

Medical Office System

Chapter 20: Electronic Transmission

This chapter discusses

- the Electronic Transmission interface for Electronic Claims.
- the steps required to set-up this add-on feature.
- the step-by-step instructions for creating a transmission file.
- general hints on creating error free transmission files.
- the new shortcut menu to provide all your daily Electronic Claims functions in one place.

COMMUNICATIONS SOFTWARE is not included with the Electronics Claim Module. It is the clients responsibility to obtain the software necessary to connect to the carrier and upload the file created. Any information available as reports or authorizations can be accessed through this software also in most states without additional programming.

FastEMC is added to the MOS to provide the ANSI formatted claims required by Medicare. The claims are posted to the FastEMC data structure, which is responsible for final editing and formatting the claims for transmission to the clearinghouse of your choice. This product is closely tied to the MOS and our partnership with FastEMC makes it possible to continue to provide electronic filing and expand our options to many clearinghouse providers.

What will happen?

The electronic claims processing requires additional data testing be done on the data you are submitting. To accomplish that and let you continue your daily work, the claims are tested for major data consistency such as carrier exists, doctor exists, location exists, insured party exists. If these things test true, the claim is posted to a work file. Then all processing is done in the work file to prepare the claim to be submitted.

Next, a very close edit is run on the claim data. This looks for much more complex problems with the data and insures that the data will comply with all the rules before it is submitted. This is called the "Download Edits". If the claims make it past this step they are ready to be collected in to a transmission file. This step is called "Create a Transmission File".

Once the transmission file has been created, it must be sent, via modem or internet upload/download, to the carrier that will collect the claims and process them for payment or disbursement. (In the case of a clearinghouse, they may just forward them to the correct carriers for you.) Now you wait for the edit report and/or payment from the carrier. It is often the case that they will offer a summary report that indicates total number of claims submitted and accepted for processing. A few days later you may get some detailed analysis indicating what will be paid and what is rejected.

ERROR CLAIMS

Any claims that have errors at any point in this process will be omitted from the batch of claims that are sent to the carrier. We recommend that you correct the error in the MOS system and mark the claim to resubmit with the next batch.

REJECTED CLAIMS

Any claim that was sent to the carrier and was then rejected due to errors in data, such as an incorrect HCFA number or policy number, DOB incorrect, etc, should be corrected in the MOS and marked for resubmit with the next batch.

INFORMATIONAL ERRORS

Some times the carrier will indicate that a claim will be paid but that some data is noted as incorrect and should be fixed at your earliest opportunity. This often happens when they are adding new edits to their system and for a short period they are sending warnings that in the future this will cause the claim to be rejected. Get these fixed quickly. There is no need to resubmit this claim for payment, it will be paid.

MOS - FastEMC Claims Menu (E)

IMPORTANT: *If any of these options are selected before installing the Electronic Claims module, error messages will be created.*

Upon entering HCFA from the command line (p mdmain) or selecting Electronic Claims Main Menu from the Electronic Transmission menu in the MOS, the menu shown in figure 20.1 is displayed. This is the initial entry point to the Electronic Claims System. The startup postings are listed on this menu as well as the manual edit reports for the Electronic Claims. This menu is included with the MOS. If the Electronic Claims module has not been installed, the functions listed on this menu will not work.

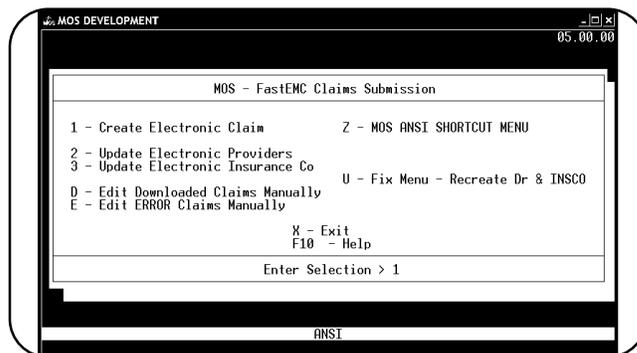


Figure 20-1 : Electronic Submission Menu

This menu acts as a gateway to the FASTEMC electronic software through choice A - FAST EMC CLAIMS MENU. If you are using that system for your electronic claims submission, then prompts on this menu will be useful. If you are using the FastEMC module, then you will be using the prompts on the Z-FastEMC Shortcut Menu.

Create Electronic Claims (E 1)(E Z A) Step 3 and Step 4)

This option will collect insurance claims in the MOS that should be submitted electronically and post them to the electronic claims files. Use this option when using FastEMC to submit your claims. See 14 for more details.

Update Electronic Providers/Ref (E 2)(E Z A) Step 1)

Select this option to update the providers and referring doctors in the FastEMC or FastEMC systems with any changes or additions in these files. See 12 For more information on the data necessary.

Special Notes: It is important that all ID numbers and addresses are supplied for any providers in your practice.

Special Note: It is required in many transmissions to include the referring doctors address. Be sure to get this information for every referring physician.

Update Electronic Insurance Companies (E 3)(E Z A) Step 2)

Select this option to update the insurance carriers in the FastEMC or FastEMC systems with any changes or additions in these files. See 28 For more information on the required data fields.

Special Note: Addresses, special electronic data such as Payer ID, Claim Office number, OCNA number, etc may be required for every carrier submitted electronically and every carrier listed as secondary to an electronic carrier. It may be helpful to get as much of this information as necessary when the carrier is first entered.

Edit Downloaded Claims Manually (E D)

This option will allow the claims posted to FastEMC or FastEMC to be edited. This step is required to verify the data completeness for submission of the claim. This will select claims posted but not yet edited. Once the claim has been edited and has been found to have no errors, it can be transmitted. See ? For a sample report.

Edit Error Status Claims (E E)

This option will select claims that were reported with errors in a previous Download Claims Report and will retest the claims. This is helpful if the errors listed were the result of a missing provider, insurance carrier or something like that. Then the missing data can be added and when the claims are tested again they may be able to be submitted.

This option is not helpful for errors such as Employment Status incorrect, Missing ID Numbers, Patient Data missing or incorrect, etc. It is best to correct this in the MOS and mark the claim to resubmit. See ? For a sample report.

MOS ANSI SHORTCUT MENU (E Z)

This option will select the special MOS ANSI menu that summarizes all the options required in the process of electronic filing.

Fix Menu (E U)

This menu has special options for making corrections and manually reviewing the data in the Provider and Insurance Carrier files. This is only necessary for support.

FastEMC Claims Shortcut Menu (E Z)

Press **Z** to select this shortcut menu for FastEMC Claims. It lists the main selections used in the Electronic Claims System so you can quickly complete the functions. (This menu is for FastEMC customer only. It is necessary to use the full FastEMC® menus provided in that state if you are using FastEMC..)

This menu includes prompts listed below that would be the most commonly used part of the Electronic Claims System. They have no different function on this menu.

This menu can be used instead of accessing the A -FASTEMC Menu option. All steps required for electronic submission can now be done from this new menu.

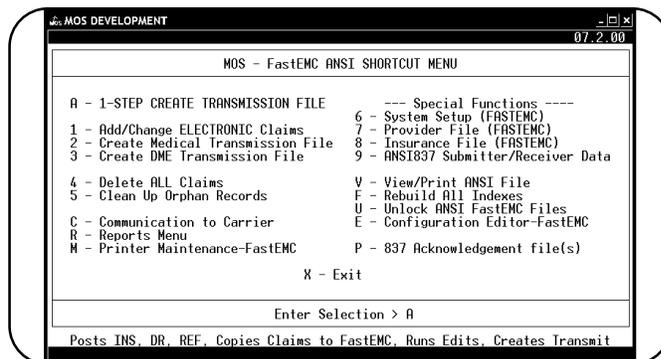


Figure 20-2: FastEMC Shortcut Menu

1-Step Create Transmission File (E Z A)

This option includes all normal steps:

- 1 - Update Providers and Referring Physicians
- 2 - Update Electronic Insurance Carriers
- 3 - Create Electronic Claims
- 4 - Edit Downloaded Claims
- 5 - Create Transmission File

If the claims went through without errors, the transmission batch has now been created and can be sent. These options will generate all the same reports and any claims that contain errors would not be loaded to the transmission file. This does not replace the other functions, it is only provided to streamline the function once you have it working smoothly. Each step shown can be run manually for troubleshooting purposes or just to pick up and repeat certain steps.

System Setup (E Z 6)

Discussed in detail later this chapter.

Provider File (E Z 7)

Discussed in detail later in this chapter.

Insurance File (E Z 8)

This function was discussed in detail later in this chapter.

View /Print ANSI File (E Z E)

This option will allow you to view the records created for transmission. This option is specially designed to adjust the file to make it easier to read. Creating a new transmission file will erase the previous file.

Rebuild ALL Indexes (E Z F)

This choice is provided to allow you to rebuild the indexes of the Electronic Claims System in the event they get out of balance.

Delete ALL Claims (E Z 3)

Use this option to delete all claims in the EMC after each submission is completed. It is recommended that this function be used to remove transmitted claims, on error claims, or just a batch with too many errors to selectively correct. It is important that this system be cleaned up to help you keep the speed up.

Clean up Orphan Records (E Z 5)

Sometimes, the files may lose track of data and the normal delete is not completing the job. Corrupted indexes can cause this to happen and this can cause service lines from old claims to be included in new claims. This option will check all the support files and make sure all the details records are removed. If the claim was deleted in the previous step, then this will make sure all the other data connected to the claim is fully deleted. It might be necessary to do this on occasion.

Create Medical Transmission File (E Z 2) (E Z A Step 5)

This will create a transmission file from claims already in the FastEMC claim structure. It can be used to create new or rerun old batches. The Delete ALL Claims function above will remove claims from this structure.

Create DME Transmission File (E Z 3)

This will create a transmission file from claims already in the FastEMC claim structure. This will just select DME claims and must be run after the A-One step to finish the process. It can be used to create new or rerun old batches. The Delete ALL Claims function above will remove claims from this structure.

Reports Menu (E A R)

This menu lists the reports available in the Electronic Claims. These reports are helpful for analyzing the information posted to the Electronic Claims system from MOS. Each report is discussed below:

Error Claims Report (E Z R 1)

This choice will allow you to print a report of all claims that are on Error Hold Status, listing the error found. These errors should be researched and corrections made in the MOS system. The claims should be deleted in this file and marked in MOS to be resubmitted.

Hold Claims Summary Report (E Z R 2)

This choice will allow you to print a report of all claims that are on Hold Status.

Service Lines Report (E Z R 3)

This choice will allow you to print a report of service lines based on user defined selection criteria.

Procedure:

Answer each question as they appear on the screen.

1. Enter a choice:

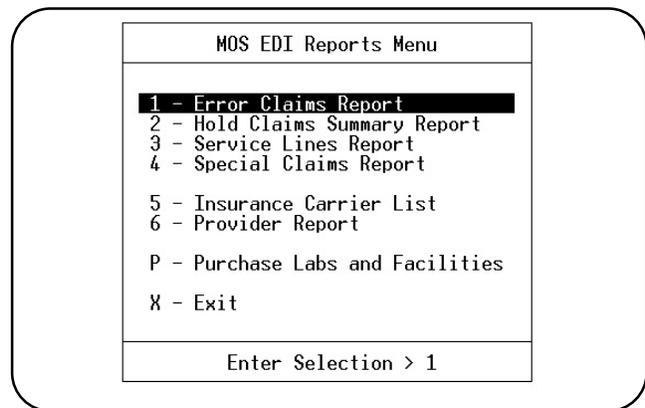


Figure 20-3: FastEMC Reports Menu

- P To Select by procedure codes.
- D To Select by a range of service dates.
- S To Select by a POS code or codes.
- a To select all service lines.

2. Enter a choice
 - T Transmitted Claims. By a range of transmission dates or press for all dates.
 - P All pending Claims.
3. Enter Y(es) or N(o) by each insurance type.
4. Enter provider code or codes or press for all.

Special Claims Report (E Z R 4)

This choice will allow you to print a report of claims based on user defined selection criteria.

1. Enter index or press for no index.
2. Select a field or group of fields to sort this report by.
3. Select all records
 - (Yes) will print all records/claims in the EMC system.
 - (No) will allow the user to define reports. See Extended Selection information in Chapter 13.

Print Provider Report (E Z R 6)

Selecting this option produces a report of all providers in the FastEMC Provider Master File.

Purchase Labs and Facilities (E Z R P)

Supply information on Purchase Diagnostic Labs and Facilities for electronic transmission. This data is collected during the download from MOS and if incomplete should be completed here.

FastEMC Communications Menu (E Z C)

This menu is provided to allow the menus for different carriers to be added to the system. Select the options that applies to your communication situation. The selected menu will list the options available for that communication selection.

For example, selecting the first menu will display the following menu.

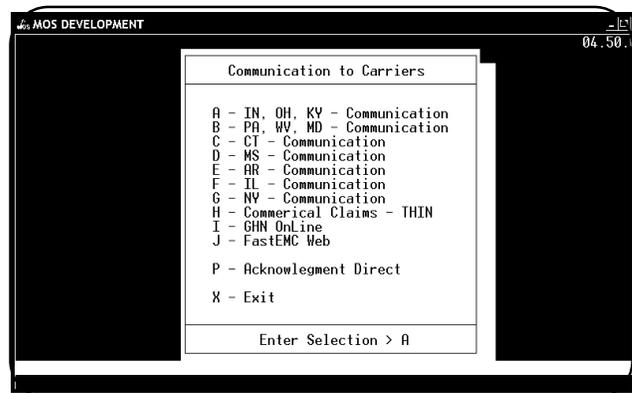


Figure 20-4: Communications Menu

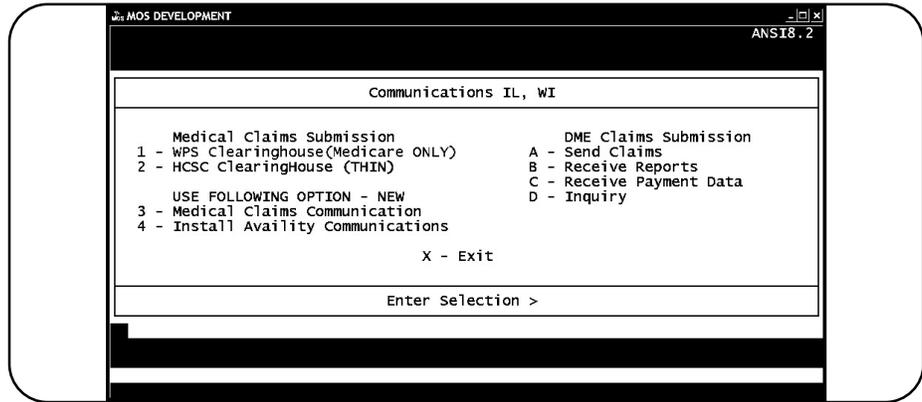


Figure 20-5: Communications with IL, WI Menu

The options on the communication menus are tuned to each state/clearinghouse and can make it easy to transmit claims. Some special programming may be necessary to provide the communication necessary for your state. This can be avoided by using the FastEMC Web or GHN OnLine clearinghouse options. These options only require an internet connection to allow you to upload your claims and download the reports they provide. Since many states have designed their own systems and they are not consistent, it is often necessary to do some special programming to get a proper connection established.

Getting Started with FastEMC Claims

Setup the MOS to Update FastEMC

When first added MOS to a system with FastEMC follow these instructions. NEVER do it again.

FIRST TIME ONLY:

W - Initialize MOS from FASTEMC. This option will load the data from the FASTEMC that is currently in the insurance, patient, procedure, diagnoses and provider file and create records in the MOS. These files in the FASTEMC will not be used again. Do not do this again.

1. Enter Practice Information Data for Electronic Defaults **[6][1]**. Make sure the information is correct.
2. Enter FastEMC System Setup Information from MOS Main Menu **[E][Z][6]**. See System Setup information on page 20 - 23.
3. Verify the MOS Provider Data for completeness from the MOS Main Menu **[6][2]**. All providers should have both provider and group numbers to properly file electronically. Provider names and practice names much match exactly with the paperwork filed with the electronic carriers. Adding special provider numbers for specific carriers may also be required to properly load numbers. Make sure only exceptions are added to the list. A provider is added to the FastEMC for each exception, grouping Rendering and Billing exceptions on the same record.
4. Update Electronic Providers from MOS Main Menu **[E][2]**. See Update Electronic Providers on page 20 - 12.
5. In the MOS, mark the carrier(s) that will be sent electronically. From the MOS Main Menu, press **[6][1][4]** and enter the code for the carrier that is to be electronic. Verify the carrier type is correct and that the information is complete. Press **[E]** to update the electronic information for this carrier. Press **[C]** to toggle the crossover answer from Y to N. Refer to page 12 - 35.
6. Update Electronic Insurance Carriers. From MOS Main Menu press **[E][3]**. See page 20 - 13.
7. Check Medicare EMC Carrier. From MOS Main Menu press **[E][U][7][4][L][1]** Medicare **[ENTER]**. Locate the Medicare Carrier by name and be sure the insurance type is "1". Make sure the Sub.Type is 1. Make sure you only have one carrier with the name used for the Insurance Company for Medicare (press the downarrow to see the next carrier and check each until all Medicare carriers are reviewed.. Refer to page 20 - 28.

WARNING: Allow time in your schedule to get this step completed in the least amount of time. Depending on the test cycle, this process can take as much as 30 days. That is why we try to do a small batch of claims and continue to file on paper. Normal turn-around for paper is 30 days, electronic is 14 days. If we could be ready for production in 14 days, we would not lose a bit.

8. Create a test batch of claims. It is best to do this when you only have about 20-30 claims waiting to be sent to the electronic carrier. You can also mark 20 claims to resubmit from a paper batch to use a test. The claims should be like the claims normally submitted. Refer to page 20 - 10.
9. The carrier will give you information about the data transmitted to identify errors or missing information. Work with the MOS Support Staff to identify what should be corrected and repeat steps 8-9 until you are approved for electronic submission.

Electronic Transmission Steps

Electronic Claims has much more stringent data rules, so expect to find a few errors on your first few transmissions. Once these have been addressed, this procedure will be very smooth.

Step-by-Step Instructions

Select  from the MOS Main Menu to select the Electronic Transmission Menu. The menu is shown in figure 20.1.

All Users

1. Enter your claims in the MOS system.
2. 1 - Step Create Transmission File - All following functions are included in this step.
 - a. Update Insurance Companies,
 - b. Update Referring Physicians and Providers in the EMC.
 - c. Create Electronic Claims
 - d. Create Transmission File. Only error free claims will be selected.
3. Review ALL Reports printed. Make sure you have a Transmission Report indicating there are claims to send.
4. Correct any errors in MOS, and mark claims to be resubmitted. These will be included when the next electronic claims are processed.
5. Follow your communications procedures to connect to your carrier and transmit your claims.
6. Collect any information the carrier has to send back to you. Print this information.
7. Delete all claims from Electronic Claims, each time or often to keep the system streamlined.

A - 1-STEP Create Transmission File (E Z A)

This option will step through the options necessary to create a transmission file. Once the steps have been worked out above to insure that all items are working correctly, this can be used to streamline the operation.

This option will do each of the following:

- Update Providers
- Update Referring Providers
- Update Electronic Insurance
- Create Electronic Transmission Claim
- Print Download Edit Report
- Create Transmission File

When these steps are complete, you will be able to transmit the file created. All reports are still printed.

The following prompts will be displayed:

```
Do you want to update FastEMC Providers? (Y/N) >
```

Press to run the provider update function. This is optional if your provider information has not changed since the last transmission. See 12.

```
Do you want to update the FastEMC Referring Providers? (Y/N)
This is not required
```

Press to run the referring provider update function. This is optional and not recommended.

```
Do you want to update FastEMC Insurance Carriers? (Y/N) >
```

Press to run the Electronic Insurance carrier update function. This should always be done. See 13.

Insert the “Create Electronic Claims” steps at this point. That will generate two reports, the MOS to MOSEDI Report and the Download Edit Report. Follow the steps for this function then return to this point.

Note: Save the MOS to FastEMC Report, Download Edit Report, and the Claim Transmission Report. These will allow you to resubmit a batch if the carrier cannot accept them. It will also show the batch identification numbers that the carrier will use to identify claims that might not be acceptable. The current system can reject only one claim or one line on a claim and you may need to identify what was listed on the carrier forms.

Insert the “Create Transmission File” steps at this point. This report will generate the Claim Transmission Report.

That indicates whether a file has been created and is ready for transmission. Review the report carefully.

FINAL STEP - do your procedure for uploading the file to your carrier. These steps are not on the menus and are set up outside this system.

Download any reports they provide if that function is available. This is not a part of the MOS, just a reminder.

Update Electronic Providers/Ref Physicians (E 2) (E Z A Step 1)

From the MOS Main Menu, press **E** to load the Electronic Transmission Menu, then press **2** to post the providers. This function will copy your MOS providers to the Electronic Claims provider's file. Then it will copy the referring physicians to the Electronic Claims Provider's File. If important information is missing a pop up box will request that it be supplied at this time. The following information must be supplied:

- Federal Tax ID
- Medicare Provider ID
- UPIN numbers are required for Referring Physicians

Once the information has been copied for the provider file, check that the information is complete in EMC. Copying the provider file each time claims are posted to electronic claims should not be necessary.

Add/Edit/View EDI Providers (E Z 7)

The electronic Provider file allows the numbers reported electronically to be different than the numbers reported on paper claims. For example, in one state on paper claims the Medicare ID Numbers are "HE123456" (2 alpha characters then 6 numerics). The same numbers when reported to Medicare electronically must be "0000123456" (6 numbers right-justified and zero filled). The numbers are transmitted exactly as listed. (In some states, the letters must be removed, we do check that with programming, since the normal numbers used for ID include letters.)

Phone Number	Federal Tax ID	Type	Prov Sign Format	State License #
(412) 555-4545	555125555	S	VICKI G HENRY M.D.	PD012995F

Figure 20-6 : EDI Provider Screen

The providers are linked by Provider Code between the two systems. This allows a more accurate match between the two systems. This should solve the problems of identification that seemed to happen from time to time on the earlier system.

Provider Name

Be sure the provider name, first, last and initial match the name in the MOS exactly, right down to the punctuation. This match and the Federal Tax ID number are used to uniquely identify each provider. The rendering provider numbers reported for Electronic Claims transmission are all pulled from the Electronic Claims provider file. This allows the format of the numbers to differ as required in many states. If difficulties with these numbers occur, be sure they are typed exactly as required. No change is made to the number internally before transmission.

New Feature:

In MOS 04.00.00, the Provider ID is added to the MOS provider information. This is then used to find the provider when posting the claims. This will eliminate all confusion about providers with the same names or ID numbers. The providers must be updated from the MOS to have this information available during Claims Creation functions.

ID Column

This column of numbers is used as Billing Provider ID numbers if the Practice Type is not Solo or a "P" indicates use Provider ID as billing ID for each provider .

PIN Column

Is not used at this time, but could be used if a different number is transmitted on the service line than the Medicare ID number used as the Ordering / Billing Provider Number.

Federal Tax ID

This field is used to enter the provider's Federal Tax Identification Number. This should be unique for each provider and match the number used in the MOS.

Medicare ID

This field is used for Option I group practices, and is the Billing Provider Number for claims submitted for this provider.

Medicare PIN

This field is used for Option II group practices, and is used to determine the performing provider ID for each service line. Rendering provider and ordering provider Medicare ID number.

Medicare DME

Enter the Medicare DME number in this field.

Blue Shield ID

This field is used for Option I group practices, and is the performing provider ID for claims submitted for this provider.

This is also utilized as the performing provider number on claims for a Type II group practice.

Medicaid ID

This field is used for Option I group practices, and is the performing provider ID for claims submitted for this provider. This is also utilized as the performing provider number on claims for a Type II group practice.

Champus ID

This field is used for Option I group practices, and is the performing provider ID for claims submitted for this provider.

This is also utilized as the performing provider number on claims for a Type II group practice.

Commercial ID

This field is used for Option I group practices, and is the performing provider ID for claims submitted for this provider.

This is also utilized as the performing provider number on claims for a Type II group practice.

Enter the MOS provider information for this provider as shown in figure at the right.

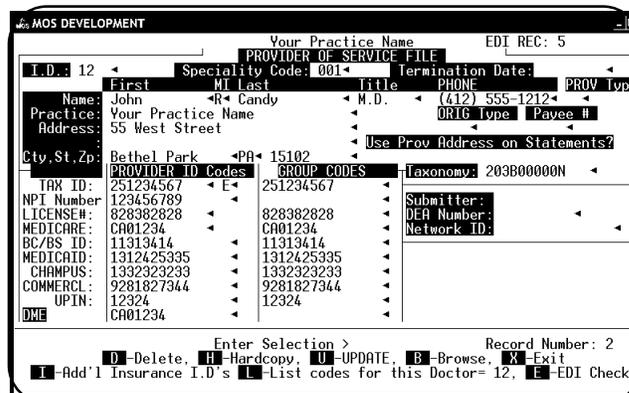


Figure 20-7 : MOS Provider Screen

Update Electronic Insurance Co. (E 3) (E Z 3) Step 2)

Insurance carrier information can be copied from the MOS to EMC from the Electronic Transmission Menu in MOS. It is only necessary to manage the information here if it is incomplete in MOS. It will be necessary to copy your insurance data to the Electronic Insurance File as new carriers are added to insure complete information is available in the EMC for claims.

The OCNA# is used first to locate an exact insurance company in the EMC. If no match is found the company name is used. It must be identical. If you are using our MOS with a carrier that provides an insurance data base, it may be necessary to check that your MOS carriers are entered exactly the same. New fields have been added in the MOS to allow you to enter the OCNA#, Payor ID, and Claim Office # so the carrier information will not have to be managed in the EMC.

New Feature:

In MOS 04.00.00, the Insurance Code will be recorded on the FastEMC Payer record. This is then used to find the correct carrier when posting the claims. This will eliminate all confusion about insurance companies with the same names or ID numbers. The Electronic Insurance companies must be updated from the MOS to have this information available during Claims Creation functions.

Hint:

If insurance carrier names are not unique, use an OCNA# to distinguish them. Some states use the OCNA# as a unique identifier. If yours does not, assign your own number to distinguish carriers.

If a carrier is listed as electronic in the MOS, an additional screen of information is displayed to allow some additional information used for electronic submission to be collected. Be sure to fill this information if needed by your carrier. Identify a carrier as a crossover carrier, if that carrier should NOT be sent as secondary to Medicare when submitting electronically. This will allow a secondary carrier to be properly entered for paper claims, but will not include the carrier information on electronic claims for crossover carriers. The Medicare computer system will know these already and does not want the confusion. Other secondary carriers to Medicare should be properly entered. The Medigap and supplemental insurance carriers should also be downloaded.

Table 1: Edit Table by Insurance Type

Insurance Type in MOS	Edit Type in FastEMC
1	Medicare edits
2	Medicaid edits
3, or 4	blue shield edits
all others	other edits

Be sure each insurance carrier has a complete address and supply the Payor ID and Claim Office # if your state requires this information. A list of the appropriate codes for all carriers and the crossover carriers can be obtained from your Medicare carrier.

Note: The Electronic Claims is specialized in some states and may include additional carrier types and lines of business for that particular state. Refer to your Electronic Claims manual for complete information. The posting from MOS to EMC will be developed as the need arises. Future changes will surely be necessary.

From the MOS Main Menu press [E] to load the Electronic Transmission Menu, then press [3] to post the insurance carriers to Electronic Insurance File. Even carriers that are not flagged as Electronic are copied, since they may be secondary carriers and the information might still be required. See Page 12-35 for more explanation of the information that might be necessary for insurance carriers.

Create Electronic Claims ([E] [1]) or ([E] [Z] [A] step 3)

All claims that are ready to be printed and assigned to carriers marked as Electronic Carriers will be selected. If you have indicated that the printer destination should be requested, then the printer selection prompt is displayed.

PLEASE ENTER YOUR USER ID >

This prompt will be displayed if your authorization is active.

NOW ENTER YOUR PASSWORD >

Now enter your password. At this point, a list is displayed of purposes for this report. Highlight "IN-OFFICE USE ONLY" or "FOR PAYMENT OF SERVICE". Either would be an appropriate answer.

Change Printer Selection? (Y/N) >

The following question appears:

IS THIS a NEW RUN OR a RERUN?

New Run

The bottom of the screen will display the date of the last run and the sequence number assigned to that run. Enter N and each claim that would normally be printed for that carrier will be copied to the Electronic Claims system.

Omit Secondary Claims (Y/N) >

This option was added to allow the secondary claims to be excluded in the first run of New Claims. Process the selected claims straight to the end and submit them. Then start here again and run this option and do not omit them. That will select only the secondary claims that were left behind on the first pass. Since these have been more difficult to properly submit, holding them for a separate batch will allow the bulk of your claims to process without issue. If the batch of secondary claims, cause any problem they will only stop the secondary batch. Refer to the document on properly entering payments on claims that will submit electronically for payment.

RETRANSMIT OVERDUE INSURANCE FORMS? <Y> or <N>

Enter Y to include overdue claims with this batch. It is recommended that the new claims be sent in one batch and then the overdue claims sent in a separate batch. This will make it easier to track the progress of these claims.

Then the following question will appear:

Select only based on claim's responsible carrier?

Answer "Y" to only select the claims based on the billing party currently assigned to this claim. If the answer is "N", the claim will be selected if any carrier listed for this patient is electronic, even if it is not the current billing party on this claim.

The sequence number assigned to this batch is displayed. The selection is complete now continue to the General Questions.

Rerun

Select R to select a batch of claims that have already been copied. A list of the recent batches sent is displayed and you can select from the list. This will be helpful when paperwork is not available or the you need to be reminded about what batches have been created.

10	4/23/03	# of Claims -	6
9	4/19/03	# of Claims -	25

This list will process the last 50 and display them for selection. If you re-run a sequence number, it will be listed again with a new date. Highlight the sequence number of the batch that should be selected again and press .

The sequence number is printed on the report that runs at this step "MOS Invoices downloaded to Electronic Claims with resulting message". The next question is:

Enter Starting Item Number:

The selection should begin with this item number in the list of claims. For example, if the batch includes 25 claims, and you would like to download the last five enter "21" for the starting number. Leave this blank to start from the beginning. Then it will ask:

Enter Number to Select:

Enter the number of claims to download from the starting point.

General Questions

Some or all of the next three questions may appear. If no default was supplied, the prompt will require a response.

And the following questions may appear:

Provider Assignment Indicator:
A -Assigned N-Not Assigned

This information is added to each claim downloaded. The normal answer would be A for assigned. The default answer can be entered in the MOS Practice Information. See MOS Practice Information to load a default for this question. Then the next question appears:

Documentation Indicator: 9

This indicates that you have documentation on file. This question will only be displayed if the default answer was not assigned in the Practice Information. See Chapter 5 - Practice Information to set this default.

Then the next question is displayed.

Provider Signature on File:
Y-Yes on File N-No not on file O-Omit

Answer this, overall, for all the providers submitting. This also has a default in Practice Information to save the need to enter it here. Then the claims will be copied to Electronic Claims.

A report is generated indicating which claims were tested and the status of the test. A claim that was incomplete will be listed with the missing information identified.

MOS to FastEMC REPORT			
MOS Invoices attempted to download to FastEMC with resulting message.			
Printed: Mar 2, 1995 at 11:55:58		Page: 1	
		Sequence #: 63	
Item	Account#	Invoice#	Message
1	1	117	Ready To Send
2	1	120	Ready To Send
3	1	129	Ready To Send
4	1	130	Ready To Send
5	6	137	Ready To Send
6	10	101	Missing Provider Record For: 2
7	11	22	Ready To Send
8	13	13	Ready To Send
9	16	16	Ready To Send
10	18	18	Ready To Send
11	20	144	Ready To Send
12	20	146	Ready To Send
31	66	75	Ready To Send
32	66	76	Ready To Send
33	77	88	Ready To Send

All claims listed with errors were not included in this sequence #.
These, once corrected, will be included in the next new run to FastEMC.

Next the Download Edit report will run, checking the claim for omissions and errors. This report should then be reviewed and if the errors are extensive, they should be corrected in the Medical Office System, the claims in FastEMC should be deleted and the batch should be rerun. If the errors are few, it is recommended that the claims be corrected in the MO. They will remain un-submitted until they are corrected. This will allow them to be listed as new claims and be selected with the next batch of new claims.

MOS to FastEMC Report (Report generated by Create Electronic Claims function.)

A report is printed listing the Accounts/Invoices selected with a comment about whether the claim was complete enough to be moved to FastEMC. The report includes a sequence number that can be used to re-select the batch. Review any invoices that list with errors, these will be checked again when the next batch of claims is selected for Electronic Claims.

Download Edit Report

() or (step 4)

A second report will print, listing the data errors found by the edits in Electronic Claims.
Sample Download Edit Report - Page 1

Record Number	Biller	Patient Account#	Patient Name	Payor Name	Amount	Insured Name	HIC/SSN/Cert#
38	1-117	HELENA ADELLS		Medicare	100.00	PETER KING	123456789A
45	1-130	HELENA ADELLS		Medicare	334.00	PETER KING	123456789A
46	1-129	HELENA ADELLS		Medicare	80.00	PETER KING	123456789A
48	1-120	HELENA ADELLS		Medicare	100.00	PETER KING	123456789A
43	6-137	JOHN M ALLENTOWN		Medicare	20.00	JOHN ALLENTOWN	187200810A *
74	58-65	JULIA AMELLIA		Medicare	50.00	JULIA AMELLIA	203127329A
75	62-70	ALMA CLEMENTIME		Medicare	55.00	ALMA CLEMENTIME	178262466B
73	53-71	LEWIS CUCUMBER		Medicare	55.00	LEWIS CUCUMBER	192102712A *
40	18-18	HOMER G HANDSOME		Medicare	25.00	HOMER HANDSOME	211096590A *
70	46-53	EDWARD HIGHLAND		Medicare	55.00	EDWARD HIGHLAND	169055975A *
67	28-34	SUE HOMECOMING		Medicare	55.00	SUE HOMECOMING	200208377A
		24f Service Line Diagnosis Pointer Missing					
		510 Diagnosis Code Required					
54	16-16	WILMA KITE		Medicare	55.00	WILMA KITE	209053883B12345*
71	47-55	DOROTHY LANDING		Medicare	55.00	DOROTHY LANDING	175303045A *
77	66-75	DOROTHY J MACKEN		Medicare	55.00	DOROTHY MACKEN	176140721D *
78	66-76	DOROTHY J MACKEN		Medicare	50.00	DOROTHY MACKEN	176140721D *
68	36-43	WANDA NEWMAN		Medicare	55.00	WANDA NEWMAN	199148790D

The only prompt displayed may ask for a Printer Destination, otherwise this just selects all claims that must be tested for accuracy and completeness. Review the errors listed on this report. It is suggested that corrections to the data be done in the MOS. The claim can be flagged to resubmit with the next batch after correction are made. A claim reported in error by the FastEMCFastEMC

Record Number	Billor	Patient Account#	Patient Name	Payor Name	Amount	Insured Name	HIC/SSN/Cert#
Date: Mar 2, 1995 Time: 11:58:01 Page: 2							
HCFA FastEMC Download Edit Report							
Batch: 63 Date: 03/02/95							
59	20-147	FRANK L SUPERMAN	FRANK L SUPERMAN	Medicare	60.00	FRANK SUPERMAN	189141548A
60	20-149	FRANK L SUPERMAN	FRANK L SUPERMAN	Medicare	60.00	FRANK SUPERMAN	189141548A
61	20-151	FRANK L SUPERMAN	FRANK L SUPERMAN	Medicare	50.00	FRANK SUPERMAN	189141548A
62	20-152	FRANK L SUPERMAN	FRANK L SUPERMAN	Medicare	100.00	FRANK SUPERMAN	189141548A
63	20-154	FRANK L SUPERMAN	FRANK L SUPERMAN	Medicare	42.00	FRANK SUPERMAN	189141548A
69	37-44	MARY ANN TUTTLE	MARY ANN TUTTLE	Medicare	55.00	MARY ANN TUTTLE	206223873A
64	21-100	MARY VASE	MARY VASE	Medicaid	80.00	MARY VASE	192384609
			132 Patient Employment Status Code Requ			9	
			232 Medicaid Recipient Id Invalid			192384609	
			24c Type Of Service Invalid			07/23/93 99203 80.00	
			24e Diagnosis Code Required			07/23/93 80.00	
			325 Third Ins Co. Insurance Type Code I			SP	
			510 Diagnosis Code Required				
			544 Hospitalization From Date Invalid			08/24/93	
76	64-72	DOROTHY ZEBRELLA	DOROTHY ZEBRELLA	Medicare	55.00	DOROTHY ZEBRELLA	184185626A
79	77-88	ELIZABETH E ZYWOWSKI	ELIZABETH E ZYWOWSKI	Medicare	30.00	ELIZABETH ZYWOWSKI	185126985A
Time: 11:58:13							
			Error Claims			Valid Claims	
			Medicare:	3	165.00	28	2056.00
			Blue Shield:	0	.00	0	.00
			Medicaid:	1	80.00	0	.00
			Champus:	0	.00	0	.00
			Other:	0	.00	0	.00
			Key Health:	0	.00	0	.00
			Total:	4	245.00	28	2056.00

Create Transmission File

() () () or () () () Step 5)

To create the transmission file, select for Create Transmission Menu from the FastEMC Claims Shortcut Menu.

This functions actually creates the file that will be sent to the carrier. It will only select claims with no errors. At this time all claims will be included in one transmission, so if you need to transmit to more than one carrier you will need to segregate the claims by putting some on hold until the first batch is created. Sending the claims to the first carrier, then take the claims off hold and create the second batch. Then send that batch to the second carrier. At this time the edits for Medicare, Blue Shield and Medicaid have been completed. These can be transmitted in one batch using HCFA NSF 01.04, 2.0 or 3.01 version format, if your carrier will accept these claims.

Selection: All un-transmitted electronic claims. This will also allow claims that must be resubmitted because they have not been paid in a timely fashion to be selected.

If the printer selection option is active a prompt will ask the following questions:

Change Printer Selection? (Y/N) >

Press to select the printer that this function will use for the summary report. Then a prompt will ask:

```
Is this a RERUN? (Y/N) >
```

New Batch

When it asks if it is a RERUN, press **N** for a New batch. All un-transmitted claims will be selected.

Rerun a previous batch

This selection will select all the claims selected in a previous batch. This is useful if a change in the programming or code table is necessary, but the claim data is not different. Press **Y** to indicate a Rerun. Then the prompt

```
ENTER RERUN DATE
```

is displayed. Enter the date the previous batch was created. Then the second prompt requests the batch number.

```
ENTER BATCH NUMBER
```

This number was printed on the top of the Transmission Report. Leaving the batch number blank will cause it to select all batches created on the given date. Then a prompt indicating your selection is displayed:

```
RERUNNING BATCH      1 FOR - 08/29/95 ARE YOU SURE?
                        Y OR N:
```

Press **Y** to continue selecting the report. Press **N** or **ENTER** to exit without selecting.

A report is created that indicates the number of claims, providers, dollars submitted for payment. Keep these reports and you may want to run the Claim Summary report for the same claims and file them together for a better record of what is being transmitted.

Output: Sample Claims Transmission Report

```
Date: 03/02/95 Time: 15:19:17 Page: 1
FastEMC System
Claims Transmission Creation Report
03/02/95 - 1
```

Billing Provider	Billing Batch	Rendering Provider	Claims	Charges Submitted
9999	001	HE7337232	28	2056.00
Payor : MEDICARE			28	2056.00
Medicare			28	2056.00

```
-----+-----
|           Claims: 28   Total Charges submitted: 2056.00           |
| Medicare: 2056.00   Blue Shield: .00   Medicaid: .00           |
| Champus: .00       Commercial: .00   HMO: .00                   |
|-----+-----
```

The files created by this function is called:

- hfacare.dat Medicare
- hflashd.dat Blue Shield
- hfacaid.dat Medicaid
- hfacomm.dat Commercial
- hfacam.dat Champus
- hfadme.dat DME claims

When the system is set-up and the information for the Receiver is entered, these files may be combined when all claims are going to the same carrier or clearinghouse. In cases where the setup indicates that claims may be distributed by Payor ID (Medicare claims sent to multiple networks? Y/N) then the files are generated with a PAYORID replacing the "hcfa" part of the name so each carriers claims are separated. Then they can be sent to different carriers.

The file is found in the directory called: `\md` (on MSDOS systems)
`/md` (on UNIX/XENIX systems)

Posting Information

As the claims are posted to FastEMC the following tests and conversions are done on the numbers for the Provider.

Tax ID

The Provider Tax ID number is not posted to Electronic Provider File, but is used to properly identify the provider. This number is required to be a number with 9 digits such as a SSNum. If you choose to create a number, please assign it accordingly. This number is not used as a billing ID number in the Electronic Claims.

Rendering Provider

The Carrier ID number is used as the rendering provider number. This ID number is assigned to the provider to uniquely identify him/her. The Carrier Type will determine which number is selected from the list. If the claims are submitted for Medicare, Medicaid or Blue Shield, the appropriate number is selected. On a paper claim this is usually shown in box 24K, performing provider.

Billing Provider ID

This ID number identifies the billing party. Each carrier type may have a different billing provider ID. On a paper claim, this is usually printed in box 33 for Group.

Finally, be sure provider names are identical. a field for middle initial has been added in the MOS to allow you to supply the name exactly as it is in the Electronic Claims. Remove any periods, the degree initials and check it carefully.

Transmit Claims (E Z C 1)(use appropriate communications method)

At this point, connect with the carrier using the appropriate communication software, and send them the electronic transmission file created in the previous step. Various menus have been added for each state we have dealt with and many clearinghouse connections. The communications requirements are so varied that we could not include a communications software package and programming that would be universal. The file can easily be uploaded to your carrier with the software they recommend.

Delete Claims (E Z 4)

Once the claims have been transmitted to the carrier, all the claims in the Electronic Claims should be deleted, (error claims and transmitted claims). Select the Shortcut Menu, then press **3**.

A prompt will ask if you want a hardcopy of the claims. I would suggest that you answer **N** but if you like to use a lot of paper press **Y**.

Remember the FastEMC is just holding a copy of the original invoice created by MOS and is not necessary once the information has been transmitted.

Correcting Errors

It is best to return to the MOS and correct any information that is incorrect or missing. The patient account number listed on the report is the patient account number and the invoice number of the claim in the MOS. The record number listed is the record number in the Electronic Claims Claims file. After you have corrected a claim in the MOS, just flag it for re-submission. It will be selected with the next batch of claims. If you had a number of corrections, you may want to add them to the Electronic Claims again from the Create Electronic Claims option. Remember to select New claims if they were marked “ resubmit” . Claims with errors in the FastEMC will never be transmitted.

When all the claims have been posted to the FastEMC, press **A** for the Electronic Claims Menu.

No claims are selected.

None of your insurance carriers are marked electronic. No claims are ready to be selected or have already been selected.

Provider Not Found.

A provider can not be found in the Electronic Claims that has the same Tax ID Number, and name as the provider attached to this claim. The provider's may not have been posted to the Electronic Provider File.

Missing Ins. Company Record Responsible INS Co Not Found

Make sure the insurance company indicated is listed in the Electronic Claims with an identical Company Name. The OCNA number is used to identify a company if one is assigned. This can be helpful if company names are not distinct.

OTHER ERRORS are generally clear about the problem indicated, such as Patient's Sex not Supplied, or Referring Physician City Blank.

Edit Downloaded Claims Manually (E D)

Press **D** from the Electronic Claims Submission Menu. This is the same report generated as step two of the Create Electronic Claims prompt. If for any reason, the report does not run properly, start it over from here. It only selects claims that have not been edited by the FastEMC at this time. Once the claim has been edited, it is marked "Ready to Transmit" or "Error". If it is marked "Error" it will not be transmitted to your carrier. Some times the error is not with the claim but with the supporting files. In that case, correct the supporting file in FastEMC and try to run the "Edit Error Status Claims" to check them all again. This might be necessary if you do not have a new provider or insurance company added to the Electronic Claims and all the claims are listed with "Unknown Provider ID" or "Unknown Carrier." Each claim is not technically wrong, the omission of the supporting file information caused the error. If the supporting file information is corrected and the claims are tested again, a big chunk of errors can be corrected quickly.

Edit Error Status Claims (E E)

Press **E** from the Electronic Claims Submission Menu. This option will run the edit checking again on any claims that has an error status. If a big bunch of claims is marked on error because of missing information on the provider file, or insurance file, the correction to the supporting file can be made and the claims checked again. Often this will correct most of the errors and eliminate the need to start from Create Electronic Claims.

NOTES ON SUBMITTER, PROVIDER AND BILLING NUMBERS

Definitions

Submitter information is entered on the System Setup Screen in the FastEMC. This information identified you to the electronic system. When you apply for your access to electronic claims submission, they will provide you will all of the submitter information that must be entered in the System Setup. As you apply for this, you will identify the Billing ID number(s) that you will be submitted electronically. This billing party is the doctor(s) or group that is sent a check. One submitter may submit many billing parties (batches). Under each Billing ID, there can be one or more rendering physicians. On each claim a rendering physician is identified.

The MOS system is designed for a group practice (one billing ID, more than one rendering physicians) or individual providers (each doctor bills individually). The claims have one provider listed on each claim. When the claim is inserted into the Electronic Claims, the provider must be matched with the provider in FastEMC. All the numbers and information used to identify the provider will be drawn from the Electronic provider and system information records.

If MOS warns you that the provider is not on file, when you attempt to “Create Electronic Claims”, check the following numbers and information. First check the Tax ID in each file. Make sure they match exactly. Then check the provider name. It compares “first name” & “middle initial” & “last name” in each file. If they are different by a period or space, it will not match the providers. Always eliminate all punctuation characters from names.

Medicare Submission

There are two key numbers used for Providers when submitting to Medicare and using the Electronic Claims. I would like to explain how they are used and how they are submitted to help you enter the numbers correctly.

When the provider is posted to the FastEMC the location of that record is noted and will be displayed in the upper right hand corner of the screen. That number is also written on the claims that are posted to FastEMC so the correct provider will be used when generating the transmission file. This makes it very easy to insure that all the right information is used for the claim. The group number for billing are also drawn from that provider record. If you have the same provider working under different billing numbers, make sure the correct provider is selected when the claim is created.

Carrier Provider Number

Solo Practice

Even in a solo practice the billing and provider numbers are drawn from the provider record.

Group Practice

The numbers for a group practice are pulled from the Provider Information in the Electronic Claims provider file.

A new field labeled PROV Type will affect the electronic file creation and determine if the claims are formed with billing information or just a solo provider. Enter S for solo and GP for group practice.

Initial Set-Up Information Sheet for Electronic Claims

The following list of responses for the System Setup file should help you use the correct set-up for your state. The answers that will be critical to the submission format used in your state are listed with entries for the correct responses.

System Demographics Screen

These default values are only useful if you are enter the data manually. You have similar defaults defined in the MOS system for use during data entry.

Disable System Functions

Patient

Account File?

This should always be "Y" when using this with the MOS system.

ICD-9 Code

File?

This should always be "Y", if using this system in conjunction with the MOS system.

CPT Code File?

This should always be "Y" if you are using the FastEMC in conjunction with the MOS system.

Submission Information Screen

You should check with your carrier and the MOS support staff before you change data on this screen. It can affect your transmission.

Submission

Format

Test/Prod

Submission

This will start as TEST. When the carrier indicates that your claims are acceptable in general with their system, you may change this to PROD. Any claims submitted under the code TEST will not be paid by the carrier and should be sent on paper or resent as PROD once you have been cleared.

Code table
list

Trans format

Characters/

Records

320 for most states. However some are 80 characters.

The following items are repeated for each type of claim.

Carrier Type	Batch type	Receiver ID	Transmission Password	Line of Business	Max Service Lines
Medicare					
Blue Shield					
Medicaid					
Champus					
Commercial					
Key Health					

System Setup

From the MOS Main Menu press **[E] [A] [2] [1]** to enter the System Setup File for Electronic Claims. Or use **[E] [Z] [A]** to access from the Electronic Claims Shortcut Menu.

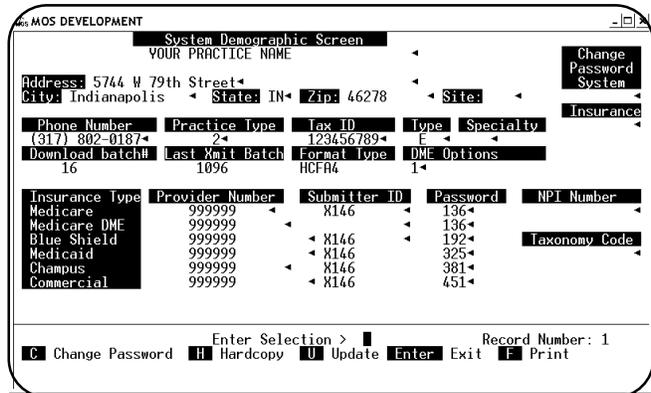


Figure 20-8 : System Setup Screen 1

Practice Name

Type the name of the group or the individual provider if a sole practitioner. This is limited to 22 characters which is all the Electronic Claims record permits.

Address

We have allowed 2 lines of 18 characters each for your address.

Type the address of your practice here. Do not include any punctuation symbols.

City

Type the city your practice is located in.

State

Type the state your practice is located in.

Zip

Type the zip code of your practice.

Phone Number

Type your phone number here. Do not use dashes or other punctuation.

Practice Type

Type **[S]** if you are a solo practitioner. Individually practicing physicians or suppliers who have only one provider code per claim type are considered to be Solo. If you choose solo, you will list all of your provider codes on this screen.

Type **[1]** if you are an Option I Provider. Providers or provider group practices who have more than one provider code assigned for any claim type are Option 1. This option will allow you to set up a separate provider table for each unique performing/rendering number for your group.

Type **[2]** if you are an Option II Provider. Providers who must bill with multiple provider codes PER CLAIM are Option 2. This option will allow you to set up multiple provider codes and will also allow you to choose a different provider code at the line item level. An example of an Option II provider is an Anesthesiologist who must bill for a Certified Registered Nurse Anesthesiologist on the same claim.

The second code in the Practice type identifies the location of the Billing Provider ID. Enter **[G]** to draw the code from the System Setup Information. Enter **[P]** to draw the code from the provider record.

Tax ID

The employer identification number should be entered when the physician is in a group practice or is employed by a health facility.

The employer identification number is entered when the supplier is not a sole proprietorship.

Type

This indicates the type of tax ID indicated.

- E Employer Identification Number
- S Social Security Number

- Specialty** Enter the practice specialty code. This code list may vary state to state and should be entered if required. Please supply leading zeros or any other characters exactly as indicated by your carrier.
- Region** Enter the code for the Region in this field.
- DME options** Enter **1** at this time. The DME alternative is not yet complete.
- Provider ID** ID Numbers for provider - These are not required.
- Submitter Number** Type the submitter ID you have been assigned by The Electronic Services Network in this field.
- Password** The password for each line of business is supplied by your MOS / EMC support staff. At this time only the Medicare format is fully tested. If your carrier is accepting Medicaid and Blue Shield also, these will be available as an additional option soon. You will be unable to update claims for any other carrier type that does not have an appropriate password. All claims must be submitted to the same electronic system. If your carrier is accepting Medicare, Blue Shield and Medicaid claims directly, you will be able to submit them with Electronic Claims.

When you have finished updating all the fields, press **ESC**. A box will appear for you to supply or update the name of the provider. This box appears when your practice type is marked S - Solo.

Phone Number	Practice Type	Tax ID	Type	Specialty
C4 Do Prefix	First Name THOMAS	MI J	Last Name PALMQUIST	Suffix
Medicare	Y87654321	E12345	128	
Medicare DME	123456789	E12345	445	
DME	807654321	E12345	128	

Figure 20-9: Signature for Solo Provider

Enter the information and press **ESC**.

SCREEN 2 in System Setup

The second screen is displayed as shown in figure 20.1.

Since all your data entry is done in MOS, it is most important that these data files are disabled in the Electronic Claims System:

- Patient Account File,
- ICD-9 Code file,
- CPT Code file

The data will be verified in the MOS and sent to the Electronic Claims claim file. Failure to disable these files, will result in errors in the download edit function, since the download will be verifying the patient, procedure or diagnosis against its own tables.

These default values are only useful if you are enter data manually. You have similar defaults defined in the MOS system for use during data entry.

- City** Enter the default city. If you leave a city field blank during data entry, this city will be supplied.

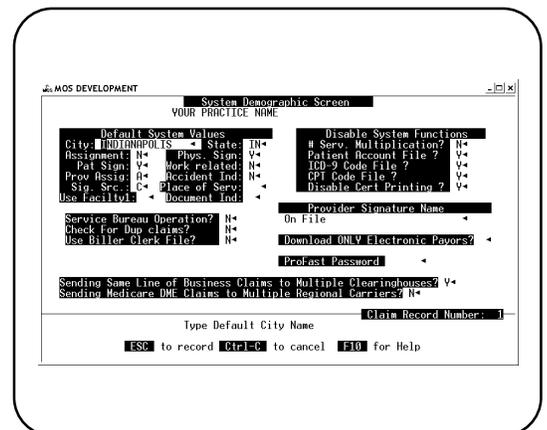


Figure 20-10: System Setup 2

<i>State</i>	Enter the default state to be used if the state field is left blank.
<i>Assignment</i>	Enter the default assignment value. When entering the patient information on the claim, the system will set this field to the default value.
<i>Signature</i>	Enter the default Signature value. When entering the patient information on the claim, the system will set this field to the default value.
<i>Privacy</i>	Enter the default Privacy value. When entering the patient information on the claim, the system will set this field to the default value. If the majority of the patient's request that their medical records be confidential, enter <input type="checkbox"/> N . If the majority of the patient's do not request that their medical records be confidential, enter <input type="checkbox"/> Y .
<i>Work Related</i>	Enter the default Work Related value. When entering the patient information on the claim, the system will set this field to the default value.
<i>Service Bureau</i>	Enter a "Y" if you are a service bureau operation.
<i>Report by biller</i>	Enter "Y" if you want the reports sorted by biller.
<i>Check for duplicate claims?</i>	Enter "Y" if you want the error checking to look for duplicate claims during data entry.
<i>Skip non required fields</i>	Enter "Y" if you want the computer to jump over fields that are not flagged as required by the edit information.

Disable System Functions

The system provides the ability to disable certain features of the system based on your particular needs. For example, a radiology practice may not need to retain a patient account file.

Disable # Services

Multiplication?

If you type here, the Electronic Claims system will not multiply the number of services times the procedure amount. In this case, you would be responsible to type the total charge and the number of services for this total charge.

This method may be preferable for anesthesiologists where the charge depends on factors such as weight, age etc. The total charge for the service would then be input by manual calculations.

Patient

Account File?

This should always be "Y" when using this with the MOS system.

ICD-9 Code File?

This should always be "Y" if using this system in conjunction with the MOS system.

CPT Code File?

This should always be "Y" if you are using the Electronic Claims in conjunction with the MOS system.

Upon completing the update of all fields desired, press .

Add/Update EDI Insurance File (E Z 8)

To select this option press **Z** from the HCFA Electronic Claims menu and **A** from the Maintenance Menu.

1. Find by Payor ID This choice will prompt you to enter the Payor ID code you wish to retrieve.
2. FUZZY SEARCH By Name This choice will prompt you to enter the name of the Company you wish to retrieve.
3. Add NEW Insurance Company This choice allows you to add new insurance companies to the Insurance File.

Screen Fields:

Payor ID

Identification number assigned for electronic identification of a carrier.

Claim Office

Identification number assigned for identifying the office of a payor.

Group

Number assigned by this carrier to your practice as a group number. If this carrier represents only one group, use this to enter the group number.

Figure 20-11: EDI Insurance Carrier Screen

OCNA ID Number

Enter the OCNA ID Number for the insurance company that is accepting Medigap.

Company Name

Enter the Insurance company name.

Address

Enter the street address of the Insurance company.

City

Enter the city of the Insurance company.

State

Enter the state of the Insurance company.

Zip

Enter the zip of the Insurance company.

Contact Name

Insurance company contact for questions. Not transmitted.

Contact Phone

Insurance company phone number. Not transmitted.

Sub Type

Type of claims carrier accepts.
 E - Electronic
 P - Electronic Paper
 Q - Paper Only

INS Type

Type of carrier. This determines the codes transmitted when describing this carrier.
 1 - Medicare
 2 - Blue Cross
 3 - Medicaid
 4 - Champus

- 5 - Commercial
- 6 - Key Health

Carrier Type Type of identification and numbers required for acceptance of a claim.
 CARD - Policy# & Office # Required
 SKIP - Office # not required
 BNC - Both numbers optional
 NC - Policy # required, Office # optional

ANSI837 Submitter/Receiver Data

This data is critical to the electronic file creation. Each Payor Type that will be used electronically must be properly defined. The selection will collect the primary Payor Types from the Insurance File and display just the records that must be filled. Usually that will be one Medicare, One Medicaid, a few Blue Shields, and so on. The data on these records is provided when you request submitter information for electronic filing. The following screen is displayed:

Figure 20-12: ANSI 837 Submitter/Receiver Data

Usually, the ISA Sender ID and GS Sender ID would be the number assigned to your practice as a submitter. The Receiver ID numbers would be the payor id or receiver id of the carrier. But the variation is great and the MOS Support staff will gladly help when you are ready to supply this data. As each screen is saved a question has been added to remind you to make a hardcopy of the information. Please do this and keep the copy. This data is stored with the insurance data and if the file is reset, this data may be lost.

Medicare Claims

Add/Change Electronic Claims

Your data will all be entered in the Medical Office System and will be copied to the Electronic Claims from the Electronic Submission Menu in MOS. It should not be necessary to enter claims directly into the Electronic Claims, however, it will be helpful if a problem occurs to look at the claim as entered in Electronic Claims to see what the error(s) are and then to make the appropriate corrections in the MOS to properly create your claim in Electronic Claims. If data is blank in Electronic Claims that should have been posted from MOS, carefully check that the data was correctly formatted and legal for the field intended. For example, the first symptom date in MOS allows you to enter "UNKNOWN" as a response that can cause an error in FastEMC since the field is a date field and is required by some states to be a real date.

Press **[E]** **[Z]** **[1]** to load the Electronic Claims Add/Change Claims option.

Updating/Reviewing a Claim

First locate the claim using appropriate information. The MOS fills the Patient account number Field with the MOS Account number - invoice number for each claim. For example, a claim for patient 112 on invoice 321 in the MOS would have the patient account number entered as "112-321". This number is reported as the Patient Control Number and will also be reported on any reports sent to you from your carrier.

Once you locate a claim the following options are available:

Screen Options:

The system will display various options on the last three lines of the screen depending on the function selected. The following is an example of some of the options displayed.

- | | |
|----------------------------|---|
| [D] -Delete | Deletes the claim on the screen. |
| [H] -Hardcopy | Prints the screen displayed to the line printer. |
| [U] -Update | Puts the system in update mode enabling modification of the claim displayed. |
| [BREAK] -To Cancel | Returns to selection options to locate another claim. |
| [X] -Exit | Terminates the screen displayed and returns to the previous screen or menu. |
| [F] -Print Form | Prints a HCFA form. This should not be used if your claims are managed in the MOS. Return there to properly print a claim. The format of this claim does not match the specifications in the MOS. It will give you a rough approximation however if that is all you need. |
| [B] -Browse | Lets you toggle between two methods of viewing data: one record at time (BROWSE OFF); or a list of records (BROWSE ON). |
| [↑] | Moves up one claim to allow you to view the prior claim in this claim. |
| [↓] | Moves down one claim to allow you to view next claim in this file. |
| [E] -Error Retrieve | Lets you go to the specific screen and field that is in error. Only displayed if errors exist. |
| [R] -Review Errors | Produces a window of all errors for this claim. Only displayed if errors exist. |

S -Update Status

Allows you to change the status of the claim. The status of a claim will help you find errors. Only claims marked with a blank status or resubmit will be transmitted in an initial batch. If you resubmit, you can only select claims marked with "T" for transmitted. To re-select you must know the date and batch number of the original batch.

- H Places the claim on Hold Status.
- R Allows a previously submitted claim to be resubmitted.
- C Removes a claim from Hold Status.
- Q Places a claim in Paper Claim Status. No Electronic Claims records will be produced.
- T Transmitted to carrier.
- E Errors were found and must be corrected.
- S Suspended. Claim was transferred and the error checking has not been done.

A -Go To
Insurance

Allows you to go directly to the Insurance Screen.

G -Go To
Procedure Billed

Allows you to go directly to the Procedure Line Item Screen.

C -Go To
Supplier Data

Allows you to go directly to the Supplier Screen.

I -Browse
Rec Number

Allows you to browse claims in record number sequence.

M -Browse Alpha

Displays claims alphabetically by patient last name.

This will be helpful when checking why a claim was not accepted electronically.

Patient Demographics Screen

Patient Account#

The patient account number entered on the previous screen is displayed. If the patient file is not disabled on the System Setup, the system creates a patient file for all claims entered into the system and will automatically recall data from prior claims submitted.

Patient Last Name

The patient's last name entered or selected from the previous screen is displayed.

First Name

The patient's first name entered or selected from the previous screen is displayed.

MI

The patient's middle initial entered or selected from the previous screen is displayed.

Gen

Abbreviation for JR, SR, III, etc. This should not be included with the first or last name of the patient.

Sex

The Patient's sex entered or selected from the previous screen is displayed.

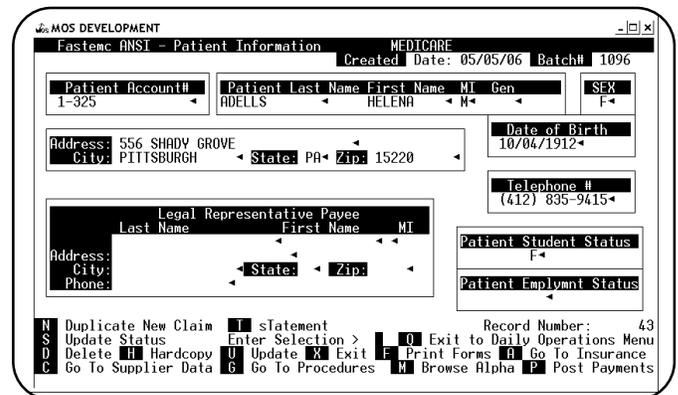


Figure 20-13 : EDI Claim Patient Screen

Address The patient's current mailing address. The payment will be mailed to the patient's address, if the provider is not accepting assignment.

The provider's address should NEVER be entered here. If the provider is accepting assignment, the assignment indicator on the next screen should be "Y".

Leave blank positions between words and numbers within the address. Do not use commas or other punctuation. The posting from MOS to FastEMC should remove special characters automatically.

City Enter the patient's city. City names that are too long may be abbreviated. Use a standard abbreviation for these cities.

State Enter the patient's state. Use the two-character alpha state abbreviations which have been authorized by the U.S. Postal Service for use in conjunction with Zip Codes. The system will not accept invalid state codes.

Zip Enter the patient's zip code.

HIC Number This field should show the patient's complete Health Insurance Claim Number (HICN) from the patient's (beneficiary's) entitlement card including all letter prefixes or suffixes. Be sure the number entered in the MOS complies with your carrier requirements.

Note *The name, HICN, and sex must match Medicare records. A discrepancy will delay processing. DO NOT use dashes or other punctuation.*

Telephone # Enter the patient's telephone number including the area code.

EX: Use 3125551212 and the system displays (312) 555-1212.

Date of Birth Type the patient's date of birth using MM/DD/YYYY or MMDDYYYY format.

EX: 7/13/41 becomes 07/13/1941 07-12-41 becomes 07/13/1941. 071341 becomes 07/13/1941.

Other Insurance? Press if Medicare is primary and the patient has other health insurance. If is entered, a screen will be displayed (after completing this screen) to allow you to enter the name of the insuring organization and the policy or medical assistance number. If the other insuring agency is a Medigap (Medicare supplement) plan and the provider is Medicare participating, the OCNA Number and the Medigap plan's complete address are also listed. The information is furnished by participating providers for automatic transmission of Medicare payment information to the Medigap insurer.

If the patient has employment related health insurance, the patient's name and employment plan policy number are entered. If the insurance is based on a spouse's or parent's employment, the spouse's or parent's name and policy number are listed.

Representative

Payee

Press **[Y]** if payment for this claim is to be made to a representative payee (Legal Representative). If this is "Y", the system will allow you to enter the name, address, city, state and zip of the person or entity to receive payment. This information is indicated in the MOS as the "Send Statements to" person on the Patient Insurance Screen, if it is other than the patient.

Representative Payee

Name

Enter the Representative Payee's name. The Send Statement To information in the MOS is posted into this area. This field is only used when the beneficiary is not competent to file his own claim and the claimant is a legal representative. When no legal representative is indicated, the notice is sent to the beneficiary or to a representative payee if indicated by the beneficiary's master record maintained by SSA in Baltimore. In non-assignment cases, the payment is also made under this rule.

Code the name as it should appear on EOMB and/or benefit check.

Address

Enter the Representative Payee's street address.

City

Enter the Representative Payee's City.

State

Enter the Representative Payee's State.

Zip

Enter the Representative Payee's Zip Code

When you have finished entering data, press **[ESC]** to continue to the next screen.

Insurance Screen

Press **[↑]** to return to the previous screen.

Primary Insurance

Company

Enter the Carrier name or press **[F5]** to browse the carriers. The name you type is matched with a fuzzy match to the carriers on file. This must be filled. You may add a carrier, update a carrier or search for a carrier until one is found. When one is selected from the insurance file, additional information is filled in automatically from the insurance information.



Figure 20-14 :EDI Insurance Screen

Office #

Claim Office Number - This is the second part of the number used to identify the carrier in the electronic system. This is a five digit field.

Trig

This is the trigger. It indicates which insurance company is primary. If you try to place this on the second line it will swap the first and second carriers immediately. It is not a transmitted field.

Type

This indicates if the carrier is electronic or paper. Since the paper carriers will be handled in the MOS this will usually be flagged as electronic (E).

Assignment

Patient has authorized the provider to receive payment for this service. This is indicated in box 13 of the paper form.

<i>Provider Assignment</i>	This is the provider assignment and indicates the provider acceptance of assignment. (box 27 on the HCFA form) The response to this is requested when you select claims for download from MOS to FastEMC. For each subsequent insurance carrier it is duplicated.
<i>Prov Sgn</i>	This is the location of the provider signature and is supplied as one of the questions during download from MOS to FastEMC. For each subsequent insurance carrier it is duplicated.
<i>Pat Sig/Rel</i>	Patient Privacy indicates if the medical records can be released. This is indicated on the paper form in box 12.
<i>Sgn Src</i>	Code to indicate the authorizing signature obtained from the patient. Browse to display a list of accepted codes.
<i>Ins Loc</i>	Insurance location identifier or Title XIX coverage.
<i>HIC#/ID/Cert#</i>	Enter the policy number of the patient assigned by the carrier. If the carrier is Medicare for this line, enter the HIC# as it appears on the MEDICARE card. Do not enter any dashes or other punctuation characters. Be sure to comply with any rules for the proper enter given by your carrier.
<i>Insured's Last Name</i>	Enter the insured's last name, if the patient is the insured as it is with Medicare, press F8 to copy the name and address to these fields.

Complete the remaining name and address fields if necessary.

Secondary Carrier/Tertiary Carrier Lines

<i>Secondary Payor Code</i>	Enter the secondary payor code. a list of codes is available with F5 . This indicates the type of relationship between the primary carrier and the secondary carrier.
<i>Source of Pay Medigap# /OCNA#</i>	Enter the source of the payment. a list of codes is available with F5 . Enter the identifying number for this carrier. These numbers allow for the computer transfer of claims from one carrier to another. Enter them as per your carrier's instructions. This number can be entered in the MOS system on the insurance carrier information as the OCNA# number and is used to identify a unique carrier in the Electronic Insurance Carriers. If the number can not be matched a match is attempted by carrier name. This may not be as unique a match. F5 is available to locate the carrier by number.
<i>Carrier Name</i>	Enter the name of the carrier. F5 to select a carrier from the file by name. You can enter an approximate name or the first few letters, then press F5 to display names alphabetically near the letters you entered. Press F8 to exchange the third line carrier with the second line carrier.
<i>Payor ID</i>	Enter the payor ID number or code in this 5 character field.
<i>Claim Office #</i>	Enter the claim office number. In one state, the payor ID and the claim office number are used to enter a number called the "long ID". Just enter the first 5 characters in the payor ID and the rest in the Claim Office Number and this will identify the carrier properly. These two numbers also uniquely identify a carrier for crossover claims.
<i>Trigger</i>	Type an X to exchange the carrier line currently indicated with the primary carrier line.
<i>Type</i>	Type of claims this carrier will accept.

E Electronic
 P Paper Only
 Q Unknown

Medigap Assgn

Indicates whether patient has authorized payment of Medigap Benefits to physician or supplier. a entry is required if Medigap Supplemental (S) was entered in the Type of Claim. This would be the information reported on the paper claim in box 13. Medicare requires this code to be yes to crossover claims to secondary carriers.

Y = Yes, Benefits assigned
 N = No, Benefits not assigned

Prov Assignment

Enter code indicating whether the provider accepts assignment as indicated on the claim in box 27 of the paper form. This code may be vital to indicating whether you get paid so take note of your carrier's requirements. The code is assigned during transfer as a screen prompt. Supply the appropriate answer at that time. It is entered for each carrier that is sent the same.

Prov Sgn

Provider Signature location. This code is "Y" or "N".

Pat Sig/Rel

Enter a code indicating the patient's request or the release of medical information. This code is indicated on the paper form in box 12.

Sgn Src

Code to indicate the authorizing signature obtained from the patient. Browse to display a list of accepted codes.

Ins Loc

Insurance location identifier or Title XIX coverage.

HIC#/ID/Cert#

Enter the policy number of the patient assigned by the carrier. If the carrier is Medicare for this line, enter the HIC# as it appears on the MEDICARE card. Do not enter any dashes or other punctuation characters. Be sure to comply with any rules for the proper enter given by your carrier.

Insured's

Last Name

Enter the insured's last name, if the patient is the insured as it is with Medicare, press **F8** to copy the name and address to these fields.

Complete the remaining name and address fields if necessary.

Employer Screen and Additional Carrier Information

If you supplied any secondary carrier information an additional screen is displayed. It will allow you to supply employer information and group numbers for the carriers.

Employer Name and Address

Enter the name and address of the patient's employer. This is usually only necessary if the employer is the insurer or if the claim is for worker's compensation.

Employer ID#

Insured's Employer ID# is entered here.

Insured's

Group Name

Enter the group name for the secondary or tertiary carrier.

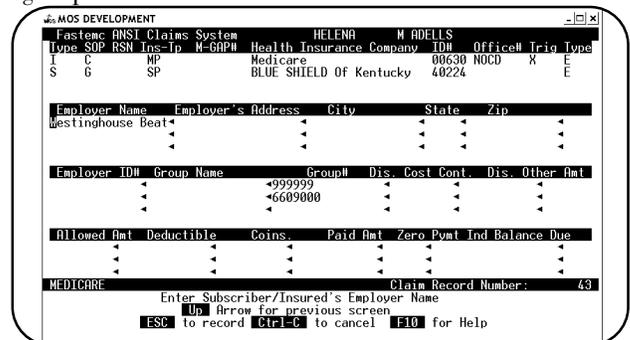


Figure 20-15: EDI Employer Screen

Group # Enter the group number for the appropriate carrier. This is very often required if a secondary or tertiary carrier is listed. Be sure it is entered as required by the carrier. For example, in PA this number must start with the letters "MGAP" if the carrier is a Medigap carrier. The number entered as the group number in the MOS is sent to this field exactly as you enter it. It is your responsibility to know what your carrier requires for electronic transmission.

Note: Enter the amounts listed if they apply. In most cases, these are left blank and are supplied by the primary carrier as the claim is transferred to the secondary carrier in crossover situations.

Primary Payor Pd Enter the amount paid by the primary payor.

Deductible Amount Enter the deductible amount for the primary payor.

Coinsurance Enter the Co-payment amount for the primary payor.

When you have finished entering data, press **ESC** to continue to the next screen.

Physician/Supplier Information

Diagnosis 1 Enter the ICD-9-CM diagnosis code to describe the primary diagnosis, condition or reason for services rendered. The listed codes must be valid, i.e., exactly as stated in the ICD-9-CM manual. The highest level of specificity should be coded. Providers are required to submit ICD-9-CM code(s) on each request for payment. The requirement applies to all claims billed by electronic media.

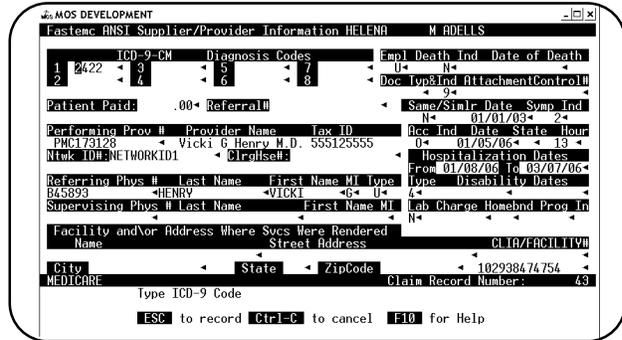


Figure 20-16: FASTEMC Supplier Screen

If the ICD-9-CM diagnosis code file is not disabled on the System Setup you will be required to maintain two procedure data sets. If you need to enter a code here be sure the code is correct since no validity will be done in the FastEMC

Diagnosis 2 Enter the second Diagnosis code for this claim.

F5 will provide a browse window of the ICD-9 codes from your file.

Diagnosis 3 Enter the third Diagnosis code for this claim.

F5 will provide a browse window of the ICD-9 codes from your file.

Diagnosis 4 Enter the fourth Diagnosis code for this claim.

Emped? This field should be marked either **Y** or **N**. If the illness or injury was work related, enter **Y**.

Stat Employment Status of the patient at the time of the treatment. **F5** will display a list of choices. Most Medicare patients would be "5" for retired.

DocInd Documentation Indicator. This identifies if additional documentation supporting this claim is available and the location of that information. "9" would indicate No Documentation.

<i>Type</i>	Type of claim being submitted. Press <input type="button" value="F5"/> for a list of claim types.
<i>Death Benefit Indicator</i>	Enter indicator for whether patient is deceased. This must be indicated as one or the other. D = Deceased N = Not Deceased.
<i>Date of Death</i>	Supply the date of death if the patient is deceased.
<i>Occasion Date</i>	Date identified by the code under REASON.
<i>Reason</i>	Code to indicate the date listed in the occasion date field. <input type="button" value="F5"/> to list codes available.
<i>Accident</i>	Type the accident code if the services performed on this claim are the result of an accident. If a incorrect code is entered or if <input type="button" value="F5"/> is entered, the system will display a browse window of the valid codes. Leave this field blank if the claim is not the result of an accident.
<i>Accident Date</i>	Type the date of the accident.
<i>State</i>	Enter State were accident occurred. Only necessary if the accident was an auto accident.
<i>Hospitalization From Date</i>	Type the date the patient was admitted to the hospital.
<i>Hospitalization to date</i>	Enter the date the patient was discharged from the hospital. If the patient is still hospitalized, use the last date of service billed.
<i>Type of Disability</i>	Enter the code indicating the type of disability. <input type="button" value="F5"/> to display a list of available codes.
<i>Disability Date</i>	Enter start date of disability. Enter expected end date of disability.

Performing Prov/Tax Id/Name/Address

If your practice is a solo practice, the provider ID is determined from the System Setup file. An Option I or Option II group practice will require the physician or provider's ID code. This is displayed for information purposes only, if the provider number is incorrect, type and valid provider codes will be displayed. This is reported as the billing provider if your practice is not a solo practice. If it is a solo practice this number is only reported as the rendering provider.

<i>Referring Physician #</i>	Enter the referring physician's UPIN-Number to identify the referring or ordering physician.
<i>Referring Physician Name</i>	Type the last and first name of the referring or ordering physician. These fields are left blank if no referral or order was made. This field must be completed on claims for consultation or treatment if the patient was referred by a physician, and on claims for all therapies (speech, physical, occupational), psychological testing, diagnostic tests, radiology and pathology services, prosthetic devices , and durable medical

equipment ordered by a physician. This requirement will necessitate the sharing of information between physicians and suppliers involved in a patient's care.

Facility Name Enter the facility name to indicate where the service was performed. This is required if the Place of Service is not HOME or OFFICE. to display a list of facilities on file. These can be entered with all their data in a special file or on the System setup screen. It is important that the facility be supplied properly.

Facility City/State/Zip Enter the city, state and zip where the facility is located.

CLIA# Enter the facility identification number as assigned by your carrier. This is required for some types of facilities.

When you have finished entering data, press to continue to the next screen.

Service Provided

will allow you to return to the previous screen.

PRIOR Authorization # Enter the 10 digit approval number in this field if applicable.

Paid by Patient The total of charges paid by the beneficiary for Medicare covered services is shown in the field. Amounts paid for non-covered services, such as eye refractions and routine examinations, should not be included.

Figure 20-17: FASTEMC Service Line Screen

If whole dollars, the system will supply the '.00', a decimal is required for cents. i.e.12.45

Primary Diag The diagnosis entered on the prior Physician/Supplier Screen is carried forward to assist you in entering service line information. If an incorrect diagnosis was entered, you may correct it on this screen.

Diag2 The second diagnosis entered on the prior Physicians/Supplier Screen is carried forward to assist you in entering service line information. If an incorrect diagnosis was entered, you may correct it on this screen.

Diag3 The third diagnosis entered on the prior Physician/Supplier Screen is carried forward to assist you in entering service line information. If an incorrect diagnosis was entered, you may correct it on this screen.

From-DOS The MM/DD/YY or MMDDYY for each service are entered in this column. Enter to fill in the computer current date. After the first service line has been entered, the first date of service is 'saved' by the system. If the first date of service is left blank on subsequent service lines, the system will fill in the 'saved' date.

This feature will save data entry key strokes when all the services are for the same date of service. When all service lines have been entered, press the key to complete processing of the claim.

To-DOS Identical services rendered on consecutive days may be entered in this line. If the TO DATE OF SERVICE is the same as the FROM DATE OF SERVICE, just press enter and the system will

make the "to date of service" equal to the "from date of service". Enter a to fill in the computer current date. The number of times the identical service was rendered is listed in the NOS Column. If consecutive services begin in one month and end in another, a separate line is required for each month.

POS Enter the appropriate numeric indicator for place of service code for this service line. If you are not sure of the code to be entered, (enter) or if you enter an invalid code, the system will pop-up a browse window of all the valid codes, simply move the highlight bar to the correct code and press the key.

PROC The CPT-4/HCPCS code must be used to fully describe the procedures, medical services, or supplies furnished for each date given.

If the CPT-4/HCPCS code file is not disabled on the System Setup, the system includes a file for procedure codes. You may add to this file as applicable to your practice. If you are transferring data from MOS to FastEMC you would always disable the test on this field since it was done in the MOS.

MD1 Enter the valid procedure code modifier for this service line if needed.

MD2 Enter a second valid procedure code modifier for this service if needed.

MD3 Enter a third valid procedure code modifier for this service, if needed.

MD4 Enter a fourth valid procedure code modifier for this service, if needed.

Diag The diagnosis code reference number (i.e. 1,2,3, or 4) is entered to link the patient's diagnosis with the line of service. Each line should show the reference number of the diagnosis that prompted the service on that line from the diagnosis codes previously entered and displayed above. You may code an additional diagnosis code not previously entered if you desire. will provide an appropriate pop-up browse window to help you find the proper code.

Changes Enter the charge for this service line. If whole dollars are entered, the system will supply the decimal and cents. Example: 123 entered will produce 123.00. This will be multiplied by the number you enter in NOS to be the total charges for the line.

TOS The type of service code is used to move you through the screen fields and skip unrelated items. It is not part of the data transmitted with the claim.

- A if this service was for anesthesia.
- B if this is a blood transfusion service line.
- D if this service was for DME.
- M if this service was for ambulance mileage

NOS Enter the number of service for this service line. Maximum of 99. The total charges will be multiplied by this number.

Blood Enter the blood units for a blood transfusion. This will not be downloaded from the MOS system.

Minutes Enter the number of minutes for anesthesia. This will not be downloaded from the MOS system.

Pur Diag Ind Enter if service was for a purchased diagnostic procedure.
Enter if not Purchased.

Pur Amount Enter amount paid for the purchased diagnostic procedure.

<i>Supplier ID</i>	Enter the Medicare B provider number of the supplies if charge is for purchased amount, net any discount. <input type="button" value="F5"/> is available for this field. The purchased diagnostic labs are downloaded as needed from the MOS system. Many states require complete information in this area.						
<i>Perf-Prov</i>	<p>This column is only completed on claims from physicians groups or clinics in the Option II group category. This would be the rendering physician and is assumed the same as the performing physician if this is blank. The MOS system will fill this in properly. The physicians listed must be on file with the Electronic Claims system also and can be downloaded from the MOS as needed. Be sure the numbers listed in the Electronic Claims are entered properly for electronic transmission. Sometimes the number printed on paper differs from the number transmitted electronically. Check with your carrier.</p> <p><input type="button" value="F5"/> will pop-up a browse window to prompt you as to the proper {Provider numbers.</p> <p>For Solo practices and Option I providers, the performing provider number will be used from the physician/supplier screen.</p>						
<i>Change Status?</i>	<p>This field is entered when the <input type="button" value="F5"/> key is pressed from the FROM DATE OF SERVICE field. Entering a <input type="button" value="Y"/> produces a pop-up window that allows you to enter the following values:</p>						
<i>Control #</i>	Enter a reference number for this line item. It is used on the reports sent by the electronic carrier to help you locate an individual service line.						
<i>Review</i>	Enter a review code. Unknown use at this time.						
<i>MSP</i>	Enter "Y" if service is for MSP.						
<i>Cert</i>	<p>Enter the Cert format that must be added. a list of available formats can be displayed if you press <input type="button" value="F5"/>.</p> <table border="0" style="margin-left: 40px;"> <tr> <td>AM</td> <td>Ambulance</td> </tr> <tr> <td>CP</td> <td>Chiropractic</td> </tr> <tr> <td>OX</td> <td>Oxygen</td> </tr> </table> <p>These are currently available and can be entered. If selected another screen of information is added that will be submitted to certify the claim. If these claim types will be submitted from MOS, this information must be added here to each claim to properly complete the claim information.</p>	AM	Ambulance	CP	Chiropractic	OX	Oxygen
AM	Ambulance						
CP	Chiropractic						
OX	Oxygen						
<i>Narrative?</i>	Press <input type="button" value="Y"/> if you would like to add a narrative record to this service line. The narrative record (HA0) is used for free form text to add information that will better your change of being paid for this service. Some procedures require this additional information. a narrative will not be sent from the MOS and must be added at this point to a service line that might require one.						
<i>Total Charges</i>	The computer will automatically calculate this amount based on the total of the charges column.						
<i>Lines</i>	The system will automatically calculate the number of service lines. You may have up to 21 lines per claim.						

Change/Delete Service Lines

To change or delete a service line, press from the "FROM-DOS" field. Move the highlight bar to the service line in question and press to delete, or press to change.

If you have finished all line items for this claim, press **ESC** to record this claim. The system will place you on a new blank record for additional claims.

To exit this screen without saving this claim, press **BREAK**.

Saving the Claim

When you press **ESC** to save the claim, or pass the last field on some screens, the message “Performing Edits for mos-care” will be displayed. At this time the claim is checked for accuracy and completeness. If any information is not acceptable an error will be displayed. This is the same check that the claim is submitted to when it is downloaded from the MOS. Each time the claim is updated on any one screen or all screens, this test is done again. If any error is found the claim status is set to “ERROR” and the claim will not be transmitted.

Other Types of Carriers

In time the FastEMC may submit claims assigned to Medicaid, Blue Shield, Commercial, etc. in your area. These screens and the information checked for editing vary slightly, but at this time a detailed data entry section is not required. Additional carriers will be supported if they can be sent with the same transmission format.

Create Electronic Claims - Non Assigned Claims

To allow non-assigned claims to be submitted electronically, the following steps should be followed.

- ▶ Each patient that will be non-assigned should have the “Assignment?” on the Patient Demographics screen answered “N”.
- ▶ Assign the Bill TO as PT.
- ▶ The primary carrier listed for the patient should be marked as electronic.
- ▶ Claim should not be marked “printed” to paper at time it is selected for Electronic Claims. They can be printed later if you want paper copies.

If these things are true, the claim will be selected when you answer the question:

Select only based on claim’s responsible carrier?

If you answer “N”, the patient responsible - non assigned claims will be selected. If a claim has been printed, it will not be selected. When the choice “R-Resubmit” is selected from the invoice detail options, it will mark the claim like it has never been printed. If you wish to print a claim for the patient at the time of the appointment, after it has been printed, press “R-Resubmit” to unmark it so it will select for the electronic.

A claim for a patient with assignment “Y”, must be billed to an electronic carrier for it to select when Creating Electronic Claims. A claim with a patient responsible bill to will only send electronically if the Patient Assignment is “N” and the claim has not been printed or sent previously.

You can tell if a claim has been sent by looking at the invoice detail screen. The upper left box indicates the insurance billing status. It will read:

CHARGE Statmnt Ins a 071797

Where the letter can be:

	Blank if New Claim
a	Printed from Daily Input
w	Printed in batch to insurance
e	Sent Electronically

The date will be the date it was first sent. The date is used for the aging and resubmit functions.

FASTEMC® of ILLINOIS or INDIANA or MICHIGAN

The smooth operation of posting MOS claims to FASTEMC® has required a special menu with some special programming be added to your FASTEMC®. Since FASTEMC® installs with insurance company, procedure and diagnosis information already supplied, it was prudent to allow a one time copying of that data to the MOS to help in your start up with MOS. Some notes on each file and what will be done is listed below.

General Information

Insurance company data

Many codes for electronic submission and carrier information have been supplied and will copy to the MOS to insure accuracy. However, the ID code used in the MOS had to be generated by the program, with the following rules:

- The first letters of each word in the Insurance company name was used. If a company already existed with that code, the first two initials were used with a number assigned to the next two positions.
- Medicare is MC, Medicaid is MD, Blue Shield should be BS== where == can be any other letters or numbers.
- It is recommended that you review the carriers you might use and make sure the code will be easy to use. Once you have begun to add claims to the MOS that use that insurance company, the code must not be changed.

Diagnoses Codes

Diagnosis data is copied to the MOS. The descriptions and codes will be identical to the MOS codes. A mnemonic code is not assigned but can be added in the MOS to make a more easily remembered code. The ICD-9 code is used if not mnemonic code is assigned. A question will ask if you want these codes copied. Answer "Y" if you do, or "N" if you don't. This will only be done once as you start the MOS system.

Procedure Codes

Procedure data is copied to the MOS. The descriptions, pricing and CPT codes will be posted. The MOS requires a mnemonic be assigned to the procedure to reference the item by a more friendly code. As these items are added to the MOS you will be asked to assign a mnemonic. The description and CPT code are displayed, just assign an alphanumeric code to each procedure item as they are displayed. For example, Office Visit might be OV15, and Office Visit extended might be OV30.

Patient Data

Finally, the patients posted before to the MOS will have the insurance numbers and carriers added to their information. Referring Physicians will not be copied. Claims will not be copied. Financial information in the FASTEMC® will not be copied. If you want to add some financial information to the patient data, that will be done at your office. You can let the rest of your current claims in the FASTEMC® get paid from there and start new financial information from the MOS when you start entering your claims in the MOS.

Steps to Initialize the MOS from FASTEMC®

Step 1 INSTALL the diskette that you will receive according to the instructions. When that is finished, start the MOS system.

Step 2 From the MOS Main Menu, select Electronic Submission Menu.

Step 3 From the Electronic Submission Menu, select **W** - Initialize MOS from FASTEMC®. This will add the programming necessary to the FASTEMC. Then it will ask if you want to add all the insurance companies to the MOS. We recommend that you answer “Y”. When this function is complete, a warning explains that we recommend checking the codes assigned as soon as possible.

Then you will be asked if you want to add all the diagnoses codes to the MOS. Answer “Y” to do this or “N” to go to the next file.

Then you will be asked if you want to add the procedure codes to the MOS. Answer “Y” to do this. At each code you will be asked for a mnemonic code, fill a unique code in for each procedure. If the code you enter has already been used, a warning will be given and you can change the code to another. I only saw about 70 procedures in this file, so this should not be left for later and will not take too long to complete.

The patients will be done last.

Step 4 It is recommend that when these functions have been completed, return to the MOS Main Menu. Select the Reports Menu, then the Diagnosis / Procedure Reports Menu, and Print the Diagnosis Report and the Procedure Report. Review this information and make any corrects as soon as possible. Then if you have added the insurance carriers, go to the Insurance Carrier Reports Menu and print the Health Insurance Carrier Report.

Step 5 Be sure you have disabled the PATIENT, DIAGNOSES and PROCEDURE files in the FASTEMC® System Setup. You will no longer be managing the data from the FASTEMC for these files.

That should make all the changes necessary to start to send the Claims to the FASTEMC® and have the editing of each claim in the FASTEMC® run at the appropriate time.

Chapter 20 in the MOS manual, document the day to day use of the Electronic Submission interface to FASTEMC® from the MOS programming. Once the claims have been sent to the FASTEMC® and the download edits run, the procedure to transmit should be followed as outlined by FASTEMC®.

Troubleshooting

It is important that the insurance carrier names be unique in your system. This is the way the MOS locates your carrier in the FASTEMC® data base. To be sure the correct information is used in the electronic submission, a report has been added to the MOS which will help you check that the numbers used for electronic submission have been added such as Payor ID and Claim Office # (Not required always, varies from state to state.) The report will also identify any carriers that have been entered with identical company names. If you have no way to change the names, a field called the OCNA # can be used to assign a unique number to any carriers that have the same company name. This number, if supplied, is used as the first way to locate a carrier between the systems. If the OCNA # is blank then the carrier name is used.

The report mentioned select by press the following keys from the MOS Main Menu:

5 **4** **5**

The report will select all carriers and is detailed separately in this document.