

# Denials Management and ABACUS Capabilities

20 February 2018 1400 – 1500 EST

22 February 2018 0800 – 0900 EST

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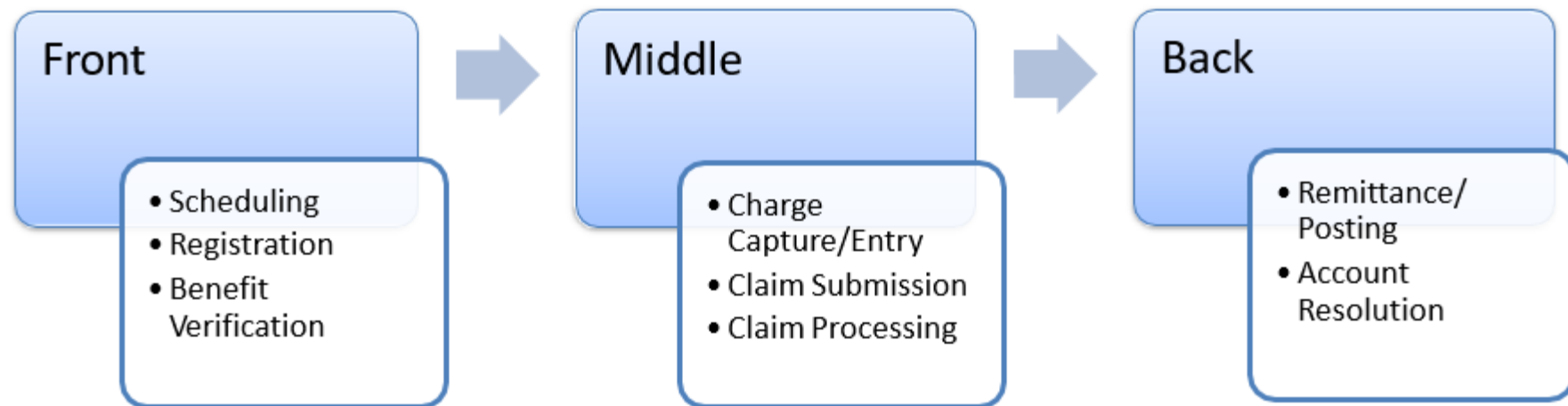
- Review relevant legislation
- What is a Denial?
- Importance of Denials Management
- Learn how to read and interpret an Explanation of Benefits (EOB)
- Identify reasons for claim denials
- Types of claim denials
- Learn how to effectively communicate with payers and MTF staff
- Discuss processes for handling claim denials
- Learn ways to track and manage claim denials and appeals in ABACUS
- Where and how to use information located in ABACUS

- Title 10, United States Code, 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, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Certain payers excluded from Third Party Collection Program
    - Applicable 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.” (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

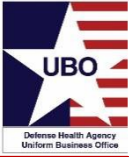
- Why Is Denials Management So Difficult?
  - Complexity of third-party denials
  - Denial information provided by third-party payers is not standardized
  - Perceived inability to capture the denial data
  - Constantly changing information
  - Requires coordination throughout the revenue cycle
  - Challenging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



- Member Not Eligible
- Coverage Termed
- Non-Covered Charges
- Out-of-Network Provider
- Member Cannot Be Identified

- Missing/Incorrect Modifiers
- Not Medically Necessary
- Missing Claim Information
- Additional Clinical Information Required

- Duplicate Claims
- Previously Paid Claim
- Additional Claims Information Required
- Incorrect Denials



- 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

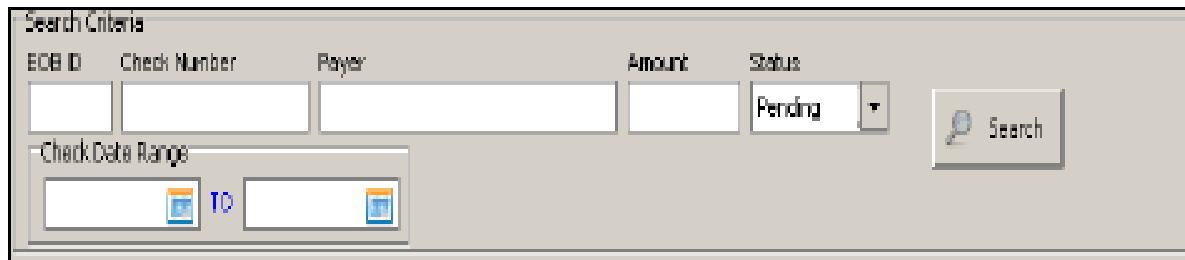
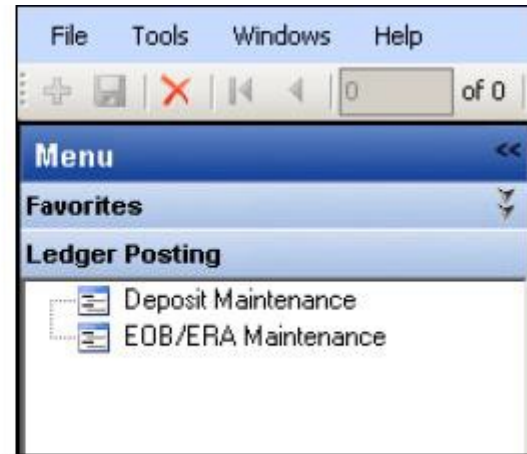
\*FY 2012 – FY 2014 outpatient claims data

“July 24, 2015, Follow-up Audit: DoD Military Treatment Facilities Continue to Miss Opportunities to Collect on Third Party Outpatient Claims”



- 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 and, if applicable, to describe why the total original charges have not been paid in full

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



A search criteria form with the following fields and controls:

EOB ID	Check Number	Payer	Amount	Status	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Pending	<input type="button" value="Search"/>
-Check Data Range					
<input type="text"/>		TO	<input type="text"/>		

## Sample EOB

Group Number: 1234567  
 Member: IMA MEMBER  
 Member's ID: 123456789-01  
 Claim Number: 800000001  
 Provider: SMITH, ROBERT  
 Payment Reference ID: 20041220112345678

**EXPLANATION OF BENEFITS**

This is **NOT** a bill.

September 6, 2011

1 Service/ product description	2 Dates you received service/product (m/d/y to m/d/y)	3 Charges billed by provider	4 Provider's fee adjustment (*)	5 Your copay (C), deductible (D) or amount not covered (**)	6 Total amount eligible for benefits	7 %	8 Your coinsurance amount	9 Adjustment	10 Total benefits from your plan	11 Amount you're responsible for
OFFICE VISIT	06/01/11 06/01/11	75.00	12.00 PDC	15.00 C	48.00	100%			48.00	15.00
LAB	06/01/11 06/01/11	89.12	15.36 PDC	50.00 D	23.76	100%			23.76	50.00
X-RAY	06/01/11 06/01/11	100.00	20.00 PDC		80.00	80%	16.00		64.00	16.00
SURGERY	06/01/11 06/01/11	50.00		50.00 575	0	0%			0.00	50.00
<b>Totals</b>		\$314.12	\$47.36	\$115.00	\$151.76		\$16.00		\$135.76	\$131.00

Your 2010/Plan Year Medical Deductible satisfied so far: \$100.00  
 Your 2010/Plan Year Family Medical deductible satisfied so far: \$300.00  
 Amount you're responsible for: \$131.00

**FUNDING ACCOUNT SUMMARY**

Amount paid on this claim: \$ 0.00  
 Your remaining family balance: \$ 0.00

For more information relating to your funding account, please see your benefit booklet or visit us on the web at: [www.premiera.com](http://www.premiera.com)

**Message Codes:**

PDC AGREEMENT DISCOUNT  
 575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

**Benefit Booklet Information:**

575 Your plan does not cover any services or supplies furnished in connection with the following conditions, services or supplies: Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.

Other plan provisions may apply. Please consult your benefit booklet for full plan information.

If you have any questions about your EOB call Customer Service at 800-722-1471, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Pacific Time.  
 Para obtener ayuda en español, llámenos al número de teléfono que se indica arriba. Sa pagtamo ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.  
 如果想用中文獲取幫助，請撥打上面的電話號碼聯繫我們。Diné k'ehji yálti'igii shika'adoolwol nínizingo díi béesh bee hane'é bich'ij' hodiñnih.  
 Our TDD/TTY number for the hearing-impaired is 800-842-5357.

**LIFEWISER**  
HEALTH PLAN OF OREGON

- 1) **Service/product description** – services the patient received from the provider
- 2) **Dates of service** – when the patient received services
- 3) **Charges** – amount billed to the patient and healthcare plan
- 4) **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment
- 5) **Copay** – the amount the patient pays the provider for a visit/service

**Deductible** – the amount the patient pays toward covered services each year before the third party payer starts paying for services

**Amount not covered** – the amount of services/products not covered by the plan

- 6) **Total amount eligible for benefits** – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered
- 7) % – percentage level of benefits for covered services/products
- 8) **Coinsurance** – what the patient must pay the health plan after the health plan pays the covered percentage
- 9) **Adjustment** – A change that relates to how a claim is paid differently from the original billing
- 10) **Total paid by health plan** – total amount eligible for benefits minus coinsurance amount
- 11) **Patient responsibility** – what the patient must pay of the billed charges after the plan benefits have paid

- 12) General Information** – patient and provider information including group #, member name, member ID, claim #, provider name, and payment reference ID
- 13) Message Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full

- 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

The screenshot displays the ABACUS Recovery Management interface. Key sections include:

- Facility:** 5TH MEDICAL WING, LOB: JVA-N, Facility # 0117, Facility NP: 1275511776, Facility RK NP: 1225137342.
- Patient Information (3):** Control #, Name (FL), SSN, ID#, Policy #, DOB, Hn Ph, RP Name, Employer.
- Placement Information (4):** Date Placed, Age at Placement, Date of Service, Date Resolved, Status (Active), Total Billed, Payments (0.00), WVO and Adj, Total Remaining.
- Carrier (6):** (ECBTX0005) ARGUS, 180 Claims for this Carrier. Table with columns: Department, Address1, Address2, City.
 

Department	Address1	Address2	City
Claims	BCBS OF TEXAS	PO BOX 860044	DALLAS
Claims	PO BOX 412019 DEF		KANSAS CITY
Professional Claims	PO BOX 860044 Prof		DALLAS
Facility Claims	PO BOX 80044 Facilit		DALLAS
- Transactions (8):**

Type	Transaction Verified	Entry Verified	Amount	Entered By	Entered	EOB ID	Note
WVO	4/16/2013	4/16/2013	-\$20.00	In Process	4/16/2013		

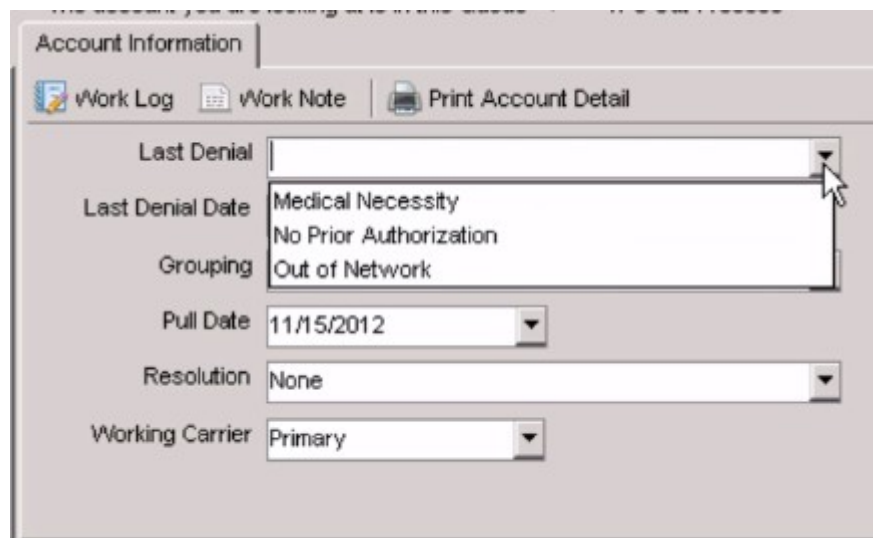
Summary: \$0.00 Remaining: \$0.00



- Non-participating provider
- Medicare EOB required
- Incorrect dates of service
- Termination of coverage
- Failure to obtain pre-authorization
- Non-covered benefit
- Untimely filing
- Out-of-network provider utilized
- Procedure or service not medically necessary
- Additional Information Needed
- Coding Errors
- Incorrect Demographic information



- 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  
No Prior Authorization  
Out of Network

Grouping Out of Network

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

## Actionable Denials

- Amount of Coverage
- MTF Did Not Comply with UR Procedures
- Other

## Un-actionable Denials

- Patient Not Covered, Care Provided Not Covered, or Policy Expired
- TRICARE and/or Income Supplemental Plans
- Medicare Supplemental Plans
- HMO/PPO
- Patient Copays and Deductibles

## Clinical Denials

- Medical Necessity
- Delay in Discharge/Procedure
- Alternate Setting
- LOS exceeds Authorization

## Administrative Denials

- Failure to pre-certify
- Lack of clinical information
- Lack of Benefit
- Exclusion Denials

- Challenges in understanding denials:
  - Variance in denial reason codes by payer
  - Denial reason does not necessarily identify the real issue
  - Inconsistently applied codes even with same payer
  - Missing denial codes
  - Denial codes that don't fit the reason the claim was denied
- Always best to call the payer for explanation. Some payers offer live online assistance through chat windows on their website.

- 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
  - Follow-up on all levels of appeals process
  - Measure denials and appeal results
  - 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

- 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

- 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

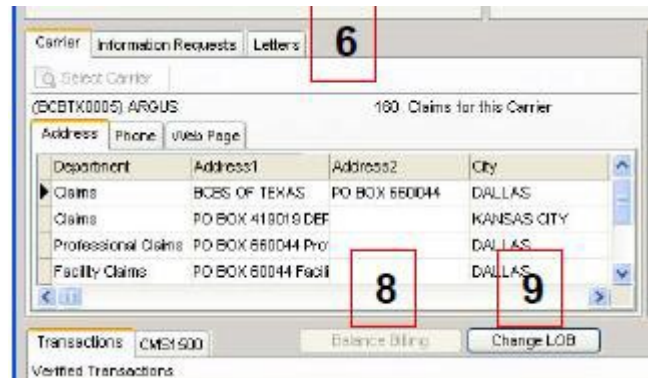
- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long you have to resubmit the claim?
  - Does the payer needs any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a 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

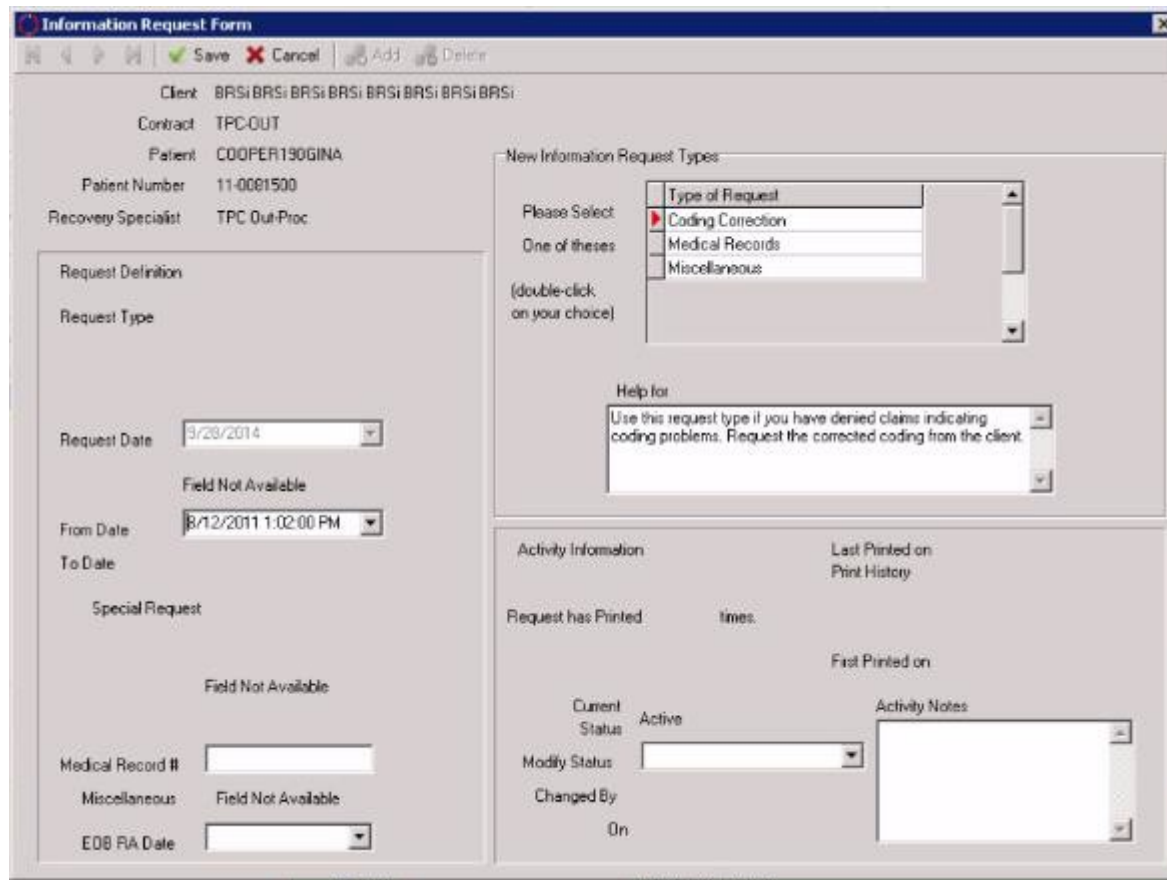


- Account Management > Recovery > Carrier Tab



- Coding
  - Accurate coding is necessary for receiving payment
  - Build relationships with coders so clean claims can be produced
- 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

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



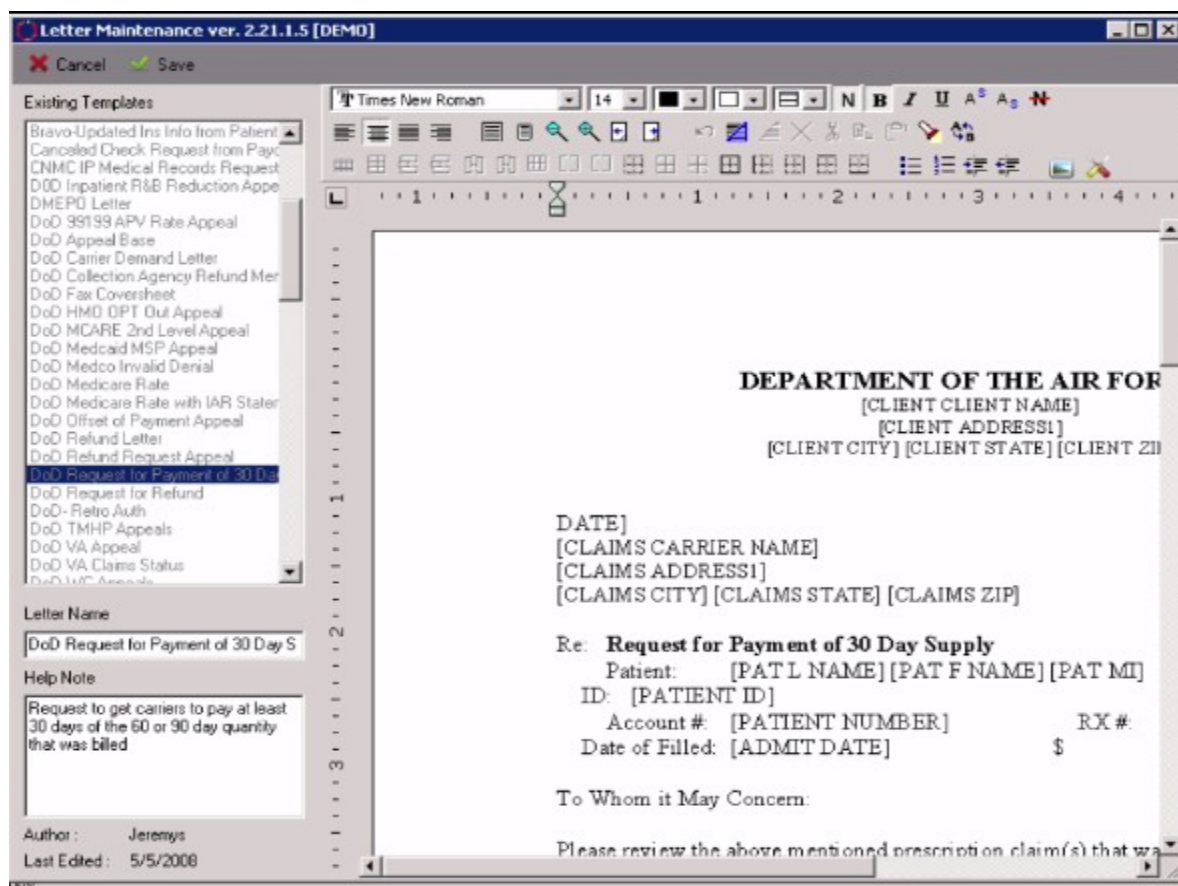
The screenshot shows the 'Information Request Form' window. The top toolbar includes 'Save', 'Cancel', 'Add', and 'Delete' buttons. The form is divided into several sections:

- 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 (3/29/2014), From Date (8/12/2011 1:02:00 PM), and To Date (Field Not Available).
- 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), and First Printed on.
- Status and Notes:** Current Status (Active), Modify Status (dropdown), Changed By (On), and Activity Notes (text area).

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

- Denied claims should be pursued aggressively
  - Denied claims should be prioritized based on date and dollar amount
  - 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



- 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

- Why track denials?
  - Defines where breakdowns are in the process to identify opportunities for performance improvement
  - Identifies unreasonable payer practices
  - Collaborative effort appeals are easier to handle in the future
  - Identifies areas where denial management efforts have been successful
  - Allows UBO to develop future goals and opportunities for preventing future denials



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

**Recovery Specialist Statistics for TPC Out-Process**

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

Active Accounts: Number 263, Amount \$84,215.49, Load Selected Accounts into Recovery

Grouping_codes	Number	Amnt Placed	Remaining Balance
Claim in Process	5	\$10,653.57	\$10,514.97
Claim in Process	129	\$36,637.07	\$36,117.98
Coinurance Amount	2	\$97.83	\$97.83
Denial Manager Review	1	\$10.60	\$10.60
Denial Review	1	\$114.88	\$160.00
Fully Paid	72	\$7,832.79	\$0.391.96
New Work	9	\$907.38	
Payer is Processing Claim	14	\$835.64	\$542.98
Pending Information from Employer	1	\$64.84	\$112.04
Pending Information from Payer	1	\$29.40	\$29.40

**Groupings in Number of Accounts**

**Groupings in Dollars**

Accounts Resolved From 8/29/2014 Thru 9/28/2014 Refresh

by Resolution
  by Facility
  by Carrier

RESOLUTION	Number	Amnt Placed	Remaining Balance
	0	\$0.00	

- “The Drill” tab allows users to search all queues using multiple levels

**Recovery Specialist Statistics for In Process**

Account Groupings | Full Date Schedule | Casier Groupings | Transactions | Daily Work Log | Inventory | DNIS Groupings | Name and Control Number Lookup | **The Drill** | Statistics

Level 1: Corporation | Level 2: Full Date | Level 3: Queue

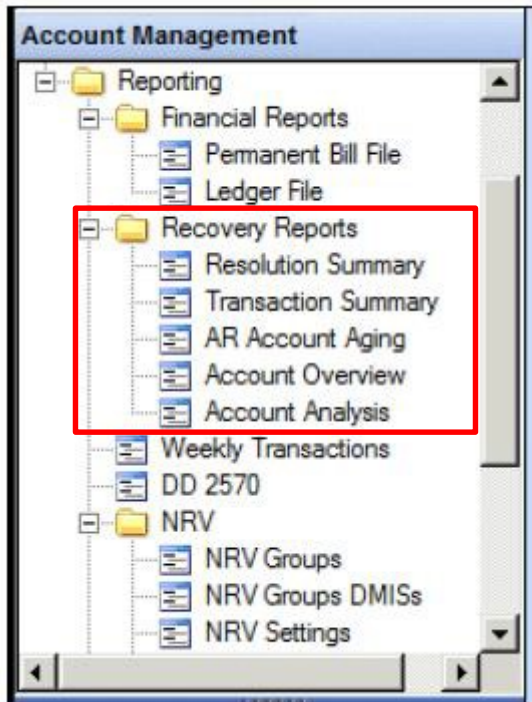
Queue Selection:

- Coding Fix
- Company ABC
- Denial Review
- GT BRSs Review
- In Process
- Out Process
- Thornton High \$
- Thornton Low \$
- Thornton Review
- TPC In-Denial
- TPC In-F/U
- TPC In-Legal
- TPC In-Process
- TPC In-Reject
- TPC Out-Denial
- TPC Out-F/U
- TPC Out-Legal
- TPC Out-Process
- TPC Out-Reject
- Transaction Rev

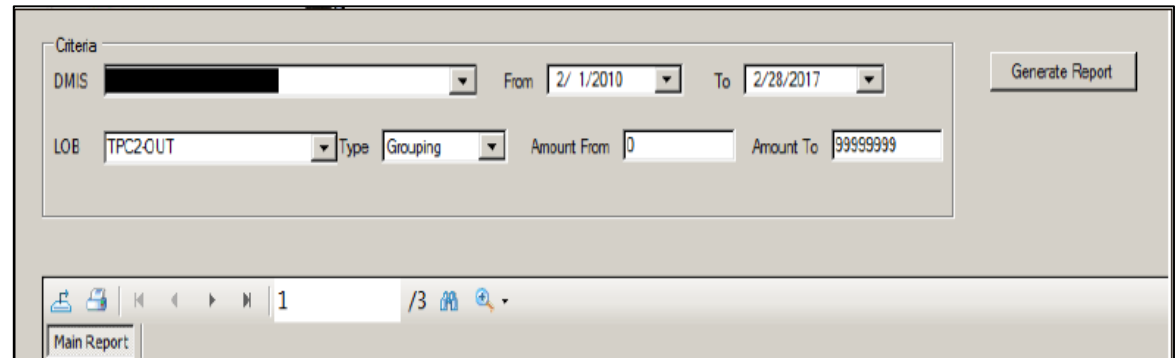
Control Number	Last Name	First Name	Placed Bal	Placement Date	Admit	Discharge	LI
0052-10-0005909	Doe	Jehn402	\$122.78	10/14/2009 7:4	10/7/2009 7	10/7/2009 7	T
0052-10-0005910	Doe	Jehn16	\$212.69	10/14/2009 8:5	10/7/2009 8	10/7/2009 8	T
0052-10-0005911	Doe	Jehn1414	\$30.10	10/14/2009 11:1	10/7/2009 1	10/7/2009 1	T
0052-10-0005928	Doe	Jehn6483	\$70.69	10/14/2009 2:11	10/7/2009 2	10/7/2009 2	T
0052-10-0005931	Doe	Jehn326	\$88.06	10/14/2009 1:38	10/7/2009 1	10/7/2009 1	T
0052-10-0005932	Doe	Jehn6178	\$131.64	10/14/2009 1:04	10/7/2009 1	10/7/2009 1	T

- Grouping claim denials
  - Payer and type
  - Reason
  - Develop denial categories
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Show impact on revenue
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
  - Communicate to leadership

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



- Resolution Summary
- Transaction Summary
- A/R Account Aging
- Account Overview
- Account Analysis



Criteria

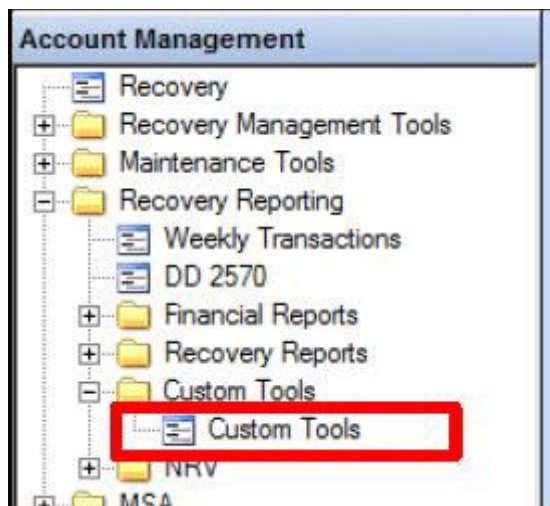
DMIS [REDACTED] From 2/ 1/2010 To 2/28/2017 Generate Report

LOB TPC2-OUT Type Grouping Amount From 0 Amount To 99999999

1 / 3

Main Report

- Custom Tools has custom reports created upon the request of the Services and NCR MD.



- Accounts in a Negative Balance
- Un-Verified Transaction Report (Accounts that need double-verification to close out)
- A/R Clean-up Aging Report
- Trend Analysis – ETU Errors 5 Week Period
- Trend Analysis – Claim Build Errors 5 Week Trend
- Trend Analysis – Recovery 5 Week Trend

- If paper claims must be filed:
  - Use only original claim forms
  - Make sure claims are printed clearly
  - Avoid folding claims, if possible
  - Avoid using terms such as “re-filed claim” or “second request”
  - Avoid handwritten claims
  - Don’t use all UPPERCASE letters
  - Don’t use punctuation or decimals on claims
  - Don’t send unnecessary attachments
  - Don’t use staples, paperclips or post-it notes
  - Don’t mark up the claim with highlighters
  - Don’t use circles or additional markings
  - Don’t attach labels or stickers
  - Don’t add notes or instructional assistance
  - Make a copy

- 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 UBO User Guide\* and online Data and Billing in Sync\*\* training modules to identify information that is required for 837I/837P transactions
  - Be familiar with claim adjustment reason codes (CARC)\*\*\*

\*<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance>

\*\*<https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses>

\*\*\*<http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes>

- Master Tables > Insurance > Electronic Payer

ABACUS - (Sensitive Information)

File Tools Windows Help

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Menu

Favorites

Master Tables

- Billing
- Billing Codes
- Insurance
  - Policy Categories
  - Insurance Type
  - Insurance Carrier
  - Electronic Payer
    - Clearinghouse
    - Electronic Payer
    - Electronic Payer ID
- Rate Tables
- Other
- Recovery

Electronic Payer ID

Overview

Electronic Payer  Payer ID  Search View All

Clearinghouse

Total Records : 114 Page 1/2

Clearinghouse	Electronic Payer	Payer Id
BRSI Clearinghouse	WELLS FARGO THIRD PARTY ADMINISTRATORS	87815
BRSI Clearinghouse	COMMUNITY HEALTH ELECTRONIC CLAIMS (CHEC ...	75261
BRSI Clearinghouse	UMR WAUSAU	39026
BRSI Clearinghouse	PUBLIC EMPLOYEES HEALTH PLAN UTAH	SX106
BRSI Clearinghouse	PRIORITY HEALTH	38217
BRSI Clearinghouse	HMA (Healthcare Management Administrator)	HMA01
BRSI Clearinghouse	CAPITAL HEALTH PLAN	95112
BRSI Clearinghouse	KAISER FOUNDATION HEALTH PLAN OF SOUTHER...	94134
BRSI Clearinghouse	UMR ONALASKA	79480
BRSI Clearinghouse	GOLDEN RULE	37602
BRSI Clearinghouse	COMMERCE BENEFITS GROUP	34181
BRSI Clearinghouse	VETERANS ADMINISTRATION	12115
BRSI Clearinghouse	AETNA	60054
BRSI Clearinghouse	KITSAP PHYSICIAN SERVICES (KPS)	KPS01
BRSI Clearinghouse	FLORIDA HEALTH CARE PLANS	59322
BRSI Clearinghouse	BCBS - Hawaii HMSA	HIBLU
BRSI Clearinghouse	NALC HEALTH BENEFIT PLAN	53011
BRSI Clearinghouse	RBMS	91176
BRSI Clearinghouse	OPTIMA HEALTH	54154
BRSI Clearinghouse	OPTIMUM CHOICE, INC	87726
BRSI Clearinghouse	MERITAIN HEALTH	41124
BRSI Clearinghouse	MEDCOST BENEFIT SVCS	56205





Recovery ver. 2.21.6.30 - (Sensitive Information) [A\_FTBLISS\_PROD]

EDISummaryForm

Patient Name: Control Number:

Clearinghouse Messages

Err Num	Error Code	Severity	Insured ID	Date of Service	Amt Billed
0		A		2/3/2017	160.47

Error Message

Forwarded to Payer~

Payer: 60054 - AETNA  
Facility: AMC WILLIAM BEAUMONT  
File Name: F:\EDI\A\_FTBLISS\_PROD\Pending\CRDatafileCR\_20170510.TXT

Payer Responses

Resp Date	Line Num	Submit Date	Date of Service	Amt Billed	Insured ID
5/16/2017	10		2/3/2017	160.47	

Payer Response

92015- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Amount- 19.56 (Code 96)~

Payer: AETNA  
Claim File  
Response File: CRDatafilePR\_20170515.TXT

Unverified Transactions

Type	Transaction Verified	Entry Verified	Declined Date	Amount	Entered By	Entered	EOB_ID	Note

Recovery ver. 2.21.6.37 - (Sensitive Information) [AB\_TRAIN]

Facility: TPC-OUT | Facility #: | Facility NPI: 1962488389 | Facility RX NPI: 1962488389

LOB: TPC-OUT | Tax ID: | Loaded From Account Lookup

The account you are looking at is in this Queue -> TPC Out-Process

Account Information: Work Log, Work Note, Print Account Detail

Account Information: Last Denial, Last Denial Date, Grouping, Pull Date, Resolution, Working Carrier

Placement Information: Date Placed, Age at Placement, Date of Service, Date Resolved, Status, Total Billed, Payments, W/O and Adj, Total Remaining

Carrier: PRNC/0009 PRIME THERAPEUTICS | 137 Claims for this Carrier

Address: PO BOX 14430 | LEXINGTON | KY

Transactions: UB04 | Balance Billing | Change LOB | Transfer to Legal | Remove Transfer

Verified Transactions:

Transaction Type	Transaction Verified	Entry Verified	Amount	Entered By	Transaction Date	EOB ID	Note
AR	8/10/2017	8/10/2017	\$22.50	TPC Out-Process	8/10/2017		Record receivable for UB04 170337P0000049 Bill Number 1 in the amount

Unverified Transactions:

Type	Transaction Verified	Entry Verified	Declined Date	Amount	Entered By	Entered	EOB_ID	Note

Notes: 8/9/2017 3:59 PM NCPDP Response loaded from F:\PHARMACY\A\_FTBLISS\_PROD\Pending\output\A08\_2017-08-09.txt Control Number 176102P0109671 Bill Number 1

RX Number Billed ICP Fee CoPay/In Amt Paid Remaining  
R660124710 P861 Non-Matched Group ID 301P862 Non-Matched Cardholder ID 302  
PLEASE REQUEST COPY OF THE CARD

Queue Grouping Pull Offset Rule/Item

- 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
- Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance



**Questions?**

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  - Login prior to the broadcast with your: 1) full name; 2) Service affiliation; and 3) e-mail address
  - View the entire broadcast
  - After completion of both of the live broadcasts and after attendance records have been verified, a Certificate of Approval including an AAPC Index Number will be sent via e-mail to participants who logged in or e-mailed as required. This may take several business days.
  
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  - [View the entire archived webinar \(free and available on demand at <http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Archived-Webinars>\)](http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Archived-Webinars)
  - Complete a post-test available *within* the archived webinar
  - E-mail answers to [UBO.LearningCenter@altatum.org](mailto:UBO.LearningCenter@altatum.org)
  - If you receive a passing score of at least 70%, we will e-mail MHS personnel with a .mil email address a Certificate of Approval including an AAPC Index Number
  
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