Follow Up:
Resolving Unpaid Insurance Balances

ICAHN Healthcare Billing Webinar Series

Session 2 – April 29th, 2020

ICAHN
Illinois Critical Access Hospital Network

efficientC
developed by OS inc.

Introduction

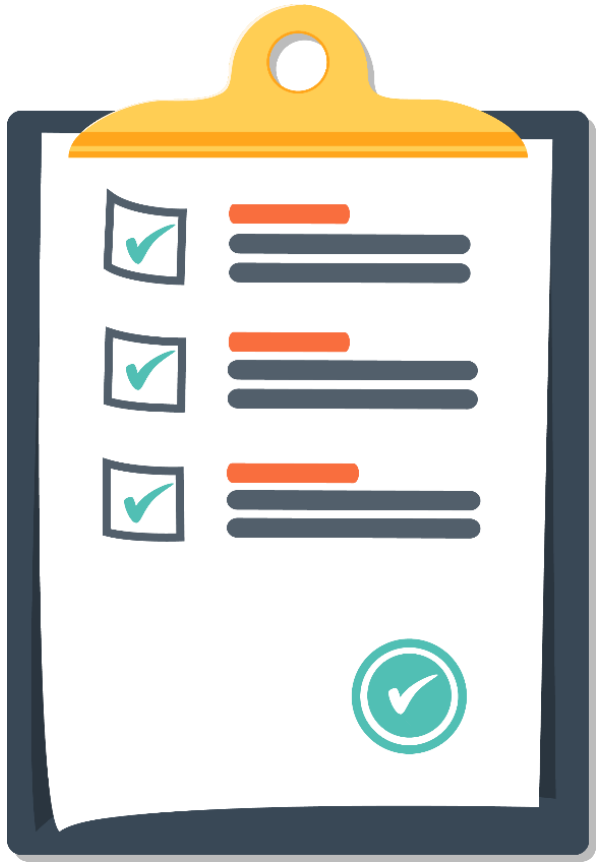
Sue York

efficientC | OS inc.

Director of Learning & Consulting Services

Be Sure to Note & Submit Questions!

Learning Objectives



- Overview of Major Payers
- Prioritizing & Planning Follow Up
- Working ATBs and/or Worklists
- Decision Making Trees

Revenue Cycle Overview

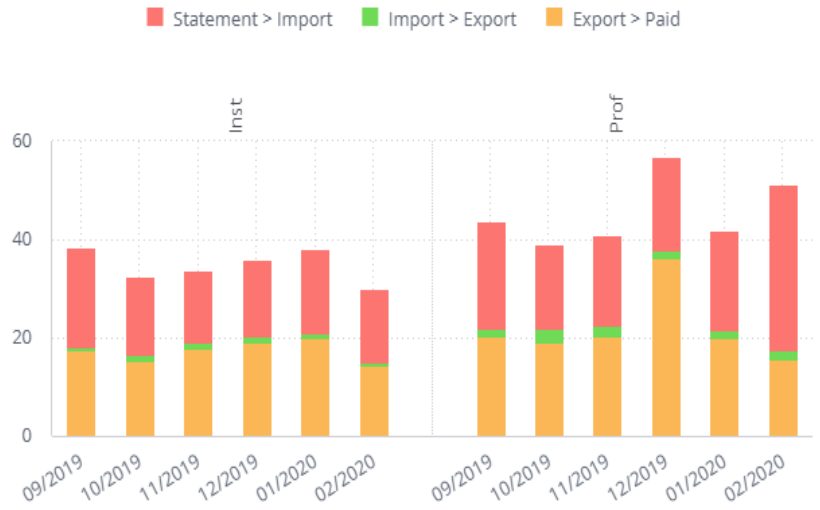
Statement Date To Import

	Current Month	Last 6 Months	Community
Institutional	16.42	16.5	17.25
Professional	25.8	22.5	14.9

Export To Paid

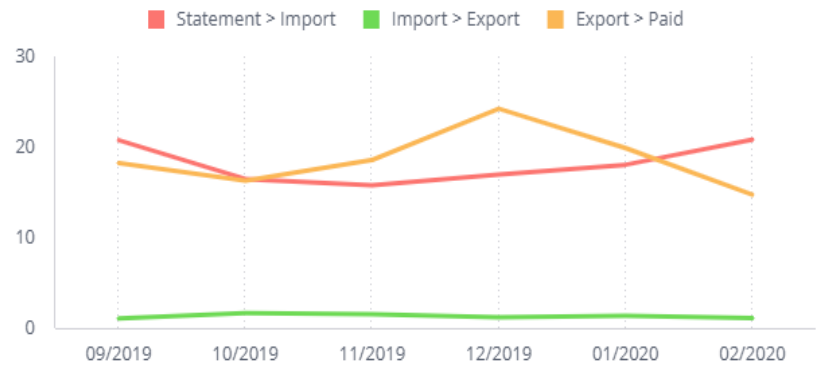
	Current Month	Last 6 Months	Community
Institutional	17.1	17.3	16.9
Professional	15.9	22.2	17.3

Claim Turnaround Trend



Contract	Provider NPI	Month
	All Providers	[-001] 2020 - March

Bill Cycle Trend



Payer Turnaround (3 Months Avg)

Parent Payer	Turnaround
HEALTHLINK MEDICAID	94.0
HEALTHLINK HMO	88.7
PHYSICIAN PARTNERS	78.0
HEALTHEOS PLANS	75.0
WPS	70.7
ILLINOIS MEDICAID	59.1
US DEPARTMENT OF VETERANS AFF	59.0
MERIDIAN HEALTHPLAN	53.5

« ‹ 1 2 3 4 5 6 7 › »
Rows 1-15 (122 Total)

Provider Turnaround (3 Months Avg)

Provider NPI	Turnaround
[redacted]	138.4
[redacted]	115.5
[redacted]	102.0
[redacted]	74.4
[redacted]	69.4
[redacted]	52.8
[redacted]	36.3
[redacted]	29.9
[redacted]	28.5

« ‹ 1 2 3 › »
Rows 1-15 (45 Total)

Type of Bill Turnaround (3 Months Avg)

Claim Type TOB	Turnaround
02	20.2
11	18.2
110	6.0
111	22.0
112	28.3
114	19.3
121	105.6
131	13.8
132	22.9

« ‹ 1 2 3 › »
Rows 1-15 (45 Total)

First Pass Yield

Clear Filters

Current Payment Rate	6 Month Payment Rate	Community 6 Month Payment Rate	Contract	Provider NPI
82.18%	83.40%	83.40%	All Contracts	All Providers

Current Denial Rate	6 Month Denial Rate	Community 6 Month Denial Rate
8.48%	7.96%	7.96%

Current No Response Rate	6 Month No Response Rate	Community 6 Month No Response Rate
9.34%	8.64%	8.64%

Claim Outcomes Over Time

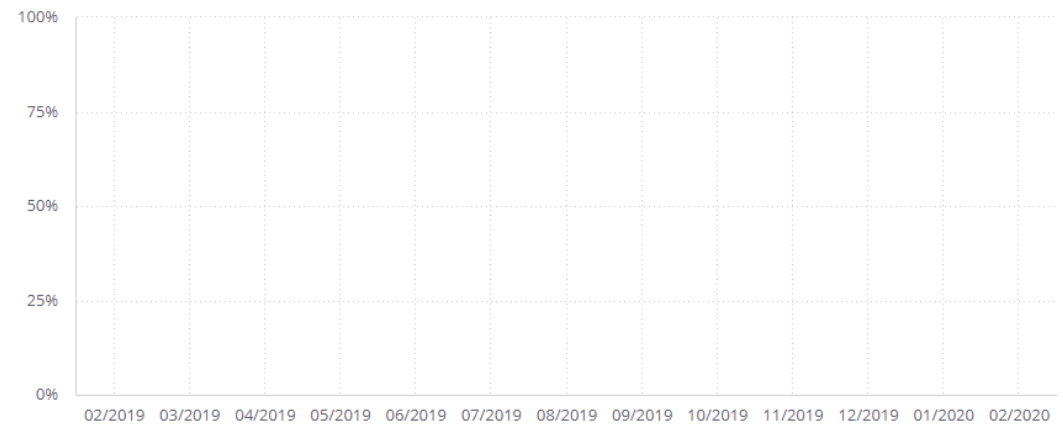
First Pass Yield

First Pass Yield Data Definition

Prioritizing Work

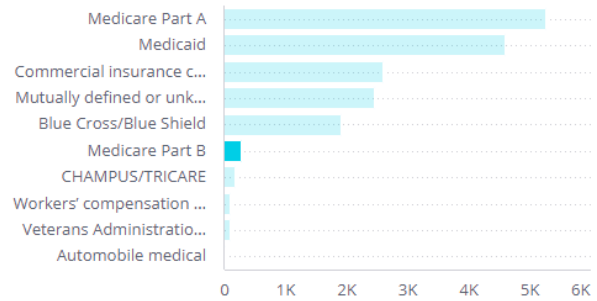
Billing Edits

Clean Claim Rate

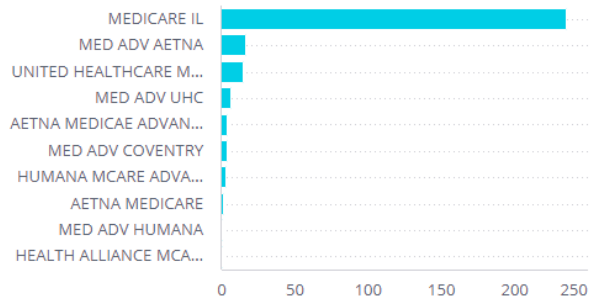


Contract	Provider NPI	Month
	All Providers	[-002] 2020 - February

Payer Code



Top 10 Payers



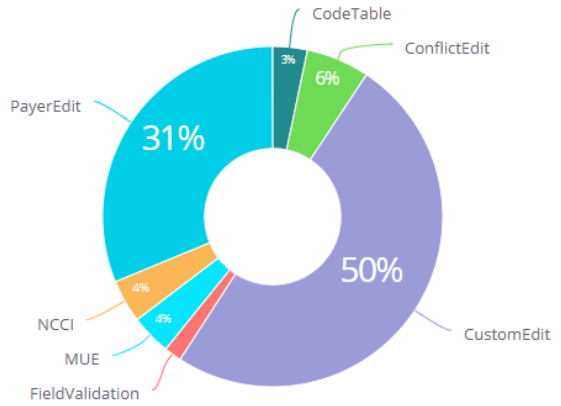
Edit Details

Edit Description	Edit Count
Hold until the correct reading physician is provided	108
Service charge unit of measure is MJ	23
Go live claim hold	22
This claim conflicts with other claim(s). See Notes for details.	22
Units > 1 without modifier reported	15
Medicare ID number is not in the correct format..	14
Charge amounts equal to zero not billable	10
Service Units required	10
Claim frequency of 7 or 8 (corrected claims) are not allowed for PROF claims	9
POS 21, 61, 51 and 52 require an admit date	9

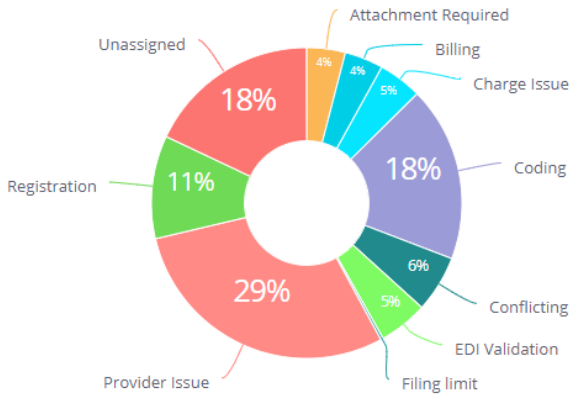
« ‹ 1 2 3 4 5 6 7 › »

Rows 1-10 (88 Total)

Edit Type



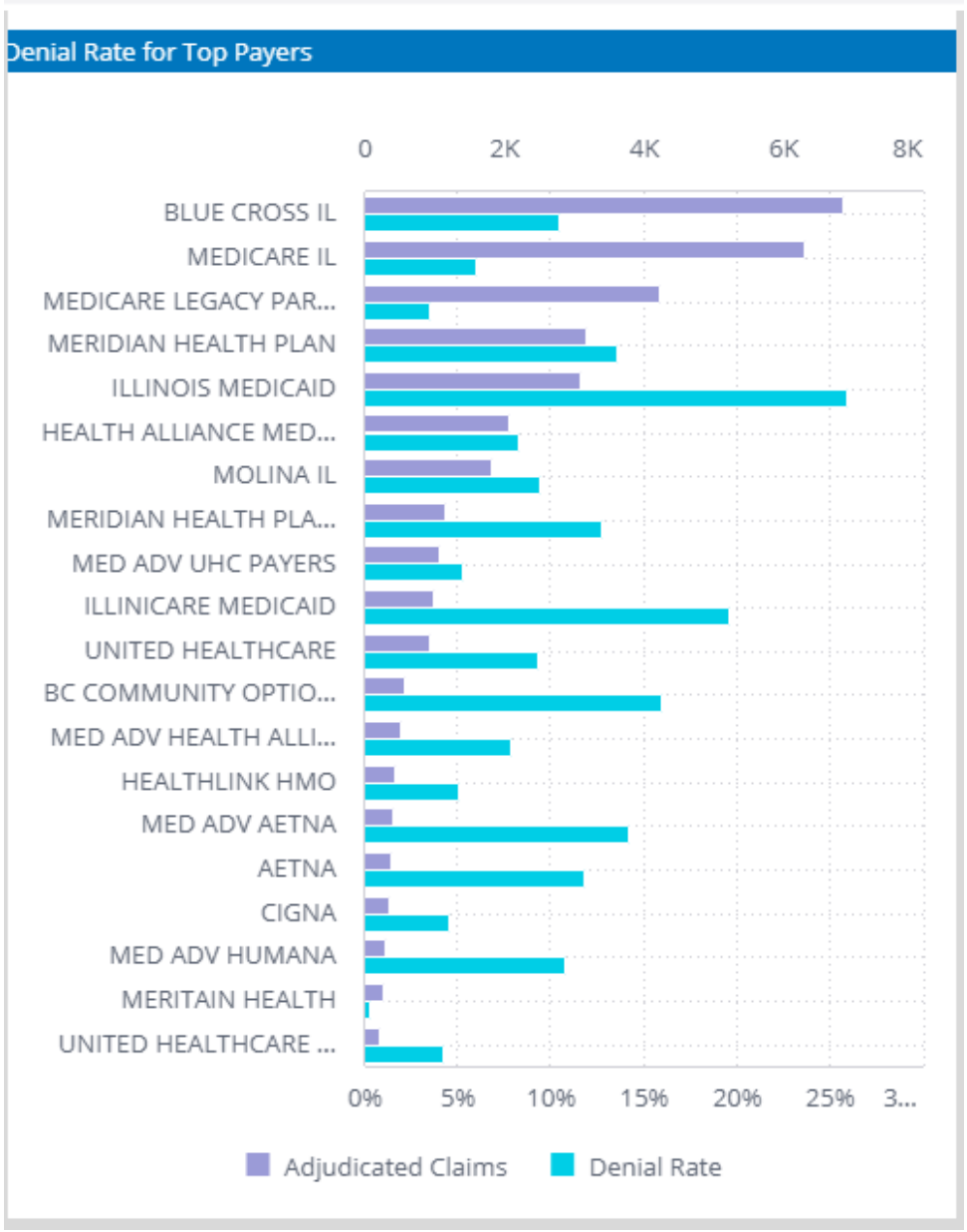
Edit Category



Daily Billing

EDIT REASON	RESPONSIBILITY
Add-on CPT requires a primary code reported. Add-on code pairings can be found in CMS Medicare Transmittal 2636. Change request 7501. Infusion charge found on claim	HIM/CODING
Adjustment claim requires original DCN	Billing
Admit DX required on this TOB Principal DX is required	HIM/CODING
Ambulance claim requires pick up location Ambulance claim requires Distance Ambulance claim requires drop off location Ambulance Distance is required Pick Up Address Line 1 is required Pick Up City is required Pick Up State is required Pick Up Zip is required Drop Off Address Line 1 is required Drop Off City is required Drop Off State is required Drop Off Zip is required Import date is greater than 365 days from service date, so past Medicaid's filing limit. Ambulance mileage being reported does not match service line units being billed	BILLING OR CHARGE SERVICES
Attending physician required. Attending Physician NPI is required	BILLING OR CHARGE SERVICES
Behavioral Health claims to Medicaid plans require modifier based on provider credentials	HIM/CODING
Cardiac Rehab charges require Occurrence Codes 46 and 11	HIM/CHARGE SERVICES
CCI edit - Component code 11100 requires a modifier if billed with Comprehensive code 11200. Review if modifier is appropriate.	HIM/CODING
CPT 90654-90662, 90672. 90685-90686 or Q2033-Q2039 requires G0008 Vaccine charges with no administration charge	CHARGE SERVICES
CPT or Revenue Code reports requires NDC information for IL Medicaid	CHARGE MASTER
CPT or Revenue Code reports requires NDC information for IL Medicaid CPT or Revenue Code reports requires NDC information for IL Medicaid	HIM/CODING
Diagnosis code E11329 is not valid for the statement dates in the ICD-10 code set.	HIM/CODING
DX code is exempt from reporting POA according to the Code Table.	HIM/CODING
External Cause of Injury codes cannot be listed as primary.	HIM/CODING
G0008 requires CPT 90630, 90654-90662, 90672, 90685-90688 or Q2033-Q2039 Vaccine administration charge requires associated drug charge reported under revenue code 636.	CHARGE SERVICES
GEHA ID must be 8 digits long	PATIENT ACCESS
Incidental only services not payable by Medicare Incidental only services not payable by Medicare Incidental only services not payable by Medicare	CHARGES SERVICES
Invalid generic payer name	PATIENT ACCESS
Invalid subscriber ID number	PATIENT ACCESS
J0881-J0886 Require modifier EA EB or EC J0881-J0886 Require value codes 48 or 49.	HIM/CODING
Medical visit on the same day as a type T or S procedure without modifier 25 CCI edit - Component code G0463 requires a modifier if billed with Comprehensive code 96365. Review if modifier is appropriate.	HIM/CODING
Medicare ID # Invalid for regular Medicare; ID is a RailRoad Medicare ID. Medicare ID # Invalid	PATIENT ACCESS
PT/OT services require approved rendering provider.	CHARGE SERVICES
Revenue code 36X requires CPT	HIM/CODING
Service date cannot be prior to admission date.	CHARGE SERVICES
Service Date must be between Statement From Date and Statement Thru Date.	CHARGE SERVICES
Units exceed MUE allowable per DOS for CPT 97163 - 1	HIM/CODING
Units exceed MUE allowable per DOS for CPT 99221 - 1 Units exceed MUE allowable per DOS for CPT 99221 – 1	HIM/CODING
Value N300 is not found in CT_DiagnosisCode for Coding Diagnosis Code 2 in the 2 code set.	HIM/CODING

Denials: Top Payers - Illinois



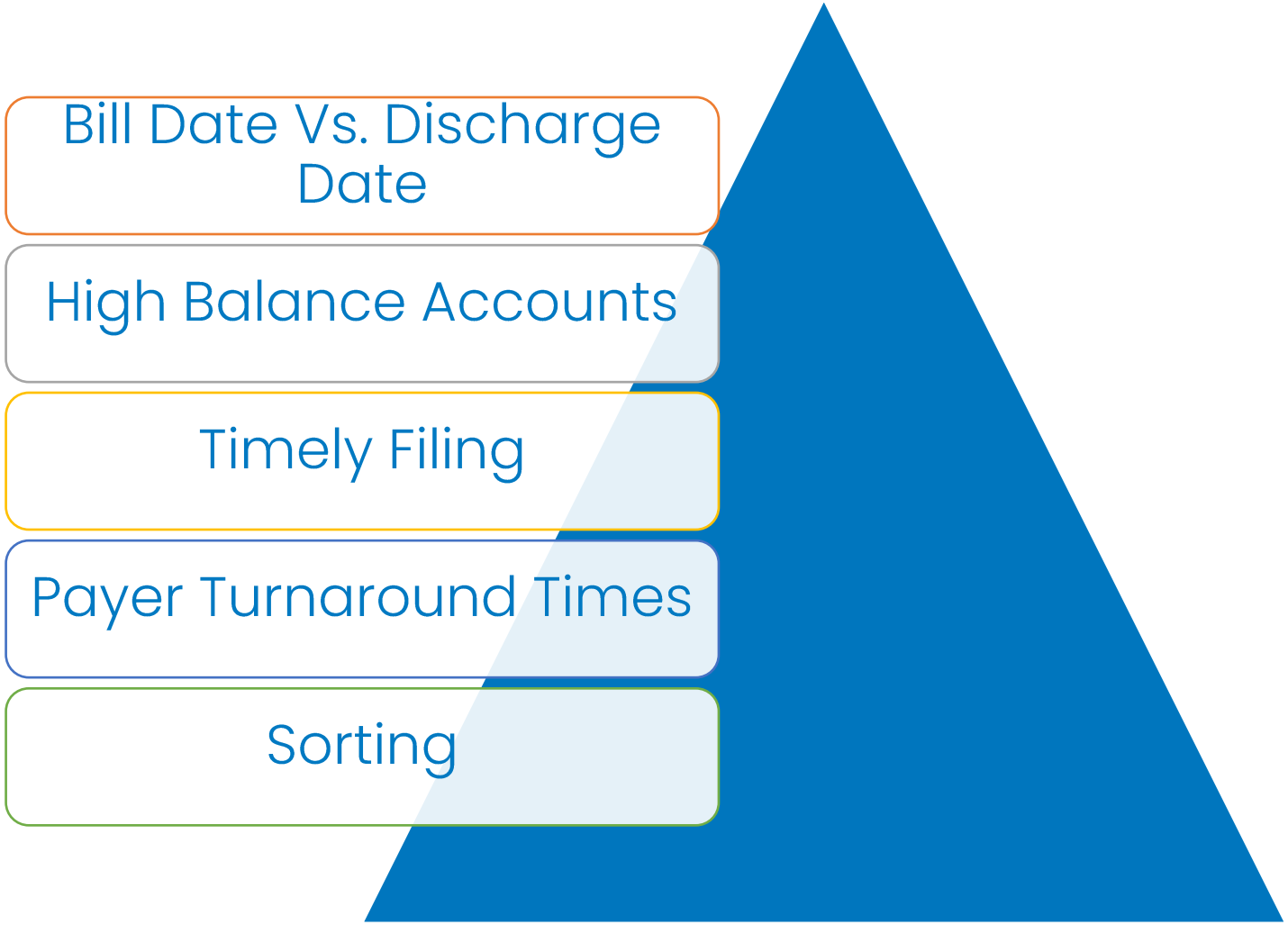
Payer Turnaround Time

Payer	Turnaround		Payer	Turnaround
AARP	30.3		HUMANA	6.3
PHYSICIAN PARTNERS	78.0		MED ADV ADVANTRA FREEDOM	7.6
AETNA	34.3		CIGNA	9.6
AMERIGROUP MEDICAID	10.0		AMERIGROUP MEDICAID	10.0
BC COMMUNITY OPTIONS	10.7		WPS COMMERCIAL	10.0
BCBS OF IL	16.8		MED ADV COVENTRY	10.2
CHAMPVA – HAC	32.1		BC COMMUNITY OPTIONS	10.7
CIGNA	9.6		ILLINICARE MEDICAID	10.7
HUMANA	6.3		TRICARE FOR LIFE	10.8
ILLINICARE	23.0		MERIDIAN HEALTH PLAN MEDICAID	10.8
ILLINICARE MEDICAID	10.7		MED ADV CARE IMPROVEMENT PLUS	11.0
ILLINOIS MEDICAID	59.1		MED ADV BLUE CROSS IL	11.5
MED ADV ADVANTRA FREEDOM	7.6		MED ADV PERSONAL CARE	13.8
MED ADV AETNA	16.2		MED ADV HUMANA	14.4
MED ADV BLUE CROSS IL	11.5		MEDICARE	15.0
MED ADV CARE IMPROVEMENT PLUS	11.0		MEDICARE KY	15.4
MED ADV COVENTRY	10.2		UNITED HEALTHCARE	15.4
MED ADV HEALTH ALLIANCE	16.2		MED ADV HEALTH ALLIANCE	16.2
MED ADV HUMANA	14.4		MED ADV AETNA	16.2
MED ADV MOLINA IL	20.7		BCBS OF IL	16.8
MED ADV PERSONAL CARE	13.8		MED ADV UHC	19.6
MED ADV UHC	19.6		MED ADV MOLINA IL	20.7
MED ADV UHC PAYERS	22.2		MOLINA IL	20.9
MEDICARE	15.0		MED ADV UHC PAYERS	22.2
MEDICARE KY	15.4		ILLINICARE	23.0
MERIDIAN HEALTH PLAN MEDICAID	10.8		AARP	30.3
MERITAIN HEALTH	32.6		CHAMPVA – HAC	32.1
MOLINA IL	20.9		TRIWEST VA REGION 3	32.4
TRICARE FOR LIFE	10.8		MERITAIN HEALTH	32.6
TRIWEST VA REGION 3	32.4		AETNA	34.3
UNITED HEALTHCARE	15.4		ILLINOIS MEDICAID	59.1
VA FEE BASIS	178.9		PHYSICIAN PARTNERS	78.0
WPS COMMERCIAL	10.0		VA FEE BASIS	178.9

Working Follow Up

Leverage
ATBs,
Work
Queues
& Work Lists

Tips & Tricks for Prioritizing



Sorting & Prioritizing Work

Sort ATB by Filing Limit

- ✓ Using the specific payer filing limits, identify those accounts on the ATB
- ✓ Accounts with service dates within 30 days of the payer's filing limits are placed at the top of the ATB
- ✓ Sort by payer name

Sort Remaining Accounts by Dollar Amount

- ✓ Take remaining accounts and sort them by dollar amount.
- ✓ Remove accounts less than 30 days old from bill date if possible
- ✓ Sort by payer name

Working the Insurance Tab of the ATB

Work accounts in this order

1. Accounts closest to the filing limit, grouped by payer
2. Accounts with the highest dollar amount, grouped by payer
   - ✓ $5,000 for hospital (this usually accounts for 2/3 of your outstanding A/R
   - ✓ $1,000 for physician

ATB - Ready to Work

Encntr Number	Admit Date	Disch Date	Current Health Plan	Total Charges	Date Worked	Action Taken	Comments
1-20129	9/20/2016	9/20/2016	AARP Medicare Complete	$ 1,314.20			
1-20128	12/14/2016	12/14/2016	AARP Medicare Complete	$ 508.50			
1-20148	11/26/2016	11/26/2016	Blue Cross Blue Shield Of Illinois	$ 7,906.35			
1-20133	12/1/2016	12/1/2016	Blue Cross Blue Shield Of Illinois	$ 1,268.80			
1-20145	12/24/2016	12/24/2016	Blue Cross Blue Shield Of Illinois	$ 1,254.25			
1-20162	10/18/2016	10/31/2016	Cigna Healthcare	$ 665.90			
1-20173	11/11/2016	11/30/2016	Cigna Healthcare	$ 4,838.00			
1-20163	12/2/2016	12/2/2016	Cigna Healthcare	$ 769.60			
1-20174	12/1/2016	12/30/2016	Cigna Healthcare	$ 3,530.30			
1-20130	5/9/2017	5/9/2017	AARP Medicare Complete	$ 6,405.70			
1-20131	6/12/2017	6/12/2017	Aetna C	$ 6,290.00			
1-20138	5/2/2017	5/2/2017	Blue Cross Blue Shield Of Illinois	$ 6,492.35			
1-20146	3/21/2017	3/21/2017	Blue Cross Blue Shield Of Illinois	$ 6,441.20			
1-20157	3/1/2017	3/1/2017	Blue Cross Blue Shield Of Illinois	$ 6,117.25			
1-20142	5/19/2017	5/19/2017	Blue Cross Blue Shield Of Illinois	$ 5,364.70			
1-20166	3/2/2017	3/2/2017	Cigna Healthcare	$ 8,285.50			
1-20167	5/1/2017	5/1/2017	Cigna Healthcare	$ 7,174.70			
1-20159	5/27/2017	5/27/2017	Cigna Healthcare	$ 6,723.95			
1-20126	5/4/2017	5/4/2017	AARP	$ 2,062.60			
1-20127	2/9/2017	2/9/2017	AARP Medicare Complete	$ 1,349.60			
1-20141	3/6/2017	3/6/2017	Blue Cross Blue Shield Of Illinois	$ 4,185.10			
1-20143	4/29/2017	4/30/2017	Blue Cross Blue Shield Of Illinois	$ 3,275.55			
1-20152	3/4/2017	3/4/2017	Blue Cross Blue Shield Of Illinois	$ 1,573.10			
1-20147	3/13/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,558.60			
1-20158	6/20/2017	6/20/2017	Blue Cross Blue Shield Of Illinois	$ 1,262.80			
1-20140	3/14/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,165.00			
1-20155	6/23/2017	6/23/2017	Blue Cross Blue Shield Of Illinois	$ 1,138.40			
1-20150	3/8/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,014.50			
1-20132	5/1/2017	5/1/2017	Blue Cross Blue Shield Of Illinois	$ 978.70			
1-20153	6/18/2017	6/18/2017	Blue Cross Blue Shield Of Illinois	$ 720.30			
1-20144	6/9/2017	6/10/2017	Blue Cross Blue Shield Of Illinois	$ 653.20			
1-20175	3/10/2017	3/10/2017	Cigna Healthcare	$ 2,236.00			
1-20161	6/19/2017	6/19/2017	Cigna Healthcare	$ 1,366.20			
1-20172	3/30/2017	3/30/2017	Cigna Healthcare	$ 987.60			
1-20160	6/9/2017	6/9/2017	Cigna Healthcare	$ 629.40			

Using Work Queues - Epic

D	Acct Class	Acct Status	Disch Date	Guar Acct Type	Billed ...	Acct Balance	Primary Payor	Days Since Last User Note	Days On Workqueue
	Outpatient	Billed	05/29/2019	Workers Comp	06/06/2019	325.00	WORKERS COMPENSATION	1	234
	Inpatient	Billed	06/03/2019	Personal/Fa...	06/17/2019	919.00	MEDICARE	9	8
	Surgery Ad...	Billed	06/21/2019	Workers Comp	06/26/2019	14,955.00	WORKERS COMPENSATION	2	234
	Outpatient	Billed	06/18/2019	Personal/Fa...	06/27/2019	238.00	MEDICARE	10	50
	Outpatient	Billed	06/26/2019	Workers Comp	07/09/2019	325.00	WORKERS COMPENSATION	1	223
	Therapies ...	Billed	06/30/2019	Personal/Fa...	07/09/2019	1,492.00	CARE WI MC PLUS MA	9	112
	Outpatient	Billed	07/03/2019	Personal/Fa...	07/11/2019	150.00	UHC WI BADGERCARE	1	236
	Outpatient	Billed	07/12/2019	Personal/Fa...	07/20/2019	2,134.00	ICARE MA ONLY	22	225
	Outpatient	Billed	07/24/2019	Workers Comp	08/02/2019	325.00	WORKERS COMPENSATION	1	199
	Therapies ...	Billed	07/31/2019	Third Party L...	08/07/2019	498.00	LIABILITY	1	69
	Outpatient	Billed	08/14/2019	Workers Comp	08/21/2019	150.00	WORKERS COMPENSATION	1	180
	Outpatient	Billed	08/14/2019	Personal/Fa...	08/23/2019	1,300.00	AETNA MEDICARE	3	3
	Outpatient	Billed	09/03/2019	Workers Comp	09/11/2019	475.00	WORKERS COMPENSATION	1	158
	Specimen	Billed	09/10/2019	Personal/Fa...	09/14/2019	1,902.00	ICARE MA ONLY	22	169
	Emergency	Billed	09/10/2019	Personal/Fa...	09/18/2019	700.00	BLUE CROSS WI BADGERCARE	4	3
	Surgery Ad...	Billed	08/16/2019	Personal/Fa...	09/26/2019	641.00	BLUE CROSS OF WISCONSIN	8	8
	Therapies ...	Billed	09/30/2019	Workers Comp	10/04/2019	398.00	WORKERS COMPENSATION	1	136

ATB - Reasons Insurance

APPEAL	You sent an appeal or reconsideration to the payer.
BILLED	You billed a payer that previously had never been billed (Secondary claim, new payer, etc.). This could be a claim that was holding in the billing system and you released, or one that you requested an initial claim to a new payer. Use REBILLED if you are sending the claim to a payer being billed previously.
CALL	Use this anytime a call was made to the payer regardless of the outcome. The outcome of the call is documented in the client system. You might still rebill, appeal or post an adjustment, but still just use CALL for the status on your spreadsheet. Only use this AFTER the call is made and the client system documented with the result of the call.
ESTABLISHED PAYMENT PLAN	Used when setting a payment plan or reviewing for bad debt.
FC CHANGE	You updated the financial class to a payer that is not OS's responsibility. Use SELF PAY if moving to patient balance.
INFORMATION REQ'D	When additional information is requested from the client: Medical Records, Account review, refund, etc.
LETTER TO PATIENT	Letter has been sent to patient for additional information or notification that the balance will be billed to them if no response to the letter.
NO ACTION	Use this anytime you pull an account that does not need action. Examples: Account balance already zero or a credit balance we are not responsible for working, balance already in self pay and we don't work self pay, claim recently* billed or action recently* taken so the account does not need follow up at this time. *Recently is defined as the payer and/or client specified follow up days (15-45 days).
OK FOR BAD DEBT	Used when approving self pay balances for bad debt.
POSTED ADJUSTMENT	You posted a contractual allowance or adjustment that resolved the balance. Use this even when the remaining balance might also be moved to self-pay.
QUESTION	Note this when you have emailed internal staff for review or assistance (Manager, Team Lead, Senior A/R rep, Trainer, etc.), or use this to flag accounts to ask about during a scheduled training session or meeting. **NOTE - you should not put a date completed in your spreadsheet for these. Wait until the account is worked to update the status and date worked.
REBILLED	You rebilled the responsible payer - could be primary, secondary or tertiary. Use this for any claim you are resending to a payer that was previously billed. Use this for corrected and faxed claims as well
SELF PAY	You moved the balance to patient responsibility.
UNCOLLECTIBLE WRITE OFF	Use this if you posted or requested a write off for untimely, no authorization, medical necessity or other write offs.
WEBSITE-PENDING	Use this if you checked a website and determined the account is pending processing or posting of payment.

Worked ATB

Encounter Number	Admit Date	Disch Date	Current Health Plan	Total Charges	Current A/R Balance	Date Worked	Action Taken
1-20131	6/12/2017	6/12/2017	Aetna C	$ 6,290.00	$ 1,759.52	9/13/2017	Call
1-20127	2/9/2017	2/9/2017	AARP Medicare Complete	$ 1,349.60	$ 1,349.60	9/13/2017	Call
1-20129	9/20/2016	9/20/2016	AARP Medicare Complete	$ 1,314.20	$ 1,314.20	9/13/2017	No Action
1-20132	5/1/2017	5/1/2017	Blue Cross Blue Shield Of Illinois	$ 978.70	$ 978.70	9/13/2017	Rebilled
1-20133	12/1/2016	12/1/2016	Blue Cross Blue Shield Of Illinois	$ 1,268.80	$ 849.50	9/13/2017	No Action
1-20126	5/4/2017	5/4/2017	AARP	$ 2,062.60	$ 794.03	9/13/2017	Self Pay
1-20130	5/9/2017	5/9/2017	AARP Medicare Complete	$ 6,405.70	$ 650.24	9/13/2017	Self Pay
1-20128	12/14/2016	12/14/2016	AARP Medicare Complete	$ 508.50	$ 508.50	9/13/2017	Call
1-20166	3/2/2017	3/2/2017	Cigna Healthcare	$ 8,285.50	$ 8,285.50	9/14/2017	Website Pending
1-20148	11/26/2016	11/26/2016	Blue Cross Blue Shield Of Illinois	$ 7,906.35	$ 6,951.75	9/14/2017	No Action
1-20138	5/2/2017	5/2/2017	Blue Cross Blue Shield Of Illinois	$ 6,492.35	$ 5,394.83	9/14/2017	No Action
1-20173	11/11/2016	11/30/2016	Cigna Healthcare	$ 4,838.00	$ 4,838.00	9/14/2017	Website Pending
1-20146	3/21/2017	3/21/2017	Blue Cross Blue Shield Of Illinois	$ 6,441.20	$ 4,403.00	9/14/2017	No Action
1-20142	5/19/2017	5/19/2017	Blue Cross Blue Shield Of Illinois	$ 5,364.70	$ 3,959.18	9/14/2017	Self Pay
1-20174	12/1/2016	12/30/2016	Cigna Healthcare	$ 3,530.30	$ 3,530.30	9/14/2017	Website Pending
1-20175	3/10/2017	3/10/2017	Cigna Healthcare	$ 2,236.00	$ 2,236.00	9/14/2017	Website Pending
1-20147	3/13/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,558.60	$ 1,558.60	9/14/2017	No Action
1-20161	6/19/2017	6/19/2017	Cigna Healthcare	$ 1,366.20	$ 1,366.20	9/14/2017	Website Pending
1-20158	6/20/2017	6/20/2017	Blue Cross Blue Shield Of Illinois	$ 1,262.80	$ 1,175.34	9/14/2017	Self Pay
1-20167	5/1/2017	5/1/2017	Cigna Healthcare	$ 7,174.70	$ 1,169.41	9/14/2017	No Action
1-20140	3/14/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,165.00	$ 1,015.00	9/14/2017	No Action
1-20150	3/8/2017	3/31/2017	Blue Cross Blue Shield Of Illinois	$ 1,014.50	$ 1,014.50	9/14/2017	No Action
1-20172	3/30/2017	3/30/2017	Cigna Healthcare	$ 987.60	$ 987.60	9/14/2017	Website Pending
1-20159	5/27/2017	5/27/2017	Cigna Healthcare	$ 6,723.95	$ 927.80	9/14/2017	Website Pending
1-20145	12/24/2016	12/24/2016	Blue Cross Blue Shield Of Illinois	$ 1,254.25	$ 848.75	9/14/2017	No Action
1-20141	3/6/2017	3/6/2017	Blue Cross Blue Shield Of Illinois	$ 4,185.10	$ 831.47	9/14/2017	No Action
1-20143	4/29/2017	4/30/2017	Blue Cross Blue Shield Of Illinois	$ 3,275.55	$ 809.70	9/14/2017	No Action
1-20152	3/4/2017	3/4/2017	Blue Cross Blue Shield Of Illinois	$ 1,573.10	$ 801.76	9/14/2017	No Action
1-20163	12/2/2016	12/2/2016	Cigna Healthcare	$ 769.60	$ 769.60	9/14/2017	Website Pending

ATB Reasons – Self Pay

CALL

- Use this anytime a call was made to the payer regardless of the outcome. The outcome of the call is documented in the client system. You might still rebill, appeal or post an adjustment, but still just use CALL for the status on your spreadsheet. Only use this AFTER the call is made and the client system documented with the result of the call.

ESTABLISHED PAYMENT PLAN

- Used when setting a payment plan or reviewing for bad debt.

FC CHANGE

- You updated the financial class to a payer that is not OS's responsibility. Use SELF PAY if moving to patient balance.

OK FOR BAD DEBT

- Used when approving self-pay balances for bad debt.

QUESTION

- Note this when you have emailed internal staff for review or assistance (Manager, Team Lead, Senior A/R rep, Trainer, etc.), or use this to flag accounts to ask about during a scheduled training session or meeting. **NOTE - you should not put a date completed in your spreadsheet for these. Wait until the account is worked to update the status and date worked.

RESTARTED STATEMENTS

- Used when restarting the cycle of self-pay balance statements going to patients.

INSURANCE VERIFIED

- Used when you verified that a self-pay patient with no insurance listed does not have Medicaid.

Worked ATB – Self Pay

Encounter Number	Disch Date	Current A/R Balance	Statement Cycle	Action	Date
1-24012	7/23/2017	$ 16,254.30	Normal # 2	CALL	9/29/2017
1-23785	11/6/2016	$ 9,662.60	Normal # 3	NO ACTION	9/11/2017
1-24001	7/6/2017	$ 7,876.85	Normal # 2	CALL	9/15/2017
1-23910	5/7/2017	$ 7,629.75	Collections # 1	OK FOR BAD DEBT	9/15/2017
1-23616	7/1/2017	$ 7,292.40	Normal # 2	CALL	9/8/2017
1-24089	8/27/2017	$ 6,401.20		NO ACTION	9/15/2017
1-23655	6/5/2017	$ 6,309.80	Normal # 3	CALL	9/8/2017
1-23985	8/31/2017	$ 5,837.90		CALL	9/15/2017
1-23876	10/26/2014	$ 5,796.60	Normal # 2	OK FOR BAD DEBT	9/19/2017
1-24201	7/11/2017	$ 5,445.30	Normal # 3	CALL	9/15/2017
1-23716	2/27/2017	$ 3,737.60	Normal # 2	CALL	9/12/2017
1-23815	7/2/2017	$ 3,284.50	Normal # 2	NO ACTION	9/13/2017
1-24178	7/20/2017	$ 2,970.95	Normal # 3	CALL	9/15/2017
1-23588	4/17/2017	$ 2,860.72	Normal # 2	CALL	9/12/2017
1-24074	5/17/2017	$ 2,502.40	Normal # 2	CALL	9/20/2017
1-23796	6/18/2017	$ 2,498.15	Normal # 3	FC CHANGE	9/12/2017
1-24189	1/23/2017	$ 2,353.47	Collections # 1	OK FOR BAD DEBT	9/15/2017
1-24171	6/22/2017	$ 2,273.15	Normal # 3	CALL	9/15/2017
1-23599	8/16/2017	$ 2,257.95	Normal # 2	CALL	9/8/2017
1-23973	5/25/2017	$ 2,211.90	Collections # 1	CALL	9/15/2017
1-23907	5/31/2017	$ 2,046.00	Normal # 3	OK FOR BAD DEBT	9/15/2017
1-23786	11/23/2016	$ 2,004.70	Normal # 3	NO ACTION	9/11/2017
1-23982	6/25/2017	$ 1,999.50		BILLED	9/14/2017
1-23709	8/11/2017	$ 1,975.45	Normal # 2	NO ACTION	9/8/2017
1-23981	7/24/2017	$ 1,950.70	Normal # 3	CALL	9/15/2017
1-23931	10/20/2016	$ 1,911.85	Normal # 2	CALL	9/26/2017
1-24099	3/27/2017	$ 1,811.34	Normal # 2	NO ACTION	9/15/2017
1-23969	8/6/2017	$ 1,707.70	Normal # 2	CALL	9/29/2017
1-23839	6/27/2017	$ 1,689.18	Normal # 3	CALL	9/15/2017
1-23769	9/13/2016	$ 1,550.18	Normal # 2	CALL	9/12/2017

Following Up on Unpaid Balances

Confirm Payer has the Claim

- If the claims went electronically - make sure you have the acknowledgment that the payer got the claim (claim system or notes in PFS)
- Check Payer Websites
- Call

Payer has claim and did not pay - Why?

- Was denial worked
- Was denial worked correctly
- Were you supposed to get paid? (make sure you know your contracts and rules)

Calling Insurance Companies

No Record of Claim

- Name and number of the person you are talking with
- Company name
- Correct address on where to send claims
- Fax number, if they accept claims faxed

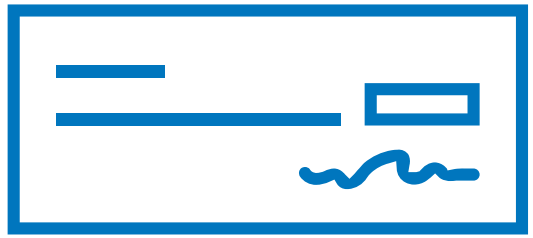
Claim Denied

- Name and number of the person you are talking with
- Company name
- Date denied
- Reason denied

Calling Insurance Companies – Continued

Claim in Process/Reviewed

- Name and number of the person you are talking with
- Company name
- Reason for review for delay
- When payment is expected



Claim Paid

- Name and number of the person you are talking with
- Company name
- Date claim paid
- Amount paid (any deductibles, coinsurance or discounts)
- If date paid was more than 30 days ago, also ask:
- Whom check was paid to
- Check number if available
- Mailing address check was mailed to
- Was check cashed or do they show the check cleared
- Request check copy (front & back)
- Is this single pay or a batch remit? Who are other patients on remit? Are those accounts posted?

Major Payers - Tips

Medicare

Medicaid

State Plans

Workers Comp

Liability

Medicare Resources

- Use online systems for:
  - Checking Status
  - Re-openings/Redeterminations
  - Eligibility
  - MSP issues

CMS.GOV

- https://www.cms.gov/

Medicaid & Medicaid MCOs

- Use online systems for:
  - Checking Status
  - Appeals
  - Eligibility
  - Sending Corrected Claims
  - IDPA (need to use your vouchers and know your codes)
- Important Websites
  - https://www.illinois.gov/hfs/MedicalProviders/Pages/default.aspx
  - https://iamhp.net/
  - https://www.illinicare.com/
  - https://www.molinahealthcare.com/providers/il/medicaid/Pages/home.aspx

Workers Compensation

Follow up Contact #	Days	Action
1.	60 days from claim billed	Message left with payer If no call back, proceed to 2
2.	7 days later	Message left with payer Contact employer for claim status Request rebill and send as a tracer; send with cover letter stating if no payment/response in 30 days we will assume not a Work Comp claim. If no call back or status, proceed to 3
3.	7 days later	Message left with payer Contact employer for claim status Call patient to request assistance; Advise if status or payment not received in 30 days, we will assume not work-related claim and will bill health insurance or patient directly If no call back or status, proceed to 4
4.	90 days from claim billed	Last contact attempt to payer and employer. If no status, send to self pay or bill health insurance

Liability

Follow up Contact #	Days	Action
1.	60 days from claim billed	Message left with payer If no call back, proceed to 2
2.	7 days later	Message left with payer Call patient to Assist(or send Letter to Patient)
3.	7 days later	Move to self pay if no Commercial Payer If Medicaid is primary- you can bill but you must accept that paid in full Medicare – If open Liability shows on common working file, you must wait 120 days
4.	120 Days- Medicare	Bill Medicare conditionally if you do not want to wait for Liability carrier to process

Before Appealing or Disputing any Denial

Consider the following:

- Payer Rules
- What is your ROI?
- Did you follow all guidelines prior to service being performed

Payer Requirements

Aetna's Process

- Reconsiderations: Formal reviews of claim reimbursements, or coding decisions, or claims that require reprocessing
- Appeals: Requests to change a reconsideration decision
- Peer to Peer Review

https://www.aetna.com/health-care-professionals/disputes-appeals/disputes-appeals-overview.html

Essential Components of an Appeal

- Heading & Subject
  - Patient name, DOB, Policy number, Claim Number and DOS, Denial Description
- Introduction to the Appeal
  - Reason for Denial and summary any previous correspondence
- Summary of the Patient's Condition Leading to the Encounter
- Summary of the Denial
- Supporting Response to the Denial
- Summary of the Appeal

Appeal Part 1

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type	Member's Group Number *(Optional)*
4/24/2020	syork78545	☑ Medical ☐ Dental	7845

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*
Susan	York	01/02/2020

Provider Name	TIN/NPI	Provider Group *(if applicable)*
United Hospital AB	4423132	12465
Contact Name and Title: Sue York, AR Specialist		
Contact Address *(Where appeal/complaint resolution should be sent)*: 123 Hospital Ave		
Contact Phone: (262) 544-4442	Contact Fax: (262) 544-4433	Contact Email Address: syork@os-healthcare.com

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)
12345324	156896531	02/05/2020
Initial Denial Notification Date(s): 3/15/2020	Reconsideration Denial Notification Date(s): 4/2/2020	
CPT/HCPC/Service Being Disputed: 72196		
Explanation of Your Request *(Please use additional pages if necessary.)*		

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Appeal Part 2

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)
12345324	156896531	02/05/2020

Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)
3/15/2020	4/2/2020

CPT/HCPC/Service Being Disputed
72196

Explanation of Your Request *(Please use additional pages if necessary.)*

Initial Claim was billed with CPT code 72196 - MRI Pelvis with Contrast, Authorization was for 72195 Without Contrast. We did send in Medical Records on our initial reconsideration with reasons why patient needed the MRI with Contrast after evaluation. Our reconsideration was denied, and we are disputing this decision.

Summary of Visit
Order was called in for an Urgent MRI w/o contrast due to severe pelvic pain on 2/4/2020. Staff contacted Aetna and authorization was granted on 2/4/2020 - Auth number 156896531.

Patient presented on 2/5/2020 and was briefllly evaluated by nursing staff. Nurse noted that patient has a very large mass upon examination and contacted the radiologist on call to indicate that per protocol, patient should have an MRI with contrast. Radiologist agreed and Contrast was given. Per standards of care the MRI with contrast was indicated. This MRI was needed urgently, and the decision was to go forward with the MRI with contrast. Due to time constraints and scheduling concerns a call was not made to Aetna.

Please review our request to process the MRI with Contrast (72196). We feel that due to circumstances and patient condition this denial should be overturned and paid.

Thank you for your consideration. We have attached the medical records and claim for your review.

Questions

Thank you for joining us today!

Don’t hesitate to get in touch with any follow up questions. We’ll be happy to address them or incorporate responses into the rest of this series.

Please make sure to add the next three sessions of this series to your calendar!

Wednesday, May 20th | 12:00 pm - 1:30 pm Central
Denials: Overview & Resolution Strategies

Wednesday, June 17th | 12:00 pm - 1:30 pm Central
Collections & Customer Service

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ICAHN
Illinois Critical Access Hospital Network