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**Q** How do I start to create a new claim?

**A** Once logged onto your secure provider Web account, click on Claims, then click on the applicable claim type - Professional, Institutional or Dental or if you have a claim up on your screen, you can click on the "New Claim" button at the bottom of the screen.

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**Q** How do I learn what each field on the internet claim means?

**A** Left click on the field name in question and a pop up box will appear with a description of the field. A quick link for 'Instructions for submitting claims' is available on the top left hand side of the claim submission page for each type of claim.

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**Q** How do I add a second detail to the claim?

**A** Click on the add button on the lower left corner of the Detail panel.

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**Q** Why am I getting the following error messages? "DOS is required, A valid procedure is required, charges must be greater than \$0.00."

**A** A new detail row was added without any of the required data entered in the detail. Either enter all required data, or to delete the detail, click on the row in question in the Detail panel and then click the delete button.

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**Q** Where do I enter my surgical procedure code on my Institutional claim?

**A** Enter a surgical procedure code performed in a hospital by clicking on the Procedure tab which is located to the right of the Diagnosis tab. Click the add button and then enter the procedure and procedure date.

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**Q** How do I determine what to put in the NDC Quantity field?

**A** Claim billing instructions for complying with the Federal Deficit Reduction Act (DRA) of 2005, which mandates the submission of National Drug Codes, can

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be found on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site by clicking on Information, then Publications and searching for the following provider bulletins:

[PB2008-35 Outpatient Hospital DRA notification](#)

[PB2008-42 Outpatient Hospital DRA Frequently Asked Questions](#)

[PB2008-36 Professional DRA notification](#)

[PB2008-43 Professional DRA Frequently Asked Questions](#)

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*Q How do I add a diagnosis code to the claim?*

A Click on the add button on the lower left corner of the Diagnosis panel. In addition to the diagnosis code, a diagnosis sequence must be included for each code entered. If more than one diagnosis code is required, you will need to click add for each one. Once you have entered the last diagnosis on the panel you do not have to hit the add button again.

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*Q Why am I getting the following error message? "A valid Diagnosis is required."*

A The add button in the lower left corner of the Diagnosis panel was clicked, creating a new diagnosis row, but no valid diagnosis code was entered. Either enter a valid diagnosis code, or to delete the diagnosis, click on the row in the Diagnosis panel and then click the delete button.

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*Q What is the Diagnosis Sequence?*

A Depending upon the claim type, the diagnosis sequence would be Principal, Admitting or Other 1, Other 2 and so on.

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*Q Why is the Client ID blank on my claim?*

A When the Client ID field on the Web claim is blank, this means the claim originally processed with an invalid client ID. The Web claim panel will not display an invalid client ID. To correct this, enter a valid client ID in this field and resubmit the claim.

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*Q How do I change a client ID on a claim?*

A The client ID is the only data that cannot be changed on the claim. If the client ID is incorrect on the claim, the claim must be recouped in full, or voided. The claim can then be copied, the client ID changed, and then the claim can be submitted.

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*Q How do I submit a claim when the client has Medicare or a private insurance coverage?*

A Detailed instructions for submitting Web claims with a prior payment or denial from either Medicare or a private insurance company can be found on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site by clicking on Information, then Publications and scrolling down and clicking on one of the following guides:

[Dental Other Insurance Billing Guide](#)

[Institutional Other Insurance/Medicare Billing Guide](#)

[Professional Other Insurance/Medicare Billing Guide](#)

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*Q How do I submit a claim when Part A is exhausted, but Part B makes payment?*

A Instructions for billing an inpatient Web claim when Medicare Part A is exhausted, but Part B makes a payment can be found on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site by clicking on Information, then Publications and scrolling down and clicking on the [Institutional Other Insurance/Medicare Billing Guide](#).

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*Q What is the carrier code and where do I find the correct code?*

A The three digit carrier code identifies the other insurance carrier. The carrier code can be obtained when you request an eligibility verification through the provider secure site on the Web site [www.ctdssmap.com](http://www.ctdssmap.com). The carrier code returned in the eligibility verification response represents an active insurance policy for the date of service entered on the eligibility verification. If the client has other insurance coverage, the Client Carriers field in the TPL Panel of the Web claim will contain the carrier code(s) that are currently on the client's eligibility file or may have been on the client's file in

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the past. A complete listing of the carrier codes is available at [www.ctdssmap.com](http://www.ctdssmap.com), under Information, then Publications, then [Chapter 5 of the Provider Manual](#).

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***Q I can not find a carrier code for an insurance carrier on the list. How should I submit this claim?***

A Select "Other" in the Client Carriers field in the TPL Panel, enter 999 in the Carrier Code field and enter the name of the Carrier in the "Plan Name" field.

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***Q The client has insurance coverage through a carrier that is not listed under the Client Carriers field. How do I submit this claim?***

A If you do not see the carrier code for the primary payer in the Client Carriers field, select "Other" and enter the three digit carrier code for the Other Insurance Payer in the next field titled "Carrier Code".

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***Q The client does not have the insurance coverage that is returned from the Automated Eligibility Verification System. It is outdated. How is this insurance policy removed from the client's file?***

A The client can either contact their DSS caseworker to request that this information be removed from their file or the provider may report the discrepancy to Health Management Systems, Inc (HMS) by completing a TPL information form. Client third party liability update procedures, including a copy of the TPL information form, can be accessed/downloaded from the Web site [www.ctdssmap.com](http://www.ctdssmap.com) by clicking on Information, then Publications and clicking on [Provider Manual Chapter 5](#). In addition HMS may be contacted directly at 1-866-277-4271 or emailed at [ctinsurance@hmsy.com](mailto:ctinsurance@hmsy.com).

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***Q How do I add another insurance payment or denial to the claim?***

A Click on the add button on the lower left corner of the TPL panel. The minimum information required is the three digit carrier code which represents the other insurance carrier, the paid amount and the date of the Explanation of Benefit.

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*Q What is the adjustment reason code?*

A The adjustment reason code is used to identify the reason why the other insurance did not make payment in full. The Other Insurance Explanation of Benefit (EOB) should contain this code. Refer to the [www.wpc-edi.com](http://www.wpc-edi.com) Web site for a list of adjustment reason codes. Enter the code exactly as seen on that list. For example, if the code is 1, do not enter 001, just enter 1. This is not a required field when submitting or adjusting claims.

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*Q What is the adjustment amount?*

A The adjustment amount is used to identify the sum that the other insurance denied. This is not a required field when submitting or adjusting claims.

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*Q How do I submit my claim once I've entered all the claim data?*

A Click the submit button in the Claim Status Information panel.

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*Q I clicked the submit button, so why is the claim still in a Not Submitted yet status?*

A The claim likely contains errors which are displayed at the top of the claim submission panel. Scroll up to the top to view the errors, make any necessary corrections and click the submit button in the Claim Status Information panel.

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*Q Why is my claim in a suspended status?*

A Claims that require a manual review by either DSS or DXC Technology will be put in a suspended status. There is no action a provider can take to change this claim. The claim status will soon change to either a paid or denied status.

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*Q What does the following error mean "Processing failed due to a communication error?"*

A This error means that the communication between DXC Technology and the provider either failed in the delivery of the claim to DXC Technology or in the claim status response back to the provider. It is recommended that a claim inquiry be performed on the claim to determine if the claim successfully processed in interChange. If the claim is not present in interChange, the claim should be resubmitted.

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*Q How do I adjust a claim?*

A Only claims in a paid status may be adjusted. Retrieve the claim by performing a claim inquiry. **DO NOT CLICK THE ADJUST BUTTON YET!** You must first make the necessary changes to the claim. Once all changes have been made to the claim, click the adjust button in the Claim Status Information panel.

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*Q Why is the adjust button missing from my claim?*

A Claims in a denied status cannot be adjusted, they must be resubmitted. Claims with a paid date prior to February 1, 2008 cannot be adjusted. These are claims that processed in the old legacy system prior to the interChange implementation. These claims may be adjusted using any other tool, such as Provider Electronic Solution software or the Paid Claim Adjustment Request form with RA attached to override timely filing. Claims with an Internal Control Number (ICN) beginning with either 12 or 13 cannot be adjusted. They are claims that have been specially handled by DXC Technology. An adjustment to these claims may also need to be specially handled. The provider should contact DXC Technology before attempting to adjust these claims. Medicare Crossover claims can not be adjusted; they must be voided, copied, corrected and submitted.

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*Q Why am I getting the following error message? "Unable to process claim; error 837-EOB Adjustment has no original ICN."*

A An adjustment was attempted with the intention to change the client ID. The error indicates that there is no claim in the system that contains the same



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ICN, Provider ID and Client ID. The client ID is the only data that cannot be changed on the claim. If the client ID is incorrect on the claim, the claim must be recouped in full, or voided. The claim can then be copied, the client ID changed, and then the claim can be submitted.

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**Q** *How do I recoup a claim in full?*

A Only claims in a paid status may be recouped in full. Retrieve the claim by performing a claim inquiry and scroll down to the bottom of the page. Click the void button in the Claim Status Information panel.

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**Q** **What is the difference between the Void button and the Cancel button?**

A Clicking the Void button on a paid claim will recoup the claim. The Cancel button is not a claim submission option and will merely clear any data you may have entered for a claim.

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**Q** *Why is the void button missing from my claim?*

A Only claims in a paid status may be recouped in full. The claim is not in a paid status.

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