



Claims Inquiry Menu (10-14)

Option 10 (Beneficiary):

The Beneficiary option is used to display the beneficiary's eligibility information. The data received back is based upon what was on CWF (Common Working File) the last time a claim was processed through the system. Please keep in mind that this information may not be the most up-to-date information available and that one should use the HIQA CWF eligibility option to be certain that the information is the most accurate. Also, if a claim has never been received for a beneficiary, there would be no information available.

To access information on a beneficiary, one needs to enter that beneficiary's HIC (Health Insurance Claim) number, last name, first name, gender, date of birth, and then press the Enter key. The system will then display the available information based on the last time a claim processed through the system. The system will not do a CWF inquiry to refresh this information.

This screen is useful because it will show the beneficiary information based upon the last claim that processed through the system. This is helpful information if your claim has been rejected or if you can no longer find your claim under the same HIC number. Some of the information returned is the CURR XREF HIC, which is the HIC number that the beneficiary's claims will now process under. There is the PREV XREF HIC, which is the beneficiary's old HIC number that claims may have processed under. The beneficiary's DOD is listed, which shows the date of death based on the last time a claim processed through CWF. If this information has been updated/corrected on CWF, the system will not show the update until after a claim has processed back from CWF again.

Other information available within this option would be the Part A and Part B entitlement dates, the benefit period data, last mammography date, Medicare Advantage plan data, and Hospice period data. It is recommended that this option only be used as a quick reference and not be used as the sole source for eligibility information. Once again, the most accurate information is available through the HIQA CWF eligibility option.

Option 11 (DRG 0 Pricer/Grouper)

Inpatient hospitals wanting to determine payment information based upon what they will be entering on a claim can do that by using Option 11. By entering certain information, the system will calculate and return the associated DRG (Diagnosis Related Group) for the provider along with payment information such as provider reimbursement amount.

To determine what DRG a claim will receive one must enter the Diag CD (diagnosis code), Proc CD (procedure code, if any), NPI (National Provider Identifier), Gender, C-I (What version of the ICD code, currently a 9), Discharge Status, Discharge Date (DT), Total Charges, Date of Birth (DOB) or patient AGE, and amount of COV Days (covered days). The eighth position of the Diag CD is for the Present on Admission indicator. If you press the Tab key, it takes you to the eighth position automatically.



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Once all the above information is complete, then the system will display the DRG associated with the entered information, the AVG# Length of Stay, Indirect Teaching ADJ#, Prov Reimb amount, and outlier cost threshold if applicable.

Option 12 (Claims Inquiry)

This is not a claims correction option. No corrections can be made through this menu option. One would use this menu option to look at individual claims that have been submitted into the system. Claims can be viewed in any status location.

Inquiries require the NPI number to be entered and at least one other piece of information. The second piece of information could be a HIC number, a status location, or a type of bill. The provider PTAN (Provider Transaction Access Number) cannot be used for claims inquiries. When a HIC number is used, then the claim dates of service can be added to help limit the search. The inquiry would then only return claims that fell within those dates of service.

When an inquiry has been completed and a claim has been found that the provider would like to view more details on, the provider would tab down to that claim, put an "S" in front of the line, and press Enter. This will open the claim detail, and the provider may review all the claim pages.

One use of this option is to review a claim history and determine which claims can and cannot be adjusted. By going into the claim, going to page 2, and either F11 twice or press F2, the provider can view the TPE-TO-TPE field. If the field is blank, then the provider may be able to adjust the claim depending on how it finalized. If there is an X in this location, then the provider could not adjust the claim and would need to enter a new claim. If there is any other indicator in the field, then the provider would need to contact customer service to determine if an adjustment could be done. When there are multiple claims with the same date of service, remember that all the claims need to be investigated prior to determining if an adjustment could be done.

Option 13 (Revenue Codes)

This option will display what revenue codes are valid. From each revenue code, the system will display what type of bills it can be accepted on, if it requires a HCPCS (Healthcare Common Procedure Coding System) code to be submitted on the same line, if units must be reported on the same line, and if a rate must be reported by the provider. For each of the previously mentioned details, the system will display a "Y" if it is allowable, an "N" if it is not allowable, and a "V" if it is not required but will be verified for accuracy if submitted.

Option 56 (Claim Count Summary)

This option displays how many claims are pending in the system and what status location they are in. It does not display counts for finalized claims. It gives a total for each status location and then a breakdown of the bill types within that status location. For each line it will display the total claim count, total charges, and total payment amount if processed far enough to receive a payment amount (claims pending on payment floor only).

The amount in total payment does not necessarily reflect the amount a provider will be reimbursed. The amount includes claim waiting on the payment floor so they will be distributed on different days. It also does not include negative amounts reflecting adjustments or cancels.



If a provider wants to see the claims in every location, then they simply enter the NPI number and press Enter. If the provider has multiple PTAN numbers associated with its NPI number, then the provider would also want to enter the specific PTAN number as well. Providers do have the option to narrow the search by entering a specific status location or category field (first two digits of the bill type).

Option FI (Check History)

This option displays the last three checks a provider has received. It will display the check number, date the check was issued, and the check amount. If the check number starts with alpha characters, then it was an electronic payment. If it is all numeric, then an actual check was issued. The inquiry is created by entering the provider's NPI number and pressing Enter. If a provider has multiple PTAN numbers to one NPI number, then the provider may also enter the PTAN number.

If a provider wants information on a check other than one of the last three checks, they would need to call the VRU (Voice Response Unit) which has the option to look up check information by specific date.