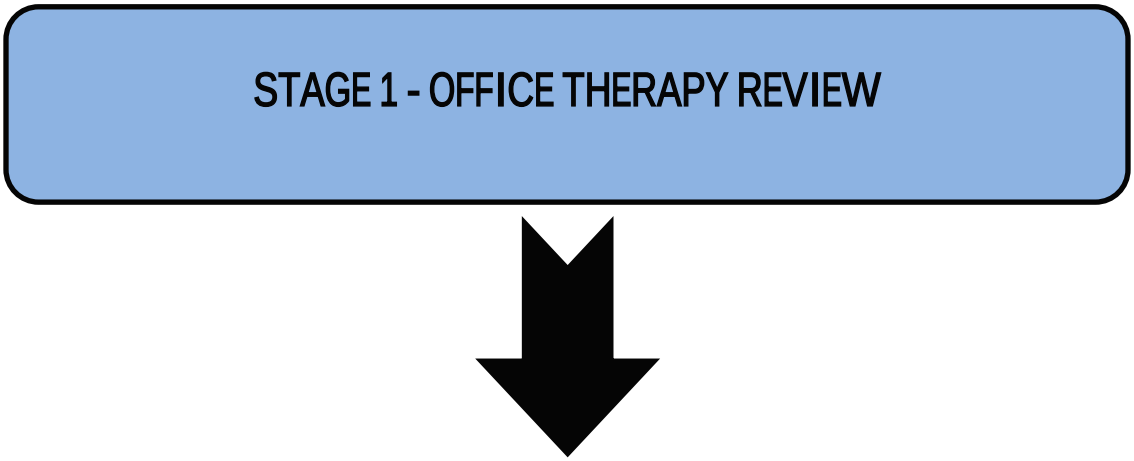
WISE SOLUTIONS FROM OFFICE THERAPY®

AVOIDING SOME OF THE MOST COMMON CLAIM ERRORS

Claim Review Process

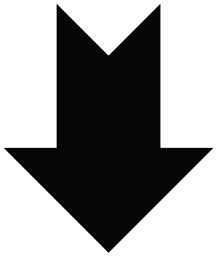
During the electronic claims filing process claims will generally undergo three different review processes or “scrubs” before they even make it to the payer for actual adjudication.



Office Therapy does the first scrub as part of the claims filing process and alerts you to errors that need to be corrected before the claims can move on to the next stage-the Clearinghouse. After this initial scrubbing a rejection report will be generated and alert you to the changes that need to be made to each individual claim before you can rebill successfully. Typically, these errors revolve around patient demographics and insurance subscriber information:

- Patient name or address are missing
- Invalid or missing date of birth
- Missing diagnoses codes
- Gender missing
- Billing provider address information
- Provider NPI/ID is missing
- Missing primary and secondary insurance subscriber/guarantor information
- Missing or valid payer ID number/information

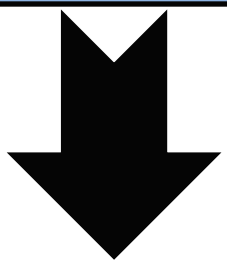
STAGE 2- CLEARINGHOUSE REVIEW



At the Clearinghouse level claims are reviewed again and this is where payer specific required information is checked for. Some common error examples are:

- Missing or incorrect Provider NPI information from what the payer has on file
- Missing or invalid procedure, modifier, or diagnosis code
- Invalid or missing place of service
- Provider billing address information submitted does not match what payer has on file
- Invalid dates of service
- Referring Provider information missing
- Inadequate COB information if filing electronically-pay date, line level balanced
- Missing onset of illness or accident dates if applicable to payer
- Duplicate claim

STAGE 3 - PAYER REVIEW



When your claims finally make it to the payer they are reviewed one last time before being adjudicated.

- Subscriber not found
- Provider ID missing
- Member ID invalid
- Billing provider not on file
- Entity not found
- Patient not eligible for dates of service submitted
- Insurance termed

Common Rejections

The first and easiest step in increasing your claim payments is through prevention. Obtaining accurate and up to date information from your clients at the first visit can dramatically increase your clean claims rate, which in turn keeps your cash cycle flowing and your accounts receivable down.

Your front desk employees play a critical role in the reimbursement process. Upon check in or when scheduling a client's initial visit make sure that all information that is required is collected. This attention to detail can have a very positive impact on submitting clean claims the first time!

COMMON ERRORS	HOW TO AVOID	WHERE TO CORRECT
Patient demographic information missing/invalid: • Patient address • Patient name- not matching what's on the insurance card or what they have on file • DOB • Age • Gender • Incomplete Primary and Secondary insurance information	Have client **completely** fill out registration and insurance forms. Make sure to either scan or copy front and back of all insurance cards and ID's. If the client is a minor- Guarantor information needs to be entered. Too many blanks on the registration forms can indicate a problem!	Select **Clients** from the **View** menu, or click the **Clients icon** on the Therapy or View Listbar, Select a **Client** and enter the correct demographic information under **General** tab of **Client Setup.** To scan paperwork or insurance card information under Client Setup , Select **Docs** and click **Scan** to scan documents using your scanner.
Subscriber eligibility • Invalid member name/ID • Not active for Date Of Service • Policy termed	**Insurance benefits should be verified before the initial visit.** Authorization requirements, referrals, co-pays, deductibles, co-insurance information should all be obtained before the patient is ever seen. This can save you an enormous amount of work later! You will also be aware if a policy is termed or inactive. This allows you to contact the patient prior	Select **Clients** from the **View** menu, or click the **Clients icon** on the Therapy or View Listbar, Select a **Client** and enter the correct insurance information under **Insurance** tab of **Client Setup**

	to the appointment and make them aware that they will be held responsible for payment in full at the time of the visit unless other arrangements have been made.	
Provider's NPI information	Make sure you have the correct NPI information entered for your Provider-Group, Individual or Both. This needs to match what the payer has on file.	Select **Providers** from the **View** menu, or click the **Providers icon** on the View Listbar, Select a **Provider** and enter the correct information under **HCFA Details** tab of **Provider Setup**
Secondary ID's-payer specific	Secondary IDs may also be required by certain payers to be on the claim in addition to your NPI. When you contract/participate with a payer that requires this additional ID they will assign one to you at that time.	Select **Providers** from the **View** menu, or click the **Providers icon** on the View Listbar, Select a **Provider** and enter the correct information under **HCFA Details** tab of **Provider Setup. You will enter this information in Box 33.**
Invalid/Missing Provider Specialty Code	This is your providers taxonomy code	Select **Providers** from the **View** menu, or click the **Providers icon** on the View Listbar, Select a **Provider**, select the **E-File Tab**, scroll down to the **Specialty** field and enter the corresponding value Taxonomy/Specialty codes can also be looked up via the **Taxonomy Code Lookup** link on the **Help** menu

Invalid Provider Billing address	The billing Provider address must match exactly what the payer has on file. The slightest difference will result in your claim kicking back. Make sure this information is entered correctly when setting up your files.	Select **Providers** from the **View** menu, or click the **Providers icon** on the View Listbar, Select a **Provider** and enter the correct information under **HCFA Details** tab of **Provider Setup**
Referring provider information	Any type of referral or consult is going to require the referring provider's information including their NPI.	Select **Clients** from the **View** menu, or click the **Clients icon** on the Therapy or View Listbar, Select a **Client**, Select the **Insurance** tab, Select the **Insurance policy**, click on the **HCFA/837 Details** button and enter the information under **Referring Physician Information** section
Invalid payer ID	Each payer has a unique 5 digit ID that must be used if you are filing electronically. Your Clearinghouse should have a listing of these available for reference.	Select **Insurance** from the **View** menu, or click the **Insurance Companies icon** on the View Listbar, Select an **Insurance Company**, Select the **E-File** tab, enter the value corresponding to **National Payer ID** field
Missing or invalid ICD-9 codes and/or CPT codes	There must be a valid ICD-9 code and CPT code linked for each line item being charged. This code that you select from the Axis 1 drop down will be cross walked to the correct ICD-9 code needed for claim submission.	Select **Clients** from the **View** menu, or click the **Clients icon** on the Therapy or View Listbar, Select a **Client**, Select the **Diagnosis** tab and add the **ICD-9** information for the client. CPT codes are entered when a new charge is created. You can add new codes to the procedure code selecting **Procedure Codes** item on the **View** menu. You can also setup procedure codes for standard charges by selecting the **Standard Charges tab** on the **Client Setup** screen

Onset of illness date	Certain payers require an accident or onset date-the date of service first associated with the diagnosis being linked to the procedure code. All Blues require this-even if they are the Secondary!	Select **Clients** from the **View** menu, or click the **Clients icon** on the Therapy or View Listbar, Select a **Client**, Select the **Insurance** tab, Select the **Insurance policy**, click on the **HCFA/837 Details** button and enter the information under **Date of Current Illness** box

REMEMBER- Attention to detail and accurate information gathering in the beginning can greatly decrease your claim rejections, hopefully, these few tips can help you take a proactive approach in avoiding them.

Happy Billing from Office Therapy!!