

# Provider Portal User Guide

For Individual and Family Plans



proprietary and confidential

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# 1. Introduction

The **Provider OnLine (POL)** was created to provide online tools that allow providers to access patient's medical history, benefit and eligibility information and communicate with the Together with Chorus Community Health Plans Providers can access valuable information 24/7 including:

- Member eligibility search
- Claims search
- Online chat
- Secure messaging
- Claims Submission
- Document repository
- Online security management

Users can navigate POL by follow the instructions listed in the User Guide.

# 2. Main Menu

After logging in, the user can use the secure POL. The left-hand navigation menu appears on all POL screens. From this menu, the user can access the following features:

- User Guide
- Eligibility
- Claims Inquiry
- Enter Claims
- Create Batches
- Messages
- Documents
- Contact Us
- Chat with a Provider Services representative

Provider OnLine	·		Preferences   Messages   Log Ho
lser Guide	Welcome Center		
ligibility laim Inquiry nter Claims reate Batches	Welcome to the Together with Child Portal	ren`s Commu	nity Health Plan Provider
Messages Documents Contact Us	As one of our providers, we want you to have the resources and support you need to provide the best possible care to our members. Our portal offers quick and easy access to updated information about member eligibility, claims, prior authorizations, and more.		Claims Inquiry Claims Inquiry allows easy access to view your claims submitted to the Children's Community Health Plan. You can search for a specific member or all your members, <u>&gt; More</u>
Chat with Provider Services Provider Chat Hours: Monday - Friday 8:00am - 5:00pm ET		T	View Eligible Members View member contract, eligibility and benefit information. <u>&gt; More</u>

Figure 1: POL Main Screen

The user should select the appropriate hyperlink to access the desired function or information.

## 2.1 Eligibility

The **Eligibility** link takes the user to the section of POL where he or she is able to confirm the eligibility of Health Plan members as well as a member'' PCP and benefit information.

#### 2.2 Claim Inquiry

The <u>Claim Inquiry</u> link takes the user to a feature of POL where he or she is able to view access to claims submitted to the Health Plan and to search for specific claims.

#### 2.3 Enter Claims

The **Enter Claims** link takes the user to a feature of POL where the user can submit claims.

#### 2.4 Create Batches

The Create Batches link takes the user to a feature of POL where the user can submit claims.

#### 2.5 Documents

The **Documents** link takes the user to a feature of POL where various reference documents can be viewed.

#### 2.6 Chat

The **<u>Chat link</u>** takes the user to the instant message system where users can communicate with Health plan provider services representatives.

# 3. Eligibility

The user is able to access/view specific member information by clicking on the **Eligibility** link on the lefthand navigation menu. The Eligibility screen is displayed below.

Member Search					
	regulations and legislature, the use of the member's social security number ation has been discontinued. Other search criteria, such as the member ID n advanced search option.				
Enter your search criteria below. Then click th criteria may be used.	e Search button. Any combination of search				
Member ID:	(As shown on ID card)				
Last Name:	(Full or partial)				
First Name: (Full or partial)					
Search Clear	Advanced Search				

Figure 2: Eligibility Screen

The user can search for a member using either the Member ID or Last Name. (The Member ID is the nine-, ten-, or eleven-digit computer-generated number on the ID card.)

By selecting the <u>Submit</u> button, the results and the Eligibility Inquiry screen are displayed. By selecting the <u>Clear</u> button, any information entered in the Member ID or Last Name fields will be cleared.

Users have the ability to perform an advanced search for the Member Eligibility, as shown in the screen print below.

ess eligibility and benef er, remain available alo	t information		inued. Other sear	
our search criteria below. Th may be used.	en dick the Sea	rch button. Any co	mbination of search	
Member ID:		(As show	n on ID card)	
Last Name:		(Full or p	artial)	
First Name:		(Full or p	artial)	
Sex: Eith	er 💌			
Date of Birth:		•		
Home Phone:	ode ex. 11122		data only, include	
Search Cle	ar	Simple Search		

Figure 3: Advanced Search for Eligibility

When searching by Last Name, more than one result may be found. When multiple names are displayed, these are listed in alphabetical order. An example of this screen is shown below:

Member Search
In light of present and future privacy regulations and legislature, the use of the member's social security number to access eligibility and benefit information has been discontinued. Other search criteria, such as the member ID number, remain available along with an advanced search option.
Enter your search criteria below. Then click the <b>Search</b> button. Any combination of search criteria may be used.
Member ID: (As shown on ID card)
Last Name: (Full or partial)
First Name: (Full or partial)
Sex: Either
Date of Birth:
Home Phone: (Numeric data only, include area code ex. 1112223333)
Search Clear Simple Search
1         2         3         4         5         6         7         8         9         10            Name         ID Card/Member#         Relationship         Birth Date         Address
Select
Select
Select
Select
Select
Select

## Figure 4: Eligibility Inquiry Result Screen

To view the Member Eligibility Detail Screen, users click on the <u>Select</u> link next to the appropriate member. (If only one match is returned during the search, the user will go directly to the Member Eligibility Detail Screen.)

Current Plan:	1.				
Primary Member:			Pharmacy Co	0.347	
			Pharmacy Co		
Employer: Plan Name:			Service Cop Coinsura		
Plan Type:			Mental He		
Plan Period:			MH Li		
Plan Year:			1 11 21	nics.	
Group Number:					
Subscriber Number:					
Subscriber Number.					
Plan Period = Enrolled mer Plan Year = Organizations			Contract Span		
Physician Details	_			_	
Physician Name:					
Practice Name:			Address:		
Phone:					
Fax:					
Member Details	L	Other Family	M	edical Claims	
Plan Documents					
-					
Schedule of Benefits			http://www.presciption.Ride	<u>r</u>	
1					
Vision Rider					
Member Details					
Nam				hone:	
					I
Gende			Ad	dress:	I
Date of Birt					I
Relationship to Subscribe	r:				I
ID Card Numbe					
	r:				I
	r:	_	_	_	_
Plans		at also		_	
	ber's span of elig		ontract Span	-	_
Plans Plan Period = Enrolled mem	ber's span of elig		ontract Span Plan Year Start	Plan Year End	Group-Division
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations (	ber's span of eliç Employer Group,	Govt Pgm, etc) C		<b>Plan Year End</b> Open	Group-Division
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
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Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
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Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End	Plan Year Start		
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2 Primary Care Physicians	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End Open	Plan Year Start	Open	M
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2 Primary Care Physicians	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End Open	Plan Year Start	Open	M
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2 Primary Care Physicians	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End Open	Plan Year Start	Open	M
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2 Primary Care Physicians	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End Open	Plan Year Start	Open	M
Plans Plan Period = Enrolled mem Plan Year = Organizations ( Name 2 Primary Care Physicians	ber's span of eliq Employer Group, Plan Start	Govt Pgm, etc) C Plan End Open	Plan Year Start	Open	M



The following information can be viewed on the Member Eligibility Detail Screen, as shown above.

- Current plan information of the member Primary member, plan name, deductible, and copayment information
- Plan documents Links to PDFs of the member's schedule of benefits and other plan riders
- Plan information Includes current start and end dates and previously held plans
- Utilization information Includes deductible information for the member

#### 3.1. Medical Claims

If the user would like to view medical claims on the member, he/she is able to do this from the member eligibility screen.

Member Det	<u>ails</u>	Other Fami	ily	Medi	<u>cal Claims</u>	1
	Select S	ecurity Setting: 🛄			•	
- Medical Claims -					1	
Date of Service	Provider	Member Name	Care Type	Status Paid	Total Billed	Patient Acct #
01/08/2008						
01/08/2008						
<u>12/08/2007</u>						
<u>11/08/2007</u>						

#### Figure 6: Viewing Medical Claims

The user is able to choose the appropriate facility by clicking the drop-down label for **Select Security Setting**. The values in this drop-down box are configured by the user's security and access settings on the back-office systems. Once the system is chosen, the user can click on the hyperlink for Medical Claims to view the medical claim information for this member.

The user is able to retrieve detailed information for particular medical claims by clicking on the hyperlink for that specific date.

Plans				
Name	Plan St	art Plan End	Group-Division	
PPO				
PPO				
PPO				
Utilization for Plan FE4 01/01/20	009 thru 12/31/2009			
	Deductible	Out of Network	Out of Pocket	
Member	Family	Member	Family	
Deductible: S	Deductible: 5	OOP: 5	OOP: 5	
Applied: 🤄	Applied: :	Applied: s	Applied: (	
Remaining: \$	Remaining:	Remaining:	Remaining: \$	
Primary Care Physicians				
Name	Code	Start Date	Phone Fa	ж
I				

Figure 7: Medical Claim Detail

By clicking on the <u>Compose</u> button, a dialog box opens for the user to send a secure message to Provider Services regarding the claim.

					Compose N	lew Clai	m Me	ssage 乡
Name: l	1		Member	Number:				
Compose a Nev	w Provider Mess	age:					ŀ	
Send Mess	age C	ancel						AGE:
т	TAX ID		F DL	AGNOSIS	111	LE		
	TAX ID				րո	œ		
т		wed Amoun	CLAI	AGNOSIS M SUMMARY Member Res			aid by	JPMC
250.00 Billed Amount		wed Amoun	CLAI	M SUMMARY	sponsibility		aid by 1	
250.00 Billed Amount	t Allo	wed Amoun	CLAI) it \$.00	M SUMMARY	sponsibility	P	aid by 1	JPMC \$.0
250.00 Billed Amount \$10 DOS	t Allo 0000.00 STATUS	wed Amoun	CLAI) it \$.00	M SUMMARY Member Res	sponsibility \$. BILLED	00 NET		
250.00 Billed Amount	t Allo	wed Amoun	CLAIJ t \$.00 CLA	M SUMMARY Member Res	sponsibility \$.	P 00		\$.0
250.00 Billed Amount \$10 DOS	t Allo 0000.00 STATUS	CODE	CLAIJ it \$.00 CLA PROCEI Mod	M SUMMARY Member Res IM DETAIL DURE QUANTITY	sponsibility \$. BILLED	00 NET		\$.0 CHECK
250.00 Billed Amount \$10 DOS 03/01/2012	t Allo 0000.00 STATUS	CODE 0120	CLAIJ it \$.00 CLA PROCEI Mod	M SUMMARY Member Res IM DETAIL DURE QUANTITY 1	sponsibility \$. BILLED	00 NET		\$.0 CHECK

Figure 8: Opening a Secure Message Window

Page | 9 Proprietary and confidential The user will type the message in the dialog box and click on the <u>Send Message</u> button. If the user chooses not to send a message, he or she can click on the <u>Cancel</u> button to close the dialog box.

The user is able to navigate back to the original list of Medical Clams by clicking on the hyperlink for **<u>Return to List</u>**.

#### 3.2. Other Family Members

The user is able to view details of other family members by clicking on the **Other Family** hyperlink.

Name:	Member Nun	nber:
Current Plan:		
Primary Member:		Pharmacy Copay:
Employer:		Service Copays:
Plan Name:		PCP:
Plan Type:		Specialist:
Plan Period:		Emergency:
Plan Year:		Coinsurance:
Group Number:		Mental Health:
Subscriber Number:		MH Limits:
HIC#:		
Plan Year = Organizations (En	nployer Group, Govt Pgm, etc) Con	tract Span
	nployer Group, Govt Pgm, etc) Con	tract Span
Plan Year = Organizations (En Physician Details Physician Name: Practice Name: Phone: Fax:	nployer Group, Govt Pgm, etc) Con	tract Span Address:
Physician Details Physician Name: Practice Name: Phone:	nployer Group, Govt Pgm, etc) Con	
Physician Details Physician Name: Practice Name: Phone: Fax:		Address:
Physician Details Physician Name: Practice Name: Phone: Fax: <u>Member Details</u>		Address:
Physician Details Physician Name: Practice Name: Phone: Phone: Fax: Member Details Covered Family Members	Other Family	Address: <u>Medical Claims</u>
Physician Details Physician Name: Practice Name: Phone: Phone: Fax: Member Details Covered Family Members Group-Division:	Other Family Effective Date:	Address: Medical Claims Term Date:

Figure 9: Accessing Other Family Information

This will open a view listing the Covered Family Members of the member.

me		Member Nur	nber.	
rrent Plan: 01/01/2009 - Open				
Primary Member:				eductible:
Employer:			Standard Servic	
Plan Name:				st Co-Pay::
Plan Type: Plan Period:				y Co-Pay:
Flan Period: Group Number:			Pharmac	y Co-Pay::
Member Number;				
hysician Details				
Physician Name:			Address:	
Practice Name:1			Address:	
Phone:				
Faoc				
nber Detais	Other Family		Medical Claims	
overed Family Members				
Group-Division:		Effective Date: 01/01/	2009	Term Date: Open
Full Name	Gender	Birth Date	Relationship	Person No.
	Female		Subscriber	01
	Male		Spouse	02
	Male		Dependent	03

Figure 10: Covered Family Member View

The user can obtain a detailed view of the family member information by clicking on the hyperlink of the member's name.

Name.	Member Number:
Current Plan: 01/01/2009 - Open	
Primary Member: Employer: Plan Name: Plan Type: Plan Period: Group Number: Member Number:	Annual Deductible: { Standard Service Co-Pay: { Specialist Co-Pay: { Emergency Co-Pay: { Pharmacy Co-Pay: {
Physician Details	
Physician Name: Practice Name: Phone:	Address:
Fax: Member Details	Other Family Medical Claims
Plan Documents	
12 Schedule of Benefits 12 Vision Rider	122 <u>Presciption Rider</u> 122 <sub>Comestic Partner Rider.</sub>
Member Details	
Name: Gender: Date of Birth: Relationship to Subscriber: ID Card Number:	Phone:- Address:



# 4. Claims Inquiry

Select Security				
Setting:	MMY PROVIDER [VO	ODEF] 🗾		
Member Information:				
Last Name:		(Fully qualify l	ast name)	
Member ID:		(As shown on	ID card)	
Claim Information:				
Claim Type: All	•			
Total Billed Amount:		(Numeric data	i only)	
Patient Acct Number:				
From Date: 07/2	5/2010	To Date:	08/24/2010	(date range up to 30
		d	ays)	
Valid (	date formats: mmddyy,	mmddyyyy, r	nm/dd/yyyy	

The user can search for a general list of all claims with their POL account by selecting the <u>Claims</u> <u>Inquiry</u> menu and option.

Figure 12: Claims Inquiry Screen

The user can search for claims by Member Last Name and/or Member ID Number. The searchable criteria that can be used to retrieve a claim is claim type (encounters or institutional), patient account number, total billed amount, and date range.

The user is able to search for claims by an appropriate facility by clicking on the drop-down label for "Select Security Setting." The values in this drop-down box are configured by the user's security and access settings.

The user will need to define the date range for the claims search. The From Date field can be set to any date; however, the date range is limited to 30 days from first date entered.

	Setting:		. j] .				
dember Informa	tion:						
	Last Name:		(Fully qualify las	t name)			
	Member ID:		(As shown on II	card)			
laim Informatio	n:						
	Claim Type: All						
Total 8	led Amount:		(Numeric data o	nly)			
Patient /	loct Number:						
	From Date: 03/01/2		To Date:			(date range	up to 30 days)
	Search Clear	formats: mmddyy, r ]	mmddyyyy, m	m/dd/yy	YY		
				Status	Total Paid	Total Billed	Patient Acct #
idical Claims Date of Service	Provider	Member Name	Care Type	status			
	Provider	Hember Name	Care Type	Paid	\$0.00	\$10000.00	

Figure 13: Claims Inquiry Result Screen

If there are multiple pages from the claims search results, there will be hyperlinked page numbers that appear at the top and the bottom of the search results of the user to navigate and view.

The user can view details of the claim by clicking on the hyperlink of the date of that particular claim.

				Member Numl			_			
				UB Claim	Detail					
CLAIM NO:				ja ja	ECEIVED D	ATE: :				
AUTH NO:					SILLED TOT	AL:				
				SUBSCRIBER IN	FORMATIO	N .				
SUBSCRIBE	R'S NO; (			NAME:					SEX:	AGE:
				COVERAGE INF	FORMATION					
	CODE		DESCRIPTION							
PLAN	306		306							
				PROVIDER INF	ORMATION					
PROVIDER NO	PROVIDE	R TYPE		NAME				TITLE		
V0H005	HOSPITAL			DIAGN	0515			ma		
/0H005	HOSPITAL							ma		
Billed /	HOSPITAL		lowed Amount	DIAGN CLAIM SU	MMARY	ber Resp	onsibility		Paid	by UPMC
			lowed Amount		MMARY Men	ber Resp	onsibility		Paid	by UPMC
tilled i		A	lowed Amount	CLAIM SU	MMARY Men ETAD	ber Resp		NET		by UPMC
tilled /	Amount	A		CLAIM SU CLAIM D	MMARY Men ETAD					
tilled i	Amount	Al PI CODE M	ROCEDURE	CLAIM SU CLAIM D	MMARY Men ETAIL	ADJUSTM	ENTS	NET		CHECK
tilled /	Amount	Al PI CODE M	ROCEDURE od QUANTITY	CLAIM SU CLAIM D	MMARY Men ETAIL TYPE	CODE [0A]	ENTS AMOUNT	NET		CHECK
Dilled /	Amount	Al PI CODE M	ROCEDURE od QUANTITY	CLAIM SU CLAIM D	MMARY Mem ETAIL TYPE	CODE [0A]	ENTS AMOUNT	NET		CHECK

Figure 14: Claim Detail Screen

leturn to List								
Name:			Member	Number:				
Compose a N	ew Provider Mess	age:					1	
								AGE:
Send Me	ssage C	ancel					Ŀ	
Send Me	TAX ID	ancel	p	_		u:	ŀ	
Send Me				AGNO515	m	Ŀ		
	TAX ID		UNCNTRL	AGNOSIS M SUMMARY		LE		
	TAX ID DB W/O COMP TYP		UNCNTRL		ponsibility	P	'aid by U	IPMC
250.00 Billed Amou	TAX ID DB W/O COMP TYP	E II/UNS NOT	UNCNTRL	M SUMMARY		P	aid by U	IPMC \$.(
250.00 Billed Amou	TAX ID DB W/O COMP TYP unt Allo	E II/UNS NOT	UNCNTRL CLAIM t \$.00	M SUMMARY	ponsibility	P	aid by U	
250.00 Billed Amor	TAX ID DB W/O COMP TYP unt Allo \$10000.00 STATUS	E II/UNS NOT	UNCNTRL CLAIM t \$.00	M SUMMARY Member Res	ponsibility \$.( BILLED	00 NET		
250.00 Billed Amor	TAX ID DB W/O COMP TYP ant Allo \$10000.00	E II/UNS NOT	UNCNTRL CLAIM \$.00 CLA	M SUMMARY Member Res	ponsibility \$.(	00		\$.(
250.00 Billed Amor	TAX ID DB W/O COMP TYP unt Allo \$10000.00 STATUS	E II/UNS NOT	UNCNTRL CLAIM tt \$.00 CLA PROCEI Mod	M SUMMARY Member Res IM DETAIL DURE QUANTITY	ponsibility \$.( BILLED	00 NET	C	\$.( HECK
250.00 Billed Amou S DOS 03/01/2012	TAX ID DB W/O COMP TYP unt Allo \$10000.00 STATUS	E II/UNS NOT	UNCNTRL CLAIM tt \$.00 CLA PROCEI Mod	M SUMMARY Member Res IM DETAIL DURE QUANTITY 1	ponsibility \$.( BILLED	00 NET	C	\$.( HECK

Figure 15: Claim Detail, Compose Message Screen

By clicking on the <u>Compose</u> button, a dialog box opens for the user to send a secure message to Provider Services regarding the claim.

The user will type the message in the dialog box, and click on the **Send Message** button. If the user chooses not to send a message, he or she can click on the **Cancel** button to close the dialog box.

The user is able to navigate back to the original list of Medical Clams by clicking on the hyperlink for **Return to List**.

The user can narrow the search results by entering multiple criteria, such as facility, last name, and the appropriate date range.

Select Security	Setting:		. 5] •	-			
Member Inform	nation:						
	Last Name: (Fully qualify last name)						
Member ID: (As shown on ID card)							
claim Informat	ion:						
	Claim Type: All						
Tota	Billed Amount:		(Numeric data o	nly)			
Patien	t Acct Number:						
	From Date: 03/01/20	12	To Date: 3			(date range	up to 30 days)
	Search Clear						
edical Claims Date of Service	Provider	Member Name	Care Type	Status	Total Paid	Total Billed	Patient Acct
3/01/2012	PTOVIDET	riemoername	UB	Paid	\$0.00	\$10000.00	Patient Acct a
3/01/2012			UB	Paid	\$0.00	\$10000.00	

Figure 16: Narrowed Search Results

# 5. Messages

The user is able to access secure messages by clicking on the <u>Messages</u> button. If the user has unread messages, the number of unread messages is listed in parenthesis — next to the word messages.





The screen below is the main screen for the Message Center. There is a key to indicate read messages and unread messages

Message Center	
Key Unread Read	Search Messages
Subject	Date
Re: rehabilitation facility stay	03/04/2010
09279BEECHK234073 This is a test message	10/06/2009
09260BEECHK245519 test of message return to provider showi	09/17/2009
09260BEECHK245070 test of message search 09/17/09	09/17/2009
09260BEECHK234761 test of message for claim dos 08/27/09,	09/17/2009
09260BEECHK234457 test of message for inquiry regarding c	09/17/2009
09260BEECHK229693 this is a test message 091709	09/17/2009
09146BEECHK255441_test 5/26/09	05/26/2009
09138BEECHK257051 Web Message Creation Test 5	05/18/2009
09138BEECHK256863 Web Message Creation Test 4	05/18/2009
09138BEECHK256127 Web Message Creation Test 3	05/18/2009
09138BEECHK255883 Web Message Creation Test 2	05/18/2009
09138BEECHK255120 Testing Message ID Creation 1	05/18/2009
09135BEECHK228555 Testing Message ID	05/15/2009
09134BEECHK281542 This is a test to validate message id	05/14/2009
09131BEECHK244499 This is a test message to determine if m	05/11/2009
This is a test claim.	05/07/2009
new message	05/05/2009
This is a test only.	05/01/2009
Authorization number 1234 on file. Pleas	04/28/2009

Figure 18: Message Center Main Screen

The user can access the details of a message by clicking on the hyperlink for the respective message's subject.

lessage Cer	ter		
Message:			
Tracking #	,		
Claim#			
Date Of Se	rvice		
Member I	>		
Provider#			
This is a test	message		
Date Subm Responses	tted: 10/06/2009		Add a Response
Date	Response	Attachments	Ву
Date 10/06/2009	Response Thank you for your inquiry. Please allow up to one business day for a response.	Attachments	<b>By</b> Health Plan
	Thank you for your inquiry. Please allow up to one business day for a response.		

Figure 19: Detailed Message Screen

# 6. Chat

Providers have the ability to chat with Provider Services representatives on an assortment of topics. Topics include:

- Member eligibility
- Coverage of a Procedure Code
- Authorization Requirements
- Locate a Provider or facility
- Durable Medical Equipment
- Vision/dental/behavioral benefits
- Chiropractic benefits
- Home health benefits
- Explanation of payment
- Status of an appeal
- Unlisted topic

In order to initiate a chat, users should follow the steps below:

- 1. Click on the **Chat with Provider Services** link or the Callout icon. This will take the user to the "Select a topic for you chat" pop up.
- 2. If applicable type in the Member ID in the **Member's ID** field.
- 3. Select a topic and then click **<u>Start Chat Session</u>**. This will take the user to the "Live Chat Session" pop up.

efore beginning your chat sessior oncern, or comment (one may hav		elow that best describes your question,
or fastest handling of all claim inqui	i <mark>ries,</mark> use the compose feature when	viewing the claim online.
lember's ID:	(if applicable)	
ly preferred security setting is:	M	
I would like to chat with a pro-	vider services representative about O durable medical equipment (DME)	• • • • • • • • • • • • • • • • • • •
- I would like to chat with a prov		
I would like to chat with a prop O a member's eligibility O coverage for a procedure code	C durable medical equipment (DME)	O an Explanation of Payment
I would like to chat with a prop O a member's eligibility O coverage for a procedure code	C durable medical equipment (DME) C vision/dental/behavioral benefits	C an Explanation of Payment C the status of an appeal

Figure 20: "Select a topic for your chat" Pop-up

- 4. A provider services representative will type a welcome message and the session can begin.
- 5. Once the session is over the user clicks on the **<u>End Chat Session</u>** link.
- 6. Before closing, the user can (but does not have to):

- Search for a claim
- Check for a member's eligibility
- View a member's schedule of benefits
- Search for a provider or facility
- Review Health plan's privacy and security policy
- Fill out a satisfaction survey
- Print the chat session
- 7. To close the popup click on the **Close Chat Window** link.

https://demodev.togetherforyourheal	th.com/PortalSystem/LiveChat.aspx#	<b>≗</b> ⊠
	Live Chat Session	Print Chat Session
Quick Information		
Search for a claim		
Check for a member's eligibility		
View a member's schedule of benefits		End Chat Session
	+	
	▼ Send	CLOSE CHAT WINDOW
	Internet   Protected Mode: Off	🖓 🔻 🍭 95% 🔻 j

Figure 21: Live Chat Session Pop-up

# 7. Preferences

The user is able to update his or her name, e-mail, and telephone information by clicking on the **<u>Preference</u>** button.



Figure 22: Choosing Preferences

The screen below will be displayed.

Edit Preferences	
First Name:	ONLINE
Last Name:	ACCOUNT-ADMIN
Work Email: 4	email@www.com (?)
Work Phone: 4	555555555
Home Phone:	
Address 1:	
Address 2:	
City:	
State:	
Zip:	
Fax:	
	Submit

Figure 23: Preferences Screen

The red asterisks indicate required fields. For the Work Email field, if the user does not have an email address, he or she is able to enter **No Email**.

# 8. Appendix A: Claim Submission Tool (CST) Information

## 8.1. Introduction to Health Plan OnLine CST

Health Plan OnLine CST (<u>C</u>laims <u>S</u>ubmission <u>T</u>ool) provides a complete Internet Portal solution for services provided by Health plan.

Health Plan OnLine is a website that gives anyone with access the ability to view transactions. A portion of its function can process claims via the Web.

Health Plan OnLine CST is the gateway into the MC400 system to input claims. All adjudication and rules are driven off MC400. The Data Warehouse does regular reporting on all claims and how they are initially received in the Health Plan.

Claims are submitted in the following methods and can be identified in MC400:

- EDI (Electronic Data Interchange) claim files electronically sent to the Health Plan.
- OCR (Optical Character Recognition) Formworks/RRI internally generated EDI files.
- MMO (Medical Mutual of Ohio) Re-priced claims returned from MMO.
- EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) claims that originate on custom forms loaded into an internal application.
- Prelog Paper claims manually keyed into Prelog or claims directly submitted by a provider via the Web portal.

All claims are entered or submitted in batches. A Submitter can be any type of user that has been configured to process claims or other electronic inbound or outbound transactions. After a batch is posted to the MC400 system, the claims run through the MC400 adjudication process. Claim errors are returned to the batch indicating invalid data that would prevent the claim from moving into the MC400 system. Claim staff will be responsible for correcting the invalid data. After all data has been corrected, the claims will either adjudicate automatically or hold for review in the MC400 system.

Health Plan OnLine CST allows for the creation of an Administrator. The Administrator will have full and unlimited access to all the features of this program, including Maintenance and Security. The Administrator will be responsible for assigning user access, setting user parameters, processing requests, monitoring claim submissions and reports, communicating with users, and general control of all ongoing processes.

## 8.2. Getting Started

When you have logged in successfully, you will see the 'Welcome' message page.

- Click on Enter Claims to access the Claims Pre-Logging screen.
- NOTE: To log off the system, click on the Log Off sidebar menu option, or exit by clicking on the at the top right of the screen.

The Claims Pre-logging screen has many fields of entry. Below are a few reminders before getting started.

- Health Plan OnLine CST is case sensitive (except in search screens); the Caps Lock key must be on.
- **<u>Tab key</u>** = Move field to field.
- **Shift + Tab** = Go back a field.
- Decimal points are used for dollar amounts and diagnosis codes.
- Fields marked with a red asterisk (\*) are system-required fields of entry.
- Binoculars indicate a search field to aid in selecting or completing information. To display a search window, the cursor must be in the selected search field.

	Health Plan OnLine CST HCFA Claims – Field Descriptions (*) Denotes System-Required Field Yellow Fields are mandatory entry fields Green Fields are situational White fields are auto-populated or not required					
Prelog Fiel	d	HCFA	Usage			
HCFA			Identifies the claim form type entered. Click on HCFA to create a separate batch for every physical batch entered.			
			Member Information			
Insured ID	*	1A	Member's 11-digit ID #. Enter the 11-digit Member # directly into the field — no dashes. If the member cannot be found, the member search screen is available. Click on the 💏 or press [Enter] to access.			
Patients Name	*		Auto-populates with the member's name, based on the Insured ID entered.			
Patients DOB	*		Auto-populates with the member's date of birth.			
Patients Sex	*		Auto-populates with the member's gender.			
Patient's Control #	*	26	Patient Account Number assigned to the patient by the billing provider. If not billed, press the space bar and tab to leave blank.			
			Provider Information			

#### 8.3. HCFA Claims Prelogging screen

Billing	*	25	Vendor or Billing Provider. TAX ID is the only search method. To access
Provider ID			the provider search screen, click on the 🊧 or press [Enter]. If a match appears, verify the name and address of the provider. Some vendor's are listed twice in Prelog. If entering an HCFA claim, select the VOP
			Vendor # (P for provider). If entering a UB claim, select the VOH Vendor # (H for hospital).
Prov. FED. TAX ID #	*		Auto-populates with the Tax ID of the Billing provider (vender) entered.
Prov			Auto-populates with the billing provider's name.
Name			
Prov. Address			Auto-populates with the billing provider's address.
Prov. City			Auto-populates with the billing provider's city.
Prov. State			Auto-populates with the billing provider's state.
Prov. Zip			Auto-populates with the billing provider's Zip Code.
Prov Phone #			Auto-populates with the billing provider's Phone #.
Prov. PCP Flag			Not used at this time.
Servicing	*	31	The individual provider who rendered the service. Identified in Prelog
Prov ID			with a 6-digit provider number. Press to access the Provider Search screen. Click on the Search button. Search by provider's last name. Prelog is configured to return <u>only</u> the providers listed under the Vendors Tax ID # selected.
Referring		17	Referring Provider. The UPIN # search can only be done by accessing
Prov ID		17A	the Provider Search screen, click on the 🚧 or press [Enter] to access.
<u>ê</u> n			Enter the UPIN # in the UPIN field, press [Enter]. Verify the name of the
			referring provider, then select the provider by double-clicking on the provider "Select" line. The referring physician can be found by either
			the UPIN # or his or her name.
Ref Phys Name			Auto-populates with the Referring Physician's name.
			Header Information
From Date	*	24	Earliest date of service.
Through Date	*	24	Last Date of service.
Diagnosis	*	21	Diagnosis code(s). Decimal points are required after the 3 <sup>rd</sup> character
1-4			(ex. 7809 is entered 780.9). If the diagnosis code has only 3 characters
<u>đ</u> đ			drop the decimal (ex. 650 is entered as 650). Click on the 🎮 or press [Enter] to access a search screen.
Total Amount Billed	*	28	Total charge billed on the claim. Decimal points are required (ex.: \$150 billed, enter 150.00).

			Notes
Claim Paper Work			ONLY USED when billing corrected HCFA claims. Enter the value of <b>CC</b> in this field. <u>IMPORTANT NOTE</u> — corrected claims requiring Health Plan review of ANY paper documentation i.e., COB, Medical notes/certificates, <u>CANNOT</u> be entered via Prelog.
Claim Note 1		10d , 19	Not used at this time.
Claim Note 2		10d , 19	Not used at this time.
			Service Line Information
From Date of Service	*	24A	Earliest or only date of service billed. Date format is MMDDYY — no dashes or slashes.
To Date of Service		24A	System will default with the "From Date" of service.
Place of Service	*	24B	Place of Service indicates where services were rendered. Click on the press [Enter] to access a list of standard codes.
Type of Service	*		Auto-populates with 01.
Diagnosis Reference	*	24E	Enter the number of the diagnosis code linked to the service line. There are four fields, enter the numbers 1234 that correspond with the diagnosis codes billed for the service line. Linking the correct diagnosis codes to a service line can affect payment.
CPT/HCPCS	*	24D	The 5-digit CPT or HCPCS procedure code billed. Click on the 🏟 or press [Enter] to access a search screen.
Modifier 1st – 4 <sup>th</sup>		24D	Modifiers are an extension to the CPT codes. Alpha characters must be entered in Upper Case (ex. AA).
Amount Billed	*	24F	The total amount billed for the individual service line. Decimal points are required for entry of dollar amounts. When a service line is billed with a zero dollar amount, enter \$00.00 for the amount billed. If the service line is billed with \$0, enter 00.00 in this field.
Days or Units	*	24G	Number of units/services for the procedure performed. System defaults to 1. Enter units billed <b>except on Anesthesia claims</b> .
OIC Allowed			Not used at this time.
OIC Paid			Not used at this time.
OIC Deductible			Not used at this time.
OIC Co-Ins			Not used at this time.
OIC Not Covered			Not used at this time.
OIC Carrier Group			Not used at this time.
Start Time (HHMM)		24	Anesthesia Start time (hours/minutes). Do not enter the (:) colon.
End Time (HHMM)		24	Anesthesia End time (hours/minutes). Do not enter (:) colon.
Total Minutes (MMMM)		24	Total Anesthesia Minutes billed. (Ex.: 2:45 – 3:45 = Enter 60 in this field).
EPSDT Indicator		24H	Required for EPSDT claims only. Click in box ☑ for pre-logged EPSDT claims to indicate 'Y" (yes). Electronic claims will arrive with an "EP" modifier on the detail line.

## 8.3.1. Member Search

Not entering the 11- digit member ID# in the Insured ID field of the Member Search screen, accessed by the binoculars, allows for several methods of searching for a member. Click on the binoculars in the Insured ID field, the following box will display.

Member Search	
$\searrow$	
SSN: Medicaid ID	:
Employee No: HCFA No:	
Member Name: Begins With 💌	
Member ID: Begins With 💌	
Search Clear Close	

Figure 65: Member Search

Member Search Fields			
Field	Usage		
SSN:	Commercial, Medicaid, Medicare – Search with member's Social Security Number		
Medicaid ID:	Medicaid – Medicaid (9 digit) Case Number		
Employee No:	Medicaid – Medicaid (10 digit) Recipient Number (commonly billed by provider) Medicare - (HCFA#) Social Security Number with an alpha character		
HCFA No:	Medicare – (HCFA#) Social Security Number with an alpha character		
Member Name:	Commercial, Medicaid, Medicare – Last Name, First Initial (comma, no spaces)		
Member ID:	Commercial, Medicaid, Medicare – (9 digit) Contract Number		

## 8.3.2. Provider Search

The Provider Search screen allows for several methods of searching for a provider.

Provider Directory Search Fields		
Field	Usage	
Provider ID	Used to search with the provider's ID number.	
Fed. Tax ID	Used to search by the provider's TAX ID number. <b>This is the only search method for the</b> <b>Billing Provider.</b>	
Provider NPI	Used to search with provider's unique personal identification number. This is the search method for the referring provider.	
Provider Name	Used to search with provider's name. Enter last name, press [Enter]. Can also use a partial name search. This is a search method for the Servicing, Referring, Admitting or Attending provider	

## 8.4. HCFA - Claim Entry

The HCFA form is a standardized form designed to contain all information necessary for billing and/or claim payment. The HCFA form is used primarily by individual providers/groups.

If sufficient information is not on the HCFA form, it could delay claim payment or may cause an unnecessary denial of charges. In order to correctly process claims, you must be able to read, interpret, and understand all of the data contained on the HCFA form.

After clicking on **Enter Claims** from the sidebar menu option:

- 1.  $\underline{\text{HCFA}}$  click on  $\underline{\text{HCFA}}$  to select the HCFA claim form type.
- 2. <u>Insured ID</u> enter the member's 11-digit ID #, press [TAB]. Verify the member's name and date of birth. Click on to access the Member Search screen if a search is needed, press [TAB].
- 3. Patient's Name, DOB, and Sex will auto-populate.
- 4. **<u>Patient's Control #</u>** enter the patient account #, press [TAB].

- 5. <u>Billing Provider ID</u> click on to access the Provider Directory Search screen. Enter the Tax ID in the Fed.Tax ID field and click "Search." Click on the correct provider/vendor, ("select" button). Press [TAB]. Some Vendors are listed twice in Prelog. If entering a HCFA claim, select the VOP Vendor # (P for provider). If entering a UB claim, select the VOH Vendor # (H for hospital).
- 6. <u>Servicing Provider</u> the individual provider who rendered the service. Identified in Prelog with a 6-digit provider number. Press on to access the Provider Search screen. Click the Search button. Search by provider's last name. Prelog is configured to return <u>only</u> the providers listed under the Vendors Tax ID # selected.
- <u>Referring Physician ID</u> click on to access the Provider Directory Search screen. Enter the referring providers UPIN # in the "UPIN" field, press [Enter]. Verify the providers name, click on the correct selection button to return to the Prelog screen. The Referring Physician Name will auto-populate. A name search can also be performed if not using UPIN. Press [TAB].
- 8. <u>**Diagnosis 1**</u> enter the first diagnosis on the claim, press [TAB], decimal point required if code is greater than 3 characters.
- 9. <u>**Diagnosis 2,3,4**</u> enter the second, third, and/or fourth diagnosis on the claim if applicable, after each, press [TAB].
- 10. <u>Total Amount Billed</u> enter the total amount of the entire claim. Enter decimal points. Press [TAB].
- 11. Total Amount Allowed not used at this time. Press [TAB].
- 12. <u>Claim Paper Work</u> tab through this field.
- 13. <u>Claim Note 1</u>— tab through.
- 14. <u>Claim Note 2</u>— tab through.
- 15. From Date of Service enter the initial date of service, press [TAB].
- 16. To Date of Service system will default with the From Date of Service, press [TAB].
- 17. Place of Service enter the place of service code, press [TAB].
- 18. **Type of Service** system will auto populate with 01, press [TAB].
- 19. <u>CPT/HCPCS</u> enter the five (5) character CPT or HCPCS code, press [TAB].
- <u>Diagnosis Reference</u> enter the number of the diagnosis code linked to the service line, press [TAB].
- 21. <u>1<sup>st</sup> Modifier</u> enter the 1st modifier if applicable, press [TAB].
- 22. <u>2nd</u>, 3rd, 4th, Modifier enter 2nd, 3rd, 4th modifier if applicable, press [TAB] after each.
- <u>Amount Billed</u> enter the total amount billed for the service line. Enter decimal point, press [TAB].

- 24. <u>Days or Units</u> system will default to 1. Enter the number of units billed for the service line if different, press [TAB].
- 25. <u>OIC Allowed</u> tab through this field.
- 26. OIC Paid tab through this field.

#### 8.4.1. Claim Detail entry (Anesthesia ONLY)

- Note: Unless the claim is for Anesthesia charges, the last entered field will be <u>Days or Units</u> before you tab to Add, and press Enter.
- The Anesthesia fields are required for Anesthesia claims only.
- Physical Status Codes: P3, P4, P5 are entered in the modifier field.
- Enter Start Time/End Time, <u>OR</u> Minutes, not both.
- The cursor will default to the Total Minutes field for entry of minutes billed. If the minutes are not billed, enter the Start Time and the End Time. The system will calculate the minutes and return an edit for verification. Example: Time billed 1:45 2:30, enter Start Time <u>145</u> End Time <u>230</u>. Do not enter the minutes.

#### 8.4.2. Adding/Finalizing a Service Line

- After the appropriate units are entered, tab to the "Add" field (highlighted yellow), and press enter. This will add the service line to Prelog.
- The cursor will move back up to the From Date of Service field to begin entering the second service line.
- After the service line has been entered and added, there will be a service line summary at the bottom of the page.
- Once a service is added, only the <u>Amt. Billed</u> and <u>Qty (Units)</u> fields can be edited in the summary lines.

## 8.4.3. Deleting a Service Line

If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.

- To delete the service line, click on the
- To make corrections to the member or the provider, click in the field selection to use the search function to make any of the necessary changes.

## 8.4.4. Finalizing a Claim

Once all of the data has been entered on the claim:

• On the last service line entry, press or click on "Add" to add the service line.

• If all the services have been entered, press **F12** or click on "Save and Clear Form" button at the bottom of the screen. This will finalize the current claim and allow for another claim to be entered.

After the form (claim) has been saved and cleared, the following message appears: "A new HCFA claim record has been added to the pre-logging file." This indicates that Prelog system has accepted the claim.

- Press Enter, or click on OK to accept.
- The cursor will return to the <u>Close Batch</u> field (highlighted in yellow). You have the option to continue entering claims or close your Prelog batch. To continue entering claims within the same batch, tab to the Insured ID field to enter another claim. Clicking on the Close Batch button will close the Prelog Batch of entered claims.

## 8.4.5. Closing a Batch

The cursor will default to the <u>**Close Batch**</u> button (highlighted in yellow). Clicking on "Close Batch" will close out the Prelog Batch (radxxxx) number and allow the user to create another. Once closed, all the claims are sitting in the Prelog claims database.

#### When do I close my batch?

- When you have completed entering the claims in your bundle of work.
- When the claim form type changes (HCFA/UB).
- When entering a new received date.
- When leaving your computer for any amount of time.

If not closing a batch, tab to the Insured ID field to enter another claim.

• Click on the **Close Batch** button to close the batch. If entering a new bundle of work, a new prelog batch will need created. Select a claim form type (HCFA or UB), click the New Batch button.

# 8.4.6. UB Claims Prelogging screen

Health Plan OnLine CST UB Claims — Field Descriptions (*) Denotes System-Required Field of Entry Yellow Fields are mandatory entry fields Green Fields are situational White Fields are auto-populated or not required			
Prelog Field		UB	Usage
UB	*		Identifies the claim form type entered. Click on UB.
			Member Information
Cert/ SSN/HIC/ Insured ID	*	60	Member's 11-digit ID #. Enter the 11-digit Member # directly into the field — no dashes. If the member cannot be found, the member search screen is available. Click on the the or press [Enter] to access.
Patients Name	*		Auto-populates with the member's name.
Patients DOB	*		Auto-populates with the member Date of Birth.
Patients Gender	*		Auto-populates with the member's gender.
Patient's Control #	*	26	Patient Account Number assigned to the patient. If not entering, press the space bar and tab to leave blank.
			Provider Information
Billing Provider ID	*	5	Vendor or Billing Provider. TAX ID is the only search method. To access the provider search screen click on the and or press [Enter]. If a match appears, verify the name and address of the provider. Some Vendors are listed twice in Prelog. If processing a HCFA claim, select the VOP Vendor # (P for provider). If processing a UB claim, select the VOH Vendor # (H for hospital).
Prov. FED. TAX ID #	*		Auto-populates with the Billing Provider's (Vendor) Tax ID number.
Prov. Name			Auto-populates with the billing provider's name.
Prov. Address			Auto-populates with the billing provider's address.
Prov. City			Auto-populates with the billing provider's city.
Prov. State			Auto-populates with the billing provider's state.
Prov. Zip Prov. Phone #			Auto-populates with the billing provider's Zip Code. Not used by the Health Plan.
Prov. PCP Flag			Not used by the Health Plan
Serv. Prov. ID		1	The cursor will bypass this field for UB entry. The servicing provider is the Billing Provider for UB entry.
Attending Phys ID		82	Attending Physician. Provider Search screen is available (UPIN look-up), click the to access. If Adm/Ref Provider cannot be found, leave blank
Admitting Phys ID		82	Admitting/Referring physician. Provider Search screen is available (UPIN look-up), click on the 🏟 to access. If Adm/Ref Provider cannot be found, leave blank.

Facility ID *	¥	1	
		I	Enter the 6-digit provider number (not Vendor "V"#). Click on to access the Provider Directory Search screen. If needed, click on the Search button. Prelog is configured to return <u>only</u> the providers listed under the Vendors Tax ID # selected.
			Header Information
From Date *	*	6	Admission Date or earliest date of service.
Through * Date	*	6	Last date of service.
Admission * Type	*	19	This is a code indicating priority of this admission/visit. (i.e., 1-Emergency, 2-Urgent, 3-Elective, 4-Newborn, 5-Trauma Center, 9-Info N/A)
Admit Date		17	Admission Date or earliest date of service.
Admission Hour		18	The hour of admission. System will default to 0.
Admission Source		20	This code indicates the source of this admission or outpatient registration.
Discharge * Date	*	6	Last date of service on the claim.
Discharge * Status	*	22	Discharge status. This code indicates the patient's status as of the "Through" date of the billing period. Field will default to 000.
Bill Type *	*	4	Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as the "frequency" code. (example 131 =Outpatient, 111=Inpatient).
Total * Amount Billed	*	47	Total charge billed for the entire claim. Decimal point required. A system control record is set that requires all service lines to balance with the total billed amount at the header level.
Total OIC Allowed			Not used at this time.
Total OIC Paid			Not used at this time.
Occurrence Code 1-8			Not used at this time.
Principal * Diagnosis Code	*	67	ICD-10 (diagnosis) code. Decimal point is required after the 3 <sup>rd</sup> character when more than 3 are billed.
Admitting Diagnosis Code		76	Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. Decimal point is required after the3 <sup>rd</sup> character when more than 3 are billed.
Other Diagnosis Code 1-8		68- 75	Additional diagnosis codes if applicable. Decimal point is required after the 3 <sup>rd</sup> character when more than 3 are billed.
E Code		77	Begin with an "E"; E-Codes billed identify conditions related to poisoning and external causes of adverse effects of drugs and other chemical substances. Decimal point is required after the 4 character (example, enter E8585 as E858.5).
Procedure Code Method			Not used at this time. Cursor will bypass this field.

· · · · · · · · · · · · · · · · · · ·			
Principal		80	The ICD-10-CM code for the inpatient principle procedure. The principal
Procedure			procedure is the surgical procedure performed for definitive treatment rather
Code 🚧			than for diagnostic or exploratory purposes, or which was necessary to take care
			of the complication. It is also the procedure most closely related to the principal
			diagnosis.
	_		Decimal point is required after 2 <sup>nd</sup> digit.
Other Proc.		81	Other ICD-10-CM procedure codes other than the principal procedure.
Code 1-5			Decimal point is required after the 2 <sup>nd</sup> digit.
<u>é</u>			
Date			The date of each procedure code (the date that the surgery was performed).
Value Code		39,	Value Code(s) and related dollar amount(s) identify data of a monetary nature
1-12		40,	monetary nature that are necessary for the processing of the claim. The codes
<i>4</i> 0		41	are 2-digit alphanumeric. If more than one valued code is shown for a billing
		a-d	period, codes are shown in ascending alphanumeric sequence. There are four
			lines of data, line "a" through "d."
Value Code			Amount associated with each Value Code.
Amount			
Claim Paper			Not used at this time.
Work			
Claim Note		84	Not used at this time.
1-4			
			Claim Details Info
Revenue	*	42	For each type of accommodation or ancillary, a Revenue Code is assigned.
Code			This is a 3-character field.
âô,			
HCPCS Code		44	The 5 character HCPCS or CPT procedure code billed by the facility.
		44	
<u>d</u> eg			
Date of	*		Date of service for the service line.
Service			(System will default with date from header.)
<b>#</b>			
Days or Units	*	46	The number of times the procedure/service was performed, system will default to
			one.
1 <sup>St</sup> – 4 <sup>th</sup>		44	If applicable for the procedure. A modifier is an extension to the
Modifier			HCPCS/CPT code.
ĝĝ.			
	*		The amount billed for that convice line
Amount			The amount billed for that service line.
Billed			Decimal point is required.
Amount	1		Not used by the Health Plan.
Allowed			
OIC Allowed			Not used at this time.
OIC Paid			Not used at this time.
OIC	1		Not used at this time.
Deductible	L		
OIC Co-Ins			Not used at this time.
OIC Not	1		Not used at this time.
Covered			
OIC Carrier	1		Not used at this time.
Group			
OIC Paid	1		Not used at this time.
	1	1	

# 8.4.7. UB - Claim Entry

The UB Form is used by hospitals and other hospital-type facilities for inpatient and outpatient billing.

From the sidebar menu: click **Enter Claims** 

- 1.  $\underline{\mathbf{UB}}$  click on  $\underline{\mathbf{UB}}$  to select the claim form type.
- <u>Cert/SSN/HIC/ Insured ID #</u> enter the member's 11-digit ID #, press [TAB]. Verify the member's name and date of birth that returns. Click on to access the Member Search screen; if search is needed, press [TAB].
- 3. <u>Patient's Control #</u> enter the patient account #, press [TAB].
- 4. <u>Billing Provider ID</u> click on to access the Provider Directory Search screen. Enter the Tax ID in the Fed. Tax ID field and click "Search." Click on the correct Vendor # ("select" button). The Providers Name, Address, City, ZIP, and State will auto-populate. Press [TAB]. Some Vendors are listed twice in Prelog. If processing a HCFA claim, select the VOP Vendor # (P for provider). If processing a UB claim, select the VOH Vendor # (H for hospital).
- 5. <u>Prov. PCP Flag</u> will auto populate.
- 6. <u>Servicing Provider</u> cursor will bypass the servicing provider field on the UB screen.
- Attending Physician ID enter the 6-digit provider #, or if not known click on to access the Provider Directory Search screen. Enter the provider's UPIN in the Fed. Prov. ID (UPIN) field and click "Search." Click on the correct provider ("select" button). Press [TAB].
- Admitting Physician ID enter the 6-digit provider #, or if not known click on to access the Provider Directory Search screen. Enter the provider's UPIN in the Fed. Prov. ID (UPIN) field and click "Search." Click on the correct provider ("select" button). Press [TAB].
- Facility ID enter the 6-digit provider number, (not Vendor "V"#). Click on to access the Provider Directory Search screen; if needed, click the Search button. Prelog is configured to return <u>only</u> the providers listed under the Vendors Tax ID # selected.
- 10. <u>From Date</u> enter the initial date of service for the claim, press [TAB].
- 11. **<u>Through Date</u>**—enter the last date of service for the claim, press [TAB].
- 12. <u>Admission Type</u> enter admission type, system defaults to 01, press [TAB].
- 13. <u>Admit Date</u> enter the admission date for the claim, press [TAB].
- 14. <u>Admission Hour</u> enter admission hour, system defaults to 01, press [TAB].
- 15. <u>Admission Source</u> enter admission source.

- 16. Discharge Date enter the date of discharge for the claim, press [TAB].
- 17. Discharge Status enter discharge status, press [TAB].
- 18. <u>Bill Type</u> enter bill type.
- 19. <u>Total Amount Billed</u> enter the total amount of the entire claim. Enter decimal point, press [TAB].
- 20. <u>Total OIC Allowed</u> not used at this time. Press [TAB].
- 21. <u>Total OIC Paid</u> \_\_ not used at this time. Press [TAB].
- 22. <u>Occurrence Code</u> not used at this time. Press [TAB].
- 23. <u>Principal Diagnosis Code</u> enter the principal diagnosis code billed on the claim. Enter decimal point after 3<sup>rd</sup> character, press [TAB].
- 24. <u>Other Diagnosis Codes 1-8</u> enter if applicable for claim. Enter decimal point after 3<sup>rd</sup> character, press [TAB].
- 25. <u>Admitting Diagnosis Code</u> enter if applicable for claim. Enter decimal point after 3<sup>rd</sup> character, press [TAB].
- 26. <u>E Code</u> enter E code if applicable for claim. Enter decimal point after 4<sup>th</sup> character. Press [TAB].
- 27. Procedure Code Method not used at this time. Press [TAB].
- 28. <u>Principal Procedure Code</u> enter code if applicable, enter decimal point after 2<sup>nd</sup> character, press [TAB].
- 29. <u>Date</u> enter the date for the principal procedure code if applicable, press [TAB].
- 30. <u>Other Procedure Code 1-5</u> enter additional codes if applicable, enter decimal point after 2<sup>nd</sup> character, and press [TAB].
- 31. <u>Date</u> enter the date for the Other Procedure codes if applicable, press [TAB].
- 32. <u>Value Code 1-12</u>—enter value codes if applicable. The cursor will only stop at the first value code. If additional value codes are being submitted, the fields must be re-entered.
- 33. <u>Amount</u> enter the value code amount for each value code entered. Decimal point required. press [TAB].
- 34. <u>Claim Paper Work, Claim Note 1-4</u> not used at this time. Press [TAB].

## 8.4.8. Claim Detail entry

- 1. <u>**Revenue Code**</u> if applicable, enter the Revenue code for service line. press [TAB].
- 2. <u>HCPCS Code</u> if applicable, enter the (5) character HCPCS/CPT code and press [TAB].

- 3. <u>1st 4th Modifier</u> enter if applicable for the service line, press [TAB].
- 4. **<u>Date of Service</u>** enter the service date for the service line.
- 5. <u>Days or Units</u> enter the number of units for the service line; system will default to 1, press [TAB].
- 6. <u>Amount Billed</u> enter the total amount billed for the service line. Decimal point required, press [TAB].
- 7. OIC Fields not used at this time. Press [TAB] through these fields.

# 8.4.9. Adding/Finalizing a Service Line

- After the appropriate <u>Units</u> are entered, tab to the "Add" (highlighted yellow) and press enter. This will add the service line to Prelog.
- The cursor will move back up to the <u>Revenue Code</u> field to begin entering the second service line.
- After the service line has been entered and added, there will be a service line summary at the bottom of the page. The screen print below illustrates this.
- Once a service is added, only the **Qty (Units)** and **Amt. Billed** fields can be edited in the summary lines.

# 8.4.10. Deleting a Service Line

If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.

- To delete the service line, click on the imes
- To make corrections to the member or the provider, click in the field to use the search function **P** to make any of the necessary changes.

## 8.4.11. Finalizing a Claim

Once all of the data has been entered on the claim

- On the last service line entry, press or click on "Add" to add the service line.
- If all the services have been entered, press <u>F12</u> or click on "Save and Clear Form" button at the bottom of the screen. This will finalize the current claim and allow for another claim to be entered.

After the form (claim) has been saved and cleared the following message appears: "A new UB claim record has been added to the pre-logging file." This indicates that Prelog has accepted the claim.

• Press Enter, or click on OK.

The cursor will return to the Close Batch field (highlighted in yellow). You have the option to continue entering claims or close your Prelog batch. To continue entering claims within the same batch, tab to the Cert/SSN/ HIC.ID# field to enter another claim. Clicking on the Close Batch button will close the Prelog Batch of entered claims.

## 8.4.12. Closing a Batch

The cursor will default to the <u>**Close Batch**</u> button (highlighted in yellow). <u>**Close Batch**</u> will close out the Prelog Batch (radxxxx) number and allow the user to create another. Once closed, all the claims are sitting in the Prelog claims database.

#### When do I close my batch?

- When you have completed entering the claims in your bundle of work.
- When the claim form type changes (HCFA/UB).
- When entering a new received date.
- When leaving your computer for any amount of time.

#### If not closing the batch:

Continue entering claims within the same batch, tab to the Cert/SSN/ID. # field to enter another claim.

• Click the <u>Close Batch</u> button. If entering new bundle of work, a new batch will need created by clicking on the claim **form type (HCFA or UB)** and then clicking on <u>New Batch</u> button.

## 8.4.13. Create Batches

When the Prelog batch or batches (i.e. radxxxx) are *Closed* (by clicking on the Close Batch button), the claims sit in the Prelog Claims table. The Create Batches function begins the editing process by consolidating all the Prelog Batches physically entered into one separate electronic batch number and automatically assigning an Internal Batch ID number and an Extended Batch ID. At the time this record is created, the data is validated against the MC400 system. The clean claims (claims without errors that pass through to MC400) will automatically Post to the MC400 System where they can be accessed by the "Form Number" (MC400 claim number). When validation and editing is complete, the system will return a batch status of "Awaiting Post Process" or "Post Complete." If there are errors within some of the claims in the batch, the MC400 system won't allow those claims to be posted. However, the claims with no errors will be posted.

From the sidebar menu: click Create Batches

Next, click on either <u>Create UB Batch</u> or <u>Create HCFA Batch</u>, or both, if claims were entered under each form type (box will be highlighted). At this time, the Prelog Claims table is read and the claims are combined into one electronic claims batch, creating a new batch number record. At the same time the claims are automatically submitted to the MC400 system for editing.

After clicking on <u>Create UB Batch</u> and/or <u>Create HCFA Batch</u>, notification is returned that "All prelog batches have been consolidated into one batch and inserted into the database." When the Prelog batches are consolidated into the database, the system assigns an Internal Batch ID number (4-characters) and an Extended Batch ID number. The Extended Batch ID number generated by Prelog will have 6-characters and will start at one every day and be prefaced with the date value (example, 20040108000001, 2004010800002, etc.) This Extended Batch ID number will display in the upper right hand corner in the Orig Batch/EntDate field of both claims screen in MC400. Both the Internal and Extended Batch ID numbers can be used as a search method to access specific batches in Prelog.

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