Gainwell Technologies Provider Electronic Solutions

Billing Instructions

Long Term Care Claims

TABLE OF CONTENTS

INTRODUCTION

Now that you have installed and become familiar with the functionality of the Gainwell Technologies PROVIDER ELECTRONIC SOLUTIONS software, it's time to begin claims data entry.

The claim entry screen consists of eight sections: Five Header, One Service, Other Insurance, and Crossover screens.

The following instructions detail requirements and general information for each section of your claim.

In the following sections, each data entry field is defined with the appropriate requirements. Edits have been built into the software to assist you in correct data entry, however, READ THESE SECTIONS CAREFULLY. Payment or denial of your claims depends on the data you supply to Gainwell Technologies.

Please reference your billing manual for detailed Connecticut Medical Assistance Program billing requirements unique to your provider type.

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit screens. For example, you can enter lists of common diagnosis codes, procedure codes, types of bill and admission sources and types. All of the lists are available from the data entry section as a drop down list where you can select previously entered data to speed the data entry process and help ensure accuracy of the form.

There are several lists that you are required to complete prior to entering a transaction. Because this software uses the HIPAA compliant transaction format, there is certain information, which is required for each transaction. To assist you in making sure that all required information is included, some of the lists are required. These lists are:

- Client
- Billing Provider
- Other Provider
- Taxonomy
- Policy Holder

If these lists are not completed prior to keying your transaction, the list will open in the transaction form.

Some of the lists contain preloaded information that is available for auto-plugging as soon as you install Provider Electronic Solutions. Other lists require you to enter the information you will use for auto-plugging. You should enter your data in these lists soon after you set up Provider Electronic Solutions to take advantage of the auto-plug feature. To create or edit a list, select List from the Main Menu and then select the appropriate item.

Working with Lists

From the Lists option on the menu bar, select the list you want to work with.

Perform one of the following:

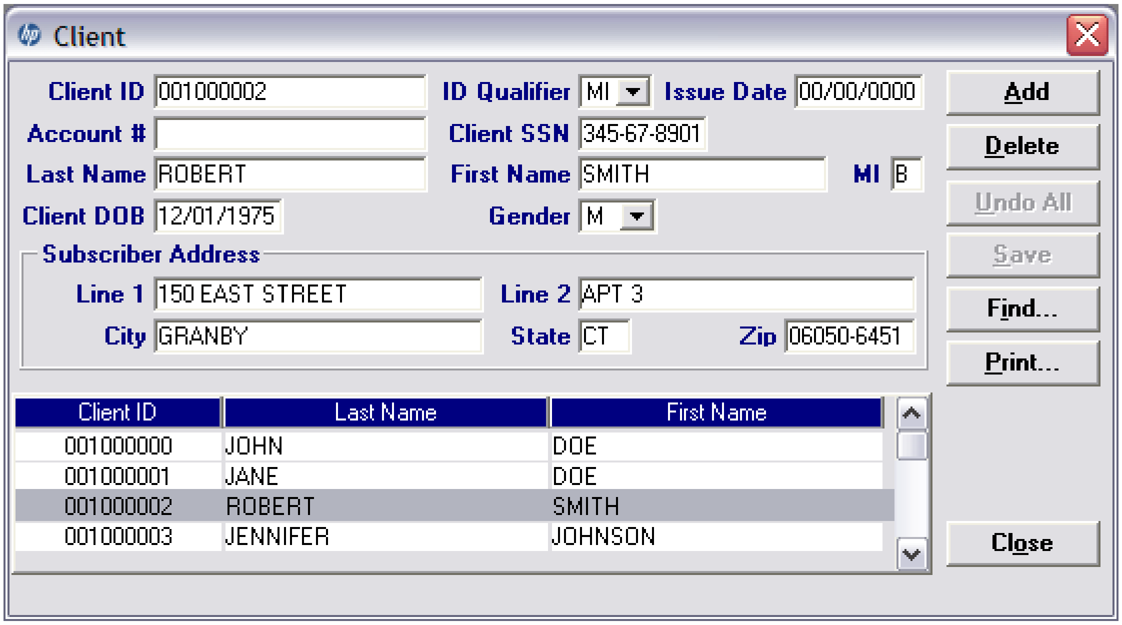
- To add a new entry, select Add.

- To edit an existing entry, select the entry and then enter your changes.

- The command buttons for Delete, Undo All, Find, Print, and Close work as titled.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

CLIENT SCREEN



The Client list requires you to collect detailed information about your clients, which are then automatically entered into forms. All of the fields are required except Issue Date, Account #, Middle Initial and Subscriber Address Line 2.

CLIENT ENTRY INSTRUCTIONS

Client ID:
Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

ID Qualifier:
This field has been preloaded with the information that identifies the type of client. This field will be by-passed.

Issue Date:
Enter the issue date found on the patient's Medical Assistance Program Identification Card.

Account #:
Enter the unique number assigned by your facility to identify a client.

Client SSN:
Enter the client's social security number.

Last Name:
Enter the last name of the client who received services.

First Name:
Enter the first name of the client who received services.

MI:
Enter the middle initial of the client who received services.

Client DOB:
Enter the date the client was born.

Gender:
Select the appropriate value from the drop down list to enter the client's gender.

Code	Description
F	Female
M	Male
U	Unknown

Subscriber Address Line 1:
Enter the street address that is on file with CT Medicaid of the client being referenced. The address is required for providers, clients and policyholders.

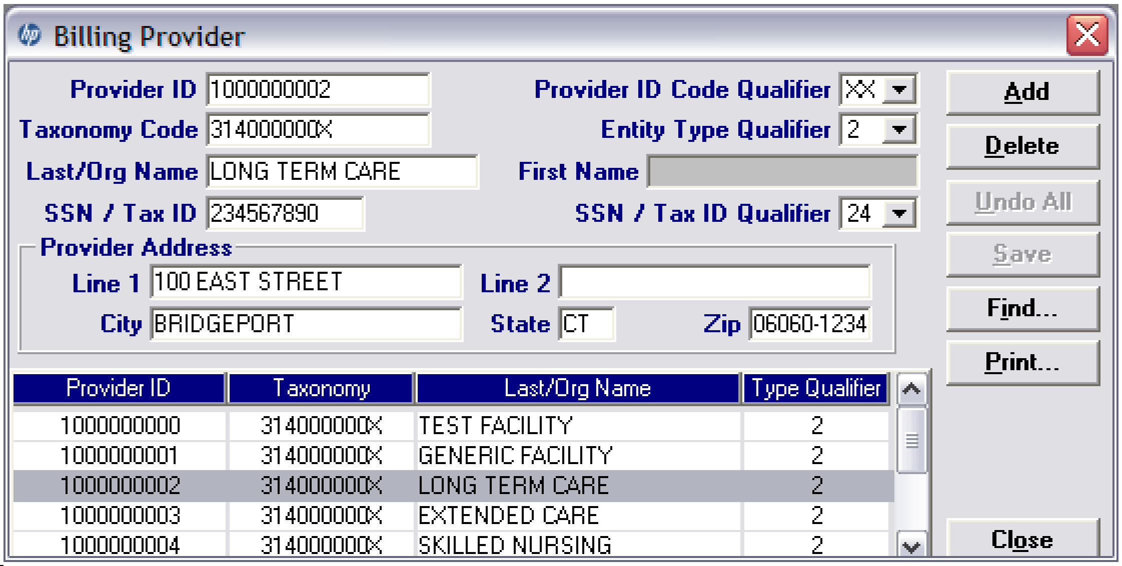
Line 2:
Enter additional address information of the client being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the client being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the client being referenced. The address is required for providers, clients and policyholders.

Zip:
Enter the 9 digit zip code of the client being referenced. The address is required for providers, clients and policyholders.

BILLING PROVIDER SCREEN



The Provider list requires you to collect information about service providers, which is then automatically entered into forms. These can be individual providers or organizations. Use this list to enter all billing provider, and Medicare rendering Medical Assistance Provider numbers. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

BILLING PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

The taxonomy code entered in this field must be among the list of taxonomy codes submitted to the Connecticut Medical Assistance Program by the provider via the provider enrollment application.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:

Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:

Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Facility Type Qualifier is a 2.

SSN / Tax ID:

Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:

Select the appropriate code from the drop down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:

Enter the street address that is on file of the provider being referenced. The address is required for providers, subscribers and policyholders.

Line 2:

Enter additional address information of the provider being referenced, such as suite or apartment number if applicable.

City:

Enter the city of the provider being referenced. The address is required for providers, clients and policyholders.

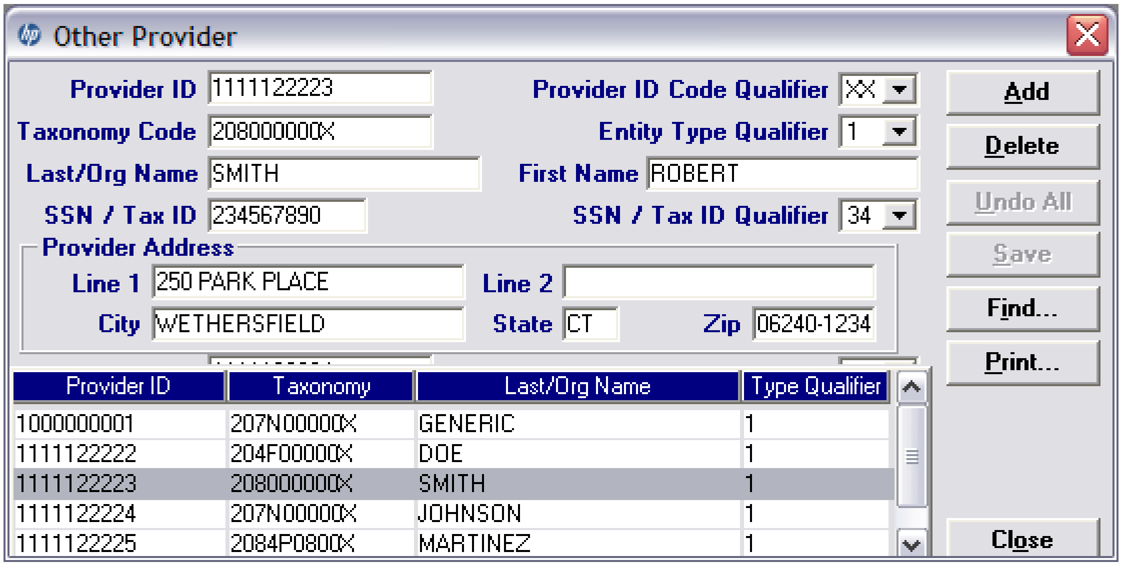
State:

Enter the state of the address of the provider being referenced. The address is required for providers, clients and policyholders.

Zip Code:

Enter the 9 digit zip code of the provider being referenced. The address is required for providers, clients and policyholders.

OTHER PROVIDER SCREEN



The Other Provider list requires you to collect information about non-billing providers, which are then automatically entered into forms. Enter the attending, operating and other Medical Assistance provider numbers in this list. All fields are required except Provider Address Line 2 and First Name when the Entity Type Qualifier is a 2 (Facility).

OTHER PROVIDER ENTRY INSTRUCTIONS

Provider ID:

Enter the National Provider Identifier (NPI) or the Connecticut Medical Assistance Program billing provider number with two leading zeros if the provider is a Non-Covered Entity (NCE). (An NCE is a Medicaid service provider who is not included in the National Provider Identifier requirement.)

Provider ID Code Qualifier:

Enter the code that identifies if the Provider ID submitted is the Medical Assistance Provider number or the Health Care Financial Administration (HCFA) National Provider Identifier (NPI).

Taxonomy Code:

An alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Entity Type Qualifier

Select the appropriate value to indicate if the provider is an individual performer or corporation.

Last/Org Name:

Enter the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

First Name:
Enter the first name of the provider when the provider is an individual. Required when the Entity Type Qualifier is a 1. Field will not be available when the Facility Type Qualifier is a 2.

SSN / Tax ID:
Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the provider being referenced.

SSN/Tax ID Qualifier:
Select the appropriate code from the drop down box that identifies what value is being submitted in the SSN/Tax ID field.

Provider Address Line 1:
Enter the street address that is on file with CT Medicaid of the provider being referenced. The address is required for providers, subscribers and policyholders.

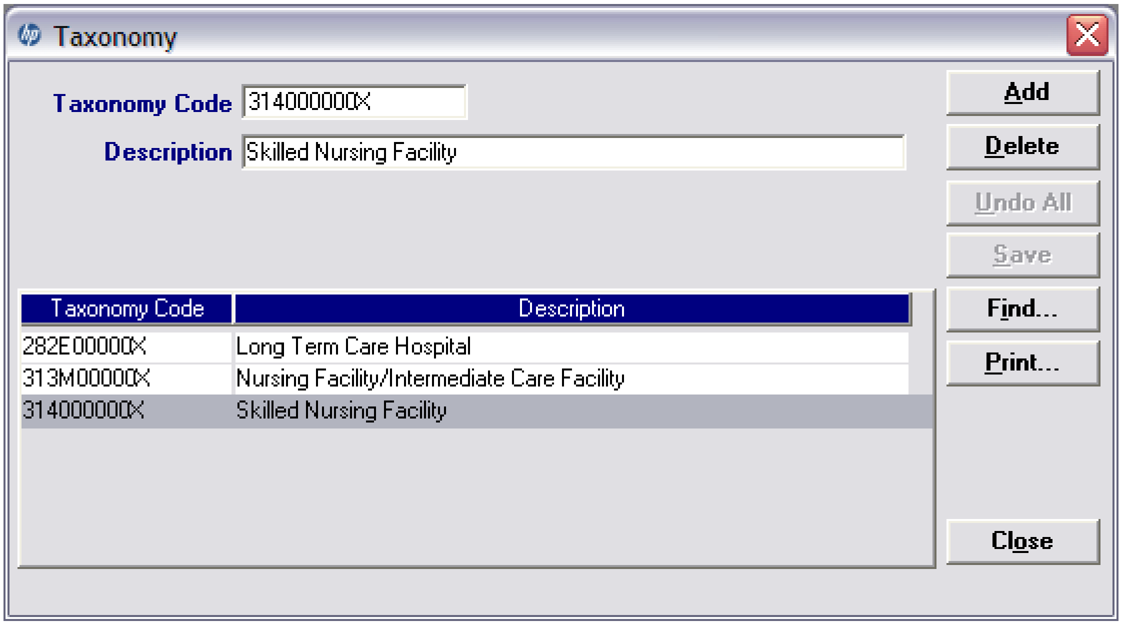
Line 2:
Enter additional address information of the provider being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the provider being referenced. The address is required for providers, clients and policyholders.

State:
Enter the state of the address of the provider being referenced. The address is required for providers, clients and policyholders.

Zip Code:
Enter the 9 digit zip code of the provider being referenced. The address is required for providers, clients and policyholders.

TAXONOMY SCREEN



The Taxonomy list allows you to list the taxonomy code, which is then automatically entered into the Provider List. All fields are required.

TAXONOMY ENTRY INSTRUCTIONS

Taxonomy Code:

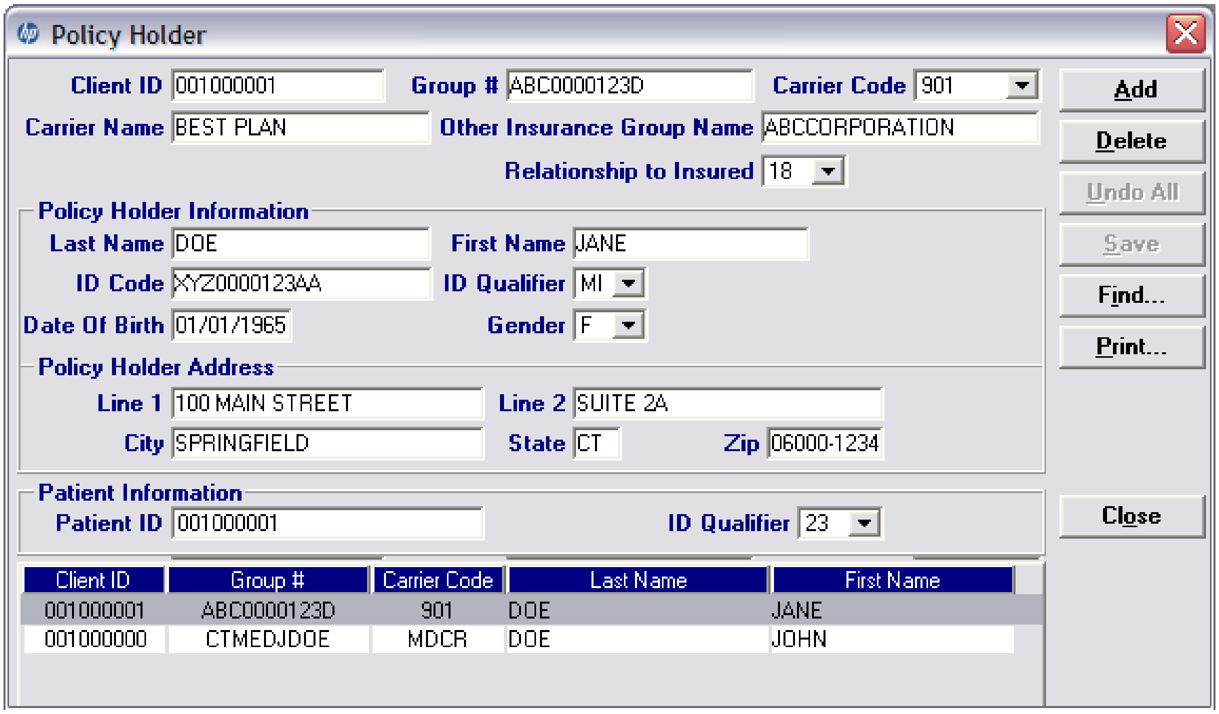
An alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Description:

Enter the description of the code listed.

POLICY HOLDER SCREEN



The Policy Holder list requires you to list the information for the policyholder of the other insurance policies and Medicare policies. As with the provider and client lists, this list must be completed before completing a claim with other insurance or Medicare. Complete a separate list for each policy when a client has both other insurance and Medicare. Like the other lists, once the code is entered into the list, it may be accessed by the drop down window and will automatically populate into the claim. All fields are required except Policy Holder Address Line 2.

POLICY HOLDER ENTRY INSTRUCTIONS

This list is required if an indicator of Y is entered in the other insurance indicator field on the Header Three screen. The information on this screen must be entered before you enter the Group Number located on the Other Insurance screen.

Client ID:

Enter the Client identification number assigned by the Connecticut Medical Assistance Program.

Group Number:

Enter group number for other insurance or Medicare. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Carrier Code:

Select the three digit other insurance carrier code from the drop down box.

Note: Provider must maintain an Explanation of Benefit (EOB) on file for audit purposes.

Carrier Name:

This field is auto-plugged by the system once the carrier code is entered and contains the name of the other insurance company listed for the client.

Other Insurance Group Name:
Enter the name of the group that the other insurance is listed under and coincides with group number.

Relationship to Insured:
Select the appropriate value from the drop down box that identifies the client's relationship to the policy-holder for the other insurance or Medicare listed. If the client is the policyholder, self will be listed.

Last Name:
Enter the last name of the policyholder of the other insurance or Medicare. Only numeric characters 0-9 and alphabetic characters A-Z are accepted. Lower case letters are automatically converted to upper case.

First Name:
Enter the first name of the policyholder of the other insurance or Medicare.

ID Code:
Enter the policyholder's identification number assigned by the other insurance company or Medicare.

ID Qualifier:
Select the appropriate value from the drop down box that identifies the type of ID that is being used.

Date of Birth:
Enter the date the policyholder was born.

Gender:
Select the appropriate value from the drop down box that identifies the sex of the individual.

Policy Holder Address Line 1:
Enter the street address of the policy holder being referenced. The address is required for providers, clients and policyholders.

Line 2:
Enter additional address information of the policy holder being referenced, such as suite or apartment number if applicable.

City:
Enter the city of the policy holder being referenced.

State:
Enter the state of the address of the policy holder being referenced.

Zip Code:
Enter the 9 digit zip code of the policy holder being referenced.

Patient ID:
Enter the other insurance identification number of the Medical Assistance Program client being billed.

ID Qualifier:
Select the appropriate value from the drop down box that identifies the type of ID that is being used.

CLAIM ENTRY INSTRUCTIONS

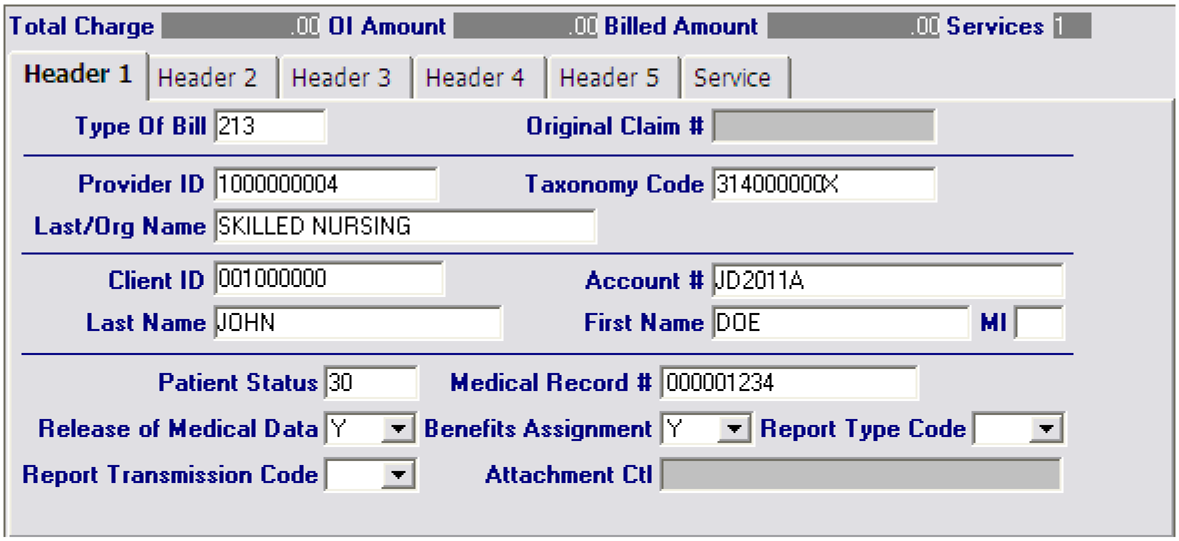
Use the following instructions to complete the claim screens. When data entry is complete, click **SAVE.** The saved claim will appear in the list below the data entry screen. If the claim data hits edits, a message window will appear with error messages. Click **SELECT** to move to the highlighted error and correct the data. Once all error messages have been resolved, you can save the claim.

Newly saved claims are in Status R (Ready). Status R claims can be edited and saved multiple times prior to submission. Be sure to click **ADD** before beginning to enter the data for each new claim.

Note: The Select Command button is not visible on the List window unless it has been invoked by double-clicking an autoplug field from a claim screen. Once a List entry has been either added or edited, the Select button ***must*** be clicked in order for the data to populate the claim screen with the selected List entry.

NURSING HOMES HEADER ONE

HEADER ONE SCREEN



<u>DESCRIPTION</u>	<u>FIELD LENGTH</u>	<u>REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)</u>	<u>ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)</u>
TYPE OF BILL	3	R	N
ORIGINAL CLAIM #	13	S	N
PROVIDER ID	9	R	N
TAXONOMY CODE	10	R	X
LAST/ORG NAME	35	R	A
CLIENT ID	16	R	X
ACCOUNT #	38	R	X
LAST NAME	35	R	A
FIRST NAME	25	R	A
MI	1	O	A
PATIENT STATUS	2	R	N
MEDICAL RECORD #	30	O	X
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
REPORT TYPE CODE	2	O	X
REPORT TRANSMISSION CODE	2	O	A
ATTACHMENT CTL	30	S	X

HEADER ONE ENTRY INSTRUCTIONS

Special Note: All data entry will default to capital letters.

Header Field Definition

$$ = Dollars
cc = Cents
A = Alpha
N = Numeric
X = Alphanumeric

Type of Bill
Enter the 3-digit code that identifies the type of bill. The code identifies the type of facility and the bill classification.

First digit indicates facility.

Code	**Description**
2	Skilled Nursing

Second Digit indicates the Bill Classification.

Code	**Description**
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	Sub-acute Inpatient (revenue code 19x required)
8	Swing Beds
9	Reserved for national use

Third Digit indicates the Frequency.

Code	**Description**
0	Non-payment / Zero Claim
1	Admit through discharge date
2	First interim claim
3	Continuing Interim claim
4	Last interim claim
7	Replacement of prior claim (designates electronic adjustment)
8	Void/Cancel of prior claim (designates electronic adjustment)

Note: If the third digit is a "7" or "8", the Original Claim field will be required.

Remarks: Required
Format: NNN

Original Claim #:
This field is populated when the last digit on the Type of Bill is a "7" or "8". When a claim is replaced or voided, indicate the original Internal Control Number as it appears on the remittance advice.

Remarks: Situational
Format: NNNNNNNNNNNNN

Provider ID:
Enter the NPI or Connecticut Medical Assistance Program's Provider number with two leading zeros.

Remarks: Required
Format: NNNNNNNNN

Taxonomy Code:
This field will be auto plugged once you enter your provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Last/Org Name:
This field will be auto plugged once you enter your provider number and contains the provider's name or the first two letters of the provider's last name as enrolled in the Connecticut Medical Assistance Programs.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
or AA

Client ID:
Enter the client's nine-digit Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: NNNNNNNNN

Account #:
Enter the patient's account number. Provider assigned, this field may be alphabetic or numeric and is used for the provider's own accounting purposes.

Remarks: Required
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Name:
This field will be auto plugged once you enter the client's Connecticut Medical Assistance Program's identification number. This field contains the client's last name or the first two characters of the client's last name.

Example: THOMPSON or 'TH'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA or AA

First Name:
This field will be auto plugged once you enter the client's Connecticut Medical Assistance Program's identification number. This field contains the client's first name or the first character of the client's first name. There are no spaces allowed in this field.

Example: JOHN or 'J'
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAA or A

MI:
This field will be auto plugged once you enter the client's Connecticut Medical Assistance Program's identification number. This field contains the first character of the client's middle name.

Example: 'J'
Remarks: Optional
Format: A

Patient Status:
Enter the appropriate patient status code as of the through date from the table below:

Code	Description
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital
03	Discharged/transferred to a skilled nursing facility
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home, under care of organized home health service organization
07	Left against medical advice
20	Expired or did not recover
30	Still a patient
40	Expired at home
41	Expired in medical facility
42	Expired – place unknown
50	Hospice – home
51	Hospice – medical facility
61	Discharge/transferred within this institution to hospital-based Medicare approved swing bed
72	Discharged/transferred/referred/to this institution for outpatient services as specified by the discharge plan of care

Remarks: Required
Format: NN

Medical Record #:
Enter the number assigned to the patient's record.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Release of Medical Data:
This code indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. Enter the value that corresponds to the release of the medical data:

Code	Description
I	Informed consent to release medical information. For conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim (default)

Remarks: Required
Format: A

Benefits Assignment:
Code identifying that the client, or authorized person, authorizes benefits to be assigned to the provider.
Enter one of the values below to indicate assignment of benefits.

Y – Yes (default)
N – No
W – Not Applicable

Remarks: Required
Format: A

Report Type Code:
Code indicating the title or contents of a document report or supporting item for this claim
Enter the two-digit value that corresponds to the report type.

Code	Description
03	Report Justifying Treatment beyond Utilization Guidelines
04	Drugs Administered
05	Treatment Diagnosis
06	Initial Assessment
07	Functional Goals
08	Plan of Treatment
09	Progress Report
10	Continued Treatment
11	Chemical Analysis
13	Certified Test Report
15	Justification for Admission
21	Recovery Plan
A3	Allergies/Sensitivities Document
A4	Autopsy Report

AM	Ambulance Certification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
BR	Benchmark Testing Results
BS	Baseline
BT	Blanket Test Results
CB	Chiropractic Justification
CK	Consent Form(s)
CT	Certification
D2	Drug Profile Document
DA	Dental Models
DB	Durable Medical Equipment Prescription
DG	Diagnostic Report
DJ	Discharge Monitoring Report
DS	Discharge Summary
EB	Explanation of Benefits
HC	Health Certificate
HR	Health Clinic Records
I5	Immunization Record
IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Notes
OC	Oxygen Content Averaging Report
OD	Orders and Treatment Document
OE	Objective Physical Examination
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

Remarks: Optional
Format: XX

Report Transmission Code:

Code defining timing, transmission method or format by which reports are to be sent. Enter the two digit value that defines the transmission method reports will be sent:

Code	Description
AA	Available on Request at Providers Site
BM	By mail
EL	Electronically only
EM	E-mail
FT	File Transfer
FX	By fax

Note: If the values BM, EL, EM or FX are used the Attachment Control field will be required.

Remarks: Optional
Format: AA

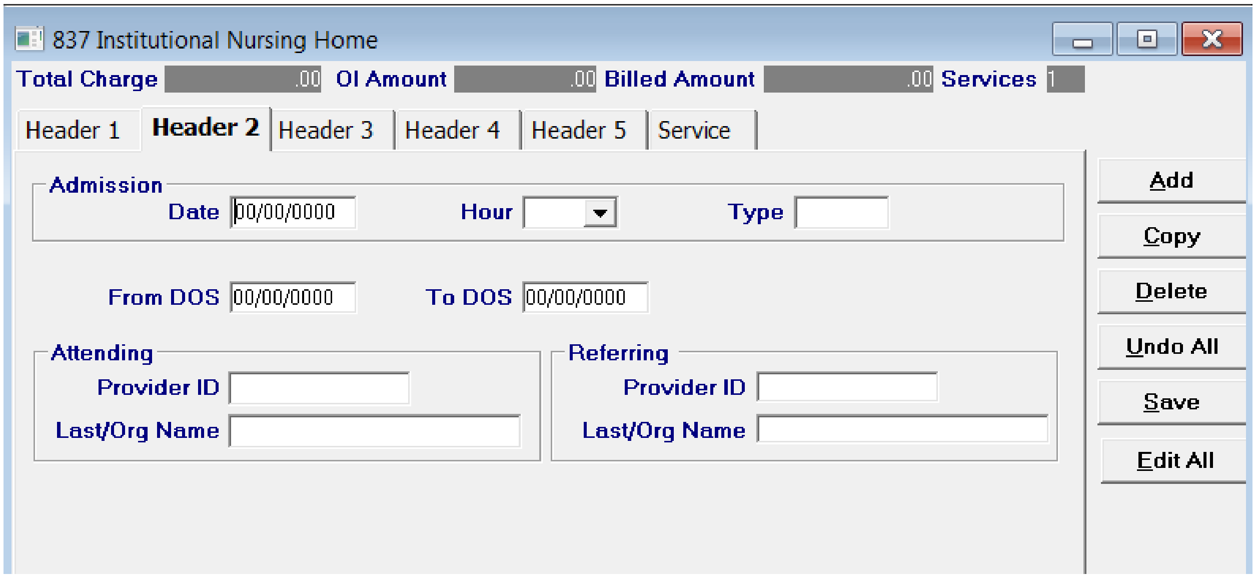
Attachment CTL:

This field is enabled when the Report Transmission Code is a “BM”, “EL”, “EM”, or “FX”. Enter the control number of the attachment.

Remarks: Situational
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

NURSING HOMES HEADER TWO

HEADER TWO SCREEN



DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
ADMISSION DATE	8	R	N
ADMISSION HOUR	2	O	N
ADMISSION TYPE	1	R	X
FROM DOS	8	R	N
TO DOS	8	R	N
ATTENDING/REFERRING PROVIDER ID	10	R	N
ATTENDING TAXONOMY CODE	10	R	X
ATTENDING/REFERRING LAST/ORG NAME	35	R	A
ATTENDING FIRST NAME	25	R	A

HEADER TWO ENTRY INSTRUCTIONS

Admission Date:

Enter the date that the client was admitted into the facility.

Note: This software will not accept dates of service prior to 1976. Therefore, if the client's admission date is prior to 1976, please enter the admission date as 01/01/1976.

Remarks:	Required
Format:	MM/DD/CCYY

Admission Hour:

Select the appropriate value for the national code which corresponds to the hour during which the client was admitted for inpatient care.

Note: "99" is not acceptable.

Code	Description	Code	Description
00	12:00 – 12:59AM Midnight	12	12:00 – 12:59PM Noon
01	1:00 - 1:59AM	13	1:00 - 1:59PM
02	2:00 - 2:59AM	14	2:00 - 2:59PM
03	3:00 - 3:59AM	15	3:00 - 3:59PM
04	4:00 - 4:59AM	16	4:00 - 4:59PM
05	5:00 - 5:59AM	17	5:00 - 5:59PM
06	6:00 - 6:59AM	18	6:00 - 6:59PM
07	7:00 - 7:59AM	19	7:00 - 7:59PM
08	8:00 - 8:59AM	20	8:00 - 8:59PM
09	9:00 - 9:59AM	21	9:00 - 9:59PM
10	10:00 – 10:59AM	22	10:00 – 10:59PM
11	11:00 – 11:59AM	23	11:00 – 11:59PM

Remarks:	Optional
Format:	NN

Admission Type:

Enter the corresponding code from the primary admission reason list below:

Code	Description
1	Emergency
2	Urgent
3	Elective
5	Trauma Center
6	Re-Admission
9	Information Not Available

Remarks:	Required
Format:	X

From Date of Service:
Enter the first date of service on which services were provided for this claim.

Remarks: Required
Format: MM/DD/CCYY

To Date of Service:
Enter the last date of service on which services were provided for this claim.

Remarks: Required
Format: MM/DD/CCYY

Attending Provider ID
Select the Connecticut Medical Assistance Program billing provider number or the HIPAA NPI from the drop down window.

Referring Provider ID
Select the Connecticut Medical Assistance Program referring provider number or the NPI from the drop down window.

Note: Once you have entered the Provider ID number the Taxonomy Code, Last/Org Name and First Name will be populated automatically.

Remarks: Required
Format: XXXXXXXXX

Attending Taxonomy Code:
This field will be auto plugged once you enter the attending provider number and contains an alphanumeric code that consists of a combination of the provider type, classification, area of specialization, and education/ training requirements.

Note: The health care provider taxonomy code list is available on the Washington Publishing Company web site: http://www.wpc-edi.com.

Remarks: Required
Format: NNNANNNNNA

Attending Last/Org Name:
This field will be auto plugged once you enter the attending provider number and contains the last name of an individual provider, or the business name of a group or facility (when the Entity Type Qualifier is a 2).

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Referring LastnameName:
This field will be auto plugged once you enter the referring provider number and contains the last name of an individual provider.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

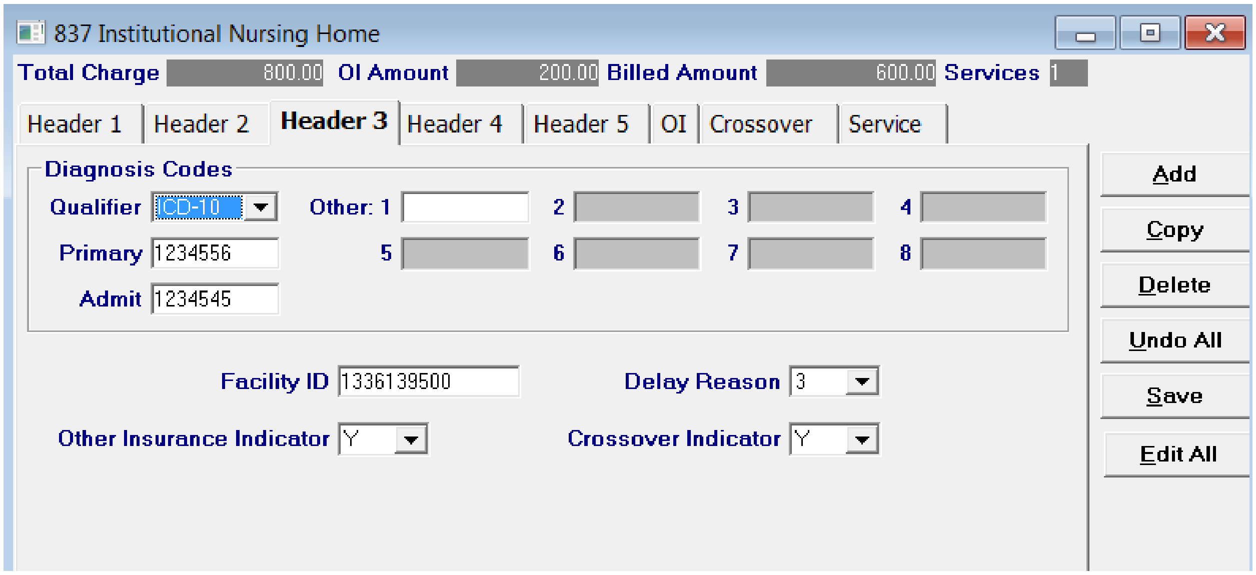
Attending First Name:

This field will be auto plugged once you enter the attending provider number and contains the first name of the provider when they are an individual.

Remarks: Situational
Format: AAAAAAAAAAAAAAAAAAAAAAAAA

NURSING HOMES HEADER THREE

HEADER THREE SCREEN



DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
DIAGNOSIS CODE QUALIFIER	7	R	X
DIAGNOSIS CODE PRIMARY	7	R	X
DIAGNOSIS CODE OTHER 1-8	7	O	X
DIAGNOSIS CODE ADMIT	7	O	X
FACILITY ID	10	O	N
DELAY REASON	2	O	N
OTHER INSURANCE INDICATOR	1	S	A
CROSSOVER INDICATOR	1	S	A

HEADER THREE ENTRY INSTRUCTIONS

Diagnosis Code Qualifier:
Select the Diagnosis Qualifier: ICD-9 or ICD-10

Diagnosis Code Primary:
Enter the primary diagnosis code from the International Classification of Diseases, Clinical Modification (ICD-9-CM or ICD-10-CM) manual.

Note: DO NOT key the decimal point. It is already assumed.

Remarks: Required
Format: XXXXXXX

Diagnosis Codes Other 1-8:
Enter up to 8 ICD-9-CM or ICD-10-CM with 3-7 digit diagnosis code for a diagnosis other than the principal diagnosis.

Note: DO NOT key the decimal point. It is already assumed.

Remarks: Optional
Format: XXXXXXX

Diagnosis Codes Admit:
Enter the ICD-9-CM or ICD-10-CM diagnosis code corresponding to the diagnosis of the client's condition, which prompted admission to the hospital.

Remarks: Optional
Format: XXXXXXX

Facility ID:
Select the Connecticut Medical Assistance Program provider number from the drop down box that identifies the facility where services were performed.

Remarks: Optional
Format: NNNNNNNNNN

Delay Reason:
Enter one of the reason codes listed below to explain why the claim was delayed.

Code	Description
1	Proof of eligibility unknown or unavailable
2	Litigation
3	Authorization delays
4	Delay in certifying provider
5	Delay in supplying billing forms
6	Delay in delivery of custom-made appliances
7	Third party processing delay
8	Delay in eligibility determination
9	Original claim rejected or denied due to a reason unrelated to the billing limitation rules
10	Administration delay in the prior approval process

11 Other
15 Natural Disaster

Remarks: Optional
Format: NN

Other Insurance Indicator:

This field indicates whether the client has other insurance or when Medicare does not pay any portion of the claim. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Other Insurance Tab is added to the claim form for entry.

Y – Yes
N – No (default)

Remarks: Situational
Format: A

Crossover Indicator:

This field should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. This field is defaulted to "N" for no. When this is changed to a "Y" for yes, the Crossover Tab is added to the claim form for entry. Use this field for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

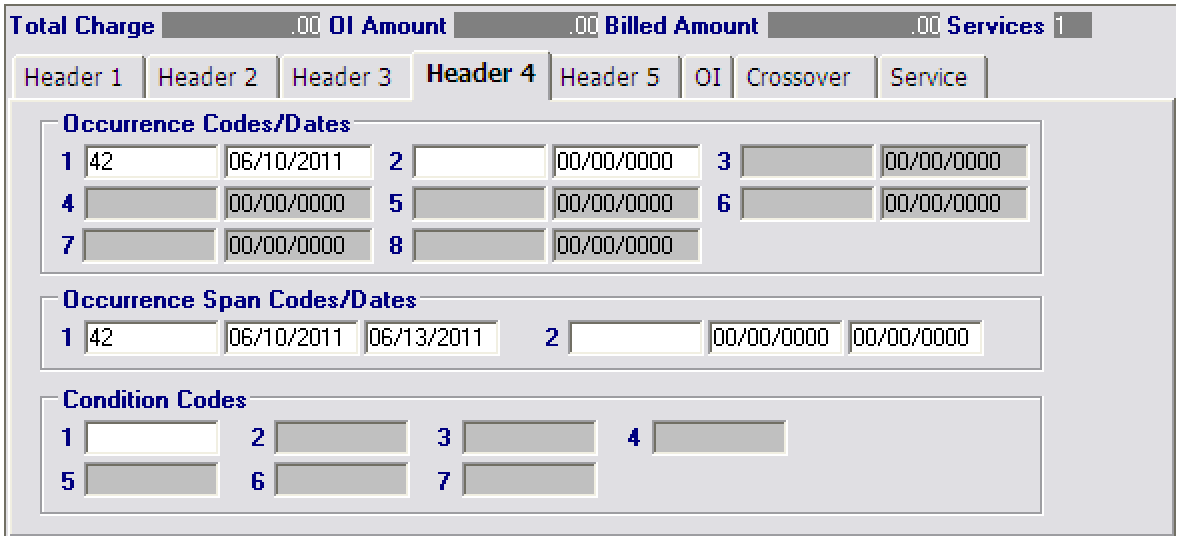
NOTE: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Y – Yes
N – No (default)

Remarks: Situational
Format: A

NURSING HOME HEADER FOUR

HEADER FOUR SCREEN



DESCRIPTION	**FIELD LENGTH**	**REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)**	**ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)**
OCCURRENCE CODES	2	O	N
OCCURRENCE CODE DATES	8	O	N
OCCURRENCE SPAN CODES	2	O	N
OCCURRENCE SPAN DATES	8	O	N
CONIDITON CODES	2	S	X

HEADER FOUR ENTRY INSTRUCTIONS

Occurrence Code:
Enter the applicable code that identifies a significant event relating to this stay. Up to eight occurrence codes can be entered with a corresponding date.

Code	Description
01	Auto Accident (out of state accident)
02	Auto Accident (used for no fault)
03	Accident Tort Liability – if known
04	Accident Employment Related
05	Type of Accident Other than 01 - 04
06	Crime Victim
11	Onset of Symptoms/Illness
21	Administratively Necessary Days
42	Date of discharge

NOTE: This field is required with value '42' if RCC 185, hospital reserve is billed. The date entered is the date the hospital reserve began.

Remarks: Optional
Format: NN

Occurrence Code Date:
Enter the date associated with the code listed.

Remarks: Optional
Format: MM/DD/CCYY

Occurrence Span Codes:
Enter the Occurrence span code.

Remarks: Optional
Format: NN

Occurrence Span Date:
Enter the date associated with the code listed.

Remarks: Optional
Format: MM/DD/CCYY

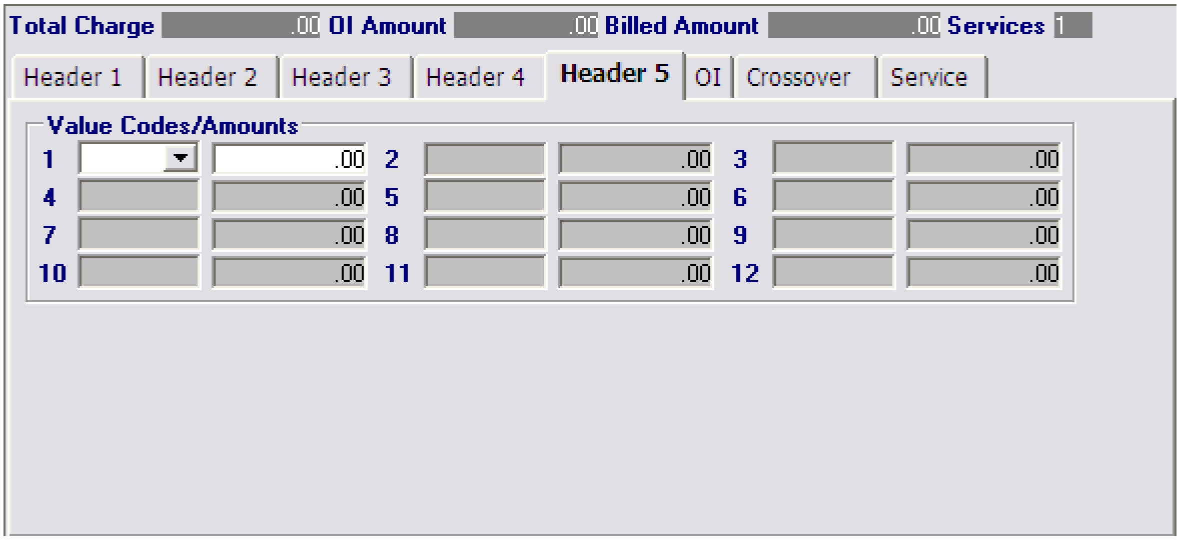
Condition Codes:
Enter the appropriate condition codes to identify conditions that determine eligibility and establish primary and/or secondary responsibility. The following codes are applicable:

Code	Description
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Shown on Claim
05	Lien Has Been Filed
A4	Family Planning

Remarks: Situational
Format: XX

NURSING HOME HEADER FIVE

HEADER FIVE SCREEN



DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
VALUE CODES	2	O	X
VALUE CODE AMOUNTS	9	O	N

HEADER FIVE ENTRY INSTRUCTIONS

Value Codes:

Enter the National Uniform Billing Committee (NUBC) code to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.

Value Codes are used to report Covered Days (Value Code 80) and Non-Covered Days (Value Code 81).
Enter the number of days for each of these value codes in the Amount field. The format of the Amount field appears as a whole number with a decimal point followed by two zeros., and is adjusted during claims processing. Covered Days are required for processing both Long Term Care and Inpatient claims.

Remarks: Optional
Format: XX

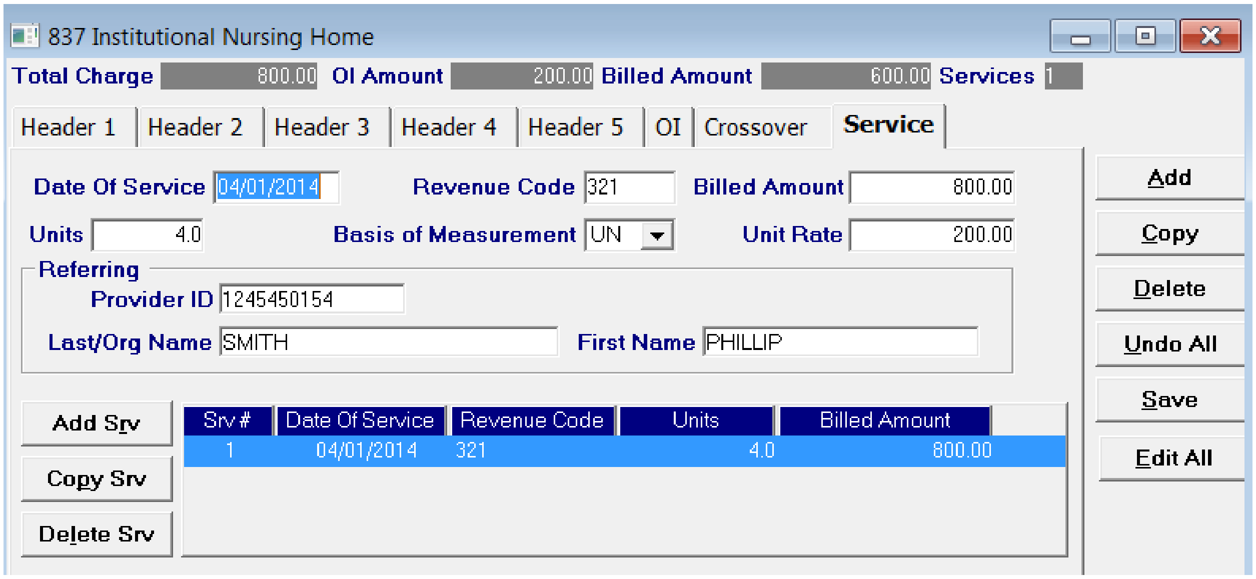
Value Code Amounts:

Enter the corresponding Value Code amount.

Remarks: Optional
Format: $$$$$$$cc

NURSING HOME SERVICE

SERVICE INFORMATION SCREEN



<u>**DESCRIPTION**</u>	<u>**FIELD LENGTH**</u>	<u>**REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)**</u>	<u>**ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)**</u>
DATE OF SERVICE	8	R	N
REVENUE CODE	3	R	N
BILLED AMOUNT	9	R	N
UNITS	4	R	N
BASIS OF MEASUREMENT	2	R	A
UNIT RATE	9	R	N

SERVICE ENTRY INSTRUCTIONS

Complete this section as though you were submitting this claim to Medicare:

- If the intent for this claim is to obtain coinsurance and deductible payments form a claim paid by Medicare.

Date of Service:

Enter the date on which service(s) were provided for this claim in MM/DD/CCYY format.

Remarks:	Required
Format:	MM/DD/CCYY

Revenue Code:

Enter the revenue code that identifies a specific accommodation or ancillary service.

Code	Description
100	Per diem rate
183	Home reserve
185	Inpatient hospital reserve
189	Non-covered reserve

Remarks:	Required
Format:	NNN

Billed Amount:

Enter the total amount for the services performed for this procedure. This should include the charge for all units listed.

Remarks:	Required
Format:	$$$$$$$cc

Units:

Enter the number of days being billed for the Revenue Center Code (RCC).

Note: For each RCC billed, the number of days must be entered. The total of all detail service units must equal the number of covered days plus the number of non-covered days. If the patient status billed is a value other than 30, 40, 41, or 42, the detail with the oldest service date must be reduced by 1 day.

Remarks:	Required
Format:	NNNN

Basis of Measurement:

Enter the code specifying the units in which a value is being expressed, or the manner in which a measurement has been taken. This field defaults to 'UN'.

Code	Description
DA	Days
UN	Units (default)

Remarks: Required
Format: AA

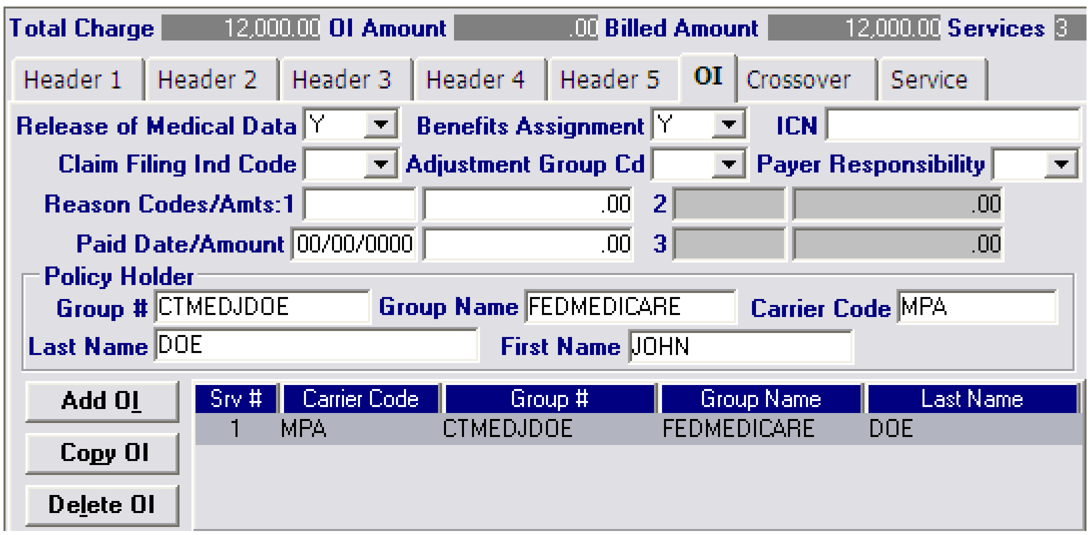
Unit Rate:

Enter the total amount of the unit rate for each unit billed.

Remarks: Required
Format: $$$$$$$cc

NURSING HOME OTHER INSURANCE

OTHER INSURANCE SCREEN



DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
ICN	30	O	X
CLAIM FILING IND CODE	2	R	X
ADJUSTMENT GROUP CD	2	R	X
PAYER RESPONSIBILITY	1	R	A
REASON CODES	5	R	X
REASON AMTS	9	R	N
PAID DATE	8	R	N
PAID AMOUNT	9	R	N
POLICY HOLDER GROUP #	17	O	X
POLICY HOLDER GROUP NAME	14	R	A
POLICY HOLDER CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	35	R	A
POLICY HOLDER FIRST NAME	25	R	A

OTHER INSURANCE ENTRY INSTRUCTIONS

Providers are required to submit other insurance information when another payer is known to potentially be involved in paying or denying a claim. This tab should also be used when Medicare does not pay any portion of the claim and all dollar fields below will contain zero amounts. Please use the crossover tab when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare.

The following fields are required when a "Y" is indicated in the other insurance indicator field on the Header Three Screen.

Release of Medical Data:

Select the appropriate value from the drop down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

ICN:

Enter the claim number from the claim processed by the other insurance.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Claim Filing Ind Code:

Select the appropriate value from the drop down box that identifies the type of other insurance claim that is being submitted Select MA or M when the denial is from Medicare.

Remarks: Required
Format: XX

Adjustment Group Cd:

Select the appropriate value from the drop down box that identifies the general category of payment adjustment by the other insurance company.

Remarks: Required
Format: XX

Payer Responsibility:

Select the code that describes the order of insurance carrier's level of responsibility for a payment of a claim.

Remarks: Required
Format: A

Reason Codes:

Enter the code identifying the reason the adjustment was made by the other insurance carrier or use this field to indicate the reason Medicare denied the claim. The reason code can be found in the Implementation Guide by clicking on the following site**:** http://www.wpc-edi.com. Follow these instructions to retrieve the reason codes:

- Click on *HIPAA*
- Click on *Code Lists*
- Click on *Claim Adjustment Reason Codes*

Use this list of codes to indicate if a payment was made by OI or denied by OI.

Remarks: Required
Format: XXXXX

Reason Amounts:

Enter the amount associated with the reason code.

Remarks: Required
Format: $$$$$$$cc

Paid Date:

Enter the date on the other insurance voucher or explanation of benefits. Use this field to enter the date Medicare denied the claim.

Remarks: Required
Format: MM/DD/CCYY

Paid Amount:

Enter the amount paid by the other insurance carrier. An amount of zero (0) may be entered. This field is required if a value is entered in the Reason Code field on the other insurance screen and a payment has been received towards the claim from a third party.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Group #:

Select the group number for the other insurance from the drop down list. If a group number is not applicable, please enter the policy number of the client. For Medicare clients, please enter the client's Health Insurance Claim (HIC) number.

Remarks: Optional
Format: XXXXXXXXXXXXXXXXX

Policy Holder Group Name:

This field is auto-plugged when a group number is entered and contains the name of the group that the other insurance is listed under and coincides with the Group number.

Remarks: Required
Format: AAAAAAAAAAAAAA

Policy Holder Carrier Code:

This field is auto-plugged when a group number is entered and contains the carrier code identifying the Other Insurance carrier from the drop down list.

Remarks: Required
Format: XXX

Policy Holder Last Name:

This field is auto-plugged when a group number is entered and contains the client's Connecticut Medical Assistance Program's identification number.

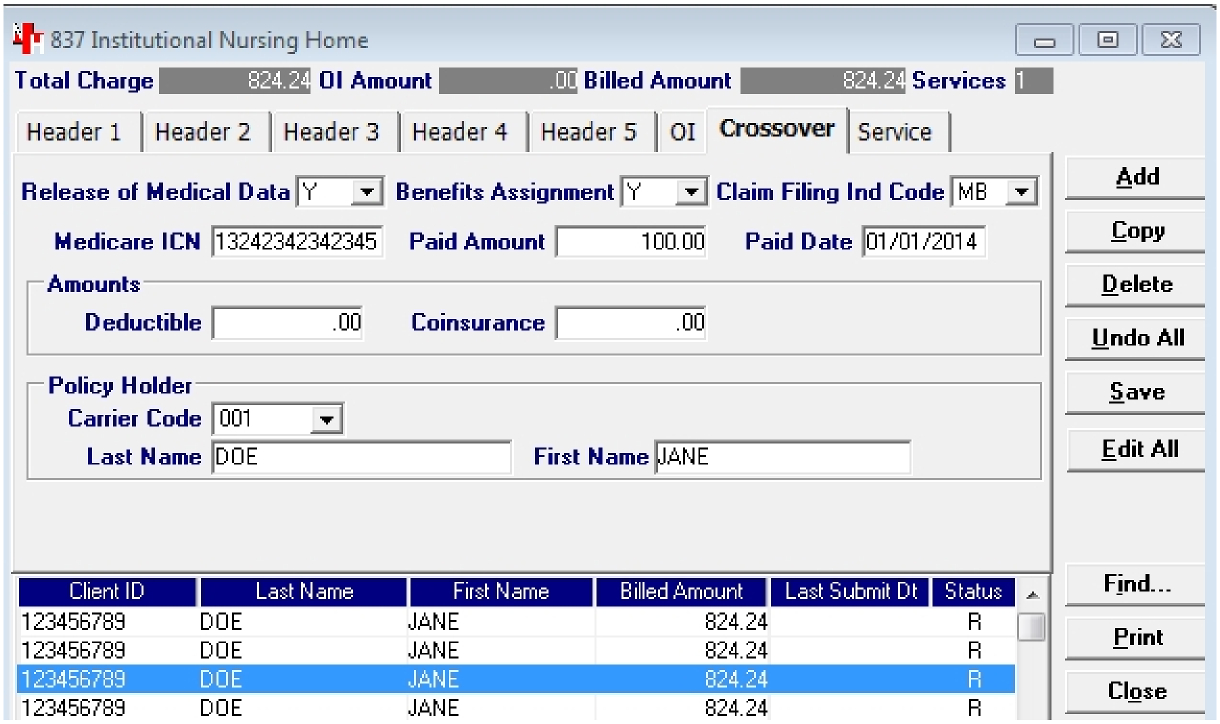
Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Policy Holder First Name:

This field is auto-plugged when a group number is entered and contains the client's Connecticut Medical Assistance Program's identification number.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAAAA

NURSING HOME CROSSOVER



CROSSOVER SCREEN

DESCRIPTION	FIELD LENGTH	REQUIRED (R) OPTIONAL (O) SITUATIONAL (S)	ALPHA (A) NUMERIC (N) ALPHANUMERIC (X)
RELEASE OF MEDICAL DATA	1	R	A
BENEFITS ASSIGNMENT	1	R	A
CLAIM FILING IND CODE	2	R	X
MEDICARE ICN	14	R	X
PAID AMOUNT	9	R	N
PAID DATE	8	R	N
AMOUNTS DEDUCTIBLE	2	R	A
AMOUNTS COINSURANCE	9	R	N
POLICY HOLDER CARRIER CODE	3	R	X
POLICY HOLDER LAST NAME	50	R	A
POLICY HOLDER FIRST NAME	25	R	A

CROSSOVER ENTRY INSTRUCTIONS

The following fields are required when a "Y" is indicated in the Crossover Indicator field on the Header Three Screen. These fields should only be used when the intent is to obtain coinsurance and deductible payments from a claim already paid by Medicare. Please see the instructions on the Other Insurance tab if Medicare did not pay any portion of the claim. Use these fields for the following situations:

- Claims that do not crossover from Medicare can be submitted electronically with Provider Electronic Solutions software.
- After claims have been submitted to other insurance, providers can submit the Connecticut Medical Assistance claim electronically with Provider Electronic Solutions software.

Note: DSS conducts monthly Electronic Claims Submission (ECS) audits, therefore, providers must retain the Explanation of Medicare Benefits (EOMB) for auditing purposes.

Release of Medical Data:

Select the appropriate value from the drop down box that indicates whether the provider, has on file, a signed statement by the client authorizing the release of medical data to other organizations. This field defaults to 'Y'.

Remarks: Required
Format: A

Benefits Assignment:

Select the appropriate value from the drop down box that identifies that the client, or authorized person, authorizes benefits to be assigned to the provider. This field defaults to 'Y'.

Remarks: Required
Format: A

Claim Filing Ind Code:

Select the appropriate code from the drop-down box that identifies the type of other insurance claim that is being submitted.

Remarks: Required
Format: XX

Medicare ICN:

Enter the claim number assigned to the claim by Medicare.

Remarks: Required
Format: XXXXXXXXXXXXXX

Paid Amount:

Enter the dollar amount paid by Medicare for the service or claim.

Remarks: Required
Format: $$$$$$$cc

Paid Date:
Enter the date on the Explanation of Medicare Benefits (EOMB) on which these services are listed.

Remarks: Required
Format: MM/DD/CCYY

Amounts Deductible:
Enter the amount of the deductible that applies to the claim or detail identified by Medicare.

Remarks: Required
Format: $$$$$$$cc

Amounts Coinsurance:
Enter the amount of coinsurance applied to the claim or detail identified by Medicare.

Remarks: Required
Format: $$$$$$$cc

Policy Holder Carrier Code:
Select the carrier code that corresponds to the policyholder for this claim.

Remarks: Required
Format: XXX

Policy Holder Last Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required
Format:
AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
AAAAAAAAAAA

Policy Holder First Name:
This field is auto-plugged once you select the carrier code.

Remarks: Required
Format: AAAAAAAAAAAAAAAAAAAAAAAAA

EDIT ALL - SPECIAL FEATURE:

Edit All Command Button

The Edit All feature allows Nursing Home providers to copy select claims from a previous submission and update the From DOS, To DOS, and Total Days for all selected claims simultaneously. Providers can then submit claims for the current month without the need to re-key claim information.

To learn more about this feature, select the Help menu, select Contents and Index, select the Help Topics button, select the Index tab, type in Edit All and press the Enter key on your keyboard. This will display the functions of and instructions for the Edit All feature.