



| technical document

>> Idaho XIX Account

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Provider Electronic Solutions (PES) Handbook

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Introduction to PES

Welcome to the EDS Medicaid software, Provider Electronic Solutions (PES). PES software is designed to allow the billing provider to submit electronic transactions directly to the EDS clearinghouse, Business Exchange Service (BES).

PES meets the current requirements of the Health Insurance Portability and Accountability Act (HIPAA) for the transmission of electronic transactions and transaction information. This software allows providers to perform two important billing tasks in the Idaho Medicaid program:

- Send and receive a transaction regarding client eligibility
- Submit electronic claims transactions

How Is This Handbook Organized?

This Idaho PES Handbook is designed to help the first-time user and the experienced user install, prepare, and use the PES software.

It has the following sections:

Section	Description
Basic Skills	Using the keyboard and mouse. Viewing the PES window layout, menu options, and correcting errors.
Getting Started	Logging on, establishing passwords, and accessing the program.
Forms	Creating transactions for eligibility requests and claims.
Communication	Submitting forms through the Web, dial-up, or diskette submission. Batch resubmission of forms through the Web, dial-up, or diskette. Viewing and printing transaction responses. Viewing and printing communication logs.
Lists	Building the lists that are used regularly to check eligibility and submit claims.
Reports	Viewing and printing detail or summary reports.
Tools and security	Archiving forms. Compacting, repairing, and unlocking the database. Obtaining upgrades. Changing passwords, Setting up software options and security.
PES Installation Guide	Installing the software application on an individual PC or on a network.
Appendices	Description of codes and troubleshooting.

System Set-Up

Equipment Requirements

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

Minimum	Recommended
Pentium II with CD-ROM	Pentium II with CD-ROM
Windows 2000, XP	Windows 2000, NT, ME, XP
Microsoft Internet Explorer 5.5 or greater	Microsoft Internet Explorer 5.5 or greater
64 MB RAM	128 MB RAM
800 X 600 resolution	1024 X 768 resolution
28.8 baud rate modem or faster is preferred	33.6 baud rate modem or faster
100 MB free hard drive space	100 MB free hard drive space
CD-ROM	CD-ROM
Printer with 8 pt MS sans serif is preferred	Printer with 8 pt MS sans serif
If using the Web to submit batch transactions, you must have an Internet Service Provider (ISP), or access to an Internet connection.	If using the Web to submit batch transactions, you must have an Internet Service Provider (ISP), or access to an Internet connection.

Note If you have a version of Internet Explorer below 5.5, contact Microsoft.

Program Installation

The software is available on a CD-ROM. Upon completion of the installation process, store the original PES program CD in a safe place. In the event the program and files are damaged or deleted, the original CD will be needed to re-install the program.

PES may be installed on a computer's hard disk drive or on a network. Providers may choose between a "Typical" or "Workstation" (network) installation. You may install PES on as many PCs as needed, but it is recommended that each PC that has the PES software installed has different logon ID and password. You may contact the EDI Helpdesk if requiring additional logon ID's and passwords.

For network installation, only the PES database is loaded onto the server and the application is loaded onto individual personal computers (PCs). PES cannot be used with terminal server solutions.

Note See the PES Installation Guide for complete installation instructions.

Getting Started

Opening the PES Application

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

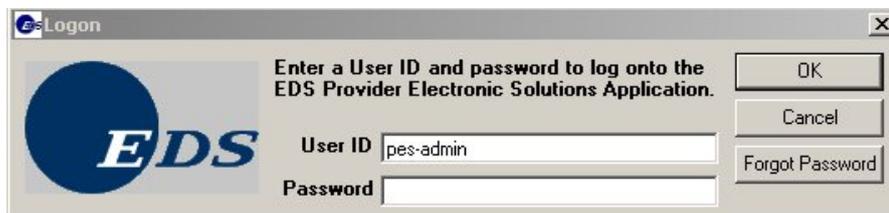
- Double click the folder named ID EDS Provider Electronic Solution on the desktop and then select EDS Provider Electronic Solutions.
- Select the **Start** button, then select Programs | ID EDS Provider Electronic Solutions | ID EDS Provider Electronic Solutions.

Logging On for the First Time

The PES software provides basic security for the user through the logging-in process. The User ID defaults to **pes-admin**. This does not need to be changed.

When logging on for the first time after installing, you will be prompted to change your password. This also allows you to set up a tool in PES to help you should you forget your password in the future.

Note If you have been set up with a User ID other than pes-admin, enter your User ID in the User ID field, then tab to the password and enter the password set up for that User ID. For instruction on how to set up separate User IDs refer to Security in the Tools section.



Step 1 The User ID field displays **pes-admin**. (This does not need to be changed unless you have been given a new User ID by your system administrator.)

Step 2 In the password field in the Logon box:

- If you are installing PES, enter the password: **eds-pes**.
- If you are upgrading PES, enter your current password.

Note Your password will not be displayed; you will see *****.

Step 3 Select **OK**. The message displayed prompts you to change your password.

Step 4 Select **OK** to continue and follow the instructions for changing the password.

Updating Your Password

The screenshot shows a dialog box titled "EsLogon" with a close button (X) in the top right corner. On the left is the EDS logo. The main text reads: "Enter all fields to change a user password on the EDS Provider Electronic Solutions Application." Below this are several input fields: "User ID" (containing "pes-admin"), "Old Password", "New Password", "Rekey New Password", "Question" (a dropdown menu showing "In what city were you born?"), "Answer" (masked with "XXXXXXXX"), and "Rekey Answer" (masked with "XXXXXXXX"). In the top right corner, there are "OK" and "Cancel" buttons.

- Step 1** At the logon window, in the Old Password field:
- If you are installing, enter **eds-pes**.
 - If you are upgrading, enter your current password.
- Step 2** In the New Password field, enter a new password.
- Step 3** In the Rekey New Password field, re-enter the password.
- Step 4** In the Question field, select the dropdown arrow. A list of three questions appears:
- What is your mother's maiden name?
 - What is your father's middle name?
 - In what city were you born?
- Select one question.
- Step 5** Enter the answer in the Answer field. Answers are not case sensitive and you may use spaces.
- Step 6** Re-enter the answer in the Rekey Answer field.
- Step 7** Select **OK**.
- Step 8** The next message displayed tells you that you have successfully updated your password. Select **OK** to continue.
- If you are doing an upgrade, the application main window will appear and you are ready to start using PES.
 - If you are doing a new installation, the system will prompt you in an application text box to set up your personal options. Select **OK**. For more on options, go to Setting up Options in this section.

Password Rules

Passwords are not case sensitive. A password may be any combination of alphabetic, numeric, and special characters. A password must be at least 5 characters in length but no more than 10 characters.

Note For instructions on what to do if you forget your password, go to Password Help.

Note Your password will expire every 30 days unless otherwise indicated in the retention settings in the **Tools | Options** menu in PES. For instructions on how to change the retention settings, refer to Setting Up Options on page 13.

Using Password Help

If you forget your PES password, you can use the password question to create a new password.

Step 1 Select **Forgot Password** in the Logon box. The Password Help box appears.

Step 2 Enter the correct answer. Select **OK**.

Note The answer is displayed in asterisks. Be sure that you type the answer correctly. You can make three attempts to answer the password question.

- If you correctly answer the password question, you will be prompted to create a new password. After creating the new password and rekeying it, select **OK**. The PES application opens.
- If you incorrectly answer the password question three times, you will receive an application prompt asking if you wish to reset your password. Select **Yes**. The system creates a 5-digit reset key number. Write down this number for contacting the EDI Help Desk.

Step 3 Select **OK**. The PES application closes. See Using a Temporary Password to continue.

Using a Temporary Password

Step 1 Call MAVIS and say TECHNICAL SUPPORT immediately after the MAVIS greeting.
 (800) 685-3757 toll free
 (208) 383-4310 in the Boise calling area
 8:00 a.m. to 5:00 p.m. MT
 Monday - Friday (excluding State holidays)

You will need the following Information when calling the EDI Help Desk to reset a password:

- Idaho Medicaid provider number
- Name

- User ID (from the Logon dialogue box)
- 5-digit reset key number (a sample is shown in below inside the red oval)



Note When you call the EDI Help Desk, you will get a temporary 8-character alphanumeric password.

- Step 2** Open the PES application.
 - Step 3** Enter the temporary password in the Logon Box Password field. Select **OK**. The PES application will now open.
 - Step 4** Go to **Tools | Change Password** in the PES toolbar to change your password and set up a new password question for possible future use.
-

Note It is strongly recommended that, immediately after logging in with a temporary password, the user set up a new password, question, and answer. See the chapter titled Tools, Changing Your Password.

Setting up Options

Options must be set up the first time you use the software. There are seven options that must be confirmed or created. They are:

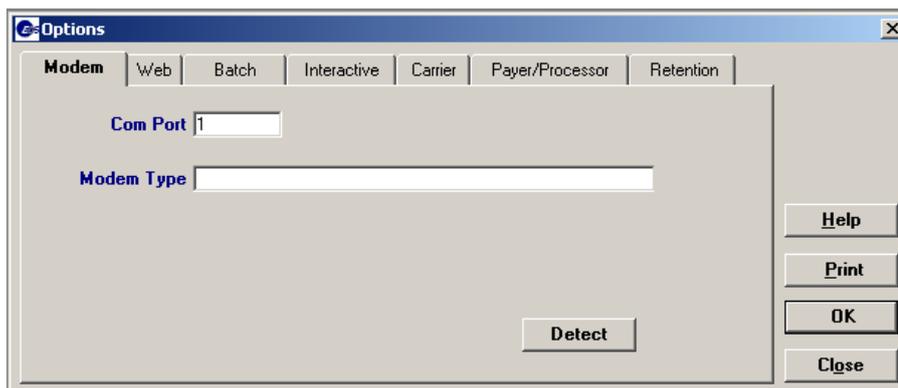
- Modem
- Web
- Batch
- Interactive
- Carrier
- Payer/Processor
- Retention

The Options window displays with the Modem tab on top.

To access Options after the initial setup, select **Tools | Options**.

Modem

Com Port should be the PC communications port (also called serial port) to which the modem is connected. The software supports only COM1, COM2, COM3 and COM4. If the modem is set up on any other Com Port, contact the hardware vendor to relocate the modem to one of the above Com Ports.



Step 1 If your PC has a modem, select the **Detect** button to allow the software detect the Modem Type and Com Port. If the modem is not detected, use the drop down window and select the generic option that most closely matches the modem installed on the system.

Step 2 Enter the appropriate Com Port number 1, 2, 3, or 4.

Note Even if you do not have a modem and are submitting claims using the web server method option, or the diskette method option, a Com Port and modem type must still be selected. Click in the field Modem Type and select any modem from the list.

Step 3 Select the **Web** tab to continue setting up options.

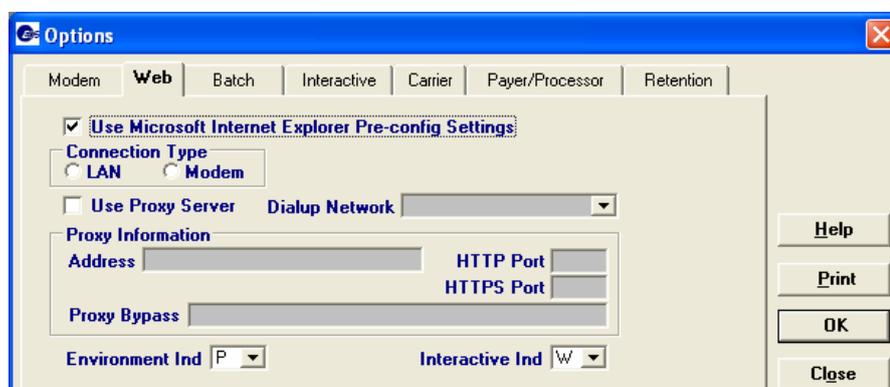
Tip If you do not know what type of modem is installed on your computer, select the **Start** button, select setting, select control panel, select phone and modem options, select modems or diagnostic to determine what type of modem is installed and what Com Port the modem is installed on.

Web

This information is necessary for connecting with the Web site for uploading and downloading batch files.

Uploading or downloading using an existing Internet connection

Use this option if you have an existing Internet connection using any of the following connection types: cable modem, DSL modem, ISDN modem, local area network (LAN) connection, or analog modem.



Step 1 Verify that the Use Microsoft Internet Explorer Pre-config Settings checkbox is selected. If this box is checked this indicates that the PES application will use the same settings as the Microsoft browser to connect to the Internet. The box is selected by default.

Tip The default is to Use Microsoft Internet Explorer Pre-config Settings. It is recommended that you leave the box checked when you use the Web option.

Step 2 Select the appropriate environment indicator. The Environment Ind box defaults to P for the production environment. Select **T** only if this is used to test for software connectivity.

Step 3 Select the appropriate interactive indicator. The Interactive indicator box defaults to W for the web method option to be done on interactive transactions. If the user is going to use the dial-up method, choose the drop down box and select the BBS and a B will display in the box.

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

Step 4 Uncheck the Use Microsoft Internet Explorer Pre-config Settings checkbox.

Step 5 Select the appropriate connection type. The Connection Type indicates whether the Internet connection is established through a LAN or a modem.

Step 6 Check the Use Proxy Server check box, when a proxy server is used to connect to the Internet. The proxy server is commonly used with a LAN connection. If checked, the Proxy Information boxes including Address, Hypertext Transfer Protocol (HTTP) Port, secure HTTPS Port, and Proxy Bypass will be available for entry.

Step 7 Enter a proxy address if you selected the Use Proxy Server. This is the IP address or Universal Resource Locator (URL) address of the proxy server used to connect to the Internet. This is a required box if you selected the Use Proxy Server checkbox.

Step 8 Enter your HTTP port if you selected the Use Proxy Server. This is the port number that the proxy server uses for standard Hypertext Transfer Protocol (HTTP) communication. This is a required box if you checked the Use Proxy Server checkbox.

Step 9 Enter the HTTPS port if you selected the Use Proxy Server. This is the port number that the proxy server uses for secure Hypertext Transfer Protocol (HTTPS) communication. This is a required box if you checked the Use Proxy Server checkbox.

Step 10 Enter a proxy bypass, if desired, if you selected Use Proxy Server. This is the URL address that does not use the proxy server.

Batch

Batch contains the Logon ID and password information that allows the user to submit claims for services in an electronic format. If you do not know what your logon ID and password are, please contact the EDS EDI help desk toll free at (800) 685-3757 or in the Boise calling area at (208) 383-4310, ask for TECHNICAL SUPPORT.

The screenshot shows the 'Options' dialog box with the 'Batch' tab selected. The fields are: Logon ID (text box), Password (text box), Entity Type Qualifier (dropdown menu), Last/Org Name (text box), First Name (text box), and Modem Init String (text box). On the right side, there are four buttons: Help, Print, OK, and Close.

- Step 1** Enter your Logon ID and Password. The logon ID has 9 digits. The password has 8 alpha-numeric characters and is case sensitive. It must be keyed exactly as displayed on the CD mailer or letter.
- Step 2** Select the one of the following Entity Type Qualifiers for the facility:
- **1** – Person (Individual Provider)
 - **2** – Non-Person (Group or Facility)
- Step 3** Enter the Last Name of the individual provider, or the Organization Name if a Facility or Group.
- Step 4** Enter the first name of the Individual if the Entity Type Qualifier is a 1.
- Step 5** The Modem Init String entry will be defaulted from the Modem selected on the Modem tab.
- Step 6** Select the Interactive tab to continue to set up options.

Interactive

The screenshot shows the 'Options' dialog box with the 'Interactive' tab selected. The 'Modem Init String' field is visible. On the right side, there are four buttons: Help, Print, OK, and Close.

The Modem Init String will be defaulted when the Modem is selected on the Modem tab.
Select the **Carrier** tab to continue to set up options.

Carrier

This screen is used by the software to interface with the EDS bulletin board system to transmit transactions to Idaho Medicaid. You will need to confirm the default settings for both the interactive and batch transmission setups. At the bottom of the screen, there is a box that shows these two options.

When you select the Carrier tab, the screen opens with the Interactive option highlighted.

Transaction Type	Carrier Id	Net Id	Phone Number	Dtr
INTACT TRANSMIT				28800
BATCH TRANSMIT				28800

You can view and confirm the setup information for each option beginning with Interactive.

Interactive Transmission Setup

- Step 1** Select **INTACT TRANSMIT** as the Transaction Type at the bottom of the screen and confirm that it says INTACT TRANSMIT in the Trans Desc field at the top of the screen.

Transaction Type	Carrier Id	Net Id	Phone Number	Dtr
INTACT TRANSMIT				28800
BATCH TRANSMIT				28800

- Step 2** Click in the Carrier ID field and select **INT-800**. When you make this selection, the other fields in the screen will auto-fill. You will now need to confirm that the information is correct.

Step 3 Confirm the following settings:

Field	Setting
Trans Desc	INTACT TRANSMIT
DTR	28800
Carrier ID	INT_800
Phone Number	18666270017
Net ID	IDMP
Net Password	idaho
ATT menu	1
Production/ Test Indicator	P

Step 4 Select **BATCH TRANSMIT** at the bottom of the screen as the Transaction Type to continue to set up options.

Batch Transmission Setup

Step 1 Select **BATCH TRANSMIT** at the bottom of the screen as the Transaction Type and confirm that it says BATCH TRANSMIT in the Trans Desc field at the top of the screen.



Step 2 Click on the **Carrier ID** field and select **BTCH_800**. When you make this selection, the other fields in the screen will auto-fill. You will now need to confirm that the information is correct.

Step 3 Confirm the following settings:

Field	Setting
Trans Desc	Batch Transmit
DTR	28800
Carrier ID	BTCH_800
Phone Number	18666270015
NET ID	IDMP
Net Password	Idaho
ATT Menu	11
Production/ Test Indicator	P

- Step 4** After completing the interactive and batch setup, select the **Payer/Processor** tab or select **OK** to save and return to the main window.

Dialing '9' for Outside Line

If you must dial a 9 (or other number) to access an outside phone line on your modem, you will need to modify the phone number for both the Interactive and Batch Carrier.

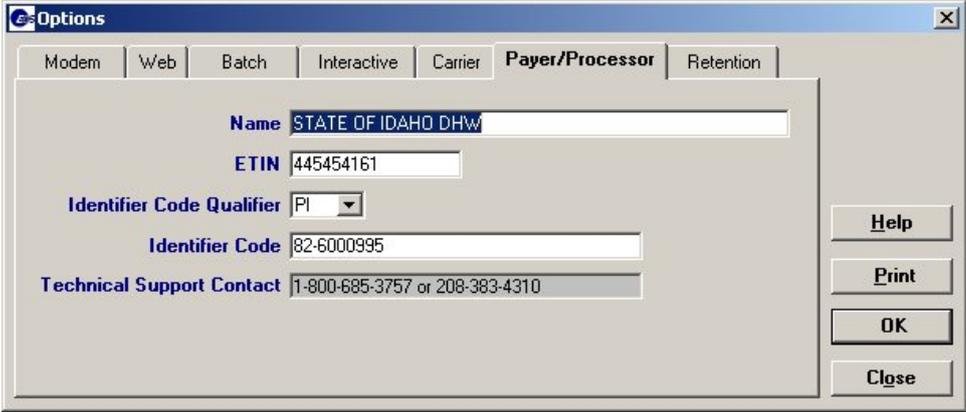
Transaction Type	Carrier Id	Net Id	Phone Number	Dtr
INTACT TRANSMIT	INT_800	idmp	9,18666270017	38400
BATCH TRANSMIT	BTCH_800	idmp	9,18666270015	38400

- Step 1** Click in the **Phone Number** field to highlight the number.
- Step 2** Use your left arrow to move the cursor to the far left of the field and then type a **9** and a comma (**,**) at the beginning of the field in front of the 1 so it displays 9,18666270015.
- Step 3** Repeat for both the Interactive and Batch Carrier options.

Payer/Processor

This screen is defaulted to the required setting for transmission of services to the Idaho Medicaid program. Please note that the technical support telephone numbers are also included on this screen for future reference.

- Step 1** Select the **Payer/Processor** tab.



Step 2 Confirm the following default settings:

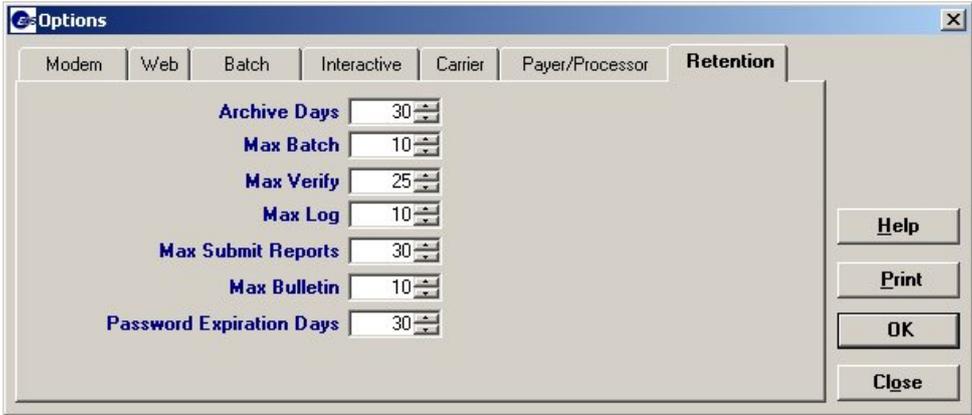
Field	Setting
Name	STATE OF IDAHO DHW
ETIN	445454161
Identifier Code Qualifier	PI
Identifier Code	82-6000995

Step 3 Select the **Retention** tab or select **OK** to save and return to the main window.

Retention

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

Step 1 Select the **Retention** tab.



Step 2 Confirm the following default settings or change the settings to meet your business needs. Use the scroll-down feature to select the appropriate setting, or key the value you have determined meets your business needs.

Retention Field	Default Setting/Description
Archive Days	<p>Default days: 30.</p> <p>Maximum number of Days is 999 before notifying the user it is time to archive submitted forms.</p> <p>When submitting large volumes of claims, archive claims every 30-60 days.</p>
Max Batch	<p>Default listings: 10.</p> <p>Maximum number of batches retained in the Resubmission option of the Communication menu.</p> <p>Listing on the Batch list will be deleted on a first-in/first-out basis. Maximum number of batches that can be retained is 999.</p>
Max Verify	<p>Default number of download files: 25.</p> <p>Maximum number of downloaded responses is 999.</p> <p>Downloaded files will be deleted on a first-in/first-out basis.</p>
Max Log	<p>Default number of Communication log backups: 10.</p> <p>Maximum number of Communication log backup files retained is 999.</p>
Max Submit Reports	<p>Default number of submission reports: 30.</p> <p>Maximum Submission Reports retained is 999.</p>
Max Bulletin	<p>Default number of Bulletins: 10.</p> <p>Maximum Bulletins retained is 999.</p>
Password Expiration	<p>Default number of days before password expires: 30.</p> <p>Maximum number of days before Password expires is 99.</p> <p>Note: This is the Logon password that will allow you to access the PES software.</p>

Step 3 Select **OK** to save.

Basic Skills

If you have average computer skills, you should find the PES environment familiar and will probably appreciate the ease of use. The keyboard, pull-down menus, toolbars, and buttons are similar to other MS Windows software.

If you are a first-time computer user or have limited experience, take the time now to get a feel for the PES screens and how they work. These few basic skills will have you checking eligibility and submitting claims quickly and efficiently!

Using the Keyboard

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

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

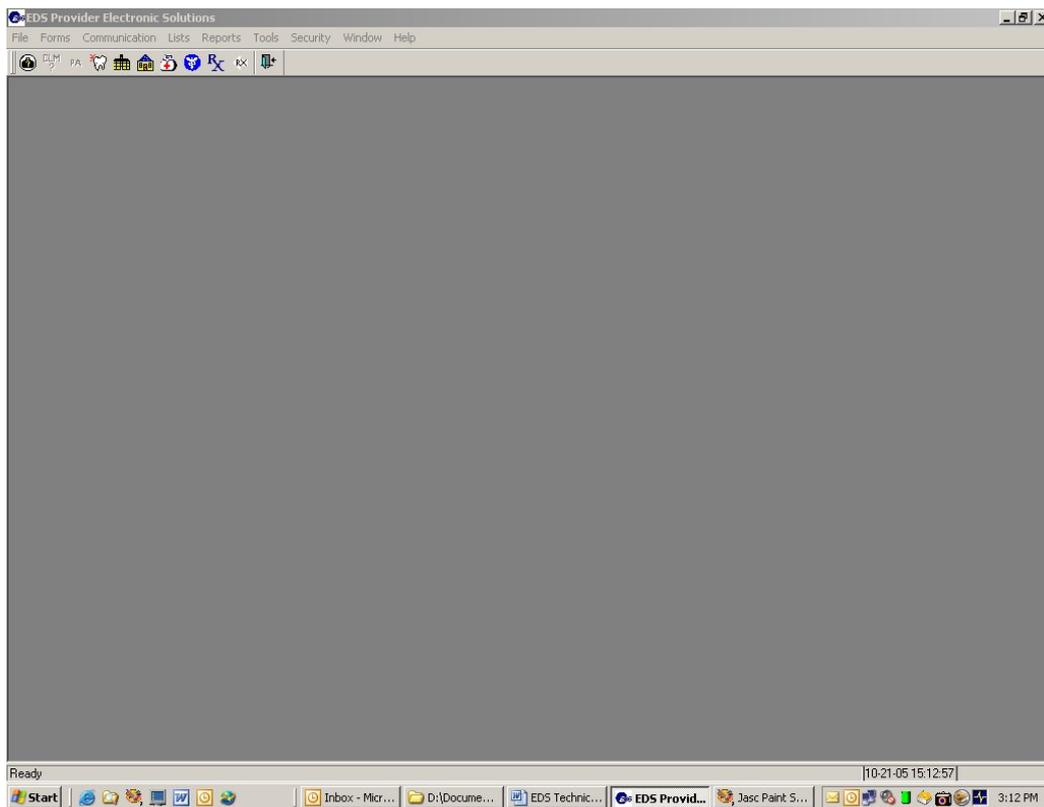
Using the Mouse

Use the mouse to navigate around the PES software screens, for example, when you want to select an option. Click the left mouse button once to position your cursor at that location or to select an option.

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

Right click to Cut, Copy, Paste, and Select All.

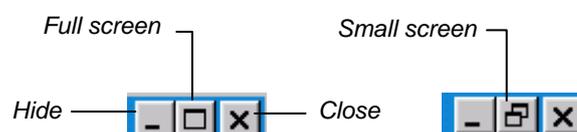
Looking at the PES Window



Here is a quick tour of the PES window. There are two basic windows and both are easy to use. The first window has the main menu of all the functions you can choose: file, forms, communication, lists, reports, tools, security, window, and help. Some of these options are then repeated in the toolbar directly below the menu bar.

Main Menu

In the upper right-hand corner of the main window there is a set of three little boxes you can use to hide, re-size, or close the window. You can also hide, re-size and close the active window inside of the main window. Be careful with the . You can close the program by clicking it. Fortunately, PES will always ask you if you are sure you want to save any changes before you close.

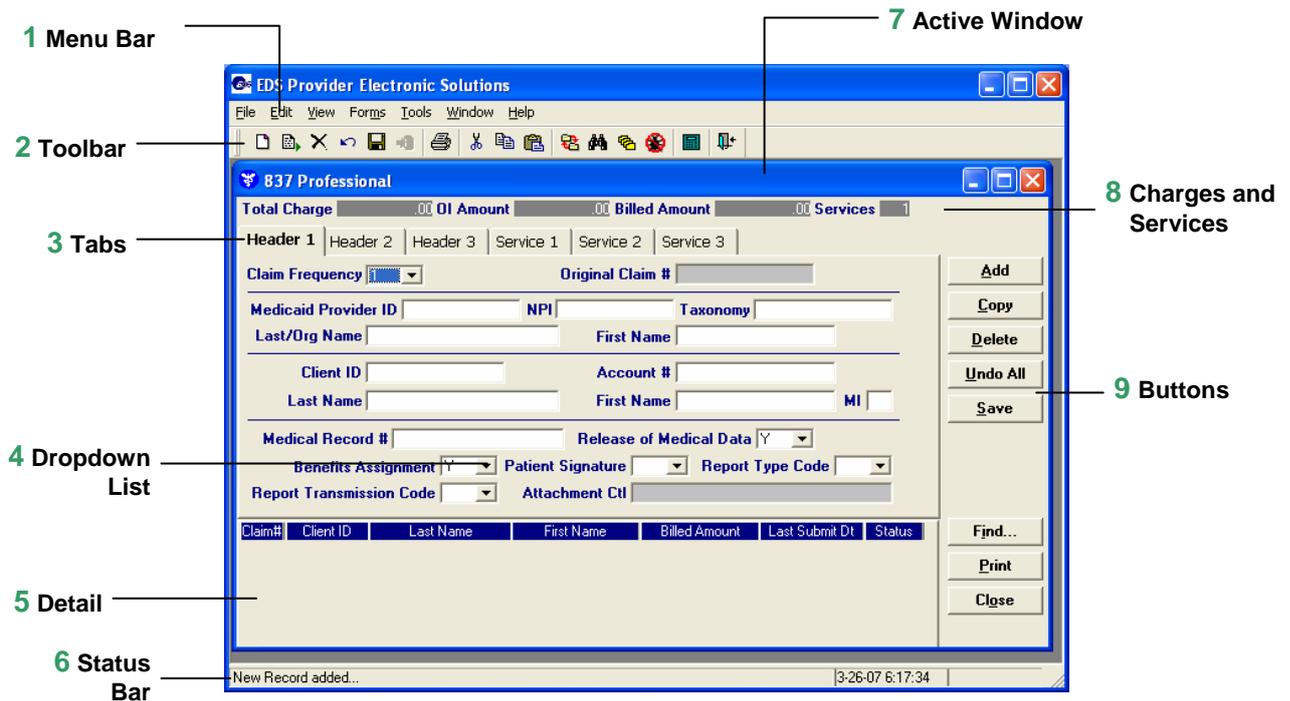


When you select one of the options from the Menu Bar, two things happen: the screen for the option you chose opens inside of the main PES window and its Menu Bar changes.

Tip Use the Hide feature to minimize PES between patients. This allows you to have access to the application through out the day.

PES Window

The explanation for each callout in the PES window is provided below the diagram.



1 Menu Bar

The menu bar appears at the top of the PES window. It is a list of basic options. There are two Menu Bars, one for the Main Window, and a second that opens once you select an option.

2 Toolbar

Toolbars are designed to work as shortcuts for frequently used menu commands to reduce the time and steps needed to activate a function when needed. A toolbar consists of small pictures or buttons that represent different menu commands. To execute a command using the toolbar, simply click on the button with the mouse. To see a name or brief description of each button, move the cursor arrow over the button but do not click the mouse. The description will appear just below the button.

3 Tabs

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

4 Dropdown List Indicator and Dropdown List

If down arrow is displayed in a field, this means options are available for that field. Click on the arrow and a list of valid values will be displayed. If there is a scroll bar on the right, be sure to use it to see all the options on the list. If you double click in the field, you will be able to create or add to the list associated to the field.

5 Detail

A detail lists all claims or transactions that have been completed for the form. In the Lists selection, the detail displays all information that was created for the specific list. Possible values are: R = Ready, F = Finalized.

6 Status Bar

Indicates the mode that the screen is in such as Ready or New Record Added. When you move your cursor down a list on the Menu Bar, the options will be displayed in the Status Bar as the cursor moves across the menu items or down the list.

7 Active Window

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

8 Charges and Services

Charges and Services Field	Description
Total Charges	Populated from the charges entered in the Service 1 tab.
OI Amount	Populated from the OI tab indicating how much a primary insurance paid on the services indicated on the Service 1 tab.
Billed Amount	Total charges to be billed to Idaho Medicaid less the amount paid by the primary insurance, if applicable.
Services	Number of service details associated to the claim.

9 Buttons

Buttons are located along the right side of each individual screen. These buttons will vary from screen to screen. See the More on Buttons section for detailed information.

Menu Options

This menu option...	Allows the user to...
File	In the Main Menu, you can exit from the application. In Forms, Lists, and Reports, you can add, delete, and print.
Forms	Select the online form needed. See chapter that describes Forms for more information about this option.
Communication	Submit batches of forms and process batch responses. Resubmit batches of forms. View Communication Log files. See the chapter that describes Communication for more information about this option.

This menu option...	Allows the user to...
Lists	Add and edit reference lists, which allow the user to collect information to be used when completing transactions within the software. See the chapter that describes Lists for more information about this option.
Reports	Print summary or detail reports with information from forms or reference lists. See the chapter that describes Reports for more information about this option.
Tools	This option allows the user to create and work with archives, perform database maintenance, retrieve upgrades, and change setup options. The Options selection allows the user to set up communications options and determine retention settings. See the chapter that describes Tools for more information about this option.
Windows	Standard options available for most Windows compatible applications.
Help	Obtain help about PES functions, screens, menus, and fields using Contents and Index. Select About to view information about this application such as version and copyright.

Tool Bar Icons



270/271 Eligibility Inquiry and Response



837 Dental



837 Institutional Inpatient



837 Institutional Nursing Home



837 Institutional Outpatient



837 Professional



NCPDP Pharmacy



NCPDP Pharmacy Reversal

More on Buttons

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

Button	Description
Add	Work with a new form. You are automatically ready to enter data into a new form when you first select a form type to work with.
Copy	Make a copy of a previously submitted form or current form if submitting multiple claims for the same client. This action enables you to make corrections to the new form as needed.
Delete	Delete the current form. You will be asked if you are sure that you want to delete it. If you select "Yes" the form will be deleted. You will only be able to delete a form if it has a status of R which indicates the form is "Ready" to be transmitted.
Undo All	Reverse all of the changes that you have made to the current form. You will only be able to undo the changes made since the last time you saved the form.
Save	<p>Save what you have entered in the current form or list. When you save a form, the data will be checked to see if it meets the criteria for the field (such as, a client ID number doesn't have enough digits in it or a required field has not been completed). A list of errors will be presented for you to correct. For more information on how to use the error list, see Correcting Errors.</p> <p>When you have finished working with a form and selected save, the form status is updated in the detail to an "R" to indicate the form is "Ready" to be transmitted.</p>
Send	Send a form to be processed immediately. This button is not visible unless the form you are working with is available for interactive transmission. The system will connect to EDS, send the form, and wait for an immediate response.
Find	Locate specific forms in the list in the lookup window.
Print	Print data associated to the form you are currently viewing in PES. Eligibility transactions, claim forms, and reports are displayed in a report format to be viewed online or may be printed. Lists can also be viewed or printed.
Close	Close the form window. If you have made changes to the current form, you will be asked if you want to save those changes before you leave the window.

Correcting Errors

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

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

Exiting from Forms

When you complete a form you then have several choices about what you want to do next.

Form Option	Description
Save a form	Select the Save button. This action will save the form in a status of "R" indicating the form is ready to be transmitted as a batch transaction. If you have more forms to be submitted, select the Add button. The software will automatically save the current form to an "R" status and allow you to enter a new form.
Add a new form	Select the Add button to add a new form or a new entry in the list options. This action automatically saves any information in the current form and indicates the form has an "R" status.
Copy a form	Transaction to be copied. Select the Copy button to copy a form or eligibility transaction that is in a status of Archived, Finalized, Ready, or Incomplete. This action copies the original transaction and allows you to make corrections to the information and readies the transaction for submission.
Send a claim immediately	PES is able to send both NCPDP and eligibility transactions interactively. What this means is that you can get an immediate response when requesting this information from EDS. If submitting an eligibility transaction you will get an immediate response on the status of the client's eligibility and any program restrictions. If submitting NCPDP you will get an immediate response about the status of payment for the prescription submitted.
Add Service	Click on the Add Srv button and complete the detail screen again.
Copy Service Detail	Click on the Copy Srv button, then change data as needed for the new service detail.
Delete Service Detail	Select the Service # then click on the Delete Srv button.

Exiting from PES

There are three ways to exit from the PES software:

- Select the **X** in the upper right corner of the screen.
- Select **File** from the menu bar and select **Exit**.
- Click on the blue book icon in the toolbar.

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

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

270/271 Eligibility Form

Use the Eligibility Request form to verify client eligibility in the Idaho Medicaid Program. Eligibility can be verified interactively or as a batch transaction.

Before entering an eligibility transaction, you must complete the Provider Billing list. Refer to the List chapter for information on how to complete this list.

Verify eligibility every time services are rendered. Eligibility can only be checked for the current day and for 365 days into the past. It can be checked for a span of dates up to one year in the past. Eligibility cannot be verified for future dates.

The Eligibility form has three screens that you will use to complete a claim depending on your provider type. They are:

- Header 1
- Header 2
- Service

To access the 270 Eligibility Request Form from the PES main menu, select the icon for 270 Eligibility Request from the Toolbar or select **Forms** in the Main Menu bar and select **270 Eligibility Request**.

270 Eligibility Request - Header 1

The screenshot shows the '270 Eligibility Request' form in the 'Header 1' tab. The form includes the following fields:

- Information Receiver Name:** Medicaid Provider ID (dropdown), NPI (text), Provider ID Code Qualifier (dropdown), Taxonomy (text), Provider Code (dropdown), Last/Org Name (text), First Name (text).
- Subscriber Name:** Client ID (text), ID Qualifier (dropdown), Client SSN (text), Client DOB (text, value: 00/00/0000), Account # (text), Last Name (text), First Name (text), MI (text).

At the bottom, there is a table with the following columns: Claim#, Client ID, Last Name, First Name, From DOS, To DOS, Last Submit Dt, Status. The table is currently empty.

The status bar at the bottom of the window displays 'New Record added...' and the date/time '3-26-07 6:20:23'.

Step 1 Enter data into all of the following fields to complete the Eligibility Request Form Header 1.

Eligibility Request Header 1 Field	Description
Medicaid Provider ID	9-digit Idaho Medicaid Provider ID for the provider of service from the drop down field. Taxonomy Code, Last/Org Name and First Name will default from the provider ID number selected.
NPI	10-digit NPI for the provider of service from the drop down field. Taxonomy Code, Last/Org Name and First Name will default from the NPI number selected.
Provider Code	Provider code that identifies the type of entity requesting the eligibility transaction. For example BI is for Billing Provider, or AD is for Admitting Provider.
Client ID	<p>Select the client from the current list of clients or enter two pieces of identifying information for the client for a successful eligibility request. The two pieces of information can be</p> <ul style="list-style-type: none"> • Idaho Medicaid Client ID and DOB • Idaho Medicaid Client ID and First/Last Name • Idaho Medicaid Client ID and SSN • SSN and DOB • SSN and First/Last Name • DOB and First/Last Name <p>Tip: If the provider or client ID is not entered in a drop down list or no data is displayed, double click in the field and follow the instructions in the chapter on Lists to add the data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim. This works for any field. These fields will autofill if you have already added the client to your client list.</p>

Step 2 Select the **Header 2** tab.

270 Eligibility Request - Header 2

This is the second screen you must complete for client eligibility.

Step 1 Enter data into all of the following fields to complete the Eligibility Request Form Header 2.

Eligibility Request Header 2 Field	Description
From DOS	From Date of Service using the MMDDCCYY format. Dates of service can span any period up to 365 days in the past.
To DOS	To Date of Service using the MMDDCCYY format.

Step 2 Select **Save** to save the data or **Add** to add the next client.

Step 3 If no further information is requested select the **Send** button for online eligibility verification. If using the online eligibility feature, only one transaction may be performed at a time.

You may choose to submit a Batch of eligibility transactions by saving the client information and using the Batch Submission feature of the software. If using the Batch Submission feature you will be required to wait a minimum of two (2) hours after the transmission before requesting the response back from the system using the Batch Files to Receive feature under "Communication and Batch Submission". For more information on how to transmit a batch refer to the Communication chapter.

270 Eligibility Request - Service

Use the service screen to verify limitations for the listed client. This is an optional screen.

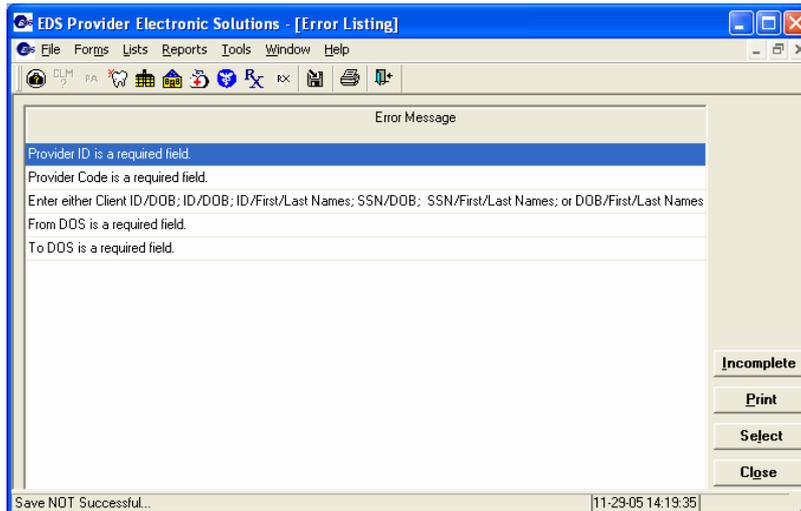
Step 1 Enter data into all of the following fields to complete the Eligibility Request Service tab.

Eligibility Request Service Field	Description
Service Type	Type/source of the procedure or service. For example (AD) is American Dental Association.
Procedure From DOS	Beginning date of service using the MMDDCCYY format. The date of service must be within or the same as the DOS requested on the Header 2 tab.
Procedure To DOS	End date of service using the MMDDCCYY format. The date of service must be within or the same as the DOS requested on the Header 2 tab.
Procedure/Service Code	5-digit procedure/service code to be verified.
Modifiers	Modifier(s) associated to the procedure/service code, if applicable.
Procedure Provider Code	Code identifying the type of provider. The software will default to BI for Billing Provider.
Procedure Provider Ref. Qualifier	Code qualifying the reference identification. The software defaults to ZZ for Mutually Defined. Note: If using the NPI Procedure Provider Number you must select a HPI for this qualifier.
Procedure Provider Number	9-digit billing provider number identifying the provider who is performing the service, or the 10 digit NPI. Note: Idaho Medicaid encourages providers to use only their Idaho Medicaid Provider for the Procedure Provider Number.

Step 2 Select **Save** to save the data or select **Add** to add another client.

Correcting Errors

If all the required data is not included in a form, a listing of error messages will display for you to correct. Double click on the error message or click on the error message and click on the **Select** button.



The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

If you cannot complete the form and wish to save it to complete later select the **Incomplete** button. This form will then display in the details with a status of I. Forms in a status of I cannot be transmitted.

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

271 Eligibility Response

The 271 Eligibility Response is the response transaction from the original 270 Eligibility Request. This response will provide eligibility, other insurance, program restrictions, and limitation information for an Idaho Medicaid client.

There are four primary sections of the 271 Eligibility Response:

Section Name	Description
Information Source	Indicates who the entity was that sent the response.
Provider Information	Indicates who requested the eligibility response.
Client Information	Indicates the client information used to request the response.
Eligibility Benefits	Displays segments on the client's Idaho Medicaid eligibility, other insurance, program restrictions, Healthy Connections, and service limitations information.

A 271 Eligibility response can return up to six different eligibility segments depending on the participants program coverage and the from and to dates of service sent in the eligibility request. For example, eligibility information requested was for dates of service June 15, 2006 to July 15, 2006 and that participant had Medicaid coverage in June and Medicaid Basic Plan coverage in July; the program description in the response would

indicate Medicaid coverage for the dates June 15-30, 2006 and a program description of Medicaid Basic Plan for the dates July 1-15, 2006.

The following section shows examples of eligibility responses. Below each box is an explanation to help you read the response. To help you read the example, important data names are bolded in the explanation and in the corresponding part of the sample.

Information Source

```

Eligibility Batch Response

Transaction Reference Number:      001
Submitter Transaction ID:

*****INFORMATION SOURCE*****
Hierarchical ID Number:           1
Hierarchical Level Cod:          20

Yes/No Condition or Response:
Reject Reason Code:
Follow-up Action Code:
Information Source
    Last/Org Name:    STATE OF IDAHO DHW
Information Source Primary ID:75-2548221

Yes/No Condition or Response:
Reject Reason Code:
Follow-up Action Code:
    
```

Information Source Last/Org Name should display **State of Idaho DHW** as the entity that responded to this request.

Provider Information

```

*****PROVIDER INFORMATION*****

Hierarchical ID Number:           2
Hierarchical Level Code:          21
Provider Last/Org Name:      SMITH
Provider First Name:        JOHN
Provider Number;                  123456789
Trading Partner ID:               XXXXXXXXXX
Yes/No Condition or Response:
Reject Reason Code:
Follow-up Action Code:
    
```

Provider Information Field	Description
Provider Last/Org	Provider name.
Provider First Name	Name of the provider who requested the eligibility verification.
Provider Number	9-digit billing provider or 10-digit NPI number indicated in

Provider Information Field	Description
	the original 270 eligibility request.
Trading Partner ID	Login ID indicated on the Batch setup tab under Tools Options from the main menu in PES. This is the ID that you received with your software.
Reject Reason Code	Populated with an error message if there are issues with the provider information. For example: Missing or Invalid Provider ID.
Follow up Action Code	<p>Corrective action needed for the transaction to be processed.</p> <p>C Please correct and resubmit N Resubmission not allowed P Please resubmit original transaction R Resubmission Allowed S Do no resubmit, inquiry initiated to a third party W Please wait 30 days and resubmit X Please wait 10 days and resubmit Y Do not re-submit, we will hold your request and respond again shortly</p>

Client Information

```

*****CLIENT INFORMATION *****

Hierarchical ID Number: 3
Hierarchical Level Code:      22

Trace Number:
Trace Assigning Entity ID:    9EDSPES000
Trace Assigning Entity
Additional ID:

Trace Number: XXXXXXXXXXXX
Trace Assigning Entity ID:
EDS/Medicaid Receiver ID)
Trace Assigning Entity Additional ID:

Client Last Name: DREW
Client First Name:      NANCY
Client Middle Initial:
Client ID: 1234567
Client SSN:
Client Account Number:
Client MID Card Number: 001
Address Line 1:
Address Line 2:
City:
State:
Zip:
Client Date of Birth:
Client Gender:
    
```

Client Information Field	Description
Trace Numbers	
Trace Number Assigning Entity ID	How the electronic transaction was received. 9EDSPES000 indicates the request was submitted using the PES software for Idaho Medicaid.
Trace Number	11-digit is the eligibility verification number assigned to the transaction by Idaho Medicaid and is the number needed when requested to provide proof of the client's eligibility verification.
Specific Client Information	
Client Last Name Client First Name	Last and First Name.
Client Middle Initial	Middle Initial is displayed if submitted in the original request.
Client ID	7-digit Idaho Medicaid Client ID.

Client Information Field	Description
Client SSN	SSN and Account Number if submitted in the original request.
Client MID Card Number	MID Card Number is 001 (the original card issued to the client) or 002, 003, etc. if the card has been replaced.
Client Date of Birth Client Gender	Date of Birth and Gender if submitted it in the original request.

You may see up to five different types of information returned in the 271 Eligibility Response in the following order.

- Medicaid Eligibility
- Program Restrictions
- Other Insurance
- Healthy Connections
- Limitations

Medicaid Eligibility

```

***ELIGIBILITY OR BENEFIT INFORMATION***

Eligibility or Benefit
Information:                1 (or 6)
Service Type Code:
Insurance Type Code:       MC (or QM)
Plan Coverage Description:  MEDICAID
Yes/No Condition or Response

Product/Service ID Qualifier:

Product/Service ID:
Modifier 1:
Modifier 2:
Modifier 3:
Modifier 4:
Eligibility Benefit
Date Time Period:         01/01/2003-01/01/2003
Provider Phone #:
    
```

Medicaid Eligibility Field	Description
Eligibility or Benefit Information	Indicator is 1 if the client is currently active, or 6 if inactive.
Insurance Type Code	MC or QM indicates the coverage is for Medicaid or the client is enrolled as a Qualified Medicare Beneficiary (QMB).
Plan Coverage Description	Type of coverage the client has. For example; Medicaid, Medicaid Basic Plan, CHIP-B, or Qualified Medicare Beneficiary (QMB).

Medicaid Eligibility Field	Description
Eligibility Benefit Date Time Period	From and to dates of services that you requested on your original 270 eligibility request.

Other Insurance

Eligibility or Benefit Information:	
Service Type Code:	R
Insurance Type Code:	30
Plan Coverage Description: GROUP HEALTH	
Yes/No Condition or Response	
Product/Service ID Qualifier:	
Product/Service ID:	
Modifier 1:	
Modifier 2:	
Modifier 3:	
Modifier 4:	
Policy:	ABC1234
Group:	12345
Payer:	CARRIER NAME
Eligibility Benefit Date Time Period: 01/01/1997-01/01/2003	
Provider Phone #:	

Other Insurance Field	Description
Eligibility or Benefit Information	Indicator is an R if the client has a primary insurance other than Medicaid.
Plan Coverage Description	Type of coverage the client has with the carrier. For example, 30 - Group Health or Medicare Part A. In this example, the client has Group Health coverage.
Policy	Policy number for the Primary Policy Holder.
Group	Group number for the Primary Policy Holder.
Payer	Name of the other insurance carrier. For example: Blue Cross or Blue Shield.
Eligibility Benefit Date Time Period	From and to dates of coverage for the primary policy.

Restricted Programs

<p>Eligibility or Benefit Information: 1 (or F)</p> <p>Service Type Code: 45, 54, 86, 88, 96</p> <p>Insurance Type Code:</p> <p>Plan Coverage Description:</p> <p>45 - Hospice Only Hsp)</p> <p>54 - Long Term Care Facility Name</p> <p>86 - Emergency Services Only</p> <p>88 - Client Locked In (Pharmacy)</p> <p>96 - Client is Locked In Physician)</p> <p>Yes/No Condition or Response</p> <p>Product/Service ID Qualifier:</p> <p>Product/Service ID:</p> <p>Modifier 1:</p> <p>Modifier 2:</p> <p>Modifier 3:</p> <p>Modifier 4:</p> <p>Eligibility Benefit</p> <p>Date Time Period: 01/01/2003-12/31/2003</p> <p>Provider Phone #:</p>
--

Restricted Programs Field	Description
Eligibility or Benefit Information	1 for Long Term Care, or F for other program restrictions.
Service Type Code	Associated with the Plan Coverage Description if the client is on a restricted program with Idaho Medicaid.
Plan Coverage Description	Based on the Service Type Code with the exception of Long Term Care Facility. Service Type Code 54 will display the name of the facility.
Eligibility Benefit Date Time Period	From and to dates of coverage for the program restriction.

Healthy Connections

<p>Eligibility or Benefit Information: L</p> <p>Service Type Code:</p> <p>Insurance Type Code:</p> <p>Plan Coverage Description:</p> <p>Yes/No Condition or Response</p> <p>Product/Service ID Qualifier:</p> <p>Product/Service ID:</p> <p>Modifier 1:</p> <p>Modifier 2:</p> <p>Modifier 3:</p> <p>Modifier 4:</p> <p>Eligibility Benefit</p> <p>Date Time Period:</p> <p>Provider Phone #:</p> <p>MCO/PCP Name:</p> <p>PCP First Name:</p> <p>PCP Middle Initial:</p> <p>Provider Phone #:</p>

This segment displays if the client is enrolled in Healthy Connections on the date(s) of service requested.

Healthy Connections Field	Description
Eligibility or Benefit Information	Always displays an L when the client is enrolled in the Healthy Connections program.
MCP/PCP Name PCP First Name PCP Middle Initial	Name of the Healthy Connections provider with whom the client is enrolled.
Provider Phone #	Telephone number of the Healthy Connections provider

Limitations

<p>Eligibility or Benefit Information: F</p> <p>Service Type Code:</p> <p>Insurance Type Code:</p> <p>Plan Coverage Description:</p> <p>Yes/No Condition or Response</p> <p>Product/Service ID Qualifier: CJ</p> <p>Product/Service ID: XXXXX</p> <p>Modifier 1: XX</p> <p>Modifier 2: XX</p> <p>Modifier 3: XX</p> <p>Modifier 4: XX</p> <p>Eligibility Benefit</p> <p>Date Time Period: 01/01/2003-01/01/2003</p> <p>Loop Identifier Code:</p> <p>Provider Phone #:</p> <p>MCO/PCP Name:</p> <p>PCP First Nam:</p> <p>PCP Middle Initial:</p> <p>Provider Phone #:</p>

Limitations Field	Description
Eligibility or Benefit Information	Default is F for limitation information.
Plan Code Description	Only be displayed if the limitation has been exceeded. For example: A90 – Only one eye exam allowed per year without justification.
Yes/No Condition or Response	Y for service requires Prior Authorization N for does not require Prior Authorization.
Product/Service ID Qualifier	From the transaction. For example. AD – American Dental Association, CJ – CPT Codes, HC – HCPCS Codes, ID – International Classification of Diseases Clinical Modification (ICD-9-CM) – Procedure, N4-National Drug Code, and ZZ – Mutually Defined. In this example the qualifier is CJ for CPT codes.
Product/Service ID	Procedure code submitted on the original limitation request transaction.
Modifiers 1-4	Only be displayed if indicated on the original limitation request transaction.
Eligibility Benefit Date Time Period	From and to dates of service supplied on the original limitation request transaction.

Viewing an Interactive 271 Eligibility Response

To view a previously submitted eligibility response that you sent interactively, open the 270 eligibility request form either from the toolbar or from the Forms menu.

Claim#	Client ID	Last Name	First Name	From DOS	To DOS	Last Submit Dt	Status
9628	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9627	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9626	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9625	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9624	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9623	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9622	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F
9621	1234567	TOM	TESTING	01/01/2007	01/01/2007	03/26/2007	F

Step 1 In the 270 Eligibility Request Form, select the claim # and client ID from the detail list. You will receive a message "Record with status of F cannot be updated". Select **OK**. The area in the red box highlights the detail list.

Step 2 Select **View** from the toolbar, and select **View Response**.

This action will display the original response for the interactive transaction. The claim number must be in a Finalized or Incomplete status.

If no data is displayed and the request is in an F status, refer to the View Batch Responses section in the Communications chapter, to determine the transaction that was sent as part of a batch submission.

837 Dental Forms

Before entering transactions, several lists can be created. This may be done now or as you key in data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider and Client. Policy Holder is also completed for those clients with other insurance. Refer to the Lists chapter of this handbook for information on how to complete these lists.

The Dental claim form has six screens that you will use to complete a claim depending on your provider type. They are:

- Header 1
- Header 2
- Header 3
- OI (for other insurance)
- Service 1
- Service 2

To access the Dental Claim Form from the PES main menu, select the icon for 837 Dental from the Toolbar or click on **Forms** in the Main Menu and select **837 Dental**.

837 Dental - Header 1

The dental claim form opens with Header 1. Use it to enter basic information such as provider and client identification.

The screenshot displays the '837 Dental' form within the 'EDS Provider Electronic Solutions' application. The form is titled '837 Dental' and has a status bar at the bottom showing 'New Record added...' and the date/time '3-26-07 6:27:33'. The form is divided into several sections:

- Summary:** Total Charge, OI Amount, Billed Amount, Services 1.
- Navigation:** Header 1, Header 2, Header 3, Service 1, Service 2.
- Provider Information:** Claim Frequency (dropdown), Original Claim # (text), Medicaid Provider ID (text), NPI (text), Taxonomy (text).
- Organization Information:** Last/Org Name (text), First Name (text).
- Client Information:** Client ID (text), Account # (text), Last Name (text), First Name (text), MI (text).
- Medical Data:** Release of Medical Data (Y/N dropdown), Benefits Assignment (Y/N dropdown), Report Type Code (dropdown), Report Transmission Code (dropdown), Attachment Ct (text).
- Table:** A table with columns: Claim#, Client ID, Last Name, First Name, Billed Amount, Last Submit Dt, Status.
- Actions:** Add, Copy, Delete, Undo All, Save, Find..., Print, Close.

Step 1 Enter data into all of the following fields to complete the Header 1.

Dental Header 1	Description
Claim Frequency	Select 1 to submit an original claim.
	<p>Replacing: Use the claim frequency 7 to replace the original claim (indicated by the ICN) with corrected claim information. You must complete all of the required fields in the claim prior to transmitting to EDS. This will result in the original claim being voided and the new information to process as a new claim.</p> <p>Note: If you want to replace a claim previously submitted through PES, you can Copy the original claim, change the Claim Frequency Indicator to a 7, enter the 15 digit ICN, and make corrections as needed to the claim, save the transaction and transmit the new claim.</p> <p>Tip: When using a claim frequency 7, this will void the original claim and have the payment withheld from future payments and a new claim with the corrected information will be created.</p> <p>Voiding: Use the claim frequency 8 to void the original claim (indicated by the ICN) and have the payment withheld from future payments. You must complete the claim exactly as it was originally submitted for this type of transaction.</p> <p>Note: If you want to void a claim previously submitted through PES, you can Copy the original claim, change Claim Frequency Indicator to a 8, enter the 15 digit ICN, save the transaction and transmit the new claim.</p>
Original Claim #	If the claim frequency is 7 or 8, enter the original 15-digit claim number assigned by EDS.
Medicaid Provider ID	9-digit billing provider number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
NPI	10-digit NPI. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
Client ID	Select the correct 7-digit client ID. This action will populate the Account Number, Last Name, First Name, and MI (Middle Initial) fields.
Release of Medical Data	Default: Yes, indicating that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Defaults: Yes, indicating that the client, or authorized person, authorizes benefits to be assigned to the provider.
Report Type Code	Code indicating the title or contents of a document, report or supporting item for this claim, if applicable. Note: Idaho Medicaid does not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.

Dental Header 1	Description
Report Transmission Code	Code defining the method or format by which reports are to be sent, if applicable.
Attachment Control	Report transmission code you assigned to the attachment. This number can be alpha, numeric, or a combination of both characters.

Step 2 Select the **Header 2** tab.

837 Dental - Header 2

Header 2 is used to enter data on a variety of fields including referring provider and prior authorization.

Step 1 Enter data into all of the following fields to complete the Header 2 tab.

Dental Header 2 Field	Description
Referring Provider ID:	<p>Click in Provider ID field and select the correct 9-nine digit Referring Provider number, or 10 digit NPI. This action populates the Taxonomy Code, Last/Org Name, and First Name fields. This is not a required field for dental services.</p> <p>Note: If the Referring Provider is not listed, or no data is displayed, double click in the field and follow the instructions in section the Lists chapter to add the data to the appropriate list.</p>

Dental Header 2 Field	Description
	Once the information has been saved, click on the Select button to return to the claim.
Referral Number:	Referring provider ID, UPIN or Medical license number. If the client is enrolled in Healthy Connections, enter the 9-digit Healthy Connections provider number in this field. (This field is only available if there is information noted in the Referring Provider ID field.)
Place of Service:	2-digit place of service code here at the Header or at the Service 1 detail. Refer to your Idaho Medicaid Provider Handbook for valid place of service codes for your provider type or specialty. A list of HIPAA place of service codes can be found in Appendix A - Lists.
EPSDT:	Select No or Yes to indicate if the service rendered is part of the Early and Periodic Screening Diagnosis and Treatment program. Note: Refer to Section 1.6 of the Idaho Medicaid Provider Handbook for additional information on the EPSDT program.
Prior Authorization:	Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS, or Qualis Health. This information may be entered in either the Header 2 tab or on the Service 1 tab.
Comment:	Comments that will clarify the services rendered, if applicable.

Step 2 Select the **Header 3** tab.

837 Dental - Header 3

Header 3 is used to enter accident or other insurance information. Depending on the services you render, you may not need to complete any of these fields.

Note If the client has other insurance, be sure to select Yes for the Other Insurance indicator and complete the Other Insurance (OI) tab.

Step 1 Enter data into all of the following fields to complete the Header 3.

Dental Header 3 Field	Description
Accident	<p>If the services are a result of an accident, complete the appropriate Accident fields. The indicators (Ind) are for:</p> <ul style="list-style-type: none"> • Employment: No or Yes • Other: No or Yes • Auto: No or Yes. If Y is selected for Auto, then State and County fields become active. • Date: If Y is selected for any of the indicators, then the date of the accident is required using the MMDDCCYY format.
Facility ID:	<p>If the services are rendered in place of service 21, 22 or 31 select the Facility ID for the Service Facility Location. Click in the Facility ID field and select the correct 9-nine digit or 10 digit Facility ID number. This action will populate the Taxonomy Code, and Facility Name fields.</p> <p>Note: If the Facility ID is not listed, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p>
Other Insurance Indicator:	<p>If the client has a primary insurance coverage for dental services, select Yes. This action will add an additional tab, titled OI.</p>

Step 2 Select the OI tab if client has a primary insurance coverage for dental services, or select **Service 1** tab.

837 Dental - OI (Other Insurance)

If you selected **Yes** for OI (Other Insurance) on Header 3, then the OI screen is activated and you must complete it.

Step 1 Enter data into the following fields to complete the Other Insurance tab.

Dental – OI Field	Description
Release of Medical Data	Select No or Yes to indicate that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Payer Responsibility	Code that indicates if the other insurance carrier is the Primary (first), Secondary (second), or Tertiary (third) payer.
Claim Filing Ind Code	Type of other insurance claim being submitted.
Adjustment Group Cd	Select the adjustment by the other insurance company.
Reason Codes/Amts	Code identifying the reason for the adjustment, the difference between the billed and paid amounts, made by the Other Insurance Carrier. Refer to the Appendix A - Lists for the valid Other Insurance Reason Codes (HIPAA Adjustment Reason Codes). Enter the amount indicated by the primary insurance for each reason code.
Paid Date/Amount	Date the primary insurance paid the claim using the MMDDCCYY format and the total amount paid by the primary.

Dental – OI Field	Description
Policy Holder Group #	Policy holder information for the client. The Group Name, Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected. Note: If the policy holder group number data has not been completed for the client, double click in the field and follow the instructions in the Lists chapter of this handbook to complete the Policy Holder List. Once the information has been saved, click on the Select button to return to the claim.
Add OI	Select the Add OI button to add additional insurance carriers and complete the OI information for the new carrier.
Copy OI	Select the Service # to be copied and click on the Copy OI button. Change the data as needed for the new service detail.
Delete OI	Select the Service # and click on the Delete OI button.

Step 2 Select the **Service 1** tab.

837 Dental - Service 1

Use the Service 1 tab to enter information about dates, place of service, procedure codes, data about the tooth/teeth, and prior authorization.

Step 1 Enter data into the following fields to complete the Service 1 tab.

Dental – Service 1 Field	Description
From DOS	From Date of Service (DOS) using the MMDDCCYY format.
To DOS	To Date of Service (DOS) using the MMDDCCYY format.
Place of Service	<p>Select the correct place of service if it is different from the place of service indicated on the Header 2 tab.</p> <p>Refer to your Idaho Medicaid Provider Handbook for valid place of service codes for your provider type or specialty. A list of HIPAA place of service codes can be found in Appendix A - Lists.</p>
Procedure	5-digit American Dental Association procedure code or select the code if you have created a list.
Modifiers 1, 2, 3, and 4	Not used for dental service claims. Idaho Medicaid does not allow modifiers for dental services.
Tooth	Tooth number, if applicable.
Surface	Surface, if applicable.
Quadrants	Area of the oral cavity, if applicable.
Prior Authorization	Prior authorization number, if applicable, assigned by Idaho Medicaid. This information may be entered in either the Header 2 tab or on the Service 1 tab.
Placement Indicator	Click in the Placement Indicator field and select the correct placement indicator, if applicable. If the Placement Indicator field is R, the placement date must be completed using the MMDDCCYY format.
Units	Number of units performed for the service billed.
Unit Rate	Per unit rate for the services billed. This field will calculate the billed amount by multiplying the units times the per unit rate. If you have selected a procedure code from the procedure list that contains a procedure amount, the unit rate will auto populate.
Billed Amount	Calculated by entering the units and the per unit rate for the services performed for this procedure. This field can be updated.
Add Srv	If more than one service was rendered, select the Add Srv button and complete the screen for the second service. The maximum number of details is 50 per claim.
Copy Srv	Select the Copy Srv button and make correction to the data as needed.
Delete Srv	Select the detail to be deleted then select the Delete Srv button.

- Step 2** If no additional services were rendered and the performing provider is part of a group, select the **Service 2** tab to add the performing provider or orthodontic information for each service detail as applicable.
- Step 3** If this is the last claim to be entered and you do not need to complete the OI, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Dental - Service 2

This screen is required for orthodontic services. It also is used if the rendering/performing provider is attached to a group billing provider. The performing provider information must be completed for each detail (charge) submitted.

- Step 1** Enter data into the following fields to complete the Service 2 tab.

Dental – Service 2 Field	Description
Appliance Placement Date:	Appliance placement date using the MMDDCCYY format, if applicable.
Rendering Provider	
Medicaid Provider ID:	9-digit provider ID of the provider who rendered the service. Required when the rendering provider is attached to a group provider number. If the billing provider number on the Header 1 screen was set up in the Billing Provider list with an entity type qualifier of 2, then the Rendering provider must be an entity type qualifier of 1 for Person (individual provider). Taxonomy Code, Last/Org Name, and First Name will

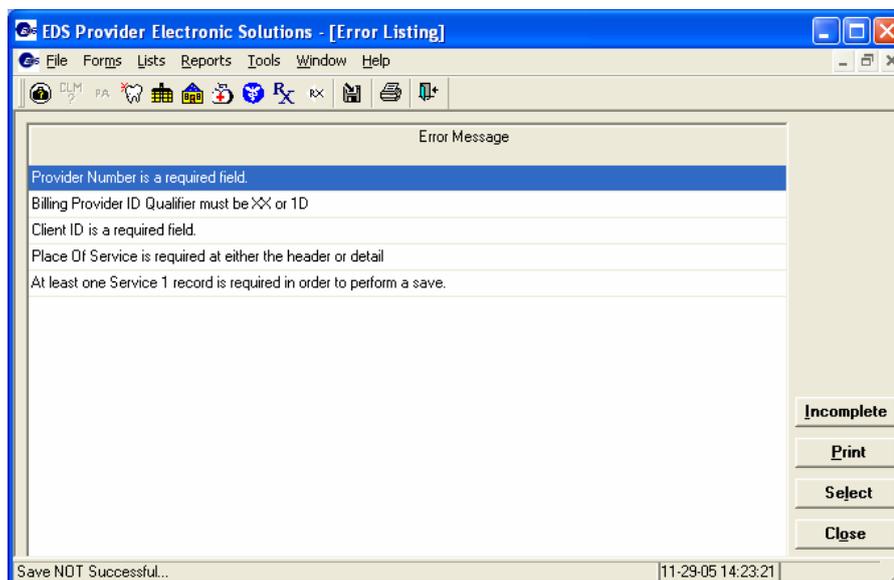
	default from the Rendering Provider ID selected.
NPI	10-digit NPI of the provider who rendered the service. Required when the rendering provider is attached to a group provider number. If the billing provider number on the Header 1 screen was set up in the Billing Provider list with an entity type qualifier of 2, then the Rendering provider must be an entity type qualifier of 1 for Person (individual provider). Taxonomy Code, Last/Org Name, and First Name will default from the Rendering Provider ID selected.
Srv #:	Rendering provider for each service billed.

Step 2 If this is the last claim to be entered and you do not need to complete the OI screen, select the **Save** button.

Step 3 Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

Correcting Errors

If all the required data is not included in a form, a listing of error messages will display for you to correct. Either double click on the error message, or click on the error message and click on the **Select** button.



The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

837 Institutional - Inpatient Claim Form

There are three different institutional provider claim forms in PES that can be found on the Main Menu:

- Inpatient
- Nursing Home
- Outpatient

Before entering transactions, several lists can be created. This may be done now or as you key in data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider and Client. Policy Holder is also completed for those clients with other insurance. Refer to the Lists chapter for information on how to complete these lists.

The Institutional Inpatient claim form has nine screens that you will use to complete a claim depending on the services you bill. They are:

- Header 1
- Header 2
- Header 3
- Header 4
- Header 5
- OI (for other insurance)
- Crossover
- Service
- RX (for prescriptions)

Access the Institutional Inpatient Claim Form from the PES main menu by selecting the icon from the toolbar or clicking on **Forms** in the Main Menu bar and selecting **837 Institutional Inpatient**.

837 Institutional Inpatient - Header 1

The Inpatient claim form opens with Header 1. Use it to enter basic information such as provider and client identification.

The screenshot shows the '837 Institutional Inpatient' form in the 'EDS Provider Electronic Solutions' application. The form is titled '837 Institutional Inpatient' and has a menu bar with 'File', 'Edit', 'View', 'Forms', 'Tools', 'Window', and 'Help'. The main area contains several sections of input fields:

- Total Charge**: .00, **OI Amount**: .00, **Billed Amount**: .00, **Services**: 1
- Header 1** (selected), Header 2, Header 3, Header 4, Header 5, Service
- Type Of Bill**: dropdown, **Original Claim #**: text
- Medicaid Provider ID**: text, **NPI**: text, **Taxonomy**: text
- Last/Org Name**: text, **First Name**: text
- Client ID**: text, **Account #**: text
- Last Name**: text, **First Name**: text, **MI**: text
- Patient Status**: text, **Medical Record #**: text
- From DDS**: 00/00/0000, **To DDS**: 00/00/0000, **Prior Authorization**: text
- Release of Medical Data**: Y, **Benefits Assignment**: Y, **Report Type Code**: dropdown
- Report Transmission Code**: dropdown, **Attachment Ctl**: text

On the right side, there are buttons: **Add**, **Copy**, **Delete**, **Undo All**, **Save**, **Find...**, **Print**, and **Close**.

At the bottom, there is a table with the following columns: **Claim#**, **Client ID**, **Last Name**, **First Name**, **Billed Amount**, **Last Submit Dt**, and **Status**. The status bar at the bottom shows 'New Record added...' and the date/time '3-26-07 6:31:57'.

Tip If a Provider or Client ID is not listed in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists section to add the provider or client to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

Step 1 Enter data into all of the following fields to complete the Header 1.

Institutional Inpatient – Header 1 Field	Description
Type of Bill	3-digit numeric type of bill code for the services rendered. See Appendix A - Lists for valid Idaho Medicaid type of bill codes.
	<p>Replacing: Use the Type of Bill code ending in 7 to replace the original claim (indicated by the ICN) with corrected claim information. You must complete all of the required fields in the claim prior to transmitting to EDS. This will result in the original claim being voided and the new information to reprocess as a new claim.</p> <p>Note: If you want to replace a claim previously submitted through PES, you can Copy the original claim, change the type of bill code to end with a 7, enter the 15 digit ICN, and make corrections as needed to the claim. Then Save the transaction and transmit the new claim.</p> <p>Tip: When using a claim frequency 7, this will void the original claim and have the payment withheld from future payments and a new claim with the corrected information will be created.</p> <p>Voiding: Use the Type of Bill code ending in 8 to void the original claim (indicated by the ICN) and have the payment withheld from future payments. You must complete the claim exactly as it was originally submitted for this type of transaction.</p> <p>Note: If you want to void a claim previously submitted through PES, you can Copy the original claim, change the type of bill code to end with a 8, and enter the 15 digit ICN. Then Save the transaction and transmit the new claim.</p>
Original Claim #	If the third digit of the Type of Bill code is a 7 or 8, enter original 15-digit claim number assigned by EDS.
Medicaid Provider ID	9-nine digit billing provider number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
NPI	10-ten digit NPI. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.

Institutional Inpatient – Header 1 Field	Description
Client ID	7-seven digit billing Client ID number. This action will populate the Account Number, Last Name, First Name, and MI (Middle Initial) fields.
Patient Status	2-digit patient status code. See the Appendix A – Lists for a valid list of Patient Status codes and their descriptions.
Medical Record #	Medical record number assigned by you that identifies the client in your records. This is an optional field and can contain both alpha and numeric characters.
From DOS	From Date of Service (DOS) using the MMDDCCYY format.
To DOS	To Date of Service (DOS) using the MMDDCCYY format.
Prior Authorization	Prior Authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS, or Qualis Health.
Release of Medical Data	Default: Yes, indicating that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Default: Yes, indicating that the client, or authorized person, authorizes benefits to be assigned to the provider.
Report Type Code	Code indicating the title or contents of a document, report or supporting item for this claim, if applicable. Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.
Report Transmission Code	Defines the method or format by which reports are to be sent, if applicable.
Attachment Control	Report Transmission code assigned to the attachment. Number can be alpha, numeric, or a combination of both characters.

Step 2 Select the **Header 2** tab.

837 Institutional Inpatient - Header 2

Use Header 2 to enter information for diagnosis, surgery, and attending providers.

Tip If a code is not entered in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the code to the appropriate list. Once the information has been saved, click the **Select** button to return to the claim. This works for any field with a drop down list.

Step 1 Enter data into all of the following fields to complete the Header 2.

Institutional Inpatient – Header 2 Field	Description
Primary Diagnosis Code	Primary 3-5 digit ICD-9 CM diagnosis code related to the visit.
Other Diagnosis Codes	Additional 3-5 digit ICD-9 CM diagnosis codes related to the visit, if applicable.
Admit Diagnosis Code	Admit 3-5 digit ICD-9 CM diagnosis code corresponding to the diagnosis of the client's condition, which prompted admission to the hospital.
E-Code	If service is accident related, enter the 3-5 digit ICD-9 CM diagnosis code that represents the cause of injury.
Surgical Codes/Dates	3-5 digit ICD-9-CM surgical procedure code that identifies the procedure that was performed during the billing period as shown in the client's medical record. Enter the date that corresponds to the listed surgical procedure using the MMDDCCYY format.

Institutional Inpatient – Header 2 Field	Description
	<p>Note Diagnosis and procedure codes can only contain alpha-numeric characters and cannot contain decimal points.</p>
<p>Attending - Provider ID</p>	<p>Identification number for the provider who rendered the service. If you have not added the provider to your Other Provider list, you can do it at this time. You can use the provider’s UPIN, Idaho Medicaid provider number, or medical license number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.</p>

Step 2 Select the Header 3 tab.

837 Institutional Inpatient - Header 3

Use Header 3 to enter information for occurrence, occurrence span, condition codes, days covered, coinsurance days, and lifetime reserve days.

Tip If a code is not entered in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the code to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

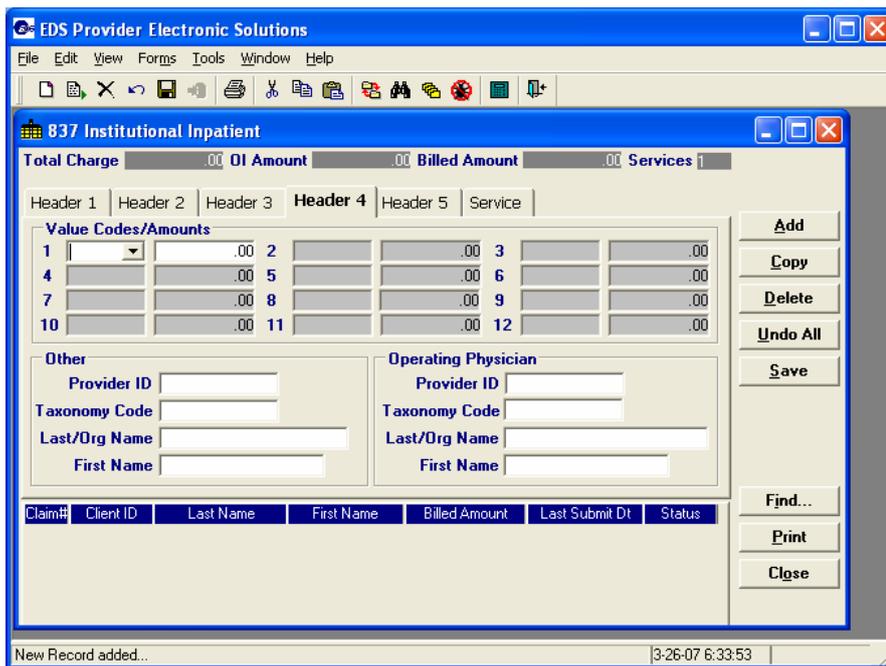
Step 1 Enter data into all of the following fields to complete the Header 3.

Institutional Inpatient – Header 3	Description
Occurrence Codes/Dates	2-digit occurrence code, if applicable. Refer to Appendix A – Lists for valid occurrence codes and description defining a significant event relating to this service. Enter the date associated with the code listed using the MMDDCCYY format.
Occurrence Span Codes/Dates	2-digit occurrence span code, if applicable. Refer to Appendix A - Lists for valid occurrence span codes and description defining the occurrence span information that applies to the claim or encounter. Enter the date associated with the code listed using the MMDDCCYY format. Note: Occurrence Codes and Occurrence Span Codes share the same list.
Condition Codes	2-digit Condition Code, if applicable. Refer to Appendix A – Lists for valid Condition Codes used to identify conditions relating to this bill that may affect Payer processing.
Days Covered	Number of covered days. Do not count the discharge day as a covered day.
Non-Covered	Number of non-covered days, if applicable. Do not count discharge day as non-covered day, if applicable.
Coinsurance	Number of coinsurance days that apply to this claim, if applicable.
Lifetime Reserve	Number of lifetime reserve days, if applicable.

Step 2 Select the **Header 4** tab.

837 Institutional Inpatient - Header 4

Use Header 4 to enter information for value codes, Healthy Connections provider, and operating physician.



Step 1 Enter data into all of the following fields to complete the Header 4.

Institutional Inpatient – Header 4 Field	Description
Value Codes/Amounts	2-digit value code, if applicable. Refer to Appendix A - Lists for valid value codes and descriptions that apply to the claim or encounter. Enter the corresponding value code amount.
Other Provider ID	Additional providers who may have assisted with this client for the services rendered. Select the correct provider information. This action populates the Taxonomy Code, Last/Org Name and First Name fields. Note: Use this field to enter the Healthy Connections number of the referring provider. You must add this information to the Other Provider list. The Provider ID from the Other Provider list displays in this field.
Operating Physician	Operating physician when surgical procedures have been performed during this client’s hospitalization. Select the correct provider information. This action populates the Taxonomy Code, Last/Org Name, and First Name fields. This field is required when billing Surgical Procedure Code on the Header 2 tab. Note: You must add this information to the Other Provider list. The Provider ID from the Other Provider list displays in this field.

Step 2 Select the **Header 5** tab.

837 Institutional Inpatient - Header 5

Use Header 5 to enter admission, discharge, comments, and other insurance information associated to the services rendered.

Step 1 Enter data into all of the following fields to complete the Header 5.

Institutional Inpatient – Header 5 Field	Description
Admission	
Date	Date the client was admitted to the facility using the MMDDCCYY format.
Hour	2-digit hour the client was admitted into the facility.
Type	1-digit code that identifies the priority of this admission. Refer to Lists for information on how to create a list of Admission Type Codes.
Source	1-digit Admission Source code indicating source of Admission. Refer to Appendix A - Lists for valid Admission Type Codes and description that applies to the claim.
Discharge Hour	2-digit hour the client was discharged from the facility.
Comment Cd	Code indicating the nature of the contents in the comment field on the claim, if applicable. This field is required if using the Comment field.
Comment	Comments that clarify services, if applicable.
Other Insurance Indicator	If the client has a primary insurance coverage for institutional services, select Yes. This adds additional tab titled OI. Be sure to complete the OI screen.

Institutional Inpatient – Header 5 Field	Description
Crossover Indicator	If the client has Medicare coverage for Institutional services, select Yes. This action populates a new tab titled Crossover. Be sure to complete the Crossover screen.

- Step 2** If there is no other insurance, select the **Service** tab.
- Step 3** If there is other insurance, select the **OI** tab.
- Step 4** If the client has Medicare as a primary insurance, select the **Crossover** tab.

837 Institutional Inpatient - OI (Other Insurance)

If Yes is selected for the Other Insurance Indicator in Header 5, then you must complete the OI tab to enter information on other insurance and policy holder.

Tip If a code is not entered in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the code to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

- Step 1** Enter data into all of the following fields to complete the OI tab.

Institutional Inpatient – OI Field	Description
Release of Medical Data	Code indicating whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.

Institutional Inpatient – OI Field	Description
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Payer Responsibility	Code that indicates if the other insurance carrier is the Primary (first), Secondary (second), or Tertiary (third) payer.
Claim Filing Ind Code	Type of other insurance claim being submitted.
Adjustment Group Cd	Code identifying the general category of payment adjustment by the other insurance company.
Reason Codes/Amts	Code identifying the reason for the adjustment, the difference between the billed and paid amounts, made by the Other Insurance Carrier. Refer to the Appendix A – Lists for the valid Other Insurance Reason Codes (HIPAA Adjustment Reason Codes). Enter the amount indicated by the primary insurance for each reason code.
Paid Date/Amount	Date the primary insurance paid the claim using the MMDDCCYY format and the total amount paid by the primary.
Policy Holder Group #	<p>Policy holder information for the client. The Group Name, Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.</p> <p>Note: If the policy holder group number data has not been completed for the client, double click in the field and follow the instructions in the “Lists” section of this handbook to complete the Policy Holder List. Once the information has been saved, click on the Select button to return to the claim.</p>
Add OI	Select the Add OI button and complete the OI information for the new carrier.
Copy OI	Select the Service # to be copied and click on the Copy OI button. Change the data as needed for the new service detail.
Delete OI	Select the Service # and click on the Delete OI button.

Step 2 Select the **Service** tab.

837 Institutional Inpatient - Crossover

If Yes is selected for the Crossover Indicator in Header 5, then you must complete the Crossover tab.

Tip If the policy holder Carrier Code is not listed for the client, double click in the field and follow the instructions in the Lists chapter to data to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

Step 1 Enter data into all of the following fields to complete the Crossover tab.

Institutional Inpatient – Crossover Field	Description
Release of Medical Data	Code indicating whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Claim Filing Ind Code	Type of other insurance claim being submitted.
Medicare Providers	
Referring ID	Identification number of the Medicare referring provider.
Last/Org Name	Last/Org Name of the referring provider.
Rendering ID	Identification number of the rendering provider.
Last/Org Name	Last/Org name of the rendering provider.

Institutional Inpatient – Crossover Field	Description
Medicare ICN	Claim ICN number assigned by Medicare. (The ICN must be at least 13 digits.)
Paid Amount	Amount paid by Medicare.
Paid Date	Medicare date of payment using the MMDDCCYY format.
Amounts	
Allowed	Allowed amount from Medicare.
Deductible	Deductible amount Medicare applied to the claim.
Coinsurance	Coinsurance amount Medicare applied to the claim.
Policy Holder Carrier Code	Policy holder information for the client. The Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.

Step 2 Select the **Service** tab.

837 Institutional Inpatient - Service

After completing the Header 1 – 5, Other Insurance, and Crossover tabs, you must complete the Service tab. Enter data on units, revenue codes, billed amount, and prescriptions.

Step 1 Enter data into all of the following fields to complete the Service tab.

Institutional Inpatient – Service Field	Description
Revenue Code	3-digit revenue code that identifies the specific accommodation or ancillary service.
Basis of Measurement	Specifies the units in which a value is being expressed as DAys or UNit. Defaults: UNit.
Units	Number of units performed for the revenue code billed.
Unit Rate	Per Unit Rate for the services billed. Calculates the billed amount by multiplying the units times the per unit rate.
Billed Amount	Calculates by entering the units and the per unit rate for the revenue code billed. This field can be updated.
RX Ind	Select No or Yes to indicate if the client received medication during the service. When Yes is selected, the RX tab is added to the claim form for data entry and that tab must be completed.
Add Srv	Add additional details by clicking on the Add Srv button and completing the screen again.
Copy Srv	Select the Service # to be copied and click on the Copy Srv button. Change the data as needed for the new service detail.
Delete Srv	Select the Service # and click on the Delete Srv button.

Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI, Crossover, or RX tabs, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Institutional Inpatient - RX

If you selected **Yes** for the RX Ind (Prescription Indicator) on the Service tab, then the RX screen is activated and must be completed.

Step 1 Enter data into all of the following fields to complete the RX tab.

Institutional Inpatient – RX Field	Description
NDC	11-digit NDC (National Drug Code) for any prescriptions dispensed to the client.
Prescription Number	Prescription number for the medication prescribed.
Units	Number of units dispensed for the prescription.
Basis of Measurement	Specifies units in which a value is being expressed as F2 (International Unit), GR (gram), ML (milliliter), or UN (unit).
Unit Price	Price per unit of product, service, commodity, etc.
Add RX	To add additional NDCs, select the Add RX button and complete the NDC information again.
Copy RX	Select the Service # to be copied and click on the Copy Srv button. You can then make changes to the data as needed for a new service detail.
Delete RX	Select the Service # and click the Delete Srv button.

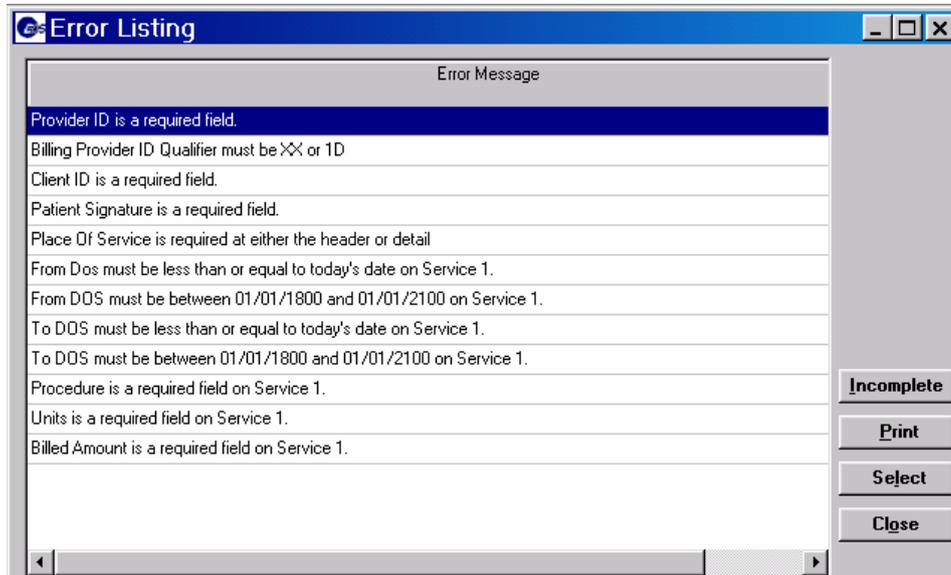
Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI or Crossover tabs, select the **Save** button. Select the **Close** button and follow

the instructions in the Communication Submission section on how to transmit these claim(s).

Correcting Errors

If all the required data is not included in a Form or List, a listing of error messages will display for you to correct.



Double click on the error message or click on the error message and click on the **Select** button.

The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

837 Institutional - Nursing Home Claim Form

There are three different institutional provider claim forms in PES that can be found on the Main Menu:

- Inpatient
- Nursing Home
- Outpatient

Before entering transactions, several lists can be created. This may be done now or as you key in data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider and Client. Policy Holder is also completed for those clients with other insurance. Refer to Lists for information on how to complete these lists.

The Institutional Nursing Home claim form has 8 screens that you will use to complete a claim. They are:

- Header 1
- Header 2
- Header 3
- Header 4
- OI (for other insurance)
- Crossover
- Service
- RX (for prescriptions)

Access the Institutional Nursing Home Claim Form from the PES main menu by selecting the Institutional Nursing Home icon or clicking on **Forms** in the Main Menu and selecting **837 Institutional Nursing Home**.

837 Institutional Nursing Home - Header 1

The Inpatient claim form opens with Header 1. Use it to enter basic information such as provider and client identification.

Tip If a provider or client ID is not listed in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the provider or client to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

Step 1 Enter data into all of the following fields to complete the Header 1.

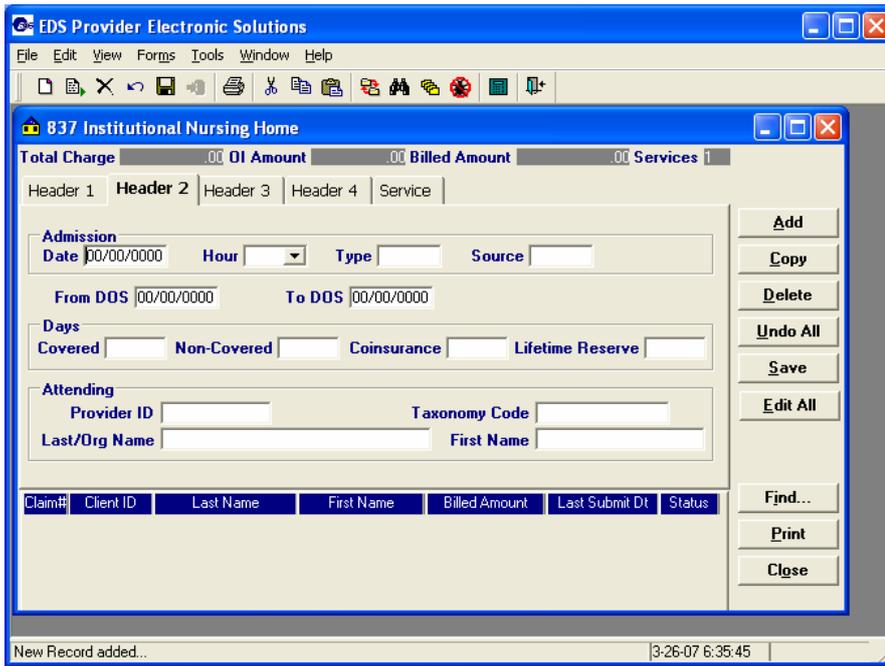
Institutional Nursing Home – Header 1 Field	Description
Type of Bill	3-digit numeric type of bill code for the services rendered. See Appendix A – Lists for valid Idaho Medicaid type of bill codes.
Original Claim #	If the third digit of the type of bill code is a 7 or 8 enter the original 15-digit claim number assigned by EDS.
	<p>Replacing: Use the type of bill code ending in 7 to replace the original claim (indicated by the ICN) with corrected claim information. You must complete all of the required fields in the claim prior to transmitting to EDS. This will result in the original claim being voided and the new information to reprocess as a new claim.</p> <p>Note: To replace a claim previously submitted through PES, you can copy the original claim, change the type of bill code to end with a 7, enter the 15 digit ICN, and make corrections as needed to the claim. Then save the transaction and transmit the new claim.</p> <p>Tip: When using a claim frequency 7, this will void the original claim and have the payment withheld from future payments and a new claim with the corrected information will be created.</p> <p>Voiding: Use the type of bill code ending in 8 to void the original claim (indicated by the ICN) and have the payment withheld from future payments. You must complete the claim exactly as it was originally submitted for this type of transaction.</p> <p>Note: If you want to void a claim previously submitted through PES, you can copy the original claim, change the type of bill code to end with a 8, and enter the 15 digit ICN. Then save the transaction and transmit the new claim.</p>
Original Claim #	If the third digit of the type of bill code is a 7 or 8, enter the original 15-digit claim number assigned by EDS.
Medicaid Provider ID	9-nine digit billing provider number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.

Institutional Nursing Home – Header 1 Field	Description
NPI	10-ten digit NPI. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
Client ID	7-seven digit billing Client ID number. This action will populate the Account Number, Last Name, First Name, and MI (Middle Initial) fields.
Patient Status	2-digit patient status code. See Appendix A – Lists for a valid list of Patient Status codes and their descriptions.
Medical Record #	Medical record number assigned by you that identifies the client in your records. This is an optional field and can contain both alpha and numeric characters.
Release of Medical Data	Default: Yes, indicating that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Default: Yes, indicating that the client, or authorized person, authorizes benefits to be assigned to the provider.
Prior Authorization	Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS or Qualis Health.
Report Type Code	Code indicating the title or contents of a document, report or supporting item for this claim, if applicable. Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.
Report Transmission Code	Code defining method or format by which reports are to be sent, if applicable.
Attachment Control	Report transmission code you have assigned to the attachment. This number can be alpha, numeric or a combination of both characters.

Step 2 Select the **Header 2** tab.

837 Institutional Nursing Home - Header 2

Use Header 2 to enter information for admission, dates of service, and attending providers.



Step 1 Enter data into all of the following fields to complete the Header 2.

Institutional Nursing Home – Header 2 Field	Description
Admission	
Date	Date the client was admitted to the facility using the MMDDCCYY format.
Hour	2-digit hour the client was admitted into the facility.
Type	1-digit code that identifies the priority of this admission. Refer to the Lists chapter for information on how to create a list of Admission Type Codes.
Source	1-digit Admission Source code indicating the source of Admission. Refer to Appendix A - Lists for valid Admission Type Codes and description that applies to the claim.
From DOS	From Date of Service (DOS) using the MMDDCCYY format.
To DOS	To Date of Service (DOS) using the MMDDCCYY format.
Days Covered	Number of covered days. Do not count the discharge day as a covered day.
Non-Covered	Number of non-covered days, if applicable. Do not count the discharge day as a non-covered day.

Institutional Nursing Home – Header 2 Field	Description
Coinsurance	Number of coinsurance days that apply to this claim, if applicable.
Lifetime Reserve	Number of lifetime reserve days, if applicable.
Attending	
Provider ID	Click in the Provider ID field and select the identification number for the provider who rendered the service. If you have not added the provider to your Other Provider list, double click in the field and add the provider. You can use the provider's UPIN, Idaho Medicaid provider number, or medical license number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.

Step 2 Select the **Header 3** tab.

837 Institutional Nursing Home - Header 3

Use Header 3 to enter diagnosis codes, comments and other insurance information associated to the services rendered

Step 1 Enter data into all of the following fields to complete the Header 3.

Institutional Nursing Home – Header 3 Field	Description
Primary Diagnosis Code	Primary 3-5 digit ICD-9 CM diagnosis code related to the visit.

Institutional Nursing Home – Header 3 Field	Description
Other Diagnosis Codes	Additional 3-5 digit ICD-9-CM diagnosis codes related to the visit, if applicable.
Admit Diagnosis Code	Admit 3-5 digit ICD-9-CM diagnosis code corresponding to the diagnosis of the client's condition, which prompted admission to the nursing home.
E-Code	If service is accident related, enter the 3 to 5 digit ICD-9-CM diagnosis code that represents the cause of injury.
Comment Cd	Indicates the nature of the contents in the comment field on the claim, if applicable. This field is required if using the Comment field.
Comment	Comments that will clarify services, if applicable.
Other Insurance Indicator	If the client has a primary insurance coverage for nursing home services, select Yes. This action will add an additional TAB titled "OI". Be sure to complete the OI screen.
Crossover Indicator	If the client has Medicare coverage for nursing home services select Yes. This action will populate a new TAB titled "Crossover". Be sure to complete the Crossover screen.

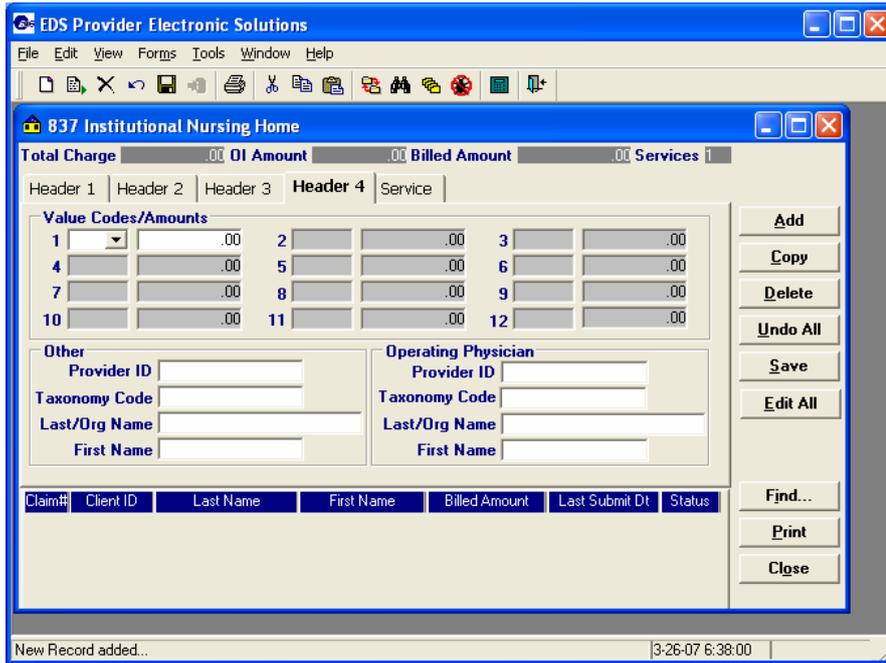
Step 2 Select the **Header 4** tab.

Step 3 If there is other insurance, select the **OI** tab.

Step 4 If the client has Medicare as a primary insurance, select the **Crossover** tab.

837 Institutional Nursing Home - Header 4

Use Header 4 to enter information for value codes, Healthy Connections provider, and operating physician.



Step 1 Enter data into all of the following fields to complete the Header 4.

Institutional Nursing Home – Header 4 Field	Description
<p>Value Codes/Amounts</p>	<p>2-digit Value code, if applicable. Refer to Appendix A – Lists for valid Value Codes and description defining the Value code information that applies to the claim or encounter. Enter the corresponding Value Code amount. If the client has a patient liability use the value code 31 and the amount of the client’s liability for the dates of services billed.</p>
<p>Other Provider ID</p>	<p>Identify any additional providers who may have assisted with this client for the services rendered. Select the correct provider information for any additional physician who provides service to the client while in the nursing home, if applicable. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.</p> <p>Note: Use this field to enter the Healthy Connections number of the referring provider. You must add this information to the Other Provider list, and the Provider ID from the Other Provider list will display in this field.</p>

Institutional Nursing Home – Header 4 Field	Description
<p>Operating Physician</p>	<p>Identify the operating physician when surgical procedures have been performed during this client’s hospitalization. Select the correct provider information, if applicable. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.</p> <p>Note: You must add this information to the Other Provider list, and the Provider ID from the Other Provider list will display in this field.</p>

Step 2 Select the **Header 5** tab.

837 Institutional Nursing Home - OI (Other Insurance)

If Yes is selected for the Other Insurance Indicator in Header 3, then you must complete the OI tab to enter information on other insurance and policy holder.

Step 1 Enter data into all of the following fields to complete the OI tab.

Institutional Nursing Home – OI Field	Description
<p>Release of Medical Data</p>	<p>Code indicating whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.</p>
<p>Benefits Assignment</p>	<p>Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.</p>
<p>Payer Responsibility</p>	<p>Indicates if the other insurance carrier is the Primary (first), Secondary (second), or Tertiary (third) payer.</p>

Institutional Nursing Home – OI Field	Description
Claim Filing Ind Code	Type of other insurance claim being submitted.
Adjustment Group Cd	Identifies the general category of payment adjustment by the other insurance company.
Reason Codes/Amts	Identifies the reason for the adjustment, the difference between the billed and paid amounts, made by the Other Insurance Carrier. Refer to Appendix A - Lists for the valid Other Insurance Reason Codes (HIPAA Adjustment Reason Codes). Enter the amount indicated by the primary insurance for each reason code.
Paid Date/Amount	Date the primary insurance paid the claim using the MMDDCCYY format and the total amount paid by the primary.
Policy Holder Group #	Policy holder information for the client. The Group Name, Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected. Note: If the policy holder group number data has not been completed for the client, double click in the field and follow the instructions in the "Lists" section of this handbook to complete the Policy Holder List. Once the information has been saved, click on the Select button to return to the claim.
Add OI	To add additional insurance carriers, select the Add OI button and complete the OI information for the new carrier.
Copy OI	Select the Service # to be copied and click on the Copy OI button. Change the data as needed for the new service detail.
Delete OI	Select the Service # and click on the Delete OI button.

Step 2 Select the **Service** tab.

837 Institutional Nursing Home - Crossover

If Yes is selected for the Crossover Indicator in Header 3, then you must complete the Crossover tab.

Step 1 Enter data into all of the following fields to complete the Crossover tab.

Institutional Nursing Home – Crossover Field	Description
Release of Medical Data	Code indicating whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Claim Filing Ind Code	Type of other insurance claim being submitted.
Medicare Providers	
Referring ID	Identification number of the Medicare referring provider.
Last/Org Name	Last/Org Name of the referring provider.
Rendering ID	Identification number of the rendering provider.
Last/Org Name	Last/Org name of the rendering provider.
Medicare ICN	Claim ICN number assigned by Medicare. (must be at least 13 digits.)
Paid Amount	Amount paid by Medicare.
Paid Date	Medicare date of payment using the MMDDCCYY format.
Amount	
Allowed	Allowed amount from Medicare.
Deductible	Deductible amount Medicare applied to the claim.

Institutional Nursing Home – Crossover Field	Description
Coinsurance	Coinsurance amount Medicare applied to the claim.
Policy Holder Carrier Code	<p>Policy holder information for the client. The Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.</p> <p>Tip: If the policy holder carrier code data has not been completed for the client, double click in the field and follow the instructions in the Lists chapter. Once the information has been saved, click on the Select button to return to the claim. This works for any field with a drop down list.</p>

Step 2 Select the **Service** tab.

837 Institutional Nursing Home - Service

After completing the Header 1 – 4, Other Insurance, and Crossover tabs, you must complete the Service tab. Enter data on revenue codes, units, billed amount, and prescriptions.

Step 1 Enter data into all of the following fields to complete the Service tab.

Institutional Nursing Home – Service Field	Description
From DOS	From Date of Service (DOS) using the MMDDCCYY format.
To DOS	To Date of Service (DOS) using the MMDDCCYY format.
Revenue Code	3-digit revenue code that identifies the specific accommodation or ancillary service.

Institutional Nursing Home – Service Field	Description
Basis of Measurement	Specifies the units in which a value is being expressed as DAys or UNit. Default is UNit.
Units	Number of units performed for the revenue code billed.
Unit Rate	Per unit rate for services billed. Field calculates the billed amount by multiplying the units times the per unit rate.
Billed Amount	Calculated by entering the units and the per unit rate for the revenue code billed. This field is updateable.
RX Ind	Select No or Yes to indicate if the client received medication during the service. When Yes is selected, the RX tab is added to the claim form for data entry and that tab must be completed.
Add Srv	Add additional details by clicking on the Add Srv button and completing the screen again.
Copy Srv	Select Service # to be copied and click on the Copy Srv button. Change data as needed for the new service detail.
Delete Srv	Select the Service # and click the Delete Srv button.

Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI, Crossover, or RX tabs, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Institutional Nursing Home - RX

If you selected Yes for the RX Ind (Prescription Indicator) on the Service tab, then the RX screen is activated and must be completed.

Step 1 Enter data into all of the following fields to complete the RX tab.

Institutional Nursing Home – RX Field	Description
NDC	11-digit NDC (National Drug Code) for any prescriptions dispensed to the client.
Prescription Number	Prescription number for the medication prescribed.
Units	Number of units dispensed for the prescription.
Basis of Measurement	Code that specifies the units in which a value is being expressed as F2 (international unit), GR (gram), ML (milliliter), or UN (unit).
Unit Price	Price per unit of product, service, commodity, etc.
Add RX	To add additional NDCs, select the Add RX button and complete the NDC information again.
Copy RX	To copy any service, select the Service # to be copied and click on the Copy Srv button. You can then make changes to the data as needed for a new service detail.
Delete RX	If you added a service in error, select the Service # and click on the Delete Srv button.

Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI or Crossover tabs, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Institutional Nursing Home - Edit All

PES offers an **Edit All** feature for creating nursing home claims. The **Edit All** button is located on the right side of the screen. Each claim to be edited must be in an R (ready to transmit) status. There are two methods of copying your claims to allow for the Edit All feature.

- Select a previously submitted claim in an F (finalized) status from the list of previously finalized claims, select the **Copy** button, and then select **Save**.
- Select a batch of previously submitted claims, copy the entire batch and save them as new claims. Follow the instructions on batch resubmission in the Communications chapter to copy claims from a previously submitted batch.

Editing Existing Claims To Submit As New Claims

Step 1 Select the **Edit All** button.

Step 2 Complete the From and To date of service (DOS) fields.

Step 3 Enter the number of days associated to the date span.

Step 4 Select **OK**. The next message that displays verifies the number of claim forms to be updated. If this is the correct number of forms select **Yes**.

Step 5 Review each form to validate the billed amount, other insurance and patient liability is correct for the number of days billed on the claim.

Step 6 After all revisions have been completed, select the **Close** button

Step 7 Follow the instructions on Submission in the Communications chapter to transmit these claim(s).

Correcting Errors

If all the required data is not included in a Form, a listing of error messages will display for you to correct.

Double-click on the error message or click on the error message and click the **Select** button.

The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

837 Institutional - Outpatient Claim Form

There are three different institutional provider claim forms in PES that can be found on the Main Menu:

- Inpatient
- Nursing Home
- Outpatient

Before entering transactions, several lists can be created. This may be done now or as you key in data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider and Client. Policy Holder is also completed for those clients with other insurance. Refer to the Lists chapter for information on how to complete these lists.

The Institutional Outpatient claim form has nine screens that you will use to complete a claim depending on your provider type. The following is a list of the Institutional Outpatient screens:

- Header 1
- Header 2
- Header 3
- Header 4
- Header 5
- OI (for other insurance)
- Crossover
- Service
- RX (for prescriptions)

Access the Institutional Outpatient Claim Form from the PES main menu by either selecting the icon for the Institutional Outpatient claim by clicking on **Forms** in the Main Menu and selecting **Institutional Outpatient**.

837 Institutional Outpatient - Header 1

The Outpatient claim form opens with Header 1. Use it to enter basic information such as provider and client identification.

Step 1 Enter data into all of the following fields to complete the Header 1.

Institutional Outpatient – Header 1 Field	Description
Type of Bill	3-digit numeric type of bill code for the services rendered. See Appendix A - Lists for valid Idaho Medicaid type of bill codes.
Original Claim #	If the third digit of the type of bill code is 7 or 8, enter the original 15-digit claim number assigned by EDS.
	<p>Replacing: Use the type of bill code ending in 7 to replace the original claim (indicated by the ICN) with corrected claim information. You must complete all of the required fields in the claim prior to transmitting to EDS. This will result in the original claim being voided and the new information to reprocess as a new claim.</p> <p>Note: If you want to replace a claim previously submitted through PES, you can copy the original claim, change the type of bill code to end with a 7, enter the 15 digit ICN, and make corrections as needed to the claim. Then save the transaction and transmit the new claim.</p> <p>Tip: When using a claim frequency 7, this will void the original claim and have the payment withheld from future payments and a new claim with the corrected information will be created.</p> <p>Voiding: Use the type of bill code ending in 8 to</p>

Institutional Outpatient – Header 1 Field	Description
	<p>void the original claim (indicated by the ICN) and have the payment withheld from future payments. You must complete the claim exactly as it was originally submitted for this type of transaction.</p> <p>Note: If you want to void a claim previously submitted through PES, you can copy the original claim, change the type of bill code to end with a 8, and enter the 15 digit ICN. Then save the transaction and transmit the new claim.</p>
Original Claim #	If the third digit of the type of bill code is a 7 or 8, enter the original 15-digit claim number assigned by EDS.
Medicaid Provider ID	9-nine digit billing provider number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
NPI	10-ten NPI. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
Client ID	7-seven digit billing Client ID number. This action will populate the Account Number, Last Name, First Name, and MI (Middle Initial) fields.
Patient Status	2-digit patient status code. See the Appendix A – Lists for a valid list of Patient Status codes and their descriptions.
Medical Record #	Medical record number assigned by you that identifies the client in your records. This is an optional field and can contain both alpha and numeric characters.
From DOS	From Date of Service (DOS) using MMDDCCYY format.
To DOS	To Date of Service (DOS) using MMDDCCYY format.
Prior Authorization	Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS or Qualis Health.
Release of Medical Data	Default: Yes, indicating that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Default: Yes, indicating that the client, or authorized person, authorizes benefits to be assigned to the provider.
Report Type Code	Code indicating the title or contents of a document, report or supporting item for this claim, if applicable.

Institutional Outpatient – Header 1 Field	Description
	<p>Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.</p>
<p>Report Transmission Code</p>	<p>Code defining the method or format by which reports are to be sent, if applicable.</p> <p>Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.</p>
<p>Attachment Control</p>	<p>Report transmission code you have assigned to the attachment. This number can be alpha, numeric, or a combination of both characters.</p> <p>Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.</p>

Step 2 Select the **Header 2** tab.

837 Institutional Outpatient - Header 2

Use Header 2 to enter information for diagnosis, surgery, and attending providers.

Step 1 Enter data into all of the following fields to complete the Header 2.

Institutional Outpatient – Header 2 Field	Description
Primary Diagnosis Code	Primary 3-5 digit ICD-9 CM diagnosis code related to the visit.
Other Diagnosis Codes	Additional 3-5 digit ICD-9 CM diagnosis codes related to the visit, if applicable.
Admit Diagnosis Code	Admit 3-5 digit ICD-9 CM diagnosis code corresponding to the diagnosis of the client's condition, which prompted admission to the hospital.
E-Code	If service is accident related, enter the 3-5 digit ICD-9 CM diagnosis code that represents the cause of injury.
Surgical Codes/Dates	3-5 digit ICD-9-CM surgical procedure code that identifies the procedure that was performed during the billing period as shown in the client's medical record. Enter the date that corresponds to the listed surgical procedure using the MMDDCCYY format. Note: Diagnosis and procedure codes can only contain alphanumeric characters and cannot contain decimal points.
Attending	
Provider ID	Identification number for the provider who rendered the service. If you have not added the provider to your Other Provider list, double click in the field and add the provider. You can use the provider's UPIN, Idaho Medicaid provider number, or medical license number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.

Step 2 Select the **Header 3** tab.

837 Institutional Outpatient - Header 3

Use Header 3 to enter information for occurrence, occurrence span, condition codes, days covered, coinsurance days, and lifetime reserve days.

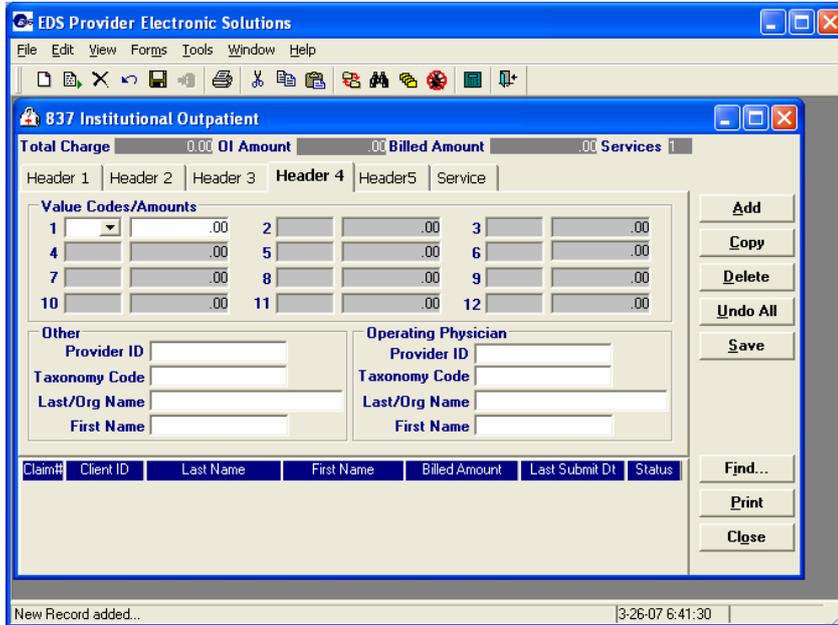
Step 1 Enter data into all of the following fields to complete the Header 3.

Institutional Outpatient – Header 3 Field	Description
Occurrence Codes/Dates	2-digit occurrence code, if applicable. Refer to Appendix A – Lists for valid occurrence codes and description defining a significant event relating to this service. Enter the date associated with the code listed using the MMDDCCYY format.
Occurrence Span Codes/Dates	2-digit occurrence span code, if applicable. Refer to Appendix A - Lists for valid occurrence span codes and description defining the occurrence span information that applies to the claim or encounter. Enter the date associated with the code listed using the MMDDCCYY format. Note: Both the Occurrence Codes and Occurrence Span Codes share the same list.
Condition Codes	2-digit Condition Code, if applicable. Refer to Appendix A – Lists for valid Condition Codes used to identify conditions relating to this bill that may affect Payer processing.
Days Covered	Number of covered days. Do not count the discharge day as a covered day.
Non-Covered	Number of non-covered days, if applicable. Do not count the discharge day as a non-covered day.
Coinsurance	Number of coinsurance days that apply to this claim, if applicable.
Lifetime Reserve	Number of lifetime reserve days, if applicable.

Step 2 Select the **Header 4** tab.

837 Institutional Outpatient - Header 4

Use Header 4 to enter information for value codes, Healthy Connections provider, and operating physician.



Step 1 Enter data into all of the following fields to complete the Header 4.

Institutional Outpatient – Header 4 Field	Description
Value Codes/Amounts	2-digit value code if applicable. Refer to Appendix A - Lists for valid value codes and value code information that applies to the claim or encounter. Enter the corresponding value code amount.
Other Provider ID:	Use this field to identify any additional providers who may have assisted with this client for the services rendered. Select the correct provider information. This action will populate the Taxonomy Code, Last/Org Name and First Name fields. Note: Use this field to enter the Healthy Connections number of the referring provider. You must add this information to the Other Provider list and the Provider ID from the Other Provider list will display in this field.
Operating Physician:	Use this field to identify the operating physician when surgical procedures have been performed during this client’s hospitalization. Select the correct provider information. This action will populate the

Institutional Outpatient – Header 4 Field	Description
	Taxonomy Code, Last/Org Name, and First Name fields. This field is required when billing Surgical Procedure Code on the Header 2 tab. Note: You must add this information to the Other Provider list and the Provider ID from the Other Provider list will display in this field.

Step 2 Select the **Header 5** tab.

837 Institutional Outpatient - Header 5

Use Header 5 to enter information for Home Health claims, comments, other primary insurance or crossover information.

Step 1 Enter data into all of the following fields to complete the Header 5.

Institutional Outpatient – Header 5 Field	Description
Home Health	
Admit Date	Date the client was admitted to the facility using the MMDDCCYY format.
Discharge Date	Date the client was discharged from the facility using the MMDDCCYY format. If the client has not been discharged, use the admit date in this field.
Nursing Facility Ind	Select No, Unknown, or Yes to indicate if the client is receiving care in a skilled nursing facility.
From DOS	From date of service using the MMDDCCYY format.

Institutional Outpatient – Header 5 Field	Description
Certification Ind	Select Initial, Renewal, or S Revised for Home Health certification.
Type of Facility	Type of facility from which the patient was most recently discharged.
Diagnosis Date	Enter the onset, or exacerbation, of the first or secondary diagnosis using the MMDDCCYY format.
Prognosis Ind	Code that indicates the physician’s prognosis for the client.
Medicare Coverage	Select Yes or No to indicate if the patient is covered by Medicare Part A.
Comment Cd	Code indicating the contents of the comment field on the claim, if applicable. This field is required if using the Comment field.
Comment	Comments that will clarify services, if applicable.
Other Insurance Indicator	If the client has a primary insurance coverage for institutional services, select Yes. This action will add an additional tab titled OI. Be sure to complete the OI screen.
Crossover Indicator	If the client has a Medicare coverage for Institutional services select Yes. This action will populate a new tab titled Crossover. Be sure to complete the Crossover screen.

Step 2 If there is no other insurance, select the **Service** tab.

Step 3 If there is other insurance, select the **OI** tab.

Step 4 If there is no crossover insurance, select the **Service** tab.

Step 5 If there is crossover insurance information, select the **Crossover** tab.

837 Institutional Outpatient - OI (Other Insurance)

If Yes is selected for the Other Insurance Indicator in Header 5, then you must complete the OI tab to enter information on other insurance and policy holder.

Step 1 Enter data into all of the following fields to complete the OI tab.

Institutional Outpatient – OI Field	Description
Release of Medical Data	Indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Payer Responsibility	Indicates if the other insurance carrier is the Primary (first), Secondary (second), or Tertiary (third) payer.
Claim Filing Ind Code	Type of other insurance claim being submitted.
Adjustment Group Cd	Identifies the general category of payment adjustment by the other insurance company.
Reason Codes/Amts	Identifies the reason for the adjustment, the difference between the billed and paid amounts, made by the Other Insurance Carrier. Refer to Appendix A – Lists for the valid Other Insurance Reason Codes (HIPAA Adjustment Reason Codes). Enter the amount indicated by the primary insurance for each reason code.
Paid Date/Amount	Date the primary insurance paid the claim using the MMDDCCYY format and total amount paid by the primary.
Policy Holder Group #	Select the policy holder information for the client. The Group Name, Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.

Institutional Outpatient – OI Field	Description
Add OI	Select the Add OI button and complete the OI information for the new carrier.
Copy OI	Select the Service # to be copied and click on the Copy Srv button. Change the data as needed for the new service detail.
Delete OI	If you entered a carrier in error, select the Service # and click on the Delete Srv button.

Step 2 Select the **Service** tab.

837 Institutional Outpatient - Crossover

If Yes is selected for the Crossover Indicator in Header 5, then you must complete the Crossover tab.

Step 1 Enter data into all of the following fields to complete the Crossover tab.

Institutional Outpatient – Crossover Field	Description
Release of Medical Data	Code indicating whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Claim Filing Ind Code	Type of other insurance claim being submitted.

Institutional Outpatient – Crossover Field	Description
Medicare Providers	
Referring ID	Identification number of the Medicare referring provider.
Last/Org Name	Last/Org Name of the referring provider.
Medicare Rendering ID	Identification number of the rendering provider.
Last/Org Name	Last/Org name of the rendering provider.
Medicare ICN	Claim ICN number assigned by Medicare. (The ICN must be at least 13 digits.)
Paid Amount	Amount paid by Medicare.
Paid Date	Medicare date of payment using the MMDDCCYY format.
Amounts	
Allowed	Allowed amount from Medicare.
Deductible	Deductible amount Medicare applied to the claim.
Coinsurance	Coinsurance amount Medicare applied to the claim.
Policy Holder Carrier Code	Policy holder information for the client. The Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.

Step 2 Select the **Service** tab.

837 Institutional Outpatient - Service

After completing the Header 1 – 5, Other Insurance, and Crossover tabs, complete the Service tab. Enter data on units, revenue codes, billed amount, and prescriptions.

Step 1 Enter data into all of the following fields to complete the Service tab.

Institutional Outpatient – Service Field	Description
Date of Service	Date of service for this service using the MMDDCCYY format.
Revenue Code	3-digit revenue code that identifies the specific accommodation or ancillary service.
Basis of Measurement	Specifies the units in which a value is being expressed as Days or UNit. Defaults: UNit.
Units	Number of units performed for the revenue code billed.
Unit Rate	Enter the per unit rate for the services billed. This field will calculate the billed amount by multiplying the units times the per unit rate. If you have selected a procedure code from the procedure list that contains a procedure amount, the unit rate will auto populate.
Billed Amount	Calculated by entering the units and the per unit rate for the revenue code billed. This field is updateable.
Procedure	5-digit CPT or HCPCS procedure code associated to the revenue code, if applicable, or select the code if you have created a list. Refer to the Idaho Medicaid Provider Handbook for Hospitals to identify which revenue codes require a corresponding procedure code.
Modifiers	Enter the 2-digit modifier, if applicable.
RX Ind	Select No or Yes to indicate if the client received

Institutional Outpatient – Service Field	Description
	medication during the service. When Yes is selected, the RX tab is added to the claim form for data entry and must be completed.
Add Srv	Add additional details by clicking on the Add Srv button and completing the screen again.
Copy Srv	Select the Service # to be copied and click on the Copy Srv button. Change the data as needed for the new service detail.
Delete Srv	Select the Service # and click on the Delete Srv button.

Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI, Crossover, or RX tabs, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Institutional Outpatient - RX Indicator

If you selected Yes for the RX Ind (Prescription Indicator) on the Service tab, then the RX screen is activated and must be completed.

Step 1 Enter data into all of the following fields to complete the RX tab.

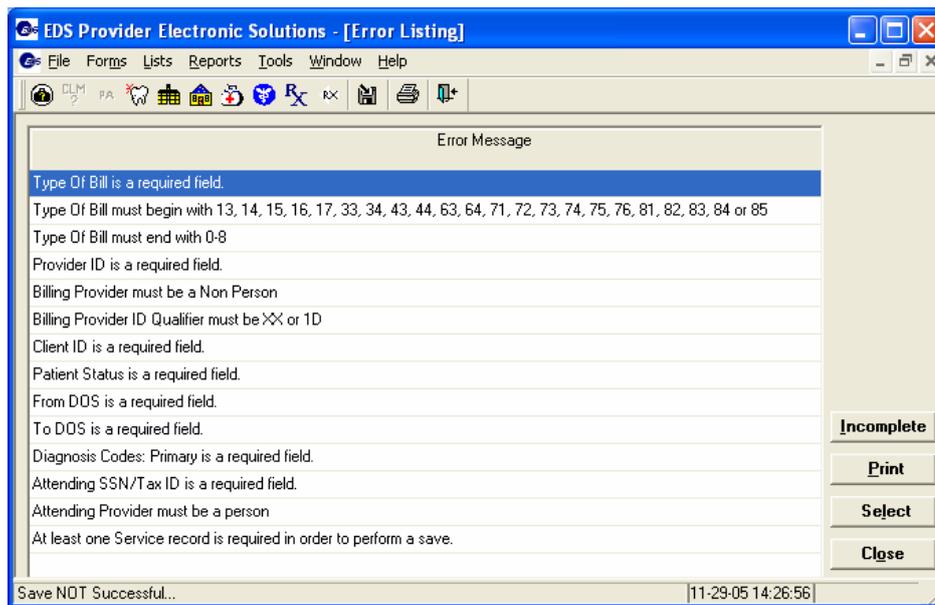
Institutional Outpatient – RX Indicator Field	Description
NDC	11-digit NDC (National Drug Code) for any prescriptions dispensed to the client.
Prescription Number	Prescription number for the medication prescribed.
Units	Number of units dispensed for the prescription.
Basis of Measurement	Specifies the units in which a value is being expressed as F2 (international unit), GR (gram), ML (milliliter), or UN (unit).
Unit Price	Price per unit of product only. Note: This field is optional and can be left blank.
Add RX	Select the Add RX button and complete the NDC information again.
Copy RX	Select the Service # to be copied and click on the Copy Srv button. You can then make changes to the data as needed for a new service detail.
Delete RX	Select the Service # and click on the Delete Srv button.

Step 2 To add additional claims, select the **Add** button and the software will automatically save the current claim.

Step 3 If this is the last claim to be entered and you do not need to complete the OI or Crossover tabs, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

Correcting Errors

If all the required data is not included in a Form or List, a list of error messages will display for you to correct. Either double click on the error message or click on the error message and click on the **Select** button.



The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

837 Professional Claim Form

Before entering transactions, several lists can be created. This may be done now or as you key in data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider and Client. Policy Holder is also completed for those clients with other insurance. Refer to the Lists section of this handbook for information on how to complete these lists.

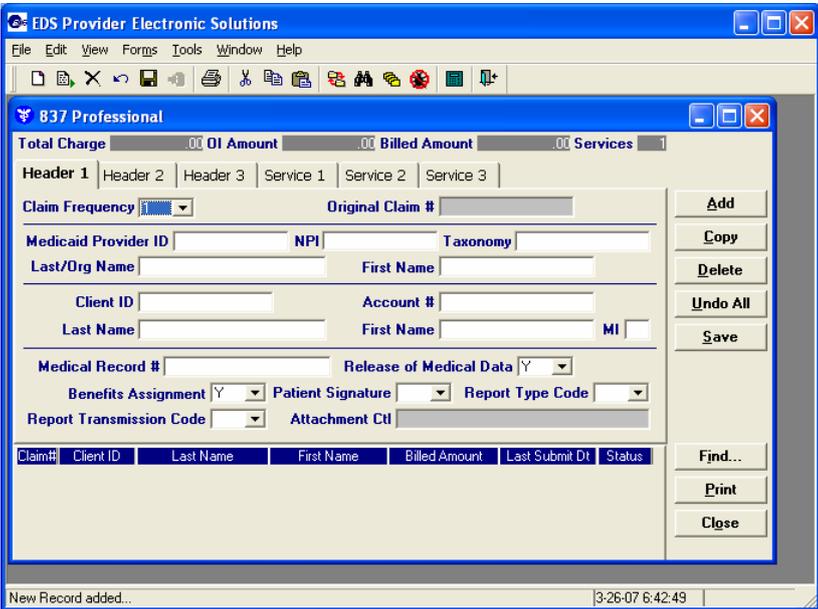
The Professional claim form has nine screens that you will use to complete a claim depending on your provider type. They are:

- Header 1
- Header 2
- Header 3
- OI (for other insurance)
- Crossover
- Service 1
- Service 2
- Service 3
- RX (for prescriptions)

Access the 837 Professional Claim Form from the PES main menu by either selecting the icon for 837 Professional from the toolbar or clicking on **Forms** in the Main Menu bar and selecting **837 Professional**.

837 Professional - Header 1

The professional claim form opens with Header 1. Use it to enter basic information such as provider and client identification.



Step 1 Enter data into all of the following fields to complete the Header 1.

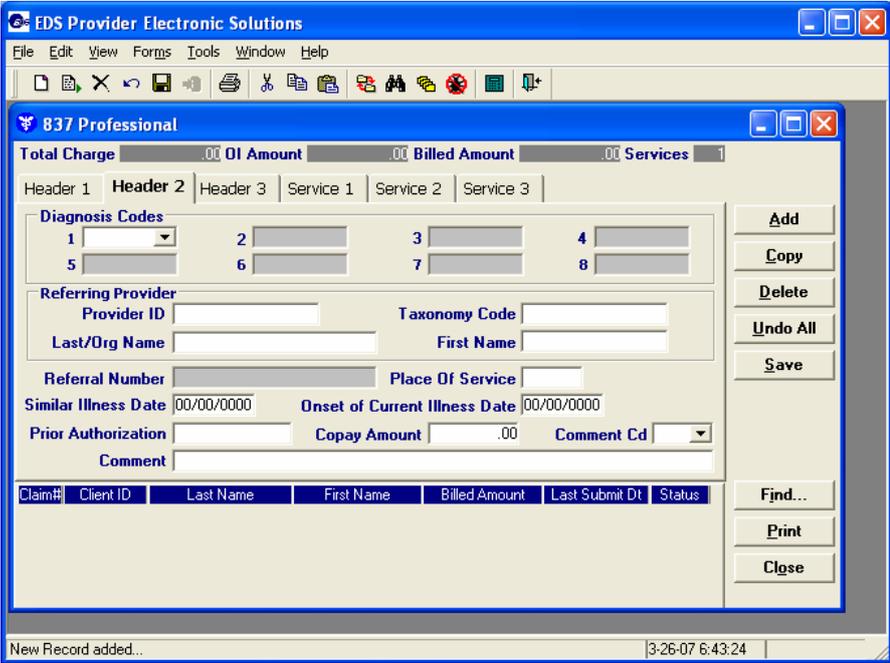
Professional – Header 1 Field	Description
Claim Frequency	Select 1 to submit an original claim.
	<p>Replacing: Use the claim frequency 7 to replace the original claim (indicated by the ICN) with corrected claim information. You must complete all of the required fields in the claim prior to transmitting to EDS. This will result in the original claim being voided and the new information to reprocess as a new claim.</p> <p>Note: If you want to replace a claim previously submitted through PES, you can Copy the original claim, change Claim Frequency Indicator to a 7, enter the 15 digit ICN, and make corrections as needed to the claim, save the transaction and transmit the new claim.</p> <p>Tip: When using a claim frequency 7, this will void the original claim and have the payment withheld from future payments and a new claim with the corrected information will be created.</p> <p>Voiding: Use the claim frequency 8 to void the original claim (indicated by the ICN) and have the payment withheld from future payments. You must complete the claim exactly as it was originally submitted for this type of transaction.</p> <p>Note: If you want to void a claim previously submitted through PES, you can Copy the original claim, change Claim Frequency Indicator to a 8, enter the 15 digit ICN, save the transaction and transmit the new claim.</p>
Original Claim #	If the claim frequency is 7 or 8, enter the original 15-digit claim number assigned by EDS.
Medicaid Provider ID	9-nine digit billing provider number. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
NPI	10-ten digit NPI. This action will populate the Taxonomy Code, Last/Org Name and First Name fields.
Client ID	<p>7-seven digit client number. This action will populate the Account Number, Last Name, First Name, and MI (Middle Initial) fields.</p> <p>Tip: If a provider or client ID is not listed, or no data is displayed, double click in the field and follow the instructions in Lists to add the provider or client to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p>
Medical Record #	Medical record number that you use to identify the client in your records. This is an optional field and can contain both alpha and numeric characters.
Release of Medical Data	Default; Yes, indicating that the provider has on file a signed statement by the client authorizing the release of medical data to other organizations.

Professional – Header 1 Field	Description
Benefits Assignment	Default: Yes, indicating that the client, or authorized person, authorizes benefits to be assigned to the provider.
Patient Signature	Code indicating how the patient or authorized person’s signature was obtained and how the provider is retaining the signature(s).
Report Type Code	Indicates the title or contents of a document, report or supporting item for this claim, if applicable. Note: Idaho Medicaid will not use the Report Type Code, Report Transmission Code, or the Attachment Control feature at this time.
Report Transmission Code	Indicates the method or format by which reports are to be sent, if applicable.
Attachment CTL	Report transmission code you have assigned to the attachment. This number can be alpha, numeric, or a combination of both characters.

Step 2 Select the **Header 2** tab.

837 Professional - Header 2

Header 2 is used to enter data on diagnosis, referring provider, referral number, place of service, similar illness, onset of illness, prior authorization, co-payment, and comments. Depending on the services you render, you may not need to complete all of these fields.



Step 1 Enter data into the following fields to complete the Header 2.

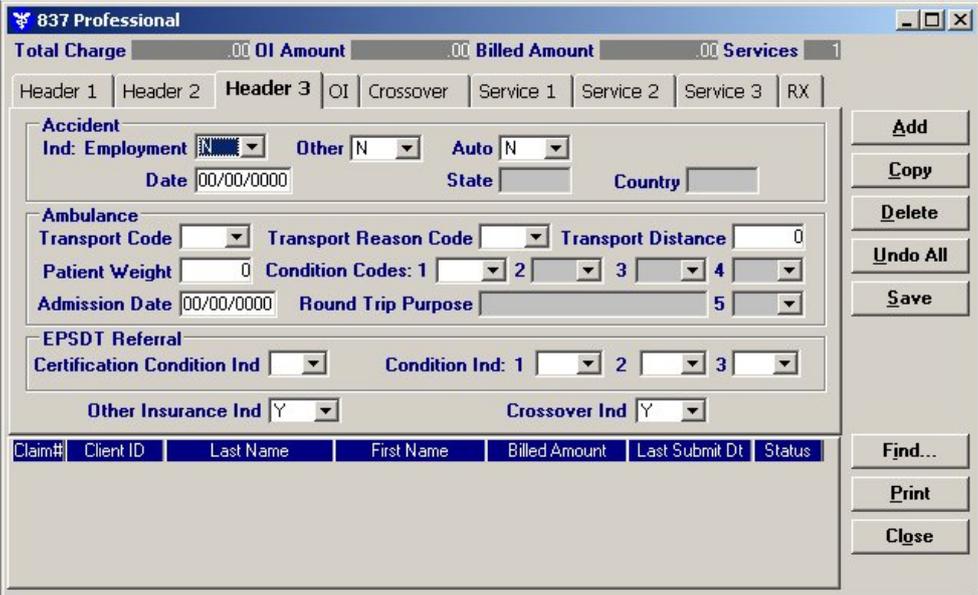
Professional – Header 2 Field	Description
Diagnosis Code	Primary 3 to 5 digit ICD-9 CM diagnosis code related to the visit. Do not use decimals or any other punctuation.
Referring Provider	<p>Referring Provider information number. This action populates the Taxonomy Code, Last/Org Name and First Name fields. Enter the 9-digit Healthy Connections provider number if the client is enrolled in Healthy Connections program. You must add this information to the Other Provider list; the Provider ID from the Other Provider list will display in this field.</p> <p>Tip: If the Diagnosis Code or Referring Provider is not listed, or no data is displayed, double click in the field and follow the instructions in Lists to add the data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p>
Referral Number	Referring provider ID, UPIN or Medical License number in this field. If the client is enrolled in Healthy Connections enter the 9-digit Healthy Connections provider number in this field. (This field is only available if there is information noted in the Referring Provider ID field.)
Place of Service	<p>2-digit place of service code here at the Header or at the Service 1 detail.</p> <p>Refer to the Idaho Medicaid Provider Handbook for valid Place of Service codes for provider type or specialty. A list of HIPAA Place of Service codes can be found in Appendix A – Lists.</p>
Similar Illness Date	Date using the MMDDCCYY format to report services to a patient experiencing symptoms similar or identical to previously reported symptoms, if applicable.
Onset of Current Illness Date	Date using the MMDDCCYY format when the onset of illness or symptoms are different from the date of service, if applicable.
Prior Authorization	<p>Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS or Qualis Health.</p> <p>Note: In electronic professional claims, the PA number can be placed either at the header or at the detail.</p> <ul style="list-style-type: none"> • When the PA is placed at the header, it is used for all detail lines to which it might apply. • When the PA is placed at the detail, it is used just for the detail line on which it is entered. • When a PA number is at the header and a second PA is on a detail line, the system will first apply the detail PA to that detail line and then apply the header PA to all other detail lines.

Professional – Header 2 Field	Description
	PAs must be entered on every claim to which they apply.
Co-pay Amount	Amount, if any, that the patient has paid towards State of Idaho Department of Health and Welfare claim, other than Medicaid. Any co-pay due would be for State of Idaho Department of Health and Welfare services that were clearly identified to have a co-pay.
Comment Code	Indicates the contents of the comment field on the claim, if applicable. This field is required if the comment field is used.
Comment	Comments that will clarify the services, if applicable.

Step 2 Select the **Header 3** tab.

837 Professional - Header 3

Header 3 is used to enter information on accident, ambulance, EPSDT, and other insurance. Depending on the services you render, you may not need to complete any of these fields.



Note If the client has other insurance, be sure to select **Yes** for the Other Insurance indicator and complete the Other Insurance (**OI**) tab.

Note If the client has Medicare, be sure to select **Yes** for the Crossover indicator.

Step 1 Enter data into the following fields to complete the Header 3.

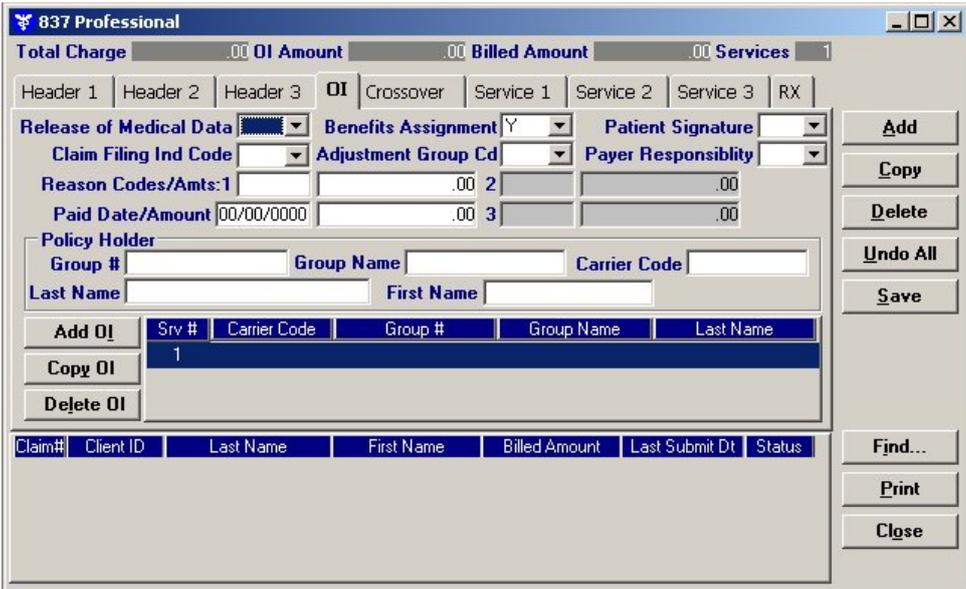
Professional – Header 3 Field	Description
Accident	If the services are a result of an accident complete the appropriate Accident fields. The indicators (Ind) are for
Employment	No or Yes
Other	No or Yes
Auto	No or Yes. If Y is selected for Auto, then State and Country fields become active.
Date	If Y is selected for any of the indicators, then the date of the accident is required.
Ambulance	If you are an ambulance service provider, then you must complete the following fields
Ambulance Transport Code	Indicates the type of ambulance transport. This is required only for Ambulance claims. If the transport code selected is X for round trip, then you must complete the Round Trip Purpose comment field.
Transport Reason Code	Indicates the reason for the transport. Required only for Ambulance claims.
Transport Distance	Number of miles the client was transported by ambulance. Required only for Ambulance claims.
Patient Weight	Weight of the patient at the time of transport by ambulance. This is optional.
Condition Codes	Identifies conditions relating to this service that may affect Payer processing List on Header 3 if this condition applies to the entire claim, or on Service 2 if it applies to a particular detail. Required only on ambulance claims.
Admission Date	Related hospitalization admission date. This field is required when the condition code is equal to 01 – Patient was admitted to a hospital.
Round Trip Purpose	If the transport code is X you must enter information regarding the necessity for the round trip.
EPSDT Referral	If the services you are rendering are the result of an EPSDT referral, then you must complete the following fields Note: Refer to Section 1.6 of the Idaho Medicaid Provider Handbook for additional information regarding the EPSDT program.
Certification Condition Ind	Indicates the condition response.
Condition Indicator 1, 2, and 3	Select the code indicating the specific condition.

Professional – Header 3 Field	Description
Other Insurance Indicator	If the client has a primary insurance coverage for professional services, select Yes. This action will add an additional TAB titled "OI". Be sure to complete the OI screen.
Crossover Indicator	If the client has Medicare coverage for Professional services select Yes. This action will populate a new TAB titled "Crossover". Be sure to complete the Crossover screen. See Important Note.

- Step 2** Select the **Service 1** tab.
- Step 3** If there is other insurance, select the **OI** tab.
- Step 4** If the client has Medicare as a primary insurance, select the **Crossover** tab.

837 Professional - OI (Other Insurance)

If you selected Yes for OI (Other Insurance) Header 3, then the OI screen is activated and you must complete it.



- Step 1** Enter data into the following fields to complete the Other Insurance tab.

Professional – OI Field	Description
Release of Medical Data	Indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.

Professional – OI Field	Description
Patient Signature	Indicates how the patient or authorized person's signature was obtained and how the provider is retaining the signature(s).
Claim Filing Ind Code	Type of other insurance claim being submitted.
Adjustment Group Cd	Identifies the general category of payment adjustment by the other insurance company.
Payer Responsibility	Indicates if the other insurance carrier is the Primary (first), Secondary (second), or Tertiary (third) payer.
Reason Codes/Amts	Identifies the reason for the adjustment, the difference between the billed and paid amounts, made by the Other Insurance Carrier. Refer to Appendix A – Lists for the valid Other Insurance Reason Codes (HIPAA Adjustment Reason Codes). Enter the amount indicated by the primary insurance for each reason code.
Paid Date/Amount	Date the primary insurance paid the claim using the MMDDCCYY format and the total amount paid by the primary.
Policy Holder Group #	<p>Policy holder information for the client. The Group Name, Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.</p> <p>Tip: If the policy holder group number data is not listed, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p> <p>Note: If the policy holder group number data has not been completed for the client, double click in the field and follow the instructions in the "Lists" section of this handbook to complete the Policy Holder List. Once the information has been saved, click on the Select button to return to the claim.</p>
Add OI	To add additional insurance carriers, select the Add OI button and complete the OI information for the new carrier.
Copy OI	To copy any carrier, select the Service # to be copied and click on the Copy OI button. Change the data as needed for the new service detail.
Delete OI	If you entered a carrier in error, select the Service # and click on the Delete OI button.

Step 2 Select the **Service 1** tab.

837 Professional - Crossover

If Yes is selected for the Crossover Indicator in Header 3, then you must complete the Crossover tab.

Step 1 Enter data into the following fields to complete the Crossover tab.

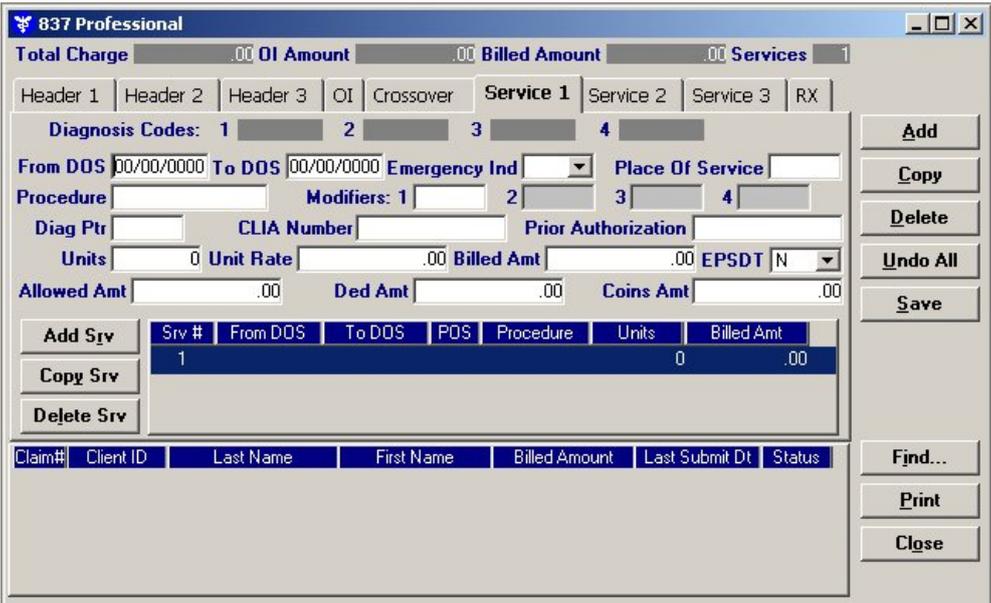
Professional – Crossover Field	Description
Release of Medical Data	Indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations.
Benefits Assignment	Select No or Yes to indicate that the client, or authorized person, authorizes benefits to be assigned to the provider.
Patient Signature	Indicates how the patient or authorized person’s signature was obtained and how the provider is retaining the signature(s).
Medicare Providers	
Referring ID	Identification number of the Medicare referring provider.
Last/Org Name	Last/Org Name of the referring provider.
Rendering ID	Identification number of the rendering provider.
Last/Org Name	Last/Org name of the rendering provider.
Medicare ICN	Claim ICN number assigned by Medicare. (The ICN must be at least 13 digits.)
Allowed Amount	Allowed amount from Medicare.
Paid Amount	Amount paid by Medicare.
Paid Date	Medicare date of payment using the MMDDCCYY format.

Professional – Crossover Field	Description
<p>Policy Holder Carrier Code</p>	<p>Policy holder information for the client. The Carrier Code, Last Name and First Name will populate to this screen when the Policy Holder information is selected.</p> <p>Tip: If the policy holder carrier code data has not been completed for the client, double click in the field and follow the instructions in Lists to data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p>

Step 2 Select the **Service 1** tab.

837 Professional - Service 1

The Service 1 tab is used to enter data on diagnosis, dates of service, procedures codes, and billed amount. If applicable, you will also enter information on CLIA, prior authorization, and EPSDT.



Tip If a code is not entered in a drop down list, or no data is displayed, double click in the field and follow the instructions in the Lists chapter to add the code to the appropriate list. Once the information has been saved, click on the **Select** button to return to the claim. This works for any field with a drop down list.

Step 1 Enter data into the following fields to complete the Service 1 tab.

Professional – Service 1 Field	Description
From DOS	From Date of Service (DOS) using the MMDDCCYY format.
To DOS	To Date of Service (DOS) using the MMDDCCYY format.
Emergency Ind	Select Yes if the service provided was emergency related.
Place of Service	<p>Correct the 2-digit place of service code here if different from the place of service code entered at the Header 2 tab.</p> <p>Note: Refer to your Idaho Medicaid Provider Handbook for valid place of service codes for your provider type or specialty. A list of HIPAA place of service codes can be found in Appendix A – Lists.</p>
Procedure	5-digit procedure code or select the code if you have created a list. Do not use decimals or any other punctuation.
Modifiers 1, 2, 3, and 4	2-digit modifier, if applicable.
Diag PTR (Pointer)	Refers to the diagnosis code fields used in Header 2. Enter the number from Header 2 (1-8) that is associated to the procedure rendered. Only one diagnosis is allowed for each detail line.
CLIA Number	If you are a facility certified to perform CLIA covered laboratory services, then enter your CLIA number. This field is required for any laboratory performing tests covered by the CLIA act.
Prior Authorization	Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS, or Qualis Health.
Units	Number of units performed for the service billed.
Unit Rate	Per unit rate for the services billed. This field will calculate the billed amount by multiplying the units times the per unit rate. If you have selected a procedure code from the procedure list that contains a procedure amount, the unit rate will auto populate.
Billed Amount	Calculated by entering the units and the per unit rate for the services performed for this procedure. This field is updateable.
EPSDT	<p>If the service rendered is part of the Early Periodic Screening Diagnosis and Treatment program, select Yes.</p> <p>Note: Refer to Section 1.6 of the Idaho Medicaid Provider Handbook for additional information regarding the EPSDT program.</p>

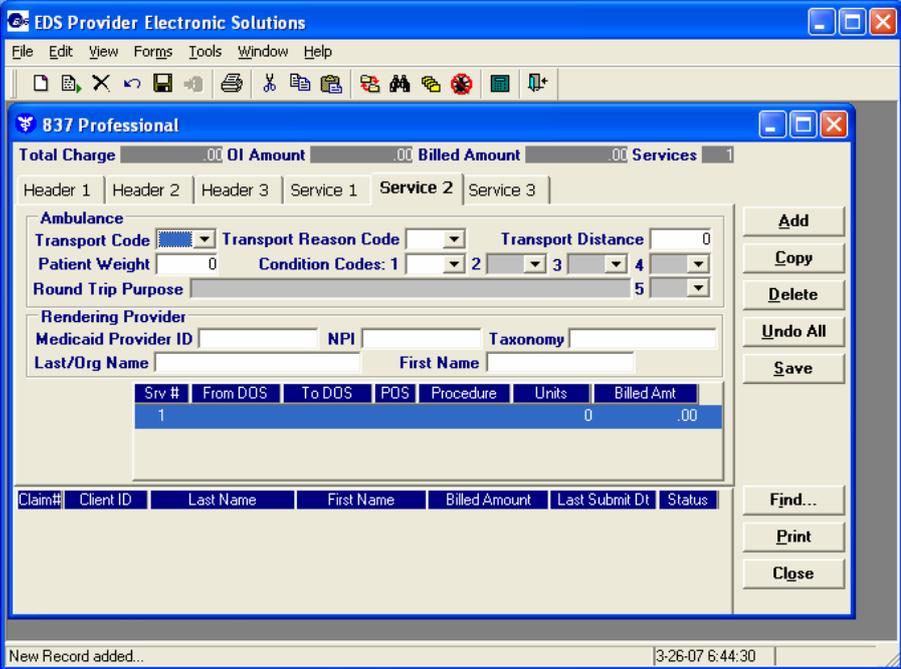
Professional – Service 1 Field	Description
Deductible Amount	Deductible amount Medicare applied to the claim. This field is only available if the Crossover Indicator is set to Yes.
Coinsurance Amount	Coinsurance amount Medicare applied to the claim. This field is only available if the Crossover Indicator is set to Yes
Add Srv	If more than one service was rendered, select the Add Svs button and complete the screen for the second service.
Copy Srv	Detail to be copied, select the Copy Srv button and make correction to the data as needed.
Delete Srv	If a detail was added in error, select the detail to be deleted then select the Delete Srv button.

Step 2 Select the **Service 2** tab.

837 Professional - Service 2

This screen must be completed if:

- Ambulance services were provided.
- The rendering (performing) provider is attached to a group billing provider. The performing provider information must be completed for each detail (charge) submitted.



Step 1 Enter data into the following fields to complete the Service 2 tab.

Professional – Service 2 Field	Description
Ambulance	If you are an ambulance service provider, and did not complete this information at Header 3, then you must complete the following fields
Ambulance Transport Code	Indicates the type of ambulance transport. This is required only for Ambulance claims. If the transport code selected is X for round trip, then you must complete the Round Trip Purpose comment field.
Transport Reason Code	Indicates the reason for the transport. Required only for Ambulance claims.
Transport Distance	Number of miles the client was transported by ambulance. Required only for Ambulance claims.
Patient Weight	Weight of the patient at the time of transport by ambulance. This is optional.
Condition Codes	Identifies conditions relating to this service that may affect Payer processing. List on Header 3 if this condition applies to the entire claim, or on Service 2 if it applies to a particular detail. Required only on ambulance claims.
Round Trip Purpose	If the transport code is X, enter information regarding the necessity for the round trip.
Rendering Provider	
Medicaid Provider ID	<p>9-digit Medicaid Provider ID, or 10-digit NPI of the provider who rendered the service. This field is only required when the Rendering provider is attached to a group provider number. If the billing provider number on the Header 1 screen was set up in the Billing Provider list with an entity type qualifier of 2, then the Rendering provider must be an entity type qualifier of 1 for Person (individual provider). The Taxonomy Code, Last/Org Name and First Name will default from the Rendering Provider ID selected.</p> <p>Tip: If a provider or client ID is not listed, or no data is displayed, double click in the field and follow the instructions in Lists to add the provider or client to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p>
Srv #	Correct rendering provider for each service billed.

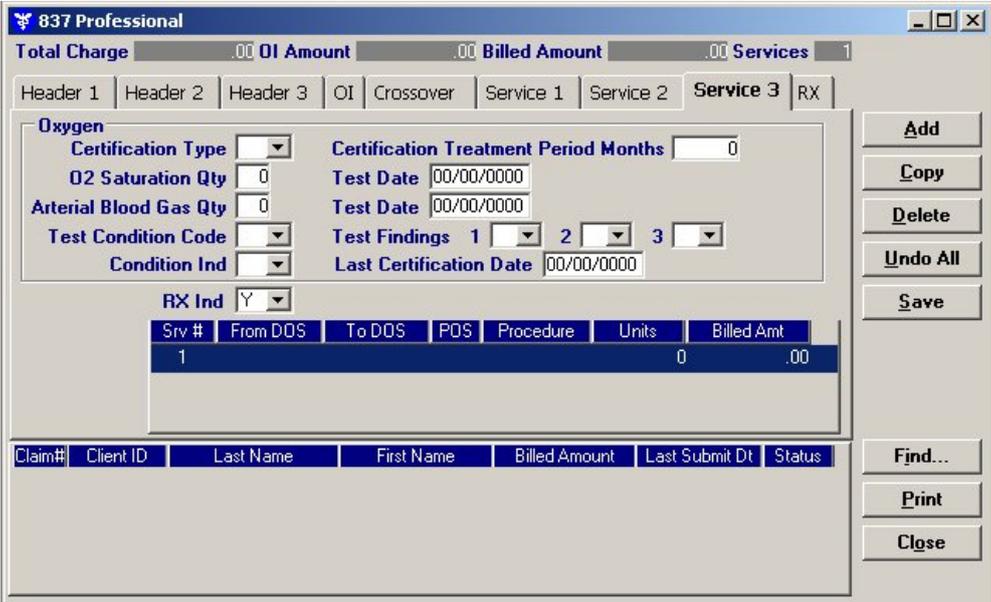
Step 2 If the claim is for oxygen services, select the **Service 3** tab; if it is for RX services, select the **Service 3** tab.

Step 3 If this is the last claim to be entered and you do not need to complete any other tab, select the **Save** button. Select the **Close** button and follow the

instructions in the Communication Submission section on how to transmit these claim(s).

837 Professional - Service 3

This screen must be completed if the services rendered were for oxygen.



Step 1 Enter data into the following fields to complete the Service 3 tab.

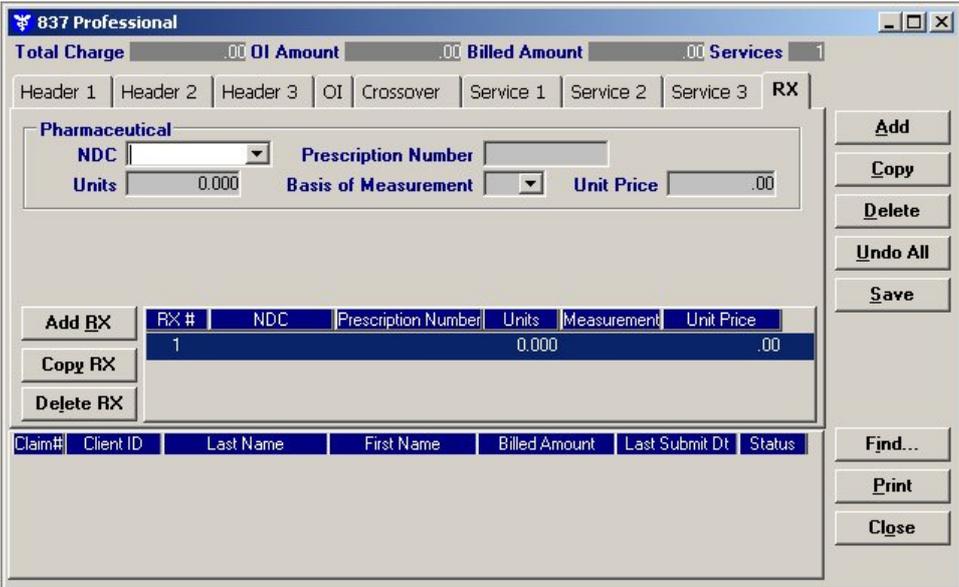
Professional – Service 3 Field	Description
Certification Type	Indicates the type of certification.
Certification Treatment Period Months	Number of months covered by this certification.
O2 Saturation Qty	Numeric value or the quantity for oxygen saturation.
Test Date	Date the O2 Saturation test was given using the MMDDCCYY format.
Arterial Blood Gas Qty	Numeric value of the quantity for oxygen arterial blood gas.
Test Date	Date the arterial blood gas test was given using the MMDDCCYY format.
Test Condition Code	Indicates the conditions under which a patient was tested.
Test Findings	Indicates the findings of the oxygen test performed on the patient, if applicable.

Professional – Service 3 Field	Description
Condition Indicator	Condition code indicator.
Last Certification Date	Date the ordering physician signed the certificate of medical necessity. Required when oxygen condition indicator is entered.
RX Ind	Select No or Yes to indicate if the client received medication during the service. When Yes is selected, the RX tab is added to the claim form for data entry and must be completed.

Step 2 If this is the last claim to be entered and you do not need to complete the RX tab, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

837 Professional - RX

If you selected Yes for the RX Ind (Prescription Indicator) on the Service tab, then the RX screen is activated and must be completed.



Step 1 Enter data into all of the following fields to complete the RX tab.

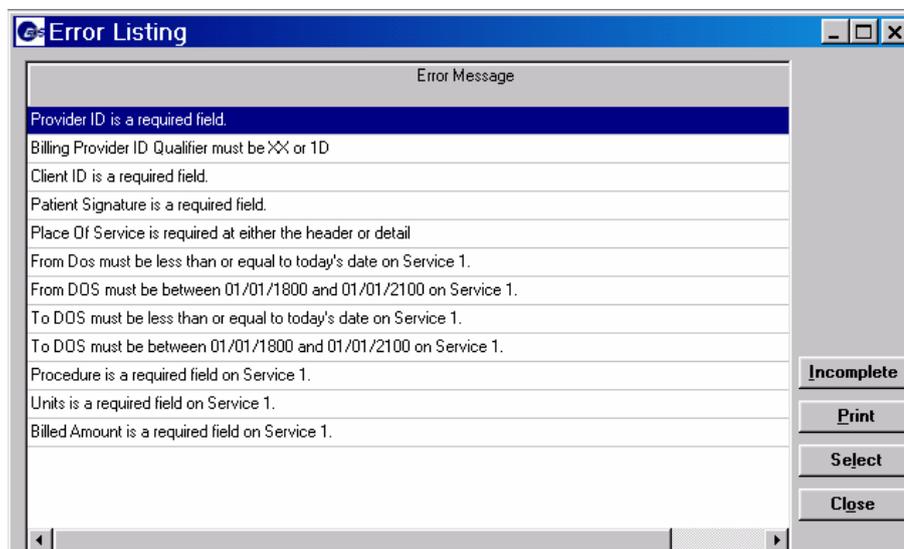
Professional – RX Field	Description
NDC	11-digit NDC (National Drug Code) for any prescriptions dispensed to the client.
Prescription Number	Prescription number for the medication prescribed.
Units	Number of units dispensed for the prescription.

Professional – RX Field	Description
Basis of Measurement	Specifies the units in which a value is being expressed as F2 (international unit), GR (gram), ML (milliliter), UN (unit).
Unit Price	Price per unit of product only. This field is optional and can be left blank.
Add RX	To add additional NDCs, select the Add RX button and complete the NDC information again.
Copy RX	To copy any service, select the Service # to be copied and click on the Copy Srv button. Change the data as needed for the new service detail.
Delete RX	Select the Service # and click on the Delete Srv button.

Step 2 If this is the last claim to be entered and you do not need to complete the Service 3 or OI tab, select the **Save** button. Select the **Close** button and follow the instructions in the Communication Submission section on how to transmit these claim(s).

Correcting Errors

If all the required data is not included in a Form or List, a listing of error messages will display for you to correct.



Double click on the error message or click on the error message and click on the **Select** button. The software will return to the field that has missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

NCPDP Pharmacy Claim Form

Before entering transactions, several lists must be completed. This may be done now, or as you key in a data. There are two lists that must be used and completed prior to finishing a claim transaction: Provider, and Client.

The NCPDP Pharmacy claim form has the following five screens that you will use to complete a claim:

- Header
- Service 1
- Service 2
- Other COB (Coordination of Benefits for other insurance)
- Compound (for compounds)

Accessing the NCPDP Pharmacy Claim Form

Access the NCPDP Pharmacy Claim Form from the PES main menu.

Select the icon for the NCPDP Pharmacy or click on **Forms** in the Main Menu bar and selecting **NCPDP Pharmacy** from the drop down menu.

NCPDP Pharmacy - Header

The pharmacy claim form opens with the Header tab.

Step 1 Enter data into all of the following fields to complete the Header.

NCPDP Pharmacy – Header Field	Description
Provider ID	9-digit billing provider number. This will populate the Provider ID Code Qualifier field.
NPI	10-digit NPI. This will populate the Provider ID Code Qualifier field.
Client ID	7-digit Client ID number. This will populate the Last Name and First Name of the client.
Date of Service	Default is the current date. If submitting services for a prior date, enter the date using the MMDDCCYY format.
Patient Location	Identifies the location of the client who is receiving the medication.

Step 2 Select the **Service 1** tab.

NCPDP Pharmacy - Service 1

Step 1 Enter data into all of the following fields to complete Service 1.

NCPDP Pharmacy – Service 1 Field	Description
Prescriber ID	Prescriber’s state license number. The Prescriber ID cannot be less than 5 digits and is an alpha-numeric field. If the Prescriber number is not available, use the current date in MMDDYY form.
Prescriber ID Code Qualifier	Select the code qualifier that identifies the information that was entered as the Prescriber ID.

NCPDP Pharmacy – Service 1 Field	Description
	Notes: codes “01” is used when an NPI was entered in the Prescriber ID field. Codes “08” is used when a State License number was entered in the Prescriber ID field.
Prescription Number	Enter the code used to identify the prescription being filled.
Compound Code	Defaults is 1 (Not a Compound). A value of 0 indicates, “Not Specified”. If the prescription to be filled is a compound, select 2 (Compound Drug). This action will insert the Compound tab that you will use to enter all of the ingredient NDCs for the compound.
DAW/Product Selection Code	Dispense as written (DAW) code indicating whether or not the prescriber’s instructions regarding generic substitution were followed.
Fill Number	Number of times the prescription has been filled. Example: the original fill is indicated as 00, the first refill as 01, the second refill as 02, etc.
Days Supply	Number of days supply of the prescription being filled.
Usual and Customary Charge	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.
Submission Clarification Code	Code for the reason of the distribution. Note: If there is an ingredient within the compound that may not be an approved NDC for Idaho Medicaid, you may submit the claim with a submission clarification code of “8” (Process compound for approved ingredients) stating you are aware there may be an ingredient which is not an approved ingredient but that you would like the rest of the claim to be processed as usual.
Gross Amount Due	Total price being billed from all sources and including all fees, including ingredient cost and dispensing fee.
Unit of Measure	Code type that describes how this prescription was measured, e.g., EA – each, GM – gram, etc.
NDC	11-digit National Drug Code for the prescription being dispensed. If submitting services for a compound drug this field will not be available. All NDCs included in a compound must be entered on the compound screen.
Quantity Dispensed	Quantity being dispensed, expressed in metric decimal quantity.
Prior Authorization	Prior authorization number, if applicable, assigned by the State of Idaho Department of Health and Welfare Program, EMS, or Qualis Health.
Diagnosis Code	3-5 digit ICD-9 diagnosis code that relates to the prescription dispensed, if applicable.

Step 2 Select tab for **Service 2**.

NCPDP Pharmacy - Service 2

Step 1 Enter data into all of the following fields to complete Service 2.

NCPDP Pharmacy – Service 2 Field	Description
Coverage Code	Default: 1 (No other coverage). If the client has other coverage, select a code to identify the action taken regarding the client’s coverage. If using coverage code 2, 3, or 4, the following fields become active and must be completed: Carrier Code, Coverage Type, Amount Paid, Paid Date, and Reject codes 1, 2, & 3. Also, the Other COB tab appears if the client has more than one primary coverage other than Medicaid.
Carrier Code	National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance carrier. Note: If you do not know what the NEIC code is for the carrier, contact EDS to obtain the correct carrier code.
Coverage Type	Coverage type for the client Primary.
Amount Paid	Payment amount from the primary insurance.
Paid Date	Date of payment from the primary using the MMDDCCYY format.
Reject Codes	Reject Reason Code from the primary payer, if applicable.
DUR/PPS Reason for Service	Identifies the type of utilization conflict detected.

NCPDP Pharmacy – Service 2 Field	Description
DUR/PPS Professional Service Code	Identifies the pharmacist intervention when a conflict code has been identified, if applicable.
DUR/PPS Result of Service Code	Action taken by a pharmacist in response to a conflict.

- Step 2** If the claim is not a compound drug claim:
- To send one claim interactively, select **Send**
 - To send claims as a batch, select **Add** to add the next claim, or select **Save** to save the current claim and follow the instructions in the Batch Submission section of the Communications chapter.
- Step 3** If the client has more than one primary insurance carrier, complete the **Other COB** tab.
- Step 4** If the claim is a compound drug claim select the **Compound** tab.
- Step 5** Select next action from the buttons to continue

NCPDP Pharmacy - Other COB

Use this screen for coordination of benefits (COB) when the client has more than one primary insurance carrier.

- Step 1** Enter data into all of the following fields to complete Other COB.

NCPDP Pharmacy – Other COB Field	Description
Other (secondary) Coverage Code	Select a code to identify the action taken regarding the client’s coverage. If using coverage code 2, 3, or 4, the following fields become active and must be completed: Carrier Code, Coverage Type, Amount Paid, Paid Date, and Reject codes 1, 2, & 3.
Carrier Code	National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance carrier. Tip: If the NEIC carrier code is not listed, or no data is displayed, double click in the field and follow the instructions in Lists to add the data to the appropriate list. Once the information has been saved, click on the Select button to return to the claim. This works for any field with a drop down list. Note: If you do not know what the NEIC code is for the carrier, contact EDS to obtain the correct carrier code.
Coverage Type	Coverage type for the client Secondary.
Amount Paid	Payment amount from the primary insurance.
Paid Date	Date of payment from the primary using the MMDDCCYY format.
Reject Codes	Reject Reason Code from the primary payer, if applicable.
Other (tertiary) Coverage Code	Select a code to identify the action taken regarding the client’s coverage. If using coverage code 2, 3, or 4, the following fields become active and must be completed: Carrier Code, Coverage Type, Amount Paid, Paid Date, and Reject codes 1, 2, & 3.
Carrier Code	National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance carrier. Note: If you do not know what the NEIC code is for the carrier, contact EDS to obtain the correct carrier code.
Coverage Type	Coverage type for the client: Tertiary.
Amount Paid	Payment amount from the primary insurance.
Paid Date	Date of payment from the primary using the MMDDCCYY format.
Reject Codes	Reject Reason Code from the primary payer, if applicable.

Step 2 Select next action from the buttons to continue.

NCPDP Pharmacy - Compound

Complete this screen if you indicated in the Service 1 tab that you are billing for a compound drug. You can add up to 25 compound ingredients into one compound drug using this form.

Step 1 Enter data into all of the following fields to complete Compound.

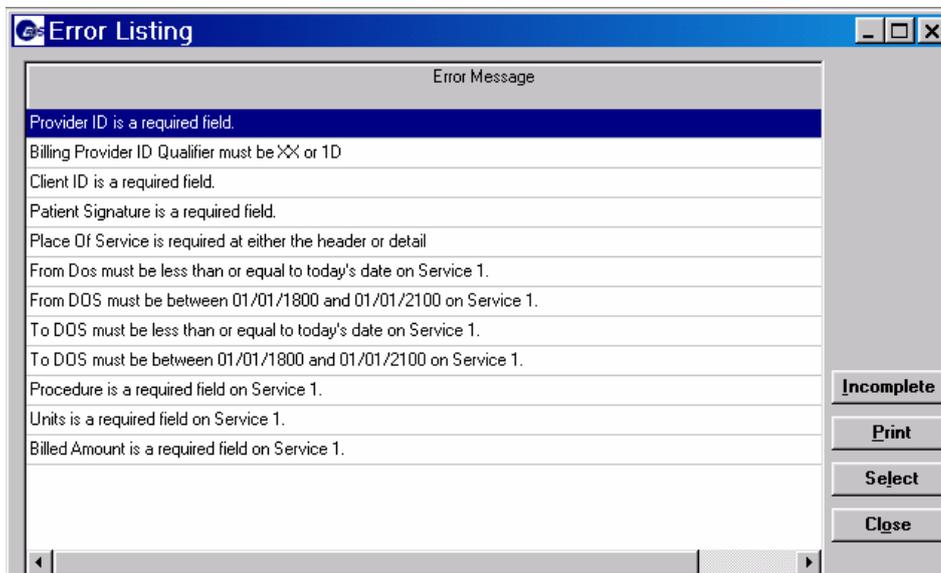
NCPDP Pharmacy – Compound Field	Description
Dosage Forms	Dosage form of the complete compound mixture.
Dispensing Unit Indicator	NCPDP standard product billing code identifying the quantity measurement
Dosage Route	Code for the route of administration of the complete compound mixture.
NDC	11-digit National Drug Code prescribed.
Ingredient Quantity	Amount expressed in metric decimal units of the product included in the compound mixture.
Ingredient Cost	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in Compound Ingredient Quantity field.
Add Ingredient	Enter up to 25 compound ingredients.
Copy Ingredient	If using the same ingredient multiple times in the same compound, select the ingredient detail, and click on the Copy Ingredient button. Make corrections to the new data as needed.

NCPDP Pharmacy – Compound Field	Description
Delete Ingredient	If an ingredient has been added incorrectly, select the ingredient number and then click on the Delete Ingredient button to remove it from the ingredient list.

Step 2 Send, add or save. After all data elements have been completed in the form select the **Send** button if submitting the prescription interactively. The software will dial up to the server and transmit the claim. Refer to the Communication Submission section if submitting claims as a batch transaction.

Correcting Errors

If all the required data is not included in a Form or List, a listing of error messages will display for you to correct.



Double click on the error message or click on the error message and click on the **Select** button.

The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of I cannot be transmitted.

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

NCPDP Pharmacy Response

The NCPDP Pharmacy Response is composed of two different sections.

- Header Response Status
- Detail Response Status

Shown below is an example of what a pharmacy response looks like. There is also an explanation to help you read the response. To help you read the example, important data names are bolded in the explanation and in the corresponding part of the sample.

```

NCPDP Pharmacy Response File

EDS Provider Electronic Solutions

Version/Release Number:          5.1
Transaction Code:                 B1-Billing
Transaction Count:                1
Header Response Status:       A or R
Response Date:              03/26/2003  17:54:00

Provider ID:                XXXXXXXXXX
Provider ID Qualifier:            05
Date of Service:           MM/DD/CCYY

Message:                    Accepted (or Rejected) claim
    
```

NCPDP Response Header

NCPDP Pharmacy Response Field	Description
Header Response Status	Indicates if the transaction was Accepted or Rejected.
Response Date	Date and time of the response.
Provider ID	Provider number or NPI that was submitted on the original NCPDP Pharmacy request.
Date of Service	Date the prescription was dispensed.
Message	Indicates if the prescription was Accepted or Rejected.

NCPDP Response Detail

```

~~~~~
Claim Detail                               1
Response Date:      03/26/2003 17:54:00
Transactions Status:          P or R
ICN:                      31234567891234
Field Occurrence:          03
Compound Ingredient #
Billing For:              Prescription
RX Number:                0000705
Total Amount Paid:          $00.00
~~~~~
    
```

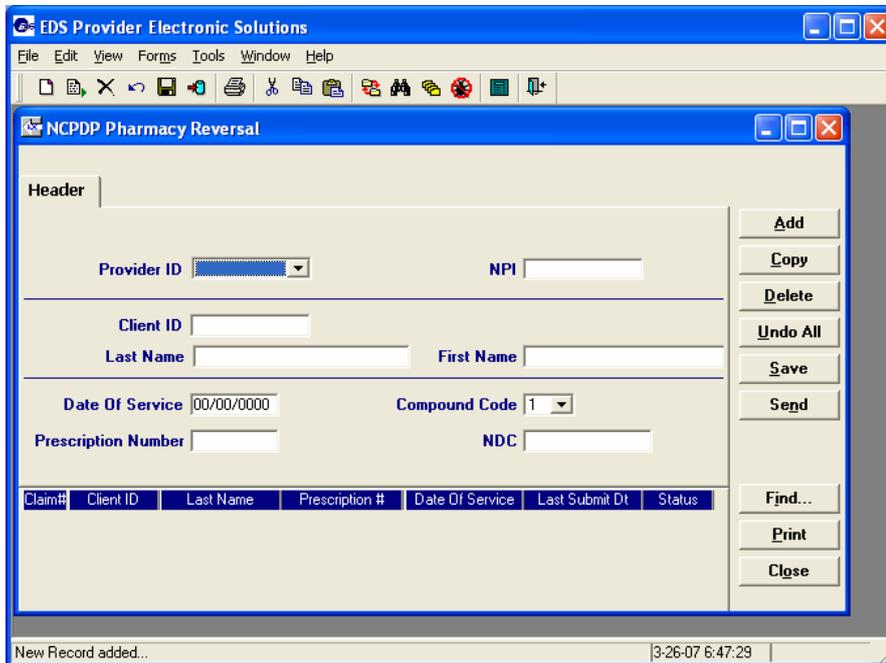
NCPDP Response Detail	Description
Response Date	Date and time of the response.
Transaction Status	Indicates if the prescription was Paid or Rejected.
ICN	Claim number returned by Medicaid for the transaction.
Field Occurrence	Only displayed if the prescription was for a compound drug and there were ingredients in the compound that were not covered by Medicaid. In this example, since 03 is indicated in this field, ingredient 3 in the compound mixture was denied.
RX Number	Prescription number that was submitted on the original transaction.
Total Amount Paid	Displayed if the transaction was submitted was approved to pay.

If the transaction was rejected you would see an additional message screen describing why the transaction was rejected.

Error Message
70-Product/Service Not covered

NCPDP Pharmacy Reversal Claim Form

Access the NCPDP Pharmacy Reversal Claim Form from the PES main menu.



Select the icon for the NCPDP Pharmacy Reversal or select **Forms** in the Main Menu bar and select **NCPDP Pharmacy Reversal**.

Note The NCPDP Pharmacy reversal may only be done as an interactive transaction. You cannot send a Pharmacy reversal as a batch.

NCPDP Pharmacy Reversal Header

Step 1 Enter data into all of the following fields to complete Reversal Header.

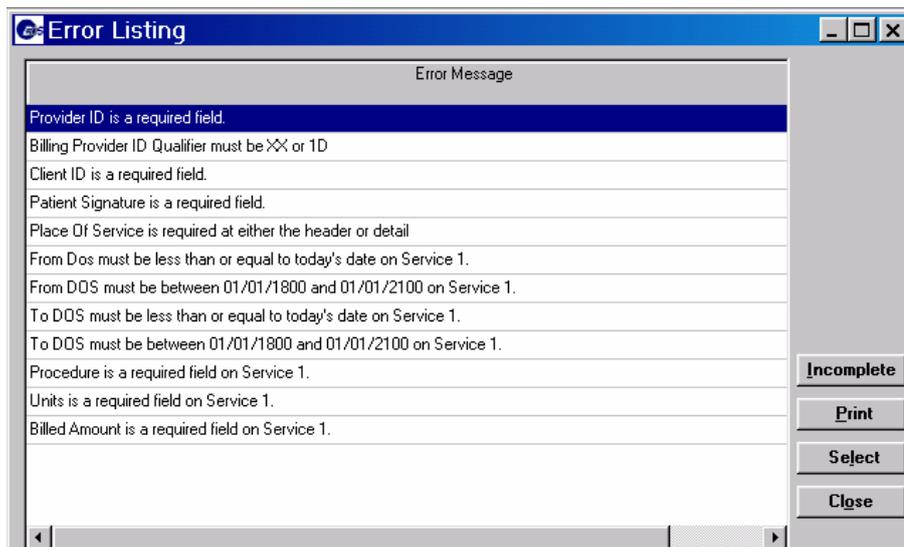
NCPDP Pharmacy Reversal Header Field	Description
Provider ID	<p>9-digit billing provider number.</p> <p>Tip: If a provider or client ID is not listed, or no data is displayed, double click in the field and follow the instructions in Lists to add the provider or client to the appropriate list. Once the information has been saved, click on the Select button to return to the claim.</p> <p>This works for any field with a drop down list.</p>
NPI	<p>10-digit NPI.</p> <p>Tip: You cannot use an NPI number if the original claim was submitted with a Medicaid Provider Number. You must submit the reversal with the Provider ID that was</p>

NCPDP Pharmacy Reversal Header Field	Description
	on the original claim.
Client ID	7-digit client number. This action will populate the Last Name and First Name of the client.
Date of Service	If submitting services for a prior date, enter the date using the MMDDCCYY format.
Compound Code	Default: 1 (Not a Compound). If the prescription to be reversed is a compound, select 2 (Compound Drug).
Prescription Number	Prescription number.
NDC	11-digit National Drug Code for the prescription you want to reverse.

Step 2 Once all data elements have been completed in the form, select the **Send** button. You will receive a response immediately.

Correcting Errors

If all the required data is not included in a Form or List, a listing of error messages will display for you to correct.



Double click on the error message or click on the error message and select the **Select** button.

The software will return to the field that has missing or incorrect data. You will not be able to save a form if there is missing or incorrect data.

Note If you cannot complete the claim and wish to save it to complete later select the **Incomplete** button. This claim will then display in the details with a status of I. Claims in a status of **I** cannot be transmitted.

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

NCPDP Pharmacy Reversal Response

The NCPDP Pharmacy Reversal Response is composed of two different sections.

- Header Response Status
- Detail Response Status

Shown below is an example of what a pharmacy reversal looks like. An explanation is also provided to help you read the response. To help you read the example, important data names are displayed in bold text in the explanation and in the corresponding part of the sample.

NCPDP Reversal Response Header

```

NCPDP Pharmacy Response File

EDS Provider Electronic Solutions

Version/Release Number:          5.1
Transaction Code:                 B2-Reversal
Transaction Count:                1
Header Response Status:      A or R
Response Date:             11/24/2003 10:13:00
Provider ID:                XXXXXXXXXX
Provider ID Qualifier:            05
Date of Service:           11/24/2003

Message:  Reversal Approved/Rejected
    
```

NCPDP Pharmacy Response Field	Description
Header Response Status	Indicates if the reversal was Accepted or Rejected .
Response Date	Date and time of the response.
Provider ID	Provider number that was submitted on the original NCPDP Pharmacy Reversal request.
Date of Service	Date the prescription was originally dispensed.
Message	Indicates if the reversal was approved or rejected.

NCPDP Reversal Response Detail

```

~~~~~
Claim Detail                               1
Response Date:                            11/24/2003
Transactions Status:                       A or R
ICN:                                       31234567891234
Billing For:                               Prescription
RX Number:                                 XXXXX
~~~~~
    
```

NCPDP Reversal Response Field	Description
Response Date	Date and time of the response.
Transaction Status	Indicates if the reversal was Approved or Rejected.
ICN	Claim number returned by Medicaid for the transaction. It only is shown if the reversal has been approved.
RX Number	Prescription number that was submitted on the original transaction.

Note If the transaction was rejected you would see an additional message screen describing why the transaction was rejected.

Error Message
70-Product/Service Not covered

Communication

The PES Communication menu option provides several functions related to communicating with the EDS host, Business Exchange Services. These functions are:

- Submitting forms through Web, dial-up or diskette submission
- Batch resubmission of forms through Web, dial-up or diskette submission
- Viewing and printing transaction responses
- Viewing and printing communication logs

The following options are listed on the Communication drop down menu:

- Submission
- Resubmission
- View Batch Response/835 ERA
- View Bulletin
- View Submit Report/997s
- View Communication Log

Note The 835 Remittance Advice will not be available in PES.

Submission

After completing a form, you can send it to Business Exchange Services (BES) translator using the Submission feature. In PES, 'forms' refers to a variety of electronic transactions, which are listed with the corresponding HIPAA transaction code:

270	Eligibility Request
837	Dental
837	Institutional Inpatient
837	Institutional Nursing Home
837	Institutional Outpatient
837	Professional
	NCPDP Pharmacy

The above forms may be submitted by using the Web, BBS Batch (dial-up), or diskette method. These options are listed after selecting Submission on the method drop down menu. The method will default to the Web Server method option.

Note You will need to set up your Submission options before you can send any forms. If you have not already done so, the system will prompt you now. You will see the following message: "Modem Type/Logon ID/Password is missing. Do you want to enter options information at this time?"

You must select **Yes** to submit forms. You will go to the modem tab in the options screen for the Submission modem setup. After you save your entries there, you will return automatically to this screen and can continue your submission.

- Step 1** Click on **Communication** on the menu bar.
- Step 2** Select **Submission**. The Batch Submission window will appear.

Web

Sending Transactions

Use this method if you have an Internet Service Provider (ISP), or access to an Internet connection. The Web method can be used by a Cable, DSL, ISDN, LAN or Analog modems. This will provide a faster and more efficient method of submissions.

- Step 1** Verify that the Web Server method is selected.
- Step 2** Select the form type by clicking on the form type under Files To Send. (You can send more than one form type at a time. Deselect by clicking on the selected item again.)
- Step 3** Select **Submit**. The following messages will display at the bottom, left hand corner of your window.
- Getting web submission options...
 - Formatting batch...
 - The Number of Bytes to be Transferred is...
 - Submission Successful

Note Prior to selecting the submit option you must be connected to the Internet.

Receiving Transactions

To electronically receive responses for eligibility batch requests, NCPDP batch requests, acknowledgments, accepted and rejected reports,:

- Step 1** Verify that the **Web Server** method is selected.

Step 2 Select the form type to be received by clicking on the form type under Files To Receive. (You can request more than one form type at a time. Deselect by clicking on the selected item again.)

Step 3 Select **Submit**. The following messages will display at the bottom, left hand corner of your window.

- Downloading files from the Web Server ...
- You have XX file(s) to be downloaded...
- Downloading file 1 of XX...
- Submission successful!

If you receive a message that the transmission failed, you will be prompted to view the communication log files to identify why the transmission was not successful.

Note When selecting **Acknowledgement** you must also select **Accepted and Rejected Submit Reports** to obtain additional information if the batch was accepted or rejected.

Step 4 To view Acknowledgement, Accepted and Rejected Submit Reports refer to View Submit Reports/997s. To view response information for Batch Eligibility refer to View Batch Responses.

Note If using the Web submission method, your password will expire every 30 days. Continue to Web Password reset for instructions.

Web Password Reset

Note PES will prompt users to update the Web login password when it expires, which is every 30 days.

If users are submitting their batch transactions using the Web Server method option, they will be prompted to change their Web password every 30 days. When the password has expired and the user attempts to do a batch submission, a window will display indicating that the Web password has expired and needs to be changed. Once the user changes their password, the password field in the batch tab, under tools and options will be auto populated with the new password. This will not effect users submitting through the BBS Batch method.

Step 1 Select either upload or download function, under communication and submission.

Step 2 A window displays, indicating that "Your web password has expired, please complete the following information to update your web password."



- Step 3** In the Old Password field, enter your old password. If you do not know the old password, cancel out of this window and select **Tools** and the **Options** from the main window. Select the **Batch** tab. In the password field, this will display the "Old" password. Note the password.
- Step 4** In the New Password field, enter a new password.
- Step 5** In the ReKey New Password field, re-enter the password.
- Step 6** Select **OK**.
- Step 7** The next message displayed tells you that you have successfully updated your password. Click **OK** to continue.
- If you are doing a file to send, the file will continue to upload.
 - If you are doing a file to retrieve, the file will continue to download.



- Step 8** The new password will be auto populated in the password field in the batch tab, under tools and options settings.

Password Rules

- Must not be the same as the Logon ID or the current password.
- Must be at least 5 characters in length, but no longer than 8 characters.
- Must contain only alphanumeric characters (A-Z, a-z, and 0-9).
- Must contain at least one alphabetic character (A-Z and a-z).
- Must contain at least one numeric character (0-9).
- Must not have the same character appear more than once.

Batch

Sending Transactions

Use this method if you have a modem, and you do not have an Internet Service Provider (ISP), or access to an Internet Connection.

- Step 1** Select **BBS Batch** from the field labeled Method. You will need to select the BBS Batch method, every time you choose to upload or download a file.

Step 2 Select the form type by clicking on the form type under Files To Send. (You can send more than one form type at a time. Deselect by clicking on the selected item again.)

Step 3 Select **Submit**. As the process of transmitting forms proceeds, a message area in the center of the screen will be visible. This message area will keep the user informed of the process of transmitting forms to the EDS host.

The following messages will appear in the Transmission popup window:

- Dialing the host at....
- Logon to BBS....
- Uploading Files....
- Submission successful!

If you receive a message that the transmission failed, you will be prompted to view the communication log files to identify why the transmission was not successful.

Receiving Transactions

To electronically receive responses for eligibility batch requests, NCPDP batch requests, acknowledgments, accepted and rejected reports,:

Step 1 Select **BBS Batch** from the field labeled Method.

Step 2 Select the form type to be received by clicking on the form type under Files To Receive. (You can request more than one form type at a time. Deselect by clicking on the selected item again.)

Step 3 Select **Submit**. As the process of transmitting forms proceeds, a message area in the center of the screen will be visible. This message area will keep the user informed of the process of transmitting forms to the EDS host.

The following messages will appear in the Transmission popup window:

```
Dialing the host at ....
Logon to BBS...
Uploading Files...
Submission successful!
```

If you receive a message that the transmission failed, you will be prompted to view the communication log files to identify why the transmission was not successful.

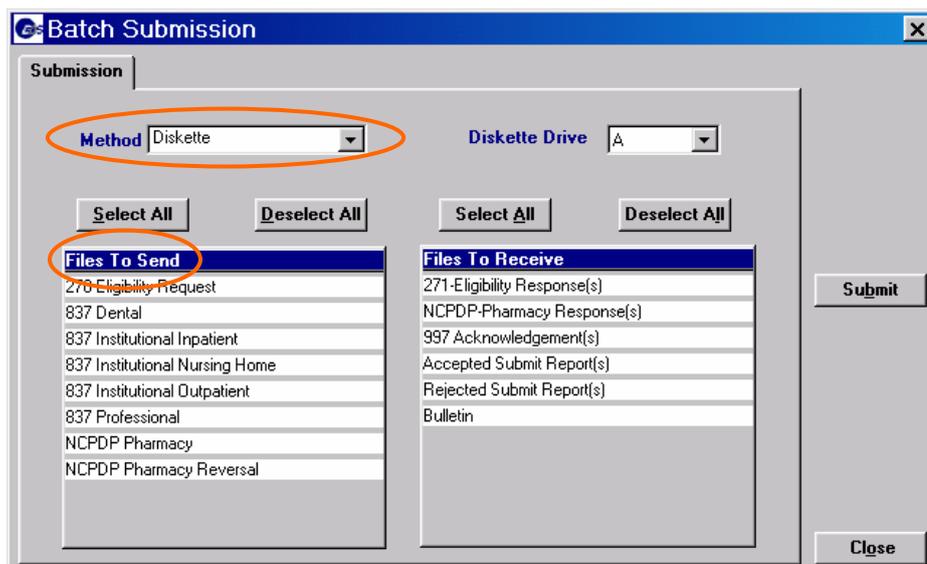
Note When selecting **Acknowledgement** you must also select **Accepted and Rejected Submit Reports** to obtain additional information if the batch was accepted or rejected.

Tip To view Acknowledgement, Accepted and Rejected Submit Reports refer to View Submit Reports/997's. To view response information for Batch Eligibility refer to View Batch Responses.

Diskette

If you do not have a modem, you will want to copy forms to a formatted diskette and then mail the diskette to EDS.

Step 1 Select **Diskette** from the field labeled Method. The diskette drive is enabled and defaults to the A drive.



Step 2 Select the form type by clicking on the form type under Files To Send. The user can select more than one form type at a time. Deselect by clicking on the selected item again.

Step 3 Write your name, address, Login ID on your diskette prior to mailing to EDS. Mail your diskette to:

EDS: Attn EDI Department
 PO Box 23
 Boise, ID 83707

Step 4 When the EDI Department receives the diskette, they will upload the file and mail the diskette back to the provider. It is the responsibility of the provider to reformat the diskette.

Note The Files to Receive option is not available on diskette.

Note Eligibility Request and the NCPDP Pharmacy reversal are not available using the diskette submission option.

Interactive Submission

Interactive submission means sending a claim or request and receiving an immediate response.

The screenshot displays the 'NCPDP Pharmacy' form within the 'EDS Provider Electronic Solutions' application. The form is divided into sections for data entry and a table. On the right side, there is a vertical toolbar with buttons for 'Add', 'Copy', 'Delete', 'Undo All', 'Save', 'Send', 'Find...', 'Print', and 'Close'. The status bar at the bottom of the window shows a message 'New Record added...' and the current date and time '3-26-07 6:48:38'.

You can send the following transactions interactively from within the form:

- Eligibility Verification
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal

When the user selects the **Send** button, found only on these forms, the computer connects to EDS via the Web or modem, sends the claim or request to EDS, and display's EDS' response. Refer to the Forms sections to review an example of a response and how to complete these types of transactions.

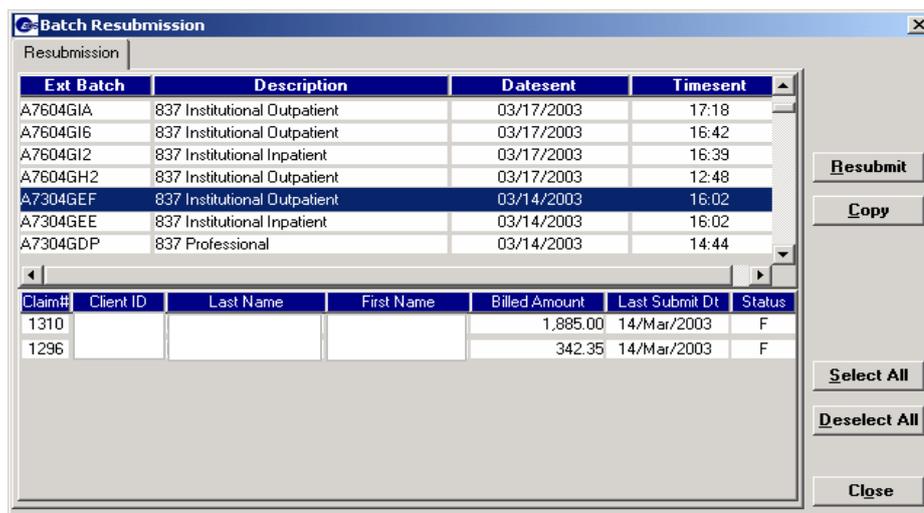
The following messages will appear in the Transmission popup window:

- Dialing the host at
- Logon to BBS....
- Uploading Files....
- Submission successful!

Note For information on how to retrieve the response after exiting the application, refer to the Eligibility and Pharmacy chapters.

Resubmission

Different forms and batches can be resubmitted using the Resubmission option. Depending on the system options you have selected, up to 999 batches can be retained and listed. You can resend a single form, several forms, or an entire batch of forms. You can also copy any form and modify it for future submission.



Use a batch resubmission when there is a recurring client eligibility batch or when there is a recurring weekly or monthly claim submission for the same clients.

- Step 1** Click on **Communication** on the toolbar.
- Step 2** Select **Resubmission**. A list of batches will be displayed. Selecting any batch will open a list of forms within that batch.

Resubmit

Select this option to resubmit an entire batch of forms or a portion of a batch of forms without changing them.

- Step 1** Place the cursor on the row showing the batch to be resubmitted and select it by left clicking with the mouse. A list of the forms that were sent in that batch

will appear in the bottom half of the window. By default, all of the forms are already selected.

- To resubmit the entire batch, click on the **Resubmit** button.
- To resubmit individual forms from the batch, select the **Deselect All** button and select the individual forms one by one by placing the mouse over the form and left clicking. Once the forms have been selected, select the **Resubmit** button.

Step 2 After clicking on the **Resubmit** button, the Submission screen will be displayed and you can proceed as if sending a regular batch. You can send the batch electronically using the Web Server, BBS Batch or diskette by selecting Method from the Batch Submission screen.

Copy Batch Forms

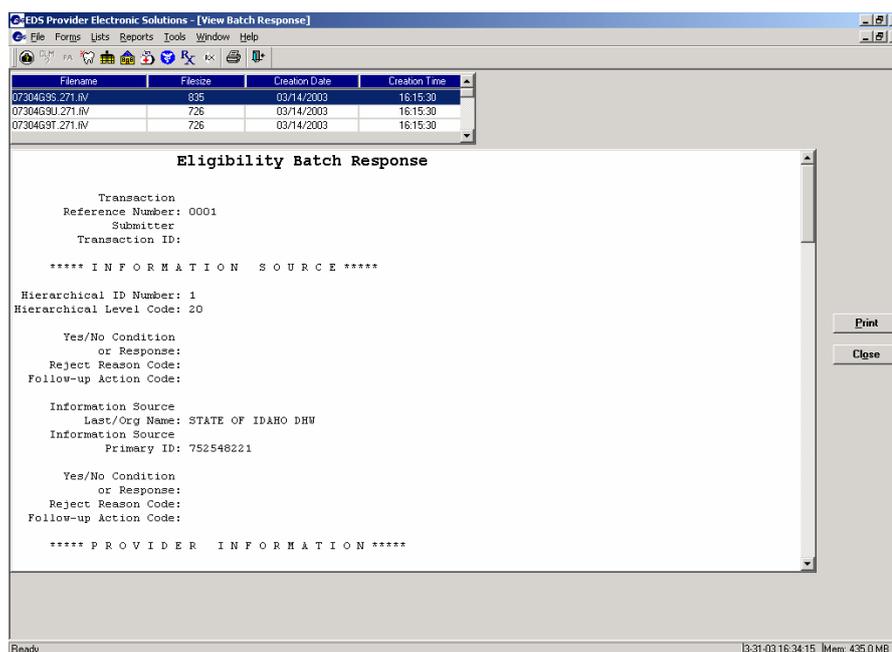
Select this option to copy an entire batch of forms or a portion of a batch of forms for use later. You can then edit the forms from the appropriate form transaction. After editing the forms, they are ready to be resubmitted using the Submission option from the Communication menu.

Step 1 Place the cursor on the row showing the batch to be copied and select it by left clicking with the mouse. A list of the forms that were sent in that batch will appear in the bottom half of the window. By default, all of the forms are already selected.

- To copy the entire batch, click on the **Copy** button.
- To copy individual forms from the batch, select the **Deselect All** button and select the forms one by one by placing the mouse over the form and left clicking. Once the forms have been selected, select the **Copy** button.

The next message you will see tells you how many forms you have selected to be copied and that they will be ready for you to modify and/or submit.

View Batch Responses/835 ERA



To view responses for 271 - Eligibility or NCPDP - Pharmacy Responses, after retrieving the response from the bulletin board:

- Step 1** Select **Communication** from the menu bar.
- Step 2** Select **View Batch Responses/835 ERA**.
- Step 3** Locate the batch submitted on the original submission date. All transactions submitted in the batch will be displayed on this report.

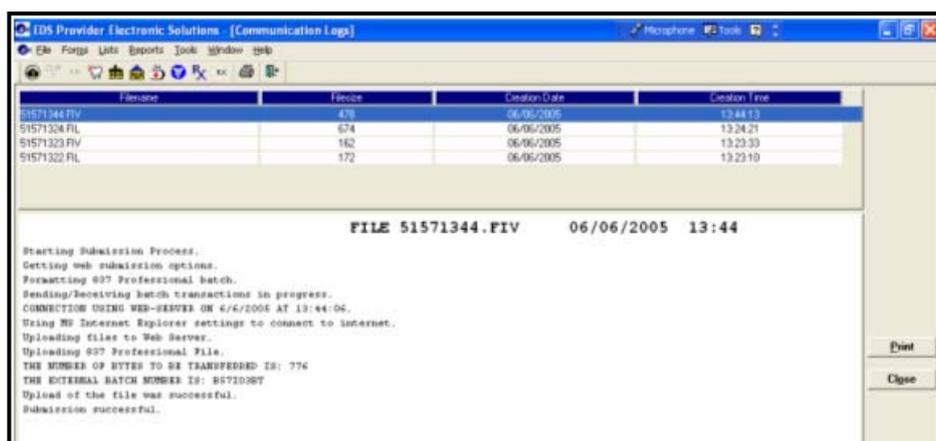
Note The 835 Remittance Advice will not be available in PES.

View Bulletin

This function is not currently used by the Idaho Medicaid program.

View Communication Log

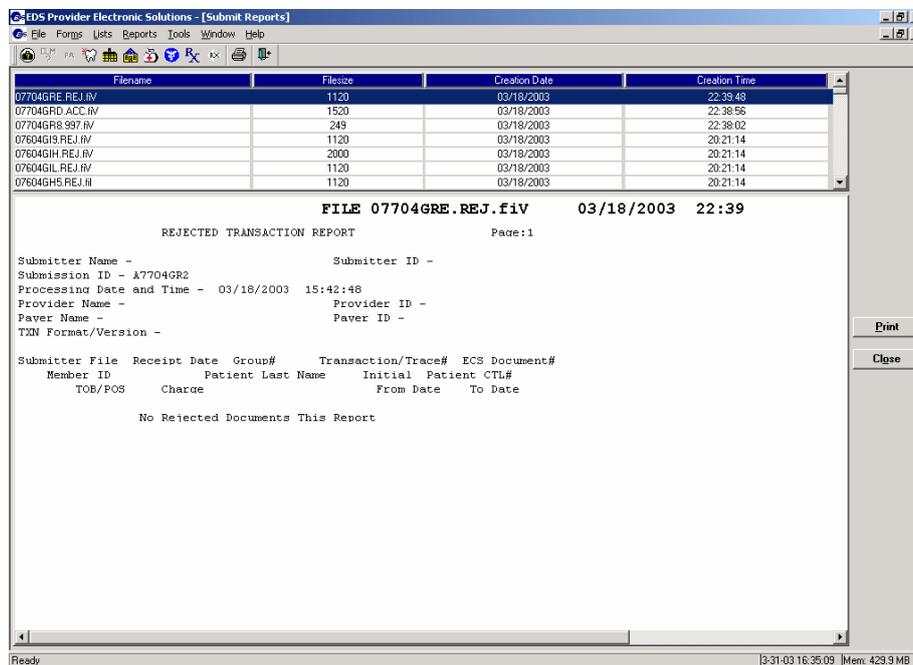
The Communications Log is a useful tool for checking on submission information. It displays a list of files submitted along with the file size, creation date, and creation time. This information can be used to debug communication problems. Depending on the system options you have selected, up to 999 communication logs can be listed.



- Step 1** Select **Communication** from the menu bar.
- Step 2** Select **View Communication Log**. The Communication Logs window opens and displays a list of recent submissions.
- Step 3** Click on the file to be viewed. The submission information for the selected file will be displayed in the lower portion of the screen. You should see "Submission successful".
- Step 4** If you receive a submission successful message you will have an External Batch number that is a combination of alpha and numeric characters. You will need this number when reviewing your Accepted and Rejected submission reports. It is called the Submission ID on the Accepted and Rejected reports.
- Step 5** Click on the **Print** button to print the log information.
- Step 6** Click on the **Close** button to close the Communication Log window.

View Submit Reports/997s

Use the View Submit Reports option to check on accepted and rejected reports for submissions made to BES. This information is important and should be referenced regularly. See Understanding the Rejected Transaction Report for more information.



- Step 1** Select **Communication** from the menu bar.
- Step 2** Select **View Submit Reports**.
- Step 3** Locate the Submission ID for the original batch submitted to view if the Batch was accepted or rejected. The Submission ID is in the Communication Log file.
- Step 4** The file name ending in REJ is for the Rejected Transaction report. If no data is found locate the same Submission ID in the file name ending ACC for the Accepted Transaction report.
- Step 5** To exit this report, select the **Close** button.

Understanding the Rejected Transaction Report

Use the Rejected Transaction Report to determine why a claim or batch was rejected by the BES. The following fields are used by the EDI Help Desk to determine the reason your claim was rejected.

Contacting EDI Help Desk:

Call MAVIS and say TECHNICAL SUPPORT immediately after the MAVIS greeting.

(800) 685-3757 toll free

(208) 383-4310 in the Boise calling area

8:00 a.m. to 5:00 p.m. MT

Monday - Friday (excluding State holidays)

REJECTED TRANSACTION REPORT					Page:1
Submitter Name - MARCUS WELBY			Submitter ID - 987654321		
Submission ID - A789WNY6					
Processing Date and Time - 03/18/2004 12:42:48					
Provider Name - MARCUS WELBY MD			Provider ID - 123456789		
Payer Name - STATE OF IDAHO DHW			Payer ID - 445454161		
TXN Format/Version - Institutional Claim A1			X12	4010	
Submitter File	Receipt Date	Group#	Transaction/Trace#	ECS Document#	
Member ID	Patient Last Name		Initial	Patient CTL#	
TOB/POS	Charge		From Date	To Date	

000000188	040318	188	PES188	708581063	
0212044		DUCK	D	1234	
117	\$4,191.00		20030701	20030704	
Reject Explanation					
Segment/Record	Field Name	Segment Count			
AMT		44			
Invalid Code Value					
Additional Explanation: 2320 AMT01=N1, SBR09 must= MA or MB					
Total Reject Txn: 1			Total Reject Charge: \$4,191.00		

Rejected Transaction Report Field	Description
Submitter ID	Same as Logon ID. It is a 9-digit number.
Submission ID	Found on the Communication Log where it is called the External Batch Number. It has 8 characters and contains both letters and numbers. In this example, the submission ID is the same as the example in the Communication Log, A789WNY6.
Processing Date and Time	Date and time your claim was received by BES.
Segment/Record	Section of the electronic claim that was rejected. In this example, the segment/record is AMT.
Invalid Code Value:	Explanation used by the EDI Help Desk to determine the specific reason the segment/record was rejected.

Lists

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

While it isn't necessary to build all lists, once you create one the information in it will be available in drop down lists within the forms. This will speed your data entry process when using forms and help ensure accuracy since you only have to enter the information once.

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

To create or edit a list, select List from the Menu bar and then select the appropriate item.

Building Lists

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

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

- Billing Provider
- Client
- Other Provider
- Diagnosis Code
- Modifier Code
- NDC
- Policy Holder
- Procedure/HCPCS

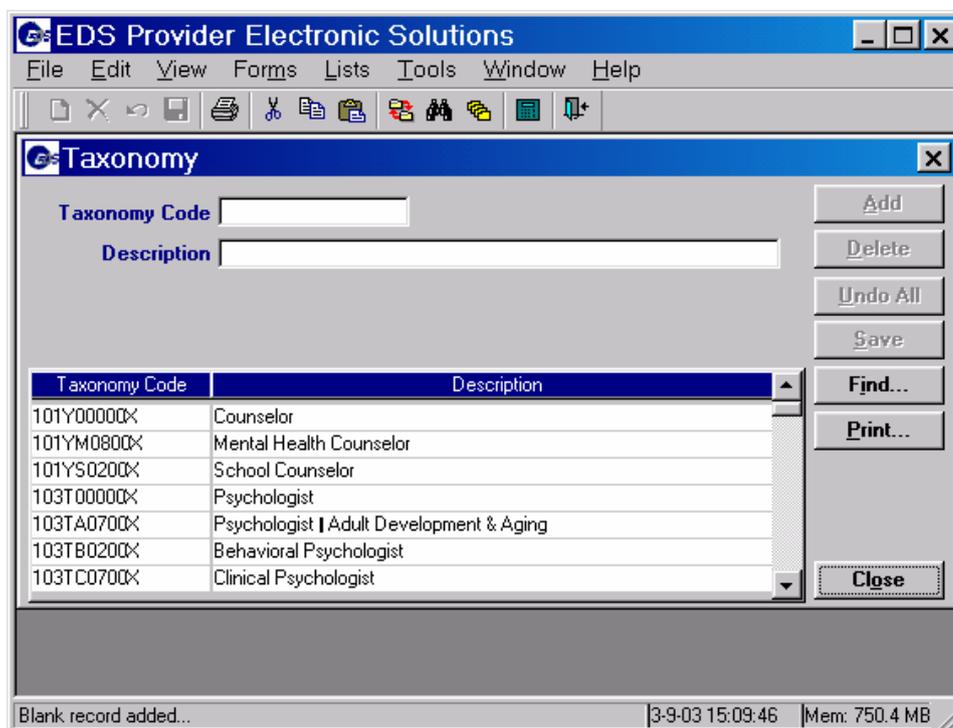
Institutional providers will want to build some or all of the following additional lists:

- Admit Source
- Admission Type
- Condition Code
- Occurrence Code
- Patient Status
- Revenue Code
- Type of Bill
- Value Code

Tip You can copy descriptions from the lists in the Appendix A – Lists while working online. Use the Text Select Tool in Acrobat Reader, copy and paste into the description field in PES. Descriptions cannot be longer than 60 characters and spaces.

To help you build these code lists, you will find valid codes to choose from in Appendix A – Lists. Valid code listings are included for all of these lists except: Diagnosis, Modifier, NDC, Procedure/HCPSCS, and Revenue codes. Refer to your Idaho Medicaid Provider Handbook for these codes.

Preloaded Lists

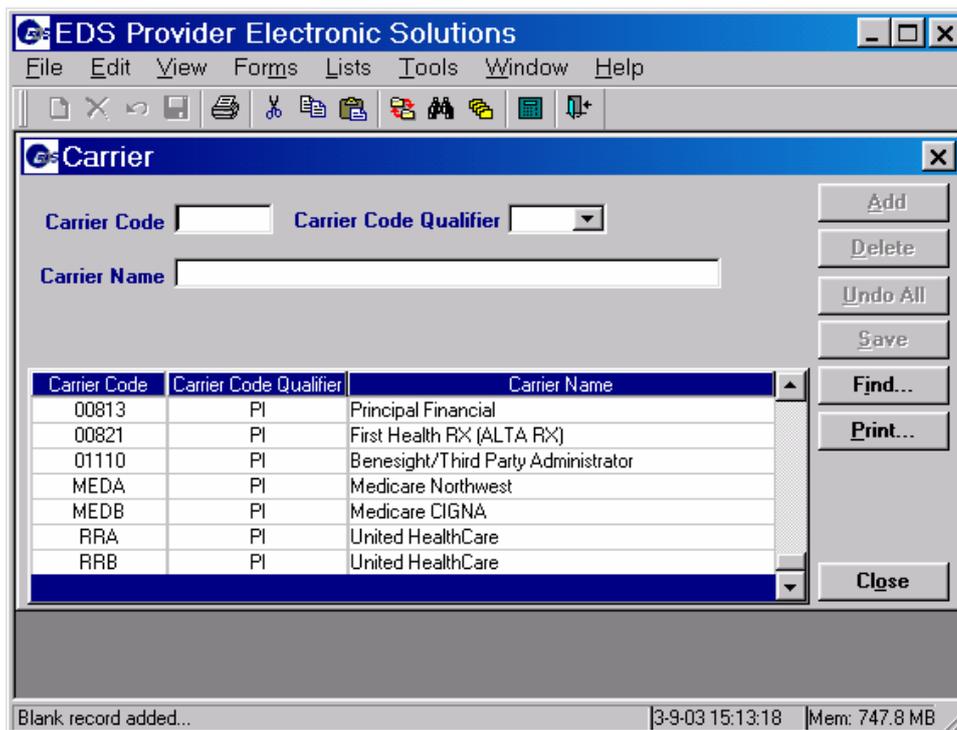


Some of the lists you can use immediately with preloaded information. Take the time to look at these lists and delete any codes you know you will not be using. This will shorten the list and make it easier to use when completing forms. The preloaded lists are:

- Taxonomy
- Carrier
- Other Insurance Reason (Adjustment Reason Codes)
- Place of Service
- Tooth

Working with Lists

From the Lists option on the menu bar, select the list that you want to create or change.



When the window opens, the **Find**, **Print**, and **Close** buttons become active (see illustration, List Bar - 1).

- Select the **Find** button on lists that already have data in them to search for an existing entry.
- Select the **Print** button to make a paper copy of all the entries on the list.
- Select the **Close** button to exit the list. If you have made any changes, you will be prompted to save those changes.

If the list is empty, begin to enter the data in a field. As soon as you place your cursor in a field, the **Save** and **Undo All** buttons become active (see illustration, List Bar - 2).

- Select the **Undo All** button to clear all of the fields in the window and start over.
- Select the **Save** button to enter a new line to a list.

To edit an existing entry, select the entry. As soon as you make any changes, the **Add** and **Delete** buttons become active (see illustration, List Bar - 3).

- Select the **Add** button to change an existing entry in the list and then use Save to keep it.
- Select the **Add** button to add a new entry to the list and use Save to keep it.
- Select the **Delete** button to remove an entry from the list.

Adding Codes

Step 1 Refer to Appendix A – Lists or coding manuals for appropriate codes.

Tip To copy the description from any of the codes in Appendix A – Lists, use the Text Select Tool in Acrobat Reader. Then copy and paste into the PES description field.

Step 2 Select the code that best describes the services you render.

Step 3 At the list window, select **Add**.

Step 4 Enter the code in the code field.

Step 5 Enter the code description into the description field. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. It can be in your own words.

Step 6 Select **Save**.

Deleting Codes

Step 1 Scroll through the list.

Step 2 Select each code that does not apply to you.

Step 3 Select **Delete**.

Step 4 Answer **Yes** or **No** to the displayed message.

Repeat until the list has only the codes that best describe the services you render.

Tip To Sort Lists: If you are working with a long list, you can sort it according to any of the columns that are displayed. Click on the blue column title. In this example, the Carrier Code List has been sorted alphabetically by carrier name.

The screenshot shows a window titled "Carrier" with a table of carrier information. The table has three columns: "Carrier Code", "Carrier Code Qualifier", and "Carrier Name". The "Carrier Name" column is highlighted in blue, indicating it is the active sort column. The table contains the following data:

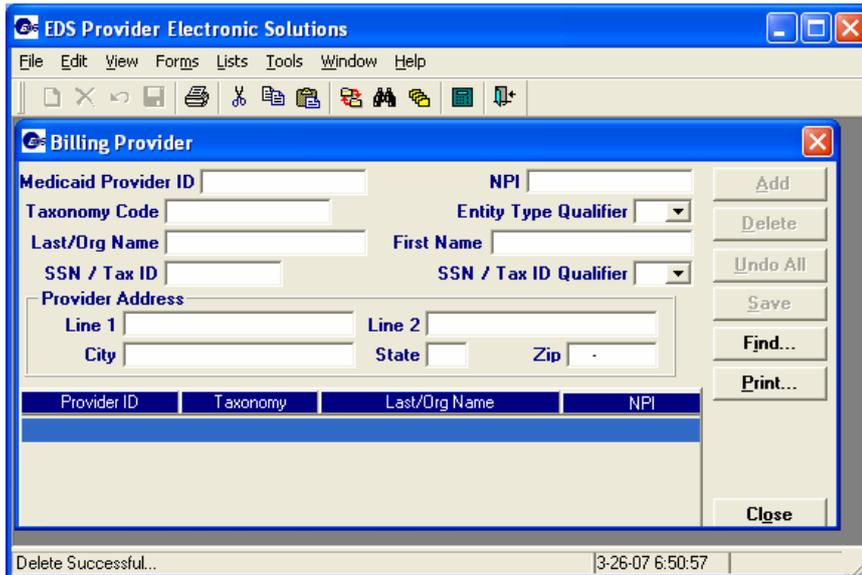
Carrier Code	Carrier Code Qualifier	Carrier Name
00437	PI	AARP
00074	PI	Administration Service
00555	PI	AETNA
00447	PI	AETNA
00380	PI	Aetna/Prudential
00037	PI	Bankers Life & Casualty
01110	PI	Benesight/Third Party Administrator

Below the table, there are several buttons: Add, Delete, Undo All, Save, Find..., Print..., and Close. Above the table, there are input fields for "Carrier Code" and "Carrier Code Qualifier" (a dropdown menu), and a "Carrier Name" input field.

Lists Used by all Providers

Billing Provider List

The Billing Provider List requires the user to enter information about service providers. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the eligibility or claims transactions. These can be individual providers or organizations.



Step 1 Enter data into all of the following fields to complete the Billing Provider List screen.

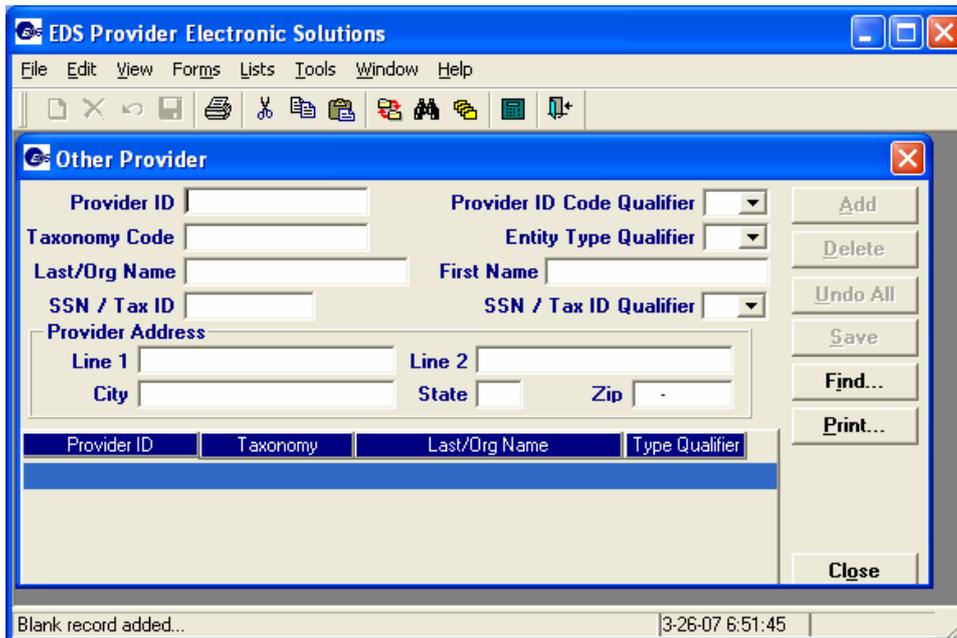
Billing Provider List Field	Description
Medicaid Provider ID	9-digit Idaho Medicaid billing provider number Note: If using multiple Medicaid Provider IDs, make sure to include every Medicaid Provider ID into the Billing Provider List.
NPI	10-digit NPI Note: If using multiple NPIs make sure to include every NPI into the Billing Provider List. If using the same NPI for different service locations, make sure to include every NPI which should include a different address and zip code.
Taxonomy Code	Select the description that best matches the service you will render as an Idaho Medicaid provider. For a complete list of all available taxonomy codes, see the Appendix A – Lists, Taxonomy Codes.

Billing Provider List Field	Description
Entity Type Qualifier	Select one of the following: <ul style="list-style-type: none"> • 1 – Person (Individual Provider) • 2 – Non-Person (Group or Institution) If the Entity Type Qualifier is a group or institution (2 – Non Person), then all fields are required except: <ul style="list-style-type: none"> • Provider Address Line 2 • First Name
Last/Org Name	Last name of person, or Organization name if a non-person
First Name	First name of the person. Only required when the Entity Type Qualifier is equal to 1 – Person
SSN/Tax ID	Social Security Number or Tax ID number for entity
SSN/Tax ID Qualifier	Select one of the following: <ul style="list-style-type: none"> • 24 – FEIN • 34 – Social Security number
Provider Address Line 1	Street or mailing address
Provider Address Line 2	Not required
Provider Address City	Name of city
Provider Address State	2-digit state code designation
Provider Zip	5-digit zip code; space is available for the additional + 4 digits to the zip code.

Step 2 Select **Save** to save the data or **Add** to add the next provider.

Other Provider List

The Other Provider List allows the user to enter information about additional providers, such as Healthy Connections referral physicians. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the claims transactions. These can be individual providers or organizations.



Step 1 Enter data into all of the following fields to complete the Other Provider List screen.

Other Provider List Field	Description
Provider ID	9-digit Idaho Medicaid billing provider number, the State license number, or provider UPIN number.
Provider ID Code Qualifier	Select one of the following: <ul style="list-style-type: none"> • 1D – if using the provider’s 9-digit Idaho Medicaid provider number • 0B – if using the physician’s state license number • 1G – if using the provider’s UPIN number • XX – if using the National Provider Identifier (NPI)
Taxonomy Code	Select the description that best matches the service in which the performing provider or referring provider specializes. You can add taxonomy codes from the complete list in Appendix A – Lists, Taxonomy Codes.
Entity Type Qualifier	Select one of the following: <ul style="list-style-type: none"> • 1 – Person (Individual Provider) • 2 – Non-Person (Group or Institution) If the Entity Type Qualifier is a group or institution (2 – Non Person) then all fields are required except:

Other Provider List Field	Description
	<ul style="list-style-type: none"> Provider Address Line 2 First Name
Last/Org Name	Last name of person or the "Organization" name if a non-person
First Name	First name of the person. Only required when the Entity Type Qualifier is equal to 1 – Person
SSN/Tax ID	Social Security Number or Tax ID number for entity
SSN/Tax ID Qualifier	Select one of the following: <ul style="list-style-type: none"> 24 – FEIN 34 – Social Security number
Provider Address Line 1	Street or mailing address
Provider Address Line 2	Not required
Provider Address City	Name of city
Provider Address State	2-character state code designation
Provider Zip	5-digit zip code; space is available for the additional + 4 digits to the zip code.

Step 2 Select **Save** to save the data or **Add** to add the next provider.

Client List

The Client List requires the user to enter detailed information about their clients. Like the other lists, once the information is entered into the list, it may be accessed from the drop down field in the eligibility or claims transactions.

The screenshot displays the 'Client' form within the 'EDS Provider Electronic Solutions' application. The form is organized into several sections:

- Client Information:** Fields for Client ID, Account #, Last Name, Client DOB (format 00/00/0000), ID Qualifier (dropdown menu), Client SSN, First Name, and Gender (dropdown menu).
- Subscriber Address:** Fields for Line 1, Line 2, City, State, and Zip.
- Table:** A table with three columns: Client ID, Last Name, and First Name.
- Buttons:** A vertical column of buttons on the right side: Add, Delete, Undo All, Save, Find..., Print..., and Close.
- Status Bar:** At the bottom, it shows 'Blank record added...', the date and time '2-21-03 14:04:45', and memory usage 'Mem: 704.3 MB'.

Step 1 Enter data into all of the following fields to complete the Client List screen. All of the fields are required except:

- Client SSN
- MI (middle initial)
- Subscriber Address Line 2

Client List Field	Description
Client ID	7-digit Medicaid identification number issued to clients who are authorized to receive State of Idaho Department of Health and Welfare services
ID Qualifier	Default: MI, for Medicaid Member ID. No action is required.
Account #	Account number assigned by the provider for their own record keeping. This field will accept both alpha and numeric characters. This is a required field.
Client SSN	Not required
Last Name	Last name of the client
First Name	First name of the client
MI	Not required.
Date of Birth	Client's date of birth using the MMDDCCYY format.
Gender	Select M for male, F for female, U for unknown.
Subscriber Address Line 1	Client's street mailing address.
Subscriber Address Line 2	Not required
Subscriber Address City	Name of city
Subscriber Address State	2-digit state code designation
Subscriber Zip	5-digit zip code; space is available for the additional + 4 digits to the zip code

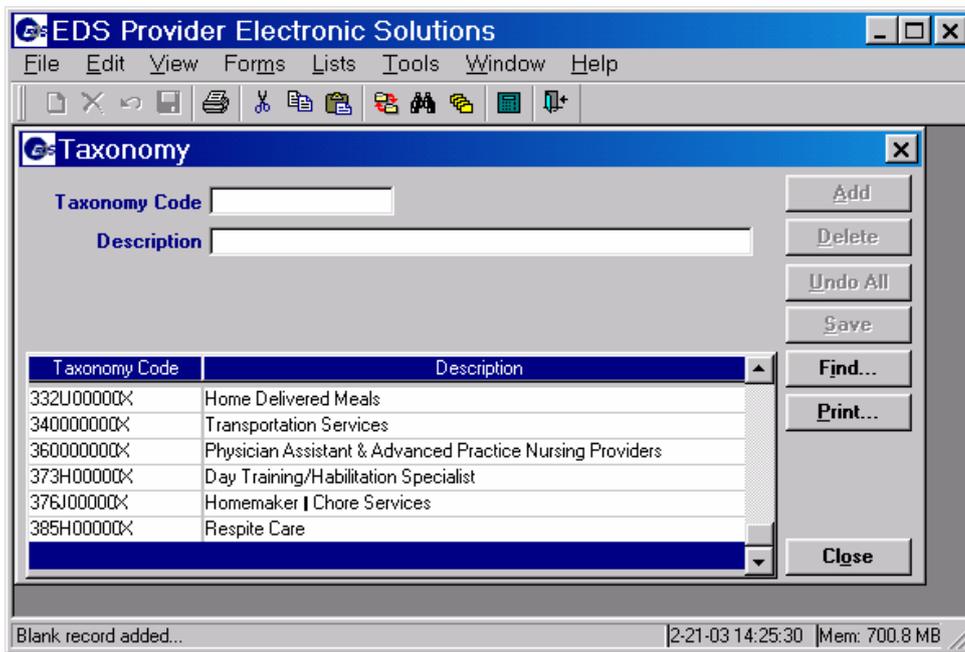
Step 2 Select **Save** to save the data or **Add** to add the next client.

Taxonomy List

The Taxonomy List is loaded with a list of provider taxonomy codes. This list has been selected to best represent the general categories of providers who participate in the Idaho Medicaid program.

Note The Taxonomy List contains all of the HIPPA pre-defined codes available for your use. These are the only codes that can be used.

You will need to choose the code that best describes the services you render. Take the time to look at this list and delete any codes you know you will not be using. This will shorten the list and make it easier to use when completing forms.



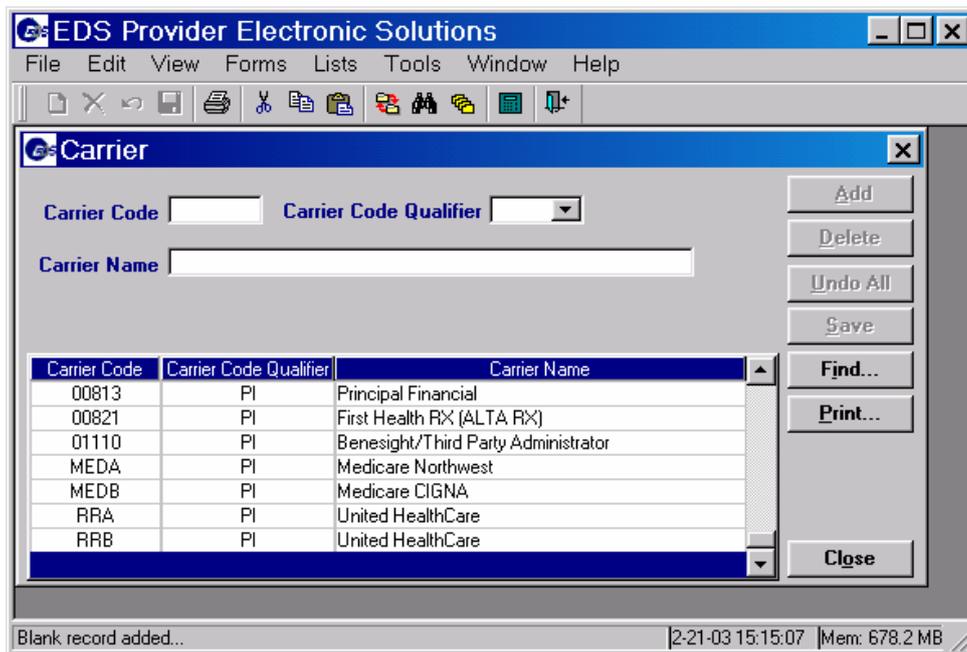
Step 1 Enter data into all of the following fields to complete the Taxonomy List screen.

Taxonomy List Field	Description
Taxonomy Code	10-digit taxonomy code that best describes the service you render. Refer to the Appendix A – Lists for the complete HIPAA-approved list of codes. This code can have both alpha and numeric characters.
Description	Description of the taxonomy code.

Step 2 Select **Save** to save the data or **Add** to add a new taxonomy code.

Carrier List

The Carrier List is preloaded with a short list of medical insurance carriers and their National Electronic Insurance Clearinghouse (NEIC) carrier codes. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Policy Holder form or the NCPDP Pharmacy form.



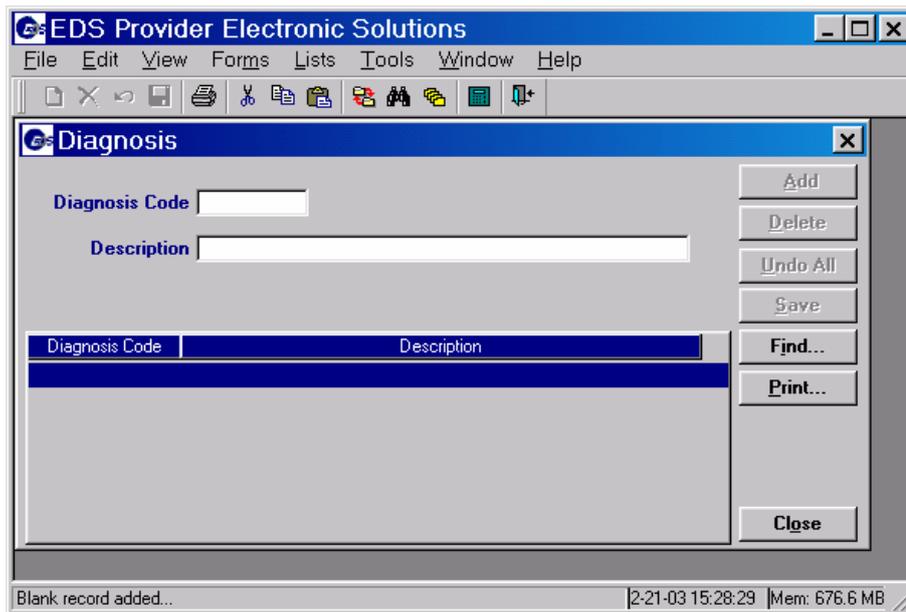
Step 1 Enter data into all of the following fields to complete the Carrier List screen.

Carrier List Field	Description
Carrier Code	National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance carrier. Note: If the carrier code is not found or unknown, contact EDS to obtain the correct carrier code.
Carrier Code Qualifier	Click in the Carrier Code Qualifier field and select PI (Payer Identification). (XV will be used after HCFA Payer Identification numbers are assigned.)
Carrier Name	Name of the other insurance company listed for the client.

Step 2 Select **Save** to save the data or **Add** to add the next carrier.

Diagnosis List

The Diagnosis List allows the user to create a list of diagnosis codes used in the 837 claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field within the claim form.



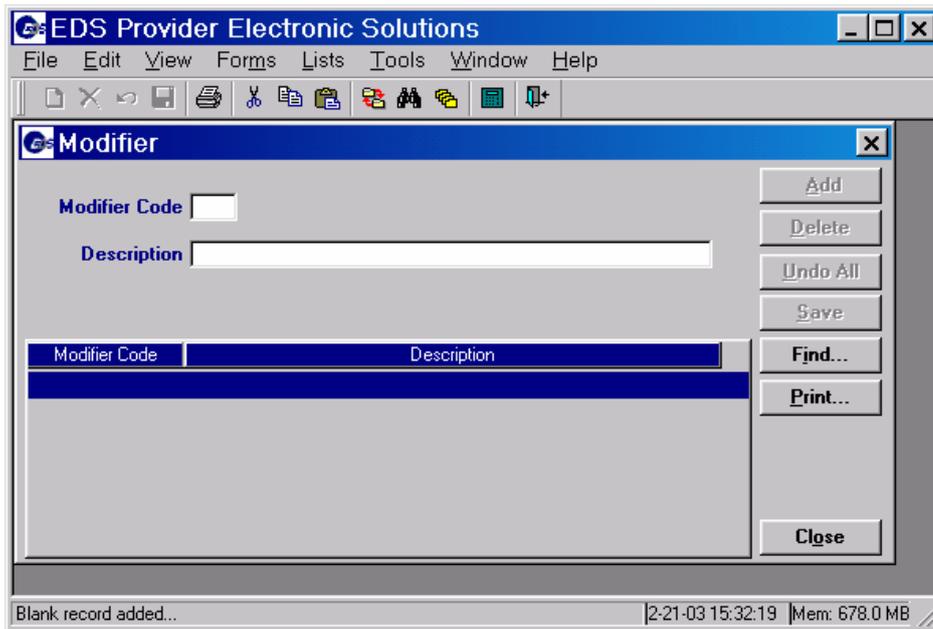
Step 1 Enter data into all of the following fields to complete the Diagnosis List screen.

Diagnosis List Field	Description
Diagnosis Code	3 to 5 digit ICD-9-CM diagnosis code that relates to the visit. This code cannot be less than 3 digits. Refer to the ICD-9-CM diagnosis code manual to obtain valid diagnosis codes.
Description	Description of the diagnosis code. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix of the ICD-9-CM coding manual or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next diagnosis code.

Modifier List

The Modifier List allows the user to create a list of modifier codes used in the 837 claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field within the claim.



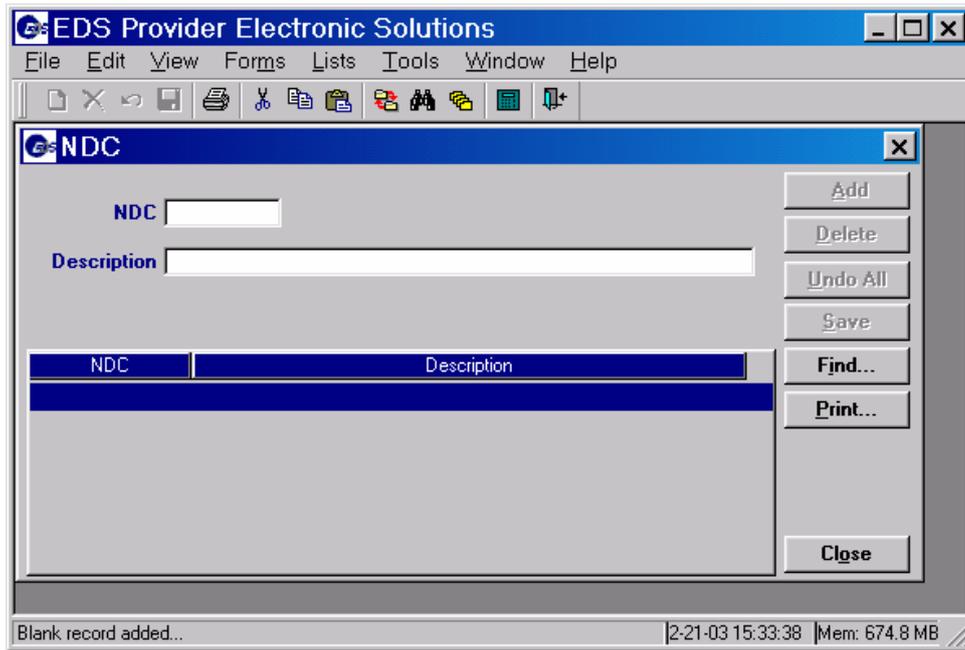
Step 1 Enter data into all of the following fields to complete the Modifier List screen.

Diagnosis List Field	Description
Modifier Code	2-character modifier code, if applicable. Up to four (4) modifiers may be entered for each detail in the transaction form.
Description	Description of the modifier code. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. It can be in your own words.

Step 2 Select **Save** to save the data or **Add** to add the next modifier code.

NDC List

The NDC (National Drug Code) List allows the user to create a list of NDCs used in the NCPDP Pharmacy, Institutional and Professional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field within the claim form.



Step 1 Enter data into all of the following fields to complete the NDC List screen.

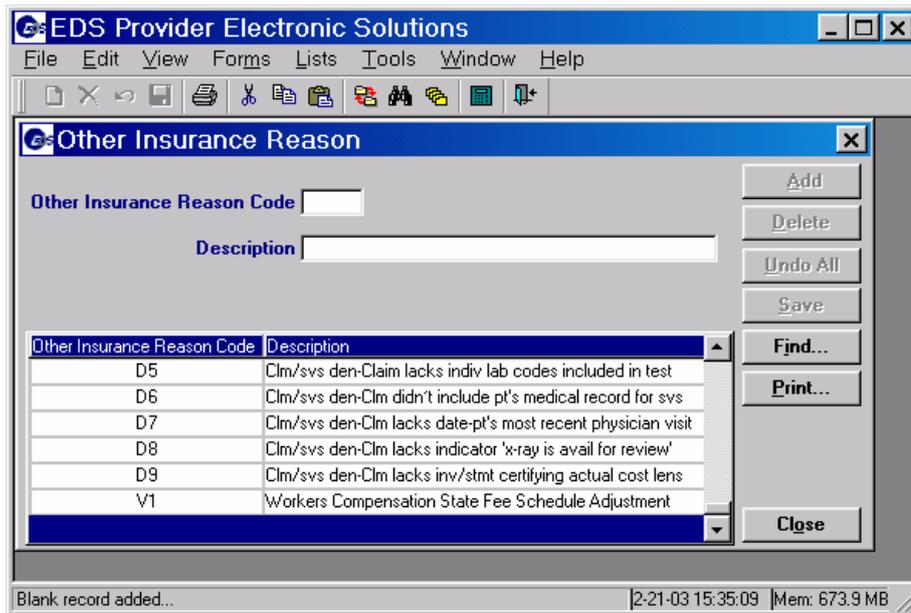
NDC List Field	Description
NDC	11-digit NDC (National Drug Code) for the drug prescribed.
Description	Description of the National Drug Code. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. It can be in your own words.

Step 2 Select **Save** to save the data or **Add** to add the next NDC.

Other Insurance Reason List

The Other Insurance Reason List is preloaded with a short list of HIPAA-approved adjustment reason codes. The Other Insurance Reason Code List allows the user to create a list of adjustment reason codes used in the 837 claim forms by other insurance carriers. These can be found on the other insurance carrier’s Explanation of Benefits statement. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field within the claim form. These codes apply only to the Dental, Professional, and Institutional claim forms.

Note The Other Insurance Reason List is preloaded with a short list of HIPAA-approved adjustment reason codes. These are the only codes that can be used. For a list of all of the HIPAA pre-defined codes, refer to Appendix A - Lists.



Step 1 Enter data into all of the following fields to complete the Other Insurance Reason List screen.

Other Insurance Reason List Field	Description
Other Insurance Reason Code	1 to 3-digit code identifying the reason for the adjustment. Refer to Adjustment Reason Codes in the Appendix A – Lists for valid codes. Enter only the codes you expect to use.
Description	Adjustment Reason Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the Appendix A – Lists or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next Other Insurance Reason Code.

Place of Service List

Important: Refer to your Idaho Medicaid Provider Handbook for valid place of service codes for your provider type or specialty.

Note The Place of Service List contains all of the HIPPA pre-defined codes; these are the only codes that can be used. For a list of all of the HIPPA pre-defined codes, refer to Appendix A - Lists.

Step 1 Enter data into all of the following fields to complete the Place of Service List screen.

Place Of Service List Field	Description
Place of Service Code	2-digit place of service code that reflects where the services for the claim were performed.
Description	Place of Service Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. It can be in your own words

Step 2 Select **Save** to save the data or **Add** to add the next place of service code.

Policy Holder List

The Policy Holder List allows the user to enter a list of information for the policy holder of other insurance policies for their clients. As with the Provider and Client lists, this list must be completed before completing a claim when the client has other insurance. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field within the 837 Dental, Professional and Institutional claim forms.

This is the most detailed list screen you will have to complete. To help you there are some drop down choices and also some fields that are not required.

Step 1 Enter data into all of the following fields to complete the Policy Holder List screen.

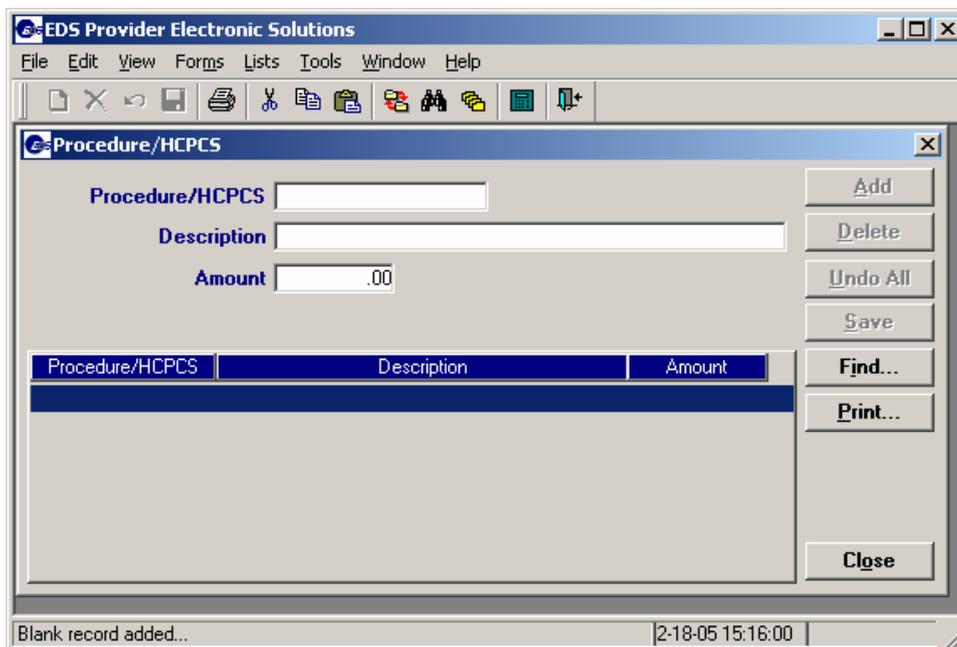
Policy Holder List Field	Description
Client ID	7-digit Idaho Medicaid client identification number issued to clients who are authorized to receive State of Idaho Medicaid services.
Group #	Group number for the Other Insurance. If a group number is not applicable, enter the policy number of the client. For Medicare clients, enter the client's HIC number.
Carrier Code	Click in the Carrier Code field and select the National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance carrier. Note: If carrier is not in the current carrier list, double click in the field and add the carrier to the Carrier List. If the NEIC number is unknown, contact EDS to obtain the correct code.
Carrier Name	Carrier name will default from the carrier code selected.
Other Insurance Group Name	Name of the group that the other insurance is listed under and coincides with Group #.
Insurance Type Code	Click in the Insurance Type Code field and select the appropriate value from the drop down field that identifies the type of insurance listed.
Relationship to Insured	Click in the Relationship to Insured field and select the appropriate value from the drop down field that identifies the relationship of the client to the policy holder. If the client is the policy holder, the code 18 for Self should be listed.
Policy Holder Information Last Name	Last name of the policy holder of the other insurance.
First Name	First name of the policy holder of the other insurance.
ID Code	Policy holder's identification number assigned by the other insurance company.
ID Qualifier	MI for Member ID
Date of Birth	Policy Holder's date of birth using the MMDDCCYY format.
Gender	Gender of the policy holder: F – Female, M – Male, U – Unknown.
Policy Holder Address Line 1	Street address of the policy holder.
Line 2	Additional address information of the policy holder, such as suite or apartment number.
City	City where the policy holder resides.
State	2 character state code for the address of the policy holder.

Policy Holder List Field	Description
Zip	Zip code of the policy holder. Space is available for the additional + 4 digits to the zip code.
Patient Information Patient ID	Not required.
ID Qualifier	Not required.

Step 2 Select **Save** to save the data or **Add** to add the next policy holder.

Procedure/HCPCS List

The Procedure/HCPCS List allows the user to create a list of procedure/HCPCS codes used most often when billing with the 837 claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the claim.



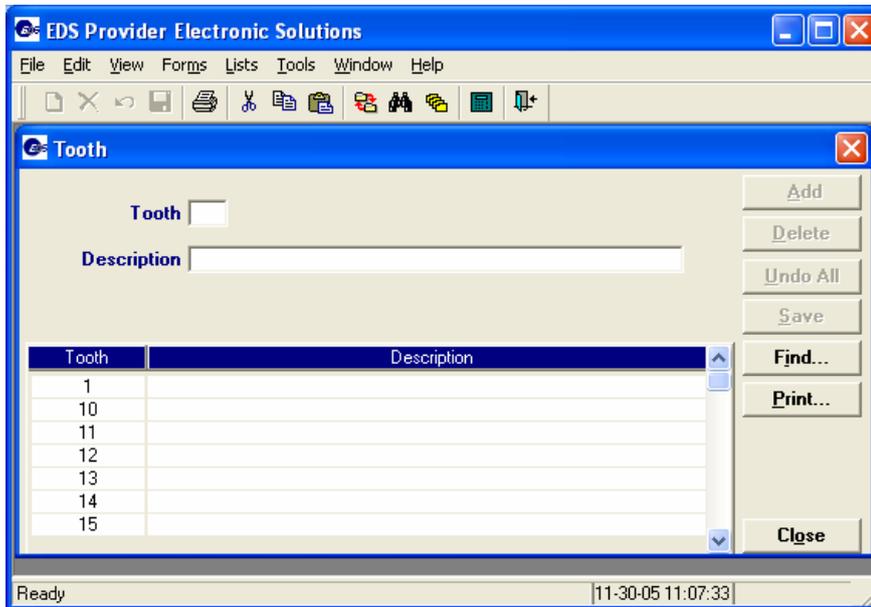
Step 1 Enter data into all of the following fields to complete the Procedure/HCPCS List screen.

Procedure/HCPCS List Field	Description
Procedure/HCPCS	3-5-digit ICD-9-CM or 5-digit national procedure/HCPCS code that best describes the services rendered.
Description	Procedure/HCPCS code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. It can be in your own words.
Amount	Unit rate amount of the procedure code.

Step 2 Select **Save** to save the data or **Add** to add the next Procedure/HCPCS code.

Tooth List

The Tooth List is preloaded with a list of tooth numbers and letters. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in Dental claim form.

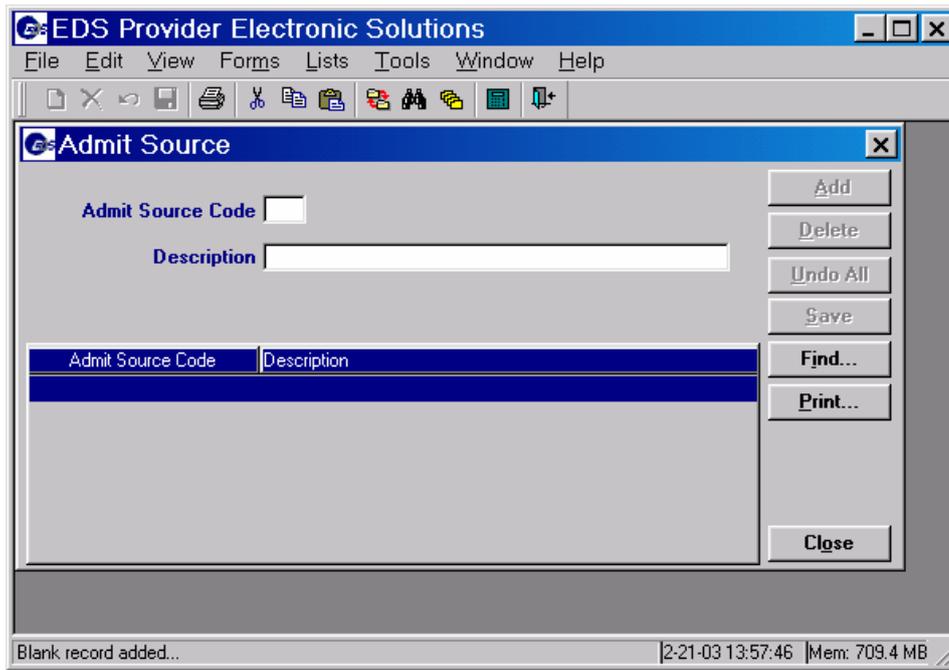


Tooth List Field	Description
Tooth	The tooth number or letter for the tooth being worked on.
Description	The tooth description.

Lists Used by Institutions

Admit Source List

The Admit Source List allows the user to enter a list of admission source codes used in the 837 Institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



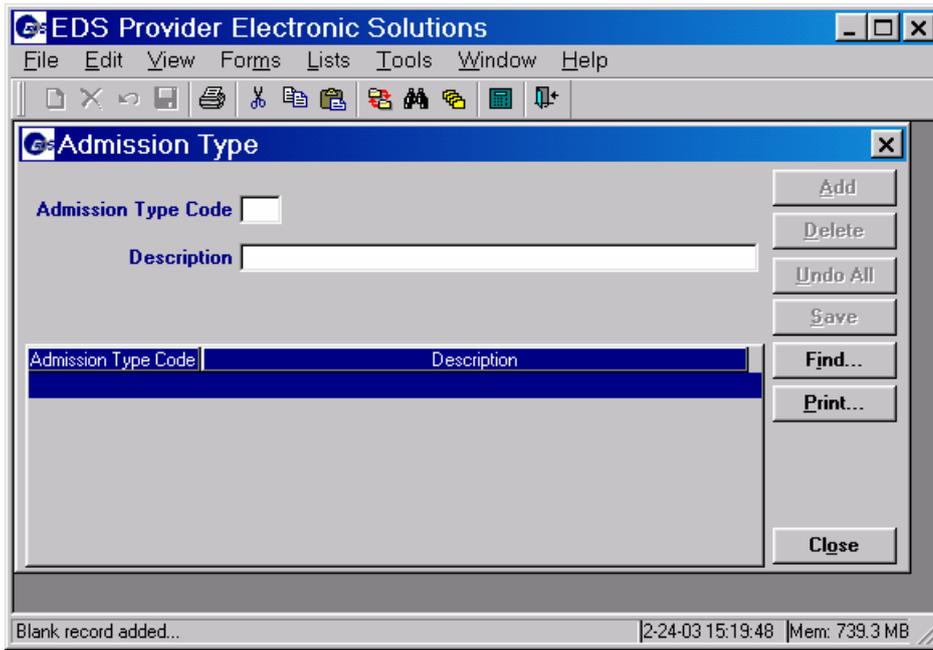
Step 1 Enter data into all of the following fields to complete the Admit Source List screen.

Admit Source List Field	Description
Admit Source Code	2-digit Admission Source Code. These codes are required for inpatient and nursing home claims. Refer to Admit Source Codes in the Appendix A – Lists for valid codes. Enter only the codes you expect to use.
Description	Admit Source Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next admit source code.

Admission Type List

The Admission Type List allows the user to enter a list of admission type codes used in the 837 Institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



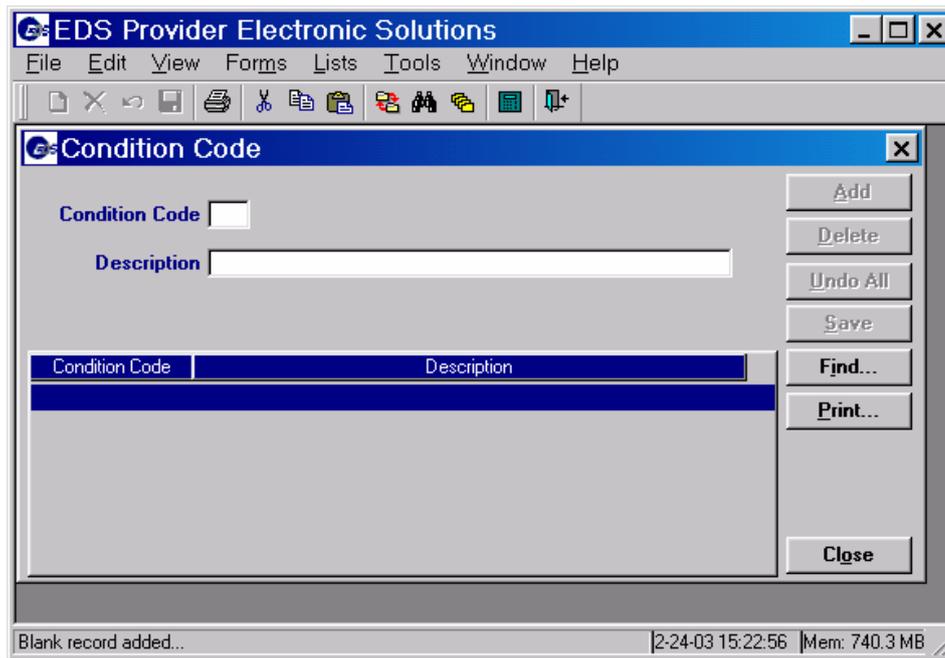
Step 1 Enter data into all of the following fields to complete the Admission Type List screen.

Admission Type List Field	Description
Admission Type Code	Refer to the priority admission codes in the UB92 manual. Only codes 1, 2, 3, and 4 are acceptable. These codes are required for inpatient and nursing home claims transactions. Refer to Admission Type Codes in Appendix A – Lists for valid codes. Enter only the codes you expect to use.
Description	Admission Type Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next admission type code.

Condition Code List

The Condition Code List allows the user to create a list of condition codes used in the 837 Institutional claim form. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



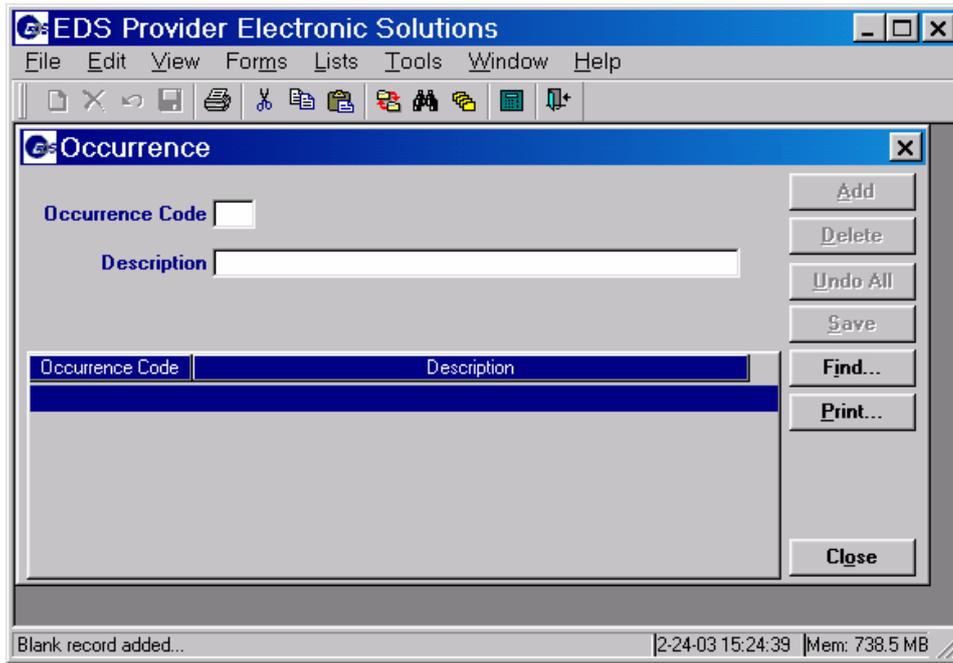
Step 1 Enter data into all of the following fields to complete the Condition Code List screen.

Condition Code List Field	Description
Condition Code	2-digit code used to identify conditions relating to the services that may affect Payer processing. Refer to Condition Codes in Appendix A - Lists for valid codes. Enter only the codes you expect to use
Description	Condition Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next condition code.

Occurrence Code List

The Occurrence Code List allows the user to create a list of occurrence codes used in the 837 Institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



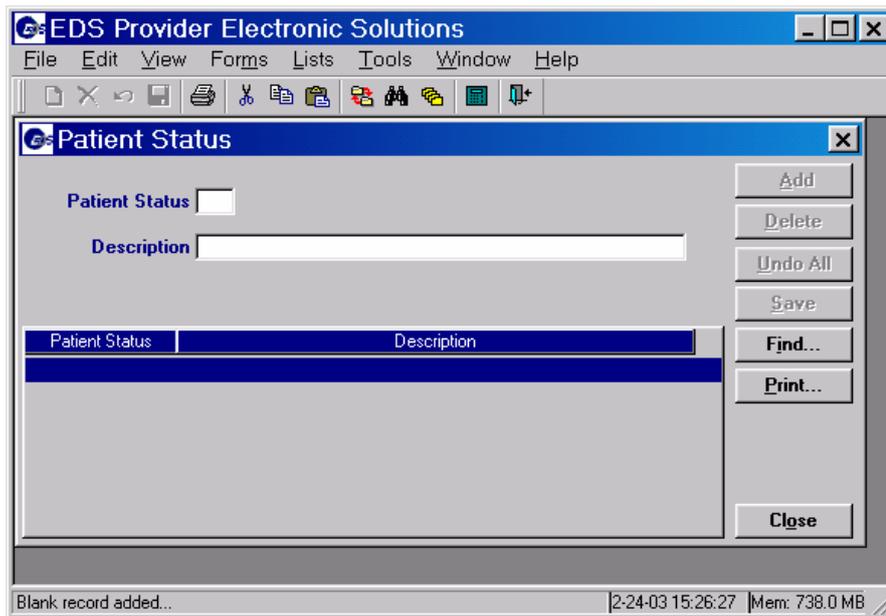
Step 1 Enter data into all of the following fields to complete the Occurrence List screen.

Occurrence Code List Field	Description
Occurrence Code	2-digit Occurrence code from the Uniform Billing Training Manual (UB92) or refer to Occurrence Codes in Appendix A - Lists for valid codes. Enter only the codes you expect to use.
Description	Occurrence Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next occurrence code.

Patient Status List

The Patient Status List allows the user to create a list of patient status codes used in the 837 Institutional claim form. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



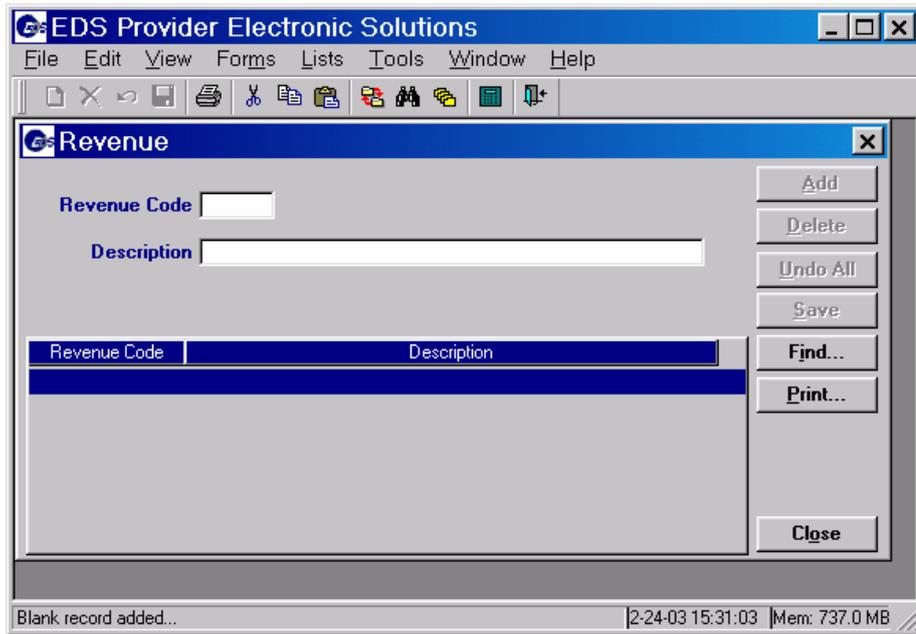
Step 1 Enter data into all of the following fields to complete the Patient Status List screen.

Patient Status List Field	Description
Patient Status	2-digit code indicating the client's status as of the statement covers through date. Refer to Patient Status Codes in Appendix A - Lists for valid codes. Enter only the codes you expect to use.
Description	Patient Status description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next patient status code.

Revenue List

The Revenue Code List allows the user to create a list of the revenue codes used most often when billing the 837 institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



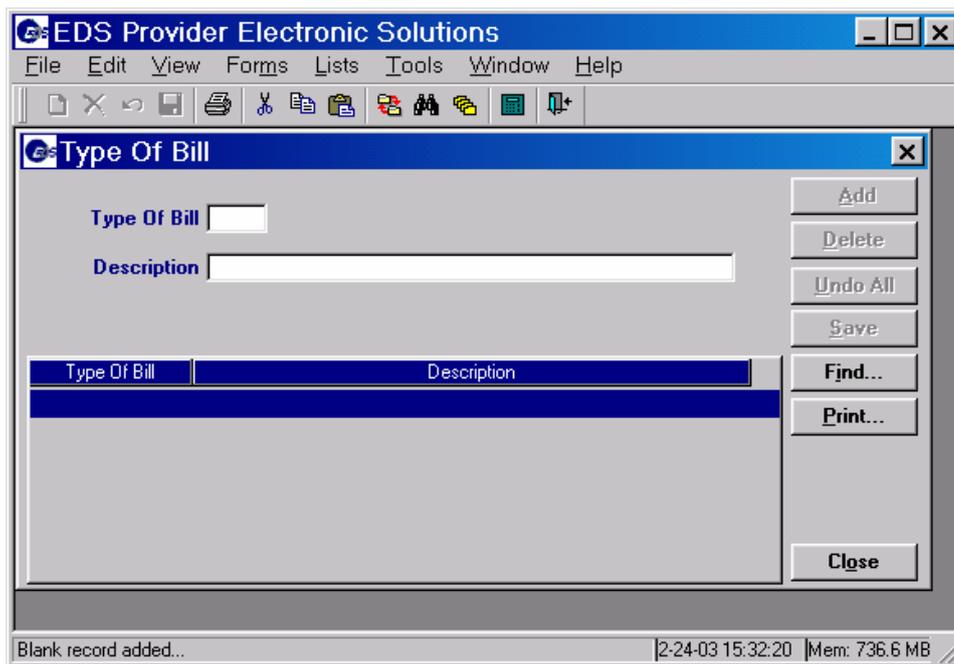
Step 1 Enter data into all of the following fields to complete the Revenue Code List screen.

Revenue List Field	Description
Revenue Code	3-digit revenue code that identifies a specific accommodation or ancillary service. Refer to the Uniform Billing Manual (UB92 Manual) or the Idaho Medicaid Provider Handbook for valid Revenue code values. Refer to Revenue Codes in Appendix A - Lists for valid codes. Enter only the codes you expect to use
Description	Revenue Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next revenue code.

Type Of Bill List

The Type of Bill List allows the user to create a list of the type of bill codes used most often when billing the 837 Institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the Institutional claim forms.



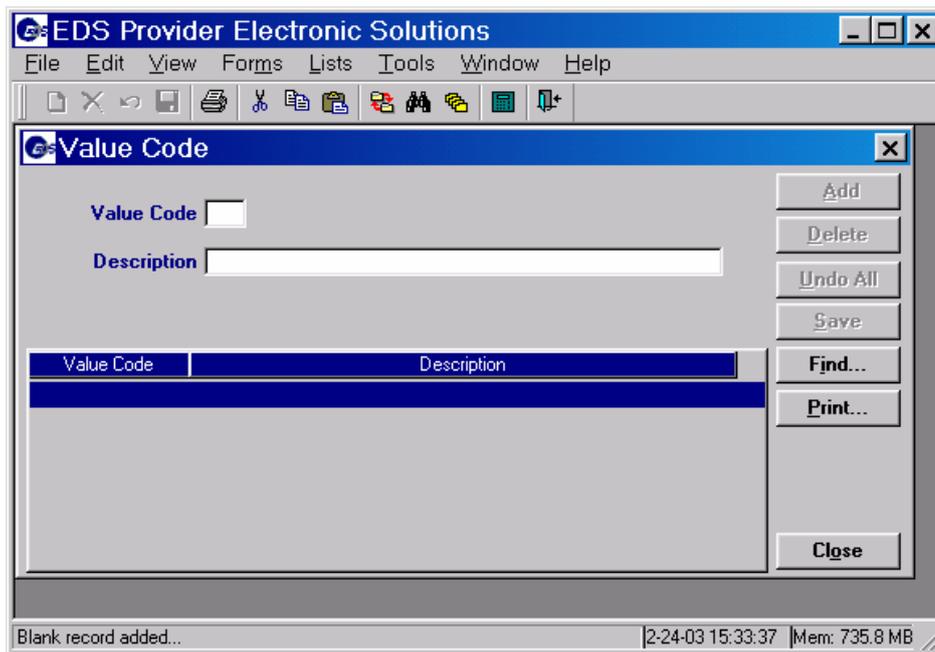
Step 1 Enter data into all of the following fields to complete the Type of Bill List screen.

Type Of Bill List Field	Description
Type of Bill	3-digit numeric code found in the Uniform Billing Training Manual (UB92) to indicate the specific type of bill or Refer to Type of Bill in Appendix A - Lists for valid codes. Enter only the codes you expect to use.
Description	Type of Bill description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next type of bill code.

Value Code List

The Value Code List allows the user to create a list of value codes used in the 837 institutional claim forms. Like the other lists, once the code is entered into the list, it may be accessed from the drop down field in the 837 Institutional claim forms.



Step 1 Enter data into all of the following fields to complete the Value Code List screen.

Value Code List Field	Description
Value Code	Enter the 2-digit National Uniform Billing Committee (UB-92) code to identify amounts and values that are necessary to process this claim as qualified by the payer organization. Refer to Value Codes in Appendix A- Lists for valid codes. Enter only the codes you expect to use.
Description	Enter the Value Code description. The description cannot be more than 60 characters and spaces. This description is intended to help the user identify what the code represents. You can use the short description given in the appendix or create your own.

Step 2 Select **Save** to save the data or **Add** to add the next value code.

Reports

You can use the Reports option on the main menu bar to select and print a variety of forms including: eligibility requests, claims, and lists.

Some of the reports include the option to choose a detail report or summary report.

Detail Form Reports

A detail report contains all the fields for a particular form. You can print a copy of the contents of any form.

- Step 1** Select **Reports**.
- Step 2** Select **Detail Forms**.
- Step 3** Select the desired form. At the new screen that comes up, you can narrow the report request by entering the batch number from the Communication Log file and/or client Medicaid Identification number.
- Step 4** Either click in **Form Status** and choose from Archived, Finalized, Incomplete or Ready, or enter the desired submission date in the Submit Date field.
- Step 5** Select **OK** to run the report. The form will open and can be viewed on line or printed.
- Step 6** Select **Print** if you want to create a paper copy of the report.

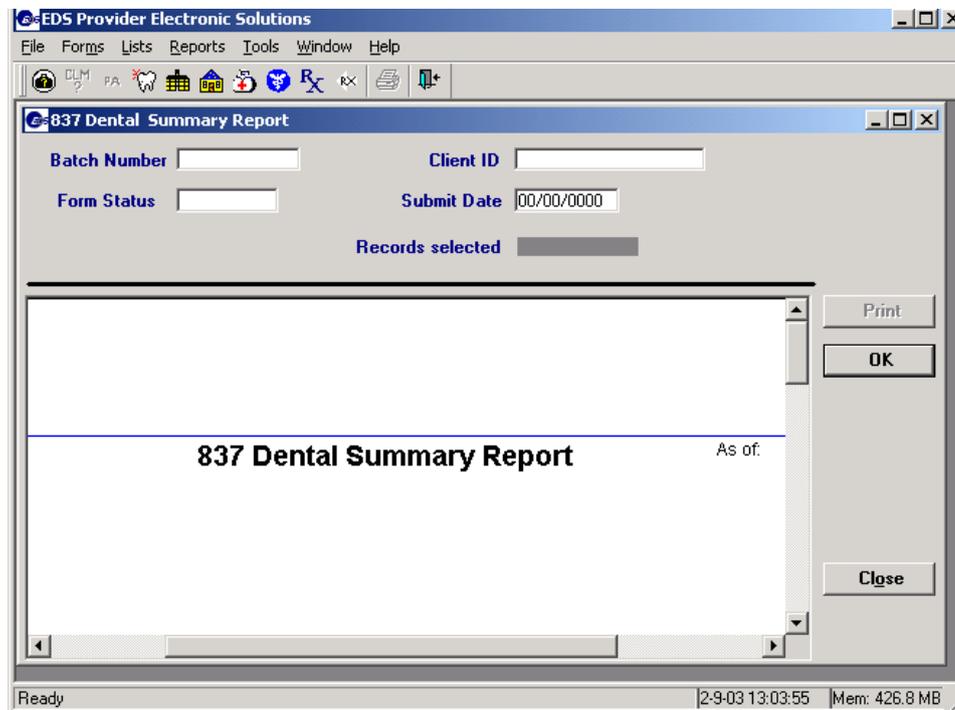
Note If you don't specify any criteria before selecting OK, the following message will be displayed:



If you select OK on the error message, ALL of the forms on the database for that form type will be included in the report.

Summary Reports

You can use a summary report as an overview of a series of forms in a single report for easier viewing. A summary report lists only a few of the fields from the detail form. Summary reports are available for all form types.



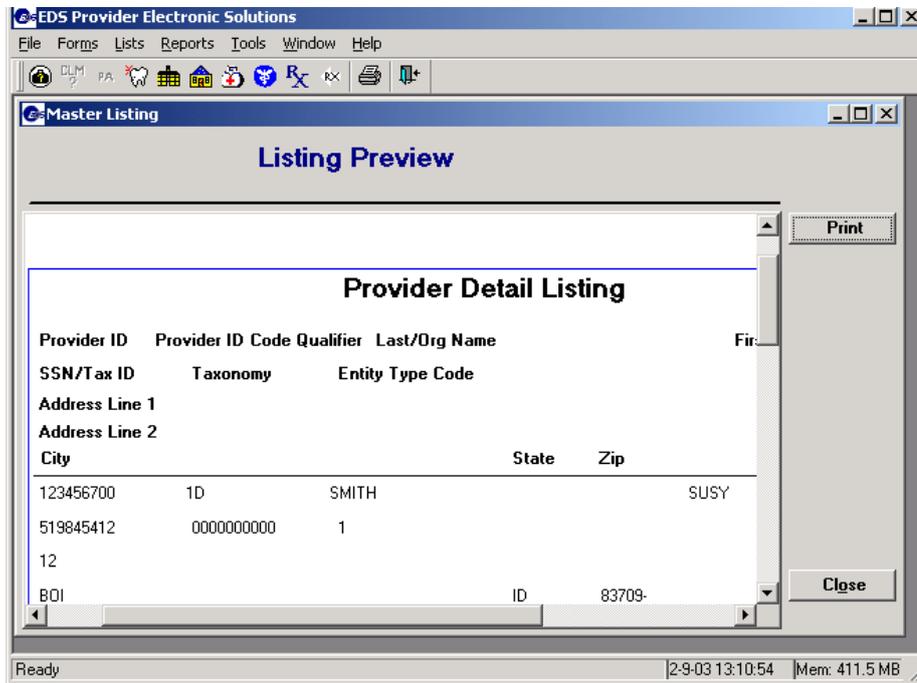
To create a Summary Report, follow the directions for Detail Form Reports, selecting **Summary Reports** in Step 2.

List Reports

List reports can be displayed on the screen or printed. Select the desired list from the Report drop down menu. All of the entries on the list will be displayed. Lists (also referred to as reference lists) include:

- Billing Provider
- Client
- Other Provider
- Taxonomy
- Admit Source
- Admission Type
- Carrier
- Condition Code
- Diagnosis
- Occurrence Code
- Other Insurance Reason
- Patient Status
- Place of Service
- Policy Holder
- Procedure/HCPCS
- Revenue
- Tooth
- Type of Bill

- Modifier
- Value Code
- NDC



Tools

The Tools Menu Options provides commands for:

- Archive
- Database Recovery
- Get Upgrades
- Change Password
- Options (the setup options you selected when you installed PES)

The Security option on the Main Menu is also discussed in this section.

Archiving

Archiving is the process used to keep the size and space required by your data small enough for it to be useful to you, while maintaining a record of the forms you have entered.

When setting up the retention option under your personal options, you can choose how many days of history you want to keep online. The standard setting is 30 days; however, you may select the setting that best suits your needs.

When you create an archive, the system will copy any form you have submitted more than 30 days ago to a compressed file and then delete that form from the database. This is designed to make the management of forms easier and keep the space on the hard drive used by the application to a minimum. You may place the compressed archive file on a diskette or leave it on your hard drive.

Tip It is a good idea to save your archive files on diskettes or CDs as a backup in case of catastrophic system failure.

Forms that are ready to be submitted will not be archived and will remain in the online database until you submit them or delete them with the **Delete** button. Forms that are incomplete and were created before the archive date will be deleted; these forms will not be saved in the archive file.

Creating a Form Archive

Step 1 Click on **Tools** on the menu bar and select **Archive**.

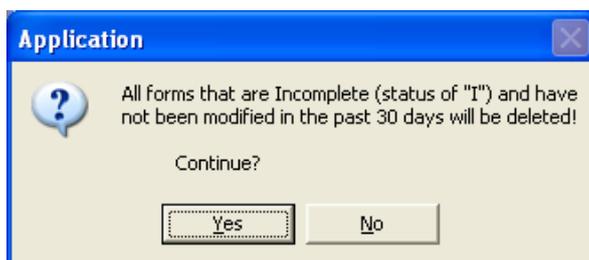
Step 2 Select **Create**. An informational message will display, reminding the user that other users must be out of the system before the archive is created.

Note If you are working in a network environment, and other users have access to PES through the network, you will need to ask all of them to exit from PES before archiving. If the software is installed on only one PC, you do not need to take any action.

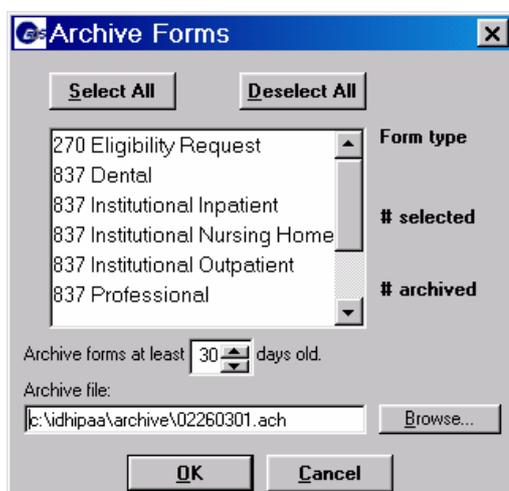
Step 3 Once you have established that all users have exited from PES, click **OK**.



- Step 4** The next message displayed tells you that all forms that are incomplete and have not been modified will be deleted. Select **Yes** to continue or select **No** to exit the archive setup.



- Step 5** Select all transactions types to be archived or use the **Select All** button. You can select all the claim types or just the ones you wish to archive.



- Step 6** Select **OK** to complete the archive or **Cancel** to exit the archive function. If you select OK, a message displays, verifying that the archive was created.

You can change the default directory, the name of the file for the archive, and the number of days used to archive the forms. This change will apply to this session only. If you want to change the number of days and have it apply to future sessions, go to **Options Retention** and select the desired number of days. Select **OK** to start the Archive.

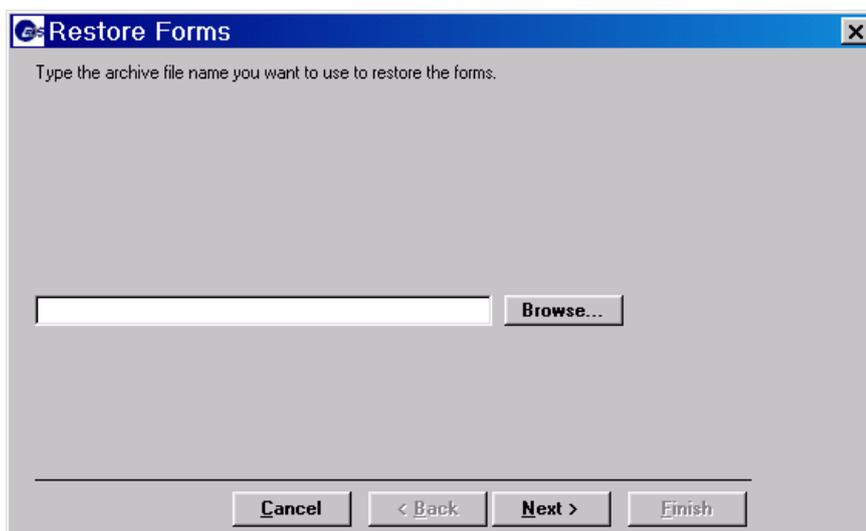
- Step 7** Select **OK** to exit the Archive window once the process has completed.

Restoring an Archive

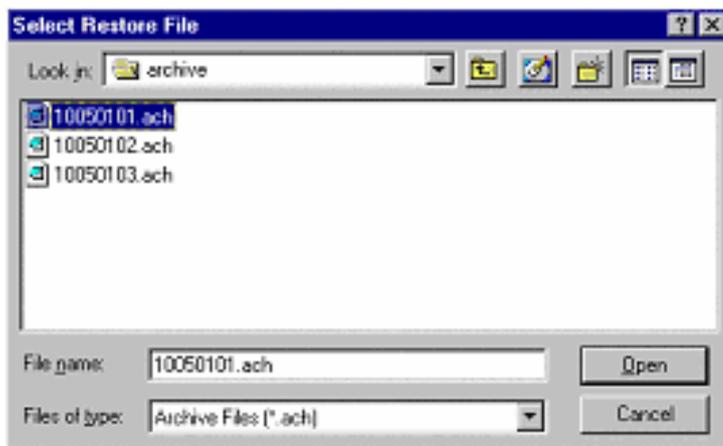
Use the Restore function to recall forms from an archive file and put them back into the on-line database. Forms that have been archived and then restored will have a status of A. You will not be able to change these forms; however, you can view them to confirm information, print them in a report, and copy them to create a new form to work with.

Step 1 Click on **Tools** on the menu bar and select **Archive**.

Step 2 Select **Restore**. The Restore Forms Browse screen displays.



Step 3 Select the **Browse** button to select the file to restore. A new window will pop up called Select Restore File.



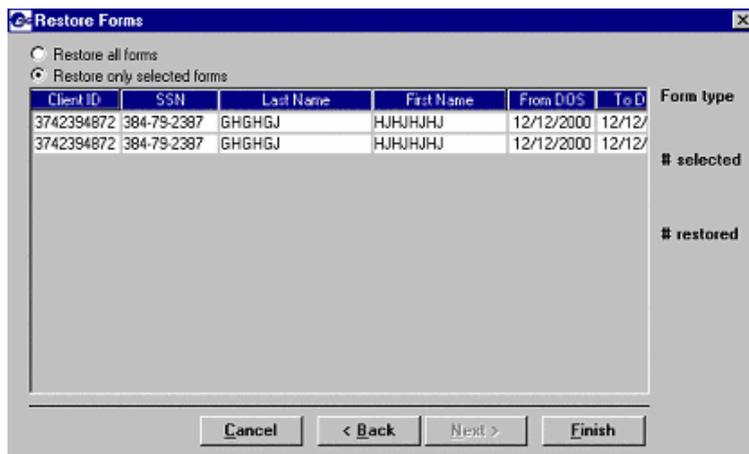
Step 4 Select the file to be restored and select **Open**. You return to the Restore window.

Step 5 Select **Next**. A list displays of the form types that are available to be restored.

Step 6 Highlight the type of form you want and select **Next**.

Note If the form type selected does not have any forms archived in the file, you will receive the following message: There are no forms to restore for the selected form type! Try another form type or a different restore file.

- Step 7** Select **OK**. Highlight another form type or select Back to change the archive file to be restored.
- Step 8** If there are available forms in the file to restore, they will be listed in the Restore Forms window.
- Step 9** Select either **Restore all forms** or **Restore only selected forms**. If you want only selected forms, highlight the ones you want to restore. After you determine which forms you want to restore, select **Finish** to complete the process.



- Step 10** You will receive a confirmation message. Select **OK** to return to the main menu.

Database Recovery

There may be times when there is a problem with the database. This option is designed to help you work with EDS Help Desk personnel to fix problems with the database.

Compacting the Database

The compact database feature is used to make database files smaller and to better organize them. Every time you delete a form, empty space is created in the database where that form used to be. The compact database option will release the empty space so that it is available to use again.

All users must be out of the database if the software is set up in a network environment.

Repairing the Database

Repair database will attempt to validate all system tables and all indexes. Generally, this feature is helpful when the user is having trouble accessing their data. The Help Desk staff will help the user identify whether or not this is necessary. The user may use this feature any time they identify it would be helpful. Compact database is recommended after Repair database.

All users must be out of the database if the software is set up in a network environment.

Unlocking the Database

Sometimes errors will cause database locks. The database may lock when the user is submitting forms, archiving forms, restoring forms, and sometimes when adding or editing forms. Unlock will unlock the database tables.

Get Upgrades

Selecting the option, **Get Upgrades**, will dial the Bulletin Board System (BBS) and download any new upgrades.

The user is occasionally prompted to check for upgrades when they log into the PES program.

If you have installed the application on several PCs, you will need to copy the upgrade file to each PC and apply the upgrade individually.

Important: Always use the upgrade function to keep your PES software current. Do not load a new version of PES unless your software application has become corrupted and you are advised to do so by the EDS/EDI Help Desk. Re-installing the software application will erase all of the data in the lists and forms that you have created or updated.

Download Upgrades Using the Web Server Method

- Step 1** Select **Tools** from the main menu
- Step 2** Select **Get Upgrades**. At the bottom left corner of the PES window, the system will indicate "downloading upgrades from the Web Server".
- Step 3** Select **OK** to return to the PES application.
- Step 4** Close the PES application and follow the instructions to apply the upgrade.

Download Upgrades Using the BBS Batch Method

- Step 1** Select **Tools** from the main menu and select **Get Upgrades**. The software will begin the dialing sequence, connect to the BBS (Bulletin Board System), and download any new available upgrades to the program folder on your hard drive where PES is installed.

You will see the following sequence of messages while the system is checking the BBS for upgrades:

```
Dialing the host at...  
Connecting to the network. Please wait.  
Logon to BBS.  
Checking for upgrade files.  
Upgrade downloading (if there is a new upgrade)  
No upgrades found (if there is no new upgrade)  
1 upgrade available (if there is a new upgrade)  
No upgrades available to apply (if there is no  
new upgrade)
```

-
- Step 2** Select **OK** to return to the PES application.
 - Step 3** Close the PES application and follow the instructions to apply the upgrade.

Apply Upgrade

- Step 1** Close PES (if still open).
- Step 2** Select the **Start** button on your desktop and select **Programs**.
- Step 3** Select the option for **ID EDS Provider Electronic Solutions** and select the option **Upgrades**. You will be prompted to exit all programs prior to continuing with the upgrade.
- Step 4** After exiting all programs, select **Yes** to the question to apply the upgrade. A series of questions will prompt you to move through the application of the upgrade.

Answer the questions until the upgrade is completed. This usually takes less than one minute.
- Step 5** Selected **Finish**. After the upgrade is complete you may access the PES application and continue your work as usual.

Passwords

All authorized users must have a password to access PES. Passwords expire every 30 days unless otherwise indicated in the retention settings in the Tools<Options feature of PES. For instructions on how to change the retention settings refer to Options in this section.

Password Rules

Passwords are not case sensitive. A password may be any combination of alphabetic, numeric, and special characters. A password must be at least 5 characters in length but no more than 10 characters.

Changing Your Password

The Change Password window allows a user to change their password. A user should change their password any time they believe their password may be known by an unauthorized person. When a password is changed, the date the password was changed is recorded.

A user is required to change their password after the number of days designated on the Options Retention setting has lapsed. The Change Password window will not allow a user to reuse their current password.

- Step 1** Select **Tools** and select Change **Password**.

Logon

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

EDS

User ID

Old Password

New Password

Rekey New Password

Question

Answer

Rekey Answer

OK

Cancel

- Step 2** Enter the old password.
- Step 3** Create a new password that is 5 to 10 characters in length.
- Step 4** Enter the new password in the New Password field.
- Step 5** Re-enter the new password in the Re-key New Password field.
- Step 6** In the Question field, select the dropdown arrow. A list of three questions appears:
- What is your mother's maiden name?
 - What is your father's middle name?
 - In what city were you born?
- Step 7** Select one question.
- Step 8** Enter the answer in the Answer field. Answers are not case sensitive and you may use spaces.
- Step 9** Re-enter the answer in the Rekey Answer field.
- Step 10** Select **OK**.
- Step 11** The next message displayed is the user password successfully updated. Select **OK** to continue.

Password Help

If you forget your PES password, you can use the password question to create a new password.

- Step 1** Select **Forgot Password** at the logon box. The Password Help box appears.

Password Help

Enter the answer to your password reset question to change your password.

EDS

Question

Answer

OK

Cancel

- Step 2** Enter the correct answer. The answer is displayed in asterisks. Be sure that you type the answer correctly. You can make three attempts to answer the password question. Select **OK**.

- Step 3** If you correctly answer the password question, you will be prompted to create a new password. After creating the new password and rekeying it, select **OK**. The PES application opens.
- Step 4** If you incorrectly answer the password question three times, you will receive an application prompt asking if you wish to reset your password. Select Yes. The system creates a 5-digit reset key number. Write down this number for contacting the EDI Help Desk.
- Step 5** Select **OK**. The PES application closes. See Using a Temporary Password to continue.

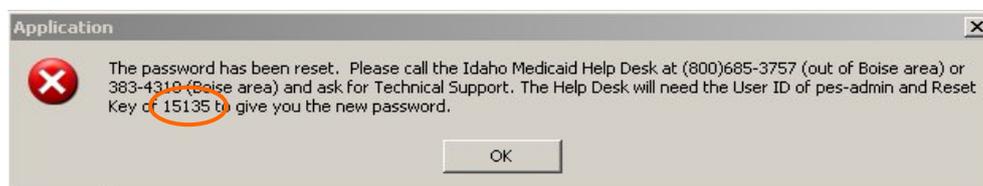
Using a Temporary Password

- Step 1** Call MAVIS and say TECHNICAL SUPPORT immediately after the MAVIS greeting.

(800) 685-3757 toll free
 (208) 383-4310 in the Boise calling area
 8:00 a.m. to 5:00 p.m. MT
 Monday - Friday (excluding State holidays)

You will need the following Information when calling the EDI Help Desk to reset a password:

- Idaho Medicaid provider number
- Name
- User ID (from the Logon dialogue box)
- 5-digit reset key number (see the Application dialog box below)



- Step 3** The EDI Help Desk will give you a temporary 8-alpha numeric character password.
- Step 4** Open the PES application.
- Step 5** Enter the temporary password into the Logon Box password field. Select OK. The PES application will now open.
- Step 6** Select **Tools | Change Password** in the PES toolbar to change your password and set up a new password question for possible future use.

Note It is strongly recommended that, immediately after logging in with a temporary password, the user set up a new password, question, and answer. See the Changing Your Password section in the Tools chapter for instructions.

Security

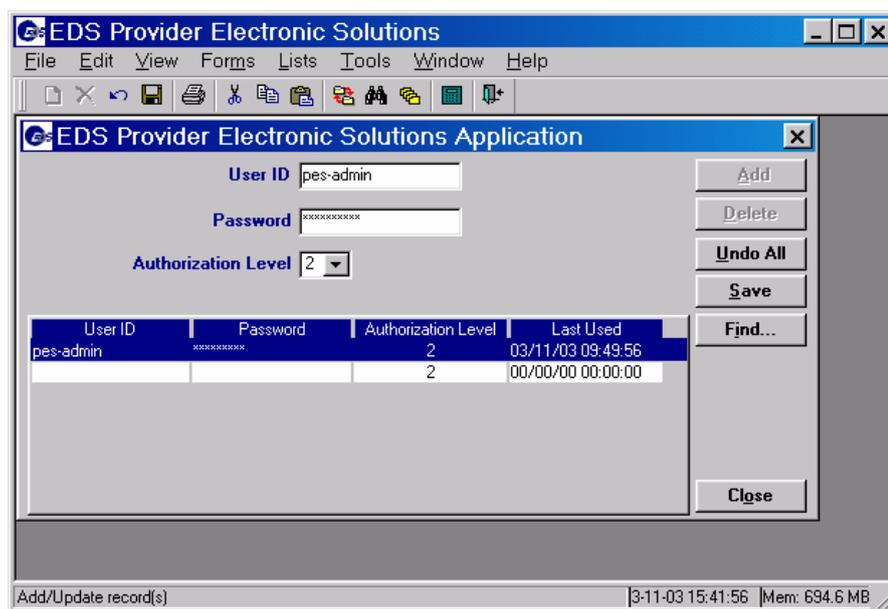
PES provides added user security through the use of passwords and authorization levels.

Security Maintenance

The Security Maintenance window is only accessible by a user logged on with a valid User ID and password that was assigned administrative authority. The Security Maintenance window is used to:

- Assign additional User IDs
- Reset a password for a user
- Delete obsolete User IDs

Access the Security Maintenance screen by selecting Security and Security Maintenance.



The Security Maintenance window initially opens with all fields blank. Selecting an existing user ID in the lookup will populate the User information. When a password is assigned or changed through Security Maintenance, the password is immediately set as expired and the user will be required to change their password the first time they log on.

- Step 1** Enter the User ID for the individual to be given access to the software application. The user ID can be alpha or numeric or both.
- Step 2** Enter a password for the new user.
- Step 3** Select the Authorization Level drop down field and select the appropriate authorization level for the new user. If selecting **2** (User-Non Administrator), the user will not have access to the Security functionality from the main tool bar selection. At least one user or the Administrator must have a security level of 1 to be able to add, change or delete users.
- Step 4** Select **Save** to save new user information or **Add** to add an additional user.

Note For a complete description of Options, refer to the Getting Started chapter.

PES Installation and Upgrade

The PES software is available on a CD. Upon completion of the installation process, store the original PES program CD in a safe place. In the event the program and files are damaged or deleted, the original CD will be needed to re-install the program.

Note Windows NT and 2000 Pro Users with Windows NT or Windows 2000 Pro must have 'administrator' rights to install this software.

Note Do not re-install the software. Re-installing will erase your PES database and any lists you have created or edited and any forms you have submitted.

PES may be installed on a computer's hard disk drive or on a network. When you begin the installation, you will need to choose between a **Typical** or **Workstation** installation. Choose **Typical** if you are installing the software on a personal computer or as a standalone. Choose **Workstation** if you are installing on a personal computer connected to a network and you wish to share a common database on the network. You may install PES on as many PCs as needed. It is recommended that each PC that has the PES software installed have different logon IDs and passwords. You may contact the EDI Helpdesk if requiring additional logon IDs and passwords.

For network installation, the database should reside on the server and the application can be loaded onto individual PCs. Choose **Typical** to install the database on the network making sure to specify a network path. Choose **Workstation** to install the application on all client PCs.

Equipment Requirements for PES

Provider Electronic Solutions (PES) is designed to operate on a personal computer (PC) system with the following equipment requirements:

Minimum	Recommended
Pentium II with CD-ROM	Pentium II with CD-ROM
Windows 2000, XP	Windows 2000, NT, ME, XP
Microsoft Internet Explorer 5.5 or greater	Microsoft Internet Explorer 5.5 or greater
64 MB RAM	128 MB RAM
800 X 600 resolution	1024 X 768 resolution
28.8 baud rate modem or faster is preferred, or other Internet connection	33.6 baud rate modem or faster, or other Internet connection
100 MB free hard drive space	100 MB free hard drive space
CD-ROM	CD-ROM
Printer with 8pt MS sans serif is preferred	Printer with 8pt MS sans serif

Minimum	Recommended
If using the Web to submit batch transactions, you must have an Internet Service Provider (ISP), or access to an Internet connection.	If using the Web to submit batch transactions, you must have an Internet Service Provider (ISP), or access to an Internet connection.

Note If you have a version of Internet Explorer below 5.5, contact Microsoft.

Before You Begin

PES software comes on a CD that includes other Idaho Medicaid provider resources. When you place the CD in your computer, it will automatically open a main menu.

If the CD does not automatically open the main menu within 30 seconds, complete the following steps before calling EDS Provider Services.

- Step 1** Remove the CD from the drive and re-insert the CD in the drive. Verify that the label is facing up when inserting the CD. The CD should auto-run. If it does not, continue to Step 2.
- Step 2** Double click the **My Computer** icon on the desktop and select the CD-ROM drive. The main menu should open automatically. If the main menu does not open, continue to Step 3.
- Step 3** Double click the **My Computer** icon on the desktop. Highlight the CD-ROM drive. Then right click the CD-ROM drive and select **Explore**. Select the **autorun.exe**. The main menu will open.
- Step 4** Click the **PES** button on the Main Menu. If you have never installed PES on your computer or computer network, you will want to select the **New Install** option. If you have installed and used PES, you will want to select the **Upgrade** option.

Warning! A new install of PES will erase any previous versions on your computer and any associated databases.

Installing PES

This section describes how to install PES on your computer or computer network from a CD. If you have never installed PES, you will want to select the **New Install** option from the PES Main Menu. If you have installed and used PES, you will want to select the **Upgrade** option described in the next section.

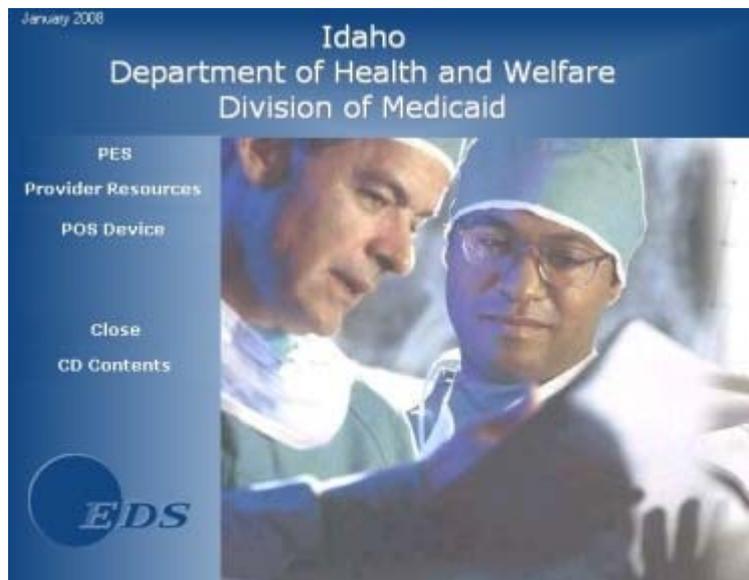
The **Typical** option installs all of the PES files, including the PES database. This option is used when installing PES on a standalone computer or an initial installation on a network server.

Installation on a Standalone Computer

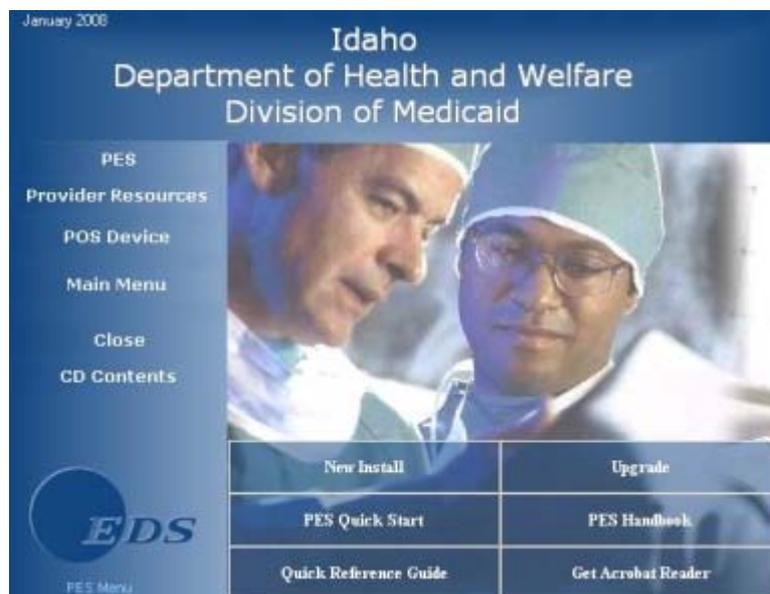
Beginning the Installation

If the AutoPlay option is running on your computer, use these instructions to begin the installation.

- Step 1** Insert the CD into the computer. (AutoPlay will automatically begin the installation.) Main Menu screen displays. Click **PES**.



- Step 2** The PES Main Menu displays. Click **New Install**.



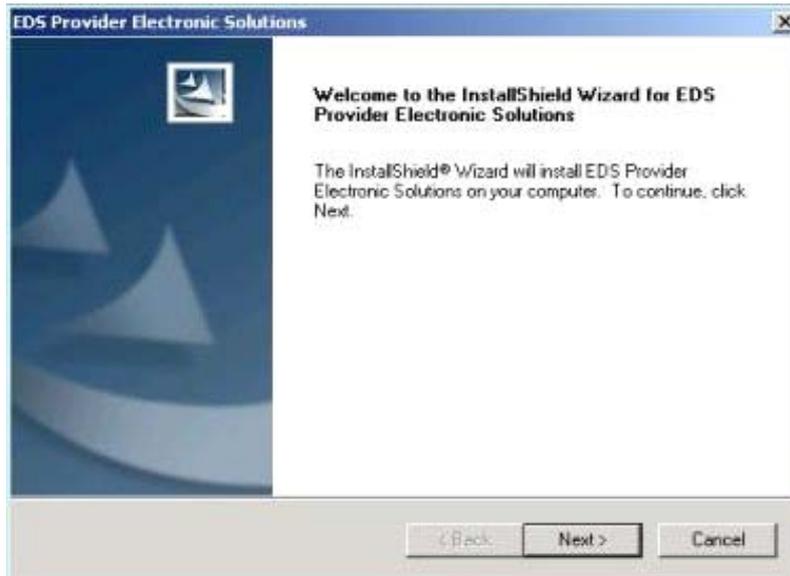
- Step 3** The New Installation screen displays. Read the warning and click **New Install**.



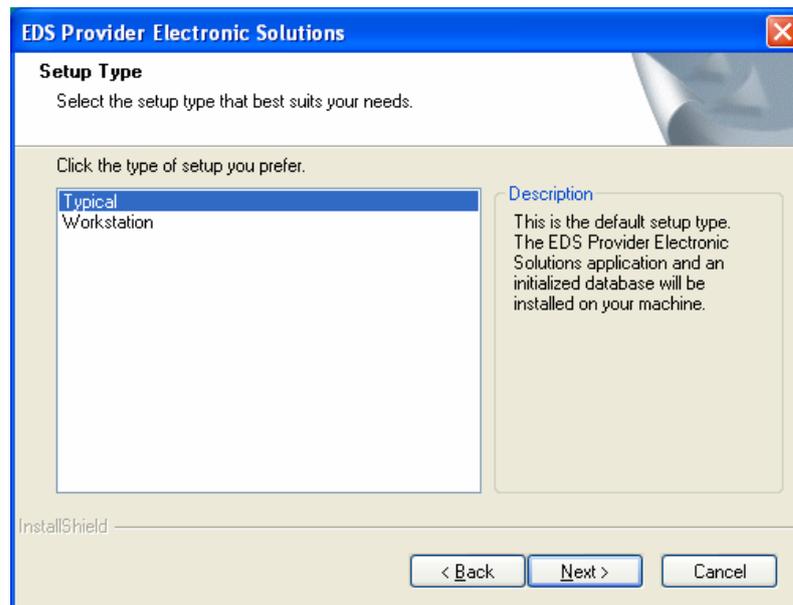
Step 4 Another warning screen displays. This screen is added insurance that users will not delete any prior installation of PES. Click **New Install**.



Step 5 The Welcome to the InstallShield Wizard screen displays. Click **Next**.



Step 6 Select the type of setup you prefer and click Next.



Note The default is **Typical**, which is for a standalone computer setup, or an initial installation on a network server

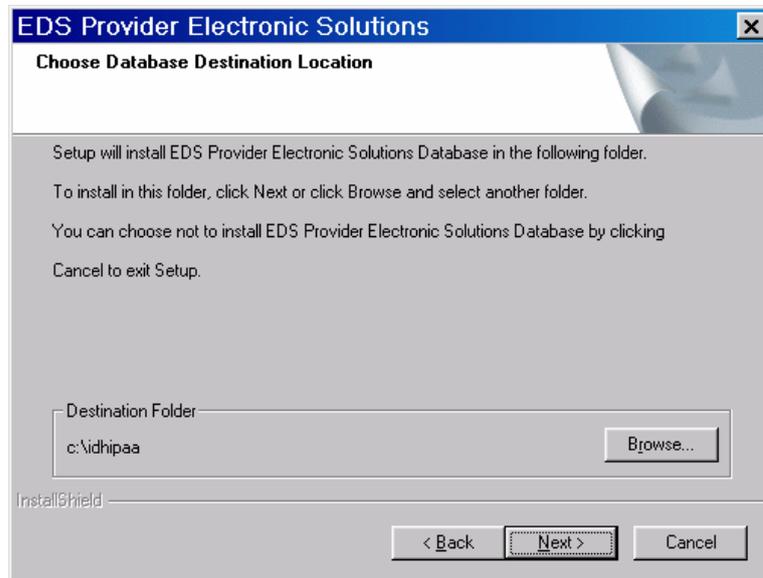
The **Typical** install option installs PES files, including the PES database. This installation option is used for installations on a standalone computer or an initial installation on a network server.

The **Workstation** install option is used for all additional computers that are connected to a network server where all users share the same database. Although this option does not

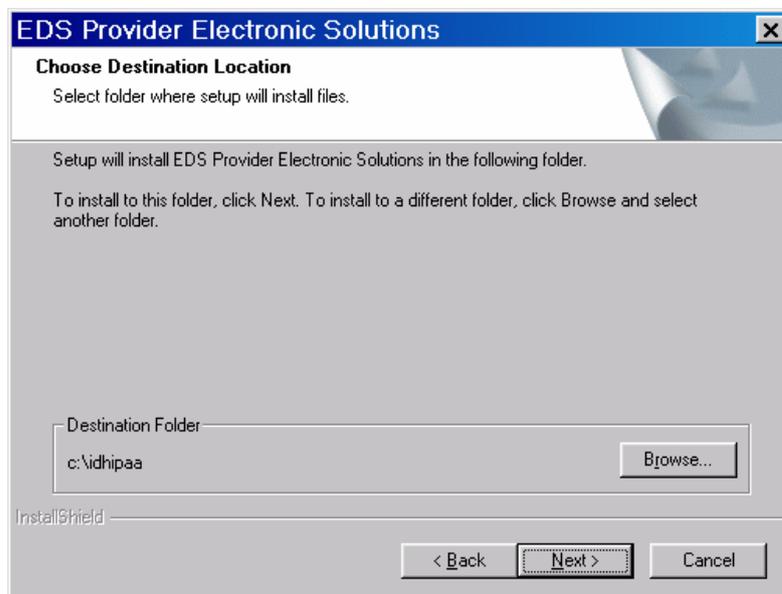
install the PES database, it does allow users to share the database installed on the network server.

Step 7 Click **Next** to accept the default destination location for the software.

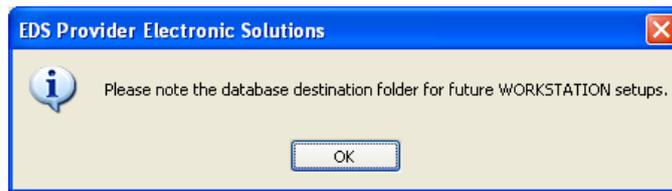
Tip Steps 7 and 8 will default to C:\ on your computer.



Step 8 Click **Next** to accept the default destination for the database.



Step 9 A pop-up box displays to note the database destination folder for future Workstation setups. Click **OK**.



Step 10 When the installation is complete, click the **Finish** button to exit the installation.



When you finish the installation, store the original PES CD in a safe place. If you experience a problem with the PES software or associated files, you will need the original CD to re-install the software.

Note You can back up the PES database by copying the IDNEW ECS.MDB file to a safe location where it can be retrieved when needed.

Completing the Installation and Getting Started

When the installation is complete, a folder will be available on the users desktop that contains two icons. A PES icon to start the application and an Upgrade icon that checks for future upgrades.

To start PES, double click the blue EDS **PES** icon in the folder labeled ID EDS Provider Electronic Solutions or click on the **Start** button in the Windows menu bar and select **Programs**. Select **ID EDS Provider Electronic Solutions**.

Network Installation

To install the application for use by several users, you will need to perform a network installation. For a network installation, the PES database can reside on the server and the PES application can be installed on individual computers. You can install PES on as many computers as needed using unique Login IDs and passwords (found in the Batch tab under **Tools | Options**).

Tip To obtain additional Logon IDs and passwords, contact the EDS Helpdesk at (800) 685-3757.

The following instructions will install the shared PES database on a network and the application on a computer.

- Step 1** Before you begin the installation, create a target directory on your network to hold the PES database.
- Step 2** Follow Steps 1 through 5 of the installation instructions for a standalone computer. When prompted for the type of installation you want (Step 6), select **Typical** on the first computer. This will be the primary computer and will need to be upgraded first when upgrading the PES software.
- Step 3** Select a target folder on the computer's C:\ drive or accept the default directory for the PES application.
- Step 4** Select a target folder (i.e., a shared network folder or another disk) for the PES database. Click **Next**.

Tip Make a note of the installation location for the PES database; future computer installations will need to refer to this location.

- Step 5** A pop-up box displays to note the database destination folder for future Workstation setups. Click **OK**.
- Step 6** When the installation is complete, click the **Finish** button to exit the installation.

Installation on Individual Computers on a Network

- Step 1** Follow Steps 1 through 5 of the installation instructions for a standalone computer.
- Step 2** When prompted to select the type of installation (Step 6), select **Workstation** and select **Next**.
- Step 3** Click **Next** to accept the default destination for the software.
- Step 4** Click **Browse** to select the target directory on the network in which you wish to locate the database. Click **OK**.
- Step 5** When the installation of the database on the network is complete, click on **Finish** to exit the installation.
- Step 6** Remove the CD from the CD-ROM drive.

Note You will need to perform Steps 1 through 6 on every workstation.

Upgrading PES

This section describes how to upgrade PES on your computer or computer network from a Web Server, Bulletin Board System (BBS), or CD. Upgrading from CD or the Web Server is recommended because it is quicker than downloading files from the BBS Batch method.

Get Upgrades

Selecting the option, **Get Upgrades**, will dial the Web Server or Bulletin Board System (BBS) and download any new upgrades.

The user is occasionally prompted to check for upgrades when they log into the PES program.

If you have installed the application on several PCs, you will need to copy the upgrade file to each PC and apply the upgrade individually.

Download Upgrades using the Web Server Method

- Step 1** Select **Tools** from the main menu
- Step 2** Select **Get Upgrades**. At the bottom left corner of the PES window, it will indicate "downloading upgrades from the Web Server".
- Step 3** Select **OK** to return to the PES application.
- Step 4** Close the PES application and follow the instructions to apply the upgrade.

Download Upgrades using the BBS Batch Method

- Step 1** Select **Tools** from the main menu.
- Step 2** Select **Get Upgrades**. The software will begin the dialing sequence, connect to the BBS (Bulletin Board System), and download any new available upgrades to the program folder on your hard drive where PES is installed.

You will see the following sequence of messages while the system is checking the BBS for upgrades:

```
Dialing the host at....  
Connecting to the network. Please wait.  
Logon to BBS.  
Checking for upgrade files.  
Upgrade downloading (if there is a new upgrade)  
No upgrades found (if there is no new upgrade)  
1 upgrade available (if there is a new upgrade)  
No upgrades available to apply (if there is no  
new upgrade)
```

- Step 3** Select **OK** to return to the PES application.
- Step 4** Close the PES application and follow the instructions to apply the upgrade.

Apply Upgrade

- Step 1** Close PES (if still open).
- Step 2** Select the **Start** button on your desktop and select **Programs**.
- Step 3** Locate the option for **ID EDS Provider Electronic Solutions** and select **Upgrades**. You will be prompted to exit all programs prior to continuing with the upgrade.
- Step 4** After exiting all programs, select **Yes** to the question to apply the upgrade. A series of questions will prompt you to move through the application of the upgrade. Answer the questions until the upgrade is completed. This usually takes less than one minute.

Upgrades From CD

Periodically, EDS will send a new Idaho Medicaid Provider Resources CD to all active providers. The CD will contain the latest version of PES for a new installation and upgrades for users who have already installed PES. Upgrading from CD or the Web Server is recommended because it is quicker than downloading files from the BBS Batch method.

To apply a computer or computer network upgrade from the CD, follow the steps for opening the Main Menu under Before You Begin.

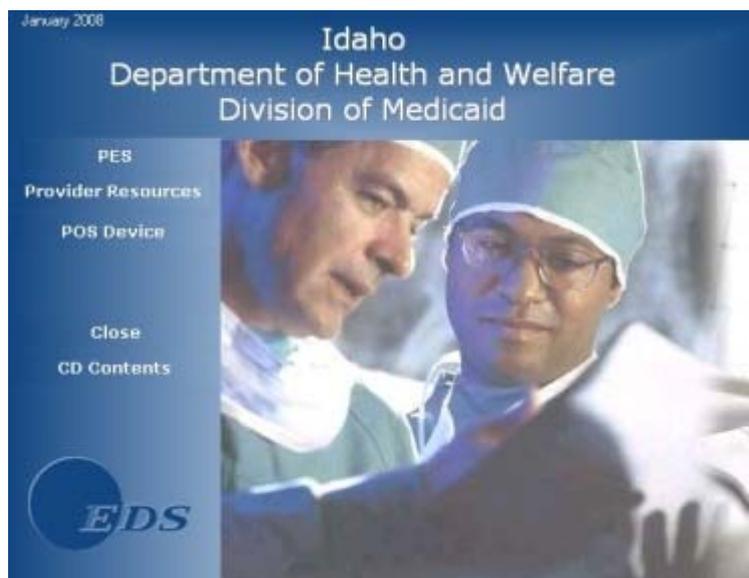
CD Upgrade for Standalone Computer

Beginning the Upgrade

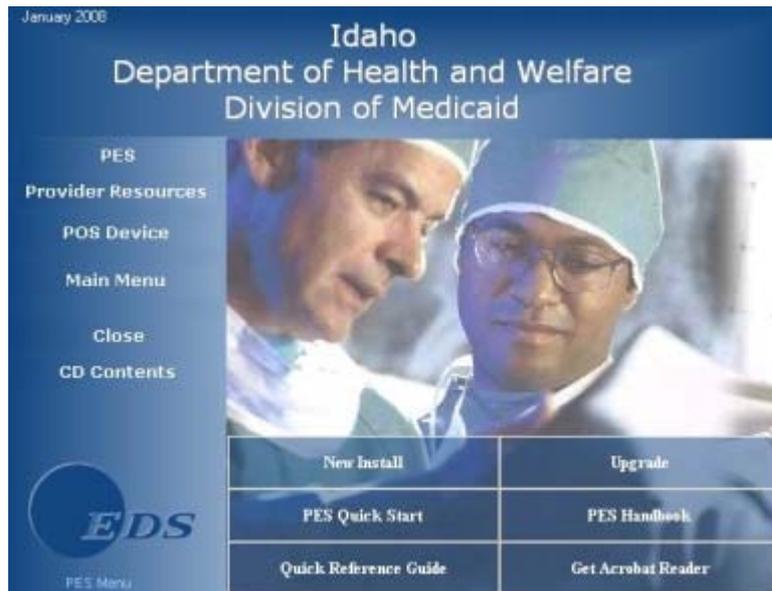
Use these instructions to begin a standalone computer upgrade.

Important: Before applying the upgrade, verify that the PES software is closed.

- Step 1** Insert the CD into the computer. The Main Menu screen displays. Click **PES**.



Step 2 The PES Main Menu displays. Click **Upgrade**.



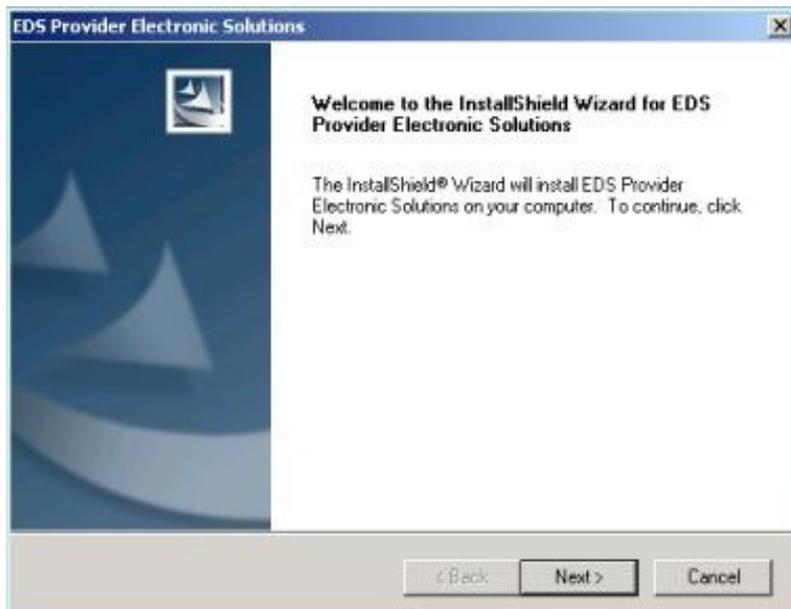
Step 3 A Warning message will display, indicating that Windows 98 users will no longer be supported with this version. If running windows 2000 or greater, select **Install Upgrade**. If running windows 98, select **Close**. EDS will no longer support users running windows 98.



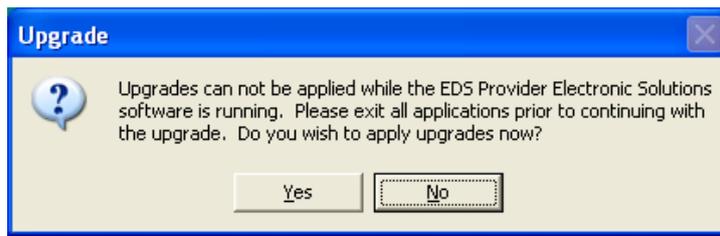
Step 4 The Upgrade screen displays. Click **Upgrade**.



Step 5 The Welcome to the InstallShield Wizard screen displays. Click **Next**.



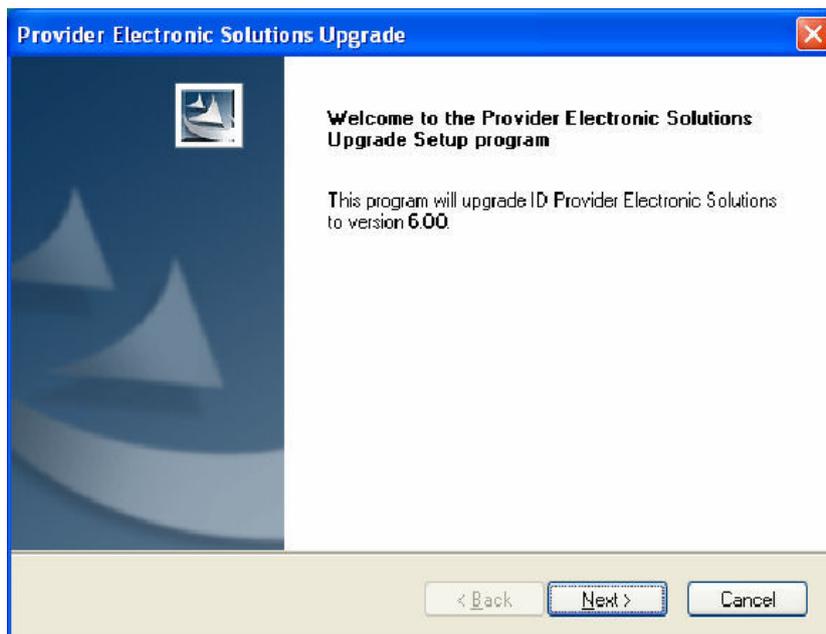
Step 6 A warning message displays, verifying that PES software is not currently running. If PES software is running, close the program and select the **Yes** button in the InstallShield Wizard screen. If PES is not currently running, select the **Yes** button to continue the upgrade.



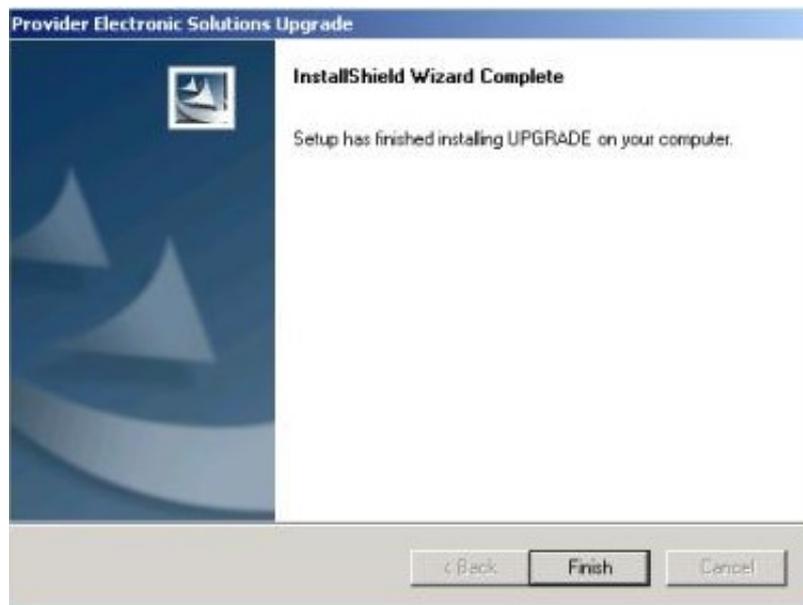
Step 7 A message displays, indicating that you have 1 upgrade to apply. Click **OK** to proceed with the upgrade.



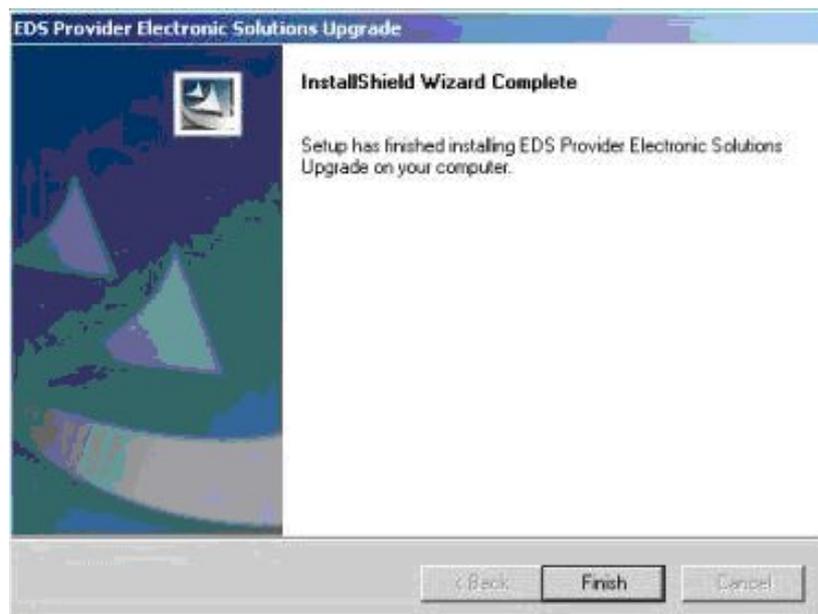
Step 8 Upgrade files are extracted and another upgrade message displays to confirm the upgrade to PES version 6.00. Click **Next**.



Step 9 A finished message displays. Click **Finish**.



Step 10 A second finished message displays. Click **Finish**.



CD Upgrade for Network Install

Important: When applying an upgrade in a network environment, make sure that you upgrade all PCs running PES (primary or **Typical** first, then **Workstations**). This will ensure that all copies of PES remain synchronized. To ensure the upgrade is successful, verify the following:

- No one is using the database at the time the upgrade is being applied
- All PCs running the application are upgraded
- The database is upgraded first

Note PES cannot be upgraded if it is installed to a compressed directory. You will need to decompress the directory before running the upgrade. Once PES is upgraded, the directory can be recompressed.

- Step 1** Locate the (primary or **Typical**) install. This is where the database resides.
- Step 2** Follow the steps for CD Upgrade for Individual PC (Steps 1 through 10)
- Step 3** Once you have upgraded the primary or **Typical** database, you can begin the workstation upgrades.
- Step 4** Follow the same steps for CD Upgrade for Individual PC (steps 1 through 10) on each workstation.

Appendix A - Lists

This section contains some of the lists that you may enter into PES. For more information on how to build and use lists, see the Lists chapter.

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

Adjustment Reason Codes (ARC)

Code	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	Procedure code is inconsistent with the modifier used or a required modifier is missing.
5	Procedure code/bill type is inconsistent with the place of service.
6	Procedure/revenue code is inconsistent with the patient's age.
7	Procedure/revenue code is inconsistent with the patient's gender.
8	Procedure code is inconsistent with the provider type/specialty (taxonomy).
9	Diagnosis is inconsistent with the patient's age.
10	Diagnosis is inconsistent with the patient's gender.
11	Diagnosis is inconsistent with the procedure.
12	Diagnosis is inconsistent with the provider type.
13	Date of death precedes the date of service.
14	Date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.

Code	Description
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	OPEN
29	Time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	OPEN
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
46	OPEN
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	OPEN
49	Non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	Non-covered services because this is not deemed a 'medical necessity' by the payer.

Code	Description
51	Non-covered services because this is a pre-existing condition
52	Referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	OPEN
64	OPEN
65	OPEN
66	Blood Deductible.
67	OPEN
68	OPEN
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	OPEN
72	OPEN
73	OPEN
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.

Code	Description
76	Disproportionate Share Adjustment.
77	OPEN
78	Non-Covered days/Room charge adjustment.
79	OPEN
80	OPEN
81	OPEN
82	OPEN
83	OPEN
84	OPEN
85	Interest amount.
86	OPEN
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	OPEN
93	OPEN
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	OPEN
99	OPEN
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.

Code	Description
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
108	Payment reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period or occurrence has been reached.
120	OPEN
121	Indemnification adjustment.
122	Psychiatric reduction.
123	OPEN
124	OPEN
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.

Code	Description
133	Disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
145	Premium payment withholding.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support this length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
155	Claim is denied because the patient refused the service/procedure.
156	Flexible spending account payments.

Code	Description
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.
158	Payment denied/reduced because the service/procedure was provided outside of the United States.
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus.
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	OPEN
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B2	OPEN
B3	OPEN
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.

Code	Description
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	Claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because 'New Patient' qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	OPEN
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	OPEN
B22	Payment is adjusted based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
W1	Workers Compensation State Fee Schedule Adjustment

Admission Type Codes

Code	Description
1	Emergency (Refers to ER admission)
2	Urgent (Generally refers to admission to the first available and suitable accommodation)
3	Elective (Scheduled admission)
4	Newborn

Admit Source Code

Code	Description
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a hospital
5	Transfer from a skilled nursing facility
6	Transfer from another health care facility
7	Emergency Room
8	Court/Law enforcement
9	Information not available – not accepted by Medicaid

Code Structure (for Newborn)

Code	Description
1	Normal Delivery
2	Premature Deliver
3	Sick Baby
4	Extramural Birth

TPR Carrier Codes

Carrier Code	Carrier Name
00010	Utah-Idaho Teamsters Health & Welfare
00011	Railroad Employees
00012	Blue Shield of Idaho (Regence)
00014	Mail Handlers
00020	Palmetto Government Benefit Admin
00025	Oregon Life & Health
00037	Bankers Life & Casualty
00038	Regence Life And Health
00039	Blue Cross Of Idaho
00041	Blue Cross Of Washington/Alaska
00051	Union Bankers Insurance
00053	Deseret Mutual Benft

Carrier Code	Carrier Name
00058	First Health
00059	TPM / Timber Product Management
00062	N A L C Health Benefit
00063	Lamb-Weston Gr Claim
00068	Globe Life & Accident
00070	I E C / Ameri-Ben Solutions
00074	Administration Service
00077	Medical Services Corporation (MSC)
00079	Mutual Of Omaha
00083	Physicians Mutual
00102	GEHA
00124	First Health
00148	Iowa Benefits
00158	Blue Cross Of California
00160	Great West Life
00162	Lamb Weston
00173	Group Health Northwest
00192	Blue Cross Blue Shield Of Utah
00194	Group Health Northwest
00197	Jensen Administrative Services
00213	Blue Cross Of Idaho
00221	Wall-Mart Benefits
00228	CIGNA
00246	Highmark B C B S of Pennsylvania
00253	Boise Cascade Insurance
00266	CIGNA
00296	Health Med / Qualmed
00302	United Health Care
00303	First Health
00307	Washington-Idaho Operating Engineer

Carrier Code	Carrier Name
00310	First Health HP Employees
00314	Blue Cross of Pennsylvania
00337	HMO Blue
00347	United Health Care
00364	Mega Life & Health
00367	United Health Care
00380	AETNA/Prudential
00433	United Health Care
00437	AARP
00447	AETNA
00485	MEGA Life & Health
00489	Combined Insurance
00504	Educators Mutual
00555	AETNA
00577	Lincoln National
00597	Principal Financial/JR Simplot
00615	I H C
00639	Retail Clerks Trust
00751	CIGNA
00752	Heller Associates
00813	Principal Financial
00821	First Health RX (Alta RX)
01110	Benesight/Third Party Administrator
MEDA	Medicare Northwest
MEDB	Medicare CIGNA
RRA	United Healthcare
RRB	United Healthcare

Condition Codes

Code	Description
Insurance Codes	
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered By Insurance Not Reflected Here
04	HMO enrollee
05	Lien Has Been Filed
06	ESRD Patient in 1st 18 months of entitlement Covered Employer Group Health Insurance
07	Treatment of Non-terminal Condition for Hospice Patient
08	Beneficiary would not provide information concerning other insurance coverage
09	Neither Patient nor spouse is employed
10	Patient and/or Spouse is employed but no EGHP Exists
11	Disabled Beneficiary but No LGHP
12-16	Payer codes – for use by payer only
Special Conditions	
17	Reserved for national assignment
18	Maiden Name Retained
19	Child Retains Mother's Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice
22	Patient on Multiple Drug Regimen
23	Homecare giver Available
24	Home IV Patient Also Receiving HHA Services
25	Reserved for national assignment
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory test
28	Patient and/or Spouse's EGHP Secondary to Medicare
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare
30	Reserved for national assignment

Code	Description
Student Status	
31	Patient is student (full time – day)
32	Patient is student (cooperative/work study program)
33	Patient is student (full time – night)
34	Patient is student (part time)
35	Reserved for national assignment
Accommodations	
36	General care Patient in a Special Unit
37	Ward Accommodations at Patient Request
38	Semi-Private Room Not Available
39	Private Room Medically Necessary
40	Same Day Transfer
41	Partial Hospitalization
42-45	Reserved for National Assignment
CHAMPUS Information	
46	Non-availability Statement on File
47	Reserved for CHAMPUS
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)
49-54	Reserved for national assignment
SNF Information	
55	SNF bed not available
56	Medical appropriateness
57	SNF readmission
58-59	Reserved for national assignment
Prospective Payment	
60	Day Outlier
61	Cost Outlier
62	Payer Code (Payer internal use only – not used by Providers)
63-65	Reserved for payer use only (not used by Providers)
66	Provider does not wish cost outlier payment
67-69	Reserved for national assignment

Code	Description
Renal Dialysis Setting	
70	Self-administered EPO
71	Full Care in Unit
72	Self-Care in Unit
73	Self-Care Training
74	Home
75	Home – 100% Reimbursement
76	Back-up in Facility Dialysis
77	Provider accepts or is obligated/required due to a contractual arrangement or law to accept payment by a primary payer as payment in full
78	New Coverage Not Implemented HMO
79	CORF Services Provided Offsite
80-99	Reserved for State Assignment
Special Programs	
A0	CHAMPUS External Partnership Program
A1	EPSDT/CHAP Treatment
A2	Physically Handicapped Children's Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	PPV/Medicare
A7	Induced abortion danger to life
A8	Induced abortion victim rape/incest
A9	Second Opinion Surgery on surgery
B0-B9	Reserved for national assignment
QIO Approval Indicator Services	
C0	Reserved for national assignment
C1	Approved as Billed
C2	Automatic approval as billed based on focused review
C3	Partial Approval
C4	Admission/Services Denied

Code	Description
C5	Post-payment Review Applicable
C6	Admission Preauthorization
C7	Extended Authorization
C8-C9	Reserved for national assignment
Claim Change Reasons	
C0	Changes to Service Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS
D3	Second or Subsequent Interim PPS Bill
D4	Change in GROUPER Input
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay an OIG Overpayment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any other Change
E0	Change in Patient Status
E1-W9	Reserved for national assignment
X0-Z9	Reserved for state assignment

Occurrence Codes

Code	Description
01	Auto Accident
02	No-Fault Insurance Involved – Including Auto Accident/Other
03	Accident/Tort Liability
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
09	Start Of Infertility Treatment Cycle
10	Last Menstrual Cycle
11	Onset Of Symptoms/Illness
12	Date Of Onset For A Chronically Dependent Individual
17	Date Occupational Therapy Plan Established Or Last Reviewed

Code	Description
18	Date of Retirement patient/Beneficiary.
19	Date of Retirement Spouse
20	Guarantee of Payment Began
21	UR Notice Received
22	Date Active Care Ended
23	Reserved for national assignment
24	Date Insurance denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF Bed Available
27	Date Home health Plan established or last reviewed
28	Date Core plan established or last reviewed
29	Date OPT plan established or last reviewed
30	Date speech pathology plan established or last reviewed
31	Date Beneficiary notified of intent to bill (accommodations)
32	Date beneficiary notified of intent to bill (procedures or treatments)
33	First day of the Medicare coordination period for ESRD beneficiaries
34	Date of election of extended care facilities
35	Date treatment started for physical therapy
36	Date of inpatient hospital discharge for covered transplant patients
37	Date of inpatient hospital discharge for non-covered transplant patient
38	Date treatment started for Home IV treatment
39	Date discharged on a continuous course of IV therapy
40	Scheduled date of admission
41	Date of first test for pre-admission testing
42	Date of discharge
43	Scheduled date of canceled surgery
44	Date treatment started for Occupational Therapy
45	Date treatment started for Speech Therapy
46	Date treatment started for cardiac rehabilitation
47-49	Payer codes, not to be used by providers
50-69	Reserved for state assignment

Code	Description
A0	Reserved for national assignment
A1	Birthdate – Insured A
A2	Insurance effective date – insured A
A3	Benefits exhausted
A4-A9	Reserved for national assignment
B0	Reserved for national assignment
B1	Birthdate - Insured B
B2	Insurance effective date – Insured B
B3	Benefits exhausted
B4-B9	Reserved for national assignment
C0	Reserved for national assignment
C1	Birthdate – Insured C
C2	Insurance effective date – Insured C
C3	Benefits Exhausted
C4-C9	Reserved for national assignment
J0-L9	Reserved for state assignment

Occurrence Span Codes

Code	Description
70	Qualifying Stay Dates (SNF)/Non-Utilization Dates – Dates represent at least a 3 day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates – Dates represent patient hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit – (Current Visit) – Dates represent the outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual From/Through service dates of locator 6, (Statement Covers Period).
73	Benefit Eligibility Period – Dates represent the period during which CHAMPUS medical benefits are available to a sponsor’s beneficiary as shown on the beneficiary’s ID card.
74	Non-Covered Level of Care – Dates represent the period at a non-covered level of care in an otherwise covered stay, excluding any period reported by occurrence span code 76, 77, or 79.
75	SNF Level of Care – Dates represent SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/QIO has approved the patient remaining in the hospital because of the non-availability of an SNF bed.

Code	Description
	Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
76	Patient Liability – Dates represent non-covered care for which the hospital is permitted to charge the Medicare beneficiary. Code should be used only where the QIO or intermediary has approved such charges in advance and patient has been notified in writing at least 3 days prior to the start date of this period.
77	Provider Liability – Utilization – Dates of non-covered care for which the provider is liable. Utilization is charged.
78	SNF Prior Stay Dates – Dates represent any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.
79	Set aside for Payer use only. Providers do not use this code.
80-99	Reserved for State Assignment
M0	QIO Approved. Dates represent days that were approved when not all of the stay was approved.
M1-W9	Reserved for national assignment
X0-Z9	Home Health Certification Begin and End Dates

Patient Status

Code	Description
01	Discharge to Home
02	Transfer to Hospital
03	Transfer to Nursing Home (SNF)
04	Transfer to State Hospital (ICF)
05	Discharged to another type of institution for Inpatient Care or referred for Outpatient services.
06	Discharge/Transfer to other (Indicate in narrative the status or location of client and time they left the hospital.)
07	Left Against Medical Advice
08	Discharged/Transferred to Home under care of Home IV Provider.
09	Admitted as an inpatient to this hospital
10-19	Discharge to be defined at state level, if necessary
20	Expired
21-29	Expired to be defined at state level, if necessary
30	Still patient: Used when patient is still within the same facility, typically used when billing for leave of absence days or interim bills.

Code	Description
31-39	Still patient to be defined at state level, if necessary.
40	Expired at home
41	Expired in an Institution
42	Expired – Place unknown.
43-49	Reserved for national assignment
50	Hospice – home
51	Hospice Medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital (Effective Retroactive to 1/1/02)
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH). (Effective 5/9/02)
64	Discharged/transferred to a nursing facility certified under Medicaid but no certified under Medicare (Effective 10/01/02)
65-70	Reserved for national assignment
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (To be discontinued on 4/1/03)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (To be discontinued on 4/1/03)
73-99	Reserved for national assignment.

Place of Service Codes

HIPAA Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service – Free-standing Facility
06	Indian Health Service – Provider-based Facility
07	Tribal 638 – Free-standing Facility
08	Tribal 638 – Provider-based Facility
11	Office
13	Assisted Living Facility
14	Group Home

HIPAA Code	Description
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Center
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air/Water
49	Independent Clinic
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Well Child Clinic
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility (CIRF)
62	Comprehensive Outpatient Rehabilitation Facility (CORF)
65	ESRD Treatment Center
71	Public Health Clinic

HIPAA Code	Description
72	Rural Health Clinic
81	Independent Laboratory
99	Community
99	Other Unlisted Facility

Type of Bill Codes

Code	Description
Type of Facility 1st digit	
1	Hospital
2	Skilled nursing
3	Home health +
4	Religious non-medical health care institutions – hospital inpatient (formerly referred to as Christian Science)
5	Religious non-medical health care institutions – post hospital extended care services (formerly referred to as Christian Science)
6	Intermediate care
7	Clinic
8	Special facility
9	Reserved for national assignment
Bill Classification (expect clinics and special facilities) - 2nd Digit	
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment) **
5	Intermediate Care – Level I**
6	Intermediate Care – Level II**
7	Subacute Inpatient (Revenue Code 19X required when this bill type is used, however 19X may be used with other types of bills.)
8	Swing beds
9	Reserved for national assignment
Bill Classification (Clinics Only) – 2nd Digit	
1	Rural health

Code	Description
2	Hospital based or independent renal dialysis center
3	Free standing
4	Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6	Community mental health center
7-8	Reserved for national assignment
9	Other
Bill Classification (Special Facilities Only) – 2nd Digit	
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory surgery center
4	Free standing birthing center
5	Critical access hospital
6	Residential facility
7-8	Reserved for national assignment
9	Other
Frequency – 3rd Digit	
0	Non-payment/zero claim
1	Admit thru discharge claim
2	Interim-first claim
3	Interim-continuing claim
4	Interim – last claim
5	Late charge(s) only claim
6	Reserved (discontinued as of 10/01/00)
7	Replacement of prior claim
8	Void/cancel of prior claim
9	Final claim for a home health PPS episode

Value Codes

Code	Description
01	Most common semi-private rate
02	Hospital has no semi-private rooms (this requires \$0.00 amount)

Code	Description
03	Reserved for national assignment
04	Inpatient professional component charges which are combined billed
05	Professional component included in charges and also billed separate to carrier
06	Medicare blood deductible
07	Reserved for national assignment
08	Medicare life time reserve amount in the first calendar year
09	Medicare co-insurance amount first calendar year
10	Lifetime reserve amount in the second calendar year
11	Coinsurance amount in the second calendar year
12	Working aged beneficiary/spouse with employer group health plan
13	ESRD Beneficiary in a Medicare Co-operation period with and employer group health plan
14	No fault, including auto/other, or any liability Insurance
15	Worker's Compensation
16	PHS or other federal agency
17	Payer Code (used by payer for internal use only - providers do not enter this)
18-20	Payer use only. Providers do not report these codes
25-29	Reserved for national assignment - Medicaid
30	Pre-admission testing
31	Patient liability amount
32-36	Reserved for national assignment
37	Pints of blood furnished
38	Blood deductible pints
39	Pints of blood replaced
40	New coverage not implemented by HMO
41	Black Lung
42	VA
43	Disabled beneficiary under age 65 with LGHP
44	Amount provider agreed to accept from primary payer
45	Accident hour

Code	Description
46	Number of grace days
47	Any liability insurance
48	Hemoglobin reading
49	Hematocrit reading
50	Physical therapy visits
51	Occupational therapy visits
52	Speech therapy visits
53	Cardiac rehabilitation visits
54-55	Reserved for national assignment
56	Skilled nurse home visit hours
57	Home health aid home visit hours (HHA only)
58	Arterial blood gas
59	Oxygen saturation
60	HHA branch MSA
61-67	Reserved for national assignment
68	EPO-drug
70-72	Payer codes (used by payer only - providers can not use)
73	Drug deductible
74	Drug coinsurance
75-79	Payer codes (used by payer only - providers can not use)
80-99	Reserved for state assignment
A1	Deductible payer A
B1	Deductible payer B
C1	Deductible payer C
A2	Coinsurance payer B
B2-C2	Coinsurance payer C
A3	Estimated responsibility payer A
B3	Estimated responsibility payer B
C3	Estimated responsibility payer C
D3	Estimated responsibility patient
A0	Reserved for national assignment

Code	Description
A4-A9	Reserved for national assignment
B0	Reserved for national assignment
B4-B9	Reserved for national assignment
C0	Reserved for national assignment
C4-C9	Reserved for national assignment
D0-D2	Reserved for national assignment
D4-W9	Reserved for national assignment
X0-Z9	Reserved for national assignment

Appendix B - PES Troubleshooting

This appendix offers solutions to problems you may encounter when using the PES program. PES Error Messages are messages that pop-up while using PES. The PES Communication Log has specific information on claims that are rejected before processing.

PES Error Messages

Performing these steps can solve many problems and often eliminate the need for telephone assistance. If you receive an error message that is not on this list, contact the EDS/EDI Helpdesk.

Additional help is available from the EDS/EDI Help Desk during normal business hours. Call MAVIS and say TECHNICAL SUPPORT immediately after the MAVIS greeting.

(800) 685-3757 toll free
 (208) 383-4310 in the Boise calling area
 8:00 a.m. to 5:00 p.m. MT
 Monday - Friday (excluding State holidays)

	Error Message	Action To Take
1.	Application version greater than Database version	<p>This message may occur when opening PES in a network installation.</p> <p>For the network administrator:</p> <p>Confirm a network installation.</p> <p>Check to see that the PCs were installed properly for a network setup. 1st PC set up as Typical Install; the remainder set up as workstations. (Note that the software is always installed on the local hard drive, while only one copy of the database is on the network.)</p> <p>Check one/all puser.ini files. The Dbpath should be set to the drive where the database was installed. Also make sure there are not any back slashes at the end of the Dbpath line.</p> <p>The version in the ecs.ini file is greater than the version in the db.ini file. Make sure that both of those files share the same version number.</p>
2.	Server name could not be resolved.	<p>This message is due to the user not being connected to the internet prior to selecting the submit option. The user must log into the internet prior to selecting the submit option.</p>
3.	The Web-site you are connecting to requires authentication.	<p>This message is caused when the logon ID or password is incorrect. Verify that the logon ID and password in the batch tab from the options settings are correct.</p>

	Error Message	Action To Take
4.	Cannot connect to production database. SQLSTATE = IM002 [Microsoft] [ODBC Driver Manager] Data source name not found and no default driver specified	This error may occur when applying a new NT install or an upgrade on a network. Run the upgrade under the user name instead of the Administrator and reapply the upgrade.
5.	Cannot format claim	One or more of the following conditions may apply: If this message occurs when attempting to submit via BBS or diskette, check to see if a logon ID was entered in the options. PES may need to be reinstalled.
6.	Cannot lock the (claim type) table	To unlock the database, go to Tools Database Recovery Unlock . See Section Tools chapter for complete instructions. After unlocking the database, resume claim submission.
7.	Cannot open log file	There may not be enough resources available. Close other applications and try again. Log out of the PES program and log back in.
8.	Carrier has been lost	The connection to the telephone carrier has been lost. To resolve this, check the communication log for errors and correct as required. Resend. Check the IDs and phone numbers in Options. For complete instructions, see the Getting Started section in the PES Handbook for instructions. Resend. Use a lower modem speed (DTR) setting. See the Getting Started section in the PES Handbook for instructions. Resend.
9.	Commit failed while trying to update the user table, return code is -1.	If working on a network, the network administrator with Administrator rights on the local machine must change the database for the user to have both read and write permissions.
10.	Could not update the key sak. The sequel code was -1.	The user doesn't have write permission on the network and cannot save any claims to the database on the network. The network administrator will have to give the user the necessary permissions.

	Error Message	Action To Take
11.	Unknown Net tag	<p>Verify that the Logon ID and password are correct in the Batch tab.</p> <p>Verify that the Carrier ID is set to INT_800 for the Intact Transmit. For a complete list of Option see the Getting Started section.</p>
12.	Error - Formatting Eligibility Batch	<p>This error occurs when attempting to send an interactive transaction. It occurs when the temp file in the install directory has been deleted or never created.</p> <p>Open Windows Explorer and create a new folder named "Temp" in the directory where the PES software is installed.</p> <p>Make sure the information in the options screen is entered completely.</p> <p>The files to which the transactions are written might be read only.</p> <p>Too many applications open.</p>
13.	<p>Error formatting (claim type) batch</p> <p>(where claim type is Professional, Institutional, Dental, or NCPDP)</p>	<p>The software may have been moved to a problematic location.</p> <p>Uninstall then reinstall PES.</p>
14.	Failed to back up the database files	Shutdown and restart the computer.
15.	<p>Failure to initialize modem</p> <p>Note: This is a communication log message. To view the communication log, go to Communication View Communication Log.</p>	<p>Check Modem tab for correct Com Port and Modem Type.</p> <p>Check for the Com Port on the PC by going to Start<Settings Control Panel Modems.</p> <p>Set the baud rate to appropriate speed. See the Getting Started section in the PES Handbook for instructions.</p>
16.	<p>Formatting eligibility batch</p> <p>Note: This is a communication log message. To view the communication log, go to Communication View Communication Log.</p>	<p>Ensure that the installation was Typical, not Workstation. Also see error 1, Application version greater than Database version.</p> <p>There are too many applications open. Close other applications and try again.</p> <p>The file in the temp directory might be open.</p> <p>Ensure that all fields in Tools Options are correct. See the Getting Started section in the PES Handbook for instructions.</p>

	Error Message	Action To Take
17.	Get Upgrade Account Failed	Contact the EDS/EDI Help Desk.
18.	Host timeout	Lower baud rate (Dtr) on Carrier tab for the batch and/or interactive. See the Getting Started section in the PES Handbook for instructions.
19.	Invalid baud rate Note: this is a Communication Log message. Go to Communication View Communication Log to view messages.	Baud rate is missing on Carrier tab. Go to the Carrier tab in Tools and enter the correct baud rate in the Dtr field (38400 for either interactive or batch). See the Getting Started section in the PES Handbook for instructions.
20.	Invalid Logon Note: this is a Communication Log message. Go to Communication View Communication Log to view messages.	This message may occur if the Logon ID and Password are incorrect. Go to Tools Options Batch . Check the Logon ID and Password. See the Getting Started section in the PES Handbook for instructions.
21.	Modem Type/Logon ID/ Password is missing.	Options need to be set up. Go to Tools Options . See the Getting Started section in the PES Handbook for instructions.
22.	The database has been locked by another user	If the installation is on a network, first verify that another user is not currently updating the same claim. Go to Tools Database Recovery Unlock to unlock the Database. See the Tools section. Resume claim submission.
23.	Unable to Connect to database	If using Windows NT, the user will not have permission to either change files in the install folder (for example, C:\idhipaa folder) or to subordinate folders. The Network Administrator with rights on the local machine must grant these rights to the user. EDS does not handle security issues such as this.
24.	Unable to open interactive transaction file.	One or more of the following conditions may apply: The data in the Options tab is incomplete. Ensure that all required data has been entered. The files to which the transactions are written are read-only.

	Error Message	Action To Take
25.	Unable to send interactive transaction file	<p>This message may occur while sending a claim.</p> <p>Ensure that the installation was Typical, not Workstation. Also see error 1, Application version greater than Database version.</p> <p>There are too many applications open. Close other applications and try again.</p> <p>The file in the temp directory might be open.</p> <p>Ensure that all fields in Tools<Options are correct.</p>
26.	Unable to update the SAK	<p>This message may occur after installing McAfee anti-virus. The only known solution is to uninstall the McAfee anti-virus program.</p>
27.	602 Couldn't open transfer file	<p>This is a communication error. The Z modem tries to open a file but reaches system's limit on file handles. There are too many applications open.</p> <p>Close the PES application, log back in, and try again.</p>
28.	610 Z modem returned. Too many errors to go on. Did not receive logon prompt.	<p>Contact the EDS/EDI Help Desk.</p>
29.	623 File Engine Failed	<p>PES has an open file conflict. For example, there is a path or permissions problem. Sometimes the communications programs fail if too many things are open on the desktop.</p> <p>To correct the error, close all applications except PES.</p>

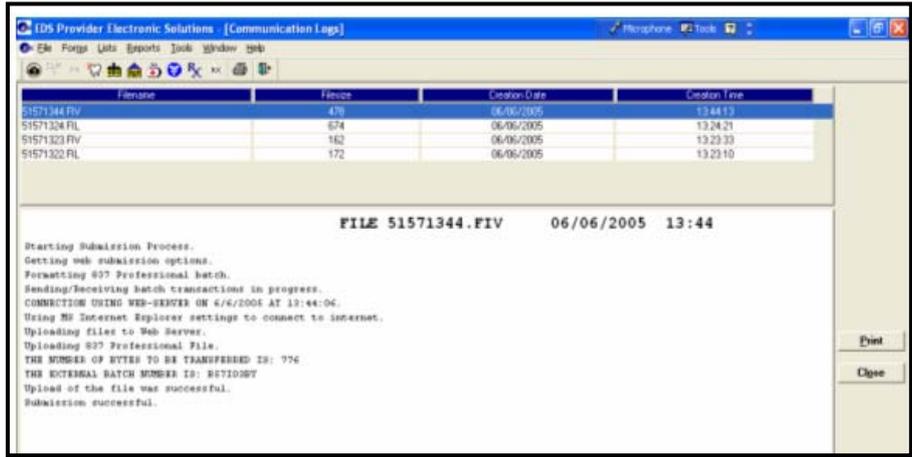
PES Communication Log

Viewing the Communication Log

The Communications Log is a useful tool for checking on submission information. It displays a list of files submitted along with the file size, creation date, and creation time. This information can be used to debug communication problems. Depending on the system options you have selected, up to 999 communication logs can be listed.

Step 1 Select Communication from the menu bar.

Step 2 Select View Communication Log. The Communication Logs window opens and displays a list of recent submissions.

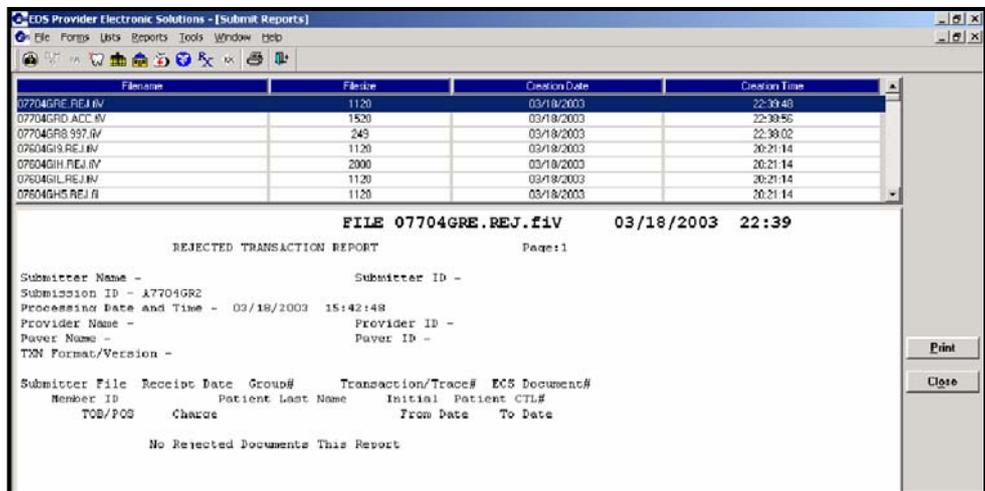


- Step 3** Click on the file to be viewed. The submission information for the selected file will be displayed in the lower portion of the screen. You should see “Submission successful”.
- Step 4** If you receive a submission successful message you will have an External Batch number that is a combination of alpha and numeric characters. You will need this number when reviewing your Accepted and Rejected submission reports. It is called the Submission ID on the reject report.
- Step 5** Click on the **Print** button to print the log information.
- Step 6** Click on the **Close** button to close the Communication Log window.

Viewing the Submit Reports/997s

Use the View Submit Reports option to check on accepted and rejected reports for submissions made to BES. This information is important and should be referenced regularly. See Understanding the Rejected Transaction Report for more information.

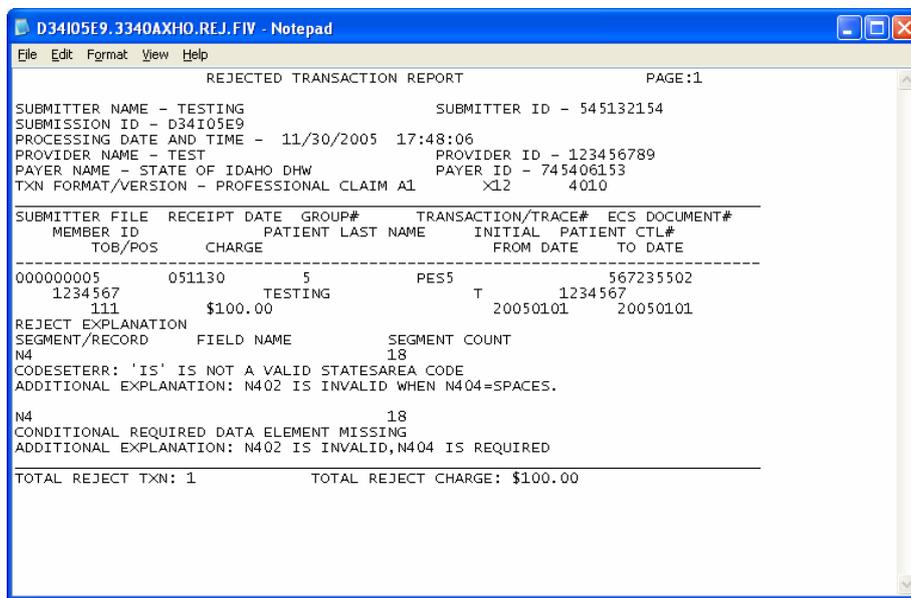
- Step 1** Select **Communication** from the menu bar.
- Step 2** Select **View Submit Reports/997s**.



- Step 3** Locate the Submission ID for the original batch submitted to view if the Batch was accepted or rejected. The Submission ID is in the Communication Log file.
- Step 4** The file name ending in REJ is for the Rejected Transaction report. If no data is found locate the same Submission ID in the file name ending ACC for the Accepted Transaction report.
- Step 5** To exit this report, select the **Close** button.

Understanding the Rejected Transaction Report

Use the Rejected Transaction Report to determine why a claim or batch was rejected by BES. The following fields are used by the EDI Help Desk to determine the reason your claim was rejected.



Rejected Transaction Report Field	Description
Submitter ID	Same as Logon ID. It is a 9-digit number.
Submission ID	Also found on the Communication Log where it is called the External Batch Number. It has 8 characters and contains both letters and numbers. In this example, the submission ID is , D34I05E9.
Processing Date and Time	Date and time your claim was received by BES.
Segment/Record	Identifies the section of the electronic claim that was rejected. In this example, the segment/record is N4.
Additional Explanation	Explanation used by the EDI Help Desk to determine the reason the segment/record was rejected.