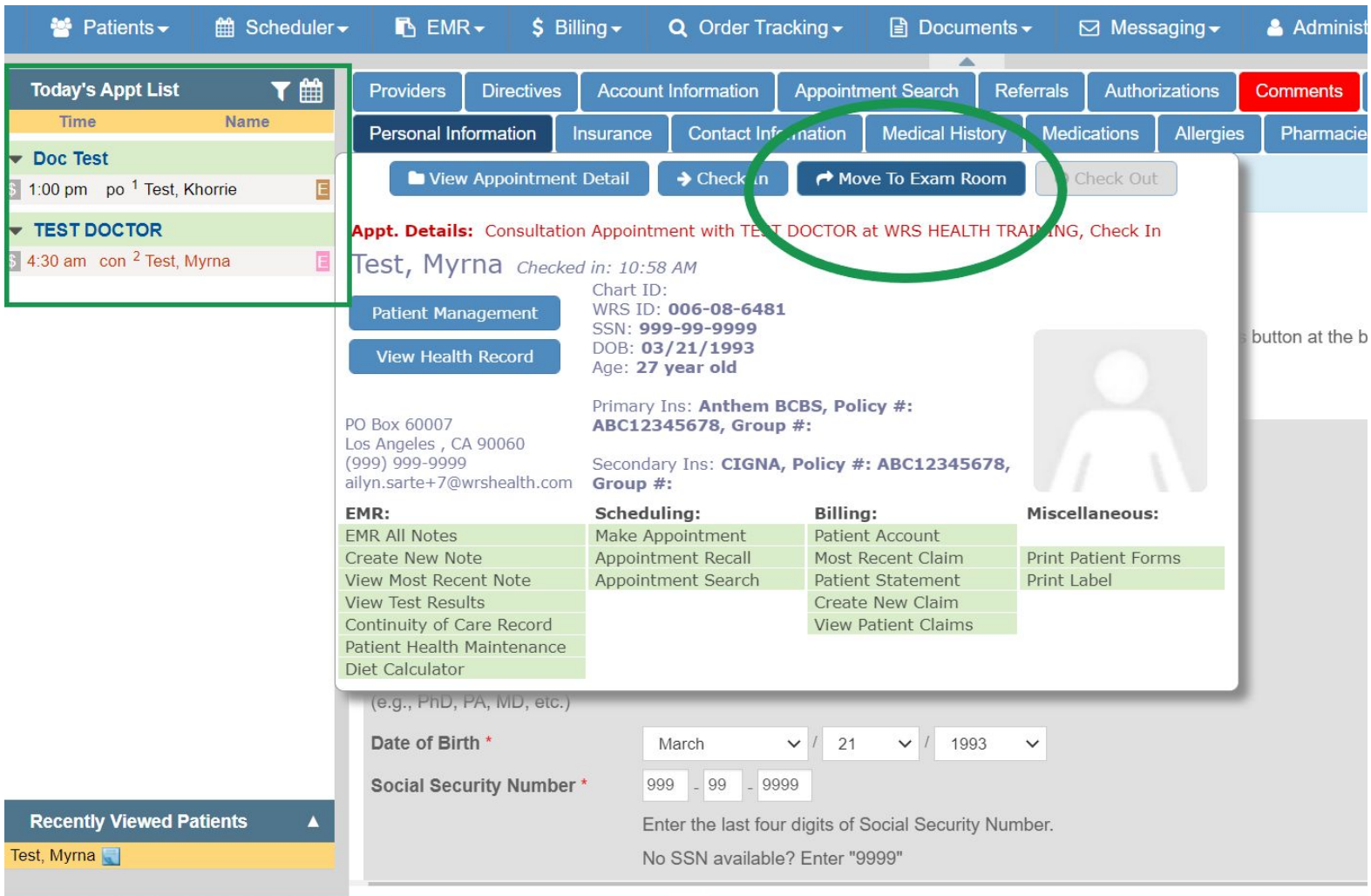**How to create a claim from the CREATE CLAIMS queue:**

Review the appointment list. This contains the patients scheduled to specific providers and locations. Front Desk performs the check-in and check-out workflow.

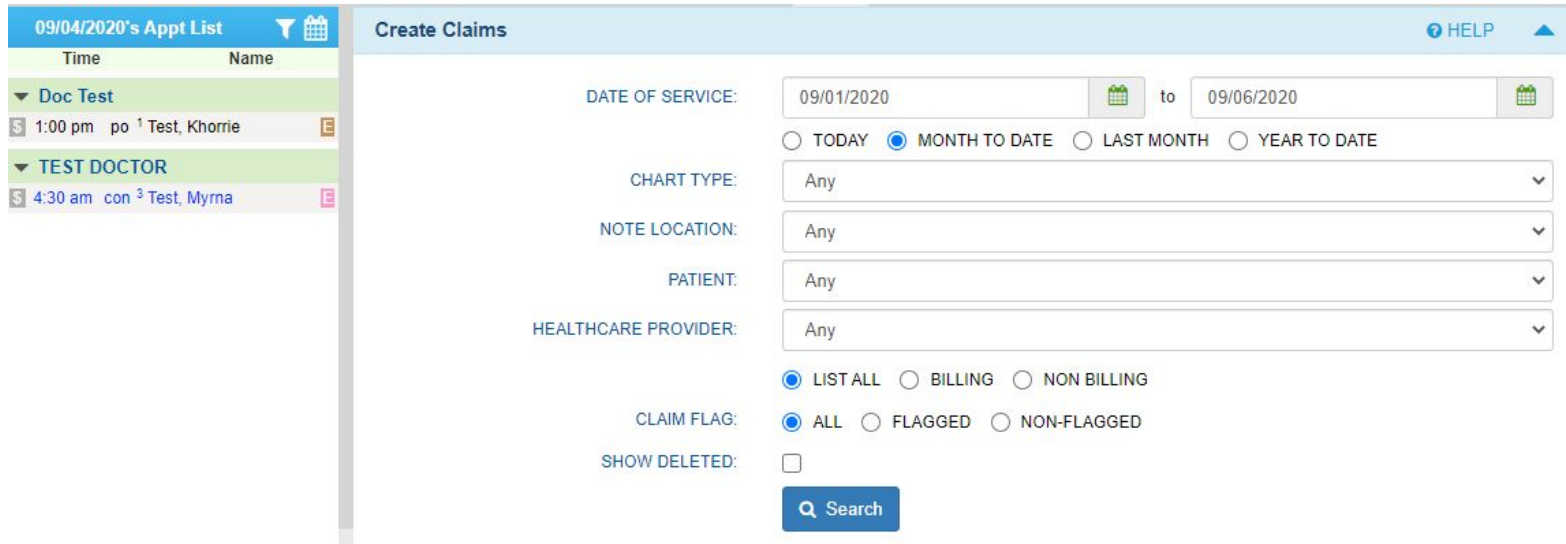When the option *Move To Exam Room* is clicked, the system automatically prepares the EMR NOTE.

*Clinical Date* - this is going to be the date of service on the claim. Click the calendar icon to modify.

*Orders & Procedures* tab - allows the user to enter CPT, Modifier, and ICD Codes

The CPT, Modifier, and ICD Codes entered in the superbill in the EMR Note automatically populate in the CMS 1500/claim form.

## CREATE CLAIMS section

To create a claim from the EMR note, go to **Billing > Claims > Create Claims**



Select the filters to pull the notes:

*Date of service* - select a date range by clicking the calendar icon. Year to Date option ensures that all claims including from older date of service are pulled up.

*Chart type* - filter the notes either signed or unsigned

*Note Location* - filter the notes by location

*Patient* - pull up notes by patient name. Choosing **Any** pulls up all patients in the queue

*Healthcare Provider* - you can bill one provider at a time. Choosing **Any** pulls up all providers in the claims queue.

*LIST ALL / BILLING / NON BILLING* - select **List All** to pull up all billable and non-billable notes (i.e. prescription notes, hospital encounters, phone conversations)

*CLAIM FLAG* - select to pull up flagged or non-flagged notes

You can also choose *Show Deleted* to view all "deleted" notes. Deleted notes are notes that the provider wanted to keep in the chart but will not be billed. An example would be a prescription refill note.

Once you choose your filters depending on the practice policy, click *Search*. Here you will see a list of notes waiting for claims to be created.



The results page will show up to 20 notes. You can move to the next page by selecting the options at the bottom of the screen.

On the far right, you will see the buttons: *V for view note, S for view superbill, R for a referral letter, and the trash bin to delete a note.*



Deleting a note in the create claims queue does not delete the note on the patient's chart.

| | | CREATE CLAIM | DATE OF SERVICE | PATIENT |
|---|---|---|---|---|
| ☐ | 🏳 | Create Claim | 9/1/2020 | **Test, Rachelle** 56 year old, Female, SSN:999-99-9999 |

*Flags* would be used to communicate that this note cannot be billed and the reason should be put in the comments. The provider can review this by selecting *Flagged* from the filters. An example of when to use a flag is when "procedure code is not valid" or "patient is inactive".

The *Create Claim* once clicked, pulls the CMS 1500. The first half of the claim form is pre-populated. It gets data from the patient's demographics.

While the second half of the form shows the ICD, procedure codes, modifiers entered on the note. Some of the fields, however, does not auto-populate.



**Box 17** is where you would add the referring, rendering, or supervising provider when needed. Chose the provider qualifier from the dropdown and the provider on the next dropdown.

**Box 21A – L** is where diagnosis codes will populate. You can remove or add right into the claim form. You can also type in a question mark and enter to pull up the **ICD-9/10 Lookup** and search for a diagnosis.



**Box 23** is where you will see a prior authorization or referral when one is on file. The CLIA number is also found in the dropdown once added in your billing setup.

**Box 24** is the procedure or CPT coding area. Above the date of service populates the NDC code, when applicable. You can type in a question mark in 24D to search for a CPT code by name. You can also reassign a diagnosis to a CPT in Box 24E.

| 24. A. DATE(S) OF SERVICE | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| From MM | DD | YY | To MM | DD | YY | | | CPT/HCPCS | MODIFIER | | | | | | |
| 1  09 | 06 | 2020 | 09 | 06 | 2020 | 11 ▾ | ▾ | 99214 | ▾ | ABC | 300.00 | 1 | | NPI | |
| N470069000501 [CYANOCOBALAMIN 1,000 MCG ▾ | ML | | | | | | | | | | | | | | |
| 2  09 | 06 | 2020 | 09 | 06 | 2020 | 11 ▾ | ▾ | J3420 | ▾ | ABCD |  | 1 | | NPI | |
| 3 | | | | | | ▾ | ▾ | | ▾ | | | | | NPI | |
| 4 | | | | | | ▾ | ▾ | | ▾ | | | | | NPI | |
| 5 | | | | | | ▾ | ▾ | | ▾ | | | | | NPI | |
| 6 | | | | | | ▾ | ▾ | | ▾ | | | | | NPI | |

**Box 24J** - The rendering provider NPI will automatically crossover to the clearinghouse. There is no need to manually enter the information in this box unless you are mailing a paper claim.

You can only enter up to 6 procedure codes unless already added in the EMR note. Once all fields are reviewed, you are now ready to verify by choosing the following options:

| Verify and Submit Electronically | Verify and Drop To Paper | Send To Hold Queue |
|---|---|---|

If you are ready to submit your claim, click *Verify and Submit Electronically*, this scrubs the claim using the CCI National Correct Coding Initiative edits as well as the LCD, Local Coverage Decision edits. If your claim passes these edits, a claim number will be assigned (also populated in Box 26) and the claim will be transmitted to the clearinghouse at midnight. If the claim is not accepted, the system will show the error reason and allow you to make changes before submitting it again.

*Verify and Drop To Paper* will allow you to print the CMS1500 and manually mail the claim form. *Send To Hold Queue* puts the claim on hold. Both options do not submit the claim to the clearinghouse.