through

Hola/as Monday.

## Denail Management

4. No Authorization: Box No:-23 CO-197.

Authorization: Which takes an approval from the payer by the provider

It is a 10 digit number. It almost starts with A.

pre Authorization:- Which takes an approval from the payer by the provider before starts the service.

Retro Authorization:- Which takes an approval from the payer by the provider After starts the Service.

(i) check CMS1500 Box23, & software wethere the Auth# is available or not.

(ii) If Auth# is available call to Rep & Ask for reprocess.

(iii) If Auth# is not available then check patient place of Service.

Note:- If in any Emergency cases there is no need to Auth# No.

(iv) If patient place of Service is 23 then its Emergency Service so no need pre Auth# ask to Rep for Reprocess.

(v) If any another pos means ask to rep retro is possible or not.

(vi) If Retro Auth # is not possible then appeal with medical records.

(vii) Take call number/ Ref number.

2) No Referral : CO-288 Box No :- 23

(i) check CMS 1500 Box # 23 wethere the ref number is available or not.

(ii) If referral is available then call to Rep & Ask for reprocess.

(iii) If referral is not available then check patient plan.

(iv) If patient belongs to ppo (or) Epo so for no ref req then ask to rep for reprocess.

(v) If patient belongs to HMO (or) pos then ask to rep that pcp name & pcp contact number.

(vi) For sending Corrected claim Ask to rep corrected mailing address, fax number & TFL.

(vii) Take call Number/ Ref number.

3) TFL : Timely Filing limit CO-29

TFL : Every insurance company will give a certain time period to submit a claim the time period is called as "TFL".

* Call to Rep and Ask what is claim received date?
* Ask to rep what is TFL for this claim.
* If we send a claim with in TFL then Ask to rep for reprocess
* If we send a claim After TFL then check we have any poTFL available (proof of Timely filing limit).

* If POTFL is available then appeal with POTFL.
* For sending Corrected Claim Ask to rep Corrected mailing address, fax number & TFL.
* If POTFL is not available then Adjust the balance.
* Take Call number / Ref number.

18/04/25
Tuesday

4) Inclusive / Bundled : [Co-97] [Box:- 24(D)]

* Call to Rep and Ask that denied CPT is included with same claim (or) different claim
* If Rep said same claim then check CMS-1506 Box 24(D) whether the correct modifier is applied (or) not
* If modifiers is not available then forward a claim to coding team for providing correct modifier.
* For sending Corrected Claim Ask to rep C.C. mailing address, Correct modifier, Fax number, TFL.
* If modifier is available then appeal with medical records (appeal TFL, different mailing address).
* Take Call number / Ref number.

I would like to tell

5) Global Inclusive : Co-97 [redacted].

* Call to Rep and Ask what is Global period.
* If date of service is not lies in Global period and Explain that Rep ask to reprocess.
* If date of service is lies in global period then check CMS 1500 Box 24(D).
* wethere the correct modifier is applied (or) not.
* If modifier is not available then forward a claim to coding team for providing correct modification.
* Ask to Rep C-C. ~~modelling~~ mailing address, Correct modifier. fax number, TFL.
* If modifier is available then appeal with medical reports.
* We can use only one modifies 24 then forward to coding team. * Take call number/ Ref number.
* 24 - Unrelated Elm code performed in Global period.

6) Maximum Benefits Exhausted :

=) Call to Rep and Ask that its denied interms of dollers wise (or) visits wise.

=) If it visits wise then ask how many visits allowed for this patient annually.

=) Then check how many visits met by patient.

=) So if still visits is there means ask to rep for reprocess.

=) If visits completed then check patient have Secondary insurance is available or not.

=) If secondary is available to contact the secondary insurance.

=) the patient dont have the secondary insurance then will be pay patient.

→ Take call number/ Ref number.

* 19/02/25 Wednesday

7) Non-covered Insurance: CO-96

* * Ask to rep it is non-covered under, patient plan (or) provider contract.

(i) patient contract:-

* If rep said its patient plan then check rendering services covered (or) non-covered for that payer.

* If its non-covered by primary insurance then bill to secondary insurance.

* For that req EOB then bill to secondary insurance.

* If patient dont have secondary insurances then bill to patient.

(ii) provider contract:-

* If rep said its provider contract then check same CPT is previously paid or not paid.

* If not paid then do a formal appeal.

* Then ~~appling~~ appeling purpose ask to rep mailing address, Fax number, TFL. (or)

* We need to work as per client instructions

* If we paid then ask to rep for reprocess the claim because already done that type of services.

(8) Not medically necessity : CO-50.

* If services not followed by LCD & NCD guidelines then claimed denained because of not medically necessity.

* LCD - Local Coverage determination.
  NCD - National Coverage determination.

* Check patient previous history wether the same CPT & dx Code combination previously paid (or) not

* If its previously paid then call to Rep & explain that and ask for reprocess.

* If its previously ~~paid~~ not paid then forward a claim to coding team for providing correct dx code.

* For sending corrected mailing Ask to rep Correct mailing address, Fax number, TFL...

* If again claim denied then appeal with medical reports to show the medical necessity.

* If apiel upheld then check insurance type.

  (i) If its medicare then check ABN.

  (ii) If patient signs in ABN then Bill to patient

  (iii) If patient not sign in ABN adjust the balance.

* If any other insurance then work asper client instructions.

(9) Duplicate : CO-18

Claim duplication:

* Call to rep ask how many claims you received for that se
date of services.
* If rep said one claim then ask to rep for reprocess
* If rep said 2 claims or multiple claims then check
date of service and rendering provider, modifiers, medi
records are same or not.
* If same then ask the original claim states
* We need asper original claim states.

CPT Duplication:-

* First we need to check CMS 1500 box 24d) that modifier
available or not
* If modifier not available means Ex if same CPT billed
on multiple time same claim by same day same doctor we
add 76 modifier and send corrected claim.
* If same CPT billed mutiple time on same claim same day
different doctor 77 modifier and send corrected claim
to insurance company.

14/02/25
Friday

## SCENARIOS.

1) Claim not on file:

* ~~Ask to~~ call to Rep and ask what is policy Effective (starting) date & term date. (ending).
* Then check patient policy is active (or) not for the date of service.
* If patient policy is active then ask to Rep that mailing address, fax number, payer id, TFL for Resending a claim.
* If patient policy is inactive then check patient have secondary insurances are available or not.
* If secondary available then bill to secondary
* If secondary is not available then bill to patient

2) Claim in process :

* Call to Rep and ask that what is claim received data.
* Ask to rep what is normal processing days for this claim? (30 to 40 days).
* If still processing days is there then allow some days.
* If processing days completed then ask to rep reason for delay.
* Ask to rep when can I call you back for claim update.
* Take claim number/ call Ref number?

3) Claim paid :

* Call to Rep and Ask what is claim process date & paid date.
* How much allowed amount & paid amount and patient responsibility.
* Ask to rep that what is payment mode.

=) If claim paid through check :

(i) Ask to rep what is check number.
(ii) It is single check (or) bulk check.
(iii) What is pay to address.
(iv) What is check encashed date.
(v) Request EOB through fax for updating the payment.

=) If claim paid EFT :

(i) Ask to rep what is EFT Id.
(ii) Ask to rep it is single EFT (or) bulk EFT.
(iii) What is EFT cleared date.
(iv) Request EOB through fax for update the payment.

(4) claim processed to words capitation:

* Call to Rep and ask what is processed date?
* Then Ask to Rep capitation period.
* If date is not lies in capitation period then ask to rep for reprocess.
* If date of service is lies in capitation then Req EOB through fax for update payment