

Denials Management Establishing Best Practices

21 February 2017 0800 – 0900 EST

23 February 2017 1400 – 1500 EST

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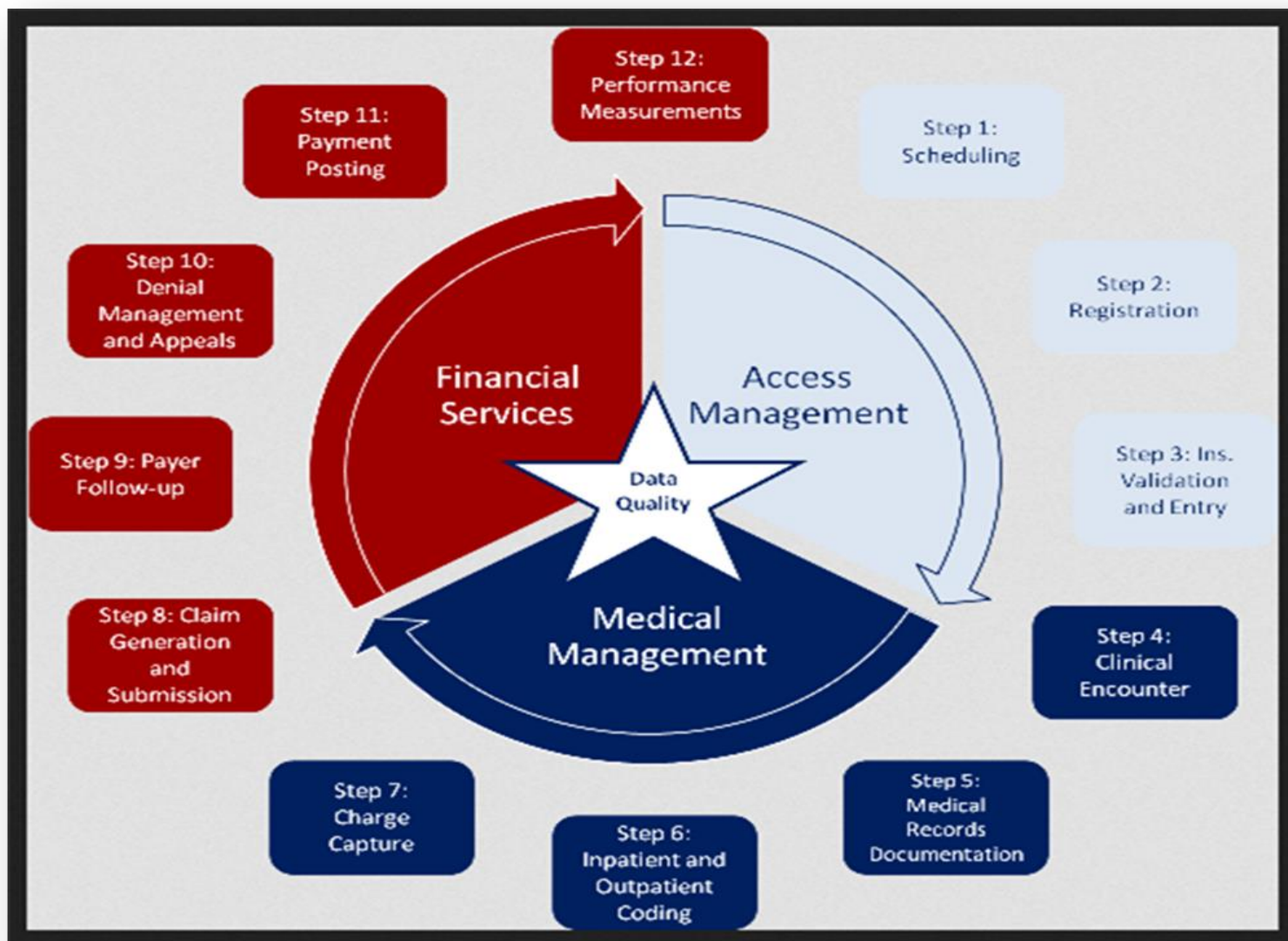
- Military Health System (MHS) Third Party Collection Program (TPCP) Background
- What is a denial?
- Denials across the revenue cycle
- Importance of Denials Management
- Types of claim denials
- Learn how to read and interpret an Explanation of Benefits (EOB)
- Process for handling claim denials
- Denials management best practices
- Tips for tracking denials in ABACUS
- Effective communication with MTF staff and payers
- Appealing denials

- Title 10, United States Code (U.S.C.), Section 1095
 - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries
- Title 32, Code of Federal Regulations (CFR), Part 220
 - Implements 10 U.S.C. 1095 and specifies:
 - Statutory obligation of third party payers to pay; no assignment of benefits required
 - Exclusions impermissible
 - Reasonable charges
 - Rights and obligations of beneficiaries
 - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

- Health care industry does not have one universal definition of a claim denial:
 - “Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers’ technical guidelines, or failure to consistently document for the services provided.” Healthcare Financial Management Association(HFMA)
 - “A claim line item or service line item that results in no payment including rejected claims.”*

*Denial Management: Key Tools and Strategies For Prevention and Recovery, Pam Waymack

Military Health System (MHS) Revenue Cycle



- Why are effective denials management processes so important?
 - Denials have increased significantly as the electronic billing and remittance process becomes increasingly sophisticated
 - Claims have less “human” contact
 - Computer based payment algorithms search for key information according to payer contract requirements
 - The average cost to rework a claim is \$25.00 (HFMA)
 - Failing to rework denials results in a loss of revenue that supports your MTF’s operation and maintenance budget
 - Manageable accounts receivable

- In 2015, the DoD Inspector General (IG) performed a review of 6 MTFs to determine if compliance audits of their TPCP were being conducted to monitor missed collection opportunities.
- Finding: the audits **were not** being conducted; additionally, these specific actions were not being performed*:
 - Initial follow up – 64,345 claims worth \$17.3M
 - Documenting write-off rationale – 67,047 claims worth \$11.9M
 - Forwarding claims to legal office for collection – 45,812 claims worth \$9.2M
 - Obtain pre-certification or pre-authorization - 19,632 claims worth \$10.3M
 - Total: 144,930 claims, \$112,518,396 billed, \$21,685,169 remained uncollected
- DoD IG Recommendations
 - Conduct an analysis to determine the sufficient time needed to conduct adequate follow up on billed claims for TPCP.
 - Review Uniform Business Office (UBO) resource issues
 - Refer outstanding TPCP claims to legal office as required
 - Update the UBO Manual
 - Establish a quality assurance program that monitors the TPCP and follow up requirements
 - Establish agreements with payers to accept claims for 90-day prescriptions

- Why Is Denials Management So Difficult?
 - Complexity of third-party denials
 - Denial information provided by third-party payers is not standardized
 - Perceived inability to capture the denial data
 - Constantly changing information
 - Requires coordination throughout the revenue cycle
 - Challenging appeals process

Hard Denials

(Appeal required)

- Untimely filing
- Non-covered benefit
- No pre-authorization
- Bundling

Soft Denials

(A temporary or interim denial)

- Missing/inaccurate information
- Charge/coding issues
- Coordination of benefits (multiple coverage)
- Pending itemized bill

Clinical

- Medical necessity
- Alternate setting
- Length of stay exceeds authorization (delay in discharge)

Administrative

- Failure to pre-authorize care
- Lack of clinical information
- Non-covered benefit
- Exclusion denials
- Termination of coverage

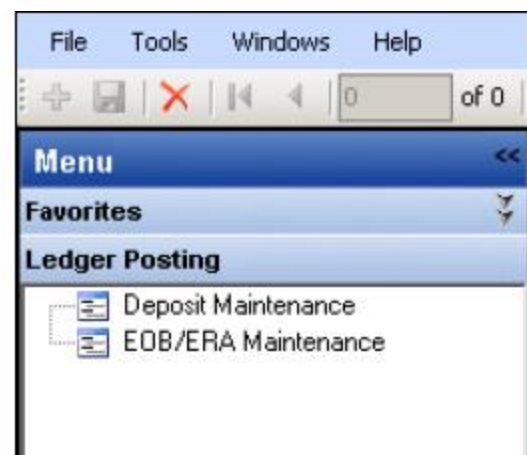
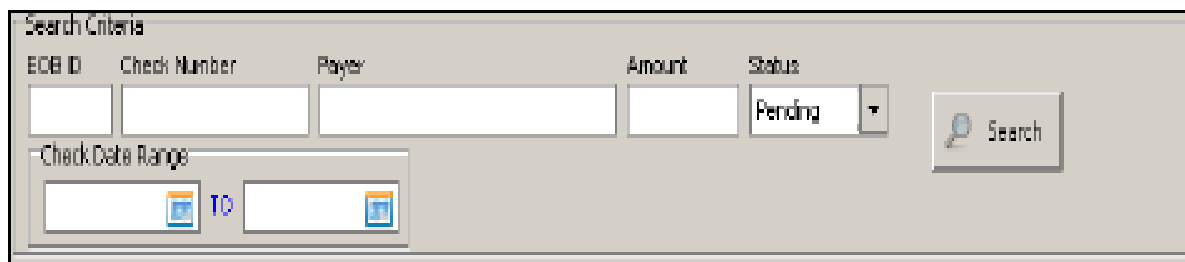
- The reason for a denial can be attributed to weaknesses within at least one of the three components of the revenue cycle

Quiz Question #1

- Which type of denial must be appealed?
 - A) Soft Denial
 - B) Administrative Denial
 - C) Hard Denial
 - D) Clinical Denial

- Definition and Purpose:
 - An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied.
 - The purpose is to provide detailed payment information relative to the claim.

- Electronic EOBs can be viewed and printed from the 835 Viewer
 - Ledger Posting > EOB/ERA Maintenance

A screenshot of the ABACUS search criteria form. The form has a title 'Search Criteria' and several input fields: EOB ID, Check Number, Payer, Amount, and Status. The 'Status' field is a dropdown menu with 'Pending' selected. There is a 'Search' button with a magnifying glass icon. Below the input fields, there is a 'Check Date Range' section with two date pickers and a 'TO' label between them.

Sample EOB

eba&m
E.B.A. & M. CORPORATION
P.O. BOX 5079
Westlake Vig. CA 91359-5079

Explanation of Benefits

**RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL**

Forwarding Service Requested

JOHN SMITH
1234 MAIN STREET
ANYTOWN, USA 12345

Customer Service
Group: EBAM
Group #: 0504
Provider: WEST MEMORIAL HO
Member ID: 00E211155
Date: 03/05/14

If you have any questions about this claim, please call (714) 668-8920 or (800) 249-8440. Status & Benefits visit www.ebam.com

Claim #: 1405000164
Patient: JOHN SMITH
Enrollee: JOHN SMITH
Patient #: H11655439555

Dates of Service	Procedure Description	Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
02/07-02/07/2014	LAB OP HOSP	\$262.78	\$183.95	\$0.00	BBP	\$78.83	\$0.00	\$0.00	\$7.88	\$78.83	90%	\$70.95
Column Totals		\$262.78	\$183.95	\$0.00		\$78.83	\$0.00	\$0.00	\$7.88	\$78.83		\$70.95
Patient Responsibility:		\$7.88										
Other Credits or Adjustments												\$0.00
Total Net Payment												\$70.95

Reason Code/Description
BBP PRUDENT BUYER PROVIDER. REDUCED ACCORDING TO BLUECROSS/PRUDENT BUYER CONTRACT. PATIENT IS NOT LIABLE FOR CHARGE. CONTACT YOUR LOCAL BLUECROSS PROVIDER APPEAL DEPT WITH ANY QUESTIONS.

Payment Details
Paid to: WEST MEMORIAL HO
Amount: \$70.95

Appeal Rights
You are entitled to a review of this benefit determination if you have questions or do not agree. Written request for review must be mailed within 180 days following receipt of this explanation. To obtain a review, submit your request to the address listed below to the attention of "Appeals Department". Your request should include your name, member ID and other identifying information shown on this form, as well as a statement of the issue and any data, documents or comments you would like to have considered. Ordinarily, you will receive notification of the final determination within 60 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such extension within 60 days following receipt of your request. SEND ALL WRITTEN APPEALS TO: APPEALS DEPARTMENT c/o E.B.A.&M. Corporation 3505 Cadillac Ave. Suite O-201 Costa Mesa, CA 92626. Please be advised this Plan is an ERISA Plan subject to the provisions of the Federal Claims and Appeals Regulation (July 2002).
Your plan may or may not require satisfaction of co-pays, annual deductibles, or coinsurance. For additional information on why a co-pay, deductible or coinsurance was applied to this claim, please refer to the Schedule of Benefits section of your Summary Plan Description.

- 1) **Payer information** – payer name and mailing address
- 2) **Standard EOB statement** – “THIS IS NOT A BILL” will be on all EOBs
- 3) **Payer contact info** – group name, group #, provider name, member ID, claim date, contact phone #
- 4) **Patient info** – claim #, patient name, enrollee name, patient #
- 5) **Dates of service** – when the patient received services
- 6) **Service/product description** – services the patient received from the provider
- 7) **Charges** – amount billed to the patient and healthcare plan
- 8) **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment

- 9) Amount not covered** – the amount of services/products not covered by the plan
- 10) Reason Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full
- 11) Covered by plan** – amount covered by healthcare plan
- 12) Deductible** – the amount the patient pays toward covered services each year before the third party payer starts paying for services
- 13) Copay** – the amount the patient pays the provider for a visit/service
- 14) Coinsurance** – what the patient must pay the health plan after the health plan pays the covered percentage
- 15) %** – percentage level of benefits for covered services/products
- 16) Payment amount** – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered

- 17) Total paid by health plan** – total amount paid to provider by payer
- 18) Reason Code/Description** – a detailed explanation of reason code
- 19) Appeal Rights** – instructions to patient for requesting a review of benefit information
- 20) Patient responsibility** – what the patient must pay to the provider of the billed charges after the plan benefits have paid

Quiz Question #2

- What is the purpose of an EOB or Remittance Advice?
 - A) To provide a pre-authorization for care
 - B) To provide detailed payment information relative to the claim
 - C) To provide payment

- Interpret the EOB to ensure that a valid denial reason has been received
- Determine if the amount needs to be written off
- Determine if denial can be corrected and resubmitted or if the claim requires an appeal
- Engage appropriate departments
- Develop your case based on the payer's guidelines
- Monitor and follow up on corrected or appealed claims

- Early Intervention
 - Respond to denials immediately
 - Establish a timeline for working denials
 - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
 - Monitor and act upon unresolved denials
 - Measure denials and appeal results
 - Follow up on all levels of appeals process
 - Trend issues by payer and reason
- Impact of Best Practices
 - Improved cash flow due to an increase in clean claims and a reduction in denials

- Start tracking denials
 - Recommend capturing at least 3 months data collection
 - Electronic reports
 - Manually (can be cumbersome but can capture more detailed info)
- Group denials together by:
 - Payer
 - Type
 - Denial Reason Code
 - Status for follow up
 - Identify services and areas that result in the majority of denials
 - Evaluate weekly what is being denied
 - Monitor action taken on denials
 - Be aware of timelines for re-filing/appealing

- Streamline billing responsibilities
 - Dedicate team specifically to manage denials
 - Standardize appeal templates by payer
- Show impact on revenue
 - Total amount denied by type
 - Denied amount as a percentage of revenue
 - Total write-off amount by transaction code
 - Write-off amount as a percentage of revenue
 - How much has been collected
- Establish goals
 - What is an acceptable percentage to write-off due to denials (point of reference - industry goal is 3%)
- Communicate results to leadership

- Accounts Management > Recovery Management
- Recovery tool used to track and reconcile accounts
- Allows users to access information, in one location, which is used
 - Account information
 - Working Notes
 - Carrier information
 - Transaction notes

Recovery - (Sensitive Information) [OHL_DEV_VER1] ver. 2.20.1.3

Facility: 59TH MEDICAL WING Facility # 0117 Facility NP: 1275511776
 LOB: JV-IN Tax ID: 742479545 Facility RX NP: 1225137342

Entire Queue - Pull Date Order - No Filter
 The account you are looking at is in this Queue --> In Process

Account Information
 Work Log Work Note Print Account Detail
 Last Denial
 Last Denial Date
 Grouping: New Work
 Pull Date: 4/12/2013
 Resolution: None
 Working Carrier: Primary

Placement Information
 Date Placed: 4/11/2013
 Age of Placement: 1718 Days
 Date of Service: 7/28/2008 to 7/28/2008
 Date Resolved
 Status: Active
 Total Billed: 52.20
 Payments: 0.00
 WFO and Adl
 Total Remaining: \$52.20

Carrier: Information Requests Letters
 Select Carrier
 (BCBHX0005) ARGUS 160 Claims for this Carrier
 Address Phone Web Page

Department	Address1	Address2	City
Claims	BCBS OF TEXAS	PO BOX 660044	DALLAS
Claims	PO BOX 419019 DEF		KANSAS CITY
Professional Claims	PO BOX 660044 Pro		DALLAS
Facility Claims	PO BOX 60044 Faci		DALLAS

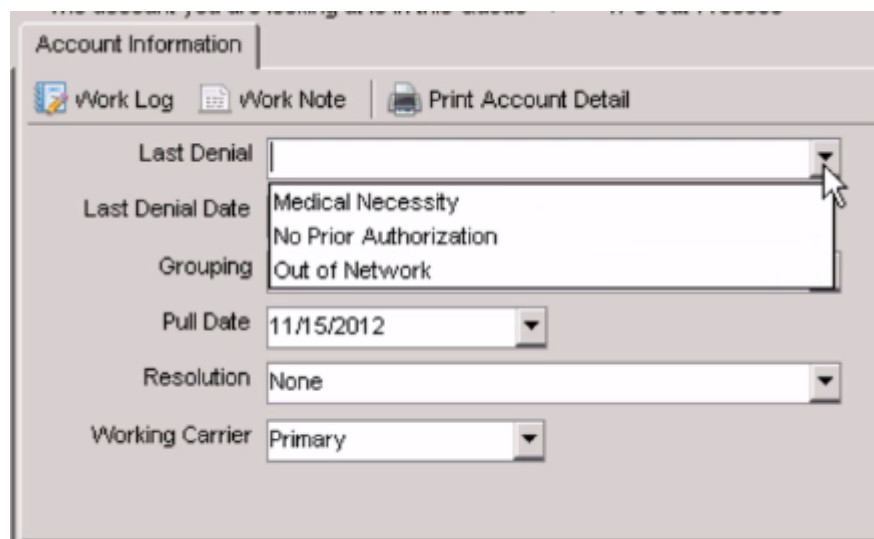
Transactions: CMS1500 Balance Billing Change LOB
 Verified Transactions

Type	Transaction	Verified Entry	Verified Amount	Entered By	Entered	EOB ID	Note
WFO	4/16/2013	4/16/2013	-120.00	In Process	4/16/2013		

 \$0.00 Remaining: \$0.00
 Unverified Transactions

Type	Transaction	Verified Entry	Declined Date	Amount	Entered By	Entered	EOB ID	Note
Payment		4/16/2013		-110.00	In Process	4/16/2013		

- Account Management > Recovery > Account Information tab
 - Groups denials into specific categories



Account Information

Work Log Work Note Print Account Detail

Last Denial


Last Denial Date Medical Necessity

Grouping No Prior Authorization

Pull Date 11/15/2012

Resolution None

Working Carrier Primary



Collection Work Note Pad

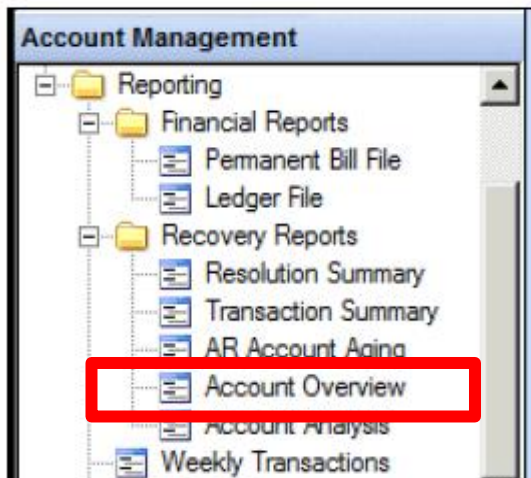
OK Cancel

Recovery Scratch Pad

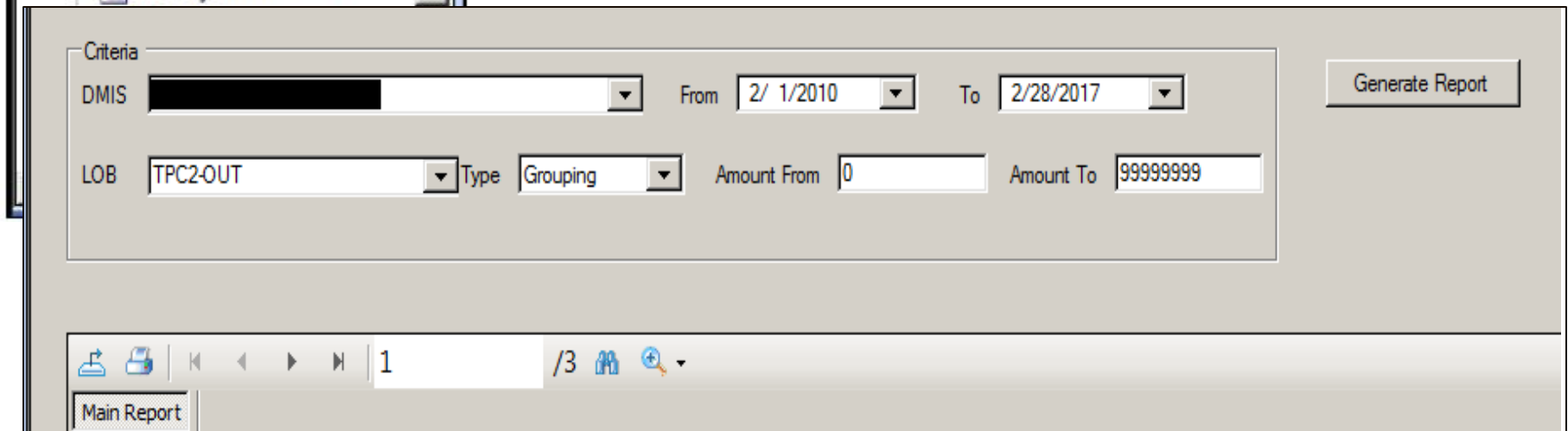
Client Info From Placement Client Transaction Data

Placement Data

- Account Management Reports allow users to enter parameters for generating specific reports



- Account Overview
- Choose DMIS
- Date Range
- LOB



The screenshot shows the 'Criteria' section of the report generation interface. It includes the following fields and controls:

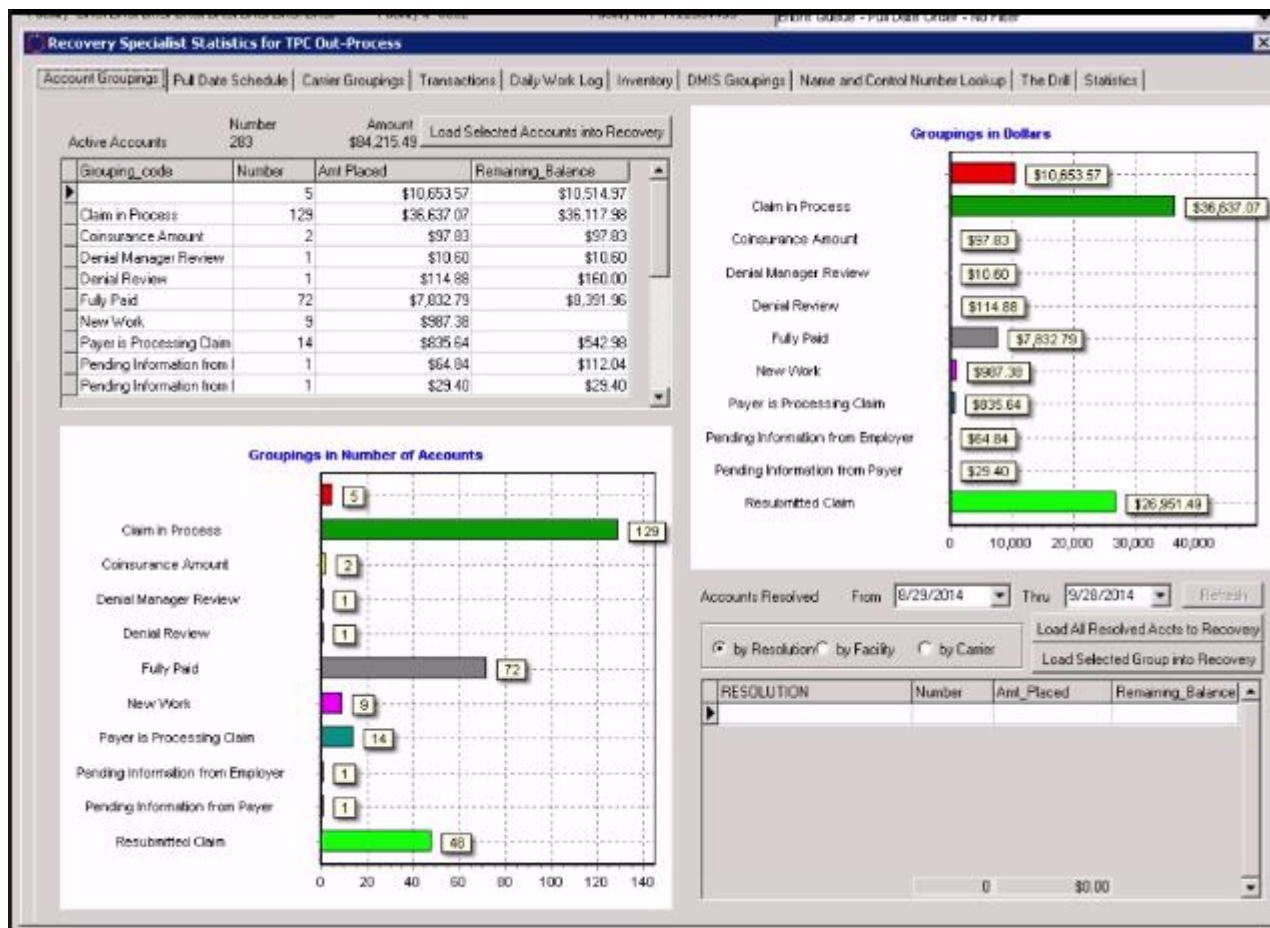
- Criteria** section with a 'Generate Report' button.
- DMIS**: A dropdown menu with a blacked-out selection.
- From**: A date field set to '2/ 1/2010'.
- To**: A date field set to '2/28/2017'.
- LOB**: A dropdown menu set to 'TPC2-OUT'.
- Type**: A dropdown menu set to 'Grouping'.
- Amount From**: A text field set to '0'.
- Amount To**: A text field set to '99999999'.

At the bottom of the form, there is a navigation bar with icons for back, forward, and search, along with a page indicator showing '1 / 3'.

- Shows where accounts are in chosen LOB

<i>For Official Use Only</i>					
Active Account Overview					
TPC2-OUT					
2/1/2010 thru 2/28/2017					
0 thru 99999999					
Report Type: Grouping					
<u>Grouping</u>	<u>Accounts</u>	<u>Billed</u>	<u>Payments</u>	<u>Write-offs & Adjustments</u>	<u>Remaining Bal</u>
1st Level Appeal Sent	3	40.39	0.00	0.00	40.39
Benefit Recovery Trouble Ticket	1	137.24	0.00	0.00	137.24
Bill Correction Needed	71	7,986.83	0.00	1,124.08	6,862.75
Bill Ready to Print	204	18,981.56	0.00	0.00	18,981.56
Claim in Process	1,440	185,857.81	2,948.92	2,610.32	180,298.57
Claim Worked	74	45,875.62	4,315.22	26,977.64	14,582.76
Denial Review	1	109.84	0.00	0.00	109.84
EOB Received	115	17,468.23	269.86	460.79	16,737.58
FedDebt Insurance	45	10,148.95	204.64	358.32	9,585.99
Flag for Review	98	15,027.66	534.59	802.04	13,691.03
No Coverage for DOS	1	247.32	0.00	0.00	247.32
Patient Payment Plan	2	952.40	0.00	162.50	789.90
Payer Data Request	1	206.58	0.00	0.00	206.58
Payer is Processing Claim	267	22,972.65	601.28	226.39	22,144.98
Payer Rejected Claim	26	1,534.66	0.00	0.00	1,534.66

- “Queue info” allows user to access more detailed information



- “The Drill” tab allows users to search for accounts in each group

Recovery Specialist Statistics for [REDACTED]

Account Groupings | Pull Date Schedule | Carrier Groupings | Transactions | Daily Work Log | Inventory | DMIS Groupings | Name and Control Number Lookup | **The Drill** | Statistics

Level 1: [Grouping] Level 2: [] Level 3: []

detail	Grouping	Count	Placed
▶	1st Level Appeal Sent	3	\$40.39
+	Benefit Recovery Trouble Ticket	1	\$137.24
+	Bill Correction Needed	71	\$7,986.83
+	Bill Ready to Print	204	\$18,981.56
+	Claim in Process	1,440	\$185,857.81
+	Claim Worked	74	\$45,875.62
+	Denial Review	1	\$109.84
+	EOB Received	115	\$17,468.23
+	FedDebt Insurance	43	\$9,792.75
+	Flag for Review	94	\$14,965.26
+	No Coverage for DOS	1	\$247.32
+	Patient Payment Plan	2	\$952.40
+	Payer Data Request	1	\$206.58
+	Payer is Processing Claim	267	\$22,972.65
+	Payer Rejected Claim	26	\$1,534.66
+	Pending Information Request	2	\$235.71
+	Pending Prior Authorization Approval	15	\$5,526.54
+	RAR FB1T	2	\$498.18
+	RAR FB54	1	\$364.40
+	RAR FB60	3	\$841.40
+	RAR FB64	22	\$4,581.77
+	RAR FB7W	1	\$16.40
+	RAR FB83	2	\$1,174.68

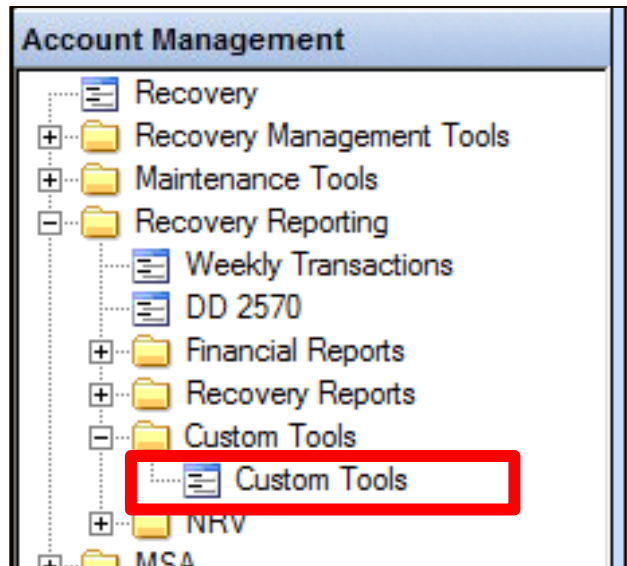
End of Level

Queue Selection

Select All

- ☐ FedDebt
- ☐ Foreign Billing
- ☐ Intra Govt
- ☐ LEGAL REVIE
- ☐ Local Govt
- ☐ MAC
- ☐ MSA Collectic
- ☐ MSA Patient
- ☐ NOAA
- ☐ Patient Invoic
- ☐ Payer Interest
- ☐ Public Health
- ☐ Special Accoi
- ☐ TPC In-Denia
- ☐ TPC In-FLUP
- ☐ TPC In-Proce
- ☐ TPC In-Rejec
- ☒ TPC Out-Den
- ☒ TPC Out-FLU
- ☒ TPC Out-Proc
- ☒ TPC Out-Reje
- ☐ Tx Candidate
- ☐ Tx Other
- ☐ Veteran Affair

- Custom Tools has custom reports to assist and can be created upon the request and feedback from users; look for favorite ones



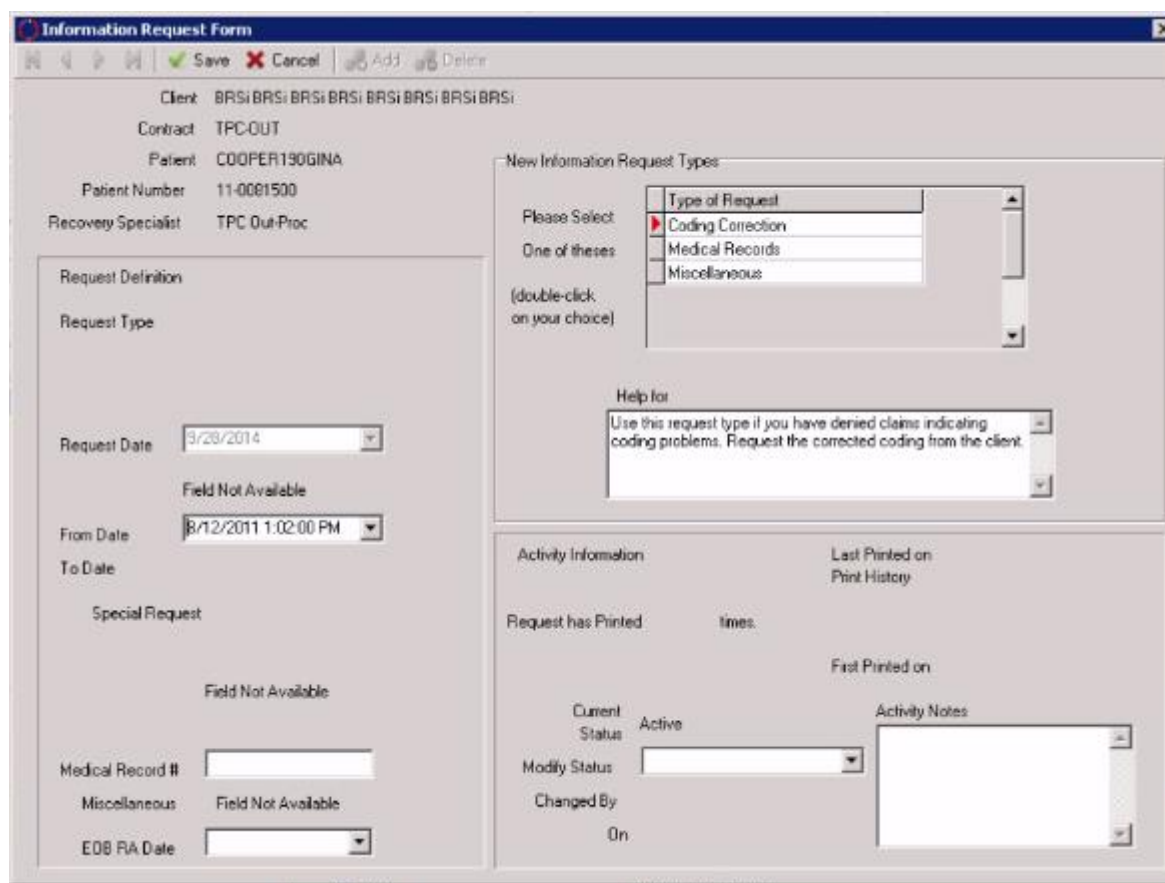
- Accounts in a Negative Balance
- Un-Verified Transaction Report (Accounts that need Double-Verification to close out)
- AR Clean Up Aging Report

Quiz Question #3

- Why should claim denials be tracked?
 - A) To identify breakdowns in established processes.
 - B) To make appeal efforts easier.
 - C) To establish processes for preventing future denials.
 - D) All of the above

- Coders
 - Accurate coding is necessary for receiving payment
- Patient Administration Directorate (PAD)
 - Registration
 - Other Health Insurance (OHI) collection
- Clinical staff
 - Complete and accurate medical record documentation
 - Timely closing of encounters to avoid coding backlogs
- **Standardize processes in all areas to avoid inconsistencies and train frequently**

- ABACUS feature used to request information internally
 - E.g., Coding correction or medical records
 - Account Management > Recovery > Information Request tab



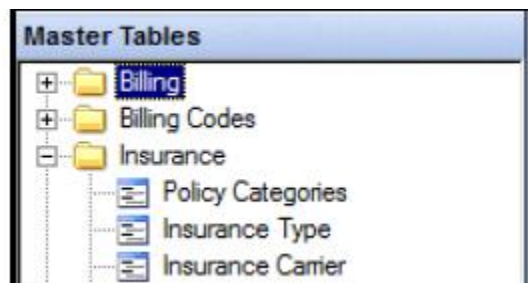
The screenshot shows the 'Information Request Form' window. The top bar includes a title bar and a menu bar with 'Save', 'Cancel', 'Add', and 'Delete' options. The form is divided into several sections:

- Client Information:** Client (BRSi BRSi BRSi BRSi BRSi BRSi BRSi BRSi), Contract (TPC-OUT), Patient (COOPER190GINA), Patient Number (11-0081500), and Recovery Specialist (TPC Out-Proc).
- Request Definition:** Request Type (dropdown), Request Date (3/20/2014), From Date (8/12/2011 1:02:00 PM), To Date (Field Not Available), and Special Request (Field Not Available).
- Medical Record #:** (Field Not Available).
- Miscellaneous:** (Field Not Available).
- E08 RA Date:** (Field Not Available).
- New Information Request Types:** A list box with 'Type of Request' (Coding Correction, Medical Records, Miscellaneous). Below it is a 'Help for' section with a text box: 'Use this request type if you have denied claims indicating coding problems. Request the corrected coding from the client.'
- Activity Information:** Request has Printed (times), Last Printed on (Print History), First Printed on, Current Status (Active), Modify Status (dropdown), Changed By (On), and Activity Notes (text box).

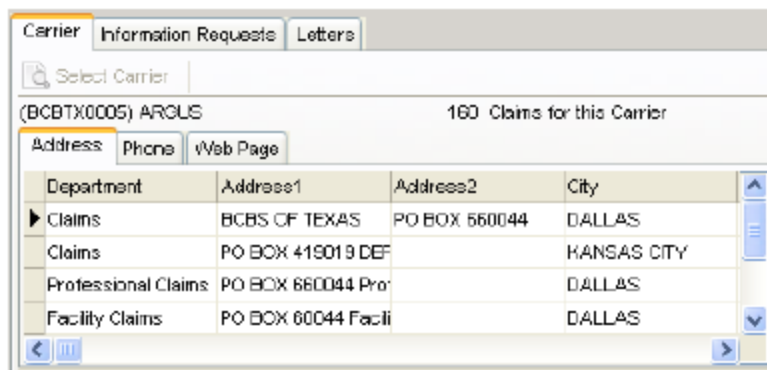
- Effective and continual communication with payers is essential
 - Develop standards for what information is required
 - Read the EOB carefully
 - Understand payer specific guidelines
 - Call the payer if a denial reason needs clarification
 - Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences
 - Develop process for receiving policy updates
 - Establish procedures for documenting communications

- When speaking with the payer, be sure to ask:
 - What data was missing or inaccurate on the claim which caused the denial?
 - How long you have to resubmit the claim?
 - Does the payer needs any additional documentation sent with the claim?
 - Does the payer require any specific indicators on a claim when it is re-sent to indicate that it is a corrected claim?
 - Where does the information need to be sent?
 - Is there a reference number for this phone call?
 - If payer representative is not helpful, ask to speak with a supervisor

- Master Tables > Insurance > Insurance Carrier



- Account Management > Recovery > Carrier Tab



- Denied claims should be pursued aggressively
 - Denied claims should be prioritized based on date of service and dollar amount; e.g., older dates of service still within timely filing limits, high dollar amounts, \$5K+ (Veterans Affairs threshold)
 - Aggressive does not mean calling every day
 - Scrutinize all denied claims for incorrect information
 - Disputed claims should be communicated to the payer in writing
 - Aggressively appealing denials has been shown to reduce denial rates

- Allows users to generate letters for specific accounts
 - E.g., coversheet, appeals, patient info request, etc.
 - Account Management > Recovery > Letters Tab > Letter Editor

Letter Maintenance ver. 2.21.1.5 [DEMO]

Cancel Save

Existing Templates

- Bravo-Updated Ins Info from Patient
- Canceled Check Request from Payor
- CNMC IP Medical Records Request
- DoD Inpatient R&B Reduction Appeal
- DMEPOS Letter
- DoD 99139 APV Rate Appeal
- DoD Appeal Base
- DoD Carrier Demand Letter
- DoD Collection Agency Refund Merit
- DoD Fast Coversheet
- DoD HMO OPT Out Appeal
- DoD MCARE 2nd Level Appeal
- DoD Medicaid MSP Appeal
- DoD Medicaid Invalid Denial
- DoD Medicare Rate
- DoD Medicare Rate with IAR Stated
- DoD Offset of Payment Appeal
- DoD Refund Letter
- DoD Refund Request Appeal
- DoD Request for Payment of 30 Day Supply**
- DoD Request for Refund
- DoD Retro Auth
- DoD TMHP Appeals
- DoD VA Appeal
- DoD VA Claims Status
- DoD WSC Appeals

Letter Name

DoD Request for Payment of 30 Day Supply

Help Note

Request to get carriers to pay at least 30 days of the 60 or 90 day quantity that was billed

Author : Jeremys
Last Edited : 5/5/2008

Times New Roman 14

DEPARTMENT OF THE AIR FORCE
[CLIENT CLIENT NAME]
[CLIENT ADDRESS1]
[CLIENT CITY] [CLIENT STATE] [CLIENT ZIP]

DATE]
[CLAIMS CARRIER NAME]
[CLAIMS ADDRESS1]
[CLAIMS CITY] [CLAIMS STATE] [CLAIMS ZIP]

Re: **Request for Payment of 30 Day Supply**
Patient: [PAT L NAME] [PAT F NAME] [PAT MI]
ID: [PATIENT ID]
Account #: [PATIENT NUMBER] RX #:
Date of Filled: [ADMIT DATE] \$

To Whom it May Concern:

Please review the above mentioned prescription claim(s) that wa

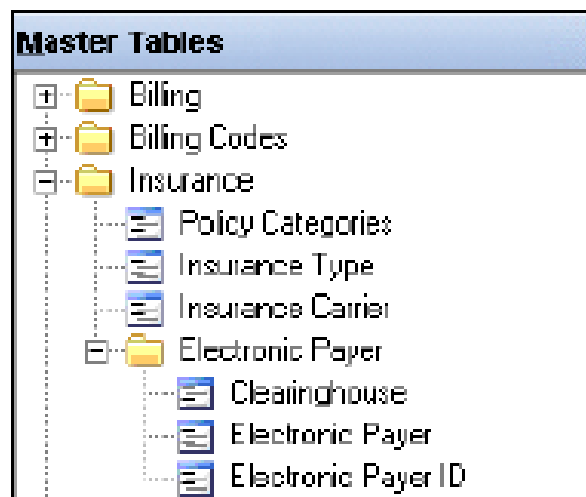
- Insurance companies frequently do not pay what they approve
 - They have no incentive to ensure that everything is paid appropriately
 - Track payments for approvals or overturns
 - When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial
 - Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute
- What About Upheld Denials?
 - Request the payer send supporting documentation
 - For incorrect payments, request a copy of the fee schedule
 - A list of CPT codes and dollar amounts a payer will allow for a particular medical service

Quiz Question #4

- What should you NOT do when appealing a claim?
 - A) Track and log payer approved appeals in the event there is a dispute.
 - B) Call the payer EVERY day asking for a status update on your appeal.
 - C) Dispute claims in writing.
 - D) Prioritize denied claims based on date and dollar amount.

- If electronic institutional and professional (837I/837P) claims are sent:
 - Identify the correct payer ID for electronic transactions
 - Consult 837I/837P EDI companion guide found on payer website
 - Use the DHA UBO User Guide and online “Data and Billing in Sync” training modules to identify information that is required for 837I/837P transactions
 - Available at
<http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance>
and
<http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses>
 - Be familiar with claim adjustment reason codes (CARC) available at
<http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/>

- Master Tables > Insurance > Electronic Payer >



- Be sure to understand the denial codes on the EOB
- Focus on effective communication with payers
- Develop a strategic plan for managing individual claim denials
- Develop a method for tracking claim denials and appeals
- Make sure claims are “clean” before they are sent
- Aggressively pursue appeals
- Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance
- Submit DHA UBO helpdesk ticket, UBO.Helpdesk@altarum.org

Questions?

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