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PES: Provider Electronic Solutions Institutional Inpatient Guide

DRAFT Version 1.0

March 31, 2008



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29 **1 ABOUT PROVIDER ELECTRONIC SOLUTIONS** 30 **(PES)**

31 Please consult the Provider *Electronic Solutions (PES) User Manual* and *General Billing Guide*
32 for more information concerning this software. Information is available on the Florida Medicaid
33 EDS website, <http://mymedicaid-florida.com>.

34 For additional assistance with PES and/or this guide, please contact the EDI Helpdesk at
35 1.800.289.7799, option 3, or contact your local field representative.

36 **1.1 Getting Started**

- 37 1. Double Click the FL MMIS PES icon located on your desktop or access PES by clicking
38 Start, All Programs, FL EDS Provider Electronic Solutions;
- 39 2. Enter your password;
- 40 3. From the Main Menu, select Forms, 837 Institutional Inpatient Claim; and
- 41 4. A new Inpatient Claim will appear.

42 **1.2 Entering an Institutional Inpatient Claim**

43 The PES Institutional Inpatient Claim is composed of six sections: five header sections and a
44 service section. Remember to complete the Crossover section and/or the Other Insurance section,
45 if applicable.

46 Providers may bill all Third Party Liability (TPL) claims with this software, even if the primary
47 insurance denied payment of the claim. In this case, the provider must simply complete the
48 appropriate attachment fields to document the details of their claim submission to the Primary
49 Insurer. However, providers may NOT bill Medicare-denied claims in PES.

50 Also, please note that Medicare is not considered a TPL or Secondary claim by Florida
51 Medicaid; therefore, if Medicare is the Primary Insurer, the claim must be submitted through
52 PES as a Crossover and not a TPL or Secondary claim. Providers may not bill claims with both
53 TPL and Medicare with PES. For instructions on this type of claim, please refer to your
54 *Medicaid Provider General Handbook*.

55 Note: This billing guide should be used in conjunction with the appropriate provider-specific
56 *Coverage & Limitations Handbook* and *Reimbursement Florida Medicaid Handbook*.

57

58 **Header 1 on the 837I Inpatient**

59 Below is a sample electronic 837I Inpatient form displaying the Header 1 tab.

60
 61 Complete the following fields under the Header 1 tab to submit an 837I Inpatient claim:

Field	Guidelines
Type Of Bill	Choose the best value to indicate the Type of Bill for this claim.
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the Internal Control Number (ICN) / Transaction Control Number (TCN) Number for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the <i>Void & Adjustment</i> section of this guide.
Billing Provider ID/NPI	Choose the appropriate Billing Provider ID/NPI from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name (Not applicable)	This field is not applicable for Inpatient Claims.
Pay-to Provider ID/NPI	Use only if different than the Billing Provider ID/NPI. Choose the appropriate payee Provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name (Not applicable)	This field is not applicable for Inpatient Claims.
Recipient ID	Choose the Recipient's ten-digit Medicaid ID number from your Recipient list. If you have not added the required ID to your list, double-click on this field to do so.
Account #	This field will auto-populate based upon your choice in the Recipient ID field.

Field	Guidelines
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
From DOS	Enter the start Date of the Service billed in a MM/DD/CCYY format.
To DOS	Enter the stop Date of the Service billed in a MM/DD/CCYY format.
Medical Record #	Enter the Medical Record Number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 30 alphanumeric characters.
Encounter Ind	If this claim is an Encounter claim, choose the appropriate value. The value 'CH' will automatically default and should remain the selected option to be considered for payment.
Prior Authorization	If authorization was obtained for the service, enter the appropriate Prior Authorization Number.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Patient Status	Enter a valid two-digit code to indicate the Patient's discharge Status, if discharged.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is 80 characters. Be sure to document this Attachment Control number, the Recipient ID, and your Provider Number clearly on the attachment, along with the cover sheet. For more information on attachments, please visit http://mymedicaid-florida.com .

62 After completing all necessary fields under the Header 1 tab, click on the Header 2 tab.

63 **Header 2 Tab on the 837I Inpatient**

64 Below is a sample electronic 837I Inpatient form displaying the Header 2 tab:

65
 66 Complete the following fields under the Header 2 tab to submit an 837I Inpatient claim:

Field	Guidelines
Diagnosis Code – Primary	Enter a valid Primary Diagnosis Code. The Code should be three to five digits with no decimal point.
Diagnosis Code – Other	If applicable, enter Other Diagnosis Codes that relate to the claim. If entered, this Code should be three to five digits with no decimal point.
Diagnosis Code – Admit	Enter a valid Admittance Diagnosis Code. The Code should be three to five digits with no decimal point.
Diagnosis – E-Code (External Cause of Injury Code)	Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. Enter the Diagnosis E-Code which describes the external cause of injury, poisoning or adverse affect. The Code should be three to five digits with no decimal point.
Surgical Codes/Dates	If applicable, please enter the ICD-9-CM code(s). If a code was entered, enter the surgery date in MM/DD/CCYY format.
Attending Provider ID/NPI	Choose the appropriate Attending Physician’s license number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so. Enter the license information in the following format: MEXXXXXXX with no spaces.
Taxonomy Code	This field will auto-populate based on your choice in the Attending Provider ID/NPI field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

67 After completing all necessary fields under the Header 2 tab, click on the Header 3 tab.

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70 **Header 3 Tab on the 837I Inpatient**

71 Below is a sample electronic 837I Inpatient form displaying the Header 3 tab.

The screenshot shows a software window titled "837 Institutional Inpatient Claim". At the top, there are summary fields: Total Charge, OI Amount, Billed Amount, and Services. Below this is a tabbed interface with "Header 3" selected. The "Header 3" tab contains several sections:

- Occurrence Codes/Dates:** A grid of 8 input fields for codes and dates.
- Occurrence Span Codes/Dates:** A grid of 2 input fields for span codes and dates.
- Condition Codes:** A grid of 7 input fields for condition codes.
- Days:** Four input fields for "Days Covered", "Non-Covered", "Coinsurance", and "Lifetime Reserve".

 To the right of the form are buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, and Close. At the bottom of the form is a table with columns: Recipient ID, Last Name, First Name, Billed Amount, Last Submit Dt, and Status.

72
 73 Complete the following fields under the Header 3 tab to submit an 837I Inpatient claim:

Field	Guidelines
Occurrence Codes/Dates	If applicable, enter the appropriate Occurrence Code(s). If a value was entered, enter the Occurrence Date(s) in MM/DD/CCYY format.
Occurrence Span Codes/Dates	If applicable, enter the appropriate Occurrence Span Code(s)/Date(s). Dates should be entered in MM/DD/CCYY format.
Condition Codes	If applicable, enter the Appropriate Condition Code(s).
Days Covered	Enter the total number of Days Covered.
Days Non-Covered	Leave blank, unless applicable.
Coinsurance	Leave blank, unless applicable.
Lifetime Reserve	Leave blank, unless applicable.

74 After completing all necessary fields under the Header 3 tab, click on the Header 4 tab.

75 **Header 4 Tab on the 837I Inpatient**

76 Below is a sample electronic 837I Inpatient form displaying the Header 4 tab.

77
 78 Complete the following fields under the Header 4 tab to submit an 837I Inpatient claim:

Field	Guidelines
Value Codes/Amounts	If applicable, enter the appropriate Value Codes and the corresponding Amounts in DD.CC format.
Operating Physician Provider ID/NPI	If applicable, choose an Operating Physician Provider ID/NPI from the Provider list. This field is required when a Surgical Procedure Code is listed on the claim. If you have not added the required ID to your list, double-click on this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Operating Physician ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.

79 After completing all necessary fields under the Header 4 tab, click on the Header 5 tab.

80 **Header 5 Tab on the 837I Inpatient**

81 Below is a sample electronic 837I Inpatient form displaying the Header 5 tab.

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Field	Guidelines
Admission Date	Enter the date the recipient was admitted into your facility in MM/DD/CCYY format. Required on Florida Medicaid Inpatient & Hospice Claims.
Admission Hour	Indicate the Hour of the recipient's Admission.
Admission Type	Choose the appropriate Admission Type value to indicate the priority of the admission.
Discharge Hour	Indicate the Hour of the recipient's Discharge.
Admit Source	Enter the referral Source code for this Admission.
Patient Responsibility	For Hospice claims only, enter the Patient's Responsibility.
Other Insurance Indicator	Choose the best value to indicate whether or not the recipient has other insurance besides Florida Medicaid.
Crossover Indicator	Choose the best value to indicate if the claim is a Crossover from Medicare.

- 84 After completing all necessary fields under the Header 5 tab, click on the Service tab.
- 85 Note: If the *Other Insurance Indicator* field was marked as 'Yes,' then click and complete the OI
- 86 tab next.
- 87 Note: If the *Crossover Indicator* field was marked as 'Yes,' then click and complete the
- 88 Crossover tab next.

89 **OI (Other Insurance) Tab on the 837I Inpatient**

90 Completing the Other Insurance (OI) tab is required if the indicator in the Other Insurance
 91 Indicator field was marked as ‘Yes’ in Header 5. Below is a sample electronic 837I Inpatient
 92 form displaying the OI (Other Insurance) tab.

93
 94 Complete the following fields under the Other Insurance tab to submit an 837I Inpatient claim:

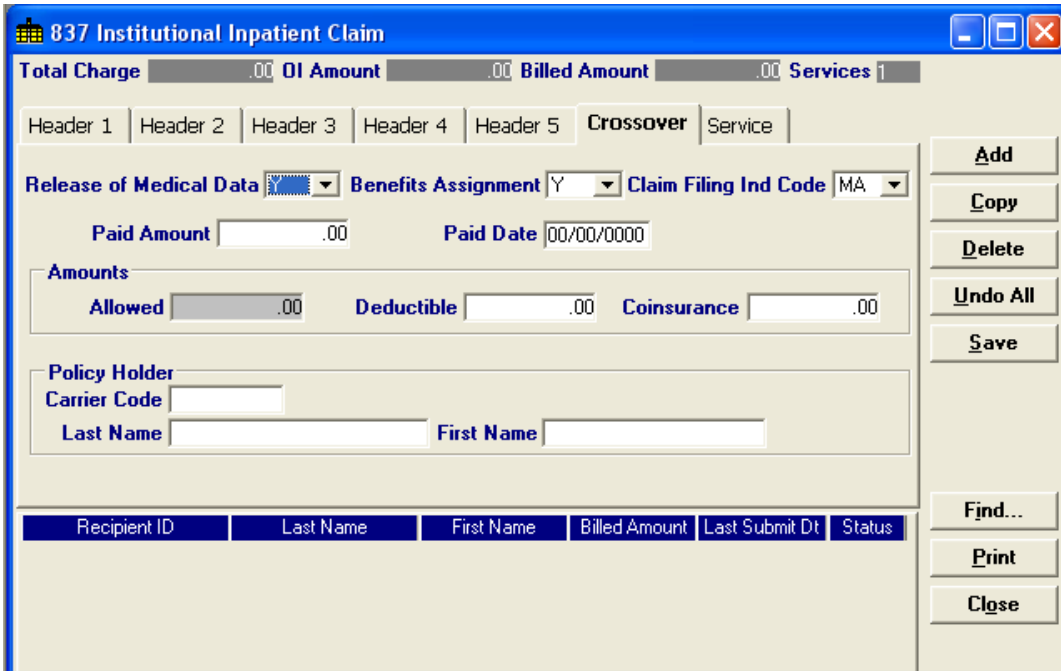
Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the recipient’s other insurance.
Adjustment Group Cd	Indicate the reason for any unpaid portion of the charges by the other insurance.
Payer Responsibility	Choose the best value to indicate the recipient’s insurance coverage status to Medicaid. P = Primary, S = Secondary, T = Tertiary
Reason Codes/Amts	Choose the appropriate qualifier code and enter the corresponding amounts in DD.CC format.
Paid Date/Amount	Enter the Paid Date for the other insurance along with the corresponding amount in DD.CC format.
Policy Holder Group #	Choose the appropriate Policy Holder Group Number from your Policy Holder list. If you have not added the Group Number to your list, double-

Field	Guidelines
	click on this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

95

96 **Crossover Tab on the 837I Inpatient**

97 Completing the Crossover tab is required if the indicator in the Crossover Indicator field was
 98 marked as 'Yes' in Header 5. If the claim is Medicare-related this tab allows you to enter the
 99 information based on the payment made. Below is a sample 837I Inpatient form displaying the
 100 Crossover tab.



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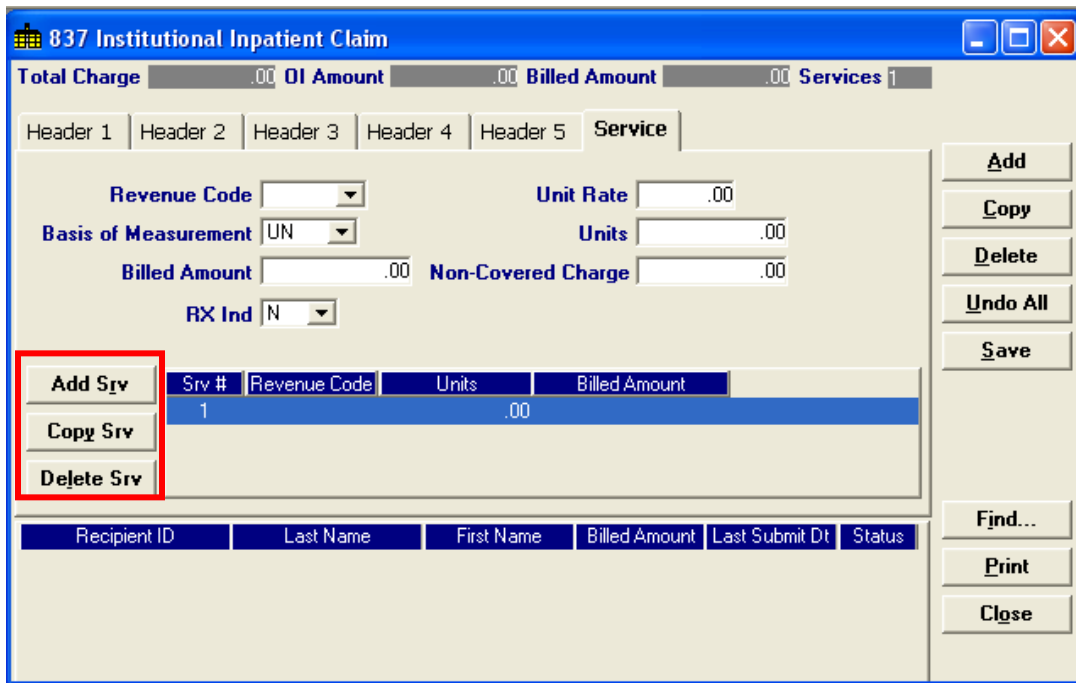
Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.

Claim Filing Ind Code	Choose the best value to indicate the category of the recipient’s other insurance.
Paid Amount	Enter the total Amount Medicare Paid toward the claim. Enter in DD.CC format.
Paid Date	Enter the Date Medicare Paid the claim in MM/DD/CCYY format.
Amounts Allowed	Enter the Medicare Allowed amount.
Deductible	If applicable, enter the Deductible related to the claim.
Coinsurance	If applicable, enter the Coinsurance related to the claim.
Policy Holder Carrier Code	Choose the appropriate Policy Holder Carrier Code from drop-down menu. If you have not added the Carrier Code to your list, double-click on this field to do so.
Last Name	This field will auto-populate based on the information chosen in the Carrier Code field.
First Name	This field will auto-populate.

103 After completing all necessary fields under the Crossover tab, click on Service tab.

104 **Service Tab on the 837I Inpatient**

105 Below is a sample electronic 837I Inpatient form displaying the Service tab.



106
 107 Complete the following fields under the Service tab to submit an 837I Inpatient claim:

Field	Guidelines
Revenue Code	Choose a Revenue Code from the Revenue Code list. If you would like to add Revenue Codes to your list, double-click on this field to do so.
Unit Rate	If applicable, enter the appropriate Unit Rate.

Field	Guidelines
Basis of Measurement	Choose appropriate Basis of Measurement for services provided.
Units	Enter the Unit(s) billed for the service.
Billed Amount	Enter the Billed Amount for the service. Enter in DD.CC format
Non-Covered Charge	Enter the Non-Covered Charge amount.
Rx Ind	If the procedure you are billing requires an NDC (National Drug Code) according to Florida Medicaid Policy, please choose 'Yes' and complete the Rx tab before adding any additional line items.

108 **Adding, Deleting, or Copying a Service**

109 Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service,
 110 you can modify it as necessary.

111 **Rx Tab on the 837I Inpatient**

112 Below is a sample electronic 837I Inpatient form displaying the Rx tab.

113

114

115 Complete the following fields under the Rx tab to submit an 837I Inpatient claim:

Field	Guidelines
Pharmaceutical NDC	Choose a Pharmaceutical NDC Code from your NDC list to indicate which applies to this service. If you have not added the required NDC to your list, double-click on this field. A screen will appear for you to do so.

Quantity	Enter the Quantity of the drug indicated by the NDC that is being billed.
Unit Price	Enter the cost per unit (Unit Price) of the NDC indicated that is billed to the patient.
Unit of Measurement	Select the Unit of Measurement used when measuring the quantity of the NDC.

116 **Adding, Deleting, or Copying a Prescription (Rx)**

117 Use the buttons to the left of the form to add, delete, or copy an Rx. Once you copy an Rx, you
118 can modify it as necessary.

119 After completing all necessary fields and reviewing entered data for accuracy, press *Save* to add
120 your claim to the Claim List.

121 **To Modify a Claim from the List**

122 Scroll through the list of claims that displays at the bottom of the form. Highlight the claim you
123 wish to modify, and perform one of the following:

- 124 1. Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready
125 to submit) or ‘I’ (incomplete). Save the changes. Click *Undo All* if you inadvertently
126 overwrite a correct claim.
- 127 2. Click *Copy* to copy a claim that closely matches the information you need to enter (for
128 example, if you must enter claims for identical services, but different recipients). Modify the
129 new record accordingly. Save the new record.
- 130 3. Click *Delete* to delete an unwanted record.

131

132 **Completing Voids/Adjustments to a Paid Claim**

133 To adjust a paid claim, wait until you have received your Remittance Advice (RA) listing the
134 paid claim ICN/TCN then follow the steps below.

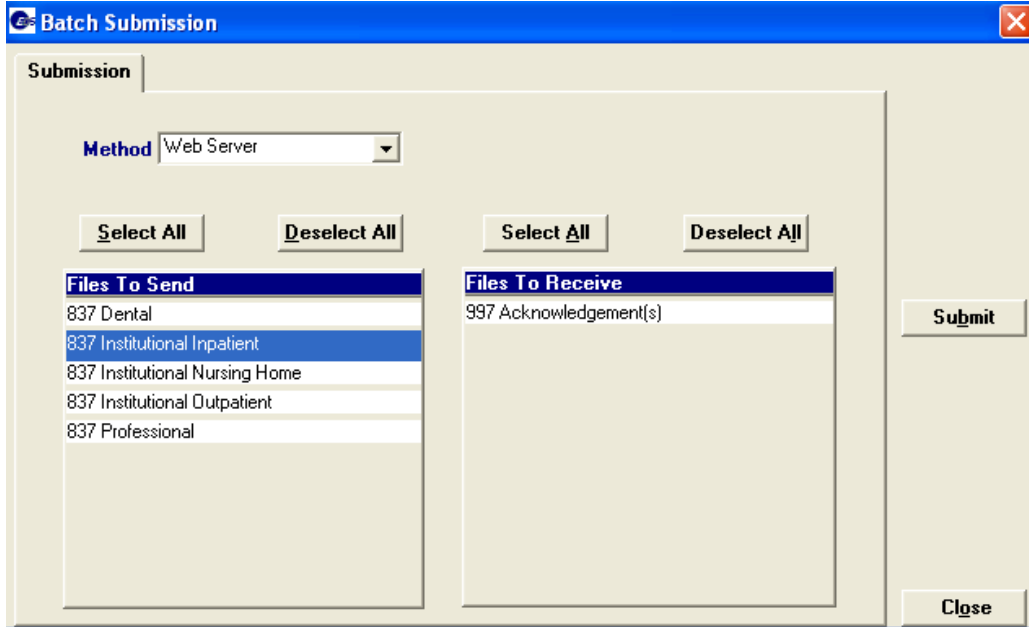
135 Note: If the claim you wish to Void/Adjust is in your Claim List, then find the claim and click
136 *Copy*. Otherwise, enter your claim as you normally would, completing all necessary fields.

- 137 1. On Header 1, in the Claim Frequency field, change the indicator to inform Medicaid if the
138 request is an Adjustment/Replacement or a Claim Void. Enter either a ‘7’ for an adjustment
139 or an ‘8’ for a void.
- 140 2. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was
141 accepted and paid. This information can be located on your *Remittance Advice*.
- 142 a. If the value ‘7’ was chosen, make any necessary corrections/adjustments to the current
143 claim; or
- 144 b. If the value ‘8’ was chosen, continue with Step 3.
- 145 3. Click *Save* to save your claim.

146

1.3 Submitting Inpatient Claims Through the Web Server

From the Main Menu, select Communication, Submission to display the Batch Submission window below:



1. Determine which files you want to send from the *Files to Send* list.
Choose *Select All* to select all files to send, *Deselect All* to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
2. Click *Submit* to send files.
Provider Electronic Solutions connects to the Web server and sends the transmission. The Verification Log (accessible by selecting Communication, View Verification) and the Communication Log (accessible by selecting Communication, View Communication Log) provide information regarding the transaction.
3. After submission, perform the next steps to receive the response from the Web server.
4. Select Web server as the correct submission method from the *Method* drop-down list.
5. Determine which files you want to receive from the *Files to Receive* list.
Choose *Select All* to select all files to receive, *Deselect All* to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.
6. Click *Submit* to receive files.
Provider Electronic Solutions connects to the Web server and receives the transmission. The Verification Log (accessible by selecting Communication, View Verification) and the Communication Log (accessible by selecting Communication, View Communication Log) provide information regarding the transaction.

171

172 Note: When you submit batch transactions, you must wait a period of time (fifteen minutes to
173 two hours, depending on the time of day you submit) to download the responses. Therefore,
174 when you access the Submission window and elect to receive files, remember you may be
175 *receiving responses to your last transmission, not necessarily the current transmission.*

176 Note: Rejected claims will not appear on your Remittance Advice.

177 Note: Submitted files are stored on the *FLhipaa\temp* folder. To open the file(s), select the
178 Notepad or UltraEdit program.

179 Note: Response files are stored on the *FLhipaa\verify* folder. To open the file(s), select the
180 Notepad or UltraEdit program.

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