

EZClaim Advanced 7
ANSI 837P

Clearinghouse
Manual

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EZClaim Medical Billing Software

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What to expect when enrolling for EDI services

1. EZClaim Rep contacts Customer to begin Enrollment process.
 - Confirms EZClaim Advanced 7 is updated to latest release, Internet connection and access to email.
 - Confirms Java is installed on computer. www.java.com/en/download/index.jsp
 - Confirms customer has received all enrollment documentation.
 - Confirms customer has been provided with a MedAvant Payer ID list.

2. Customer completes the Provider Enrollment Form, Credit Card Authorization and faxes to EZClaim at 248-651-9273.
 - Contacted by EZClaim Rep to confirm Enrollment data.

3. Using the Clearinghouse Manual, customer enters claim data for 2 claims (Including 1 Commercial claim and 1 BCBS, Medicare or Medicaid Claim. See Sample claim on page 7)
 - Customer faxes sample claims to EZClaim at 248-651-9273.
 - Contacted by EZClaim Rep for claim data entry corrections, if needed.
 - Final claim approval received from EZClaim.

4. EZClaim Rep sends Payer Agreements to customer by fax or email. Payer Agreements are completed by customer with assist from EDI rep.
 - Customer schedules a time with EZClaim Rep to go over any Payer Agreement questions.
 - Agreements are mailed to the Payer as indicated by MedAvant cover letter instructions.

5. EZClaim Rep schedules a remote session and assists customer in sending first batch of claims to MedAvant. (Customer will need the printed Clearinghouse Manual for the session.)
 - Customer prints 'test' claim report and faxes to EZClaim Rep.
 - Customer follows up with payers to check on the status of electronic claims approval. Once customer has received verbal or written approval, fax or email a notice of the approval to EZClaim Rep. See 'Contacting the Payer' page 4.

6. Customer moved to 'Production' status and is able to send electronic claims.

7. Customer retrieves Reports. See page19 for 'Report Overview'.

Have a Question? We have the Answers!

Q: When will I be able to submit claims electronically?

A: The enrollment period can vary depending upon the time your office has available to complete the steps required. EZClaim will begin the enrollment process as soon as all Enrollment forms are received by EZClaim. The enrollment process for some payers such as BCBS, Medicare and Medicaid could take longer depending on the requirements of that specific payer.

Q: When can I transmit my claims?

A: Claim transactions are accepted 24 hours a day, 365 days a year.

Q: When are my claims processed?

A: Claims are processed by MedAvant and sent to the Payers on the same business day.

Q: How will I know if my transmission is successful?

A: You will receive a "successful upload" message when we detect 100% of your submission has been received.

Q: How long does it take to receive a response on claims sent to the clearinghouse?

A: A Daily Verification Report (REC) report will be generated within 24 hours.

Q: If a claim is rejected at what point will I be charged again?

A: If the claim is rejected at the clearinghouse level, (not yet sent on to payer) you are not charged for a re-submission of that claim.

Q: How do I receive reports?

A: Each time you submit claims new reports are automatically downloaded for you to view on MedAvant FTP screen.

Q: What do I need to do with claims that are rejected?

A: You will need to correct the claim data in EZClaim and resubmit to the clearinghouse.

Q: Are there reports to show me the status of the claim at the Payer level?

A: Yes. Payer status reports (INS) are available 2-7 business days after processing depending on the Payer. See "Reports" at the end of this document.

Q: May I include a secondary insurance on my claims submitted electronically?

A: Secondary insurance may be submitted to those payers who accept secondary claims such as Medicare, Blue Cross and Medicaid. MedAvant is able to process MSP (Medicare Secondary Payer) claims.

Q: Some insurance companies are not included in the Payer Directory. Can I still submit those with my electronic claims?

A: Yes, you may submit all claims electronically and those not included in the Payer Directory will be mailed to the insurance carrier by the clearinghouse. Full address of the Payer must be entered. See the price list for paper claim pricing.

Helpful Tips when Contacting the Payer for ‘Electronic Claims Approval’

Q - Where can I find the Payer’s telephone number?

A -The Payer’s contact number may be on an EOB or go to the Payer’s web site for contact information. Also some Payer Agreements have a contact telephone number. EZClaim does not have individual Payer telephone numbers.

Before you contact the Payer have the following information available:

- A copy of your ‘Payer Agreement’.
- Group and/or Individual NPI’s PIN or PTAN numbers if applicable. (Refer to your copy of the Payer Agreement)
- The agreement ‘tracking’ number if the agreement was sent to the payer by a tracking method.

Contacting the Payer

If you are asked for your ‘Submitter’ number, explain that you will be submitting your claims through the clearinghouse MedAvant. The payer will then ask for your NPI, PIN or PTAN number.

What to ask the payer

“Have I been approved to submit my claims electronically through the clearinghouse MedAvant? What is the date of the approval?”

If you have been approved, ask the Payer if they would provide a written approval by fax, mail or email.

Notify EZClaim

Once you have written or verbal approval from the Payer, fax or email information to your EZClaim Rep. You will be contacted by your EZClaim Rep to begin submitting your electronic claims.
EZClaim fax - 248.651.9273

Payer Lists, Claim and ERA Agreements

www.medavanthealth.com/payerlist

1. For printing the **Payer List** click on the PDF format and print list.
(For required state specific **Claim and ERA Agreements** see instructions below)
2. For **Claim and ERA Agreements** click on the 'Searchable Payer List'.
3. Using the dropdown arrow select state. (See example below)

MedAvant Payer List Database

PAYER LIST SEARCH

All Payers
 Non-Par
 CO
 HI
 IL
 IN
 MI
 MN
 NY
 OH
 RI
 VA
 WI
 WY

Choose a group, then click "Submit" to return records based on that criteria.

Search for a specific Payer ID or Payer Name by entering the information in the text field, then click "Submit".

urrent Listing: CO

nt by clicking on column headings...

How to list	Par / Non-Par	Payer ID	Contract / Govt	ST	Payer Name	Provider ID Req.	Enrollment Authorization	Response Level from Payer	Test Required	M/D	Claims Agreement	ERA Agreement	Status
1:46:05	Non-Par	COACC	Comm.	CO	Access Behavioral Care			Payer Acknowledgment		M			
1:36:05	Non-Par	B9020	0venIT	CO	Blue Shield - Colorado -- Authen	Yes	Authorization	Payer Claim Status		M			
1:46:05	Non-Par	COACC	Comm.	CO	Colorado Access HMO			Payer Acknowledgment		M			
1:54:06	Non-Par	COMMO	Comm.	CO	Colorado Blue Advantage			Payer Acknowledgment		M			
1:57:05	Non-Par	COUSA	Comm.	CO	Colorado Kaiser Permanente (Colorado plans only "EXCEPT Colorado Springs")			Payer Acknowledgment		M			
1:57:06	Non-Par	K5RCS	Comm.	CO	Colorado Springs Kaiser Permanente (Colorado Springs plan only)			Payer Acknowledgment		M			
1:45:05	Non-Par	MR032	Govt	CO	DMERC - Colorado (Region C)	Yes	Enl. Auth.	Payer Claim Status		M			
1:45:05	Non-Par	COFHP	Comm.	CO	FHP of Colorado - HMO Claims Only			Payer Acknowledgment		M			
1:46:05	Non-Par	COFHP	Comm.	CO	FHP of Colorado - PPO			Payer Acknowledgment		M			

Sample Claim

This CMS-1500 Sample claim is for a single provider. Practices with 'Group' numbers may require additional information.

Confirm the Payer ID# has been entered in Payer Library.

1500

MEDICARE
555 MAIN STREET
ANYTOWN MI 55555

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA PICA <input type="checkbox"/>									
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT GEORGE G				3. PATIENT'S BIRTH DATE MM DD YY 10061947		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 222333444A7	
5. PATIENT'S ADDRESS (No., Street) 245 HIGHLAND AVE CITY: PATERSON STATE: NY ZIP CODE: 42356 TELEPHONE (Include Area Code): (555) 248 3434				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 245 HIGHLAND AVE CITY: PATERSON STATE: NY ZIP CODE: 42356 TELEPHONE (Include Area Code): (555) 248 3434		4. INSURED'S NAME (Last Name, First Name, Middle Initial) PATIENT GEORGE G	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER		11a. INSURED'S DATE OF BIRTH MM DD YY 10061947	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 10061947		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED: SIGNATURE ON FILE DATE					SIGNED: SIGNATURE ON FILE DATE				
14. DATE OF CURRENT: MM DD YY 01112008				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE REFERRING DOCTOR				17a. NPI 0987654321		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 8	
19. RESERVED FOR LOCAL USE				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
1. 1300.4 2. 1296.04				3. _____ 4. _____		F. \$ CHARGES 100.00		G. DAYS OR UNITS 1	
B. PLACE OF SERVICE 11				C. EMG 11		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 90807 MD		E. DIAGNOSIS POINTER 1	
1 11052008 11052008 11 90807 MD 1 100.00 1 NPI				2 11112008 11112008 11 90807 1 100.00 1 NPI		3 11122008 11122008 11 90807 TS 1 100.00 1 NPI		4 NPI	
5 NPI				6 NPI		25. FEDERAL TAX I.D. NUMBER 222333444		26. PATIENT'S ACCOUNT NO. 4567	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 300.00		29. AMOUNT PAID \$ 0.00		30. BALANCE DUE \$ 300.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # (555) 243 6654		SAMPLE DOCTOR 555 MAIN STREET ROCHESTER MI 55555	
SIGNED: SIGNATURE ON FILE 11252008				a. NPI		b.		# 1234567890	

Date of Current – Usually required by Medicare. Situational for other Payers.

Signature date required.

NUCC Instruction Manual available at: www.nucc.org

Setting Up Your Data

Before you will be able to submit claims to MedAvant, you must have your test claims set up in the following format! Please read instructions carefully. You will not be able to test until claims are set up in the MedAvant required format.

Step 1 - Setting up the Payer Library

Menu Location: Tools > Payer Library

MedAvant Payer ID# list: For an updated MedAvant Payer ID# list go to <http://www.medavanthealth.com/payerlist/> and print or download either the PDF or the Excel format. You will need a Payer ID for each insurance company that is set up in the Payer Library.

Name	Address	ST	Payer ID	Ins Type ...
AETNA	555 ROCHESTER ST.	MI	99999	C1
BLUE CROSS	555 MAIN STREET	MI	44444	GP
MEDICAID	4444 HIGHWAY	ND	76543	MC
MEDICARE	555 MAIN STREET	MI	66666	47

Add Payer Information to Library

Required: You must have a Payer entry and ID# for every insurance company you are sending claims electronically.

1. Enter name and address of Insurance carrier.
2. Enter Payer ID# in 'Payer ID' field.
3. Using the dropdown arrow select 'Ins. Type Code'.
4. Click on the 'Add/Save' button.
5. Payer information is now listed in the box below.

Edit Payer Information

To edit Payer information once it has been entered, highlight the Payer, click on 'Edit', change Payer information and then click on 'Add/Save'.

Step 2 - Physician, Organization and Facility Library

Click the 'Tools' menu and select 'Physician/Facility Library'

Setting up the Library correctly is very important for error free claim submission. Once the entries are made in the library, they will be selected on EZClaim's data entry screens. **This information must be entered before entering patient data.**

Physician Library Information

- Classification – Use dropdown arrow to select classification type. The classification determines in which list the name will appear. For example, if you select 'Billing', the name will only show in the Billing selection drop down (Box 33 on the 1500 form).

- Entity Type – ‘Person’ is an individual provider. ‘Non-Entity’ is an Organization, Agency, Company etc.
- ‘Specialty Code’ is not used.
- Notes, Fax and email is used for your reference only.
- To edit a current entry, click the name, make the changes and click the Save button.
- Under ‘Additional ID Numbers’ you must click in the blank line to bring up dropdown selection arrows.

Entering Billing Provider Information (Box 33 on CMS 1500 form)

1. Enter the Name of Provider, Agency or Business Name.

2. Select ‘Billing’ as Classification.
3. Select ‘Entity Type’ as ‘Person’ or ‘Non-Person’ if Agency or Business name.
4. Enter Last Name and First Name or Organization name.
5. Enter Address information.
6. Enter Individual or Organizational NPI number.
7. Using the dropdown arrow, select ‘Tax ID Type’ and enter number. DO NOT ENTER ‘SPECIALITY (TAXONOMY) CODE’ UNLESS REQUESTED BY INSURANCE COMPANY. ERRORS WILL BE GENERATED.

Note: As of May 23rd, Legacy numbers are not required for most insurance companies. If required, enter a Legacy number for a specific payer, follow directions below.

1. Select Payer by clicking in the blank line. Continue entering ID Type and either the providers Individual or Group ID Number. (If entering a Group number see Rendering Provider data entry below.) Click on ‘Save’.

2. Click on ‘Save’.

Entering Rendering Provider Information (Box 24j on CMS 1500 form)

If the Billing provider has obtained an Organizational NPI, the provider may also need a Rendering Provider entry for their Individual NPI/ Provider number.

1. Enter First and Last name.

Physician, Organization and Facility Library

Physician/Organization Library Entries: Use the Tab key to move to the next field. Enter to save.

DOCTOR JONES - Rendering
ABC LABS
MEDICAL GROUP
REFERRING DOCTOR
SAMPLE DOCTOR - Billing
SMITH COUNSELING

Full Name (Required)
DOCTOR JONES - Rendering

Classification: Rendering Select 'General' to include the entry in all

Entity Type: Person Non-Person Entity

Last Name or Organization Name if record is a Non-Person Entity:
JONES

First Name: DOCTOR Middle:

Address Line 1:
Address Line 2:

City, State, Zip:

Telephone: Fax:

E-Mail:

NPI: 0987654321 Specialty/Taxonomy Code:

Tax ID Type: Tax ID:
24 Tax ID Number 999888777

Additional ID Numbers (Legacy Numbers):

Payer	ID Type/Qualifier	ID Number
Del	MEDICARE - 555 MAIN STREET	Medicare Number-1C GB65432

Delete Library List Report Library Usage Report New Close Save

2. Select 'Rendering' as Classification.
3. Select 'Entity Type'.
4. Enter Last and First name.
5. Enter NPI number.
6. Using the dropdown arrow, select 'Tax ID Type' and enter number.
7. Click on 'Save'.

Entering Facility Information

Enter Facility information only if different than the Billing Provider information. (Box 33 of the 1500 form.)

1. Enter Facility Name.
2. Select 'Facility' Classification
3. Select 'Non-Person Entity'.
4. Enter Name and Address information.
5. Click on 'Save'.

Entering Referring Provider Information

1. Enter Name.
2. Select 'Referring' as Classification .
3. Select 'Entity Type'.
4. Enter Last and First names or Organization name.
5. Enter NPI number.
6. Enter required Additional ID numbers.
7. Click on 'Save'.

Step 3 - Patient/Insured Info Screen

- Recommend that date formats are set to MMDDYYYY. Go to Tools>Options>Default Print Options to set date format.
- Do not use initials or credentials. MR., MS., DR., MD, INC. etc.
- Do not use words such as 'SAME' or 'NONE' or 'N/A'.

NOTE: Refer to a CMS-1500 form for Box numbers.

Box 1 – Required - Select Insurance carrier check box.

Box 1a – Required - Enter Insured ID Number in this format, 222333444. Do not use dashes.

Box 2 & 5 - Enter Patient Information. (Once Patient Data is entered, you may use the 'Copy>' button to copy data to right side of form.)

Box 3 – Required - Enter Patient's Birth Date.

Box 4 – Required - Enter Insured information.

Box 6 – Required - 'Patient Relationship to Insured'.

Box 9 a-d – Situational: Other Insured Information – Enter secondary data only if submitting a secondary insurance for this claim. **Note:** Enter secondary insured's ID# on the Payer/Other Info tab.

Box 11 – Situational - Subscriber information is required if 'Subscriber' is different than 'Patient'.

Box 12 – Required - Check 'Patient Signature on File'.

Box 13 – Situational - Check 'Insured Signature on File' if you are requesting payment of this claim to be sent to the Provider.

Enter any other information requested by the insurance company.

Step 4 - Physician/Diagnostic Info Screen

Box 14 – Situational - Enter 'Date of Current' which is the date of current illness, injury or pregnancy.

Box 15 – Leave Blank

Box 17 – Situational - Use dropdown to select Referring Provider name and ID numbers previously set up in the Physician/Facility Library. (See Tools>Options>Physician/Facility Library) **Note: DME providers must enter Ordering Provider Info on the Charges screen>View Other Fields.**

Box 26 – Situational - Enter 'Patient Account Number'. You may use a number of your choice or go to Tools>Options>Data Entry Options and check the box for 'Automatically enter a Patient Acct. #'.

Box 27 – Required - Select 'Accept Assignment?' indicator.

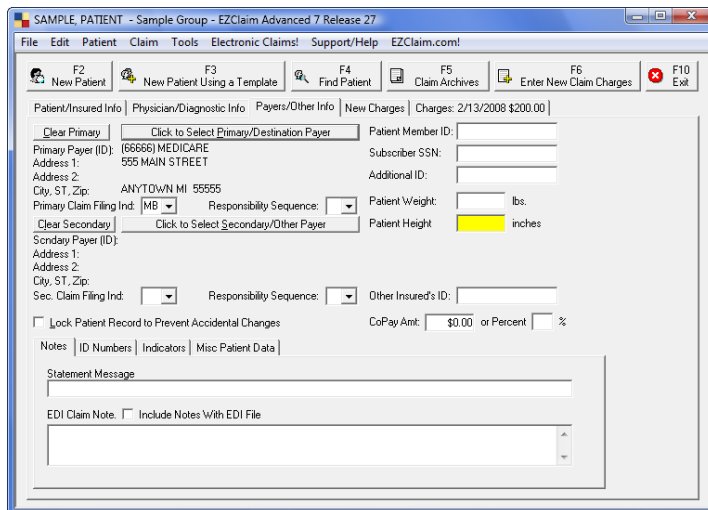
Box 31 – Required – Check 'Signature on File' or select name of Rendering Provider if required. Check 'Print Date' checkbox. (Rendering Provider ID/NPI numbers will be entered into Box 24j.)

Note: DME Companies do not use Rendering Providers. Leave the rendering provider field blank.

Box 32 – Situational - Enter 'Facility' information in Box 32 **only** if the Facility address is different than the Billing address in Box 33 unless required by your insurance company.

Box 33 – Required - Using the dropdown arrow, enter Physician or Agency Name previously set up in the Physician Library.

Step 5 - Payers and Others Info Screen



Primary/Destination Payer

1. Click on the 'Click to Select Primary/Destination Payer' button.
2. Select by highlighting the Primary/Destination Payer and click 'OK'.
3. **Required:** Using the dropdown arrow select 'Primary Claim Filing Indicator'.
4. **DO NOT** enter additional information unless requested by insurance company.

Secondary/Other Payer

NOTE: When submitting claims to a commercial insurance company, do not enter secondary claim information as the information will not be processed as 'Secondary'.

1. Click on the 'Click to Select Secondary/Other Payer' button.
2. **Required:** Using the dropdown arrow select 'Claim Filing Indicator'.
3. **Required:** Enter ID# of secondary insurance holder in Other Insured's ID Number.
4. **Situational: Do not enter the situational** information below unless required by your Payer or errors will be generated.
 - Resp Seq
 - Subscriber SS#
 - Patient Weight
 - Patient Height

Note: To delete a Payer on Payer/Others Info screen, click on the 'Clear Primary' or 'Clear Secondary' button.

EDI Claim Notes: To include notes with your electronic file, check the 'Include Notes with EDI' file checkbox.

Step 6 - New Charges Screen

Box 21 – Required - Enter Diagnostic codes. (Recommended that Diagnostic codes be entered without decimal points.)

Box 24A – Required - Click on the calendar to select 'Date of Service'.

Enter charges and other service line information.

Box 24B - Required - Place of Service: Must use 2 digits.

- 11 - Office
- 12 - Home
- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room - Hospital
- 24 - Ambulatory Surgical Center
- 25 - Birthing Center
- 26 - Military Treatment Facility
- 31 - Skilled Nursing Facility
- 32 - Nursing Facility
- 33 - Custodial Care Facility
- 34 - Hospice
- 41 - Ambulance - Land
- 42 - Ambulance - Air or Water
- 51 - Inpatient Psychiatric Facility
- 52 - Psychiatric Facility Partial Hospitalization
- 53 - Community Mental Health Center
- 54 - Intermediate Care Facility/Mentally Retarded
- 55 - Residential Substance Abuse Treatment Facility
- 56 - Psychiatric Residential Treatment Center
- 61 - Comprehensive Inpatient Rehab Facility
- 62 - Comprehensive Outpatient Rehab Facility
- 71 - State or Local Public Health Clinic
- 72 - Rural Health Clinic
- 81 - Independent Laboratory
- 99 - Other Unlisted Facility

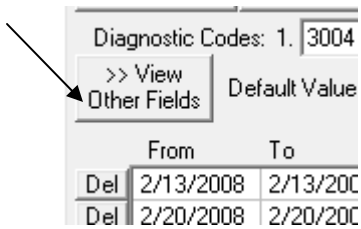
Box 24C – Situational – Enter EMG only if requested by your insurance company. Usually left blank.

Box 24D – Required - Enter Procedure Code

Box 24E - Required - Enter the diagnostic code line number (POINTER) on the charges line. Do not use the actual diagnosis code in this box, 24E, only pointers. Enter up to four pointers if necessary. Ex: 1234

Box 24J – Situational This data is pulled from the Rendering Provider information which has been selected on the Physician/Diag Info tab. If Rendering Provider information has not been selected on the Physician Diagnostic Info tab, use the dropdown arrow on the Charges tab to select Rendering Provider previously set up in the Physician/Facility Library.

NOTE: DME Companies do not use Rendering Providers. Leave the rendering provider fields blank. Also **DME** suppliers will need to select 'Ordering Provider' information on the 'View Other Fields' screen.

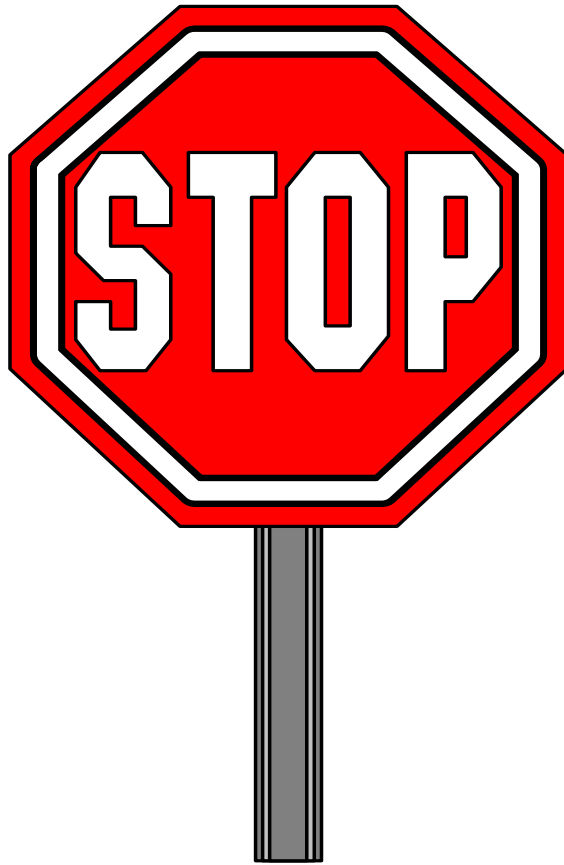


Step 7 - SAMPLE CLAIMS

If you have not yet submitted your **'Sample Claims'** to EZClaim, follow these instructions.

1. Go to the Patient/Insured screen and confirm that 'Print Form and Data' is checked on the bottom right of the screen.
2. Go to the Charges screen and click on 'Print 1500' button.
3. Fax Sample claims to EZClaim at 248.651.9273.

Uploading Claims to the Clearinghouse



Final Checklist Before Submitting Electronic Claims. These fields are REQUIRED or Errors will be generated.

- Are words such as SAME, NONE, N/A etc. removed from data? DR., MD., INC.?

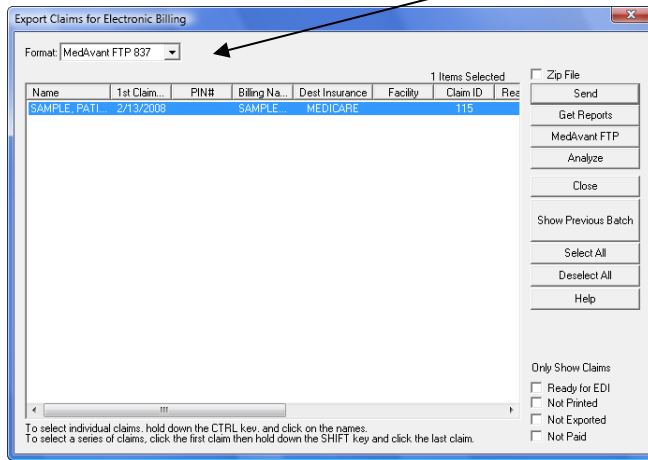
On the Physician/Diagnostic Tab:

- Is the 'Print Date' checkbox selected?
- Is the "Sig on File" checkbox selected?
- If required, is the Rendering Provider Name selected?
- If required is 'Accept Assignment' checked?

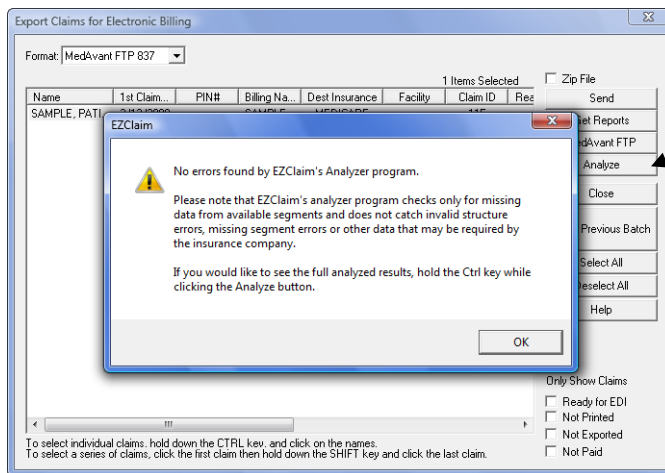
Do not Upload claims to the Clearinghouse until instructed by your EZClaim EDI Rep.

Step 8 - Submitting Claims Using EZClaim FTP

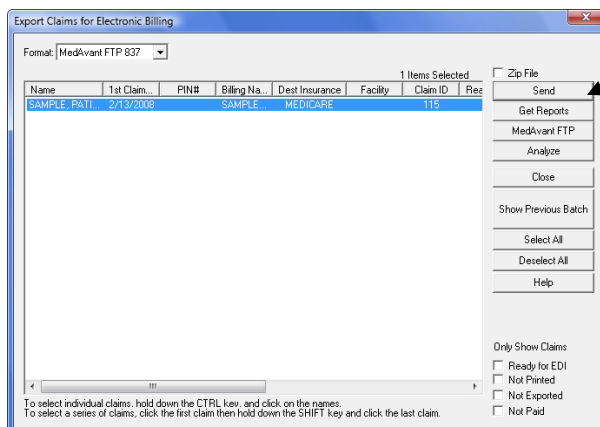
1. Go to 'Electronic Claims' on the Menu bar.
2. Using the dropdown arrow select 'MedAvant FTP 837'.



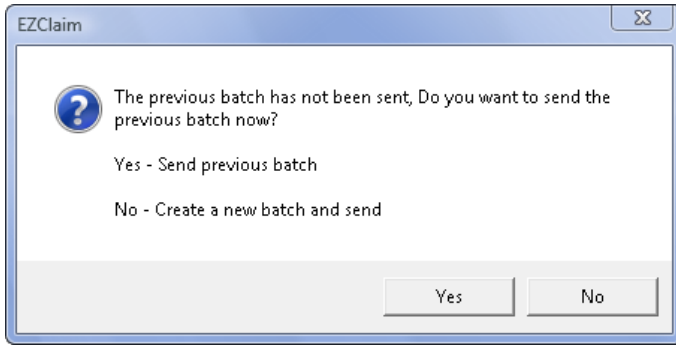
3. Select by highlighting claims to be exported.
4. Click on the 'Analyze' button.



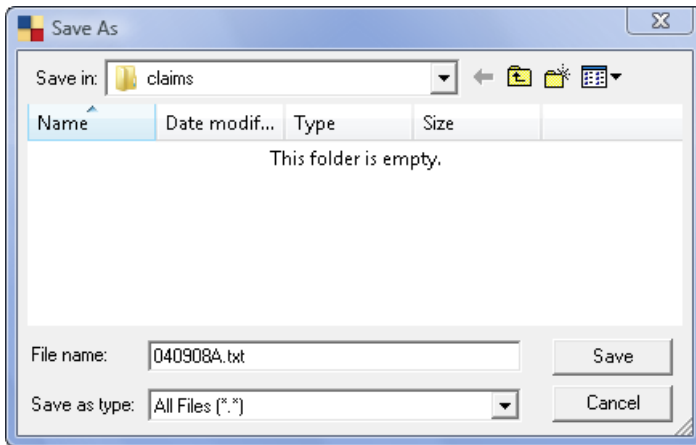
5. If the analyzed report states there are errors, return to the claim and correct errors. Once errors have been corrected, return to 'Electronic Claims' and continue.
6. If the report states there are no errors, click on OK, click on the 'Send' button.



NOTE: If a batch of claims is already waiting to be sent, you will receive the following message. Click 'Yes' to send a previous batch or 'No' to delete the previous batch.

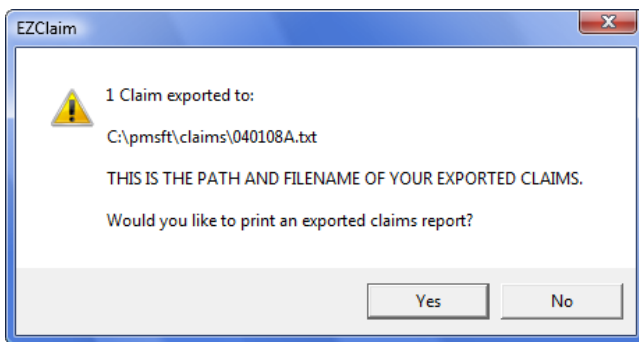


7. If clicking 'No', the 'Save As' box will appear and EZClaim will automatically enter the suggested file name.
8. Click on the 'Save' button.



NOTE: If sending more than one file per day, the file name will automatically change to reflect multiple submissions; do not change the file name.

9. Select 'Yes' to print an 'Exported Claims' Report. This 'Submission Report' will list the claims that have been batched together for submitting to the Clearinghouse. You must receive the message 'Upload Successful' to confirm your claims have been sent to the Clearinghouse

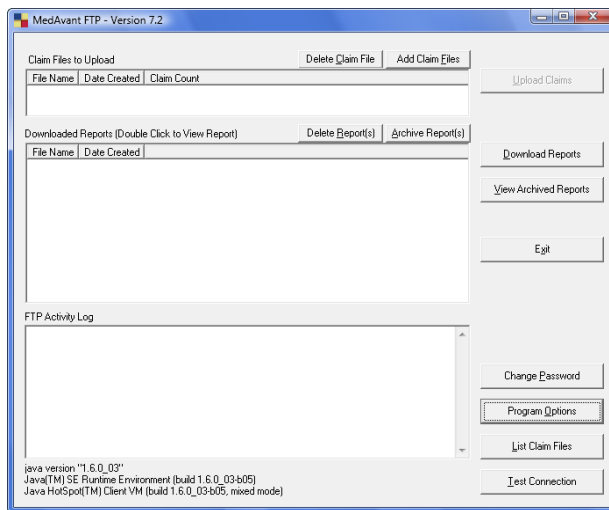


10. File will then automatically upload and a confirmation message, 'Claim File Upload Successful' will be displayed and transmission is complete. If the file fails to upload, see 'Common MedAvant Errors' page 20.



Step 9 - Reports

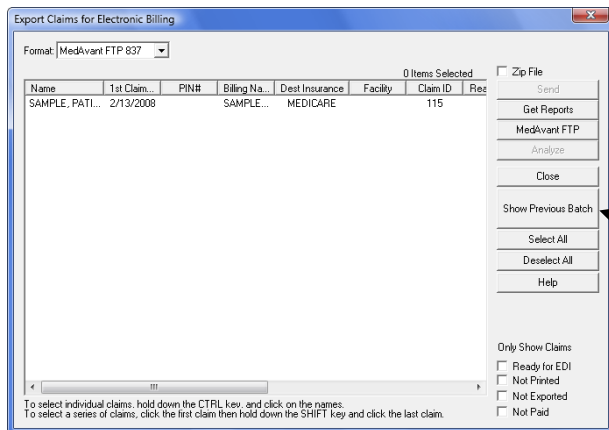
1. To download reports open the MedAvant FTP program and click on 'Download Reports'.



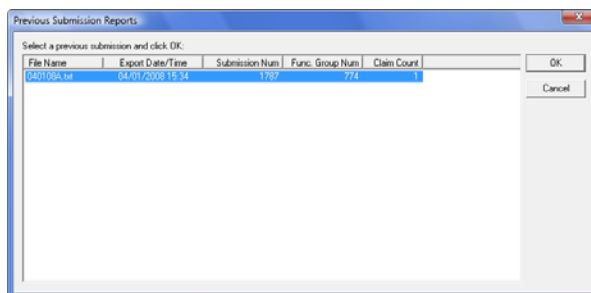
2. Double click on a Report file name to open
3. View Reports. If your report states that your claims have errors, make necessary changes to claims and resubmit.
4. To view FTP Activity Log click on 'List Claim Files'.

Step 10 - Resubmitting Claims

1. Go to the 'Electronic Claims' dialog box.
2. Click on the 'Show Previous Batch' button.



3. Highlight and then double click on the previous batch of claims to view.



4. Select by highlighting all claims or individual claims to re-export.
5. Click on the 'Send' button.
6. Confirm 'Claim File Upload Successful'.

Electronic Report Overview

MedAvant currently offers the following electronic reports to assist in the prompt and accurate processing of electronic submissions:

- (REC) – Daily Verification Report – Processed & Rejected**
- (INS) – Payor Response Report**
- (ARA) - Electronic Remittance Advice (835) Report***

Daily Verification Report (REC)

Daily Verification Report: This report is generated within 24 hours of submission and verifies each claim transmitted to MedAvant. The Status code indicates that the claim was Processed by MedAvant and has been submitted to the Payor for processing or that the claim was Rejected by MedAvant.

Payor Reports (INS)

Note: Not all payers will return each report. Some payers will provide Rejection reports only.

Payor Status Reports: These reports are provided 2-7 days after MedAvant processing and shows processing and adjudication information from the Payor. The Payor report types provided vary by Payor. The most common Payor report types are:

Payor Acceptance Report: This report indicates the Payor has received (accepted) the claim for further processing.

Payor Status Report: This report indicates that the Payor is processing the claim and has a processing update to report.

Payor Rejection Report: This report indicates the Payor has attempted to process the claim, but it contains invalid or missing information.

Common MedAvant Errors.

ACKNOWLEDGEMENT/RETURNED AS UNPROCESSABLE CLAIM ; PROVIDER OR AGENCY NOT APPROVED AS AN ELECTRONIC SUBMITTER

Provider is not enrolled with MedAvant.

BILLING PROVIDER PRIMARY IDENTIFICATION NUMBER IS MISSING OR INVALID (Box 33a)

The Primary Identifier must be either the NPI or Tax ID#. If insurance company is not accepting the NPI then the Tax ID# must be present.

BILLING PROVIDER SECONDARY IDENTIFIER IS MISSING OR INVALID (Box 33b)

Provider has not entered a required secondary ID# such as Medicare, Medicaid or BC.

BILLING PROVIDER SECONDARY QUALIFIER IS MISSING OR INVALID (Box 33b)

If a Qualifier has been entered, it may not be correct for that insurance company. Contact your insurance company for correct Qualifier use.

BILLING PROVIDER NOT ON FILE BATCH DELETED (Payer Error) Payer error generated when the provider had entered incorrect NPI/Legacy number in Box 33. Provider should contact insurance company for correct NPI/Legacy number data entry.

CLAIM FREQUENCY CODE IS MISSING OR INVALID. VALUE CANNOT BE 0 (ZERO)

Provider has entered a 'Resubmission Code' or an 'Original Ref' number ('View Additional Fields' on the charges screen). Remove code and resubmit claim.

CLAIM REJECTED AT CLEARINGHOUS FOR HIPAA COMPLIANCE

This error is a generic error. Usually MedAvant would need to be contacted for specific error. Contact your EZClaim rep.

DESTINATION PAYER SECONDARY IDENTIFIER IS MISSING, INVALID, OR GREATER THAN 30 BYTES

Payer requires a Secondary ID#. This error is usually generated when the Payer requires a 'Claim Office Number'. If submitting MedAvant print image, this number may be mapped in 10d, Reserved for Local Use. Contact EZClaim rep.

INVALID PROVIDER GROUP - (Payer Error) Payer error generated when the Provider is entering incorrect NPI or Legacy number in the Billing Provider info, Box 33. Contact insurance company for correct NPI and/or Legacy numbers.

PATIENT RELATIONSHIP TO INSURED CODE IS MISSING OR INVALID (Box 6)

Confirm that 'Relationship Code' has been entered. If Relationship Code has been entered, check for other missing Patient data. EX: Missing 'Patient Name'.

PLACE OF SERVICE CODE IS MISSING OR INVALID (Box 24B)

If the place of service code has been entered correctly then the error could refer to a missing Diag code line pointer.

PROCEDURE CODE MODIFIER IS MISSING OR INVALID (Box 24D)

Modifier is entered incorrectly, is invalid or the mapping is not picking the modifier up correctly. If Modifier is valid and entered correctly and error continues, contact EZClaim rep.

REFERENCE NUMBER IS MISSING OR INVALID

This error is generated when a reference number at the claim level is missing. It is usually an Authorization number or CLIA number. When submitting the 'Print Image', MedAvant must map CLIA numbers. Provider may need to contact EZClaim rep for mapping.

REFERRING PROVIDER SECONDARY IDENTIFIER IS MISSING, INVALID, OR GREATER THAN 30 BYTES (Box 17a) Confirm that 'Secondary ID#' has been entered and has the correct Qualifier.

RENDERING PROVIDER SECONDARY IDENTIFIER IS MISSING, INVALID (Box 24J)
Secondary Identifier is usually a Legacy number. Usually must be entered until insurance company accepts only the NPI.

RENDERING PROVIDER NAME / PRIMARY IDENTIFIER IS MISSING OR INVALID (Box 24j)
RENDERING PROVIDER FIRST NAME IS MISSING OR INVALID
This is usually generated if MedAvant is suppressing the NPI. Confirm Rendering Provider name has been entered. Contact EZClaim rep.

SERVICE FACILITY NAME / PRIMARY IDENTIFIER IS MISSING OR INVALID (Box 32)
Service Facility loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) loop. Do not enter Facility if same as Billing Info. Exception; Some Medicare carriers require Facility information. Provider is responsible for knowing billing requirements.

SUPPLEMENTAL DIAGNOSIS CODE IS MISSING OR INVALID
The DX code is missing or is an incorrect code. Code may require a 4th or 5th digit. Provider will need to confirm codes.

SUBSCRIBER MIDDLE NAME IS MISSING, HAS INVALID CHARACTERS, OR GREATER THAN 25 BYTES
This error is usually generate if the provider did not have 'M' or 'F' selected for the subscriber.

SUBSCRIBER PRIMARY IDENTIFICATION NUMBER IS MISSING OR INVALID
Confirm that the subscriber ID# is correct. If the same subscriber number had also been entered in Box 11, this error will be generated. The same subscriber ID# should not be in both Box 1a and Box 11.

SUBSCRIBER DATE OF BIRTH IS MISSING OR INVALID. MUST BE IN THE CCYYMMDD FORMAT
Confirm that DOB is correct. If DOB is correct, then check if they have M or F selected.

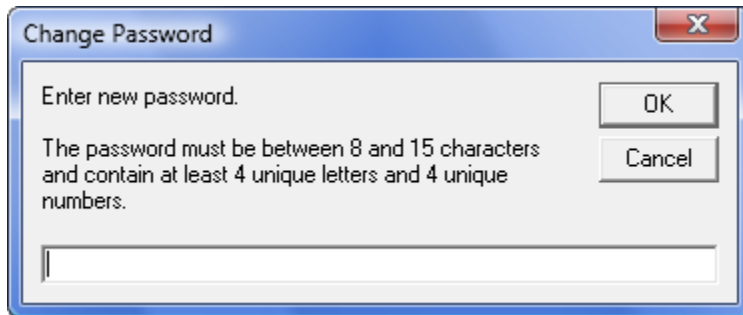
SUBSCRIBER SECONDARY IDENTIFICATION NUMBER QUALIFIER IS MISSING OR INVALID (BAD DATA: 1W)
The provider has entered a number in 'Additional ID#' on the Payers/Other Info tab. Delete number and resend claim.

SUBSCRIBER SECONDARY IDENTIFICATION NUMBER QUALIFIER IS MISSING OR INVALID (SY)
The subscriber's SSN is entered on the Payers/Other Info tab. Delete and resend. If the SSN is being automatically entered when importing data from Amazing Charts, update Import/Export wizard to latest release. (See EZClaim Updates web page.)

Troubleshooting

Changing Your Password

Do not change password until prompted by the FTP program. When your password needs to be changed, use at least 4 letters and 4 numbers. Do not repeat letters or numbers and use all lowercase letters. Ex: paul1234 or claim5678. Once your password is changed you will not need to enter it each time you submit claims.



Troubleshooting MedAvant FTP Submissions

File Upload Failed

Open the MedAvant FTP program and check to see if there are any files in the "Claim Files to Upload" field. Delete all files, exit the MedAvant FTP program, reselect claims, click Send, confirm the file name is correct, (ex:022807.txt) and resend file. File names cannot have spaces or characters such as / -. If sending more than one file per day, alter filename by at least one character for additional submissions. Ex:022807B.txt

Run-time Error 70 - Permission denied

Two possible solutions:

NOTE: MedAvant may occasionally have a service outage and you will receive this 'Error 70' message. Retry sending your claims at a later time.

1. Open the MedAvant FTP program and check to see if there are any files in the "Claim Files to Upload" field. Delete all files, exit the MedAvant FTP program, reselect claims, click 'Send', confirm the correct file name (ex:022807.txt) and resend file.

If you still receive Runtime Error 70, delete any claims in the 'Claim Files to Upload' box, close all programs and reboot computer.

2. After rebooting the computer, if clicking the 'Test Connection' button causes the error immediately, there is a computer/network permission issue. Possible causes include changes in computer network configuration.
3. If during the initial setup you click on the 'Test Connection' button and receive the following log:
File(s) not found

'File Upload Failed' (Error 141)

Open the MedAvant FTP program and click on the 'Test Connection' button. If 'Test Connection' is successful, check to see if there are any files in the "Claim Files to Upload" field. Delete all files, exit the MedAvant FTP program. In the Electronic Claims submission box reselect claims, click Send, confirm the correct file name (Ex:022807.txt or claims.txt) and resend file. File names cannot have spaces or characters such as / - and must have an extension of .txt

Note: If submitting more than one file per day, alter filename by at least one character for additional submissions. Ex:0228072.txt

If during the initial setup you click on the 'Test Connection' button and receive the following log:
File(s) not found **Client exited with (66)**

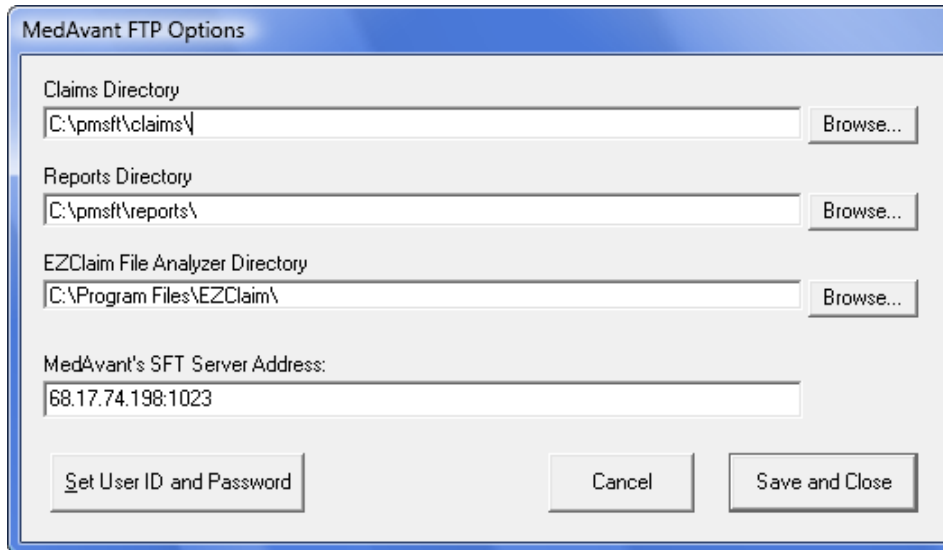
This error may occur on Vista machines. Update to the latest release of EZClaim to resolve the issue.

Client exited with (73)

If when clicking the Test Connection button you receive the following log:

```
Secure File Transfer Client  
Unknown Host
```

This means the internet connection is down or the client can not reach the web address. Confirm internet connection is working. Client may need to temporarily disable their virus software. One fix that has worked often is to change MedAvant's SFT Server Address from **pmsft.proxymed.com:1023** to **68.17.74.198:1023**. To change the setting, open the MedAvant FTP program, click the Program Setup button, change the setting, click the Save and Close button.



Client exited with (74)

If when clicking the Test Connection button you receive the following log:

```
Secure File Transfer Client  
IO Exception
```

This error means port 1023 is firewalled or not accessible. If it's worked in the past and you have not recently installed a firewall, rebooting your computer may resolve the issue. If this does not resolve the issue contact EZClaim.

Client exited with (120)

If during the initial setup you click on the 'Test Connection' button and receive the following log:

```
Authentication failed or Server Denied Login
```

Contact the clearinghouse to reset the initial login and password.

Client exited with (123)

If during the initial setup you click on the 'Test Connection' button and receive the following log:

```
Authentication failed or Server Denied Login
```

Contact the clearinghouse to reset the initial login and password.

Glossary

Legacy Numbers – Previously referred to as the Provider’s ‘PIN Numbers’.

Crosswalk Errors – Errors that refer to a conflict between a Provider’s NPI number and their Legacy numbers. NPI and Legacy numbers entered on claims MUST correspond with the information listed in the NPPES registry. <https://nppes.cms.hhs.gov>

Payor or Payer - ‘Payer’ or ‘Payor’ is often used to refer to an insurance company.

Insurance Carrier - Another name used to refer to an insurance company.

Intake or Enrollment– The process of being set up as an electronic submitter by the clearinghouse.

Payer Agreements – A document giving authorization for the clearinghouse to submit claims from the provider. A Payer agreement is usually required by BCBS, Medicare, Medicaid, Champus and Tri Care.

Electronic Approval – Once your ‘Payer Agreements’ have been approved by the insurance companies, the provider will receive ‘electronic approval’ to submit claims.

Payer ID# - An identification number used in electronic submission of claims to identify an insurance company. A list of payer’s and the ID#’s will be provided for setting up electronic claims.

EDI - Electronic Data Interchange - This acronym is commonly used to refer to electronic claims.

ERA – An ERA is an Electronic Remittance Advice file. It is the information previously received on an EOB, but in electronic format. It is referred to as an ANSI 835 file.

File Format - Type of file sent and/or received with electronic billing. Examples of file formats would be the ‘Print Image’ or ‘ANSI 837’. Each file format has the same type of information (patient name, services dates, etc), it’s just formatted differently.

CMS - Centers for Medicare and Medicaid Services - Government agencies that control Medicare and Medicaid. More information can be found at <http://www.cms.hhs.gov/>

HIPAA - Health Insurance Portability and Accountability Act of 1996 - Dictated the use of a new electronic file format. Also covers private medical information and security. EZClaim is HIPAA compliant in it’s electronic billing.

MSP – Medicare Secondary Payer is the term used to describe when another payer is responsible for paying the beneficiary’s claims before Medicare pays.

Export – Process in which you save claims to the computer to send to the clearinghouse.

TP – Acronym for ‘Trading Partner’

ANSI – Acronym used when designating electronic billing formats. Examples are ANSI 837 for claims, or ANSI 835 for EOBs.

EZClaim Implementation - How Did We Do?

Client Name _____ Client ID # _____

Contact Person _____

EZClaim EDI Rep _____

Implementation Date _____

After completing each section during the remote assist session please place a check in the box.

Fax completed form to EZClaim at (248) 651-9273 after the implementation appointment.

Remote Assist Topics:

	Data entry guidelines for electronic claims.
	Payer ID codes, their placement within the payer library, and what happens if they are missing from the claims.
	Physician Library entries and their connection to CMS 1500 form.
	Creating an electronic claim file to upload to MedAvant with appropriate file naming convention (example 082807.txt).
	Uploading an electronic claim file to MedAvant and printing a submission report.
	Knowing how and where to retrieve the MedAvant Reports (REC, INS, & ARA).
	Understanding MedAvant Daily Verification Report and Payer Response Report. Refer to page 19 in EZClaim Clearinghouse Manual for details.
	Common MedAvant claim errors. Refer to page 20 in EZClaim Clearinghouse Manual for details.
	Troubleshooting MedAvant errors. Refer to page 22 in EZClaim Clearinghouse Manual.

Comments: