PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Guide

Section 6: Online Reports

Main Menu Option 04

September 2018

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ACRONYMS

Acronym	Description
A	
ACS	Automated Correspondence System
ADR	Additional Development Request
ADJ	Adjustment
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
ANSI	American National Standards Institute
B	
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMG	Case-mix Group
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CO	Contractual Obligation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital
E	
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Centers
G	
H	
HCPC	Healthcare Common Procedure Code

Acronym	Description
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HIPPS	Health Insurance Prospective Payment System (the coding system for home health claims)
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRR	Hospital Readmission Reduction
HSA	Health Service Area
HSP	Hospital Specific Payment
HSR	Hospital Specific Rate
I	
ICD	Internal Classification of Diseases
ICN	Internal Control Number
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
J	
K	
L	
LGHP	Large Group Health Plan
LOS	Length of Stay
LTR	Lifetime Reserve days
M	
MA	Medicare Advantage Plan
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MID	Beneficiary's Medicare Number (formerly Health Insurance Claim Number)
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
NIF	Not in File
NPI	National Provider Identifier
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
ORF	Outpatient Rehabilitation Facility
OSC	Occurrence Span Code
OTAF	Obligated To Accept in Full
OT	Occupational Therapy
P	
PC	Professional Component
PHS	Public Health Service
PPS	Prospective Payment System
PR	Patient Responsibility
PRO	Peer Review Organization
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SLP	Speech Language Pathology
SMSA	Standard Metropolitan Statistical Area
T	
TC	Technical Component
TOB	Type of Bill
U	
UB	Uniform Billing
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
URC	Utilization Review Committee
V	
W	
X	
X-Ref	Cross-reference
Y	
Y2K	Year 2000
Z	

DIRECT DATA ENTRY (DDE) USER'S GUIDE BREAKDOWN

Refer to the following sections of the DDE User Guide for detailed information about using the DDE screens.

Section	Section Title	Descriptive Language
1	Introduction & Connectivity	This section introduces you to the Direct Data Entry (DDE) system, and provides a list of the most common acronyms as well navigational tips to include function keys, shortcuts, and common claim status and locations. This section also provides screen illustrations with instructions for signing on, the main menu display, signing off, and changing passwords.
2	Checking Beneficiary Eligibility	This section explains how to access beneficiary eligibility information via the Common Working File (CWF) screens, Health Insurance Query Access (HIQA) and Health Insurance Query for HHAs (HIQH), to verify and ensure correct information is submitted on your Medicare claim. Screen examples and field descriptors are provided.
3	Inquiries (Main Menu Option 01)	This section provides screen illustrations and information about the inquiry options available in DDE, such as viewing inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes, checking beneficiary/patient eligibility, check the status of claims, view Additional Development Requests (ADRs) letters, Medicare check history, and home health payment totals.
4	Claims & Attachments (Main Menu Option 02)	This section includes instructions, screen illustrations, and field descriptions on how to enter UB-04 claim information, including home health requests for anticipated payment (RAPs), hospice notice of elections (NOEs), and roster bill data entry.
5	Claims Correction (Main Menu Option 03)	This section provides instructions, screen illustrations, and field descriptions on how to correct claims that are in the Return to Provider (RTP) file, adjust or cancel finalized claims.
6	Online Reports (Main Menu Option 04)	This section provides information on certain provider-specific reports that are available through the DDE system.

This publication was current at the time it was published. Medicare policy may change so links to the source documents have been provided within the document for your reference.

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Any changes or new information superseding the information in this guide are provided in the Medicare Part A and Home Health and Hospice (HHH) Bulletins/Advisories with publication dates after September 2018. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

SECTION 6 – ONLINE REPORTS

The Online Reports View function allows viewing of certain provider specific reports by the Direct Data Entry Provider. The purpose of the reports is to inform the providers of the status of claims submitted for processing and provide a monitoring mechanism for claims management and customer service to use in determining problem areas for providers during their claim submission process.

As reports are viewed on-line, it will be necessary to scroll (or toggle) between the left view (Scroll L) and the right view (Scroll Right). Use the **[F11]** key to move to the right and the **[F10]** key to return to the left.

To access the online reports, choose menu selection 04 from the DDE Main Menu. The Online Reports Menu will display (Figure 1).

Online Reports Menu (MAP1705) – A description of the type of reports that can be viewed is provided following Figure 1.

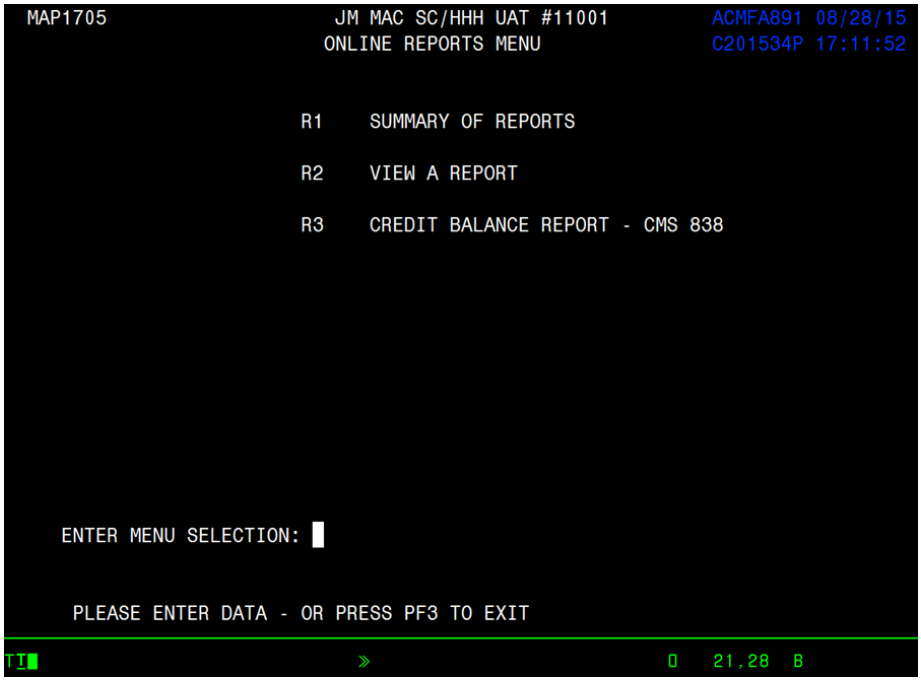

Figure 1 – Online Report Menu

The most frequently viewed provider reports are the Claims Returned to Provider Report (050); Pending, the Processed and Returned Claims Report (201); and the Errors on Initial Bills Report (316).

050 The **Claims Returned to Provider Report** lists the claims that are being returned to the provider for correction. The claims on the report are in status/location T B9997. The main difference between this report and the 201 is that it contains the description of the Reason Code(s) for the claim being returned.

201 The **Pending, Processed and Returned Claims Report** lists claims that are pending claims returned to the provider for correction and claims processed, but not necessarily shown as paid on a remittance advice. This report will exclude Medicare Choices, ESRD Managed Care and plan submitted HMO (Encounter) claims.

316 The **Errors on Initial Bills Report** is a listing, by provider, of errors received on new claims (claims which were entered into the system for the present cycle.)

From the Online Reports Menu (Figure 2), you can select R1 for a summary of reports from which you can select R2 to view a report by entering the report number (Figure 3) or R3 to view a credit balance report (Figure 4).

Online Reports Selection Inquiry R1 (MAP1671) – Field descriptions are provided in the table following Figure 2.

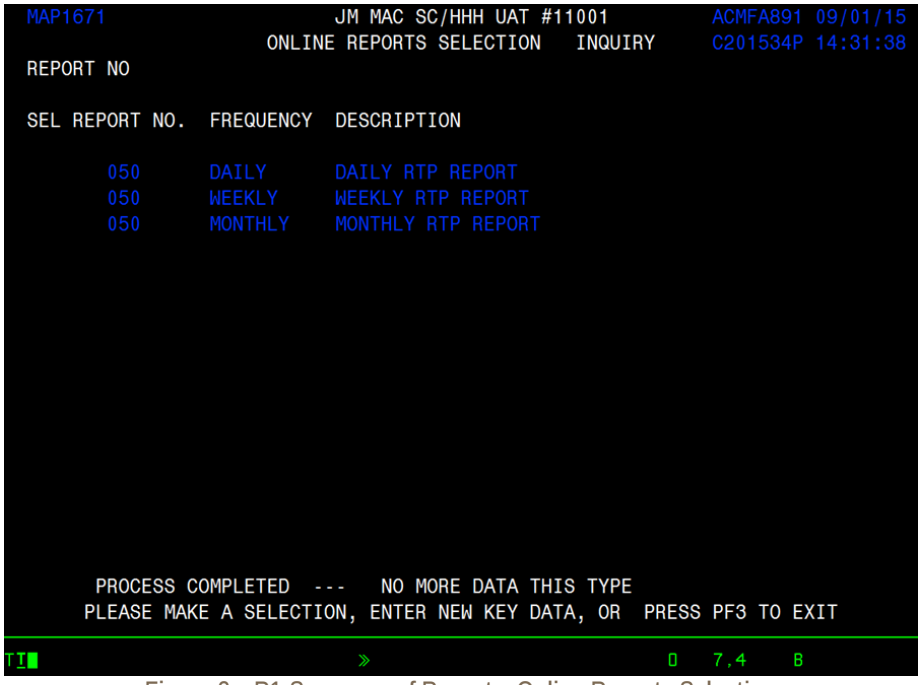

Figure 2 – R1-Summary of Reports, Online Reports Selection

Field Name	Description
REPORT NO	This field identifies the number of the report. Type in the desired report to view on-line.
SEL	The Selection field is used to select the report to be viewed. Type an 'S' before the desired report.
REPORT NO	Indicates the report number.
FREQUENCY	Reflects the frequency of the report – Daily, Weekly, or Monthly.
DESCRIPTION	Identifies the name or title of the report.

Report View Inquiry Screen R2 – Scroll Layout (MAP1661) – Field descriptions are provided in the table following Figure 3.

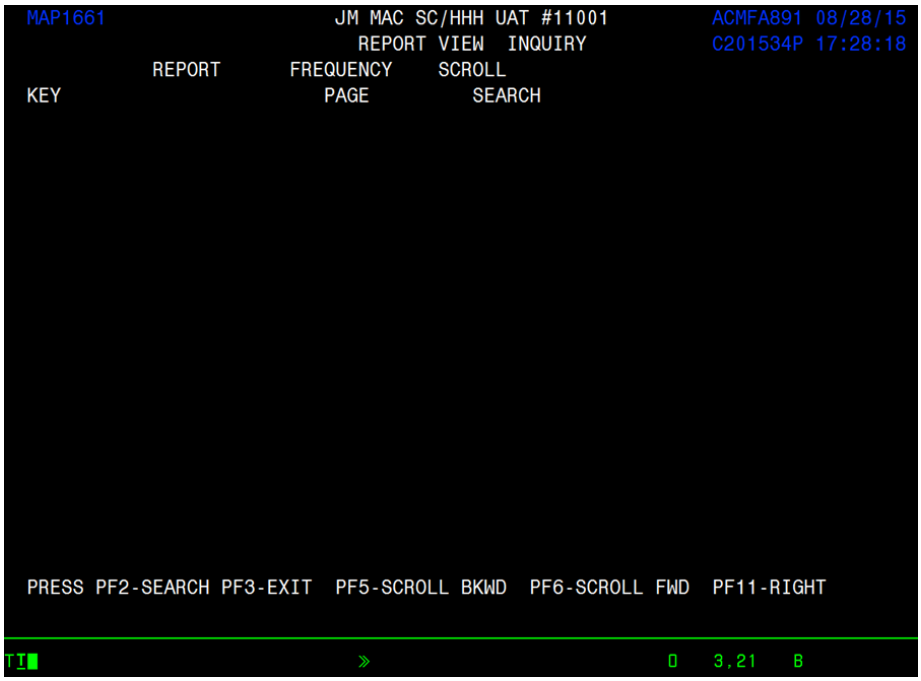

Figure 3 – R2-View A Report

Field Name	Description
REPORT	This field identifies the number of the report. Type in the desired report to view on-line.
FREQUENCY	Reflects how often the report is generated. Valid values are: 'D' = Daily 'W' = Weekly 'M' = Monthly.
SCROLL	This field is used to scroll to the left or right sides of the report.
KEY	This field reflects the key or sort field for the selected report.
PAGE	This field identifies the page number of the report being viewed.
SEARCH	This field searches for a specific field name or value.

Credit Balance Report R3- FORM 838 Inquiry Screen (MAP1B21) – Field descriptions are provided in the table following Figure 4.

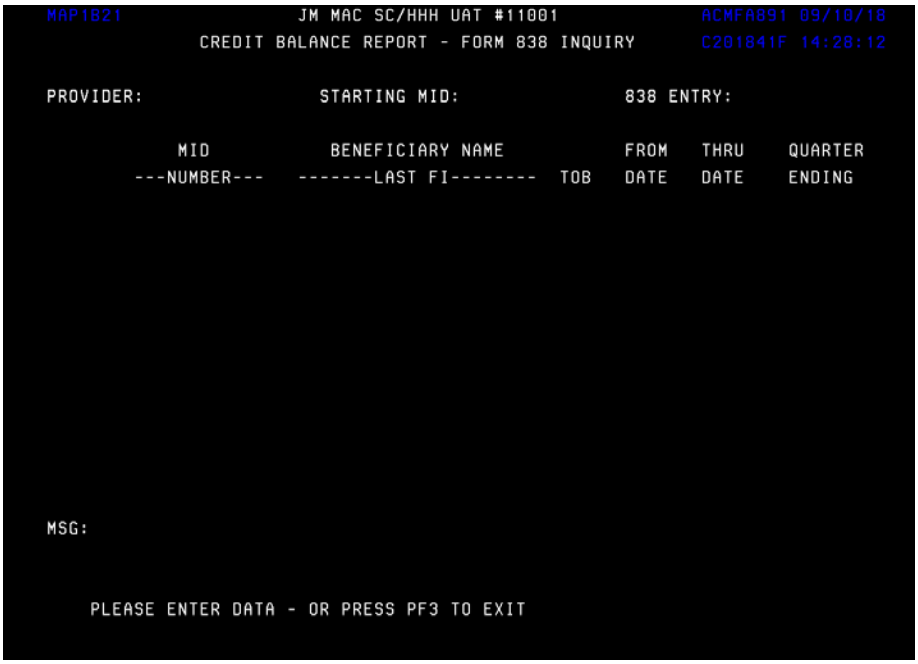

Figure 4 – R3-Credit Balance Report-Form 838 Inquiry

Field Name	Description
PROVIDER	This field displays the six-digit provider number issued by CMS.
STARTING MID	This field identifies the beneficiary/patient's Medicare number as shown on the Medicare card.
838 ENTRY	This field identifies the 838 Entry field. Valid values are: 'Y' = Yes 'N' = No **Note:** When this field is populated with a 'Y' the credit balance entry screen is displayed and allows the provider to enter a new record. **Note:** This option is not currently support by Palmetto GBA.
MID NUMBER	This field identifies the beneficiary/patient's Medicare number as shown the Medicare cared.
BENEFICIARY NAME LAST FI	This field displays the beneficiary/patient's last name and the initial of the first name.
TOB	This field displays the Type of Bill for a particular period of care.
FROM DATE	Statement From Date – This field identifies the beginning date of service for the period included on the claim in MMDDYY format.
THRU DATE	Statement Through Date – This field identifies the ending date of service for the period included on the claim in MMDDYY format.
QUARTER ENDING	This field identifies the quarter ending date in CCYYMM format.

6.A. 050 Report – Claims Returned to Provider

The Claims Returned to Provider Report lists the claims that are being returned to the Provider for correction. The claims on the report are in status/location T B9997. It is primarily used by providers who are not on DDE to identify the Reason Code(s) for the returned claims. This report includes the Reason Code(s) by number and narrative (Figures 6 and 7).

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 6.

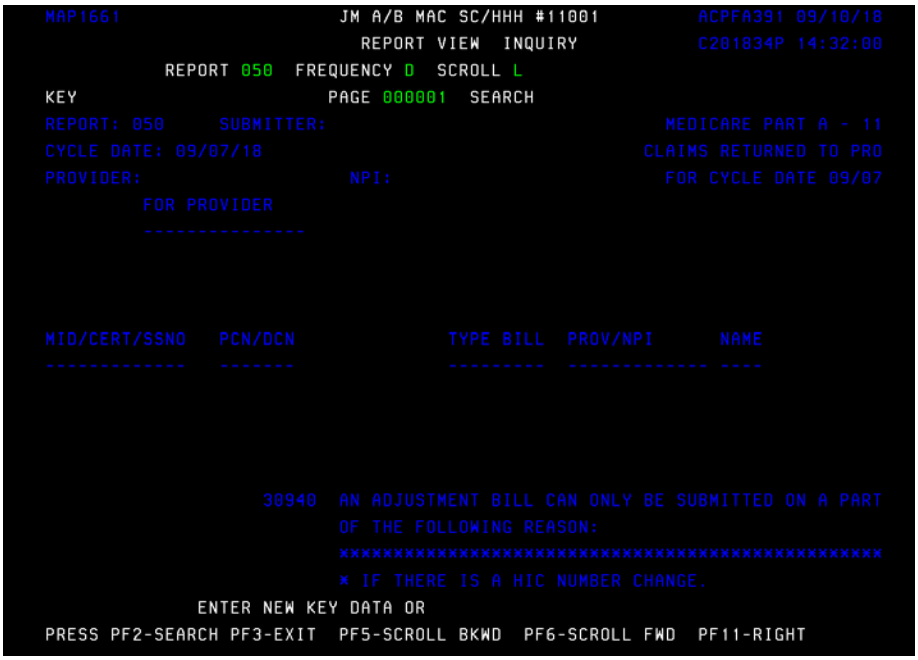

Figure 5 – 050 Claims Returned to Provider, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 6.

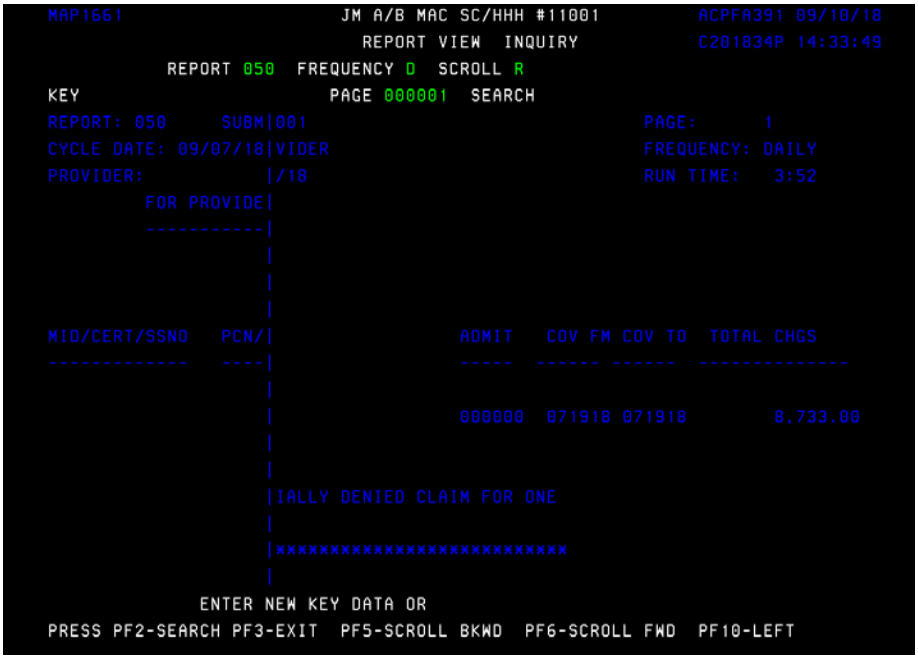

Figure 6 – 050 Claims Returned to Provider, Scroll Right View

Field Name	Description
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
SEARCH	Allows searching for specific information contained in report fields by using [F2].
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
PAGE	The specific page you are viewing within the report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
FREQUENCY	The frequency the report is run.
PROVIDER	Identifies the facility that rendered services for the claims being returned.
RUN TIME	The time of the production cycle that produced the reports.
FOR PROVIDER	The provider name and address for report remittance. This information is taken from the Provider File and is a total of 4 lines of 31 characters each.
MID/CERT/SSNO	Identifies the Medicare number submitted by the provider for the beneficiary/patient listed in the name field.
PCN/DCN	The Document Control Number identifies the returned claim.
TYPE OF BILL	Identifies the type of facility, type of care, source and frequency of this claim in a particular period of care.
PROVIDER	Identifies the facility listed on the claim.
NAME	Lists the beneficiary/patient's last and first name as submitted by the provider of the beneficiary/patient who received the services.
ADMIT DATE	The date (in MMDDYY format) that the beneficiary/patient was admitted for inpatient services or the beginning of the outpatient, home health or hospice services.
COV FM	Identifies the beginning date (in MMDDYY format) of services rendered to the beneficiary/patient as indicated on the claim.
COV TO	Identifies the ending date of services rendered to the beneficiary/patient as indicated on the claim.
TOTAL CHGS	Displays the total charges as submitted by the provider.
[REASON CODE AND NARRATIVE]	Displays the reason code(s) and narrative for the returned claim. There is a maximum of 150 occurrences for each reason code/narrative.
TOTAL RETURNED CLAIMS	The total number of reported claims being returned to the provider listed in the Provider field.
TOTAL RETURNED CHARGES	The total amount of charges for claims returned to the provider listed in the Provider field.

6.B. 201 Report – Pended, Processed and Returned Claims

Figures 7 and 8 show the left view and right view of the Pended, Processed and Returned Claims report. The fields described in the table following the figures, display for Inpatient, Outpatient and Lab Pended Claims.

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 8.

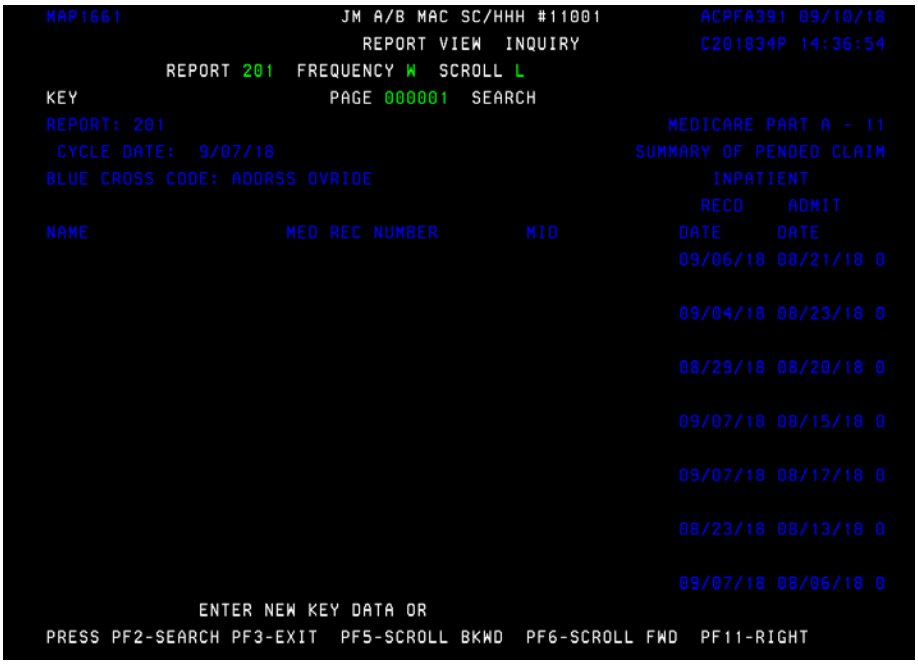

Figure 7 – 201 Pended, Processed and Returned Claims, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 8.

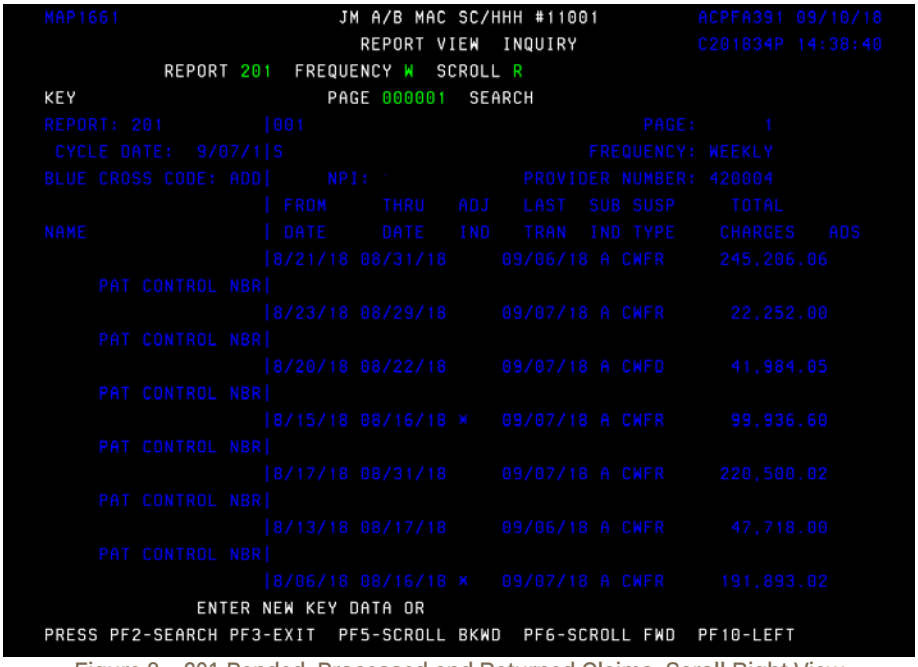

Figure 8 – 201 Pended, Processed and Returned Claims, Scroll Right View

Field Name	Description
Scroll Left	
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	The right side of the Scroll Left screen shows the title of the report. This field is not labeled, but the Report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned).
BLUE CROSS CODE	The BCBS identification number assigned to a particular provider/facility.
TYPE OF CLAIM	The field is not titled, but the type of claim can be found under the report title on the right side of the Scroll Left screen. This field identifies the type of claim being reflected on the report (e.g., Inpatient/Outpatient/ Lab/Other).
NAME	The Beneficiary/patient's Last Name/First Name.
MED REC NUMBER	The unique number assigned to the beneficiary/patient at the medical facility.
MID NUMBER	Identifies the Medicare number assigned to the beneficiary/patient as shown on the Medicare card. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	The date on which the Medicare contractor received the claim from the provider (in MMDDYY format).
ADMIT DATE	The date the beneficiary/patient was admitted to the provider for inpatient care, outpatient service or start of care (in MMDDYY format).
PAT CONTROL NBR	Unique number assigned to the beneficiary/patient at the medical facility.
(MED) MEDICAL	The total charges of the medical suspense category. Location code positions 2 & 3 - '50'.
MSP	Medicare Secondary Payer identifies the category heading identifying counts, by Type of Bill, of adjustment records meeting the following criteria: Adjustment requester ID - 'H' (hospital) or 'F' (Fiscal Intermediary), and the adjustment reason code - 'AU', 'BL', 'DB', 'ES', 'LI', 'VA', 'WC' or 'WE'. Location code positions 2 & 3 - '80' or '85'.
(CWFR) CWF REGULAR	The total charges of the CWF category. Location code positions 2 & 3 - '90,' Location code position 4 **is not** 'B', 'F', 'J', 'L' or 'M'.
Scroll Right	
NPI	The National Provider Identifier (NPI) number of the provider rendering services to the beneficiary/patient.
PROVIDER NUMBER	The Provider Number of the Medicare provider rendering services to the beneficiary/patient.
FROM DATE	The beginning date of service for the period included on the claim (in MMDDYY format).
THRU DATE	The ending date of service for the period included on the claim (in MMDDYY format).
ADJ IND	Indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank.

Field Name	Description
LAST TRAN	Identifies the date of the most recent transaction on this claim (in MMDDYY format).
SUB IND	Identifies the mode of submission of the claim. If the UBC is a '7' or '8' (hard copy indicator), this will be a 'P' (paper claim); otherwise, it will contain an 'A' (automated claim).
SUSP TYPE	The suspense location where the claim resides within the system. Valid values are: MED = (Medical) Location code positions 2 & 3 is '50' MS = Location code positions 2 & 3 is '80' or '85' CWFR = Location code positions 2 & 3 is '90,' CWF = (Regular) Location code position 4 is not 'B', 'F', 'J', 'L' or 'M' CWFD = Location code positions 2 & 3 is '90,' CWF = (Delayed) Location code position 4 IS 'B', 'F', 'J', 'L' or 'M' SUSP = (Suspense) Any suspended claim (Status 'S') that does not fall into any of the categories listed above.
TOTAL CHARGES	Reflects total charges by beneficiary/patient line item.
ADS	Additional Development System identifies if the claim has been to or currently resides in ADR. If Location code positions 2 & 3 have ever equaled 60, this field will contain a 'Y'; otherwise, it will be blank.
PAT CONTROL NBR	Unique number assigned to the beneficiary/patient at the medical facility.
ADS REASON CODES	Identifies contains up to 10 5-digit reason codes requesting specific information from the provider on claims for which the ADS indicator is 'Y'.
TOTAL CHARGES	Identifies by suspense category the total charges for pending claims or adjustments at the end of the processing cycle.

6.C. 316 – Errors on Initial Bills

The Errors on Initial Bills report (Figures 9 and 10) lists (by Provider) errors received on new claims (claims entered into the system for the present cycle). The purpose of this report is to provide a monitoring mechanism for claims management and customer service to use in determining problem areas for Providers during their claim submission process.

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 10.

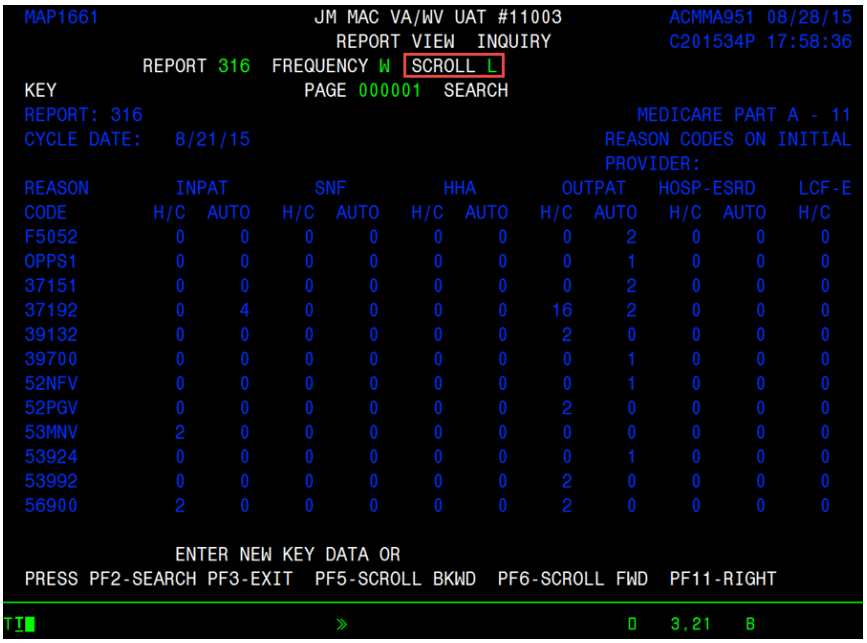

Figure 9 – 316 Errors on Initial Bills, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 10.

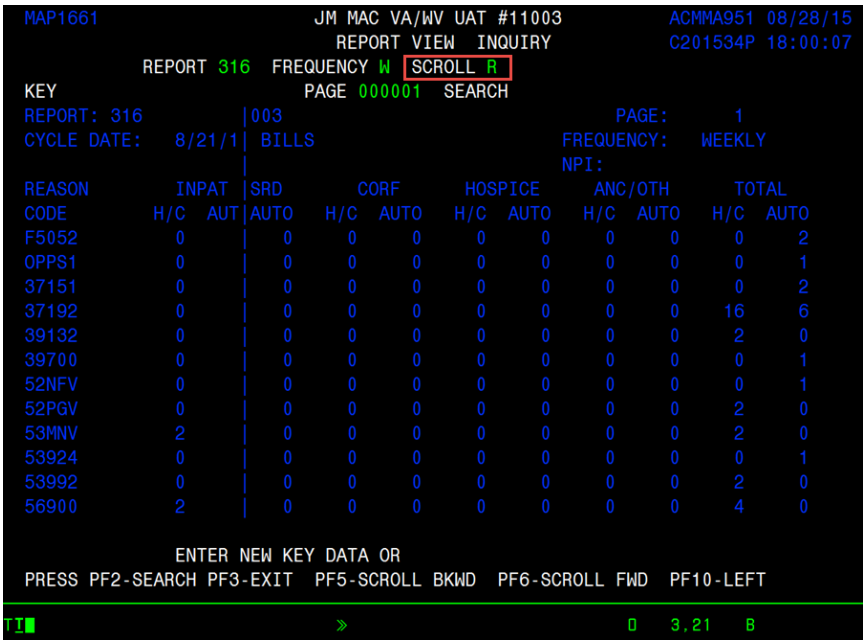

Figure 10 – 316 Errors on Initial Bills, Scroll Right View

Field Name	Description
Scroll Left View	
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).

Field Name	Description
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/ Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	This field is not labeled, but the report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned). It is located on the far right side of the screen.
PROVIDER	Identifies the Medicare Provider rendering services to the beneficiary/patient.
REASON CODE	The reason code for a specific error reason condition, existing. The first position indicates the type and location of the reason code. Valid values include: 1 = CMS Unibill 2 = Reserved for future use 3 = Fiscal Intermediary Standard System 4 = File maintenance 5 = State (site) specific 6 = Post payment A-X = Miscellaneous errors Positions 2-5 indicate either a file or application error. If position 2 contains an alpha character, it is file related; otherwise, it is application related.
INPAT	Reflects all claims/adjustments with a Type of Bill 11X or 41X.
SNF	Reflects all SNF claims/adjustments with a Type of Bill 18X, 21X, 28X or 51X.
HHA	Reflects all HHA claims/adjustments with a Type of Bill 32X, 33X or 34X.
OUTPAT	Reflects all outpatient claims/adjustments with a Type of Bill 13X, 23X, 43X, 53X, 73X or 83X.
HOSP-ESRD	Reflects all Hospital End Stage Renal Disease claims with a Type of Bill 72X.
LCF-ESRD	Reflects all claims with a Long Term Care Facility End Stage Renal Disease Type of Bill 72X and a provider number greater than XX299 and less than XX2500 (XX represents the state code).
H/C	Claims by bill type, which are produced on paper and submitted to the Medicare contractor designated by a Uniform Bill Code less than 8.
AUTO	Claims by bill type, which are submitted to the Medicare contractor in an electronic mode, designated by a Uniform Bill Code greater than 7.
Right Scroll View	
CORF	Reflects all CORF claims/adjustments with a Type of Bill 75X.
HOSPICE	Reflects all Hospice claims/adjustments with a Type of Bill 81X or 82X.
ANC/OTHER	Reflects all Ancillary and Other claims with a Type of Bill 12X, 14X, 22X, 24X, 42X, 44X, 52X, 54X, 71X, 74X or 79X.
TOTAL	The total of all claims printed on this report for each specific Reason Code.
H/C	Claims by bill type, which are produced on paper and submitted to the Medicare contractor designated by a Uniform Bill Code less than 8.
AUTO	Claims by bill type, which are submitted to the Medicare contractor in an electronic mode, designated by a Uniform Bill Code greater than 7.