# Direct Data Entry for Institutional Claims

Submitting a Tertiary direct data entry (DDE) institutional claim within CHAMPS

Direct Data Entry, DDE, is an online process in which data is entered into a system and written into its online files. DDE serves as an alternative method for submitting claims to Medicaid. To submit a claim via DDE providers must have access to CHAMPS. Once logged into CHAMPS follow the below directions; ****Make sure pop up blockers are turned off within the internet browser****

1. Click on the **Claims Tab**
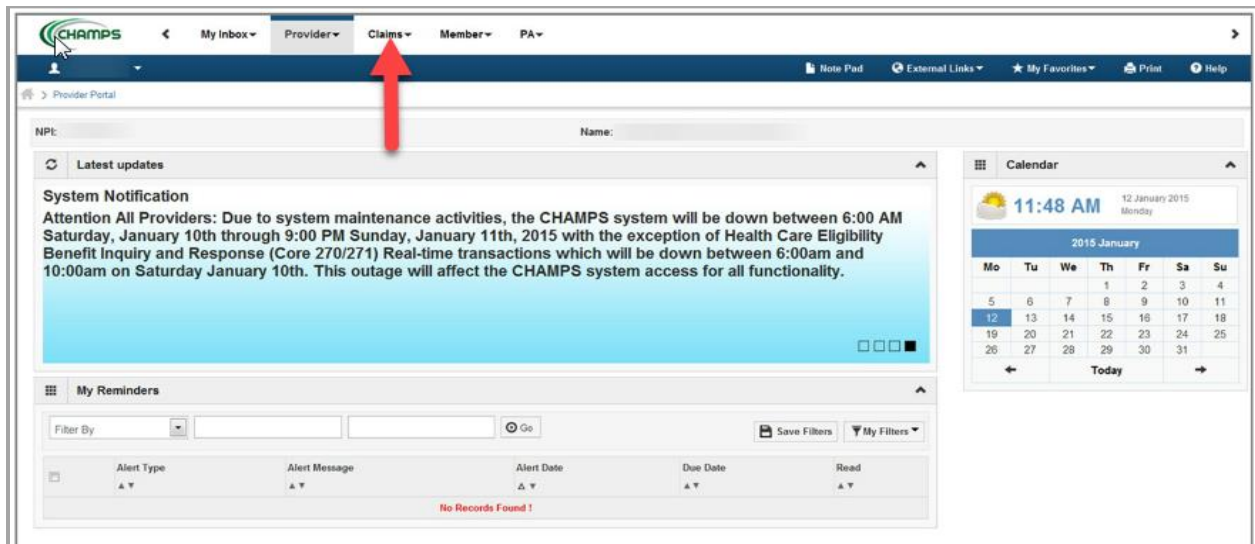
2. Select **Submit Institutional**
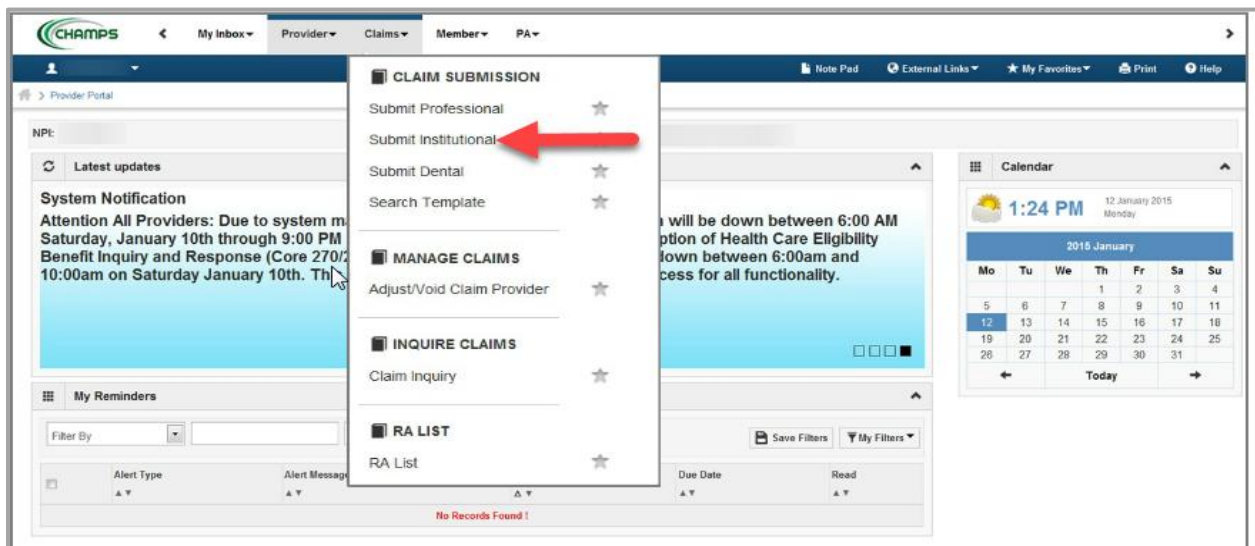
3. Go through each section below, fill in the fields and answer the questions.

> Please Note: If a beneficiary has insurance other than Medicaid it will be pertinent to have this information prior to entering a claim. Also, asterisks (*) denote required fields.

a. **Provider Information**
b. **Beneficiary Information**
c. **Claim Information**
d. **Service Line Item Information**
e. **Definitions**

PROVIDER INFORMATION

- Note:
    - o Billing Provider Information - Enter the billing NPI in the provider ID field and select NPI from the Type drop down (taxonomy is not required)
    - o Attending Provider Information - Enter the attending provider NPI in the provider ID field and select NPI from the Type drop down (taxonomy is not required)

BENEFICIARY INFORMATION

- Note:
    - o Fill in beneficiary information and then continue to Claim Information

CLAIM INFORMATION

- Note:
  - **Admission Date/Hour:** enter the admission date and hour (not an asterisk field, however this is required for inpatient, hospice, and NF)
  - To see further explanation of a field please reference the Definitions section.

- Note:
  - Continue to look through each section to enter additional information.
  - To see further explanation of a field please reference the Definitions section.

ADDING OTHER INSURANCE - HEADER

Providers need to click on the **Red Plus** sign next to the Other Insurance Information

 within the Claim Information section of the DDE Institutional claim form.

Once the **Red Plus** has been selected, a section will open allowing the provider to input payer information. There are no asterisks for **Reason Code** and **Amount**, but that information will be required. The values reported for amount MUST total the submitted charges on the provider's claim.

In the below example, the Provider billed $100.00 to Medicare, and Medicare rejected the claim because the services were non-covered services.

If the provider needs to report more than 1 reason code, they will need to click on the **Add Another Reason Code** [Add Another Reason Code] found in the bottom right corner of the section.

In the below example, the provider is reporting more than 1 payer. $100.00 was submitted to Medicare, and then to Blue Cross Blue Shield.   To report a secondary payer, select the **Add Another Payer** [Add Another Payer] in the bottom left corner of the Other Subscriber Information section.

Once you have selected the Payer Responsibility Code as secondary, the same information will be required for the second payer just as it was required for the Primary Payer.

Here is another example, but in this instance, there are 3 insurances primary to Medicaid, with the same $100.00 charge. The charges were first submitted to Medicare, then to Blue Cross Blue Shield, and finally to United Health Care. To report the tertiary payer, you will need to select the **Add Another Payer** `Add Another Payer` in the bottom left corner of the Other Subscriber Information section at the top (NOT in the 2. Other Subscriber Information, you can only DELETE PAYER):

Just like when reporting a single payer, each payer MUST total the submitted charges.

- Note:
  - o To see further explanation of a field please reference the Definitions section.

- Note:
  - o Be sure to enter in the Prior Authorization number if one is required for the claim.
  - o To see further explanation of a field please reference the Definitions section.

- Note:
  o Continue to look through each section to enter additional information.
  o To see further explanation of a field please reference the Definitions section.

SERVICE LINE ITEM INFORMATION

- Note:
  o Once all the information is entered for the service line. Click **+Add Service Line Item**. The service line has now been added to the claim (Figure 1). The Service Line Item Information fields will become blank to enter additional service line information.
  o To see further explanation of a field please reference the Definitions section.

Figure 1: Line number 1 information

1. If the Beneficiary does not have insurance other than Medicaid click, **Submit Claim (Figure 2)**

Figure 2: Submit Claim

2. Once the claim has been submitted a pop-up will show claim details. From here Providers have the option to upload documents, print, or close to continue.

DEFINITIONS

<div align="center">**In order of direct data entry****</div>

Claim Information:

a. **Patient Control No:** This number is the provider's account number for the beneficiary
b. **Medical Record No:** The medical record for the beneficiary (not required)
c. **Type of Bill:** Enter 4 digits with leading zero this identifies the specific type of bill.
d. **Statement Dates:** Enter the from and To Dates for the claim
e. **Admission Date/Hour:** enter the admission date and hour (not an asterisk field, however this is required for inpatient, hospice, and NF)
f. **Admission Type:** Enter one of the following primary reason for admission codes: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information Not Available (Only required for Inpatient Claims)
g. **Admission Source:** Enter one of the following admission sources: 1= Non-health care facility point of origin 2= Clinic 3= HMO referral 4= Transfer From Hospital 5= Transfer from SNF 6= Transfer from some other health care facility 7= Emergency Room 8= Court/Law 9= No information available B= Transfer from Home Health Agency C= Readmission to a Home Health Agency D= Transfer within same Hospital E= Transfer from ASC F= Transfer from Hospice
   a. In the Case of a **Newborn** 1= Normal Delivery 2= Premature Delivery 3= Sick Baby 4= Extramural Birth 5 = Born inside this hospital 6 = Born outside of this hospital
h. **Discharge Hour:** Enter the discharge hour (not required)
i. **Patient Status:** This is the patient's status prior to discharge
j. **Principal Diagnosis Code:** This is the diagnosis code that describes the nature of the illness or injury
k. **POA:** Present on Admission Indicator- Select Yes or No
l. **Auto Accident State/Providence:** If claim is related to an auto accident select the State in which the auto accident occurred
m. **Diagnosis Code Category:** Select ICD-9-CM or ICD-10-CM
n. **Condition information:** this identifies conditions or events related to the bill that may affect the processing of it
o. **Occurrence information:** this identifies a significant event that may affect payer processing
p. **Occurrence span information:** this identifies a significant event that may affect payer processing
q. **Value information:** this field contains the codes and related dollar amounts to identify the monetary data for processing claims (example-patient pay amount)
r. **Delay reason:** select the delay reason code from the drop-down menu
s. **Other insurance information:** if the beneficiary has other insurance click the + sign and enter at least everything with the asterisks (*). If no other insurance do not click + sign
t. **Other subscriber information**
   a. **Payer responsibility code:** use the drop-down menu to select p-primary, s-secondary or t-tertiary
   b. **Remittance date:** enter the date the commercial insurance processed the claim (not required)
   c. **Payer id number:** this is the number that corresponds to the payer id # listed in champs under the beneficiary's commercial insurance (eight digit # and this has to match what is listed in champs).
   d. **Subscriber member id:** the id # for the subscriber of the commercial insurance (not required)
   e. **Subscriber last name:** the last name of the subscriber of the commercial insurance (not required)
   f. **First name:** the first name of the subscriber of the commercial insurance (not required)
   g. **Insured's group or policy number:** the group or policy number for the commercial insurance (see what listed in champs, no alpha prefix)

  h. **Beneficiary's relationship:** select the relationship from the drop-down menu (not required)

  i. **Claim filing indicator:** use the drop-down menu to indicate the type of primary insurance

  j. **Total cob payer paid amount:** enter the total amount the primary insurance paid on the entire claim.

  k. **Reason code:** enter the reason code- this is the reason code submitted by the commercial payer

    a. **Amount $:** enter the dollar amount that corresponds with this reason code

    b. **Adjustment quantity:** this is mutually exclusive to the amount, so only the amount or adjustment quantity should be entered

  l. **Reason code:** if the line has more than 1 reason code enter it here.

    a. **Amount $:** enter the dollar amount that corresponds with this reason code

    b. **Adjustment quantity:** this is mutually exclusive to the amount, so only the amount or adjustment quantity should be entered

    c. **Add another reason code:** if the line has more than 2 reason codes click here and enter the information

    d. **Add another payer:** if this claim has more than one insurance then click here and it will open up an exact field as the first insurance that was entered; fill it in the same way except select secondary or tertiary as the payer responsibility code.

m. **Prior authorization/pro/referral number**

  a. Prior authorization number: if the code requires a prior authorization enter this pa number here

  b. MDHHS PA: select yes or no

  c. Pro number: for all elective admissions, an MPRO admission number is required, enter this number here

  d. Referral number: if this admission is a result of a referral enter the referral number here

n. **Diagnosis information:** (do not use decimals or spaces)

  a. **Admitting diagnosis:** the diagnosis code that describes the beneficiary's condition at the time of admission

  b. **PPS/DRG:** not a required field

  c. **Reason for visit:** the diagnosis code that describes the beneficiary's reason for visit

  d. **E-code:** external cause of inquiry code

  e. **POA:** present on admission- this indicator applies to diagnosis codes for inpatient claims (it is not required for e-codes or for admission diagnosis) select yes or no

    a. **Add another:** click add another if another e-code is needed

  f. **Other diagnosis information**

    a. **Other diagnosis:** enter other diagnosis information here

    b. **POA:** if billing an inpatient claim select yes or no

    c. **Add another:** click add another is another other diagnosis code is needed

o. **Procedure information**

  a. **Principal procedure code:** used for surgical codes

  b. **Procedure date:** enter the procedure date

  c. **Other procedure information**

    a. **Other procedure code:** if another surgical code is required enter

    b. **Procedure date:** enter procedure date

p. **Operating physician information:** if an operating provider needs to be listed on the claim click + sign

  a. **Provider ID:** enter NPI operating provider NPI

  b. **Type:** select NPI from the drop-down menu

DDE for Institutional Claims: Submitting a Tertiary claim – 11/16/20

www.Michigan.gov/MedicaidProviders   Page **10** of **11**

q. **Other operating physician information:** if another operating provider needs to be listed on the claim click + sign
   a. **Provider ID:** enter other operating physician's NPI
   b. **Type:** select NPI from the drop down menu
r. **Rendering physician information:** if a rendering NPI needs to be listed on the claim click + sign
   a. **Provider id:** enter the rendering provider's NPI
   b. **Type:** select NPI from the drop-down menu
s. **Referring Physician Information:** if a referring provider needs to be listed on the claim click + sign
   a. **Provider id:** enter the referring provider's NPI
   b. **Type:** select NPI from the drop-down menu
t. **Claim Note:** if a claim note needs to be entered click the + sign

Service Line Information

a. **Revenue Code:** Enter 4-digit revenue code
b. **HCPCS Code:** This is used to report the HCPCS codes for ancillary services
c. **Modifiers:** Enter modifier if the procedure code requires one
d. **Service Date:** Enter service start date for this line item
e. **HCPCS Description:** Description of HCPCS code (not required)
f. **Last Date of Service:** Enter last date of service for this line item
g. **Service Units:** Enter units of service for this line item
h. **Total Line Charges:** Enter total charges for this line item
i. **Non-covered Line Charges:** Enter total line amount charges for non-covered items (not required)
j. **Operating Physician ID: (If different from header)** enter NPI   **Type:** Select NPI
k. **Other Operating Physician ID: (If different from header)** enter NPI   **Type:** Select NPI
l. **Rendering Physician: (If different from header)** enter NPI   **Type:** Select NPI
m. **Referring Physician ID: (If different from header)** enter NPI   **Type:** Select NPI
n. **National Drug Code:** If procedure code requires an NDC enter number here (not required)
o. **Quantity:** Enter the quantity
p. **Unit:** Select unit from drop-down menu
q. **Qualifier:** Select Qualifier from drop-down menu
r. **Prescription/Link No:** Enter Prescription link #