Dear Provider/Trading Partner:

Thank you for being a part of the West Virginia Medicaid ICD-10 Pilot Provider/Trading Partner Testing!

The following manual is provided as a guide for stakeholders participating in the testing of the online claims processing environment in preparation for the transition from ICD-9 to ICD-10 on October 1, 2015.

To begin, please review the privacy rules below and the introduction on page 10. If you have any questions about the information in this manual, please contact Molina at 1-888-483-0793, option 6.

Thanks again,

ICD-10 Workgroup

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1 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule
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Revision History

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1. Introduction

Welcome to West Virginia Pilot Trading Partner ICD-10 Testing! The following manual is designed to provide users with all of the information needed to submit test claims using the Molina Medicaid Solutions User Acceptance Testing (UAT) environment online web portal.

It is very important to always remember to use the UAT web portal when submitting test claims using the [www.wvmmisuat.com](http://www.wvmmisuat.com) web address. Submitting claims in the production web portal environment will result in the submission of actual claims to the current information system production environment. This will result in testing errors and potentially impact the efficient processing of current WV Medicaid medical claims.

The ICD-10 pilot trading partner testing will utilize a mock compliance date of 10/1/2014. Trading partners may use sample claims that have been previously submitted to perform test claim submission, however it is important to change the claim information in order to avoid duplication of these claims. Examples of altered information include:

- Dates of Service
- Diagnosis Information

For Electronic Data Interchange (EDI) files, the X12 file upload should have test indicator “T” in ISA15 to distinguish the test claims.

Throughout the testing process, if a trading partner has questions about the process, please contact the Molina EDI department at 1-888-483-0793; option 6. Call representatives are available to assist during the business hours of 8:00AM to 5:00PM Monday – Friday.
2. Information the User will Need

2.1 Claim Submission Dates

The ICD-10 testing process utilizes a mock compliance date of 10/1/2014 and remains effective through 12/31/2014. Claims submitted for testing purposes should be submitted within dates of service related to this period. Claims submitted with ICD-9 codes after the mock compliance date of 10/1/2014 will result in an error. Likewise, ICD-10 claims submitted prior to 10/1/2014 will result in an error. Please note that this rule differs for Institutional Claim submission: UB04 submission should go to Section 3.3 - Institutional Claim for further information regarding these claims. Users should test a variety of claims within these dates to maximize the testing effort. Molina recommends a testing sample of 75 claims in order to conduct an adequate test of ICD-10 functionality.

2.2 Resetting a Password

1. Select the Reset Password link from the Navigation Pane on the left side of the screen. Refer to Figure 2-1.

![Figure 2-1 Reset Password Selection](image-url)
2. Specify the trading partner User Name in the box and click on the Continue button. Refer to Figure 2-2.

![Figure 2-2 Entering Username](image)

3. The dialog box displays the e-mail address and the security question associated with the user name. Refer to Figure 2-3.

![Figure 2-3 Email Address Dialog Box](image)

4. Enter the answer to the security question in the Security Answer box and click on the Continue button. If the answer to the question is successful, the system sends an e-mail to the address associated with the user name and displays the confirmation message. Refer to Figure 2-4.

![Figure 2-4 Email Confirmation Message](image)

5. The e-mail contains a confirmation link and activation PIN. After the e-mail is received, click the link or copy and paste it into the browser. A sample of the e-mail is shown below. Refer to Figure 2-5.
6. A pop-up box displays for the Password Recovery screen with the user name and activation PIN pre-populated. Refer to Figure 2-6.

![Figure 2-5 Email Confirmation](image)

Figure 2-5 Email Confirmation

To complete the Trading Partner Password Recovery screen, follow these steps:

7. Enter a **New Password** that follows the password guidelines.
8. It must be at least six characters long and contain at least one each of:
   - an upper case letter
   - a lower case letter
   - a special character
   - a number
   - password may not contain spaces.
9. **Confirm New Password** by retyping the password exactly as typed in the New Password box.

![Figure 2-6 Password Recovery Screen](image)
10. Click the **Change Password** button. The portal displays a confirmation message. Click the OK button. Refer to Figure 2-7.

![Figure 2-7 Password Confirmation Message](image)

**2.3 User Name Retrieval**

1. If the User Name for the trading partner account is lost or forgotten, use the Retrieve User Name link in the top portion of the Navigation Pane on the left side of the portal Welcome page. Refer to Figure 2-8.

![Figure 2-8 Retrieve Username Link](image)
2. After clicking the link, the Forgot User Name pop-up screen will display. Refer to Figure 2-9.

![Figure 2-9 Forgot User Name pop-up screen](image)

3. Type the e-mail address that is associated to the User Name.

4. Click on the Continue button. If the e-mail address is associated to only one trading partner account, answer the Security Question that was created during registration or last password reset. Refer to Figure 2-10.

![Figure 2-10 Security Question](image)
5. If the email address entered is associated with multiple trading partner accounts, the message below will display. Refer to Figure 2-11. Enter the Trading Partner ID in the field provided. (This number was e-mailed when the trading partner account was created. It is the same number that is used as the sender ID for X12 submissions. Please contact the EDI Helpdesk at 855-248-7536, if you cannot locate your trading partner ID.)

1. Enter the Trading Partner ID.
2. Click on the Continue button

![Figure 2-11 Multiple Trading Partner Accounts](image)

6. Type the answer to the security question in the Security Answer field and click on the Continue button.

7. If the answer to the question is successful, the system sends an e-mail to the address associated with the User Name and displays the confirmation message shown below. Click on the OK button. Refer to Figure 2-12 and Figure 2-13.

![Figure 2-12 Retrieve User Name Confirmation](image)
8. Return to the Trading Partner Sign In tab and login. Refer to Figure 2-14.

![Figure 2-14 Trading Partner Sign In tab]

2.4 **ICD-10 Technical Reference Guide**

The user will need to sign on to the Test Website at [www.wvmmisuat.com](http://www.wvmmisuat.com) on the Provider tab using their account credentials from the Production website. If the user needs to reset their password, refer to Section 2.2 **Resetting a Password**. If the user cannot recall their User Name, refer to Section 2.3 **User Name Retrieval**.

Once logged in, the user should review and update account information accordingly. This should include the following:

- Providers should verify how they will receive either an electronic remittance advice or 835 file aggregation.
- If choosing to receive the 835 and electing a third party receiver, it is advisable to contact the receiver to inform of the testing being performed.
Users may contact the WV EDI Helpdesk for any other issues.

2.4.1 **Form Entry – Claim Submission/Direct Data Entry (DDE)**

ICD-10 Code Version selection is located at the top of the Diagnosis section in Claim Submission of Form Entry. Once a version is selected, the code can be manually entered in the Code field or by using the Search tool. The CMS Claims Guidelines for ICD-10 implementation is available as a link as well. Refer to **Figure 2-15**.

![Figure 2-15 ICD-10 Code Version Selection](image)

The following image is a sample of a Professional claim submission. Refer to **Figure 2-16**.

![Figure 2-16 Professional Claim Submission Sample](image)

The following image is a sample of an Institutional claim submission. Refer to **Figure 2-17**.
2.4.2 File Exchange - X12 Upload

Please use the following Indicators and Qualifiers for your test X12 submissions. Interchange Usage Indicator (ISA15) should be set to “T”. Refer to Figure 2-18

<table>
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<th>ISA15</th>
<th>Usage Indicator</th>
<th>T = Test Data</th>
<th>P = Production Data</th>
</tr>
</thead>
</table>

Institutional Claims

ICD-9 Qualifiers:

- Principal Diagnosis: Code List Qualifier for ICD-9 codes is “BK” in HI01-1.
- Other Diagnosis Information: Code List Qualifier for ICD-9 codes is “BF” in HI01-1 – HI12-1.

ICD-10 Qualifiers:

- Principal Diagnosis: Code List Qualifier for ICD-10 codes is “ABK” in HI01-1.
- Other Diagnosis Information: Code List Qualifier for ICD-10 codes is “ABF” in HI01-1 – HI12-1.

Professional and Dental Claims

ICD-9 Qualifiers:

- Health Care Diagnosis: Code List Qualifier for ICD-9 codes is “BK” in HI01-1.
- Additional Diagnosis: Code List Qualifier for ICD-9 codes is “BF” in HI01-1 – HI12-1.

ICD-10 Qualifiers:

- Principal Diagnosis: Code List Qualifier for ICD-10 codes is “ABK” in HI01-1.
- Additional Diagnosis: Code List Qualifier for ICD-10 codes is “ABF” in HI01-1 – HI12-1.
2.4.3 Verifying & Accessing Electronic Remittance Advices (PDF Remittance Advice & 835)

1. Select 'Provider Associations’ under ‘Account Maintenance’ to verify or setup ERA/835 elections. Refer to Figure 2-19.

2. Each provider associated will need to be individually setup. To setup ERA elections, select the ‘Edit ERA’ option under ‘Action’. Refer to Figure 2-20.
3. Within the ‘Electronic Remittance Advice Information’ section, verify/edit elections to receive remits in form of PDF and 835 formats. If electing to receive remittance data, please choose whether to receive by NPI or Tax ID from the ‘Preference for Aggregation of Remittance Data’ drop down menu. Refer to Figure 2-21.

![Figure 2-21 ERA Information](image)

There are three methods of retrieval:

4. ‘Download PDF’ is unchecked by default during the initial account setup and when adding provider associations to the account. Checking the box indicates electing to receive the remit in PDF format. Refer to Figure 2-22.

![Figure 2-22 Download PDF Method of Retrieval](image)
5. The next method is to elect whether or not to receive the remit in 835 format to this account. By default, the ‘No 835’ option is preselected. To receive, select ‘Generate 835’. Refer to Figure 2-23.

![Figure 2-23 Download 835 Method of Retrieval](image)

6. The third method is to elect a third party to receive the 835. Notice that only the third party or the account can receive the 835, not both at the same time. A drop down menu will appear. Within the menu, please select from the list of third party recipients. Refer to Figure 2-24.

![Figure 2-24 Third Party Method of Retrieval](image)
7. If changes are made, proceed to the ‘Submission Information’ section to confirm. The identity in ‘Authorized Signature’ will be the user’s account owner and is prepopulated. The ‘Electronic Signature of Person Submitting Enrollment’ field should match ‘Authorized Signature’. The date on which to elect to receive the remit is entered in the ‘Requested ERA Effective Date’ field. The date cannot be retroactive, however, can be today’s date or a future date. Select ‘Update’ to finish changes. Refer to Figure 2-25.

8. To access ERA select PDF remits in ‘File Exchange’ under ‘Reports’. Refer to Figure 2-26.
9. To access 835 remits select **Finance (835, 820)** in ‘File Exchange’ under ‘Responses’. Refer to **Figure 2-27**.

*Figure 2-27 Selecting 835 Remits*

*Please note that the test 835 file will be indicated by a “T” in ISA15 and within the filename itself.*
3. Claim Form Entry
To access online claim entry, go to the navigation pane, **Form Entry**. Click on the expansion symbol (⟩) and the list of forms will open. Click on **Claim Submission**. Refer to **Figure 3-1**.

![Figure 3-1 Claims Submission in the Navigation Pane]

**Reminder:** All fields with a red asterisk (*) are required fields

On the first screen, identify the **Billing Provider**. The field may have filled automatically. If not, click on the down arrow to open the drop-down menu. Click on the appropriate provider name.

On the next line, click on the radio button next to the type of claim to be entered: Refer to **Figure 3-2**.

- **Professional**, CMS 1500
- **Dental** Claim Form
- **Institutional**, UB-04 (also called CMS 1450)

*Please note that Copy Last Claim is not a Claim Type – please see Section 3.4 - ‘Copy Last Claim’ feature to learn more about this feature.*
3.1 Professional Claim, CMS 1500

The CMS 1500 is used for non-institutional providers (generally group or individual provider practices) or suppliers. There are four sections to the claim screen:

- Claim Information
- Diagnosis
- Services
- Additional Information

Reminder: Any fields with a red asterisk (*) are required. An error message will be displayed if these values are left blank at time of submission.

3.1.1 Claim Information for Professional Claim

The Patient Account # is the number assigned to the patient in the billing system; it is a required field. The Medical Record # (as used by the office) may be entered if the office chooses to do so.

The Rendering Provider, also a required field, can be entered using the down arrow which opens a drop-down menu. Click on the name of the rendering provider and the field will fill.

Please note that the rendering provider must be enrolled, credentialed, and affiliated to the billing provider in order for them to appear in the drop-down menu.

The optional Service Location field may be selected in the available drop down field. Refer to Figure 3-3.

At this time, only the Ordering or Referring Provider’s NPI will need to be entered in the Claim Information tab if relevant.

The Ordering Provider’s NPI will be entered if applicable. (Required for Independent Lab, Independent Imaging, Pharmacy, DME, and Orthotic/Prosthetic)
The **Referring Provider’s NPI** will be used if the member and service require approval from PAAS physician (Physician Assured Access System).

![Claim Information for the Professional Claim](image)

**Figure 3-3 Claim Information for the Professional Claim**

### 3.1.2 Diagnoses for Professional Claim

This screen is used to enter all the diagnoses for the participant for this claim. As many diagnoses as needed may be entered. To add a new line, press the **Tab** key at the end of the last line and a new line will appear. There are four fields in the diagnosis section:

- **Line #**
- **Code**
- **Description**
- **Type:** whether the diagnosis is primary or secondary

The only field the user can edit is **Code**. The **Line #** will increase automatically as each line is added. The **Description** and **Type** will appear once the code is entered. If the code cannot be used currently for billing, an error message will appear in the description field. The first line entered will be the primary diagnosis. The primary diagnosis must be closely related to the procedure. All lines entered after that will be considered secondary diagnoses.

To delete a line from the list, click the **Recycle Bin** icon, next to the **Line #** field. A diagnosis line cannot be deleted if it will be listed in one of the **Related Diagnosis** fields on a **Service Code** line on the claim.

To search for a **Diagnosis Code**, click in the **Code** field then click on the **Search** icon (🔍) to the left of the **Line #** and a search window will open.
3.1.3 Services for the Professional Claim

Refer to Figure 3-4. The fields for entering Services are as follows:

- Line #
- Dates of Service (From and To)*: Format: MM/DD/YYYY
- Place of Service*
- Code*
- Modifier(s)
- Related Diagnosis*
- Charge*
- Units*
- Minutes* (This field is grayed out as it is not required at this time)
- EPSDT (Early Periodic Screening, Diagnosis and Treatment)
- Emergency
- Authorization #
- Rendering Provider

Please note that the total charges and also total units will need to be entered.

When the Tab key is pressed through all these fields without entering anything, some of the fields will fill automatically. The following information will display:

- Dates of Service (From and To): Current date
- Place of Service: 11
- Charge: $0.00
- Units: 1
- EPSDT:
- Rendering Provider: Same rendering provider listed above in the Claim Information section at the top of the screen.
When a service **Code** is entered, the description will appear below in the **CPT Code Description** box. If the code cannot be used currently for billing, an error message will appear in the description field.

As in the diagnosis area, to add more lines, press the **Tab** key at the end of the last line and a new line will appear. Up to 99 service lines are available for entry. If any required field has not been entered, the cursor will jump back to that field before displaying a new line.

The **Total $** and **Total Units** will appear in the grey area next to the **CPT Code Description** box.

If the service is for a drug product, click on the NDC check box (**Enter NDC Codes**) at the left end of the screen. Refer to **Figure 3-5**, the applicable fields will be available for entry at the right end of the array. The fields are:

- **National Drug Code (NDC)**
- **Unit of Measure**
- **Quantity/Units**
- **Price**

![Figure 3-5 Enter NDC Codes](image)

To search for any service code, click first on the **Code** field, then click on the **Search** icon, near the **Line #** and a new search window will open.
Coordination of Benefits (COB) Information

Coordination of Benefits (COB) Information may be added to the claim by clicking the link at the bottom of the claim form entry screen: Refer to Figure 3-6.

In the COB Information screen, click on the applicable radio button to have the COB information entered by Claim or Service Line. The data should represent the amount already paid to the provider either by Medicare or by a Commercial insurer. Medicare and Commercial information can be entered either by the claim line or claim header for each COB type. If COB is entered at the line, totals are displayed at the top of the data-entry grid. Up to four action codes may be entered for Medicare.

There are two different lines for entry, one for Medicare and one for Commercial. The Medicare line contains the following fields. Note that the first three fields do not display if the By Claim radio button was chosen:

- Line #/Total
- Service Code
- DOS (Date(s) of Service): Format: MM/DD/YYYY
- Allowed Amount
- Paid Amount
- Deductible Amount
- Coinsurance Amount
- Act Code (Action Code)
- Paid Date: Format: MM/DD/YYYY

NOTE: Psych Reduction and Blood Deductibles can be combined with Coinsurance Amount, when applicable.

TPL has the same fields with the exception of the Action Code.

The dollar sign is not required and should not be entered. Whole dollars can be entered without the decimal and the additional zeros. For example, the following entry conventions apply:

- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

(Note that it is not necessary to enter the last 0)
Enter/update information on this page, click **Submit** at the bottom of the page, and then either **Save** or **Adjudicate** the claim in order to store the information.

Please note that for Professional Claims, the ‘by Service Line’ will need to be selected. Refer to **Figure 3-7**.

![Figure 3-7 COB Information](image)

### 3.1.4 Additional Information for the Professional Claim

The **Additional Information** section contains information about whether these services are related to any kind of accident. The choices are:

- Employment
- Auto Accident
- Other Accident

If the claim relates to an **Auto Accident**, enter the **State** in which the accident occurred in the field just below **Auto Accident**. Refer to **Figure 3-8**.

![Figure 3-8 Additional Information for the Professional Claim](image)
3.1.5 Submitting the Professional Claim

When all the information has been entered, review the entries for accuracy and click on the Submit button to submit the claim. Any error messages will appear at the top of the page in a red font and must be corrected before the claim will actually be submitted. Refer to Figure 3-9 for a confirmation page that a claim has been submitted. See Section 3.5 - Submit and Process a Claim, for additional information and options.

3.2 Dental Claim

This claim is used for dental providers. There are three parts to the claim:

- Claim Information (see Section 3.2.1)
- Services (see Section 3.2.2)
- Additional Information (see Section 3.2.3)

Any entry fields with a red asterisk (*) are required. An error message will be displayed if these fields are left blank.

3.2.1 Claim Information for the Dental Claim

Refer to Figure 3-10 for the Claim Information for the dental claim.

The Patient Account #, the number assigned to the patient in the billing system, is a required field. The Medical Record # (as used by the office) may be entered if the office chooses to do so.

Rendering Provider, a required field, can be entered by clicking on the down arrow which opens a drop-down menu. Click on the name of the dentist and the field will auto fill.

Please note that the rendering provider must be enrolled, credentialed, and affiliated to the billing provider in order for them to appear in the drop-down menu.

The Service Location will automatically default with the correct service location for the rendering dentist for this particular service. The field will fill automatically.
Only the **Ordering** or **Referring Provider**’s NPI will need to be entered in the Claim Information tab if relevant.

![Figure 3-10 Claims Information for the Dental Claim](image)

The **Encounter claim** check box in the lower left is optional. It is used when a claim is being submitted for management/tracking purposes and no reimbursement is expected.

### 3.2.2 Services for the Dental Claim

Dental Service fields include:

- **Line #**
- **DOS (Date(s) of Service-From and To)**: Format: MM/DD/YYYY
- **Place of Service**
- **CDT Code (Current Dental Terminology)**
- **Modifiers**
- **Tooth**
- **Area**
- **Surface**
- **Quantity**
- **Fee**
- **Authorization Number (Predetermination Number)**
- **Rendering Provider** (With a drop-down arrow)
- **CDT Code Description**
- **Totals**

**Note:** A Predetermination number is not required on the claim form. The system will automatically fill in the authorization number on each service line.

**Note:** If the **Tab** key is pressed through all these fields without entering anything, some of the fields will fill automatically. The information to appear is as follows:

- **Dates of Service (From and To):** Current date
- **Place of Service:** 11
- **Quantity:** 1
- **Fee:** $0.00
- **Rendering Provider:** Same rendering provider listed above in the *Claim Information* section at the top of the screen

When a service code is entered, the description will appear below in the *CDT Code Description* box. If the code cannot be used currently for billing, an error message will appear in the description field.

The **Total $** and **Total Units** are calculated and displayed in the grey area to the right of the *CDT Code Description* box. Refer to **Figure 3-11**.

![Figure 3-11 Services for the Dental Claim](image-url)

To add more lines press the **Tab** key at the end of the last line and a new line will appear. To delete a line from the list, click the recycle bin symbol (🗑️) to the left of the **Line #** field.

To search for a **Service Code**, first click on the **Code** field, then click on the **Search** icon (🔍) near the **Line #** and a new search window will open.

**Coordination of Benefits (COB) for the Dental Claim**

More information for Coordination of Benefits (COB) may be added by clicking the link for COB information. Refer to **Figure 3-12**.

![Figure 3-12 COB Hyperlink](image-url)

Click on the applicable radio button to have the COB information entered by **Claim** or by **Service Line**. The data should show the amount(s) already paid to the provider from the third party. Refer to **Figure 3-13**. Note that the first three fields do not display if the **By Claim** radio button was clicked. The fields include:

- **Line #**
- **Service Code**
- **DOS (Date(s) of Service):** Format MM/DD/YYYY
- **Allowed Amount**
- **Paid Amount**
- **Deductible Amount**
- Coinsurance Amount
- Copayment Amount
- **Paid Date**: Format MM/DD/YYYY

![Figure 3-13 COB Information Screen](image)

All dollar amounts should be entered without the dollar sign. Whole dollars can be entered without the decimal and the additional zeros. For example the following entry conventions apply:

- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

(Note that it is not necessary to enter the last 0)
3.2.3 Additional Information for the Dental Claim

The Additional Information section contains information about whether these services are related to any kind of accident. The choices are:

- Employment
- Auto Accident
- Other Accident

If the claim relates to an auto accident, enter the State in which the accident occurred in the State field. Refer to Figure 3-14.

In the two miscellaneous areas: Orthodontics and Prosthesis. Enter the applicable month, day, and year in the format shown in the screen.

![Figure 3-14 Additional Information for the Dental Claim](image)

3.2.4 Submit the Dental Claim

When all the information has been entered, review the entries for accuracy and then click on the Submit button to submit the claim. Any errors will appear at the top of the page in a red font and must be corrected before the claim can be submitted. See Section 3.5 - Submit and Process a Claim, for additional information and options.
3.3  Institutional Claim

This claim, comparable to the paper UB-04, is used for all providers who bill Medicare fiscal intermediaries. There are six parts to this claim:

- **Claim Information** (see Section 3.3.1)
- **Admission Data** (see Section 3.3.3)
- **Diagnosis, Visit, and Injury** (see Section 3.3.4)
- **Procedures** (see Section 3.3.5)
- **Condition, Occurrence, and Value Codes** (see Section 3.3.6)
- **Service Codes** (see Section 3.3.7)

Any input fields with a red asterisk (*) are required. An error message will display if these values are left blank.

3.3.1  Date Spanning

Depending on the bill type associated with the testing claims submission, trading partners will need to use either ICD-9 or ICD-10 codes when submitting claims spanning the mock compliance date of 10/01/2014. Please see the CMS Guidelines for ICD-10 claim submission for further information regarding billing types. The following table is provided as a resource for determining the appropriate method of billing per bill type for institutional providers.

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Requirement</td>
<td>Effective Date</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>318X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Code</td>
<td>Service Type</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.</td>
<td>See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient )</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Details</td>
<td>FROM</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>81X</td>
<td>Hospice- Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
</tbody>
</table>
82X  Hospice – Non hospital  Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.  FROM

83X  Hospice – Hospital Based  N/A  N/A

85X  Critical Access Hospital  Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.  FROM

Table 3-1 Institutional Provider Bill Types

3.3.2 Claim Information for the Institutional Claim
For Claim Information for the Institutional Claim, Refer to Figure 3-15. The Billing Provider is automatically filled in based on the user sign on.

The Member Name, Date of Birth, and Member ID will be pre-populated based on the participant chosen. To edit the information or find a different participant, use the same processes.

The Patient Account # is the number assigned to the patient in the billing system; it is a required field.

Rendering Provider is a required value. Rendering Provider and Service Location can be selected by clicking on the drop-down menu arrow, then clicking on an item in the list.

Bill Type is a required value. Click on the down arrow for the drop-down menu; click on the appropriate type.

Only the Referring, Attending or Operating provider’s NPI will need to be entered, depending on the Bill Type or the Service Codes entered.

The Referring Provider’s NPI will be used if the member and service require approval from PAAS physician (Physician Assured Access System).

The Attending’s NPI is used for the Ordering Provider. (Required for Home Health)

Enter Covered Days, Non-Covered Days, Lifetime Reserve, and Co-insured Days as needed.
The **Encounter Claim** box is optional. It is used when a claim is being submitted for management/tracking purposes and no reimbursement is expected.

![Figure 3-15 Claims Information for the Institutional Claim](image)

### 3.3.3 Admission Data for the Institutional Claim

This section of the claim form has six data fields:

- **Admission Date**: Format MM/DD/YYYY
- **Admission Source Code**
- **Admission Time**: Format: HH
- **Discharge Time**: Format: HH
- **Admission Type Code**
- **Patient Status Code**

*Enter times using a 24-hour format. For example:

- 8:32 am would be entered as 08
- 7:25 pm would be entered as 19 (note that 12 + 7=19)

Note that only the hour of Admission or Discharge is necessary. The minute is not necessary.

Enter as much information as possible in the applicable fields. Refer to **Figure 3-16**.

![Figure 3-16 Admission Data for the Institutional Claims](image)
3.3.4 Diagnosis, Visit, and Injury Codes for the Institutional Claim

This section of entry for the institutional claim has four sets of fields, Refer to Figure 3-17. For all four fields when the code is entered, tab to the next field and the system will confirm that the entry is currently an active code; if the code is not active an error message will display in the description field.

- Diagnosis
- Admitting Diagnosis
- Reason for Visit
- External Cause of Injury

Except for Reason for Visit, each has four fields:

- Code: editable
- Description: information will fill automatically once the code is entered
- Type: primary or secondary, filled in automatically once the code is entered
- POA (Present on Admission): can be edited, use one of the following codes:
  - Y for Yes
  - N for No
  - U for Unknown/Undetermined
  - Field does not appear for Reason for Visit

Up to 12 diagnosis codes may be entered. Press the Tab key at the end of the line last line entered and a new line will appear. To delete a line from the list, click the recycle bin symbol (🗑️) to the left of the Line # field.

The first line entered will be the primary type. This primary diagnosis must be closely related to the procedure(s) associated with the claim. All subsequent lines entered will be secondary.

![Figure 3-17 Diagnoses, Visit, and Injury Codes for the Institutional Claim](image)
3.3.5 Procedures for the Institutional Claim

The fields for entering the principle procedure code include:

- Code
- Description
- Date of Service: Format MM/DD/YYYY
- Type: First code is considered primary, all others are secondary

Other Procedures may also be entered using:

- Code
- Description
- Type

Note the absence of date of service for the additional procedure codes. To add a new line press the Tab key and a new line will appear.

For all Procedure Codes, the Code and the Date of Service can be entered or edited. The Description and the Type will fill automatically. If the code cannot be used for billing, an error message will appear in the description field. The first line entered will be the primary type. All following lines entered will be secondary. Refer to Figure 3-18.

To delete a line from the list, click the recycle bin (🗑️) to the left of the Line # field.

![Figure 3-18 Procedure Codes for the Institutional Claim](image)

To search for either kind of procedure code, click on the Code field under Principle Procedure for the primary procedure or under Other Procedure for all other codes. Click on the Search icon, (🔍) to the left of the word Code and a new window will open.
Enter a description of the code in the **Description** box and then click on the **Search** button ( ) a list of results will display. Refer to **Figure 3-19**.

![Figure 3-19 Search for a Procedure Code](image)

If none of the options is appropriate, then click on the ( ) button to clear the description field.

Clicking on the **Search** button ( ) or pressing **Enter** with no description entered, will display the whole list of available procedures.

The results consist of **Code IDs** and **Descriptions**, as seen in **Figure 3-20**. Click the appropriate **Code ID** to enter that **Code ID** to the applicable procedure area. The **Description** and the **Type** will fill automatically.

![Figure 3-20 Results of Procedure Code Search](image)
3.3.6 Condition, Occurrence, and Value Codes for the Institutional Claim

Condition, Occurrence, and Value Codes provide additional information used in adjudicating an institutional claim.

**Condition Codes** have two fields:
- Code
- Description

If necessary, use the Search icon (🔍) to the left of the Code field; see Code Search below for the process.

**Occurrence Codes** have either three or four fields:
- Code
- Description
- Date: Format: MM/DD/YYYY
  - For an Occurrence Code there is one Date
  - For an Occurrence Span there are From and Thru date

If necessary use the Search icon (🔍) near the Code field; see Code Search below for the process.

**Value Codes** have the three fields:
- Code
- Description
- Amount

The Condition, Occurrence, and Value Codes are immediately checked for accuracy by the system; if the code cannot be used, there will be an error message in the description field.

All dollar amounts should be entered without the dollar sign. Whole dollars can be entered without the decimal and the additional zeros. For example, the following entry conventions apply:
- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

(Note that it is not necessary to enter the last 0)

If necessary, use the Search icon (🔍) near the Code field; see Code Search below for the process. Refer to Figure 3-21.
Using **Condition Codes** as an example for these three areas, click the **Code** field, click on the **Search** icon (🔎) and enter the description in the **Description** field. Refer to Figure 3-22.

Then click on the **Search** button (🔍) and a list of codes and descriptions will display. Refer to Figure 3-23. Clicking on the **Search** button or pressing **Enter** without having entered a **Description** will display the whole list of available codes.

If necessary, click on the **Reset** button (🔄) to clear the description field and enter a different description.

In the list of results, click the **Code ID** and that **Code ID** and **Description** will automatically fill the fields in the **Condition Code** area.
3.3.7 Service Codes for the Institutional Claim

Service Code fields include:

- Line #
- Code
- HCPCS (Healthcare Common Procedure Coding System)
- Modifiers
- Dates of Service (From and To): Format: MM/DD/YYYY
- Units
- Charge
- Non-Covered Charges
- Referral
- NDC (National Drug Code)*
- Unit of Measure for NDC Code*
- Quantity/Units for NDC*
- Price for NDC*
- Service Code Description

*NDC, Units of Measure, Quantity/Units, and Price will open and be available only when the box to the right of Enter NDC Codes contains a check mark; click on the box, a check mark will appear, and the four fields will open.

To add more lines press the Tab key at the end of the line and a new line will appear. Up to 99 lines of service codes may be entered.

When a Revenue Code is entered, the system will check the accuracy of the code; if it matches the list of active revenue codes active on the dates of service, the description will appear in the Description box; if it does not match, an error message will appear. The total price and total units will be displayed at the bottom of this area.

When a service code is entered, the system will check the accuracy of the code; if it matches the list of active service codes active on the dates of service, the description will appear below in the Description box; if it does not match, an error message will appear. The total price and total units will be displayed in the grey area next to the CPT Code Description box. Refer to Figure 3-24.

Pressing the Tab key to move through the fields, will automatically fill the fields listed below:

- DOS From and DOS To: The current date
- Units: 1
- Charge: $0.00
- Non-Covered Charges: $0.00
To search for a Service/Revenue Code, click on the Code field and click on the Search icon (🔍) to the left of the Line # and a new search window will open.

Coordination of Benefits
More information for the COB (Coordination of Benefits) for the claim may be added by clicking the link in the lower left of the Service Codes area. Refer to Figure 3-25.

The COB Information can be entered for the whole claim or for each individual claim line for any amounts previously paid to the provider. Click on the radio button to indicate how the COB information is to be entered. Refer to Figure 3-26.
All dollar amounts can be entered without the dollar sign. Whole dollars can be entered without the decimal and the additional zeros. For example the following entry conventions apply:

- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

(Note: that it is not necessary to enter the last 0)

3.3.8 Submit the Institutional Claim

When all the information has been entered, review the entries for accuracy and click on the button to submit the claim. Any errors will appear at the top of the page in a red font and must be corrected before the claim will actually be submitted. See Section 3.5 - Submit and Process a Claim, for additional information.

3.4 ‘Copy Last Claim’ feature

This feature allows a trading partner to select the most recent claim by date of service for the Member ID entered. If there is more than one claim with the same date of service, the system will select the most recent claim submitted based on time stamp. If the system does not find a claim for the member entered, the user will get message that No Claim Found. In this case, the user will resubmit the claim without using the Copy Last Claim feature.

3.4.1 Search for last claim submitted

On the first screen, Figure 3-27, identify the Billing Provider. The field may have filled automatically. If not, click on the down arrow to open the drop-down menu. Click on the appropriate provider name.

On the next line, click on the radio button next to the field labeled Copy Last Claim:
Identify the participant who received the services associated with the claim the user wants to copy, using the fields in the **Find Member** screen, and click on the **Submit** button to search for a claim that meets that criteria entered. Refer to **Figure 3-28**.

![Figure 3-28 Search for Member](image)

### 3.4.2 Search Results

The system will return the member information that meets the criteria entered in the member search screen in the **Find Member Results** tab at the bottom of the screen. If more than one member meets the criteria, select the radio button next to the member the user wants to copy the claim for, and select the **Continue** button. Refer to **Figure 3-29**.

![Figure 3-29 Member Search Results](image)

### 3.4.3 Copy Claim Detail Feature

The system will return the most recent claim detail based on date of service. The **Patient Identifier** and **Claim DOS** fields will not be copied over to the new screen. This is done to ensure these fields are entered/reviewed by the user. The claim type is identified at the top of the screen under label titled **You Are Here: Claim Wizard**. All fields on the Claim Detail screen must be reviewed and completed before resubmitting the claim for payment. The claim fields/sections of the claim detail form that are required are outlined below.

**Reminder:** All fields with a red asterisk (*) are required fields.
3.4.3.1  Review Claim Information
The claim detail displays on the screen, where the provider can modify as needed before resubmitting the claim. The Rendering Provider field and service location are auto-populated based on the original claim. Figure 3-30 identifies the fields that are required. A search can be done to find the Referring Provider by selecting the Magnifying glass (🔍) and typing in the provider information.

![Figure 3-30 Claim Detail Review](image)

3.4.3.2  Diagnosis
At least one diagnosis code is required to resubmit the claim. The original diagnosis code is displayed on the screen. The provider can update/modify the diagnosis code if needed. Refer to Figure 3-31.

![Figure 3-31 Diagnosis Code Review](image)

3.4.3.3  Service Codes
The DOS From and DOS To fields must be entered to resubmit the claim. Use the format of MM/DD/YYYY to enter the dates. Enter the date in the DOS From field and press the Tab button. The DOS TO field will auto-populate with the same date entered in the DOS From field. Ensure the DOS TO field aligns to the claim the user is resubmitting. Review all fields with a red asterisk (*), and press the Submit button (Submit). Refer to Figure 3-32.
3.4.3.4 Claim Submit Confirmation

Once the claim is submitted the user will receive a confirmation screen similar to Figure 3-33. Please see Section 3.5 - Submit and Process a Claim to learn about the buttons seen on the bottom of the confirmation screen.

3.5 Submit and Process a Claim

When all the information for any claim has been entered, review the entries for accuracy and click on the ( ) button near the bottom of the screen to submit the claim.

The Claim Confirmation will be displayed. Refer to Figure 3-34. The Claim ID is in the upper left corner. TheSubmitted Claim screen presents the following options:

- **Claim View**: Click on Claim View to see all information that was entered on the claim
- **Adjudicate Claim**: Click on the Adjudicate Claim button; the claim is immediately processed for payment
- **Edit Claim**: Click on the Edit Claim button if changes need to be made to the entry
- **Upload Attachment**: Click on the Upload Attachment button.
- **New Claim**: Opens a new claim form for entry
Any entry errors will appear at the top of the page in a red font and must be corrected before the claim can be submitted.

3.5.1 Adjudicate Claim

Adjudication processes the claim for payment and identifies the amount that will be paid to the provider. If the claim cannot be adjudicated, Figure 3-35, the screen will show the error message, “There are outstanding edits.” Click on the Edit Claim button at the bottom of the section to fix these errors in order to attempt to adjudicate the claim again.

![Figure 3-35 Adjudication Results](image)

Please note that the user can adjudicate up to nine times and correct any errors after adjudication. However, if the user needs to re-adjudicate a tenth time, then QNXT must process the claim.

3.5.2 Edit Claim

Clicking the Edit Claim button presents the list of edits needed and allows for additions or deletions to parts of the claims. Click the radio button in front of the edit to select it for correction. Refer to Figure 3-36.

A check box displays in front of each edit so that the user can check them off and track the changes as they are made to the claim. The Claim Type, Billing Provider, and Member are the only fields that cannot be changed when editing a claim.

![Figure 3-36 Outstanding Edits](image)
In the **Diagnosis** example from a Professional claim, a new line can be added; press the **Tab** key in each of the fields of the last active line; after pressing **Tab** on the last field, a new line will be displayed. In order to delete a line, click on the radio button in front of the line, then click the **Delete** button. Refer to **Figure 3-37**.

![Figure 3-37 Add / Delete Claims Lines, Diagnoses](image)

In the Services example from a Professional claim, a new line #2 has already been added. To add more lines, press the **Tab** key through each of the fields in the last active line.

In order to delete a line, click the **Recycle Bin** just before the line number to be deleted. Refer to **Figure 3-38**.

![Figure 3-38 Add / Delete Claim Lines, Services](image)

After entering all the corrections and revisions, there are three options:

- **Back**: Click on the **Back** button to return to the previous screen.
- **Save**: Click on the **Save** button to save the changes made so far.
- **Adjudicate**: Click on the **Adjudicate** button to adjudicate the edited claim.

Refer to **Figure 3-39**.

![Figure 3-39 Options after Correcting Claim](image)
4. Payment Verification

4.1 Setting up the Verification Type

To configure the user’s account for generating payment notification via Remittance Advice or 835 Transactions generated by test claims, go to the navigation pane under the Trading Partner tab, select Account Maintenance. Click on Provider Associations. Choose the Edit option on the bottom right hand of the window. Refer to Figure 4-1.

![Figure 4-1: Choosing the Remittance option](image)

Under Electronic Remittance Advice Information section, the user will choose their preference for collecting the Remittance Data by selecting either the Provider Tax Identification Number (TIM) or National Provider Identifier (NPI) option. Refer to Figure 4-2.

![Figure 4-2: Selecting Remittance Aggregation Preference](image)
Once the Preference for Aggregation of Remittance Advice has been selected, the user will select the Method of Retrieval by checking the Download PDF box and either selecting the No 835 or Generate 835 radio buttons. Refer to Figure 4-3.

![Figure 4-3: Method of Retrieval (No 835)](image)

If the user selects the Generate 835 radio button, the user must choose to receive the 835 at the user’s account level or to elect a billing agent/clearinghouse to receive the remittance advice. This will be done in the required Medical field. Refer to Figure 4-4.

![Figure 4-4: Method of Retrieval (Generate 835)](image)

## 4.2 Viewing Remittance Advice or 835 Transactions

If the user’s preference is to receive a downloadable remittance advice via the online portal, the user will go to the navigation pane under File Exchange. Expand the Reports option and click on Remittance Advice (PDF). All of the records associated with the tests that have been run will be populated. The report type will be indicated by the Electronic Remittance Advice (ERA). Refer to Figure 4-5.
Figure 4-5: Retrieving Electronic Remittance Advice

If the user’s preference is to receive 835 generated transactions, the user will go to the navigation pane under File Exchange. Expand the Responses option and click on Finance (835, 820). All of the records associated with the tests that have been run will be populated. Refer to Figure 4-6.

Figure 4-6: Retrieving 835 Generated Transactions

Please note that throughout the pilot testing period, corresponding 835s/remittance advices can be expected for availability shortly after 10:00 am EST each week.