

CONDUENT



CLAIMS PROCESSING

Procedure Manual

NM Medicaid Project

September 13, 2017

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Processing Return to Provider (RTP) Letters

Scope of Responsibility

- Exam entry
- Adjustments

Description and Purpose

During processing, claims determined to be incomplete or containing obvious errors are attached to a return-to-provider (RTP) letter indicating the specific problems which the provider must correct before the claim can be resubmitted. The claim and RTP letter are then returned to the provider.

Claims or adjustments which have any of the following problems must be returned to the provider with an RTP letter:

RTP Reasons
All Claims
<ul style="list-style-type: none">• Claim form is not legible or printed too lightly for processing
<ul style="list-style-type: none">• Claim form information is filled out in red ink
<ul style="list-style-type: none">• Information is misaligned<ul style="list-style-type: none">– Outside the proper field
<ul style="list-style-type: none">• Claim form submitted is not current or is not an original form (CMS 1500 or UB-04)<ul style="list-style-type: none">– Check the RTP letter for current claim forms accepted
<ul style="list-style-type: none">• Number of lines on the claim exceeds maximum for the claim type<ul style="list-style-type: none">– Check the RTP letter for totals allowed
<ul style="list-style-type: none">• X-rays or dental casts<ul style="list-style-type: none">– Note: the claim will be processed normally, only the x-ray or cast should be returned
CMS-1500 (HCFA) Claims
<ul style="list-style-type: none">• Diagnosis codes do not match on each page of multiple page claims• Data appears in boxes 10d or 19
UB-04 Claims
<ul style="list-style-type: none">• Data appears in boxes 30 or 37

All Crossover Claims
<ul style="list-style-type: none"> • EOMB form type does not match claim type • Recipient name does not match between claim and EOMB
CMS-1500 Crossover Claims
<ul style="list-style-type: none"> • Dates of service, procedure codes, and totals on each detail line do not match between claim and EOMB • <u>Procedure codes have exceptions; check exam entry keying procedure</u> • <u>Key Surgery Center EOMB's with Revenue code on the EOMB – and CPT on 1500 claim for - these providers have to bill this way – Place of Service = 24</u>
Adjustment Claims
<ul style="list-style-type: none"> • Adjustment must be within the timely filing limits • Claim form not included • Signature missing from Adjustment/Void form • Description of problem is unclear or blank • This claim has already been voided • We cannot adjust a Medicare crossover without a Medicare EOB • We cannot change a non-crossover to a Medicare crossover with an adjustment

Service Level Agreement

- Claims which cannot be processed because of errors or omissions should be returned to the provider with clearly filled out RTP letters in a timely manner

Processing Steps

Complete an RTP letter for each claim, document or adjustment as following:

1. Open the RTP form letter: H:\Claims\RTP\RTP LETTER.docx
2. Enter the information exactly as printed on the claim. If the claim is illegible, or there is no claim, leave the fields blank.
 - A. Client ID: Box 1a on 1500, box 3a on UB, box 15 on Dental.
 - B. Dates of Service: box 24a first line on 1500, box 45, first line on UB.
 - C. Clerk ID: your NMCT number
 - D. Received Date:
Enter the date the claim was received (from the Julian date) in the Received Date field (should be the current day)
3. Enter the billing provider mailing information, exactly as printed on the claim or document. Box 33 on 1500, box 1 on UB, box 48 on Dental.
4. The RTP date is automatically populated. This date is used for timely filing of resubmitted claims.
5. Check all boxes applicable to the errors on the claim
 - If more detail is needed to describe the error, enter the reason in the other space
6. Print the RTP letter.

7. Place the RTP letter on top of the claim and attachments. Do not staple.
 - If more than one claim is addressed to the same provider, bundle them with a paper clip so they can be mailed together.
8. Open the RTP log for the current year, located at H:\Claims\RTP. Enter all required information for each RTPed claim.
9. Insert the RTPs and their associated claims in window envelopes. If more than one claim is addressed to the same provider, put them in the same envelope. Place the envelopes in the 'Claims' bin to be mailed.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	4/28/09	• All	• All	• Complete revision with updated instructions
003	8/9/11	• All	• 1,2	• Revised for new RTP letter and policy
004	09/07/11	• All	• All	• Updated all steps and added to procedure manual
005	12/1/11	• 1	• 2-10	• Rearranged steps to match new RTP letter, added to Step 2, added Step 7, changed Step 10 to no stapling
006	March 2014	• All	• All	• Edited for clarity. • Added RTP reasons to UB04 and Adjustment sections. • Added RTP log instructions.

Keying CMS-1500 Claims

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing CMS-1500 claims. This procedure outlines the steps to follow when a CMS-1500 claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Creating a CMS-1500 Batch

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and dropdown box will appear at the top of the main screen. From this menu, select "CE_ENTR". A list of all available claim batches will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available CMS-1500 batch (batch range 250-299). A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the batch already exists.
5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "C" in the 'Document Type' field; the window should read 'C – FFS'. In the 'Batch Type' field, enter "H" for a CMS-1500 batch.
9. Once you have entered everything correctly in Batch Control, save the new batch and close this window.
10. In AbleDoc, click on the blue icon under 'Open' on the list of claims for the first claim in the batch you are going to work. This will open the claim.

11. Open OmniCaid Exam Entry, and enter the Julian date of the CMS-1500 batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.

Keying CMS-1500 Header Information

The cursor will appear in the Doc # field in the upper left corner.

NOTE: There are several fields that are not writable when keying in claim information. Those fields are: St, DTy, CTy, TTy, Locn, LCycl, Reimb, Major Program, System ID, Age, Gender, COE, Fed Match, MC Plan Prov, Plan # Begin Dt, Type, Specialty, Medicare Claim Nbr.

1. Key the claim's number, the last 2 digits of the TCN number.
 - Example: 01, 50
2. Tab to the ID field. Key the recipient ID from box 1a.
 - Do not enter letters or dashes.
 - Note: The system may change the recipient ID number when there are 14 digits entered by removing the first five digits.
3. Tab past the F/Mi/L name fields. Do not key anything in these fields.
4. Tab to the DOB field. Key the date of birth from box 3, using the format MM/DD/YYYY.
 - If the century is not listed, use logical judgment to choose 19XX or 20XX.
 - If the box is blank, leave the field empty.
5. Tab to the Employment field. If the yes box in box 10a is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
6. Tab to the Auto Accident field. If the yes box in box 10b is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
7. Tab to the Other Accident field. If the yes box in box 10c is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
8. Tab to the Other Insurance field. If the yes box in box 11a is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
9. Tab to the Illness Date field. Key the date from box 14. If the box is blank, leave the field empty.
10. Tab to the Referring Provider ID field. If "ID" appears in box 17a, key the provider ID number from the adjacent box.
 - If "ID" does not appear, leave the field empty.
 - NOTE: this field may auto populate after validation, if NPI is entered into 17b.
11. Tab to the Referring NPI field. Key the number from box 17b.
12. Tab to the Hospitalization Dates From/To field. Key the from and to dates from box 18.
13. Tab to the Dx 1 field. Key the first diagnosis code from box 21.
14. Key any additional diagnosis codes in their respective fields.
 - If more than 4 codes are present, press the ESC key to open a pull down menu.
 - There is a limit of 8 diagnosis codes.
 - On a multi-page claim, there may be different diagnosis codes on each page. Key these diagnoses in order. For example, the four diagnosis codes on page 1

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would be #1-#4, while the first new diagnosis code on page 2 would be diagnosis #5.

- If a diagnosis code appears in box 24e but not in box 21, key the code in the first available Dx field.
 - If there are no codes in box 21 or 24e, leave the fields empty.
15. Tab to the Prior Authorization field. Key the prior authorization number from box 23.
- If the number is longer than 11 characters, key only the first 11 characters.
 - Do not key symbols or spaces.

Keying CMS-1500 Line Information

1. Tab to the charge line, FDOS field. Key the “from date of service” from box 24A in MM/DD/YY format.
2. Tab to the LDOS field and key the “to date of service”.
3. Tab to the PS field. Key the place of service code from box 24B.
4. Tab to the PROC field. Key the 5 character procedure code from box 24D.
5. Tab to the M1 field. Key the modifiers from box 24D. Each modifier must be 2 alpha or numeric characters.
 - Do not key any symbols.
 - Modifiers may be listed separately or together with no spaces.
 - Examples: RR KJ LN, 26AA39P3, or 12AB.
 - If more than two modifiers appear, press the Esc key to open a detail window. Click on the additional fields and key the modifiers, then click the OK button to close the window.
 - Providers sometimes write other information about the procedure performed in this area. Do not enter this information.
6. If an “N4” followed by a string of numbers and letters appears anywhere in the shaded area above the charge line being keyed, press the Esc key to open the detail window. Click on the NDC field and key the 11 digit number following the N4.
 - Tab to the NDC Unit of Measure field and key the 2 digits following the NDC. Note: typical codes are F2, GR, ML & UN.
 - Tab to the NDC Quantity field and key the number following the unit of measure. Note: a maximum of 2 places past the decimal can be entered.
 - Click the OK button to close the window.
7. Tab to the DxRlt field. If a single digit appears in box 24E corresponding to a diagnosis code in box 21, key the digit shown.
 - If a diagnosis code appears in box 24E, key the number of the Dx line the diagnosis code was entered above.
 - If more than one digit or code appears, key the digits together with no spaces or punctuation.
 - If a letter appears in box 24E, enter the corresponding number in order. If A appears, enter 1, B = 2, etc.
 - If keying a multi-page claim with more than four diagnosis codes, make sure you enter the correct number for the correct diagnosis codes on each page.
8. Tab to the Submit Chrg field. Key the charges amount from box 24F.

- If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents. Examples: \$597300, key as 5973.00; \$12345, key as 123.45.
- If there is a negative amount listed, leave this field blank.
- 9. Tab to the SUnit field. Key the days or units from box 24G.
 - On anesthesia claims, the number of units may change after the claim is validated.
 - When units equal 0 on the claim, OmniCaid will auto populate a 1 in the Units box.
- 10. Tab to the Rend Prov field. If "1D" appears in the upper shaded area of box 24I, key the rendering provider ID from the upper shaded area of box 24J.
 - If "1D" does not appear, leave the field empty.
- 11. Tab to the Rend NPI field. Key the NPI number from the lower area of box 24J.
 - If the number is longer than 10 digits, key only the first 10 digits.
- 12. Tab to the Rndr Txnmy field. If "ZZ" appears in the upper shaded area of box 24I, key the taxonomy number from the upper shaded area of box 24J.
 - If "ZZ" does not appear, leave the field empty.
- 13. Go to the next Charge Line field, and repeat steps 1-15 for keying CMS-1500 line information. If there are no more charge lines, press F5 to continue and proceed to the next section.
 - Note: This claim type is limited to 50 charge lines.

Keying CMS-1500 Payer Information

1. Tab to the Patient Account # field, and key the patient's account number from box 26. Enter all symbols, but no spaces.
 - Example: 12 3*4 key as 123*4
 - If multi-page, key Patient Account number from last page keyed.
2. Tab to the Tot Chrg field. Key the total charge amount from box 28.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If keying a multi-page claim, this box may be empty on all but the last page. If so, key the total charge amount from the claim's final page.
3. Tab to the TPL field. Key the amount paid from box 29.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed or the box is blank, leave the field empty.
 - If keying a multi-page claim, this box may be empty on all but the last page. If so, key the TPL amount from the claim's final page.
4. Tab to the Net field. Key the balance due amount from box 30.
 - If the box is blank, key the amount from box 28.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.

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- If keying a multi-page claim, this box may be empty on all but the last page. If so, key the net charge amount from the claim's final page.
- 5. Tab to the Attachments field. Key the attachment codes from box 10d.
 - If more than 5 codes appear, enter the first 5 in order from lowest to highest.
 - Example: if 98, 55, 74, and 56 appear, key 55, 56, 74, and 98.
- 6. Tab to Sign field. If a signature or name appears in box 31, press the space bar. If no signature or name appears, leave the field empty.
- 7. Tab to the Sign Date field. Key the signature date from box 31 in MM/DD/YY format.
 - If the signature date is illegible or missing, leave the field empty.
 - If the field is blank, Omnicaid will auto populate the date with the last date of service.
 - If there are two signature dates (one printed and one hand written) enter the Printed date
- 8. Tab to the Service Facility NPI field. Key the NPI number from box 32a. If the number is longer than 10 digits, key only the first 10 digits.
- 9. Tab to the Billing Zip Code field. Key the zip code from box 33.
- 10. Tab to the Billing NPI field. Key the NPI number from box 33a.
 - If the number is longer than 10 digits, key only the first 10 digits
- 11. Tab to the Billing Taxonomy field. If “ZZ” and a taxonomy number appear in box 33b, key the taxonomy number.
 - If “ZZ” does not appear, leave the field empty.
- 12. Tab to the Billing Provider ID field. If “1D” and a provider ID number appear in box 33b, key the provider ID number.
 - If “1D” does not appear, leave the field blank.
- 13. Tab to the Override Location field. If the batch being keyed is an emergency batch with a location code listed on the cover sheet, key the 3 digit code in this field.
 - Example: 145, 790.
- 14. Press the F9 key to validate the claim.
- 15. After validation, check the Li/Exc/St/ClerkID box in the lower right corner.
 - If no exception lines appear, proceed to the next step.
 - If exception lines appear, double click inside the box. A pop-up window will appear listing the exceptions.
 - If an exception description is preceded by an “E-”, double click on the line.
 - Click inside the lower text box and search for the “Exam Entry” section
 - It may be necessary to click the “Next Page” button to continue searching.
 - Follow the instructions listed under “Exam Entry” to check the claim for errors.
 - If a correction is made to the claim screen, press the F9 key to validate again.
 - Continue to edit until all “E-” exceptions have been checked.
 - Click OK to close the edit pop-up window.
 - If an exception code appears both in the exception box and in box 19 of the claim, and an NMCT # appears on the claim, the exception must be forced.
 - In the exception box, click on the exception and enter an F.
 - Repeat for all lines with that exception in the exception box.

- If there is an override code that will not be forced, bring the claim to your supervisor.
- 16. Press CTRL+S to save the claim and proceed to the next claim.
- 17. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.
- 18. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.
- 19. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.
- 20. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	05/10/07	• All	• All	• Complete revision for new claim forms
003	12/20/07	• 5	• 43	• Added State auth. requirement for Exception codes
004	01/07/11	• 1	• Desc Purpose	• Updated first two paragraphs.
005	8/31/11	• 5	• 43	• Deleted step 43, keying exception codes
	09/02/11	• All	• All	• Updated all steps and added to procedure

Claims Support

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006	10/23/12	Step 10	21. Tab to the Referring Provider ID field - If "1D" appears in box 17a, key the provider ID number from the adjacent box - If "1D" does not appear, leave the field empty - NOTE: this field may auto populate after validation, if NPI is entered into 17b.	<ul style="list-style-type: none"> Added Omnicaid box 17b auto populate field
007	12/18/12	3-9	6	Added capture of NDC Unit of Measure and NDC Quantity
008	5/9/13	3-10	1	Patient ID information updated Patient ID for Multi page claims updated
009	2/17/14	3-7	Step 2	Added "or dashes"
010	March 2014	All	All	Edited for clarity. Added Workflow 2.0, adjustment log, and batch control instructions.

Keying CMS-1500 Crossovers

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing CMS-1500 crossover claims. This procedure outlines the steps to follow when a CMS-1500 crossover claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Creating a CMS-1500 Crossover Batch

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and drop down box will appear at the top of the main screen. From this menu, select "CE_ENTR". A list of all available claim batches will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available CMS-1500 Crossover batch (batch range 600-649). A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the batch already exists.
5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "C" in the 'Document Type' field; the window should read "C – FFS". In the 'Batch Type' field, enter "B" for a CMS-1500 Crossover batch.
9. Once you have entered everything correctly in Batch Control, save the new batch and close this window.

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10. In Abledoc, click on the blue icon under 'Open' on the list of claims for the first claim in the batch you are going to work. This will open the claim.
11. Open OmniCaid Exam Entry, and enter the Julian date of the CMS-1500 Crossover batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.

Keying CMS-1500 Crossover Header Information

The cursor will appear in the Doc # field in the upper left corner.

1. Key the claim's number, the last 2 digits of the TCN number.
 - Example: 01, 50
2. Tab to the ID field. Key the recipient ID from box 1a.
 - Do not enter letters or dashes.
 - Note: The system may change the recipient ID number when there are 14 digits entered by removing the first five digits.
3. Tab past the F/Mi/L name fields. Do not key anything in these fields.
4. Tab to the DOB field. Key the date of birth from box 3, using the format MM/DD/YYYY.
 - If the century is not listed, use logical judgment to choose 19XX or 20XX.
 - If the box is blank, leave the field empty.
5. Tab to the Employment field. If the yes box in box 10a is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
6. Tab to the Auto Accident field. If the yes box in box 10b is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
7. Tab to the Other Accident field. If the yes box in box 10c is checked, press the space bar. If the no box is checked or the boxes are blank, leave the field empty.
8. Tab to the Other Insurance field. If the yes box in box 11a is checked and there is a TPL attachment 56, press the space bar. If the yes box in 11a is checked and there is not a TPL attachment, leave the field empty. If the no box is checked or the boxes are blank, leave the field empty.
9. Tab to the Illness Date field. Key the date from box 14. If the box is blank, leave the field empty.
10. Tab to the Referring Provider ID field. If "1D" appears in box 17a, key the provider ID number from the adjacent box.
 - If "1D" does not appear, leave the field empty.
 - NOTE: this field may auto populate after validation, if NPI is entered into 17b.
11. Tab to the Referring NPI field. Key the number from box 17b.
12. Tab to the Hospitalization Dates From/To field. Key the from and to dates from box 18.
13. Tab to the Dx 1 field. Key the first diagnosis code from box 21.
14. Key any additional diagnosis codes in their respective fields.
 - If more than 4 codes are present, press the ESC key to open a pull down menu.
 - There is a limit of 8 diagnosis codes.
 - On a multi-page claim, there may be different diagnosis codes on each page. Key these diagnoses in order. For example, the four diagnosis codes on page 1

would be #1-#4, while the first new diagnosis code on page 2 would be diagnosis #5.

- If a diagnosis code appears in box 24e but not in box 21, key the code in the first available Dx field.
 - If there are no codes in box 21 or 24e, leave the fields empty.
15. Tab to the Prior Authorization field. Key the prior authorization number from box 23.
- If the number is longer than 11 characters, key only the first 11 characters.
 - Do not key symbols or spaces.

Medicare Exhaust Instructions

- ‘Partial Medicare Exhaust’ and ‘Medicare Exhaust’ claims dates of service may not match the Medicare EOB dates of service completely.
 - These should NOT be RTPed
- If ‘Partial Medicare Exhaust’ is written on the claim form and there is no attachment code 59, do not RTP the claim. Work normal E edits and allow other exceptions to post.

Keying CMS-1500 Crossover Line Information

1. Tab to the charge line, FDOS field. Key the “from date of service” from box 24A in MM/DD/YY format.
2. Tab to the LDOS field and key the “to date of service”.
3. Tab to the PS field. Key the place of service code from box 24B.
4. Tab to the PROC field. Key the 5 character procedure code from box 24D.
5. Tab to the M1 field. Key the modifiers from box 24D. Each modifier must be 2 alpha or numeric characters.
 - Do not key any symbols.
 - Modifiers may be listed separately or together with no spaces.
 - Examples: RR KJ LN, 26AA39P3, or 12AB.
 - If more than two modifiers appear, press the Esc key to open a detail window. Click on the additional fields and key the modifiers, then click the OK button to close the window.
 - Providers sometimes write other information about the procedure performed in this area. Do not enter this information.
6. If an “N4” followed by a string of numbers and letters appears anywhere in the shaded area above the charge line being keyed, press the Esc key to open the detail window. Click on the NDC field and key the 11 digit number following the N4.
 - Tab to the NDC Unit of Measure field and key the 2 digits following the NDC. Note: typical codes are F2, GR, ML & UN.
 - Tab to the NDC Quantity field and key the number following the unit of measure. Note: a maximum of 2 places past the decimal can be entered.
 - Click the OK button to close the window.
7. Tab to the DxRlt field. If a single digit appears in box 24E corresponding to a diagnosis code in box 21, key the digit shown.

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- If a diagnosis code appears in box 24E, key the number of the Dx line the diagnosis code was entered above.
 - If more than one digit or code appears, key the digits together with no spaces or punctuation.
 - If a letter appears in box 24E, enter the corresponding number in order. If A appears, enter 1, B = 2, etc.
 - If keying a multi-page claim with more than four diagnosis codes, make sure you enter the correct number for the correct diagnosis codes on each page.
8. Tab to the Submit Chrg field. Key the charges amount from box 24F.
- If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents. Examples: \$597300, key as 5973.00; \$12345, key as 123.45.
 - If there is a negative amount listed, leave this field blank.
9. Tab to the SUnit field. Key the days or units from box 24G.
- On anesthesia claims, the number of units may change after the claim is validated.
10. On the Medicare EOMB, find the entry matching the recipient on the claim.
- Check that the following match on the claim and EOMB for each charge line:
 - Dates of service
 - Procedure codes
 - Procedure modifiers (modifiers must match, but if the claim has modifiers and the EOB does not or vice versa, that's allowed)
 - Billed amounts
 - If the line information does not match, do not enter the Medicare info, leave blank.
 - Exception 1: Accept procedure codes A0380 or A0390 on the claim when A0388 or A0425 are on the EOMBs and Medicare or the Medicare Replacement Plan denied A0388 or A0425.
 - Exception 2: Accept procedure codes A0427 or A0998 on the claim when A0433 or A0999 is on the EOMB and Medicare or the Medicare Replacement Plan denied A0433 or A0999.
 - Exception 3: The line charges may not match because of the charges being split on the claim or EOMB. Add up or divide charges as necessary to match.
 - Exception 4: If a charge line appears on the claim but not on the EOMB, key the charge line from the claim and leave the crossover information from the EOMB blank.
11. Tab to the Allow Amt field. Key the amount from the allowed amount, DRG, amount approved, or allowable column on the EOMB (if Exception 0118 posts see directions below).
- If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If there is **not** an Allowed amount on the EOMB; do the math
 - Medicare Paid amount + the Patient Responsibility = Medicare Allowed Amount

- If you've enter the Allowed amount as shown on the EOMB and EXCEPTION 0118 posts on your claim; please follow the instructions below
 - → Take the Patient responsibility + Medicare Paid = Medicare allowable
 - → Enter the Total sum as the Medicare allowable on your claim
- 12. Tab to the Deductible field. Key the amount from the deductible, PR1, or OA1 column on the EOMB.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If the amount is not covered by Medicare – then do not enter the amount.
- 13. Tab to the Coinsurance field. Key the amount from the coinsurance, PR2, or OA2 column on the EOMB.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If a PR-122 code appears with the coinsurance amount, hit ESC to open the “CMSDetail” window. Key in the PR-122 amount in the “Psych Reduction” field.
- 14. Hit ESC to open the “CMS Detail” window. If there is a Copay, PR3, or OA3 column on the EOMB, enter that amount in the “Patient Resp” field.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If the EOB lists the copay and the coinsurance and/or deductible all in one column, enter that amount in the “Patient Resp” field only, not the coinsurance or deductible fields.
 - If there is a negative amount listed, leave the field empty.
 - If the amount is not covered by Medicare – then do not enter the amount.
- 15. Tab to the Paid Amt field. Key the amount from the provider paid or net reimbursement column on the EOMB.
 - If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If the EOMB shows an allowable and any patient responsibility but \$0.00 as payment please follow the instructions below
 - If the EOMB shows a reason such as “*charges are covered under a capitation agreement/managed care plan*” or has the wording “*capitation*” follow the steps below
 - Take the Medicare Allowable – Patient Responsibility = Medicare Payment
 - Enter the difference between the Medicare Allowable and Patient Responsibility as the Medicare Paid on your claim
- 16. If Medicare made the charge **Patient Responsibility (PR)** put that amount in the Patient Resp Amt field.
- 17. On the line being keyed, press the Esc key to open the “CMSDetail” popup window.

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- If an “E” or “F” appears in the bottom unshaded area of box 24H, click on the Family Planning check box. If any other character or mark appears, or if the box is blank, leave the field empty
 - If there are 2 characters in the upper shaded area of box 24H, click on the EPSDT Specific check box. Examples: AV, S2, ST, or NU
 - If the box does not contain 2 characters or is blank, leave the field empty
18. Tab to the Rendr NPI field. Key the NPI number from the lower unshaded area of box 24J.
- If the number is longer than 10 digits, key only the first 10 digits.
19. Tab to the Rendr Prov ID field. If “1D” appears in the upper shaded area of box 24I, key the rendering provider ID from the upper shaded area of box 24J.
20. Click “OK” to exit the popup window.
21. Go to the next Charge Line field, and repeat steps 1-15 for keying CMS-1500 Crossover line information. If there are no more charge lines, press F5 to continue and proceed to the next section.
- Note: This claim type is limited to 50 charge lines

Keying CMS-1500 Crossover Payer Information

1. Tab to the Patient Account # field, and key the patient’s account number from box 26. Enter all symbols, but no spaces.
- Example: 12 3*4 key as 123*4
 - If multi-page, key Patient Account number from last page keyed.
2. Tab to the Tot Chrg field. Key the total charge amount from box 28.
- If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If keying a multi-page claim, this box may be empty on all but the last page. If so, key the total charge amount from the claim’s final page.
3. Tab to the TPL field. If there is an attachment code 56 in box 10d, key the amount paid from box 29. Otherwise, leave this box blank.
- If the dollar amount appears without a decimal, key the dollar amount with the last two digits as the cents.
 - If there is a negative amount listed, leave the field empty.
 - If keying a multi-page claim, this box may be empty on all but the last page. If so, key the TPL amount from the claim’s final page if there is a 56 attachment.
4. Tab past the Net field.
5. Tab to the Attachments field. Key the attachment codes from box 10d.
- If more than 5 codes appear, enter the first 5 in order from lowest to highest.
 - Example: if 98, 55, 74, and 56 appear, key 55, 56, 74, and 98.
6. Tab to Sign field. If a signature or name appears in box 31, press the space bar. If no signature or name appears, leave the field empty.
7. Tab to the Sign Date field. Key the signature date from box 31 in MM/DD/YY format.
- If the signature date is illegible or missing, leave the field empty.
 - If the field is blank, Omnicaid will auto populate the date with the last date of service.

8. Tab to the Service Facility NPI field. Key the NPI number from box 32a. If the number is longer than 10 digits, key only the first 10 digits.
9. Tab to the Billing Zip Code field. Key the zip code from box 33.
10. Tab to the Billing NPI field. Key the NPI number from box 33a.
 - If the number is longer than 10 digits, key only the first 10 digits
11. Tab to the Billing Taxonomy field. If "ZZ" and a taxonomy number appear in box 33b, key the taxonomy number.
 - If "ZZ" does not appear, leave the field empty.
12. Tab to the Billing Provider ID field. If "1D" and a provider ID number appear in box 33b, key the provider ID number.
 - If "1D" does not appear, leave the field blank.
13. Tab to the EOMB Dt field. Key the paid date from the Medicare EOMB in MM/DD/YY format.
 - A handwritten paid date is acceptable.
 - The date may be labeled Payment, Check, Issued, Medicare Production, Run, RA, Remit, or Settlement Date. It may also be unlabeled.
- 14.15. Tab to the Override Location field. If the batch being keyed is an emergency batch with a location code listed on the cover sheet, key the 3 digit code in this field.
 - Example: 145, 790.
- 15.16. Press the F9 key to validate the claim.
- 16.17. After validation, check the Li/Exc/St/ClerkID box in the lower right corner.
 - If no exception lines appear, proceed to the next step.
 - If exception lines appear, double click inside the box. A pop-up window will appear listing the exceptions.
 - If an exception description is preceded by an "E-", double click on the line.
 - Click inside the lower text box and search for the "Exam Entry" section
 - It may be necessary to click the "Next Page" button to continue searching.
 - Follow the instructions listed under "Exam Entry" to check the claim for errors.
 - If a correction is made to the claim screen, press the F9 key to validate again.
 - Continue to edit until all "E-" exceptions have been checked.
 - Click OK to close the edit pop-up window.
 - If an exception code appears both in the exception box and in box 19 of the claim, and an NMCT # appears on the claim, the exception must be forced.
 - In the exception box, click on the exception and enter an F.
 - Repeat for all lines with that exception in the exception box.
 - If there is an override code that will not be forced, bring the claim to your supervisor.
- 17.18. Press CTRL+S to save the claim and proceed to the next claim.
- 18.19. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.

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~~48~~19. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.

~~49~~20. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.

~~20~~21. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

Additional Documentation

TPL Amount Keyed from Claim Instead of EOB - Memo number 27-0821.pdf

Handwritten Medicare paid date is now valid – Memo number 12-1221.pdf

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	05/10/07	• All	• All	• Complete revision for new claim form
003	06/07/07	• 5 of 7	• 32	• Modified step # 32.
004	07/09/07	• 7	•	• Add Memo Number 27-0821 TPL Amount
005	12/20/07	• 6	• 47	• Added State auth. requirement for Exception codes
006	03/26/08	• 3	• 17	• Deleted obsolete step
007	03/26/08	• 3	• 17	• Deleted the override

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				exception
008	03/31/08	• 3	• 17	• Add Memo Number 28-0368
009	08/22/08	• 3 of 8	• 16	• Add Memo # 28-1222 Medicare Exhaust Instructions DB
010	01/30/09	• 3	• #17,Exc.1	• Per Memo # 29-0011 added instructions
011	04/06/09	• 3	• #17,Exc.1	• Per email for Memo#29-0011 added TPL EOMB
012	01/07/11	• 1	• Desc/Purpose	• Updated first two paragraphs.
013	8/31/11	• 6	• 48	• Removed step 48, keying exception codes
014	09/02/11	• All	• All	• Updated all steps and added to procedure manual
015	8/13/12	• 7	• 15	• Added hand-written Medicare date instruction
016	12/18/12	• Multiple	• 9 & 17	• Added capture of Co-pay amount, NDC Unit of Measure & NDC Quantity
017		• 3-20	• 1	• Patient ID information updated • Patient ID for multipage claims updated
018	1/20/14	• 3-19	• 15,16,17	• Added OA fields
019	2/17/14	• 3-15	• 2	• Added “or dashes”

Claims Support

020	March 2014	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• Edited for clarity.• Added Workflow 2.0, batch control, and adjustment log instructions.
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Keying Dental Claims

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing American Dental Association (ADA) 2006 claims. This procedure outlines the steps to follow when an ADA claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Creating a Dental Batch

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and drop down box will appear at the top of the main screen. From this menu, select "CE_ENTR". A list of all available claim batches will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available Dental batch (batch range 510-599). A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the batch already exists.
5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "C" in the 'Document Type' field; the window should read 'C - FFS'. In the 'Batch Type' field, enter "D" for a Dental batch.
9. Once you have entered everything correctly in Batch Control, save the new batch and close this window.

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10. In Abledoc, click on the blue icon under 'Open' on the list of claims for the first claim in the batch you are going to work. This will open the claim.
11. Open OmniCaid Exam Entry, and enter the Julian date of the Dental batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.

Keying Dental Header Information

The cursor will appear in the Doc field in the upper left corner.

1. Key the claim's number, the last 2 digits of the TCN number.
 - Example: 01, 50
2. Tab to the PA number field. Key the PA number from Box 2, exactly as it appears.
3. Tab to the Other Coverage check box. If the "Yes" box in box 4 is checked, press the space bar. If the "No" box is checked or the boxes are blank, leave the box empty.
4. Tab to the Client ID field. Key the ID from box 15.
 - If box 15 is blank, key the ID from box 23.
5. Tab past the L/F/Mi name fields. Do not key in these fields.
 - If an exception requires keying the client name, key the fields exactly as they appear.
6. Tab to the DOB field. Key the date of birth from box 13 in MM/DD/YYYY format.
 - If the information from box 13 is blank, key the date of birth from box 21.
 - If the century is not listed, use logical judgment to choose 19XX or 20XX.
7. Tab to the Med Rec Nbr field. Key the information from box 23.
 - Key as presented, with no spaces. Example: 12 3*4 key as 123*4
 - If multi-page, enter the information from the last page keyed.

Keying Dental Line Information

1. Tab to the first Charge Line, Svc Date field. Key the date from box 24 in MM/DD/YY format.
 - If there is no date of service listed in box 24 and box 1 (Header Information) on the claim is checked for request for Predetermination/Preauthorization, RTP the claim. Predetermination/Preauthorization requests must be sent to DentaQwest.
2. Tab to the OralC field. Key the code from box 25 exactly as it appears.
3. Tab to the Tth field. Key the tooth number from box 27.
 - Do not key symbols.
 - If a single digit number appears, key a "0" before the number. Example: 5, key as 05
4. Tab to the Surface field. Key the code from box 28 exactly as it appears.
5. Tab to the Proc field. Key the procedure code from box 29 exactly as it appears.
6. Tab to the SUnit field. Key a "1".
7. Tab to the Submit Chrg field. Key the dollar amount from box 31.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents. Examples: \$597300, key as 5973.00; \$12345, key as 123.45

- If there is a negative amount listed, key the line but leave the amount blank.
- 8. Tab to the next Charge Line field and repeat the process for keying line information. If there are no more charge lines, press F5 to continue to the next field.
 - Note: this claim type is limited to 50 charge lines
- 9. Note: if the TPL or Primary Insurance amount is billed on a line item instead of the TPL field, RTP the claim. The claim should not be released, as it will overpay.

Keying Dental Payer Information

1. Tab to the Tot Chrg field, and key the dollar amount from box 33.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, leave the field empty.
2. Tab to the TPL field. Key the dollar amount from box 32.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, key it as a positive amount.
3. Tab to the Net field.
 - If there is no TPL amount in box 32, key the dollar amount from box 33.
 - If there is an amount in box 32, subtract the amount in box 32 from the amount in box 33 and key the difference in the Net field. If the result is a negative amount, leave the field empty.
4. Tab to the Attachments field. Key the attachment codes from box 16.
 - If more than 5 codes appear, enter the first 5 in order from lowest to highest
5. Tab to the Place of Service field. Check the appropriate box – Office, Hosp, ECF, or Other.
 - If no boxes are checked, leave the field empty.
6. Tab to the Treatment Resulting From field. Check the appropriate box – Employment Related, Occupational Illness/Injury, or Auto Accident.
 - If no boxes are checked, leave the field empty.
7. Tab to the Date of Accident field. If any box in box 45 is checked, key the date from box 46 in MM/DD/YY format.
 - If no boxes are checked or box 46 is blank, leave the field empty.
8. Tab to the Zip Code field. Key the zip code from box 48.
9. Tab to the Billing Dentist NPI field. Key the NPI number from box 49.
10. Tab to the Billing Dentist Provider ID field. Key the ID number from box 52A exactly as it appears.
11. Tab to the Sign check box. If a signature or name appears in box 53, press the space bar.
 - If no signature or name appears, leave the box empty
12. Tab to the Sign Date field. Key the signature date from box 53 in MM/DD/YY format.
 - If the signature date is illegible or missing, leave the field empty.
13. Tab to the Treating Dentist, NPI field. Key the NPI number from box 54.
14. Tab to the Additional Provider ID field. Key the ID number from box 58 exactly as it appears.

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15. Tab to the Override Locn field. If the batch being keyed is an emergency batch with a location code listed on the cover sheet, key the 3 digit code in this field (Example: 145, 790)
16. Press the F9 key to validate the claim.
17. After validation, check the Li/Exc/St/ClerkID box in the lower right corner.
 - If no exception lines appear, proceed to the next step.
 - If exception lines appear, double click inside the box. A pop-up window will appear listing the exceptions.
 - If an exception description is preceded by an "E-", double click on the line.
 - Click inside the lower text box and search for the "Exam Entry" section
 - It may be necessary to click the "Next Page" button to continue searching.
 - Follow the instructions listed under "Exam Entry" to check the claim for errors.
 - If a correction is made to the claim screen, press the F9 key to validate again.
 - Continue to edit until all "E-" exceptions have been checked.
 - Click OK to close the edit pop-up window.
 - If an exception code appears both in the exception box and in box 19 of the claim, and an NMCT # appears on the claim, the exception must be forced.
 - In the exception box, click on the exception and enter an F.
 - Repeat for all lines with that exception in the exception box.
 - If there is an override code that will not be forced, bring the claim to your supervisor.
18. Press CTRL+S to save the claim and proceed to the next claim.
19. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.
20. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.
21. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.
22. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	9/28/06	• 3 of 5	• 15	• Key from Oral Cavity Field
003	5/10/07	• All	• All	• Complete revision for new claim form
004	6/1/07	• 2 of 5	• # 10	• Box 27
005	7/1/07	• 3 of 5	• # 19	• Attachment codes box change to box 11 not 20.
006	7/11/07	• 2 of 5, 3 of 5	• # 6 & 19	<ul style="list-style-type: none"> • DOB key from box 21 only. • Attachment codes from box 16.
007	7/30/07	• 2 of 5	• # 7	• Key Alpha Numeric in box 23.
008	8/2/2007	• 2 of 5	• # 6	• DOB key from box 21 or Box 13.
009	12/20/07	• 4	• 35	• Added State auth. Requirement for Exception codes
010	04/09/08	• 2	• 7	• Key information
011	01/07/11	• 1	• Desc/Purpose	• Updated first two paragraphs.

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012	07/28/11	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • 4,15,35,39 	<ul style="list-style-type: none"> • Updated claim fields
013	8/31/11	<ul style="list-style-type: none"> • 6 	<ul style="list-style-type: none"> • 35 	<ul style="list-style-type: none"> • Deleted step 35, keying exception codes
014	09/02/11	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Updated all steps and added to procedure manual
015	12-1-11	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • 2-19 	<ul style="list-style-type: none"> • Refined keying criteria for each field
016	5/9/13	<ul style="list-style-type: none"> • 3-25 	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Medical Record Number information updated • Information for multipage claims and med rec number updated
017	8/13/13	<ul style="list-style-type: none"> • 3 	<ul style="list-style-type: none"> • 9 	<ul style="list-style-type: none"> • Added step on incorrectly billed TPL amounts
018	March 2014	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Edited for clarity. • Added Workflow 2.0, batch control, and adjustment log instructions.

Keying Pharmacy Claims

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing pharmacy claims. This procedure outlines the steps to follow when a pharmacy claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Opening a Pharmacy Batch

1. Open Internet Explorer, click the Favorites menu, and click CONDUEMENT Portal Login
2. From the Change Default Application menu, select X21 Production
3. Enter your User ID and Password and press Enter
4. On the Customer Search page, click on NEWMEX under Customer ID
5. On the Customer Information page, click on Claims and select Exam Entry from the pull down menu
6. On the Exam Entry Batch Search page, click on the Batch Date box and enter the 5 digit Julian date from the batch cover sheet
7. Tab to the Batch Number box and enter a "0" followed by the 3 digit batch number from the batch cover sheet
8. Click the Search button
9. Click the correct TCN for the batch under the Batch Key header
 - The claim entry screen will appear

Keying Pharmacy Claims

1. Verify that the TCN displayed above the Exam Entry field on the screen matches the TCN indicated on the claim
 - Carefully check that the claim number is correctly entered
 - If both claim boxes on the page are filled out, the claims must be keyed separately
 - In the six digit claim number box, enter "00", followed by the two digit batch number, followed by "01" for the first claim and "02" for the second

Claims Support

- For each new claim, be certain that the claim number is correct
- 2. The cursor will appear in the Participant ID field
 - Key the number from the ID line on the claim
- 3. Tab to the DOB field
 - Key the date from the Patient Date of Birth line in MM/DD/YYYY format, keying the forward slashes
- 4. Tab to the Provider Pharmacy ID field
 - Key the number from the Service Provider ID line
- 5. Tab to the Pharmacy Type pull-down box
 - Key QUAL number from the claim form and verify that “01 – National Provider Identifier” is displayed in the Pharmacy Type pull-down box
 - If 07 is on the claim then verify, that “07- NCPDP Provider ID is displayed in the Pharmacy Type pull-down box
 - If 05 is on claim then verify, that “05-Medicaid is displayed in the pharmacy Type pull-down box
 - If not, click on the tab and select it
- 6. Tab to the Pharmacy Source pull-down box
 - Verify that “NM MCD – New Mexico Medicaid” is displayed in the Pharmacy Source pull-down box if 01 is on the claim form
 - If 07 are on the claim form then verifies that “NCPDP-NCPDP” is displayed in the Pharmacy Source pull-down box
 - If 05 is on the claim form then verify that “NM MCD-New Mexico Medicaid” is displayed in the Pharmacy Source pull-down box
 - If not, click the tab and select it
- 7. Tab to the Provider Prescriber ID field
 - Key the number from the Prescriber ID box
- 8. Tab to the Prescriber Type pull-down box
 - If a 10 digit number was keyed in the Prescriber ID field, verify that “01 – National Provider Identifier” is displayed
 - If not, click the tab and select it. If the Prescriber ID is two letters followed by numbers, click the tab and select “12 – Drug Enforcement Administration”
 - If the Prescriber ID is an 8 digit number, click the tab and select “05 - Medicaid”
- 9. Tab to the Prescriber Source pull-down box
 - If “01” was selected in the Prescriber Type box, verify that “NM MCD – New Mexico Medicaid” is displayed
 - If not, click the tab and select it
 - If “12” was selected in the Type box, click the tab and select “DEA – DEA File”
 - If “05” was selected in the Type box, click the tab and select “NM MCD – New Mexico Medicaid”
- 10. Tab to the Rx/Service field
 - Key the number from the Prescription/Serv. Ref # box
- 11. Tab to the New/Refill field
 - If the provider puts an N on the claim form then key a 0
 - If the provider puts a Y on the claim form then key a 1

- If any other number from 0 – 99 is present then key what you see
- 12. Tab to the Submit Days field
 - Key the number from the Days Supply box
- 13. Tab to the Medical Certification Code
 - If the provider writes “Change in Therapy” on the claim form and put a 2 in PA TYPE (11) 2 pull-down box and selected 2-Medical Certification
- 14. Tab to the Submit Qty field
 - Key the number from the Qty Dispensed box
- 15. Tab to the Drug NDC field
 - Key the number from the Product/Service ID box
 - Do not key symbols
 - NDC number must be 11 digits if not key zeros in front
- 16. Tab to the Date Written field
 - Key the date from the Date Written box in MM/DD/YYYY format, keying the forward slashes
- 17. Tab to the Date Filled field
 - Key the date from the Date of Service box in MM/DD/YYYY format, keying the forward slashes
- 18. Tab to the Qty Prescribed field
 - Key the number from the Qty Dispensed box
- 19. Tab to the Compound pull-down box
 - Verify that “01” is displayed
 - If not, click the tab and select it
- 20. Tab to the Submit Ingr Cost field
 - Key the dollar amount from the Ingredient Cost Submitted box
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents (Examples: \$597300, key as 5973.00; \$12345, key as 123.45)
 - If there is a negative amount listed, leave the amount blank
- 21. Tab to the Total Charge field
 - Key the dollar amount from the Net Amount Due box
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents
 - If there is a negative amount listed, leave the amount blank
 - If a Management Override request appears on the claim and the claim attachments include an authorization from the State allowing the override, scroll down and click on the Management Override pull-down box
 - Select “Y – Management Override Allowed”
- 22. Click the Verify button
 - An exceptions box will appear above the claim entry screen
 - If no exceptions appear, proceed to the next step
 - If there are exceptions listed, check each for errors in keying and verify that information from the claim was entered in the proper fields
- 23. Correct any errors found

Claims Support

24. Click the Verify button again if corrections have been made
25. Click the Save button to save the claim and continue to the next screen

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• Initial Publication
002	5/10/07	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• Complete revision for X2I system
003	9/10/07	<ul style="list-style-type: none">• Pg. 2	<ul style="list-style-type: none">• # 5 & # 6	<ul style="list-style-type: none">• Key QUAL number from the claim.
004	9/10/07	<ul style="list-style-type: none">• Pg. 3	<ul style="list-style-type: none">• # 11 & 14	<ul style="list-style-type: none">• Key 0 through 99. And NDC number must be 11 digits long.
005	9/12/07	<ul style="list-style-type: none">• Pg.2&3	<ul style="list-style-type: none">• #5,#6 and 11	<ul style="list-style-type: none">• Reword of the description.
006	12/20/07	<ul style="list-style-type: none">• 4	<ul style="list-style-type: none">• 21	<ul style="list-style-type: none">• Added State auth. requirement for overrides
007	8/11/08	<ul style="list-style-type: none">• Pg. 3 of 4	<ul style="list-style-type: none">• Add #13	<ul style="list-style-type: none">• Change in Therapy writes on claim form
008	09/07/11	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• Updated all steps and added to procedure manual
		<ul style="list-style-type: none">•	<ul style="list-style-type: none">•	<ul style="list-style-type: none">•

Keying Pharmacy Claims with Prior Authorization

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing pharmacy claims with prior authorization. This procedure outlines the steps to follow when a pharmacy claim with prior authorization is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Opening a Pharmacy Batch

1. Open Internet Explorer, click the Favorites menu, and click CONDUEENT Portal Login
2. From the Change Default Application menu, select X2I Production
3. Enter your User ID and Password and press Enter
4. On the Customer Search page, click on NEWMEX under Customer ID
5. On the Customer Information page, click on Claims and select Exam Entry from the pull down menu
6. On the Exam Entry Batch Search page, click on the Batch Date box and enter the 5 digit Julian date from the batch cover sheet
7. Tab to the Batch Number box and enter a "0" followed by the 3 digit batch number from the batch cover sheet
8. Click the Search button
9. Click the correct TCN for the batch under the Batch Key header
 - The claim entry screen will appear

Keying Pharmacy Claims with Prior Authorizations

1. Verify that the TCN displayed above the Exam Entry field on the screen matches the TCN indicated on the claim
 - Carefully check that the claim number is correctly entered
 - If both claim boxes on the page are filled out, the claims must be keyed separately

Claims Support

- In the six digit claim number box, enter “00”, followed by the two digit batch number, followed by “01” for the first claim and “02” for the second
- For each new claim, be certain that the claim number is correct
- 2. The cursor will appear in the Participant ID field, key the number from the ID line on the claim
- 3. Tab to the DOB field
 - Key the date from the Patient Date of Birth line in MM/DD/YYYY format, keying the forward slashes
- 4. Tab to the Provider Pharmacy ID field
 - Key the number from the Service Provider ID line
- 5. Tab to the Pharmacy Type pull-down box
 - Key QUAL number from the claim form and verify that “01 – National Provider Identifier” is displayed in the Pharmacy Type pull-down box
 - If 07 is on the claim then verify, that “07- NCPDP Provider ID is displayed in the Pharmacy Type pull-down box
 - If 05 is on claim then verify, that “05-Medicaid is displayed in the pharmacy Type pull-down box
 - If not, click on the tab and select it
- 6. Tab to the Pharmacy Source pull-down box
 - Verify that “NM MCD – New Mexico Medicaid” is displayed in the Pharmacy Source pull-down box if 01 is on the claim form
 - If 07 are on the claim form then verifies that “NCPDP-NCPDP” is displayed in the Pharmacy Source pull-down box
 - If 05 is on the claim form then verify that “NM MCD-New Mexico Medicaid” is displayed in the Pharmacy Source pull-down box
 - If not, click the tab and select it
- 7. Tab to the Provider Prescriber ID field
 - Key the number from the Prescriber ID box
- 8. Tab to the Prescriber Type pull-down box
 - If a 10 digit number was keyed in the Prescriber ID field, verify that “01 – National Provider Identifier” is displayed
 - If not, click the tab and select it
 - If the Prescriber ID is two letters followed by numbers, click the tab and select “12 – Drug Enforcement Administration”
 - If the Prescriber ID is an 8 digit number, click the tab and select “05 - Medicaid”
- 9. Tab to the Prescriber Source pull-down box
 - If “01” was selected in the Prescriber Type box, verify that “NM MCD – New Mexico Medicaid” is displayed
 - If not, click the tab and select it
 - If “12” was selected in the Type box, click the tab and select “DEA – DEA File”
 - If “05” was selected in the Type box, click the tab and select “NM MCD – New Mexico Medicaid”
- 10. Tab to the Rx/Service field
 - Key the number from the Prescription/Serv. Ref # box
- 11. Tab to the New/Refill field

- If the provider puts an N on the claim form then key a 0
 - If the provider puts a Y on the claim form then key a 1
 - If any other number from 0 – 99 is present then key what you see
12. Tab to the Submit Days field
 - Key the number from the Days Supply box
 13. Tab to the Medical Certification Code pull-down box
 - Click the tab and select “01 – Prior Authorization”
 14. Tab to the Submit Qty field
 - Key the number from the Qty Dispensed box
 15. Tab to the Drug NDC field
 - Key the number from the Product/Service ID box
 - Do not key symbols
 - NDC number must be 11 digits if not key zeros in front
 16. Tab to the Date Written field
 - Key the date from the Date Written box in MM/DD/YYYY format, keying the forward slashes
 17. Tab to the Date Filled field
 - Key the date from the Date of Service box in MM/DD/YYYY format, keying the forward slashes
 18. Tab to the Qty Prescribed field
 - Key the number from the Qty Dispensed box
 19. Tab to the Compound pull-down box
 - Verify that “01 – Not a Compound” is displayed
 - If not, click the tab and select “01”
 20. Tab to the Submit Ingr Cost field
 - Key the dollar amount from the Ingredient Cost Submitted box
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents (Examples: \$597300, key as 5973.00; \$12345, key as 123.45)
 - If there is a negative amount listed, leave the amount blank
 21. Tab to the Total Charge field
 - Key the dollar amount from the Net Amount Due box
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents
 - If there is a negative amount listed, leave the amount blank
 22. If a Management Override request appears on the claim and the claim attachments include an authorization from the State allowing the Override, scroll down and click on the Management Override pull-down box
 - Select “Y – Management Override Allowed”
 23. Click the Save button at the bottom of the screen
 24. Click the Line Items tab at the top of the screen
 25. Click the “1” in the left column under Line Items
 26. Click the Prior Auth ID field and key the 11 digit Prior Authorization number from the PA attachment

Claims Support

27. Click the Update button at the bottom of the screen
28. Click the Misc Fields tab at the top of the screen
29. Click on the Authorization Number field and key the 11 digit Prior Authorization number from the PA attachment
30. Click the PA Type pull-down box and select "01 – Prior Authorization"
31. Click the Save button at the bottom of the screen
32. Click on each box displaying ".00" or ".000" and key "0.00"
33. Click the Save button at the bottom of the screen
34. Click the Claim tab at the top of the screen
35. Click the Verify button at the bottom of the screen
36. An Exceptions box will appear above the claim entry field, if no exceptions appear, proceed to the next step
 - If there are exceptions listed, check each exception for errors in keying and verify that information from the claim was entered in the proper fields
 - Correct any errors found
 - Click the Verify button again if corrections have been made
37. Click the Save button to save the claim and continue to the next claim

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	5/10/07	• All	• All	• Complete revision for X2I system
003	5/30/07	• 29	• # 26 & 29	• Prior Authorization 11 Digit long
004	9/10/07	• Pg. 2	• # 5 & # 6	• Key QUAL number from the claim.
005	9/10/07	• Pg. 3	• # 11 & 14	• Key 0 through 99. And NDC number must be 11 digits long.
	9/12/07	• Pg.2&3	• #5,#6 and 11	• Reword of the description.

Claims Support

	12/20/07	<ul style="list-style-type: none">• 4	<ul style="list-style-type: none">• 22	<ul style="list-style-type: none">• Added State auth. requirement for overrides
	09/02/11	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• All	<ul style="list-style-type: none">• Updated all steps and added to procedure manual
		<ul style="list-style-type: none">•	<ul style="list-style-type: none">•	<ul style="list-style-type: none">•

Keying UB-04 Claims

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing UB-04 claims. This procedure outlines the steps to follow when a UB-04 claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Creating a UB-04 Batch

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and drop down box will appear at the top of the main screen. From this menu, select "CE_ENTR". A list of all available claim batches will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available UB-04 batch (batch range 350-399). A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the batch already exists.
5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "C" in the 'Document Type' field; the window should read 'C - FFS'. In the 'Batch Type' field, enter "U" for a UB-04 batch.
9. Once you have entered everything correctly in Batch Control, save the new batch and close this window.

10. In Abledoc, click on the blue icon under 'Open' on the list of claims for the first claim in the batch you are going to work. This will open the claim.
11. Open OmniCaid Exam Entry, and enter the Julian date of the UB-04 batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.

Keying UB-04 Header Information

If 'Medicare Exhaust' is written on the claim form and there is an attachment code 59, do not return to the claim to the mailroom. Key the claim as a normal UB without entering anything from the Medicare EOB.

1. The cursor will appear in the Doc field in the upper left corner.
 - Key the claim's number, the last 2 digits of the TCN number. (Example: 01, 50)
2. Tab to the Billing Prov Zip field. Key the Zip code from box 1.
3. Tab to the Pat # field. Key the Patient Control number from box 3a.
 - Key as presented (no spaces). Example: 12 3*4 key as 123*4
 - If multi page, key from last page.
4. Tab to the Med Rec Nbr field. Key the number from box 3b.
 - Key as presented (no spaces). Example: 12 3*4 key as 123*4
 - If multi page, key from last page.
5. Tab to the Type of Bill field. Key the 3- or 4-digit number from box 4.
6. Tab to the Service From/To fields. Key the From/Through dates from box 6 in MM/DD/YY format.
7. Tab past the F/Mi/L name fields. Do not key in these fields.
8. With the cursor in the DOB field, key the Date of Birth from box 10 in MM/DD/YYYY format.
 - If the century is not listed, use logical judgment to choose 19XX or 20XX.
 - If the box is blank, leave the field empty.
9. Tab to the Adm Dt field. Key the date from box 12 in MM/DD/YY format.
 - If the box is blank, leave the field empty.
10. Tab to the Hr field. Key the 2 digit hour from box 13.
 - If the box is blank, leave the field empty.
11. Tab to the Ty field. Key the 1 digit Type from box 14.
 - If the box has 2 digits, key in the second one. Example: 01 key 1
 - If the box is blank, leave the field empty.
12. Tab to the Src field. Key the 1 digit Src from box 15.
 - If the box has 2 digits, key in the second one. Example: 01 key 1
 - If the box is blank, leave the field empty.
13. Tab to the Dis Hr field. Key the 2 digit hour from box 16.
 - If the box is blank, leave the field empty.
14. Tab to the Stat field. Key the 2 digit code from box 17.
 - If the box is blank, leave the field empty.
15. Tab to the first Cond field. Key each 2 digit code from boxes 18 through 28.
 - If the boxes are blank, leave the field empty.

Claims Support

16. Tab to the first Occ/Dt field. Key each 2 digit code and date in MM/DD/YY format from boxes 31 through 34.
 - If the boxes are blank, leave the field empty.
17. Tab to the first Spn field. Key each 2 digit code and From/To date in MM/DD/YY format from boxes 35 and 36.
 - If the boxes are blank, leave the fields empty
18. Tab to the first Val field and key in each 2 digit code. Key in the dollar amounts from boxes 39 through 41.
 - If there is a negative amount listed, key the code but leave the amount blank.
19. Press the F5 key to continue to the next field.

Keying UB-04 Line Information

1. With the cursor in the first charge line's Rev field, key the 3- or 4-digit code from box 42.
2. Tab to the Proc field. If a 5-character code appears in box 44, key it.
 - The code may be letters and/or numbers.
 - If the code is shorter than 5 characters, leave the field blank.
 - If the code is longer than 5 characters, key the first 5 characters only.
 - If revenue code is in the range 100-219, enter the number in box 44 in the Rate field no matter how many digits it has.
3. Tab to the M1 and M2 fields. Key the modifiers from box 44 from left to right.
 - Each modifier must be 2 alpha or numeric characters, and usually follows the procedure code. Do not key any symbols.
 - Modifiers may be listed separately or together with no spaces. Examples: RR KJ, 26AA, or AB12BG
 - If you need to enter more than two modifiers, press the Esc key to open the pop-up window with fields for up to four modifiers.
4. If an "N4" followed by a string of numbers and letters appears in box 43, press the Esc key to open the detail window. Click on the NDC field and key the 11 digit number immediately following the N4.
 - Tab to the NDC Unit of Measure field and key the 2 digits immediately following the NDC. Note: typical codes are F2, GR, ML & UN
 - Tab to the NDC Quantity field and key the number immediately following the unit of measure. Note: a maximum of 2 places past the decimal can be entered.
5. Click the OK button to close the window.
6. Tab to the Rate field. If a dollar amount appears in box 44, key it.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If no dollar amount appears, leave the field empty.
 - If there is a negative amount listed, key the charge line information but leave the amount blank.
7. Tab to the FDOS field. Key the date from box 45 in MM/DD/YY format.
8. Tab to the SUnit field. Key the units from box 46.
 - If the box is blank, leave the field empty.
9. Tab to the Submit Chrg field. Key the dollar amount from box 47.

- If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, key the charge line information but leave the amount blank.
10. If an amount appears in box 48, press ESC to open the detail window.
- Click on the Non-Cvrd Chrg field and key the dollar amount from box 48.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, key the charge line information but leave the amount blank.
11. Tab to the next Charge Line field and repeat the process for keying UB04 line information.
12. After keying all the charge lines, tab to the next line and key the rev code 001 from line 23. Tab to the Submit Chrg field and key from the Totals box.
13. Press F5 to continue to the next field.
- Note: this claim type is limited to 999 charge lines

Keying UB-04 Payer Information

1. Tab past the Medicare check box.
2. With the cursor in the Other Insr check box, examine the payer information in box 50. If any payer merits an "F" or "I" letter code in Step 4 below, press the space bar. If not, leave the check box blank.
3. Tab to the Creation Dt field. Key the date from Line 23, box 45 in MM/DD/YY format.
4. Tab to the first Py Cd field.
 - Key the following letter code according to the payer information in box 50:
 - C-Medicare (BCBS Arkansas, Omaha, Aetna, etc.)
 - The claim must have an attachment code 59. (If the claim has an attachment code 59, it must be scanned and keyed as a UB-04 Crossover claim, not a UB-04 claim)
 - Helpful hint: key a "C" if there is an attachment code 59.
 - D-Medicaid (CONDUENT, Affiliated Computer Services, Medicaid, Consultec, PHS, I, EPSDT, CMS, Children's Medical Services, Healthier Kids' Fund, Alien Emergency, CYFD, Children Youth and Family, MAD, State of New Mexico, HSD)
 - Helpful hint: key a "D" if there is an attachment Code 55.
 - F-Insurance company (Prudential, BCBS of New Mexico, Cigna, American General Life, Cimarron HMO)
 - Helpful hint: key an "F" if there is an attachment code 56.
 - I-Other
 - Helpful hint: key an "I" if there is a company listed and there is no attachment code.
 - If "Self Pay", "Recipient", or recipient's name appears in box 50, leave the field blank.
 - Note: Only one "D" payer can be entered for each claim. If more than one appears, consult the supervisor.

Claims Support

5. Tab to the Healthcare Plan ID field. Key the ID number from box 51.
 - If the box is blank, leave the field empty.
6. Tab to the Cert-SSN-HIC-ID field. Key the ID number from box 60.
 - If the box appears in the same line as the Medicaid letter code (D), do not key letters.
 - Do not enter dashes.
 - The system may change a 14 digit ID number after it has been entered.
7. Tab to the Prior Payment field. Key the dollar amount from box 54.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, leave the amount blank.
8. Tab to the Est Amt Due field. Key the dollar amount from box 55.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, leave the amount blank.
9. Tab to the Auth Code field. Key what appears in box 63 on the same line as the Medicaid letter code (D).
 - Do not key spaces or symbols.
 - If the number is longer than 18 characters, key only the first 18 characters.
 - If there are multiple authorization codes, key only the first one.
 - If only one payer line is listed on the claim and a code appears on a different line in box 63, key the code on the first line.
10. Tab to the next Payer line and begin again with Step 4.
 - If there are no more Payer lines, press F5 to continue to the next field.
11. With the cursor in the Billing NPI field, key the 10 digit NPI number from box 56.
12. Tab to the Blng Txnmy field. If a “B3” appears in box 81a followed by a 10-character ID, click on the Blng Txnmy field and key the ID.
13. Tab to the Blng Prov ID field. Key the ID number from box 57 on the same Payer line where the Medicaid letter code (D) appears.
 - If a number does not appear on the proper line, leave the field empty.
14. Tab to the Pr Dx (1) field. Key the Diagnosis code from box 67 (the box number appears in the background).
15. Tab to the POA indicator field for the Pr Dx. Key the POA from the shaded area of box 67.
16. Key any diagnosis codes and POAs in boxes 67A-Q in the Other Dx fields.
 - Press the Esc key to open a pop-up window with additional fields if needed.
 - Do not key punctuation.
 - Key each diagnosis code’s POA from the corresponding shaded section of the field.
17. Tab to the Ad Dx field. Key the admit code from box 69.
 - Do not key any punctuation
18. If any diagnosis codes appear in boxes 70 or 72, click on the first available box in the Othr Dx field (where box 67 was keyed) and key the diagnosis codes.
 - Press the Esc key to open a pop-up window with additional fields if needed.

- Note: If any of these diagnosis codes are the same as the ones in box 67A-Q, do not key them in again.
- 19. Tab to the Pr Surg Proc/Dt field. Key the 4 digit code and date in MM/DD/YY format from box 74.
- 20. Tab to the Othr Surg Proc/Dt field. Key the 4 digit codes and dates in MM/DD/YY format from boxes 74A through E in fields 1 through 5.
- 21. Tab to the Additional Providers check box. If any numbers appear in boxes 76, 77, and 78 of the claim, press the space bar to open a pop-up window
- 22. With the cursor in the Attending NPI field, key the ID number from box 76 (NPI).
- 23. If a “B3” appears in the QUAL box of box 76, tab to the Attending Taxonomy field and key the number that follows the B3.
- 24. Repeat steps 22 and 23 for the Operating NPI and Taxonomy fields, keying from box 77.
- 25. Repeat steps 22 and 23 for the Other NPI and Taxonomy fields, keying from box 78.
- 26. Click the OK button to close the pop-up window.
- 27. Tab to the Attachments field. Key the Attachment codes from box 37.
 - If more than 5 codes appear, enter the first 5 in order from lowest to highest. (Example: if 98, 55, 74, and 56 appear, key 55, 56, 74, and 98)
- 28. Tab to the Override Locn field. If the batch being keyed is an Emergency batch with a Location code listed on the cover sheet, key the 3 digit code in this field. (Example: 145, 790)
- 29. Press the F9 key to validate the claim.
- 30. After validation, check the Li/Exc/St/ClerkID box in the lower right corner.
 - If no exception lines appear, proceed to the next step.
 - If exception lines appear, double click inside the box. A pop-up window will appear listing the exceptions.
 - If an exception description is preceded by an “E-”, double click on the line.
 - Click inside the lower text box and search for the “Exam Entry” section
 - It may be necessary to click the “Next Page” button to continue searching.
 - Follow the instructions listed under “Exam Entry” to check the claim for errors.
 - If a correction is made to the claim screen, press the F9 key to validate again.
 - Continue to edit until all “E-” exceptions have been checked.
 - Click OK to close the edit pop-up window.
 - If an exception code appears both in the exception box and in box 19 of the claim, and an NMCT # appears on the claim, the exception must be forced.
 - In the exception box, click on the exception and enter an F.
 - Repeat for all lines with that exception in the exception box.
 - If there is an override code that will not be forced, bring the claim to your supervisor.
- 31. Press CTRL+S to save the claim and proceed to the next claim.
- 32. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim’s image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate

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information to have the error fixed. Open the QA Claims Review log at ([hyperlink goes here](#)) and enter the appropriate information so QA is aware of the error.

33. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.
34. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.
35. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	5/10/07	• All	• All	• Complete revision for new claim form
003	6/20/07	• 3 of 7	• # 18	• Box 39-41 this is not a dollar amount.
004	6/21/07	• 3 of 7	• # 18	• Box 39-41 Codes 80-83 are non-dollar amount.
005	6/29/07	• 3 of 7	• # 18	• Box 39-41 Remove if the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents (Examples:

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				\$597300, key as 5937.00)
006	12/20/07	• 6	• 50	• Added State auth. Requirement for Exception codes
007	04/14/08	• 3	• 29	• If revenue code is in the range to 100-219, treat the number as a rate no matter how many digits.
008	05/06/08	• 6	• 44	• Note – If any of these diagnosis codes are the same as what was in Box 67A-Q then do not key them in again.
009	06/06/08	• 5 of 8	• # 32-F	• Helpful hint key an “F” if there is an attachment code 20.
010	09/03/08	• 2 of 5	• Before #1	• Instructions for Medicare Exhaust per: Memo# 28-1222
011	10/10/08	• 4 of 8	• #22	• Correct Box# to 43 not Box # 44.
012	01/07/11	• 1	• Desc/Purpose	• Updated first two paragraphs.
013	07/11/11	• 6	• 37	• Updated wording for capturing box 63.
014	8/31/11	• 6	• 50	• Deleted step 50, keying exception codes
015	09/07/11	• All	• All	• Updated all steps and added to procedure manual
016	12/18/12	• Multiple	• 4, 16 & 17	• Added capture of POA

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				indicators, NDC Unit of Measure and NDC Quantity
017	5/9/13	<ul style="list-style-type: none"> • 3-40 	<ul style="list-style-type: none"> • all 	<ul style="list-style-type: none"> • Patient ID and Medical record information updated for single page claims and multipage claims
018	2/17/14	<ul style="list-style-type: none"> • 3-43 	<ul style="list-style-type: none"> • 6 	<ul style="list-style-type: none"> • Added “do not enter dashes”
019	March 2014	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Edited for clarity. • Added instructions to key only 1 digit in Ty and Src fields to steps 11 and 12 of Header Information. • Added instructions to only enter 1 PA to step 9 of Payer Information. • Added Workflow 2.0, batch control, and adjustment log instructions.

Keying UB-04 Crossover Claims

Updated last 5/9/13

Scope of Responsibility

- Exam entry

Description and Purpose

This procedure ensures contractual guidelines are met with Department regarding processing UB-04 crossover claims. This procedure outlines the steps to follow when a UB-04 crossover claim is keyed into OmniCaid.

Service Level Agreement

- Process claims efficiently and accurately in accordance with Department policy
- Hard copy claims shall be entered within ten business days of receipt

Processing Steps

Creating a UB-04 Crossover Batch

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and drop down box will appear at the top of the main screen. From this menu, select "CE_ENTR". A list of all available claim batches will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available UB-04 Crossover batch (batch range 650-664). A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the batch already exists.
5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "C" in the 'Document Type' field; the window should read 'C – FFS'. In the 'Batch Type' field, enter "A" for a UB-04 Crossover batch.
9. Once you have entered everything correctly in Batch Control, save the new batch and close this window.

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10. In Abledoc, click on the blue icon under 'Open' on the list of claims for the first claim in the batch you are going to work. This will open the claim.
11. Open OmniCaid Exam Entry, and enter the Julian date of the UB-04 Crossover batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.

Keying UB-04 Crossover Header Information

1. The cursor will appear in the Doc field in the upper left corner.
 - Key the claim's number, the last 2 digits of the TCN number. (Example: 01, 50)
2. Tab to the Billing Prov Zip field. Key the Zip code from box 1.
3. Tab to the Pat # field. Key the Patient Control number from box 3a.
 - Key as presented (no spaces). Example: 12 3*4 key as 123*4
 - If multi page, key from last page.
4. Tab to the Med Rec Nbr field. Key the number from box 3b.
 - Key as presented (no spaces). Example: 12 3*4 key as 123*4
 - If multi page, key from last page.
5. Tab to the Type of Bill field. Key the 3- or 4-digit number from box 4.
6. Tab to the Service From/To fields. Key the From/Through dates from box 6 in MM/DD/YY format.
7. Tab past the F/Mi/L name fields. Do not key in these fields.
8. With the cursor in the DOB field, key the Date of Birth from box 10 in MM/DD/YYYY format.
 - If the century is not listed, use logical judgment to choose 19XX or 20XX.
 - If the box is blank, leave the field empty.
9. Tab to the Adm Dt field. Key the date from box 12 in MM/DD/YY format.
 - If the box is blank, leave the field empty.
10. Tab to the Hr field. Key the 2 digit hour from box 13.
 - If the box is blank, leave the field empty.
11. Tab to the Ty field. Key the 1 digit Type from box 14.
 - If the box has 2 digits, key in the second one. Example: 01 key 1
 - If the box is blank, leave the field empty.
12. Tab to the Src field. Key the 1 digit Src from box 15.
 - If the box has 2 digits, key in the second one. Example: 01 key 1
 - If the box is blank, leave the field empty.
13. Tab to the Dis Hr field. Key the 2 digit hour from box 16.
 - If the box is blank, leave the field empty.
14. Tab to the Stat field. Key the 2 digit code from box 17.
 - If the box is blank, leave the field empty.
15. Tab to the first Cond field. Key each 2 digit code from boxes 18 through 28.
 - If the boxes are blank, leave the field empty.
16. Tab to the first Occ/Dt field. Key each 2 digit code and date in MM/DD/YY format from boxes 31 through 34.
 - If the boxes are blank, leave the field empty.

17. Tab to the first Spn field. Key each 2 digit code and From/To date in MM/DD/YY format from boxes 35 and 36.
 - If the boxes are blank, leave the fields empty
18. Tab to the first Val field and key in each 2 digit code. Key in the dollar amounts from boxes 39 through 41.
 - If there is a negative amount listed, key the code but leave the amount blank.
19. Press the F5 key to continue to the next field.

Keying UB-04 Crossover Line Information

1. With the cursor in the first charge line's Rev field, key the 3- or 4-digit code from box 42.
2. Tab to the Proc field. If a 5-character code appears in box 44, key it.
 - The code may be letters and/or numbers.
 - If the code is shorter than 5 characters, leave the field blank.
 - If the code is longer than 5 characters, key the first 5 characters only.
 - If revenue code is in the range 100-219, enter the number in box 44 in the Rate field no matter how many digits it has.
3. Tab to the M1 and M2 fields. Key the modifiers from box 44 from left to right.
 - Each modifier must be 2 alpha or numeric characters, and usually follows the procedure code. Do not key any symbols.
 - Modifiers may be listed separately or together with no spaces. Examples: RR KJ, 26AA, or AB12BG
 - If you need to enter more than two modifiers, press the Esc key to open the pop-up window with fields for up to four modifiers.
4. If an "N4" followed by a string of numbers and letters appears in box 43, press the Esc key to open the detail window. Click on the NDC field and key the 11 digit number immediately following the N4.
 - Tab to the NDC Unit of Measure field and key the 2 digits immediately following the NDC. Note: typical codes are F2, GR, ML & UN
 - Tab to the NDC Quantity field and key the number immediately following the unit of measure. Note: a maximum of 2 places past the decimal can be entered.
5. Click the OK button to close the window.
6. Tab to the Rate field. If a dollar amount appears in box 44, key it.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If no dollar amount appears, leave the field empty.
 - If there is a negative amount listed, key the charge line information but leave the amount blank.
7. Tab to the FDOS field. Key the date from box 45 in MM/DD/YY format.
8. Tab to the SUnit field. Key the units from box 46.
 - If the box is blank, leave the field empty.
9. Tab to the Submit Chrg field. Key the dollar amount from box 47.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.

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- If there is a negative amount listed, key the charge line information but leave the amount blank.
- 10. If an amount appears in box 48, press ESC to open the detail window.
 - Click on the Non-Cvrd Chrg field and key the dollar amount from box 48.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, key the charge line information but leave the amount blank.
- 11. Tab to the next Charge Line field and repeat the process for keying UB04 line information.
- 12. After keying all the charge lines, tab to the next line and key the rev code 001 from line 23. Tab to the Submit Chrg field and key from the Totals box.
- 13. Press F5 to continue to the next field.
 - Note: this claim type is limited to 999 charge lines

Medicare Exhaust & Partial Medicare Exhaust Instructions

- If 'Medicare Exhaust' is written on the claim form and there is an attachment code 59, do not return to the mailroom, just key as a normal UB without keying from the Medicare EOB attachment.
- If 'Partial Medicare Exhaust' is written on the claim form and there is no attachment code 59, do not return to mailroom, just work normal E edits and allow other exceptions to post.
- If 'Partial Medicare Exhaust' is written on the claim form and there is an attachment code 59, the claims DOS may not match the Medicare EOB DOS completely, and that is okay.
- These should not be RTPed.
- Key all fields from the attached EOB according to the regular XO procedures.

Keying UB-04 Crossover Payer Information

1. With the cursor in the Medicare check box, press the space bar to open the Medicare pop-up window.
2. On the EOMB, find the entry matching the recipient on the claim. Check that one of the Service From/Through dates on the claim matches one of the Dates of Service on the EOMB.
 - If none of the Dates of Service match, RTP the claim.
3. With the cursor in the Carr field, key the Carrier number if it appears on the EOMB
 - If no Carrier number appears, leave the field blank.
4. Tab to the EOMB Date field. Key the Paid date from the EOMB in MM/DD/YY format.
 - The Paid date may be labeled as Payment, Check, Issued, Medicare Production, Settlement, Run, Remit, R/A date, or the date may be unlabeled.
 - A handwritten paid date is acceptable.
5. Tab past the Allow Amt field.
6. With the cursor in the Paid Amt field, key the Net Payment amount from the EOMB.
 - The amount may be labeled Payment, Net, Reimbursement, or Prov Pd.

- If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
- If there is no amount or a negative amount listed, leave the field blank.
- 7. Tab to the Coins Amt field. Key the Co-insurance amount from the Coinsurance, PR2, or OA2 column from the EOMB.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is no amount or a negative amount listed, leave the field blank.
- 8. Tab to the Ded Amt field. Key the Deductible amount from the Deductible, PR1, or OA1 column on the EOMB.
 - Cash Deductible and Blood Deductible amounts should be added together and the total keyed as the Deductible.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is no amount or a negative amount listed, leave the field blank.
- 9. Tab to the Patient Amt field. Key the Co-Pay amount from the Co-Pay, PR3, or OA3 column on the EOMB
 - **If Medicare made the charge(s) Patient Responsibility (PR) key in the amount in the Patient Amt Field.**
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If the EOB lists the copay and the coinsurance and/or deductible all in one column, enter that amount in the “Patient Resp” field only, not the coinsurance or deductible fields.
 - If there is no amount or a negative amount listed, leave the field blank.
- 10. Click the OK button to close the pop-up window.
- 11. Tab to the Other Insr check box.
- 12. With the cursor in the Other Insr check box, examine the payer information in box 50. If any payer merits an “F” or “I” letter code in Step 4 below, press the space bar. If not, leave the check box blank.
- 13. Tab to the Creation Dt field. Key the date from Line 23, box 45 in MM/DD/YY format.
- 14. Tab to the first Py Cd field.
 - Key the following letter code according to the payer information in box 50:
 - C-Medicare (BCBS Arkansas, Omaha, Aetna, etc.)
 - The claim must have an attachment code 59. (If the claim has an attachment code 59, it must be scanned and keyed as a UB-04 Crossover claim, not a UB-04 claim)
 - Helpful hint: key a “C” if there is an attachment code 59.
 - D-Medicaid (CONDUENT, Affiliated Computer Services, Medicaid, Consultec, PHS, I, EPSDT, CMS, Children’s Medical Services, Healthier Kids’ Fund, Alien Emergency, CYFD, Children Youth and Family, MAD, State of New Mexico, HSD)
 - Helpful hint: key a “D” if there is an attachment Code 55.
 - F-Insurance company (Prudential, BCBS of New Mexico, Cigna, American General Life, Cimarron HMO)

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- Helpful hint: key an “F” if there is an attachment code 56
 - I-Other
 - Helpful hint: key an “I” if there is a company listed and there is no attachment code.
 - If “Self Pay”, “Recipient”, or recipient’s name appears in box 50, leave the field blank.
 - Note: Only one “D” payer can be entered for each claim. If more than one appears, consult the supervisor.
15. Tab to the Healthcare Plan ID field. Key the ID number from box 51.
 - If the box is blank, leave the field empty.
 16. Tab to the Cert-SSN-HIC-ID field. Key the ID number from box 60.
 - If the box appears in the same line as the Medicaid letter code (D), do not key letters.
 - Do not enter dashes.
 - The system may change a 14 digit ID number after it has been entered.
 17. Tab to the Prior Payment field. If the letter code for the line is “F”, key the dollar amount from box 54. If the letter code is anything other than “F”, leave the field blank.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, leave the field blank.
 18. Tab to the Est Amt Due field. Key the dollar amount from box 55.
 - If the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents.
 - If there is a negative amount listed, leave the amount blank.
 19. Tab to the Auth Code field. Key what appears in box 63 on the same line as the Medicaid letter code (D).
 - Do not key spaces or symbols.
 - If the number is longer than 18 characters, key only the first 18 characters.
 - If there are multiple authorization codes, key only the first one.
 - If only one payer line is listed on the claim and a code appears on a different line in box 63, key the code on the first line.
 20. Tab to the next Payer line and begin again with Step 4.
 - If there are no more Payer lines, press F5 to continue to the next field.
 21. With the cursor in the Billing NPI field, key the 10 digit NPI number from box 56.
 22. Tab to the BlnG Txnmy field. If a “B3” appears in box 81a followed by a 10-character ID, click on the BlnG Txnmy field and key the ID.
 23. Tab to the BlnG Prov ID field. Key the ID number from box 57 on the same Payer line where the Medicaid letter code (D) appears.
 - If a number does not appear on the proper line, leave the field empty.
 24. Tab to the Pr Dx (1) field. Key the Diagnosis code from box 67 (the box number appears in the background).
 25. Tab to the POA indicator field for the Pr Dx. Key the POA from the shaded area of box 67.
 26. Key any diagnosis codes and POAs in boxes 67A-Q in the Other Dx fields.

- Press the Esc key to open a pop-up window with additional fields if needed.
 - Do not key punctuation.
 - Key each diagnosis code's POA from the corresponding shaded section of the field.
27. Tab to the Ad Dx field. Key the admit code from box 69.
- Do not key any punctuation
28. If any diagnosis codes appear in boxes 70 or 72, click on the first available box in the Othr Dx field (where box 67 was keyed) and key the diagnosis codes.
- Press the Esc key to open a pop-up window with additional fields if needed.
 - Note: If any of these diagnosis codes are the same as the ones in box 67A-Q, do not key them in again.
29. Tab to the Pr Surg Proc/Dt field. Key the 4 digit code and date in MM/DD/YY format from box 74.
30. Tab to the Othr Surg Proc/Dt field. Key the 4 digit codes and dates in MM/DD/YY format from boxes 74A through E in fields 1 through 5.
31. Tab to the Additional Providers check box. If any numbers appear in boxes 76, 77, and 78 of the claim, press the space bar to open a pop-up window
32. With the cursor in the Attending NPI field, key the ID number from box 76 (NPI).
33. If a "B3" appears in the QUAL box of box 76, tab to the Attending Taxonomy field and key the number that follows the B3.
34. Repeat steps 22 and 23 for the Operating NPI and Taxonomy fields, keying from box 77.
35. Repeat steps 22 and 23 for the Other NPI and Taxonomy fields, keying from box 78.
36. Click the OK button to close the pop-up window.
37. Tab to the Attachments field. Key the Attachment codes from box 37.
- If more than 5 codes appear, enter the first 5 in order from lowest to highest. (Example: if 98, 55, 74, and 56 appear, key 55, 56, 74, and 98)
38. Tab to the Override Locn field. If the batch being keyed is an Emergency batch with a Location code listed on the cover sheet, key the 3 digit code in this field. (Example: 145, 790)
39. Press the F9 key to validate the claim.
40. After validation, check the Li/Exc/St/ClerkID box in the lower right corner.
- If no exception lines appear, proceed to the next step.
 - If exception lines appear, double click inside the box. A pop-up window will appear listing the exceptions.
 - If an exception description is preceded by an "E-", double click on the line.
 - Click inside the lower text box and search for the "Exam Entry" section
 - It may be necessary to click the "Next Page" button to continue searching.
 - Follow the instructions listed under "Exam Entry" to check the claim for errors.
 - If a correction is made to the claim screen, press the F9 key to validate again.
 - Continue to edit until all "E-" exceptions have been checked.
 - Click OK to close the edit pop-up window.
 - If an exception code appears both in the exception box and in box 19 of the claim, and an NMCT # appears on the claim, the exception must be forced.

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- In the exception box, click on the exception and enter an F.
 - Repeat for all lines with that exception in the exception box.
 - If there is an override code that will not be forced, bring the claim to your supervisor.
41. Press CTRL+S to save the claim and proceed to the next claim.
 42. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.
 43. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.
 44. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.
 45. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

References

[TPL Amount Keyed from Claim Instead of EOB- Memo Number 27-0821.pdf](#)

Handwritten Medicare paid date is now valid – Memo number 12-1221.pdf

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	5/10/07	• All	• All	• Complete revision for new claim form
003	6/20/07	• 3 of 8	• # 18	• This is not a dollar amount.
004	6/21/07	• 3 of 8	• #18	• Box 39-40 Codes 80-83 are

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				non-dollar amount.
005	6/29/07	• 3 of 8	• # 18	<ul style="list-style-type: none"> Box 39-41 Remove if the dollar amount appears without a decimal, key the dollar amount with the last 2 digits as the cents (Examples: \$597300, key as 5937.00)
006	07/09/07	• 8	•	<ul style="list-style-type: none"> Add Memo Number 27-0821 TLP Amount
007	10/23/07	• 5	• # 35	<ul style="list-style-type: none"> Added Cash and Blood line to item 35
008	12/20/07	• 7	• 57	<ul style="list-style-type: none"> Added State auth. Requirement for Exception codes
009	04/14/08	• 3	• 20	<ul style="list-style-type: none"> If revenue code is in the range to 100-219, treat the number as a rate no matter how many digits.
010	05/06/08	• 6	• 51	<ul style="list-style-type: none"> Note – If any of these diagnosis codes are the same as what was in Box 67A-Q then do not key them in again.
011	06/06/08	• 5 of 9	• # 39-F	<ul style="list-style-type: none"> Helpful hint key an “F” if there is an attachment code 20.
012	08/26/08	• 4 of 9	• #28	<ul style="list-style-type: none"> Add Memo # 28-1222 Medicare

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				Exhaust Instructions DB
013	10/10/08	• 4 of 8	• #22	• Correct box# to 43 not box# 44
014	08/27/09	• 4 & 5	• #29, 35 & 36	• Added PR1 & PR2 info. Correct Exhaust instruction
015	01/07/11	• 1	• Desc/Purpose	• Updated first two paragraphs.
016	07/07/11	• 6	• 45	• Updated wording for capturing box 63.
017	8/31/11	• 7	• 58	• Deleted step 58, keying exception codes
018	09/07/11	• All	• All	• Updated all steps and added to procedure manual
019	8/13/12	• 4	• 4	• Added hand-written Medicare date instruction
020	12/18/12	• Multiple	• 4, 9, 24 & 25	• Added step to capture co-pay, POA indicators, NDC Unit of Measure & NDC Quantity
021	5/9/13	• Multiple	• All	• Patient ID and medical record number information was updated for single page claims and for multipage claims
022	2/17/14	• 3-53	• 15	• Added “do not enter dashes”
019	March 2014	• All	• All	• Edited for clarity. • Added

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				<p>instructions to key only 1 digit in Ty and Src fields to steps 11 and 12 of Header Information.</p> <ul style="list-style-type: none">• Added instructions to only enter 1 PA to step 9 of Payer Information.• Added Workflow 2.0, batch control, and adjustment log instructions.
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Claims Support

Exception Resolution

Scope of Responsibility

- Claims Processing department, Exception Resolution

Description and Purpose

Claims department associates are responsible for screening and processing exceptions that appear on claims from providers or those initiated internally by the fiscal agent. The process starts when the associate receives a claim with exceptions set to 'Suspend' or 'Super Suspend' in a location they are responsible for. All such claims are accessible via OmniCaid's Correction function.

Service Level Agreement

- 90% of exceptions worked in <10 days. 100% of exceptions worked in <30 days.
- "Claims" refers to new claims, adjustments to claims, recycling claims, suspended claims, voided claims, corrections to previously suspended or processed claims, and encounters claims submitted by Managed Care Organizations (3.5.1)

Processing Steps

1. Log onto OmniCaid and open Correction.
2. On the 'Search by' dropdown menu, select 'Location', then tab to the 'Search for' field. Enter the number of the location you wish to work and press enter.
The claims department is responsible for working the following locations: 165, 175, 200, 210, 220, 240, 255, 275, 280, 300, 350, 390, 400, 450, 470, 500, 520, 550, 600, 640, 650, 680, 700, 720, 730, 740, and 780.
3. A list of claims in that location will appear. Click 'Select' to open the first claim in the location.
4. The claim will open in Correction. If the claim is a paper claim, open the claim's image via Simple Find in IntraViewer.
5. Ensure that all information in OmniCaid matches the claim. Correct any fields with incorrect entries. (Skip this step for electronic claims, as there is nothing to check them against.)
6. Double-click on the exceptions field in the lower right to bring up the exception box. The claims department is responsible for working exceptions with '1' (Super-Suspend) or '4' (Suspend) in the 'Status Disc' column.
7. Double-click on an exception with '1' or '4' in the 'Status Disc' column. The resolution text will appear in the lower box. Double-click on the text box and

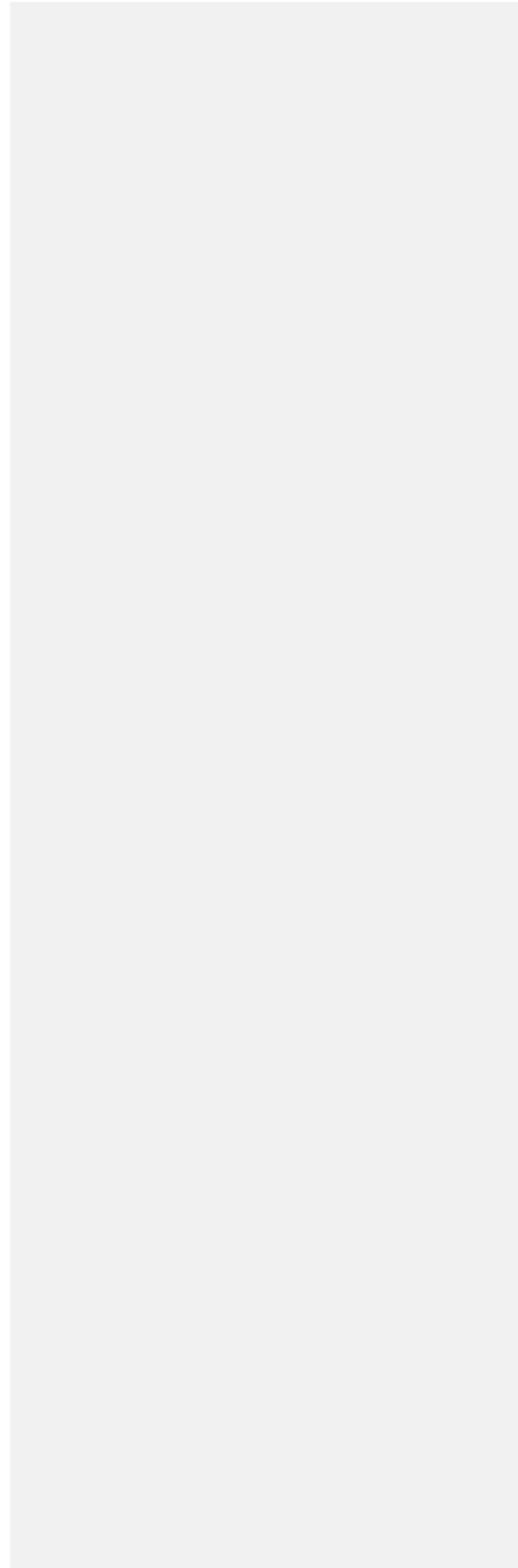
scroll down to the 'Resolution' section. Click 'Next Pg>>' if necessary to find that section.

8. Follow the resolution text to determine how to work the exception. Each exception has its own instructions, and may have separate instructions for different types of claims, different provider types, etc.
9. You will need to either force or deny some exceptions. To force an exception, enter 'F' in the exception's 'St' column. To deny an exception, enter 'D' in the exception's 'St' column.
10. For some exceptions, you will need to pend the claim to a different location. To pend a claim, enter the three-digit location number in the 'Override Location' box in the lower right section of the claim. Record the number of claims you pend while working exceptions. Enter that number in the appropriate field on the Claims Production Log when you have finished with exception resolution.
11. When all exceptions with '1' or '4' in the 'Status Disc' column have been forced or denied, and any location overrides have been entered, press F9 to validate the claim.
12. Correcting errors or making other changes to the claim may cause some exceptions to disappear upon validation. Record the number of exceptions you clear while working exceptions. Enter that number in the appropriate field on the Claims Production Log when you have finished with exception resolution.
13. When all viable exceptions have been worked or cleared, the claim should be set to go to location 900, location 910, or the location entered in the 'Override Location' box. When the claim is in this state, save the claim.
14. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.
15. Repeat steps 5-14 until the location is empty.

Change History

Revision	Date	Page	Section or Step	Description
001	March 2014	• All	• All	• Initial Publication

Adjustments



Entering Adjustments, Voids, and TPL and Financial Voids

Scope of Responsibility

- Claims Processing department, Adjustments

Description and Purpose

Claims department associates are responsible for screening and processing adjustment and void requests from providers or those initiated internally by the fiscal agent. The process starts when the associate receives an appropriately completed adjustment or void form and documentation to support the request. All such requests are received and sorted from all other claim types in the mailroom and transferred on a daily basis to the assigned adjustment specialist for specialized screening.

After screening, requests that are incomplete or inaccurate are returned to the initiating party for correction and re-submission. For adjustments initiated by providers, the request is then handled identically to all claims returned to providers (RTPs).

Requests that can be processed are batched, scanned, and controlled as all other claims. Claims department associates enter the adjustment data for all other adjustments into the system.

Service Level Agreement

- Hard copy claims shall be entered within ten (10) business days of receipt.
- Electronically submitted claims shall be loaded within one business day of receipt (3.5.3.6).
 - "Claims" refers to new claims, adjustments to claims, recycling claims, suspended claims, voided claims, corrections to previously suspended or processed claims, and encounters claims submitted by Managed Care Organizations (3.5.1).

Processing Steps

1. Log onto Workflow and click on 'Workflow 2.0'. The 'Step' menu and drop down box will appear at the top of the main screen. From this menu, select "ADJ_ENTR". A list of all available adjustments will appear on the main screen.
2. Log onto OmniCaid and open Batch Control.
3. From the Batch Control Selection screen, enter the TCN from the first available adjustment batch. A message should pop up saying "No matching record on file for key(s) entered".
4. If this message does not appear, do not proceed. Check the OIT Scanning Log and determine why the adjustment or void batch already exists.

5. If the message appears, click OK, then click 'New' on the Batch Control Selection screen.
6. A new screen will appear with the entered TCN on the left side. Ensure this TCN is correct; if not, close this window and begin again from step 3.
7. Go to the 'Documents Information' section. Enter the number of documents in the batch in the 'Total Documents' field. The 'Begin Document' field should remain at '1' unless the batch starts at a different number; if so, enter that number. Enter the number of the last document in the 'End Document' field. Under most circumstances, this will match the 'Total Documents' field.
8. Tab to the 'Batch Information' section. Enter "A" in the 'Document Type' field; the window should read 'A – Adjustment'. In the 'Batch Type' field, enter "Y" for an adjustment batch, "Z" for a void batch.
9. If you are entering a Financial or TPL Void batch, go to the 'Payment Type' section and check the 'History Only' box. This step is essential for Financial Voids and any other 'history only' batches; do not forget it or you will have to re-enter and re-void every claim in the batch. If you are not entering a Financial or TPL Void batch, do not change anything in this section.
10. Once you have entered everything correctly in Batch Control, save the new batch and close this window.
11. Repeat steps 3-10 for all adjustment or void batches.
12. In AbleDoc, go to the left panel and click on 'Wkfl GetNextBatch'. The GetNext window will pop up. Select "ADJ_ENTR" from the 'Step' list and click "Submit". This will open up the first available adjustment or void batch and flag the entire batch for your use. It will also open the adjustment or void claim.
13. Open OmniCaid Exam Entry, and enter the Julian date of the adjustment or void batch. If the batch is not found, make sure you entered it correctly in Batch Control; re-enter the batch if necessary.
14. The adjustment/void entry screen will open. Enter the document number in the 'Doc' field. Using the adjustment or void claim that Workflow opened, enter the provider ID or NPI (only one is necessary), the client ID, and the TCN in the appropriate fields.
15. Tab to the 'Adjustment Reason' section. Enter reason code 014 for adjustments or 081 for voids.
16. If keying a Financial or TPL Void batch, enter the reason code from the lower section of the request form. Tab to the FCN field and enter the date from the bottom section of the request form. Tab to the next field and enter '0', then tab to the last field and enter the two-digit number listed on the request form. If you receive an error message, make sure you have entered the FCN information correctly. If all the information is correct and you still receive an error message, speak to the person in Financial or TPL who assembled the batch to see if they entered the correct information on the request form.
17. Once you have entered all the necessary information, press F9 to validate.
18. If any exceptions post, you must clear them before continuing. **Do not force or deny any exceptions on this screen.**
19. Exceptions 0842, 0843, and 0844 occur when the client ID, provider ID, and/or NPI on the adjustment/void entry screen does not match the claim to be adjusted or voided. To clear them, enter the information from the claim in Inquiry in the appropriate field. Press Alt+G to pull down the 'Go To' menu, then press 'Q' to go to the Inquiry screen that shows the claim to be adjusted or voided. Copy any

Adjustments

information you need, then paste it into the appropriate field on the adjustment/void entry screen and re-validate. The exception(s) should clear.

20. Exception 0845 occurs when the claim has already been adjusted. To clear it, enter the TCN from 'TCN replacement' on the bottom section of the claim to be adjusted or voided (see previous step) in the adjustment/void entry screen's TCN field. Validate. The exception should clear. If exception 0845 remains, repeat the process; this occurs when the claim has already been adjusted multiple times.
21. Some exceptions cannot be cleared, so you must return the adjustment or void to the provider (RTP). Some of these exceptions are 0177 (replacement or credit of denied claim), 0840 (replacement or credit is in progress), and 0856 (a credit may not be adjusted).
22. Once you have cleared all the exceptions, save the adjustment or void to continue.
23. If you are entering voids, the entry screen will clear itself for the next claim. In the Workflow claim window, go to the first pulldown menu and mark the void as 'Processed', then click 'Validate here'. After validating the claim, click 'GetNext' to move on to the next claim. Repeat steps 14-23 until the batch is complete.
24. If you are entering adjustments, the claim you are adjusting will open. Make any changes the provider is requesting under "Reason for Request" on the adjustment form. Review the claim as if keying the first time. Update any and all changes from the new claim into OmniCaid, including attachment codes, procedure codes, new or updated line items and charges. If the "Reason for Request" does not match the corrected claim, RTP the Adjustment. Validate the claim (F9).
25. If you are entering in-house adjustments (batches 678 and 679), you must pull up the original claims manually. Log into IntraViewer, click on 'Simple Find', and enter the TCN of the claim you are adjusting in the 'TCN' field. Follow the instructions on the adjustment form to correct any errors. Review the claim as if keying the first time. Update any and all changes from the new claim into OmniCaid, including attachment codes, procedure codes, new or updated line items and charges. Validate the claim (F9).
26. Work any viable exceptions that post. **Do not deny timely filing** (exceptions 0496, 0497, 0815 and 0820) **when working adjustments**; see those exceptions' reso text for special adjustment instructions. If you cannot force the timely filing exceptions, you must RTP the adjustment.
27. Once you have worked all viable exceptions and everything on the claim is correct, press Ctrl+S to save the claim. In the Workflow claim window, go to the first pulldown menu and mark the adjustment as 'Processed', then click 'Validate here'. After validating the claim, click 'GetNext' to move on to the next claim.
28. Repeat this process until the batch is complete.
29. If you realize you have made an error on a claim after saving that claim, open the claim in Inquiry and pull up the claim's image from IntraViewer. Verify that you have made an error. If so, open the Adjustment Request Log located at <H:\Claims\Adjustments\Adjustment Request Log.xls> and enter the appropriate information to have the error fixed. Open the QA Claims Review log at (hyperlink goes here) and enter the appropriate information so QA is aware of the error.
30. If you had to RTP any claims while working a batch, you will need to go back into Batch Control and change the numbers in the 'Documents Information' section. Enter the TCN in Batch Control as in step 3, then subtract the number of claims RTPed from the batch from the total documents in the batch. Enter this number in the 'Total Documents' field in the 'Documents Information' section.

31. If the first and/or last document of the batch was RTPed, enter the new first and/or last document number in the 'Begin Document' or 'End Document' field.
32. Once you have entered all the new information correctly, hit Ctrl+S to save the batch. A message saying that this change will change the batch status/type to "A – Accepted" should appear if all the numbers match. Hit OK to complete saving and close the Batch Control window.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	10/17/06	• All	• All	• Updated to current procedure
003	6/11/09	• All	• All	• Updated to current procedure
004	09/07/11	• All	• All	• Updated all steps and added to procedure manual
005	April 25-current	• All	• All	• April-May department review and revision updates
006	March 2014	• All	• All	• Updated, edited, and rewrote for clarity.

Entering Pharmacy Voids

Scope of Responsibility

- Adjustments

Description and Purpose

Claims department associates are responsible for screening and processing individual void requests from providers or those initiated internally by the fiscal agent. The process starts when the associate receives an appropriately completed Individual claim adjustment form and documentation to support the request. All such requests are centrally received and sorted from all other claim types in the mailroom and transferred on a daily basis to the assigned adjustment specialist for specialized screening.

After screening, requests that are incomplete or inaccurate are returned to the initiating party for correction and re-submission. For adjustments initiated by providers, the request is then handled identically to all claims returned to providers (RTPs).

Requests that can be processed are batched, scanned, and controlled as all other claims. Claims department associates enter the adjustment data for all other adjustments into the system.

Service Level Agreement

Hard copy claims shall be entered within ten (10) business days of receipt. Electronically submitted claims shall be loaded within one business day of receipt. (3.5.3.6)

"Claims" refers to new claims, adjustments to claims, recycling claims, suspended claims, voided claims, corrections to previously suspended or processed claims, and encounters claims submitted by managed care organizations. (3.5.1)

Processing Steps

1. Identify the void request as a pharmacy void:
 - If the claim TCN begins with "1", it may be a pharmacy TCN
 - In OmniCaid, go to Inquiry and enter the TCN
 - If the TCN is a valid claim, check that the claim type is "Pharmacy"
 - If the TCN is valid, proceed to Step 2
 - If the TCN a different claim type, process the request as a regular void
2. Obtain the PDCS (Pharmacy system) TCN:
 - a. Log into PDCS (X21 Production)
 - b. Click on NEWMEX under Customer ID
 - c. Click on Claims, then Inquiry on the pull down menu
 - d. Click Search by TCN

- e. In the Search for box, enter the void TCN and click Search
 - If a valid claim appears in the search box, proceed to the next step
 - If the claim TCN was valid in OmniCaid, it must be translated to PDCS format
 - Add a “0” after the seventh digit and drop the first digit “1”
 - Enter the new TCN in the search for box
 - If a valid claim appears in the search box, continue to the next step
 - If a valid claim cannot be found, RTP the void for invalid TCN
- f. Click on the claim type to view the claim
- g. Check that the client and paid amount match the void request
 - If the claim does not match, RTP the void
- h. If the TCN was translated to PDCS format, write it on the void request
3. Prepare the pharmacy voids for scanning as with regular voids
 - Indicate the batch range for Pharmacy claims (starting at 800) on the cover sheet
4. After the batch is scanned, prepare the batch for keying:
 - a. Log into PDCS (X21 Production). Click on NEWMEX under Customer ID
 - b. Click Claims, then Batch Control on the pull down menu
 - c. Click Add Batch
 - d. Enter the batch date, batch number in 4 digit format, and batch total under Total and End Documents
 - e. Under Document Type, select A-Adjustment claims
 - f. Under Batch Type, select Z-Credit
 - g. Click the Save button
5. Key the batch:
 - a. Click on Claims, then Credit on the pull down menu
 - b. Enter the Batch Date and Batch Number, then click Search
 - c. Click on the batch under Batch Key
 - d. Under Reason Code, choose the code matching the text on the void request
 - If in doubt, select “84”
 - e. Under Group ID, select “MED”
 - f. Under TCN, enter the PDCS TCN from the void request
 - g. Click the Credit button
 - If the claim is indicated as “Paid”, continue to the next void
 - If an error occurs, check that the TCN was entered correctly
 - h. After the last void is entered, click Claims, then Batch Control on the pull down menu
 - i. Enter the batch date and number, and check that the batch status is “Accepted”
 - If the status is not accepted, check that the Total Documents in Batch Control is correct
6. Enter Keyer ID and Date on the batch cover sheet
7. Enter the batch information in the QA Adjustment log
8. Place the batch on the keyed batch shelf

References

Adjustments

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	01/12/11	• All	• All	• Initial Publication
002	10/19/11	• All	• All	• Added to procedure manual (TLB)
003		•	•	•
004		•	•	•
005		•	•	•

Reviewing the Adjustment Request Logs

Scope of Responsibility

- Claims Processing department, Adjustments

Description and Purpose

The claims department is responsible for processing internal adjustment requests. The requests are recorded on the Adjustment Request Log and the CRM Adjustment Log, then reviewed and prepared for processing by claims department personnel.

Service Level Agreement

- Internal procedure and five day turnaround.
- No contractual commitment defined.

Processing Steps

Part 1: Adjustment Request Log Review

1. Open the Adjustment Request log, located on the shared drive at <H:\Claims\Adjustments\Adjustment Request Log.xls>.
2. Go to the earliest sheet with new requests.
3. Review the status of previous adjustment requests. If a request has “Yes” in the ‘Submitted to be adjusted’ column but the ‘Status’ column is blank, copy the TCN and enter it in Omnicaid Inquiry.
4. The Inquiry screen will show a replacement TCN at the bottom of the ‘header’ tab. Enter that TCN in the ‘Adjusted TCN’ column of the log. Enter “Completed” in the ‘Status’ column of the log.
5. Repeat steps 3 and 4 for all claims with “Yes” in the ‘Submitted to be adjusted’ column and nothing in the ‘Status’ column.
6. For claims with no entry in the ‘Submitted to be adjusted’ column, enter the TCN in Omnicaid Inquiry. If reviewing a paper claim, open IntraViewer and select the Simple Find function, and enter the TCN to view the claim.
7. Consult the ‘Reason for Adjustment’ column for that claim, and determine whether the request for correction or resubmission is valid.
8. If the request is not valid, enter your name and today’s date in the ‘Received by’ and ‘Date’ columns. Enter “No” in the ‘Submitted to be adjusted’ column, and explain why the request is not valid in the ‘Reason’ column. Enter “Rejected” in the ‘Status’ column.
9. If the request is valid, fill out an Adjustment Request form, located at <H:\Claims\Adjustments>.

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10. On the Adjustment Request form, enter the Provider ID or NPI in section A. Enter the client ID and claim TCN in section B. In section C, indicate the reason for the adjustment. Be specific and clear. Enter your name and today's date in section D. Print the adjustment request form.
11. In the adjustment request log, enter your name and today's date in the 'Received by' and 'Date' columns, and "Yes" in the 'Submitted to be Adjusted' column for the valid request. Close the claim if necessary.
12. Proceed to the next TCN for review. Repeat steps 6-11. Continue until you have reviewed all the TCNs, then close the Adjustment Request log and proceed to the CRM Adjustment Log.

Part 2: CRM Adjustment Log Review

1. Open the CRM site, located at <http://nmcrmweb:5555/ConduentGHSCRM/main.aspx>.
2. Click on 'Workplace' on the lower left section of the screen. This will open a new column above that section, with 'Workplace' at the top. Click on 'Activities' in this new column. This will open up a new section in the main part of the screen.
3. In the new section, click on "My Activities". A box with several options will drop down. Click 'Task' to open a new submenu, then click 'Adjustment Log 4'. The adjustment log will open in the main part of the screen.
4. Begin reviewing the adjustment requests with status 'In Process'. Click on the first request's TCN to open the adjustment request window.
5. From the adjustment request window, copy the TCN from the 'Subject' field and enter it in Omnicaid Inquiry, then open the claim. The screen will show a replacement TCN at the bottom of the 'header' tab. Copy the 'TCN replacement' field. In the main field of the adjustment request window, type "Adjusted TCN:" and paste in the copied replacement TCN. Enter your name or initials on the next line.
6. In the 'Status' field in the lower right section of the adjustment request window, change the status from 'In Process' to 'Completed'. Click on 'Mark Complete' in the upper left corner of the window. The window will close.
7. Repeat steps 4-6 for all adjustment requests with status 'In Process'.
8. Begin reviewing the adjustment requests with a blank 'Status' field. Click on the first request's TCN to open the adjustment request window.
9. From the adjustment request window, copy the TCN from the 'Subject' field and enter it into Omnicaid Inquiry, then open the claim. If reviewing a paper claim, open IntraViewer and select the Simple Find function, and enter the TCN to view the claim.
10. Consult the adjustment request window's main field to find the reason for correction or resubmission. Determine whether this request is valid. For example, if the request states that an exception was worked incorrectly, determine if the exception was forced or denied correctly or not.
11. If the request is not valid, explain why in the main field of the adjustment request window, and enter your name or initials on the next line. Go to the 'status' field in the lower right section of the window, and change the status to 'Rejected'. Click on 'Mark Complete' in the upper left corner of the adjustment request window. The window will close.
12. If the request is valid, fill out and print an Adjustment Request form, as detailed in step 10 of Part 1.

13. Go to the 'status' field in the lower right section of the adjustment request window, and change the status to 'In Process'. Click on 'Save & Close' in the upper left corner of the adjustment request window. The window will close.
14. Proceed to the next TCN for review. Repeat steps 8-13. Continue until all TCNs have been reviewed, then close the CRM Adjustment log and assemble the adjustment batch.

Part 3: Assembling the Adjustment Batch

1. When you have finished reviewing all the requests from both adjustment logs, gather the printed adjustment request forms. Sort the forms by the date of each request from the logs. If you work the adjustment log every day, you should only have one date's worth of adjustments.
2. Create a batch cover sheet for each date. Enter this date as the Julian date on the cover sheet.
3. Bundle the claims and place them with the adjustments from the mailroom for scanning.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	11/12/10	• All	• All	• Initial Publication
002	09/07/11	• All	• All	• Updated all steps and added to procedure manual
003	March 2014	• All	• All	• Complete rewrite. • Added instructions for CRM adjustment log.
004		•	•	•
005		•	•	•

Sorting and Screen Adjustments

Scope of Responsibility

- Adjustments

Description and Purpose

The claims department is responsible for processing adjustment requests from providers or from within the claims process. Adjustment and void requests are sorted and scanned according to the date received or requested. Incorrectly submitted adjustments must be returned to the initiating party for correction.

Service Level Agreement

- Claims, including replacement claims and voids, must be processed within 10 days of receipt by CONDUENT

Processing Steps

1. Retrieve the adjustments for processing from the basket in the mailroom, noting the date the adjustments were received.
2. Sort the adjustments by type:
 - Separate the mailroom bundle according to the Adjustment or Void selection on the cover sheet. Keep the stacks separated by Julian dates if more than one date is represented.
 - In-house adjustments will be labeled with their submitted Julian date.
 - Separate adjustments from voids, and keep the Julian dates separated.
 - Departmental adjustments such as Financial Voids are submitted already batched with cover sheets, and Julian dates already indicated.
3. Review, code, and patch the voids and adjustments:
 - Review the mailroom adjustment and void cover sheets, checking that a TCN and signature are present. If either field is blank, set the adjustment aside to be returned to the provider
 - Remove all staples and paper clips from each adjustment.
 - For the mailroom adjustments, review and code each attached claim in the standard screening process. If an adjustment does not have a claim attached, set it aside to be returned to the provider.
 - Place patches between the adjustments and voids in each bundle.
4. Prepare an adjustment cover sheet for each bundle. Enter adjustment or void, Julian date, attachment or single, and the total adjustments in the bundle.
5. Determine the starting batch numbers for each adjustment bundle:
 - Open the OIT scanning log at `Shared\Claims\Scanning\OIT Batch Log-Albuquerque` for the current month.
 - Open the worksheet page for the Julian date of each adjustment bundle. Determine the starting batch range for each bundle

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- Regular adjustments and voids have a batch range of 665-677, in-house adjustments and voids have a batch range of 678-679, and Financial Voids begin at 800
 - If previous batches exist for the Julian date, use the next available batch number for the starting batch range
6. Note the starting batch range for each bundle on its cover sheet. If a batch has a cover sheet with a batch number, it should not be changed
 7. Secure each bundle with a rubber band or clip and take them to scanning.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	10/17/06	• All	• All	• Updated to current procedure
003	7/31/07	• 1	• 3	• Added step to code attachments
004	6/11/09	• All	• All	• Updated to current procedure
005	8/10/11	• All	• All	• Complete revision
006	09/07/11	• All	• All	• Updated all steps and added to procedure manual
007	March 2014	• All	• All	• Updated/edited for clarity.

Reporting Procedures

Producing the Daily and Weekly Suspense Reports

Scope of Responsibility

- Claims support

Description and Purpose

In order to maximize our opportunities, manage, and control the workflow of the suspense file, the claims unit utilizes several reports. The following two reports are used to create the claims suspense daily & weekly reports:

Report	Description
Suspended Claims Analysis by Claim Type (RC023)	<ul style="list-style-type: none">• Displays summary information by input media within claim type• Shows the number of claims suspended within a location for a period of time as defined by the column headings• Displays totals by location code, along with grand totals• Displays total claim exception count• Generated daily
Age Detail Suspense Report (RC021)	<ul style="list-style-type: none">• Generated by the system on a daily basis when the batch adjudication cycle is run to process all the claims entered that day• Lists the suspended claims by claim type and length of time in suspense• Sorted by current location code, claim type, and TCN

Service Level Agreement

- Internal procedure
- No contractual commitment defined

Processing Steps

Claims Daily Report

1. Log into IntraViewer.
2. Click on “Run Saved Query” on the toolbar to the left.
3. Select “Claims” from under “Groups” in the pull-down menu in the box in the main window.
4. Click on “Daily CS Reports”, and click the “Run” button. This will open up a listing of several reports in the lower frame
5. Make sure the file type at the top of the lower frame is set to ‘Browser’, then find report NMMC2300-RC023 (Suspended Claim Analysis by Claim Type), which will be listed under “Report/Doc ID”.
 - The date listed to the left, under ‘Date YYYY-MM-DD’ should be the business day that you are reporting, usually the previous work day.
6. Click on the ‘View’ button to the left of the report date. The RC023 report will display.
7. Go into H:\Claims\Reports\CS Daily.
8. Open the folder with the correct year (i.e. Daily2010).
9. Open the Excel file for the month you are in (i.e. April Daily 2010). At the bottom of the report, there are tabs with dates.
10. Go to the most recent date tab (should be two business days old) Right click on that tab and select “Move or copy”, then select “Move to End” from the ‘Before Sheet’ window.
11. Click the “Create a copy” box and click OK. This will create a new tab with the same information as the tab you clicked on.
12. Double click on this new tab and change the date to the reported day’s date.
13. Go to the top of the spreadsheet and change the Daily Suspense Report date to the reported day’s date.
14. Go to the bottom of the spreadsheet and enter all the numbers from the “Daily Totals” boxes into the “Previous Day Totals” boxes. All of the “Daily Change Totals” should now read zero.
15. Using the RC023 report, enter all the numbers from the “Current Number” column onto the “Claims” column on the daily report, matching by location.
 - If a location does not have an amount, enter zero in its box.
 - Do not enter any claims from location 000.
 - The “Grand Total” from the RC023 must equal the “Daily Totals” box on the “Claims” column of the daily report, less any claims from location 000.
16. Save your changes.
17. Do not close the window with the RC023 report, as you will be using that for the weekly report.
18. Do not close the daily report, as you will be using information from it for the weekly report.

Claims Weekly Report

1. Go into H:\Claims\Reports\CS Weekly.

2. Open the folder with the correct year (i.e. 2010), and then open the Excel file for the month you are in (i.e. April Weekly 2010).
3. If you are entering information for a Monday, you will need to make a new report page.
 - For all other days, you will need to change the report so that the “Daily Change” column shows the correct amounts.
 - Click on the first box with a number in it in the “Daily Change” column, and look to the function bar at the top of the Excel window.
 - Change the equation that shows up in the function bar to subtract the new day’s column from the previous column (Example: enter =sum (F4-E4) to subtract Monday’s number from Tuesday’s).
 - Then, move your cursor over the black square in the selected box’s lower right corner until the cursor changes to a black ‘+’ symbol.
 - Click, hold, and drag all the way down to the end of the report, the row labeled “Mass Adjustments”, then release.
 - This will enter the changed formula into all the selected boxes, so that the “Daily Change” column shows the correct amounts.
4. Change all the dates at the top of the report for the new week.
5. Delete all the numbers entered in the white squares of the dated columns from the previous week – columns E through I.
6. Do not delete anything from the “Daily Change” column.
7. Then, delete the numbers from the “CONDUENT Workable”, “State”, “CONDUENT Non-Workable”, and “Mass Adjustments” lines below the “Totals” line, in all columns
8. Do not delete anything from the “Totals” line.
9. Using the RC023 report, enter all the numbers from the “Current Number” column into the column of the date of the report, matching by location.
 - If a location does not have an amount, enter zero in its box.
 - Do not enter any claims from location 000.
 - The “Grand Total” from the RC023 must equal the “Totals” on the weekly report less any claims from location 000.
10. Enter the numbers from the Daily report’s “Daily Totals” into the following boxes:
 - Add together the “CONDUENT/Reso” and “CONDUENT/Other”, and enter that total into the “CONDUENT Workable” box on the Weekly report.
 - Enter the number from the “State” box into the “State” box on the Weekly report.
 - Enter the number from the “Non-Workable” box into the “CONDUENT Non-Workable” box on the Weekly report.
 - Enter the number from the “Mass Adj” box into the “Mass Adjustments” box on the Weekly report.
11. In IntraViewer, select “Simple Find” from the toolbar to the left and enter “NMMC2300-RC021” in the “Report Name/Doc ID” box.
12. Enter the date of the report you’re working on in the “Date YYYY-MM-DD” box.
13. Enter “0” in the “Location/Primary Type” box, and hit Enter. A list of reports will appear in the lower frame.
14. Locate the “Location/Primary Type” column. This indicates which location the report is for.

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15. Find a report for location 050 and click on “View” to display the RC021 report. You will see the columns labeled “Loc. Days” and “Clm. Age” on the report. You are looking for the highest “Clm. Age” for each location.
16. Using the RC021 reports, enter the highest number from the “Clm. Age” column in the “Claim Age” column on the weekly report for location 050.
17. Enter the “Loc. Days” number that’s listed with the oldest “Clm. Age” in the “Location Age” column.
18. Repeat this process with every location. You can get lists of other locations by entering numbers “1” through “9” in the “Location/Primary Type” box.
 - If a location has no reports, leave its boxes blank on the weekly report
19. Save your changes.
20. Do not close the IntraViewer window, as you will be using that for the other reports.
21. Close both the Daily and Weekly reports.

Other Reports

For these reports, you will not be filling out any spreadsheets. Instead, you will be reporting your findings in an e-mail to the appropriate people.

1. In ‘Simple Find’ in IntraViewer, enter NMMC2345-RC111 in the ‘Report/Doc ID’ field, and the previous day’s date in the ‘Date’ field. Hit enter to bring up the report.
2. Open the report NMMC2345-RC111.
 - For this report, you will be looking at the column “Oldest claim days”.
 - From the locations that Claims Support works, look for the location with the highest number in this column.
 - Note this number and add it to the e-mail detailed in the “E-Mailing” step below.
 - You may need to subtract two days from the number on the report if the dates it notes cover a weekend. For example, if the report states the oldest claim is six days old, but checking the Julian dates of those claims shows the dates include a weekend, then the oldest claim is actually four days old.
3. Once you are done with that report, click the back button on your browser, then open the report NMMC2300-RC032
 - For this report, you will be looking at the claim types that had a Pct Deny greater than 30 and a Total Denied Claims greater than 300
 - Go through the report and note the error codes (the leftmost column) for any error that has a number greater than 100 for the claim types you noted on the previous report
 - For example, if on the RC005 report, “MCARE B CS” had over 30 Pct Deny and over 300 Denied Claims, and its number under the error code “0032 E-Provider/Claim Type Conflict” was over 100, you would note the error code 0032
 - Once you have noted all the appropriate error codes on this report, prepare an e-mail to the appropriate people

E-Mailing

1. In this e-mail, attach the Claims Support Daily and Weekly reports.

2. List the number of days for adjustments, the adjustment log, and the oldest claim days from “Other Reports” above.
3. Once all this is complete, send the e-mail to the claims department and operations (deputy account) manager.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	5/26/06	• All	• All	• Updated to current procedure.
003	8/30/06	• All	• All	• Updated because of COLD implementation.
004	2/12/07	• 1	• 1-5	• Additional info added to step 5 and 20.
005	4/2/07	• All	• 6&14	• Updated location of Reports in Shared drive
006	6/9/09	• All	• All	• Updated to current procedure.
007	5/3/10	• All	• All	• Updated to current procedure. Added instructions for Adj & PA Report and Other Reports.
008	1/5/11	• All	• All	• Minor wording and instruction fixes.
009	3/10/11	• All	• All	• Corrected typo in step 14.
010	09/07/11	• All	• All	• Updated all steps and added to procedure manual
011	March 2014	• All	• All	• Removed instructions for Adjustment & PA

Adjustments

				<div>report.</div> <ul style="list-style-type: none">Removed references to Adjustment & PA report.Added instructions for NMMC2345-RC111 report.
012		<div>•</div>	<div>•</div>	<div>•</div>

Completing Individual Production Logs

Scope of Responsibility

- Claims support

Description and Purpose

The claims unit uses several reports in order to manage and control the workflow of the suspense file and to track production. This report tracks employee production.

Service Level Agreement

- Internal procedure
- No contractual commitment defined

Processing Steps

1. At the end of each workday, go to H:\Claims\ABC Claims Production LOG.
2. Click on the file for the current year (ex: Claims Production Log 09).
3. Select tab for current day (e.g. 5-04-09).
4. Find the column under your name.
5. For each task, enter the amount of items worked for each type of job.
 - Data for the “Exceptions Forced” and “Exceptions Denied” rows will be entered by the person assigned to the claims reports each morning. This is obtained from the RC026 & RC027 reports in IntraViewer.
6. Under the “Time for” rows and for the entire bottom section of the form (“Training – 92 Time” through “Unpaid Time Off” categories), enter the total time spent on each type of job.
7. For any time listed in the “Other” category, enter a brief description of the task(s) performed in the empty boxes beneath the “Total Time in Hours” category.
8. Save changes.

References

Related Resources

Adjustments

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	• All	• All	• Initial Publication
002	10/12/06	• All	• All	• Reviewed and updated to current procedure
003	06/27/07	• All	• All	• Reviewed and updated to current procedure
004	05/22/09	• All	• All	• Reviewed and updated to current procedure
005	6/9/09	• All	• All	• Reviewed and updated to current procedure
006	09/07/11	• All	• All	• Updated all steps and added to procedure manual
007	March 2014	• All	• All	• Minor edits for clarity.

Producing the Weekly MAD Report

Scope of Responsibility

- Claims support

Description and Purpose

Some reports used by the State, CONDUENT, and other outside agencies are printed or sent on a weekly basis. These reports contain detailed information about claims processing, adjudication and payment cycles, (Surveillance and Utilization Review) SURs, third party liability, etc.

For this report, you will need the following completed reports:

- Claims Daily
- Claims Weekly
- Adjustment & PA Production & Inventory (current week and previous week)

Produce the Weekly MAD Report only after completing the above three reports.

Service Level Agreement

- Internal procedure
- No contractual commitment defined
- This report should be completed every Monday (or Tuesday if Monday is a holiday)

Processing Steps

1. On the shared drive, go to H:\Administrative\WEEKLY\ThisWeek.
2. Open the Excel file dated for the previous Friday.
3. Click on the “Claim Support” tab on the bottom of the report.
4. Enter information into the boxes as per the following instructions:

Field	Instructions
CONDUENT Workable (Claims Support)	<ul style="list-style-type: none">• Enter the Daily Total from “CONDUENT/Reso” from the Claims Daily report.
CONDUENT Workable (LTC)	<ul style="list-style-type: none">• Enter the number of claims from Location 650 on the Claims Daily report.
CONDUENT	<ul style="list-style-type: none">• Enter the Daily Total from “CONDUENT/Other” from the Claims Daily report minus the amount in Location

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Workable (Other)	650.
Total Workable CONDUEMENT	<ul style="list-style-type: none"> Enter the total of the above three items.
CONDUEMENT Not Workable – Recycles	<ul style="list-style-type: none"> Enter the number of claims from Location 260 on the Claims Daily report.
CONDUEMENT Not Workable – Other	<ul style="list-style-type: none"> Enter the Daily Total from “Non-Workable” from the Claims Daily report minus the amount in Location 260.
State Pends	<ul style="list-style-type: none"> Enter the “Daily Total” number from the State column from the Claims Daily report.
Total Suspended Claims	<ul style="list-style-type: none"> Enter the total of the above three items plus the number from “Total Workable CONDUEMENT”. <ul style="list-style-type: none"> This should match the daily total from the Claims Daily report minus Mass Adjustments.
CONDUEMENT Workable – Oldest	<ul style="list-style-type: none"> From the Claims Weekly report, find the location with the highest “Claim Age”, counting only non-state locations (up to and including Location 790). Determine the date for that claim by counting backwards using the Julian calendar, and enter that date in the box.
Location of Oldest Claim	<ul style="list-style-type: none"> Enter the location number that contains the oldest claim as reported in “Conduent Workable – Oldest”.
Adjustments without FCNs – Entered	<ul style="list-style-type: none"> Open the previous week’s page of the Adj & PA Production & Inventory report. Enter total adjustments, voids, and RTPs, minus FCNs (financial adjustments and voids), from “Adjustments Production Summary”. <ul style="list-style-type: none"> For example, if you are doing this report on Monday of the second week of the month, you will get the ‘Entered’ information from the tab for the first week of the month on the Claims Adjustment & PA Inventory report. If there are no adjustments or voids in the production summary, enter “0”.
Adjustments without FCNs – Remaining Inventory	<ul style="list-style-type: none"> Open the current week’s page of the Adj & PA report Enter total adjustments, voids, and RTPs, minus FCNs, from “Adjustments Inventory Report”. If there are no adjustments or voids in the inventory report, enter “0”.
Adjustments without FCNs – Oldest	<ul style="list-style-type: none"> Using the current week’s Adj & PA Report Find the oldest adjustments or voids without FCNs in Inventory and count how many business days old these

Adjustments

	<ul style="list-style-type: none"> are (do not count weekend days). Enter this number as work days. If there are no adjustments or voids in inventory, enter "0 work days".
Adjustments with FCNs – Entered	<ul style="list-style-type: none"> Enter total financial adjustments and voids from "Adjustments Production Summary" on the Claims Adjustment & PA Inventory report. You should be using information from the previous week's page of the report, as noted above. If there are no financial adjustments or voids in the summary, enter "0".
Adjustments with FCNs – Remaining Inventory	<ul style="list-style-type: none"> Enter total financial adjustments and voids from "Adjustments Inventory Report" on the current week's page of the Claims Adjustment & PA Inventory report. If there are no financial adjustments or voids in inventory, enter "0".
Adjustments with FCNs – Oldest	<ul style="list-style-type: none"> Using the Inventory Report, find the oldest financial adjustments or voids in Inventory and count how many business days old these are (do not count weekend days). Enter this number as work days. If there are no financial adjustments or voids in inventory, enter "0 work days".
PAs Entered	<ul style="list-style-type: none"> Enter total PAs from "Prior Authorizations Production Summary" from the previous week of the Claims Adjustment & PA Inventory report (see 'Adjustments without FCNs – Entered', above). If there are no prior authorizations in the summary, enter "0".
Remaining Inventory PA	<ul style="list-style-type: none"> Enter total PAs from "Prior Authorizations Inventory Report" on the current week's page of the Claims Adjustment & PA Inventory report. If there are no prior authorizations in inventory, enter "0".
Oldest	<ul style="list-style-type: none"> Using the Inventory Report, find the oldest date of Prior Authorizations in Inventory and count how many business days old these are (do not count weekend days). Enter this number as work days. If there are no prior authorizations in inventory, enter "0 work days".

- Click on the "State Pends" tab on the bottom of the report.
- Enter information into the boxes as per the following instructions:

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Field	Instructions
State Pends	<ul style="list-style-type: none">Enter the number for each state location listed (locations in the 800 and 900 ranges) and the total from the Claims Daily report.
State Pend Sheets – Oldest	<ul style="list-style-type: none">Using the Claims Weekly report, look at the Claim Age column.Find the oldest claim of all the state locations and find the calendar date of this claim. Enter that date.If none of the state locations have a Claim Age listed, then go into OmniCaid and look for the oldest Julian date in all the State locations.Once this is done, determine the date for that claim using the Julian calendar, and enter that date in the box.
Location of Oldest Pend Sheet	<ul style="list-style-type: none">Enter which State location contained the oldest claim of all the state locations.

- Save changes.
- Whoever is assigned this report is also doing the Claims Daily and Claims Weekly reports. Attach this report to the e-mail along with the others.

References

Related Resources

Change History

Revision	Date	Page	Section or Step	Description
001	10/28/05	<ul style="list-style-type: none">All	<ul style="list-style-type: none">All	<ul style="list-style-type: none">Initial Publication
002	05/26/06	<ul style="list-style-type: none">All	<ul style="list-style-type: none">All	<ul style="list-style-type: none">Updated to current Procedure
003	08/30/06	<ul style="list-style-type: none">All	<ul style="list-style-type: none">All	<ul style="list-style-type: none">Update due to implementation of COLD
004	01/04/07	<ul style="list-style-type: none">1	<ul style="list-style-type: none">6	<ul style="list-style-type: none">Updated due to change to Daily Report columns
005	09/17/07	<ul style="list-style-type: none">1	<ul style="list-style-type: none">1	<ul style="list-style-type: none">Updated location of file

Adjustments

006	6/9/09	• All	• All	• Updated to current Procedure
007	5/3/10	• All	• All	• Updated to current procedure
008	09/07/11	• All	• All	• Updated all steps and added to procedure manual
009	March 2014	• All	• All	<ul style="list-style-type: none"> • Minor edits for clarity. • Removed references to Adjustment & PA report.