

XPressClaim Help

Keying Information

Professional Claims – CMS 1500

Claim type

Please select the type of claim:

1- Original claim

7- Replacement of prior claim

Please note: “7- Replacement of prior claim” should only be selected when TRICARE has previously paid the claim, and you have the prior TRICARE claim number.

Prior claim number

When submitting a replacement or corrected claim (Claim type 7 - Replacement of prior claim), please enter the prior TRICARE claim number.

Diagnosis code(s)

Enter the three to five-digit ICD-9 diagnosis code(s) to indicate the illness or injury that caused the patient to seek services. Remember, the more digits you use, the more accurate the description of the diagnosis. Using the most accurate diagnosis code ensures the most accurate claims processing.

From and to dates of service

Enter the actual date the provider performed the procedure or provided services. Enter numbers in mm/dd/yyyy format (month, day, year). Example: 04/19/2012.

Place of service

Select the place where the procedure or service(s) was actually performed - that is, the place the doctor actually saw the patient.

Procedure & modifiers

Enter the five-digit CPT-4 or HCPCS code that describes the service(s) rendered. A modifier gives us more information about the procedure. For example, a modifier of 80 tells us an assistant surgeon was present. The more accurate this code is, the more accurate your claim will be process.

Diagnosis 1,2,3,etc.

Enter the number(s) of the corresponding diagnosis code(s) that applies to this service.

NDC

Select the NDC checkbox when you have drug or injection information to enter. In HIPAA 5010, professional claims for injectable medications must include additional drug information and qualifiers, such as National Drug Code (NDC), quantity and measurement code.

NDC code

Enter the unique 11-digit, 3-segment National Drug Code number assigned by the FDA. Please enter a number with no hyphens or spaces between segments. The required associated data for the NDC consists of the **Quantity** (National Drug Unit Count) and the **Measurement code** which can be one of the 5 qualifiers: International Unit (F2), Gram (GR), Milliliter (ML), Milligram (ME) or Unit (UN).



XPressClaim Help

Units/Pkg

In HIPAA 5010, this field is now the Measurement code field.

Minutes (for anesthesia)

Select the total number of minutes the anesthesia was delivered. Example: If anesthesia was delivered from 1:20 p.m. to 4:40 p.m., enter 200 minutes. **Please note:** This field only appears after an anesthesia procedure code has been entered in the Procedure field.

Charge

Enter your dollar amount charge for the procedure or service on this claim.

Units

Enter the number of times the procedure was performed for the date on the claim. Most of the time, this number is 1. Exceptions might be injections, mileage, and physical therapy.

Your total submitted charges

These are the total charges for the procedures and services that appear on this claim. We calculate these charges automatically.

Patient paid you

Enter the amount the patient has already paid you for any of the services on this claim. This is usually the upfront, out-of-pocket cost-share or copayment you collected from the patient at time of service.

Add another claim line

On the claims entry screen, beneath the first line of fields where you enter claims information, you will see a hyperlink to the left labeled "[Add another line.](#)" When you click that link, a new line of fields will open up for you to enter the claim information.

Clear the line above

Below each claim line, you will see a hyperlink labeled "[Clear this line.](#)" You can click this link to clear any data you have entered on that line.

Accepts assignment

By "accepting assignment," a provider agrees to accept the TRICARE maximum allowable charge as payment in full and to write off the difference between TRICARE maximum allowable charge and the billed charges. **Please note:** This field only appears for non-network providers.

Referring provider information

To enter referring provider information, select the option: No, I have supplemental claim and/or line data to enter. Select the checkbox for Referring provider information. Enter the referring provider's name and primary ID (NPI) or secondary ID (atypical providers only). These fields correspond to block 17 on the CMS 1500 claim form.

Institutional Claims – UB04

Facility type, Claim frequency

These values combined make up the "Type of Bill" from block 4 on the UB04 claim form. Choose the appropriate values for each field from the drop-down menus provided. Example: Hospital Outpatient, Admit thru discharge claim equal a Type of Bill 131.



XPressClaim Help

Payer claim control number

This field corresponds to block 64 on the UB04 claim form. Enter the prior TRICARE claim number when submitting a replacement or corrected claim (claim frequency 7). Enter the claim number assigned to the original RAP (Request for Anticipated Payment) when cancelling a RAP or submitting a final claim (bill types 328 or 338).

Prior authorization number

Enter the 18-byte treatment authorization number for HHA/PPS and RAP (Request for Anticipated Payment) claims. This field is used to link the RAP to the specific OASIS (Outcome Assessment Information Set) assessment.

Admission Date

In this field, enter the date the patient was admitted to the provider for inpatient care, outpatient care or start of care. This value is required for inpatient and Home Health Agency (HHA) claims.

Admission time

Choose the hour during which the patient was admitted for inpatient or outpatient care (admission hour). This value is required for inpatient and Home Health Agency (HHA) claims.

Priority (Type) of admission or visit

In this field choose the priority of this admission. Example: Urgent.

Point of origin for admission or visit

Choose the point of origin/source of this admission. This value is required for inpatient and Home Health Agency (HHA) claims. Example: Clinic or Physician's Office.

Discharge time

Choose the time that the patient was discharged from inpatient care.

Patient's status

In this field, choose the patient's status as of the last date of service represented on the current billing. Example: Discharged to home/self care.

Principal diagnosis code

Enter the ICD-9-CM code describing the principal (primary) diagnosis.

Present on Admission (POA) codes

POA codes are associated with diagnosis codes and indicate whether the diagnosis was observed when the patient entered the hospital, or if it developed at a later time. This indicator affects DRG reimbursement and is critical to accurate claims processing and payment. For inpatient claims, please enter a valid POA code for each diagnosis code entered:

- Y – Diagnosis was present at time of admission
- N – Diagnosis was not present at time of admission
- U – Documentation insufficient to determine if condition was present at time of admission
- W – Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of admission
- 1 – Code exempt from POA reporting

Admitting diagnosis code

In this field, enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician. This value is required for inpatient claims.



XPressClaim Help

Attending physician's information

Enter the name and primary ID (NPI) or secondary ID (atypical providers only) of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

E-codes

Enter External Cause of Injury Codes as needed to describe an injury, poisoning or adverse effect.

Principal procedure code and date

Enter the ICD-9-CM procedure code that identifies the principal procedures performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Condition codes

Enter the code(s) used to identify conditions relating to this bill that may affect payer processing. A condition code indicates special circumstances about the claim or the patient. These fields correspond to blocks 18 through 28 on the UB04 claim form.

Occurrence codes and dates

Enter the code(s) and associated date(s) to define a significant event relating to this bill that may affect payer processing. These fields correspond to blocks 31 through 34 on the UB04 claim form.

Home health Internal Control Number (ICN)

HIPAA 5010 removed this field. Use the Payer claim control number field to enter the claim number assigned to the original RAP (Request for Anticipated Payment) when canceling a RAP or submitting a final claim (bill types 328 or 338). This field corresponds to block 64 on the UB04 claim form.

Authorization treatment code

HIPAA 5010 removed this field. Use the Prior authorization number field to enter the 18-byte treatment authorization number for HHA/PPS and RAP (Request for Anticipated Payment) claims. This field is used to link the RAP to the specific OASIS (Outcome Assessment Information Set) assessment.

Value codes and amounts

Enter the value code (61) followed by the four-digit MSA code. These fields correspond to blocks 39 through 41 on the UB04 claim form.

Occurrence span codes and dates

Enter the code(s) and the related date(s) that identify an event that relates to the payment of the claim. These fields correspond to blocks 35 through 36 on the UB04 claim form. **Please note:** These fields are only used with HHA/PPS and SNF/PPS claims.

Treatment codes

Enter treatment codes to report Home Health Agency Plan of Treatment information.



XPressClaim Help

Please enter any additional remarks

HIPAA 5010 removed this field. Use the Claim note field to enter remarks to describe the change when the Condition code is D5 (when a change is being made to the subscriber number or provider ID number), D6 (when repaying a duplicate payment or overpayment) or D9 (to indicate a change on bill type 3X7).

Revenue code

In this field, enter the code that identifies a special accommodation, ancillary service or billing calculation. **Please note:** A revenue code of 023 is required on all HHA/PPS claims.

Procedure

Enter the five-digit HCPCS (HCFA Common Procedure Coding System) or CPT-4 code. This field is applicable to ancillary services and outpatient bills. For HHA/ PPS claims enter the HIPPS (Health Insurance Prospective Payment System) code in this field. The more accurate this code is, the more accurately your claim will be processed.

Modifiers

A modifier gives us more information about the procedure. Example: Modifier of 80 tells us an assistant surgeon was used.

Units/days

In this field, enter the number of services rendered by revenue code for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

Charge

Enter your dollar amount charge for the procedure or service on this claim. **Please note:** A zero charge is only allowed on an HHA/PPS claim with revenue code 023.

Your total submitted charges

These are the total charges for the procedures and services that appear on this claim. We calculate these charges automatically.

Add another claim line

Beneath the last line of fields where you enter claims information, you will see a hyperlink to the left labeled "[Add another claim line.](#)" Click that link and a new line of fields will open up for you to enter the claim information.

Clear the line above

Below each claim line, you will see a hyperlink labeled "[Clear the line above.](#)" Click this link to clear any data you have entered on that line.

Other Health Insurance (OHI)

Please enter other health insurance information as received from the other payer, including claim and/or line adjustments. This information tells TRICARE how the claim was processed by the other payer and what needs to be considered for coverage under TRICARE.



XPressClaim Help

OHI amount allowed

HIPAA 5010 removed this field. The amount allowed as determined by the payer is calculated using the prior payer's payment information coupled with adjustment information. **Please note:** Coordination of Benefits and Claim/Line Adjustments must be entered on the Other Health Insurance information page to ensure proper payment of the balance due after OHI.

OHI paid

Enter the amount the other health insurance company paid for this procedure or service. You will find this amount on the electronic (835) or paper remit from the other insurance company. **Please note:** A value should only be entered if patient has OHI. Otherwise, leave this field blank.

Coordination of Benefits

Please note: This section only appears after a value has been entered in the OHI paid field.

Level of adjustments

Please indicate how you would like to enter adjustments for the other payer (Claim Adjustments Only, Claim Line Adjustments Only or Claim and Line Adjustments). The choice should be driven by how the other payer provided the adjustment information to you on their electronic (835) or paper remit. The most common claim adjustments are Deductible, Co-Insurance or Non-Covered.

Other payer paid

This field is pre-populated with the amount entered in the OHI paid field.

Prior adjudication date

Please enter the date the other payer processed the claim.

Claim Adjustments

Please note: This section only appears when either "Claim Adjustments Only" or "Claim and Line Adjustments" has been selected from the drop-down menu as the Level of adjustment.

Claim adjustment group code

A Claim adjustment group code categorizes the adjustment reason codes that are contained in a particular adjustment. Please select an adjustment group:

- Contractual obligations (CO) — indicates a contractual agreement between the payer and payee, or a regulatory requirement that resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient
- Correction and reversals (CR) — indicates the claim is the correction or reversal of a previously reported claim or claim payment
- Other adjustments (OA) — indicates no other adjustment code group applies
- Payer initiated reductions (PI) — indicates that the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer
- Patient responsibility (PR) — indicates the amount adjusted is the patient's responsibility



XPressClaim Help

Reason code, Amount and Quantity

Claim adjustment reason codes communicate that an adjustment was made to the claim or service line and explain why it was paid differently than it was billed. The Adjustment Reason code, Amount and Quantity must be entered for TRICARE to consider payment after the OHI. If you would like to view a list of HIPAA Claim Adjustment Reason Codes, please go to www.wpc-edi.com.

Line Adjustments

Select the "Add" link beside the line you wish to adjust. **Please note:** This section only appears when "Claim Line Adjustments Only" or "Claim and Line Adjustments" has been selected as the Level of adjustment.

Procedure code type

Select the type of procedure code processed by the other payer for this claim line: HCPCS (Health Care Procedure Coding System) or HIPPS (Health Insurance Prospective Payment System)

Procedure code

Enter the procedure code processed by the other payer for this claim line.

Payer paid amount

Enter the amount paid by the other payer for this claim line.

Paid units

Enter the number of units processed for the procedure by the other payer for this claim line.

Prior adjudication date

Enter the date that the other payer processed the claim line.

Claim Results

Edits

"Edits" are online messages that tell you information on the claim is missing, incorrect or does not match. The processing system generates edits if the claim cannot be processed automatically as it was entered. When you are submitting an XPressClaim online, you may receive edits that you can correct or resolve immediately. If you need to research information, you may choose to save the claim and come back to it later. Once you've resolved the edits, you will be able to submit the claim.

Completed claim

The claim has been accepted and processed. Some lines on a claim may be rejected for coverage while other lines are accepted and paid. Payment may or may not be paid on an accepted claim.

In-process claim

The claim has been accepted and is being processed. Claims associates may be working the claim manually to resolve discrepancies or find missing information.

