

## 7A. CREATING CLAIMS

### A. Entering the Charges into the MPM Office Program

The MPM Office program allows the user four different ways to get to the **Edit New Claims Data** screen to enter (**Add/Create**) a Claim for a Patient:

- By selecting the **Claims** option on the Top Navigational Menu, and selecting **Claims** once again from the drop down menu provided, and from the opened **Claims Data** screen, clicking on the **ADD** button at the bottom.
- By clicking on the **Charges** icon on the Left Navigational Menu, and from the opened **Claims Data** screen, clicking on the **ADD** button at the bottom.
- By clicking the **Add Claim** button from within a Patient's appointment in the **Schedules Module** by clicking on the **Schedules** icon from the Left Navigational Menu and opening their appointment slot.
- By selecting the **Add Claim** button from within the **Patient Record**.

The most common way to enter claims for Patients using the MPM Office program is to go through the **Patient Record**.

- Click on the **Patients** icon on the Left Navigational Menu, or, from the Top Navigational Menu, select **Patients Data**.
- Find your **Patient's Record** and double click on their name to open the **Edit Patient Data** screen.
- Click on the **Add Claim** button at the top of the opened record to open the **Edit New Claims Data** screen (see the example below).

The screenshot shows the 'Edit New Claims Data' window with the following fields and sections:

- Name:** [Text Field] [User Icon]
- File Date:** [ // ]
- Rendering:** [Dropdown]
- Insurance:** [Dropdown]
- Facility:** [Dropdown]
- Referring:** [Dropdown]
- Supervising:** [Dropdown]
- Ordering:** [Dropdown]
- Current Illness:** [ // ]
- Same or Similar:** [ // ]
- Date last Seen:** [ // ]
- Medicaid/Lab:** [Button]
- Acute Man:** [ // ]
- Condition:** [Dropdown]
- XRays?:**
- Hospitalized:** [ // ] To [ // ]
- Unable:** [ // ] To [ // ]
- Condition:** [Dropdown] **State:** [Dropdown] **Date:** [ // ]
- 10d Local Use:** [Text Field]
- Box 19:** [Text Field]
- Anesthesia:** [ // ] To [ // ] **Total Minutes:** [ 0 ] **Minutes into Units:** [ 0.00 ] **Minutes \$:** [ 0.00 ]
- Procedures:** [Add] [Edit] [Delete] buttons and a table with columns: From, To, Diag1, Diag2, Diag3, Diag4, Proc, Mod 1, Mod 2, Units, Charge.
- Summary:**  Do not bill Patient **Credit = \$0** **Total Balance Due = 0.00** **Total Charge = \$0.00**
- Buttons:** Save & Add, Pay & Adj, Repeat Procedures, Print, Save, Cancel.

The **Edit New Claims Data** screen is broken up into 3 main sections: a **General** claim information section at the top, an **Anesthesia** section in the middle, and the **Procedures** section at the bottom. We will discuss each section in detail.

## 1. GENERAL CLAIM INFORMATION (TOP SECTION):

The **General Claim Information** section is separated into three sections: the **Left Side**, **Middle Section**, and the **Right Side**.

### a) The Left Side

#### **Name & Patient Account Number**

The first field is for the **Patient Account Number** while the field next to it to the right is where the **Patient's Name** (*Last Name, First Name MI*) will be entered. This information is entered automatically when creating a claim from within the **Patient Record** or within the **Schedules Module**.

If not accessed from either of those two, this field will be blank. Click on the **search box** to the right of this field (with the three dots in it) and find and select the Patient the claim is being created for.

#### **File Date**

This field is automatically populated with the date the claim is being created. You can change this date by highlighting over the date in this field and typing the date you want to use.

#### **Rendering Physician**

This information is entered automatically based on the **Provider** selected in the **Patient Record** under the **Demographic Tab**.

You can change the **Rendering Physician** by clicking on the drop down menu and selecting one from the available list.

This information prints in Box 31 of the HCFA/CMS 1500 Claim Form.

#### **Insurance**

This information is entered automatically based on the **Primary Insurance** entered in the **Patient Record** under the **Insurance Tab**.

If the Patient has both a **Primary** and an **Independent** Insurance, and you need to change it from Primary to Independent, click on the drop down menu and select it from the list.

This information prints in Boxes 1, 1a, 4, 7, 11 (A-D) of the HCFA/CMS 1500 Claim Form.

### **Facility**

This information is entered automatically if the Rendering Provider record includes a default facility. If not, click on the drop down menu and select it from the list.

This information prints in Boxes 32, 32A, and 32B of the HCFA/CMS 1500 Claim Form.

### **Referring Physician**

This information is entered automatically based on the **Referring Physician** selected in the **Patient Record** under the **Demographic Tab**.

You can change the **Referring Physician** by clicking on the drop down menu and selecting one from the available list.

This information prints in Boxes 17, 17A, and 17B of the HCFA/CMS 1500 Claim Form.

### **Supervising Physician**

You can select a **Supervising Physician** by clicking on the drop down menu and selecting one from the available list. (The Supervising Physician list uses the same providers as the **Referring Physician** list).

### **Ordering Physician**

You can select an **Ordering Physician** by clicking on the drop down menu and selecting one from the available list. (The Supervising Physician list uses the same providers as the **Referring Physician** list).

**b) The Middle Section**

**Current Illness Date Field**

This information is entered automatically based on the **Current Illness Date** entered in the **Patient Record** under the **Default Tab**. If not, you can enter it yourself.

This information prints in Box 14 of the HCFA/CMS 1500 Claim Form.

**Same or Similar Date Field**

Enter the date the Patient has experienced this same illness or issue before.

This information prints in Box 15 of the HCFA/CMS 1500 Claim Form.

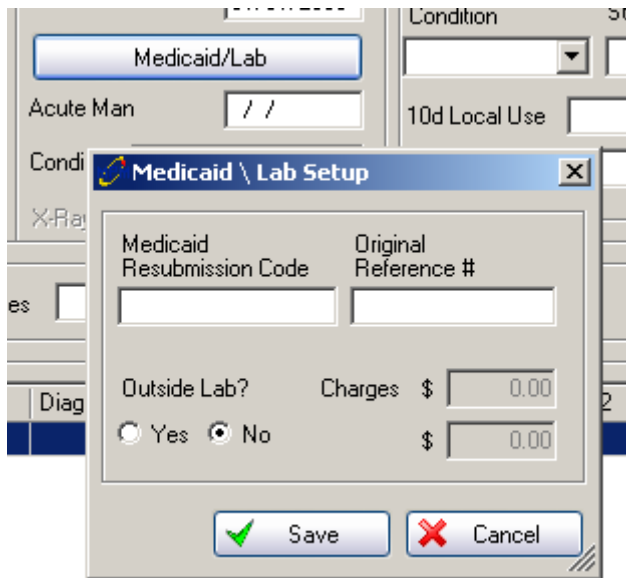
**Date Last Seen Field**

This information is entered automatically based on the **Date Last Seen** entered in the **Patient Record** under the **Default Tab**. If not, you can enter it yourself.

This information prints at the top of the date fields of the 1<sup>st</sup> line item in Box 24A of the HCFA/CMS 1500 Claim Form with the date followed by the words “**Last Seen By Referring MD**”. See example below:

2. I _____, _____ 4. I _____, _____												
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	\$
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1/1/2009 LAST SEEN BY REFERRING MD												
05	06	09	05	06	09	11		00100			1	

**Medicaid/Lab Options Button**



If you bill **Medicaid Claims**, or if you bill claims with **Lab services**, this section applies to you. If not, move on to the next section.

When you click on the **Medicaid/Lab** button it will open the **Medicaid/Lab Set Up** screen with the top portion for Medicaid Claim filing, and the bottom portion having to do with Lab services billed on your claim.

For **Medicaid** related services: the fields provided are used when you resubmit a claim to Medicaid. Fill in the appropriate fields with the **Resubmission Code Number** and/or **Original Reference Number** as given you by Medicaid, and click the **SAVE** button when done. This information prints in Box 22 of the HCFA/CMS 1500 Claim Form.

For **Lab** related services: If you are billing for lab services that you sent to an **outside laboratory** to process (whereby they bill you and you bill the Patient or their Insurance), select **YES**. If not, select **NO**. If **YES**, enter the **charges** in the fields provided. This information prints in Box 20 of the HCFA/CMS 1500 Claim Form.

### **Acute Manifestation Date, Condition, and X-Rays**

These three items are for **Chiropractic** services. If they do not apply to you, move on to the next section.

When billing for Chiropractic services, enter the Acute Manifestation Date in the **ACUTE MAN** field and select the **CONDITION** from the drop down menu. If **XRAYs** were taken, place a click in the box to the right of the label "**XRAYs?**" and in the **Box 19** field, enter the XRAY date (i.e.: XRAY 010197).

### c) **The Right Side**

#### **Hospitalized From/To Date Fields**

Enter the date the Patient was hospitalized when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

This information prints in Box 18 of the HCFA/CMS 1500 Claim Form.

#### **Unable to Work From/To Date Fields**

If the Patient is employed and is unable to work in his/her current occupation, enter the date when the Patient is unable to work. An entry in this field may indicate employment related insurance coverage.

This information prints in Box 16 of the HCFA/CMS 1500 Claim Form.

#### **Condition/State/Date (Accident Related)**

The following three items are to be completed if the services being billed are as a result of the Patient being involved in an Accident (all three must be completed).

**Condition:** Select what type of accident the Patient was involved in from the drop down menu provided in this field. This information prints in Box 10 (A, B, or C) of the HCFA/CMS 1500 Claim Form.

**State:** Select the State that the Patient's accident occurred in. This information prints in Box 10B "Place" of the HCFA/CMS 1500 Claim Form.

**Date:** Enter the date the Patient's accident took place in. This information prints in Box 14 of the HCFA/CMS 1500 Claim Form.

Note that this information is entered automatically based on the information entered for these same fields in the **Patient Record** under the **Default Tab**.

#### **10d Local Use Field**

This field is normally left blank; however, according to Medicare's instructions, when billing a claim to Medicare when a Patient also has Medicaid, you must enter the Patient's Medicaid number preceded by the letters MCD in this field. This information prints in Box 10D of the HCFA/CMS 1500 Claim Form.

## Box 19 Field

Use the Box 19 field to place information that a specific insurance carrier may need when billing your claim. For example, Medicare has a long list of items that could go in this field when billing Medicare for services. Other insurance carriers may have specific instructions as well. This information prints in Box 19 of the HCFA/CMS 1500 Claim Form.

## 2. ANESTHESIA INFORMATION (MIDDLE SECTION):

Anesthesia								
<input type="text"/>	To	<input type="text"/>	Total Minutes	<input type="text" value="0"/>	Minutes into Units	<input type="text" value="0.00"/>	Minutes \$	<input type="text" value="0.00"/>

This section pertains to Anesthesiology related claims. If this does not apply to you, move on to the next section. Additional information about working with Anesthesia claims can be found in the section titled “**Anesthesia Billing Using the MPM Office Program**”.

This section is separated into four areas:

### Start/End Time Fields

There are two boxes immediately the word “**Anesthesia**”. These boxes represent the Start and End Time of the anesthesia service. In the left box enter the **Start Time** of the Anesthesia Service. In the box on the right of the word “**TO**”, enter the **End Time** of the Anesthesia Service. The time is entered in Military Time. For example: 11:00am would be entered as 1100, 1:30pm would be entered as 1330.

This information prints at the top of the date fields of the 1<sup>st</sup> line item in Box 24 of the HCFA/CMS 1500 Claim Form with the words “**Begin \_\_\_\_ End \_\_\_\_ Time**”. See example below:

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	
	From	To							(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER	
1	05	06	09	05	06	09	11		00100	

### Total Minutes Field

The total number of minutes of anesthesia time is automatically filled in for you based on the start and end time entered in the previous fields. It is calculated at 60 minutes per hour.

This information prints at the top of the date fields of the 1<sup>st</sup> line item in Box 24 of the HCFA/CMS 1500 Claim Form with the words “\_\_\_ Minutes”. See the example above.

### Minutes into Units Field

The number of units shown in this field is automatically filled in for you. It is calculated at 1 unit for every 15 minutes of time from the **Start Time** to the **End Time**, and is used to calculate the number of units in Box 24G of the HCFA/CMS 1500 Claim Form for the Anesthesia procedure code billed.

If selected from the Insurance Set Up, the units may calculate at 1 unit for every 10 minutes. Please refer to the section titled “**Software Set Up: Insurance**” for more information.

### Minutes \$ Field

The amount calculated in this field is based on the Fee Schedule initially set up for the Rendering Physician. Please refer to the section titled “**Software Set Up: Fee Schedules**” for more information.

## 3. PROCEDURES (BOTTOM SECTION):

The image shows two overlapping software windows. The background window is titled 'Procedures' and contains a table with columns: From, To, Diag1, Diag2, Diag3, Diag4, Proc, Mod 1, Mod 2, Units, and Charge. It has 'Add', 'Edit', and 'Delete' buttons. The foreground window is titled 'Edit New Transaction Data' and contains a form for entering procedure details. It includes six 'Diagnosis' dropdown menus, a table for 'Dates of Service' (From/To), 'Procedures' (dropdown), 'Pointers' (checkboxes 1-6), 'Modifiers' (dropdowns), 'Units', and 'Dollars'. At the bottom, there are fields for 'Place of Service', 'Type of Service', 'Prior Authorization #', 'Family Plan', 'EMG', and 'COB'. A 'Balance' field shows '\$0.00' in green, and 'Save' and 'Cancel' buttons are at the bottom right.

The section on the bottom will appear empty until a claim is created and saved, and at that point you will be able to “preview” the claim details from this section and decide whether you want to continue saving what you entered, or go back in and edit it.

To begin creating the claim, you need to click on the **ADD** button to open the **Edit New Transaction Data** screen.

Note: To move from *field to field* when entering claim information, click the “**Tab**” button on your keyboard. To move from *line to line*, click the “**Enter**” button on your keyboard.

The screen displays a total of **6 line items** matching the 6 line items that can be printed on in Box 24 of the HCFA/CMS 1500 Claim Form. If your claim has more than 6 line items, you will be given the opportunity at the end to **SAVE & ADD**.

### **Diagnosis Fields:**

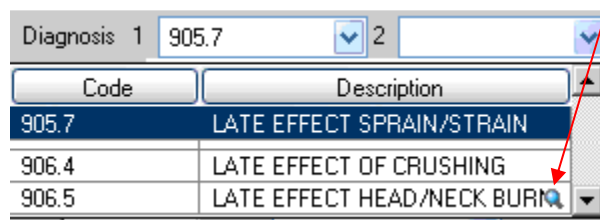
There are 6 fields to enter Diagnosis Codes (matching the 6 fields that print in Box 21 of the HCFA/CMS 1500 Claim Form).

**Although you can enter up to 6 Diagnosis Codes on the claim itself, if you send this claim ELECTRONICALLY, you can only have a MAXIMUM of 4 Diagnosis Codes per Procedure Code entered.**

Enter (or select from the drop down menu that appears in this field) the Diagnosis Code(s) to be billed on the claim. These fields will automatically populate with the Diagnosis Codes entered under the **Default Tab** of the “**Edit Patient Data**” screen when the **Patient Record** was created.


You can search for a Diagnosis Code either by code or description. Click on the drop down arrow in the **Diagnosis** field you want the code to appear in. This opens a list of **Diagnosis Codes** and their matching **Descriptions**. From here, select the code you want to use by double-clicking on it from the list that appeared.

If the list does not contain the code you need, click on the **magnifying glass** that appears on the bottom right of the Description column (see example below):



Code	Description
905.7	LATE EFFECT SPRAIN/STRAIN
906.4	LATE EFFECT OF CRUSHING
906.5	LATE EFFECT HEAD/NECK BURN

A **FIND** option field will appear as shown below:

002.2	PARATYPHOID FEVER B	
002.3	PARATYPHOID FEVER C	
Find:	<input type="text"/>	<input type="button" value="Next"/> <input type="button" value="Ok"/>

In the **FIND** field, type in the code number or the description of the Diagnosis Code that you are looking for and click on the **NEXT** button. Continue to click on the **NEXT** button until the one that you are looking for appears. When you find it, double click on it to append it into the Diagnosis field.

### Dates of Service Fields:

Enter the date (or date range) that the services were rendered. If the **From** and **To** dates are the same, hit the **Tab** button on your keyboard after entering the **From** date to automatically enter the same date as the **To** date. This information will print in Box 24A under the **Date(s) of Service** column on the HCFA/CMS 1500 Claim Form.

### Procedure Code Fields:

Enter (or select from the drop down menu that appears in this field) the Procedure Code(s) to be billed on the claim. You can search for a Procedure Code either by code or description. Click on the drop down arrow in the **Procedures** field to open a list of **Procedure Codes** and their matching **Descriptions**. From here, select the code you want to use by double-clicking on it from the list that appeared.

If the list does not contain the code you need, click on the **magnifying glass** that appears on the bottom right of the Description column and a **FIND** option field will appear. In the **FIND** field, type in the code number or the description of the **Procedure Code** that you are looking for and click on the **NEXT** button. Continue to click on the **NEXT** button until the one that you are looking for appears. When you find it, double click on it to append it into the Procedures field.

If the Procedure Code has not previously been entered in the **Software Set Up**, when you type in the code it will erase as soon as you Tab out of that field. You can enter a Procedure Code into MPM Office program from this field by clicking on the word **ADD** in the drop down menu which will open the **Edit New Procedure Code** screen and allow you to create the code in the Software Set Up.

Procedure Codes print in Box 24D of the HCFA/CMS 1500 Claim Form under the heading "**CPT/HCPCS**".

**Pointers:**

The six Pointers option boxes correspond with the 6 Diagnosis Code fields. When more than one Diagnosis Code is entered, each Pointer box, per line item, will be automatically fill in based on the number of Diagnosis Codes entered. You can manually uncheck the box that does not apply. For example, if you have three Diagnosis Codes entered and only the 1<sup>st</sup> code applies to the line item, you would uncheck the other two.

Procedure Codes print in Box 24E of the HCFA/CMS 1500 Claim Form under the heading “**Diagnosis Pointer**”.

**Modifier Code Fields:**

Enter (or select from the drop down menu that appears in this field) the Modifier Code(s) to be billed on the claim. Click on the drop down arrow in the **Modifiers** field to open a list of **Modifier Codes** and their matching **Descriptions**. From here, select the code you want to use by double-clicking on it from the list that appeared.

If the list does not contain the code you need (because has not previously been entered in the **Software Set Up**), when you type in the code it will erase as soon as you Tab out of that field. You can enter a Modifier Code into MPM Office program from this field by clicking on the word **ADD** in the drop down menu which will open the **Edit New Modifier Data** screen and allow you to create the code in the Software Set Up.

Modifier Codes print in Box 21 of the HCFA/CMS 1500 Claim Form under the heading “**Modifier**”.

**Units Field:**

The Units field will automatically populate with the number of units entered in the **Procedure Code** set up for the Procedure Code being used. If not, enter the number of units you are billing for the chosen Procedure Code. You can also edit the number of units appearing in this field by highlighting the current number of units and entering the correct one.

Units print in Box 24G of the HCFA/CMS 1500 Claim Form under the heading “**Days or Units**”.

**Dollars Field:**

The **Dollars** field will automatically populate with the amount in the **\$ Per Unit field** in the **Procedure Code** set up for the Procedure Code being used. If not, enter the amount

of your charge for the chosen Procedure Code. You can also edit the amount appearing in this field by highlighting the current number and entering the correct one.

This will print in Box 24F of the HCFA/CMS 1500 Claim Form under the heading “**\$ Charges**”.

### **Place of Service Field:**

The **Place of Service** field will automatically populate with the number representing the Place of Service selected in the **Facility** set pp for the Facility selected when first creating this claim.

If not, from the menu provided in this field click on the number that represents the **Place of Service** where the services were rendered (i.e.: **11** Office, **21** Inpatient Hospital, **22** Outpatient Hospital, etc.).

*Note: If selecting an INPATIENT FACILITY Place of Service (codes 21, 31, 32, 34, 51, 52, 55, or 56), the HOSPITALIZED FROM/TO dates fields must be filled in so as to avoid a possible claim rejection by either the clearinghouse or the insurer.*

This information will print under the **Place of Service** column in box 24B of the HCFA/CMS 1500 Claim Form.

### **Type of Service Field:**

Type of Service was an option that used to be needed on the old HCFA 1500 Claim Form. It used to print in box 24C. This information is **no longer necessary** on the new CMS 1500 Claim Form. However, if you want to use it, select the type of business entity that best describes your provider (*Is he a Solo Practice, Partnership, Professional Org., etc.?*), from the drop down menu provided in this field.

### **Prior Authorization # Field:**

If the service requires one, select it from the drop down menu provided in this field, so long as you created one before (either through a previous claim or through the **Defaults Tab** of the Patient Record.

If you need to add a Prior Authorization for the first time, enter it by selecting “**Edit**” from the drop down menu provided in this field, and then selecting “**Add**” in the “**Prior Authorization For**” box that appears in the “**Edit New Prior Authorization Code**” window. In the fields provided, enter the **Prior Authorization Number**, a short **Description** as to what this Prior Auth is for, select the **Number of Visits** from the drop down menu provided, and enter the date the authorization **Expires**. Click the “**Save**”

button when done and then the “Close” button to return to the “**Edit New Transaction Data**” screen.

**\*\*\* Note regarding Prior Authorizations:** When more than one service date requires a Prior Authorization to be printed on the claim, each service date must be entered as a separate claim in order to apply the Prior Authorization correctly.

### **Family Plan Field:**

The information to be entered in the **Family Plan (EPSDT)** field applies only to Medicaid claim and is used to report Family Planning Services as well as Early & Periodic Screening, Diagnosis, and Treatment related services. In the field provided, enter the appropriate two character code response (identifying certain services that may be covered under some state plans) based on the instructions provided to you by your State’s Medicaid program.

If this field is completed, a Y will print in Box 24H of the HCFA/CMS 1500 Claim Form. If this field is left blank, Box 24H will remain blank.

### **EMG Field:**

The information to be entered in the **EMG (Emergency)** field advises the Insurance Company if the visit was due to an emergency. In the field provided, enter “Y” if this was an emergency visit, or “N” if not. This will print in Box 24I of the old HCFA 1500 Claim Form, or in box 24C of the CMS 1500 Claim Form.

### **COB Field:**

**The Coordination of Benefits** information applies to the old HCFA 1500 Claim Form and is no longer used for the new CMS 1500 Claim Form. It applies to paper claim submissions only.

Enter the appropriate code from the list below. If none of the following conditions apply, leave this item blank:

- 1** = An insurance carrier other than Medicare made payment.
- 2** = Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only.
- 3** = An insurance carrier other than Medicare applied the charges to the deductible.
- 4** = Both Medicare and another carrier made payment.
- 5** = Medicare only made payment.

- 6** = Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only.
- 7** = Medicare applied all charges to the deductible.
- 8** = The patient has other insurance (other than Medicare) and this service is not covered OR the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in Box 19. The policy number of the other insurance must be reported in box 11 even if the other insurance is terminated or expired.
- 9** = Spend-down liability. Enter the spend-down liability of the patient in item 24K.

**Note: Do not bill Medicare covered and excluded services on the same claim. The Medicare EOB and/or the other insurance EOB must be submitted with the paper claim if you entered 1, 3, 4, 5, or 7.**

When done filling in all of the required information, do one of the following:

*If you more than 6 lines of services to bill for this patient, click the "Save and Add" button on the bottom left side of this screen to open a new "Edit New Transaction Data" screen to enter more charges.*

*If there are no additional services, click the "Save" button on the bottom right side of this screen to return to the "Edit New Claims Data" screen.*

## **B. Reviewing the Entered Charges and Saving your Work**

In the opened **Edit New Transaction Data** screen, make sure that all of the fields have been entered correctly. This gives you an opportunity to check your claim before submitting it.

If you **do not** want the Patient to be billed for any remaining balances for this claim, click in the box to the left of the label **DO NOT BILL PATIENT**.

When done, click the "**Save**" button to exit out of this screen and return to the "**Edit Patient Data**" screen.

## **C. Save Time by Using the "Repeat Procedures" Option**

If you have already entered a claim for a Patient and they are being treated again for the **same conditions** using the **same Procedure Codes and Diagnosis Codes** as on their last visit, you can save time in entering future claims for this Patient by doing the following from the opened "**Edit Patient Data**" screen:

- a) Click on the “**Add Claim**” button.
- b) In the opened “**Edit New Claims Data**” screen, complete the **General Information** (Top Section), and the **Anesthesia Information** (Middle Section), as needed.
- c) Click on the “**Repeat Procedures**” button, and in the “**Repeat Procedures, New Claim**” screen, change the Date of Service (**DoS**) field to reflect the correct service date.
- d) Click the “**Save**” button when done to return you to the “**Edit New Claims Data**” screen.
- e) Review the entered Procedures. Click the “**Edit**” button to edit any entries made, or the “**Delete**” button to remove an entry made. If everything is correct as entered, click the “**Save**” button to return you back to the “**Edit Patient Data**” screen.