141	Entity's administrative services organization ID (ASO).
142	Entity's license/certification number.
143	Entity's state license number.
144	Entity's specialty license number.
145	Entity's specialty code.
146	Entity's anesthesia license number.
147	Entity's qualification degree/designation (e.g. RN,PhD,MD).
148	Entity's social security number.
149	Entity's employer ID.
150	Entity's drug enforcement agency (DEA) number.
152	Pharmacy processor number.
153	Entity's ID number.
154	Relationship of surgeon & assistant surgeon.
155	Entity's relationship to patient.
156	Patient relationship to subscriber.
157	Entity's Gender.
158	Entity's date of birth.
159	Entity's date of death.
160	Entity's marital status.
161	Entity's employment status.
162	Entity's health insurance claim number (HICN).
163	Entity's policy number.
164	Entity's contract/member number.
165	Entity's employer name, address and phone.
166	Entity's employer name.
167	Entity's employer address.
168	Entity's employer phone number.
169	Entity's employer ID.
170	Entity's employee ID.
171	Other insurance coverage information (health, liability, auto, etc.).
172	Other employer name, address and telephone number.

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CSC	Description
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.
174	Entity's student status.
175	Entity's school name.
176	Entity's school address.
177	Transplant recipient's name, date of birth, gender, relationship to insured.
178	Submitted charges.
179	Outside lab charges.
180	Hospital s semi-private room rate.
181	Hospital s room rate.
182	Allowable/paid from primary coverage.
183	Amount entity has paid.
184	Purchase price for the rented durable medical equipment.
185	Rental price for durable medical equipment.
186	Purchase and rental price of durable medical equipment.
187	Date(s) of service.
188	Statement from-through dates.
189	Hospital admission date.
190	Hospital discharge date.
191	Date of Last Menstrual Period (LMP).
192	Date of first service for current series/symptom/illness.
193	First consultation/evaluation date.
194	Confinement dates.
195	Unable to work dates.
196	Return to work dates.
197	Effective coverage date(s).
198	Medicare effective date.
199	Date of conception and expected date of delivery.
200	Date of equipment return.
201	Date of dental appliance prior placement.
202	Date of dental prior replacement/reason for replacement.
203	Date of dental appliance placed.
204	Date dental canal(s) opened and date service completed.
205	Date(s) dental root canal therapy previously performed.

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CSC	Description
206	Most recent date of curettage, root planing, or periodontal surgery.
207	Dental impression and seating date.
208	Most recent date pacemaker was implanted.
209	Most recent pacemaker battery change date.
210	Date of the last x-ray.
211	Date(s) of dialysis training provided to patient.
212	Date of last routine dialysis.
213	Date of first routine dialysis.
214	Original date of prescription/orders/referral.
215	Date of tooth extraction/evolution.
216	Drug information.
217	Drug name, strength and dosage form.
218	NDC number.
219	Prescription number.
220	Drug product ID number.
221	Drug days supply and dosage.
222	Drug dispensing units and average wholesale price (AWP).
223	Route of drug/myelogram administration.
224	Anatomical location for joint injection.
225	Anatomical location.
226	Joint injection site.
227	Hospital information.
228	Type of bill for UB-04 claim.
229	Hospital admission source.
230	Hospital admission hour.
231	Hospital admission type.
232	Admitting diagnosis.
233	Hospital discharge hour.
234	Patient discharge status.
235	Units of blood furnished.
236	Units of blood replaced.
237	Units of deductible blood.
238	Separate claim for mother/baby charges.
239	Dental information.
240	Tooth surface(s) involved.

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CSC	Description
241	List of all missing teeth (upper and lower).
242	Tooth numbers, surfaces, and/or quadrants involved.
243	Months of dental treatment remaining.
244	Tooth number or letter.
245	Dental quadrant/arch.
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.
247	Line information.
248	Accident date, state, description and cause.
249	Place of service.
250	Type of service.
251	Total anesthesia minutes.
252	Authorization/certification number.
253	Procedure/revenue code for service(s) rendered. Please use codes 454 or 455.
254	Primary diagnosis code.
255	Diagnosis code.
256	DRG code(s).
257	ADSM-III-R code for services rendered.
258	Days/units for procedure/revenue code.
259	Frequency of service.
260	Length of medical necessity, including begin date.
261	Obesity measurements.
262	Type of surgery/service for which anesthesia was administered.
263	Length of time for services rendered.
264	Number of liters/minute & total hours/day for respiratory support.
265	Number of lesions excised.
266	Facility point of origin and destination - ambulance.
267	Number of miles patient was transported.
268	Location of durable medical equipment use.
269	Length/size of laceration/tumor.
270	Subluxation location.
271	Number of spine segments.
272	Oxygen contents for oxygen system rental.
273	Weight.

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CSC	Description
274	Height.
275	Claim.
276	UB-04/CMS-1450/CMS-1500 claim form.
277	Paper claim.
278	Signed claim form.
279	Itemized claim.
280	Itemized claim by provider.
281	Related confinement claim.
282	Copy of prescription.
283	Medicare worksheet.
284	Copy of Medicare ID card.
285	Vouchers/Remittance Advices (RAs).
286	Other payer's Explanation of Benefits/payment information.
287	Medical necessity for service.
288	Reason for late hospital charges.
289	Reason for late discharge.
290	Pre-existing information.
291	Reason for termination of pregnancy.
292	Purpose of family conference/therapy.
293	Reason for physical therapy.
294	Supporting documentation.
295	Attending physician report.
296	Nurse's notes.
297	Medical notes/report.
298	Operative report.
299	Emergency room notes/report.
300	Lab/test report/notes/results.
301	MRI report.
302	Refer to codes 300 for lab notes and 311 for pathology notes.
303	Physical therapy notes. Please use code 297:6O (6 'OH' - not zero).
304	Reports for service.
305	X-ray reports/interpretation.
306	Detailed description of service.
307	Narrative with pocket depth chart.
308	Discharge summary.

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CSC	Description
309	Code was duplicate of code 299.
310	Progress notes for the six months prior to statement date.
311	Pathology notes/report.
312	Dental charting.
313	Bridgework information.
314	Dental records for this service.
315	Past period treatment history.
316	Complete medical history.
317	Patient's medical records.
318	X-rays.
319	Pre/post-operative x-rays/photographs.
320	Study models.
321	Radiographs or models.
322	Recent fm x-rays.
323	Study models, x-rays, and/or narrative.
324	Recent x-ray of treatment area and/or narrative.
325	Recent fm x-rays and/or narrative.
326	Copy of transplant acquisition invoice.
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.
328	Speech therapy notes. Please use code 297:6R.
329	Exercise notes.
330	Occupational notes.
331	History and physical.
332	Authorization/certification (include period covered).
333	Patient release of information authorization.
334	Oxygen certification.
335	Durable medical equipment certification.
336	Chiropractic certification.
337	Ambulance certification/documentation.
338	Home health certification. Please use code 332:4Y.
339	Enteral/parenteral certification.
340	Pacemaker certification.
341	Private duty nursing certification.
342	Podiatric certification.

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CSC	Description
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.
344	Documentation that provider of physical therapy is Medicare Part B approved.
345	Treatment plan for service/diagnosis.
346	Proposed treatment plan for next 6 months.
347	Refer to code 345 for treatment plan and code 282 for prescription.
348	Chiropractic treatment plan.
349	Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P.
350	Speech pathology treatment plan. Please use code 345:6R.
351	Physical/occupational therapy treatment plan. Please use codes 345:6O (6 'OH' - not zero), 6N.
352	Duration of treatment plan.
353	Orthodontics treatment plan.
354	Treatment plan for replacement of remaining missing teeth.
355	Has claim been paid?
356	Was blood furnished?
357	Has or will blood be replaced?
358	Does provider accept assignment of benefits?
359	Is there a release of information signature on file?
360	Is there an assignment of benefits signature on file?
361	Is there other insurance?
362	Is the dental patient covered by medical insurance?
363	Will worker's compensation cover submitted charges?
364	Is accident/illness/condition employment related?
365	Is service the result of an accident?
366	Is injury due to auto accident?
367	Is service performed for a recurring condition or new condition?
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?
369	Does patient condition preclude use of ordinary bed?
370	Can patient operate controls of bed?
371	Is patient confined to room?
372	Is patient confined to bed?
373	Is patient an insulin diabetic?

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CSC	Description
374	Is prescribed lenses a result of cataract surgery?
375	Was refraction performed?
376	Was charge for ambulance for a round-trip?
377	Was durable medical equipment purchased new or used?
378	Is pacemaker temporary or permanent?
379	Were services performed supervised by a physician?
380	Were services performed by a CRNA under appropriate medical direction?
381	Is drug generic?
382	Did provider authorize generic or brand name dispensing?
383	Was nerve block used for surgical procedure or pain management?
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?
385	Is appliance upper or lower arch & is appliance fixed or removable?
386	Is service for orthodontic purposes?
387	Date patient last examined by entity.
388	Date post-operative care assumed.
389	Date post-operative care relinquished.
390	Date of most recent medical event necessitating service(s).
391	Date(s) dialysis conducted.
392	Date(s) of blood transfusion(s).
393	Date of previous pacemaker check.
394	Date(s) of most recent hospitalization related to service.
395	Date entity signed certification/recertification.
396	Date home dialysis began.
397	Date of onset/exacerbation of illness/condition.
398	Visual field test results.
399	Report of prior testing related to this service, including dates.
400	Claim is out of balance.
401	Source of payment is not valid.
402	Amount must be greater than zero.
403	Entity referral notes/orders/prescription.
404	Specific findings, complaints, or symptoms necessitating service.
405	Summary of services.
406	Brief medical history as related to service(s).

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CSC	Description
407	Complications/mitigating circumstances.
408	Initial certification.
409	Medication logs/records (including medication therapy).
410	Explain differences between treatment plan and patient's condition.
411	Medical necessity for non-routine service(s).
412	Medical records to substantiate decision of non-coverage.
413	Explain/justify differences between treatment plan and services rendered.
414	Need for more than one physician to treat patient.
415	Justify services outside composite rate.
416	Verification of patient's ability to retain and use information.
417	Prior testing, including result(s) and date(s) as related to service(s).
418	Indicating why medications cannot be taken orally.
419	Individual test(s) comprising the panel and the charges for each test.
420	Name, dosage and medical justification of contrast material used for radiology procedure.
421	Medical review attachment/information for service(s).
422	Homebound status.
423	Prognosis.
424	Statement of non-coverage including itemized bill.
425	Itemize non-covered services.
426	All current diagnoses.
427	Emergency care provided during transport.
428	Reason for transport by ambulance.
429	Loaded miles and charges for transport to nearest facility with appropriate services.
430	Nearest appropriate facility.
431	Provide condition/functional status at time of service.
432	Date benefits exhausted.
433	Copy of patient revocation of hospice benefits.
434	Reasons for more than one transfer per entitlement period.
435	Notice of Admission.
436	Short term goals.
437	Long term goals.
438	Number of patients attending session.
439	Size, depth, amount, and type of drainage wounds.

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CSC	Description
440	Why non-skilled caregiver has not been taught procedure.
441	Entity professional qualification for service(s).
442	Modalities of service.
443	Initial evaluation report.
444	Method used to obtain test sample.
445	Explain why hearing loss not correctable by hearing aid.
446	Documentation from prior claim(s) related to service(s).
447	Plan of teaching.
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.
449	Projected date to discontinue service(s).
450	Awaiting spend down determination.
451	Preoperative and post-operative diagnosis.
452	Total visits in total number of hours/day and total number of hours/week.
453	Procedure Code Modifier(s) for Service(s) Rendered.
454	Procedure code for services rendered.
455	Revenue code for services rendered.
456	Covered Day(s).
457	Non-Covered Day(s).
458	Coinsurance Day(s).
459	Lifetime Reserve Day(s).
460	NUBC Condition Code(s).
461	NUBC Occurrence Code(s) and Date(s).
462	NUBC Occurrence Span Code(s) and Date(s).
463	NUBC Value Code(s) and/or Amount(s).
464	Payer Assigned Control Number.
465	Principal Procedure Code for Service(s) Rendered.
466	Entities Original Signature.
467	Entity Signature Date.
468	Patient Signature Source.
469	Purchase Service Charge.
470	Was service purchased from another entity?
471	Were services related to an emergency?

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CSC	Description
472	Ambulance Run Sheet.
473	Missing or invalid lab indicator.
474	Procedure code and patient gender mismatch.
475	Procedure code not valid for patient age.
476	Missing or invalid units of service.
477	Diagnosis code pointer is missing or invalid.
478	Claim submitter's identifier (patient account number) is missing.
479	Other Carrier payer ID is missing or invalid.
480	Other Carrier Claim filing indicator is missing or invalid.
481	Claim/submission format is invalid.
482	Date Error, Century Missing.
483	Maximum coverage amount met or exceeded for benefit period.
484	Business Application Currently Not Available.
485	More information available than can be returned in real time mode. Narrow your current search criteria.
486	Principal Procedure Date.
487	Claim not found, claim should have been submitted to/through 'entity'.
488	Diagnosis code(s) for the services rendered.

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B

B Code Lists

This Appendix gives the various codes listed from the drop down menus of the Alabama Provider Electronic Solutions Software.

B.1 Occurrence Codes

Occurrence Codes	Description
01	Auto Accident
02	No Fault Insurance Involved-Including Auto Accident/Other
03	Accident/Tort Liability
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual
17	Date Outpatient Occupational Therapy Plan Established
18	Date of Retirement - Patient/Beneficiary
19	Date of Retirement - Spouse
20	Date Guarantee of Payment Began
21	Date UR Notice Received
22	Date Active Care Ended
23	Date of Cancellation of Hospice Election Period
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF Bed Became Available
27	Date of Hospice Certification or Precertification
28	Date Comprehensive Outpatient Rehab Plan Established
29	Date Outpatient Physical Therapy Plan Established
30	Date Outpatient Speech Pathology Plan Established
31	Date Beneficiary Notified of Intent to Bill Accommodations
32	Date Beneficiary Notified of Intent to Bill Procedures
33	First Day of Medicare Coordination Period-ESRD Beneficiaries
34	Date of Election of Extended Care Facilities
35	Date Treatment Started for Physical Therapy
36	Date of Inpatient Hosp Discharge-Covered Transplant Patients
37	Date of Inpatient Hospital Discharge-Noncovrd Transplant Pat
38	Date Treatment Started for Home IV Therapy

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39	Date Discharged on a Continuous Course of IV Therapy
40	Scheduled Date of Admission
41	Date of First Test Pre-Admission Testing
42	Date of Discharge
43	Scheduled Date of Canceled Surgery
44	Date Treatment Started Occupational Therapy
45	Date Treatment Started for Speech Therapy
46	Date Treatment Started for Cardiac Rehabilitation
51	Overnight Delivery Room
74	Noncovered Level of Care/Leave of Absence
99	ICU/CCU Stay
A0	Reserved For National Assignment
A1	Birthdate - Insured A
A2	Effective Date - Insured A Policy
A3	Benefits Exhausted
A4	Split Bill Date
B0	Reserved For National Assignment
B1	Birthdate - Insured B
B2	Effective Date - Insured B Policy
B3	Benefits Exhausted
C0	Reserved For National Assignment
C1	Birthdate - Insured C
C2	Effective Date - Insured C Policy
C3	Benefits Exhausted
E0	Reserved For National Assignment
E1	Birthdate - Insured D
E2	Effective Date - Insured D Policy
E3	Benefits Exhausted
F0	Reserved For National Assignment
F1	Birthday - Insured E
F2	Effective Date - Insured E Policy
F3	Benefits Exhausted
G0	Reserved For National Assignment
G1	Birthdate - Insured F
G2	Effective Date - Insured F Policy
G3	Benefits Exhausted
M3	ICF Level of Care
M4	Residential Level of Care

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B.2 Condition Codes

Condition Code	Description
15	Payer Codes
16	Payer Codes
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mothers Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice
22	Patient On Multiple Drug Regimen
23	Home Caregiver Available
24	Home IV Patient Also Receiving-HHA Services
25	Patient is Non-U.S. Resident
26	VA Eligible Patient Receive Svcs in Medicare Cert Facility
27	Patient Referred to a Sole Community Hospital
28	Patient and/or Spouse EGHP is Secondary to Medicare
29	Disabled Beneficiary/Family Mbr LGHP Secondary to Medicare
30	Qualifying Clinical Trails
31	Patient is Student (Full Time - Day)
32	Patient is Student (Cooperative/Work Study Program)
33	Patient is Student (Full Time - Night)
34	Patient is Student (Part Time)
35	Reserved For National Assignment
36	General Care Patient in a Special Unit
37	Ward Accommodation at Patient Request
38	Semi-Private Room not Available
39	Private Room Medically Necessary
40	Same Day Transfer
41	Partial Hospitalization
42	Continuing Care Not Related To Inpatient Admission
43	Continuing Care Not Provided Within Postdischarge Window
44	Inpatient Admission Change to Outpatient
46	Non-Availability Statement on File
47	Reserved For Champus Assignment
48	Psychiatric Residential Treatment Ctr for Children & Adolesc
49	Product Replacement Within Product Lifecycle
50	Product Replacement for Known Recall of a Product
55	SNF Bed not Available
56	Medical Appropriateness

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57	SNF Readmission
58	Terminated Medicare+Choice Organization Enrollee
59	Reserved For National Assignment
60	Day Outlier
61	Cost Outlier
62	Payer Code
66	Provider Does Not Wish Cost Outlier Payment
67	Beneficiary Elects Not To Use Life Time Reserve Days
68	Beneficiary Elects To Use Life Time Reserve Days
69	IME/Payment Only Bill
70	Self-Administered Anemia Management Drug
71	Full Care in Unit
72	Self Care in Unit
73	Self Care Training
74	Home
75	Home - 100 Percent Reimbursement
76	Back-up in Facility Dialysis
77	Provider Accepts or Obligated Due to Contractual Arrangement
78	New Coverage not Implemented by HMO
79	CORF Services Provided Offsite
80	Home Dialysis - Nursing Facility
81	Indian Health Clinic
A0	CHAMPUS External Partnership Program
A1	EPSDT
A2	Physically Handicapped Childrens Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	Vaccines/Medicare 100% Payment
A7	Induced Abortion-Danger To Life
A8	Induced Abortion-Victim Rape/Incest
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
AB	Abortion Performed Due to Incest
AC	Abortion Performed Due to Serious Fetal Genetic Defect
AD	Abortion Performed Due to Life Endangering Phys Condition
AE	Abortion Performed Due to Physical Health of Mother
AF	Abortion Performed Due to Emotional Health of Mother
AG	Abortion Performed Due to Social or Economic Reasons
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Copayment
AK	Air Ambulance Required

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AL	Specialized Treatment/Bed Unavailable
AM	Non-emergency Medically Necessary Stretcher Transport Reqd
AN	Preadmission Screening not Required
B0	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary is Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
C1	Approved as Billed
C2	Automatic Approval as Billed Based on Focused Review
C3	Partial Approval
C4	Admission/Services Denied
C5	Postpayment Review Applicable
C6	Admission Preauthorization
C7	Extended Authorization
C8	Reserved For National Assignment
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/HIPPS Rate Codes
D3	Second or Subsequent Interim PPS Bill
D4	Change in ICD-9-CM Diagnosis and/or Procedure Codes
D5	Cancel to Correct HICN or Provider Id
D6	Cancel Only to Repay a Duplicate or OIG Overpayment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
DR	Disaster Related
E0	Change in Patient Status
E1	Reserved For National Assignment
G0	Distinct Medical Visit
H0	Delayed Filing, Statement of Intent Submitted
P1	Do Not Resuscitate Indicator
X2	SVC Rendered Due To Managed Care Referral
X3	SVC Rendered Due To Managed Care Referral

B.3 Service Type Code

Service Type Code	Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab

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Service Type Code	Description
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
30	Health Benefit Plan Coverage
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric Inpatient
A8	Psychiatric Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care

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Service Type Code	Description
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

B.4 Adjustment Group Codes

Adjustment Group Code	Description
CO	Contractual Obligations
CR	Correction and Reversals
OA	Other Adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

B.5 Reason Codes

Reason Codes	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-Payment Amount

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C Application Update Log

C.1 Application Updates

This section details the changes between this user manual version and the previous user manual versions including the Provider Electronic Solutions software version these changes apply to.

Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	n/a	n/a	**NOTE:** Version 3.02 contains ICD-10 changes however only ICD-9 codes should be submitted at this time. Please continue to check the Alabama Medicaid website at www.medicaid.alabama.gov for information about when Alabama Medicaid will be ready to accept ICD-10 codes. The ICD-10 list for entering and saving diagnosis and procedure codes is available and we suggest you enter this data in advance so you are ready for when ICD-10 is implemented.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	n/a	n/a	**All Crossover Claims** • Negative amounts in the Crossover Paid Amount field on all crossover claims are now allowed.
10/10/2012	Jason Cory	3.02	Chapter 2	Section 2.7.1	**Archiving** • Updated Note for versions prior to 3.0 will not be able to have their archived transactions restored. • Added note that 3.02 version of the software will not restore archived transactions originally from previous versions.
10/10/2012	Jason Cory	3.02	Chapter 4	Section 4.1	**Lists Heading** Remove diagnosis list and replace with the following new list: • Diagnosis ICD-9 • Diagnosis ICD-10 Add new ICD Procedure list: • Procedure ICD-9

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Procedure ICD-10 Procedure/HCPCS • Should only be used to hold non-ICD procedure codes.
10/10/2012	Jason Cory	3.02	Chapter 4	Section 4.2	**Dental Form/Provider List** Rendering Provider Taxonomy is required on Dental forms. Please ensure that the Taxonomy code is filled in on the Provider list.
10/10/2012	Jason Cory	3.02	Chapter 8	Sections 8.2.2, 8.3.5	**Professional Form** • Added ICD version dropdown list to Header 2. • Updated Service 2 screenshot. • Added Service Facility Provider ID to table description.
10/10/2012	Jason Cory	3.02	Chapter 9	Sections 9 (intro), 9.2.1, 9.2.2, 9.2.3, 9.2.4, 9.2.5, 9.2.6, 9.2.7, 9.2.8, 9.2.9	**Institutional Inpatient Form** • Updated introduction text to include mention of Header 5 and Header 6. • Updated screenshot to capture new Header 6. • Added ICD version dropdown list on Header 2. • Added fields for up to 24 Other Diagnosis Codes on Header 2. • Moved Surgical Code, Operating Physician, Attending, Referring fields to Header 3.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Updated table description to include read only field for ICD version. • Moved Occurrence Codes/Dates, Occurrence Codes/Spanned Dates, Covered Days, Non-Covered Days, Service Facility Provider fields to Header 4. • Updated table description to include spanned occurrence code dates description. • Moved Condition Code fields to Header 5. • Added Header 6 to hold Admission Date, Hour, Type, Discharge Hour Delay Reason, Service Authorization, Other Insurance Indicator, Crossover Indicator fields.
10/10/2012	Jason Cory	3.02	Chapter 10	Sections 10 (intro), 10.1, 10.2.1, 10.2.2, 10.2.3, 10.2.4, 10.2.5, 10.2.6, 10.2.7, 10.2.8	**Institutional Outpatient Form** • Updated introduction text to include mention of Header 4. • Updated screenshots to capture new Header 4. • Added ICD version dropdown list to Header 2. • Added table description for ICD Version “read only” field on Header 3. • Added fields for up to 24 Other Diagnosis Codes on Header 2. • Moved Surgical Code, Operating Physician, Attending, Referring fields to Header 3. • Moved Occurrence Codes/Dates, Condition Codes, Service Authorization, Other Insurance Indicator, Service Facility Provider fields to a new Header 4. • Added table description for Non Covered Amount.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	Chapter 11	Sections 11.2.2, 11.2.3	**Institutional Nursing Home Form** • Updated screenshot to include Service Facility Provider ID. • Added table description for Service Facility Provider ID. • Added ICD version dropdown list. • Added fields for up to 24 Other Diagnosis Codes on Header 2.
10/10/2012	Jason Cory	3.02	Chapter 14	Section 14.2	**Other Reports** • Updated Other Reports listing to include UPIN, Diagnosis ICD-9, Diagnosis ICD-10, Procedure ICD-9, and Procedure ICD-10. • Reordered Prescriber and Provider listings to match the order in the software listing. • Removed Other Insurance Reason report listing.
10/10/2012	Jason Cory	3.02	Chapter 15	Sections 15.2, 15.4.1, 15.4.2	**Prior Authorization Form – Header 2** • Updated all screenshots to capture Service tab name change to Service 1. • Added ICD version dropdown list. • Add to table description #17 for Diagnosis Type to include ICD-9 and ICD-10 diagnosis code qualifiers.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	Appendix C	n/a	**Created Appendix C – Application Update Log** • Added Appendix C to describe software and documentation changes.
11/20/2012	Jason Cory	3.02	Appendix B	n/a	**Created Appendix B – Code Lists** • Added Appendix B to hold large lists of codes.
11/20/2012	Jason Cory	3.02	Chapter 4	Section 4.4	• Update Insurance Type Code descriptions in the manual to match software description.
11/20/2012	Jason Cory	3.02	Chapter 15	Sections 15.2.1, 15.2.2	• Updated Provider Code listing in the manual to match what is in the software. • Updated Certification Code listing in the manual to match what is in the software. • Updated Oxygen Equipment Type list in the manual to be listed as multiple lines rather than single line as it was previously.
11/21/2012	Jason Cory	3.02	Chapter 15	Section 15.2.2	• Trimmed down Diagnosis Code description by removing Dental PA requests only information.
11/21/2012	Jason Cory	3.02	Chapter 9	Sections 9 (intro), 9.2.4, 9.2.5	• Updated count of tabs on the form in the introduction.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Update occurrence code and condition code descriptions to reference Appendix B for the code list.
11/21/2012	Jason Cory	3.02	Chapter 10	Sections 10 (intro), 10.2.4	• Updated count of tabs on the form in the introduction. • Update occurrence code and condition code descriptions to reference Appendix B for the code list.
11/21/2012	Jason Cory	3.02	Chapter 11	Sections 11.2.3, 11.2.4	• Update occurrence code and condition code descriptions to reference Appendix B for the code list.
9/25/2013	Jason Cory	3.03	n/a	n/a	Please note that Version 3.03 contains changes for CORE Operating Rules eligibility information. Changes include the ability to request multiple service types on the eligibility request form. In addition, the following Base changes have been made to the manual: • Allow entry of 91 day supply on Pharmacy claims. • Ordering Provider Field added to Professional (837P) claim form for entry at the detail. • Allow for future “To Date of Service” on all Institutional claims, Professional claims, and Dental claims. This is to accommodate the need for future “To Dates of Service” on certain procedures for NCCI updated on 10/1/2013.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Minor other changes listed in below items for version 3.03.
9/25/2013	Jason Cory	3.03	n/a	n/a	• Update date on Cover Page.
9/25/2013	Jason Cory	3.03	n/a	n/a	• Update Table of Contents.
9/25/2013	Jason Cory	3.03	Chapter 14	Section 14.2	**Other Reports** • Update report listing to show Ordering Provider report.
9/5/2013	Jason Cory	3.03	Appendix B Code Lists	Section B.3 Created	**Section B.3 Service Type Code** • Service Type Code list was added to include the codes and descriptions for each code.
9/5/2013	Jason Cory	3.03	Chapter 5	Sections 5.2	**Eligibility 270 Form** • Updated screenshots for Eligibility form to show the addition of the Service Type Code tab that holds the Service Type Code dropdown list. • Added Service Type Code tab screenshot along with table description for the Service Type Code. • Changed text describing the 270 form as having 2 tabs so that it states there are 3 tabs.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
9/25/2013	Jason Cory	3.03	Chapter 4	Section 4.1	**Building Lists** • Screenshot updated to show Ordering Provider list.
9/25/2013	Jason Cory	3.03	Chapter 7	Section 7.2.2	**Service 1 Tab** • Update table description for Days Supply field showing allowance of 999 days.
9/25/2013	Jason Cory	3.03	Chapter 8	Section 8.3.5	**Service 2 Tab** • Update screenshot to include Ordering Provider field. • Ordering Provider ID added to table description.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
1/28/2015	Jason Cory	3.04	n/a	n/a	**NOTE:** Version 3.04 contains updates to allow specific other insurance information to be entered on claims including Remaining Patient Liability, Deductible Amounts, Coinsurance Amounts, and Co-Payment Amounts. Other insurance information can be entered at a header level only on some claims or header and detail level for other claim types for up to three other insurances. In addition, the following Base changes have been made to the manual: • SOBRA and AEF application status for recipient eligibility. • Medicare 2% sequestration. • Allow 0 billed amount on
1/30/2015	Jason Cory	3.04	Table of Contents	n/a	• Updated page numbers • Added B.3 Service Type Code • Added B.4 Adjustment Group Codes • Added B.5 Reason Codes
1/23/2015	Jason Cory	3.04	n/a	n/a	• Update date on Cover Page.
1/23/2015	Jason Cory	3.04	Chapter 6	Sections 6 (intro), 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.5, 6.2.6	**Dental Form** • Updated tab count and new tab names. • Updated Header 1 screenshot. • Updated Header 2 screenshot.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Updated Header 2 table description, specifically for Other Insurance Indicator field. • Updated OI screenshot. • Updated OI table description, specifically for Payer Responsibility. • Updated Service screenshot. • Updated Service table description to include Service Adjustment Ind field. • Added new section for OI Adj. All subsequent section numbers adjusted. • Added description for the Adjustment Group Codes/Reason Codes/Amounts fields on the form. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/30/2015	Jason Cory	3.04	Chapter 8	Section 8.1,Section 8.2.1, Section 8.2.2, Section 8.2.3, Section 8.2.4, Section 8.2.5, Section 8.2.6, Section 8.2.7, Section 8.2.8, Section 8.2.9, Section 8.2.10	**Professional Form** • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service 1 tab screenshot. • Updated Service 2 tab screenshot. • Update Service 2 tab table descriptions.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Added section for Service Adj tab. All subsequent section numbers adjusted. • Added description of Service Adj tab. • Added Service Adj tab screenshot. • Added Service Adj table descriptions. • Updated NDC tab screenshot.
1/23/2015	Jason Cory	3.04	Chapter 9	Sections 9 (intro), 9.2.1, 9.2.2, 9.2.3, 9.2.4, 9.2.5, 9.2.6, 9.2.7, 9.2.8, 9.2.9, 9.2.10	**Institutional Inpatient Form** • Updated tab count introduction showing the OI Adj tab as a new optional tab. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated Header 5 screenshot. • Updated Header 6 screenshot. • Updated OI screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj screenshot. • Added OI Adj table descriptions. • Updated Crossover screenshot. • Updated Crossover tab table descriptions. • Updated Service screenshot. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/28/2015	Jason Cory	3.04	Chapter 10	Section 10 Intro, Section 10.2.1,	**Institutional Outpatient Form**

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
				Section 10.2.2, Section 10.2.3, Section 10.2.4, Section 10.2.5, Section 10.2.6, Section 10.2.7, Section 10.2.8, Section 10.2.9, Section 10.2.10	• Updated form tab count in the introduction. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service tab screenshot. • Added section for Service Adj tab. All subsequent section numbers adjusted. • Added Service Adj screenshot. • Added description of Service Adj tab. • Added Service Adj table description. • Updated NDC tab screenshot.
1/23/2015	Jason Cory	3.04	Chapter 11	Sections 11 (intro), Section 11.2.1, Section 11.2.2, Section 11.2.3, Section 11.2.4, Section 11.2.5, Section 11.2.6, Section 11.2.7, Section 11.2.8	**Institutional Nursing Home Form** • Updated tab count introduction showing the OI Adj tab as a new optional tab. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service tab screenshot. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/23/2015	Jason Cory	3.04	Appendix B Code Lists	Section B.4 Created	**Section B.4 Adjustment Group Codes** • Adjustment Group Codes list was added to include codes and descriptions for each code.
1/23/2015	Jason Cory	3.04	Appendix B Code Lists	Section B.5 Created	**Section B.5 Reason Codes** • Reason Codes list was added to include codes and descriptions for each code.

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11/06/2015	Jason Cory	3.05	n/a	n/a	**NOTE:** Version 3.05 contains updates including the following. • Global update HP Enterprise name change. • Addition of 11 external cause of injury codes for a total of 12 codes possible (e-codes) on inpatient and outpatient claim forms. • Resolution of defect that could cause extra subelements to created on some institutional crossover claims. • All ICD version drop downs defaulted to blank rather than ICD-9. These must now be selected by the user to indicate which diagnosis code version they are billing. • PA fields now allow alpha-numeric data to be entered. • PRCO information is displayed on eligibility requests (271) for recipients assigned to a PRCO. • An application status note was added to eligibility responses (271) stating “Please note that awarded status does not mean every member in the household has AL Medicaid coverage.
11/06/2015	Jason Cory	3.05	n/a	n/a	• Update date on cover page.
11/06/2015	Jason Cory	3.05	Chapter 9	Section 9.2.2, Section 9.2.3	**Institutional Inpatient Form** • Updated Header 2 screenshot to show additional 11 e-codes added for a total of 12 codes and

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					blank ICD version dropdown as the new default selection. • Updated field description to indicate more than just one e-code can be entered. • Updated header 3 screenshot to show blank ICD version indicator.
11/06/2015	Jason Cory	3.05	Chapter 10	Section 10.2.2, Section 10.2.3	**Institutional Outpatient Form** • Updated Header 2 screenshot to show additional 11 e-codes added for a total of 12 codes and blank ICD version dropdown as the new default selection. • Updated field description to indicate more than just one e-code can be entered. • Updated header 3 screenshot to show blank ICD version indicator.
11/06/2015	Jason Cory	3.05	Chapter 11	Section 11.2.3	**Institutional Nursing Home Form** • Updated header 3 screenshot to show blank ICD version indicator. • Updated description table for Occurrence Codes to see chapter 5 of provider billing manual for specific occurrence code requirements.
04/07/2016	Jason Cory	3.06	n/a	n/a	**NOTE:** Version 3.06 contains updates to include RCO enrollment information in the eligibility response file. Also an update to include the HPE logo.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
04/07/2016	Jason Cory	3.06	Chapter 4	Section 4.4	Added note about FQHCs and RHCs able to enter a carrier code equal to the NPI for the RCO plans to submit claims with RCO payment as other payers. Also updated location information related to the Alabama Medicaid website for the provider manual appendix K for top 200 Third Party Carrier Codes.
04/07/2016	Jason Cory	3.06	Chapter 5	Section 5 (intro)	Added note explaining version 3.06 includes updates for RCO enrollment on eligibility response as well as a note that benefit limits returned are fee-for-service limits only and EPSDT screening dates are both fee-for-service claim related and encounter claim related.
04/14/2016	Jason Cory	3.06	Chapter 8	Section 8.2.4	Added note to claim filing indicator for FQHC and Rural Health Clinics about using code 14.
04/08/2016	Jason Cory	3.06	Chapter 15	Section 15 (intro)	Added note to explain 278 prior authorization request should be used for fee-for-service requests for Alabama Medicaid. PAs for RCOs need to be requested through the process setup by the RCO.
04/08/2016	Jason Cory	3.06	Chapter 16	Section 16 (intro)	Added note about 276 claim status only returning Alabama Medicaid fee-for-service claims.

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1/18/2017	Amber King	3.07	Chapter 9	Section 2.3	Updated the screenshot of Header 3 to include new birthweight fields and updated description table on birthweight field.
06/30/2017	Sandra Richardson	3.08	n/a	n/a	**NOTE:** Version 3.08 contains updates including the following. • Global update DXC Technology name change. • All ICD version drop downs defaulted to ICD 10 rather than blank. These must now be selected by the user to indicate which diagnosis code version they are billing.
06/30/2017	Sandra Richardson	3.08	n/a	n/a	• Update date on cover page.
06/30/2017	Sandra Richardson	3.08	Chapter 9	Section 9.2.2, Section 9.2.3	Institutional Inpatient Form • Updated Header 2 screenshot to show ICD 10 version dropdown as the new default selection. • Updated header 3 screenshot to show ICD 10 ICD version indicator.
06/30/2017	Sandra Richardson	3.08	Chapter 10	Section 10.2.2, Section 10.2.3	Institutional Outpatient Form • Updated Header 2 screenshot to show ICD 10 version dropdown as the new default selection.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Updated header 3 screenshot to show ICD 10 version indicator.
06/30/2017	Sandra Richardson	3.08	Chapter 11	Section 11.2.3	Institutional Nursing Home Form • Updated header 3 screenshot to show ICD 10 version indicator.
10/30/2017	Sandra Richardson	3.09	n/a	n/a	**NOTE:** Version 3.09 contains the following changes: • Change references to “RCO” to “MCO” on eligibility response file. • Remove the message from claim status response regarding RCO. • Updated field label on 837 claim forms crossover tab and eligibility batch response to display Medicare ID field label instead of HIC Number.
10/30/2017	Sandra Richardson	3.09	Chapter 4	Section 4.4	• Updated note to carrier code indicator for FQHCs and RHCs able to enter a carrier code equal to the NPI for the MCO plans to submit claims with MCO payment as other payers. Changed “RCO” to “MCO”.
10/30/2017	Sandra Richardson	3.09	Chapter 5	Section 5 (intro)	• Updated note explaining version 3.09 includes MCO enrollment on eligibility response.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/30/2017	Sandra Richardson	3.09	Chapter 8	Section 8.2.4, Section 8.2.6	• Updated note to claim filing indicator for FQHC and Rural Health Clinics. Changed “RCO” to “MCO”. • Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wording to say “Enter the recipient’s Medicare ID”.
10/30/2017	Sandra Richardson	3.09	Chapter 9	Section 9.2.9	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID”
10/30/2017	Sandra Richardson	3.09	Chapter 10	Section 10.2.7	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wording to say “Enter the recipient’s Medicare ID assigned by Medicare”.
10/30/2017	Sandra Richardson	3.09	Chapter 11	Section 11.2.7	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wordking to say “Enter the recipient’s Medicare ID assigned by Medicare”.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/30/2017	Sandra Richardson	3.09	Chapter 15	Section 15 (intro)	• Updated note for 278 prior authorization request to indicate contact MCOs for their process to submit prior authorizations to them. Changed "RCO" to "MCO".
02/23//2018	Sandra Richardson	3.10	n/a	n/a	**NOTE:** Version 3.10 contains the following changes: • Updated NCPDP form to include conflict code ingredient duplication. • Updated 837 Professional claim form to include new maternity date fields.
02/23/2018	Sandra Richardson	3.10	Chapter 7	Section 7.2.3	• Updated conflict code guidelines to include ID-Ingredient duplication value.
02/23/2018	Sandra Richardson	3.10	Chapter 8	Section 8.2.3	• Updated Header 3 screenshot to capture last menstrual period and prenatal visit new fields. Also add new fields and guidelines for qualifier, date of last menstrual period, qualifier and date of first prenatal visit.
04/18/2018	Sandra Richardson	3.10	Chapter 15	Section 15.4.1 Section 15.4.2	Redact PHI/PII as well as non-public test data Updated screen layout for: • 15.4.1 Prior Authorization Request response • 15.4.2 Prior Authorization Request response

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01/09/2019	Sandra Richardson	3.10	All	Footers	Update CDT/CPT licensening agreement date in footer to 2019.
5/11/2020	Gwen Crenshaw	3.11	Chapters 6-11	Sections 6.2.1, 7.2.2, 8.2.1, 9.2.1, 10,2,1, 11.2.1	Updated Header 1 tab screenshot and added Attachment Group Box descriptions to the Field Guidelines.
5/11/2020	Gwen Crenshaw, Amber King	3.11	All	Throughout	Removed all references to CD Rom and Diskettes. We no longer support these means of download or submissions.
5/11/2020	Gwen Crenshaw	3.11	Chapter 2	Section 2.5.3 and Section 2.5.4	Removed reference to the Interactive tab in Step 3. Updated Payer/Processor screenshot to show new Name and ETIN

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