PedsOne
Pediatric Business Specialists

UC 2023

PROACTIVELY MANAGE INSURANCE A/R

Presented by Rebecca Lamb, PedsOne Billing Specialist

INSURANCE A/R IS LIKE THE TIDES. ONCE YOU WORK IT DOWN, ANOTHER WAVE OF IT COMES ROARING BACK.

KEEP PADDLING...

TIMELY REIMBURSEMENT STARTS LONG BEFORE A CLAIM GOES OUT

BILLERS HAVE LOTS OF NEEDS...

Train the Front Desk to scan insurance cards into the patient chart, verify eligibility and update demographics at each visit.

Ensure Providers have charges ready to bill within 48 hours of time of service. Waiting to post creates unpredictable revenue and can affect timely filing.

The billing team should be expected to drop claims within 72 hours of time of service.

UNPOSTABLE CHARGES SPREADSHEET

PCC#	LAST NAME	DOCTOR	TYPE OF VISIT	REASON FOR NOT POSTING
12345	SMITH	JONES	WELL VISIT	NOT SIGNED BY PROVIDER
67890	WILLIAMS	JONES	SICK VISIT	MISSING SICK E&M CODE
51426	DOE	JOHN	SICK VISIT	MISSING INSURANCE CARD IN PATIENT CHART
21563	SMITH	MARY	WELL VISIT	MEMBER ID# NOT FOUND WITH PAYER; NO INSURANCE CARD
45124	SMITH	WILL	SICK VISIT	CHARGES INCLUDE A LEVEL 3 AND 4, NEED TO CHOOSE ONE
13452	GREEN	MIKE	WELL VISIT	NEW INSURANCE ADD TO CHART, BUT OLD PLAN WAS NOT TERMED
44112	WALLACE	MIKE	SICK VISIT	DX CODE NEEDED
12415	BLACK	MARCI	SICK VISIT	DX CODE CANNOT BE USED AS PRIMARY
22222	FORD	JAMES	IMM ONLY	1ST, 2ND OR BOOSTER FOR COVID VACCINE?
21546	PATEL	PERLA	SICK VISIT	LEVEL 5 NEEDS MORE COMPLETE DOCUMENTATION IN CHART

AND FINALLY

Enroll in EFT and ERA

Waiting on paper checks and EOBs, or Virtual Credit Card payments only slows the reimbursement process. Working any corresponding denials is further delayed by relying on these forms of payment.


WORK SMARTER
Not Harder

ENCOURAGE THE BILLING TEAM TO WORK DENIALS WHILE PAYMENT POSTING TO AVOID WAITING 30-45 DAYS BEFORE TOUCHING THE CLAIM

WAYS TO APPROACH YOUR A/R

How will your staff be most productive?

1. Set Realistic Benchmarks for A/R (under 10% in the 60+ category for Insurance only)
2. 60+ First, then work 30-59 days from TOS
3. Count Outstanding Claims and Determine How Many Need to be Worked Daily Every Week
4. By Patterns (For ex: Payer Denies Payable Code on Multiple Claims)

FIRST, WORK CLAIM ERROR & NEVER SUBMITTED REPORTS

Research Payer Rejection Reasons

- **Subscriber ID Error**
- **Patient Ineligible**
- **"Smart Edits"**
- **Code Rejections (New & Retired Codes)**
- **Provider/Entity Not Recognized**

Don't Understand the Rejection? Google It!

BEFORE YOU GO ANY FURTHER

Get to Know Your Payer Websites

AND AVOID THE PHONE WHERE POSSIBLE

Sign up for Payer Bulletins

Learn the latest changes in reimbursement rules. Keep your "rule" spreadsheet updated as things change.

Learn More about Denials

Claims on payer websites give more detail about a specific denial reason.

Utilize the Online Dispute/Appeal

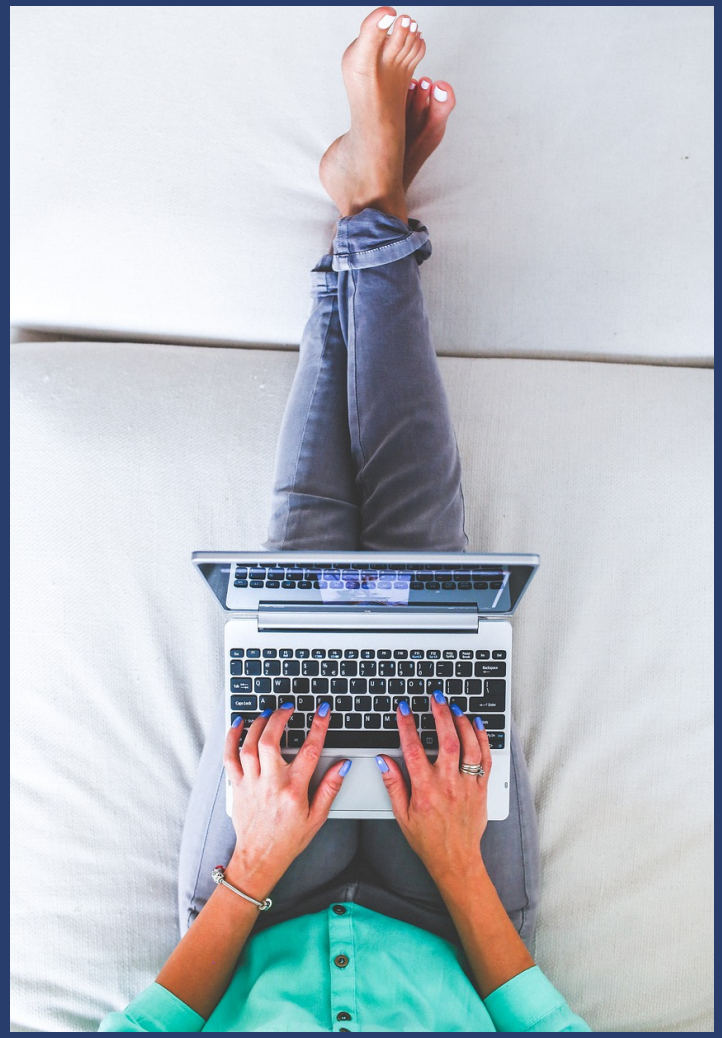
Many payers offer the ability to dispute or correct a claim online.

Upload Medical Records Online

When requested, don't mail; submit them online and keep reference number in the notes. Follow up in 30 days.

Upload Proof of TF, Insurance Term Dates, or Primary EOB

Anything the payer needs to reprocess the claim correctly can often be uploaded online. Keep the reference number and follow up.



INSURANCE RULES SPREADSHEET

Code	Aetna	Brown and Toland	Blue Cross	Blue Shield	Cigna	HealthNet	Tricare	UHC	UMR
Links					Reimb. Policies				
96161 Postnatal Depression Screening	Yes	Yes	Yes	Yes	Yes		Yes	No	Yes
96160 Health Risk Assessment Oral, TB, Lead, CRAFFT									
96110 ASQ MCHAT	Yes	No (research)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
96127 Brief Emotional Screening Teen Screen/ Vanderbilt	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
99173 Snellen Vision Screen	Yes	Yes	Z00.129/121		Yes	Yes	Yes	Yes	Yes
99177 Go-check Vision Screening w/ on-site analysis									
92551 Hearing Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
92552 Audio Screen	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
92587 OAE									
99188 Dental Varnish									
85018 Hemoglobin	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes
83655 Blood Lead Screening									

UNITED HEALTHCARE

* Claim reconsiderations
* Claim corrections
* Claim appeals

Request Details

Reconsideration Status: **Decision Overturned**

Amount Requested

I do not know the dollar amount

Request Reason

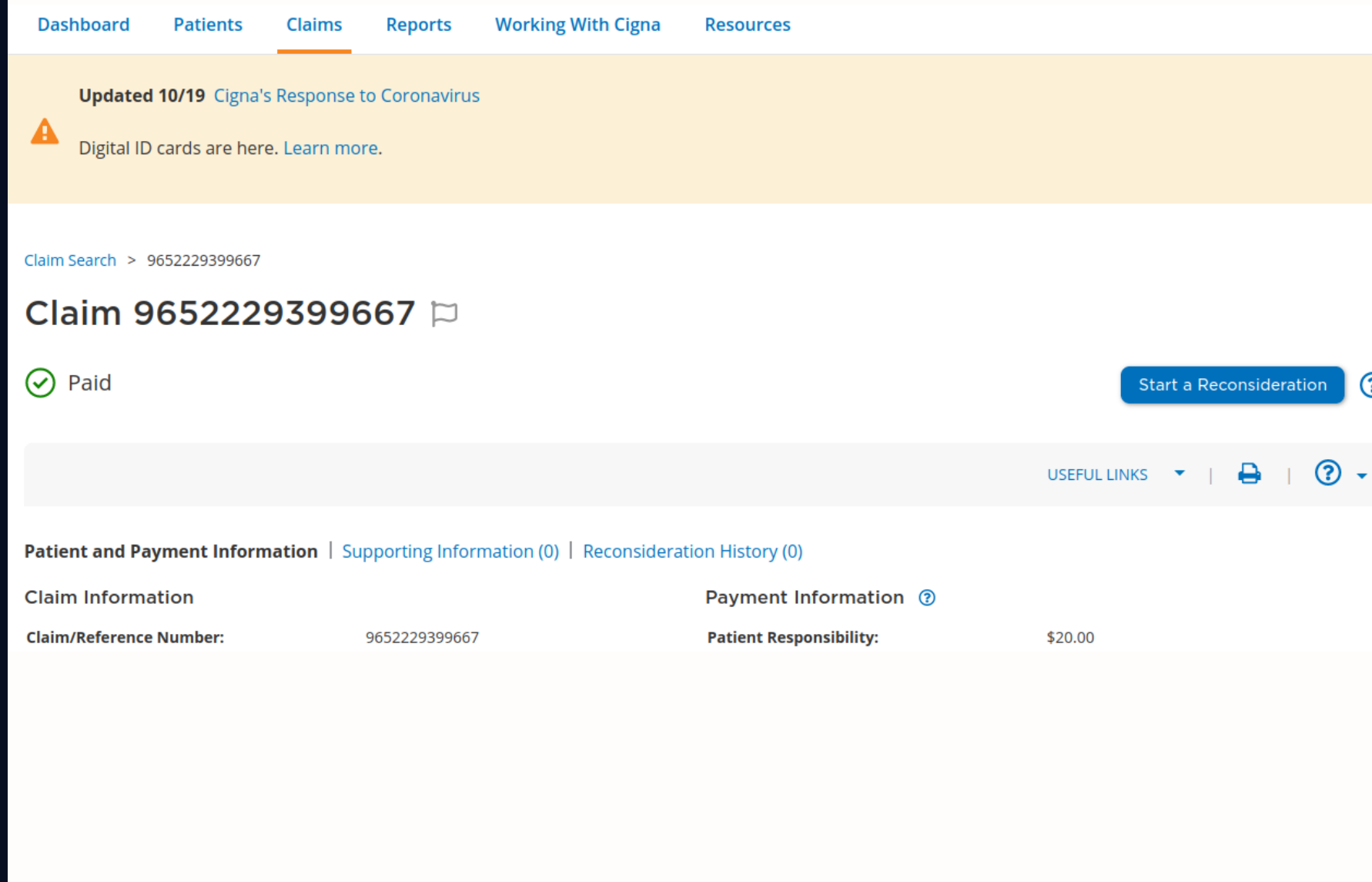
Reimbursement or Medical Policy Decision

Request History

Date	Commenter	Comment
11/08/2022	**System**	**We've completed our review of your reconsideration request and were able to make an adjustment to the claim or provide you with the information you requested. If an adjustment took place, a new Explanation of Benefits will be provided within the next 15 business days. For more information about this claim decision, including a link to applicable reimbursement policies (excluding the Oxford plan), search the claim number. Once you've located your claim, in the CLAIM DETAILS - LINE ITEMS section, select 'view' under the details column.** Show less
11/07/2022	System	Under Review
11/07/2022	Antronette Williams	Hey there, the claim did not pay code 90460 on line 3 but that needs to be paid. That is the vaccine admin code and there are vaccines on the claim. You paid code 90461 with is a add on code to 90460, so obviously you should be paying 90460 as well. Please send back for

CIGNA

Claim Reconsiderations & Reconsideration History Code Lookup Tool



Cigna. Clear Claim Connection

McKesson Edit Development | Glossary | About

CLAIM ENTRY

CODE LOOKUP TOOL

Form Type: CMS 1500

Line Of Business: (•) Commercial ( ) Medicare ( ) Medicaid

Gender: (•) Male ( ) Female

Date of Birth: __/__/____

Diagnosis Codes: 1 2 3 4

Bill Type:

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE (MEDICARE ONLY)	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4
1								__/__/____	__/__/____						
2								__/__/____	__/__/____						
3								__/__/____	__/__/____						
4								__/__/____	__/__/____						
5								__/__/____	__/__/____						
6								__/__/____	__/__/____						
7								__/__/____	__/__/____						
8								__/__/____	__/__/____						
9								__/__/____	__/__/____						
10								__/__/____	__/__/____						

Add More Procedures >>

LOOKUP RESULTS

Diagnosis Codes **1** J45.30 **2** **3** **4**

Bill Type

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

LINE	PROCEDURE	DESCRIPTION	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE (MEDICARE ONLY)	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	RVU	PAY %	RECOMMENDATION
1	99214	OFFICE O/P EST MOD 30-39 MIN	25				1		12/13/2022	12/13/2022	11 (Office)						n/a		ALLOW
2	94667	CHEST WALL MANIPULATION					1		12/13/2022	12/13/2022	11 (Office)						n/a		ALLOW
3	94760	MEASURE BLOOD OXYGEN LEVEL	59				1		12/13/2022	12/13/2022	11 (Office)						0		**DISALLOW**
4	94010	BREATHING CAPACITY TEST	59				1		12/13/2022	12/13/2022	11 (Office)						n/a		ALLOW

AETNA'S RECONDISERATION FORM

Faxing this makes it easy!

aetna

Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Aetna.

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 ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*

Contact Name and Title

Contact Address *(Where appeal/complaint resolution should be sent)*

Contact Phone	Contact Fax	Contact Email Address

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)

Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)

CPT/HCPC/Service Being Disputed

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

Note: If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a preauthorization denial and the services have yet to be rendered, use the member complaint and appeal form.

You may mail your request to:

Aetna-Provider Resolution Team
PO Box 14020
Lexington, KY 40512

Or use our National Fax Number: 859-455-8650

USEFUL AVAILITY TOOLS

Eligibility

Confirm exact match for name, effective and term dates, as well as "other payer" name and ID# for COB denials.

Payer Chat

Work with claims rep on denials while multi-tasking and avoiding long phone calls.

Remittance Viewer

This feature allows you to find that one EOB that never made it to your office.

Dispute, Appeal, & Secure Messaging

Include a message/explanation for the adjuster embedded in the dispute, and uploading useful documentation.

My Favorites

Georgia

ders Reporting Payer Spaces More

Verify Eligibility Print this Page Secure Messaging Send Attachments

Claim 22214EB1763

Dates of Service	Processed Date	Status
07/27/2022 - 07/27/2022	**11/04/2022**	**FINALIZED**

Billed
$95.01

Status as of 11/04/2022

- Finalized/Revised-Adjudication information has been changed

Eligibility and Benefits View in Eligibility &

Availity | essentials | Home | Notifications 6 | My Favorites | Georgia | Help &

Patient Registration | Claims & Payments | My Providers | Reporting | Payer Spaces | More

Home > Anthem Georgia > Chat With Payer

Chat With Payer

Anthem

Organization* Select an Organization

Tax ID* Select a Tax ID

Select a Provider Select a Provider

NPI*

Topic for Chat* Select a reason for the chat

Service Date* 12/11/2022

Patient ID*

Patient First Name*

Patient Last Name*

Date of Birth* mm/dd/yyyy

REGISTER FOR SMALLER PAYER WEBSITES TOO!

Quick Reference for:

Eligibility,

Claim Status

Date a Check Cleared and To Whom! (If subscriber was paid, bill the family for the allowable.)

IF YOU MUST RESORT TO CALLING

- **Can't Get Past the Automated System? Get Louder!**
- **Try using the phonetic alphabet for prefixes that sound similar**
- **Language Barrier? Ask for an On-Shore Rep**
- **Automated System Doesn't Recognize Patient & DOS? Call in on a patient they do recognize and ask claims rep to look up the patient you actually want to talk about.**
- **Always get name of rep and reference number from the call and add it to notes in patient account. Follow up, using this information.**
- **If claims rep is not helpful, ask for a supervisor. Don't take No for an Answer!**

  Question Everything. Reps often learn what can be done from you!

NO CLAIM ON FILE

Don't Just Resend Your Claim if Your System Shows It Went Out! (Chances are it did!)

Verify Payer ID

Is the payer ID (and claims address) a match to the patient insurance card?

Subscriber ID

Is the subscriber ID a match to the patient insurance card? Check suffix for errors where applicable.

Name and DOB

Is the Name/DOB a match between payer and your software? Consider calling the payer to find out what they have on file.

If All Else Fails...

Ask for a Fax Number for Claims!

Follow up in 3-5 days to ensure it's been acknowledged and get a DCN.

IN PROCESS...

Is the claim over 60 Days?

- Call the payer and ask if there is anything missing
- Request claim be expedited for processing
- Ask for a supervisor, if necessary
- Get name of claims rep and call reference number
- Follow up in 30 days


COMMON DENIALS

TIMELY FILING DENIALS

Know Your Payer's TF Limits

- For Original Claim Submissions
- For Corrected Claims & Appeals
- Combat Timely Filing Denials with Proof of Submission
- New Insurance Information, Past TF? No Problem; Submitting proof of original electronic claim submission to wrong Payer serves as proof enough to get the claim paid by the right Payer
- If mailing proof, send certified mail and follow up to ensure receipt

TWIN DENIALS

Some payers just don't get the twin thing...

- If you have one twin's claim deny as a duplicate to the other, verify exact name of each newborn on payer site. Call payer, include the claim# of the claim that paid and ask the rep to reprocess the denial with notes explaining they are twins! If that fails, ask for a supervisor.
- Send an appeal with notes for each twin's visit, and include paper copies of each claim, along with claim numbers of the paid and denied claims. Spell it out for the appeals department!
- Moving forward, consider mailing or faxing the original claim for each twin for any new date of service. This may help to get them paid the first time they process. Include a note at the top of each paper claim.
- If it's Aetna, you may need to get a provider rep to assist in setting the twins up correctly in the Aetna system to get new claims paid. The subscriber's HR Department may also be helpful getting the babies set up in the payer's records to pay smoothly.

NEWBORN DENIALS

- **Newborn Auto-Coverage**

  Baby's not on the policy; claim denies for DOB. Call to confirm whether the policy includes automatic coverage for 31 days and if so, have newborn claim sent back for review.

- **Subscriber Slow to Add Newborn to Policy**

  After 30 days, if baby is not added to commercial policy, bill the parent in order to get things moving. Include a letter explaining how to add baby to the policy to assist these exhausted parents!

- **And Finally…**

NEVER RESUBMIT A NEWBORN CLAIM OR COB DENIAL ONCE IT'S ACKNOWLEDGED BY THE PAYER THE FIRST TIME!

IF NEWBORN IS NOT YET ON POLICY, ONCE THEY ARE ADDED, CALL THE PAYER TO REPROCESS OR DISPUTE IT ONLINE; SAME FOR COB DENIALS: ONCE PARENT UPDATES, CALL TO REPROCESS. OTHERWISE A RESUBMITTED CLAIM WILL DENY AS A DUPLICATE.

Run PCC's "Claims Submitted Over X Times" Report in SRS to find these errors!

DX CODE DRIVEN DENIALS

P Codes

No more P codes on claims once the baby is 29 days old and older!

Age Related Dx

Newborn Dx codes on Mom's autocoverage policy (when baby hasn't been added yet). Maternal codes are not covered for pediatric patients.

BMI Codes

BMI codes on patients under 3 can cause denials.

Vague Dx

This goes back to "know your payer." Some will not reimburse for the "Feared complaint, but no diagnosis made" code, Z71.1

BE RESOURCEFUL! DON'T WAIT ON PARENTS TO RESPOND

DENIALS FOR PRIMARY EOB

Pull eligibility on Payer Website. Often other insurance is listed with ID

Next, Verify eligibility with the other payer. If patient is active, and the plan is primary, load the plan and batch claim.

If "other insurance" termed, download proof and submit online dispute to have the original claim reprocessed for payment.

BUNDLED BUT PAYABLE

Play around with these modifiers

Quantity vs Single Line

Vaccine admin codes, for ex, may need to be billed as quantity for multiple vaccines to pay.

Global Period

Mod 24 for an E/M unrelated to a previous procedure during the global period.

Cerumen Removal

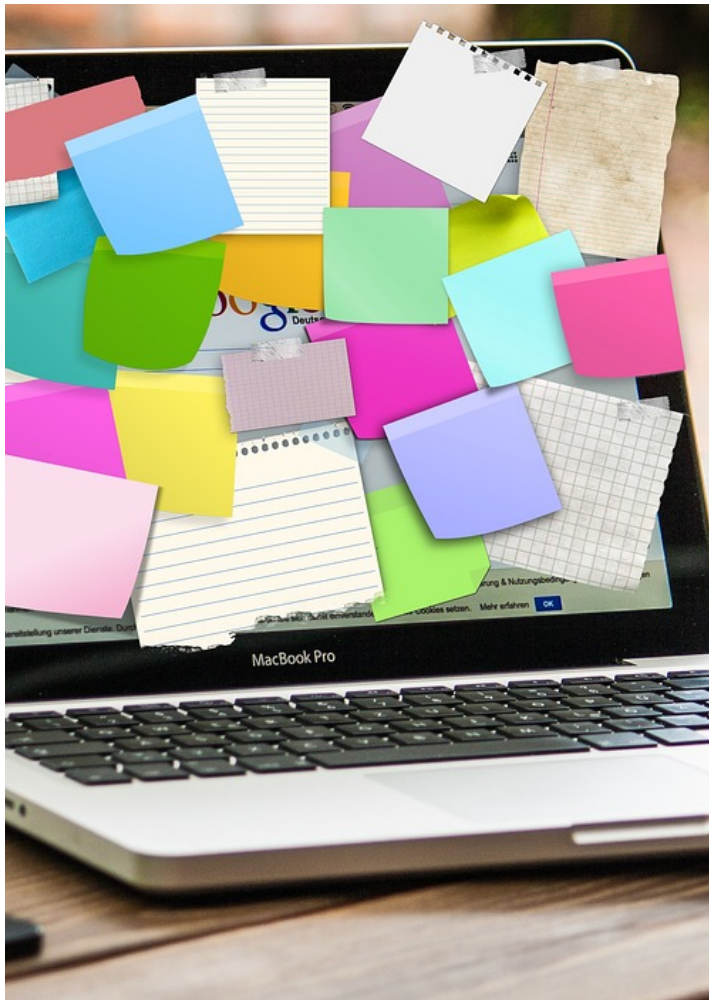
Try 50, 59, RT or LT depending upon your payer's rules.

Screenings & Labs

Developmental Screenings, Vision & Teen Depression screenings often need 59 mod to pay. In House Labs often require a QW mod.

Telemedicine Codes

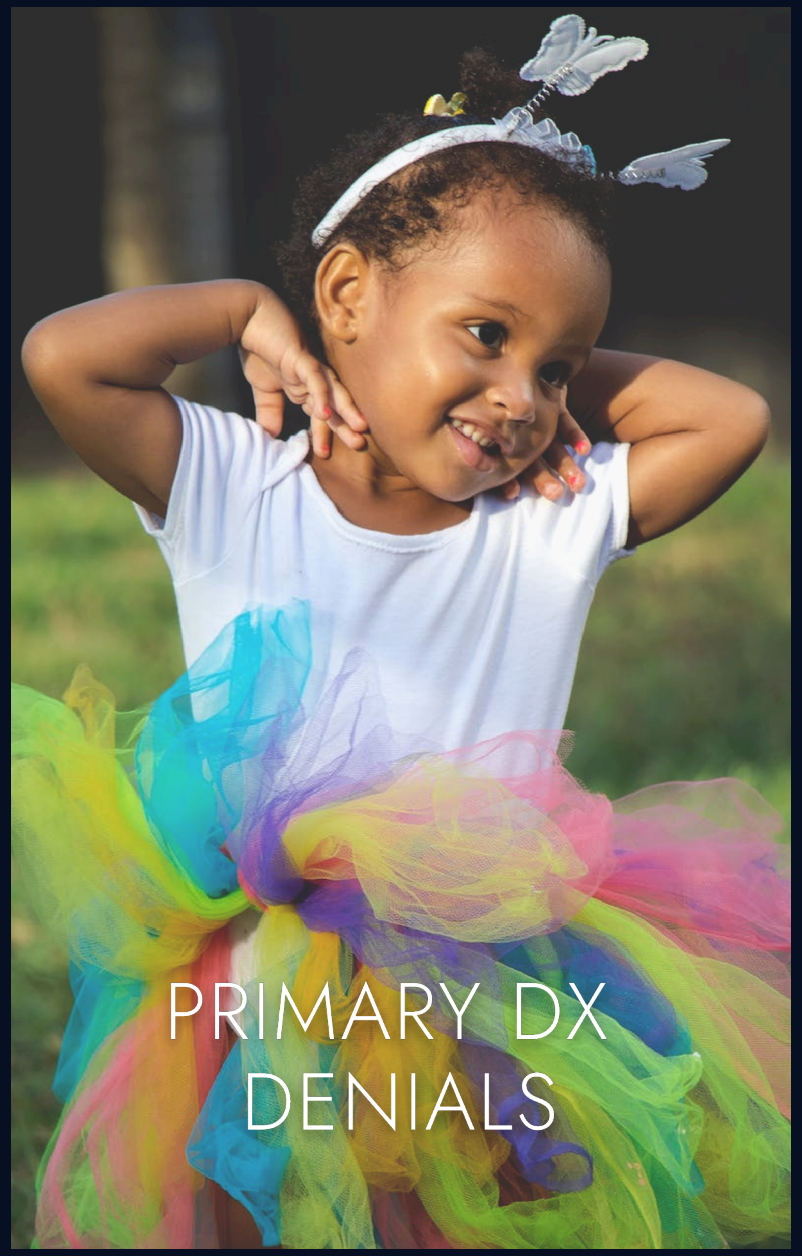
Check your payer's guidelines for the required modifier, 95, GT, CR or GQ. Confirm the POS should be 02, 10 or 11.



TOGETHER OR SEPARATE?

Labs & Tele-Medicine Codes

Bill any labs run on the same day with a telemed visit separately from the E/M code if the provider didn't see the patient in office. The labs will need POS 11 to pay.



1

External Cause Codes

ie- fall from bicycle (code laceration BEFORE the bicycle fall) These are W codes and most T codes.

2

Follow up Dx

Follow up code, Z09, cannot be primary. The condition should be listed first.

3

Common Cold and RSV Dx

Many payers will deny claim with J00 as primary. Also B97.4, the RSV code, cannot be primary.

4

Asthma as primary Wheezing as 2nd

E/M code only needs the asthma Dx; some payers will deny E/M with Wheezing Dx as 2ndary

5

Auto injuries

Insurances will not cover a visit based on an auto accident- you need a “symptom” for the primary

QUIRKY DENIALS

And Clever Solutions…

PATIENT NAME NOT A MATCH

Don't wait on the parent...

- Find the patient name on the payer website
- Change the name to match in your software, then submit claim
- Once claim goes out on paper or electronically, change name back in your software to what it should be
- Reach out to the parent to request they update name with payer for future dates of service

MEDICAID AND COB DENIALS

Again, don't wait on the parent to get paid!

- **Often Medicaid will provide "other insurance" information**

  Verify whether the policy they see on file is actually active

- **If the policy Medicaid sees termed**

  Dispute claim and upload proof of termination from other payer's site; this generally will get that one claim paid

- **Some Medicaid Plans will allow**

  An "other insurance inquiry." Medicaid will take 30 days to verify the status of the other plan they see. If it's termed, they will update the patient record. Call after 30 days for status update and to get the claims in question paid.

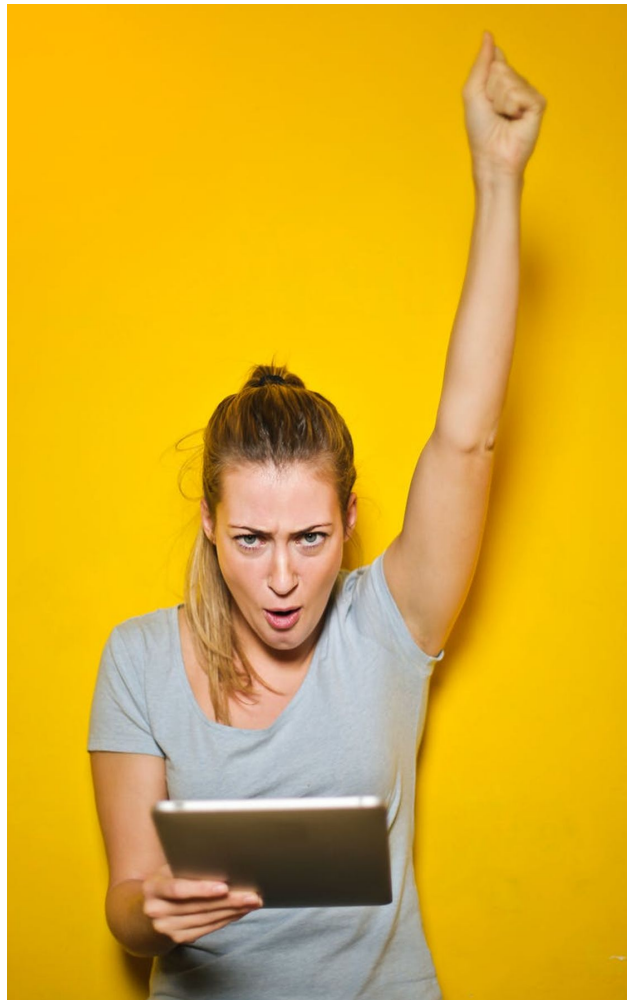
CPT CODE NOT IN FEE SCHEDULE

This is frequently a problem with Covid Vaccines & New Labs

Once the code begins to pay on recent claims, call on older denials using the claim numbers for those that did pay as support for overturning the original denials. This works well when there are not too many to call on.

For practices with lots of denials, reach out to your provider rep to help resolve the problem. If your provider rep is sluggish responding, try reaching out to a rep you've worked with well before, and cc the new rep. Generally this will get things moving in the right direction. For smaller payers, try googling a directory of managers and copy someone in contracting. This could produce the desire effect of getting the attention you need.

Some payers will accept a spreadsheet with large denial patterns, such as a claim edit issue, or incorrect copay problem (PCP vs Specialist Copay). The provider rep can then do a bulk reprocessing project to overturn all denials at one time, or a claims sweep by TIN and CPT code if they are willing.



PAYER GUIDELINES INDICATE CODE IS PAYABLE

If you've done your research on the payer website and found guidelines to support reimbursement of CPT code, but your claims continue to deny, appeal with appropriate reasoning and include the payer's own guidelines.

Boost your chances of getting the denials overturned by reaching out to higher level staff in some position of authority (supervisors, provider reps, or if it's medicaid, reach out to the appropriate department at the state level for support). Generally this nudge will produce positive results.


COMBAT
DOWNCODING

Provider Letter to Payer

Have your provider draft letter explaining to the Payer he/she is following coding guidelines; explain the rational behind the code chosen. Claims should be reprocessed for payment at the level billed.

Continue Sending Letters on Down Coded Claims

Once you've submitted enough, payer should significantly reduce the down coding on future claims. Consider giving examples to your provider rep as well.

If the Down Coding Doesn't Stop...

You could play hardball and threaten to pull your contract with the payer, and/or stop accepting any new families with this plan. Some providers have had good results with this strategy.

OTHER DENIALS WORTH MENTIONING

PCP Denials

Consider updating your software by renaming plans that require PCP so that Front Desk is prompted to remind parent at Check-In of PCP requirement.

Plans with No Preventative Benefits

Keep a list of plans with limited benefits at Front Desk as cheat sheet for those loading plan in patient account. Flag account with VFC or “Under-Insured.”

Medicaid Plans and PCP Designation

Don’t miss out on PCP designation on medicaid plans which affect your Monthly Capitation Payments. If another provider is listed as PCP, they receive your payments!

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

HASSLE FACTOR FORM

Please complete this HIPAA compliant form to report insurance administrative and claims processing concerns including settlement disputes that you may have filed. This data is confidential and assists the NJAAP in identifying common areas of concern and in facilitating dialogue with payers. ***Please provide as much detailed information as possible, such as de-identified documents that support the grievance.***

SECTION A: Personal Information - *OPTIONAL*

Physician Name | Subspecialty | Practice Name

Street | City | State | Zip Code

Contact Person | Contact Fax # | Contact e-mail address

SECTION B: Grievance Information

Name of organization/insurance company with whom the grievance is related

This is a: ☐ First time grievance ☐ Recurring grievance (How many times? _____)

Please check all that apply and describe problems in detail on the next page. If provided examples do not describe your grievance, please check "Other Problem Not Listed," and detail on the next page.

CLAIMS PROCESSING
- ☐ Claim lost by organization
- ☐ Medical records request problem
- ☐ Uncustomary request for patient information
- ☐ Inaccurate data entry following clean claim

PAYMENT PROCESSING
- ☐ Denial of payment
- ☐ Reduction of payment
- ☐ Recoding of billed services (bundling, downcoding, etc.)
- ☐ Payment incorrect as per contract

IF ALL ELSE FAILS, WE GET TO HASSLE THE PAYER!!

THERE IS JUSTICE IN THE INSURANCE WORLD…

NEGATIVE TRENDS IN A/R

Sluggish attention by billing team for working A/R on a weekly schedule

First of Year, Deductible restarts and more $$ out to personal

Credentialing/Enrollment Process, charges held for weeks/months until payer shows provider par and loaded

Flu Clinics, Prepare staff for extra charge and payment posting; Provider with high volume patient population on vacation

Payer Edits, New Codes not Loaded, Errors in System Updates

POSITIVE TRENDS IN A/R

Efficient Front Desk: Eligibility Checks, Updated Demographics, Collect Insurance Card at each visit

ERA and EFT Enrollment, This speeds up the opportunity for the billing team to work any denials, and limits time spent looking for paper/virtual card payments with their EOBs

Providers have visits ready to bill within 48 hours of Time of Service

Strategic A/R Plan and Goals within Billing Team with regular oversight

Credentialing/Enrollment Process managed closely using spreadsheet of dates, notes and contacts; follow up bi-weekly where appropriate