INTERNAL - Lifecycle of a Claim

07/24/2024 5:30 pm EDT

Once the patient has been treated and the clinical note is written, it is time to submit the claim to the payer for reimbursement. This article will explain what happens with the claim after the billing status is set to "Bill Insurance".

For Change Healthcare, TriZetto, and Carisk Partners

- The DrChrono system will gather all claims in a bill to insurance status (Bill Insurance, Bill Secondary Insurance, Worker's Comp Claim, Auto Accident Claim, Durable Medical Equipment Claim) and batch them together in the "837 file". Claims are batched and sent out 7 days a week/365 days a year. Due to the size of some of these claim files and the clearinghouse's inability to handle large files, as of spring 2022, DrChrono has started batching files in no more than 5,000 claims. These smaller files are held and submitted together at normal times. The only difference is, we are now sending multiple smaller files, instead of one very large file.

For ePS (eProvider Solutions)

- The DrChrono system will gather all claims that are in a bill to insurance status (Bill Insurance, Bill Secondary Insurance, Worker's Comp Claim, Auto Accident Claim, Durable Medical Equipment Claim) and batch them together, ***by client***, in a file named the "837 file". Claims are batched and sent out 7 days a week/365 days a year. By batching by client, if there is an issue with any particular file, it impacts a single client and not multiple who may have had claims in that batch file.

The time of submission will differ by the clearinghouse (and by the type of claim for TriZetto and Carisk Partners).

  - **Change Healthcare (fka Emdeon)** - daily at 5pm EST
  - **TriZetto professional claims**- daily at 10:15am EST, 7:15pm EST
  - **TriZetto institutional claims**- daily at 7:45pm EST
  - **Carisk Partners (fka iHCFA) professional claims** - daily at 7:05pm EST
  - **Carisk Partners (fka iHCFA) institutional claims** - daily at 7:05pm EST
  - **ePS (eProvider Solutions)** - daily at 7:15am and 7:15pm EST

- DrChrono will do an initial scrub of each claim to ensure all required information is listed. If it is missing, the claim will be sent back to the client as "Missing Information." The specific reason for the rejection is listed under each individual claim. If you scroll down to where the CPT/charges are listed, there will be an error message on the right. If you click on it, you will see the exact rejection reason received from the clearinghouse.

- The clearinghouse will receive the 837 claim file and complete a primary scrub.

    - If a claim fails any of the upfront rejections, that information will be sent back to DrChrono on a status, or 277 file. These claims will be visible under the "Rejected" or "Missing Information" status in your Live Claims Feed. The reason for rejection will be listed in each claim, by clicking on the "rejected/missing information" status within the appointment. Once the information has been updated, the claim can be resubmitted.

    - All claims that pass the clearinghouse primary scrub will be sent to the appropriate payer. The clearinghouse will send back a status update/277 file, giving the current status of each claim. The information will be updated in each patient account, so you know exactly where the claim is at each step of the process. The statuses you may see at this step are "in-process at the clearinghouse, in-process at payer, payer acknowledged".

        - **PRO TIP** - claims generally pass through "in process at clearinghouse/payer" pretty quickly, so don't be alarmed if you don't see claims in these statuses. The most important one is **Payer Acknowledged**. This means the insurance company/payer has accepted the claim into their system for processing. On average, it takes a payer around ~30-35 days to process a claim. Some payers are faster, and some, like work comp/auto accident, are slower. Claims will remain in the "Payer Acknowledged" status until we receive either an additional 277/status update or an 835/ERA file.

- Once the payer processes the claim and calculates any adjustment amount, any amount that is due from the payer, and any amount due from the patient, they will send the information back through the clearinghouse and to your DrChrono account via an ERA or 835 file (provided you are set up to receive ERAs from the payer. If not, they will generate a paper EOB and mail it to the address on record. The client will also receive a paper check/loaded debit card if they have not signed up for EFT.)
    - This information will be updated in each patient account, per line item. Some settings can be enabled that will automatically change the status to "paid in full" or "balance due" depending on how each claim is adjudicated.
    - All of your ERAs/Remittance Reports are listed under Billing > Remittance Reports. You can find more information about this section here.
    - ERAs are posted automatically as we receive them. There is a setting that can be enabled that will hold the ERA until you manually review and/or confirm that the matching EFT deposit has been received. It will post as soon as you mark the ERA confirmed. These ERAs will also be found under Billing > Remittance Reports.

- A detailed explanation of all of the claim statuses you may see in DrChrono can be accessedhere.