

Wisconsin Provider Electronic Solutions Manual



Provider Electronic Solutions User Manual
for BadgerCare Plus, Wisconsin Medicaid,
Wisconsin AIDS/HIV Drug Assistance Program,
Wisconsin Chronic Disease Program, and
Wisconsin Well Woman Program Providers



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Introduction

Provider Electronic Solutions (PES) is Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant software used for submitting claims to ForwardHealth, which includes four payers: Wisconsin Medicaid, Wisconsin AIDS Drug Assistance Program (ADAP), Wisconsin Chronic Disease Program (WCDP), and Wisconsin Well Woman Program (WWWP). As a payer, Wisconsin Medicaid includes BadgerCare Plus and SeniorCare. PES software cannot be used for submitting claims to Medicare or other commercial health insurance payers. Hewlett Packard Enterprise, the current ForwardHealth fiscal agent, supports PES software. PES is available only to BadgerCare Plus, Wisconsin Medicaid, SeniorCare, ADAP, WCDP, and WWWP providers and electronic billing services and will allow them to submit HIPAA-compliant electronic claims and adjustments to ForwardHealth. This includes the 837 Health Care Claim: Dental (837D), the 837 Health Care Claim: Professional (837P), the 837 Health Care Claim: Institutional (837I), and the National Council for Prescription Drug Programs batch standard version 1.2 (NCPDP 1.2). PES software will instruct you at the appropriate time to select Wisconsin Medicaid, ADAP, WCDP, or WWWP.

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

HIPAA Transactions

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

Transaction	Description
835	Electronic Remittance Advice
837	Health Care Claims: Dental Institutional Professional
999	Functional Acknowledgement
NCPDP 1.2	National Council for Prescription Drug Programs 1.2 Batch
TA1	Interchange Acknowledgement

Equipment Requirements

PES is designed to operate on a personal computer system with the following equipment requirements.

Minimum
Computer with at least a 500 Mhz processor
Windows 2000, XP, or 7 Operating System
100 MB of free disk space available
256 MB RAM
Internet connection
Microsoft Internet Explorer 6.0 or higher or Firefox v. 1.5 or higher
Printer with 8 pt sans serif font (optional)

Note: If you have a version of Internet Explorer below 6.0, you can download a newer version from the Microsoft® website at www.microsoft.com/.

PES Registration and Installation

Registration Enrollment

Prior to submitting claims to the ForwardHealth Electronic Data Interchange (EDI) Department, you will need to complete a Trading Partner Profile form (the form can be submitted online at www.forwardhealth.wi.gov/) and obtain a nine-digit Trading Partner ID and unique nine-digit personal identification number (PIN). Once these numbers are obtained, you may register as an EDI user by establishing an account on the ForwardHealth Portal at www.forwardhealth.wi.gov/. Complete this step before setting up your options.

Note: When creating a username and password during registration enrollment, choose a username that is eight characters in length, and a password that is between eight and 20 characters in length. The password must contain at least one alpha and one numeric character; it may also include the following special characters: @ # \$ % ^. The Web login and password are case sensitive. Enter both in the Batch tab exactly as they were entered when registering.

Installation Types

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

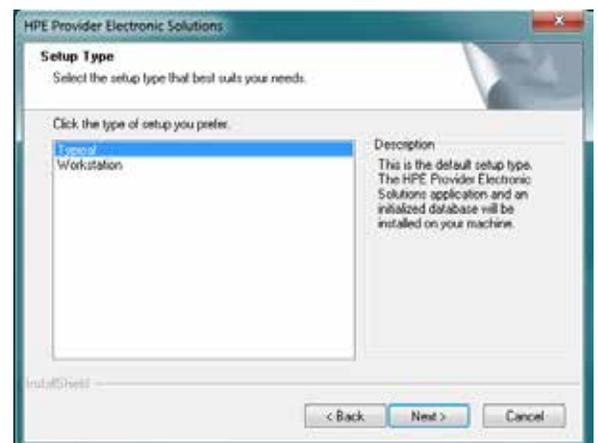
Downloading PES

PES can be downloaded from the Portal.

Complete the following steps. If you experience problems, contact the EDI Department. The EDI Helpdesk telephone number is 866-416-4979.

1. Access the Portal at www.forwardhealth.wi.gov/.
2. Click on the Trading Partners button.
3. Click the Provider Electronic Solutions link. This page contains the PES downloads.
4. Click the link for the WI_v0308_setup.zip file. This will begin the software download.

Type of Installation



Individual PC Installation

Once PES has been downloaded, follow these steps to install the software on your computer:

1. Double-click the WI_v0308_setup.exe icon.
2. The welcome screen displays. Click **Next**.
3. Select type of setup you need. "Typical" is for an individual PC setup. Click **Next**.
4. Click **Next** to accept the default destination for the software.
5. Click **Next** to accept the default destination for the database.
6. Click **OK**. A status bar displays showing the progress of the installation. You can cancel installation at any time by clicking **Cancel**.
7. When installation is complete, click **Finish** to exit installation.

Network Installation

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

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

1. Follow the Individual PC Installation instructions until step 3. When asked what type of installation you desire (step 3 of Individual PC Installation instructions), select "Typical" on the first PC. This computer will be the "primary computer" and will need to be upgraded first when there are new PES updates.
2. Select a target folder on the PC's C: drive or accept the default directory for the PES application.
3. Select a target folder (i.e., a shared network folder or another disk) for the PES database. If you want the PES database to reside in the C:\wihipaa directory, click **Next**.

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

Installation Notes

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

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

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

Getting Started

Opening PES

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

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

Initial Logon

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

In the Password field in the Logon window, enter the password: "hpe-pes." Click **OK**. The next field displayed alerts you that the password has expired.

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

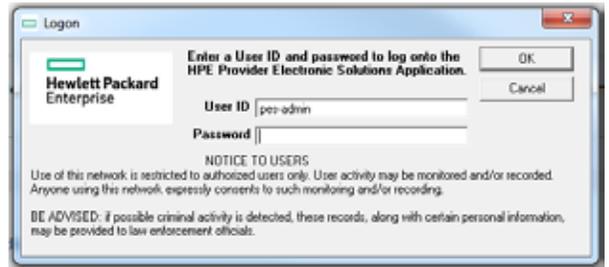
Note: Do not attempt to change the User ID.

Password Rules

Use the following guidelines when choosing passwords:

- Passwords are not case sensitive.
- A password may be any combination of alphabetic, numeric, and special characters.
- A password must be at least five characters in length but no more than 10 characters.

Logon Box



Logon Window

Logon

Hewlett Packard Enterprise

Enter all fields to change a user password on the HPE Provider Electronic Solutions Application.

OK

Cancel

User ID pes-admin

Old Password

New Password

Rekey New Password

Question What is your mother's maiden name?

Answer xxxxxxxx

Rekey Answer xxxxxxxx

Setting Your Password

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

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

Setting Up Options

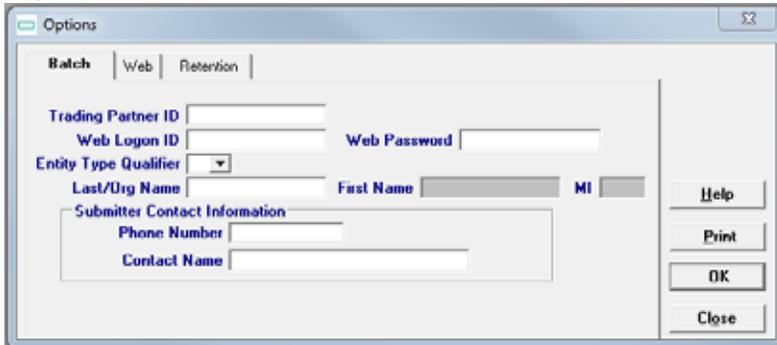
To submit claims and receive information, Options must be set up on each personal computer (PC) the first time you use the software. There are three options that must be confirmed or created. They are Batch, Web, and Retention. The Options window displays with the Batch tab on top.

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

Batch Tab

This tab is used to set up communication protocols with the EDI Department.

Options — Batch Tab



1. Select the Batch tab.
2. Select the Trading Partner ID from the drop-down list. To add items to the drop-down list, double-click the Trading Partner ID field to access the list. The Trading Partner ID can be found on your Trading Partner Profile, which was mailed or emailed back to you upon completion.
3. Enter the Web logon ID (called a username on the registration site) and Web password you created at www.forwardhealth.wi.gov/. The username must be eight characters in length, and the password must be between eight and 20 characters in length and may include the following special characters: @ # \$ % ^. Refer to the PES Registration and Installation chapter of this manual for more information.

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

4. Select the correct Entity Type Qualifier. Choose “Person” (individual provider) or “Non-P” (billing service, group, or facility).
5. Enter the last name of the individual provider or the organization name if a billing service, facility, or group in the Last/Org Name field.
6. In the First Name field, enter the first name of the individual if the Entity Type Qualifier is set to “Person.”
7. Enter the middle initial of the individual provider in the MI field, if applicable.

TIP

Be sure to enter the Web logon and Web password associated with the ForwardHealth trading partner ID you will be using on your PES transactions.

Prior to submitting transactions through PES, you must also make sure your trading partner account is entered as the “Default Provider ID” on the Switch Organization page of the secure Trading Partner account on the ForwardHealth Portal.

8. Enter the telephone number of the person who will be submitting the transaction in the Submitter Contact Information field.
9. Enter the name of the person who will be submitting the transaction in the Submitter Contact Information field.

Web Tab

This tab will allow you to submit claims to the EDI Department using an existing Internet connection.

Testing packets are available on the ForwardHealth Portal at www.forwardhealth.wi.gov/. The testing packets contain requirements for testing connectivity after you successfully complete the Trading Profile forms.

Options — Web Tab



Submitting claims using an existing Internet connection

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

1. Verify that the Use Microsoft Internet Explorer Pre-config Settings check box is checked. Checking this box indicates that the PES application will use the same settings as the Microsoft browser to connect to the Internet. The box is selected by default.
2. Select the appropriate environment indicator. The Environment Ind field defaults to “P” for production environment. Select “T” if this claim is used to test for software connectivity.

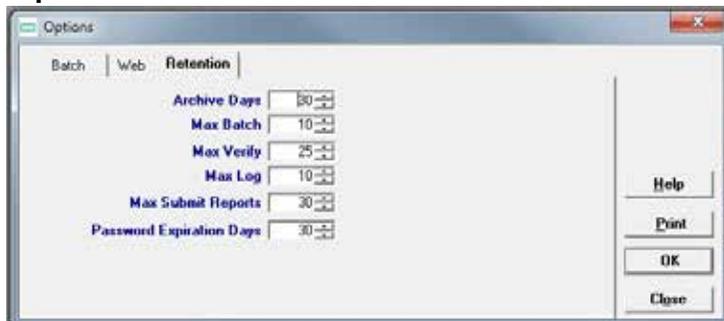
If you need to connect to the Internet using a proxy setting for the PES application, use the following steps:

1. Uncheck the Use Microsoft Internet Explorer Pre-config Settings check box.
2. Select the appropriate connection type. The Connection Type indicates whether the Internet connection is established through a LAN or a modem.
3. Check the Use Proxy Server check box when a proxy server is used to connect to the Internet. The proxy server is commonly used with a LAN connection. If checked, the Proxy Information fields, including Address, Hypertext Transfer Protocol (HTTP) Port, secure Hypertext Transfer Protocol (HTTPS) Port, and Proxy Bypass will be available for entry.
4. Enter a proxy address if you selected Use Proxy Server. This is the IP address or Universal Resource Locator (URL) address of the proxy server used to connect to the Internet. This is a required field if you checked the Use Proxy Server check box.
5. Enter your HTTP port if you selected Use Proxy Server. This is the port number that the proxy server uses for standard HTTP communication. This is a required field if you checked the Use Proxy Server check box.
6. Enter the HTTPS port if you selected Use Proxy Server. This is the port number that the proxy server uses for HTTPS communication. This is a required field if you checked the Use Proxy Server check box.
7. Enter a proxy bypass, if desired, if you selected Use Proxy Server. This is the URL address that does not use the proxy server.

Retention Tab

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

Options — Retention Tab



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

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

Max Batch: The default maximum number of batches is 10. This is the maximum number of batches retained in the resubmission option of the communication menu. Batches on the batch list will be deleted on a first-in/first-out basis. The maximum number of batches that can be retained is 999.

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

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

Max Submit Reports: The default number of submission reports is 30. The maximum number of submission reports that can be retained is 999.

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

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

Basic Skills

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

Using the Keyboard

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

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

Using the Mouse

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

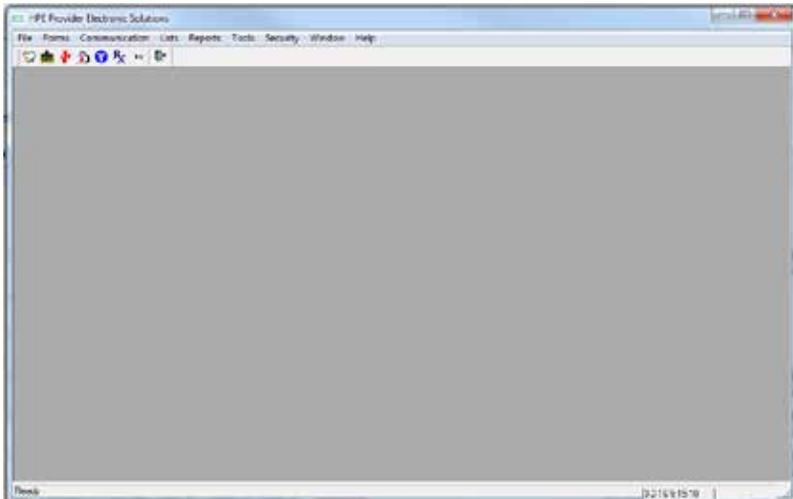
Double-Click: When the down arrow in a field is selected, either a window or a list selection will appear. If no data has been entered in the list, double-click the field to “jump” to it and add the required data. Refer to the Lists chapter for assistance in completing the required fields for each list.

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

PES Main Window

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

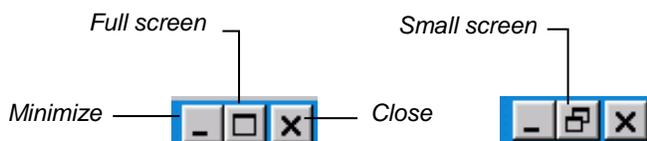
Main Menu Window



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

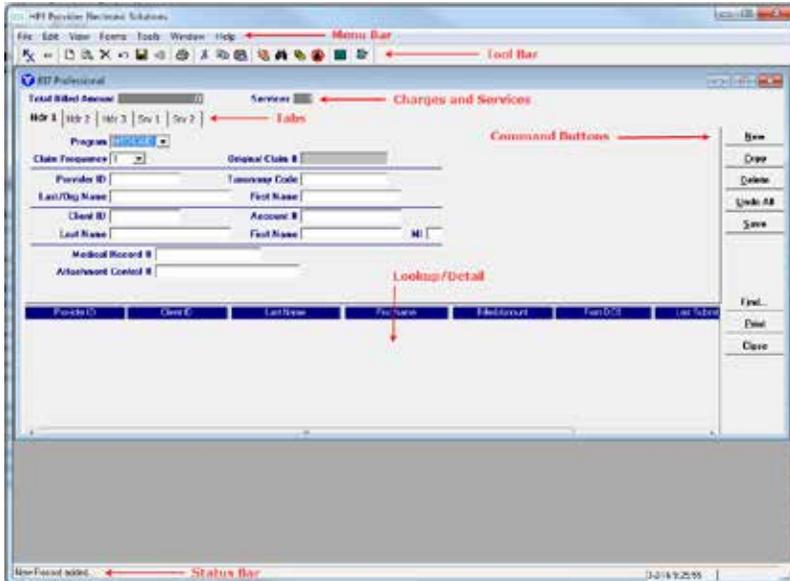
TIP

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



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

PES Window with 837 Professional Form Open



Menu Bar

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

Tool Bar

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

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

Filter: You may limit or filter the forms that are displayed in the detail window. This feature allows you to see only the forms you are interested in while keeping the forms you do not want to see available for future use.

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

Charges and Services

Total Billed Amount: The total charges to be billed to ForwardHealth.

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

Tabs

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

Drop-Down Lists

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

Detail

A detail lists all claims entered for the transaction.

Status Bar

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

Active Window

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

Command Buttons

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

Drop-Down List



Menu Bar

This command...	Allows you to...
File	In the main menu, exit from the application. While in a form, add, delete, save, undo, and print forms.
Forms	Select the online form needed. See the Claims chapters (chs. 6-11) for more information about this option.
Communication	Submit batches of forms and process batch responses, resubmit batches of forms, and view communication log files. See the Communication chapter for more information about this option.
Lists	Add and edit reference lists, which allow the user to collect information to be used when completing transactions within the software. See the Lists chapter for more information about this option.
Reports	Print summary or detail reports with information from forms or reference lists. See the Reports chapter for more information about this option.
Tools	Create and work with archives, perform database maintenance, retrieve upgrades, and change setup options. The Options selection allows the user to set up communication options and determine retention settings. See the Tools chapter for more information about this option.
Security	Prevent unauthorized use of the PES software application. See the Tools chapter for more information.
Windows	Organize windows for most Windows-compatible applications.
Help	Obtain help about PES functions, screens, menus, and fields using Contents and Index. Select About to view information about this application such as version and copyright. To reach help, you may also use F1, or double-click in a field name to get field-specific help.

Toolbar Buttons	
	837 Dental
	837 Institutional Inpatient
	837 Institutional Nursing Home
	837 Institutional Outpatient
	837 Professional
	National Council for Prescription Drug Programs (NCPDP), Batch 1.2 Pharmacy
	NCPDP Pharmacy Reversal

Command Buttons

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

New

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

Copy

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

Delete

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

Undo All

Click this button to reverse all of the changes that you have made to the current form. You will only be able to undo the changes made since the last time you saved the form. You will be asked if you are sure you want to undo; if you click “Yes,” all changes made since the last save will be undone.

Save

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

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

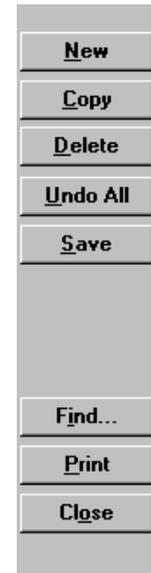
Find

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

Print

Click this button to print data associated to the form you are currently viewing in PES. Claim forms and

Command Buttons



TIP

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

reports are displayed in a report format to be viewed online or may be printed. Lists can also be viewed or printed.

Close

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

Screen-Specific Command Buttons

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

Compound Screen Buttons

Add Ingredient

Click this button to add additional ingredients to a compound drug mixture.

Copy Ingredient

Click this button to copy the current compound drug ingredient information and make changes to it. This feature is helpful when you wish to add drug ingredients that share many of the same elements.

Delete Ingredient

Click this button to delete the compound drug ingredient.



Other Insurance Screen Buttons

Add OI

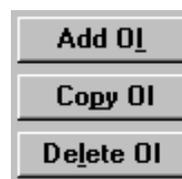
Click this button to add additional commercial insurance carriers to the claim.

Copy OI

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

Delete OI

Click this button to delete the current insurance carrier information.



Service Screen Buttons

Add Srv

Click this button to add additional services to the claim.

Copy Srv

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

Delete Srv

Click this button to delete the current service information.



Service Adjustment Buttons

Add Srv Adj

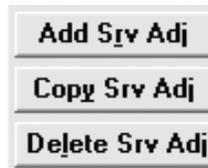
Click this button to add other payer information, including cutbacks and payments, to the claim.

Copy Srv Adj

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

Delete Srv Adj

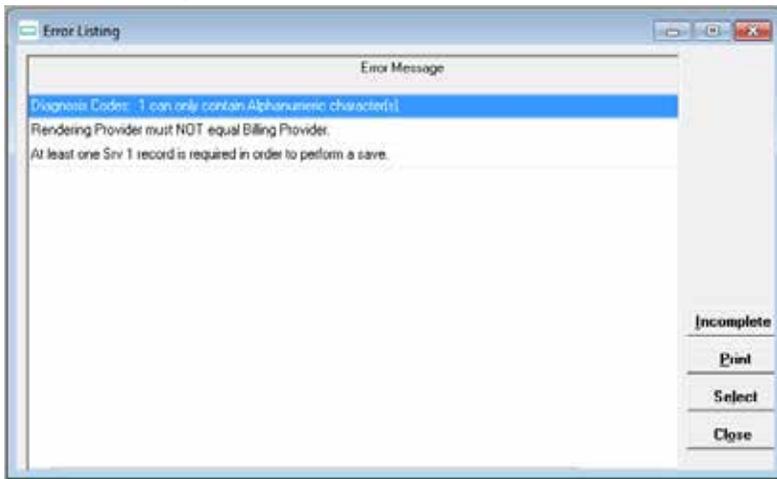
Click this button to delete the current service adjustment information.



Correcting Errors

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

Error Listing



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

Exiting from Forms

Once you complete a form, you have several choices:

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

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

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

TIP

Status Indicators in PES:

A = Archived

F = Finalized

I = Incomplete

R = Ready

Exiting from PES

There are three ways to exit from the PES software:

- Select the **X** in the upper right corner of the screen.
- Select **File** from the menu bar and click **Exit**.

- Click the blue door icon from the toolbar.

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

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

Lists

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

Provider ID	Taxonomy Code	Last/Org Name	Type Qualifier
1111111111	208200000X	PROVIDER	Person

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

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

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

Lists to Build

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

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

- Provider.*
- Client.*

TIP

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

Descriptions can be up to 60 characters and spaces.

- Diagnosis.
- Modifier.
- Other Payer Reject Code.
- Other Provider.*
- Policyholder.*
- Procedure/Healthcare Common Procedure Coding System (HCPCS).
- Taxonomy.
- Trading Partner.

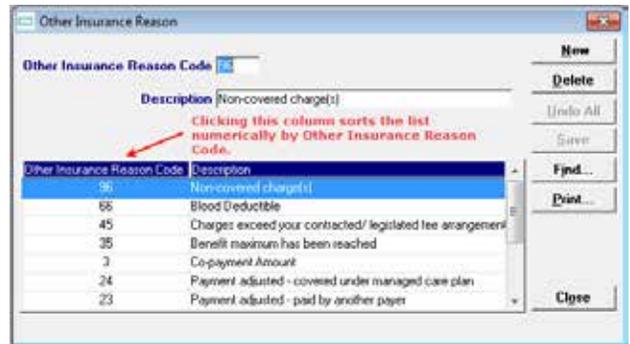
TIP

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

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

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

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



List Appendix

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

Preloaded Lists

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

- Carrier.
- Condition Code.
- Occurrence Code.

- Other Insurance Reason Codes (Adjustment Reason Codes).
- Patient Status.
- Place of Service.
- Program.
Note: The Program list cannot be edited.
- Value Code.
- Visit Point of Origin.
- Visit Priority.



Working with Lists

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

- New:** Click **New** to either change an existing entry in the list or to create a new entry to the list. You must then click **Save** to keep the new/alterd entry.
- Delete:** Click **Delete** to remove an entry from the list.
- Undo All:** Click **Undo All** to clear all of the fields and start over.
- Save:** Click **Save** to enter new data into a list.
- Find:** Click **Find** to locate entries in lists that have data already entered.
- Print:** Click **Print** to make a paper copy of all entries on the list.
- Close:** Click **Close** to exit the list.

Adding Codes to a List

To add codes to any list, follow these steps:

1. Select the **Lists** option.
2. Choose the list to which you wish to add new codes.
3. Click **New**.

4. Enter the code in the Code field.
5. Enter the code description in the Description field. The description can be up to 60 characters and spaces.
6. Click **Save**.

Deleting Codes on a List

To delete codes from a list, follow these steps:

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

Lists

Carrier List

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

Providers may choose from any of the carrier codes listed.

TIP

Spaces, apostrophes, dashes, slashes, periods, and ampersands are allowed characters in the Carrier Name field.

Carrier List	
Field	Description
Carrier Code	Three-character alphanumeric code. Refer to the Lists Appendix for valid codes.
Carrier Code Qualifier	"PI" is for payer identification.
Carrier Name	The name associated with the carrier code.

Client List

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

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

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces and dashes are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System (EVS) and enter the same spelling in PES.

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

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

Condition Code List

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

1. Select the **Lists** option on the menu bar.
2. Select the Condition Code list.

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

Condition Code List	
Field	Description
Condition Code	Enter the two-digit code from the Uniform Billing (UB-04) Manual used to identify conditions relating to the services that may affect payer processing. Refer to the Lists Appendix for valid codes.
Description	Enter the condition code description. The description can be up to 60 characters and spaces.

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

TIP

When entering diagnosis codes, do not use decimals.

Diagnosis List

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

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

TIP

The appropriate ICD code version should be used based on date of service (DOS), date of discharge, or filled date.

TIP

When entering diagnosis codes, for ease of use, identify the ICD code version in the description.

Diagnosis List	
Field	Description
Diagnosis Code	Enter the <i>International Classification of Disease (ICD)</i> diagnosis code.
Description	Enter the description of the diagnosis code. The description can be up to 60 characters and spaces.

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

Modifier List

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

1. Select the **Lists** option on the menu bar.
2. Select the Modifier list.

TIP

Refer to your service-specific *ForwardHealth Updates* and the Online Handbook for applicable modifiers.

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

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

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

Occurrence List

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

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

Occurrence Code List	
Field	Description
Occurrence Code	Enter the two-digit occurrence code from the Uniform Billing (UB-04) Manual or refer to the Lists Appendix for valid codes.
Description	Enter the occurrence code description. The description can be up to 60 characters and spaces.

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

Other Insurance Reason Code List

The Other Insurance Reason Code list is preloaded with a short list of Health Insurance Portability and Accountability Act of 1996 (HIPAA)-approved adjustment reason codes that are used by ForwardHealth to process claims. This list allows you to enter or modify a list of adjustment reason codes used in claim forms by insurance companies and Medicare. As with other lists, once the code is entered into the list, it may be accessed from drop-down fields within

the claim form screens. To enter other insurance reason codes, follow these steps:

1. Select the **Lists** option on the menu bar.
2. Select the Other Insurance Reason list.
3. Enter data into all of the required fields on the screen using the following table as a guide.

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

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

Other Payer Reject Code

The Other Payer Reject Code list allows you to enter frequently used reject codes from the National Council for Prescription Drug Programs (NCPDP) External Code List (ECL), dated September 2010. As with other lists, once entered into the list, the code may be accessed from drop-down fields within the pharmacy claim form.

1. Select the **Lists** option on the menu bar.
2. Select the Other Payer Reject Code list.
3. Enter data into all of the required fields on the screen using the following table as a guide.

Other Payer Reject Code List	
Field	Description
Other Payer Reject Code	Enter the two- to three-digit alphanumeric code indicating the reason for the claim rejection from the other insurance or Medicare.
Description	Enter the reject code description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new other payer reject code.

Other Provider List

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

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

TIP

In the Provider ZIP field on the Other Provider List screen, a ZIP code is required. If a ZIP+4 code is known for the provider, please enter this code; it will help identify the provider's practice location.

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces and dashes are allowed.

Names must be submitted the same way they appear in ForwardHealth files.

Other Provider List	
Field	Description
Provider ID	Enter the National Provider Identifier (NPI) (for health care providers) or provider number (for non-healthcare providers) of the billing/rendering provider.
Provider ID Code Qualifier	Select the type of provider identification number used in the Provider ID field.
Taxonomy Code	Enter the taxonomy code that corresponds to the NPI entered. This field should be left blank for providers who do not use an NPI.
Entity Type Qualifier	Select "Person" for an individual provider or "Non-P" for a group or institution.
Last/Org Name	Enter the last name of the provider if the entity qualifier is "Person" or the organization name if the entity qualifier is "Non-P."
First Name	Enter the first name if the provider is an individual. This field is not required if the entity qualifier is "Non-P."
Provider Address Line 1	Enter the provider's street or mailing address. This field is required.
Provider Address Line 2	This field is optional.
Provider Address City	Enter the name of the provider's city. This field is required.
Provider Address State	Select the two-digit state code designation. This field is required.
Provider ZIP	Enter the provider's ZIP code. This field is required.

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

Patient Status List

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

1. Select the **Lists** option on the menu bar.
2. Select the Patient Status list.

TIP

Providers who have one NPI with multiple taxonomy codes or multiple ZIP+4 codes may make duplicate Provider and Other Provider lists.

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

Patient Status List	
Field	Description
Patient Status	Enter the two-digit code from the Uniform Billing (UB-04) Manual indicating the patient's status as of the statement "covers through" date. Refer to the Lists Appendix for valid codes.
Description	Enter the patient status description. The description can be up to 60 characters and spaces.

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

Place of Service List

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

- Select the **Lists** option on the menu bar.
- Select the Place of Service list.
- Enter data into all of the required fields on the Place of Service screen using the following table as a guide.

TIP

Refer to your service-specific *ForwardHealth Updates* and the Online Handbook for applicable POS codes.

TIP

The NCPDP Pharmacy Claim form has a drop-down list with applicable POS codes for compound and noncompound claims.

Place of Service List	
Field	Description
Place of Service Code	Enter the two-digit POS code. Refer to the Lists Appendix for valid codes.
Description	Enter the POS code description. The description can be up to 60 characters and spaces.

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

Policyholder List

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

TIP

The most common Insurance Type Codes used in the policyholder list are:

- C1: Commercial Insurance
- HM: Health Maintenance Organization
- MB: Medicare Part B
- MP: Medicare Primary

To enter policyholder information, follow these steps:

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

Policyholder List	
Field	Description
Client ID	Select or enter the client's member ID.
Carrier Code	Select the carrier code that identifies the other insurance or Medicare.
Carrier Name	Enter the name of the insurance carrier. The carrier name will default to the carrier code selected.
Insurance Type Code	Select the appropriate value that identifies the type of insurance listed.
Relationship to Insured	Select the appropriate value that identifies the relationship of the client to the policyholder.
Policyholder Information Last Name	Enter the last name of the policyholder of the other insurance or Medicare.
First Name	Enter the first name of the policyholder of the other insurance or Medicare.
ID Code	Enter the policyholder's identification number assigned by the other insurance or Medicare, up to 16 characters in length.
Policyholder Address Line 1	This field will be populated automatically once the Client ID is entered.
Line 2	This field will be populated automatically once the Client ID is entered.
City	This field will be populated automatically once the Client ID is entered.
State	This field will be populated automatically once the Client ID is entered.
ZIP	This field will be populated automatically once the Client ID is entered.

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

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces and dashes are allowed.

Names must be submitted the same way they appear in ForwardHealth files.

TIP

Policyholder address fields will be populated automatically once the Client ID is entered. However, if different or updated address information is available, this function may be overridden.

Procedure/HCPCS List

The Procedure/HCPCS list allows you to create a list of procedure codes used most often when billing on 837 Health Care Claim: Institutional Inpatient, Institutional Outpatient, Professional, and Dental claim forms. As with other lists, once the code is entered into the list, it may be accessed from drop-down fields within the claim form screens.

TIP

The appropriate ICD code version should be used based on DOS, date of discharge, or filled date.

To enter procedure codes, follow these steps:

1. Select the **Lists** option on the menu bar.
2. Select the Procedure/HCPCS list.
3. Enter data into all of the required fields on the Procedure/HCPCS screen using the table below.

TIP

When entering diagnosis codes, for ease of use, identify the ICD code version in the description.

Procedure/HCPCS List	
Field	Description
Procedure/HCPCS	Enter the <i>Current Procedural Terminology (CPT)</i> , <i>Current Dental Terminology (CDT)</i> , HCPCS, or ICD code.
Description	Enter the procedure/HCPCS code description. The description can be up to 60 characters and spaces.

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

Program List

This list is a pre-loaded list that may be accessed from drop-down fields within the claim form screens. The Program list is not available through the Lists option on the menu bar and providers cannot edit or create the Program list. This list allows providers to select the proper program for the claim that is being submitted. Providers should use the following table as a guide when making selections from the Program list.

Program List	
Field	Description
Medicaid	Select "Medicaid" when submitting claims to Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.
WWWP	Select "WWWP" when submitting claims to the Wisconsin Well Woman Program.
WCDP	Select "WCDP" when submitting claims to the Wisconsin Chronic Disease Program for Chronic Renal Disease, Adult Cystic Fibrosis, or Hemophilia Home Care services.
ADAP	Select "ADAP" when submitting claims to the Wisconsin AIDS/HIV Drug Assistance Program.

Provider List

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

TIP

All health care providers are required to use an NPI for PES transactions. However, non-healthcare or "atypical" providers (personal care-only providers, specialized medical vehicle providers, and blood banks) are not required to use an NPI and should use a Medicaid provider number.

To enter a provider, follow these steps:

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

TIP

If you put in a different address in the Provider List field than what is in the ForwardHealth system, PES will *not* update the ForwardHealth system to the address shown on the PES screens.

Provider List	
Field	Description
Provider ID	Enter the NPI (for health care providers) or provider number (for non-healthcare providers) of the billing/rendering provider.
Provider ID Code Qualifier	Select "National Provider Identifier (NPI)" or "Medicaid Provider Number" to indicate the type of number entered in Provider ID.
Taxonomy Code	Enter or select a taxonomy code that corresponds with the NPI entered. The drop-down list can be created using the Taxonomy list screen. Providers who do not use an NPI should leave this field blank.
Entity Type Qualifier	Select "Person" for an individual provider or "Non-P" for a non-person, i.e., a group or institution. All providers billing on the institutional claims, including personal care, home health, and independent nurses, should enter "Non-P" in this field.
Last/Org Name	Enter the last name of the provider if the entity qualifier is "Person" or the organization name if the entity qualifier is "Non-P." Personal care, home health, and independent nurses should enter their last name in this field.
First Name	Enter the first name if the provider is an individual. This field is not required if the entity qualifier is "Non-P."
SSN/Tax ID	Enter the Social Security number (SSN) for an individual provider or the Tax identification number for an organization. You may not enter all zeros in this field. This field is required.
ID Code Qualifier	Select "EIN" to indicate an employer's identification number or "SSN" to indicate an SSN.
Provider Address Line 1	Enter the provider's street or mailing address. Do not enter a Post Office Box in this field.
Provider Address Line 2	This field is not required.
Provider Address City	Enter the name of the provider's city.
Provider Address State	Select the two-digit state code designation.
Provider ZIP	Enter the provider's ZIP+4 code. Do not enter a ZIP+4 code associated with a PO Box in this field.

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

TIP

Providers who have one NPI with multiple taxonomy codes or multiple ZIP+4 codes may make duplicate Provider and Other Provider lists.

TIP

For billing providers, a ZIP+4 code is required in the Provider ZIP field on the Provider List screen. For rendering providers, enter the ZIP+4 code, if possible; it will help identify the provider's practice location.

Revenue Code List

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

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

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

Revenue Code List	
Field	Description
Revenue Code	Enter the four-digit revenue code from the Uniform Billing (UB-04) Manual that identifies a specific accommodation or ancillary service. <i>Note:</i> Code 0001 is no longer valid for electronic claim submission. PES will calculate the total accumulated charge.
Description	Enter the revenue code description. The description can be up to 60 characters and spaces.

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

Taxonomy List

The Taxonomy list allows you to enter taxonomy codes, which are necessary for submitting claims to ForwardHealth for providers who use an NPI. Taxonomy codes entered in this list are available for use when you enter provider information in the Provider list. To enter taxonomy codes, follow these steps:

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

Taxonomy List	
Field	Description
Taxonomy Code	Enter a 10-digit taxonomy code that corresponds to a provider's NPI.
Description	Enter a description for the taxonomy code entered. The description can be up to 60 characters and spaces.

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

Trading Partner List

The Trading Partner list allows you to enter multiple trading partner identification (ID) numbers, which are necessary for submitting claims to ForwardHealth. To enter trading partner IDs, follow these steps:

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

Trading Partner List	
Field	Description
Trading Partner	Enter a nine-digit trading partner ID to submit to interChange.
Description	Enter a description for the trading partner ID entered. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new trading partner ID.

Type of Bill List

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

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

Type of Bill List	
Field	Description
Type of Bill	Enter the three-digit numeric code from the Uniform Billing (UB-04) Manual or the Online Handbook to indicate the specific type of bill. Refer to the Lists Appendix for valid codes.
Description	Enter the type of bill description. The description can be up to 60 characters and spaces.

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

Value Code List

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

1. Select the **Lists** option on the menu bar.
2. Select the Value Code list.
3. Enter data into all of the required fields on the Value Code screen using the following table as a guide.

Value Code List	
Field	Description
Value Code	Enter the two-digit value code found in the Uniform Billing (UB-04) Manual that relates to amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Refer to the Lists Appendix for valid codes.
Description	Enter the value code description. The description can be up to 60 characters and spaces.

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

Visit Point of Origin List

The Visit Point of Origin list, formerly known as Admit Source, is preloaded and allows you to select or modify the list of visit point of origin codes. As with other lists, once the code is entered into the list, it may be accessed from drop-down fields within the institutional claim form screens. To enter or edit visit point of origin codes, follow these steps:

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

Visit Point of Origin List	
Field	Description
Visit Point of Origin Code	Enter or select the visit point of origin code. These codes are required for inpatient and nursing home claims. Refer to the Lists Appendix for valid codes.
Description	Enter the visit point of origin description. The description can be up to 60 characters and spaces.

4. Click **Save** to save the data or **New** to add a new visit point of origin code.

Visit Priority List

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

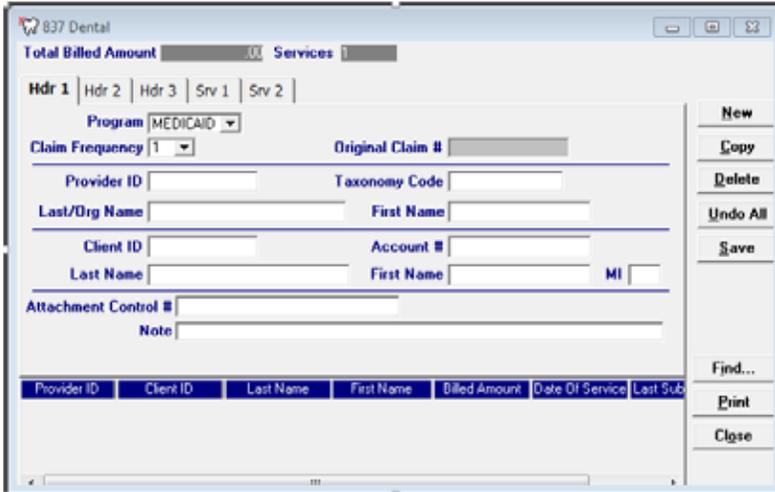
1. Select the **Lists** option on the menu bar.
2. Select the Visit Priority list.
3. Enter data into all of the required fields on the Visit Priority screen using the table below as a guide.

Visit Priority List	
Field	Description
Visit Priority Code	Enter the visit priority codes from the Uniform Billing (UB-04) Manual. Only codes 1, 2, 3, and 4 are acceptable. These codes are required for inpatient claims. Refer to the Lists Appendix for valid codes.
Description	Enter the visit priority code description. The description can be up to 60 characters and spaces.

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

Dental Claims

The 837 Dental claim form has several screens necessary for completing a Medicaid or Wisconsin Chronic Disease Program (WCDP) claim, depending on your provider type. These screens include:



The screenshot shows the '837 Dental' software window. At the top, there are fields for 'Total Billed Amount' and 'Services'. Below this is a header section with 'Hdr 1', 'Hdr 2', 'Hdr 3', 'Srv 1', and 'Srv 2'. The main form area includes a 'Program' dropdown menu set to 'MEDICAID', a 'Claim Frequency' dropdown set to '1', and an 'Original Claim #' field. There are several text input fields for 'Provider ID', 'Taxonomy Code', 'Last/Org Name', 'First Name', 'Client ID', 'Account #', 'Last Name', 'First Name', and 'MI'. An 'Attachment Control #' field and a 'Note' text area are also present. On the right side, there is a vertical toolbar with buttons for 'New', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close'. At the bottom, a table header is visible with columns: 'Provider ID', 'Client ID', 'Last Name', 'First Name', 'Billed Amount', 'Date Of Service', and 'Last Sub'.

- Headers 1-3.
- Services 1 and 2.
- Other Insurance.
- Other Insurance Adjustments.
- Other Insurance Service Adjustments.

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System and enter the same spelling in Provider Electronic Solutions (PES).

TIP

Providers may submit paper attachments to electronic claims submitted through PES. Enter an Attachment Control Number (ACN) in the Header 1 screen and mail the paper attachment to ForwardHealth within 30 calendar days of claim submission. You must include the Claim Form Attachment Cover Page, F-13470, with the paper attachment and indicate the same ACN on the form. ForwardHealth forms are available via the ForwardHealth Portal, www.forwardhealth.wi.gov/. If ForwardHealth does not receive the attachment within the 30-day deadline, the claim will be processed without the attachment and may be denied.

Completing New Dental Claims

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

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

Dental Header 1	
Field	Description
Program	Select Medicaid or WCDP.
Claim Frequency	Select "1" to submit an original claim.
Provider ID	Select the National Provider Identifier (for health care providers) or the provider number (for non-healthcare providers) of the billing provider.
Client ID	Select the client's member identification number.
Attachment Control # (optional)	Enter the ACN that corresponds to the paper attachment for this claim, if applicable. The ACN may be two to 80 characters long and is chosen by the provider.
Note	Enter a description of the service for an unlisted, or not otherwise classified, procedure code. The note may be up to 80 characters long.

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

TIP

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

Dental Header 2	
Field	Description
Diagnosis Codes	Enter up to four <i>International Classification of Disease</i> (ICD) diagnosis codes in the fields provided. The primary diagnosis code must be entered in the first field. This field is optional.
Place of Service	Enter or select the two-digit place of service (POS) code. The same POS code cannot be entered both here and on the Service 1 screen.
Emergency Ind	Select "Y" if the service was emergency related. If "Y" is selected, bill nonemergency services on a separate claim. This field defaults to "N."
Orthodontic Treatment Total Months	Enter the total number of months of orthodontic treatment, if applicable. This field is required for orthodontic services only.
Months Remaining	Enter the number of treatment months remaining for a transfer patient, if applicable. This field applies to orthodontics only.
Rendering Provider Provider ID	Select the provider number of the rendering (performing) provider, if different from the billing provider.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for dental services.

4. If the service was rendered at a different location than the billing provider's address, select the Header 3 tab.
5. Enter data into the required field on Header 3 using the following table as a guide.

TIP

Place of service codes entered on Header 2 will apply to all lines on the claim unless overridden by POS codes entered on the Service 1 tab.

Dental Header 3

Field	Description
Facility ID	Enter or select the service facility. To enter a service facility, double-click to access the Other Provider List and enter data into all of the required fields.

6. If you do not have other insurance information to enter, proceed to step 11.
7. If you have other insurance information to enter, select the OI tab.
8. Enter data into all of the required fields on the OI tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Dental OI

Field	Description
Benefits Assignment	Select "Yes" or "No" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the policyholder's carrier code. Then press <i>Save</i> to populate the Policyholder Last Name and First Name fields.

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

TIP

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

Dental OI Adjustment

Field	Description
OI Y	Select "Y" if other insurance exists but was not billed for the reasons described in the ForwardHealth Online Handbook. This field defaults to "N." If you indicate "Y" for OI Y, refer to the Claim Filing Ind Code under the Dental OI tab.
Paid Date/Amount	Enter the date that other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by the other insurance. This field is required if it is not entered on the service adjustment tab.
Remaining Patient Liability Amt	Enter the amount that remains to be paid after the other insurance has adjudicated the claim, if applicable.
Adjustment Group Codes	Select the code identifying the general category of payment adjustment by other insurance, if applicable. Enter "PR" if insurance deductible, coinsurance, or co-pay has been indicated on the insurance claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This field is only required if an insurance carrier did not pay the claim in full.

Dental OI Adjustment	
Field	Description
Reason Codes/Amounts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — given by the other insurance. Enter the amount indicated by other insurance for each reason code. This field is only required if an insurance carrier did not pay the claim in full.

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

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

- Select the Service 1 tab.
- Enter data into all of the required fields on the Service 1 tab using the following table as a guide.

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

Dental Service 1	
Field	Description
Diagnosis Codes	These fields display the diagnosis codes entered on the Header 2 tab. These fields may only be edited on the Header 2 tab.
Date of Service	Enter the DOS using the MM/DD/CCYY format.
Place of Service	Enter or select the two-digit POS code here, only if it is different from the POS indicated on the Header 2 tab.
Diag Ptr 1	Enter the number(s) of the appropriate ICD diagnosis code(s) (listed in the diagnosis code fields at the top of the tab) that apply to this detail. Valid diagnosis pointers are digits 1 through 4.
Procedure	Enter or select the <i>Current Dental Terminology</i> (CDT) procedure code.
Modifiers	Enter or select the two-digit modifier(s), if applicable.
Tooth	Enter the tooth number, if applicable.
Surfaces	Select the surface(s), if applicable.
Oral Cavity Designation	Select the area(s), if applicable. The areas of the oral cavity are designated by a two-digit code; where at least one digit is zero, the valid values for these areas can be found in the CDT book.
Placement Ind	Select the placement indicator, if applicable. If the placement indicator is "R," the placement date must be completed using the MM/DD/CCYY format. This field is for use with prosthodontics only.
Prior Placement Date	Enter the prior placement date of the prosthetic, if a replacement was indicated in the Placement Ind field.
Units	Enter the number of units performed for the service billed. Example: 1.00 = 1 unit.
Billed Amount	Enter the total charges for the services rendered.

- Select the Service 2 tab.
- Enter data into all of the required fields on the Service 2 tab using the following table as a guide.

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

15. If Other Insurance did not make service-level payments, proceed to step 18.

16. If Other Insurance made service-level payment, select the Srv Adj tab.

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

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

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

Correcting Errors on Dental Claims

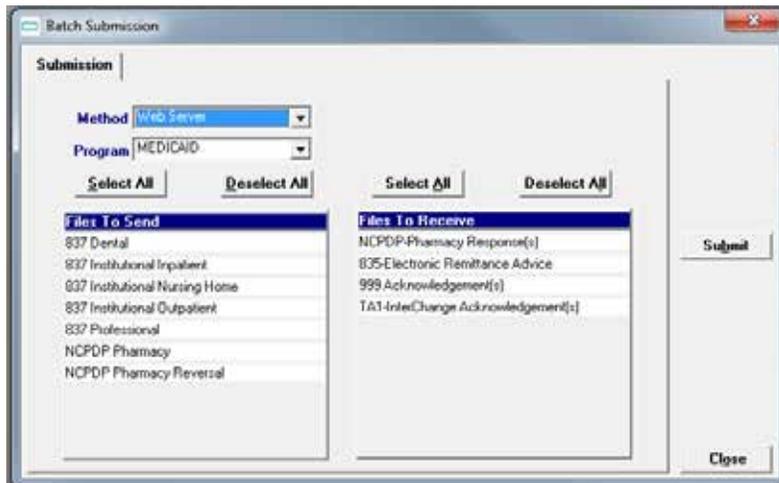
If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

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

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

Submitting New Dental Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Electronic Data Interchange (EDI) Department.



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

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

Resubmitting Dental Claims

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

TIP

To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

TIP

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

TIP

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

Resubmitting a Single Claim

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

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

Resubmitting or Copying a Partial or Entire Batch

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

1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by:

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

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

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

4. The Batch Submission window will display.

5. Select "Web Server" from the Method field.
6. Click on the appropriate form type(s) under Files to Send.
7. Click **Submit**.
8. PES will post messages in the Transmission window updating you on the progress of the transmission.

Adjusting Paid Status Dental Claims

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

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select "7" in the Claim Frequency field.
4. Enter the 13-digit internal control number (ICN) in the Original Claim # field. Refer to your Remittance Advice for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make adjustments to the incorrect portions of the claim as needed.

Note: In addition to the adjusted information, all correct details of the original claim must be included, as all details and amounts will be resubmitted in your adjustment.

6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select "Web Server" from the Method field.
10. Select "Medicaid" or "WCDP" from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

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

Voiding Dental Claims

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

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select "8" in the Claim Frequency field.
4. Enter the 13-digit ICN in the Original Claim # field.
5. Click **Save**.
6. Click on **Communication** on the menu bar.
7. Click on **Submission**.
8. Select "Web Server" from the Method field.
9. Select "Medicaid" or "WCDP" from the Program field.
10. Click on the appropriate form type under Files to Send.
11. Click **Submit**.

Professional Claims

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

- Headers 1-4.
- Services 1 and 2.
- Ambulance.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.
- Rx.

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System and enter the same spelling in Provider Electronic Solutions (PES).

TIP

Providers may submit paper attachments to electronic claims submitted through PES. Enter an Attachment Control Number (ACN) in the Header 1 screen and mail the paper attachment to ForwardHealth within 30 calendar days of claim submission. You must include the Claim Form Attachment Cover Page, F-13470, with the paper attachment and indicate the same ACN on the form. ForwardHealth forms are available via the ForwardHealth Portal, www.forwardhealth.wi.gov/. If ForwardHealth does not receive the attachment within the 30-day deadline, the claim will be processed without the attachment and may be denied.

Completing New Professional Claims

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

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

Professional Header 1	
Field	Description
Program	Select Medicaid, WWWP, or WCDP.
Claim Frequency	Select "1" to submit an original claim.
Provider ID	Select the National Provider Identifier (for health care providers) or provider number (for non-healthcare providers) of the billing provider.
Client ID	Select the member identification number.
Medical Record #	Enter the medical record number that identifies the client in your records. This field is optional.
Attachment Control # (optional)	Enter the ACN for the corresponding paper attachment to this claim, if applicable. The ACN may be two to 80 characters long and is chosen by the provider.

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

Professional Header 2	
Field	Description
Diagnosis Codes	Enter the <i>International Classification of Disease</i> (ICD) diagnosis code(s) related to the visit.
Referring Provider Provider ID	Select the provider identification number that identifies the referring provider, if applicable.
Place of Service	Enter or select the two-digit place of service (POS) code.
Onset of Current Illness Date	Enter the date when the onset of the patient's illness or symptoms is different from the date of service (DOS), if applicable. Use the MM/DD/CCYY format.
Rendering Provider Provider ID	Select the rendering provider identification number if it is different from the billing provider and required for your provider type and/or specialty.

4. Select the Header 3 tab.

TIP

POS codes entered on Header 2 will apply to all lines on the claim unless overridden POS codes entered on the Service 1 tab.

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

Professional Header 3	
Field	Description
Accident Related Causes	Select the related cause value(s) if the services are a result of an accident. If "AA" is selected, enter the state and country where the accident occurred.
Date	Enter the date the accident occurred, if applicable.
Condition Codes	Enter any condition codes applicable to the claim using the drop-down list.
Anesthesia Related Surgical Procedure	Enter the primary and secondary anesthesia-related surgical procedure codes, if applicable.
Patient Weight	Enter the patient's weight.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for professional services.
Initial Treatment Date	Enter the initial treatment date for chiropractic spell of illness, if applicable.
Medicare Ind	Select "Y" if the client has Medicare coverage for professional services.
Ambulance Ind	Select "Y" if the client was transported by ambulance.

- If the service was rendered at a different location than the billing provider's address, select the Header 4 tab.
- Enter data into the required field on Header 4 using the following table as a guide.

Professional Header 4	
Field	Description
Facility ID	Enter or select the service facility. To enter a service facility, double-click to access the Other Provider List and enter data into all of the required fields.

- If you do not have ambulance trip information to enter, proceed to step 10.
- Enter data into all the required fields on the Ambulance tab using the following table as a guide.

Professional Ambulance	
Field	Description
Ambulance Pick-Up Location	Enter address information for the location at which the member was picked up.
Ambulance Drop-Off Location	Enter the name of the facility to which the member was transported in the "Location" field and enter address information for that location in the appropriate fields.

- If you do not have commercial insurance carrier information to enter, proceed to step 15.
- If you have commercial insurance carrier information to enter, select the OI tab.

TIP

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

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

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

Professional OI	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the policyholder carrier code. Then tab off the field to populate the Policyholder Last Name and First Name fields.

13. Select the OI Adj tab.

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

TIP

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

Professional OI Adjustment	
Field	Description
OI-Y	Select "Y" if other insurance exists but was not billed for reasons described in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Professional OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid by other insurance (if applicable). This field is required if the information was not entered in the service adjustment tab.
Remaining Patient Liability	Enter the amount that remains to be paid after the other insurance has adjudicated the claim, if applicable.
Adjustment Group Codes	Select the code identifying the general category of payment adjustment by the other insurance, if applicable. Enter "PR" if insurance deductible, coinsurance, or co-pay has been indicated on the insurance claim or Remittance Advice (RA). If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This field is only required if an insurance carrier did not pay the claim in full.
Reason Codes/Amounts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance (if applicable). Enter the amount indicated by the other insurance for each reason code. This field is only required if an insurance carrier did not pay the claim in full.

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

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

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

Professional Medicare	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This field defaults to "MB."
Carrier Code	Select the carrier code for the policyholder. Tab off the field to populate the policyholder first and last name fields.
M-8	Select "Y" if Medicare exists, but was not billed for reasons described in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N."
Paid Date/Amount	Enter the amount paid by Medicare in the Paid Amount field. The Paid Date field is grayed out as the information is now entered on the service adjustment detail screen.
Remaining Patient Liability	Enter the amount that remains to be paid after Medicare has adjudicated the claim, if applicable.
Adjustment Group Codes	These fields are grayed out as the information is now entered on the service adjustment detail screen.
Reason Codes/Amounts	These fields are grayed out as the information is now entered on the service adjustment detail screen.

TIP

If Medicare paid for part of the claim, providers are required to fill out the the Paid Amount field.

TIP

Medicare information for each detail is entered on the service adjustment screen for providers using the 837 Professional claim form in PES, which is why providers are not able to enter reason codes on the Professional Medicare screen.

TIP

Providers should refer to the Online Handbook and *ForwardHealth Updates* for more information on procedure codes and modifiers.

18. Select the Service 1 tab.

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

Professional Service 1	
Field	Description
Diagnosis Codes	These fields display the diagnosis codes entered on the Header 2 tab. These fields may only be edited on the Header 2 tab.
From DOS	Enter the "from" DOS using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format, if applicable.

Professional Service 1	
Field	Description
Emergency Ind	Select "Y" only if the services provided were emergency related. This field defaults to "N."
Place of Service	Enter or select the POS in this field if it is different from the POS code entered at the Header 2 tab.
Diag Ptr	Enter the number(s) indicating the diagnosis code(s) listed at the top of the screen that are associated with the service rendered. Valid numbers are 1-12.
Modifiers	Enter or select the modifier(s) (if applicable).
Procedure	Select the procedure code related to the visit. To add a procedure code or description, double-click the field to access the Procedure/Healthcare Common Procedure Coding System (HCPCS) List.
Units	Enter the number of units performed for the service billed. Example: 1.00 = 1 unit.
Unit Rate	Enter the dollar amount billed per unit for the service.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed. This field defaults to "UN" (unit).
Billed Amount	This field auto-populates using the Units x the Unit Rate. Example: 4.00 units multiplied by 10.00 unit rate = 40.00 billed amount.
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by the other insurance and/or Medicare. This field defaults to "N."
Rx Ind	Select "Y" or "N" to indicate whether the service includes a pharmaceutical. When "Y" is indicated, the Rx tab is added to the claim form for entry.
Obstetric Anesthesia Additional Units	Enter the number of additional units reported by an anesthesia provider that reflect an increased complexity of services.
Ambulance Patient	Enter the number of patients transported if more than one patient is transported in the same vehicle for ambulance or non-emergency transportation services.

20. Select the Service 2 tab.

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

Professional Service 2	
Field	Description
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number will be returned on the 835 Health Care Claim Payment/Advice (835).
CLIA Number	Enter your organization's Clinical Laboratory Improvement Amendment (CLIA) number, if yours is a facility certified to perform CLIA covered laboratory services. This field is required for any laboratory performing tests covered by the CLIA act.
Family Planning	Select "Y" if the service provided was related to family planning. This field defaults to "N."
Rendering Provider Provider ID	Select the provider identification for the provider who rendered the service (if applicable). The rendering provider must have an entity type qualifier of "1" and must not be the same as the header billing or rendering provider indicated on the Header 1 tab.
Note	Enter a description of the service for an unlisted, or not otherwise classified (NOC), procedure code. The note may be up to 80 characters long.

22. If Medicare or other insurance did not make service-level payments, proceed to step 25.
23. If Medicare or other insurance made a service-level payment, select the Srv Adj tab.
24. Enter data into all of the required fields on the Service Adj tab using the table below as a guide.

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

25. If pharmaceuticals were not dispensed to the client, proceed to step 28.
26. If pharmaceuticals were dispensed to the client, select the Rx tab.
27. Enter data into all the required fields on the Rx tab using the table below as a guide.

TIP

Up to 25 NDCs may be entered for each drug-related HCPCS J-code.

Professional Rx	
Field	Description
NDC	Enter the National Drug Code (NDC) for the drug prescribed.
Quantity	Enter the quantity dispensed, in metric decimal units.
Unit of Measurement	Select the code specifying the units in which a value was expressed, or the manner in which a measurement was taken.
Prescription Date	Enter the prescription date for the drug prescribed.

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

Correcting Errors on Professional Claims

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

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

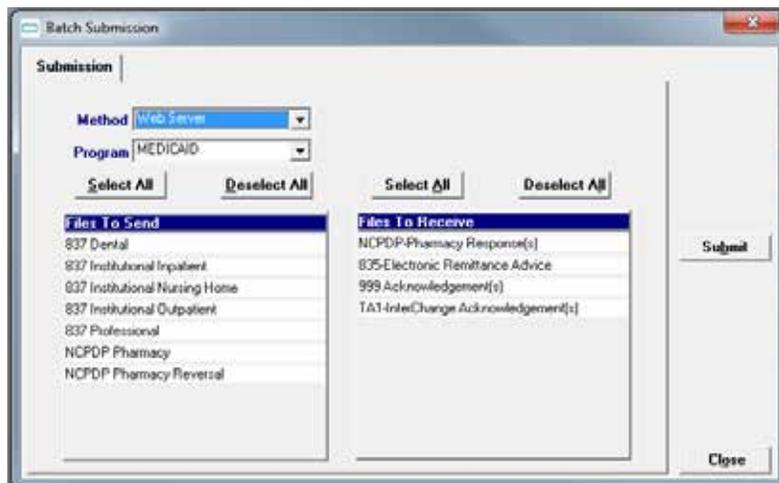
PES will return to the field that has missing or incorrect data.

Submitting New Professional Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Electronic Data Interchange Department.

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

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



2. Click **Submission**. The Batch Submission window will display.
3. Select "Web Server" from the Method field.
4. Select "Medicaid," "WWWP," or "WCDP" from the Program field.
5. Click on the appropriate form type(s) under Files to Send.
6. Click **Submit**.

TIP

Status Indicators in PES: A = Archived, F = Finalized, I = Incomplete, R = Ready

TIP

To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

TIP

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

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

Resubmitting Professional Claims

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

Resubmitting a Single Claim

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

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

TIP

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

Resubmitting or Copying a Partial or Entire Batch

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

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

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

- Clicking **Resubmit** to resubmit the entire batch.
 - Highlighting **Deselect All** and selecting individual claims to resubmit specific claims from the batch. Click **Resubmit**.
4. The Batch Submission window will display.
 5. Select “Web Server” from the Method field.
 6. Click on the appropriate form type(s) under Files to Send.
 7. Click **Submit**.

Adjusting Paid Status Professional Claims

PES allows you to resubmit a claim(s) to Wisconsin Medicaid, WCDP, or WWWP even after the claim shows a status of “paid.” To resubmit a paid claim, click the professional button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select “7” in the Claim Frequency field.
4. Enter the 13-digit internal control number (ICN) in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make adjustments to the incorrect portions of the claim as needed.

Note: In addition to the adjusted information, all correct details of the original claim must be included, as all details and amounts will be resubmitted in your adjustment.

6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method field.

TIP

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

10. Select “Medicaid,” “WWWP,” or “WCDP” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

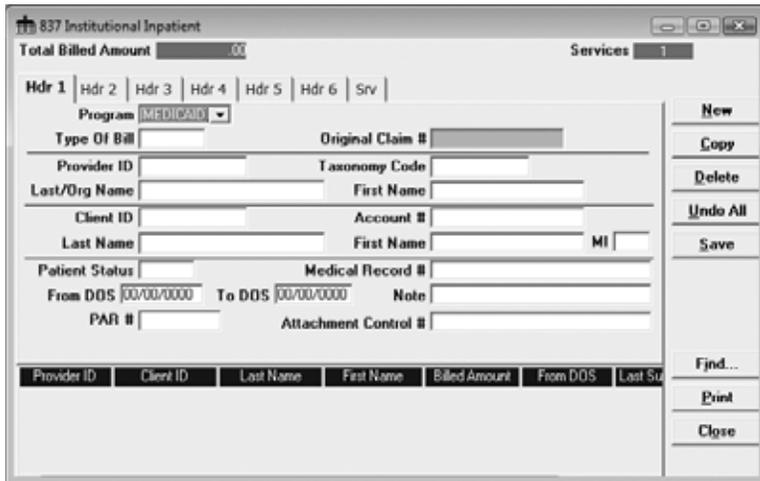
Voiding Professional Claims

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

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. Select “8” in the Claim Frequency field.
4. Enter the 13-digit ICN in the Original Claim # field.
5. Click **Save**.
6. Click **Communication** on the menu bar.
7. Click **Submission**.
8. Select “Web Server” from the Method field.
9. Select “Medicaid,” “WWWP,” or “WCDP” from the Program field.
10. Click on the appropriate form type under Files to Send.
11. Click **Submit**.

Institutional Inpatient Claims

The 837 Institutional Inpatient claim form has several screens that you will use to complete a Medicaid or Wisconsin Chronic Disease Program (WCDP) claim, depending upon the services that you bill. These screens include:



- Headers 1-8.
- Service.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System and enter the same spelling in Provider Electronic Solutions (PES).

TIP

Providers may submit paper attachments to electronic claims submitted through PES. Enter an Attachment Control Number (ACN) in the Header 1 screen and mail the paper attachment to ForwardHealth within 30 calendar days of claim submission. You must include the Claim Form Attachment Cover Page, F-13470, with the paper attachment and indicate the same ACN on the form. ForwardHealth forms are available via the ForwardHealth Portal, www.forwardhealth.wi.gov/. If ForwardHealth does not receive the attachment within the 30-day deadline, the claim will be processed without the attachment and may be denied.

Completing New Institutional Inpatient Claims

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

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

Institutional Inpatient Header 1	
Field	Description
Program	Select Medicaid or WCDP.
Type of Bill	Enter or select the numeric type of bill code for the services rendered.
Provider ID	Select the National Provider Identifier (NPI) (for health care providers) or provider number (for non-healthcare providers) of the billing provider.
Client ID	Select the 10-digit member identification number.
Patient Status	Enter or select the two-digit patient status code.
Medical Record #	Enter the medical record number that identifies the client in your records. This field is optional.
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Note	Enter a description of the service for an unlisted, or not otherwise classified, procedure code. The note may be up to 80 characters long.
PAR #	Leave this field blank. It is no longer used by ForwardHealth.
Attachment Control # (optional)	Enter the ACN for the corresponding paper attachment to this claim, if applicable. The ACN may be two to 80 characters long and is chosen by the provider.

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

Institutional Inpatient Header 2	
Field	Description
Diagnosis Codes Admit	Enter or select the <i>International Classification of Disease</i> (ICD) diagnosis code relating to the client's condition that prompted admission to the hospital.
Other	Select "Y – Yes," "N – No," "U – Unknown," or "W – Not Applicable" in the "POA" field to indicate whether the condition was present at the time the order for inpatient admission occurred. Then, enter or select additional diagnosis codes related to the discharge (if applicable). List in order of importance. Up to 12 codes may be entered on Header 2. Use Header 7 to enter additional diagnosis codes.
Primary	Select an option in the "POA" field to indicate whether the primary condition was present at the time the order for inpatient admission occurred. Then, enter or select the primary diagnosis code related to the discharge.
External Cause of Morbidity	Select "Y" to enter diagnosis codes related to the client's cause of injury. A new header tab will open if "Y" is selected.
Attending Provider ID	Enter or select the NPI, state license, or Unique Provider Identification Number (UPIN) of the attending provider.

4. Select the Header 3 tab.

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

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

6. Select the Header 4 tab.
7. Enter data into all of the required fields on Header 4 using the table below as a guide.

TIP

Covered days and noncovered days should be entered in the Value Codes/Amounts field. See Appendix 1 for a list of value codes.

Institutional Inpatient Header 4	
Field	Description
Value Codes/Amounts	Enter or select the two-digit value code(s) (if applicable). Enter the corresponding value code amount(s).
Operating Physician Provider ID	Enter or select the NPI, state license number, or UPIN that identifies the operating physician when surgical procedures have been performed during the client's institutionalization. This field is required when billing an ICD procedure code on the Header 5 tab.
Other Operating Physician Provider ID	Enter or select the NPI, state license number, or UPIN of any additional providers that are used on the claim.

8. Select the Header 5 tab.
9. Enter data into all of the required fields on Header 5 using the following table as a guide.

TIP

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

Institutional Inpatient Header 5	
Field	Description
ICD Procedure Codes/Dates	Enter or select the principal ICD procedure code(s) that identifies the procedure performed during the billing period (if applicable). Enter the date that corresponds to the principal ICD procedure using the MM/DD/CCYY format. Enter or select up to 12 additional ICD procedure codes and dates. Use Header 7 to enter additional ICD procedure codes.

10. Select the Header 6 tab.

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

Institutional Inpatient Header 6	
Field	Description
Condition Codes	Enter or select the two-digit condition codes used to identify conditions relating to this bill that may affect payer processing (if applicable).
Admission Date	Enter the date the client was admitted to the facility using the MM/DD/CCYY format.
Hour	Select the hour the client was admitted to the facility.
Priority	Enter or select the code that identifies the priority of the admission.
Point of Origin	Enter or select the code that identifies the source of admission.
Discharge Hour	Select the hour the client was discharged from the facility.
Medicare Ind	Select "Y" if the client has Medicare coverage for institutional services.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for institutional services.
New Header Ind	Select "Y" if there are additional diagnosis codes or ICD procedure codes to enter. Selecting "Y" will open the Header 7 tab.

12. If you do not have additional diagnosis codes or ICD procedure codes to enter, proceed to step 15.

13. If you have additional diagnosis codes or ICD procedure codes to enter, select the Header 7 tab.

14. Enter data into all of the required fields on the Header 7 tab using the following table as a guide.

Institutional Inpatient Header 7	
Field	Description
Diagnosis Codes Other	Enter or select any additional diagnosis codes related to the discharge (if applicable), selecting a present on admission (POA) indicator for each code. List in order of importance.
ICD Procedure Codes/Dates	Enter or select the ICD procedure code(s) that identifies the procedure performed during the billing period (if applicable). Enter the date that corresponds to the listed ICD procedure using the MM/DD/CCYY format.

15. If you do not have external cause of morbidity diagnosis codes to enter, proceed to step 18.

16. If you have external cause of morbidity diagnosis codes to enter, select the Header 8 tab.

17. Enter data into all of the required fields of the Header 8 tab using the following table as guide:

Institutional Inpatient Header 8	
Field	Description
External Cause of Morbidity	Enter or select any additional diagnosis codes related to the client's cause of injury, selecting a POA indicator for each code. List in order of importance.

18. If you do not have commercial insurance carrier information to enter, proceed to step 23.
19. If you have commercial insurance carrier information to enter, select the OI tab.
20. Enter data into all of the required fields on the OI tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

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

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

Institutional Inpatient OI	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for this client. Tab off the field to populate the policyholder first and last name fields.

21. Select the OI Adj tab.
22. Enter data into all of the required fields on the OI Adj tab using the following table as a guide.

TIP

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

Institutional Inpatient OI Adjustment	
Field	Description
OI-Y	Select "Y" if other insurance exists but was not billed for reasons as outlined in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N." If you indicate "Y" for OI-Y, refer to the Claim Filing Ind Code under the Institutional Inpatient OI tab.
Paid Date/Amount	Enter the date the other insurance paid the claim using the MM/DD/CCYY format and the total amount paid. This field is required if the information was not entered on the Service Adjustment tab.
Remaining Patient Liability	Enter the amount that remains to be paid after the other insurance has adjudicated the claim, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by other insurance (if applicable). Enter "PR" if insurance deductible, coinsurance, or copay has been indicated on the insurance claim or Remittance Advice (RA). If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code. This field is only required if an insurance carrier did not pay the claim in full.

Institutional Inpatient OI Adjustment	
Field	Description
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by the other insurance. Enter the amount indicated by the other insurance for each reason code. This field is only required if an insurance carrier did not pay the claim in full.

23. If the client does not have Medicare insurance information, proceed to step 26.
24. If the client has Medicare insurance information, select the Medicare tab.
25. Enter data into all of the required fields on the Medicare tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

Institutional Inpatient Medicare	
Field	Description
Benefits Assignment	Select "N" only to indicate that the client, or an authorized person, did not authorize benefits to be assigned to the provider. This field defaults to "Y."
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This field defaults to "MA."
Carrier Code	Select the carrier code for this client. Tab off of this field to populate the policyholder first and last name fields.
M-8	Select "Y" if other Medicare exists, but was not billed for reasons as outlined in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment using the MM/DD/CCYY format (if applicable). Enter the amount paid by Medicare (if applicable). This field is required if this information was not entered in the Service Adjustment tab.
Remaining Patient Liability	Enter the amount that remains to be paid after Medicare has adjudicated the claim, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. This field is only required if Medicare made an adjustment.

26. Select the Service tab.
27. Enter data into all of the required fields on the Service tab using the following table as a guide.

Institutional Inpatient Service	
Field	Description
Revenue Code	Enter or select the four-digit revenue code that identifies the specific accommodation or ancillary services.
Unit Rate	Enter the rate per unit of associated revenue for hospital accommodation (if applicable). This field is required when the associated revenue code is 0100-0219.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (units). This field defaults to "UN."
Units	Enter the number of units provided for the revenue code billed. Example: 1 = 1 unit.
Billed Amount	The billed amount is calculated automatically.
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by an insurance company and/or Medicare.
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number will be returned on the 835 Health Care Claim Payment/Advice (835).

28. If Medicare or other insurance did not make service-level payments, proceed to step 31.

29. If Medicare or other insurance made a service-level payment, select the Srv Adj tab.

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

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

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

Correcting Errors on Institutional Inpatient Claims

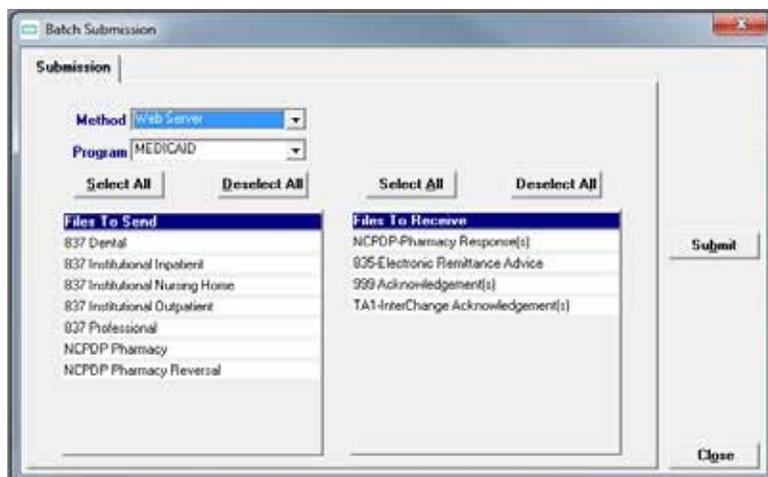
If all of the required information is not included in a form, a list of error messages will display that will need to be corrected before the form can be submitted. To correct an error, do one of the following:

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

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

Submitting New Institutional Inpatient Claims

Once you have completed the form and have saved the information, you are ready to submit the claim to the Electronic Data Interchange Department.



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

Click **Communication** on the menu bar.

1. Click **Submission**. The Batch Submission window will display.
2. Select "Web Server" from the Method field.
3. Select "Medicaid" or "WCDP" from the Program field.
4. Click on the appropriate form type(s) under Files to Send.
5. Click **Submit**.

TIP

Status Indicators in PES: A = Archived, F = Finalized, I = Incomplete, R = Ready

TIP

To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

TIP

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

TIP

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

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

Resubmitting Institutional Inpatient Claims

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

Resubmitting a Single Claim

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

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

Resubmitting or Copying a Partial or Entire Batch

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

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

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

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

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

Adjusting Paid Status Institutional Inpatient Claims

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

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “7” as the final digit.
4. Enter the 13-digit internal control number (ICN) in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make adjustments to the incorrect portions of the claim as needed.

Note: In addition to the adjusted information, all correct details of the original claim must be included, as all details and amounts will be resubmitted in your adjustment.

6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.

TIP

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

9. Select “Web Server” from the Method field.
10. Select “Medicaid” or “WCDP” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

Late Billing for Institutional Inpatient Claims

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

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “5” as the final digit.
4. Enter the 13-digit ICN in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your transaction.
5. Make additions to the claim as needed. Refer to the Tip field on this page for more information.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method field.
10. Select “Medicaid” or “WCDP” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

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

Voiding Institutional Inpatient Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid or WCDP to recoup the entire claim.

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

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
19. In the Type of Bill field, enter the first two digits of the type of bill and enter "8" as the final digit.
20. Enter the 13-digit ICN in the Original Claim # field.
21. Click **Save**.
22. Click **Communication** on the menu bar.
23. Click **Submission**.
24. Select "Medicaid" or "WCDP" from the Program field.
25. Click on the appropriate form type under Files to Send.
26. Click **Submit**.

Institutional Nursing Home Claims

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

- Headers 1-4.
- Service.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.

TIP

Providers may submit paper attachments to electronic claims submitted through PES. Enter an Attachment Control Number (ACN) in the Header 1 screen and mail the paper attachment to ForwardHealth within 30 calendar days of claim submission. You must include the Claim Form Attachment Cover Page, F-13470, with the paper attachment and indicate the same ACN on the form. ForwardHealth forms are available via the ForwardHealth Portal, www.forwardhealth.wi.gov/. If ForwardHealth does not receive the attachment within the 30-day deadline, the claim will be processed without the attachment and may be denied.

Nursing Home Claims

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

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

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

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

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System and enter the same spelling in PES.

Completing Institutional Nursing Home Claims

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

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

Institutional Nursing Home Header 1	
Field	Description
Program	Select the Medicaid program.
Type of Bill	Enter or select the numeric type of bill code for the services rendered.
Provider ID	Select the National Provider Identifier (NPI) (for health care providers) or the provider number (for non-healthcare providers) of the billing/rendering provider.
Client ID	Select the 10-digit member identification number.
Note	Enter a description of the service for an unlisted, or not otherwise classified, procedure code. The note may be up to 80 characters long.
Medical Record #	Enter the medical record number assigned by your organization that identifies the client in your records. This field is optional.
Patient Status	Enter or select the two-digit patient status code.
Attachment Control # (optional)	Enter the ACN for the corresponding paper attachment to this claim, if applicable. The ACN may be two to 80 characters long and is chosen by the provider.

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

Tip

Status Indicators in PES:

A = Archived

I = Incomplete

R = Ready

F = Finalized

Institutional Nursing Home Header 2	
Field	Description
Admission Date	Enter the date the client was admitted to the facility using the MM/DD/CCYY format.
Hour	Select the hour the client was admitted to the facility.
Priority	Enter or select the code that identifies the priority of this admission (if applicable).
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Point of Origin	Enter or select the code that identifies the source of this admission.
Attending Physician Provider ID	Enter or select the NPI of the attending provider.

4. Select the Header 3 tab.

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

Institutional Nursing Home Header 3	
Field	Description
Diagnosis Codes Primary	Enter or select the primary <i>International Classification of Disease</i> (ICD) diagnosis code related to the visit.
Other	Enter or select any additional diagnosis codes related to the visit.
Admit	Enter or select the admit diagnosis code corresponding to the diagnosis that prompted admission to the nursing home.
Condition Codes	Enter or select the condition codes used to identify conditions relating to this bill that may affect payer processing (if applicable).
Other Insurance Ind	Select "Y" if the client has other insurance coverage for institutional services. This field defaults to "N."
Medicare Ind	Select "Y" if the client has Medicare coverage for institutional services. This field defaults to "N."

- Select the Header 4 tab.
- Enter data into all of the required fields on Header 4 using the table below as a guide.

Institutional Nursing Home Header 4	
Field	Description
Value Codes/Amounts	Select the appropriate value code from the drop-down list, then enter the corresponding amount.
Occurrence Span Codes/Dates	Select the appropriate occurrence span code from the drop-down list, then enter the corresponding date(s).

- If you do not have commercial insurance carrier information to enter, proceed to step 13.
- If you have commercial insurance carrier information to enter, select the OI tab.
- Enter data into all of the required fields on the OI tab using the table below as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

To indicate each hospital leave of absence date range on a institutional nursing home claim, enter Occurrence span code 75 along with the range of dates on Header 4. Occurrence span code 75 must be used in conjunction with revenue code 0185.

Institutional Nursing Home OI	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for this client. Tab off the field to populate the policyholder first and last name fields.

TIP

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

11. Select the OI Adj tab.

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

TIP

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

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

13. If the client does not have Medicare insurance information, proceed to step 16.
14. If the patient has Medicare insurance information, select the Medicare tab.
15. Enter data into all of the required fields on the Medicare tab using the following table as a guide. Refer to the Other Insurance and Medicare chapter of this manual for more information.

TIP

In the Remaining Patient Liability field in PES, providers should enter the amount still remaining after other insurance or Medicare has adjudicated the claim. The Remaining Patient Liability field in PES is not the same as patient liability known in the nursing home industry as the monthly amount owed by a patient based on his or her income and other qualifiers.

Institutional Nursing Home Medicare	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This field defaults to "MA."
Carrier Code	Select the carrier code for the policyholder. Tab off of the field to populate the policyholder name fields.
M-8	Select "Y" if Medicare exists, but was not billed for reasons as outlined in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N."
Paid Date/Amount	Enter the Medicare date of payment (if applicable), using the MM/DD/CCYY format. Enter the amount paid by Medicare (if applicable). This field is required if the information was not entered in the Service Adjustment tab.
Remaining Patient Liability	Enter the amount that remains to be paid after Medicare has adjudicated the claim, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. This field is only required if Medicare made an adjustment.

16. Select the Service tab.
17. Enter data into all of the required fields on the Service tab using the following table as a guide.

Institutional Nursing Home Service	
Field	Description
Revenue Code	Enter or select the four-digit revenue code or the two-digit local code preceded by two zeros that identifies the specific accommodation or ancillary service.
Unit Rate	Enter the rate per unit of the associated revenue code for nursing home accommodation (if applicable). This field is required when the associated revenue code is 0100-0219.
Units	Enter the number of units performed for the revenue code billed. Example: 1.00 = 1 unit.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (units). This field defaults to "UN."
Billed Amount	The billed amount is calculated automatically.
Service Adjustment Ind	Select "Y" or "N" to indicate if service level payments or adjustments were made by the commercial insurance carrier and/or Medicare. This field defaults to "N."
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number will be returned on the 835 Health Care Claim Payment/Advice (835).

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

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

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

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

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

Correcting Errors on Institutional Nursing Home Claims

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

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

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

Edit All Feature for Institutional Nursing Home Claims

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

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

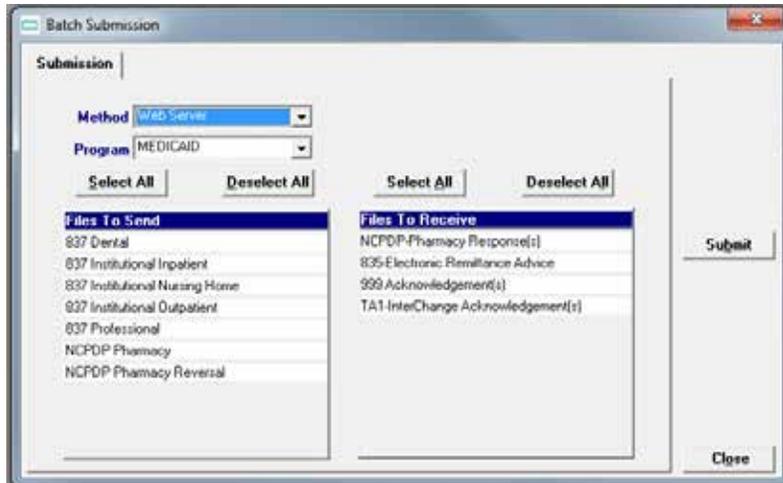
TIP

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

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

Submitting New Institutional Nursing Home Claims

Once you have completed all required screens for your claim and have saved the information, you are ready to submit the claim to the Electronic Data Interchange Department.



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

- Click **Communication** on the menu bar.
- Click **Submission**. The Batch Submission window will display.
- Select "Web Server" from the Method field.
- Select "Medicaid" from the Program field.
- Click on the appropriate form type(s) under Files to Send.
- Click **Submit**.
- PES will post messages in the Transmission window updating you on the progress of the transmission.

Resubmitting Institutional Nursing Home Claims

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

TIP

To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

TIP

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

TIP

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

TIP

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

Resubmitting a Single Claim

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

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

Resubmitting or Copying a Partial or Entire Batch

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

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

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

- Clicking **Resubmit** to resubmit the entire batch.
 - Highlighting **Deselect All** and selecting individual forms to resubmit specific forms from the batch. Click **Resubmit**.
4. The Batch Submission window will display.
 5. Select "Web Server" from the Method field.

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

Adjusting Paid Status Institutional Nursing Home Claims

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

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “7” as the final digit.
4. Enter the 13-digit internal control number (ICN) in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make adjustments to the incorrect portions of the claim as needed.

Note: In addition to the adjusted information, all correct details of the original claim must be included, as all details and amounts will be resubmitted in your adjustment.

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

TIP

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

Late Billing for Institutional Nursing Home Claims

PES allows you to resubmit a late billing claim(s) to ForwardHealth even after the claim shows a status of “paid.” To resubmit a paid late billing claim, click the institutional nursing home button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “5” as the final digit.
4. Enter the 13-digit ICN in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make additions to the claim as needed. Refer to the Tip field on this page for more information.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method field.
10. Select “Medicaid” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

Voiding Institutional Nursing Home Claims

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

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “8” as the final digit.
4. Enter the 13-digit ICN in the Original Claim # field.

TIP

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

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

Institutional Outpatient Claims

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

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

- Headers 1-7.
- Services 1 and 2.
- Other Insurance.
- Other Insurance Adjustments.
- Medicare.
- Other Insurance/Medicare Service Adjustments.
- Rx.

TIP

In general, no special characters (such as apostrophes) may be entered in name fields. Spaces are allowed.

When entering names, verify the spelling with Wisconsin's Enrollment Verification System and enter the same spelling in Provider Electronic Solutions (PES).

TIP

Providers may submit paper attachments to electronic claims submitted through PES. Enter an Attachment Control Number (ACN) in the Header 1 screen and mail the paper attachment to ForwardHealth within 30 calendar days of claim submission. You must include the Claim Form Attachment Cover Page, F-13470, with the paper attachment and indicate the same ACN on the form. ForwardHealth forms are available via the ForwardHealth Portal, www.forwardhealth.wi.gov/. If ForwardHealth does not receive the attachment within the 30-day deadline, the claim will be processed without the attachment and may be denied.

Completing New Institutional Outpatient Claims

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

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

Institutional Outpatient Header 1	
Field	Description
Program	Select Medicaid, WWWP, or WCDP.
Type of Bill	Enter or select the type of bill code for the services rendered.
Provider ID	Select the National Provider Identifier (NPI) (for health care providers) or the provider number (for non-healthcare providers) of the billing provider.
Client ID	Select the member identification number.
Medical Record #	Enter the medical record number assigned by your organization that identifies the client. This field is optional.
Patient Status	Enter or select the two-digit patient status code.
Priority	Enter or select the code that identifies the priority of this admission.
From DOS	Enter the "from" date of service (DOS) using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format.
Point of Origin	Enter or select the code that identifies the source of admission (if applicable).
Note	Enter a description of the service for an unlisted, or not otherwise classified, procedure code. The note may be up to 80 characters long.
Attachment Control # (optional)	Enter the ACN for the corresponding paper attachment to this claim, if applicable. The ACN may be two to 80 characters long and is chosen by the provider.

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

Institutional Outpatient Header 2	
Field	Description
Diagnosis Codes Primary	Enter or select the <i>International Classification of Disease</i> (ICD) diagnosis code related to the visit.
Other	Enter or select additional diagnosis codes related to the visit (if applicable). Up to 12 codes may be entered on Header 2. Use Header 7 to enter additional diagnosis codes.
Patient Reason for Visit	Enter or select the diagnosis code that best describes the reason for the patient's visit at the time of outpatient registration.
Condition Codes	Enter or select the condition code(s), if applicable.
Attending Provider ID	Select the NPI of the attending provider.

4. Select the Header 3 tab.
5. Enter data into all of the required fields on Header 3, using the table below as a guide.

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

- Select the Header 4 tab.
- Enter data into all of the required fields on Header 4 using the table below as a guide.

Institutional Outpatient Header 4	
Field	Description
Value Codes/Amounts	Enter or select the two-digit value code(s) (if applicable). Enter the corresponding value code amount(s).
Operating Physician Provider ID	Select the NPI(s) of any operating physicians. Use only when surgical procedures have been performed during the client's institutionalization. This field is required when billing an ICD procedure code on the Header 5 tab.
Other Operating Physician Provider ID	Select the NPI(s) of any additional providers.

- Select the Header 5 tab.
- Enter data into all of the required fields on Header 5, using the following table as a guide.

Institutional Outpatient Header 5	
Field	Description
ICD Procedure Codes / Dates Principal	Enter or select the ICD procedure code(s) that identifies the procedure performed during the billing period, beginning with the principal code (if applicable). Enter the date that corresponds to the listed ICD procedure(s) using the MM/DD/CCYY format. Up to 12 codes may be entered on Header 5. Use Header 7 to enter additional ICD procedure codes.
Other Insurance Ind	Select "Y" if the client has other insurance coverage for institutional services. This field defaults to "N."
Medicare Ind	Select "Y" if the client has Medicare coverage for institutional services. This field defaults to "N."
New Header Ind	Select "Y" if there are additional diagnosis codes or ICD procedure codes to enter. Selecting "Y" will open the Header 7 tab.

- If you do not have referring or rendering providers or external cause of morbidity codes to enter, proceed to step 13.
- If you have a referring or rendering provider or external cause of morbidity codes to enter, select the Header 6 tab.

12. Enter data into all of the required fields on the Header 6 tab using the table below as a guide.

Institutional Outpatient Header 6	
Field	Description
Referring Provider Provider ID	Enter the NPI of the referring provider, if applicable.
Rendering Provider Provider ID	Enter the NPI of the rendering provider, if applicable.
External Cause of Morbidity	Enter or select any additional diagnosis codes related to the client's cause of injury, selecting a present on admission indicator for each code. List in order of importance.

13. If you do not have additional diagnosis codes or ICD procedure codes to enter, proceed to step 16.

14. If you have additional diagnosis codes and ICD procedure codes to enter, select the Header 7 tab.

TIP

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

15. Enter data into all of the required fields on the Header 6 tab using the table below as a guide.

Institutional Outpatient Header 7	
Field	Description
Diagnosis Codes Other	Enter or select any additional diagnosis codes related to the discharge (if applicable). List in order of importance.
ICD Procedure Codes/ Dates	Enter or select the ICD procedure code(s) that identifies the procedure performed during the billing period (if applicable). Enter the date that corresponds to the listed ICD procedure using the MM/DD/CCYY format.

16. If you do not have commercial insurance carrier information to enter, proceed to step 21.

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

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

Institutional Outpatient OI	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted.
Carrier Code	Select the carrier code for the policyholder. Tab off the field to populate the first and last name fields.

19. Select the OI Adj tab.

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

TIP

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

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

21. If the client does not have Medicare insurance information, proceed to step 24.

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

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

TIP

If Medicare adjudicated a claim at the detail level, ForwardHealth requires you to indicate this information (e.g. allowed amount, paid amount, coinsurance, copayment, and deductible) at the detail level of the claim.

Failure to indicate detail-level payments may impact reimbursement.

Institutional Outpatient Medicare	
Field	Description
Benefits Assignment	Select "Y" or "N" to indicate whether or not the client or authorized person authorized benefits to be assigned to the provider, if applicable. The information entered in this field has no impact on the outcome of your claim.
Claim Filing Ind Code	Select the type of other insurance claim being submitted. This field defaults to "MA."
Carrier Code	Select the carrier code for the policyholder. Tab off of the field to populate the policyholder name fields.
M-8	Select "Y" if Medicare exists, but was not billed for reasons as outlined in your <i>ForwardHealth Updates</i> and Online Handbook. This field defaults to "N."

Institutional Outpatient Medicare	
Field	Description
Paid Date/Amount	Enter the Medicare date of payment (if applicable) using the MM/DD/CCYY format. Enter the amount paid by Medicare (if applicable). This field is required if the information was not entered on the Service Adjustment screen.
Remaining Patient Liability	Enter the amount that remains to be paid after Medicare has adjudicated the claim, if applicable.
Adjustment Group Cd	Select the code identifying the general category of payment adjustment by the Medicare (if applicable). Enter "PR" if Medicare deductible, coinsurance, or copay has been indicated on the Medicare claim or remittance advice. If you enter an adjustment group code, you must also enter at least one adjustment reason code. You may enter up to six adjustment reason codes per adjustment group code.
Reason Codes/Amts	Select the code identifying the reason for the adjustment — the difference between the billed and paid amounts — made by Medicare. Enter the amount indicated by Medicare for each reason code. This field is only required if Medicare made an adjustment.

24. Select the Service 1 tab.

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

Institutional Outpatient Service 1	
Field	Description
From DOS	Enter the "from" DOS using the MM/DD/CCYY format.
To DOS	Enter the "to" DOS using the MM/DD/CCYY format (if applicable).
Revenue Code	Enter or select the revenue code that identifies the specific accommodation or ancillary service.
Unit Rate	Enter the rate per unit of the associated revenue code for hospital accommodation (if applicable). This field is required only when the associated revenue code is 0100-0219.
Units	Enter the number of units performed for the revenue code billed. Example: 1.00 = 1 unit.
Basis of Measurement	Select the code that specifies the units in which a value is being expressed: "DA" (days) or "UN" (unit). This field defaults to "N."
Billed Amount	The billed amount is calculated automatically.
Modifiers	Enter the modifier(s) (if applicable).
Procedure	Select the procedure code associated to the revenue code (if applicable). To add a procedure code or description, double-click the field to access the Procedure/Healthcare Common Procedure Coding System (HCPCS) List.
Line Item Ctl	Enter an internal number to be used for tracking purposes (if desired). If submitted on the claim, this number will be returned on the 835 Health Care Claim Payment/Advice (835).
Service Adjustment Ind	Select "Y" or "N" to indicate whether service-level payments or adjustments were made by the other insurance and/or Medicare. This field defaults to "N."
Rx Ind	Select "Y" or "N" to indicate if the service includes a pharmaceutical. When "Y" is indicated, the Rx tab is added to the claim form for entry.

26. Select the Service 2 tab.

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

Institutional Outpatient Service 2	
Field	Description
Referring Provider Provider ID	Enter the NPI of the referring provider, if applicable.
Rendering Provider Provider ID	Enter the NPI of the rendering provider, if applicable.

28. If Medicare or other insurance did not make service-level payments, proceed to step 31.

29. If Medicare or other insurance made a service-level payment, select the Srv Adj tab.

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

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

31. If pharmaceuticals were not dispensed to the client, proceed to step 34.

32. If pharmaceuticals were dispensed to the client, select the Rx tab.

33. Enter data into all the required fields on the Rx tab using the table below as a guide.

TIP

Up to 25 National Drug Codes (NDCs) may be entered for each drug-related HCPCS J-code.

Institutional Outpatient Rx	
Field	Description
NDC	Enter or select the NDC for the drug being prescribed.
Quantity	Enter the quantity being dispensed, in metric decimal units.
Unit of Measurement	Select the code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken.

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

TIP

Only providers of end-stage renal disease services are required to report NDC information.

Correcting Errors on Institutional Outpatient Claims

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

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

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

Edit All Feature for Institutional Outpatient Claims

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

1. Choose one of the following two methods of copying your claims:
 - Select a previously submitted claim in an “F” (finalized) status from the list of previously finalized claims. Click **Copy**. Click **Save**.
 - Select a batch of previously submitted claims, copy the entire batch, and save them as new claims. Refer to the instructions for copying batch forms in the Communication chapter of this manual.
2. Click **Edit All**.
3. Enter DOS in the From and To DOS fields.

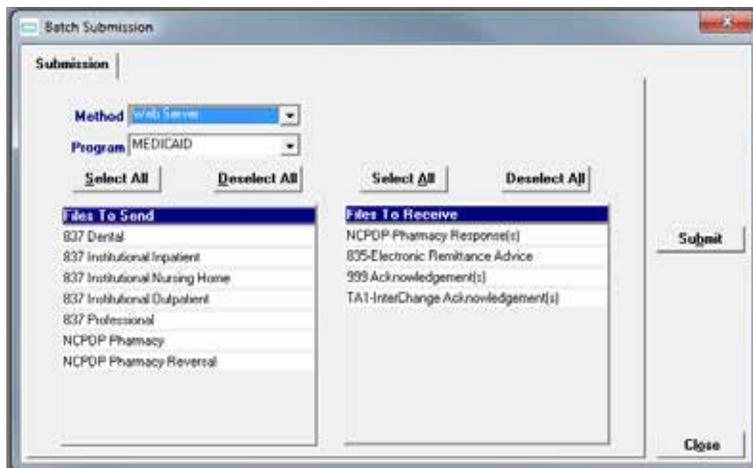
TIP

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

4. Enter the number of days associated with the date span.
5. Click **OK**. A message displays verifying the number of claim forms to be submitted. If correct, click **Yes**.
6. Review each form to verify that the billed amount is correct for the number of days billed on the claim.
7. Click **Close**.
8. Follow the instructions for submission in Submitting New Institutional Outpatient Claims in this chapter.

Submitting New Institutional Outpatient Claims

Once you have completed all required screens for your claim and have saved the information, you are ready to submit the claim to the Electronic Data Interchange Department.



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

1. Click **Communication** on the menu bar.
2. Click **Submission**. The Batch Submission window will display.
3. Select "Web Server" from the Method field.
4. Select "Medicaid," "WCDP," or "WWWP" from the Program field.
5. Click on the appropriate form type(s) under Files to Send.

TIP

To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

TIP

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

TIP

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

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

Resubmitting Institutional Outpatient Claims

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

Resubmitting a Single Claim

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

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

Resubmitting or Copying a Partial or Entire Batch

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

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

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

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

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

Adjusting Paid Status Institutional Outpatient Claims

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

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “7” as the final digit.
4. Enter the 13-digit internal control number (ICN) in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make adjustments to the incorrect portions of the claim as needed.

Note: In addition to the adjusted information, all correct details of the original claim must be included, as all details and amounts will be resubmitted in your adjustment.

6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.

TIP

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

9. Select “Web Server” from the Method field.
10. Select “Medicaid,” “WCDP,” or “WWWP” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

Late Billing for Institutional Outpatient Claims

PES allows you to resubmit a late billing claim(s) to Wisconsin Medicaid, WCDP, or WWWP even after the claim shows a status of “paid.” To resubmit a paid late billing claim, click the institutional outpatient button on your toolbar and follow these steps:

1. Select the claim you want to resubmit at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter “5” as the final digit.
4. Enter the 13-digit ICN in the Original Claim # field. Refer to your RA for the ICN, or look for the payer claim control number on your 835 transaction.
5. Make additions to the claim as needed. Refer to the Tip field on this page for more information.
6. Click **Save**.
7. Click **Communication** on the menu bar.
8. Click **Submission**.
9. Select “Web Server” from the Method field.
10. Select “Medicaid,” “WCDP,” or “WWWP” from the Program field.
11. Click on the appropriate form type under Files to Send.
12. Click **Submit**.

TIP

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

Voiding Institutional Outpatient Claims

Use this feature when your claim was paid and you now want Wisconsin Medicaid, WCDP, or WWWP to recoup the entire claim.

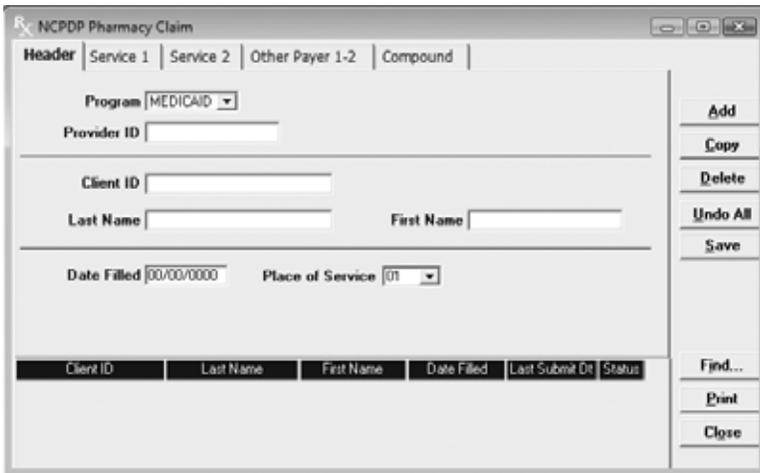
To void a claim, click the institutional outpatient button on your toolbar and follow these steps:

1. Select the claim you want to void at the bottom of the Header 1 tab.
2. Click **Copy**.
3. In the Type of Bill field, enter the first two digits of the type of bill and enter "8" as the final digit.
4. Enter the 13-digit ICN in the Original Claim # field.
5. Click **Save**.
6. Click **Communication** on the menu bar.
7. Click **Submission**.
8. Select "Web Server" from the Method field.
9. Select "Medicaid," "WCDP," or "WWWP" from the Program field.
10. Click on the appropriate form type under Files to Send.
11. Click **Submit**.

Pharmacy Claims



The National Council for Prescription Drug Programs batch standard version 1.2 (NCPDP 1.2) claim form has several screens that you will use to complete a Medicaid, Wisconsin AIDS/HIV Drug Assistance Program (ADAP), or Wisconsin Chronic Disease Program (WCDP) claim. These screens include:



- Header.
- Services 1 & 2.
- Other Payer.
- Compound.

Completing NCPDP Pharmacy Claims

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

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

NCPDP Pharmacy Header	
Field	Description
Program	Select Medicaid, ADAP, or WCDP.
Provider ID	Select the National Provider Identifier (NPI) (for health care providers) or provider number (for non-healthcare providers) of the billing provider.
Client ID	Enter or select the member identification number.
Date Filled	Enter the date the drug was filled.
Place of Service	Select the place of service from the list provided.

2. Select the Service 1 tab.
3. Enter data into all of the required fields on the Service 1 tab using the table below as a guide.

NCPDP Service 1	
Field	Description
Prescriber Number	Enter the NPI of the prescriber.
Prescriber Qualifier	Select "01" to indicate an NPI.
Prescription Number	Enter the code used to identify the prescription being filled.
DAW/Product Selection Code	Select the appropriate code that indicates whether or not the prescriber's instructions regarding generic substitution were followed.
Compound Code	Select the code that identifies whether or not this prescription is a compound. The field defaults to "1" for "Not a Compound." Select "2" for "Compound." When "2" is indicated, the Compound tab is added to the claim form for entry.
Fill Number	Enter the number of the prescription. A new prescription is always "0." The first refill of a prescription is "1," a second refill is "2," etc.
Days Supply	Enter the number of days supply for the prescription being filled.
NDC	Enter the National Drug Code (NDC) for the drug being prescribed, if the drug is not a compound. If a "2" was selected for the Compound Code, the NDC for each ingredient of the compound drug will be entered on the Compound tab.
Quantity	Enter the quantity being dispensed, indicated in metric decimal units.
Usual & Customary Charge	Enter the amount charged to cash customers for the prescription, excluding sales tax or other amounts claimed.
Date Prescribed	Enter the date, in MM/DD/CCYY format, that the drug was prescribed.
Copay Exempt	Select "Yes" or "No" to indicate whether or not copay is exempt.
Special Packaging Indicator	Select the code indicating the type of dispensing dose.
Prescription Origin Code	Select the code indicating how the pharmacy received the prescription.
Diagnosis Code	Enter or select the <i>International Classification of Disease</i> (ICD) diagnosis code(s), beginning with the primary code.
Submission Clarification	Select the code indicating the appropriate submission clarification.

4. Select the Service 2 tab.
5. Enter data into all of the required fields on the Service 2 tab using the table below as a guide.

TIP

Drug Enforcement Agency numbers are not accepted for the prescriber number.

NCPDP Service 2	
Field	Description
Ingredient Cost	Enter the ingredient cost amount in this field for a noncompound drug. This field will be uneditable if Compound Code "2" was selected on the Service 1 tab.
Dispensing Fee	Enter the pharmacy's fee for preparing and dispensing the drug.
Gross Amount Due	This field will automatically calculate the gross amount due based on entries made for ingredient cost and dispensing fees. Ingredient costs for compound components are entered on the Compound tab.
Basis of Cost Determination	Enter the code that describes the basis on which the provider established the drug's price. This field will be uneditable if Compound Code "2" was selected on the Service 1 tab.
Coverage Code	Select the code identifying when the client has other insurance and action taken regarding that coverage.

NCPDP Service 2	
Field	Description
Number of Other Payers	Select the number of other payers, from zero to nine, for whom you wish to enter coverage information. Other Payer tabs will open according to the number entered.
DUR/PPS Reason for Service	Select the code identifying the type of utilization conflict detected, if applicable.
DUR/PPS Professional Service Code	Select the code indicating pharmacist intervention when a conflict code has been identified, if applicable.
DUR/PPS Result of Service Code	Select the code identifying the action taken by a pharmacist in response to a conflict, if applicable.
DUR/PPS Level of Effort	Select the code indicating the level of effort as determined by the complexity of decision-making, if applicable. This field is required for compound drugs.

- If no other payers were identified on the Service 2 tab, proceed to step 9.
- If other payers were identified on the Service 2 tab, select the Other Payers tab.
- Enter data into all the required fields on the Other Payer tab using the table below as a guide.

TIP

Fill out all four DUR/PPS fields for the pharmaceutical care dispensing fee.

Other Payer	
Field	Description
Other Payer Type	Select the code identifying the type of payer.
Other Payer Date	Enter the date the other payer paid or denied the claim.
Reject/Paid	Click the "Reject" or "Paid" button to indicate whether the payer rejected or paid the claim.
Reject Code	Enter up to four reject codes, if applicable. These fields will only be editable after the "Reject" button is clicked.
Amount Paid	Select the amount paid qualifier in the drop-down field, then enter the amount associated with the qualifier, if applicable. These fields will only be editable after the "Paid" button is clicked.
Patient Responsibility Paid Amount	Enter the amount (e.g., copayment or deductible) for which a SeniorCare member is responsible to another payer.

- If the prescription is not a compound drug, proceed to step 12.
- If the prescription is a compound drug, select the Compound tab.
- Enter data into all the required fields on the Compound tab using the table below as a guide.

NCPDP Compound	
Field	Description
Dosage Form	Select the code identifying the dosage form of the complete compound mixture.

NCPDP Compound	
Field	Description
Dispensing Unit Ind	Select the code indicating the quantity measurement of the complete compound mixture.
Compound Ingredients — NDC	Enter the NDC for the ingredient used in the compound mixture.
Ingredient Quantity	Enter the amount of the ingredient included in the compound mixture, indicated in metric decimal units.
Compound Ingredient Cost	Enter the total cost for the metric decimal quantity of the ingredient included in the compound mixture.
Basis of Cost Determination	Enter the code that describes the basis on which the provider established the compound ingredient's price.

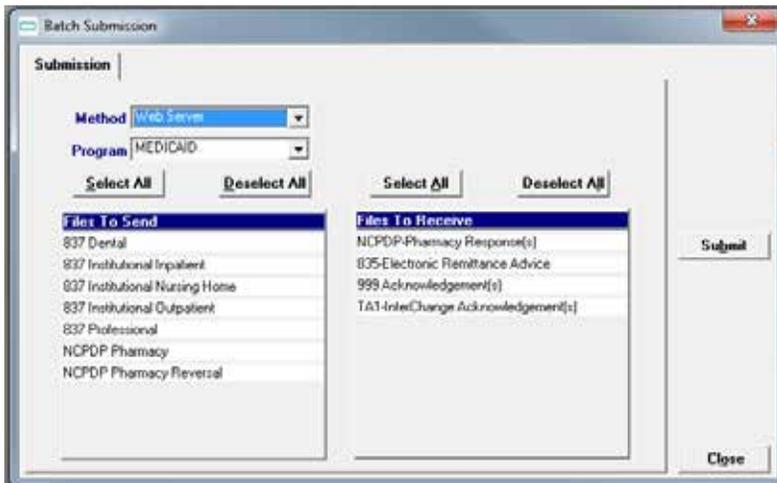
- Click on the Add Ingredients field to enter data about the remaining ingredients in the compound mixture. Enter data into the NDC, Ingredient Quantity, Compound Ingredient Cost, and Basis of Cost Determination fields for all of the ingredients.
- Click **Save**, then **Close**. Proceed to Submitting New Pharmacy Claims.

Submitting New Pharmacy Claims

Once you have completed all required screens for your claim and have saved the information, you are ready to submit the claim to the Electronic Data Interchange Department.

TIP
To prevent submission of a specific claim(s) within a batch, save the claim(s) as incomplete ("I" status) by inserting a tick mark ("~") in any of the form's fields and pressing Save.

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



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

- Click **Communication** on the menu bar.
- Click **Submission**. The Batch Submission window will display.

3. Select “Web Server” from the Method field.
4. Select “Medicaid,” “ADAP” or “WCDP” from the Program field.
5. Click on the appropriate form type(s) under Files to Send.
6. Click **Submit**.
7. Provider Electronic Solutions will post messages in the Transmission window updating you on the progress of the transmission.

Resubmitting Pharmacy Claims

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

TIP

In order to resubmit a formerly paid claim, the claim must first be reversed.

Resubmitting a Single Claim

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

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

Resubmitting or Copying a Partial or Entire Batch

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

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

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

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

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

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

4. The Batch Submission window will display.

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

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

7. Click **Submit**.

Reversing Pharmacy Claims



Use this feature when you have initially submitted a pharmacy claim and have received a response, but you wish to void the claim for any reason.

Provider ID	Prescription Number	Date Filled	Last Submit Dt	Status
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1. Click on the NCPDP Pharmacy Claim Reversal icon on the toolbar.

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

NCPDP Pharmacy Reversal Header	
Field	Description
Program	Select Medicaid, ADAP, or WCDP.
Provider ID	Select the NPI (for health care providers) or provider number (for non-healthcare providers) of the billing provider.
Client ID	Enter or select the member identification number.
Date Filled	Enter the date the drug was filled.
Prescription Number	Enter the number used to identify the prescription.
NDC	Enter the NDC of the prescription being reversed. For a compound drug reversal, enter the NDC of the first component.

3. Click **Save** and **Close**.
4. Click **Communication** on the menu bar.
5. Click **Submission**.
6. Select "Web Server" from the Method field.
7. Select "Medicaid," "ADAP," or "WCDP" from the Program field.
8. Click on the appropriate form type under Files to Send.
9. Click **Submit**.

Other Insurance and Medicare

This chapter will provide you with supplemental information about submitting claims when a client has other insurance, Medicare, or both. These instructions only apply to the 837 Health Care Claim: Dental (837D), the 837 Health Care Claim: Professional (837P), and the 837 Health Care Claim: Institutional (837I). For step-by-step instructions on completing forms, refer to the individual claim chapters.

Other Insurance

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

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

Reporting Other Insurance Payments

You will use the OI Adj tab (header level) and in some cases the Srv Adj tab (detail level) to report other insurance payment information in Provider Electronic Solutions (PES).

Look at the Remittance Advice (RA) that was sent to you by other insurance. For payment information that was reported at the header level, complete the OI Adj tab in PES. For payment information that was reported at the service level, complete the Srv Adj tab.

The instructions in this section apply to all 837 claim types. The screens for Institutional Nursing Home are shown just as examples.

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

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

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

Example of a Payable Claim

- On the OI Adj tab, the Paid Date/Amount should be the date and dollar amount reported to you by the other insurance carrier.
- The Remaining Patient Liability is the amount owed after adjudication of the claim by the other insurance.

- Choose the appropriate adjustment group code that describes the reason that the other insurance carrier did not pay the charges in full. For example, “PR” indicates patient responsibility and should be used when reporting coinsurance or deductible amounts.
- Choose the most appropriate code (or the ANSI code given to you by the carrier on the explanation of benefits) in the reason code field. Adjustment reason codes that are used by ForwardHealth to process claims are located in Appendix 1 of this manual.
- Enter the dollar amount that correlates with the reason code.

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

Medicare

If you are billing Medicare Managed Care, refer to the section called “Medicare Managed Care” found in this chapter. For more information on Medicare denials, refer to the “Reporting Other Insurance or Medicare Denials” section in this chapter.

Note: Not all providers are required to bill Medicare, even though the policyholder may have Medicare coverage. Refer to the ForwardHealth Online Handbook for more information.

You will use the Medicare tab (header level) and in some cases the Srv Adj tab (detail level) to report Medicare payment information in PES.

Look at the RA that was sent to you by Medicare. For payment information that was reported at the header level, complete the Medicare screen in PES. For payment information that was reported at the service level, complete the Srv Adj tab. To access the Srv Adj tab, select “Y” in the Service Adjustment Ind field on the appropriate service tab.

Note: For each detail in which you wish to complete service adjustment information, you will need to highlight that service line and select “Y.”

Medicare Information for Institutional Claims

Medicare pays at the header level for inpatient hospital and nursing home providers. Outpatient hospital claims may pay at the header level or the detail level, so providers should enter Medicare adjudication amounts (e.g., allowed, paid, coinsurance, copayment, and deductible amounts) in the same way they were received on the Medicare remittance information.

When Medicare pays at the detail level for outpatient hospital claims, begin by completing only the top portion of the Medicare tab.

837 Institutional Outpatient

Total Billed Amount 3,000.00

Services

Hdr 1 | Hdr 2 | Hdr 3 | Hdr 4 | Hdr 5 | Hdr 6 | Medicare | Srv | Srv 2

Benefits Assignment [Y] Claim Filing Ind Code [MA]

Policy Holder
Carrier Code 004
Last Name HOTLEY First Name TOLLY

M-B [N] Paid Date/Amount 03/01/2013 1,000.00

Remaining Patient Liability 00

Adjustment Group Codes/Reason Codes/Amounts

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

Provider ID	Client ID	Last Name	First Name	Billed Amount	From DOS	Last Subm
-------------	-----------	-----------	------------	---------------	----------	-----------

Buttons: New, Copy, Delete, Undo All, Save, Edit All, Find..., Print, Close

To complete the rest of the Medicare adjudication information on the detail level, select Y in the Service Adjustment Ind field on the Srv tab, then click the Srv Adj tab and enter the Medicare detail information.

837 Institutional Outpatient

Total Billed Amount 3,000.00

Services

Hdr 1 | Hdr 2 | Hdr 3 | Hdr 4 | Hdr 5 | Hdr 6 | Medicare | Srv | Srv 2 | Srv Adj

From DOS 02/01/2013 To DOS 00/00/0000 Revenue Code

Unit Rate 20.00 Units 150.00 Basis of Measurement [UN]

Billed Amount 3,000.00 Modifiers: 1 2 3 4

Procedure

Line Item CUI

Service Adjustment Ind [Y] RX Ind [N]

Srv #	DOS	Revenue Code	Units	Billed Amount
1	2/1/2013		150.00	3,000.00

Provider ID	Client ID	Last Name	First Name	Billed Amount	From DOS	Last Subm
-------------	-----------	-----------	------------	---------------	----------	-----------

Buttons: New, Copy, Delete, Undo All, Save, Edit All, Find..., Print, Close

837 Institutional Outpatient

Total Billed Amount: 3,000.00

Carrier Code: 004 Name: MEDICARE

Paid Date/Amount: 03/01/2013 1,000.00

Remaining Patient Liability: .00

Adj	Code	Reason	Amount
1	45		2,000.00
2		5	.00
3		6	.00

Adj	Code	Reason	Amount
1			1,000.00

Provider ID | Client ID | Last Name | First Name | Billed Amount | From DOS | Last Subm

When completing the Medicare tab for 837I claims, keep in mind the following:

837 Institutional Nursing Home

Total Billed Amount: 2,073.00

Carrier Code: 004 Name: MEDICARE

Paid Date/Amount: 07/10/2011 1,573.00

Remaining Patient Liability: 327.00

Adj	Code	Reason	Amount
1	45		1,730.00
2		5	.00
3		6	.00

Adj	Code	Reason	Amount
1			327.00

Provider ID | Client ID | Last Name | First Name | Billed Amount | From DOS | Last Subm

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

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

Medicare Information for Professional Claims

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

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

When reporting Medicare information for 837P claims, you should complete the following fields on the Medicare tab:

- Benefits Assignment.
- Claim Filing Ind Code.
- Policyholder fields.
- Paid Amount.

Note: Enter the paid amount *for the entire claim* at the header level. You will enter the paid amount for each detail of the claim on the Srv Adj tab.

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

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

837 Professional

Total Billed Amount 3,600.00 Services

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

Carrier Code 004 Name MEDICARE

Paid Date/Amount 07/10/2011 50.00 Detail Number 1

Remaining Patient Liability 10.00

Adjustment Group Code/Reason Codes/Amounts

Adj Group	Reason Code	Amount
1	96	35.00
2	5	00
3	6	00

Ol #	Carrier Code	Carrier Name	Adj Group	Paid Amount
1	004	MEDICARE	PR	50.00

Provider ID | Client ID | Last Name | First Name | Billed Amount | From DOS | Last Sub

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

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

In the example above, assume that the dollar amount billed for the detail was \$95.00, so \$50.00 (Paid Amount) + \$10.00 (PR-1) + \$35.00 (CO-96) = \$95.00 (dollar amount billed for the detail).

Medicare Managed Care

To submit a Medicare Managed Care (MMC, also known as Medicare + Choice, Medicare Cost, or Medicare Risk) claim using PES software, you will need to use the Medicare tabs. To activate and make the Medicare tabs

visible, set the Medicare Ind field to “Y.” This indicator may be found on the last Header Tab of any open claim form.

The screenshot shows a software window titled "837 Institutional Nursing Home" with a "Services" tab. The "Total Billed Amount" is 0.00. The header tabs are Hdr 1, Hdr 2, Hdr 3, Hdr 4, Medicare, and Srv. The Medicare tab is selected. The "Diagnosis Codes" section includes Primary, Admit, and Other (1-4) fields. The "Condition Codes" section includes 11 numbered fields. The "Other Insurance Ind" is set to "N" and the "Medicare Ind" is set to "Y". A table at the bottom shows columns for Provider ID, Client ID, Last Name, First Name, Billed Amount, From DOS, and Last Sub.

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

The screenshot shows the same software window with the "Medicare" tab selected. The "Total Billed Amount" is 0.00. The header tabs are Hdr 1, Hdr 2, Hdr 3, Hdr 4, Medicare, and Srv. The Medicare tab is selected. The "Benefits Assignment" dropdown is set to "N" and the "Claim Filing Ind Code" is "MA". The "Policy Holder" section includes Carrier Code, Last Name, and First Name fields. The "M-8" dropdown is set to "N" and the "Paid Date/Amount" is 00/00/0000. The "Remaining Patient Liability" is 0.00. The "Adjustment Group Codes/Reason Codes/Amounts" section includes a table with 3 rows and 6 columns. A table at the bottom shows columns for Provider ID, Client ID, Last Name, First Name, Billed Amount, From DOS, and Last Sub.

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

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

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

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

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

TIP

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

- 1 — Deductible Amount
- 2 — Coinsurance Amount
- 3 — Copayment Amount

Medicare Managed Care for Institutional Claims

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

FR	CO	Amount
1 3	1 45	227.00 4
2 1	2	100.00 5
3	3	.00 6

Provider ID	Client ID	Last Name	First Name	Billed Amount	From DDS	Last Sub

- The Policyholder carrier code should be “004.” The “004” code is labeled as “Medicare,” but this carrier code should also be used when submitting MMC claims.
- The Paid Date/Amount should be the date and dollar amount reported to you by the MMC organization on their RA.
- Choose the appropriate adjustment group code that describes the reason that Medicare did not pay the charges in full. For example, “PR” indicates patient responsibility and is used when reporting coinsurance, copayment, or deductibles. In the event the MMC RA does not differentiate between copayment and coinsurance, these dollars should be reported as copayment.
- Choose the most appropriate code (or the ANSI code given to you by the carrier on the EOB) in the reason code field. Adjustment reason codes used by ForwardHealth to process claims are located in Appendix 1 of this manual.
- Enter the dollar amount that correlates with the reason code.

Note: The dollar amount entered in the Paid Amount field and the dollar amount entered in the Adjustment Group Codes/Reason Codes/Amounts and Non

Covered Charges fields must equal the amount indicated in the Total Billed Amount field at the top of the Medicare screen.

Medicare Managed Care for Professional Claims

Medicare Managed Care may pay at the detail level for certain services such as physician, home health, PT, OT, and SLP.

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

- Benefits Assignment.
- Claim Filing Indicator Code.
- Policyholder fields.
- Paid Amount.

Note: Enter the paid amount *for the entire claim* at the header level. You will enter the paid amount for each detail of the claim on the Srv Adj tab.

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

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

The screenshot shows the 'Srv Adj' tab in the B37 Professional software. At the top, the 'Total Billed Amount' is 3,600.00. Below this, there are tabs for Hdr 1, Hdr 2, Hdr 3, Medicare, Srv 1, Srv 2, and Srv Adj. The 'Srv Adj' tab is active, showing a 'Carrier Code' of 004 and a 'Name' of MEDICARE. The 'Paid Date/Amount' is 07/10/2011 with a value of 60.00, and the 'Detail Number' is 1. The 'Remaining Patient Liability' is 40.00. Below these fields is a table for 'Adjustment Group Code/Reason Codes/Amounts' with a dropdown menu set to 'PR'. The table has three rows of data:

	Adj Group	Reason Code	Amount
1	3	30.00	.00
2	1	10.00	.00
3	6	.00	.00

Below the table is a section for 'Add Srv Adj' with a table showing the current adjustment:

Adj #	Carrier Code	Carrier Name	Adj Group	Paid Amount
1	004	MEDICARE	PR	60.00

Buttons for 'New', 'Copy', 'Delete', 'Undo All', 'Save', 'Find...', 'Print', and 'Close' are located on the right side of the window.

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

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

In the example above, assume that the dollar amount billed for the detail was \$100.00, so \$60.00 (Paid Amount) + \$30.00 (PR-3) + \$10.00 (PR-1) = \$100.00 (dollar amount billed for the detail).

Other Insurance and Medicare Payment on the Same Claim

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

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

In this example, assume that Medicare paid \$320.00 as primary.

The Other Insurance tab will need to report the Medicare payment as Adjustment Group Code Other Adjustment (OA) and Reason Code 23 (Payment adjusted – paid by another payer). Other noncovered charges may also be reported under Adjustment Group Code OA with an appropriate Reason Code.

The Total Billed Amount is \$560.00. To balance the claim, add the Paid Amount and the Adjustment Group Codes/Reason Codes/Amounts. \$40.00 (Paid Amount) + \$40.00 (PR-2) + \$320.00 (OA-23) + \$160.00 (OA-45) = \$560.00 (Total Billed Amount).

- Enter data on the OI tab.

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

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

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

TIP

Providers can only select two Adjustment Group Codes on the OI Adj tab. Patient responsibility amounts should always be indicated under Adjustment Group Code PR. For claims that indicate payments by both Medicare and OI, the Medicare paid amount should always be indicated under Adjustment Group Code OA.

If there are other noncovered amounts (commonly reported as Adjustment Group Code/Reason Code CO-45 or CO-96 on remittance information), indicate the noncovered amounts under Adjustment Group Code OA with the correct Reason Code (45 or 96).

Amounts for coinsurance, the Medicare payment amount, and other noncovered charges.

837 Institutional Nursing Home

Total Billed Amount: 160.00

Services: []

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

OI Y: N | Paid Date/Amount: 07/10/1201 | 40.00

Remaining Patient Liability: 40.00

Adjustment Group Codes/Reason Codes/Amounts

	PR			GA			
1	2	40.00	4			320.00	4
2		.00	5		.00	160.00	5
3		.00	6		.00	.00	6

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

Provider ID | Client ID | Last Name | First Name | Billed Amount | From DOS | Last Sub

Reporting Other Insurance or Medicare Denials

Example of a Header-Level Claim Denied by OI/Medicare

837 Institutional Nursing Home

Total Billed Amount: 1550.00

Services: []

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

Benefits Assignment: Y | Claim Filing Ind Code: MA

Policy Holder

Carrier Code: 004

Last Name: SMITH | First Name: DONNA

M-8: N | Paid Date/Amount: 07/10/2011 | .00

Remaining Patient Liability: .00

Adjustment Group Codes/Reason Codes/Amounts

	CO						
1	119	1,550.00	4		.00	.00	4
2		.00	5		.00	.00	5
3		.00	6		.00	.00	6

OI #	Carrier Code	Carrier Name	Last Name	First Name
1	004	SMITH	SMITH	DONNA

Provider ID | Client ID | Last Name | First Name | Billed Amount | From DOS | Last Sub

The Total Billed Amount must equal the sum of any Adjustment Group Codes/Reason Codes/Amounts.

Note: You may need to select the appropriate tab to indicate the denial (the example above is a nursing home claim indicating a Medicare Part A denial).

Example of a Detail-Level Claim Denied by Medicare

Srv 1 Tab

Srv #	From DOS	To DOS	POS	Procedure	Units	Billed Amount
1	07/01/2011		12	50806	5.00	100.00
2	06/14/2011			A2847	4.00	100.00
3	06/17/2011			90806	5.00	250.00

Provider ID	Client ID	Last Name	First Name	Billed Amount	From DOS	Last Subr
0987654321	0000000000	MEMBER	IMA	450.00	06/14/2011	00/00/0

The Billed Amount for the service detail must match the amount indicated on the Srv Adj tab for that service detail.

Srv Adj Tab

AD #	Carrier Code	Carrier Name	Adj Group	Paid Amount
1	004	MEDICARE	CO	.00

Provider ID	Client ID	Last Name	First Name	Billed Amount	From DOS	Last Subr
0987654321	0000000000	MEMBER	IMA	450.00	06/14/2011	00/00/0

The Adjustment Amount for this service detail must be the same as the Billed Amount for the service detail.

When reporting OI or Medicare denials, keep in mind the following:

- On the Medicare tab, OI Adj tab, or Srv Adj tab, the Paid Date/Amount should be the date and dollar amount reported to you by the other carrier.
- Choose the appropriate adjustment group code that describes the reason that the other insurance carrier did not pay the charges in full. For example, "PR" indicates patient responsibility and should be used when reporting coinsurance or deductible amounts.

- Choose the most appropriate code (or the ANSI code given to you by the carrier on the explanation of benefits) in the reason code field. Adjustment reason codes used by ForwardHealth to process claims are located in Appendix 1 of this manual.
- Enter the dollar amount that correlates with the reason code.

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

Communication

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

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

Copying Batch Forms

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

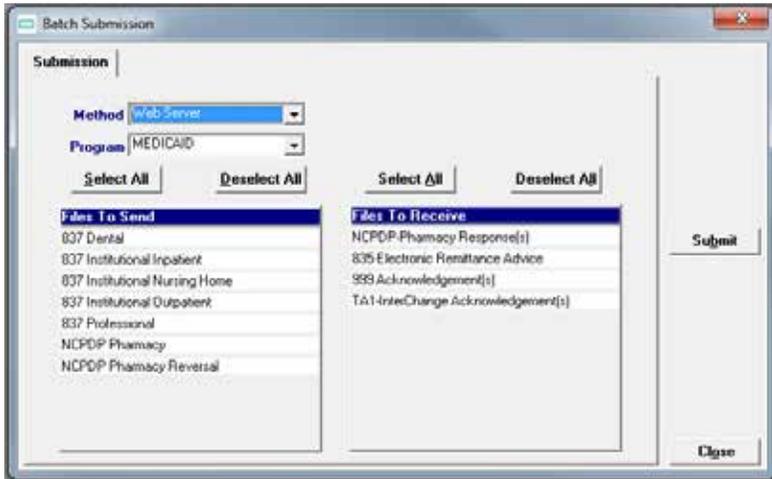
1. Click **Communication** on the menu bar.
2. Click **Resubmission**.
3. Select the appropriate batch from the list of batches displayed by clicking on the batch.
 - Click **Copy** to copy the entire batch.
 - Click **Deselect All** and select individual forms to copy from the batch. Click **Copy**.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

Retrieving Batch Responses

To retrieve a 999 Functional Acknowledgement (999), 835 Health Care Claim Payment/Advice (835) transaction, or a National Council for Prescription Drug Programs (NCPDP) Pharmacy Batch Response, do the following:

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

2. Click **Submission**. The Batch Submission window will display.
3. Select “Web Server.”



4. Select “Medicaid,” “WCDP,” “ADAP,” or “WWWP” from the Program field.
5. Click on the appropriate form type(s) under Files to Receive.
6. Click **Submit**.

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

Viewing Batch Responses

To view a 999 Acknowledgement, an 835 transaction, or the NCPDP Pharmacy Batch Response(s), do the following:

1. Click **Communication** from the menu bar.
2. Click **View Batch Response**.
3. Locate the desired batch. All transactions submitted within the batch will be displayed in the batch report.

TIP

You can track your 999 Acknowledgement back to its respective 837 Health Care Claim (837) submission by matching the Group Control Number from the 999 to the Group Control Number in the communication log of the 837 submission.

999 - Acknowledgment Batch Response

Production/Test
Indicator: P Production

Trading Partner ID: 100000080
Submission Date: 07/18/2008
Submission Time: 17:50
Claim Type: 005010

Functional Identifier: HC Health Care Claim (837)
Group Control Number: 42
Version/Release Code: No Data

Transaction Set
Acknowledgment: A Accepted

Note: If an Acknowledgement shows that a submission has been rejected, contact the EDI Help desk for assistance. The telephone number for the EDI Helpdesk is 866-416-4979. The Helpdesk can also be contacted using the Contact Information tab in the secure Provider area of the ForwardHealth Portal.

Reading Pharmacy Batch Responses

The Pharmacy Batch Response includes useful information about how the pharmacy claim has processed. Pharmacy providers may use the batch response to respond to the claim right away. The sample Pharmacy Batch Responses below display the following information:

- The status of the transaction (e.g., paid or denied), internal control number for tracking purposes, and explanation of benefit code descriptions.
- The actions taken on the claim, such as the amount that the patient should pay toward the prescription, the ingredient cost or dispensing fee that ForwardHealth will pay, and deductible or copayment amounts that the patient owes.
- For all denied claims, the name(s) of the ForwardHealth program(s) in which the member was enrolled on the date of service.

Pharmacy Batch Response

HP PROVIDER ELECTRONIC SOLUTIONS

VERSION/RELEASE NUMBER: D.0
TRANSACTION CODE: B1 - BILLING
HEADER RESPONSE STATUS: ACCEPTED
RESPONSE DATE: 09/26/2011 09:55:06

PROVIDER ID QUALIFIER: 01
PROVIDER ID: [REDACTED]
DATE OF SERVICE: 09/26/2011

***** INSURANCE SEGMENT *****

GROUP ID: WISC TXIX

***** STATUS SEGMENT *****

TRANSACTION STATUS: P - PAID
AUTHORIZATION NUMBER: 2011269001013
ADDITIONAL INFORMATION: PRICING ADJUSTMENT - THE SUBMITTED CHARG
ADDITIONAL INFORMATION: E EXCEEDS THE ALLOWED CHARGE. CLAIM PAID
ADDITIONAL INFORMATION: AT THE PROGRAM ALLOWED AMOUNT.
ADDITIONAL INFORMATION: PRICING ADJUSTMENT - TRADITIONAL DISPENS
ADDITIONAL INFORMATION: ING FEE APPLIED.
ADDITIONAL INFORMATION: PRICING ADJUSTMENT - REIMBURSEMENT REDUC
ADDITIONAL INFORMATION: ED BY THE MEMBER'S COPAYMENT AMOUNT.
ADDITIONAL INFORMATION: NDC WAS REIMBURSED AT BRAND WAC RATE.
ADDITIONAL INFORMATION: PRICING ADJUSTMENT - PHARMACY PRICING AP

***** CLAIM SEGMENT *****

BILLING FOR: 1 - RX BILLING

RX NUMBER: 234567890123

Pharmacy Batch Response

HP PROVIDER ELECTRONIC SOLUTIONS

VERSION/RELEASE NUMBER: D.0
TRANSACTION CODE: B1 - BILLING
HEADER RESPONSE STATUS: ACCEPTED
RESPONSE DATE: 09/26/2011 09:56:41

PROVIDER ID QUALIFIER: 01
PROVIDER ID: [REDACTED]
DATE OF SERVICE: 09/26/2011

MESSAGE: WISCONSIN CHRONIC DISEASE-RENAL DISEASE*WISCONSIN CHRON
IC DISEASE-HEMOPHILIA HOMECARE

***** INSURANCE SEGMENT *****

GROUP ID: WISC WCDP

***** STATUS SEGMENT *****

TRANSACTION STATUS: R - REJECTED
AUTHORIZATION NUMBER: 2011269001014
REJECT CODE: 21
ADDITIONAL INFORMATION: NDC IS OBSOLETE FOR THE DATE OF SERVICE.
ADDITIONAL INFORMATION: NATIONAL DRUG CODE (NDC) IS INVALID FOR
ADDITIONAL INFORMATION: THE DISPENSE DATE OF SERVICE.
HELP DESK PHONE CODE: 03 - PROCESSOR/PBM
HELP DESK PHONE: 8009479627

***** CLAIM SEGMENT *****

BILLING FOR: 1 - RX BILLING

RX NUMBER: 234567890123

CLAIM DETAIL: 1
RESPONSE DATE: 09/26/2011 09:56:41

Providers who have questions about a Pharmacy Batch Response should contact the EDI Helpdesk for assistance. The telephone number for the EDI Helpdesk is 866-416-4979. The Helpdesk can also be contacted using the Contact Information tab in the secure Provider area of the ForwardHealth Portal.

Viewing Communication Logs

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

1. Click **Communication** on the menu bar.
2. Click **View Communication Log**. The Communication Log window opens and displays a list of recent submissions.
3. Click on the desired file. The submission information for the selected file will be displayed in the lower portion of the screen.

FILE 42601136.FIV

```
Starting Submission Process.
Getting web submission options.
Formatting 837 Professional batch.
Sending/Receiving batch transactions in progress.
CONNECTION USING WEB-SERVER ON 9/16/04 AT 11:36:45.
Using MS Internet Explorer settings to connect to internet.
Uploading files to Web Server.
Submitter ID for upload pes-admin.
Uploading 837 Professional File.
THE NUMBER OF BYTES TO BE TRANSFERED IS: 833
THE HTTP REQUEST RETURNED AN XML MESSAGE CODE OF:
0
TRANSACTION ACCEPTED WITH NO ERRORS.
THE EXTERNAL BATCH NUMBER IS: 5429
Group Control Number is: 16
Upload of the file was successful.
```

Reports

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

Detail Form Reports

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

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



FILE 42601136.FIV

```
Starting Submission Process.
Getting web submission options.
Formatting 837 Professional batch.
Sending/Receiving batch transactions in progress.
CONNECTION USING WEB-SERVER ON 9/16/04 AT 11:36:45.
Using MS Internet Explorer settings to connect to internet.
Uploading files to Web Server.
Submitter ID for upload pes-admin.
Uploading 837 Professional File.
THE NUMBER OF BYTES TO BE TRANSFERRED IS: 833
THE HTTP REQUEST RETURNED AN XML MESSAGE CODE OF:
0
TRANSACTION ACCEPTED WITH NO ERRORS.
THE EXTERNAL BATCH NUMBER IS: 5429
Group Control Number is: 16
Upload of the file was successful.
```

Batch Number

5. In the Form Status field, choose a status from the drop-down list or enter the submission date in the Submit Date field.
6. Click **OK**.
7. Click **Print** to create a hard copy of the form.

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

Summary Reports

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

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

List Reports

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

Tools

The Tools menu commands discussed in this chapter include:

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

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

Archive

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

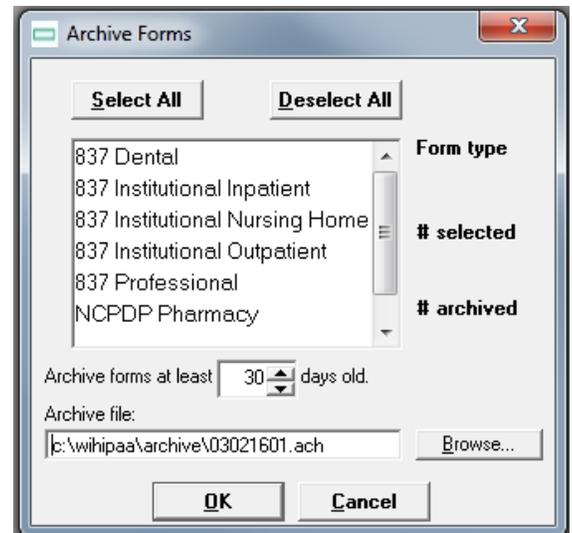
When setting up the retention option under your personal options, you can choose how many days history you want to keep online. The standard setting is 30 days; however, you may select the setting that best suits your needs.

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

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

To create a form archive, follow these steps:

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



3. Click **Create**.

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

4. Click **OK**.
5. Click **Yes**.
6. Select all transaction types to be archived, or click **Select All**.

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

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

Restore Archive

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

1. Click **Tools** on the menu bar.
2. Click Archive.
3. Click Restore.
4. Click **Browse** to select the file to restore.
5. Select the file to be restored and click **Open**.
6. Click **Next**.
7. Select the type of form desired on the list of form types available. Click **Next**.

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

TIP

Although you cannot select individual claims to archive, you may archive all claims and then restore an individual claim or claims that you wish to keep within your claim form for copying or referral.

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

Database Recovery

The Database Recovery option is designed to help you work with the Electronic Data Interchange (EDI) Helpdesk personnel to fix problems with the database. The telephone number for the EDI Helpdesk is 866-416-4979. The Helpdesk can also be contacted using the Contact Information tab in the secure Provider area of the ForwardHealth Portal.

Compact Database

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

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

To use compact database:

1. Click **Tools**.
2. Click **Database Recovery**.
3. Click **Compact**.

Repair Database

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

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

To run the repair database option:

1. Click **Tools**.
2. Click **Database Recovery**.
3. Click **Repair**.

Unlock Database

Sometimes errors will cause database locks. The database may lock after submitting forms, archiving forms, restoring forms, and sometimes when adding or editing forms. To unlock the database:

1. Click **Tools**.
2. Click **Database Recovery**.
3. Click **Unlock**.

Get Upgrades

The EDI Department will inform users when a PES upgrade is available via email. Users should check for upgrades on a weekly basis and download them when available, using the instructions below. Failure to perform upgrades will prevent users from submitting claims to Wisconsin Medicaid, Wisconsin AIDS/HIV Drug Assistance Program, Wisconsin Chronic Disease Program, or Wisconsin Well Woman Program.

To get an upgrade for PES:

1. Choose **Tools**.
2. Choose **Get Upgrades**.
3. Follow online instructions.

Once the upgrade is downloaded, exit the application and go into the upgrade application to apply the upgrade. If you have installed PES on several PCs, you will need to get upgrades for each PC and apply the upgrades individually.

Note: Always use the upgrade function. Do not load a new version of PES; this would result in the loss of all lists and forms that have been created.

TIP

If you are performing multiple upgrades, be sure to execute *each* upgrade to receive all software changes.

Passwords

All authorized users must have a password to access PES software. A password may be any combination of alphabetic, numeric, and special characters. It is not case sensitive. A password must be at least five, and no more than 10, characters in length.

Changing Passwords

The Change Password option allows you to change your login password at any time. PES records the date the password was changed.

PES requires you to change your password after the number of days designated in the options retention setting has elapsed. To change your password:

1. Click **Tools**.
2. Click **Change Password**.



The screenshot shows a dialog box titled "Logon" with the Hewlett Packard Enterprise logo. The main text reads: "Enter all fields to change a user password on the HPE Provider Electronic Solutions Application." Below this, there are several input fields: "User ID" (containing "pes-admin"), "Old Password", "New Password", "Rekey New Password", "Question" (a dropdown menu with "What is your mother's maiden name?" selected), "Answer" (masked with asterisks), and "Rekey Answer" (masked with asterisks). There are "OK" and "Cancel" buttons in the top right corner.

3. Enter the old password.
4. Enter a new password that is five to 10 characters in length in the New Password field.
5. Re-enter the new password in the Rekey New Password field.
6. Click **OK**.

Security

Security Maintenance

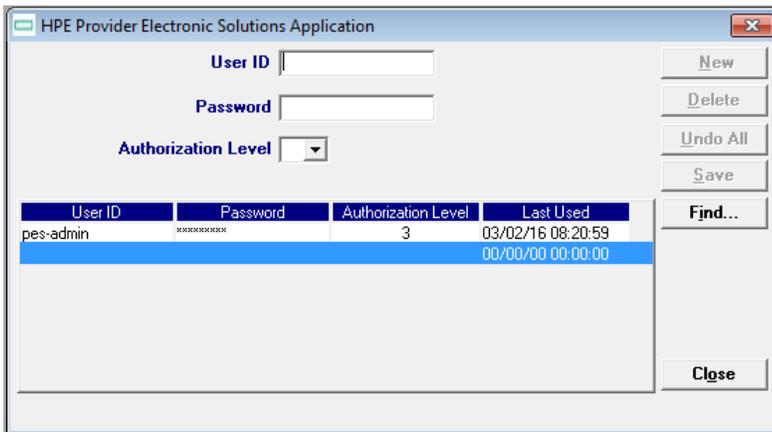
The Security Maintenance window is only accessible by a user logged on with a valid user identification (ID) and

password with assigned administrative authority. The security maintenance function is used to:

- Assign additional user IDs.
- Reset a password for a user.
- Delete obsolete user IDs.

To enter or edit a user's information, follow these steps:

1. Click **Security**.
2. Click **Security Maintenance**.



3. Enter a user ID. If you select an existing user ID, the user information fields will populate with the user's data.
4. Enter or edit the Password field. When a password is assigned or changed through the security maintenance function, the password is automatically set as expired and the user will have to change his or her password at the first login.
5. Enter or edit the Authorization Level field. Users with an authorization level of "2" will not have access to the security functions in PES.
6. Click **Save** to save the new user information or **Add** to add an additional user.

Web Password Reset

When the Web login password has expired, PES will notify users with a message. The Web login password can be changed on the ForwardHealth Portal at www.forwardhealth.wi.gov/.

Forgotten Password

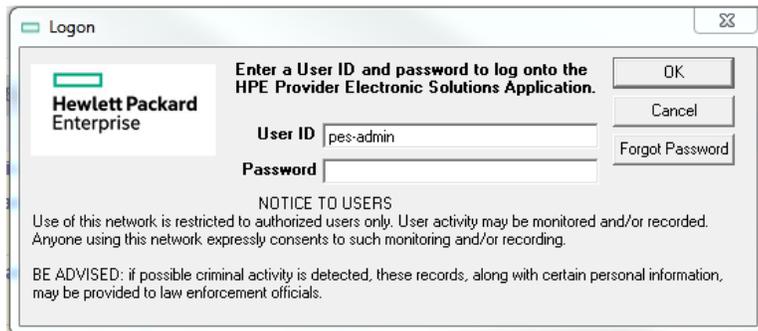
If you forget your login password, the Forget Password function in PES will prompt you with the question that you entered when you first keyed in your password. Once the correct answer to this question is entered, PES will allow you to reset your password.

Note: The Forgotten Password feature is only available on the primary (Typical install) computer.

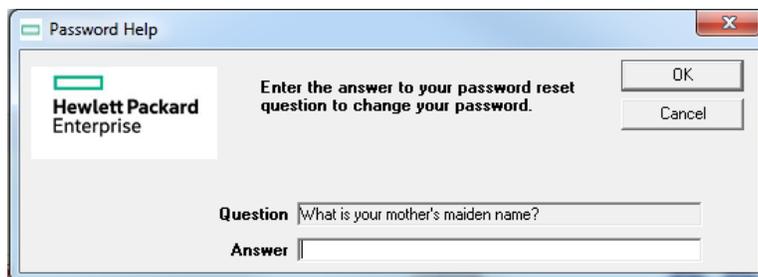
If you know you have forgotten your password, follow the steps below starting with step 1.

If you enter incorrect passwords on three consecutive attempts, the Forget Password function will be invoked automatically; in this case, begin with the instructions in step 2.

1. Click **Forgot Password** on the Logon window.



2. Enter the answer to your password reset question.



3. Click **OK**.
4. Enter and rekey your new password in the Password Reset window. Click **OK**.
5. A message will display indicating that the password update was successful.

TIP

If after three consecutive attempts you do not enter a correct answer in the Password Help window, PES will ask if you want to reset your password.

If you click **Yes**, the password will be reset for you. If you click **No**, the application will close. You will then need to call the EDI Helpdesk to request a new password. The EDI Helpdesk will need your User ID and Reset Key to set up a new password.

Options

For a complete description of options, refer to the Getting Started chapter of this manual.

Appendix 1 – Lists

This section contains some of the lists that exist in Provider Electronic Solutions (PES). For more information on how to build and use lists, refer to the [Lists chapter](#).

You may copy descriptions from the lists in this appendix while working online. Use the text select tool in Adobe® Reader, then copy and paste into the description field in PES.

Please note that these lists are subject to change. Please review your program materials and other sources for current codes.

ANSI Adjustment Reason Codes (ARC)

This list includes ANSI codes that are used by ForwardHealth to process claims. Refer to www.wpc-edi.com/codes online for a current listing of 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 NCPDP 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.

Carrier Codes

Code	Description
001	Other Insurance Carrier 1
002	Other Insurance Carrier 2
003	TriCare
004	Medicare
005	Medigap

Claim Filing Indicator Codes

Code	Description
11	Other Non-Federal Programs
12	Preferred provider organization (PPO)
13	Point of service (POS)
14	Exclusive provider organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Condition Codes

Code	Description
01	Military service related
02	Condition is employment related
03	Client covered by insurance not reflected here
04	HMO enrollee
05	Lien has been filed
06	ESRD patient in first 18 Months of group health insurance
07	Treatment of non-terminal condition for hospice treatment
08	Beneficiary would not provide other insurance information
09	Neither patient nor spouse is employed
10	Patient and/or spouse is employed but no EGHP exists
11	Disabled beneficiary, but no LGHP
17	Patient is homeless
18	Maiden name retained
19	Child retains mother's name
20	Beneficiary requested billing
21	Billing for denial notice
22	Client on multiple drug regimen
23	Home caregiver available
24	Home IV patient also receiving HHA services
25	Patient is non-U.S. resident
26	VA-eligible patient receive services in Medicare cert facility
27	Patient referred to a sole community hospital
28	Patient and/or spouse EGHP is secondary to Medicare
29	Disabled beneficiary/family mbr LGHP secondary to Medicare
30	Qualifying clinical trials
31	Patient is student (full time — day)
32	Patient is student (cooperative/work study program)
33	Patient is student (full time — night)
34	Patient is student (part time)
36	General care patient in a special unit
37	Ward accommodation at patient request
38	Semi-private room not available
39	Private room medically necessary
40	Same day transfer
41	Partial hospitalization
42	Continuing care not related to inpatient admission
43	Continuing care not provided within postdischarge window
44	Inpatient admission change to outpatient
46	Non-availability statement on file
48	Psychiatric residential treatment ctr for children & adolesc
49	Product replacement within product lifecycle
50	Product replacement for known recall of a product
55	SNF bed not available

Code	Description
56	Medical appropriateness
57	SNF readmission
58	Terminated Medicare+Choice organization of enrollee
59	Non-primary ESRD facility
60	Day outlier
61	Cost outlier
62	Payer code
63	Incarcerated beneficiaries
66	Provider does not wish cost outlier payment
67	Beneficiary elects not to use life time reserve days
68	Beneficiary elects to use life time reserve days
69	IME/payment only bill
70	Self-administered anemia management drug
71	Full care in unit
72	Self care in unit
73	Self care training
74	Home
75	Home — 100 percent reimbursement
76	Back-up in facility dialysis
77	Provider accepts or obligated due to contractual arrangement
78	New coverage not implemented by HMO
79	CORF services provided offsite
80	Home dialysis — nursing facility
A0	CHAMPUS External Partnership Program
A1	EPSDT/CHAP
A2	Physically Handicapped Children's Program
A3	Special federal funding
A4	Family planning
A5	Disability
A7	Induced abortion — danger to life
A8	Induced abortion — victim rape/incest
A9	Second opinion surgery
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AC	Abortion performed due to serious fetal genetic defect
AD	Abortion performed due to life endangering phys condition
AE	Abortion performed due to physical health of the mother
AF	Abortion performed due to emotional health of the mother
AG	Abortion performed due to social or economic reasons
AH	Elective abortion
AI	Sterilization
AJ	Payer responsible for copayment
AK	Air ambulance required
AL	Specialized treatment/bed unavailable
AM	Non-emergency medically necessary stretcher transport req
AN	Preadmission screening not required

Code	Description
B0	Medicare coordinated care demonstration claim
B1	Beneficiary is ineligible for demonstration program
B2	Critical access hospital ambulance attestation
B3	Pregnancy indicator
B4	Admission unrelated to discharge on same day
C1	Approved as billed
C2	Automatic approval as billed based on focused review
C3	Partial approval
C4	Admission/services denied
C5	Post-payment review applicable
C6	Admission preauthorization
C7	Extended authorization
D0	Changes to service dates
D1	Changes to charges
D2	Changes in revenue codes/HCPCS/HIPPS rate codes
D3	Second or subsequent interim PPS bill
D4	Change in ICD diagnosis and/or procedure codes
D5	Cancel to correct HICN or provider ID
D6	Cancel only to repay a duplicate or OIG overpayment
D7	Change to make Medicare the secondary payer
D8	Change to make Medicare the primary payer
D9	Any other change
DR	Disaster related
E0	Change in patient status
G0	Distinct medical visit
H0	Delayed filing, statement of intent submitted
M0	All-inclusive rate for outpatient services
M1	Roster billed influenza virus vaccine
M2	HHA payment significantly exceeds total charges

Occurrence Codes

Code	Description
01	Auto accident
02	No fault insurance involved — including auto accident/other
03	Accident/tort liability
04	Accident/employment related
05	Other accident
06	Crime victim
09	Start of infertility treatment cycle
10	Last menstrual period
11	Onset of symptoms/illness
12	Date of onset for a chronically dependent individual
16	Date of last therapy
17	Date outpatient occupational therapy plan established
18	Date of retirement — patient/beneficiary
19	Date of retirement — spouse
20	Date guarantee of payment began
21	Date UR notice received
22	Date active care ended
23	Date of cancellation of hospice election period
24	Date insurance denied
25	Date benefits terminated by primary payer
26	Date SNF bed became available
27	Date of hospice certification or precertification
28	Date comprehensive outpatient rehab plan established
29	Date outpatient physical therapy plan established
30	Date outpatient speech pathology plan established
31	Date beneficiary notified of intent to bill accommodations
32	Date beneficiary notified of intent to bill procedures
33	First day of Medicare coordination period — ESRD beneficiaries
34	Date of election of extended care facilities
35	Date treatment started for physical therapy
36	Date of inpatient hosp discharge — covered transplant patient
37	Date of inpatient hospital discharge — noncovrd transplant patient
38	Date treatment started for home IV therapy
39	Date discharged on a continuous course of IV therapy
40	Scheduled date of admission
41	Date of first test preadmission testing
42	Date of discharge
43	Scheduled date of canceled surgery
44	Date treatment started occupational therapy
45	Date treatment started for speech therapy
46	Date treatment started for cardiac rehabilitation
47	Date cost outlier status begins
A1	Birthdate — insured A
A2	Effective date — insured A policy
A3	Benefits exhausted
A4	Split bill date
B1	Birthdate — insured B

Code	Description
B2	Effective date — insured B policy
B3	Benefits exhausted
C1	Birthdate — insured C
C2	Effective date — insured C policy
C3	Benefits exhausted
E1	Birthdate — insured D
E2	Effective date — insured D policy
E3	Benefits exhausted
F1	Birthdate — insured E
F2	Effective date — insured E policy
F3	Benefits exhausted
G1	Birthdate — insured F
G2	Effective date — insured F policy
G3	Benefits exhausted
M0	PRO/UR stay dates
M1	Provider liability — no utilization
M2	Dates of inpatient respite care
M3	ICF level of care
M4	Residential level of care

Occurrence Span Codes

Code	Description
70	Qualifying stay dates (SNF)/non-utilization dates — dates represent at least a three-day hospital stay that qualifies the client for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior stay dates — dates represent client hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/last visit (current visit) — dates represent the outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual From/Through service dates of locator 6 (Statement Covers Period).
73	Benefit eligibility period — dates represent the period during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Non-covered level of care/leave of absence — dates represent the period at a non-covered level of care in an otherwise covered stay, excluding any period reported by occurrence span code 76, 77, or 79.
75	SNF level of care — dates represent SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/QIO has approved the patient remaining in the hospital because of the non-availability of an SNF bed. Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
76	Patient liability — dates represent non-covered care for which the hospital is permitted to charge the Medicare beneficiary. Code should be used only where the QIO or intermediary has approved such charges in advance and client has been notified in writing at least three days prior to the start date of this period.
77	Provider liability period — utilization — dates of non-covered care for which the provider is liable. Utilization is charged.
78	SNF prior stay dates — dates represent any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.

Patient Status

Code	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to other short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under organized care
07	Left against medical advice
09	Admitted as an inpatient to this hospital
20	Expired
30	Still client
40	Expired at home
41	Expired in a medical facility
42	Expired — place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice — home
51	Hospice — medical facility
61	Discharged/transferred to hospital-based swing bed
62	Discharged/transferred to inpatient rehabilitation facility
63	Discharged/transferred to Medicare long term care hospital
64	Discharged/transferred to nursing facility under Medicaid
65	Discharged/transferred to psychiatric hospital
66	Discharged/transferred to critical access hospital
70	Discharged/transferred to another type of health care institution not defined elsewhere
71	Discharged/transferred/referred to another institution for outpatient services
72	Discharged/transferred/referred to this institution for outpatient services

Place of Service Codes

Code	Description
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment — Worksite
19	Off Campus — Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance — Land
42	Ambulance — Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility — Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease (ESRD) Treatment Facility

Code	Description
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Type of Bill Codes

Code	Description
Type of Facility — 1st digit	
1	Hospital
2	Skilled nursing
3	Home health +
4	Religious non-medical health care institutions — hospital inpatient (formerly referred to as Christian Science)
5	Religious non-medical health care institutions — post-hospital extended care services (formerly referred to as Christian Science)
6	Intermediate care
7	Clinic
8	Special facility
9	Reserved for national assignment
Bill Classification (except clinics and special facilities) — 2nd Digit	
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment) **
5	Intermediate care — Level I**
6	Intermediate care — Level II**
7	Subacute inpatient (revenue code 19X required when this bill type is used; however, 19X may be used with other types of bills)
8	Swing beds
9	Reserved for national assignment
Bill Classification (clinics only) — 2nd Digit	
1	Rural health
2	Hospital based or independent renal dialysis center
3	Free standing
4	Outpatient rehabilitation facility (ORF)
5	Comprehensive outpatient rehabilitation facilities (CORFs)
6	Community mental health center
7-8	Reserved for national assignment
9	Other

Bill Classification (special facilities only) – 2nd Digit	
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory surgery center
4	Free-standing birthing center
5	Critical access hospital
6	Residential facility
7-8	Reserved for national assignment
9	Other
Frequency – 3rd Digit	
0	Non-payment/zero claim
1	Admit thru discharge claim
2	Interim – first claim
3	Interim – continuing claim
4	Interim – last claim
5	Late charge(s) only claim
6	Reserved (discontinued as of 10/01/00)
7	Replacement of prior claim
8	Void/cancel of prior claim
9	Final claim for a home health PPS episode

Value Codes

Code	Description
01	Most common semi-private rate
02	Hospital has no semi-private rooms
04	Inpatient professional component charges
05	Professional component included in charges
06	Medicare blood deductible
07	Reserve for national assignment
08	Medicare lifetime reserve amount in the first calendar year
09	Medicare coinsurance amount in the first calendar year
10	Lifetime reserve amount in the second calendar year
11	Coinsurance amount in the second calendar year
12	Working aged beneficiary with employer group health plan
13	ESRD beneficiary in a Medicare coordination period
14	No-fault
15	Worker's compensation
16	PHS, or other federal agency
21	Catastrophic
22	Surplus
23	Recurring monthly income
24	Medicaid rate code
25	Offset to the patient-payment amount — prescription drugs
26	Offset to the patient-payment amount — hearing & ear svcs
27	Offset to the patient-payment amount — vision & eye svcs
28	Offset to the patient-payment amount — dental svcs
29	Offset to the patient-payment amount — chiropractic svcs
30	Preadmission testing
31	Patient liability amount
32	Multiple-patient ambulance transport
33	Offset to the patient-payment amount — podiatric svcs
34	Offset to the patient-payment amount — other service
35	Offset to the patient-payment amount — health ins premium
37	Pints of blood furnished
38	Blood deductible pints
39	Pints of blood replaced
40	New coverage not implemented by HMO
41	Black lung
42	VA
43	Disabled beneficiary under age 65 for LGHP
44	Amount provider agreed to accept from primary payer
45	Accident hour
46	Number of grace days
47	Any liability insurance
48	Hemoglobin reading
49	Hematocrit reading

Code	Description
50	Physical therapy visit
51	Occupational therapy visits
52	Speech therapy visits
53	Cardiac rehab visits
54	Newborn birth weight in grams
55	Eligibility threshold for charity care
56	Skilled nurse — home visit hours
57	Home health aide — home visit hours
58	Arterial blood gas
59	Oxygen saturation
60	HHA branch MSA
61	Location where service is furnished
66	Medicaid spenddown amount
67	Peritoneal dialysis
68	EPO drug
69	State charity care percent
73	Drug deductible
74	Drug coinsurance
80	Covered days
81	Non-covered days
83	Medicare Part A — charges when Part A exhausted
A0	Special ZIP code reporting
A1	Deductible, payer A
A2	Coinsurance, payer B
A3	Estimated responsibility, payer A
A4	Covered self-administrable drugs — emergency
A5	Covered self-administrable drugs — not self-administrable
A6	Covered self-administrable drugs — diagnostic study & other
A7	Copayment, payer A
A8	Patient weight
A9	Patient height
AA	Regulatory surcharges, assessments, allowances, payer A
AB	Other assessments or allowances, payer A
B1	Deductible, payer B
B2	Coinsurance, payer B
B3	Estimated responsibility, payer B
B7	Copayment, payer B
BA	Regulatory surcharges, assessments, allowances, payer B
BB	Other assessments or allowances, payer B
C1	Deductible, payer C
C2	Coinsurance, payer C
C3	Estimated responsibility, payer C
C7	Copayment, payer C
CA	Regulatory surcharges, assessments, allowances, payer C
CB	Other assessments or allowances, payer C
D3	Estimated responsibility, client

Code	Description
E1	Deductible, payer D
E2	Coinsurance, payer D
E3	Estimated responsibility, payer D
E7	Copayment, payer D
EA	Regulatory surcharges, assessments, allowances, payer D
EB	Other assessments or allowances, payer D
F1	Deductible, payer E
F2	Coinsurance, payer E
F3	Estimated responsibility, payer E
F7	Copayment, payer E
FA	Regulatory surcharges, assessments, allowances, payer E
FB	Other assessments or allowances, payer E
G1	Deductible, payer F
G2	Coinsurance, payer F
G3	Estimated responsibility, payer F
G7	Copayment, payer F
GA	Regulatory surcharges, assessments, allowances, payer F
GB	Other assessments or allowances, payer F
Y1	Part A demonstration payment
Y2	Part B demonstration payment
Y3	Part B coinsurance
Y4	Conventional provider payment amount for non-demonstration claims

Visit Point of Origin Codes

Code	Description
1	Physician referral (or newborn normal delivery)
2	Clinic referral (or newborn premature delivery)
3	HMO referral (or newborn — sick baby)
4	Transfer from a hospital (or newborn — extramural birth)
5	Transfer from a skilled nursing facility
6	Transfer from another health care facility
8	Court/law enforcement
9	Information not available
A	Transfer from a critical access hospital
D	Transfer from hospital

Visit Priority Codes

Code	Description
1	Emergency (refers to ER admission)
2	Urgent (generally refers to admission to the first available and suitable accommodation)
3	Elective (scheduled admission)
4	Newborn
5	Trauma Center

Appendix 2 – Here’s Help

A Quick Access Guide to ForwardHealth Program Information

Billing, Enrollment, and Policy Questions

Provider Services — 800-947-9627

Member enrollment information and all other provider service inquiries (including pharmacy):

7:00 a.m. to 6:00 p.m. Mondays–Fridays.

Not available on holidays.

Enrollment Questions

WiCall Automated Voice Response System — 800-947-3544

Available 24 hours a day, seven days a week.

Electronic Data Interchange

Electronic Data Interchange (EDI) Helpdesk — 866-416-4979

8:30 a.m. to 4:30 p.m., Mondays–Fridays.

Not available on holidays.

EDI Helpdesk Online — Use the Contact Information tab in the secure Provider area of the Portal.

ForwardHealth Portal

ForwardHealth Portal — www.forwardhealth.wi.gov/

Available 24 hours a day, seven days a week.

To contact Provider Services via email, use the Contact Information button in the secure Provider area of the Portal.

To look up billing and policy information for BadgerCare Plus, Wisconsin Medicaid, or the Wisconsin Chronic Disease Program, refer to the Online Handbook.

Medicaid Managed Care Contract Monitors

For Providers or Members — 800-760-0001

7:00 a.m. to 6:00 p.m. Mondays–Fridays.

Not available on holidays.

Member Services (for members only)

800-362-3002

8:00 a.m. to 6:00 p.m. Mondays–Fridays.

Not available on holidays.