

'Key Concepts' & 'Online System'

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Common Claim Status/Locations Quick-Reference Guide

Status/ Location	Claim Disposition
P B9996	<i>Claim waiting the <u>payment floor hold</u></i>
P B9997	<i><u>Paid</u> claim – finalized location</i>
P O9998	<i><u>Paid</u> claim (off-line) – finalized location</i>
R B9997	<i><u>Rejected</u> claim – finalized location</i>
D B9997	<i><u>Denied</u> claim – finalized location</i>
T B9900	<i><u>Daily RTP</u> location – claims <u>cannot</u> be worked when in this location</i>
T B9997	<i><u>Finalized RTP</u> location – claims <u>can</u> be worked when in this location</i>
S B0100	<i>Claim is at the <u>beginning</u> of the system - all claims start here</i>
S B2500	<i>Claim has been <u>updated</u> by the provider “online” – awaiting duplicate check</i>
S B4000	<i>ESRD claim <u>waiting to go to CWF</u> – has cleared all online edits</i>
S B6000	<i>Claim waiting for <u>Additional Development Request (ADR)</u> to be <u>created</u></i>
S B6001	<i>Claim <u>waiting for ADR response</u> to be returned by the provider</i>
S B9000	<i>Non-ESRD claim <u>waiting to go to CWF</u> – has cleared all online edits</i>
S B9099	<i>Claim <u>awaiting response</u> from CWF</i>

Reason Code Overview

Reason codes are six-digit codes that direct the outcome of a claim edit or process. They are the ‘traffic cops’ of the system. The following chart outlines the various positions of the online reason code:

<i>IF</i> – Position 1 is:	<i>THEN</i> – The <u>Type</u> of Edit Is:	<i>AND</i> – Positions 2 – 5 Can Be:
1	Consistency Edits	0125 – 9999
3	Online System Edits	0000 – 9799
4	File Maintenance	Alpha 001 – Alpha 899
5	Medical Review	0001 – 9999
7	Site Specific	0001 – 9999
A - Z	CWF (Except W)	Current CWF 4-Digit Error Codes
W	OCE/MCE and GROUPER	0001 - 2999

Status Code Overview

The following chart defines the valid values for status codes in the appropriate hierarchy listing.

Priority	Status Code	Definition	Condition
1	F (<u>F</u> orce)	Suspended on-line; system will add the claim record to the file with active errors.	Pending
2	T (Return to Provider) -OR- U (Return to Pro)	Claim has reached final disposition with no reimbursement and has been returned to the Provider with billing errors. Claim has reached final disposition and has been returned to the Peer Review Organization (PRO) for corrections.	Finalized Finalized
3	I (In <u>active</u>)	Claim moves from the active processing file to the inactive file.	Finalized
4	R (<u>R</u> eject)	Claim has reached final disposition with no reimbursement (non-medical reject).	Finalized
5	D (<u>D</u> eny)	Claim has reached final disposition with no reimbursement (medical denial).	Finalized
6	M (<u>M</u> anual Move)	Designates a manual claim move to another department, employee, desk, etc. NOTE: Once a 'M' value is inserted in the status field, the system changes the status to a 'S' for suspense after the move.	Pending
7	S (<u>S</u> uspense)	A manual update is needed before claim processing can continue.	Pending
8	P (<u>P</u> aid)	Claim has reached final disposition with reimbursement.	Finalized
9	A (Take NO <u>A</u> ction)	No processing errors; claim continues to the next processing location (Only seen on the Reason Code File).	

Location Code Overview

<i>Processing Type</i>	<i>Driver</i>	<i>Location</i>
M - Manual	01 Status/Location	00 Batch Process
O - Off-line	02 Control	01 Common
B - Batch	04 UB-92 Data	02 Adj. Orbit
	05 Consistency (I)	10 Inpatient
	06 Consistency (II)	11 Outpatient
	15 Administrative	12 Special Claims
	25 Duplicate	13 Med. Review
	30 Entitlement	14 Program Integrity
	35 Lab/HCPC	16 MSP
	40 ESRD	18 Prod. QC
	50 Medical Policy	19 System Research
	55 Utilization	21 Waiver
	60 ADR	67 DDE Home Health
	63 HHPPS Pricer	96 Payment Floor
	65 PPS/Pricer	97 Final On-line
	70 Payment	98 Final Off-line
	75 Post Pay	99 Final Purged/Awaiting CWF Response
	80 MSP Primary	22-64 User Defined
	85 MSP Secondary	68-79 User Defined
	90 CWF	AA-ZZ User Defined
	95 Denial	
	99 Session Term	
	AA-ZZ User Defined	

Reason Code/Claim Driver Overview

The following chart outlines the association between the online claim drivers and the reason code ranges:

<i>Driver #</i>	<i>Driver Description</i>	<i>Reason Code Range(s)</i>
02	Control	30001 – 30999 → Bene/Eligibility
04	UB-92	10125 – 19999 → Unibill
05	Consistency I	31000 – 31299 → Common to all bill types
06	Consistency II	31300 – 31649
15	Administrative	31650 – 32999 W0001 – W2999 → MCE/OCE and GROUPER
25	Duplicate	38000 – 38599
30	Entitlement	39000 – 39499 → HMO editing
35	Lab/HCCPC	36300 – 36999
40	ESRD	36000 – 36299
50	Medical Policy	50000 – 59999
55	Benefit Utilization	39500 – 39699
60	ADR	39700 – 39799
65	PPS Pricer	37000 – 37150
70	Payment Module	37500 – 37999
75	Post Payment	38600 – 38999
80	MSP Primary	34000 – 34499
85	MSP Secondary	33000 – 33999 34500 – 34900
90	CWF	A0001 – X0999
95	Denial	39800 – 39899
99	Session Termination	37151 – 37199

Online System Menu Quick-Reference Guide

<i>Main Menu</i>	<i>Inquiries Submenu (01)</i>	<i>Claims/Attachments Submenu (02)</i>
01 – Inquiries 02 – Claims/Attachments 03 – Claims Correction 04 – Online Reports View	10 – Beneficiary/CWF 11 – DRG (Pricer/Grouper) 12 – Claims 13 – Revenue Codes 14 – HCPC Codes 15 – DX/Proc Codes 16 – Adjustment Reason Codes 17 – Reason Codes 56 – Claim Count Summary 68 – ANSI Reason Codes FI – Check History	<u>Claims Entry:</u> 20 – Inpatient 22 – Outpatient 24 – SNF 26 – Home Health 28 – Hospice 49 – Hospice Elections 87 – Roster Bill Entry <u>Attachment Entry:</u> 41 – Home Health 54 – DME History 57 – ESRD HCFA-382 Form

<i>Claims Correction Submenu (03)</i>	<i>Online Reports View Submenu (04)</i>
<u>Claims Correction:</u> 21 – Inpatient 23 – Outpatient 25 – SNF 27 – Home Health 29 – Hospice <u>Claim Adjustments:</u> 30 – Inpatient 31 – Outpatient 32 – SNF 33 – Home Health 35 – Hospice	<u>Claim Cancels:</u> 50 – Inpatient 51 – Outpatient 52 – SNF 53 – Home Health 55 – Hospice <u>Attachments:</u> 42 – Pacemaker 43 – Ambulance 44 – Therapy 45 – Home Health
	R1 – Summary of Reports R2 – View a Report

Program Function (PF) Key/Escape (ESC) Key Cross-Walk Quick Reference Guide

<i>Program Function Key</i>	<i>Online 'ESC' X- Walk</i>	<i>Function</i>
PF1	ESC 1	Serves as a "Help" key. Allows you to access information contained on the reason code file about the error received.
PF2	ESC 2	From claim page 3, jumps the user to claim page 32 for the first revenue code in error; or, when placed on a specific revenue code line on claim page 3.
PF3	ESC 3	Exits you to the menu or submenu. When in a 'roll-out' screen, this key will return you to your originating screen.
PF4	ESC 4	Exits the entire online system by terminating the session.
PF5	ESC 5	Scrolls the user backward within a page of screen data.
PF6	ESC 6	Scrolls the user forward within a page of screen data.
PF7	ESC 7	Moves the user back a page, one page at a time.
PF8	ESC 8	Moves the user forward a page, one page at a time.
PF9	ESC 9	"Stores" or "updates" data that has been entered in an entry or update/claim correction type transaction.
PF10	ESC 10	Moves the user to the left of their viewing screen (columns 1-80).
PF11	ESC -	Moves the user to the right of their viewing screen (columns 81-132).
PF12	ESC =	No function.

Online System - Data Entry <Tab> Defaults

The following charts outline the online system data entry 'Claim Page' default <Tab> stops according to the type of claim, i.e., inpatient hospital, inpatient SNF and outpatient. The field/<Tab> stops noted in each chart are the minimum entries required for each 'Claim Page.'

<i>Inpatient Hospital – 'Claim Page 01'</i>	
Field/<Tab> Stop	Field Description
HIC	Health Insurance Claim #
TOB	Type of bill (111 is the default – you may change the third digit as necessary)
PATIENT CONTROL NBR	Patient control number as assigned by the provider
STMT DATES FROM	The 'from' date of the billing period
TO	The 'through' date of the billing period
DAYS COV	Total number of covered days for the billing period
N-C	Total number of noncovered days for the billing period
CO	Total number of coinsurance days for the billing period
LTR	Total number of Lifetime Reserve Days the beneficiary elected to utilize
LAST	Patient last name
FIRST	Patient first name
MI	Patient middle initial
STREET	Patient street address
CITY	Patient city address
ST	Patient state
ZIP	Patient zip code
DOB	Patient date of birth
SEX	Patient sex

Inpatient Hospital Data Entry Guide Continued...

ADMIT DATE	The date the patient was admitted as an inpatient
TYPE	Type of admission
SRC	Source of the admission
STAT	Patient status upon discharge
MEDICAL RECORD NBR	Medical record number as assigned by the provider
COND CODES	Condition codes (as appropriate)
OCC CDS/DATE	Occurrence codes and dates (as appropriate)
SPAN CODES/DATES	Occurrence span codes and dates (as appropriate)
VALUE CODES AND AMOUNTS	Value code and related amounts (as appropriate)

NOTE: Not all inpatient claims will require condition, occurrence, occurrence span and value codes. Report only as required by Medicare.

Inpatient Hospital – ‘Claim Page 02’

Field/<Tab> Stop	Field Description
REV	Revenue Code
HCPC	HCPCS code (as appropriate)
RATE	Rate associated with the identified revenue code
TOT UNT	Total units of service for the identified revenue code
COV UNT	Total covered units of service for the identified revenue code
TOT CHARGE	Total charges for the identified revenue code
NCOV CHARGE	Total noncovered charges for the identified revenue code

NOTE: Complete the ‘HCPC’ field only if Medicare requires additional HCPCS coding.

Inpatient Hospital Data Entry Guide Continued...

<i>Inpatient Hospital – ‘Claim Page 03’</i>	
Field/<Tab> Stop	Field Description
CD (Lines A, B, C)	Payer code
PAYER (Lines A, B, C)	Payer name
PROVIDER NO. (Lines A, B, C)	Provider number as assigned by the indicated payer
RI (Lines A, B, C)	Release of information to other organizations indicator
AB (Lines A, B, C)	Assignment of benefits for third party payment to provider indicator
PRIOR PAY (Lines A, B, C)	Dollar amount received from patient toward payment of claim prior to billing date
DIAGNOSIS CODES	Primary and secondary diagnosis codes
ADMITTING DIAGNOSIS	Diagnosis chiefly responsible for admission
E CODE	Diagnosis representing the external cause of injury, poisoning or adverse effect
PROCEDURE CODES AND DATES	Primary and secondary procedure codes and dates
ATTENDING PHYS	Attending physician UPIN
LN	Attending physician last name
FN	Attending physician first name
MI	Attending physician middle initial
OPERATING PHYS	Operating physician UPIN (as appropriate)
LN	Operating physician last name (as appropriate)
FN	Operating physician first name (as appropriate)
MI	Operating physician middle initial (as appropriate)
OTHER PHYS	Assisting licensed physician UPIN (as appropriate)
LN	Assisting licensed physician last name (as appropriate)
FN	Assisting licensed physician first name (as appropriate)

Inpatient Hospital Data Entry Guide Continued...

MI	Assisting licensed physician middle initial (as appropriate)
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Inpatient Hospital – ‘Claim Page 04’

Field/<Tab> Stop	Field Description
REMARKS	Claim remarks (as appropriate)

Inpatient Hospital – ‘Claim Page 05’

Field/<Tab> Stop	Field Description
INSURED NAME (Lines A, B, C)	Insureds name for the respective payer indicated
REL (Lines A, B, C)	Patients relationship to the insured
CERT.-SSN-HIC-ID (Lines A, B, C)	Health Insurance Claim # if Medicare is primary
GROUP NAME (Lines A, B, C)	Group name through which insurance is provided (as appropriate)
INS GROUP NUMBER (Lines A, B, C)	Identification number assigned to identify the insurance group (as appropriate)
TREAT. AUTH. CODE (1, 2, 3)	Treatment authorization code (as appropriate)
ESC (1, 2, 3)	Employment status code (as appropriate)
EMPLOYER NAME (1, 2, 3)	Employer’s name (as appropriate)
STREET (1, 2, 3)	Employer’s street address (as appropriate)
CITY (1, 2, 3)	Employer’s city (as appropriate)
ST (1, 2, 3)	Employer’s state (as appropriate)
ZIP (1, 2, 3)	Employer’s zip code (as appropriate)

Inpatient Hospital Data Entry Guide Continued...

<i>Inpatient Hospital – ‘Claim Page 06’</i>	
Field/<Tab> Stop	Field Description
1 st INSURERS ADDRESS 1, 2	First insurance company address (as appropriate)
CITY	First insurance company city (as appropriate)
ST	First insurance company state (as appropriate)
ZIP	First insurance company zip code (as appropriate)
2 ND INSURERS ADDRESS 1, 2	Second insurance company address (as appropriate)
CITY	Second insurance company city (as appropriate)
ST	Second insurance company state (as appropriate)
ZIP	Second insurance company zip code (as appropriate)

NOTE: ‘Claim Page 06’ only needs to be completed if Medicare is the secondary payer.

Outpatient – ‘Claim Page 01’	
Field/<Tab> Stop	Field Description
HIC	Health Insurance Claim #
TOB	Type of bill (131 is the default – you may change the third digit as necessary)
PATIENT CONTROL NBR	Patient control number as assigned by the provider
STMT DATES FROM	The ‘from’ date of the billing period
TO	The ‘through’ date of the billing period
LAST	Patient last name
FIRST	Patient first name
MI	Patient middle initial
STREET	Patient street address
CITY	Patient city address
ST	Patient state
ZIP	Patient zip code
DOB	Patient date of birth
SEX	Patient sex
SRC	Source of the admission
STAT	Patient status upon discharge
MEDICAL RECORD NBR	Medical record number as assigned by the provider
COND CODES	Condition codes (as appropriate)
OCC CDS/DATE	Occurrence codes and dates (as appropriate)
SPAN CODES/DATES	Occurrence span codes and dates (as appropriate)
VALUE CODES AND AMOUNTS	Value code and related amounts (as appropriate)

NOTE: Not all outpatient claims will require condition, occurrence, occurrence span and value codes. Report only as required by Medicare.

Outpatient Data Entry Guide Continued...

Outpatient – ‘Claim Page 02’	
Field/<Tab> Stop	Field Description
REV	Revenue code
HCPC	HCPCS code (as appropriate)
MODIFS	HCPCS modifiers (as appropriate)
RATE	Rate associated with the identified revenue code
TOT UNT	Total units of service for the identified revenue code
COV UNT	Total covered units of service for the identified revenue code
TOT CHARGE	Total charges for the identified revenue code
NCOV CHARGE	Total noncovered charges for the identified revenue code
SERV DT	Line item date of service (as appropriate)
IDE AUTH	Investigational device exemption authorization number (as appropriate)

NOTE: Report HCPCS, HCPCS modifiers, line item service dates and IDE authorization numbers only as required by Medicare.

Outpatient – ‘Claim Page 03’	
Field/<Tab> Stop	Field Description
CD (Lines A, B, C)	Payer code
PAYER (Lines A, B, C)	Payer name
PROVIDER NO. (Lines A, B, C)	Provider number as assigned by the indicated payer
RI (Lines A, B, C)	Release of information to other organizations indicator
AB (Lines A, B, C)	Assignment of benefits for third party payment to provider indicator

Outpatient Data Entry Guide Continued...

PRIOR PAY (Lines A, B, C)	Dollar amount received from payer toward payment of claim prior to billing date
DUE FROM PATIENT	Dollar amount received from patient toward payment of claim prior to billing date
DIAGNOSIS CODES	Primary and secondary diagnosis codes
ADMITTING DIAGNOSIS	Diagnosis chiefly responsible for admission
E CODE	Diagnosis representing the external cause of injury, poisoning or adverse effect
PROCEDURE CODES AND DATES	Primary and secondary procedure codes and dates
ATTENDING PHYS	Attending physician UPIN
LN	Attending physician last name
FN	Attending physician first name
MI	Attending physician middle initial
OPERATING PHYS	Operating physician UPIN (as appropriate)
LN	Operating physician last name (as appropriate)
FN	Operating physician first name (as appropriate)
MI	Operating physician middle initial (as appropriate)
OTHER PHYS	Assisting licensed physician UPIN (as appropriate)
LN	Assisting licensed physician last name (as appropriate)
FN	Assisting licensed physician first name (as appropriate)
MI	Assisting licensed physician middle initial (as appropriate)

Outpatient Data Entry Guide Continued...

<i>Outpatient – ‘Claim Page 04’</i>	
Field/<Tab> Stop	Field Description
REMARKS	Claim remarks (as appropriate)

<i>Outpatient – ‘Claim Page 05’</i>	
Field/<Tab> Stop	Field Description
INSURED NAME (Lines A, B, C)	Insureds name for the respective payer indicated
REL (Lines A, B, C)	Patients relationship to the insured
CERT.-SSN-HIC-ID (Lines A, B, C)	Health Insurance Claim # if Medicare is primary
GROUP NAME (Lines A, B, C)	Group name through which insurance is provided (as appropriate)
INS GROUP NUMBER (Lines A, B, C)	Identification number assigned to identify the insurance group (as appropriate)
TREAT. AUTH. CODE (1, 2, 3)	Treatment authorization code (as appropriate)
ESC (1, 2, 3)	Employment status code (as appropriate)
EMPLOYER NAME (1, 2, 3)	Employer’s name (as appropriate)
STREET (1, 2, 3)	Employer’s street address (as appropriate)
CITY (1, 2, 3)	Employer’s city (as appropriate)
ST (1, 2, 3)	Employer’s state (as appropriate)
ZIP (1, 2, 3)	Employer’s zip code (as appropriate)

Outpatient Data Entry Guide Continued...

Outpatient – ‘Claim Page 06’	
Field/<Tab> Stop	Field Description
1 st INSURERS ADDRESS 1, 2	First insurance company address (as appropriate)
CITY	First insurance company city (as appropriate)
ST	First insurance company state (as appropriate)
ZIP	First insurance company zip code (as appropriate)
2 ND INSURERS ADDRESS 1, 2	Second insurance company address (as appropriate)
CITY	Second insurance company city (as appropriate)
ST	Second insurance company state (as appropriate)
ZIP	Second insurance company zip code (as appropriate)

NOTE: ‘Claim Page 06’ only needs to be completed if Medicare is the secondary payer.

Inpatient SNF – ‘Claim Page 01’	
Field/<Tab> Stop	Field Description
HIC	Health Insurance Claim #
TOB	Type of bill (211 is the default – you may change the third digit as necessary)
PATIENT CONTROL NBR	Patient control number as assigned by the provider
STMT DATES FROM	The ‘from’ date of the billing period
TO	The ‘through’ date of the billing period
DAYS COV	Total number of covered days for the billing period
N-C	Total number of noncovered days for the billing period
CO	Total number of coinsurance days for the billing period
LAST	Patient last name
FIRST	Patient first name
MI	Patient middle initial
STREET	Patient street address
CITY	Patient city address
ST	Patient state
ZIP	Patient zip code
DOB	Patient date of birth
SEX	Patient sex
ADMIT DATE	The date the patient was admitted as an inpatient
SRC	Source of the admission
STAT	Patient status upon discharge
MEDICAL RECORD NBR	Medical record number as assigned by the provider
COND CODES	Condition codes (as appropriate)
OCC CDS/DATE	Occurrence codes and dates (as appropriate)

Inpatient SNF Data Entry Guide Continued...

SPAN CODES/DATES	Occurrence span codes and dates (as appropriate)
VALUE CODES AND AMOUNTS	Value code and related amounts (as appropriate)

NOTE: Not all inpatient SNF claims will require condition, occurrence, occurrence span and value codes. Report only as required by Medicare.

<i>Inpatient SNF – ‘Claim Page 02’</i>	
Field/<Tab> Stop	Field Description
REV	Revenue Code
HCPC	HCPCS code (as appropriate)
RATE	Rate associated with the identified revenue code
TOT UNT	Total units of service for the identified revenue code
COV UNT	Total covered units of service for the identified revenue code
TOT CHARGE	Total charges for the identified revenue code
NCOV CHARGE	Total noncovered charges for the identified revenue code

NOTE: Complete the ‘HCPC’ field only if Medicare requires additional HCPCS coding.

<i>Inpatient SNF – ‘Claim Page 03’</i>	
Field/<Tab> Stop	Field Description
CD (Lines A, B, C)	Payer code
PAYER (Lines A, B, C)	Payer name
PROVIDER NO. (Lines A, B, C)	Provider number as assigned by the indicated payer
RI (Lines A, B, C)	Release of information to other organizations indicator

Inpatient SNF Data Entry Guide Continued...

AB (Lines A, B, C)	Assignment of benefits for third party payment to provider indicator
PRIOR PAY (Lines A, B, C)	Dollar amount received from patient toward payment of claim prior to billing date
DIAGNOSIS CODES	Primary and secondary diagnosis codes
ADMITTING DIAGNOSIS	Diagnosis chiefly responsible for admission
E CODE	Diagnosis representing the external cause of injury, poisoning or adverse effect
PROCEDURE CODES AND DATES	Primary and secondary procedure codes and dates
ATTENDING PHYS	Attending physician UPIN
LN	Attending physician last name
FN	Attending physician first name
MI	Attending physician middle initial
OPERATING PHYS	Operating physician UPIN (as appropriate)
LN	Operating physician last name (as appropriate)
FN	Operating physician first name (as appropriate)
MI	Operating physician middle initial (as appropriate)
OTHER PHYS	Assisting licensed physician UPIN (as appropriate)
LN	Assisting licensed physician last name (as appropriate)
FN	Assisting licensed physician first name (as appropriate)
MI	Assisting licensed physician middle initial (as appropriate)

Inpatient SNF Data Entry Guide Continued...

<i>Inpatient SNF – ‘Claim Page 04’</i>	
Field/<Tab> Stop	Field Description
REMARKS	Claim remarks (as appropriate)

<i>Inpatient SNF – ‘Claim Page 05’</i>	
Field/<Tab> Stop	Field Description
INSURED NAME (Lines A, B, C)	Insureds name for the respective payer indicated
REL (Lines A, B, C)	Patients relationship to the insured
CERT.-SSN-HIC-ID (Lines A, B, C)	Health Insurance Claim # if Medicare is primary
GROUP NAME (Lines A, B, C)	Group name through which insurance is provided (as appropriate)
INS GROUP NUMBER (Lines A, B, C)	Identification number assigned to identify the insurance group (as appropriate)
TREAT. AUTH. CODE (1, 2, 3)	Treatment authorization code (as appropriate)
ESC (1, 2, 3)	Employment status code (as appropriate)
EMPLOYER NAME (1, 2, 3)	Employer’s name (as appropriate)
STREET (1, 2, 3)	Employer’s street address (as appropriate)
CITY (1, 2, 3)	Employer’s city (as appropriate)
ST (1, 2, 3)	Employer’s state (as appropriate)
ZIP (1, 2, 3)	Employer’s zip code (as appropriate)

Inpatient SNF Data Entry Guide Continued...

<i>Inpatient SNF – ‘Claim Page 06’</i>	
Field/<Tab> Stop	Field Description
1 st INSURERS ADDRESS 1, 2	First insurance company address (as appropriate)
CITY	First insurance company city (as appropriate)
ST	First insurance company state (as appropriate)
ZIP	First insurance company zip code (as appropriate)
2 ND INSURERS ADDRESS 1, 2	Second insurance company address (as appropriate)
CITY	Second insurance company city (as appropriate)
ST	Second insurance company state (as appropriate)
ZIP	Second insurance company zip code (as appropriate)

NOTE: ‘Claim Page 06’ only needs to be completed if Medicare is the secondary payer.

UB-92 Data Entry Payer Codes

The following payer codes may be reported in the 'CD' field on 'Claim Page 03' of the online UB-92 claim entry record:

<i>Payer Code</i>	<i>Description</i>
1	Medicaid
2	Blue Cross
3	Other
A	Working Aged
B	End Stage Renal Disease (ESRD) beneficiary in 18 month coordination with an Employer Group Health Plan (EGHP)
C	Conditional Payment
D	Automobile, no-fault or any liability insurance
E	Worker's Compensation
F	Public Health Service (PHS) or other Federal Agency
G	Disabled
H	Federal Black Lung Program
I	Veterans Administration
Z	Medicare Part A (and Part B of A)

→ The payer codes listed above also need to be filled on regular EMC claims.

Online System - How to Correct an RTPd Claim

To correct an RTPd claim on the online system, follow these steps:

Step	Action
1	Select the 'CLAIMS CORRECTION' (03) submenu from the 'MAIN MENU.'
2	Key the appropriate claims correction option number from the 'CLAIMS CORRECTION' directory at the 'ENTER MENU SELECTION:' prompt. Valid entries are: 21 – Inpatient 23 – Outpatient 25 – SNF
3	Depress “<Enter>.”
4	Select the RTPd claims you wish to correct by performing any of the following <u>claim selection methods:</u> A. Enter the HIC # and the dates of service of a <u>specific</u> claim that you wish to correct in the 'HIC' and 'FROM DATE'/'TO DATE' fields and depress “<Enter>.” B. Depress “<Enter>” and a <u>list</u> of all RTP claims for the bill type selected will appear for your provider number. -OR- C. Enter the appropriate DDE sort option code in the 'DDE SORT' field. <u>Valid entries are:</u> N -Sort by beneficiary last name; R -Sort in ascending reason code order; D -Sort in receipt date order (oldest appearing first on list); Blank -Sort by type of bill (this is the default sort process); H -Sort according to HIC # (ascending order); or, M -Sort according to medical record number (ascending number) -OR- D. Enter the appropriate Medical Review Select option code in the 'MEDICAL REVIEW SELECT' field. <u>Valid entries are:</u> Blank -Select all claims;

Correcting RTP Claims Continued...

	<p>1 -Selects all claims; 2 -Selects all claims excluding medical review; or, 3 -Selects only medical review claims</p>
5	Select the claim you wish to update by placing a “ S ” next to the claim record under the ‘ SEL ’ field.
6	Depress “<Enter>.”
7	<p>Make the necessary corrections based on the reason code(s) identified in the lower left-hand corner of the claim screen.</p> <p>➤ NOTE: To view the narrative for the <i>first</i> reason code, depress the ‘PF1’ Help key. If there are <i>subsequent</i> reason codes, position your cursor anywhere underneath the reason code, and then depress ‘PF1’ to view the narrative. To <i>return</i> to the claim record, depress ‘PF3.’</p>
8	After all corrections have been made, depress the ‘ PF9 ’ key to “ store ” or “ update ” the claim.

Online System - How to 'Adjust' a Claim

To adjust a claim on the online system, follow these steps:

Step	Action
1	Select the ' CLAIMS CORRECTION ' (03) submenu from the ' MAIN MENU. '
2	Key the appropriate option number from the ' CLAIM ADJUSTMENTS ' directory associated with the type of claim to be adjusted at the ' ENTER MENU SELECTION: ' prompt. Valid entries are: 30 – Inpatient 31 – Outpatient 32 – SNF
3	Depress " <ENTER> ."
4	Key in the HIC # and dates of service for the claim you want to adjust. NOTE: Keying in the date of service is optional .
5	Depress " <ENTER> ."
6	Select the claim you want to adjust by placing a " S " next to the claim record under the ' SEL ' field.
7	Depress " <ENTER> ."
8	Key in the appropriate Claim Change Reason Code in the ' COND CODE ' field on ' CLAIM PAGE 01. '
9	Depress ' PF8 ' to advance to ' CLAIM PAGE 03. '
10	Key in the appropriate Adjustment Reason Code in the ' ADJUSTMENT REASON CODE ' field on ' CLAIM PAGE 03. '
11	Key all appropriate corrections to the claim.
12	Depress the ' PF9 ' key to " store " the adjustment.
13	Verify that the adjustment was accepted by checking the status/location of the claim on the ' CLAIM SUMMARY INQUIRY ' option (01 submenu – option 12). NOTE: Successfully stored <u>adjustments</u> will appear in status/location S B2500.

Online System - How to 'Cancel' a Claim

To cancel a claim on the online system, follow these steps:

Step	Action
1	Select the ' CLAIMS CORRECTION ' (03) submenu from the ' MAIN MENU .'
2	Key the appropriate option number from the ' CLAIM CANCELS ' directory associated with the type of claim to be canceled at the ' ENTER MENU SELECTION: ' prompt. Valid entries are: 50 – Inpatient 51 – Outpatient 52 – SNF
3	Depress “<ENTER>.”
4	Key in the HIC # and dates of service for the claim you want to cancel. NOTE: Keying in the date of service is optional .
5	Depress “<ENTER>.”
6	Select the claim you want to cancel by placing a “ S ” next to the claim record under the ' SEL ' field.
7	Depress “<ENTER>.”
8	Key in the appropriate Claim Change Reason Code in the ' COND CODE ' field on ' CLAIM PAGE 01 .'
9	Depress the ' PF9 ' key to “ store ” the cancel.
10	Verify that the cancel was accepted by checking the status/location of the claim on the ' CLAIM SUMMARY INQUIRY ' option (01 submenu – option 12). NOTE: Successfully stored <u>cancels</u> will appear in status/location S B9000.

Claim Change Reason Codes

The following adjustment/cancel change reason codes may be reported in the 'COND CODE' field on 'CLAIM Page 01' of the adjustment/cancel claim record:

For Adjustment Claims Only (TOB XX7)		For Cancel Claims Only (TOB XX8)	
<i>Condition Code</i>	<i>Description</i>	<i>Condition Code</i>	<i>Description</i>
D0	Change in Service Dates	D5	Incorrect HIC # / Provider #
D1	Change in Charges	D6	Overpayment
D2	Change in Revenue Code/HCPCS		
D3	PPS Interim Payment		
D4	Change in Diagnosis/ Procedure Code		
D7	Change to Make Medicare Secondary		
D8	Change to Make Medicare Primary		
D9	Other Change		
E0	Change in Patient Status		

- Only one reason code may be reported on the adjustment/cancel claim request.
- If more than one reason could apply, choose the single reason that best describes the adjustment being requested.
- Use reason code 'D1' only when the charges are the only change on the claim.
- If reason code 'D9' is reported, indicate the reason for the adjustment in the 'REMARKS' field on 'Claim Page 04.'