



Integra Partners



Frequently Asked Questions



April 2022

Table of Contents

I. General Inquiries	3
1.1 How do I locate contact information to get help?	3
1.2 Where should I mail paper claims?.....	3
1.3 Where can I find timely filing information?	3
II. Accessing Que.....	3
1.4 What do I do if I've forgotten my Que username?	3
1.5 What do I do if I've forgotten my Que password?	3
1.6 I do not have a Que account, what do I do?	4
1.7 How do I determine who my organization's Que administrator is?	4
1.8 How do I change a user's access level in Que?.....	4
1.9 What are the differences in user access levels in Que?.....	4
1.10 How do I add another user to Que?	5
1.11 How do I add a user to an office?	5
1.12 What do I do if I've lost access to the Que portal?	6
III. Functions in Que.....	6
1.13 How do I search for a claim?	6
1.14 How do I enter a new claim?.....	7
1.15 What is the difference between "Quick-save", "Validate", and "Validate and Submit"?.....	8
1.16 What do I do if a claim does not pass validation/cannot be submitted?	8
1.17 How do I enter a new patient?	6
1.18 How do I add a referring physician?	9
1.19 How do I bill a secondary insurance plan?	9
1.20 What does the "Copy Claim" button do?	11
1.21 What is the Needs Attention Queue (NAQ)?.....	12
1.22 Why was my claim rejected?	13
IV. Claim Pricing	13
1.23 What do I do if a claim populates with a \$0 charge?	13
1.24 What do I do if a HCPCS does not populate?	14
V. Adding Documentation	14
1.25 How do I attach documentation to a claim?.....	14
1.26 Which codes/types of claims require attachments?	15
VI. Corrections and Appeals.....	16
1.27 How do I submit a corrected claim?	16
1.28 How do I request an appeal?	16
VII. Resources on Que.....	16
1.29 How do I locate 4-digit Payer IDs on Que for EDI setup?.....	16
1.30 How do I review EDI claim status in Que?	17
1.31 Are there reporting features available on Que?.....	17
1.32 How do I obtain my Explanation of Payments (EOPs)?	18
1.33 How do I obtain my Explanation of Benefits (EOBs)?	18
1.34 How do I locate "Forms and Training" resources?	18

I. GENERAL INQUIRIES

1.1 How do I locate contact information to get help?

- **Claims Inquiries:** <https://accessintegra.com/crmform/>
 - Claim status, questions about payments, denials, and/or adjustments, etc.
 - Please note that claim status is available in *Que* after the typical 45-day processing time we see for most Payers. For additional claim status questions or claim denial clarification, you may reach out to the Claims Team for information.
- **Electronic Data Interchange:** edihelp@accessintegra.com
 - If you would like to connect your Practice Management System (PMS) / Clearinghouse to *Que* and submit claims via EDI, please fill out the **EDI Enrollment Form** prior to contacting out EDI team.
 - Please note that our EDI team is unable to assist with any specific claim inquiries.

1.2 Where should I mail paper claims?

- Providers should not mail paper claims to Integra Partners or to the Payer.
- **All claims must be entered in *Que* only.** Integra's Claims Team has dedicated representatives who monitor for claims awaiting Secondary submission and for claims requiring manual pricing (cost invoice/MSRP).
- These claims will be printed from *Que* by Integra. We will mail these claims directly to the Payer on the Provider's behalf.
- *Failure to submit any claim through *Que* may result in improperly remitted payment.*

1.3 Where can I find timely filing information?

- Providers can find each Payer's timely filing information in the Provider Manual located in *Que* Forms and Training.
- See question 1.34, "**How do I locate 'Forms and Training' resources?**" for more information.

II. ACCESSING QUE

1.4 What if I've forgotten my *Que* username?

- If you've already been given a User ID, you can have a reminder emailed to you by hitting the "Forgot Username" button on the login page and your username will be sent to the email address on file for your account.

1.5 What do I do if I've forgotten my *Que* password?

- If you have forgotten your password, you can have a temporary one emailed to you by hitting the “Forgot Password” button on the login screen. Your password will be sent to the email address on file for your account.

1.6 I do not have a *Que* account, what do I do?

- All *Que* users must be listed on your organization’s staff roster in DORI^(R), Integra’s proprietary credentialing platform. If the employee is not yet on the staff roster, please add the employee to the staff roster prior to following the instructions below.
 - If you have questions about Dori or how to add a user to the staff roster, please review the DORI Training Manual available on *Que* Forms & Training.
 - Please see question 1.34, “*How do I locate ‘Forms and Training’ resources?*” for more information on how to find Provider Resources.
- If you are a new employee who has been credentialed but has not yet been given access to the system, talk to your organization’s *Que* Administrator.
- A Provider’s *Que* Administrator has the ability to create new users for their organization in *Que*.
 - It is the Provider’s responsibility to create and update new *Que* users for their organization.

1.7 How do I determine who my organization’s *Que* administrator is?

- Your organization's *Que* administrator can be identified via DORI. If you are not aware of who in your organization has access to DORI, please contact credentialing@accessintegra.com. If you have access to DORI, please log into your account.
- Navigate to your organization's Staff List.
- In the “Staff Roles” column, one or more individuals will have the role “Billing System Admin”.
 - A user labelled as “Billing System Admin” is your organization’s *Que* administrator.
 - A Provider’s *Que* Administrator has the ability to create new users and modify existing users for their organization in *Que*.
- If the individual labelled as “Billing System Admin” is not aware of their login credentials, please follow the steps for a forgotten password.

1.8 What are the differences in user access levels in *Que*?

- *Provider Admins* have access to all functions and all screens in the system, including payments.
- *Office Admins* have access to all functions and all screens for an assigned office, except for payments.
- *Provider Staff* have access to all billing functions, but they don’t have access to payment or user administration.

1.9 How do I change a user’s access level in *Que*?

- Please note that this function is only available for Provider Administrators—this is indicated by a staff role of, “Billing System Admin” in the DORI portal.
- To change an existing user’s access level in *Que*, follow the instructions below:
 - Click the “Users” tab
 - Search for employee by entering their Name, Email, and/or Role.
 - To view the user details, click the user’s name
 - Click “Edit” next to User Details.
 - If you want to change a user’s access, select a new role from the drop-down menu.
 - Click “Save” to save any edits.

1.10 How do I add another user to *Que*?

- All *Que* users must be listed on your organization’s staff roster in DORI. If the employee is not yet on the staff roster, please add the employee to the staff roster prior to following the instructions below.
 - If you have questions about DORI or how to add a user to the staff roster, please review the DORI Training Manual available on *Que* Forms & Training. Allow at least 24 hours for all staff roster changes to process.
 - Please see question 1.34, *“How do I locate ‘Forms and Training’ resources?”* for more information on how to find Provider Resources.
 - Please note that this function is only available for Provider Administrators—this is indicated by a staff role of, “Billing System Admin” in the DORI portal.
- To add a new user in *Que*, please follow the instructions below:
 - Click on the “Users” tab.
 - Click “New”
 - Fill in all required fields marked with the asterisk (*) including user’s name, account credentials and email address.
 - Assign the user to a role.
 - Mark the user as “Active”.
 - Add the user to an office
 - Save user.

1.11 How do I add a user to an office?

- If the user hasn’t been created in the system yet, please see question 1.10, *“How do I add another user to Que?”*
 - Please note that this function is only available for Provider Administrators—this is indicated by a staff role of, “Billing System Admin” in the DORI portal.
- If the user already exists, follow the steps below.
 - Click the “Users” tab.
 - In the fields at the top of the page, type in the user’s name. You can search by the user’s first name, last name, or both.
 - Alternatively, you can search by typing the user’s email or by selecting the user’s role from the drop-down menu.
 - Click “Search” or press Enter on your keyboard. The user search results will appear below.

- Please note that you can click a user's email to send that person an email through Outlook.
- To view the user details, click the user's name.
- Select "Add Assigned Office" under the Assigned Offices section.
- Select the Office name from the drop-down menu.
- If you want to delete an office, check the box under the "X."
- Click "Save" to add the user to the office.

1.12 What if I've lost access to the *Que* portal?

- If you have lost access to the *Que* portal, immediately check your organization's DORI account. DORI is Integra Partners' proprietary credentialing platform.
- In order to remain in compliance, your organization must submit all required documentation in a timely fashion. If your organization has fallen out of compliance, your *Que* portal access may be temporarily rescinded. Submit updated documentation as soon as possible in order to regain access to *Que*.
 - If you have questions regarding credentialing or expired documentation, please contact credentialing@accessintegra.com.

III. FUNCTIONS IN *QUE*

1.13 How do I search for a claim?

- The Claims Tab displays the following types of claims:
 - New
 - Needs Attention
 - In Progress
 - Denied
 - Closed
- Hover your mouse over the "My Claims" tab and select "Claims".
 - Click on the "Advanced Toolbar" on the left side of the screen.
 - You can search by claim number, patient name, date of birth, etc.
 - Click "search".

1.14 How do I enter a new patient?

- Hover your mouse over the "My Patients" tab and select "Patients"
- To prevent duplicate records, before creating a new patient record in *Que*, please confirm that the patient isn't already in the system by doing a quick search.
 - To search for an existing patient, first enter the patient's name and/or policy number.
 - Click the green "Search" button.
- If the search determines that the patient is not already in the system, enter a new patient by completing the following instructions.
 - Select the "New" button at the middle of the page.
 - In "Patient Primary Info" enter the following information:

- Payer
- Policy number
- First name
- Last name
- Date of birth
- Gender
- Click “Next” to populate the “New Patient” page.
 - Fill out all required fields marked with an asterisk (*), including the member’s phone number.
 - When entering the address, you must select “Default” in the first column next to “Type”.
 - Payer name can be selected from the dropdown menu.
 - The Provider must add the policy number and select relationship to the insured.
 - Please note that if relationship to the insured is a selection other than “self”, the Provider will need to fill out the Primary Subscriber information.
 - Please note that the “Effective Date” of the coverage, must be before the Date of Service specified on the claim.
- Click “Save” to make sure all the information is successfully captured.
- You may also select “Verify Eligibility” to verify the patient’s eligibility with the Payer.
 - Please note that this feature is not currently available for all Payers.

1.15 How do I enter a new claim?

- Hover your mouse over the “My Claims” tab and select “Claims”.
- Click the “New” button on the top right corner of the screen.
 - Begin by entering the patient’s name.
 - If there are multiple patients with the same name, use date of birth and Payer to identify the correct patient.
 - *Que* will automatically populate the “Policy” field with the patient’s primary insurance.
 - This is a dropdown menu. If you need to bill the secondary insurance, you can manually adjust the insurance to the secondary payer.
 - Enter the authorization number.
 - Enter the patient’s diagnosis code.
 - If the patient has multiple diagnosis codes, boxes “A” through “L” are available for entry.
 - The primary diagnosis code must be in box “A”.
 - Scroll down to “Line Items” and enter information for all fields, including:
 - Date of Service

- HCPCS
- Modifier(s)
- ICD-10
 - Select “A” if you entered the ICD-10 code in primary position “A” above. Select “A” “B” if you entered the ICD-10 codes in positions “A” and “B” above. Etc.
- Units
 - The charge amount will automatically populate to the contractual rate with the Payer.
 - If \$0 charge populates, there is no contractual rate available. The Provider must attach a cost invoice and the claim will be subject to Integra manual review. Please see question 1.23, “What do I do if a claim populates with a \$0 charge?” for more information.
 - Attach any required documentation,
 - Please see question 1.25, “How do I attach documentation to a claim?” for more information on adding documentation.
- When you are finished filling out the claim, select “Validate”.
- If the claim passes validation select “Validate and Submit”.
 - A claim will not be sent to the Payer until you click “Validate and Submit”.
 - The “Validate and Submit” button should be used for all claims, including \$0 charge claims.

1.16 What is the difference between “Quick-save”, “Validate”, and “Validate and Submit”?

- *“Quick-save”* saves the fields you have entered on a claim so you can easily come back to it later. Quick saving a claim does not send the claim to the Health Plan.
- *“Validate”* is a quick scan to ensure that the claim meets the basic requirements for successful claim submission. Validating a claim does not send the claim to the Health Plan.
- *“Validate and submit”* sends the claim to the Health Plan to review.

1.17 What if a claim does not pass validation/cannot be submitted?

- If a claim does not pass validation that means it does not meet the Health Plan’s preset rules built into the system.
- To determine why a claim has not passed validation, scroll down on your screen to the section titled “Validation History”.
 - Click on “Details” to see why the claim did not pass validation.
 - To return to the claim, click on the number next to “Claim”
 - After making the specified changes to meet the claim rules, click “Validate” to run the claim by the claim rules again.

- Once the claim has passed validation it is ready to be sent.
- A claim will not be sent to the Payer until you click “Validate and Submit”.

1.18 How do I add a referring physician?

- Hover your mouse over the “My Patients” tab and select “Referring Physicians”
- Prior to creating a new referring physician, you should utilize the search feature to determine if they are already in the system.
 - To search for a physician, click the “Advanced Tools” tab on the left side of the screen.
 - Enter the physician’s NPI and click “Search”.
 - The screen will then populate with either the physician’s information or a message stating, “No referring physicians found”.
- If there are no referring physicians found, please follow the steps below to add them to the system.
 - Select the “New” button at the top right corner of the screen.
 - Fields with asterisks (*) are required.
 - This includes:
 - First name
 - Last name
 - NPI
 - Address
 - Select the first checkbox under “Default” when entering a physician’s address.
 - You must enter an NPI.
 - You can verify the referring physician’s information by clicking the “Registry” button next to the “NPI” field.
 - This will navigate you to the CMS website where you can enter the referring physician’s NPI and click “Search”.
 - This will populate a complete view of the referring physician’s information.
 - After confirming that the referring physician’s information is correct, click “Save”.
 - After saving *the* entry, an ID number will populate at the top left side of the screen. This Que ID number confirms that the referring physician has been successfully added to *Que*.

1.19 How do I bill a secondary insurance plan?

- A secondary or tertiary insurance ranking is typically used when billing for additional coinsurance, copayment, deductible payments. A Primary EOB attachment will be required to submit these claims.

- **To bill a patient's secondary insurance plan, you must submit the claim manually via *Que*.**
 - This includes Providers that typically submit claims via Electronic Data Interchange (EDI).
- **The secondary claim will be sent to Integra Partners' Claims Team, who will print and mail the claim with the attached primary EOB on your behalf.**
- **First, you must verify that the patient's secondary insurance is listed in the claim.**
 - Hover your mouse over the "My Patients" tab and select "Patients".
 - Search for the patient and select the patient by clicking on their name.
 - Once you have selected the patient, click "Edit" at the top of the screen next to "Patient Details".
 - Scroll down to the section labelled "Insurance".
 - Select "Add Insurance"
 - In the dropdown menus, select Secondary Insurance, Payer, Policy Number, Relationship to Insured, and the Effective Date.
 - Scroll down to the bottom of the page and click "Save".
- **To create a claim for this patient, click "Add Claim".**
 - The patient's name will automatically populate.
 - The "Policy" field will automatically default to the primary insurance.
 - You must manually change the insurance to the secondary payer.
 - Enter the patient's diagnosis code(s).
 - Scroll down to "Line Items" and enter the information for items you are billing to the secondary insurance. The information must match exactly to that which is specified on the primary EOB. Fields include:
 - Date of Service
 - HCPCS
 - Modifier(s)
 - ICD-10
 - Select "A" if you entered the ICD-10 code in primary position "A" above. Select "A" "B" if you entered the ICD-10 codes in positions "A" and "B" above. Etc.
 - Units
 - Scroll down to "Attached Files" and click "Add Attached File".
 - Select "Primary EOB" as the file type.
 - Click "Select File".
 - This will allow you to upload the appropriate documentation from your desktop.
 - Next, select "Validate" or "Validate and Submit" and a red banner will appear with the message, "The billing of secondary claims should have updated Primary EOB information to proceed. [Click here to proceed](#)".
 - To proceed, click the underlined link in the red banner.
 - A popup screen will appear with the options, "Yes" and "No".
 - Select "No" if a Primary EOB is not required.

- If selecting “No”, please enter a note detailing why an EOB is not required and click “Save”.
- Then, select “Validate and Submit” to complete the claims submission process.
- Select “Yes” and “Continue: if a Primary EOB is required.”
 - *Please note that Providers must adhere to CMS guidelines in determining which codes require a Primary EOB.*
- After selecting “Yes” and “Continue”, a screen will appear in which the Provider must complete all fields marked with an asterisk (*).
 - *Please note, only Primary Claim information should be entered here. Failure to enter complete and accurate charges may result in improperly remitted payment.*
- Providers may note an additional field under each line item. Any additional claim adjustments that do not fall under deductible, coinsurance, co-pay, etc. should be entered in this field.
- After entering all required information, select “Save” to navigate back to the Saved Secondary Claims Details Page.
 - A Primary EOB button will appear at the top of the screen. If a Provider wishes to review or make changes to the primary charges that were previously entered, click this button to navigate back to the Primary EOB Update page.
- When ready to submit claim to the Plan, select “Validate and Submit” to complete the secondary claims submission process.
 - After selecting “Validate and Submit” the claim will be printed by Integra and mailed to the Plan.
 - After submitting the claim, a Provider may click the Primary EOB button at the top of the page to review the Primary EOB Update page, however, Providers are unable to make changes to the Primary EOB at this stage.

1.20 What does the “Copy Claim” button do?

- Located at the top of the claim page, there is a green button titled, “Copy Claim”. When a Provider clicks this button, *Que* will create a near-identical copy of the claim.
- The information copied onto the new claim includes:
 - All patient information
 - All provider information
 - Diagnosis codes (ICD-10)
 - HCPCS
 - Units
- The information that is not copied onto the new claim is the Date of Service (DOS).

- You may consider using the “Copy Claim” feature when billing monthly rentals or for recurring orders (such as incontinence supplies). Rather than creating each new claim from scratch, you will save time by leveraging this feature.

1.21 What is the Needs Attention Queue (NAQ)?

- **Que** allows you to communicate with Payers and Integra Partners using the Needs Attention Queue (NAQ).
 - The NAQ lists claims that have been reviewed by Integra Partners and require your immediate action in order to submit the claim to the Payer.
- The NAQ is featured on the top right section of the *Que* homepage.
- Claims in the NAQ are sorted into buckets:
 - **Rejections**
 - “Rejected” claims are claims that have not been processed because they have been rejected by the Payer.
 - i.e., They may have been rejected due to member eligibility or missing referring physician information.
 - **More Information Needed**
 - Claims that need additional information in order for Integra Partners to process them.
 - i.e., Missing medical records, a cost invoice for pricing, or an invalid DX code.
 - **Eligibility**
 - Claims that have been denied due to an eligibility issue.
 - i.e., The member is not covered under the Plan, or no member was found with that name, DOB, or member ID combination.
 - **Needs Authorization Data**
 - Claims that were denied due to authorization-related issues.
 - i.e., Missing authorization or invalid authorization for that DOS.
 - **Timely Filing**
 - Claims that are approaching timely filing with the Payer and require your immediate attention.
 - It is important to regularly review the claims in your NAQ so that claims are processed within timely filing limitations.
- To view all claims in the NAQ, select “View All Claims That Need Attention”.
- To view claims within a specific bucket, select the arrow next to the bucket.
- To review a specific claim, select the “Details” button on the claim you wish to review.
 - Scroll to the bottom of the page to view Integra’s note regarding this claim.
 - To reply to Integra, scroll to the top of the page and select “Edit” next to “Sent Claim Details”.

- Scroll back to the bottom and select “Add Note”.
 - Write a message with any information that you want to share with Integra.
 - Click “Save”.
- At the top of the page, select “Send to Integra” button.

1.22 Why was my claim rejected?

- Rejected claims occur when one or more errors are found on a claim prior to being processed and accepted by the Payer.
 - *Que* allows you to review and make updates to these claims directly in the system.
 - Common rejection reasons include:
 - Patient information entered does not match the Payer’s records.
 - Referring physician’s NPI is missing.
- To view your rejected claims, select the “Rejections” bucket in the Needs Attention Queue (NAQ) on the homepage.
 - Select “Details” on the rejected claims that you want to review.
 - Select “Edit” at the top of the “Claim Details” page.
 - At the top of this page, a purple banner will present the rejection reason.
 - You can also scroll down to the “Notes” section at the bottom of the page to see the rejection reason.
 - Using the rejection reason, you will be able to identify what needs to be changed.
 - After making the necessary changes, click “Validate and Submit”.
 - When prompted, enter a note specifying the updates that were made.
 - This claim will be transmitted to the Payer electronically within one hour.

IV. CLAIM PRICING

1.23 What if a claim populates with a \$0 charge?

- While submitting claims for certain HCPCS codes, the charge will populate in *Que* as \$0. These codes require manual pricing by Integra’s Claims Team.
 - Include the item description/brand serviced in the “Remarks” field on the claim item level.
 - Attach the cost invoice or MSRP invoice to the claim.
 - Providers still need to click “Validate and Submit” when entering claims that require manual pricing.
- After the claim is submitted, Integra’s Claims Team will review the claim and price according to the contractual Fee Schedule.

- Providers should review the contractual Fee Schedule for rates and miscellaneous code logic.
- This will also enable the Provider to identify what type of cost invoice is required for processing.
- Providers should review the Needs Attention Queue (NAQ) regularly, as additional information may be required on certain claims.

1.24 What if a HCPCS does not populate?

- If a HCPCS does not populate, you should first check the following fields:
 - Patient information.
 - Check for accuracy of patient name, gender, and date of birth.
 - Date of Service.
 - Check that the policy was not terminated prior to date of service.
 - Health Plan.
 - Check that the correct Health Plan/Line of Business has been selected.
- If the fields above are accurate and complete, then the HCPCS may not be populating because it is not a covered service under the Health Plan selected.
- In the event that a HCPCS does not populate in the system, please complete the following steps:
 - *Please note that there must be an authorization for the non-contractual code.*
 - Delete the line item by clicking the white box to the right of the claim.
 - Scroll to the bottom of the page and click “Validate” (note—do not click “Validate and Submit”).
 - After validating the claim, you can click “Add a Note” at the bottom of the page.
 - Enter a note including the following information:
 - HCPCS
 - Modifier
 - Units
 - Diagnosis code(s)
 - Date of Service
- After submitting the note, submit a Claims inquiry via <https://accessintegra.com/crmform/> and a representative from the Claims Team will assist.

V. ADDING DOCUMENTATION

1.25 How do I attach documentation to a claim?

- If a claim requires documentation, you can add it in the “Attached Files” section.

- **First, click “Add Attached File”**
 - **You can select the file type from the dropdown menu. Please note, that it is important to select the correct file type or else the claim may not pass validation.**
- **Next, click “Select File” to attach the document to the claim.**
- **You can delete an attachment by clicking the small “x” next to the file name.**
- **You can also delete an attachment by clicking the white box to the right of the attachment.**
- **If you need to add additional documentation, you can do so by selecting “Add Attached File” and following the steps above.**

1.26 Which codes/types of claims require attachments?

- **The information below is intended to provide an overview of the most common situations in which attachments may be required to pass validation rules in *Que*. Providers are reminded to consult the Plan provider manuals for specific Plan information. Similarly, Medicare and Medicaid guidelines should always be reviewed when billing for covered services.**
- **These are the three most common situations in which attachments will be required:**
 - **Cost Invoice/MSRP Invoice.**
 - **This is required for any miscellaneous/NOC codes, as well as codes not listed on the Payer’s fee schedule.**
 - **Miscellaneous codes can be identified through the description of the code.**
 - **For all other codes, you must review the fee schedule to see if it has a corresponding fee.**
 - **You can also determine whether a code doesn’t have a rate on the fee schedule by entering it into *Que*. If the code does not populate with a price, then it does not have a rate on the selected fee schedule.**
 - **Primary Explanation of Benefits (EOB).**
 - **If you are submitting a claim to a secondary insurance, the EOB from the primary insurance is required.**
 - **The secondary claim must match exactly to the primary EOB (HCPCS, date of service, charge amount, etc.).**
 - **If you fail to attach the primary EOB, the secondary insurance will deny the claim.**
 - **Medical Records.**
 - **Certain codes for specific Payers require attached medical records.**
 - **When you validate a claim in *Que*, it will alert you if the code requires medical records. In this case, the claim will not pass validation until you attach the required documentation.**

- Review the validation message for more information on each claim.
 - Please refer to question 1.17, *“What do I do if a claim does not pass validation/cannot be submitted?”* for more information.

VI. CORRECTIONS AND APPEALS

1.27 How do I submit a corrected claim?

- When you submit a new claim, the claim is held on standby for one hour. During this one-hour window, you may make any necessary changes to the claim by selecting the “Modify Claim” button. After one hour the window elapses and “Modify Claim” button will no longer be accessible.
- If the claim has been submitted and has passed the one-hour window, please allow 45 days for the claim to process before submitting a request for a corrected claim.
- Integra will submit the corrected claim on the Provider’s behalf.
 - Please note that Providers *should not* submit their own corrected claims—they will deny for duplicate billing.
- To submit a request for a corrected claim, please submit a request via <https://accessintegra.com/crmform/>.

1.28 How do I request an appeal?

- Integra’s Claims Team submits appeals on Providers’ behalf as part of the working denial process. Claims will be worked within timely filing limits established by the Payer.
- Providers do not need to notify the Claims Team when an appeal is needed—doing so may lead to longer response times and delays.
- Providers wishing to inquire about the status of a claim may do so by submitting an inquiry via <https://accessintegra.com/crmform/>.
 - Providers *should not* contact any Payer directly for claim clarification, escalation, or appeal. Integra Partners will work these matters on our Providers’ behalf. Providers may respond to specific record or recoupment requests, but we ask that you share information about these issues with Integra by emailing medicalrecords@accessintegra.com.

VII. RESOURCES IN QUE

1.29 How do I locate 4-digit Payer IDs in Que for EDI setup?

- In *Que*, you are able to automatically generate a report of all Integra Payer IDs. First, log in to *Que*, navigate to the 'My Reports' tab, and select 'Integra Payor Report". Here you will see a list of all Payer IDs.
- You also have the option to export the report to Excel by clicking the "x" in the top right corner.

1.30 How do I review EDI claim status in *Que*?

- The "My EDI" tab is an informational tool that allows you to see EDI claims.
- Click on the "My EDI" tab to view:
 - Rejected claims
 - These claims have been rejected by *Que*—this does not include rejections from our Clearinghouse or your Clearinghouse.
 - These claims are rejected by the *Que* system and are sent in a 277CA response report.
 - Please note that Providers hooked up to EDI are encouraged to review their ACK 999s if submitted files were accepted or rejected.
 - If a claim submitted via EDI is not appearing in *Que*, there is a high likelihood that the initial file was rejected. You must review the ACK 999 and work with your Clearinghouse to make the necessary changes to successfully transmit the file and get the claim loaded into *Que* for processing.
 - Claims that are marked as "Needs Attention"
 - These claims have been received in *Que* but require immediate action. You will need to log in to your *Que* account and update the claims manually in order to successfully submit them.
 - Processed claims
 - These claims have been accepted and processed.
- "My EDI" automatically defaults to a view of rejected claims only.
- Using the Advanced Toolbar on the lefthand side of the screen, the Provider can use filters to get desired data. Filters options include transaction dates, archived status, NPIs, etc.
- It is important to note that "My EDI" is an informational tool only; Providers cannot resubmit claims via "My EDI" in *Que*. You must resubmit claims through your Clearinghouse.

1.31 Are there reporting features available on *Que*?

- Yes, Providers have access to multiple reporting features in *Que*.
 - To locate these reports, navigate to the 'My Reports' tab. Here you will find:
 - Patient Billing Report

- Rejection Summary Report
- Provider Office Report
- Integra Payer Report

1.32 How do I obtain my Explanation of Payments (EOPs)?

- To view EOPs for all claim payments at any time, log in to *Que*:
 - Go to the “My Fees” tab.
 - Click “Payments” from the drop-down menu.
 - Search for the payment of interest.
 - Click “Details” to view the payment information
 - To view EOP, click the link to the PDF Report under Disbursement Details.

1.33 How do I obtain my Explanation of Benefits (EOBs)?

- A Provider can obtain an EOB via *Que* by clicking the “Clearinghouse History” button located at the top of the claim page.
 - Once clicked, it opens a new page with a clickable link to the EOB.
- There are rare instances in which an EOB may not be available in the Clearinghouse History. If this is the case, please submit a Claims inquiry via <https://accessintegra.com/crmform/> to request the EOB.

1.34 How do I locate “Forms and Training” resources?

- Log in to your *Que* account.
- Access the Help Center from the *Que* Homepage by clicking the question mark icon at the top right side of the page.
- Click “Integra Partners Forms and Resources,” then “Forms and Training” twice to continue.
- Click the link at the end of the sentence: “To access documentation pertaining to the below information, please access the following link, “Click Here”
- Click on “Resources”, “Forms”, and/or “Integra Group Purchasing Organization (GPO)” to expand each section.
 - In “Resources” you will find materials including, but not limited to:
 - Integra Partners Provider Manual
 - Primary and Custom Fee Schedule Grids
 - *Que* Training Manual
 - EDI Enrollment Information
 - In “Forms” you will find materials including, but not limited to:
 - Preauthorization Forms
 - Pick Up Ticket
 - Staff Update Form

- **Change Date of Service Form**
- **In “Integra Group Purchasing Organization (GPO)” you will find materials detailing the GPO options offered through Integra Partners, including, but not limited to:**
 - **Premier GPO Information**
 - **O&P Solutions Information**
 - **CyraCom Information**