Home Health & Hospice

Claims and Attachments Menu

Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Guide

Chapter 4

CGS®

A CELERIAN GROUP COMPANY

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Claims and Attachments Menu Options

The Fiscal Intermediary Standard System (FISS) Claims/Attachments option (FISS Main Menu option 02) allows you to enter the following billing transactions by using a process called Direct Data Entry or DDE:

- ☑ Claims (home health and hospice)
- ☑ Home Health Requests for Anticipated Payment (RAPs)
- ☑ Hospice Notices of Election (NOEs)
- ☑ Hospice Notices of Election Termination/Revocation (NOTRs)
- ☑ Roster Bills

Even though this option also offers the entry of attachments (e.g., Home Health Plan of Treatment) CGS does not accept those electronically via DDE. Those options, therefore, are not discussed in this guide.

➔ All FISS direct data entry (DDE) screens display two lines of information in the top right corner that identifies the region (ACPFA052), the current date, release number (e.g., C200928S) and the time of day. This information is for internal purposes only and is used to assist CGS staff in researching issues when screen prints are provided.

➔ This guide explains how to enter provider-specific Medicare billing information into the claim pages. It does not indicate what information to enter. For information about what is entered for your provider type, please access the Centers for Medicare & Medicaid Services (CMS) *Claims Processing Manual* (CMS Pub. 100-04) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website. Home health agencies access Chapter 10, and hospice agencies access Chapter 11. A list of approved codes that can be submitted on the CMS-1450 claim form (and on the FISS claim pages) is available in the "National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual", which is available for purchase at: http://www.nubc.org

➔ A variety of resources related to filing Medicare home health and hospice billing transactions are available on the CGS Educational Materials & Resources Web page (https://www.cgsmedicare.com/hhh/education/materials/index.html). The following links, which are found under the "Home Health Education" and "Hospice Education" headings, are helpful when entering home health and hospice billing transactions.

- Home Health Claims Filing and Special Claims Filing Situations - https://www.cgsmedicare.com/hhh/education/materials/HHE_Claims_Main.html
- Hospice Claims Filing and Special Claims Filing Situations - https://www.cgsmedicare.com/hhh/education/materials/Hospice_CF.html

The following "Quick Resource Tools" are also helpful when entering information on home health or hospice billing transactions:

- Home Health Medicare Billing Codes Sheet - https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf
- Hospice Billing Codes Sheet - https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_medicare_billing_codes_sheet.pdf

Access the Claims/Attachments Menu

1. From the FISS Main Menu, type *02* in the **Enter Menu Selection** field and press *Enter*.

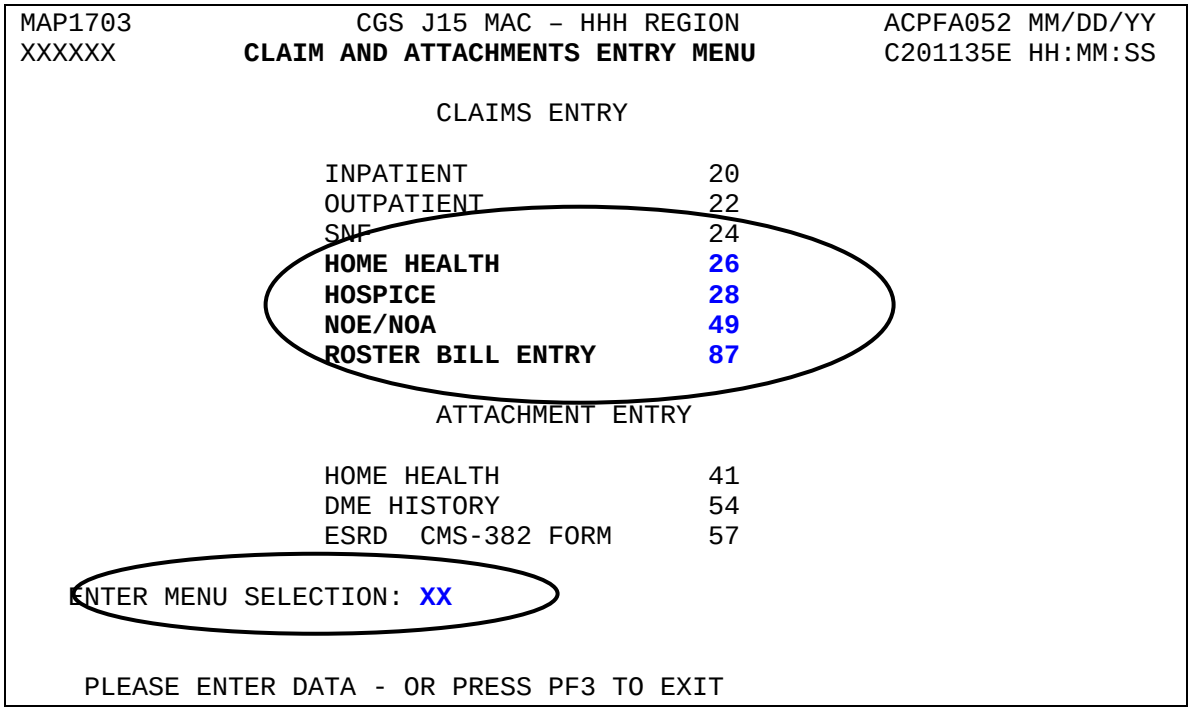
```
MAP1701              CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
XXXXXX                   MAIN MENU                     C20112WS HH:MM:SS

                         01    INQUIRIES

                         02    CLAIMS/ATTACHMENTS

                         03    CLAIMS CORRECTION

                         04    ONLINE REPORTS


    ENTER MENU SELECTION: 02


     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

2. The Claim and Attachments Entry Menu screen (Map 1703) appears:

```
MAP1703              CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
XXXXXX        CLAIM AND ATTACHMENTS ENTRY MENU         C201135E HH:MM:SS

                          CLAIMS ENTRY

                    INPATIENT               20
                    OUTPATIENT              22
                    SNF                     24
                    HOME HEALTH             26
                    HOSPICE                 28
                    NOE/NOA                 49
                    ROSTER BILL ENTRY       87

                          ATTACHMENT ENTRY

                    HOME HEALTH             41
                    DME HISTORY             54
                    ESRD  CMS-382 FORM      57

   ENTER MENU SELECTION:

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Entering Medicare Claim Information

1. From the Claim and Attachments Entry Menu (Map 1703), enter the appropriate claims entry option in the **Enter Menu Selection** field and press *Enter.*
   - Home Health (**26**)—use to enter home health RAPs (322 type of bill) and final claims (329 type of bill). This option is also used to enter individual flu or pneumonia claims, outpatient therapy services and other types of services billed by home health providers on 34X type of bills.
   - Hospice (**28**)—use to enter hospice claims (81X or 82X type of bill).
   - NOE/NOA (**49**)—use to enter hospice notices of election (NOEs) (8XA type of bill), notices of election termination/revocation (NOTRs) (8XB type of bills) or to cancel an NOE (8XD type of bill)
   - Roster Bill Entry (**87**)—use to enter flu and pneumonia roster bills.



2. When options 26, 28, and 49 are selected, Page 01 of the claim (Map 1711) appears. When option 87 (Roster Bill Entry) is selected, Map 1681 displays. For additional information about Map 1681, refer to “Entering a Roster Bill”, which is found later in this chapter.

3. When Page 01 of the claim appears, FISS automatically inserts default information into the type of bill (**TOB**) field and the status/location (**S/LOC**) field. A list of the default TOBs is provided below. You may need to change this information to reflect the most appropriate bill type. Do not change the default S/LOC field.

Claim Entry Option	Default TOB
26	322
28	811
49	81A

➔ In the screen example below, because option 26 was selected, FISS inserted the default home health TOB of 322.

Page 01—Map 1711

```
MAP1711   PAGE 01        CGS J15 MAC – HHH REGION            ACPFA052 MM/DD/YY
XXXXXX    SC             INST CLAIM ENTRY                    C20112WS HH:MM:SS
 MID          TOB 322  S/LOC S B0100 OSCAR                    SV:    UB-FORM
NPI           TRANS HOSP PROV                 PROCESS NEW MID
PAT.CNTL#:                      TAX#/SUB:                TAXO.CD:
 STMT DATES FROM        TO         DAYS COV       N-C       CO      LTR
 LAST                          FIRST                  MI    DOB
 ADDR 1                                 2
 3                                 4                                  CARR:
 5                                 6                                   LOC:
ZIP           SEX   MS   ADMIT DATE        HR    TYPE   SRC   D HM      STAT
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                02                  03
04                  05                06                  07
08                  09                10                  FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01                      02                      03
04                      05                      06
07                      08                      09

   PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

There are six claim pages within FISS:

- **Page 01** (Map 1711) contains general patient information, condition codes, occurrence codes, occurrence span codes, and value codes.
- **Page 02** (Map 1712) contains revenue code information, HCPCS codes, charges and service dates.
    - MAP171E (Press F11 one time from Page 02) was used by hospice providers when billing non-injectable drugs (revenue code 0250). For claims with dates of service on or after October 1, 2018, hospices are no longer required to report this information. Refer to MM10573 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNmattersArticles/downloads/mm10573.pdf for additional information.
- **Page 03** (Map 1713) contains payer information, diagnosis/procedure code information, and physician information.
    - MAP1719 (Press F11 one time from Page 03) contains Claim Adjustment Segment (CAS) information, required on all Medicare Secondary Payer (MSP) claims.
- **Page 04** (Map 1714) contains space for remarks.
- **Page 05** (Map 1715) contains Home Health Prospective Payment System (HH PPS) Claim-OASIS Matching Key code.

- **Page 06** (Map 1716) contains Medicare payment information upon processing of the claim.

➔ Use the following keys to move around the FISS claim pages:

Tab – Moves your cursor from left to right, placing it in a valid field

Shift + Tab – Moves your cursor from right to left, placing it in a valid field

F3 – Exits the entry process and returns to the Claims/Attachments Menu (note that you will lose your work if you press *F3* during claim entry)

F5 – Scrolls back through a list (billing transactions, revenue codes, diagnosis and procedure codes, charges, etc.)

F6 – Scrolls forward through a list

F7 – Moves backward one page (e.g., FISS Page 03 to FISS Page 02)

F8 – Moves forward one page (e.g., FISS Page 01 to FISS Page 02)

F9 – Updates/submits the claim into FISS

F10 – Moves to the left

F11 – Moves to the right

➔ **After you've entered your appropriate type of bill, and before you begin to enter your claim information, press *Enter*. This allows you access to all of the fields required for your bill type.**

4. Begin entering data on Page 01 of the claim and continue until the appropriate fields are completed. The easiest way to move from field to field is to use your Tab key.

➔ When keying dollar amounts in the **VALUE CODES - AMOUNTS** fields, you may type or omit the decimal point as you choose (i.e., $45.92 can be keyed as 45.92 or 4592; $1500.00 can be keyed as 1500.00 or 150000). However, it is important to ensure that the appropriate cents value is entered, regardless of whether the decimal point is used.

➔ Home health and hospice providers must key a five-digit core based statistical area (CBSA) code in the **VALUE CODE AND AMOUNTS** field (using value code 61 or G8). Two zeroes must be added behind the CBSA code (i.e., CBSA code 19000 must be entered as 1900000 or 19000.00). If you do not add two zeroes, the CBSA code will be incorrect (i.e., entering the CBSA code as 19000 instead of 1900000 will result in FISS reading the code as 190 instead of 19000). CBSA codes can be found on the "Rates and Fee Schedules" Web page at https://www.cgsmedicare.com/hhh/claims/fees/index.html on the CGS website by selecting the appropriate link for your provider type (Home Health Prospective Payment System Rates or Hospice Rates), then selecting the Calendar Year link (for home health) or Fiscal Year (FY) Wage Index link (for

hospice). HHAs are reminded that when an episode spans the calendar year (e.g., 11/27/16 – 01/25/2017), they should determine the CBSA code by using the calendar year information based on the claim's "TO" date.

➔ Page 01 of the claim allows space for ten condition codes, ten occurrence codes/dates, and nine values codes/amounts. However, you can enter up to 30 condition codes, 30 occurrence codes/dates, and up to 36 value codes/amounts. To access the additional space for these fields, press *F6* to scroll forward.

Field Descriptions for Page 01 – Map 1711

Field Name	Description	UB-04 Form Locator (FL)
SC	Screen control. Used to access the Inquiry screens while entering a claim.	N/A
MID	The beneficiary's Medicare ID number.	FL 60
TOB	Type of Bill (system generated; you may need to change this depending on the TOB you are entering).	FL 4
S/LOC	Status/location code (system generated).	N/A
OSCAR	Online Survey Certification and Reporting System (OSCAR). Not used during claim entry.	FL 51
SV	Suppress View. Only used from the Claims Correction menu. Not used during claim entry.	N/A
NPI	National Provider Identifier.	FL 56
TRANS HOSP PROV	Medicare number of transferring hospice provider (system generated).	N/A
PROCESS NEW MID	Corrected Medicare ID number. Only used from the Claims Correction menu. Not used during claim entry.	N/A
PAT CNTL #	Patient Control Number.	FL 3a

Map 1711 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
TAX # / SUB	Federal Tax Number (subsidiary) (do not enter).	FL 5
TAXO. CD	Taxonomy code. Not required by home health and hospice providers.	FL 81
STMT DATES FROM/TO	Statement covers period.	FL 6
DAYS COV	Number of covered days billed. Not applicable to home health and hospice claims.	N/A
N-C	Number of noncovered days billed. Not applicable to home health and hospice claims.	N/A
CO	Number of coinsurance days used. Not applicable to home health and hospice claims.	N/A
LTR	Number of lifetime reserve days used. Not applicable to home health and hospice claims.	N/A
LAST	Beneficiary's last name.	FL 8
FIRST	Beneficiary's first name.	FL 8
MI	Beneficiary's middle initial.	FL 8
DOB	Beneficiary's date of birth (MMDDCCYY).	FL 10
ADDR 1-6	Beneficiary's street address, city and state.	FL 9
CARR	Carrier number associated with the nine-digit service facility zip code. Not applicable to home health and hospice claims.	N/A

Map 1711 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
LOC:	Locality code associated with the nine-digit service facility zip code. Not applicable to home health and hospice claims.	N/A
ZIP	Beneficiary's zip code (5- or 9-digit).	FL 9
SEX	Beneficiary's gender (M or F).	FL 11
MS	Beneficiary's marital status.	N/A
ADMIT DATE	Admission date.	FL 12
HR	Admission hour.	FL 13
TYPE	Priority (type) of admission.	FL 14
SRC	Point of Origin (previously known as source of admission).	FL 15
D HM	Discharge hour and minutes. Not applicable to home health and hospice claims.	FL 16
STAT	Beneficiary's status code.	FL 17
COND CODES	Condition codes.	FL 18-28
OCC CDS/DATES	Occurrence codes and dates.	FL 31-34
SPAN CODES/ DATES	Occurrence span codes and dates.	FL 35-36

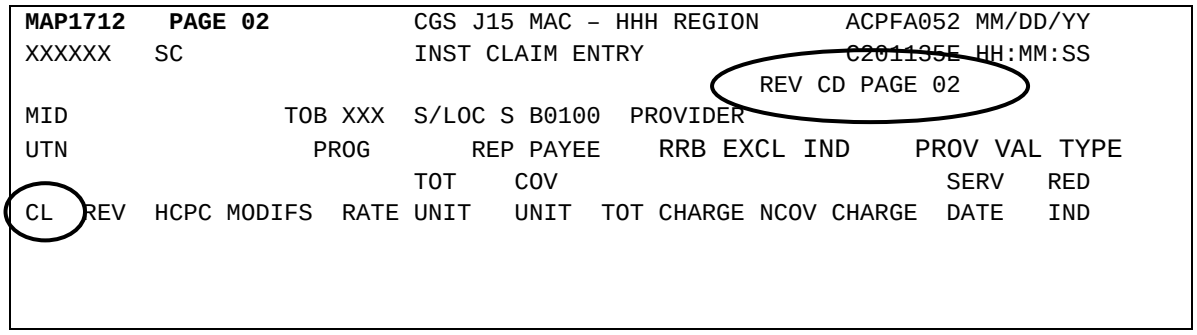
Map 1711 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
FAC ZIP	Nine-digit ZIP code of the service facility.	FL 1
DCN	Document Control Number. Not used on claims entry – for adjustments/cancellations only.	N/A
VALUE CODES – AMOUNTS	Value codes and amounts.	FL 39-41
ANSI	ANSI codes (system generated after claim is processed).	N/A
MSP APP IND	MSP Apportion Indicator	N/A

Page 02—Map 1712

```
MAP1712     PAGE 02          CGS J15 MAC – HHH REGION       ACPFA052 MM/DD/YY
XXXXXX      SC               INST CLAIM ENTRY               C201135E HH:MM:SS
                                                    REV CD PAGE 01
MID                TOB XXX  S/LOC S B0100  PROVIDER
UTN                  PROG       REP PAYEE   RRB EXCL IND     PROV VAL TYPE
                               TOT    COV                          SERV   RED
CL  REV  HCPC MODIFS  RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE  DATE   IND




       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

1. Enter revenue code information on Page 02 of the claim. This page will hold up to 14 revenue code lines. To enter additional revenue code lines, press *F6* to scroll down to access the second revenue code page (REV CD PAGE 02). There are 33 revenue code pages and 450 total revenue code lines available.



➔ The **CL** field identifies the line number of the revenue code and is automatically generated by the system. These will display after pressing Enter.

➔ The **REV** field is a four-position field. You may key a zero before the revenue code (e.g., 0420) or key the three-digit code (e.g., 420) and then use your Tab key to go to the next field.

➔ You do not need to enter information in the **RATE** field. When appropriate, FISS inserts this information during claims processing.

➔ When keying dollar amounts in the **TOT CHARGE** field, the decimal point is optional (i.e., $1500.00 can be keyed as 1500.00 or 150000). However, you must key two digits for the cents.

➔ If after you key your revenue codes, you realize you need to delete a revenue code line:

- Key the letter “D” in the first position of the revenue code that you wish to delete.
- Press the HOME key on your keyboard so that your cursor is placed in the upper left hand corner of the screen (the “Page” field).
- Press *Enter*.

➔ If after you key the 0001 total revenue code line, you realize an additional revenue code needs to be added, key the added revenue code line below the 0001 line. You do not need to rekey the revenue codes that you have already entered. Be sure to update your total charge amount on the 0001 line to reflect the addition of the revenue code charge, and then press the HOME key on your keyboard so that your cursor is placed in the upper left hand corner of the screen (the “Page” field). Press *Enter*. FISS will automatically reorder the revenue code line that you added to appear above the 0001 line.

Field Descriptions for Page 02 – Map 1712

The MID, TOB, and S/LOC fields are system generated from Page 01 of the claim.

Field Name	Description	UB-04 Form Locator (FL)
UTN	Unique Tracking Number	NA
PROG	Prior Authorization Program Indicator	NA
REP PAYEE	Identifies a Medicare beneficiary with a Rep Payee. Valid values are: **R** – Bypass Rep Payee ‘ ’– Blank	NA
RRB EXCL IND	Railroad Board (RRB) Exclusion Indicator. Valid values are: Y – Exclude RRB beneficiary services from the prior authorization program Blank – Subject RRB beneficiary services to prior authorization	NA
PROV VAL TYPE	Provider validation type. Valid values are: RP (Rendering Provider) OP (Operating Physician) CP (Ordering / Referring Physician) AP (Attending Physician) FA (Facility)	NA

Map 1712 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
CL	Claim line item number (1 – 450).	NA
REV	Revenue code.	FL 42
HCPC	Healthcare Common Procedure Coding System (HCPCS) code.	FL 44
MODIFS	Modifiers.	FL 44
RATE	Per unit rate for revenue code line item service. Not used for claim entry.	FL 44
TOT UNT	Total units.	FL 46
COV UNT	Covered units.	FL 46
TOT CHARGE	Total charges per revenue code line.	FL 47
NCOV CHARGE	Noncovered charges billed per revenue code line.	FL 48
SERV DATE	Date service was provided.	FL 45
RED IND	Therapy Reduction Indicator. Valid values: **P** = partial (if all units except 1 were reduced) **R** = all units were reduced. **M** = multiple surgery reduction Not used for claim entry.	NA

Page 02—MAP 171E

From Page 02 of the claim, press *F11* one time and Map 171E will display.

At this time, Map 171E is not used by home health and hospice providers. For claims with dates of service on or after October 1, 2018, hospices are no longer required to report this information. Refer to MM10573 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNmattersArticles/downloads/mm10573.pdf for additional information.

```
MAP171E   PAGE 02          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXXX   SC              INST CLAIM ENTRY                   C201415E HH:MM:SS
                                                  NDC CD PAGE 01
MID               TOB      S/LOC          PROVIDER
                                                            RETURN
          CL   NDC FIELD    NDC QUANTITY   QUALIFIER   HIPPS1  HIPPS2   MOLDX
           1
LLR NPI                L                      F            M    SC
LLO NPI
           2
LLR NPI                L                      F            M    SC
LLO NPI
           3
LLR NPI                L                      F            M    SC
LLO NPI
           4
LLR NPI                L                      F            M    SC
LLO NPI
           5
LLR NPI                L                      F            M    SC
LLO NPI

      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DN PF7-PRE PF8-NXT PF9-UPDT PF10-LT PF11-RT
```

➔ From Map 171E, press *F11* again, Map 171A will display; press *F11* again and Map 171D displays. Typically, these screens are not used during claim entry and will display information after the claim has processed. Refer to the FISS Guide (Chapter 3): "Inquiry Menu" at https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf for information about Map 171A and 171D. Home health agency providers (HHAs) may need to enter additional modifiers on MAP 171A when submitting claims containing outpatient therapy services on a 34X type of bill. See the "Home Health Outpatient Therapy Billing" Web page at https://www.cgsmedicare.com/hhh/education/materials/Home_Health_Outpatient_Therapy_Billing.html for additional information.

From Map 171E, to proceed to Page 03, press *F8* to page forward to Page 03 of the claim and continue entering claim information.

Page 03—Map 1713

```
MAP1713   PAGE 03          CGS J15 MAC – HHH REGION      ACPFA052 MM/DD/YY
XXXXXX    SC               INST CLAIM ENTRY              C201135E HH:MM:SS
MID               TOB XXX  S/LOC S B0100  PROVIDER
NDC CD                           OFFSITE ZIP:      ADJ MBI           IND
 CD  ID    PAYER                   OSCAR        RI AB          EST AMT DUE
A
B
C
DUE FROM PATIENT                              SERV FAC NPI
MEDICAL RECORD NBR                     COST RPT DAYS      NON COST RPT DAYS
DIAG CODES 01           02           03           04           05
06           07           08           09                END OF POA IND
ADMITTING DIAGNOSIS             E CODE             HOSPICE TERM ILL IND
IDE                    GAF                      PRV
PROCEDURE CODES AND DATES 01                  02
03               04                05                06
ESRD HOURS     ADJ REAS CD     REJ CD        NONPAY CD    ATT TAXO
ATT PHYS        NPI               L                    F           M    SC
OPR PHYS        NPI               L                    F           M    SC
OTH OPR         NPI               L                    F           M    SC
REN PHYS        NPI               L                    F           M    SC
REF PHYS        NPI               L                    F           M    SC
       PROCESS COMPLETED  ---   PLEASE CONTINUE
 PRESS PF3-EXIT  PF5- BKWD  PF6- FWD  PF7-PREV  PF8-NEXT  PF9-UPDT PF11-RIGHT
```

1. Enter payer information, applicable diagnosis and procedure codes, and physician information.

   The payer code “Z” (Medicare is the primary payer) is automatically entered by FISS when the NOE option (49) is selected. For the home health and hospice claim entry options (26 and 28), you must enter “Z” (Medicare) into the **CD** field on line **A** when Medicare is the primary payer. When entering home health Requests for Anticipated Payment (RAPs), enter a “Z” on line A to indicate Medicare is the primary payer, regardless of any other insurers that may pay primary to Medicare. The payer name “Medicare” does not have to be entered in the **PAYER** field. FISS will insert it automatically. Line A reflects the primary payer, line B reflects the secondary payer, and line C reflects the tertiary payer. Refer to the field descriptions for a list of valid payer codes.

   The **DIAG CODES** field is a seven position field followed by a one position field for the Present on Admission (POA) indicator code. Because the POA indicator is not applicable for home health and hospice providers, you will need to **press your Tab key twice to move your cursor to the correct field to key additional diagnosis codes**.

➔ The **DIAG CODES** and the **PROCEDURE CODES AND DATES** fields allow for up to 25 codes, by pressing F6 to move forward. Press *F5* to move backward.

2. If entering an MSP claim, press *F11* to access the MSP Payment Information screen, Map 1719. If MSP does not apply, press *F8* to go to Page 04 of the claim.

➔ For information about entering MSP claims, refer to the Page 03 – MAP 1719 information, which follows the MAP1713 field descriptions.

Field Descriptions for Page 03 – Map 1713

The MID, TOB, and S/LOC fields are system generated from information on Page 01 of the claim.

Field Name	Description	UB-04 Form Locator (FL)
NDC CD	National drug code. Not used by home health or hospice providers.	FL 43
OFFSITE ZIP	Not applicable to home health and hospice providers.	N/A
ADJ MBI	Identifies the submitted ID indicator and submitted Medicare Beneficiary Identifier on adjustments and cancels.	N/A
IND	Auto populated with an **M** on adjustments and cancels when the MBI is entered on MAP1741 (Claim Summary Inquiry) screen. An **H** will display on adjustments and cancels when a MID is entered on MAP1741.	N/A
CD	Primary payer code. Valid values are: **Z** – Medicare The following payer codes are only used on lines B (secondary payer) and C (tertiary payer) to identify supplemental insurers. **1** – Medicaid **2** – Blue Cross **3** – Other Refer to the Medicare Secondary Payer Billing & Adjustments quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/msp_billing.pdf for payer codes appropriate for secondary payer situations.	N/A

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
ID	Payer ID (not used by FISS).	N/A
PAYER	Name of insurance company paying bill. A – primary (FISS will automatically insert the payer name “Medicare” when a “Z” is entered in the CD field.) B – secondary C – tertiary	FL 50
OSCAR	Online Survey Certification and Reporting System (OSCAR). Also known as PTAN. Automatically added by FISS.	FL 51
RI	Release of Information.	FL 52
AB	Assignment of Benefits.	FL 53
EST AMT DUE	Estimated amount due. Not used by home health or hospice providers.	FL 55
DUE FROM PATIENT	Estimated amount due from patient. Not used by home health or hospice providers.	N/A
SERV FAC NPI	NPI of the nursing facility, hospital or hospice inpatient facility where the patient received services. (Hospice providers only)	N/A
MEDICAL RECORD NBR	Beneficiary’s medical record number.	FL 3b
COST RPT DAYS	Not applicable to home health and hospice providers.	N/A
NON COST RPT DAYS	Not applicable to home health and hospice providers.	N/A

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
DIAG CODES	ICD-9-CM or ICD-10-CM (effective October 1, 2015) diagnosis codes. The diagnosis code field is a seven position field followed by a one position field for the Present on Admission (POA) indicator code. The POA field is not applicable for home health and hospice providers; therefore, use your Tab key to move your cursor to key additional diagnosis codes. Do not enter decimal points. Press *F6* if you need to enter additional diagnosis codes.	FL 67A – Q
END OF POA IND	Not applicable for home health and hospice providers.	
ADMITTING DIAGNOSIS	ICD-9-CM or ICD-10-CM (effective October 1, 2015) diagnosis code indicating reason for admission. Do not enter decimal points. Not required for home health and hospice providers.	FL 69
E CODE	ICD-9-CM or ICD-10-CM (effective October 1, 2015) diagnosis code indicating external cause of injury. Do not enter decimal points. Not required for home health and hospice providers.	FL 72
HOSPICE TERM ILL IND	Hospice Terminal Illness Indicator. Do not enter information.	N/A
IDE	Not applicable for home health and hospice providers.	N/A
GAF	Identifies the Geographic Adjustment Factors for state, carrier and locality at the claim level. Not used by home health or hospice providers.	NA
PRV	The ICD-9-CM or ICD-10-CM (effective October 1, 2015) code describing the reason for seeking care. Not used by home health or hospice providers.	NA
PROCEDURE CODES AND DATES	ICD-9-CM or ICD-10-CM (effective October 1, 2015) procedure codes/dates. Do not enter decimal points. Press *F6* to display additional procedure codes fields.	FL 74a – e

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
ESRD HOURS	ESRD hours/duration of dialysis. Not used by home health or hospice providers.	N/A
ADJ REAS CD	Reason for adjustment of claim (not for use on claim entry– use with claim adjustment/cancel).	N/A
REJ CD	Reject code. For CGS use only.	N/A
NONPAY CD	Nonpayment code. For CGS use only.	N/A
ATT TAXO	The attending physician taxonomy codes. Not required.	N/A
ATT PHYS NPI	Attending physician's national provider identifier. For hospice notice of elections (NOEs) and claims, enter the NPI of the patient's attending physician, if they have one. If there is no attending physician, enter the NPI of the certifying physician. For home health, enter the NPI of the attending physician who signs the patient's plan of care.	FL 76
L	Attending physician's last name.	FL 76
F	Attending physician's first name.	FL 76
M	Attending physician's middle initial (not required).	FL 76

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
SC	Attending physician's specialty code. (This code is applied by FISS based on whether the NPI appears and/or matches an NPI on the Provider Enrollment, Chain, and Ownership System (PECOS).) • If the attending NPI on the claim in not present in the PECOS record, FISS will place a '99' in the 'SC' field. • If the attending NPI on the claim is present in the PECOS record, but the name on the claim does not match the name in the PECOS record, the 'SC' field will be left blank. • If the attending NPI on the claim is present in the phys/non-phys file and the name on the claim matches the name in the PECOS record, the specialty code of the first matching record will be placed in the 'SC' field.	N/A
OPR PHYS NPI	Operating physician's national provider identifier.	FL 77
L	Operating physician's last name.	FL 77
F	Operating physician's first name.	FL 77
M	Operating physician's middle initial (not required).	FL 77

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
SC	Operating physician's specialty code. (This code is applied by FISS based on whether the NPI appears and/or matches an NPI on the Provider Enrollment, Chain, and Ownership System (PECOS).) • If the operating NPI on the claim is not present in the PECOS record, FISS will place a '99' in the 'SC' field. • If the operating NPI on the claim is present in the PECOS record, but the name on the claim does not match the name in the PECOS record, the 'SC' field will be left blank. • If the operating NPI on the claim is present in the phys/non-phys file and the name on the claim matches the name in the PECOS record, the specialty code of the first matching record will be placed in the 'SC' field.	N/A
OTH OPR NPI	Other operating physician's national provider identifier.	FL 78 – 79
L	Other physician's last name.	FL 78 – 79
F	Other physician's first name.	FL 78 – 79
M	Other physician's middle initial (not required).	FL 78 – 79

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
SC	Other physician's specialty code. (This code is applied by FISS based on whether the NPI appears and/or matches an NPI on the Provider Enrollment, Chain, and Ownership System (PECOS).) • If the other NPI on the claim in not present in the PECOS record, FISS will place a '99' in the 'SC' field. • If the other NPI on the claim is present in the PECOS record, but the name on the claim does not match the name in the PECOS record, the 'SC' field will be left blank. • If the other NPI on the claim is present in the phys/non-phys file and the name on the claim matches the name in the PECOS record, the specialty code of the first matching record will be placed in the 'SC' field.	N/A
REN PHYS NPI	Rendering physician's national provider identifier. Not required for home health and hospice providers.	N/A
L	Rendering physician's last name. Not required for home health and hospice providers.	N/A
F	Rendering physician's first name. Not required for home health and hospice providers.	N/A
M	Rendering physician's middle initial (not required). Not required for home health and hospice providers.	N/A
SC	Rendering physician's specialty code. Not required for home health and hospice providers.	N/A

Map 1713 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
REF PHYS NPI	Referring physician's national provider identifier. • For hospice notice of elections (NOEs) and claims, enter the NPI of the physician responsible for certifying the patient as terminally ill, if different than the attending physician • For home health outpatient therapy claims (type of bill 34X), enter the referring physician's NPI. • For home health 32X type of bills, enter the NPI of the physician responsible for certifying/recertifying the eligibility for home health services.	N/A
L	Referring physician's last name.	N/A
F	Referring physician's first name.	N/A
M	Referring physician's middle initial (not required).	N/A
SC	Referring physician's specialty code. (This code is applied by FISS based on whether the NPI appears and/or matches an NPI on the Provider Enrollment, Chain, and Ownership System (PECOS).) • If the operating NPI on the claim in not present in the PECOS record, FISS will place a '99' in the 'SC' field. • If the operating NPI on the claim is present in the PECOS record, but the name on the claim does not match the name in the PECOS record, the 'SC' field will be left blank. If the operating NPI on the claim is present in the phys/non-phys file and the name on the claim matches the name in the PECOS record, the specialty code of the first matching record will be placed in the 'SC' field.	N/A

➔ The majority of the information necessary on a claim is entered into the first three claim pages within FISS. If you have no remarks to make regarding this claim, and you do not need to add a HH PPS Claim-OASIS Matching Key code, you can press *F9* at this point to store your claim as no further information is required. If, after you press *F9*, an error appears, see the information titled *Saving your Claim* later in this chapter.

➔ If entering an MSP claim, press *F11* to access the MSP Payment Information screen, Map 1719.

Page 03—Map 1719

```
MAP1719   PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
  XXXXXXX   SC               INST CLAIM ENTRY                C201624F HH:MM:SS
  MID               TOB XXX  S/LOC S B0100  PROVIDER
                   M S P   P A Y M E N T   I N F O R M A T I O N
  RI:

  PRIMARY PAYER 1  MSP PAYMENT INFORMATION

  PAID DATE:           PAID AMOUNT:

  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT
  GRP     CARC       AMT                  GRP     CARC       AMT


        PROCESS COMPLETED  ---   PLEASE CONTINUE
  PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT
```

1. Enter the claim adjustment segment (CAS) information in the Primary Payer 1 MSP Payment Information screen. The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information.

➔ Press *F6* to access the "MSP Payment Information" screen for primary payer 2 (if there is one). Press *F5* to move back to the primary payer 1 "MSP Payment Information" screen.

➔ If the CAS code information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. This information is available from the following websites:

- **Washington Publishing Company** - http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
- **CAQH** (Access the current version of the *CORE Code Combinations)* - http://www.caqh.org/CORECodeCombinations.php

➔ For additional information, refer to the CGS Submitting Medicare Secondary Payer (MSP) Claims and Adjustments Web page at https://www.cgsmedicare.com/hhh/education/materials/Submitting_MSP.html

Field Descriptions for Page 03 – Map 1719

The MID, TOB, and S/LOC fields are system generated from information on Page 01 of the claim.

Field Name	Description	UB-04 Form Locator (FL)
RI	Residual Payment Indicator – allows for secondary payment. FISS will auto populate an X when CARC codes 27, 35, 119 or 149 are present.	NA
PAID DATE	Enter the paid date shown on the primary payer's remittance advice (MMDDYY format).	NA
PAID AMOUNT	The payment amount made by the primary payer	NA
GRP	The ANSI group code. Valid values are: **CO** Contractual Obligation **PI** Payer Initiated Reductions **OA** Other Adjustment **PR** Patient Responsibility	NA
CARC	Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. CARC codes explain the difference between the billed amount and the amount paid by the primary payer. For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/	NA
AMT	The dollar amount associated with the group/CARC combination.	NA

Page 03—Map 171F

Map 171F is no applicable to home health and hospice providers.

```
MAP171F   PAGE 03         CGS J15 MAC - HHH REGION          ACMFA552 MM/DD/YY
XXXXXXX   SC               INST CLAIM ENTRY                 C201822P HH:MM:SS

 MID              TOB XXX  S/LOC S B0100  PROVIDER
     P R O V I D E R   P R A C T I C E   L O C A T I O N   A D D R E S S

 ADDRESS 1:

 ADDRESS 2:

 CITY     :                                  STATE:      ZIP:









      PROCESS COMPLETED  ---   PLEASE CONTINUE
 PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT
```

Field Descriptions for Page 03 – Map 171F

The MID, TOB, and S/LOC fields are system generated from information on Page 01 of the claim.

Field Name	Description
ADDRESS 1	The Service Facility address 1.
ADDRESS 2	The Service Facility address 2.
CITY	The Service Facility city.
STATE	The Service Facility state.
ZIP	The Service Facility zip code.

Page 04—Map 1714

```
MAP1714   PAGE 04        CGS J15 MAC – HHH REGION         ACPFA052 MM/DD/YY
XXXXXX    SC             INST CLAIM ENTRY                 C201135E HH:MM:SS
                                                 REMARK PAGE 01
MID               TOB XXX  S/LOC S B0100  PROVIDER

REMARKS









 47  PACEMAKER     48  AMBULANCE     40  THERAPY     41  HOME HEALTH
 58  HBP CLAIMS (MED B)              E1  ESRD ATTACH
 ANSI CODES - GROUP:     ADJ REASONS:      APPEALS:

       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT  PF9-UPDT
```

1. When you submit claims to CGS, using the **REMARKS** field is optional. However, we encourage you to enter any pertinent information that assists with the processing of the claim. CGS may also use this field to relay information back to the provider when the claim is in process or processed. There are 3 pages available for remarks. To use additional pages, press *F6* to scroll forward and *F5* to scroll backward.

Field Descriptions for Page 04 – Map 1714

The MID, TOB, and S/LOC, fields are system generated from information on Page 01 of the claim.

Field Name	Description	UB-04 Form Locator (FL)
REMARKS	Additional pertinent information to assist the processing of the claim. Three pages are available to make remarks. Each page holds 10 lines of remarks. Press *F6* to scroll forward to the next remark page.	FL 80
47 PACEMAKER	Attachment screen indicator. This function should not be used.	N/A

Map 1714 Field Descriptions (continued)

Field Name	Description	UB-04 Form Locator (FL)
48 AMBULANCE	Attachment screen indicator. This function should not be used.	N/A
40 THERAPY	Attachment screen indicator. This function should not be used.	N/A
41 HOME HEALTH	Attachment screen indicator. This function should not be used.	N/A
58 HPB CLAIMS (MED B)	N/A	N/A
E1 ESRD ATTACH	Attachment screen indicator. This function should not be used.	N/A
ANSI CODES	ANSI reason codes (see the "ANSI Standard Codes Inquiry screen (Map 1581)" information in the Inquiry Menu (Chapter 3) at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf for details).	N/A
GROUP	Adjustment group code identifying the general category of the adjustment.	N/A
ADJ REASONS	Claim adjustment standard reason code identifying the reason for the adjustment (see "Adjustment Reason Codes Inquiry screen (Map 1821)" information in the Inquiry Menu (Chapter 3) at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf for details).	N/A
APPEALS	ANSI appeal codes (not applicable for home health and hospice providers).	N/A

Page 05—Map 1715

```
MAP1715   PAGE 05          CGS J15 MAC – HHH REGION      ACPFA052 MM/DD/YY
XXXXXX    SC               INST CLAIM ENTRY              C201135E HH:MM:SS

MID               TOB XXX  S/LOC S B0100  PROVIDER
INSURED NAME REL CERT-SSN-MID  SEX GROUP NAME   DOB   INS GROUP NUMBER
A
B
C

 TREAT. AUTH. CODE


 TREAT. AUTH. CODE


 TREAT. AUTH. CODE



      PROCESS COMPLETED  ---   PLEASE CONTINUE
           PRESS PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

1. If Medicare is the primary payer, it is not necessary for the insured's information to be entered on Line A. However, if the beneficiary has supplemental insurance, key the insured's supplemental insurance information on Line B.

➔ For MSP billing instructions, please see the "Medicare Secondary Payer (MSP) Billing and Adjustments" quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf. CGS has also developed the "Medicare Secondary Payer (MSP) Online Tool" at https://www.cgsmedicare.com/hhh/coverage/MSPTool.html used to determine appropriate billing of MSP claims.

2. On Home Health Prospective Payment System (HH PPS) RAPs and claims, the Claim- OASIS Matching Key code must be entered underneath the appropriate **TREAT. AUTH. CODE** (Treatment Authorization Code) field. When Medicare is the primary payer, the OASIS matching key must be typed in the first **TREAT. AUTH. CODE** field immediately under Line C.

➔ A 14-digit field immediately follows the 18-digit TREAT. AUTH. CODE field. This field is used for 32X (home health) bill types to report the Unique Tracking Number (UTN) related to the implementation of the Pre-Claim Review (PCR) Demonstration, (may also be referred to as Prior Authorization).

3. Press *F8* to go to Page 06 of the claim.

Field Descriptions for Page 05 – Map 1715

The MID, TOB, and S/LOC fields are system generated from information on Page 01 of the claim.

➔ Two separate lines are available for the insured's information. When Medicare is primary, it is not necessary to enter information on Line A. Only enter supplemental insurance information on Line B. For MSP billing instructions, please see the "Medicare Secondary Payer (MSP) Billing and Adjustments" quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf. CGS has also developed the "Medicare Secondary Payer (MSP) Online Tool" at https://www.cgsmedicare.com/hhh/coverage/MSPTool.html used to determine appropriate billing of MSP claims. The field names below are listed in the order they are entered.

Field Name	Description	UB-04 Form Locator (FL)
INSURED NAME	Name of policyholder, last name (then press the Tab key) and first name.	FL 58
SEX	Identifies the gender (M or F) of the insured.	FL 11
DOB	Identifies the insured's date of birth.	FL 10
REL	Relationship code of patient to the insured.	FL 59
CERT.-SSN-MID	Certificate/Social Security No./Medicare ID No./Identification No.	FL 60
GROUP NAME	Name of group (payer/other coverage).	FL 61
INS GROUP NUMBER	Insurance policy group number.	FL 62
TREAT. AUTH. CODE	Treatment Authorization Code. HH PPS Claim-OASIS Matching Key code entry field (home health only).	FL 63
Untitled	Unique Tracking Number (UTN). A 14-digit field immediately following the TREAT. AUTH. CODE field, for 32X bill types to report the UTN related to the implementation of the Pre-Claim Review (PCR) Demonstration, (may also be referred to as Prior Authorization).	NA

Page 06—Map 1716

```
MAP1716   PAGE 06      CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC           INST CLAIM ENTRY                  C201135E HH:MM:SS

MID              TOB XXX  S/LOC S B0100  PROVIDER
          MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
               CITY                  ST     ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
               CITY                  ST     ZIP
PAYMENT DATA ---  DEDUCTIBLE             COIN          CROSSOVER IND
PARTNER ID

PAID DATE         PROVIDER PAYMENT                PAID BY PATIENT
REIMB RATE         RECEIPT DATE         PROVIDER INTEREST
CHECK/EFT NO             CHECK/EFT ISSUE DATE           PAYMENT CODE
PIP PAY AS CASH            PRICER DATA              HOSPICE PRIOR DYS
DRG      OUTLIER AMT              TTL BLNDED PAYMT            FED SPEC
INIT DRG         GRH ORIG REIMB AMT             NET INL
TECH PROV DAYS      TECH PROV CHARGES
 OTHER INS ID             CLINIC CODE        IOCE CLM PR FL
      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF7-PREV PAGE  PF9-UPDT  ENTER-CONTINUE
```

1. For claims where Medicare is primary, Page 06 of the claim should be left blank. Page 06 should also be left blank when entering a home health Request for Anticipated Payment (RAP).

➔ If the claim is for services unrelated to an MSP record and you are submitting it for conditional Medicare payment, complete the **MSP ADDITIONAL INSURER INFORMATION** area.

➔ For MSP billing instructions, please see the “Medicare Secondary Payer (MSP) Billing and Adjustments” quick resource tool at http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf. CGS has also developed the “Medicare Secondary Payer (MSP) Online Tool” at http://www.cgsmedicare.com/hhh/coverage/MSPTool.html used to determine appropriate billing of MSP claims.

2. If you need to go back and review information before saving the claim, use your F7 and F8 keys to page backward and forward. You can also press your HOME key to move your cursor into the **PAGE** field then type the page number you wish to review and press *Enter*.

3. When you have completed entering information on the claim, press *F9* to store your claim in FISS. See *Saving your Claim*, which follows directly after the Map 1716 field descriptions.

Field Descriptions for Page 06 – Map 1716

The MID, TOB, and S/LOC fields are system generated from information on Page 01 of the claim.

Field Name	Description
1ST INSURERS ADDRESS 1, 2	These fields are left blank when Medicare is the primary payer. For MSP billing instructions, please see the "Medicare Secondary Payer (MSP) Billing and Adjustments" quick resource tool at http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf. CGS has also developed the "Medicare Secondary Payer (MSP) Online Tool" at http://www.cgsmedicare.com/hhh/coverage/MSPTool.html used to determine appropriate billing of MSP claims.
CITY	
ST	
ZIP	
2ND INSURERS ADDRESS 1, 2	
CITY	
ST	
ZIP	

The following payment and pricer data will appear after FISS has completed processing of the claim.

Field Name	Description
DEDUCTIBLE	Amount applied toward deductible (system generated).
COIN	Coinsurance. Amount applied toward coinsurance (system generated).
CROSSOVER IND	Crossover Indicator. The code which identifies the Medicare payer on the claim. Valid values are:1 Primary, 2 Secondary, 3 Tertiary
PARTNER ID	The trading partner's identification number. Access the COBA Trading Partners document from the "Downloads" section at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html to associate the identification number with the insurer's name.
PAID DATE	Date of payment.
PROVIDER PAYMENT	Amount paid to provider.

Map 1716 Field Descriptions (continued)

Field Name	Description
PAID BY PATIENT	N/A
REIMB RATE	Provider's specific reimbursement rate (per diem or percentage).
RECEIPT DATE	Date claim was received by FISS.
PROVIDER INTEREST	Amount of interest paid to the provider on this claim.
CHECK/EFT NO	Identification number of the check or the electronic funds being transferred.
CHECK/EFT ISSUE DATE	Date check was issued or the date the electronic funds transfer were released.
PAYMENT CODE	Payment method of the check or electronic funds transfer. Valid values are: **ACH** = Automated clearing house or electronic funds transfer **CHK** = check **NON** = non-payment data
PIP PAY AS CASH	Periodic Interim Payment (PIP) indicator. A "Y" displays when the provider payment method is PIP, or when the Adjustment Reason Code equals RI indicating a Recovery Auditor-initiated adjustment.
HOSPICE PRIOR DYS	Identifies the prior hospice benefit period days.
DRG	N/A
OUTLIER AMT	Capital outlier payment. Outlier portion of the PPS payment.
TTL BLENDED PAYMENT	N/A
FED SPEC	N/A
INIT DRG	N/A
GRH ORIG REIMB AMT	N/A
TECH PROV DAYS	Technical provider liable days. Days present on benefit savings record or days reflected in Occurrence Span Code 77 if benefit savings not present.
TECH PROV CHARGES	Charges present on benefit savings record.
OTHER INS IND	N/A
CLINIC CODE	N/A

Map 1716 Field Descriptions (continued)

IOCE CLM PR FL	Integrated Outpatient Code Editor Claim Processed Flag Valid values: **0** – Claim processed **1** – Claim could not be processed (TOB 83X or other invalid bill type **2** – Claim could not be processed (claim has no line items) **3** – Claim could not be processed (condition code 21 is present) **4** – Error - Claim could not be processed as input values are not valid or are incorrectly formatted **9** – Error - OCE cannot run

Saving your Claim

1. Once you have entered all the pertinent information on the claim pages, press *F9* to update (store/save) the claim. If there are no errors on the claim, FISS will automatically display a new, blank Page 01 (Map 1711) and the message *RECORD SUCCESSFULLY ADDED* will appear at the bottom of the screen. Your cursor will be in the MID field. You can begin entering a new claim, or you can press *F3* to return to the Claim and Attachments Entry Menu.

```
MAP1711   PAGE 01          CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC               INST CLAIM ENTRY                  C20112WS HH:MM:SS
 MID              TOB XXX  S/LOC S B0100 OSCAR                SV:    UB-FORM
NPI           TRANS HOSP PROV                PROCESS NEW MID
PAT.CNTL#:                     TAX#/SUB:                TAXO.CD:
 STMT DATES FROM         TO         DAYS COV      N-C       CO      LTR
 LAST                           FIRST                MI    DOB
 ADDR 1                                  2
 3                                  4                                CARR:
 5                                  6                                 LOC:
ZIP           SEX   MS   ADMIT DATE        HR    TYPE   SRC   D HM      STAT
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                  02                  03
04                  05                  06                  07
08                  09                  10                  FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01                      02                      03
04                      05                      06
07                      08                      09
   RECORD SUCCESSFULLY ADDED  PLEASE ENTER DATA
     PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

2. If, after you press *F9*, you do not see the message *RECORD SUCCESSFULLY ADDED* at the bottom of your screen, there is missing or invalid information on the claim. At least one reason code, identifying the problem with the claim, will appear in the bottom left-hand corner of the screen. See the example on the next page.

```
MAP1711   PAGE 01          CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC               INST CLAIM ENTRY                  C20112WS HH:MM:SS
 MID XXXXXXXXXA    TOB 322  S/LOC S B0100 OSCAR  XXXXXX       SV:    UB-FORM
NPI XXXXXXXXXX TRANS HOSP PROV                PROCESS NEW MID
PAT.CNTL#:                      TAX#/SUB:               TAXO.CD:
 STMT DATES FROM 1206XX  TO 1206XX  DAYS COV      N-C       CO      LTR
 LAST SMITH                     FIRST JOHN          MI    DOB 01011929
 ADDR 1 101 MAIN ST                        2 ANYTOWN  IA
 3                                 4                                CARR:
 5                                 6                                 LOC:
ZIP 50001     SEX M MS M ADMIT DATE 1206XX HR 01 TYPE 9 SRC 1 D HM      STAT 30
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                02                  03
04                  05                06                  07
08                  09                10                  FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 61     99916.00       02                     03
04                       05                     06
07                       08                     09
 30703                                                  <== REASON CODES
     PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

3. Press *F1* to access the Reason Codes Inquiry screen (Map 1881). The reason code narrative that appears will provide you with information about the problem.

```
MAP1881                    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC               REASON CODES INQUIRY              C201135E HH:MM:SS
                                                          MNT: XXXXXX   XXXXXX
PLAN REAS  NARR   EFF      MSN      EFF      TERM    EMC    HC/PRO  PP   CC
IND  CODE  TYPE   DATE     REAS     DATE     DATE  ST/LOC  ST/LOC  LOC  IND
 1   30703   E   110790                            S MDLTD S MDLTD
 TPTP A    B    NPCD A     B     HD CPY A    B    NB ADR     CAL DY     C/L C
  ------------------------------NARRATIVE-------------------------------------
MISSING PATIENT'S STATE CODE.
    *CHECK SCREEN 1 (MAP 1711) FOR STATE (UB92 FL 13).
    *ENTER CORRECT DATA AND UPDATE THE CLAIM.









       PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
 PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

4. Once you have reviewed the narrative, press *F3* one time to return to the claim. Make the correction and press *F9* again. If the *RECORD SUCCESFULLY ADDED* message appears, you have successfully entered the claim. If this message does not appear, another reason code will display indicating that you still have missing or invalid information on your claim. Press *F1* again to see the narrative for the reason code. When you have finished reviewing the narrative, press *F3* one time to return to the claim. Make your correction and press *F9*. Repeat this process until the *RECORD SUCCESSFULLY ADDED* message appears. The claim will not be stored or saved until all reason codes are resolved and you see the *RECORD SUCCESSFULLY ADDED* message at the bottom of the screen. If you press *F3* without getting the *RECORD SUCCESSFULLY ADDED* message, the claim information is lost and you will need to re-key the entire claim.

➔ More than one reason code may appear at the bottom of your screen. Pressing F1 displays the first reason code. You should correct the reason codes one at a time, beginning with the first reason code. Sometimes, by correcting the first code, other related codes will also be corrected. Sometimes new codes will appear. Continue to work through the reason codes until you see the *RECORD SUCCESSFULLY ADDED* message.

➔ If, as you are working on your claim, you are unable to determine how to correct the error, call the Provider Contact Center at 1.877.299.4500 (select Option 1) for assistance.

➔ If you are viewing a FISS Claim Page and press *F3* before the *RECORD SUCCESSFULLY ADDED* message appears, you will lose the claim data you entered. FISS does not save the claim information until all errors on the claim are corrected.

➔ Even though you may be required to fix errors (reason codes) before your claim is accepted into the system, the claim could still go to the Return to Provider (RTP) file for other corrections. It is very important to check the RTP (claims correction) status/location T B9997 in FISS to see if you have claims to correct. See the “Chapter Five: Claims Corrections” at https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf in this FISS Guide for details.

Hospice Providers: Entering a Notice of Election (NOE) or Notice of Termination/Revocation (NOTR) or Canceling an NOE or Benefit Period

The NOE (type of bill 81A or 82A) is submitted at the start date of the beneficiary's election to the hospice benefit. Hospices must submit the Form CMS-1450 (UB-04) by mail, or via Direct Data Entry (DDE) as instructed below. The NOE must be submitted to, and accepted by CGS within 5 calendar days after the hospice admission.

The NOTR (type of bill 81B or 82B) must be submitted to, and accepted by CGS within 5 calendar days after the hospice discharge or revocation, unless a final hospice claim has already been submitted.

For additional information about submitting NOEs and NOTRs, refer to the CGS "Hospice Claims Filing" Web page at https://www.cgsmedicare.com/hhh/education/materials/hospice_cf.html and scroll down to access appropriate information related to the NOE and NOTR. In addition, refer to the Medicare Claims Processing Manual, Pub. 100-04, Ch. 11, Section 20.1.1 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf).

When an NOE is processed with an incorrect date of admission, an incorrect benefit period will display at the Common Working File (CWF). To correct the benefit period, an 81D or 82D type of bill must be submitted to cancel the incorrect NOE before a corrected NOE can be submitted. For additional information, refer to the "Canceling a Hospice Notice of Election or Benefit Period" Web page at https://www.cgsmedicare.com/hhh/education/materials/cancel_hos_notice.html

Entering a Roster Bill

Roster billing is a quick and convenient way to bill for flu and pneumonia vaccinations. To submit a roster bill through the Roster Bill Entry option, you must have given the same type of vaccination to five or more people on the same date of service. Each type of vaccination must be billed on a separate roster bill. You cannot have pneumonia and flu shots on the same roster bill. Additional roster billing information is available on the "Roster Billing for Mass Influenza and Pneumococcal Pneumonia Vaccines" Web page at https://www.cgsmedicare.com/hhh/education/materials/RBMIPPV.html .

➔ If you administered a vaccine to fewer than five Medicare beneficiaries on the same day, you must submit the claim(s) individually via Option 26 (Home Health) or Option 28 (Hospice) from the Claims and Attachments Entry Menu. Instructions for submitting individual vaccination claims to Medicare are available on the "Billing Individual Influenza and Pneumococcal Pneumonia Vaccines" Web page at https://www.cgsmedicare.com/hhh/education/materials/BIIPPV.html on the CGS website.

1. From the Claims and Attachments Entry Menu, type *87* and press *Enter*.

```
MAP1703                  CGS J15 MAC -  HHH REGION          ACPFA052 MM/DD/YY
XXXXXX              CLAIM AND ATTACHMENTS ENTRY MENU        C201135E HH:MM:SS

                          CLAIMS ENTRY

                   INPATIENT                20
                   OUTPATIENT               22
                   SNF                      24
                   HOME HEALTH              26
                   HOSPICE                  28
                   NOE/NOA                  49
                   ROSTER BILL ENTRY        87

                          ATTACHMENT ENTRY

                   HOME HEALTH              41
                   DME HISTORY              54
                   ESRD  CMS-382 FORM       57

   ENTER MENU SELECTION: 87


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

2. The Vaccine Roster for Mass Immunizers screen (Map 1681) appears:

```
MAP1681                    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC          VACCINE ROSTER FOR MASS IMMUNIZERS     C201135E HH:MM:SS

RECEIPT DATE: XXXXXX
OSCAR:                 DATE OF SERV:                  TYPE-OF-BILL:
NPI:             TAXO.CD:             FAC.ZIP
REVENUE CODE    HCPC       CHARGES PER BENEFICIARY



                       PATIENT INFORMATION
MID NUMBER   LAST NAME            FIRST NAME       INIT  BIRTH DATE  SEX
  ADMIT DATE               ADMIT TYPE   ADMIT DIAG   PAT STATUS   ADMIT SRCE




    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

➔ The **RECEIPT DATE** is system generated.

3. Complete the following fields:
   - Date of Serv (MMDDYY)
   - Type of Bill (key only the first two digits of the type of bill)
   - NPI (National Provider Identifier)
   - Fac. Zip
   - Revenue Code (up to 2 lines)
   - HCPC (up to 2 lines)
   - Charges per Beneficiary (up to 2 lines)

   Before completing the patient information, press *ENTER*.
   - Medicare ID Number
   - Last Name
   - First Name
   - Init (optional field)
   - Birth Date (MMDDCCYY)
   - Sex
   - Admit Type

➔ Before you can access the ADMIT TYPE field, you will need to press the Enter key after keying the first beneficiary's Medicare number, Last Name, First Name, Birth Date, and Sex code information. After you press *ENTER*, FISS will allow access to the ADMIT TYPE field for that first beneficiary, and any additional beneficiary information that needs to be entered.

➔ The Roster Bill screen allows entry of up to 10 beneficiaries; however, only four beneficiaries can be entered on the first screen. To continue the entry of information for the remaining beneficiaries, press *F6* to enter the next four beneficiaries and press *F6* again to enter the last two beneficiaries. When you have more than 10 beneficiaries to enter, refer to the "shortcut" information found below.

4. Press *F9* to submit the Roster Bill information into FISS. If the entered information is accepted, the message *RECORD SUCCESSFULLY ADDED* will display. You can continue to enter additional roster bill information or press *F3* to return to the Claim and Attachments Entry Menu.

   If, after you press *F9*, you do not see the message *RECORD SUCCESSFULLY ADDED* at the bottom of your screen, there is missing or invalid information entered on the roster bill. Some names may "disappear" from the list because their specific identification information was correct. Other names may remain because of identification problems (e.g., wrong Medicare ID, invalid date of birth, etc.). Reason codes explaining problems with the information will appear at the bottom left of the screen. Press *F1* to review the reason code narrative and then press *F3* one time to return to the roster bill. Correct the error and press *F9* again. If additional reason codes display, continue this process (F1, F3, F9) until all reason codes are eliminated. Your roster bill will not be stored or saved until all reason codes are resolved and you see the *RECORD SUCCESSFULLY ADDED* message at the bottom of the screen.

➔ **Shortcut:** You can use a shortcut to enter beneficiary information on the roster billing screen when you have more than 10 beneficiaries that received the same vaccine on the same day. After entering the required data above the "PATIENT INFORMATION" section of the roster bill screen, leave the MID Number field blank, but enter the rest of the beneficiary specific information. Enter the remaining nine beneficiaries' information accurately, and then press the *F9* key to submit the claim information. The accurate information for the nine will disappear and the information for the beneficiary with the blank MID Number field will remain along with the vaccination information at the top of the roster bill screen. Keep accurately entering and submitting (F9) the information for the remaining beneficiary – nine at a time – until all have been billed. You can then correct your intentional error of leaving the MID Number field blank and submit the first beneficiary's information to Medicare by pressing F9.

➔ An example of a completed roster bill (how it looks before pressing F9) is pictured below.

```
MAP1681                    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC          VACCINE ROSTER FOR MASS IMMUNIZERS     C201135E HH:MM:SS

RECEIPT DATE: XXXXXX
OSCAR:                 DATE OF SERV: MMDDYY         TYPE-OF-BILL: 34
NPI: XXXXXXXXXX  TAXO.CD:              FAC.ZIP  XXXXX XXXX
REVENUE CODE    HCPC       CHARGES PER BENEFICIARY
    636        90654           15.00
    771        G0008           20.00


                        PATIENT INFORMATION
MID NUMBER   LAST NAME            FIRST NAME       INIT  BIRTH DATE  SEX
  ADMIT DATE               ADMIT TYPE   ADMIT DIAG   PAT STATUS   ADMIT SRCE
XXXXXXXXXX   PATIENT              JOHN               E      MMDDCCYY    M
                            9
XXXXXXXXXX   NAME                 MIA                       MMDDCCYY    F
                            9




    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Field Descriptions for Vaccine Roster for Mass Immunizers screen – Map 1681

Field Name	Description
RECEIPT DATE	System generated.
OSCAR	Online Survey Certification and Reporting System (OSCAR). No longer applicable.
DATE OF SERV	Date vaccine was administered. MMDDYY
TYPE OF BILL	Type of bill. Enter only the first 2 positions of the type of bill. HHAs enter 34 in this field.
NPI	National Provider Identifier.
TAXO. CD	Taxonomy code. Not required for home health and hospice providers.
FAC ZIP	Facility nine digit zip code of the provider or the subpart.
REVENUE CODE	Enter the appropriate revenue code(s).

Map 1681 Field Descriptions (continued)

Field Name	Description
HCPC	Enter the appropriate Healthcare Common Procedure Code System (HCPCS) code(s).
CHARGES PER BENEFICIARY	Total charge per patient for the revenue codes indicated.
MID NUMBER	Beneficiary's Medicare ID number.
LAST NAME	Beneficiary's last name.
FIRST NAME	Beneficiary's first name.
INIT	Beneficiary's middle initial. (optional)
BIRTH DATE	Beneficiary's date of birth. MMDDCCYY
SEX	Beneficiary's gender.
ADMIT DATE	Date of the admission (MMDDYY). Not applicable for home health and hospice providers.
ADMIT TYPE	Admission type. Required for claims received on/after April 1, 2011. Valid type of admission codes include: 1 – Emergency 2 – Urgent 3 – Elective 4 – Newborn 5 – Trauma 9 – Information not available Note: FISS does not allow access to the ADMIT TYPE field, until you press the Enter key. Therefore, enter the roster bill information for one beneficiary, and then press *ENTER* to allow access to the ADMIT TYPE field.
ADMIT DIAG	Admission diagnosis. Not applicable for home health and hospice providers.
PAT STATUS	Patient status code. Not applicable for home health and hospice providers.
ADMIT SRCE	Admission source code. Not applicable for home health and hospice providers.