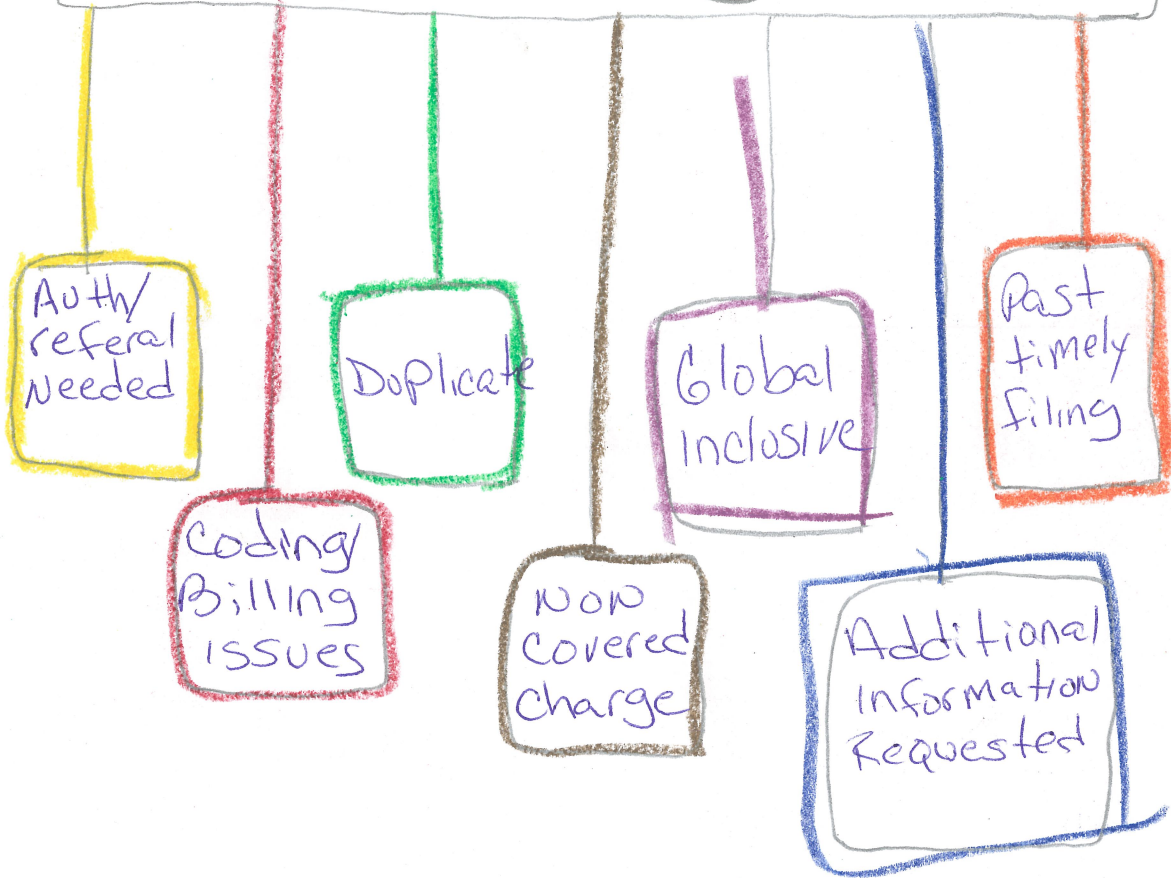


Claim Has Denied



Claim denied for no authorization/referral.

Contact carrier. Was claim processed in network or out of network.

Claim has processed correctly as in network provider. Medical records printed and appeal sent for medical necessity.

Claim processed out of network. Contact with Carrier shows claim processed out of network in error.

Will representative send the claim back for review?

Appeal denied as services were not emergent. Balance is patient responsibility.

Appeal for claim paid.

Claim has been sent back for review. Follow up in 14 days.

Representative will not send the claim back for review. Appeal sent to carrier. Follow up 30 days.

Authorization/referral needed.

1. If you are a network provider verify that the claim processed correctly in network. If claim processed out of network have the claim sent back to process or send appeal stating that claim processed incorrectly out of network.
2. If you are not a network provider you may send an appeal with medical records attached stating to reprocess and pay claim based on medical necessity.

Notes on account should include:

Claim number

Denial date

Processed in or out of network

Coding Denial
CPT/DX/Modifier

Contact made with carrier.

Claim denied in error
and has been sent back
to process.

Coding review
performed and claim
rebilled.

Claim denied
correctly
for ~~error~~
coding error

forwarded
to Physician
for review

corrected
and rebilled
as a
corrected
claim

Claim denied as a duplicate
Verify that your office has not
Sent two claims for this date
of service.

Only 1 claim
billed.
Contact with
Carrier shows
other claim billed
under a different
NPI or tax ID,
will representative
Send claim back
to process?

Rep.
Sent claim
back to
process for
payment

Rep will not
Send claim
back to process.
Send appeal
with medical
records

Two claims
billed. If
additional
charges were
added combine
charges and
rebill as corrected
claim.
If two identical
claims sent in
error void
claim.

Claim denied as non-covered
contact the carrier

Claim denied
Correctly.
What is noncovered -
the diagnosis or
CPT Code?

Is the diagnosis
a Policy exclusion
(ex - Obesity related
Dx)

Send back to the
Physician to see
if diagnosis can be
changed

Claim denied
in error
and claim
has been
sent back
to process

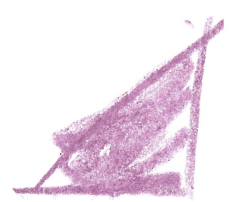
Dx updated
and re-billed
claim billed
as corrected claim

Physician unable to change
Dx - Appeal with medical
records

Claim denied AS ^{Global}Inclusive

Claim denied and has been sent back to Process

Claim is Global Inclusive to Claim _____
Resolved Account.



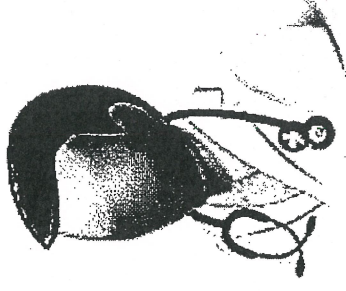
GLOBAL SURGICAL PACKAGE

- The global surgical package is a single payment for all care associated with a surgical procedure. Within 10 days.
- Other names for the Global Surgical Package include: Postoperative Period, Global Period, Global Services, Surgical Period, Global package and Global Surgery.
- Care of a patient during the global surgical period is not restricted to any specific location. A patient may be treated by the surgeon (or other provider of the same medical group and specialty) in just about any location including: inpatient hospital, outpatient hospital, ambulatory surgical nursing home, surgeon's office, emergency room, urgent care, and even the intensive care unit of a hospital.

NO CHARGE SERVICES:

There are several services that are not charged services as they are associated with another service.

- Suture removal placed at *this office* ~~our facility~~
- Routine I&D follow up
- Sprain follow up
- Corneal abrasion follow up



Additional information requested



Additional information requested from provider.
See attached.

Additional information requested from the patient.
See attached.

Applied to patient responsibility.

Claim paid.

* Primary EOB
* Medical records

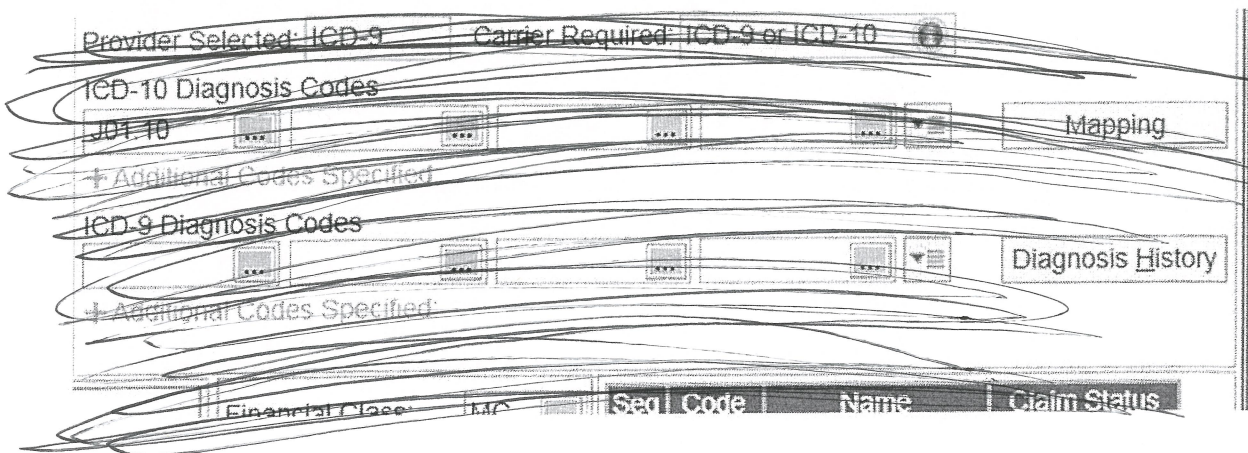
* COB update
* Third Party Liability form

Claim has been denied requesting additional information from the patient:

Carrier Questions for note:

- *Who did you speak to?
- *What is the phone number?
- *What is the claim number?
- *When did the claim deny?
- *What has been requested from the patient? When was the patient last contacted?
- *How can the patient respond to your request? Fax? Phone? Mail?

*Claim denied for Third Party Liability Form/Accident Details (TPL) verify via Advanced MD that the service performed was due to an injury by going to the History tab and double clicking on the date of service of the claim. Click on the diagnosis code and it will show why patient was seen. Below was Acute frontal sinusitis, unspecified. Obviously not an injury. IF services was not for an injury have the rep send claim back to process.



*Claim denied for Coordination of Benefits update (COB) Ask what other carrier they are showing on file. ID number ect...

*Claim denied for missing or incomplete e policy information. What is missing? Have other claims paid? How?

~~*Go to account in Advanced MD Forms See example below.~~

Sincerely,

Patient | Resp Party | Insurance | Referrals | Apps | Tasks | Trans Entry | History | Memos | Notes | Forms | Chart F

~~Templates- Open appropriate letter COB, TPL or Insurance not in effect on DOS.~~

***Make sure it is in Display mode and hit Save. This will create a pop up note every time some one goes into the account.**

***Add your note to the account. Account note should end with : " printed letter to GHA printer to send to the patient.**

***Set next action code to : Pending information from patient. Set follow up for 2 weeks.**

***GHA Specialist will send the patient letter and note the account.**

***Follow up on the account in 2 weeks. IF patient has not responded move balance to patient responsibility – deductible and note the account.**

Pending Information from the Patient

- 1) Claim has been denied or pended by the carrier requesting additional information from the patient:

What is included in account note:

- *How information was obtained.
- *Phone number
- *Claim number
- *Denial date
- *What has been requested from the patient
- *When was the patient last contacted
- *How can the patient respond to request (phone, mail, fax)
- *Timely filing limit

- 2) Third Party Liability Form/Accident Details (TPL)
 - a. verify via Advanced MD that the service performed was due to an injury by going to the History tab and double clicking on the date of service of the claim.
 - b. Click on the diagnosis code and it will show why patient was seen. Below was Acute frontal sinusitis, unspecified. Obviously not an injury. IF services was not for an injury have the rep send claim back to process.

Provider Selected:	ICD-9	Carrier Required:	ICD-9 or ICD-10			
ICD-10 Diagnosis Codes						
J01.10						Mapping
+ Additional Codes Specified						
ICD-9 Diagnosis Codes						
						Diagnosis History
+ Additional Codes Specified						
Financial Class:	MC		Seq	Code	Name	Claim Status

- c. If claim was accurately denied for TPL, in the patient chart, under forms, select the TPL letter.
- d. Print the populated form letter to the GHA printer.
- e. Notate the account that the first TPL letter has been printed.
- f. GHA will notate the account once the first letter is sent

- g. TS will also need to add a Memo (Memo tab) in the patient chart indicating Text "This patient's accounts are currently pended by their insurance for third party liability details. Please have patient contact their insurance to update." And be sure to select the display option.
- h. Set the next action code to: Pending information from patient. Set follow up for 2 weeks.
- i. If in two weeks there has been no response to the TPL letter directly by the patient to ASPG/GHA, TS will need to contact the carrier to confirm if TPL details have been updated.
- j. If TPL details have been updated/received by the carrier please have the claim reprocessed and notate accordingly
 - i. Remove the previous memo from the patient's account
- k. If TPL details have NOT been updated/received by the carrier please print a second TPL letter to the GHA printer and notate accordingly. Keep action code as pending information from the patient and set follow up for 3 weeks.
- l. *Follow up on the account in 3weeks. IF patient has not responded to GHA/ASPG, please contact the carrier for a status update.
- m. If TPL details have been updated/received by the carrier please have the claim reprocessed and notate accordingly.
 - i. Remove the previous memo from the patient's account
- n. If TPL details have NOT been updated/received by the carrier please write off the balance to Bad Debt and notate the account accordingly

3) Coordination of Benefit (COB) details

- a. Request for the carrier to validate those details have not been updated already.
 - i. If they have not, please proceed to submit the COB letter to the patient.
 - 1. If claim was accurately denied for COB, in the patient chart, under forms, select the COB letter.
 - 2. Print the populated form letter to the GHA printer.
 - 3. Notate the account that the first COB letter has been printed.
 - 4. GHA will notate the account once the first letter is sent
 - 5. TS will also need to add a Memo (Memo tab) in the patient chart indicating Text "This patient's accounts are currently pended by their insurance for coordination of benefit details details. Please have patient contact their insurance to update." And be sure to select the display option.
 - 6. Set the next action code to : Pending information from patient. Set follow up for 2 weeks.
 - 7. If in two weeks there has been no response to the TPL letter directly by the patient to ASPG/GHA, TS will need to contact the carrier to confirm if COB details have been updated.
 - 8. If COB details have been updated/received by the carrier please have the claim reprocessed and notate accordingly
 - a. Remove the previous memo from the patient's account
 - 9. If COB details have NOT been updated/received by the carrier please print a second COB letter to the GHA printer and notate accordingly. Keep action code as pending information from the patient and set follow up for 3 weeks.

10. *Follow up on the account in 3weeks. IF patient has not responded to GHA/ASPG, please contact the carrier for a status update.
11. If COB details have been updated/received by the carrier please have the claim reprocessed and notate accordingly.
 - a. Remove the previous memo from the patient's account
12. If COB details have NOT been updated/received by the carrier please write off the balance to Bad Debt and notate the account accordingly
 - ii. If they have, please request the claim be reprocessed

4) Coverage was not in effect for the date of service

- a. If the carrier states there was no coverage for the date of service
 - i. Please identify the date that coverage terminated
 - ii. If the patient never showed as having coverage, please confirm you have the right patient details by referencing the chart scanned documents
 - iii. Populate and print the insurance not in effect for the date of service letter to GHA printer and notate the account
 1. Add a memo to the memo tab that the patient coverage was not in effect for the date of service and to please obtain updated insurance details from the patient
 2. Update the action step to pending information from the patient and set the tickler to 2 weeks
 - iv. If there is no response from the patient or updated insurance information has not been added by the clinic staff a second letter should be sent to the patient and the tickler set to 3 weeks
 - v. If there is no response from the patient at three weeks then the balance should be written off as bad debt.
 - vi. If the patient responds to the letter then the new insurance should be billed.

Pending Information from
Provider

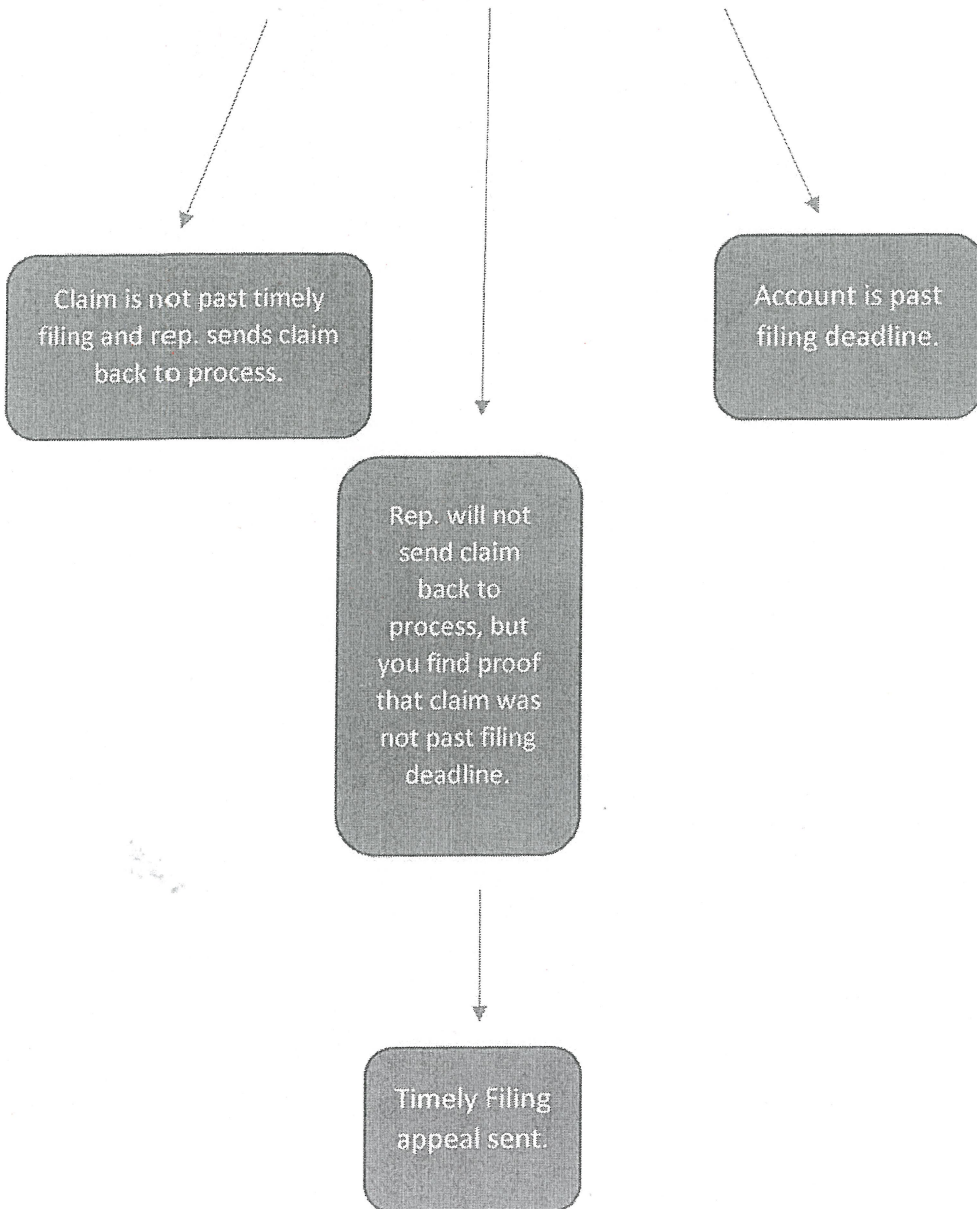
Primary EOB required

Account note will include:

- *How information was obtained
- *Name of representative
- *Phone number
- *Claim number
- *Denial date
- *Name of primary carrier on file

1. Claim has previously been billed to the primary carrier: Print EOB and rebill with claim.
2. Claim was not sent to primary carrier: Send claim to that carrier.
3. Claim was not billed to primary carrier as the patient did not inform clinic of other insurance coverage. Representative supplies primary carrier on file: Call will be made to the carrier to verify: ID number, group number, effective dates, claim address, timely filing deadline. Insurance information will be added to patient information and claim will be sent.
4. Claim was not billed to the primary carrier, representative did not give other health insurance information patient will be sent Coordination of Benefits letter.

Claim/appeal denied for past timely filing.



Past Timely Filing

*Carrier filing Limits:

AARP: Claim: 60 days appeals: 180 days
Aetna: Claim: 120 days appeals: 180 days
BCBS: Claim: 90 days.
Cigna: Claim: 90 days appeals: 180 days
Coventry: Claim 180 days
Humana: Claim 90 days appeals: 18 months
Novitas: 365 days
United: claim 90 days
Tricare: 365 days

*Account notes will include:

- *Claim number
- *Denial date
- *Date the claim/appeal was received.
- *Filing deadline
- *Date original (first) claim or appeal was received?
- *Appeal address
- *Appeal timely filing

* Claim is not past timely filing have the representative send the claim back to process.

*If rep. will not send claim back to process. Send appeal.

~~Claim is past timely filing and it has been verified via the Claim Acknowledgement Report. Send on Spreadsheet to client review.~~