Provider Electronic Solutions Software Manual

Provider Electronic Solutions Software
User Manual for Wisconsin Medicaid,
HIRSP, and WWWP Providers

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EDS

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Introduction

Provider Electronic Solutions (PES) is Health Insurance Portability and Accountability Act (HIPAA)-compliant software used for submitting claims to Wisconsin Medicaid, the Wisconsin Health Insurance Risk Sharing Plan (HIRSP), and the Wisconsin Well Woman Program (WWWP). PES software cannot be used for submitting claims to Medicare or other commercial health insurance payers. EDS, the current Medicaid fiscal agent, supports the PES software. PES is available only to Wisconsin Medicaid providers and electronic billing services and will allow them to submit HIPAA-compliant electronic claims and adjustments to Wisconsin Medicaid, HIRSP, and WWWP. This includes the 837 Health Care Claim Dental (commonly referred to as the 837D), the 837 Health Care Claim Professional (or 837P), and the 837 Health Care Claim Institutional (or 837I). Provider Electronic Solutions software will instruct you at the appropriate time to select Wisconsin Medicaid, HIRSP, or WWWP.

This manual is intended only to provide information specific to the electronic submission of claims. Providers should continue to refer to their Wisconsin Medicaid, HIRSP, or WWWP billing manuals for general information on how to bill their claims. This manual is not intended to replace, supersede, or contradict existing Wisconsin Medicaid, HIRSP, or WWWP guidelines (i.e., benefit limitations or exclusions). All existing program guidelines, instructions, manuals, bulletins, etc. continue to apply as appropriate to all claims submitted electronically, and should be referred to on a continuing basis.

HIPAA Transactions

With HIPAA, each electronic transaction has an assigned number. The following table shows the transactions used by PES and their respective descriptions.

Transaction	Description
835	Electronic remittance advice
837	Health care claims: Professional Institutional Dental
997	Functional Acknowledgement

Equipment Requirements

Provider Electronic Solutions is designed to operate on a personal computer system with the following equipment requirements:

Minimum
Pentium II personal computer or equivalent
Windows 2000/XP operating system
100 MB hard drive space available
64 MB RAM
Resolution 800 X 600
28.8K modem/Broadband Connection
CD-ROM drive
Microsoft Internet Explorer 5.5 or higher
Printer with 8 pt sans serif font (optional)

Note: If you have a version of Internet Explorer below 5.5 and don't have access to the Internet, contact Microsoft® to order a copy of the latest Internet Explorer on CD. Microsoft® can be contacted by calling (800) 360-7561.

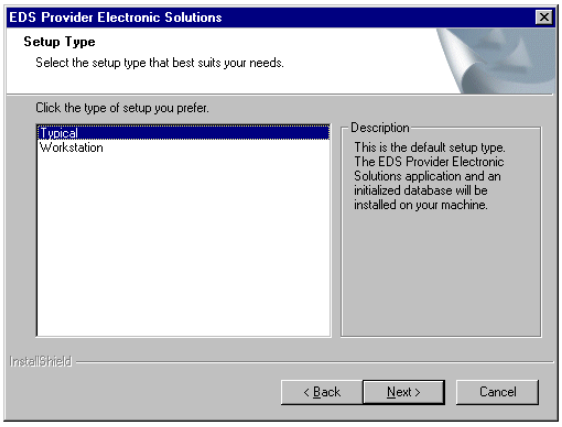
PES Installation

Installation Types

Provider Electronic Solutions (PES) may be installed on a computer's hard disk drive or on a network. When you begin the installation, you will need to choose a network or individual personal computer (PC) installation.

Provider Electronic Solutions comes on a CD. When you place the CD in your computer, it should automatically open a main menu.

Type of Installation



Autorun CD

If the PES autorun CD does not open the main menu within 30 seconds, complete the following steps before contacting the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department. The DHCF EDI Help desk telephone number is (608) 221-9036.

1. Remove the CD from the drive and reinsert the CD. Verify that the label is facing up when inserting the CD. The CD should run automatically. If it does not, continue to step 2.

2. Double-click the My Computer icon on your desktop. Select the CD-ROM drive.

3. Click on "Software" on the CD interface.

4. Select "Run this program from its current location" or select "Save this program to disk." If you select the latter option, save the file to your desktop.

5. Double-click the WI_v0206_setup.exe icon on your desktop.

The main menu will open; proceed to the instructions for Individual PC Installation.

Individual PC Installation

1. Insert the PES CD into your computer.

2. Click **Start**. Click **Run**.

3. Click **Browse**, select your CD drive, and select WI_v0206_setup.exe.

4. Click **Open**.

5. Click **OK**.

6. The welcome screen displays. Click **Next**.

7. Select type of setup you need. “Typical” is for an individual PC setup. Click **Next**.

8. Click **Next** to accept the default destination for the software.

9. Click **Next** to accept the default destination for the database.

10. Click **OK**. A status bar displays showing the progress of the installation. You can cancel installation at any time by clicking **Cancel**.

11. When installation is complete, click **Finish** to exit installation.

Network Installation

To install the application for use by several users, you will need to perform a network installation. For network installation, the database can reside on the server and the application can be loaded onto individual PCs. The user may install PES on as many PCs as needed using the same Trading Partner ID.

The following instructions will install the shared database on a network and the application on the PC on which you are installing.

1. Follow the Individual PC Installation instructions until step 7. When asked what type of installation you desire (step 7 of Individual PC Installation instructions), select “Typical” on the first PC. This computer will be the “primary computer” and will need to be upgraded first when there are new PES updates.

2. Select a target folder on the PC’s C: drive or accept the default directory for the PES application.

3. Select a target folder (i.e., a shared network folder or another disk) for the PES database. If you want the PES database to reside in the C:\wihipaa directory, click **Next**.

4. When installing PES on PCs other than the primary computer, select “Workstation” setup instead of “Typical.”

5. Enter the location where the database was installed when installing PES on other PCs (be it on your network, disk, or default directory). Note that the Workstation computer(s) must be updated after the Typical (primary computer) is updated, each time an upgrade is released.

Installation Notes

- If you install PES as a stand-alone PC application on more than one PC, you will not be able to share data between the PCs.

- When applying a PES upgrade in a network environment, make sure that you upgrade all PCs running PES (primary or “typical” first, then workstations), in addition to upgrading the database (this only has to be done once per upgrade). This will ensure that all copies of PES remain synchronized.

Upon completion of the installation process, store the original PES program CD in a safe place. In the event the program and files are damaged or deleted, the original CD will be needed to re-install the program.

If a re-install is required, the PES database will be overwritten. You can backup your PES database by simply making a copy of the WINEWECS.MDB file and pasting it into a safe folder or directory.

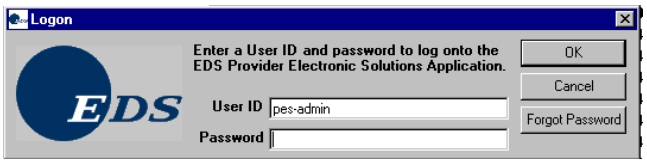
Getting Started

Opening PES

To access the Provider Electronic Solutions (PES) application after installation, use one of two methods:

- Open the application folder named WI EDS Provider Electronic Solutions from the desktop, then double-click EDS Provider Electronic Solutions.
- Click the **Start** button, select **Program**, select WI EDS Provider Electronic Solutions and then WI EDS Provider Electronic Solutions.

Login Box



Initial Login

The PES software provides basic security for the user through the login process.

In the Password box in the Login window, enter the password: “eds-pes.” Click **OK**. The next box displayed alerts you that the password has expired.

Click **OK** to continue and follow the instructions for changing the password.

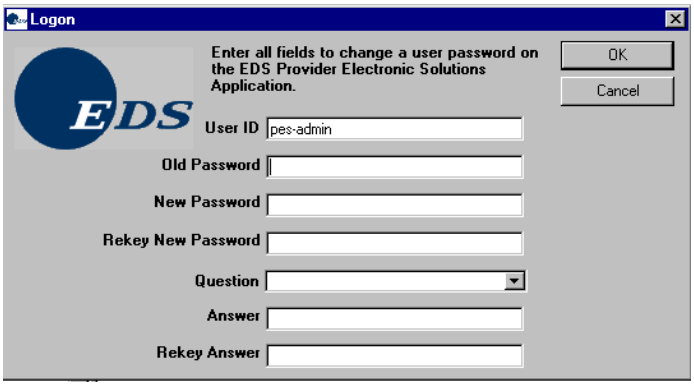
Note: Do *not* attempt to change the User ID.

Password Rules

Use the following guidelines when choosing passwords:

- Passwords are not case sensitive.
- A password may be any combination of alphabetic, numeric, and special characters.

Login Window



- A password must be at least five characters in length but no more than 10 characters.

Setting Your Password

1. At the Login window, in the Old Password box, type “eds-pes.”
2. In the New Password box, enter a new password.
3. In the Rekey New Password box, re-enter the new password.
4. Select a question from the drop-down list.
5. Enter an answer to the question in step 4.
6. Rekey the answer to the question in step 4.
7. Click **OK**.
8. The next message displayed tells you that you have successfully updated your password. Click **OK** to continue.

The system will prompt you to set up your personal options. Click **OK**. For more on options, proceed to Setting Up Options in this chapter.

Registration Enrollment

Prior to submitting claims to the DHCF EDI Department, you will need to create a Web login and password by registering at *www.wisconsinedi.org/*. Complete this step before setting up your options.

Note: When creating a username and password during registration enrollment, choose a username that is six to 15 characters in length, and a password that is eight to 12 characters in length. The password must contain at least one alpha and one numeric character. The Web login and password are case sensitive. Enter both in the Batch tab exactly as they were entered when registering.

Setting Up Options

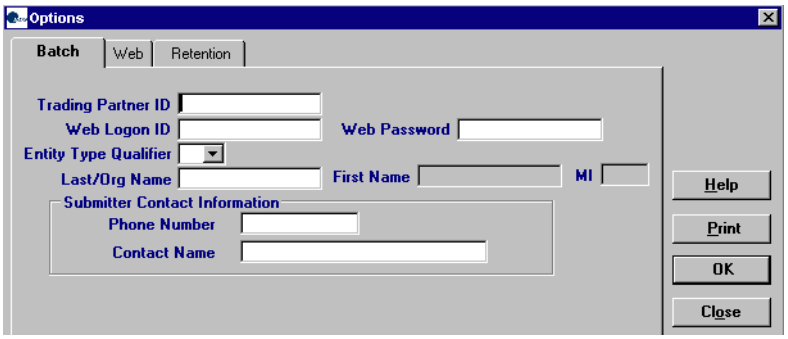
To submit claims and receive information, Options must be set up on each personal computer (PC) the first time you use the software. There are three options that must be confirmed or created. They are Batch, Web, and Retention. The Options window displays with the Batch tab on top.

To access Options after the initial setup, select **Tools** from the menu bar and then **Options**.

Batch Tab

This tab is used to set up communication protocols with the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

Options – Batch Tab



1. Select the Batch tab.

2. Enter the Trading Partner ID as assigned by the DHCF EDI Department. The Trading Partner ID can be found on your Trading Partner Profile, which was mailed or e-mailed back to you upon completion.

3. Enter the Web login ID (called a username on the registration site) and Web password you created at *www.wisconsinedi.org/*. Refer to the Registration Enrollment section in this chapter for more information.

   Note: When PES is installed on a network, all users on the network use the same Web login ID and Web password.

4. Select the correct Entity Type Qualifier. Choose “1 – Person” (individual provider) or “2 – Non-Person” (billing service, group, or facility). Personal care, home health, and independent nurses should enter a “2” in this box.

5. Enter the last name of the individual provider or the organization name if a billing service, facility, or group in the Last/Org Name box. Personal care, home health, and independent nurses should enter their last name in this box.

6. In the First Name box, enter the first name of the individual if the Entity Type Qualifier is set to “1.”

7. Enter the middle initial of the individual provider in the MI box, if applicable.

8. Enter the phone number of the person who will be submitting the transaction in the Submitter Contact Information box.

9. Enter the name of the person who will be submitting the transaction in the Submitter Contact Information box.

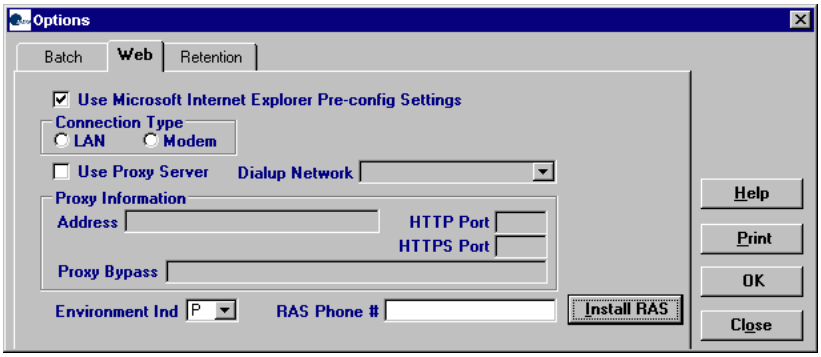
Web Tab

This tab will allow you to submit claims to the DHCF EDI Department using one of two methods:

- Using an existing Internet connection.
- Using the Remote Access Server (RAS).

Wisconsin Medicaid will send you requirements for testing connectivity after you successfully complete the Trading Profile forms.

Options – Web Tab



Submitting claims using an existing Internet connection

Use this option if you have an existing Internet connection using any of the following connection types: cable modem, DSL modem, ISDN modem, local area network (LAN) connection, or analog modem. In most cases, the analog modem is the dial-up network for your Internet Service Provider (ISP).

1. Verify that the Use Microsoft Internet Explorer Pre-config Settings check box is checked. Checking this box indicates that the PES application will use the same settings as the Microsoft browser to connect to the Internet. The box is selected by default.

2. Select the appropriate environment indicator. The Environment Ind box defaults to “P” for production environment. Select “T” only if this claim is used to test for software connectivity.

If you need to connect to the Internet using a proxy setting for the PES application, use the following steps:

1. Uncheck the Use Microsoft Internet Explorer Pre-config Settings check box.

2. Select the appropriate connection type. The Connection Type indicates whether the Internet connection is established through a LAN or a modem.

3. Check the Use Proxy Server check box when a proxy server is used to connect to the Internet. The proxy server is commonly used with a LAN connection. If checked, the Proxy Information boxes, including Address, Hypertext Transfer Protocol (HTTP) Port, secure HTTPS Port, and Proxy Bypass will be available for entry.

4. Enter a proxy address if you selected Use Proxy Server. This is the IP address or Universal Resource Locator (URL) address of the proxy server used to connect to the Internet. This is a required box if you checked the Use Proxy Server check box.

5. Enter your HTTP port if you selected Use Proxy Server. This is the port number that the proxy server uses for standard Hypertext Transfer Protocol (HTTP) communication. This is a required box if you checked the Use Proxy Server check box.

6. Enter the HTTPS port if you selected Use Proxy Server. This is the port number that the proxy server uses for secure Hypertext Transfer Protocol (HTTPS) communication. This is a required box if you checked the Use Proxy Server check box.

7. Enter a proxy bypass, if desired, if you selected Use Proxy Server. This is the URL address that does not use the proxy server.

Submitting claims using a Remote Access Server connection

This option is available to users who do not have an existing Internet connection. The remote access connection will only allow a connection for submitting claims to the DHCF EDI Department. Please note that this is *not* an ISP connection.

1. Select the appropriate environment indicator. The Environment Ind box defaults to “P” for production environment. Select “T” only if this claim is used to test for software connectivity.

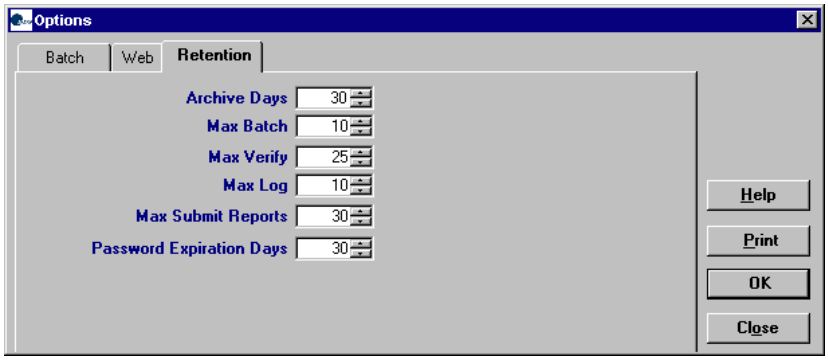
2. Enter the RAS telephone number, (608) 221-2152. (The area code is only required for long distance dial-ups.)

3. Click **Install RAS**. Clicking this button will install a dial-up network entry into Microsoft Windows. It will also update the connection type to “Modem” and the Dial-up Network to the RAS connection.

Retention

The retention settings allow you to retain data for a specific number of days or transactions before the information is deleted from the software or before notification is given for transactions that can be archived.

Options – Retention Tab



1. Confirm the following default settings or change the settings to meet your business needs. Use the scroll-down feature to select the appropriate setting, or enter the value that you have determined meets your business needs.

   Archive Days: The default number of days is 30; the maximum number of days is 999 before the system notifies the user that it is time to archive submitted claims. If you submit large volumes of claims, it is recommended that you archive your claims at least every 30-60 days.

   Max Batch: The default maximum number of batches is 10. This is the maximum number of batches retained in the resubmission option of the communication menu. Batches on the batch list will be deleted on a first-

in/first-out basis. The maximum number of batches that can be retained is 999.

Max Verify: The default number of download files (835 and 997) is 25. Downloaded files will be deleted on a first-in/first-out basis. The maximum number of downloaded responses that can be retained is 999. Refer to the Communication chapter of this manual for more information on batch responses.

Max Log: The default number of communication log backups is 10. The maximum number of communication log backup files that can be retained is 999. Refer to the Communication chapter for more information on communication logs.

Max Submit Reports: The default number of submission reports is 30. The maximum number of submission reports that can be retained is 999. This option is not available.

Password Expiration: The default number of days before a password expires in PES is 30. The maximum number of days before a password expires is 99.

2. After completing or viewing the retention settings, select **OK** to save the settings.

Basic Skills

The keyboard shortcuts, menus, toolbars, and buttons used in Provider Electronic Solutions (PES) software are similar to other Microsoft Windows® software. We recommend that you use this chapter to familiarize yourself with some common functions in PES, which may save time when you enter claims.

Using the Keyboard

Many computer users find it easiest to use the computer keyboard to move around on a screen. The following is a list of keys that can be used with the PES software.

Click this key:	**To do this:**
Tab or Enter	Go to the next box
Shift + Tab	Go to the previous box
Left Arrow	Move backward within a box
Right Arrow	Move forward within a box
Up Arrow	Scroll up through a list
Down Arrow	Scroll down through a list
F1	Open online help when the pointer is on a data entry box
ESC	Exit the help window
Alt + Down Arrow	Show available list choices
Alt + hot keys	Hot keys are identified on the menu by an underlined letter that you hit along with the Alt key on the keyboard. These buttons vary from screen to screen.

Using the Mouse

Use the mouse the same as you would in any other software. That is, move the mouse pointer to the position on the screen where you want to work or select an option. Click the mouse button once to position your pointer at that location or to select an option.

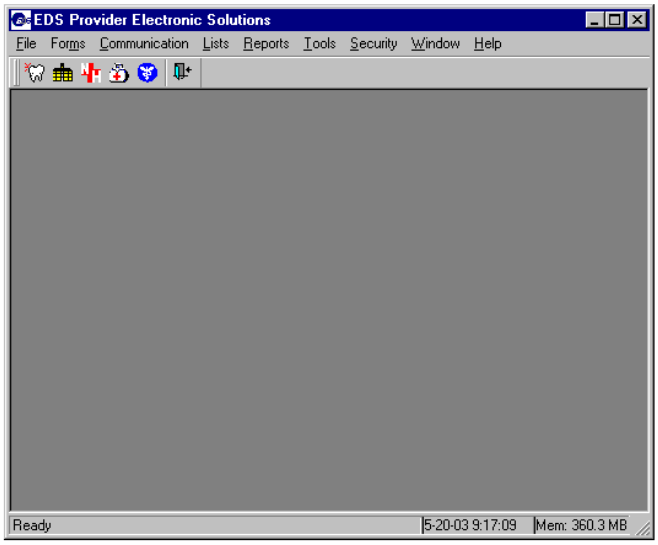
Double-Click: When the down arrow in a box is selected, either a window or a list selection will appear. If no data has been entered in the list, double-click the box to “jump” to it and add the required data. Refer to the Lists chapter for assistance in completing the required boxes for each list.

Right-Click: Use the right mouse button for Cut, Copy, Paste, and Select All.

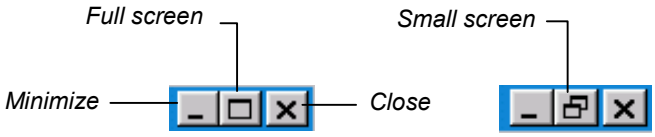
PES Main Window

There are two basic windows in PES. The first window has the main menu of all the functions you can choose: File, Forms, Communication, Lists, Reports, Tools, Security, Window, and Help. Some of these options are then repeated in the toolbar directly below the menu bar.

Main Menu Window



In the upper right-hand corner of the main window there is a set of three little boxes you can use to hide, re-size, or close the window. You can also hide, re-size, and close the active window inside of the main window. Be careful with the **X**. You can close the program by clicking it. PES will always prompt you to save any changes before you close.

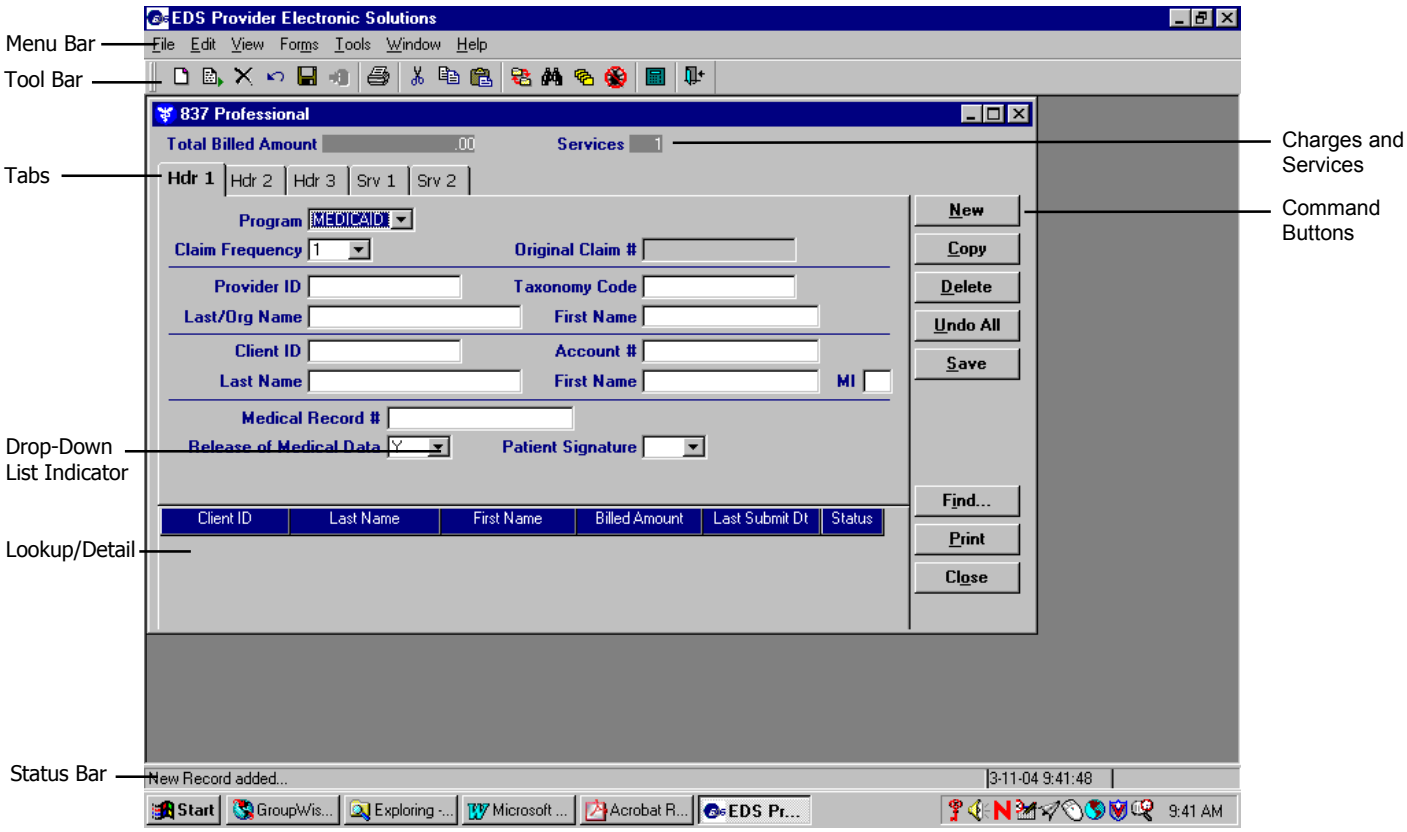


Another way to resize the main window is to grab the lower right hand corner of the window with your pointer and drag it until you have the size you want.

Tip

Use the Minimize feature to minimize PES during periods of non-use. This allows you to have access to the application throughout the day.

PES Window with 837 Professional Form Open



Menu Bar

The menu bar appears at the top of the PES window. It is a list of basic commands. There are two menu bars: one for the main window, and a second that opens once you select an option.

Toolbar

The toolbar contains shortcuts for frequently used commands that reduce the time and steps needed to activate a function. The toolbar consists of icons that represent different menu commands. To execute a command using the toolbar, simply click the button. To see a name or brief description of each button, hover the pointer over the button but do not click. The description will appear just below the button.

Find: You may use this command to locate a specific form. If you have set up a filter on the forms, you will only be able to find forms that match the filter. In other words, the find command will not search forms that do not appear in the detail window.

Filter: You may limit or filter the forms that are displayed in the detail window. This feature allows you to see only

the forms you are interested in while keeping the forms you do not want to see available for future use.

Sort: You may use the sort command to control the detail window display. You may display the forms in sorted order based upon the column headings in the detail window.

Charges and Services

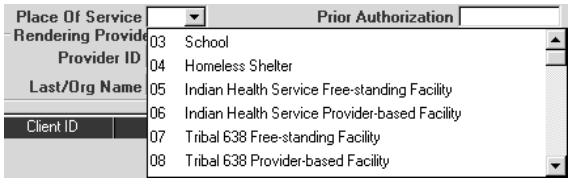
Total Billed Amount: The total charges to be billed to Wisconsin Medicaid.

Services: The number of service details associated with the claim.

Tabs
Information on the claim forms is organized into tabs with related boxes in separate Header or Service tabs. Additional tabs also are added to some forms, such as when other insurance is indicated.

Drop-Down Lists
Click the down arrow to display a list of values. If there is a scroll bar on the right, use it to see all the options on the list. If you double-click in the box, you will be able to create or add to the list.

Drop-Down List



Detail
A detail lists all claims entered for the transaction.

Status Bar
The status bar indicates the state of the software, such as *Ready* or *New Record Added.* When you hover over comments, a description will be displayed in the status bar.

Active Window
You can open up to three separate forms, lists, and/or reports at one time. Select **Window** on the menu bar to display screens in a cascade, tiled, or layered view.

Command Buttons
The command buttons are located along the right side of each screen. These buttons will vary from screen to screen. See Command Buttons in this chapter for more information.

Menu Bar

This command…	Allows you to…
File	In the main menu, you can exit from the application. While in a form, the file option will allow you to add, delete, save, undo, and print forms.
Forms	Select the online form needed. See the Claims chapters (chs. 6-10) for more information about this option.
Communication	Submit batches of forms and process batch responses. Resubmit batches of forms. View communication log files. See the Communication chapter for more information about this option.
Lists	Add and edit reference lists, which allows the user to collect information to be used when completing transactions within the software. See the Lists chapter for more information about this option.
Reports	Print summary or detail reports with information from forms or reference lists. See the Reports chapter for more information about this option.
Tools	This option allows the user to create and work with archives, perform database maintenance, retrieve upgrades, and change setup options. The Options selection allows the user to set up communications options and determine retention settings. See the Tools chapter for more information about this option.
Security	This option aids in prevention of unauthorized use of the PES software application. See the Tools chapter for more information.
Windows	Standard features are available in this option for most Windows-compatible applications.
Help	Obtain help about PES functions, screens, menus, and boxes using Contents and Index. Select About to view information about this application such as version and copyright. To reach help, you may also use F1, or double-click in a box name to get box-specific help.

Toolbar Buttons

837 Dental

837 Institutional Inpatient

837 Institutional Nursing Home

837 Institutional Outpatient

837 Professional

Command Buttons

The user can activate command buttons by clicking them or using the hot key associated with that button. These buttons will vary from screen to screen.

Command Buttons

New
Click this button to work with a new form. You are automatically ready to enter data into a new form when you first select a form type.

Copy
Click this button to make a copy of a previously submitted form or current form if submitting multiple claims for the same client. This action enables you to make corrections to the new form as needed.

Delete
Click this button to delete the current form. You will be asked if you are sure that you want to delete it. If you click "Yes," the form will be deleted. You will only be able to delete a form if it has a status of "R," which indicates the form is ready to be transmitted.

Undo All
Click this button to reverse all of the changes that you have made to the current form. You will only be able to undo the changes made since the last time you saved the form.

Save
Click this button to save what you have entered in the current form or list. When you save a form, the data will be checked to see if it meets the criteria for the box (such as when a client ID number doesn't have enough digits in it or a required box has not been completed). A list of errors will be presented for you to correct. For more information on how to use the error list, see Correcting Errors in this chapter.

When you have finished working with a form, select **Save**, and, if there are no errors on the page, the form status updates in the detail to an "R" to indicate the form is ready to be transmitted.

Find
Click this button to locate specific forms in the list in the lookup window.

Print
Click this button to print data associated to the form you are currently viewing in PES. Claim forms and reports are displayed in a report format to be viewed online or may be printed. Lists can also be viewed or printed.

Tip

Hot keys are identified on the Command Buttons and on Menu Bar by an underlined letter that needs to be clicked along with the Alt key on the keyboard. To display the hot keys on any particular screen, hit Alt.

Close
Click this button or the toolbar option to close the form window. If you have made changes to the current form, you will be asked if you want to save those changes before you leave the window.

Screen-Specific Command Buttons

Three types of screens in PES have screen-specific command buttons. The screens on which these buttons are located include other insurance screens, service screens, and service adjustment screens.

Other Insurance Screen Buttons

Add OI
Click this button to add additional commercial insurance carriers to the claim.

Copy OI
Click this button to copy the current insurance carrier information and make changes to the data. This feature is helpful when you wish to add insurance carriers that share much of the same data as the current insurance carrier.

Delete OI
Click this button to delete the current insurance carrier information.

Service Screen Buttons

Add Srv
Click this button to add additional services to the claim.

Copy Srv
Click this button to copy the current service screen and make changes to the data. This feature is helpful when you wish to add services that share much of the same data as the current service.

Delete Srv
Click this button to delete the current service information.

Service Adjustment Buttons

Add Srv Adj
Click this button to add other payer information, including cutbacks and payments, to the claim.

Copy Srv Adj
Click this button to copy the current service adjustment and make changes to the data. This feature is helpful when you

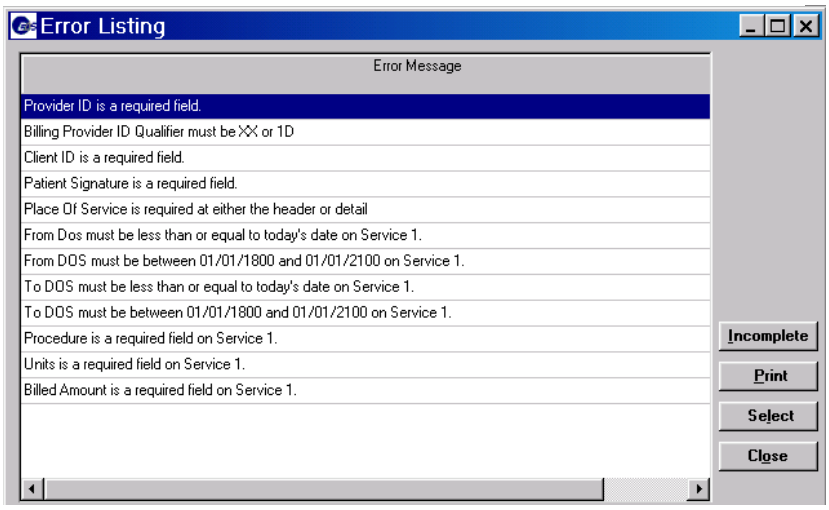
wish to add service adjustments that share much of the same data as the current service adjustment.

Delete Srv Adj
Click this button to delete the current service adjustment information.

Correcting Errors

If all the required data is not included in a form or list, a listing of error messages will display for you to correct. Either double-click on the error message or click the **Select** button. The software will return to the box that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Error Listing



Note: The software only recognizes errors such as an empty box or alpha characters in a box that should be all numbers. If you enter the wrong information, such as too many or too few units, the software will not recognize this as an error.

Exiting from Forms

Once you complete a form, you have several choices:

To save a form: Choose the **Save** command button. This action will save the form in a status of “R” indicating the form is ready to be transmitted as a batch transaction. If you have more forms to be submitted, choose the **New** command button. The software will automatically save the current form to an “R” status and allow you to enter a new form.

Tip

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

To create a new form: Select the **New** command button to add a new form or a new entry in the list options. This action automatically saves any information in the current form and indicates the form has an “R” status.

To copy a form: Select the form to be copied. Select the **Copy** command button to copy a form that is in a status of archived, finalized, ready, or incomplete. This action copies the original form, allows you to make corrections to the information, and readies the form for resubmission.

Exiting from PES

There are three ways to exit from the PES software:

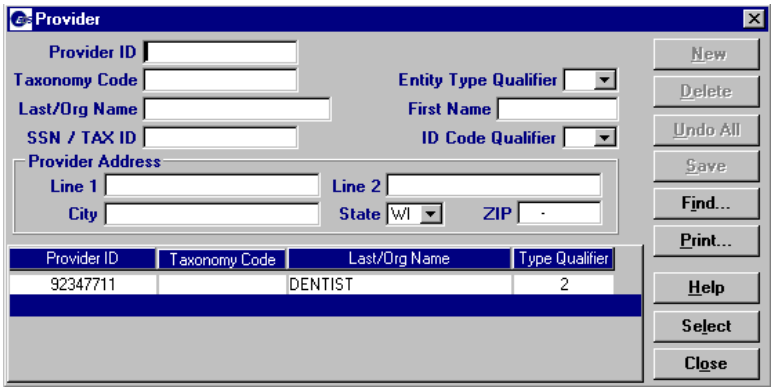
- Select the **X** in the upper right corner of the screen.
- Select **File** from the menu bar and click **Exit**.
- Click the blue door icon from the toolbar.

If you have not saved your work, you will receive a prompt asking if you want to save your changes. You have three choices.

- Click **Yes** to close PES and exit.
- Click **No** to close the active window but stay in PES.
- Click **Cancel** to stay in the active window.

Lists

PES contains lists of information that are frequently used when entering or editing data in a form. Some of the lists you will have to build; others come preloaded in the software.



Once you create a list, the information in it will be available in drop-down lists within the forms. This will speed up the data entry process when using forms and help ensure accuracy since the information is only entered once. It is strongly recommended that you build and customize your lists prior to completing claim forms.

You can also build lists during the claim submission process. When using a drop-down list in a screen, if the listing you want is not there, double-click in the box to go to the appropriate list. You can then add the required data. After you save your new list entry, you will be returned to the screen in which you were working originally.

Note: It is your responsibility to update and maintain both loaded and pre-loaded lists in PES.

Lists to Build

You will have to build many of the lists you use by entering required information. These lists will take a little time to build, but once they are complete, you will use them frequently.

Depending on the type of services you render, you will need to build some or all of the following lists:

- Provider.*

TIP

You can copy descriptions from the lists in the List Appendix while working online. Use the Text Select Tool in Acrobat Reader, copy and paste into the description box in PES.

Descriptions can be up to 60 characters and spaces.

- Client.*
- Diagnosis Code.
- Modifier Code.
- Other Provider.*
- Policyholder.*
- Procedure/Healthcare Common Procedure Coding System (HCPCS).

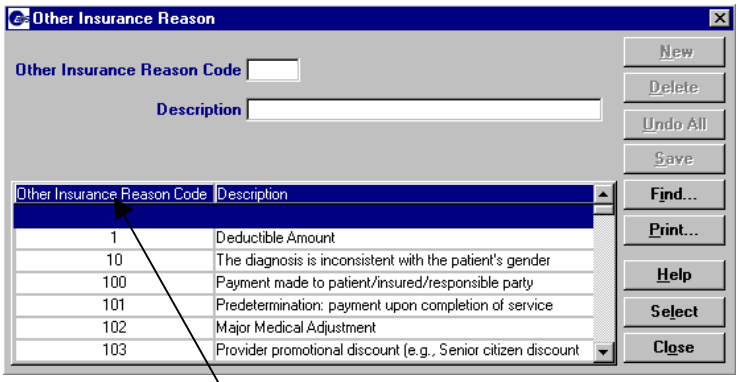
Note: We recommend that you build the lists above marked with an asterisk (*) prior to completing any claims.

Institutional providers will want to build some or all of the following additional lists:

- Revenue Code.
- Type of Bill.
- Condition Code.
- Value Code.

TIP

If you are working with a long list, you can sort it according to any of the columns that are displayed. Click on the blue column title. The table will then be sorted either alphabetically or numerically by the data in that column.



Clicking on this column sorts the list numerically by Other Insurance Reason Code.

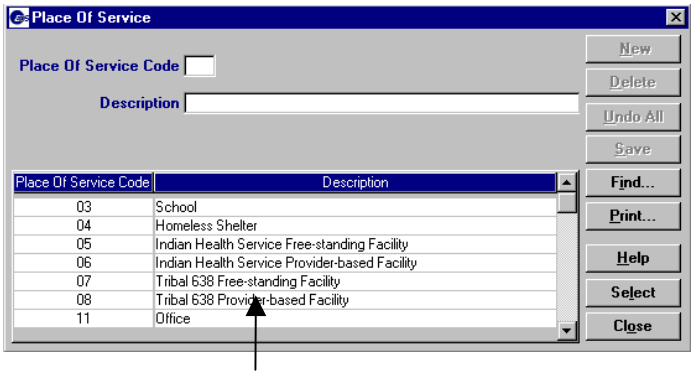
List Appendix

To help you build these code lists, you will find valid codes to choose from in the List Appendix. Valid code listings are included for all of these lists except: Diagnosis, Modifier, Procedure/HCPCS, Revenue, and Taxonomy codes.

Preloaded Lists

Some of the lists have preloaded information that you can use immediately. Take the time to look at these lists and delete any codes you know you will not be using. This will shorten the list and make it easier to use when completing forms. The preloaded lists are:

- Admission Type.
- Admit Source.
- Carrier.
- Condition Code.
- Occurrence Code.



Preloaded List

- Other Insurance Reason Codes (Adjustment Reason Codes).
- Patient Status.
- Place of Service.
- Value Code.

Working with Lists

Select the list that you would like to create or edit from the Lists option on the menu bar. You will notice the following buttons on the right side of the window:

New: Click **New** to either change an existing entry in the list or to create a new entry to the list. You must then click **Save** to keep the new/altered entry.

Delete: Click **Delete** to remove an entry from the list.

Undo All: Click **Undo All** to clear all of the boxes and start over.

Save: Click **Save** to enter new data into a list.

Find: Click **Find** to locate entries in lists that have data already entered.

Print: Click **Print** to make a paper copy of all entries on the list.

Close: Click **Close** to exit the list

Adding Codes to a List

To add codes to any list, follow these steps:

1. Select the **Lists** option.
2. Choose the list to which you wish to add new codes.
3. Click **New**.
4. Enter the code in the Code box.
5. Enter the code description in the Description box. The description can be up to 60 characters and spaces.
6. Click **Save**.

Deleting Codes on a List

To delete codes from a list, follow these steps:

1. Select the **Lists** option.
2. Choose the list from which you wish to delete codes.
3. Select a code in the list that does not apply.
4. Click **Delete**.
5. Click **Yes**.
6. Continue deleting inappropriate codes until the list contains only those codes that describe the services you provide.

Lists

Admission Type List

The Admission Type list is preloaded and allows you to select or modify the list of admission type codes used in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter or edit admission type codes, follow these steps:

1. Select the **Lists** option on the menu bar.
2. Select the Admission Type list.
3. Enter data into all of the required boxes on the Admission Type screen using the table below as a guide.

Admission Type List	
Field	**Description**
Admission Type Code	Enter the priority admission codes from the Uniform Billing (UB-92) Manual. Only codes 1,2,3, and 4 are acceptable. These codes are required for inpatient claims. Refer to the Lists Appendix for valid codes.
Description	Enter the admission type code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new admission type code.

Admit Source List

The Admit Source list is preloaded and allows you to select or modify the list of admit source codes. As with other lists,

once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter or edit admit source codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Admit Source list.

3. Enter data into all of the required boxes on the Admit Source screen using the table below as a guide.

Admit Source List	
Field	**Description**
Admit Source Code	Enter or select the admission source code. These codes are required for inpatient and nursing home claims.
Description	Enter the admit source code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new admit source code.

Carrier List

The carrier code is a pre-loaded, three-character number that identifies an insurance carrier. This information is necessary to match all service-level adjustments to the carrier code on the header screen.

Providers may choose from any of the carrier codes listed. *Do not create additional carrier codes.*

TIP

In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

Carrier List	
Field	**Description**
Carrier Code	Three-character alphanumeric code.
Carrier Code Qualifier	"PI" is for payer identification.
Carrier Name	The name associated with the carrier code.

Client List

The Client List requires you to enter detailed information about your clients (i.e., patients, recipients, policyholders). As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter a client, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Client list.

3. Enter data into all of the required boxes on the Client screen using the following table as a guide.

Client List	
Field	**Description**
Client ID	Enter the 10-digit Medicaid or HIRSP identification number. The client's (Medicaid recipient or HIRSP policyholder) name must correspond with the ID number given. The Eligibility Verification System (EVS) may be used to verify a Medicaid client's ID number and name spelling.
ID Qualifier	Select "MI" for Medicaid member identification.
Account #	Enter the account number assigned to this client by your organization. This is a required field. This field will accept 1-20 alphanumeric characters.
Last Name	Enter the last name of the client.
First Name	Enter the first name of the client.
MI	The client's middle initial is not required.
Client DOB	Enter the client's date of birth (DOB) using the MM/DD/CCYY format.
Gender	Select the client's gender.
Subscriber Address Line 1	Enter the client's street mailing address.
Subscriber Address Line 2	This field is not required.
Subscriber Address City	Enter the name of the client's city.
Subscriber Address State	Select the client's two-digit state code designation.
Subscriber ZIP	Enter the client's ZIP code.

4. Click **Save** to save the data or **New** to add a new client.

Condition Code List

The Condition Code list is preloaded and allows you to select or modify the list of condition codes used in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter or edit condition codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Condition Code list.

3. Enter data into all of the required boxes on the Condition Code screen using the following table as a guide.

Condition Code List	
Field	**Description**
Condition Code	Enter the two-digit code from the Uniform Billing (UB-92) Manual used to identify conditions relating to the services that may affect payer processing.
Description	Enter the condition code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new condition code.

Diagnosis List

The Diagnosis list allows you to create a list of diagnosis codes to use in the claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter a diagnosis code, follow these steps:

> **TIP**
>
> When entering diagnosis codes, do not use decimals.

1. Select the **Lists** option on the menu bar.
2. Select the Diagnosis list.
3. Enter data into all of the required boxes on the Diagnosis screen using the table below as a guide.

Diagnosis List	
Field	**Description**
Diagnosis Code	Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code.
Description	Enter the description of the diagnosis code. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new diagnosis code.

Modifier List

The Modifier list allows you to create a list of modifier codes for use on claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter a modifier, follow these steps:

> **TIP**
>
> Refer to your service-specific Medicaid *Updates* and handbook for applicable modifiers.

1. Select the **Lists** option on the menu bar.
2. Select the Modifier list.
3. Enter data into all of the required boxes on the Modifier screen using the table below as a guide.

Modifier List	
Field	**Description**
Modifier Code	Enter the two-character modifier code.
Description	Enter the description of the modifier code. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new modifier code.

Occurrence List

The Occurrence list is preloaded and allows you to select or modify the list of occurrence codes and occurrence span codes used in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter or edit occurrence codes and occurrence span codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Occurrence list.

3. Enter data into all of the required boxes on the Occurrence screen using the table below as a guide.

Occurrence Code List	
Field	**Description**
Occurrence Code	Enter the two-digit occurrence code from the Uniform Billing (UB-92) Manual or refer to the Lists Appendix for valid codes.
Description	Enter the occurrence code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new occurrence code.

Other Insurance Reason Code List

The Other Insurance Reason Code list is preloaded with a short list of Health Insurance Portability and Accountability Act (HIPAA)-approved adjustment reason codes. This list allows you to enter or modify a list of adjustment reason codes used in claim forms by insurance companies and Medicare. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter other insurance reason codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Other Insurance Reason list.

3. Enter data into all of the required boxes on the screen using the following table as a guide.

Other Insurance Reason Code List	
Field	**Description**
Other Insurance Reason Code	Enter the one- to three-digit American National Standards Institute (ANSI) code identifying the reason for the adjustment. Refer to the adjustment reason codes in the Lists Appendix for valid codes.
Description	Enter the adjustment reason code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new insurance reason code.

Other Provider List

The Other Provider list allows you to enter information about additional providers such as referring, attending, or operating physicians. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. Other providers can be either individual providers or organizations. To enter other providers, follow these steps:

TIP

In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

1. Select the **Lists** option on the menu bar.

2. Select the Other Provider list.

3. Enter data into all of the required boxes on the Other Provider screen using the table below as a guide.

Other Provider List	
Field	**Description**
Provider ID	Enter the eight-digit Wisconsin Medicaid billing provider number, state license number, or Unique Provider Identification Number (UPIN).
Provider ID Code Qualifier	Select the appropriate code to identify the type of provider identification number used, if applicable.
Taxonomy Code	Select the description that best matches the service in which the performing provider or referring provider specializes. This field is not required.
Entity Type Qualifier	Select "1 — Person" for an individual provider, or "2 — Non-Person" for a group or institution.
Last/Org Name	Enter the last name of the provider if the entity qualifier is "1," or the organization name if the entity qualifier is "2."
First Name	Enter the first name if the provider is an individual. This field is not required if the entity qualifier is "2."
SSN/Tax ID	Enter the Social Security number (SSN) for an individual provider, or the employer's identification number (EIN) for an organization. This field is required for institutional and professional providers; however, if you are a professional provider, you may use all zeros in place of an SSN or EIN.
ID Code Qualifier	Select "24" for EIN, or "34" for SSN.
Provider Address Line 1	Enter the provider's street or mailing address. This field is optional.
Provider Address Line 2	This field is optional.
Provider Address City	Enter the name of the provider's city. This field is optional.
Provider Address State	Select the two-digit state code designation. This field is optional.
Provider ZIP	Enter the provider's ZIP code. This field is optional.

4. Click **Save** to save the data or **New** to add a provider.

Patient Status List

The Patient Status list is preloaded and allows you to select or modify the list of patient status codes used in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter or edit patient status, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Patient Status list.

3. Enter data into all of the required boxes on the Patient Status screen using the following table as a guide.

Patient Status List	
Field	**Description**
Patient Status	Enter the two-digit code from the Uniform Billing (UB-92) Manual indicating the patient's status as of the statement "covers through" date.
Description	Enter the patient status description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new patient status.

Place of Service List

The Place of Service (POS) list allows you to create a list of POS codes used in the claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter a POS code, follow these steps:

> **TIP**
>
> Refer to your service-specific Medicaid *Updates* and handbook for applicable POS codes.

1. Select the **Lists** option on the menu bar.

2. Select the Place of Service list.

3. Enter data into all of the required boxes on the Place of Service screen using the following table as a guide.

Place of Service List	
Field	**Description**
Place of Service Code	Enter the two-digit place of service (POS) code.
Description	Enter the POS code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new POS code.

Policyholder List

The Policyholder list allows you to enter a list of information for the policyholder of commercial insurance carrier and Medicare policies. As with the Provider and Client lists, this list should be entered before completing a claim when the client has a commercial insurance carrier or Medicare. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter policyholder information, follow these steps:

> **TIP**
>
> The most common Insurance Type Codes used in the policyholder list are:
>
> C1: Commercial Insurance
>
> HM: Health Maintenance Organization
>
> MB: Medicare Part B

1. Select the **Lists** option on the menu bar.

2. Select the Policyholder list.

3. Enter data into all of the required boxes on the Policyholder screen using the table below as a guide.

Policyholder List	
Field	**Description**
Client ID	Select or enter the client's 10-digit Wisconsin Medicaid identification number.
Carrier Code	Select the carrier code that identifies the other insurance or Medicare.
Carrier Name	Enter the name of the insurance carrier. The carrier name will default to the carrier code selected.
Insurance Type Code	Select the appropriate value that identifies the type of insurance listed.
Relationship to Insured	Select the appropriate value that identifies the relationship of the client to the policyholder.
Policyholder Information Last Name	Enter the last name of the policyholder of the other insurance or Medicare.
First Name	Enter the first name of the policyholder of the other insurance or Medicare.
ID Code	Enter the policyholder's identification number assigned by the other insurance or Medicare.
Date of Birth	Enter the policyholder's date of birth using the MM/DD/CCYY format.
Gender	Select the gender of the policyholder.
Policyholder Address Line 1	Enter the street address of the policyholder.
Line 2	This field is not required.
City	Enter the policyholder's city of residence.
State	Select the two-character state code for the policyholder's residence.
ZIP	Enter the policyholder's ZIP code.

4. Click **Save** to save the data or **New** to add a new policyholder.

Procedure/HCPCS List

The Procedure/Healthcare Common Procedure Coding System (HCPCS) list allows you to create a list of procedure codes used most often when billing on 837 Outpatient, Professional, and Dental claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. To enter procedure codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Procedure/HCPCS list.

3. Enter data into all of the required boxes on the Procedure/HCPCS screen using the table below as a guide.

Procedure/HCPCS List	
Field	**Description**
Procedure/HCPCS	Enter the *Current Procedural Terminology* (CPT), Current Dental Terminology (CDT), or Healthcare Common Procedure Coding System (HCPCS) code.
Description	Enter the procedure/HCPCS code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new procedure code.

Provider List

This list requires you to enter information about billing/rendering providers. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the claim form screens. Providers can be either individual providers or organizations. To enter a provider, follow these steps:

TIP

If you put in a different address in the Provider List box than what is in Wisconsin Medicaid's system, PES will *not* update the Medicaid system to the address shown on the PES screens.

1. Select the **Lists** option on the menu bar.

2. Select the Provider list.

3. Enter data into all of the required boxes on the Provider screen using the following table as a guide.

Provider List	
Field	**Description**
Provider ID	Enter the eight-digit Wisconsin Medicaid billing/rendering provider number.
Taxonomy Code	Select the description that best matches the service you will provide as a Wisconsin Medicaid provider. This field is not required.
Entity Type Qualifier	Select "1 — Person" for an individual provider, or "2 — Non-Person" for a group or institution. All providers billing on the institutional claims, including personal care, home health, and independent nurses, should enter a "2" in this field.
Last/Org Name	Enter the last name of the provider if the entity qualifier is "1" or the organization name if the entity qualifier is "2." Personal care, home health, and independent nurses should enter their last name in this field.
First Name	Enter the first name if the provider is an individual. This field is not required if the entity qualifier is "2."
SSN/Tax ID	Enter the Social Security number (SSN) for an individual provider or the Tax identification number for an organization. You may not enter all zeros in this field. This field is required.
ID Code Qualifier	Select "24" for employer's identification number or "34" for SSN.
Provider Address Line 1	Enter the provider's street or mailing address.
Provider Address Line 2	This field is not required.
Provider Address City	Enter the name of the provider's city.
Provider Address State	Select the two-digit state code designation.
Provider ZIP	Enter the provider's ZIP code.

4. Click **Save** to save the data or **New** to add a provider.

Revenue Code List

The Revenue Code list allows you to create a list of revenue codes used most often on the institutional claim form. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the

institutional claim form screens. To enter revenue codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Revenue Code list.

3. Enter data into all of the required boxes on the Revenue Code screen using the table below as a guide.

Revenue Code List	
Field	**Description**
Revenue Code	Enter the four-digit revenue code from the Uniform Billing (UB-92) Manual that identifies a specific accommodation or ancillary service. *Note:* Code 0001 is no longer valid for electronic claim submission. PES will calculate the total accumulated charge.
Description	Enter the revenue code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new revenue code.

Type of Bill List

The Type of Bill list allows you to create a list of type of bill codes used most often in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter type of bill codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Type of Bill list.

3. Enter data into all of the required boxes on the Type of Bill screen using the table below as a guide.

Type of Bill List	
Field	**Description**
Type of Bill	Enter the three-digit numeric code from the Uniform Billing (UB-92) Manual or your Wisconsin Medicaid provider handbook to indicate the specific type of bill.
Description	Enter the type of bill description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new type of bill code.

Value Code List

The Value Code list allows you to create or modify a list of value codes used most often in the institutional claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down boxes within the institutional claim form screens. To enter value codes, follow these steps:

1. Select the **Lists** option on the menu bar.

2. Select the Value Code list.

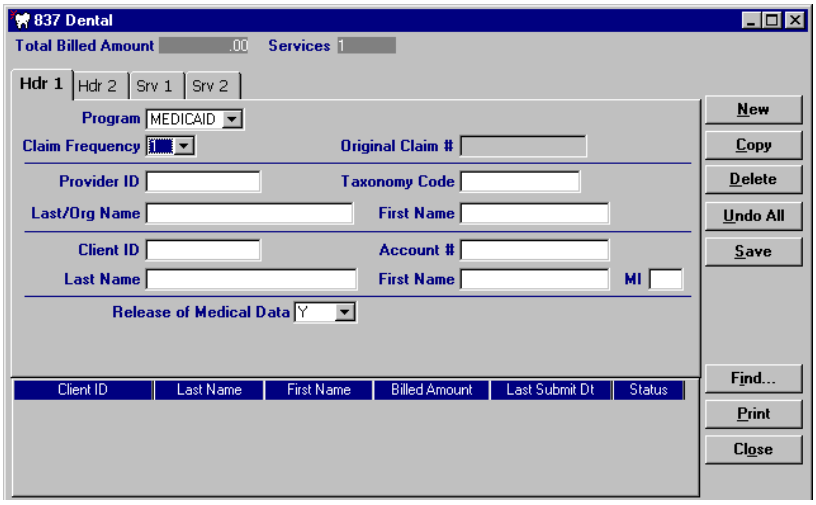
3. Enter data into all of the required boxes on the Value Code screen using the following table as a guide.

Value Code List	
Field	**Description**
Value Code	Enter the two-digit value code from the Uniform Billing (UB-92) Manual that relates to amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.
Description	Enter the value code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new value code.

Dental Claims

The 837 Dental claim form has several screens necessary for completing a Medicaid or HIRSP claim, depending on your provider type. These screens include:



- Headers 1 and 2.
- Services 1 and 2.
- Other Insurance.
- Other Insurance Adjustments.

Completing New Dental Claims

Click on the dental button on your toolbar and follow these steps:

1. Enter data into all of the required boxes on Header 1 using the table below as a guide.

> **TIP**
>
> In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

Dental Header 1	
Field	**Description**
Program	Select either the Medicaid or HIRSP program.
Claim Frequency	Select "1" to submit an original claim.
Provider ID	Select the eight-digit Medicaid billing provider number.
Client ID	Select the 10-digit recipient/policyholder identification number.
Release of Medical Data	This box defaults to "Y." Select "N" only to indicate that the provider does not have a signed statement on file authorizing the release of medical data to other organizations.

2. Select the Header 2 tab.

3. Enter data into all of the required boxes on Header 2 using the following table as a guide.

> **TIP**
>
> Prior authorization (PA) numbers and Place of Service (POS) codes entered on Header 2 will apply to all lines on the claim unless overridden by PA numbers and POS codes entered on the Service 1 tab.

Dental Header 2	
Field	**Description**
Place of Service	Enter or select the two-digit place of service code. The same place of service code cannot be entered both here and on the Service 1 screen.
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable). The same PA cannot be entered both here and on the Service 1 screen.
Emergency Ind	Select "Y" if the service was emergency related. If "Y" is selected, bill nonemergency services on a separate claim. This box defaults to "N."
Total Months	Enter the total number of months of orthodontic treatment (if applicable). This box is required for orthodontic services only.
Months Remaining	Enter the number of treatment months remaining for a transfer patient (if applicable). This box applies to orthodontics only.
Rendering Provider ID	Select the eight-digit rendering (performing) provider number, if different from the billing provider.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for dental services.

4. If you do not have other insurance information to enter, proceed to step 9.

5. If you have other insurance information to enter, select the OI tab.

6. Enter data into all of the required boxes on the OI tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

> **TIP**
>
> You may report other insurance payments or adjustments on the OI Adjustment tab (header level) in PES.

Dental OI	
Field	**Description**
Release of Medical Data	Select "Y" or "N" to indicate whether the provider has a signed statement on file authorizing the release of medical data to other organizations. The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate that the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the policyholder's carrier code. Then press *Save* to populate the Policyholder Last Name and First Name boxes.

7. Select the OI Adj tab.

8. Enter data into all the required boxes on the OI Adj tab using the following table as a guide.

> **TIP**
>
> When there are multiple payers for a single client, complete all information for each payer prior to beginning a new payer.

TIP

Refer to the Basic Skills chapter of this manual for information on screen-specific command buttons, such as Add Srv and Copy OI.

TIP

An area of the oral cavity can represent a specific quadrant or sextant, the maxillary or mandibular area, or the entire oral cavity.

Dental OI Adjustment	
Field	**Description**
Paid Date/Amount	Enter the date that other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by the other insurance. This field is required if it is not entered on the service adjustment tab.
Allowed Amount	Enter the amount allowed by other insurance, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by other insurance, if applicable. Enter "PR" if insurance deductible, coinsurance, or co-pay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This box is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amts	Select the code identifying the reason for the adjustment—the difference between the billed and paid amounts—given by the other insurance. Enter the amount indicated by other insurance for each reason code. This box is only required if an insurance carrier did not pay the claim in full.

9. Select the Service 1 tab.

10. Enter data into all of the required boxes on the Service 1 tab using the following table as a guide.

TIP

The maximum number of details that can be submitted per form is 50.

Dental Service 1	
Field	**Description**
Date of Service	Enter the date of service using the MM/DD/CCYY format.
Place of Service	Enter or select the two-digit place of service (POS) code here, only if it is different from the POS indicated on the Header 2 tab.
Procedure	Enter or select the *Current Dental Terminology* (CDT) procedure code.
Modifiers	Enter or select the two-digit modifier(s), if applicable.
Tooth	Enter the tooth number, if applicable.
Surfaces	Select the surface(s), if applicable.
Oral Cavity Designation	Select the area(s), if applicable. The areas of the oral cavity are designated by a two-digit code; where at least one digit is zero, the valid values for these areas can be found in the *Current Dental Terminology–4* (CDT-4) book.
Placement Indicator	Select the placement indicator, if applicable. If the placement indicator is "R," the placement date must be completed using the MM/DD/CCYY format. This field is for use with prosthodontics only.
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable). The same PA cannot be entered both here and on the Header 2 screen.
Units	Enter the number of units performed for the service billed. Example: 1.00 = 1 unit.
Billed Amount	Enter the total charges for the services rendered.

11. Select the Service 2 tab.

12. Enter data into all of the required boxes on the Service 2 tab using the following table as a guide.

Dental Service 2	
Field	**Description**
Appliance Placement Date	Enter the appliance placement date using the MM/DD/YYYY format (if applicable).
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number must be returned on the 835 Health Care Payment/Advice.
Provider ID	Select the provider identification for the provider who rendered the service. The rendering provider must not be the same as the header billing provider indicated on the Header 1 tab.

13. Click **Save**, then **Close**. Proceed to Submitting New Dental Claims.

Correcting Errors on Dental Claims

If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

- Double-click on the error message.
- Click on the error message and click **Select**.

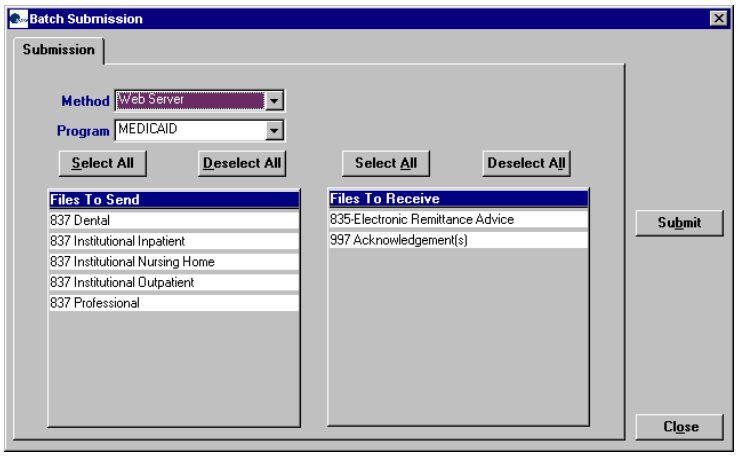
PES will return to the box that has missing or incorrect data.

Submitting New Dental Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

TIP

Denied claims may be copied, corrected, and submitted as new claims.



All forms are submitted by batch. To submit new claims, follow these steps:

1. Click **Communication** on the menu bar.
2. Click **Submission**. The Batch Submission window will display.
3. Select “Web Server” from the Method box.
4. Select “Medicaid” or “HIRSP” from the Program box.
5. Click on the appropriate form type(s) under Files to Send.
6. Click **Submit**.
7. PES will post messages in the Transmission window updating you on the progress of the transmission.

TIP

You may only submit claims that have a status of “R.” All claims in “R” status will be submitted when you perform a batch submission.

TIP

To ensure a successful transmission, establish a dial-up connection before submitting claims.

Resubmitting Dental Claims

Use this feature when, although you have previously submitted a claim or batch of claims, Wisconsin Medicaid requests that you resubmit the claim(s).

Resubmitting a Single Claim

To resubmit a single claim, click the dental button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Click **Save**. Click **Close**.
4. Click **Communication** on the menu bar.
5. Click **Submission**.
6. Select “Web Server” from the Method box.
7. Select “Medicaid” or “HIRSP” from the Program box.
8. Click on the appropriate form type under Files to Send.
9. Click **Submit**.
10. PES will post messages in the Transmission window updating you on the progress of the transmission.

TIP

If a claim requires an attachment, that claim must be sent as a paper claim.

Resubmitting or Copying a Partial or Entire Batch

To resubmit a partial or entire batch of claims, click the dental button on your toolbar and follow these steps:

1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by:
   - Clicking **Copy** to copy the entire batch.
   - Highlighting **Deselect All** and selecting individual forms to copy from the batch. Click **Copy**.

   Once you have copied the desired forms, you may modify and resubmit them by:

   - Clicking **Resubmit** to resubmit the entire batch.
   - Highlighting **Deselect All** and selecting individual forms to resubmit specific forms from the batch. Click **Resubmit**.
4. The Batch Submission window will display.
5. Select "Web Server" from the Method box.
6. Click on the appropriate form type(s) under Files to Send.
7. Click **Submit**.
8. PES will post messages in the Transmission window updating you on the progress of the transmission.

Adjusting Paid Status Dental Claims

PES allows you to resubmit a claim or claims to Wisconsin Medicaid even after the claims show a status of "paid." To resubmit a paid claim, click the dental button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select "7" in the Claim Frequency box.
4. Enter the 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and

TIP

Use the adjusting paid status claims feature of PES when you have made an error on a claim in paid status and want to adjust the claim. You may only adjust a claim in paid status.

Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.

5. Make corrections to the claim as needed.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method box.
10. Select “Medicaid” or “HIRSP” from the Program box.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

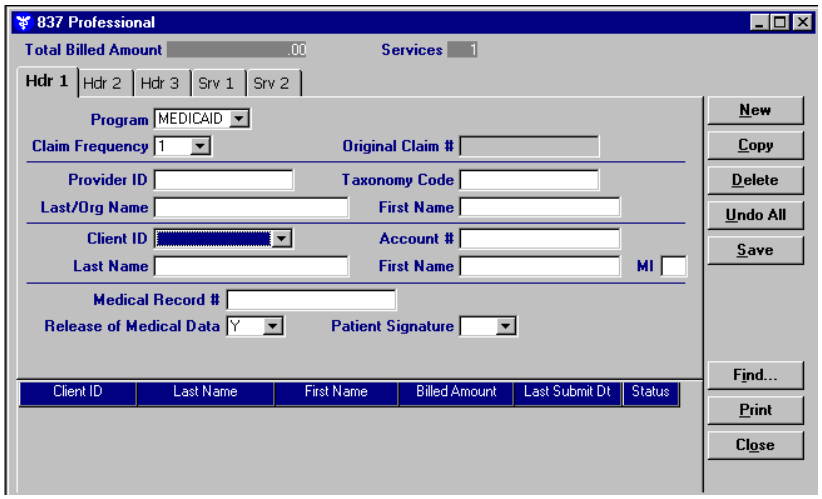
Voiding Dental Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid/HIRSP to recoup the entire claim. To void a claim, click the dental button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select “8” in the Claim Frequency box.
4. Enter the 15-digit internal control number (ICN) in the Original Claim # box.
5. Click **Save**.
6. Click on **Communication** on the menu bar.
7. Click on **Submission**.
8. Select “Web Server” from the Method box.
9. Select “Medicaid” or “HIRSP” from the Program box.
10. Click on the appropriate form type under Files to Send.
11. Click **Submit**.

Professional Claims

The 837 Professional claim form has several screens that you will use to complete a Medicaid, HIRSP, or Wisconsin Well Woman Program (WWWP) claim, depending on your provider type. These screens include:



- Headers 1-3.
- Service 1, 2.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

Completing New Professional Claims

Click on the professional button on your toolbar and follow these steps:

1. Enter data into all of the required boxes on Header 1 using the following table as a guide.

> **TIP**
>
> In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

Professional Header 1	
Field	**Description**
Program	Select Medicaid, HIRSP or WWWP.
Claim Frequency	Select "1" to submit an original claim.
Provider ID	Select the eight-digit Medicaid billing provider number.
Client ID	Select the 10-digit recipient/policyholder identification number.
Medical Record #	Enter the medical record number that identifies the client in your records. This box is optional.
Release of Medical Data	Select "N" only to indicate that the provider does not have a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Patient Signature	Select the code indicating how the patient or authorized person's signature was obtained and how the provider is retaining the signature.

2. Select the Header 2 tab.

3. Enter data into all of the required boxes on Header 2 using the following table as a guide.

TIP

Prior authorization (PA) numbers and Place of Service (POS) codes entered on Header 2 will apply to all lines on the claim unless overridden by PA numbers and POS codes entered on the Service 1 tab.

Professional Header 2	
Field	**Description**
Diagnosis Code	Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code(s) related to the visit.
Referring Provider Provider ID	Select the provider identification number that identifies the referring provider (if applicable).
Similar Illness Date	Enter the date of services rendered to a patient experiencing symptoms similar to previously reported symptoms (if applicable). Use the MM/DD/CCYY format.
Onset of Current Illness Date	Enter the date when the onset of the patient's illness or symptoms is different from the DOS, if applicable. Use the MM/DD/CCYY format.
Place of Service	Enter or select the two-digit place of service code.
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable). The same PA cannot be entered both here and on the Service 1 screen.
Rendering Provider Provider ID	Select the eight-digit rendering provider identification number, if it is different from the billing provider.

4. Select the Header 3 tab.

5. Enter data into all of the required boxes on Header 3 using the table below as a guide.

Professional Header 3	
Field	**Description**
Accident Related Causes	Select the related cause value(s) if the services are a result of an accident. If "AA" is selected, enter the state and country where the accident occurred.
Date	Enter the date the accident occurred (if applicable).
Other Insurance Ind	Select "Y" if the client has other insurance coverage for professional services.
Medicare Ind	Select "Y" if the client has Medicare coverage for professional services.

6. If you do not have commercial insurance carrier information to enter, proceed to step 11.

7. If you have commercial insurance carrier information to enter, select the OI tab.

8. Enter data into all the required boxes on the OI tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

You should report other insurance payments or adjustments on the OI Adjustment tab (header level) in PES.

The maximum number of details that can be submitted per form is 50.

Professional OI	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate that the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the policyholder carrier code. Then tab off the field to populate the Policyholder Last Name and First Name boxes.

9. Select the OI Adj tab.

10. Enter data into all the required boxes on the OI Adj tab using the following table as a guide.

TIP

When there are multiple payers for a single client, complete all information for each payer prior to beginning a new payer.

Professional OI Adjustment	
Field	**Description**
OI-Y	Select "Y" if other insurance exists, but was not billed for reasons described in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Professional OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by other insurance (if applicable). This box is required if the information was not entered in the service adjustment tab.
Allowed Amount	Enter the amount allowed by other insurance (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the other insurance (if applicable). Enter "PR" if insurance deductible, coinsurance, or co-pay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This box is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance (if applicable). Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier did not pay the claim in full.

11. If the client does not have Medicare insurance information, proceed to step 14.

12. If the client has Medicare insurance information, select the Medicare tab.

13. Enter data into all the required boxes on the Medicare tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Professional Medicare	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Benefits Assignment	Select "N" only to indicate that the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y."
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This field defaults to "MB."
Carrier Code	Select the carrier code for the policyholder. Tab off the box to populate the policyholder first and last name boxes.
M-8	Select "Y" if Medicare exists, but was not billed for reasons described in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment, if applicable, using the MM/DD/CCYY format. Enter the amount paid by Medicare (if applicable). This box is required if the information was not entered on the Service Adjustment tab.
Allowed Amount	Enter the allowed amount from Medicare (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated Medicare for each reason code. This box is only required if Medicare made an adjustment.

TIP

Depending on how Medicare reported their payment information to you, you are required to either report Medicare payments and adjustments on the Medicare tab (header level) or Service Adjustment tab (detail level) in PES.

Look at the remittance advice that was sent to you by Medicare. If the payment information sent was reported at the header level, complete the Medicare screen in PES for that payer. If the payment information sent was at the service level, complete the Service Adjustment screen for that payer. *To access the Service Adjustment screen, select "Y" in the Service Adjustment Ind box on the Srv 1 tab. Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select "Y."*

Do not complete both the bottom portion of the Medicare screen and the Service Adjustment screen for the same payer. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

Both HIRSP and Medicaid providers should refer to the Medicaid provider handbook and *Updates* for more information on procedure codes and modifiers.

14. Select the Service 1 tab.

15. Enter data into all of the required boxes on Service 1 using the following table as a guide.

Professional Service 1	
Field	**Description**
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format, if applicable.
Emergency Ind	Select "Y" only if the services provided were emergency related. This box defaults to "N."
Place of Service	Enter or select the place of service (POS) in this field if it is different from the POS code entered at the Header 2 tab.
Procedure	Enter or select the procedure code related to the visit.
Modifiers	Enter or select the modifier(s) (if applicable).
Diag Pointer	Enter the number from the Header 2 tab that is associated with the procedure rendered.
CLIA Number	Enter your organization's Clinical Laboratory Improvement Amendment (CLIA) number, if yours is a facility certified to perform CLIA covered laboratory services. This box is required for any laboratory performing tests covered by the CLIA act.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days), "UN" (unit), "F2" (international unit), or "MJ" (minutes). This box defaults to "UN."
Units	Enter the number of units performed for the service billed. Example: 1.00 = 1 unit.
Billed Amount	Enter the total amount billed for the services performed for this procedure. Include the charge for all units listed.
Family Planning	Select "Y" if the service provided was related to family planning. This box defaults to "N."
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable). The same PA cannot be entered both here and on the Header 2 screen.
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by the other insurance and/or Medicare. This box defaults to "N."

16. Select the Service 2 tab.

17. Enter data into all the required boxes on the Service 2 tab using the table below as a guide.

Professional Service 2	
Field	**Description**
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number will be returned on the 835 Health Care Claim Payment/Advice.
Rendering Provider Provider ID	Select the provider identification for the provider who rendered the service (if applicable). The rendering provider must have an entity type qualifier of "1" and must not be the same as the header billing or rendering provider indicated on the Header 1 tab.

18. If Medicare did not make service-level payments, proceed to step 21.

19. If Medicare made a service-level payment, select the Srv Adj tab.

20. Enter data into all of the required boxes on the Service Adj tab using the table below as a guide.

TIP

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

Professional Service Adjustment	
Field	**Description**
Carrier Code	Select the appropriate Medicare carrier code.
Paid Date/Amount	Enter the date Medicare paid the claim using the MM/DD/CCYY format. Enter the total amount paid by Medicare.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance or Medicare (if applicable). Enter the amount indicated by the other insurance or Medicare for each reason code. This box is only required if an insurance carrier or Medicare made an adjustment. Refer to Appendix 1 of this manual for a code list and descriptions.

21. Click **Save**, then **Close**. Proceed to Submitting New Professional Claims.

Correcting Errors on Professional Claims

If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

- Double-click on the error message.
- Click on the error message and click **Select**.

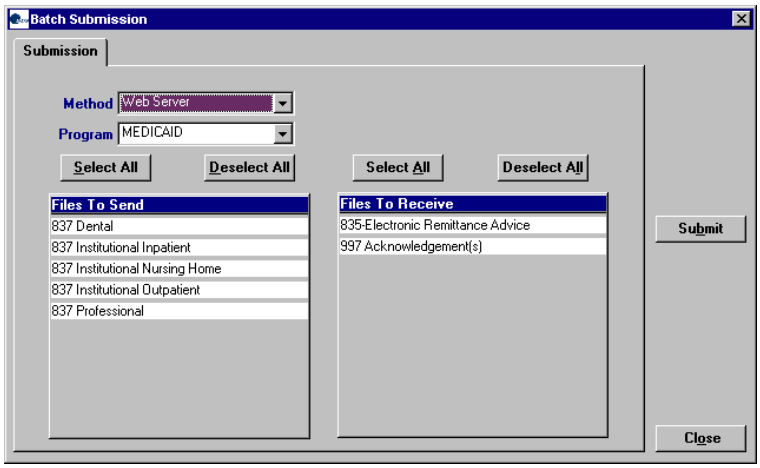
PES will return to the box that has missing or incorrect data.

Submitting New Professional Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

All forms are submitted by batch. To submit new claims, follow these steps:

1. Click **Communication** on the menu bar.



2. Click **Submission**. The Batch Submission window will display.
3. Select "Web Server" from the Method box.
4. Select "Medicaid," "HIRSP," or "WWWP" from the Program box.
5. Click on the appropriate form type(s) under Files to Send.
6. Click **Submit**.
7. PES will post messages in the Transmission window updating you on the progress of the transmission.

TIP

You may only submit claims that have a status of "R." All claims in "R" status will be submitted when you perform a batch submission.

TIP

To ensure a successful transmission, establish a dial-up connection before submitting claims.

Resubmitting Professional Claims

Use this feature when, although you have previously submitted a claim or batch of claims, Wisconsin Medicaid, HIRSP, or WWWP requests that you resubmit the claim(s).

Resubmitting a Single Claim

To resubmit a single claim, click the professional button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.

TIP

If a claim requires an attachment, that claim must be sent as a paper claim.

TIP

Denied claims may be copied, corrected, and submitted as new claims.

3. Click **Save**. Click **Close**.

4. Click **Communication** on the menu bar.

5. Click **Submission**.

6. Select “Web Server” from the Method box.

7. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.

8. Click on the appropriate form type under Files to Send.

9. Click **Submit**.

Resubmitting or Copying a Partial or Entire Batch

To resubmit a partial or entire batch of claims, click the professional button on your toolbar and follow these steps:

1. Click **Communication** on the menu bar.

2. Click **Resubmission**.

3. Select the appropriate batch from the list of batches displayed by:

   - Clicking **Copy** to copy the entire batch.

   - Highlighting **Deselect All** and selecting individual claims to copy from the batch. Click **Copy**.

   Once you have copied the desired claims, you may modify and resubmit them by:

   - Clicking **Resubmit** to resubmit the entire batch.

   - Highlighting **Deselect All** and selecting individual claims to resubmit specific claims from the batch. Click **Resubmit**.

4. The Batch Submission window will display.

5. Select “Web Server” from the Method box.

6. Click on the appropriate form type(s) under Files to Send.

7. Click **Submit**.

Adjusting Paid Status Professional Claims

PES allows you to resubmit a claim or claims to Wisconsin Medicaid, HIRSP, or WWWP even after the claims show a status of "paid." To resubmit a paid claim, click the professional button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select "7" in the Claim Frequency box.
4. Enter the 11- or 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.
5. Make corrections to the claim as needed.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select "Web Server" from the Method box.
10. Select "Medicaid," "HIRSP," or "WWWP" from the Program box.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

Use the adjusting paid status claims feature of PES when you have made an error on a claim in paid status and want to adjust the claim. You may only adjust a claim in paid status.

Voiding Professional Claims

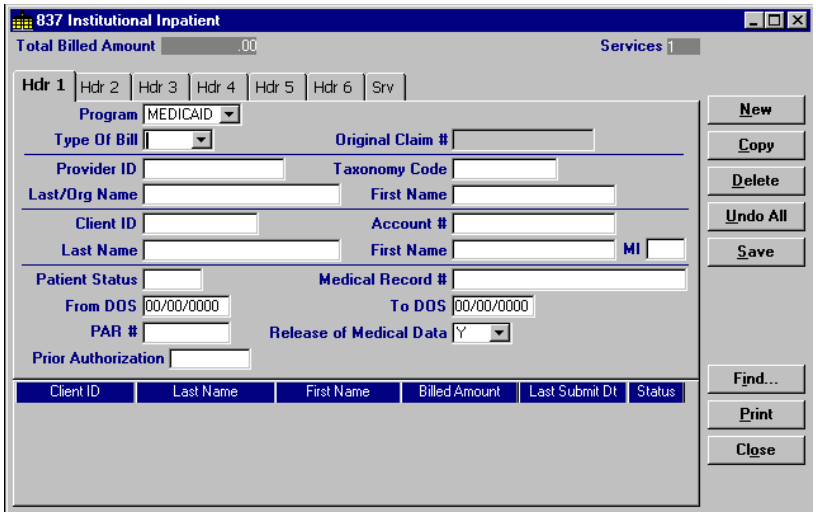
Use this feature when your claim was paid and you now want Wisconsin Medicaid, HIRSP, or WWWP to recoup the entire claim. To void a claim, click the professional button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select "8" in the Claim Frequency box.
4. Enter the 11- or 15-digit internal control number (ICN) in the Original Claim # box.

5. Click **Save**.
6. Click **Communication** on the menu bar.
7. Click **Submission**.
8. Select “Web Server” from the Method box.
9. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.
10. Click on the appropriate form type under Files to Send.
11. Click **Submit**.

Institutional Inpatient Claims

The 837 Institutional Inpatient claim form has several screens that you will use to complete a Medicaid or HIRSP claim, depending upon the services that you bill. These screens include:



- Headers 1-6.
- Service.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

Completing New Institutional Inpatient Claims

Click on the Institutional Inpatient toolbar button and follow these steps:

1. Enter data into all of the required boxes on Header 1 using the table as a guide.

TIP

In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

Institutional Inpatient Header 1	
Field	**Description**
Program	Select either the Medicaid or HIRSP program.
Type of Bill	Enter or select the numeric type of bill code for the services rendered.
Provider ID	Select the eight-digit Medicaid billing provider number.
Client ID	Select the 10-digit recipient/policyholder identification number.
Patient Status	Enter or select the two-digit patient status code.
Medical Record #	Enter the medical record number that identifies the client in your records. This box is optional.
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
PAR #	Enter up to 12 characters of the pre-admission review number (if applicable).
Release of Medical Data	Select "N" only to indicate that the provider does not have a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable).

2. Select the Header 2 tab.

3. Enter data into all of the required boxes on Header 2 using the following table as a guide.

Institutional Inpatient Header 2	
Field	**Description**
Diagnosis Code Primary	Enter or select the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code related to the discharge.
Other	Enter or select any additional diagnosis codes related to the discharge (if applicable). List in order of importance.
Admit	Enter or select the diagnosis code relating to the client's condition that prompted admission to the hospital.
E-Code	If the service is accident related, enter or select the diagnosis code that represents the cause of the injury.
Attending SSN/Tax ID	Select the Social Security number or employer identification number of the attending provider.
Days Covered	Enter the number of covered days. This box is required only if the type of bill is "11x" (Inpatient Hospital), "15x" (Intermediate Care Hospital Crossover), or "85x" (Critical Access). Do not count the discharge day as a covered day.
Non-Covered	Enter the number of noncovered days (if applicable). Do not count the discharge day as a noncovered day.

4. Select the Header 3 tab.

5. Enter data into all of the required boxes on Header 3 using the table below as a guide.

TIP

Refer to the Basic Skills chapter of this manual for information on screen-specific command buttons, such as Add Srv and Copy OI.

Institutional Inpatient Header 3	
Field	**Description**
Occurrence Codes/Dates	Enter or select the two-digit occurrence code(s) (if applicable). Enter the date associated with the code using the MM/DD/CCYY format.
Occurrence Span Codes/Dates	Enter or select the two-digit occurrence span code(s) (if applicable). Enter the dates associated with the code listed using the MM/DD/CCYY format.

6. Select the Header 4 tab.

7. Enter data into all of the required boxes on Header 4 using the table below as a guide.

Institutional Inpatient Header 4	
Field	**Description**
Value Codes/Amounts	Enter or select the two-digit value code(s) (if applicable). Enter the corresponding value code amount(s).
Other Physician SSN/Tax ID	Select the Social Security number (SSN) or employer identification number (EIN) of any additional providers that are used on the claim.
Operating Physician SSN/Tax ID	Select the SSN or EIN that identifies the operating physician when surgical procedures have been performed during the client's institutionalization. This box is required when billing a surgical procedure code on the Header 5 tab.

8. Select the Header 5 tab.

9. Enter data into all of the required boxes on Header 5 using the following table as a guide.

Institutional Inpatient Header 5	
Field	**Description**
Surgical Codes/Dates	Enter or select the surgical procedure code(s) that identifies the procedure performed during the billing period (if applicable). Enter the date that corresponds to the listed surgical procedure using the MM/DD/CCYY format.
Condition Codes	Enter or select the two-digit condition codes used to identify conditions relating to this bill that may affect payer processing (if applicable).

10. Select the Header 6 tab.

11. Enter data into all of the required boxes on Header 6 using the table below as a guide.

Institutional Inpatient Header 6	
Field	**Description**
Admission Date	Enter the date the client was admitted to the facility using the MM/DD/CCYY format.
Hour	Select the hour the client was admitted to the facility.
Type	Enter or select the code that identifies the priority of the admission.
Source	Enter or select the admission source code indicating the source of admission.
Discharge Hour	Select the hour the client was discharged from the facility.
Medicare Ind	Select "Y" if the client has Medicare coverage for institutional services.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for institutional services.

12. If you do not have commercial insurance carrier information to enter, proceed to step 17.

13. If you have commercial insurance carrier information to enter, select the OI tab.

14. Enter data into all of the required boxes on the OI tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

You should report other insurance payments or adjustments on the OI Adjustment tab (header level) in PES.

The maximum number of details that can be submitted per form is 999.

Institutional Inpatient OI	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate that the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for this client. Tab off the field to populate the policyholder first and last name fields.

15. Select the OI Adj tab.

16. Enter data into all of the required boxes on the OI Adj tab using the following table as a guide.

Institutional Inpatient OI Adjustment	
Field	**Description**
OI-Y	Select "Y" if other insurance exists, but was not billed for reasons as outlined in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Institutional Inpatient OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid. This box is required if the information was not entered on the Service Adjustment tab.
Allowed Amount	Enter the amount allowed by the other insurance carrier, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by other insurance (if applicable). Enter "PR" if insurance deductible, coinsurance, or co-pay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This box is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amts	Select the code identifying the reason for the adjustment—the difference between the billed and paid amounts—made by the other insurance. Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier did not pay the claim in full.

17. If the client does not have Medicare insurance information, proceed to step 20.

18. If the client has Medicare insurance information, select the Medicare tab.

19. Enter data into all of the required boxes on the Medicare tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

When there are multiple payers for a single client, complete all information for each payer prior to beginning a new payer.

Institutional Inpatient Medicare	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Benefits Assignment	Select "N" only to indicate that the client, or an authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y."
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This box defaults to "MA."
Carrier Code	Select the carrier code for this client. Tab off of this field to populate the policyholder first and last name boxes.
M-8	Select "Y" if other Medicare exists, but was not billed for reasons as outlined in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment using the MM/DD/CCYY format (if applicable). Enter the amount paid by Medicare (if applicable). This box is required if this information was not entered in the Service Adjustment tab.
Allowed Amount	Enter the allowed amount from Medicare (if applicable).
Non-Covered Charges	Enter the total noncovered amount from Medicare (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. Enter the amount indicated by Medicare for each reason code. This box is only required if Medicare made an adjustment.

TIP

Depending on how Medicare reported their payment information to you, you are required to either report Medicare payments and adjustments on the Medicare tab (header level) or Service Adjustment tab (detail level) in PES.

Look at the remittance advice that was sent to you by Medicare. If the payment information sent was reported at the header level, complete the Medicare screen in PES for that payer. If the payment information sent was at the service level, complete the Service Adjustment screen for that payer. *To access the Service Adjustment screen, select "Y" in the Service Adjustment Ind box on the Srv tab. Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select "Y."*

Do not complete both the bottom portion of the Medicare screen and the Service Adjustment screen for the same payer. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

20. Select the Service tab.

21. Enter data into all of the required boxes on the Service tab using the following table as a guide.

Institutional Inpatient Service	
Field	**Description**
Revenue Code	Enter or select the four-digit revenue code that identifies the specific accommodation or ancillary services.
Unit Rate	Enter the rate per unit of associated revenue for hospital accommodation (if applicable). This box is required when the associated revenue code is 0100-0219.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (units). This box defaults to "UN."
Units	Enter the number of units provided for the revenue code billed. Example: 1 = 1 unit.
Billed Amount	The billed amount is calculated automatically.
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by an insurance company and/or Medicare.

22. If Medicare did not make service-level payments, proceed to step 25.

23. If Medicare made a service-level payment, select the Srv Adj tab.

24. Enter data into all of the required boxes on the Srv Adj tab using the table below as a guide.

Institutional Inpatient Service Adjustments	
Field	**Description**
Carrier Code	Select the appropriate Medicare carrier code. This code must match the corresponding claim-level carrier code entered on the other insurance (OI) screen.
Paid Date/Amount	Enter the date Medicare paid the claim using the MM/DD/CCYY format. Enter the total amount paid by Medicare.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance or Medicare (if applicable). Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier made an adjustment. Refer to Appendix 1 of this manual for a code list and descriptions.

25. Click **Save**, then **Close**. Proceed to Submitting New Institutional Inpatient Claims.

Correcting Errors on Institutional Inpatient Claims

If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

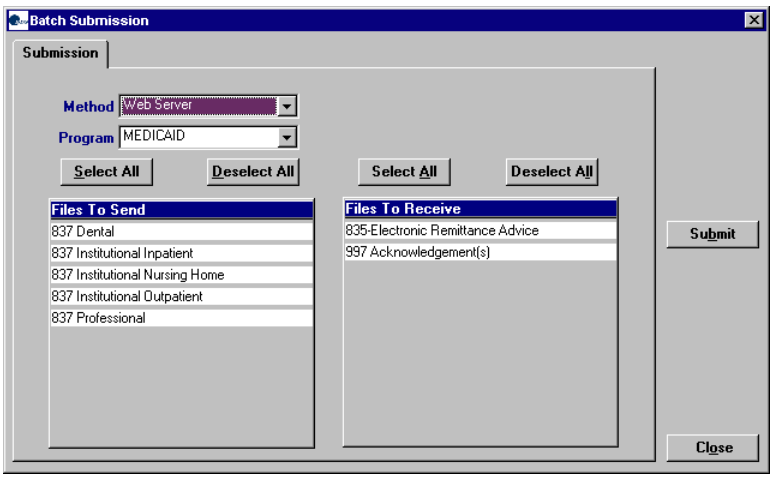
- Double-click on the error message.
- Click on the error message and click **Select**.

PES will return to the box that has missing or incorrect data.

Submitting New Institutional Inpatient Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

All forms are submitted by batch. To submit new claims, follow these steps:



1. Click **Communication** on the menu bar.
2. Click **Submission**. The Batch Submission window will display.
3. Select “Web Server” from the Method box.
4. Select “Medicaid” or “HIRSP” from the Program box.

TIP

Denied claims may be copied, corrected, and submitted as new claims.

TIP

You may only submit claims that have a status of “R.” All claims in “R” status will be submitted when you perform a batch submission.

TIP

To ensure a successful transmission, establish a dial-up connection before submitting claims.

5. Click on the appropriate form type(s) under Files to Send.

6. Click **Submit**.

7. PES will post messages in the Transmission window updating you on the progress of the transmission.

Resubmitting Institutional Inpatient Claims

Use this feature when, although you have previously submitted a claim or batch of claims, Wisconsin Medicaid or HIRSP requests that you resubmit the claim(s).

TIP

If a claim requires an attachment, that claim must be sent as a paper claim.

Resubmitting a Single Claim

To resubmit a single claim, click the institutional inpatient button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.

2. Click **Copy**.

3. Click **Save**. Click **Close**.

4. Click **Communication** on the menu bar.

5. Click **Submission**.

6. Select “Web Server” from the Method box.

7. Select “Medicaid” or “HIRSP” from the Program box.

8. Click on the appropriate form type under Files to Send.

9. Click **Submit**.

Resubmitting or Copying a Partial or Entire Batch

To resubmit a partial or entire batch of claims, click the institutional inpatient button on your toolbar and follow these steps:

1. Click **Communication** on the menu bar.

2. Click **Resubmission**.

3. Select the appropriate batch from the list of batches displayed by:

   - Clicking **Copy** to copy the entire batch.

- Highlighting **Deselect All** and selecting individual claims to copy from the batch. Click **Copy**.

Once you have copied the desired forms, you may modify and resubmit them by:

- Clicking **Resubmit** to resubmit the entire batch.
- Highlighting **Deselect All** and selecting individual forms to resubmit specific forms from the batch. Click **Resubmit**.

4. The Batch Submission window will display.
5. Select “Web Server” from the Method box.
6. Click on the appropriate form type(s) under Files to Send.
7. Click **Submit**.

Adjusting Paid Status Institutional Inpatient Claims

PES allows you to resubmit a claim or claims to Wisconsin Medicaid or HIRSP even after the claim shows a status of “paid.” To resubmit a paid claim, click the institutional inpatient button on your toolbar and follow these steps:

TIP

Use the adjusting paid status claims feature of PES when you have made an error on a claim in paid status and want to adjust the claim. You may only adjust a claim in paid status.

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill box, enter the first two digits of the type of bill and enter “7” as the final digit.
4. Enter the 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.
5. Make corrections to the claim as needed.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method box.

9. Select “Medicaid” or “HIRSP” from the Program box.

10. Click on the appropriate form type under Files to Send.

11. Click **Submit**.

Late Billing for Institutional Inpatient Claims

PES allows you to resubmit a late billing claim or claims to Wisconsin Medicaid or HIRSP even after the claim shows a status of “paid.” To resubmit a paid late billing claim, click the institutional inpatient button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.

2. Click **Copy**.

3. In the Type of Bill box, enter the first two digits of the type of bill and enter “5” as the final digit.

4. Enter the 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.

5. Make additions to the claim as needed. Refer to the Tip box on this page for more information.

6. Click **Save**.

7. Click **Communication** on the menu bar.

8. Click **Submission**.

9. Select “Web Server” from the Method box.

10. Select “Medicaid” or “HIRSP” from the Program box.

11. Click on the appropriate form type under Files to Send.

12. Click **Submit**.

TIP

Late billing should not be confused with timely filing. Refer to your Wisconsin Medicaid *Updates* and handbooks on requirements for timely filing. *Note:* Late billing is a charge(s) not billed on the original paid claim or adjustment.

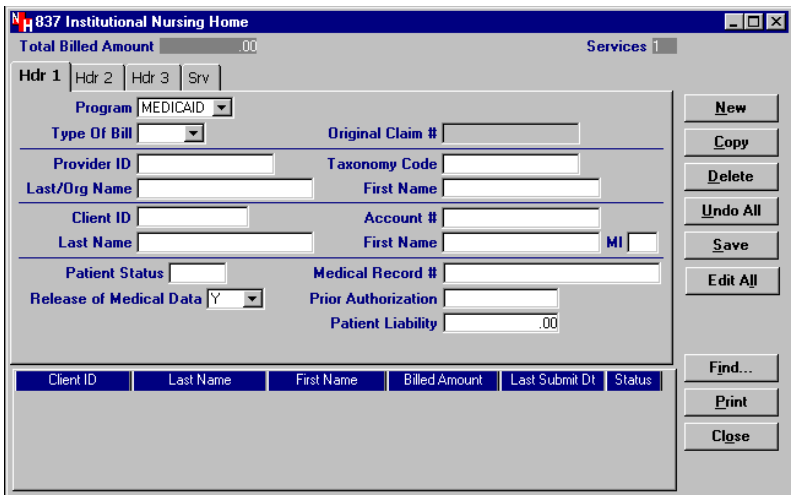
Voiding Institutional Inpatient Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid or HIRSP to recoup the entire claim. To void a claim, click the institutional inpatient button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill box, enter the first two digits of the type of bill and enter “8” as the final digit.
4. Enter the 15-digit internal control number (ICN) in the Original Claim # box.
5. Click **Save**.
6. Click **Communication** on the menu bar.
7. Click **Submission**.
8. Select “Medicaid” or “HIRSP” from the Program box.
9. Click on the appropriate form type under Files to Send.
10. Click **Submit**.

Institutional Nursing Home Claims

The 837 Institutional Nursing Home has several screens that you will use to complete a Medicaid or HIRSP claim. These include the following:



- Headers 1-3.
- Service.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

Nursing Home Claims

For dual entitlees, outpatient charges such as therapies, durable medical equipment (DME), and X-rays are billed to Medicare Part B. Bill these crossover claims using the Institutional Outpatient claim form in PES. If this is a straight Medicaid claim, however, use the Professional claim form.

Room and board charges are billed to Medicare Part A. Bill these crossover claims using the Institutional Nursing Home claim form.

If you are billing for Medicare Part A coinsurance days, the crossover claim must only show the days covered by Medicare. If those days fall in the middle of the month, bill as follows:

First part — Straight Medicaid claim
Second part — Medicare crossover claim
Third part— Straight Medicaid claim for the remainder.

Completing Institutional Nursing Home Claims

Click on the institutional nursing home button on your toolbar and follow these steps:

1. Enter data into all of the required boxes on Header 1 using the table below as a guide.

TIP

In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

Institutional Nursing Home Header 1	
Field	**Description**
Program	Select either the Medicaid or HIRSP program.
Type of Bill	Enter or select the numeric type of bill code for the services rendered.
Provider ID	Select the eight-digit Medicaid billing provider number.
Client ID	Select the 10-digit recipient/policyholder identification number.
Patient Status	Enter or select the two-digit patient status code.
Medical Record #	Enter the medical record number assigned by your organization that identifies the client in your records. This box is optional.
Release of Medical Data	Select "N" only to indicate that the provider does not have a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Prior Authorization	Enter the seven-digit prior authorization number (if applicable).
Patient Liability	Enter the amount the patient is liable to pay.

2. Select the Header 2 tab.

3. Enter data into all of the required boxes on Header 2 using the following table as a guide.

Institutional Nursing Home Header 2	
Field	**Description**
Admission Date	Enter the date the client was admitted to the facility using the MM/DD/CCYY format.
Hour	Select the hour the client was admitted to the facility.
Type	Enter or select the code that identifies the priority of this admission (if applicable).
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Admit Source	Enter or select the admission source code.
Days Covered	Enter the number of covered days. Do not count the discharge day as a covered day. This box is required only if the type of bill is 21 (nursing home).
Non-Covered	Enter the number of noncovered days (if applicable). Do not count the discharge day as a noncovered day.
Attending Physician SSN/Tax ID	Select the Social Security number (SSN) or employer identification number (EIN) of the attending provider.
Other Physician SSN/Tax ID	Select the SSN/EIN for any additional providers.

4. Select the Header 3 tab.

5. Enter data into all of the required boxes on Header 3 using the table below as a guide.

Institutional Nursing Home Header 3	
Field	**Description**
Diagnosis Codes Primary	Enter or select the primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code related to the visit.
Other	Enter or select any additional diagnosis codes related to the visit.
Admit	Enter or select the admit diagnosis code corresponding to the diagnosis that prompted admission to the nursing home.
Condition Codes	Enter or select the condition codes used to identify conditions relating to this bill that may affect payer processing (if applicable).
Other Insurance Indicator	Select "Y" if the client has other insurance coverage for institutional services. This box defaults to "N."
Medicare Indicator	Select "Y" if the client has Medicare coverage for institutional services. This box defaults to "N."

6. If you do not have commercial insurance carrier information to enter, proceed to step 11.

7. If you have commercial insurance carrier information to enter, select the OI tab.

8. Enter data into all of the required boxes on the OI tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Institutional Nursing Home OI	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate whether the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for this client. Tab off the box to populate the policyholder first and last name boxes.

TIP

When there are multiple payers for a single client, complete all information for each payer prior to beginning a new payer.

TIP

Refer to the Basic Skills chapter of this manual for information on screen-specific command buttons, such as Add Srv and Copy OI.

TIP

You may report other insurance payments or adjustments on the OI Adjustment tab (header level).

The maximum number of details that can be submitted per form is 999.

9. Select the OI Adj tab.

10. Enter data into all of the required boxes on the OI Adj tab using the table below as a guide.

Institutional Nursing Home OI Adjustment	
Field	**Description**
OI-Y	Select "Y" or "N" if other insurance exists, but was not billed for various reasons as outlined in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Institutional Inpatient OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by the other insurance (if applicable). This box is required if the information was not entered on the Service Adjustment tab.
Allowed Amount	Enter the amount allowed by the other insurance (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the other insurance (if applicable). Enter "PR" if insurance deductible, coinsurance, or copay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This box is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance (if applicable). Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier did not pay the claim in full.

TIP

Depending on how Medicare reported their payment information to you, you are required to either report Medicare payments and adjustments on the Medicare tab (header level) or Service Adjustment tab (detail level) in PES.

Look at the remittance advice that was sent to you by Medicare. If the payment information sent was reported at the header level, complete the Medicare screen in PES for that payer. If the payment information sent was at the service level, complete the Service Adjustment screen for that payer. *To access the Service Adjustment screen, select "Y" in the Service Adjustment Ind box on the Srv tab. Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select "Y."*

Do not complete both the bottom portion of the Medicare screen and the Service Adjustment screen for the same payer. Refer to the Other Insurance and Medicare chapter of this manual for more information.

11. If the client does not have Medicare insurance information, proceed to step 14.

12. If the patient has Medicare insurance information, select the Medicare tab.

13. Enter data into all of the required boxes on the Medicare tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Institutional Nursing Home Medicare	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."
Benefits Assignment	Select "N" only to indicate whether the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y."
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This box defaults to "MA."
Carrier Code	Select the carrier code for the policyholder. Tab off of the box to populate the policyholder name boxes.
M-8	Select "Y" if Medicare exists, but was not billed for reasons as outlined in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment (if applicable), using the MM/DD/CCYY format. Enter the amount paid by Medicare (if applicable). This box is required if the information was not entered in the Service Adjustment tab.
Allowed Amount	Enter the allowed amount from Medicare (if applicable).
Non Covered Charges	Enter the total noncovered amount from Medicare (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. This box is only required if Medicare made an adjustment.

Tip

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

14. Select the Service tab.

15. Enter data into all of the required boxes on the Service tab using the following table as a guide.

Institutional Nursing Home Service	
Field	**Description**
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Revenue Code	Enter or select the four-digit revenue code or the two-digit local code preceded by two zeros that identifies the specific accommodation or ancillary service.
Billed Amount	The billed amount is calculated automatically.
Units	Enter the number of units performed for the revenue code billed. Example: 1.00 = 1 unit.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (units). This box defaults to "UN."
Unit Rate	Enter the rate per unit of the associated revenue code for nursing home accommodation (if applicable). This field is required when the associated revenue code is 0100-0219.
Service Adjustment Ind	Select "Y" or "N" to indicate if service level payments or adjustments were made by the commercial insurance carrier and/or Medicare. This box defaults to "N."

16. If Medicare did not make service-level payments, proceed to step 19.

17. If Medicare made a service-level payment, select the Srv Adj tab.

18. Enter data into all of the required boxes on the Service Adj tab using the table below as a guide.

Institutional Nursing Home Service Adjustment	
Field	**Description**
Carrier Code	Select the appropriate Medicare carrier code.
Paid Date/Amount	Enter the date Medicare paid the claim using the MM/DD/CCYY format. Enter the total amount paid by Medicare.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance, if applicable. Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier made an adjustment. Refer to Appendix 1 of this manual for a code list and descriptions.

19. Click **Save**, then **Close**. Proceed to Submitting New Institutional Nursing Home Claims.

Correcting Errors on Institutional Nursing Home Claims

If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

- Double-click on the error message.
- Click on the error message and click **Select**.

PES will return to the box that has missing or incorrect data.

Edit All Feature for Institutional Nursing Home Claims

PES offers an Edit All feature for creating nursing home claims. Each claim to be edited must be in an "R" (ready to transmit) status. To use the Edit All feature, follow these steps:

1. Choose one of the following two methods of copying your claims:
   - Select a previously submitted claim in an "F" (finalized) status from the list of previously finalized claims. Click **Copy**. Click **Save**.
   - Select a batch of previously submitted claims, copy the entire batch, and save them as new claims. Refer to the instructions for copying batch forms in the Communication chapter.
2. Click **Edit All**.
3. Enter the dates of service (DOS) in the From and To DOS boxes.
4. Enter the number of days associated with the date span.
5. Click **OK**. A message displays verifying the number of claim forms to be submitted. If correct, click **Yes**.
6. Review each form to verify that the billed amount and client liability are correct for the number of days billed on the claim.
7. Click **Close**.

TIP

Perform the "Edit All" feature first, then add any new claims to the batch. If you choose to edit the entire batch instead of single claims, be sure to verify that you provided each of the services submitted.

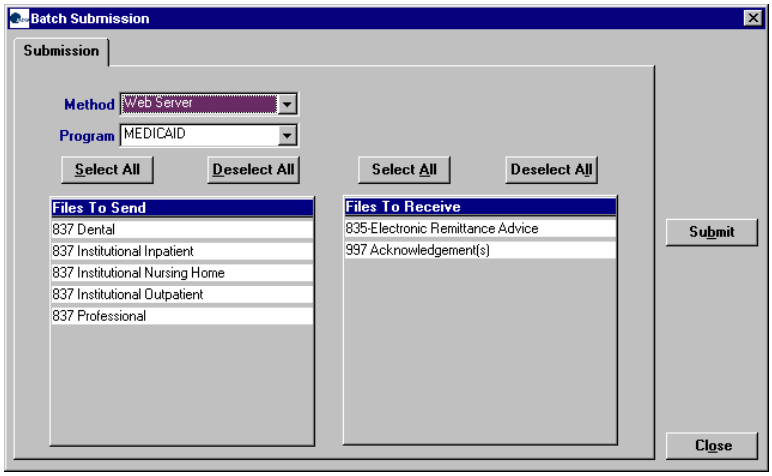
8. Follow the instructions for submission in Submitting New Institutional Nursing Home Claims in this chapter.

Submitting New Institutional Nursing Home Claims

Once you have completed all required screens for your claim and have saved the information, you are ready to submit the claim to the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

TIP

Denied claims may be copied, corrected, and submitted as new claims.



All forms are submitted by batch. To submit new claims, follow these steps:

1. Click **Communication** on the menu bar.
2. Click **Submission**. The Batch Submission window will display.
3. Select “Web Server” from the Method box.
4. Select “Medicaid” or “HIRSP” from the Program box.
5. Click on the appropriate form type(s) under Files to Send.
6. Click **Submit**.
7. PES will post messages in the Transmission window updating you on the progress of the transmission.

TIP

You may only submit claims that have a status of “R.” All claims in “R” status will be submitted when you perform a batch submission.

TIP

Do not click on Files to Retrieve when you are submitting a claim. Refer to the Communications chapter of this manual for more information on retrieving batch responses.

TIP

To ensure a successful transmission, establish a dial-up connection before submitting claims.

Resubmitting Institutional Nursing Home Claims

Use this feature when, although you have previously submitted a claim or batch of claims, Wisconsin Medicaid or HIRSP requests that you resubmit the claim(s).

Resubmitting a Single Claim

To resubmit a single claim, click the institutional nursing home button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Click **Save**. Click **Close**.
4. Click **Communication** on the menu bar.
5. Click **Submission**.
6. Select “Web Server” from the Method box.
7. Select “Medicaid” or “HIRSP” from the Program box.
8. Click on the appropriate form type under Files to Send.
9. Click **Submit**.

TIP

If a claim requires an attachment, that claim must be sent as a paper claim.

Resubmitting or Copying a Partial or Entire Batch

To resubmit a partial or entire batch of claims, click the institutional nursing home button on your toolbar and follow these steps:

1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by:
   - Clicking **Copy** to copy the entire batch.
   - Highlighting **Deselect All** and selecting individual forms to copy from the batch. Click **Copy**.

   Once you have copied the desired forms, you may modify and resubmit them by:

   - Clicking **Resubmit** to resubmit the entire batch.

- Highlighting **Deselect All** and selecting individual forms to resubmit specific forms from the batch. Click **Resubmit**.

4. The Batch Submission window will display.

5. Select “Web Server” from the Method box.

6. Click on the appropriate form type(s) under Files to Send.

7. Click **Submit**.

Adjusting Paid Status Institutional Nursing Home Claims

PES allows you to resubmit a claim or claims to Wisconsin Medicaid or HIRSP even after the claims show a status of “paid.” To resubmit a paid claim, click the institutional nursing home button on your toolbar and follow these steps:

TIP

Use the adjusting paid status claims feature of PES when you have made an error on a claim in paid status and want to adjust the claim. You may only adjust a claim in paid status.

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.

2. Click **Copy**.

3. In the Type of Bill box, enter the first two digits of the type of bill and enter “7” as the final digit.

4. Enter the 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.

5. Make corrections to the claim as needed.

6. Click **Save**.

7. Click **Communication** on the menu bar.

8. Click **Submission**.

9. Select “Web Server” from the Method box.

10. Select “Medicaid” or “HIRSP” from the Program box.

11. Click on the appropriate form type under Files to Send.

12. Click **Submit**.

Late Billing for Institutional Nursing Home Claims

PES allows you to resubmit a late billing claim or claims to Wisconsin Medicaid or HIRSP even after the claim shows a status of "paid." To resubmit a paid late billing claim, click the institutional nursing home button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill box, enter the first two digits of the type of bill and enter "5" as the final digit.
4. Enter the 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.
5. Make additions to the claim as needed. Refer to the Tip box on this page for more information.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select "Web Server" from the Method box.
10. Select "Medicaid" or "HIRSP" from the Program box.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

Late billing should not be confused with timely filing. Refer to your Wisconsin Medicaid *Updates* and handbooks on requirements for timely filing. *Note:* Late billing is a charge(s) not billed on the original paid claim or adjustment.

Voiding Institutional Nursing Home Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid or HIRSP to recoup the entire claim. To void a claim, click the institutional nursing home button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.

3. In the Type of Bill box, enter the first two digits of the type of bill and enter “8” as the final digit.

4. Enter the 15-digit internal control number (ICN) in the Original Claim # box.

5. Click **Save**.

6. Click **Communication** on the menu bar.

7. Click **Submission**.

8. Select “Web Server” from the Method box.

9. Select “Medicaid” or “HIRSP” from the Program box.

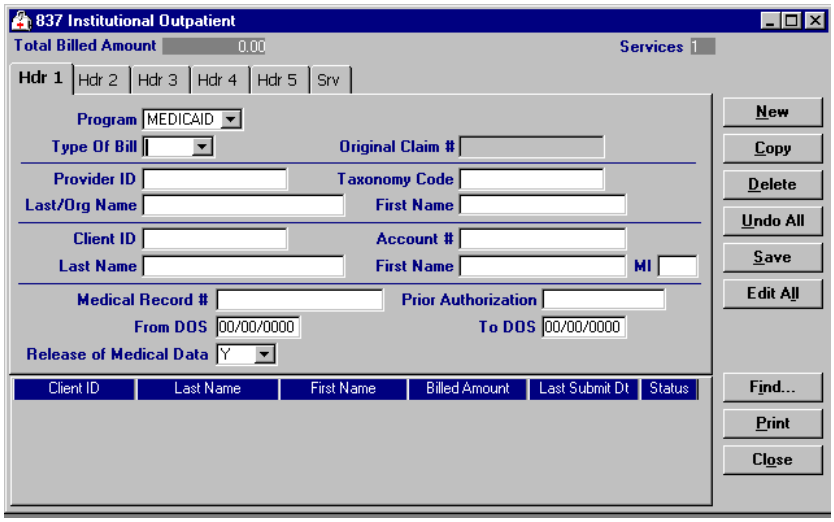
10. Click on the appropriate form type under Files to Send.

11. Click **Submit**.

Institutional Outpatient Claims

The 837 Institutional Outpatient claim form is used by the following types of providers: home health, critical access, hospice, personal care, nurses in independent practice, and outpatient hospital.

The 837 Institutional Outpatient claim form has several screens that you will use to complete a Medicaid, HIRSP, or Wisconsin Well Woman Program (WWWP) claim, depending on your provider type. These screens include:



- Headers 1-5.
- Service.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

Completing New Institutional Outpatient Claims

Click on the institutional outpatient button on your toolbar and follow these steps:

TIP

In name boxes, no special characters, such as apostrophes or hyphens, may be entered, except for spaces.

1. Enter data into all of the required boxes on Header 1 using the table below as a guide.

Institutional Outpatient Header 1	
Field	**Description**
Program	Select Medicaid, HIRSP or WWWP.
Type of Bill	Enter or select the type of bill code for the services rendered.
Provider ID	Select the eight-digit Medicaid billing provider number.
Client ID	Select the 10-digit recipient/policyholder identification number.
Medical Record #	Enter the medical record number assigned by your organization that identifies the client.
Prior Authorization	Enter the seven-digit prior authorization (PA) number (if applicable).
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Release of Medical Data	Select "N" only to indicate that the provider does not have a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y."

2. Select the Header 2 tab.

3. Enter data into all of the required boxes on Header 2 using the following table as a guide.

Institutional Outpatient Header 2	
Field	**Description**
Diagnosis Codes Primary	Enter or select the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code related to the visit.
Other	Enter or select additional diagnosis codes related to the visit (if applicable).
E-Code	Enter or select the diagnosis code that represents the cause of injury, if the service is accident related.
Attending SSN/Tax ID	Select the Social Security number (SSN) or employer identification number (EIN) of the attending provider.

4. Select the Header 3 tab.

5. Enter data into all of the required boxes on Header 3, using the table below as a guide.

Institutional Outpatient Header 3	
Field	**Description**
Occurrence Codes/Dates	Enter or select an occurrence code(s) (if applicable). Enter the date associated with the code using the MM/DD/CCYY format.
Occurrence Span Codes/Dates	Enter or select the occurrence span code(s) (if applicable). Enter the dates associated with the code listed using the MM/DD/CCYY format.

6. Select the Header 4 tab.

7. Enter data into all of the required boxes on Header 4 using the table below as a guide.

Institutional Outpatient Header 4	
Field	**Description**
Value Codes/Amounts	Enter or select the two-digit value code(s) (if applicable). Enter the corresponding value code amount(s).
Other Physician SSN/Tax ID	Select the Social Security number (SSN) or employer identification number (EIN) of any additional providers.
Operating Physician SSN/Tax ID	Select the SSN/EIN of any operating physicians. Use only when surgical procedures have been performed during the client's institutionalization. This box is required when billing a surgical procedure code on the Header 5 tab.

8. Select the Header 5 tab.

9. Enter data into all of the required boxes on Header 5, using the following table as a guide.

Institutional Outpatient Header 5	
Field	**Description**
Surgical Procedure Codes / Dates Principal	Enter or select the surgical procedure code(s) that identifies the procedure performed during the billing period (if applicable). Enter the date that corresponds to the listed surgical procedure(s) using the MM/DD/CCYY format.
Condition Codes	Enter or select the condition code(s) (if applicable).
Admit Source	Enter or select the admission source code (if applicable).
Other Insurance Ind	Select "Y" if the client has other insurance coverage for institutional services. This box defaults to "N."
Medicare Ind	Select "Y" if the client has Medicare coverage for institutional services. This box defaults to "N."

10. If you do not have commercial insurance carrier information to enter, proceed to step 15.

11. If you have commercial insurance carrier information to enter, select the OI tab.

12. Enter data into all of the required boxes on the OI tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

You should report other insurance payments or adjustments on the OI Adjustment tab (header level) in PES.

The maximum number of details that can be submitted per form is 999.

Institutional Outpatient OI	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate whether the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for the policyholder. Tab off of the box to populate the first and last name boxes.

13. Select the OI Adj tab.

14. Enter data into all of the required boxes on the OI Adj tab using the table below as a guide.

TIP

When there are multiple payers for a single client, complete all information for each payer prior to beginning a new payer.

Institutional Outpatient OI Adjustment	
Field	**Description**
OI-Y	Select "Y" if other insurance exists, but was not billed for reasons as outlined in your Wisconsin Medicaid *Updates* and service specific handbook. This box defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Institutional Inpatient OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by the other insurance (if applicable). This box is required if the information was not entered in the service adjustment tab.
Allowed Amount	Enter the amount allowed by the other insurance (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the other insurance (if applicable). Enter "PR" if insurance deductible, coinsurance, or copay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This box is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance (if applicable). Enter the amount indicated by the other insurance for each reason code. This box is only required if an insurance carrier did not pay the claim in full.

TIP

Depending on how Medicare reported their payment information to you, you are required to either report Medicare payments and adjustments on the Medicare tab (header level) or Service Adjustment tab (detail level) in PES.

Look at the remittance advice that was sent to you by Medicare. If the payment information sent was reported at the header level, complete the Medicare screen in PES for that payer. If the payment information sent was at the service level, complete the Service Adjustment screen for that payer. *To access the Service Adjustment screen, select "Y" in the Service Adjustment Ind box on the Srv tab. Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select "Y."*

Do not complete both the bottom portion of the Medicare screen and the Service Adjustment screen for the same payer. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

TIP

Refer to the Basic Skills chapter of this manual for information on screen-specific command buttons, such as Add Srv and Copy OI.

15. If the client does not have Medicare insurance information, proceed to step 18.

16. If the patient has Medicare insurance information, select the Medicare tab.

17. Enter data into all of the required boxes on the Medicare tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Institutional Outpatient Medicare	
Field	**Description**
Release of Medical Data	Select an option to indicate whether the provider has a statement on file signed by the client authorizing the release of medical data to other organizations. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Benefits Assignment	Select "N" only to indicate whether the client, or authorized person, did not authorize benefits to be assigned to the provider. This box defaults to "Y." The information entered in this box has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This box defaults to "MA."
Carrier Code	Select the carrier code for the policyholder. Tab off of the box to populate the policyholder name fields.
M-8	Select "Y" if Medicare exists, but was not billed for reasons as outlined in your Wisconsin Medicaid *Updates* and service-specific handbook. This box defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment (if applicable) using the MM/DD/CCYY format. Enter the amount paid by Medicare (if applicable). This box is required if the information was not entered on the Service Adjustment screen.
Allowed Amount	Enter the allowed amount from Medicare (if applicable).
Non Covered Charges	Enter the total noncovered amount from Medicare (if applicable).
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. This box is only required if Medicare made an adjustment.

18. Select the Service tab.

19. Enter data into all of the required boxes on the Service tab using the table below as a guide.

Institutional Outpatient Service	
Field	**Description**
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format (if applicable).
Revenue Code	Enter or select the revenue code that identifies the specific accommodation or ancillary service.
Billed Amount	The billed amount is calculated automatically.
Units	Enter the number of units performed for the revenue code billed. Example: 1.00 = 1 unit.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (unit). This box defaults to "N."
Unit Rate	Enter the rate per unit of the associated revenue code for hospital accommodation (if applicable). This box is required only when the associated revenue code is 0100-0219.
Procedure	Enter or select the procedure code associated to the revenue code (if applicable).
Modifiers	Enter the modifier (if applicable).
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by the other insurance and/or Medicare. This box defaults to "N."

20. If Medicare did not make service-level payments, proceed to step 23.

21. If Medicare made a service-level payment, select the Srv Adj tab.

22. Enter data into all of the required boxes on the Service Adj tab using the table below as a guide.

Institutional Outpatient Service Adjustments	
Field	**Description**
Carrier Code	Select the appropriate Medicare carrier code.
Paid Date/Amount	Enter the date Medicare paid the claim using the MM/DD/CCYY format. Enter the total amount paid by Medicare.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance or Medicare (if applicable). Enter the amount indicated by other insurance for each reason code. This box is only required if an insurance carrier made an adjustment. Refer to Appendix 1 of this manual for a code list and descriptions.

23. Click **Save**, then **Close**. Proceed to Submitting New Institutional Outpatient Claims.

Correcting Errors on Institutional Outpatient Claims

If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

- Double-click on the error message.
- Click on the error message and click **Select**.

PES will return to the box that has missing or incorrect data.

Edit All Feature for Institutional Outpatient Claims

PES offers an Edit All feature for creating home health claims. Only home health providers (those using type of bill "33") may use this feature. Each claim to be edited must be in an "R" (ready to transmit) status. To use the Edit All feature, follow these steps:

1. Choose one of the following two methods of copying your claims:
   - Select a previously submitted claim in an "F" (finalized) status from the list of previously finalized claims. Click **Copy**. Click **Save**.
   - Select a batch of previously submitted claims, copy the entire batch, and save them as new claims. Refer to the instructions for copying batch forms in the Communication chapter of this manual.
2. Click **Edit All**.
3. Enter the dates of service (DOS) in the From and To DOS boxes.
4. Enter the number of days associated with the date span.
5. Click **OK**. A message displays verifying the number of claim forms to be submitted. If correct, click **Yes**.
6. Review each form to verify that the billed amount is correct for the number of days billed on the claim.

TIP

Perform the "Edit All" feature first, then add any new claims to the batch. If you choose to edit the entire batch instead of single claims, be sure to verify that you provided each of the services submitted.

7. Click **Close**.

8. Follow the instructions for submission in Submitting New Institutional Outpatient Claims in this chapter.

Submitting New Institutional Outpatient Claims

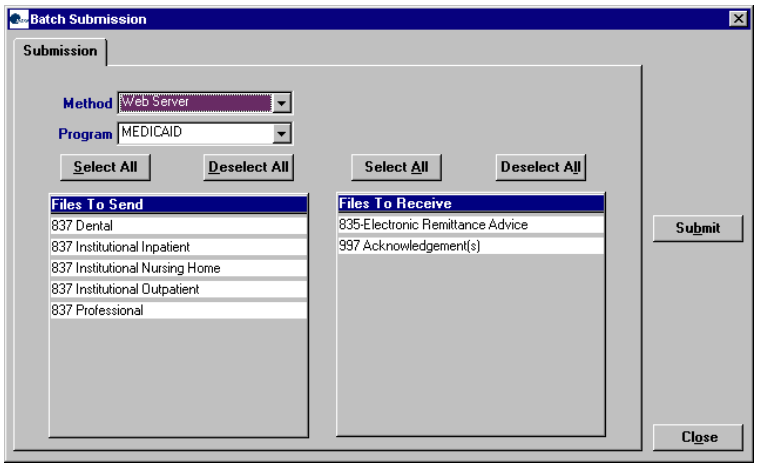
Once you have completed all required screens for your claim and have saved the information, you are ready to submit the claim to the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department.

TIP

Denied claims may be copied, corrected, and submitted as new claims.

TIP

If a claim requires an attachment, that claim must be sent as a paper claim.



All forms are submitted by batch. To submit new claims, follow these steps:

TIP

You may only submit claims that have a status of "R." All claims in "R" status will be submitted when you perform a batch submission.

1. Click **Communication** on the menu bar.

2. Click **Submission**. The Batch Submission window will display.

3. Select "Web Server" from the Method box.

4. Select "Medicaid," "HIRSP," or "WWWP" from the Program box.

5. Click on the appropriate form type(s) under Files to Send.

6. Click **Submit**.

7. PES will post messages in the Transmission window updating you on the progress of the transmission.

TIP

To ensure a successful transmission, establish a dial-up connection before submitting claims.

Resubmitting Institutional Outpatient Claims

Use this feature when, although you have previously submitted a claim or batch of claims, Wisconsin Medicaid, HIRSP, or WWWP requests that you resubmit the claim(s).

Resubmitting a Single Claim

To resubmit a single claim, click the institutional outpatient button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Click **Save**. Click **Close**.
4. Click **Communication** on the menu bar.
5. Click **Submission**.
6. Select “Web Server” from the Method box.
7. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.
8. Click on the appropriate form type under Files to Send.
9. Click **Submit**.

Resubmitting or Copying a Partial or Entire Batch

To resubmit a partial or entire batch of claims, click the institutional outpatient button on your toolbar and follow these steps:

1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by:
   - Clicking **Copy** to copy the entire batch.
   - Highlighting **Deselect All** and selecting individual forms to copy from the batch. Click **Copy**.

   Once you have copied the desired forms, you may modify and resubmit them by:

   - Clicking **Resubmit** to resubmit the entire batch.

- Highlighting **Deselect All** and selecting individual claims to resubmit specific claims from the batch. Click **Resubmit**.

4. The Batch Submission window will display.

5. Select “Web Server” from the Method box.

6. Click on the appropriate form type(s) under Files to Send.

7. Click **Submit**.

Adjusting Paid Status Institutional Outpatient Claims

PES allows you to resubmit a claim or claims to Wisconsin Medicaid, HIRSP, or WWWP even after the claims show a status of “paid.” To resubmit a paid claim, click the institutional outpatient button on your toolbar and follow these steps:

TIP

Use the adjusting paid status claims feature of PES when you have made an error on a claim in paid status and want to adjust the claim. You may only adjust a claim in paid status.

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.

2. Click **Copy**.

3. In the Type of Bill box, enter the first two digits of the type of bill and enter “7” as the final digit.

4. Enter the 11- or 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.

5. Make corrections to the claim as needed.

6. Click **Save**.

7. Click **Communication** on the menu bar.

8. Click **Submission**.

9. Select “Web Server” from the Method box.

10. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.

11. Click on the appropriate form type under Files to Send.

12. Click **Submit**.

Late Billing for Institutional Outpatient Claims

PES allows you to resubmit a late billing claim or claims to Wisconsin Medicaid, HIRSP, or WWWP even after the claim shows a status of "paid." To resubmit a paid late billing claim, click the institutional outpatient button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill box, enter the first two digits of the type of bill and enter "5" as the final digit.
4. Enter the 11- or 15-digit internal control number (ICN) in the Original Claim # box. Refer to your Remittance and Status Report for the ICN, or look for the payer claim control number on your 835 Electronic Remittance and Status Report.
5. Make additions to the claim as needed. Refer to the Tip box on this page for more information.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select "Web Server" from the Method box.
10. Select "Medicaid," "HIRSP," or "WWWP" from the Program box.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

Late billing should not be confused with timely filing. Refer to your Wisconsin Medicaid *Updates* and handbooks on requirements for timely filing. *Note:* Late billing is a charge(s) not billed on the original paid claim or adjustment.

Voiding Institutional Outpatient Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid, HIRSP, or WWWP to recoup the entire claim. To void a claim, click the institutional outpatient button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill box, enter the first two digits of the type of bill and enter "8" as the final digit.

4. Enter the 11- or 15-digit internal control number (ICN) in the Original Claim # box.

5. Click **Save**.

6. Click **Communication** on the menu bar.

7. Click **Submission**.

8. Select “Web Server” from the Method box.

9. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.

10. Click on the appropriate form type under Files to Send.

11. Click **Submit**.

Other Insurance and Medicare

This chapter will provide you with supplemental information about submitting Medicaid claims when a client has other insurance, Medicare, or both. For step-by-step instructions on completing forms, refer to the individual claim chapters.

Wisconsin Medicaid and Other Insurance

Not all providers are required to bill Other Insurance (OI), even though the policyholder may have other insurance. The following providers do not have to bill other insurance, and should not enter a “Y” in the Other Insurance Ind box:

- Specialized Medical Vehicle.
- Personal Care.
- Case Management.
- Family Planning Clinics.

Reporting Other Insurance Payments

When reporting other insurance payments, report the complete payment information on the OI Adj tab. It is not necessary to report the payments at the service detail (Srv tab[s]).

The instructions in this section apply to all claim types. The screens for Institutional Nursing Home are shown just as examples.

When completing the screens for other insurance, keep in mind the following:

837 Institutional Nursing Home

Total Billed Amount .00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | OI | OI Adj | Medicare | Srv | Srv Adj

Release of Medical Data Benefits Assignment Y

Claim Filing Ind Code

Policy Holder

Carrier Code

Last Name First Name

Add OI | Copy OI | Delete OI

OI #	Carrier Code	Carrier Name	Last Name	First Name
1				

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

- The policyholder carrier code should be “001,” “002,” “003,” or “005.”
- On the OI tab, pick the most appropriate code for the Claim Filing Ind Code. For example, use “CI” to indicate commercial insurance, or use “HM” to indicate an HMO.

Note: Do *not* use claim filing indicator code “16” to indicate an HMO. This code indicates a Medicare plan.

Example of a payable claim

837 Institutional Nursing Home

Total Billed Amount 6,000.00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | OI | OI Adj | Srv

OI Y N Paid Date/Amount 01/01/2004 4,900.00

Allowed Amount 6,000.00

Adjustment Group Codes/Reason Codes/Amounts

	PR										
1	1	1,000.00	4		.00	1		.00	4		.00
2	3	100.00	5		.00	2		.00	5		.00
3		.00	6		.00	3		.00	6		.00

OI #	Carrier Code	Carrier Name	Last Name	First Name
1	001	OTHER INSURANCE	GIBSON	JOAN

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
5510003470	GIBSON	JOAN	6,000.00	00/00/0000	R

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

Example of a claim that would be denied

837 Institutional Nursing Home

Total Billed Amount 6,300.00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | OI | OI Adj | Srv

OI Y N Paid Date/Amount 01/01/2004 .00

Allowed Amount .00

Adjustment Group Codes/Reason Codes/Amounts

PR

1	31	6,300.00	4		.00	1		.00	4		.00
2		.00	5		.00	2		.00	5		.00
3		.00	6		.00	3		.00	6		.00

OI #	Carrier Code	Carrier Name	Last Name	First Name
1	001	OTHER INSURANCE	GIBSON	JOAN

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
5510003470	GIBSON	JOAN	6,300.00	00/00/0000	R

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

- On the OI Adj tab, the Paid Date/Amount should be the date and dollar amount reported to you by the other insurance carrier.
- The Allowed Amount is the amount the other insurance allowed on the Explanation of Benefits.
- Choose the appropriate adjustment group code that describes the reason that the other insurance carrier did not pay the charges in full. For example, “PR” indicates patient responsibility and should be used when reporting coinsurance or deductible amounts.
- Choose the most appropriate code (or the ANSI code given to you by the carrier on the explanation of benefits) in the reason code field. Adjustment reason codes are located in Appendix 1 of this manual; the most commonly used codes are bolded.
- Enter the dollar amount that correlates with the reason code.

Note: The dollar amount entered in the Paid Amount box and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts box must equal the total amount of your claim. If you have completed the Srv tab, the total billed amount will be displayed at the top of the OI Adj tab.

Wisconsin Medicaid and Medicare

If you are billing Medicare Managed Care, please refer to the section called “Wisconsin Medicaid and Medicare Managed Care” found in this chapter.

Please note that not all providers are required to bill Medicare, even though the policyholder may have Medicare coverage. Do not enter a “Y” in the Medicare Ind box for the following provider types:

- Nurses in Independent Practice.
- Specialized Medical Vehicle.
- Personal Care.
- Dental.
- School-Based Services.
- Case Management.
- Crisis Intervention.
- Family Planning Clinics.

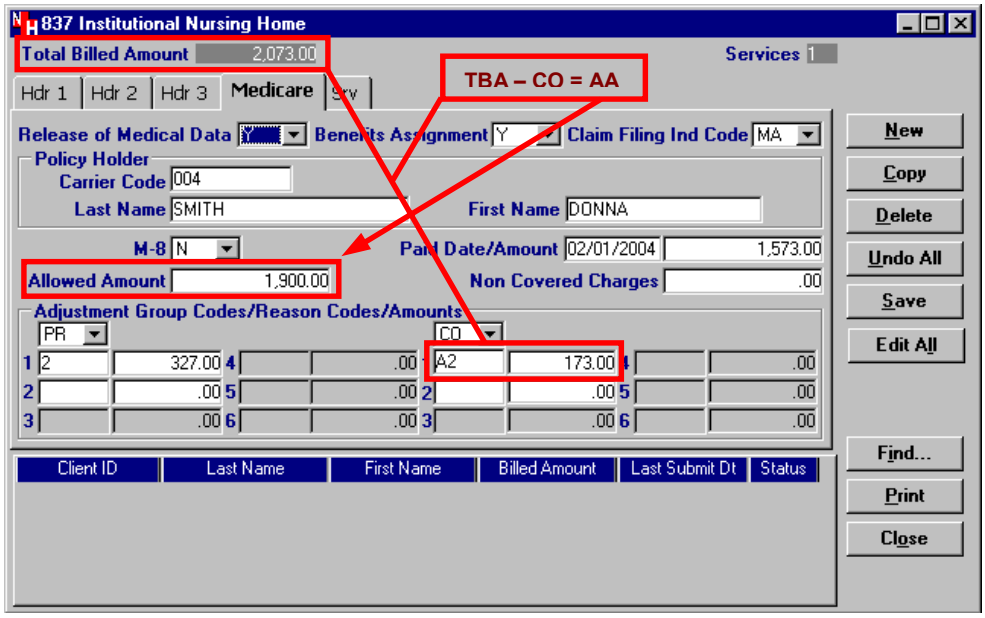
Depending on how Medicare reported their payment information to you, you must either report Medicare payments and adjustments on the Medicare tab (header level) or Srv Adj tab (detail level) in PES.

Look at the remittance advice that was sent to you by Medicare. If the payment information sent was reported at the header level, complete the Medicare screen in PES. If the payment information sent was at the service level, complete the Srv Adj tab. To access the Srv Adj tab, select “Y” in the Service Adjustment Ind box on the appropriate service tab. *Do not complete both the bottom portion of the Medicare screen and the Service Adjustment screen for the same payer.*

Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select “Y.”

Medicare Paid at the Header Level

Medicare pays at the header level for inpatient hospital, outpatient hospital, and nursing home providers. When completing the Medicare tab for these types of claims, keep in mind the following:



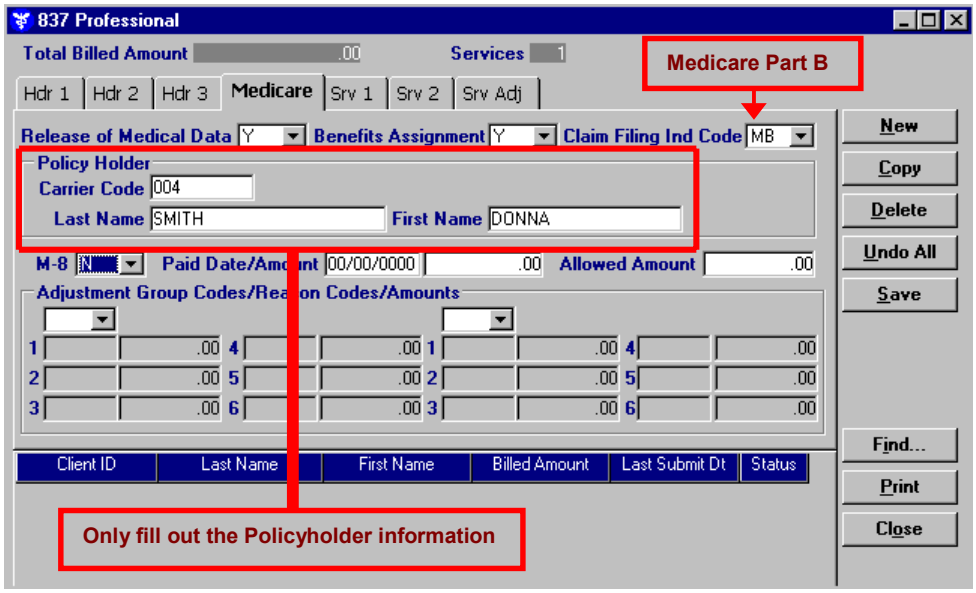
- The policyholder carrier code should be “004.”
- The Paid Date/Amount should be the date and dollar amount reported to you by Medicare.
- Choose the appropriate adjustment group code that describes the reason that Medicare did not pay the charges in full. For example, “PR” indicates patient responsibility and should be used when reporting coinsurance or deductible amounts.
- Choose the most appropriate code (or the ANSI code given to you by the carrier on the explanation of benefits) in the reason code field. Adjustment reason codes are located in Appendix 1 of this manual; the most commonly used codes are bolded.
- Enter the dollar amount that correlates with the reason code.

Note: The dollar amount entered in the Paid Amount box and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts box must equal the amount indicated in the Total Billed Amount box at the top of the Medicare screen.

Medicare Paid at the Detail Level

Medicare pays at the detail level for different providers, such as physician, home health, physical therapy, occupational therapy, and speech and language pathology.

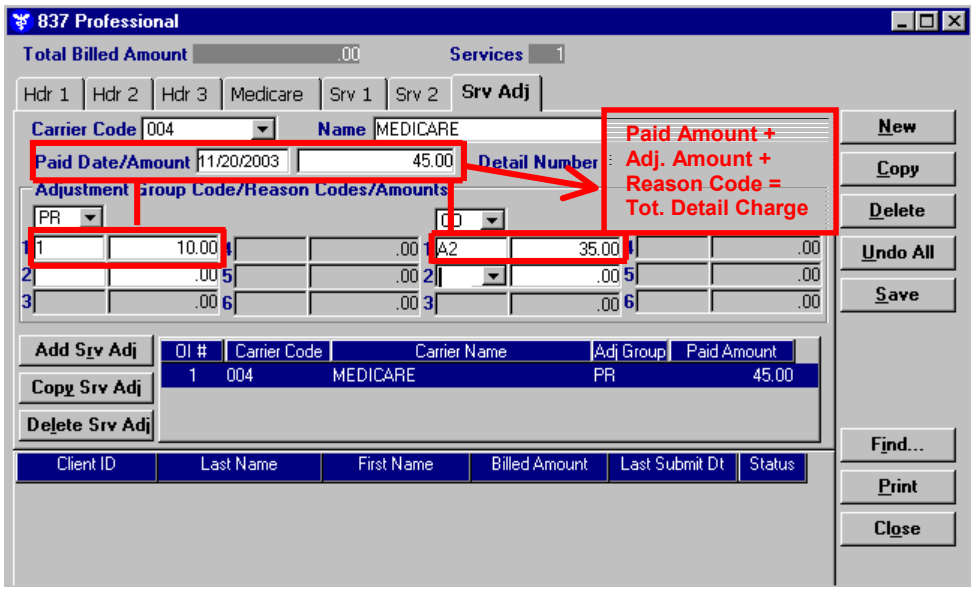
When Medicare pays at the detail level, you should complete only the following boxes on the Medicare tab:



- Release of Medical Data.
- Benefits Assignment.
- Claim Filing Ind Code.
- Policyholder boxes.

When reporting detail-level payments, keep in mind the following:

- On the Srv tab, change the Service Adjustment Ind to a 'Y' for each detail of service.
- On the Srv tab, click the detail in which you want to make a service adjustment and then select the Srv Adj tab. You will need to do this for each detail.

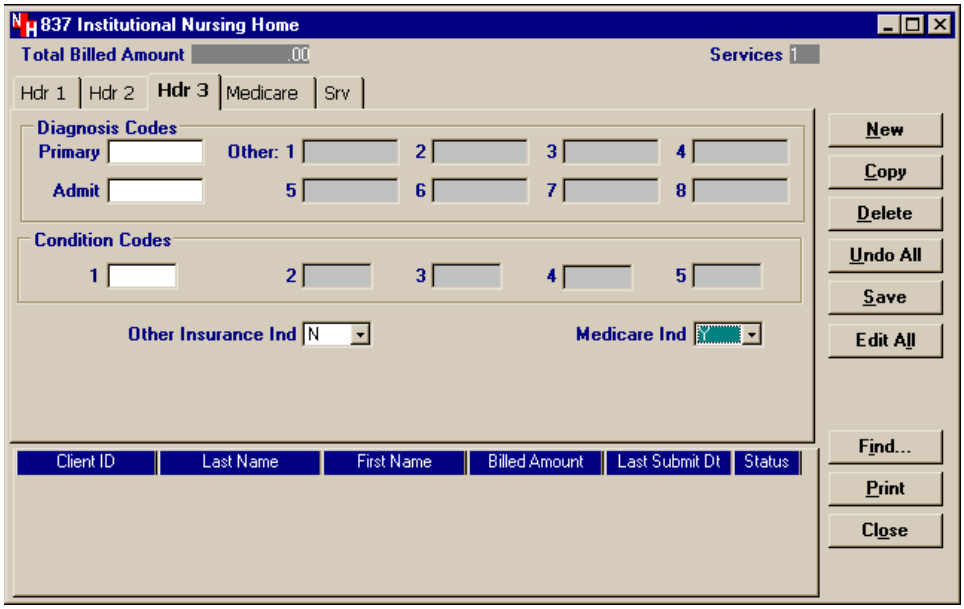


- On the Srv Adj tab, choose the “004 Medicare” carrier code.
- The Paid Date and Amount should be the date and dollar amount reported to you by Medicare for the service detail noted on the screen after the Paid Date/Amount boxes.
- Choose the appropriate adjustment group code that describes the reason that Medicare did not pay the specific detail in full.
- Choose the most appropriate code (or the ANSI code given to you by Medicare on the remittance advice) in the reason code field. Refer to Appendix 1 for a list of codes.
- Enter the dollar amount that correlates with the reason code.

Note: The dollar amount entered in the paid amount field and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts field must equal the dollar amount billed for each detail of service.

Wisconsin Medicaid and Medicare Managed Care

To submit a Medicare Managed Care (MMC, also known as Medicare + Choice, Medicare Cost, or Medicare Risk) claim to Wisconsin Medicaid using PES software, you will need to use the Medicare tabs. To activate and make the Medicare tabs visible, set the Medicare Ind box to “Y.” This indicator may be found on the last Header Tab of any open claim form.



Once the Medicare Ind has been set to “Y,” a new Medicare tab will appear. Medicare Managed Care information can be entered at the header level on this tab. When MMC information is entered at the header level, all payments and dollar amounts will be applied to every service line on the claim.

837 Institutional Nursing Home

Total Billed Amount .00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | Medicare | Srv

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

Policy Holder
Carrier Code
Last Name First Name

M-8 N Paid Date/Amount 00/00/0000 .00

Allowed Amount .00 Non Covered Charges .00

Adjustment Group Codes/Reason Codes/Amounts

1		.00	4		.00	1		.00	4		.00
2		.00	5		.00	2		.00	5		.00
3		.00	6		.00	3		.00	6		.00

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

To supply information and payments made by the MMC organization on individual service lines, you will need to use the Srv Adj tab. As with the header Medicare tab, the Srv Adj tab will not be immediately visible until you set the Service Adjustment Ind to “Y.” This indicator is found on the Srv tab.

837 Institutional Nursing Home

Total Billed Amount .00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | Medicare | Srv | Srv Adj

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

Revenue Code Unit Rate .00

Units 0 Basis of Measurement UN

Billed Amount .00 Service Adjustment Ind Y

Add Srv | Copy Srv | Delete Srv

Srv #	From DOS	To DOS	Revenue Code	Units	Billed Amount
1	00/00/0000	00/00/0000		0	.00

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

After setting the Service Adjustment Ind to “Y,” the Srv Adj tab should appear, allowing you to enter MMC information at the detail level.

837 Institutional Nursing Home

Total Billed Amount .00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | Medicare | Srv | Srv Adj

Carrier Code Name

Paid Date/Amount 00/00/0000 .00 Detail Number 1

Adjustment Group Code/Reason Codes/Amounts

1	.00	4	.00	1	.00	4	.00
2	.00	5	.00	2	.00	5	.00
3	.00	6	.00	3	.00	6	.00

Add Srv Adj | Copy Srv Adj | Delete Srv Adj

OI #	Carrier Code	Carrier Name	Adj Group	Paid Amount
1				.0

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

After sending the claim first to the MMC organization, you should receive from the organization either an electronic (835 Health Care Claim Payment/Advice transaction) or paper remittance advice. If the remittance advice gives header-level payments, you should report the information to Wisconsin Medicaid using the Medicare tab. If the remittance advice gives detail-level payments for each service, you should report the information to Wisconsin Medicaid using the Srv Adj tab.

Please note that for each detail in which you wish to complete service adjustment information, you will need to highlight that service line and set the Service Adjustment Ind to “Y.”

837 Institutional Outpatient

Total Billed Amount 3,289.02 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | Hdr 4 | Hdr 5 | OI | OI Adj | Medicare | Srv | Srv Adj

From DOS 04/01/2004 To DOS 04/07/2004 Revenue Code 0160

Unit Rate 469.86 Units 7.00 Basis of Measurement UN

Billed Amount 3,289.02

Procedure Modifiers: 1 2 3 4

Service Adjustment Ind Y

Add Srv | Copy Srv | Delete Srv

Srv #	DOS	Revenue Code	Units	Billed Amount
1	4/1/04	0160	7.00	3,289.02

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
8300000100	SMITH	DONNA	3,289.00	00/00/0000	R
8300000100	SMITH	DONNA	3,289.02	00/00/0000	R

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

Note: Adjustment reason codes should be submitted on either the Medicare or Srv Adj Tab, but not both.

Medicare Managed Care Paid at the Header Level

Medicare Managed Care pays at the header level for inpatient hospital, outpatient hospital, and nursing home providers. When completing the Medicare tab, keep in mind the following:

837 Institutional Nursing Home

Total Billed Amount 2,073.00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | Medicare | Srv

Release of Medical Data Y Benefits Assignment Y Claim Filing Ind Code 16

Policy Holder
Carrier Code 004
Last Name SMITH First Name DONNA

M-8 N Paid Date/Amount 02/01/2004 1,573.00

Allowed Amount 1,900.00 Non Covered Charges 173.00

Adjustment Group Codes/Reason Codes/Amounts

	PR										
1	3	227.00	4		.00	1		.00	4		.00
2	1	100.00	5		.00	2		.00	5		.00
3		.00	6		.00	3		.00	6		.00

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
8300000100	SMITH	DONNA	2,073.00	00/00/0000	R

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

- The Policyholder carrier code should be “004.” The “004” code is labeled as “Medicare,” but this carrier code should also be used when submitting MMC claims.

- The Paid Date/Amount should be the date and dollar amount reported to you by the MMC organization on their remittance advice.

- Choose the appropriate adjustment group code that describes the reason that Medicare did not pay the charges in full. For example, “PR” indicates patient responsibility and is used when reporting coinsurance, copayment, or deductibles. In the event the MMC remittance advice does not differentiate between copayment and coinsurance, these dollars should be reported to Wisconsin Medicaid as copayment.

- Choose the most appropriate code (or the ANSI code given to you by the carrier on the explanation of benefits) in the reason code field. Adjustment reason codes are located in Appendix 1 of this manual; the most commonly used codes are bolded.

TIP

On MMC claims, you should use one or more of the following adjustment reason codes:

1 — Deductible Amount

2 — Coinsurance Amount

3 — Copayment Amount

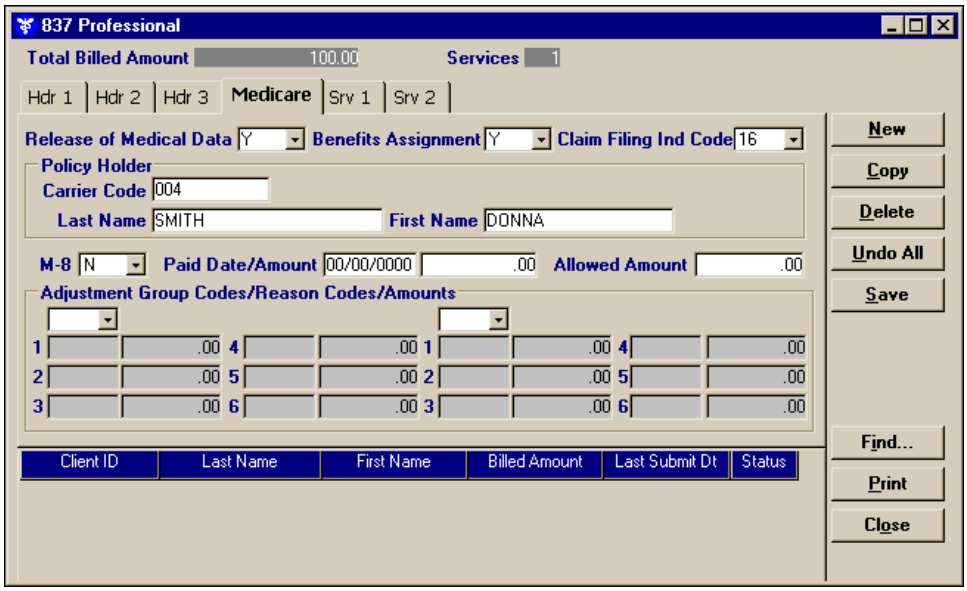
- Enter the dollar amount that correlates with the reason code.

Note: The dollar amount entered in the Paid Amount box and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts and Non Covered Charges boxes must equal the amount indicated in the Total Billed Amount box at the top of the Medicare screen.

Medicare Managed Care Paid at the Detail Level

Medicare Managed Care may pay at the detail level for certain services such as physician, home health, physical therapy, occupational therapy, and speech and language pathology.

When MMC pays at the detail level, you should complete only the following boxes on the Medicare tab:

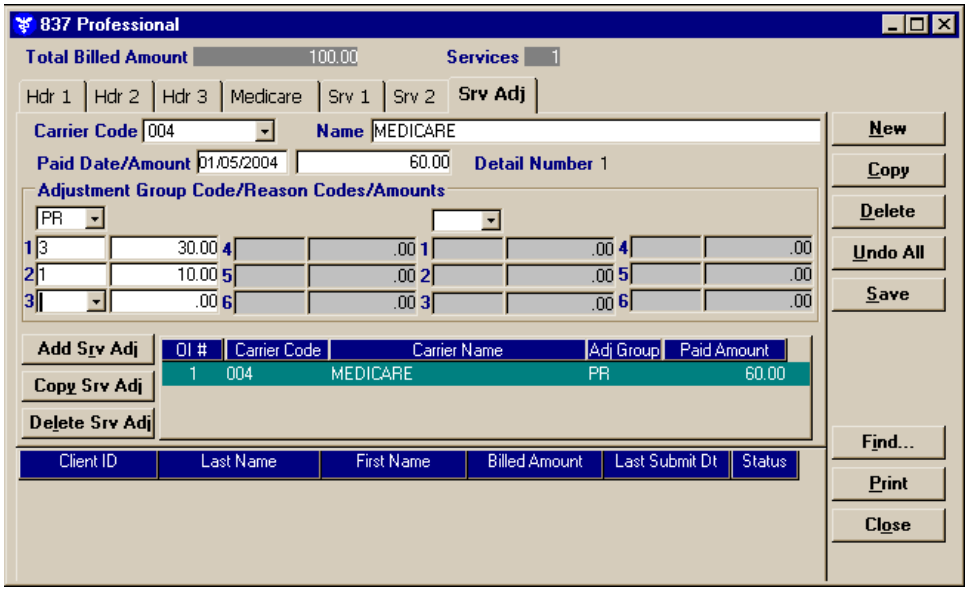


- Release of Medical Data.
- Benefits Assignment.
- Claim Filing Indicator Code.
- Policyholder boxes.

When reporting detail-level payments, keep in mind the following:

- On the Srv tab, change the Service Adjustment Ind to a "Y" for each detail of service.

- On the Srv tab, click the detail in which you want to make a service adjustment and then select the Srv Adj Tab. You will need to do this for each detail.



- On the Srv Adj tab, choose the "004 Medicare" carrier code.

- The Paid Date/Amount should be the date and dollar amount reported to you by the MMC organization for the service detail noted on the screen after the Paid Date/Amount boxes.

- Choose the appropriate adjustment group code that describes the reason that the MMC organization did not pay the specific detail in full.

- Choose the most appropriate code (or the ANSI code given to you by the MMC organization on the remittance advice) in the reason code field. Refer to Appendix 1 of this manual for a list of codes.

- Enter the dollar amount that correlates with the reason code.

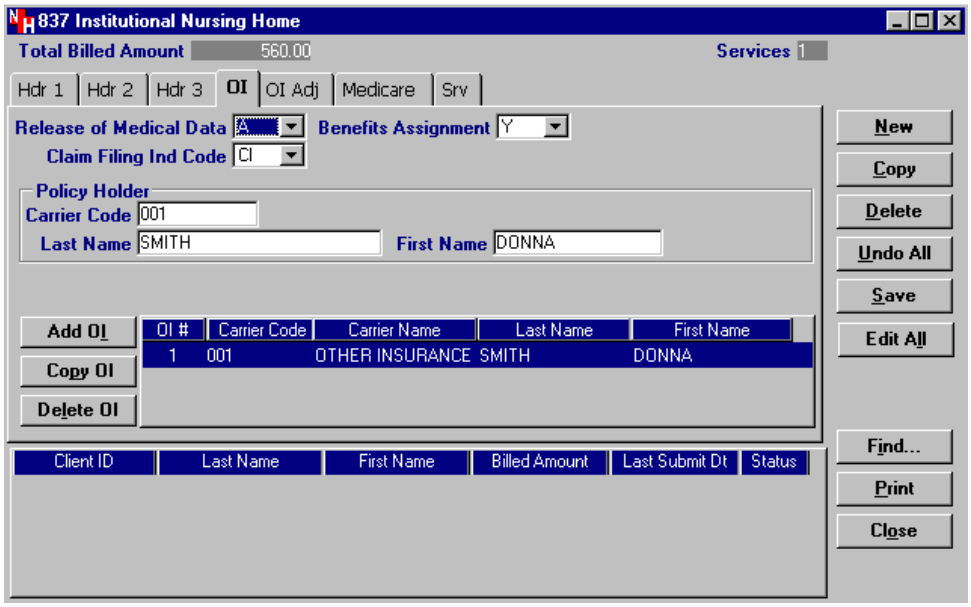
Note: The dollar amount entered in the paid amount field and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts field must equal the dollar amount billed for the corresponding detail of service. The detailed service billed amount can be found on the Service 1 tab.

Other Insurance and Medicare Payment on the Same Claim

When reporting both other insurance and Medicare payments on the same claim, you will need to report Medicare payments first.

- Report Medicare payments at either the header level or the detail level, as previously discussed in this chapter.

- Next, enter data on the OI tab.



- Finally, enter the data on the OI Adj Tab. You will need to report the primary payer payment in the Adjustment Group Code/Reason Codes/Amounts area.

Note: All data entered on the OI Adj tab must equal the Total Billed Amount (also known as total charges). This balancing will be done by entering the Adjustment Group Code, Reason Code, and Amount along with the Coinsurance Reason Code and Amount.

In the following example, the sum of the outlined boxes must equal the Total Billed Amount for the claim.

837 Institutional Nursing Home

Total Billed Amount 560.00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | OI | OI Adj | Medicare | Srv

OI Y N Paid Date/Amount 10/21/2003 40.00

Allowed Amount 560.00

Adjustment Group Codes/Reason Codes/Amounts

	PR				OA			
1	2	40.00	4	.00	A2	160.00	4	
2		.00	5	.00	23	320.00	5	
3		.00	6	.00		.00	6	.00

Amounts must balance to total charges

OI #	Carrier Code	Carrier Name	Last Name	First Name
1	001	OTHER INSURANCE	SMITH	DONNA

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status

New | Copy | Delete | Undo All | Save | Edit All | Find... | Print | Close

Example:

Medicare paid $320.00 as primary.

The Other Insurance tab will need to report the Medicare payment as:

Adjustment Group Code:	*OA* (Other Adjustment)
Reason Codes:	*23* (Payment adjusted - paid by another payer) and A2 (Contractual Adjustment)
Amounts:	*$320.00 (23); $160 (A2)*

Communication

Provider Electronic Solutions (PES) software provides several functions related to communicating with the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) host. The most basic functions of communication, submitting and resubmitting claims, are found in the individual claim chapters in this manual. Communication functions outlined in this chapter include:

- Copying batch forms.
- Viewing batch responses.
- Viewing the communication log.

Copying Batch Forms

Use this option to copy an entire batch of forms or a portion of a batch of forms for use later. You can then edit the forms in the appropriate claim windows. After editing the forms, you may resubmit them using the resubmission procedures described in the appropriate claim form chapter. To copy an entire or partial batch of forms:

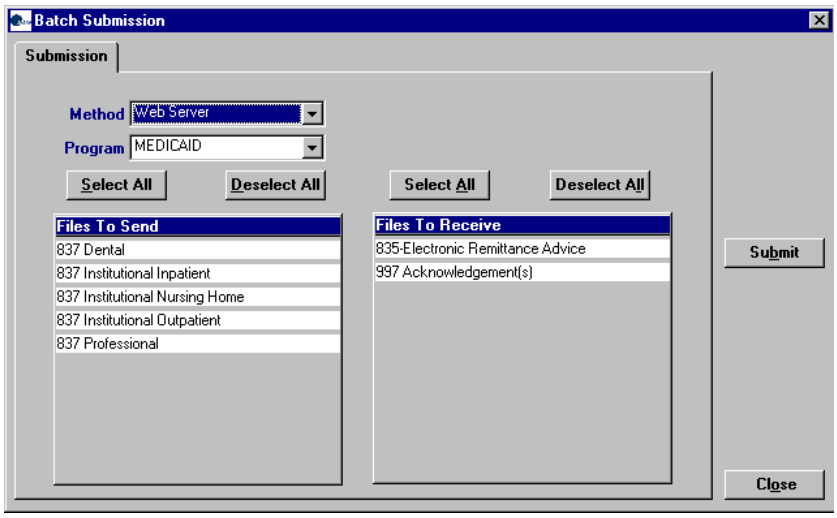
1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by clicking on the batch.
    - Click **Copy** to copy the entire batch.
    - Click **Deselect All** and select individual forms to copy from the batch. Click **Copy**.
4. Once you have copied the desired forms, you may modify and resubmit them.

Retrieving Batch Responses

To retrieve a 997 Acknowledgement or the 835 Health Care Claim Payment/Advice, do the following:

1. Click **Communication** from the menu bar.
2. Click **Submission.** The Batch Submission window will display.

3. Select “Web Server.”



4. Select “Medicaid,” “HIRSP,” or “WWWP” from the Program box.

5. Click on the appropriate form type(s) under Files to Receive.

6. Click **Submit**.

PES will post messages in the Transmission window updating you on the progress of the transmission.

Viewing Batch Responses

To view a 997 Acknowledgement or the 835 Electronic Remittance and Status Report, do the following:

1. Click **Communication** from the menu bar.

2. Click **View Batch Response**.

3. Locate the desired batch. All transactions submitted within the batch will be displayed in the batch report.

> **TIP**
>
> You can track your 997 Acknowledgement back to its respective 837 submission by matching the Group Control Number from the 997 to the Group Control Number in the communication log of the 837 submission.

```
                997 - Acknowledgment Batc

       Production/Test
            Indicator:  T Test

   Trading Partner ID:  59000100
      Submission Date:  06/11/2004
      Submission Time:  08:51
   Professional Claim:  004010X098A1

Functional Identifier:  HC Health Care Claim (837)
 Group Control Number:  44

       Transaction Set
```

Note: If an Acknowledgement has been rejected, contact the EDI help desk for assistance. The telephone number for the EDI help desk is (608) 221-9036. The help desk e-mail address is *wiedi@dhfs.state.wi.us*.

Viewing Communication Logs

Use the communication log to check on submission information. The log displays a list of files submitted along with the file size, creation date, and creation time. To view the communications log:

1. Click **Communication** on the menu bar.

2. Click **View Communication Log**. The Communication Log window opens and displays a list of recent submissions.

3. Click on the desired file. The submission information for the selected file will be displayed in the lower portion of the screen.

```
                    FILE 41621611.FIV

Starting Submission Process.
Getting web submission options.
Formatting 837 Professional batch.
Sending/Receiving batch transactions in progress.
CONNECTION USING WEB-SERVER ON 6/10/04 AT 16:11:57.
Using MS Internet Explorer settings to connect to internet.
Uploading files to Web Server.
Uploading 837 Professional File.
THE NUMBER OF BYTES TO BE TRANSFERED IS: 1086
THE HTTP REQUEST RETURNED AN XML MESSAGE CODE OF:
0
TRANSACTION ACCEPTED WITH NO ERRORS.
THE EXTERNAL BATCH NUMBER IS: 4025
Group Control Number is: 44
Upload of the file was successful.
```

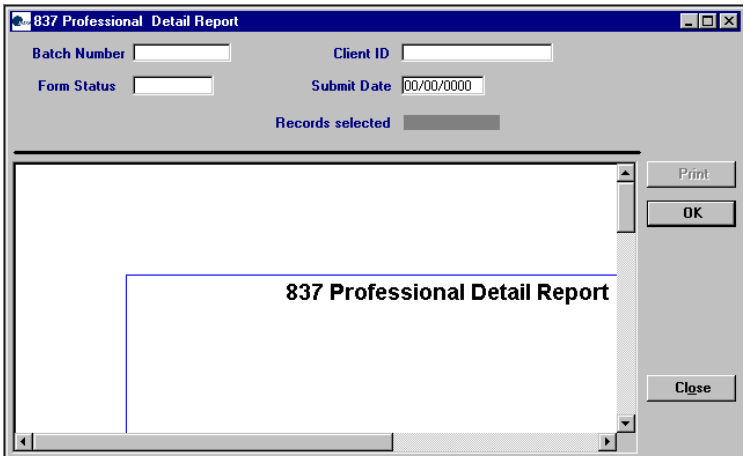
Reports

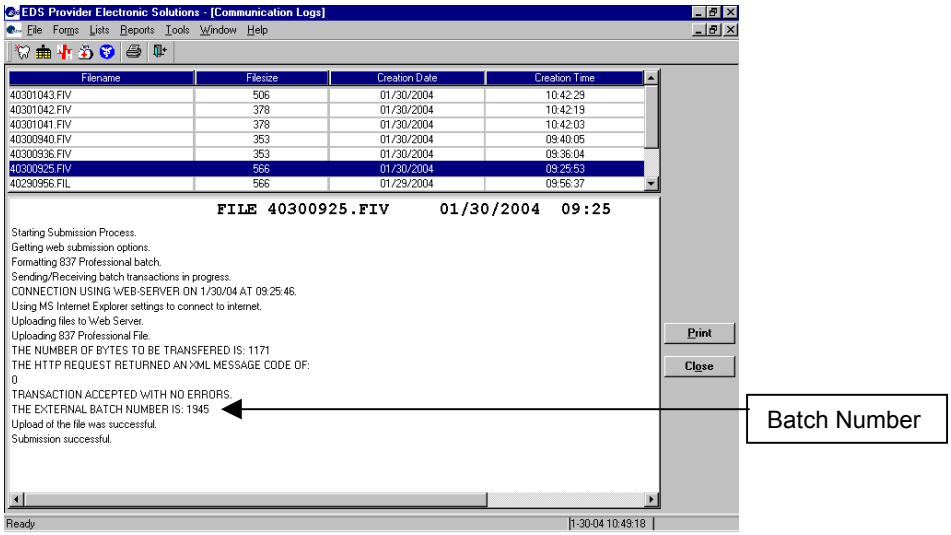
Use the Reports command on the menu bar to select and print a variety of reports, including claims and lists.

Detail Form Reports

A detail report contains all the boxes for a particular form. You may print a copy of the contents of any form. To view a detail report:

1. Click **Reports** on the menu bar.
2. Click **Detail Forms**.
3. Select the desired form type.
4. To narrow a report request, enter the batch number from the communication log file or the client's Medicaid identification number.





5. In the Form Status box, choose a status from the drop-down list or enter the submission date in the Submit Date box.

6. Click **OK**.

7. Click **Print** to create a hard copy of the form.

Note: If no criteria is specified before clicking **OK**, all of the forms in the database for that form type will be included in the report.

Summary Reports

A summary report lists only a few of the boxes from the detail form and is a good way to get an overview of a series of forms in a single report. Summary reports are available for all form types.

To create a summary report, follow the directions for Detail Form Reports, but select **Summary Reports** in step 2.

List Reports

List reports can be displayed online or printed. The report will include all of the codes available under that list and their respective descriptions. To view a list report, select the desired list from the **Reports** command on the menu bar.

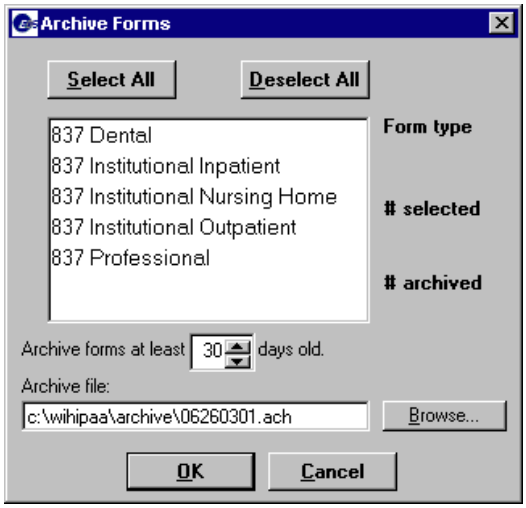
Tools

The Tools menu commands discussed in this chapter include:

- Archive.
- Database Recovery.
- Get Upgrades.
- Change Password.
- Options.

The Security command on the menu bar is also discussed in this chapter.

Archive



Archiving is the process that is used to keep the size and space required by your data small enough for it to be useful to you, while maintaining a record of the forms you have entered. It is recommended that you archive your claims.

When setting up the retention option under your personal options, you can choose how many days history you want to keep online. The standard setting is 30 days; however, you may select the setting that best suits your needs.

When you create an archive, the system will copy any form you have submitted more than 30 days ago to a compressed file and then delete that form from the database. This is designed to make the management of forms easier and keep the space on the hard drive used by the application to a minimum. You may place the compressed archive file on a disk or leave it on your hard drive.

Forms that are ready to be submitted will not be archived and will remain in the online database until you submit them or delete them. Forms that are incomplete and were created before the archive date will be deleted; these forms will not be saved in the archive file.

To create a form archive, follow these steps:

1. Click **Tools** on the menu bar.
2. Click **Archive**.

3. Click **Create**.

   Note: If you are working in a network environment and other users have access to Provider Electronic Solutions (PES) through the network, you will need to ask all users to exit PES before archiving.

4. Click **OK**.

5. Click **Yes**.

6. Select all transaction types to be archived, or click **Select All**.

   You may change the default directory, the name of the file for the archive, and the number of days used to archive forms. These changes will apply to this session only.

7. Click **OK**.

8. Click **OK** to exit the Archive window once the process is complete.

Restore Archive

The Restore function recalls forms from an archive file and puts them back into the online database. Forms that have been restored will have a status of "A." You will not be able to change these forms; however, you can view, print, or copy them. To restore files from an archive file:

TIP

You cannot restore archives done in previous versions of PES.

1. Click **Tools** on the menu bar.

2. Click Archive.

3. Click Restore.

4. Click **Browse** to select the file to restore.

5. Select the file to be restored and click **Open**.

6. Click **Next**.

7. Select the type of form desired on the list of form types available. Click **Next**.

   Note: If the form type selected does not have any forms archived in the file, you will receive a message to this effect. Click **OK**, and select another form type or click **Back** to change the archive file to be restored.

8. Click either **Restore All Forms** or **Restore Only Selected Forms**. If you choose to restore only selected forms, select the forms you want to restore and click **Finish**.

9. Click **OK**.

Database Recovery

The Database Recovery option is designed to help you work with the DHCF EDI help desk personnel to fix problems with the database. The telephone number for the EDI help desk is (608) 221-9036. The help desk e-mail address is *wiedi@dhfs.state.wi.us*.

Compact Database

This option is used to make database files smaller and to better organize them. Each time you delete a form, empty space is created. The compact database option releases the empty space so that it may be used again.

Prior to running the compact database option, all users must be out of the database if the software is set up in a network environment.

To use compact database:

1. Click **Tools**.

2. Click **Database Recovery**.

3. Click **Compact**.

Repair Database

This option will attempt to validate all system tables and all indexes. Generally, this feature is helpful when you are having trouble accessing your data. You may use this feature any time you decide it may be helpful. It is recommended that you run the compact database utility after you use the repair database option.

Prior to running repair database, all users must be out of the database if the software is set up in a network environment.

To run the repair database option:

1. Click **Tools**.

2. Click **Database Recovery**.

3. Click **Repair**.

Unlock Database

Sometimes errors will cause database locks. The database may lock after submitting forms, archiving forms, restoring forms, and sometimes when adding or editing forms. To unlock the database:

1. Click **Tools**.
2. Click **Database Recovery**.
3. Click **Unlock**.

Get Upgrades

The Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department will inform users when a PES upgrade is available via e-mail and postings to the Wisconsin Medicaid Web site located at *dhfs.wisconsin.gov/medicaid/*. Users should check for upgrades on a weekly basis and download them when available, using the instructions below. Failure to perform upgrades will prevent users from submitting claims to Wisconsin Medicaid and the Health Insurance Risk Sharing Plan.

TIP

If you are performing multiple upgrades, be sure to execute *each* upgrade to receive all software changes.

To get an upgrade for PES:

1. Choose **Tools**.
2. Choose **Get Upgrades**.
3. Follow online instructions.

Once the upgrade is downloaded, exit the application and go into the upgrade application to apply the upgrade. If you have installed PES on several PCs, you will need to get upgrades for each PC and apply the upgrades individually.

Note: Always use the upgrade function. Do not load a new version of PES; this would result in the loss of all lists and forms that have been created.

Passwords

All authorized users must have a password to access PES software. A password may be any combination of alphabetic, numeric, and special characters. It is not case sensitive. A password must be at least five, and no more than 10, characters in length.

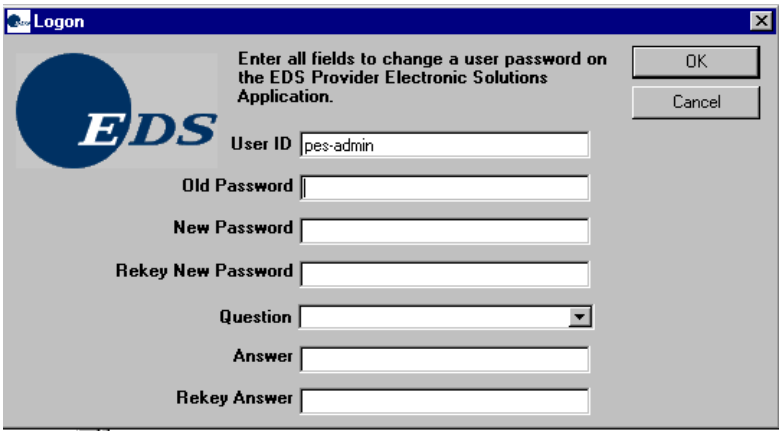
Changing Passwords

The Change Password option allows you to change your login password at any time. PES records the date the password was changed.

PES requires you to change your password after the number of days designated in the options retention setting has elapsed. To change your password:

1. Click **Tools**.

2. Click **Change Password**.



3. Enter the old password.

4. Enter a new password that is five to 10 characters in length in the New Password box.

5. Re-enter the new password in the Re-key New Password box.

6. Click **OK**.

Security

Security Maintenance

The Security Maintenance window is only accessible by a user logged on with a valid user identification (ID) and password with assigned administrative authority. The security maintenance function is used to:

- Assign additional user IDs.

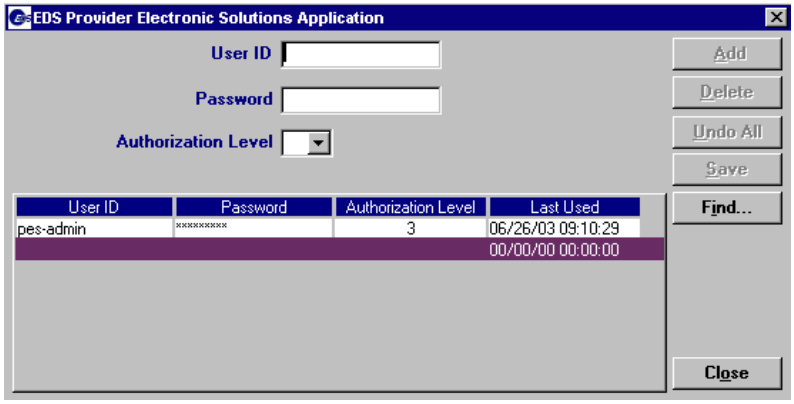
- Reset a password for a user.

- Delete obsolete user IDs.

To enter or edit a user's information, follow these steps:

1. Click **Security**.

2. Click **Security Maintenance**.



3. Enter a user ID. If you select an existing user ID, the user information boxes will populate with the user's data.

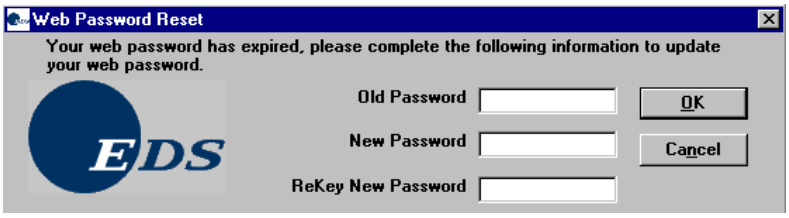
4. Enter or edit the Password box. When a password is assigned or changed through the security maintenance function, the password is automatically set as expired and the user will have to change his or her password at the first login.

5. Enter or edit the Authorization Level box. Users with an authorization level of "2" will not have access to the security functions in PES.

6. Click **Save** to save the new user information or **Add** to add an additional user.

Web Password Reset

PES will prompt users to update the Web login password when it expires. This capability will update the password in PES as well as the password stored on *www.wisconsinedi.org/.*



The Web Password Reset window allows a user to change their expired Web password through the PES application.

To verify your password, follow these steps:

1. Exit all claim forms.
2. Click **Tools**.
3. Click **Options**.
4. Select the Batch tab.

Forgotten Password

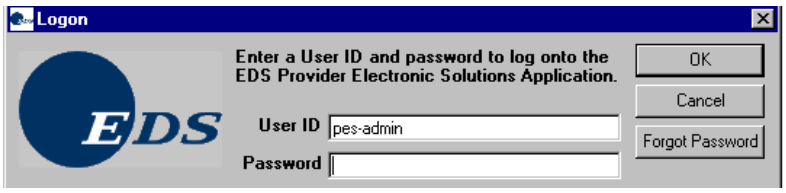
If you forget your login password, the Forget Password function in PES will prompt you with the question that you entered when you first keyed in your password. Once the correct answer to this question is entered, PES will allow you to reset your password.

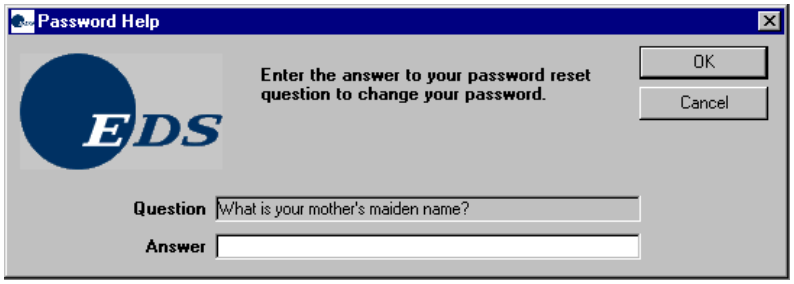
Note: The Forgotten Password feature is only available on the primary (Typical install) computer.

If you know you've forgotten your password, follow the steps below starting with step 1.

If you enter incorrect passwords on three consecutive attempts, the Forget Password function will be invoked automatically; in this case, begin with the instructions in step 2.

1. Click **Forgot Password** on the Login window.





2. Enter the answer to your password reset question. Click **OK**.

3. Enter and rekey your new password in the Password Reset window. Click **OK**.

4. A message will display indicating that the password update was successful.

Options

For a complete description of options, refer to the Getting Started chapter of this manual.

TIP

If after three consecutive attempts you do not enter a correct answer in the Password Help window, PES will ask if you want to reset your password.

If you click **Yes**, the password will be reset for you. If you click **No**, the application will close. You will then need to call the Wisconsin Help Desk to request a new password. The EDI Help Desk will need your User ID and Reset Key to set up a new password.

Appendix 1 – Lists

This section contains some of the lists that exist in Provider Electronic Solutions (PES). For more information on how to build and use lists, refer to the Lists chapter.

You may copy descriptions from the lists in this appendix while working online. Use the text select tool in Acrobat Reader®, then copy and paste into the description box in PES.

Please note that these lists are subject to change. Please review your program materials and other sources for current codes.

ANSI Adjustment Reason Codes (ARC)

The most commonly used ANSI codes are bolded. Please do not use deleted or inactive codes; they are included for reference purposes only.

Code	Description
1	**Deductible Amount.**
2	**Coinsurance Amount.**
3	**Copayment Amount.**
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

Code	Description
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	**Payment adjusted — paid by another payer.**
24	**Payment adjusted — covered under managed care plan.**
25	Payment denied — stop loss deductible has not been met.
26	**Expenses incurred prior to coverage.**
27	**Expenses incurred after coverage terminated.**
28	Coverage not in effect at the time the service was provided. *Note: Inactive — do not use. Redundant to codes 26 & 27.*
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as client cannot be identified as our insured.
32	This dependent is not an eligible dependent as defined.
33	**Claim denied — insured has no dependent coverage.**
34	Claim denied — insured has no coverage for newborns.
35	**Benefit maximum has been reached.**
36	Balance does not exceed copayment amount. *Note: Inactive — do not use.*
37	Balance does not exceed deductible. *Note: Inactive — do not use.*
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at authorization/pre-certification request.
40	Charges do not meet qualifications for emergent/urgent care.
41	Discount agreed to in Preferred Provider contract. *Note: Inactive — do not use.*
42	Charges exceed our fee schedule or maximum allowable amount.

Code	Description
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	**Charges exceed your contracted/legislated fee arrangement.**
46	This (these) service(s) is (are) not covered. *Note: Inactive — do not use. Use code 96.*
47	Diagnosis(es) is (are) not covered, missing, or invalid.
48	This (these) procedure(s) is (are) not covered. *Note: Inactive — do not use. Use code 96.*
49	Non-covered services done in conjunction with routine exam.
50	Non-covered services not deemed medical necessity by payer.
51	Non-covered services — pre-existing condition.
52	Provider not eligible to refer/prescribe/order/perform.
53	Non-covered services — immediate relative/household member.
54	Multiple physicians/assistants are not covered in this case.
55	Denied procedure/treatment-deemed experimental by payer.
56	Denied procedure — not deemed proven to be effective by payer.
57	Denied/reduced — info does not support this level of service, this length of service, this dosage, or this day's supply. *Note: Inactive — do not use. Split into codes 150, 151, 152, 153, and 154.*
58	Payment adjusted — inappropriate/invalid place of service.
59	Charges adjusted based on multiple surgery/anesthesia rules.
60	Non-covered — outpatient services proximity to inpatient.
61	Adjusted — penalty — failure to obtain second surgery opinion.
62	Absence of, or exceeded, pre-certification/authorization.
63	Correction to a prior claim. *Note: Inactive — do not use.*
64	Denial reversed per Medical Review. *Note: Inactive — do not use.*
65	Procedure code was incorrect — corrected with this payment. *Note: Inactive — do not use.*
66	Blood Deductible.
67	Lifetime reserve days. *Note: Inactive — do not use.*
68	DRG weight. *Note: Inactive — do not use.*
69	Day outlier amount.
70	Cost outlier — Adjustment to compensate for additional costs.
71	Primary Payer amount. *Note: Deleted as of 6/00. Use code 23.*
72	Coinsurance day. *Note: Inactive — do not use.*
73	Administrative days. *Note: Inactive — do not use.*
74	Indirect Medical Education Adjustment.

Code	Description
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. *Note: Inactive — do not use.*
78	Non-Covered days/Room charge adjustment
79	Cost Report days. *Note: Inactive — do not use.*
80	Outlier days. *Note: Inactive — do not use.*
81	Discharges. *Note: Inactive — do not use.*
82	PIP days. *Note: Inactive — do not use.*
83	Total visits. *Note: Inactive — do not use.*
84	Capital Adjustment. *Note: Inactive — do not use.*
85	Interest amount.
86	Statutory Adjustment. *Note: Inactive — do not use. Duplicative of code 45.*
87	Transfer amount.
88	Collection against receivable created in prior overpayment. *Note: Inactive — do not use.*
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim paid in full. *Note: Inactive — do not use.*
93	No claim-level adjustments. *Note: Inactive — do not use.*
94	Processed in excess of charges.
95	Benefits adjusted — plan procedures not followed.
96	**Non-covered charge(s).**
97	Payment included in allowance for another service/procedure.
98	Hospital must file Medicare inpatient nonphysician service. *Note: Inactive — do not use.*
99	Medicare Secondary Payer Adjustment Amount. *Note: Inactive — do not use.*
100	Payment made to client/insured/responsible party.
101	Predetermination: payment upon completion of service.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount.
104	Managed care withholding.
105	Tax withholding.
106	Client payment option/election not in effect.
107	Denied — related or qualifying claim/service was not paid or identified on this claim.
108	Payment adjusted because rent/purchase guidelines not met.

Code	Description
109	**Claim not covered by this payer/contractor.**
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted — not furnished to client/not documented.
113	Payment denied — service performed outside US or result of war. *Note: Inactive — do not use. Use codes 157, 158, or 159.*
114	Procedure/product not approved by the FDA.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied — advance indemnification not in compliance.
117	Payment adjusted — transportation covered to closest facility.
118	Charges reduced for ESRD network support.
119	**Benefit maximum for this time period or occurrence has been reached.**
120	Client is covered by a managed care plan. *Note: Inactive — do not use. Use code 24.*
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment. *Note: Inactive — do not use.*
124	Payer refund amount — not our client. *Note: Inactive — do not use.*
125	Payment adjusted due to a submission/billing error(s).
126	Deductible — Major Medical.
127	Coinsurance — Major Medical.
128	Newborn's services are covered in the mother's allowance.
129	Payment denied — Prior processing info appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	Disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied — Interim bills cannot be processed.
136	Claim Adjusted — plan procedures of a prior payer not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, etc.
138	Claim denied — appeal procedures or time limits not met.
139	Contracted Funding Agreement — employed by service provider.
140	Insured health identification number and name do not match.
141	Claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by monthly Medicaid client liability amount.

Code	Description
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
145	Premium payment withholding.
146	Claim Denied — diagnosis invalid for dates of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Info from another provider was not provided or incomplete.
149	**Lifetime benefit maximum has been reached for this service.**
150	Payment adjusted, info does not support level of services.
151	Payment adjusted, info does not support this many services.
152	Payment adjusted, info does not support length of services.
153	Payment adjusted, info does not support this dosage.
154	Payment adjusted, info does not support this day's supply.
155	This claim is denied because the patient refused the service/procedure. *Note: New as of 6/03.*
156	Flexible spending account payments. *Note: New as of 9/03.*
157	Payment denied/reduced because service/procedure was provided as a result of an act of war. *Note: New as of 9/03.*
158	Payment denied/reduced because the service/procedure was provided outside the United States. *Note: New as of 9/03.*
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism. *Note: New as of 9/03.*
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. *Note: New as of 9/03.*
161	Provider performance bonus. *Note: New as of 2/04.*
162	State-Mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. *Note: New as of 2/04.*
A0	Client refund amount.
A1	**Claim denied charges.**
A2	Contractual adjustment. *Note: Inactive — do not use. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.*
A3	Medicare Secondary Payer liability met. *Note: Inactive — do not use.*
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment.
A8	Claim denied; ungroupable DRG.
B1	Non-covered visits.

Code	Description
B2	Covered visits. *Note: Inactive — do not use.*
B3	Covered charges. *Note: Inactive — do not use.*
B4	Late filing penalty.
B5	Coverage/program guidelines were not met or were exceeded.
B6	Payment adjusted when performed by this type of provider.
B7	Provider was not eligible to be paid for this procedure.
B8	Alternative services available and should have been utilized.
B9	Services not covered because client is enrolled in Hospice.
B10	Amount reduced because component of basic procedure was paid.
B11	Claim transferred to proper payer/processor for processing.
B12	Services not documented in client's medical records.
B13	Previously paid.
B14	Denied — only one visit per physician per day is covered.
B15	Payment adjusted because this service is not paid separately.
B16	New client qualifications were not met — payment adjusted.
B17	Payment adjusted — this service not prescribed by a physician.
B18	Procedure code/modifier was invalid on the date of service.
B19	Claim/service adjusted — finding of a Review Organization. *Note: Inactive — do not use.*
B20	Procedure/service partially furnished by another provider.
B21	Service/care was partially furnished by another physician. *Note: Inactive — do not use.*
B22	This payment is adjusted based on the diagnosis.
B23	Provider has failed an aspect of proficiency testing program.
D1	Level of subluxation is missing or inadequate. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D2	Claim lacks the name, strength, or dosage of drug furnished. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D3	Info indicating client owns equipment needing part missing. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D4	Claim/service does not indicate the period of time needed. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D5	Claim lacks individual lab codes included in the test. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D6	Claim did not include client's medical record for service. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*

Code	Description
D7	Claim lacks date of client's most recent physician visit. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D8	Claim lacks indicator that x-ray is available for review. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D9	Claim lacks invoice certifying the actual cost of lens used. *Note: Inactive — do not use. Use code 16 and remark codes if necessary.*
D10	Completed physician financial relationship form not on file. *Note: Inactive — do not use. Use code 17.*
D11	Claim lacks completed pacemaker registration form. *Note: Inactive — do not use. Use code 17.*
D12	Claim missing who performed the purchased diagnostic test. *Note: Inactive — do not use. Use code 17.*
D13	Performed by a facility that ordering physician has interest. *Note: Inactive — do not use. Use code 17.*
D14	Claim lacks indication that plan of treatment is on file. *Note: Inactive — do not use. Use code 17.*
D15	Claim lacks indication that service was physician supervised. *Note: Inactive — do not use. Use code 17.*
W1	Workers Compensation State Fee Schedule Adjustment.

Admission Type Codes

Code	Description
1	Emergency (refers to ER admission)
2	Urgent (generally refers to admission to the first available and suitable accommodation)
3	Elective (scheduled admission)
4	Newborn

Admit Source Codes

Code	Description
1	Physician Referral (or Newborn Normal Delivery)
2	Clinic Referral (or Newborn Premature Delivery)
3	HMO Referral (or Newborn - Sick Baby)
4	Transfer From A Hospital (or Newborn - Extramural Birth)
5	Transfer From A Skilled Nursing Facility
6	Transfer From Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer From A Rural Primary Care Hospital
B	Transfer From Another Home Health Agency
C	Readmission To Same Home Health Agency

Carrier Codes

Code	Description
001	Other Insurance Carrier 1
002	Other Insurance Carrier 2
003	TriCare
004	Medicare
005	Medigap

Claim Filing Indicator Codes

Code	Description
09	Self-pay
10	Central Certification
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Managed Care Non-HMO
OF	Other Federal Program
SA	Self-Administered Group
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Condition Codes

Code	Description
01	Military Service Related
02	Condition Is Employment Related
03	Client Covered by Insurance Not Reflected Here
04	HMO Enrollee
05	Lien Has Been Filed
08	Beneficiary Would Not Provide Other Insurance Information
22	Client On Multiple Drug Regimen
23	Home Caregiver Available
30	Qualifying Clinical Trails
39	Private Room Medically Necessary
42	Continuing Care Not Related To Inpatient Admission
43	Continuing Care Not Provided Within Postdischarge Window
60	Day Outlier
61	Cost Outlier
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
A1	EPSDT/CHAP
A2	Physically Handicapped Children's Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A7	Induced Abortion — Danger To Life
A8	Induced Abortion — Victim Rape/Incest
A9	Second Opinion Surgery
M0	All-Inclusive Rate For Outpatient Services
M1	Roster Billed Influenza Virus Vaccine
M2	HHA Payment Significantly Exceeds Total Charges
H0	Delayed Filing, Statement of Intent Submitted

Occurrence Codes

Code	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
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
27	Date of Hospice Certification or Precertification
38	Date Treatment Started for Home IV Therapy
42	Date of Discharge
43	Scheduled Date of Canceled Surgery
A1	Birthdate — Insured A
A2	Effective Date — Insured A Policy
B1	Birthdate — Insured B
B2	Effective Date — Insured B Policy
C1	Birthdate — Insured C
C2	Effective Date — Insured C Policy
M0	PRO/UR Stay Dates
M1	Provider Liability — No Utilization
M2	Dates of Inpatient Respite Care

Occurrence Span Codes

Code	Description
70	Qualifying Stay Dates (SNF)/Non-Utilization Dates — Dates represent at least a three-day hospital stay that qualifies the client for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates — Dates represent client hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit (Current Visit) — Dates represent the outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual From/Through service dates of locator 6 (Statement Covers Period).
73	Benefit Eligibility Period — Dates represent the period during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Non-Covered Level of Care — Dates represent the period at a non-covered level of care in an otherwise covered stay, excluding any period reported by occurrence span code 76, 77, or 79.
75	SNF Level of Care — Dates represent SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/QIO has approved the patient remaining in the hospital because of the non-availability of an SNF bed. Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
76	Client Liability — Dates represent non-covered care for which the hospital is permitted to charge the Medicare beneficiary. Code should be used only where the QIO or intermediary has approved such charges in advance and client has been notified in writing at least three days prior to the start date of this period.
77	Provider Liability — Utilization — Dates of non-covered care for which the provider is liable. Utilization is charged.
78	SNF Prior Stay Dates — Dates represent any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.
79	Set aside for Payer use only. Providers do not use this code.
80-99	Reserved for State Assignment.
M0	QIO Approved. Dates represent days that were approved when not all of the stay was approved.
M1-W9	Reserved for national assignment.
X0-Z9	Home Health Certification Begin and End Dates.

Patient Status

Code	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to other short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under organized care
07	Left against medical advice
20	Expired
30	Still client
50	Hospice — Home
51	Hospice — Medical Facility
71	Discharge/transfer/referred to institution for outpatient
72	Discharge/transfer/referred to institution for outpatient

Place of Service Codes

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility — Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility

Code	Description
65	End-Stage Renal Disease (ESRD) Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Type of Bill Codes

Code	Description
Type of Facility 1st digit	
1	Hospital
2	Skilled nursing
3	Home health +
4	Religious non-medical health care institutions — hospital inpatient (formerly referred to as Christian Science)
5	Religious non-medical health care institutions — post-hospital extended care services (formerly referred to as Christian Science)
6	Intermediate care
7	Clinic
8	Special facility
9	Reserved for national assignment
Bill Classification (except clinics and special facilities) - 2nd Digit	
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment) **
5	Intermediate Care — Level I**
6	Intermediate Care — Level II**
7	Subacute Inpatient (Revenue Code 19X required when this bill type is used; however, 19X may be used with other types of bills)
8	Swing beds
9	Reserved for national assignment
Bill Classification (clinics only) – 2nd Digit	
1	Rural health
2	Hospital based or independent renal dialysis center
3	Free standing
4	Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6	Community mental health center
7-8	Reserved for national assignment
9	Other
Bill Classification (special facilities only) – 2nd Digit	

Code	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory surgery center
4	Free-standing birthing center
5	Critical access hospital
6	Residential facility
7-8	Reserved for national assignment
9	Other
Frequency – 3rd Digit	
0	Non-payment/zero claim
1	Admit thru discharge claim
2	Interim — first claim
3	Interim — continuing claim
4	Interim — last claim
5	Late charge(s) only claim
6	Reserved (discontinued as of 10/01/00)
7	Replacement of prior claim
8	Voice/cancel of prior claim
9	Final claim for a home health PPS episode

Value Codes

Code	Description
06	Medicare blood deductible
07	Reserve for national assignment
08	Medicare lifetime reserve amount in the first calendar year
09	Medicare co-insurance amount first calendar year
10	Lifetime reserve amount in the second calendar year
11	Coinsurance amount in the second calendar year
68	EPO Drug
73	Drug deductible
74	Drug coinsurance
81	Medicare Part B — Charges when Part A exhausted
83	Medicare Part A — Charges when Part A exhausted
A1	Deductible payer A
A2	Coinsurance payer B
A3	Estimated responsibility payer A
B1	Deductible payer B
B3	Estimated responsibility payer B
C3	Estimated responsibility payer C
D3	Estimated responsibility client

Appendix 2 – Here's Help

A Quick Access Guide to Medicaid Information

Billing, Eligibility, and Policy Questions

EDS Provider Services — (800) 947-9627 or (608) 221-9883
Recipient eligibility information and all other provider service inquiries (except pharmacy):
8:30 a.m. to 4:30 p.m. Mondays, Wednesdays - Fridays.
9:30 a.m. to 4:30 p.m. on Tuesdays.
Not available on holidays.

Recipient eligibility information and policy/billing information relating to pharmacy services:
8:30 a.m. to 6:00 p.m., Mondays, Wednesdays - Fridays.
9:30 a.m. to 6:00 p.m., Tuesdays.
Not available on holidays.

Eligibility Questions

Automated Voice Response — (800) 947-3544 or (608) 221-4247
Available 24 hours a day, seven days a week.

Electronic Data Interchange

Electronic Data Interchange (EDI) Help Desk — (608) 221-9036
8:30 a.m. to 4:30 p.m., Mondays - Fridays.
www.wisconsinedi.org/
EDI Help Desk e-mail: wiedi@dhfs.state.wi.us

Medicaid Managed Care Contract Monitors

For Providers or Recipients — (800) 760-0001
7:45 a.m. to 4:30 p.m., Mondays - Fridays.

Recipient Services (for recipients only)

(800) 362-3002 or (608) 221-5720
7:30 a.m. to 5:00 p.m., Mondays - Fridays

SeniorCare Customer Service (for participants only)

(800) 657-2038
7:30 a.m. to 5:00 p.m., Mondays - Fridays
Not available on holidays.
dhfs.wisconsin.gov/seniorcare/

Medicaid and BadgerCare Web Sites

dhfs.wisconsin.gov/medicaid/
dhfs.wisconsin.gov/badgercare/

06/2004

Wisconsin Medicaid Professional Relations Representatives Map

David Miess, Director
(608) 221-4746

PES Software Representative Support

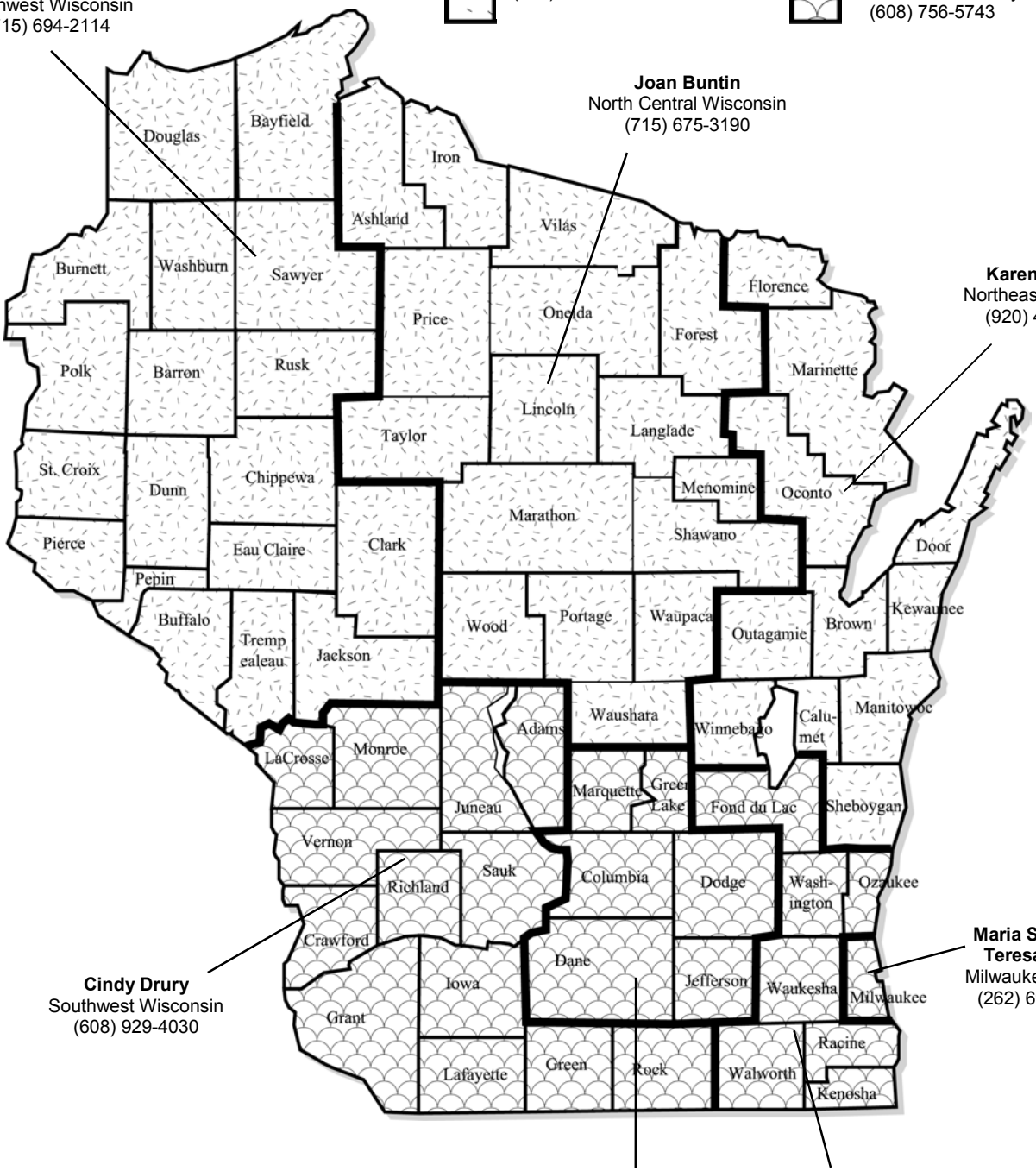
Joan Buntin
Northwest, North Central, and Northeast Wisconsin
(715) 675-1058

Vicky Murphy
Southwest, South Central, and Southeast Wisconsin, Milwaukee County
(608) 756-5743

Denise Kruswicki
Northwest Wisconsin
(715) 694-2114

Joan Buntin
North Central Wisconsin
(715) 675-3190

Karen Gordon
Northeast Wisconsin
(920) 465-9425



Cindy Drury
Southwest Wisconsin
(608) 929-4030

Maria Schwartz
Teresa Miller
Milwaukee County
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Teresa Miller
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