



PC-ACE Pro32 Claims Management Transcript

Hello and thank you for joining the PC-ACE Pro32 Claims Management Webinar. This Webinar will walk you through how to setup your own code list, enter claims, prepare to send claim files, and how to restore and edit a claim previously sent. You may follow along while using your PC-ACE Pro32 software or in the Claims Management document provided on the CEDI Web site <http://www.ngscedi.com>. If you follow along in your software, you can minimize the Webinar window to give you access to your computer. Before we begin, we would like to note that the CEDI technical support staff is not trained in medical billing. The information provided in this Webinar is intended to provide the user with enough information in order to successfully enter claims using the medical policy knowledge that the user already has. Please contact the Jurisdiction that will be billed with any medical policy questions. We will begin with how to manage the code lists. The Procedure or HCPCS codes, the modifiers, and the ICD-9 codes are maintained by the software developers. However, the PC-ACE Pro32 software allows you to create a specific HCPCS code set to be used when entering claims instead of using the global list provided by the software developers. This will also allow you to assign a "standard charge amount" to the code for the claims you will be billing. To setup this information, you will need to open the PC-ACE Pro32 software. You will want to select the Reference File Maintenance Menu which is the yellow file folder icon on the main menu. If you have not already logged into the software, you will be asked to log in at this point. Type the user ID and password and select OK. Select the Codes/Misc tab. To setup the HCPCS code list, you will want to select the Charges Master option located in the Professional area in the right column. You will need to enter each code individually by selecting the New option. Select the LOB field as MCB, the Payer ID field can be left blank. Enter your code by typing the desired code or using the right-click or F2 look up feature to select your code. If you selected the code from the list, the description will be filled in for you. If you typed in the code, you will need to type in the description. Finally, you will want to enter the standard charge amount for the code. Select OK to save the information. You can enter a list of procedure codes, and their standard charges, that you will use when billing DME claims. You can add additional codes to this list at any time. Close the Charges Master and Reference File Maintenance when the list is complete. Once the list is created, you will need to tell the software that you want to use your list instead of the global list. From the PC-ACE Pro32 main menu, select File and Preferences. This will produce the Preferences menu. Place a checkmark in the box for Use Charge Master reference file for Professional procedure code lookup. This option is about half way down the General Preferences list. Only codes entered into the Charges Master area will be listed in the right-click or F2 lookup function for the Procedure code selection when entering claims. You will only be able to add additional codes in the Reference File Maintenance menu. You will not be able to add codes to this list while entering a claim.

Now that you have setup your code list, we will walk through how to enter a claim into the PC-ACE Pro32 software. You will want to begin by selecting the Professional Claims Processing



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icon on the Main Menu. This is the second icon with the letters P-R-O-F down the side. This will bring up the Professional Claims Menu.

There are two ways to enter claims. Enter Claims allows you to enter claims back to back. If you have a stack of paper claims forms and need to enter them all one after the other, this would be a good choice for you. The List Claims option will allow you to enter a new claim and displays a list of claims that you have already entered. We will be selecting List Claims for our example.

The Professional Claim List screen displays the claims that are in your system. A blank screen indicates that you currently have no claims that are ready to be prepared and billed.

To enter a new claim, select New at the bottom of the screen. This will display the Professional Claim Form for you to enter claim information. If you only have one billing provider, the LOB and Billing Provider fields will be filled in. If you have more than one billing provider, you may need to select these fields. You can use the F2 or Right-click lookup feature to complete these fields.

To enter the patient information, click in the Patient Control No. field (box 26). Use the right-click or F2 lookup feature to bring up the Patient Selection window. If your patient is already entered, you can click on the patient to highlight it and click the Select option in the bottom right corner. You can use the filter options to search for your patient if a lot of patients have been entered. If your patient is new and has not been entered, you can select the new option to add the patient information to the software. We are going to walk through how to add a new patient that is not in the Patient Selection List. Select the New option. You will need to enter the new patient's information in the Patient Information screen.

Make sure the patient's name is entered exactly as it appears on the patient's Medicare ID card. The Patient Control Number is an ID number assigned by you. The ID must be unique to the patient. Fill in the patient's address and phone number information. You will also be required to indicate the patient's Sex and date of birth or DOB. The other fields are optional and should only be filled in if they apply to the patient. In the left column, there are two boxes by Signature on File. The first box is for Medicare Part A Institutional claims and will be left blank. The second box is for DME and Medicare Part B Professional claims. Right click or use the F2 lookup feature to get the list of valid values. The Release of Info has several options listed on its right click or F2 lookup list. Only I or Y are valid for DME. Any other entries will result in front end rejections. You can also fill in the Release of Information or ROI Date field. This is the date that the Release of Information form was signed by the patient.

Next you will want to fill in the Primary Insured (Prof) tab. This is the fourth tab at the top. Right-click or use the F2 lookup feature to select the primary payer. The DME MAC insurances have been pre-entered into the software for you. You can select any of the 4 Jurisdictions Payer IDs to use for the DME claims. However, CEDI recommends always using the same Payer ID regardless of the Jurisdiction the patient's claim will be sent to. CEDI will route all claims

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submitted for DME according to the patient's address information you provided in the General Information tab. Click on the Payer ID you will be using and click Select. This should fill in the Payer ID, Payer Name, and LOB (Line of Business) fields. We have chosen 17003 in our example.

The Group Name Group Number and Claim Office fields will be left blank for Medicare. Next you will need to fill in the Insured Information (F7) tab. It is about half way down the Primary Insured screen.

The Rel field indicates that patient's relationship to the insured party. Use the right-click or F2 lookup feature to make the appropriate choice. For Medicare, this is always 18 – Self. This will fill out the most of the required information. On the right side of the screen, you will need to fill in the Insured ID from the patient's Medicare ID card and the Assign of Benefits field. You can use the F2 or right-click look up feature to select the appropriate option. Select Save once all patient information is entered.

Once the patient is entered, you can then select the patient. Selecting the patient information will fill in most of the required fields for the Patient Info & General tab. You will need to enter Item 10 – Patient Condition Related to Employment. You can use the right click or F2 lookup feature to select the appropriate response.

Next we will be selecting the Insured Information tab at the top. By selecting the patient information on the Patient Info & General tab, most of the fields should be filled in automatically based on what was entered for the insurance information in the patient entry area. Any required entry not filled in automatically will trigger edit validation warning flags when the claim is saved for you to enter the required information.

Next we will need to select the Billing Line Items tab. Billing Line Items has multiple sub tabs including Line Item Details, Extended Details, Ext Details 2 and Ext Details 3. The information you enter for the charge will determine the information required to be entered on the extended detail tabs.

We are going to start by entering information on the Line Item Details sub tab. This tab should automatically be displayed.

You will want to start by entering the Claim Diagnosis Codes that will apply to this claim. Use the right click or F2 lookup feature to select a valid diagnosis code. If you know the codes you will be using, you can type your Diagnosis codes in the boxes provided. Remember to enter these codes without the decimal points. The claims format will not allow them, but they are implied. For Example entering 25002 will be read by the system as 250.02. Up to twelve diagnosis codes can be entered on a claim, however, only four pointers can be used on a charge line. More places for the diagnosis codes are provided on the Ext. Pat/Gen (2) tab. We will go over this tab later.



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Next you will want to enter the charge line information. You will place the 1st charge line in LN 1. Each charge line of the claim will be entered as a separate LN entry here. The line you are on will control the Extended Details sub tabs. For Example, data is being entered on LN 1 so all of the Extended Detail sub tabs indicate they are also for Line 1. Box 24a Service Dates; you will want to enter the date of service for the charge line. Box 24b PS is for the place of service. You are either type in the code for the place of service or use the right click or F2 lookup feature to select the Place of Service for the claim. Box 24c EMG is not used and will be left blank. Box 24d Proc is for the procedure/HCPCS code. You can either type in the code or use the right-click or F2 lookup feature to select the HCPCS procedure code. Box 24d Modifiers can enter the first 2 modifiers for this procedure code if modifiers are required. You do not need to fill in all or any of the modifier boxes. Only use the modifiers you have been advised to use. Additional modifiers can be entered on the first Extended Details tab if needed. Box 24e Diagnosis; this field indicates which of the diagnosis codes above are relevant for this charge line. Up to four codes can be referenced by typing the number of the box the diagnosis code was entered into. If you are indicating the 1st and 2nd boxes you will type 12. To indicate the 2nd box only, enter 2. Box 24f Charges; enter the Charges appropriate for the line item. If you are using the Charges Master this will already be filled in for you. Box 24g Units; enter the Units appropriate for the line item. If you are using the Charges Master, the charge amount will be multiplied by the units you enter. If you are not using the Charges Master, you will need to place the total charged amount for this charge line in the 24f Charges box. The small boxes to the right of Units (EP, FP, and AT) are used to indicate a situation or include an attachment. EP and FP are not used for DME claims. AT is only used to indicate a Certificate of Medical Necessity (CMN) or DME Information Form (DIF). For more information about entering a CMN or DIF, please refer to the PC-ACE Pro32 Certificate of Medical Necessity document located on the CEDI Web site <http://www.ngscedi.com> under Resource Materials. The Rendering Phys. field is not used for DME.

Next you will want to select the Extended Details (Line 1) tab. The (Line #) will change based on the charge line being entered. Under Miscellaneous Extended Details, if needed, you can list the additional Modifiers 3 and 4 here. For more information about entering more than 4 modifiers, please contact the Jurisdiction that will process the claim. Under Line-Level Supporting Provider Information, only the Ordering will be used for DME claims. The other fields should be left blank. To enter the Ordering information, right-click or use the F2 lookup to select the appropriate Ordering Provider for the selected charge line. If the ordering provider is not listed, you can use the New option in the bottom left corner to add the doctor's information. Use the Select option to add the ordering provider to the claim.

Next you will want to select the Ext Details 2 (Line 1) tab. Under Line-Level Miscellaneous Information, the Proc Type/Desc is only used if the procedure code you are using requires a description because it is a generic or miscellaneous procedure code. You will need to enter the



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description in the Proc Desc box which is the second longer box. The first little box will be left blank. All other narratives will be entered later.

If you will be billing an NDC, please refer to the PC-ACE Pro32 National Drug Code document on the CEDI Web site <http://www.ngscedi.com> under Resource Materials for more information.

The DME Fields are not used for DME Medicare billing.

The Facility Information is only entered on this tab if it is for this charge line only.

Finally you will need to select the Ext Details 3 (Line 1) tab. Line-Level Miscellaneous Information (continued), the Ordering Provider Address should automatically populate when the ordering provider is selected on the Extended Details tab. The Line Supplemental Information (PWK) field is not used. The Line Notes (NTE)/File Information (K3) field is used to enter narrative information. Select ADD for additional information. Type your narrative in the Narrative box. Only use letters and numbers and avoid any special characters as they can cause 999 rejection errors. This field will only allow up to 80 characters.

Return to the Line Item Details tab. Enter each charge line by repeating these steps and entering the required information on all tabs as needed. Once all charge lines are entered, select the Recalculate button at the bottom of the Line Items Details tab.

If you selected a place of service code that requires facility information to be sent, you will need to indicate that in your claim. First you will need to go to the Patient Info & General tab. Item 31 – Facility? at the bottom of the screen must be selected as Y if facility information is required in this claim. This will take you to the Ext. Patient/General tab. The Facility Information in the bottom left corner will need to be filled in. You can use the F2 or right-click look up feature in the Facility Name box to bring up and Facility Setup screen. You can either select your facility here or add the facility information to select here. If you are not sure if you should be sending facility information, please check with your Jurisdiction regarding the code you are using for the place of service.

The Ext. Pat/Gen (2) tab is only used in DME claim billing if you have more than 8 diagnosis codes for your claim or if you are sending a Claim Notes narrative instead of a line level note. You can verify with the jurisdiction where the narrative you are sending needs to be place.

When all the information is entered, select Save. Before saving I am going to remove the Ordering Provider information to show how the PC-ACE Pro32 software will provide validation checks when the claim is saved. You should not remove this information before saving the claim.

Once you select Save, the software will validate the Claim Information you entered. Data entered in your claim may trigger the need for additional data to be entered in fields not covered in this Webinar. PC-ACE Pro32 will run a series of validation edits to check for missing or incorrect information. Any missing or incorrect information will generate a dialogue box



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displaying the errors. In our example claim, we saved the claim without the Ordering Provider field being entered. Double-clicking on the error will take you to the tab where the error is located. All fields with errors will be flashing red or purple.

You can save a claim with errors, even fatal errors. This will give you an opportunity to gather the information needed if it is not readily available.

Saving the claim will take you back to the Professional Claims List screen. The Professional Claims List will provide the status of the claim. Status equaling ERR or ERF indicates the claim has errors. This means that the claim will need to be corrected before it can be sent. To correct the error, you can double click on the claim or select the claim and click the View/Update option. Selecting Save will run the validation check again to show you what errors are in the claim. You can then correct the error and save the claim. Claims with no errors will show a status of CLN.

Now you are ready to prepare a file to send to CEDI. To create a file to transmit, select the Prepare Claims icon. The Professional Claim Prepare For Transmission screen will display. If you are only using the software to bill DME claims, as recommended, you should not need to select any of the options here unless otherwise advised to. Select Prepare Claims. It will prompt you for confirmation that you wish to create a file to send and will display a message when it is finished creating the file. When completed, you will see a Claim Prepare Operation Complete message.

You can View Results showing the claims that were prepared in this transmission or you can Close which will take you back to the Professional Claims Menu. The Results page will be saved by the software if you would like to view it at a later time.

At this time you are ready to send your file. The file name is BSTRANS.DAT. You will want to contact your Network Service Vendor for more information about sending the file. Remember to only prepare a file to send when you are ready to log in and send it.

If you receive a rejection on a claim and need to resend the claim for processing, you can restore the Claim and make corrections before resending. From the Professional Claims Menu, select List Claims. Use the drop down menu for Location to select TR for claims that have already been transmitted. This will display any claims that have been prepared for transmission. To restore a previously sent claim, right-click on the claim you wish to restore and select Reactivate Selected Claim. To restore multiple claims previously sent, select the boxes in front of a series of claims you wish to restore, right-click or use Actions at the top of the screen, and select Reactivate All Checked Claims. Change your Location back to CL – To Be Transmitted. The claim should now be marked UNP. Select View/Update to edit the claim. You can then make any corrections and resend the claim.

This concludes the Webinar. We discussed how to create your own code list, enter a basic claim, prepare the claim file for sending, and restore a claim that was previously sent for editing. If





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you have any questions about the information provided in the Webinar or need additional information, please review the PC-ACE Pro32 Documentation on the CEDI Web site at <http://www.ngscedi.com> or contact the CEDI Help Desk at 866-311-9184.