



DHA UBO Webinar: Denials Management Best Practices

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Objectives

- 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



Relevant Legislation

- 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



What is a Claim Denial?

- 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)
 - “The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.”
(healthinsurance.org)



Denials Management

- 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



Claim Denials Across Revenue Cycle



Member not Eligible	Missing/Incorrect Modifiers	Duplicate Claims
Termed Coverage	Not Medically Necessary	Previously Paid Claims
Non-Covered Charges	Missing Claim Information	Additional Claims Information Required
Out-of-Network Provider	Additional Clinical Information Required	Incorrect Denials
Member Cannot be Identified		



The Importance of Denials Management

- 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



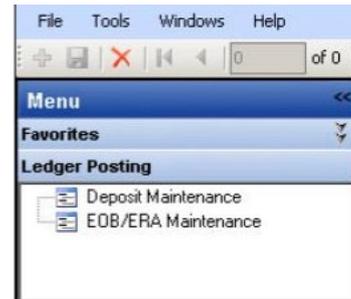
Explanation of Benefits (EOB)

- 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



EOBs in ABACUS

- 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

Check Date Range: TO



Interpreting an EOB

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
Totals		\$314.12	\$47.36	\$115.00	\$151.76		\$16.00		\$135.76	\$131.00

FUNDING ACCOUNT SUMMARY

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

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.premera.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 pagatano ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.
 如果您用中文獲取幫助，請撥打上面的電話號碼聯繫我們。Dine k'edj yáht'igil shika'adofwot ninziringo díi béeh bee hame'É bich'i'bod'iqah.
 Our TDD/TTY number for the hearing-impaired is 800-842-5357.

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HEALTH PLAN OF OREGON



Interpreting an EOB, cont.

- 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



Interpreting an EOB, cont.

- 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



Interpreting an EOB, cont.

- 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



ABACUS Denials Management Features

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

The screenshot displays the 'Recovery - (Sensitive Information) [DHL DEV: 981] ver. 2.20.1.3' application window. The interface is divided into several sections:

- 3 Patient Information:** Includes fields for Center #, Name (F/L), SSN, Policy #, DOB, RP Name, and Employer.
- 4 Placement Information:** Includes fields for Date Placed, Age at Placement, Date of Service, Date Resolved, Status, Total Bill, Payments, VSD and AB, and Total Remaining.
- 5 Account Information:** Includes fields for Last Denial, Last Denial Date, Growing, Put Date, Production, and Working Carrier.
- 6 Center Information:** A table listing 100 claims to this center with columns for Department, Address, Address2, and City.
- 7 Notes:** A section for adding and viewing notes.
- 8 Transactions:** A table showing verified and unverified transactions with columns for Type, Transaction, Verified, Entry, Verified, Amount, Entered By, Entered, EOC ID, and Note.



Common Reasons for Claim Denials

- 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



Denial Reasons in ABACUS

- 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

Grouping

Pull Date

Resolution

Working Carrier

Collection Work Note Pad

OK Cancel

Recovery Scratch Pad

Client Info From Placement Client Transaction Data

Placement Data



Types of Denial

Actionable Denials

- Amount of Coverage
- Registration Inaccuracies
- 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



Types of Denial, cont.

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 Benefits
- Exclusion Denials



Understanding Denial Reason Codes

- 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.



Denials - Best Practices

- 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



How to Establish a Best Practice

- 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



Payer Communication

- 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



Payer Communication, cont.

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

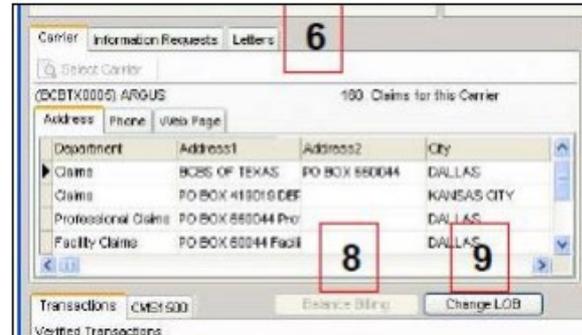


Payer Information in ABACUS

- Master Tables > Insurance > Insurance Carrier



- Account Management > Recovery > Carrier Tab



Communication Between Billers and MTF Staff

- Front Desk Staff
 - Registration
 - Other Health Insurance (OHI) collection
- Clinical Staff
 - Complete and accurate medical record documentation
 - Timely closing of encounters to avoid coding backlogs
- Coding
 - Accurate coding is necessary for receiving payment
 - Build relationships with coders so clean claims can be produced



Information Request

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

The screenshot shows a software window titled "Information Request Form". At the top, there are menu options: Save, Cancel, Add, and Delete. Below the menu, the form contains several sections:

- Client Information:** Client: BRSI BRSI BRSI BRSI BRSI BRSI BRSI; Contract: TPCOUT; Patient: COOPER190GINA; Patient Number: 11-0081500; Recovery Specialist: TPC Out-Proc.
- Request Definition:** Request Type: (blank); Request Date: 3/29/2014; From Date: 8/12/2011 1:02:00 PM; To Date: (blank).
- Special Request:** (blank).
- Medical Record #:** (blank).
- Miscellaneous:** Field Not Available.
- EOB RA Date:** (blank).
- New Information Request Types:** A list box containing "Coding Correction", "Medical Records", and "Miscellaneous". A "Please Select" label and a "(double-click on your choice)" instruction are present.
- Help for:** A text box containing the instruction: "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; Fast Printed on: (blank).
- Current Status:** Active.
- Modify Status:** (blank).
- Changed By:** On.
- Activity Notes:** (blank).

Process For Handling Claim Denials

- 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



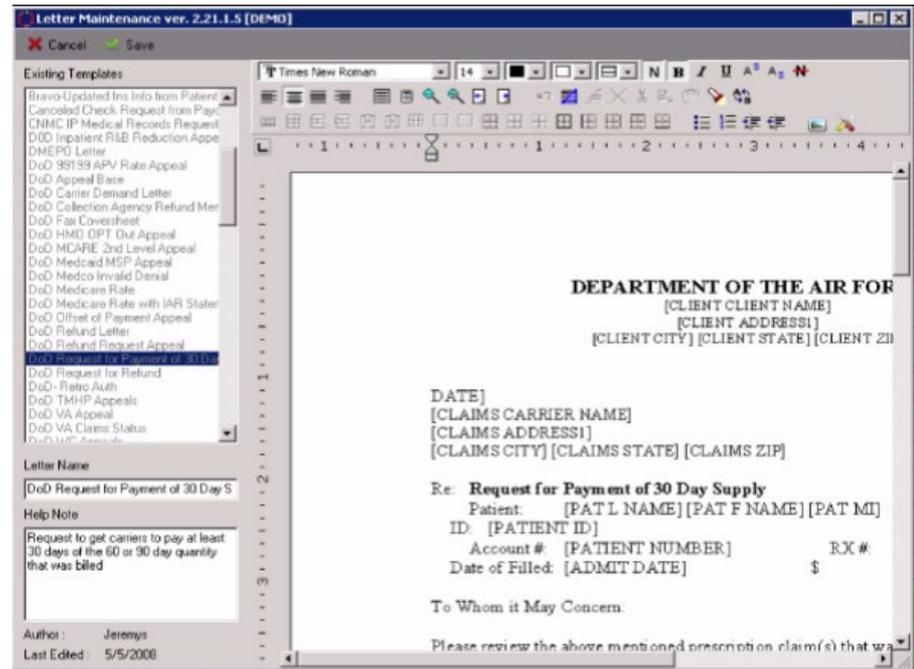
Appealing Denials

- 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



ABACUS Templates

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



Follow-up on Appeals

- 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



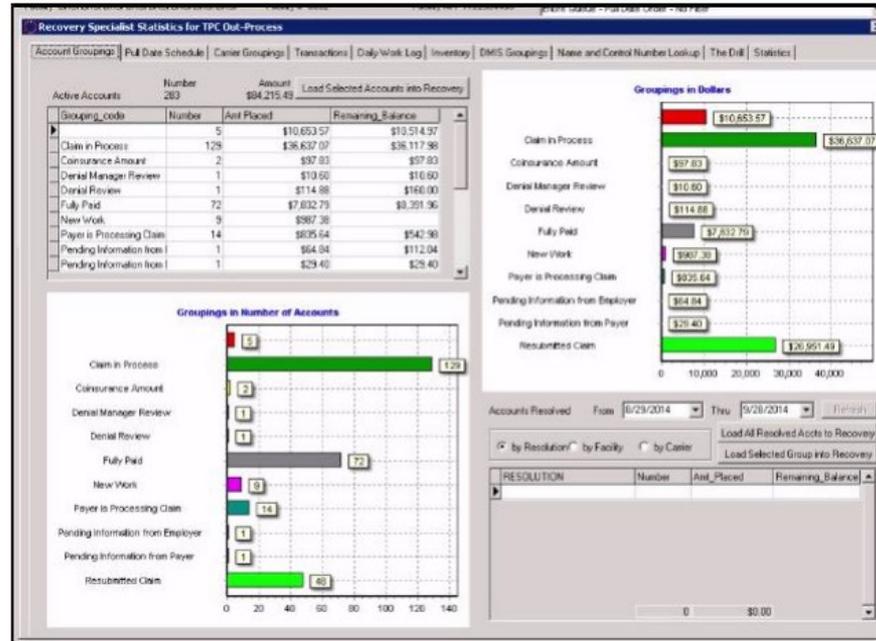
Tips for Tracking Denials

- 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



Tips for Tracking Denials, cont.

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



Tips for Tracking Denials, cont.

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

Recovery Specialist Statistics for In Process

Account Groupings | Full Date Schedule | Center Groupings | Transactions | Daily/Week Log | Inventory | DMIS Groupings | Name and Control Number Lookup | The Drill | Statistics

Level 1: Corporation | Level 2: FullDate | Level 3: Queue

Level	Count	Placed
0002	3,127	\$846,871.88
Jun 16 2012	3	\$2,978.97
Dec 27 2009	21	\$5,638.56
TPC: DuH-FU	21	\$5,638.56
Jun 18 2010	10	\$3,881.78
Jun 17 2010	13	\$1,482.94
Jun 8 2012	10	\$74,263.71
Feb 1 2012	2,676	\$555,862.85
Jan 16 2010	17	\$1,674.04
Dec 25 2009	14	\$3,125.35
Dec 21 2009	14	\$512.73
Dec 30 2009	4	\$98.55
Dec 29 2009	12	\$778.25
Jan 11 2010	10	\$4,814.13
Dec 31 2009	6	\$2,177.71
Jan 15 2010	11	\$3,219.66
Jan 20 2010	1	\$79.92

Control Number | Last Name | First Name | Placed Bal. | Placement Date Adit. | Discharge

0952-10-0009009	Doe	Johel802	\$12.78	10/14/2009 7:4	10/7/2009 7:1
0952-10-0009010	Doe	Johel6	\$212.99	10/14/2009 6:5	10/7/2009 6:1
0952-10-0009011	Doe	Johel414	\$30.10	10/14/2009 11:14	10/7/2009 1:1
0952-10-0009026	Doe	Johel6483	\$70.59	10/14/2009 2:1	10/7/2009 2:1
0952-10-0009037	Doe	Johel206	\$86.36	10/14/2009 1:3	10/7/2009 1:1
0952-10-0009032	Doe	Johel719	\$131.54	10/14/2009 1:9	10/7/2009 1:1

Queue Selection: Unselect All

- Lodging Fix
- Company/ABC
- Denial Review
- GT BRIS Review
- InProcess
- Out Process
- Thomson High \$
- Thomson Low \$
- Thomson Review
- TPC: In-Denial
- TPC: In-FU
- TPC: In-Legal
- TPC: In-Process
- TPC: In-Reject
- TPC: Out-Denial
- TPC: Out-FU
- TPC: Out-Legal
- TPC: Out-Process
- TPC: Out-Reject
- Transaction Rev

c-Load detail into Grid | c-Load Selected into Recovery | If None Selected, entire list will be loaded into recovery

Done



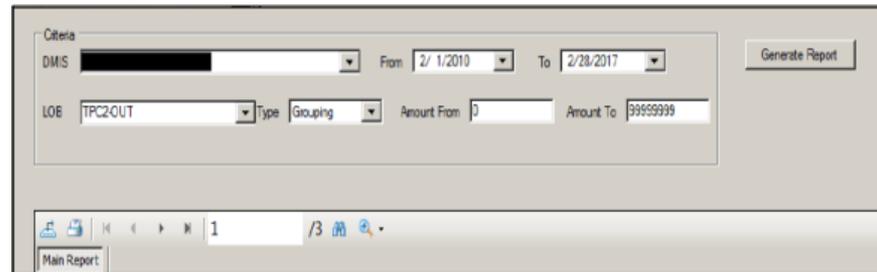
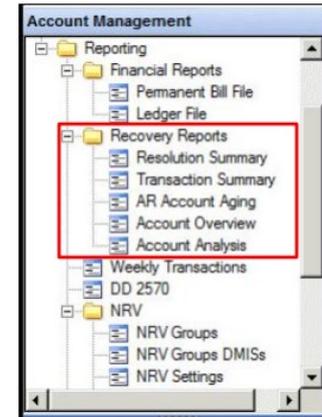
Tips for Tracking Denials, cont.

- 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



Tips for Tracking Denials, cont.

- Account Management Reports allows users to enter parameters for generating specific reports
 - Resolution Summary
 - Transaction Summary
 - A/R Account Aging
 - Account Overview
 - Account Analysis

A screenshot of a report generation criteria form. It has a "Criteria" section with a dropdown menu for "DMIS" (value is redacted), a "From" date field set to "2/1/2010", and a "To" date field set to "2/28/2017". There is a "Generate Report" button to the right. Below this, there is a "LOE" dropdown set to "TPC2OUT", a "Type" dropdown set to "Grouping", and "Amount From" and "Amount To" fields with values "0" and "99999999" respectively. At the bottom, there is a "Main Report" button and a navigation bar with icons for back, forward, and search, along with a page indicator "1 / 3".

Tips for Tracking Denials, cont.

- 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 doubleverification 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



Tips For Submitting Clean Claims

- 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



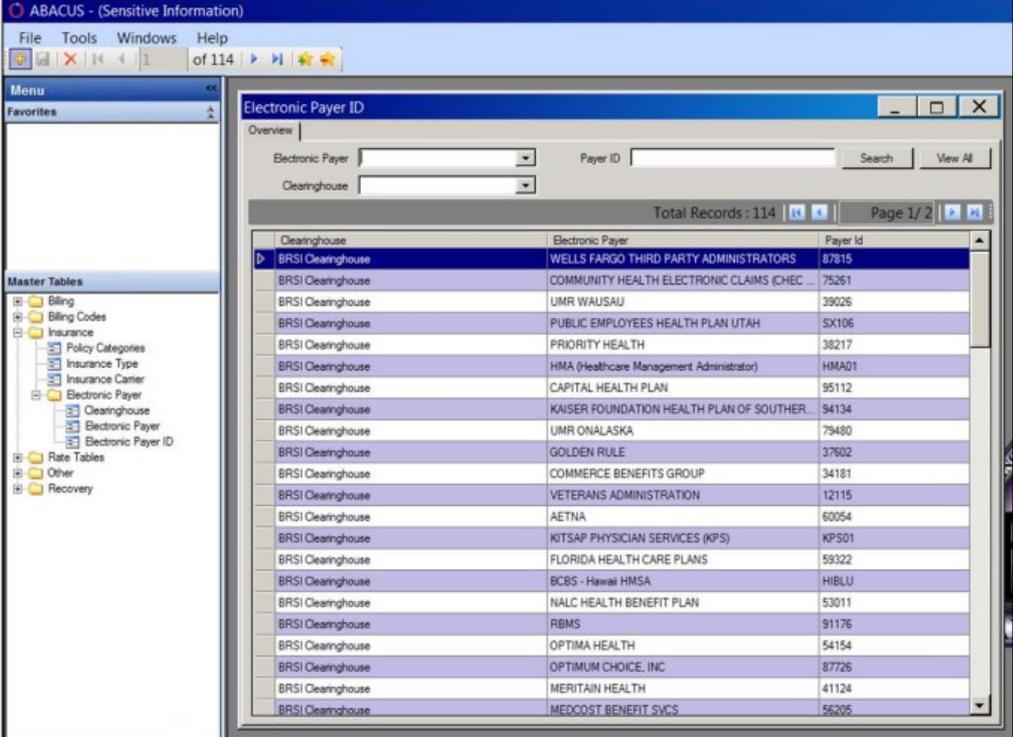
Submitting 837I/837P Claims

- 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)***



Submitting 837I/837P Claims, cont.

- Master Tables > Insurance > Electronic Payer



ABACUS - (Sensitive Information)

File Tools Windows Help

of 114

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



Submitting 837I/837P Claims, cont.

The screenshot displays the 'EDISummaryForm' window. At the top, it shows 'Recovery ver. 2.21.6.30 - (Sensitive Information) [A_FTBLSS_PROD]'. The main form area is divided into several sections:

- Clearinghouse Messages:** A table with columns: Err Num, Error Code, Severity, Insured ID, Date of Service, Amt Billed. One entry is visible: Err Num: 0, Error Code: A, Severity: A, Date of Service: 2/3/2017, Amt Billed: 160.47.
- Error Message:** A dropdown menu set to 'Forwarded to Payer--'.
- Payer Responses:** A table with columns: Resp Date, Line Num, Submit Date, Date of Service, Amt Billed, Insured ID. One entry is visible: Resp Date: 5/14/2017, Line Num: 10, Submit Date: 2/3/2017, Amt Billed: 160.47.
- Payer Response:** A text area containing the message: '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)'. This section is highlighted with a red box.
- Unverified Transactions:** A table with columns: Type, Transaction Verified, Entry Verified, Declined Date, Amount, Entered By, Entered, EOB_ID, Note.

Metadata fields on the right side of the form include: Patient Name, Control Number, Payer (00054 - AETNA), Facility (AMC WILLIAM BEALMONT), and File Name (I:EDIA_FTBLSS_PROD\Pending\CRData\leCR_20170510.TXT). A 'Number 1 in the amount' field is also visible.



Submitting 837I/837P Claims, cont.

The screenshot displays the 'Recovery ver. 2.21.6.37 - (Sensitive Information) (AB_TRAIN)' application window. The interface is divided into several sections:

- Facility Information:** Facility # 1902468309, Facility NPI 1902468309, Facility RX NPI 1902468309.
- Patient Information:** Control # 1703379000049, Name (L) ALEJANDRO721 MCKENZIE778, SSN 620, Policy # H4769026301, DOB 05/17/1912, RP Name ALEJANDRO721 JR MCKENZIE778.
- Placement Information:** Date Placed 7/19/2017, Age at Placement 59 Days, Date of Service 5/22/2017 to 5/22/2017, Date Received, Status Active, Total Billed 22.50, Payments 0.00, WD and Adj 0.00, Total Remaining 22.50.
- Account Information:** Last Denial, Last Denial Date, Grouping Claim in Process, Pul Date 6/18/2017, Resolution None, Working Carrier Primary.
- Carrier:** (PRKY0009) PRIME THERAPEUTICS, 137 Claims for this Carrier. Address: PO BOX 14430, LEWINGTON, KY.
- Notes:** A red-bordered window shows a note dated 5/18/2017 3:28 PM: 'NCPDP Response loaded from F:\PHARMACVIA_FTBLES_PROD\PendingOutput\A08_2017-08-09.txt Control Number 170103P19671 Bill Number 1. RX Number Billed ICP PS Fee CoPaytho Amt Paid Remaining R00024701 F001 Non-Matched Group ID 301F002 Non-Matched Cardholder ID 302. PLEASE REQUEST COPY OF THE CARD'.
- Transactions:** A table showing verified transactions for AR type, with columns for Transaction Verified, Entry Verified, Amount, Entered By, Transaction Date, COB ID, and Note. A total remaining of \$22.50 is shown.

Improving Health and Building Readiness. Anytime, Anywhere — Always



Summary

- 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



Questions?



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