This document is a guide to assist PC-ACE users in entering and managing Medicare Durable Medical Equipment (DME) claim information.

This document includes:

The information in this document is intended to provide the user with enough information in order to successfully enter claims using medical policy knowledge that the user already has. Please contact the DME MAC Jurisdiction for any medical policy questions.

For more information concerning other aspects of the PC-ACE software, please review the PC-ACE manuals and documents on the CEDI Web site https://www.ngscedi.com.

For questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@anthem.com or at 866-311-9184.

Claim Entry

From the PC-ACE main menu, select the **Professional Claims Processing** button.
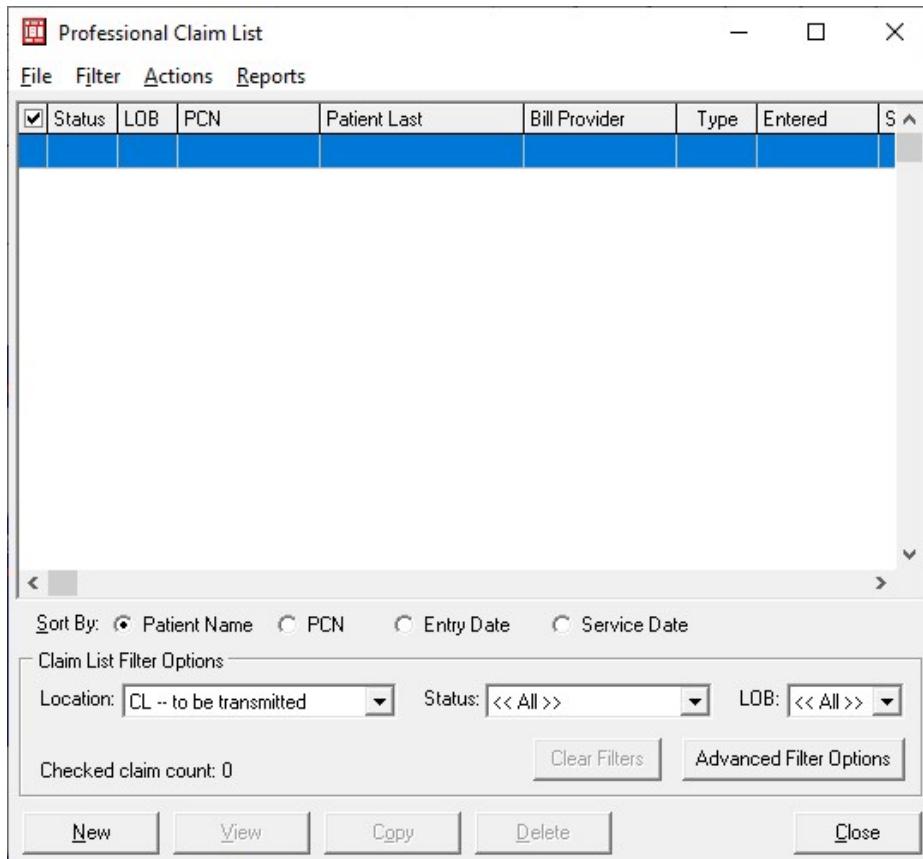
This will bring up the **Professional Claims Menu**.

There are two ways to enter claims.

1) **Enter Claims** allows you to enter claims back to back. If you have a stack of paper claims forms and need to enter them all one after the other, this would be a good choice for you.

2) The **List Claims** option will allow you to enter a new claim and lists claims that you have already entered. We will be selecting **List Claims** for our examples.
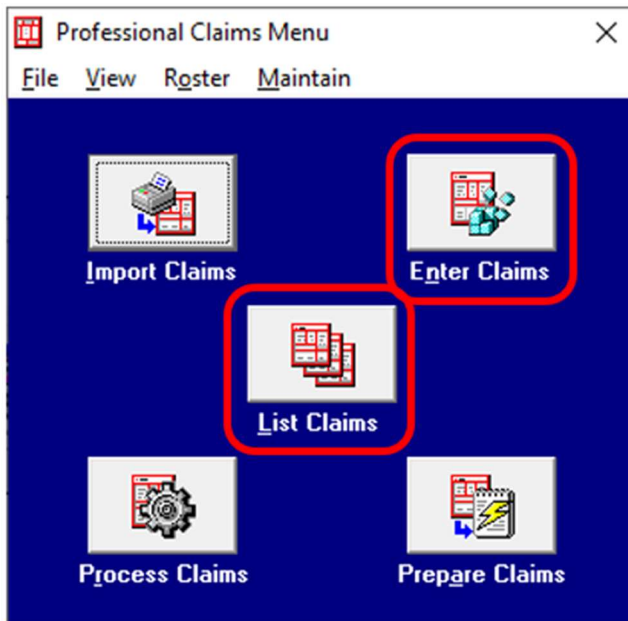
The **Professional Claims List** screen displays the claims that are in your system.
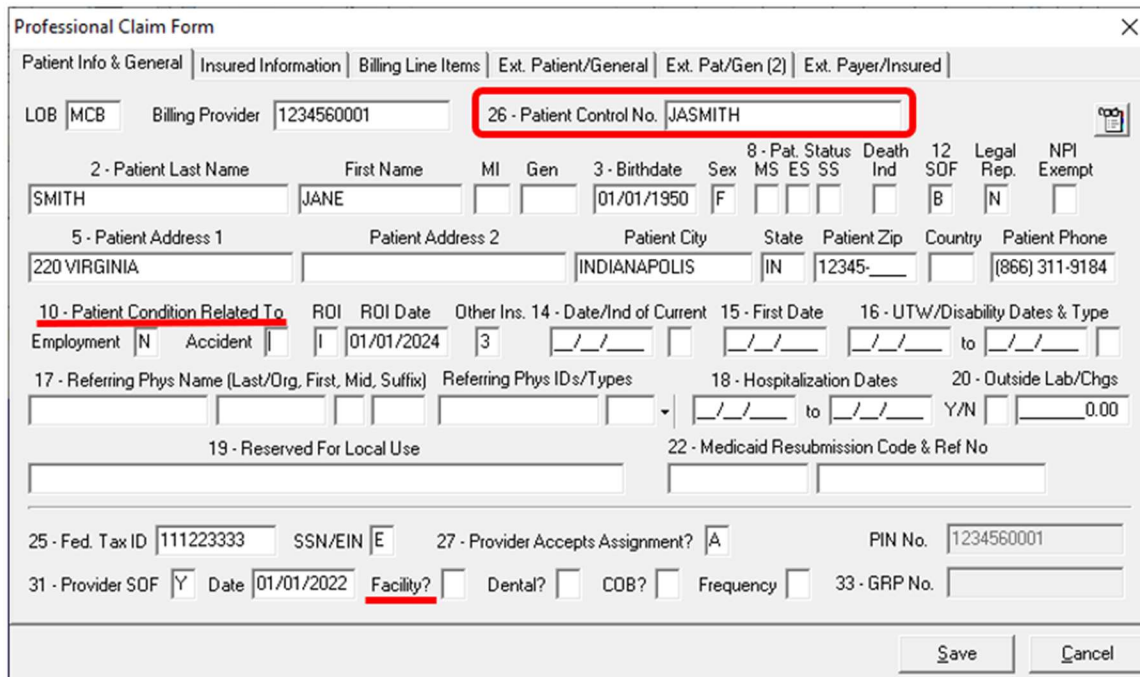
- When you have several claims listed, it may be useful to use the **Sort By** and **Claim List Filter** options.

- See the built in help documentation (available by using the F1 lookup feature) for more information on using the filter options in PC-ACE.

Select **New** to enter your first claim.

Note: Right-clicking or using the F2 lookup feature is very useful for selecting data on these tabs. Numbered entries correspond to items on the paper CMS-1500 claims form.

Patient Info & General tab:

1) Select the patient via **Patient Control No**. Use the right-click or F2 lookup feature to bring up the Patient Selection screen. (For more information about entering a new patient, see Appendix A.)

- If you only have one billing provider or have linked the patient to the billing provider as indicated in the section on patient entry, the **Billing Provider** field will be entered when you select the **Patient Control No**.

- Patient name and address information will be filled out automatically when you select the **Patient Control No**.

- If this claim is for a different billing provider than what is linked in the patient information area, select the correct **Billing Provider** to override the link for this claim only.

2) Item **10 – Patient Condition Related to Employment** must be entered.

Note: Along the bottom row is an entry for **COB?**. Enter a **Y** in this field to bring up COB tabs for entering Medicare as Secondary Payer, or MSP, claims. The Medicare as Secondary Payer Setup document and the PC-ACE User Guide on the CEDI Web site https://www.ngscedi.com as well as the on-line help (F1) have more details on how to enter this information.

Insured Information tab:

1) This tab should have most of the fields filled in automatically based on what was entered for the insurance information in the patient entry area.

2) Any required entry not filled in automatically will trigger edit validation warning flags when the claim is saved for you to enter the required information.
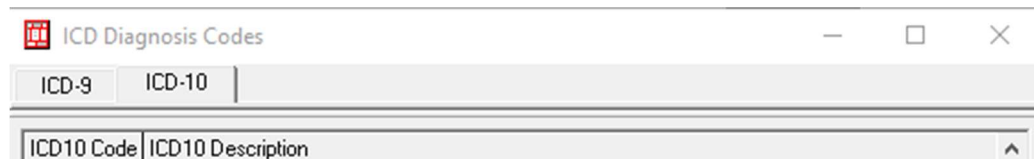
Billing Line Items tab:

Billing Line Items has multiple sub tabs including **Line Item Details, Extended Details, Ext Details 2, and Ext Details 3**.

Line Item Details sub tab (the first one on the second row of tabs in the screenshot above):

1) **Claim Diagnosis Codes**

- Use the right click or F2 lookup feature to select a valid diagnosis code

  – ICD-9 and ICD-10 codes are listed on separate tabs when the right click or F2 lookup feature is selected

- Diagnosis codes are entered without decimal points. The claims format will not allow them, but they are implied.

  E**xample:** M6281 will be read by the system as M62.81.

- The diagnosis codes are maintained by the PC-ACE software developers. However, if a diagnosis code changes, it can be updated under the **Codes/Misc** tab on the **Reference File Maintenance** screen by selecting option **ICD**.

- Up to twelve diagnosis codes can be entered on a claim; however, only four diagnosis pointers can be used on a charge line. More places for the diagnosis codes are displayed later in the document.

2) **LN** – Charge Line Information

- Each charge line of the claim will be entered as a separate **LN** entry here.

- The line you are on will control the **Extended Details** tabs.

  Example: Data is being entered on **LN 1** so the Extended Detail tabs indicate they are also for Line 1.

  Note: Per the claims format specifications, the maximum number of allowed charge lines on any given claim is 50.

Entering Information on the Charge Line:

− **24a Service Dates:** Enter the date of service for the charge line

− **24b PS**: Use the right click or F2 lookup feature to select the **Place of Service** for the claim.

− **24c EMG:** This is not used, and will be left blank

− **24d CPT/HCPCS:** Use the right-click or F2 lookup feature to select the **HCPCS procedure code.** This information can also be typed in if you already know the HCPCS you want to use.

  Warning: This list is maintained by the PC-ACE software developer and contains codes which are valid for other insurances but are not used for Medicare DME claims.

  ➢ Make sure you select a valid Medicare DME HCPCS code.

  ➢ If you would like to create a specific code set to be used, follow the directions in Appendix B - Managing Code Lists for **Creating a Specific HCPCS Code Set**.

  ➢ The PDAC website, www.dmepdac.com, is available for coding assistance.

  ➢ If a HCPCS procedure code changes, it can be updated under the **Codes/Misc** tab on the **Reference File Maintenance** screen by selecting the **HCPCS** button.

  ➢ To enter an NDC (National Drug Code), refer to the **PC-ACE User Guide** or the **National Drug Code Entry** document on the CEDI Web site https://www.ngscedi.com for more information.

  Modifiers: Only two modifiers can be entered on the **Line Item Details** for **24d**.

  ➢ Additional modifiers will be entered on the first **Extended Details** tab.

− **24e Diagnosis:** This field indicates which of the diagnosis codes above are relevant for this charge line.

  ➢ Up to four codes can be referenced by typing the numbers.

  ➢ To indicate both the 1st and 2nd diagnosis codes entered, type "**1,2**".

- To indicate the second diagnosis only, a **2** would be entered.

- **24f Charges:** Enter the **Charges** appropriate for the line item.

  - Charges should be entered as the total charge

  - **For example:** If an item costs $10 per unit, and there are 3 units, enter the charge as $30.

  - If you use the Charges Master to set your own code list, the charge amount for 1 unit will be entered automatically for you.

- **24g Units:** Enter the **Units** appropriate for the line item.

  - Units should be limited to no more than 9999.9. Billing more than 9999.9 units on a single charge line will result in front end errors.

  - If more than 9999.9 units need to be billed, contact the DME MAC Jurisdiction where the claim will be processed for clarification on how they want the charge billed.

- **Indicators and Attachments:** The small boxes to the right of **Units** (**EP**, **FP**, and **AT)** are not used, and will be left blank

- **Rendering Phys.:** This field is not used for Medicare DME.
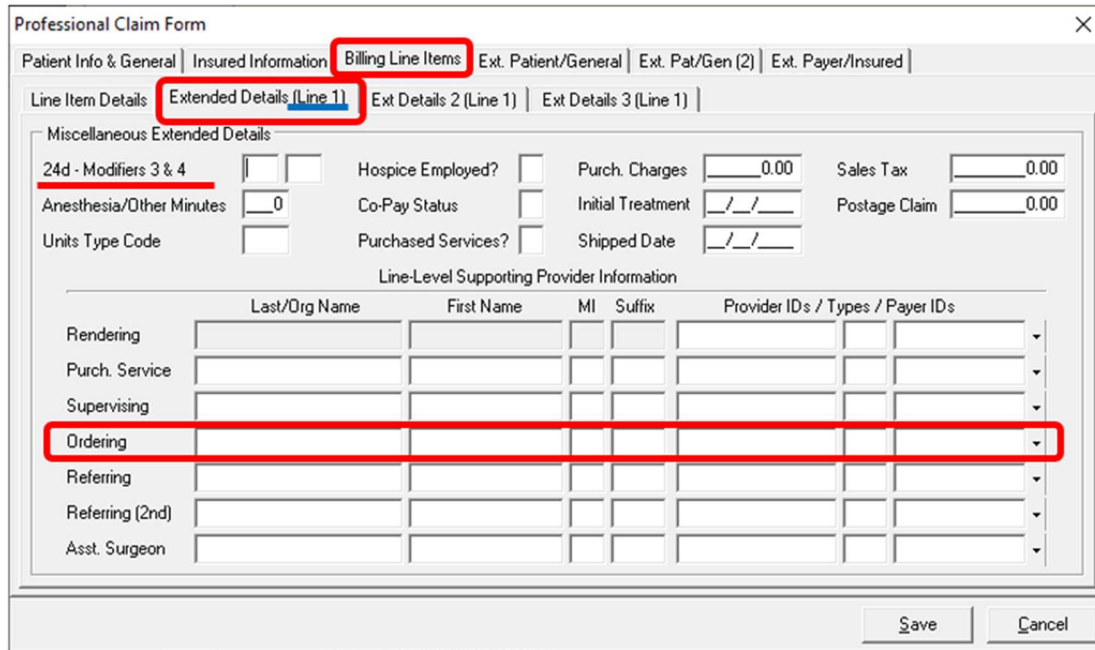
Extended Details (Line #) tab:

The (Line #) will change based on the charge line being entered.

Each charge line on a claim will enter information on a separate tab.

Verify the **(Line #)** indicates the charge line under **Line Items Details** you wish to add the additional information.

1) **Miscellaneous Extended Details**

   Modifiers: As previously indicated, additional Modifiers 3 and 4 are entered here.

   Under some circumstances, there will be more than four modifiers.

   - A special modifier is used in the fourth modifier slot to indicate there are more than four modifiers on a claim.

   - Modifiers four, five, and any additional modifiers are entered in the narrative. (Information about entering a narrative will be covered at a later point.)

   - The DME MAC Jurisdiction which will process the claim should be contacted for more information on what modifiers to use in this situation.

   Units Type Code: Use if the units of service are anything other than Units.

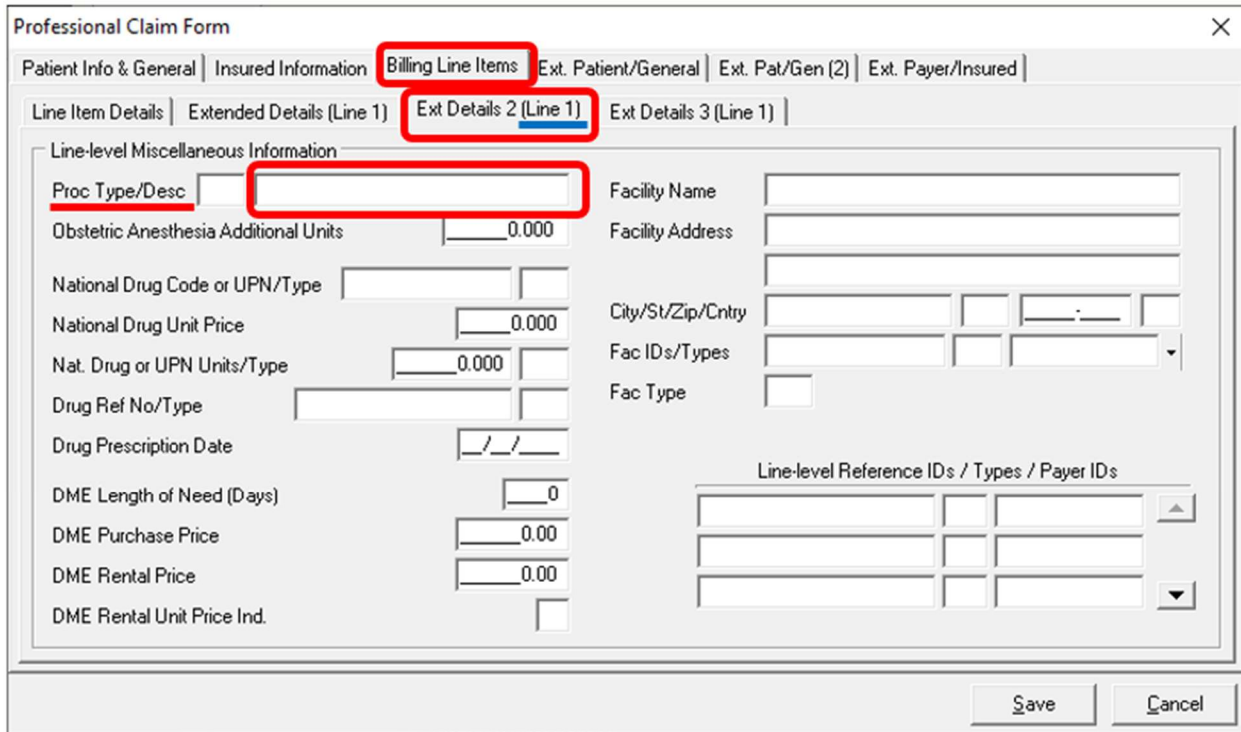   - This can usually be left blank.

2) **Line-Level Supporting Provider Information:**

   Only the Ordering Physician will be used for Medicare DME claims. The other fields should be left blank.

- **Ordering:** Right-click or use the F2 lookup to select the appropriate Ordering Physician for the selected charge line.

3) Other information on this screen should only be entered if it is needed, and can cause edits/errors in the claims. These fields are usually not needed for a Medicare DME claim.

Ext Details 2 (Line #) tab:

Line-Level Miscellaneous Information

Proc Type/Desc: If you are using a procedure code requiring a description because it is a generic or miscellaneous procedure code, you will need to enter the description in the Proc Desc box.

- The first little box will be left blank.

- The description is entered into the second longer box

- All other narratives will be entered later.

National Drug Code Information: This information is only used when billing information pertaining to a National Drug Code (NDC).
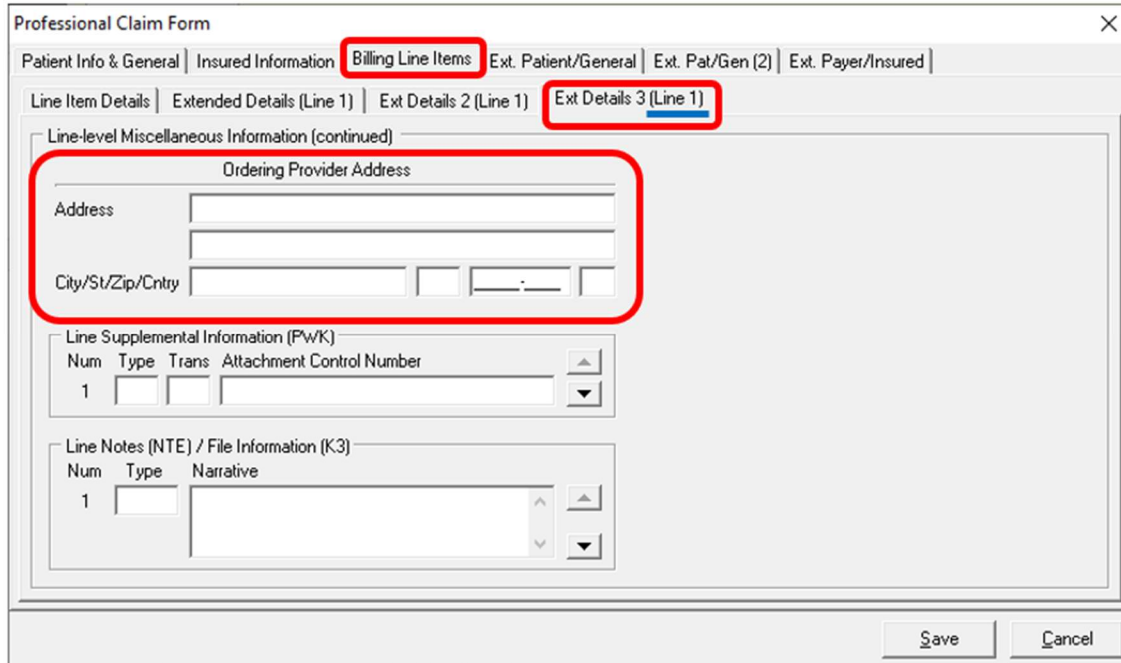
- If you will be billing an NDC, please refer to the **PC-ACE User Guide** or the **National Drug Code Entry** document on the CEDI Web site https://www.ngscedi.com for more information.

DME Fields: These fields are not used for Medicare DME billing.

Facility: Information entered on this tab is for line level only.

- If the Place of Service requires facility information, you must enter it at the claim level.

- Only use the line level facility information to indicate a different facility from what is reported at claim level.

Ext Details 3 (Line #) tab:

Line-Level Miscellaneous Information (continued)

Ordering Provider Address: The address information for the ordering provider.

- If the ordering provider was entered in the Reference File Maintenance Menu, the ordering provider's address will automatically populate when the ordering provider is selected on the Extended Details (Line #) tab.

- If the ordering provider was not entered in the Reference File Maintenance Menu, you will need to add the address information manually.

Line Supplemental Information (PWK): This field is not typically used. Please refer to the Entering the PWK (Paperwork) Segment document located on the CEDI Web site https://www.ngscedi.com under the PC-ACE Document section for more information on the use of this field.

Line Notes (NTE)/File Information (K3): Use this field to enter narrative information.

- Select **ADD** for general narrative.

- Only letters and numbers should be entered in the Narrative field.

- Do not use special characters such as *, ~, or : as they can cause 999 rejection errors.

Return to the Line Item Details tab. Repeat the above steps as needed for to bill multiple charge lines on a claim.

Once all charge lines are entered for the claim select the **Recalculate** button at the bottom of the Line Items Details tab.
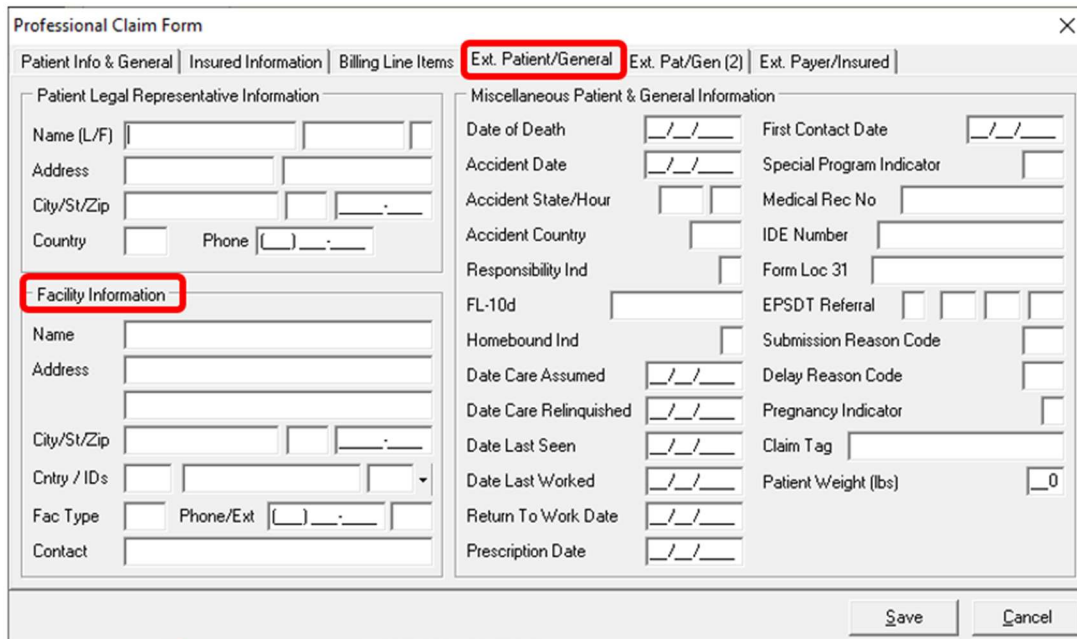
Ext. Patient/General tab:

If the Place of Service code you entered for your charge lines requires facility information to be sent, return to the Patient Info & General tab.

Item **31** – **Facility?** Must be selected as **Y** if facility information is required in this claim.

- If you are not sure if your place of service requires facility information, contact the DME MAC Jurisdiction which will process the claim.

Selecting Y in the Facility field will automatically take you to the Ext. Patient/General tab. The Facility Information section is the only section used for Medicare DME claims.
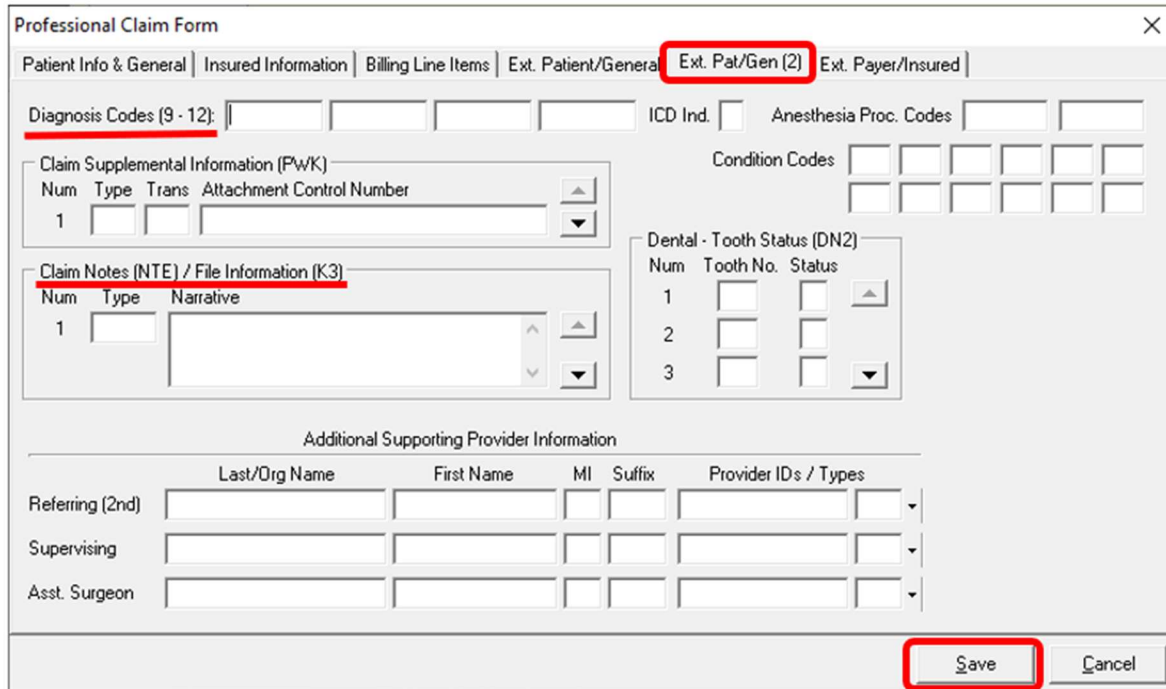

1) **Facility Information**

- Use the right click or F2 lookup feature in the Facility Name field to bring up the Facility Selection screen. Select the facility you need to send for this claim, if required.

- Places of service codes which do not require facility information may reject if this information is sent.

2) **Miscellaneous Patient & General Information** and **Representative Information**

This information is generally is not required.

Ext. Pat/Gen (2) tab:

1) **Diagnosis Codes (9-12):** If more than 8 diagnosis codes need to be entered in the claim, the first 8 will be placed on the Billing Line Items tab and the remaining diagnosis codes will be placed here.

2) **Claim Supplemental Information (PWK):** This field is not typically used. Please refer to the Entering the PWK (Paperwork) Segment document located on the CEDI Web site www.ngscedi.com under the PC-ACE Document section for more information on the use of this field.

3) **Claim Notes (NTE)/File Information (K3):** This field is used for a claim level narrative if needed.

   - **Type** should be **ADD** to indicate claim level narrative

   Note: Not all DME MAC Jurisdictions use this level of narrative. If you are in doubt, enter the narrative at the line level instead or contact the Provider Contact Center for the DME MAC Jurisdiction which will process the claim.

4) **Other Fields:** All other fields on this tab should not be used for Medicare DME claims.

Note: Please note Medicare DME claims will not utilize all tabs or fields in the PC-ACE Software.

When all the information is entered, select **Save.**

Validating Claim Information:

Data entered in the claim may trigger the need for data in fields not covered in this document. PC-ACE will run a series of validation edits to check for missing or incorrect information. Any missing or incorrect information will generate a dialogue box displaying the errors. You can save a claim with errors, even fatal errors.

Example: The claim in this document will be saved without the **Ordering Provider** field being entered.
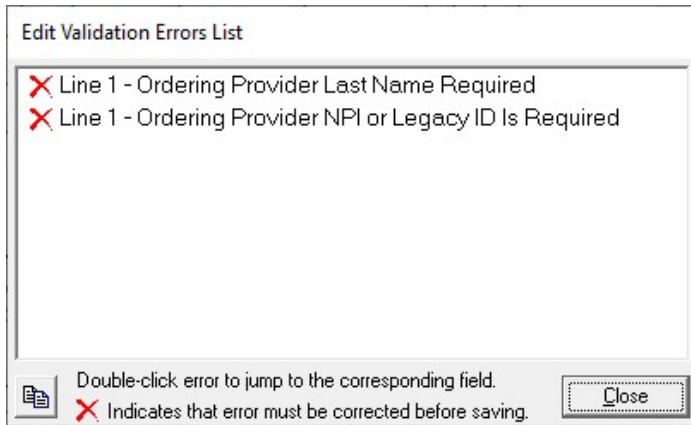
Double-click on the error to go to the tab where the error is located.

All fields with errors will be flashing red or purple.
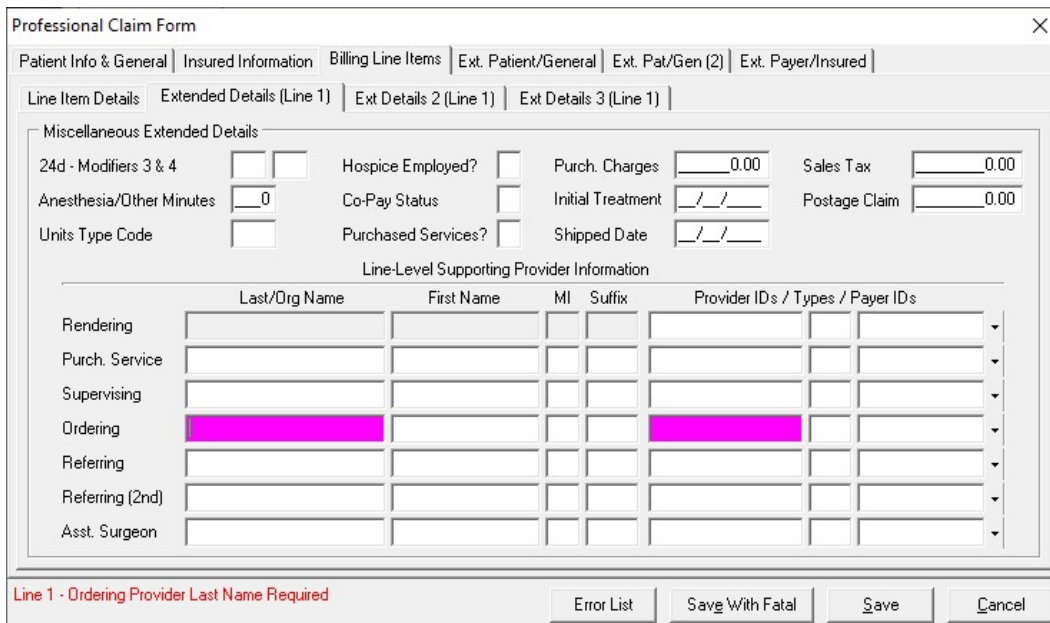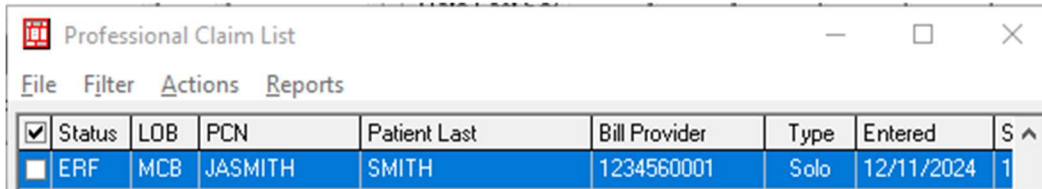
Saving the claim will take you back to the **Professional Claims List** screen.

Check the status of the claim:

Status equaling **ERR** or **ERF** indicates the claim has errors.

Claims with no errors will show a status of **CLN.**

☑	Status	LOB	PCN	Patient Last	Bill Provider	Type	Entered	S ∧
☐	ERF	MCB	JASMITH	SMITH	1234560001	Solo	12/11/2024	1

Managing Claims

Claims can be managed from the **Professional Claims List.**

- Select the **Professional Claims Processing** option on the PC-ACE main menu
- Select **List Claims**
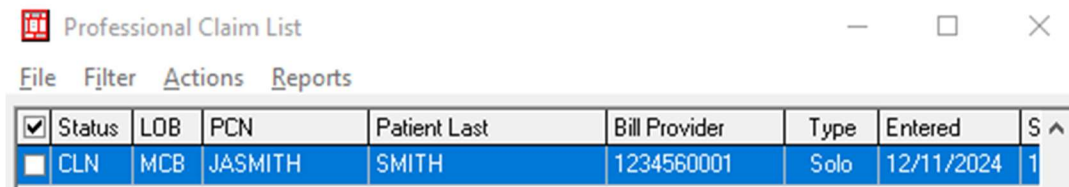
Claims can have several different status indicators.

From the PC-ACE built-in Help feature (F1 from any screen in PC-ACE):

- The possible status codes are: "clean/ready" **(CLN),** "deleted" **(DEL)**, "has fatal errors" **(ERF)**, "has errors" **(ERR),** "held" **(HLD)** and "unprocessed" **(UNP)**.
  - ➢ **CLN:** This indicates the claim is ready to be prepared into a claims file for submission through the CEDI SFTP Gateway.
  - ➢ **ERR:** This indicates the claim will not be put into claims files for transmission to the CEDI SFTP Gateway unless you select the option to include them when preparing a file for transmission.
  - ➢ **ERF:** This indicates the claim cannot be sent until it is corrected.

Select **View/Update** to return to a claim to make any needed corrections.

Example: In the example used during the Claims Entry part of this document, we have selected the **Ordering Provider** and saved the claim again, so it is now reflecting a **CLN** (clean) status.
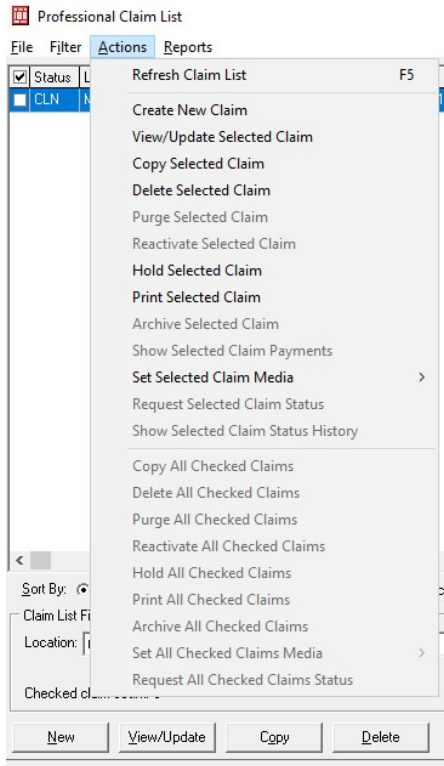
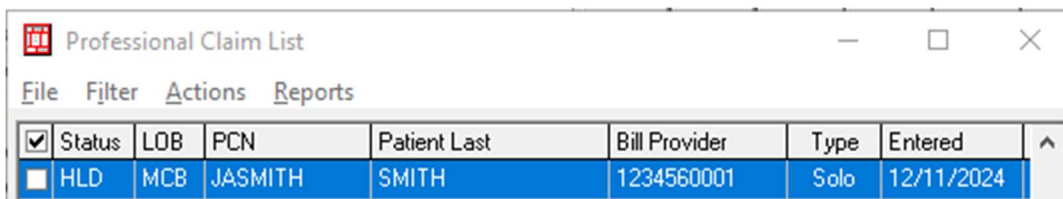| ☑	Status	LOB	PCN	Patient Last	Bill Provider	Type	Entered	S ∧
☐	CLN	MCB	JASMITH	SMITH	1234560001	Solo	12/11/2024	1

Placing claims on hold:

This will allow a clean claim to not be batched into the claims file for submission to CEDI. The claim status will show **HLD** once the claim is placed on hold.

- To place one claim on hold, right-click on the claim you wish to hold and select **Hold Selected Claim**.

- To place multiple claims on hold, select the boxes in front of a series of claims you wish to hold, right-click or use **Actions** at the top of the screen, and select **Hold All Checked Claims** (which is further down the list in the example).

The status will show **HLD** and the claim will not be sent until the status is changed back.

Releasing a claim on hold:

This is done by the same process as putting the claim on hold.

- Check the box of the claim(s) you wish to release.

- Select **Actions** at the top of the menu.

- Select **Release Selected Claim** or **Release All Checked Claims**.
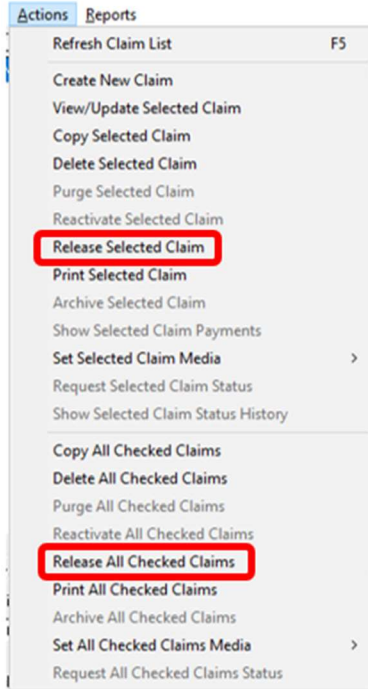
The status will then show **UNP** for Unprocessed.

Note: Claims marked **UNP** will not be included when you prepare batches. Only claims with a status of **CLN** will be included in the claims file to be transmitted.

To change the status to **CLN:**

- Select **View/Update** to open the claim, then select **Save**.

- For a large number of reactivated claims, exit to the **Professional Claims Menu** and select **Process Claims.**

Select **Close** to return to the **Professional Claims Menu** when finished entering claims.

Preparing to Send a File

To create a file to transmit, start from the **Professional Claims Menu** and select **Prepare Claims**.
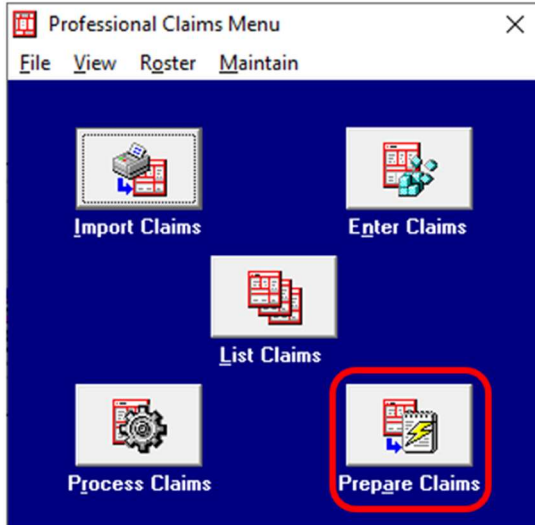
Professional Claim Prepare For Transmission screen:

1) **Include Claims Matching**

   LOB: This should reflect **<<ALL>>**

   - If you use the PC-ACE software to bill Medicare Part A or Medicare Part B, you may need to adjust this field.

   Payer: Only one Medicare Payer can be selected at a time. If the PC-ACE software is only used for Medicare DME claim submission and only one payer ID was entered in the claims, you can leave this field as **<<ALL Payers for LOB(s)>>**.

- If you selected one Medicare DME Payer ID for all patients and providers regardless of the DME MAC Jurisdiction they live in, you will be able to send all claims in one transmission.

  Note: CEDI will send the claims to the correct Jurisdiction based on the patient's address information entered in the claim, not the Medicare DME Payer ID.

- If you selected the proper Medicare Payer ID for the Jurisdiction the patient lives in, you will need to prepare the claims as separate transmissions.

  Note: You will need to send the created file before batching a new file.

Provider: This will allow you to select to build a claims file for all providers or for a specific one if you have multiple billing providers.

2) **Submission Status**

   Production: This will indicate the claims are sent to be processed for payment.

   Test: This will allow you to send trial claims which will not be forwarded to the appropriate DME MAC even if they have no CEDI front end errors.
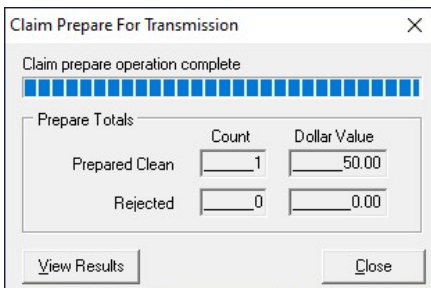
3) **Include Error Claims?**

   This indicates whether or not to include claims with an **ERR** status in this transmission.

   - Make sure all claims with an **ERR** status are claims you intend to send

   - Any **ERR** status claim you do not wish to send must be flagged as **HLD** for hold.

   Note: Error claims with a status of **ERF** (indicating a fatal error) will not be sent no matter what setting is selected.

When you click **Prepare Claims**, it will prompt you for confirmation you wish to create a file to send and will display a message when it is finished creating the file.

When completed, the following dialogue box will be displayed:

View Results will display a printable report of the claims prepared in this transmission.

**Close** will return you to the **Professional Claims Menu**.

Note: The PC-ACE software does not offer a communication component to send claims to the CEDI SFTP Gateway. All Trading Partners must use a Network Service Vendor to connect to the CEDI SFTP Gateway to send and receive claim files. A list of approved Network Service

Vendors is available on the CEDI Web site https://www.ngscedi.com under Telecommunications.

Restoring a Previously Sent Claim

From the **Professional Claims Menu**, select **List Claims**.

Use the drop down menu for **Location** to select **TR** for claims which have already been transmitted.
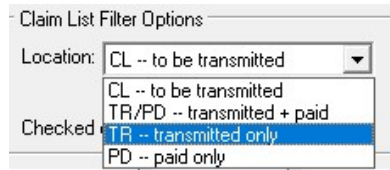
This will display any claims prepared for transmission.

- To restore a previously sent claim, right-click on the claim you wish to restore and select **Reactivate Selected Claim**.

- To restore multiple claims previously sent, select the boxes in front of a series of claims you wish to restore, right-click or use **Actions** at the top of the screen, and select **Reactivate All Checked Claims** (which is further down the list).
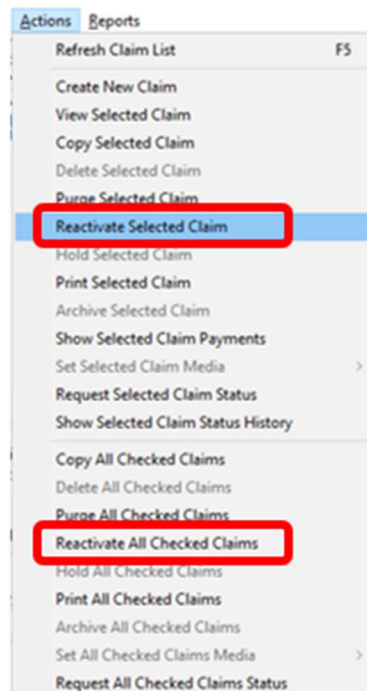
Change your **Location** back to **CL**.

The claim should now be marked **UNP**.

Select **View/Update** to edit the claim.

- This is useful for correcting errors received on the front end edit reports. Saving the claim should result in it being returned to a **CLN** status, ready to be prepared for transmission.

You can also reactivate an entire file for retransmission.

- Use the built-in F1 help document for instructions to search for the topic **Reactivating an Entire EMC File for Retransmission.**

- This will recreate the exact claims file prepared during the transmission, including control numbers and create dates.

- This is for resending when an entire file did not make it into the editing system.

WARNING: By default, PC-ACE keeps a backup copy of the claims file in a zipped/compressed format for 90 days. These zipped/compressed files cannot be sent to CEDI and must be reactivated as instructed above.

To change the length of time the file is kept, you can change the setting from the PC-ACE main menu.
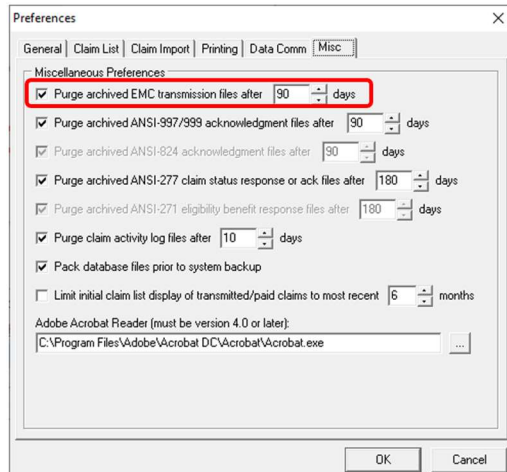
Select **File** and **Preferences**.
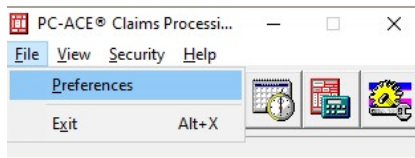
This will produce the **Preferences** menu.

Select the **Misc** tab.

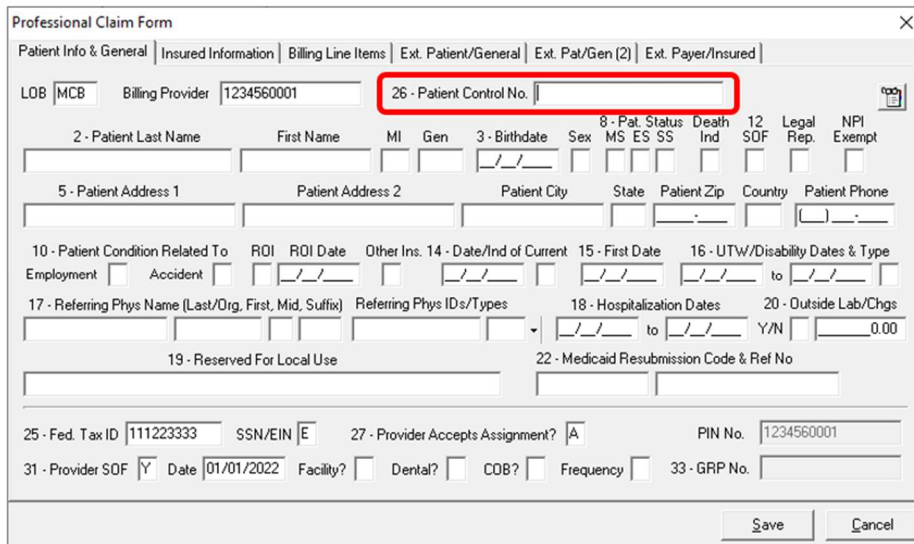The first item listed is **Purge archived EMC transmission file after 90 days.**

Adjust the number of days to the desired length of time to maintain a duplicate copy of the claims file.

Appendix A – New Patient Entry

Entering a new patient while on the Professional Claim form

Click in field 26 – Patient Control No. Use the right-click or F2 lookup feature to bring up the Patient Selection screen.

Select **New** in the bottom left corner of the Patient Selection Screen.

Enter your patient information

General Information tab:

Right click or use the F2 lookup feature for lists of options in many of these fields.

Make sure the patient's name is entered exactly as it appears on the patient's Medicare ID card.

Patient Control Number is an ID number assigned by the provider or submitter.
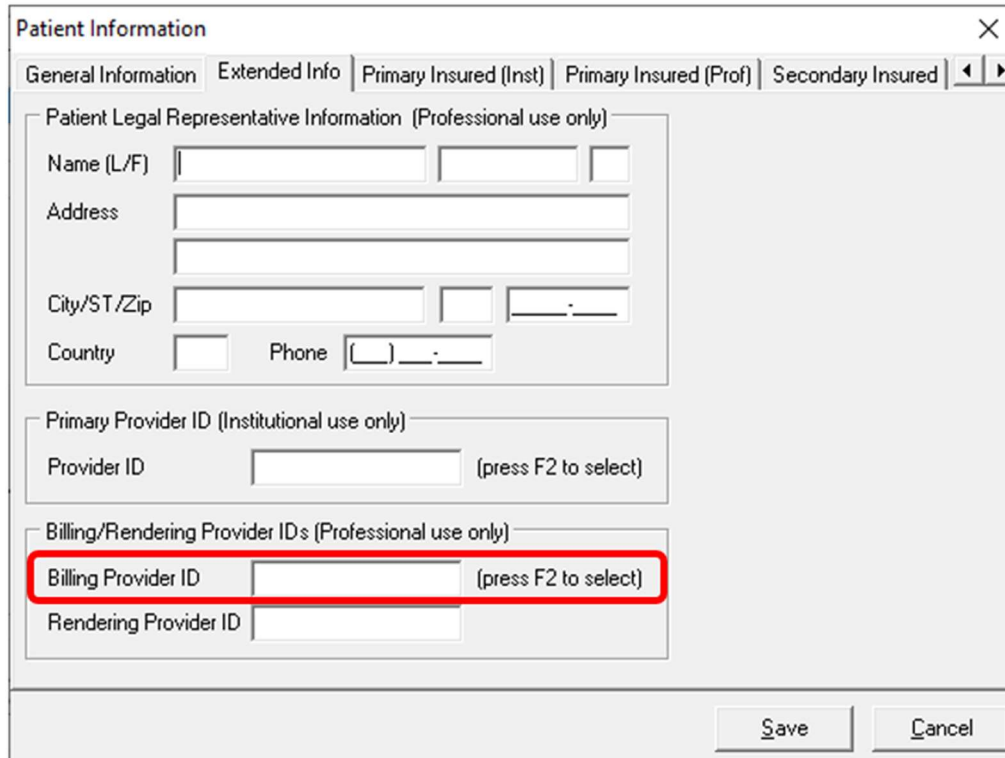
There are two boxes by **Signature on File**.

- The first box (empty in the example above) is for Medicare Part A Institutional claims and will be blank.

- The second box is for Medicare DME and Medicare Part B Professional. Right click or use the F2 lookup feature to get the list of valid values.

Release of Info has several options listed on its right click/F2 lookup list. Only **I** or **Y** are valid for Medicare DME. Any other entries will result in front end rejections.

Note: Some fields may not be required. Only enter information if it applies to this patient.

Extended Info tab:

Patient Legal Representative Information: This field should only be filled out when the patient is legally represented by someone else. For example, this would be the name of the person who has power of attorney.
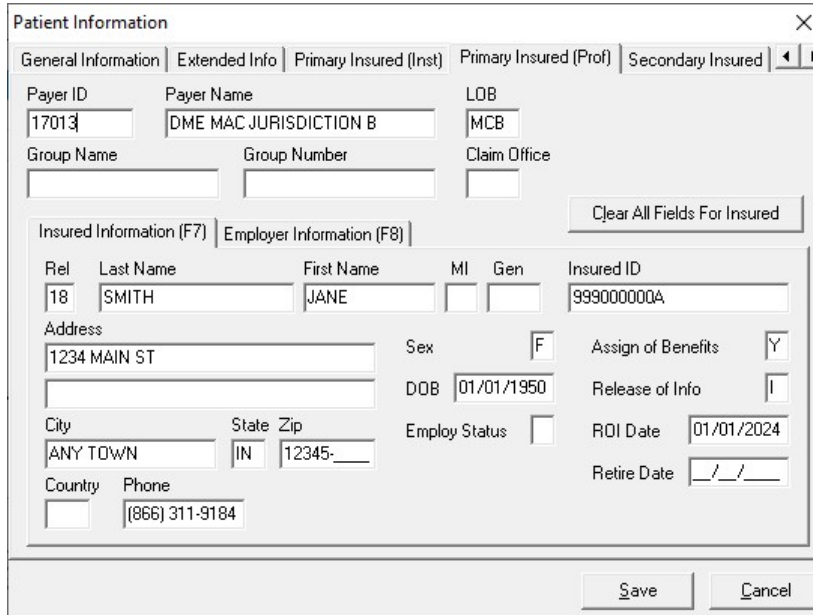
Primary Provider ID (Institutional use only): This is not used for Medicare DME and will be left blank.

Billing/Rendering Provider IDs (Professional use only):

- **Billing Provider ID** is where you can indicate which supplier is most likely the one this patient will have claims for. This will save time during claims entry.

- **Rendering Provider ID** is left blank – this is for Medicare Part B (office visit) claims, not DME.

Primary Insured (Prof) tab:

Right-click or use the F2 lookup feature to select the primary payer. This should fill in the Payer ID, Payer Name, and LOB (Line of Business) fields.

Payer ID: When claims are prepared for submission, only one Medicare Payer can be selected at a time. Either

- Select one Medicare DME Payer ID for all patients regardless of the DME MAC Jurisdiction they live in. This will allow you to send all Medicare DME claims in one transmission

- Select the proper Medicare Payer ID for the DME MAC Jurisdiction the patient lives in. This will force you to prepare separate submissions for each DME MAC Jurisdiction

Group Name and **Group Number:** These are only entered if they are indicated on the patient's insurance ID card – these are left blank for Medicare.

Claim Office: This will most likely be blank unless indicated on the insurance ID card.

Insured Information (F7):

Rel: Select the relationship of the patient to the insured party.

- For Medicare, this is always **18 – Self**. This will fill out the rest of the information.

- Use the right-click or F2 lookup function to make the appropriate choice.

Insured ID:

- For Medicare, this is the field for the Medicare ID number. It must match the information on the patient's Medicare ID card exactly.

If the patient has a secondary insurance, the insured party will be added on the **Secondary Insured** tab. For Medicare DME patients, secondary insurance information will need to be entered under **Secondary Insured (Prof).**

For more information about entering secondary insurances or Medicare as a secondary payer, please refer to the PC-ACE help documents and the PC-ACE User Guide on the CEDI Web site https://www.ngscedi.com.

Medicare does not allow tertiary insurance claims, so this tab should be left blank.

Click **Save** once all patient information is entered.

Highlight the patient you entered and click Select in the bottom right corner of the Patient Selection screen.
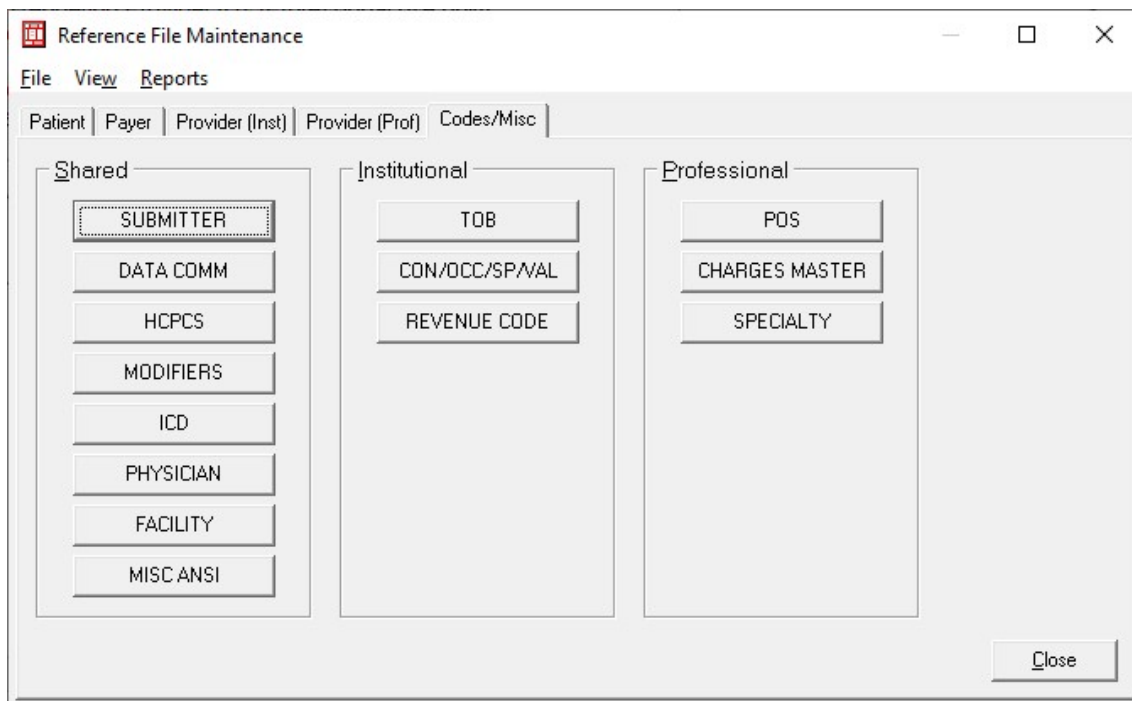
Return to "Patient Info & General tab" instructions to finish entering claim information.

Appendix B – Managing Code Lists

The Procedure codes (HCPCS), Modifiers, and ICD codes are maintained by the software. However, if a code changes or a new code is not in the list, the information can be updated under the **Reference File Maintenance** screen.
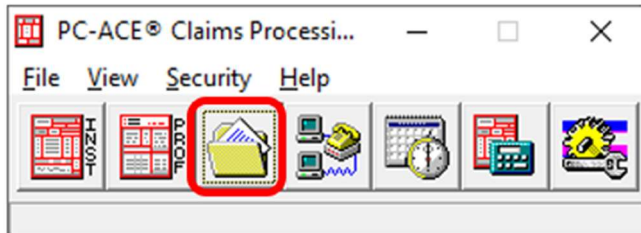
Select the **Codes/Misc** tab.

To update or add a HCPCS, Modifier, or ICD code, select the appropriate option from the list under the Shared column.

Select **New** if adding a new code not in the list.

Select **View/Update** if updating information for a current code in the list.

Managing the HCPCS List (used when entering claim information):

When entering claim information, the right-click and F2 lookup functions will access the global HCPCS list. If you would like to create a specific code set to be used, follow the directions below for **Creating a Specific HCPCS Code Set**.

Creating a Specific HCPCS Code Set:

Users can specify a specific set of codes for the Procedure Code (HCPCS) lookup feature instead of using the global list.

1. From the **Reference File Maintenance** on the tab for **Codes/Misc,** the **Charges Master** option is located in the **Professional** area on the right.

2. Enter a limited list of procedure codes (and their standard charges) which will be used.

3. **Close** the **Charges Master** and **Reference File Maintenance** when the list is complete.
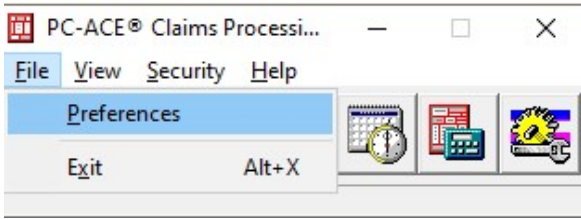
4. From the PC-ACE main menu, select **File** and **Preferences**.

5. This will produce the **Preferences** menu.
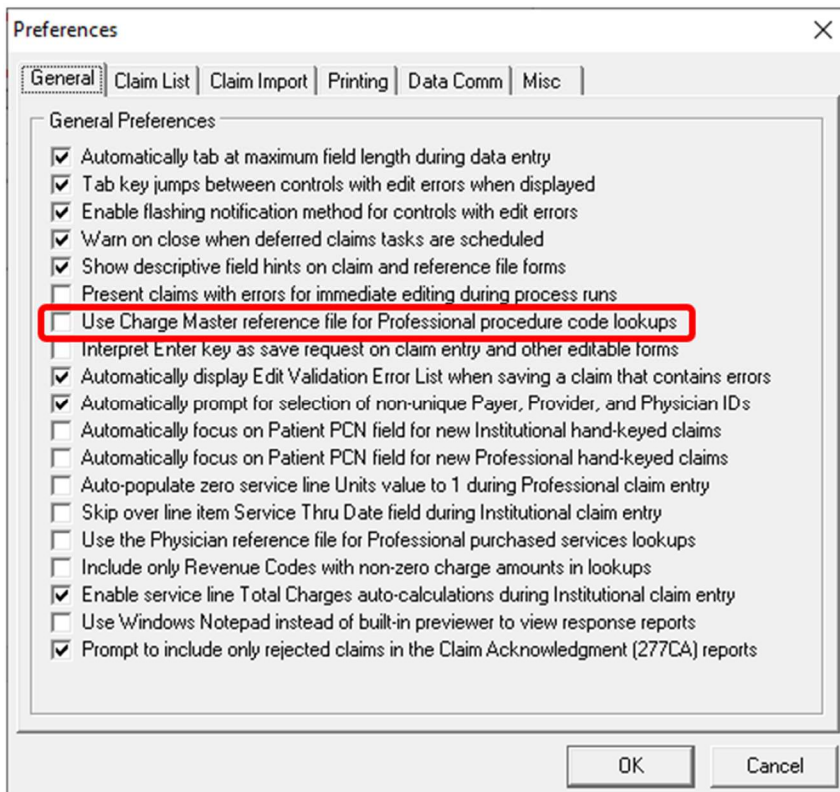
6. Place a checkmark in the box for **Use Charge Master reference file for Professional procedure code lookup**.

7. Only codes entered into the **Charges Master** area will be listed in the right-click or F2 lookup functions.

Note: The lookup functions for procedure code either make use of the general list **or** the list entered in **Charges Master**, not both.