|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **SOP– 09**  **Clearing House Rejections** | | Standard Operating Procedure | | |  |  | | --- | --- | | **Department:** | Clearing house Rejection – Initial Billing | | **SOP ID:** | 2024.03.09 | | **Date:** | 2/15/2024 | | **Sign Off:** | Sabrina Gomez | |

### **Overview:**

This document outlines the NEA Electronic Billing GH processes to improve efficiency resulting in ***WQ Error(s) resolved.***

### **Definitions:**

|  |  |
| --- | --- |
| **Fee Schedule/Plan** | *The insurance allowed amount, copay amount, or contracted rate.* |
| **Payer** | *The insuring entity* |
| **EOB** | *Explanation of benefits from payer outlining allowed amount, copays, or contracted amount.* |
| **Online Claim submission** | *Claim filed online with necessary attachments and billing details.* |
| **Delivery Date** | *Date restoration or appliance was delivered to patient for specific dental procedures.* |
|  |  |
| **Pre-Authorization** | *Or predetermination is the processes that payers make available to dentists to clearly determine the potential benefits for a specific patient.* |
| **Subscriber** | *Primary policy holder on the insurance coverage.* |
| **Member/ Dependent** | *The patient who the insurance covers.* |
| **Guarantor**  **Release of Information** | *The person or entity financially responsible for the account.*  *Aka ROI. Area attachments stored specific to an invoice for billing purposes* |
|  |  |
|  |  |

### 

### **Required Operation Software**

* NEA Desktop application
* Onbase
* CyberArk
* Web viewer
* EPIC Access
* Credentialing Grid
* Fresh Service
* Box

|  |  |
| --- | --- |
| |  | | --- | | **Overview of Steps** | |

* Prerequisite:
* Log into context of each treating location.
* Understand the EOB
* Call to Double Check patient information if matches current data.
* Prior Authorization
* Verifying Dental Patient's Insurance Coverage
* Determine the appropriate action necessary based on the error.
* Payer findings
* Ensure all WQ errors line and claim level are addressed together when error is correlating.

**Scenario 1-** Patient Demographic and coverage

* 1.1 Rejection due to Patient Demographic and coverage information.
  + 1.1a Update Patient / Subscriber demographics
  + 1.1b Visit / Invalid Coverage
* 1.2 Take Appropriate Action
  + 1.2a Skip to Action Step 1 for resolution

**Scenario 2**- Provider issues

* 2.1 Determine reason for provider discrepancy.
  + 2.1a Provider not registered for ECS
  + 2.1b Provider NPI miss match
* 2.2 Take Appropriate Action
  + 2.2a Skip to Action Step 2 for resolution

**Scenario 3-** Tooth/Quad rejections

* 3.1 Review error account and determined payer / tooth / Quad rejection.
  + 3.1a Claim EDIT for missing tooth
  + 3.1b Updating tooth / Quad from clearing house rejection
* 3.2 Take Appropriate Action
  + 3.2a Skip to Action Step 3 for resolution

**Scenario 4-** Transfers from non CHWQ Claim EDIT WQ’s

* 4.1 Claim transferred to incorrect WQ.
  + 4.1a Claims transferred into WQ from another WQ.
* 4.2 Take Appropriate Action
  + 4.2a Skip to Action Step 4 for resolution

**Scenario 5-** Claim Data issue

* 5.1 Claim data rejections
  + 5.1a Fee Exceeds
  + 5.1b Zip Code error
  + 5.1c Too Many Service lines on claim
  + 5.1d Metlife alternate ID’s
* 5.2 Take Appropriate Action
  + 5.2a Skip to Action step 5 for resolution.

**Scenario 6**- Claim Frequency Code

* 6.1 Determine claim frequency indicated as correct code.
* 6.1a If claim is an original claim
* 6.2 Take Appropriate action.
  + 6.2a Skip to Action step 6 for resolution.

**Scenario 7**- Adjustment amount [519] and date claim paid [554]

* 7.1a Updating amount in EOB section.
* 7.2 Skip to action step 7 for resolution

**Scenario 8** - Claim duplicate or rejected already on file and/or paid

* 8.1a identifying claim already on file
* 8.1b Duplicate claim
* 8.2 Skip to action step 8 for resolution

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 1 – Patient demographic and coverage** | |

**BEFORE YOU START:** Review payer web or call insurance, review documents in media, prior paid EOB’s. Demographic updates based off SRG “Updating Patient Demographics in Registration” team is also able to update patient / Subscriber demographic if card or document is in Media. Guarantor account information cannot be updated by GH. Ensure All notes in transfers start with the ask followed by space then the reason for the ask.

* 1.1 Rejection due to patient demographic.
  + 1.1a Update Patient / Subscriber Demographic
    - In Scope –
      * Update Demographics, add history note and override error.
    - Out of scope –
      * Cannot locate patient/ Subscriber – Transfer- to Treating location Front office with reason Cannot ID patient verify insurance info [14] , Invalid Subscriber - Please Update Registration [29]
      * Patient / Subscriber information mismatch – Transfer to treating location front office to update with the correct information with Member First/Last Name Invalid [32] Or Invalid Subscriber - Please Update Registration [29].
      * Plan is inactive – Transfer to Treating location Front office with reason, Criteria not met [19].
      * Address is incomplete – Transfer to Treating location Front office with reason need completed address in registration [36]
      * Address is mismatch information – Transfer to Treating location Front office with reason Patient Needs To Contact Insurance To Update Address [67]
      * Patient / Subscriber not covered under policy – Transfer to Treating location Front office with reason Criteria not met [19]
  + 1.1b Visit / Invalid Coverage
    - Current coverage needs to be updated to a new coverage –
      * Transfer to Treating Location Eligibility Claim edits – Offshore with reason Update Coverage and Dental Eligibility Form [206]
        1. Notes - Update Coverage and Eligibility form from **Current ins name** to **Requested insurance name** followed by space line, and additional comments on how we verified this information.
    - Current Coverage present and not correctly associated with visit of Filing order –
      * Due to rejected Retro review rejection – Place Coverage Change Ticket (See Conclusion), Defer with reason Coverage Change Ticket Submitted [98010] for 30 days. Ensure notes include Ticket# and requested information.
      * Due to needs Transfer to treating location Front office with reason Update Coverage and Dental Eligibility [206]
    - Coverage Change request transferred from Eligibility with reason Eligibility Coverage Update Completed [235]
      * Defer for 14 days with Reason Coverage Change [98003]

**BEFORE YOU MOVE ON:**

Add pre/ post-step notes, explanation in history, quality assurance checks, and verify all actions have been completed.

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 2 – Provider Issues** | |

**BEFORE YOU START:** Find the appropriate action below based rejection from insurance company and review of provider status from eligibility form. Review eligibility form, identify provider, status and effective date.

* 2.1a Provider Not registered for ECS
  + Rejections States “Provider not registered for ECS” or indicated EDI enrollment.
    - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209]
* 2.1b Provider NPI Miss match.
  + Rejection due to Provider not contracted or NPI/Lic not found on provider files.
    - BC out of state and non-Delta or Premier Access – Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209] with notes requesting to bill with a w-9
    - Delta, Premier Access, and in-state BC
      1. Initial Claim rejection – Defer with reason Provider not contracted [1665] for 30 days from DOS or 30 Days from Contract submission per credentialing grid. Whichever is greater.
    - After 30 days expires –
      1. If Contracted – Override Error
      2. Premier Access If not contracted – Place eligibility ticket and defer for 2 weeks.
      3. Delta – If not contracted – Defer for 2 weeks as “Provider Not contracted.”
      4. In state BC – If not contracted – Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209] with notes requesting to bill with a w-9.
    - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209]
    - 45 days expires –
      1. If contracted - Override Error
      2. Premier Access If not contracted – Place eligibility ticket and defer for 2 weeks as “Provider Not contracted.”
      3. Delta – Place another ticket or follow up on existing ticket if no response received.
    - 60 days expires –
      1. Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209] with notes requesting to bill with a w-9.

**BEFORE YOU MOVE ON:**

Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 3 – Tooth / quad rejections.** | |

**BEFORE YOU START:** Review Read and review all claim edit fix instruction and [TOOTH QUAD REJECTIONS](https://pacificdental.box.com/s/k8ekcrcui19cgm4vbzkx68kjmdskjebm) document for tooth / quad specifics.

.

* 3.1a Claim EDIT for missing tooth – Perio Procedure is missing Tooth Number Rule 719275
  + Identify tooth # for procedure D4342 and D4921 be reviewing chart notes or identifying highest number per quad in Perio Charting
    - Go to TX Inquiry, right click procedure, and select EDIT.
    - Under EDIT tab add tooth# in Tooth field and click Accept.
    - Add notes indicating tooth’s, added and where tooth numbers were identified and Override Error.
* 3.1b Updating tooth / Quad from clearing house rejection
  + Identify tooth # for procedure be reviewing chart notes or identifying highest number per quad in Perio Charting
  + Determine correction needed by [TOOTH QUAD REJECTIONS](https://pacificdental.box.com/s/k8ekcrcui19cgm4vbzkx68kjmdskjebm) document.
    - Go to TX Inquiry, right click procedure, and select EDIT.
    - Under EDIT tab add missing information in Tooth or Quad field and click Accept.
  + Tooth Quads on Paper Claim image
    - Some Scenarios will require user to remove a Quad that cannot be removed via EDIT function. This can be performed on Paper claims image.
    - Go to paper claim and click line items that needs correcting.
    - Scroll down to line indicating ADA procedure – Dental Information and remove Quad from “Oral Cavity Destination” then click accept.
    - Document corrections and Override Error

**BEFORE YOU MOVE ON:**

Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 4 –Transfers from Non CHWQ Claim EDIT WQ’s** | |

**BEFORE YOU START:** Within Claim EDIT WQ CHWQ, ensure Column WQ Transfer in Date is visible. This will indicate if invoice originated from your WQ or if it was transferred to your WQ. User must read history to understand why items is in WQ.

* 4.1a Claims transferred into WQ from another WQ.
  + Transfer was a request from CHWQ and response is returned from office with requested information.
    - Information provided - Follow resolution steps based upon Scenario see Action Step1, 2, 3.
    - Information not provided – Place request back to office based off of scenario, see action step 1, 2, 3.
    - Information not provided after 2 request – Attach all relevant information based on Action step 1, 2, 3, Document account an override error.
  + Transfer is from or for another WQ.
    - Per history note request originate or was intended for another WQ
    - Identify WQ and transfer back to WQ with reason Incorrect review assignment [3]

**BEFORE YOU MOVE ON:**

Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **Action Step 5 – Claim Data Issue** | |   **BEFORE YOU START:** Review rejection reason from the clearing house.   * 5.1a Fee Exceeds   + Occasionally a single fee will exceed 9999.99. These fees cannot be sent electronically and may result in a line error.     - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209] * 5.1b Zip Code Error   + Identify Correct Zip code reason.     - Out of Country. - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209]     - Zip code for patient incorrect see Action steps 1.     - Zip code for office is incorrect – Review Credentialing Grid, review Zip code look up <https://tools.usps.com/zip-code-lookup.htm> Document errors, place on Query log and defer 14 days with reason Waiting for Supervisor response [1009] * 5.1c Too Many Service lines on claim –   + - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209] * 5.1d Metlife Alternate ID’s   + Verify Correct Billing ID via, DE form, Web or by Calling Metlife.     - Billing ID# is an alternate or Group# - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209]     - Billing ID is SS# and was not submitted on original claim, Override Error     - Billing ID# is a SS# and we do not have correct SS# - Transfer to Treating Location GP Billing – Offshore with reason Clearing House rejection requires paper Billing [209]   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 6- Claim Frequency Code** | |   **BEFORE YOU START:** Within Claim EDIT WQ CHWQ, ensure to review the claim paper image and review the frequency code indicated.   * 6.1a If claim is an original claim * Double click account in WQ * Navigate to paper image tab, In paper image in claim edit click the box 2 * Locate frequency code and update from Frequency code 7 to Frequency code 1 and click accept. * Override Error   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 7- Adjustment Amount [519] & Date Claim Paid [554]** | |   **Before you start:** For all the above Rejection if the primary has EOB on file, we need to add the information (Paid or Denial) by adding  in Claim Edit by Service line in EOB Tab.   * 7.1a Updating amount in EOB section * Once we get in the Error “Date Claim Paid[554]/Adjustment amount[519] in PB claim Edit -> Double clicks on the Invoice * Will be taken to **“Claim Edit Assistant” - > EOB TAB** * We can notice the claim level information as unbalanced, in this case we need to -> Tx Inquiry Screen * Open the First invoice that is the primary payer to pull the remittance/EOB * Back in Claim Edit Assistant Screen EOB TAB add the adjudication date and accept * Add all the service lines information referring to paid and adjudicated amount in first invoice * Once all service lines information completed and balanced you can see the claim level information as Green notating its balanced. * Override error   **Before you move on**  **Post Override Add note ->** “Claim rejected as External Status Code: 519-Adjustment Amount [519] -  A7 [3087112301] – Therefore we validated the Primary EOB and balanced the claim accordingly and Override.”  **Summary :** <Payer Name> <Invoice#> <DOS>  **Type :** Claim  Accept the claim to get resubmitted.  **Note:** If primary is discount plan use refer to the invoice that has been closed example primary invoice which is closed for the discount plan and refer to the claim lines. Paid date would be DOS.    **Action Step 8- Claim duplicate or rejected already on file and/or paid.**  **BEFORE YOU START:** Within Claim EDIT WQ CHWQ, ensure to review the claim paper image and review the frequency code indicated.   * 8.1a identifying claim already on file - While following Action step 1-7 claim was identified as already on file with payer   + Payer paid and posted needing Audit review.     - Go to Registration visit, select “Claim Info” icon and click “New Claim Information record”.     - Create new record select box Request write off and change to YES.     - Defer with activity with reason Other 1011   + Claim processing or payer paid and not posted.     - Double click WQ, navigate to invoice hyperlink. This will take you to TX inquiry. Keep this tab open and go back to WQ.     - Override Claim EDIT errors and refresh, close WQ.     - Navigate back to TX inquiry and click refresh status will change from error to processed.     - Click on each transaction on claim with cntrl+, when all procedures are highlighted, click Demand claim. Print claim to Null printer. * 8.1b Duplicate claim   + While following Action step 1-7 claim was identified as already on file with payer and needs trace follow up   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed. **Conclusion** | |  | |

List any post-procedure actions that can be taken. For example:

**Coverage Change Ticket process.**

Service Provider: ROC – Insurance Billing operations

Request Category: Audit

Sub-category: Coverage Change

Subject: Coverage Change request

Body – Ensure to include office, Invoice, MRN.

Notes Please update coverage from: REGENCE BLUE CROSS BLUE SHIELD OF ID PPO [756] to REGENCE OR BLUE CROSS BLUE SHIELD PPO [762] patient correct coverage is

**Payer Findings –**

***PAYER FINDINGS:***

Argus PPO- Aflac (Findings)

ID starting with AFA, AFCA, TRB need to call 855-819-1873 (ARGUS DENTAL PPO), which is 3rd party payer for Aflac. Claims mailing address- PO Box 211276. Eagan, MN 55121. Payer ID# ARG01

Guardian- Individual vs Guardian PPO (Findings)

* + Guardian PPO ID# is 9 digits and begins with 9 or is SS# with EID 64246
  + Guardian Individual ID# is 10 digits long and begins with 17, 18, 18 with EID GI813

Careington payer specific group# and group name

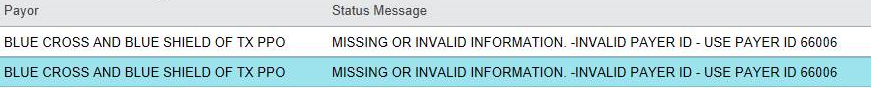
Please refer file- Careington ACTIVE GROUPS\_12.16.21, Careington EPIC grid in updates folder

Lincoln Group# format to search in portal

01-D039890(Group#)-00000 to get the search results

 BCBSTX PPO -Rejection - Invalid Payer ID, use payer ID 66006

In order for claims to route correctly electronically for Medicare Advantage through BCBSTX PPO we will need to ensure the ID # contains the prefix ZGD or ZGJ. We will see that these plans contain TX in their group#



If group contains TX and ID starts with 804, employer is Medicare Advantage

|  |  |
| --- | --- |
| Group | ID prefix |
| TX9706 | **ZGJ** |
| TX1666 | **ZGD** |
| TX4801 |
| TX-ALL OTHERS |  |

Example -From 804123456 To ZGD804123456

This will allow the claim to route Correctly and process for payment

For Subscriber IDs cannot include an alpha-prefix that begins with JLX, JYN, XOD, XOJ, YDJ, YDL, YDV, YID, YIJ, YUB, YUW, YUX, ZGD, ZGJ, or ZZT. To submit an inquiry with one of these alpha-prefixes, please submit the inquiry through Blue Cross Medicare Advantage.

We can use AVAILTY to identify the patient or DNOA website to call MEDICARE advantage use telephone # 1877 774 8592

BCBS OF TX MEDICARE ADVANTAGE cannot use FAX CLAIM resubmission payer id# CB900 PO BOX 660247 Dallas TX 75266

**For Metlife**

From time to time, we find that an insurance may have a different abbreviation on an address then we do. In some scenarios a payer will want the patient address to be a 1 to 1 match on what they have on file. If the suffix or abbreviation needs to be corrected, we can do so. A request to the office is not necessary. Please ensure this is only performed in cases when we know this address is causing an issue.

Example:

EPIC - Address is 1234 Main Street

Payor- Insurance has 1234 Main St.

Can update address to 1234 Main St.

EPIC - Address is 1234 Main Blvd.

Payor- Insurance has 1234 Main Dr.

Can update address to 1234 Main Dr.

EPIC - Address is 1234 Main Cir.

Payor- Insurance has 1234 Main Circle.

Can update address to 1234 Main Circle

A table of street abbreviations

Description automatically generated

**Delta Dental of CO Id format -error INS ID NOT FOUND ON PAYER FILE**

- Delta of Colorado REQUIRES us to bill with a 14-digit ID#. This ID# should start with a 08 and should not include a -01 etc. at the end. If we do not bill in this format. The claim will reject 100% of the time.

- Delta dental of CO IF Format 08000000123456-01 is not acceptable to file claim please update iD format as 080000123456 and **override the error**

|  |  |
| --- | --- |
| |  | | --- | | **Revision History** | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Draft** | **BETA test** | **Guidehouse** | **Final Draft** | **Version** | **Description** | **Approved By:** |
| 4/8/2024 |  |  | 4/8/2024 |  |  | Approved | Stephanie Jones |
| 06/06/24 | 03/01/24 | 03/28/24 |  | 03/24/24 |  | Approved | Sabrina Gomez |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |