Provider Express Claim Submission Overview:

- Long Form (including COB Claims)
- Corrected Claims
- Claim Adjustment Request

www.providerexpress.com

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Important Note: Any specific member/provider data has been redacted for this training tool.

Topics Covered:

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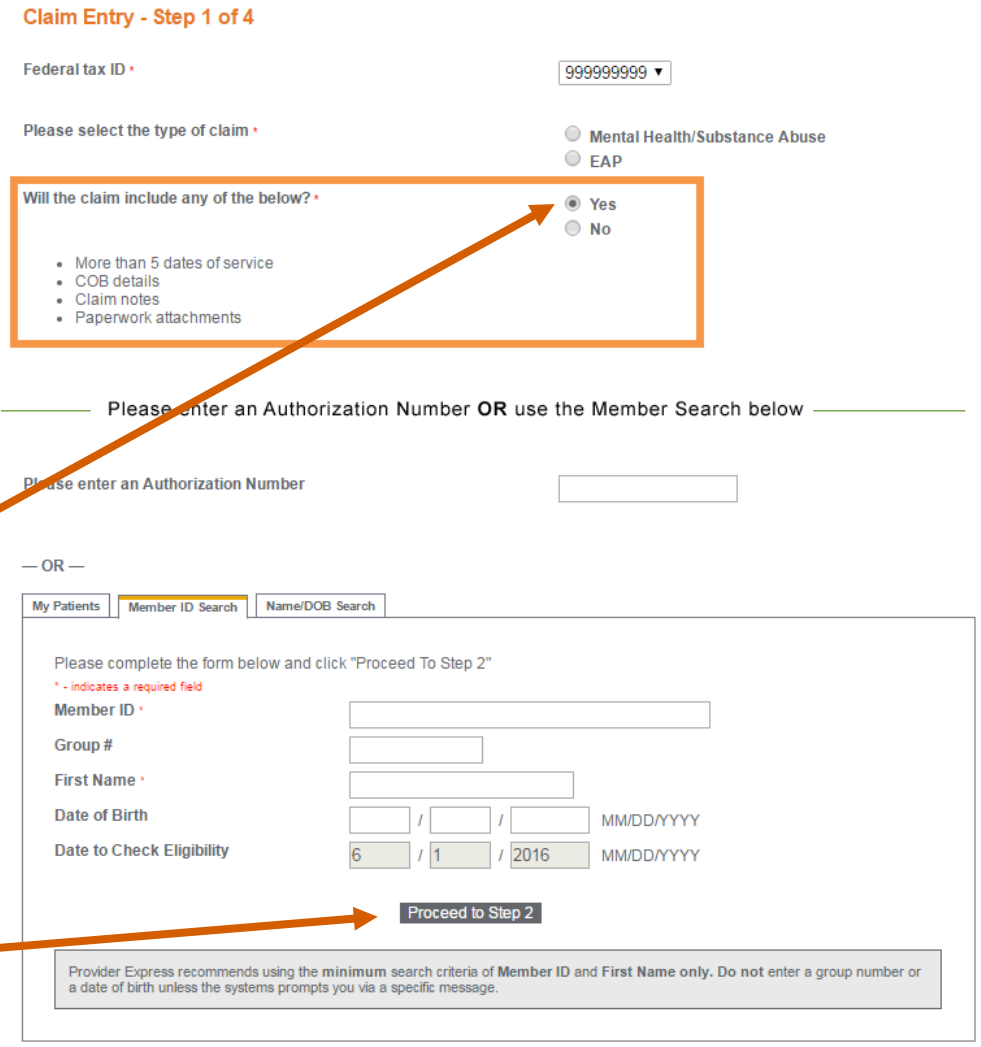
LONG FORM: STEPS 1 AND 2 OVERVIEW

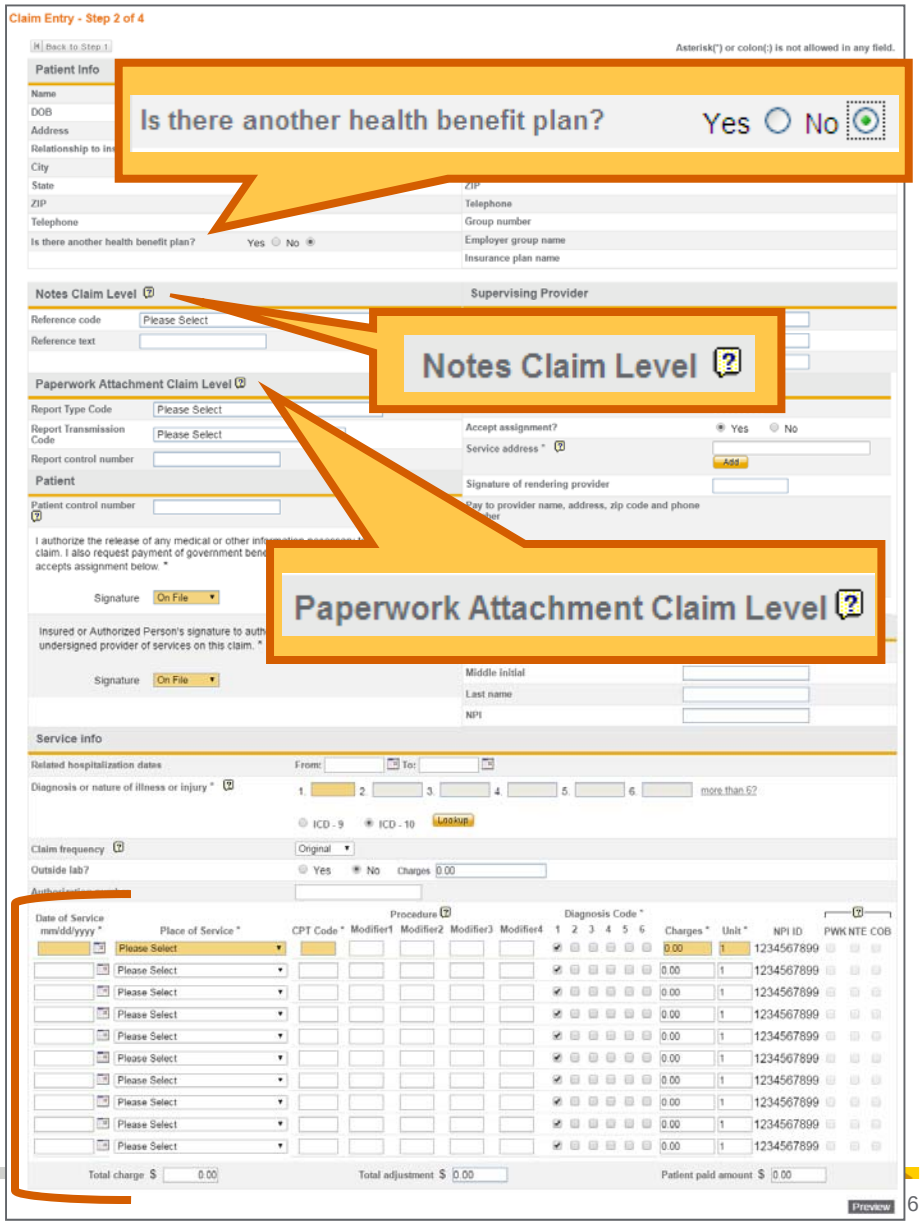
Claim Entry > Long Form – Overview and Step 1

- The Long Form is presented when a user identifies in Step 1 that any of the following elements are needed:
  - More than 5 dates of service
  - COB Details
  - Claim notes
  - Paperwork attachments
- If the claim includes any of those elements, the User would click “Yes” (default is “No”).
- User would also fill out the other fields as required to get to any of the claim forms, then clicks the “Proceed to Step 2” button.



Long Form – Overview and Step 2

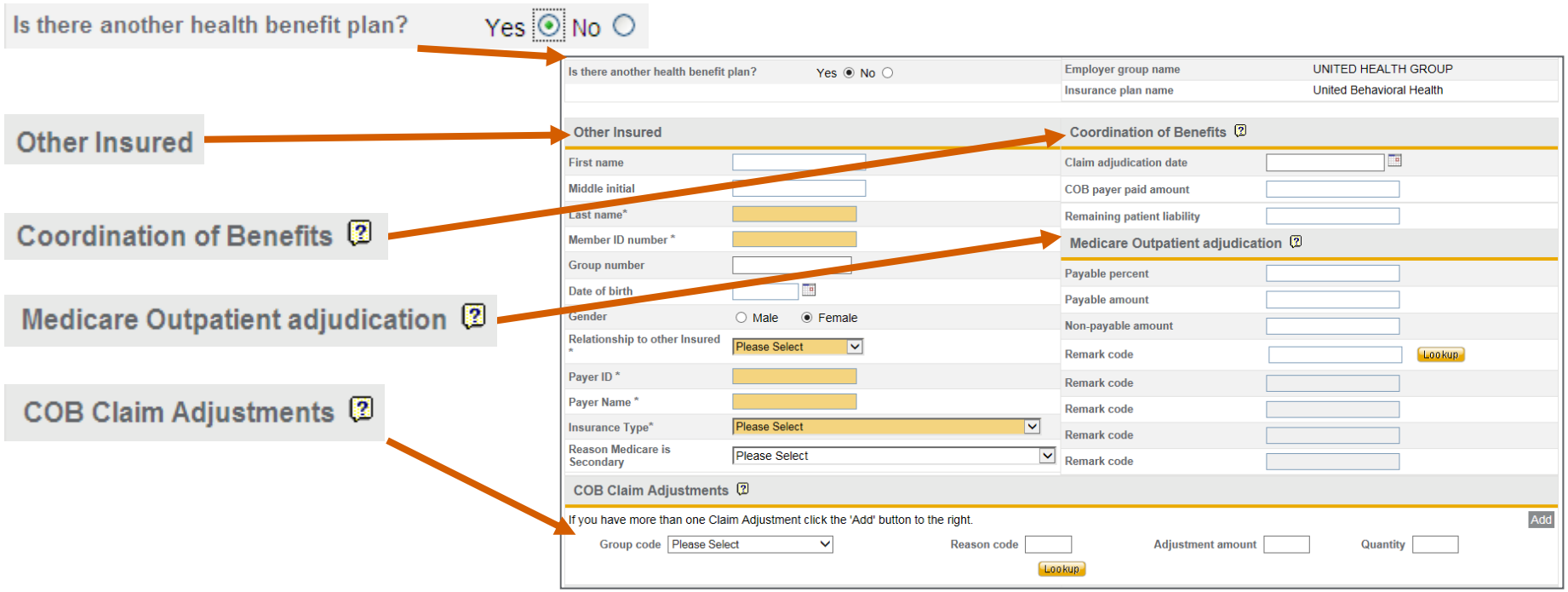
- The Long Form brings up a claim similar to the Short Form, with the addition of several sections:
  1. “Is there another health benefit plan?” If ‘yes’ is checked, then several more fields will display
  2. Notes Claim Level
  3. Paperwork Attachment Claim Level
  4. 10 Lines of Service



LONG FORM: STEP 2 > FILING COB (aka Secondary) CLAIMS

Long Form – Step 2 > COB Details

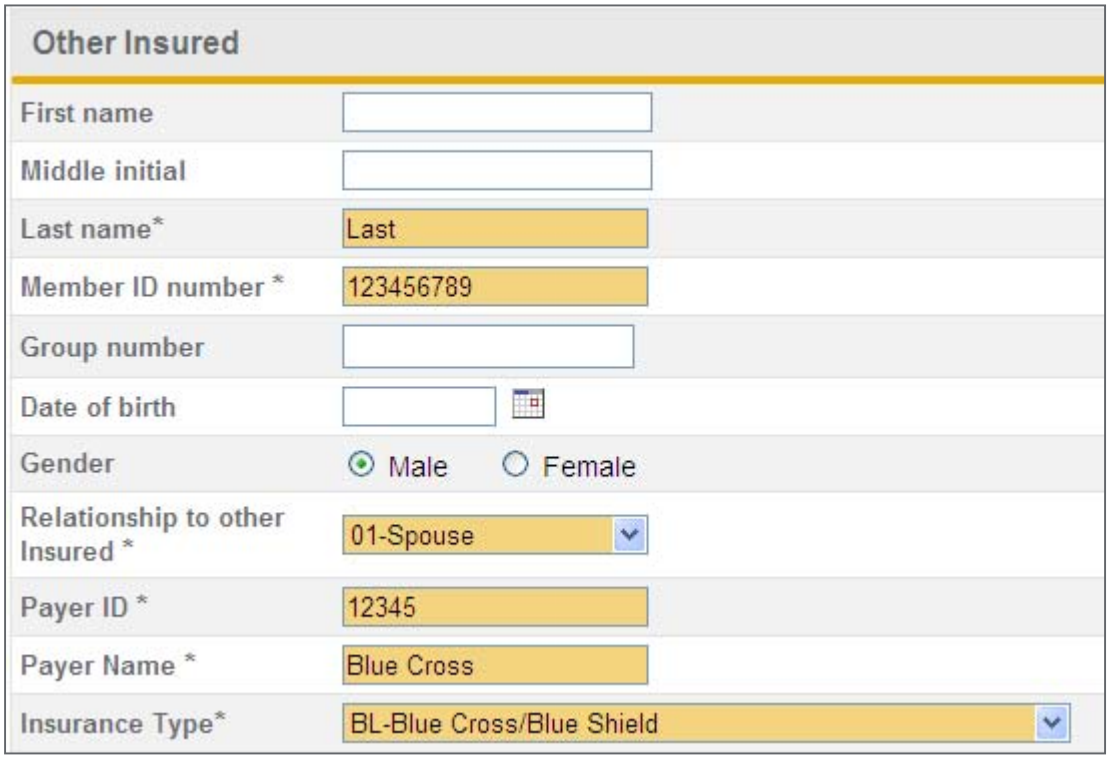
- If “Yes” is chosen as the answer to “Is there another health benefit plan?” it will result in additional fields being displayed: Other Insured, Coordination of Benefits, Medicare Outpatient adjudication, and COB Claim Adjustments.



Please note: By filling in these sections, the primary EOB/statement does NOT need to be submitted separately.

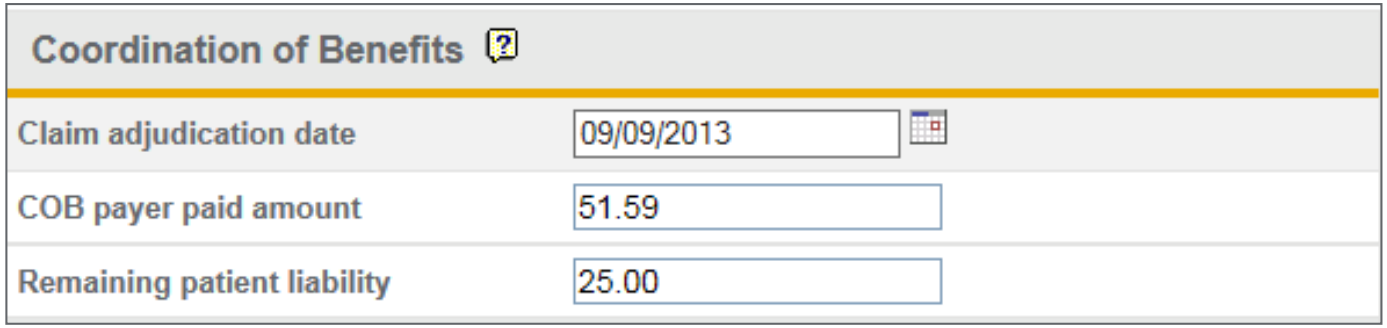
Long Form – Step 2 > COB Details > Other Insured

- For all COB claims, the Other Insured section must be filled out. The orange highlighted sections are required fields.
- Payer ID is typically a 5-digit # used for electronic claim submission, but can be any other identifying number specific to that insurance.
- Insurance Type has a dropdown of many options including:
  - Preferred Provider Org
  - BCBS
  - Medicare



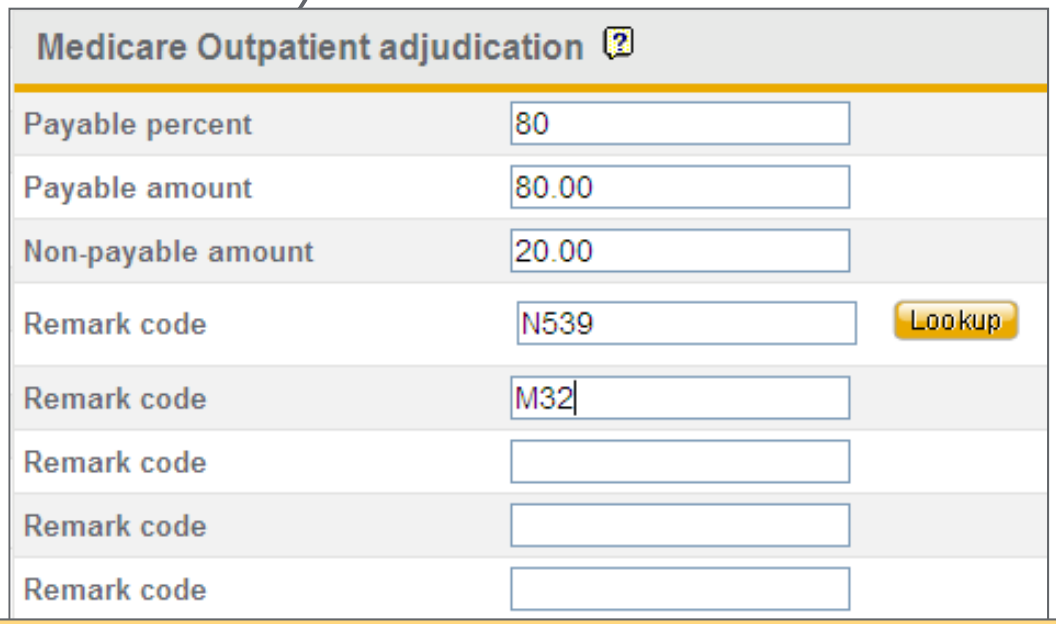
Long Form – Step 2 > COB Details > Coord of Benefits

- The Coordination of Benefits section details payment info from the primary insured and would be found on the primary EOB/PRA:
  - Claim adjudication date (date claim was paid)
  - COB payer paid amount (amount paid by primary – if nothing paid, then this should be left blank or listed as 0.00)
  - Remaining patient liability (*auto-populates from amount(s) entered in COB Claim Adjustments section*)



Long Form – Step 2 > COB Details > MOA

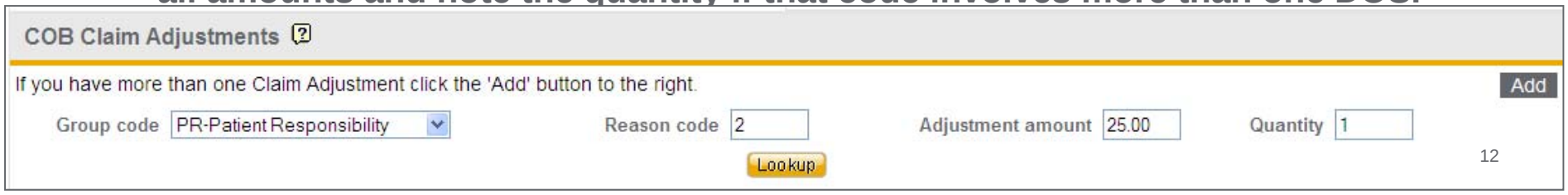
- If the Insurance Type is Medicare, this section needs to be completed.
- Primary claims that have been processed through Medicare need to have additional information provided, all of which can be retrieved from the Medicare EOB:
  - Payable percent (if one is indicated)
  - Payable amount
  - Non-payable amount
  - Remark code(s)



Please note: Required fields vary depending on information submitted in other areas. If a required field is not completed, Provider Express messaging will inform you prior to submitting the claim.

Long Form – Step 2 > COB Details > COB Claim Adjs

- Finally, COB Claim Adjustments would be added to the mix, whether at a Claim Level (completed in the upper section of the form) or at a Line Level (completed for each line of service entered at the bottom of the form).
  - This section would be used to identify the unpaid portions of the claim, including patient responsibility, all info coming from the primary EOB.
  - Group code would be chosen:
    - CO-Contractual Obligation
    - CR-Correction and Reversals
    - OA-Other Adjustments
    - PI-Payer Initiated Reductions (e.g. non-allowed)
    - PR-Patient Responsibility (e.g. copay, coinsurance, deductible)
  - Reason code (reason amount was not paid – code should be on EOB, but Provider Express offers a lookup option)
  - Adjustment amount (the amount not covered by the Primary Payer)
  - Clicking “Add” will allow multiple adjustments to be entered, if necessary. **IMPORTANT: Do not duplicate Reason codes if filing at a Claim Level. Add up all amounts and note the quantity if that code involves more than one DOS.**

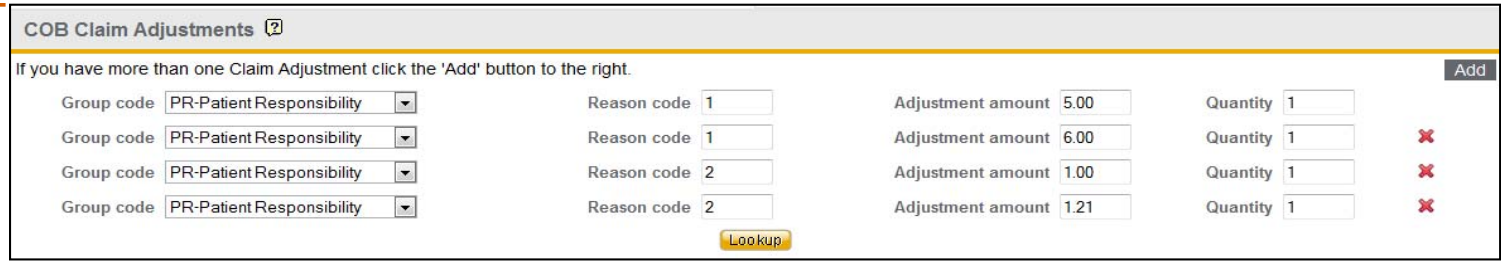


Long Form – Step 2 > Filing Adjustments at Claim Level

- When filing adjustments, you have the option to file them at a Claim Level or at a Line Level.
- Filing adjustments at a Claim Level is most effective when there is only one DOS on the claim, or if all adjustment reasons and amounts are the same.
- If filing at a Claim Level for multiple DOS and multiple codes, you need to file one line per code, otherwise the claim will reject, which will delay processing.

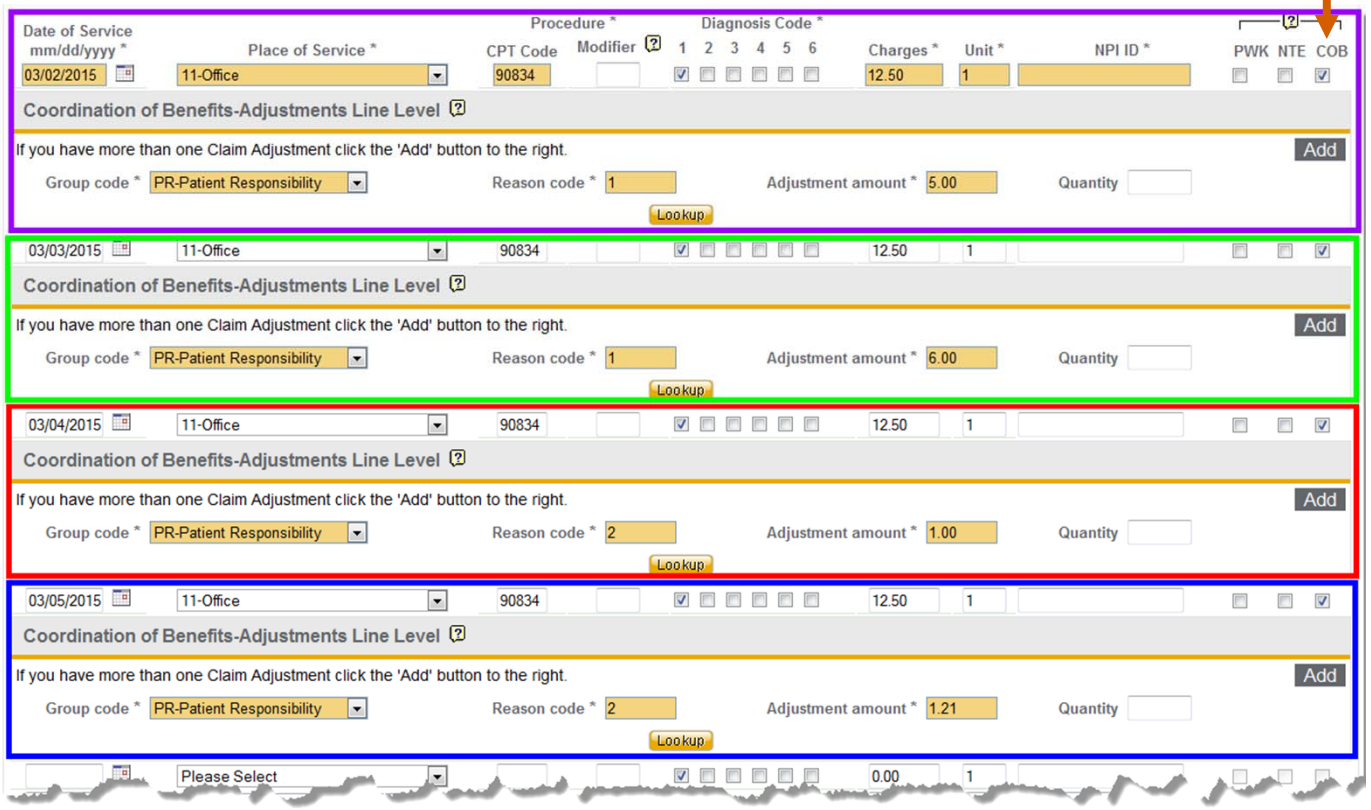
CORRECT

INCORRECT



Long Form – Step 2 > Filing Adjustments at a Line Level

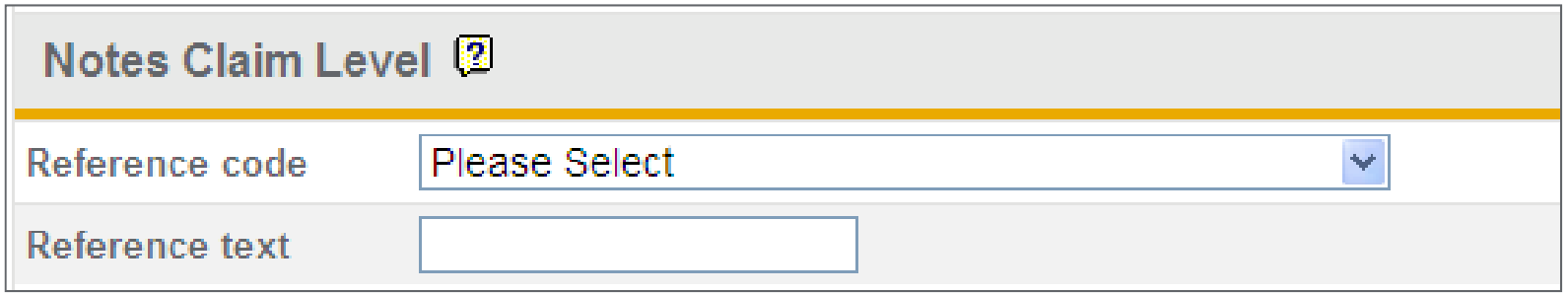
- The Line Level option offers the most accurate portrayal of how the primary payer processed the claim, and allows you to enter multiple codes and/or amounts, based on a specific date of service.
- Just click on the COB box to the right of each date of service that requires an adjustment.



LONG FORM: OTHER ATTRIBUTES

Long Form – Step 2 > Notes Claim Level

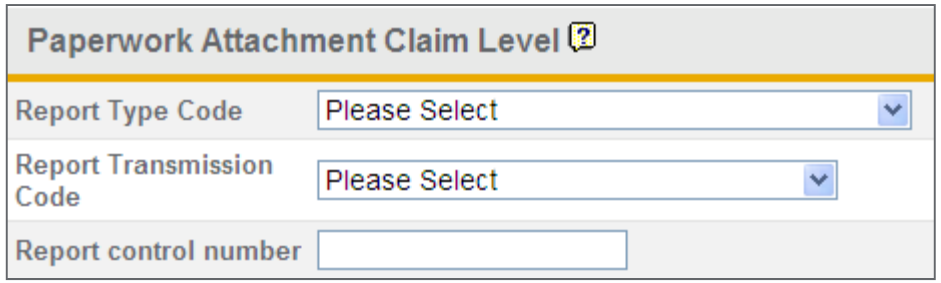
- Additional information, descriptive types of detail that need to be added to a claim can now be done using the “Notes Claim Level” field.



- User would choose one of the four Reference Codes:
  - Additional Information
  - Certification Narrative
  - Goals, Rehab Potential, or Discharge Plans
  - Diagnosis Description
- Then add text in the Reference Text field with the necessary information.

Long Form – Step 2 > Paperwork Attachment

- Sometimes paperwork needs to be included for a claim to be processed correctly.
- Choose the Report Type Code from the dropdown list
  - Examples: Progress Notes, Drug/ Lab Reports, Admit Summary



- Choose the Report Transmission Code from the dropdown list
  - Examples: By mail, E-mail, By Fax
- User would enter the Report control number found on the actual report (this is so claims can reference the report and match it up to the correct claim)

Please note: a paperwork attachment cannot be attached to the claim itself via Provider Express – this section is only used to note to Claims that paperwork is available and/or forthcoming via the transmission method noted.

Long Form – Step 2 > Entering info at a line level

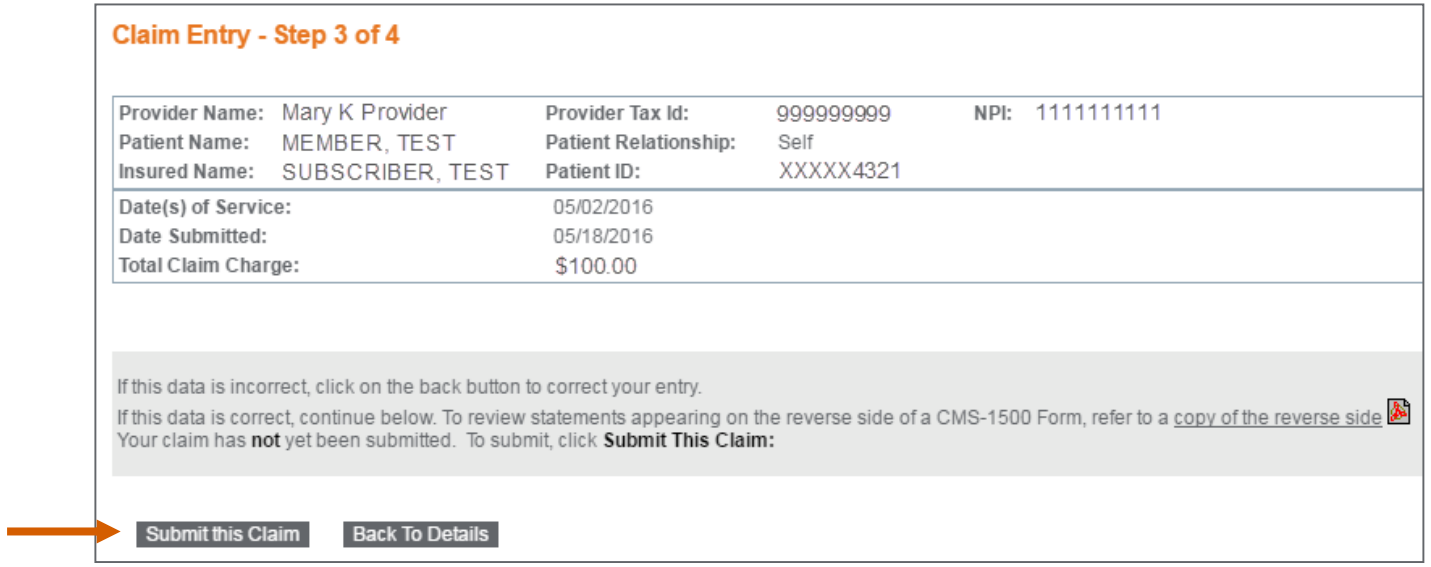
- The previous pages showed how to enter Paperwork, Notes and COB info at a full claim level.
- The same info can be entered for one or more specific dates of service instead, indicating a “line level” entry.
- To the right of each line of service are three options:
  - PWK = paperwork
  - NTE = notes
  - COB = coordination of benefits (adjustment info only)
- When any of these options are checked, fields will drop down below that will need to be completed.
- It is not necessary to enter any of these sections at both the full claim AND line levels.

Please note: for COB, the upper portions of the form, including the “Other Insured” and the “Coordination of Benefits” sections, will still need to be completed. The COB section at this “line level” only indicates the “COB Claim Adjustments” info.

LONG FORM: STEPS 3 AND 4 OVERVIEW

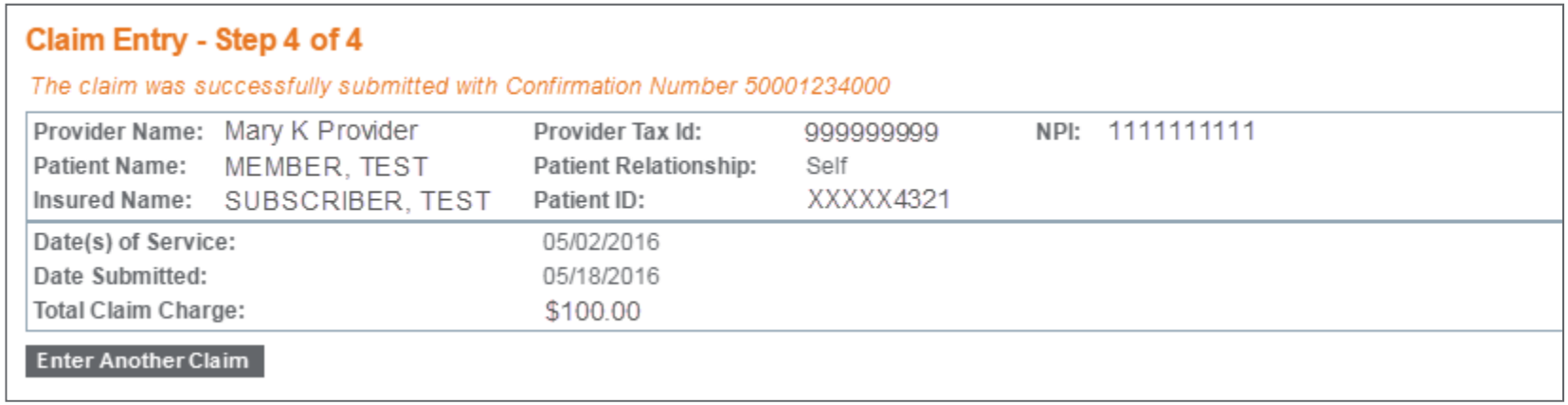
Long Form – Step 3

- As with any claim submitted online, once the necessary fields are filled out, user would click the preview button in the lower right portion of the claim form.
  - Any errors found will be noted and must be corrected before the claim can be submitted.
- If there are no errors found, user can then click the “Submit this Claim” button to submit the claim.



Long Form – Step 4

- Once the claim is submitted, user will receive a Confirmation Number, which can be used to reference the status of the claim online via My Provider Express > My Submitted Claims.



Claim Entry - Step 4 of 4

The claim was successfully submitted with Confirmation Number 50001234000

Provider Name:	Mary K Provider	**Provider Tax Id:**	999999999	**NPI:**	1111111111
Patient Name:	MEMBER, TEST	**Patient Relationship:**	Self		
Insured Name:	SUBSCRIBER, TEST	**Patient ID:**	XXXXX4321		

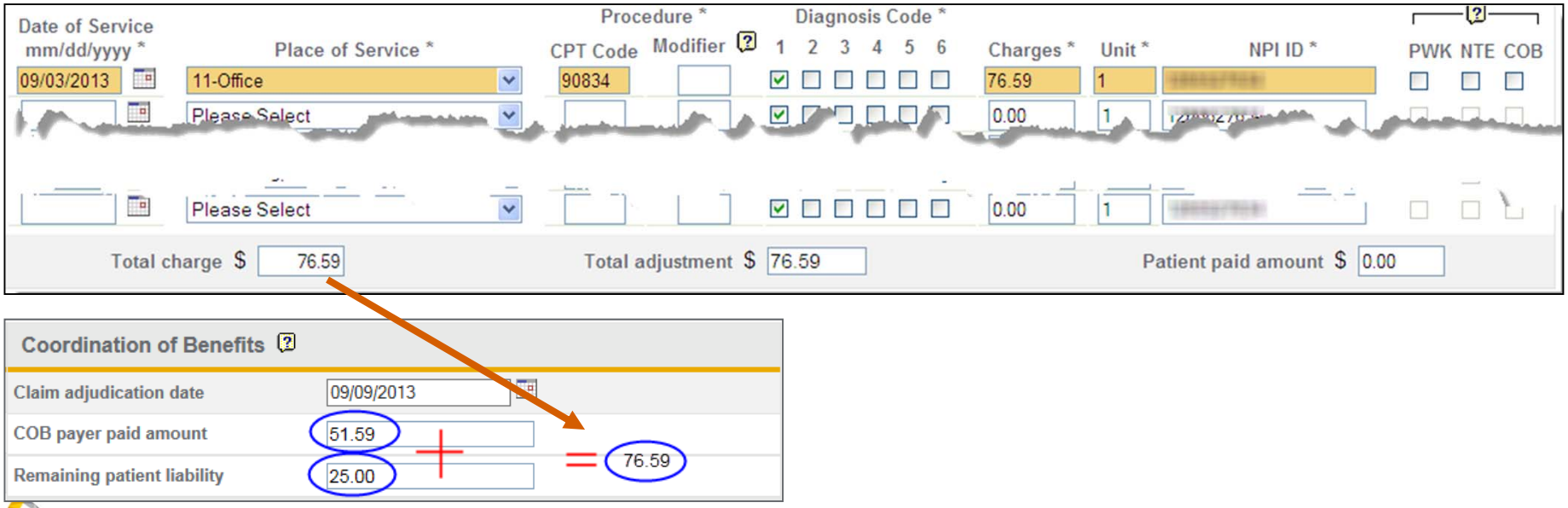
Date(s) of Service:	05/02/2016
Date Submitted:	05/18/2016
Total Claim Charge:	$100.00

Enter Another Claim

LONG FORM: THE MOST COMMON ERROR MESSAGE FOR COB (SECONDARY) CLAIMS

The Most Common Error Messages for COB Claims

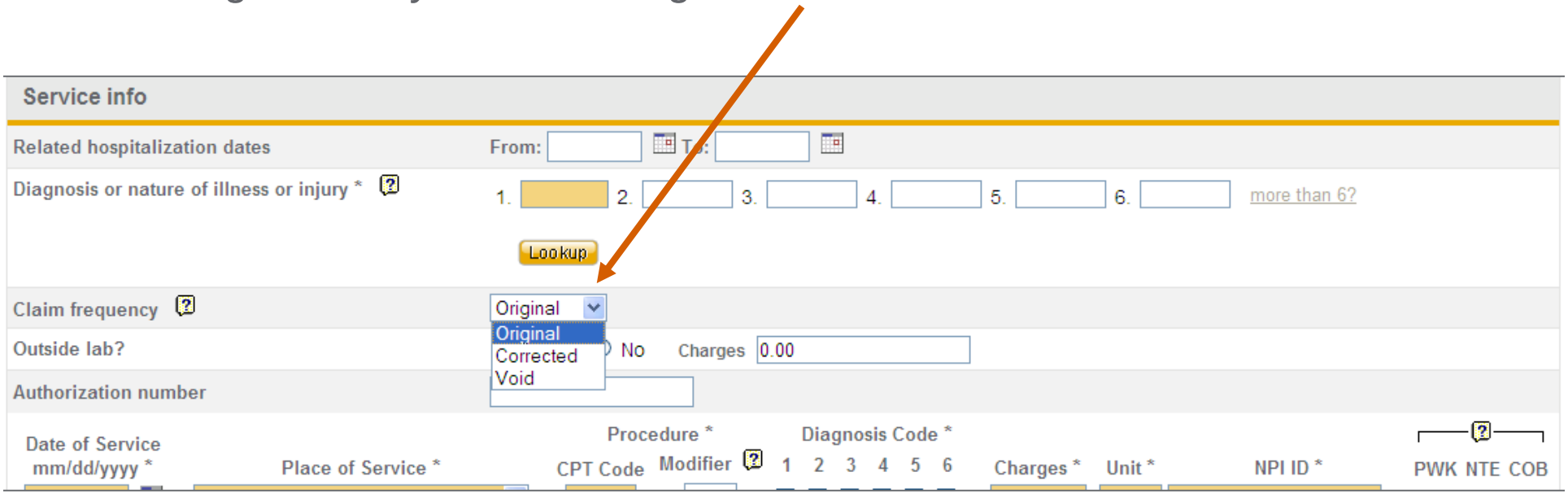
- Total charges must equal the sum of COB payer paid amount and all Claim adjustment amounts.
  - This means that the total charge for the date(s) of service entered should ONLY equal what the COB payer paid amount and Remaining patient liability amounts total.
  - In other words, do not enter any amounts that were disallowed/written off by the primary payer, unless you entered an adjustment for them.



SUBMITTING CORRECTED (OR VOID) CLAIMS

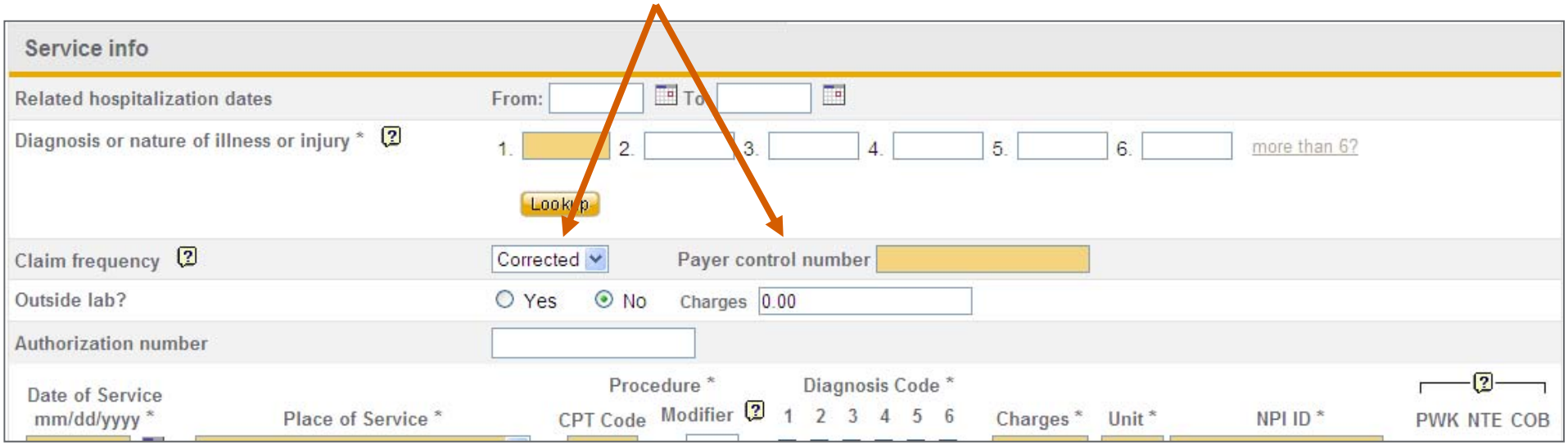
Submitting Corrected (or Void) Claims

- Regardless of the claim form (short or long), you do have the ability to submit a corrected or void claim request as well, when a previously-submitted claim had incorrect information on it.
- In the Service info section, the “Claim frequency” code is what is used to determine the type of claim you are filing. Provider Express defaults to ‘Original’ but you can change it to ‘Corrected’ or ‘Void’.



Submitting Corrected (or Void) Claims

- As the help icon next to this section indicates:
  - **Claim frequency -** To submit a Corrected or Void claim, you will need to enter the Claim Number found on the claim record in Claim Inquiry. The claim number will also be reported on the paper remittance advice or electronic 835 file. You can not submit a Corrected or Void claim until a claim number has been assigned.



"Payer control number" = Claim number

WHEN TO USE THE CORRECTED CLAIM OPTION VIA CLAIM ENTRY
vs.
THE CLAIM ADJUSTMENT REQUEST FEATURE VIA CLAIM INQUIRY

Submitting Corrected Claim vs Claim Adjustment

Q: When should I submit a corrected claim via Claim Entry vs an adjustment via Claim Inquiry?

A: Use the following guidelines to help in your decision:

- If the issue with the claim was because of a problem in how it was originally filed by the provider/group that now needs to be corrected, submit a corrected claim via Claim Entry *(see pg 25)*

  e.g. filing an incorrect procedure code; forgetting a modifier

- If the issue with the claim was because of an alleged problem in how Optum processed it, submit an adjustment request via Claim Inquiry

  e.g. processing against member's deductible when it was already met; noting an auth was required when there is an auth on file

(please reference the Guided Tour video titled "Claim Inquiry and Claim Adjustment Request" for additional information)

Please contact Provider Express Live Chat (via Tech Support on the Contact Us page) if you need further assistance.

Thank You!