USER GROUP MEETING
Mandalay Bay, Las Vegas  |  November 1-4, 2015
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Topic
Claims Troubleshooting

Level
200
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NextGen Healthcare

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• Please silence all electronic devices

• Questions will be addressed following the presentation

• Please refrain from personal discussion
Claims Troubleshooting - Agenda

• Most Common Clearinghouse Claim Rejections
• Top Claims-related NextGen Support Incidents
• Electronic vs. Paper Claims
• NextGen EPM Master Files – Tips and Tricks
• Enhancements in 5.8UD2
• ICD10 – Lessons Learned
• Resources - Where to find HELP!
• Q&A
Top Preferred Clearinghouse Claim Rejections
Top Claim Rejections

Eligibility
• Incorrect Policy ID’s or dates (Check with Payer)

Enrollment
• Check with your Clearinghouse, and/or Payer (if direct)
• Separate Enrollment needed for EDI Claims vs. ERA

Invalid Payer Information
• Check Payer Address
• Wrong Payer ID (electronic trans ID)
Top Claim Rejections - continued

Coding Issues

- Diagnosis Codes: ICD-10 vs ICD-9
- Invalid CPT4 codes and Modifiers
- Referring Provider Required (i.e. Medicare labs, etc.)
- Invalid NDC info (need both 2410 LIN and CTP segments)
- UB’s (invalid or missing Value Code and amounts)

Invalid Provider/Group Information

- Check NPI’s and Taxonomy Codes
Top Claim Rejections - continued

Coordination of Benefits (Secondary/Tertiary Claims)
- Missing Adjudication Payment Date
- Missing Reason Codes and Amounts
- Balancing Formula: \( \text{Paid Amt} + \text{Adjustments} = \text{Billed Amt} \)
- COB enhancements in 5.8UD2 (to be covered later)

Duplicate Claims
- Missing/invalid Claim frequency resubmission codes
- ICN issues (5.8UD2 Enhancements to be covered)
Top Claims-related NextGen Support Incidents
Top Support Incidents

- **ERA Payer Number** (Encounter Payer Not Found during ERA Processing)
  - Populate the ERA Payer Number field from the ERA file in Payer master

- **Payer/Provider not found when billing encounters**
  - Populate a Provider Number (i.e. Tax ID) and valid effective/expiration dates on the Provider>Practice tab default row

- **Supervisor Billing Setup**
  - Update the setup for supervisor/midlevel on Provider>Practice tab

- **Assistance with UB billing (Payer>Practice>UB tab)**
  - Populate FL51, confirm Rendering Provider is selected, or confirm Rendering/Referring Provider has a UPIN setup (Provider>System tab)
  - UB’s – Type of Admission & Source of Admission required per 5010 (setup on Payer/Practice/UB tab and Practice/Preferences/Claims).
Troubleshooting Tips and Tricks
How to Identify the Issue?

Identifying the issue

• Are you receiving rejections at your Clearinghouse? or from the Payer?
• Are your rejections from electronic claims or paper claims?
• Is it affecting ALL claims? Or just a specific Provider? Or Payer?
• When did the issue start happening?

What does the rejection mean?

• Reach out to your Clearinghouse first! They can often contact the Payer on your behalf. Or call the Payer’s EDI department directly.
• Utilize Payer companion guides, websites/links
• Crosswalks – interpreting EDI loops & segments, vs. Paper “boxes”
• Contact NextGen Support with all the info you have gathered, plus a copy of the actual Payer rejection and the rejected 837 file
Things aren’t always as they seem – Keep digging!
Electronic vs. Paper Claims: Understanding 837 Loops/Segments vs. Paper boxes

<table>
<thead>
<tr>
<th>Loop</th>
<th>Description</th>
<th>CMS-1500</th>
<th>UB04</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010AA</td>
<td>Billing Provider (Group)</td>
<td>Box 33</td>
<td>FL56</td>
</tr>
<tr>
<td>2310B</td>
<td>Rendering Provider</td>
<td>Box 24J</td>
<td></td>
</tr>
<tr>
<td>2310A</td>
<td>Attending Provider</td>
<td></td>
<td>FL76</td>
</tr>
<tr>
<td>2310C</td>
<td>Facility/Location</td>
<td>Box 32</td>
<td></td>
</tr>
<tr>
<td>2310E</td>
<td>Facility/Location</td>
<td></td>
<td>FL2</td>
</tr>
<tr>
<td>2300</td>
<td>Claim Header (items that relate to the ENTIRE claim, unless specified at 2400 loop, such as Claim #, POS, Total Billed Amt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2400</td>
<td>Claim Detail (items specific to a line item, such as CPT4, modifiers, Dx pointers, Line Billed Amt)</td>
<td>Example: Boxes 24A-G</td>
<td></td>
</tr>
</tbody>
</table>
NextGen Master File Review

In the upcoming slides, we’ll discuss common places to reference in troubleshooting Claims-related issues:

- Claim Edit Libraries
- Claim Form Type Hierarchy
- Provider and Group Hierarchy
- EDI Descriptor for Not Otherwise Classified drugs
- NDC (National Drug Codes)
Claim Edit Library


• **Who is managing your claim edits?**
  - These could be master file setup related, or
  - These could be user/coding errors that end user can fix

• **Who is working your rejections? (from clearinghouse/payers)**
  - Work daily, make corrections in NextGen, then rebill

• **Do you have Worklog manager setup (i.e. Tasking)?**
  - This helps streamline who/how claim edits are being worked – a NextGen Implementation Specialist can help with this setup.
Claim Form Type Hierarchy

From most-specific to least-specific, this is how NextGen determines what Claim Form type to use for claims. This is helpful in troubleshooting when a claim generates on the wrong form type.

1. Payer/Alt Payer tab

2. Payer/Practice/UB tab (IF Rendering Providers are checked, and FL 51 is populated)

3. SIM/Payer tab

4. SIM/General tab
Group & Provider Hierarchy

NextGen uses a hierarchy in its logic for determining which row is the most specific, in Provider/Practice and Group Master setup, to determine how to bill the claim.

- Location-specific AND Payer-specific
- Location-specific with a “Default” Payer row
- “Default” Location with a Payer-specific row
- “Default” Location with “Default” Payer = catch all

TIP: Only build more specific rows if exceptions are needed!
Group & Provider Master Files

- Default/Default row
- Default location/Payer specific row
Group & Provider Master Files

Here is an example of a more specific Default Location/Payer-specific row, due to different Provider Number, as well as SIM Exception attachment.
Here is an example of a more specific Location/Payer defined row. NOTE: Because nothing is built on the Default Payer, the system will continue searching (to the Default Location level).
Provider/Group/Location Troubleshooting Tips

Adding new Providers – Commonly missed items:
• Populate “Provider Number” field (Provider/Practice tab)
• Set Effective and Expiration Dates
• Enable “Rendering Providers” on Payer/Practice/UB tab (if applicable)
  • Common miss if an 837P generates, instead of an 837I

Group Master – Bill To:
• 5010 does not allow PO Boxes in 2010AA (Box 33)
• Use “Bill To” field to point to a physical location, then PO Box info will populate the 2010AB (Pay To) loop for remits

Location Master:
• Location Master NPI’s should not be populated if same as Billing NPI
• Location loop (2310C – 837P) should be suppressed automatically if same exact name/address info as the Billing loop (2010AA)
CMS requires “Not Otherwise Classified” drug codes to have an EDI Descriptor in the 2400/SV101-7 (837P) or 2400/SV201-7 (837I).

1) Enable the SIM/Payer option to “Send Descriptor on EDI File”
2) Enter Narrative (under SIM/Other if always the same, or in Charge Entry)
EDI File Lookup

Have you ever “lost” an EDI File (including 837’s, 835’s, 277’s, etc.)? This is likely due to the “Send Filename” file path that was selected (or not!).

NOTE: Enable Enterprise Preference to archive electronic send files in order to use this lookup feature. Saving to a shared network drive/folder is recommended.

• Tasks/Lookup/Files, select file type, Right click, choose Export, and specify where to save the file.
National Drug Code (NDC) Setup
National Drug Code (NDC) Setup

To bill out NDC information, enable these two options under Payer>System>Electronic Claims tab. 5010 requires 2410/CTP segment (basis of measure and drug unit count), in addition to the 2410/LIN (NDC code).
NDC Improvements in 5.8UD2

- Originally, the drug unit count on the claim was reported as the drug unit count in the NDC library, instead of the actual amount dispensed.

- Drug unit count has been changed to now report the actual quantity supplied to the patient. (NDC “Drug Unit Count” field X Charge entry “Quantity”)

- Multiple Records for the same NDC are no longer needed
  - Prior to 5.8 UD2, multiple records were needed if the same NDC had different drug unit counts to be reported.
  - Now, clients can enter the NDC record once in the NDC library, without requiring values for Basis of Measure or Drug Unit Count. These fields can be entered on-the-fly in charge entry via the “Rx” icon.
Prior to 5.8UD2:

As of 5.8 UD2:
NDC in Charge Entry

Prior to 5.8UD2:
Users could not modify the Basis of Measure or the Drug Unit Count fields. Thus, multiple rows had to be built in the NDC library to account for every variation.
NDC in Charge Entry

New in 5.8UD2: Users can now modify data on the fly.
NDC Setup – New Claim Edits

It’s recommended to setup new Claim Edits # 290 & 291, to catch NDC library entries that have missing data. This is important if using the EHR Holding Tank, since users are not prompted to enter required NDC values when accepting charges into PM.
NDC Setup - Claim Print Library

Box 24 “Supplemental charge-related data to display above line” has been enhanced to include the following additional options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>[22] Medicaid resubmission code</td>
<td>Blank</td>
</tr>
<tr>
<td>[22] Original Ref. No</td>
<td>Blank</td>
</tr>
<tr>
<td>[23] Authorization number</td>
<td>CLIA Number</td>
</tr>
<tr>
<td>[24] Display supplemental data qualifier</td>
<td>Blank</td>
</tr>
<tr>
<td>[24a] Supplemental charge-related data to display above line</td>
<td>Blank (Z2)</td>
</tr>
<tr>
<td>[24a] Date format for dates of service</td>
<td>Charge Narrative (Z2)</td>
</tr>
<tr>
<td>[24b] Force 2 digit year on output to file</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
<tr>
<td>[24c] EMG indicator</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
<tr>
<td>[24d] Diagnosis code</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
<tr>
<td>[24e] Modifier Options for Box 24d</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
<tr>
<td>[24f] Suppress commas in amount</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
<tr>
<td>[24g] Display days/units</td>
<td>NDC desc/basis of measure/drug units(N4)</td>
</tr>
</tbody>
</table>

Selections made for fields on this tab will apply regardless of whether the payer this library is associated with is Primary, Secondary, or Tertiary.
What’s New in 5.8UD2? (current general release)
ICN Improvements

Interchange Control Numbers manually entered or received via ERA will now always be stored in the Transactions table. Storing the ICN is no longer controlled by Payer master settings.

“Populate ICN Number” has been renamed to “Send ICN on Resubmission” to better reflect the resubmission nature of the functionality.

If enabled (checked):
- 2300 REF*F8 qualifier will be populated with the ICN and CLM05-3 will be populated with the value from Payer Master->Defaults-2->Default Resubmission Code (typically 7 or 8).

If disabled (unchecked):
- The ICN and resubmission code will display on the Claim Header in Claim Maintenance but will not be included on the electronic claim.
ICN - continued

NextGen can now send the Prior payer’s ICN in the 2330B loop.

“Send Medicare ICN on COB Claims” has been renamed to “Send Prior Payer ICN on COB Claims” (on Payer/Defaults2 tab)
• This functionality has been modified to handle all payers (not just Medicare).

A new “Prior Payers Resubmission Reference Number” field has been added to the Claim Header tab of Claim Maintenance.

**If enabled (checked):**
The prior payer’s ICN from the “Prior Payers Resubmission Reference Number” field in the Claim Header will populate the 2330B Other Payer Claim Control Number (REF*F8) on all COB claims.

**If disabled (unchecked):**
The prior payer’s ICN, although populated in Claim Maintenance, will not populate in the EDI file.
ICNs are entered into the Resub # field either manually at the time of Payment Entry or automatically via Electronic Remittance.
5.8 UD2 allows clients to now modify the ICN number on posted transactions, prior to claim creation, directly from the Patient Chart. It can still be modified from Claim Maintenance > Claim Header tab too.
Coordination of Benefits (COB) Enhancements

COB can now be accessed directly from the Patient’s Chart!

Two new right click menu options have been added to allow users to quickly access the COB window directly from the Patient Chart.

Prior to 5.8UD2, a user would have to go into Transaction Detail, and then access the COB button. Now, upon right clicking a transaction, the following menu will display:
COB Enhancements

There is now an “All Payers” option in the COB window so you can see everything in one place, rather than multiple screens.

![Coordination of Benefits Information](image)

<table>
<thead>
<tr>
<th>Adj Date</th>
<th>COB</th>
<th>Include</th>
<th>CPT4</th>
<th>Chg Amt</th>
<th>Billed</th>
<th>Allowed</th>
<th>Payment</th>
<th>Adjustme</th>
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<td>211.77</td>
<td>90.00</td>
<td>11.77</td>
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<tr>
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</tbody>
</table>
COB Imbalance Warnings

5010 no longer requires balancing to the Allowed amount. We have split out into separate warnings, so that you can just balance to the Billed amount. (Note: Make sure Claim Edit 255 is enabled, not 254.)
ICD10 “Lessons Learned”
Resources Available

**NextGen Resources:**
- NextGen Application “HELP”
- Knowledge Exchange 2.0
- NextGen Training Manuals and White Papers
- E-Learning (especially for new staff!)
- Training Webinars (including complimentary, such as ERA, COB, RTE, new releases)
- Monthly PM Claims Webinars – 3rd Thursday at 3pm EST
- NextGen Client Website (including attaching to Known Issues, etc.)
- Monthly CHC Webinars – 3rd Tuesday at 3pm EST
- askICD10@nextgen.com email for any ICD10 questions
- upgradeservices@nextgen.com email for questions re. upgrading your NextGen software

**Industry Resources:**
- Payer websites, including companion guides
- Clearinghouse websites
- Wpc-edi.com

And last, but not least…
NextGen Support Help Desk

Help US help YOU!...
...by including the following info when logging a Support Incident:

- EPM Release - What version of NextGen® is the client using?
- Who – One user vs. all users?
- What – What is the issue? Be descriptive and concise about the problem.
- When – All the time or sporadically? When does it happen?
- How – Exact steps to recreate the issue (i.e. “error appears in Charge entry/Save button”)
- Where – All workstations vs. one workstation?
- Environment - Is the user working on FAT or Thin?
- Clearinghouse and/or Direct Payer Connections – Which one(s)? Call them first to dig deeper regarding specific rejections!
- Attach screenshots of all errors the user is receiving, and actual EDI files/reports
- Obtain a SQL Server® log if possible, via Help>About from main toolbar.
- Impact – Is this affecting a handful of claims, or ALL claims for a given Payer? Provider? What claims #/$/% of your business?
Any Questions?
Session Survey

Please take a moment to complete a brief survey regarding this session.

1. Open your ONE UGM Mobile App (please note: you must have already logged in and accepted the “Terms of Use” to access this feature)
2. Click the Navigation Button at the top left of the screen
3. Select “Sessions”
4. Search for and select this session
5. From the sessions details screen, select “Survey” at the bottom right of the screen
6. Remember to hit “Save” at the bottom of the survey once you have answered the questions