FIRST COAST SERVICE OPTIONS

Medicare Part A
Direct Data Entry (DDE)
User Manual for the Fiscal Intermediary Standard System (FISS)

Created January 1997
Revised September 2025

An important notice to users of this manual

First Coast Service Options, Inc. (First Coast) Direct Data Entry (DDE) department has produced this manual to assist providers that have access to the DDE application through the Fiscal Intermediary Standard System (FISS). This manual does not include billing information. DDE is available from 7:00 am – 7:00 pm Monday - Friday and 7:00 am – 4:00 pm Saturday ET.

First Coast makes every effort to ensure that the material in this manual is accurate and current. However, since the Medicare program is constantly changing, it is the responsibility of each provider to remain abreast of changes in the Medicare program.

This manual serves as a reference and is ideal for users (both experienced and inexperienced) of DDE. It provides guidance on how to enter information onto the claim pages associated with the uniform bill (UB-04) claim form. The manual also provides field descriptions of the DDE Screens.

To have a pleasant experience working within DDE, the Manual will walk you through each screen option (i.e.: Option 01-Inquiry Menu will give you inquiry access to several screens). Please note the claim entry and claim inquiry screens are identical. So that you do not become lost, it is important to keep in mind the menu option you have chosen. In addition, while working on line as you follow along with your manual you will see that the pages in DDE are known as Map Pages and are located in the upper left hand corner. Paying attention to the tabs and Map Pages will ensure that you will never be lost.

When entering information remember to TAB among the fields until you have completed the screen. To move on to the next screen/page, press F8. Depending on the Type of Bill, the cursor will skip fields that are not required. If you press F3 while you are in the middle of data entering your claim before you have 'stored' the claim, you will lose all the information you have keyed. If, at any time, you press <F4>, you will be bumped totally off the system, and you must sign back on.

Table of Contents

Section 1 – Introduction

The Direct Data Entry (DDE) system was designed as an integral part of the Fiscal Intermediary Standard System (FISS) to be used by all Medicare A providers. DDE will offer various tools to help providers obtain answers to many questions without contacting Medicare Part A via telephone or written inquiry. It will also provide another avenue for electronically submitting claims to the fiscal intermediary, which are listed below.

- Key and send UB-04 claims
- Correct, adjust and cancel claims
- Inquire about the patient's eligibility
- Access the Revenue Code, HCPCS Code and ICD-9 Code inquiry tables
- Access the Reason Code and Adjustment Reason Code inquiry tables
- Determine DRG for Inpatient Hospital Claims

There are four areas designed to assist you with questions concerning problems/issues relating to DDE. The type of question or problem you encounter will determine which area you should call. The following information briefly describes the type of calls each area handles. Please familiarize yourself with this section so calls will be correctly routed to the appropriate department. Also, please refer to the DDE manual before contacting a Customer Support area. The guidelines in the manual may answer your question eliminating the need to contact a Customer Support Representative.

For questions and information, please refer to the following list and the accompanying phone number of the area you wish to call:
Medicare DDE Support: 888-670-0940

- Reset DDE User ID Passwords
- DDE Information

Medicare A Customer Service Department: 1-888-664-4112

- Medicare Billing and Coverage Questions
- DDE Information
- System Information

Use of this publication along with the UB04 Manual is suggested. The UB04 manual can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

Keyboard

Command/Term	Function
ARROWS	Use the arrow keys to move one character at a time in any direction within a field. See “Tab Keys” section for information regarding moving between fields.
TAB	Press TAB to move forward between fields. Press SHIFT + TAB to move backward between fields. Tabbing backwards is helpful if the cursor is at the top of the screen and you need to move to the bottom of the screen.
CTRL + L	Prints Screen
[CTRL]+[R]	If your screen “freezes up” or “locks up”, hold down the CTRL key and press the R key to reset the screen. Note: Do not use this key combination if the clock symbol “( ) X” displays at the bottom of the screen. The clock lets you know the system is processing your request.
CURSOR	The cursor is the flashing underline that shows you where you are on the screen.
X	In the examples in this manual, an “X” indicates “any number” 0 - 9. Sometimes, only one number is variable, for example, 72X. “72X represents 720 through 729.
(X) 🕓	When this symbol displays at the bottom of the screen, the system is processing your request. Do not press keys until the “( ) X” goes away.
[SHIFT]+[TAB]	Press and hold down the SHIFT key, while you press the TAB key to move back to the previous field. When your cursor is in the top field, this [SHIFT]-[TAB] will move your cursor to the bottom field.

Function Keys

[F1]	The FISS Help Function – The PF1 key may be used to obtain a description of a reason code.
[F2]	Revenue Code Jump – From claim page 2, press [F2] to jump to MAP171D for the first Revenue Code in error. Also, if your cursor is placed on a specific Revenue Code line on page 2, press [F2] to jump to the same Revenue Code on MAP171D.
[F3]	Exiting a Menu or Submenu – Depending on the location of the cursor in the system, you may use the PF3 key to exit a menu or submenu to return to the previous screen.
[F4]	Exiting the System – The PF4 key exits the entire system or terminates the session. After depressing the PF4 key, type “CSSF LOGOFF” and press ENTER key to complete the exit process.
[F5]	Scrolling Backwards in a Screen Page – Not all information on a page may be seen on the screen at one time. To review hidden data from the same screen page, use the PF5 key to scroll backwards.
[F6]	Scrolling Forward in a Screen Page – To view hidden data from the same screen page, use the PF6 key to scroll forward.
[F7]	View Previous Page – The PF7 key is designed to review a previous page, or move backwards one page at a time.
[F8]	Page Forward – The PF8 key is used to view the next page, or to move forward one page at a time.
[F9]	Updating Data – Due to the system's design, a claim will not be accepted until either all front-end errors have been corrected, or the system is instructed to reject or return the claim. By depressing the PF9 key, the system will return any claim errors for correction and will update and store any data that has been entered while in the entry or correction transaction mode.
[F10]	Screen Left – Moves left to columns 1-80 within a claim record.
[F11]	Screen Right – Moves right to columns 81-132.

Status/Location Codes

The Status/Location (S/LOC) code for Medicare DDE screens indicates whether a particular claim is paid, suspended, rejected, returned for correction, etc. The six-character alphanumeric code is made up of a combination of four sub-codes: the claim status, processing type, location, and additional location information. Each S/LOC code is made up of two alpha characters followed by four numeric characters. For example, P B9997 is a status location code.

- The first position (position a) is the claim's current status. In this example, "P" indicates the claim has been *paid* (or *partially paid*).
- The second position (position b) is the claim processing type. In this example, "B" indicates *batch*.
- The third and fourth positions (positions cc) are the location of the claim in FISS. In the example, "99" indicates that the *session terminated*.
- The last two positions (positions dd) are for additional location information. In the example, "97" indicates that the provider's claim is *final on-line*.

A provider may perform certain transactions when there is a specific S/LOC code on the claim. Other transactions cannot be done at all with certain S/LOC codes. The following table provides descriptions of the S/LOC code components.

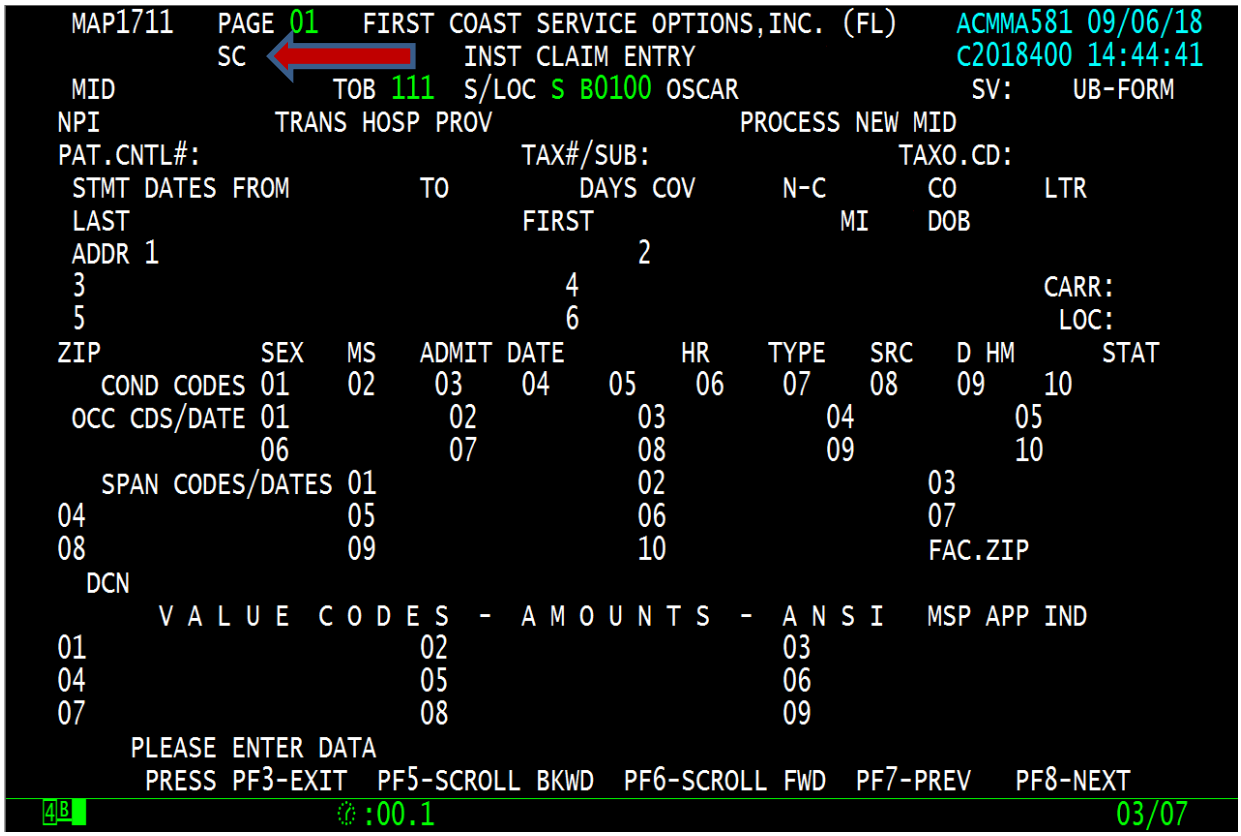
Status (Position a)	Processing Type (Position b)	Driver Location (Positions cc)	Location (Positions dd)
A = Accept F = Force I = Inactive S = Suspense M = Manual Move P = Paid R = Reject D = Deny T = Return to Provider (RTP) U = Return to PRO	M = Manual O = Offline B = Batch	01 = Status/Location 02 = Control Driver 04 = UB-04 Data 05 = Consistency I 06 = Consistency II 15 = Administrative 25 = Duplicate 30 = Entitlement 35 = Lab/HCPC 40 = ESRD 50 = Medical Policy 55 = Utilization 60 = ADR 63 = HHPPS Pricer 65 = PPS/Pricer 70 = Payment 75 = Post Pay 80 = MSP Primary 85 = MSP Secondary 89 = Claim Clean Up/Final Online Edits 90 = CWF Driver 99 = Session Termination AA-ZZ = User Defined (Manual Location)	00 = Batch Process 01 = Common 02 = Adj. Orbit 10 = Inpatient 11 = Outpatient 12 = Special Claims 13 = Medical Review 14 = Program Integrity 16 = MSP 18 = Prod. QC 19 = System Research 21 = Waiver 65 = Non DDE Pacemaker 66 = DDE Pacemaker 67 = DDE Home Health 96 = Payment Floor 97 = Final Online 98 = Final Offline 99 = Final Purged/Awaiting CWF Response User defined locations (Manual location) 22-64 68-79 AA-ZZ

Screen Control Files

The screen control (SC) field (also referred to as 'short cut' field), located in the upper left-hand corner of every entry and inquiry screen allows providers to move from one DDE function to another and back again in order to verify information without exiting the system.

To move to another screen, enter the Inquiry Menu transaction number (i.e., 11-17, 56 & 58) in the upper left hand corner in the SC field and press [ENTER]. These are an example of the same numbers on the inquiry submenu.

For example: to verify a revenue code while you are keying a claim, key code 13 in the SC field and press [ENTER]. After verifying the revenue code, press F3 to return to the claim screen.



Document Control Number (DCN)

The DCN number is located on the remittance advice. This number must be used with adjustment/cancellation bills.

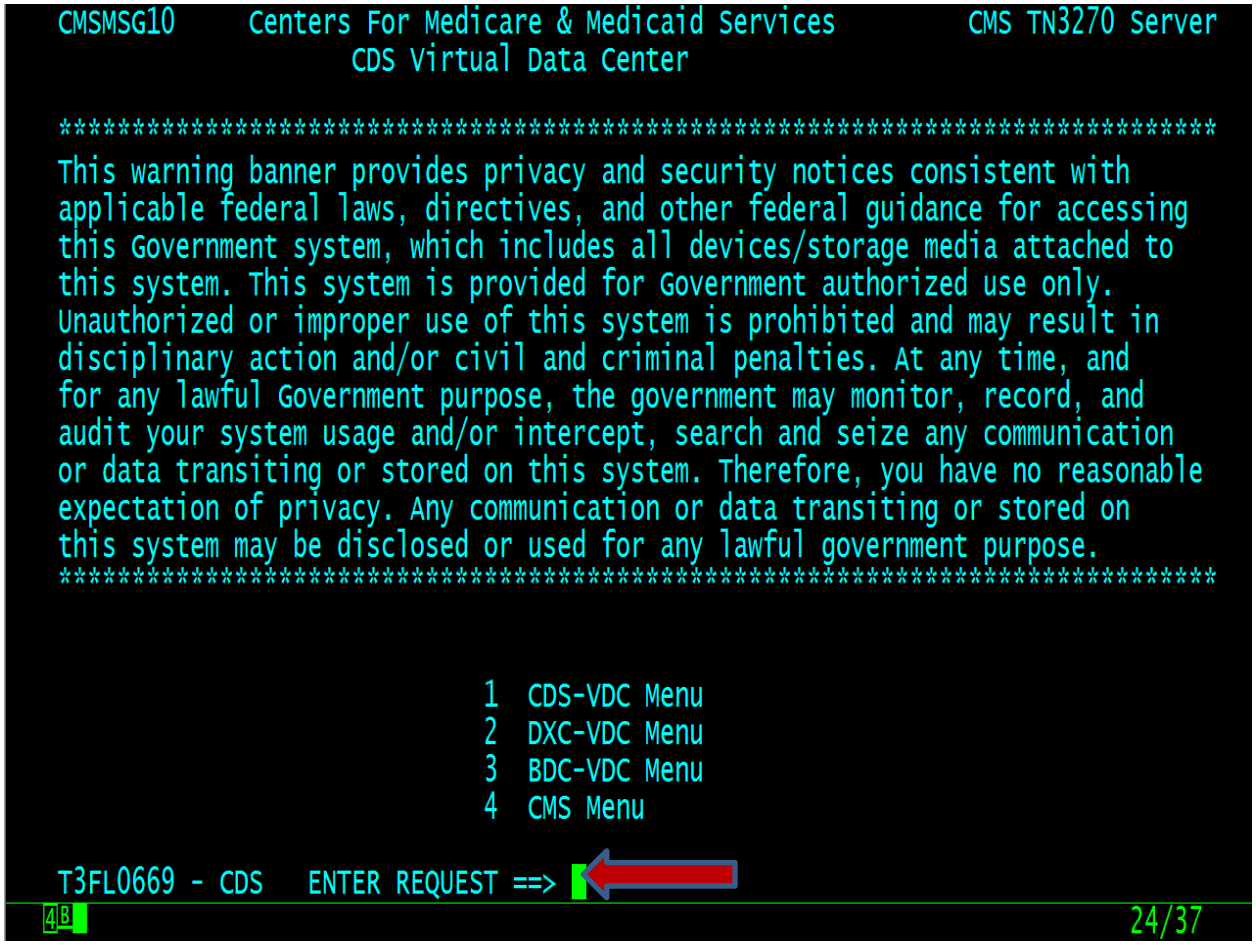
Field Position	Field	Definition
1 - 1	Plan Code	Code used to differentiate between plans that share a processing site. This code will always be a "1."
1 - 1	Century Code	Code used to indicate the century in which the DCN was established. Valid values include: 1 = 1900-1999 2 = 2000 +
2 – 3	Year	The last two digits of the year during which the claim was entered. This is system generated.
4 – 6	Julian Date	Julian days corresponding to the calendar entry date of the claim. This is system generated.
7 – 10	Batch Sequence	Primary sequencing field, beginning with 0000 and ending with 9999. This is system generated with automated DCN assignment.
11 – 12	Claim Sequence	Secondary sequencing field, beginning with 00 and ending with 99.
13	Split/Demo Indicator	Site-specific field used on split bills. Valid values include: Value Description C Medicare Choices Claim E ESRD Managed Care P Encounter V Veteran's Administration (VA) 0 Default value - when not used at a site
14	Origin	Code designating method of claim entry into the system. Valid values are: Value Description 0 Unknown 1 EMC/UB-04/CMS Format 2 EMC Tape/UB-04/Other 3 EMC Tape/Other (Other is defined as PRO Automated Adjustment for FISS) 4 EMC Telecom/UB-04 (DDE Claim) 5 EMC Telecom/Not UB-04 6 Other EMC/UB-04 7 Other EMC/Not UB-04 8 UB-04 Hardcopy 9 Other Hardcopy
15 – 17	Business Segment Identifier (BSI)	This is a three-position alphanumeric field. The first two characters are the jurisdiction code: for fiscal intermediary, carrier and regional home health intermediary workloads, the code is the office United States Postal Service (USPS) state abbreviation for the state jurisdiction. For durable medical equipment regional carriers, these two positions identify the DME region, for example region A is RA. The next character identifies the type of Medicare FFS contract: fiscal intermediary (A), carrier (B), regional home health intermediary ®, or durable medical equipment regional carrier (D).
18 – 21	Home Health Split/Mass Adjustment/Future Area	Home health split: Value Description D The DCN number has been altered due to a file fix to make the DCN unique. H In first position, system generated trailer 15 or 16 adjustment P In first position, system generated post pay activity R In the first position, system generated trailer 24 with a mask of 'O' for interrupted stay. Q Demo code 62/63 and qualifying stay Value Description T Unsolicited adjustments U Unsolicited trailer 24 responses

		Z In first position, system generated for trailer '24' with mask 'N', adjustment for incorrect patient status on IPPS claims.
22 - 23	Site ID	Code used to identify site location controlling the workload where more than one location processes claims for an intermediary. When "Use Site Processing" on the Site Control is set to "Y," these positions of the DCN will coincide with the value indicated in the "Site" field on the Operator Control File.

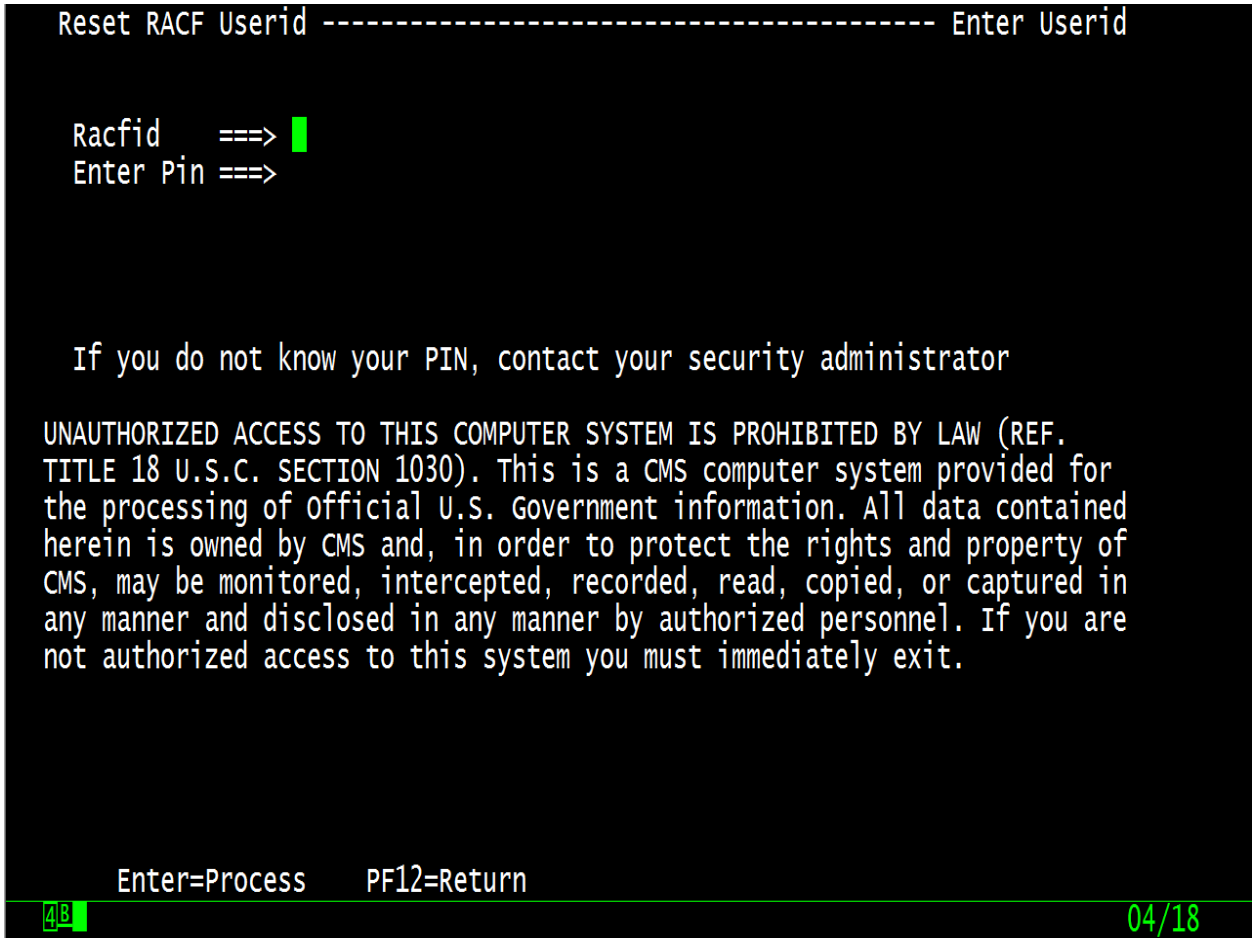
Section 2 – Log-In/Log-Out Instructions

Follow the steps outlined below once you have made a successful connection.

1. Type cdstpx on the line titled CDS ENTER REQUEST



2. At the USERID prompt, select F5 for the self-password reset option.



3. Enter your User ID and 4 digit PIN as indicated on your DDE User ID application and select [ENTER] and a temporary default password will be provided at the bottom of the screen.
4. Select F12 to return to log in screen.

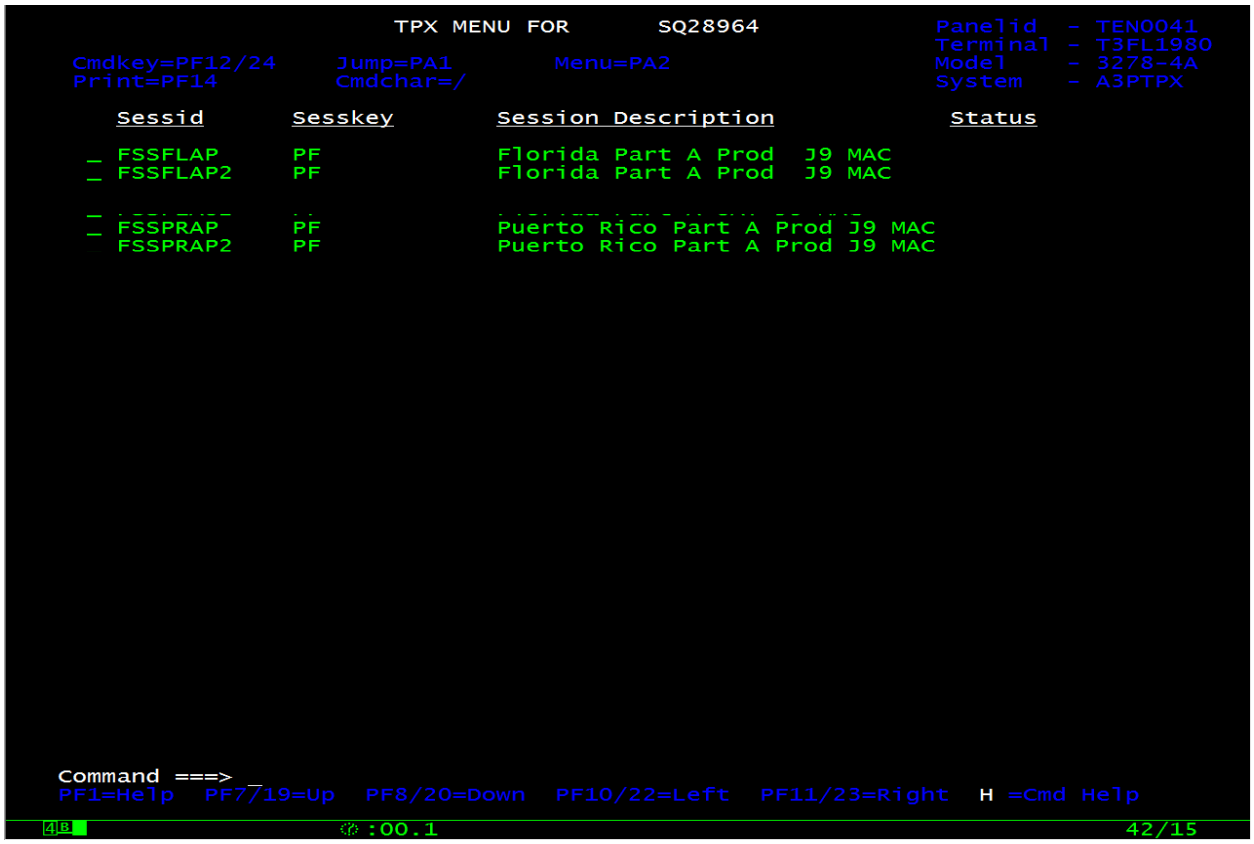
As you enter your default password, nothing will show on the screen but you will see the cursor move to the right. After your press [ENTER], the system will prompt you to change the password. Follow the directions noted on the screen regarding password requirements when changing your password.

Note: Your password will expire every 30 days and you must make at least 12 password changes before you can repeat a previously used password. If you receive a notice that your password has 'expired', please follow the directions noted on the screen when changing your password. If you have not used DDE for several months, it may be automatically revoked and please contact the First Coast Medicare DDE Support: 888-670-0940.

Guidelines for New Passwords

1. The password must be exactly eight characters long.
2. It must contain at least one uppercase alpha letter, 1 lowercase alpha letter and 1 number. It must also contain a special character $, # or @.
3. The password will expire every 30 days.
4. Your password must be different from your previous password by at least 4 characters.
5. Your User ID cannot be a part of your password.
6. You may not use your User ID, name, social security number or date of birth as part of your password.
7. All ID's are systematically monitored for inactivity. After 60 days of inactivity, ID's are subject to automatic deletion. A new User ID Request form will be needed to add deleted users back into the system.
8. Do not start the password with a number.
9. The user's name cannot be in the password.
10. The DDE user ID cannot be in the password.
11. No contiguous repeating characters are allowed. (e.g. "Ppeg42c#" would not be allowed, however, "Pgep42c#" would be allowed).

12. The following character strings are not allowed:
    [APPL APR AUG ASDF BASIC CADAM DEC DEMO FEB FOCUS GAME IBM JAN JUL JUN LOG MAR MAY NET NEW NOV OCT PASS ROS SEP SIGN SYS TEST TSO VALID VTAM XXX 1234]
13. User ID's or passwords should never be shared between users. The user is responsible for all activity conducted under their user ID.

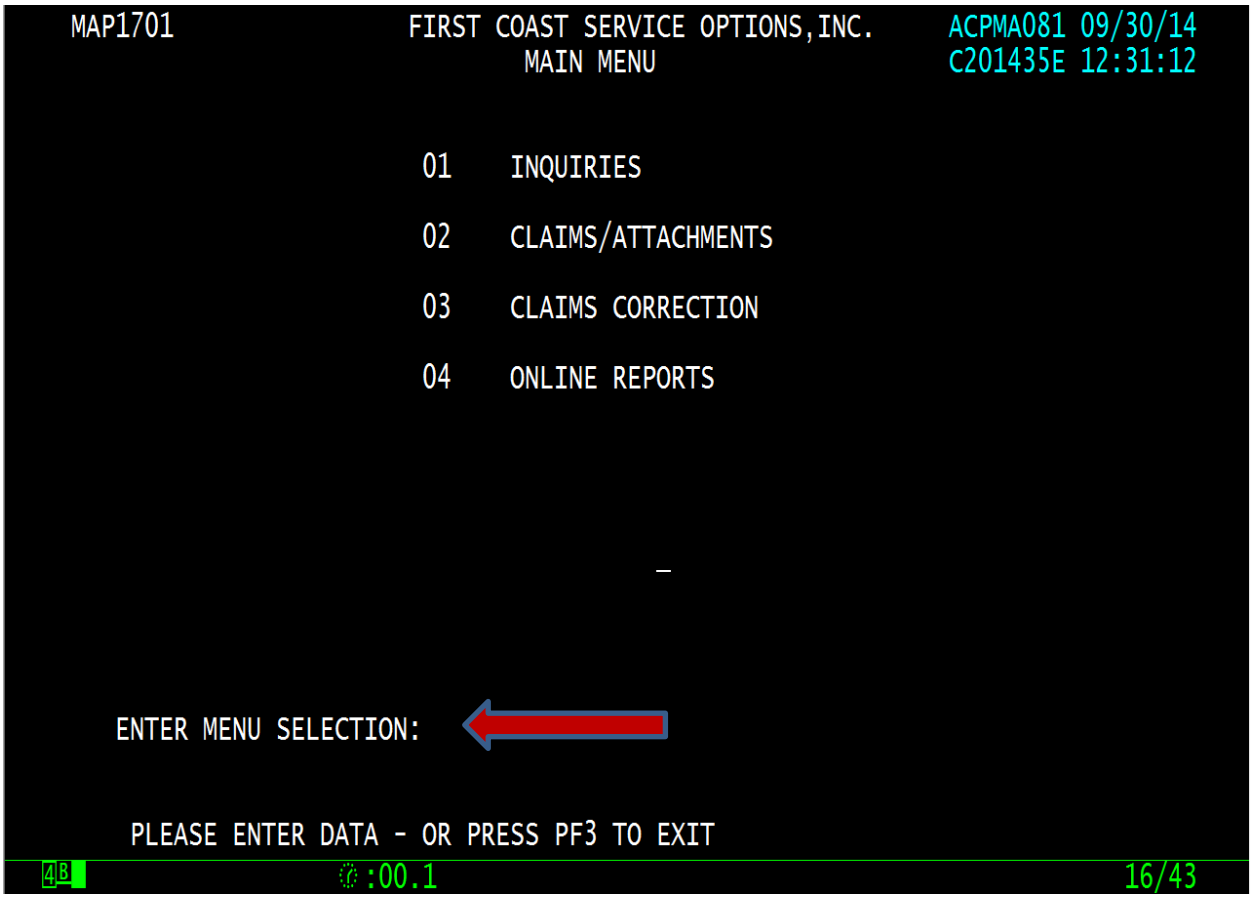


Choose the appropriate selection from the screen above by placing an 'S' next to the Sessid name.

Section 3 – Main Menu

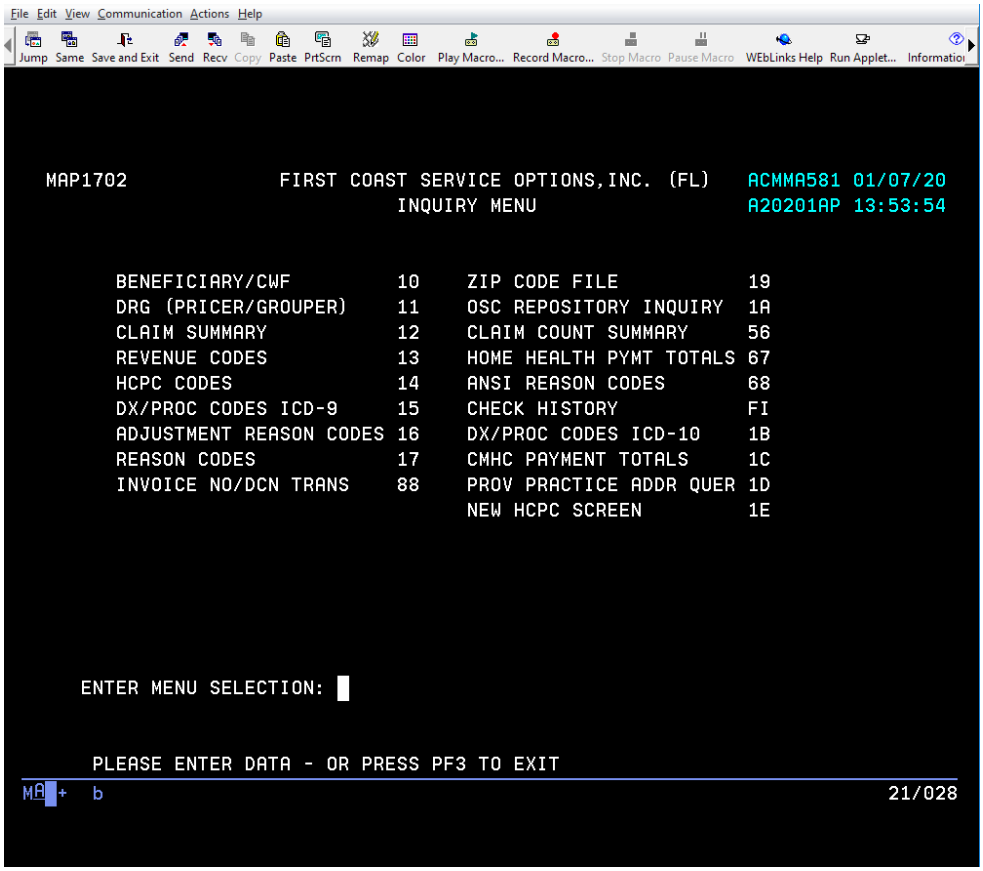
The DDE Online system Main Menu displays after completing the logon procedure. Each menu option at the Main Menu displays a sub-menu for that option.

The Inquiries (01), Claims/Attachments (02), Claims Correction (03) and Online Reports (04) sub-menus are explained in the following sections.



Section 4 – Inquiry Menu (01)

The Inquiry Menu gives DDE users access to the following claims information in an inquiry mode:



The system will automatically enter your provider number into the Provider field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information.

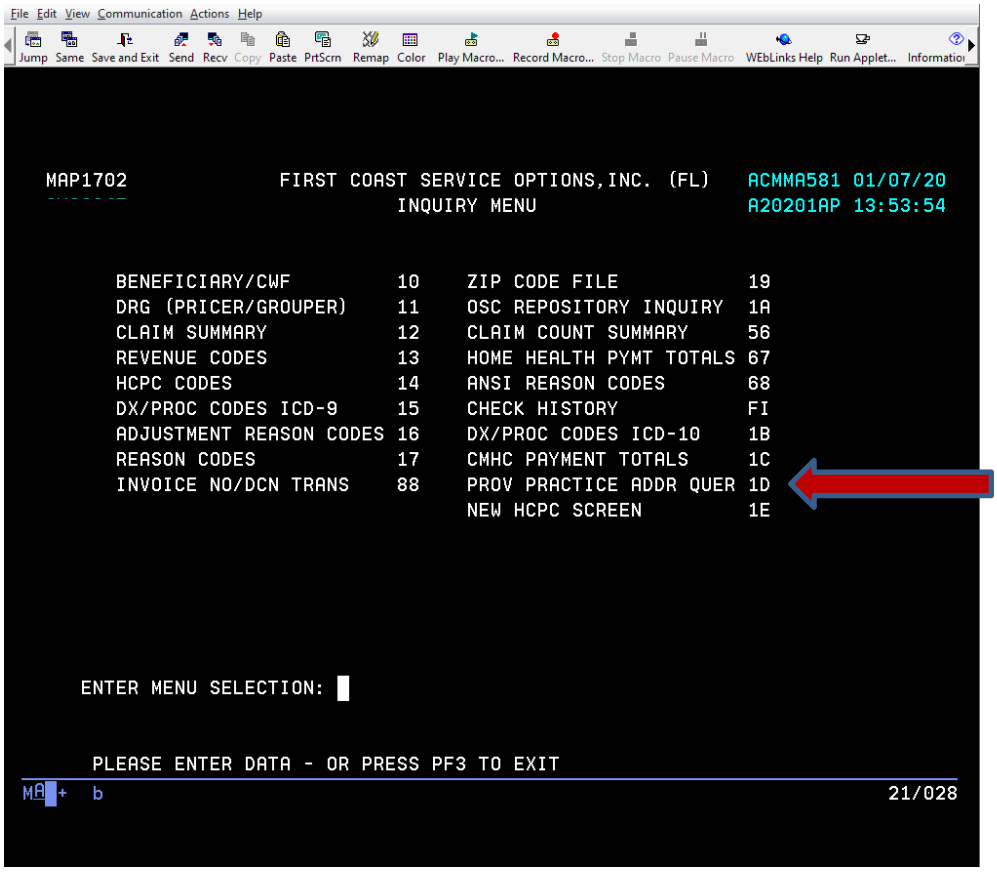
TAB to the provider field and type in the appropriate provider number.

To access the Inquiry Menu, select option 01 from the Main Menu. The Inquiry Menu will display. Information on each of the Inquiry Menu options follows.

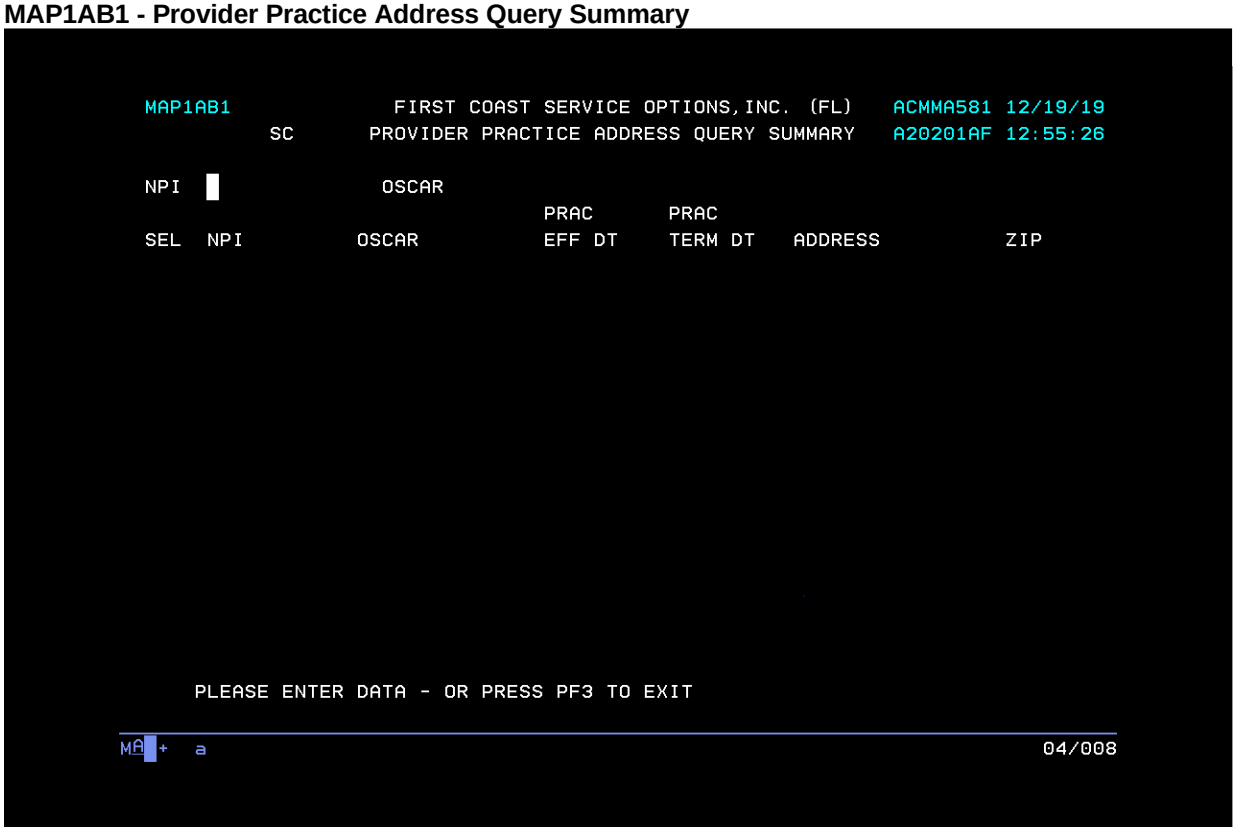
Note: The option 10 – Beneficiary/CWF is no longer updated and the HETS or SPOT should be used to obtain beneficiary information.

MAP1702 - Provider Practice Address Query (1D)

Access the Provider Practice Address Query screen by selecting 1D from the Inquiry Menu Screen.

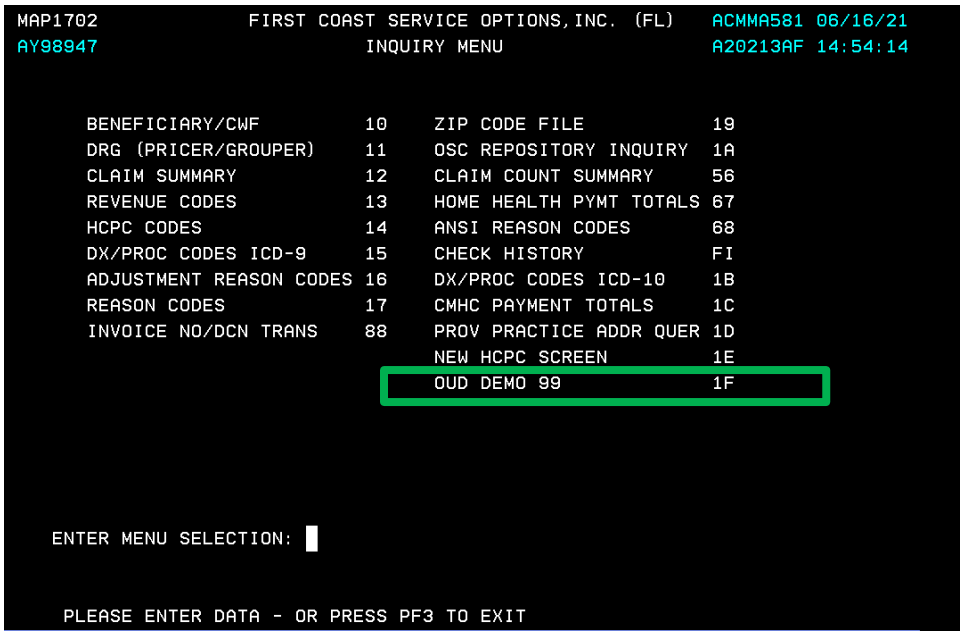


MAP1AB1 - Provider Practice Address Query Summary

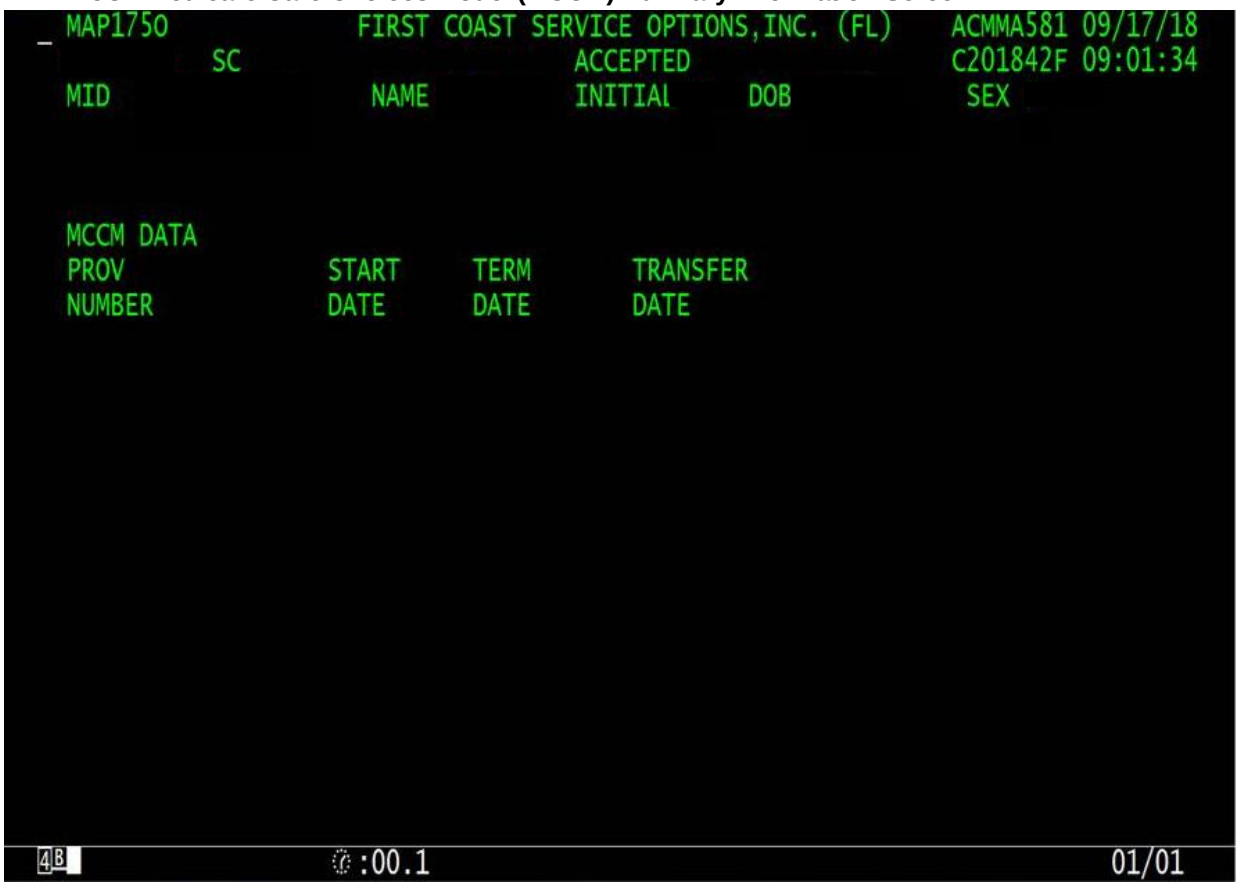


MAP1702 – OUD DEMO 99

Access the Opioid Use Disorder Demo99 - OUD Demo 99 screen by selecting 1F from the Inquiry Menu Screen.



MAP175O - Medicare Care Choices Model (MCCM) Auxiliary Information Screen



MAP1751 - Eligibility Detail Inquiry (10)

General Information about the Common Working File (CWF) System

The Common Working File (CWF) is the source of eligibility and entitlement information for Medicare beneficiaries.

CWF is comprised of nine databases throughout the United States called "Hosts." The Hosts maintain the CWF databases.

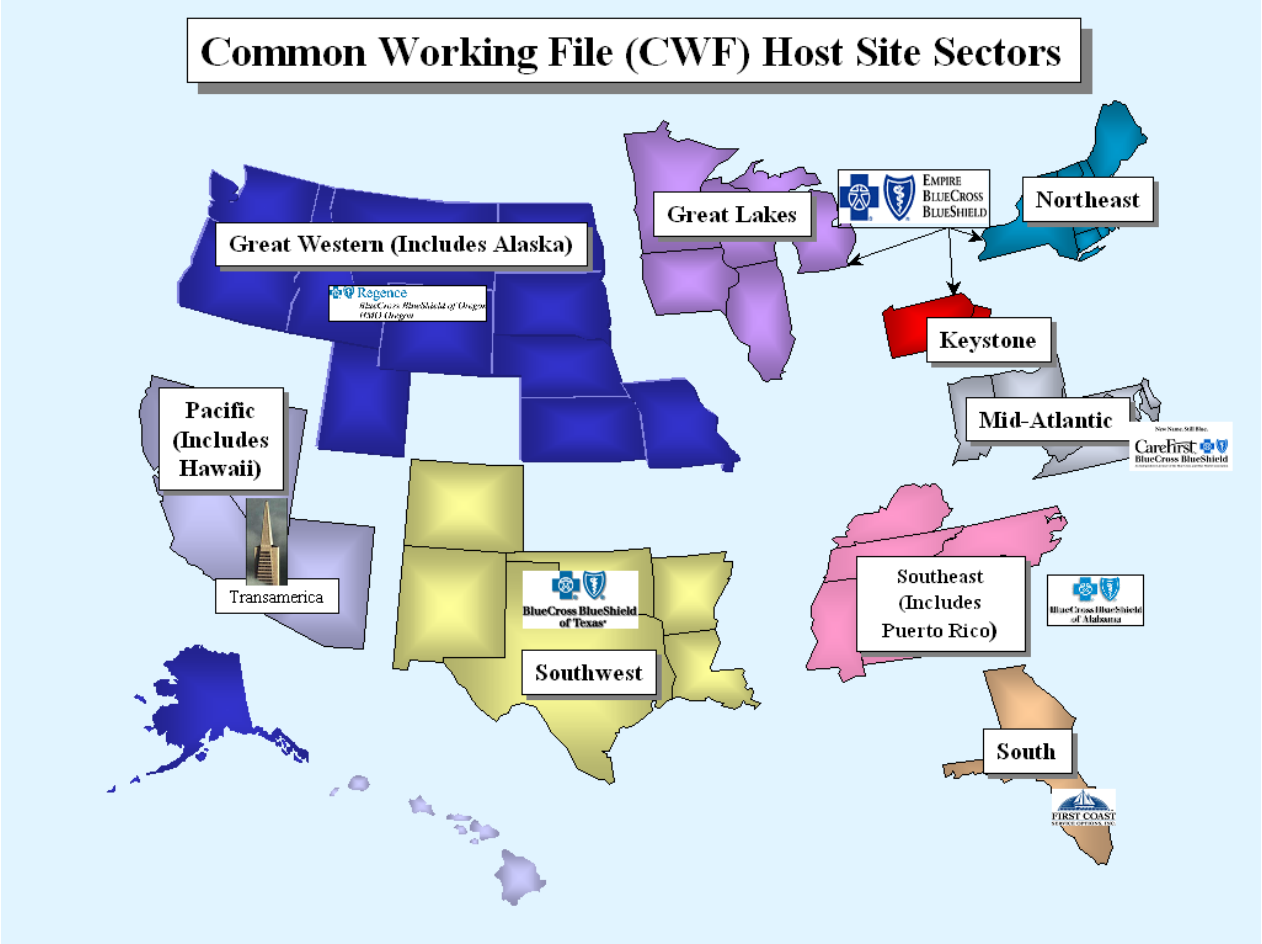
At the point of payment or denial, a detailed claim record is submitted to the Host. The Host uses the CWF data to determine the beneficiary's most recent utilization and entitlement status and uses that information to decide if the claim should be approved for payment.

Claims are processed by CWF in the order they are received, regardless of the dates the services were incurred. This first-in, first-out method of processing requests facilitates prompt handling. Most claims are expedited quickly through CWF. However, sometimes there are delays. Below is an example of a circumstance that can delay payments.

Common Working File (CWF) Host Site Sectors

Great Western (GW)	**Washington; Oregon; Idaho; Montana; Wyoming; Utah; North Dakota; South Dakota; Nebraska; Kansas; Missouri; Alaska; Iowa**
Great Lakes (GL)	Minnesota; Wisconsin; Illinois; Michigan
Pacific (PA)	California; Nevada; Arizona; Hawaii; American Samoa; Guam
Southwest (SW)	Colorado; New Mexico; Oklahoma; Texas; Arkansas; Louisiana
Northeast (NE)	Maine; Vermont; New Hampshire; Massachusetts; Connecticut, New York, Rhode Island
Keystone (KS)	Pennsylvania; New Jersey; Delaware
Mid-Atlantic (MA)	Indiana; Ohio; West Virginia; Maryland; Washington DC; Virginia

Southeast (SE)	Kentucky; Tennessee; North Carolina; South Carolina; Mississippi; Alabama; Puerto Rico; Virgin Islands
Southern (SO)	Georgia; Florida; Railroad Board (RRB)



Not In File (NIF) Error

This response on the reply record indicates that the beneficiary record for which the Fiscal Intermediary submitted a claim is not in the CWF Region being accessed by your Intermediary. Further research may be needed throughout the CWF Hosts to locate the information. Sometimes, because of the complexity of the CWF, it may take extra time to locate the records of a beneficiary. The claim will 'orbit' until all hosts have been polled and, if the information is not found successfully, a CWF error message will be received.

Beneficiary Not Found

If the Eligibility detail inquiry screen reports that the Medicare ID number you keyed in is "Not Found," you may want to check the additional eligibility information, which is contained in CMS's national database, the common working file (CWF). The cursor will automatically position itself in the LN (Last Name) field.

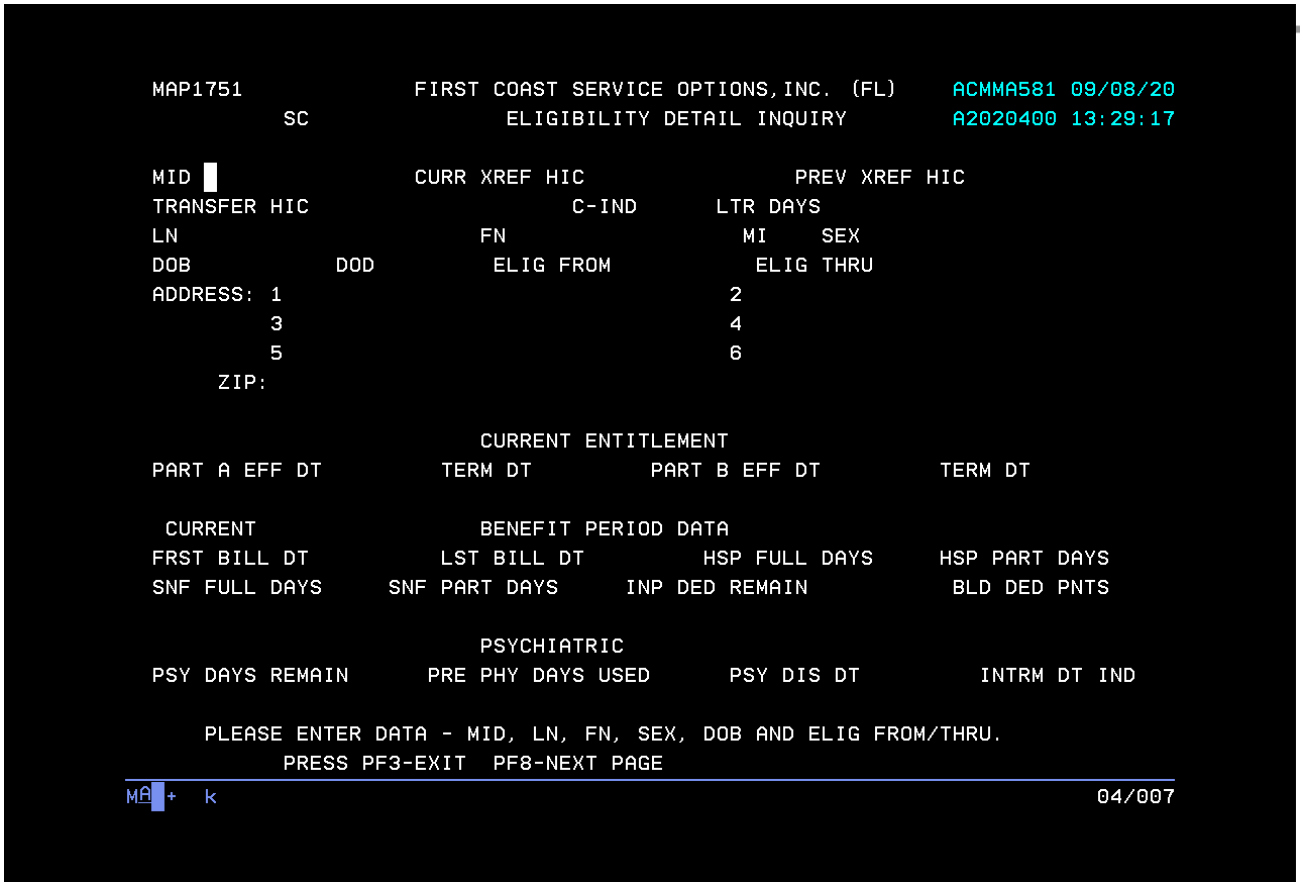
To start the inquiry process to verify eligibility/utilization for a specific beneficiary, enter the following information as it appears on the Medicare card:
Health Insurance Claim (HIC) Number/Medicare Beneficiary Identifier (MBI)

Last Name and First Initial

Note: Include the beneficiary's suffix after the last name to avoid possible mismatches on last name. For example, if the beneficiary's name is John Smith Jr., enter SMITHJR in the last name field.
Gender / Sex

8 digit date of birth in MMDDYYYY format

Use the TAB key to move among the fields. Do not press ENTER until all fields are completed. Once you press ENTER, the system will search for the beneficiary information. If a match is found, the remaining fields will be populated. If the beneficiary record does not exist on the file, the message “Error has occurred in FSS01750AT: STATUS IS: NOT FOUND” appears at the bottom of the screen. If error occurs, verify the beneficiary information and repeat the process.



MAP175J – Beneficiary/CWF Screen

```
MAP175J
           SC
 MID                    NM          IT     DB             SX
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH
CARD/80061                DIAB/82951                  AAA /
CARD/82465                PCBE/G0101                  PTWR/G9143
CARD/83718                DIAB/83036                  IPPE/G0402
CARD/84478                PROS/G0102                  IPPE/G0403
COLO/G0104                PROS/G0103                  IPPE/G0404
COLO/G0105                PAPT/Q0091                  IPPE/G0405
COLO/G0106                GLAU/                       PULM/G0424
COLO/G0120                MAMM/                       CR  /
COLO/G0121                PAPT/                       ICR /
FOBT/G0107                HIBC/G0445                  AWV /G0438
FOBT/G0328                HBV/                        AWV /G0439
FOBT/82270                SETS/93668                  BEHV/G0447
IPPE/G0344                CCBB/G0327                  APRP/G0465
IPPE/G0366                AUDG/
IPPE/G0367                HIVP/
IPPE/G0368                HIVS/
DIAB/82947                HPBV/
DIAB/82950
```

MAP175Q - PRBO Auxiliary File Inquiry

Displays information from CWF for Radiation Oncology Model (PBRO) Auxiliary File for up to 10 episodes of care for a beneficiary.

```
MAP175Q  PG     FISS MAINTAINER - CICSxxx        REGION   MM/DD/Y
xxxxxx   SC    PBRO AUXILIARY FILE INQUIRY         TIME     HH:MM:S

 MID xxxxxxxxxxxx   NAME xxxxxx     INITIAL  x   DOB xxxxxxxx    SEX
PROF-HCPCS  ACT-SOE-DT  ACT-EOE-DT PROF-DIAG-CD RENDERING-NPI TAX-ID-
  TECH-HCPCS  TEMP-SOE-DT  TEMP-EOE-DT  TECH-DIAG-CD  CCN/TIN

 xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx    xxxxxxxxxxx xxxxxxxxxx
  xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx     xxxxxxxxxxxxxx

 xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx    xxxxxxxxxxx xxxxxxxxxx
  xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx     xxxxxxxxxxxxxx

 xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx    xxxxxxxxxxx xxxxxxxxxx
  xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx     xxxxxxxxxxxxxx

 xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx    xxxxxxxxxxx xxxxxxxxxx
  xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx     xxxxxxxxxxxxxx

 xxxxx     xxxxxxxxx   xxxxxxxxx   xxxxxxxxx    xxxxxxxxxxx xxxxxxxxxx
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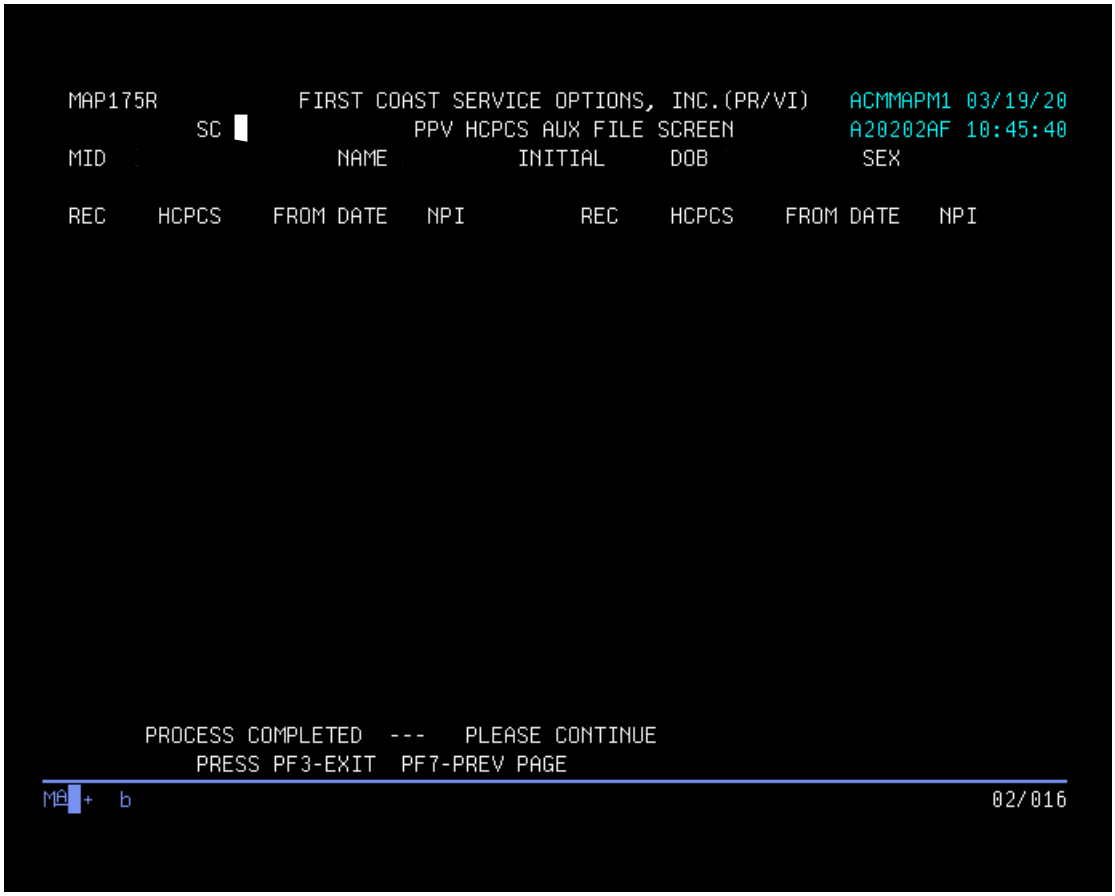
MAP175R – PPV HCPC Aux File Screen

This screen will show PPV HCPCS codes billed and the Date of Service (DOS) used. To access the Inquiry Menu, select option 01 from the Main Menu and then select option 10, Beneficiary /CWF. Key the beneficiary MID (HIC or MBI), Last name, first name, sex, date of birth, and enter.

F8 to MAP1752 and press F8 until you reach MAP175R.



MAP1781 - DRG/PPS Inquiry (11)

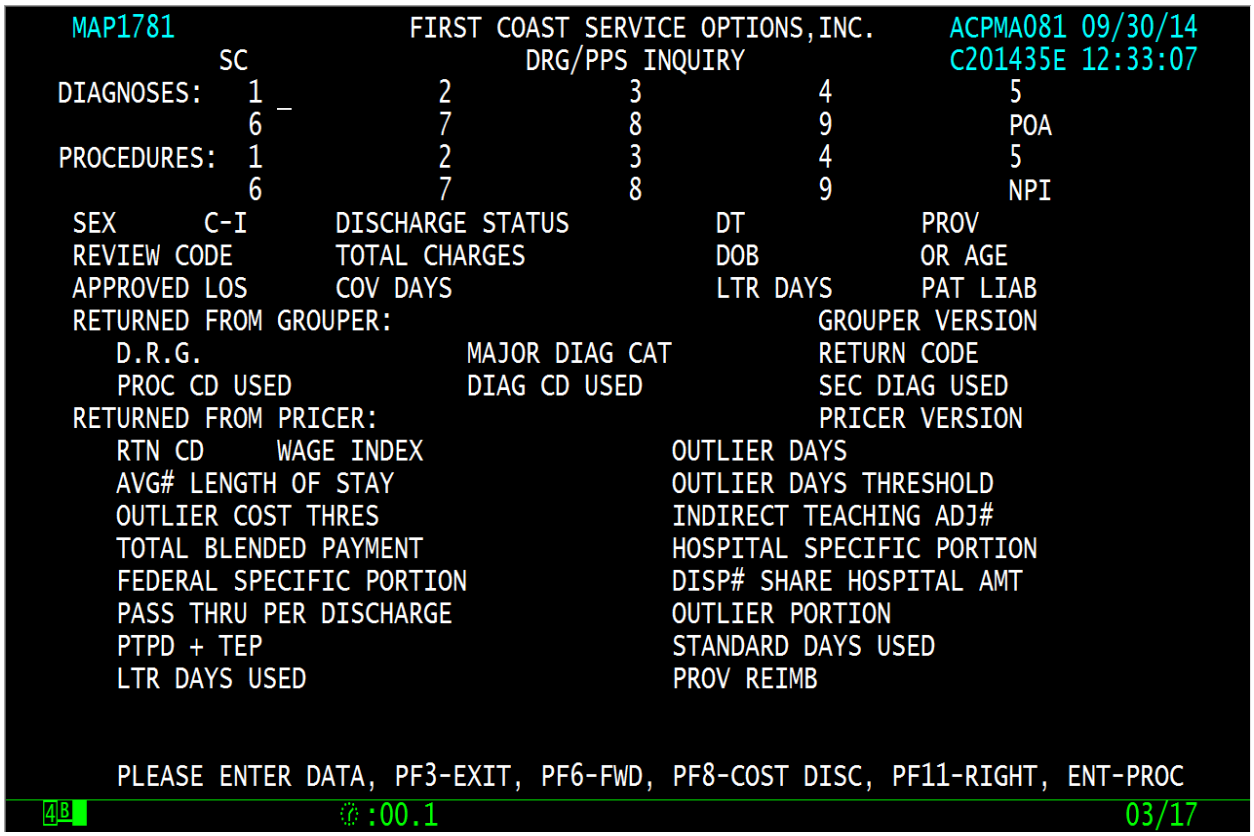
The Diagnostic related grouper/prospective payment system (DRG/PPS) inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs. Its purpose is to provide specific DRG assignment and PPS payment calculations. It should be used to research PPS information as it pertains to an inpatient stay.

To start the inquiry process, enter the following information:

Note: The decimal point is not required for the codes

▪ Diagnosis code	▪ End of POA (present on admission) indicator	▪ Procedure code
▪ National provider identifier (NPI)	▪ Sex	▪ Discharge status
▪ Discharge date	▪ Provider number	▪ Total charge on UB04
▪ Date of birth (Key either age or DOB) MMDDYYYY	▪ Or Age (at time of discharge)	▪ Approved length of stay (must equal covered days)
▪ Covered days (must equal approved length of stay)	▪	▪

TAB to move between fields on the screen, o*nly press* [ENTER] *when all fields have been completed.*



To view the cost disclosure screens press F8, you will see MAP pages 1782-1784.

DIAG CD	This field identifies up to nine ICD-9-CM Diagnosis Codes for conditions coexisting on a particular claim. This is a seven-position alphanumeric field, with 25 occurrences. There are also two additional positions with one being blank, and the next position is the first character of the Present On Admission (POA) Indicator.
POA	This field identifies the End of POA Indicator. This is the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. This is a one-position alphanumeric field. The valid values are: Value Description 'Z' The end of POA indicators for principal and, if applicable, other diagnoses 'X' The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' Not acute care, POA's do not apply
PROC CD	The ICD-9-CM code(s) identifies the principal procedure (1st code) and up to 25 other procedures performed during the billing period covered by this claim. Required for inpatient claims. This is a seven-position alphanumeric field, with 25 occurrences. **Note:** The first page displays occurrences 01 through 09. Pressing PF6 displays occurrences 10 through 18. Pressing PF6 again displays occurrences 19 through 25. The last two occurrences on the last page are protected (no data may be entered.) Pressing PF5 allows the previous page to display.
SEX	This field identifies the beneficiary's sex. This is a one-position alphanumeric field. The valid values are: Value Description 'M' Male 'F' Female
C-I	This field identifies the Century Indicator for when the beneficiary was born. This is a one-digit field. The valid values are: Value Description '8' The beneficiary was born in the 1800's

	'9' The beneficiary was born in the 1900's
DISCHARGE STATUS	This field identifies the discharge status of the patient at the statement through date. This is a two-position alphanumeric field. The valid values are: Value Description 01 Discharged to home or self-care (routine discharge) 02 Discharged/transferred to another short-term general hospital 03 Discharged/transferred to SNF 04 Discharged/transferred to an ICF 05 Discharged/transferred to another type of institution 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice 08 Discharged from outpatient care to be admitted to the same hospital from which the patient received outpatient services 09 Discharged from outpatient care to be admitted to the same hospital from which the patient received outpatient services 20 Expired (Or did not recover – Christian Science Patient) 30 Still a patient 40 Expired at home. For use only on Medicare hospice care claims. 41 Expired in a medical facility, i.e., hospital, SNF, ICF or freestanding hospice 42 Expired – place unknown. For use only on Medicare hospice care claims 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred to a hospital based Medicare approved swing bed 62 Discharged/transferred to inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital. 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH). 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. 64 Discharged/transferred to a psychiatric hospital or psychiatric distinct part of a hospital (effective for discharges on or after April 1, 2004).
DT	This field identifies the discharge date for when the patient was discharged from the type of care. This is a six-position alphanumeric field in MMDDYY format.
PROV	This field displays the provider's identification number of the institution that rendered the services to the beneficiary/patient. This number is assigned by CMS. This is a 13-position alphanumeric field.
REVIEW CODE	Indicates the code used in calculating the standard payment. The valid values are: 00 – Pay with outlier 04 – Pay average stay only 01 – Pay days outlier 05 – Pay transfer with cost 02 – Pay cost outlier 06 – Pay transfer no cost 03 – Pay per diem days 07 – Pay without cost
TOTAL CHARGES	This field identifies the total charges as submitted on the claim. This is a nine-digit field in 9999999.99 formats.
D.O. B.	This field identifies the date of birth for the beneficiary. This is an eight-position alphanumeric field in MMDDYYYY format.
OR AGE	This field identifies the age of the beneficiary. This or the date of birth may be used to identify the age of the patient. This is a three-digit field.
APPROVED LOS	This field identifies the approved number of days (length of stay) for treatment. This field is necessary for Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay is the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay. This is a three-digit field.
COV DAYS	This field identifies the number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the

	assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary. This is a three-digit field.
LTR DAYS	This field identifies the number of Lifetime Reserve Days used for a particular claim. This is a three-digit field.
PAT LIAB	This field identifies the patient liability that is due, which is the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges. This is a nine digit field in 999999.99 format.

After the DRG has been assigned by the system and the PPS payment has been determined, the following information will be displayed on the screen under Returned from Grouper or Returned from Pricer.

D.R.G. MAJOR DRG CAT	The DRG number assigned by the grouper. Identifies the category in which the DRG resides. Valid values are: Value Description 01 Diseases and disorders of the nervous system 02 Diseases and disorders of the eye 03 Diseases and disorders of the ear, nose, mouth and throat 04 Diseases and disorders of the respiratory system 05 Diseases and disorders of the circulatory system 06 Diseases and disorders of the digestive system 07 Diseases and disorders of the hepatobiliary system and pancreas 09 Diseases and disorders of the musculoskeletal system and connective tissue 10 Endocrine, nutritional, and metabolic diseases and disorders 11 Diseases and disorders of the kidney and urinary tract 12 Diseases and disorders of the male reproductive system 13 Diseases and disorders of the female reproductive system 14 Pregnancy, childbirth and the puerperium 15 Newborns and other neonates with conditions originating in the prenatal period 16 Diseases and disorders of the blood and blood forming organs and immunological disorders 17 Myeloproliferative diseases and disorders, and poorly differentiated neoplasms 18 Infectious and parasitic diseases 19 Mental diseases and disorders 20 Alcohol/Drug use and alcohol/drug induced organic mental disorders 21 Injuries, poisonings, and toxic effects of drugs 22 Burns 23 Factors influencing health status and other contacts with health services 24 Multiple significant traumas 25 Human immunodeficiency viral infections
RTN CT	This field identifies the return code (status) of the claim when it has returned from the Grouper program. This is a one-position alphanumeric field. <u>Return codes 00-49 describe how the bill was priced:</u> Value Description 00 Priced standard DRG payment 01 Paid as day outlier/send to PRO for post payment review 02 Paid as cost outlier/send to PRO for post payment review 03 Paid as per diem/not potentially eligible for cost outlier 04 Standard DRG but covered days indicate day outlier but day or cost outlier status was ignored 05 Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 Pay per diem days for transfers without an approved outlier 10 Bad state code for SNF RUG demo or post-acute transfer for inpatient PPS pricer DRG is 209, 210, or 211

	12 Post-acute transfer with specific DRGs of 14, 113, 236, 264, 429, 483 14 Paid normal DRG payment with perdiem days = or > average length of stay 16 Paid as a cost outlier with perdiem days = or > average length of stay 20 Bad revenue code for SNF RUG demo or invalid HIPPS code for SNF PPS pricer 30 Bad metropolitan statistical area (MSA) code <u>Return codes 50-99 describe why the bill was not priced:</u> Value Description 51 No provider specific information found 52 Invalid MSA in provider file 53 Waiver State – not calculated by PPS 54 DRG not '001' – '468' or '471' – '910' 55 Discharge date is earlier than provider's PPS start date 56 Invalid length of stay 57 Review code not '00' – '07' 58 Charges not numeric 59 Possible day outlier candidate 60 Review code '02' and length of stay indicates day outlier, bill is thus not eligible as cost outlier 61 Lifetime reserve days are not numeric 62 Invalid number of covered days; (i.e., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) 63 Review code of '00' or '03' and bill is cost outlier candidate 64 Disproportionate share percentage and bed size conflict on provider specific files 98 Cannot process bill older than 10/01/87
PROC CD USED	This field identifies the procedure code used by the Grouper program for calculation. The procedure code is an ICD-9-CM code(s) that identifies the principal procedure(s) performed during the billing period covered by this claim. Required for inpatient claims. This is a seven-position alphanumeric field.
DIAG CD USED	This field identifies the primary ICD-9-CM diagnosis code used by the Grouper program for calculation. This is a seven-position alphanumeric field. **Note:** Refer to the ICD-9-CM manual for valid codes.
SEC DIAG USED	This field identifies the secondary ICD-9-CM diagnosis code used by the Grouper program for calculation. This is a six-position alphanumeric field. **Note:** Refer to the ICD-9-CM manual for valid codes.
GROUPER	The program identification number for the Grouper program used.
RTN CD	Return code identifies the status of the claim when it has returned from the Pricer program. <u>Return codes 00-49 describe how the bill was priced:</u> Value Description 00 Priced standard DRG payment 01 Paid as day outlier/send to PRO for post payment review 02 Paid as cost outlier/send to PRO for post payment review 03 Paid as per diem/not potentially eligible for cost outlier 04 Standard DRG but covered days indicate day outlier but day or cost outlier status was ignored 05 Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 Pay per diem days for transfers without an approved outlier <u>Return codes 50-99 describe why the bill was not priced:</u> Value Description 51 No provider specific information found 52 Invalid MSA in provider file 53 Waiver State – not calculated by PPS 54 DRG not '001' – '468' or '471' – '910'

	55 Discharge date is earlier than provider's PPS start date 56 Invalid length of stay 57 Review code not '00' – '07' 58 Charges not numeric 59 Possible day outlier candidate 60 Review code '02' and length of stay indicates day outlier. Bill is thus not eligible as cost outlier. 61 Lifetime reserve days are not numeric 62 Invalid number of covered days; (i.e., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) 63 Review code of '00' or '03' and bill is cost outlier candidate 64 Disproportionate share percentage and bed size conflict on provider specific files 98 Cannot process bill older than 10/01/87
WAGE INDEX	This field identifies the wage index as supplied by CMS to be used for the state in which the services were provided to determine reimbursement rates for the services rendered. This is a seven-digit field in 99.9999 formats.
OUTLIER DAYS	This field identifies the number of Outlier days beyond the cutoff point for the applicable DRG. This is a three-digit field.
AVG # LENGTH OF STAY	The average length of stay for the assigned DRG. This is a four digit numeric field in 99.99 format.
OUTLIER DAYS THRESHOLD	This field identifies the Outlier Days Threshold. This is the number of days of utilization permissible for the DRG code in this claim. Day outlier payment is made when the length of stay (including days for a beneficiary awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS mandated adjustment calculation. This is a four-digit field in 99.9 formats.
OUTLIER COST THRESHOLD	This field identifies the Outlier Cost Threshold. If the claim has extraordinarily high charges and does not qualify as a day outlier, then the claim may qualify as a cost outlier. The additional payment amount is the applicable Federal rate percentage times 75 percent of the difference between the hospital's cost for the discharge and the threshold criteria established for the applicable DRG. This is an eleven-digit field in 9999999.999 formats.
INDIRECT TEACHING ADJ#	This field identifies the indirect teaching amount of the adjustment calculated by the Pricer program for teaching hospitals. This is a nine-digit field in 999999.99 formats.
TOTAL BLENDED PAYMENT	This field identifies the total PPS blended payment amount consisting of the Federal, hospital, outlier and indirect teaching portions. This is a nine-digit field in 999999.99 formats. **Note:** This amount represents the payment before any reductions (such as Gramm Rudman) or additions (such as interest).
HOSPITAL SPECIFIC PORTION	This field identifies the hospital specific portion of the total blended payment used in reimbursing this PPS claim. This is a nine-digit field in 999999.99 formats.
FEDERAL SPECIFIC PORTION	This field identifies the Federal specific portion of the total blended payment used in reimbursing this PPS claim. This is a nine-digit field in 999999.99 formats.
DISP# SHARE HOSPITAL AMT	This field identifies the disproportionate share hospital amount. This is the percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI (this percentage is supplied by CMS). Medicaid days and total days are available on the hospitals' cost reports. This is a nine-digit field in 999999.99 formats.
PASS THRU PER DISCHARGE	This field identifies the pass through per discharge cost. This is a five-digit field in 999.9 formats.
OUTLIER PORTION	This field identifies the dollar amount calculated that reflects the outlier portion of the charges. This is a ten-digit field in 9999999.99 formats.
PTPD + TEP	This field identifies the sum of the pass through per discharge cost plus the total blended payment amount. This is a nine-digit field in 999999.99 formats.

STANDARD DAYS USED	This field identifies the number of standard Medicare Part A days covered for this claim. This is a three-digit field.
LTR DAYS USED	This field identifies the number of Lifetime Reserve Days used during this benefit period. This is a three-digit field.
PROV REIM	This field identifies the provider reimbursement amount. This is the actual payment amount to the provider for this claim. This is the amount on the Remittance Advice/Voucher. This is an eleven-digit field in 99999999.99 formats.
PRICER VER	The program version number for the Pricer program used.

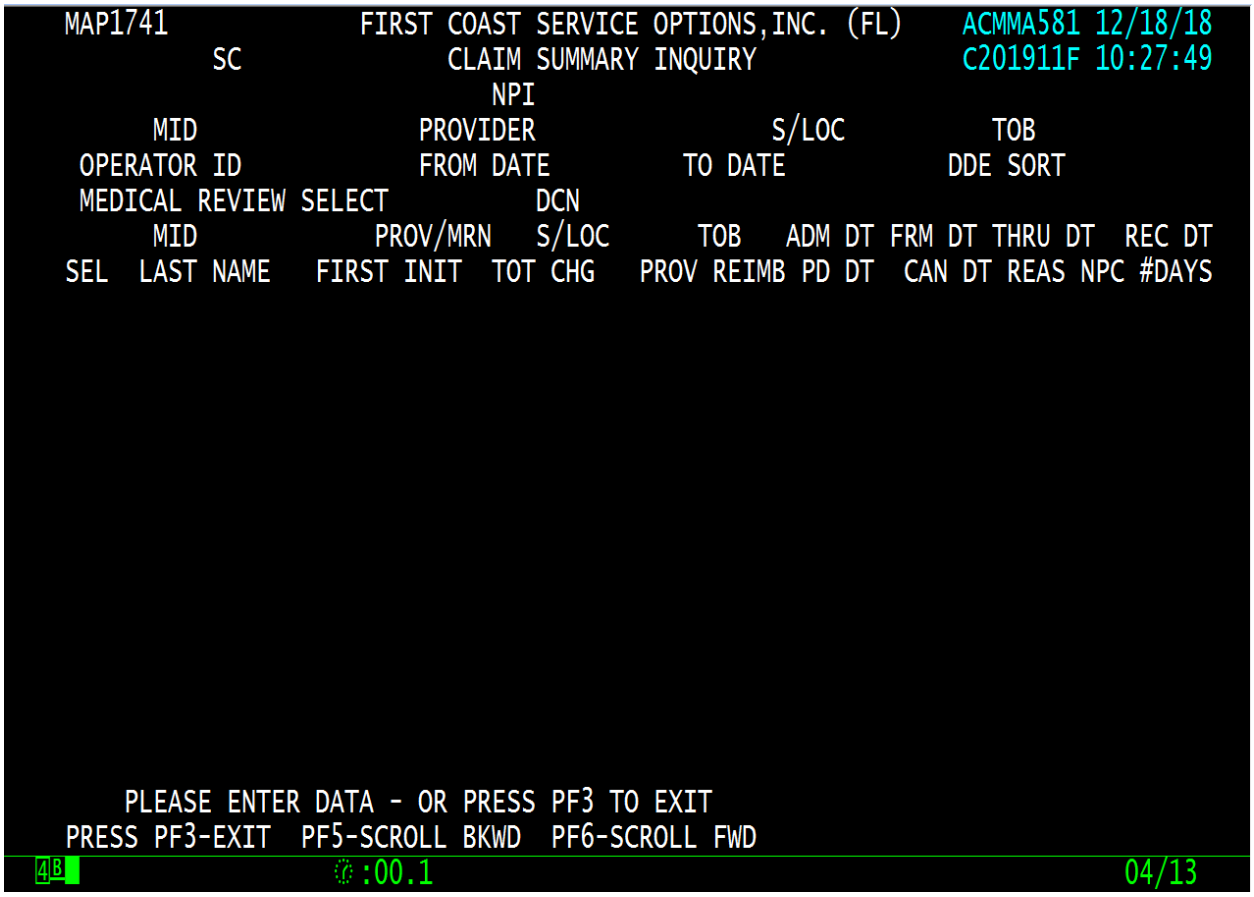
MAP1741 - Claims Summary Inquiry (12)

The claims summary inquiry screen displays specific claim history information for *all* pending (RTP claims, MSP claims, medical review claims) and processed (paid, rejected, denied) claims. The claim status information is available on-line for viewing immediately after the claim is updated/ entered on DDE. The entire claim (six pages) can be viewed on-line through the claim inquiry function but it cannot be updated from this screen.

Common status and location codes (S/LOC) are listed in the following table.

Code	Description
P B9996	Payment floor
P B9997	Paid/Processed claim
P B7501	Post-pay review
P B7505	Post-pay review
R B9997	Claims processing rejection
D B9997	Medical review denial
T B9900	Daily return to provider (RTP) claim – not yet accessible
T B9997	RTP claim – claim may be accessed and corrected through the Claim and Attachments Corrections Menu (Main menu option 03)
S B0100	Beginning of the FISS batch process
S B6000	Claims awaiting the creation of an additional development request (ADR) letter. Do not press [F9] on these claims because FISS will generate another ADR.
S B6001	Claims awaiting a provider's response to an ADR letter
S B6099	Claims awaiting a provider's response to an ADR letter
S B9000	Claims ready to go to a common working file (CWF) host site
S B9099	Claims awaiting a response from a CWF host site

To start the inquiry process, enter the beneficiary's Medicare ID number and the dates of service for the claim you wish to see and press ENTER. DDE will display a list of all claims for the date you specified for that beneficiary. You can customize your search by entering the Medicare ID number in combination with any of the following fields: TOB, Status/Location and From/To date before pressing enter.



Field name	Description
NPI	This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field.
MEDICARE ID	This field identifies the health insurance claim number assigned to the beneficiary by CMS. This is a 12-position alphanumeric field.
PROVIDER	This field displays the identification number of the institution that rendered services to the beneficiary/patient. This field is pre-filled by the system for external operators that are directly associated with one provider (as indicated on the operator control file). This number is assigned by CMS. This is a 13-position alphanumeric field.
S/LOC	This field is a combination of status and location. The first-alphanumeric position represents the status of the claim. The next five-alphanumeric positions represent the location of the claim.
TOB	This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field. **Note:** The first two (2) positions are required for search. The third position is optional.
OPERATOR ID	This field identifies the operator identification number that is currently utilizing the file, based on the logon ID. This is a nine-position alphanumeric field.
FROM DATE	This field identifies the first date to be covered in the period included on a claim. This is a six-position alphanumeric field in MMDDYY format.
TO DATE	This field identifies the last date to be covered in the period included on a claim. This is a six-position alphanumeric field in MMDDYY format.
DDE SORT	This field allows the listed claims to be sorted according to specific criteria. This is a one-position alphanumeric field. The valid values are: Value Description 'M' Medical record number sort 'N' Name sort 'H' Medicare ID sort

Field name	Description
	'R' Reason code sort 'D' Receipt date sort ' ' TOB/DNC sort
MEDICAL REVIEW SELECT	This field is used to narrow the claim selection for inquiry. This provides the ability to view only claims pending or returned for medical review, or non-medical review. This is a one-position alphanumeric field. The valid values are: Value Description ' ' Selects all claims '1' Selects all claims '2' Selects all claims excluding medical review '3' Selects medical review only
MEDICARE ID	This field identifies the Health Insurance Claim Number assigned to the beneficiary by CMS. This is a 12- position alphanumeric field.
PROV/MRN	The provider number/medical record number field displays either the provider number or the medical record number of the claim. If no value is entered in the DDE SORT field, the PROV/MRN field displays the Provider number. If the DDE SORT field contains a valid value, the PROV/MRN field displays the medical record number. This is a 17-position alphanumeric field.
S/LOC	This field is a combination of status and location. The first-alphanumeric position represents the status of the claim. The next five-alphanumeric positions represent the location of the claim.
TOB	This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field.
ADM DT	This field identifies the date the patient was admitted to the facility for inpatient care. This is a six-position alphanumeric field in MMDDYY format.
FRM DT	This field identifies the beginning service date for the claim. This is a six-position alphanumeric field in MMDDYY format.
THRU DT	This field identifies the ending service date for the claim. This is a six-position alphanumeric field in MMDDYY format.
REC DT	This field identifies the date the claim was received by the Medicare Intermediary. This is a six-position alphanumeric field in MMDDYY format.
SEL	Key an 'S' to select a specific claim. Press ENTER to display 'detailed' claim information for the claim you selected. Refer to the Claim Entry section of the DDE manual for descriptions of the fields on the entire claim inquiry screen.
LAST NAME	This field identifies the patient's last name at the time services were rendered. This is a 20-position alphanumeric field. Spaces and special characters are prohibited for this field.
FIRST INIT	This field identifies the first initial of the patient's first name at the time services were rendered. This is a one-position alphanumeric field.
TOT CHG	This field identifies the total charges as submitted on the claim. This is a nine-digit field in 9999999.99 format.
PROV REIMB	This field identifies the amount of actual payment to a provider on an individual claim. This is a nine-digit field in 9999999.99 format.
PD DT	This field identifies the date that the claim is paid or written to the Remittance Advice. This is a six-position alphanumeric field in MMDDYY format.
CAN DT	This field identifies the date of cancellation of original payment when an adjustment has been processed through the system. This is a six-position alphanumeric field in MMDDYY format.
REAS	This field identifies a specific condition detected during processing a record. Each position of the reason code further identifies the process being performed. This is a five-position alphanumeric field.
NPC	This field identifies the non-pay codes; which is the reason for Medicare's decision not to make payment. This is a two-position alphanumeric field. Value Description B Benefits exhausted

Field name	Description
	C Non-covered care (discontinued) E First claim development (Contractor 11107) F Trauma code development (Contractor 11108) G Secondary claims investigation (Contractor 11109) H Self reports (Contractor 11110) J 411.25 (Contractor 11111) K Insurer voluntary reporting (Contractor 11106) N All other reasons for non-payment P Payment requested Q MSP voluntary agreements (Contractor 88888) or Employer voluntary reporting (Contractor 11105) R Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, or waiver of liability T MSP initial enrollment questionnaire (Contractor 11101 or 99999) U MSP HMO cell rate adjustment (Contractor 55555) U HMO/Rate Cell (Contractor 11103) V MSP litigation settlement (Contractor 33333) V Litigation settlement (Contractor 11104) W Workers compensation X MSP cost avoided Y IRS/SSA data match project MSP cost avoided (Contractor 77777) Y IRS/SSA CMS data match project cost avoided (Contractor 11102) Z System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows FISS to process the claim to CWF and allows CWF to accept the claim as billed. 00 COB contractor (Contractor 11100) 12 Blue Cross Blue Shield voluntary agreements (Contractor 11112) 13 Office of personnel management (OPM) data match (Contractor 11113) 14 Workers' compensation (WC) data match (Contractor 11114) 15 Workers compensation insurer voluntary data sharing agreements (WC VDSA) (contractor 1115) 16 Liability insurer VDSA (Contractor 11116) 17 No-fault insurer VDSA (Contractor 11117) 18 Pharmacy benefit manager data sharing agreement (Contractor 11118) 19 Workers compensation Medicare set-aside arrangements (WCMSA) (Contractor 11119) 21 MIR group health plan (Contractor 11121) 22 MIR non-group health plan (Contractor 11122) 25 Recovery audit contractor MSP (California) (Contractor 11125) 26 Recovery audit contractor MSP (Florida) (Contractor 11126) 39 Group health plan recovery (Contractor 11139) 42 Non-group health plan ORM recovery (Contractor 11142)
# DAYS	This field identifies the number of days in which a claim has remained in an 'RTP' (return to provider) status. The number is based on the claim paid date and the current system date. This is a three-digit field.

Performing Claims Inquiries

1. To start the inquiry process, enter the beneficiary's Medicare number or enter any of the following field:
   - Enter TOB
   - Status/Location
     - Enter a 'S' in the first position of the S/LOC field to view all the suspended claims
     - Enter a 'P' in the first position of the S/LOC field to view all the paid/processed claims
     - Enter a 'T' in the first position of the S/LOC field to view claims returned for correction
   - From date (optional field – enter a date if you only want to view claims within a certain date range)

- To date (option field – enter a date only if you want to view claims within a certain date range)

2. Once the appropriate claim history displays, enter an 'S' in the SEL field in front of the claim you wish to view.
3. Press [ENTER] to display the DDE claim. Refer to section 5 – Claim entry for illustrations of the UB-04 claim screens and field descriptions.

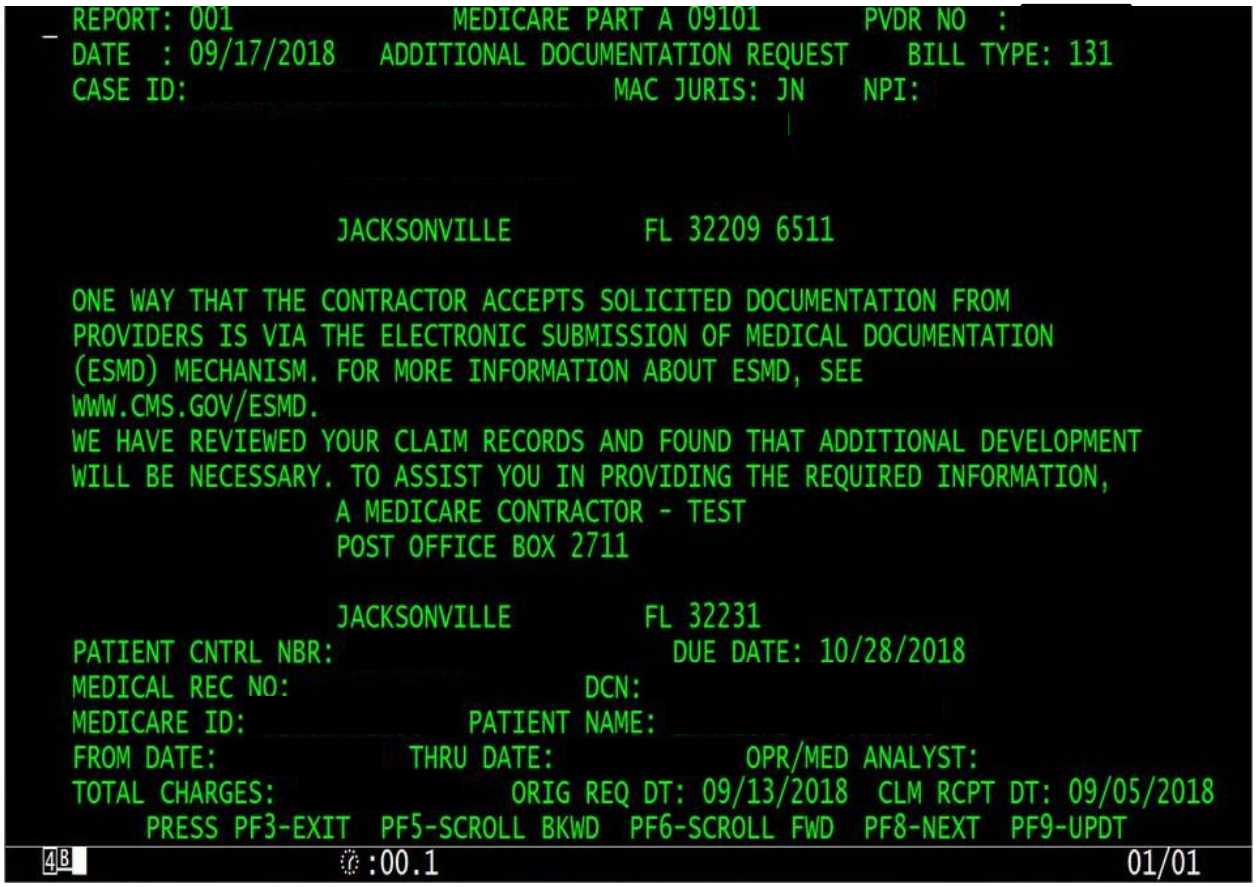
Note: Only one claim can be selected at a time.

Viewing an Additional Development Request (ADR) Letter

An ADR is an additional development request for medical records. First Coast Service Options, Inc. medical review department uses ADRs to request medical records from providers during the medical review process. Do the following to view an ADR letter for claims in the ADR status/location:

1. Type 'S B6' in the S/LOC field
2. Press [ENTER] and all claims in an S B6000, S B6001 and S B6099 status/location will display.
3. Type an 'S' in the SEL field of the desired claim and press [ENTER]
4. The ADR letter immediately follows claim page 6 (MAP 1716). The ADR will consist of two pages, to go to the second page press 'F8'.

NOTE: Do not use the [F9] function key with these claims. If you press [F9] FISS will generate a new ADR.

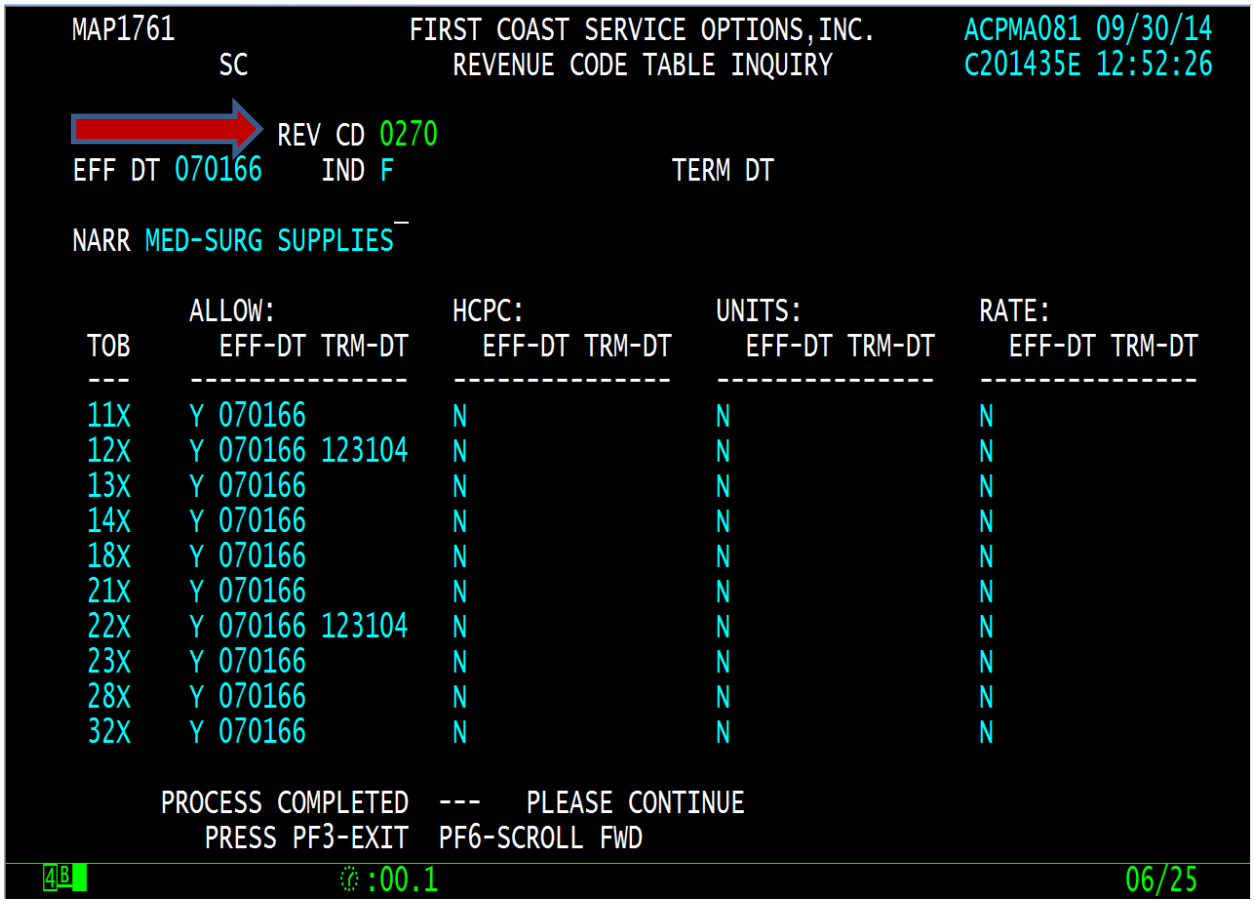


MAP1761 - Revenue Code Table Inquiry (13)

This screen provides information regarding revenue codes that are billable for certain types of bills with FISS. This should be referenced when you need to determine:

- The type of revenue codes that are allowed with certain types of bills
- If a HCPCS code is required
- If a unit is required
- If a rate is required

To start the inquiry type in the revenue code you are inquiring on and press [ENTER]



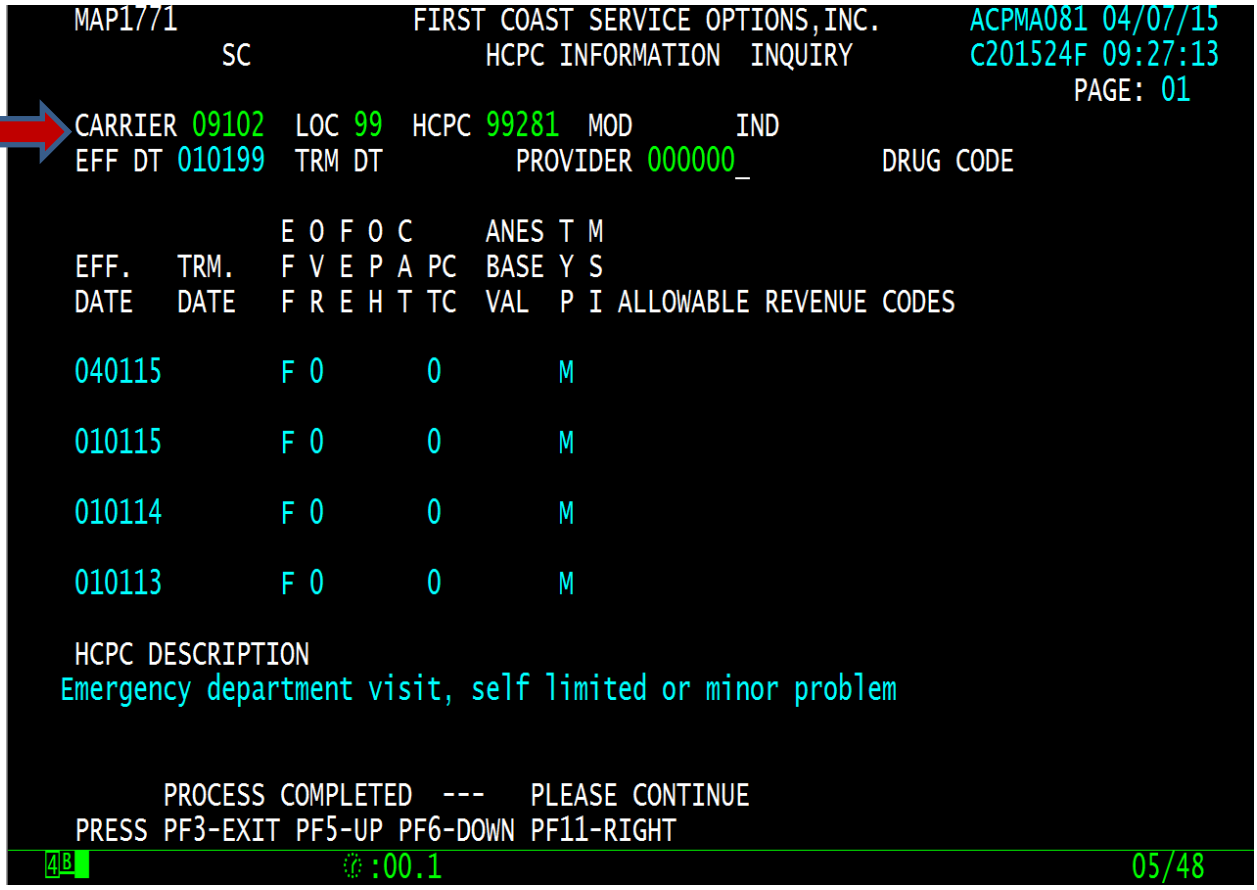
Field name	Description
REV CD	This field identifies the specific service that is being billed for Medicare reimbursement. This is a four-position alphanumeric field. The valid values are 0001 through 9999.
EFF DT	This field identifies the date this revenue code became effective. This is a six-position alphanumeric field in MMDDYY format.
IND	The effective indicator instructs the system to either use the FROM date on the claim or to use the system run date to perform edits for this particular revenue code. This is a one-position alphanumeric field. The valid values are: Value Description 'F' Claim from date 'R' Claim receipt date 'D' Claim discharge date
TERM DT	This field identifies the date this revenue code became invalid. This is a six-position alphanumeric field in MMDDYY format.
NARR	This field identifies the description or narrative for the revenue code. This is a 70-position alphanumeric field.
TOB	This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field.
ALLOW	This field identifies whether or not this revenue code is currently valid. This is a one-position alphanumeric field. The valid values are: Value Description 'Y' Yes 'N' No

Field name	Description
EFF-DT	This field identifies when the revenue code became a valid code. This is a six-position alphanumeric field in MMDDYY format.
TRM-DT	This field identifies when the revenue code was no longer a valid code. This is a six-position alphanumeric field in MMDDYY format.
HCPC	This field identifies whether or not a HCPC code is required for this revenue code. This is a one- position alphanumeric field. The valid values are: Value Description 'Y' Yes 'N' No
EFF-DT	This field identifies the beginning date for the HCPC code requirement. This is a six-position alphanumeric field in MMDDYY format.
TRM-DT	This field identifies the ending date for the HCPC code requirement. This is a six-position alphanumeric field in MMDDYY format.
UNITS	Identifies if the revenue code requires units to be present for a specific type of bill. Valid values are: Value Description 'Y' Yes 'N' No
RATE	Identifies if the revenue codes require a rate to be present for a specific type of bill. Valid values are: Value Description 'Y' Yes 'N' No

MAP1771 - HCPC Information Inquiry (14)

This screen displays the current rate utilized to price specific outpatient services identified by a HCPCS code. FISS performs pre-payment processing of HCPCS codes for laboratory services; but radiology, ambulatory surgery center (ASC), durable medical equipment (DME), and medical diagnostics HCPC service codes are processed post-payment.

To start the inquiry process, enter the HCPCS code and the locality code, then press [ENTER].



Field name	Description
CARRIER	This field identifies the carrier number assigned to the HCPC being displayed and is system generated. This is a five-position alphanumeric field.
LOC	This field identifies a two position alphanumeric identification number for the area (or county) where the provider is located. This field accepts as a valid value only the six locality codes entered on the provider file (MAP1101) and '01'. If a HCPC does not exist for the specific locality, the system defaults to '01'. If you enter an invalid value in this field, the system defaults to the most recent locality code on the provider file.
HCPC	Key the five-digit HCPC code to view.
MOD	This field identifies the HCPC modifier with multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC. This is a two-position alphanumeric field.
IND	Not applicable.
EFF DT	This field identifies the national drug code effective date. This is a six-digit field in MMDDYY format.
TRM DT	This field identifies the national drug code termination date. This is a six-digit field in MMDDYY format.
PROVIDER	This field identifies the identification number of the alias provider. This is a 13-position alphanumeric field.

Field name	Description
DRUG CD	This field identifies whether the HCPC is a drug. This is a one position alphanumeric field. The valid values are: Value Description 'E' The HCPC is a drug ' ' The HCPC is not a drug
EFF DATE	This field identifies when the change in pricing went into effect. This is a six-position alphanumeric field in MMDDYY format, with four occurrences.
TRM DATE	This field identifies the termination date for each rate listed for this HCPC. This is a six-position alphanumeric field in MMDDYY format, with four occurrences.
EFF	This indicator instructs the system to use From and Through dates on claims or to use the system run date to perform edits for this particular HCPCS date. This is a one-position alphanumeric field. The valid values are: Value Description 'R' Claim receipt date 'F' Claim from date 'D' Discharge date
OVR	The override code instructs the system in applying the services to the beneficiary's deductible and coinsurance. This is a one-position alphanumeric field. Value Description 0 Apply deductible and coinsurance 1 Do not apply deductible 2 Do not apply coinsurance 3 Do not apply deductible or coinsurance 4 No need for total charges 5 RHC or CORF psychiatric A Voluntary agreement H HMO cell rate I IRS/SSA/CMS date match project L Litigation M EGHP N Non-EGHP Q Initial enrollment questionnaire Y MSP cost avoided
FEE	This field identifies the fee indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position field, with six occurrences. The valid values are: Value Description ' ' Default value 'B' Bundled procedure 'R' Rehab/audiology function test/CORF services
OPH	This field identifies the outpatient hospital indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position alphanumeric field, with six occurrences. The valid values are: Value Description ' ' HCPCS not affected, does not require an update '0' Fee is applicable '1' Fee is not applicable
CAT	This field identifies the CMS category code of the DME equipment. This is a one-position alphanumeric field. The valid values are: Value Description '1' Inexpensive or other routinely purchased DME '2' DME items requiring frequent maintenance and substantial servicing '3' Certain customized DME items '4' Prosthetic and orthotic devices '5' Capped rental DME items '6' Oxygen and oxygen equipment

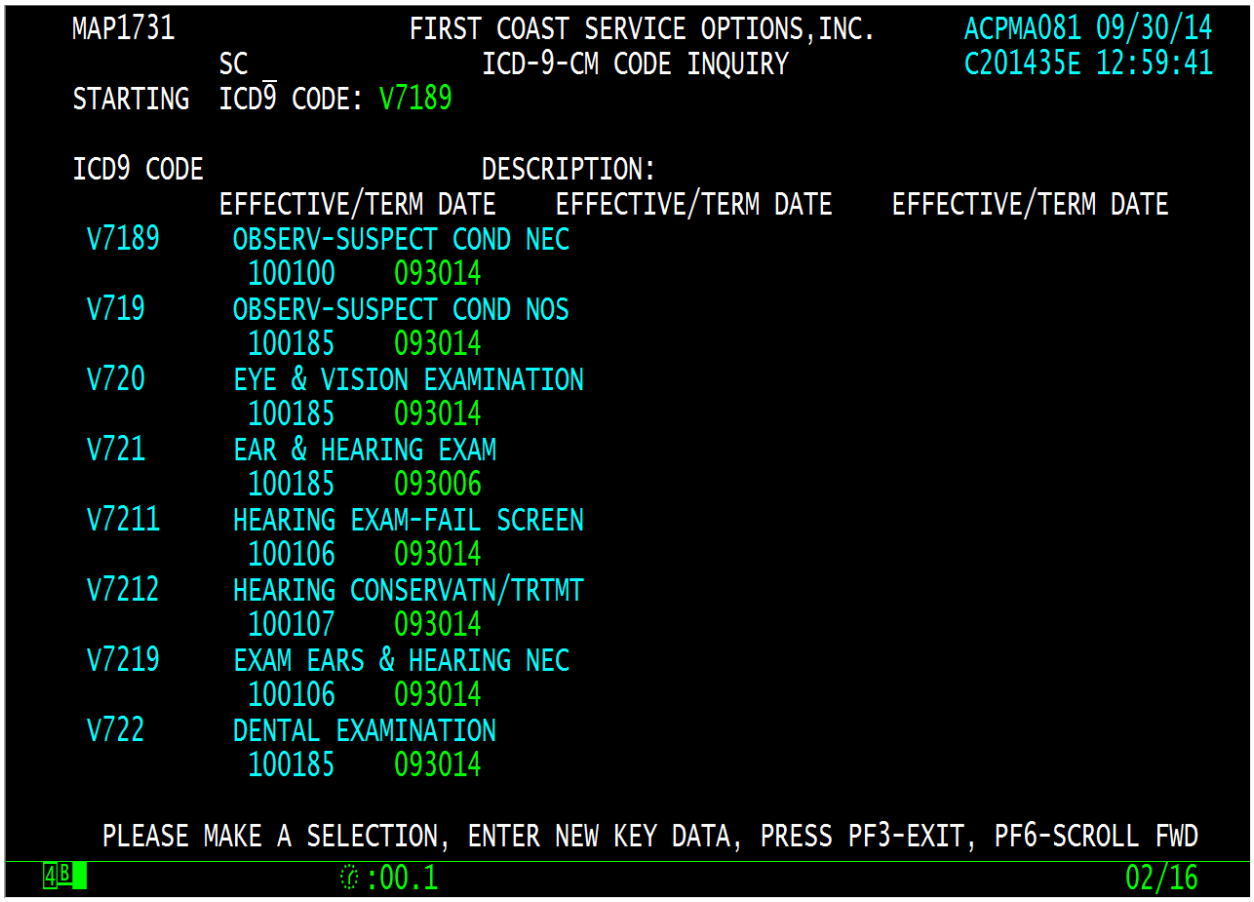
Field name	Description
PC/TC	This field identifies the professional component/technical component (PC/TC) indicator that is added to the comprehensive outpatient rehabilitation facility (CORF) services supplemental fee schedule. This is used to identify professional services eligible for the health professional shortage area (HPSA) bonus payments. This field is only applicable when pricing critical access hospitals (CAHs) that have elected the optional method (Method 2) of payment. This is a one-position alphanumeric field, with 40 occurrences. The valid values are: PC/TC — HPSA payment policy '0' — Pay the health professional shortage area (HPSA) bonus '1' — Globally billed, only the professional component of this service qualifies for the HPSA bonus payment. The HPSA bonus cannot be paid on the technical component of globally billed services. '2' — Professional component only, pay the HPSA bonus '3' — Technical component only, do not pay the HPSA bonus '4' — Global test only, the professional component of this service qualifies for the HPSA bonus payment '5' — Incident codes, do not pay the HPSA bonus '6' — Laboratory physician interpretation codes, pay the HPSA bonus '7' — Physical therapy service, do not pay the HPSA bonus '8' — Physician interpretation codes, pay the HPSA bonus '9' — Concept of PC/TC does not apply, do not pay the HPSA bonus
ANES BASE VAL	This field identifies the anesthesia base unit value. This is a three-position alphanumeric field and occurs 40 times. The valid values are 1-199.
TYP	This field identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The valid values are: Value — Description 'M' — Originated from MPFS database files ' ' — Did not originate from the MPFS database files **Note:** 'M' indicates the claim is considered an MPFS claim and is edited based on the zip code of the provider master address record. If it's an 'M' and the plus four flag of the 5-digit zip code record is a '1', and then the provider master address must contain a valid 4-digit extension. The carrier and locality on the provider master address record and the carrier and locality of the zip code file must match. Otherwise, the claim receives an edit.
MSI	This field identifies the multiple service indicators. This is a one-position alphanumeric field.
ALLOWABLE REVENUE CODES	This field identifies the allowable revenue code(s) that this particular HCPC code may use in billing. This is a four-position alphanumeric field, with ten occurrences. The fourth digit of the revenue code may be stored with an 'X' indicating that it is a variable. For example, by storing the revenue code '029X', the system allows this HCPC code with any revenue code that begins with '029'. By leaving this field blank, the system allows a HCPC code on any revenue code.
HCPC DESCRIPTION	This field identifies the narrative description of the HCPC code. This is a 77-position alphanumeric field, with three occurrences.

MAP1731 - ICD-9-CM Code Inquiry (15)

This file is for inquiry only, updates are not permitted (all fields are protected). The file provides a reference of ICD-9-CM code(s) used to identify specific diagnosis(es) or inpatient surgical procedure(s) relating to the bill, which may be used to calculate payment (i.e., DRG) or make medical determinations relating to the claim.

To inquire about an ICD-9-CM diagnosis code, type the three-, four-, or five-digit code in the Starting ICD9 Code field. Do not type the decimal point or zero-fill the code. If the code entered requires a fourth and/or fifth digit, an asterisk (*) will appear after the description. If an invalid code is entered, the system will select

the nearest code. If more than one ICD-9 code is listed, review the most current effective and termination date. To make additional ICD-9-CM inquiries, type new information over the previously entered data.



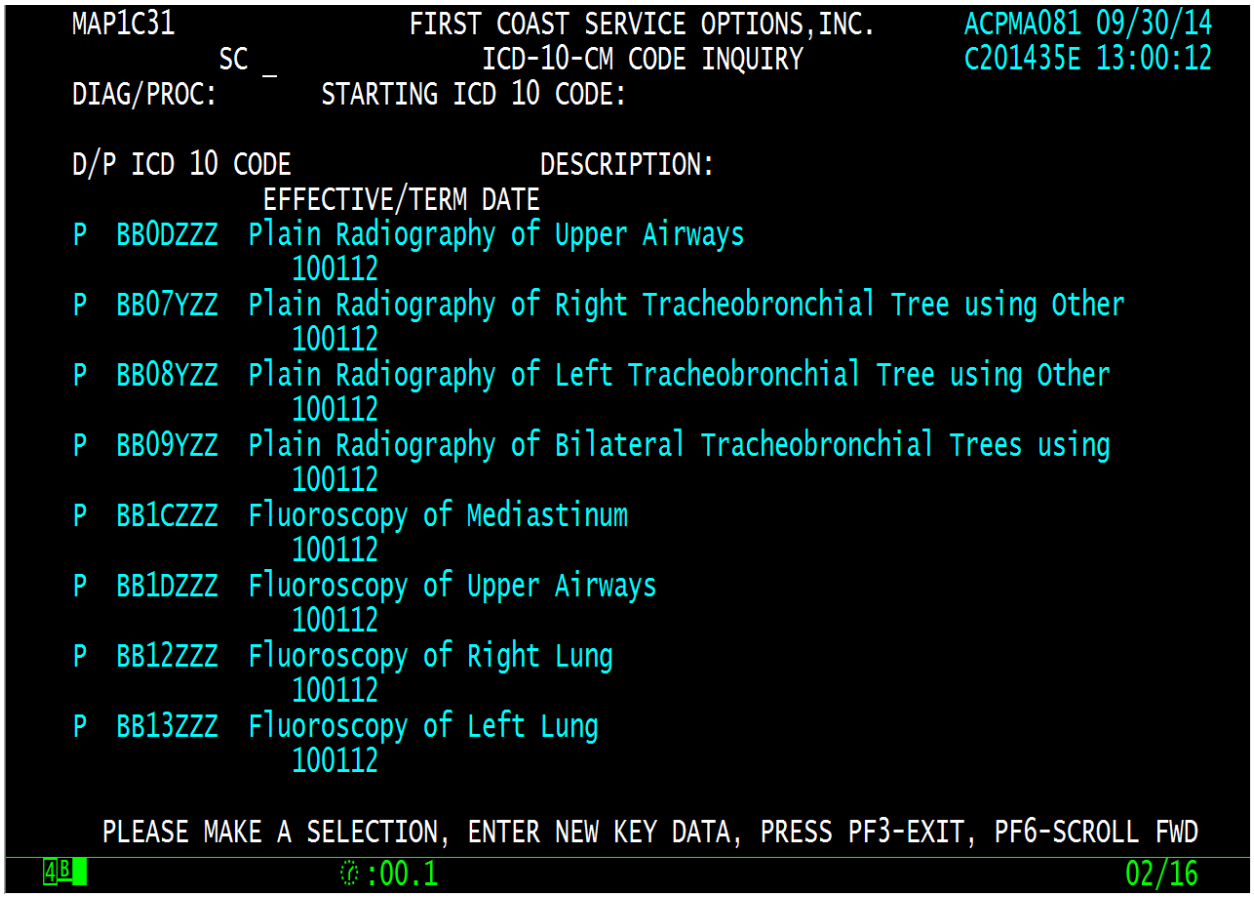
Field name	Description
STARTING ICD-9 CODE	To view all ICD-9-CM codes, press [ENTER] in this field. The ICD-9-CM code is used to identify a specific diagnosis (es) or inpatient surgical procedure(s) relating to a bill, which may be used to calculate payment (i.e., DRG) or make medical determination relating to a claim. This is a seven-position alphanumeric field. **Note:** Refer to the ICD-9-CM manual for the valid values.
ICD-9 CODE	This field identifies a specific diagnosis (es) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make a medical determination relating to a claim. This is a seven-position alphanumeric field. NOTE: Refer to the ICD-9-CM manual for the valid values.
DESCRIPTION	This field displays the description for the ICD-9-CM code. This is a 64 position alphanumeric field.
EFF DT	This field identifies the effective date of the program. This is a six-position alphanumeric field in MMDDYY format, with three occurrences
TERM DT	This field identifies the date in which this program was no longer in effect. This is a six-position alphanumeric field in MMDDYY format, with three occurrences

MAP1C31 - ICD-10-CM Code Inquiry (1B)

This screen displays an electronic description for the ICD-10-CM codebook. This screen should be used as reference for ICD-10-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill. An effective date will be listed below each code and, if applicable, a termination date is also provided.

To inquire about an ICD-10-CM diagnosis code, type a 'D' in the DIAG/PROC field then tab to the STARTING ICD 10 CODE field and type in the code.

To inquire about an ICD-10-CM procedure code, type the letter 'P' in the DIAG/PROC field and tab to the STARTING ICD 10 CODE field and type in the code.



Field name	Description
DIAG/PROC	This field identifies whether or not this is an ICD-10 diagnosis or procedure. Valid values are: Value Description 'D' Diagnosis code being entered/updated 'P' Procedure code being entered/updated
STARTING ICD 10 CODE	The ICD-10 code is used to identify a specific diagnosis(s) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim. This is a seven-position alphanumeric field.
D/P	This field identifies whether or not this is an ICD-10 diagnosis or procedure. This is a one-position alphanumeric field. Valid values are: Value Description 'D' Diagnosis code being entered/updated 'P' Procedure code being entered/updated

Field name	Description
ICD-10 CODE	The ICD-10 code is used to identify a specific diagnosis(s) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim.
DESCRIPTION	This field displays the description for the ICD-10 code. This is a 60-position alphanumeric field.
EFFECTIVE DATE	This field identifies the effective date of the program. This is a six-digit field in MMDDYY format, with three occurrences.
TERM DATE	This field identifies the date in which this program was no longer in effect. This is a six-digit field in MMDDYY format, with three occurrences.

MAP1581 - Adjustment Reason Code Inquiry (16)

The ANSI reason code file establishes and maintains the ANSI reason codes used to standardize the current FISS reason codes. These codes are used to communicate to the provider all financial changes made to the claim by the payer. The ANSI reason code file contains the following data:

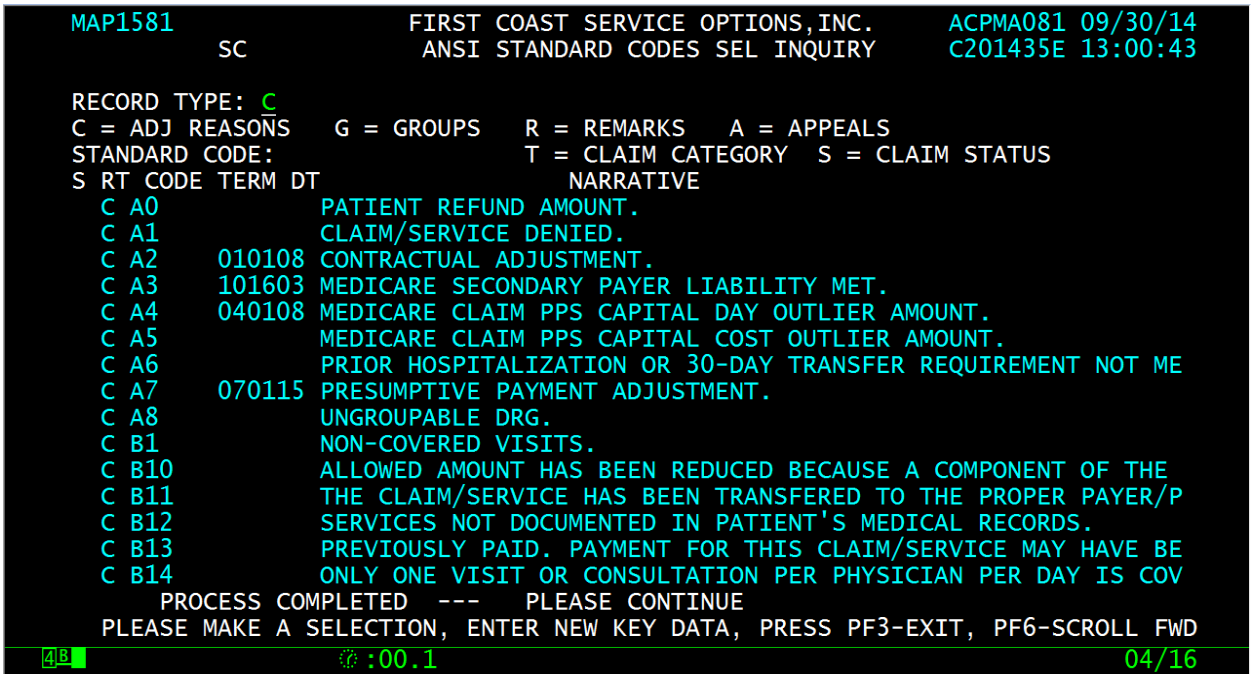
Record type

Type	Description
'A'	Appeals
'C'	Adjustment reasons
'G'	Groups
'R'	Reference remarks
'S'	Claim status
'T'	Claim category

The screen provides an on-line access method to identify a two-digit adjustment reason code and a narrative description for the adjustment reason code. It can also be used to validate the adjustment reason code entered on an adjustment.

To start the inquiry process, type in an adjustment reason code and press [ENTER], or just press [ENTER] and a list of adjustment reason codes will be displayed.

To display the entire narrative for one specific adjustment reason code, type an 'S' in the select (S) field to select the entire narrative for the code.



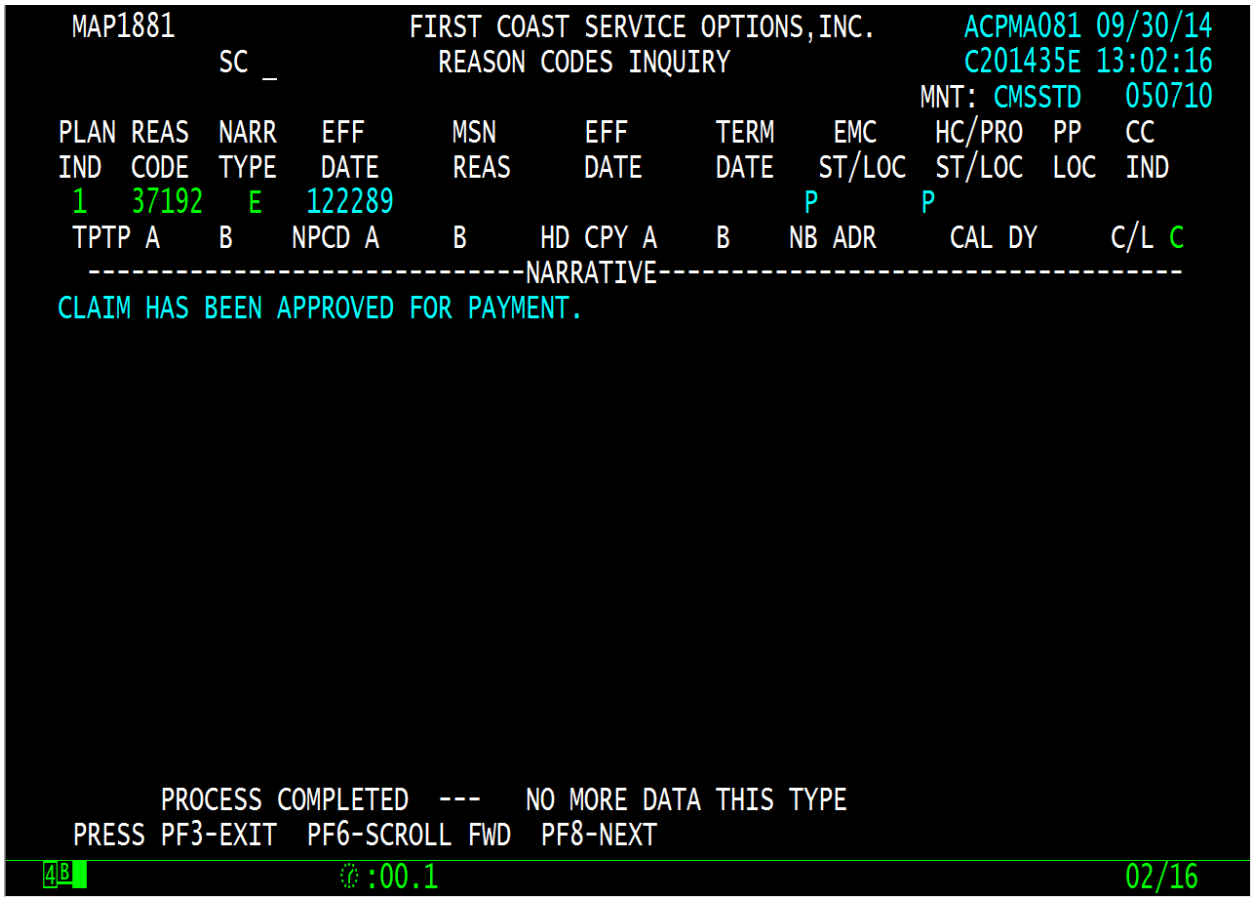
Field name	Description
RECORD TYPE	This field identifies the record type for the standard code that is being inquired upon or updated. This is a one-position alphanumeric field. Valid values are: Value Description A Appeals C Adj Reasons G Groups R Remarks S Claim status T Claim category
STANDARD CODE	This field identifies the standard code within the above record type that is being inquired upon or updated. If record code is present and no standard code is shown, all standard codes for the record type displays. If both record type and standard codes are present, the specific standard code displays. If neither the record type nor the standard code is shown, all ANSI codes are displayed in record type/standard code sequence. This is a five-position alphanumeric field.
S	The selection field is used to select a specific code when a list is displayed during update mode. When entered, only that code is displayed in the fields below. This is a one-position alphanumeric field.
RT	The record type selected field identifies the record type you selected. This is a one-position alphanumeric field.
CODE	The standard code selected field identifies the standard code you selected. This is a five-position alphanumeric field.
TERM DT	The term date field identifies the date the ANSI Standard Code is deactivated. This is a six-digit field in MMDDYY format. NOTE: ANSI codes that do not have a termination date has a default value of 'blank.
NARRATIVE	This is the description of the standard code. This is the only field that can be updated for a standard code by the MACs. This is a 66-position alphanumeric field.

MAP1881 - Reason Codes Inquiry (17)

The reason code file establishes and maintains information needed to control automated and manual handling of system identified conditions. The screen displays the reason code narrative used for billing errors on the claim, and it explains what fields need to be changed or completed in order to resubmit the claim for processing. The reason code file contains the following data:

- Reason code identification number and effective/termination date
- Alternative reason code identification number and effective/termination date
- Status and location set on the claim
- Post payment location
- Reason code narrative
- Clean claim indicator
- Additional development request (ADR) orbit counter and frequency

To start the inquiry process, enter the five-digit numeric reason code and press [ENTER]. To make additional inquiries, type over the reason code with next reason code and press [ENTER].



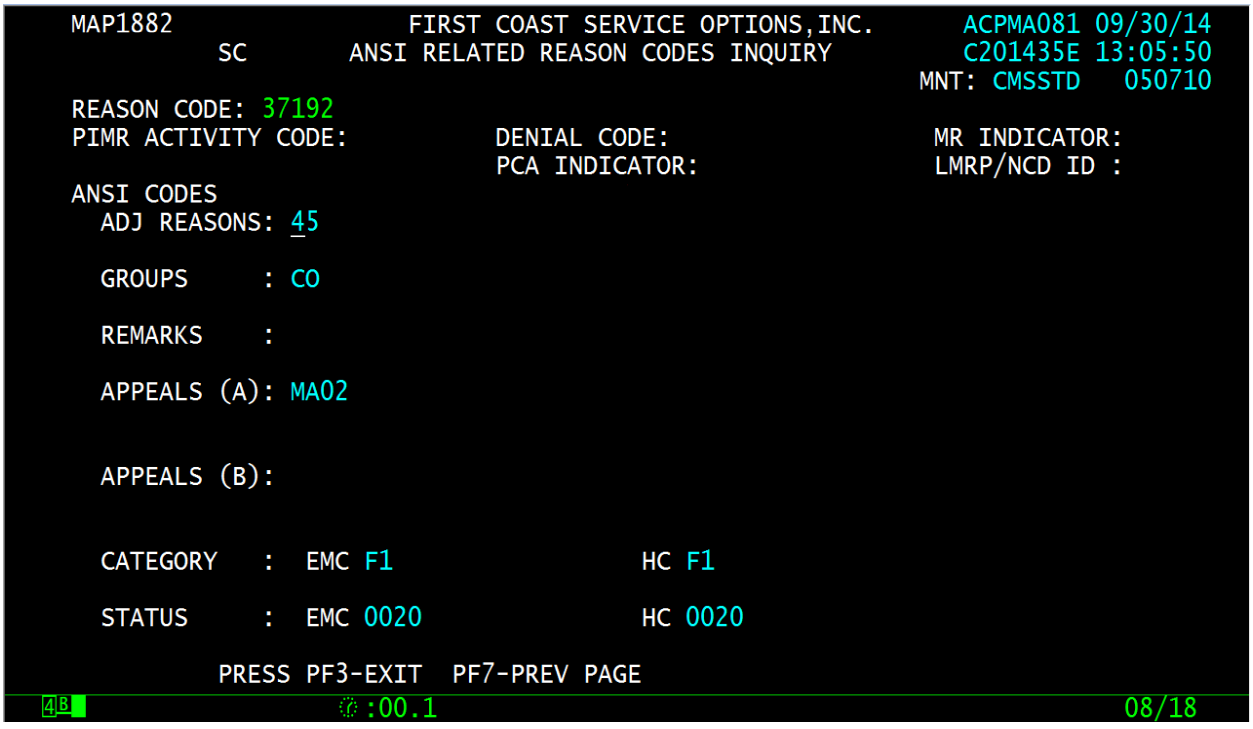
Field name	Description
OP	This field identifies the last operator who created or revised the reason code. This is a nine -position alphanumeric field.
DT	This field identifies the date this code was last saved. This is a six-position alphanumeric field in MMDDYY format.
PLAN IND	The plan indicator for all FISS shared maintenance customers is '1'. The value for FISS shared processing customers is determined at a later date. This is a one-position alphanumeric field.
REASON CODE	This field identifies a specific condition detected during processing a record. Each position of the reason code further identifies the process being performed. This is a five-position alphanumeric field.

Field name	Description
NARR TYPE	This narrative type identifies whether the message is the standard, internal, or external message. This field defaults to the external message for DDE providers. This is a one-position alphanumeric field.
EFF DATE	This field identifies an effective date for the reason code or condition. This is a six-position alphanumeric field in MMDDYY format.
MSN REAS	This field is used when MSNs that require BDL messages are produced. The reason code on the claim tied to a specific MSN reason code on the reason code file that points to a specific MSN message on the ACS file. This is a five-position alphanumeric field.
EFF DATE	This field identifies the effective date for the alternate reason code. This is a six-position alphanumeric field in MMDDYY format.
TERM DATE	This field identifies the termination date for the alternate reason code. This is a six-position alphanumeric field in MMDDYY format.
EMC ST/LOC	This field identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. The first-alphanumeric position represents the status of the claim. The next five-alphanumeric positions represent the location.
HC/PRO	This field identifies the status and location to be set on a hardcopy or PRO claim when it encounters the condition for a particular reason code. The first-alphanumeric position represents the status of the claim. The next five-alphanumeric positions represent the location of the claim. Value Description 2 Medical ADR (additional development request) 3 Non-medical ADR 4 MSP ADR (Medicare secondary payer) 5 MSP Cost avoidance ADR 7 ADR to beneficiary 8 MSN (Medicare secondary notice) [Line item] or partial benefit denial letter 9 MSN [Claim level] or benefit denial letter
PP LOC	This field identifies the five-position alphanumeric post pay location of 'B75XX' if the reason code is to send a claim to the Post Pay Driver for post pay developmental activities.
CC IND	The clean claim indicator instructs the system whether to pay interest or not if applicable. This is a one-position alphanumeric field.
TP/TP A	The tape-to-tape indicator controls the flow of the claim to CWF, to the provider via the remittance advice, to the PS&R system and for counting the claim for workload purposes. This is done separately for both Medicare Part A and Part B. The valid values are the flag indicators across the top of the chart. Each indicator instructs the system to either perform or skip each of the four functions listed on the left of the chart. The first indicator column represents a blank. If this field is blank all functions are performed (as indicated on the chart). This is a one-position alphanumeric field.
TP/TP B	The tape-to-tape indicator controls the flow of the claim to CWF, to the provider via the remittance advice, to the PS&R system and for counting the claim for workload purposes. This is done separately for both Medicare Part A and Part B. The valid values are the flag indicators across the top of the chart. Each indicator instructs the system to either perform or skip each of the four functions listed on the left of the chart. The first indicator column represents a blank. If this field is blank all functions are performed (as indicated on the chart). This is a one-position alphanumeric field.
NP CD A	The non-pay code Medicare Part A field identifies the reason for Medicare's decision not to make payment. This is a two-position alphanumeric field.
NP CD B	The non-pay code Medicare Part B field identifies the reason for Medicare's decision not to make payment. This is a two-position alphanumeric field.
HD CPY A	The hard copy Medicare Part A field instructs the system to generate a specific hardcopy document during the claim process. This is a one-position alphanumeric field.

Field name	Description
HD CPY B	This field instructs the system to generate a specific hardcopy document during the claim process. This is a one-position alphanumeric field.
NB ADR	This field identifies the number of times an Additional Development Request form is to be generated. If a second request is to be generated after the initial request is generated, a '2' appears in this field. If only request is to be generated with no second request, a '1' appears in this field. This is a one-digit field.
CAL DY	This field identifies the number of calendar days a claim is to orbit after the generation of an Additional Development Request. For example, if '30' is entered in this field and '1' is entered in the prior field (NB ADR), the claim orbits for 30 days after the generation of the first Additional Development Request form. At the end of 30 days if the requested information is not received, the system rejects the claim. If a second request is required to be generated 15 days after the original generation of the Additional Development Request form, a '2' appears in the 'NB ADR' field and '15' in the 'CAL DY' field. After generation of the initial request form, the claim orbits for 15 days and then generates the second request. The claim orbits another 15 days and if the requested information is not received within 15 days, the system rejects the claim. This is a two-digit field.
C/L	This field identifies if the reason code has been has been depicted as applying to the Claim or Line. This code is updated by FISS. This is a one-position alphanumeric field.
NARRATIVE	This field displays the short description for the reason code. This is a 77-position alphanumeric field.

Press [F8] on the reason code inquiry screen to display the ANSI related reason code inquiry screen (Figure 26). This screen provides the ANSI reason code equivalent to the FISS reason code. Press [F7] to return to the reason codes inquiry screen. This screen is system generated.

MAP1882 - ANSI Related Reason Codes Inquiry

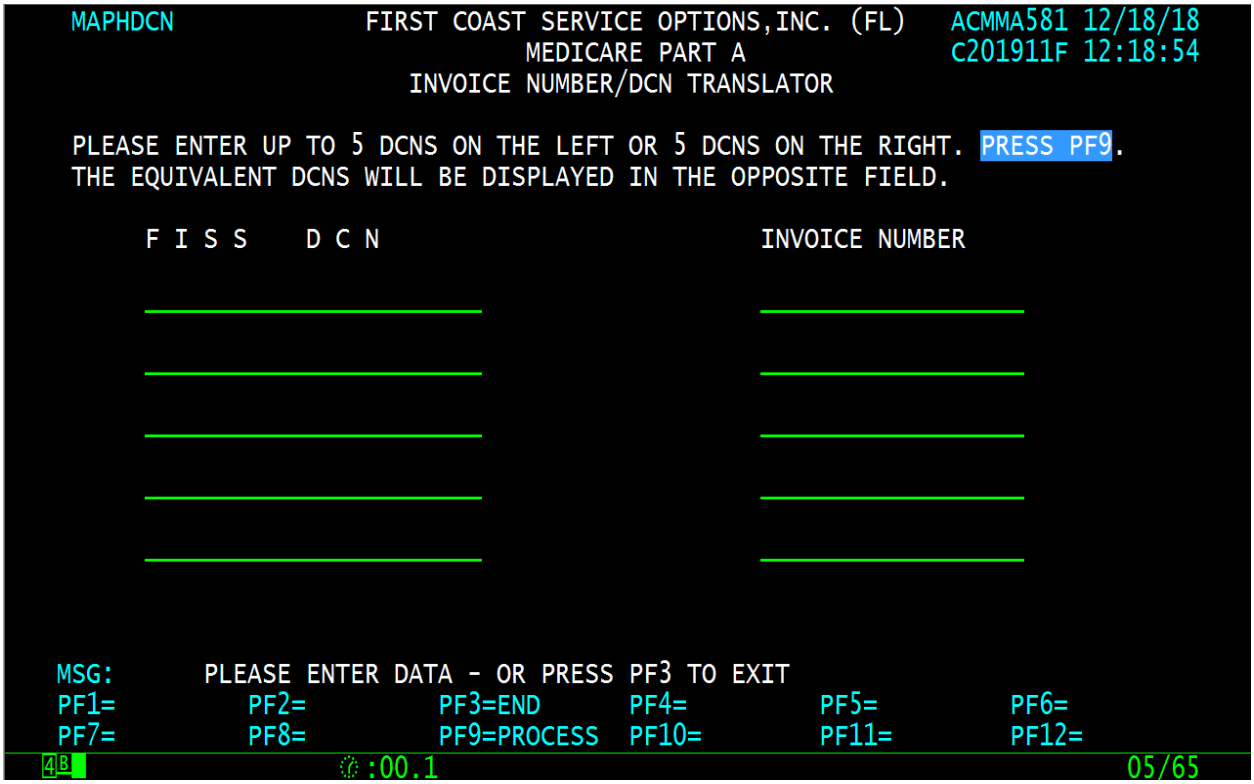


Field name	Description
REASON CODE	FISS reason code for which the following American national standards institute (ANSI) codes relate.

Field name	Description
PIMR ACTIVITY	Code program integrity management reporting (PIMR) activity code. This field identifies the PIMR activity code for which the reason code is being categorized.
DENIAL CODE	This field identifies the PIMR denial reason code that is being categorized.
MR INDICATOR	This field identifies whether or not the service received complex manual medical review. This is a one-position alphanumeric field. The valid values are: Value Description ‘ ‘ The services did not receive manual medical review (default value) ‘Y’ Medical records received. This service received complex manual medical review ‘N’ Medical records were not received. This service received routine manual medical review.
PCA INDICATOR	This field identifies the progressive correction action indicator. This is a one-position alphanumeric field. The valid values are: Value Description ‘ ‘ The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. ‘Y’ The Medical Policy Parameter is PCA-related and is included in the PCA transfer files. ‘N’ The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID	This field identifies the local medical review policy (LMRP) and/or national coverage determination (NCD) identification numbers, which are assigned to the FMR reason code for reporting on the beneficiaries Medicare Summary Notice. This is an eleven-position alphanumeric field, with five occurrences. The values for the LMRP are user defined and the NCD is CMS defined.
ADJ REASONS	This is the ANSI reason code that is related to the FISS reason code. This is a three-position alphanumeric field, with ten occurrences.
GROUPS	This is a two-position alphanumeric field, with four occurrences.
REMARKS	This field identifies the reason for non-payment. This is a five-position alphanumeric field, with four occurrences.
APPEALS (A)	These codes are used for inpatient only. This is a five-position alphanumeric field, with 20 occurrences.
APPEALS (B)	These codes are used for outpatient only. This is a five-position alphanumeric field, with 20 occurrences.
EMC CATEGORY	This field identifies the EMC category of the claim that is returned on a 277 claim response. This is a three-position alphanumeric field.
HC CATEGORY	This field identifies the Hard Copy category of the claim that is returned on a 277 claim response. This is a three-position alphanumeric field.
EMC STATUS	This field identifies the EMC status of the claim that is returned on a 277 claim response. This is a four-position alphanumeric field.
HC STATUS	This field identifies the Hard Copy status of the claim that is returned on a 277 claim response. This is a four-position alphanumeric field.

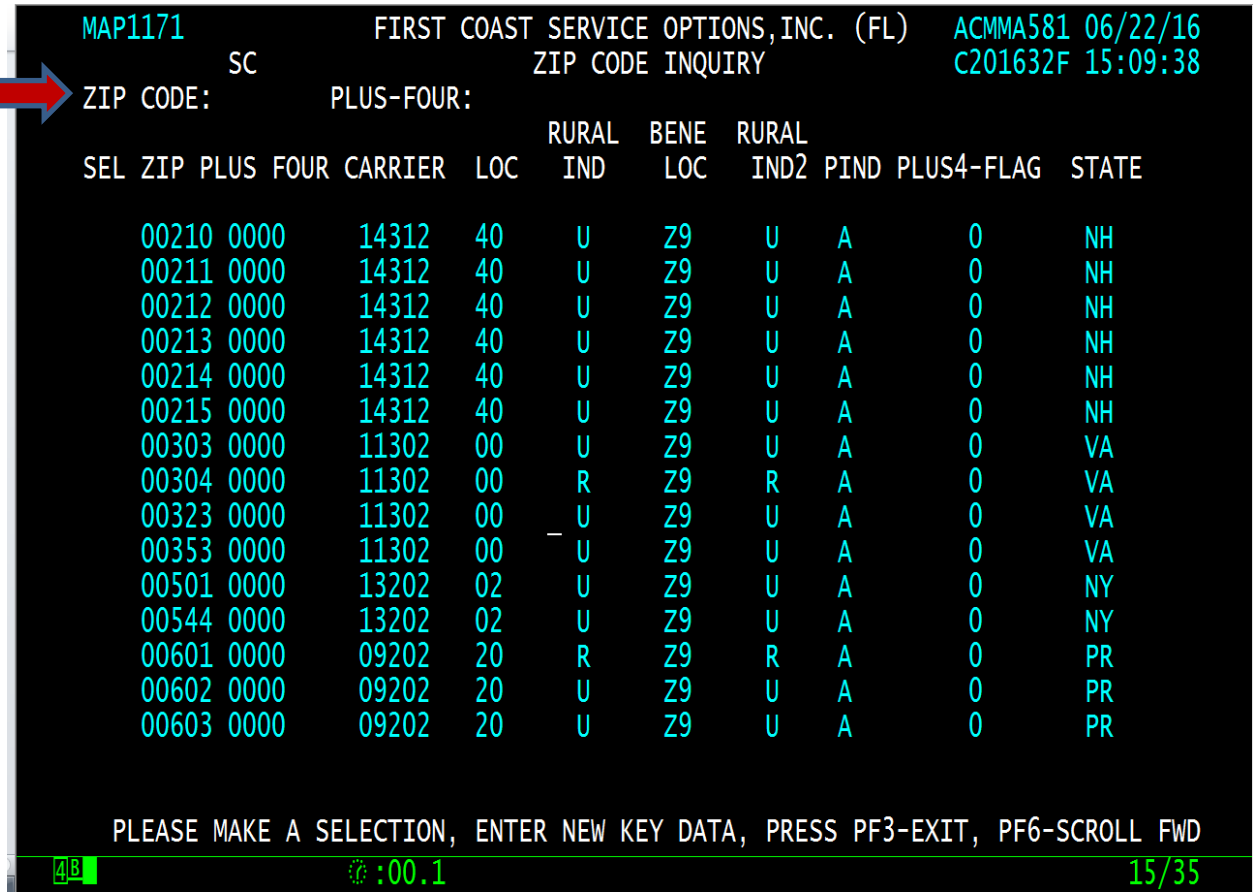
MAPHDCN - Invoice Number/DCN Translator (88)

The FISS/HIGLAS DCN Translator provides users to look up the claims associated with a Document Control Number (DCN), allowing providers to find the claim associated with the AR and reconcile it back to their patient accounts.



MAP1171 - ZIP Code Inquiry (19)

The purpose of the zip code screen is to provide access to the Zip Code file in inquiry mode. The first zip code loaded on the zip code file displays first. The next ten (10) zip code records display in ascending order. A zip code may be entered to display a specific record or you can press Enter for a list. Options to page forward or backwards are available using the function (F3) keys indicated.



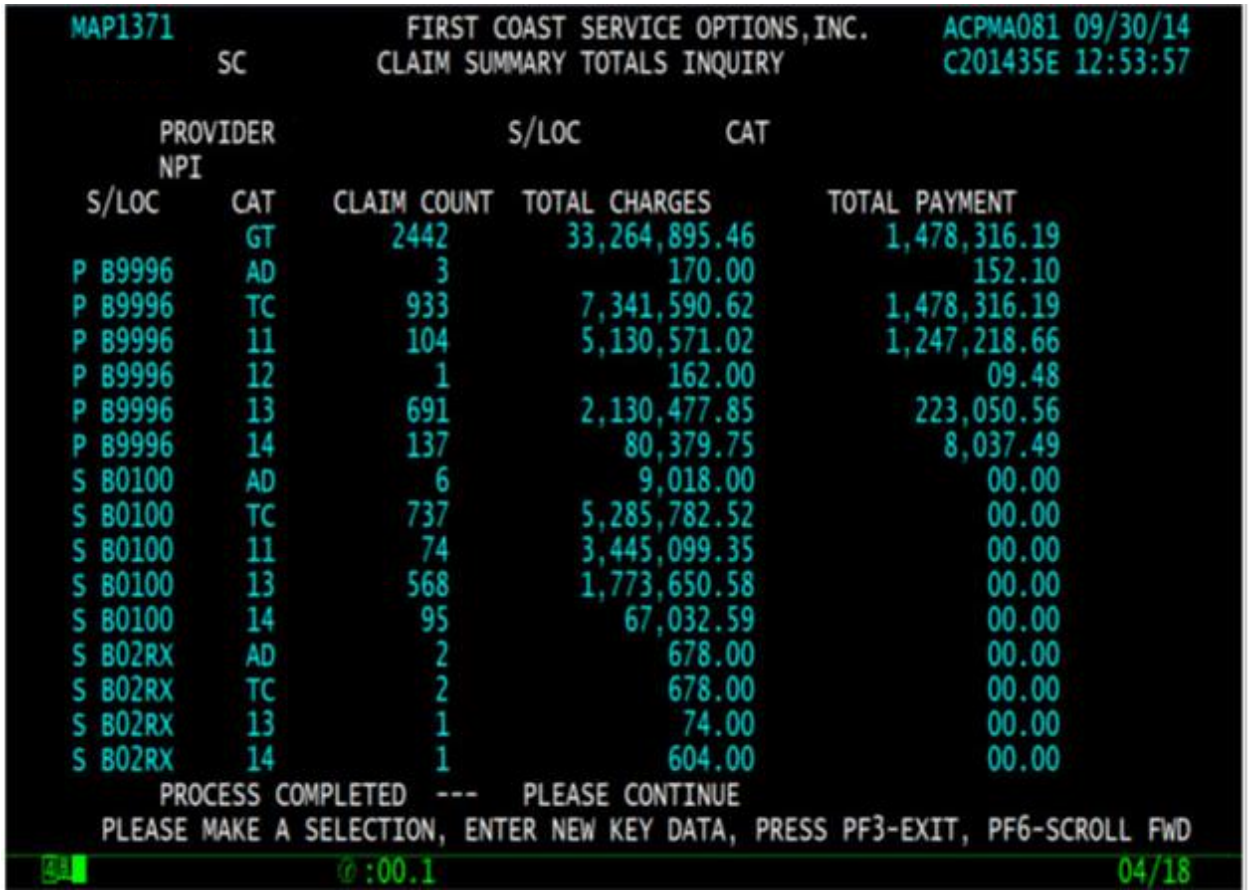
Field name	Description
ZIP CODE	This field identifies the zip code on the zip code file. This is a five-position alphanumeric field.
CARRIER	This field identifies the carrier number assigned to the HCPC. This is a five-position alphanumeric field.
LOCALITY	This field identifies the locality identification number for the area (or county) where the provider is located. This is a two-position alphanumeric field.
RURAL IND	This field identifies the rural indicator. This is a one-position alphanumeric field. The valid values are: Value Description 'U' Urban 'R' Rural 'B' Rural Bonus
STATE	The state field identifies the state associated with the zip code. This is a two-position alphanumeric field.

MAP1371 - Claims Summary Totals Inquiry (56)

The purpose of the claim summary totals screen is to provide a mechanism to the DDE provider to view a total claim count and total dollar amount for a specific location. The report gives the following information:

- Total number of pending claims
- Total charges billed
- Total reimbursement for claims in each FISS status/location

Press ENTER to display the data applicable to the provider number identified, or you can type in a specific status/location or category type to narrow the search.

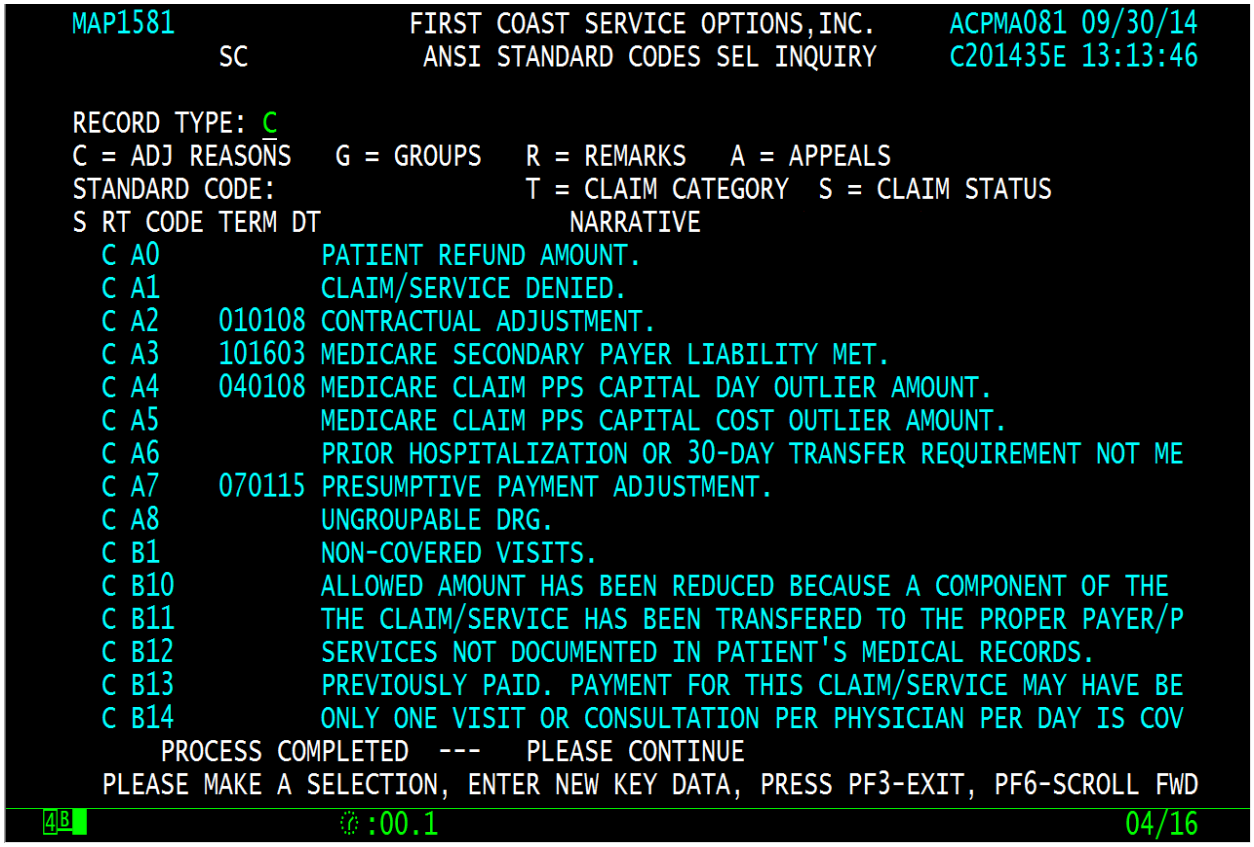


Field name	Description
PROVIDER	This field identifies the specific provider number of the facility the inquirer is logged into the system. This is a 13- position alphanumeric field and is pre-filled by the system. However, if the provider is authorized to view other provider number information, the field is accessible for entry.
S/LOC	This field is a combination of status and location. The first-alphanumeric position represents the status of the claim. The next five-alphanumeric positions represent the location of the claim. Status Valid Values: Value Description S Suspend R Reject T Return to provider P Paid Location: Five digit field that identifies where the claim resides in the system First position = Type of processing (M = Manual; B = Batch; O = Offline) Second and third positions = Type of driver (01-99)

Field name	Description
	Fourth and fifth positions = Allow for more definition with the driver for the location.
CAT	The type of claims in specific locations by the first two positions of the claim bill type. In addition, total claim number for each status/location. Valid Values: Value Description 11-14 N/A 72 N/A 75 N/A 83 N/A 85 N/A MP Medical Policy applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code is a 5. Claims in this category are also counted under the standard bill category and are not included in the total count (TC) category. NM Non-Medical Policy applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code is not a 5. Claims in this category are also counted under the standard bill category and are not included in the total count (TC) category. AD Adjustment within each status/location. Claims in this category are also counted under the standard bill category. Therefore, claims in this category are not included in the total count (TC). TC Total Count is the total within each status/location excluding claims with a category of AD, NM or MP. GT Grand Total is for the provider of all categories in all status/locations. This total will print at the beginning of the listing and associated status/locations will be blank. The grand total is displayed only when the total by provider is requested.
NPI	This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field.
CLAIM COUNT	This field identifies a total claim count for each specific status/location. This is a seven-digit field.
TOTAL CHARGES	This field identifies the total dollar amount accumulated for the total number of claims identified in the claim count. This is a 12-digit field in 9999999999.99 format.
TOTAL PAYMENT	This field identifies the total dollar payment amount that has been calculated by the system. This is an accumulated dollar amount for the total number of claims identified in the claim count. For those claims suspended in locations before payment calculations, the total payment equals zeros. This is a 12-digit field in 9999999999.99

MAP1581 - ANSI Standard Reason Codes Inquiry (68)

The ANSI reason code file establishes and maintains the ANSI reason code used to standardize the current FISS reason codes. These codes are used to communicate to the provider all financial changes made to the claim by the payer. To start the inquiry process, enter the specific ANSI reason code and press [ENTER], or you can just press [ENTER] and a list of ANSI reason codes will display.



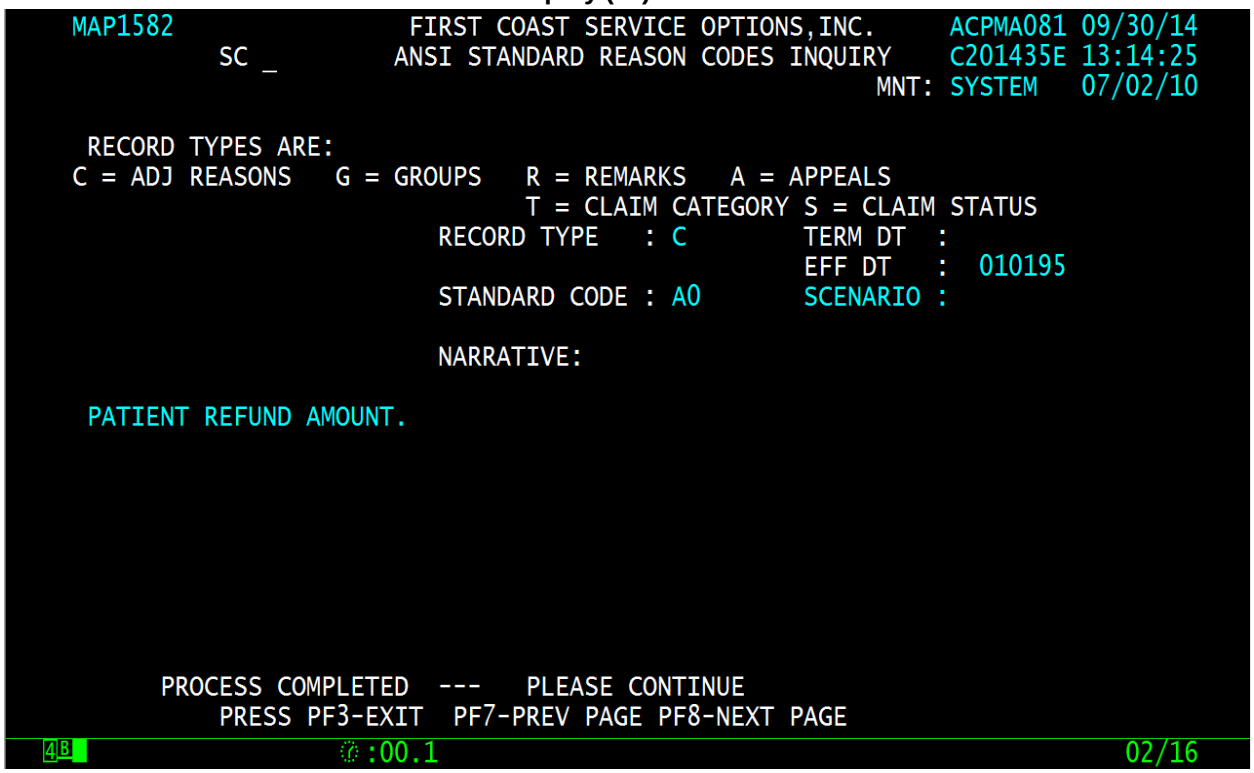
Field name	Description
RECORD TYPE	Identifies the ANSI record type for the standard code for inquiry or updating. Valid values include: Type Description 'A' Appeals 'C' Adjustment reason 'G' Groups 'R' Reference remarks 'S' Claim status 'T' Claim category
STANDARD CODE	The standard code within the above record type for inquiry or updating. If the record code is present and no standard code is shown, all standard codes for the record type will display. If both record and standard codes are present, the specific standard codes are shown. All ANSI codes will be displayed in record type/standard code sequence. This is a five-position alphanumeric field.
S	This field is used to select a specific code when a list is displayed during update mode. When entered, only that code is displayed in the fields below. This is a one-position alphanumeric field. **Note:** The selection field is not active in the inquiry mode.
RT	This field identifies the record type you selected. This is a one-position alphanumeric field.
CODE	This field identifies the standard code you selected. This is a five-position alphanumeric field.

Field name	Description
TERM DT	This field identifies the date the ANSI Standard Code is deactivated. This is a six-digit field in MMDDYY format. NOTE: ANSI codes that do not have a termination date have a default value of 'blank'.
NARRATIVE	This is the description of the standard code. This is the only field that can be updated for a standard code. This is a 66-position alphanumeric field.

To display the entire narrative for one specific ANSI code, type an 'S' in the select (S) field to select the entire narrative for the ANSI reason code.

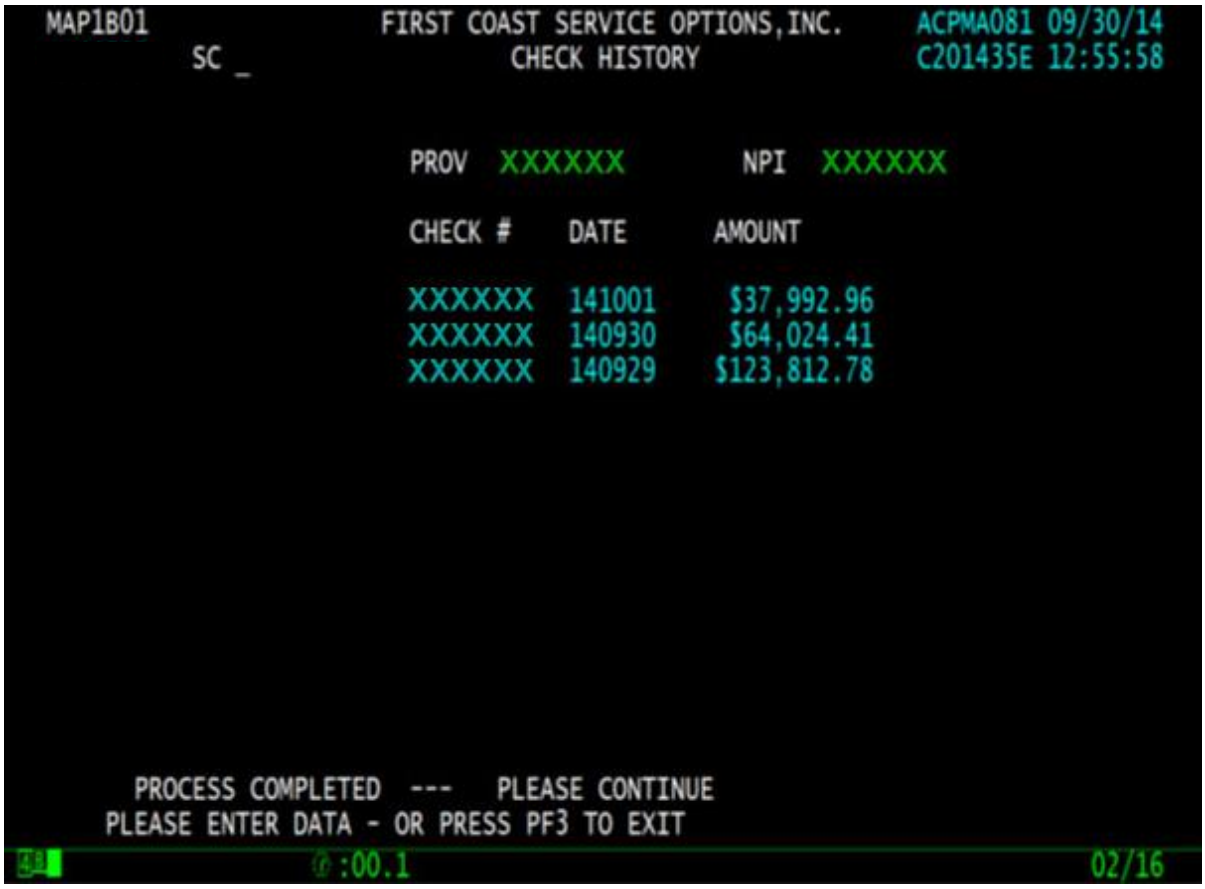
Press ENTER to display the ANSI standard codes inquiry screen.

MAP1582 - ANSI Standard Reason Codes Inquiry (68)



MAP1B01 - Check History (FI)

This screen lists Medicare payments for the last three issued checks, paid hardcopy or electronically. (If interested in electronic payments, contact the EDI Department at (888-670-0940.) After entering your provider and NPI numbers press [ENTER] and the last three checks issued by Medicare will display.

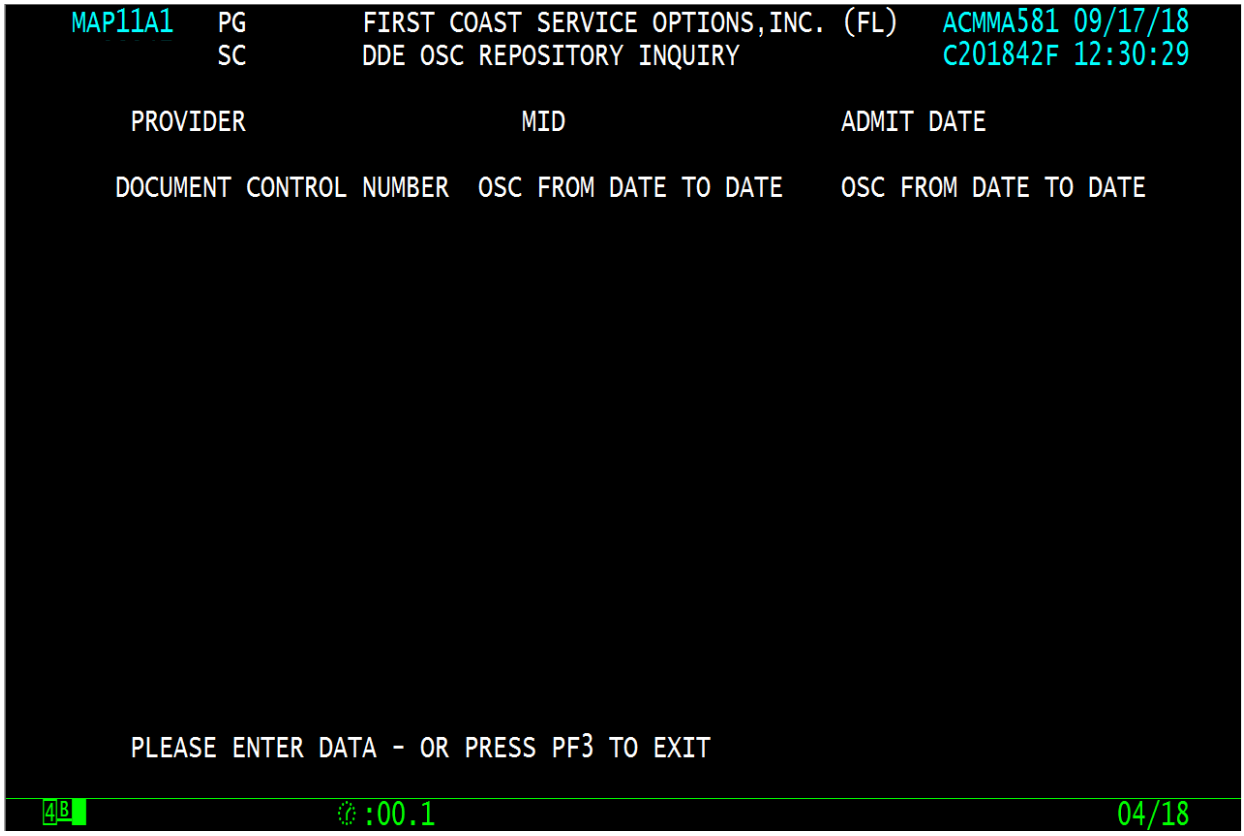


Field name	Description
PROV	The Medicare assigned provider number
CHECK #	The last three (3) checks issued to the provider by Medicare
DATE	The date when the check was issued to the provider
AMOUNT	The dollar amount of the last three (3) checks issued to the provider by Medicare

MAP11A1 - DDE Occurrence Span Code (OSC) Repository Inquiry (1A)

The purpose of this screen is to display the occurrence span code repository record. Up to three occurrences can display on a page. Specific occurrences can be displayed by typing a page number in the 'PG' field at the upper left hand corner of the screen. Additionally, F5 pages backward through the data and F6 pages forward.

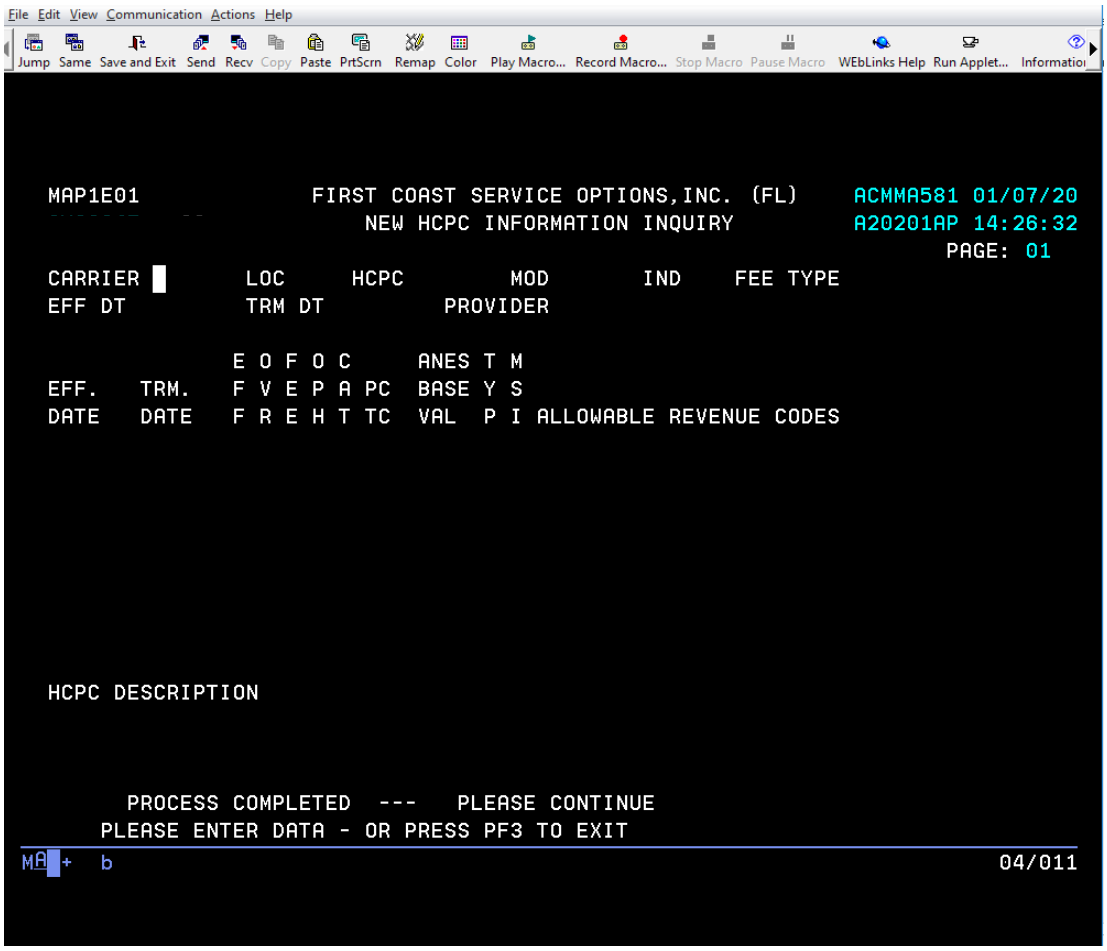
Note: The occurrence span code repository can contain up to 100 sets of data. Each set consists of a document control number, along with ten occurrence span codes and the 'from' and 'to dates'. This screen MAP13B1 displays up to three sets per page.



Field name	Description
PG	The page field navigates to the possible pages of data. Valid values range from 01 to 34, depending on the number of occurrences that exist on the record. Typing a number greater than the possible entries results in a display of the last page of data.
SC	The scroll field allows displaying other menu options, without having to return to the main menu. When a menu option related to processing a claim is entered, the key of the record transfers over to the requested screen, allowing the requested data to automatically display. This is a two-position alphanumeric field.
PROVIDER	This field displays the identification number of the institution who rendered services to a particular beneficiary/patient. This number is designated by CMS as the identification number of the provider. This is a 12-position alphanumeric field.
MEDICARE ID	This field identifies the Health Insurance Claim Number used to display existing therapy attachments. This is a 12-position alphanumeric field. Required.
ADMIT DATE	This field identifies the patient's admission date. This is an eight-position alphanumeric field in MM/DD/YY format.
DOCUMENT CONTROL NUMBER	This field displays the identification number for a claim. If an adjustment or an RTP is being processed, enter the DCN for that claim. If this is an MSP claim, leave this field blank. This is a 23-position alphanumeric field.
OSC	This field identifies the occurrence span code that identifies events that relate to the payment of the claim. This is a two-position alphanumeric field.

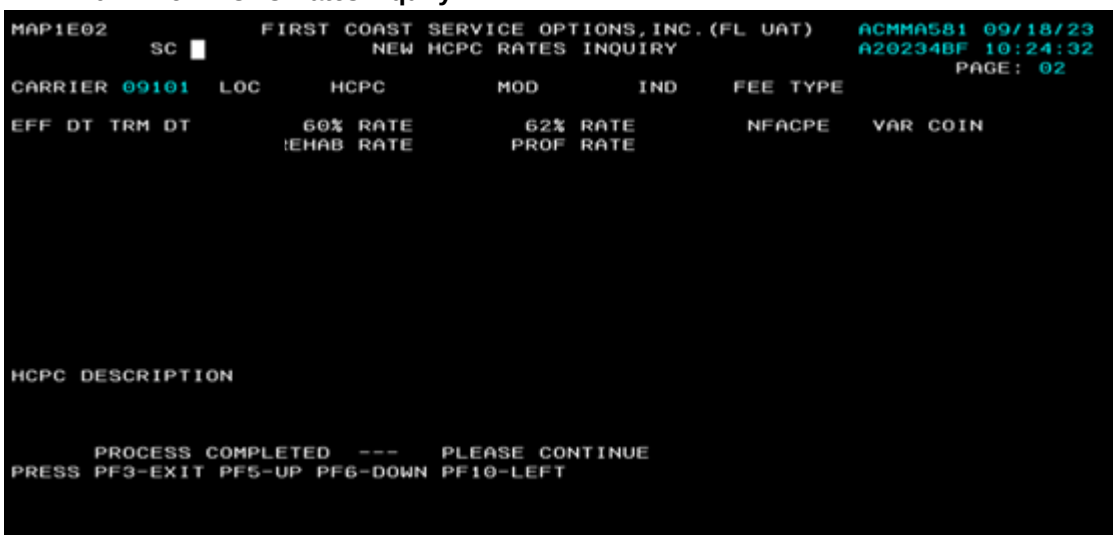
Field name	Description
FROM DATE	This field identifies the commencement of an event that relates to the payment of a claim. This is an eight-position alphanumeric field in MM/DD/YY format.
TO DATE	This field identifies the ending of an event that relates to the payment of a claim. This is an eight-position alphanumeric field in MM/DD/YY format.

MAP1E01 – New HCPC Information Inquiry



From the Main Menu MAP1701 select 01 Inquiries. Once the user is at the Inquiry Menu MAP1702 they may select NEW HCPC Screen 1E. The user shall key in the Carrier, Locality (LOC), HCPC and when necessary may need the Modifier (MOD) and Indicator (IND), Fee Type and Provider.

MAP1E02 – New HCPC Rates Inquiry



Selecting F11 will move the user to MAP1E02 where the HCPC description is displayed.

Section 5 – Claim Entry

This section provides information on how to enter:

- UB-04 claims into the DDE format
- Electronic roster bills
- Hospice election statements

The Claims and Attachments Entry Menu (Main menu option 02) may be used for online entry of patient billing information from the UB-04. Options are available to allow entry of various attachments. The UB-04 claim entry consists of six (6) separate screens/pages:

- Page 01 Patient information (corresponds to form locators 1-41)
- Page 02 Revenue/HCPCS codes and charges (corresponds to form locators 42-49)
- Page 03 Payer information, diagnoses/procedure codes (corresponds to form locators 50-57 and 67-83)
- Page 04 Remarks and attachments (corresponds to form locators 84-86)
- Page 05 Other payer and MSP information (corresponds to form locators 58-66)
- Page 06 MSP information, crossover, and other inquiry (does not correspond to any form locator)

General Information

- The online system defaults to the 111 type of bill for inpatient claims, 131 for outpatient claims, and 211 for SNF claims. If entering a different type of bill, type over the default with the desired type of bill.
- On the bottom of each screen, is a list of the PF keys and the functions they perform.
- Field names within DDE will not always follow the same order as found on the UB-04 claim form.
- For valid values associated with the claim entry field, please refer to the current UB-04 manual.

Transmitting Data

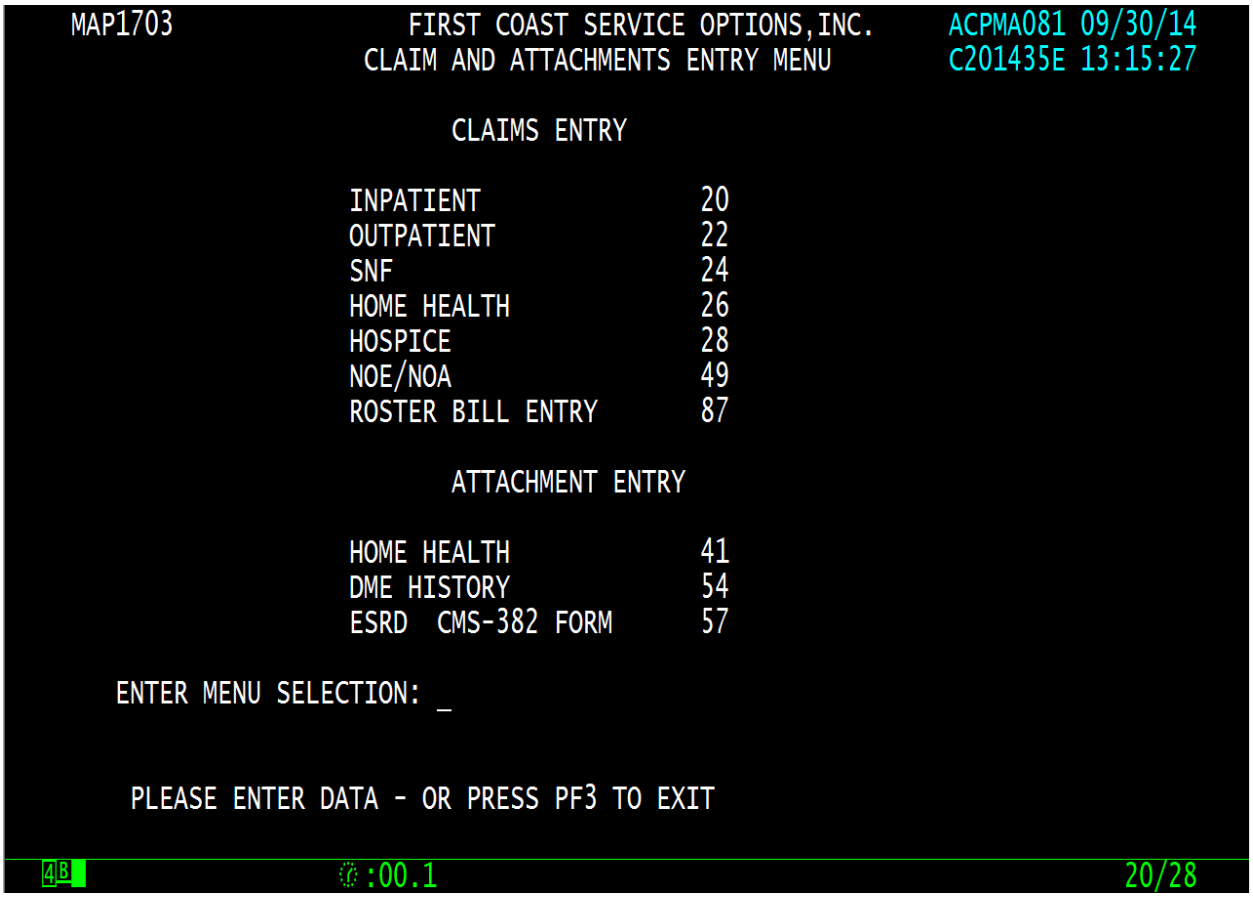
- When claim entry is completed, press [F9] to store the claim and transmit the data.
- If any information is missing or entered incorrectly, reason codes will display at the bottom of the claim screen in order for you to make corrections. The claim will not transmit until it is free of front-end edit errors.
- Correcting reason codes:
  - Press [F1] to see an explanation of the reason code. After reviewing the explanation, press [F3] to return to your claim and make the necessary corrections. If more than one reason code

appears, continue this process until all reason codes are corrected and the claim is successfully entered into the system.

- If more than one reason code is present, pressing [F1] will always bring up the explanation of the first reason code unless the cursor is positioned under one of the other reason codes. Working through the reason codes in the order they are listed is the most efficient method. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected as well.

Note: The system will automatically populate your provider number into the Provider field. If the facility has multiple provider numbers, you will need to change the number to inquire or input information. [TAB] to the Provider field and type in the provider number.

To access the Claim and Attachments Entry Menu, select option '02' from the Main Menu.



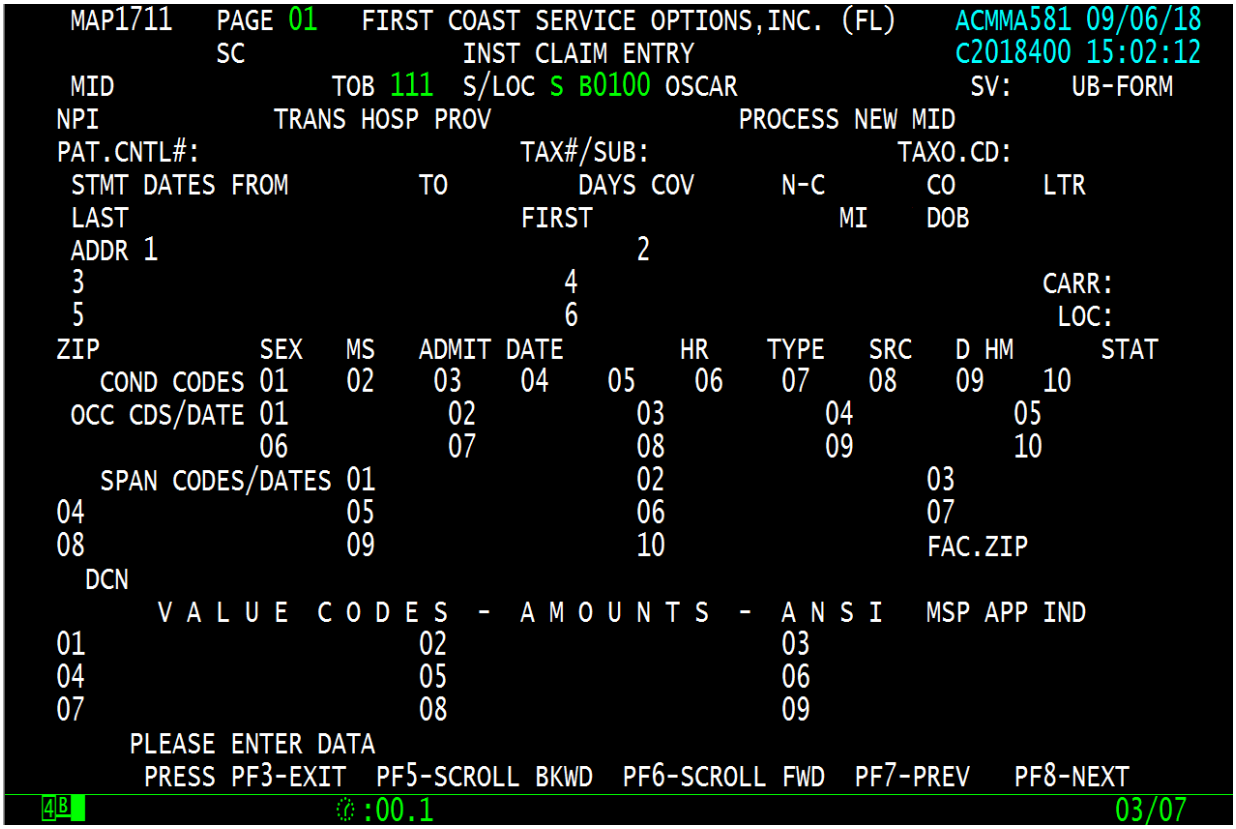
DDE Claim Entry

When entering claims select the option from the Claim and Attachments Entry Menu that best describes your Medicare line of business:

- INPATIENT 20
- OUTPATIENT 22
- SNF 24
- HOSPICE 28
- NOE/NOA 49
- ROSTER BILL ENTRY 87

MAP1711 - Claim Entry – Page 1

After you select an option, page one of the UB-04 claim entry screen will display. The screen will include the provider number, type of bill, and default status/location. Enter the beneficiary information (name, address, date of birth, etc.) and any other information needed to process the claim. Field descriptions are provided in the table. Refer to the UB-04 manual for valid values if they're not listed in the tables below.



Field name	Description
MEDICARE ID	The patient's health insurance claim (Medicare ID) number as it appears on the Medicare ID card.
TOB	The type of bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to the UB-04 manual for valid values.
S/LOC	The status location field identifies the condition and location of the claim within the system.
OSCAR	Displays the identification number of the institution that rendered services to be beneficiary/patient. The system will automatically populate the Medicare Provider number when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, CORF, ORF) the Medicare Provider number must be changed to reflect the provider you wish to submit claims for. If the Medicare provider number is not changed for your sub-units, the claims will be processed under the incorrect provider number.
NPI	National provider number
TRANSFERRING HOSPICE (TRANS HOSP PROV)	Displays the identification number of the institution that rendered services to the beneficiary/patient. System generated for external operators that are directly associated with one provider.
PROCESS NEW MEDICARE ID	Not applicable in claim entry

Field name	Description
	Identifies when the incorrect beneficiary health insurance claim number is present, and then the correct health insurance claim number can be keyed. Not applicable on new claim entries. Valid values include: Value Description 'Y' Incorrect Medicare ID is present 'E' The new Medicare ID number is in a cross-reference loop or the new Medicare ID entered is cross-referenced on the beneficiary file and this cross-referenced Medicare ID is also cross-referenced. The chain continues for 25 Medicare ID numbers. 'S' The cross-referenced Medicare ID number on the beneficiary file is the same as the original Medicare ID number on the claim.
PAT. CNTL#	Patient control number that's a unique number assigned by the provider to facilitate retrieval of individual patient records and posting of the payment.
TAX#/SUB	Not required Federal tax number and Federal tax subsidiary number
STMT DATES	The statement covers (from and to) dates of the period covered by this bill (in MMDDYY format).
DAYS COV	Indicates the total number of covered days. • Enter the total number of covered days during the billing period, which are applicable to the cost report, including lifetime reserve days elected (for which hospital requested Medicare payment). • The numeric entry should be the same total as the total number of covered accommodation units. • Exclude any days classified as non-covered and leave of absence days. • Exclude the day of discharge or death (unless the patient is admitted and discharged the same day). Do not deduct days for payment made by another primary payer.
N-C	Indicates the total number of non-covered days. Enter the total number of non-covered days in the billing period. • Enter the total number of covered days during the billing period. These days are not covered Medicare payment days on the cost report and the beneficiary will not be charged utilization for Medicare Part A Services. • The reason for non-coverage should be explained by occurrence codes, and/or occurrence span code. Provider a brief explanation of any non-covered days not described via occurrence codes in 'Remarks.' (Show the number of days for each category of non-covered days, e.g., '5 leave days'). Do not deduct days for payment made by another primary payer.
CO	Co-Insurance days are the inpatient Medicare hospital days occurring after the 60th day and before the 91st day. Enter the total number of inpatient or SNF co-insurance days.
LTR	Lifetime Reserve Days field is only used for hospital inpatient stays. Enter the total number of inpatient lifetime reserve days the patient elected to use during this billing period.
LAST	Patient's last name; at the time services were rendered
FIRST	Patient's first name
MI	Patient's middle initial
DOB	Enter numerically in month, day, century and year format (MMDDCCYY)
ADDR 1-6	Patient's street address must input in fields 1 and 2. State is a 2-character field.
CARR	Carrier code
LOC	Locality code
ZIP	Valid ZIP code (minimum of 5 digits)
SEX	Patient's sex Valid values are: F = Female and M = Male
MS	Not required for Medicare claims but must accept all valid values under HIPAA. Valid values are:

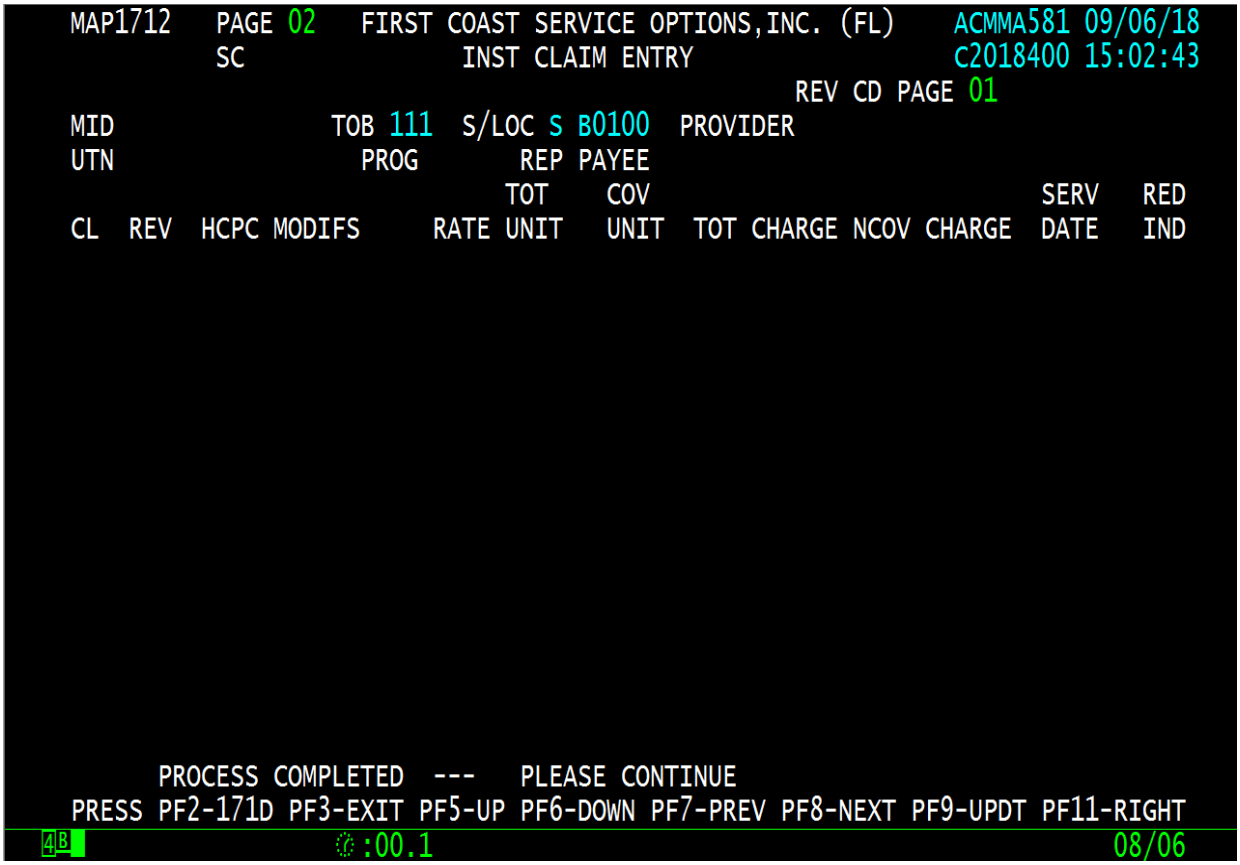
Field name	Description
	Value Description 'S' Single 'M' Married 'P' Life Partner 'X' Legally Separated 'D' Divorced 'W' Widowed 'U' Unknown
ADMIT DATE	Enter date patient was admitted. Required for inpatient claims
HR	Hour the patient was admitted (for hospitals only)
TYPE	Type of admission is an inpatient code that indicates the priority of the admission. (This is not required for SNFs or outpatient facilities).
SRC	Source of admission indicating the source of this admission.
D HM	Discharge hour and minutes with valid values of 0000-2359. Value entered (HHMM) determines the time the patient was discharged.
STAT	Patient status code for the patient's status at the end of service date in the period.
COND CODES	The condition codes are used to identify conditions relating to this bill that may affect claim processing, up to 24 occurrences.
OCC CDS/DATE	Occurrence codes and dates field consists of a two-digit alphanumeric code and a six-digit date in MMDDYY format. Report all appropriate occurrences, up to 24 occurrences.
SPAN CODES/ DATES	Occurrence span codes and dates field are associated with the beginning (From) and ending (Thru) dates defining a specific event relating to this billing period.
FAC.ZIP	Facility ZIP code (must be 9 digits)
DCN	Document control number is not required when entering a new bill. Applicable only on adjustments, void/cancel TOB xx7 and xx8.
VALUE CODES – AMOUNTS	Value codes and related dollar amount(s) identify monetary data necessary for the processing of a claim.
ANSI	American National Standards Institute codes are system generated after the claim is processed. It is a 5-digit field made up of 2-digit group codes and 3-digit reason (Adjustment) code. Once generated it is used for sending ANSI information for the value codes to the financial system for reporting on the remittance advice.
MSP APP IND	Medicare Secondary Payer apportion indicator (no longer available)

MAP1712 - Claim Entry – Page 2

Enter the following information on page two of the claim entry screen:

- Lists revenue codes
- Dollar amounts (without decimal points)
- Revenue code 0001 should be used in the final revenue code entry and correspond with the totals for 'Total Charges' and 'Non-covered Charges'
- List revenue codes in ascending numeric sequence
- Type in the dollar amounts without a decimal point (e.g., for $45.50, type '4550')
- Revenue code 001 should always be the final revenue code entry and correspond with the totals for 'Total Charges' and 'Non-covered Charges'
- To delete a revenue code line, type a 'D' and three (3) zeros (D000) over the revenue code and press Enter
- To insert a revenue code line, type it at the bottom of the list and press Enter, DDE will automatically re-sort the lines
- [F2] – a 'jump key' when placed on a revenue code on MAP171A, allows you to scroll to the same revenue code line on MAP171A

There are additional revenue screens available. Press [F6] to page forward and [F5] to page back. To delete a revenue code line, type a D and three zeros over the revenue code and press [ENTER]. To insert a revenue code line, type it at the bottom of the list and press [ENTER]. The system will re-sort the lines.

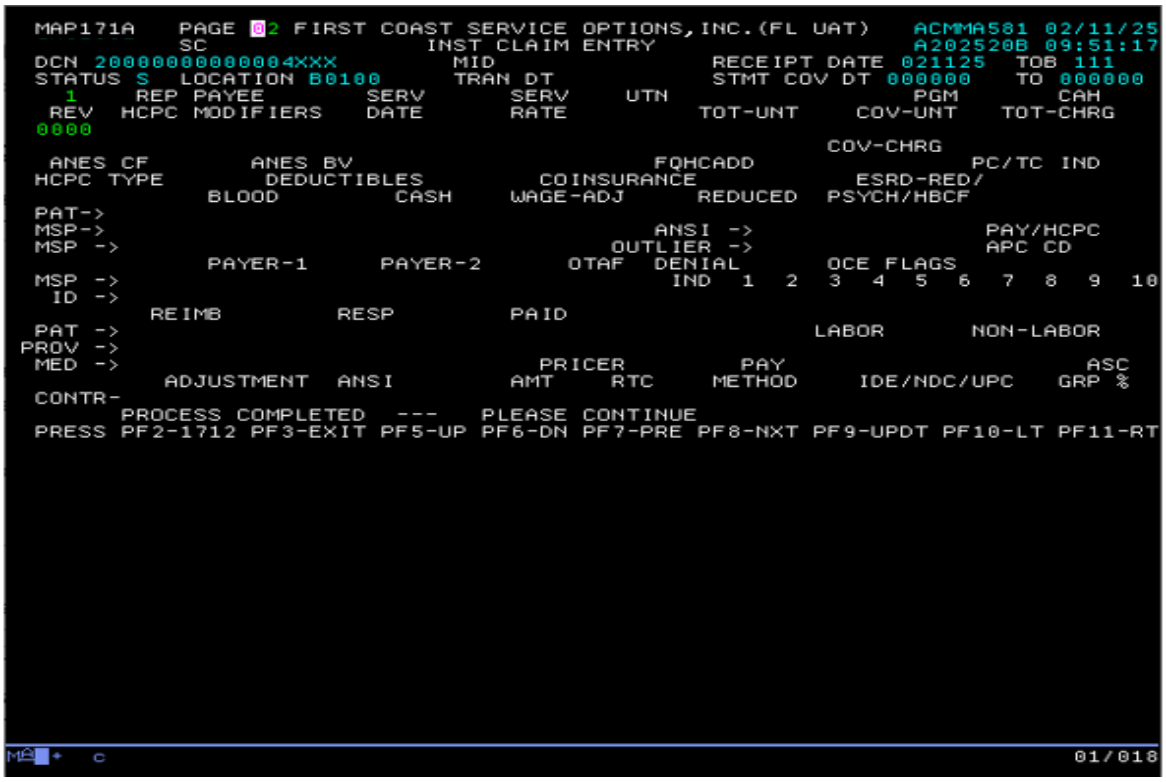


Field name	Description
CL	Identifies the claim line number of the revenue code. There are 13 revenue code lines per page with a total of 450 revenue code lines possible per claim. The system will input the revenue code line number when [F9] is pressed. It will be present for update and inquiry.
REV	The revenue code for a specific accommodation or service that was billed on the claim. Valid values are 0001 through 9999. ▪ List revenue codes in an ascending sequence and do not repeat revenue codes on the same bill if possible ▪ To limit line item entries on each bill, report each revenue code only once, except when distinct HCPCS code reporting requires repeating a revenue code (e.g., laboratory services, revenue code 300, repeated with different HCPCS codes), or an accommodation revenue code that requires repeating with a different rate. ▪ Revenue code 0001 (total charges) should always be the final revenue code entry. ▪ Some codes require CPT/HCPCS codes, units and/or rates.
HCPC	Enter the HCPCS code describing the service, if applicable. HCPCS coding must be reported for specific outpatient services including, but not limited to: ▪ Outpatient clinical diagnostic laboratory services billed to Medicare, enter the HCPCS code describing the lab service; ▪ Outpatient hospital bills for Medicare defined ‘surgery’ procedure; ▪ Outpatient hospital bills for outpatient partial hospitalization; ▪ Radiology and other diagnostic services; ▪ ESRD drugs, supplies, and laboratory services;

Field name	Description
	▪ Inpatient rehabilitation facility (IRF) PPS claims, this HCPC field contains the submitted HIPPS/CMG code required for IRF PPS claims; and other provider services in accordance with CMS billing guidelines.
MODIFS	A 2-digit alphanumeric modifier (up to 2 occurrences). May be required for hospital outpatient prospective payment system (OPPS)
RATE	Enter the rate for the revenue code if required
TOT UNIT	Total units of service indicate the total units billed. This reflects the units of service as a quantitative measure of service rendered by revenue category.
COV UNIT	Covered units of service indicate the total covered units. This reflects the units of service as a quantitative measure of service rendered by revenue category.
TOT CHARGE	Report the total charge pertaining to the related revenue code for the current billing period as entered in the statement covers period.
NCOV CHARGE	Report non-covered charges for the primary payer pertaining to the related revenue code. Submission of bills by providers for all stays, including those for which no payment can be made, is required to enable the intermediary and CMS to maintain utilization records and determine eligibility on subsequent claims.
SERV DATE	The service date is required for every line item where a HCPCS code is required effective April 1, 2000, including claims where from and through dates are equal. For inpatient rehabilitation facility (IRF) PPS claims, this field is not required on the revenue code 0024 line. However, if present on the revenue code 0024 line, it indicates the date the provider transmitted the patient assessment. This date, if present, must be equal to or greater than the discharge date (Statement cover to date).
RED IND	Reduction indicator

MAP171A - Claim Entry – Page 2, Line Level Reimbursement

This screen displays line item payment information and allows entry of more than two modifiers. Access the MAP171A screen by pressing [F2] or [F11] on Page 2 MAP171.



Field name	Description
REV	Revenue Code - This field identifies the revenue code indicating the specific service that is being billed on the claim. This is a four-digit field. This is a four-digit field; valid values are '0001' through '9999'. The information in this field is the revenue code entered on MAP1033.
HCPC	This field identifies the HCPC code that further defines the revenue code being submitted. The information in this field was entered on MAP1033. This is a five-position alphanumeric field.
MODIFIERS	This field identifies the HCPCS modifier codes for claims processing. This is a ten-position alphanumeric field to contain five 2-position modifiers. The two modifiers entered on MAP1033 are displayed and the user can enter any remaining modifiers.
SERV DATE	This is the line item date of service and is required for many outpatient bills. The information in this field was entered on MAP1033. This is a six-digit field in MMDDYY format.
SERV RATE	This field identifies the per unit cost for a particular line item. This information was entered on MAP1033. This is a 13-digit field in 9999999999.999 **Note:** Claims which pay based on the fee schedule and are in a suspense status or in RTP status, display three decimal places in the rate field. Claims having been paid, display three decimal places if the HCPC Drug Code equals 'E', and displays two decimal places if the HCPC Drug Code equals spaces.
TOT-UNIT	This field identifies the total units billed by revenue category. The information in this field was entered on MAP1033. This is a seven-digit field in 999999.9 format.
COV-UNIT	This field identifies the covered units billed by revenue category. The information in this field was entered on MAP1033. This is a seven-digit field in 999999.9 format.
TOT-CHRG	This field identifies the total amount of charges for a particular revenue line for the current billing period. The information in this field was entered on MAP1033. This is a nine-digit field in 9999999.99 format.
COV-CHRG	This field identifies the total amount of covered charges for a particular revenue line for the current billing period. The information in this field was entered on MAP1033. This is a nine-digit field in 9999999.99 format.
ANES CF	This field identifies the anesthesia conversion factor. This is a four-digit field in 99.99 format.
ANES BV	This field identifies the Anesthesia Base Unit Value. This is a three-digit field, valid values are 1-199.
FQHCADD	This field has the new patient/initial Medicare visit for the FQHC claims.
PC/TC IND	This field identifies the Professional Component/Technical Component (PC/TC) indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) extract of the Medicare Physician Fee Schedule Supplementary File. This is used to identify professional services eligible for the Health Professional Shortage Area (HPSA) bonus payments. This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. This is a one-position alphanumeric field, with 40 occurrences. The valid values are:
HCPC TYPE	This field identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The value values are: Value Description 'M' Originated from MPFS database files ' ' Did not originate from MPFS database files

Field name	Description
	Note: 'M' indicates the claim is considered an MPFS claim and is edited based on the zip code of the provider master address record. If it's an 'M' and the plus four flag of the 5-digit zip code record is a '1', then the provider master address must contain a valid 4-digit extension. The carrier and locality on the provider master address record and the carrier and locality of the zip code file must match. Otherwise, the claim receives an edit.
BLOOD	This field identifies the amount of the patients Medicare blood deductible applied to the line item. The blood deductible is applied at the line level on revenue codes 380, 381, and 382. This is a 10-digit field in 99999999.99 format.
CASH	This field identifies the amount of the patients Medicare cash deductible applied to the line item. This is a 10-digit field in 99999999.99 format.
COINSURANCE WAGE-ADJ	This field identifies the amount of coinsurance applicable to the line, based on the particular service rendered. The service is defined by the revenue and HCPCS code submitted. For services subject to outpatient PPS (OPPS) in hospitals (TOBs '12X', '13X', and '14X') and in community mental health centers (TOB '76X'), the applicable coinsurance is wage adjusted. This field will have either a zero (for services which no coinsurance is applicable), or a regular coinsurance amount (calculated on either charges or a fee schedule) unless the service is subject to OPPS. If the service is subject to OPPS, the national coinsurance amount will be wage adjusted based on the MSA where the provider is located or assigned as the result of a reclassification. CMS supplies the national coinsurance amount to the Intermediaries, as well as the MSA by provider. This is a 10-digit field in 99999999.99 format.
REDUCED	This field identifies the amount of the reduced coinsurance applicable to the line for a particular service (HCPCS) rendered on which the provider has elected to reduce the coinsurance amount for all services subject to OPPS (TOB '12X', '13X', '14X', '76X'). This is a 10-digit field in 99999999.99 format. **Note:** Providers are only permitted to reduce the coinsurance amount due from the beneficiary for services paid under OPPS, and the reduced amount cannot be lower than 20% of the payment rate for the line. If the provider does not elect to reduce the coinsurance amount, this field will contain zeros.
ESRD-RED/ PSYCH/HBCF	ESRD Reduction Amount / Psychiatric Reduction Amount / Hemophilia Blood Clotting Factor Amount - This is an eleven-digit field in 99999999.99 format. ESRD Reduction Amount - This value refers to the ESRD Network Reduction amount. Refer to claim page 2 in value code '7'. Psychiatric Reduction Amount - Applies to line items that have a 'P' Pricing Indicator. The amount represents the psychiatric coinsurance amount (37.5% of covered charges). Hemophilia Blood Clotting Factor Amount - An additional payment to the DRG payment for hemophilia. The payment is based on the applicable HCPC and add-on applies to inpatient claims.
VALCD-05/ OTHER	This field identifies whether value code '05' is present on the claim. It contains the portion of the value code '05' amount that is applicable to this line item. The value code '05' amount is first applied to revenue codes '96X', '97X', '98X' and then applied to revenue code lines in numeric order that are subject to deductible and/or coinsurance. This is an 11-digit field in 99999999.99 format.
MSP BLOOD DEDUCTIBLES	This field identifies the blood deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. This is a nine-digit field in 9999999.99 format.
MSP CASH DEDUCTIBLES	This field identifies the cash deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. This is a seven-digit field in 99999.99 format.
MSP COINSURANCE	This field identifies the coinsurance amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. This is a seven-digit field in 99999.99 format.

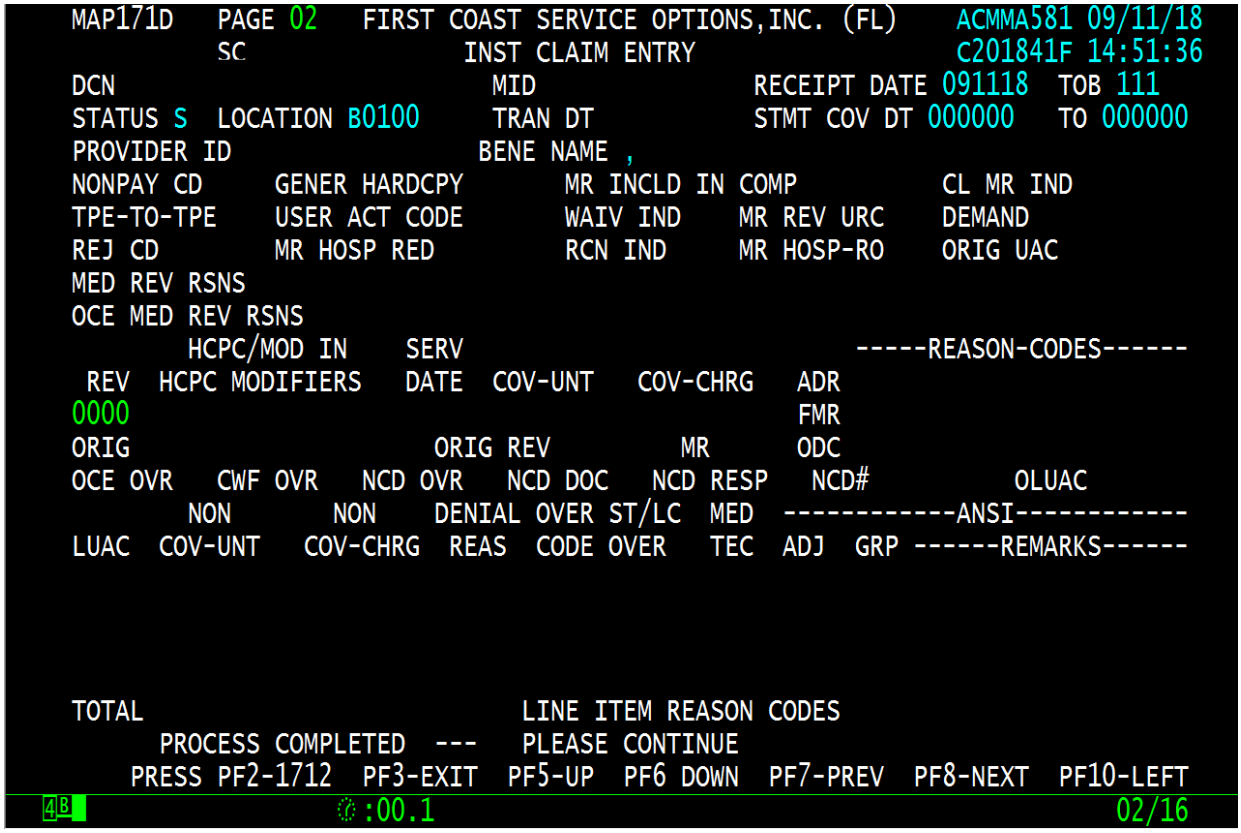
Field name	Description
ANSI ESRD-RED/PSYCH/ HBCF	This field identifies the 2 position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice for the ESRD Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor.
ANSI VAL CD-05/OTHER	This field identifies the 2 position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice for the Value Code 05/Other amount.
MSP PAYER 1	This field identifies the amount entered by the user (if available) or apportioned by MSPPAY as payment from the primary payer. The MSPPAY Module based on the amount in the value code for the primary payer apportions this amount. This is a nine-digit field in 9999999.99 format.
MSP PAYER 2	This field identifies the amount entered by the user (if available) or apportioned by MSPPAY as payment from the secondary payer. The MSPPAY Module based on the amount in the value code for the secondary payer apportions this amount. This is a nine-digit field in 9999999.99 format
OTAF	The obligated to accept payment in full field identifies the line item apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full, when value code 44 is present. This is a nine-digit field in 9999999.99 format.
DENIAL IND	The denial indicator field identifies to the MSPPAY module that an insurer primary to Medicare has denied this line item. This is a one-position alphanumeric field. The valid values are: Value Description ‘ ‘ Not Denied ‘D’ Denied
OCE FLAGS	This field identifies eight flags, two alphanumeric positions each. The OCE module returns these flags via the APC return buffer.
PAY/HCPC APC CD	The payment ambulatory patient classification code or HCPC ambulatory patient classification code field displays the number that identifies the APC group. Payment for services under the OPPS is calculated based on grouping outpatient services into APC groups. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. Both APC codes appear on the claims file, but only one display on the screen. If their values are different, this indicates a partial hospitalization item. In this case the payment APC code is displayed. When the item is not a partial hospitalization, the HCPC APC code is displayed. This data is read from the claims file. This is a five-position alphanumeric field. **Note:** Claim page 31 displays the HIPPS code if different from what is billed. If medical changes the code, the new HIPPS code is displayed in the PAY/HCPC APC CD field and a value of 'M' is in the OCE flag 1 field. When a value of 'M' is in the OCE flag 1 field, the MR IND field is automatically populated with a 'Y'. If pricer changes the code, the new HHRG is displayed in the PAY/HCPC APC CD field and a value of 'P' is in the OCE flag 1 field. If the HIPPS code was not changed, fields PAY/HCPC APC CD and OCE flag 1 are blank. **Note:** For Home Health PPS claims, claim page 31 displays the HIPPS code if different from what is billed. **Note:** For Inpatient Rehabilitation Facility (IRF) PPS claims, if the IRF PPS pricer returns a HIPPS/CMG code different from what was billed, the new HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field and a value of 'I' is displayed in the OCE FLAG 1 field. If the IRF PPS pricer does not change the HIPPS/CMG code, these fields are blank.

Field name	Description
MSP PAYER 1	This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is primary, this field is to be blank.
MSP PAYER 2	This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is secondary, this field is to be blank.
PAT REIMB	The patient reimbursement field identifies the system generated calculated line amount to be paid to the patient on the basis of the amount entered by the provider on claim page 4, in the Due From PAT field. This is a 10-digit field in 99999999.99 format.
PAT RESP	The patient responsible field identifies the amount for which the individual receiving services is responsible. This is a 10-digit field in 99999999.99 format. The amount is calculated as follows: If Payer 1 indicator is 'C' or 'Z', then the amount equals: cash deductible + coinsurance + blood deductible. If Payer 1 indicator is not 'C' or 'Z', then the amount equals: MSP blood + MSP cash deductible + MSP coinsurance.
PAT PAID	The patient paid field identifies the line item patient paid amount calculated by the system. This amount is the lower of (patient reimbursement + patient responsibility) or the remaining patient paid(after the preceding lines have reduced the amount entered on claim page 4). This is a nine-digit field in 9999999.99 format.
REDUCT-AMT	The reduction amount field identifies the 10% reduction amount by a processed 121 re-billed demonstration claim that paid 90% of allowable services identified by including Claim Adjustment Reason Codes (CARC) '45' to report the adjustment due to difference in billed charged and allowed amount, and CARC '132' to report adjustments due to a 10% reduction in conjunction with Group Code of 'CO'. This is a ten-position alphanumeric field in 99999999.99- format. **Note:** CARC descriptions Value Description ‘45’ Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement ‘132’ Pre-arranged demonstration project adjustment Value Description ‘ ‘ Not denied ‘D’ Denied
ANSI	This field identifies the group code and the CARC code for the reduction amount above. The group code is a one-position alphanumeric field. The CARC code is a three-position alphanumeric field.
REIMB	The provider reimbursement field identifies the system calculated line item amount to be paid to the provider. This is a 10-digit field in 99999999.99 format.
LABOR	This field identifies the labor amount of the payment as calculated by the pricer. This is an eight-digit field in 999999.99 format.
NON-LABOR	Non-Labor - This field identifies the non-labor amount of the payment as calculated by the pricer. This is an eight-digit field in 999999.99 format.
MED REIMB	The Medicare reimbursement field identifies the total Medicare reimbursement for the line item, which is the sum of the patient reimbursement and the provider reimbursement. This is a 10-digit field in 99999999.99 format.
CONTR ADJUSTMENT	The field identifies the total contractual adjustment. The calculation is: submitted charge - deductible - wage adjusted coinsurance - blood deductible - value code 71 - psychiatric reduction - value code 05/other - reimbursement amount. This is a 10-digit field in 99999999.99 format. **Note:** For MSP Claims, the MSP deductible, MSP blood deductible, and MSP coinsurance is use in the above calculation in place of the deductible, blood deductible, and coinsurance amounts.

Field name	Description
ANSI	This field identifies the two-position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice.
OUTLIER	The outlier amount field identifies the apportioned line level outlier amount returned from MSPPAYOL. This is an nine-digit field in 9999999.99 format.
PRICER AMT	The pricer amount field identifies the total reimbursement received from a pricer. This is a 10-digit field in 99999999.99 format.
PRICER RTC	The pricer return code field identifies the return code from Outpatient Prospective Payment System (OPPS). This is two-position alphanumeric field
PAY METHOD	The payment method field identifies the payment method returned from OCE. This is two-position alphanumeric field. The valid values are: Value Description ‘1’ Paid standard OPPS amount (‘K’, ‘S’, ‘T’, ‘V’, ‘X’ or ‘P” Description ‘2’ Services not paid under OPPS (status indicator ‘A’) ‘3’ Not paid (status indicators ‘W’, ‘Y’, or ‘E’) or not paid under OPPS (status indicators ‘B’. ‘C’. ‘Z’) ‘4’ Acquisition cost paid (status indicator ‘F’ or ‘L’) ‘5’ Additional payment for drug or biological (status indicator ‘G’) ‘6’ Additional payment for device (status indicator ‘H’) ‘7’ Additional payment for new drug or new biological (status indicator ‘J’) ‘8’ Paid partial hospitalization per diem (status indicator ‘P’) 9’’ Therapy or G0177 parital hospitalization program services Value Description ‘45’ Charge exceeds fee schedule/maximum allowable or contracted allowable or contracted/legislated fee arrangement ‘132’ Pre-arranges demonstration project adjustment Value Description ‘ ‘ Not denied ‘D; Denied
IDE/NDC/UPC	This field contains IDE, NDC, or UPC. This is a 15-position alphanumeric field.
IDE	Investigational Device Exemption authorization number assigned by the FDA. It is only used for revenue code 0624. This is a seven position alphanumeric field beginning with 'G'.
NDC	Reserved for future use.
UPC	Reserved for future use.
ASC GRP	This field identifies the ASC Group code for the indicated revenue code. This is a three-position alphanumeric field.
%	This field identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code. This is a one-position alphanumeric field.

MAP171D - Claim Entry – Page 2, Line Level Reimbursement

This screen displays line item payment information and allows entry of more than two modifiers. Access the MAP171D screen by pressing [F2] or [F10] on Page 2 MAP171.



Field name	Description
PROVIDER ID	identifies the identification number of the provider submitting the claim
BENE NAME	The name of the beneficiary (20 positions for the last name and 10 positions for the first name).
NON PAY CD	The Non-Pay Code identifies the reason for Medicare's decision not to make payment. Valid values are: Value Description 'B' Benefits exhausted 'C' Non-covered care (discontinued) 'E' First claim development (Contractor 11107) 'F' Trauma code development (Contractor 11108) 'G' Secondary claims investigation (Contractor 11109) 'H' Self reports (Contractor 11110) 'J' 411.25 (Contractor 11111) 'K' Insurer voluntary reporting (Contractor 11106) 'N' All other reasons for non-payment 'P' Payment requested 'Q' MSP voluntary agreements (Contractor 88888) 'R' Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, or waiver of liability 'T' MSP initial enrollment questionnaire (Contractor 99999) 'U' MSP HMO cell rate adjustment (Contractor 55555) 'U' HMO/Rate Cell (Contractor 11103) 'V' MSP litigation settlement (Contractor 33333) 'V' Litigation settlement (Contractor 11104)

<table>
<tr><th>Field name</th><th>Description</th></tr>
<tr><td></td><td>‘W’ Workers compensation
‘X’ MSP cost avoided
‘Y’ IRS/SSA data match project MSP cost avoided (Contractor 77777)
‘Y’ IRS/SSA CMS data match project cost avoided (Contractor 11102)
‘Z’ System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows FISS to process the claim to CWF and allows CWF to accept the claim as billed.
‘12’ Blue Cross Blue Shield voluntary agreements (Contractor 11112)
‘13’ Office of personnel management (OPM) data match (Contractor 11113)
‘14’ Workers’ compensation (WC) data match (Contractor 11114)
‘15’ Workers compensation insurer voluntary data sharing agreements (WC VDSA) (contractor 1115)
‘16’ Liability insurer VDSA (Contractor 11116)
‘17’ No-fault insurer VDSA (Contractor 11117)
‘18’ Pharmacy benefit manager data sharing agreement (Contractor 11118)
‘19’ Workers compensation Medicare set-aside arrangements (WCMSA) (Contractor 11119)
‘21’ MIR group health plan (Contractor 11121)
‘22’ MIR non-group health plan (Contractor 11122)
‘25’ Recovery audit contractor MSP (California) (Contractor 11125)
‘26’ Recovery audit contractor MSP (Florida) (Contractor 11126)
‘39’ Group health plan recovery (Contractor 11139)
‘42’ Non-group health plan ORM recovery (Contractor 11142)</td></tr>
<tr><td>GENER HARDCPY</td><td>Instructs the system to generate a specific type of hard copy document. Valid values include:
Value Description
‘2’ Medical ADR
‘3’ Non-Medical ADR
‘4’ MSP ADR
‘5’ MSP Cost Avoidance ADR
‘7’ ADR to Beneficiary
‘8’ MSN (Line item) or Partial Benefit Denial Letter
‘9’ MSN (Claim level) or Benefit Denial Letter</td></tr>
<tr><td>MR INCLD IN COMP</td><td>The Composite Medical Review included in the composite rate field that identifies (for ESRD bills) if the claim has been denied because the service should have been included in the Comp Rate. Valid values are ‘Y’ (the claim has been denied).</td></tr>
<tr><td>CL MR IND</td><td>This indicator identifies if all services on the claim received Complex Manual Medial Review. The value entered in this field automatically populates the MR IND field for all revenue code lines on the claim. Valid values are:
Value Description
‘ ‘ The services did not receive manual medical review (default)
‘Y’ Medical records received. This service received complex manual medical review
‘N’ Medical records were not received. This service received routine manual medical review</td></tr>
<tr><td>TPE-TO-TPE</td><td>Identifies the tape-to-tape flag (if applicable). The flag indicators across the top of the chart instruct the system to either perform or skip each of the four functions listed on the left of the chart below. The first indicator column represents a blank. If this field is blank, all functions are performed (as indicated on this chart).
<table>
<tr><td>Function</td><td>‘ ‘</td><td>Q</td><td>R</td><td>S</td><td>T</td><td>U</td><td>V</td><td>W</td><td>X</td><td>Y</td><td>Z</td></tr>
<tr><td>Transmit to CWF</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>N</td></tr>
</table></td></tr>
</table>

Field name	Description											
	Print on Remittance Advice	Y	Y	Y	Y	N	N	Y	N	Y	Y	N
	Include on PS&R	Y	N	N	N	N	N	Y	Y	Y	Y	N
	Include on Workload	Y	Y	N	Y	Y	N	N	Y	Y	N	N
USER ACT CODE	The User Action Code is to be used for medical review and reconsideration only. First position: User Action Code; second position: Reconsideration Code. The reconsideration user action code will always be 'R'. when a recon is performed on the claim, the user should enter an 'R' in the second position of the claim user action code, or in the line user action code field. This tells the system that reconsideration has been performed. The valid values are: <u>Medical Review</u> '1' Religious Non-Medical Health Care Institutions (RNHCI) indicator; 'Excepted' medical treatment '2' Religious Non-Medical Health Care Institutions (RNHCI) indicator; 'Non-Excepted' medical. 'A' Pay per waiver – full technical 'B' Pay per waiver – full medical 'C' Provider liability – full medical – subject to waiver provisions 'D' Beneficiary liability – full – subject to waiver provisions 'E' Pay claim – line full 'F' Pay claim – partial – claim must be updated to reflect liability 'G' Provider liability – full technical – subject to waiver provisions 'H' Full or partial denial with multiple liabilities. Claim must be updated to reflect liability. 'I' Full provider liability – medical – not subject to waiver provisions 'J' Full provider liability – technical – not subject to waiver provisions 'K' Full provider liability – not subject to waiver provisions 'M' Pay per waiver – line or partial line 'N' Provider liability – line or partial line 'O' Beneficiary liability – line or partial line 'P' Open biopsy changed to closed biopsy 'Q' Release with no medical review performed 'R' Common working file (CWF) denied but medical review was performed 'Z' Force claim to be re-edited by Medical Policy <u>Special Screening</u> '5' Generates systematically from the reason code file to identify claims for which special processing is required. '7' Force claim to be re-edited by Medical Policy edits in the 5xxxx range but not the 7xxxx range. '8' A claim was suspended via an OCE MED review reason '9' Claim has been identified as 'First Claim Review'											
WAIV IND	Identifies whether the provider has their presumptive waiver status. The valid values are: Value Description 'Y' The provider does have their waiver status 'N' The provider does not have their waiver status											
MR REV URC	The Medical Revue Utilization review committee reversal field indicates whether an SNF URC claim has been reversed. This indicator can be used for a partial or a full reversal. This is a one-position alphanumeric field. The valid values are: Value Description 'P' Partial reversal 'F' Full reversal, the system reverses all charges and days											

Field name	Description
DEMAND	The Medical Review Demand reversal field identifies if a SNF demand claim has been reversed. This is a one-position alphanumeric field. The valid values are: Value Description 'P' Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal. 'F' Full reversal, the system reverses all charges and days.
REJ CD	The reject code field identifies the reason code for which the claim is being denied.
MR HOSP RED	The Medical Review hospice reduced field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. This is a one-position alphanumeric field. The Valid values are: Value Description ' ' Not reduced 'Y' Reduced
RCN IND	The Reconsideration Indicator field is used only for home health claims. The valid values are: Value Description 'A' Finalized count affirmed 'B' Finalized no adjustment count (pay per waiver) 'R' Finalized count reversal (adjustment) 'U' Reconsideration
MR HOSP-RO-REF	The Medical Review Regional Office referred field identifies (for RO hospice bills) if the claim has been referred to the regional office for questionable revocation. This is a one position alphanumeric field. The valid values are: Value Description ' ' Not referred 'Y' Referred
MED REV RSNS	The Medical Review reasons field identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field displays medical review reasons specific to claim level. The system determines this by a 'C' in the claim/line indicator on the reason code file. The medical review reasons must contain a '5' in the first position.
OCE MED REV RSNS	Displays the two-digit edit returned from the OPPS version of OCE. The valid values are: Value Description '11' Non-covered service submitted for review (condition code 20) '12' Questionable covered service '30' Insufficient services on day of partialization '31' Partial hospitalization on same day as electroconvulsive therapy or type T procedure '32' Partial hospitalization claim spans 3 or less days with insufficient services, or electroconvulsive therapy or significant procedure on at least one of the days. '33' Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services.
UNTITLED	This claim line number field identifies the line number of the revenue code. The line number is located above the revenue code on this map. To move to another revenue code, enter the new line number and press Enter.
REV	Identifies the Revenue Code for a specific accommodation or service that was billed on the claim. This information was entered on MAP1712. Valid values are 01 to 9999. To move to the next revenue code with a line level reason code, position the cursor in the page number field and press [F2].
HCPC/MOD IN	Identifies if the HCPC code, modifier or REV code was changed. Valid values are:

Field name	Description
	Value Description 'U' Up coding 'D' Down coding ' ' Blank A 'U' or 'D' in this field opens the REV code and HCPC/Mod fields to accept the changed code. Enter 'U' or 'D', tab down to the REV Code and HCPC/MOD fields. After the new code is entered, the original REV Code and HCPC/MOD fields move down to the ORIG REV or ORIG HCPC/MOD field.
HCPC	Identifies the HCPC code that further defines the revenue code being submitted. The information on this field was entered on MAP1712.
MODIFIERS	Identifies HCPCS modifier codes for claim processing. This field may contain five-2 position modifiers.
SERV DATE	The line item date of service, in MMDDYY format, and is required for many outpatient bills. This information was entered on MAP1712.
COV-UNIT	The number of covered units associated with the revenue code line item being denied.
COV-CHRG	The number of covered charges associated with the revenue code line item being denied.
ADR REASON CODES	Identifies the Additional Development Reason Codes that are present on the screen. The system reads the ADR code narrative to print the letter. The letter prints the reason code narrative as they appear on each revenue code line.
FMR REASON CODES	The Focused Medical Review Suspense Codes identify when a claim is edited in the system, based on a parameter in the Medical Policy Parameter file. The system generates the medical review code for the corresponding line item on the second page of the Denial/Non-Covered/Charges screen. The system assigns the same focused medical review ID edits on lines that are duplicated for multiple denial reasons. Claim level suspense codes should not apply to the line level. The medical policy reasons are defined by a '5' or '7' in the first position of the reason code.
ORIG	Identifies the original HCPC billed and modifiers billed, accommodating a 5-digit HCPC and up to 5 2-digit modifiers.
ORIG REV CD	Identifies the original revenue code billed.
MR	This indicator identifies if all services on the claim received complex manual medical review. The value entered in this field automatically populates the MR IND field for all revenue code lines on the claim. Valid values are: Value Description ' ' The services did not receive manual medical review (default) 'Y' Medical records received. This service received complex manual medical review 'N' Medical records were not received. This service received routine manual medical review.
ODC	A field with four occurrences that identifies the original denial reason codes.
OCE OVR	The OCE Override is used to override the way the OCE module controls the line item. Valid values include: Value Description '0' OCE line item denial or rejection is not ignored '1' OCE line item denial or rejection is ignored '2' External line item denial. Line item is denied even if no OCE edits '3' External line item rejection. Line item is rejected even if no OCE edits '4' External line item adjustment. Technical charge rules apply.
CWF OVR	First Coast Service Options use only, CWF override code
NCD OVR	This National Coverage Determinations override indicator field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. This is a one-position alphanumeric field.

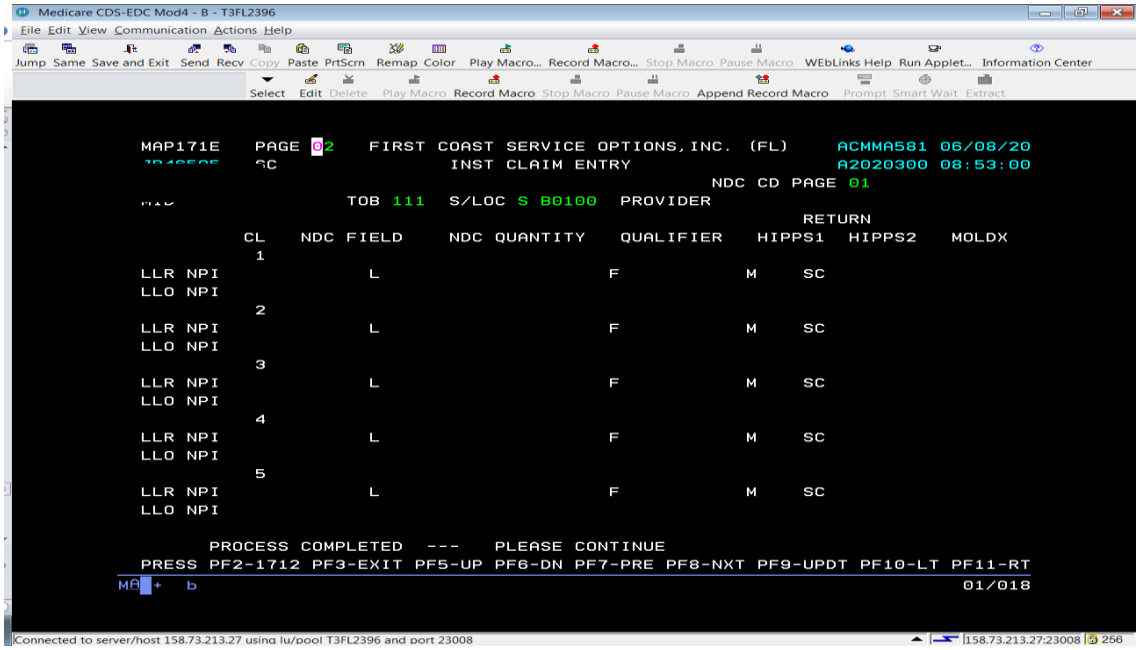
Field name	Description
	The valid values are: Value Description ‘ ‘ The NCD edits are not bypassed, (default value). Note a blank in this field is set on all lines for resubmitted RTP’d claims. ‘Y’ The line has been reviewed for medical necessity and will bypass the NCD edits. The line has no covered charges and will bypass the NCD edits.
NCD DOC	This National Coverage Determination Documentation indicator field identifies whether the documentation was received for the medically necessary service. Note: This indicator will not be reset on resubmitted RTP’d claims. This is a one-position alphanumeric field. The valid values are: Value Description ‘Y’ The documentation supporting the medical necessity was received ‘N’ The documentation supporting the medical necessity was not received, (default value).
NCD RESP	This RESP National Coverage Determination Response code field identifies the response code that is returned from NCD edits. This is a one-position alphanumeric field. The valid values are: Value Description ‘ ‘ Set to space for all lines on resubmitted RTP’d claims, (default value). ‘0’ The HCPCS/Diagnosis code watched the NCD edit table ‘pass’ criteria. The line continues through the system’s internal local medical necessity edits. ‘1’ The line continues through the system’s internal local medical necessity edits, because: the HCPCS code was not applicable to the NCD edit table process, the date of service was not within the range of the effective dates for the codes, the override indicator is set to ‘Y’ or ‘D’, or the HCPCS code field is blank. ‘2’ None of the diagnoses supported the medical necessity of the claim (list 3 codes), but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. ‘3’ The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list two codes). The line suspends and indicates liable due to non-coverage by statute. ‘4’ None of the diagnosis codes on the claim support the medical necessity for the procedure (list three codes) and no additional documentation is provided. This line suspends as not medically necessary and will be denied. ‘5’ Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the MAC (FI) will RTP the claim.
NCD #	The National Coverage Determination Number field identifies the NCD number associated with the beneficiaries claim denial.
OLUAC	Identifies the Original Line User Action Code. It is only populated when there is a line user action code and a corresponding medical review denial reason code and a corresponding medical review denial reason code in the Benefits Savings potion of FISS.
LUAC	The Line User Action Code identifies the cause of denial for the revenue line and a reconsideration code. The denial code (first position) must be present in the system and pre-defined in order to capture the correct denial reason. The values are equal to the values listed for User Action Codes. The reconsideration code (second position) has a value equal to ‘R’, indicating to the system that reconsideration has been performed.

Field name	Description
	For the Revenue Code Total Line 0001, the system generates a value in the first two line occurrences of the LUAC field. These values indicate the type of total amount displayed on the total non-covered units and non-covered charges for the revenue code line 0001, only on MAP171D. These values do not apply to this field for any other revenue code line other than 0001. Valid values are: Value Description '1' LUAC lines present on MAP171D '2' Non-LUAC lines present on MAP171D
NON COV-UNIT	Non-Covered Units identifies the number of days/visits that are being denied. Denied days/visits are required for those revenue codes that require units on Revenue Code file. The first line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines not containing a LUAC on MAP171D.
NON COV-CHRG	Non-Covered Charges identifies the total number of denied/rejected/non-covered charges for each line item being denied. This is a nine-digit field in 9999999.99 formats. The first line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines containing a LUAC on MAP103I. The second line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines not containing a LUAC on MAP171D.
DENIAL REAS	The Denial Reason identifies the cause of denial for the revenue code line. The denial code must be present in the system and pre-defined in order to capture the correct denial reason.
OVER CODE	The Override Code identifies the override code that allows First Coast operator to manually override the system generated ANSI codes taken from the Denial Reason Code File. The valid values are: Value Description ' ' Default to system generated 'A' Override system generated ANSI codes
ST/LC OVER	The Status Location Override identifies the override of the reason code file status when a line item has been suspended. The valid values are: Value Description ' ' Process claim with no override code 'D' Denied, for the reason code on the line 'R' Rejected, for the reason code on the line The override code remains in this field for editing purposes performed on the claim. When the override code is deleted, the system generates the ANSI codes from the reason code file.
MED TEC	This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. The valid values are: Value Description 'A' Home Health only – not intermittent care – technical and waiver was applied 'B' Home Health only – not homebound – technical and waiver was applied 'C' Home Health only – lack of physicians orders – technical deletion and waiver was not applied

Field name	Description
	'D' Home Health only – records not submitted after the request – technical deletion and waiver was not applied 'E' New value – Provider Technical – provider submitted bill in error 'M' Medical denial and waiver was applied 'S' Medical denial and waiver was not applied 'T' Technical denial and waiver was applied 'U' Technical denial and waiver was not applied
ANSI ADJ	This field identifies the ANSI Adjustment Reason Code. The data for this field is from the ANSI file housed as the second page in the reason code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen.
ANSI GRP	This field identifies the ANSI Group code. The data for this field is from the ANSI file housed as the second page in the reason code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This is a four-position field with a maximum of four occurrences.
ANSI REMARKS	This field identifies the ANSI Remarks codes. The data for this field is taken from the ANSI file housed as the second page in the reason code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen.
TOTAL	This field identifies the total of all revenue code non-covered units and charges present on MAP171D.
LINE ITEM REASON CODES	This field identifies the reason code that is assigned out of the system for suspending the line item. There are four (4) FISS reason codes that can be assigned to the line level. This is a five-digit field.

MAP171E - Claim Entry – Page 2

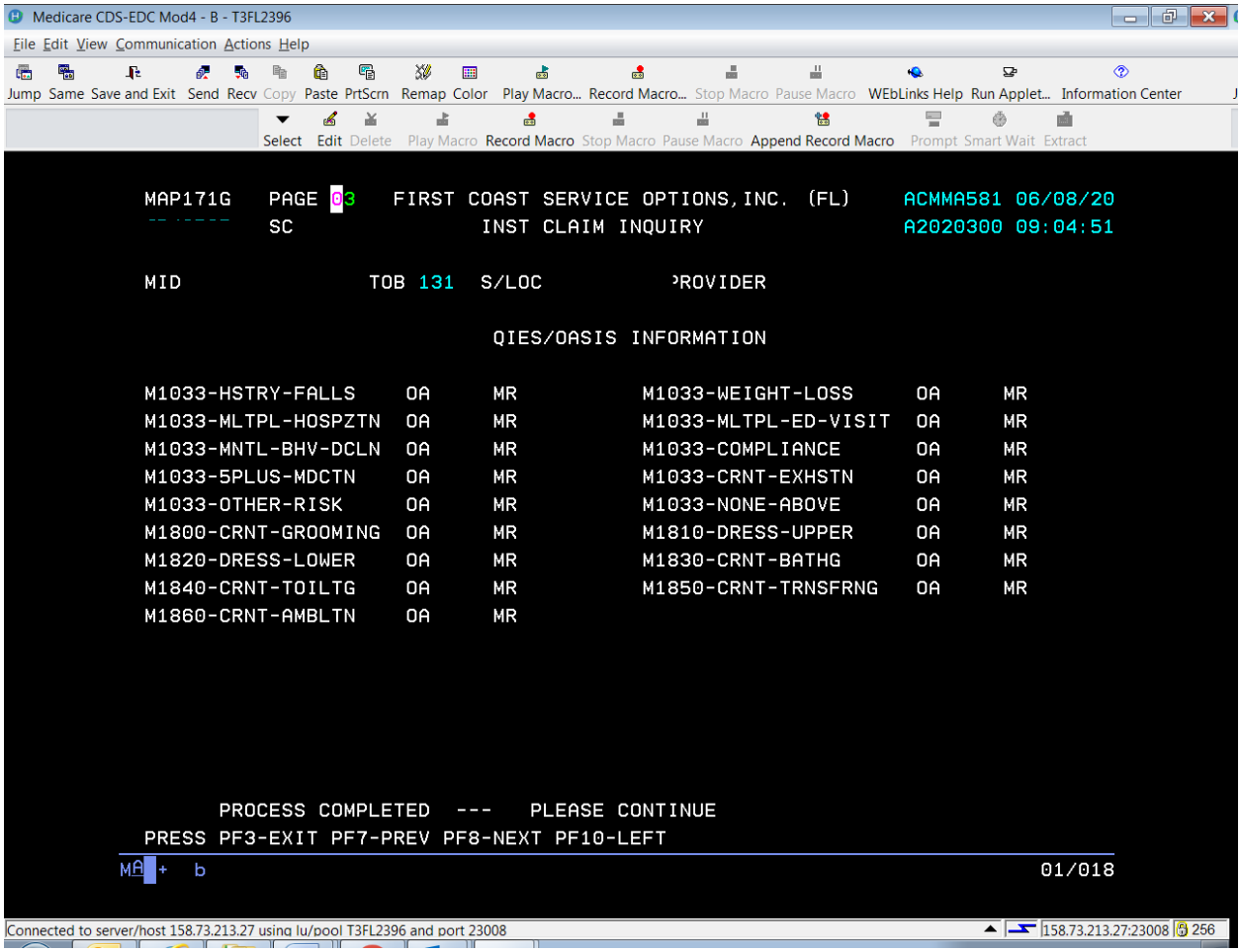
This screen allows users to be able to input a unique test ID into their claims at the detail line level for the Molecular Diagnostic Services (MolDX). This screen also allows for reporting Line Level Ordering Provider (LLO) NPI on Institutional claims for advanced diagnostic imaging. Access the MAP171E screen by the Claim page 02 – F2 and then F10 to this MAP



MAP171G – Claim Entry Page 3

Displays the Outcome and Assessment Information Set (OASIS) data returned by the Quality Improvement and Evaluation System (QIES)

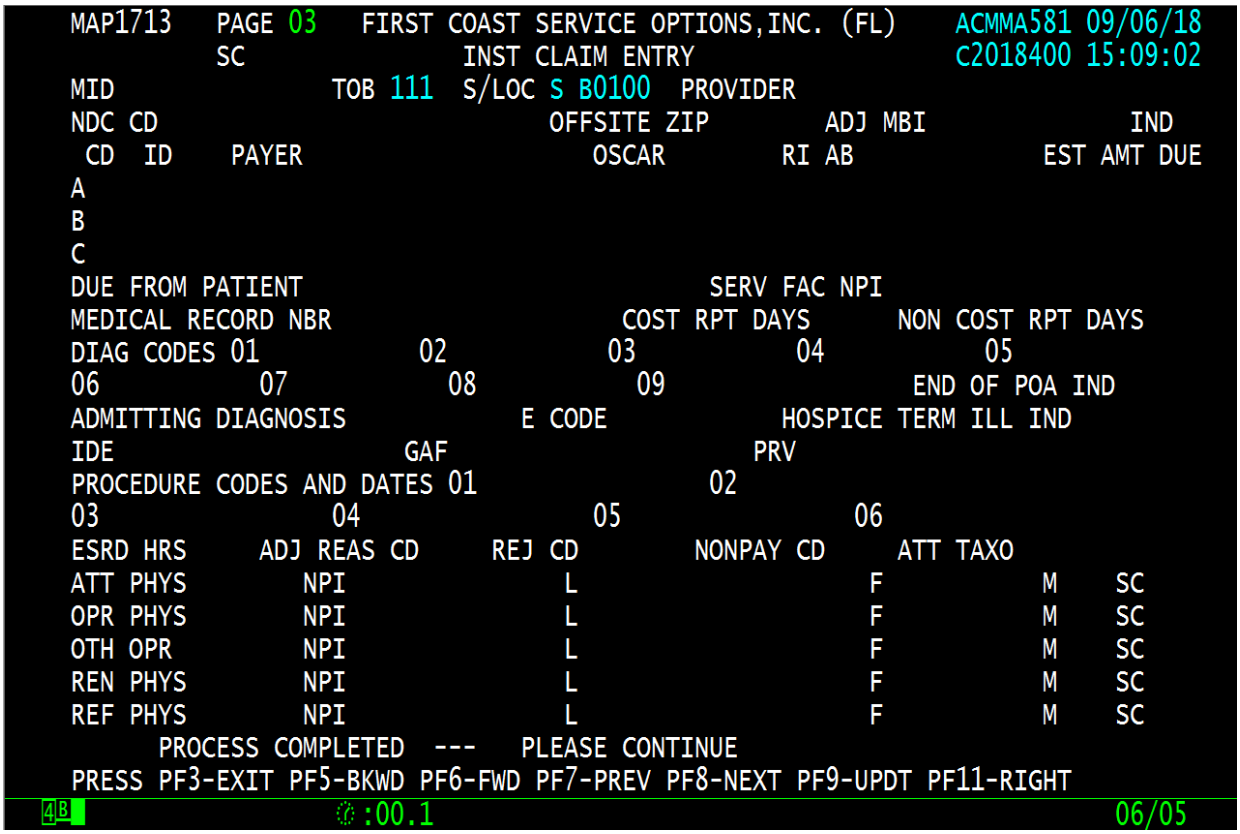
To access the new MAP171G screen select Claims/Attachments from MAP1701. Select Option 20 or 22 depending on what type of claim you are working. F8 to claim page 03, MAP1713. Press F11 to MAP171G.



MAP1713 - Claim Entry – Page 3

Enter the following information onto page 3 of the claim entry screen:

- Payer information
- Diagnoses codes
- Attending physician (NPI, first and last name)



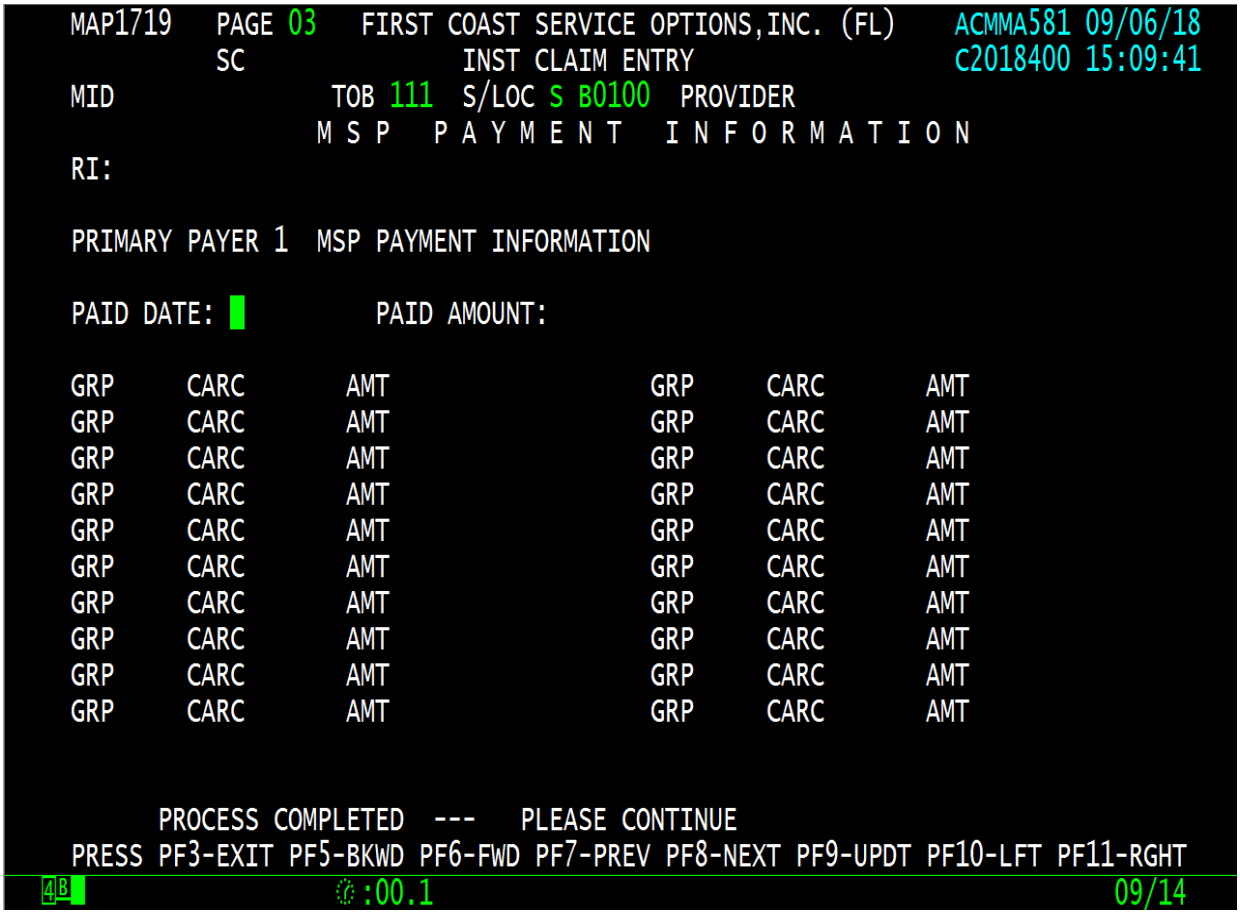
Field name	Description
CD	Primary Payer Code – use the following list of codes when submitting electronic claims for payer information. The codes listed in the following table are for Medicare requirements only. Other payers' required codes are not reflected. Valid entries: Value Description B End Stage Renal Disease (ESRD) beneficiary in 18-month coordinated period with an employer group health plan (EGHP) C Conditional payment D Auto – no fault E Workers' compensation F Public health service (PHS) or other federal agency G Disabled – large group health plan (LGHP) H Black lung (federal black lung program) I Veteran's administration L Liability Z Medicare A
ID	Not required
PAYER	Payer Identification (A) Primary Payer – If Medicare is the primary payer, enter 'Medicare' on line A. Entering Medicare indicates that the hospital developed for other insurance and determined that Medicare is the primary payer. If there are payer(s) of higher priority than Medicare, enter the name of the higher priority payer on line A. (B) Secondary Payer – If Medicare is the secondary payer, identify the primary payer on line A and enter 'Medicare' on line B. (C) Tertiary Payer – If Medicare is the tertiary payer, identify the primary payer on line A, the secondary payer on line B and enter 'Medicare' on line C.
PROVIDER NO	Enter the Provider Number assigned to the provider by the payer indicated in form locator 50 A, B or C.

Field name	Description
RI	The Release of Information certification indicator indicates whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. Valid entries: Value Description 'Y' Yes 'R' Restricted or modified release 'N' No release
AB	The Assignment of Benefits certification indicator shows whether the provider has a signed form authorizing the third party payer to pay the provider. Valid entries: Value Description 'Y' Yes 'N' No Not applicable
PRIOR PAY	Enter the amount the provider has received from the indicated payer toward payment on the bill prior to the Medicare billing date.
EST AMT DUE	Not applicable
DUE FROM PATIENT	The Due From Patient field is for outpatient services only. Enter the amount the provider has received from the patient toward payment.
MEDICAL RECORD NBR	Alphanumeric field used to enter patient's Medical Record Number.
COST RPT DAYS	The Cost Report Days identify the number of days claimable as Medicare patient days for inpatient and SNF types of bills (11x, 41x, 18x, 21x, 28x, and 51x) on the cost report. The system calculates this field and inserts the applicable data.
NON COST RPT DAYS	Identifies the number of Non-Cost Report Days not claimable as Medicare patient days for inpatient and SNF types of bills (11x, 18x, 21x, 28x, 41x, and 51x) on the cost report.
DIAGNOSIS CODE	Enter the full ICD-9-CM codes for the principal diagnosis code and up to eight (8) additional conditions co-existing at the time of admission which developed subsequently, and which had an effect upon the treatment given or the length of stay. Note: Decimal points are not required.
ADMITTING DIAGNOSIS	In the Admitting Diagnosis field, for inpatient, enter the full ICD-9-CM code for the principal diagnosis relating to condition established after study to be chiefly responsible for the admission. Note: Decimal points are not required.
E CODE	The External Cause of Injury Code field is used for E-codes should be reported in second diagnosis field form locator 68.
HOSPICE TERM ILL IND	Not required
IDE	This field will contain an IDE authorization number assigned by the FDA. The IDE is only used for revenue code 0624 and should always begin with a 'G'.
GAF	This field will contain the Geographic adjustment factor that's at a claim level.
PROCEDURE CODES AND DATES	Enter the full ICD-9-CM, including all four-digit codes where applicable for the principal procedure (first code). Enter the date in MMDDYY format that the procedure was performed during the billing period (within the 'from' and 'through' dates of services in form locator 6).
PRV ESRD HOURS	This field identifies the ICD-9-CM or ICD-10-CM code describing the patient's stated reason for seeking care at the time of outpatient registration. This is a seven-position alphanumeric field with three occurrences. Enter the number of hours a patient dialyzed on peritoneal dialysis.
ADJUSTMENT REASON CODE	Not required for new claim entry. Adjustment reason codes are applicable only on adjustments TOB xx7 or xx8.
REJECT CODE	Not required by provider. For intermediary use only.
NON-PAY CODE	Not required by provider. For intermediary use only.

Field name	Description
ATTENDING PHYS	Enter the National Provider Identification Number (NPI) and name of the attending physician for inpatient bills or the physician that requested the outpatient services. Inpatient Part A – Enter the NPI and name of the clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. Enter the NPI in the first 10 positions, followed by two spaces, the last name, one space, the first name, one space and middle initial. Outpatient and Other Part B - Enter the NPI of the physician who requested the surgery, therapy, diagnostic tests, or the physician who has ordered Home Health, Hospice, or a Skilled Nursing Facility (SNF) admission in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial. Attending Physician I.D. – All Medicare claims require NPIs, e.g., including cases when there is a private primary insurer involved. Physicians not participating in the Medicare program may obtain NPIs. Additionally, for outpatient and other Part B, if there is more than one referring physician, enter the NPI of the physician requesting the service with the highest charge.
OPERATING/ OTHER	Enter the NPI and name of the physician who performed the principal procedure. Inpatient Part A Hospital – Enter the NPI and name of the physician who performed the principal procedure. If no principal procedure is performed, leave blank. Outpatient Hospital – Enter the NPI and name of the physician who performed the principal procedure. If there is no principal procedure, enter the NPI and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. Use the format for inpatient. Other bill types – Not required.

MAP1719 - Claim Entry – Page 3 Medicare Secondary Payer Payment Information

DDE claim submitters are to use the new DDE screen MAP1719 for claim level adjustments and the Coordination of Benefits (COB) payer paid amounts. To access the new MAP1719 screen press F11 from page 3 (MAP1713). The new MAP1719 screen allows DDE claims submitters up to 2 iterations of MSP Payment information (MSPPAY). If more than 1 iteration is needed simply press F6 from the first MSP payment information screen.

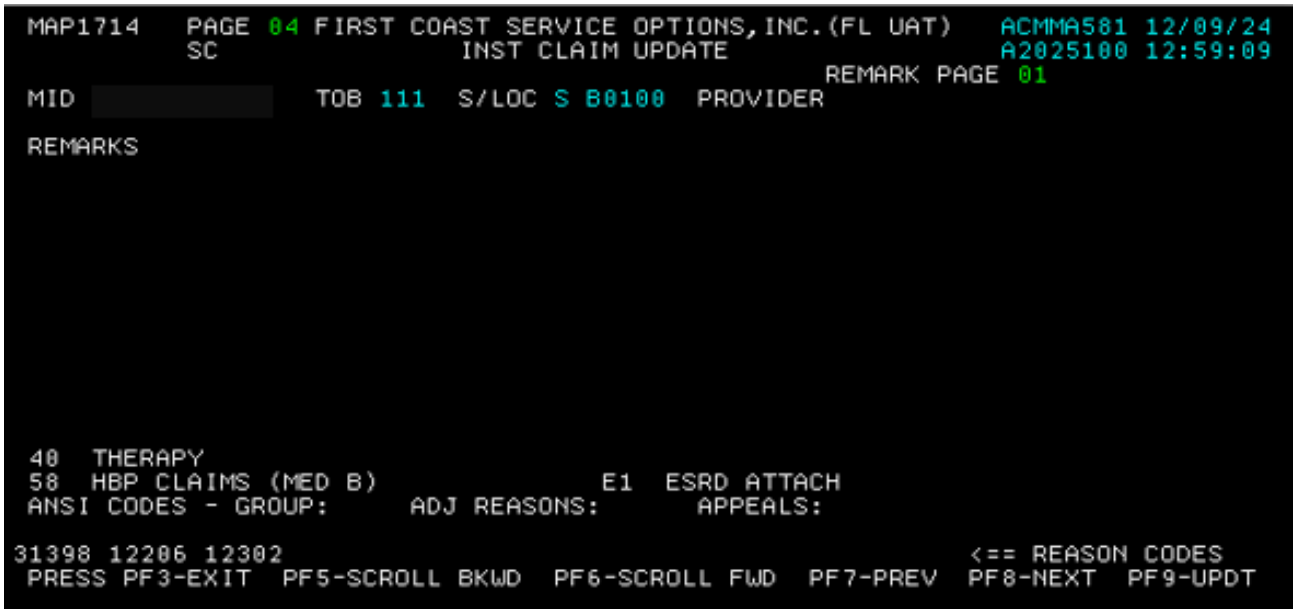


Field name	Description
PAID DATE	This field identifies the date that the provider received payment from Primary Payer 1. This is a six-position alphanumeric field in MMDDYY format. PF6 and PF7 to scroll forward and backward between the screen for Primary Payer 1 and Primary Payer 2.
PAID AMOUNT	This field identifies the payment that the provider received from Primary Payer 1. This is an eleven-position numeric field in 999999999.99 format.
GRP	This field identifies the ANSI group codes. This is a two-position alphanumeric field, with 20 occurrences
CARC	This field identifies the ANSI CARC codes. This is a four-position alphanumeric field, with 20 occurrences.
AMT	This field identifies the dollar amount associated with the group/CARC combination. This field is an eleven-position numeric field in 999999999.99 format, with 20 occurrences.

MAP1714 - Claim Entry – Page 4 Remarks
The remarks page is used to transmit information submitted on automated claims, and it allows the staff at First Coast a mechanism to make comments on claims that need special consideration for adjudication.

Provider may utilize page 4 to:

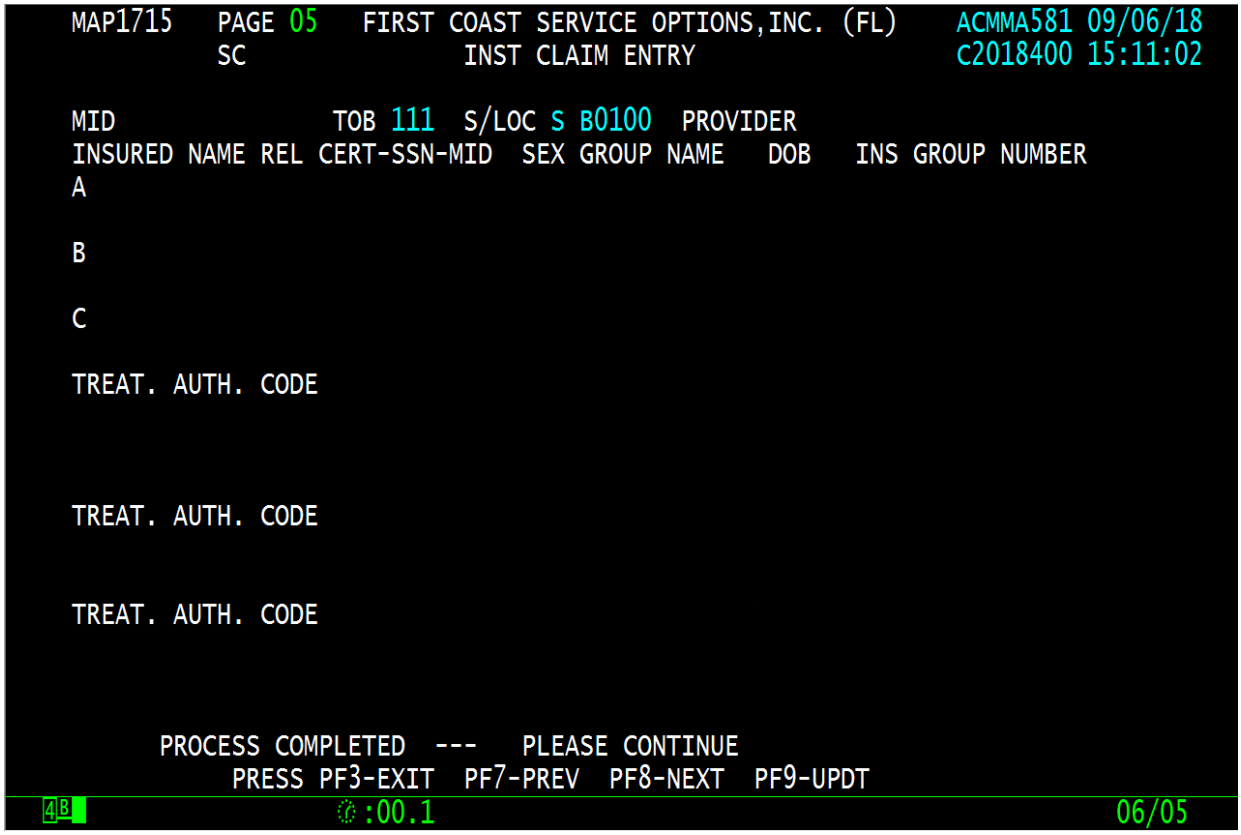
- Justify claims filed untimely
- Justify adjustments to paid claims (required when using the ‘D0 – E0’ condition codes)
- Justify cancels to paid claims
- Justify other reasons that may delay claim adjudication



Field name	Description
REMARKS	Maximum of 711 positions. Enter any remarks needed to provide information not reported elsewhere on the bill, but which may be necessary to ensure proper Medicare payment. This field carries the remarks information as submitted on automated claims, as well as provides internal staff with a mechanism to provide permanent comments regarding special considerations that played a part in adjudicating the claim; e.g., the Medical Review department may use this area to document their rationale for the final medical determination or to provide additional information to assist with claim finalization. The remarks field is also used for providers to furnish justification of late filed claims that override the intermediary's existing reason code for timeliness. The following information must be entered on the first line. Additional information may be entered on the second and subsequent lines of the remarks section for further justification. Select one of the following reasons and enter the information exactly as it appears below: Justify: MSP involvement Justify: SSA involvement Justify: PRO Review involved Justify: Other involvement
[ATTACHMENTS]	The following provides information on attachments: Value Description Used or Not Used 47 Pacemaker Not used 48 Ambulance Not used 40 Therapy Not used 41 Home Health Not used 58 HBP claims (Med B) Not used E1 ESRD Not used
ANSI CODES – GROUP	Identifies the general category of payment adjustment. Used for claims submitted in an ANSI automated format only.
ADJ REASONS	Claim adjustment standard reason code that identifies appeals codes for inpatient or outpatient.
APPEALS	Identifies ANSI appeals codes for inpatient or outpatient.

MAP1715 - Claim Entry – Page 5

Page five of the claim entry screen is used to enter a patient's payer information.



Field name	Description
INSURED NAME	Maximum of 25 digits; last name, first name. On the same line that corresponds to the line on which Medicare payer information is reported, enter patient's name as reported on his/her Medicare health insurance card. If billing supplemental insurance, enter the name of the individual insured under Medicare on line A and enter the name of the individual insured under a supplemental policy on line B. Complete this section by entering the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and the provider is requesting payment because: ▪ Another payer paid some of the charges and Medicare is secondarily liable for the remainder; ▪ Another payer denied the claim; or ▪ The provider is requesting conditional payment.
REL	On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is reported, enter the code indicating the relationship of the patient to the identified insured. The following codes are for Medicare requirements only. Other payers may require codes not reflected. Value Description 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown

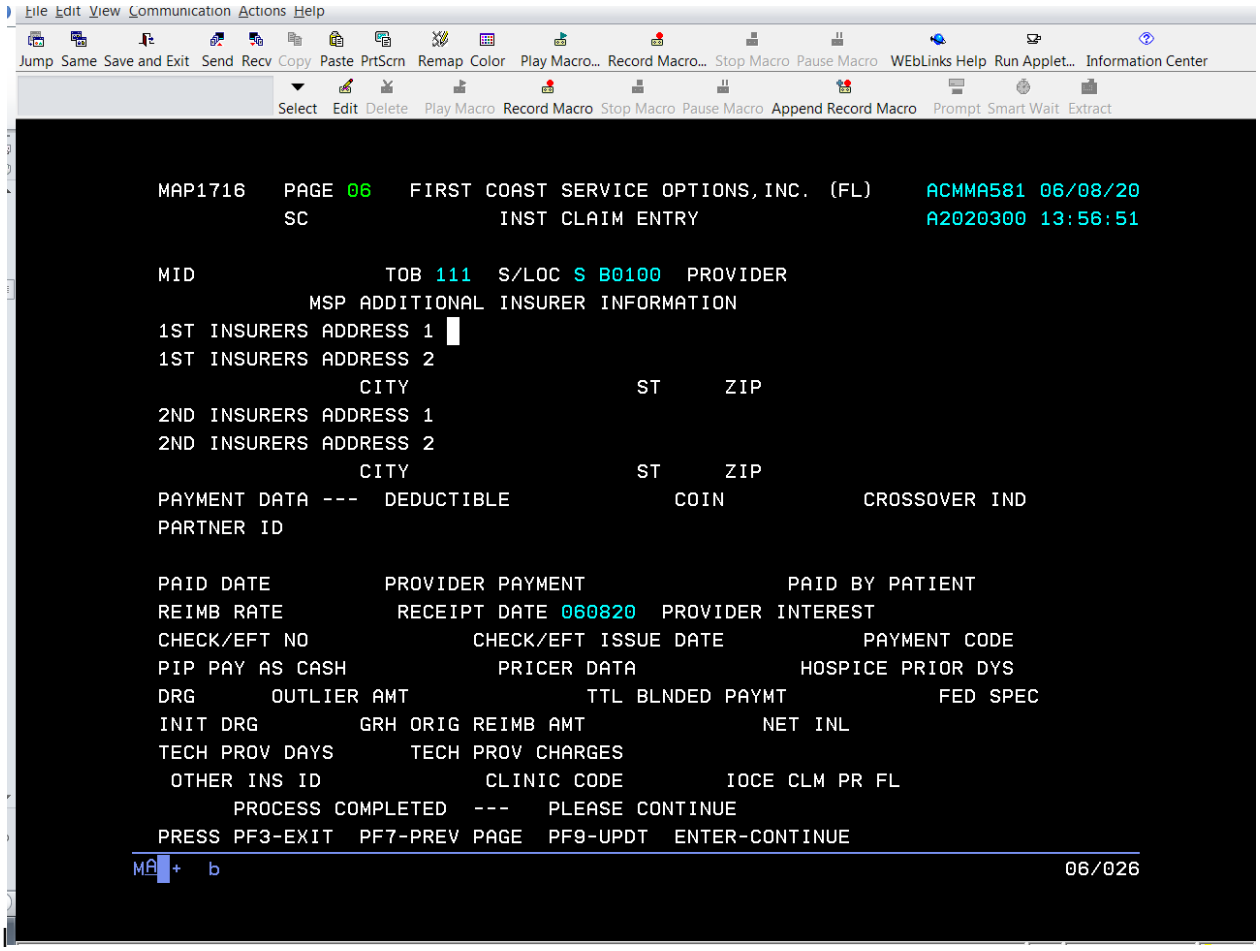
Field name	Description
	22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child where insured has no financial responsibility 53 Life Partner G8 Other relationship
CERT.-SSN-MEDICARE ID NUMBER	Enter the patient's Health Insurance Card Number (Medicare ID) if Medicare is the primary payer.
SEX	The sex of the beneficiary/patient. Use 'F' for female, 'M' for male or 'U' for unknown.
GROUP NAME	Enter the name of the group or plan through which that insurance is provided. Entry required, if applicable.
DOB	Enter numerically in century, year, month, and day format (CCYYMMDD) for the Insured Subscriber.
INS GROUP NUMBER	Enter the Insurance Group identification number, control number, or code assigned by that health insurance company to identify the group under which the insured individual is covered. Entry required, if applicable.
TREAT. AUTH CODE	HHPPS Treatment Authorization Code – This field identifies a matching key to the OASIS (Outcome Assessment Information Set) of the patient. This field is two 8-digit dates (MMDDCCYYMMDDCCYY) followed by a 2-digit code (01-10). The first date comes from M0030 that is the Start of Care Date; the second date is from M0090 that is the Date Assessment Completed. The codes are from M0100 that is for the assessment currently being completed for the following reasons: Value Description 01 Start of care – further visits planned 02 State of care – no further visits planned 03 Resumption of care (after inpatient stay) 04 Recertification 05 Other follow-up 06 Transferred to an inpatient facility – patient not discharged from agency 07 Transferred to an inpatient facility – patient discharged from agency 08 Death at home This field is also used to identify a Center for Excellence, Provider Partnership Demonstration for NOA type of Bill '11A' and '11D', and Re-billed Demonstration. The valid values are: Value Description 07 Centers for Excellence 08 Providers Partnership Demonstration SPN65 State of care – no further visits planned SPN66 Re-billed claims due to provider self-audit after claim submission/payment SPN67 Re-billed claims due to provider self-audit after the patient has been discharged, but prior to submission for payment. **Note:** This field is also used to report the Unique Tracking Number (UTN) associated with the Medicare Payer iteration. For bill types other than 32X or 33X, report the UTN in positions 1-14. For 32X bill types, report the 14-position UTN immediately following the 18-position OASIS Treatment Authorization Number. The valid format of the UTN is:

Field name	Description
	Position Description 1-2 MAC Jurisdiction (alpha-numeric) 3 A for Part A program, or H for Home Health/Hospice Program 4-14 Numberic Valid data is: ▪ Trial 49 ▪ SPN66 ▪ 64 ▪ 56 ▪ A/B Rebilling ▪ 54 ▪ SPN65 ▪ 07 ▪ 08 ▪ Valid 18-byte OASIS Treatment Number for Home Health claims

MAP1716 - Claim Entry – Page 6 MSP Additional Insurer Information

The following information can be found on page 6 of the claim entry screen:

- Medicare secondary payer (MSP) address
- Payment data (coinsurance, deductible, etc.)
- Pricer data (DRG, etc.)
- Integrated Code Editor (IOCE) CLM PR FL



Field name	Description
INSURER'S ADDRESS 1 AND 2	Enter the address of the insurance company that corresponds to the line on which Medicare payer information is reported (FL 58A, B or C).
CITY 1 AND 2	Enter the specific city of the insurance company
ST 1 and 2	Enter the specific state of the insurance company
ZIP 1 and 2	Enter the specific ZIP code of the insurance company

Payment Data - this information is available for viewing in detail claim inquiry (Option 12) immediately after the claim is updated or entered on DDE.

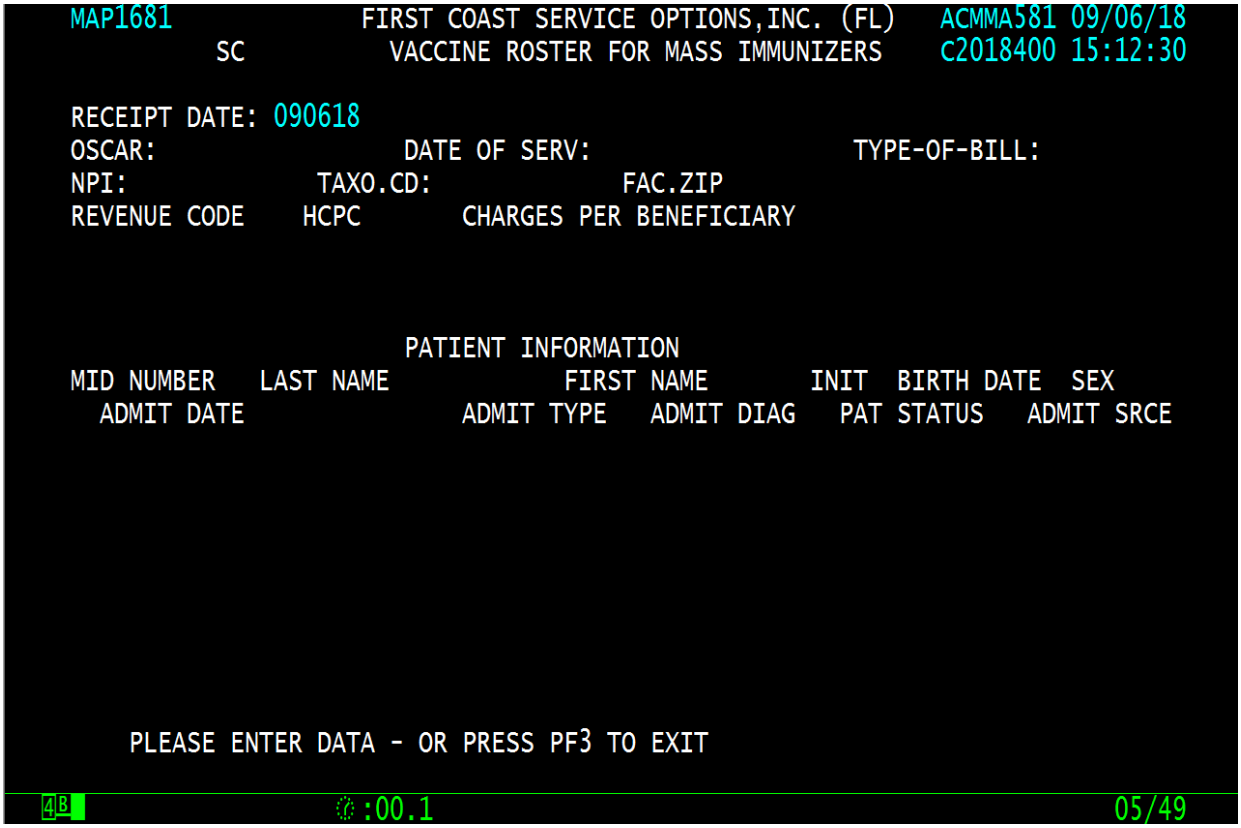
Field name	Description
DEDUCTIBLE	Amount applied to the beneficiary's deductible payment.
COIN	Amount applied to the beneficiary's co-insurance payment.
CROSSOVER IND	The crossover indicator identifies the Medicare Payor on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. Valid values are: Value Description 1 Primary 2 Secondary 3 Tertiary
PARTNER ID	Identifies the Trading Partner number. 'N' means the claim did not cross over.
PAID DATE	This is the actual date that claim was processed for payment consideration.
PROIVDER PAYMENT	This is the actual amount that provider was reimbursed for services.
PAID BY PATIENT	Actual amount reimbursed to the beneficiary.
REIMB RATE	Provider's specific reimbursement rate (PPS).
RECEIPT DATE	Date claim was first received in the FISS system.
PROVIDER INTEREST	Interest paid to the provider.
CHECK/EFT NO	This field displays the identification number of the check or electronic file transfer.
CHECK/EFT ISSUE DATE	This field displays the date the check was issued or the date the electronic file transfer occurred.
PAYMENT CODE	Displays the payment method of the check or electronic funds transfer. Valid values are: Value Description ACH Automated clearing house or Electronic funds transfer CHK Check NON Non-payment data
DRG	The Diagnostic Related Grouping code assigned by the pricer's calculation.
OUTLIER AMOUNT	Amount qualified for outlier reimbursement.
TTL BLNDED PAYMENT	Not utilized in DDE
FED SPEC	Not utilized in DDE
GRAMM RUDMAN ORIG REIMBURSEMENT AMT	The Gramm Rudman Original Reimbursement Amount
NET INL	Not utilized in DDE
TECHNICAL PROV DAYS	The number of days for which the provider is liable.
TECHNICAL PROV CHARGES	The dollar amount for which the provider is liable.
OTHER INS ID	Not utilized in DDE
CLINIC CODE	Not utilized in DDE

MAP1681 - Vaccine Roster for Mass Immunizers (87)

To access the Roster Bill entry page, open the claim and attachments entry menu (select option 02 from the main menu) and then select option 87. The DDE roster bill page will display. This page allows providers to enter their pneumococcal pneumonia and flu shots in a roster bill format. After typing roster bill information, press [9]to transmit the claim.

When completing the roster bill providers should observe the following points

- Only one date of service per roster page
- A maximum of ten patients per roster page may be reported on a DDE roster page



Field name	Description
RECEIPT DATE	The system date that the intermediary received the claim.
PROVIDER NUMBER	The identification number of the institution that rendered services to the beneficiary/ patient. Note: The system will populate the Medicare provider number used when logging onto the DDE system. If your facility has sub-units (SNF, ESRD, Inpatient, etc.) the Medicare provider number must be changed to reflect the provider number you wish to submit claims for. If the Medicare provider number is not changed for your sub-units, the claims will be processed under the incorrect provider number.
DATE OF SERVICE	The date of service was rendered to the beneficiary (in MM/DD/CCYY format).
TYPE OF BILL (TOB)	Key the type of bill for the roster bill being submitted.
REVENUE CODE	Enter the specific accommodation or service that was billed on the claim. This should be done by line item.
HCPC	Healthcare common procedure coding system (HCPCS) applicable to ancillary services.
CHARGES PER BENEFICIARY	Enter the charges per revenue code being charged to the beneficiary.
MEDICARE ID	The health insurance claim number assigned when a beneficiary becomes eligible for Medicare.

Field name	Description
LAST NAME	Enter the last name of the patient as it appears on the patient's health insurance card or other Medicare notice.
FIRST NAME	Enter the first name of the patient as it appears on the patient's health insurance card or other Medicare notice.
INITIAL	Enter the middle initial of the patient.
BIRTH DATE	Enter the date in MMDDCCYY format.
SEX	Enter the sex of the patient.

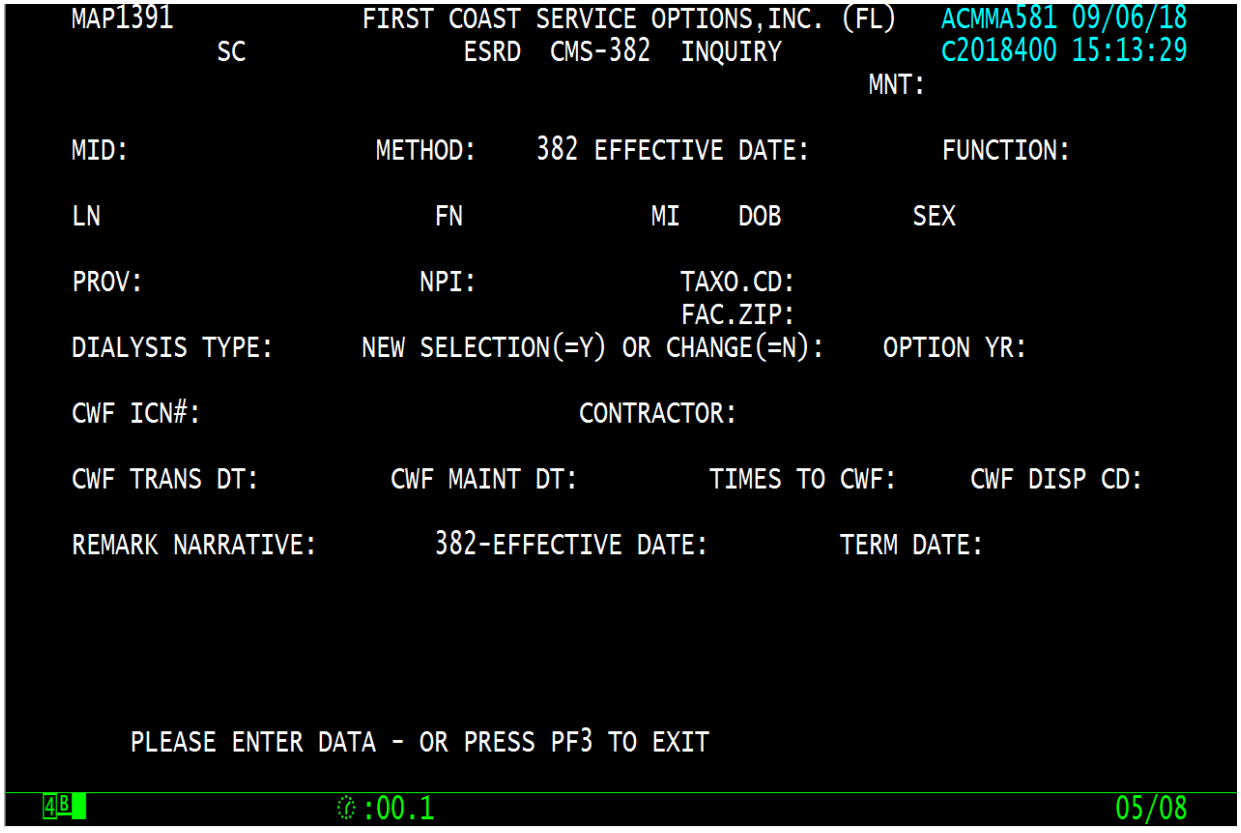
MAP1391 - ESRD CMS-382 Inquiry (57)

The ESRD attachment form allows ESRD providers to inquire, update, and enter an ESRD method selection data. Select option '57' from the Claim and Attachments Entry Menu. Enter a MEDICARE ID number and function.

Choose one of the following functions:

- E = Entry
- U = Update
- I = Inquiry

Press ENTER to access the additional fields for entry. If a beneficiary is currently on file when you enter an 'E' for the method selection form the system will automatically enter the beneficiary's last name, first name, middle initial, date of birth, and sex based on the information stored on the beneficiary file. In addition, the system should allow access to the provider number, dialysis type, and selection or change fields.



Field name	Description
OP	The Operator Code identifies the last operator to update this record.
DT	The last date that this record was processed.
MEDICARE ID	The beneficiary's health insurance card number.
METHOD	The method of home dialysis selected by the beneficiary. Valid values are:

Field name	Description
	Value Description Method I Beneficiary receives all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claims for their services. Method II Beneficiary deals directly with one supplier and is responsible for submitting their own claim.
382 EFFECTIVE DATE	Identifies the date the beneficiary's ESRD method selection becomes effective on the (CMS-382) form.
FUNCTION	Three valid functions include: Value Description E Entry U Update I Inquiry
LN	Last name of the beneficiary at the time the method selection occurred.
FN	First name of the beneficiary.
MI	Middle initial of the beneficiary.
DOB	Beneficiary's date of birth.
SEX	Sex of the beneficiary.
PROV	Enter the ESRD provider number or the facility for which you are entering the ESRD attachment. The Medicare provider number will populate with the provider number you used to log onto the DDE system. Therefore, if you have sub-units (multiple ESRD facilities) you will need to change the provider number to reflect the ESRD facility for which the attachment information is being entered.
DIALYSIS TYPE	Valid types of dialysis include: Value Description 1 Hemodialysis 2 Continuous ambulatory peritoneal dialysis (CAPD) 3 Continuous cycling peritoneal dialysis (CCPD) 4 Peritoneal dialysis
NEW SELECTION OR CHANGE	Indicates an exception to other ESRD data. Valid values are: Value Description 'Y' Selection – entered on initial selection or for exceptions such as when the option year is equal to the year of the select date 'N' Change – entered for a change in selection, e.g., option year is one year greater than the year of select date.
OPTION YR	Identifies the year that a beneficiary selection or change is effective. A selection change becomes effective on January 1 of the year following the year the ESRD beneficiary signed the selection form.
CWF ICN#	Common working file (CWF) internal control number (ICN) is inserted by FISS on the ESRD remarks screen to ensure the correction is being made to the appropriate ESRD remark segment.
CONTRACTOR	Identifies the carrier or intermediary responsible for a particular ESRD maintenance file.
CWF TRANS DT	The date that information was transmitted to the CWF.
CWF MAINT DT	Identifies the date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	Number of times the record was transmitted to CWF.
CWF DISP CD	The CWF disposition code. Valid values include: Value Description 01 Debit accepted, no automated adjustment 02 Debit accepted, automated adjustment 03 Cancel accepted 04 Outpatient history only accepted 50 Not in file (NIF) 51 True NIF on CMS (HCFA) batch system 52 Master record housed at another CWF site

Field name	Description
	53 Record in CMS (HCFA) alpha match 55 Name/personal character mismatch 57 Beneficiary record archived, only skeleton exists 58 Beneficiary record blocked for cross reference 59 Beneficiary record frozen for clerical correction 60 Input/output error on data 61 Cross-reference database problem AA Debit accepted, automatic adjustment AB Transaction caused CICS abnormal end of job (abend) BN Claim not crossed over to COBC BT History claim not present to support spell of illness CI CICS processing error CR Crossover reject ER Consistency edit reject RD Transaction error RT Retrieve pending trailer UR Utilization reject
REMARK NARRATIVE	Valid remark narrative types include: Value Description M1 Method I M2 Method II
382 EFFECTIVE DATE	The method effective date. Valid values are: Value Description Y The 382 effective date is equal to the 382 signature date N The 382 effective date will be January 1 of the following year
TERM DATE	Projected date of termination of dialysis coverage.

Section 6 – Claim Correction and Adjustments (03)

Introduction

When a claim is submitted, it goes through two levels of editing to determine whether it can be processed. The front-end edits catch errors before the claim is transmitted and results in reason codes. The back-end edits look for additional problems after the claim has been transmitted and may be returned if an error exists.

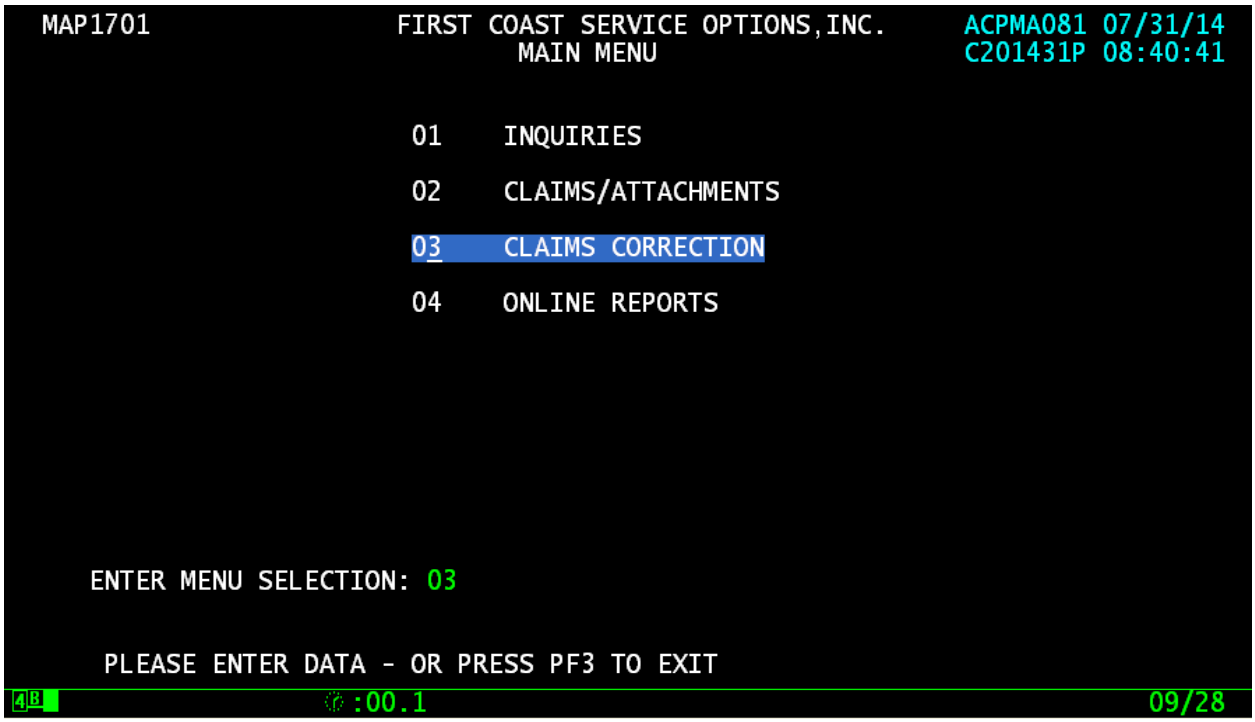
When the back-end edits determine that a claim requires correction, the claim is given a status/location code beginning with the letter 'T' and routed to the claim summary inquiry screen.

You are permitted to correct only those claims appearing on the summary screen in status/location "TB9997". Claims that have been given "T" status have not yet been processed for payment consideration, so it is important to review your claims daily and correct them in order to avoid delays in payment.

When correcting a claim, the correct NPI number for the facility's claims you wish to access must be keyed in the "NPI" field. If the correct NPI number associated with the claim is not entered, the system will give you an error message that it cannot locate the claim. If you receive an error message, verify that the correct NPI number is showing in the "NPI" field. If the NPI is incorrect tab to the NPI field and type in the correct NPI number.

Medicare Secondary Payer (MSP) claims that are returned to the provider cannot be corrected through Direct Data Entry (DDE).

The Claims Correction option 03 will allow you to correct claims in RTP, status location T B9997, adjust claims in status location P B9997 and certain claims in status location R B9997, and cancel paid claims in status location P B9997.



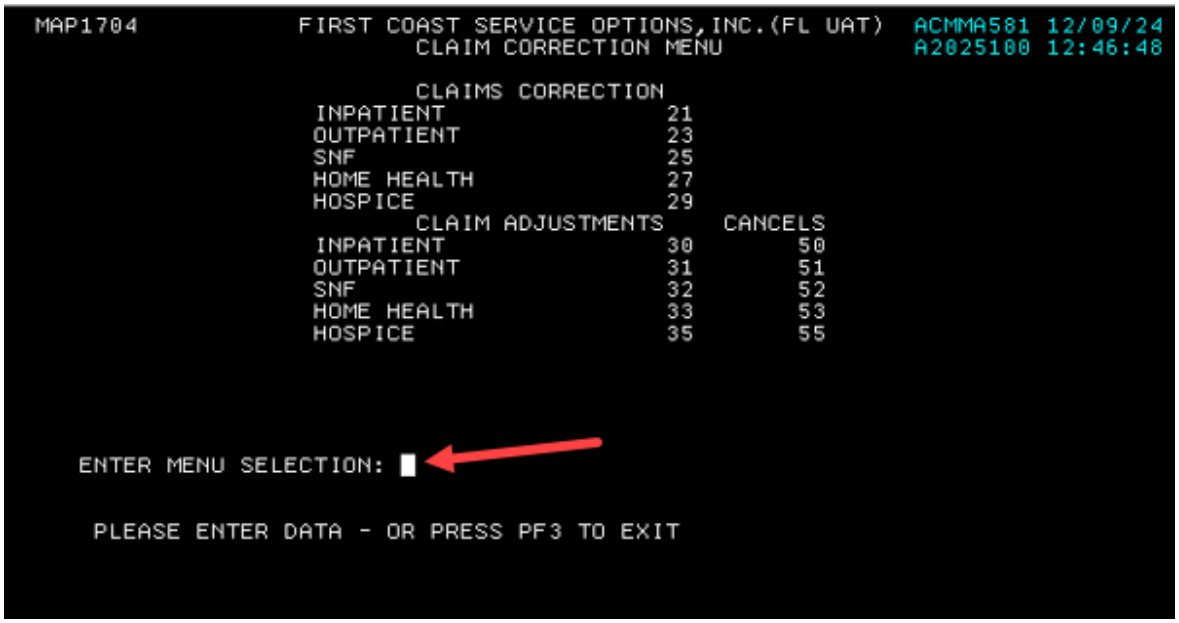
Claims Correction (21, 23, 25)

The Claims Correction file contains the claims that are returned for corrections. It is often referred to as your Returned to Provider (RTP) file.

To correct claims that have been returned, enter the CLAIMS CORRECTION MENU and choose the option that matches your provider type. Key the appropriate option in the ENTER MENU SELECTION field. Press Enter.

End Stage Renal Facilities (ESRD), Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Facilities (ORF) will need to select the Outpatient option and then change the type of bill (TOB) to reflect the TOB used for that specific facility. By doing this, returned claims for your particular facility will appear.

Selections for Home Health (27) and Hospice (29) corrections are not applicable to First Coast Service Options, Inc.



Claims correction allows you to:

- Correct return to provider (RTP) claims
- Suppress RTP claims that you do not wish to correct
- Adjust claims
- Cancel claims

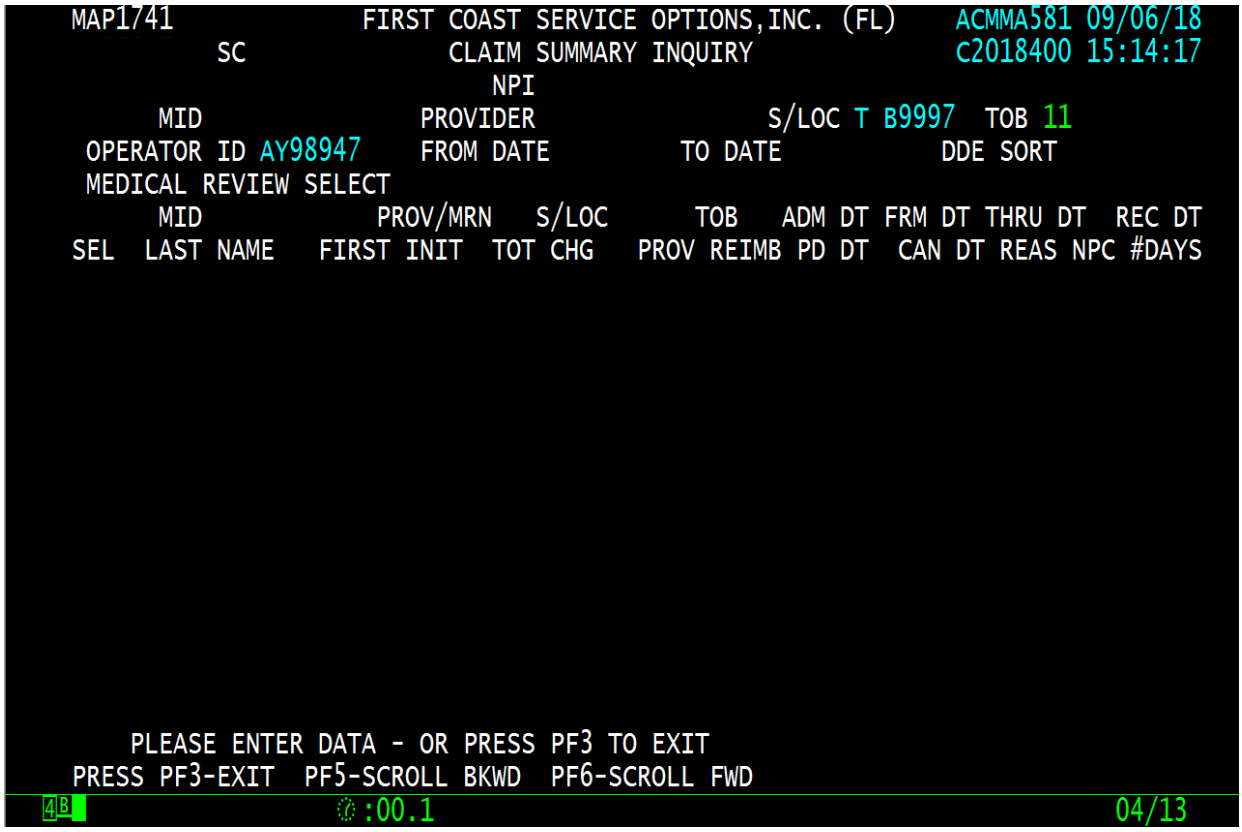
Note: The system will automatically enter your provider number into the provider field. If the facility has multiple provider numbers, the user will need to change the provider number to inquire or input information. TAB to the provider field and type in the correct provider number.

Online Claims Correction

If a claim receives an edit (FISS reason code), a return to provider (RTP) is issued. An RTP is generated after the transmission of the claim. The claim is returned for correction. Until the claim is corrected via DDE or hardcopy, it will not process. When an RTP is received, the claim is given a status/location code beginning with the letter ‘T’ and routed to the claims summary inquiry screen. Claims requiring correction are located on the claim summary screen shortly after claim entry. It is not possible to correct a claim until it appears on the summary screen. Providers are permitted to correct only those claims appearing on the summary screen with status ‘T’. Claims that have been given ‘T’ status have not yet been processed for payment consideration, so it is important to review your claims daily and correct them in order to avoid delays in payment.

Processing Claim Corrections

Once an option is chosen from the claim and attachments correction menu, the claim summary inquiry screen will display.



Certain information is already completed, including the provider number, the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter any or all of the information in the following table.

Field name	Description
DDE SORT	Allows multiple sorting of displayed information. Valid values are: Value Description M Medical record number sort (Ascending order, Medicare ID) N Name sort (Alpha by last name, first initial, receipt date, MR#, Medicare ID) H Medicare IDN sort (Ascending order, receipt date, MR#) R Reason code sort (Ascending order, receipt date, MR#, Medicare ID) D Receipt date (Oldest date displaying first, MR#, Medicare ID) _ TOB/DCN (Current default sorting process, S/LOC, name)
MEDICAL REVIEW SELECT	Used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. Valid values include: Value Description ‘ ‘ Selects all claims ‘1’ Selects all claims ‘2’ Selects all claims excluding medical review ‘3’ Selects medical review only

To see a list of the claims that require correction press [ENTER]. The selection screen will then display all claims that have been returned for correction (status/location T B9997). To narrow the scope of the claims viewed, enter one of the following selection criteria, type of bill, from date, to date, and Medicare ID number. If the claim you are looking for does not display on the screen, do the following:

- Verify the Medicare ID number that you typed.
- Verify the from and through dates.

- Verify that the type of bill (TOB) is the same as the TOB on the claim you originally submitted. If not, [TAB] to the TOB field and enter the first two digits of the TOB for the claim you are trying to retrieve.
- If you still cannot find the claim, back out of claims correction (press [F3]) to return to the main menu. Choose inquiry (Option 01), then claims (Option 12), and select the claim. Check the status/locations (S/LOC). Only claims in status location T B9997 can be corrected. Status locations that cannot be corrected include:
  P B9997 – This claim has paid. An adjustment is required in order to change a paid claim.
  P O9998 – This claim was paid but due to its age, it has been moved to off-line history. Timeliness of filing will not allow you to adjust this claim.
  P B9996 – This claim is waiting to be released from the 14-day payment floor (not showing on the RA). No correction allowed.
  R B9997 – This claim was rejected, submit a new claim or an adjustment.
  D B9997 – This claim was denied and may not be corrected or adjusted.

Claims Correction Processing Tips

- The revenue code screen has multiple sub-screens. If you have more revenue codes than can fit on one screen, press [F6] to go to the next sub-screen. Press [F5] to go back to the first screen.
- To go from page to page enter the page number in the top right hand corner of the screen (claim page).
- Reason codes will display at the bottom of the screen to explain why the claim was returned. Up to 10 reason codes can appear on a claim.
  - Pressing [F1] will access the reason code file
  - Press [F3] to return to the claim
- The reason codes can be accessed from any claim screen.
- The inquiry screen can be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen, for instance '13' Revenue codes. Press [F3] to return to the claim.

Correcting Revenue Code Lines

To delete an entire Revenue Code line:

- TAB to the line and type 'D000' over the revenue code to be deleted. (D zero zero zero)
- Press HOME to go to the page number field. Press ENTER, the line will be deleted once the claim has been submitted back into the system.
- Next, add up the individual line items and correct the total charge amount on revenue code line (0001) and remove non-covered charges.

To add a Revenue Code line:

- Tab to the line below the total line (0001 revenue code).
- Type the new revenue code information.
- Press [HOME] to go to the page number field and press [ENTER]. The system will resort the revenue codes into numerical order.
- Correct the total charge amount of revenue code line (0001).

Changing total and non-covered charge amounts:

- TAB to get to the beginning of the total charge field on a line item.
- Press Delete to delete the old dollar amount. It is very important not to use the spacebar to delete field information. Always use [Delete] when clearing a field.
- Type the new dollar amount without a decimal point. Example: for $23.50 type '2350'.
- Press ENTER, the system will align the numbers and insert the decimal point.
- Correct the totals line, if necessary.
- To exit without transmitting any corrections, press [F3] to return to the selection screen. Any changes made to the screen will not be updated.
- Press F9 to update/enter the claim into DDE for reprocessing and payment considerations. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the claim correction summary.
- The on-line system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check (S B2500) unless otherwise set in the system control file. The claim will continue forward when nightly production (batch) is run. Potentially the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: 'Process completed – enter next data.'

RTP Selection Process
Select the claim to be corrected by tabbing to the 'SEL' field for the first line of the claim to be corrected.

Type a 'U' or 'S' and press ENTER, the patient's original UB-04 claim will display. (This will be MAP1711, the first page of the claim).

Type information:
- Use the function keys listed at the bottom of the screen to move through the claim (i.e., F8 to go to the next screen, and F7 to back up a screen).
- The revenue code screen has multiple sub-screens. If you have more revenue codes than can fit on one screen, press F6 to go to the next sub-screen. Press F5 to go back to the first screen.
- You can also get from page to page by entering the page number in the top right hand corner of the screen (Claim page).

Reason codes will appear at the bottom of the screen, and there can be up to ten codes. Press F1 to access the reason code file from the claim. The system automatically pulls up the first reason code with its message. The message will identify the fields that are in error and will suggest corrective action. Press F3 to return to the claim, or type in an additional reason code and press ENTER.
- The reason codes may be accessed from any claim screen.
- The inquiry screen can be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen, for instance '15' for DX/PROC codes. Press F3 to return to the claim.

Deleting or Adding Revenue Code Lines
To delete a Revenue Code line, type 'D' in the first position of the Revenue Code to be deleted and press HOME (this will position the cursor in 'CLAIM PAGE 02') and press ENTER.

To add a Revenue Code line, type the appropriate information below the 0001 line. Once you have typed all the information, press HOME (this will position the cursor in CLAIM PAGE 02) and press ENTER. DDE will resort the Revenue Code lines in numeric sequence.

Whether you are deleting or adding revenue code lines and/or charges be sure to adjust the Total Charges to reflect any changes.

When lines are deleted or corrected without following these instructions, the entire claim will reject.

You cannot delete a claim from the RTP file. However, all claims will continue to display through the Inquiry Menu option until they become inactive.

Suppress View
If circumstances indicate that the claim was billed in error or some other reason it cannot be corrected in FISS, you may suppress the claim.

To suppress a claim, select the claim from your return to provider list.

Place an 'S' on the SEL field and enter.

On Claim Page 01, there is a Suppress View (SV) field located in the upper right hand corner.

Tab to the SV field and type a Y and press <F9>.

The system will automatically return you to the Claims Summary Inquiry screen and the claim will no longer appear on your RTP list.

All claims will continue to display through the Inquiry Menu option until they become inactive.

Once you suppress a claim, it cannot be retrieved or returned if it was suppressed in error. So, please make sure you are suppressing the correct claim.

Any changes made to the screens will not be updated. Press [F9] to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the

bottom of the screen. Continue the correction process until the system takes you back to the claim correction summary.

Note: The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check. The claim will continue forward when the nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will display at the bottom of the screen Process Completed – Enter Next Data.

Processing Claim Adjustments (30, 31 or 32)

When claims are keyed and submitted through DDE for payment consideration, the user can sometimes make entry mistakes that are not errors to the DDE/FISS system. As a result, the claim is processed through the system to a final disposition and payment. To change this situation, the on-line claim adjustment option can be used to submit adjustments for previously paid/finalized claims. After a claim is finalized, it is given a status code beginning with the letter 'P' or an 'R' and is recorded on the claim status inquiry screen.

A claim cannot be adjusted unless it has been finalized and is reflected on the remittance advice.

Providers must be very careful when creating adjustments. If you go into the adjustment system and update a claim without making the right corrections, the adjustment will still be created and process through the system. Errors could cause payment to be taken back unnecessarily. No adjustments can be made on the following claims:

- T = RTP claims
- D = Medically denied claims
- Type of bill xxP (PRO adjustment) or xxI (Intermediary adjustment)

If a claim has been denied with a full or partial medical denial, the provider cannot submit an adjustment. Any attempted adjustments will reject with reason code 30904 (a provider is not permitted to adjust a partially or fully medically denied claim).

To access the claim and make the adjustment:

- Select the option on the claim and attachments correction menu for the type of claim to be adjusted and press [ENTER]. End stage renal disease (ESRD), comprehensive outpatient rehab facilities (CORF), and outpatient rehab facilities (ORF) will need to select the outpatient option and then change the TOB.
- Enter the Medicare ID number, whether the claim is an 'R' or 'P', and the from and to dates of service, and then press [ENTER]. The system will automatically default the TOB frequency to an xx7. The Medicare ID number field is now protected and may no longer be changed.
- Indicate why you are adjusting the claim by entering the claim change condition code, on page 01 of the claim and a valid adjustment reason code on page 03. Valid adjustment reason codes can be found typing '16' in the 'SC' field in the upper right hand corner of the screen and pressing [ENTER] or see the end of this section.
- Give a short explanation of the reason for the adjustment in the remarks section on page 04 of the claim.
- To back out without transmitting the adjustment press [F3]. Any changes made to the screens will not be updated.
- Press [F9] to update/enter the claim into DDE for reprocessing and payment consideration. Claims being adjusted will still show on the claim summary screen. Always check the inquiry claim summary screen (12) to affirm location of the claim being adjusted.
- Check the remittance advice to ensure that the claim adjusted properly.

Claim Voids/Cancels (50, 51, or 52)

Using the claim cancels option; providers can cancel previously paid/finalized claims. After a claim is finalized, it is given a status code beginning with the letter 'P' and is recorded on the claim status inquiry screen. A claim cannot be voided (canceled) unless it has been finalized and is reflected on the remittance advice.

Providers must be very careful when creating cancel claims. If you go into the adjustment system and update a claim without making the right corrections, the cancel will still be created and processed through the system. Errors could cause payment to be taken back unnecessarily. In addition, once a claim has been voided (canceled), no other processing can occur on that bill.

- All bill types can be voided except one that has been denied with full or partial medical denial.
- Do not cancel TOB xxP (PRO adjustments) or xxi (Intermediary adjustments).
- A cancel bill must be made to the original paid claim.
- Providers may not reverse a cancel. Errors will cause payment to be taken back by the intermediary.
- Provider cannot cancel on MSP claim. Provider must submit an adjustment even if the claims are being changed into a 'no-pay' claim.
- Providers should add remarks on claim page 04 to document the reason for the cancel.
- After the cancel has been 'stored', the claim will appear in status/location S B9000.
- Cancels do not appear on provider weekly monitoring reports; therefore, use the claim summary inquiry to follow the status/location of a cancel.

To access the claim and cancel it, follow the steps under 'Processing claim adjustment' and make sure the status is 'P'.

Valid Claim Change Condition Codes

An adjustment or void/cancel condition code will be needed to indicate the primary reason for initiating an on-line claim adjustment or void/cancel. Valid code values include:

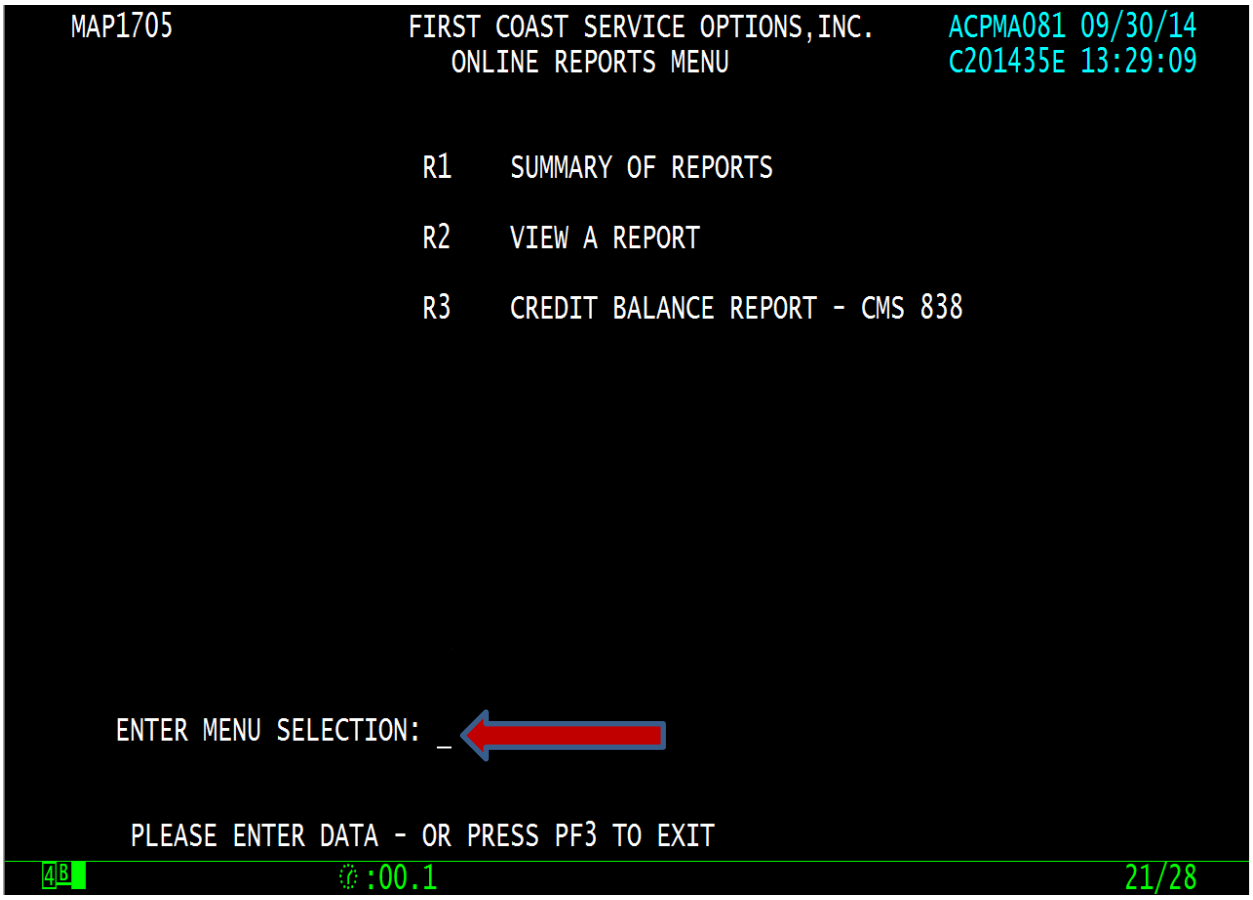
Value	Description
D0	Changes to service dates
D1	Changes to charges – Note: When there are multiple changes to a claim in addition to changes to charges, the D1 'Changes to charges' code value will take precedence.
D2	Changes to revenue codes/HCPCS
D3	Second or subsequent interim PPS bill
D4	Change in Grouper input
D5	Cancel only to correct a Medicare ID or provider identification number – For xx8 TOB only
D6	Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill) – For xx8 TOB only
D7	Change to make Medicare the secondary payer
D8	Change to make Medicare the primary payer
D9	Any other change
E0	Change in patient status

Section 7 – Online Reports Menu

The Online Report View function allows viewing of certain provider specific reports by the DDE provider. The purpose of the reports is to inform the providers of the status of claims submitted for processing and provide a monitoring mechanism for claims management and customer service to use in determining problem areas for providers during their claim submission process.

As reports are viewed online, it will be necessary to scroll (or toggle) between the left view and the right view. Use the [F11] key to move to the right and the [F10] key to return to the left.

To access the online reports, choose menu selection 04 from the DDE main menu. The online reports menu will display.

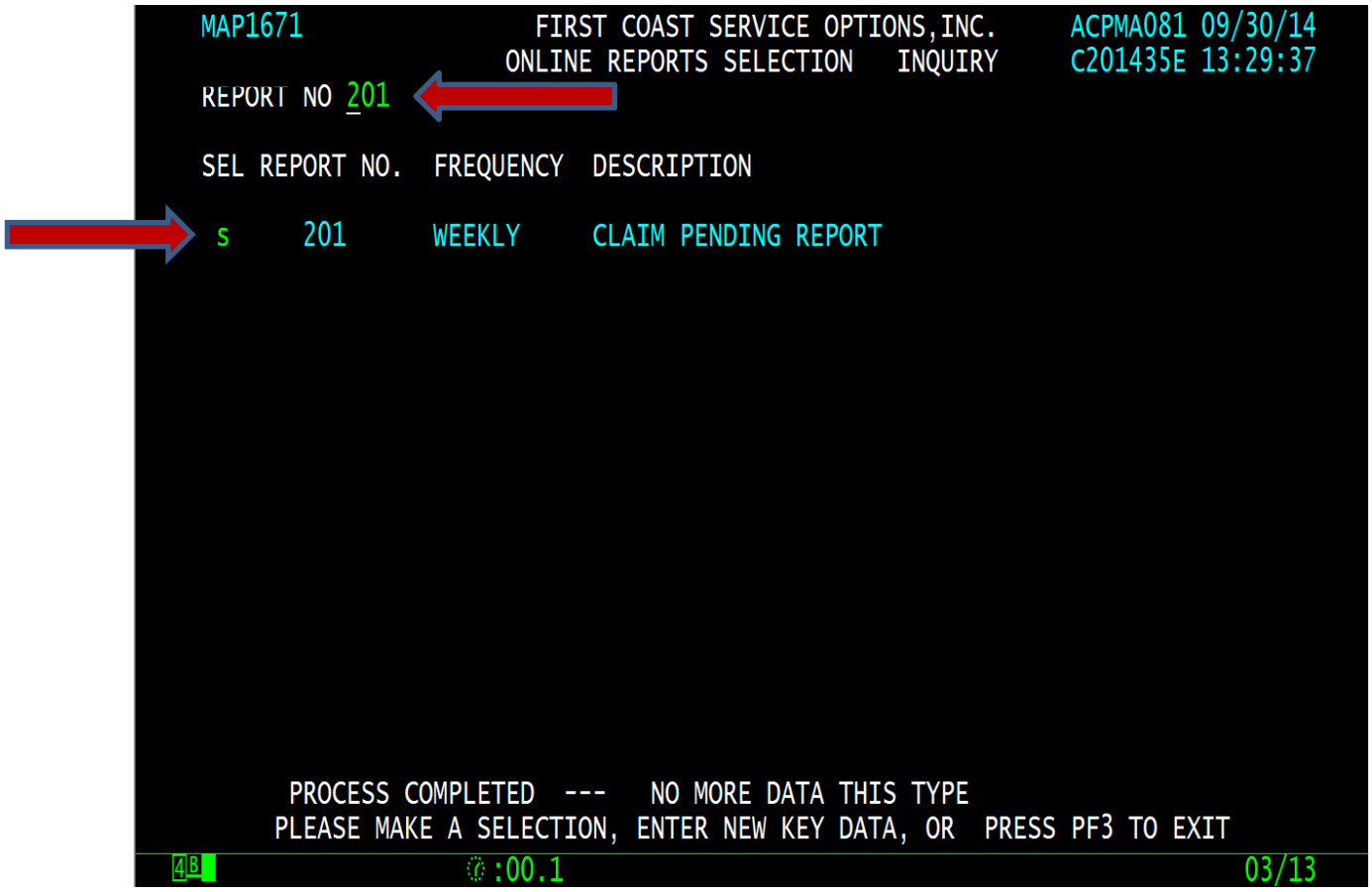


The purpose of the 201 report is to assist providers in accessing information regarding the status of their submitted claims. The report has three main sections:

- Summary of pended claims
- Summary of processed claims
- Summary of returned claims

The pended, processed, and returned claims report lists claims that are pending, claims returned to the provider for correction, and claims processed but not necessarily shown as paid on a remittance advice.

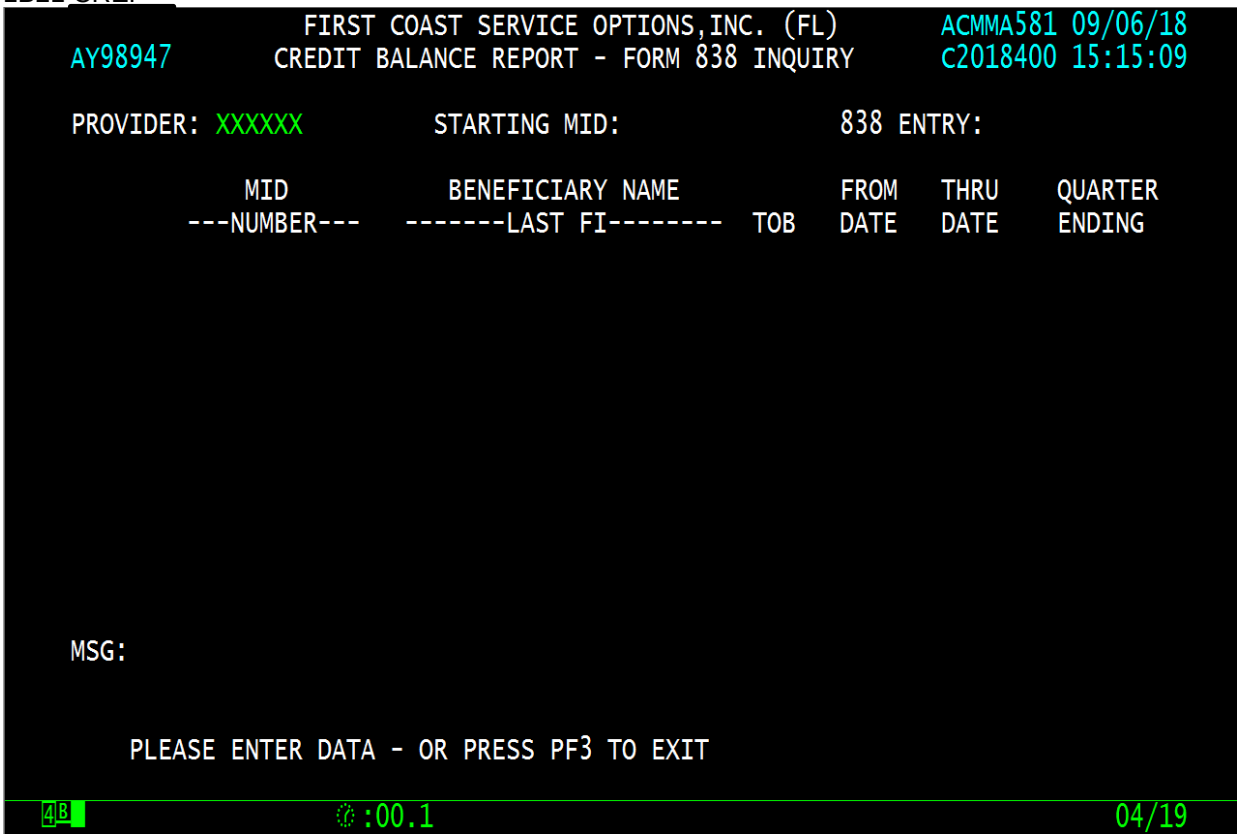
Each summary section of the report provides a separate count for both original claims and adjustment claims. Each report section is labeled based on type of bill.



Field name	Description
SEL	Selection - This field selects the report to be viewed. An 'S' is entered in this field beside the report number. This is a one-position alphanumeric field.
REPORT NO	Report Number - This field identifies number of the report. This is a three-position alphanumeric field.
FREQUENCY	Frequency - This field reflects the frequency of the report. This is a nine-position alphanumeric field. The valid values are: Value Description 'D' Daily 'M' Monthly 'W' Weekly
DESCRIPTION	Description - This field identifies the name or title of the report. This is a 30-position alphanumeric field.
SCROLL	Scroll - This field is used to scroll to the left or right sides of the report. This is a one-position alphanumeric field.
KEY	Key - This field reflects the key or sort field for the selected report. This is a 20-position alphanumeric field.
PAGE	Page Number - This field identifies the page number of the report being viewed. This is a six-digit field.
SEARCH	Search - This field searches for a specific field name or value. This is a 21-position alphanumeric field.

MAP1B21 - Credit Balance Report – Form 838 Inquiry

1B21 CREF



Field name	Description
PROVIDER	This field displays the identification number of the institution who rendered services to a particular beneficiary/patient. This number is designated by CMS as the identification number of the provider. This is a thirteen-position alphanumeric field.
STARTING MEDICARE ID	This field identifies the Health Insurance Claim Number assigned to the beneficiary by the CMS, to be used on all correspondence and to facilitate the payment of claims. This is a twelve-position alphanumeric field.
838 ENTRY	This field identifies the 838 Entry field. This is a one- position alphanumeric field. The valid values are: Value Description 'Y' Yes 'N' No **Note:** When this field is populated with a 'Y', the credit balance entry screen is displayed and allows the provider to enter a new record.
MEDICARE ID	Health Insurance Claim Number assigned to the beneficiary by the CMS, to be used on all correspondence and to facilitate the payment of claims. This is a twelve-position alphanumeric field.
BENEFICIARY NAME LAST FI	This field identifies the beneficiary's last name and the first initial.
TOB	This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field.
FROM DATE	This field identifies the beginning date of service for the period

Field name	Description
	included on the claim. This is a six-digit field in MMDDYY format.
THRU DATE	This field identifies the ending date of service for the period included on the claim. This is a six-digit field in MMDDYY format.
QUARTER ENDING	This field identifies the quarter ending date. This is a six-digit field in CCYYMM format.

Section 8 - Tips

Deleting and/or adding revenue code lines

When correcting information on claim page 02 in claims correction (RTP T B9997), you must delete the entire revenue code line and re-key it.

To delete a revenue code line, type 'D' in the first position of the revenue code to be deleted and press HOME (this will position the cursor in 'CLAIM PAGE 02'), press enter.

To add a revenue code line, type the appropriate information below the 0001 line. Once you have typed all the information, press HOME (this will position the cursor in CLAIM PAGE 02) then press enter. DDE will resort the revenue code lines in numeric sequence.

Whether you are deleting and/or adding information to a revenue code line, ensure the total charges reflect all changes.

When lines are deleted or corrected without following these instructions, the entire claim will reject.

You cannot delete a claim from the RTP file. However, all claims will continue to display through the Inquiry Menu until they become inactive (I B9997).

Note: You may need to check with your vendor for specific guidelines for deleting a revenue code line.

Example: Key 'DDDD' over the revenue code and press home, press enter.

DDE sort

Once you are on the claim correction screen, ensure the TOB field is showing the first two digits of your TOB. If not, tab over to that field and type the appropriate TOB. Press enter and all claims in T B9997 will appear.

To make it easier to correct these claims, you can sort them in several ways. To do this, tab over to the DDE Sort field, key one of the following characters and press Enter.

- D – Receipt date
- H – HIC/MBI
- M – Medical record number
- N – Last name of the patient
- R – Reason code

Online return to provider (RTP) report 050

The 050 Online RTP Report is an accumulative report of returned claims. The report is sorted by MID (HIC/MBI) then by service date. To see the 'from and through' dates on a claim, F11 to the right.

The 050 Report displays the reason code description with each claim allowing you to be more efficient in correcting claims.

Note: The on-line claims correction process has not changed.

To view the 050 Report on-line within FISS:

- Choose option 04 on-line reports from the FISS main menu
- At the on-line reports menu, choose option R2, view a report
- Type 050 in the report field
- Type the letter 'W' in the frequency field
- Press enter

Claims in the RTP file will be displayed.

The 050 report is a visual report and run on Fridays. Claims worked on Friday will not appear until the following week.

As a reminder, you have the option to view RTP claims through either claims correction or claims inquiry.

Retrieve additional documentation request (ADR) letter

You may receive an ADR letter to request additional documentation needed to process your claim. You have 45 days to respond to the ADR letter. You no longer must wait for the letter to arrive in the mail, simply download it from the FISS system.

Steps to retrieve your ADR letter:

1. Access the claim summary inquiry screen, option 12 from the inquiry menu
2. Type the MID (HIC/MBI) and press enter
3. If the claim is in status/location S B6000-B6001, there is an ADR on this claim
4. Select the claim by typing “S” in the SEL field and press enter
5. Go to page 06, hit F8 to page 07 to view/print the ADR letter
6. Fax the printed ADR letter along with your documentation to 877-439-5479, available 24/7.

Faxing tips

Do not exceed 200 pages

Include the first page of the ADR as the cover sheet

Supporting documentation or requested medical records should follow the ADR letter

Each response should be faxed separately with the corresponding cover sheet

All additional information requests will continue to follow the same guidelines related to timeliness, legibility, and completeness.

You are encouraged to review medical records prior to submission to ensure all the requested documentation is provided and that the documentation is legible.

As always, we encourage you to submit your ADR responses in a timely manner to prevent unnecessary denials.

Retrieve offline claims

Claims in status/location P O9998 are offline; meaning, only summary information is available on the claims summary screen and the detail information is stored in offline storage.

To adjust or cancel an offline claim via DDE, you must bring the offline claim back to online status. Once the claims are in online status (P B9997 or R B9997) you may adjust or cancel the claim.

Note: Timely filing requirements apply.

Steps to retrieve claims from offline status:

- Select 03 - Claims correction from the main menu
- Select the claim adjustment/claim cancels option matching your bill type
- Key the MID (MBI), status/location P O9998, and date of service
- Select the claim to be retrieved by placing an “S” in the “SEL” field next to the claim and press enter. The message “ADJUSTMENT CLAIM IS PRESENTLY OFFLINE-F10 TO RETRIEVE” will appear
- Press F10 to retrieve claim
- Press enter twice
- The message “THE OFFLINE CLAIM WILL BE RETRIEVED WITHIN 7 DAYS” will appear.

A weekend cycle must run before the claim will appear on the system. Claims retrieved from offline status should appear the Monday following the retrieval request.

Note: The third weekend of every month, the system performs maintenance, and the offline claim may not appear online until the following Monday.

Once the offline claim appears in status/location P B9997 or R B9997, you must perform the adjustment/cancel in DDE within 4 to 6 weeks. Adjustments/cancels not completed within 4 to 6 weeks will return to offline status. If this occurs, you must retrieve the claim again.

Suppress view

FISS does not allow you to delete a claim from the return to provider (RTP) file, but it will allow you to suppress the claim.

Once on the claim correction screen, depress 'enter' to get a list of all claims in T B9997 or narrow the list of claims by keying one or all the following:

- MID (Medicare Beneficiary Identifier)
- Provider number, if different
- Type of bill
- From and thru date

To select the claim you wish to suppress, place an ‘S’ in the SEL field and enter.

On claim page 01, there is a suppress view (SV) field located in the upper right-hand corner. Tab to the SV field, type a Y and depress your F9 key.

MAP1711 showing 'Y' in the SV field

The system will automatically return you to the claims summary inquiry screen and the claim will no longer appear in your RTP file.

All claims will continue to display through the claims summary inquiry (12) until they become inactive.

Once you suppress a claim, it cannot be retrieved or returned. So, please make sure you suppress the correct claim.

Note: Do not suppress cancel claims (TOB XX8).

Acronym List

A

ADR: Additional development request
ADJ: Adjustment
ASC: Ambulatory surgical center
ANSI: American national standards institute

B

C

CLIA: Clinical laboratory improvement amendments of 1988
CMHC: Community mental health center
CMN: Certificate of medical necessity
CMS: Centers for Medicare & Medicaid Services
CWF: Common working file

D

DCN: Document control number
DDE: Direct date entry
DME: Durable medical equipment
DRG: Diagnosis related grouping

E

EGHP: Employer group health plan
EMC: Electronic media claims
ERA: Electronic remittance advice
ESRD: End stage renal disease

F

FDA: Food and drug administration
FI: Fiscal intermediary
FISS: Fiscal intermediary standard system
FQHC: Federally qualified health centers

G

H

HCFA: Health Care Financing Administration
HCPC: Healthcare common procedure code
HCPCS: Healthcare common procedure coding system
HHA: Home health agency
HMO: Health maintenance organization
HOPPS: Hospital outpatient prospective payment system

I

IDE: Investigational device exemption
IEQ: Initial enrollment questionnaire
IME: Indirect medical education
IRS: Internal revenue service

J

K

L

M

MCE: Medicare code editor
MR: Medical review
MSA: Metropolitan statistical area
MSN: Medicare summary notice
MSP: Medicare secondary payer

N

NPI: National Provider Identifier
NDC: National drug code

O

OCE: Outpatient code editor
OMB: Office of management and budget
OTAF: Obligated to accept in full

P

PHS: Public health service
PPS: Prospective payment system
PRO: Peer review organization

Q

R

RA: Remittance advice
RHC: Rural health clinic
RTP: Return to provider

S

SNF: Skilled nursing facility
SSA: Social security administration

T

U

UPIN: Unique physician identification number
URC: Utilization review committee

V

W

X

Y

Z

Change Summary

Date	Section(s) Changed	Change Summary
October 2021	Section 4 – Inquiry Menu	MAP175J added CCBB/G0327 as the 38th entry

January 2022	N/A	MAP1711 – Home Health DDE screen TOB will 329 will populate in the TOP field.
January 2022	N/A	MAP1741 – Home Health DDE screen TON 32 will populate in the TOB field.
January 2022	N/A	MAP175F DDE screen will now display the one-byte NOA IND Field and will be system generated and protected. The valid values for this field are Space, 1 (NOA received without condition code 47 and 2 (NOA received with condition code 47)
April 2022	N/A	MAP175R Added 5 rows of data above the 'process completed' line to show the 2 new PPV codes 90671 and 90677. 01-Inquiries, 10-Beneficiary/CWF, add appropriate information and enter. F8 to MAP175R for information.
July 2022	N/A	MAP175J – Beneficiary/CWF Screen - New field added is the APRP/G0465 field. The first date that G0465 is billed on a claim for the beneficiary will be displayed in the TECH D and PROF D columns for the APRP field.
January 2023	Section 5 – Claim Entry	MAP171A Remove REDUCT-AMY and ANSI headings and associated fields
April 2023	Section 5 - Claim Entry	MAP171A

		Coinsurance field was expanded from 9.99 to 9.99999.
September 2023	Section 4 – Inquiry Menu	Modified the HCPC Rate Inquiry DDE Screen- expand the following HCPCS Rate fields from PIC 9(06)V999 to PIC 9(08)V999
November 2024	Section - An important notice to users of this manual	Added DDE availability days and times.
December 2024	Section 5 Claim Entry and and Section 6 Claim Correction and Adjustments	Updated screenshots for MAP1714 and MAP1704. MAP1714 - Removed Pacemaker option 47 and Ambulance option 48 from the screen and shifted the remaining options left to fill the gap. MAP1704 - Removed Pacemaker option 42 and Ambulance option 43. Removed the ATTACHMENT heading. Changed the screen title to remove AND ATTACHMENTS as all attachment options have been removed from MAP1704.
March 2025	Section 4 – Inquiry Menu	DDE Inquiries (01), Beneficiary/CWF (10) - Added HIVP/, HIVS/ AND HPBV/ fields to the middle column of screen. The technical and professional date fields for each new field also added to the right accordingly.
March 2025	Section 4 – Inquiry Menu	DDE MAP175J to no longer display the MAMM (Mammography) eligibility TECH and PROF dates when the beneficiary sex

		indicatory on MAP175J is not equal to 'F'. FISS will populate the TECH and PROF date fields with zeroes. DDE MAP175J to no longer display the PAPT and PAPT/Q0091 (screening Pap Smear) eligibility TECH and PROF dates when the beneficiary sex indicator on MAP175J is not equal to 'F'. FISS will populate the TECH and PROF date fields with zeroes. DDE MAP175J to no longer display the PCBE/G0101 (Pelvic Exam) eligibility TECH and PROF dates when the beneficiary sex indicatory on MAP175J is not equal to 'F'. FISS will populate the TECH and PROF date fields with zeroes. DDE MAP175J to no longer display the PROS/G0102 and PROS/G0103 (Prostate Cancer) eligibility TECH and PROF dates when the beneficiary sex is not equal to 'M'. FISS will populate the TECH and PROF fields with zeroes. DDE MAP175M to no longer display the HPVS/G0476 (Human Papillomavirus) eligibility TECH and PROF dates when the beneficiary sex is not equal to 'F'. FISS will

		populate the TECH and PROF fields with zeroes.
March 2025	Section 5 – Claims entry	Claims (02), Claims (20), Claims Page 31 - Removed VALCD-05/OTHER from the screen map as well as the FSSD103H-OTHER1-AMT field below the screen tag. Also removed FSSD103H-OTHER1-GRP and FSSD103H-OTHER1-RSN fields after the ANSI tag and the FSSD103H-PSY-ESRD-BLD-RSN and FSSD103H-PSY-ESRD-BLD-GRP fields.
March 2025	Section 5 – Claims entry	DDE Inquiries (01), Beneficiary/CWF (10) - Added HIVP/, HIVS/ AND HPBV/ fields to the middle column of screen. The technical and professional date fields for each new field also added to the right accordingly.
September 2025	Section 8 – Tips	New section added.
October 2025	Section 4 – Inquiry Menu	DDE Inquiries (01) Beneficiary/CWF (10). Monetary Amt fields are expanded to 10 digits on MAP1751
October 2025	Section 4 – Inquiry Menu	DDE Inquiries (01) Beneficiary/CWF (10). Monetary Amt fields are expanded to 10 digits on MAP1752
October 2025	Section 4 – Inquiry Menu	DDE – Inquiries (01) - Beneficiary/CWF (10), CWF Inquiry Screen (20 of 25) Removed G0472 from the HCAS row as it will also include G0567.
October 2025	Section 4 – Inquiry Menu	DDE Inquires (01), Reason Codes (17). Add two

		additional MSN, EFF DATE and TERM DATE fields. Also reduced the narrative description lines from 14 to 12.