PC-ACE PRO32

CLAIMS PROCESSING SYSTEM

USER'S MANUAL

Release 1.84

April, 2007

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Introducing PC-ACE Pro32

Welcome to MedLink Technologies' **PC-ACE Pro32 Claims Processing System** - the system of choice for electronic healthcare claims submission and management. PC-ACE Pro32 is a complete, self-contained electronic claims processing system. It can be used in a stand-alone configuration or in conjunction with your existing claims management system. Designed exclusively for Microsoft Windows, PC-ACE Pro32 is the latest generation of MedLink Technologies' electronic claims processing systems that have been successfully serving the healthcare community for over ten years.

Key Features

PC-ACE Pro32 is a comprehensive claims management system. Some of the more prominent features include:

- Combined Medicare Part A, Institutional All-Payer and Professional claims system
- Electronic submission of claims in ANSI-837 format
- Flexible claim import from existing systems
- Remittance translation/export to existing systems
- Comprehensive real-time claims editing minimizes rejected claims
- Field-level edit validation provides immediate user feedback
- Automatic code validation (diagnosis, procedure, etc.)
- Detailed claim import & edit validation error reporting
- Context-sensitive pop-up selection lists speed claim entry and promote accuracy
- Prints Institutional and Professional claims on plain paper or pre-printed forms
- Maintains claim payment history
- Unattended scheduling of claims activities
- Integrated backup, restore and file maintenance functions
- Familiar Microsoft Windows "look and feel"
- Comprehensive on-line help system
- Technical support through direct customer service line and Internet web site
- Ongoing maintenance, updates and enhancements

Thank you for choosing PC-ACE Pro32 as the electronic claims processing system for your facility or organization. It is our commitment to provide you with a quality product and outstanding support. We will strive to constantly improve and enhance PC-ACE Pro32 to serve the ever-changing needs of the healthcare community well into the 21st century.

Getting started with PC-ACE Pro32

The **PC-ACE Pro32 Claims Processing System** was designed from the ground up for the Windows environment. Special care has been taken to ensure that PC-ACE Pro32 looks and feels like other popular Windows programs. This means that you can concentrate on PC-ACE Pro32's features rather than worrying about how to navigate the program.

This section describes the recommended minimum system requirements for PC-ACE Pro32. Follow the steps to install the PC-ACE Pro32 server and client (optional) modules. The final paragraph of this "Getting Started" section will direct you to the relevant setup tasks required to get you operational with PC-ACE Pro32.

Minimum System Requirements:

- SVGA monitor resolution (800 x 600)
- Windows Vista, XP, 2000 or NT 4.0 operating system
- Adobe Acrobat Reader Version 4.0 or later (for overlaid claim printing)

Note: When the Windows "Large Fonts" display setting is enabled, the screen resolution must be 1024 x 768 or higher. The Institutional Claim Form and Professional Claim Form will not display properly at lower screen resolutions.

PC-ACE Pro32 Server Installation:

Perform these steps to install the PC-ACE Pro32 server (or single-user install):

1) If you are downloading PC-ACE Pro32, save the installation program (SETUP.EXE) to a temporary folder on your computer (for example, the Windows desktop). Double-click the **SETUP.EXE** icon to begin the PC-ACE Pro32 installation process.

   For compact disk media, the installation program should execute automatically when you insert the disk into your CDROM drive. If the Windows auto-detect feature is disabled, you may need to start the installation program manually. To do so, type "**D:\setup**" in the "Run" dialog (accessible from the Windows Start menu), substituting the drive letter of your CDROM drive for the "**D**" in this example.

2) Follow the on-screen wizard steps to complete the server installation. You will be prompted to select a destination drive. For best performance, select a drive local to your machine. If multi-user operation is required, select a drive accessible by all workstations on the network that will require PC-ACE Pro32 access. The PC-ACE Pro32 files will be installed to the WINPCACE directory on the selected drive. Desktop icons will be created for PC-ACE Pro32 and the current README file.

Note: If you performed this server installation to a remote hard drive, you can improve program execution speed on this workstation by also performing the client installation below. This will install a copy of the PC-ACE Pro32 main program and support files to your local hard drive. If you performed the server installation to a local hard drive, you should skip the client installation for this workstation. You will still be required to perform the client installation for any additional workstations that require PC-ACE Pro32 access.

PC-ACE Pro32 Client Installation:

If multi-user operation is required, perform this client installation procedure from each workstation that requires PC-ACE Pro32 access. Perform these steps to install the PC-ACE Pro32 client:

1) Confirm that the workstation has network access (via a mapped drive letter) to the hard drive volume containing the PC-ACE Pro32 server installation directory (WINPCACE). You must have access to this remote drive volume before proceeding with the PC-ACE Pro32 client installation.
2) Using the Windows Explorer, locate the client installation program (**CLIENT32.EXE**) in the **WINPCACE** directory on the server. Execute this program directly from the remote drive volume (do not copy CLIENT32.EXE to your local system).
3) Follow the on-screen wizard steps to complete the client installation. You will be prompted to select a local destination drive. The PC-ACE Pro32 program and client support files will be installed to the WINPCACE directory on the selected local drive. In addition, a PC-ACE Pro32 shortcut icon will be created and placed on your Windows desktop

Logging In The First Time

Users are required to log into PC-ACE Pro32 before performing any system activities. The login process involves entering a User ID and optional Password. As shipped, PC-ACE Pro32 is configured with a single default user with full system access rights. The default user's User ID is "**SYSADMIN**" and password is "**SYSADMIN**" as well. If you are logging into PC-ACE Pro32 for the first time, use this default login (unless instructed otherwise by your distributor). If the default login does not work, review the installation guidelines provided by your distributor. Distributors often pre-configure the security system according to their own internal specifications. If you still have difficulties logging into the system, contact your distributor for assistance. **IMPORTANT:** You should change the default user's password as soon as possible if you are concerned about controlling user access at your facility.

How To Use This Help System

This on-line help system provides instant access to helpful information from anywhere in the PC-ACE Pro32 system. Features of the on-line help system include:

- **Context-Sensitive Access** - Just press the "**F1**" key from anywhere in PC-ACE Pro32 to display help information relevant to your current location in the program. For example, hitting "**F1**" while entering an Institutional claim will display the "Institutional Claim Form" topic.
- **Help System Contents** - The "**Contents**" tab of the PC-ACE Pro32 help system presents all help topics in a nested "table of contents" format. Just double-click on a topic entry to display the topic, or double-click on a folder entry to reveal the next level of topics and folders.
- **Help System Index** - The "**Index**" tab of the PC-ACE Pro32 help system lists all available index entries and allows the user to easily jump to the first index entry that matches a user-entered search string. Just double-click on an index entry to display the corresponding topic.
- **Help System Search** - The "**Search**" tab (labeled "Find" on older Help systems) of the PC-ACE Pro32 help system permits the user to perform a free-form text search of all topics in the entire help system. Simply enter the search word or phrase and the topics that include this search string will be automatically listed. Again, just double-click an entry in the search results list to open the corresponding topic.

Within the various help topic windows, you will encounter several informational icons positioned in the left margin. These are used to convey additional information that may be of special interest.

This informational icon is used to pass along tips that improve the usability of the application.

This informational icon is used to present special notes relating to the current help topic. These may indicate a requirement or restriction of the application. In some cases, they are simply general interest items.

This informational icon is used to bring attention to an important issue relating to the current topic. Often these instructions must be taken to ensure optimum operation of an application feature.

Where Do I Go From Here?

You will need to perform a few setup tasks before using PC-ACE Pro32 to process claims. Proceed to the appropriate setup section below based on the type of claims you will be processing.

- Medicare Part A clients proceed to the Setup of Medicare Part A Systems section.
- Institutional All-Payer clients proceed to the Setup of Institutional All-Payer Systems section.
- Professional clients proceed to the Setup of Professional Systems section.

These sections present detailed instructions on how to set-up your PC-ACE Pro32 system.

PC-ACE Pro32 Setup Procedures

Setup of Medicare Part A Systems

This section describes the setup procedures required to prepare your **PC-ACE Pro32** system for **Medicare Part A Only** claims processing. Topics to be covered include setting up the Payer, Provider, and Patient (optional) reference files. A section on claim import considerations is included for users who will be importing claims from an upstream claims management system. Finally, a section covering considerations for claims preparation and transmission should be reviewed.

Your distributor may have already completed some of the setup steps described in this section. Supplement this setup topic with any installation notes provided by your distributor. If you are in doubt about exactly which steps you need to perform, contact your distributor for assistance.

You may want to print this help topic and refer to the printed version as you perform these setup steps. You can check off the steps as they are completed. This technique also frees you to jump around between on-line help topics without losing your place in the setup procedure. To print the topic, just click the "**Print**" button at the top of this on-line Help screen.

Payer Reference File Setup

This section describes the process of setting up the Payer reference file. This file contains information about the valid payers in your system. All payers to be specified on your Medicare Part A claims must exist in the Payer reference file (with the exception of a special "dump" payer). Complete the following steps as needed:

You may want to refer to the "Adding and maintaining payers" topic for more information on entering Payer records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Payer**" tab to display a list of all existing Payer records.

   One or more Payer records may already exist in the system if your distributor has already setup this reference file for you. Consult the distributor's installation notes or contact your distributor for assistance before continuing this Payer setup procedure.

2) Click the "**New**" button to display the Payer Information form. Enter the new payer's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

   The "**Payer ID**", "**LOB**", and "**Usage**" fields together serve as the identification "key" for this Payer record. A specific "Payer ID / LOB" combination may exist for a maximum of two Payer records. If two such Payer records are defined, then their "Usage" settings must not overlap. Valid "Usage" settings include "**U**" (Institutional use only), "**H**" (Professional

use only), and "**B**" or **blank** (unrestricted use). The only valid situation where two Payer records with the same "Payer ID / LOB" combination may exist is when one of the records specifies a "Usage" value of "U" (Institutional use only) and the other record specifies a "Usage" value of "H" (Professional use only). This feature permits Payers for shared LOBs such as Commercial (COM) to optionally have distinct settings and PrintLink matching strings for Institutional versus Professional use.

An individual Payer record must be setup for each line-of-business (LOB) handled by that payer. For example, if payer "12345" will receive both Medicare and Medicaid claims, then two Payer records must be added - both with Payer ID = "**12345**", one with LOB = "**MCA**", and the other with LOB = "**MCD**".

Since this is a Medicare Part A Only system, it is conceivable that you will only be required to setup one Payer record. This record would contain the Payer ID of your Medicare Part A payer and an LOB of "MCA". You may decide to add additional Payer records for other lines of business if you want to include these on the claim's secondary and tertiary payer lines.

3) Click the "**Save**" button to save the new Payer record. An edit validation process will be performed to check for problems with the payer information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Payer record should now be visible in the Payer list.

If you plan on using the **PrintLink** feature of PC-ACE Pro32 to import claims from "print image" files, then you will also need to add **PrintLink Matching Description** strings to this Payer record. The "Claim Import Considerations" section later in this topic will lead you through this process.

4) Repeat the relevant steps to create additional Payer records as needed. This may include records for the same payer (and different LOBs) or records for additional payers.

5) When all desired Payer records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Provider Reference File Setup

This section describes the process of setting up the Institutional Provider reference file. This file contains information about the valid providers in your system. All providers for whom you will be billing Medicare Part A claims must exist in the Institutional Provider reference file. The Institutional Provider reference file is organized such that each record describes a valid provider for a ***single*** line of business (LOB). This organization allows for greater flexibility in specifying Provider IDs and support information (Tax ID, address, etc) that can vary across multiple LOBs for a single provider. Complete the following steps as needed:

You may want to refer to the "Adding and maintaining providers (Institutional)" topic for more information on entering Institutional Provider records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Provider**" tab to display a list of all existing Provider records.

2) If you have just installed PC-ACE Pro32, the Provider list should be empty. If so, skip to the next step.

Some distributors include sample provider records for illustration purposes. You can choose to either modify these existing records to add any missing information, or delete them and build your Provider reference file from scratch.

If the list is not empty, consult your distributor's installation instructions or contact the distributor to confirm that the existing Provider records can be safely deleted. To delete a Provider record, select the desired record in the list and click the "**Delete**" button. Click the "**OK**" button on the Provider Deletion Confirmation form to confirm the deletion request. Make sure the list is empty before continuing with the next step.

3) Click the "**New**" button to display the Institutional Provider Information form. Enter the first provider's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

4) Enter the provider's name and address information. Enter the Provider ID in the "**Provider ID/No.**" field and the line of business in the "**LOB**" field (probably "**MCA**"). The "**Payer ID**" field is only needed if you want to restrict assignment of this provider to a specific payer. Normally, the "**Payer ID**" field will be left blank. You can also leave the "**Tag**" field blank. Complete entry of the remaining provider fields as desired.

5) Click the "**Save**" button to save the new Provider record. An edit validation process will be performed to check for problems with the provider information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Provider record should now be visible in the Provider list.

6) Repeat the last few steps to add each additional Provider record. Now each time you click the "**New**" button, you will be prompted to select whether you want a completely new provider (all fields blank to start with), or whether you would like to inherit the name/address information from the currently selected provider. If you choose the "inherit" option, you will also have the option to "associate" the new provider record with the selected provider record. Provider records should be "associated" when they represent the same entity. For example, if a provider supports multiple lines of business, one provider record for each LOB should be created, and these related provider records should be "associated" with each other. The "inherit" and "associate" options can be a real timesaver when setting up providers that support multiple lines of business. In this scenario, select an existing provider in the list, click the "**New**" button, and choose the "**inherit**" and "**associate**" options. You will see that the top portion of the Provider Information form will be completed automatically. Simply tab through or overwrite the "**Provider ID/No.**" field (may be the same or different), enter a unique line of business identifier in the "**LOB**" field, and click the "**Save**" button.

7) When you have finished adding Provider records, you should have one record for each applicable line of business (LOB) for each provider entity. When all desired Provider records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Patient Reference File Setup

This section describes the process of setting up the Patient reference file. Setup of the Patient reference file is optional. If you choose to setup patients, the complete patient list will be accessible during claim entry using the variable-list lookup feature. When a patient is selected from the lookup list during claim entry, all applicable patient information will be automatically loaded into the appropriate claim form fields. Complete the following steps as needed:

You may want to refer to the "Adding and maintaining patients" topic for more information on entering Patient records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Patient**" tab to display a list of all existing Patient records.

2) If you have just installed PC-ACE Pro32, the Patient list should be empty. If so, skip to the next step. If the list is not empty, any existing Patient records are likely there as samples only. Once you have confirmed that this is the case, delete all sample Patient records. To delete a Patient record, select the desired record in the list, click the "**Delete**" button, and confirm the deletion.

3) Click the "**New**" button to display the Patient Information form. Enter the patient information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

   The Patient reference file contains general patient information as well as optional primary, secondary, and tertiary insured details. Enter as much information as you have available for the patient.

4) Click the "**Save**" button to save the new Patient record. An edit validation process will be performed to check for problems with the patient information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Patient record should now be visible in the Patient list.

5) Repeat the relevant steps to create additional Patient records as needed.

6) When all desired Patient records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

User Account Setup

PC-ACE Pro32 requires that a valid login and optional password be entered by anyone desiring access to the system. The system administrator must set up a "user" account for each person that will use PC-ACE Pro32. The user account specifies the user's login/password values and defines which activities the user has permission to perform. As shipped, PC-ACE Pro32 is configured with a single default user with full system access rights. The default user's User ID is "**SYSADMIN**" and password is "**SYSADMIN**" as well. Complete the following steps to add additional user accounts:

You may want to refer to the "Adding or modifying a system user" topic for more information on adding and maintaining users. If you do, make sure and return to this topic to continue the setup steps.

1) Select the main "Security" menu from the PC-ACE Pro32 Main Toolbar and choose the "Add/Update User" item. The Security List form will display a list of all existing user accounts.

2) To add a new user account, click the "New" button on the Security List form and assign the user a User ID, Password and Name. Assign permissions to this user and click the "OK" button to save the new user record.

Check the checkbox next to the permission to allow access to the activity. Click the "**Check All**" and "**Clear All**" buttons to quickly check or un-check all user permission checkboxes.

3) Repeat the previous step to create additional user accounts.

If changes are made to a user profile, the changes will not go into effect until the next time that user logs into system. Select the "**Logout Current User**" item on the main "**Security**" menu to manually log out without exiting the system.

You should change the default user's password as soon as possible if you are concerned about controlling user access at your facility.

Claim Import Considerations

This section describes setup considerations that should be reviewed **only** if you intend to import claims into PC-ACE Pro32 from an upstream system. If you will not be importing claims, skip this section entirely. Three methods are available for importing claims - **Print Image (PrintLink)**, **Intermediate Delimited Format**, and **Electronic Media Claims (EMC) Format**.

Getting setup to import claims into PC-ACE Pro32 typically involves coordination with your distributor. If you are interested in importing claims using the PrintLink print image method, but your distributor does not provide PrintLink support, ask that they refer you directly to the software manufacturer for assistance. PrintLink functionality may be licensed and supported as an "add-on" to your base PC-ACE Pro32 system.

You may want to refer to the "Importing claims" topic for a discussion of these claim import methods. If you do, make sure and return to this topic to continue the setup steps.

Review only the setup considerations applicable to the claim import method you intend to use.

- **Print Image (PrintLink)** - imports claims from a print image file. If using this claim import method, complete the following steps:

  1) Have your distributor perform a one-time "**PrintLink mapping**" procedure on a sample print image file that you have supplied. This mapping process defines the template used to extract and interpret fields from your print image file. Since all upstream systems print claims in a slightly different format, this mapping process is required to build your custom template.

  2) Obtain the resulting "**map**" file from your distributor. This file is typically named "**ub92.map**", but can be any valid filename with a "**.map**" extension. The map file must be placed in the server's "**winpcace\impub92**" directory.

  3) Confirm the existence of the required "**map control**" file. This file provides a control interface between the output of the PrintLink translator and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlu.win**", and should be located in the server's "**winpcace\impub92**" directory.

  4) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the print file to specific Payer reference file records. Refer to the "Adding and maintaining payers" topic for details on setting up your PrintLink Matching Description strings.

Each time you want to import claims, copy the new print image file generated by your upstream system into the server's "**winpcace\impub92**" directory. The first line of the map file provided by your distributor dictates what the print image file must be named (typically "**ub92.prt**").

- **Intermediate Delimited Format** - imports claims from a file in "intermediate delimited" format. If using this claim import method, complete the following steps:

  1) Work with your distributor to develop the programs necessary to produce a file in "**intermediate delimited**" format from your upstream system. Your distributor should have detailed specifications of this internal file format. Verify that the generated files meet these specifications.

  2) Confirm the existence of the required "**map control**" file. This file provides a control interface between the intermediate delimited file and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlu.win**", and should be located in the server's "**winpcace\impub92**" directory.

  3) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the intermediate delimited file to specific Payer reference file records. Refer to the "Adding and maintaining payers" topic for details on setting up your PrintLink Matching Description strings.

  4) Each time you want to import claims, copy the new intermediate delimited file generated by your upstream system into the server's "**winpcace\impub92**" directory. The file must be named "**plink.out**".

- **Electronic Media Claims (EMC) Format** - import claims from a file in Electronic Media Claims (EMC) format. If using this claim import method, complete the following steps:

  1) Confirm that your upstream system is capable of producing a supported version Electronic Media Claims (EMC) format file. Contact your distributor for the list of supported EMC file versions.

  2) Each time you want to import claims, copy the new EMC file generated by your upstream system into the server's "**winpcace\impub92**" directory. The file must have a "**.dat**" file extension (e.g., "EMC192.DAT").

Claim Prepare & Transmit Considerations

This section describes setup considerations that should be reviewed before you attempt to prepare and transmit claims using PC-ACE Pro32.

Your distributor may have already performed some (or all) of this setup for you. Consult your distributor's installation instructions or contact the distributor if it is unclear how to proceed.

1) Setup default Institutional **submitter** information in the PC-ACE Pro32 Submitter reference file. Information from this reference file is required during preparation of Electronic Media Claims (EMC) files. Consult your distributor's installation instructions or contact the distributor for assistance in setting up this critical reference file.

   Refer to the "Submitter File Maintenance" topic for more information on setting up the default Submitter record.

2) If required by your distributor, setup default Institutional **data communications** parameters in the PC-ACE Pro32 Data Communications reference file. This reference file contains the Institutional data communications parameters exported to the "bcdatcom.dat" file prior to the

launch of any external data communications program (e.g., file transmission). These parameters are used by the third-party data communications program to control the file transmission, etc.

Refer to the "Data Communications File Maintenance" topic for more information on setting up the default Data Communications record.

This completes the required setup steps to ready PC-ACE Pro32 for **Medicare Part A Only** claims processing.

Setup of Institutional All-Payer Systems

This section describes the setup procedures required to prepare your **PC-ACE Pro32** system for **Institutional All-Payer** claims processing. Topics to be covered include setting up the Payer, Provider, and Patient (optional) reference files. A section on claim import considerations is included for users who will be importing claims from an upstream claims management system. Finally, a section covering considerations for claims preparation and transmission should be reviewed.

Your distributor may have already completed some of the setup steps described in this section. Supplement this setup topic with any installation notes provided by your distributor. If you are in doubt about exactly which steps you need to perform, contact your distributor for assistance.

You may want to print this help topic and refer to the printed version as you perform these setup steps. You can check off the steps as they are completed. This technique also frees you to jump around between on-line help topics without losing your place in the setup procedure. To print the topic, just click the "**Print**" button at the top of this on-line Help screen.

Payer Reference File Setup

This section describes the process of setting up the Payer reference file. This file contains information about the valid payers in your system. All payers to be specified on your Institutional claims must exist in the Payer reference file (with the exception of a special "dump" payer). Complete the following steps as needed:

You may want to refer to the "Adding and maintaining payers" topic for more information on entering Payer records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Payer**" tab to display a list of all existing Payer records.

   One or more Payer records may already exist in the system if your distributor has already setup this reference file for you. Consult the distributor's installation notes or contact your distributor for assistance before continuing this Payer setup procedure.

2) Click the "**New**" button to display the Payer Information form. Enter the new payer's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

   The "**Payer ID**", "**LOB**", and "**Usage**" fields together serve as the identification "key" for this Payer record. A specific "Payer ID / LOB" combination may exist for a maximum of two Payer records. If two such Payer records are defined, then their "Usage" settings must not overlap. Valid "Usage" settings include "**U**" (Institutional use only), "**H**" (Professional use only), and "**B**" or **blank** (unrestricted use). The only valid situation where two Payer records with the same "Payer ID / LOB" combination may exist is when one of the records

specifies a "Usage" value of "U" (Institutional use only) and the other record specifies a "Usage" value of "H" (Professional use only). This feature permits Payers for shared LOBs such as Commercial (COM) to optionally have distinct settings and PrintLink matching strings for Institutional versus Professional use.

An individual Payer record must be setup for each line-of-business (LOB) handled by that payer. For example, if payer "12345" will receive both Medicare and Medicaid claims, then two Payer records must be added - both with Payer ID = "**12345**", one with LOB = "**MCA**", and the other with LOB = "**MCD**".

3) Click the "**Save**" button to save the new Payer record. An edit validation process will be performed to check for problems with the payer information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Payer record should now be visible in the Payer list.

If you plan on using the **PrintLink** feature of PC-ACE Pro32 to import claims from "print image" files, then you will also need to add **PrintLink Matching Description** strings to this Payer record. The "Claim Import Considerations" section later in this topic will lead you through this process.

4) Repeat the relevant steps to create additional Payer records as needed. This may include records for the same payer (and different LOBs) or records for additional payers.

5) When all desired Payer records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Provider Reference File Setup

This section describes the process of setting up the Institutional Provider reference file. This file contains information about the valid providers in your system. All providers for whom you will be billing Institutional claims must exist in the Institutional Provider reference file. The Institutional Provider reference file is organized such that each record describes a valid provider for a ***single*** line of business (LOB). This organization allows for greater flexibility in specifying Provider IDs and support information (Tax ID, address, etc) that can vary across multiple LOBs for a single provider. Complete the following steps as needed:

You may want to refer to the "Adding and maintaining providers (Institutional)" topic for more information on entering Institutional Provider records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Provider (Inst)**" (or just "**Provider**") tab to display a list of all existing Provider records.

2) If you have just installed PC-ACE Pro32, the Provider list should be empty. If so, skip to the next step. If the list is <u>not</u> empty, contact your distributor to confirm that the existing Provider records can be safely deleted. To delete a Provider record, select the desired record in the list and click the "**Delete**" button. Click the "**OK**" button on the Provider Deletion Confirmation form to confirm the deletion request. Make sure the list is empty before continuing with the next step.

3) Click the "**New**" button to display the Institutional Provider Information form. Enter the first provider's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

4) Enter the provider's name and address information. Enter the Provider ID in the "**Provider ID/No.**" field and the line of business in the "**LOB**" field. The "**Payer ID**" field is only needed if you want to restrict assignment of this provider to a specific payer. Normally, the "**Payer ID**" field will be left blank. You can also leave the "**Tag**" field blank. Complete entry of the remaining provider fields as desired.

5) Click the "**Save**" button to save the new Provider record. An edit validation process will be performed to check for problems with the provider information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Provider record should now be visible in the Provider list.

6) Repeat the last few steps to add each additional Provider record. Now each time you click the "**New**" button, you will be prompted to select whether you want a completely new provider (all fields blank to start with), or whether you would like to inherit the name/address information from the currently selected provider. If you choose the "inherit" option, you will also have the option to "associate" the new provider record with the selected provider record. Provider records should be "associated" when they represent the same entity. For example, if a provider supports multiple lines of business, one provider record for each LOB should be created, and these related provider records should be "associated" with each other. The "inherit" and "associate" options can be a real timesaver when setting up providers that support multiple lines of business. In this scenario, select an existing provider in the list, click the "**New**" button, and choose the "**inherit**" and "**associate**" options. You will see that the top portion of the Provider Information form will be completed automatically. Simply tab through or overwrite the "**Provider ID/No.**" field (may be the same or different), enter a unique line of business identifier in the "**LOB**" field, and click the "**Save**" button.

7) When you have finished adding Provider records, you should have one record for each applicable line of business (LOB) for each provider entity. When all desired Provider records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Patient Reference File Setup

This section describes the process of setting up the Patient reference file. Setup of the Patient reference file is optional. If you choose to setup patients, the complete patient list will be accessible during claim entry using the variable-list lookup feature. When a patient is selected from the lookup list during claim entry, all applicable patient information will be automatically loaded into the appropriate claim form fields. Complete the following steps as needed:

You may want to refer to the "Adding and maintaining patients" topic for more information on entering Patient records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Patient**" tab to display a list of all existing Patient records.

2) If you have just installed PC-ACE Pro32, the Patient list should be empty. If so, skip to the next step. If the list is <u>not</u> empty, any existing Patient records are likely there as samples only. Once you have confirmed that this is the case, delete all sample Patient records. To delete a Patient record, select the desired record in the list, click the "**Delete**" button, and confirm the deletion.

3) Click the "**New**" button to display the Patient Information form. Enter the patient information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

The Patient reference file contains general patient information as well as optional primary, secondary, and tertiary insured details. Enter as much information as you have available for the patient.

4) Click the "**Save**" button to save the new Patient record. An edit validation process will be performed to check for problems with the patient information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Patient record should now be visible in the Patient list.

5) Repeat the relevant steps to create additional Patient records as needed.

6) When all desired Patient records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

User Account Setup

PC-ACE Pro32 requires that a valid login and optional password be entered by anyone desiring access to the system. The system administrator must set up a "user" account for each person that will use PC-ACE Pro32. The user account specifies the user's login/password values and defines which activities the user has permission to perform. As shipped, PC-ACE Pro32 is configured with a single default user with full system access rights. The default user's User ID is "**SYSADMIN**" and password is "**SYSADMIN**" as well. Complete the following steps to add additional user accounts:

You may want to refer to the "Adding or modifying a system user" topic for more information on adding and maintaining users. If you do, make sure and return to this topic to continue the setup steps.

1) Select the main "**Security**" menu from the PC-ACE Pro32 Main Toolbar and choose the "**Add/Update User**" item. The Security List form will display a list of all existing user accounts.

2) To add a new user account, click the "**New**" button on the Security List form and assign the user a User ID, Password and Name. Assign permissions to this user and click the "**OK**" button to save the new user record.

   Check the checkbox next to the permission to allow access to the activity. Click the "**Check All**" and "**Clear All**" buttons to quickly check or un-check all user permission checkboxes.

3) Repeat the previous step to create additional user accounts.

If changes are made to a user profile, the changes will not go into effect until the next time that user logs into system. Select the "**Logout Current User**" item on the main "**Security**" menu to manually log out without exiting the system.

You should change the default user's password as soon as possible if you are concerned about controlling user access at your facility.

Claim Import Considerations

This section describes setup considerations that should be reviewed **only** if you intend to import claims into PC-ACE Pro32 from an upstream system. If you will not be importing claims, skip this section entirely. Three methods are available for importing claims - **Print Image (PrintLink)**, **Intermediate Delimited Format**, and **Electronic Media Claims (EMC) Format**.

Getting setup to import claims into PC-ACE Pro32 typically involves coordination with your distributor. If you are interested in importing claims using the PrintLink print image method, but your distributor does not provide PrintLink support, ask that they refer you directly to the software manufacturer for assistance. PrintLink functionality may be licensed and supported as an "add-on" to your base PC-ACE Pro32 system.

You may want to refer to the "Importing claims" topic for a discussion of these claim import methods. If you do, make sure and return to this topic to continue the setup steps.

Review only the setup considerations applicable to the claim import method you intend to use.

- **Print Image (PrintLink)** - imports claims from a print image file. If using this claim import method, complete the following steps:
  1) Have your distributor perform a one-time "PrintLink mapping" procedure on a sample print image file that you have supplied. This mapping process defines the template used to extract and interpret fields from your print image file. Since all upstream systems print claims in a slightly different format, this mapping process is required to build your custom template.
  2) Obtain the resulting "**map**" file from your distributor. This file is typically named "**ub92.map**", but can be any valid filename with a "**.map**" extension. The map file must be placed in the server's "**winpcace\impub92**" directory.
  3) Confirm the existence of the required "**map control**" file. This file provides a control interface between the output of the PrintLink translator and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlu.win**", and should be located in the server's "**winpcace\impub92**" directory.
  4) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the print file to specific Payer reference file records. Refer to the "Adding and maintaining payers" topic for details on setting up your PrintLink Matching Description strings.
  5) Each time you want to import claims, copy the new print image file generated by your upstream system into the server's "**winpcace\impub92**" directory. The first line of the map file provided by your distributor dictates what the print image file must be named (typically "**ub92.prt**").
- **Intermediate Delimited Format** - imports claims from a file in "intermediate delimited" format. If using this claim import method, complete the following steps:
  1) Work with your distributor to develop the programs necessary to produce a file in "**intermediate delimited**" format from your upstream system. Your distributor should have detailed specifications of this internal file format. Verify that the generated files meet these specifications.
  2) Confirm the existence of the required "**map control**" file. This file provides a control interface between the intermediate delimited file and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlu.win**", and should be located in the server's "**winpcace\impub92**" directory.
  3) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the intermediate delimited file to specific Payer reference file records. Refer to the "Adding and

maintaining payers" topic for details on setting up your PrintLink Matching Description strings.

4) Each time you want to import claims, copy the new intermediate delimited file generated by your upstream system into the server's "**winpcace\impub92**" directory. The file must be named "**plink.out**".

- **Electronic Media Claims (EMC) Format** - import claims from a file in Electronic Media Claims (EMC) format. If using this claim import method, complete the following steps:

  1) Confirm that your upstream system is capable of producing a supported version Electronic Media Claims (EMC) format file. Contact your distributor for the list of supported EMC file versions.

  2) Each time you want to import claims, copy the new EMC file generated by your upstream system into the server's "**winpcace\impub92**" directory. The file must have a "**.dat**" file extension (e.g., "EMC192.DAT").

Claim Prepare & Transmit Considerations

This section describes setup considerations that should be reviewed before you attempt to prepare and transmit claims using PC-ACE Pro32.

Your distributor may have already performed some (or all) of this setup for you. Consult your distributor's installation instructions or contact the distributor if it is unclear how to proceed.

1) Setup default Institutional **submitter** information in the PC-ACE Pro32 Submitter reference file. Information from this reference file is required during preparation of Electronic Media Claims (EMC) files. Consult your distributor's installation instructions or contact the distributor for assistance in setting up this critical reference file.

   Refer to the "Submitter File Maintenance" topic for more information on setting up the default Submitter record.

2) If required by your distributor, setup default Institutional **data communications** parameters in the PC-ACE Pro32 Data Communications reference file. This reference file contains the Institutional data communications parameters exported to the "bcdatcom.dat" file prior to the launch of any external data communications program (e.g., file transmission). These parameters are used by the third-party data communications program to control the file transmission, etc.

   Refer to the "Data Communications File Maintenance" topic for more information on setting up the default Data Communications record.

This completes the required setup steps to ready PC-ACE Pro32 for **Institutional All-Payer** claims processing.

Setup of Professional Systems

This section describes the setup procedures required to prepare your **PC-ACE Pro32** system for **Professional All-Payer** claims processing. Topics to be covered include setting up the Payer, Provider, and Patient (optional) reference files. A section on claim import considerations is included for users who will be importing claims from an upstream claims management system. Finally, a section covering considerations for claims preparation and transmission should be reviewed.

Your distributor may have already completed some of the setup steps described in this section. Supplement this setup topic with any installation notes provided by your distributor. If you are in doubt about exactly which steps you need to perform, contact your distributor for assistance.

You may want to print this help topic and refer to the printed version as you perform these setup steps. You can check off the steps as they are completed. This technique also frees you to jump around between on-line help topics without losing your place in the setup procedure. To print the topic, just click the "**Print**" button at the top of this on-line Help screen.

Payer Reference File Setup

This section describes the process of setting up the Payer reference file. This file contains information about the valid payers in your system. All payers to be specified on your Professional claims must exist in the Payer reference file (with the exception of a special "dump" payer). Complete the following steps as needed:

You may want to refer to the "Adding and maintaining payers" topic for more information on entering Payer records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Payer**" tab to display a list of all existing Payer records.

   One or more Payer records may already exist in the system if your distributor has already setup this reference file for you. Consult the distributor's installation notes or contact your distributor for assistance before continuing this Payer setup procedure.

2) Click the "**New**" button to display the Payer Information form. Enter the new payer's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

   The "**Payer ID**", "**LOB**", and "**Usage**" fields together serve as the identification "key" for this Payer record. A specific "Payer ID / LOB" combination may exist for a maximum of two Payer records. If two such Payer records are defined, then their "Usage" settings must not overlap. Valid "Usage" settings include "**U**" (Institutional use only), "**H**" (Professional use only), and "**B**" or **blank** (unrestricted use). The only valid situation where two Payer records with the same "Payer ID / LOB" combination may exist is when one of the records

specifies a "Usage" value of "U" (Institutional use only) and the other record specifies a "Usage" value of "H" (Professional use only). This feature permits Payers for shared LOBs such as Commercial (COM) to optionally have distinct settings and PrintLink matching strings for Institutional versus Professional use.

An individual Payer record must be setup for each line-of-business (LOB) handled by that payer. For example, if payer "12345" will receive both Medicare and Medicaid claims, then two Payer records must be added - both with Payer ID = "**12345**", one with LOB = "**MCB**", and the other with LOB = "**MCD**".

3) Click the "**Save**" button to save the new Payer record. An edit validation process will be performed to check for problems with the payer information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Payer record should now be visible in the Payer list.

If you plan on using the **PrintLink** feature of PC-ACE Pro32 to import claims from "print image" files, then you will also need to add **PrintLink Matching Description** strings to this Payer record. The "Claim Import Considerations" section later in this topic will lead you through this process.

4) Repeat the relevant steps to create additional Payer records as needed. This may include records for the same payer (and different LOBs) or records for additional payers.

5) When all desired Payer records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Provider Reference File Setup

This section describes the process of setting up the Professional Provider reference file. This file contains information about the valid providers in your system. All providers for whom you will be billing Professional claims must exist in the Professional Provider reference file. The Professional Provider reference file is organized such that each record describes a valid provider for a ***single*** line of business (LOB). This organization allows for greater flexibility in specifying Provider IDs and support information (Tax ID, address, etc) that can vary across multiple LOBs for a single provider. Complete the following steps as needed:

The Professional provider structure defines 3 distinct provider types – (1) Provider Groups, (2) Individual Providers Within A Group, and (3) Solo Providers. Professional claims require a "billing" provider that can be either a "group" or "solo" provider (but not an "individual within a group"). The Professional claim entry provider lookups and claim editing process will enforce this requirement. You will be required to assign one of the 3 provider types to each provider you add during this setup procedure.

If it is not clear which type is appropriate in each instance, you may want to refer to the "Adding and maintaining providers (Professional)" topic for a more complete description of the various provider types. If you do, make sure and return to this topic to continue the setup steps. If you are sill unsure, contact your distributor for assistance.

To setup the Professional Provider reference file, complete the following steps:

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Provider (Prof)**" (or just "**Provider**") tab to display a list of all existing Provider records.

2) If you have just installed PC-ACE Pro32, the Provider list should be empty. If so, skip to the next step. If the list is <u>not</u> empty, contact your distributor to confirm that the existing Provider records can be safely deleted. To delete a Provider record, select the desired record in the list and click the "**Delete**" button. Click the "**OK**" button on the Provider Deletion Confirmation form to confirm the deletion request. You must delete all "Indiv" type Provider

records before deleting "Solo" and "Group" type Provider records. Make sure the list is empty before continuing with the next step.

3) Click the "**New**" button to display the Professional Provider Information form. Enter the first provider's information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

4) Select the desired "**Provider Type**" and enter the provider's name, address and contact information. Enter the Provider ID in the "**Provider ID/No.**" field and the line of business in the "**LOB**" field. The "**Payer ID**" field is only needed if you want to restrict assignment of this provider to a specific payer. Normally, the "**Payer ID**" field will be left blank. You can also leave the "**Tag**" field blank. Enter a unique "**Group Label**" for the first "group" provider record defined for each group. When adding an "individual in group" provider record, perform a lookup in the "Group Label" field and select the group in which this individual provider will be a member. Complete entry of the remaining provider fields as desired.

5) Click the "**Save**" button to save the new Provider record. An edit validation process will be performed to check for problems with the provider information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Provider record should now be visible in the Provider list.

6) Repeat the last few steps to add each additional Professional Provider record. Now each time you click the "**New**" button, you will be prompted to select whether you want a completely new provider (all fields blank to start with), or whether you would like to inherit the name/address information from the currently selected provider. If you choose the "inherit" option, you will also have the option to "associate" the new provider record with the selected provider record. Provider records should be "associated" when they represent the same entity. For example, if a solo provider supports multiple lines of business, one "solo" provider record for each LOB should be created, and these related provider records should be "associated" with each other. The "inherit" and "associate" options can be a real timesaver when setting up providers that support multiple lines of business. In this scenario, select an existing provider in the list, click the "**New**" button, and choose the "**inherit**" and "**associate**" options. You will see that the top portion of the Provider Information form will be completed automatically. Simply tab through or overwrite the "**Provider ID/No.**" field (may be the same or different), enter a unique line of business identifier in the "**LOB**" field, and click the "**Save**" button.

7) When you have finished adding Professional Provider records, you should have one record for each applicable line of business (LOB) for each "solo", "group", or "individual in group" provider entity. When all desired Provider records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

Patient Reference File Setup

This section describes the process of setting up the Patient reference file. Setup of the Patient reference file is optional. If you choose to setup patients, the complete patient list will be accessible during claim entry using the variable-list lookup feature. When a patient is selected from the lookup list during claim entry, all applicable patient information will be automatically loaded into the appropriate claim form fields. Complete the following steps as needed:

You may want to refer to the "Adding and maintaining patients" topic for more information on entering Patient records. If you do, make sure and return to this topic to continue the setup steps.

1) From the PC-ACE Pro32 Main Toolbar, click the "**Reference File Maintenance**" button to display the Reference File Maintenance form. Select the "**Patient**" tab to display a list of all existing Patient records.

2) If you have just installed PC-ACE Pro32, the Patient list should be empty. If so, skip to the next step. If the list is not empty, any existing Patient records are likely there as samples only. Once you have confirmed that this is the case, delete all sample Patient records. To delete a Patient record, select the desired record in the list, click the "**Delete**" button, and confirm the deletion.

3) Click the "**New**" button to display the Patient Information form. Enter the patient information, taking advantage of the built-in lookups where possible (by pressing the "**F2**" key or right-clicking the mouse).

   Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

   The Patient reference file contains general patient information as well as optional primary, secondary, and tertiary insured details. Enter as much information as you have available for the patient.

4) Click the "**Save**" button to save the new Patient record. An edit validation process will be performed to check for problems with the patient information. When prompted, correct any missing or invalid field values (if present) and re-save as needed. The new Patient record should now be visible in the Patient list.

5) Repeat the relevant steps to create additional Patient records as needed.

6) When all desired Patient records have been added, click the "**Close**" button on the Reference File Maintenance form to return to the PC-ACE Pro32 Main Toolbar.

User Account Setup

PC-ACE Pro32 requires that a valid login and optional password be entered by anyone desiring access to the system. The system administrator must set up a "user" account for each person that will use PC-ACE Pro32. The user account specifies the user's login/password values and defines which activities the user has permission to perform. As shipped, PC-ACE Pro32 is configured with a single default user with full system access rights. The default user's User ID is "**SYSADMIN**" and password is "**SYSADMIN**" as well. Complete the following steps to add additional user accounts:

You may want to refer to the "Adding or modifying a system user" topic for more information on adding and maintaining users. If you do, make sure and return to this topic to continue the setup steps.

1) Select the main "**Security**" menu from the PC-ACE Pro32 Main Toolbar and choose the "**Add/Update User**" item. The Security List form will display a list of all existing user accounts.

2) To add a new user account, click the "**New**" button on the Security List form and assign the user a User ID, Password and Name. Assign permissions to this user and click the "**OK**" button to save the new user record.

   Check the checkbox next to the permission to allow access to the activity. Click the "**Check All**" and "**Clear All**" buttons to quickly check or un-check all user permission checkboxes.

3) Repeat the previous step to create additional user accounts.

If changes are made to a user profile, the changes will not go into effect until the next time that user logs into system. Select the "**Logout Current User**" item on the main "**Security**" menu to manually log out without exiting the system.

You should change the default user's password as soon as possible if you are concerned about controlling user access at your facility.

Claim Import Considerations

This section describes setup considerations that should be reviewed **only** if you intend to import claims into PC-ACE Pro32 from an upstream system. If you will not be importing claims, skip this section entirely. Three methods are available for importing claims - **Print Image (PrintLink)**, **Intermediate Delimited Format**, and **Electronic Media Claims (EMC) Format**.

Getting setup to import claims into PC-ACE Pro32 typically involves coordination with your distributor. If you are interested in importing claims using the PrintLink print image method, but your distributor does not provide PrintLink support, ask that they refer you directly to the software manufacturer for assistance. PrintLink functionality may be licensed and supported as an "add-on" to your base PC-ACE Pro32 system.

You may want to refer to the "Importing claims" topic for a discussion of these claim import methods. If you do, make sure and return to this topic to continue the setup steps.

Review only the setup considerations applicable to the claim import method you intend to use.

- **Print Image (PrintLink)** - imports claims from a print image file. If using this claim import method, complete the following steps:

  1) Have your distributor perform a one-time "**PrintLink mapping**" procedure on a sample print image file that you have supplied. This mapping process defines the template used to extract and interpret fields from your print image file. Since all upstream systems print claims in a slightly different format, this mapping process is required to build your custom template.

  2) Obtain the resulting "**map**" file from your distributor. This file is typically named "**h1500.map**", but can be any valid filename with a "**.map**" extension. The map file must be placed in the server's "**winpcace\imp1500**" directory.

  3) Confirm the existence of the required "**map control**" file. This file provides a control interface between the output of the PrintLink translator and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlh.win**", and should be located in the server's "**winpcace\imp1500**" directory.

  4) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the print file to specific Payer reference file records. Refer to the "Adding and maintaining payers" topic for details on setting up your PrintLink Matching Description strings.

  5) Each time you want to import claims, copy the new print image file generated by your upstream system into the server's "**winpcace\imp1500**" directory. The first line of the map file provided by your distributor dictates what the print image file must be named (typically "**h1500.prt**").

- **Intermediate Delimited Format** - imports claims from a file in "intermediate delimited" format. If using this claim import method, complete the following steps:

1) Work with your distributor to develop the programs necessary to produce a file in "**intermediate delimited**" format from your upstream system. Your distributor should have detailed specifications of this internal file format. Verify that the generated files meet these specifications.
2) Confirm the existence of the required "**map control**" file. This file provides a control interface between the intermediate delimited file and the PC-ACE Pro32 claim import routines. The map control file is always named "**mapcntlh.win**", and should be located in the server's "**winpcace\imp1500**" directory.
3) Setup all required PrintLink Matching Description strings in the Payer reference file. These strings are used to match payer descriptions from claims in the intermediate delimited file to specific Payer reference file records. Refer to the "Adding and maintaining payers" topic for details on setting up your PrintLink Matching Description strings.
4) Each time you want to import claims, copy the new intermediate delimited file generated by your upstream system into the server's "**winpcace\imp1500**" directory. The file must be named "**plink.out**".

❖ **Electronic Media Claims (EMC) Format** - import claims from a file in Electronic Media Claims (EMC) format. If using this claim import method, complete the following steps:

1) Confirm that your upstream system is capable of producing a supported version Electronic Media Claims (EMC) format file. Contact your distributor for the list of supported EMC file versions.
2) Each time you want to import claims, copy the new EMC file generated by your upstream system into the server's "**winpcace\imp1500**" directory. The file must have a "**.dat**" file extension (e.g., "EMC320.DAT").

Claim Prepare & Transmit Considerations

This section describes setup considerations that should be reviewed before you attempt to prepare and transmit claims using PC-ACE Pro32.

Your distributor may have already performed some (or all) of this setup for you. Consult your distributor's installation instructions or contact the distributor if it is unclear how to proceed.

1) Setup default Professional **submitter** information in the PC-ACE Pro32 Submitter reference file. Information from this reference file is required during preparation of Electronic Media Claims (EMC) files. Consult your distributor's installation instructions or contact the distributor for assistance in setting up this critical reference file.

   Refer to the "Submitter File Maintenance" topic for more information on setting up the default Submitter record.

2) If required by your distributor, setup default Professional **data communications** parameters in the PC-ACE Pro32 Data Communications reference file. This reference file contains the Professional data communications parameters exported to the "bsdatcom.dat" file prior to the launch of any external data communications program (e.g., file transmission). These parameters are used by the third-party data communications program to control the file transmission, etc.

   Refer to the "Data Communications File Maintenance" topic for more information on setting up the default Data Communications record.

This completes the required setup steps to ready PC-ACE Pro32 for **Professional All-Payer** claims processing.

Main Toolbar & Forms

The PC-ACE Pro32 Main Toolbar

All **PC-ACE Pro32** functions are available from the main toolbar action buttons and menu. This toolbar consumes only a small amount of your valuable desktop space, and can be set to dock automatically to any desktop corner (or float if desired). The toolbar action buttons provide quick access to:

Import, enter, modify, process, and prepare Institutional claims and attachments.

Import, enter, modify, process, and prepare Professional claims.

Maintain all supporting reference files (patient, payer, provider, etc.).

Launch your claim submission and related data communication software.

Schedule delayed and daily recurring claim activities.

Launch the ANSI-835 Electronic Remittance program.

Perform system backup/restore and other maintenance functions.

Send support mail to your distributor (may not be available).

The main "**File**" menu provides access to the Preferences dialog used to customize PC-ACE Pro32 to your particular installation and style. The main "**Security**" menu provides access to the system's user maintenance and security features and also allows the current user to logout. The main "**Help**" menu provides access to this on-line help system, the **Online Software Update** utility, and the PC-ACE Pro32 "About" box (containing the PC-ACE Pro32 program version number and important copyright information).

Institutional & Professional Claims Menus

Most claim activities in **PC-ACE Pro32** are initiated from one of 2 essentially identical claim activity menu forms (one each for Institutional and Professional claim activities). The menu's action buttons provide access to the most commonly used claim activities:

Import claims from a print file (PrintLink) or alternate source.

Enter claims manually.

Maintain existing claims from a comprehensive list.

Process imported or reactivated claims automatically.

Prepare claims into an EMC file for transmission.

The form's "**View**" menu provides access to the most recent claim import, claim status request, and eligibility benefit request reports, as well as the claim activity log. The "**Attachments**" menu (Institutional only) includes options to create and maintain Home Health Plans of Care (Form No. CMS-485 / CMS-486). Options to create and maintain Institutional Medical Attachments (Rehab 700/701, Ambulance, ESRD) are also provided. In addition, a few handy claim activity maintenance functions are available from the "**Maintain**" menu. These include the ability to reverse the most recent claim import run, to review and reactivate previously prepared EMC files for re-transmission, to review and maintain ANSI-997 transmission acknowledgment files, to launch the PC-ACE Pro32 Report Manager, to add and maintain patient eligibility benefit requests, to prepare an ANSI-270 eligibility benefit request file for transmission, to view and maintain ANSI-271 eligibility benefit response files, to prepare an ANSI-276 claim status request file, and to review and maintain ANSI-277 claim status response files. **Note:** Certain capabilities may not be available on your installations. Only those capabilities supported by your distributor will be visible in these menus.

Claim List Form Features

The **PC-ACE Pro32** Claim List form provides a versatile interface from which the user can create, list, modify, print, and otherwise maintain claims. Click either the "**Institutional Claims Processing**" button or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to open the corresponding Claims Menu form. Then click the "**List Claims**" button on the Claims Menu form to open the desired Claim List form. You may reposition and resize this form if desired. The list can be easily sorted and filtered to display only the claims of interest. The Institutional and Professional Claim List forms are virtually identical. All procedures described in this section pertain to both claim types unless otherwise specified.

Sorting Claims

The claim list may be sorted by Patient Name, Patient Control Number (PCN), Entry Date, Service Date and Transmit Date. Simply select the desired sort order from the available "**Sort By**" radio buttons.

Filtering Claims

The claim list may be filtered to display a select subset of claims by manipulating the "**Claim List Filter Options**" drop-down lists. Basic filter options include:

- **Location** - filters the claim list to include only claims in the "to be transmitted" (**CL**), "transmitted" (**TR**), or "paid" (**PD**) locations. An additional "transmitted + paid" **(TR/PD)** selection is available to display both transmitted and paid claims. This selection may provide a more comprehensive view of the claims during payment posting, for example.
- **Status** - filters the claim list to include only claims assigned a specific status. The possible status codes are: "clean/ready" **(CLN),** "deleted" **(DEL)**, "has fatal errors" **(ERF)**, "has errors" **(ERR),** "held" **(HLD)** and "unprocessed" **(UNP)**.

  Note that selecting a status of "**DEL**" is the only way to view "deleted" claims (which can be recovered until they are purged from the system).
- **LOB** - filters the claim list to include only claims for a specific line of business.

In addition to these basic filter options, the Claim List form also provides a number of **Advanced Filter Options**. These advanced options permit filtering on the claim's patient, payer, provider, date ranges, batch information, bill type and numerous other criteria. When multiple filter criteria are specified, only those claims that meet **all** filter criteria will be displayed.

The initial display of transmitted/paid claims in the Claim List form may be optionally limited to only the most recently transmitted claims. Refer to the PC-ACE Pro32 Miscellaneous preferences topic for a description of this feature, and to review the current settings. Limiting the number of transmitted/paid claims being displayed in the claim list can improve the list's responsiveness in some situations. To display transmitted/paid claims older than the current transmit date window, simply click the **"Advanced Filter Options"** button and enter the desired Transmit Date range.

Claim Actions

The Claim List form may also be used to perform specific actions on any individual claim or a group of selected claims. To perform an action on an individual claim, simply select the claim from the list and click the desired action button (along the lower edge of the form). The

complete list of claim actions can be accessed from the Claim List form's main "**Actions**" menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected claim). Available claim actions include:

- **Creating New Claims** -- Click the "**New**" button (or choose the "**Create New Claim**" action) to create a new claim. See the "Adding a new claim" topic for more details.
- **Viewing/Modifying Claims** -- Click the "**View/Update**" button (or choose the "**View/Update Selected Claim**" action) to view and/or modify the selected claim. See the "Institutional Claim Form" or "Professional Claim Form" topics for details on using the PC-ACE Pro32 claim entry forms.

  The View/Update action is the default claim action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired claim record or by selecting the desired record and pressing the "**ENTER**" key.

  Holding down the "**SHIFT**" key while invoking the View/Update action on an eligible claim will force an automatic save attempt on the claim. This is a shortcut technique equivalent to invoking the View/Update action and subsequently clicking the "Save" button on the claim entry form. It minimizes the keystrokes required to work claims from the Claim List form. Eligible claims are those in the "to be transmitted" (CL) location with a status of either "unprocessed" (UNP), "has errors" (ERR), or "has fatal errors" (ERF).
- **Deleting Claims** -- Click the "**Delete**" button (or choose the "**Delete Selected Claim**" action) to delete the selected claim. Deleted claims are assigned a "DEL" status, and can be recovered (i.e., "un-deleted") if needed. See the "Purging Claims" action description below for instructions on permanently removing claims from the PC-ACE Pro32 database.
- **Copying Claims** -- Click the "**Copy**" button (or choose the "**Copy Selected Claim**" action) to copy the selected claim. When copying a single claim, the claim entry form will be displayed containing the details of the newly copied claim. The claim copy function may be used to create a duplicate of a previously transmitted claim for repeat billing in a subsequent period, or for submission of a Coordination of Benefits (COB) claim to the secondary or tertiary payer.
- **Holding Claims** -- Choose the "**Hold Selected Claim**" action to change the status of the selected claim to "hold" (HLD). Held claims are not considered for future claim activities such as automated claim processing or claim preparation.
- **Releasing Claims** -- Choose the "**Release Selected Claim**" action to release a previously held claim. In addition to releasing the claim, this action also sets the status of the selected claim to "unprocessed" (UNP).
- **Printing Claims** -- Choose the "**Print Selected Claim**" action to print the selected claim. Claims may be printed using either a plain paper image overlay technique or the traditional pre-printed forms method. See the "Printing claims" topics for more details.
- **Posting Claim Payments** -- Choose the "**Show Selected Claim Payments**" action to post, view, or modify payments for the selected claim. Claim posting may also be performed from the appropriate claim entry form. See the "Posting claim payments (Institutional)" and "Posting claim payments (Professional)" topics for more details.
- **Purging Claims** -- Choose the "**Purge Selected Claim**" action to purge the selected claim. Claims in the "to be transmitted" (CL) location must be deleted before being purged.

  IMPORTANT: Purged claims are permanently deleted from PC-ACE Pro32 … they cannot be recovered.

- **Reactivating Claims** -- Choose the "**Reactivate Selected Claim**" action to reactivate the selected claim. This action will move the previously transmitted claim from the "transmitted" (TR) or "paid" (PD) location into the "to be transmitted" (CL) location. The reactivated claim will be assigned the "unprocessed" (UNP) status. See the "Reactivating previously transmitted claims" topic for more details.
- **Archiving Claims** -- Choose the "**Archive Selected Claim**" action to move the selected claim from the current claim database to the open claim archive database. Only claims in the "transmitted" (TR) and "paid" (PD) locations are eligible for archiving. Refer to the "Archiving and unarchiving claims" topic for more information on the PC-ACE Pro32 claim archiving feature.
- **Unarchiving Claims** -- Choose the "**Unarchive Selected Claim**" action while viewing the claims in an open claim archive to move the selected claim from the archive database to the current claim database. Refer to the "Archiving and unarchiving claims" topic for more information on the PC-ACE Pro32 claim archiving feature.
- **Setting Claim Media** -- Choose the "**Set Selected Claim Media**" action to designate the selected claim for either "electronic" or "paper" submission. Only claims with a media setting of "electronic" (E) will be eligible for preparation into an EMC file. Claims with a media setting of "paper" (P) can be printed and submitted in hardcopy form. When a "paper" claim is printed, you will be given the option to move the claim from the "to be transmitted" (CL) location to the "transmitted" (TR) location automatically.

  Support for "paper" claims may be disabled by the distributor. If the "**Set Selected Claim Media**" action item is not visible, then your system does not support paper claim processing and all claims must be submitted electronically.
- **Requesting Claim Status** -- Choose the "**Request Selected Claim Status**" action to add the selected claim to the claim status request queue. Status requests can only be made for claims in the "transmitted" (TR) and "paid" (PD) locations. Any number of claims can be queued using this action item. Once all desired claims have been queued, refer to the "Preparing claim status request files for transmission" topic for instructions on preparing the ANSI-276 claim status response file.

  Support for the ANSI-276/277 claim status request/response feature may be disabled by the distributor. If the "**Request Selected Claim Status**" action item is not visible, then your system does not support the claim status request/response feature.
- **Show Selected Claim Status History** -- Choose the "**Show Selected Claim Status History**" action to view and maintain the claim status request/response history for the selected claim. This action is available for claims in the "transmitted" (TR) and "paid" (PD) locations only. Refer to the "Viewing and maintaining the claim status request/response history" topic for more information on how to use the Claim Status Request/Response History form.

  Support for the ANSI-276/277 claim status request/response feature may be disabled by the distributor. If the "**Show Selected Claim Status History**" action item is not visible, then your system does not support the claim status request/response feature.
- **Refreshing the Claim List** -- Choose the "**Refresh Claim List**" action (or press the "**F5**" function key) to refresh the current Claim List form contents. This action can be useful in a multi-user installation to be sure that the claim list properly reflects claim additions and/or modifications made by other users.

You will notice that only applicable actions are enabled for use in the main "**Actions**" menu or pop-up menu. For example, it makes no sense to "reactivate" a claim that has yet to be transmitted, so this action will be disabled for claims in the "CL" location.

Actions on Multiple Claims

Some actions can be performed on multiple claims at once. Multiple claim selection is accomplished by "checking" the claim of interest and subsequently performing one of the "**… All Checked Claims**" actions. To check a claim, click the left mouse button over the checkbox in the first column of the desired list row. Alternatively, all claims in the current list can be checked using the "**Check All Claims**" item from the list's pop-up menu. Use the flexible Claim List form filter techniques to display only the subset of claims to be printed, deleted, held, etc. Then simply check all claims and perform the desired action on all checked claims at once.

Use the "**Check All Claims From Selected Transmission**" filter option to quickly identify (i.e., "check") all claims that were included in a specific transmission file. This filter option can be especially useful if, for example, it becomes necessary to reactivate all claims from a recent transmission file. A warning will be displayed if one or more of the claims from the selected transmission file are no longer present in the claim list. This filter option can be accessed from the Claim List form's main "**Filter**" menu, and will be available only when viewing claims in the "transmitted" (TR) and "transmitted + paid" (TR/PD) locations.

Claim List Field Customization

The Claim List form field definitions are highly customizable. Many of the Institutional and Professional claim data elements may be included (or excluded) from the list. The display order, column width, and column headings of each selected field may also be customized. See the "Claim List Preferences" topic for a description of the list customization process. **NOTE:** Some distributors may disable this customization feature.

Claim List Filter Menu

Several claim list filtering and related functions are accessible from the Claim List form's main "**Filter**" menu:

- **Clear Filters** – Clears any existing filter criteria and refreshes the claim list to display all claims in the selected location.
- **Advanced Filter Options** – Opens the Advanced Claim List Filter Criteria for to permit filtering on the claim's patient, payer, provider, date ranges, batch information, bill type and numerous other criteria. When multiple filter criteria are specified, only those claims that meet **all** filter criteria will be displayed.

  You may observe that the Transmit Date is being populated automatically even when you've cleared the advanced filter settings. This is normal when the Claim List form is configured to limit the initial display of transmitted/paid claims. Refer to the PC-ACE Pro32 Miscellaneous preferences topic for a description of this feature, and to review the current settings.
- **Check (Uncheck) All Claims** – Permits the user to "check" (or "uncheck") all claims currently displayed in the claim list – presumably in anticipation of some action to be performed on this block of claims. See the "Actions on Multiple Claims" section above for more information.

- **Check All Claims From Selected Transmission** – Provides an easy way to "check" all claims included in a previous transmission file. The Institutional or Professional Claim Transmission Log form will display a list of recent transmission files (with the most recent automatically selected). Select the desired transmission file entry and click the "**Select**" button. Upon return to the Claim List form, the program will automatically check all claims included in the selected transmission. This feature is especially useful in situations where all claims from a previous transmission need to be reactivated, modified, and then re-prepared into a new transmission file. After selecting the desired transmission file entry, the user would simply choose the "**Reactivate All Checked Claims**" item from the form's main "**Actions**" menu to complete the reactivation process. Refer to the "Reactivating previously transmitted claims" topic for more information on reactivating previously transmitted claims.
- **Check All Queued Claims For Status Request** – This is simply a convenience feature that will "check" all claims that are currently queued for inclusion in the next ANSI-276 claim status request file. It can be used as a reminder of which claims have already been added to the queue. See the "Preparing claim status request files for transmission" topic for information on how to use the ANSI-276/277 claim status request/response feature.
- **Clear Claim Status Request Queue** – Clears the ANSI-276 claim status request queue. See the "Preparing claim status request files for transmission" topic for information on how to use the ANSI-276/277 claim status request/response feature.

  Support for the ANSI-276/277 claim status request/response feature may be disabled by the distributor. If the "**Check All Queued Claims For Status Request**" and "**Check Claim Status Request Queue**" action items are not visible, then your system does not support the claim status request/response feature.

Claim List Reports

Several reports and special print functions are accessible from the Claim List form's main "**Reports**" menu:

- **Print Claim Detail Report** – Select this item to print a detailed report of either all "listed" or all "checked" claims. If one or more claims in the list are "checked", then only the checked claims will be included in the report. If no claims are checked, then the report will include all listed claims. The previewed report may be printed if desired by clicking the printer button at the top of the report preview form. To print a detailed report on a specific subset of claims, first use the Claim List form's filter capabilities to display only the claims of interest. If even more specific identification is required, then simply "check" only those claims that are to be included in the report.
- **Print Claims for Paper Submission** – Select this item to print all (or a subset) of claims currently eligible for paper submission. A claim is eligible for paper submission if it has a media setting of "paper" (P), resides in the "to be transmitted" (CL) location, and has a "clean" (CLN) status (or, optionally, a "non-fatal errors" (ERR) status). When printing claims for paper submission, you will have the option to print all eligible claims or just eligible claims for a selected payer. You will also choose whether or not to include eligible claims with a status of "non-fatal errors" (ERR). After each eligible claim is printed, you will be prompted to automatically move the claim to the "transmitted" (TR) location. Since paper claims will never be prepared into an EMC file, this prompt provides the only available mechanism for moving these claims out of the "to be transmitted" (CL) location. When multiple paper claims are eligible for submission, you may use the convenient "Yes To All" ("No To All") button to move (not move) all eligible paper claims to the "transmitted" (TR) location after printing.

When printing claims for paper submission, you will also have the option to print these same claims on behalf of their alternate (non-submission) payers. This feature can be useful if you also need to submit paper claims to the secondary or tertiary payers, for example. Refer to the "Printing claims" topic for more details on the alternate payer printing feature.

Support for "paper" claims may be disabled by the distributor. If the "**Print Claims for Paper Submission**" menu item is not visible, then your system does not support paper claim processing and all claims must be submitted electronically.

The Institutional Claim Form

The Institutional Claim Form provides access to all data elements of an Institutional claim. New claims are entered and existing claims are viewed and/or modified from this form. The Institutional Claim Form has been designed to provide a data entry flow resembling that of the printed Institutional (CMS-1450) claim form. Claim fields are grouped logically on these major tabs:

- **Patient Info & Codes** - includes fields for general claim and patient information. Also includes the Condition, Occurrence, Span, and Value code fields.
- **Billing Line Items** - includes all claim line item fields, extended line item fields, and line-level MSP/COB fields. This major tab contains a number of second-level tabs to accommodate the additional line-level fields.
- **Payer Info** - includes payer, provider, insured, and employer fields for the primary, secondary, and tertiary payers.
- **Diagnosis/Procedure** - includes fields for diagnosis codes, procedure codes and dates, physician information, and a few miscellaneous data elements.
- **Extended General** - includes additional patient and general claim-level fields.
- **Ext. General (2)** - includes additional Condition, Occurrence, Occurrence Span and Value code fields and most reserved CMS-1450 form locator fields.
- **Extended Payer** - includes less frequently used payer, insured, and authorization fields for the primary, secondary, and tertiary payers. Also includes fields for Medicare Secondary Payer (MSP) and other secondary claims where Coordination of Benefits (COB) information is required. This major tab consists of a number of second-level tabs that provide access to this extended information in a logical and efficient manner.
- **Home Health** (situational) - includes additional certification data elements which may be required for submission of Home Health claims in ANSI-837 format. This tab will be shown or hidden based on the value in the associated ANSI-837 Home Health indicator (located on the "Diagnosis/Procedure" tab).

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between these major claim form sections.

Entering Claim Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the claim form fields, respectively.

A number of productivity enhancing features are available during claim data entry:

- **Fixed-List Lookups** - The claim entry form supports fixed-list lookups on many of the claim's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, "Patient Sex" typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the claim form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - The claim entry form supports variable-list lookups on a number of the claim's fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Most variable-list lookups use other claim field values (the specified claim "LOB", for example) to filter the presented list. For example, provider lookups attempt to present only those provider records applicable to the claim being entered. In addition, variable-list lookups often retrieve data used to fill in other claim form fields. For example, selection of a Patient from the variable-list lookup completes numerous patient-related fields on the claim. Access variable list lookups using the same method described above for fixed-list lookups.
- **Recurring Field Sets** - Field "sets" consist of two or more logically-related fields. For example, most ANSI/X12 reference identifiers include an identification number and a type code, or qualifier. It is often a requirement to support a variable number of occurrences of a particular field set. The claim entry form provides an intelligent combo (i.e., dropdown) control to allow entry and maintenance of such recurring field sets.

  To identify a recurring field set, look for the selector which will be positioned adjacent to the rightmost field in the set. The recurring field set and associated selector function in the following manner:

  - As the user tabs normally away from the last field in the set, the focus will automatically return to the first field in the set and the next data occurrence will be displayed. Only when all occurrences have been displayed will the focus move to the next field on the claim entry form. This behavior permits the user to view all occurrences without using the mouse, and also provides an opportunity to enter new data if desired.
  - Click the selector graphic to open the dropdown list and display all existing data occurrences. A vertical scrollbar will appear as needed to permit access to all occurrences. Select an entry from the list or press the "**ESC**" key (or click elsewhere on the form) to close the dropdown list. The data values corresponding to the selected entry will be displayed in the field set and are now available for editing as needed.
  - To add a new occurrence to a field set, either tab through all existing occurrences until an empty field set is displayed or simply select the "**[Enter New ...]**" item in the dropdown list.
  - Press the "**F7**" key while positioned on any field in the set to delete the selected occurrence. You will be prompted to confirm the deletion.
  - If the focus moves away from a recurring field set while an empty occurrence is displayed, the field set will automatically display the data for the first occurrence, if any, rather than leave the screen fields blank.
  - The edit validation process understands the recurring nature of these special field sets, and will automatically reposition to the proper occurrence when displaying edit validation errors.
- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Intelligent Groups Tabs** - The Institutional claim form contains a number of field "groups". Examples of such groups include Condition, Occurrence, Span, Value, Diagnosis, and Procedure codes. Fields in these groups are always completed sequentially. Therefore, when a field in one of these groups is left empty, it can be assumed that data entry in the group is complete. When the "**TAB**" key is pressed, the remaining fields in that group will be skipped and the cursor will be positioned on the first field in the tab sequence beyond the group fields.

- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most claim form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.
- **Descriptive Field Hints** - Most claim form fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over" hints, since they become visible when the mouse pointer moves over the specified field (without actually selecting the field). This feature can be disabled in the general preferences settings if desired.
- **Line Item Scrolling** - The Billing Line Items tab displays 8 claim lines at a time. For claims that contain more than 8 line items, the user may scroll through the claim line items one line at a time or one page (i.e., 8 lines) at a time using the buttons provided along the right edge of this tab.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all claim line items one page at a time.
- **Line Item Features** - The following productivity features are available on the Billing Line Items tab:
  - **Current Line Tracking** - The Billing Line Items tab contains a number of second-level tabs. The first second-level tab (Line Item Details) displays the basic line item fields available on the hard-copy Institutional claim form. The remaining second-level tabs are linked to the currently selected line on the Line Item Details tab. As the cursor moves from one line to another on the Line Item Details tab, the remaining second-level tabs will track the new current line. This technique provides an efficient method of providing access to a large number of data elements on a potentially large number of claim lines. Notice that the Extended Details tab caption always reports the current line for reference.
  - **Line Duplication** - Press the "**F5**" key while positioned on any field on a line to copy the values in <u>all</u> fields of the previous line into the current line.
  - **Field Duplication** -- Press the "**F4**" key while positioned on a specific field on a line to copy the value of that single field from the previous line into the current line.
  - **Line Deletion** - Press the "**F7**" key while positioned on any field on a line to delete the line. You will be prompted to confirm the deletion. Alternatively, enter the value "***DEL***" (that's an asterisk plus "DEL" plus another asterisk, without the double-quotes) into the HCPCS field on a claim line to delete the line.

    Claim lines are automatically re-sequenced by Revenue Code when a claim is saved. As such, there is no need to provide line rearrangement capabilities.
  - **Advance To Next Line** - Press the "**F8**" key while positioned on any field on a line to automatically advance the cursor to the first field of the next line, skipping over any remaining fields on the current line.
  - **Jump To Narrative** - Press the "**<ALT>N**" key combination while positioned on any field on a line to automatically position on the "84 - Remarks" field. Enter the desired narrative text and press the "**<TAB>**" key to return to the original line field.

- **Line Item Totals Recalculation** – The Billing Line Items tab provides a "**Recalculate**" button located near the bottom of the tab adjacent to the totals fields. Click this button to recalculate and update the "Total Charges" and "Total Non-Covered Charges" fields from the current claim line item charges values. NOTE: This button may not be available on some installations.
- **Payer / Insured Features** - The following payer and/or insured information productivity features are available:
  - **Quick Payer Access** - Press the "**<ALT>I**" key combination while positioned anywhere on the Patient Info & Codes tab to move immediately to the primary payer's "Payer ID" field. Press the "**<ALT>O**" key combination to move immediately to the secondary payer's "Payer ID" field.
  - **Clear Payer Feature** - The Payer Information tab provides a "**Clear Payer**" button for each of the 3 claim payers. Click this button to clear **all** payer, provider, insured, and employer fields for the associated payer.
- **Coordination of Benefits (COB) Support** – The claim form includes fields to allow entry of Coordination of Benefits (COB) data at both the claim and line levels when appropriate. Enter a "**Y**" in the "COB?" field to make these COB-related fields available for use. The "COB?" field is located in the upper right quadrant of the Diagnosis/Procedure tab. See the section entitled "Coordination of Benefits" later in this topic for details on this advanced capability.

When the focus leaves a claim form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the claim form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process.

Coordination of Benefits

The Institutional Claim Form includes fields to allow entry of Coordination of Benefits (COB) information at the claim and/or line level. Claims submitted to secondary or tertiary payers may be required to report the payment remittance data returned by prior payers. Medicare Secondary Payer (MSP) claims, for example, must include specific COB information obtained from the primary payer in order to insure prompt processing by Medicare.

Since Coordination of Benefits information is not required on all claims, the screen tabs containing COB-related fields are hidden by default. Enter a "**Y**" in the "COB?" field to make these COB-related fields available for use The "COB?" field is located in the upper right quadrant of the Diagnosis/Procedure tab.

Two distinct levels of Coordination of Benefits reporting are supported:

- **Claim-Level COB Reporting** – Remittance data which is not specific to a particular service line is reported at the claim level. The claim form provides claim-level COB fields for both the primary and secondary payers. These fields are located on the "COB Info (Primary) and "COB Info (Secondary)" sub-tabs of the Extended Payer tab.
- **Line-Level COB Reporting** – Remittance data specific to a particular service line is reported at the line level. The claim form provides a set of line-level COB fields for each service line. These fields are located on the "MSP/COB" sub-tab of the Billing Line Items tab. This sub-tab tracks the currently selected service line in the same manner as the

other extended line item sub-tabs. The current service line is identified in the "MSP/COB" sub-tab caption (e.g., "MSP/COB (Line 4)").

The decision to report COB information at the claim versus line level is made by the payer and communicated to the provider via a remittance. The remittance may be in electronic (ANSI-835) or paper format, and typically serves as the source for all COB data to be entered into the claim form's COB fields.

There's no need to re-enter claims for submission to secondary payers if the original claim was processed through PC-ACE Pro32. Simply use the Institutional Claim List form to locate the original claim in the "TR – transmitted" location, select the "**Copy**" action to create the new secondary claim, and enter the LOB applicable to the secondary payer. Finally, enter a "**Y**" in the "COB?" field on the Diagnosis/Procedure tab to activate the COB-related fields. You will then have a duplicate of the original claim ready to add the primary payer's COB information.

The claim-level COB data is entered on the "**COB Info (Primary)**" and "**COB Info (Secondary)**" sub-tabs of the Extended Payer tab. The purpose and use of the various field groups on these sub-tabs are as follows:

- **Claim-Level Adjustments (CAS)** – Permits entry of one or more claim-level adjustments as reported by the payer. Adjustments are defined by a specific "Group" code and "Reason" code combination. Enter these codes manually or select them from the available lookup lists. Each claim-level adjustment must specify a non-zero "Amount" value and may also specify an optional "Units" value.
- **COB / MOA Amounts** – Permits entry of various general claim-level COB amount values as well as amount values defined specifically for Medicare Inpatient Adjudication (MIA) and Medicare Outpatient Adjudication (MOA) use. Enter or select the "Code" which defines the amount type to be reported, and enter the corresponding "Amount" value.
- **Medicare Inpatient Adjudication (MIA) Remarks Codes** – Permits entry of up to 5 remarks codes for Medicare Inpatient Adjudication (MIA) use. These optional codes may be entered manually or selected from the available lookup list.
- Medicare Outpatient Adjudication (MOA) Remarks Codes – Permits entry of up to 5 remarks codes for Medicare Outpatient Adjudication (MOA) use. These optional codes may be entered manually or selected from the available lookup list.
- Claim Adjudication Date – Permits entry of the date on which the payer adjudicated the claim. This date is typically required at either the claim or line level.

The line-level COB data is entered on the "**MSP/COB**" sub-tab of the Billing Line Items tab. The purpose and use of the various field groups on this sub-tab are as follows:

- **Service Line Adjudication (SVD) Information** – Permits entry of one or more Service Line Adjudication (SVD) lines as reported by the payer for the current service line. The "P/S" field identifies the payer (primary/secondary) reporting this line adjudication notice. The revenue code reflects that of the service line being adjusted. The procedure code and modifier fields identify the specific procedure being adjusted. The practice of procedure code "bundling" and "unbundling" utilizes these fields to provide specific information regarding how the payer has grouped the procedures for payment. The "Paid Amount" indicates the amount the payer has paid on this procedure. The "Paid Units" value permits reporting of payments for less than the originally billed units. Finally, the "B/U Line" field identifies the service line on the original claim to which this SVD line applies. This reference identifier should be included on the remittance, and is primarily used in scenarios where procedure code bundling/unbundling has occurred.
- **Line Adjustment (CAS) & Miscellaneous Adjudication Info** – Permits entry of several additional Service Line Adjudication (SVD) fields for the current SVD line. The fields in

this control group track the currently selected SVD line. The control group's caption indicates the current SVD line (e.g., "(for SVD 1 above)").

- Line-Level Adjustments (CAS) – Permits entry of one or more line-level adjustments as reported by the payer for the current Service Line Adjudication (SVD) line. Adjustments are defined by a specific "Group" code and "Reason" code combination. Enter these codes manually or select them from the available lookup lists. Each line-level adjustment must specify a non-zero "Amount" value and may also specify an optional "Units" value.

Fixed-list or variable-list lookups are available on many of the COB-related fields to improve user efficiency. In addition, the standard line duplication (**F5**), field duplication (**F4**), and line deletion (**F7**) functions are available on all COB-related scrolling arrays. As an additional convenience, pressing the "**F5**" key while positioned on the first Service Line Adjudication (SVD) line will populate the SVD fields with their equivalent values from the original service line.

Saving & Canceling Claims

After completing data entry on the claim form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the claim. Alternatively, click the "**Cancel**" button to abandon any changes and exit the claim. When an attempt is made to save a claim, the following occurs:

- **Submission Payer Determination** - At least one of the payers specified on a claim must have the same LOB (line-of-business) as the claim itself. You will not be allowed to save a claim unless this condition is met. If only one of the claim payers has a LOB that matches the claim LOB, then this payer is automatically designated as the "**submission**" payer -- the payer to which the claim is to be submitted. If you view the claim after saving, you will see a checkmark adjacent to the submission payer line on the Payer Information tab. It is possible that multiple payers on a claim will have an LOB that matches the claim's LOB. In this case, you will be prompted to select which of these payers is to be designated as the submission payer.
- **Edit Validation** - During the claim save process, an edit validation process is performed on all fields on the claim. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all claim "**file-level**" edits are evaluated. File-level edits are evaluated only when the claim is saved, and are typically those edits that require multiple data elements from the claim in order to be evaluated. If no edit validation errors occur, the claim is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form (unless disabled in the Preference settings). This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process and the Edit Validation Errors List form. If edit errors exist, you will usually have the option to correct the errors or save the claim with errors. If a fatal error exists on the "LOB", "PCN", or "TOB" field, however, you must correct the error before saving the claim. Click the "**Save With Errors**" button to save a claim that contains only non-fatal errors. Such claims are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a claim that contains fatal errors. Such claims are assigned the "has fatal errors" (ERF) status. Claims with an "ERF" status will not be eligible for preparation into an electronic (EMC) file.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" claim. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Claim Form Topics

The following comments cover a few miscellaneous features of the Institutional Claim Form:

- **Entering Form Locator Data** - In order to preserve space on the Institutional Claim Form, most of the fields that permit free-form text entry have been implemented as pop-up windows. These fields are activated by clicking the associated button (e.g., the "**FL1**" button at the top of the Patient Info & Codes tab activates the "Form Locator 1" popup window. Simply enter the text in this pop-up window - pressing the "**ENTER**" key to start a new line if desired - and press the "**TAB**" key to exit and close the window.
- **Viewing Home Health Plans of Care** - Type "**<ALT>H**" to display a list of Home Health Plans of Care (Form No. CMS-485 / CMS-486) on file for the patient specified in the claim. The plan information cannot be modified from this list. Refer to the "Listing, modifying and maintaining Plans of Care" topic for details on how plans can be added or updated.
- **Displaying Audit information** - Click the picture button in the upper right corner of the Patient Info & Codes tab to display audit information for this claim. This audit information includes the date the claim was created, the last modification date, and the User ID of the user that modified the claim last.

Common Claim Activities

The following hyperlinks provide additional instruction on several common claim activities:

- Refer to the "Adding a new claim" topic for more information on adding claims.
- Refer to the "Listing, modifying and maintaining claims" topic for tips on maintaining claims from the Institutional Claim List form.
- Refer to the "Printing claims" topic to learn about printing claims.
- Refer to the "Posting claim payments (Institutional)" topic to learn about Institutional claim payment posting.

The Professional Claim Form

The Professional Claim Form provides access to all data elements of an Professional claim. New claims are entered and existing claims are viewed and/or modified from this form. The Professional Claim Form has been designed to provide a data entry flow resembling that of the printed Professional claim form whenever possible. Claim fields are grouped logically on six major tabs:

- **Patient Info & General** - includes fields for general claim and patient information.
- **Insured Information** - includes payer, insured, and employer fields for the primary, secondary, and tertiary payers.
- **Billing Line Items** - includes the claim diagnosis codes as well as all claim line item fields, extended line item fields, claim attachment fields, and line-level MSP/COB fields. This major tab contains a number of second-level tabs to accommodate the many line-level fields.
- **Ext. Patient/General** - includes patient legal representative fields, facility information fields, and numerous general claim fields that are not present on the hard-copy Professional claim form.
- **Ext. Pat/Gen (2)** - includes additional claim-level information not present on the hard-copy Professional claim form. Most of the fields on this tab populate data elements defined only for the ANSI-837 EMC format.
- **Ext. Payer/Insured** - includes less frequently used payer, insured, and employer fields for the primary, secondary, and tertiary payers. Also includes fields for Medicare Secondary Payer (MSP) and other secondary claims where Coordination of Benefits (COB) information is required. This major tab consists of a number of second-level tabs that provide access to this extended information in a logical and efficient manner.

Click the appropriate tab or simply press the "**PAGE UP**" and " **PAGE DOWN**" keys to move between these major claim form sections. Holding down the "**SHIFT**" key while pressing the "**PAGE UP**" and "**PAGE DOWN**" keys will cycle between second-level tabs, where applicable.

Entering Claim Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the claim form fields, respectively.

A number of productivity enhancing features are available during claim data entry:

- **Fixed-List Lookups** - The claim entry form supports fixed-list lookups on many of the claim's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, "Patient Sex" typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the claim form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - The claim entry form supports variable-list lookups on a number of the claim's fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Most variable-list lookups use other claim field values (the specified claim "LOB", for example) to filter the presented list. For example, provider

lookups attempt to present only those provider records applicable to the claim being entered. In addition, variable-list lookups often retrieve data used to fill in other claim form fields. For example, selection of a Patient from the variable-list lookup completes numerous patient-related fields on the claim. Access variable list lookups using the same method described above for fixed-list lookups.

- **Recurring Field Sets** - Field "sets" consist of two or more logically-related fields. For example, most ANSI/X12 reference identifiers include an identification number and a type code, or qualifier. It is often a requirement to support a variable number of occurrences of a particular field set. The claim entry form provides an intelligent combo (i.e., dropdown) control to allow entry and maintenance of such recurring field sets.

  To identify a recurring field set, look for the selector which will be positioned adjacent to the rightmost field in the set. The recurring field set and associated selector function in the following manner:

  - As the user tabs normally away from the last field in the set, the focus will automatically return to the first field in the set and the next data occurrence will be displayed. Only when all occurrences have been displayed will the focus move to the next field on the claim entry form. This behavior permits the user to view all occurrences without using the mouse, and also provides an opportunity to enter new data if desired.
  - Click the selector graphic to open the dropdown list and display all existing data occurrences. A vertical scrollbar will appear as needed to permit access to all occurrences. Select an entry from the list or press the "**ESC**" key (or click elsewhere on the form) to close the dropdown list. The data values corresponding to the selected entry will be displayed in the field set and are now available for editing as needed.
  - To add a new occurrence to a field set, either tab through all existing occurrences until an empty field set is displayed or simply select the "**[Enter New ...]**" item in the dropdown list.
  - Press the "**F7**" key while positioned on any field in the set to delete the selected occurrence. You will be prompted to confirm the deletion.
  - If the focus moves away from a recurring field set while an empty occurrence is displayed, the field set will automatically display the data for the first occurrence, if any, rather than leave the screen fields blank.
  - The edit validation process understands the recurring nature of these special field sets, and will automatically reposition to the proper occurrence when displaying edit validation errors.
- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most claim form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.
- **Descriptive Field Hints** - Most claim form fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over hints", since they become visible when the mouse pointer moves over the specified field (without actually

selecting the field). This feature can be disabled in the general preferences settings if desired.

- **Line Item Scrolling** - The Billing Line Items tab displays 6 claim lines at a time. For claims that contain more than 6 line items, the user may scroll through the claim line items one line at a time or one page (i.e., 6 lines) at a time using the buttons provided along the right edge of this tab.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all claim line items one page at a time.

- **Line Item Features** - The following productivity features are available on the Billing Line Items tab:
  - **Current Line Tracking** - The Billing Line Items tab contains a number of second-level tabs. The first second-level tab (Line Item Details) displays the claim diagnosis codes as well as the basic line item fields available on the hard-copy Professional claim form. The remaining second-level tabs are linked to the currently selected line on the Line Item Details tab. As the cursor moves from one line to another on the Line Item Details tab, the remaining second-level tabs will track the new current line. This technique provides an efficient method of providing access to a large number of data elements on a potentially large number of claim lines. Notice that the Extended Details tab caption always reports the current line for reference.
  - **Line Duplication** - Press the "**F5**" key while positioned on any field on a line to copy the values in all fields of the previous line (except the service date fields) into the current line. The service date fields in the current line are blanked and the cursor is then positioned on the first field of the current line.
  - **Field Duplication** -- Press the "**F4**" key while positioned on a specific field on a line to copy the value of that single field from the previous line into the current line.

    You can also use the "**F4**" key to duplicate the service line "Narrative" text from the previous line into the current line. This convenient feature eliminates the need to re-type narrative text on consecutive service lines. The "Narrative" field is located on the service line's Extended Details sub-tab.
  - **Line Deletion** - Press the "**F7**" key while positioned on any field on a line to delete the line. You will be prompted to confirm the deletion. Alternatively, enter the value "***DEL***" (that's an asterisk plus "DEL" plus another asterisk, without the double-quotes) into the Procedure Code field (24d) on a claim line to delete the line.
  - **Advance To Next Line** - Press the "**F8**" key while positioned on any field on a line to automatically advance the cursor to the first field of the next line, skipping over any remaining fields on the current line.
  - **Jump To Narrative** - Press the "**<ALT>N**" key combination while positioned on any field on a line to automatically position on the "Narrative" field. Enter the desired narrative text and press the "**<TAB>**" key to return to the original line field.
- **Line Item Totals Recalculation** – The Billing Line Items tab provides a "**Recalculate**" button located near the bottom of the tab adjacent to the totals fields. Click this button to recalculate and update the "Total Charge" and "Balance Due" fields from the current claim line item charges values and the "Amount Paid" field value. NOTE: This button may not be available on some installations.
- **Payer / Insured Features** - The following payer and/or insured information productivity features are available:
  - **Quick Payer Access** - Press the "**<ALT>I**" key combination while positioned anywhere on the Patient Info & General tab to move immediately to the primary

payer's "Payer ID" field. Press the "**<ALT>O**" key combination to move immediately to the secondary payer's "Payer ID" field.

- **Clear Payer Feature** - The Insured Information tab provides a "**Clear Payer**" button for each of the 3 claim payers. Click this button to clear **all** payer, insured and employer fields for the associated payer.

- **Coordination of Benefits (COB) Support** – The claim form includes fields to allow entry of Coordination of Benefits (COB) data at both the claim and line levels when appropriate. Enter a "**Y**" in the "COB?" field to make these COB-related fields available for use. The "COB?" field is located along the lower edge of the Patient Info & General tab. See the section entitled "Coordination of Benefits" later in this topic for details on this advanced capability.

When the focus leaves a claim form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the claim form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process.

Claim Attachments

Claims submitted for certain types of professional services require supporting data that is not included on the basic Professional claim. In the world of "paper" claims, this supporting data is usually submitted on separate forms know as "**attachments**". PC-ACE Pro32 has extended this attachment metaphor into the world of electronic claims submission. The Professional Claim Form supports most of the commonly used attachment types.

Claim attachments can be "**triggered**" (activated) for a claim's line item in one of 2 ways:

- **Automatically Triggered Attachments** - Since the procedure (HCPCS) code on a claim's line item describes the type of service provided, it is logical that this same procedure code would dictate which attachment is required (if any) for the line. Using automatically triggered attachments, certain procedure codes are pre-defined to trigger specific attachment types. Automatically triggered claim attachments fall into one of 2 categories - "**line-level**" attachments and "**claim-level**" attachments. Line-level attachments are defined separately for each service line item on the claim that triggers the attachment. If the procedure codes for 3 line items all trigger a certain line-level attachment, then the user will be required to enter a separate set of attachment data for each of the 3 lines. Claim-level attachments, on the other hand, are defined only once for the entire claim regardless of how many service line items have triggered the attachment. The Professional Claim Form supports both types of automatically triggered attachments.

  The decisions regarding which procedure codes should automatically trigger which attachments are typically made by the distributor (or whoever makes your claim submission rules). PC-ACE Pro32 supports an external attachment trigger control file to provide flexibility in this area. On program startup, PC-ACE Pro32 reads the trigger control file and uses this information to present the appropriate attachment at the appropriate time.

- **Manually Triggered Attachments** - To provide maximum flexibility, PC-ACE Pro32 also allows the user to "manually" trigger a specific claim attachment on any claim line item. Simply enter the appropriate **attachment trigger code** in the desired claim line item's "**AT**" control. For convenience, you may press the "**F2**" key or right-click the mouse while

focused on the "**AT**" control to display a popup selection menu. All manually triggered attachments are "line-level" by definition.

The special "**Cancel automatic attachment**" manual trigger code is available to override (cancel) any automatically triggered claim line item attachment. This override is useful in exception situations where it is desirable not to send a typically required claim attachment.

The manual attachment trigger feature may not be available in all installations. If the claim line item's "**AT**" control is disabled and will not allow entry of the attachment trigger code, then this feature is unavailable.

Attachments are displayed on second-level tabs on the Billing Line Items tab. These attachment tabs are shown or hidden dynamically based on the currently selected service line and the attachment type (line-level or claim-level). If the procedure code on the current line automatically triggers a particular attachment, or if an attachment is manually triggered, then the corresponding attachment tab will be shown. Since claim-level attachments exist only once for the entire claim, the associated attachment tabs are visible regardless of the current line position. Claim-level attachments are identified by a "**(C)**" designator on the attachment tab's caption.

The following attachment productivity features are also available:

- **CLIA and Mammography Certification Numbers** – When a CLIA or Mammography attachment is triggered, the corresponding certification number is retrieved from the claim's billing (solo) or rendering (group) provider reference file record if available. These certification numbers can be setup in advance in the Professional Provider reference file, thus freeing the user from remembering and entering these numbers on each claim attachment.
- **Attachment Field Duplication** - Press the "**F5**" key while positioned on any line-level attachment field to copy all attachment field values from the closest previous line with the same attachment type into the current line's attachment fields. This feature minimizes the need to type line-level attachment data multiple times on a single claim.

Coordination of Benefits

The Professional Claim Form includes fields to allow entry of Coordination of Benefits (COB) information at the claim and/or line level. Claims submitted to secondary or tertiary payers may be required to report the payment remittance data returned by prior payers. Medicare Secondary Payer (MSP) claims, for example, must include specific COB information obtained from the primary payer in order to insure prompt processing by Medicare.

Since Coordination of Benefits information is not required on all claims, the screen tabs containing COB-related fields are hidden by default. Enter a "**Y**" in the "COB?" field to make these COB-related fields available for use. The "COB?" field is located along the lower edge of the Patient Info & General tab.

Two distinct levels of Coordination of Benefits reporting are supported:

- **Claim-Level COB Reporting** – Remittance data which is not specific to a particular service line is reported at the claim level. The claim form provides claim-level COB fields for both the primary and secondary payers. These fields are located on the "COB Info (Primary) and "COB Info (Secondary)" sub-tabs of the Extended Payer/Insured tab.

- **Line-Level COB Reporting** – Remittance data specific to a particular service line is reported at the line level. The claim form provides a set of line-level COB fields for each service line. These fields are located on the "MSP/COB" sub-tab of the Billing Line Items tab. This sub-tab tracks the currently selected service line in the same manner as the other extended line item sub-tabs. The current service line is identified in the "MSP/COB" sub-tab caption (e.g., "MSP/COB (Line 4)").

The decision to report COB information at the claim versus line level is made by the payer and communicated to the provider via a remittance. The remittance may be in electronic (ANSI-835) or paper format, and typically serves as the source for all COB data to be entered into the claim form's COB fields.

There's no need to re-enter claims for submission to secondary payers if the original claim was processed through PC-ACE Pro32. Simply use the Professional Claim List form to locate the original claim in the "TR – transmitted" location, select the "**Copy**" action to create the new secondary claim, and enter the LOB and Billing Provider applicable to the secondary payer. Finally, enter a "**Y**" in the "COB?" field on the Patient Info & General tab to activate the COB-related fields. You will then have a duplicate of the original claim ready to add the primary payer's COB information.

The claim-level COB data is entered on the "**COB Info (Primary)**" and "**COB Info (Secondary)**" sub-tabs of the Extended Payer/Insured tab. The purpose and use of the various field groups on these sub-tabs are as follows:

- **Claim-Level Adjustments (CAS)** – Permits entry of one or more claim-level adjustments as reported by the payer. Adjustments are defined by a specific "Group" code and "Reason" code combination. Enter these codes manually or select them from the available lookup lists. Each claim-level adjustment must specify a non-zero "Amount" value and may also specify an optional "Units" value.
- **COB / MOA Amounts** – Permits entry of various general claim-level COB amount values as well as amount values defined specifically for Medicare Outpatient Adjudication (MOA) use. Enter or select the "Code" which defines the amount type to be reported, and enter the corresponding "Amount" value.
- **Medicare Outpatient Adjudication (MOA) Remarks Codes** – Permits entry of up to 5 remarks codes for Medicare Outpatient Adjudication (MOA) use. These optional codes may be entered manually or selected from the available lookup list.
- **Claim Adjudication Date** – Permits entry of the date on which the payer adjudicated the claim. This date is typically required at either the claim or line level.
- **Common Payer MSP Information** – This field group exists primarily to provide a bridge between the MSP/COB reporting standards defined in the older NSF format and those defined in the ANSI / X12 implementation. Only the "Insurance Type" and "OTAF" (Obligated To Accept In Full Amount) fields are actually needed to process COB claims in the newer ANSI / X12 format. All remaining fields in this group can be reported using equivalent values in the CAS or COB/MOA field groups. For backward compatibility, PC-ACE Pro32 will continue to recognize and report values in these obsolete fields whenever it is practical to do so.

The line-level COB data is entered on the "**MSP/COB**" sub-tab of the Billing Line Items tab. The purpose and use of the various field groups on this sub-tab are as follows:

- **Service Line Adjudication (SVD) Information** – Permits entry of one or more Service Line Adjudication (SVD) lines as reported by the payer for the current service line. The "P/S" field identifies the payer (primary/secondary) reporting this line adjudication notice. The procedure code and modifier fields identify the specific procedure being adjusted. The practice of procedure code "bundling" and "unbundling" utilizes these fields to provide specific information regarding how the payer has grouped the procedures for

payment. The "Paid Amount" indicates the amount the payer has paid on this procedure. The "Paid Units" value permits reporting of payments for less than the originally billed units. Finally, the "B/U Line" field identifies the service line on the original claim to which this SVD line applies. This reference identifier should be included on the remittance, and is primarily used in scenarios where procedure code bundling/unbundling has occurred.

- **Line Adjustment (CAS) & Miscellaneous Adjudication Info** – Permits entry of several additional Service Line Adjudication (SVD) fields for the current SVD line. The fields in this control group track the currently selected SVD line. The control group's caption indicates the current SVD line (e.g., "(for SVD 1 above)").
  - **Line-Level Adjustments (CAS)** – Permits entry of one or more line-level adjustments as reported by the payer for the current Service Line Adjudication (SVD) line. Adjustments are defined by a specific "Group" code and "Reason" code combination. Enter these codes manually or select them from the available lookup lists. Each line-level adjustment must specify a non-zero "Amount" value and may also specify an optional "Units" value.
- **Common Line MSP Information** – This field group exists primarily to provide a bridge between the MSP/COB reporting standards defined in the older NSF format and those defined in the ANSI / X12 implementation. Only the "Approved" and "OTAF" (Obligated To Accept In Full) amount fields are actually needed to process COB claims in the newer ANSI / X12 format. All remaining fields in this group can be reported using equivalent values in the SVD or CAS field groups. For backward compatibility, PC-ACE Pro32 will continue to recognize and report values in these obsolete fields whenever it is practical to do so.

  Fixed-list or variable-list lookups are available on many of the COB-related fields to improve user efficiency. In addition, the standard line duplication (**F5**), field duplication (**F4**), and line deletion (**F7**) functions are available on all COB-related scrolling arrays. As an additional convenience, pressing the "**F5**" key while positioned on the first Service Line Adjudication (SVD) line will populate the SVD fields with their equivalent values from the original service line.

Saving & Canceling Claims

After completing data entry on the claim form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the claim. Alternatively, click the "**Cancel**" button to abandon any changes and exit the claim. When an attempt is made to save a claim, the following occurs:

- **Submission Payer Determination** - At least one of the payers specified on a claim must have the same LOB (line-of-business) as the claim itself. You will not be allowed to save a claim unless this condition is met. If only one of the claim payers has a LOB that matches the claim LOB, then this payer is automatically designated as the "**submission**" payer -- the payer to which the claim is to be submitted. If you view the claim after saving, you will see a checkmark adjacent to the submission payer line on the Payer Information tab. It is possible that multiple payers on a claim will have a LOB that matches the claim's LOB. In this case, you will be prompted to select which of these payers is to be designated as the submission payer.
- **Edit Validation** - During the claim save process, an edit validation process is performed on all fields on the claim. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all claim "**file-level**" edits are evaluated. File-level edits are evaluated only when the claim is saved, and are typically those edits that require multiple data elements from the claim in order to be evaluated. If no edit validation errors occur, the claim is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form (unless disabled in the Preference settings). This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the

"Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process and the Edit Validation Errors List form. If edit errors exist, you will usually have the option to correct the errors or save the claim with errors. If a fatal error exists on the "LOB" or "PCN" field, however, you must correct the error before saving the claim. Click the "**Save With Errors**" button to save a claim that contains only non-fatal errors. Such claims are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a claim that contains fatal errors. Such claims are assigned the "has fatal errors" (ERF) status. Claims with an "ERF" status will not be eligible for preparation into an electronic (EMC) file.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" claim. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Claim Form Topics

The following comments cover a few miscellaneous features of the Professional Claim Form:

- **Optional Local Fields** - Your distributor may have configured additional "**local**" fields at the claim, payer, and/or line item levels. Local fields are typically defined to provide data elements that are needed by the distributor but are not included in the Professional specification. If such local fields are defined at the claim level, you will see an additional "Local Fields" tab on the claim form. If local fields are defined at the payer and line item levels, you will see similar "Local Fields" second-level tabs on the Extended Payer/Insured tab and Billing Line Items tab, respectively.
- **Displaying Audit information** - Click the picture button in the upper right corner of the Patient Info & General tab to display audit information for this claim. This audit information includes the date the claim was created, the last modification date, and the User ID of the user that modified the claim last.

Common Claim Activities

The following hyperlinks provide additional instruction on several common claim activities:

- Refer to the "Adding a new claim" topic for more information on adding claims.
- Refer to the "Listing, modifying and maintaining claims" topic for tips on maintaining claims from the Professional Claim List form.
- Refer to the "Printing claims" topic to learn about printing claims.
- Refer to the "Posting claim payments (Professional)" topic to learn about Professional claim payment posting.

Eligibility Benefit Request List Form Features

The **PC-ACE Pro32** Eligibility Benefit Request List form provides a versatile interface from which the user can create, list, modify and otherwise maintain patient eligibility benefit requests. Click either the "**Institutional Claims Processing**" button or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to open the corresponding Claims Menu form. Then click the "**Maintain Eligibility Benefit Requests**" item on the Claims Menu form's "**Maintain**" menu to open the Eligibility Benefit Request List form. You may reposition and resize this form if desired. The list can be easily sorted and filtered to display only the requests of interest. The Institutional and Professional Eligibility Benefit Request List forms are virtually identical. All procedures described in this section pertain to both request types unless otherwise specified.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Maintain Eligibility Benefit Requests" item is not visible on the "Maintain" menu, then this capability is not available on your installation.

Sorting Eligibility Benefit Requests

The eligibility benefit request list may be sorted by Patient Name, Patient Control Number (PCN), Entry Date and Submit Date. Simply select the desired sort order from the available "**Sort By**" radio buttons.

Filtering Eligibility Benefit Requests

The eligibility benefit request list may be filtered to display a select subset of requests by manipulating the "**Eligibility Request List Filter Options**" drop-down lists. Basic filter options include:

- **Location** - filters the eligibility benefit request list to include only requests in the "to be submitted" (**EL**) or "transmitted" (**TR**) locations.
- **Status** - filters the eligibility benefit request list to include only requests assigned a specific status. The possible status codes are: "clean/ready" **(CLN)**, "has fatal errors" **(ERF)**, "has errors" **(ERR),** "held" **(HLD)** and "unprocessed" **(UNP)**.
- **LOB** - filters the eligibility benefit request list to include only requests for a specific line of business.

In addition to these basic filter options, the Eligibility Benefit Request List form also provides a number of **Advanced Filter Options**. These advanced options permit filtering on the request's patient, payer, entry date range, submission date range, and numerous other criteria. When multiple filter criteria are specified, only those requests that meet **all** filter criteria will be displayed.

Eligibility Benefit Request Actions

The Eligibility Benefit Request List form may also be used to perform specific actions on any individual request or a group of selected requests. To perform an action on an individual request, simply select the request from the list and click the desired action button (along the lower edge of the form). The complete list of request actions can be accessed from the Eligibility Benefit Request List form's main "**Actions**" menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected request). Available eligibility benefit request actions include:

- **Creating New Requests** -- Click the "**New**" button (or choose the "**Create New Request**", "**Create New Request (Service Type)**" or "**Create New Request (Complete)**" action) to create a new eligibility benefit request. See the "Adding a new eligibility benefit request" topic for more details.

  The "Create New Request (Service Type)" action may not be available on all installations. When this action is unavailable, all new requests should be initiated by clicking the "New" button or selecting the "Create New Request" action.

- **Viewing/Modifying Requests** -- Click the "**View/Update**" button (or choose the "**View/Update Selected Request**" action) to view and/or modify the selected eligibility benefit request. See the "Eligibility Benefit Request Form" topic for details on using the PC-ACE Pro32 eligibility benefit request entry form.

  The View/Update action is the default eligibility benefit request action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired request record or by selecting the desired record and pressing the "**ENTER**" key.

  Holding down the "**SHIFT**" key while invoking the View/Update action on an eligible eligibility benefit request will force an automatic save attempt on the request. This is a shortcut technique equivalent to invoking the View/Update action and subsequently clicking the "Save" button on the request entry form. It minimizes the keystrokes required to work requests from the Eligibility Benefit Request List form. Eligible requests are those in the "to be submitted" (EL) location with a status of either "unprocessed" (UNP), "has errors" (ERR), or "has fatal errors" (ERF).

- **Deleting Requests** -- Click the "**Delete**" button (or choose the "**Delete Selected Request**" action) to delete the selected eligibility benefit request.

  IMPORTANT: Deleted eligibility benefit requests are permanently removed from PC-ACE Pro32 … they cannot be recovered.

- **Copying Requests** -- Click the "**Copy**" button (or choose the "**Copy Selected Request**" action) to copy the selected eligibility benefit request. The eligibility benefit request entry form will be displayed containing the details of the newly copied request.

- **Holding Requests** -- Choose the "**Hold Selected Request**" action to change the status of the selected eligibility benefit request to "held" (HLD). Held requests are not eligible for preparation.

- **Releasing Requests** -- Choose the "**Release Selected Request**" action to release a previously held eligibility benefit request. In addition to releasing the request, this action also sets the status of the selected request to "unprocessed" (UNP).

- **Reactivating Requests** -- Choose the "**Reactivate Selected Request**" action to reactivate the selected eligibility benefit request. This action will move the previously submitted request from the "submitted" (TR) location into the "to be submitted" (EL) location. The reactivated request will be assigned the "unprocessed" (UNP) status.

- **Viewing Responses** -- Choose the "**View Response for Selected Request**" action to view the ANSI-271 eligibility benefit response information for the selected eligibility benefit request. Refer to the "Viewing the eligibility benefit response for a specific request" topic for additional information.

  This action is available only when the Eligibility Benefit Request List is filtered to view requests in the "submitted" (TR) location. The "Reply?" column will contain

the value "Yes" when a response has been received and posted for the selected eligibility benefit request.

- **Refreshing the Request List** -- Choose the "**Refresh Request List**" action (or press the "**F5**" function key) to refresh the current Eligibility Benefit Request List form contents. This action can be useful in a multi-user installation to be sure that the request list properly reflects additions and/or modifications made by other users.

You will notice that only applicable actions are enabled for use in the main "**Actions**" menu or pop-up menu. For example, it makes no sense to "reactivate" an eligibility benefit request that has yet to be submitted, so this action will be disabled for requests in the "to be submitted" (EL) location.

Actions on Multiple Eligibility Benefit Requests

Some actions can be performed on multiple eligibility benefit requests at once. Multiple request selection is accomplished by "checking" the request of interest and subsequently performing one of the "**… All Checked Requests**" actions. To check a request, click the left mouse button over the checkbox in the first column of the desired list row. Alternatively, all requests in the current list can be checked using the "**Check All Requests**" item from the list's pop-up menu. Use the flexible Eligibility Benefit Request List form filter techniques to display only the subset of requests to be deleted, held, reactivated, etc. Then simply check all eligibility benefit requests and perform the desired action on all checked requests at once.

Eligibility Benefit Request List Filter Menu

Several eligibility benefit request list filtering and related functions are accessible from the Eligibility Benefit Request List form's main "**Filter**" menu:

- **Clear Filters** – Clears any existing filter criteria and refreshes the eligibility benefit request list to display all requests in the selected location.
- **Advanced Filter Options** – Opens the Advanced Eligibility Request List Filter Criteria form to permit filtering on the request's patient, payer, entry date range, submission date range and numerous other criteria. When multiple filter criteria are specified, only those requests that meet **all** filter criteria will be displayed.
- **Check (Uncheck) All Requests** – Permits the user to "check" (or "uncheck") all eligibility benefit requests currently displayed in the request list – presumably in anticipation of some action to be performed on this block of requests. See the "Actions on Multiple Eligibility Benefit Requests" section above for more information.

Eligibility Benefit Request Preferences

Certain aspects of the Eligibility Benefit Request Form operation are customizable. The default behavior is typically determined by your software distributor, so you should check with their support department before making changes to these settings. The Eligibility Benefit Request Preferences are accessible from the Eligibility Benefit Request List form's main "**File**" menu "**Preferences**" item. The following options are available for configuration:

General Eligibility Benefit Preferences – Select the **"General"** tab to view and/or modify general eligibility/benefit preferences:

- **Default Information Source Type to Payer (Code = 'PR')** - This option controls the default value assigned to the Information Source Type field for new requests.
  - ☑ When checked, the Information Source Type is defaulted to the "Payer" code (PR). Most distributors expect a payer to be identified in the Information Source fields.

Setting this field to "PR" enables Information Source lookups from the Payer reference file.

- ☐ When unchecked, the Information Source Type field is left empty and must be entered by the user (or selected from the right-click popup menu).

- **Default Information Source Primary Identification Type to NAIC (Code = 'NI')** - This option controls the default value assigned to the Information Source Primary Identification Type field for new requests. It is available only when the Information Source Type is being defaulted to the "Payer" code (PR).
  - ☑ When checked, the Information Source Primary Identification Type will be defaulted to the "NAIC" code (NI) during Information Source lookups from the Payer reference file.
  - ☐ When unchecked, the Information Source Primary Identification Type will be defaulted to the "Payer Identification" code (PI) during Information Source lookups from the Payer reference file.

- **Default Information Receiver Type to Provider (Qualifier = '1P')** - This option controls the default value assigned to the Information Receiver Type field for new requests.
  - ☑ When checked, the Information Receiver Type is defaulted to the "Provider" code (1P). Most distributors expect a provider to be identified in the Information Receiver fields. Setting this field to "1P" enables Information Receiver lookups from the Provider reference file.
  - ☐ When unchecked, the Information Receiver Type field is left empty and must be entered by the user (or selected from the right-click popup menu).

- **Load Information Receiver Primary ID with Federal Tax ID on Provider lookups** - This option controls the source for the value assigned to the Information Receiver Primary ID / Type fields during lookups from the Provider reference file.
  - ☑ When checked, the Information Receiver Primary ID / Type fields are populated with the Federal Tax ID / Type fields from the selected Provider record.
  - ☐ When unchecked, the Information Receiver Primary ID / Type fields are populated with the standard Provider ID/No. / Type fields from the selected Provider record.

  - **Default Tax ID Type to generic code 'FI' instead of '24' (EIN) or '34' (SSN)** - This option controls the source for the value assigned to the Information Receiver Primary ID Type field during lookups from the Provider reference file. This option is only available when the Federal Tax ID has been selected to populate the Information Receiver Primary ID field.
    - ☑ When checked, the Information Receiver Primary ID Type field is forced to the generic Tax ID type code (FI).
    - ☐ When unchecked, the Information Receiver Primary ID Type field is populated with the ANSI/X12 qualifier corresponding to the Federal Tax ID Type value from the selected Provider record. Valid qualifier values are "24" (EIN) and "34" (SSN).

- **Give preference to non-person Organization name on Information Receiver lookups** - This option controls the preferred source for the value assigned to the Information Receiver Name fields during lookups from the Provider reference file.
  - ☑ When checked, the Information Receiver Name fields are populated with the non-person "Organization" field from the selected Provider record, if available. If no organization is specified on the selected Provider record, then the proper (i.e., person) name fields are used instead.
  - ☐ When unchecked, the Information Receiver Name fields are populated with the proper (i.e., person) name fields from the selected Provider record, if available. If no

proper name is specified on the selected Provider record, then the value in the "Organization" field is used instead.

Simplified Service Type Request Form Preferences – Select the **"Service Type"** tab to view and/or modify Service Type Eligibility Benefit Request Form preferences:

The simplified Service Type Eligibility Benefit Request Form may not be available on all installations. If you do not see the "Service Type" preferences tab, then this feature is unavailable.

- **Use the simplified Service Type request form by default for new eligibility benefit requests** - This option controls which of the two available eligibility/benefit request forms to display when the user clicks the **"New"** button on the Eligibility Benefit Request List Form.
  - ☑ When checked, the simplified Service Type Eligibility Benefit Request Form will be displayed when the user clicks the **"New"** button on the Eligibility Benefit Request List Form.
  - ☐ When unchecked, the complete Eligibility Benefit Request Form will be displayed when the user clicks the **"New"** button on the Eligibility Benefit Request List Form.

  New eligibility/benefit requests may be added using either request form by selecting the desired **"Create New Request …"** item from the Eligibility Benefit Request List form's main "**Actions**" menu.

- **Payer Selection List** - This list box holds the payers that will be available for selection on the simplified Service Type Eligibility Benefit Request Form. If visible, click the **"Add"** button to choose a payer from the Payer reference file and add this payer to the selection list. Select an existing payer in the list and click the **"Remove"** button to remove this payer from the selection list. Use the **"Up Arrow"** and **"Down Arrow"** picture buttons to rearrange the order of payers in the selection list. The first payer in the selection list will be the default payer when creating new Service Type eligibility benefit requests.

  PC-ACE Pro32 distributors have the option to pre-configure and restrict this default eligibility/benefit payer selection list. The "Add", "Remove", "Up Arrow", and "Down Arrow" buttons will not be visible when this restriction has been imposed by the distributor.

  - **Allow selection from Payer reference file** - This option controls whether or not users will be allowed to select payers other than those in the Payer Selection List when creating new Service Type eligibility/benefit requests.
    - ☑ When checked, selection of alternate payers from the Payer reference file will be allowed. The payer dropdown list on the Service Type Eligibility Benefit Request Form will include a special "<< Select From Payer Reference File >>" item to initiate the Payer file selection process.
    - ☐ When unchecked, only payers included in the Payer Selection List will be available for selection when creating new Service Type eligibility/benefit requests.

- **Provider Selection List** - This list box holds the providers that will be available for selection on the simplified Service Type Eligibility Benefit Request Form. Users should add commonly used providers to this list in order to streamline the process of creating new Service Type eligibility/benefit requests. Click the **"Add"** button to choose a provider from the Institutional or Professional Provider reference file and add this provider to the selection list. Select an existing provider in the list and click the **"Remove"** button to remove this provider from the selection list. Use the **"Up Arrow"** and **"Down Arrow"**

picture buttons to rearrange the order of providers in the selection list. The first provider in the selection list for a given LOB and Payer ID combination will become the default provider when creating new Service Type eligibility benefit requests for that payer.

In addition to the providers listed in the Provider Selection List, users will also be allowed to select from the complete Institutional or Professional Provider reference files when creating new Service Type eligibility/benefit requests. The provider dropdown list on the Service Type Eligibility Benefit Request Form will include a special "<< Select From Provider Reference File >>" item to initiate this Provider file selection process.

The Eligibility Benefit Request Form

The Eligibility Benefit Request Form provides access to all data elements defined in the ANSI-270 Health Care Eligibility Benefit Inquiry transaction. New requests are entered and existing requests are viewed and/or modified from this form. Request fields are grouped logically on these major tabs:

- **Patient/Subscriber Info** - includes fields for patient and subscriber name, address, relationship, and demographic information.
- **Eligibility/Benefit Inquiry** - includes fields describing the eligibility benefit information being requested – from general coverage information to detailed coverage for specific diagnoses and procedures.
- **Source/Receiver Info** - includes fields defining the Information Source (Payer, typically) and the Information Receiver (Provider, typically) associated with this request.
- **Patient/Subscriber Extended** - includes less frequently used patient and subscriber fields (e.g., additional identification numbers).
- **Receiver Extended** - includes less frequently used Information Receiver fields such as additional identification numbers and the provider's Taxonomy code.

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between these major eligibility benefit request form sections.

Entering Eligibility Benefit Request Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the eligibility benefit request form fields, respectively.

A number of productivity enhancing features are available during eligibility benefit request data entry:

- **Fixed-List Lookups** - The eligibility benefit request entry form supports fixed-list lookups on many of the request's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, the "Patient Sex" field has only two possible values: "M" (male) and "F" (female).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the request form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - The eligibility benefit request entry form supports variable-list lookups on a number of the request's fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Most variable-list lookups use other eligibility benefit request field values (the specified request "LOB", for example) to filter the presented list. For example, provider lookups attempt to present only those provider records applicable to the request being entered. In addition, variable-list lookups often retrieve data used to fill in other request form fields. For example, selection of a Patient from the variable-list lookup completes numerous patient-related and subscriber-related fields on the request. Access variable list lookups using the same method described above for fixed-list lookups.

- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Intelligent Groups Tabs** - The eligibility benefit request entry form contains one or more field "groups". The Diagnosis & Facility Type Codes control array on the Eligibility/Benefit Inquiry tab is an example of such a group. Fields in these groups are always completed sequentially. Therefore, when a field in one of these groups is left empty, it can be assumed that data entry in the group is complete. When the "**TAB**" key is pressed, the remaining fields in that group will be skipped and the cursor will be positioned on the first field in the tab sequence beyond the group fields.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most eligibility benefit request form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.
- **Inquiry Line Item Scrolling** - The Eligibility/Benefit Inquiry tab displays 4 inquiry lines at a time. For requests that contain more than 4 line items, the user may scroll through the inquiry line items one line at a time or one page (i.e., 4 lines) at a time using the buttons provided along the right edge of this tab.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all inquiry line items one page at a time.
- **Inquiry Line Item Features** - The following line-item productivity features are available on the Eligibility/Benefit Inquiry tab:
  - **Current Line Tracking** - The Eligibility/Benefit Inquiry tab contains the "Additional Eligibility/Benefit Information" control group. This control group is linked to the currently selected inquiry line on this tab. As the cursor moves from one inquiry line to another, the information displayed in the Additional Eligibility/Benefit Information fields will track the new current inquiry line. Notice that the Additional Eligibility/Benefit Information control group caption always reports the current inquiry line for reference.
  - **Line Duplication** - Press the "**F5**" key while positioned on any field on an inquiry line to copy the values in <u>all</u> fields of the previous line into the current line.
  - **Field Duplication** -- Press the "**F4**" key while positioned on a specific field on an inquiry line to copy the value of that single field from the previous line into the current line.
  - **Line Deletion** - Press the "**F7**" key while positioned on any field on an inquiry line to delete the line. You will be prompted to confirm the deletion.
  - **Advance To Next Line** - Press the "**F8**" key while positioned on any field on an inquiry line to automatically advance the cursor to the first field of the next line, skipping over any remaining fields on the current line.

When the focus leaves a request form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the

lower left corner of the eligibility benefit request form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the edit validation process.

Key Concepts Regarding Eligibility Benefit Requests

The design of the ANSI-270 Health Care Eligibility Benefit Inquiry transaction allows the requestor to enter as little or as much information as desired to ensure a match by the source organization who will be processing the request. Fields that are required by the ANSI-270 specifications are enforced by edits on the Eligibility Benefit Request Form. The process of entering an eligibility benefit request can be greatly streamlined by effective use of the available variable-list lookups.

- **Patient Lookup** - Press the "**<F2>**" key (or right-click the mouse) while positioned on the Patient PCN or Patient Last/First Name fields to select a patient from the Patient reference file. All applicable information on file for the selected patient will be used to populate the corresponding eligibility benefit request fields. This will include the Patient General Information fields, the Subscriber General Information fields (if Insured info is setup on the Patient record), the Information Source fields (uses the Insured Payer info), and the Information Receiver fields (if the Provider is setup on the Patient record, or if only one Provider record is available).

  If secondary and/or tertiary payer/insured information is present on the selected Patient record, the program will prompt the user to choose which of these payers is applicable to this eligibility benefit request. Only the information from the selected payer/insured set will be used to populate the corresponding request fields.

- **Information Source** - The Information Source refers to the entity serving as the "source" of the eligibility benefit information. This role is typically performed by the payer (e.g., Medicare, commercial insurance, etc), however, the ANSI-270 transaction also allows for several entity types other than payer. The "Information Source Type" field specifies the intended entity type, which is assumed to be "PR - Payer" when left empty. Press the "**<F2>**" key (or right-click the mouse) while positioned on the Information Source ID or Organization field to select a payer from the Payer reference file. All applicable information on file for the selected payer will be used to populate the corresponding eligibility benefit request fields. This lookup feature is only available when the Information Source Type field is set to "PR" (or is left empty).

  The eligibility benefit request also requires that a line of business (LOB) be specified. This represents the line of business for the Information Source (payer) to whom the inquiry is being submitted, and is necessary to enforce prepare break rules and to permit more specific editing of the Information Source/Receiver fields.

- **Information Receiver** - The Information Receiver refers to the entity which is requesting and will "receive" the eligibility benefit information. This role is typically performed by the provider, however, the ANSI-270 transaction also allows for several other entity types. The "Information Receiver Type" field specifies the intended entity type, which is assumed to be "1P - Provider" when left empty. Press the "**<F2>**" key (or right-click the mouse) while positioned on the Information Receiver ID or Organization field to select a provider from the Institutional or Professional Provider reference file. All applicable information on file for the selected provider will be used to populate the corresponding eligibility benefit request fields. This lookup feature is only available when the Information Receiver Type field is set to "1P" (or is left empty).

- **Inquiry Service Lines** - Each eligibility benefit request must include one or more Eligibility Benefit Inquiry service lines. The simplest inquiry service line consists of Service Type = 30 (general health care coverage inquiry) with the remaining service line entries left empty. Inquiries can also be made for specific procedure (HCPCS) codes, and can include a number of extended service line data elements if desired. The Information Source will provide eligibility benefit response information consistent with the level of detail requested, if available.

Type "**<ALT>F2**" (press the "**F2**" function key while holding down the "**ALT**" key) to provide a visual indication of all fields that support lookups. Press the "**ESC**" key to turn off the flashing indicator.

Saving & Canceling Eligibility Benefit Requests

After completing data entry on the eligibility benefit request form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the request. Alternatively, click the "**Cancel**" button to abandon any changes and exit the request. When an attempt is made to save a request, the following occurs:

- **Edit Validation** - During the request save process, an edit validation process is performed on all fields on the request. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all request "**file-level**" edits are evaluated. File-level edits are evaluated only when the request is saved, and are typically those edits that require multiple data elements from the request in order to be evaluated. If no edit validation errors occur, the request is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form (unless disabled in the Preference settings). This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process and the Edit Validation Errors List form. If edit errors exist, you will have the option to correct the errors or save the request with errors. Click the "**Save With Errors**" button to save a request that contains only non-fatal errors. Such requests are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a request that contains fatal errors. Such requests are assigned the "has fatal errors" (ERF) status. Requests with an "ERF" status will not be eligible for preparation.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" eligibility benefit request. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Eligibility Benefit Request Form Topics

The following comments cover miscellaneous features of the Eligibility Benefit Request Form:

- **Displaying Audit information** - Click the picture button in the upper right corner of the Patient/Subscriber Info tab to display audit information for this eligibility benefit request. This audit information includes the date the request was created, the last modification date, and the User ID of the user that modified the request last.

Common Eligibility Benefit Request Activities

The following hyperlinks provide additional instruction on several common eligibility benefit request activities:

- Refer to the "Adding a new eligibility benefit request" topic for more information on adding eligibility benefit requests.

- Refer to the "Listing, modifying and maintaining eligibility benefit requests" topic for tips on maintaining eligibility benefit requests from the Eligibility Benefit Request List form.
- Refer to the "Preparing eligibility benefit request files for transmission" topic to learn about preparing eligibility benefit requests into an ANSI-270 format file for transmission.
- Refer to the "Viewing and maintaining eligibility benefit response files" topic to learn about handling ANSI-271 response files returned from the Information Source (Payer).

The Service Type Eligibility Benefit Request Form

The Service Type Eligibility Benefit Request Form provides a simple user interface for creating new "service type" patient eligibility/benefit requests. This form provides access to only the most commonly used data elements defined in the ANSI-270 Health Care Eligibility Benefit Inquiry transaction. Service type requests are used for general eligibility inquiries, and must include one of the valid eligibility Service Type codes.

The Service Type Eligibility Benefit Request Form cannot be used to make eligibility inquiries for specific procedure codes. Use the complete Eligibility Benefit Request Form for such detailed inquiries.

Entering Service Type Eligibility Benefit Request Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Drop-down "combo box" controls permit selection from a list of available items. All other edit controls allow key entry of the desired field's information.

A number of productivity enhancing features are available during service type eligibility benefit request data entry:

- **Fixed-List Lookups** - The service type eligibility benefit request entry form supports fixed-list lookups on several of the request's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, the "Gender" fields have only two possible values: "M" (male) and "F" (female).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the request form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - The service type eligibility benefit request entry form supports variable-list lookups on the Payer, Provider, and Eligibility Type fields. Variable-list lookups apply primarily to fields whose values are selected from reference files or other dynamically-changing sources. Some variable-list lookups use other service type eligibility benefit request field values to filter the presented list. For example, provider lookups present only those provider records applicable to the payer specified for the request. It is therefore necessary to select a valid payer before selecting the desired provider. To access the Payer, Provider, and Eligibility Type variable list lookups, click the down-arrow button adjacent to the respective combo box.

- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.

- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most service type eligibility benefit request form fields.

- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically

derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.

When the focus leaves a request form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the eligibility benefit request form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the edit validation process.

Additional Service Type Eligibility Benefit Request Form Information

The design of the ANSI-270 Health Care Eligibility Benefit Inquiry transaction allows the requestor to enter as little or as much information as desired to ensure a match by the source organization who will be processing the request. The simplified Service Type Eligibility Benefit Request Form targets only general eligibility/benefit requests. These simple "service type" requests typically include only the subscriber and/or patient name, the Subscriber (Member) ID, and a code specifying the service type for which general eligibility information is being requested.

You may encounter situations where you need to enter a value for one of the ANSI-270 data elements that isn't represented on this simplified Service Type Eligibility Benefit Request Form. When this situation arises, consider creating the request with this simplified form and then modifying the resulting request to add the additional data element. This two-step process may still be quicker that entering the entire request on the complete Eligibility Benefit Request Form.

Fields that are required by the ANSI-270 specifications are enforced by edits on the Service Type Eligibility Benefit Request Form. Here are a few important details concerning the use of this simplified request form.

- **Payer Selection** - Click the down-arrow button adjacent to the "**Payer**" combo box to select the payer to whom this eligibility/benefit request will be submitted. The drop-down list will include the preferred payers previously configured on the Eligibility Benefit Request Preferences form. See the "Eligibility Benefit Request Preferences" section of the "Eligibility Benefit Request List Form Features" help topic for information on setting up preferred payers.

  The drop-down Payer selection list may also include the special "**<< Select From Payer Reference File >>**" item. Choosing this item allows the user to select a payer from the complete Payer reference file. See the "Eligibility Benefit Request Preferences" section of the "Eligibility Benefit Request List Form Features" help topic for more information on this feature.

- **Provider Selection** - Click the down-arrow button adjacent to the "**Provider**" combo box to select the provider requesting this eligibility/benefit information. The drop-down list will include the preferred providers previously configured on the Eligibility Benefit Request Preferences form. See the "Eligibility Benefit Request Preferences" section of the "Eligibility Benefit Request List Form Features" help topic for information on setting up preferred providers.

The drop-down Provider selection list will only include providers applicable to the selected payer. A valid payer must therefore be selected before selecting the provider. This selection list will also include the special "**<< Select From Provider Reference File >>**" item. Choosing this item allows the user to select a provider from the Institutional or Professional Provider reference file. Again, the selection list will be filtered to display only those providers applicable to the selected payer.

- **Eligibility Type Selection** - Click the down-arrow button adjacent to the "**Eligibility Type**" combo box to select the desired eligibility Service Type code. The list will default to "**30 – Health Benefit Plan Coverage**", which is the most commonly requested code.
- **Patient's Relationship To Subscriber** - Enter the ANSI/X12 qualifier which describes the patient's relationship to the subscriber in the "**Relationship**" field. Alternatively, you may press the "**<F2>**" key (or right-click the mouse) while positioned on this field to select from a list of valid qualifiers. When the "**18 – Self**" relationship qualifier is entered, the "Patient Information" control group will be disabled. Since by definition the patient and subscriber are the same person in this scenario, it is only necessary to enter the personal information once, in the Subscriber Information fields. All other relationship codes will permit entry of both the subscriber and patient information, although it may not be necessary to enter both in order to perform a successful eligibility/benefit inquiry.

Saving & Canceling Service Type Eligibility Benefit Requests

After completing data entry on the service type eligibility benefit request form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the request. Alternatively, click the "**Cancel**" button to abandon any changes and exit the request. When an attempt is made to save a request, the following occurs:

- **Edit Validation** - During the request save process, an edit validation process is performed on all fields on the request. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all request "**file-level**" edits are evaluated. File-level edits are evaluated only when the request is saved, and are typically those edits that require multiple data elements from the request in order to be evaluated. If no edit validation errors occur, the request is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form (unless disabled in the Preference settings). This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the claim edit validation process and the Edit Validation Errors List form. If edit errors exist, you will have the option to correct the errors or save the request with errors. Click the "**Save With Errors**" button to save a request that contains only non-fatal errors. Such requests are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a request that contains fatal errors. Such requests are assigned the "has fatal errors" (ERF) status. Requests with an "ERF" status will not be eligible for preparation.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" service type eligibility benefit request. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Common Service Type Eligibility Benefit Request Activities

The following hyperlinks provide additional instruction on several common service type eligibility benefit request activities:

- Refer to the "Adding a new eligibility benefit request" topic for more information on adding eligibility benefit requests.

- Refer to the "Listing, modifying and maintaining eligibility benefit requests" topic for tips on maintaining eligibility benefit requests from the Eligibility Benefit Request List form.
- Refer to the "Preparing eligibility benefit request files for transmission" topic to learn about preparing eligibility benefit requests into an ANSI-270 format file for transmission.
- Refer to the "Viewing and maintaining eligibility benefit response files" topic to learn about handling ANSI-271 response files returned from the Information Source (Payer).

Roster Billing List Form Features

The **PC-ACE Pro32** Roster Billing List form provides a versatile interface from which the user can create, list, modify, print, and otherwise maintain Professional roster billings. Click the "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to open the corresponding Claims Menu form. Then select the "**Maintain Roster Billings**" item from the Professional Claims Menu form's main "**Roster**" menu to open the Roster Billing List form. You may reposition and resize this form if desired. The list can be easily sorted and filtered to display only the roster billings of interest.

Sorting Roster Billings

The roster billing list may be sorted by Service Date, Provider, Roster Type, and Entry Date. Simply select the desired sort order from the available "**Sort By**" radio buttons.

Filtering Roster Billings

The roster billing list may be filtered to display a select subset of roster billings by manipulating the "**Roster Billing List Filter Options**" drop-down lists. Basic filter options include:

- **Location** - filters the roster billing list to include only roster billings in the "to be generated" (**RL**) or "generated" (**GR**) locations.
- **Status** - filters the roster billing list to include only roster billings assigned a specific status. The possible status codes are: "clean/ready" (**CLN**), "deleted" (**DEL**), "has fatal errors" (**ERF**), and "has errors" (**ERR**).

  Note that selecting a status of "**DEL**" is the only way to view "deleted" roster billings (which can be recovered until they are purged from the system).

When multiple filter criteria are specified, only those roster billings that meet **all** filter criteria will be displayed.

Roster Billing Actions

The Roster Billing List form may also be used to perform specific actions on any individual roster billing. To perform an action on a roster billing, simply select the roster billing from the list and click the desired action button (along the lower edge of the form). The complete list of roster billing actions can be accessed from the Roster Billing List form's main "**Actions**" menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected roster billing record). Available roster billing actions include:

- **Creating New Roster Billings** -- Click the "**New**" button (or choose the "**Create New Roster**" action) to create a new roster billing. See the "Adding a new roster billing" topic for more details.
- **Viewing/Modifying Roster Billings** -- Click the "**View/Update**" button (or choose the "**View/Update Selected Roster**" action) to view and/or modify the selected roster billing. See the "Professional Roster Billing Form" topic for details on using this roster billing entry form.

  The View/Update action is the default roster billing action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired roster billing record or by selecting the desired record and pressing the "**ENTER**" key.

- **Deleting Roster Billings** -- Click the "**Delete**" button (or choose the "**Delete Selected Roster**" action) to delete the selected roster billing. Deleted roster billings are assigned a "DEL" status, and can be recovered (i.e., "un-deleted") if needed. See the "Purging Roster Billings" action description below for instructions on permanently removing roster billings from the PC-ACE Pro32 database.
- **Copying Roster Billings** -- Click the "**Copy**" button (or choose the "**Copy Selected Roster**" action) to copy the selected roster billing. The roster billing entry form will be displayed containing the details of the newly copied roster billing. The "Service Date" field is cleared automatically in the new roster billing. This roster billing copy function is often used to duplicate a previous roster billing, greatly simplifying the process of billing for periodic immunizations on a relatively consistent set of patients.
- **Generating Roster Billing Claims** -- Click the "**Generate**" button (or choose the "**Generate Selected Roster**" action) to automatically generate claims for the selected roster billing. Upon completion of the claim generation process, you may view the roster billing report if desired. A successfully generated roster billing is automatically moved to the "generated" (GR) location. Refer to the "Listing, modifying and maintaining roster billings" topic for more information on this claim generation process.

  PC-ACE Pro32 uses the claim import report preference settings to define the default reporting options for the roster billing generation process. Refer to the "Printing Preferences" topic for information on configuring claim import (and roster billing generation) reports to be printed automatically or to a specific printer.
- **Viewing Roster Billing Reports** -- Choose the "**View Selected Roster Report**" action to preview the report for a previously generated roster billing. The report may be printed from the preview screen if desired.
- **Purging Roster Billings** -- Choose the "**Purge Selected Roster**" action to purge the selected roster billing. Roster billings in the "to be generated" (RL) location must be deleted before being purged.

  IMPORTANT: Purged roster billings are permanently deleted from PC-ACE Pro32 … they cannot be recovered.
- **Refreshing the Roster Billing List** -- Choose the "**Refresh Roster List**" action to refresh the current Roster Billing List form contents. This action can be useful in a multi-user installation to be sure that the roster billing list properly reflects additions and/or modifications made by other users.

You will notice that only applicable actions are enabled for use in the main "**Actions**" menu or pop-up menu. For example, it makes no sense to "view the roster report" of a roster billing that has yet to be generated, so this action will be disabled for roster billings in the "RL" location.

The Professional Roster Billing Form

The Professional Roster Billing Form provides access to all data elements of an Professional roster billing. New roster billings are entered and existing roster billings are viewed and/or modified from this form. The form consists of the following major tabs:

- **Patient Info & General** - includes general roster and patient information fields. The upper section of this tab presents those fields that will be common to all claims generated from the roster billing. The lower section of the form presents those fields that are unique to each claim generated from the roster billing.
- **Extended Roster Info** - includes any supplemental common fields that may be required in certain situations.

Click the appropriate tab or simply press the "**PAGE UP**" and " **PAGE DOWN**" keys to move between these major roster billing form sections.

Entering Roster Billing Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the roster billing form fields, respectively.

A number of productivity enhancing features are available during roster billing data entry:

- **Fixed-List Lookups** - The roster billing form supports fixed-list lookups on many of its fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, "Patient Sex" typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the roster billing form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.
- **Variable-List Lookups** - The roster billing form supports variable-list lookups on a number of its fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Many of the variable-list lookups use other roster billing field values to filter the presented list. For example, the provider lookup presents only those provider records applicable to the roster billing being entered. In addition, variable-list lookups often retrieve data used to fill in other roster billing form fields. For example, selection of a Patient from the variable-list lookup completes numerous patient-related fields on the roster billing form. Access variable list lookups using the same method described above for fixed-list lookups.
- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most roster billing form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically

derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.

- **Descriptive Field Hints** - Most roster billing form fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over" hints, since they become visible when the mouse pointer moves over the specified field (without actually selecting the field). This feature can be disabled in the general preferences settings if desired.
- **Line Item Scrolling** - The lower section of the "Patient Info & General" tab displays 5 patient billing lines at a time. For roster billings that contain more than 5 patients, the user may scroll through the patient billing lines one line at a time or one page (i.e., 5 lines) at a time using the buttons provided along the right edge of this tab.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all roster billing lines one page at a time.
- **Billing Line Item Features** - The following productivity features are available for roster patient billing lines:
  - **Billing Line Field Duplication** - Pressing the "**F4**" key while positioned on a specific roster billing line field will copy the value of that single field from the previous line into the current line.

    Pressing the "**F4**" key while positioned on the "**Address Line 1**" field will copy all address fields from the previous line into the current line.
  - **Line Deletion** - Press the "**F7**" key (or the "**<ALT>D**" key sequence) while positioned on any field on a roster billing line to delete the line. You will be prompted to confirm the deletion.
  - **Advance To Next Line** - Press the "**F8**" key while positioned on any field on a roster billing line to automatically advance the cursor to the first field of the next line, skipping over any remaining fields on the current line.
- **Automatic Patient Control Number Generation (optional)** – The roster billing form supports automatic generation of the Patient Control Number field. The decision to enable automatic PCN generation is typically made by the distributor. When this feature is disabled, the PCN field must be entered manually or looked up from the Patient reference file (via the "**F2**" shortcut key).

  Lookups from the Patient reference file may be performed even when automatic PCN generation is enabled. In this scenario, the lookup operation will retrieve all patient information except the PCN.

When the focus leaves a roster billing form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the roster billing form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the roster billing edit validation process.

Saving & Canceling Roster Billings

After completing data entry on the roster billing form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the roster billing. Alternatively, click the "**Cancel**" button to abandon any changes and exit the roster billing. When an attempt is made to save a roster billing, an edit validation process is performed on all fields on the form. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all "**file-level**" edits are evaluated. File-level edits are evaluated only when the roster billing is saved, and are typically those edits that require multiple data elements from the roster billing in order to be evaluated. If no edit validation errors occur, the roster billing is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the edit validation process and the Edit Validation Errors List form. If edit errors exist, you will usually have the option to correct the errors or save the roster billing with errors. If a fatal error exists on the "Payer ID", "Provider ID/No.", "Service Date", or "Type" field, however, you must correct the error before saving the roster billing. Click the "**Save With Errors**" button to save a roster billing that contains only non-fatal errors. Such roster billings are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a roster billing that contains fatal errors. Such roster billings are assigned the "has fatal errors" (ERF) status. Claims cannot be generated from a roster billing with an "ERF" status. If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" roster billing. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Roster Billing Form Topics

The following comments cover any miscellaneous features of the Professional Roster Billing Form:

- **Displaying Audit information** - Click the picture button in the upper right corner of the form to display audit information for this roster billing. This audit information includes the date the roster billing was created, the last modification date, and the User ID of the user that modified the roster billing last.

Common Roster Billing Activities

The following hyperlinks provide additional instruction on several common roster billing activities:

- Refer to the "Adding a new roster billing" topic for more information on adding roster billings.
- Refer to the "Listing, modifying and maintaining roster billings" topic for tips on maintaining roster billings from the Roster Billing List form.

Home Health Plan of Care List Form Features

The **PC-ACE Pro32** Home Health Plan of Care List form provides a versatile interface from which the user can create, list, modify, print, and otherwise maintain Plans of Care. Click the "**Institutional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to open the Institutional Claims Menu form. Then select the "**Attachments**" and "**Maintain HH Plans of Care**" menu items on the Institutional Claims Menu form to open the Plan of Care List form. You may reposition and resize this form if desired. The list can be easily sorted and filtered to display only the plans of interest.

Sorting Plans of Care

The plan list may be sorted by Patient Control Number (PCN), Patient Name, Entry Date, and Start of Care (SOC) Date. Simply select the desired sort order from the available "**Sort By**" radio buttons.

Filtering Plans of Care

The Plan of Care List may be filtered to display a select subset of plans using the **Advanced Filter Options** (accessible from the "**Filter**" main menu item). These advanced options permit filtering on the plan's patient PCN, patient name, provider, as well as a selection of date fields. When multiple filter criteria are specified, only those plans that meet **all** filter criteria will be displayed. A convenient "**Clear Filters**" item is also available from the "**Filter**" main menu to quickly remove any existing filter criteria.

Plan of Care Actions

The Plan of Care List form may also be used to perform specific actions on any individual plan or a group of selected plans. To perform an action on an individual plan, simply select the plan from the list and click the desired action button (along the lower edge of the form). The complete list of plan actions can be accessed from the Plan of Care List form's main "**Actions**" menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected plan). Available plan actions include:

- **Creating New Plans of Care** -- Click the "**New**" button (or choose the "**Create New Plan of Care**" action) to create a new plan. See the "Adding a new Home Health Plan of Care" topic for more details.
- **Viewing/Modifying Plans of Care** -- Click the "**View/Update**" button (or choose the "**View/Update Selected Plan of Care**" action) to view and/or modify the selected plan. See the "Home Health Plan of Care Form" topic for details on using the PC-ACE Pro32 Plan of Care entry form.

  The View/Update action is the default plan action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired plan record or by selecting the desired record and pressing the "**ENTER**" key.

  Holding down the "**SHIFT**" key while invoking the View/Update action on an eligible plan will force an automatic save attempt on the plan. This is a shortcut technique equivalent to invoking the View/Update action and subsequently clicking the "Save" button on the plan entry form. Eligible plans are those with a status of "unprocessed" (UNP), "has errors" (ERR), or "has fatal errors" (ERF).
- **Copying Plans of Care** -- Click the "**Copy**" button (or choose the "**Copy Selected Plan of Care**" action) to copy the selected plan. If the plan being copied includes a Medical Update (CMS-486) section, you will be given the option to include or omit this data on

the new plan. The Plan of Care entry form will be displayed containing the details of the newly copied plan. Make modifications as required and save the new plan.

- **Deleting Plans of Care** – Click the "**Delete**" button (or choose the "**Delete Selected Plan of Care**" action) to delete the selected plan.

  IMPORTANT: Deleted plans are permanently purged from PC-ACE Pro32 … they cannot be recovered.

- **Printing Plans of Care** -- Choose the "**Print Selected Plan of Care**" action to print the selected plan. See the "Printing Home Health Plans of Care" topic for more details.
- **Refreshing the Plan of Care List** -- Choose the "**Refresh Plan of Care List**" action (or press the "**F5**" function key) to refresh the current Plan of Care List form contents. This action can be useful in a multi-user installation to be sure that the list properly reflects plan additions and/or modifications made by other users.

You will notice that only applicable actions are enabled for use in the main "**Actions**" menu or pop-up menu. For example, the "all checked" actions will be enabled only when one or more plans in the list are checked.

Actions on Multiple Plans of Care

Some actions can be performed on multiple plans at once. Multiple plan selection is accomplished by "checking" the plans of interest and subsequently performing one of the "**… All Checked Plans of Care**" actions. To check a plan, click the left mouse button over the checkbox in the first column of the desired list row. Alternatively, all plans in the current list can be checked using the "**Check All Plans of Care**" item from the list's pop-up menu. Use the form's flexible advanced filter techniques to display only the subset of plans to be printed, deleted, etc. Then simply check all plans and perform the desired action on all checked plans at once.

The Home Health Plan of Care Form

The Home Health Plan of Care Form provides access to all data elements of a Home Health Plan of Care. New plans are entered and existing plans are viewed and/or modified from this form. The Home Health Plan of Care Form has been designed to provide a data entry flow resembling that of the printed Home Health Certification And Plan of Care (CMS-485) and Medical Update And Patient Information (CMS-486) forms. Plan fields are grouped logically on five major tabs:

- **Plan of Care (485-1)** – includes most of the CMS-485 form's general plan and patient information fields, as well as all diagnosis and procedure codes/dates. Patient medication information, the DME and supplies listing, and the safety measures narratives are also included on this tab.
- **Plan of Care (485-2)** - includes all remaining CMS-485 form fields (e.g., patient status selections, diagnosis and treatment orders, goals/rehab narrative, and physician information).
- **Medical Update (486-1)** - includes all non-narrative fields from the CMS-486 form. This tab also provides line item entry of all service/treatment information per discipline (including actual/projected visits, frequency/duration, and applicable treatment codes).
- **Medical Update (486-2)** - includes all remaining CMS-486 narrative fields.
- **Miscellaneous** - includes any miscellaneous fields which are not specifically assigned to an CMS-485/486 form location, but which may be required in certain situations. This tab also provides line entry of any expanded narrative information to be associated with a specified form location.

The two "Medical Update" tabs will be visible only if the "**Include Medical Update (Form 486)**" checkbox on the "Plan of Care (485-1)" tab is checked. This feature allows the user to optionally include the Medical Update (CMS-486) data with the Plan of Care.

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between these major Plan of Care form sections.

Entering Plan of Care Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the plan form fields, respectively.

A number of productivity enhancing features are available during plan data entry:

- **Fixed-List Lookups** - The Plan of Care form supports fixed-list lookups on many of the plan's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, the patient's sex field typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

  USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the Plan of Care form field.

  Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.
- **Variable-List Lookups** - The Plan of Care form supports variable-list lookups on a number of the plan's fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Some variable-list lookups use other plan field values

to filter the presented list. For example, treatment code lookups present only those codes applicable to the specified discipline. In addition, variable-list lookups often retrieve data used to fill in other Plan of Care form fields. For example, selection of a Patient PCN from the variable-list lookup completes numerous patient-related fields on the plan. Access variable list lookups using the same method described above for fixed-list lookups.

- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Intelligent Groups Tabs** – The Plan of Care form contains a number of field "groups". Examples of such groups include Other Diagnosis, Functional Limitations, and Mental Status codes. Fields in these groups are always completed sequentially. Therefore, when a field in one of these groups is left empty, it can be assumed that data entry in the group is complete. When the "**TAB**" key is pressed, the remaining fields in that group will be skipped and the cursor will be positioned on the first field in the tab sequence beyond the group fields.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most Plan of Care form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.
- **Descriptive Field Hints** - Most Plan of Care form fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over" hints, since they become visible when the mouse pointer moves over the specified field (without actually selecting the field). This feature can be disabled in the general preferences settings if desired.
- **Line Item Scrolling** – A variable number of Service/Treatment lines (on the "Medical Update (486-1)" tab) and Expanded Narrative lines (on the "Miscellaneous" tab) may be entered on a Plan of Care form. This form displays two Service/Treatment lines and three Expanded Narrative lines at a time. For plans that contain additional line items, the user may scroll through the line items one line at a time or one page at a time using the buttons provided along the right edge of the respective tabs.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all line items one page at a time.
- **Line Item Deletion** - Press the "**F7**" key while positioned on any field of a Service/Treatment line or Expanded Narrative line to delete the line. You will be prompted to confirm the deletion.

When the focus leaves a Plan of Care form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the plan form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the plan edit validation process.

Saving & Canceling Plans of Care

After completing data entry on the Plan of Care form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the plan. Alternatively, click the "**Cancel**" button to abandon any changes and exit the plan.

When an attempt is made to save a plan, an edit validation process is performed on all fields on the plan. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all plan "**file-level**" edits are evaluated. File-level edits are evaluated only when the plan is saved, and are typically those edits that require multiple data elements from the plan in order to be evaluated. If no edit validation errors occur, the plan is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the plan edit validation process and the Edit Validation Errors List form. If edit errors exist, you will usually have the option to correct the errors or save the plan with errors. If a fatal error exists on the "PCN" field, however, you must correct the error before saving the plan. Click the "**Save With Errors**" button to save a plan that contains only non-fatal errors. Such plans are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a plan that contains fatal errors. Such plans are assigned the "has fatal errors" (ERF) status.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" plan. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Plan of Care Form Topics

The following comments cover a few miscellaneous features of the Home Health Plan of Care Form:

- **Entering Free-Form Narrative Data** - The free-form narrative fields on the Plan of Care form will automatically wrap to the next line as typing proceeds beyond the right margin of the control. It is not necessary to enter any manual carriage returns in a narrative field. If, however, a "hard" carriage return is desired, simply press the ENTER key and resume typing on the next line of the narrative control.
- **Displaying Audit information** - Click the picture button in the upper right corner of the "Plan of Care (485-1)" tab to display audit information for this plan. This audit information includes the date the plan record was created, the last modification date, and the User ID of the user that modified the plan last.

Common Plan of Care Activities

The following hyperlinks provide additional instruction on several common plan activities:

- Refer to the "Adding a new Home Health Plan of Care" topic for more information on adding plans.
- Refer to the "Listing, modifying and maintaining Plans of Care" topic for tips on maintaining plans from the Home Health Plan of Care List form.
- Refer to the "Printing Home Health Plans of Care" topic to learn about printing plans.

Institutional Medical Attachment List Form Features

The **PC-ACE Pro32** Institutional Medical Attachment List form provides a versatile interface from which the user can create, list, modify, and otherwise maintain standalone Institutional Medical Attachments. Click the "**Institutional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to open the Institutional Claims Menu form. Then select the "**Attachments**" and "**Maintain Medical Attachments**" menu items on the Institutional Claims Menu form to open the Institutional Medical Attachment List form. You may reposition and resize this form if desired. The list can be easily sorted and filtered to display only the medical attachments of interest.

Sorting Institutional Medical Attachments

The medical attachment list may be sorted by Patient Name, Patient Control Number (PCN), Entry Date, Service From Date, and Transmit Date (when applicable). Simply select the desired sort order from the available "**Sort By**" radio buttons.

Filtering Institutional Medical Attachments

The medical attachment list may be filtered to display a select subset of attachments by manipulating the "**Medical Attachment List Filter Options**" drop-down lists. Basic filter options include:

- **Location** - filters the medical attachment list to include only attachments in the "to be transmitted" (**CL**) or "transmitted" (**TR**) locations.
- **Status** - filters the medical attachment list to include only attachments assigned a specific status. The possible status codes are: "clean/ready" **(CLN)**, "has fatal errors" **(ERF)**, "has errors" **(ERR),** "held" **(HLD)** and "unprocessed" **(UNP)**.
- **Type** - filters the medical attachment list to include only attachments of a specific type. Supported attachment types are: Outpatient Rehab Plan of Treatment **(700)**, Outpatient Rehab Plan of Treatment Update **(701)**, Ambulance Medical Data **(AMB)**, and End Stage Renal Disease **(ESR)**.

In addition to these basic filter options, the Institutional Medical Attachment List form also provides a number of **Advanced Filter Options**. These advanced options permit filtering on the medical attachment's patient, payer, provider, date ranges, batch information and bill types. When multiple filter criteria are specified, only those medical attachments that meet **all** filter criteria will be displayed. A convenient "**Clear Filters**" item is also available from the "**Filter**" main menu to quickly remove any existing filter criteria.

Institutional Medical Attachments Actions

The Institutional Medical Attachment List form may also be used to perform specific actions on any individual medical attachment or a group of selected medical attachments. To perform an action on an individual medical attachment, simply select the medical attachment from the list and click the desired action button (along the lower edge of the form). The complete list of medical attachment actions can be accessed from the Institutional Medical Attachment List form's main "**Actions**" menu or from the convenient pop-up menu (accessed by right clicking the mouse over the selected medical attachment). Available medical attachment actions include:

- **Creating New Medical Attachments** -- Click the "**New**" button (or choose the "**Create New Attachment**" action) to create a new medical attachment. You will be prompted to select the desired medical attachment type. See the "Adding a new Institutional Medical Attachment" topic for more details.

- **Viewing/Modifying Medical Attachments** -- Click the "**View/Update**" button (or choose the "**View/Update Selected Attachment**" action) to view and/or modify the selected medical attachment. See the "Institutional Medical Attachment Forms" topic for details on using the PC-ACE Pro32 Institutional Medical Attachment entry forms.

  The View/Update action is the default medical attachment action. In addition to the techniques described above, this action can also be invoked by double-clicking on the desired medical attachment record or by selecting the desired record and pressing the "**ENTER**" key.

  Holding down the "**SHIFT**" key while invoking the View/Update action on an eligible medical attachment will force an automatic save attempt on the attachment. This is a shortcut technique equivalent to invoking the View/Update action and subsequently clicking the "Save" button on the medical attachment entry form. Eligible medical attachments are those with a status of "unprocessed" (UNP), "has errors" (ERR), or "has fatal errors" (ERF).

- **Copying Medical Attachments** -- Click the "**Copy**" button (or choose the "**Copy Selected Attachment**" action) to copy the selected medical attachment. The appropriate Institutional Medical Attachment entry form will be displayed containing the details of the newly copied attachment. Make modifications as required and save the new medical attachment.

  When copying an Outpatient Rehab Plan of Treatment (700) attachment, you will be given the option to create the copy as an Outpatient Rehab Plan of Treatment Update (701).

- **Holding Medical Attachments** -- Choose the "**Hold Selected Attachment**" action to change the status of the selected medical attachment to "hold" (HLD). Held medical attachments are not eligible for preparation into an EMC file.

- **Releasing Medical Attachments** -- Choose the "**Release Selected Attachment**" action to release a previously held medical attachment. In addition to releasing the medical attachment, this action also sets the status of the selected attachment to "unprocessed" (UNP).

- **Deleting Medical Attachments** – Click the "**Delete**" button (or choose the "**Delete Selected Attachment**" action) to delete the selected medical attachment.

  IMPORTANT: Deleted medical attachments are permanently purged from PC-ACE Pro32 … they cannot be recovered.

- **Reactivating Medical Attachments** -- Choose the "**Reactivate Selected Attachment**" action to reactivate the selected medical attachment. This action will move the previously transmitted medical attachment from the "transmitted" (TR) location into the "to be transmitted" (CL) location. The reactivated medical attachment will be assigned the "unprocessed" (UNP) status. See the "Reactivating previously transmitted claims" topic for more details on reactivating claims and medical attachments.

- **Refreshing the Medical Attachment List** -- Choose the "**Refresh Attachment List**" action (or press the "**F5**" function key) to refresh the current Institutional Medical Attachment List form contents. This action can be useful in a multi-user installation to be sure that the list properly reflects medical attachment additions and/or modifications made by other users.

You will notice that only applicable actions are enabled for use in the main "**Actions**" menu or pop-up menu. For example, the "all checked" actions will be enabled only when one or more medical attachments in the list are checked.

Actions on Multiple Institutional Medical Attachments

Some actions can be performed on multiple medical attachments at once. Multiple attachment selection is accomplished by "checking" the medical attachments of interest and subsequently performing one of the "**… All Checked Attachments**" actions. To check a medical attachment, click the left mouse button over the checkbox in the first column of the desired list row. Alternatively, all medical attachments in the current list can be checked using the "**Check All Attachments**" item from the list's pop-up menu. Use the form's flexible advanced filter techniques to display only the subset of medical attachments to be deleted, reactivated, etc. Then simply check all medical attachments and perform the desired action on all checked attachments at once.

The Institutional Medical Attachment Forms

The Institutional Medical Attachment Forms provide access to all data elements of the supported standalone Institutional medical attachments. New medical attachments are entered and existing attachments are viewed and/or modified from these forms. PC-ACE Pro32 supports the following medical attachment types:

- **Outpatient Rehabilitation Plan of Treatment (Form 700)** – The fields on this form are grouped logically on three major tabs:
  - **General Information** – includes the Rehab Plan of Treatment's general claim and patient information. The discipline, rehabilitation therapist, and attending physician information is also included on this tab.
  - **Treatment Details** - includes all specific treatment details (e.g., relevant dates, treatment diagnosis, frequency/duration, and certification status).
  - **Rehabilitation Narratives** - includes all free-form narratives (e.g., medical history, functional goals, drugs administered).
- **Outpatient Rehabilitation Plan of Treatment Update (Form 701)** – The fields on this form are identical to those on the Outpatient Rehabilitation Plan of Treatment (700) form.
- **Ambulance Medical Data Attachment** – The fields on this form are grouped logically on two major tabs:
  - **General Information** – includes the Ambulance attachment's general claim and patient information. Justification codes, mileage, and various costs are also included on this tab.
  - **Pickup/Destination/Remarks** - includes the codes, facility and address information for the ambulance service pickup (origin) and destination. A free-form narrative used to provide additional information or justification is also included on this tab.
- **End Stage Renal Disease (ESRD) Attachment** – The fields on this form are grouped logically on two major tabs:
  - **General Info & Lab Tests** – includes the ESRD attachment's general claim and patient information, as well as the ESRD lab test results.
  - **Medical Documentation** - includes ESRD medical documentation (e.g., medication, extra dialysis, and other services).

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between tabs on the specific Institutional Medical Attachment Form.

Entering Institutional Medical Attachment Data

Click on any field to activate it for data entry, or press the "**TAB**" key to move from field to field in a predefined sequence (generally left-to-right and top-to-bottom). Use the "**UP ARROW**" and "**DOWN ARROW**" keys to move up and down through the medical attachment form fields, respectively.

A number of productivity enhancing features are available during medical attachment data entry:

- **Fixed-List Lookups** - The medical attachment forms support fixed-list lookups on many of the form's fields. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, the patient's sex field typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the medical attachment form field.

Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - The medical attachment forms support variable-list lookups on a number of the form's fields. Variable-list lookups apply primarily to fields whose values are selected from reference files. Some variable-list lookups use other medical attachment field values to filter the presented list. For example, provider lookups present only those providers who are setup for the medical attachment's line of business (as determined by the payer selection). In addition, variable-list lookups often retrieve data used to fill in other medical attachment form fields. For example, selection of a Patient PCN from the variable-list lookup completes numerous patient-related fields on the medical attachment. Access variable list lookups using the same method described above for fixed-list lookups.
- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the general preferences settings if desired.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most medical attachment form fields.
- **Date Completion** - Date values may be entered with or without the century for convenience. PC-ACE Pro32 uses a user-definable century pivot year to automatically derive the century when omitted. To insure accuracy, birthdate fields require that a full 4-digit year be entered.
- **Descriptive Field Hints** - Most medical attachment form fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over" hints, since they become visible when the mouse pointer moves over the specified field (without actually selecting the field). This feature can be disabled in the general preferences settings if desired.
- **Line Item Scrolling** – A variable number of Lab Test Result lines and Medical Documentation lines may be entered on the End Stage Renal Disease (ESRD) medical attachment form. This form displays four Lab Test Result lines and three Medical Documentation lines at a time. For ESRD medical attachments that contain additional line items, the user may scroll through the line items one line at a time or one page at a time using the buttons provided along the right or bottom edge of the respective tabs.

  You can also use the **up/down arrow keys** to move from line to line, scrolling when appropriate. Type "**<ALT><PAGE UP>**" (press the "**Page Up**" key while holding the "**ALT**" key down) or "**<ALT><PAGE DOWN>**" to scroll up/down through all line items one page at a time.
- **Line Item Deletion** - Press the "**F7**" key while positioned on any field of the End Stage Renal Disease (ESRD) medical attachment's Lab Test Result line or Medical Documentation line to delete the line. You will be prompted to confirm the deletion.

When the focus leaves a medical attachment form field (either by pressing the "**TAB**" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error occurs, you will receive an audible response and the edit validation error message will be

displayed in the lower left corner of the medical attachment form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, simply press the "**TAB**" key again to move to the next field. Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the medical attachment edit validation process.

Saving & Canceling Institutional Medical Attachments

After completing data entry on one of the Institutional Medical Attachment forms, click the "**Save**" button (or type "**<ALT>S**") to save and exit the medical attachment. Alternatively, click the "**Cancel**" button to abandon any changes and exit the medical attachment.

When an attempt is made to save a medical attachment, an edit validation process is performed on all fields on the attachment. This process includes re-evaluating all "field-level" edits (as defined above). In addition, all attachment "**file-level**" edits are evaluated. File-level edits are evaluated only when the medical attachment is saved, and are typically those edits that require multiple data elements from the attachment in order to be evaluated. If no edit validation errors occur, the medical attachment is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the medical attachment edit validation process and the Edit Validation Errors List form. If edit errors exist, you will usually have the option to correct the errors or save the medical attachment with errors. If a fatal error exists on the "PCN" field, however, you must correct the error before saving the medical attachment. Click the "**Save With Errors**" button to save a medical attachment that contains only non-fatal errors. Such attachments are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a medical attachment that contains fatal errors. Such attachments are assigned the "has fatal errors" (ERF) status.

If edit validation errors occur, several "**Save**" attempts may be required to correct and save a "clean" medical attachment. At any time, click the "**Errors List**" button to review the remaining edit validation errors.

Miscellaneous Institutional Medical Attachment Form Topics

The following comments cover a few miscellaneous features of the Institutional Medical Attachment Forms:

- **Entering Free-Form Narrative Data** - The free-form narrative fields on the Institutional Medical Attachment Forms will automatically wrap to the next line as typing proceeds beyond the right margin of the control. It is not necessary to enter any manual carriage returns in a narrative field. If, however, a "hard" carriage return is desired, simply press the ENTER key and resume typing on the next line of the narrative control.
- **Displaying Audit information** - Click the picture button in the upper right corner of the first tab of each Institutional Medical Attachment Form to display audit information for this medical attachment. This audit information includes the date the medical attachment record was created, the last modification date, and the User ID of the user that modified the attachment last.

Common Institutional Medical Attachment Activities

The following hyperlinks provide additional instruction on several common standalone Institutional Medical Attachment activities:

- Refer to the "Adding a new Institutional Medical Attachment" topic for more information on adding medical attachments.

- Refer to the "Listing, modifying and maintaining Institutional Medical Attachments" topic for tips on maintaining medical attachments from the Institutional Medical Attachments List form.
- Refer to the "Preparing Institutional Medical Attachments for transmission" topic to learn how to prepare standalone medical attachments into an EMC file ready for transmission.

Reference File Maintenance Form

The Reference File Maintenance form provides an interface to access all **PC-ACE Pro32** reference files. Click the "**Reference File Maintenance**" button on the PC-ACE Pro32 Main Toolbar to open the Reference File Maintenance form. The form consists of up to 5 major tabs ("Patient", "Payer", "Provider (Inst)", "Provider (Prof)", and "Codes/Misc."). If you are licensed for only Institutional claims processing or only Professional claims processing, then you will see only 4 tabs and the provider tab will be labeled simply "Provider". You may reposition and resize this form if desired. The following is a brief explanation of these major tabs, including the operations available on each.

- **Patient** - provides access to maintain general patient information as well as primary, secondary, and tertiary insured details. Setup of the Patient reference file is optional. Patient information from this reference file is available for lookup during claim entry. The Patient tab provides a convenient "**Sort By**" selection that quickly sorts the Patient list by "Patient PCN" or "Patient Name". Operations available include:
  - To add a new patient record, click the "**New**" button and enter the new patient record information. Refer to the "Adding and maintaining patients" topic for more information.
  - To view or modify an existing patient record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
  - To delete an existing patient record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
- **Payer** - provides access to maintain system payer information and PrintLink matching descriptions. Setup of the Payer reference file is mandatory (although it may be setup in advance by your distributor). All payers referenced on claims must exist in the Payer reference file, with the exception of the special "dump" payer (Payer ID=99999). The Payer tab provides a convenient "**Sort By**" selection that quickly sorts the Payer list by "Payer ID", "Payer Description", "Payer LOB" or "Payer State". Operations available include:
  - To add a new payer record, click the "**New**" button and enter the new payer record information. Refer to the "Adding and maintaining payers" topic for additional information on payer and PrintLink matching description requirements.
  - To view or modify an existing payer record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
  - To create a new payer record that is similar to an existing record, select the desired payer record, click the "**Copy**" button and change only the desired fields. This feature makes it easy to create multiple payer records for the same payer to support more than one line of business (LOB).
  - To delete an existing payer record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
  - Click the "**PrintLink Matching Descriptions**" button while viewing a Payer's details to view/edit the PrintLink matching strings for the selected payer. Refer to the "Adding and maintaining payers" topic for more details.
- **Provider (Inst)** - provides access to maintain the providers to be referenced on Institutional claims. Setup of the Institutional Provider reference file is required to process Institutional claims. All providers referenced on Institutional claims must be represented in this reference file. The Institutional Provider tab provides a convenient "**Sort By**" selection that quickly sorts the Provider list by LOB", "Provider Name", "Provider ID", and "Tag". Operations available include:
  - To add a new Institutional provider record, click the "**New**" button and enter the new provider information. If providers already exist in this reference file, you will have the

option to create a completely new provider record, or inherit and associate the new provider record with the provider record currently selected in the list. Select the desired creation options and click the "**OK**" button to continue. Refer to the "Adding and maintaining providers (Institutional)" topic for a discussion of these creation options and their applicability.

- To view or modify an existing provider record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete an existing provider record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

Claims are linked to provider records by an internal control number. Deleting a provider record will irrevocably break any such links that may exist to claims in the system. The Provider Deletion Confirmation form outlines alternatives to deletion, and provides a convenient utility to determine how many claims reference the provider record to be deleted.

❖ **Provider (Prof)** - provides access to maintain the providers to be referenced on Professional claims. Setup of the Professional Provider reference file is required to process Professional claims. All providers referenced on Professional claims must be represented in this reference file. The Professional Provider form provides a convenient "**Sort By**" selection that quickly sorts the Provider list by LOB", "Type", "Provider/Group Name", "Provider ID", "Group Label.", and "Tag". Operations available include:

- To add a new Professional provider record, click the "**New**" button and enter the new provider information. If providers already exist in this reference file, you will have the option to create a completely new provider record, or inherit and associate the new provider record with the provider record currently selected in the list. Select the desired creation options and click the "**OK**" button to continue. Refer to the "Adding and maintaining providers (Professional)" topic for a discussion of these creation options and their applicability.
- To view or modify an existing provider record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete an existing provider record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

Claims are linked to provider records by an internal control number. Deleting a provider record will irrevocably break any such links that may exist to claims in the system. The Provider Deletion Confirmation form outlines alternatives to deletion, and provides a convenient utility to determine how many claims reference the provider record to be deleted.

❖ **Codes/Misc** - provides access to the core PC-ACE Pro32 codes and miscellaneous reference files. Refer to the "Codes & Miscellaneous Reference Files Overview" topic for additional information on each of these reference files.

Common Reference File Form Features

A number of productivity enhancing features are available while entering reference file information.

- **Fixed-List Lookups** - Fixed-list lookups are available on many of the fields on these forms. Fixed-list lookups apply to fields whose list of valid values can be determined in advance. For example, "Patient Sex" typically has 3 possible values: "M" (male), "F" (female), and "U" (unknown).

USAGE: Access the lookup list for a field by positioning the cursor on the field and pressing the "**F2**" function key (or right-clicking the mouse). When an item from the list is selected, its value is automatically entered in the form field.

Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification.

- **Variable-List Lookups** - Variable-list lookups are available on many of the fields on these forms. Variable-list lookups apply primarily to fields whose values are selected from other reference files. Such lookups often retrieve data used to fill in other form fields. For example, if you use the variable-list lookup feature to select a Payer ID on the "Primary Insured" tab of the Patient Information form, the Payer Description and Payer LOB will be retrieved as well. Access variable list lookups using the same method described above for fixed-list lookups.
- **Automatic Field Tabs** - When entering data in a field, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence. This feature can be disabled in the "General Preferences" settings if desired.
- **Cancel Field Changes** - If a change is inadvertently made to the contents of a field, press the "**ESC**" key to cancel this change and restore the field's value to what it was when the field received the focus. This feature is available for most fields on any of the reference file information forms.
- **Edit Validation** - Edit validation rules apply to patient, payer, provider, and submitter reference file records. When a new or modified patient, payer, provider, or submitter record is saved, an edit validation process is performed on all fields. If no edit validation errors occur, the updated record is saved. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "**fatal**" and which are "**non-fatal**". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the Edit Validation Errors List form. If any fatal edit errors exist, you must correct them before the record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the record with errors. Click the "**Save With Errors**" button to save a record that contains only non-fatal errors.
- **Descriptive Field Hints** - Most reference file fields have field hints that provide a brief description of the field's purpose. These hints are often called "fly-over hints", since they become visible when the mouse pointer moves over the specified field (without actually selecting the field). This feature can be disabled in the general preference settings if desired.

Common Reference File Filter Options

Many of the reference file forms provide a common set of "List Filter Options" that can be helpful in locating a specific record in the list. These common filter options are defined as follows:

- **"Show all …(no filter applied)"** - When selected, any existing filter is removed and all records in the list are displayed.
- **"Filter list to include … starting with …"** - When selected, the list is filtered to include only those records whose PCN, ID, code, name, or description starts with the pattern entered in the adjacent filter control. The filter is dynamically re-applied as characters are added to (or deleted from) the pattern.

  This filter option is invoked automatically if the user types one or more alphanumeric characters while the focus is on the list (which it is by default when

the form is opened). This behavior permits the user to easily filter the list if the first few characters of the code or description are known. The user may then use the standard list navigation keys to move around in the filtered list. Once the desired record is selected, the user may press the "ENTER" key to "view/update" (or "select" in a lookup context) the highlighted record. These features are designed to increase operator efficiency by minimizing the need to use the mouse.

- **"Filter list to include descriptions containing …"** - When selected, the list is filtered to include only those records whose description field value contains the pattern entered in the adjacent filter control. Click the "**Apply**" button (or press the "**ENTER**" key) after entering the search string to perform the filter operation.
- **"Show only providers associated with selected provider"** - When selected, filters the list to include only those provider records associated with the currently selected provider record. This filter option is only available with the Institutional and Professional provider lists. Refer to the "Adding and maintaining providers (Institutional)" and "Adding and maintaining providers (Professional)" topics for a discussion of provider associations.

Common Reference File Sort & Selection Features

Most reference file forms support a common set of sort and selection features that can be helpful in locating a specific record in the list. These features are designed to increase operator efficiency by minimizing the need to use the mouse (especially when accessing lookup lists during manual claim entry). These common features include:

- **Quick Sort Order Toggle** – In addition to the standard "Sort By" selection controls, most reference file forms also recornize the "**F3**" function key as a way to quickly toggle between the most commonly desired sorting selections. Typically, the "F3" key can be used to toggle between the "ID" (or "Code") sort order and the "Name" (or "Description") sort order.
- **List Navigation Keys** – Most reference file forms recognize all common list navigation keys. These include the **up/down arrow** keys (moves up/down one record), **page up/down** keys (moves up/down one page), and **home/end keys** (moves to the first/last record). In addition, the "**<TAB>**" key can be used to move down through the currently visible records, and the "**<SHIFT><TAB>**" key combination can be used to move up through the visible records. **Note**: These navigation keys are recognized only when the list is the active control (i.e., has the focus).

Reference File Reports

Common reference file reports are accessible from the Reference File Maintenance form's main "**Reports**" menu. Currently available reports include:

- **Patient List** - previews and/or prints a summary report of all (or a selection of) patient records. The Patient List Report Filter Criteria form will be displayed to allow the user to restrict the patient records to be included in the report. Enter any desired report filter criteria and preview or print the report as desired.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Adding and maintaining patients", "Adding and maintaining payers", "Adding and maintaining providers (Institutional)", "Adding and maintaining providers (Professional)", and "Codes & Miscellaneous Reference Files Overview" topics for additional information on these core PC-ACE Pro32's reference files.

- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Claim & Reference File Edit Validation

The term "**edit**" is commonly used in claims processing to describe a specific rule imposed on a claim field (or combination of claim fields). The plural term "**edits**" refers to the collection of individual rules imposed on a specific claim field or on the entire claim. Sequentially applying all applicable edits on a claim field (or all claim fields) is referred to as the "**edit validation**" process. The set of rules (edits) to be imposed on a claim's fields varies with the type of claim, and is typically defined by the distributor. **PC-ACE Pro32** provides a powerful and flexible system for defining, maintaining, and validating claim edits. In addition, edits are available for validating Institutional Home Health Plans of Care, standalone Institutional Medical Attachments, Professional roster billings, as well as records in the Patient, Payer, Provider, and Submitter reference files. This discussion will focus on the claim editing process, however, the same concepts and procedures apply to plan of care, standalone medical attachment, roster billing, patient, payer, provider, and submitter editing unless specified otherwise.

Field-Level vs. File-Level Edits - Edits in PC-ACE Pro32 are defined at the time they are created as one of two possible types:

- **Field-Level** - During claim entry, when the focus leaves a claim form field (either by pressing the "TAB" key or clicking on a new field), an edit validation process is performed on the field losing the focus. Edits performed at this time are referred to as "**field-level**" edits. If a field-level edit validation error is detected, you can either correct the problem at that time or leave it for later.
- **File-Level** - Edits that are validated only when an attempt is made to save the claim are referred to as "**file-level**" edits. File-level edits are typically those that require multiple data elements from the claim in order to be evaluated. For example, looking for duplicate procedure codes on all lines of a claim is a task that can only be performed correctly when all lines have been entered. As such, this type of duplicate check is the ideal candidate for a "**file-level**" edit.

All field-level edits for the entire claim are re-evaluated when an attempt is made to save the claim. This is necessary to catch those field-level edit errors that were never corrected, and to catch any new edit errors that may have been introduced by other changes on the claim.

Fatal vs. Non-Fatal Edits - Edits in PC-ACE Pro32 are defined at the time they are created as either "fatal" or "non-fatal":

- **Fatal Edits** - Fatal edits describe rules that should never be broken. For example, a claim has no useful meaning until at least one valid payer has been specified. Therefore, a "fatal" edit exists to ensure that a valid payer has been specified. Claims with fatal errors can be saved, unless the fatal errors exist on one of the claim's key fields. Key fields include "LOB", "PCN" and "TOB" for Institutional claims and "LOB" and "PCN" for Professional claims. Claims saved with fatal errors will not be eligible for preparation into an electronic (EMC) file. All fatal errors in reference file records must be corrected before the user can save the record. There are relatively few fatal edits defined in PC-ACE Pro32.
- **Non-Fatal Edits** - Non-fatal edits describe rules that should probably not be broken, however, PC-ACE Pro32 will look the other way if they are. Claims containing only non-fatal edit errors can be saved (and even prepared into an EMC file if desired). It is up to the user to decide when a non-fatal edit validation error can be ignored.

Handling Edit Validation Errors

Field-level edit validation errors are reported as the focus leaves the offending field during claim entry. If such an error occurs, you will receive an audible response and the edit validation error message will be displayed in the lower left corner of the claim form. In addition, the focus will remain on the field so that you can correct the problem if desired. If you choose not to correct the data at this time, you can simply press the "**TAB**" key again to move to the next field.

When an attempt is made to save the claim, an edit validation process is performed on all claim fields. This process includes re-evaluating all "field-level" edits. In addition, all claim "file-level" edits are evaluated. If no edit validation errors occur, the claim is saved with a "clean" (CLN) status. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form (unless disabled in the General Preference settings). This form lists all the edit validation errors that have occurred, flagging fatal errors with a red "X" graphic. Double-click on any of the listed errors to jump directly to the offending field on the claim form. Claims with fatal errors can be saved, unless the fatal errors exist on one of the claim's key fields. Key fields include "LOB", "PCN" and "TOB" for Institutional claims and "LOB" and "PCN" for Professional claims. Click the "**Save With Errors**" button to save a claim that contains only non-fatal errors. Such claims are assigned the "has errors" (ERR) status. Click the "**Save With Fatal**" button to save a claim that contains fatal errors. Such claims are assigned the "has fatal errors" (ERF) status. Claims with an "ERF" status will not be eligible for preparation into an electronic (EMC) file. Fatal edit errors on reference file records must be corrected before the user can save the record.

If edit validation errors are reported, several "Save" attempts may be required to correct and save a "clean" claim. At any time, click the "**Errors List**" button to review the remaining claim edit validation errors. Remember that file-level edit errors are only re-checked when the claim is saved. Therefore, these edit errors will remain in the list even though the problem may have already been corrected. The next claim save attempt will clear any corrected file-level edit validation errors from the list.

When the Edit Validation Errors List form closes, all claim fields reporting edit validation errors will begin flashing. By default, the normal tab sequence is overridden and will now jump between these error fields. This special tab feature is intended to speed up the process of correcting multiple edit validation errors, and can be disabled in the "general preferences" settings if desired. Press the "**ESC**" key to stop the error fields from flashing and to restore the normal tab sequence.

The "Errors List" button is not available on the Patient, Payer, Provider, and Submitter reference file information forms.

Security & User Maintenance

The Security & User Maintenance features accessible from the main "Security" menu allow a System Administrator to add and delete system users, and to maintain security access permissions for these users. Select the "**Add/Update User**" item from the main "**Security**" menu to display the current system user list.

- To add a user, click the "**New**" button. Each user must be assigned a User ID, Password and Name. During the user creation process, it is important to set the user's access permissions to allow complete or selective access to activities within the system. The user permissions are grouped as follows:
  - **Institutional Claim Activities** - specifies user permission to view, enter, modify, delete, import, process, prepare, and archive Institutional claims.
  - **Professional Claim Activities** - specifies user permission to view, enter, modify, delete, import, process, prepare, and archive Professional claims.
  - **Reference File Activities** - specifies user permission to view and update reference files.
  - **Miscellaneous Activities** - specifies user permission to access data communications and system utilities, schedule claim activities, perform database maintenance and system restores.
  - **Security Maintenance Activities** - specifies user permission to add and modify system users and their permission settings.

  Check the checkbox next to the permission to allow access to the activity. Click the "**Check All**" and "**Clear All**" buttons to quickly check or un-check all user permission checkboxes.

  Grant "Security Maintenance Activities" permissions only to users who need access to add/delete users and set user permissions.

- To modify the password, name, or permissions for an existing user, select the user from the Security List and click the "**View/Update**" button (or double-click the selection).
- To delete a user, select the user from the Security List, click the "**Delete**" button and confirm the deletion.

If changes are made to a user profile, the change will not go into effect until the next time that user logs into system. The "**Logout Current User**" option, available from the main "**Security**" menu, provides a convenient way to log out the current user without exiting the system.

As shipped, PC-ACE Pro32 is configured with a single default user with full system access rights. The default user's User ID is "**SYSADMIN**" and password is "**SYSADMIN**" as well. If you are logging into PC-ACE Pro32 for the first time, use this default login (unless instructed otherwise by your distributor). If the default login does not work, review the installation guidelines provided by your distributor. Distributors often pre-configure the security system according to their own internal specifications. If you still have difficulties logging into the system, contact your distributor for assistance. **IMPORTANT:** You should change the default user's password as soon as possible if you are concerned about controlling user access at your facility.

Audit Tracking

An integrated audit tracking feature tracks modifications to user, claim, and reference files records. You will see these audit buttons throughout PC-ACE Pro32. Click the button to display the date the record was added, the date the record was last changed and the User ID responsible for the last change.

System Security Level

The "**Set Security Options**" on the main "**Security**" menu provides access to PC-ACE Pro32's security level setting. Three security levels are available:

- **Full password protection** - requires users to enter a valid User ID and Password to log in. User activity permissions are enforced at this security level.
- **Password required (no function checking)** - requires users to enter a valid User ID and Password to log in. User activity permissions are not enforced at this security level. Once a user logs in, all system functions are allowed.
- **Password not required (User ID for Audit only)** - requires users to enter only a valid User ID to log in. This minimum-security level uses the User ID for audit purposes only.

Access to the Security Options form requires a master System Administrator password.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Adding or modifying a system user" topic for more information on user maintenance.

System Preferences

Preferences Overview

Many of the features in **PC-ACE Pro32** are customizable. These preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The major tabs on this dialog include:

- General Preferences - includes settings to control general claim entry and other basic aspects of the program's behavior.
- Claim List Preferences - permits customization of the Institutional and Professional Claim List forms, including column field selection, order, width and headings.
- Claim Import Preferences - permits selection of the Institutional and Professional claim import processing method as well as specification of an optional import preprocessor.
- Printing Preferences - includes Institutional and Professional report and claim printing options.
- Data Communication Preferences - allows assignment of launch file paths and button captions for external data communication programs.
- Miscellaneous Preferences - includes settings to configure and control several maintenance options and other miscellaneous features.

Click on the links above for a description of the available preference options in each category.

Preference settings are workstation-specific. In a multi-user installation, each client workstation may set these preferences to best suit their work flow and data entry style.

General Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **General Preferences** tab settings control a number of claim entry options as well as other basic aspects of PC-ACE Pro32 operation. A description of each available option is included below:

- **Automatically tab at maximum field length during data entry** - This option applies to data entry in the Institutional Claim Form, Professional Claim Form, and a number of other editable forms.
  - ☑ When checked, an automatic tab will occur when the field has been completely filled. For example, entering a single character in a one-character field will automatically position the cursor on the next field in the tab sequence.
  - ☐ When unchecked, the user must physically tab to the next field regardless of the contents of the current field.
- **Tab key jumps between controls with edit errors when displayed** - This option applies to data entry in the Institutional Claim Form, Professional Claim Form, and a number of other editable forms. When edit validation errors are encountered during a save operation, the fields with errors will display in color (and optionally flash) to help the user locate them. This option will be in effect while these fields are displayed in this manner.
  - ☑ When checked, the tab sequence will be altered to include only those fields with errors (i.e., those fields that are displayed in color), allowing the user to rapidly locate and correct the edit validation errors.
  - ☐ When unchecked, the normal tab sequence remains in effect at all times.

  If this feature is enabled, press the "**ESC**" key to deactivate the special notification error mode and return to normal tab operation.
- **Enable flashing notification method for controls with edit errors** - This option applies to the Institutional Claim Form, Professional Claim Form, and a number of other editable forms. When edit validation errors are encountered during a save operation, the fields with errors will display in color (and optionally flash) to help the user locate them. This option controls whether or not the background of these fields will alternate (flash) between the error color and the standard field color.
  - ☑ When checked, the background of the fields with edit validation errors will alternate (flash) between their standard color and the appropriate error color.
  - ☐ When unchecked, the background of the fields with edit validation errors will be statically displayed in the appropriate error color.
- **Warn on close when deferred claims tasks are scheduled** - Scheduled claim import, processing, and transmission activities can only be initiated when PC-ACE Pro32 is running.
  - ☑ When checked, the user will be warned when exiting PC-ACE Pro32 if claims activities are currently scheduled. The user will have the option to leave the program running if desired.
  - ☐ When unchecked, no warnings will be issued when exiting PC-ACE Pro32. Scheduled claims activities will not be performed while the program is down.
- **Show descriptive field hints on claim and reference file forms** - The Institutional Claim Form, Professional Claim Form, and a number of other editable forms support "hint" (or "fly-over") popup windows for each field. This "hint" provides a brief description of the data required in the associated field.

- ☑ When checked, the hint popup window will be displayed for a few seconds whenever the mouse pointer moves over a supported field.
- ☐ When unchecked, the field hints feature is disabled.

- **Present claims with errors for immediate editing during process runs** - During automated claim processing runs, the user may choose to review and/or correct claims with edit validation errors as they are encountered. This option controls the default setting for this "interactive" claim-processing mode.
  - ☑ When checked, claims with edit validation errors will be presented for review and/or correction as soon as they are encountered in the automated claim processing run.
  - ☐ When unchecked, all claims in the automated processing run will be processed without user intervention. Claims with edit validation errors can be worked from the Claim List form after the automated processing run completes.

  The user may override this default setting when initiating an automated claim processing run.

- **Use Charge Master reference file for Professional procedure code lookups** - Controls the data source for procedure code lookups in the Professional Claim Form.
  - ☑ When checked, the optional Charges Master reference file will serve as the source for claim line procedure code lookups.
  - ☐ When unchecked, the master HCPCS Codes reference file will serve as the source for claim line procedure code lookups.

- **Interpret Enter key as save request on claim entry and other editable forms** - Controls the action taken when the "ENTER" key is pressed on the claim entry and other editable forms (e.g., Patient, Payer, Provider, and Submitter Information forms).
  - ☑ When checked, pressing the "ENTER" key during data entry on an applicable form will invoke a save request. Thus, pressing the "ENTER" key is equivalent to clicking the "Save" button.
  - ☐ When unchecked, pressing the "ENTER" key during data entry on an applicable form will simply tab to the next field in the form's tab sequence.

- **Automatically display Edit Validation Error List when saving a claim that contains errors** – Determines whether the Edit Validation Errors List form is displayed automatically when a claim containing edit validation errors is saved. This setting controls the display of this errors list when a claim is saved manually (e.g., clicking the "Save" button on the "Institutional Claim Form" or "Professional Claim Form") or when an implied save operation is performed during an interactive claim processing run.
  - ☑ When checked, the Edit Validation Errors List will be displayed automatically during a claim save operation if the claim contains edit validation errors. The user may jump directly to the offending field for any listed edit validation error.
  - ☐ When unchecked, the Edit Validation Errors List will not be displayed automatically. If the claim contains one or more edit validation errors, focus will be directed to the field representing the first listed error. The user may view the Edit Validation Errors List form if desired by clicking the "Error List" button on the claim entry form.

- **Automatically prompt for selection of non-unique Payer, Provider, and Physician IDs** – Determines whether or not a variable-list lookup operation will be initiated automatically when the user enters a non-unique Payer ID, Provider ID, or Physician ID / UPIN while hand-keying data into claims and selected reference files.
  - ☑ When checked, the appropriate variable-list lookup will be automatically initiated whenever the hand-keyed ID / UPIN cannot be uniquely resolved in the corresponding reference file. The lookup list will automatically position itself on the

first of several records with the specified ID / UPIN. The user may then select the desired record from the list.

- ☐ When unchecked, the variable-list lookup will not be initiated and the non-unique ID / UPIN value will be left unresolved. In most cases, this will result in a subsequent edit validation error. To correct this, the user should manually initiate a variable-list lookup operation and select the desired unique record. Right-click the mouse (or press the "**F2**" key) while positioned on the offending ID / UPIN field to manually initiate the lookup operation.

❖ **Automatically focus on Patient PCN field for new Institutional hand-keyed claims** – Determines whether or not the cursor (focus) should be forced directly to the Patient PCN field when the user manually creates a new Institutional claim. Enable this "patient-centered" configuration option for installations that make extensive use of the Patient reference file. Upon patient selection, the claim's LOB field and primary provider field (optional) will be populated automatically from information on-file in the patient record.

- ☑ When checked, the cursor (focus) will be forced to the Patient PCN field when a new Institutional claim is created. Upon patient selection, the claim's LOB will be assigned automatically from the primary payer's LOB specified on the patient record. The provider associated with the claim's primary payer will also be populated automatically, if it has been specified on the patient record.
- ☐ When unchecked, the cursor (focus) will be positioned normally on the LOB field. The user is expected to enter or select the desired LOB for the new claim.

❖ **Automatically focus on Patient PCN field for new Professional hand-keyed claims** – Determines whether or not the cursor (focus) should be forced directly to the Patient PCN field when the user manually creates a new Professional claim. Enable this "patient-centered" configuration option for installations that make extensive use of the Patient reference file. Upon patient selection, the claim's LOB field and billing/rendering provider fields (optional) will be populated automatically from information on-file in the patient record.

- ☑ When checked, the cursor (focus) will be forced to the Patient PCN field when a new Professional claim is created. Upon patient selection, the claim's LOB will be assigned automatically from the primary payer's LOB specified on the patient record. The claim's billing provider and rendering provider will also be populated automatically, if they have been specified on the patient record.
- ☐ When unchecked, the cursor (focus) will be positioned normally on the LOB field. The user is expected to enter or select the desired LOB and Billing Provider for the new claim.

❖ **Auto-populate zero service line Units value to 1 during Professional claim entry** – Enables or disables auto-population of the service line "Units" value to one (1) during Professional claim entry. This auto-population will occur when the user exits the "24d – Procedure Code" field only if the "Units" value is currently zero.

- ☑ When checked, the service line "Units" value will be initialized to "1" (if currently zero) when the service line's procedure code is entered.
- ☐ When unchecked, the service line "Units" value will not be initialized, and must always be entered by the user if a non-zero value is desired.

❖ **Skip over line item Service Thru Date field during Institutional claim entry** – Controls whether or not the "Service Thru Date" field on the Institutional claim service line is include in the forward tab sequence.

- ☑ When checked, the service line "Service Thru Date" field will not be included in the forward tab sequence, unless a date is already present in this field. Hand-key users who are accustomed to a single line item service date field may prefer to skip the Service Thru Date field when entering claims.

- ☐ When unchecked, the service line "Service Thru Date" field will be included in the forward tab sequence.

- **Use the Physician reference file for Professional purchased services lookups** – Controls the source reference file for line-level Purchased Services provider lookup operations during Professional claim entry.
  - ☑ When checked, all line-level Purchased Services provider lookups are performed from the Physician reference file.
  - ☐ When unchecked, all line-level Purchased Services provider lookups are performed from the Facility reference file.

- **Include only Revenue Codes with non-zero charge amounts in lookups** – Determines which Revenue Codes will be included in the lookup list during Institutional claim entry. Consider enabling this option if most claims are to be hand-keyed and the Revenue Code charge amounts for most of the codes to be billed have been setup in advance.
  - ☑ When checked, revenue code lookups will include only those Revenue Codes for which a non-zero charge amount has been setup.
  - ☐ When unchecked, revenue code lookups will include all valid Revenue Codes regardless of whether or not a charge amount has been setup.

- **Enable service line Total Charges auto-calculations during Institutional claim entry** – Controls whether or not the Institutional claim's service line "Total Charges" field will be automatically recalculated when appropriate in response to changes in the "Rate" and/or "Units" field values.
  - ☑ When checked, the service line "Total Charges" field will be automatically recalculated when appropriate in response to changes in the "Rate" and/or "Units" field values.
  - ☐ When unchecked, changes to other fields on the service line will not impact the "Total Charges" field value.

Claim List Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **Claim List Preferences** tab allows the user to customize the Institutional & Professional Claim List form column configurations. Columns are configured separately for the Institutional Claim List form and Professional Claim List form. In addition, unique column configurations exist for each of the primary claim locations - "to be transmitted" (CL), "transmitted" (TR), and "paid/history" (PD).

If your installation is licensed for both Institutional and Professional claim activities, then you will need to select the appropriate claim type from the "**Institutional Claim List**" or "**Professional Claim List**" radio buttons near the top of this tab. If your installation is licensed for only one claim type, then this selection option will not be visible.

Select the second-level tab for the desired primary claim location - **CL**, **TR**, or **PD**. The various controls on this tab will be populated with the current column configuration for the selected location.

The remaining controls on this tab include:

- The "**Available Fields**" listbox contains the names of all fields that are available for selection.
- The "**Selected Fields**" listbox contains the names of all fields that are currently configured for the selected claim type and claim location. The order in which the Selected Fields are listed represents the order in which they will be displayed on the Claim List form (from left-to-right).
- The "**>**" and "**<**" buttons located between the listboxes move fields to/from the Selected Fields list, respectively. To add a field to the current column configuration, just select the field from the "Available Fields" listbox and click the "**>**" button. To remove a field, select the desired field in the "Selected Fields" listbox and click the "**<**" button.
- The **Up/Down Arrow** buttons allow the user to order the fields in the "Selected Fields" listbox as desired. Simply select a field and click the up or down arrow to reposition the field in the list.
- The "**Width**" and "**Heading**" fields specify the column width and heading caption for the currently selected field in the "Selected Fields" listbox. The default width and heading are usually acceptable, but the user may change these if desired. The width values are in approximate character increments.

This customization feature may not be available in all installations. If the Claim List Preferences tab is visible, then the feature is supported.

Claim Import Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **Claim Import Preferences** tab allows the user to select the processing method used to import claim files from an up-stream system or other external source. These preferences can be defined independently for Institutional and Professional claim types.

If your installation is licensed for both Institutional and Professional claim activities, then you will need to select the appropriate claim type from the "**Institutional Claim Import**" or "**Professional Claim Import**" radio buttons near the top of this tab. If your installation is licensed for only one claim type, then this selection option will not be visible.

- **Claim Import Processing Method** - specifies the preferred claim import method. The following claim import methods are available:
  - **Import claims from print file using standard PrintLink mapping technique** - Import claims from a print image file using our advanced PrintLink mapping technique. This is the default claim import method in most installations.
  - **Import claims directly from pre-built file in intermediate delimited format** - Import claims directly from a pre-built file in intermediate delimited format. This method bypasses the PrintLink translation step for facilities that can produce the intermediate format file directly from an upstream system.
  - **Import claims from file in Electronic Media Claims (EMC) format** - Import claims directly from a file in Electronic Media Claims (EMC) format. This method may be used in facilities where the upstream system can generate a reliable EMC output file.
- **Claim Import Preprocessor** - specifies an optional external "**preprocessor**" program to be called prior to claim import processing. This preprocessor may be an executable program or a DOS batch file (with associated PIF file). The PC-ACE Pro32 import code will launch this preprocessor automatically and wait for completion before continuing with import processing. Claims preprocessing can be performed with any of the 3 claim import methods.

Your distributor may have already configured these claim import settings. The distributor can determine which settings (if any) a user can modify. Therefore, some or all of the controls may be disabled.

You should modify these claim import settings only under the supervision of your distributor or a technical support specialist. Incorrectly configuring these options will render the claim import feature non-functional.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Importing claims" topic for a detailed description of the claim import methods and optional preprocessor.

Printing Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **Printing Preference** tab allows the user to specify options to control the printing of Institutional and Professional claim activity reports, claim forms, and claim attachments.

If your installation is licensed for both Institutional and Professional claim activities, first select the appropriate claim type from the "**Institutional Printing Options**" or "**Professional Printing Options**" radio buttons near the top of this tab. If your installation is licensed for only one claim type, then this selection option will not be visible.

The printing options are organized in a series of nested tabs as follows:

- **Import** - settings on this tab control the printing of claim import reports. These include:
  - **Automatically print claim import reports on completion** - specifies whether claim import reports will be printed automatically.
    - ☑ When checked, the claim import reports automatically print after the claim import operation has completed.
    - ☐ When unchecked, the claim import reports will not print automatically. You will still have the option to print the reports manually.
  - **Print claim import rejection report even when all claims accepted** - specifies whether empty claim import rejection reports will be printed automatically. This option is only enabled if you have chosen to print claim import reports automatically.
    - ☑ When checked, the claim import rejection report automatically prints even if there are no rejected claims.
    - ☐ When unchecked, the import claim rejection report will not automatically print if it is empty.
  - **Import Report Printer** - specifies the claim import reports printer.
  - **Sort and subtotal claim import report by LOB and Payer ID** - controls the sort order and subtotaling method used for claim import reports.
    - ☑ When checked, the claim import report will be presorted by LOB and Payer ID, and the resulting report will be subtotaled by LOB/Payer (and by Provider ID within each LOB/Payer group).
    - ☐ When unchecked, claims will be be listed in the order they appear in the imported file, and no subtotaling will be performed.
  - **Report claims for each LOB/Payer on a separate page** - controls the page break method used for claim import reports. This option is only available when sorting the import report in LOB/Payer order.
    - ☑ When checked, the claim import reports will break to a new page prior to printing the first claim for each unique LOB/Payer combination. Enable this option to insure that imported claims for each LOB/Payer combination are printed on separate pages.
    - ☐ When unchecked, the claim import reports will be printed in a continuous fashion, with no forced page breaks.

- **Process** - settings on this tab control the printing of claim processing reports. These include:
  - **Automatically print claim process reports on completion** - specifies whether claim processing reports will be printed automatically.

- ☑ When checked, the claim processing reports automatically print after the claim processing operation has completed.
- ☐ When unchecked, the claim processing reports will not print automatically. You will still have the option to print the reports manually.

- **Print claim process error report even when no errors exist** - specifies whether empty processing error reports will be printed automatically. This option is only enabled if you have chosen to print claim processing reports automatically.
  - ☑ When checked, the claim processing error report automatically prints even if all processed claims were clean.
  - ☐ When unchecked, the claim processing error report will not automatically print if it is empty.
- **Process Report Printer** - specifies the claim processing reports printer.
- **Include error details on process error report** - specifies whether detailed edit validation error descriptions are to be included in the processing error report by default. This default value can be overridden for each processing run if desired.
  - ☑ When checked, the processing error report will include edit validation error descriptions for each claim by default.
  - ☐ When unchecked, the processing claim report will not include edit validation error descriptions.
- **Maximum number of process errors reported per claim** - specifies the maximum number of processing edit validation errors to be reported per claim. The default value of 5 errors per claim helps to limit the size of the processing error report. Increase this value substantially if you prefer that all errors be included in the report.

- **Prepare** - settings on this tab control the printing of claim prepare reports. These include:
  - **Automatically print claim prepare reports on completion** - specifies whether claim prepare reports will be printed automatically.
    - ☑ When checked, the claim prepare reports automatically print after the claim prepare run has completed.
    - ☐ When unchecked, the claim prepare reports will not print automatically. You will still have the option to print the reports manually.
  - **Print claim prepare error report even when no errors exist** - specifies whether empty claim prepare error reports will be printed automatically. This option is only enabled if you have chosen to print claim prepare reports automatically.
    - ☑ When checked, the claim prepare error report automatically prints even if all claims were successfully prepared.
    - ☐ When unchecked, the claim prepare error report will not automatically print if it is empty.
  - **Prepare Report Printer** - specifies the claim prepare reports printer.
  - **Report claims for each LOB/Payer on a separate page** - controls the page break method used for claim prepare reports.
    - ☑ When checked, the claim prepare reports will break to a new page prior to printing the first claim for each unique LOB/Payer combination. Enable this option to insure that prepared claims for each LOB/Payer combination are printed on separate pages.
    - ☐ When unchecked, the claim prepare reports will be printed in a continuous fashion, with no forced page breaks.

- **Claim Form** - settings on this tab control printing of Institutional and Professional claim forms and claim attachments. These include:
  - **Default Printer** - specifies the default claim form printer. This default selection may be overridden when the claim form is printed.
  - **Default Method** - specifies the default claim form printing method. This method may be overridden when the claim form is printed. The available printing methods include:
    - ◉ **Pre-printed Forms** - specifies the traditional printing method requiring pre-printed CMS-1450/1500 claim forms.
    - ◉ **Image Overlay** - specifies an advanced overlay technique in which both the claim form graphics and claim data are printed on stock paper. This method requires the Adobe Acrobat Reader, and will only be enabled if this reader is properly installed on the client workstation. Refer to the "Printing claims" topic for more information on this advanced printing technique.
  - **Pre-printed Claim Form Options** - specifies page positioning adjustment settings for printing claims using the pre-printed forms method. These settings allow the user to adjust the top and left margins (in 1/100 inch increments) as well as the character font (point) size.
  - **Default Form Version** – specifies the default claim form version. This selection may be overridden when the claim form is printed. The available claim form versions include:
    - **Traditional CMS-1450 (UB92) Format** – the standard Institutional claim form for many years. This format will become obsolete when the National Provider ID (NPI) rollout is complete.
    - **Enhanced CMS-1450 (UB-04) Format** – the enhanced Institutional UB-04 claim form capable of reporting the National Provider ID (NPI) for the claim's Billing Provider and Attending, Operating and Other Physicians. Increases the number of Condition, Occurrence, Occurrence Span and Value codes that can be reported and adds several miscellaneous fields.
    - **Traditional CMS-1500 Format** – the standard Professional claim form for many years. This format will become obsolete when the National Provider ID (NPI) rollout is complete.
    - **Enhanced CMS-1500 Format (Aug 2005)** – the enhanced Professional claim form capable of reporting the National Provider ID (NPI) for the claim's Billing, Rendering and Referring Providers.
  - **Print with Payer Description (Payer Source Code / Payer ID)** - specifies whether to include the Payer Source Code and/or Payer ID values when printing the Payer Description. The selected values are printed to the left of the Payer Description.
    - ☑ When checked, the Payer Source Code or Payer ID will be printed to the left of the Payer Description.
    - ☐ When unchecked, the Payer Source Code or Payer ID will not be printed with the Payer Description.
  - **Print decimal point on all dollar amount fields** - specifies whether to print the decimal point on all currency fields. When printing forms, it is often desirable to omit the decimal point.
    - ☑ When checked, the decimal point will be printed on all currency fields.
    - ☐ When unchecked, the decimal point will not be printed on currency fields.
  - **Print the signature block date by default when appropriate** (Institutional, UB92 form only) - specifies whether the Institutional claim form signature block date is to be

printed automatically by default. This default setting can be overridden when a claim is printed.

- ☑ When checked, the current system date will be printed automatically by default in the claim form signature block. An alternate date (or no date at all) may be specified instead when a claim is printed.
- ☐ When unchecked, the claim form signature block date will be left blank by default.

- **Override the provider signature block date by default** (Professional only) - specifies whether to print the provider "signature on file" date from the Professional Claim Form, or to instead allow the user to override the signature block date by default. This default setting can be overridden when a claim is printed.
  - ☑ When checked, the provider "signature on file" date on the Professional Claim Form will be ignored by default during claim printing. An alternate date (or no date at all) may be specified instead when a claim is printed.
  - ☐ When unchecked, the provider "signature on file" date on the Professional Claim Form will be printed by default to the claim form signature block.
- **Print line items using single spacing when appropriate** (Professional only) - specifies whether single spacing of line items is to be used when appropriate on Professional claim forms. The standard Professional form layout implies that double-spacing is to be used by default.
  - ☑ When checked, all Professional claims containing more than 6 line items will be printed with the line items single-spaced. This technique accommodates up to 11 line items per claim form page.
  - ☐ When unchecked, all Professional claims will be printed using the standard pre-printed form line item spacing (6 line items per page).
- **Print claim attachments by default** (Professional only) - specifies whether Professional claim attachments should be printed by default. This default setting can be overridden when a claim is printed if desired.
  - ☑ When checked, any existing claim attachments for the selected claim(s) will be printed by default.
  - ☐ When unchecked, no claim attachments for the selected claim(s) will be printed by default.
- **Print all claim attachments at the end of multiple-claim print run when appropriate** - specifies whether claim attachments should be printed as a group at the end of a multiple-claim print session.
  - ☑ When checked, claim attachments will be printed as a group following the printing of all selected claims when using the pre-printed form method. You will be prompted to load stock paper in the printer prior to claim attachment printing.
  - ☐ When unchecked, claim attachments for each claim will always be printed immediately following the associated claim.

  Checking this option will typically result in the most reasonable approach to printing claim attachments. The system will print attachments immediately following the associated claim form unless the pre-printed forms method is being used.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Printing claims" topic for more information on the "pre-printed" versus "image overlay" techniques.

Data Communication Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **Data Communication Preferences** tab includes settings to control the PC-ACE Pro32 data communications interface. PC-ACE Pro32 can be configured to launch external data communications programs or scripts to perform electronic claim file transfers or other data communication related operations.

The identical "**Option**" tabs correspond to each of the available launch buttons on the Data Communications Options form. The controls on each tab include:

- **Option N Program** - specifies the complete path and filename of the program or batch file (with corresponding Windows PIF file) to be launched.

  Use the convenient "**browse**" button adjacent to this control to easily locate and retrieve the full path of the desired program or batch file. Enclose paths that contain spaces (i.e., Windows long file and directory names) in double-quotes to ensure proper launch interpretation.

- **Button Caption** - specifies the desired button caption text.

  Use a single "**&**" character in the button caption to define a windows shortcut key. Place the "**&**" character immediately before the desired shortcut character.

Once a valid program/script path and button caption are defined on any of these tabs, the corresponding launch button will be enabled on the Data Communications Options form.

Your distributor may have already configured these data communication launch paths and captions. The distributor can determine which data communications settings (if any) a user can modify. Therefore, some of the tabs/controls may be disabled or even hidden.

You should modify these data communications settings only under the supervision of your distributor or a technical support specialist. Incorrectly configuring these options will render the data communications feature non-functional.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Transmitting electronic claim files" topic for more information on a typical application of the PC-ACE Pro32 data communications launch capabilities.
- Refer to the "Data Communications File Maintenance" topic for information on configuring data communications parameters and the Data Communications Control File.

Miscellaneous Preferences

PC-ACE Pro32 preference settings are organized on a tabbed dialog accessible from the PC-ACE Pro32 Main Toolbar's main "**File**" menu. The **Miscellaneous Preferences** tab includes the following maintenance and configuration settings:

- **Purge archived EMC transmission files after "NN" days** - specifies whether archived Institutional and Professional EMC transmission files are to be automatically purged by the system. If automatic purging is enabled, specifies the number of days EMC files are to be retained.
  - ☑ When checked, all EMC transmission files older than the specified number of days will be automatically purged from the transmission file archive.
  - ☐ When unchecked, all EMC transmission files will remain archived until manually deleted. Refer to the "Reactivating previously transmitted claims" topic for more information on maintaining the transmission file archive.
- **Purge archived ANSI-997 acknowledgment files after "NN" days** - specifies whether archived Institutional and Professional ANSI-997 transmission acknowledgment files are to be automatically purged by the system. If automatic purging is enabled, specifies the number of days the acknowledgment files are to be retained.
  - ☑ When checked, all ANSI-997 transmission acknowledgment files older than the specified number of days will be automatically purged from the acknowledgment file archive.
  - ☐ When unchecked, all ANSI-997 transmission acknowledgment files will remain archived until manually deleted. Refer to the "Viewing and maintaining transmission acknowledgment files" topic for more information on maintaining the acknowledgment file archive.

  If this preference option is disabled, support for ANSI-997 transmission acknowledgment files is not available on your installation.
- **Purge archived ANSI-277 claim status response files after "NN" days** - specifies whether archived Institutional and Professional ANSI-277 claim status response files are to be automatically purged by the system. If automatic purging is enabled, specifies the number of days the response files are to be retained.
  - ☑ When checked, all ANSI-277 claim status response files older than the specified number of days will be automatically purged from the response file archive.
  - ☐ When unchecked, all ANSI-277 claim status response files will remain archived until manually deleted. Refer to the "Viewing and maintaining claim status response files" topic for more information on maintaining the response file archive.

  If this preference option is disabled, support for the ANSI-276/277 claim status request/response feature is not available on your installation.
- **Purge archived ANSI-271 eligibility benefit response files after "NN" days** - specifies whether archived Institutional and Professional ANSI-271 eligibility benefit response files are to be automatically purged by the system. If automatic purging is enabled, specifies the number of days the response files are to be retained.
  - ☑ When checked, all ANSI-271 eligibility benefit response files older than the specified number of days will be automatically purged from the response file archive.

- ☐ When unchecked, all ANSI-271 eligibility benefit response files will remain archived until manually deleted. Refer to the "Viewing and maintaining eligibility benefit response files" topic for more information on maintaining the response file archive.

If this preference option is disabled, support for the ANSI-270/271 eligibility benefit request/response feature is not available on your installation.

- **Purge claim activity log after "NN" days** - specifies whether the Institutional and Professional claim activity logs will be automatically maintained by the system. If automatic maintenance is enabled, specifies the number of days that log entries are to be retained.
  - ☑ When checked, the claim activity logs will be maintained to include only entries for the specified number of days.
  - ☐ When unchecked, the claim activity logs will grow indefinitely until it they are purged manually. Refer to the "Reviewing the claim activity logs" topic for more information on the viewing and purging the claim activity logs.
- **Limit initial claim list display of transmitted/paid claims to most recent "NN" months** - specifies whether or not to limit the initial display of transmitted/paid claims in the Institutional and Professional Claim List forms based on the claim's transmission date. If this feature is enabled, specifies the number of months of the most recent claims to be displayed by default.
  - ☑ When checked, only claims that have been transmitted (i.e., prepared) in the most recent number of months, as specified, will be displayed by default when viewing the transmitted/paid claim list locations (TR, PD and TR/PD).
  - ☐ When unchecked, all transmitted/paid claims in the database will be displayed by default when viewing the transmitted/paid claim list locations (TR, PD and TR/PD).

To display transmitted/paid claims older than the specified number of months, simply click the "Advanced Filter Options" button on the Claim List form and enter the desired Transmit Date range.

Limiting the number of transmitted/paid claims being displayed in the claim list improves the list's responsiveness. Claim list performance improvements should be particularly noticable when accessing the "TR", "PD" and "TR/PD" locations on networked installations with large active claims databases. If this preference option is disabled, support for this feature is not available on your installation.

- **Adobe Acrobat Reader** - specifies the complete path for the Adobe Acrobat Reader program (ACRORD32.EXE) required for printing claims using the "image overlay" method. When the Acrobat Reader is properly installed, PC-ACE Pro32 will automatically detect and configure this path. The Adobe Acrobat Reader is available for download from Adobe (http://www.adobe.com). Refer to the "Printing claims" topic for more information on printing claim forms and attachments.

Common Claim Activities

Adding a new claim

New claims can be added to **PC-ACE Pro32** using any of these techniques:

- Import the claims from a print file or other supported source. See the "Importing claims" topic for more details.
- Click the "**Enter Claims**" button on the Claims Menu form (Institutional or Professional) to enter claims manually. The system will automatically create and display new empty claims in succession until a claim is cancelled. Use this technique to enter multiple claims in a single session.
- Click the "**New**" button on the Claim List form (Institutional or Professional) to enter a single claim manually. The new claim will automatically be selected in the list when it is saved.

Claims are manually entered on the "Institutional Claim Form" or "Professional Claim Form". The data fields are typically entered in the order presented - from left-to-right and top-to-bottom - on each tab of the claim form. Edit validation errors may be encountered during this entry process if the data entered violates any of the predefined edits for the specific claim type. Correct any such edit errors and click the "**Save**" button to save the claim. Claims containing unresolved edit errors may be saved if desired by clicking either the "**Save With Errors**" button (visible if only non-fatal errors exist) or "**Save With Fatal**" button (visible if any fatal errors exist). Only one of these buttons will be visible at any given time. If neither button is visible, then fatal errors exist on one or more key claim fields. These fatal edit errors must be corrected before the claim can be saved.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional & Professional Claims Menus" topic for more information about the Claims Menu form.
- Refer to the "Claim List Form Features" topic for details on using the Claim List form.
- Refer to the "Institutional Claim Form" and "Professional Claim Form" topics for more information on using the Institutional and Professional claim forms.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Listing, modifying and maintaining claims

Claims in **PC-ACE Pro32** are listed, modified, and otherwise maintained from the Institutional & Professional Claim List forms. The Claim List form operation is identical for Institutional and Professional claim types. To access the Claim List form:

1) Click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the respective Claims Menu form.
2) From the Institutional or Professional Claims Menu form, click the "**List Claims**" button to open the respective Claim List form.

Most actions to be performed on a claim may be executed from the Claim List form. Claims can be created, viewed/modified, copied, deleted/undeleted, purged, reactivated, held/released, printed, and archived/unarchived from the list. In addition, payments may be posted to a selected claim from the Claim List form. Refer to the "Claim List Form Features" topic for complete details on the features and operation of the powerful Claim List form.

Viewing & Modifying Claims

Viewing and/or modifying existing claims from the Claim List form can be performed with these general steps:

1) Use the Claim List form's powerful sorting and filtering capabilities to locate the claim of interest in the list.
2) Select the desired claim in the list and click the "**View/Update**" button to display the claim details in the appropriate claim form. Alternatively, just double-click the desired claim record in the list.
3) Make all desired changes to the claim. Refer to the Institutional Claim Form or Professional Claim Form topics for details on the many productivity enhancing features available on these powerful claim forms.
4) When all changes have been made, click the "**Save**" button to save the claim record and close the form. Review and correct any edit validation errors as needed. Alternatively, click the "**Cancel**" (or "**Close**") button to cancel any pending claim changes.

Actions On Multiple Claims

Many of the claim actions available in the Claim List form are applicable to both single (selected) claims as well as groups of "checked" claims. This powerful multi-selection capability makes operating on groups of claims a snap! Simply use the Claim List form's advanced filtering options to narrow the claim list contents down until it contains only the desired claims. Then select the "**Check All Claims**" action from the main or popup menu to instantly mark (i.e., "check") all the claims of interest. A number of actions are available from the main or popup menu to operate on the entire group of claims in a single session. Refer to the "Claim List Form Features" topic for complete details on selecting and acting on multiple claims at once.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Claim List Form Features" topic for details on using the Claim List form.
- Refer to the "Institutional Claim Form" and "Professional Claim Form" topics for more information on using the Institutional and Professional claim forms.

- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.
- Refer to the on-line help "**Common Claim Activities**" folder for hyperlinks to other claim-related topics of interest.

Importing claims

Claims are introduced into **PC-ACE Pro32** by either entering them manually or by importing them from an external source. The claim **import** method is ideal for facilities that maintain their claims in an upstream claims management system. Using our versatile claim import capabilities, these claims can be quickly and accurately loaded into the PC-ACE Pro32 database for subsequent processing, preparation, and transmission. Three external claim import sources are supported:

- **Print Image (PrintLink)** - Using PC-ACE Pro32's advanced PrintLink mapping technique, claims can be imported from print image files produced by your upstream system. This is the default claim import method in most installations.
- **Intermediate Delimited Format** - Claims can be imported directly from a pre-built file in "intermediate delimited" format. This internal delimited ASCII format is the same as that produced by the PrintLink translator in the "print image" import technique. This claim import method provides a more versatile solution for facilities that can produce the intermediate format file directly from an upstream system.
- **Electronic Media Claims (EMC) Format** - Claims can be imported directly from a file in Electronic Media Claims (EMC) format. This method may be used in facilities where the upstream system can generate a reliable EMC output file. PC-ACE Pro32 currently supports UB92 Version 5.0, UB92 Version 6.0, and ANSI-837 file formats for Institutional claims. Professional claim import formats include NSF 1.04 thru NSF 3.01 and ANSI-837.

Support for the listed import formats varies among PC-ACE Pro32 distributors. Check with your software distributor first if you intend to import claims into the product. Fee-based support from Medlink Technologies, Inc. may also be available for import formats which are not being supported by your software distributor.

Refer to the "Claim Import Preferences" topic to select the desired claim import method and configure the optional preprocessor (described later in this topic).

You should modify these claim import settings only under the supervision of your distributor or a technical support specialist. Incorrectly configuring these options will render the claim import feature non-functional.

Getting Ready To Import Claims

Some preparation is required before claims can be imported into PC-ACE Pro32. Certain preparation steps need only be performed once, while others must be performed each time a new set of claims is to be imported. The preparation steps required for each claim import method are listed below. You need only be concerned with the preparation steps for your selected claim import method.

- **Print Image (PrintLink)** - importing claims using the PrintLink method requires the following preparation:

  1) Perform all required "once-only" preparation steps for importing claims using the PrintLink method. Complete these steps as part of the initial PC-ACE Pro32 system setup described in either the "Setup of Medicare Part A Systems", "Setup of Institutional All-Payer Systems", or "Setup of Professional Systems" topic. In summary, this "once-only" setup consists of:

     - Performing PrintLink mapping on a sample print file to generate the corresponding "**map**" file. Copying the map file to the server's claim import directory.

- Confirming that the correct "**map control**" file has been placed in the server's claim import directory.

  Check with your distributor before performing these "once-only" setup steps. Some distributors build this setup into the program installation procedure.

2) Copy the print file to be imported into the server's claim import directory. The print file must be named as defined in the corresponding print "map" file. The claim import directory is named "**winpcace\impub92**" for Institutional claim import operations and "**winpcace\imp1500**" for Professional claim import operations.

   Windows long filenames are partially supported for the PrintLink import method map and print files. The map filename may contain space characters, periods, underscores, and most other characters permitted in long filenames under Windows. However, the parenthesis characters "(" and ")" **are not allowed** in the **map** filename. The **print** filename **must not contain** parenthesis or space characters. Use the underscore "_" character instead of the space character when naming the print file.

- **Intermediate Delimited Format** - importing claims using the intermediate delimited format method requires the following preparation**:**

  1) Perform all required "once-only" preparation steps for importing claims using the intermediate delimited format method. Complete these steps as part of the initial PC-ACE Pro32 system setup described in either the "Setup of Medicare Part A Systems", "Setup of Institutional All-Payer Systems", or "Setup of Professional Systems" topic. In summary, this "once-only" setup consists of:

     - Confirming that the correct "**map control**" file has been placed in the server's claim import directory.

       Check with your distributor before performing these "once-only" setup steps. Some distributors build this setup into the program installation procedure.

  2) Generate the intermediate format file containing the claims to be imported.

  3) Copy the intermediate format file to be imported into the server's claim import directory. The intermediate format file must be named "**plink.out**". The claim import directory is named "**winpcace\impub92**" for Institutional claim import operations and "**winpcace\imp1500**" for Professional claim import operations.

- **Electronic Media Claims (EMC) Format** - importing claims using the EMC format method requires the following preparation:

  1) Perform all required "once-only" preparation steps for importing claims using the EMC format method. Complete these steps as part of the initial PC-ACE Pro32 system setup described in either the "Setup of Medicare Part A Systems", "Setup of Institutional All-Payer Systems", or "Setup of Professional Systems" topic.

     Check with your distributor before performing these "once-only" setup steps. Some distributors build this setup into the program installation procedure.

  2) Generate the EMC format file containing the claims to be imported.

  3) Copy the EMC format file to be imported into the server's claim import directory. The file must have a "**.dat**" file extension (e.g., "EMC192.DAT"). The claim import directory is named "**winpcace\impub92**" for Institutional claim import operations and "**winpcace\imp1500**" for Professional claim import operations.

Windows long filenames are supported for the EMC Format claim import method.

Once these preparation steps are complete, you are ready to import the claims into PC-ACE Pro32.

Importing the Claims

Once the preparation steps are complete, importing claims into PC-ACE Pro32 is quick and simple. The following steps outline the claim import process:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.

2) Click the "**Import Claims**" button on the Claims Menu form to open the Institutional or Professional Claim Import form. The form's caption should reflect the chosen claim import method.

3) If you are using the PrintLink claim import method, and you have multiple "map" files in the server's claim import directory, you will see a drop-down list labeled "**Select PrintLink Map File**". Select the map/print file to be imported from this list. If you are using the PrintLink claim import method, but only one map file is defined, this drop-down list will not be visible.

   If you are using the Intermediate Delimited Format claim import method, the system assumes that the file to be imported has already been placed in the claim import directory. This file must be named "**plink.out**".

   If you are using the Electronic Media Claims (EMC) File claim import method, and you have multiple EMC files in the server's claim import directory with "**.dat**" extensions, you will see a drop-down list labeled "**Select EMC File**". Select the EMC file to be imported from this list. If you are using the EMC File claim import method, but only one EMC file is present in the claim import directory, this drop-down list will not be visible.

4) Click the "**Import**" button to initiate the claim import operation. As the import proceeds, running totals of the count and dollar value of all "imported" and "rejected" claims are displayed on the Claim Import form. You will be notified when the claim import operation completes.

   Claims are rarely rejected during import into PC-ACE Pro32. The most common reason for rejecting a claim is that the claim is a duplicate of an existing "unprocessed" (UNP) claim in the "to be transmitted" (CL) location. This can sometimes occur if the same file is inadvertently re-imported into the system.

5) If desired, click the "**View Results**" and/or "**View Rejects**" buttons to view the accepted and rejected claim reports, respectively. These reports can be printed from the report previewer if desired.

   Refer to the "Printing Preferences" topic for information on configuring claim import reports to be printed automatically or to a specific printer.

6) When you have completed your review of the claim import reports, click the "**Close**" button on the Claim Import form. You may now proceed to process the imported claims automatically or work the claims one-by-one from the Claim List form.

Optional Import Preprocessor Feature

Additional claim import flexibility is available with PC-ACE Pro32's optional import "**preprocessor**" feature. A user-developed executable program or a DOS batch file (with

associated PIF file) can be configured for execution prior to standard claim import processing. The PC-ACE Pro32 import sequence will launch this preprocessor automatically and wait for completion before continuing with standard import processing. The preprocessor might simply copy a print image file from one directory to another. Alternatively, it might perform a complex data translation operation to generate the supported claim import file. Claims preprocessing can be performed with any of the 3 claim import methods described above. See the "Claim Import Preferences" topic for information on configuring a claim import preprocessor.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Claim Import Preferences" topic to select the desired claim import method and configure the optional preprocessor.
- Refer to the "Processing claims automatically" topic to learn how the imported claims can be processed automatically.
- Refer to the "Printing Preferences" topic for information on claim import report options (automatic printing, printer selection, etc.).

Reversing the most recent claim import run

On occasion, it may become desirable to "**reverse**" the most recent claim import operation. In other words, to remove the imported claims from the database as if they had never been imported in the first place. Possible scenarios that might give rise to this requirement include:

- A partially corrupted print file resulted in an incomplete claim import run. The print file has been repaired and it is desirable to perform the import again from the beginning.
- The PrintLink map file had a minor mapping error that resulted in the truncation of the first character of a specific data field on every claim. The map file has now been corrected and the original print file is to be re-imported.
- The same claim file was inadvertently imported more than once.

Follow the steps below to reverse the most recent claim import run:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.
2) From the Claims Menu form, select the main menu "**Maintain**" and "**Reverse Claim Import**" items to display the Claim Import Reversal Utility form.
3) Select the "**Reverse most recent claim import operation**" radio button and click the "**Continue**" button to proceed. The Claim Import Reversal Confirmation form will be displayed, containing a list of all claims imported in the most recent run.

   If the "**Reverse most recent claim import operation**" radio button is disabled, the system cannot determine the specific details of the most recent claim run. Also notice the "**Delete all unprocessed claims for date range**" radio button, which provides an alternate technique for selectively deleting unprocessed claims by date range.

4) Click the "**Check All Claims**" button to mark all claims from the previous claim import run for deletion. Click the "**Delete Checked Claims**" button to perform the deletion.

   Claims can only be "reversed" if they remain "unprocessed" (i.e., their claim status = "UNP"). Once a claim has been processed or materially changed, it is no longer eligible for reversal. If any claims in the selected deletion list are no longer eligible for reversal, you will receive a notification message for each such claim. These ineligible claims must be located and deleted manually from the Claim List form.

5) When the reversal operation completes, the Claim Import Reversal Confirmation form will close automatically.

Processing claims automatically

Claim "**processing**" in **PC-ACE Pro32** refers to the application of a specific set of edit validation rules to the claim. A processed claim is pronounced as either "clean", "contains non-fatal errors", or "contains fatal errors". This claim is assigned a status code of "CLN", "ERR", or "ERF", respectively, to indicate the state of the processed claim.

In addition to processing (or "working") claims one-by-one from the Claim List form, PC-ACE Pro32 also provides an automatic processing function that can sequentially process all (or a filtered selection of) unprocessed claims in the "to be transmitted" (CL) location. Automatic claim processing is an ideal way to quickly work a batch of imported claims. Once automatic processing has completed, the user can focus attention only on the claims with errors - greatly improving user productivity. To process claims automatically, follow these simple steps:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.

2) From the Claims Menu form, click the "**Process Claims**" button to open the Automated Claim Processing form. This form provides the following processing options:

   - **Claim Filter Parameters** - claims must meet all specified filter criteria to be considered for automatic processing.
     - **LOB** - specifies a single line of business (LOB) to be considered. Only claims with this LOB will be eligible for automatic processing. Leave this field empty to include claims for any line of business.
     - **TOB** (Institutional only) - specifies a single type of bill (TOB) to be considered. Only claims with this TOB (first 2 characters only) will be eligible for automatic processing. Leave this field empty to include claims for all bill types.
     - **Provider** - specifies one or more Provider IDs to be considered. Only claims for the specified provider(s) will be eligible for automatic processing. Leave this field empty to include claims for all providers. If multiple Provider ID values are specified, claims for any of the specified providers will be included. Separate multiple Provider ID values with a semi-colon. For Institutional claim processing, the specified Provider ID value(s) will be compared to the claim's Provider ID field for the "**submission**" payer. For Professional claim processing, the specified Provider ID value(s) will be compared to the claim's "**billing**" Provider ID.
     - **Reprocess claims with errors** - specifies whether or not claims in the "to be transmitted" (CL) location that currently have a "has errors" (ERR) or a "has fatal errors" (ERF) status are eligible for automatic processing. If this option is unchecked, only "unprocessed" claims (UNP) will be considered eligible.

       Reprocessing claims with errors might be helpful, for example, after a change is made to the edit validation rules. It is feasible that a group of claims all failed the same ill-conceived edit validation rule, which has subsequently been reviewed and changed.

   - **Processing Options** - options that control the automatic processing operation.
     - **Present claims with errors for immediate editing** - instructs the automatic processing engine to pause each time a claim with errors is processed and to present the claim for immediate consideration in the Institutional Claim Form or Professional Claim Form. This is referred to as "interactive" processing mode. When the user closes the claim form, the automatic processing run will resume with the next claim in the sequence.
     - **Include edit error details in process error report** - instructs the automatic processing engine to include the specific edit validation error descriptions in the

compiled error report. Check this option when plan to research the specific edit validation errors for each claim from this hardcopy report.

If you rarely refer to the specific edit validation error descriptions in the error report, you can significantly speed up automatic processing by leaving this option unchecked. This allows the edit engine to stop processing a claim on the first detected error, since it is only important to know that the claim has errors - not specifically which errors.

3) Specify the desired filter parameters (if any) and processing options. When ready, click the "**Process**" button and confirm your intention to process the claims. Each eligible claim will be processed in sequence. As the processing operation proceeds, running totals of the count and dollar value of all "clean" claims and claims with "errors" are displayed on the Automated Claim Processing form. You will be notified when the claim processing operation completes.

If you are processing claims in "interactive" mode, automatic processing will be temporarily paused each time a claim containing errors is processed. The claim will be automatically displayed in either the Institutional Claim Form or Professional Claim Form with the Edit Validation Errors List form open to display the claim's edit validation errors (unless disabled in the Preference settings). You can either work the claim until it is clean, save the claim with errors, or cancel the claim to leave it unprocessed. Once you have closed the claim form, the automatic processing run will continue with the next eligible claim in the sequence.

A convenient "**Cancel Run**" button will be available on the Institutional Claim Form or Professional Claim Form when processing claims in "interactive" mode. Click this button to cancel the currently displayed claim and abort the automatic processing run. The current claim and all remaining eligible claims will remain unprocessed.

4) If desired, click the "**View Results**" and/or "**View Errors**" buttons to view reports of the clean claims and claims with errors, respectively. These reports can be printed from the report previewer if desired.

If you checked the "**Include edit error details in process error report**" processing option, the claims with errors report will include the specific edit validation errors reported for each claim (up to 5 per-claim maximum by default). If this option was not checked, the claim reference will be reported without any supporting edit validation error details.

Refer to the "Printing Preferences" topic for information on configuring claim processing reports to be printed automatically or to a specific printer. You can also set the maximum number of edit validation errors to be listed per claim.

5) When you have completed your review of the claim processing reports, click the "**Close**" button on the Automated Claim Processing form. You may now proceed to work the remaining unprocessed claims and claims with errors one-by-one from the Claim List form.

Claims containing non-fatal errors will be assigned a status of "unprocessed" (UNP) during automatic processing, rather than the "has errors" (ERR) status that you might expect. This is done to avoid inadvertently including these claims in a subsequent prepare run (since "ERR" status claims can optionally be included in the prepare). When you eventually work these claims, you can decide on an individual basis whether

the claim should be corrected, transmitted with the non-fatal error(s), or held pending further evaluation.

Preparing claims for transmission

Claim "**preparation**" in **PC-ACE Pro32** refers to the act of generating an Electronic Media Claims (EMC) file suitable for transmission to your claims processor. This EMC file will contain all relevant submission details for one or more processed claims. Only claims in the "to be transmitted" (CL) location with an "electronic" (E) media setting are eligible for preparation. When a claim is "prepared" into an EMC file, it is automatically moved to the "transmitted" (TR) location. Residence in the "transmitted" (TR) location reflects its transmitted state and also prevents the claim from being inadvertently retransmitted.

Before preparing claims for the first time, you may need to setup your Submitter reference file. This file contains important data that will be used to build the EMC file. Separate submitter details exist for Institutional and Professional claim types. Since some distributors pre-configure the Submitter reference file, you should check with them before making any changes. Refer to the "Submitter File Maintenance" topic for more information on configuring this important reference file.

In addition to standard claims, PC-ACE Pro32 also supports electronic submission of several commonly used Institutional standalone medical attachments. If such medical attachments have been created and are eligible for transmission, they will by default be prepared into the same EMC file as the eligible claims. See the "Preparing Institutional Medical Attachments for transmission" topic for more information.

To prepare claims in PC-ACE Pro32, follow these simple steps:

3) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.

4) From the Claims Menu form, click the "**Prepare Claims**" button to open the Claim Prepare For Transmission form. This form provides the following preparation options:

   - **Claim Filter Parameters** - claims must meet all specified filter criteria to be considered for preparation.

     - **LOB** - specifies a single line of business (LOB) to be considered. Only claims with this LOB will be eligible for preparation. Select the "**<< All >>**" item to include claims for any line of business.

       The Submitter reference file supports LOB-specific setup information if desired. Selecting a specific LOB for preparation will trigger the use of the matching LOB-specific submitter information (if any). Refer to the "Submitter File Maintenance" topic for more information on this advanced feature.

     - **Payer** - specifies a single Payer to be considered. Only claims being submitted to the selected payer will be eligible for preparation. Select the "**<< All Payers for LOB(s) >>**" item to include claims for all payers. Note: This selection is only enabled when a specific LOB has been selected for preparation.

       The Submitter reference file supports Payer-specific setup information if desired. Selecting a specific LOB and Payer for preparation will trigger the use of the matching LOB/Payer-specific submitter information (if any). Refer to the "Submitter File Maintenance" topic for more information on this advanced feature.

- **Provider** - specifies one or more Providers to be considered. Only claims for the selected provider(s) will be eligible for preparation. Select the "**<< All Providers for Payer(s) >>**" item to include claims for all providers. For Institutional claim preparation, the provider to be compared is the one associated with the claim's "**submission**" payer. For Professional claim preparation, the provider to be compared is the claim's "**billing**" provider. Note: This selection is only enabled when a specific LOB and Payer have been selected for preparation.

  Choose the "**<< Selected Providers for Payer >>**" item in the drop-down list to specify multiple Provider IDs. Enter any number of Provider IDs (separated by semicolons) on the Multiple Provider Selection form. If multiple providers are specified, claims for any of the specified providers will be included. For your convenience, the system remembers the last multiple-provider filter string specified.

▶ **Prepare Options** - options that control the claim preparation operation. **Note:** These options may not be available on some systems.

- **Output Format** - specifies the desired EMC file output format. PC-ACE Pro32 currently supports NSF and ANSI-837 file formats. The initial state of this option is determined by a Submitter reference file setting.
- **Submission Status** - specifies whether the EMC file should be designated as a "production" or "test" submission. The initial state of this option is determined by a Submitter reference file setting.
- **Include Error Claims?** - specifies whether claims with "non-fatal errors" (Status = "ERR") are to be eligible for preparation. When checked, all claims in the "to be transmitted" (CL) location with a status or either "CLN" (clean) or "ERR" (contains non-fatal errors) will be eligible for preparation. When unchecked, only clean claims will be eligible for preparation. The initial state of this option is determined by a Submitter reference file setting.

  The default settings for these control options are typically configured by your distributor. We recommend overriding these option settings only under the instruction of your distributor or an authorized technical support specialist. The distributor may restrict which of these prepare options you are permitted to override.

5) Specify the desired filter parameters (if any) and preparation options. When ready, click the "**Prepare Claims**" button and confirm your intention to prepare all eligible claims. As the preparation operation proceeds, running totals of the count and dollar value of all prepared claims will be displayed on the Claim Prepare For Transmission form. You will be notified when the claim preparation operation completes.

   Claim preparation requires exclusive system access. When you attempt to prepare claims, you will be notified if exclusive system access cannot be granted (i.e., other users are running PC-ACE Pro32). When this occurs, you should instruct all users to exit the program before proceeding.

6) If desired, click the "**View Results**" and/or "**View Errors**" buttons to view reports of the successfully prepare claims and rejected claims, respectively. These reports can be printed from the report previewer if desired.

Claims will rarely be rejected during the prepare operation. A claim will be rejected, for example, if the "submission" payer specified on the claim is no longer present in the Payer reference file. Rejected claims must be re-processed and corrected before they can be successfully prepared.

Refer to the "Printing Preferences" topic for information on configuring claim preparation reports to be printed automatically or to a specific printer.

7) When you have completed your review of the claim preparation reports, click the "**Close**" button on the Claim Prepare For Transmission form. You may now proceed to transmit the EMC file generated during this claim preparation session.

The prepared EMC file is located in the server's "**winpcace**" directory. The file is named "**bctrans.dat**" for Institutional claims and "**bstrans.dat**" for Professional claims, by default. This default naming convention may be overridden in the Submitter reference file.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Submitter File Maintenance" topic for details on configuring the Submitter reference file.
- Refer to the "Transmitting electronic claim files" topic for more information on transmitting the prepared EMC file.
- Refer to the "Reactivating previously transmitted claims" topic to learn how transmitted claims can be selectively reactivated for re-transmission.
- Refer to the "Recovering from an interrupted claim prepare run" topic to see how PC-ACE Pro32 can recover from an interruption in the preparation process.

Transmitting electronic claim files

PC-ACE Pro32 interfaces seamlessly with third party communications packages to transmit Electronic Media Claims (EMC) files. This approach assures maximum flexibility for the distributor and eliminates any PC-ACE Pro32 dependencies. A convenient "**launch**" facility makes it easy for the user to initiate file transmissions and other data communications functions (terminal emulation sessions, for example). PC-ACE Pro32 may be configured to launch any required data communications functions without exiting the program.

Before you are ready to transmit, you must have already entered (or imported and processed) one or more claims, and prepared these claims into an EMC file suitable for transmission. Let's assume your system has been configured to launch a data communications program that will transmit the prepared EMC file to your claims processor. You can initiate this file transmission with the following steps:

1) Complete the pre-transmit procedures provided by your distributor, if any.
2) From the PC-ACE Pro32 Main Toolbar, click the "**Data Communications Functions**" button to open the Data Communications Options form. Each pre-configured data communications function will be represented by one of the available "launch" buttons.

   Only the pre-configured launch buttons will be enabled. These available buttons may be presented on up to 3 distributor-defined tabs. If all buttons are disabled, then your system has not been setup for any data communications functions. Refer to the "Data Communication Preferences" topic for information on configuring these launch buttons.

3) For this example, let's assume the first button is labeled "Transmit Claims" and is pre-configured to launch the EMC file transmission program. Your button labels and functions may be different, but the launch procedure is basically the same. Simply click the "**Transmit Claims**" button to initiate the transmission process.

   PC-ACE Pro32 only initiates (or launches) the third-party file transmission program. It does not monitor the transmission program's progress, nor is it informed of the transmission's completion status. All exception handling must be done by the third-party data communications program or script (e.g., re-dial, restart on dropped line, etc.).

4) Click the "**Close**" button on the Data Communications Options form when the file transmission has completed.
5) Complete the post-transmit procedures provided by your distributor, if any.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Reactivating previously transmitted claims" topic to learn how a previously transmitted EMC file can be reactivated for re-transmission.
- Refer to the "Viewing and maintaining transmission acknowledgment files" topic for information on how to archive, view, print, and maintain ANSI-997 transmission acknowledgment files.
- Refer to the "Data Communications File Maintenance" topic for information on configuring data communications parameters and the Data Communications Control File.
- Refer to the "Data Communication Preferences" topic for information on configuring the Data Communication Options form "launch" buttons.

Viewing and maintaining transmission acknowledgment files

Intermediaries or clearinghouses receiving ANSI-837 format EMC files will acknowledge receipt by sending an ANSI-997 transmission acknowledgment file back to the submitter. **PC-ACE Pro32** provides a facility by which users can archive these ANSI-997 transmission acknowledgment files for subsequent review and/or printing. This topic describes how to stage your ANSI-997 files so that they are automatically archived by PC-ACE Pro32, as well as the functions available for viewing, printing, maintaining and using the archived acknowledgment files.

Support for ANSI-997 transmission acknowledgment files may not be available on all installations. If the "**Purge archived ANSI-997 acknowledgment files after 'NN' days**" option is disabled (grayed out) on the PC-ACE Pro32 Miscellaneous preferences form, then this capability is not available on your installation.

Staging Acknowledgment Files For Automatic Archiving

At program startup, PC-ACE Pro32 automatically scans separate Institutional and Professional "staging" directories looking for new ANSI-997 transmission acknowledgment files to be archived. If new ANSI-997 files are present in the staging directories, they are checked for proper format and archived automatically. This automatic archiving process is also performed when the **ANSI-997 Acknowledgment File Log** form is opened or when the user manually refreshes the ANSI-997 Acknowledgment File list (see next section for details).

On most PC-ACE Pro32 installations, the user will be required to manually copy the ANSI-997 files received from the intermediary into the appropriate staging directory. The Institutional and Professional staging directories are:

Institutional: winpcace\ansi997\ackub92

Professional: winpcace\ansi997\ack1500

For single-user installations, these directories will reside on the local drive letter to which PC-ACE Pro32 was originally installed. For multi-user "networked" installations, these directories will reside on the shared network drive letter to which PC-ACE Pro32 was originally installed.

Care must be taken to copy Institutional acknowledgment files to the Institutional staging directory, and Professional acknowledgment files to the Professional staging directory. In addition, if your intermediary assigns the same filename to all ANSI-997 files, you will need to make sure that the most recently staged acknowledgment file has been archived before copying a newer acknowledgment file into the staging directory.

Installations that use data communications scripts to retrieve the ANSI-997 acknowledgment files may also automatically copy them to the appropriate staging directory. Your distributor should be able to confirm whether or not automatic ANSI-997 file staging will be performed on your installation.

Viewing, Printing & Maintaining Acknowledgment Files

Archived ANSI-997 transmission acknowledgment files can be viewed and/or printed from the ANSI-997 Acknowledgment File Log form. To view the currently archived ANSI-997 files, select the "**Maintain**" and "**Acknowledgment File Log**" menu items on either the Institutional or Professional Claims Menu form. The following operations are available:

- To view and/or print an archived ANSI-997 file, select the desired record and click the "**View Report**" button (or double-click the desired record). The report may be printed from the preview form if desired.
- To delete an archived ANSI-997 file, select the desired record, click the "**Delete**" button, and confirm the deletion.

  By default, archived ANSI-997 transmission acknowledgment files will be automatically purged after a certain number of days. Refer to the PC-ACE Pro32 Miscellaneous preferences topic for details on how to change the archive period (or disable automatic purging altogether, if desired).
- To refresh the list of archived ANSI-997 files, click the "**Refresh**" button. The staging directory will be re-scanned for the presence of new ANSI-997 files. If new files are present in the staging directory, they will be checked for proper format and automatically archived. The displayed list will then be rebuilt to reflect the current archive contents.

Using the Acknowledgment Reports

A detailed discussion of the ANSI-997 transmission acknowledgment file format is beyond the scope of this document. Interpretation questions should be directed to your intermediary's support department. The key fields present in the archive list display and on the individual acknowledgment reports are as follows:

- **Acknowledgment Creation Date/Time** – Specifies the date and time that the ANSI-997 transmission acknowledgment file was created. This date/time permits ANSI-997 files to be ordered chronologically and provides a general timeframe for locating the associated ANSI-837 claim transmission file.
- **Serial No.** – Specifies the starting serial number assigned during preparation of the ANSI-837 claim transmission file. The serial number can be compared against the "Serial No" column in the Claim Transmission Log to identify the specific EMC file associated with this acknowledgment file. To view the Claim Transmission Log form, select the "**Maintain**" and "**Transmission Log**" menu items on either the Institutional or Professional Claims Menu form.
- **Status** – Displays a status code indicating whether or not the ANSI-837 transmission file was accepted or rejected.

Additional identification information is included in the acknowledgment report to aid in researching transmission errors. Contact your intermediary's support department for assistance in understanding the ANSI-997 report nomenclature.

Reactivating previously transmitted claims

In some situations, it may become necessary to reactivate one or more previously transmitted claims for retransmission. **PC-ACE Pro32** provides two techniques for reactivating claims:

- Individual claims in the "transmitted" (TR) location may be reactivated for inclusion in a subsequent EMC file.
- An entire EMC file may be reactivated for retransmission.

This section will describe the procedures required to perform both types of claim reactivation.

Reactivating Transmitted Claims Individually

If one or more transmitted claims need to be resubmitted in a future EMC file, these claims must first be reactivated. Only claims in the "transmitted" (TR) location may be reactivated. Once a payment has been made on a claim, it will move to the "paid" (PD) location, and is no longer eligible for reactivation. This "reactivation" process simply moves the selected claim(s) from the "transmitted" (TR) location to the "to be transmitted" (CL) location, and sets the status to "unprocessed" (UNP). The reactivated claim can then be processed and, if no fatal edit validation errors are present, becomes eligible for inclusion into the next EMC file prepared.

Claim reactivation is performed from the Institutional or Professional Claim List form:

1) Filter the claim list to include only "**transmitted only**" (TR) claims.
2) If a single claim is to be reactivated, simply select the claim record in the list and choose the "**Reactivate Selected Claim**" item from the form's main "**Actions**" menu. Confirm the reactivation when prompted. The claim should disappear from the list, since it is no longer in the "transmitted" (TR) location. You should now find the unprocessed (Status = "UNP") claim in the "to be transmitted" (CL) location.
3) To reactivate several claims at one time, simply "**check**" the desired claims. A claim in the list is "checked" by clicking the left mouse button once while the mouse pointer is positioned over the list row's left-most column. A checkmark will be visible in the left-most column for all currently "checked" claims in the list. Choose the "**Reactivate All Checked Claims**" item from the form's main "**Actions**" menu. Confirm the reactivation of all "checked" claims when prompted.

   To automatically "check" all claims included in a previous transmission file, select the "**Check All Claims From Selected Transmission**" item from the form's main "**Filter**" menu. The Institutional or Professional Claim Transmission Log form will display a list of recent transmission files (with the most recent automatically selected). Select the desired transmission file entry and click the "**Select**" button. Upon return to the Claim List form, the program will automatically check all claims included in the selected transmission. You may then simply choose the "**Reactivate All Checked Claims**" item from the form's main "**Actions**" menu to reactivate these "checked" claims. Refer to the "Claim List Form Features" topic for more information.

Refer to the "Claim List Form Features" topic for more information on using the Institutional and Professional Claim List forms.

Reactivating an Entire EMC File for Retransmission

PC-ACE Pro32 archives all prepared EMC files for a duration determined by a Miscellaneous Preferences setting. Until an EMC file is purged from the archive, it is available for reactivation and subsequent retransmission. Retransmission of an EMC file might be required, for example, if the receiver has determined that a previously sent file was somehow corrupted during transmission.

Reactivation of an EMC file consists of restoring the selected file from the archive to its original prepared filename in the server's "**winpcace**" directory. After reactivation, the EMC file and other associated system settings exist just as they did when the file was originally prepared for transmission.

EMC file reactivation is performed from the "Claim Transmission Log" form.

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to display the appropriate Claims Menu form.
2) Select the "**Transmission Log**" item from the Claims Menu form's main "**Maintain**" menu. This action will display the Claim Transmission Log form, which lists details for all archived EMC files in chronological order. You may resize the form to see any additional list columns if desired.
3) Select the row describing the EMC file to be reactivated. Click the "**View Details**" and/or "**View Errors**" buttons to preview the original prepare reports, if desired.
4) Click the "**Reactivate**" button and confirm the reactivation operation when prompted. You will be notified when the reactivation operation has successfully completed. The EMC file is now ready for retransmission. Click the "**Close**" button to close the form.

Archived EMC files (and associated reports) may be manually deleted from the EMC file archive by selecting the row describing the file to be deleted, and clicking the "**Delete**" button. Confirm the deletion when prompted.

Preparing claim status request files for transmission

Claim status request file "**preparation**" in **PC-ACE Pro32** refers to the act of generating an ANSI-276 claim status request file suitable for transmission to your claims processor. This file will contain all relevant status request details for one or more previously transmitted claims. Upon receipt of the ANSI-276 file, the claims processor will generate a corresponding ANSI-277 claim status response file containing status information for the requested claims. This ANSI-277 response file can be processed by PC-ACE Pro32, and the user will be able to view the status information returned for each claim represented in the original ANSI-276 claim status request file.

Only claims that have been added to the status request queue will be included in the ANSI-276 claim status request file. See the "Claim List Form Features" topic for details on how to build the status request queue.

Before preparing claims into a status request file for the first time, you may need to setup your Submitter reference file. This file contains important data that will be used to build the ANSI-276 file. Separate submitter details exist for Institutional and Professional claim types. Since some distributors pre-configure the Submitter reference file, you should check with them before making any changes. Refer to the "Submitter File Maintenance" topic for more information on configuring this important reference file.

To prepare a claim status request file in PC-ACE Pro32, follow these steps:

1) Add one or more transmitted claims to the status request queue using the "**Request Selected Claim Status**" or "**Request All Checked Claims Status**" action in the Institutional or Professional Claim List form.

2) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.

3) From the Claims Menu form, select the "**Prepare Claim Status Request File**" option from the form's "**Maintain**" menu. This will display the Claim Status Request File Prepare form, which provides the following preparation options:

   - **Claim Filter Parameters** – queued claims must meet all specified filter criteria to be considered for preparation.

     - **LOB** - specifies a single line of business (LOB) to be considered. Only queued claims with this LOB will be eligible for preparation. Select the "**<< All >>**" item to include queued claims for any line of business.

       The Submitter reference file supports LOB-specific setup information if desired. Selecting a specific LOB for preparation will trigger the use of the matching LOB-specific submitter information (if any). Refer to the "Submitter File Maintenance" topic for more information on this advanced feature.

     - **Payer** - specifies a single Payer to be considered. Only queued claims for the selected payer will be eligible for preparation. Select the "**<< All Payers for LOB(s) >>**" item to include queued claims for all payers. Note: This selection is only enabled when a specific LOB has been selected for preparation.

       The Submitter reference file supports Payer-specific setup information if desired. Selecting a specific LOB and Payer for preparation will trigger the use of the matching LOB/Payer-specific submitter information (if any). Refer

to the "Submitter File Maintenance" topic for more information on this advanced feature.

- **Prepare Options** – options that control the claim status request preparation operation.
  - **Submission Status** - specifies whether the claim status request file should be designated as a "production" or "test" submission. The initial state of this option is determined by a Submitter reference file setting.

4) Specify the desired filter parameters (if any). When ready, click the "**Prepare Status Request**" button and confirm your intention to prepare the claim status request file. Progress information will be displayed as the prepare operation proceeds. You will be notified when the claim status file prepare operation completes.

5) If desired, click the "**View Results**" and/or "**View Errors**" buttons to view reports of the successfully prepared claim status requests and any failed requests, respectively. These reports can be printed from the report previewer if desired.

   Claims will rarely be rejected during the claim status request prepare operation. A claim will be rejected, for example, if the "submission" payer specified on the claim is no longer present in the Payer reference file. Since the claim has already been transmitted and cannot be modified, you will not be able to request claim status for these rejected claims.

6) When you have completed your review of the claim status request preparation reports, click the "**Close**" button on the Claim Status Request File Prepare form.

7) The prepared ANSI-276 claim status request file is located in the server's "**winpcace**" directory. The file is named "**bcreq276.dat**" for Institutional claims and "**bsreq276.dat**" for Professional claims. You may now proceed to transmit the ANSI-276 claim status request file to your claims processor using their prescribed file transmission procedure.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Claim List Form Features" topic for more information on adding claims to the status request queues (Institutional and Professional).
- Refer to the "Viewing and maintaining claim status response files" topic for information on viewing and maintaining the ANSI-277 claim status response files that will be returned by your claims processor.
- Refer to the "Viewing and maintaining the claim status request/response history" topic for information on viewing and maintaining status request/response history for transmitted claims.
- Refer to the "Submitter File Maintenance" topic for details on configuring the Submitter reference file.

Viewing and maintaining claim status response files

Intermediaries or clearinghouses receiving ANSI-276 format claim status request files generated by **PC-ACE Pro32** will retrieve the requested status information from their adjudication system and respond by sending an ANSI-277 claim status response file back to the submitter. PC-ACE Pro32 provides a facility by which users can archive these ANSI-277 claim status response files for subsequent review and/or printing. In addition to simply viewing the response file, PC-ACE Pro32 will automatically process this file and post the claim status responses directly to the appropriate Institutional or Professional claims. This topic describes how to stage your ANSI-277 files so that they are automatically archived and posted by PC-ACE Pro32, as well as the functions available for viewing, printing, maintaining and using the archived claim status response files and post reports.

Support for ANSI-276/277 claim status request/response files may not be available on all installations. If the "**Purge archived ANSI-277 acknowledgment files after 'NN' days**" option is disabled (grayed out) on the PC-ACE Pro32 Miscellaneous preferences form, then this capability is not available on your installation.

Staging Claim Status Response Files For Automatic Archiving

At program startup, PC-ACE Pro32 automatically scans separate Institutional and Professional "staging" directories looking for new ANSI-277 claim status response files to be archived. If any ANSI-277 files are present in the staging directories, they are checked for proper format and archived automatically. In addition, the individual responses are automatically posted to the appropriate claims. This automatic archive/post process is also performed when the **Claim Status Response Log** form is opened or when the user manually refreshes the Claim Status Response Log list (see next section for details).

On most PC-ACE Pro32 installations, the user will be required to manually copy the ANSI-277 files received from the intermediary into the appropriate staging directory. The Institutional and Professional staging directories are:

Institutional: winpcace\ansi277\statub92

Professional: winpcace\ansi277\stat1500

For single-user installations, these directories will reside on the local drive letter to which PC-ACE Pro32 was originally installed. For multi-user "networked" installations, these directories will reside on the shared network drive letter to which PC-ACE Pro32 was originally installed.

Care must be taken to copy Institutional claim status response files to the Institutional staging directory, and Professional claim status response files to the Professional staging directory. In addition, if your intermediary assigns the same filename to all ANSI-277 files, you will need to make sure that the most recently staged claim status response file has been archived before copying a newer response file into the staging directory.

Installations that use data communications scripts to retrieve the ANSI-277 acknowledgment files may also automatically copy them to the appropriate staging directory. Your distributor should be able to confirm whether or not automatic ANSI-277 file staging will be performed on your installation.

Viewing, Printing & Maintaining Claim Status Response Files and Post Reports

Archived ANSI-277 claim status response files and response post reports can be viewed and/or printed from the Claim Status Response Log form. To view the currently archived ANSI-277 files, select the "**Maintain**" and "**Claim Status Response Log**" menu items on either the Institutional or Professional Claims Menu form. The following operations are available:

- To view and/or print an archived ANSI-277 response file report, select the desired record and click the "**View Response Report**" button (or double-click the desired record). The report may be printed from the preview form if desired.
- To view and/or print the post report for an archived ANSI-277 response file, select the desired record and click the "**View Post Report**" button. The report may be printed from the preview form if desired.
- To delete an archived ANSI-277 file and its associated post report, select the desired record, click the "**Delete**" button, and confirm the deletion.

  By default, archived ANSI-277 claim status response files will be automatically purged after a certain number of days. Refer to the PC-ACE Pro32 Miscellaneous preferences topic for details on how to change the archive period (or disable automatic purging altogether, if desired). Individual claim status responses which have been posted to claims will remain on file even after the original archived response file has been manually deleted or automatically purged.
- To refresh the list of archived ANSI-277 files, click the "**Refresh**" button. The staging directory will be re-scanned for the presence of new ANSI-277 files. If new files are present in the staging directory, they will be checked for proper format, and automatically archived and posted. The displayed list will then be rebuilt to reflect the current archive contents.

  Right-click the mouse on the desired ANSI-277 archive record to access all available actions. This popup menu provides several additional actions which allow the user to print post reports containing only the successfully posted responses or only responses that could not be posted.

Using the Claim Status Response Reports

The ANSI-277 claim status response file is presented by PC-ACE Pro32 in a human-readable report format. The report presents general identification information along with the claim-level status response codes and payment details returned by the intermediary for each claim. Since the individual responses are posted directly to the applicable claims, this report is typically used as a secondary reference source. There may be situations in which ambiguous status responses returned by the intermediary will not be posted to the original claim. In these situations, you will be referred back to the original claim status response file (and this report) for additional information. Contact your intermediary's support department for assistance in understanding the ANSI-277 report nomenclature and claim status code interpretation.

Using the Claim Status Response Post Reports

The ANSI-277 claim status response post report presents the claim-by-claim results of the automatic response posting operation. A response posting will fail for either of the following reasons:

- The claim for which status was requested no longer exists. The claim has been purged, archived, or reactivated from the "TR – transmitted only" or "PD – paid only" location.

- Multiple claim status responses have been returned by the intermediary for the same unique claim trace number. This typically indicates that the intermediary could not uniquely identify the claim of interest based on the identifying information included in the ANSI-276 claim status request file. Multiple responses may be returned at the discretion of the intermediary. PC-ACE Pro32 will not post any of the ambiguous responses directly to the claim, but will instead post an "attention" notification which directs the user back to the original archived claim status response file/report. The user must review this report manually to determine which one of the multiple responses is applicable (if any).

The ANSI-277 claim status response post report will display an explanatory error message for each response that could not be posted.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Claim List Form Features" topic for more information on adding claims to the status request queues (Institutional and Professional).
- Refer to the "Preparing claim status request files for transmission" topic for information on creating ANSI-276 claim status request files to send to your claims processor.
- Refer to the "Viewing and maintaining the claim status request/response history" topic for information on viewing and maintaining status request/response history for transmitted claims.

Viewing and maintaining the claim status request/response history

PC-ACE Pro32 keeps a history of claim status requests and responses for each transmitted claim. Requests are added to this history log as the final step of the ANSI-276 claim status request prepare operation. Responses are recorded in the history log during automatic posting of the ANSI-277 claim status response files returned from the intermediary or clearinghouse. PC-ACE Pro32 provides a facility by which users can view, print and maintain this claim request/response history. This topic describes how to access and use this advanced capability. Refer to the "Related Topics" links at the end of this topic for more information on how to request claim status and process the returned status response files.

Support for ANSI-276/277 claim status request/response files may not be available on all installations. If the "**Purge archived ANSI-277 acknowledgment files after 'NN' days**" option is disabled (grayed out) on the PC-ACE Pro32 Miscellaneous preferences form, then this capability is not available on your installation.

Determining Status Request/Response Availability

The Institutional and Professional Claim List forms include the following columns for use in determining the availability of status request/response history for transmitted claims.

- **SR** (Status Response Indicator) – This indicator will display an "**R**" on claims where status has been requested, but where a response has not yet been received. An "**A**" value indicates that status response information is available for this claim. An empty SR column indicates that no claim status request/response history is available for the claim.
- **Status Date** (Status Response Date) – Specifies the date of the most recent status request or posted status response for the claim. This date column will be empty if no claim status request/response history is available for the claim.

These columns should be visible by default at the far right of the Institutional and Professional Claim List forms whenever the "TR", "PD" or "TR/PD" claim location is selected. You may need to maximize the window or scroll the list horizontally to bring these columns into view. If these columns are not present, you will need to add the associated fields to the current claim list column configuration in the "Claim List Preferences" form. Select the "**Preferences**" item from the PC-ACE Pro32 main toolbar's "**File**" menu to display the Preferences form. Select the "**Claim List**" tab, choose either the "**Institutional Claim List**" or "**Professional Claim List**" radio button (if available), and then select the "**Transmitted (TR)**" nested tab. Move the "**Status Response Ind**" and "**Status Response Date**" fields from the available fields list to the selected fields list. Reorder the new fields in the selected fields list as desired. Select the "**Paid/History (PD)**" tab and repeat this configuration process. Save the preference setting changes. This configuration process must be performed separately for the Institutional Claim List form and the Professional Claim List form.

Viewing, Printing & Maintaining Claim Status Request/Response History

The status request/response history for any transmitted claim can be viewed and/or printed from the Claim Status Request/Response History form. Access to this history log is available from the Institutional and Professional Claim List forms. On either claim list, select the "**TR/PD – transmitted+paid**" location to display all transmitted claims. To access the history log, select

the claim record of interest in the list and choose the "**Show Selected Claim Status History**" item from the form's main "**Actions**" menu. The Claim Status Request/Response History form will display all available status requests and responses for this claim.

The Claim Status Request/Response History form displays a summary of each request or response, including the associated date/time, the "Action" (or type), and a few key status response data elements. The possible "Action" types include:

- **Request** – Records the date/time a claim status history request was made on behalf of this claim. This is actually the date/time associated with the ANSI-276 claim status request file prepared by PC-ACE Pro32.
- **Response** – Identifies a posted response for this claim. A summary of the status response is displayed in the list's columns. Additional details for this response are available for viewing if desired (see below for instructions). This includes general claim identification information along with the claim-level status response codes and payment details returned by the intermediary. Reference information is also available to locate the original claim status response file should it be needed.
- **Attention** – Indicates that a response was available for this claim, however, could not be posted for some specific reason. Additional information directs the user to the original claim status response report. The most common cause for this "attention" condition is an ambiguous claim status response. This occurs when the response file contains more than one response referencing the same unique claim trace number.

The following operations are available on the Claim Status Request/Response History form:

- To view status response details or "attention" information, select the desired record and click the "**View**" button (or double-click the desired record).
- To delete a request/response entry, select the desired record, click the "**Delete**" button, and confirm the deletion.
- To view and/or print the complete status request/response history for this claim, click the "**Print History**" button. The report may be printed from the preview form if desired.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Claim List Form Features" topic for more information on adding claims to the status request queues (Institutional and Professional).
- Refer to the "Preparing claim status request files for transmission" topic for information on creating ANSI-276 claim status request files to send to your claims processor.
- Refer to the "Viewing and maintaining claim status response files" topic for information on viewing and maintaining the ANSI-277 claim status response files that will be returned by your claims processor.

Printing claims

Claims can be printed in **PC-ACE Pro32** using either the traditional "pre-printed forms" method or an advanced "image overlay" technique. These 2 approaches are described below, along with suggestions on when each method might be appropriate.

- **Pre-Printed Forms Method** - This traditional method prints just the actual claim field values at positions on the page that should line up with pre-printed CMS-1450 (Institutional) or Professional claim forms. Use this printing method when you require claims to be printed on the actual red pre-printed claim forms. Most optical character recognition (OCR) equipment used to scan paper claims requires that these red forms be used. This method also provides the quickest means to get a claim printout for hardcopy review.
- **Image-Overlay Method** - This advanced method automatically overlays the claim field values onto a graphical image of the blank claim form, resulting in a complete claim image that can be printed on stock paper. The image-overlay technique eliminates all the paper alignment headaches often associated with printing onto pre-printed claim forms. Use this printing method to print claims for archiving or distribution.

  The image-overlay printing method requires that the free Adobe Acrobat Reader (Version 4.0 or later) be installed on your system. This reader is available for download from Adobe (www.adobe.com). When the Acrobat Reader is properly installed, PC-ACE Pro32 will automatically detect and configure the path to the ACRORD32.EXE program.

The steps involved in printing a claim (or selection of claims) are the same regardless of the selected printing method:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the appropriate Claims Menu form.
2) Click the "**List Claims**" button on the Claims Menu form to display the appropriate Claim List form. All claim printing is performed from the claim list.
3) To print a single claim, simply select the desired claim from the list and select the "**Print Selected Claim**" item from the Claim List form's main "**Actions**" menu (or convenient right-click popup menu). The Claim Print Options form will be displayed.

   To print a selection of claims, simply "check" the desired claims and select the "**Print All Checked Claims**" item from the Claim List form's main "**Actions**" menu. Refer to the "Claim List Form Features" topic for more information on multiple-claim selection.
4) The Claim Print Options form allows the user to override default preferences for things like destination printer, printing method (pre-printed forms versus image-overlay), claim form version, and miscellaneous options. Click the "**Preview**" button to preview the claim(s) before printing (available with image-overlay method only). Click the "**Print**" button to print the claim(s) without previewing them.

   Claim "previewing" for claims printed using the image-overlay method employs the Adobe Acrobat Reader. Use the Acrobat Reader's "print" option to print a previewed claim. When you have previewed and optionally printed the claim, close the Acrobat Reader program. This will signal PC-ACE Pro32 that you are ready to continue.

   You will not be able to resume activities in PC-ACE Pro32 until the Acrobat Reader program has been exited. Simply closing the claim document within the reader is not enough to signal PC-ACE Pro32 to continue.

5) If you have selected multiple claims, they will be printed in sequence based on the current Claim List form's "**Sort By:**" selection. A progress form will display details about the claim currently being printed. Click the "**Cancel**" button on this progress form to cancel the printing session following the claim currently being printed.

A Few Technical Notes

Here is some additional technical information that you need to know about printing claims in PC-ACE Pro32:

- The image-overlay printing method option will be enabled only if the Adobe Acrobat Reader (Version 4.0 or later) is properly installed on the system. You must exit PC-ACE Pro32 before installing the Acrobat Reader. A properly installed reader will be detected automatically the next time PC-ACE Pro32 is started. If necessary, you can manually configure the Acrobat Reader executable file (ACRORD32.EXE) path from the "**Misc**" tab of the PC-ACE Pro32 Preferences form.

  The Adobe Acrobat Reader has its own preference settings that will let you choose the initial document magnification level and get rid of the splash screen that is shown by default every time the reader is started.

- Claim printing default values for destination printer, printing method (pre-printed forms versus image-overlay), pre-printed position and point size adjustments, claim form version, and numerous miscellaneous options can be set from the "**Printing**" tab of the PC-ACE Pro32 Preferences form. Claim printing defaults are set independently for Institutional and Professional claim printing (if you are licensed for both claim types). These default settings will be used during claim print operations unless overridden at print time from the Claim Print Options form.

- Using the **"Payer Options"** selections, claims may be printed on behalf of the their alternate payers if desired. An "alternate" payer is any payer specified on the claim other than the submission payer. For example, if a Medicare payer is specified as primary on a Medicare claim, then the primary payer will be designated as the "submission" payer. In this scenario, the secondary and tertiary payers are considered "alternate" payers. Alternate Payers 1 and 2 are defined based on the claim's submission payer as follows:

Submission:	Primary	Secondary	Tertiary
Alt. Payer 1:	Secondary	Primary	Primary
Alt. Payer 2:	Tertiary	Tertiary	Secondary

  When a claim is printed for an alternate payer, PC-ACE Pro32 will attempt to populate the printed fields "as though" the selected alternate payer was the submission payer. In general, this means that the payer-specific and provider-specific information included on the printed claim will reflect the alternate Payer ID and LOB (line of business). For alternate payer printing to work most effectively, all payers specified on the claim must be on-file in the PC-ACE Pro32 Payer reference file. In addition, provider records for the alternate claim payer LOBs must also be on-file in the PC-ACE Pro32 Institutional (or Professional) Provider reference file, and must be associated with the submission provider record.

  This capability makes it easy to print secondary/tertiary claims without requiring the creation of a separate claim for the alternate payer.

  If a request is made to print an alternate payer that does not exist on the claim being printed, the request will simply be ignored. This behavior makes it possible to request alternate payer printing for multiple "checked" claims without regard for whether or not the alternate payers are actually present on all the claims.

- Claim attachments can be optionally printed (when present) by checking the "**Print claim attachments if present**" option on the Claim Print Options form. Claim attachments should always be printed on stock paper. If you are printing your claims using the pre-printed forms method onto actual CMS-1450/1500 red forms, then you will want to print all attachments at the end of the print run. Doing this will give you the opportunity to change the printer paper prior to printing the attachments. Make sure the "**Print all claim attachments at the end of multiple-claim print run when appropriate**" option on the "**Printing**" tab of the PC-ACE Pro32 Preferences form is checked.

Posting claim payments (Institutional)

PC-ACE Pro32 maintains an optional Institutional claim payments database for organizations that wish to track payment data in the system. Any number of "payments" may be posted against a transmitted Institutional claim. The payment history for a claim can be accessed from either the Institutional Claim List form or the Institutional Claim Form as follows:

1) Click the "**Institutional Claims Processing**" button from the PC-ACE Pro32 Main Toolbar to display the Institutional Claims Menu form.

2) Click the "**List Claims**" button on the Institutional Claims Menu form to display the Institutional Claim List form. By default, the list will display claims in the "to be transmitted" (CL) location.

3) On the Institutional Claim List form, select either the "transmitted only" (**TR**), "paid only" (**PD**), or "transmitted + paid" (**TR/PD**) claims location to display claims eligible for payment.

   Claims are assigned to the "transmitted" (TR) location as soon as they are prepared into an EMC file for transmission. When the first payment is posted to a "transmitted" claim, the claim is moved to the "paid" (PD) location, where it will remain indefinitely. Payments may be posted to claims in either the "transmitted" (TR) or "paid" (PD) locations, but not to claims in the "to be transmitted" (CL) location.

   If you plan on posting payments to more than one claim, we recommend that you select the combined "transmitted + paid" (**TR/PD**) claims location. Updates to the claim list are more efficient to process from this location, since claims being moved from the "transmitted" (TR) to "paid" (PD) status will not force a requery of the list's contents.

4) Select the desired claim from the list and perform <u>either</u> of the following to access the claim's payment history.
   - Select the "**Show Selected Claim Payments**" item from the Institutional Claim List form's main "**Actions**" menu (or from the convenient right-click popup menu).
   - Click the "**View**" button (or double-click the selected record) to display the claim in the Institutional Claim Form. Click the "**Show Payment History**" button to access the payment history for this claim.

5) The Claim Payment History form lists all existing payments made to the selected claim (if any). Perform the desired payment-related tasks from this list, including:
   - To post a new payment, click the "**New**" button and enter the payment date and amount on the Claim Payment Details form. The "Date Paid" field is defaulted to the current system date and can be changed if desired. Complete some or all of the optional payment record fields if desired. When all desired payment fields have been entered, click the "**OK**" button to save the payment record.
   - To modify an existing payment record, select the desired record, click the "**View/Update**" button (or double-click the selected record) and modify the payment field values as required. Click the "**OK**" button to save the modified payment record.
   - To delete a payment record, select the desired record, click the "**Delete**" button, and confirm the deletion.

6) The Claim Payment History form maintains running totals of all claim payments posted to the selected claim. When you have completed the payment posting activities for this claim, click the "**Close**" button to return to the previous form. The Institutional Claim List form will

reflect the most recent payment date and total amount paid in the "Paid Date" and "Paid Amount" columns, respectively.

Posting claim payments (Professional)

PC-ACE Pro32 maintains an optional Professional claim payments database for organizations that wish to track payment data in the system. Any number of "payments" may be posted against a transmitted Professional claim. The payment history for a claim can be accessed from either the Professional Claim List form or the "The Professional Claim Form" as follows:

1) Click the "**Professional Claims Processing**" button from the PC-ACE Pro32 Main Toolbar to display the Professional Claims Menu form.

2) Click the "**List Claims**" button on the Professional Claims Menu form to display the Professional Claim List form. By default, the list will display claims in the "to be transmitted" (CL) location.

3) On the Professional Claim List form, select either the "transmitted only" (**TR**), "paid only" (**PD**), or "transmitted + paid" (**TR/PD**) claims location to display claims eligible for payment.

   Claims are assigned to the "transmitted" (TR) location as soon as they are prepared into an EMC file for transmission. When the first payment is posted to a "transmitted" claim, the claim is moved to the "paid" (PD) location, where it will remain indefinitely. Payments may be posted to claims in either the "transmitted" (TR) or "paid" (PD) locations, but not to claims in the "to be transmitted" (CL) location.

   If you plan on posting payments to more than one claim, we recommend that you select the combined "transmitted + paid" (**TR/PD**) claims location. Updates to the claim list are more efficient to process from this location, since claims being moved from the "transmitted" (TR) to "paid" (PD) status will not force a requery of the list's contents.

4) Select the desired claim from the list and perform <u>either</u> of the following to access the claim's payment history.
   - Select the "**Show Selected Claim Payments**" item from the Professional Claim List form's main "**Actions**" menu (or from the convenient right-click popup menu).
   - Click the "**View**" button (or double-click the selected record) to display the claim in the Professional Claim Form. Click the "**Show Payment History**" button to access the payment history for this claim.

5) The Claim Payment History form lists all existing payments made to the selected claim (if any). Perform the desired payment-related tasks from this list, including:
   - To post a new payment, click the "**New**" button and enter the payment date on the Claim Payment Details form. The "Date Paid" field is defaulted to the current system date and can be changed if desired. Payment data for Professional claims must be entered on a "per-line-item" basis. Click the "**Amount Paid**" cell for the line item to be paid (click twice for "edit" mode), enter the payment amount, and press the "**ENTER**" or "**TAB**" key to accept the entry. Complete some or all of the optional payment record fields and line item cells if desired. The claim-level "Amount Paid" field at the top of the form will display a running total of the "Amount Paid" values entered for all claim lines. When all desired payment fields have been entered, click the "**OK**" button to save the payment record.
   - To modify an existing payment record, select the desired record, click the "**View/Update**" button (or double-click the selected record) and modify the payment field values as required. Click the "**OK**" button to save the modified payment record.

The "Date Paid" value for an existing claim payment record cannot be modified. To change the payment date, you must delete the existing payment record and add a new one with the correct date.

- To delete a payment record, select the desired record, click the "**Delete**" button, and confirm the deletion.

6) The Claim Payment History form maintains running totals of all claim payments posted to the selected claim. When you have completed the payment posting activities for this claim, click the "**Close**" button to return to the previous form. The Professional Claim List form will reflect the most recent payment date and total amount paid in the "Paid Date" and "Paid Amount" columns, respectively.

Archiving and unarchiving claims

Transmitted claims in **PC-ACE Pro32** can be optionally moved "off-line" to any number of user-defined **claim archives**. Claim archiving provides the following advantages:

- Archiving claims **reduces the size** and **optimizes the performance** of the current claims database.
- Archiving claims eliminates claims that are no longer of interest from the current claims database, making it **easier to locate and work** with the current claims.
- Archiving **promotes organized storage** of older claims without requiring that they be purged. Claim archives can be maintained by transmit date, line-of business, "submission" payer, or other preferred criteria.

Claim archive databases look and act much like the current database. With a few minor exceptions, the same actions that can be taken on transmitted claims in the current database can also be taken on archived claims. For example, archived claims can be viewed and printed just like claims in the current database. The payment history of archived claims can be viewed as well.

To greatly reduce the time required to perform claim archiving activities on networked installations, it is strongly recommended that such activities be initiated from the server's console. It is also recommended, though not required, that no other users be accessing PC-ACE Pro32 during claim archiving activities.

Access to various features of the PC-ACE Pro32 claim archiving system is controlled by user permissions. For example, a user may be able to archive and unarchive claims, but not have permission to create new claim archives. If any (or all) of the claim archiving features described in this topic are unavailable, then you either do not have the required archive permissions, or your distributor does not support the claim archiving function.

All claim archive functions are performed from the familiar Institutional or Professional Claim List form. To archive and unarchive claims, follow these general steps:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" button or "**Professional Claims Processing**" button to display the corresponding Claims Menu form.
2) Click the "**List Claims**" button on the Claims Menu form to display the Institutional or Professional Claim List form. By default, the list will display claims in the "to be transmitted" (CL) location.
3) From the Claim List form's main "**File**" menu, select the "**Open Claim Archive**" item to display the Open Claim Archive form. This form will display a list of all existing claim archives (if any).
4) To open an existing claim archive, select the desired archive from the list and click the "**Open**" button (or just double-click the list entry). The claim archive will be opened and you will be returned to the Claim List form. Skip over the next step.
5) To create a new archive (if you have archive maintenance permission), click the "**New**" button and enter a descriptive name for the new archive. The empty archive will be created and the corresponding entry will be added to the selection list. Select the new archive from the list and click the "**Open**" button (or just double-click the new list entry). The new claim archive will be opened and you will be returned to the Claim List form.

Claim archive names must adhere to your server's directory naming convention. If Windows long file/directory names are permitted, then you can give the archive a descriptive name. Otherwise, you may be limited to 8 characters. Archive names can contain only alphabetic characters, numeric characters, underscore ("_") characters, and spaces. You will receive an error message if the chosen archive name is unacceptable.

6) Once you're back to the Claim List form, select the "**View Archived Claims**" item from the form's main "**File**" menu to view the claims in the open claim archive. Select the "**View Current Claims**" item from the main "**File**" menu to toggle back to the current claims.

7) Only transmitted and paid claims can be archived, so choose either the "**transmitted only**" (TR), "**paid only**" (PD), or "**transmitted + paid**" (TR/PD) item from the "**Location**" drop-down list.

8) To archive a single claim, select the desired claim from the list and choose the "**Archive Selected Claim**" item from the Claim List form's main "**Actions**" menu (or the convenient right-click popup menu). The selected claim will disappear from the current claims list. To archive multiple claims at once, simply "check" the desired claims and select the "**Archive All Checked Claims**" item from main "**Actions**" menu. All "checked" claims will disappear from the current claims list. Refer to the "Claim List Form Features" topic for more information on using this form's powerful multi-selection feature.

9) Select the "**View Archived Claims**" item from the Claim List form's main "**File**" menu to once again view the claims in the open claim archive. You should see the claims you just archived.

10) If you desire, you can unarchive the same claims by selecting (single) or "checking" (multiple) the desired claim(s) and choosing either the "**Unarchive Selected Claim**" or "**Unarchive All Checked Claims**" item from the Claim List form's main "**Actions**" menu.

11) When you are finished reviewing (and possibly unarchiving) claims in the claim archive, select the "**View Current Claims**" item from the main "**File**" menu to toggle back to the current claims.

12) Select the "**Close Claim Archive**" item from the main "**File**" menu to close the open claim archive. You will be prompted to "pack" the claim archive before closing. Click the "**Yes**" button to pack and close the archive, the "**No**" button to close the archive without packing, or the "**Cancel**" button to leave the archive open.

Packing a claim archive database minimizes the disk space requirements and enhances performance. It is recommended that claim archive databases be packed periodically, especially after groups of claims have been unarchived or purged from the archive. **The packing process can be lengthy for large databases. Once the packing operation has started, it must continue to completion. We recommend packing claim archives only when no other users are accessing PC-ACE Pro32.**

If you close the Claim List form without first closing an open claim archive, the archive is closed automatically, and you will receive the "pack" prompt (described above).

If claims have been archived, you will receive a notification when the archive is closed concerning "packing" the current claims database. The system administrator should pack the current claims database periodically to keep the database size minimized and to maintain optimum system performance. Refer to the "Packing and reindexing the

databases" topic for information on packing the Institutional and/or Professional current claims database.

Adding a new eligibility benefit request

New patient eligibility benefit requests can be added to **PC-ACE Pro32** from the Eligibility Benefit Request List form. The operation of this list form is identical for Institutional and Professional request types. Perform the following steps to access the Eligibility Benefit Request List form and open a new eligibility benefit request:

1) Click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the respective Claims Menu form.
2) From the Institutional or Professional Claims Menu form, select the "**Maintain**" and "**Maintain Eligibility Benefit Requests**" menu items to open the respective Eligibility Benefit Request List form.
3) Click the "**New**" button on the request list form to open either the complete Eligibility Benefit Request Form or the simplified Service Type Eligibility Benefit Request Form (depending on preference settings) and begin entering information on the new eligibility benefit request. You may also open either request form from the Eligibility Benefit List Form's main "**Actions**" menu.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Maintain Eligibility Benefit Requests" item is not visible on the "Maintain" menu, then this capability is not available on your installation. In addition, the simplified Service Type Eligibility Benefit Request Form may not be available on all installations.

Requests are manually entered on the respective Eligibility Benefit Request Form or simplified Service Type Eligibility Benefit Request Form. Refer to the associated Help topic for information on entering eligibility benefit requests. The data fields on the complete Eligibility Benefit Request Form are typically entered in the order presented - from left-to-right and top-to-bottom - on each tab of the request form. The fields that are most commonly used are concentrated on the leftmost tabs. Lookups available on key fields (e.g., Patient PCN) can significantly speed the process of entering eligibility benefit requests. The data fields on the simplified Service Type Eligibility Benefit Request Form should be completed in top-to-bottom order. Edit validation errors may be encountered during this entry process if the data entered violates any of the predefined edits for the specific request type. Correct any such edit errors and click the "**Save**" button to save the request. Requests containing unresolved edit errors may be saved if desired by clicking either the "**Save With Errors**" button (visible if only non-fatal errors exist) or "**Save With Fatal**" button (visible if any fatal errors exist). Only one of these buttons will be visible at any given time.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional & Professional Claims Menus" topic for more information about the Claims Menu form.
- Refer to the "Eligibility Benefit Request List Form Features" topic for details on using the Eligibility Benefit Request List form.
- Refer to the "Eligibility Benefit Request Form" topic for more information on using the eligibility benefit request form.
- Refer to the "Service Type Eligibility Benefit Request Form" topic for more information on using the simplified Service Type eligibility benefit request form (if available on your installation).

- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.
- Refer to the on-line help "**Common Claim Activities**" folder for hyperlinks to other eligibility benefit request topics of interest.

Listing, modifying and maintaining eligibility benefit requests

Patient eligibility benefit requests in **PC-ACE Pro32** are listed, modified, and otherwise maintained from the Eligibility Benefit Request List Form. The operation of this list form is identical for Institutional and Professional request types. To access the Eligibility Benefit Request List form:

1) Click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the respective Claims Menu form.
2) From the Institutional or Professional Claims Menu form, select the "**Maintain**" and "**Maintain Eligibility Benefit Requests**" menu items to open the respective Eligibility Benefit Request List form.

Most actions to be performed on an eligibility benefit request may be executed from the Eligibility Benefit Request List form. Requests can be created, viewed/modified, copied, deleted, reactivated, and held/released from the list. In addition, archived eligibility benefit responses for individual requests can be viewed and printed from the request list form. Refer to the "Eligibility Benefit Request List Form Features" topic for complete details on the features and operation of the powerful Eligibility Benefit Request List form.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Maintain Eligibility Benefit Requests" item is not visible on the "Maintain" menu, then this capability is not available on your installation.

Viewing & Modifying Eligibility Benefit Requests

Viewing and/or modifying existing eligibility benefit requests from the Eligibility Benefit Request List form can be performed with these general steps:

1) Use the Eligibility Benefit Request List form's powerful sorting and filtering capabilities to locate the request of interest in the list.
2) Select the desired eligibility benefit request in the list and click the "**View/Update**" button to display the request details in the request form. Alternatively, just double-click the desired request record in the list.
3) Make all desired changes to the request. Refer to the Eligibility Benefit Request Form topic for details on the many productivity enhancing features available on this powerful request form.
4) When all changes have been made, click the "**Save**" button to save the request record and close the form. Review and correct any edit validation errors as needed. Alternatively, click the "**Cancel**" (or "**Close**") button to cancel any pending request changes.

Actions On Multiple Eligibility Benefit Requests

Many of the eligibility benefit request actions available in the Eligibility Benefit Request List form are applicable to both single (selected) requests as well as groups of "checked" requests. This powerful multi-selection capability makes operating on groups of requests a snap! Simply use the Eligibility Benefit Request List form's advanced filtering options to narrow the eligibility benefit request list contents down until it contains only the desired requests. Then select the "**Check All Requests**" action from the main or popup menu to instantly mark (i.e., "check") all the requests of interest. A number of actions are available from the main or popup menu to operate on the entire group of requests in a single session. Refer to the "Eligibility Benefit

Request List Form Features" topic for complete details on selecting and acting on multiple eligibility benefit requests at once.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Eligibility Benefit Request List Form Features" topic for details on using the Eligibility Benefit Request List form.
- Refer to the "Eligibility Benefit Request Form" topic for more information on using the Institutional and Professional eligibility benefit request forms.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.
- Refer to the on-line help "**Common Claim Activities**" folder for hyperlinks to other eligibility benefit request topics of interest.

Preparing eligibility benefit request files for transmission

Patient eligibility benefit request file "**preparation**" in **PC-ACE Pro32** refers to the act of generating an ANSI-270 eligibility benefit request file suitable for transmission to your claims processor. This file will contain all relevant details for one or more eligibility benefit requests. Upon receipt of the ANSI-270 file, the claims processor will generate a corresponding ANSI-271 eligibility benefit response file containing the requested eligibility/benefit information. This ANSI-271 response file can be processed by PC-ACE Pro32, and the user will be able to view the eligibility/benefit information returned for each request represented in the original ANSI-270 eligibility benefit request file.

Only eligibility benefit requests in the "to be submitted" (EL) location are eligible for preparation. When a request is "prepared" into an ANSI-270 eligibility benefit request file, it is automatically moved to the "submitted" (TR) location. Residence in the "submitted" (TR) location reflects its transmitted state and also prevents the request from being inadvertently retransmitted.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Prepare Eligibility Benefit Request File" item is not visible on the "Maintain" menu when performing the steps described in this topic, then this capability is not available on your installation.

Before preparing eligibility benefit requests for the first time, you may need to setup your Submitter reference file. This file contains important data that will be used to build the ANSI-270 file. Separate submitter details exist for Institutional and Professional request types. Since some distributors pre-configure the Submitter reference file, you should check with them before making any changes. Refer to the "Submitter File Maintenance" topic for more information on configuring this important reference file.

To prepare eligibility benefit requests in PC-ACE Pro32, follow these simple steps:

1) From the PC-ACE Pro32 Main Toolbar, click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button to open the desired Claims Menu form.

2) From the Claims Menu form, select the "**Maintain**" and "**Prepare Eligibility Benefit Request File**" menu items to open the respective Eligibility/Benefit Request Prepare form. This form provides the following preparation options:

   - **Request Filter Parameters** – eligibility benefit requests must meet all specified filter criteria to be considered for preparation.

     - **LOB** - specifies a single line of business (LOB) to be considered. Only requests with this LOB will be eligible for preparation. Select the "**<< All >>**" item to include requests for any line of business.

       The Submitter reference file supports LOB-specific setup information if desired. Selecting a specific LOB for preparation will trigger the use of the matching LOB-specific submitter information (if any). Refer to the "Submitter File Maintenance" topic for more information on this advanced feature.

     - **Payer** - specifies a single Payer to be considered. Only requests being submitted to the selected payer will be eligible for preparation. Select the "**<< All Payers for LOB(s) >>**" item to include requests for all payers. Note: This selection is only enabled when a specific LOB has been selected for preparation.

The Submitter reference file supports Payer-specific setup information if desired. Selecting a specific LOB and Payer for preparation will trigger the use of the matching LOB/Payer-specific submitter information (if any). Refer to the "Submitter File Maintenance" topic for more information on this advanced feature.

- **Prepare Options** - options that control the eligibility benefit request preparation operation.
  - **Submission Status** - specifies whether the ANSI-270 file should be designated as a "production" or "test" submission. The initial state of this option is determined by a Submitter reference file setting.
  - **Include Error Requests?** - specifies whether eligibility benefit requests with "non-fatal errors" (Status = "ERR") are to be eligible for preparation. When checked, all requests in the "to be submitted" (EL) location with a status or either "CLN" (clean) or "ERR" (contains non-fatal errors) will be eligible for preparation. When unchecked, only clean requests will be eligible for preparation. The initial state of this option is determined by a Submitter reference file setting.

The default settings for these control options are typically configured by your distributor. We recommend overriding these option settings only under the instruction of your distributor or an authorized technical support specialist.

3) Specify the desired filter parameters (if any) and preparation options. When ready, click the "**Prepare Eligibility Request**" button and confirm your intention to prepare all eligible eligibility benefit requests. Progress information will be displayed as the prepare operation proceeds. You will be notified when the eligibility benefit request file prepare operation completes.

4) If desired, click the "**View Results**" and/or "**View Errors**" buttons to view reports of the successfully prepared eligibility benefit requests and rejected requests, respectively. These reports can be printed from the report preview form if desired. The reports for the most recent eligibility benefit request prepare operation are also available from the "View" menu on the Institutional & Professional Claims Menu forms.

Eligibility benefit requests will rarely be rejected during the prepare operation. A request may be rejected, for example, if the Information Source (i.e., payer) specified on the request is no longer present in the Payer reference file. Rejected eligibility benefit requests must be re-processed and corrected before they can be successfully prepared.

5) When you have completed your review of the eligibility benefit request preparation reports, click the "**Close**" button on the Eligibility/Benefit Request Prepare form.

6) The prepared ANSI-270 eligibility benefit request file is located in the server's "**winpcace**" directory. The file is named "**bcreq270.dat**" for Institutional requests and "**bsreq270.dat**" for Professional requests. You may now proceed to transmit the ANSI-270 eligibility benefit request file to your claims processor using their prescribed file transmission procedure.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Adding a new eligibility benefit request" topic for more information on creating patient eligibility benefit requests.

- Refer to the "Viewing and maintaining eligibility benefit response files" topic for information on viewing and maintaining the ANSI-271 eligibility benefit response files that will be returned by your claims processor.
- Refer to the "Viewing the eligibility benefit response for a specific request" topic for information on viewing the eligibility benefit response returned for a specific request.
- Refer to the "Submitter File Maintenance" topic for details on configuring the Submitter reference file.

Viewing and maintaining eligibility benefit response files

Claims processors receiving ANSI-270 format patient eligibility benefit request files generated by **PC-ACE Pro32** will retrieve the requested eligibility/benefit information from their system and respond by sending an ANSI-271 eligibility benefit response file back to the submitter. PC-ACE Pro32 provides a facility by which users can archive these ANSI-271 eligibility benefit response files for subsequent review and/or printing. In addition to simply viewing the entire response file, PC-ACE Pro32 will automatically process this file and post the responses directly to the original Institutional or Professional eligibility benefit request. This topic describes how to stage your ANSI-271 files so that they are automatically archived and processed by PC-ACE Pro32, as well as the functions available for viewing, printing, maintaining and using the archived eligibility benefit response reports.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Eligibility Benefit Response Log" item is not visible on the "Maintain" menu when performing the steps described in this topic, then this capability is not available on your installation.

Staging Eligibility Benefit Response Files For Automatic Archiving

At program startup, PC-ACE Pro32 automatically scans separate Institutional and Professional "staging" directories looking for new ANSI-271 eligibility benefit response files to be archived. If any ANSI-271 files are present in the staging directories, they are checked for proper format and archived automatically. In addition, the individual responses are automatically posted to the original eligibility benefit requests. This automatic archive/post process is also performed when the **Eligibility Benefit Response Log** form is opened or when the user manually refreshes the Eligibility Benefit Response Log list (see next section for details).

On most PC-ACE Pro32 installations, the user will be required to manually copy the ANSI-271 files received from the claims processor into the appropriate staging directory. The Institutional and Professional staging directories are:

Institutional: winpcace\ansi271\eligub92

Professional: winpcace\ansi271\elig1500

For single-user installations, these directories will reside on the local drive letter to which PC-ACE Pro32 was originally installed. For multi-user "networked" installations, these directories will reside on the shared network drive letter to which PC-ACE Pro32 was originally installed.

Care must be taken to copy Institutional eligibility benefit response files to the Institutional staging directory, and Professional eligibility benefit response files to the Professional staging directory. In addition, if your claims processor assigns the same filename to all ANSI-271 files, you will need to make sure that the most recently staged eligibility benefit response file has been archived before copying a newer response file into the staging directory.

Installations that use data communications scripts to retrieve the ANSI-271 eligibility benefit response files may also automatically copy them to the appropriate staging directory. Your distributor should be able to confirm whether or not automatic ANSI-271 file staging will be performed on your installation.

Viewing, Printing & Maintaining Eligibility Benefit Response Files

Archived ANSI-271 eligibility benefit response files can be viewed and/or printed from the Eligibility Benefit Response Log form. To view a list of the currently archived ANSI-271 files, select the "**Maintain**" and "**Eligibility Benefit Response Log**" menu items on either the Institutional or Professional Claims Menu form. The following operations are available:

- To view and/or print an archived ANSI-271 response file report, select the desired record and click the "**View Response Report**" button (or double-click the desired record). The report may be printed from the preview form if desired.
- To delete an archived ANSI-271 file, select the desired record, click the "**Delete**" button, and confirm the deletion.

  By default, archived ANSI-271 eligibility benefit response files will be automatically purged after a certain number of days. Refer to the PC-ACE Pro32 Miscellaneous preferences topic for details on how to change the archive period (or disable automatic purging altogether, if desired).

  Once an archived ANSI-271 response file has been manually deleted or automatically purged, the individual responses for the eligibility benefit requests represented in this file will no longer be available. Be sure to set the ANSI-271 archive period such that eligibility benefit response files remain available long enough to meet your needs.
- To refresh the list of archived ANSI-271 files, click the "**Refresh**" button. The staging directory will be re-scanned for the presence of new ANSI-271 files. If new files are present in the staging directory, they will be checked for proper format, and automatically archived and posted. The displayed list will then be rebuilt to reflect the current archive contents.

  You can also right-click the mouse on the desired ANSI-271 archive record to access all available actions.

Using the Eligibility Benefit Response Reports

The ANSI-271 eligibility benefit response information is presented by PC-ACE Pro32 in a human-readable report format. The report presents general identification information along with the eligibility benefit inquiry details returned by the claims processor for all requests. Since the responses can be viewed for individual eligibility benefit requests from the Eligibility Benefit Request List Form, this report is typically used as a secondary reference source. There may be situations in which a response returned by the claims processor cannot be posted to the original eligibility benefit request. In these situations, you can refer back to this complete ANSI-271 eligibility benefit response report for the missing information. Contact your claims processor's support department for assistance in understanding the ANSI-271 report nomenclature and eligibility benefit code interpretation.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Eligibility Benefit Request List Form Features" topic for more information on adding and maintaining eligibility benefit requests.
- Refer to the "Preparing eligibility benefit request files for transmission" topic for information on creating ANSI-270 eligibility benefit request files to send to your claims processor.
- Refer to the "Viewing the eligibility benefit response for a specific request" topic for information on viewing the eligibility benefit response returned for a specific request.

Viewing the eligibility benefit response for a specific request

When **PC-ACE Pro32** archives an ANSI-271 eligibility benefit response file, certain access information is posted back to each individual eligibility benefit request represented in the response file. This stored access information makes it possible for users to view and print just the portion of the ANSI-271 response report that pertains to a single eligibility benefit request.

The patient eligibility benefit request/response capability may not be available on all installations. If the "Maintain Eligibility Benefit Requests" item is not visible on the "Maintain" menu when performing the steps described in this topic, then this capability is not available on your installation.

Responses for individual eligibility benefit requests can be accessed from the Eligibility Benefit Request List Form. Perform the following steps to access the request list form and view these response reports:

1) Click either the "**Institutional Claims Processing**" or "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the respective Claims Menu form.
2) From the Institutional or Professional Claims Menu form, select the "**Maintain**" and "**Maintain Eligibility Benefit Requests**" menu items to open the respective Eligibility Benefit Request List form.
3) In the Eligibility Request List Filter Options control group, click the "**Location:**" filter dropdown list and select the "**TR – submitted**" location entry. Response reports will only be available for eligibility benefit requests that have already been submitted (transmitted) .

   The Eligibility Benefit Request List Form displays a "**Reply?**" column at the far left when the "TR – submitted" location filter is selected. This column will contain the value "**Yes**" for eligibility benefit requests that have responses available.
4) Select the desired eligibility benefit request from the list. Then select the "**View Response For Selected Request**" item from the Eligibility Benefit List Form's main "**Actions**" menu (or from the convenient right-click popup menu) to preview the response report for this request. The report may be printed from the preview form if desired.

   The "View Response For Selected Request" item will be grayed if no response has been posted for the selected eligibility benefit request.

Eligibility benefit responses will be available for individual requests until the original archived ANSI-271 response file is manually deleted or automatically purged from the system. The user will be notified when an attempt is made to view a response which is no longer available. Be sure to set the ANSI-271 archive period such that eligibility benefit response files remain available long enough to meet your needs. The archive period can be adjusted from the PC-ACE Pro32 Miscellaneous preferences form.

Using the Eligibility Benefit Response Reports

The ANSI-271 eligibility benefit response information is presented by PC-ACE Pro32 in a human-readable report format. The report presents general identification information along with the eligibility benefit inquiry details returned by the claims processor for the selected

request. Contact your claims processor's support department for assistance in understanding the ANSI-271 report nomenclature and eligibility benefit code interpretation.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Eligibility Benefit Request List Form Features" topic for more information on adding and maintaining eligibility benefit requests.
- Refer to the "Preparing eligibility benefit request files for transmission" topic for information on creating ANSI-270 eligibility benefit request files to send to your claims processor.
- Refer to the "Viewing and maintaining eligibility benefit response files" topic for information on viewing and maintaining the ANSI-271 eligibility benefit response files returned by your claims processor.

Adding a new roster billing

New Professional roster billings can be added to **PC-ACE Pro32** using either of the following techniques:

- Select the "**New Roster Billing**" item from the Professional Claims Menu form's main "**Roster**" menu. The system will automatically create and display an empty roster billing form.
- Click the "**New**" button on the Roster Billing List Form. The system will automatically create and display an empty roster billing form. The new roster billing will automatically be selected in the list when it is saved.

Professional roster billings are manually entered on the "Professional Roster Billing Form". The data fields are typically entered in the order presented - from left-to-right and top-to-bottom. Enter the common roster billing information in the top section of the "Patient Info & General" tab. Enter patient-specific information for any number of patients in the lower section of this tab. Enter supplemental information on the "Extended Roster Info" tab if required. Edit validation errors may be encountered during this entry process if the data entered violates any of the predefined roster billing edits. Correct any such edit errors and click the "**Save**" button to save the roster billing. Roster billings containing unresolved edit errors may be saved if desired by clicking either the "**Save With Errors**" button (visible if only non-fatal errors exist) or "**Save With Fatal**" button (visible if any fatal errors exist). Only one of these buttons will be visible at any given time. If neither button is visible, then fatal errors exist on one or more key roster billing fields. These fatal edit errors must be corrected before the roster billing can be saved.

When a new Professional roster billing is created from the "**New Roster Billing**" menu item and saved error-free, you will be prompted to proceed automatically to the claim generation step. If you choose not to generate the claims at this time (or if the roster billing was saved with errors), you may generate the claims at a later time from the Roster Billing List Form.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional & Professional Claims Menus" topic for more information about the Claims Menu form.
- Refer to the "Roster Billing List Form Features" topic for details on using the Professional Roster Billing List form.
- Refer to the "Professional Roster Billing Form" topic for more information on using the Professional Roster Billing form.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Listing, modifying and maintaining roster billings

Professional roster billings in **PC-ACE Pro32** are listed, modified, generated, printed, and otherwise maintained from the Professional Roster Billing List Form. To access this form:

1) Click the "**Professional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the Professional Claims Menu form.
2) From the Professional Claims Menu form, select the "**Maintain Roster Billings**" item from the main "**Roster**" menu to open the Professional Roster Billing List Form.

All actions to be performed on a roster billing may be executed from the Roster Billing List form. Roster billings can be created, viewed/modified, copied, deleted/undeleted, and purged from the list. In addition, claims may be generated for a selected roster billing and the resulting roster billing report may be printed from this list. Refer to the "Roster Billing List Form Features" topic for complete details on the features and operation of the powerful Roster Billing List form.

Viewing & Modifying Roster Billings

Viewing and/or modifying existing roster billings from the Professional Roster Billing List form can be performed with these general steps:

1) Use the Roster Billing List form's sorting and filtering capabilities to locate the roster billing of interest in the list.
2) Select the desired roster billing in the list and click the "**View/Update**" button to display the roster billing details in the appropriate roster billing form. Alternatively, just double-click the desired roster billing record in the list.
3) Make all desired changes to the roster billing. Refer to the Professional Roster Billing Form topic for details on the many productivity enhancing features available on the powerful roster billing form.
4) When all changes have been made, click the "**Save**" button to save the roster billing record and close the form. Review and correct any edit validation errors as needed. Alternatively, click the "**Cancel**" (or "**Close**") button to cancel any pending roster billing changes.

Generating Roster Billing Claims

A roster billing defines both the common and patient-specific details required to create the corresponding set of claims. Once you are satisfied with the roster billing contents (and no fatal edit validation errors exist), you can "**generate**" claims for this roster billing using either of the following techniques:

- When a new Professional roster billing is created from the "**New Roster Billing**" menu item and saved error-free, you will be prompted to proceed automatically to the claim generation step.
- Claims for existing Professional roster billings can be generated from the Roster Billing List Form. To be eligible for generation, a roster billing must reside in the "to be generated" (RL) location and have a "clean" (CLN) or "has errors' (ERR) status. Select the desired roster billing record and click the "**Generate**" button (or choose the "**Generate Selected Roster**" action) to initiate the claim generation process.

You will be prompted to confirm your intent to generate claims for this roster billing. As the operation proceeds, running totals of the count and dollar value of all generated claims will be displayed on the Roster Claim Generation form. You will be notified when the claim generation operation completes. If desired, click the "**View Results**" or "**View Rejects**" buttons to view

reports of the successfully generated claims or rejected claims, respectively. These reports can be printed from the report previewer if desired. If any claim rejects occur during the generation process, the entire process will be reversed. Review the rejects report, correct the offense, and run the roster billing generation process again. Successfully generated roster billings will be moved automatically to the "generated" (GR) location.

The claim billing report for any previously generated roster billing may be previewed and/or printed by selecting the desired roster billing record in the "Roster Billing List Form" and choosing the "**View Selected Roster Report**" action.

PC-ACE Pro32 uses the claim import report preference settings to define the default reporting options for the roster billing generation process. Refer to the "Printing Preferences" topic for information on configuring claim import (and roster billing generation) reports to be printed automatically or to a specific printer.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Roster Billing List Form Features" topic for details on using the Professional Roster Billing List form.
- Refer to the "Professional Roster Billing Form" topic for more information on using the Professional Roster Billing form.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.
- Refer to the on-line help "**Common Claim Activities**" folder for hyperlinks to other claim-related topics of interest.

Adding a new Home Health Plan of Care

New Home Health Plans of Care can be added to **PC-ACE Pro32** using either of these techniques:

- Select the "**Attachments**" and "**New HH Plan of Care**" menu items on the Institutional Claims Menu form.
- Click the "**New**" button on the Home Health Plan of Care List form. This form can be accessed by selecting the "**Attachments**" and "**Maintain HH Plans of Care**" menu items on the Institutional Claims Menu form, or by clicking the "**Plan of Care**" button on the "**Patient**" tab of the Reference File Maintenance form. When creating the new Plan of Care from the patient listing, the Patient Control Number (PCN) and pertinent patient information for the currently selected patient will be completed automatically.

Plans of Care are entered on the "Home Health Plan of Care Form". The data fields are typically entered in the order presented - from left-to-right and top-to-bottom - on each tab of the Plan of Care form. Edit validation errors may be encountered during this entry process if the data entered violates any of the predefined Plan of Care edits. Correct any such edit errors and click the "**Save**" button to save the Plan of Care. Plans of Care containing unresolved edit errors may be saved if desired by clicking either the "**Save With Errors**" button (visible if only non-fatal errors exist) or "**Save With Fatal**" button (visible if any fatal errors exist). Only one of these buttons will be visible at any given time. If neither button is visible, then fatal errors exist on one or more key Plan of Care fields. These key fatal edit errors must be corrected before the Plan of Care can be saved.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional & Professional Claims Menus" topic for more information about the Institutional Claims Menu form.
- Refer to the "Home Health Plan of Care List Form Features" topic for details on using the Home Health Plan of Care List form.
- Refer to the "Home Health Plan of Care Form" topic for more information on using the Plan of Care entry form.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Listing, modifying and maintaining Plans of Care

Home Health Plans of Care in **PC-ACE Pro32** are listed, modified, and otherwise maintained from the Home Health Plan of Care List form. To access the Plan of Care List form:

1) Click the "**Institutional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the Institutional Claims Menu form.
2) From the Institutional Claims Menu form, select the "**Attachments**" and "**Maintain HH Plans of Care**" menu items to open the Home Health Plan of Care List form.

Most actions to be performed on a Plan of Care may be executed from the Plan of Care List form. Plans of Care can be created, viewed/modified, copied, deleted, and printed from the list. Refer to the "Home Health Plan of Care List Form Features" topic for complete details on the features and operation of the powerful Plan of Care List form.

Viewing & Modifying Plans of Care

Viewing and/or modifying existing plans from the Plan of Care List form can be performed with these general steps:

1) Use the Plan of Care List form's sorting and advanced filtering capabilities to locate the plan of interest in the list.
2) Select the desired plan in the list and click the "**View/Update**" button to display the plan details. Alternatively, just double-click the desired plan record in the list.
3) Make all desired changes to the Plan of Care. Refer to the "Home Health Plan of Care Form" topic for details on the many productivity enhancing features available on this powerful form.
4) When all changes have been made, click the "**Save**" button to save the Plan of Care record and close the form. Review and correct any edit validation errors as needed. Alternatively, click the "**Cancel**" (or "**Close**") button to cancel any pending plan changes.

Actions On Multiple Plans of Care

Many of the actions available in the Plan of Care List form are applicable to both single (selected) plans as well as groups of "checked" plans. This powerful multi-selection capability makes operating on groups of plans a snap! Simply use the Plan of Care List form's advanced filtering options to narrow the plan list contents down until it contains only the desired plans. Then select the "**Check All Plans of Care**" action from the main or popup menu to instantly mark (i.e., "check") all the plans of interest. A number of actions are available from the main or popup menu to operate on the entire group of plans in a single session. Refer to the "Home Health Plan of Care List Form Features" topic for complete details on selecting and acting on multiple plans at once.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Home Health Plan of Care List Form Features" topic for details on using the Plan of Care List form.
- Refer to the "Home Health Plan of Care Form" topic for more information on using the Plan of Care entry form.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Printing Home Health Plans of Care

Home Health Plans of Care are printed in **PC-ACE Pro32** using an advanced "image overlay" technique. This advanced method automatically overlays the plan field values onto a graphical image of the blank Plan of Care (CMS-485/486/487) form, resulting in a complete plan image that can be printed on stock paper. The image-overlay technique eliminates all the paper alignment headaches often associated with printing onto pre-printed forms.

Home Health Plan of Care printing requires that the free Adobe Acrobat Reader (Version 4.0 or later) be installed on your system. This reader is available for download from Adobe (www.adobe.com). When the Acrobat Reader is properly installed, PC-ACE Pro32 will automatically detect and configure the path to the ACRORD32.EXE program.

The steps involved in printing a Plan of Care (or a selection of plans) are as follows:

1) From the PC-ACE Pro32 Main Toolbar, click the "**Institutional Claims Processing**" button to open the Institutional Claims Menu form.

2) Select the "**Attachments**" and "**Maintain HH Plans of Care**" menu items to display the Home Health Plan of Care List form. All plan printing is performed from the Plan of Care list.

3) To print a single Plan of Care, simply select the desired plan from the list and select the "**Print Selected Plan of Care**" item from the Plan of Care List form's main "**Actions**" menu (or convenient right-click popup menu). The Home Health Plan of Care Print Options form will be displayed.

   To print a selection of plans, simply "check" the desired plans and select the "**Print All Checked Plans of Care**" item from the Plan of Care List form's main "**Actions**" menu. Refer to the "Home Health Plan of Care List Form Features" topic for more information on multiple-plan selection.

4) The Home Health Plan of Care Print Options form allows the user to override the default destination printer and to select the desired Plan of Care forms (i.e., CMS-485 only, CMS-486 only, or both if available). Click the "**Preview**" button to preview the plan(s) before printing. Click the "**Print**" button to print the plan(s) without previewing them.

   Plan of Care "previewing" employs the Adobe Acrobat Reader. Use the Acrobat Reader's "print" option to print a previewed plan. When you have previewed and optionally printed the plan, close the Acrobat Reader program. This will signal PC-ACE Pro32 that you are ready to continue.

   You will not be able to resume activities in PC-ACE Pro32 until the Acrobat Reader program has been exited. Simply closing the plan document within the reader is not enough to signal PC-ACE Pro32 to continue.

5) If you have selected multiple plans, they will be printed in sequence based on the current Plan of Care List form's "**Sort By:**" selection. A progress form will display details about the plan currently being printed. Click the "**Cancel**" button on this progress form to cancel the printing session following the plan currently being printed.

A Few Technical Notes

Here is some additional technical information that you need to know about printing Plans of Care in PC-ACE Pro32:

- One or more Home Health Plan of Care Addendum (CMS-487) forms will be printed automatically if needed to handle overflow from both the Home Health Certification And Plan of Care (CMS-485) and Medical Update And Patient Information (CMS-486) forms.
- Home Health Plan of Care printing will be available only if the Adobe Acrobat Reader (Version 4.0 or later) is properly installed on the system. You must exit PC-ACE Pro32 before installing the Acrobat Reader. A properly installed reader will be detected automatically the next time PC-ACE Pro32 is started. If necessary, you can manually configure the Acrobat Reader executable file (ACRORD32.EXE) path from the "**Misc**" tab of the PC-ACE Pro32 Preferences form.

  The Adobe Acrobat Reader has its own preference settings that will let you choose the initial document magnification level and get rid of the splash screen that is shown by default every time the reader is started.
- The default destination printer for Institutional Claims printing is also used as the Plan of Care default destination printer. This default can be set from the "**Printing**" tab of the PC-ACE Pro32 Preferences form. This default destination printer setting will be used during Plan of Care print operations unless overridden at print time from the Home Health Plan of Care Print Options form.

Adding a new Institutional Medical Attachment

New standalone Institutional Medical Attachments can be added to **PC-ACE Pro32** using either of these techniques:

- Select the "**Attachments**" and "**New Medical Attachment**" menu items on the Institutional Claims Menu form.
- Click the "**New**" button on the Institutional Medical Attachment List form. This form can be accessed by selecting the "**Attachments**" and "**Maintain Medical Attachments**" menu items on the Institutional Claims Menu form.

You will be prompted to select the desired attachment type. PC-ACE Pro32 supports the following standalone Institutional Medical Attachments:

- Outpatient Rehabilitation Plan of Treatment (Form 700)
- Outpatient Rehabilitation Plan of Treatment Update (Form 701)
- Ambulance Medical Data Attachment
- End Stage Renal Disease (ESRD) Attachment

Standalone Institutional Medical Attachments are entered on the appropriate "Institutional Medical Attachment Form" for the specified attachment type. The data fields are typically entered in the order presented - from left-to-right and top-to-bottom - on each tab of the Institutional Medical Attachment form. Edit validation errors may be encountered during this entry process if the data entered violates any of the predefined Institutional Medical Attachment edits. Correct any such edit errors and click the "**Save**" button to save the Institutional Medical Attachment. Institutional Medical Attachments containing unresolved edit errors may be saved if desired by clicking either the "**Save With Errors**" button (visible if only non-fatal errors exist) or "**Save With Fatal**" button (visible if any fatal errors exist). Only one of these buttons will be visible at any given time. If neither button is visible, then fatal errors exist on one or more key Institutional Medical Attachment fields. These key fatal edit errors must be corrected before the Institutional Medical Attachment can be saved.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional & Professional Claims Menus" topic for more information about the Institutional Claims Menu form.
- Refer to the "Institutional Medical Attachment List Form Features" topic for details on using the Institutional Medical Attachment List form.
- Refer to the "Institutional Medical Attachment Forms" topic for more information on using the Institutional Medical Attachment entry forms.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Listing, modifying and maintaining Institutional Medical Attachments

Standalone Institutional Medical Attachments in **PC-ACE Pro32** are listed, modified, and otherwise maintained from the Institutional Medical Attachment List form. To access the Institutional Medical Attachment List form:

1) Click the "**Institutional Claims Processing**" button on the PC-ACE Pro32 Main Toolbar to display the Institutional Claims Menu form.
2) From the Institutional Claims Menu form, select the "**Attachments**" and "**Maintain Medical Attachments**" menu items to open the Institutional Medical Attachment List form.

Most actions to be performed on an Institutional Medical Attachment may be executed from the Institutional Medical Attachment List form. Institutional Medical Attachments can be created, viewed/modified, copied, deleted, held/released and reactivated from the list. Refer to the "Institutional Medical Attachment List Form Features" topic for complete details on the features and operation of the powerful Institutional Medical Attachment List form.

Viewing & Modifying Institutional Medical Attachments

Viewing and/or modifying existing medical attachments from the Institutional Medical Attachment List form can be performed with these general steps:

1) Use the Institutional Medical Attachment List form's sorting and advanced filtering capabilities to locate the medical attachment of interest in the list.
2) Select the desired medical attachment in the list and click the "**View/Update**" button to display the medical attachment details. Alternatively, just double-click the desired medical attachment record in the list.
3) Make all desired changes to the medical attachment. Refer to the "Institutional Medical Attachment Forms" topic for details on the many productivity enhancing features available on this powerful form.
4) When all changes have been made, click the "**Save**" button to save the medical attachment record and close the form. Review and correct any edit validation errors as needed. Alternatively, click the "**Cancel**" (or "**Close**") button to cancel any pending medical attachment changes.

Actions On Multiple Institutional Medical Attachments

Many of the actions available in the Institutional Medical Attachment List form are applicable to both single (selected) medical attachments as well as groups of "checked" medical attachments. This powerful multi-selection capability makes operating on groups of medical attachments a snap! Simply use the Institutional Medical Attachment List form's advanced filtering options to narrow the list contents down until it contains only the desired medical attachments. Then select the "**Check All Attachments**" action from the main or popup menu to instantly mark (i.e., "check") all the medical attachments of interest. A number of actions are available from the main or popup menu to operate on the entire group of medical attachments in a single session. Refer to the "Institutional Medical Attachment List Form Features" topic for complete details on selecting and acting on multiple medical attachments at once.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Institutional Medical Attachment List Form Features" topic for details on using the Institutional Medical Attachment List form.
- Refer to the "Institutional Medical Attachment Forms" topic for more information on using the Institutional Medical Attachment entry forms.
- Refer to the "Claim & Reference File Edit Validation" topic for more information about the edit validation process and associated forms.

Preparing Institutional Medical Attachments for transmission

Medical attachment "**preparation**" in **PC-ACE Pro32** refers to the act of generating an Electronic Media Claims (EMC) file suitable for transmission to your claims processor. This EMC file will contain all relevant submission details for one or more processed Institutional claims and/or standalone medical attachments. Only Institutional medical attachments in the "to be transmitted" (CL) location are eligible for preparation. When a medical attachment is "prepared" into an EMC file, it is automatically moved to the "transmitted" (TR) location. Residence in the "transmitted" (TR) location reflects its transmitted state and also prevents the medical attachment from being inadvertently retransmitted.

Eligible Institutional medical attachments will be automatically included along with any eligible Institutional claims whenever a claim prepare operation is performed. If no eligible claims are present when the prepare operation is performed, then the EMC file will contain only the eligible Institutional medical attachments.

Like claims, Institutional medical attachments can be put on "hold" to prevent them from being inadvertently prepared and transmitted. See the "Institutional Medical Attachment List Form Features" topic for more information on holding (and releasing) Institutional medical attachments.

Some installations may require that Institutional claims and medical attachments always be prepared into separate EMC files. In such situations, the claims will always be prepared first. If medical attachments are also eligible for preparation, a warning to this effect will be presented at the end of the first prepare operation. Simply transmit the EMC file containing the claims and then perform a subsequent prepare operation to build a second EMC file containing the Institutional medical attachments.

Some installations may be configured to disallow preparation of Institutional medical attachments in ANSI-837 format. If your system is also configured to prepare Institutional claims in ANSI-837 format, then any eligible claims will always be prepared first (into the ANSI-837 format transmission file). Simply transmit the EMC file containing the claims and then perform a subsequent prepare operation to build a second EMC file in NSF format containing the Institutional medical attachments. In this scenario, the Institutional medical attachments will always be prepared in NSF format even if the default EMC file output format is set to ANSI-837.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Preparing claims for transmission" topic for more information on how to prepare claims and medical attachments.
- Refer to the "Transmitting electronic claim files" topic for more information on transmitting the prepared EMC file.
- Refer to the "Reactivating previously transmitted claims" topic to learn how transmitted claims can be selectively reactivated for re-transmission. The Institutional Medical Attachment List Form provides a similar reactivation capability for standalone medical attachments.
- Refer to the "Recovering from an interrupted claim prepare run" topic to see how PC-ACE Pro32 can recover from an interruption in the preparation process.

Common Reference File Procedures

Adding and maintaining patients

The "**Patient**" tab of the Reference File Maintenance form provides an interface to add and maintain patient information, including the patient's primary, secondary, and tertiary insured details. Setup of the Patient reference file is optional. If you choose to setup patients, the complete patient list will be accessible during claim entry using the variable-list lookup feature. When a patient is selected from the lookup list during claim entry, all applicable patient information will be automatically loaded into the appropriate claim form fields. The Patient tab provides a convenient "**Sort By**" selection that quickly sorts the patient list by "Patient PCN" or "Patient Name". Operations available include:

- To add a new patient record, click the "**New**" button and enter the new patient information.
- To view or modify an existing patient record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete an existing patient record, select the desired record, click the "**Delete**" button, and confirm the deletion.
- To display a list of the Home Health Plans of Care (POCs) on file for an existing patient record, select the desired record and click the "**Plan of Care**" button. See the "Listing, modifying and maintaining Plans of Care" topic for more information.

The Patient Information form provides several List Filter Options that can be helpful in locating specific patients. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Entering Patient Information

The Patient Information form provides access to a patient's details on the following information tabs:

- **General Information** - provides access to general patient information such as the patient's name, address, birthdate, and various status flags.
- **Extended Info** - provides access to extended patient information such as information on the patient's legal representative (Professional use only), the primary Provider ID (Institutional use only), and the Billing and Rendering Provider IDs (Professional use only).
- **Primary Insured** - provides access to the payer, insured, and employer information for the primary Institutional and/or Professional payer(s). If your system is licensed for both Institutional and Professional claim activities, then you will have the option to enter separate Institutional and Professional insured information. See the "Common vs. Separate Insured Information?" section below for details.
- **Secondary Insured** - provides access to insured information for the secondary Institutional and/or Professional payer(s). See the Primary Insured information bullet above for details.
- **Tertiary Insured** - provides access to insured information for the tertiary Institutional and/or Professional payer(s). See the Primary Insured information bullet above for details.

A number of fields on the Patient/Insured Information tabs support data entry via fixed-list or variable-list lookups. These lookup lists are accessed by right-clicking the mouse over

the field or pressing the "**F2**" key while focused on the field. Helpful "fly-over" hints are also available for many fields.

Saving & Canceling Patient Updates

After completing data entry on the Patient Information form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the form. Alternatively, click the "**Cancel**" button to abandon any changes and exit the form. During the patient save operation, an edit validation process is performed on all patient record fields. If no edit validation errors occur, the patient record is saved without further user intervention. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "fatal" and which are "non-fatal". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the reference file edit validation process and the Edit Validation Errors List form. If any fatal edit errors exist, you must correct them before the patient record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the patient record with errors. Click the "**Save With Errors**" button to save a patient record that contains only non-fatal errors. If edit validation errors occur, several "Save" attempts may be required to correct and save a "clean" patient record.

Common vs. Separate Insured Information?

NOTE: This discussion applies only if your system is licensed for both Institutional and Professional claim activities. If you are licensed for only a single claim type, the form controls described in this section will not even be visible in your system.

The Patient reference file is shared between Institutional and Professional claim activities. In terms of general patient information, this shared approach is satisfactory. However, it is quite possible that the "payer/insured" information will need to be different when an Institutional claim is billed for a patient versus when a Professional claim is billed for the same patient. For example, an Institutional Medicare claim requires that the submission payer have an "MCA" line of business (LOB), while a Professional Medicare claim requires a submission payer LOB of "MCB". In order to deal with this need for separate Institutional and Professional "payer/insured" information sets, the Patient Information form provides the "**Insured Information Options**" selection group. This selection group exists on each of the Insured tabs, and controls whether "common" or "separate" payer/insured information is required. The available selections include:

- **Common Inst & Prof** - When selected, instructs the system to maintain a single set of payer/insured information. The same payer/insured information will be brought forward into both Institutional and Professional claims during the patient lookup process.
- **Separate Inst & Prof** - When selected, instructs the system to maintain separate payer/insured information sets for Institutional and Professional use. The single Insured tab will be replaced by separate "(Inst)" and "(Prof)" Insured tabs. The appropriate payer/insured information will be brought forward into the Institutional or Professional claim during the patient lookup process.

The decision as to whether "common" or "separate" payer/insured information is required can be made separately for the primary, secondary, and tertiary Insured tabs.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Reference File Maintenance Form" topic for a discussion of the common reference file form features and filter options.

- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Adding and maintaining payers

The "**Payer**" tab of the Reference File Maintenance form provides access to maintain system payer information. Setup of the Payer reference file is mandatory (although it may be setup in advance by your distributor). Payers are accessible during claim entry using the variable-list lookup feature. When a payer is selected from the lookup list during claim entry, all applicable payer information will be automatically loaded into the appropriate claim form fields. Payers are uniquely defined by their Payer ID, Line of Business (LOB), and an optional "Usage" flag (see below). All payers referenced on claims must exist in the Payer reference file, with the exception of the special "dump" payer (Payer ID=99999). The Payer tab provides a convenient "**Sort By**" selection that quickly sorts the payer list by "Payer ID", "Payer Description", "Payer LOB" or "Payer State". Operations available include:

- To add a new payer record, click the "**New**" button and enter the new payer information.
- To view or modify an existing payer record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To create a new payer record that is similar to an existing record, select the desired payer record, click the "**Copy**" button, and change only the desired fields. This feature makes it easy to create multiple payer records for the same payer to support more than one line of business (LOB).
- To delete an existing payer record, select the desired record, click the "**Delete**" button, and confirm the deletion.

The Payer Information form provides several List Filter Options that can be helpful in locating specific payers. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Entering Payer Information

The Payer Information form provides access to a payer's identification fields (Payer ID, LOB, and Description), address information, control flags, and optional local fields (defined by the distributor). The available control flags are defined as follows:

- **Source** - indicates the national payment source code for this payer.
- **Edit Ind** - claim editing indicator assigned by the receiver to determine the adjudication program (Professional use only).
- **Media** - specifies whether the payer receives claims electronically or on paper. The media flag of a claim's "submission" payer will determine whether the claim is eligible for preparation into an EMC file or whether it must be submitted on paper.
- **Card** - setting used to govern payer-specific requirements (e.g., claim office requirements). Consult your distributor concerning the correct card setting for new payers.
- **Address** - indicates whether the payer address is a required for this payer.
- **Usage** - indicates whether the payer record is restricted for Institutional use only, Professional use only, or unrestricted use. This feature permits Payers for shared LOBs such as Commercial (COM) to optionally have distinct settings and PrintLink matching strings for Institutional versus Professional use. If the specified Payer LOB is valid for only one of these claim types, then the "Usage" value will be forced to the appropriate setting by the program.

A number of fields on the Payer Information tab support data entry via fixed-list or variable-list lookups. These lookup lists are accessed by right-clicking the mouse over

the field or pressing the "**F2**" key while focused on the field. Helpful "fly-over" hints are also available for many fields.

Saving & Canceling Payer Updates

After completing data entry on the Payer Information form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the form. Alternatively, click the "**Cancel**" button to abandon any changes and exit the form. During the payer save operation, an edit validation process is performed on all payer record fields. If no edit validation errors occur, the payer record is saved without further user intervention. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "fatal" and which are "non-fatal". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the reference file edit validation process and the Edit Validation Errors List form. If any fatal edit errors exist, you must correct them before the payer record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the payer record with errors. Click the "**Save With Errors**" button to save a payer record that contains only non-fatal errors. If edit validation errors occur, several "Save" attempts may be required to correct and save a "clean" payer record.

PrintLink Matching Descriptions

PrintLink refers to a unique process by which claims can be imported into PC-ACE Pro32 from print image files generated by the user's upstream system. Since the "Payer ID" field for a claim's primary, secondary, and tertiary payers is not available on the printed claim form, PC-ACE Pro32 uses a novel "matching" technique to map the "Payer Description" field (which is available on the printed claim) to the correct payer record in PC-ACE Pro32's Payer reference file. During the one-time Payer reference file setup process, one or more "matching strings" should be defined for each payer record. These matching strings are used exclusively to map print file Payer Descriptions to PC-ACE Pro32 Payer records during the PrintLink claim import process. Each PrintLink matching string must adhere to one of these 3 formats:

- **String ends with a "~" (tilde) character** - A match is found if the string appears anywhere in the claim's payer description field.
- **String ends with a "|" (vertical bar) character** - A match is found only if the string appears at the start of the claim's payer description field. The payer description may contain additional trailing characters not included in the matching string.
- **String ends with an alphanumeric character** - A match is found only if the string and the payer description field are identical. The 2 strings must be the same length and contain exactly the same characters in the same order.

All PrintLink matching string comparisons are case-insensitive.

Click the "**PrintLink Matching Descriptions**" button while viewing a payer's details to view/edit the PrintLink matching strings for the selected payer. Click the "**New**", "**Edit**", and "**Delete**" buttons to add, modify, and delete matching strings for the selected payer record, respectively. In addition to maintaining the selected payer's matching strings, the user also has the option to view all currently defined matching string (for all payers) in the order that they will be searched during the claim import process.

This form also provides a handy "**Test Match**" feature that allows the user to quickly identify which payer will be matched to a given print file payer description. To use the test match feature, select the "**Show all strings**" radio button, select either the "**Institutional**" or "**Professional**" radio button (if visible), and click the "**Test Match**" button. Enter the payer

description as it would appear on the printed claim and click the "**OK**" button. If a match is found, the matching string record will be highlighted in the list. You will be notified if no match is found.

Related Topics

The following hyperlinks provide additional information related to this topic:

- Refer to the "Reference File Maintenance Form" topic for a discussion of the common reference file form features and filter options.
- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Adding and maintaining providers (Institutional)

The "**Provider (Inst)**" tab of the Reference File Maintenance form provides access to maintain the providers to be referenced on Institutional claims. NOTE: If you are licensed for Institutional claim activities only, then this tab will be labeled simply "Provider". Setup of the Institutional Provider reference file is mandatory if you intend to process Institutional claims. All providers referenced on Institutional claims must be represented in this reference file. The Provider tab provides a convenient "**Sort By**" selection that quickly sorts the Provider list by "LOB", "Provider Name", "Provider ID", or "Tag". Operations available include:

- To add a new provider record, click the "**New**" button and enter the new provider's information. If providers already exist in this reference file, you will have the option to create a completely new provider record, or to inherit and associate the new provider record with the provider record currently selected in the list. Select the desired creation options and click the "**OK**" button to continue. See the discussion below for more information on provider "inheritance" and "association".
- To view or modify an existing provider record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete an existing provider record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

  Claims are linked to provider records by an internal control number. Deleting a provider record will irrevocably break any such links that may exist to claims in the system. The Provider Deletion Confirmation form will be displayed when you attempt to delete a provider record. This form outlines alternatives to deletion, and provides a convenient utility to determine how many claims reference the provider record to be deleted. Consider clearing the "**Include In Lookups?**" option on the Institutional Provider Information form as an alternative to deleting the provider.

The "Provider (Inst)" tab of the Reference File Maintenance form provides several list filter options that can be helpful in locating specific providers. Refer to the "Reference File Maintenance Form" topic for a discussion of these common filter options.

Entering Institutional Provider Information

The Institutional Provider Information form provides access to all Institutional provider fields. These fields are grouped logically on the following tabs:

- **General Info** - includes fields for the provider name, address, contact, and identification information (ID, LOB, Payer ID, and tax number).
- **Extended Info** - includes fields for any additional extended provider information (e.g., the "pay-to" provider name and address, if different).
- **Local Fields** - includes up to six additional "local" provider fields to be defined by the distributor. This tab will only be visible if the distributor has defined one or more of these local fields. Contact your distributor for completion details.

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between tabs.

Provider records are uniquely defined by the "Provider ID/No." (Provider ID) and "LOB" (Line of Business) fields, and optionally by the "Payer ID" field as well. These critical fields are defined as follows:

- **Provider ID/No.** - The provider identifier to be used on claims for the line of business specified in the "LOB" field.

- **LOB** - Specifies the line of business applicable to this provider record.
- **Payer ID** - An optional field that, if specified, identifies this provider record as "payer-specific" to the payer identified by this Payer ID.

The "LOB" field value is used to filter the list of providers presented to the user during claim entry lookup operations. Only provider records with an "LOB" value matching the LOB of the selected claim payer line will be available for selection.

If required, this provider record's "associations" may be maintained from this form using the "**Select**" (adds a new association) and "**None**" (deletes all associations) buttons adjacent to the "Provider Associations" listbox.

A number of fields on the Institutional Provider Information form support data entry via fixed-list or variable-list lookups. These lookup lists are accessed by right-clicking the mouse over the field or pressing the "**F2**" key while focused on the field. Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification. Helpful "fly-over" hints are also available for many fields.

Saving & Canceling Provider Updates

After completing data entry on the Institutional Provider Information form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the form. Alternatively, click the "**Cancel**" button to abandon any changes and exit the form. During the provider save operation, an edit validation process is performed on all provider record fields. If no edit validation errors occur, the provider record is saved without further user intervention. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List screen. This screen lists all the edit validation errors that have occurred, indicating which ones are "fatal" and which are "non-fatal". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the reference file edit validation process and the Edit Validation Errors List screen. If any fatal edit errors exist, you must correct them before the provider record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the provider record with errors. Click the "**Save With Errors**" button to save a provider record that contains only non-fatal errors. If edit validation errors occur, several "Save" attempts may be required to correct and save a "clean" provider record.

Provider Inheritance and Associations

PC-ACE Pro32 requires that each Institutional provider record be defined for a single line of business (LOB). As such, if a provider supports multiple LOBs, then separate records for each are required. This hierarchy results in greatly enhanced flexibility by allowing the user to define unique IDs and support information (addresses, etc) on a per-LOB basis. If necessary, provider records may even be defined such that the information is unique to a single payer within the LOB (by completing the "Payer ID" field on the Institutional Provider Information form).

In order to link provider records that represent the same entity, PC-ACE Pro32 has introduced the concept of provider "**associations**". For example, if Jones Memorial Hospital is an Institutional provider for Medicare Part A (MCA) and Blue Cross (BC) patients, two separate provider records must be added. However, since these 2 records really represent the same provider, they should be "associated" with each other. The Provider tab of the Reference File Maintenance form provides a convenient "inheritance" option that makes creation of associated provider records a snap. Simply click the "**New**" button and create the first Jones Memorial Hospital provider record from scratch (start with all fields blank), assign the "**MCA**" line of business, complete all applicable fields on the Institutional Provider Information form, and save the provider record. Then select the newly created provider record in the provider list

and click the "**New**" button again. When prompted, select the "**Inherit name/address information from the selected provider**" option. Also check the "**Associate the new provider with the selected provider**" checkbox and click the "**OK**" button. A duplicate of the selected provider will be created and displayed. Enter "**BC**" in the "LOB" field and save the new provider record. These provider records are now "associated" with each other to reflect that they represent the same entity. Repeat this "inherit and associate" process to create additional Jones Memorial Hospital provider records for other LOBs if desired. Associations are used during the claim preparation process to identify the various lines of business applicable to a specific provider.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Setup of Medicare Part A Systems" or "Setup of Institutional All-Payer Systems" topic for a suggested approach to initial setup of the provider reference file.
- Refer to the "Reference File Maintenance Form" topic for a discussion of the common reference file form features and filter options.
- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Adding and maintaining providers (Professional)

The "**Provider (Prof)**" tab of the Reference File Maintenance form provides access to maintain the providers to be referenced on Professional claims. NOTE: If you are licensed for Professional claim activities only, then this tab will be labeled simply "Provider". Setup of the Professional Provider reference file is mandatory if you intend to process Professional claims. All providers referenced on Professional claims must be represented in this reference file. The Provider tab provides a convenient "**Sort By**" selection that quickly sorts the Provider list by "LOB", "Type", "Provider/Group Name", "Provider ID", "Group Label", or "Tag". Operations available include:

- To add a new provider record, click the "**New**" button and enter the new provider's information. If providers already exist in this reference file, you will have the option to create a completely new provider record, or to inherit and associate the new provider record with the provider record currently selected in the list. Select the desired creation options and click the "**OK**" button to continue. See the discussion below for more information on provider "inheritance" and "association".
- To view or modify an existing provider record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete an existing provider record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

  Claims are linked to provider records by an internal control number. Deleting a provider record will irrevocably break any such links that may exist to claims in the system. The Provider Deletion Confirmation form will be displayed when you attempt to delete a provider record. This form outlines alternatives to deletion, and provides a convenient utility to determine how many claims reference the provider record to be deleted. Consider clearing the "**Include In Lookups?**" option on the Professional Provider Information form as an alternative to deleting the provider.

The "Provider (Prof)" tab of the Reference File Maintenance form provides several list filter options that can be helpful in locating specific providers. Refer to the "Reference File Maintenance Form" topic for a discussion of these common filter options.

Entering Professional Provider Information

The Professional Provider Information form provides access to all Professional provider fields. These fields are grouped logically on the following tabs:

- **General Info** - includes fields for the provider type, name, address, contact, identification (Provider or Group ID/No., LOB, Payer ID, Group Label, tax number), and other miscellaneous information.
- **Extended Info** - includes fields for any additional extended provider information (e.g., the "pay-to" provider name and address, if different).
- **Local Fields** - includes up to six additional "local" provider fields to be defined by the distributor. This tab will only be visible if the distributor has defined one or more of these local fields. Contact your distributor for completion details.

Click the appropriate tab or simply press the "**PAGE UP**" and "**PAGE DOWN**" keys to move between tabs.

The Professional provider structure defines 3 distinct provider types:

❖ **Group Practice** - Identifies the provider record as representing a group practice for billing purposes. When creating group provider records, the user must assign a unique "Group

Label" to identify the group. It is assumed that a group provider will be assigned members (see "Individual in Group" provider type below).

- **Individual in Group** - Identifies the provider record as representing an individual provider that is a member of one of the existing "group" providers (see "Group Practice" provider type above). When creating "individual in group" provider records, the user can select the desired "Group Label" from a lookup list of applicable group providers. Claims may not be billed directly to "individual in group" providers, rather these providers are specified as rendering providers on Professional claims.
- **Solo Practice** - Identifies the provider record as representing a solo practice provider. Solo practice providers are not associated with any provider group, and will bill claims directly.

Professional claims require a "billing" provider that can be either a "group" or "solo" provider (but not an "individual in group"). The Professional claim entry provider lookup and claim editing process will enforce this requirement.

Provider records are uniquely defined by the "Provider ID/No." (Provider ID) and "LOB" (Line of Business) fields, and optionally by the "Payer ID" field as well. These critical fields are defined as follows:

- **Provider ID/No.** (or **Group ID/No.** for "group" providers) - The provider (group) identifier to be used on claims for the line of business specified in the "LOB" field.
- **LOB** - Specifies the line of business applicable to this provider record.
- **Payer ID** - An optional field that, if specified, identifies this provider record as "payer-specific" to the payer identified by this Payer ID.

The "Provider Type" selection and "LOB" field value are used to filter the list of providers presented to the user during claim entry lookup operations. Only provider records with an "LOB" value matching the claim's LOB will be available for selection. Claim billing provider lookup lists will include only "group" and "solo" providers, while rendering provider lookup lists will include only "individual in group" providers.

If required, this provider record's "associations" may be maintained from this form using the "**Select**" (adds a new association) and "**None**" (deletes all associations) buttons adjacent to the "Provider Associations" listbox.

When setting up provider records for a group and its members, always create the "Group Practice" provider record(s) first. Associated group provider records must be created for each line of business (LOB) in which the group (or <u>any</u> of its members) will participate. Once the group provider records are in place, create "Individual in Group" provider records for each group member. Associated group member provider records must then be created for each line of business (LOB) in which the member will participate. Refer to the "Setup of Professional Systems" topic for a suggested approach to initial setup of the provider reference file.

A number of fields on the Professional Provider Information form support data entry via fixed-list or variable-list lookups. These lookup lists are accessed by right-clicking the mouse over the field or pressing the "**F2**" key while focused on the field. Type "**<ALT>F2**" (press the "**F2**" key while holding the "**ALT**" key down) to identify all fields that support a lookup list. Press the "**ESC**" key to disable the flashing notification. Helpful "fly-over" hints are also available for many fields.

Saving & Canceling Provider Updates

After completing data entry on the Professional Provider Information form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the form. Alternatively, click the "**Cancel**" button to

abandon any changes and exit the form. During the provider save operation, an edit validation process is performed on all provider record fields. If no edit validation errors occur, the provider record is saved without further user intervention. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List screen. This screen lists all the edit validation errors that have occurred, indicating which ones are "fatal" and which are "non-fatal". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the reference file edit validation process and the Edit Validation Errors List screen. If any fatal edit errors exist, you must correct them before the provider record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the provider record with errors. Click the "**Save With Errors**" button to save a provider record that contains only non-fatal errors. If edit validation errors occur, several "Save" attempts may be required to correct and save a "clean" provider record.

Provider Inheritance and Associations

PC-ACE Pro32 requires that each Professional provider record be defined for a single line of business (LOB). As such, if a provider supports multiple LOBs, then separate records for each are required. This hierarchy results in greatly enhanced flexibility by allowing the user to define unique IDs and support information (addresses, etc) on a per-LOB basis. If necessary, provider records may even be defined such that the information is unique to a single payer within the LOB (by completing the "Payer ID" field on the Professional Provider Information form).

In order to link provider records that represent the same entity, PC-ACE Pro32 has introduced the concept of provider "**associations**". For example, if John D. Solo is a Professional solo provider for Medicare Part B (MCB) and Blue Shield (BS) patients, two separate provider records must be added. However, since these 2 records really represent the same provider, they should be "associated" with each other. The Provider tab of the Reference File Maintenance form provides a convenient "inheritance" option that makes creation of associated provider records a snap. Simply click the "**New**" button and create the first John D. Solo provider record from scratch (start with all fields blank), assign the "**MCB**" line of business, complete all applicable fields on the Professional Provider Information form, and save the provider record. Then select the newly created provider record in the provider list and click the "**New**" button again. When prompted, select the "**Inherit name/address information from the selected provider**" option. Also check the "**Associate the new provider with the selected provider**" checkbox and click the "**OK**" button. A duplicate of the selected provider will be created and displayed. Enter "**BS**" in the "LOB" field and save the new provider record. These provider records are now "associated" with each other to reflect that they represent the same entity. Repeat this "inherit and associate" process to create additional John D. Solo provider records for other LOBs if desired. Associations are used during the claim preparation process to identify the various lines of business applicable to a specific provider.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Setup of Professional Systems" topic for a suggested approach to initial setup of the provider reference file.
- Refer to the "Reference File Maintenance Form" topic for a discussion of the common reference file form features and filter options.
- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Maintaining Codes & Miscellaneous Reference Files

Codes & Miscellaneous Reference Files Overview

The "**Codes/Misc**" tab of the Reference File Maintenance form provides access to many of the core **PC-ACE Pro32** reference files. Most of these files will be pre-loaded and ready for use when PC-ACE Pro32 is installed. Others are optional and will require setup before use. The buttons on this tab are grouped as "Shared" (Institutional and Professional), "Institutional" only and "Professional" only.

The following reference file topics apply to both Institutional and Professional claims:

- Submitter File Maintenance - maintain submitter identification and related information
- Data Communications File Maintenance - maintain data communications parameters
- HCPCS Codes File Maintenance - maintain HCPCS procedure codes and descriptions
- HCPCS Modifiers File Maintenance - maintain HCPCS procedure code modifiers, descriptions, and assignments
- ICD9 Codes File Maintenance - maintain ICD-9 diagnosis codes, procedure codes, and descriptions
- Physician (UPIN) File Maintenance - maintain the Physician (UPIN) file
- Provider Taxonomy Code File Maintenance - (MISC ANSI) maintain provider taxonomy codes and classification/specialization descriptions
- Claim Adjustment Reason Codes File Maintenance - (MISC ANSI) maintain claim adjustment reason codes and descriptions
- Remittance Remark Codes File Maintenance - (MISC ANSI) maintain remittance remark codes and descriptions
- Eligibility Request Service Type Codes File Maintenance - (MISC ANSI) maintain eligibility/benefit request service type codes and descriptions
- Claim Status Response Codes File Maintenance - (MISC ANSI) maintain claim status response codes and descriptions

The following reference file topics apply exclusively to Institutional claims:

- Type of Bill (TOB) File Maintenance - maintain TOB assignments and related information
- Condition/Occurrence/Span/Value Codes File Maintenance - maintain condition, occurrence, span and value codes, descriptions and assignments
- Revenue Codes File Maintenance - maintain revenue codes, descriptions, assignments, and related information

The remaining reference file topics apply exclusively to Professional claims:

- Place of Service (POS) File Maintenance - maintain POS codes, descriptions, and assignments
- Type of Service (TOS) File Maintenance - maintain TOS codes, descriptions, and assignments
- Facility File Maintenance - maintain facility information
- Charges Master File Maintenance - maintain charge master procedure codes, descriptions, and charge amounts
- Provider Specialty File Maintenance - maintain provider specialty codes and descriptions

Follow any of the hyperlinks above for more information about the purpose and maintenance of these core reference files.

Submitter File Maintenance

Submitter Information in **PC-ACE Pro32** is maintained from the Submitter Setup form for both Institutional and Professional claim types. Information from the Submitter reference file is required during preparation of Electronic Media Claims (EMC) files. As such, at least one default submitter record (LOB = "<<ALL>>" ; Payer ID = "<<ALL>>") must be created before claims can be prepared. Additional LOB/Payer-specific submitter records may also be created if required (see discussion later in this topic for more details).

If your installation is licensed for both Institutional and Professional claim activities, you must first select the appropriate claim type from the "**Institutional**" or "**Professional**" radio buttons near the top of this tab. If you are licensed for only one of these claim types, this selection will not be available.

The maintenance options available on this form include:

- To add a new submitter record, click the "**New**" button and enter the required submitter information.
- To view or modify an existing submitter record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To copy an existing submitter record, select the record to be copied from the list and click the "**Copy**" button. This copy feature provides a convenient means of creating new LOB/Payer-specific submitter records. Enter the desired LOB and/or Payer ID and make any other required changes to the copied fields.
- To delete a submitter record, select the desired record from the list, click "**Delete**" button, and confirm the deletion.

Entering Submitter Information

The Submitter Information form contains three tabs:

- **General** - specifies the LOB (line of business), Payer ID, submitter name, address and IDs.
- **Prepare** - specifies flags used to control the claim preparation process as well as information to be placed directly in the EMC transmission file. The currently defined prepare control fields include:
  - **Include Error Claims** - specifies whether claims with non-fatal errors will be included in the electronic transmission file by default. This default setting may be overridden when the claims are prepared.
  - **Submission Status** - specifies if the electronic transmission file will be flagged as a "Production" or a "Test" file by default. This default setting may be overridden when the claims are prepared.
  - **EMC Output Format** - specifies the default electronic file format. Currently supported formats include NSF and ANSI-837. This default setting may be overridden when the claims are prepared.
  - **Submission Type** (Professional only) - specifies the Submission Type code used in the EMC file header.
  - **Multiple Provider** (Institutional only) - specifies the Multiple Provider Billing File Indicator field value used in the EMC submitter record. A default value of "1" will be used if this field is left blank.

- **EMC Version** (Institutional only) - specifies the desired NSF version of the EMC file. For example, a value of "60" indicates that a NSF 6.0 output file should be generated.
- **EMC National Version** (Professional only) - specifies the desired NSF version of the EMC file. For example, a value of "00301" indicates that an NSF 3.01 output file should be generated.
- **EMC Local Version** (Professional only) - specifies a local version number required by some distributors.
- **ANSI Version (837)** - specifies the desired version of the ANSI-837 transmission file. You should change this value only under instructions from your distributor.
- **ANSI Version (270)** - specifies the desired version of the ANSI-270 eligibility benefit request file (if this feature is enabled on your installation). You should change this value only under instructions from your distributor.
- **ANSI Version (276)** - specifies the desired version of the ANSI-276 claim status request file (if this feature is enabled on your installation). You should change this value only under instructions from your distributor.
- **EMC File** - specifies the desired EMC filename using the standard DOS 8.3 naming convention. Leave this field blank to use the default EMC filename.
- **Vendor** - specifies an optional Vendor number required by some distributors.
- **Code No**. - specifies an optional Submitter Code Number required by some distributors.
- **Password** (Professional only) - specifies a submission password required by some distributors.
- **Acknowledge Request (NSF)** (Professional) - specifies whether or not a functional acknowledgment is requested for NSF transmissions. Some distributors require this option.
- **Intermediary** - specifies the unique Intermediary (distributor) identification number of the organization processing your electronic claims. This identifier is used to trigger distributor-specific claim prepare rules.
- **Next Serial No**. - specifies the next Serial Number to be assigned during the prepare process. This value is automatically updated each time claims are prepared.
- **Next File Seq.** (Institutional only) - specifies the next File Sequence Number to be assigned during the prepare process. This value is automatically updated each time claims are prepared.
- **Force Separate Prepare** – specifies whether or not claims for the LOB and/or Payer ID combination specified on this Submitter record are to be prepared separately from all other claims. Use this option to insure that restricted groups of claims are not inadvertently included in prepare runs containing claims outside of the restricted group. This advanced feature should typically be used only when instructed to do so by your distributor. The "Force Separate Prepare" option may not be available on all installations, and will not override any permanent prepare restrictions defined by the distributor.

- **ANSI Info** - specifies flags and data element values to be used exclusively during the preparation of transmission files in ANSI-837 format. The currently defined ANSI information fields include:
  - **Submitter Interchange ID Qualifier** - specifies the system/method of code structure used to designate the Submitter ID in all electronic interchanges. This qualifier

populates element ISA05 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file. The distributor will provide this qualifier if required.

- **Receiver Interchange ID Qualifier** - specifies the system/method of code structure used to designate the Receiver ID in all electronic interchanges. This qualifier populates element ISA07 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file. The distributor will provide this qualifier if required.
- **Authorization Info** - specifies optional Interchange Sender Authorization or identification information. This value populates element ISA02 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file.
- **Security Info** - specifies optional Interchange Sender Security information. This value populates element ISA04 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file.
- **Acknowledgment Requested** – specifies whether or not an interchange acknowledgment (TA1) is requested. This value populates element ISA14 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file. You should change this value only under instructions from your distributor.
- **Additional EDI Submitter Contact Information** – specifies up to three (3) additional EDI communication.numbers for the person in the submitter organization who deals with data transmission issues. Each number has a corresponding "type" field to identify the number's purpose. This information populates the "Submitter EDI Contact Information" (PER) segment in the ANSI-837 format EMC file.

  Use the "TE – Telephone" and "FX – Facsimile" contact types only if an alternate phone/fax number is needed. The primary phone and/or fax number should always be entered in the fields provided on the "General" tab.

- **ANSI Info (2)** - specifies optional data element override values to be used exclusively during the preparation of transmission files in ANSI-837 format. Leave these override fields empty for default ANSI-837 processing. You should change these values only under instructions from your distributor. The currently defined ANSI-837 override fields include:
  - **Interchange Sender ID (ISA06)** - specifies the Interchange Sender ID override value. This value populates element ISA06 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file.
  - **Interchange Receiver ID (ISA08)** - specifies the Interchange Receiver ID override value. This value populates element ISA08 of the Interchange Control Header (ISA) segment in the ANSI-837 format EMC file.
  - **Application Sender's Code (GS02)** - specifies the Application Sender's Code override value. This value populates element GS02 of the Functional Group Header (GS) segment in the ANSI-837 format EMC file.
  - **Application Receiver's Code (GS03)** - specifies the Application Receiver's Code override value. This value populates element GS03 of the Functional Group Header (GS) segment in the ANSI-837 format EMC file.
  - **Submitter Primary Identifier (NM109/1000A)** - specifies the Submitter Primary Identifier override value. This value populates element NM109 of the Submitter Name (NM1) segment in the Submitter Name (1000A) loop in the ANSI-837 format EMC file.

- **Receiver Name (NM103/1000B)** - specifies the Receiver Name override value. This value populates element NM103 of the Receiver Name (NM1) segment in the Receiver Name (1000B) loop in the ANSI-837 format EMC file.
- **Receiver Primary Identifier (NM109/1000B)** - specifies the Receiver Primary Identifier override value. This value populates element NM109 of the Receiver Name (NM1) segment in the Receiver Name (1000B) loop in the ANSI-837 format EMC file.

- **ANSI Info (3)** - specifies optional data element override values to be used exclusively during the preparation of patient eligibility/benefit request files in ANSI-270 format. This tab will only be available if the ANSI-270/271 Eligibility Benefit Request/Response feature is enabled on your installation. Leave these override fields empty for default ANSI-270 processing. You should change these values only under instructions from your distributor. The currently defined ANSI-270 override fields include:
  - **Intchg Sender ID/Qual (ISA06/05)** - specifies the Interchange Sender ID and ID Qualifier override values. These values populate elements ISA06 and ISA05 of the Interchange Control Header (ISA) segment in the ANSI-270 format EMC file, respectively.
  - **Intchg Receiver ID/Qual (ISA08/07)** - specifies the Interchange Receiver ID and ID Qualifier override values. These values populate elements ISA08 and ISA07 of the Interchange Control Header (ISA) segment in the ANSI-270 format EMC file, respectively.
  - **Application Sender's Code (GS02)** - specifies the Application Sender's Code override value. This value populates element GS02 of the Functional Group Header (GS) segment in the ANSI-270 format EMC file.
  - **Application Receiver's Code (GS03)** - specifies the Application Receiver's Code override value. This value populates element GS03 of the Functional Group Header (GS) segment in the ANSI-270 format EMC file.
- **ANSI Info (4)** - specifies optional data element override values to be used exclusively during the preparation of claim status request files in ANSI-276 format. This tab will only be available if the ANSI-276/277 Claim Status Request/Response feature is enabled on your installation. Leave these override fields empty for default ANSI-276 processing. You should change these values only under instructions from your distributor. The currently defined ANSI-276 override fields include:
  - **Intchg Sender ID/Qual (ISA06/05)** - specifies the Interchange Sender ID and ID Qualifier override values. These values populate elements ISA06 and ISA05 of the Interchange Control Header (ISA) segment in the ANSI-276 format EMC file, respectively.
  - **Intchg Receiver ID/Qual (ISA08/07)** - specifies the Interchange Receiver ID and ID Qualifier override values. These values populate elements ISA08 and ISA07 of the Interchange Control Header (ISA) segment in the ANSI-276 format EMC file, respectively.
  - **Application Sender's Code (GS02)** - specifies the Application Sender's Code override value. This value populates element GS02 of the Functional Group Header (GS) segment in the ANSI-276 format EMC file.
  - **Application Receiver's Code (GS03)** - specifies the Application Receiver's Code override value. This value populates element GS03 of the Functional Group Header (GS) segment in the ANSI-276 format EMC file.
  - **Payer ID/Qual (NM109/08/2100A)** - specifies the Payer Primary Identifier and ID Qualifier override values. These values populate elements NM109 and NM108 of the

Payer Name (NM1) segment in the Payer Name (2100A) loop in the ANSI-276 format EMC file, respectively.

- **Info Rcvr ID/Qual (NM109/08/2100B)** - specifies the Information Receiver Primary Identifier and ID Qualifier override values. These values populate elements NM109 and NM108 of the Information Receiver Name (NM1) segment in the Information Receiver Name (2100B) loop in the ANSI-276 format EMC file, respectively.

- **Local fields** - specifies up to six additional submitter fields to be defined by the distributor. This tab will only be visible if the distributor has defined one or more of these local fields. Contact your distributor for completion details.

A number of fields on the Submitter Information form support data entry via fixed-list and variable-list lookups. These lookup lists are accessed by right-clicking the mouse over the field or pressing the "**F2**" key while focused on the field.

You should add and/or modify submitter information only under the supervision of your distributor or an authorized technical support specialist. Incorrectly configuring submitter records will result in EMC file incompatibilities.

Saving & Canceling Submitter Updates

After completing data entry on the Submitter Information form, click the "**Save**" button (or type "**<ALT>S**") to save and exit the form. Alternatively, click the "**Cancel**" button to abandon any changes and exit the form. During the submitter save operation, an edit validation process is performed on all submitter record fields. If no edit validation errors occur, the submitter record is saved without further user intervention. If, however, one or more edit validation errors occur, you will be presented with the Edit Validation Errors List form. This form lists all the edit validation errors that have occurred, indicating which ones are "fatal" and which are "non-fatal". Refer to the "Claim & Reference File Edit Validation" topic for a more complete discussion of the reference file edit validation process and the Edit Validation Errors List form. If any fatal edit errors exist, you must correct them before the submitter record can be saved. If only non-fatal edit errors exist, you will have the option to correct the errors or save the submitter record with errors. Click the "**Save With Errors**" button to save a submitter record that contains only non-fatal errors. If edit validation errors occur, several "Save" attempts may be required to correct and save a "clean" submitter record.

LOB/Payer-Specific Submitter Records

In addition to the default submitter record, the Submitter Setup form allows you to create submitter records that are specific to a particular line-of-business (LOB), a particular Payer ID, or a combination of LOB and Payer ID. This feature provides flexibility in cases where the submitter information to be included in the EMC file varies depending on the LOB and/or Payer ID. For example, you might use this feature if you are required to prepare and submit your Medicare (MCA/MCB) claims to a different claims processor than claims for other LOBs. Likewise, you might have a requirement to define unique submitter identification information (Submitter ID, address, etc) for a specific LOB and Payer ID combination.

When the prepare process generates a new submitter record, the Submitter reference file is searched for the most specific match available. For example, assume that a Submitter reference file record for LOB = "MCA" and Payer ID = "12345" is defined (in addition to the always-present default record which has empty LOB and Payer ID values). When the EMC file submission header for a batch of "MCA" claims for Payer ID "12345" is to be built, then the information in this "MCA/12345-specific" reference file record will be used. Submission

headers for claims with LOB = "MCA" and Payer IDs other than "12345" (as well as claims for all other LOBs) will use the default Submitter reference file record.

If desired, the "Intermediary" value may be specified on LOB-specific and/or Payer-specific submitter records. This feature is useful to control custom prepare and claim-printing rules defined by a particular distributor. If the "Intermediary" value is left blank (default value) on an LOB-specific and/or Payer-specific submitter record, then the value specified on the next least-specific submitter record will be used. The "Intermediary" value on the default submitter record serves as the "last resort" value. The "Intermediary" values should be modified only when directed to do so by your distributor.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Preparing claims for transmission" topic for more information on preparing electronic claim files.
- Refer to the "Reference File Maintenance Form" topic for a discussion of the common reference file form features and filter options.
- Refer to the "Claim & Reference File Edit Validation" topic for a discussion of the edit validation process.

Data Communications File Maintenance

Data communications information in **PC-ACE Pro32** is maintained from the Data Communications Setup form for both Institutional and Professional claim types. This reference file defines the data communication parameter values to be made available to an external data communications program.

If your installation is licensed for both Institutional and Professional claim activities, you must first select the appropriate claim type from the "**Institutional**" or "**Professional**" radio buttons near the top of this tab. If you are licensed for only one of these claim types, this selection will not be available.

The Data Communications Setup form provides the following maintenance options:

- To add a new data communications record, click the "**New**" button and enter the desired information on the Data Communication Information form.
- To view or modify an existing data communications record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To copy an existing data communications record, select the desired record from the list and click the "**Copy**" button. The copy feature provides a convenient means of creating new LOB-specific or LOB/Payer-specific data communications records. Enter the desired LOB (and optional Payer ID) and make any other required changes to the copied fields.
- To delete an existing data communications record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

Entering Data Communications Information

The Data Communication Information Form contains three tabs:

- **General** - specifies the LOB, optional Payer ID and a description of this data communications record.
- **Host Info** - specifies up to 3 distributor defined data communications variables as well as several "Host Phone" fields. The distributor receiving your electronic claims transmission will define the communications variable names and content requirements.
- **Local** - specifies up to six additional data communications fields to be defined by the distributor. This tab will only be visible if the distributor has defined one or more of these local fields. Contact your distributor for completion details.

You should add and/or modify data communications information only under the supervision of your distributor or an authorized technical support specialist. Incorrectly configuring data communications records will result in EMC file transmission problems.

LOB & Payer-Specific Data Communications Records

In addition to the default record, the Data Communications Setup form allows you to create data communications records that are specific to a particular line-of-business (LOB) or a specific LOB/Payer combination. This feature provides flexibility in cases where the claims for specific LOBs and/or payers must be transmitted to different locations. For example, you might use this feature if you are required to prepare and submit your Medicare (MCA/MCB) claims to a different physical location than claims for other LOBs. Read the Data Communications Control File section below to see how these specific data communications records are used.

The Data Communications Control File

Transmission of the electronic claim files generated by PC-ACE Pro32 will be performed by a third party communications package. The Data Communications Options form provides "launch" buttons by which users can initiate claims transmission, terminal emulation sessions, or any other data communication function defined by your distributor. Each time any of these data communications launch buttons are clicked, PC-ACE Pro32 automatically creates a **Data Communications Control File** containing applicable parameters from the Data Communications reference file. This control file will be located in the server's "**winpcace**" directory, and will be named "**bcdatcom.dat**" for Institutional claim activities and "**bsdatcom.dat**" for Professional claim activities.

Actually, both the Institutional and Professional Data Communications Control Files are created each time any of the launch buttons are clicked. This approach relieves PC-ACE Pro32 from needing to know whether a certain launch button is configured as an Institutional activity, a Professional activity, or an activity common to both claim types. If your system is licensed for a single claim type, then only the appropriate control file will be created.

The Data Communications Control File can be read by the external data communications program to obtain the needed transmission parameters (phone number, password, etc.). The layout of this control file is defined in a separate document, and is available to distributors or facilities developing their own data communications scripts.

As explained earlier in this topic, the Data Communications reference file supports multiple records defined for specific LOB and/or LOB/Payer combinations. For example, a Data Communications record can be defined for LOB = "MCA" and Payer = "00190". Another might be defined for LOB = "MCA" and no Payer (i.e., left empty). The Data Communications Control File will be built using data from the record that most precisely describes the filter options used to prepare the current EMC file. For example, if the last EMC file was prepared to include only claims for LOB = "MCA" and Payer ID = "00190", then the Data Communications reference file will be searched for a record specific to this LOB/Payer combination. Since this record exists in our example, it would serve as the source for the data communications parameters written to the control file. If instead, the last EMC file was prepared for LOB = "MCA" and any other Payer ID (or all payers), then the Data Communications reference file record for LOB = "MCA" and Payer = "" (unspecified) would be used. Finally, if the last EMC file was build with no filter selections, or with and LOB selection of anything other than "MCA", then the default Data Communication reference file record (LOB = "" and Payer = "") would be used.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Preparing claims for transmission" topic for more information on preparing electronic claim files.
- Refer to the "Transmitting electronic claim files" topic for a typical example of how the data communications launch facility can be used.
- Refer to the "Data Communication Preferences" topic for information on configuring the Data Communication Options form "launch" buttons.

HCPCS Codes File Maintenance

The HCPCS Codes form provides an interface to maintain the HCPCS codes used in **PC-ACE Pro32**. Separate database files are used to maintain "global" versus "local" HCPCS codes. Global HCPCS codes are maintained and updated by your distributor. Changes to global HCPCS codes should be rare, and should always be performed under a distributor's supervision. Local HCPCS codes, if any, can be maintained by the distributor or user and include any additional HCPCS codes valid in your area (but not included in the global list). Select the "**Global codes**" or "**Local codes**" radio button to display the desired list. Then perform one of the following functions.

- To add a new HCPCS code, click the "**New**" button and enter the new HCPCS code information. Enter the effective date range using a 4-digit year format.
- To view or modify an existing HCPCS code, select the desired code from the list and click the "**View/Update**" button (or double-click on the desired code).
- To delete an existing HCPCS code, select the desired code from the list, click the "**Delete**" button, and confirm the deletion.

The HCPCS Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Effective Date Range

The Effective Date Range dates are compared to the claim's date of service range during the claim edit validation process. If the effective date range for a HCPCS code falls outside the claim's service date range, an edit validation error will be reported. If the effective date range is left blank, the HCPCS code is valid for all dates of service. If the start date is completed but the end date is left blank, the HCPCS is valid for all dates of service from (and including) the start date forward. If the start date is left blank but the end date is completed, the HCPCS code is valid for all dates of service up to (and including) the end date.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "HCPCS Modifiers File Maintenance" topic for information on maintaining HCPCS code modifiers and their assignments.

HCPCS Modifiers File Maintenance

The HCPCS Modifiers form provides an interface to maintain the HCPCS modifiers and their assignments. HCPCS modifiers and assignments are pre-loaded and should require minimal maintenance. The HCPCS Modifiers form includes two tabs:

- **Descriptions** - displays a list of HCPCS modifiers and their descriptions. Maintenance operations available include:
  - To add a modifier, click the "**New**" button and enter the new modifier information. Enter the effective date range using a 4-digit year format.
  - To view or modify an existing HCPCS modifier, select the desired modifier from the list and click the "**View/Update**" button (or double-click the desired HCPCS modifier in the list).
  - To delete a HCPCS modifier, select the desired modifier from the list, click the "**Delete**" button, and confirm the deletion.
- **Assignments** - defines the list of valid modifiers for each line of business (LOB). These assignments will also determine which modifiers will be included in the modifier lookup lists presented during claim entry. The modifier assignment maintenance options include:
  - **Select LOB** - filters the assignment list to include only assignments for a specific line of business. When a specific LOB is selected, it will be used as the default LOB for new HCPCS modifier assignments.
  - To add a new modifier assignment, click the "**New**" button on the Assignments tab. On the HCPCS Modifier Assignment form, select (or change) the LOB and select a valid modifier from the drop-down list. Specify the claim type(s) for which this LOB/modifier assignment is to be considered valid. The validity selections are defined as follows:
    - **Valid for Inst claims** - specifies whether the modifier is valid for use on Institutional claims for the specified LOB.
      - ☑ When checked, the modifier will be considered valid for use on Institutional claims for the specified LOB. This modifier will be included in claim entry lookup lists for the specified LOB. The validity of this modifier may also be checked during the claim edit validation process.
      - ☐ When unchecked, the modifier will not be considered valid for use on Institutional claims for the specified LOB.
    - **Valid for Prof claims** - specifies whether the modifier is valid for use on Professional claims for the specified LOB.
      - ☑ When checked, the modifier will be considered valid for use on Professional claims for the specified LOB. This modifier will be included in claim entry lookup lists for the specified LOB. The validity of this modifier may also be checked during the claim edit validation process.
      - ☐ When unchecked, the modifier will not be considered valid for use on Professional claims for the specified LOB.
  - To view or modify an existing HCPCS modifier assignment, select the desired modifier from the list and click the "**View/Update**" button (or double-click the desired HCPCS modifier). Only the "**Valid**" flags may be modified.
  - To delete a HCPCS modifier assignment, select the desired modifier assignment from the list, click the "**Delete**" button, and confirm the deletion.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "HCPCS Codes File Maintenance" topic for information on maintaining HCPCS codes.

ICD9 Codes File Maintenance

The ICD9 Codes form provides an interface to maintain the ICD-9 diagnosis and procedure codes used in **PC-ACE Pro32**. These codes are pre-loaded and should not require frequent additions or modifications. Select the desired radio button to display either the "**Diagnosis codes**" list or the "**Procedure codes**" list. The following maintenance options are available:

- To add a new ICD-9 code, click the "**New**" button and enter the new code's information. Enter the effective date range using a 4-digit year format.
- To view or modify an existing ICD-9 code, select the desired code from the list and click the "**View/Update**" button (or double-click the selected ICD-9 code).
- To delete an ICD-9 code, select the desired code from the list, click the "**Delete**" button, and confirm the deletion.

The ICD9 Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Effective Date Range

The Effective Date Range dates are compared to the claim's date of service range during the claim edit validation process. If the effective date range for an ICD-9 code falls outside the claim's service date range, an edit validation error will be reported. If the effective date range is left blank, the ICD-9 code is valid for all dates of service. If the start date is completed but the end date is left blank, the ICD-9 code is valid for all dates of service from (and including) the start date forward. If the start date is left blank but the end date is completed, the ICD-9 code is valid for all dates of service up to (and including) the end date.

Physician (UPIN) File Maintenance

The Physician Setup form provides an interface to maintain the optional Physician (UPIN) reference file. The list of physicians (and associated ID / UPIN, address, and miscellaneous information) is made available via lookups to speed the claim entry process. The following maintenance operations can be performed:

- To add a new Physician record, click the "**New**" button and enter the new physician information.
- To view or modify an existing Physician record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete a Physician record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

A convenient "**Sort By**" feature quickly sorts the Physician's list by "Name" or "Physician ID". The Physician Setup form also provides several **List Filter Options** that can be helpful in locating specific physician records. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Type of Bill (TOB) File Maintenance

The Type of Bill (TOB) Codes form provides an interface to maintain the Type of Bill (TOB) codes used in **PC-ACE Pro32**. TOB codes apply exclusively to Institutional claims. The TOB codes are pre-loaded and should not require frequent additions or modifications. The following maintenance operations can be performed:

- **Select LOB** - filters the list to include only valid TOBs for a specific line of business. When a specific LOB is selected, it will be used as the default LOB for new TOB code assignments.
- To add a new TOB record, click the "**New**" button and enter the new TOB information. On the Type of Bill (TOB) Information form, select (or change) the LOB in the drop-down list and enter a valid TOB (first 2 positions only). Identify the TOB assignment as either "**Inpatient**" or "**Outpatient**" by selecting the appropriate Patient Category radio button.
- To delete a TOB record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

To modify an existing TOB record, you must delete the existing record and add a new record with the correct information.

Condition/Occurrence/Span/Value Codes File Maintenance

The Condition/Occurrence/Span/Value Codes form provides an interface to maintain the condition/occurrence/span/value codes and assignments. This reference file applies exclusively to Institutional claims. These codes are pre-loaded and should not require frequent additions or modifications. The Condition/Occurrence/Span/Value Codes form includes two tabs:

- **Descriptions** - displays a list of Condition/Occurrence/Span/Value codes and descriptions. Maintenance operations available include:
  - **Type** - filters the Condition/Occurrence/Span/Value code list to include only those codes of the specified type.
  - To add a Condition/Occurrence/Span/Value code, click the "**New**" button and enter the new code information.
  - To view or modify an existing Condition/Occurrence/Span/Value code record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
  - To delete a Condition/Occurrence/Span/Value Code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
- **Codes/TOB** - displays a list of valid code assignments for specific Line of Business (LOB), code type, and Type of Bill (TOB) combinations. Code assignments for a specific code type (Condition, Occurrence, Span, or Value) are made for each applicable LOB/TOB combination. These assignments are used to filter the code lookup lists during Institutional claim entry and to define the acceptable list of codes during the claim edit validation process. To display the current list of valid code assignments for a specific LOB/TOB combination, select the desired LOB, Type, and TOB. After a selection is made, the maintenance operations available will include:
  - To add a Condition/Occurrence/Span/Value code assignment record for the selected LOB/Type/TOB combination, click the "**New**" button and select the new code from the drop-down list.
  - To delete a code assignment record for the selected LOB/Type/TOB combination, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
  - To delete all code assignment records for the selected LOB/Type/TOB combination, click the "**Delete All**" button, and confirm the deletion.
  - To copy an existing set of code assignment records from a specified source LOB/Type/TOB combination into the assignment list for the currently specified LOB/Type/TOB combination, select the desired destination LOB/Type/TOB and click the "**Copy**" button. Select the code assignments set from which to copy on the Code Assignments Copy Source form, click the "**Copy**" button, and confirm the copy request. If required, you may then add/delete code assignment records to/from the newly created list.

The TOB drop-down list on the Codes/TOB tab will include only valid TOBs for the selected LOB. Refer to the "Type of Bill (TOB) File Maintenance" topic for information on maintaining the list of valid TOBs for each line of business.

Revenue Codes File Maintenance

The Revenue Codes form provides an interface to maintain the revenue codes used in **PC-ACE Pro32**. Revenue codes apply exclusively to Institutional claims. They are pre-loaded and should require minimal maintenance. The Revenue Code form displays the current list of revenue codes, their descriptions and an indication of whether or not revenue code assignment details exist for this code. Maintenance operations available include:

- To add a revenue code, click the "**New**" button and enter the new revenue code information. Enter the effective date range using a 4-digit year format.
- To view or modify an existing revenue code record, select the desired record from the list and click the "**View/Update**" button (or double-click the desired record).
- To delete a revenue code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
- To view revenue code assignment details, select the desired record from the list and click the "**TOB Detail**" button. See the "Revenue Code Assignments" discussion later in this topic for more information.

The Revenue Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Effective Date Range

The Effective Date Range dates are compared to the claim's date of service range during the claim edit validation process. If the effective date range for a revenue code falls outside the claim's service date range, an edit validation error will be reported. If the effective date range is left blank, the revenue code is valid for all dates of service. If the start date is completed but the end date is left blank, the revenue code is valid for all dates of service from (and including) the start date forward. If the start date is left blank but the end date is completed, the revenue code is valid for all dates of service up to (and including) the end date.

Revenue Code Assignments

The Revenue Code Assignments form provides an interface to maintain optional assignment details for a specific revenue code. If no details exist for a specific revenue code, then the code will be considered valid for all LOBs and the various flags (described below) will assume their default values. Maintenance operations available on the Revenue Code Assignments form include:

- To add a new revenue code assignment record, click the "**New**" button and enter the desired information on the Revenue Code Assignment Information form.
- To view or modify an existing revenue code assignment record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete a revenue code assignment record, select the desired record, click the "**Delete**" button, and confirm the deletion.
- To copy all revenue code assignments records from another revenue code, click the "**Copy**" button and enter the revenue code from which the assignment records are to be copied. This feature makes it easy to duplicate assignment record sets from one revenue code to another.

The Revenue Code Assignments Information form provides the following assignment detail fields:

- **LOB** - specifies the Line of Business (LOB) for which this assignment applies. If the "<< All LOBs >>" option is selected, then this assignment will apply to all LOBs.
- **TOB** - specifies the Type of Bill (TOB) for which this assignment applies. If this field is left blank, then this assignment will apply to all TOBs. Only the first 2 characters of the TOB are required.

  Two special TOB values are available to make it easier to define Revenue Code Assignments applicable to inpatient or outpatient claims. Enter "**IP**" in the TOB field to indicate that the assignment applies to all "inpatient" TOBs. Alternatively, enter "**OP**" in this field to indicate that the assignment applies to all "outpatient" TOBs. The inpatient/outpatient designations for all TOBs are defined in the Type of Bill (TOB) Maintenance File. Revenue Code Assignments that use these special inpatient/outpatient designators will automatically adapt to changes in the Type of Bill Maintenance File.
- **Control Settings** - includes control flags which describe the assignment as follows:
  - **Valid** - Determines the validity of the revenue code for claims having the specified LOB/TOB combination. (Default = Valid)
    - ☑ When checked, the revenue code is valid for claims having the specified LOB/TOB combination.
    - ☐ When unchecked, the revenue code is not valid for claims having the specified LOB/TOB combination. The remaining Control Setting flags will be ignored.
  - **Required Flags** - determine which claim line fields are required for lines containing this revenue code on claims having the specified LOB/TOB. The claim line "Units", "Rate", "HCPCS", and "Remarks" fields are represented by these flags. (Default = Not Required)
    - ☑ When checked, the corresponding field is required for claim lines containing this revenue code on claims having the specified LOB/TOB combination.
    - ☐ When unchecked, the corresponding field is not required for claim lines containing this revenue code on claims having the specified LOB/TOB combination.
  - **Is Accommodation?** - determines whether or not the revenue code represents an "accommodation" for claims having the specified LOB/TOB combination. (Default = Not An Accommodation)
    - ☑ When checked, the revenue code represents an "accommodation" for claims having the specified LOB/TOB combination.
    - ☐ When unchecked, the revenue code does not represent an "accommodation" for claims having the specified LOB/TOB combination.

Evaluating Revenue Code Assignments

During the claim edit validation process, revenue code assignment records are considered in order from "most-specific" to "least-specific" (i.e., from bottom-to-top as they appear on the Revenue Code Assignments form). As soon as an acceptable match is found, the search ends and edit validation decisions are made based on control settings for the matching assignment record (if any). For example, if the following 3 detail assignment records exist for revenue code "0022":

LOB = **<< ALL >>** ; TOB = **<< ALL >>**

LOB = **<< ALL >>** ; TOB = **11**

LOB = **MCA** ; TOB = **11**

Case 1: Medicare claim (LOB = "**MCA**") with a TOB = "**112**" - claim lines with a revenue code of "0022" would use control settings from the third record above during edit validation, since both the LOB and TOB are an exact match.

Case 2: Commercial claim (LOB = "**COM**") with a TOB = "**112**" - claim lines with a revenue code of "0022" would use control settings from the second record above during edit validation, since the TOB matches and the LOB of "<< ALL >>" matches any claim LOB. The third record was rejected because of the LOB mismatch ("MCA" versus "COM").

Case 3: Medicare claim (LOB = "**MCA**") with a TOB = "**122**" - claim lines with a revenue code of "0022" would use control settings from the first record above during edit validation, since the TOB of "<< ALL >>" matches any claim TOB, and the LOB of "<< ALL >>" matches any claim LOB. The third and second records were rejected because of the TOB mismatch ("12" versus "11").

In our example, the first record was a "catch-all" record since it matched all LOBs and TOBs. If that assignment record were not present, then Case 3 above (MCA/122) would not have matched any of the detail assignment records. When this occurs, the revenue code is considered valid and the remaining control setting flags will assume their default values during edit validation processing.

Revenue Code Assignment records that include a specific TOB value take precedence over records with the special "**IP**" (inpatient) and "**OP**" (outpatient) TOB values. This evaluation sequence makes it possible to define an inpatient/outpatient group assignment that is valid for most TOBs in the group. Separate assignment records with specific TOB values can be created as needed to handle exceptions to the group rule.

By understanding this matching process, it is possible to build a revenue code assignment details set that can be as open or as specific as required.

Place of Service (POS) File Maintenance

The Place of Service (POS) Codes form provides an interface to maintain the Place of Service (POS) codes and assignments. POS codes apply exclusively to Professional claims. The POS codes are pre-loaded and should not require frequent additions or modifications. The Place of Service (POS) form includes two tabs:

- **Descriptions** - displays a list of Place of Service (POS) codes and their descriptions. Maintenance operations available are:
  - To add a POS code, click the "**New**" button and enter the new POS code information. Enter the effective date range using a 4-digit year format.
  - To view or modify an existing POS record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
  - To delete a POS record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
- **Assignments** - defines the list of valid Place of Service (POS) codes for each line of business (LOB). These assignments will also determine which POS codes will be included in the POS lookup list presented during claim entry. The POS assignment maintenance options include:
  - **Select LOB** - filters the assignment list to include only assignments for a specific line of business. When a specific LOB is selected, it will be used as the default LOB for new POS code assignments.
  - To add a new POS code assignment record, click the "**New**" button on the Assignments tab. Select the default LOB and POS code from the drop-down lists.
  - To delete a POS code assignment record, select the desired record, click the "**Delete**" button, and confirm the deletion.

Effective Date Range

The Effective Date Range dates are compared to the associated claim line's service date range during the claim edit validation process. If the effective date range for a Place of Service (POS) code falls outside the line's service date range, an edit validation error will be reported. If the effective date range is left blank, the POS code is valid for all dates of service. If the start date is completed but the end date is left blank, the POS code is valid for all dates of service from (and including) the start date forward. If the start date is left blank but the end date is completed, the POS code is valid for all dates of service up to (and including) the end date.

Type of Service (TOS) File Maintenance

The Type of Service (TOS) Codes form provides an interface to maintain the TOS codes and assignments. TOS codes apply exclusively to Professional claims. TOS codes are pre-loaded and should require minimal maintenance. The Type of Service (TOS) form includes two tabs:

- **Descriptions** - displays a list of TOS codes and their descriptions. Maintenance operations available are:
  - To add a TOS code, click the "**New**" button and enter the new TOS code information. Enter the effective date range using a 4-digit year format.
  - To view or modify an existing TOS record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
  - To delete a TOS record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.
- **Assignments** - defines the list of valid TOS codes for each line of business (LOB). These assignments will also determine which TOS codes will be included in the TOS lookup list presented during claim entry. The TOS assignment maintenance options include:
  - **Select LOB** - filters the assignment list to include only assignments for a specific line of business (LOB). When a specific LOB is selected, it will be used as the default LOB for new TOS code assignments.
  - To add a new TOS code assignment record, click the "**New**" button on the Assignments tab. Select the desired LOB and TOS code from the drop-down lists.
  - To delete a TOS code assignment record, select the desired record, click the "**Delete**" button, and confirm the deletion.

Effective Date Range

The Effective Date Range dates are compared to the associated claim line's service date range during the claim edit validation process. If the effective date range for a Type of Service (TOS) code falls outside the line's service date range, an edit validation error will be reported. If the effective date range is left blank, the TOS code is valid for all dates of service. If the start date is completed but the end date is left blank, the TOS code is valid for all dates of service from (and including) the start date forward. If the start date is left blank but the end date is completed, the TOS code is valid for all dates of service up to (and including) the end date.

Facility File Maintenance

The Facility Setup form provides an interface to maintain the optional Facility reference file. The Facility file applies exclusively to Professional claims. The user may enter Facility records for each frequently referenced facility if desired. The Facility reference file is available as a lookup list from the Extended Patient/General tab on the "Professional Claim Form". Maintenance operations available include:

- To add a Facility, click the "**New**" button and enter the new facility information.
- To view or modify an existing Facility record, select the desired record, click the "**View/Update**" button (or double-click the desired record).
- To delete a Facility record, select the desired record, click the "**Delete**" button, and confirm the deletion.

A convenient "**Sort By**" feature quickly sorts the Facility list by "Facility Name" or "Facility ID".

Charges Master File Maintenance

The Charges Master form provides an interface to maintain the Charges Master reference file. Charges Master codes apply exclusively to Professional claims. If you choose to use this optional reference file, it should be setup to include only those procedure codes that are to be used by the billing office (rather than the entire HCPCS code universe). Using a Charges Master file will reduce the size of the HCPCS code lookup lists during claim entry, thus promoting accuracy and enhancing productivity. In addition, a dollar amount may be assigned to each Charges Master entry. This value is automatically brought forward to the claim line item "Charges" field when a valid Charges Master code is entered (or looked up) during claim entry. Maintenance operations available include:

- To add a new Charges Master code, click the "**New**" button and optionally select a specific line of business (**LOB**) from the dropdown list if the charge is specific to claims for a particular LOB. Enter an optional "**Payer ID**" value if the charge is specific to claims billed to a particular payer. See the discussion of LOB/Payer-specific Charges Master records below for more information. Enter a valid HCPCS **Code**. Alternatively, the Payer ID and HCPCS Code values can be selected from a lookup list by pressing the "**F2**" key or right-clicking the mouse while positioned on the respective control. Enter the desired "**Charges**" value and click the "**OK**" button to save the new record.
- To view or modify an existing Charges Master record, select the desired record and click the "**View/Update**" button (or double-click the desired record). Only the description and charge amount fields may be modified.
- To delete a Charges Master record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

LOB/Payer-Specific Charges Master Records

The Charges Master reference file allows you to create multiple records for the same HCPCS code, each applicable to a specific line of business (LOB) and, optionally, to a specific payer within that line of business. This feature is useful if your "standard" charge for a procedure varies depending on the claim's LOB (or depending on the payer within that LOB). In addition, a default record for each HCPCS code may be added using the special "**<< All >>**" pseudo-LOB option. During Professional claim entry, the HCPCS code lookup lists will include only the most specific record(s) available for each HCPCS code. For example, suppose three Charges Master records have been added for HCPCS code "00100" as follows:

Code = **00100** ; LOB = **<< ALL >>** ; Payer ID = (left blank)

Code = **00100** ; LOB = **COM** ; Payer ID = (left blank)

Code = **00100** ; LOB = **COM** ; Payer ID = **12345**

The HCPCS code lookup list presented during entry of a commercial claim (LOB = "COM") would include only the LOB-specific "COM" records for code "00100" (i.e., the last 2 records). The same lookup operation performed during entry of claims for all other LOBs would include only the non-LOB-specific "<< All >>" record for code "00100".

When an HCPCS code is entered manually in the Professional Claim Form (as opposed to performing a lookup operation), the program will attempt to locate the most specific record match based on the claim's line of business and payer(s). For example, if the HCPCS code "00100" is entered manually on a commercial claim (LOB = "COM") for Payer ID = "12345", the program will automatically use the charge amount associated with the matching payer-specific record (i.e., the third record above). If the commercial claim is being billed to any other payer, however, the program will instead use the charge amount from the non-payer-specific record (i.e., the second record above). Finally, if the HCPCS code "00100" is entered manually on a non-commercial claim, the program will use the charge amount from the default (i.e., first)

Charges Master record. If the appropriate Charges Master record cannot be automatically determined with complete certainty, then the user will be prompted to select the desired record.

If your installation does not require LOB-specific and/or LOB/Payer-specific charge amounts, then simply setup all Charges Master records using the "<< All >>" pseudo line of business, and leave the "Payer ID" field empty.

By default, procedure code lookups performed during Professional claim entry access the master HCPCS reference file. To use the Charges Master file instead, you must first create records in this reference file for all desired procedure codes (along with their standard "Charges" amounts). Second, enable lookups to this file by checking the "**Use Charges Master reference file for Professional procedure code lookups**" option in the PC-ACE Pro32 "General Preferences" tab.

The Charges Master form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Provider Specialty File Maintenance

The Provider Specialties form provides an interface to maintain the Provider Specialty codes. Provider Specialty codes apply exclusively to Professional providers. The Provider Specialty is a required field on the Professional Provider Information form. These codes are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add a Provider Specialty code, click the "**New**" button and enter the new code information.
- To view or modify an existing Provider Specialty record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete a Provider Specialty record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Adding and maintaining providers (Professional)" topic for a discussion of Professional provider maintenance.

Provider Taxonomy Codes File Maintenance

The Provider Taxonomy Codes form provides an interface to maintain the Provider Taxonomy codes. Provider Taxonomy codes may be required for submission of EMC files in ANSI-837 format. The Provider Taxonomy code is a field on the Institutional and Professional Provider Information forms. These codes are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add a Provider Taxonomy code, click the "**New**" button and enter the new code information.
- To view or modify an existing Provider Taxonomy code record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete a Provider Taxonomy code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

The Provider Taxonomy Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Adding and maintaining providers (Institutional)" topic for a discussion of Institutional provider maintenance.
- Refer to the "Adding and maintaining providers (Professional)" topic for a discussion of Professional provider maintenance.

Claim Adjustment Reason Codes File Maintenance

The Claim Adjustment Reason Codes form provides an interface to maintain the Claim Adjustment Reason codes. These reason codes are used on Coordination of Benefits (COB) claims to report prior payer information. They are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add a Claim Adjustment Reason code, click the "**New**" button and enter the new code information.
- To view or modify an existing Claim Adjustment Reason code record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete a Claim Adjustment Reason code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

The Claim Adjustment Reason Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Remittance Remark Codes File Maintenance

The Remittance Remark Codes form provides an interface to maintain the Remittance Remark codes. These remark codes are used on Coordination of Benefits (COB) claims to report prior payer information. They are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add a Remittance Remark Reason code, click the "**New**" button and enter the new code information.
- To view or modify an existing Remittance Remark code record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete a Remittance Remark code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

When the Remittance Remark Code description is too long to be displayed in the list, the description is truncated and the phrase "(right-click for full text)" is displayed. To view the complete code description, simply right-click on the desired record. The full description text will be presented in a read-only window.

The Remittance Remark Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Eligibility Request Service Type Codes File Maintenance

The Eligibility Request Service Type Codes form provides an interface to maintain the Eligibility Request Service Type codes. These service type codes are used on ANSI-270 eligibility/benefit requests to indicate the service for which benefit information is being requested. They are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add an Eligibility Request Service Type code, click the "**New**" button and enter the new code information.
- To view or modify an existing Eligibility Request Service Type code record, select the desired record and click the "**View/Update**" button (or double-click the desired record).
- To delete an Eligibility Request Service Type code record, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

The Eligibility Request Service Type Codes form provides several List Filter Options that can be helpful in locating specific codes. Refer to the "Reference File Maintenance Form" topic for more discussion of these common filter options.

Claim Status Response Codes File Maintenance

The Claim Status Response Codes form provides an interface to maintain the Claim Status Response codes. Three groups of response codes are defined: **category** codes, **status** codes, and **entity** codes. Select the desired "**List includes:**" radio button to display the desired group. Claim Status Response codes are reported on ANSI-277 claim status response transactions. They are pre-loaded and should require minimal maintenance. Maintenance operations available include:

- To add a Claim Status Response code, select the desired "**List includes:**" group, click the "**New**" button, and enter the new code information.
- To view or modify an existing Claim Status Response code record, select the desired "**List includes:**" group, select the desired record in this group, and click the "**View/Update**" button (or double-click the desired record).
- To delete a Claim Status Response record, select the desired "**List includes:**" group, select the desired record from the list, click the "**Delete**" button, and confirm the deletion.

Miscellaneous Functions

Adding or modifying a system user

PC-ACE Pro32 requires that a valid login and optional password be entered by anyone desiring access to the system. The system administrator must set up a "user" account for each person that will use PC-ACE Pro32. The user account specifies the user's login/password values and defines which activities the user has permission to perform. To add a new user or modify an existing user, select the main "**Security**" menu from the PC-ACE Pro32 Main Toolbar and choose the "**Add/Update User**" item. Only users with "User Add/Modify" privileges can perform these maintenance functions, which include:

- To add a new user, click the "**New**" button on the Security List form and assign the user a User ID, Password and Name. Assign permissions to this user and save the new user record.
- To modify an existing user, select the desired user from the Security List form and click the "**View/Update**" button (or double-click the user record). Modify the Password, User Name, and User Permissions fields as desired. When all changes have been made, save the modified user record.

Check the checkbox next to the permission to allow access to the activity. Click the "**Check All**" and "**Clear All**" buttons to quickly check or un-check all user permission checkboxes.

If changes are made to a user profile, the changes will not go into effect until the next time that user logs into system. Select the "**Logout Current User**" item, available from the main "**Security**" menu to manually log out without exiting the system.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Security & User Maintenance" topic for more information about the PC-ACE Pro32 security implementation and the User Security Update form.

Scheduling unattended claim activities

Claim import, processing, and transmission activities may be scheduled for unattended operation if desired. This feature can be used to enhance productivity by automatically performing time-consuming tasks that night otherwise require an operator to be present. Tasks may be scheduled for either one-time deferred execution or daily recurring execution at a specified time by clicking the "**Claim Activity Scheduling**" button on the PC-ACE Pro32 Main Toolbar.

This claim activity scheduling feature may not be available in all installations. You will be notified when you attempt to enter the scheduling module if the distributor has disabled this feature.

The Claim Activity Scheduling form consists of 3 tabs each for Institutional and Professional claim activity scheduling. If you are licensed for only Institutional or Professional claim activities (but not both), then you will see only a single set of 3 tabs. A common set of 3 scheduling options are presented on each of the tabs:

- **No claim … scheduling** - when selected, no claim import, processing, or transmission activity is currently scheduled.
- **Manually initiate deferred claim … (one-time execution)** - when selected, the scheduler will initiate a one-time claim import, processing, or transmission activity at the next occurrence of the specified start time.
- **Automatically initiate deferred claim … each day** - when selected, the scheduler will initiate a claim import, processing, or transmission activity daily at the specified start time.

In addition to selecting the desired scheduling option, each scheduled activity type requires some specific configuration.

- **Claim Import Scheduling** - To schedule an unattended claim import operation, click the desired Institutional or Professional "**Claim Import**" tab, select either the one-time or daily scheduling option, and enter the desired "**Start Time**". Specify the following import-specific scheduling options:
  - **Import claims only** - instructs the scheduler to perform the claim import operation only. See the "Import and process claims" option description below for an alternate approach.
  - **Import and process claims** - instructs the scheduler to perform the claim import operation followed immediately by a claim processing operation on all unprocessed claims in the system. This option provides a smooth transition from the claim import operation to the claim processing operation, and relieves the user from the need to schedule the claim processing run separately.

    Selecting the "Import and process claims" option will disable the 3 scheduling options on the "Claim Process" tab, since claim processing is now "chained" to the claim import operation.
  - **Import Map/Print File Selection** - select (check) one or more PrintLink map files to be imported at the scheduled time. Each valid PrintLink map file present in the pre-defined claim import directory will be represented in this selection list.

This selection list will be visible only if PC-ACE Pro32 is configured to use the standard PrintLink claim import method. Refer to the "Claim Import Preferences" topic for more information on claim import configuration.

Once all scheduling options are completed, click the "**Initiate Deferred Claim Import**" button to complete the scheduling task. If all scheduling tasks have been completed, click the "**OK**" button to close the form and return to the PC-ACE Pro32 Main Toolbar.

- **Claim Process Scheduling** - To schedule an unattended claim processing operation, click the desired Institutional or Professional "**Claim Process**" tab, select either the one-time or daily scheduling option, and enter the desired "**Start Time**". Specify the following process-specific scheduling options:
  - **Include claims with errors** - When checked, instructs the scheduler to process all claims that have been previously saved with errors (fatal or non-fatal) in addition to all unprocessed claims. When left unchecked, only unprocessed claims will be included in the processing run.
  - **Process LOB Selection** - select (check) one or more lines of business (LOB) to be considered during the claim processing operation. Only claims with the specified LOBs will be processed. Select the special "<< PROCESS ALL LOBS >>" item to process claims for all LOBs.

  Once all scheduling options are completed, click the "**Initiate Deferred Claim Processing**" button to complete the scheduling task. If all scheduling tasks have been completed, click the "**OK**" button to close the form and return to the PC-ACE Pro32 Main Toolbar.

  If the "**Import and process claims**" option is checked on the "Claim Import" scheduling tab, then the scheduler will initiate claim processing immediately upon completion of the claim import operation. The claim process schedule will be reported as "**controlled by claim import settings**."

- **Claim Transmission Scheduling** - To schedule an unattended claim transmission (or other data communication) operation, click the desired Institutional or Professional "**Claim Transmit**" tab, select either the one-time or daily scheduling option, and enter the desired "**Start Time**". Specify the following transmit-specific scheduling options:
  - **Data Comm Claim Transmission Function** - specifies the data communication function to be launched at the specified start time. Select the desired function from the drop-down list provided.

  The scheduler is responsible only for launching the program or batch file associated with the selected claim transmission function. It does not attempt to monitor the progress or completion status of this data communications operation. If no items are available in the drop-down list, then no data communications programs have been configured for launch from PC-ACE Pro32. Refer to the "Data Communication Preferences" topic for more information on configuring Data Communications program access.

  Once all scheduling options are completed, click the "**Initiate Deferred Claim Transmission**" button to complete the scheduling task. If all scheduling tasks have been completed, click the "**OK**" button to close the form and return to the PC-ACE Pro32 Main Toolbar.

Don't forget to click the "**Initiate Deferred Claim …**" button after setting up for a scheduled claim activity. You will see a notification message in red at the bottom of the tab when the activity is properly scheduled.

Scheduled Activity Notification

Approximately 5 minutes prior to the start time of a scheduled claim activity, the Scheduled Activity Notification form will be automatically displayed on the client workstation. This notification form describes the scheduled activity type and displays an approximate countdown timer. To insure success of the scheduled claim activity, the user should refrain from using the system until the scheduled activity has completed. When you see this notification form, click the "**OK**" button and return to the PC-ACE Pro32 Main Toolbar. Once the scheduled activity is initiated, the status bar along the lower edge of the PC-ACE Pro32 Main Toolbar will display messages describing the progress of the scheduled activity. The status bar will be blanked when the scheduled activity completes. You may then review the claim activity log to see the outcome of the scheduled claim activity, if desired. Once the scheduled activity has completed, you may resume normal use of PC-ACE Pro32.

PC-ACE Pro32 must be running for scheduled activities to execute. If desired, minimize the PC-ACE Pro32 Main Toolbar on your desktop after scheduling claim activities.

Launching the ANSI-835 Electronic Remittance Module

The optional ANSI-835 Electronic Remittance modules provide tools for processing the electronic remittance files returned from your claims processor. Electronic remittance data can be viewed, printed and/or exported using these tools. Exported remittance data can, for example, be used to automatically post payments to an upstream claims management system. Separate ANSI-835 modules exist for use with Institutional and Professional claims.

- The ANSI-835 Electronic Remittance modules expect to find remittance files in the following directory:
  - Place Institutional remittance files in the server's "**winpcace\etraub92\ansi835**" directory.
  - Place Professional remittance files in the server's "**winpcace\etra1500\ansi835**" directory.
- To launch an ANSI-835 program, click the "**ANSI-835 Functions**" button on the "PC-ACE Pro32 Main Toolbar". Click the desired button to launch either the Institutional (ETRA) or Professional (ETRA1500) electronic remittance program.

The second-level launch buttons may not be presented if only a single ANSI-835 Electronic Remittance module is configured for your installation. Refer to the separate ANSI-835 Electronic Remittance (ETRA) module manuals for information about the capabilities and operation of these programs.

The ANSI-835 Electronic Remittance modules are not available on all systems. If either or both of these launch buttons are disabled, then the corresponding ANSI-835 module is not available.

Performing system backups/restores

PC-ACE Pro32 provides complete database backup, validation, and restore facilities to protect your valuable system data. All claims, reference files, and system configuration settings can be backed up to either removable media (diskettes, writeable CDROM) or a standard Windows directory (local or remote). In the event a catastrophic system failure results in the loss or compromise of PC-ACE Pro32 database files, a complete database restore operation can be performed from the most recent backup.

These backup facilities are designed to protect just the PC-ACE Pro32 databases and configuration information. The program executable files and other support files are not included in the backup archive. It is strongly recommended that you supplement these backups with a comprehensive backup schedule for your server and client systems. In the event a full restore is required, you would first restore from a full-system backup to rebuild the system's directory hierarchy and restore all program and support files. The most recent PC-ACE Pro32 backup could then be restored to recover your databases and configuration settings.

You will be prompted to perform a backup each time you exit the PC-ACE Pro32 program (unless your distributor has disabled this prompt feature). You may also perform a backup from the "**Backup/Restore**" tab of the System Utilities form. This form can be accessed by clicking the "**System Utilities**" button from the PC-ACE Pro32 Main Toolbar. The following sections describe the backup, validate, and restore options and operation:

- **Backup** - performs a backup of the PC-ACE Pro32 database files and configuration settings. All files to be included are compressed into a single archive and written to the specified destination drive or directory. The following controls and options apply to the backup operation:
  - **Destination Drive or Folder** - specifies the drive or Windows folder (directory) to which the backup archive file will be written. This path may point to a removable media device (diskettes, writeable CDROM) or to a standard Windows directory on a hard disk drive (local or remote). Disk "spanning" is supported for backups to diskette. The user will be prompted to insert blank diskettes as needed.

    If you are unable to perform the backup directly to your writeable CDROM drive for any reason, simply set the destination to a hard drive folder and then copy the resulting PCACEPBK.ZIP file to the CD using whatever technique you normally use for saving files to the CDROM drive..
  - **Include infrequently changed database files** - specifies whether or not to include certain infrequently changed database files in the backup. The optional files include only reference file databases that are generally static for long periods of time. Examples include the HCPCS Codes and Edit Validation database files. The backup archive will be somewhat smaller if these optional files are omitted.

    To ensure minimal problems in the event a database restore is required, we recommend leaving this option checked for all backups.
  - **Options Button: Include archived claim transmission (EMC) files in backup** - specifies whether or not to include all archived EMC files in the backup.
  - **Options Button: Include claim archive database files in backup** - specifies whether or not to include the claim archive database files in the backup. Refer to the "Archiving and unarchiving claims" topic for more information on the PC-ACE Pro32 claim archive feature.

- **Options Button: Include archived ANSI response files in backup** - specifies whether or not to include all archived ANSI-271, ANSI-277, and ANSI-997 files in the backup.
- **Options Button: Include archived ANSI-835 remittance files in backup** - specifies whether or not to include the ANSI-835 remittance file archive and related configuration files in the backup. This option will be disabled if the ANSI-835 Electronic Remittance Processors are not available on your installation.
- **Options Button: Include archived Report Manager response report files in backup** - specifies whether or not to include the response reports archived by the optional PC-ACE Pro32 Report Manager program in the backup. This option will be disabled if the Report Manager is not available on your installation.

Once the desired destination and options have been specified, click the "**Start Backup**" button to proceed. You will be notified upon successful backup completion.

Exclusive system access is required to perform backups in PC-ACE Pro32. If this program is in use on another client workstation, you will be notified when the "**Start Backup**" button is clicked. You can either instruct the other users to exit PC-ACE Pro32 and then continue the backup, or simply cancel the backup request.

❖ **Validate** - validates an existing backup file. The backup archive's integrity is confirmed, and the archive details (date of backup, etc) are presented to the user. No data will be restored during the validation process, so it is always "safe" (and advisable) to validate an archive before attempting a subsequent restore operation. The following controls and options apply to the validate operation:

- **Source Drive or Folder** - specifies the drive or Windows folder (directory) from which the backup archive file will be read. This path may point to a removable media device (diskettes, writeable CDROM) or to a standard Windows directory on a hard disk drive (local or remote). Disk "spanning" is supported for backup archives on diskette. The user will be prompted to insert specific diskettes from the backup archive as needed.

  When validating backup archives that span multiple diskettes, insert the last diskette in the set first. The system will prompt for the first and subsequent diskettes as the validation proceeds.

Once the desired source drive/folder path has been specified, click the "**Start Validate**" button to proceed. You will be presented with details of the validated backup archive on completion.

❖ **Restore** - restores the PC-ACE Pro32 database files and configuration settings (optional) from an existing backup file. The "Restore" tab will be visible only to users with the appropriate permissions. The following controls and options apply to the restore operation:

- **Source Drive or Folder** - specifies the drive or Windows folder (directory) from which the backup archive file will be read. This path may point to a removable media device (diskettes, writeable CDROM) or to a standard Windows directory on a hard disk drive (local or remote). Disk "spanning" is supported for backup archives on diskette. The user will be prompted to insert specific diskettes from the backup archive as needed.

  When restoring backup archives that span multiple diskettes, insert the last diskette in the set first. The system will prompt for the first and subsequent diskettes as the restoration proceeds.

- **Restore system and user configuration settings** - specifies whether or not to restore the system and user configuration settings that were included in the backup

archive. These settings define system/user preference settings, for example. Unless otherwise instructed by a technical support specialist, this option should always be checked.

Once the desired source drive/folder path and option settings have been specified, click the "**Start Restore**" button to proceed.

The restore operation will overwrite your current database files with older data from the specified backup. You should perform this operation only under the supervision of authorized technical support personnel.

You will be notified when the restore operation completes. PC-ACE Pro32 will terminate automatically following a restore operation. The restored database files and configuration settings will be available the next time the program is executed.

Exclusive system access is required to perform a restore operation in PC-ACE Pro32. If this program is in use on another client workstation, you will be notified when the "**Start Restore**" button is clicked. You can either instruct the other users to exit PC-ACE Pro32 and then continue the restore operation, or simply cancel the restore request.

Packing and reindexing the databases

PC-ACE Pro32 uses proven database technology that is, for the most part, self-maintaining. Database files (or "tables") contain the data records that define a claim, patient, provider, etc. Most tables are equipped with "indexes" that organize the records in the table for optimal access. As records are added to, modified, or deleted from a database table, the PC-ACE Pro32 database engine performs all necessary housekeeping. For example, all indexes are maintained to reflect the current set of records after one or more records has been added, modified, or deleted.

Having said this, there are certain situations when the system administrator may be required to perform manual database maintenance operations. The most common scenarios include:

- Frequently updated tables (claim tables, for example) may require periodic maintenance to keep their size at a minimum and their performance optimized.
- Indexes may become out-of-date due to an abnormal system or network problem that interferes with the PC-ACE Pro32 database engine's self-maintenance tasks.

In these scenarios, and others that occur less frequently, database tables(s) may require manual "**packing**" and/or "**reindexing**".

- **Database Packing** - As records are deleted from PC-ACE Pro32 database tables, the file/disk space consumed by these deleted records is not automatically recovered. Over time, this unrecovered space can result in a table that consumes more disk space that it really needs. In addition, the unnecessarily large table can have an impact on database performance. When a database table is "**packed**", this unrecovered space is eliminated, resulting in a table that is as small as possible, and optimum performance is restored. As an example of when packing would be recommended, consider the claim archiving process. One of the primary motivations behind claim archiving is to keep the current claims database tables as small and as fast as possible by moving older claims to "off-line" storage. However, once a group of claims have been archived, the current claims database tables must be packed in order to fully realize the size and performance benefits. Database packing is typically the responsibility of your system administrator.
- **Database Reindexing** - Database "indexes" facilitate optimized access to the information in a database table. As data in the table changes, these indexes must be updated to accurately reflect the current table contents. Indexes are normally maintained automatically by the PC-ACE Pro32 database engine. If an index gets "out-of-date" as the result of some unexpected system or network malfunction, it may become necessary to manually reindex the associated table. Database reindexing is typically the responsibility of your system administrator.

File maintenance operations like packing and reindexing require appropriate user permission. You will be notified if your user is not authorized to perform these functions. In addition, these functions require exclusive system access.

To greatly reduce the time required to perform claim archiving activities on networked installations, it is strongly recommended that such activities be initiated from the server's console.

To pack or reindex a table(s):

1) Click the "**System Utilities**" button on the PC-ACE Pro32 Main Toolbar to display the System Utilities form. Select the "**File Maintenance**" tab.
2) Select one or more tables from the "**Database Files**" list.

   Select multiple database files by holding down the "**CTRL**" key while clicking the desired list items. Click the "**Select All**" button to select all database files.

3) Click the "**Pack**" button or "**Reindex**" button to perform the desired operation on all selected database files.

Certain database files (tables) should normally be worked with as a group. For example, there are 5 separate database files that make up the Institutional claims database. The "**Select Group**" drop-down list provides a convenient means of selecting all associated files in one of several commonly used groups. Use this selection technique instead of selecting database files individually from the list.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Archiving and unarchiving claims" topic for information on the PC-ACE Pro32 claim archiving feature and its potential to enhance system performance.

Sending support mail to your distributor

Technical support e-mail can be initiated directly from the **PC-ACE Pro32** system. Click the "**Send E-Mail**" button on the PC-ACE Pro32 Main Toolbar to command your default e-mail program to open a new message addressed to your distributor.

This feature may not be available on some systems. If the support mail feature is disabled, the "Send E-Mail" button will not be present on the PC-ACE Pro32 Main Toolbar. If the button is available, but does not open an e-mail message window, it is likely that your system does not have its default mailer properly configured.

Troubleshooting

Reviewing the claim activity logs

The Claim Activity Log files provide details of all claim import, process, prepare, and transmission activities. The logs also record any abnormal activities that may occur in the course of operation. Separate log files are maintained for Institutional and Professional claim activities. The logs can be useful when researching past claim processing activity or reviewing the outcome of scheduled claim activities.

- To view a claim activity log file, select the "**View**" and "**Claim Activity Log**" items from the Institutional or Professional Claims Menu form's main menu. The applicable log file will be opened in the Windows "Wordpad" program. Activities are logged chronologically, with the most recent entries at the end of the file.

  Be sure and close Wordpad when you are finished reviewing the log.

- To purge a claim activity log file, select the "**Maintain**" and "**Purge Claim Activity Log**" items from the Institutional or Professional Claims Menu form's main menu. This action simply deletes the appropriate Claim Activity Log file. The next claim import, process, prepare, or transmission will start a new log file. Since the number of days for which entries are maintained in this log can be set in the PC-ACE Pro32 preferences, this function will rarely be used.

Related Topics:

The following hyperlinks provide additional information related to this topic:

- Refer to the "Miscellaneous Preferences" topic for more information on the claim activity log auto-purge feature.

Recovering from an interrupted claim prepare run

Claim prepare operations in **PC-ACE Pro32** require exclusive system access. No other users may be running the program while claims are being prepared. This exclusivity restriction is imposed intentionally in order to help guarantee the integrity of the prepare operation. Even with this protection, however, it is still possible that an abnormal system and/or network failure could result in an interruption of the prepare operation prior to successful completion. If this were to happen, it becomes important to recover from the interruption in such a way that maintains the integrity of the claims being prepared.

When the user clicks the "Prepare" button and confirms the request, PC-ACE Pro32 saves detailed information about the claims to be prepared before the actual prepare work begins. If the prepare process is subsequently interrupted, this saved information can be accessed to restore all affected claims to their state prior to initiation of the prepare operation. The next time PC-ACE Pro32 is executed following the system interruption, the program will automatically recognize that a prepare operation was in progress when the interruption occurred.

Claim Prepare Recovery Options

The distributor determines the level of user interaction required to recover from an interrupted claim prepare run. There are two possible scenarios:

- **Silent recovery** - No user interaction is required. PC-ACE Pro32 automatically detects that a prepare run was interrupted, restores the affected claims to their pre-prepare state, and simply notifies the user that this recovery process has taken place.
- **Verbose recovery** - Upon detecting that a prepare operation has been interrupted, the user is presented with the Claim Prepare Recovery Options form. This form notifies the user that a prepare run was interrupted and provides specific details of the prepare operation in progress including time, date, EMC filename, EMC file format, and the prepare filter and option settings specified by the user when the prepare run was initiated. In the "verbose" recovery mode, the user has 3 options (represented by buttons on the recovery options form):
  - **Perform Recovery** - Performs the prepare recovery process without further prompting. All affected claims will be restored to their pre-prepare state. This is the recommended course of action, unless a technical support specialist has instructed you otherwise.
  - **Skip Recovery** - Skips the recovery process and leaves the affected claims in an undetermined state. You will be warned that some affected claims may be flagged as "transmitted" and may need to be reactivated. Skipping the recovery process should only be done under the instruction of a technical support specialist.
  - **Cancel** - Cancels the prepare recovery process and exits the program. Selecting this option is the equivalent of saying "I have no idea what to do." Consult with your system administrator or a technical support specialist for the suggested course of action. The next time you execute PC-ACE Pro32, you will be presented with this same prepare recovery options form.

  If the first or second option is selected, the user will be required to log in using the same User ID and password that was in effect when the prepare interruption occurred. Upon successful login, the prepare recovery process will either be performed or skipped based on the user's selection.

Once the recovery process has completed successfully, we suggest that you review the affected claims using the Claims List form to insure that everything looks like it did before the

prepare operation was initiated. You may then run the prepare operation again to prepare the eligible claims.

If the original prepare operation included Institutional standalone medical attachments (e.g., Rehab, Ambulance, ESRD), then these attachments will be recovered along with the claims. In this scenario, the term "claims" as it is used in this topic can be interpreted as "claims and attachments."

Claim prepare recovery requires exclusive system access. Since the prepare operation itself requires exclusivity, this should never become an issue. In any event, you will be notified if exclusive system access cannot be granted.

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