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# **PES: Provider Electronic Solutions Institutional Outpatient Guide**

**DRAFT Version 1.0**

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# 28 **1 ABOUT PROVIDER ELECTRONIC SOLUTIONS** 29 **(PES)**

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

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

## 35 **1.1 Getting Started**

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

## 41 **1.2 Entering an Institutional Outpatient Claim**

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

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

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

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

### 56 **Header 1 on the 837I Outpatient**

57 Below is a sample electronic 837I Outpatient form displaying the Header 1 tab:

58

59 Complete the following fields under the Header 1 tab to submit an 837I Outpatient 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) for the claim you are adjusting or voiding. For additional information on completing this process, please refer to the <i>Void &amp; Adjustment</i> section of this guide.
Billing Provider ID/NPI	Choose the appropriate Billing 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	This field will auto-populate.
Pay-to Provider ID/NPI	Use only if different than the Billing Provider ID. 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	This field will auto-populate.
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.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.

<b>Field</b>	<b>Guidelines</b>
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 thirty alphanumeric characters.
Encounter Ind	If this claim is an Encounter claim, choose the appropriate value. The value 'CH' will automatically default and should remain as the selected option to be considered for payment.
Contract Type	Not applicable for Outpatient claims.
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. Not required for Freestanding Dialysis Centers.
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 <a href="http://mymedicaid-florida.com">http://mymedicaid-florida.com</a> .

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

61 **Header 2 Tab on the 837I Outpatient**

62 Below is a sample electronic 837I Outpatient form displaying the Header 2 tab.

The screenshot shows a software window titled "837 Institutional Outpatient Claim". At the top, there are summary fields: Total Charge (0.00), OI Amount (.00), Billed Amount (.00), and Services (1). Below this are tabs for Header 1, Header 2, Header 3, Header 4, Header 5, and Service. The Header 2 tab is active, showing sections for "Diagnosis Codes" (Primary, Other 1-8, E-Code), "Surgical Procedure Codes/Dates" (1-6), and "Attending" (Provider ID/NPI, Taxonomy Code, Last/Org Name, First Name). A table at the bottom shows recipient data: Recipient ID 111111111, Last Name RECIPIENT, First Name THIS, Billed Amount 56.00, Last Submit Dt, and Status R. On the right side, there are buttons for Add, Copy, Delete, Undo All, Save, Find..., Print, and Close.

63  
 64 Complete the following fields under the Header 2 tab to submit an 837I Outpatient 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 – 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. If entered, this code should be three to five digits with no decimal point.
Surgical Procedure 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: ME99999999 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.

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

66 **Header 3 Tab on the 837I Outpatient**

67 Below is a sample electronic 837I Outpatient form displaying the Header 3 tab:

- 68
- 69 Complete the following fields under the Header 3 tab to submit an 837I Outpatient claim:

Field	Guidelines
Occurrence Codes/Dates	If applicable, enter the appropriate Occurrence Code(s). If a value was entered, enter the Occurrence Date in MM/DD/CCYY format.
Occurrence Span Codes/Dates	If applicable, enter the appropriate Occurrence Span Codes/Dates. 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	Not applicable for Outpatient claims.
Coinsurance	Leave blank, unless applicable.
Lifetime Reserve	Leave blank, unless applicable.

- 70 After completing all necessary fields under the Header 3 tab, click on the Header 4 tab.
- 71 **Header 4 Tab on the 837I Outpatient**
- 72 Below is a sample electronic 837I Outpatient form displaying the Header 4 tab.

73

74 Complete the following fields under the Header 4 tab to submit an 837I Outpatient 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.
Other Physician Provider ID/NPI	If applicable, choose another Physician Provider ID/NPI from the Provider list. This field is required when the Referring Provider is different than the Attending Physician; report the Referring Physician's information. If you have not added the required ID to your list, double-click on this field to do so.
Physician Taxonomy Code	This field will auto-populate based on your choice in the Other Physician ID/NPI field.
Physician Last/Org Name	This field will auto-populate.
Physician First Name	This field will auto-populate.

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

76 **Header 5 Tab on the 837I Outpatient**

77 Below is a sample electronic 837I Outpatient form displaying the Header 5 tab:

The screenshot shows a software window titled "837 Institutional Outpatient Claim". At the top, there are summary fields: "Total Charge" (0.00), "OI Amount" (.00), "Billed Amount" (.00), and "Services" (1). Below this is a tabbed interface with "Header 1", "Header 2", "Header 3", "Header 4", "Header5" (selected), and "Service". The "Header5" tab contains several input fields: "Patient Responsibility" (text box with ".00"), "Prior Auth/Referral Qualifier: 1" (dropdown), "Prior Auth/Referral Number: 1" (text box), "Prior Auth/Referral Qualifier: 2" (dropdown), "Prior Auth/Referral Number: 2" (text box), "Other Insurance Indicator" (dropdown with "N"), and "Crossover Indicator" (dropdown with "N"). To the right of these fields is a vertical stack of buttons: "Add", "Copy", "Delete", "Undo All", "Save", "Find...", "Print", and "Close". At the bottom of the form is a table with the following columns: "Recipient ID", "Last Name", "First Name", "Billed Amount", "Last Submit Dt", and "Status".

78

Field	Guidelines
Patient Responsibility	Not applicable for Outpatient Claims.
Prior Auth/Referral Qualifier 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop down menu. (See note below)
Prior Auth/Referral Number 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (See note below)
Prior Auth/Referral Qualifier 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop down menu. (See note below)
Prior Auth/Referral Number 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (See note below)
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.

79 Note: If the claim requires the entry of a Referral Number and a Prior Authorization Number, the  
 80 Referral Qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral  
 81 Number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization  
 82 Qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization  
 83 Number must be entered in the Prior Auth/Referral Number 2 field.

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 on and complete the  
 86 OI tab next.

87 Note: If the *Crossover Indicator* field was marked as ‘Yes,’ then click on and complete the  
 88 Crossover tab next.

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

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

93

94

95 Complete the following fields under the Other Insurance tab to submit an 837I Outpatient 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

Field	Guidelines
	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. For example: CI Commercial Insurance Co.
Payer Responsibility	Choose the best value to indicate the recipient's insurance coverage status to Medicaid. P = Primary; S = Secondary; T = Tertiary
Paid Amount	Enter the Amount Paid in dollars and cents that was paid towards the service(s) being billed. Enter in a 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-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.

96 After completing all necessary fields under the OI tab, click on the Service 1 tab.

97 **Crossover Tab on the 837I Outpatient**

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

102

<b>Field</b>	<b>Guidelines</b>
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. For example: MB: Medicare Part B.
Paid Amount	Enter the total Amount Medicare Paid toward the claim. Enter in DD.CC format.
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 the Service tab.

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

105 Below is a sample electronic 837I Outpatient form displaying the Service tab:

106

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

<b>Field</b>	<b>Guidelines</b>
Date of Service	Enter the Date of Service for each procedure provided, in a MM/DD/CCYY format.
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.
Billed Amount	Enter the Amount Billed for the service. Enter in DD.CC format.
Units	Enter the Unit(s) billed for the service.
Basis of Measurement	Choose appropriate Measurement for services provided.
Unit Rate	If applicable, enter the appropriate Unit Rate.
Procedure	If applicable, enter the appropriate five-digit Procedure code for each procedure or service billed.
Modifiers	If applicable, enter the Modifier(s) for the procedure.
Non-Covered Charge	If applicable, 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.
Service Adjustment Indicator	If applicable, choose the best value to acknowledge <i>Other Insurance (OI)</i> adjudication.

108 If the *Service Adjustment Indicator* field was marked as 'Yes,' click on and complete the Service  
 109 2 tab.

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

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

113 **Service 2 Tab on the 837I Outpatient**

114 Below is a sample electronic 837I Outpatient form displaying the Service 2 tab:

115

116

117

118 Complete the following fields under the Service 2 tab to submit an 837I Outpatient claim:

119

Field	Guidelines
Adjustment Group Cd	Choose the best value.
Reason Codes/Amts	If applicable, choose the appropriate Reason Code(s) and then enter the corresponding Amount(s) in DD.CC format.
Paid Date/Amount	If applicable, enter the Paid Date the Other Insurance paid and the Amount in dollars and cents that was paid towards the service(s) being billed. Enter in a DD.CC format.
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the carrier to your list, double-click on this field to do so.
Carrier Name	This field will auto-populate.

120 After completing all necessary fields under the Service 2 tab, review your claim and press Save.

121 **Rx Tab on the 837I Outpatient**

122 Below is a sample electronic 837I Outpatient form displaying the Rx tab.

123

124 Complete the following fields under the Rx tab to submit an 837I Outpatient 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 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.

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

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

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

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

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

- 133 1. Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready  
 134 to submit) or 'I' (incomplete). Save the changes. Click *Undo All* if you inadvertently  
 135 overwrite a correct claim.

136 2. Click *Copy* to copy a claim that closely matches the information you need to enter (for  
137 example, if you must enter claims for identical services, but different recipients). Modify the  
138 new record accordingly. Save the new record.

139 3. Click *Delete* to delete an unwanted record.

140

### 141 **Completing Voids/Adjustments to a Paid Claim**

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

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

146 1. On Header 1, in the Claim Frequency field, change the indicator to inform Medicaid if the  
147 request is an Adjustment/Replacement or a Claim Void. Enter either a ‘7’ for an adjustment  
148 or an ‘8’ for a void.

149 2. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was  
150 accepted and paid. This information can be located on your *Remittance Advice*.

151 a. If the value ‘7’ was chosen, make any necessary corrections/adjustments to the current  
152 claim; or

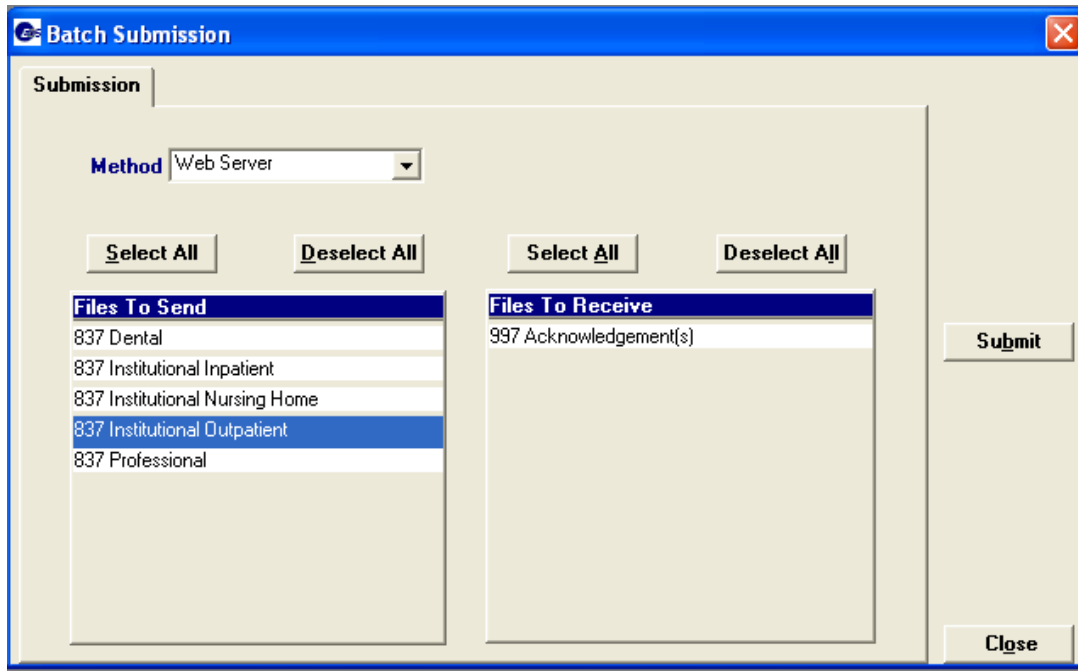
153 b. If the value ‘8’ was chosen, continue with Step 3.

154 3. Click *Save* to save your claim.

155

## 156 **1.3 Submitting Outpatient Claims Through the Web Server**

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



159

160 1. Determine which files you want to send from the *Files to Send* list.

161 Choose *Select All* to select all files to send, *Deselect All* to undo any selections you have  
162 made, or use the mouse (click once with the left mouse button) to select one form at a time,  
163 or multiple form types for submission.

164 2. Click *Submit* to send files.

165 Provider Electronic Solutions connects to the Web server and sends the transmission. The  
166 Verification Log (accessible by selecting Communication, View Verification) and the  
167 Communication Log (accessible by selecting Communication, View Communication Log)  
168 provide information regarding the transaction.

169 3. After submission, perform the next steps to receive the response from the Web server.

170 4. Select Web server as the correct submission method from the *Method* drop-down list.

171 5. Determine which files you want to receive from the *Files to Receive* list.

172 Choose *Select All* to select all files to receive, *Deselect All* to undo any selections you have  
173 made, or use the mouse (click once with the left mouse button) to select one form at a time,  
174 or multiple form types for submission.

175 6. Click *Submit* to receive files.

176 Provider Electronic Solutions connects to the Web server and receives the transmission. The  
177 Verification Log (accessible by selecting Communication, View Verification) and the  
178 Communication Log (accessible by selecting Communication, View Communication Log)  
179 provide information regarding the transaction.

180

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

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

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

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

190