Claims Data Frequently Asked Questions

Q: Which patients will I see in the MX Platform?
A: Clinical users may search and view records for the individuals with whom they have a treatment relationship. Payers may only search for and view records for individuals actively covered by their health plan(s) as reflected in their active eligibility file with MX.

Q: As a payer, how often does my eligibility file need to be updated?
A: Your organization can choose to upload eligibility files daily, weekly, biweekly, or monthly. If your organization chooses to provide incremental daily updates to MX, you must upload a new complete and current eligibility file with MX at least once every 30 days. If your organization chooses to update weekly or monthly, you must upload a new complete and current eligibility file at least once every 45 days.

Q: As a payer, what happens if I don't send MX a complete and current new eligibility file as planned?
A: If your organization chooses to provide incremental daily updates to MX, you must upload a new complete and current eligibility file with MX at least once every 30 days. If your organization chooses to update weekly or monthly, you must upload a new complete and current eligibility file at least once every 45 days. If a new complete eligibility file is not received within the listed timeframes, all user accounts associated with your organization will be deactivated until a new complete elibigiblity file is received. This means that users in your organization will not have access to any of MX products and services.

Q: As a payer, where do I send my eligibility files?
A: You will upload your eligibility files to the MX BrickFTP site.

Q: As a payer, what format should my eligibility file be in?
A: MX prefers files to be sent using a .CSV format, however messages in X12 834 format is also accepted.

Q: What types of claims data is sent to MX?
A: Eligibility files, medical claims, pharmacy claims, and provider files. A provider file is a directory of providers contracted with the health plan.

Q: From the time a provider submits a claim to the time the claim is displayed in the Platform, what is the delay in time?
A: Typically, claims are submitted to the payer within 30 days, there is an additional 1-15 days required for the insurer to process the claim, and one additional day for MX to process the claim. Pharmacy claims (i.e filled medications) will appear within 1-3 days from the time the patient picked up his/her medication.

Q: Why do I see empty fields in some tabs?
A: Some data from claims is not available. You will see the following fields empty if the data is claim-sourced:

- Medications tab: **Form**/**Dose**, **Sig/Instructions** and **Route**

- Encounters tab: **Discharge Date**, **Patient Class**, and **Service Provided**

Q: What is the difference between filled and prescribed medications?
A: **Filled Meds** (claims-sourced data) are medications the patient has picked up from the pharmacy. **Prescribed Meds** (clinically-sourced data) are medications that were prescribed to the patient.

Q: How do I know if the medication is a refill?
A: Medication status will indicate whether this is a refill (**RP – Refill Claim Paid**) or a new claim (**CP – New Claim Paid**).

Q: Why do some medications have an expand button and other medications do not?
A: If a medication was prescribed or filled more than once, the medications will be grouped together, with the most recent presecription/fill displayed in the default row. To view all past activities related to that medication, click on the **Expand** button to the left of the medication name.

Q: Why am I seeing some historical medications (medications prescribed/filled over 90 days) grouped together with recent medications (meds prescribed/filled within 90 days)?
A: In order to keep repeat prescriptions and filled medications in one location, the entire group will either be placed under **Recent** or **Historical**. For example, if the default row was prescribed or filled within the past 90 days, the grouped medications will all be displayed in the **Recent Medications** table. If the default row was prescribed or filled over 90 days ago, the grouped medications will all be displayed in the **Historical Medications** table.

Q: At times, a claim will have more than one diagnosis. How are the diagnoses displayed?
A: In the diagnoses tab, primary diagnoses are identified as **Principal claims**. You will also see **Admission Claims** displayed in this tab. If a claim is not the primary or admission claim, it will be identified as **Other Claims** (e.g., secondary diagnoses, etc.).

Q: What are the different types of statuses that will be displayed for diagnoses?
A: Claims data will display a status of **Final** and clinical data will display a status of **Active** or **Inactive**.

Q: What does an inactive status mean in the problems & diagnoses tab?
A: **Inactive** means the diagnosis is no longer relevant. The diagnosis is part of the patient's past medical condition, but this is now a resolved past health issue.

Q: Does claims data include a patient's discharge disposition in the Encounter tab?
A: **Discharge Disposition** can be populated by claims data however it is rarely sent by health plans, so it is common for this field to be left blank.

Q: In patient demographics, is the PCP being displayed from claims-sourced data?
A: No, the **PCP** in the patient's demographics is clinically-sourced data from participating hospitals and clinics.