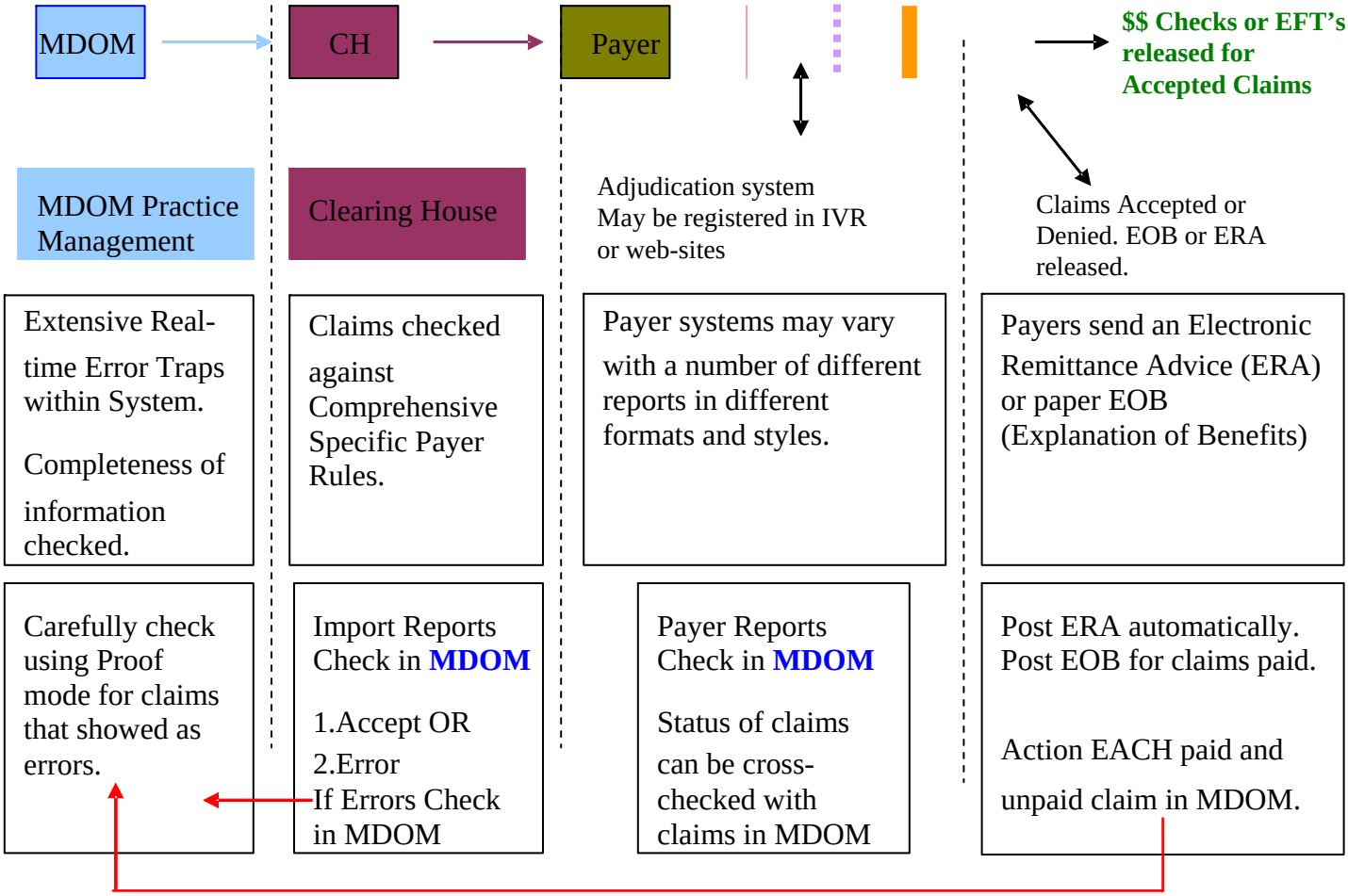
MDofficeManager.com – Section 6 – Troubleshooting E-Claims

Trouble Shooting E-Claims – Quick Reference Guide

Introduction

This short quick reference guide is to help users trouble shoot the most frequently asked questions on claims processing. In order to do that effectively you must first understand the processes the electronic claims are going through.



Key Steps

1. MDOM allows for a wide range of syntax error checking allowing a high degree of errors on claims to be captured before it leaves the system.
    a. Any errors here need to be corrected before they can leave the system.
    b. This includes items like missing information or insurance details

2. Once the claims are processed and go out of MDOM they automatically enter the Clearing House where further checks and edits on more payer specific rules takes place.
    a. These Reports will be seen in MDOM I-Hub via the Payer link response.
    b. Two main types of reports will be generated
        i. **Acceptance** reports in which case the claims will then proceed to the specific Payers automatically
        ii. **Error** Reports. There will be NO action taken on these and it is the **<u>responsibility</u>** of the Billing Service to address these by going back into MDOM.
            - Careful checking of these claims is essential and running the claims in Proof mode will help see the CMS claim form filled in.
            - Once corrected these will need to be refilled.
3. The Totals for the Accept and Error report should match the total on the Charge batch submitted.
4. Once the payer receives the electronic files, they may or may not acknowledge them. Most Payers have at least a 3 level checking system.
    a. Level 1 – This imports the claims and checks they are compliant ANSIx12 format
    b. Level 2 – This checks the key items like patient ID, name, Provider details etc to ensure they are claims related to that payer. Some may also check items like CPT code, Modifiers, Authorization codes etc.
    c. Level 3 – They pass into the adjudication system where they pass through a batch process and all items are validated against the patient, plans, providers and contracts. Only then do they determine if it is to be paid or denied.
    d. Any reports that they payer generates can be seen in MDOM I-Hub. The Billing service needs to act upon these Payer response reports.

MDOM I-Hub and Claim Responses

1. All reports are placed in MDOM I -Hub and it is the responsibility of the Billing service to check these. It is highly recommended that these be checked <u>at least once per day</u>.
2. MDOM has noted that it gets most of its responses around 4:00PM MST. This is a 24/7 processes by MDOM.
3. By jumping on the Errors or denials immediately will insure that those claims are addressed before they build up in the Accounts Receivables.

5 most common issues causing errors or denials are:

1. Incorrect or Invalid Payer ID
2. Incorrect or omitted Provider PIN
3. Invalid Insurance ID# for Payer. E.g. Payer accepts insurance ID# with 9 or 11 digits and insurance ID# on claim has 10 digits
4. Discrepancy in claim data. E.g. Patients Id is 123456789A and is entered as 132456789A (Transposed Numbers)
5. Invalid data. E.g. DOS 062608, DOB 010110, “#”, “-“, “:” and or unnecessary spaces included on addresses or Id#’s.

Paying <u>attention to detail</u> will ensure your claims are clean, reduce your work downstream and help you build a higher appreciation of services by your clients and thus allowing you to grow.