PC Ace

User’s Guide

Professional Claims

V2.4
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Contact Us:
Medicare Part B – MAC J5 (866) 518-3285 (Option 1), MAC J8 (866) 234-7331 (Option 1)
WPS Health Insurance, ARISE, VAPC3 and TRICARE – 800-782-2680 (Option 1)
or visit our website at:
http://www.wpshealth.com/resources/provider-resources/edi/
WPS EDI Disclaimer

This User’s Guide is designed to assist PC ACE users with entering claim data and preparing electronic claim files for transmission to WPS Health Solutions only. Not all the software functionality is addressed in this document. For additional assistance with the software, access the ‘Help’ function referenced above. It is the sole responsibility of the software user to ensure that all claim submission and/or policy requirements are met.

PC ACE is a standalone software. WPS Health Solutions does not support Networking or Server set up.

WPS does not support PC ACE software that has been downloaded onto a MAC based computer. This is also not supported by the vendor.

Go to https://www.wpsic.com/edi/pcacepro32.shtml on a quarterly basis (January, April, July and October), to update your program, to avoid the software expiring.

**NOTE: The Installation of PC ACE will create a folder in your C: Drive titled ‘WINPCACE’. It is important that this folder is not manipulated (Add, Remove or Move folders within this folder) in any way as it will cause the PC ACE software to not proper correctly.

Installation

Website Full Install

Go to: https://www.wpsic.com/edi/pcacepro32.shtml

Complete the following steps to install PC ACE:

•Step 1: Scroll down to the PC ACE Installations. Click the link titled “Download the PC ACE Full Install” (The screen shown below will appear.)

•Step 2: Click “Run”
•Step 3:  You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to the line of Business you bill for, to receive the password.

Medicare Helpdesk:
1-866-518-3285 (Option 1) - J5 and J5 National
1-866-234-7331 (Option 1) - J8

Or by email
Part A  edimedicarea@wpsic.com
Part B  edimedicareb@wpsic.com

TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS Help desk at:
1-800-782-2680

Or by e-mail
edi@wpsic.com

Note: The password will appear as asterisks (******) on your screen when you type it.

•Step 4:  A window labeled ‘Drive Selection’ will appear. PC ACE must be installed on your systems hard drive (C). DO NOT SELECT A DIFFERENT DRIVE.
Step 5: A window labeled ‘Start Installation’ will appear.

Step 6: A ‘Read Me File’ window will now appear. Read this information.

Step 7: A window labeled ‘Installation Complete’ will appear.
Website Upgrade

Quarterly updates to the software are created. You will need to regularly access the following link to determine if the current quarterly upgrade applies to your software. Please make sure you are always on the most current version of the software to utilize the most up-to-date industry information and business edits for the Line of Business you submit claims for.

If you have internet access on the computer with your PC ACE, please follow the directions below to upgrade via the internet. If you do not have internet access, please contact the EDI Help Desk to request that a disc with the upgrade be sent to you in the mail.

- **Note:** You must have the WPS version of PC ACE already installed to complete this upgrade.

**Step 1:**
- On the Main PC ACE toolbar select ‘Help’ and ‘Upgrade your PC ACE’. This will open your default internet browser to URL: [http://www.wpsic.com/edi/pcacepro32.shtml](http://www.wpsic.com/edi/pcacepro32.shtml). This is the website where you will find the link to upgrade to the most current version and find other helpful information regarding PC ACE.
*** Be sure your PC ACE is shut down after selecting ‘Upgrade your PC ACE or you will not be able to successfully upgrade. The Upgrade will not work while PC ACE is running.

- **Once on the website, close you’re PC ACE completely** (the upgrade cannot be done while PC ACE is open). Be sure to view the ‘Upgrade Instructions’, as these instructions contain helpful information you should know, including how to obtain the upgrade password. Then select: ‘Download the PC ACE Upgrade to Version…’ and proceed through the update.

**PC ACE Installations**

**PC ACE Full Installation V4.5**
(If you do not have any version of PC ACE on your PC)

- Complete Install Instructions
- Download the PC ACE Full Install

**PC ACE Upgrade to V4.5**
(If you currently have a version of PC ACE on your PC)

- Upgrade Instructions
- Download the PC ACE Upgrade to Version 4.4
  **Note:** You must first quit PC ACE in order to install the upgrade.

**PC ACE Version 4.5 Change Summary**

- Professional Change Summary
- Institutional Change Summary
Step 2:
The ‘File Download’ box will appear

![File Download - Security Warning]

a) Select ‘Run’ if you wish to perform the upgrade now, while on-line.

b) Select ‘Save’ if you wish to save the file, pcaceup.exe, to your hard (C drive and run the upgrade later. **DO NOT SAVE PCACEUP.EXE TO YOUR WINPCACE FOLDER.** When you are ready to perform the upgrade, locate the file pcaceup.exe in your hard drive and double click on the file to execute the upgrade program.

Step 3:
A pop-up box will appear that acknowledges the PC ACE Claims Processing System Wise Installation Wizard has been initialized.

![PC-ACE Prc32 Claims Processing System]

Step 4:
You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to the line of Business you bill for, to receive the password.

You can email the Medicare Helpdesk for Medicare at:
- edimedicarea@wpsic.com
- edimedicareb@wpsic.com

or call
- **J5 and J5 National** – 866-518-3285
- **J8** – 866-234-7331

You can contact TRICARE/VAPC3/WPS Health Insurance/ARISE/Family Care/BLTS Help desk at:
- 1-800-782-2680 or by e-mail at edi@wpsic.com.
Note: The password will appear as asterisks (******) on your screen when you type it.

Step 5:
You will see a ‘Backup Reminder’, if you wish to back up your PC ACE prior to doing the upgrade click ‘No’ and do so. If not, click ‘Yes’ to proceed with the update.

Step 6:
Review the ‘Welcome’ information and follow the suggested actions. When you are ready to continue, click the ‘Next’ button.
Step 7:
Click the ‘Next’ button to continue with the upgrade.

Step 8:
Click the ‘Next’ button to continue with the upgrade.

Step 9:
Upon successful completion of the upgrade you will see the ‘Update Complete’ pop-up box. Click ‘Finish.’
Step 10:
The last notice is a ‘Backup Reminder’, be sure to run another backup after you have completed this upgrade. Click ‘Ok’ to exit.

Disk Full Install

Please complete the following steps to install your PC ACE software:

Step 1:
- Double-click the ‘setup.exe’ icon in your CD-ROM drive:

Step 2:
- You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to what line of Business you bill for, to receive the password.

**Medicare** Helpdesk:
1-866-518-3285 (Option 1) – J5 and J5 National
1-866-234-7331 (Option 1) – J8

Or by email
Part A  edimedicarea@wpsic.com
Part B  edimedicareb@wpsic.com

**TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS** Help desk at:
1-800-782-2680

Or by e-mail
edi@wpsic.com
Note: The password will appear as asterisks (******) on your screen when you type it.

Step 3:

- Once the password is entered you will see the following warning. If you wish to proceed click ‘Next’. If not, select ‘Cancel’ and the installation will close.

Step 4:

- A window labeled ‘Drive Selection’ will appear. PC ACE must be installed on your systems hard drive (normally the (C: drive). DO NOT SELECT A DIFFERENT DRIVE. Click ‘Next’ to proceed.
Step 5:
• You are now ready to begin the installation. Click ‘Next’ to begin the installation:

Step 6:
• You will see this screen as the installation begins:

Step 7:
• You will now see a ‘Read Me’ file. Read this information and click ‘Next’ to proceed:
Step 8:

- Click ‘Finish’ and the installation is complete:

![Installation Complete]

- You will now have the **PC ACE** icon on your desktop:

![PC ACE icon]

**Disk Upgrade**

**Please complete the following steps to upgrade your PC ACE software to the most current version:**

**Step 1:**

- Double-click the ‘**pcaceup.exe**’ icon in your CD-ROM drive:

![pcaceup.exe]

**Step 2:**

- You will be asked to enter a password to continue. You will want to contact one of the numbers below that applies to what line of Business you bill for, to receive the password.

**Medicare Helpdesk:**
1-866-518-3285 (Option 1) – J5 and J5 National
1-866-234-7331 (Option 1) – J8
Or by email
Part A  edimedicarea@wpsic.com
Part B  edimedicareb@wpsic.com

TRICARE/VAPC3/ARISE/WPS Health Insurance /Family Care/BLTS Help
desk at:
1-800-782-2680

Or by e-mail
edi@wpsic.com

Note: The password will appear as asterisks (*******) when you type it.

Step 3:

• You will see a ‘Backup Reminder’. If you wish to back up your PC ACE prior to doing the
  upgrade, click ‘No’. If not, click ‘Yes’ to proceed with the update.

Step 4:
• You will now see the following warning. If you wish to proceed click ‘Next’. If not, select ‘Cancel’ and the update will close.

Step 5:
• You are now ready to start the update. Click ‘Next’.

Step 6:
• You will see this screen as the upgrade begins installing:

Step 7:
• You will now see a ‘Read Me’ file. Read this information and click ‘Next’ to proceed:
Step 8:

- Click ‘Finish’ and the update is complete:

Step 9:

- You will see a ‘Backup Reminder’. Read the reminder and click ‘OK’.

- You have now been updated to the most recent version of PC ACE!

Access/Exit PC ACE

Once PC ACE installation is complete, an icon for the software will be present on your desktop. Double click this icon to access PC ACE.
The ‘Main Form’ of PC ACE should now appear on your screen.

Click on the ‘X’ in the upper right corner of the ‘Main Form’ to exit the software. You will receive a text message asking if you wish to back up the software.

If you wish to back up your software, type the path indicating where you want the software backed up in the field labeled ‘Destination Drive or Folder’, or click ‘Browse’ and find the destination you wish, and then click ‘Start Backup’. Click ‘Cancel’ if you do not wish to back up your PC ACE at this time.

**It is strongly recommended that you routinely perform the backup operation when exiting the software to ensure you have the most current data backed up should there be system issues.**

You should back up the PC ACE program as described on page 111 of this User Guide. If you don’t back-up PC ACE and rely upon backing up your entire PC, problems can arise during the restore operation. See page 111 for more detailed instructions on backing up and restoring your databases.

**Overview ‘Main Form’:**
INST (Institutional) Claims Processing

Professional Claims Processing

Reference File Maintenance

Data Communications Functions

Claim Activity Scheduling (not available at this time)

ANSI 835 Functions (can be used to process Electronic Remittance Advice (ERA) files

System Utilities

**Sign On**

Each time you begin a PC ACE session by selecting from the `Main Form`, you will be prompted to enter a **User ID** and **Password**.
The initial User ID is **SYSADMIN**. The initial password is **SYSADMIN**. This User ID and password can be used at any time to initiate a PC ACE session. You can also set up your own PC ACE User IDs and passwords by accessing the security option from the Main Form toolbar.

**THIS IS NOT THE SAME USER ID AND PASSWORD THAT WAS ASSIGNED TO YOU BY WPS HEALTH SOLUTIONS FOR TRANSMISSION**

**Security/Create User ID’s**

WPS Health Solutions suggests that a unique User ID be created for each individual PC ACE user in your office.

**Note:** The User IDs and passwords you create for PC ACE have nothing to do with your User ID and Passwords for the WPS Bulletin Board System (BBS) or Gateway Express Website. User IDs for the WPS BBS and Gateway Express Website are all assigned by WPS Health Solutions EDI staff and are not affected by PC ACE access. Do not confuse the two.

Complete the following steps to create a new PC ACE User ID:

**Step 1:** Click ‘Security’ from the ‘Main Form’ toolbar and select ‘Add/Update User’.

**Step 2:** Click ‘New’ at the bottom of the ‘Security List’ screen that appears.
The ‘User Security Update’ screen will appear.

**Step 3:** Type the User ID and Password you wish to assign in the appropriate fields. Then type the user’s name.

**Step 4:** Use the scroll bar at the right of the ‘User Security Update’ screen to view access options. Click on the access option(s) you wish to grant to this user.

If you wish to give the user full access to all options for which you are licensed, click ‘Check All’.

**Step 5:** Click ‘OK’ when you have finished with this user. You will be returned to the ‘Security List’ and the user you added will appear on the list.

You can make changes at any time by selecting the user you wish to change and clicking ‘View/Update’ and modifying the record.

**PC ACE Key/Mouse Functions**

Basic Key Functions:
Pressing the `<Tab>` key will move your cursor forward from one field to the next in all screens.

Hold down the `<Shift>` key and press `<Tab>` to move your cursor back one field within any screen.

Press the `<F2>` key to display a menu of valid values when your cursor is in a field with an associated ‘lookup’.

Hold down the `<Alt>` key and press `<F2>` to display all the fields on any screen with associated ‘lookup’ menus of valid values.

Press `<F4>` to copy data from the same field on the previous line when entering line item data.

Press `<Backspace>` to move backward one space within a field while deleting data.

**Basic Mouse Functions**

‘**Left Click**’

Use a single left click to make menu selections, select screen tabs, activate buttons, etc.

*Note:* Any time you are instructed to ‘**Click**’ (or select) an item, assume it is a single left click unless otherwise specified.

‘**Right Click**’

Use a single right click to display a menu of valid values when your cursor is in a field with an associated ‘lookup’. (Same as `<F2>`)

Note: Once you have finished using any of the PC ACE screens, click on ‘**X**’ in the upper right corner of the screen to exit and return to the previous menu or Main Form.

**Getting Started**

Before importing or entering claim data, you will need to complete some system setup. Specifically, you will need to create Submitter Information records, Provider File records and Payer records using the ‘Reference File Maintenance’ function.

The ‘Reference File Maintenance’ function is also used to enter Patient records, Referring/Ordering/Supervising Physician records and Facility records as well as others. These records
can be created ‘on-the-fly’ while entering claim information and do not have to be present prior to claim entry.

**System Setup/Reference File Maintenance**

**Submitter File Setup**

Must be completed before entering claim data.

**Version 2.32 and beyond default to the 5010A1 format**

The first database that needs to be created is the **Submitter** reference file. This database attaches Submitter information to each file you create and transmit to WPS Health Solutions.

Complete the following steps to create a **Submitter** record:

**Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

**Step 2:** Select the ‘Codes/Misc’ Tab from the ‘Reference File Maintenance’ screen that appears.

**Step 3:** Select the ‘Submitter’ button from the list of Reference Files on the ‘Codes/Misc’ tab.

**Step 4:** If you will be using only one WPS Submitter ID (regardless of how many Lines of Business you are submitting for), **DO NOT** click ‘NEW’, click ‘View/Update’ at the bottom of the **Submitter Setup** list that appears. Then continue with Step 5 below. If you have more than one WPS Submitter ID, click ‘New’ and add a record for each Submitter ID you have for each line of business.
**Step 5:** Complete the following *Required* fields on the ‘General’ Tab of the ‘Professional Submitter Information’ screen:

1. **LOB Field (Line of Business) – Required**

   *If updating the ALL/ALL default record, this field will be unavailable.*

   (Right click in field to obtain list of values.)

   - ‘MCB’ = Medicare Part B
   - ‘COM’ = WPS Health Insurance
   - ‘TRI’ = TRICARE
   - ‘VA’ = VAPC3

2. **Payer ID Field – Required**

   *If updating the ALL/ALL default record, this field will be unavailable.*

   (Right click in field to obtain list of values.)

   - ‘08202’ = Medicare for MI
   - 08102 = Medicare for IN
   - ‘05102’ = Medicare B for Iowa
   - ‘05202’ = Medicare B Kansas
   - ‘05302’ = Medicare B for Missouri
3. **ID Field – Required**

Enter your **WPS Health Solutions Submitter ID** (User ID for the WPS Bulletin Board System (BBS) or Gateway Express). Press <Tab> to go on to the next field.

4. **EIN Field (Employer Identification Number) – Not Applicable**

Press <Tab> to skip this field.

5. **Name Field – Required**

Enter the submitter’s company name. Press <Tab>.

6. **Address/City/State/Zip Fields – Required**

Complete these fields with the submitter address information. Press <Tab> to move from field to field.

7. **Phone Field – Required**

Type the submitter’s telephone number, including the Area Code. Press <Tab>.

8. **Fax Field – Optional**

Type the submitter’s Fax number, including the Area Code or press <Tab> to leave this field blank.

9. **Country Field – Not Applicable**

Press <Tab> to skip this field.

10. **Contact Field – Required**

   Enter the submitter’s contact name (your name). Press <Tab>.

11. **E-Mail Field – WPS requests this portion be populated**

   Enter the submitter’s email address.

---

**Step 6:** Complete the following ‘**Required**’ fields on the ‘**Prepare**’ Tab of the ‘**Professional Submitter Information**’ screen:

- ‘05402’ = Medicare B for Nebraska
- ‘WPS’ = WPS Health Insurance
- ‘00235’ = WPS Secondary Medigap
- ‘ARISE’ = Arise Health Plan
- ‘EPIC’ = Epic
- ‘FOREN’ = TRICARE Overseas (Foreign)
- ‘TDFIC’ = TRICARE For Life
- ‘TREST’ = TRICARE EAST
- ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region 3)
- ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
- ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5 😎)
- ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)
1. **Include Error Claims Field – Required**

Default is ‘N’ for No. Leave this field as is. Press <Tab> to access the next field.

2. **Submission Status Field – Required**

Press <F2> or ‘right click’ while your cursor is positioned in this field and select

- P – Production
- T – Test

Begins with ‘T’ in this field. Change to ‘P’ when approved to submit production files.

3. **EMC Output Format Field – Required**

- A = ANSI 837 Output Format.

4. **ANSI Version (837) Field – Required**

- 005010A1 – Version 5010 Addendum 1 (This is the default setting in Version 2.32 and beyond and must be used 1/1/12 and after).

5. **ANSI Version (837 Dent) Field – Required**

- Default is 005010A2, leave this field as is. WPS Health Solutions does not accept the 837 Dental formats in any version. Press <Tab> to access the next field.

6. **ANSI Version (270) Field – Required**

- 005010A = Version 5010 Addendum 1 (This is the default setting in Version 2.32 and beyond and must be used 1/1/12 and after)
7. **ANSI Version (276) Field – Required**

- 005010 = Version 5010 Non-Addendum (This is the default setting in Version 2.32 and beyond and must be used 1/1/12 and after)

8. **EMC File Field – Required (IMPORTANT!)**

Type your **Submitter ID** followed by ‘.DAT’

**Example:** If your User ID is 94999, type 94999.DAT (Note: This is an EXAMPLE. Your Submitter ID is specific to you!)

**This field determines the name of the file that is created and transmitted to WPS**

9. **Vendor/Intermediary Fields – Default is 00951. If different please contact the Edi help Desk**

**Vendor/Intermediary and Next Serial No./Next File Seq. Fields are automatically tracked by the software and should not be change/accessed by the user.**

10. **Next Serial No. Field – Automatically Assigned**

**Step 7:** Complete the following **Required** fields on the ‘ANSI Info’ Tab.

1. **Submitter Intchg ID Qual Field – Required**

Enter: ‘ZZ’.

2. **Receiver Intchg ID Qual Field – Required**

Enter: ‘ZZ’.

3. **Authorization Info Field – Not Used**

Leave this field blank.

4. **Security Info Field – Not Used**

Leave this field blank.
5. **Acknowledgement Requested Field – Required**

This field defaults to ‘0’ but PC ACE is hard coded to always create your claim file with a ‘1’ (you will receive acknowledgements) regardless of what is entered here.

6. **Additional Submitter EDI Contact Information Fields – Optional**

These fields can be used to enter your email address, fax number, etc. They can be left blank.

**NOTE:** Information is not required on the ‘ANSI Info (2), (3), (4)’ or the ‘Local’ Tabs. Do not change/add any of the data on these screens.

**•Step 8:** Once you have completed all the required fields on the ‘General’, ‘Prepare’ and ‘ANSI Info’ tabs, click on ‘Save’.

You will be returned to the initial ‘Submitter Setup’ screen and the Submitter Record that you added will appear on the list.

Complete the same steps to create another ‘Submitter’ record if you have more than one WPS Submitter ID.

You can modify/correct or update the information in any of your ‘Submitter’ records by selecting the record from the ‘Submitter Setup’ screen and clicking on ‘View/Update’. Be sure to click on ‘Save’ after making any modifications.

**Provider File Setup**

*Must be completed before entering claim data.*

PC ACE requires the differentiation between ‘Solo’ providers (where the Billing and Rendering Provider NPI/Tax ID’s are the same) and ‘Group’ providers (where there is one Billing Provider NPI/Tax ID and one or more individual Rendering Provider Tax ID/NPI(s)).

**IMPORTANT NOTE:** You MUST create a separate provider record for EACH line of business. For example, if you plan on using PC ACE to bill Medicare Part B and WPS Health Insurance, you need to create a Medicare record for each provider and a WPS Health Insurance record for each provider.

**Creating a Solo Provider Record:**

Complete the following steps to create a ‘Solo’ provider number:

**Note:** ‘Solo’ applies to private practitioners, ambulance services, independent labs or any provider with the same Billing and Rendering provider numbers.

**•Step 1:** Select ‘Reference File Maintenance’ from the PC ACE Main Form.
• **Step 2:** Select the ‘**Provider (Prof)**’ Tab from the ‘**Reference File Maintenance**’ screen that appears.

• **Step 3:** Click on ‘**New**’ at the bottom of the Provider Tab screen that appears.

• **Step 4:** Select ‘Create a completely new provider (all fields blank)’ from the ‘**New Provider Options**’ window that appears. Click ‘**OK**’. This will not appear when entering the first provider record.

The ‘**Professional Provider Information – General Info**’ Tab will be displayed.

• **Step 5:** Select ‘**Solo Practice**’ and complete the following ‘**Required**’ fields on the ‘**Professional Provider Information – General Info**’ Tab:
1. **Organization Field – Situational**
   
   Type the ‘Organization’ name in this field if it applies (i.e. the ambulance service company name). If the solo provider is a person, leave this field blank and complete ‘Name’ fields that follow.

2. **Last/First/MI Fields – Situational**
   
   Type the provider’s Last Name, First Name and Middle Initial in the appropriate fields. If the solo provider is an organization (i.e. ambulance service) these fields do not need to be completed.

3. **Address/City/St/Zip – Required**
   
   Type the provider’s address, city, state and zip code in the appropriate fields. 
   *This must be a physical address, not a PO Box, Bin #, etc.  
   -MUST USE 9-digit ZIP Code*

4. **Phone – Required**
   
   Type the provider’s telephone number (including the area code).

5. **Fax – Optional**
   
   Type the provider’s fax number (including the area code) if applicable.

6. **Contact Field – Required**
   
   Type the contact name for your office.

7. **Provider ID/No. Field – Required**
   
   Type the Provider’s ID that is appropriate for the line of business this record will be used for.
• For Medicare Part B, this field should contain the Medicare-assigned provider number for this solo practice.
• For WPS Health Insurance, TRICARE and VAPC3, this field should contain the provider’s Federal Tax ID.

Note: Provider ID/NO Type of the ‘Extended Info’ Tab should be ‘EI’ for VAPC3.

8. **LOB Field (Line of Business) – Required**

Press <F2> or right click while your cursor is in the field to obtain a list of valid Line of Business values.

- ‘MCB’ = Medicare Part B
- ‘COM’ = WPS Commercial Insurance
- ‘TRI’ = TRICARE
- ‘VA’ = VAPC3

9. **Payer ID Field – Required**

- ‘08202’ = Medicare B for MI
- ‘08102’ = Medicare B for IN
- ‘05102’ = Medicare B for Iowa
- ‘05202’ = Medicare B Kansas
- ‘05302’ = Medicare B for Missouri
- ‘05402’ = Medicare B for Nebraska
- ‘WPS’ = WPS Health Insurance
- ‘00235’ = WPS Secondary Medigap
- ‘ARISE’ = Arise Health Plan
- ‘EPIC’ = Epic
- ‘FOREN’ = TRICARE Overseas (Foreign)
- ‘TDFIC’ = TRICARE For Life
- ‘TREST’ = TRICARE EAST
- ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region3)
- ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
- ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5B)
- ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)

10. **Tag Field – Optional**

This field can be used to ‘Tag’ this provider records for your identification. The data from this field is not required, nor is it submitted to WPS Health Insurance. You can press <Tab> to bypass this field.

11. **Group Label Field – Not applicable for solo provider**

12. **NPI (National Provider Identifier – Required)**

Enter the NPI number assigned to the provider.

**Note:** If you are an atypical provider who is not required to obtain an NPI enter ‘EXEMPT’ in the NPI field.
13. **Tax ID/Type Fields – Required**

Type the provider’s 9-digit Federal Tax ID in the first field. **Do not include hyphens, spaces or other special characters.**

The second field is for ‘Tax Type’. Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of Tax Type values.
- ‘E’ – Employer Identification Number
- ‘S’ – Social Security Number

14. **UPIN Field – Not Used**

This is a legacy number, no longer used by Medicare Part B

**Note:** For information regarding ‘Referring/Ordering/Supervising’ physician UPIN refer to the ‘Physician File Setup’ section of this guide.

15. **Specialty Field – Optional**

Type the appropriate ‘Provider Specialty’ code <F2> or right click while your cursor is in the field for a list of valid Provider Specialty codes.

16. **Type Org Field – Optional**

Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid values or press <Tab> to bypass the field.

17. **Taxonomy Field – Situational but Recommended**

This is required for Ambulance providers and strongly recommended for other providers. Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid Provider Taxonomy codes.

- ‘Right click’ in the small box to the right of this field and choose whether the Taxonomy applies to the Billing provider or Pay-To provider (if entered on the ‘Extended Info’ tab and is different).

18. **Accept Assign? Field – Required**

Indicate whether the provider accepts assignment for this line of business. Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid values.

- ‘A’ = Assigned
- ‘B’ = Assignment accepted for clinical lab services only
- ‘C’ = Not assigned

19. **Participating? Field – Required**

- ‘Y’ = Provider has a participation agreement on file with Medicare Part B.
- ‘N’ = Provider does not have a participation agreement on file with Medicare Part B.

20. **Signature Ind Field – Required**
21. **Date Field – Required**

Enter the date (or approximate date) that the signed agreement was filed with this line of business.

22. **Provider Roles Fields – Required and defaults to values listed below**

**The default values for Solo Provider Roles are ‘Billing’ Field = ‘Y’ and ‘Rendering’ Field = ‘N’. DO NOT CHANGE.**

- **Step 6:** Once you have completed all the fields on the ‘General Info’ tab, select the ‘Extended Info’ tab.

None of the fields on the ‘Professional Provider Information – Extended Info’ tab is required. Complete any that applies to this provider record.

- **Step 7:** Once you have completed all the required ‘Professional Provider Information’ fields, click on ‘Save’.

If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.

Once the record has been saved, you will be returned to the ‘Provider’ Tab of the ‘Reference File Maintenance’ screen. The provider records you added will appear on the list. If you wish to view or modify the record, click on ‘View/Update’ and make any necessary changes. Be sure to ‘Save’ the record again.

**Creating Group Provider Records:**

Group practices must first create a Group Provider record (containing Billing provider information). You must then create a record for each individual provider within the group.

The ‘Individual’ provider records will contain the Rendering Provider information.

**First** – Create Provider Record for the Group (Billing Provider Information):
• **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

• **Step 2:** Select the ‘Provider (Prof)’ Tab from the ‘Reference File Maintenance’ screen.

• **Step 3:** Click ‘New’ at the bottom of the ‘Provider (Prof)’ Tab.

• **Step 4:** Select ‘Create a completely new provider (all fields blank)’ from the ‘New Provider Options’ window. Click ‘OK’.

The ‘Professional Provider Information – General Info’ Tab will be displayed.
Step 5: Select ‘Group Practice’ and complete the following ‘Required’ fields on the ‘Professional Provider Information – General Info’ Tab:

1. **Group Name Field – Required**

   Type the ‘Group’ name in this field.

2. **Last/First/MI Fields – Not applicable for group record**

3. **Address/City/St/Zip – Required**

   Type the group’s address, city, state and zip code in the appropriate fields.
   - This must be a PHYSICAL LOCATION.
   - DO NOT USE POST OFFICE BOX ADDRESSES.
   - You must provide the 9-digit Zip Code.

4. **Phone – Required**

   Type the group’s telephone number (including the area code).

5. **Fax – Optional**

   Type the group’s fax number (including the area code) if applicable.

6. **Contact Field – Optional**

   Type the contact name.

7. **Group ID/No. Field – Required**
Type the Billing Provider ID (Group ID) that is appropriate for the line of business this record will be used for

a. For Medicare Part B, this field should contain the group’s Medicare – assigned billing provider number (PTAN).
b. For WPS Health Insurance, TRICARE and VAPC3, this field should contain the provider’s Federal Tax ID.

Note: Provider ID/NO Type of the ‘Extended Info’ Tab should be blank.

8. LOB Field (Line of Business) – Required

Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of valid Line of Business values.

- ‘MCB’ = Medicare Part B
- ‘COM’ = WPS Health Insurance
- ‘TRI’ = TRICARE
- ‘VA’ = VAPC3

9. Payer ID Field – Required

- ‘08102’ = Medicare for Indiana
- ‘08202’ = Medicare for Michigan
- ‘05102’ = Medicare B for Iowa
- ‘05202’ = Medicare B for Kansas
- ‘05302’ = Medicare B Missouri
- ‘05402’ = Medicare B for Nebraska
- ‘WPS’ = WPS Health Insurance
- ‘00235’ = WPS Secondary Medigap
- ‘ARISE’ = Arise Health Plan
- ‘EPIC’ = Epic
- ‘FOREN’ = TRICARE Overseas (Foreign)
- ‘TDFIC’ = TRICARE For Life
- ‘TREST’ = TRICARE EAST
- ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region 3)
- ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
- ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5B)
- ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)

10. Tag Field – Optional

This field can be used to ‘Tag’ this provider records for your identification. The data from this field is not required, nor is it submitted to WPS Health Solutions. You can press <Tab> to bypass this field.

11. Group Label Field – Required for Group Records

The ‘Group Label’ is assigned by you, the user. This label is used to associate records for individuals in the group.

12. NPI (National Provider Identifier) – Required

Enter the NPI Number assigned to the group.
NOTE: If you are an atypical provider who is not required to obtain an NPI, please type EXEMPT in the NPI field.

13. **Tax ID/Type Fields – Required**

Type the group’s 9-digit Federal Tax ID in the first field. **Do not include hyphens, spaces or other special characters.**

The second field is for ‘Tax Type’. Press <F2> or right click while your cursor is in the field to obtain a list of Tax Type values.

- ‘E’ = Employer Identification Number
- ‘S’ = Social Security Number

14. **UPIN Field – Optional (UPIN is no longer used by Medicare; they are considered legacy provider numbers.)**

Type the group’s UPIN if known.

Note: For information regarding ‘Referring/Ordering/Supervising’ physician refer to the ‘Physician File’ Setup section of this guide.

15. **Specialty Field – Required for Medicare Part B.**

Type the appropriate ‘Provider Specialty’ code for the group. <F2> or ‘right click’ while your cursor is in the field for a list of valid Provider Specialty codes.

16. **Type Org Field – Optional**

Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid values or press <Tab> to bypass the field.

17. **Taxonomy Field – Situational but recommended**

This is required for Ambulance providers only but strongly recommended for other providers. Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid Provider Taxonomy codes.

18. **Accept Assign? Field – Required**

Indicate whether the group accepts assignment for this line of business. Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid values.

- ‘A’ = Assigned
- ‘B’ = Assignment accepted on Clinical Lab services only
- ‘C’ = Not Assigned

19. **Participating? Field – Required**
Type ‘Y’ if the group has a participation agreement on file with Medicare Part B. Type ‘N’ if the provider does not have a participation agreement on file with Medicare Part B.

20. Signature Ind. Field – Required

Type ‘Y’ to indicate that the group has a signed agreement for electronic claim filing on file with this line of business.

21. Date Field – Required

Type the date (or approximate date) that the signed agreement was filed with this line of business.

22. Provider Roles Fields – Required and defaults to values listed below

** The default values for Group Provider Roles are ‘Billing’ Field = ‘Y’ and ‘Rendering’ Field = ‘N’. DO NOT CHANGE.

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**Step 6:** Once you have completed all the fields on the ‘General Info’ tab, select the ‘Extended Info’ tab.

None of the fields on the ‘Professional Provider Information – Extended Info’ tab is required. Complete any that applies to this provider record.

**Step 7:** Once you have completed all the required ‘Provider Information’ fields, click ‘Save’.

If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.
Once the record has been saved, you will be returned to the ‘Provider’ Tab of the ‘Reference File Maintenance’ screen. The provider records you added will appear on the list. If you wish to view or modify the record, click ‘View/Update’, make any changes and ‘Save’ the record again.

*** YOU NOW NEED TO CREATE A PROVIDER FILE RECORD FOR EACH **INDIVIDUAL** IN THE GROUP.

Creating Individual Provider Records for Group Members:

• **Step 1:** Select the Group record you just created from the list of provider records on the ‘Provider’ tab screen. Click ‘New’.

• **Step 2:** Select ‘Inherit name/address information from the selected provider’ from the ‘New Provider Options’ window that appears. Click ‘OK’.

The ‘Professional Provider Information – General Info’ Tab will be displayed.

• **Step 3:** Select ‘Individual in Group’. Data for most of the ‘**Required**’ fields will be inherited from the Group Provider record. Complete the following fields:

1. **Last/First/MI Fields – **Required

   Type the individual’s last name, first name and middle initial in the appropriate fields.

2. **Provider ID/Number – Required**
Type the Provider’s ID that is appropriate for the line of business this record will be used for.

- For Medicare Part B, this field should contain the Medicare-assigned provider number for this solo Practice (PTAN).
- For WPS Health Insurance, TRICARE and VAPC3, this field should contain the provider’s Federal Tax ID.

*Note: Provider ID/NO Type of the ‘Extended Info’ Tab should be blank.*

3. **LOB Field (Line of Business) – Required**

Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of valid Line of Business values.

- ‘MCB’ = Medicare Part B
- ‘COM’ = WPS Health Insurance
- ‘TRI’ = TRICARE
- ‘VA’ = VAPC3

4. **Payer ID Field – Required**

- ‘08102’ = Medicare for Indiana
- ‘08202’ = Medicare for Michigan
- ‘05102’ = Medicare B for Iowa
- ‘05202’ = Medicare B for Kansas
- ‘05302’ = Medicare B Missouri
- ‘05402’ = Medicare B for Nebraska
- ‘WPS’ = WPS Health Insurance
- ‘00235’ = WPS Secondary Medigap
- ‘ARISE’ = Arise Health Plan
- ‘EPIC’ = EPIC
- ‘FOREN’ = TRICARE Overseas (Foreign)
- ‘TDFIC’ = TRICARE For Life
- ‘TREST’ = TRICARE EAST
- ‘VAPCCC3’ = Patient-Centered Community Care (VAPC3 Region)
- ‘VAPCCC5A’ = Patient-Centered Community Care (VAPC3 Region 5A)
- ‘VAPCCC5B’ = Patient-Centered Community Care (VAPC3 Region 5B)
- ‘VAPCCC6’ = Patient-Centered Community Care (VAPC3 Region 6)

5. **Tag Field – Optional**

This field can be used to ‘Tag’ this provider records for your identification. The data from this field is not required, nor is it submitted to WPS Health Solutions. You can press <Tab> to bypass this field.

6. **Group Label Field – Required**
Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of ‘Group Label’ values you have assigned. Select the value that matches the Group Label you are associating the Individual Provider too. This will tie this individual provider record (Rendering Provider) with the group provider record (Billing Provider).

7. **NPI (National Provider Identifier) – Required for test approval**

Enter the NPI number assigned to the individual provider.

8. **UPIN Field – Optional (UPIN are no longer used at Medicare, they are considered Legacy provider numbers.)**

Type the individual's UPIN if known:

Note: For information regarding ‘Referring/Ordering/Supervising’ physician refer to the ‘Physician File Setup’ section of this guide.

9. **Provider Roles Fields – Required and defaults to values listed below**

   ** The default values for Group Provider Roles are ‘Billing’ Field = ‘N’ and ‘Rendering’ Field = ‘Y’. **DO NOT CHANGE**

• **Step 4:** Once you have completed all the fields on the ‘General Info’ tab, select the ‘Extended Info’ tab.

   ![Extended Info Tab]

   Note: Some of the data in these fields will be inherited from the Group Provider record. Data on this screen can be modified for the individual if necessary.

• **Step 5:** Once you have completed all the required ‘Provider Information’ fields, click ‘Save’.
If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.

Once the individual record has been saved, you will be returned to the ‘Provider’ tab of the ‘Reference File Maintenance’ screen. The individual provider records you added will appear on the list.

You can now complete steps 1 through 5 above for everyone in the group.

Payer File Setup

Must be completed before entering claim data if the Payer ID is not already on the list. If the Payer ID is on the list already, no action is necessary.

Anytime you need to report insurance coverage other than Medicare Part B, WPS Health Insurance or TRICARE/VAPC3, a ‘Payer’ record must exist for the plan before entering patient data and claim information. You will need to create a ‘Payer’ record for each insurance company/benefit that your patients have as PRIMARY or SECONDARY (including Medigap) plans. Complete the following steps to create a ‘Payer File’ record for a primary or secondary insurance plan/benefit:

• Step 1: Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

• Step 2: Select the ‘Payer’ Tab from the Reference File Maintenance screen that appears.

A list of ‘Payer’ records that have already been added to the file will be displayed.

• Step 3: Click on ‘New’ at the bottom of the ‘Payer’
Step 4: Complete the following ‘Required’ fields on the ‘Payer Information’ screen:

1. **Payer ID Field – Required**

   Type the ‘Payer ID’ assigned to this Payer. If you are creating a record for a Medigap policy, this is the Medigap Number assigned by Medicare. You can obtain a list of valid Medigap payer numbers on CMS website.:

   If you do not know the ‘Payer ID’, use ‘99999’. If you have multiple payers for which you don’t know the payer IDs, you must add them with a different number. We suggest using ‘99999A’, ‘99999B’, ‘99999C’, etc.

2. **LOB Field (Line of Business) – Required**
Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of valid values.

- 'BC' = Blue Cross (Inst)
- 'BS' = Blue Shield (Prof)
- 'COM' = Commercial Insurance Plan
- 'GAP' = Medigap Policy
- 'HMO' = Managed Care
- 'MCA' = Medicare Part A
- 'MCB' = Medicare Part B
- 'MCD' = Medicaid
- 'TRI' = TRICARE
- ‘VA’ = VAPC3

3. Receiver ID Field – Not Applicable for Primary and Secondary Payers

Press <Tab> to bypass this field.

4. ISA Override – Not Applicable

Press <Tab> to bypass this field.

5. **Full Description Field – Required**

Type the ‘Payer’ (Insurance Plan/Benefit) name.

6. **Address/City/State/Zip Fields – Optional**

Type the payer’s address in the appropriate fields if known. WPS Health Solutions recommends that these fields are completed.

7. **Contact Name/Phone/Ext/Fax fields – Optional**

Type the name and telephone/fax number(s) of your contact at this payer’s office if known.

8. **Source Field – Required**

Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid ‘Source’ values. Select the most appropriate value for this payer.

9. **Media Field – Optional**

Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid ‘Media’ values. Select the most appropriate value for this payer.

10. **Usage Field – Leave Blank**

Leave this field blank. The software will auto-populate this field.

**Step 5:** Once you have completed all the required ‘Payer Information’ fields, click ‘Save’.
If any required fields are not completed or if any fields contain invalid code values, the specific errors will be highlighted. You will need to make corrections before saving the record.

Once the record has been saved, you will be returned to the ‘Payer’ Tab of the ‘Reference File Maintenance’ screen. The payer records you added will appear on the list. If you wish to view or modify the record, click ‘View/Update’, make any modifications and ‘Save’ the record again.

Physician File Setup

Records can be added to this file ‘on-the-fly’ while entering claim data.

Create a ‘Physician’ record for all ‘Referring’, ‘Ordering’ and ‘Supervising’ providers. The Referring/Ordering/Supervising Provider records from this file can be inserted into any claim you enter.

Complete the following steps to create a ‘Physician’ record:

• **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

• **Step 2:** Select the ‘Codes/Misc’ Tab from the ‘Reference File Maintenance’ screen that appears.

• **Step 3:** Select the ‘PHYSICIAN’ button from ‘Shared’ list on the ‘Codes/Misc’ Tab.

• **Step 4:** Click ‘New’ at the bottom of the ‘Physician Setup’ screen that appears.
Step 5: Complete the following **Required** fields on the ‘Physician Information’ screen:

1. **Physician/ID Type Field – Not Required**

   Enter the physician’s/provider’s UPIN if you wish to use it. For Medicare Part B, this UPIN is no longer used. Press <Tab> to access the next field. Hit the <F2> key for type and choose the appropriate code which should be 1G for a UPIN number. Alternately, you can choose to enter the physician’s **NPI number** in this field with the correct code of ‘XX’ for an NPI. The easier choice would be to use the NPI field referenced below.

2. **Physician’s Last Name/First Name/MI – Required**
   - Enter the physician’s/provider’s Last Name. Press <Tab>.
   - Enter the physician’s/provider’s First Name (or at least first initial). Press <Tab>.
   - Enter the physician’s/provider’s Middle Initial (‘MI’) is optional. Press <Tab>.
3. **Address/City/State/Zip/Phone – Optional**

Enter the physician's/provider's address, city, state, zip and phone number in the appropriate fields if known.

4. **Federal Tax ID/Type – Optional**

Enter the physician's/provider's Federal Tax ID in the appropriate field if known. **Do not include hyphens or spaces.** The ‘Type’ of ‘E’ must be entered in the smaller of the two fields if you indicate the Federal Tax ID.

5. **NPI (National Provider Identifier) – Required**

Enter the NPI number assigned to the physician/provider. For Medicare, this would be the preferred way of entering the provider's NPI.

- **Step 6:** Click ‘Save’ to store the record.

You will be returned to the initial ‘Physician/UPIN Setup’ screen and the UPIN record that you saved will appear on the list.

Complete the same steps to create another ‘UPIN’ record.

You can modify/correct or update the information in any of your ‘UPIN’ records by selecting the record from the ‘Physician/UPIN Setup’ screen and clicking on ‘View/Update’. Be sure to click ‘Save’ after making any modifications.

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**Facility File Setup**

Records can be added to this file ‘on-the-fly’ while entering claim data.

Create a ‘Facility’ record for all facilities) where services you bill are provided (other than the billing provider’s office).

Complete the following steps to create a ‘Facility’ record:

- **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.
• **Step 2:** Select the ‘Codes/Misc’ Tab from the ‘Reference File Maintenance’ screen that appears.

![Reference File Maintenance](image)

• **Step 3:** Select the ‘Facility’ button from the ‘Shared’ list on the ‘Codes/Misc’ Tab.

![Facility Button](image)

• **Step 4:** Click ‘New’ at the bottom of the ‘Facility Setup’ list that appears.

![Facility Setup](image)

• **Step 5:** Complete the following ‘**Required**’ fields on the ‘Facility Information’ screen that appears:

  *Only the facility name and address, city, state and zip are required.*

For Medicare Part B, no ID numbers except NPI are allowed for a facility.
1. **Facility ID/Type Field – Optional**
   
   Type the facility ID if known. Press <Tab> to access the next field. Hit the <F2> key for type and choose the appropriate code.

2. **Facility Name – Required**
   
   Type the name of the facility. Press <Tab>.

3. **Address/City/State/Zip – Required**
   
   Type the facility address, city, state and zip code.

4. **Facility Type – Optional**
   
   Type the facility type if known.

5. **NPI – Optional (If used, must be valid.)**
   
   Type the facility NPI if known. If including an NPI number, you must also include the facility ID number. If you do not know the facility ID number, use ‘Facility 1’.

   **Step 6:** Click ‘Save’ to store the record.

   You will be returned to the initial ‘Facility Setup’ screen and the Facility record that you saved will appear on the list.

   Complete the same steps to create another ‘Facility’ record.

   You can modify/correct or update the information in any of your ‘Facility’ records by selecting the record from the ‘Facility Setup’ screen and clicking on ‘View/Update’. Be sure to click ‘Save’ after making any modifications.

**Patient File Setup**

Records can be added to this file ‘on-the-fly’ while entering claim data. You need to create a Patient File record for each patient either before entering claims for that patient or while entering the first claim for the patient.

The Patient Information function of PC ACE consists of 6 separate tabs:

- **General Information Tab (Required)**

  This tab contains general information such as the patient’s name, address and demographic information.
• **Extended Information Tab** *(Optional)*

This tab contains ‘Legal Representative’ and patient-specific provider information. None of this information is required.

• **Primary Insured Tab Institutional (INST) (Not Used for Professional Claims)**

This tab is used only for Institutional Claims.

• **Primary Insured Tab Professional (Prof) (Required)**

This tab contains information regarding the patient’s PRIMARY INSURANCE information. This tab can contain Medicare Part B information if Medicare is the primary payer. It can also contain WPS Health Insurance information or information pertaining to any other primary payer.

• **Secondary Insured Information** *(Situational)*

This tab must be completed only if the patient has a secondary insurance benefit (i.e. Medigap policy). If the patient has insurance primary to Medicare, this tab would contain Medicare Part B information.

• **Tertiary Insured Information** *(Optional)*

This tab is used to report information pertaining to a patient’s third insurance benefit if applicable.

Complete the following steps to create a new patient record:

• **Step 1:** Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

![Reference File Maintenance](image)

**Note:** If you are entering the patient record while keying the first claim for the patient, you will access the Patient File by right clicking on the ‘Patient Control No.’ field on the first claim entry screen.

• **Step 2:** Select the ‘Patient’ Tab from the ‘Reference File Maintenance’ screen that appears.

• **Step 3:** Click ‘New’ at the bottom of the Patient Tab screen that appears.
Step 4: Complete the following ‘Required’ fields on the ‘Patient – General Information’ tab:

1. **Last Name Field – Required**
   - Enter the patient’s last name.

2. **First Name Field – Required**
   - Enter the patient’s first name.

3. **MI (Middle Initial) Field – Optional**
   - Enter the patient’s Middle Initial or press `<Tab>` to bypass the field.

4. **Gen. (Generation) Field – Optional**
Enter any applicable ‘generation’ information (i.e. I, II, III, Jr, Sr, etc.) or press <Tab> to bypass the field.

5. **Patient Control No. (PCN) Field – Required**

   Enter a ‘Patient Control Number’ that you have assigned to this patient. This field can be any patient account number you wish to use. The data can be alpha, numeric or a combination of the 2 data types.

6. **Address/City/State/Zip Fields – Required**

   Enter the patient’s address, city, state and zip code in the appropriate fields.

7. **Phone Field – Optional**

   Enter the patient’s home telephone number (including the area code) or press <Tab> to bypass the field.

8. **Active Patient Field – Required**

   Enter ‘Y’ to indicate that this is an active patient. ‘N’ will indicate that the patient record is inactive.

9. **Sex Field – Required**

   Enter ‘F’ for female; ‘M’ for Male.

10. **DOB (Date of Birth) Field – Required**

    Enter the patient’s date of birth (MM/DD/CCYY). You must use the 4-digit year (i.e. 1944).

11. **Marital/Employment/Student Status Fields – Optional**

    Press <F2> or ‘right click’ in any of these fields to obtain a list of valid values for each. You can press <Tab> to bypass these fields.

12. **CBSA – Situational (Used for Institutional Only)**

    Core Based Statistical Area, a 5-digit code specifying the core statistical area in which the patient lives. This field is used during patient lookup on specific Institutional Medicare claims to populate the Value Code 61 amount.

13. **Discharge Status Field – Optional**
This applies to institutional, UB-92 claim billing only. Press <Tab> to bypass the field.

14. **Death Ind. Field – Optional**

‘Y’ indicates that the patient is deceased. ‘N’ or blank indicates that the patient is not deceased. You can press <Tab> to bypass this field.

15. **DOD (Date of Death) Field – Situational**

Enter the date of death (if applicable) or press <Tab> to bypass the field.

16. **Signature on File Fields (2 Fields)**

- **First Field (SOF1) – Not Applicable**
  
  This field will not be available.

- **Second Field (SOF2) – Required**

  Press <F2> or right click while in this field to obtain a list of valid ‘Signature on File’ values.

17. **Release of Info. Field – Required**

‘Y’ indicates that the provider has signed a statement permitting data release.

‘I’ indicates informed consent to release data regulated by statute.

18. **ROI (Release of Information) Date – Optional.**

Type the date the patient authorized the release of information. (MM/DD/CCYY).

**Step 5:** Once you have completed the required fields on the ‘Patient – General Information’ tab, you can select the optional ‘Patient – Extended Information’ tab and complete any of the fields that may apply.

**Step 6:** Select the ‘Primary Insured Prof’ tab and complete the following ‘Required’ fields.
1. **Payer ID Field – Required**

Press <F2> or ‘right click’ while your cursor is in this field to access the ‘Payer Selection’ screen from the ‘Reference File – Payer Tab’. Left click on the record from this selection screen that corresponds with this patient’s primary insurance and click ‘Select’.

You will be returned to the ‘Patient – Primary Insured’ screen and the required ‘Payer ID’, ‘Payer Name’ and ‘LOB’ fields will be completed.

**Note:** All payers MUST have a record in the ‘Payer’ reference file before entering patient information. You may need to add payer records.

2. **Group Name – Optional**
This field does not apply to Medicare Part B. Enter the Group Name for any other benefit or press <Tab> to bypass the field.

3. **Group Number** – *Optional*

   This field is not applicable. Enter the Group Number for any other benefit or press <Tab> to bypass the field.

4. **Claim Office** – *Optional*

   This field is not applicable. Enter the Claim Office ID for any other benefit or press <Tab> to bypass the field.

5. **Rel (Relationship) Field** – *Required*

   This field appears on the ‘Insured Information’ tab at the bottom of the ‘Primary Insured’ tab screen.

   For Medicare Part B:

   The ‘Rel’ field should always contain ‘18’ indicating that the patient is the insured. Press <F2> or ‘right click’ while your cursor is in the field to obtain a list of valid relationship codes.

   If the patient is the insured and you type ‘18’ in the ‘Rel’ field, most of the other required ‘Insured Information’ tab will be filled with the patient’s information. You will only need to complete the ‘Insured ID’ and ‘Assign of Benefits’ fields.

   For TRICARE/VAPC3:

   If the patient is the insured (Tricare/VAPC3 Sponsor) and you type ‘01’ in the ‘Rel’ field, most of the other required ‘Insured Information’ will be filled with the patient’s information. You will only need to complete the ‘Insured ID’ and ‘Assign of Benefits’ fields.

6. **Last Name Field** – *Required*

   Enter the insured’s last name.

7. **First Name Field** – *Required*

   Enter the insured’s first name.

8. **MI (Middle Initial) Field** – *Optional*

   Enter the insured’s middle initial or press <Tab> to bypass the field.
9. **Insured ID Field – Required**

Enter the Insured ID. For Medicare Part B, this is the patient’s HIC Number. For WPS Health Insurance, this is the ‘Customer Number’ from the patient’s insurance card. For TRICARE/VAPC3 this is the TRICARE/VAPC3 Sponsor’s Social Security Number. Check the TRICARE Insurance card for the appropriate Sponsor Number.

10. **Gen (Generation) Field – Optional**

Enter the insured’s generation (i.e. II, III, Jr, Sr, etc.) or press <Tab> to bypass the field.

11. **Address/City/State/Zip Fields- Optional**

Enter the insured’s address, city, state and zip code in the appropriate fields or press <Tab> to bypass each field.

12. **Telephone Field – Optional**

Enter the insured’s telephone number (including the area code) or press <Tab> to bypass the field.

13. **Sex Field – Required**

Enter ‘F’ if the insured is female; ‘M’ if the insured is male.

14. **DOB (Date of Birth) Field – Required**

Enter the insured’s date of birth (MM/DD/CCYY).

15. **Employ Status Field – Optional**

This field indicates the insured’s employment status. Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of valid employment status code values or press <Tab> to bypass the field.

16. **Assign of Benefits Field – Required**

Enter ‘Y’ if the provider is authorized to receive benefit payments on behalf of the insured individual. Enter ‘N’ if this is not the case.

17. **Release of Info Field – Required**

‘Y’ indicates that the provider has signed a statement permitting data release.

‘I’ indicates informed consent to release data regulated by the state.

18. **ROI Date Field – Optional**

Enter the date the patient/insured authorized the release of information. (MM/DD/CCYY).
19. **Retire Date – Optional**

Enter the insured’s retirement date (if applicable) or press <Tab> to skip this field.

- **Step 7:** If the patient has a secondary insurance benefit (i.e. Medigap Policy), select the ‘Secondary Insured’ Tab and complete the same fields you completed on the ‘Primary Insured’ Tab. Select ‘Separate Inst & Prof’, and complete the same fields you completed on the ‘Primary Insured’ tab.

Remember, the ‘Payer’ information must reside on the ‘Payer’ Tab of the ‘Reference File Maintenance’ database before completing the patient’s insured information.

If Medicare is secondary, please add the Medicare information on this tab.

- **Step 8:** If the patient has a tertiary insurance benefit select the ‘Tertiary Insured’ Tab and complete the same fields you completed on the ‘Primary Insured’ Tab.

Remember, the ‘Payer’ information must reside on the ‘Payer’ Tab of the ‘Reference File Maintenance’ database before completing the patient’s insured information.

- **Step 9:** Once you have entered the patient’s general information, primary insured information and any applicable secondary and tertiary insured information, click ‘Save’ at the bottom of the ‘Patient Information’ screen.

If you have not completed any required patient information, a list of errors will appear. The fields involved will be highlighted. Complete these fields and click ‘Save’ again.

After the patient record has been saved, you will be returned to the ‘Patient’ tab of the ‘Reference File Maintenance’ screen. The patient you just added will appear on the ‘Patient’ List.
Steps to Create a Claim File for Submission to WPS

Step 1: To Enter Claim Information, click on the Professional Claim Form ICN on the PC ACE Toolbar

Then click ‘Enter Claims’ from the Professional Claims Menu

Once all claims have been entered, follow the instructions in Step 2 to create a report and prepare your file

Step 2: List Claims and Create a Detail Report.

Click on List claims to see all claims that are ready to be sent or that are in progress.

Click on Reports and choose the ‘Print Claim Detail Report’. This will list all claims, the LOB and their status.

Step 3: Prepare Claims (Create Claim File for Transmission, page 75).
Enter Claim Information

The claim entry function of PC ACE consists of multiple ‘tabs’ of data. Some of the data required on these ‘tabs’ will be filled when you select records from other files (i.e. Patient/Insured Information, Provider Information, etc.).

Complete the following steps to enter claim information:

**Note1:** Additional information is required for some ‘Specialty’ claims (i.e. ambulance, chiropractic, podiatry, physical therapy, etc.). Refer to the appropriate section of this document for additional claim entry information for specific claim types.

**Note2:** Providers who utilize a ‘roster billing’ format to bill Medicare Part B for influenza and pneumococcal vaccinations do not have to follow these claim entry instructions. Refer to the ‘Roster Billing’ section of this document for claim entry instructions.

**Step 1:** Select ‘Professional Claims Processing’ from the ‘Main Form’.

The ‘Professional Claims Menu’ will appear. Select ‘Enter Claims’ from the ‘Professional Claims Menu’

**Step 2:** The ‘Professional Claim Form’ window will be displayed. The first tab, ‘Patient Info and General’ will be presented initially.
Step 3: Complete the following ‘Required’ fields on the ‘Patient Info and General’ tab.

1. LOB (Line of Business) Field – **Required**

   Press <F2> or right click while your cursor is in this field to obtain a list of valid ‘LOB’ codes.

   **Note:** If the software is licensed to you for one LOB only (i.e. Medicare), that code value will automatically appear.

2. Billing Provider Field – **Required**

   Press <F2> or ‘right click’ while your cursor is in this field to obtain your list of ‘Billing Providers’. Once you have highlighted the appropriate record from your list, click ‘Select’. You will be returned to the ‘Professional Claim Form’.

   **Note:** If you have only one ‘Billing Provider’ record entered in your ‘Reference File Maintenance’ database, this field will be populated with that Provider Number.

3. Patient Control No. Field – **Required**

   Press <F2> or ‘right click’ while your cursor is in this field to access a list of patients’ you have already entered in PC ACE. You can select the patient record from this list. **[Hint: Use the ‘List Filter’ section at the bottom of the ‘Patient Selection’ window that appears to sort the list by PCN (Patient Control Number) or Patient Name.]**

   If the patient record you wish to use does not appear on the list, click ‘New’ and add the patient record.

   Click ‘Select’ once you have highlighted the patient record you wish to use.
You will be returned to the ‘Professional Claim Form’ and the following patient information fields will be filled in for you.

- Patient Last Name/First Name/MI/Gen Fields
- Birthdate (Patient) Field
- Sex (Patient) Field
- Patient Status (Marital/Student/Employment) Fields
- Death Ind. Field
- SOF (Signature on File) Field
- Legal Rep. Field
- Patient Address/City/State/Zip/Phone Fields
- ROI (Release of Information) and ROI Date Fields
- Other Ins. (Other Insurance Indicator) Field

4. **Patient Condition Related Fields (Employment/Accident) – Situational**

5. **Date/Ind of Current Fields – Optional**

   This field corresponds to box 14 on the HCFA-1500 paper claim form. Enter the date (if applicable). If you enter the date, you need to press <F2> or ‘right click’ while your cursor is positioned in the next field (indicator) and select an appropriate value.

   **Note:** This is NOT the ‘Date Last Seen’ by a physician (Required for Podiatry and Physical Therapy) NOR is it the ‘Initial Treatment Date’ for Chiropractic Services. Refer to the appropriate section of this document for additional ‘Specialty Claim’ requirements.

6. **First Date (Same or Similar Illness) Field – Optional**

   Enter the first of a same or similar illness (if applicable) or press <Tab> to bypass the field. This corresponds to box 15 of the HCFA-1500 paper claim form.

7. **UTW (Unable to Work)/Disability Date & Type Fields – Optional**

   Type the date range that the patient was unable to work (if applicable). If you enter a date range in these fields press <F2> or ‘right, click’ in the next (‘Type’) field to select an appropriate ‘type’ value.

   These fields correspond to box 16 of the HCFA-1500 paper claim form.

8. **Referring Physician’s Name (Last/First/MI)/Referring Phys ID Fields – Optional**

   Press <F2> or ‘right click’ while your cursor is in the ‘Last Name’ field to obtain a list of referring physician records in your ‘Physician’ file. Click ‘Select’ once you have highlighted the record from your Physician file that you wish to use. You will be returned to the ‘Professional Claim Form’ and
the referring physician name and NPI will be filled for you. Use this field for 'Ordering' as well as 'Referring Physician' information.

**Note:** If the referring physician does not appear in your 'Physician' file list, you can click on 'New' and add a record for the individual before clicking 'Select'.

9. **Hospitalization Dates – Admission date required if inpatient services**

Type the date range specifying when the patient was hospitalized (if applicable to this claim) or press <Tab> to bypass the fields. These fields correspond to box 18 on the HCFA-1500 paper claim form.

10. **Outside Lab & Charges Fields – Optional**

Type ‘Y’ in the ‘Y/N?’ field if the claim will contain services provided by an outside laboratory. You will have to enter the charges if you indicate ‘Y’. These fields correspond to box 20 of the HCFA-1500 paper claim form.

11. **Reserved for Local Use Field – Not Applicable**

Always press <Tab> to bypass this field. **THIS IS NOT THE NARRATIVE FOR AN ELECTRONIC CLAIM.**

12. **Medicaid Resubmission Code and Ref. No. Fields – Not Applicable**

Press <Tab> to bypass these fields. They do not apply to Medicare Part B or WPS Health Insurance.

13. **Fed. Tax ID/SSN/EIN/Provider Accepts Assignment? /Provider SOF/Date Fields – Required**

These fields will be automatically filled when you select the billing provider record in the 'Billing Provider' field.

14. **Facility Info? Field – Situational**

Enter ‘Y’ in this field if the services you are billing on this claim were provided at a facility other than the provider’s office. The other facility information will be entered on a subsequent tab.

15. **Dental? And Frequency Fields – Not Applicable**

Leave these fields blank.

16. **COB? Field – Situational**
Enter a ‘Y’ in this field if another payer has processed the claim prior to sending it to the carrier you are billing. Enter a ‘N’ in this field if the carrier you are billing to is Primary. A ‘Y’ response will create a new sub-tab [MSP/COB] on the Billing Line Items Tab. Enter the appropriate information related to services provided. This tab can be used to enter MSP/COB (Medicare as a Secondary Payer/Coordination of Benefits) information for each line item, if applicable.

In addition, if you enter ‘COB? =Y’, it will also create additional COB sub-tabs. On the ‘Ext. Payer/Insured’ main-tab, it will display ‘COB Info (Primary)’ and ‘COB Info (Secondary)’ sub-tabs. Refer to the ‘Specialty Claims’ portion of this Users Guide for more information on MSP/COB

17. PIN No. Field – Situational

This field is for the ‘Rendering Provider ID’.

**If Rendering Provider is Group Member:**

a. If the rendering provider is an individual in a group AND the same rendering provider number applies to ALL line items that will be billed on this claim, press <F2> or ‘right click’ while your cursor is positioned in this field. You will be presented with a list of valid ‘Rendering Provider’ records in your system. Highlight the appropriate record and click ‘Select’. You will be returned to the ‘Professional claim Form’.

b. If different group members provided services being billed on separate line items within this claim, leave this field blank. You can select a different ‘Rendering Provider’ record when you enter each line item.

**If Rendering Provider is a Solo Practice:**

If the rendering provider is a solo practitioner (or ambulance service, etc.) the PIN No. field will not be available for you to modify. It will be automatically filled in for you.

18. GRP (Group) No. Field – Situational

If the ‘Billing Provider’ record you selected for this claim is a group, this field will be automatically filled for you. It does not apply for solo practices

- **Step 4:** Select the ‘Insured Information’ tab of the ‘Professional Claim Form’.
The information on the ‘Insured Information’ tab will be automatically populated with the insurance data from the patient’s record. If this information needs to be modified, WPS Health Solutions strongly suggests that it is done in the patient’s record in the ‘Reference File Maintenance’ database of PC ACE. Do not modify the insurance information from this screen.

**Step 5:** Select the ‘Billing Line Items’ tab of the ‘Professional Claim Form’.

The ‘Billing Line Items’ tab consists of the following 3 tabs:

- **Line Item Details – Required**
  - **Extended Details (for each line item) – Optional**
  - **Ext Details2 (for each line item) – Optional**
  - **Ext Details 3 (for each line item) – Optional**
**Note:** If you selected COB? = Y on the ‘Patient Info & General’ main tab, it creates a 5th tab here titled, ‘MSP/COB’.

- **MSP/COB** – Required if Medicare is Secondary payer

**Step 6:** Select the ‘Line Item Details’ tab and complete the following **required** fields.

1. **Claim Diagnosis Fields (1-8) – Situational**

   Required for all claims except Ambulance or Independent Lab. Enter any diagnosis code that applies to this claim. Do not include the decimal point.

   For a list of valid diagnosis codes, press <F2> or ‘right click’ while your cursor is in the field. A list of valid diagnosis codes will appear. Use the ‘List Filter Options’ at the bottom of the screen to sort the codes and narrow your search. Highlight the appropriate code and click ‘Select’.

![List Filter Options for sort]

2. **Service Dates (‘From’ and ‘To’) Fields – Required**

   Enter the ‘From’ and ‘To’ date(s) for the first line item. (Format: MMDDCCYY).

3. **PS (Place of Service) Field – Required**

   Enter the 2-digit ‘Place of Service’ code.

   For a list of valid ‘Place of Service’ codes, press <F2> or ‘right click’ while your cursor is positioned in the field. Highlight the appropriate code from the list and click ‘Select’. If the correct ‘Place of Service’ code is not present, please see page 108 for instructions on how to add it to the list.

   If Place of Service is 12 for patient’s home, the patient’s address including a 9-digit zip code will be required in the Facility field, see Extended Patient/General tab in this user guide. You will also be required to enter a “Y” in the Facility Info field on the Patient Info & General tab. For a list of valid ‘Place of Service’ codes, press <F2> or ‘right click’ while your cursor is positioned in the field. Highlight the appropriate code from the list and click ‘Select’. If the correct ‘Place of Service’ code is not present, please see page 108 for instructions on how to add it to the list.
4. **EMG (Emergency related) – Situational**
Enter ‘Y’ if service is Emergency related
Enter ‘N’ or leave blank if service is not Emergency related.

5. **Proc (Procedure Code) Field – Required**
Enter the 5-digit procedure (HCPCS or CPT) code for this line item.

You can press `<F2>` or ‘right click’ while your cursor is positioned in the field
to obtain a list of valid procedure codes. Use the ‘List Filter Options’ at the
bottom of the screen to sort the codes and narrow your search. Highlight the
appropriate code and click ‘Select’.

**Note:** If you have entered information into the ‘Charges Master’ file, that
complete list will appear when you press `<F2>`. Select the appropriate code
and the charge for that code will plug into the ‘charges’ field automatically.

6. **Modifiers (1 and 2) Fields – Situational**

Type any applicable 2-digit modifier in field 1. Any additional applicable
modifier should be entered in field 2.
**Note:** There are additional ‘Modifier’ fields available in the ‘Extended Details’ for each line item. Refer to Medicare policy and claim-filing guidelines for information regarding the use of these fields.

For a list of valid ‘Modifier’ codes, press <F2> or ‘right click’ while your cursor is positioned in the field. Highlight the appropriate code from the list and click ‘Select’.

![Modifier Selection](image)

7. **Diagnosis Field – Situational**

   Required if a ‘Diagnosis Code’ is present on the claim.

   This is a ‘Diagnosis Pointer’ field that corresponds to box 24e on a paper HCFMA-1500 claim form. Enter ‘1’ if the first diagnosis code you entered is the main diagnosis for this line item. Enter ‘2’ if the second diagnosis code you entered is the main diagnosis for this line item, etc.

   **Note:** You should only enter between one and four ‘Diagnosis Pointer’ values per service line in order of relevance.

8. **Charges Field – Required**

   Enter the dollar amount you are billing for this line item (include the decimal point). The charge will automatically be entered if you have added the procedure to the ‘Charges Master’ file.

9. **Units Field – Required**

   Enter the number of ‘units’ or ‘like services’ for this line item. If sending Anesthesia claims, key 1 unit of service in this field. Then click on the ‘Extended Details (Line 1)’ tab and enter the anesthesia minutes in the ‘Anesthesia/Other Minutes’ field.

10. **EP (EPSDT) Field – Optional**

    Type ‘Y’ if ‘Early and Periodic Screening for Diagnosis and Treatment of Children’ (EPSDT) is involved or press <Tab> to bypass the field.

11. **FP (Family Planning) Field – Optional**

    Enter ‘Y’ if ‘Family Planning’ is involved or press <Tab> to bypass the field.
12. **AT (Attachment) Field – Situational**

Press `<F2>` or ‘right click’ while your cursor is positioned in this field for a list of valid ‘Attachment’ values.

If you select an attachment value from the list, an additional tab for the specified attachment will appear. You must complete any required fields on the attachment tab before saving the claim data.

When you are entering claims for any of the listed specialties, you only need to complete the ‘Specialty’ tab on the first line item detail. Do not enter the attachment indicator or complete the “tab” on every line item. Enter all payable procedure details for the appropriate specialty prior to entering the non-payable procedure details.

***************IMPORTANT NOTE***************

Medicare Part B requires that attachment information from certain ‘Specialty’ claims is included with the claim information (i.e. ambulance, CLIA, podiatry, chiropractic, mammography, physical therapy).

Some of these attachments will be triggered automatically based on the claim data entered. **OTHERS WILL NOT BE AUTOMATICALLY TRIGGERED.** Refer to the ‘Specialty Claims’ section of this document for additional ‘Attachment’ information.

-------------------------------------------

**Valid Attachment Indicators:**

- 0 = Cancel Automatic Attachment
- 1 = Ambulance Attachment
- 2 = CLIA Attachment
- 3 = Podiatry Attachment
- 4 = Chiropractic Attachment
- 5 = Mammography Attachment
- 6 = EPO Attachment
- 7 = Physical Therapy Attachment
- A = Dental Attachment

13. **Rendering Physician Field – Situational**
This field applies \textit{only} to group practices and \textit{only} if the Rendering Provider’s PIN number was not entered on the ‘Patient Info & General’ tab of the ‘Professional Claim Form’ (box 33).

This field can be used to specify different ‘Rendering Providers’ for different line items of the claim.

To use this field, press <F2> or ‘right click’ while your cursor is positioned in the field to obtain a list of valid ‘Rendering Provider’ records. Click the record you wish to use from the list and click ‘Select’.

14. \textbf{Amount Paid Field – Optional}

Type the amount paid by the patient if applicable.

\textbf{Step 7:} Once you have entered all the line items you wish to include on the claim, click ‘Recalculate’. The ‘Total Charge’ and ‘Amount Due’ fields will be automatically updated. If you enter a line in error, place your cursor on that line and click the <F7> key. You will be asked if you want to delete the information. Click ‘OK’ and the line in error will be deleted.

\textbf{Step 8:} Select the ‘Extended Details’ tab while your cursor is on the line item requiring any of the information included on the tab.

This tab can be used to enter any of the following data if it applies to the line item or claim:

- Third and Fourth Modifiers that apply to the line
- Anesthesia Minutes
- Purchased Service Information
- Hospice Information
- Supervising Provider Information (Podiatry and Physical Therapy) – (enter for first line item of the claim)
- \textbf{IMPORTANT NOTE: Do not use this tab to enter Referring/Ordering Physician Information}

\textbf{Step 9:} Select the ‘Ext Details 2’ tab while your cursor is on the line item requiring any of the information included on the tab
This tab can be used to enter any line level miscellaneous information as applicable.

**Step 10:** Select the ‘**Ext Details 3**’ tab while your cursor is on the line item requiring any of the information included on this tab.

This tab can be used to enter any of the information on this tab if it applies to the line item for this claim.

**Step 11:** After you have completed the necessary fields/tabs contained in ‘**Billing Line Items**’, you can select the ‘**Extended Patient/General**’ and ‘**Extended Patient/General (2)**’ tabs.
Most of the fields on this screen are not required for all claims. Some of the fields (but not ALL) that MIGHT be required for certain claims are:

- **Facility Name and Address** (required if box 32 is required to be completed on a paper claim)
- **Homebound Indicator**
- **Special Program Indicator** (select F2 for a listing of special programs. If the code for your Demonstration Project is not listed, you can just type it in the field.

Do **NOT** use this screen to enter:

- **Date Last Seen for Podiatry or Physical Therapy claims.** This information should be entered on the ‘Attachment’ for the claim specialty. Refer to the ‘Specialty Claims’ section of this guide for additional instructions.

**Step 12:** The only additional claim entry tab is ‘Extended Payer/Insured’ tab. This tab is used to enter payment information when Medicare, TRICARE, VAPC3, ARISE or WPS Health Insurance is the secondary payer (MSP/COB). Refer to the ‘Specialty Claims’ section of this document for MSP/COB instructions.

**Step 13:** After you have completed all the required and applicable situational fields for the claim, click ‘Save’. You will be returned to a blank ‘Professional Claim Form’ where you will be able to enter another claim.

If you have entered all the claims you wish to transmit at this time, click ‘Cancel’. You will be asked if you wish to abandon these changes. Click ‘Yes’ to return to the ‘Professional Claims Menu’.

You are now ready to create a report of the claim information you will be placing in your file for transmission to WPS Health Solutions.

---

**Create and Print a Report of Claims to be Transmitted**

After you have entered the claims you wish to include in your claim file, create a report of those claims for your records.
Complete the following steps to create a report of the claims that will be in your next claim file:

• **Step 1:** Select ‘Professional Claims Processing’ from the ‘Main Form’.

The ‘Professional Claims Menu’ will appear.

• **Step 2:** Click on the ‘List Claims’ button.

A screen containing a list of the ‘New’ (ready for transmission) claims will appear.

**Note:** The ‘Location’ code ‘CL’ (to be transmitted) indicates you are viewing a list of claims that have not been placed in a file for transmission. To view claims that were in previously built claim files click on the ‘Arrow’ to the right of the ‘Location’ field and select a different location.
Note: The ‘Status’ code ‘CLN’ indicates that a claim has passed the PC ACE software edits and is ready for transmission. ‘Status’ code ‘ERR’ indicates that the claim was saved with at least one error. ‘ERF’ indicates that the claim contains at least one error that needs to be fixed before you create the file for transmission. CLAIM MUST BE EDITED TO CORRECT ERROR(S). ‘UNP’ indicates that the claim has multiple errors and could not be processed. CLAIM MUST BE EDITED TO CORRECT ERRORS.

• Step 3: Click ‘Reports’ (toolbar at top of screen) and select ‘Print Claim Detail Report (All listed claims)’.

Note: If you ‘Check’ (✓) any claims, you will be able to create a report of ‘All checked claims’ instead of ‘All listed claims’.

A report of the listed (or checked) claims will be created:

PC-ACE Pro32 CLAIM DETAIL REPORT
Report Date: 09/30/2002

<table>
<thead>
<tr>
<th>LOR</th>
<th>PAYER/</th>
<th>PCN/</th>
<th>BILL PROVIDER</th>
<th>SERVICE DATES</th>
<th>NAME/</th>
<th>CHARGES</th>
<th>FIRST/</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCB</td>
<td>00954</td>
<td>JONE0002</td>
<td>JONES</td>
<td>03/02/02 03/03/02</td>
<td>JANE</td>
<td>$67.72</td>
<td>SOLO</td>
<td>CLN</td>
<td></td>
</tr>
<tr>
<td>MCB</td>
<td>00954</td>
<td>SMITH0001</td>
<td>SMITH</td>
<td>02/02/02 02/02/02</td>
<td>JOHN</td>
<td>$25.00</td>
<td>SOLO</td>
<td>CLN</td>
<td></td>
</tr>
</tbody>
</table>

REPORT TOTALS: CLAIMS: 2 CHARGES: $122.72 AMT PAID: $0.00 UNITS: 2 AMT DUE: $122.72

• Step 4: Click on to direct the report to your printer.

• Step 5: Click on to return to the ‘Professional Claims List’.

Prepare Claims for Transmission (Create a Claim File to Transmit to WPS)

The next step is to create a file of claims for transmission to WPS Health Solutions. You will have to create separate claim files for any line of business for which you wish to submit claims.

**Notice: Date editing on all inbound transactions will be done based on WPS Health Solutions local time, e.g. CST (Central Standard Time)
Complete the following steps to create a claim file:

• **Step 1:** Select ‘Professional Claims Processing’ from the ‘Main Form’.

The ‘Professional Claims Menu’ will appear.

• **Step 2:** Click ‘Prepare Claims’.

• **Step 3:** The ‘Professional Claim Prepare for Transmission’ screen will appear. Select the line of business (LOB) assigned to the claims you wish to submit.

- ‘MCB’ = Medicare Part B
- ‘COM’ = WPS Health Insurance
- ‘TRI’ = TRICARE
- ‘VA’ = VAPC3

• **Step 4:** Select the appropriate ‘Payer’

- ‘08102’ = Medicare B Indiana
- ‘08202’ = Medicare for Michigan
- ‘05102’ = Medicare B for Iowa
- ‘05202’ = Medicare B for Kansas
• '05302' = Medicare B Missouri
• '05402' = Medicare B for Nebraska
• 'WPS' = WPS Health Insurance
• '00235' = WPS Secondary Medigap
• 'ARISE' = Arise Health Plan
• 'EPIC' = EPIC
• 'FOREN' = TRICARE Overseas (Foreign)
• 'TDFIC' = TRICAE For Life
• 'TREST' = TRICARE EAST
• 'VAPCCC3' = Patient-Centered Community Care (VAPC3 Region 3)
• 'VAPCCC5A' = Patient-Centered Community Care (VAPC3 Region 5A)
• 'VAPCCC5B' = Patient-Centered Community Care (VAPC3 Region 5B)
• 'VAPCCC6' = Patient-Centered Community Care (VAPC3 Region 6)

**Step 5:** Click ‘Submission Status’ (‘P’ for Production or ‘T’ for Test) and then ‘Prepare Claims’. You will be asked to confirm the preparation of your claim file. Click ‘OK’. Only claims that are in a ‘CLN’ status will be added to the claim file.

Your claim file will now be built, and the following screen will appear.

Click ‘OK’ to return to the ‘Claim Prepare for Transmission’ screen to view the results.
•Step 6: Click ‘View Results’ to create a detailed report of the claims that were actually placed in your claim file that you can print for your records.

•Step 7: Click ‘Close’ to return to the ‘Professional Claims Menu’.

You have now created a file for transmission and are ready to begin the transmission process.

File name and Path

The file you just created will be in the C:\WINPCACE directory (folder). The file should be named your User ID followed by .DAT if you set up your ‘Submitter Setup’ information correctly (i.e. If your User ID is ‘99999’, your file name should be ‘99999.dat’.) If you did not set up your ‘Submitter’ information correctly, the file name will be BSTRANS.DAT.

Note: You must now transmit this claim file to our Bulletin Board System (BBS) or Gateway Express Website. If you prepare another file of claims prior to transmitting, the file will be over-written by the new file.

Upload Claim File to the WPS

Until you upload (send) your file to WPS Health Solutions using the Bulletin Board System (BBS) or Gateway Express your claim file is still on your computer. PC ACE only creates the claim file; it does not transmit it to WPS Health Solutions.

When you registered with WPS Health Solutions to become a trading partner, you would have selected your transmission method and should have received a User Guide, Username and Password for that protocol. If you have any questions regarding this, please contact the appropriate EDI Helpdesk

Contact Us:

Medicare Part B – MAC J5 (866) 518-3285 Option 1), MAC J8 (866) 234-7331 (Option 1)

WPS Health Insurance, ARISE, VAPC3 and TRICARE – 800-782-2680 (Option 1)

or visit our website at:

http://www.wpshealth.com/resources/provider-resources/edi/index.shtml
Once your claims are transmitted to WPS Health Solutions, the data is subjected to a short series of edits that check information at the file level as well as the claim level. Individual claims are loaded into the appropriate Medicare, TRICARE, VAPC3, ARISE or WPS Health Insurance claims processing system only after the data received passes these edits.

I. INITIAL EDIT STEP

When WPS Health Solutions receives your claim file, it is run through the INITIAL EDIT step. This edit step checks the file you transmitted to ensure that the data is in the correct format. This is usually done immediately after the file is received. At times, however; there may be a delay if the WPS Health Solutions processor is unusually busy or not available.

The results of the initial edit step are sent to you in the form of a download report for you to retrieve from the WPS BBS or Gateway Express Website. If the report indicates that your file passed the initial edits, it will be sent on to the next edit step. If the report indicates that your file failed the initial edits, your entire file of claims is rejected.

Note: If your file fails the initial edit step and you do not understand the reason(s) in the Acknowledgement, contact the appropriate WPS Health Solutions EDI Department for your line of business.

II. SECOND EDIT STEP

If your file passes the initial edits, information on individual claims is checked for compatibility with the claims processing system. The results of this edit step are obtained through the WPS BBS or Gateway Express Website.

Reports from this edit step are sent to you in the form of a downloadable file. These reports will be available for you to download minutes after you transmit your claim file.

Note: It is IMPERATIVE that you download this file after EACH transmission!!! Claims that appear on these reports with error messages MUST BE CORRECTED AND RESUBMITTED. Claims deleted during this phase are not referenced in any other way, so this is your only notice of deleted claims.

TA1 – Interchange Acknowledgement

Starting with version 5010A1 the ‘TA1Interchange Acknowledgment’ allows WPS Health Solutions to notify you that a valid envelope was received or that problems were encountered within the interchange control structure. The TA1 verifies the envelope of the file only.

To translate your TA1 into a ‘human-readable’ format:

1. Download the TA1 using your selected transmission method of either the WPS BBS (Bulletin Board System) or Gateway Express Website.
2. Place the TA1 file in folder: \WINPCACE\Mailbox

3. Open PC ACE

4. Click the ‘Professional Claims Processing’ icon from the ‘PC ACE main form’:

![PC-ACE Pro32 Claims Processing...](image)

5. Click ‘Maintain’ on the toolbar of the ‘Professional Claims Menu’, then Click ‘Acknowledgement File Log’ on the drop-down menu.

![Professional Claims Menu](image)

6. You will now see the ‘Professional Acknowledgement Log’. Select the record you wish to view by clicking on it to highlight it. Then click ‘View Report’.

![Professional Acknowledgement Log](image)

7. You will now see your ‘TA1 Interchange Report’. You will also have the capability to print this report by clicking the ‘Print’ icon on the toolbar:

![Print](image)
999 – Acknowledgement for Health Care Insurance

Starting with version 5010A1 WPS Health Solutions will send 999 Acknowledgement reports which will report syntactical and implementation errors against a functional group based on implementation guidelines. The 999 will also confirm receipt of a functional group which fully complies with implementation guidelines.

To translate your 999 (5010A1) into a ‘human-readable’ format:

1. Download the 999 using your selected transmission method of either the WPS BBS (Bulletin Board System) or Gateway Express Website.

2. Follow the same steps as listed above for translating the ‘TA1 Interchange Acknowledgement’ starting on page 80.

277CA – Health Care Acknowledgement

Starting with version 5010A1, WPS Health Solutions will be sending the 277CA (Claim Acknowledgement) transaction.

To translate your 277CA into a ‘human-readable’ format:

1. Download the 277CA using your selected transmission method of either the WPS BBS (Bulletin Board System) or Gateway Express Website.

2. Place the 277CA file in folder: C:\WINPCACE\Mailbox

3. Open PC ACE

4. Click the ‘Professional Claims Processing’ icon from the ‘PC ACE main form’:

5. Click ‘Maintain’ on the toolbar of the ‘Professional Claims Menu’.

6. Click ‘Claim Status Response & Acknowledgement Log’ on the drop-down menu.
7. You will now see the ‘Professional Claim Status Response & Acknowledgement Log’. Select the record you wish to view by clicking on it to highlight it. Then click ‘View Ack Report’.

8. You will now see your ‘PC ACE

9. ANSI -277CA Claim Acknowledgment Report’. You will also have the capability to print this report by clicking the ‘Print’ icon on the toolbar.

**Specialty Claims**

Medicare Part B and HIPAA legislation require that certain claim types contain information in addition to basic claim information. SOME of these claim types are addressed below.

**Note:** This section of the PC ACE User’s Guide gives basic instruction in the entry of certain specialty claims. FOR MORE THOROUGH CLAIM SUBMISSION GUIDELINES, REFER TO MEDICARE/WPS/TRICARE/VAPC3/ARISE POLICY.

**Ambulance Claims – Special Requirements:**

1. Key ‘Y’ in the ‘Facility Info?’ field at the bottom of the ‘Patient Info & General’ tab of the ‘Professional Claim Form’. 
II. Use the ‘Facility Name/Address/City/State/ZIP’ fields to enter the address where the patient was picked up (the origin of the transport). The ‘Facility’ fields are located on the ‘Extended Patient/General’ tab.

Note: The software will require the ‘Facility Name’. You can use ‘Patient Home’ or ‘Transport Origin’, etc. in this field.

III. The ‘Ambulance Attachment’ fields must be completed on the ‘Billing Line Items’ screen. Only enter the attachment indicator on the first line of service. Do not enter it on every detail.

Note: The ‘Ambulance’ tab is programmed to automatically appear when ambulance service procedure codes are entered. If the tab is not triggered, go to the ‘AT’ field on the first line item and type ‘1’.
Complete the following 'Required' fields on the 'Ambulance' tab:

The following fields are **Required**. Press <F2> or ‘right click’ while your cursor is positioned in the field for a list of valid values:

- **Type of Transport Field**
- **Transport To/For Field**
- **At least one of the Yes/No fields regarding the situation are required**
- **Miles Field** – Type the number of miles the patient was transported. If you are billing a separate charge for mileage, this should match the number of units on the line item for that charge. If no transport made, enter zero (0).

The following fields are **Situational**. Press <F2> or ‘right click’ while your cursor is positioned in the field for a list of valid values:

- **Physical Restraints Field (Y/N)**
- **Visible Hemorrhaging Field (Y/N)**
- **Services Available Field (Y/N)** – Use this field to indicate whether required services were available at the first facility for facility-to-facility transfers only.
- **Patient Discharged Field (Y/N)**
  Use this field to indicate whether the patient was discharged from the first facility for facility-to-facility transfers only.
- **Patient Admit (2nd Facility) Field (Y/N)** – Use this field to indicate whether the patient was admitted to the second facility for facility-to-facility transfers only.
- **Patient Weight Field** – Enter the patient’s weight in this field if applicable.
- **Time of Run** – This information is currently not required.
- **EMT/Paramedic Name (Last/First/MI) Field** – Enter the EMT/Paramedic name if applicable.
- **Origin Information** - Enter the transport origin.
- **Destination Information** – Enter the transport destination.
- **Purpose of Round Trip** – Enter the reason for a round trip transport.
- **Purpose of Stretcher** – Enter the reason that the patient was moved by stretcher (if applicable).
- **EKG Order UPIN** – *Not Used*

Use the ‘Referring Physician’ fields on the ‘Patient Info & General’ tab to report the ‘Ordering Physician’ information for EKG services provided.

**IV.** Enter any additional information in the ‘Narrative’ field on the ‘Extended Details 3 (Line 1)’ tab. This is not required.

Podiatry Claims – *Special Requirements:*

**I.** Include the ‘Supervising Provider’ information on the ‘Extended Details (Line 1)’ tab.

**II.** The ‘Podiatry Tab’ fields must be completed on the ‘Billing Line Items’ screen.
**Note:** The ‘Podiatry’ tab is programmed to automatically appear when the provider’s taxonomy indicates ‘Podiatrist’ and a routine foot care procedure code is used. If the tab does not appear, go to the ‘AT’ field on the first line item and type ‘3’. Only enter the attachment indicator on the first line of service. Do not enter it on every detail.

![AT field = 3]

Complete the following ‘**Required**’ fields (‘Date Last Seen’ and ‘Supervising Provider ID’) on the ‘Podiatry’ tab:

![Claim Form]

The following fields are **Required**:

**Date Last Seen Field**

Type the date the patient was last seen by the supervising physician.

**Supervising Provider ID**

Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of provider records in your ‘Physician Reference File’. Select the appropriate record and click ‘Select’.

**Physical Therapy Claims – Special Requirements:**

1. Include the ‘**Supervising Provider**’ information on the ‘**Extended Details (Line 1)**’ tab.
II. The ‘Physical Therapy Tab’ fields must be completed on the ‘Billing Line Items’ screen.

**Note:** The ‘Physical Therapy’ tab is programmed to automatically appear when the provider’s taxonomy indicates ‘Physical/Occupational Therapist’ and a PT/OT procedure code is used. If the tab does not appear, go to the ‘AT’ field on the first line item and Enter ‘7’.

Complete the following ‘Required’ fields (‘Attending/Supervising Physician ID’ and ‘Date Last Seen’) on the ‘Physical Therapy’ tab:
1. **Attending/Supervising Physician ID Field – Required**

   Press <F2> or ‘right click’ while your cursor is in this field to obtain a list of provider records in your UPIN file. Select the appropriate record and click ‘Select’.

2. **Date Last Seen Field – Required**

   Enter the date the patient was last seen by the ‘Attending/Supervising Physician’.

3. **Treatment Plan on File Field – Optional**

   Press <F2> or ‘right click’ while your cursor is positioned in the field to obtain a list of valid code values.

**Chiropractic Claims – Special Requirements:**

I. The ‘Chiropractic Attachment’ fields must be completed on the ‘Billing Line Items’ screen.

   **Note:** The chiropractic tab is programmed to automatically appear when a spinal manipulation procedure code is entered. If the tab is not triggered, go to the ‘AT’ field on the first line item and enter ‘4’.

   Complete the following ‘Required’ fields on the ‘Chiropractic’ tab:
1. **Initial Treatment Date Field – Required**

Enter the date the treatment for this ‘episode’.

2. **Date of Last X-Ray Field – Optional**

Enter the date of the patient’s last X-ray.

3. **X-Rays on file at Site Field (Y/N) – Optional**

Enter ‘Y’ if you have the X-rays on file at your office. ‘N’ indicates the X-rays are not on file.

4. **Nature of Condition Field – Optional**

Press <F2> or ‘right click’ while your cursor is positioned in the field to obtain a list of valid code values.

5. **Acute Manifestation Date Field – Situational**

Enter the date of acute manifestation, if applicable.

II. Enter ‘Referring (Ordering) Physician’ name and NPI in the ‘Referring Physician Name’ and ‘Referring Physician ID’ fields on the ‘Patient Info & General’ screen IF the claim contains charges for X-rays.

**Note:** Please remember to enter any Demonstration Project information that may apply to your situation.

**Clinical Lab Claims – Special Requirements (CLIA Number):**

1. Clinical Lab charges require a ‘CLIA Number’. The CLIA Number is entered on the ‘CLIA Attachment’.

   **Note:** The CLIA Attachment tab is not programmed to appear automatically. You will need to access the attachment by entering a ‘2’ in the ‘AT’ field on the ‘Billing Line Items’ tab.
Once the ‘CLIA’ tab appears, click the tab to access the ‘CLIA Certification Number’ field.

Enter the CLIA Number in the field.

**Note:** If you included the CLIA Number in the ‘Extended Info’ section of the ‘Provider Information’, it will automatically appear in the field.

Mammography Claims – **Special Requirements**:

1. Mammography charges require a ‘Mammography Certification Number’. The Mammography Certification Number is entered on the ‘Mammography Attachment’.

   **Note:** The Mammography Attachment tab is programmed to automatically appear when a Mammogram procedure code is entered. If the tab does not appear, enter a ‘5’ in the ‘AT’ field.

Once the ‘Mammography’ tab appears, click the tab to access the ‘Mammography Certification Number’ field.

   **Note:** If you included the Mammography Certification Number in the ‘Extended Info’ section of the ‘Provider Information’, it will automatically appear in the field.
MSP/COB (Payer/Coordination of Benefits) Claims – Special Requirements:

1. When you create the ‘Patient Information’ record for a patient who has an insurance benefit that is primary to the insurance you are currently billing, be sure to enter the other insurance information in the ‘Primary Insured Tab’ fields. The payment information for the insurance you are currently billing would be entered in the ‘Secondary Insured Tab’ fields. Remember to choose the option (Separate Inst and Prof) on the Patient Information screen as below:

2. When entering a new claim for a patient that has been set with insurance that is primary to Medicare, you will need to enter a ‘Y’ in the ‘COB?’ field on the ‘Patient Info & General’ tab.
3. When you enter MSP claim data, you need to access the ‘Extended Payer/Insured’ tab to enter the primary payment information.

From the ‘Extended Payer/Insured’ tab, select the ‘COB info (Primary)’ tab.

Enter the payment information from the primary payer’s Explanation of Benefits in the appropriate fields of the ‘COB info (Primary)’ tab. Press <F2> when in the ‘Group’, ‘Reason’ and ‘Code’ fields to see a list of options for coding the claim.
Zero Payment:
Enter ‘Z’ if the primary payer paid zero
Enter ‘N’ if the primary payer’s payment was non-zero

Paid Amount:
This is required data. Please enter the entire paid amount for the claim from the EOB in the COB/MOA field preceded by a ‘D’ code.

**NOTE: Non-Covered Amount – In situations where you choose to bypass the submission of the claim to the primary payer, because they never pay for the service, use the following instructions. Please enter the total charge of the claim in the COB/MOA field preceded by the ‘A8’ code.

Claim Adjudication Date:
LEAVE THIS FIELD BLANK. YOU WILL ENTER THE ADJUDICATION DATE AT THE LINE LEVEL AS OUTLINED BELOW.

4. Now go to the ‘Secondary Payer/Insured’ tab and enter the ‘Insurance Type’ (press <F2>’ to produce a list of Insurance Type codes

**Note: No other fields on this screen are required.
5. After entering the Billing Line Items, you can now enter the line level MSP information for each line of service. Select the ‘MSP/COB (Line 1)’ tab. Make sure the line in parenthesis coordinates to the line you are entering information for. To do this, put your cursor on the detail line prior to selecting this tab.

Enter the payment information from the primary payer’s EOB for the charges on this service line in the appropriate fields.

All the fields listed below are required:

**Note:** This is the only field you need to fill out on this tab.

- **Approved:** Enter the amount that the primary payer approved for this service. Then put your cursor in the ‘P/S’ field under the ‘Service Line Adjudication (SVD) Information’.

- **P/S:** Enter ‘P’ for Primary.

- **Proc:** Click in the Box and hit F2. Select the type of procedure code used in billing.
  - ‘AD’ = American Dental Association Code (Dental Only)
  - ‘ER’ = Jurisdiction Specific Procedure and Supply Codes
  - ‘HC’ = Common Procedural Coding System (HCPCS) Code
  - ‘IV’ = Home Infusion EDI Coalition (HIEC) Codes
  - ‘WK’ = Advanced Billing Concepts (ABC) Codes

- **Qual/Code:** Enter the procedure code that describes the service to which this adjustment is applicable. This is typically duplicated from the original claim service line.

- **Paid Amount:** Enter the amount that was paid by the primary payer for this line of service.

- **Paid Units:** Enter the unit(s) that was (were) paid for this service line.

- **Adj/Payment Date:** Enter the date this service line was adjudicated by the payer. Then put your cursor in the ‘Group’ field under the ‘Line Level Adjustments (CAS) information’.

- **Group:** Press <F2> to get a list. Choose the code that identifies the general group/category of payment adjustment.

- **Reason:** Press <F2> to get a list. Choose the code that identifies the detailed reason the adjustment was made.

- **Amount:** Enter the amount of the adjustment.
Units: Enter the units of service being adjusted.

For example: If the adjustment is due to the patient’s deductible, you would choose ‘PR’ for the Group code and you would choose ‘1’ for the Reason code.

Do this for each line level adjustment.

**NOTE: No other fields on this screen are required.

Roster Billing Instructions – Vaccination Billing Only

Submitters who bill Medicare Part B for influenza vaccinations and/or pneumococcal vaccinations only can use the ‘Roster Billing’ function to enter claim information and create claim files to transmit to WPS Health Solutions.

Complete the following steps to enter claim information and create a file for transmission utilizing the ‘Roster Billing’ function of PC ACE:

• Step 1: Complete the ‘System Setup/Reference File Maintenance’ instructions before entering claim data (Refer to the appropriate section of this document for instructions).

The following ‘Setup’ functions are required for Roster Billing:

- Submitter File Setup
- Provider File Setup (most likely ‘Solo Practice’ only)
- Facility File Setup

The following ‘Setup’ functions are optional for Roster Billing:

- UPIN File Setup
- Payer File Setup
- Patient File Setup

• Step 2: Select ‘Professional Claims Processing’ from the ‘Main Form.’

The ‘Professional Claims Menu’ will appear.
•Step 3: Select ‘Roster’ from the ‘Professional Claims Menu’.

Then select ‘New Roster Billing’ from the drop-down menu that appears.

The ‘Professional Roster Billing Form’ will appear:

•Step 4: Complete the following ‘Required’ fields on the ‘Professional Roster Billing Form’

Notes: You can enter up to 99 patients on each ‘Roster’.
Separate ‘Rosters’ must be created for influenza and pneumococcal vaccination billing. Separate ‘Rosters’ must be created for each service date. Each patient's name, Medicare HIC number, demographic information and address are entered on 2 separate lines of fields. DO NOT fill out the ‘Insured & Misc Info’ tab.

Patient Info and General Screen

- **Payer ID Field – Required**
  Press <F2> or ‘right click’ while your cursor is positioned in this field to obtain a list of valid ‘Payer IDs’. Highlight the appropriate ID and click ‘Select’.

- **Provider ID/No. Field – Required**
  Press <F2> or ‘right click’ while your cursor is positioned in the field to obtain a list of valid ‘Provider IDs’. Select the appropriate ID from the list.

- **Service Date Field – Required**
  Enter the date of service for all the claims that will appear on this ‘Roster’. (Format: MM/DD/CCYY).

- **POS (Place of Service) Field – Required**
  Enter the appropriate 2-digit ‘Place of Service’ code that applies to all claims on this ‘Roster’. Always use Place of Service ‘60’.

- **Type Field – Required**
  Enter ‘I’ in this field if this ‘Roster’ will contain claims for influenza vaccinations. Enter ‘P’ in this field if this ‘Roster’ will contain claims for pneumococcal vaccinations.

- **HCPCS Field – Required**
  Press <F2> or ‘right click’ while your cursor is positioned in this field to obtain a list of valid procedure codes for this type of ‘Roster’. Select the code from the list that applies to all claims on the ‘Roster’.

- **Refer Physician Field – Optional**
  Press <F2> or ‘right click’ while your cursor is positioned in this field to obtain a list of UPINs from your ‘UPIN’ File. This is not required.

- **Vaccine Chg. Field – Optional**
  Type the dollar amount you bill for the vaccine only. Be sure that it is the charge for the appropriate type of vaccine (influenza vs. pneumococcal).

- **Admin Chg. Field – Optional**
Type the dollar amount you bill for the administration of the vaccine if you bill it separately from the vaccine itself.

- **Patient Control Number Field – Not Used**

  A ‘Patient Control Number’ will be automatically assigned for each patient. You will not have access to this field.

- **HIC Field – Required**

  Enter the Medicare Part B ‘Health Insurance Claim Number’ (HIC) from the patient’s Medicare Part B card. Do not include any hyphens or spaces.

- **Patient’s Last Name/First Name/MI Fields – Required**

  Enter the patient’s last name, first name and middle initial (if known) in the fields provided.

- **Sex Field – Required**

  Enter ‘M’ if this patient is male; ‘F’ if this patient is female.

- **Birthdate Field – Required**

  Enter the patient’s date of birth. (Format: MM/DD/CCYY)

- **Address Line 1 Field – Required**

  Enter the patient’s street address or PO Box.

- **Address Line 2 Field – Optional**

  Enter any street address or PO Box information that does not fit in the ‘Address Line 1’ field.

- **City Field – Required**

  Enter the patient’s city.

- **State Field – Required**

  Enter the 2-digit postal abbreviation for the patient’s state.

- **Zip Code Field – Required**

  Enter the patient’s zip code.

**Extended Roster Info Screen**

You are now required to submit facility information on your roster claims.

See below for the instructions:
Click the ‘Extended Roster Info’ screen.

Enter the name and address of the facility where the service was rendered. You must complete the following fields on this screen: There is a new field in 5010A1, *(Proc Desc)* field is where you must put the description of a **NOC (Not Otherwise Classified) code** if applicable. You must enter the name of the drug, dosage and route of administration, IM, IV, etc.

- **Name** – Enter the name of the facility
- **Address** – Enter the street address of the facility
- **City/St/Zip** – Enter the city, state and zip code for the facility **MUST USE valid 9-digit ZIP Code.**

**Note:** NPI is not required for the facility.

When you have completed this screen, return to the ‘Patient Info & General’.

**Step 1:** Complete the ‘Patient Information’ data for each claim you wish to appear on the ‘Roster’.

**Step 2:** Once you have entered all the patients you wish to appear on this ‘Roster’, click ‘Save’ at the bottom of the ‘Professional Roster Billing Form’.

**Step 3:** You will receive the following, instructional message after clicking ‘Save’.
• If this ‘Roster’ is finished:

Click ‘Yes’. The following window will appear. Click ‘Generate’ and answer the subsequent prompts.

The results of the ‘Roster Generation’ will appear. If you click ‘View Results’, you can generate a report of the claims contained in the ‘Roster’.

• If this ‘Roster’ is NOT finished:

Click ‘No’. You will be able to access the roster by selecting ‘Roster’ from the ‘Professional Claims Menu’ and selecting ‘Maintain Roster Billing’.

This ‘Roster’ will be displayed with ‘Location’ code ‘RL’ indicating it has not been generated. If you double click on the ‘Roster’ from the list, you will be able to continue entering patients before you ‘Generate’.

If you wish to ‘Generate’ from this screen, click on ‘Actions’ (toolbar) and select ‘Generate Selected Roster’.

• Step 4: Once you have generated your ‘Roster’, you can select ‘List Claims’ from the ‘Professional Claims Menu’. All of the claims from the ‘Roster’ will appear on the list with ‘Location’ code ‘CL-to be transmitted’ and ‘Status’ code ‘UNP’ (unprocessed). You will now need to ‘Process’ the claims through the PC ACE edits. Close the window.
•Step 5: Select ‘Process Claims’ from the ‘Professional Claims Menu’.

The following screen will appear:

![Process Claims](image)

Type ‘MCB’ in the ‘LOB’ field and click on ‘Process’. The claims will now be run through the PC ACE edits and the results will be displayed for you. You can select ‘View Results’ to create a report of the claims that will be in the file you create in the next step. Print this report for your records.

Close the window to return to the ‘Professional Claims Menu’.

•Step 6: Select ‘Prepare Claims’ from the ‘Professional Claims Menu’ and refer to the ‘Prepare Claims for Transmission’ section of this document for instruction regarding creation of the file that will be transmitted to WPS Health Solutions.
Step 7: Transmit your claim file to WPS Health Solutions. Refer to the ‘Transmit Claim File to the WPS Health Insurance’ section of this document for instructions.

TRICARE/VAPC3 Resource Sharing Program

If you are entering claims for the TRICARE/VAPC3 Resource Sharing Program, you MUST indicate this by keying ‘R’ in the ‘Special Program Indicator’ field that appears on the ‘Extended Patient/General’ tab for each claim.

Any paper claim filing requirements for this special program apply as well (i.e. place of service codes, facility information, TRICARE/VAPC3 provider numbers and physical zip code, etc.).

Correcting Claims that have been Transmitted and/or Reactivating Entire Files

Step 1: Select ‘Professional Claims Processing’ from the ‘Main Form’.

Step 2: Select ‘List Claims’ from the ‘Professional Claims Menu’.

Step 3: In the ‘Claim List Filter Options’ section at the bottom of the screen, click on the down arrow button at the end of the ‘Location’ box. Choose ‘TR – transmitted only’. This will give you a list of all the claims that have been prepared for transmission.

Step 4: On the top menu bar, choose ‘Filter’. A drop-down menu will appear. Choose ‘Check all claims from selected transmission’. A new box will appear titled ‘Professional Claim Transmission Log’. Highlight the line of the file that the claim needing corrected is in. Click the ‘Select’ button. This will take you back to the ‘Professional Claim List’ screen. This will put a check mark on the lines for the claims that are included in the transmission file that you selected.
• Step 5: On the top menu bar, choose ‘Actions’. A drop-down menu will appear. Choose ‘Reactivate all Checked Claims’.

• Step 6: In the ‘Claim List Filter Options’ section at the bottom of the screen, click on the down arrow button at the end of the ‘Location’ box. Choose ‘CL – to be transmitted’. This will give you a list of all the claims that have not yet been prepared for transmission. If you do not need to make corrections to any claims, skip to Step 8.

• Step 7: Locate the line of the claim that must be corrected. Highlight the line. Choose ‘View/Update’ button on the bottom of the screen. This will bring up the ‘Professional Claim Form’. Make your corrections and ‘Save’ the claim.

• Step 8: Once you have corrected all the claims necessary, click ‘Close’ on the ‘Professional Claim List’ screen.

• Step 9: Click ‘Process Claims’. This will bring up a new screen. Choose the correct Line of Business (LOB). Click the ‘Process’ button. Click ‘OK’. Click ‘OK’. Then click ‘Close’.

• Step 10: Now follow the instructions for ‘Prepare Claims for Transmission’ in this manual.

**Printing Claim Forms**

_This option should not be used for submitting claims to Medicare Part B._

• Step 1: Select ‘Professional Claims Processing’ from the ‘Main Form’
  The ‘Professional Claims Menu’ will appear.

• Step 2: Click the ‘List Claims’ button.
  A screen containing a list of the ‘New’ (ready for transmission) claims will appear.

• Step 3: Locate and select the claim you wish to print.

• Step 4: Click ‘Actions’ from the top menu bar. Then select ‘Print Selected Claim’ from the drop-down menu. The ‘Claim Print Options’ window will be displayed.

• Step 5: Select the appropriate Printer and Method.

• Step 6: Select the appropriate Payer Options. 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. The secondary and tertiary payers would be considered ‘alternate’ payers.

• Step 7: Select appropriate claim form option as shown below:

![Claim Print Options](image)

• Step 8: To view the claim prior to printing, click the ‘Preview’ button. You must have Adobe Acrobat Reader Version 4.0 or higher for viewing.

• Step 9: Click ‘Print’ when ready to print.

Posting Claim Payments

• Step 1: Select ‘Professional Claims Processing’ from the ‘Main Form’.

The ‘Professional Claims Menu’ will appear.

• Step 2: Click the ‘List Claims’ button.

A screen containing a list of the ‘New’ (ready for transmission) claims will appear.

• Step 3: On the ‘Professional Claim List’ screen, select ‘Transmitted Only’ (TR) to display claims eligible for payment.

• Step 4: Select the desired claim from the list and click the ‘View’ button at the bottom of the screen.
•Step 5: This will bring the claim up to view. Click the ‘Show Payment History’ button to access the payment history for this claim.

•Step 6: To post a 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 must be entered on a ‘per line-item’ basis. Click the ‘Amount Paid’ field for the line item to be paid, enter the payment amount, and press the ‘Enter’ or ‘Tab’ key to accept the entry. Complete some or all the optional payment records fields and line item cells if desired.

•Step 7: When all desired payment fields have been entered, click the ‘OK’ button to save the payment record.

•Step 8: 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. When the payment is saved, the claim is moved to the ‘Paid (PD)’ location.

Charges Master File Maintenance

If you choose to use this optional reference file, it should be setup to include all the procedure codes that are to be used by your office. Using this master file will reduce the size of the HCPCS code lookup lists during claim entry, thus promoting accuracy and enhancing productivity. The charge that is assigned to each procedure will automatically be brought forward to the claim line item ‘Charges’ field when a valid code is entered or looked up during claim entry.

•Step 1: Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

•Step 2: Select the ‘Codes/Misc’ tab from the ‘Reference File Maintenance’ screen that appears.

•Step 3: Select the ‘Charges Master’ button from the list of Reference Files on the ‘Codes/Misc’ tab.

•Step 4: Click ‘New’ at the bottom of the screen.
• Step 5: In the ‘Code’ field, enter the HCPCS or CPT code. The description of the code will automatically be entered in the ‘Description’ field.

• Step 6: Enter the amount that your office will be charging for this service in the ‘Charge’ field. This amount will automatically be entered in the charges field when entering claim data. Click ‘OK’ when completed.

• Step 7: Continue to enter as many codes/charges as necessary for your office. When finished, click ‘Close’.

• Step 8: Click on ‘File’ on the ‘Main Form’, then click ‘Preferences’ and on the ‘General’ tab, check the box beside ‘Use Charge Master Reference File for Professional procedure code lookups’. This will activate the Charge Master file.

### Place of Service File Maintenance

If you perform services in a Place of Service that is not present when trying to enter a claim, you can follow the steps below to add it to the list.

• Step 1: Select ‘Reference File Maintenance’ from the PC ACE ‘Main Form’.

• Step 2: Select the ‘Codes/Misc’ Tab from the ‘Reference File Maintenance’ screen that appears.

• Step 3: Select the ‘POS’ button from the list of Reference Files on the ‘Codes/Misc’ tab.

• Step 4: Click ‘New’ at the bottom of the screen.

• Step 5: In the ‘Code’ field, enter the Place of Service code.

• Step 6: Enter the appropriate description for the Place of Service.

• Step 7: When finished, click ‘OK’.

### HCPCS File Maintenance

Periodically new HCPCS codes are issued. These new codes can easily be added to your PC ACE software by using the following instructions:

- Access the ‘Reference File Maintenance’ from your ‘Main Menu’.
• Click on the ‘Codes/Misc’ tab.

![Reference File Maintenance]

• Click on the ‘HCPCS’ button.

![HCPCS]

• Click on ‘NEW’.

![HCPCS Codes]

Enter the new HCPCS code in the box marked ‘Code’.

Enter the description of the procedure in the box marked ‘Description’.

If you wish to enter the effective date ranges, you may. This step is not necessary.

• Click ‘OK’ to close.

**Modifier File Maintenance**

Periodically new modifiers are issued. These new codes can easily be added to your PC ACE software by using the following instructions:

• Access the ‘Reference File Maintenance’ from your ‘Main Menu’.
• Click the ‘Codes/Misc’ tab.

![Reference File Maintenance]

• Click the ‘MODIFIERS’ button.

![MODIFIERS]

• Click ‘NEW’.

![NEPCS Modifiers]

• Type the new modifier in the box marked ‘Modifier’.

• Enter the description of the modifier in the box marked ‘Description’.
  If you wish to enter the effective date ranges, you may. This step is not necessary.

• Click ‘OK’ to close.

![NEPCS Modifier Information]

• Click ‘Assignments’ tab, then click ‘New’.
• Choose the appropriate line of business using the arrow in the ‘LOB’ box.

• Choose the new modifier using the arrow in the ‘Modifier’ box.

• Check the box beside ‘Valid for Professional Claims’.

• Click ‘OK’

Performing System Backs and Restores

You will be prompted to perform a backup each time you exit the PC Ace program. Creating a backup and storing it in a place other than where your PC Ace is installed to is an important step to ensure that your most up to date information is stored in a safe place. In the event of computer failure or other issues you will have a copy of PC Ace which can be restored and bring all your data back to where it was before the incident. Therefore, creating a backup frequently is important and why you are prompted to update your backup every time you exit the software.

To Backup:

• If backing up when closing PC ACE skip to next step. If backing up from the ‘Main Form’ Click ‘System Utilities’ button from the ‘Main Form’. Then click the ‘Backup’ tab.

• Select the ‘Destination Drive’ that you wish the backup to be saved to. Do not select ‘Include infrequently changed database files’.
• Click ‘Start Backup’. Then click ‘OK’. You will be notified upon successful backup completion.

To Restore your Backup:

• Click ‘System Utilities’ button from the ‘Main Form’. Then click the ‘Restore’ tab.

• Select the ‘Source Drive’ containing the backup to be restored. This would be the ‘Destination Drive’ you saved your backup to (Please note if you saved the backup to on removable storage i.e. flash/jump drive, CD, etc., you may have to move the backup to your hard drive/desktop before you can ‘Restore’). Then click ‘Start Restore’.

• Click ‘OK’

• Click ‘OK’ again.

You will be notified when the restore operation completes. PC Ace will terminate automatically following a restore operation. The restored database files and configuration settings will be available the next time the program is executed.

Note: The restore operation will overwrite your current database files with older data from the specified backup.

Using PC ACE for Electronic Remittance – 835

Your PC Ace software can be used to read and print your electronic remittances. You must sign up for this service with your carrier.

Once an electronic remittance is available to you, you will download the file to the following location: C:\WINPCACE/Mailbox

• Open your PC ACE software and select ‘ANSI 835 Functions’ from the ‘Main Form’.
• Select ‘Professional’

• Select ‘Select ANSI File’

• Highlight file to be printed or viewed

• Select ‘Translate/Import ETRA’
• Select ‘Print/View Reports’

• Select ‘Provider Remittance Detail’ or ‘Provider Remittance Summary’

• Enter Page ‘1’

• Select ‘OK’
At this time either the **Detail** or the **Summary** will appear on the screen. You may print at this time.

---

**276 (Claims Status Request) Preparation/Transmission**

Before completing these steps, you will need to contact the EDI department at WPS Health Solutions to request the 276/277 transaction functionality to be enabled.

Claims status request file ‘**preparation**’ in PC ACE refers to the action required to generate an **ANSI-276 claims status request file** appropriate for transmission. This transmittable file will contain all relevant status request details for one, or more, previously transmitted claims. Once WPS Health Solutions receives your **ANSI-276 file**, we will generate a corresponding **ANSI-277 claim status response file** containing status information for the requested claim(s). The actual **ANSI-277 response file** can be processed by PC ACE and the user will be able to view the status request file.

**Note:** Only the claims that have been added to the status request queue will be included in the ANSI-276 claim status request file. Refer to the ‘**Claim List Form Features**’ summary in the ‘**Help Topic Tutorial**’ feature of PC ACE for specific details on how to build the ‘**Status Request Queue**’.

Complete the following to prepare a claim status request file in PC ACE:

- Add one or more transmitted claims in the status request queue using the ‘**Requested Selected Claim Status**’ or ‘**Request All Checked Claims Status**’ action in the ‘**Professional Claims List**’ form.

- Click the ‘**Professional**’ icon:
• Choose the ‘List Claims’ option:

• Change your claim location to ‘TR-Transmitted only’ and select your LOB for the claim(s) you are requesting. Hit the ‘right click’ button on your mouse and select either ‘Request Selected Claim Status’ (for one claim) or ‘Request All Checked Claims Status’ (for more than one claim) options. Hit the ‘Close’ button to return to the ‘Professional Claims Menu’.

• Within the ‘Professional Claims Menu’ select ‘Maintain’ and choose the ‘Prepare Claim Status Request File’
• Select your Line of Business (LOB) and ‘Payer’; then click on the ‘Prepare Status Request’ button. You will then get a ‘Confirm’ box asking if you are ready to ‘Prepare the Professional Claim Status Request File’, click ‘OK’.

![Professional Claim Status Request File Prepare](image)

• Click the ‘View Results’ button to see the ‘PC ACE Claim Status Request Report’. Select the ‘Print’ and/or ‘Close’ button to exit this page when your review is complete.

![PC ACE Pro32 CLAIM STATUS REQUEST REPORT](image)

• The prepared ANSI-276 claim status request file is in your ‘(C: drive’ within the ‘WINPCACE’ folder. The file is named ‘bsreq276.dat’.

• You may now proceed to transmit the ANSI-276 claim status request file to WPS Health Solutions via the WPS Bulletin Board System (BBS) or Gateway Express Website. Follow the steps outlined in the BBS or Gateway Express Website Instructions to transmit/upload your request file to WPS Health Solutions.

If you need to request a copy of the BBS or Gateway Express Website instructions, please contact the WPS Health Solutions EDI Help Desk for your line of business.

277 (Claim Status Response)
After WPS Health Solutions receives your **ANSI-276 format claim status request file** generated by PC Ace, WPS Health Solutions will retrieve the requested claim status information and respond to you by sending an **ANSI-277 Claim Status response file** back to you. PC ACE allows you to archive the **ANSI-277 claim status response files** for subsequent review and/or printing.

This section will summarize how to stage your **ANSI-277 files** so that they are automatically archived and posted by PC ACE. Other summarized topics include: **functions for viewing, printing, maintaining and archiving** claim status response files and **posting** files.

### Staging Claim Status Response File for Automatic Archiving

At program startup, PC ACE 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, the staging directories are edited for the appropriate format and automatically archived. 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.

With this edition of PC ACE, the user is required to manually copy the **ANSI-277 files** received from WPS Health Solutions into the appropriate staging directory. The Professional staging directory is:

```
c: Winpcace/ansi277/stat1500/archive
```

For single-user installations, this directory will reside on the local drive to which PC ACE was originally installed, typically your ‘(C drive.’ For multi-user or networked installations, this directory will reside on the shared network drive letter to which PC ACE was installed.

**Note:** It is critical that you ensure copying only Professional Claim Status Response files to the Professional staging directory. In addition, 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.

### Viewing, Printing & Maintaining Claim Status Response Files and Post Report

The archived **277-ANSI Claim Status Response Files** and **Post Reports** can be viewed and/or printed from the **Claims Status Response Log** form. To view the currently archived **ANSI-277 files**, select the ‘Maintain’ option from the **Professional Claims Menu**. From the drop-down list of options, select ‘Claim Status Response Log’ menu item on the **Professional Claims Menu** form.
This will bring up the ‘Professional Claim Status Response Log’ screen displaying information related to your ANSI-277 files.

The following options are available at this point:

- 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.

- To delete an archived **ANSI-277 file** and its associated post report, select the desired record, click the ‘**Delete**’ button and confirm the deletion.

**Note:** Archived **ANSI-277 Claim Status Response Files** will be automatically purged, usually after six months. Individual claim status responses that 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 the proper format and automatically archived and posted. The displayed list will then be rebuilt to reflect the current archive contents. You can ‘right click’ the mouse on your desired archive record to access all the available actions.
This popup menu provides several additional actions which will 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 report will provide the user with general identification information along with the claim-level status response codes and payment returned by WPS Health Solutions 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 where WPS Health Solutions will need to post ambiguous status responses to the original claim. In these situations, you will be referred to the original claim status response file (and this report) for additional information.

Using the Claim Status Response Post Reports

The ANSI-277 claim status response report provides the claim-by-claim results of the automatic response posting operation. A response posting will fail for either of the following reasons:

1) 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’ locations.
2) Multiple claim status responses have been returned by the intermediary/carrier for the same unique claim trace number. This typically indicates that WPS Health Solutions 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 WPS Health Solutions discretion. PC ACE will not post any of the ambiguous responses back directly to the claim but will instead post an ‘attention’ notification that will direct you back to the original archived claim status response file/report. The user must review this report to determine which one of the multiple responses (if any) is applicable. The ANSI-277 Claim Status Response Post Report will display an explanatory error message for each response that could not be posted.

277 Claim Status Request/Response History with PC ACE

Complete the following to generate a 277-transaction history report:

- From the ‘PC Ace Claims Processing System’ toolbar select the ‘Prof’ icon.
This will bring you to the ‘Professional Claims Menu’ screen. Select the ‘List Claims’ option.

Within the ‘Professional Claim List’ you need to change your location to ‘TR-Transmitted only’ and you need to select your Line of Business (LOB)

Select and highlight the claim for which you will be creating the ‘Claim Status Request/Response History’ report.

Hit the ‘right click’ button on your mouse. From the drop-down list, select the ‘Show Selected Claim Status History’ option. This will bring up the ‘Claim Status Request/Response History’ screen.
• Click on the ‘Print History’ button. This will bring up the ‘Report Preview’ screen displaying a copy of your report that you can review and print.

• Click the ‘Close’ button to exit the ‘Report Preview’ screen.

• Click the ‘Close’ button to exit the ‘Claim Status Request/Response History’ screen.
• You will be returned to the ‘Professional Claim List’ screen. Click the ‘Close’ button in the lower right-hand corner to exit this screen.

• At this point the ‘Professional Claims Menu’ screen will appear. Select ‘Maintain’ from the top of the page and select the ‘Prepare Claim Status Request File’ option.

• This will bring up the ‘Professional Claim Status Request File Prepare’ box. Select your Line of Business (LOB) and Payer; then click on the ‘Prepare Status Request’ button.
You will be prompted with a 'Confirm' box, click 'OK' to continue.

The 'Information' box will advise that your claim status request has successfully completed. Click 'OK'; then select the 'View Results' button for your report.

Then select the 'View Results' button for your report.

Results will appear like this.
You can select the print icon to print this report for your records. Click the ‘Close’ button to return to the prior screen. Click ‘Close’ again to return to the ‘Professional Claims Menu’ and continue with other functions within PC ACE.

**270/271 Eligibility Benefit Request List Form features**

The **PC ACE 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 the “**Professional Claims Processing**” button on the PC ACE 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. After your list has been created, it can be easily sorted and filtered to display only the requests of interest.
• Creating New Requests – Click the “New” button (or choose the “Create New Request”, “Create New Request (Service Type/Facility Type)” or “Create New Request (Complete)” action) to create a new eligibility benefit request.

After selecting the New Request Type, you will get the screen below. The required fields for this screen are:

Payer
Provider
Member ID
Relationship
Subscriber Last name
Subscriber First Name
After entering this information select save. If you have any errors, please correct and save again. If no errors, you will see the following screen, where your request was added to the list.
• **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 eligibility benefit request entry form.

**Tip:** 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.

**Tip:** 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.

*** Note: Deleted eligibility benefit requests are permanently removed from PC ACE ... they cannot be recovered.

**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 many **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:
• **Copy 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.

• **Hold 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.

• **Release 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).

• **Reactivate 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.

• **View 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.

  **Note:** 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 selected eligibility benefit request.
• **Refresh 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.

Note: 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.

### 270/271 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.
PC ACE User’s Manual 54. 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 nonperson “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 Main Toolbar & Forms 55 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:

- **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. Tip: 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.

  **Note:** PC ACE 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 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 to streamline the process of creating new Service Type eligibility/benefit requests. Click the “Add” button to choose a provider from the 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.

Note: In addition to the providers listed in the Provider Selection List, users will also be allowed to select from the complete 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.

Preparing your Eligibility Benefit Request

Once you have one or more clean requests, select the “Maintain” and “Prepare Eligibility Benefit Request File” menu options to access the Eligibility/Benefit Request form. This form functions just like its claim counterpart. The ANSI-270 file produced by the prepare operation is named BSREQ270.DAT (Professional), and are written to the “Winpcace” folder.

Downloading your 999 and 271 response reports

To translate your 999 into a ‘human-readable’ format:

1. Download the 999 using your selected transmission method of either the WPS BBS (Bulletin Board System) or Gateway Express Website.
2. Place the 999 files in folder: C:\WINPCACE\Mailbox
3. Open PC ACE
4. Click the ‘Professional Claims Processing’ icon from the ‘PC ACE main form’
5. Click ‘Maintain’ on the toolbar on the ‘Professional Claims Menu’ and then click ‘Acknowledgement File Log’ on the drop-down menu.
6. You will now see the 'Professional Acknowledgement Log'. Select the record you wish to view by clicking on it to highlight it. Then click 'View Report'.

You will now see your 999 'Report'. You will also have the capability to print this report by clicking the 'Print' icon on the toolbar:

**Downloading your 271 Eligibility Benefit response**

The returned 271 response files should be saved to the “C:\WINPCACE\Ansi271\Elig1500” (Professional) staging folders.

Once the ANSI-271 files are in the appropriate staging folder, select the “Eligibility Benefit Response Log” item from the “Maintain” menu on the appropriate Claims Menu (5-button) form.
The staging folder will be scanned, and all ANSI-271 files present in this folder will be archived and made available in the list. Double-click a response record to view/print the corresponding report in its entirety.
The ANSI-270 files are not archived to keep the module as simple as possible. Neither are the prepare reports archived. You can view the report for the most recent request prepare operation from “View” menu on the Claims Menu form.

**Electronic Media Claim (EMC) Import**

PC Ace allows you to import an ANSI X12 file created on different claim entry software. This function is normally performed to utilize the Payer specific business edits for the Line of Business you are creating claims for. If you choose to use PC Ace to import EMC claims, you must first set up your PC ACE. Be sure you have already set up the:

- **Submitter File Setup** (pg. 24)
- **Provider File Setup** (pg. 29)
- **Preferences for EMC Claim Import** (Contact the EDI Help Desk for assistance)

  - TRICARE/VAPC3/ARISE/WPS: 1-800-782-2680 (Option 1)
  - MAC J5 and J5 National Part A 1-866-518-3285 (Option 1)
  - MAC J8 1-866-234-7331 (Option 1)

Once you set up your PC Ace and create a claim file on your other software you are ready to import.

Find the claim file created by your other software and rename it with a .DAT extension (i.e. TestFile.DAT)

Go to the drive where your PC ACE is installed (normally your C:\ drive)

1. Enter the ‘WINPCACE’ folder
2. Place your claim file in the ‘IMP1500’ folder.
3. Back on the PC Ace Main Form click:
4. Then click:

5. On the **Professional Claim Import** screen click ‘**Import**’:

6. You will be asked if you are ready to import, click ‘**OK**’

7. If there were no errors click ‘**OK**’ (If you receive an error and are unable to determine the cause, call the EDI Help Desk at the telephone number listed above).
8. You will now see the results of your Import. Click ‘Close’.

![Import Results]

9. Your claims are now ready to be **Prepare Claims for Transmission (pg. 74)**.

**Additional Assistance through the ‘Help Topics’ Link**

- On the Main PC ACE toolbar select ‘Help’ and then ‘Help Topics’ on the dropdown menu.

![Help Topics]

- Enter a general keyword in the ‘Search’ tab regarding the type of assistance needed. This tool has a wealth of detailed information relating to all aspects of PC Ace functionality.
Change Summary

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