



## Contenido

Before you begin.....	3
Identifying the claim .....	4
Where to find the claim .....	4
Identifying the NPI number. ....	4
Looking for the claim in Availity. ....	5
If both the claim number and NPI number are available:.....	5
If there is no claim number in Connance.....	6
Common Denials .....	6
No claim on file .....	6
On or after termination date. ....	7
Verifying eligibility in Availity. ....	8
Verifying eligibility in OneSource.....	9
If the patient is eligible for services: .....	11
If the patient is ineligible during the service:.....	12
Dependent not listed in policy. ....	13
Medical records related denials. ....	14
Other coverage/insurance information related denials (COB/EOB). ....	16
Medicare as primary insurance. ....	17
If the signed cob is on file:.....	18
If the collector before us called and sent a letter. ....	19
No preauthorization/authorization related denials.....	20
DRG downgrade denial.....	21
If the denial is ED Level 3 or lower .....	21
Denials Related to coding. ....	22
Short payments on account with no denials.....	23
Iplan in account is incorrect. ....	23
DRG Claims When Patients Are Transferred Early .....	27
Overpayments in account .....	32

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:

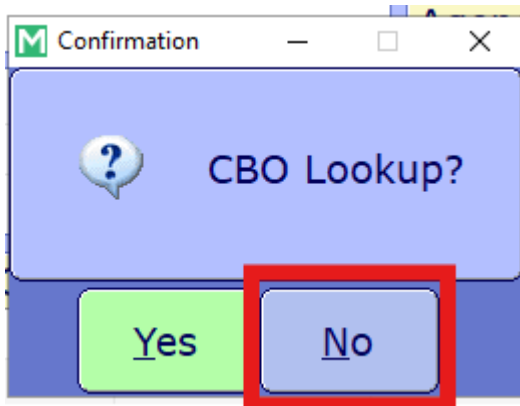
### Account Summary

Patient Account Id: [REDACTED]	Admit Date: [REDACTED]	Discharge Date: [REDACTED]
Line Item: -1	Hospital System: CHRISTUS_AR	Current Agency: PFS
Accounting System:	Facility: <b>CHRISTUS Santa Rosa Westover Hills</b>	Current Balance: \$0.00
Visit Id:	Physician Mnemonic: [REDACTED]	Current Status: Placed
Patient Name: [REDACTED]	CPT:	Last Placement Date: [REDACTED]
Guarantor Name: [REDACTED]	Team Name:	Current Account Handling: Standard

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

Mnemonic	Name
ALT.LIVE	ArkLaTex LIVE HCIS
CLA.LIVE	Central Louisiana LIVE HCIS
NLA.LIVE	Northern Louisiana LIVE HCIS
SETX.LIVE	Southeast Texas LIVE HCIS
<b>SRH.LIVE</b>	<b>Santa Rosa LIVE HCIS</b>
SWLA.LIVE	Southwest Louisiana Live HCIS

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.

Demographics	Transactions	Collection Activity	History	Notes	Related Accounts	Events / Status Changes	837 / 835	Insurance
--------------	--------------	---------------------	---------	-------	------------------	-------------------------	-----------	-----------

Claim number should be under the column ICN.

Patient Account Id	UCRN	Type	Bill Date	Remit Date	Statement From Date	Statement Thru Date	Claim Type	Payer Name	Total Charges	ICN	View
		837	04/10/24		02/27/24	03/07/24	Institutional	BLUE CROSS PPO TX	\$108,815.55		<a href="#">Open</a>
		835	04/16/24	04/10/24	02/27/24	03/07/24	Institutional	BLUECROSS BLUESHIELD OF TEXAS	\$108,815.55		<a href="#">Open</a>

### 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."

Patient Account Id	UCRN	Type	Bill Date	Remit Date	Statement From Date	Statement Thru Date	Claim Type	Payer Name	Total Charges	ICN	View
		837	04/10/24		02/27/24	03/07/24	Institutional	BLUE CROSS PPO TX	\$108,815.55		<a href="#">Open</a>
		835	04/16/24	04/10/24	02/27/24	03/07/24	Institutional	BLUECROSS BLUESHIELD OF TEXAS	\$108,815.55		<a href="#">Open</a>

CHRISTUS HLTH NORTHERN LOUISIANA  
PO BOX 843577  
DALLAS TX, 752843577  
NPI: 1417950106

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

Patient Account Id	UCRN	Type	Bill Date	Remit Date	Statement From Date	Statement Thru Date	Claim Type	Payer Name	Total Charges	ICN	View
		837	05/17/24		05/11/24	05/11/24	Institutional	CHRISTUS ASSOCIATE HEALTH PLAN	\$2,819.00		<a href="#">Open</a>

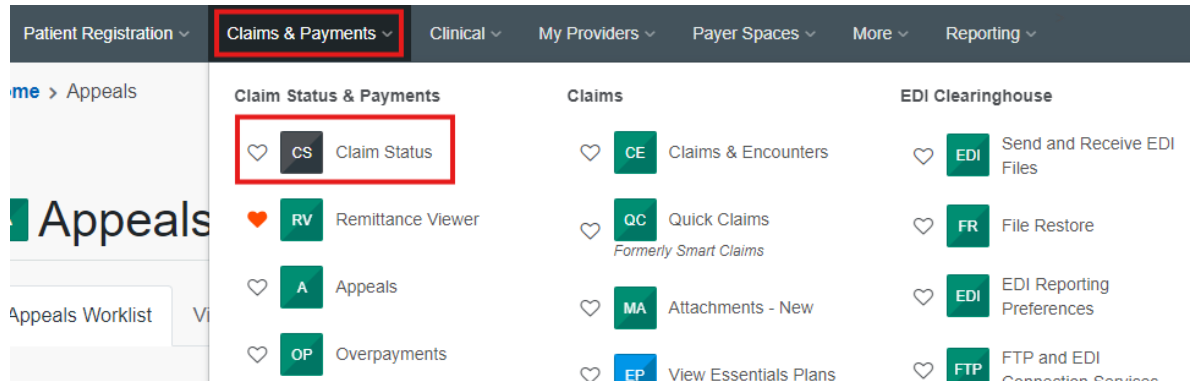
If that's the case, you can click in the hyperlinked open. This will open the ub04, and within that file you can see the NPI. You can see it in the #56 section of the ub04.

56 NPI	1417950106
57	
OTHER	
PRV ID	

## Looking for the claim in Availity.

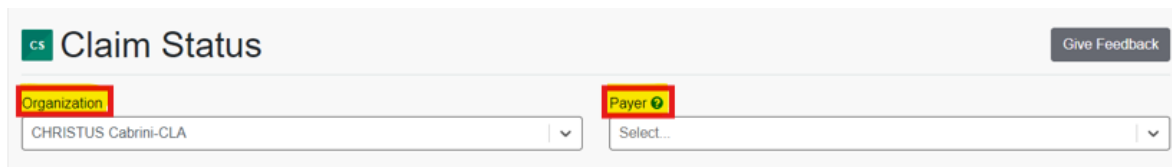
If both the claim number and NPI number are available:

- 1) Go to claim status.



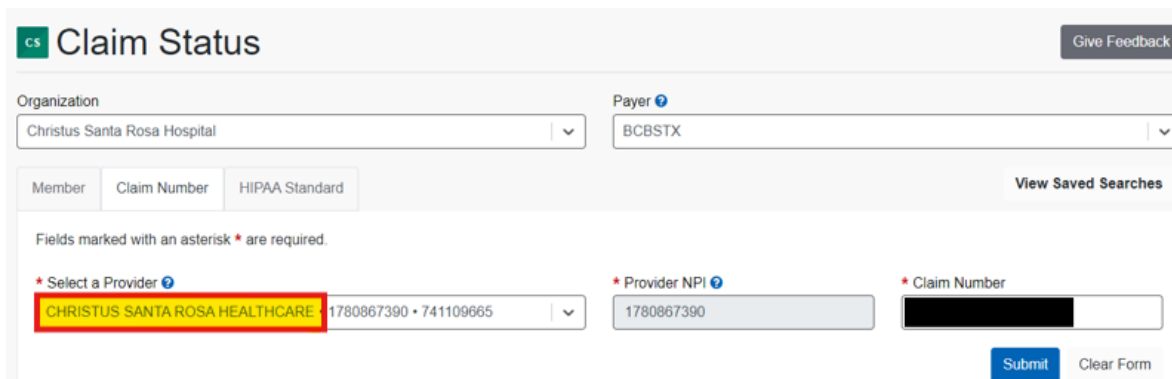
The screenshot shows the Availity dashboard with the 'Claims & Payments' menu highlighted in red. Under this menu, the 'Claim Status' option is also highlighted in red. Other options visible include 'RV Remittance Viewer', 'A Appeals', 'OP Overpayments', 'CE Claims & Encounters', 'QC Quick Claims', 'MA Attachments - New', 'EP View Essentials Plans', and 'ED Clearinghouse'.

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



The screenshot shows the 'Claim Status' form. The 'Organization' dropdown is set to 'CHRISTUS Cabrini-CLA' and the 'Payer' dropdown is set to 'BCBSTX'. A 'Give Feedback' button is visible in the top right corner.

- 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.



The screenshot shows the 'Claim Status' form with the 'Claim Number' section selected. The 'Select a Provider' dropdown is set to 'CHRISTUS SANTA ROSA HEALTHCARE' and the 'Provider NPI' field is set to '1780867390'. The 'Claim Number' field is empty. A 'Submit' button is visible at the bottom right.

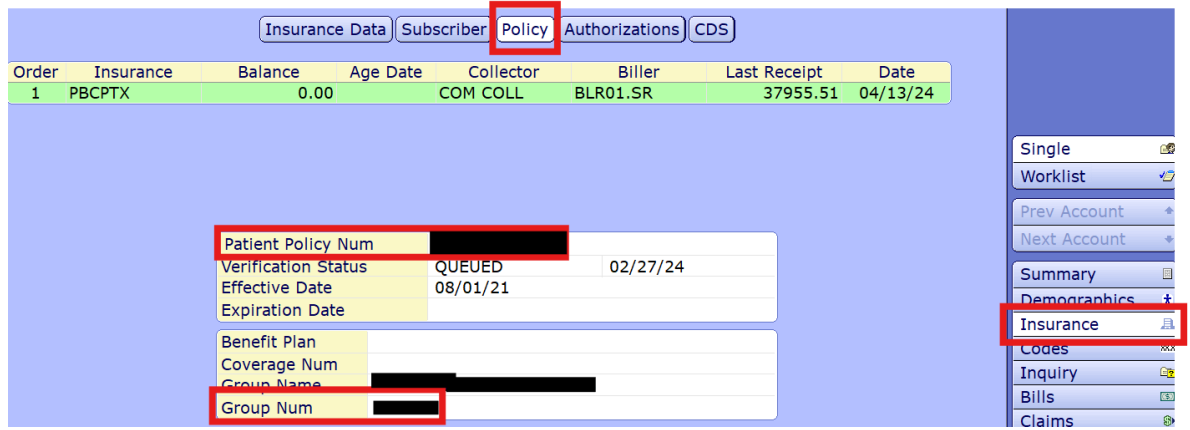
- 4) Once you click submit, the information of the patient will show up. Go to the bottom of the page and you will see the denial

### Codes

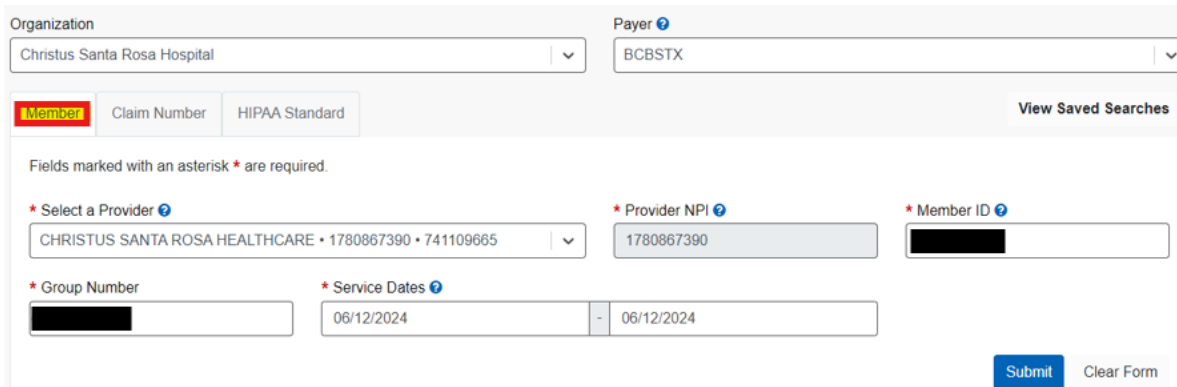
Type	Code	Description	Additional Action(s)
Ineligible Reason	006	No record of membership. Amount is patient responsibility.	Contact patient to confirm coverage for date of service. Submit new claim with the active subscriber ID.

## 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 1<sup>st</sup> and 2<sup>nd</sup> 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.

Insurance/ Claim	UCRN	Date Sent - Age	Amount	Receipt Total	Insurance Bill Balance
<b>PBCPTX - BLUE CROSS PPO TX</b>				37955.51	0
837BCOTXAH		04/10/24 - 112	108815.55	37955.51	
837T O AJ		05/07/24 - 85	31525.00		
ZPCONBCTX		04/10/24 - 112	108815.55		
<b>SELFPPY - SELF PAY</b>					0
ZPCON7			108815.55		

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.

Dest: E	Bill Type: 131	Billed Status: PAYER PROCESSING CLAIM	Claim Status: Billed
---------	----------------	---------------------------------------	----------------------

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.

Insurance Data
Subscriber
Policy
Authorizations
CDS

Order	Insurance	Balance	Age Date	Collector	Biller	Last Receipt	Date
1	PBCPTX	3480.00	07/14/24	COM COLL	Z-CATCH	0	07/25/24
NC	SELFT1	0.00		SP COLL	SP BILL		

Subscriber ID  
Name  
Address  
City/State/Zip  
Country  
Phone  
Email

Birthdate  
Sex | Marital Status  
Soc Sec Num

Race  
US Citizenship  
Pt Relation

WH  
Y  
SP

Subscriber Policy Num

Single  
Worklist  
Prev Account  
Next Account  
Summary  
Demographics  
Insurance  
Codes  
Inquiry  
Bills  
Claims  
Collections  
Scanning  
Other

Order	Insurance	Balance	Age Date	Collector	Billor	Last Receipt	Date
1	PBCPTX	3480.00	07/14/24	COM COLL	Z-CATCH	0	07/25/24
NC	SELF1	0.00		SP COLL	SP BILL		

Patient Policy Num	[REDACTED]
Verification Status	VERIFIED 07/14/24
Effective Date	05/01/24
Expiration Date	

[Single](#)  
[Worklist](#)  
[Prev Account](#)  
[Next Account](#)  
[Summary](#)  
[Demographics](#)  
[Insurance](#)

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

Verifying eligibility in Availity:

Verifying eligibility in Availity.

[Availity](#) | [essentials](#) | [Home](#) | [Notifications](#) 2 | [My Favorites](#) | [Texas](#) | [Help and Training](#)

[Patient Registration](#) | [My Providers](#) | [Claims & Payments](#) | [Payer Spaces](#) | [Clinical](#) | [More](#) | [Reporting](#)

[Eligibility and Benefits Inquiry](#)  
[Authorizations & Referrals](#)  
[View Essentials Plans](#)

[Messaging](#)  
Un  
Pe  
Re

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.

**EB Eligibility & Benefits**
[Feedback](#)

Fields marked with an asterisk \* are required.

\* Organization  
Christus Santa Rosa Hospital

\* Payer  
BCBSTX

**Provider Information**
[Clear Section](#)

Select a provider or enter one of the following: Provider NPI or Provider Tax ID

Provider  
CHRISTUS SANTA ROSA HOSPITAL (NPI: 1194787)

Search for a provider by name, NPI, tax ID, taxonomy code, or address

Next, change the "provider type" to Institutional



<b>Provider NPI ?</b> <input type="text" value="1194787218"/>	<b>Provider Tax ID ?</b> <input type="text" value="741109665"/>
<b>* Provider Type</b> <div style="border: 1px solid #ccc; padding: 2px;">Please Select a Provider Type ▼</div> <div style="border: 1px solid #ccc; padding: 2px; margin-top: 2px;"> <div style="background-color: #e6f2ff; padding: 2px;">Professional</div> <div style="background-color: #fff; padding: 2px; border: 1px solid #ccc;">Institutional</div> </div>	<b>Provider First Name</b> <input type="text"/>

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.

<div style="display: flex; gap: 10px;"> <div style="border: 1px solid #ccc; padding: 2px 10px;">Single Patient</div> <div style="border: 1px solid #ccc; padding: 2px 10px;">Multiple Patients</div> </div>	
<b>Patient Search Option ?</b> <div style="border: 1px solid #ccc; padding: 2px;">Patient ID, Date of Birth ▼</div> <div style="border: 1px solid #ccc; padding: 2px; margin-top: 2px;"> <div style="background-color: #0056b3; color: white; padding: 2px;">Patient ID, Date of Birth</div> <div style="padding: 2px;">Patient ID, Patient Last Name, Patient First Name, Date of Birth</div> <div style="padding: 2px;">Patient ID, Patient Last Name, Patient First Name</div> <div style="padding: 2px;">Patient ID, Patient Last Name, Date of Birth</div> <div style="padding: 2px;">Patient ID, Patient First Name, Date of Birth</div> <div style="padding: 2px;">Patient ID, Patient Last Name, Patient First Name, Date of Birth, Group Number</div> </div>	<b>* Date of Birth</b> <input type="text" value="01/01/1966"/>  <b>Patient's Relationship to Subscriber ?</b> <div style="border: 1px solid #ccc; padding: 2px;">Self ▼</div>

### Verifying eligibility in OneSource

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

### Blue Cross Blue Shield of Texas Eligibility

**Search Options:**

**NPI:**

**Place of Service:**

**Subscriber ID:**

Subscriber ID's cannot include an alpha-prefix that begins with ZGD ZGJ ZZT ZGC ZGE ZGT WZG

**Patient Group Number:**

**Patient Last Name:**

**Patient First Name:**

**Patient Date of Birth:**

**Relationship to Subscriber:**

**Eligibility Coverage Type:**

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

**Beginning Date of Service:**

**Ending Date of Service:**

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

**Member is Ineligible**

SEARCH CRITERIA	
NPI	[REDACTED]
Subscriber ID	[REDACTED]
Patient Date of Birth	[REDACTED]
Relationship to Subscriber	Self
Eligibility Coverage Type	Other Medical
Beginning Date of Service	[REDACTED]
Ending Date of Service	[REDACTED]

SUBSCRIBER	
Name	[REDACTED]
Member ID Number	[REDACTED]
Group Number	[REDACTED]
Address	[REDACTED]
Date of Birth	[REDACTED]
Sex	Female


**INACTIVE**

Service Type	Health Benefit Plan Coverage
Insurance Type	HMO
Description	MyBlue Health
Eligibility Begin Date	01/01/2024
Eligibility End Date	05/01/2024

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

[Edit](#)

 **Print**

[Feedback](#)

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	[REDACTED]	Male	[REDACTED]	Self

Member ID Card

Patient Cost Estimator

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.

Subscriber Policy Num	
Employer Name	TRI TEC
Employer Location	ORANGE
Employment Status	FT

Add Edit Reorder Offset

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:

Documents Search

Encounter#

Ctrl Click on Documents to Add to Output Queue

Global - TEL

- 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.

Order	Insurance	Balance	Age Date	Collector	Billor	Last Receipt	Date
1	PBCPTX	0.00		COM COLL	BLR01.SR	37955.51	04/13/24

Subscriber ID: [REDACTED]  
 Name: [REDACTED]  
 Address: [REDACTED]  
 City/State/Zip: [REDACTED]  
 Country: [REDACTED]  
 Phone: [REDACTED]  
 Email: [REDACTED]

Birthdate: [REDACTED] Race: WH  
 Sex | Marital Status: F | M US Citizenship: Y  
 Soc Sec Num: [REDACTED] Pt Relation: SP

Subscriber Policy Num: [REDACTED]

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

Order	Insurance	Balance	Age Date	Collector	Billor	Last Receipt	Date
1	PBCPTX	0.00		COM COLL	BLR01.SR	37955.51	04/13/24

Patient Policy Num: [REDACTED]  
 Verification Status: QUEUED  
 Effective Date: [REDACTED]  
 Expiration Date: [REDACTED]

Benefit Plan: [REDACTED]  
 Coverage Num: [REDACTED]  
 Group Name: [REDACTED]  
 Group Num: [REDACTED]

- 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. (chechar si hay guía)

Birthdate		Race	WH
Sex   Marital Status	F   M	US Citizenship	Y
Soc Sec Num		Pt Relation	WI
Subscriber Policy Num			

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

Insurance/ Claim	UCRN	Date Sent - Age	Amount	Receipt Total	Insurance Bill Balance
<b>PBCPTX - BLUE CROSS PRO TX</b>					
837BCITX		06/27/24 - 5	9879.14	0	8072.50
837T AI					
ZPCONBCTX		06/27/24 - 5	9879.14		
<b>SELF PY - SELF PAY</b>					
ZPCON7			9879.14		0

Demographics  
Insurance  
Codes  
Inquiry  
Bills  
**Claims**  
Corrections

Suggested note:

WORKING ON CLAIM 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.”

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



Dispute Claim ⚠️

Patient Information

- 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”

Claim [REDACTED] was successfully added to your worklist. x

CS

Look for this request in your worklist to complete and send to the payer. You can review the status of your requests from the worklist.

Claim Number [REDACTED]

Status: **Initiated**

Close

Go To Request

- v) Click on Complete Dispute Request



**Initiated**  
Created: 07/02/2024 • Updated 07/02/2024

Complete Dispute Request

Delete Initiated Appeal

Return to Worklist

Claim Number [REDACTED]

Payment Information

Patient Name [REDACTED]

Service Begin Date

06/20/2024

Method of Receipt

Payment Date

06/28/2024

Patient Account Number [REDACTED]

Service End Date

06/22/2024

\$40,363.50

Payment Amount

\$0.00

- 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

\* Request Reason

Reconsideration

\* Please explain the supporting rationale for your request

0/2000

\* As the Appellant, are you submitting this request on behalf of the Rendering or the Billing Provider:

☐ Rendering

☐ Billing

\* Contact Phone Number


8007567999

Upload Supporting Documentation

**IMPORTANT:** Maximum number of files to upload is 10 with a maximum individual file size of 20 MB, total 80 MB across all files.

Supported file types include: .jpg, .jpeg, .pdf, .tif, .tiff

**NOTE:** File names cannot contain spaces or special characters with the exception of "\_" and "-".



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.

### Other or Additional Payer Information

#### Primary Payer

Payer: MEDICARE  
Insurance Type: Medicare Part B  
Eligibility Date: [REDACTED]

#### Primary Payer

Payer: MEDICARE  
Insurance Type: Medicare Part A  
Eligibility Date: [REDACTED]

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

### HEALTH BENEFIT PLAN COVERAGE

Eligibility or Benefit Information	Other or Additional Payer
Insurance Type	Medicare Part A
Coordination of Benefits Date	[REDACTED]
Member ID Number	[REDACTED]
Payer Name	Medicare A

### HEALTH BENEFIT PLAN COVERAGE

Eligibility or Benefit Information	Other or Additional Payer
Insurance Type	Medicare Part B
Coordination of Benefits Date	[REDACTED]
Member ID Number	[REDACTED]
Payer Name	Medicare B

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 Availity 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:

**Assembly Request**  
Mail

**\* Mail To**  
  
Patient  
Guarantor

**Mail To**  
Company Name   
Address   
Address 2   
City   
State   
Zip Code

**Last Name**   
**Fax**   
**Phone**   
**Email**

**Line Items**  
\* Line Item Type

**\* Notes**  
PATIENT LETTER

**Attachment**  
Elegir archivo No se eligió ningún archivo

**Add New Item**

**Assembly Notes**  
HI TEAM, PLEASE SEND THE LETTER ATTACHED TO PATIENT/GUARANTOR.

**Save** **Cancel**

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.**

- Call BCBS to confirm if patient updated his COB.
- 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.
- After doing this, sent the account to MEDUPFU agency in Meditech.

**Transfer Out of Collection Agency (O) or change Collection Agency (C)**  
\*Assign To Collection Agency  
Next Event Number

**MEDUPFU**  
1

**Cancel** **OK**

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.

Insurance Data Subscriber Policy <b>Authorizations</b> CDS							
Order	Insurance	Balance	Age Date	Collector	Billor	Last Receipt	Date
1	PBCPTX	8072.50	06/04/24	COM COLL	BLR01.SR	0	06/30/24

	Authorization Num	Eff Date	Exp Date	Auth Status	Verif Status	Verif Date
1	[REDACTED]	06/02/24		CLOSED	VERIFIED	06/04/24
2						
3						
4						
5						

- 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.

63 TREATMENT AUTHORIZATION CODES	
[REDACTED]	

- 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 Carelton 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 Availability, 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:

- 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.
- 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

Admit/Service	06/28/24
Discharge	06/28/24
Admit Status	ER
Service/Location	AJ.ED

Account Type	
Status	FB 07/03/24
Agency	CLMEDDNL

	RWH
	ER
Group	

Single
Worklist
Prev Account
Next Account
Summary
Demographics
Insurance

## 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 APPROPRIATE ANATOMICAL MODIFIER. NEXT ACTION – REVIEW HIM RESPONSE.”

## Short payments on account with no denials.

You might have 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 CROSS 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 change 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.

Admit/Service	10/02/24
Discharge	10/06/24
Admit Status	INP
Service/Location	OB

Then go to the Codes section and look for the DRG

PPS Codes Billing Codes SNF Data Leave of Absence

Groupier Version: 42 ABS Status: FINAL

**Code Type**

- Diagnosis
- Procedure
- DRG
  - Submitted DRG: 540 CESAREAN SECTION WITHOUT STERILIZATION
 

Status	3
DRG Amount	0.00
Day Outlier Amount	
Cost Outlier Amount	
Minimum Days	
Standard Days	4.2
Maximum Days	
Arithmetic Length of Stay	5.6
Geometric Length of Stay	4.2

Single Worklist Prev Account Next Account Summary Demographics Insurance Codes Inquiry Bills

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.

Patient Registration Physicians Guarantor CDS

Severity of Illness

Severity of Illness I10	3
Risk of Mortality I10	1
APR DRG I10	540
APR DRG Cost Weight	0.9873
MS DRG I10	786
MS DRG Cost Weight	1.6158
Patient's Country Code:	
Payment Plan Start Date (T+1)	
Monthly Payment	
First Payment Due Date (T+30)	
Payment Recurrence	
Estimate / Deposit Due	
Estimate / Deposit Paid	

4 of 5 Goto 5

Single Worklist Prev Account Next Account Summary Demographics Insurance Codes Inquiry Bills Claims Collections Scanning Other EMR

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.

INFORMATION FROM THE HOSPITAL-- TO BE INPUT BY THE USER		
Total charges	\$32,340.20	UB-04 Form Locator 47
Hospital-specific cost-to-charge ratio	37.00%	Used to estimate the hospital's cost of this stay
Length of stay	4	Used for transfer pricing adjustment
Patient discharge status = 02, 05, 65 or 66? (transfer)	NO	Used for transfer pricing adjustment
Patient age (in years)	41	Used for age adjustor
Is discharge status equal to 30?	No	Indicates an interim claim
Designated NICU facility	Yes	Policy adjustor for designated NICU facilities
APR-DRG	530-3	From separate APR-DRG grouping software

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.

Payment amount	\$32,340.20	amount. Otherwise, subtract other health coverage (E62) and patient share of cost (E63) from "Lesser of" (E64) to obtain payment amount.
0/2015		
<p><b>HUIZAR, Debbie:</b> Is the expected &gt; or = the billed chrgs?? If so, reduce by 10% per the Minimum Discount language in the contract.</p> <p><b>Minimum Discount</b></p> <ol style="list-style-type: none"> <li>1. If the total Claim Allowed Amount is equal to or greater than the total Claim Eligible Charge, the compensation is recalculated based on the Minimum Discount provisions on <b>Exhibit B, Part II</b> in lieu of the otherwise applicable Contract Rates.</li> <li>2. The compensation is the lesser of (a) the Minimum Discount percent applied to the total Claim Eligible Charges, or (b) the total Claim Allowed Amount.</li> </ol>		

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.

Insurance	PBCPTC
Prorated	32340.20
-Receipts	0
-Adjustments	3234.02
+Refunds	
+Edits	
-Transfers	
= Balance	29106.18
Receipts/Exp/H...	1/2/0
Expected Reimb	29106.18
Variance	
% Received	

**\*\*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 (recurring) or any other should be calculated as Outpatient Account.

Admit/Service	08/10/24
Discharge	
Admit Status	ER
Service/Location	AH.OBED

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 plan patient has, this could be Blue Advantage or Traditional.

Insurance	PBCPTC
Prorated	7108.21
-Receipts	2638.63
-Adjustments	3810.00
+Refunds	
+Edits	-659.58
-Transfers	
= Balance	0
Receipts/Exp/H...	1/1/0
Expected Reimb	3298.21
Variance	-659.58
% Received	80.0

## 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

Admit/Service	07/31/24
Discharge	08/03/24
Admit Status	INP
Service/Location	PED

Account Type	
Status	FB 08/10/24
Agency	PCAT

	RCH
	IO.SUPR
Group	

Single  
Worklist  
Prev Account  
Next Account  
**Summary**  
Demographics  
Insurance

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

Patient
**Registration**
Physicians
Guarantor
CDS

Dates/Services
Maternity

Status and Service		Priority and Location	
*Pt Status	OBSERV	Admit Priority	ER
*Inp Svc	SUR	Admit Source	PHY
Out Pt Svc		Room	
Out Pt Loc		Bed	
Account Type	RCHOOBV	Location	

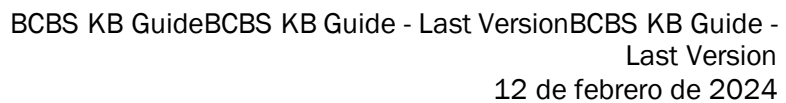
Registration		Discharge	
Admit Date		Date	03/11/24
Time		Time	1317
Svc Date	03/11/24	Disposition	<b>HOM</b>
Time	0108	Diagnosis	
Rec Date			
Diagnosis			

Mnemonic	Name
HHS	HOME HEALTH SERVICES 06

Single  
Worklist  
Prev Account  
Next Account  
Summary  
**Demographics**  
Insurance  
Codes  
Inquiry  
Bills  
Claims  
Collections  
Scanning



PPS Codes

Billing Codes

SNF Data

Leave of Absence

Groupver: 41.1

ABS Status: FINAL

Code Type

Diagnosis

Procedure

DRG

Submitted

DRG: 853

- INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES

Status	3
DRG Amount	0.00
Day Outlier Amount	
Cost Outlier Amount	
Minimum Days	
Standard Days	10.3
Maximum Days	
Arithmetic Length of Stay	13.3
Geometric Length of Stay	10.3

Single

Worklist

Prev Account

Next Account

Summary

Demographics

Insurance

Codes

Inquiry

Bill

## Inpatient Services

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

28

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

**RWHIINP** **07/04/24 - 07/12/24**  
**PBCTTX - BLUE CROSS TRADITIONAL TX**

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

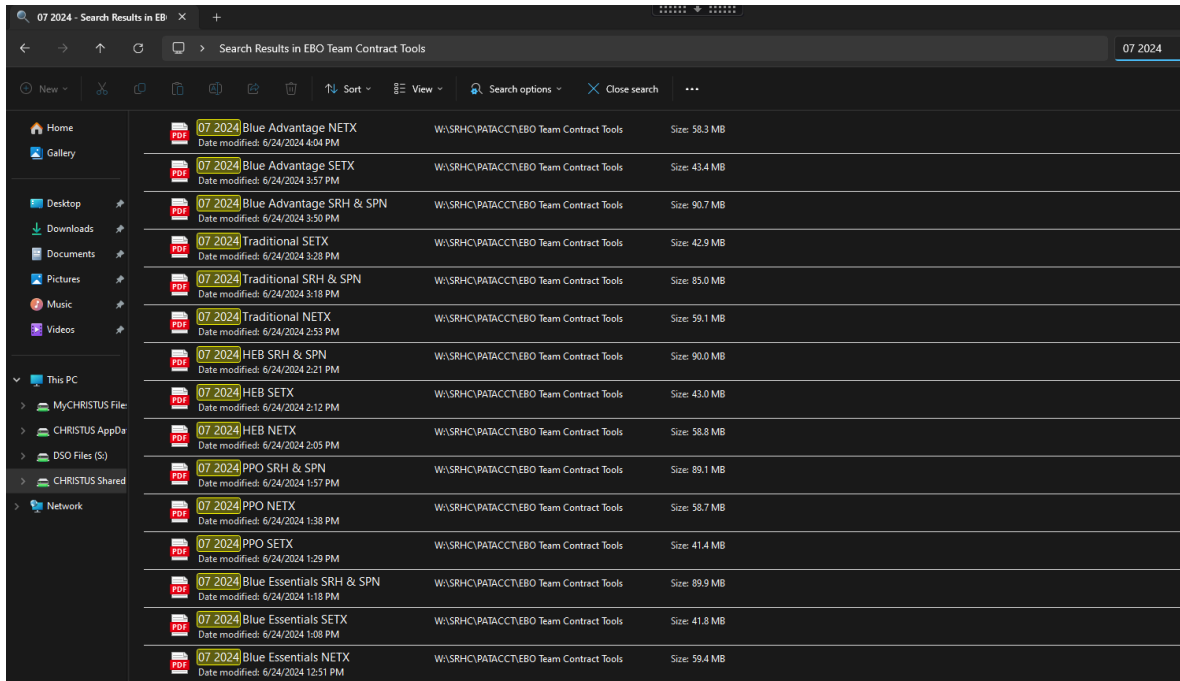
Insurance	PBCTTX
Prorated	108422.23
-Receipts	35211.80
-Adjustments	73210.43
+Refunds	
+Edits	0
-Transfers	
= Balance	0
Receipts/Exp/H...	1/99/0
Expected Reimb	57219.18
Variance	-22007.38
% Received	61.5

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.

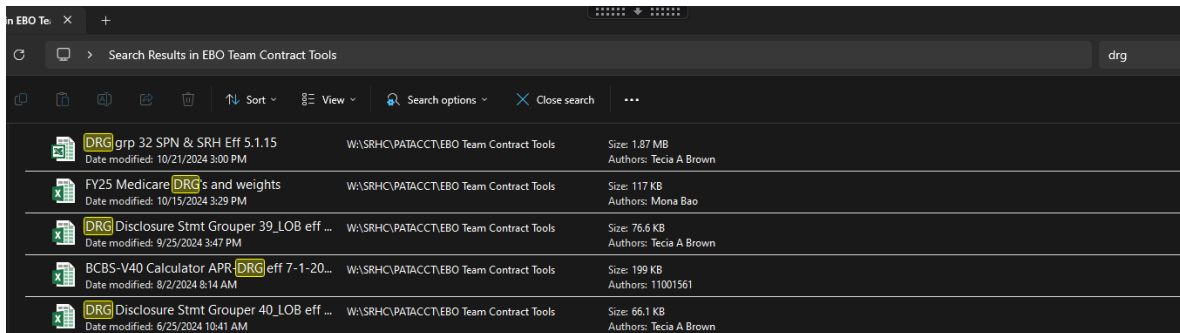
Remember, depending on the lplan, it will be the type or archive or DRG calculator you'll need. You can find them all in the following path

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 Inquiry Insurance Inquiry Bill Inquiry Collection Inquiry Other Inquiry			
Category	Detail	Department	Procedure Bill Event
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	Case Rate	\$ 3,500 (Day 0-3)
Section Delivery Mom only		\$ 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

GROUPE 32 Facility Name							Traditional		PPO	
The Cross Blue Shield of Texas - DRG Disclosure Statement for Inpatient Services Eff 5/1/15							DRG BASE RATE		DRG BASE RATE	
							\$0.00		\$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	\$25,612.14	\$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	1.16104	3	0	6	\$0.00	\$0.00	\$2,889.05	\$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 greater than \$2,500.00 (This also applies for implants).

Calculating  $\$5,553.65 \times .35 = 1,943.78$ . **\*\*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	SELPY	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		

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

- Once you verify it, review the member ID. Depending on the member ID, they could have different lplans.  
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

<b>Patient Policy Num</b>	T2G	
<b>Verification Status</b>	VERIFIED	08/23/24
<b>Effective Date</b>	07/01/24	
<b>Expiration Date</b>		

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

