User Guide

ForwardHealth Provider Portal Institutional Claims

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WISCONSIN DEPARTMENT of HEALTH SERVICES

Table of Contents

1 Introduction..... 1

2 Access the Claims Page..... 2

3 Submit an Institutional Claim 6
3.1 Institutional Claim Panel..... 7
3.1.1 Diagnosis Panel..... 11
3.1.2 Condition Panel 13
3.1.3 Medicare Information (Header) Panel 15
3.1.4 Payer Panel..... 17
3.1.5 Procedure Panel 17
3.1.6 Occurrence/Span Panel 19
3.1.7 Value Panel..... 20
3.1.8 Patient Reason for Visit Panel 20
3.1.9 External Cause of Morbidity Panel 21
3.1.10 Other Insurance Header Information Panel 22
3.2 Detail Panel 25
3.2.1 NDC Panel..... 26
3.3 Other Insurance Detail Information Panel..... 28
3.4 Other Insurance EOB Information Panel 30
3.5 Medicare Information (Detail) Panel..... 34
3.6 Attachments Panel 35
3.7 Submit the Claim 36

1 Introduction

Providers may submit institutional claims directly to ForwardHealth using Direct Data Entry, an online application, available through their secure provider account on the ForwardHealth Portal. Using the institutional claim form, providers may submit several types of claims, including inpatient, outpatient, home health, hospice, and long-term care. This user guide provides general instructions for completing an institutional claim through the Portal. For detailed instructions, refer to the UB-04 Claim Form completion instructions in the applicable service area of the ForwardHealth Online Handbook.

2 Access the Claims Page

1. Access the Portal at www.forwardhealth.wi.gov/.

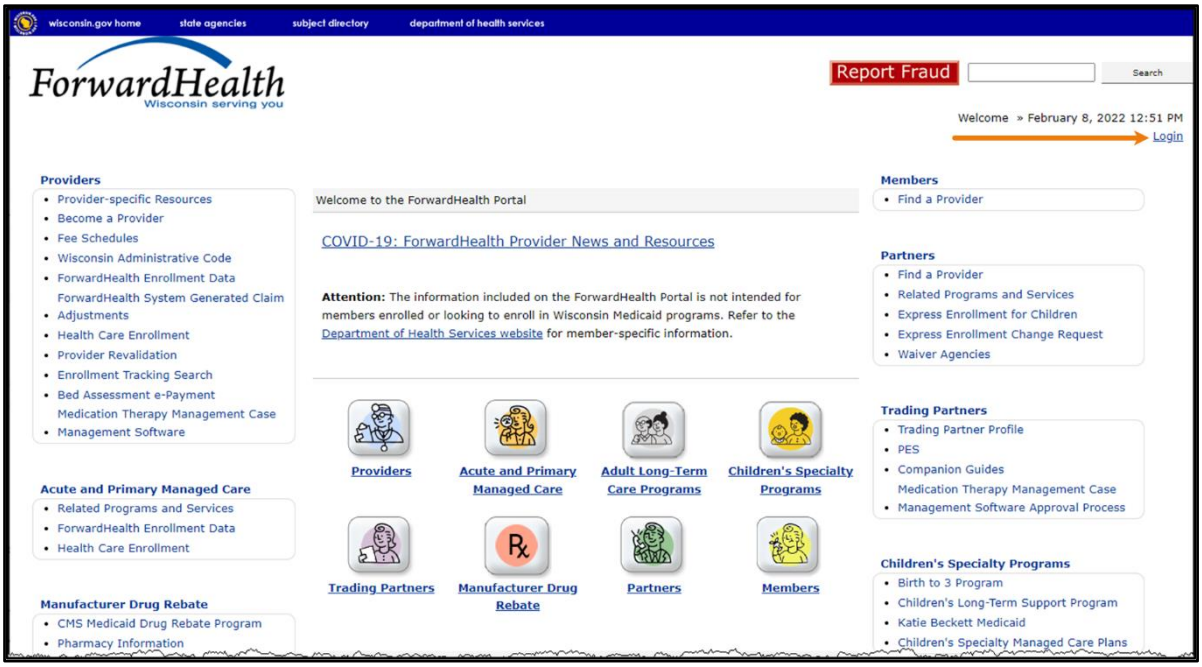

Figure 1 ForwardHealth Portal Homepage

2. Click **Login**. A Sign In box will be displayed.

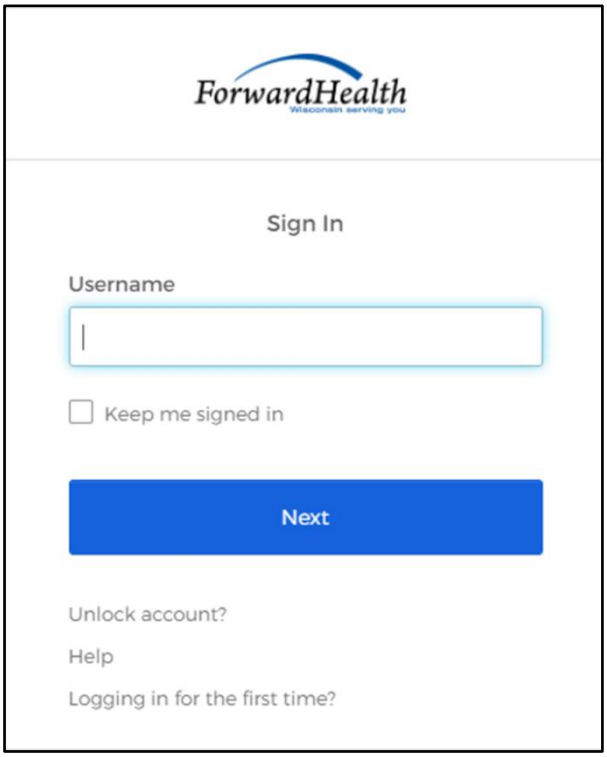

Figure 2 Sign In Box

3. Enter the user's username.

4. Click **Next**. A Verify with your password box will be displayed.

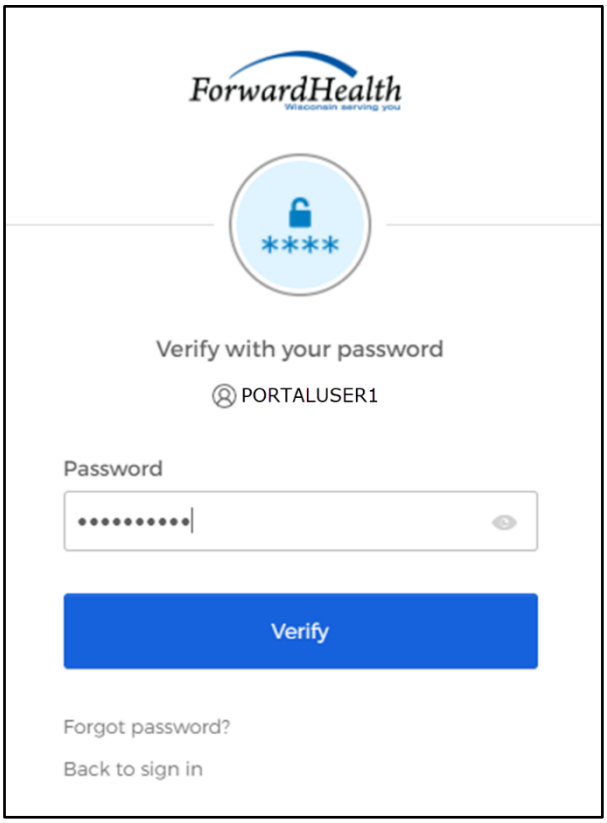

Figure 3 Verify With Your Password Box

5. Enter the user's password.

6. Click **Verify**. The secure Provider page will be displayed.

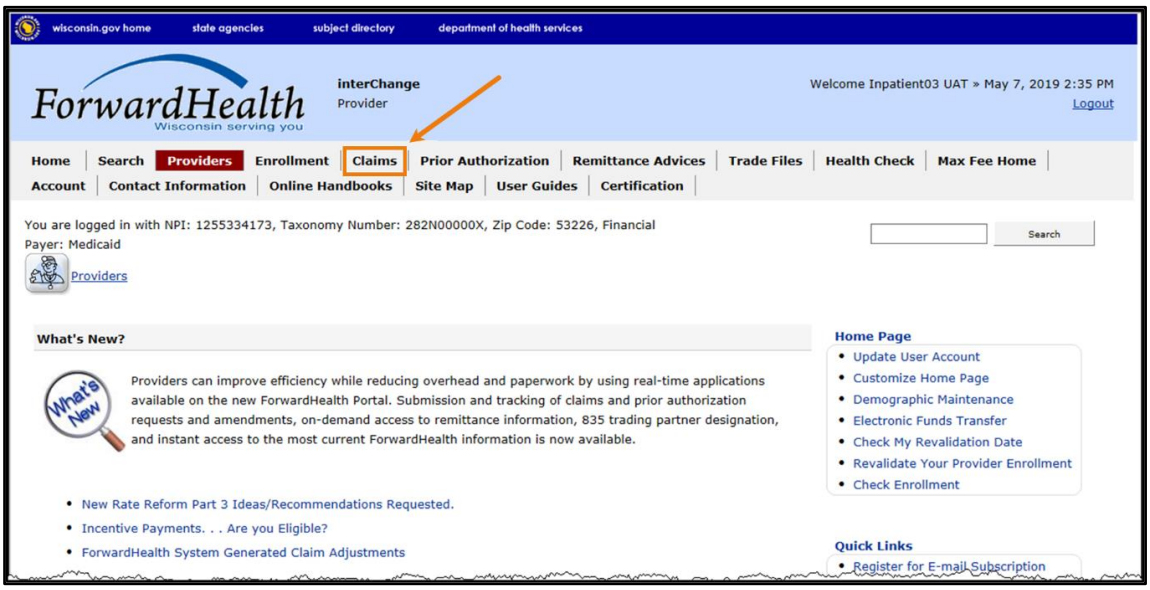

Figure 4 Secure Provider Page

7. Click **Claims** on the main menu at the top of the page. The Claims page will be displayed.

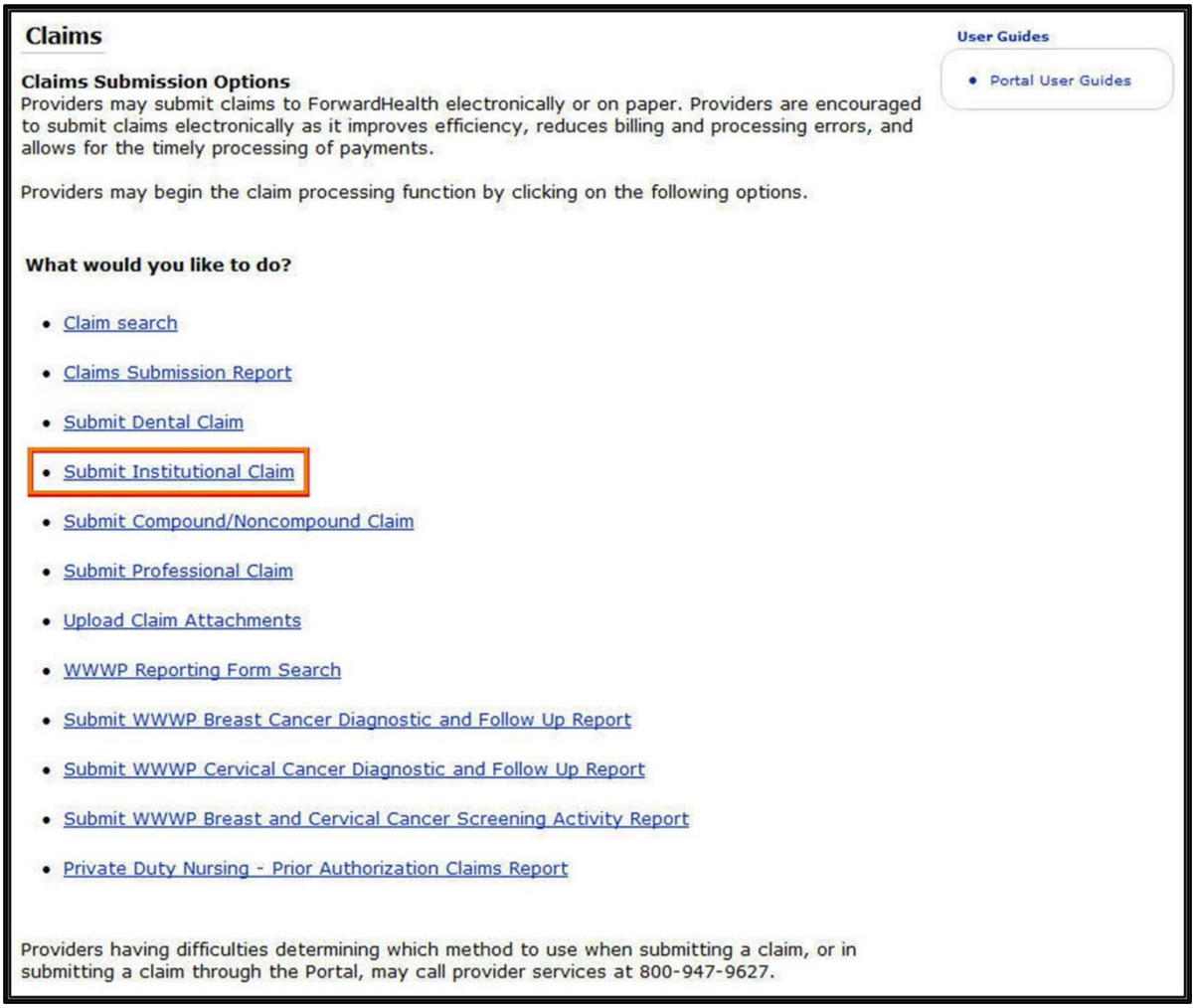

Figure 5 Claims Page

All claim type submission options are available from this page.

3 Submit an Institutional Claim

1. Click **Submit Institutional Claim** on the Claims page. The Institutional Claim form will be displayed.

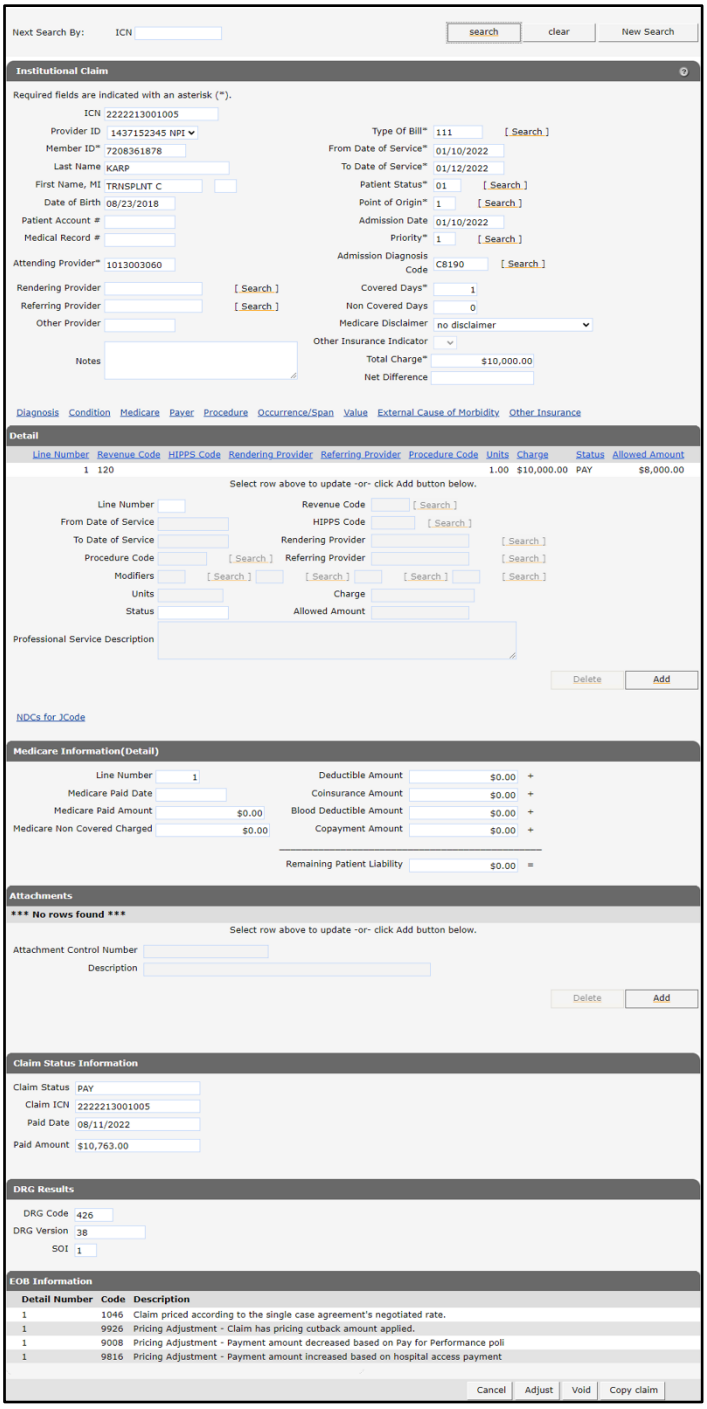

Figure 6 Institutional Claim Form

3.1 Institutional Claim Panel

Users may enter a claim's header information on the Institutional Claim panel.

Note: Fields marked with an asterisk (*) are required fields.

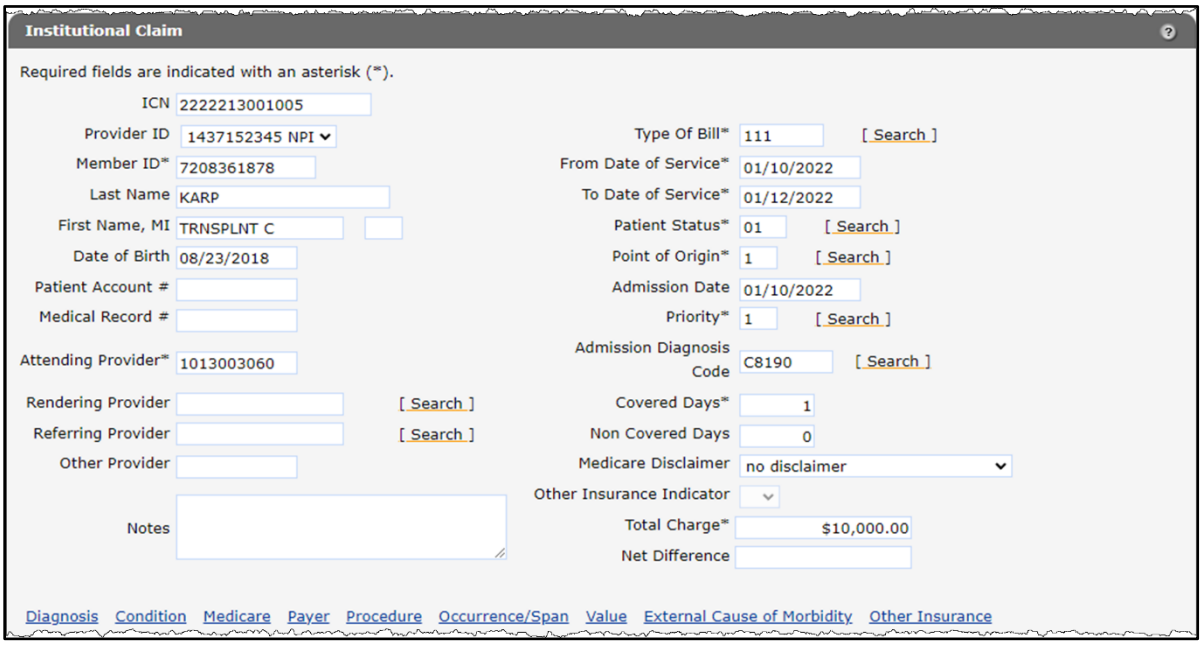

Figure 7 Institutional Claim Panel

Information cannot be entered in the ICN field. ForwardHealth will automatically assign an internal control number (ICN) when the claim is submitted.

The National Provider Identifier (NPI) under which the user is logged in will populate the Provider ID field for all providers except hospitals.

For users logged in with a hospital account, this field will have a drop-down menu containing the hospital's main NPI and any sub-part NPIs assigned to that hospital.

From the Provider ID drop-down menu, select the NPI to be indicated on the claim being submitted.

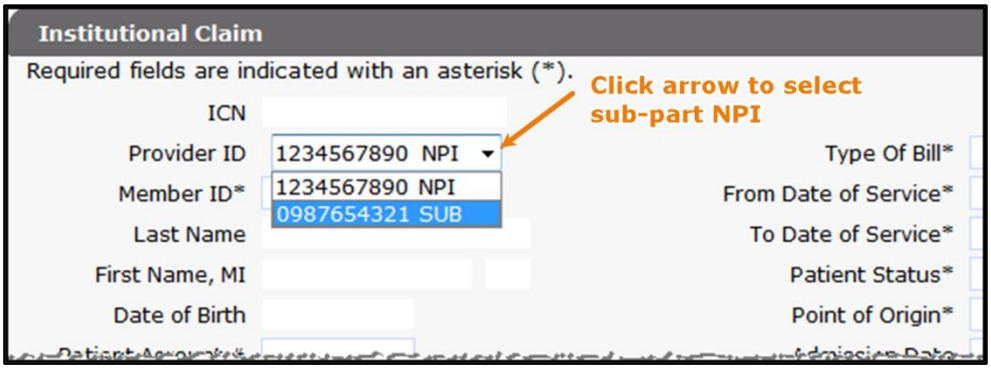

Figure 8 Provider ID Drop-Down Menu for Hospital Accounts

1. Enter the member ID number in the Member ID field.

   Note: After entering the member ID, click anywhere on the gray area of the form. The Last Name, First Name, MI, and Date of Birth fields will populate with the member's information.

2. Enter the provider's internal number assigned to the patient's account in the Patient Account # field.

3. Enter the provider-assigned medical record number for the service(s) being processed in this claim in the Medical Record # field.

4. Enter the NPI of the attending provider in the Attending Provider field. Personal care providers should enter the Medicaid ID of the personal care agency.

5. Enter the NPI of any provider who performed services in the Rendering Provider field.

6. Enter the NPI of the provider, or providers, who referred the member for services in the Referring Provider field if applicable. Users may enter an NPI in the field, or search for the NPI using the adjoining Search link.

7. Enter the NPI of any other provider who was in attendance during a service that was performed or provided prior to the member being admitted to the institution in the Other Provider field.

   Note: If a field exists at both the header and detail level, enter the information in one or the other but not necessarily both. The header will apply automatically to all details. Enter information at the detail only if different than the header value for these details.

8. Enter a brief description in the Notes field if additional information is needed to substantiate the medical treatment indicated if the information is not supported elsewhere on the claim form.

9. Enter the three-digit type of bill code, without the leading zero, in the Type of Bill field or search for the code.

   a. Click Search to the right of the Type of Bill field. The Type of Bill search panel will be displayed.

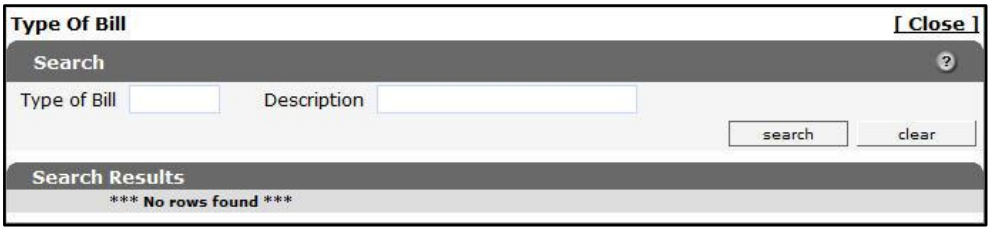

Figure 9 Type of Bill Search Panel

   b. Enter a description of the type of bill code:

      - If the entire description is unknown, enter a key word or partial description.

- When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word or group of words to display all codes containing that word.

c. Click Search. The Search Results section of the panel will be displayed.

Note: If a "No rows found" message is displayed, the user may need to correct inaccurate information and search again.

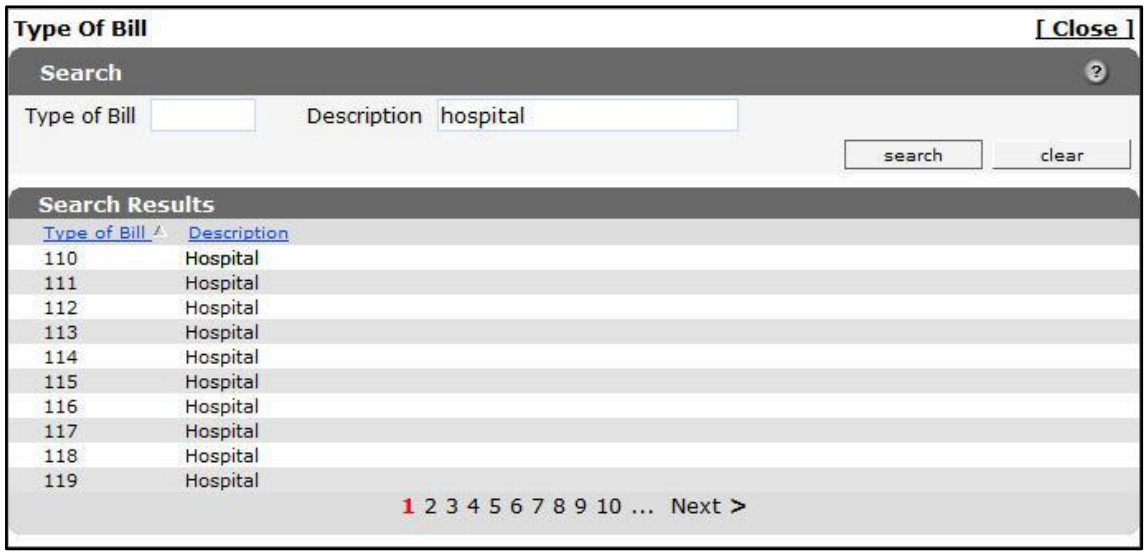

Figure 10 Type of Bill Search Results Panel

d. Click the applicable code. The Type of Bill search panel will close, and the selected code will populate the Type of Bill field on the Institutional Claim form.

Note: The same procedure can be used with other search links on the claim form.

10. Enter the date when services began in the From Date of Service field.
11. Enter the date when services ended or will end in the To Date of Service field.
12. Enter the patient status in the Patient Status field or search for a status using the Search link to the right of the field.
13. Enter a code indicating the source of the admission in the Point of Origin field or search for a code using the Search link to the right of the field.
14. Enter the date the member was admitted to a facility for treatment in the Admission Date field.
15. Enter a code indicating the priority of the admission for inpatient or outpatient care in the Priority field or search for a code using the Search link to the right of the field.
16. Enter a valid admission diagnosis code from the International Classification of Diseases (ICD) coding structure in the Admission Diagnosis Code field or search for a code using the Search link to the right of the field.

Note: The Admission Diagnosis Code field should only be used for claims in which the member was admitted to a facility. For specific requirements based on the provider type, refer to the Online Handbook. For a member in a non-admission situation, enter a primary diagnosis code on the Diagnosis Panel.

17. Enter the number of treatment days covered by the primary payer for the dates of service (DOS) indicated on the claim in the Covered Days field.

18. Enter the number of treatment days not covered by the primary payer for the DOS indicated on the claim in the Non Covered Days field.

19. Select a Medicare disclaimer status from the Medicare Disclaimer drop-down menu for traditional Medicare Part A, traditional Medicare Part B, or Medicare Advantage payers. The only valid options include the following:

    - No Disclaimer—No disclaimer exists.
    - 7 Mcare disallowed/denied pymt—Medicare has disallowed or denied the payment according to Medicare rules. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.
    - 8 Noncovered Mcare srv—The service provided to the member was not billed to Medicare because the service is not covered under certain circumstances.

    Note: The Medicare Disclaimer field should be used to indicate a claim by a Medicare provider for a member with Medicare coverage that the provider wishes to have processed as if it were a primary claim by ForwardHealth, that is, not secondary to Medicare. If a Medicare disclaimer is used, no information should be entered in the Medicare Information (Header) or the Medicare Information (Detail) panels.

20. The Other Insurance Indicator drop-down menu is no longer used on claims submitted on and after June 14, 2014, but remains on this panel for viewing claims submitted before June 14, 2014. Providers are required to use the Other Insurance Header, Detail, and EOB Information panels to report other insurance (OI) information.

21. Enter the total charge for the service(s) being provided to the member in the Total Charge field.

22. The Net Difference is the paid amount differences between the original ICN and adjustment ICN. This amount is displayed after an adjustment is processed to completion (paid/deny) for an ICN.

3.1.1 Diagnosis Panel

1. Click **Diagnosis** at the bottom of the Institutional Claim panel.

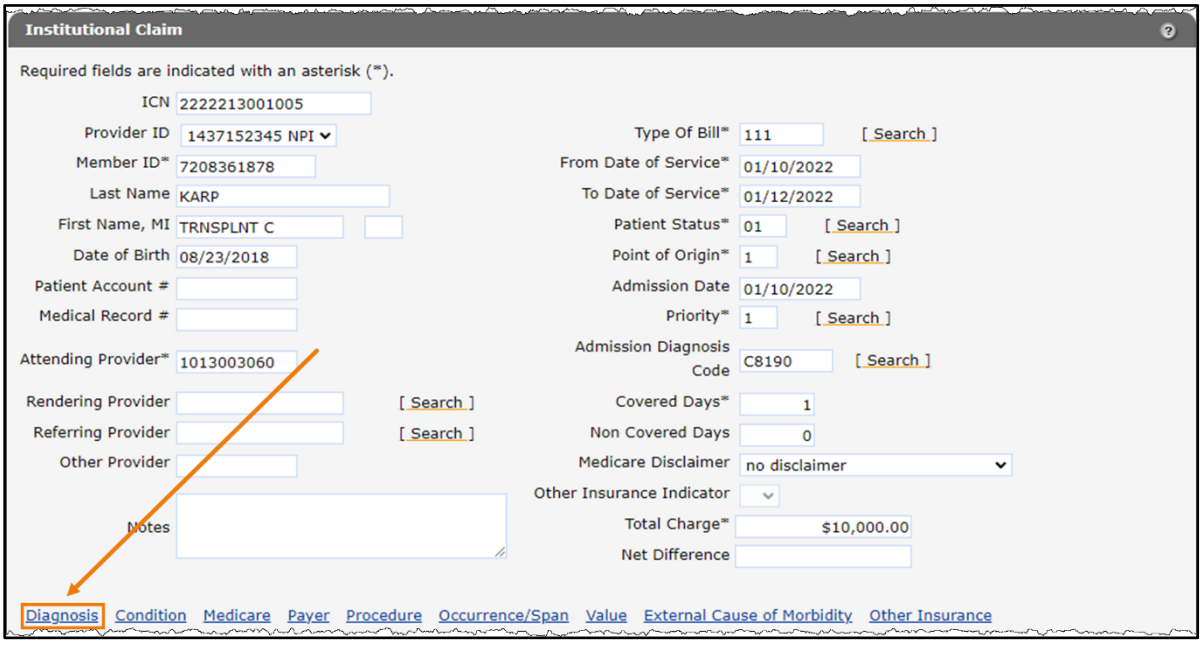

Figure 11 Diagnosis Link

The Diagnosis panel will be displayed.

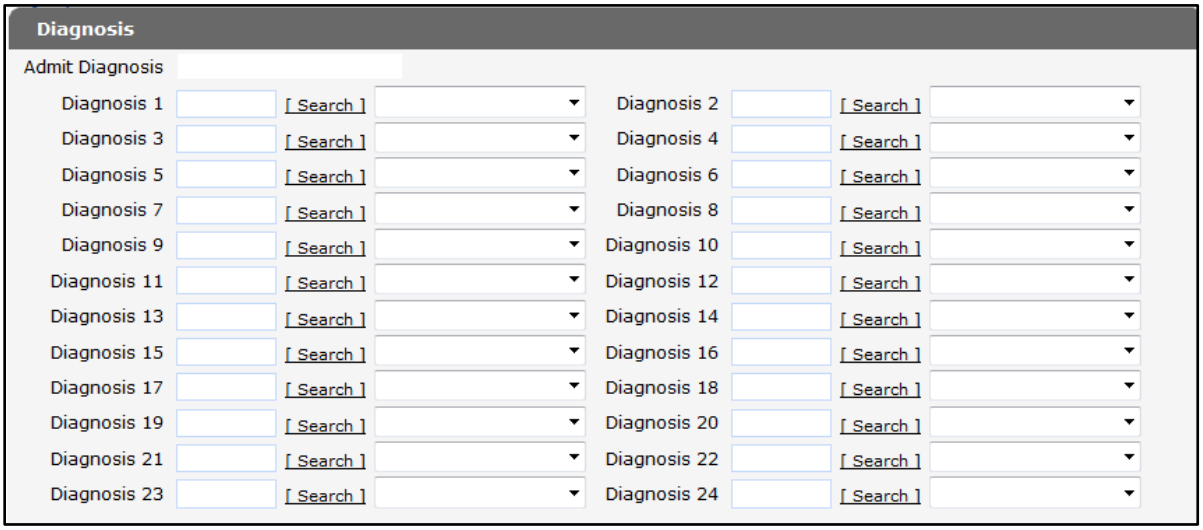

Figure 12 Diagnosis Panel

If a code is entered in the Admission Diagnosis Code field on the Institutional Claim panel, the Admit Diagnosis field will be populated with that code.

2. Enter a diagnosis code from the ICD coding structure in the Diagnosis 1 field or search for a code using the Search link to the right of the field.

Note: Do not use a decimal point when entering a diagnosis code. For example, for ICD diagnosis code 041.00, enter 04100.

For more information about covered services and reimbursement, refer to the Covered and Noncovered Services section of the Online Handbook.

To search for a diagnosis code, complete the following steps:

a. Click **Search** to the right of the applicable Diagnosis field. The Diagnosis search panel will be displayed.

Figure 13 Diagnosis Search Panel

b. Enter a description of the code:

- If the entire description is unknown, enter a key word or partial description.
- When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word to display all codes containing that word.

c. Click **Search**. Any diagnosis codes matching the query will be displayed in the Search Results section of the panel.

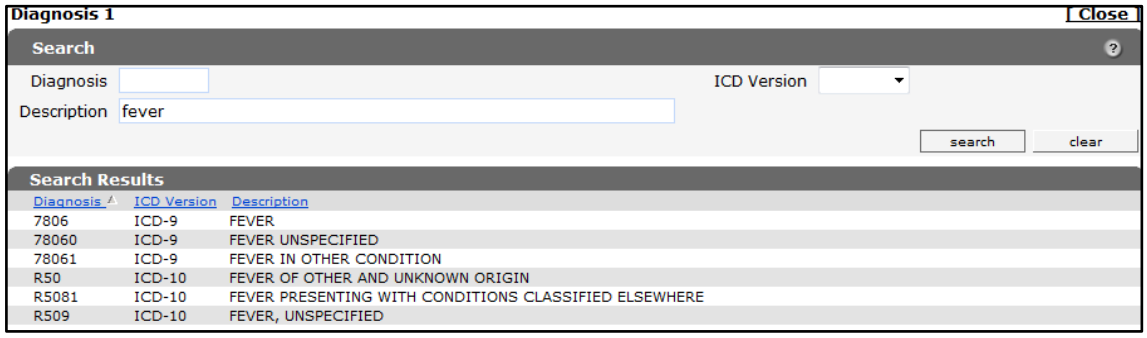

Figure 14 Diagnosis Search Results Panel

d. Click the applicable diagnosis code. The Diagnosis search panel will close, and the selected code will populate the Diagnosis field.

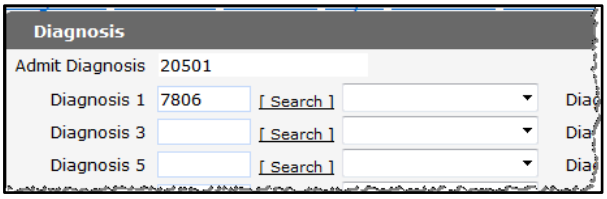

Figure 15 Diagnosis Code Added to the Claim Form

3. Add additional diagnosis codes to the claim, if necessary. To delete a diagnosis code, erase the entry.

4. A POA indicator is required for inpatient claims when the provider or diagnosis code is not exempt from collection of present on admission (POA) information. Select one of the following POA indicators from the drop-down menu:

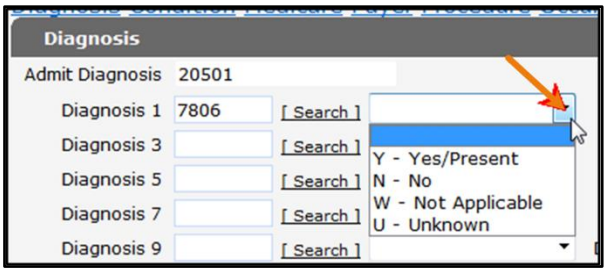

Figure 16 POA Code Indicator

- Y—Yes/Present—Indicates the diagnosis was present at the time of inpatient admission.
- N—No—Indicates the diagnosis was not present at the time of inpatient admission.
- W—Not Applicable—Indicates the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
- U—Unknown—Indicates the documentation is insufficient to determine if the condition was present at the time of inpatient admission.

3.1.2 Condition Panel

Through the Condition panel, users can enter a code(s) identifying a condition related to this claim, if applicable. For more information, refer to the UB-04 Billing Manual available through the National Uniform Billing Committee website at www.nubc.org/.

1. Click **Condition** at the bottom of the Institutional Claim panel. The Condition panel will be displayed.

Figure 17 Condition Panel

2. Click **Add**. A row will be added to the Condition panel, and the Condition Code field will activate.

Figure 18 Condition Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code that identifies conditions relating to the claim that may affect processing in the Condition field.

   To search for a code, complete the following steps:

   a. Click **Search** to the right of the field. The Condition Code search panel will be displayed.

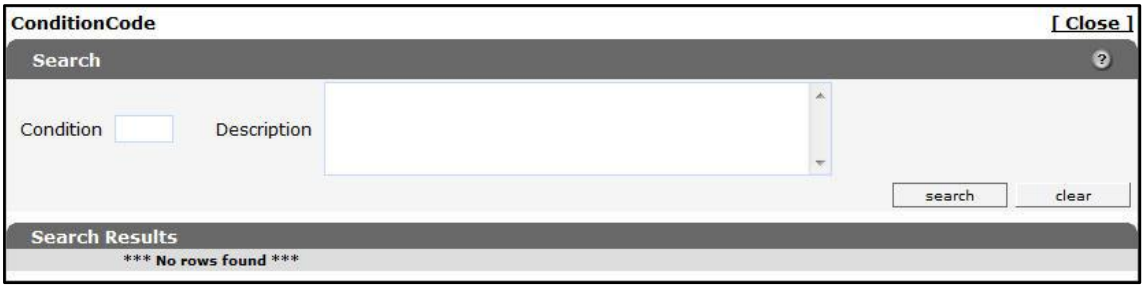

Figure 19 Condition Code Search Panel

   b. Enter a description of the code:

      - If the entire description is unknown, enter a key word or partial description.
      - When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word or group of words to display all codes containing that word.

c. Click **Search**. Any codes matching the query will be displayed in the Search Results section of the panel.

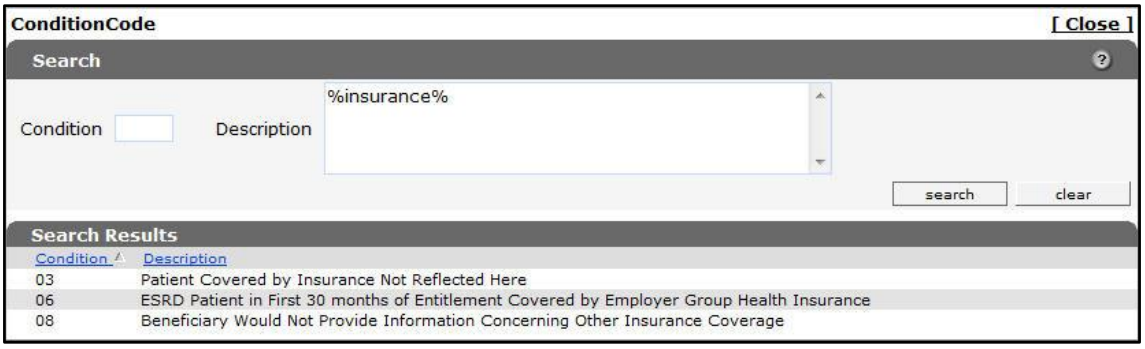

Figure 20 Condition Code Search Results Panel

d. Click the applicable code. The Condition Code search panel will close, and the selected code will populate the Condition field. The code information will also populate the added row.

Figure 21 Conditions Panel With Added Information

To add additional condition codes to the claim, click **Add** and either enter the code in the Condition Code field or search for a code using the Search link to the right of the field.

To remove a row, select the desired row and click **Delete**. A dialog panel will be displayed. Click **OK** to delete the specified row.

3.1.3 Medicare Information (Header) Panel

On the Medicare Information panels (Header and Detail), users can report Medicare (or Medicare Advantage Plan) payment and adjustment information, which allows ForwardHealth to process a Medicare secondary claim.

Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to Step 19 of 3.1 Institutional Claim Panel to select the appropriate Medicare disclaimer code.

1. Click **Medicare** at the bottom of the Institutional Claim panel. The Medicare Information (Header) panel will be displayed.

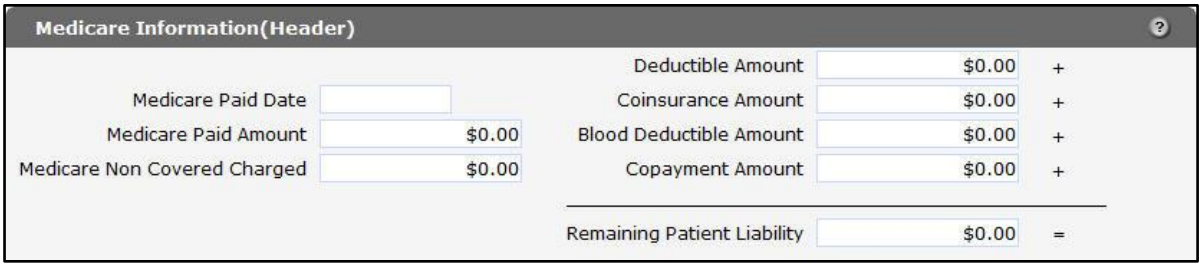

Figure 22 Medicare Information (Header) Panel

2. Enter the date that Medicare paid the claim in the Medicare Paid Date field.
3. Enter the amount Medicare paid for the claim in the Medicare Paid Amount field.

   Note: The Medicare paid amount on the Medicare Information (Header) panel should be a sum of the paid amounts on the Medicare Information (Detail) panel. The paid amounts must be entered on both panels or the claim will not pay correctly.

4. Enter the amount of the claim not allowed by Medicare in the Medicare Non Covered Charge field. (The noncovered amount on the Medicare Information [Header] panel is the difference between the claim's total charge amount on the Institutional Claim panel and the Medicare paid amount on the Medicare Information [Header] panel.)
5. Enter the amount that the member is required to pay before Medicare begins to pay in the Deductible Amount field.
6. Enter the coinsurance amount (percentage of the Medicare payment) that the member is required to pay after payment of the deductible in the Coinsurance Amount field.
7. Enter the dollar amount that Medicare has determined that a member is required to pay for blood work in the Blood Deductible Amount field.
8. Enter the copayment amount (percentage of the Medicare payment) that the member is required to pay after payment of the deductible in the Copayment Amount field.
9. Enter the remaining patient liability amount in the Remaining Patient Liability field. Remaining patient liability must equal the sum of the deductible amount, coinsurance amount, blood deductible amount, and copayment amount.

3.1.4 Payer Panel

Only other commercial health insurance information should be entered on the Payer panel.

1. Click **Payer** at the bottom of the Institutional Claim panel. The Payer panel will be displayed.

Figure 23 Payer Panel

2. Click **Add**. A row will be added to the Payer panel, and the fields will activate.

Figure 24 Payer Panel With Added Row

3. The Sequence field gives numerical order to the OI information. Enter a **1** for the first added row. If multiple commercial insurance companies paid on the claim, enter numbers in numerical order for each row added.
4. Enter the amount received from the payer prior to this billing in the Prior Payment field.
5. Select **Other** from the Payer drop-down menu.
6. To add additional payers to the claim, click **Add** and enter applicable information.
7. To remove a payer, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.5 Procedure Panel

On the Procedure panel, users can report ICD procedure codes.

Note: To add a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) procedure code, use the Procedure Code field on the Detail Panel.

1. Click **Procedure** at the bottom of the Institutional Claim panel. The Procedure panel will be displayed.

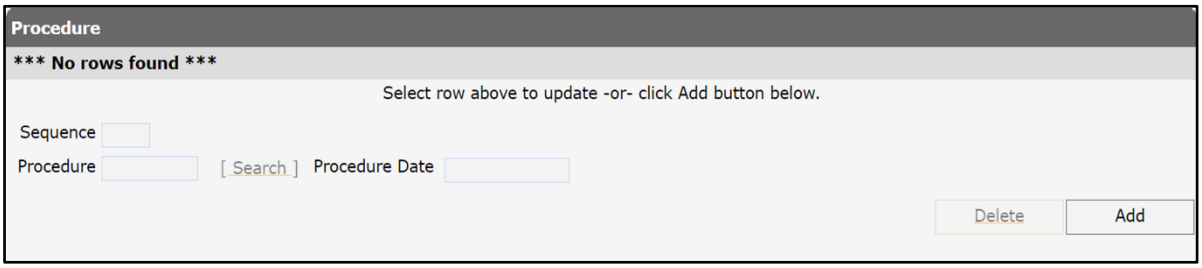

Figure 25 Procedure Panel

2. Click **Add**. A row will be added to the panel, and the Procedure and Procedure Date fields will activate.

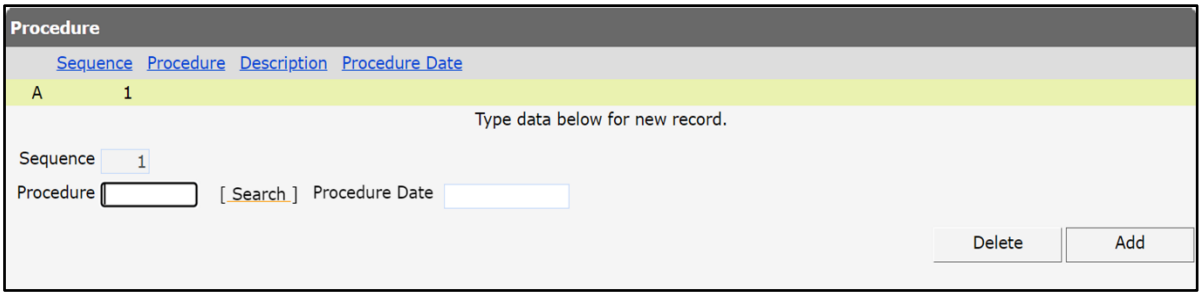

Figure 26 Procedure Panel With Added Row

3. The Sequence field provides numerical order for the procedure code. A sequence number will automatically be generated when a new row is added.

4. Enter an ICD procedure code that identifies the procedure performed in the in the Procedure field or search for a code using the Search link to the right of the field.

5. Enter the date that the procedure was completed in the Procedure Date field.

6. To add additional procedure codes to the claim, click **Add** and either enter the code in the Procedure field or search for a code using the Search link to the right of the field.

7. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.6 Occurrence/Span Panel

1. Click **Occurrence/Span** at the bottom of the Institutional Claim panel. The Occurrence/Span panel will be displayed.

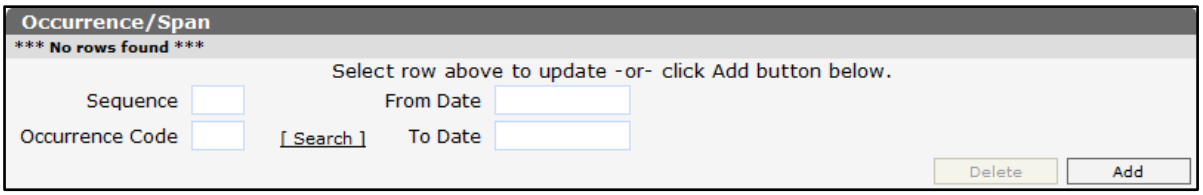

Figure 27 Occurrence/Span Panel

2. Click **Add**. A row will be added to the panel, and the fields will activate.

Figure 28 Occurrence/Span Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code defining a significant event relating to this claim that may affect payer processing in the Occurrence Code field or search for a code using the Search link to the right of the field.

4. Enter the date that the service began in the From Date field.

5. Enter the date that the service was completed in the To Date field, if applicable.

6. To add additional occurrence codes to the claim, click **Add** and either enter the code in the Occurrence Code field or search for a code using the Search link to the right of the field.

7. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.7 Value Panel

1. Click **Value** at the bottom of the Institutional Claim panel. The Value panel will be displayed.

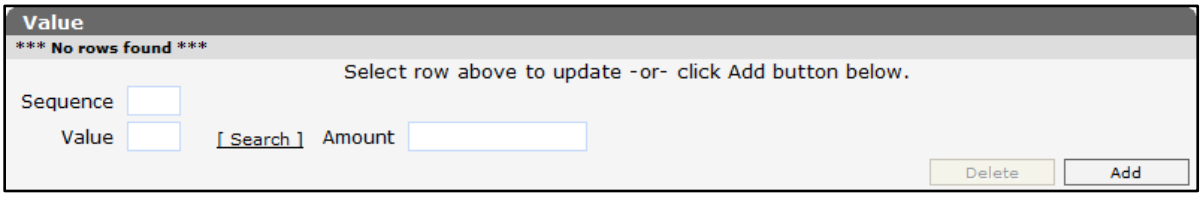

Figure 29 Value Panel

2. Click **Add**. A row will be added to the panel and the fields will activate.

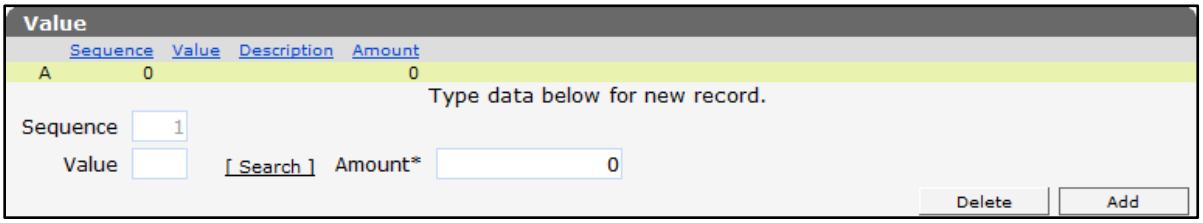

Figure 30 Value Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code that relates values used to identify data elements necessary to process the claim in the Value field or search for a code using the Search link to the right of the field.

4. Enter the amount of the value code used to identify the data elements necessary to process the claim in the Amount field.

5. To add additional value codes to the claim, click **Add** and either enter the code in the Value field or search for a code using the Search link to the right of the field.

6. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.8 Patient Reason for Visit Panel

1. Click **Patient Reason for Visit** at the bottom of the Institutional Claim panel. The Patient Reason for Visit panel will be displayed.

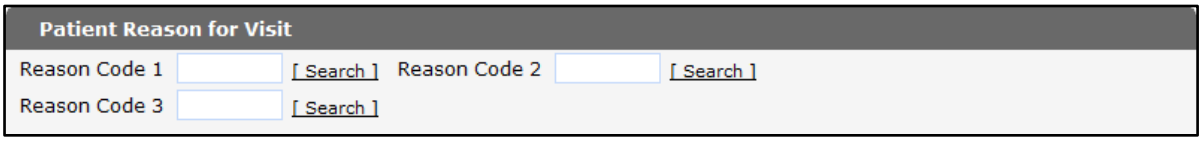

Figure 31 Patient Reason for Visit Panel

2. Enter the ICD diagnosis code identifying the medical condition that caused the member to seek care in the Reason Code 1 field or search for a code using the Search link to the right of the field.

3. If necessary, enter additional codes identifying the medical condition that caused the member to seek care.

3.1.9 External Cause of Morbidity Panel

1. Click **External Cause of Morbidity** at the bottom of the Institutional Claim panel. The External Cause of Morbidity panel will be displayed.

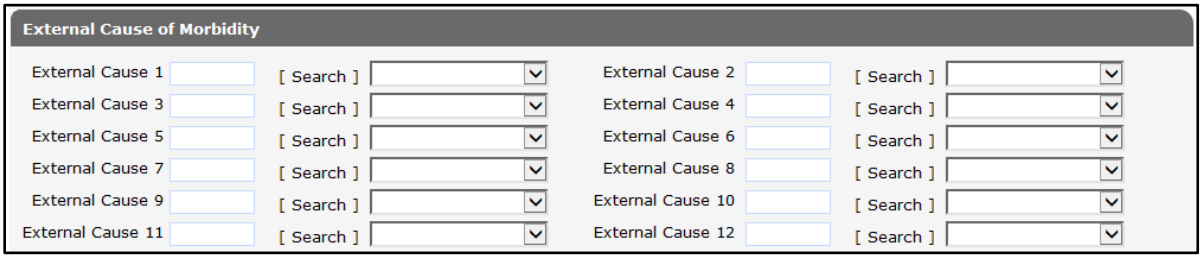

Figure 32 External Cause of Morbidity Panel

2. Enter the ICD diagnosis code that indicates the cause of injury if the injury was from an external source (for example, an accident as opposed to a disease or illness) in the External Cause 1 field or search for a code using the Search link to the right of the field.

3. A POA indicator is required for inpatient claims when the provider or diagnosis code is not exempt from collection of POA information. Select a POA indicator from the drop-down menu. Valid indicators include the following:

   - **Y—Yes/Present**—Indicates the diagnosis was present at the time of inpatient admission.
   - **N—Not Present**—Indicates the diagnosis was not present at the time of inpatient admission.
   - **W—Not Applicable**—Indicates the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
   - **U—Unknown**—Indicates the documentation is insufficient to determine if the condition was present at the time of inpatient admission.

4. If necessary, enter additional codes.

3.1.10 Other Insurance Header Information Panel

The Other Insurance Header Information panel is used to enter header level information for each OI carrier.

1. Click **Other Insurance** at the bottom of the Institutional Claim panel.

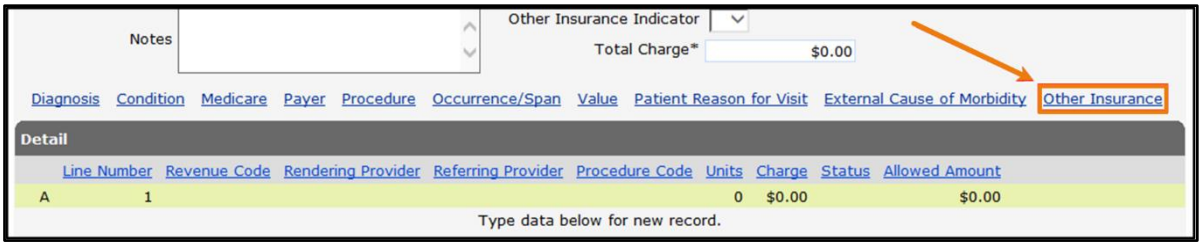

Figure 33 Other Insurance Link

The Other Insurance Header Information panel will be displayed. The Other Insurance Detail Information and Other Insurance EOB Information panels will also be displayed further down the form.

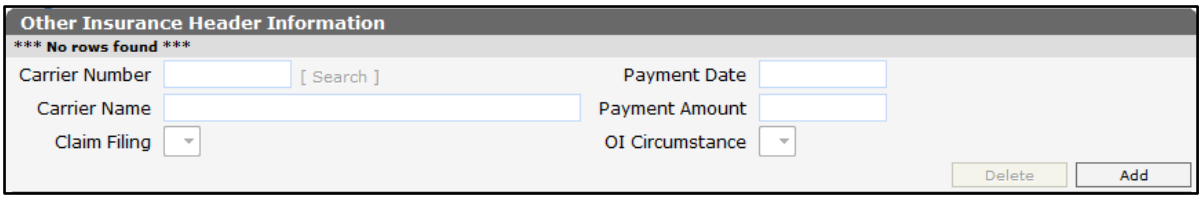

Figure 34 Other Insurance Header Information Panel

2. Click **Add**. The page will refresh, a yellow row will be added to the top of the panel, and the fields will become active to allow for information to be entered.

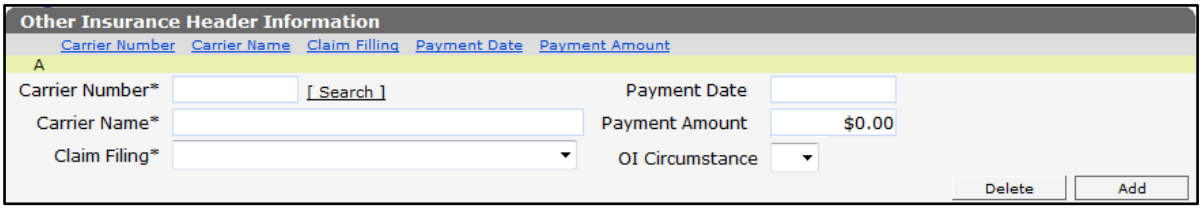

Figure 35 Add Other Insurance

3. Enter a carrier number and name, or search for a carrier using the Search link next to the Carrier Number field.

To search for a Carrier, complete the following steps:

a. Click **Search** to the right of the Carrier Number field. The Carrier Number search panel will be displayed.

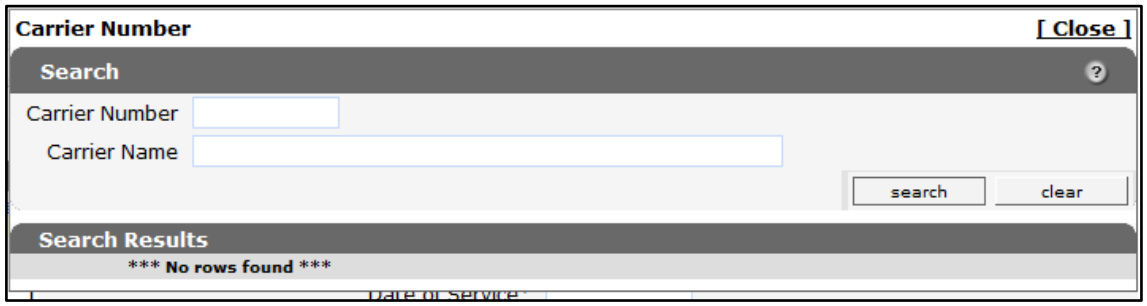

Figure 36 Carrier Number Search Panel

b. Enter a full or partial name for the carrier. The user may search using the carrier number, if known.

c. Click **Search**. Any carrier number matching the query will be displayed in the Search Results section of the panel.

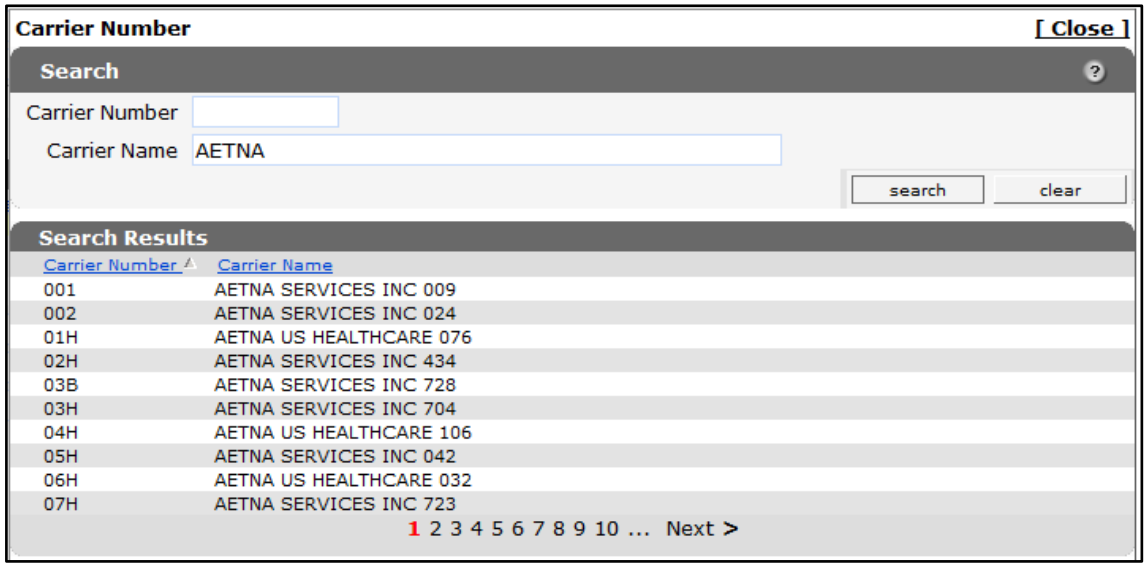

Figure 37 Carrier Number Search Results Panel

d. Click the applicable carrier. The Carrier Number search panel will close, and the selected carrier's number and name will populate the carrier fields.

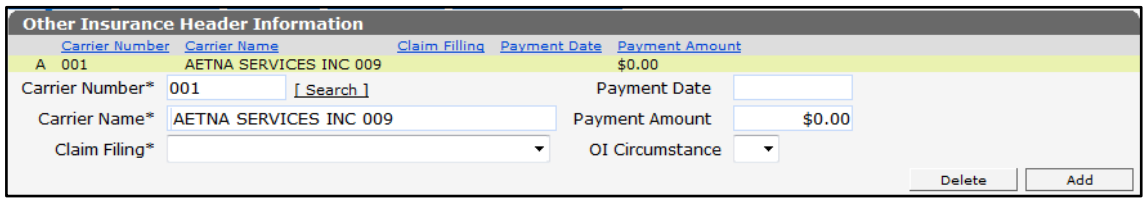

Figure 38 Carrier Number and Name Added to Institutional Claim Form

Note: The above procedure can be used for other search links on the Institutional Claim Form.

4. Add additional carriers to the claim if necessary. To delete a carrier, select the applicable row and click **Delete**.

5. Select the Claim Filing from the drop-down menu.

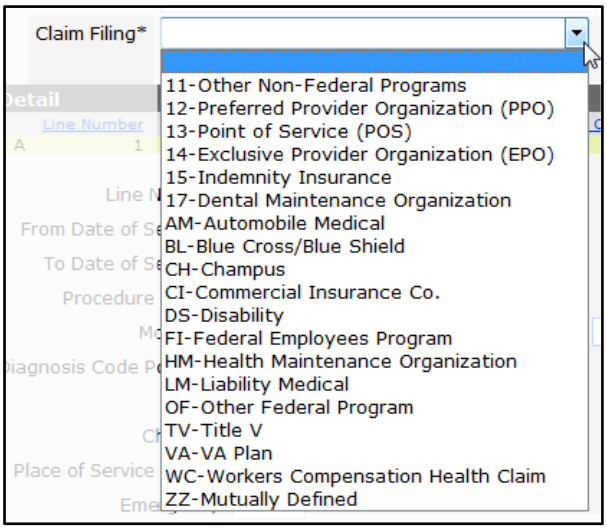

Figure 39 Claim Filing Drop-Down Menu

The claim filing indicates the type of OI billed prior to Medicaid claims submission.

6. Enter the Payment Date.

7. Enter the Payment Amount.

Note: The Payment Date and Payment Amount will not be active if **Y** is selected in the OI Circumstance drop-down menu. If the user inadvertently enters information in these fields and then selects **Y**, the information will be deleted and the fields will be blank.

8. Use the OI Circumstance drop-down menu to select **Y** for any of the reasons listed below.

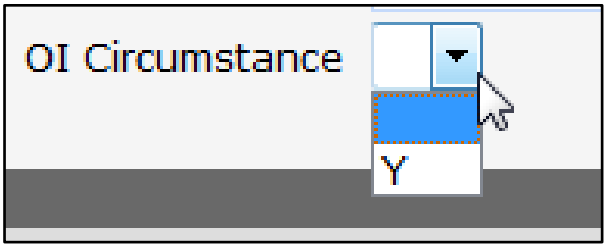

Figure 40 OI Circumstance Drop-Down Menu

A Y indicates the member has commercial health insurance or commercial HMO coverage, but the commercial plan was not billed for reasons including the following:

- The member denied coverage or will not cooperate.

- The provider knows the service in question is not covered by the carrier.
- The member's commercial health insurance failed to respond to initial and follow-up claims.
- Benefits are not assignable or cannot get assignment.
- Benefits are exhausted.

For any carrier where OI Circumstance is set to Y, the user is not allowed to enter a paid amount, paid date, or detail or EOB information.

9. Click **Add** to add any other carriers.

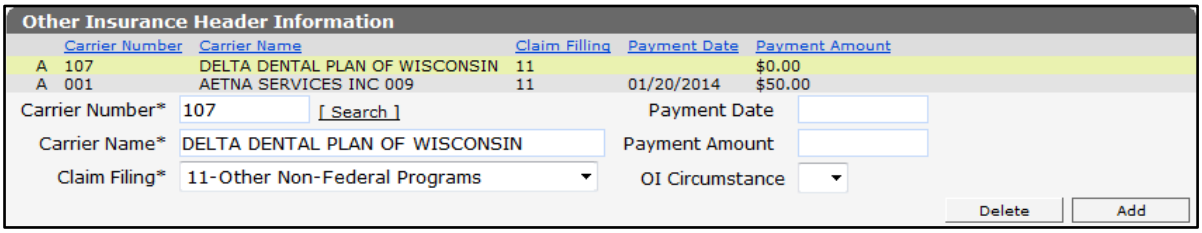

Figure 41 Noncovered Carrier Added to Claim

When finished adding carriers, the information for the last carrier entered will be added to the top row when proceeding to another panel or clicking the Submit button.

3.2 Detail Panel

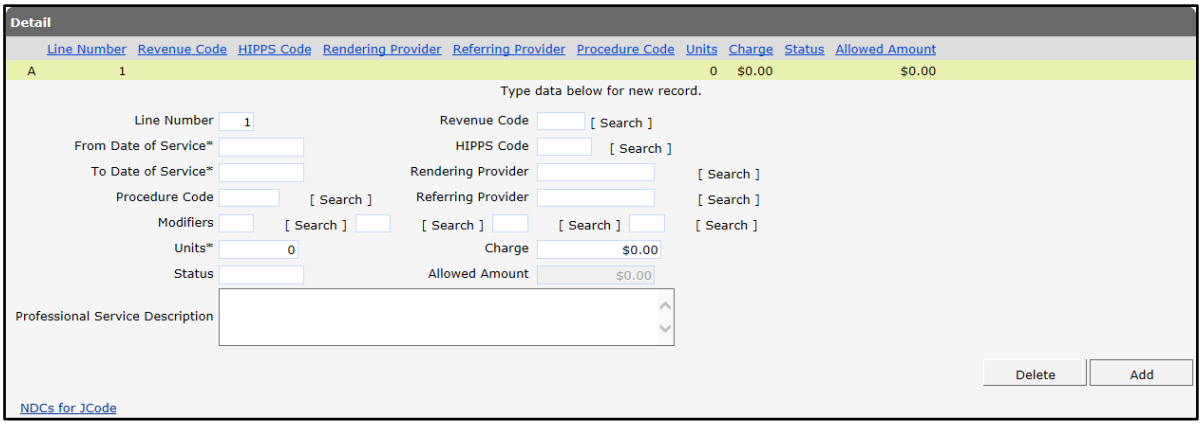

Figure 42 Detail Section

The From Date of Service field is populated with the date entered in the From Date of Service field on the Institutional Claim panel (the header).

The To Date of Service field is populated with the date entered in the To Date of Service field on the Institutional Claim panel (the header).

1. Enter the HCPCS or CPT procedure code that identifies the service performed or provided in the Procedure Code field or search for a code using the Search link to the right of the field.

2. Enter a modifier that provides additional information about the service provided in the first Modifiers field or search for a modifier using the Search link to the right of the field, if applicable. Enter all modifiers that apply to the service provided.

3. If the user indicated a non-specific procedure code, enter a description of the code in the Professional Service Description field.

4. Enter the revenue code that identifies a specific accommodation, ancillary service, or billing calculation in the Revenue Code field or search for a code using the Search link to the right of the field.

5. Enter the Health Insurance Prospective Payment System (HIPPS) code that is used for pricing nursing home (long-term care) claims or search for a code using the Search link to the right of the field. A HIPPS code consists of a series of codes representing a nursing home resident Patient Driven Payment Model classification and the Assessment Indicator.

6. Enter the NPI of the provider performing the services if the rendering provider ID is different from the ID with which the user is logged in and the provider ID was not entered at the header level. Generally, only enter a number if there are two or more rendering providers on the claim and it is necessary to distinguish between the providers at the detail level.

7. Enter the NPI of any provider who referred the member to another provider for services in the Referring Provider field if the provider ID was not entered at the header level.

8. Enter the number of covered accommodation days or ancillary units of service in the Units field.

9. Enter the amount charged for the service provided in the Charge field.

   Information cannot be entered in the Status and Allowed Amount fields. The Status and Allowed Amount fields will be populated when the claim is submitted. The Status field will display the current status of the detail, and the Allowed Amount field will display the amount Wisconsin Medicaid has allowed for the detail.

10. Click **Add** to add more details to the claim. Enter the necessary information for each detail added. Providers may enter up to 999 detail lines per claim.

11. Select the desired row and click **Delete** to remove a detail line. A dialog box will be displayed. Click **OK** to delete the specified row.

3.2.1 NDC Panel

ForwardHealth requires that National Drug Codes (NDCs) be indicated on claims for all provider-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. A provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (for example, nurse, nurse practitioner, physician assistant) or incidental to a physician service.

1. Click **NDC for JCode** at the bottom of the Detail panel. The NDC panel will be displayed.

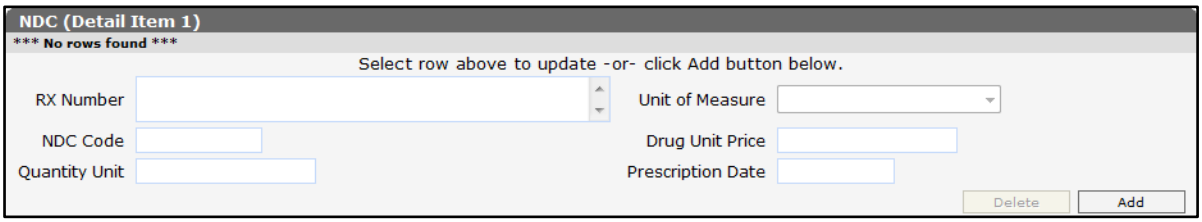

Figure 43 NDC Panel

Note: A corresponding detail line must be added before any information can be entered on the NDC panel.

2. Click **Add**. A row will be added to the NDC panel, and the fields will activate.

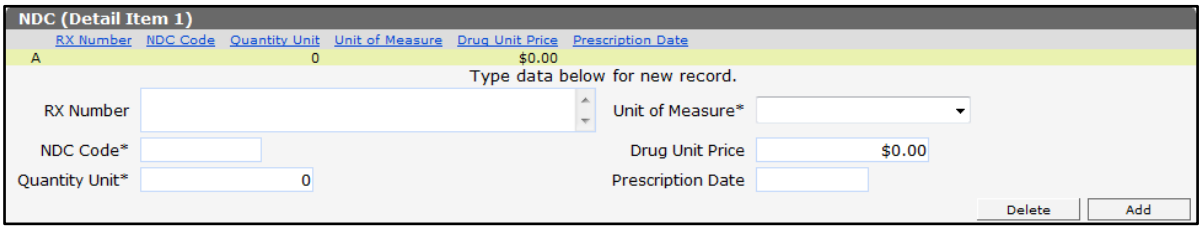

Figure 44 NDC Panel With Added Row

3. If the user added multiple line items to the Detail panel, click the applicable line item from the Detail panel. The NDC panel title will reflect the detail line item selected.
4. Enter the prescription number of the NDC in the RX Number field. If more than three numbers are entered, the up and down arrows will become active, allowing the user to scroll through the information entered.
5. Enter the NDC that supplements the procedure code entered on the detail line item in the NDC Code field.
6. Enter the number of units that are being requested for this claim in the Quantity Unit field.
7. Select one of the applicable Unit of Measure from the drop-down menu:
   - F2—International Unit
   - GR—Gram
   - ME—Milligram
   - ML—Milliliter
   - UN—Unit
8. Enter the price per unit in the Drug Unit Price field.
9. Enter the date of the prescription in the Prescription Date field.

3.3 Other Insurance Detail Information Panel

The Other Insurance Detail Information panel is used to enter OI-related information for the claim details.

If any information is entered in the Other Insurance Detail Information panel, all information must be supplied, even if it seems similar to information entered in the Other Insurance Header Information panel.

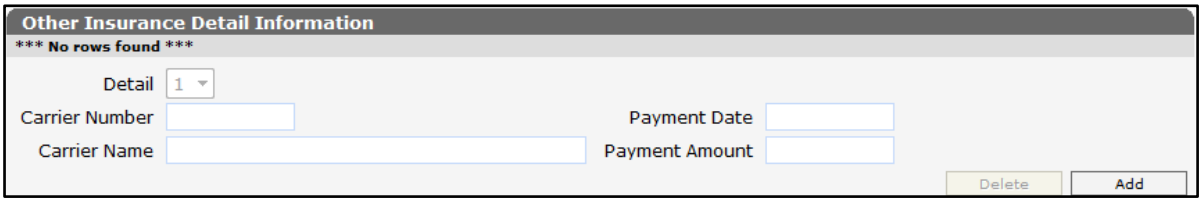

Figure 45 Other Insurance Detail Information Panel

Note: Other Insurance information should be added to the header or both the header and detail depending on how the individual carrier adjudicated the claim:

- If the other payer's EOB to the provider contains detail-specific information, the information should be added to both the header and detail.
- If the other payer adjudicated the claim only at the header (no detail-specific information), the provider can only enter header information.
- If there is more than one other payer involved, it is possible for one payer to be entered only in the header and the other in both the header and detail depending on how the individual carriers adjudicated the claim.

To enter an Other Insurance detail:

1. If there is more than one carrier in the Other Insurance Header Information panel, scroll up to that panel and click the appropriate carrier to add the detail information for that carrier to those fields. The page will refresh and the carrier will be highlighted.

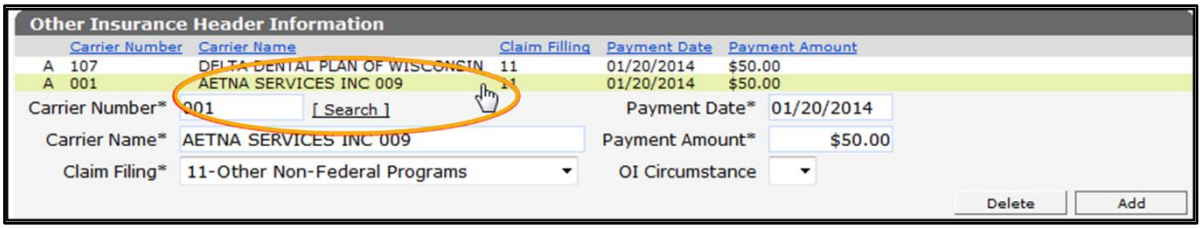

Figure 46 Select Carrier in Header

If there is only one carrier listed in the Other Insurance Header panel, step 1 may be skipped.

2. Return to the Other Insurance Detail Information panel and click **Add**.

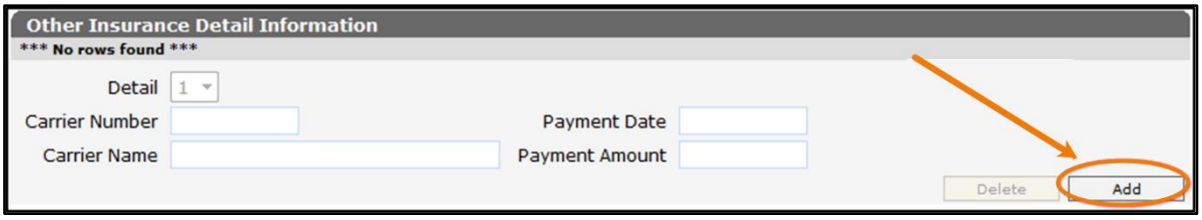

Figure 47 Other Insurance Detail Panel

Note: If **Y** is selected for a carrier in the OI Circumstance field in the header, the user will be unable to add information for that carrier in the Other Insurance Detail Information panel.

The page will refresh, and a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered. The Detail number will display as 1 but can be changed when adding additional information.

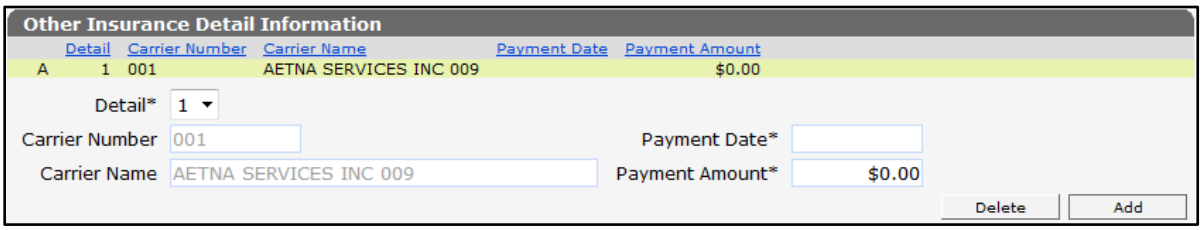

Figure 48 Carrier Added to Other Insurance Detail Information Panel

3. Select the detail number for which the OI information applies from the drop-down menu, if applicable. The default setting is the number of the detail selected on the Other Insurance Detail Information panel. A header value of 0 (zero) is not allowed on this panel.

4. Enter the date the other insurance paid the claim in the Payment Date field.

5. Enter the total amount of dollars the OI carrier paid on the detail in the Payment Amount field.

6. To add another carrier, scroll up to the Other Insurance Header Information panel and click the carrier to add the detail information for that carrier.

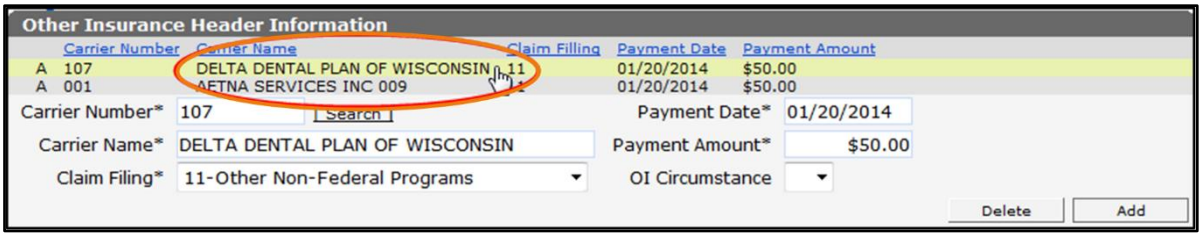

Figure 49 Select Additional Carrier in Header

When returning to the Other Insurance Detail Information panel, the previous carrier's information will be removed and the fields will be grayed out.

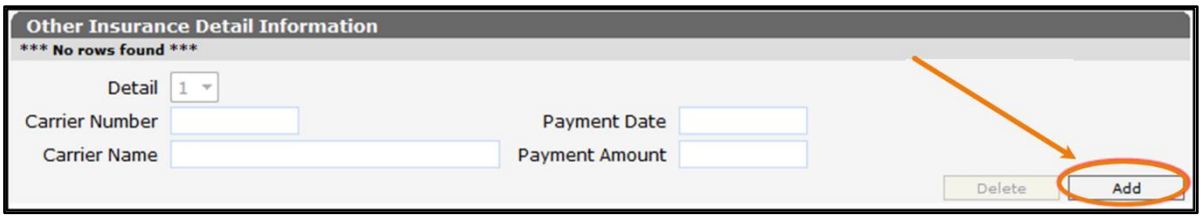

Figure 50 Blank Other Insurance Detail Information Panel

7. Click **Add**. The page will refresh, and a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered.

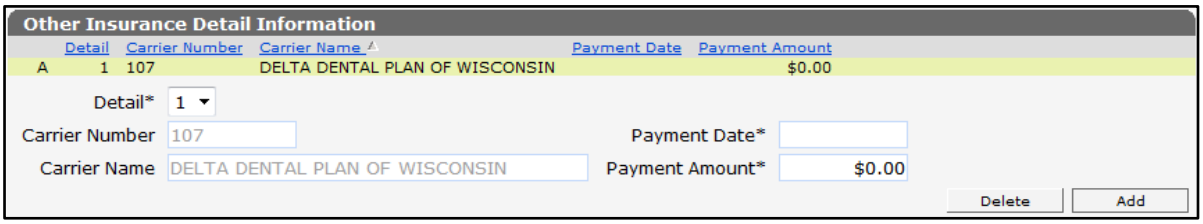

Figure 51 Additional Carrier Added

8. When finished adding carriers, the information for the last carrier entered will be added to the top row when going to another panel or clicking the **Submit** button.

3.4 Other Insurance EOB Information Panel

The Other Insurance EOB Information panel is used to enter the adjustment codes that explain why a carrier did not pay the billed amount.

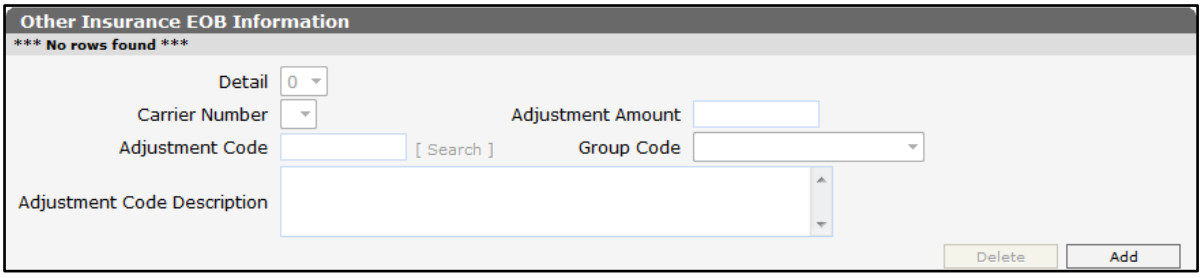

Figure 52 Other Insurance EOB Information Panel

Note: If **Y** is selected for a carrier in the OI Circumstance field in the header, information cannot be added for that carrier in the Other Insurance EOB Information panel.

To enter an OI EOB code:

1. Click **Add**. A yellow row will be added to the top of the panel and the fields will become active to allow further information to be entered.

2. Select the Detail Number from the drop-down menu, if applicable. Leave at 0 (zero) if the OI paid at the header. Detail 0 indicates that the other insurance paid the claim at the header.

3. Use the drop-down menu in the Carrier Number field to select the Carrier Number from the carriers already entered on the claim.

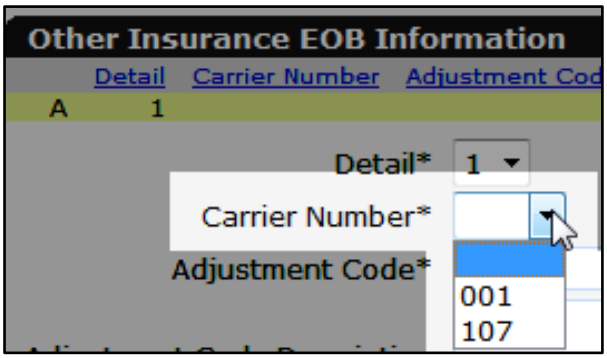

Figure 53 Select Carrier Number

4. In the Adjustment Code field, enter the EOB adjustment code from the carrier's EOB. The EOB description will be entered automatically.

   If an adjustment code is not available, search for one:

   a. Click **Search** to the right of the Adjustment Code field.

Figure 54 Adjustment Code Search Link

   The Adjustment Code search panel will be displayed.

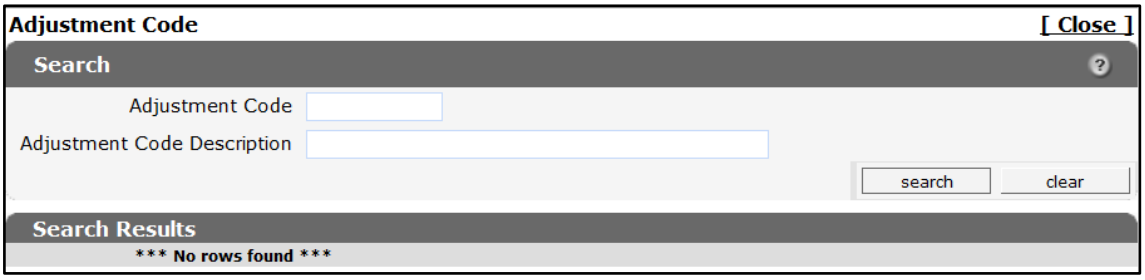

Figure 55 Adjustment Code Search Panel

b. Enter the adjustment code description.

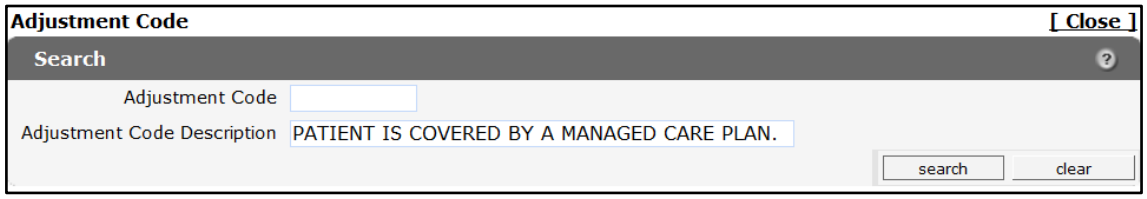

Figure 56 Exact Description

If the exact description is unknown, use the percent (%) symbol as a wildcard to search for any word or group of words in the description.

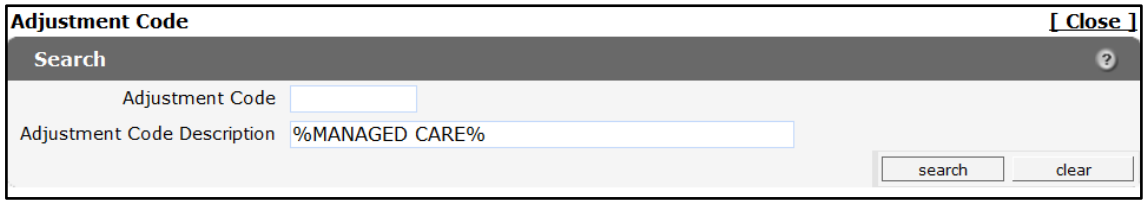

Figure 57 Wild Card Search

c. Click **Search**. The codes matching the query will be displayed in the Search Results section of the panel.

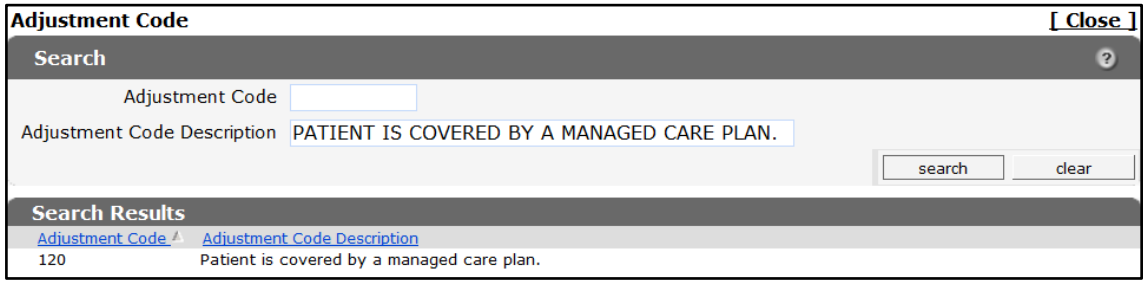

Figure 58 Exact Description Search Results

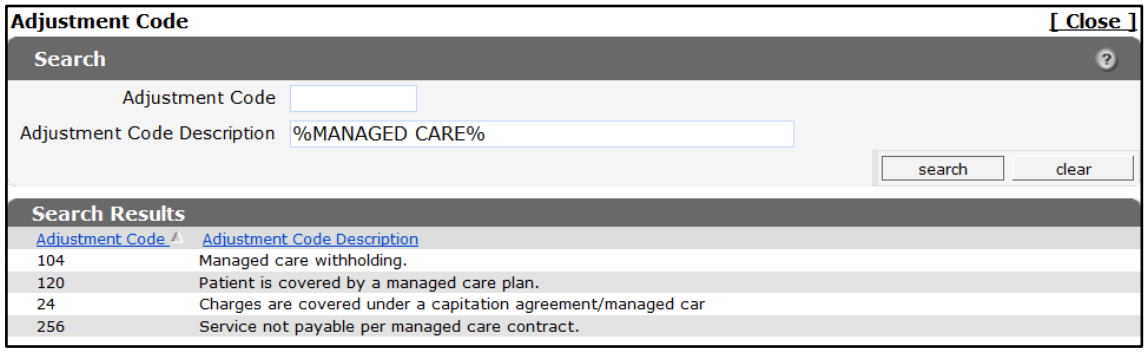

Figure 59 Wild Card Search Results

d. Click the applicable code. The Adjustment Code search panel will close, and the selected adjustment code and description will populate the fields on the Other Insurance EOB Information Panel.

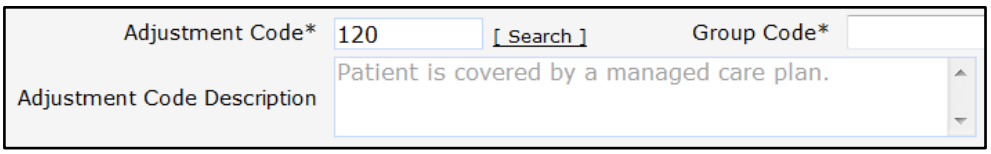

Figure 60 Adjustment Code and Description Added to the Panel

The following list includes some common American National Standards Institute (ANSI) codes that are used by ForwardHealth to process claims. Refer to www.wpc-edi.com/reference/ online for the most current and complete listing of all valid ANSI codes.

Code	Description
1	Deductible Amount.
2	Coinsurance Amount.
3	Co-payment Amount.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
35	Lifetime benefit maximum has been reached.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
66	Blood Deductible.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or National Council for Prescription Drug Programs Reject Reason Code.)
119	Benefit maximum for this time period or occurrence has been reached.
122	Psychiatric reduction.
149	Lifetime benefit maximum has been reached for this service/benefit category.

5. Enter the Adjustment Amount.

6. Select the Group Code from the drop-down menu.

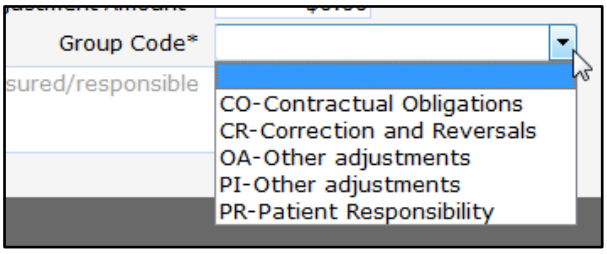

Figure 61 Select Group Code

7. Click **Add** to add additional adjustment codes.

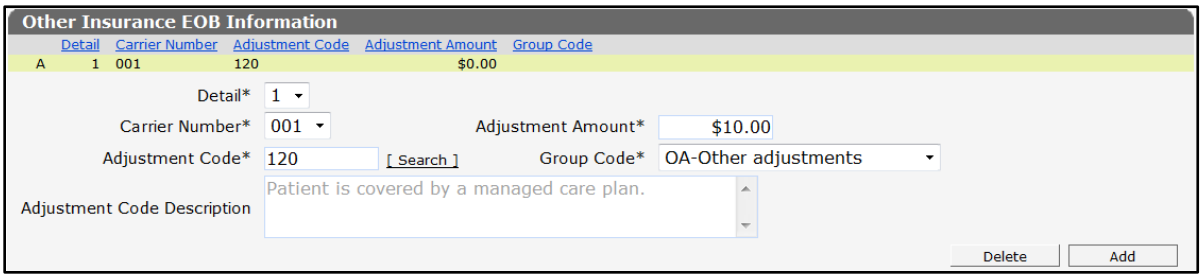

Figure 62 EOB Added

When finished adding EOBs, the last EOB entered will be added to the top row when going on to another panel or clicking the **Submit** button.

3.5 Medicare Information (Detail) Panel

1. Click **Medicare** at the bottom of the Institutional Claim panel. The Medicare Information (Detail) panel will be displayed.

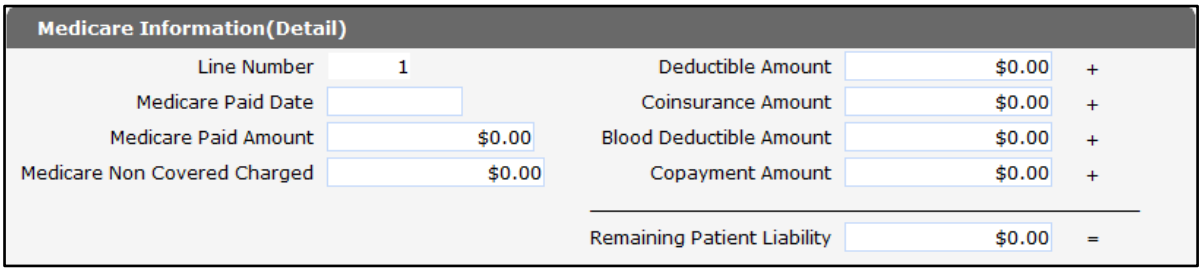

Figure 63 Medicare Information (Detail) Panel

Important: Under the Enhanced Ambulatory Patient Groups reimbursement methodology, providers adjusting or resubmitting outpatient hospital claims for crossover are required to indicate Medicare adjudication amounts (for example, Medicare allowed, paid, coinsurance, copayment, and deductible amounts) on the Detail panel.

Medicare adjudication amounts for inpatient hospital and nursing home must be entered on the Medicare Information (Header) panel.

2. Enter the date that Medicare paid the detail line in the Medicare Paid Date field.

3. Enter the amount Medicare paid for the detail line in the Medicare Paid Amount field.
4. Enter the amount of the detail line not allowed by Medicare in the Medicare Non Covered Charged field.

   Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to Step 19 of 3.1 Institutional Claim Panel to select the appropriate Medicare disclaimer code.
5. Enter the deductible amount (the amount the member is required to pay before Medicare begins to pay) that Medicare applied to the detail line in the Deductible Amount field.
6. Enter the coinsurance amount (percentage of the Medicare payment) indicated by Medicare for the detail line in the Coinsurance Amount field.
7. Enter the dollar amount that Medicare has determined that a member is required to pay for blood work in the Blood Deductible Amount field for that detail line.
8. Enter the copayment amount (percentage of the Medicare payment) indicated by Medicare for the detail line in the Copayment Amount field.
9. Enter the remaining patient liability amount for that detail in the Remaining Patient Liability field. The remaining patient liability must equal the sum of the deductible amount, coinsurance amount, blood deductible amount, and copayment amount.

3.6 Attachments Panel

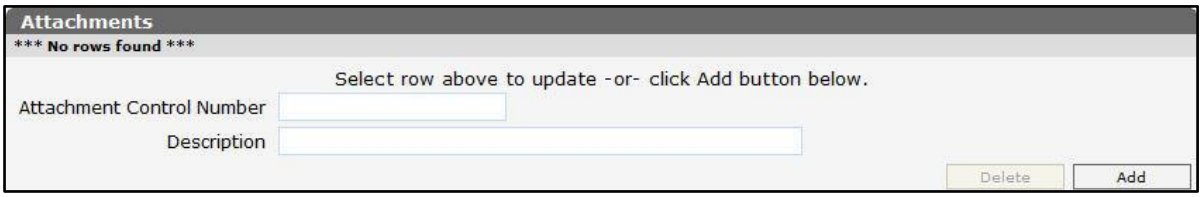

Figure 64 Attachments Panel

1. Click **Add** if any attachments need to be included with the claim. A row will be added to the Attachments panel, and the Description field will activate.

   The Attachment Control Number field is read-only. ForwardHealth will assign a number after the claim is submitted.
2. Enter a description of the attachment being submitted.

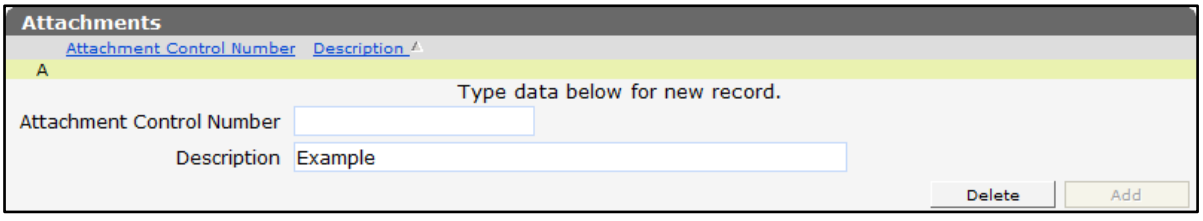

Figure 65 Attachments Panel With Added Row

Note: If it is indicated that an attachment will be included with the claim, the claim will suspend for seven days pending the receipt of the indicated attachment. Users may upload attachments electronically through the Portal or submit the attachment by mail or fax using the Claim Form Attachment Cover Page, F-13470, available on the ForwardHealth Forms page of the Portal.

3.7 Submit the Claim

The Claim Status Information panel at the bottom of the Institutional Claim form will indicate that the claim has not yet been submitted.

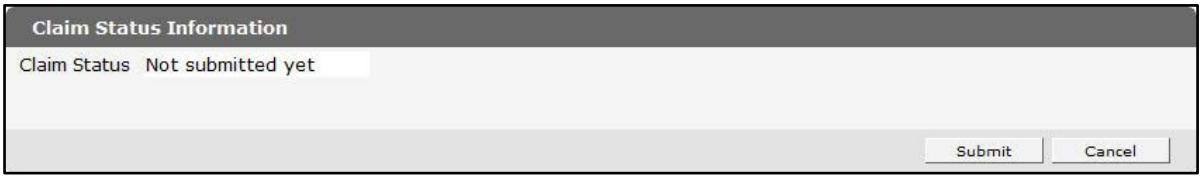

Figure 66 Claim Status Information Panel

1. Ensure that information has been entered in all the required fields on the Institutional Claim form.

   Note: Since there is no Save feature for the Institutional Claim form, if the claim is not submitted successfully and assigned an ICN, all information will be lost.

2. Click **Submit**.

   a. If there is a problem and the claim does not process, an ICN will not be assigned, and an error message that indicates what needs to be corrected will be displayed at the top of the page.

      Note: If information on the Institutional Claim panel (the header) is missing or needs correction, the fields missing the information or needing correction will be yellow; however, fields missing information or needing correction on the rest of the form will remain white.

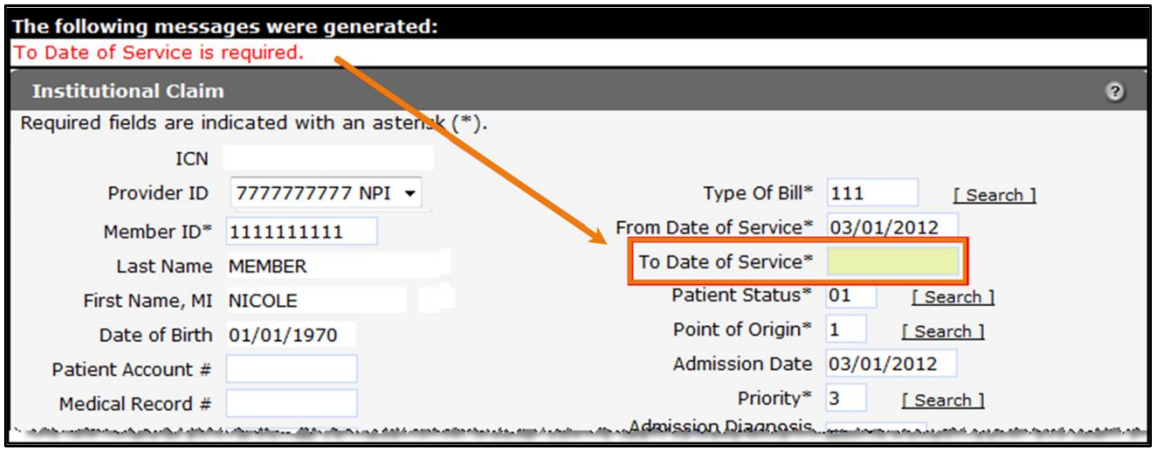

Figure 67 Error Message

b. If an attachment was indicated to be submitted with the claim, the claim will suspend, an attachment control number will be added to the Attachments panel, and the Upload Claim Attachments button will be displayed at the bottom of the page:

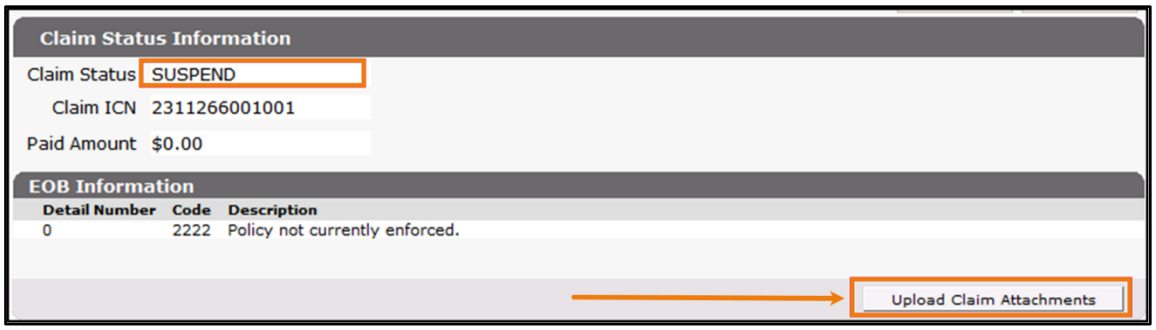

Figure 68 Submitted Claim With Attachments

- If not ready to upload a file, exit from this page or go to another area of the Portal.
- If ready to upload an attachment, click **Upload Claim Attachments**.

The Upload Claim Attachment File panel will be displayed. For information about uploading attachments, refer to the ForwardHealth Portal Uploading Claim Attachments Instruction Sheet, which is located on the User Guides page of the ForwardHealth Portal.

3. If the claim is successfully submitted without an attachment, the Claim Status Information panel will display the ForwardHealth-assigned ICN and the claim's status. In addition, if the claim was priced using a diagnosis-related grouping system, the DRG Results panel will be displayed. The EOB Information panel will also be displayed, indicating how the claim was processed by ForwardHealth.

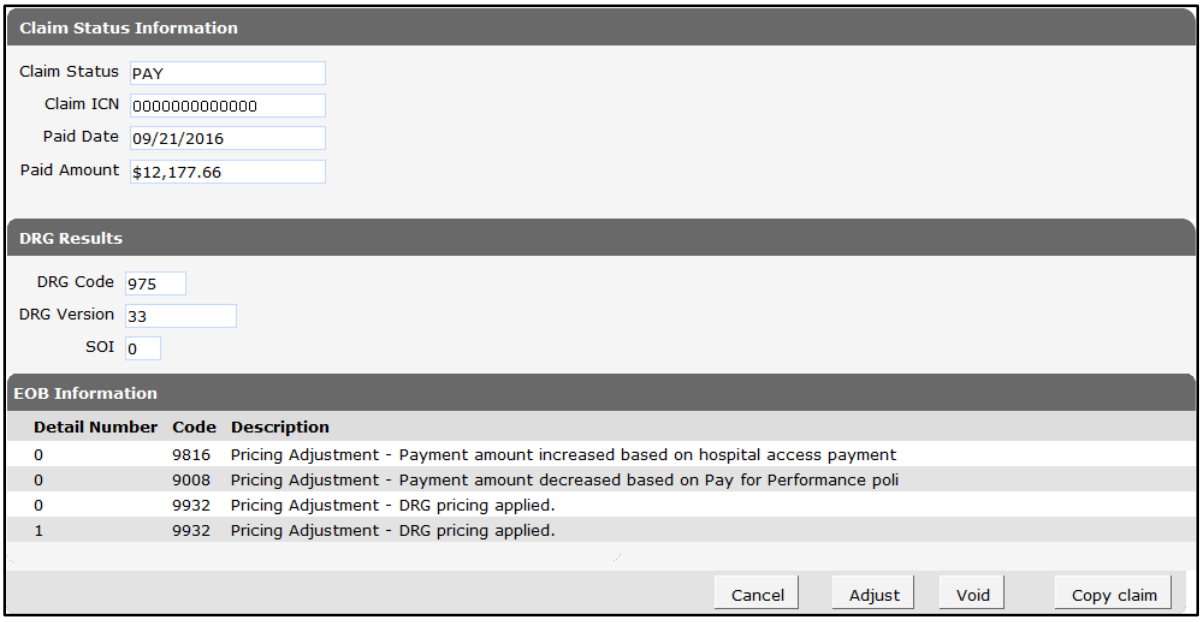

Figure 69 Claim Status Information, DRG Results, and EOB Information Panels

If diagnosis-related grouping was used to price the claim, the DRG Results panel will show the DRG code, DRG version, and severity of illness (SOI) indicator.

If the claim is denied or adjusted, an EOB code or codes will be displayed indicating the reason for the denial or adjustment.