

2. Hard Copy Versus Electronic Claims Processing

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2.1 Hard-Copy Claims Processing

Hard-copy claims are printed on a paper form, such as UB92 (now called the CMS 1450), ADA, HCFA 1500 (now called CMS 1500), NCPDP, or other paper forms.

If you are unable to submit claims electronically, a paper form must be submitted. Prior to mailing the claim to the insurer,

- All corrections should be made.
- All forms should be reviewed by the biller for accuracy, based on payer requirements.

Examples of using a hard-copy claims process include payer requirements and resubmission.

Billing on a paper claim will delay your reimbursement. To be HIPAA compliant and to expedite payment, every effort should be made to submit claims electronically.

It is highly recommended that any high dollar claim (over \$5000) be sent certified, either initially or through resubmission when the insurer has not received the original claim.

Always attach an EOB with the secondary or tertiary claim.

For private insurance, if there are two accounts on the same day, for example, a pre-operative visit and a surgery or admission, the two accounts should be merged together for billing.

Note: Insurers keep a record of errors on coding or documentation and may use this information as part of any future audits.

2.1.1 Procedure for hard copy claims processing:

All forms should be printed and mailed in a timely manner – within 72 hours. The biller completes the claim review, and then

- Sorts claims by payer
- Addresses envelopes with payer information
- Delivers them to the mailroom

2.2 Monitoring Approved Claims

Sites should frequently monitor the Bills Awaiting Export report. This report is an RPMS Third Party Billing function and allows the user to see the number of bills approved and ready to be printed (exported).

To run this report, access the RPMS Third Party Billing system. From the main menu:

1. Type **PRTP** to access the Print Bills menu.
2. Type **AWPR** to select the Bills Awaiting Export report.

The system displays three options.

3. Choose Summarize Report by Insurer (2).

You will be listed as the default approving official.

4. At the prompt, type 4, to remove yourself as the approving official (this option allows you to view all approving officials).
5. Select your device.

The report will display a bill summary by insurer with an average number of days from approval date to present, plus a total billed amount

This report may also be provided to Billing staff as a reminder to print or export existing claims.

2.3 Electronic HIPAA compliant claims processing

Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically, or “paperless” claims processing, as well as electronic remittance, electronic funds transfer, and electronic inquiry for claim status and patient eligibility.

Health care service information is a detailed, itemized record of health care services performed that are provided to a health plan for reimbursement. The ASC X12N 837 electronic claim form format has been adopted by Health and Human Services and Indian Health Services and is used by professionals (providers), institutions (facilities), and dental.

Some insurers may require an institutional guide versus a professional guide. It is important that you communicate with your health plans or payers to determine which of these guides will be used and what changes to the current claims submission process to expect.

In addition, the ASC-X12N 835 Health Care Claim Payment guide is used for the explanation of claim processing and/or payment sent by the health plan to a provider or facility.

HIPAA does not require providers to conduct any standard transactions electronically. You may process some transactions on paper and others may be submitted electronically. However, those HIPAA standard transactions you choose to conduct electronically must comply with the HIPAA format and content requirements

The transmission of claim files is done in packages which contain a specific amount of data. The size of the packets varies, based on the protocol selected.

Following the transmission of claims files, the system performs edits on the files and provides a report. Edits include:

- File level (structural, security and file requirements are validated). These edits normally provide a response to the user right away. Some payers use a 997 acknowledgement, 824 acknowledgement, or TA1 acknowledgement. Generally, these acknowledgements indicate missing or incorrect data or incorrect format. The user will have to make necessary corrections, re-create the batch, and re-submit.
- Batch level (structural, security and batch requirements are validated). These edits are provided to the user. Unlike the file level edits, not all claims records are rejected. The user is encouraged to make the necessary corrections once the bill is cancelled and re-approve.
- Claim level (claim field requirements are validated). During this level of edit, the payer is processing the claim, utilizing their system edits. Rejections are reported on the remittance advice or 835's. The claim usually has to be researched and re-submitted for payment. After each system cycle, accepted facility forms pay, suspend, or deny. Claims suspended due to errors related to Federal or State guidelines, require a manual review.

In preparation for submitting claims electronically, the following items need to be completed:

- Notify appropriate IT contacts.
- Identify payer that can receive an electronic form.
- Complete business associate agreement and/or trading partner agreement.
- Complete EDI application.
- Obtain companion document.
- Contact insurer and set up test file.
- Set up billing system to correctly populate electronic batch files.
- Run test file and correct transmission errors.
- Change, if necessary, testing status to production status.

The benefits of submitting claims electronically are:

- The claims will be processed faster, improving cash flow.
- Mailing and administrative costs are significantly reduced.
- The front-end editing system saves staff time and effort in that fewer claims are returned.
- The facility can also use Electronic Remittance Notice (ERN) and Electronic Funds Transfer (EFT).
- Online query allows access to claims status information and patient eligibility in real time.
- Records and tracks timely filing – supporting documentation and submission dates to insurer.
- Becomes HIPAA compliant.

2.4 Electronic Data Interchange Alternatives

- A software vendor can be selected to enhance the software system currently in place.
- Claims can be transmitted directly to the payer or use a separate clearinghouse.
- A billing agent can be used.

Each facility will need to use the requirements and processes established by the various payer alternatives.

2.5 Tips for Electronic Submission of Claims

- Enrollment forms will need to be completed and agreements must be signed.
- FTP, web site connectivity, or a dedicated phone line is recommended to prevent interrupted transmissions.
- Make regular backups for all patient and claim data (Disaster-Recovery Procedures).
- Consider using Un-interruptible Power Supply (UPS) with a surge suppressor to protect your equipment if the facility is prone to power outages.
- Always read the response file from EDI to know what and when was received and whether transmission was accepted.
- Promptly make claim corrections and re-submit.
- When you dial into the insurance company to send claims or retrieve responses and remittances, you are connecting with their communication platform.
- Test a wide variety of claims – inpatient, outpatient, surgery, and such, based on batch limitations set by insurer.
- Reference EDI procedures under HIPAA privacy and security regulations.
- System issues that may cause payment delays should be reported to the supervisor.
- When transmitting claims, the biller needs to print a receipt from the insurer to determine that the transmission was successful.