Failure Description					Cause(s) of Failure		
Failure Point	**Description of failure point in the claim submission process**	**Magnitude of Impact** (e.g., high, moderate, low)	**Frequency** (e.g., common, occasional, rare)	**Prevalence** (e.g., widespread, isolated)	**Cause #1**	**Cause #2**	**Cause #3**
Provider claim creation	Incomplete information - business rules.	Low	Rare	Isolated	Biller Training	Provider closes encounter unfinished	EHR missing required field
Provider claim creation	Invalid codes - deleted, local codes, code combinations.	**High**	**Common**	**Widespread**	Untimely system updates	Scanning errors	
Provider claim creation	Missing or incomplete data on scanned claims.	Low	Rare	Isolated	Scanning errors	Lack of edits	Misdirects
Provider claim creation	Paper claims from facilities.	Low	Occasional	**Widespread**	Biller training	Misunderstandin g DOFR	Attachments
Provider claim creation	Misunderstanding DOFR - financial responsibility unclear. Splitting claims.	Low	Occasional	Isolated	Biller training	Unclear billing guidelines from health plans for how claims should be billed	Provders do not have access to DOFR between health plan and group or hospital. Therefore, do not understand what procedure should be directed to another payer.
Provider claim creation	Multiple submissions of same services. (Duplicate claim)	Moderate	**Common**	**Widespread**	Not timely reconciliation or review of the denial reason code explaining the claim was forwarded to the correct payer	Short billing cycle	Misunderstand DOFR

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Provider claim creation	Corrected claims are not submitted as 'corrections'.	Moderate	**Common**	**Widespread**	Easier to resubmit	Lack of training	PMG system does not auto default to a corrected claim type when the biller is correcting a claim
Claim adjudication system	Lack of front end edits.	Low		Isolated	New system	Resources	Company policy
Claim adjudication system	Multiple data sources to create encounters.	Moderate	**Common**	Isolated	Adjudication system does not store all claim data	Incomplete incoming data	Default data
Claim adjudication system	Unclean data.	Low	Occasional	Isolated	Insufficient front end edits	Lack of complete or timely code updates	Payment policy for minimal requirements
Claim adjudication system	Incomplete data.	Low	Occasional	Isolated	Mapping from multiple data sources	Insufficient front end edits	Melissa data not perfect
Claim adjudication system	Erroneous denials. I.e. Encounter denies for invalid code or combination but the codes are valid.	Moderate	Occasional	**Widespread**	Insufficient detail in programming DOFR	Claims editing system may be denying based on rules in core product	
Mailroom	Sorting errors for paper claims.	Low	Rare	Isolated	Policy	Training	Resources
Practice Management System	May alter claim information - i.e rearranging diagnosis order, dropping codes etc.	Low	Occasional	isolated	System design	Difficult to change	
Practice Management System	Lacks capability to correct a claim accurately.	Low	Occasional				
Practice Management System	Diagnoses greater than 12 potentially drop or lost.	Low	Rare				
Direct Submission (no clearinghouse)	Lack of edits .	Low	**Common**	**Widespread**	Incomplete information	Incorrect information	

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Inbound Clearinghouse Edits	Claims that should error out get through	Low	Occasional	Isolated	Multiple platforms	Failure, frequent or late code updates	Edits inconsistent among entities
Inbound Clearinghouse Edits	Eligibility Edits	**High**	**Common**	**Widespread**	Name form mismatch	Missing newborns	Eligibility not up to date
Limitations of ANSI format	No good way to submit more than max number Dx	Low	Rare	**Widespread**	Regulatory		
Clearinghouse Edits	SNIP level edits being applied in varying degrees by clearinghouse.	**High**	**Common**	**Widespread**	Portal not available for all CH	Can only fix one error at a time	Insufficient staffing
Healthplan/Healthplan partner Edits	SNIP level edits being applied in varying degrees by healthplans.	**High**	**Common**	**Widespread**			
Clearinghouse Capability	Clearinghouses are sometimes not capable of changing the edits they have in place.	**High**	**Common**	**Widespread**			
Clearinghouse Edits	Duplicate logic is not consistent.	**High**	**Common**	**Widespread**	There is no industry best practice developed		
Clearinghouse Edits	Drop to paper for HIPAA errors.	Low	**Common**		Misdirects missing data		
Clearinghouse Edits	Medical group sends a claim typ 7 but initial claim had an edit from health plan, so claim type 7 claim fails as no initial claim is recorded at clearinghouse.	Moderate	**Common**		Corrected claims are submitted and the provider does not recognized original edited at payer.		
Company Policies and Procedures	Internal policies do not align with external requirements.	Low	Occasional		Payment policy/deny one line, pay the rest	Lack of integration with other depts	Lack of assigned resources
Difference between EC and Payer formats	Loss of data.	Low	Occasional	**Widespread**	Regulatory	Edits	

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Encounter file corrections	Encounter errors are not corrected or followed up.	Moderate	**Common**		Resources	Enrollment errors	Volume
Encounter file creation	Sequential internal processes must run without failures.	Moderate	True		System updates post check run	Computer resource allocation	Unknown system issues
Encounter file creation	Excessive encounter errors.	Moderate	Occasional	Isolated	Lack of filtering	Pay claims with errors	Sweeps
Encounter file tracking	Encounters or files could be missing, fail to send.	Low	Rare	**Widespread**	File tracking process may be manual	Insufficient standard reporting	
Enrollment	Time gap for receipt of enrollment files.	**High**	**Common**	**Widespread**	Timing of files		
Enrollment	Claims Processing errors or delays due to enrollment.	**High**	**Common**	**Widespread**	Mismatches due to inconsistent demo details	New borns/twins/multiple	Incorrect information
Health Plan	Enrollment edits.	**High**	**Common**	**Widespread**	Mismatch		
Health Plan	Paid claim/encounter failure .	Moderate	Occasional	Isolated	Suspended enrollment	Out of synch edits	Duplicate criteria
Health Plan	Duplicate logic is not consistent with our system duplicate logic.	**High**	**Common**	**Widespread**	Differences in duplicate criteria	Paid dupe off denied	
Health Plan	Edits for new requirements.	Low	Rare	**Widespread**	Not enough time		
Health Plan	Lack of relationship between submitters and Health Plans.	Low	True	Isolated	Insufficient contact	Lack of comparable reports	lack of detailed info from DHCS, Medicare
Health Plan	Delay in Health Plans sending second level edits				Legacy reports are difficult to parse and submit via edi or cvs file.		
Health Plan	Health Plan Portal does not have capability to search to verify claim filed into health plan system						
Health Plan Receipt	Failing timliness requirements	Moderate	Occasional	**Widespread**	Too strict considering process		

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Outbound Clearinghouse	Error corrections and limitations.	Moderate	Occasional	**Widespread**	Inefficient process (one at a time)	Burden on middleman	
Outbound clearinghouse	Edit corrections do not get updated in payer data storage.	Low		Isolated	Manual process to update DW		
Codes not on cross walk	Codes that are valid on the MCL fee schedule but considered invalid at DHCS. Local codes need to be cross walked to national codes or local codes completely removed.	**High**	**Common**	**Widespread**			
Newborns rejections	Using Mothers CIN to submit newborn claims. Claims getting rejected. DHCS guidance on avoiding duplicate rejections for newborn claims is not applicable to facility claims.	**High**	**Common**	**Widespread**			
Health Plan and Third party submitted data to DHCS or CMS	Health Plans have difficulty reporting Edits from DHCS and CMS specific to submitter	Moderate	**Common**		Health plans can't easily parse data by submitter as third parties don't capture in their submission data.		