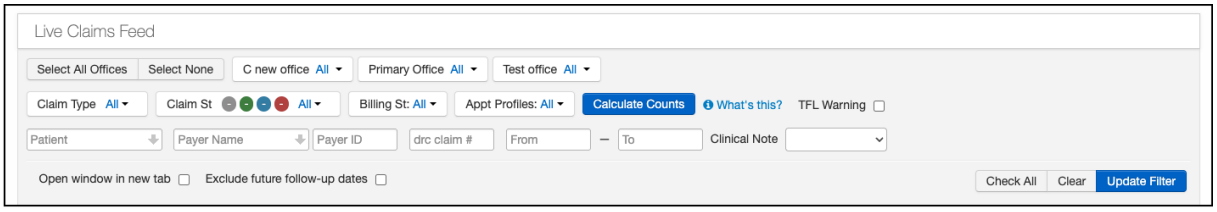
ePS Claim Validation

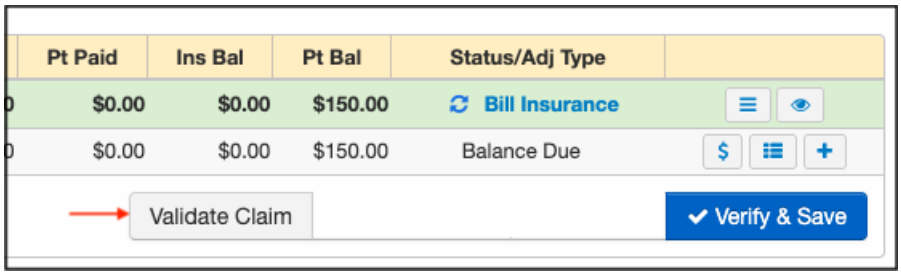
Last modified on 03/19/2026 11:44 am EDT

Customers utilizing eProvider Solutions (ePS) can now validate claims on demand. This ability will identify any errors quickly and allow for correction before the claim is submitted to the clearinghouse for processing.

1. Navigate to **Billing > Live Claims Feed**
2. Pull up the claim needing validation by entering the patient's name, billing status, or date of service.



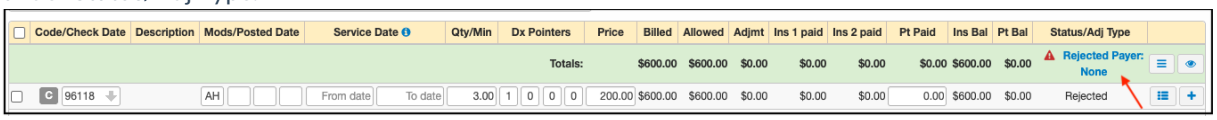
3. Scroll down to the area where the charges appear.
4. Press **Validate Claim**.



5. Any upfront errors found will be notated so they can be adjusted prior to submission.
6. The following list is of common, but not all-inclusive, upfront edits. Please note that upfront edits can be specific to a payer and may not be included in this list.

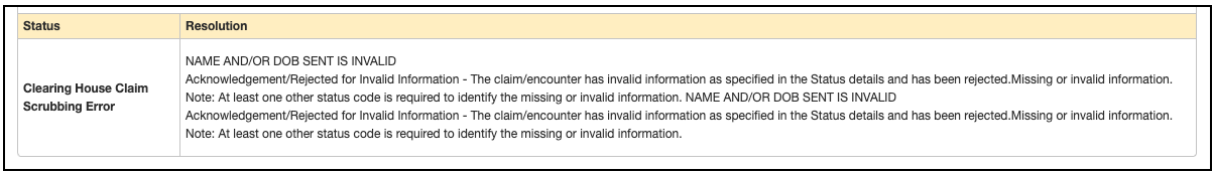
- **National Correct Coding Initiative (NCCI) Edits:** These edits prevent improper payment when incorrect code combinations are reported for procedures (Procedure-to-Procedure or PTP edits) or when services are reported with incorrect units of service (Medically Unlikely Edits or MUEs).
- **Correct Coding or ICD-10-CM Edits:** These edits verify that the submitted claim uses the correct and most specific ICD-10-CM codes to support the medical necessity of the services provided.
- **Generic Edits:** These edits ensure the accuracy of elements required on every claim, such as patient and facility names, according to standard formats like 837I or 837P.
- **All Payer Edits:** These edits are based on standard implementation guides and check for compliance and code validity across various code sets like ICD-10, HCPCS, and CPT.
- **Medicare Specific Edits:** Medicare has specific requirements that necessitate unique edits to ensure compliance for claims submitted to them.
- **Duplicate Claim Edits:** These edits prevent the submission of duplicate claims for the same services rendered to the same patient.
- **Medical Necessity Edits:** These edits ensure that procedures are appropriate for the patient's diagnosis and that supporting documentation is present.
- **Age and Gender Specific Edits:** These edits ensure that procedures are appropriately billed according to the patient's age and gender.
- **Outdated or Invalid Information:** Checks for inaccurate patient demographics, outdated insurance information, incorrect provider NPIs, and expired insurance coverage.
- **Missing or Incorrect Pre-authorizations:** Ensures that required pre-authorizations are obtained and documented before submitting claims for certain procedures or services.
- **Incorrect Modifiers:** Verifies that necessary modifiers are included on claims to avoid denials for improper bundling.

7. If the claim does not successfully pass all of the upfront edits, a message will appear in the patient's claim under Status/Adj Type.



8. Depending on how the information is returned to DrChrono, the abbreviated reason may or may not tell you what the exact error is. More information about the rejection can be found by pressing on the blue words "Rejected Payer: None" (for the example above).

9. A window will open with additional information regarding the rejection. Once that is known, the information on the claim can be updated and then resubmitted to the clearinghouse.



Status	Resolution
Clearing House Claim Scrubbing Error	NAME AND/OR DOB SENT IS INVALID Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information. NAME AND/OR DOB SENT IS INVALID Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.