Tutorial Instructions

Slide 1
Note:

Slide 2
Note: Welcome to FISS Tutor Interactive. This learning tool will engage users in a simulation of the Fiscal Intermediary Standard System. Before you begin, you should become familiar with the menu choices and the recommended order for learning. You will also need to know how to navigate through sections of the simulation. Let's look at the menu together.

Slide 3
Note: Your first step should be to print the necessary UB92 forms in order too complete the Self-Guided Tour. Click on the menu link.

Slide 4
Note: Click on Claims Entry

Slide 5
Note: Click on the link to print the Inpatient UB92 forms.

Slide 6
Note: By clicking on the link, you will open the files in your browser.

Slide 7
Note: This UB92 will be necessary for input in the Self-Guided Tour.

Slide 8
Note: These .pdf files can then be printed by going to your FILE menu at the top and choosing PRINT.

Slide 9
Note: After printing the necessary UB92 form, you may close the browser window and return to the main menu.

Slide 10
Note: Now you are ready to begin the Self-Guided Tour. You will click on the Self-Guided Tour menu link to view your choices.

Slide 11
Note: We recommend that you begin with Claims Entry and work through all the tutorials in the Self-Guided Tour before beginning the Interactive sections of the tutorial.

Slide 12
Note: There will be instructions at the beginning of each lesson. Read them carefully.

Slide 13
Note: In the Self-Guided Tour, each screen will give you navigational buttons at the top left and right corners of the screen. It is only necessary to use these buttons when you are unsure of the input necessary on the screen or if there is no input required. This screen requires the HIC number to be entered in the gray box. Once you enter in the HIC, you will TAB to the next field for entry. If you enter the correct HIC from your printed UB92 form, the tutorial will move on to the next field of entry. You have an unlimited number of tries for each input box. Pressing NEXT is an alternative when you do not know the answer.

Slide 14

Transcript

Note: Here you see the correct answer displayed in the HIC field and a new input box for your input on the TOB.

Slide 15
Note: Users will practice entering UB92 data into the simulated DDE system. Users should enter the information into this simulated system exactly as given on the UB92 form.

Slide 16
Note: Other menu selections within the Self-Guided Tour are Claims Corrections, Claims Adjustments, Claims Cancel, Reason Codes, and Reports. You will not need a UB92 form for these selections. Let's click on "Return to previous menu."

Slide 17
Note: Before you begin the Interactive Section, you will need to print your UB92 form that matches your Provider type.

Slide 18
Note: Once the forms are printed, you are ready to begin the Interactive session.

Slide 19
Note: Functions to emulate the actual FISS System are the F7 key for moving to the previous screen, F8 for moving to the next screen, and F3 to exit. In Claims Corrections, you will also be able to F1 to read a reason code narrative and F9 to update a claim.

Slide 20
Note: Your Main Menu has two choices for you to practice: Claims/Attachments and Claims Corrections.

Slide 21
Note: For this example, we will choose the inpatient claims entry.

Slide 22
Note: Once you enter the HIC number from your printed UB92 form, the input box will either auto TAB to the next available field of entry or wait for you to press TAB, depending on the length of the data.

Slide 23
Note: Remember that you use your Function keys to navigate. Use F8 to move to the next claim page. When you have completed all your entries on claim pages one through six, you are ready to submit or update the claim by pressing F9.

Slide 24
Note: The scoring page allows you to correct your claim errors by allowing you to revert back to the claim page where the error occured.

Slide 25
Note:

Slide 26
Note:

Slide 27
Note: All correct answers will be displayed in green. If an answer was required and no answer was given, you will see an red exclamation point. If you see an answer in red, it is incorrect. Correct your errors in all pages and update or F9 when you are on claim page 6.

Slide 28

Transcript

Note: Let's look at the Claims Corrections Section.

Slide 29
Note: Let's choose the inpatient type. Remember that you must have already printed the Inpatient UB92 forms for the inpatient Type of Bill to complete this section.

Slide 30
Note: Use your TAB key to move to the S/Loc field and enter TB9997 to show the available claims for corrections.

Slide 31
Note: Then just type an S in the Select field and Press ENTER.

Slide 32
Note: Here you see the reason code for the error on the claim ready for correction. Press the F1 key to read the reason code narrative. F3 will return you to this screen.
Correct the error according to the reason code narrative and press F9 to update the claim. The reason code will disappear upon completion of the correct update.

Slide 33
Note: We hope that you have found FISS Tutor Interactive to be an enjoyable learning tool for Direct Data Entry in FISS.

OVERVIEW

Slide 1
Note:

Slide 2
Note: Welcome to the world of FISS. FISS is an acronym for Fiscal Intermediary Standard System. This training module will introduce you to the basic concepts of FISS and the Medicare world, as well as help you gain knowledge in the actual processing of a Medicare Part A claim from a Provider's point of view. This overview explains the background of the FISS application.

Slide 3
Note: FISS is a mainframe standard system that has its changes controlled by the federal government under the direction of CMS, which stands for Centers for Medicare & Medicaid Services, headquartered in Baltimore, Maryland. CMS controls all changes that are made to the FISS system through a maintenance contract with a FISS maintainer.

Slide 4
Note: The current FISS maintainer is Pinnacle Business Solutions, Inc. As a FISS maintainer, it is their job to properly interpret and code all changes as mandated by CMS, with releases on a quarterly basis.

Slide 5
Note: These changes are then released to a number of data centers across the country. These data centers install the FISS code and provide service to the Fiscal Intermediaries across the nation. One data center may run six FI sites. The FI is then the main contact with the hospital with regards to processing and Medicare Part A claim. All communication from Provider regarding claim entry or claim status is routed to the designated FI.

Slide 6

Note: This tutorial is geared toward the understanding of the overall system and to give guidance on correcting claims in the FI system from a Provider so as to provide adjudication of that claim to the Provider. Over 90% of all Part A claims are entered through Electronic Media Connections (or EMC). The entry of these claims is produced by a Provider's hospital information system and stored on a file that is sent electronically to the FI of that hospital. The FI in receipt of the claims then processes the file into the FISS system and creates an online account of those claims for the Provider. The majority of claims do not pass through adjudication without intervention from either the FI or the Provider.

Slide 7
Note: A menu driven modular mainframe system runs at a CMS approved data center. Many functions can be performed within FISS, such as: enter, correct, adjust, or cancel hospital claims, inquire for status of claims, inquire for additional development requests, or inquire for eligibility and various codes.

Slide 8
Note: Signing onto the FISS system is the first step in DDE. Once you have signed onto your region, to actually access the FISS system, you will type FSS0 in the top left corner of the blank screen and press <ENTER>.

Slide 9
Note: To access the DDE Main Menu, you must first type in your Operator ID (press <TAB>) and password (press <ENTER>).

Slide 10
Note: Here are some FISS shortcuts. You can always look at the bottom of the screen to see which function keys are available to use. Be very careful when pressing <F3>. This key takes you back to your previous screen. You will lose any data if you were in the process of keying in a claim.

Slide 11
Note: Here is a list of the FISS menu options.

Slide 12
Note: If your function keys do not work, you may try pressing the <ALT>, <ESC>, or <CTRL> key with the <Function> key. Always use the <TAB> key to move between fields, not the <ENTER> Key. To move backwards to a field, just press and hold the <SHIFT> key then press <TAB>.

Slide 13
Note: The UB-92 consists of six pages. To move to a particular page press the <HOME> key, and type the number of the page that you wish to display. Notice that in addition to page numbers, your screens are also assigned Map numbers. Map numbers are on the upper left corner of the screen and page numbers are on the upper right corner. When you would like to quickly move to an option within the inquiry menu, just use the SC (or Screen Control) field in the upper left corner of the screen. Type the appropriate number next to the SC field and press <ENTER>.

Slide 14
Note: Return to the main menu to begin the Self-Guided Tour. Press EXIT.

CLAIMS INQUIRIES

Slide 1
Note: The purpose of the DDE main menu is to provide navigation to the DDE system. It gives Providers a direct access to claim processing, beneficiary information, and the ability to enter claims electronically. You would type in '01' here to begin an inquiry.

Slide 2

Transcript

Note: Type in ‘10’ here to choose Beneficiary/CWF

Slide 3
Note: Here is a screenshot of the Beneficiary/CWF Inquiry Eligibility Detail Inquiry page.

Slide 4
Note: Type in ‘11’ here to choose DRG (Pricer/Grouper)

Slide 5
Note: In order to bring up the information, you must first input all the diagnosis codes, procedure codes, discharge status, date, total charges, and date of birth or age.

Slide 6
Note: Type in ‘12’ here to choose claims.

Slide 7
Note: To start the Claims Summary inquiry process enter the patient's HIC number and the Type of Bill code for the claim you wish to see and press <ENTER>.

Slide 8
Note: Page 2 allows the Provider to view covered and non-covered charges as submitted on the claim. In FISS you would press F11 to see other iterations.

Slide 9
Note: This screen was designed to allow viewing of line item payment information. In FISS you would press F2 to return to the claim.

Slide 10
Note: This screen was designed to allow viewing of the line and claim level Reason Codes.

Slide 11
Note: Type in ‘13’ here to read data needed for revenue code processing.

Slide 12
Note: Revenue Codes- Type the 4 digit Revenue Code you wish to view in the REV CD field.

Slide 13
Note: Type in ‘56’ here to view a total claim count and total dollar amount by status and location.

Slide 14
Note: Claim Count Summary allows the Provider to monitor where claims are in the FISS system by dollar amounts.

Slide 15
Note: In this example, if you want to know which 4 claims are in Status/Location PB9996, press <F3> to exit Option 56. Then you must choose Option 12 from the Inquiry Menu and press <Enter>. Tab to the Status/Location field and enter PB9996 once more and press <Enter>. You will then view all claims for your site in the Staus/Location PB9996.

Slide 16
Note: Type in 'FI' here to view funds reflected on their Remittance Advice whether payment is by check or electronic funds transfer.

Slide 17
Note: Check History allows the viewing of the most current three payments whether by check or EFT.

Transcript

Slide 18
Note: Type in '14' here to access HCPCS pricing and allowable revenue codes related to HCPCS.

Slide 19
Note: Type the Locality Code and the HCPCS code you wish to view in the appropriate fields and press <ENTER>.

Slide 20
Note: Type in '15' here to reference DX/PROC codes.

Slide 21
Notes: Diagnosis and Procedure Codes Table: Type the first ICD-9 code desired and press <Enter>.

Slide 22
Note: Type in '16' here to identify the two-digit adjustment reason code and narrative for a particular type of adjustment.

Slide 23
Note: Adjustment Reason Codes Inquiry is required any time you make an adjustment to a processed claim.

Slide 24
Note: Type in '17' here to display a reason code narrative used to explain the reason code.

Slide 25
Note: Type the 5-position reason code and press <ENTER>.
Slide notes
The narrative reason code file will be displayed for the selected reason code.

Slide 26
Note: Type in '68' here to view ANSI reason codes.
Slide notes
Listed on this screen are the ANSI Standard Codes. Notice to the right of each ANSI Standard code is a description of the standard code. You can select an ANSI Standard Code by placing an "S" to the left of the ANSI Standard Code.

CLAIMS ENTRY–INPATIENT

Slide 1
Notes: In this section of the tutorial you will enter information from a UB92 form. By placing the mouse on the entry blank you will receive hints for that field. If you enter the correct information and press the TAB button, you will automatically be taken to the next field. You may also use the NEXT button in the top right corner of the screen to continue. You may always press EXIT to return to the menu.

Slide 2
Note: You are probably already familiar with the UB-92 form. This tutorial will take you through Direct Data Entry for the UB-92 form.

Slide 3
Note: Enter Menu selection 02.

Slide 4

Transcript

Note: We will begin with Inpatient Claims entry. Typing in '20' will indicate that selection.

Slide 5
Note: The claim process consists of six main screens. The default type of bill is based on the selection you make in your menu selection: inpatient, outpatient, or SNF.

Slide 6
Note: Enter the 12 digit alphanumeric from field 60 of the selected UB92.

Slide 7
Note: In the actual system, type of bill (TOB), status and location (S/LOC), and the Provider number will be filled by the system after selecting the claim entry bill type. The Medicare Provider number used when logging on the system will be used. The HIC, TOB, S/LOC, Provider, and Process New HIC fields comprise the header record and appear on DDE claim pages 01-06.

Slide 8
Note: The on-line system defaults to bill type 111 for inpatient, 131 for outpatient, and 211 for SNF. If you are entering data for a different bill type, you must type over the default with the correct Type of Bill. ESRD, CORF, OPT, RHC, CMHC, and FQHC facilities will need to select either 20 or 22 and change the TOB.

Slide 9
Note: Enter the 3 digit type of bill from field 4 of the selected UB92.

Slide 10
Note: Patient Control Number is assigned by the provider to each patient to help access the records of the patient and to assist in payment posting.

Slide 11
Note: Type in the number from field 3 of the UB92.

Slide 12
Note: Federal Tax number is not a required field.

Slide 13
Note: Tax Subsidiaries -This field does not require provider input. This number is assigned by the system.

Slide 14
Note: Statement Dates From identifies the beginning service date of the period included on this claim. It should be six-digit in the MMDDYY format. Required field for inpatient entry.

Slide 15
Note: Enter the date from field 6 of the UB92. (format=MMDDYY)

Slide 16
Note: Statement Dates To indicates the ending service date of the period included on this claim. It is a six-digit number in the MMDDYY format. Required field for inpatient entry.

Slide 17
Note: Enter the date from field 6 of the UB92. format(MMDDYY)

Slide 18
Note: Days Covered identifies the number of days covered by Medicare. The valid values are: '000' - '999'. This field is skipped on Home Health or Hospice claims. Required field if inpatient claim.

Transcript

Slide 19
Note: Enter the number from field 7 of the UB92.

Slide 20
Note: N-C refers to Non-covered days. This number will show days that cannot be shown as Medicare payment days. The occurrence codes you'll see later explains the non-coverage. This field is conditionally required. It is located in field 8 of the UB92 form.

Slide 21
Note: Co stands for Co-Insurance Days. Here you would enter the Medicare hospital days after the 60th day and before the 91st day. It is conditionally required and can be found in field 9 of the UB92 form.

Slide 22
Note: LTR means Lifetime Reserve Days. After using the 90 days of inpatient hospital services, a patient can choose to use up to 60 lifetime reserve days during the billing period. It is conditionally required and can be found in field 10 of the UB92 form.

Slide 23
Note: Patient's last name at time of service goes here. No spaces or special characters are allowed. Patient's first name and middle initial are also on this line. A space is permissible for the middle initial. This is a required field.

Slide 24
Note: Enter the name from field 12 of the UB92.

Slide 25
Note: Enter the name from field 12 of the UB92.

Slide 26
Note: Enter the middle initial from field 12 of the UB92.

Slide 27
Note: Date of birth is an eight digit field in MMDDCCYY format. This is a required field. DOB is located in Field 14 of the UB92 form.

Slide 28
Note: Enter the date from field 14 of the UB92.(format=MMDDCCYY)

Slide 29
Note: ADDR identifies the patient's street address including the house number, post office box number, and/or apt. number, city, and state abbreviation.

Slide 30
Note: Enter the name from field 13 of the UB92.

Slide 31
Note: Enter the information from field 13 of the UB92.

Slide 32
Note: Enter the information from field 13 of the UB92.

Slide 33
Note: Zip identifies the patient's ZIP code address with a minimum of 5 digits and a maximum of 9 digits.

Slide 34

Transcript

Note: Enter the zip code from field 13 of the UB92.

Slide 35
Note: Valid entries for this field identifying sex at time of services are:‘M’=male, ‘F’=female, and ‘U’= unknown

Slide 36
Note: Enter the information from field 15 of the UB92.

Slide 37
Note: Marital Status at time of services rendered. Valid values are shown above. This is not a required field. It is an optional field and is located in field 16 of the UB92 form.

Slide 38
Note: Admission date is a six-digit number in the MMDDYY format that shows when the patient was admitted for care. Required field for inpatient claims.

Slide 39
Note: Enter the date from field 17 of the UB92.

Slide 40
Note: Admission hour and minutes entered in military time or a ‘99’ if unknown. This is not a required field. It is an optional field and is located in field 18 of the UB92 form.

Slide 41
Note: Admission Type identifies the code indicating the priority of the admission. This is a required field on inpatient claims.

'1' Emergency
'2' Urgent
'3' Elective
'4' Newborn (this code not valid for Medicare claims)
'5' Trauma Center
'9' Information not available

Slide 42
Note: Enter the code from field 19 of the UB92.

Slide 43
Note: Source of admission identifies the source of a patient referral. This is a required field.
1 Physician Referral
2 Clinical Referral
3 HMO (Health Maintenance Organization) referral
4 Transfer from a Hospital
5 Transfer from a SNF (Skilled Nursing Facility)
6 Transfer from another health care facility
7 Emergency Room
8 Court/Law Enforcement
9 Information not Available
A Transfer from a Critical Access Hospital (CAH)
B Transfer from another Home Health Agency
C Readmission to the same Home Health Agency

Slide 44
Note: Type in the code from field 20 of the UB92.

Transcript

Note: Admission hour and minutes entered in military time or a '99' if unknown. This is not a required field. It is an optional field and is located in field 18 of the UB92 form.

Slide 45
Note: Discharge Hour and Minutes should be entered in military time (HHMM format) or use '99' if unknown. This is not a required field. It is an optional field. It is located in field 21 of the UB92 form.

Slide 46
Note: Patient Status- This field identifies the code indicating status at the ending service date in the period. This is a required field.

Slide 47
Note: Enter the code from field 22 of the UB92.

Slide 48
Note: Condition codes identify conditions relating to the claim that may affect processing. It is possible to have up to 30 codes or occurrences. This field is conditionally required. It is found on fields 24-30 on the UB92.

Slide 49
Note: Occurrence Codes and dates identify a significant event relating to payment of this claim. You may use up to 30 pairs of codes. Each date should be in the MMDDYY format. This field is conditionally required. It is found on fields 32-35 on the UB92.

Slide 50
Note: Occurrence Codes and dates identify a significant event relating to payment of this claim. You may use up to 30 pairs of codes. Each date should be in the MMDDYY format. This field is conditionally required. It is found on fields 32-35 on the UB92.

Slide 51
Note: Adjusting Document Control Number is not required when entering new bills. It is only applicable on adjustments.

Slide 52
Note: The Value Codes field displays the code that identifies data of a monetary nature that is necessary for processing the claim. This field is conditionally required.

Slide 53
Note: Enter the code from field 39a of the UB92.

Slide 54
Note: Enter the amount from field 39a of the UB92. No decimals are necessary.

Slide 55
Note: Enter the code from field 40a of the UB92.

Slide 56
Note: Enter the amount from field 40a of the UB92. No decimals are necessary.

Slide 57
Note: Enter the code from field 41a of the UB92.

Slide 58

Transcript

Note: Enter the amount from field 41a of the UB92.

Slide 59
Note: In FISS, you would press F8 to move to the next page of the claim.

Slide 60
Notes: MSP Apportion Indictor identifies to the MSP Pay Module whether the system apportions the primary payer's amount and the OTAF amounts, if present. At CMS's direction, this field has been protected and is no longer available.

Slide 61
Note: On the Inpatient Claim Page 2, you will insert revenue codes in ascending numeric sequence. You may type in the dollar amounts without a decimal point. Revenue Code 0001 should be the final Revenue code. It will correspond with the Total Charges and Non-Covered Charges for the claim. Press NEXT to continue.

Slide 62
Note: Revenue Code identifies the code for a specific service that was billed on the claim. The valid values are '0001'-'9999'. You should list these codes in numerical sequence and not repeat revenue codes. Your total charges should always be last. This is a required field.

Slide 63
Note: Enter the code from field 42 of the UB92.

Slide 64
Note: Deleting a Revenue Code line: place a "D" in the first position of the affected line, position the cursor on the page number field, press Enter. Adding a Revenue Code line: pass the 0001 line, add the revenue Code, position the cursor on the page number field, press Enter.

Slide 65 note: Health Care Common Procedure Coding identifies certain outpatient services. For example, outpatient hospital bills for a partial hospitalization of an outpatient would be noted here as well as many other outpatient and other services.

Slide 66
Note: Common Procedure Coding System Modifier identifies the HCPCS modifier codes. The valid values vary according to sites.

Slide 67
Note: This field is a rate for a particular revenue code line item. You may enter this ten-digit field in the 99999999.99 format. You may choose between two formats for entering this dollar amount: i.e., forty-five dollars may be entered as '4500' or '45.00' This information is found in field 44 of the UB92 form.

Slide 68
Note: Enter the code from field 44 of the UB92.

Slide 69
Note: Total Units of service is a measure of service rendered by revenue category. You don't have to enter the leading zeros for the units field. The system formats the units, thus changing '1' to '0001' as appropriate. This number will be the total units billed. This is a required field.

Slide 70
Note: Enter the number of units from field 46 of the UB92.

Slide 71

Transcript

Note: Covered Units of service is a measure of service rendered by revenue category. Like the Total units of service, you only enter the amounts and it will be formatted appropriately. This field tells us the total covered units. It is located in field 46 of the UB92.

Slide 72
Note: Total Charges identifies the total amount of charges for a particular revenue line identifying a specific service for the current period. This is a nine digit field in 9999999.99 format. It is a required field and is located in field 47 of the UB92 form

Slide 73
Note: Enter the amount from field 47 of the UB92.

Slide 74
Note: Non-Covered Charges asks for the total amount of non-covered charges for a particular revenue line. This is a nine-digit field in 9999999.99 format. It is conditionally required. It is located in field 48 of the UB92 form.

Slide 75
Note: Line Item Date of Service is reported by Hospitals and CMHCS every time a HCPCS code is required effective April 1, 2000, including claims where the from and thru dates are equal. It is a required field on outpatient claims. It is located in field 45 of the UB92 form.

Slide 76
Note: Enter the code from field 42, claim Line 2, of the UB92.

Slide 77
Note: Enter the units from field 46 of the UB92.

Slide 78
Note: Enter the amount from field 47, claim line 2 of the UB92. Typing the decimal is optional.

Slide 79
Note: Enter the code from field 42, Claim Line 3, of the UB92. This is your final revenue code and is for the total charges.

Slide 80
Note: In FISS, you would press F8 to move to the next page of the claim. Press NEXT to continue.

Slide 81
Note: Claim Page Three is used to enter diagnosis codes, procedure codes, as well as physician information. Press NEXT to continue.

Slide 82
Note: Payer Code represents the one position alphanumeric code identifying the specific payer. This is located in field 50 on the UB92 form.

Slide 83
Note: Enter the code from field 50 of the UB92.

Slide 84
Note: ID field is not used by FISS

Slide 85
Note: Enter the payer identification from field 50 of the UB92.

Slide 86

Transcript

Note: Payer identification: (A) Primary Payer - If Medicare is the primary payer, enter "Medicare" on line A. 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 the "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. It is located in field 50 of the UB92 form.

Slide 87
Note: Provider Number displays the identification number of the institution which rendered services to the beneficiary/patient. It is system generated for external operators that are directly associated with one provider (as indicated on the operator control file). This number is assigned by CMS. It is a required field. It is located in field 51 of the UB92 form.

Slide 88
Note: Enter the number from field 51 of the UB92.

Slide 89
Note: Release of information identifies whether or not the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are: 'R' for Restricted or modified release; 'Y' for Yes; 'N' for No release. It is a required field and is located in field 52 of the UB92 form.

Slide 90
Note: Enter the information from field 52 of the UB92.

Slide 91
Note: Assignment of Benefits identifies whether or not the provider has a signed form authorizing the third party to pay the provider. This is an optional field from field 53 of the UB92.
The valid values are: 'Y' Yes benefits assigned
'N' No benefits assigned

Slide 92
Note: Prior Pay identifies the amount the provider has received toward payment of the claim prior to the billing date by the indicated payer, and is required on outpatient claims if applicable. This is an eight-digit field in 999999.99 format. This is a required field on inpatient and SNF claims. It is located in field 54 of the UB92 form.

Slide 93
Note: Estimated Amount Due tells the amount estimated by the provider to be still due from the indicated payer (estimated responsibility less prior payments). This is an eight-digit field in 99999.99 format. This is an optional field. It is located in field 55 of the UB92 form.

Slide 94
Note: Estimated Amount Due from Patient is required only in Prior Payments portion of this field. This field identifies the amount the provider has received from the beneficiary toward payment of this claim prior to the billing date. This is an eight-digit field in 999999.99 format.

Slide 95
Note: Medical Record Number identifies the number assigned to the patient's medical/health record by the provider. This is a 17 position alphanumeric field and is located in field 23 of the UB92 form. It is an optional field.

Slide 96
Note: Cost Report Days identifies the number of days claimable as Medicare patient days for inpatient and SNF types of bills ('11x', '41x', '18x' '21x' and '51x') on the cost report. This is a three-digit field. The system calculates this field and generates the applicable data.

Transcript

Slide 97
Note: Non-cost report days identifies the number of days not claimable as Medicare patient days for inpatient and SNF type of bills (‘11x’, ‘18x’, ‘21x’, ‘28x’, ‘41x’, and ‘51x’) on the cost report. This is a three digit field.

Slide 98
Note: Diagnosis codes identifies the ICD-9-CM code describing the principal diagnosis (first code) and additional conditions (codes through nine) that co-exist at the time of admission, or develop subsequently. Each diagnosis code is a six-position alphanumeric field.

Slide 99
Note: Enter the code from field 67 of the UB92.

Slide 100
Note: Admitting diagnosis identifies the diagnosis code describing the inpatient condition at the time of the admission. This is a six-position alphanumeric field. It is a required field on inpatient. It is located in field 76 of the UB92 form.

Slide 101
Note: E-code stands for external cause code and identifies the ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. This is a six-digit alphanumeric field. It is an optional field located in field 77 of the UB92 form.

Slide 102
Note: Hospice Patient Terminal Illness Indicator identifies whether or not a hospice patient has a terminal illness. It is only used for hospice claims.

Slide 103
Note: Procedure Codes and dates identifies the principal procedure (first code) and other procedures (codes two through six) performed, and dates on which they occurred, during the billing period covered by this claim including the date on which each procedure was performed. It is an optional field unless inpatient with surgery is the case. It is located in fields 79-81 of the UB92 form.

Slide 104
Note: Procedure codes are a seven position alphanumeric field with the procedure dates being a six-digit field in a MMDDYY format.

Slide 105
Note: End Stage Renal Disease Hours identifies the number of hours of certain dialysis treatments such as peritoneal. This is a two-digit field.

Slide 106
Note: Adjustment Reason Codes are two-position identifiers for the type of adjustment being performed. (not required for new claim entry)

Slide 107
Note: Reject code is not required by Provider.

Slide 108
Note: Non Pay Code is not required by provider.

Slide 109

Transcript

Note: Attending Physician/UPIN code identifies the attending physician for inpatient bills or the physician that requested the outpatient services. The UPIN is entered in the first 6 digits followed by two spaces. It is a required field and is located in field 82 of the UB92 form.

Slide 110
Note: Enter the Unique Physician Identification Number(UPIN) from field 82 of the UB92.

Slide 111
Note: Enter the last name from field 82 of the UB92.

Slide 112
Note: Enter the first name from field 82 of the UB92.

Slide 113
Note: Enter the initial from box 82 of the UB92.

Slide 114
Note: Operating Physician/UPIN Code identifies the name and/or number of the operating licensed physician who performed the principal procedure. If no principal procedure is performed, leave this field blank. It is conditionally required and located in field 83 of the UB92 form.

Slide 115
Note: Other physician/UPIN Code identifies the name and/or number of the operating licensed physician who performed the principal procedure. If no principal procedure is performed, leave it blank. It is conditionally required and located in field 83 of the UB92 form.

Slide 116
Note: In FISS, you would press F8 to move to the next page of the claim. Press NEXT.

Slide 117
Note: The Remarks field carries information as submitted on automated claims as well as provide internal staff with a way to provide permanent comments regarding special considerations that played a part in adjudicating the claim. It is conditionally required.

Slide 118
Note: Attachment records are additional required documents that are submitted by the provider attached to a claim. The system considers these part of the claim record either after manual entry or system generation of the information. By utilizing the SC field and inserting the number of the appropriate attachment to be entered, the system provides the appropriate entry screen. The attachment selections are: Home Health, therapy screens (physical, speech, cardiac rehab, occupational, pulmonary rehab and inhalation) , Hospital Based Physician Claims, Ambulance, and ESRD Attach.

Slide 119
Note: ANSI Codes-Group identifies the general category of payment adjustment. Used for claims submitted in an ANSI automated format only. This is a two-position field.

Slide 120
Note: Adjustment Reasons identifies the detailed reason the adjustment was made. See MAP1713 for values.

Slide 121
Note: ANSI Appeals Codes identifies codes for inpatient or outpatient. This is a five-position field with 20 occurrences.

Slide 122

Transcript

Note: There are no remarks on this claim. If remarks are present in field 84 of the UB92, you must type the notes here. In FISS, you would press F8 to continue to the next page. For this example, press NEXT.

Slide 123
Note: Claim Page Five requires entry of insurance and employer information and treatment authorization codes. Press NEXT.

Slide 124
Note: Insured Name identifies the individual whose name the insurance is carried under. You enter the last name , first name, and middle initial. This name must be the same as one on the patient's health insurance card or other Medicare notice. This is a ten- position alphanumeric field for the first name, and a 15-position field for the last name. This is a required field and is located in field 58 of the UB92 form.

Slide 125
Note: Enter the Insured's Last Name from field 58 of the UB92.

Slide 126
Note: Enter the Insured's First Name from field 58 of the UB92.

Slide 127
Note: Patient Relationship to Insurer is a maximum of 2 digits. 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. This field is conditionally required and is located in field 59 of the UB92 form.

Slide 128
Note: Certification SS#-Health Ins. Claim identifies the insurer's assigned beneficiary number or health insurance claim number used in all correspondence and to facilitate the payment of claims. This is a required field and is located in field 60 of the UB92 form.

Slide 129
Note: Group Name identifies the name of the group or plan through which the insurance is provided to the insured. This field is conditionally required and is located in field 61 of the UB92 form.

Slide 130
Note: Insurance Group Number displays the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. This is a 20-position alphanumeric field. This field is conditionally required and is located in field 62 of the UB92 form.

Slide 131
Note: HHPPS Treatment Authorization Code identifies a matching key to the OASIS (Outcome Assessment Information Set) of the patient. This field is 18 positions with 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 M00090 that is the Date Assessment Completed. The codes are from M0100 that is for the assessment currently being completed. This field is a required field on inpatient claims. It is located in field 63 of the UB92 form.

Slide 132
Note: In FISS, you would press F8 to move to the next page of the claim. Press NEXT.

Slide 133
Note: This screen is used to enter MSP information for viewing Payment/Pricer data. Press NEXT.

Slide 134

Transcript

Note: 1st Insurers Address 1 identifies the street address of the beneficiary's insurer. This is a 32-position alphanumeric field.

Slide 135
Notes: 1st Insurer's Address 2: identifies the second street address line of the beneficiary's insurer and is used to indicate the post office box, apartment number, etc. This is a 32-position alphanumeric field.

Slide 136
Note: The following fields are intended for the city, state, and zip code of the insurer. Fields are limited in spaces and make sure to use the accepted two-letter postal abbreviation for the state.

Slide 137
Note: Here, you may enter address information for the 2nd insurer.

Slide 138
Note: Deductible identifies the amount of deductibles for which the beneficiary/patient is liable. When the claim has processed to finalization, this field is system generated.

Slide 139
Note: Coinsurance identifies the amount of coinsurance for which the beneficiary/patient is responsible. When the claim has processed to finalization, this field is system generated.

Slide 140
Note: Crossover IND identifies the Medicare payor on the claim for payment evaluation of claims crossed over to their insurer's to coordinate benefits. The valid values are:'1' Primary'2' Secondary'3' Tertiary

Slide 141
Note: The Partner Identification number goes here.

Slide 142
Note: Paid Date identifies the scheduled payment date of the claim or the date the provider is actually reimbursed. This is a six-digit field in MMDDYY format.

Slide 143
Note: Provider Payment is the actual amount that the Provider was reimbursed for services.

Slide 144
Note: The Paid By Patient field is not utilized in DDE.

Slide 145
Note: Reimbursement Rate identifies the per diem amount to be paid for an individual claim for those providers reimbursed on per diem reimbursement or percentage of reimbursement if the provider's type reimbursement is based on a percentage of charges. This is a six-digit field in 9999.99 format

Slide 146
Note: Receipt Date identifies the date the claim was received by the Medicare Intermediary. This is a six-digit field in MMDDYY format.

Slide 147
Note: Provider Interest identifies the amount of interest paid to the provider for late payment on clean claims. This is a nine-digit field in 9999999.99 format.

Slide 148

Transcript

Notes: Check / Electronic Funds Transfer Number displays the identification number of the check or electronic funds transfer. This is a ten-position alphanumeric field.

Slide 149
Note: Check / Electronic Funds Transfer Issue Date displays the date the check was issued or the date the electronic funds transfer occurred.

Slide 150
Note: Payment Code displays the payment method of the check or electronic funds transfer. This is a three-position alphanumeric field. The valid values are:'ACH' Automated Clearing House or Electronics Funds Transfer; 'CHK' Check; 'NON' Non-Payment Data

Slide 151
Note: Diagnosis Related Group Code identifies the Diagnosis Related Group Code assigned by the CMS grouper program using length of stay, covered days, sex, age, diagnosis and procedure codes, discharge date, and total charges. This is a three-position alphanumeric field.

Slide 152
Notes: Capital Outlier Payment identifies the outlier portion of the PPS payment for capital and the PPS dollar threshold for a cost outlier. This is a numeric field in 9999999.99 format.

Slide 153
Note: TTL BLENDED PAYMENT and FED SPECThese fields are not utilized in DDE.

Slide 154
Note: Gramm Rudman Original Reimbursement Amount identifies the amount reduced from the provider's reimbursement as mandated by Gramm/Rudman/Hollings legislation. This is a nine-digit field in 9999999.99 format. NOTE: For Inpatient Rehabilitation Facility (IRF) PPS claims, the IRF PPS pricer populates this field if a late assessment penalty has been applied to the claim. If present, the field contains the dollar amount of the penalty applied.

Slide 155
Note: NET INL is not used in DDE.

Slide 156
Note: Technical Provider Days and Technical Provider Liable Charges requires the days and dollar amount for which the provider is liable.

Slide 157
Note: Others INS ID and Clinic Code are not utilized in DDE.

Slide 158
Note: There is no MSP information for this claim. In FISS, you would press F9 to update the claim. Press NEXT.

Slide 159
Note: To sign off from the system, you must press PF4 here. Then type CESF LOGOFF. Press <ENTER> to complete the log off.

Slide 160
Note: End of Claims Entry
Press EXIT to return to the main menu.

Slide 161
Note: Shortcut links to topics in the inpatient claims entry self-guided tour

Transcript

Slide 162
Notes:

CLAIMS CORRECTION

Slide 1
Note: In this section of the tutorial you will learn about correcting claims. Some screens require input and will prompt you for information. You may press EXIT to return to the menu at any time.

Slide 2
Note: The main menu screen you will see as a provider is as shown. This screen allows you to do inquiries, enter new claims or attachments, correct claims, or view online reports. For this module, we will concentrate on claim correction and selection number 03.

Slide 3
Note: Press ENTER after entering 3 as a menu selection for Claims Correction.

Slide 4
Note: Once the appropriate selection has been entered, the claim and attachment correction menu will appear . Once on this screen, a claim or attachment is viewed based on the type of bill or TOB that the claim was processed under.

Slide 5
Note: For demonstration purposes, we will assume that an inpatient claim type is selected. Once selection number 21 is entered, the claims summary inquiry screen will be displayed .

Slide 6
Note: This is the Claims and Attachments Correction Menu. AThis the Claims and Attachments Correction Menu. After typing 21 in the Enter Menu Selection box, press ENTER. For this tutorial, we will review the process for the Inpatient Claims Correction, although all Types of Bill corrections are similiar in procedure.

Slide 7
Note: There are three fields that you may enter data into for viewing available claims.
1. You may enter in the HIC number to view a specific claim.
2. The type of bill will default here to match your provider type. You may change it if necessary.
3. You may enter the S/LOC of the bills you would like to view
Press NEXT.

Slide 8
Note: One of the fields on a claim data record that is added by the standard system is called the claim status/location field.

Slide 9
Note: It is not possible to correct a claim until it appears on the summary screen. Also, you will only be allowed to correct those claims that appear with a "T" status. It is important to view these daily. Press NEXT.

Slide 10
Note: If a claim is placed in a RTP (return to provider) status as a result of the standard system, a claim status of “T” will be placed on the claim. The claim then appears on the claim summary inquiry screen. It

Transcript

is recommended that RTP's be worked daily to prevent an unmanageable workload. A hardcopy of the RTP is not required to begin work on a claim for correction purposes. Once the claim is in a 'T' location, the claim can be worked towards adjudication.

Slide 11
Note: The online system does not fully process a claim to adjudication. The duplicate check edits are a batch process and thus a nightly cycle must be run for duplicate processing. The claim may RTP again once the batch cycle has run for a duplicate error. If you resubmitted a claim by re-keying a claim, it will not duplicate against those claims in an RTP status.

Slide 12
Note: TIP Those claims suspended for a Medical Review reason, those with a reason code in the "5XXXX" series, cannot be corrected by the provider. In most instances, the Fiscal Intermediary is awaiting medical attachments for further determination of action to take on the claim. Medical records must be submitted hardcopy, and those claims will continue to show RTP status until adjudicated or the RTP purge process takes place.
Note: RTP claims will be purged after 60 days normally. This is controlled by the Fiscal Intermediary. Once purged, the claim must be resubmitted. Medical review RTP's will normally stay in the system for 95 days.

Slide 13
Note: These claims will appear on the day after the claim is submitted. A daily process must be run at the FI for the claim to process to error.

Slide 14
Note: The initial location status of a returned claim is TB9900 which indicates the day the RTP letter is created. The next day the claim should appear in a TB9997 location status meaning it is now available for claims correction.

Slide 15
Note: The claim cannot be corrected until it appears on the claim summary inquiry screen. The claim that appears on the claim summary inquiry screen with a "T" status has not been processed to payment, thus attention must be given to the claim in order for adjudication to take place.

Slide 16
Note: This screen will display on the inpatient claims for a particular provider that is available for correction or cancellation. Several fields on the screen are available for modification based on selected criteria.

Slide 17
Note: For instance, if a large number of claims reside in the RTP status, you may desire to narrow your selection criteria for a more condensed view of claims you are looking to correct. Among the fields that are modifiable are HIC number, Status/Location, Type of Bill, DDE Sort, and provider number.

Slide 18
Note: You may limit the listing to one field or a combination of these fields. For example, if you are responsible for the correction of all 11X type of bills, you would enter "11" in the TOB field.

Slide 19
Note: Before you hit enter however, be aware of the DDE Sort field. This field defines in what sequence the results of your inquiry will be displayed.

Slide 20
Note: sort by the following codes:
BLANK= Current default :TOB, S/LOC, Name
M= Medical Record Number in ascending order

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N= Name by last name, first initial, reciept date, MR#, and HIC
H= HICN by ascending order, receipt date, MR#
R= Reason code acsending order, receipt date, MR#, HIC
D= Receipt date by oldest date, MR#, and HIC
Press NEXT.

Slide 21
Note: One more note: If you are interested in those claims in or out of Medical Review, the Medical Review Select field may be entered as appropriate. The valid values are as follows:
blank; 1-selects all claims; 2-selects all except Medical review; 3- selects Medical review only.

Slide 22
Note: We will now discuss some of the processing requirements a provider must perform in order for the claim to be corrected and processed through to adjudication. Once the claim summary inquiry screen has been displayed, you must now select a claim to be corrected.

Slide 23
Note: To scroll through the complete list of claims you must depress the F6 key for forward scrolling.
If you have verified your information and the correct claim still is not reflected, back out of claims correction by depressing F3 back to the main menu, choose Inquiry (Selection 01) and Claim (option 12) and select the claim.

Slide 24
Note: Once the claim has been displayed, view the status/location field. The claim must have a status of "T" and a location of "B9997" to appear on the claims summary list for corrections.

Slide 25
Note: Type an "S" in the Sel column to indicate the claim you wish to correct. Press enter after typing the S next to the claim.

Slide 26
Note: The revenue code screen (page 02) has multiple sub screens. If there are more revenue lines than can fit on one screen, F6 must be depressed to page forward.
You can use F5 to page backward if so desired.

Slide 27
Note: Another way to page to a specific page on the claim, you can change the page number in the upper right corner to go directly to the page you desire.

Slide 28
Note: On the bottom of the screen, reason codes will appear that explain why the claim was suspended. By pressing F1 on the claim screen, the reason code information screen will be displayed explaining the reason code. To return to the claim display, just enter F3.

Slide 29
Note: Here is a reason code for the error in this claim. This reason code indicates that the patient's last name and first initial doesn't match the BENE record for this patient.
Press NEXT.

Slide 30
Note: After checking the Medicare card in the patient record, you see that the name is actually spelled "Roble". You would edit the spelling here.
Press NEXT.

Slide 31

Transcript

Note: Type in the correct spelling of "Roble". In FISS, typing F9 would update the claim. For our example, press ENTER.

Slide 32
Note: You see that the update has been successful and the reason code has disappeared. There may be more than one reason code listed at the bottom left during this procedure. You should work through one reason code at a time in sequential order. An error may be related to more than one reason code. If so, all related reason codes will disappear after correction.
Press NEXT.

Slide 33
Note: In FISS, pressing F3 would return you to the selection screen. For our example, press NEXT.

Slide 34
Note: Here you would have the option to select another claim. Notice that the corrected claim no longer appears on the selection list. Press NEXT.

Slide 35
Note: As far as corrections on the revenue code page, you can add a revenue line, delete a revenue line or change the total dollar amount or non-covered charges amount on a revenue line.

Slide 36
Note: Deleting a Revenue Line:
To delete a revenue line, tab to the revenue line you desire to delete and enter zeros over the revenue code or place a D in the first position of the revenue code, hit the HOME key to place the cursor in the upper right corner of Page Number and press ENTER and the line will be deleted. The claim will now be out of balance and the total charges must be modified.

Slide 37
Note: Inserting a Revenue Line:
To insert a revenue line, tab to the line below the Revenue Total Line which is reflected by the 0001 revenue code.
Type the new revenue code line information and press the HOME key to place the cursor in the upper right hand corner at the page number field.

Slide 38
Note: Press ENTER and the system will add the revenue line and resort the lines in revenue code number order with the total revenue line (0001) at the end.
The claim will be out of balance and the total charges must be modified.

Slide 39
Note: To correct the amount fields on any revenue line, including the total revenue line, tab to the beginning of the amount field and enter END to delete the amount Do not use the space key, it will appear correct but the system will store it incorrectly and the claim will reject again.

Slide 40
Note: Once you have pressed the END key, type the dollar amount without the decimal point.
Once you hit ENTER, the system will align the dollar amounts properly. Remember, if you add, delete, or change any amount fields, you must manually total all amounts and update the total revenue line field - revenue code 0001.

Slide 41
Note: If you decide to discard your changes, press F3 and the system will go back to the inquiry summary screen and not retain any updates that were entered. To save the corrections, you must depress F9 to store

Transcript

the changes. As you depress F9, if there are additional errors on the claim, they will show up as reason codes at the bottom of the screen.

Slide 42
Note: Once all reason codes have been cleared on an RTP claim, the screen will display "PROCESS COMPLETED - ENTER NEXT DATA". You will then need to question the RTP suppression process.

Slide 43
Note: SV is for Suppressing the RTP Claim. You might want to supress this claim from appearing on the list of claims needed correction if it does not need to be resubmitted. SV is for Suppressing the RTP Claim. You might want to supress this claim from appearing on the list of claims needed correction if it does not need to be resubmitted. Typing a "Y" for Yes and then pressing F9 would supress this claim.
Press NEXT.

Slide 44
Note: End of Claims Correction
Press EXIT to return to the menu.

CLAIMS ADJUSTMENT

Slide 1
Note: In this section of the tutorial you will learn about claims adjustments. If no input is required, you may press the NEXT button in the top right corner of the screen to continue. You may press EXIT to return to the menu.

Slide 2
Note: Enter the menu selection 3. Then press ENTER.

Slide 3
Note: Along with claims correction, one of the available features of the FISS software, is the capability to process claim adjustments online. When claims are keyed and submitted through DDE for payment consideration, the provider can sometimes make entry mistakes that are not errors to the DDE/FISS system.

Slide 4
Note: From the Claims and Attachments Correction Menu, to access a Claim adjustment, type 30 through 35 in the enter menu selection field. Special note - if you want to adjust an ESRD, CORF, or ORF claim, you must select outpatient and then change to the appropriate TOB for the proper display of claims available for adjustment.

Slide 5
Note: Please enter 30 for an inpatient claims adjustment. Then press ENTER.

Slide 6
Note: 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. After a claim is finalized, it is given a status/location code beginning with the letter "P" and is recorded on the claim status inquiry screen.

Slide 7
Note: To access the claim to be adjusted, key the HIC number and the from and to dates of service and press Enter. The system automatically changes the bill type to XX7. You then must indicate why you are adjusting the claim by entering a claim change condition code on page 01 and a valid adjustment reason code on page 03.

Slide 8

Note: It is necessary to use the HIC number to access the claims for review. Enter S in the SELECT column to choose the appropriate claim. Then press ENTER.

Slide 9
Note: Here you may enter the condition code that best describes the adjustment made to the claim. Press ENTER. The next screen gives you other valid condition codes. Enter the condition code D0 here.

Slide 10
Note: You must also enter a valid Adjustment Reason Code on claim page three. You may type the code SD in the highlighted SC field to access the Adjustment Reason Code table. Press ENTER.

Slide 11
Note: Note: Valid adjustment reason codes can be found by tabbing to the SC field in the upper right hand corner of the screen and entering 16 and pressing enter. This will bring up the Adjustment Reason Code table. You must give a short reason for the adjustment in the remarks section on page 04 of the claim.

Slide 12
Note: For Adjustment Claims (TOB XX8)
D0 = Change in Service Dates
D1 = Change in charges
D2 = Change in Revenue Code/ HCPCS
D3 = PPS Interim Payment
D4 = Change in Diagnosis/ Procedure Cdoe
D7 = Change to Make Medicare Secondary
D8 = Change to Make Medicare Primary
D9 = Other Change
E0 = Change in Patient Status
Press NEXT.

Slide 13
Note: If a mistake is made and you would like to exit without saving the adjustment request, enter F3 at any time to return to the previous list screen. To save the adjustment, enter F9 to save and process.

Slide 14
Note: At times, a claim may need to be adjusted that is not online. Due to storage concerns, claims will be off loaded to tape history after a certain period of time from finalization. Usually, this is anywhere from 18 to 24 months, but is controlled by the Fiscal Intermediary.

Slide 15
Note: To bring a claim back online, access the claims correction sub-menu from the DDE main menu. Once you get to the summary inquiry screen, the HIC number is required for the claim to be marked for retrieval. Once the claim is selected the message "ADJUSTMENT CLAIM IS PRESENTLY OFFLINE PF10 TO RETRIEVE" will appear on the bottom of the screen.

Slide 16
Note: Once F10 is pressed, the message "THE OFFLINE CLAIM WILL BE RETRIEVED WITHIN 7 DAYS" will appear on the bottom of the claim screen on page 01. Press F3 to return to the claims summary inquiry menu and the claim will be processed by the Fiscal Intermediary.

Slide 17
Note: The only exception to this is a rejected claim that has non-covered charges. To adjust this type of claim, the claim must have already been processed through CWF and you must know the HIC number.

Slide 18

Transcript

Note: Proceed to the claim summary inquiry screen as normal for an adjustment. Then perform the following steps: type the correct HIC number and provider number in the header section, change the P to an R in the status location field by overtyping and correct the TOB if necessary.

Slide 19
Note: You would press F3 if you wanted to exit without saving changes. Here, we would press F9 to update the claim changes for this adjustment. For our purposes, enter NEXT.

Slide 20
Note: End of Claims Adjustment
Press EXIT to return to the menu.

CLAMS CANCEL

Slide 1
Note: In this section of the tutorial you will learn about the process necessary to cancel claims in FISS. If input is not required, you will press the NEXT button in the top right corner of the screen to continue. You may press EXIT to return to the menu.

Slide 2
Note: Please enter 3 here to access the Claims Correction Menu.

Slide 3
Note: Please enter 50 here for an Inpatient Claims Cancel.

Slide 4
Note: You 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. These errors could cause payment to be taken back unnecessarily. In addition, once a claim has been canceled, no other processing can occur on that claim.

Slide 5
Note: All bill types can be cancelled except one that has been denied with a full or partial medical denial. A claim that has MSP indicated on it cannot be cancelled even if the claim is a no pay.

Slide 6
Note: After a claim is finalized, it is given a status/location code beginning with the letter "P" and is recorded on the claim status inquiry screen. A claim cannot be cancelled unless it has been finalized and is reflected on the remittance advice.

Slide 7
Note: To access the claim to be cancelled, type the HIC number and the from and to dates of service and press enter.

Slide 8
Note: It is necessary to to use the HIC number as well as the TO and FROM dates of service to access the claims for review. Type "S" in the SELECT column to choose the appropriate claim.

Slide 9
Note: Here you may enter the condition code that best describes the reason for canceling the claim. D5 is used for an Incorrect HIC #/ Provider #. D6 is used for canceling an overpayment. Enter D5 for the condition code entry. Press ENTER.

Slide 10

Transcript

Note: Indicate the reason for the cancel by entering text on page 04 in the remarks section. Press F9 to initiate the cancel or press F3 to exit without canceling the claim. Cancelled claims do not appear on the Provider weekly monitoring reports; therefore use the Claim Summary Inquiry to follow the status/location of a cancel. Make note to check the remittance advice to assure the claim canceled properly.

Slide 11
Note: Enter the following: Provider billed for incorrect Bene services.

Slide 12
Note: You would press F3 if you wanted to exit without saving changes. Please remember that Providers may not reverse a cancel. Also, Providers may not cancel an MSP claim. It will be necessary to submit an adjustment even if the claims are being changed into a "no-pay" claim. Here, we would press F9 to update the claim changes for this adjustment. For our example, press NEXT.

Slide 13
Note: End of Claims Cancel. PLEASE PRESS EXIT TO RETURN TO THE MENU.

REASON CODES

Slide 1
Note: In this section of the tutorial, you will see examples of reason codes and will be able to read the narrative associated with that reason code .
You will press the NEXT button in the top right corner of the screen to continue. You may press EXIT to return to the menu at any time.

Slide 2
Note: Reason codes are listed in the left bottom corner of the claim page. In FISS, you are able to press F1 to see narrative. Press F1 now.

Slide 3
Note: This screen gives you the explanation of the reason code. Press NEXT.

Slide 4
Note: Based on the UB92 form, you will see that the last name is misspelled. Press NEXT to continue.

Slide 5
Note: Press F1 to see the narrative for this reason code.

Slide 6
Note: 16806
THE ALPHA SUFFIX ON THE MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER IS INVALID OR INCONSISTENT. PLEASE RESUBMIT/REK

Slide 7
Note: If you reference field 60 in the UB92 form, you will see that the HIC number is incorrect. Press NEXT.

Slide 8
Note: Here is an example of a reason code W7006.

Slide 9
Note: THIS CLAIM CONTAINS AN INVALID HCPCS PROCEDURE CODE.
This screen gives you the explanation of the reason code. Press NEXT.

Transcript

Slide 10
Note: Claim Page Two contains the HCPC codes for identification of the error. Press NEXT.

Slide 11
Note: Prior to the submission of a claim, verify that the HCPCS code is valid. Press NEXT.

Slide 12
Note: END OF REASON CODES. PRESS EXIT TO RETURN TO THE MAIN MENU.

REPORTS

Slide 1
Note: In this section of the tutorial you will learn about reports. If input is not required, you may press the NEXT button in the top right corner of the screen to continue. You may press EXIT to return to the menu at any time.

Slide 2
Note: Online Reports: This online function allows viewing of provider specific reports to aid you in the status of claims submitted for processing and providing a monitoring mechanism for claims management and customer service to use to determine problem areas in claims submission. The Fiscal Intermediary must set up this option for you in order for you as the provider to view the appropriate reports.

Slide 3
Note: Select option 04 to view online reports by entering it into the box below.
Slide notes
Access to Reports is via menu items R1- Summary of Reports or R2- View a Report. Choose R1 by entering it into the box below. The most frequently viewed provider reports are the 050, 201, and 316.

Slide 4
Note: Claims Returned to Provider Report: If you would like to view the claims being returned for correction and the description of the Reason Codes, then you would choose 050.
Pending Processed and Returned Claims Report: The 201 also lists claims pending for correction without the descriptions of Reason Codes.
Errors on Initials Bills Report: The 316 is a listing of errors received on new claims.

Slide 5
Note: Select report 201 to view by placing an "S" before that selection.

Slide 6
Note: The 201 report is a weekly report created at the end of each week with a cycle date on the report of Friday. The report lists claims that are pending, processed and returned to the provider (RTP) for the week ending with the cycle date. This report will exclude Medicare Choices, ESRD Managed Care and Plan Submitted HMO (Encounter) Claims. Press NEXT.

Slide 7
Note: The 316 Provider Report is a listing, by Provider of errors received on new claims (claims which were entered into the system for the present cycle). As reports are viewed online, it will be necessary to toggle between a "left to right" viewing screen environment. To accomplish this, you would use you <F11> to move your viewing screen to the right and your <F10> to return your screen to the left. Press NEXT.

Slide 8
Note: We are now viewing the left side of the screen. This can be achieved in FISS by pressing the appropriate function key as explained earlier. Press NEXT.

Slide 9

Transcript

Note: Here is an example of an 050 report. The claims returned to Provider Report lists the claims that are being returned to the Provider for correction. The claims on the report are in status/location T B9998. The main difference between this report and the 201 is that it contains the description of the reason code(s) for the returned claims. Press NEXT.

Slide 10
Note: The 201 report is sorted first by pended claims, then within pended by type of claim, and then alpha by the last name of the beneficiary. At the end of the pended claims section is a summary of claims by type of bill. You may search for specific detail from the 'search' field, PF2 at the bottom of your screen. Search criteria can include name(last or first), HIC number, dates, type of claim, etc.
The search takes place from the current cursor position down.
Press NEXT.

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Note: Processed claims are the next major section on the report. All claims processed (paid, rejected or denied) during the week ending with the cycle date will appear in this section of the report. Press NEXT.

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Note: This is page two of the example of a 201 processed claim report. Press NEXT.

Slide 13
Note: Returned claims which are in a Returned to Provider (RTP) location status T B9997 are found in the last section of the 201 report. Press NEXT.

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Note: END OF REPORTS
Press EXIT to return to the menu.

Transcript