

Chapter VII: ONLINE REPORTS VIEW Submenu (04)

Overview

Summary

This chapter addresses the various file options housed within the **ONLINE REPORTS VIEW** submenu.

In This Chapter

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Accessing the ONLINE REPORTS VIEW Submenu

Purpose This section will explain how to access the **ONLINE REPORTS VIEW** submenu from the **MAIN MENU**.

```

MAP1701

                                MAIN MENU

                                01  INQUIRIES
                                02  CLAIMS/ATTACHMENTS
                                03  CLAIMS CORRECTION
                                04  ONLINE REPORTS VIEW

ENTER MENU SELECTION: 04

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

Task: To access the **ONLINE REPORTS VIEW** submenu from the **MAIN MENU**, follow these steps:

STEP	ACTION
1	Key "04" at the ENTER MENU SELECTION: prompt.
2	Press <Enter>.

Summary of Reports (R1)

Purpose This option allows the provider to review a list of all reports currently available to view online. Additionally, the provider will be able to view the data contained within each report.

```

MAP1671          M E D I C A R E A O N L I N E S Y S T E M
                  O N L I N E R E P O R T S S E L E C T I O N
REPORT NO

SEL REPORT NO.  FREQUENCY  DESCRIPTION
                050        DAILY    CLAIMS RETURNED TO PROVIDER
                201        WEEKLY   PENDING/PROCESSED/RETURNED
                702        DAILY    ACS APPEALS RECEIVED

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT  MAP1671
    
```

Task: To access the **SUMMARY OF REPORTS** option from the **FISS ONLINE REPORTS VIEW** submenu, follow these steps:

STEP	ACTION
1	Key "R1" at the ENTER MENU SELECTION: prompt.
2	Press <Enter>.

Initial ONLINE REPORTS SELECTION Screen Upon Selecting the SUMMARY OF REPORTS Option

```

MAP1671          M E D I C A R E A O N L I N E S Y S T E M
                  O N L I N E R E P O R T S S E L E C T I O N
REPORT NO

SEL REPORT NO.  FREQUENCY  DESCRIPTION

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD
    
```

Task: To view a listing of all reports available through the FISS online system, follow this step:

STEP	ACTION
1	Press <Enter>.

ONLINE REPORTS SELECTION Screen After Pressing <Enter>

```

MAP1671          M E D I C A R E  A  O N L I N E  S Y S T E M
                   O N L I N E  R E P O R T S  S E L E C T I O N
REPORT NO
SEL REPORT NO.  FREQUENCY  DESCRIPTION
S      050      DAILY      CLAIMS RETURNED TO PROVIDER
      201      WEEKLY     PENDING/PROCESSED/RETURNED
      702      DAILY      ACS APPEALS RECEIVED

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT  MAP1671
    
```

Task To view data contained within a report, follow these steps:

STEP	ACTION
1	Key <S> next to the report that you wish to view, under the SEL field.
2	Press <Enter>.

INITIAL REPORTS Screen Upon Making Selection (MAP1661)

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL L
KEY XXXXXX          PAGE 000001  SEARCH

PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
    
```

Task To view the data for the selected report, follow these steps:

STEP	ACTION
1	Key the report number in the REPORT field.
2	Key the appropriate frequency in the FREQUENCY field. Valid Values: D = Daily W = Weekly M = Monthly
3	Key in the appropriate provider number in the KEY field.
4	Press <Enter> .

You will now be viewing the data for the selected report.

View a Report (R2)

Purpose This option allows the provider to go directly to **MAP1661** for report viewing.

```

MAP1705

                                ONLINE REPORTS MENU

                                R1    SUMMARY OF REPORTS

                                R2    VIEW A REPORT

                                R3    CREDIT BALANCE REPORT - CMS 838

ENTER MENU SELECTION: R2

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

Task To access the **VIEW A REPORT** option from the **FISS ONLINE REPORTS VIEW** submenu, follow these steps:

STEP	ACTION
1	Key "R2" at the ENTER MENU SELECTION: prompt.
2	Press <Enter>.

INITIAL REPORTS Screen upon Selecting the VIEW A REPORT Option

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL L
KEY XXXXXX                                PAGE 000001  SEARCH

SELETED REPORT NOT AVAILABLE
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
    
```

Note: You will now be viewing **MAP1661**. This is the same screen that you were brought to through option **R1**. Go ahead and key in the **REPORT**, **FREQUENCY**, and **KEY** data in the respective fields, then press <Enter> to view the report data.

Credit Balance Report (R3)

```
MAP1701
                                MAIN MENU
                                01   INQUIRIES
                                02   CLAIMS / ATTACHMENTS
                                03   CLAIMS CORRECTION
                                04   ONLINE REPORTS
                                04
ENTER MENU SELECTION: 04
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Task To access Online Reports, follow these steps:

STEP	ACTION
1	Key "04" at the ENTER MENU SELECTION: prompt.
2	Press <Enter>.

```

MAP1705
                                ONLINE REPORTS MENU

                                R1    SUMMARY OF REPORTS
                                R2    VIEW A REPORT
                                R3    CREDIT BALANCE REPORT - CMS 838

ENTER MENU SELECTION:    R3

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

Task To access the **CREDIT BALANCE REPORT – CMS 838** option from the **FISS ONLINE REPORTS VIEW** submenu, follow these steps:

STEP	ACTION
1	Key "R3" at the ENTER MENU SELECTION: prompt.
2	Press <Enter>.

Initial ONLINE REPORTS SELECTION Screen upon selecting the CREDIT BALANCE REPORT CMS – 838 INQUIRY option

From this screen (MAP 1B21), to enter a credit balance you will put a 'Y' in the 838 entry field. The system will return the credit balance entry screen.

```

MAP1B21                                ACMMMA561 02/07/09
RZ05318    CREDIT BALANCE REPORT - FORM 838 INQUIRY    C200919E 12:09:30

PROVIDER: XX0XXX    STARTING HIC:    838 ENTRY: y

HIC    BENEFICIARY NAME    FROM    THRU    QUARTER
---NUMBER---    -----LAST FI-----    TOB    DATE    DATE    ENDING

MSG:

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

MAP 1B22 – Credit Balance Report Entry

```

MAP1B22                                ACMMMA561 02/07/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 ENTRY          C200919E 12:16:52
                                                                MNT: RZ05318

PROVIDER: XX0XXX
HIC NUMBER: 123456789A          ICN/DCN: 20810600000408
TOB:          FROM/THRU DATE:          PAID DATE:
CONTACT PERSON: JOHN DOE          PHONE NUMBER: 555 555 5555
BENEFICIARY NAME: LAST PATIENT          FIRST INITIAL: M
QUARTER ENDING: 200812          CREDIT BALANCE AMOUNT:          3000.00
CREDIT BALANCE REASON: 1          AMOUNT REPAID:          3000.00
VALUE CODE:          MEDICARE AMT OUTSTANDING:          0.00
MEDICARE PART: A          METHOD OF PAYMENT: A
                                COST REPORT STATUS: O

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
CITY:          STATE:          ZIP CODE:
REMARKS:

MSG:

PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE
HARDCOPY MEDICARE CREDIT BALANCE RPT CERTIFICATION REQD FOR EACH QUARTER
    
```

Provider number – this field auto populates with your provider number (Note: if you have a different provider number you want to enter, you will have to overlay the existing number)

HIC Number – enter the beneficiary’s HIC number in this field <ENTER>

ICN/DCN – enter the Internal Control Number/Document Control Number <ENTER>

Type of Bill (TOB) and From/Thru Date and Paid Date – these fields auto populate

Contact Person – enter the name of the contact person at your facility

Phone Number – enter the telephone number for the contact person at your facility

Quarter Ending – this field auto populates

Credit Balance Amount – enter the amount of your credit balance in this field

Credit Balance Reason – enter the reason for the credit balance

- 1 = duplicate payment
- 2 = primary payment by another insurer
- 3 = other (provide an explanation in remarks for reason 3)

Amount repaid – enter the amount of the credit balance being repaid

Value Code – this field is completed if the credit balance was caused by a payment when Medicare was not the primary payer

Medicare Amt. Outstanding – enter amount of the Medicare credit balance that remains outstanding. Shows a zero if you made full payment

Medicare Part – enter ‘A’ or ‘B’ as applicable

Method of Payment – choose one of the following

- C = check
- A = adjustment (hard copy)
- Z = combination of adjustment and check
- X = adjustment submitted electronically

Cost Report Status – choose one of the following

- O= open Medicare cost reporting period
- C = closed Medicare cost reporting period

Primary Payer Name – Name of the primary insurer (if MSP)

Primary Payer Address – Street, City, State and Zip Code

Remarks – complete this field with any additional information or explanation when billing credit balance reason '3'

MSG – error message will be displayed if needed (see detailed error messages provided)

Example of Credit Balance Successfully Added

Once you store F9/PF9 you should received this message and can begin to enter the next credit balance.

```

MAP1B22                                ACMMA561 02/24/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 ENTRY          C20091WF 08:48:40
                                                    MNT:

PROVIDER: XXX0XX
HIC NUMBER:                                ICN/DCN:
TOB:          FROM/THRU DATE:              PAID DATE:
CONTACT PERSON:                            PHONE NUMBER:
BENEFICIARY NAME: LAST                     FIRST INITIAL:
QUARTER ENDING: 200812                    CREDIT BALANCE AMOUNT:
CREDIT BALANCE REASON:                    AMOUNT REPAID:
VALUE CODE:                               MEDICARE AMT OUTSTANDING:
MEDICARE PART:                            METHOD OF PAYMENT:
                                                    COST REPORT STATUS:

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
      CITY:                                STATE:              ZIP CODE:
REMARKS:

MSG:

RECORD SUCCESSFULLY ADDED PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
    
```

MAP1B21 Credit Balance Report – Form 838 Inquiry

DDE inquiry screen displays the credit balance information that has already been entered. Select 'R3' from the on-line reports menu.

```

MAP1B21                                ACMA561 02/19/09
RZ05318      CREDIT BALANCE REPORT - FORM 838 INQUIRY      C20091VF 09:29:55

PROVIDER: XX0XXX      STARTING HIC:                                838 ENTRY:

      HIC      BENEFICIARY NAME      FROM      THRU      QUARTER
      ---NUMBER---      -----LAST FI-----      TOB      DATE      DATE      ENDING

MSG:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

```

Press <ENTER>.

The Inquiry screen will be populated with the HIC numbers that have been entered during the current quarter.

```

MAP1B21                                ACMA561 02/19/09
RZ05318      CREDIT BALANCE REPORT - FORM 838 INQUIRY      C20091VF 09:31:53

PROVIDER: XX0XXX      STARTING HIC: 123456789A      838 ENTRY:

      HIC      BENEFICIARY NAME      FROM      THRU      QUARTER
      ---NUMBER---      -----LAST FI-----      TOB      DATE      DATE      ENDING
      123456789A      PATIENT      A 11M      061108      061308      200812
      123456789A      PATIENT      A 111      010109      011109      200812

MSG:

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT

```

Sample of Submitted Credit Balance Reports

From the list of credit balances HIC numbers already entered you can perform the following functions:

'S' = the select option will display the credit balance information that was entered for that HIC number by the provider

'D' = the delete option will remove the HIC number and the previously-entered credit balance information

'U' = the update option will display the credit balance information and allow the provider to update the information previously stored

Please note: 30 days after the quarter end date all available information will be removed.

MAP1B21 Credit Balance Report – Update

Screen sample for updates to the credit balance report.

This is a screen sample of how to update a credit balance, after you select 'R3' you will be on the inquiry screen, you place a "U" next to the HIC number you want to update and <ENTER>.

```

MAP1B21                                ACMA561 02/19/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 INQUIRY          C20091VF 09:31:53

PROVIDER: XX0XXX          STARTING HIC: 123456789A          838 ENTRY:

          HIC          BENEFICIARY NAME          FROM THRU QUARTER
          ---NUMBER---          -----LAST FI----- TOB DATE DATE ENDING
U          123456789A          PATIENT          A 11M 061108 061308 200812
          123456789A          PATIENT          A 111 010109 011109 200812

MSG:

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
    
```

MAP1B22 Credit Balance Report – Update

Screen sample for updates to the credit balance report.

When 'U' for update is accessed and changes are performed the F9/PF9 key will be displayed as an option at the bottom of the screen. The F9/PF9 is used to store the updated record.

```

MAP1B22                                ACMA561 02/19/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 UPDATE          C20091VF 09:37:39
                                                MNT: RZ05318 02/19/09

PROVIDER: XX0XXX
HIC NUMBER: 123456789A          ICN/DCN: 19930200000708
TOB: 111 FROM/THRU DATE: 010109 011109 PAID DATE: 020909
CONTACT PERSON: JOHN DOE          PHONE NUMBER: 555 555 5555
BENEFICIARY NAME: LAST PATIENT          FIRST INITIAL: A
QUARTER ENDING: 200812          CREDIT BALANCE AMOUNT:          5000.00
CREDIT BALANCE REASON: 1          AMOUNT REPAID:          5000.00
VALUE CODE:          MEDICARE AMT OUTSTANDING:          0.00
MEDICARE PART: A          METHOD OF PAYMENT: A
                                                COST REPORT STATUS: C

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
CITY:          STATE:          ZIP CODE:
REMARKS:

MSG:

PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE
    
```

MAP1B21 Credit Balance Report – Delete

Screen sample for deletes to the credit balance report.

This is a screen sample of how to delete a credit balance, after you select 'R3' you will be on the inquiry screen, you place a "D" next to the HIC number you want to delete and <ENTER>.

```

MAP1B21                                ACMA561 02/19/09
RZ05318      CREDIT BALANCE REPORT - FORM 838 INQUIRY      C20091VF 14:28:08

PROVIDER: 330101      STARTING HIC: 001010810A      838 ENTRY:

      HIC      BENEFICIARY NAME      FROM THRU QUARTER
      ---NUMBER---      -----LAST FI----- TOB  DATE  DATE  ENDING
      123456789A      PATIENT      A 11M  061108 061308  200812
D 123456789A      PATIENT      A 111  010109 011109  200812

MSG:

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT
    
```

MAP 1B22 – Credit Balance Report - Delete

When 'D' for delete is selected, this option will remove the HIC number and the previously entered credit balance information.

If the HIC number/Credit balance was entered in error, hit F9/PF9 to delete.

The F9/PF9 is listed on the bottom screen.

```

MAP1B22                                ACMA561 02/19/09
RZ05318      CREDIT BALANCE REPORT - FORM 838 DELETE      C20091VF 14:39:58
                                                MNT: RZ05318 02/19/09

PROVIDER: XX0XXX
HIC NUMBER: 123456789A      ICN/DCN: 19930200000708
TOB: 111 FROM/THRU DATE: 010109 011109 PAID DATE: 020909
CONTACT PERSON: JOHN DOE      PHONE NUMBER: 555 555 5555
BENEFICIARY NAME: LAST PATIENT      FIRST INITIAL: A
QUARTER ENDING: 200812      CREDIT BALANCE AMOUNT:      5000.00
CREDIT BALANCE REASON: 1      AMOUNT REPAID:      5000.00
VALUE CODE:      MEDICARE AMT OUTSTANDING:      0.00
MEDICARE PART: A      METHOD OF PAYMENT: A
                                                COST REPORT STATUS: C

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
CITY:      STATE:      ZIP CODE:
REMARKS:

MSG:

PRESS PF3-EXIT PF7-PREV PAGE PF9-DELETE ENTER-CONTINUE
    
```

Credit Balance Error Messages

When an error has been encountered, you will see a message at the bottom of the screen. In this example, you can see the HIC number and DCN are required

The following error messages will be displayed on the entry screen when an error is encountered:

1. If a HIC and DCN is not entered return the following error message: "HIC and DCN numbers required".
2. If a HIC/DCN combination does not match a HIC/DCN present in the FISS, return the following error message: "No match for the HIC and DCN numbers entered".
3. If a duplicate HIC/DCN combination record is entered during the same report quarter, return the following error message: "Duplicate HIC and DCN entered for same quarter".
4. If the type of bill present is equal to 'xx0' (Third digit = zero), return the following error message: "Type of bill for HIC/DCN entered = xx0 - no credit balance required". FS5106 - Add Credit Balance Process to System July 2008 Fiscal Intermediary Standard Systems 101"
5. If the contact name and phone number information is not entered, return the following error message: "Contact name and phone number required."
6. If the phone number is entered with non-numeric data, return the following error message: "Phone number must be numeric."
7. If the beneficiary name: last and first initial is not entered, return the following error message: "Beneficiary last name and first initial required."
8. If the quarter ending date is entered with non-numeric data, return the following error message: "Quarter end must be numeric".
9. If the quarter ending date month not equal to 03, 06, 09 or 12, return the following error message: "Quarter end month must equal 03, 06, 09 or 12."
10. If the quarter ending date year is greater than the current year, return the following error message: "Quarter end year must be less than or equal to current year."
11. If the quarter ending date entered is within the current quarter, return the following error message: "Credit balance report not allowed until quarter ends."
12. If the credit balance reason is equal to '1' or '3,' a Medicare amount outstanding can not be present; or if the credit balance reason is equal to '2' and the paid date is not greater than 60 days prior and a Medicare amount outstanding is present, return the following error message: "MED AMT outstanding invalid with bal reason 1, 3 or 2 & PDDT > 60 days prior."
13. If a credit balance amount is not entered, return the following error message: "Credit balance amount required."
14. If the credit balance amount is entered with non-numeric data, return the following error message: "Credit balance amount must be numeric."
15. If the credit balance reason is equal to '1' and the credit balance amount and amount repaid is not equal, return the following error message: "credit balance reason equals 1: credit balance amount and amount repaid must equal."
16. If the credit balance reason is equal to '1' and an amount outstanding is present, return the following error message: "Credit balance reason equals 1: amount outstanding must equal zero."
17. If the credit balance reason is equal to '2' and the value code, payer name or address is blank, return the following error message: "Credit balance reason equals 2: value code, payer name and address required."

18. If the credit balance reason is equal to '3' and the remarks are blank, return the following error message: "Credit balance reason equals 3: remarks required."
19. If the quarter ending date entered is prior to the current quarter, return the following error message: "quarter ending date entered is prior to current quarter."
20. If the credit balance amount minus the amount paid is not equal to the amount outstanding, return the following error message: "Credit balance amount minus amount paid must equal amount outstanding."
21. If the amount repaid is non-numeric, return the following error message: "Amount repaid must be numeric."
22. If the cost report status field is not equal 'O' or 'C,' return the following error message: "cost report status invalid: valid values 'O' or 'C'."
23. If the method of payment field is not equal to 'A,' 'C,' 'X' or 'Z,' return the following error message: "Method of payment invalid: valid values 'A,' 'C,' 'X' or 'Z'."
24. If the method of payment is equal to 'X' and the credit balance amount and amount repaid values are not equal, return the following error message: "Method of payment = X: credit balance amount and amount repaid must equal."
25. If the Medicare amount outstanding field value is non-numeric, return the following error message: "Medicare amount outstanding must be numeric."
26. If the credit balance reason is not equal to '1,' '2' or '3,' return the following error message: "Reason for credit balance invalid: valid values '1,' '2' or '3'."
27. If the value code present is not equal to 12-16, 41, 42, 43, 44 or 47, return the following error message: "Value code, if present, must equal 12-16, 41, 42, 43, 44, or 47."
28. If the payer name and address is present and the credit balance reason is not equal to '2,' return the following error message: "Payer name and address present: credit balance reason must equal '2'."
29. If the provider number entered is not valid, return the following error message: "Invalid provider number entered. Please reenter provider number."

Examples of Credit Balance Error Messages

```

MAP1B22                                ACMMA561 02/19/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 ENTRY          C20091VF 14:45:24
                                                MNT: RZ05318

PROVIDER: XX0XXX
HIC NUMBER:                                ICN/DCN:
TOB:          FROM/THRU DATE:                    PAID DATE:
CONTACT PERSON: JOHN DOE                          PHONE NUMBER: 555 555 5555
BENEFICIARY NAME: PATIENT                          FIRST INITIAL: A
QUARTER ENDING: 200812                            CREDIT BALANCE AMOUNT:      4000.00
CREDIT BALANCE REASON: 1                          AMOUNT REPAID:              4000.00
VALUE CODE:                                        MEDICARE AMT OUTSTANDING:    0.00
MEDICARE PART:                                    METHOD OF PAYMENT: X
                                                COST REPORT STATUS:

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
CITY:                                STATE:                ZIP CODE:
REMARKS:

MSG: HIC AND DCN NUMBERS REQUIRED

PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE
HARDCOPY MEDICARE CREDIT BALANCE RPT CERTIFICATION REQD FOR EACH QUARTER

```

```

MAP1B22                                ACMMA561 02/19/09
RZ05318          CREDIT BALANCE REPORT - FORM 838 ENTRY          C20091VF 14:49:41
                                                MNT: RZ05318

PROVIDER: XX0XXX
HIC NUMBER: 123456789A                    ICN/DCN: 20730600000008
TOB:          FROM/THRU DATE:                    PAID DATE:
CONTACT PERSON:                                PHONE NUMBER:
BENEFICIARY NAME: LAST PATIENT                    FIRST INITIAL: A
QUARTER ENDING: 200812                            CREDIT BALANCE AMOUNT:      6000.00
CREDIT BALANCE REASON: 1                          AMOUNT REPAID:              6000.00
VALUE CODE:                                        MEDICARE AMT OUTSTANDING:    0.00
MEDICARE PART: B                                  METHOD OF PAYMENT: X
                                                COST REPORT STATUS: O

PRIMARY PAYER NAME:
PRIMARY PAYER ADDRESS: STREET:
CITY:                                STATE:                ZIP CODE:
REMARKS:

MSG: CONTACT NAME AND PHONE NUMBER REQUIRED
CONTACT PHONE NUMBER MUST BE NUMERIC

PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE
HARDCOPY MEDICARE CREDIT BALANCE RPT CERTIFICATION REQD FOR EACH QUARTER

```

About the 201 Pend Report

Purpose The 201 Pend Report is designed to *assist providers in accessing information regarding the status of their submitted claims*. This report is available to view directly through the **FISS online system**.

The 201 report has **three main sections**:

- “Summary of Pended Claims”;
- “Summary of Processed Claims”; and
- “Summary of Returned Claims”

Each summary section of the report provides a separate count for both **original claims** and **adjustment claims**. Each report section is labeled based on **type of bill** (TOB).

The **last page** of the 201 Pend Report contains a summary of the pended, processed, and returned sections. This page of the report is titled “Claims Summary Totals.”

The remainder of this section will address the information contained within each section of the 201 Pend Report, and will show you how the report will visually appear online.

Whenever you are viewing a report on the FISS online system, you will need to *toggle between a “left to right” viewing screen environment*. To accomplish this, you will use your <PF11> key to move your viewing screen to the right, and your <PF10> key to return your viewing screen to the left.

Summary of Pended Claims– First Report Section

Claims will remain on the **SUMMARY OF PENDED CLAIMS** section of the report until they are either paid, rejected, or return to provider (RTP).

The following two screen prints show you how the **SUMMARY OF PENDED CLAIMS** section appears on the FISS online system:

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL L
KEY XXXXXX          PAGE 000001  SEARCH
REPORT: 201
CYCLE DATE: 6/13/08
BLUE CROSS CODE: 0723
MEDICARE PART A - 00
SUMMARY OF PENDED CLAIM
INPATIENT
RECD  ADMIT
DATE  DATE
NAME  MED REC NUMBER  HIC NUMBER
APATIENT, WILLIAM  1252858  29334XXXXA  06/05/08  05/02/08  0
PAT CONTROL NBR: 30766695
BPATIENT, CHARLES  030157  29426XXXXA  06/09/08  12/03/08  1
PAT CONTROL NBR: 29046307
CPATIENT, ROBERT  1278140  51522XXXXA  06/13/08  05/08/08  0
PAT CONTROL NBR: 30833008
DPATIENT, PHILIP  1181723  10403XXXXA  06/10/08  04/30/08  0
PAT CONTROL NBR: 30713531
EPATIENT, CHARLES  721953  29416XXXXA  06/13/08  05/16/08  0
PAT CONTROL NBR: 30901037
FPATIENT, MARY  1271767  40342XXXXB  06/12/08  05/15/08  0
PAT CONTROL NBR: 30887293
GPATIENT, JOSEPHINE  155433  29122XXXXA  03/21/08  02/08/08  0
PAT CONTROL NBR: 29775202
HPATIENT, ELSIE  1283153  31020XXXXD  06/13/08  05/13/08  0
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF11-RIGHT
    
```

SUMMARY OF PENDED CLAIMS- Left View

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL R
KEY 33XX00XX      PAGE 000001  SEARCH
REPORT: 201
CYCLE DATE: 6/13/08
BLUE CROSS CODE: 072
332
S
PAGE: 1
FREQUENCY: WEEKLY
PROVIDER NUMBER: 33XX00XX
FROM  THRU  ADJ  LAST  SUB SUSP  TOTAL
DATE  DATE  IND  TRAN  IND TYPE  CHARGES  ADS
NAME
APATIENT, WILLIAM  5/02/08  05/09/08  06/09/08  A  CWFD  6,058.50
PAT CONTROL NBR
BPATIENT, CHARLES  2/03/07  12/05/07  06/09/08  A  SUSP  16,873.04
PAT CONTROL NBR
CPATIENT, ROBERT  5/08/08  05/18/08  06/13/08  A  CWFR  8,229.35
PAT CONTROL NBR
DPATIENT, PHILIP  4/30/08  05/06/08  06/12/08  P  CWFD  4,598.60
PAT CONTROL NBR
EPATIENT, CHARLES  5/16/08  05/17/08  06/13/08  A  CWFR  4,085.80
PAT CONTROL NBR
FPATIENT, MARY  5/15/08  05/16/08  06/13/08  A  CWFR  5,211.14
PAT CONTROL NBR
GPATIENT, JOSEPHINE  2/08/08  02/10/08  05/02/08  A  SUSP  2,012.30
PAT CONTROL NBR
HPATIENT, ELSIE  5/13/08  05/17/08  06/13/08  A  CWFR  19,425.45
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF10-LEFT
    
```

SUMMARY OF PENDED CLAIMS- Right View

The following chart describes the various fields/report headings contained within the **SUMMARY OF PENDED CLAIMS** section of the 201 Pend Report:

FIELD/REPORT HEADING	DESCRIPTION
NAME	The patient's name as you reported it.
MEDICAL RECORD NUMBER	This is the medical record number that you give us. If one is not given to us, the field should be blank.
HIC NUMBER	The patient's Medicare number as you reported.
RECD DATE	The day we received the claim.
ADMIT DATE	Date from block 17 of the UB- 04.
FROM DATE	Date from block 6 of the UB- 04.
THRU DATE	Date from block 6 of the UB- 04.
ADJ IND	An asterisk indicates that the claim is an adjustment, blank indicates an original claim.
LAST TRAN	Last date that some activity occurred on the claim.
SUB IND	Valid Values A= Claim submitted via electronic media claim (EMC) P= Claim submitted via paper
SUSP TYPE	The suspend type field indicates why the claim is suspended. Valid Values MED =Medical Review MSP = Medicare Secondary Payer CWFR = Common working file (CWF) regular (these claims are in initial query to the common working system.) CWFD = CWF delayed (the claim has been sent to CWF but has to be required so that it is no longer considered a "clean claim.") SUSP =General suspended claims Note: Some internal review of this document is necessary before it can be released for payment, rejection, or additional development.
TOTAL CHARGES	Charges as reported in column 47 of the UB- 04.
ADS	Additional development suspense, 'Y' indicates a request for additional information that has been generated to you by Medical Review, Medicare Secondary Payer (MSP), or the Claims Unit. On the next line of the report you should also see a reason code that will describe the information that we have requested via additional development request (ADR).

The last page of each of the pended claims categories contains a summary of the total claim count and associated dollar amount for the corresponding **SUSP TYPE**. Totals are provided for both original claims and adjustment claims.

SUMMARY OF PROCESSED CLAIMS– Second Report Section

The processed claims identified in this section of the 201 Pend Report are those that we have adjudicated through the FISS to a point of completion.

The following two screen prints show you how the **SUMMARY OF PROCESSED CLAIMS** section appears on the FISS online system:

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL L
KEY XXXXXX          PAGE 000053  SEARCH PROCESSED
REPORT: 201
CYCLE DATE: 6/13/08
BLUE CROSS CODE: 0723
MEDICARE PART A - 00
SUMMARY OF PROCESSED CLAIM
INPATIENT
RECD   ADMIT
NAME           MED REC NUMBER      HIC NUMBER      DATE      DATE
IPATIENT,JENICE 1227350          53907XXXXD    06/06/08 05/07/08 0
  PAT CONTROL NBR: 30806343
JPATIENT,HOMER  710897          27156XXXXA    06/05/08 05/07/08 0
  PAT CONTROL NBR: 30808307
KPATIENT,MOLLIE 329972          29628XXXXA    06/05/08 05/07/08 0
  PAT CONTROL NBR: 30793160
LPATIENT,SHARON E 637684          29844XXXXA    06/10/08 05/10/08 0
  PAT CONTROL NBR: 30850853
MPATIENT,PHILIP 1181723          10403XXXXA    06/04/08 04/18/08 0
  PAT CONTROL NBR: 30600860
NPATIENT,DONALD 726686          WCA81XXXX     06/04/08 04/18/08 0
  PAT CONTROL NBR: 30600332
OPATIENT,ROSCOE 121766          27816XXXXA    06/06/08 04/18/08 0
  PAT CONTROL NBR: 30576870
PPATIENT,HAROLD 571779          28444XXXXA    06/09/08 05/12/08 0
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF11-RIGHT
    
```

SUMMARY OF PROCESSED CLAIMS– Left View

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL R
KEY XXXXXX          PAGE 000053  SEARCH
REPORT: 201
CYCLE DATE: 6/13/08
BLUE CROSS CODE: 072
332
IMS
PAGE: 53
FREQUENCY: WEEKLY
PROVIDER NUMBER: XXXXXX
FROM   THRU   ADJ   PAID   CLEAN   REJECT
NAME   DATE    DATE   IND   DATE   IND    CODE
IPATIENT, JENICE 5/07/08 05/12/08  06/13/08  B
  PAT CONTROL NBR
JPATIENT, HOMER  5/07/08 05/10/08  06/13/08  B
  PAT CONTROL NBR
KPATIENT,MOLLIE  5/07/08 05/09/08  06/13/08  B
  PAT CONTROL NBR
LPATIENT,SHARON  5/10/08 05/19/08  06/13/08  B
  PAT CONTROL NBR
MPATIENT,MOLLIE  4/18/08 04/25/08  06/11/08  B
  PAT CONTROL NBR
NPATIENT,DONALD  4/18/08 04/21/08  06/11/08  B
  PAT CONTROL NBR
OPATIENT,ROSCOE  4/18/08 04/22/08  06/11/08  B
  PAT CONTROL NBR
PPATIENT,HAROLD  5/12/08 05/14/08  06/13/08  B
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF10-LEFT
    
```

SUMMARY OF PROCESSED CLAIMS– Right View

The fields/report headings contained within the **SUMMARY OF PROCESSED CLAIMS** section of the 201 Pend Report are the same as for the **PENDED CLAIMS** section, with the exception of the last three. These fields are:

FIELD/REPORT HEADING	DESCRIPTION
PAID DATE	The date the claim was finalized or the date of remittance advice on which the paid claim will appear. All of the paid claims will appear in this report <i>only once</i> . The rejected or denied claim will also appear <i>only once</i> on this report.
CLEAN IND	<p>This code will be an alpha A–P, a code D <i>may</i> indicate interest payment due.</p> <p>Valid Values: A = PIP other B = PIP clean C = Non-PIP other D = Non-PIP clean E = Additional Information requested-non-PIP F = Additional Information requested-PIP G = Date of Death response received from host-non-PIP H = Date of Death response received from host-PIP I = Nondefinitive reply-non-PIP J = Nondefinitive reply-PIP K = Delayed response-non-PIP L = Delayed response-PIP M = Manually set to nonclean-non-PIP N = Manually set to nonclean-PIP O = Sequential claim in which prior pending claim-non-PIP P = Sequential claim in which prior pending claim-PIP</p>
REJECT CODE	If the claim is rejected, a code will appear. For some rejections, there will also be a letter to you and to the beneficiary.

The last page of each of the processed claim categories identifies the total number of claims and adjustments.

SUMMARY OF RETURNED CLAIMS– Third Report Section

This section is of particular importance to providers because it identifies all claims that are being returned to the provider or RTP. If a claim appears on this section of the 201 Pend Report, **it is no longer considered in the FISS claim inventory, i.e., it is no longer in our system.** Claims identified in this section will never be adjudicated for payment, rejection, or denial **unless** the provider either:

- Corrects the claim through the online system; or
- Resubmits the claim through normal billing channels.

Claims will appear **only once** on the **SUMMARY OF RETURNED CLAIMS** section.

The following two screen prints show you how the **SUMMARY OF RETURNED CLAIMS** section appears on the FISS online system:

```

MAP1661   REPORT 201  FREQUENCY W  SCROLL L
KEY XXXXXX           PAGE 000127  SEARCH RETURNED
REPORT: 201
CYCLE DATE: 6/13/08
BLUE CROSS CODE: 0723
MEDICARE PART A - 00
SUMMARY OF RETURNED CLAIM
INPATIENT
NAME           MED REC NUMBER      HIC NUMBER      RECD   ADMIT
DATE           DATE
QPATIENT,BILLY 282861             29916XXXXA      06/10/08 05/08/08 0
  PAT CONTROL NBR: 30832927
  REASON CODES: 30715
RPATIENT,LESSIE 19770              29828XXXXA      06/10/08 01/30/08 0
  PAT CONTROL NBR: 29670395
  REASON CODES: 12503
SPATIENT,JACK   1174246            26922XXXXA      06/10/08 05/06/08 0
  PAT CONTROL NBR: 30796916
  REASON CODES: W0455 32155 32099 32154
TPATIENT,WILLIAM 397070             27232XXXXA      06/04/08 12/04/08 1
  PAT CONTROL NBR: 24860181
  REASON CODES: 12302
UPATIENT,CARLOS 1218404            27622XXXXA      06/13/08 05/14/08 0
  PAT CONTROL NBR: 30878631
  REASON CODES: 30715
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF11-RIGHT
    
```

SUMMARY OF RETURNED CLAIMS- Left View

```

MAP1661  REPORT 201  FREQUENCY W  SCROLL R
KEY XXXXXX          PAGE 000127  SEARCH
REPORT: 201          |332                                PAGE: 127
CYCLE DATE: 6/13/0  |MS                                FREQUENCY: WEEKLY
BLUE CROSS CODE: 072|                                PROVIDER NUMBER: XXXXXX

  NAME      FROM      THRU      ADJ      RTP
  DATE      DATE      IND      DATE
QPATIENT, BILLY  5/08/08  05/14/08  06/13/08
  PAT CONTROL NBR
  REASON CODES: 3071
RPATIENT, LESSIE 1/30/08  05/30/08  06/13/08
  PAT CONTROL NBR
  REASON CODES: 1250
SPATIENT, JACK   5/06/08  05/07/08  06/13/08
  PAT CONTROL NBR
  REASON CODES: W045
TPATIENT, WILLIAM 2/04/07  12/04/07  06/13/08
  PAT CONTROL NBR
  REASON CODES: 1230
UPATIENT, CARLOS  5/14/08  05/16/08  06/13/08
  PAT CONTROL NBR
  REASON CODES: 3071
ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF10-LEFT
    
```

SUMMARY OF RETURNED CLAIMS– Right View

The fields/report headings contained within the **SUMMARY OF RETURNED CLAIMS** section of the 201 Pend Report are the same as for the **PENDED CLAIMS** section, with the exception of the last two. These fields are:

FIELD/REPORT HEADING	DESCRIPTION
RTP DATE	The date the claim was returned to the provider for correction.
RTP REASON CODE	States why the claim has been returned. You must locate the code and follow the instructions to correct and resubmit the claim.

The last page of each of the returned claims categories identifies the total number of claims and adjustments that have been RTP.

CLAIMS SUMMARY TOTALS– Last Page of the 201 Pend Report

This last page of the 201 Pend Report provides a summary of the total claim counts associated with the pended, processed, and returned claims sections.

The following two screen prints show you how the **CLAIMS SUMMARY TOTALS** page appears on the FISS online system:

	INP	OTP	SNF	HHA	HOSPICE	CORF
PENDING	106	1,071	0	0	0	0
CLAIMS	106	1,071	0	0	0	0
ADJUSTMENTS	0	0	0	0	0	0
PROCESSED	0	0	0	0	0	0
CLAIMS	101	1,805	0	0	0	0
PAID	91	1,583	0	0	0	0
REJECTED	10	222	0	0	0	0
ADJUSTMENTS	0	0	0	0	0	0
PAID	0	0	0	0	0	0
REJECTED	0	0	0	0	0	0
RETURNED	7	277	0	0	0	0
CLAIMS	7	277	0	0	0	0
ADJUSTMENTS	0	0	0	0	0	0

ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD **PF11-RIGHT**

CLAIMS SUMMARY TOTALS- Left View

MAP1661 **REPORT 201** FREQUENCY W SCROLL R
 KEY XX00XX PAGE 000145 SEARCH
 REPORT: 201 | 332 PAGE: 145
 CYCLE DATE: 6/13/0 | FREQUENCY: WEEKLY
 BLUE CROSS CODE: 072 PROVIDER NUMBER: 3300XX

	ESRD	LAB	OTHER	TOTAL
PENDING	0	31	0	1,208
CLAIMS	0	31	0	1,208
ADJUSTMENTS	0	0	0	0
PROCESSED	0	0	0	0
CLAIMS	0	48	2	1,956
PAID	0	27	2	1,703
REJECTED	0	21	0	253
ADJUSTMENTS	0	0	0	0
PAID	0	0	0	0
REJECTED	0	0	0	0
RETURNED	0	5	0	289
CLAIMS	0	5	0	289
ADJUSTMENTS	0	0	0	0

ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD **PF10-LEFT**

CLAIMS SUMMARY TOTALS- Right View

About the 50 Claims Returned to Provider

Description: This is a listing by provider of claims that are being returned to the provider for correction. The claims on the report are in **STATUS/LOCATION TB9997**. The daily report will be available online for five days.

Report Purpose: To provide a listing of claims that are being returned to the provider for correction. This report will be used by providers to identify the reason code(s) for the returned claims.

```

REPORT: 050                MEDICARE PART A - 00308                PAGE: 1
CYCLE DATE: 07/15/08      CLAIMS RETURNED TO PROVIDER      FREQUENCY: DAILY
PROVIDER: XXXXXX          FOR CYCLE DATE 07/15/08        RUN TIME: 7:19
  FOR PROVIDER              PROVIDER NAME
-----                     PROVIDER ADDRESS

HIC/CERT/SSNO  PCN/DCN  TYPE  BILL  PROVIDER  NAME  ADMIT  COV  FM  COV  TO  TOTAL  CHGS
-----  -
2211XXXXXA   00002804227XXXX  141   XXXXXX  PATIENT  070208  070208  070208  251.50
          XXXX940000XXXX

19202  ATTENDING PHYSICIAN UPIN ERROR: FORMAT INVALID

1  THE FIRST POSITION OF THE ATTENDING PHYSICIAN UPIN IS NOT ALPHABETIC.
2  THE SECOND POSITION OF THE ATTENDING PHYSICIAN UPIN IS NEITHER
   ALPHABETIC NOR NUMERIC.
3  THE THIRD POSITION OF THE ATTENDING PHYSICIAN UPIN IS NEITHER ALPHABETIC
   NOR NUMERIC.

CORRECT AND RESUBMIT.
    
```

About the 702 ACS Appeals Received Report

Description: The Automated Correspondence System (ACS) master record inputs into the system so that this daily report can be created to allow providers to view which appeals were received. These entries will be available for 90 days before they are removed from the FISS system.

Report Purpose: To provide a listing of appeals for the providers so that they can verify that their redetermination request(s) were received. This will also indicate if any appeals need to be resubmitted.

The following two screen prints show you how the ACS APPEALS RECEIVED section appears on the FISS online system:

```

MAP1661  REPORT 702          FREQUENCY D  SCROLL L
KEY XXXXXX          PAGE 001463          SEARCH
REPORT: 702          MEDICARE PART A
CYCLE DATE: 1/11/08          ACS APPEALS RECEIVED
PROVIDER  XXXXXX

      HIC          DCN          TOB          STMT          STMT          CATE
      2211XXXXXA  20528711948701  130          10/03/07  10/03/07  A

      ENTER NEW KEY DATA OR
      PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF11-RIGHT
  
```

SUMMARY OF ACS APPEALS RECEIVED- Left View

```

MAP1661  REPORT 702          FREQUENCY D  SCROLL R
KEY XXXXXX          PAGE 000002          SEARCH
REPORT: 702          |CES          PAGE 001290
CYCLE DATE: 1/11/0  |          FREQUENCY: DAILY
PROVIDER  XXXXXX    |
      HIC          D          |G  RECEIPT
      2211XXXXXA  20528  |G  TYPE  DATE
                          ABB  12/27/07

      ENTER NEW KEY DATA OR
      PRESS PF2-SEARCH PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF10-LEFT
  
```

SUMMARY OF ACS APPEALS RECEIVED- Right View

The following chart describes the various fields/report headings contained within the ACS Appeals Received report.

FIELD/REPORT HEADING	DESCRIPTION
PROVIDER	Provider number obtained from ACS master record.
HIC	Healthcare Identification Claim Number obtained from the ACS master record.
DCN	Document control number obtained from the ACS master record.
TOB	Type of bill obtained from the claim record.
STMT FROM	Statement from date obtained from the claim record.
STMT THRU	Statement thru date obtained from the claim record.
CATEG	Category obtained from ACS master record. Value A = Appeal.
TYPE	ACS category type from ACS master record.
RECEIPT DATE	Date of appeal receipt obtained from ACS master record.