



## Option 02 Claims/Attachments

This main menu option has sub-menu options that will be broken down to three groups. First group is claims entry basic, which are sub-menus 20, 22, 24, 26, 28, and 49. The second group is Roster bill entry, which is sub-menu option 87. The last group is the attachment entry, which are sub-menu options 41, 54, and 57. The attachment entry options are not available for provider use.

### Claims Entry:

This is how a provider can submit a claim directly to their Contractor. Since the only difference between the options, as far as the system, is the bill type, then all options will be treated the same way. The sub-menu selected determines the bill type, but the type of bill can be changed once the provider has started keying the claim. This is to help providers that have already keyed most of the claim information only to discover they have been keying the wrong bill type. So they do not have to rekey the whole claim, the provider can just type in a different bill type and press the Enter key.

The 20 option creates a 111 bill type, the 22 creates a 131 bill type, the 24 option creates a 211 bill type, the 26 creates a 322 bill type, the 28 creates an 811 bill type, and the 49 creates an 81A bill type. The system will only allow a provider to key into fields appropriate for the claim type of bill. An example of this is that a provider cannot enter covered days on an outpatient bill type. To be able to enter the covered days, the provider would have to change the bill to an inpatient bill type and press the Enter key.

The information the provider would enter within this option would be the same information the provider would have populated on a UB-04. The only exception is that the covered, non-covered, coinsurance, and lifetime reserve days are listed as value codes on a UB-04 instead of having specific fields. Please refer back to the Claim Overview CBT if there are any questions on what fields are available.

If modifiers are being added to a charge line on claim page two, only two modifiers can be added on this page. The provider must press the F11 key to move to the next page (MAP171A) that will allow the provider to enter up to five modifiers per line. If a charge line is keyed, and the provider wishes to delete it, the provider does have a fast option to completely remove the line. Place a "D" in the first position of the revenue code field, press the Home key, and then press the Enter key. The complete line will be deleted. Make sure the total charge amount on revenue code line 0001 is added and updated before storing the claim.

Once all the claim information has been keyed into the system, the provider would F9 the claim to store it into the system. The following errors will keep the claim from being accepted into the system: NPI (National Provider Identifier) number not on claim, 5 or 9 digit Facility ZIP code not entered, or the patient's first name, last name, date of birth, address, or ZIP code was not keyed. Remember that if a claim is accepted into the system, it does not mean the claim is going to pay. The provider's claim may be returned to the provider the next day for corrections. The reason the claim is accepted and does not just keep hitting errors until all the claim errors have been corrected is to prevent the provider from having to rekey the claim if they do not know how to make the correction and need to back out of the claim to do some investigation.



A tip for providers when keying claims charges on page two and the line needs more than two modifiers, just need press the F11 key to scroll to the next page, which will allow up to five modifiers instead of just two.

### **Roster Billing**

Roster billing is used when a facility has multiple vaccination or immunization claims performed on the same day. Since they have multiple patients that receive the same service on the same day, the provider can submit a claim for each patient or use roster billing to submit information so the system will produce a claim for each patient without the facility having to do all the keying.

To submit a Roster Bill the provider needs to first enter the date of service, type of bill, NPI number, FAC, ZIP, revenue code, HCPCS, and charge amount. All the patients who are being entered on the roster bill need to have had the same services on the same day as is entered. The rest of the claim information (excluding the beneficiary information) will be auto-populated by the system. This takes a lot of keying off of the provider. The appropriate diagnosis codes will be populated based on the revenue/HCPCS code combination submitted, and the attending physician will auto-populate with the NPI of the facility.

Next, the provider needs to enter beneficiary information based on bill type. For inpatient Part B bills (example would be 12X or 22X bills) there will be two rows of needed information. In order to get the second row to accept claim information, the provider needs to enter the correct bill type and press Enter. The fields will then become available. The required fields for these bill types are the HIC number, patient's last name, first name, date of birth, and gender, Admit Date, Admit Type, Admit Diagnosis, Patient Status, and Admit Source.

For outpatient claims (example 13X or 23X), the provider would need to enter less beneficiary information. The provider would just need to enter the HIC number, patient's last name, first name, date of birth, and gender. Remember that all claims being submitted must be the same bill type. Providers can enter up to four beneficiaries per page and can F6 to scroll to the next page to enter more beneficiaries. Up to 10 beneficiaries can be entered at one time.

### **Attachment Entry**

Attachment Entry is not used by this Fiscal Intermediary. Any necessary documentation should be submitted hard copy to the Fiscal Intermediary.