UHIN

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LIFE OF A CLAIM

CREATION, REJECTION, ELATION

WHAT IS AN ELECTRONIC CLAIM?

An Electronic Claim is an 837.

This transaction established to meet HIPAA requirements for healthcare claims

It provides the same information available on CMS form such as:

- Patient & demographic information
- Patient condition
- Treatment provided, including cost and date

ACKNOWLEDGEMENTS

After sending the electronic claim, there will be two types of acknowledgments: 999 and 277CA

Some Practice Management Systems (PMS) have a function for you to view these acknowledgement in a human readable format.

WHAT IS A 999 ACKNOWLEDGEMENT?

A 999 is an Electronic Acknowledgement of a claim or batch of claims. This is the first form of an acknowledgment if a file was received by the entity

This electronic acknowledgement will tell the following:

- What happened to the file? Was it:
  - A – Accepted
  - E – Accepted with errors
  - R – Rejected
- If there were errors, it will indicate: Where the error(s) are in the file.

High level overview of the error type:

- Required or conditionally needed information missing
- Too short/too long
- Invalid character/code value/date/time
- Too many repetitions/components
- Too few repetitions/components
- Submitted 'Not Used' Data
- Code not used in version submitted

WHAT IS A 277CA ACKNOWLEDGEMENT?

Provides claim level acknowledgement of all claims before sent to be adjudicated such as:

PATIENT A | PATIENT B | PATIENT C | PATIENT D | PATIENT E

Claims for patient A, C, D, E were accepted, and provider will receive an ERA/RA/EOB.

Patient B was rejected, and provider will need to take action (correct & resubmit).

WHAT IS A 277CA ACKNOWLEDGEMENT?

Claim Status Codes

- 20 – Accepted for processing
- 54 – Duplicate claim
- 88 – Patient not eligible
- 158 – Dependent not found (DOB)

Claim Status Category Codes

- A (acknowledge)
- E (error)
- P (pending)
- R (request for information)
- F (finalized)

Most common are :

- A2 – accepted for processing
- A3 – returned as not processed

Each Practice Management System (PMS) will show the 277CA Acknowledgement differently. Some PMS will have translate it into a human readable, others will just give you codes and some will show it in the EDI format.

837 REJECTIONS

TOP THREE ISSUES

Missing a Required Segment

- Diagnosis code(s)
- Patient address
- Service Line (claim sent with no procedure codes)

Invalid ICD -10 Code

- Typo in diagnosis code
- Too general (lacking specificity)

**UHIN doesn't utilize date of service in diagnosis checking*

Invalid ICD -9 Code

- Billing an ICD-9 code with an ICD-10 qualifier

COB CLAIM DOESN'T BALANCE

- REMEMBER:

Total Claim Charge = Payer Paid +
Adjustment Amounts (CO+PR+OA+PI)

Payer Allowed Amount = Paid + PR Amounts

- Adjustment reasons are missing or invalid
- Date Claim Paid is missing or is not in CCYYMMDD format

CONDITIONAL REQUIREMENT MISSING

- Referring provider sent without an NPI
- Contact name but no contact number
- Missing subscriber ID
- COB Adjustment Reason with no dollars:

CAS*PR*1*0~ or CAS*CO*45~

- Your software vendor may allow for these types of edits to be fixed before the claims are submitted.

837I REJECTIONS

Specific to Institutional/UB claims

TRAILING BLANK SPACES

- Example:

  N3*3879 HOGWARTS LANE ~ or N3*3879 HOGWARTS LANE~

- Your software should strip trailing spaces before generating the EDI claim. Work with your vendor to solve for this.

INVALID DATE/TIME FORMAT

- Example of correct Date/Time format:
  DTP*435*DT*201803301242~
- Example of correct date format:
  DTP*472*D8*20180331~
- Example of correct time format:
  DTP*096*TM*1130~
- Example of correct date range format:
  DTP*434*RD8*20180301-20180331~

Your software should format date/times properly on the backend. If you are using MYUHIN, it will format for you.

COMMON 999 REJECTIONS

Top 5 Issues

INVALID CODE VALUE

- Example: Lowercase letter in State abbreviation

  SBR*P*18*******12~
  NM1*IL*1*ANN*RAGGADY*D***MI*800828732~
  N3*3879 DOLL PLACE~
  N4*SALT LAKE CITY*Ut *84124~

- Example: Letter in numeric field

  N4*TORONTO*CA* M4B1B ~

- Potential Fixes:

  Ask your software vendor/clearinghouse to change field not to allow invalid (lowercase) characters force field to uppercase (front-end or back-end)

IMPLEMENTATION DEPENDENT DATA ELEMENT MISSING

- Example: Unspecific procedure code sent without a description

  SV1|HC:J3301:59|8.00|UN|4|||1~

- This means the payer requires a description for the procedure code.
  - Ask software vendor where this needs to go, usually there is an edit box where you can put the description for the claim.
  - Your software vendor may allow for these types of edits for specific payers so they are fixed before they are submitted.

Missing Claim Level Information

Example: Unspecific procedure code sent without a description

CLM*11440 -1-41089*283.00***11:B:1*Y*A*Y*Y*P~
DTP*455*D8*20220827~

One of the following dates could be missing, included, or invalid:

- Onset of current Illness
- Initial Treatment
- Disability
- Acute Manifestation
- Last Seen
- Last Worked
- Accident
- Last Menstrual Period
- Authorized to work
- Last X-ray
- Hearing or Vision Rx Date
- Admission
- Discharge
- Assumed & Relinquished Care
- Property & Casualty

Ask software vendor:

- Where this needs to go if missing
- Where it is located if it can't be found to be removed
- How it should be formatted

Your software vendor may allow for these types of edits to be payer specific so they are identified and can be fixed before they are submitted.

MISSING/INVALID CLAIM PROVIDER INFORMATION

- Example: Issues with Rendering/Referring Provider or Service Facility Location

  NM1*77*2*LUKE COMBS MD PC***XX*9998887776~**

- Referring provider is required for diagnostic and lab services.
  - For DME, this should be reported at the LINE level, not the claim level.
- Rendering provider is required when different from the name listed in the billing
- Service facility location is required when the address is different than the address in the billing loop
- Your software vendor may allow for these types of edits to be payer specific so they are identified and can be fixed before they are submitted.

BILLING PROVIDER ISSUES

- Example: Incorrectly formatted Tax ID

  REF*EI*111222333 4~ or REF*EI*11122233 ~ or REF*EI*111 A2233~

- Make sure tax ID is always 9 digits
  - For DME, this should be reported at the LINE level, not the claim level.
- Valid NPI's are a requirement for providers (algorithm can determine validity)
- Can only be an individual if an SSN is submitted instead of an EIN
- Ask software vendor to change the Tax ID field so it requires 9 numeric characters

277CA REJECTIONS

Top 5 Issues

DIAGNOSIS CODES

- Example: Diagnosis code is invalid for date of service

  HI|ABK: H5441|ABF:H5711

  (*Code termed 9/30/2017, Date of service of claim is 12/6/2017*)

- Make sure all diagnosis codes are sent (include supplemental ones)
- Make sure ICD-10 is being utilized
- Update codes with each new release (effective October each year)
- See if software vendor or clearinghouse has edits for procedure/diagnosis code sets. Good solutions will use logic based on date of service.

PATIENT IS INELIGIBLE

- Example: Patient termed before date of service

  Member ID 999999354 Effective 1/1/18 Termed 2/24/18

  (Date of Service is 3/1/18)

- **Utilize eligibility tools** – Benefits Eligibility Request/Response to determine eligibility dates
- Remember, Eligibility/Terminations can be backdated
- Ensure submitting to correct payer with correct subscriber ID (not old ID)

DUPLICATE CLAIM

- Example: The exact same claim was sent via EDI 30 days earlier

  Each payer will have different date spans for how far back they look in their system.

- Contact payer utilizing their portal or customer service hotline to check if claim was received before submitting a second time
- **Utilize electronic claims status** – Claims Status Request to see if the payer has the claim and its current status (paid, pended, not on file)
- If sending a correction, be sure to make the needed change(s) before submitting and flag it as a correction (claim frequency code 7 or 8)

CLAIM/ENCOUNTER NOT FOUND

- Example: Provider NPI or Tax ID does not match or not in payer system
- Double check the submitted NPI(s) and Tax ID for typos
- Contact payer to ensure the provider is in their adjudication system

PATIENT/SUBSCRIBER NOT FOUND

- Example: **Typo in the name** or differs from what payer has in system.
  - You can have in your system for a First name: **JACKI**
  - The Payer system has a First name: **JACQUI**
  - You can have in your system for a Last name: **CONE-CODER**
  - The Payer system has a Last name: **CONE**
    - Note: This can be especially problematic in twins and when child has the name of a parent
- Example: **Typo in the date of birth**
  - Your system can state: **3/20/1999**
  - The payer system can state: **3/2/1999**

PATIENT/SUBSCRIBER NOT FOUND (CONTINUED)

- Example: **Typo in the subscriber ID number**
  - Wrong payer subscriber ID submitted to payer (Medicaid ID sent to commercial insurer, Regence ID sent to EMI, etc.)
  - Name submitted different from what payer has (bigger issue with twins or children with same name as a parent)
- Double check the submitted NPI(s) and Tax ID for typos
- Contact payer to ensure the provider is in their adjudication system

SUMMARY

837 Rejections

- Missing a required segment
- Invalid ICD-10 code
- Invalid ICD-9 code
- COB claim does not balance
- Conditional requirement missing

837I Rejections

- Trailing blank spaces
- Invalid date/time format

999 Rejections

- Invalid code value
- Implementation dependent data element missing
- Missing claim level information
- Missing/Invalid claim provider information
- Billing provider issues

277CA Rejections

- Diagnosis code
- Patient is ineligible
- Duplicate claim
- Claim/Encounter not found
- Patient/Subscriber not found

THANK YOU
FOR LISTENING

DO YOU HAVE ANY QUESTIONS?