CHRISTUS®
Excellence and Innovation Center

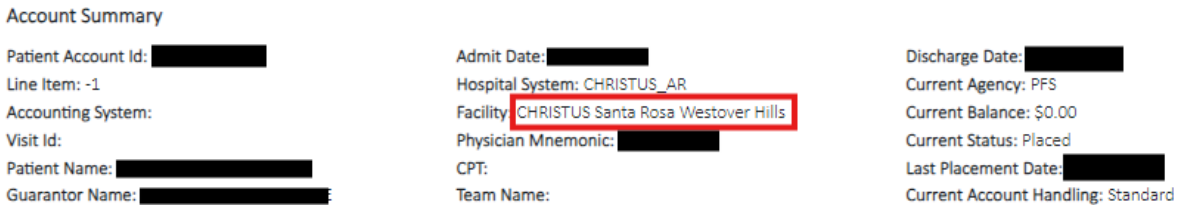
Contenido

WORKING ACCOUNTS IN BCBS EBO1.

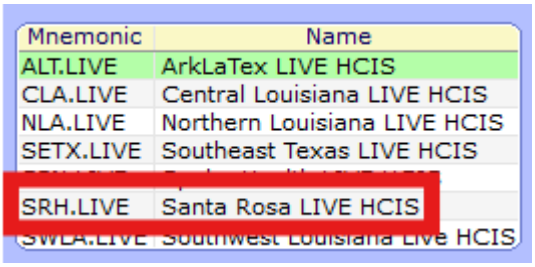
Before you begin.

Your queue will usually have the Region fixed. This can help you when looking for the accounts in Meditech.

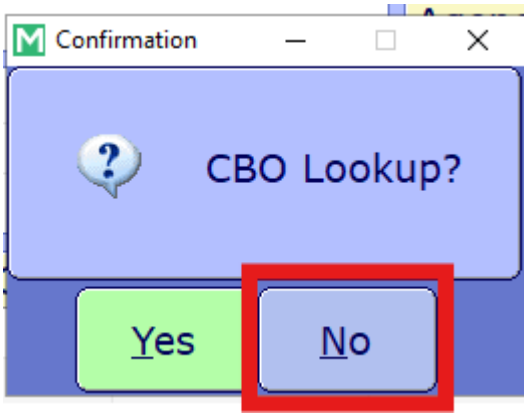
In Connance, look at the account you will be working on:



As soon as you log in in Meditech, choose Santa Rosa, for this particular example.



When you look for the account, you can choose “no” and it will open. If the message of “bad debt” shows up, just click in okay.

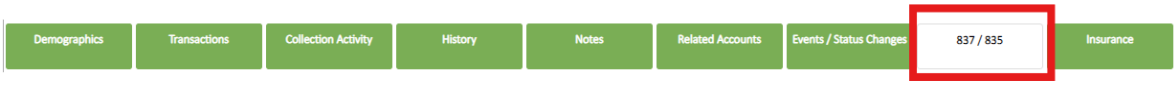


This will make the process for looking for accounts easier as well as making a pcon adjustment if needed.

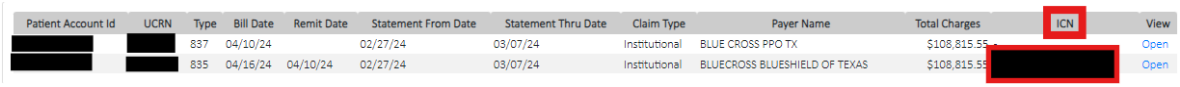
Identifying the claim

Where to find the claim

Open the account in Connance and go to the 837/835 tab.

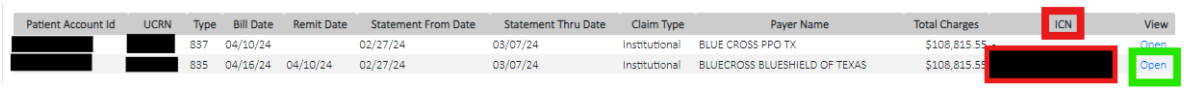


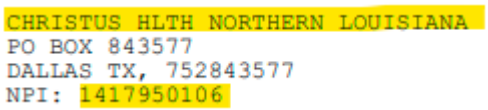
Claim number should be under the column ICN.



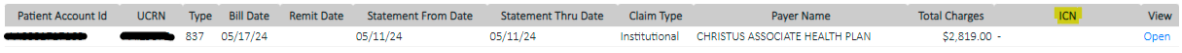
Identifying the NPI number.

The NPI is the Facility/Minister Number. You'll also need to check the location of the NPI. You can see it by clicking "open."

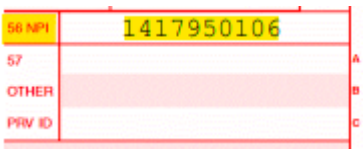




In some cases, there won't be a claim number under the ICN tab.



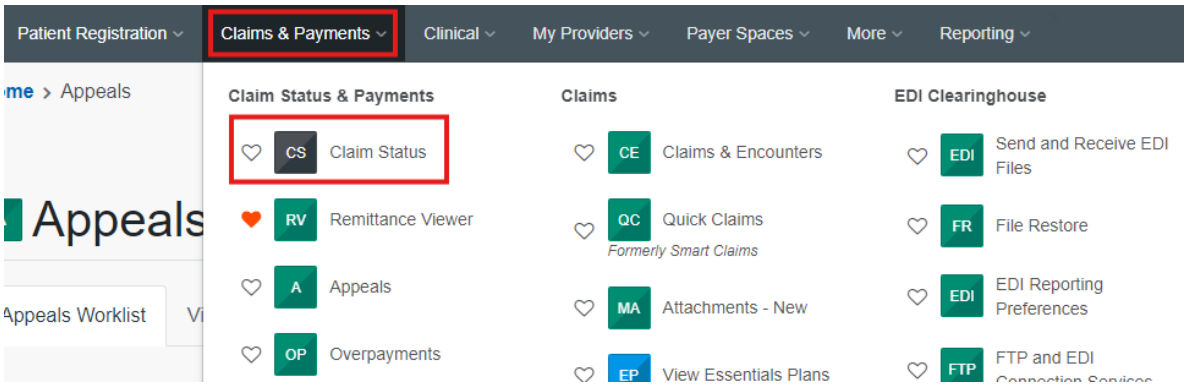
If that's the case, you can click in the hyperlinked open. This will open the ub04, and within that file you can see the NPI. You can see it in the #56 section of the ub04.



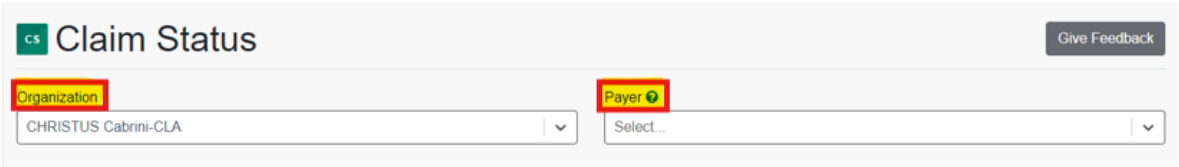
Looking for the claim in Availity.

If both the claim number and NPI number are available:

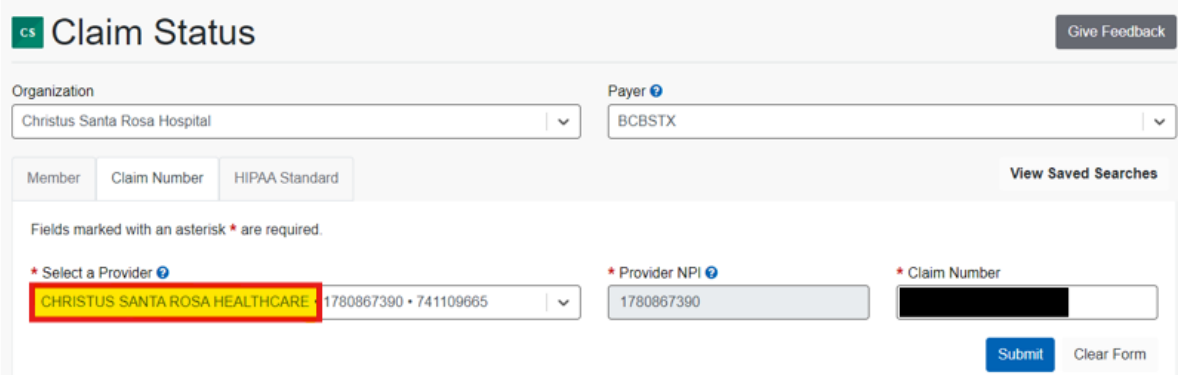
1) Go to claim status.



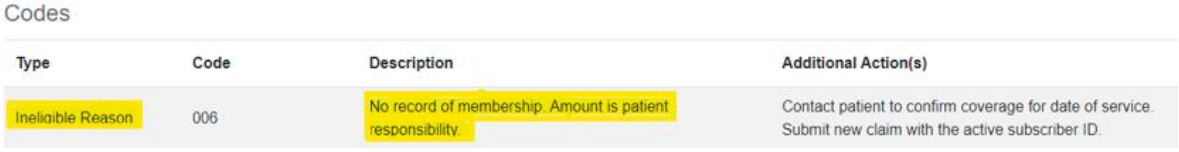
2) In the organization section choose the location of the NPI and then choose BCBSTX in the payer section.



3) Go to the Claim Number Section, then, in the select provider section, put in the NPI number found in the ub04, and then in the claim number put the claim number found in Connance and click submit.

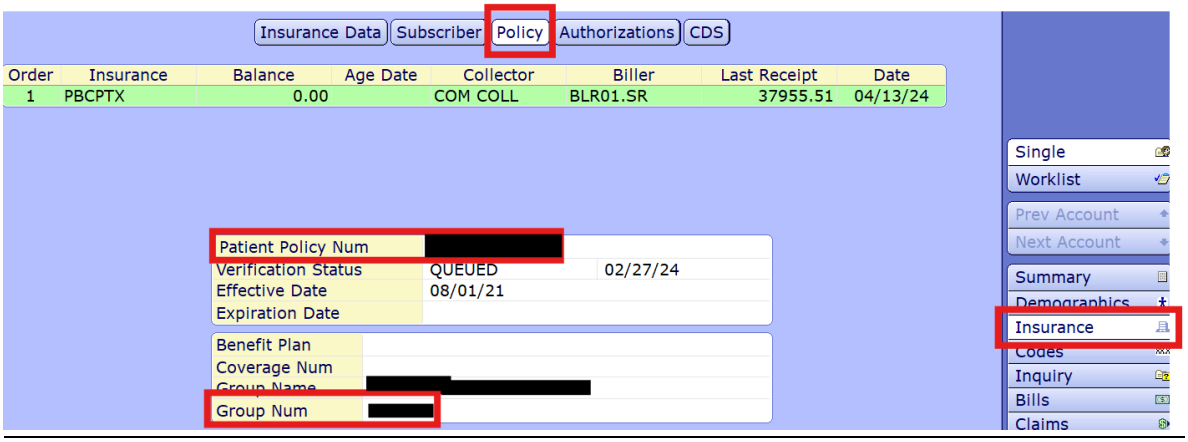


4) Once you click submit, the information of the patient will show up. Go to the bottom of the page and you will see the denial

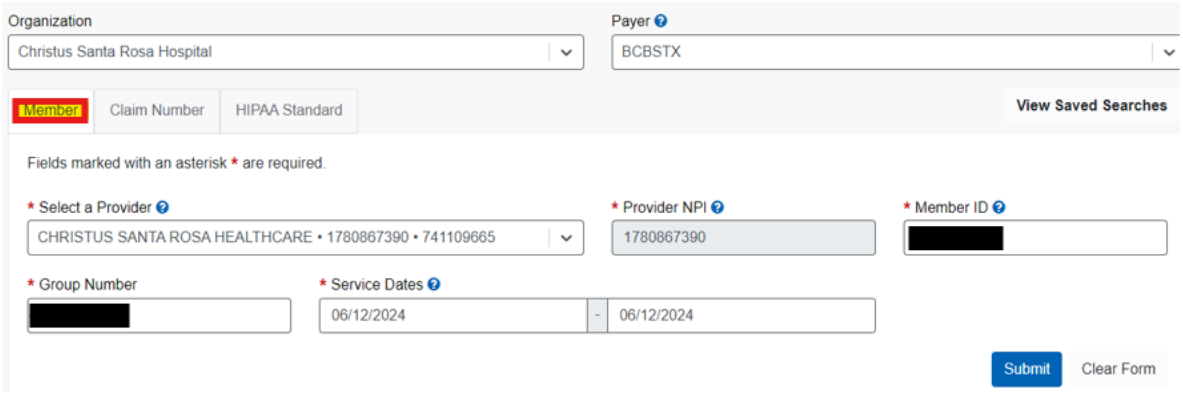


If there is no claim number in Connance.

1) Go to Meditech and click on, then click on Insurance and then click on the Policy Section



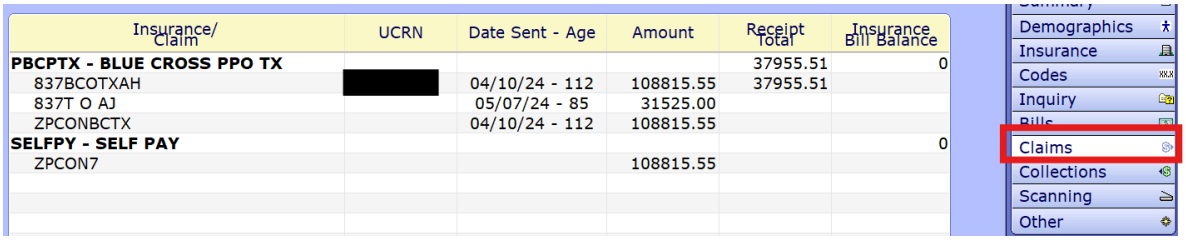
2) Follow steps of the 1st and 2nd section of the previous section. And then go to Member section. Put in the NPI number in the Select a Provider section. Put in the Patient Policy Number and the group number.



Common Denials

No claim on file

On some occasions, the section 837/835 will be empty. In that case, we must look for the UCRN number in the SSI tool. The UCRN number, can be found in Meditech under the Claims section.



Once you have the UCRN number, please follow the instructions found in the following guidelines. Starting page 11.

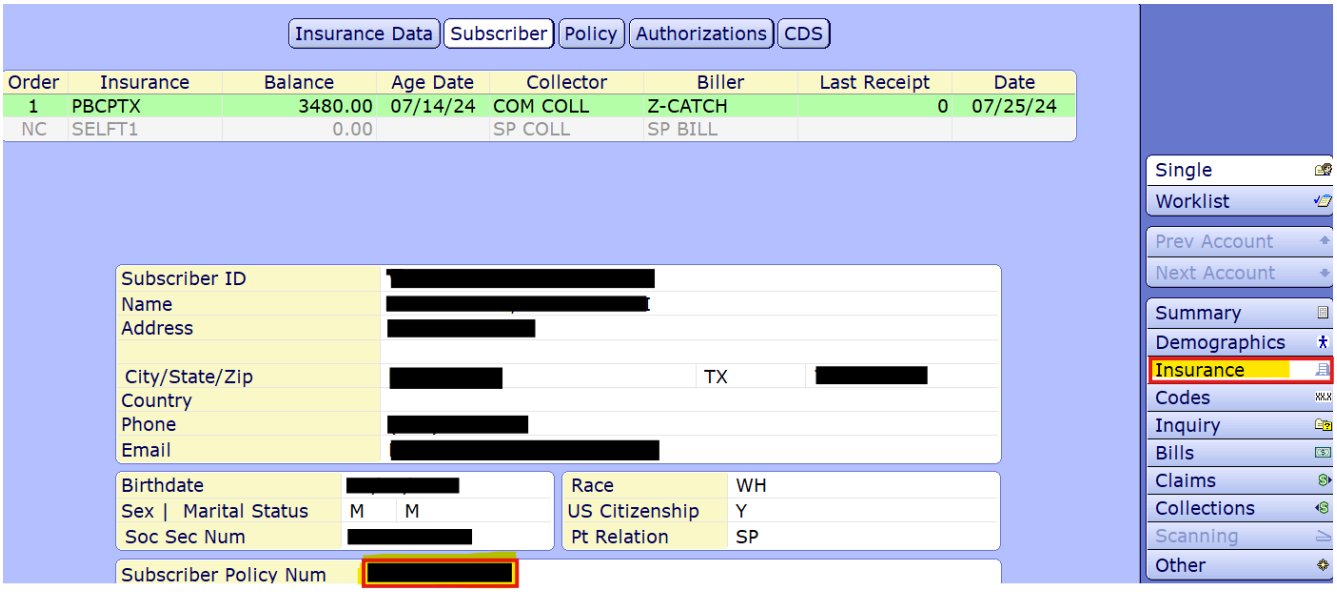
If the status is as in the image below, that means that the claim has not been created. If fewer than 30 days have passed, you should allow time for claim to be created. If more than 30 days have passed, a WQ should be submitted to billing letting them know that no claim has been created.

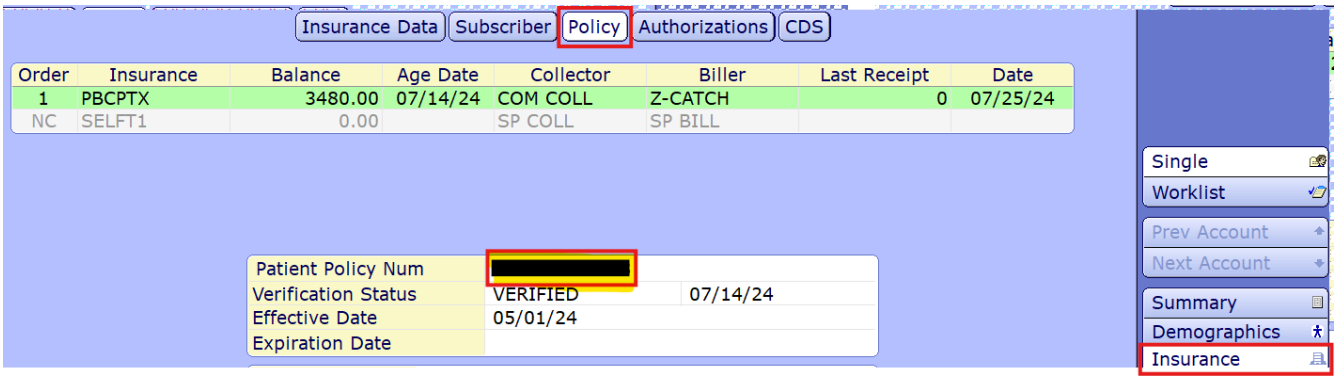
Suggested note for activity in Connance:

"WORKING CWL, NO CLAIM NUMBER NOR UCRN. WQ SUBMITTED TO BILLING AS THERE IS NO UB-04 NOR CLAIM NUMBER ON FILE. SUSCRIBER POLICY NUMBER (XXXXXX) IS VALID AS VERIFIED IN ONESOURCE. NEXT ACTION, PLEASE REVIEW IF CLAIM WAS CREATED.

On or after termination date.

This denial is used by BCBS when patient policy membership has expired. Verify that both Policy Numbers for patient are the same in the Subscriber and Policy sections under the Insurance section in Meditech.

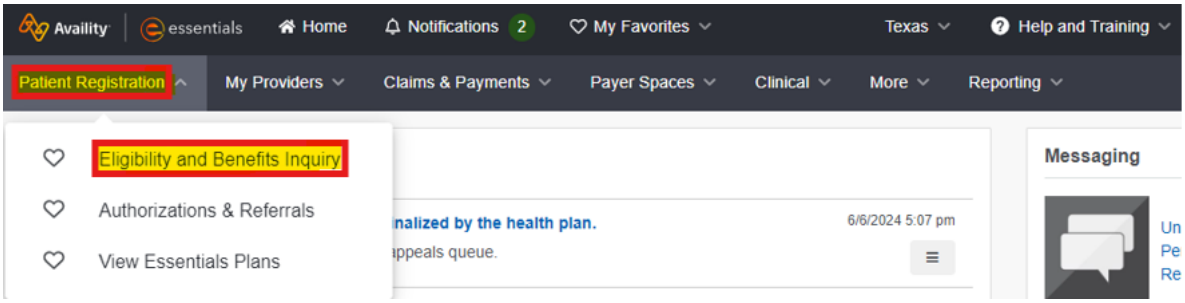




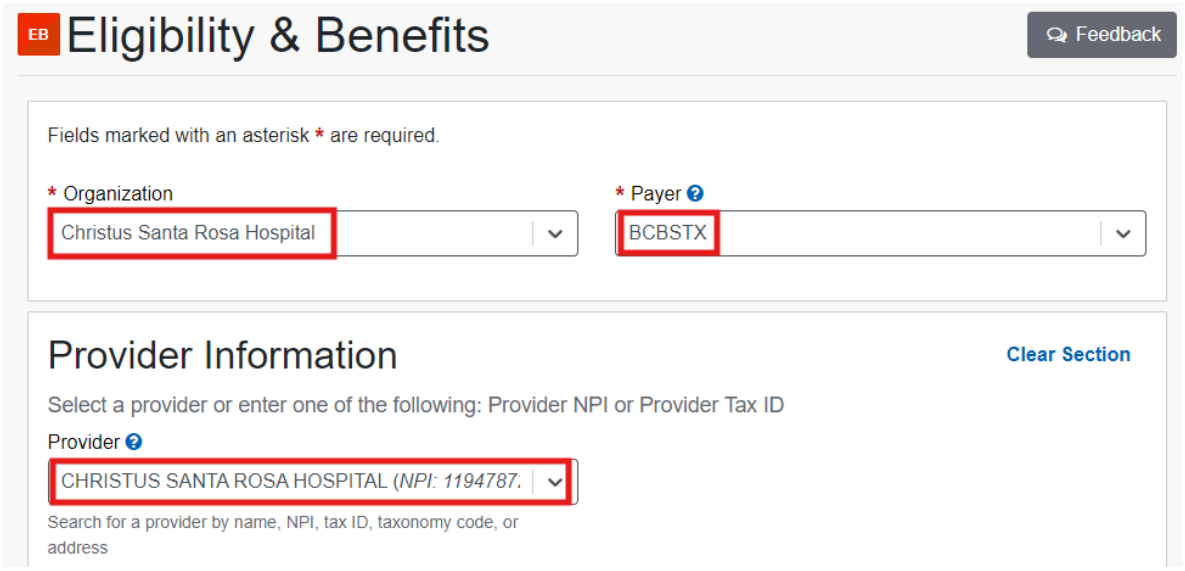
It does not matter if they are the same or different, verify their eligibility in Availity.

Verifying eligibility in Availity:

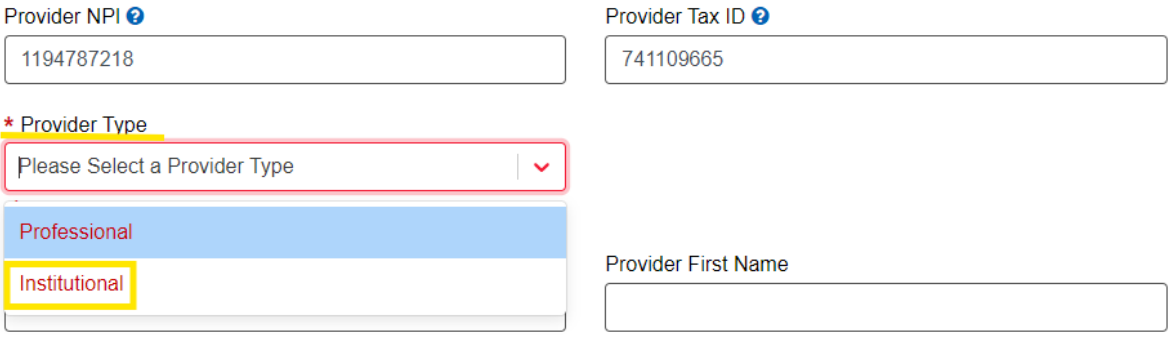
Verifying eligibility in Availity.



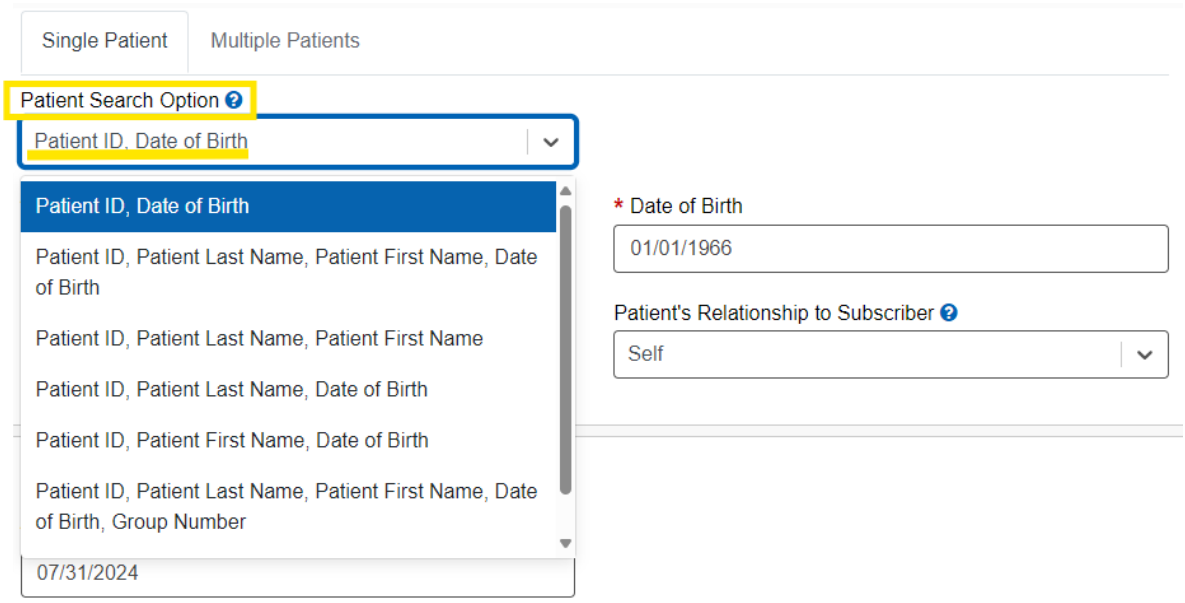
In the organization section, choose the area you are working on at that moment. In the payer section, choose BCBSTX. Then, write the NPI information in “Provider Information,” this should fill out the reminding information.



Next, change the “provider type” to Institutional



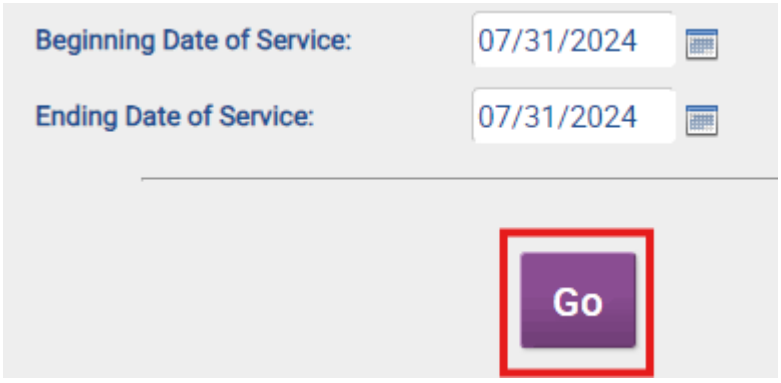
Then, fill out the patient search option as you wish, by default, Patient Id (Patient Policy Number) and the date of birth are set by default. But you can use any of the options in the drop-down menu.



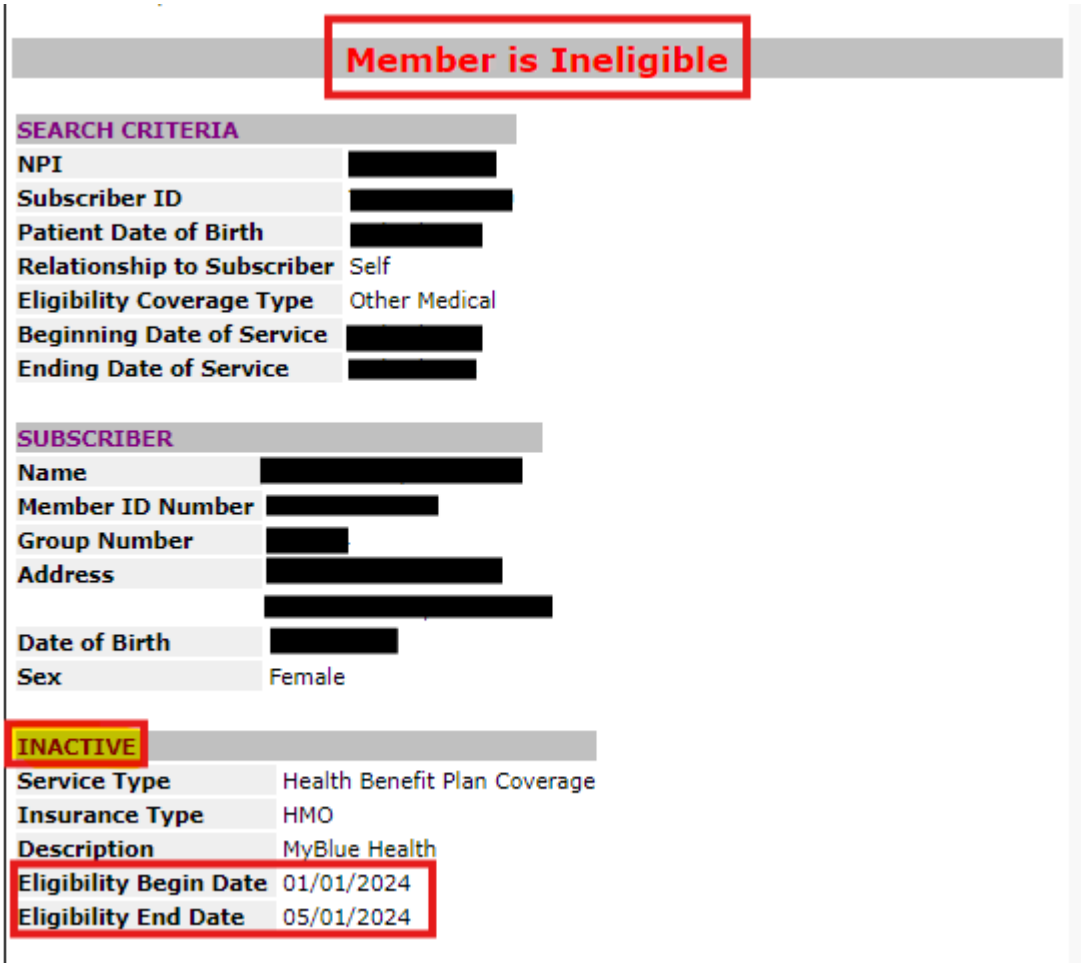
Verifying eligibility in OneSource

- Fill out the Suscriber ID and Patient Date of birth. Verify that patient relationship is according to the account you are working on and choose other medical.

- You can leave the Beginning Date of Service and Ending Date of service as is and then click Go.

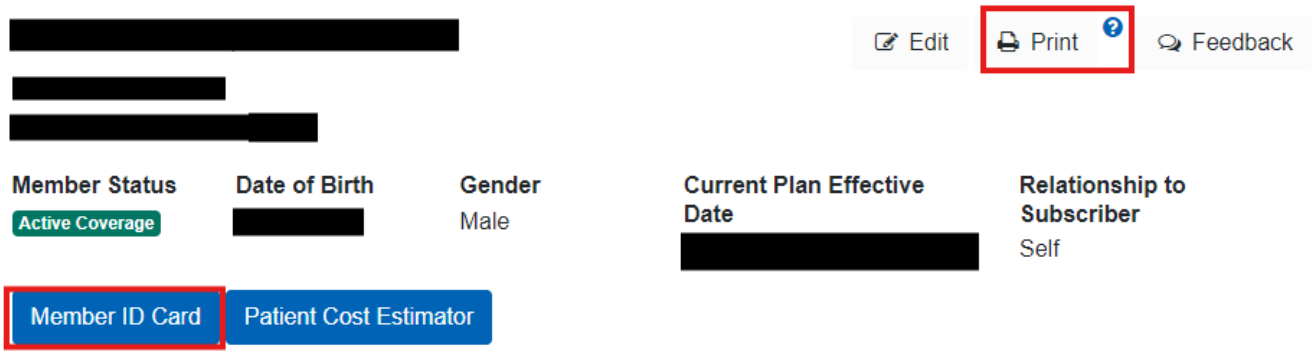


- The outcome may vary. You can check when the service expired in the inactive section highlighted in the image below.



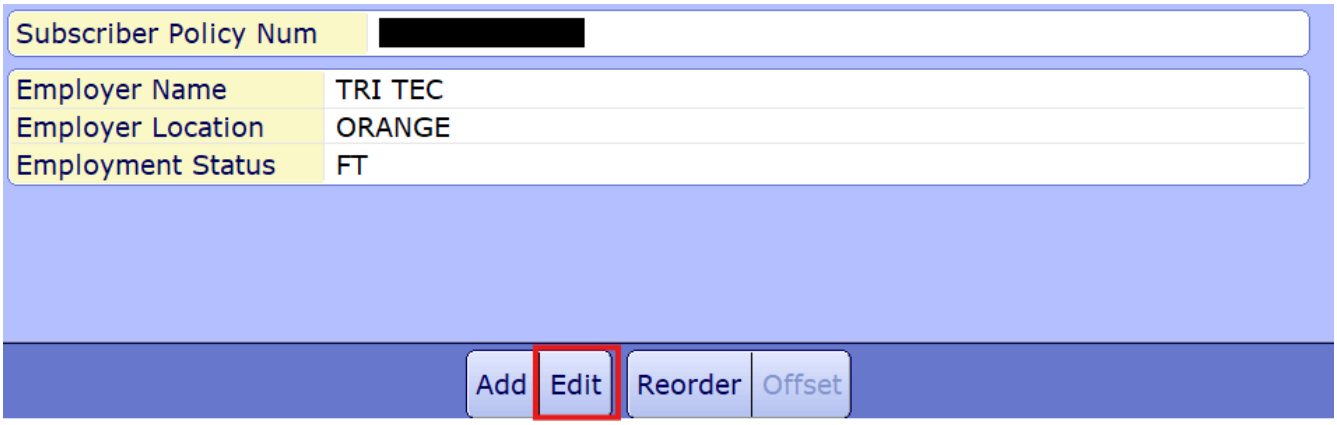
If the patient is eligible for services:

- You can print the card. If a message pops up stating that the card is not available, then you can click in the print button



Verifying Eligibility in OneSource:

If the Policy Number under the Policy Section is the one Valid, but the one in the Subscriber Section is not, update the Policy Number.



Once update, queue the claim and screen it:

If the patient is ineligible during the service:

- Go to OneContent and look for the account. Verify that patient does not have any other insurance card, either from BCBS or any other insurance company. You can find this under the Global – TEL folder in OneContent:

- If you find another Policy ID Number for BCBS, verify eligibility for that card again.
- If you find a different insurance Policy ID, submit a WQ to admitting so they can verify if this can be added it to Meditech.
- If there is no other insurance card in OneContent, make an Iplan Change to Selft1 Iplan

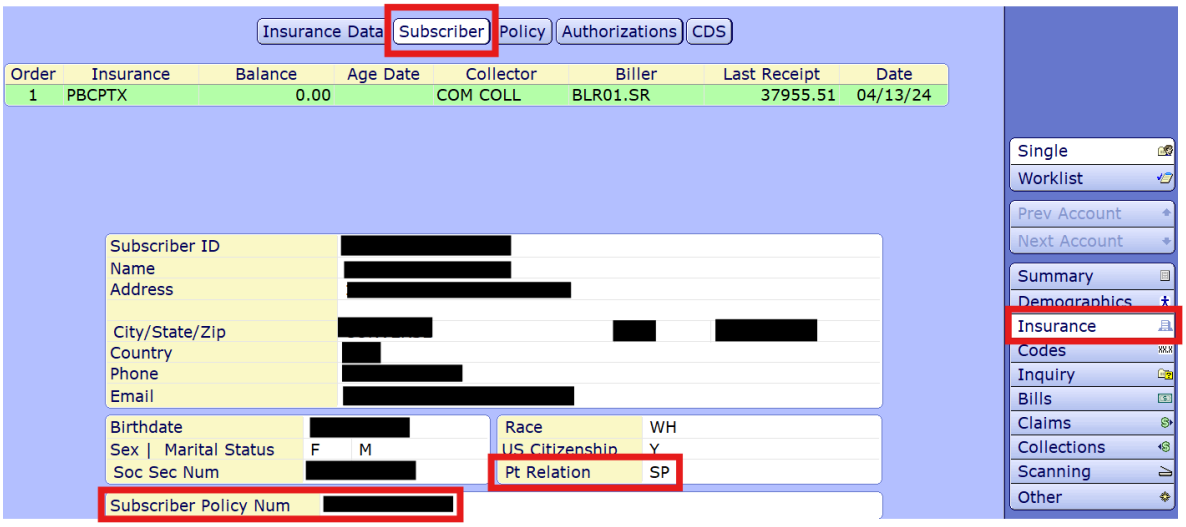
Suggested note:

WORKING ON CWL, CLAIM NUMBER XXXXXXXXXX. CLAIM WAS DENIED DUE TO: “On or after termination date. Amount is patient responsibility.” CLAIM REJECTED IN FULL ($xx.xx) SUSCRIBER POLICY NUMBER XXXXX UPDATED TO XXXXX. PATIENT RELATION CHANGED FROM SP TO CH. CLAIM WAS REQUEUED; SCREEN PASSED ALL CHECKS. NEXT FOLLOW UP: REVIEW CLAIM STATUS

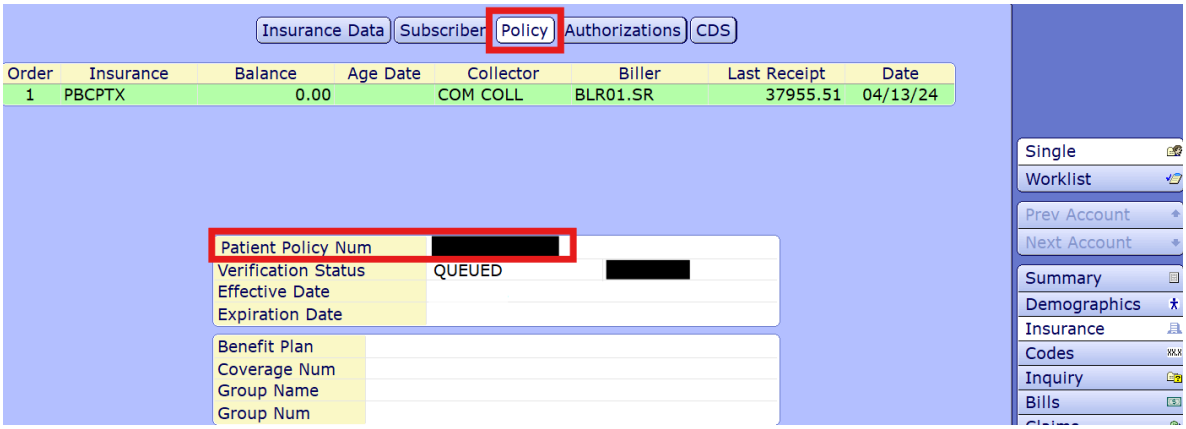
Dependent not listed in policy.

There are 2 possible scenarios when it comes to this denial.

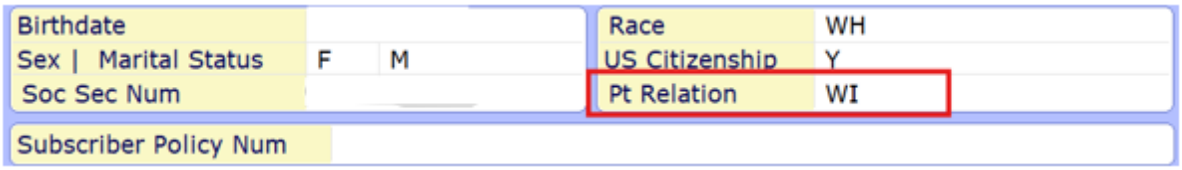
1) Go to Subscriber Section which can be found in the Insurance Section in Meditech. As seen in the image below. Pay special attention to Subscriber Policy Number and to the patient relation.



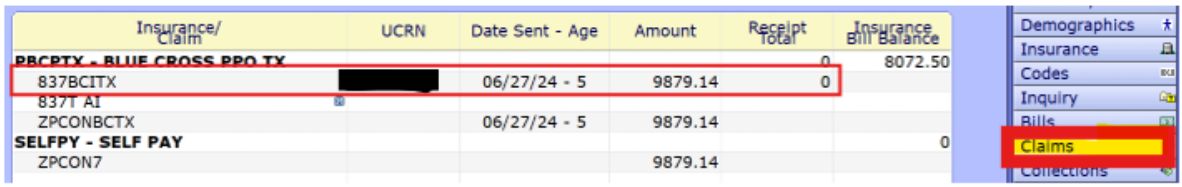
2) Compare the Patient Policy Number with the one found in the Policy Section.



3) If the Patient Policy Number is different in each section, verify eligibility for both Policies
4) If the Policy Number in the Subscriber Section is invalid, but the one in the Policy Section is valid, update the Subscriber Policy Number in the Subscriber Section. IMPORTANT, verify that the Subscriber Relation is correct. They usually confuse SP with SPOUSE, like in the image of the example. If they are a couple, change WI for Wife and HU for husband, accordingly. (checar si hay guía)



5) Once updated, go to the Claims Section, and choose the line with the UCRN number. Queue the claim and screen it.



Suggested note:

WORKING ON CLIAM NUMBER XXXXX. CLAIM DENIED DUE TO: Dependent not listed on policy. Amount is patient responsibility. CLAIM WAS REJECTED IN FULL (xx.xx) ONE SOURCE WAS CHECKED; PATIENT IS LISTED AS DEPENDANT BY THE SUSCRIBER. PATIENT RELATION UPDATED FROM SP TO CH IN MEDITECH. CLAIM WAS REQUEUED, AND IT PASSED ALL CHECKS – NEXT STEP CHECK UPDATED CLAIM STATUS.

Medical records related denials.

Here is a list of possible denials related to requesting medical records.

“A separate notification has been sent requesting additional information including medical records and/or itemized bills which is required in order to process this claim.”

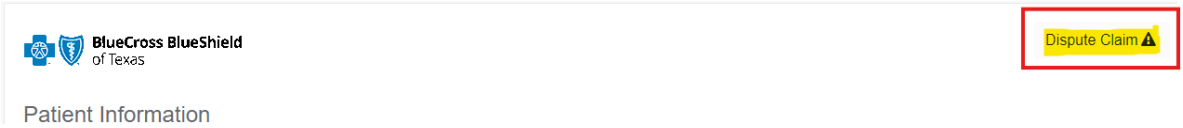
“The members plan requires a review of medical necessity before a benefit decision can be made. Medical records are required before a final determination can be made.”

“The level of service for the evaluation and management code submitted is not supported by the claim information received. A more appropriate code has been suggested. For reconsideration of payment, please submit records for further review. Medical records have been requested through assembly.”

“Medical records required.”

“Emergency services records needed to complete claim processing.”

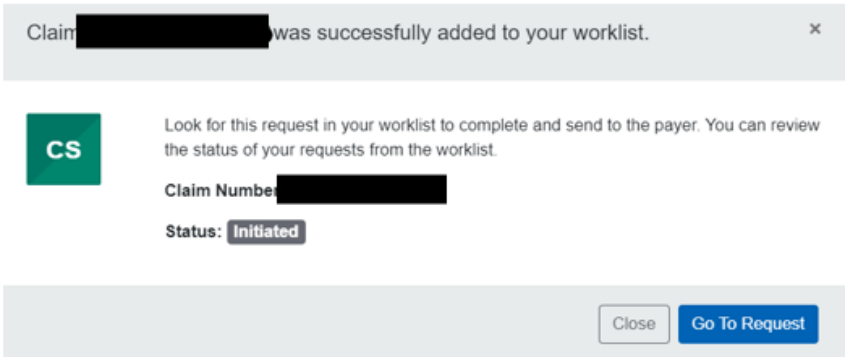
a) Verify that the letter sent by BCBS is in OneContent
b) If there is no letter requesting something specific, request medical records through Assembly in Connance.
    i) Verify that the dispute claim button is active in Availity. If the button is active, make the Assembly Request as Internal



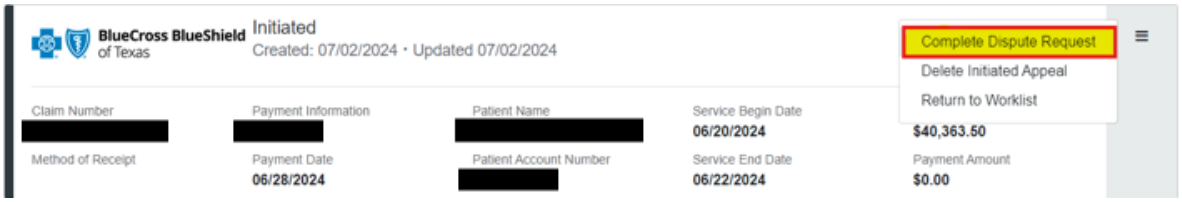
ii) If the button is not active in Availity, make the Assembly Request as Certified Mail to BCBS.

iii) If the notes state that Medical Records have been requested and that Medical Records are already in the W Drive, follow the following path in the W Drive: W:\GCTX\HSO\Business\ASSEMBLY TEAM. Then go to Availity and press the Dispute Claim button in Availity.

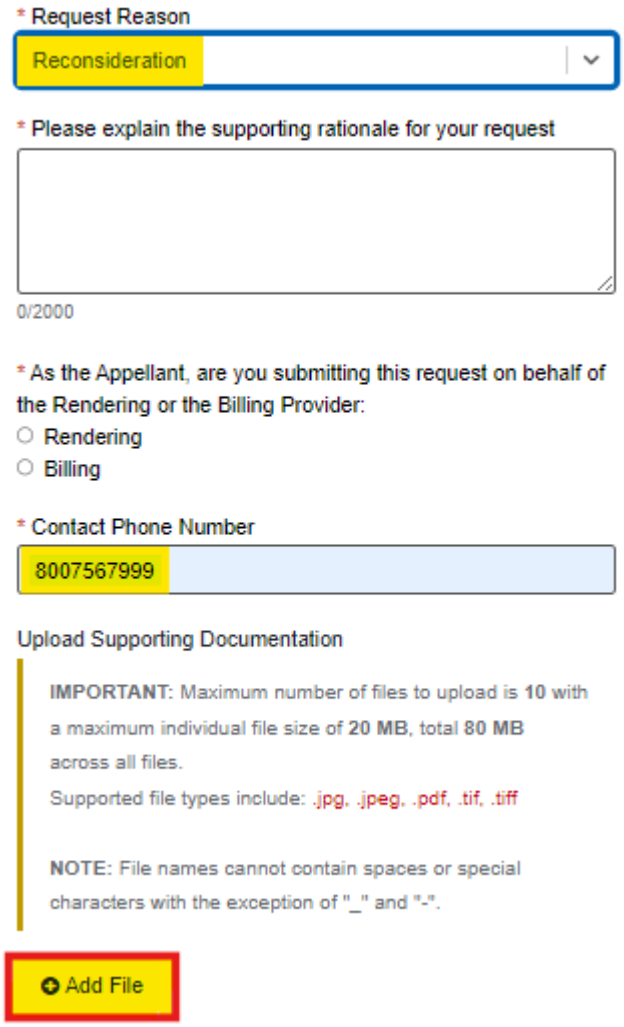
iv) The following message will pop up, click on "Go to Request"



v) Click on Complete Dispute Request



vi) Fill out the format. The request reason should be Reconsideration, then write a brief message in the blank space. In Contact Phone Number use the customer service number. When clicking add file, upload the medical records found in the W Drive. Submit the Request



Suggested note:

WORKING CWL, CLAIM #XXXXX. CLAIM DENIED IN FULL [$XX.XX] DUE TO: The level of service for the Evaluation and Management code submitted is not supported by the claim information received. A more appropriate code has been suggested. ASSEMBLY SUBMITTED REQUESTING MEDICAL RECORDS INTO W DRIVE. NEXT ACTION - SUBMIT MEDICAL RECORDS THROUGH THE DISPUTE CLAIM BUTTON IN AVAILITY

Other coverage/insurance information related denials (COB/EOB).

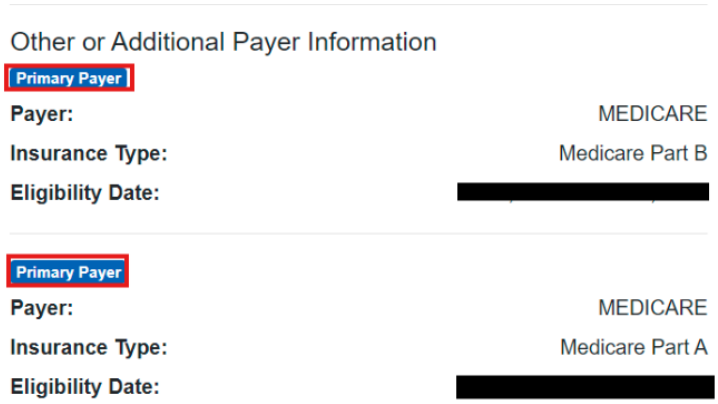
These denials are usually related to Customer having to share the Coordination of Benefits (COB), as the main insurance (in this case, BCBS) needs that information to process the claim.

Usually the denial is: Subscriber has not responded to request for other coverage information.

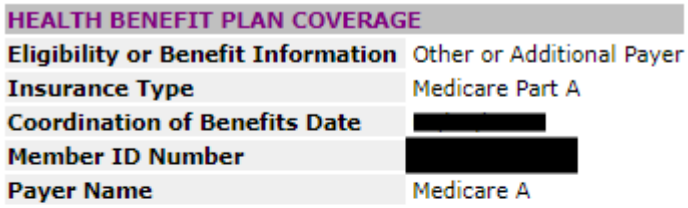
Medicare as primary insurance.

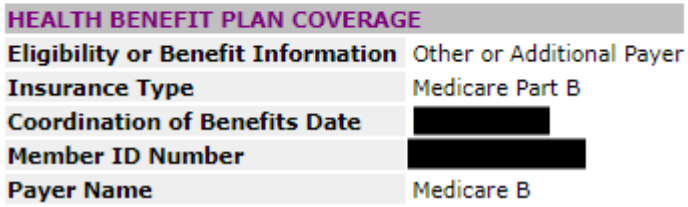
Some accounts will have the following denial: “Medicare explanation of benefits (EOMB) information required before benefits can be applied.”

If this is the case, you will need to verify eligibility in Availity. Usually, Medicare will have the status of primary insurance.



If the policy number is not in Availity, you can try to get it | OneSource





Once you find this information, you should add Medicare as Iplan and make it primary. Important: Patients over 65 have Medicare as primary insurance, so if the patient is over 65 and this is not specified in Avaiity or OneSource, this should be made primary anyways.

If the Member ID is neither in OneSource nor in Availity, a WQ should be submitted to Admitting requesting Medicare to be added into Medicare.

Once the Insurance is added, you can follow the guidance for making the Iplan change in the following link.

Suggested notes: WORKING CWL, CLAIM #40755009K670X00. CLAIM (5,996.75) DENIED DUE TO: Medicare explanation of benefits (EOMB) information required before benefits

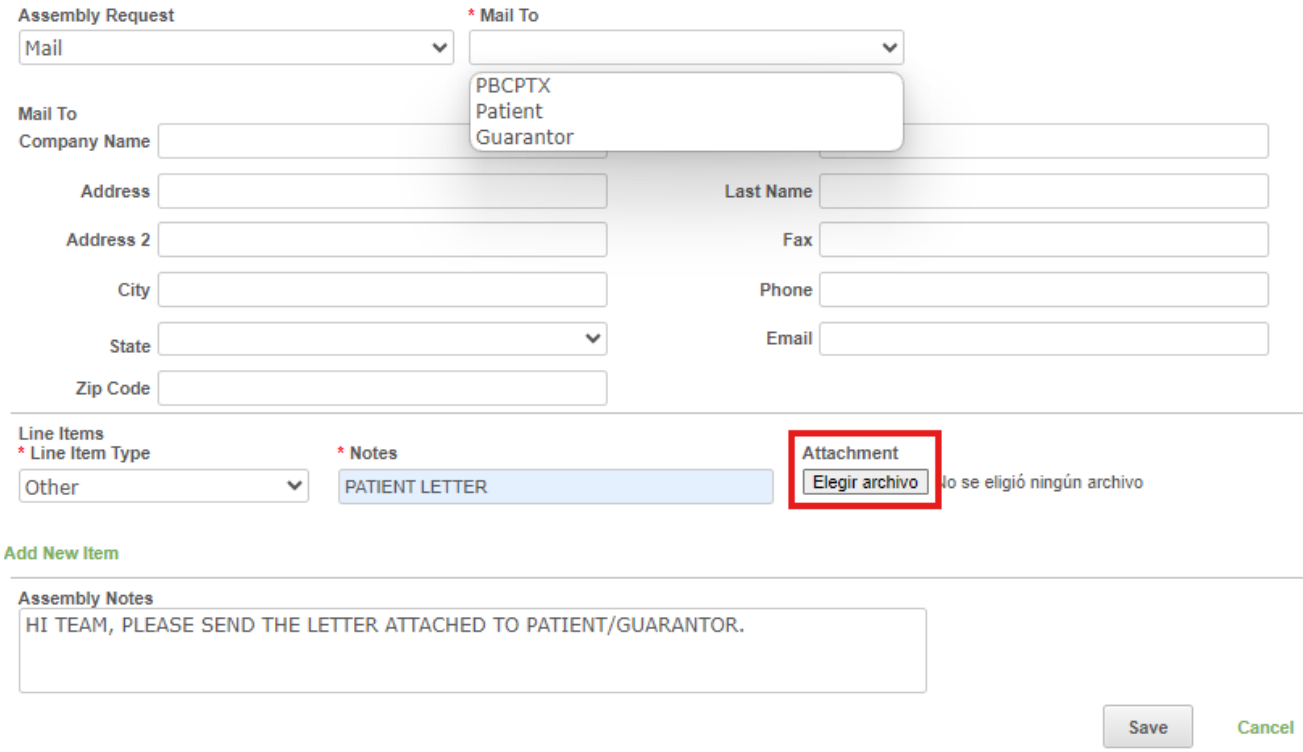
can be applied. WQ SUBMITTED TO ADMITTING TO CONFIRM THEY HAVE MEDICARE, AND IF SO, TO ADD IT INTO THE ACCOUNT. NEXT ACTION - REVIEW ADMITTING RESPONSE

If the signed cob is on file:

a) Check OneContent under the section COB
b) If the document is there, make sure it signed. The signature is usually in the second page

If after verifying that the COB on file is not signed:

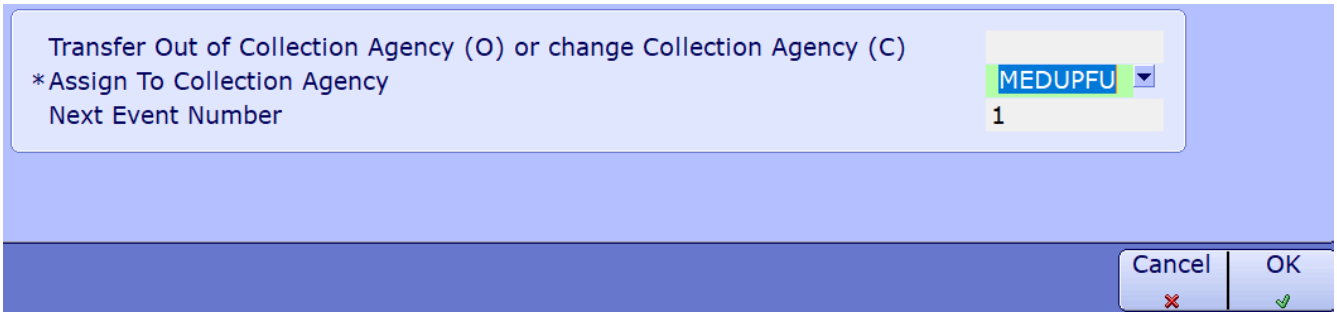
1) Call the patient or guarantor. If they answer, perform a HIPAA verification. This consists of asking patient or guarantor the Date of Birth or their address registered in Meditech. You can use the suggested script:
"Good morning, my name is ____ and I am calling from (Christus Facility/minister). I'm calling in regards of a business matter. In order to disclose more information. I would need to make a HIPPA verification. Could you please tell me your date of birth (if the guarantor is the one answering: could you please provide the patient's date of birth?) BCBS is calling as they need the updated coordination of benefits."
2) In case they don't answer, you can leave a voice message. This is the suggested voice mail script:
"Good morning, my name is ____ and I am calling from (Christus Facility/minister). I'm calling in regards of a business matter. If you need any further information, please call 800-756-7999 or you can call the phone number in the back of your insurance card, thank you."
3) A letter to the patient should be sent, even if they pick up the call. If that's the case, please go to the following link. Send the letter named "Request for Updated COB". In Connance, you can send it through assembly as shown in the screenshot below:



Suggested note: WORKING ON CWL. CLAIM #_____. CLAIM IS BEING REJECTED DUE TO Subscriber has not responded to request for other coverage information. BALANCE REJECTED IS $XX.XX. ONECONTENT REVIEWED, NO COB ON FILE. PHONE NUMBER XXX-XXX-XXXX CALLED, NO ANSWER, VOICE MAIL LEFT. UPDATED COB LETTER SENT TO CUSTOMER VIA ASSEMBLY. NEXT ACTION, CONTACT BCBS TO VERIFY PATIENT HAS CALLED THE INSURANCE. IF NOT, CONTACT CUSTOMER, IN CASE THERE IS NO ANSWER, MOVE ACCOUNT TO MEDUPFU

If the collector before us called and sent a letter.

a) Call BCBS to confirm if patient updated his COB.
b) If patient did not update his information, then call the patient/guarantor again. If they answer, make HIPPA verification again. If they do not answer, leave a voice mail.
c) After doing this, sent the account to MEDUPFU agency in Meditech.

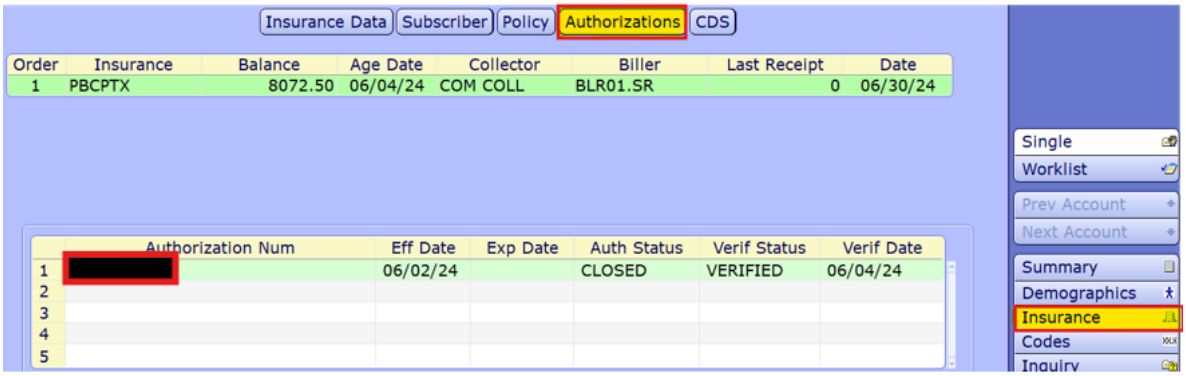


Suggested note: "WORKING CWL: CLAIM #_____. CLAIM REJECTED DUE TO: Subscriber has not responded to request for other coverage information. BCBS CALLED, I SPOKE TO _____.THEY CONFIRMED PATIENT HAD NOT UPDATED HIS COB (Reference number/Duration of the call). PATIENT CALLED, NO ANSWER, VOICE MAIL LEFT. SINCE THIS IS THE 3RD ATTEMPT, ACCOUNT MOVED TO MEDUPFU.

No preauthorization/authorization related denials.

This denial occurs when BCBS denies the claim due to the lack of authorization numbers. This is applicable to either inpatient or outpatient accounts. However, if this is an ER account, authorization number is not necessary. These are the steps to be taken to check if there is in authorization number in file

a) Go to the Insurance Section and then to the Authorization Number in Meditech. If there is an authorization number you'll find it.



b))Confirm in the UB04 that the authorization number is found within the ub04. Confirm that both authorization numbers are the same. You can find it in section 63.

c) Once you have confirmed this information, submit the UB04 through the dispute claim number in Availity.

In other occasion, there might be a document in OneContent with the authorization number printed.

For all other questions regarding authorization number, please go to the Refer to file, in pages 11-13 there is a table with possible situations, as in some occasions, the lack of authorization number in account could be do a clinical appeal.

Suggested note:

WORKING CWL, CLAIM #XXXXX. CLAIM DENIED IN FULL DUE TO: Service required Prior Authorization from Carelon Medical benefits management. To have your claim considered for

payment please initiate a prior authorization request directly with Carelon at providerportal.com. WQ SUBMITTED TO ADMITTING REQUESTING THE NUMBER. NEXT ACTION, REVIEW ADMITTING RESPONSE.

DRG downgrade denial.

This denial usually has the following wording: “The level of service for the Evaluation and Management code submitted is not supported by the claim information received.” In Availity, click on the plus symbol

+	07/16/2024 07/16/2024	450	N912	99284	$3,226.00	$828.84	$2,041.95	V75	$0.00	$0.00	$355.21	$0.00	1

This message should pop up, although the message should vary:

> THE LEVEL OF SERVICE FOR THE EVALUATION AND MANAGEMENT CODE 99284 CODE WAS REDUCED TO 99283 BASED ON CLAIM EVIDENCE OF THE RESOURCES CONSUMED BY THE FACILITY FOR THE EMERGENCY ROOM VISIT.

There are two ways to solve this situation:

a) If the amount due is less than $500.00, an adjustment is required. Let’s suppose the total amount due, including patient share is $600.00. But patient share is $250 so the remaining unpaid balance will be $350.00. If that’s the case, we should adjust the $350.00 with the CAJ code.
b) If the total unpaid balance is more than $500, after considering patient share, then a WQ to Clinical Appeals level 1 should be submitted

If the account is sent to Clinical Appeals, remember to move the account to PCAT agency.

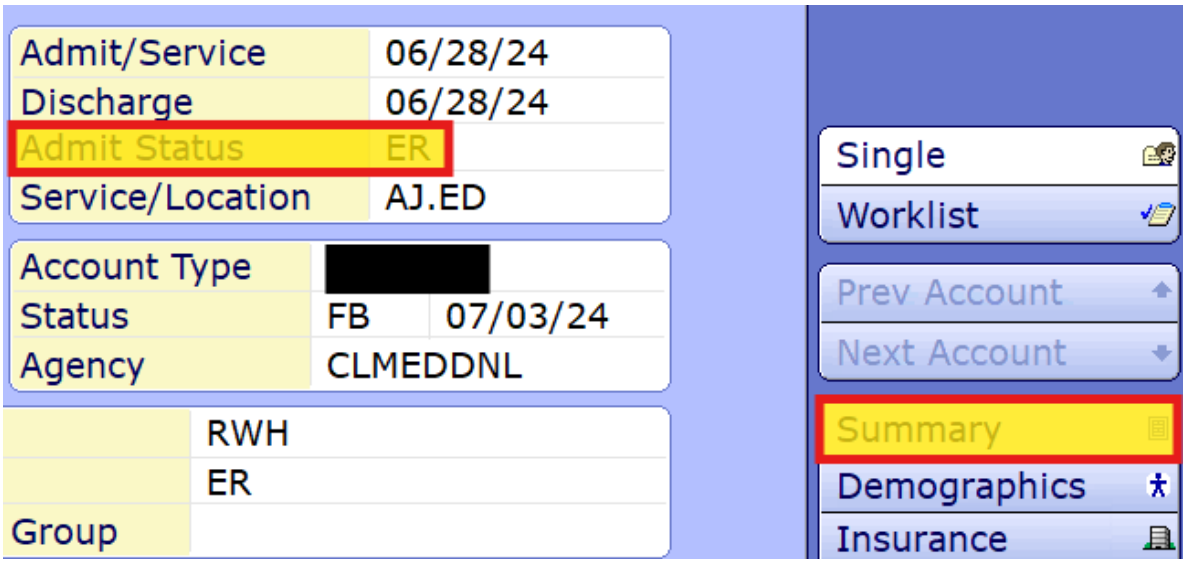
Suggested note:

WORKIG CWL, CLAIM #XXXXX. CLAIM [$1,352.00] DENIED DUE TO: THE EVALUATION AND MANAGEMENT CODE 99284 CODE WAS REDUCED TO 99283. ED LEVEL DOWNGRADED FROM LEVEL 4 TO LEVEL 3. ACCOUNT MOVED TO PCAT AGENCY IN MEDITECH. WQ SENT TO CLINICAL APPEALS LVL1. NEXT ACTION - REVIEW CLINICAL APPEALS RESPONSE

If the denial is ED Level 3 or lower

You can verify the expected reimbursement by checking the contract in the following folder that can be found in the following route for the digital desktop.

W:\SRHC\PATACCT\EBO Team Contract Tools



Denials Related to coding.

There is a variety of messages related to coding. These are some examples:

“Charge exceeds total number of units allowed when billed by same provider for same date of service. Amount is provider write-off for participating providers.”

“The procedure code was not submitted with the appropriate anatomical modifier. The information submitted on the claim is inconsistent with current coding protocols.”

“Charge exceeds total number of units allowed when billed by same provider for same date of service".

“Information submitted on claim is inconsistent with current coding protocol. The primary procedure code was not submitted; therefore, the add-on code is not allowed. Amount is provider write-off for participating providers.”

“After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. For reconsideration of payment, please submit records for further review. Patient cannot be balance billed for the disallowed.”

“Claim must include a supporting HCPCS or CPT code with a revenue code. Coding practice is inconsistent with current coding protocol.”

“After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made.”

“The diagnosis code(s) submitted is inconsistent with ICD-10-CM coding guidelines. No medical records are necessary at this time. Please submit a corrected claim. Patient cannot be billed for the disallowed code.”

"The procedure code was not submitted with the appropriate anatomical modifier. The information submitted on the claim is inconsistent with current coding protocols. Patient cannot be billed for the disallowed code"

To resolve these denials, we must submit a WQ to either RNA or HIM. To determine to which department you should submit the WQ to, please see the following guide.

Important: In some cases, there are two denials or more to the ones above. Only submit one WQ to either RNA or HIM.

The WQ submitted will have a response from the department. You should work according to what they advised you to do. Answers may vary depending on the case.

Suggested note for Connance:

"WORKING ON CWL, CLAM NUMBER 405150T55300X00. CLAIM ($328.00) WAS DENIED IN FULL TO "The procedure code was not submitted with the appropriate anatomical modifier. The information submitted on the claim is inconsistent with current coding protocols. Patient cannot be billed for the disallowed code." WORK QUEUE TO HIM SUBMITTED FOR THEM TO REVIEW APPROPIATE ANATOMICAL MODIFIER. NEXT ACTION – REVIEW HIM RESPONSE."

Short payments on account with no denials.

You might some accounts where there is no denial and there are short payments. There are two possible reasons for this

Iplan in account is incorrect.

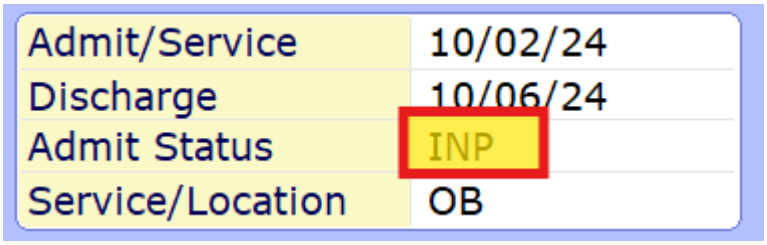
Verify the alpha prefix in Meditech and compare it to Iplan. For instance, account could have been processed as PBCPTC - BLUE CROS PPO TX, but the Alpha Prefix in the Policy Section is CHF. This would mean that this account should have been processed as PCHAP. To solve the situation, you should do a Iplan Change. Please follow the steps in the following guide.

Calculating Expected Reimbursement.

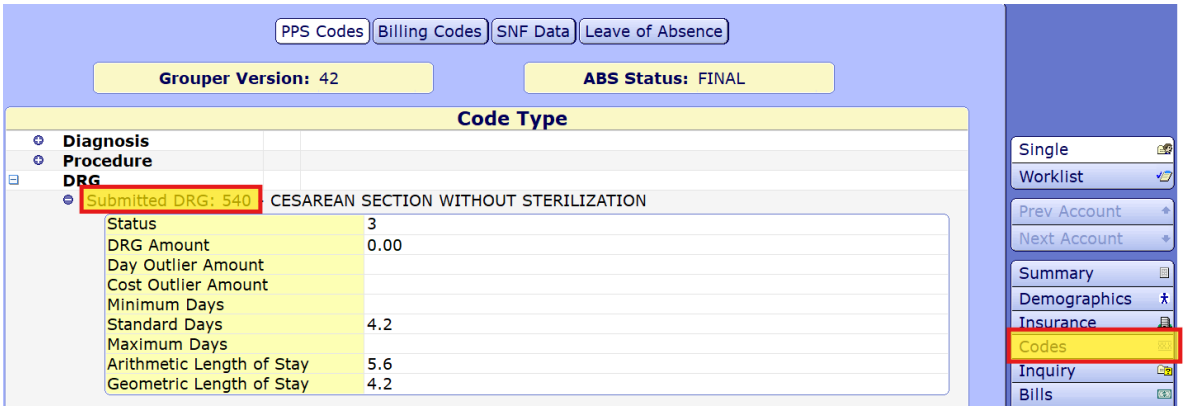
It is necessary to have access to the following folder W:\SRHC\PATACCT\EBO Team Contract Tools. This is because contracts and calculators needed for this can be found there. Also, take into consideration that prices changes every July of the year, so you should pay attention to dates in which the services were performed.

Calculating the Expected Reimbursement on Inpatient Children accounts.

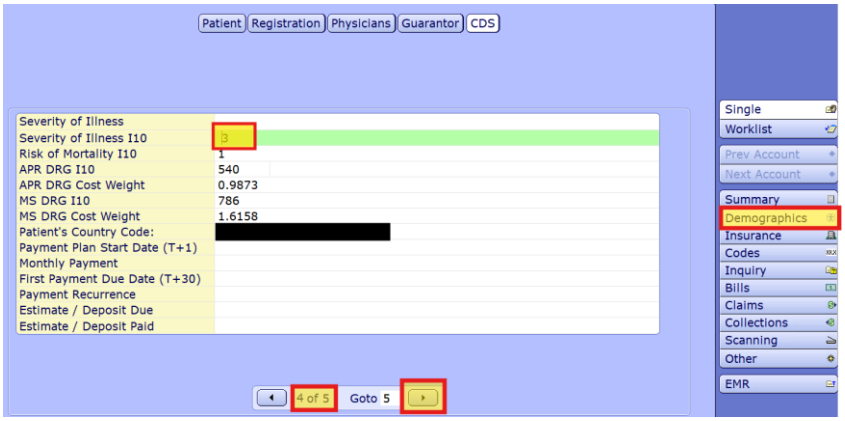
Make sure account is inpatient in the summary section of Meditech, as DRG codes needed to calculate the expected reimbursement exclusively for inpatient accounts.



Then go to the Codes section and look for the DRG



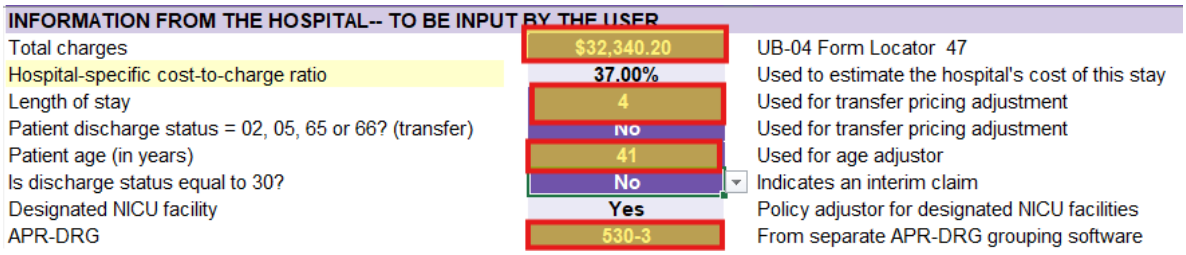
Then go to Demographics, in the CDs, press the right arrow until you get to page 4 out of 5. There, you will find the severity of illness.



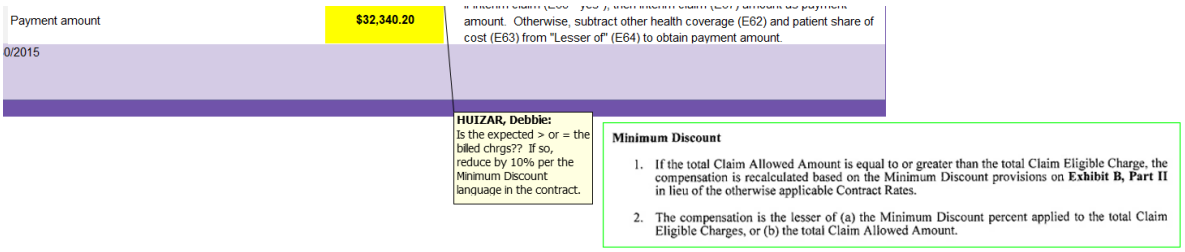
Open the following path in the folder mentioned before.

"W:\SRHC\PATACCT\EBO Team Contract Tools\BCBS-V40 Calculator APR-DRG eff 7-1-2024.xlsx"

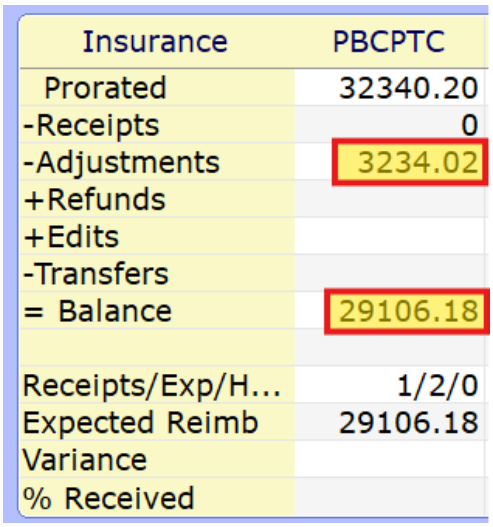
Fill in with the information according to the account you are working with, when you get to the section "APR-DRG" you will need to enter the DRG code, then the dash symbol "-" followed by the severity of illness level, based off of the example, this should be 540-3.



The expected reimbursement will be different depending on the severity of the illness, however, like in this particular case, the expected reimbursement was equal to the Total Charges.



If that's the case, then we should pay attention to the note there. We'll make a 10% discount for the total amount due. For this particular example, this should be $3,234.02, and the remaining balance should be the expected reimbursement.

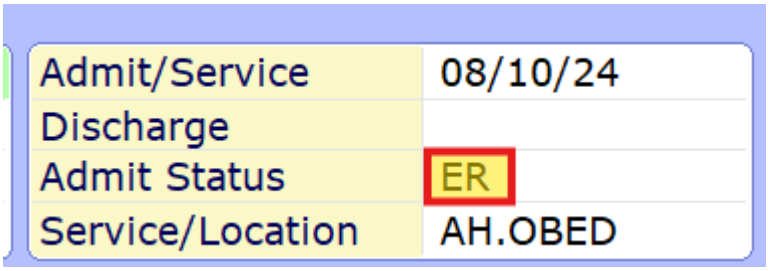


IMPORTANT

BCBS sometimes may pay an account with a different severity of illness. That should be considered as a “DRG Downgrade.” If that’s the case, then you should send a WQ to Clinical Appeals Level 1 for that reason.

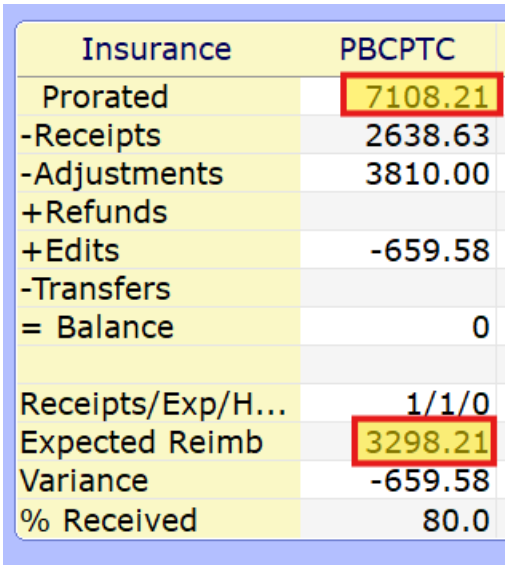
Calculating the Expected Reimbursement for Outpatient Children accounts.

Most of accounts that are not inpatient are outpatient accounts. If the admit status is, ER, OBS (observation), SDC (Same Day Service), or REC (recuring) or any other should be calculated as Oupatient Account.



Since the services were performed in Santa Rosa, and this is a PPO plan (PBCPTC), we’ll use the following file found in this path "W:\SRHC\PATACCT\EBO Team Contract Tools\07 2024 PPO SRH & SPN.pdf". The contract on page 20 stated that all Outpatient services should be calculated at 46.4%. You’ll need to calculate the total amount due times .464. For instance, in the example below, BCBS calculated $7,108.21 x .464 = $3,928.21. this was divided by the payment they did and the patient share. If you add $2,638.63 plus $659.28 = $3,928.21. The amount paid and patient share may vary depending on the contract or plan the patient might have.

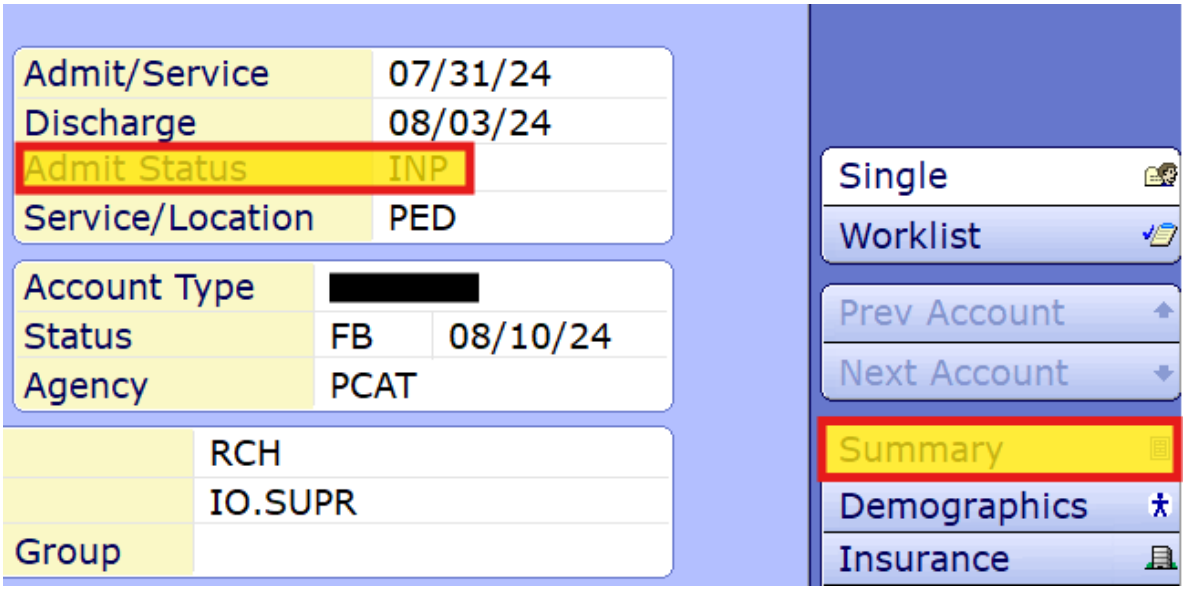
IMPORTANT Most of the services for children are performed in the ministry located in Santa Rosa, depending on the Iplan patient has, this could be Blue Advantage or Traditional.



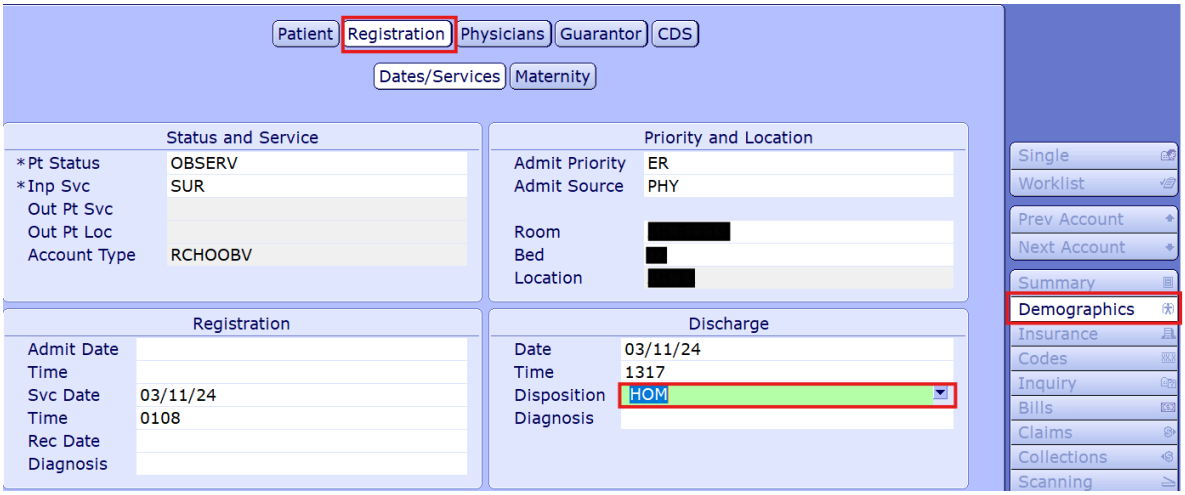
DRG Claims When Patients Are Transferred Early

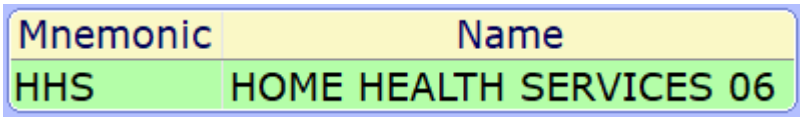
When this happens, you'll need to calculate the Expected Reimbursement. First, you'll need to verify the Disposition Discharge in the Demographic Section. The codes for the disposition that apply can be found in this link.

The account is very likely to be an Inpatient Account. You can verify that in Summary Section

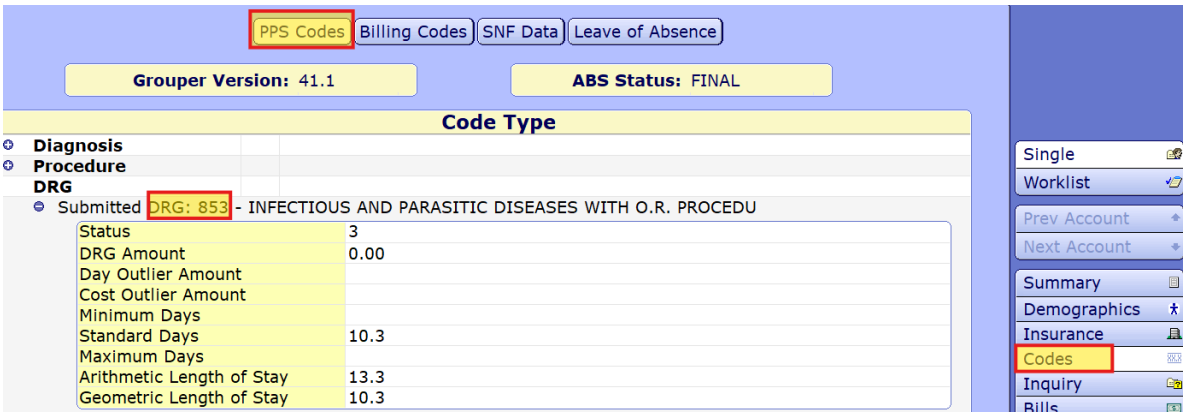


You'll need to click on the Edit button to find out, and then click on the disposition:

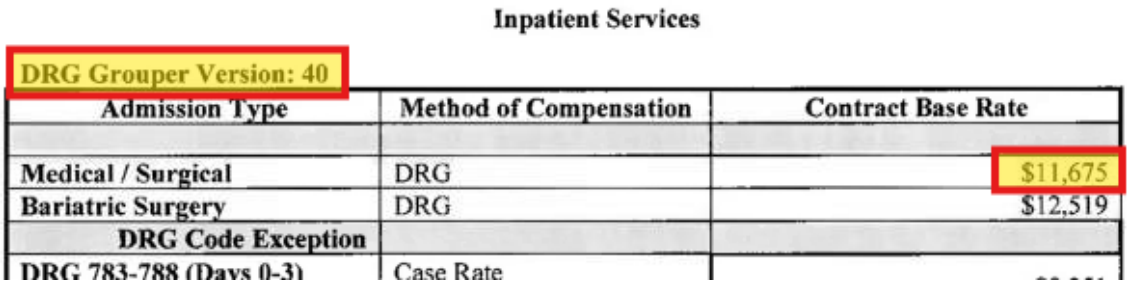




Then you need to verify the DRG code found in the Codes Section



For this account, patient has PBCTTX Iplan, which belongs to TRADITIONAL, and since the service was performed at Santa Rosa Ministry, we'll use the following file "W:\SRHC\PATACCT\EBO Team Contract Tools\07 2024 Traditional SRH & SPN.pdf." Once you open the file, you'll see the following. Contract Base Rate and DRG Grouper are the ones we'll pay special attention to.

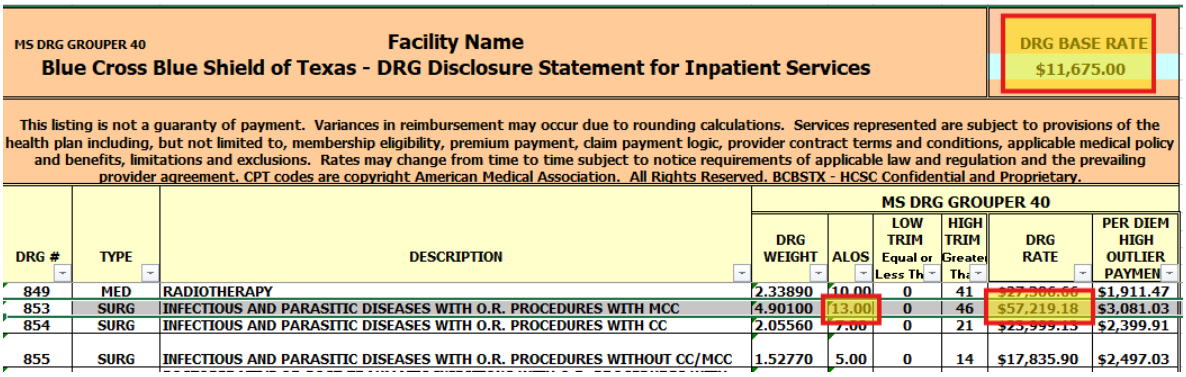


Inpatient Services

DRG Grouper Version: 40

Admission Type	Method of Compensation	Contract Base Rate
Medical / Surgical	DRG	$11,675
Bariatric Surgery	DRG	$12,519
DRG Code Exception		
DRG 783-788 (Days 0-3)	Case Rate	

Once you identify it, then you'll need to open the calculator for the DRG Grouper, in this particular case we'll use "W:\SRHC\PATACCT\EBO Team Contract Tools\DRG Disclosure Stmt Grouper 40_LOB eff July 2024.xlsx" Once you open the file, you'll need to fill up as shown below, pay attention to the highlighted areas



MS DRG GROUPER 40 — **Facility Name**

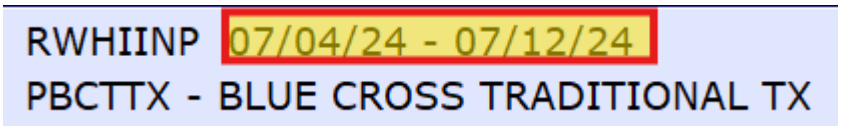
Blue Cross Blue Shield of Texas - DRG Disclosure Statement for Inpatient Services

DRG BASE RATE $11,675.00

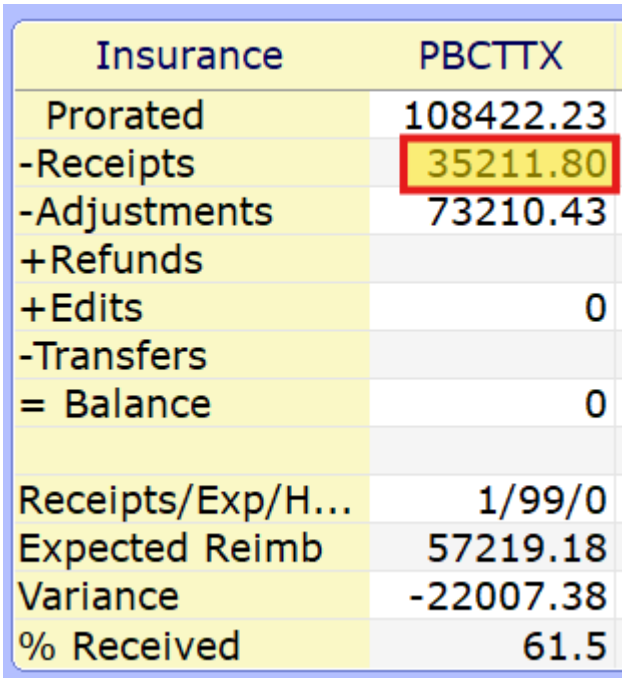
This listing is not a guaranty of payment. Variances in reimbursement may occur due to rounding calculations. Services represented are subject to provisions of the health plan including, but not limited to, membership eligibility, premium payment, claim payment logic, provider contract terms and conditions, applicable medical policy and benefits, limitations and exclusions. Rates may change from time to time subject to notice requirements of applicable law and regulation and the prevailing provider agreement. CPT codes are copyright American Medical Association. All Rights Reserved. BCBSTX - HCSC Confidential and Proprietary.

			MS DRG GROUPER 40					
DRG #	TYPE	DESCRIPTION	DRG WEIGHT	ALOS	LOW TRIM Equal or Less Th	HIGH TRIM Greate Tha	DRG RATE	PER DIEM HIGH OUTLIER PAYMEN
849	MED	RADIOTHERAPY	2.33890	10.00	0	41	[illegible]	$1,911.47
853	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	4.90100	13.00	0	46	$57,219.18	$3,081.03
854	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC	2.05560	7.00	0	21	$23,999.13	$2,399.91
855	SURG	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITHOUT CC/MCC	1.52770	5.00	0	14	$17,835.90	$2,497.03

Patient for this account stayed in the hospital for 8 days. We need to take this detail into consideration.



So, in the calculator, the ALOS is 13, which is the number of days. What you need to do is to divide the total amount due ($57,219.18) by the Also (13). The result for this division is $ 4,401.47. This amount should be calculated by the number of day, in this case 8 days. So we multiply $4,401.47 x 8 days = 35,211.80. Which is the amount that BCBS paid



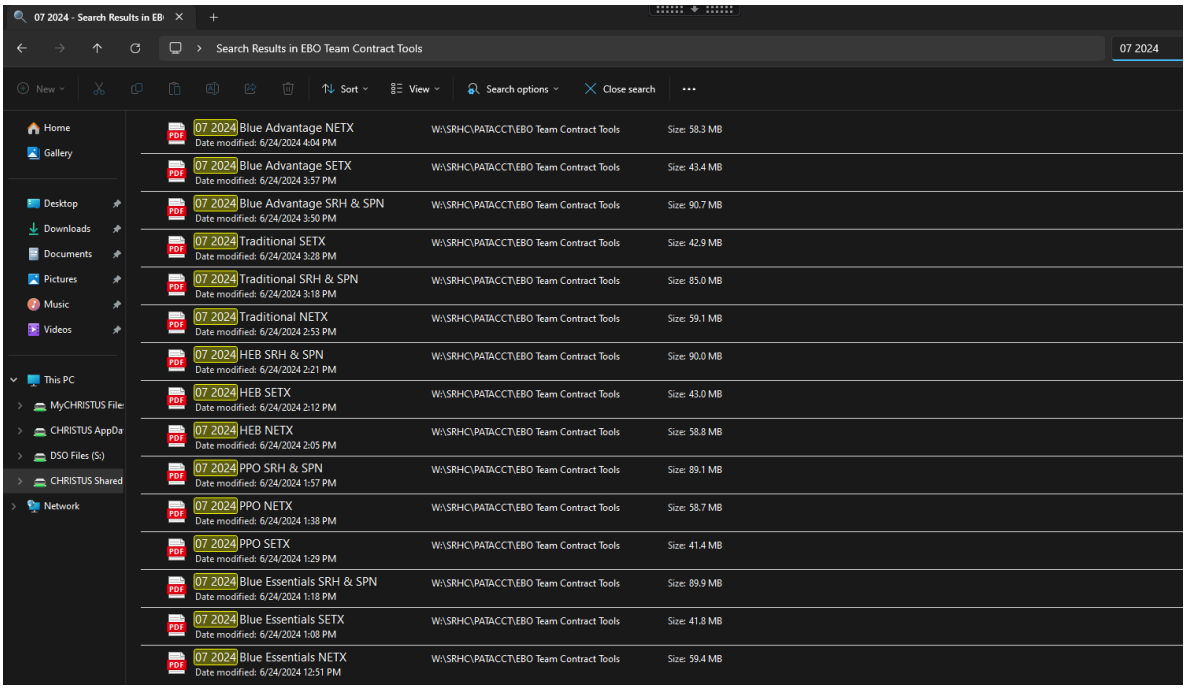
Insurance	PBCTTX
Prorated	108422.23
-Receipts	35211.80
-Adjustments	73210.43
+Refunds	
+Edits	0
-Transfers	
= Balance	0
Receipts/Exp/H...	1/99/0
Expected Reimb	57219.18
Variance	-22007.38
% Received	61.5

For this particular case, an adjustment for $ 22,007.38 was submitted since we had a disposition code and in this case, this needs to be paid prorated.

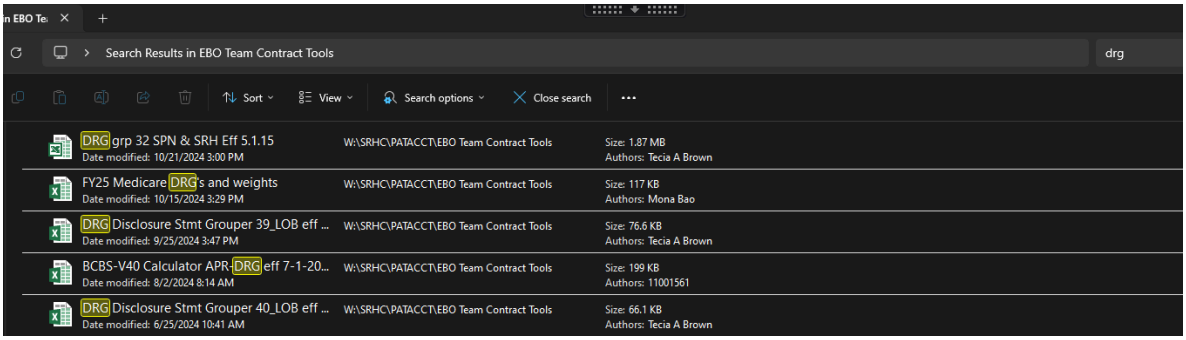
Remember, depending on the Iplan, it will be the type or archive or DRG calculator you'll need. You can find them all in the following path

W:\SRHC\PATACCT\EBO Team Contract Tools.

TIPS, if you are looking for contracts for a year in particular, write in the search bar 07 2024 (current year this was worked on)

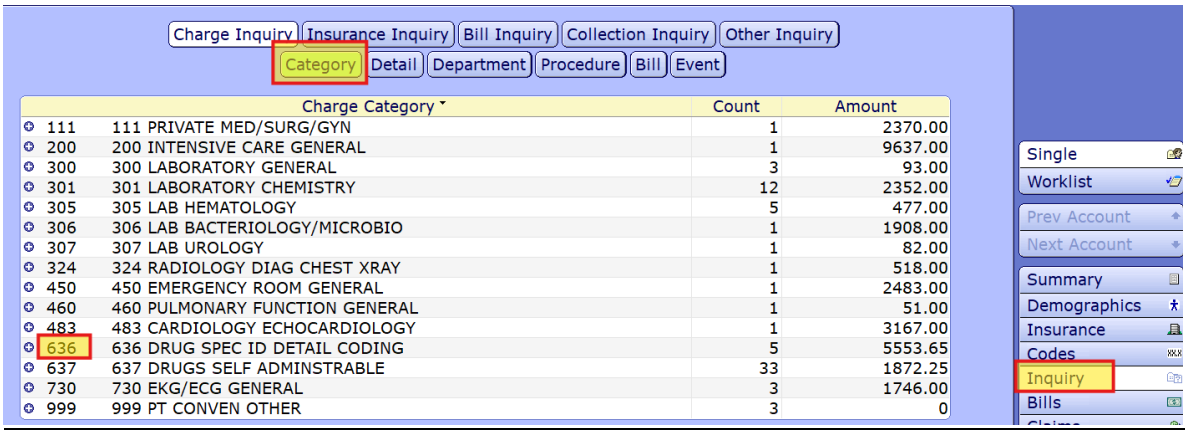


To look for the calculator, write DRG in the search bar



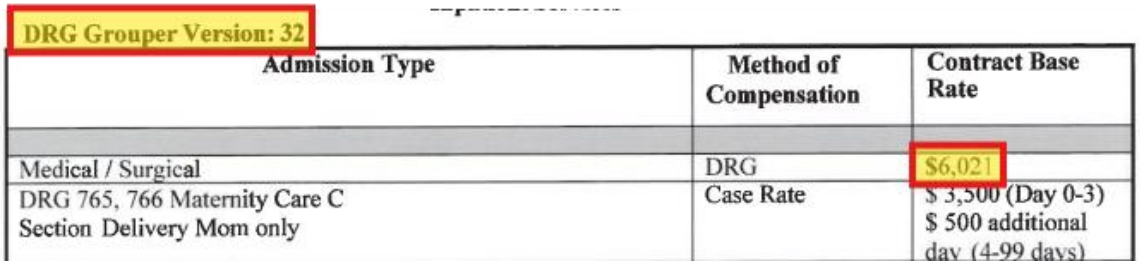
Important information For PCHAP account. You also need to pay attention the services. They can be identified with the Code 636, for high-cost drugs. And code 278, which are for Implants. They can be found in the Inquiry, and Category Section in Meditech. Once you identify this, you will need to review the contracts as well as calculating them according to the DRG grouper. You can find both documents the following path for the Desktop.

The codes can be found in the section shown below



Charge Category	Count	Amount
111 111 PRIVATE MED/SURG/GYN	1	2370.00
200 200 INTENSIVE CARE GENERAL	1	9637.00
300 300 LABORATORY GENERAL	3	93.00
301 301 LABORATORY CHEMISTRY	12	2352.00
305 305 LAB HEMATOLOGY	5	477.00
306 306 LAB BACTERIOLOGY/MICROBIO	1	1908.00
307 307 LAB UROLOGY	1	82.00
324 324 RADIOLOGY DIAG CHEST XRAY	1	518.00
450 450 EMERGENCY ROOM GENERAL	1	2483.00
460 460 PULMONARY FUNCTION GENERAL	1	51.00
483 483 CARDIOLOGY ECHOCARDIOLOGY	1	3167.00
636 636 DRUG SPEC ID DETAIL CODING	5	5553.65
637 637 DRUGS SELF ADMINSTRABLE	33	1872.25
730 730 EKG/ECG GENERAL	3	1746.00
999 999 PT CONVEN OTHER	3	0

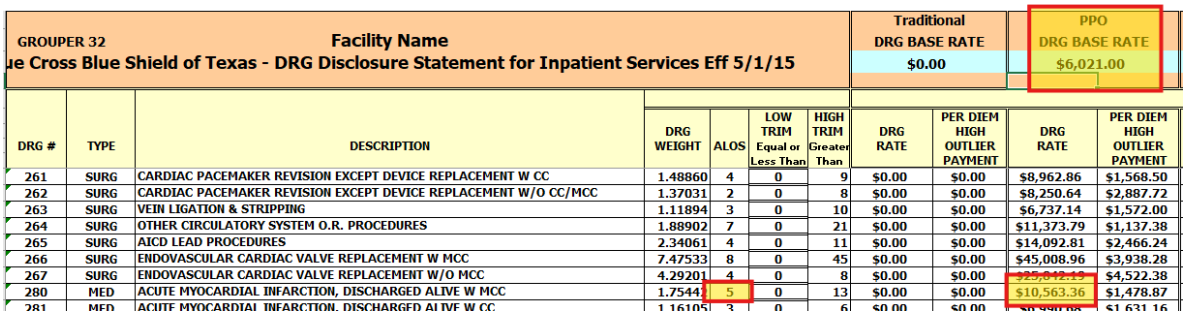
For the Example above, the DRG code was 280, and we used the contract exclusively for PCHAP Iplan that can be found "W:\SRHC\PATACCT\EBO Team Contract Tools\CHRISTUS Employer Group Amendment - Eff 01_01_2023 FE.pdf"}



DRG Grouper Version: 32

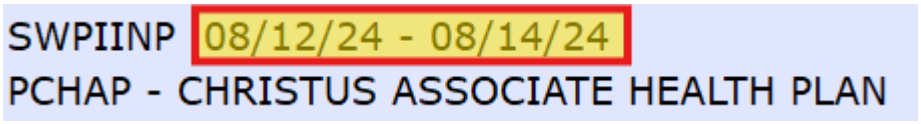
Admission Type	Method of Compensation	Contract Base Rate
Medical / Surgical	DRG	$6,021
DRG 765, 766 Maternity Care C Section Delivery Mom only	Case Rate	$ 3,500 (Day 0-3) $ 500 additional day (4-99 days)

And we used the following calculator "W:\SRHC\PATACCT\EBO Team Contract Tools\DRG grp 32 SPN & SRH Eff 5.1.15.xls" and we fill it in as follows



GROUPER 32 Facility Name ue Cross Blue Shield of Texas - DRG Disclosure Statement for Inpatient Services Eff 5/1/15							Traditional DRG BASE RATE $0.00		PPO DRG BASE RATE $6,021.00	
DRG #	TYPE	DESCRIPTION	DRG WEIGHT	ALOS	LOW TRIM Equal or Less Than	HIGH TRIM Greater Than	DRG RATE	PER DIEM HIGH OUTLIER PAYMENT	DRG RATE	PER DIEM HIGH OUTLIER PAYMENT
261	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.48860	4	0	9	$0.00	$0.00	$8,962.86	$1,568.50
262	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.37031	2	0	8	$0.00	$0.00	$8,250.64	$2,887.72
263	SURG	VEIN LIGATION & STRIPPING	1.11894	3	0	10	$0.00	$0.00	$6,737.14	$1,572.00
264	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.88902	7	0	21	$0.00	$0.00	$11,373.79	$1,137.38
265	SURG	AICD LEAD PROCEDURES	2.34061	4	0	11	$0.00	$0.00	$14,092.81	$2,466.24
266	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.47533	8	0	45	$0.00	$0.00	$45,008.96	$3,938.28
267	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	4.29201	4	0	8	$0.00	$0.00	[illegible]	$4,522.38
280	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.75441	5	0	13	$0.00	$0.00	$10,563.36	$1,478.87
281	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.16105	3	0	6	$0.00	$0.00	[illegible]	$1,631.16

In this account ,the ALOS is 5 so we divide $10,563.36 divided by 5 = $ 2,112.67. Since patient stayed for 2 days, we multiply $2,112.67 times 2, which equals $ 4,225.34



SWPIINP 08/12/24 - 08/14/24
PCHAP - CHRISTUS ASSOCIATE HEALTH PLAN

Then we add High Cost Drugs, as shown in the image the total amount due is $5,553.65.

483	483 CARDIOLOGY ECHOCARDIOLOGY	1	3167.00
636	636 DRUG SPEC ID DETAIL CODING	5	5553.65
637	637 DRUGS SELF ADMINSTRABLE	33	1872.25

This amount is going to be multiplied by .35, as per contract, BCBS needs to pay them at 35% as long as the charges are greated that $2,500.00 (This also applies for implants).

Calculating $5,553.65 x.35 = 1,943.78. **IMPORTANT** These charges are not going to be prorated.

Carve Out Service
See Below for Definition of Services

Service	Carve out of:	Method of Compensation	Contract Base
Implants/Prosthetics	DRG and Per Diem compensation, not allowed in addition to stop loss	Greater than $2,500, Percent of Eligible Charge	35%
High Cost Drugs	DRG and Per Diem compensation, not allowed in addition to stop loss	Greater than $2,500, Percent of Eligible Charge	35%

So we add the prorated charges $ 4,225.34 plus $ 1,943.78 = $6,169.13. In this case, BCBS paid $6,034.13 plus $135.00 for patient share = $6,169.13.

For this account, an adjustment was submitted for $6,338.01, which is yet to be reflected.

Insurance	PCHAP
Prorated	32309.90
-Receipts	6034.13
-Adjustments	19802.76
+Refunds	
+Edits	-135.00
-Transfers	
= Balance	6338.01
Receipts/Exp/H...	1/99/0
Expected Reimb	12507.14
Variance	

Overpayments in account

Sometimes it may seem as BCBS overpaid the account. Verify the following before considering moving the patient share (if applicable) or performing a positive adjustment.

- First, verify that patient share in Meditech matches the one in Availity

Insurance	HBCHTX	SELFPY	Total
Prorated	30014.88	0	30014.88
-Receipts	5864.10		5864.10
-Adjustments	22085.33		22085.33
+Refunds			
+Edits	-4363.20	4363.20	0
-Transfers			
= Balance	-2297.75	4363.20	2065.45
Receipts/Exp/H...	1/1/0	0/1/0	
Expected Reimb	7929.55	0	7929.55
Variance	-2065.45		
% Received	74.0		

Claim Status	PAID
Custom Status Description	
Status Detail	
Billed Amount	$30,014.88
Paid Amount	$5,864.10
Coinsurance Amount	$2,513.20
Copay/Deductible Amount	$1,850.00
Ineligible Amount	$0.00

- Once you verify it, review the member ID. Depending on the member ID, they could have different Iplans.
  For instance, this account should be PBCTTX and not HBCHTX as the Member ID starts with the prefix T2G

RMCIINP 08/23/24 - 08/25/24
HBCHTX - BLUE CROSS HMO TX

Patient Policy Num	T2G[redacted]	
Verification Status	VERIFIED	08/23/24
Effective Date	07/01/24	
Expiration Date		

- To solve the situation in account, you should do an Iplan Change and and Payment transfer. Follow the guidelines in the hyperlinks to compete it.