



Alabama Medicaid Agency



Provider Electronic Solutions User Guide

HIPAA Compliant

July 2023

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1 Introducing Provider Electronic Solutions

Thank you for using Gainwell Technologies' *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 Gainwell 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 Gainwell 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 Gainwell. A batch may contain one record or many records. These transactions are sent to the Gainwell system via our public-Internet website. Gainwell processes the batches of transactions and returns a response to the website. Providers may retrieve their responses through the *Provider Electronic Solutions* application.

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, Gainwell 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 Gainwell 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**

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 Provider Assistance Center 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 <i>Provider Electronic Solutions</i> | Describes what you need to know to use <i>Provider Electronic Solutions</i> , how to use the user manual, and who to contact if you have questions. |
| 2. | Installing <i>Provider Electronic Solutions</i> | 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |

| | Chapter Title | Contents |
|-----|--|---|
| 12. | Submitting Claim Reversals | Provides instructions for entering reversals or adjustments in the electronic claim forms and submitting the request via a web server. |
| 13. | Viewing Response files | Provides instructions on how to receive an electronic response to the claims submitted via web server. |
| 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. |
| 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. |
| 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. Gainwell provides a user manual 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 Gainwell 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.

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 |
|--|--|
| <ul style="list-style-type: none"> • Microsoft Internet Explorer Version 6.0 • Pentium III • Windows 2000 (service pack 4 or higher) • 256 Megabytes RAM • 1024 x 768 Resolution • 56K Baud Rate modem (required only for dial-up transmission) • 100 Megabytes free Hard Drive space • Dial-Up Networking (If user has no ISP, Internet Service Provider) | <ul style="list-style-type: none"> • Microsoft Internet Explorer Version 6.0 • Pentium IV • 512 Megabytes RAM • 1024 x 768 Resolution • 56K+ Baud Rate modem (required only for dial-up transmission) • Printer with 8pt MS Sans Serif font (Optional) |

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 Gainwell Electronic Media Claims (EMC) Help Desk at 1 (800) 456-1242 for instructions.

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.

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. 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.

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

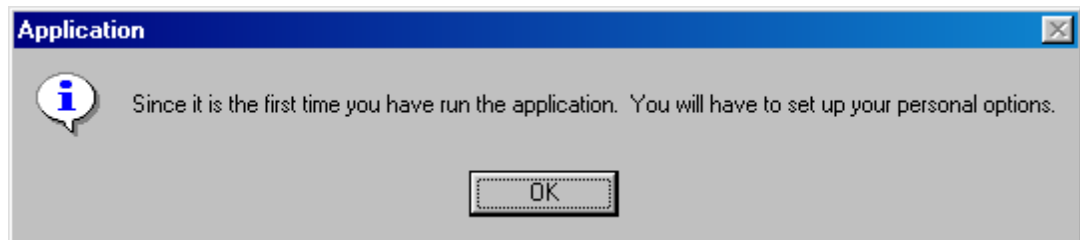
NOTE:

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

| <i>Tab</i> | <i>Usage</i> |
|-----------------|--|
| 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. |
| 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

| <i>Button</i> | <i>Usage</i> |
|---------------|---|
| 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

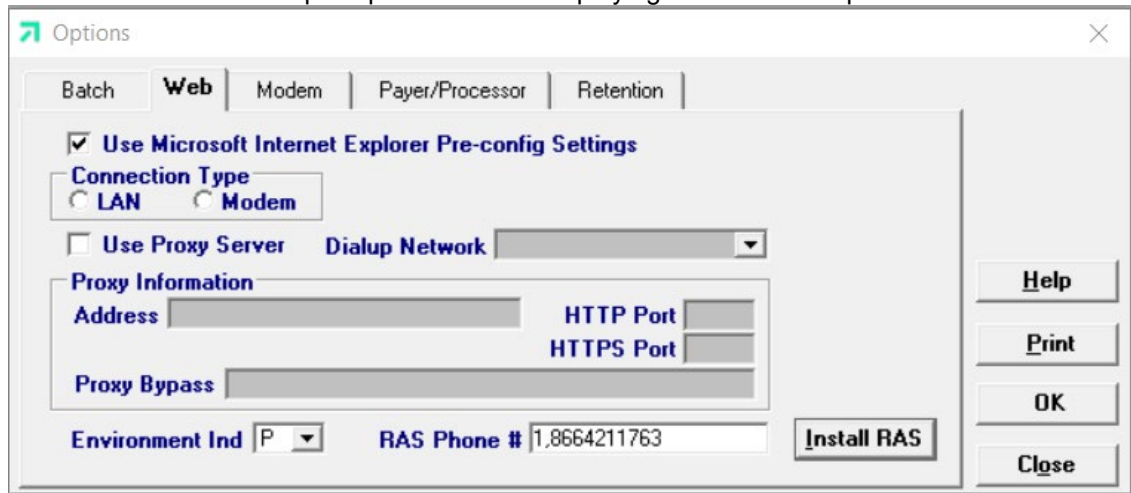
Users access the Batch tab to enter a trading partner ID, web logon ID, password and the requesters contact information. A sample Options window displaying the Batch tab is pictured below:

| <i>Field</i> | <i>Guidelines</i> |
|-----------------------|--|
| 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. |

| Field | Guidelines |
|--------------------------|--|
| 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. |
| 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:

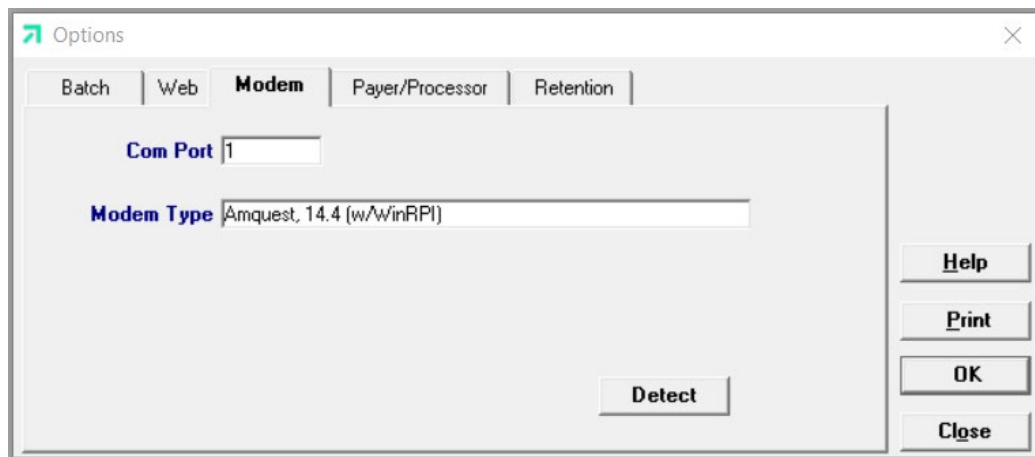


| Field | Guidelines |
|--------------------------------------|---|
| Use Microsoft IE Pre-config Settings | If checked, the pre-config settings within your Internet Explorer will be accessed to connect to the batch submission website. |
| Connection Type | If the Internet Explorer Pre-config Settings 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. |

| Field | Guidelines |
|-----------------|--|
| 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. |
| 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 .

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 Gainwell. A sample Options window displaying the Payer/Processor tab is pictured below:

The screenshot shows the 'Options' window with the 'Payer/Processor' tab selected. The fields are as follows:

| Field | Value |
|---------------------------|---------------------------------|
| Name | DXC Technology Alabama Medicaid |
| ETIN | 822287119 |
| Identifier Code Qualifier | PI |
| Identifier Code | ALXIX |

Buttons on the right: Help, Print, OK, Close.

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:

The screenshot shows the 'Options' window with the 'Retention' tab selected. The fields are as follows:

| Field | Value |
|--------------------------|-------|
| Archive Days | 30 |
| Max Batch | 10 |
| Max Verify | 10 |
| Max Log | 10 |
| Max Submit Reports | 0 |
| Password Expiration Days | 90 |

Buttons on the right: Help, Print, OK, Close.

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.

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, Gainwell 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

Gainwell 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.

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.

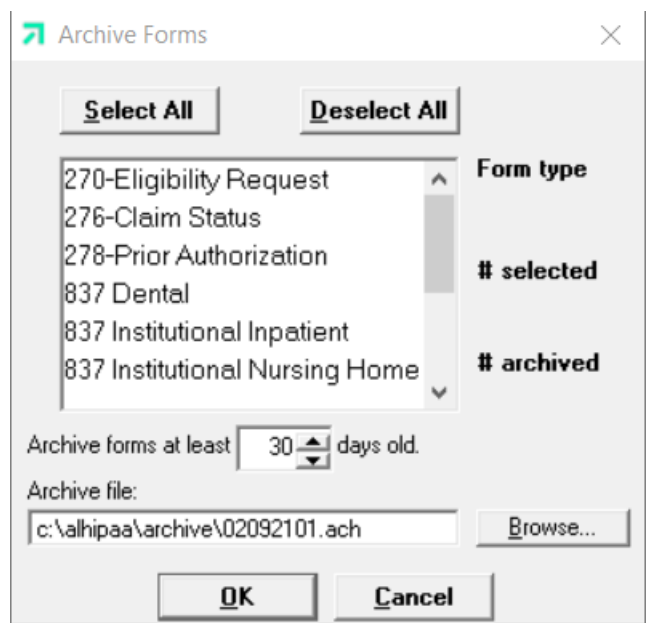
You can store the compressed file on a diskette or leave it on your hard drive. Forms that are ready to be submitted (that have a status of 'R') are not archived, but remain on your online database until you have submitted or deleted them. Forms that are incomplete (that have a status of 'I') and are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



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

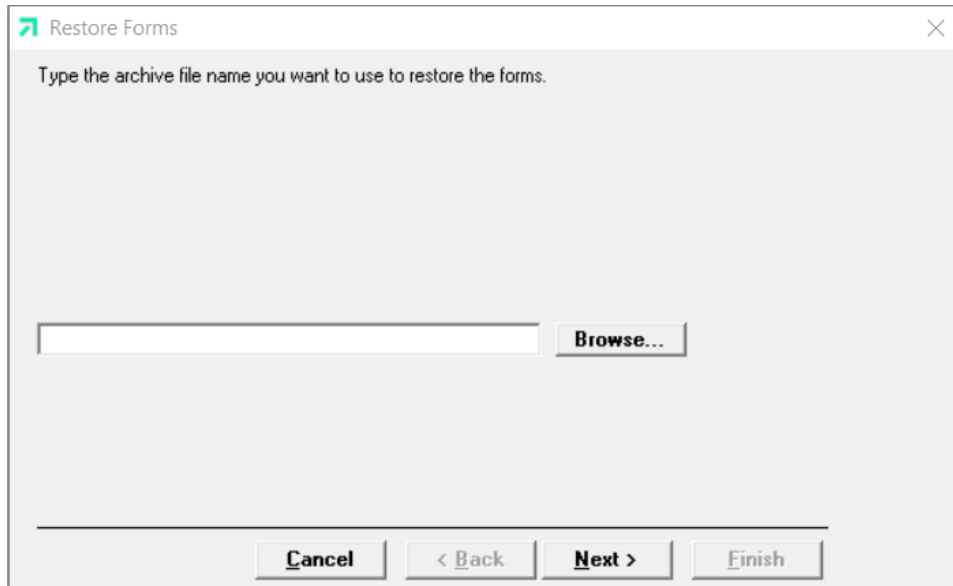
PES version 3.0 will not restore archived transactions originally submitted/archived with a previous version (2.16 and earlier).

ICD-10

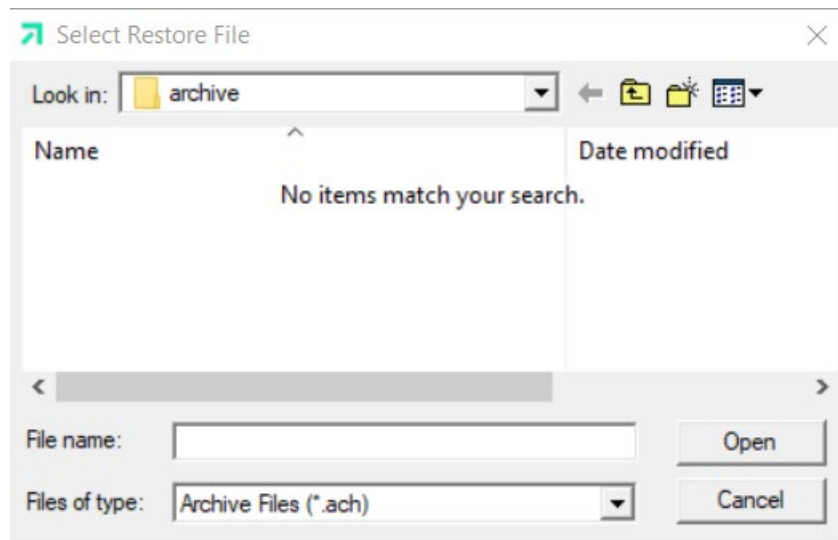
PES version 3.02 will not restore archived transactions originally submitted/archived with a previous version.

Perform the following to restore archived forms:

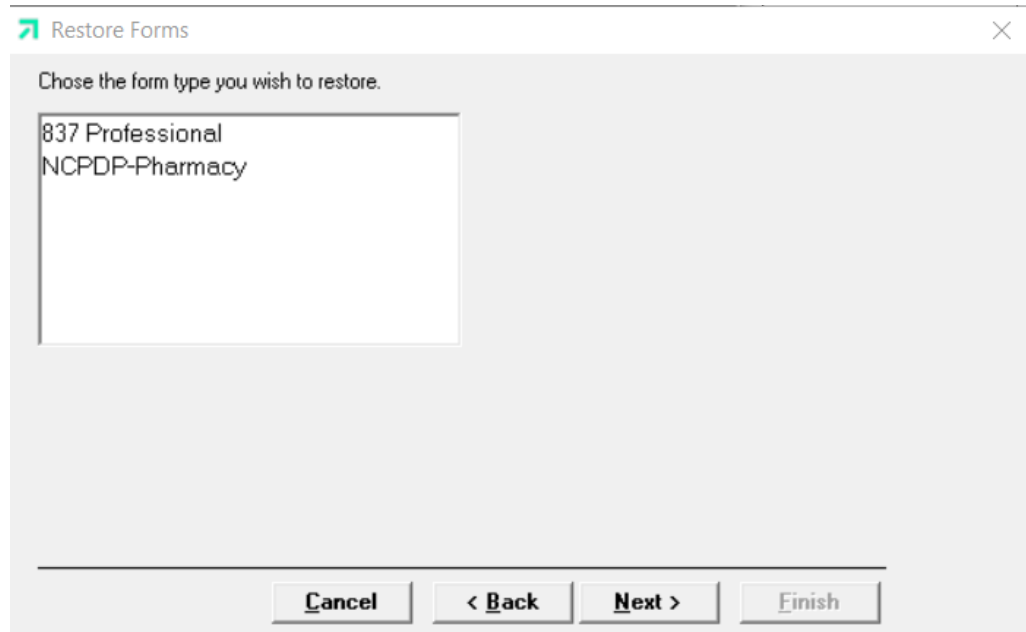
Step 1 Select Tools>>Archive>>Restore from the menu line. The Restore Forms window displays:



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:



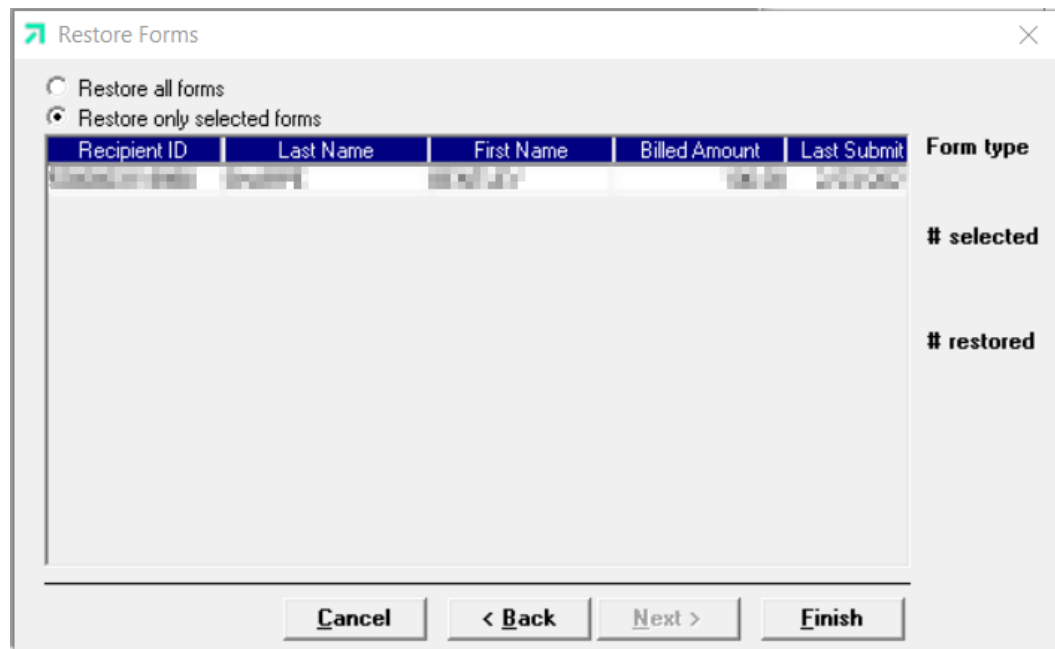
Step 3 Select the file and path name and click 'Open' button. Click 'Next' to display the Restore Forms window, pictured below:



- 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.

- Step 5** When *Provider Electronic Solutions* finds forms that match the selection criteria, the following displays:



Step 6 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.

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.)
 - 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.

3 Getting Around

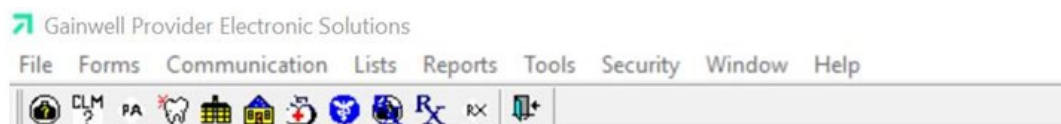
This chapter describes general navigation concepts and provides an overview of the online help feature.

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:

| <i>This menu option...</i> | <i>Allows you to...</i> |
|----------------------------|---|
| 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. |
| Reports | Print summary or detail reports with information from forms or reference |

| <i>This menu option...</i> | <i>Allows you to...</i> |
|----------------------------|--|
| | 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 <i>Provider Electronic Solutions</i> 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.
-  (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*:

| <i>To do this...</i> | <i>Press this key...</i> |
|---|--------------------------|
| 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> |

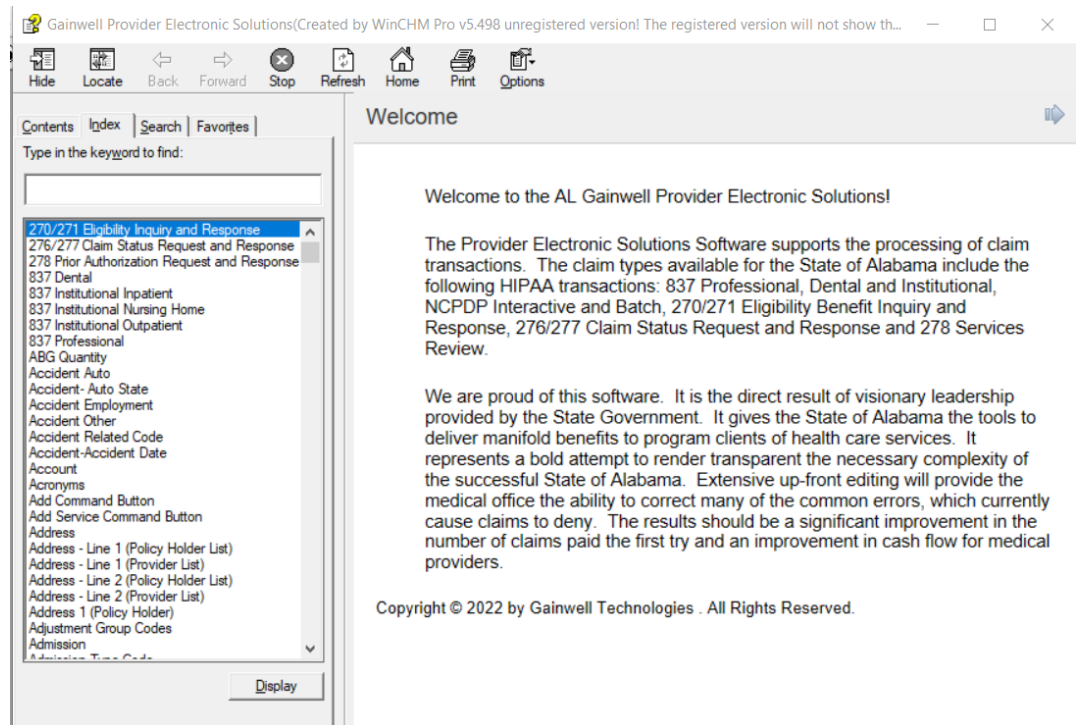
The list above includes function keys (usually located at the top of the keyboard and numbered 'F1' through 'F12'), command keys (such as <Alt>, <Shift>, <Tab>, <Ctrl>, and <Enter>), and arrow keys. Depending on your keyboard, the arrow keys may be located on the numeric keypad, or in a separate section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

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 Home 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. You can download a copy of the manual from the Alabama Medicaid website at <http://www.medicaid.alabama.gov>

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*:

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

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.

- 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:

| NPI | Taxonomy Code | Last/Org Name | Type Qualif |
|------------|---------------|---------------|-------------|
| 1234567890 | 111111111X | PROVIDER | 1 |

| 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 | 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 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.

4.3 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:

The screenshot shows a 'Recipient' form window with the following fields and values:

- Recipient ID: 1234567891234
- ID Qualifier: MI
- Account #: ABC1234
- SSN: 999-99-9999
- Last Name: DOE
- First Name: JANE
- MI: R
- Suffix: (empty)
- Date of Birth: 01/01/1900
- Gender: F
- Recipient Address:
 - Line 1: 123 EASY STREET
 - Line 2: (empty)
 - City: ANYWHERE
 - State: AL
 - Zip: 12345-6789

At the bottom, there is a table listing recipients:

| Recipient ID | Last Name | First Name |
|---------------|-----------|------------|
| 1234567891234 | DOE | JANE |
| (faded) | (faded) | (faded) |
| (faded) | (faded) | (faded) |

| 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. |

| 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. |

| 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. |

| 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:

| Field | Guidelines |
|-----------------------|--|
| UPIN | Enter the provider's 6-character unique provider identifier (ANNNNN or AAANN 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.

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.

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,

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.

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:

The screenshot shows a software window titled "270 Eligibility Request" with a tabbed interface. The "Header 1" tab is active. The form contains the following fields and controls:

- NPI:** 1234567891 (dropdown)
- Medicaid ID:** (empty text box)
- ID Code Qualifier:** XX (dropdown)
- Entity Type Qualifier:** 1 (dropdown)
- Last/Org Name:** TEST (text box)
- First Name:** PROVIDER (text box)
- Taxonomy Code:** 98765432X1 (text box)
- Address Line 1:** 123 MAIN ST (text box)
- Address Line 2:** (empty text box)
- City:** MERCY (text box)
- State:** AL (dropdown)
- Zip:** 12345-6789 (text box)

On the right side of the form, there is a vertical stack of buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close. At the bottom of the form, there is a table header with the following columns: Recipient ID, Last Name, First Name, From DOS, To DOS, Last Submit Dt, and Status.

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

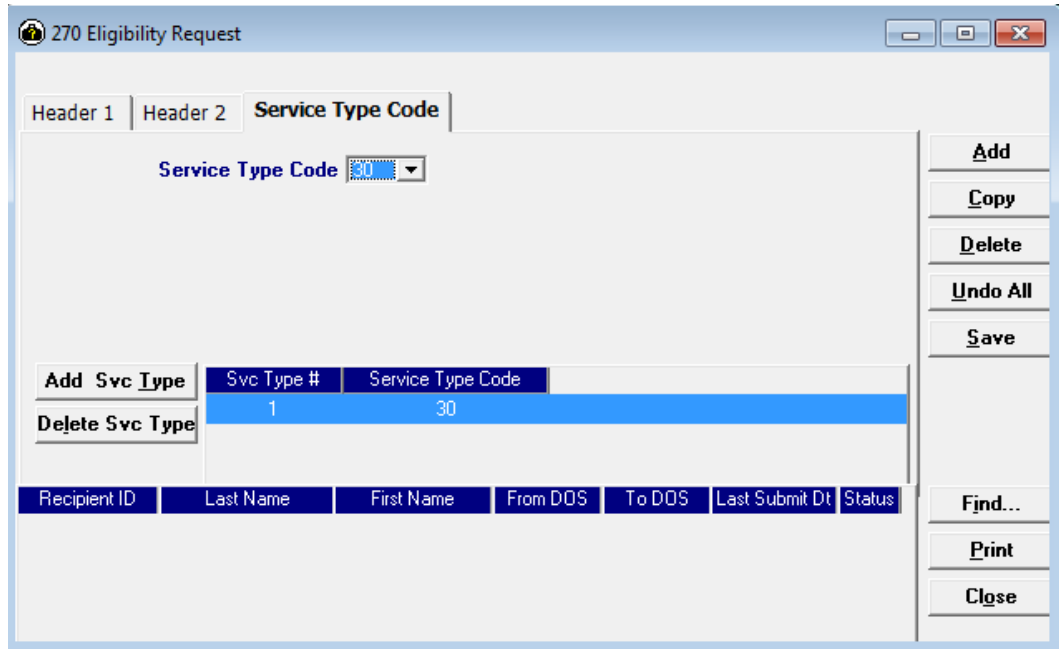
| Field | Guidelines |
|---------------------------|---|
| NPI | Choose the desired NPI from your Provider list. If you have not added the required NPI to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions. |
| Medicaid 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. |

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. |

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 | <p>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.</p> <p>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.</p> <p>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.</p> |

5.3 Completing the NCPDP Pharmacy Eligibility form

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

The screenshot shows a software window titled "Pharmacy Eligibility". Inside, there is a "Header" section with several input fields: "Provider ID" (1234567890), "Provider ID Qualifier" (01), "Date Of Service" (12/10/2006), "CardHolder ID" (1234567890000), "Last Name" (DOE), and "First Name" (JOHN). Below these fields is a table with columns: Cardholder ID, Last Name, First Name, Date Of Service, Last Submit Dt, and Status. To the right of the form are buttons for "Add", "Copy", "Delete", "Undo All", "Save", "Find...", "Print", and "Close".

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. |

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.

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 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. |
| 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)
- 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:

| 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. |

| Field | Guidelines |
|------------------------------|--|
| 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. |

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. |

| Field | Guidelines |
|-----------------------|--|
| Place of Service | Choose the best value to indicate where the service took place. <ul style="list-style-type: none"> • 11 – Dental Office • 21 – Inpatient Hospital • 22 – Outpatient Hospital • 31 – Nursing Facility |
| Service Authorization | Choose the best value to indicate if this procedure was due to an emergency of if the claim is Admin Review. This field is optional <ul style="list-style-type: none"> • Immediate Urgent Care • Services Rendered in a Retroactive Period • Emergency Care • Client has temporary Medicaid • Request from County for Second Opinion to Determine if Recipient Can Work • Request for Override Pending • Special Handling |
| 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. |

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 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.

| 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). |

| Field | Guidelines |
|----------------------------|---|
| 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. |
| 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. |
| 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.

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. |
| 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. |

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

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.

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 Dispersed | 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. |

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. |
| Quantity Prescribed | Enter the Quantity Prescribed |
| 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 | <p>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:</p> <ul style="list-style-type: none"> 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. <p>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-<i>decimal</i>-5 (35.500).</p> |

| Field | Guidelines |
|---------------------|---|
| Incentive Amount | If applicable, enter the fee submitted by the pharmacy for contractually agreed upon services. |
| 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. |

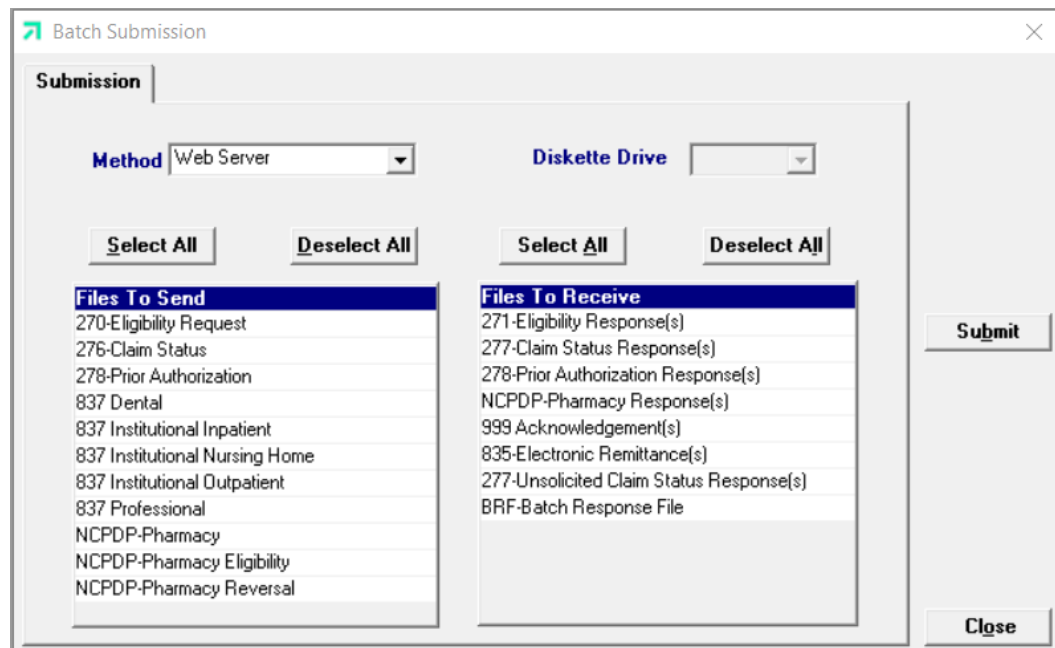
| Field | Guidelines |
|--------------------------|---|
| Conflict Code | Choose the best value for a soft-edit prescription override. Conflict Codes are always system generated and are as follows: DD - Drug - Drug Interaction; ER - Overuse; HD - High Dose Alert; LD - Low Dose Alert; LR - Under-use Precaution; 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. |
| Submission Clarification | Chose the best value for a soft-edit prescription override. The values are as follows: 0 - Not Specified; 1 - No override; 2 - Other override; 3 - Vacation Supply; 4 - Lost Prescription; 5 - Therapy Change; 6 - Starter Dose; 7 - Medically Necessary; 8 - Process Compound for Approved Ingredients; 10 - Meet Plan Limitations; 13 - Payer Recognized Emergency/Disaster Assistance Request; 42 - Prescriber ID Submitted has been verified; 99 - Other |

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.

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. |

| 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.
- 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.

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 claim 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. |
| 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. |

| Field | Guidelines |
|------------------------------|--|
| 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. <ul style="list-style-type: none"> • 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.' <ul style="list-style-type: none"> • 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. |

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. <ul style="list-style-type: none"> • Immediate Urgent Care • Services Rendered in a Retroactive Period • Emergency Care • Client has temporary Medicaid • Request from County for Second Opinion to Determine if Recipient Can Work • Request for Override Pending • Special Handling |
| Prior Authorization | Enter the Prior Authorization number issued by the State Agency. This field is optional. |
| Referral Number | Enter the referral number. Up to 30 characters alphanumeric. This field is optional. |

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 <u>not</u> 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. |

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 Self pay 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. |
| 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. |

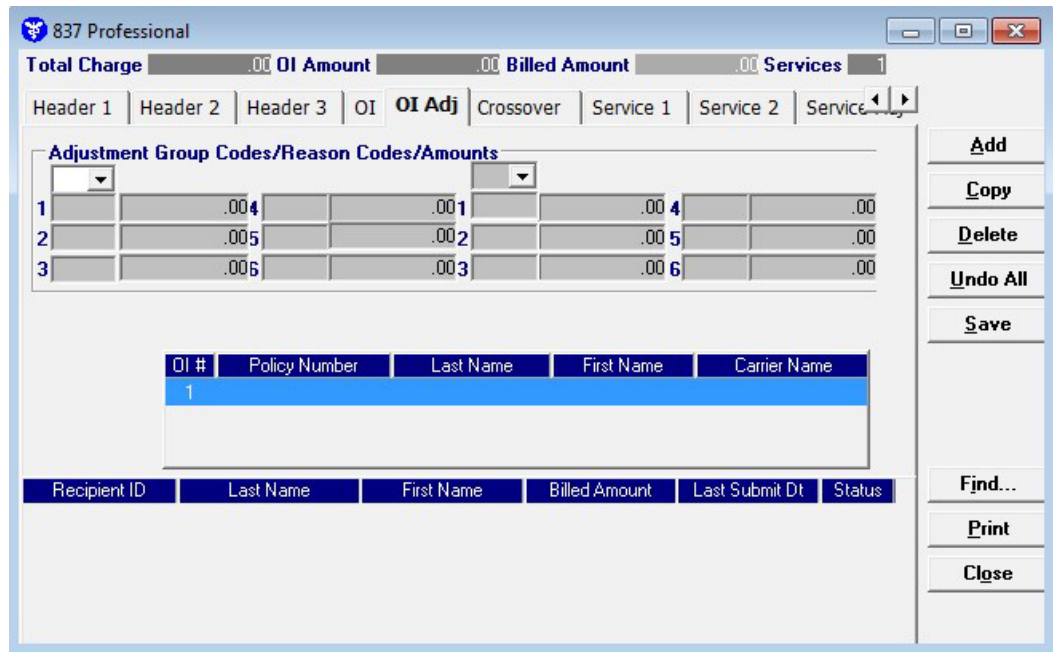
Adding, Deleting, or copying another insurance.

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.

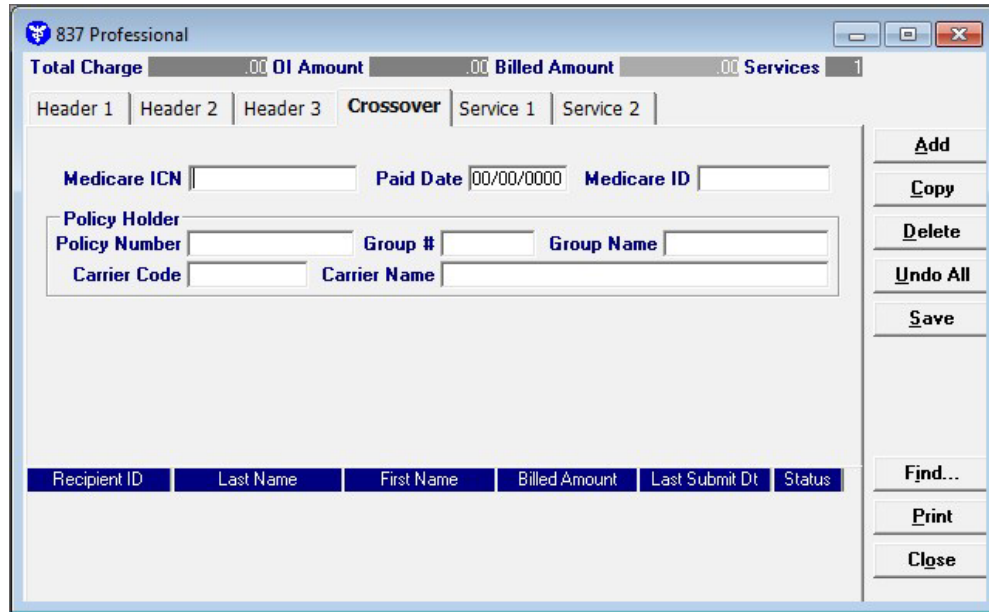


Complete the following fields under the OI Adj tab to submit an 837 Professional claim:

| 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. |
| 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. |

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. |

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. |
| Coins Amt | If applicable, enter the coinsurance amount issued by Medicare for the specific service currently being charge to Medicaid. |

| Field | Guidelines |
|-------------------|--|
| 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 Adj 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. |
| 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. |
| 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.

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.

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.

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. |
| 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.

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.

837 Institutional Inpatient

Total Charge OI Amount Billed Amount Services

Header 1 | Header 2 | Header 3 | Header 4 | Header 5 | Header 6 | Service

Type Of Bill Original Claim #

Provider ID

Last/Org Name First Name

Recipient ID Account #

Last Name First Name MI

Patient Status Medical Record #

From DOS To DOS Prior Authorization

Release of Medical Data Benefits Assignment

Attachment

Type Code Transmission Code

Control #

| Recipient ID | Last Name | First Name | Billed Amount | Last Submit Dt | Status |
|--------------|-----------|------------|---------------|----------------|--------|
| | | | | | |

Find...
Print
Close

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

| Field | Guidelines |
|------------------|---|
| Type Of Bill | <p>Enter a Type of Bill according to the values below.</p> <p>1st Digit – Type of Facility 1 Hospital</p> <p>2nd Digit – Bill Classification 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 8 Reserved for National Assignment</p> <p>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. <i>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.</i> 8 Void or reverse a prior claim. <i>You must have the ICN of the original paid claim in order to complete this process.</i> 9 Final Claim for a Home Health PPS Episode</p> |
| 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. |

| Field | Guidelines |
|------------------------------|--|
| Patient Status | <p>Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period:</p> <p>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.</p> <p>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).</p> |
| 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 | <p>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.</p> <ul style="list-style-type: none"> • I - Informed Consent to Release Medical Information for Conditions or Diagnoses regulated by Federal Statutes. • Y - Yes, Provider has a signed statement permitting release of medical billing data related to a claim |
| 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. |

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: <ul style="list-style-type: none"> • Y – Yes • N – No • U – Unknown • W – Not Applicable • Blank – Exempt from POA reporting. |

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. |

9.2.4 Header 4 Tab

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

The screenshot shows a software window titled "837 Institutional Inpatient". At the top, there is a summary bar with the following values: Total Charge .00, OI Amount .00, Billed Amount .00, and Services 1. Below this is a tabbed interface with tabs for Header 1, Header 2, Header 3, Header 4 (selected), Header 5, Header 6, OI, OI Adj, and Cro. The Header 4 tab contains several input fields: "Occurrence Codes/Dates" with three dropdown menus and date fields; "Occurrence Codes/Spanned Dates" with two date range inputs; "Days Covered" and "Days Non-Covered" with numeric input boxes; and "Service Facility Provider ID" with a text input box. On the right side of the window, there is a vertical toolbar with buttons for Add, Copy, Delete, Undo All, Save, Find..., Print, and Close. At the bottom of the window, there is a table with columns: Recipient ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status.

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. |

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 | <p>If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral.</p> <p>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.</p> <p>For a full list of these codes see Appendix B Code Lists, Section B.2 Condition Codes.</p> |

9.2.6 Header 6 Tab

Below is a sample 837 Inpatient form displaying the Header 6 tab.

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. |
| 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. <ul style="list-style-type: none"> • Immediate Urgent Care • Services Rendered in a Retroactive Period • Emergency Care • Client has temporary Medicaid • Request from County for Second Opinion to Determine if Recipient Can Work • Request for Override Pending • Special Handling |
| Other Insurance Ind | Choose the best value to indicate if the recipient has other insurance. Medicare is <u>not</u> 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. |
| 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.

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.

| 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. |
| 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. |

| Field | Guidelines |
|---------------|--|
| 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.

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.

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.

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.

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. |
| 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.

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.

837 Institutional Outpatient

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

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

Type Of Bill Original Claim #

Provider ID

Last/Org Name First Name

Recipient ID Account #

Last Name First Name MI

From DOS 00/00/0000 To DOS 00/00/0000 Medical Record #

Delay Reason Prior Authorization

Benefits Assignment Release of Medical Data

Attachment

Type Code Transmission Code

Control #

| Recipient ID | Last Name | First Name | Billed Amount | Last Submit Dt | Status |
|--------------|-----------|------------|---------------|----------------|--------|
| | | | | | |

Find...
Print
Close

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

| Field | Guidelines |
|------------------|--|
| Type Of Bill | <p>Enter a Type of Bill according to the values below.</p> <p>1st Digit – Type of Facility</p> <ul style="list-style-type: none"> 1 Hospital 3 Home Health Agency 7 Clinic (RHC, FQHC) 8 Special Facility <p>2nd Digit – Bill Classification</p> <ul style="list-style-type: none"> 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 <p>3rd Digit – Frequency</p> <ul style="list-style-type: none"> 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. <i>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.</i> 8 Void or reverse a prior claim. <i>You must have the ICN of the original paid claim in order to complete this process.</i> 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. |

| 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. <ul style="list-style-type: none"> 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. |

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. |

| Field | Guidelines |
|---|--|
| 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. |

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. |

10.2.4 Header 4 Tab

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

The screenshot shows the '837 Institutional Outpatient' software window. At the top, there are summary fields: Total Charge (0.00), OI Amount (00), Billed Amount (00), and Services (1). Below this is a tabbed interface with 'Header 4' selected. The 'Header 4' tab contains several sections:

- Occurrence Codes/Dates:** Five input fields for codes and dates, labeled 1 through 5.
- Condition Codes:** Five input fields for condition codes, labeled 1 through 5.
- Service Authorization:** A dropdown menu.
- Other Insurance Ind:** A dropdown menu with 'Y' selected.
- Service Facility Provider:** An input field.
- Crossover Ind:** A dropdown menu with 'Y' selected.

 On the right side of the form, there is a vertical toolbar with buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close. At the bottom of the form, there is a table with columns: Recipient ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status.

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. <ul style="list-style-type: none"> • Immediate Urgent Care • Services Rendered in a Retroactive Period • Emergency Care • Client has temporary Medicaid • Request from County for Second Opinion to Determine if Recipient Can Work • Request for Override Pending • Special Handling |
| 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. |
| Crossover Ind. | Choose 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. |
| 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.

The screenshot shows the '837 Institutional Outpatient' application window. At the top, there are fields for 'Total Charge' (0.00), 'OI Amount' (.00), and 'Billed Amount' (.00). Below these are tabs for 'Header 1', 'Header 2', 'Header 3', 'Header 4', 'OI', 'OI Adj', 'Crossover', 'Service', and 'Service'. The 'OI Adj' tab is active, displaying a table titled 'Adjustment Group Codes/Reason Codes/Amounts' with three rows of data. Below this table is a smaller table titled 'Other Insurance Carrier Listing' with one row of data. To the right of the main table are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

| 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. |

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. |
| Group Name | This field will auto-write based on the information chosen in the Policy number field. |

| 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. |

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. |

10.2.8 Service Adj Tab

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

The screenshot shows the 'Service Adj' tab in the 837 Institutional Outpatient form. At the top, it displays 'Total Charge 0.00', 'OI Amount .00', 'Billed Amount .00', and 'Services 1'. Below this are tabs for 'Header 3', 'Header 4', 'OI', 'OI Adj', 'Crossover', 'Service', and 'Service Adj' (which is selected), and 'NDC'. The form includes fields for 'Carrier Code' (a dropdown), 'Name', 'Paid Date/Amount' (00/00/0000), 'Remaining Patient Liability', and 'Detail Number 1'. A section for 'Adjustment Group Code/Reason Codes/Amounts' contains a table with three rows of data. Below this table are buttons for 'Add Srv Adj', 'Copy Srv Adj', and 'Delete Srv Adj'. At the bottom of the form is a table with columns for 'Recipient ID', 'Last Name', 'First Name', 'Billed Amount', 'Last Submit Dt', and 'Status'. On the right side, there are buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'.

| Adjustment Group Code | Reason Codes | Amounts |
|-----------------------|--------------|---------|
| 1 | 4 | .00 |
| 2 | 5 | .00 |
| 3 | 6 | .00 |

| Add Srv Adj | OI # | Carrier Code | Carrier Name | Adj Group | Paid Amount |
|----------------|------|--------------|--------------|-----------|-------------|
| Copy Srv Adj | 1 | | | | .00 |
| Delete Srv Adj | | | | | |

| 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. |

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.

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.

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.

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. |

| 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.

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.

The screenshot shows a software window titled "837 Institutional Nursing Home". At the top, there are summary fields: "Total Charge", "OI Amount", "Billed Amount", and "Services". Below this is a tabbed interface with "Header 1" selected. The form contains various input fields and dropdown menus for provider and recipient information, dates, and codes. A table at the bottom of the form displays columns for "Recipient ID", "Last Name", "First Name", "Billed Amount", "Last Submit Dt", and "Status". On the right side, a vertical toolbar provides actions like "Add", "Copy", "Delete", "Undo All", "Save", "Edit All", "Find...", "Print", and "Close".

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

| Field | Guidelines |
|------------------|--|
| Type Of Bill | <p>Enter a Type of Bill according to the values below.</p> <p>1st Digit – Type of Facility</p> <p>1 Hospital 2 Long Term Care</p> <p>2nd Digit – Bill Classification</p> <p>1 Inpatient (including Medicare Part A) 3 Inpatient (Medicare Part B only) 8 Reserved for National Assignment</p> <p>3rd Digit – Frequency</p> <p>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. <i>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.</i> 8 Void or reverse a prior claim. <i>You must have the ICN of the original paid claim in order to complete this process.</i> 9 Final Claim for a Home Health PPS Episode</p> |
| 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. |

| Field | Guidelines |
|------------------------------|--|
| Patient Status | <p>Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period:</p> <p>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.</p> <p>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).</p> |
| 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 | <p>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.</p> <ul style="list-style-type: none"> • 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. |

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. |

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. |

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 <u>not</u> 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.

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. |
| 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.

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. |

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. |

| 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.

The screenshot shows a software window titled "837 Institutional Nursing Home". At the top, there are summary fields: Total Charge .00, OI Amount .00, Billed Amount .00, and Services 1. Below this is a tabbed interface with tabs for Header 1, Header 2, Header 3, Header 4, OI, OI Adj, Crossover, and Service (which is selected). The Service tab contains several input fields: Date Of Service (00/00/0000), Revenue Code (empty), Billed Amount (.00), Units (0), and Unit Rate (.00). To the right of these fields are buttons: Add, Copy, Delete, Undo All, Save, and Edit All. Below the input fields is a table with columns: Srv #, Date Of Service, Revenue Code, Units, and Billed Amount. The table contains one row with values: 1, 00/00/0000, (empty), 0, and .00. To the left of this table are buttons: Add Srv, Copy Srv, and Delete Srv. At the bottom of the form is another table with columns: Recipient ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status. To the right of this table are buttons: Find..., Print, and Close.

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.

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.

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*.


12 Submitting Claim Reversals and Adjusting Paid Claims

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


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.

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.

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:

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.

- 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.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of service; 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:

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.

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.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of service; 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:

The screenshot shows a window titled "Pharmacy Reversal" with the following fields and controls:

- Provider ID** and **ID Code Qualifier** (text boxes)
- Provider Name** (text box)
- Recipient ID** and **Patient Account #** (text boxes)
- Last Name** and **First Name** (text boxes)
- Date Of Service** (text box with value 00/00/0000)
- Prescription #** and **NDC** (text boxes)
- A table with columns: **Recipient ID**, **Last Name**, **Prescription #**, **Date Of Service**, **Last Submit Dt**, **Status**
- Buttons on the right: **Add**, **Copy**, **Delete**, **Undo All**, **Save**, **Find...**, **Print**, **Close**

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.

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.

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.

13 Receiving a Response

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

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 Gainwell 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.

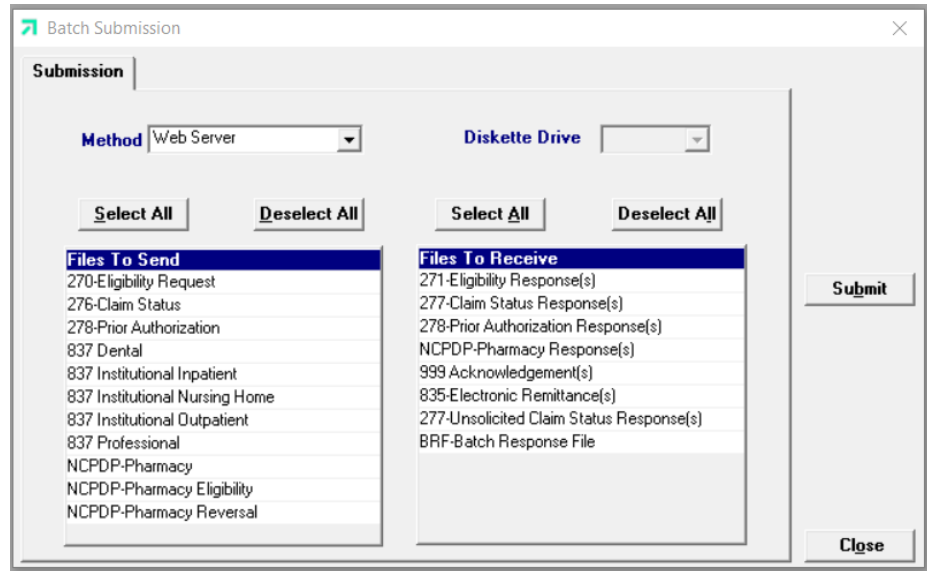
Likewise, you can submit eligibility verification and claim records together in the same batch transmission. *Provider Electronic Solutions* also enables you to upload responses while you are downloading batches to the Web Server.

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:

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.

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.

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.

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

- 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

- 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 Gainwell. 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 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.

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 |

| Button | Usage |
|---------------|--|
| | 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.
- 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

15.2.1 Header 1 Tab

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

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. |

| 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 '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. |

15.2.2 Header 2 Tab

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

The screenshot shows a software window titled "PA 278 Prior Authorization Request" with a tabbed interface. The "Header 2" tab is active. The form contains the following fields and controls:

- Diagnosis Code:** A dropdown menu.
- Recipient Tracking #:** A text input field.
- Company ID:** A text input field.
- Reference ID:** A text input field.
- Accident Date:** A date input field showing "00/00/0000".
- Trace #:** A label "Trace # 302".
- Request Category:** A dropdown menu showing "HS".
- Certification Code:** A dropdown menu showing "1".
- Service Type:** A dropdown menu.
- Place Of Service:** A text input field.
- Prognosis:** A dropdown menu.
- Release Of Information:** A dropdown menu.
- Previous PA #:** A text input field.

At the bottom of the form is a table with the following columns: Recipient ID, Last Name, First Name, Last Submit Dt, and Status. To the right of the form are several action buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close.

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. |

| 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. |

15.2.3 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. |

| 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. |

15.2.4 Header 4 Tab

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

The screenshot shows a software window titled "PA 278 Prior Authorization Request". At the top, there are tabs for Header 1 through Header 7 and Service 1, with "Header 4" selected. The main area contains an "Attachment" section with five rows. Each row has a "Type" dropdown menu (the first is set to a blue icon), a "Transmission Code" dropdown menu, and a "Control #" text input field. Below this are five "Description" text input fields. To the right of the attachment section is a vertical toolbar with buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close. At the bottom of the window is a table with columns: Recipient ID, Last Name, First Name, Last Submit Dt, and Status.

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. |

| Field | Guidelines |
|-------------------|---|
| 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: Gainwell Technologies Attn: PA Unit PO Box 244032 Montgomery, AL 36124 |
| Description | Enter the attachments description. This field is optional. |

15.2.5 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. |

| Field | Guidelines |
|-------------------|---|
| 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: Gainwell Technologies Attn: PA Unit PO Box 244032 Montgomery, AL 36124 |
| Description | Enter the attachments description. This field is optional. |

15.2.6 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 |
| 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. |

15.2.7 Header 7 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 7 tab.

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. |

| Field | Guidelines |
|---|---|
| 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. |

15.2.8 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 |

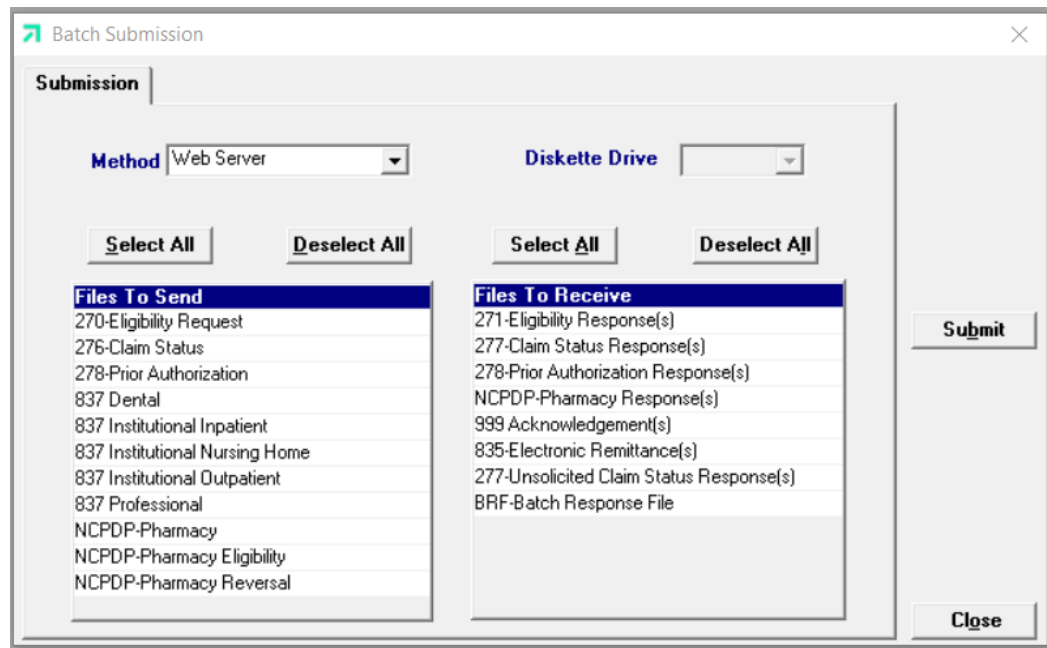
| Field | Guidelines |
|-----------|--|
| Procedure | <p>Choose the procedure being billed from the Procedure/HCP/PCS list.</p> <p>For <u>Dental</u> Providers: If a procedure code needs to be associated with a tooth number, first key a valid 5-digit procedure code. Press 'Copy Srv' to add a second detail 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.</p> <p>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 <u>after</u> the tooth numbers have been properly associated with the previous procedure code.</p> <p>For <u>Inpatient/Psychiatric</u> request: Instead of a procedure code, enter a valid revenue code.</p> |
| Quantity | Enter the quantity being billed. |
| 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

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.

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.

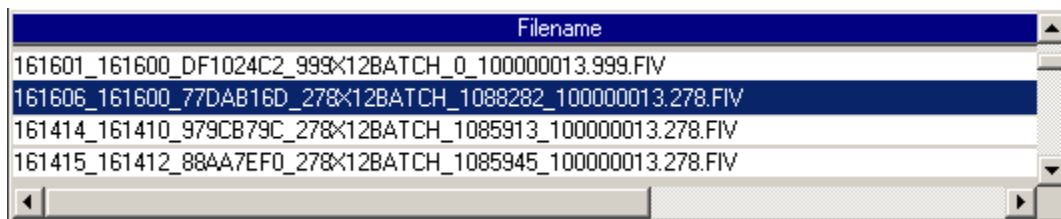
NOTE:
 The batch number received is confirmation that your Prior Authorization Request has been received. It does not denote approval or denial of the requested service. After the Medicaid Agency reviews and approves or denies the request, a decision letter will be mailed to the rendering provider.

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:



Prior Authorization Request Batch Response 1

***** TRANSACTION INFORMATION *****

| | |
|--|---|
| Transaction Set Creation Date: 10/03/2011 | 2 |
| Transaction Set Creation Time: 1420 | 3 |

***** PROVIDER INFORMATION *****

| | |
|---------------------------------------|---|
| Requesting Provider ID: 1234567890 | 4 |
|---------------------------------------|---|

***** RECIPIENT INFORMATION *****

| | |
|---|---|
| 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 |

***** SERVICE PROVIDER INFORMATION *****

| | |
|--|----|
| 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: ██████████ | 20 |

***** SERVICE LEVEL INFORMATION *****

| | |
|-------------------------------------|----|
| 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 |

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. |

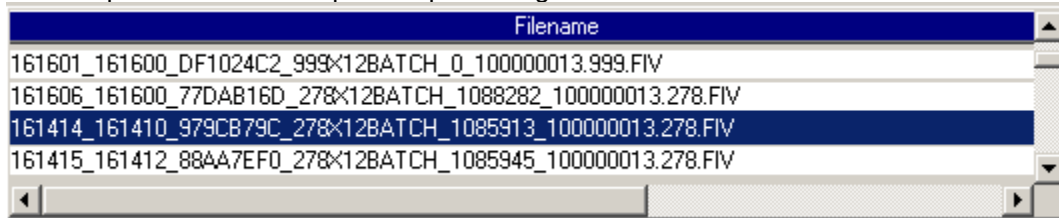
| <i>Field #</i> | <i>Field</i> | <i>Guidelines</i> |
|----------------|--------------|--|
| 25 | Quantity | This reflects the number of units entered in the 'Quantity' field on the Service 1 tab of the PA request form. |

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:



Prior Authorization Request Batch Response 1

***** TRANSACTION INFORMATION *****

| | |
|---------------------------|---|
| Transaction Set | |
| Creation Date: 10/01/2011 | 2 |
| Transaction Set | |
| Creation Time: 1720 | 3 |

***** PROVIDER INFORMATION *****

| | |
|-------------------------|---|
| Requesting | |
| Provider ID: [REDACTED] | 4 |

***** RECIPIENT INFORMATION *****

| | |
|---------------------------------------|---|
| Recipient ID: [REDACTED] | 5 |
| Recipient Account #: TEST FOR DF 9431 | 6 |

***** SERVICE PROVIDER INFORMATION *****

| | |
|---------------------------|----|
| Trace Type Code: 1 | 7 |
| Trace Number: 210 | 8 |
| Trace Assigning | |
| Entity ID: 111111111 | 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 FURTHER REVIEW | 19 |
|---|----|

| | |
|-------------------------|----|
| Rendering | |
| Provider ID: [REDACTED] | 20 |

***** SERVICE LEVEL INFORMATION *****

| | |
|-------------------------------------|----|
| Service Date: 10/01/2011-12/31/2011 | 21 |
| Procedure Qualifier: HC | 22 |
| Procedure Code: E1150 | 23 |
| Procedure Amount: No Data | 24 |
| Quantity: 1.000 | 25 |

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. |
| 15 | PA Number | 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 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. |
| 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.

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.

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.

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. |

| 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.

The screenshot shows a software window titled "276 Claim Status Request" with a "Header 2" tab selected. The main area contains several input fields: "From DOS" (00/00/0000), "To DOS" (00/00/0000), "Type Of Bill" (empty), "Billed Amount" (0.00), "ICN" (empty), and "Trace # 201". Below these fields is a table with columns: Recipient ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status. To the right of the main area is a vertical toolbar with buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close.

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. <i>Do Not</i> 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. |

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)
-

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 through an ISP (Internet Service Provider).

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 AT&T, Spectrum, 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/ALPortal> Continue to **Step 3** in section 17.1.2 Updating your Password for further instructions.

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 1 Continue to **Step 3** in section 17.1.3 Updating your Password for further instructions.

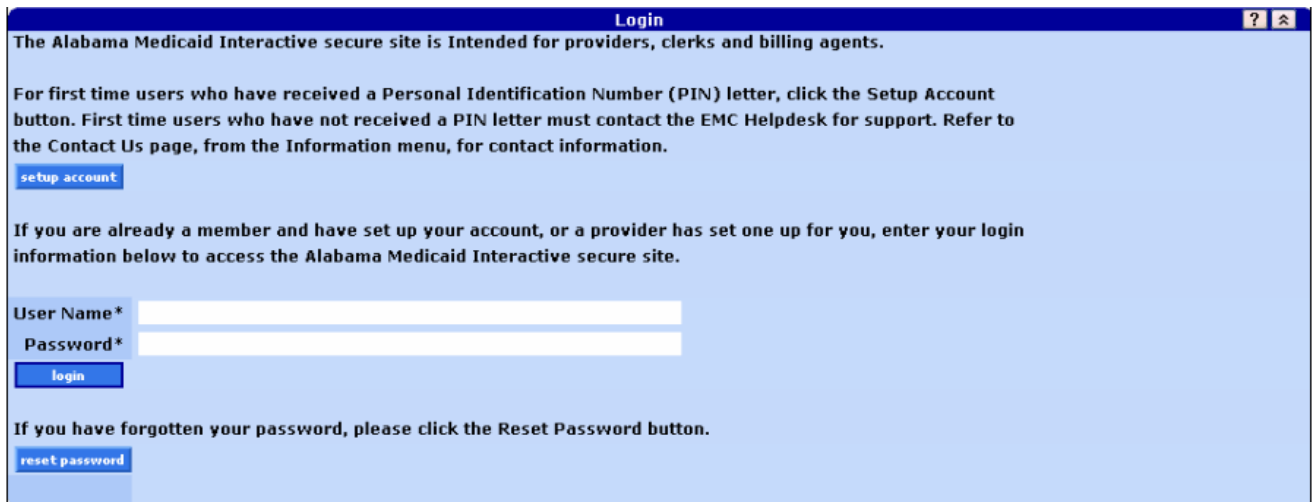
17.1.2 Updating your Password

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.

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. |

| 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. |

| 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. |

| 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. |

| 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. |

| 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 297:60 (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. |

| 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? |

| 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). |

| 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. |

| 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? |

| 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 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 |

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 |

| | |
|----|--|
| 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 |

| | |
|----|---|
| AL | Specialized Treatment/Bed Unavailable |
| AM | Non-emergency Medically Necessary Stretcher Transport Req'd |
| 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 |

| 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 |

| 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. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|-----------|---------------|---|
| 10/10/2012 | Jason Cory | 3.02 | n/a | n/a | <p>All Crossover Claims</p> <ul style="list-style-type: none"> 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 | <p>Archiving</p> <ul style="list-style-type: none"> 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 | <p>Lists Heading</p> <p>Remove diagnosis list and replace with the following new list:</p> <ul style="list-style-type: none"> Diagnosis ICD-9 Diagnosis ICD-10 <p>Add new ICD Procedure list:</p> <ul style="list-style-type: none"> Procedure ICD-9 |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|-----------|---|---|
| | | | | | <ul style="list-style-type: none"> Procedure ICD-10 Procedure/HCPSCS <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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. |
|------------|------------|------------------|------------|---|--|
| | | | | | <ul style="list-style-type: none"> • 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 | <p>Institutional Outpatient Form</p> <ul style="list-style-type: none"> • 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. |

| 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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. |
| 10/10/2012 | Jason Cory | 3.02 | Appendix C | n/a | Created Appendix C – Application Update Log |

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Application Update Log

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|------------|----------------------------------|--|
| | | | | | <ul style="list-style-type: none"> Added Appendix C to describe software and documentation changes. |
| 11/20/2012 | Jason Cory | 3.02 | Appendix B | n/a | <p>Created Appendix B – Code Lists</p> <ul style="list-style-type: none"> Added Appendix B to hold large lists of codes. |
| 11/20/2012 | Jason Cory | 3.02 | Chapter 4 | Section 4.4 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|------------|-----------------------------|---|
| 11/21/2012 | Jason Cory | 3.02 | Chapter 10 | Sections 10 (intro), 10.2.4 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <p>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.</p> <p>In addition, the following Base changes have been made to the manual:</p> <ul style="list-style-type: none"> 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. Minor other changes listed in below items for version 3.03. |

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| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-------------|---------------|-------------------------|-----------------------|---------------------|--|
| 9/25/2013 | Jason Cory | 3.03 | n/a | n/a | <ul style="list-style-type: none"> Update date on Cover Page. |
| 9/25/2013 | Jason Cory | 3.03 | n/a | n/a | <ul style="list-style-type: none"> Update Table of Contents. |
| 9/25/2013 | Jason Cory | 3.03 | Chapter 14 | Section 14.2 | <p>Other Reports</p> <ul style="list-style-type: none"> Update report listing to show Ordering Provider report. |
| 9/5/2013 | Jason Cory | 3.03 | Appendix B Code Lists | Section B.3 Created | <p>Section B.3 Service Type Code</p> <ul style="list-style-type: none"> 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 | <p>Eligibility 270 Form</p> <ul style="list-style-type: none"> 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. |
| 9/25/2013 | Jason Cory | 3.03 | Chapter 4 | Section 4.1 | <p>Building Lists</p> |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-----------|------------|------------------|-----------|---------------|--|
| | | | | | <ul style="list-style-type: none"> • Screenshot updated to show Ordering Provider list. |
| 9/25/2013 | Jason Cory | 3.03 | Chapter 7 | Section 7.2.2 | <p>Service 1 Tab</p> <ul style="list-style-type: none"> • 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 | <p>Service 2 Tab</p> <ul style="list-style-type: none"> • Update screenshot to include Ordering Provider field. • Ordering Provider ID added to table description. |
| 1/28/2015 | Jason Cory | 3.04 | n/a | n/a | <p>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.</p> <p>In addition, the following Base changes have been made to the manual:</p> <ul style="list-style-type: none"> • SOBRA and AEF application status for recipient eligibility. • Medicare 2% sequestration. • Allow 0 billed amount on |

Application Update Log

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-----------|------------|------------------|-------------------|--|--|
| 1/30/2015 | Jason Cory | 3.04 | Table of Contents | n/a | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <p>Dental Form</p> <ul style="list-style-type: none"> • Updated tab count and new tab names. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • 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. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-----------|------------|------------------|-----------|--|---|
| 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 | <p>Professional Form</p> <ul style="list-style-type: none"> • 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. • 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 | <p>Institutional Inpatient Form</p> <ul style="list-style-type: none"> • 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. |

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| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-----------|------------|------------------|------------|---|---|
| | | | | | <ul style="list-style-type: none"> • 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, 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 | <p>Institutional Outpatient Form</p> <ul style="list-style-type: none"> • 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. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|-----------|------------|------------------|--------------------------|---|--|
| | | | | | <ul style="list-style-type: none"> • 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 | <p>Institutional Nursing Home Form</p> <ul style="list-style-type: none"> • 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. • 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 | <p>Section B.4 Adjustment Group Codes</p> <ul style="list-style-type: none"> • Adjustment Group Codes list was added to include codes and descriptions for each code. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|-----------------------|---------------------|---|
| 1/23/2015 | Jason Cory | 3.04 | Appendix B Code Lists | Section B.5 Created | <p>Section B.5 Reason Codes</p> <ul style="list-style-type: none"> Reason Codes list was added to include codes and descriptions for each code. |
| 11/06/2015 | Jason Cory | 3.05 | n/a | n/a | <p>NOTE: Version 3.05 contains updates including the following.</p> <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Update date on cover page. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|------------|-----------------------------------|---|
| 11/06/2015 | Jason Cory | 3.05 | Chapter 9 | Section 9.2.2, Section 9.2.3 | <p>Institutional Inpatient Form</p> <ul style="list-style-type: none"> 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 10 | Section 10.2.2, Section 10.2.3 | <p>Institutional Outpatient Form</p> <ul style="list-style-type: none"> 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 | <p>Institutional Nursing Home Form</p> <ul style="list-style-type: none"> 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. |

Application Update Log

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|------------|------------------|------------|--------------------|--|
| 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. |
| 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. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|-------------------|------------------|------------|---------------------------------|---|
| 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. |
| 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 | <p>NOTE: Version 3.08 contains updates including the following.</p> <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Update date on cover page. |
| 06/30/2017 | Sandra Richardson | 3.08 | Chapter 9 | Section 9.2.2, Section 9.2.3 | <p>Institutional Inpatient Form</p> <ul style="list-style-type: none"> • 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. |

Application Update Log

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|-------------------|------------------|------------|-----------------------------------|---|
| 06/30/2017 | Sandra Richardson | 3.08 | Chapter 10 | Section 10.2.2, Section 10.2.3 | Institutional Outpatient Form <ul style="list-style-type: none"> • Updated Header 2 screenshot to show ICD 10 version dropdown as the new default selection. • 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 <ul style="list-style-type: none"> • Updated header 3 screenshot to show ICD 10 version indicator. |
| 10/30/2017 | Sandra Richardson | 3.09 | n/a | n/a | <p>NOTE: Version 3.09 contains the following changes:</p> <ul style="list-style-type: none"> • Change references from “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 | <ul style="list-style-type: none"> • 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”. |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|-------------------|------------------|------------|---------------------------------|--|
| 10/30/2017 | Sandra Richardson | 3.09 | Chapter 5 | Section 5 (intro) | <ul style="list-style-type: none"> Updated note explaining version 3.09 includes MCO enrollment on eligibility response. |
| 10/30/2017 | Sandra Richardson | 3.09 | Chapter 8 | Section 8.2.4, Section 8.2.6 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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". |

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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) | <ul style="list-style-type: none"> 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 | <p>NOTE: Version 3.10 contains the following changes:</p> <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Updated conflict code guidelines to include ID-Ingredient duplication value. |
| 02/23/2018 | Sandra Richardson | 3.10 | Chapter 8 | Section 8.2.3 | <ul style="list-style-type: none"> 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 | <p>Redact PHI/PII as well as non-public test data Updated screen layout for:</p> <ul style="list-style-type: none"> 15.4.1 Prior Authorization Request response 15.4.2 Prior Authorization Request response |

| Date | Author | Software Version | Chapter | Section/Page | Description of changes. |
|------------|---------------------------|------------------|---------------------------------------|---|---|
| 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 |
| 3/10/2021 | Amber King | 3.12 | Chapter 12 Chapter 7 Chapter 17 | Throughout Section 7.2.2 Section 17.1.2 | <ul style="list-style-type: none"> Removed all references to 4010 Updated 3 years from date of payment to date of service Added Quantity Prescribed field Updated Service 1 screenshot Removed all references to RAS (Remote Access Server) and instructions on how to use RAS. Section 17.1.3 is now 17.1.2 Global update to Gainwell technologies name. |
| 10/1/2022 | Amber King | 3.13 | Chapter 7 | Section 7.2.3 | <ul style="list-style-type: none"> Added Submission Clarification to table |

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|-----------|------------|------------------|--|--|---|
| | Amber King | 3.13 | Chapter 8 | Section 8.2.2 | <ul style="list-style-type: none"> • Added Referral Number to table • Updated Header 2 Screenshot |
| 7/13/2023 | Amber King | 3.14 | Chapter 3 Chapter 6 Chapter 8 Chapter 9 Chapter 10 | Section 3.2 Section 6.2.2 Section 8.2.2 Section 9.2.6 Section 10.2.4 | <ul style="list-style-type: none"> • Replaced Help Topics with Home and Updated Screenshot • Updated Provider Manual Note • Updated 837 Dental screenshot • Replaced Emergency Ind with Service Authorization • Updated Service Authorization Guidelines |