CLAIMS MANAGEMENT SYSTEM
(CMS)

A new Claims Management System screen replaces the Follow up List for All Accounts. A new command CMS replaces the old command and terminology for FL3.

Additional new items in the CMS screen include:

Each line reflects an individual CHARGE item. Profile(s) may be created or the default profile can be used. Profiles may be saved according to carrier or employee needs. The screen supports many more search options (e.g.):

- Aging rows
- Audit Trail Rejection codes
- DST Claim errors
- Primary or Secondary claims

Searches may be created and saved for assignment to specific people to work. A blank field is equivalent to the old default all. Accounts can be moved into one of three buckets: working, hold, or finished. A standard report or a report from each Tab on your profile can be printed. Totals may be viewed before pulling in all data. Trends in AR may be tracked more easily.
Suggested Claims Management Actions By Category

The Claims Management Recap and Claims Management Insurance Carrier Recap reports are the summary of the CMS online tool. These reports present outstanding items in suspense by carrier, category, and age. Use these reports to access overall outstanding claims and to develop strategies for working online claims management with CMS.

Online claims management reporting should be worked following each insurance run. New data is presented the following day. Changes in claims status are reflected at this time due to actions taken on the claims in Account Analysis or through the posting of insurance payments and rejections. Depending upon the action taken on a claim, the item may have been released from claims management altogether or moved to another category in aging row 1. If no action was taken on the item, it will advance to the next aging row. The highest aging reflected is row 11. Categories that do not require action until after 5 weeks of aging will not display items online until that time.

Standards and practices for managing insurance follow-up are established by each practice; however, these general suggestions are offered in priority order for working the various categories.

- **NFL – Not Filed.**
  - Work all aging rows 11-2.
  - Use SEL – Select item to review the charge. In Account Analysis, determine if the charge is suspended to appropriate carrier, change suspense carrier, if indicated, and file the charges from Account Analysis. Items can also be released from suspense.
  - Note: Each week DST will run a program to create automatically a claim request with NFL charges older than seven (7) days for active insurance carriers. If charges are suspended to inactive carriers, DST will generate a report for your review and modification as deemed appropriate.

- **COE – Correctable Errors.**
  - Work all aging rows 11-1.
  - Use SEL – Select item to review the claim. The Claim Information tab of the Single Claim Display indicates the DST-generated numeric claim edit code. To view the detail of the error code, select Show Errors from the Function Menu.
  - The action taken will be based upon the error codes for the claim. Corrections of patient demographic and insurance information should be made in Patient Inquiry. In Account Analysis, correction can be made to the charge information or to claim during the claim refile action.

- **ATR – Audit Trail Rejected.**
  - This claims status is determined only for Alabama Medicare and Blue Cross claims data received through electronic remits.
  - Work aging rows 11-1.
  - Use SEL – Select item to view the rejection information displayed in the Related Transactions of the Single Claim Display.
  - Make the necessary corrections and refile the claim.
• Review InfoSolutions for valid contract numbers and eligibility. If the contract number is not valid and a correct one cannot be found on InfoSolutions, release the charges.

• **EBR – EOB Rejected.**
  • These claims were held in suspense by this action being taken during payments posting of rejections from the EOB remittances.
  • Work aging rows 11-1.
  • Use SEL – Select item to view the rejected payment posted in the Related Transactions of the Single Claim Display.
  • If the rejection is a Medicare payment, then select the REJ – Reject Item command on the payment item to view the rejection explanation online. For Alabama, Blue Cross rejection explanations are also available online.
  • If online explanation is not available, review comments keyed with the rejection, the EOB explanation, or Account Notes for further information.
  • Release or refile, as appropriate.
  • Remove any paid charges from the claim during the refile process.

• **ATA – Audit Trail Accepted.**
  • This claims status is determined only for Alabama Medicare and Blue Cross claims data received through electronic remits.
  • Work aging rows 11-6.
  • Use SEL – Select item to view the claim.
  • Review the claim status in InfoSolutions. If claim is not present, refile it. If the claim is present, call the insurance company to determine the claim’s status. Take directed action.
  • Release the claim if payment is the patient’s responsibility.

• **RCP and RCE – Refile Claim Paper and Refile Claim Electronic.**
  • Work aging rows 11-6.
  • Use SEL – Select item to review the claim for filing accuracy.
  • If insurance carrier is contracted, call the carrier to check the claims status, release or refile, as appropriate.
  • If insurance carrier is not contracted, release the charges to the patient.

• **OCP and OCE – Original Claim Paper and Original Claim Electronic.**
  • Work aging rows 11-6.
  • Use SEL – Select item to review the claim for filing accuracy. Call the carrier to check claims status. Refile or release item, as appropriate.

• **CBU – Claims Bumped.**
  • This claims status is determined only for Alabama Medicare and Blue Cross claims data received through electronic remits.
  • Work aging rows 11-6.
  • Use SEL – Select item to review the claim. Call the carrier for claims status or review claims status in InfoSolutions.
  • Release or refile, as appropriate.

**Note:** The aging categories are as follows:

- 0-7 days
- 8-14 days
- 15-21 days
- 22-28 days
Other Online Claims Management Components

The other available components are:

- **FL1 – Follow-up List by Patient.**
  - This listing of all patients that have items in claims management is accessed from the FL3 Function menu selection by keying FL1 in a Go To… Function selection, or by selecting Follow-up List by Patient in the Viewing Criteria tab on Account Analysis.
  - The listing is sorted by patient number and insurance. It has several limiting parameters. It displays the oldest DOS for the patient’s suspended items, A/R and/or suspended balance, and the number of items in claims management. If a patient has items in claims management for more than one carrier, then the patient name, patient number, and account balance will be given only on the first line.
  - Detail options are available to access the Account Follow-up, Update Follow-up, Account Analysis, and Patient Inquiry, or to print the item detail.
  - This listing is useful for claims follow-up by patient.

- **FL2 – Account Follow-up List.**
  - This listing of all the claims management items for a given account is accessed from any Account Analysis Go To…. Function selection by keying FL2 or the selecting Account Follow-up List in the Viewing Criteria tab, or by selecting Account Follow-up from the line item command on the Follow-up List by Patient or Follow-up Listing for All Accounts.
  - This listing can be limited by insurance carrier, doctor, or department. It has several sort options. It displays the charge detail for each individual item in suspense and the insurance contract number and phone numbers.
  - Detail options are available to access the item detail, Update Follow-up, Account Analysis, and Patient Inquiry, or to print the item detail.
  - This listing is useful for working with all suspense items for a single account on one screen regardless of category or aging of the items.
Profiling the CMS screen

You may setup a new profile or use the default shown below:

Default Screen Display

Click on Profiles – Select Add Profile.

A window will pop up. Enter the name of your profile and click OK.
Begin to setup your profile. The Add and Remove buttons will allow you to add a name to your Tab or delete a tab.
To move your fields, you can double click on them or highlight the field to be formatted and click the > button. A pop-up message will appear if the field will not fit without creating a scrollbar.

Red highlighted items indicate their use on a previous tab.

After setting up your profile – click the OK button.
Go to the Functions menu and select new search.

**Note:** A major difference between CMS and the older model is each line represents an individual CHARGE item on the claim not the CLAIM itself.

The search selection screen works nearly the same as the old one; however, it has additional search options. For example, you may now search by Aging rows, Audit Trail Rejection codes, DST Claim errors, and search by Primary/Secondary claims.

Fields used on this screen are:
1. Reviewer ID. The reviewer for whom the list is to be shown. Up to three reviewer codes may be entered. Only applicable if reviewers are setup for the client.

2. Follow-up Codes. The follow-up codes to be used to limit the listing. Up to three follow-up codes may be selected, one from each drop down box. To remove the codes from the second and third drop down boxes, select the blank space at the top of the listing.

   Code. This 3-character follow-up code corresponds to the current claims management column for the item. A suspended item is located in one of these 10 claim filing status categories:

   A. NFL Not filed  No claim generated.
   B. COE Correctable Errors  Insurance claims edits.
   C. OCP Original Claim Paper  Original claim filed paper.
   D. OCE Original Claim Electronic  Original claim filed electronic.
   E. RCP Refiled Claim Paper  Refiled claim filed paper.
   F. RCE Refiled Claim Electronic  Refiled claim electronically.
   G. CBU Claim Bumped  Claim crossover automatically.
   H. ATR Audit Trail Rejected  Electronic audit trail rejection.
   I. ATA Audit Trail Accepted  Electronic audit trail accepted.
   J. EBR EOB Rejected  Claim held in suspense by user.

3. Department/Doctor. The department/doctor code to be used when limiting the items shown.

4. Insurance. The insurance carrier code(s) to be used when limiting the items shown. Up to three insurance carrier codes may be entered.

5. Beginning Date. This field is used to indicate the beginning date to be used to limit the list. Enter the date in MMDDCCYY format.

6. Ending Date. This field is used to indicate the ending date to be used to limit the list. Enter the date in MMDDCCYY format.

7. Claim Status. These fields are used to indicate whether only open (unpaid claims management items, closed (paid) claims management items, or responded to should be displayed. The default is only open items.

8. Beginning Bal. This field is used to specify the beginning claims outstanding balance to be used to limit the list. Enter value as a whole dollar amount.

9. Ending Bal. This field is used to specify the ending claims outstanding balance to be used to limit the list. Enter value as a whole dollar amount.
Search items may be created and saved for assignment of selected data to specific people. A blank field is equivalent to the formerly used All.

Totals may be checked before saving the search.

Use Save Search Results Global in the Functions Menu to name the search and, if desired, assign the lines of data to specific personnel. When you return to New Search, click on the List button in the Name of Search field.
A pop-up window will appear with a listing of the global searches that have been saved. Click on the search file that needs to be worked.

Accounts may be moved into 3 buckets: Working, Hold, and Finished. The working bucket is the default.
To view the data in a specific bucket, click on Buckets drop down menu.

A standard report or a report created from each Tab on your profile may be printed.
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On-line Claims Printing

Introduction

The On-Line Claims Printing (OLCP) program is used to print claims. The primary purpose of this feature is to regularly print claims that have to be sent on paper (referred to as hardcopy claims). OLCP also allows for printing out any claims, including claims that were sent electronically, for special requirements. There are several claim forms that can be printed using OLCP: NPI-1500, HCFA-1500, Crossover, UB92 and UB04.

Logging In

The On-Line Claims Printing (OLCP) username and password are the same as those for MREP for each employee. The username and password must be entered in lowercase.

To access OLCP, select File then On-Line Claims Printing from within MDr PracticeManager. The first time the user accesses OLCP they will be prompted for the username and password. Upon successful login validation the username and password will be saved on that PC and will not have to be entered again.

Once user successfully logs in the Claims Printing screen is presented as shown below.
The columns presented include the following:

**Type** – indicates the type of claims in this insurance run

**Date of Claims** – insurance run date that corresponds with the claim date as found on the claim in Account Analysis

**Claim Run #** – internal number of insurance run

**Printed** – indicates if claims in this group have been printed or not

**# of Claims** – indicates how many claims are in this group of claims. This field is only updated on those lines (group of claims) that have been accessed during the time the user is logged into OLCP.

**Claim Group Selection**

After finding the group of claims that need to be printed, double-click on that line. This will bring up a listing of claims in the bottom portion of the screen. The list of claims in the lower section is grouped and listed by insurance carrier. The columns include the claims basics, such as Patient Number, Dept, Doc, Ins, Amount and From/To Dates. The other columns listed include:

**Elec** – This indicates if the claim was sent electronically or not. Values of *Elec* or *Auto-Elec* indicates that claim was filed electronically. *Blank* or *Auto* indicates a hardcopy claim. The “auto” indicates that the claim was filed using special assistance from DST.

**Provider** – This field is typically blank. It will contain a provider number if no exception record was found for the doctor and the insurance carrier is not set to use NPI.

**Refile** – If this claim is a re-filed claim, then this field will contain a Yes.

**Errors** – These are the errors/edits as found on the Insurance Control Summary in WebReport

Double-clicking on any of the column headings such as Pt Number, Dept, Doc, etc. will sort the claims in that order. For example, if you want to see how many hardcopy
claims there are, then double-click on the **Elec** column and these will be presented at the top of the list.

**Printing Claims**

After the claims display at the bottom of the screen and the **# of Claims** for this run displays in the box, right-click on this same line. The user will be presented with a pop-up menu.

There are 3 selections for printing the claims.

1. **Print All Claims** – Prints all claims including electronic ones.

2. **Print Only HardCopy Claims** – Prints only the hardcopy claims.

3. **Print Range of Claims** – Prints a range of claims along with excluding specific error codes if desired. There is also an option to include electronic claims.

This function is primarily used if the printer jams and you need to restart at a particular claim. Click on **Last Claim Printed** and find the patient number where you need to re-start your print job.
This feature will be discussed in more detail later in this document.

**NOTE:** Any of the first 3 selections constitutes printing the entire group of claims.

**Print Preview**

Typically, the reason for using this function is to print the claims that have to be sent on paper.

All three of the above print options work in the same manner. Upon clicking on the **Print Only HardCopy Claims** option, the **Print Preview** screen will be displayed. This is a picture of the claim screen. You can do the following within this screen.

**Print** – Can choose the Printer Icon (or use File ➔ Print menu option) to print a single claim, multiple claims or all claims.

**Navigate** – Can choose one of the Navigation Icons (or use Navigation option) to go to the first page, one page backward, one page forward or last page.

**Zoom** – Can choose one of the Zoom Icons (magnifying glass) (or use Zoom menu option) to enlarge or reduce image size.

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As part of the typical process of printing only hardcopy claims, then click on the Printer Icon (or click on File ➔ Print) to print out all the hardcopy claims.

**Successful Printing**

After the group of claims is printed, click on the X in the upper right-hand corner of the Print Preview screen. This will close the window. A message will appear asking if the claims have been printed successfully. Click the **YES** button to indicate that the claims have been printed.
Once the claims have been printed the Printed column will indicate a Yes. This will serve as a flag showing which groups of claims have been printed.

**Hint:** If there is a batch that contains only electronic claims, then choose to Print All Claims. Do not print the claims, but instead close the Print Preview window and indicate that “all claims were printed successfully”. This will provide a flag showing that these are done.

### Additional Printing Options

Once a group of claims have been printed and the Printed indicator is Yes, then there are additional options available. The group of claims you have selected at the top (double-clicked on) can be right clicked and there are now more selections for printing. The following is a description of the different options available.

#### Print Range of Claims

This option allows you to choose which claims to be printed. The screen to the right will be displayed. The fields/sections on this screen are as follows:

- **Include Electronic Claims** – this checkbox at the bottom of the screen will indicate if the electronic claims need to be printed. If this checkbox is left unchecked then only hardcopy claims will be considered. This checkbox can be used in conjunction with any of the other selections on this screen.

- **Print Claim From** – these fields default to the first claim to the last claim. These are sequencing numbers of the claims in the group. These numbers can be changed to print a series of claims, such as the first 5 claims (e.g., 1 to 5), last claims (e.g., 50 to 59) or some group in the middle (e.g., 20 to 30).

- **Last Claim Printed** – this option is useful if printing is stopped or unsuccessful. You can start printing from a particular claim. By clicking on the drop-down arrow the claims will be listed. Choose the last claim printed successfully. The claims will then be
presented in the **Print Preview** screen starting with the next claim that needs to be printed.

**Error Codes / Exclude** – This section allows user to exclude printing claims that have certain error codes. To choose to exclude a particular error then double-click on the error code in the **Error Codes** box. This moves the error code to the **Exclude** box. The error definition will also be shown underneath. If you want to remove the error from the Exclude list, double-click on the error.

A practical application of this is when you want to print only the hardcopy claims that do not have errors. For example, if there were a number of claims that had errors, you could first select to **Print Only HardCopy Claims** and print these claims on plain paper. The claims with errors could then be worked. Then the user could choose to **Print Range of Claims** and exclude all error codes. This would allow the printing of the “clean” hardcopy claims on the claim forms, thus not wasting claim forms.

**Print Specific Insurance Carrier**

This option works similarly to the **Print Range of Claims**. However, it gives you the option to narrow the selection down to a particular insurance carrier. Click on the drop-down arrow next to the **Select Insurance** field and choose the insurance carrier. Then indicate if any errors need to be excluded and/or electronic claims need to be included.
**Print Specific Dept Doc**

This option also works similarly to the **Print Range of Claims**. However, it gives you the option to narrow the selection down to a particular department and doctor. Click in the **Enter Dept** field and enter the department of interest then click in the **Doct** field and enter the particular doctor. Both the department and doctor must be specified. Then indicate if any errors need to be excluded and/or electronic claims need to be included.

**Printing a Single Claim**

Once a group of claims have been printed and the **Printed** indicator is **Yes**, a single claim can be printed. To print a single claim, double-click on a group of claims that have already been printed. When the claims appear in the lower section, find the particular claim that needs to be printed and double-click on this claim. This single claim will be presented for you to print.

**Change Print Alignment**

If when printing the claims the text is not aligned on the claim form, then some adjustments must be made.

To make an adjustment, right-click in the top section of the screen on one of the claim lines. Click on the last option, **Change Format**, to change how the text is being printed.

Click in the top and/or left margin fields of the form that needs to be adjusted.

The **top margin** fields are for up and down alignment and the **left margin** fields are for right to left alignment. If the print needs to be moved down or right on the claim then use a positive number (e.g., 3), otherwise use a negative number (e.g., -3).
The number to use will be dependent on how far the text needs to be moved. Rule of thumb is that a character/letter is equal to 5. You may need to change the value(s) a couple of times to get the desired results. As you are testing the print alignment, be sure to only choose to print a single claim.

Note: Each time you obtain new claim forms from the store/printer, be sure to check the alignment of the text on the claim. Choose a previously printed claim to test before printing a group of claims.