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| |  | | --- | | **SOP-12**  **Audit Overpaid**  Standard Operating Procedure Title | |  | | |  |  | | --- | --- | | **Department:** | [Audit] | | **SOP ID:** | 2024.03.12 | | **Date:** | 2/23/24 | | **Sign Off:** | Natalia Udroiu | |

### **Overview:**

Define success - to ensure the correct claim processing/adjustment when there is incorrect fee schedule/plan attached or incorrect processing of the claim.

### **Definitions:**

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| **Fee Schedule/Plan** | *The insurance allowed amount, copay amount, or contracted rate.* |
| **Payer** | *The insuring entity* |
| **Coordination of Benefits** | *Aka COB. Takes place when a patient is entitled to benefits from more than one dental plan. Plans will coordinate to eliminate over-insurance or duplication of benefits.* |
| **Refund** | *An amount of money given back to insurance, especially because an overpayment.* |
| **Benefit Period** | *The length of time during which an insurance policyholder or their dependents may file and receive payment for a covered procedure. Benefit periods may affect certain benefit frequencies.* |
| **Offset** | *When an insurance company inaccurately makes an excess or wrong payment to its provider, it would adjust the amount in its successive claims.* |
| **Subscriber** | *Primary policy holder on the insurance coverage.* |
| **Member/ Dependent** | *The patient who the insurance covers.* |
| **Guarantor** | *The person or entity financially responsible for the account.* |
|  | *The guarantor receives the bill for any charges that insurance does not cover.*  *The guarantor can be the patient, another person, or even an employer.*  *Patients over age 18 are their own guarantors because they are financially responsible for themselves even if they are not the insurance holder.*  *\*\*\*These three people could all be the same person or different people. \*\*\** |
| **Explanation of Benefits** | *Aka EOB. A paper or electronic statement provided by the patient dental insurance company, which breaks down any dental treatments or services that have been billed.* |
| **Dental Eligibility** | *Aka DE. Dental Eligibility, a form used to verify patient eligibility.* |
| **Financial Arrangement**  **Out of Network**  **Duplicate Payment**  **Payer Contractual Allowance**  **Remittance Tracker**  **Work Comp (W/C)** | *Aka FA. patient financial agreement or a patient financial responsibility form, is a legal document that outlines the financial obligations and responsibilities of a patient for the healthcare services they receive.*  *Aka OON. Payment received due to provider not contracted.*  *Aka PCA. The amount of discount from standard charges that is allowed by a particular payer for that service.*  *.*  *A tool used to verify the status of the checks in our system.*  Work comp claims are related to accident |

### **Prerequisite: Non-negotiable process (Must do)**

* Verify the EOB for payment discrepancies.
* Verify the insurance website for paper EOB or benefit information.
* Review the Epic notes (History notes, line-item history notes, WQ notes)
* Verify the insurance website for paper EOB or benefit information.
* Review Audit (Offshore) SOP for services denied/underpaid

### **Required Operations Software**

* OnBase
* CyberArk
* EPIC Access
* Credentialing Grid
* Fresh Service
* Box
* Fee finder
* Remittance Tracker

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

**Step 1** – Combined adjustment

* 1.1 Credit and debit (due to overmax) under GP and Specialty invoices for same patient. Combined adjustment (GP/Spec/Hygiene, same year, and one claim denied due to overmax).
* 1.2. Insurance credit and debit under GP and Specialty invoices for same patient. The invoice with balance is still in process.
* 1.3. Insurance credit is under the LMC workqueue and the debit is under the Audit Overpaid workqueue

**Step 2** - Claim processed Out of Network

* 2.1 Provider not contracted for Date of Service and paid more than negotiated fees.
* 2.2. Claim processed OON, provider in network.

**Step 3** – Medical payment/Medical invoice

* 3.1 Medical payment posted to dental invoice or dental payment posted to medical invoice
* 3.2 Medical payment posted under dental insurance
* 3.3. Medical payment and dental payment posted correctly

**Step 4** – Overpayment - Dental

* 4.1 Insurance paid more than expected.
* 4.2 GP processed as ortho /incorrectly processed OON;the insurance has been informed (Anthem , Metlife).
* 4.3 GP processed as ortho /incorrectly processed OON;the insurance has not been informed (Anthem, Metlife).
* 4.4 Insurance additional payment – patient maximum rollover amount
* 4.5 Claim processed incorrectly OON
* 4.6. Services voided and not reposted. Insurance payment applied to other services
* 4.7. Services not billed. Insurance payment received

**Step 5** -Deductible transfer

* 5.1 Insurance applied Deductible in one line and Deductible collected in different code

**Step 6** – Duplicate Payment

* 6.1 Duplicate payment posted.

**Step 7** – Balancing the account

* 7.1 incorrect patent balance
* 7.2. Charge Error adjustment – end of month
* 7.3. Adjustment done before payment received
* 7.4. Incorrect Payer Contractual Allowance

**Step 8** – Posting review needed

* 8.1. If the payment is posted in the account, but not accordingly with the EOB

**Step 9** – Charge Error correction

* 9.1. DE form shows 0% coverage, patient not eligible for the denied procedure, or DE form is not updated prior to DOS
* 9.2. DE form shows patient eligible for the denied procedure, or the procedure is not listed on DE form

**Step 10** – Workers Comp Payment

* 10.1. Workers Comp claim billed and paid
* 10.2. Workers Comp claim billed and paid. Dental payment received.
* 10.3. Workers Comp underpaid the claim
* 10.4. Workers Comp claim billed and not paid yet. Dental payment received.

· 10.5. No Workers Comp account. Workers Comp claim billed and paid.

**Step 11** – Credit created as Tx not completed/ Unsatisfactory Outcome adjustment taken

* 11.1. Credit created as TX Not Completed - Patient adjustment taken
* 11.2. Credit created as Unsatisfactory Outcome - Patient adjustment taken

**Step 12** – Refund request submitted. Credit/Debit for services.

* 12.1 Refund request submitted; refund applied incorrectly to the line items.

**Step 13** – Insurance refund returned

* 13.1. Insurance payment refunded as unexpected medical payment received. Refund returned by the insurance as claim is paid correctly.
* 13.2. OON refund returned as claim is paid correctly
* 13.2. Insurance payment refund returned as overpayment has been used for other claims

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| |  | | --- | | **Action Step 1 - Combined Adjustment (Credit and Debit)** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review Payments tab and Dental Eligibility form, to confirm that the maximum year has been reached; Resolve Overposted Insurance Credits SRG for adjudication Epic steps; Splitting an Insurance Credit Between Doctor and Patient SRG.

* 1.1 Credit and debit (due to overmax) under GP and Specialty invoices for same patient. Combined adjustment (GP/Spec/Hygiene same day, same year, and one claim denied due to over max).
* If there are multiple invoices that can be combined with the following conditions: SP/GP/hygiene same day, same calendar year and criteria met for over maximum combined adjustment Defer [200] for 30 days with reason SP/GP Adjustment Pending [98037] with a note indicating claim deferred for combined adjustment. Escalate the invoice.
* 1.2. Insurance credit and debit under GP and Specialty invoices for same patient. Combined adjustment (GP/Spec/Hygiene same day, same year, and the invoice with balance is still in process; a denial due to overmax can be anticipated (verifying insurance payments and maximum year on DE form))
* Defer for 90 days with reason Pending for SP/GP Claim to be Processed with a note indicating claim deferred for combined adjustment, waiting for debit invoice to be processed
* 1.3 Insurance credit is under the LMC workqueue and the debit is under the Audit Overpaid workqueue (same invoice)

§ 1.3.1 If debit is from a service that can be reprocessed with additional information, resubmit the information

v If paper, Route to Paper Resubmission [592]

v if a new claim needs to be sent, use Resubmit New Claim with NEA [455]

v If electronic, Send Additional Information via NEA [425]

* 1.3.2 If a debit is from a service that can no longer be processed due to frequency, over max, wait period, etc., combine line items and adjust

V If resulting balance is a debit, write off using the most appropriate code for the denial on the EOB.

v If resulting balance is a credit, write off using estimate correction [7919].

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken.

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| |  | | --- | | **Action Step 2 – Claim Processed Out of Network** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Credentialing grid for status of provider, Dental Eligibility form and Coverage tab for plan information; Financial Arrangement for patient responsibility; OON Refund packet to determine if refund was already completed

* 2.1 Provider not contracted for date of service.
  + 2.1.1. If claim processed correctly, route the invoice to Out of Network [588].
  + 2.1.2. If patient plan is an indemnity/ Worker’s Comp/HMO Medicaid/Medicare or paid UCR

Determine if the credit belongs to the patient, the provider, or needs to be split according to the EOB.

* + 2.1.2.1. If the entire credit belongs to the patient (invoice level, all item lines), regardless the amount (greater/less than $75.00), Select Other →Transfer to Self-Pay action from Prof Tx screen.
  + 2.1.2.2. If only partial credit needs to be transferred to the patient (not all item lines have credit, there are item lines with debit balance), consider each item line with credit
    - If credit belongs to the patient, and credit is > $75 route to Ins to Patient Credit/Balance Transfer [551]
    - If credit belongs to the patient, and credit is < $75 select Other → Transfer to Self-Pay.
* If credit belongs to the provider, Write-Off as Estimate Correction – Insurance Credit [7919].
* If the credit needs to be split between the provider and patient, please use SRG, “Splitting an Insurance Credit Between Doctor and Patient.”
  + 2.1.3. If incorrectly processed OON, route to ICS Inquiry [546] - ICS Needed- Provider Network Status requesting to verify provider network status and reprocess the claim.
  + 2.1.4. If an invoice that was previously refunded for OON (OON refund packet has been created) is reprocessed again by insurance and now there are new payments posted, defer for 30 days with reason Escalation. Add the invoice on OON Escalation sheet

**BEFORE YOU MOVE ON:**

* 2.2. Claim processed OON, provider is in network on credentialing grid, and per insurance call notes the provider is OON and claim processed correctly
  + - * 2.2.1. Open credentialing help ticket requesting to confirm with insurance provider credentialing status for DOS. Attach the EOB to the ticket and provide plan name (Coverage tab)
      * 2.2.2. If credentialing help ticket already opened, defer the claim for 30 days with reason Pending Credentialing Ticket [1657].
      * 2.2.3. If If credentialing help ticket already opened and closed without clear resolution, Open a new ticket.. Defer the claim for 30 days with reason Pending Credentialing Ticket (1567)

Note for help ticket: Please confirm with insurance provider credentialing status for DOS, as claim processed OON and overpaid; provider shows on credentialing grid in network for DOS. Previous help ticket# closed without solving the request.

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken.

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| |  | | --- | | **Action Step 3 – Medical Payment/Medical Invoice** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Review EOB to confirm medical and dental payment was received and posted correctly. Visit tab to confirm if there is shadow visit/medical visit for DOS and payment posted to the correct visit.

* 3.1 Medical payment posted to dental visit or dental payment posted to medical visit (shadow visit)
* 3.1.1 If medical payment (commercial insurance) posted to dental visit or dental payment posted to medical visit Route to Posting Review Needed [441]
* 3.1.2 If medical payment posted to dental visit and procedure code paid by medical plan is missing from medical visit/shadow visit open help ticket following the below path: Roc – *Insurance Billing Operation*, under Area select *Audit*, under Level 1 Category select *Medical Dental*. Defer the invoice for 14 days with reason Other
* 3.2. If medical payment posted under dental insurance, name (the payer name for medical payment shows dental insurance name), route to Posting Review Needed [441].
* 3.3 Medical payment and dental payment posted correctly

3.3.1 If there is shadow visit (medical visit), medical payment posted to medical visit, dental payment posted to dental visit Dental credit can be audited/adjusted accordingly

3.3.2 If there is not shadow visit (medical visit), only dental visit for DOS

* + - If there is medical payment (commercial insurance paid) for the services with credit - route the invoice to Audit - Onshore [561] as credit requires dental-medical adjudication.
    - If no medical payment for the services with credit - audit/adjust accordingly

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken.

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**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review:Onbase for refund letter. Insurance Refund Process SRG; Dental Eligibility form, Coverage tab for plan information. Patient chart for treatment completed on the visit or addendum regarding services not completed

* + 4.1 Insurance paid more than expected.
* Determine if the credit belongs to the patient, the office or needs to be split according to the EOB.
  + 4.1.1 If the entire credit belongs to the patient (invoice level, all item lines), regardless of the amount (greater/less than $75.00), select Other, Transfer to Self-Pay action from Prof Tx screen.
  + 4.1.2 If not all the entire credit (invoice level) needs to be transferred to the patient
    - If credit belongs to the patient, and credit is > $75 route to Ins to Patient Credit/Balance Transfer [551]
* If credit belongs to the patient, and credit is < $75 select Other → Transfer to Self-Pay
* If credit belongs to the provider, Write-Off as Estimate Correction – Insurance Credit [7919].
* If the credit needs to be split between the provider and patient, please use SRG, “Splitting an Insurance Credit Between Doctor and Patient.”
  + 4.1.3 If there is an insurance credit due to capitation payment Write-Off as Estimate Correction – Insurance Credit [7919].
* 4.2 GP processed as ortho the insurance has been informed.
* 4.2.1 Refund letter received?
  + Yes, process the refund. Audit/Adjust accordingly if any remaining balance.
  + No, transfer to ICS Inquiry [546]– to obtain the refund letter.
* 4.2.2 Final Notice letter received (Anthem , Metlife)

§ Yes,route the invoice to Audit - Onshore [561] with a detailed note - overpayment will be used for future offsets

* No, process the refund. Audit/Adjust accordingly if any remaining balance

4.2.3 For Metlife, if overpayment is less than $100.00, route the invoice to Audit - Onshore [561] with a detailed note, overpayment will be used for future offsets. If overpayment is greater than $100, follow steps 4.2.1., 4.2.2.

* 4.2.4 If there are history notes stating that the insurance overpayment will be used for future offsets, route to Audit Onshore [561] with a detailed note.
* 4.3 GP processed as ortho and the insurance has not been informed .
* If the insurance is Anthem or Metlife, GP processed as ortho, and the patient does not have an Ortho account, Write-Off as Estimate Correction – Insurance Credit [7919].
  + - * For any other insurances/scenario: § route to Send Additional Information via NEA [425] with mention to reprocess for GP purposes, not for ortho purposes. Attach chart notes, EOB.
* 44 Insurance additional payment – patient maximum rollover amount

§ If per insurance call notes the additional payment represent patient maximum rollover amount: Apply the payment to one line item and transfer the credit to Self-Pay. Enter a complete note.

* 4.5 Claim processed incorrectly OON
* 4.5.1 If refund letter not received, route the invoice to ICS Inquiry [546] - ICS Needed -Offset/Refund requesting the insurance to process the claim in network/to obtain refund letter
* 4.5.2 If refund letter received, proceed with the insurance refund Audit/Adjust accordingly if any remaining balance

~~§~~  4.5.3 If Final Notice received (Anthem, Metlife), route the invoice to Audit - Onshore [561] with the reason Offset/Refund [98030] with a detailed note - overpayment will be used for future offsets

~~§~~ 4.5.4 For Metlife, if overpayment is less than $100.00, route the invoice to Audit - Onshore [561] with the reason Offset/Refund [98030] with a detailed note - overpayment will be used for future offsets, If overpayment is greater than $100, follow steps 4.2.1., 4.2.2

~~§~~ 4.5.5 If there are notes stating that the insurance overpayment will be used for future offsets, route the invoice to Audit - Onshore [561] with the reason Offset/Refund [98030] with a detailed note - overpayment will be used for future offsets

* 4.6. Services voided and not reposted. Insurance payment applied to other services.
* 4.6.1. If there are office notes in patient chart stating services not completed, submit insurance refund request

§ 4.6.2. If there are not office notes, open Request for Information [535]. Use the note below:

Note for Request for Information: Per the EOB insurance paid $\_ for D\_ DOS\_, payment is undistributed. Invoice/services are voided. Unable to apply payment to voided services Please repost the services, so that we may apply the payment and adjust. If services not completed, please add an addendum in the patient chart regarding services not completed, so that we may refund the payment. Thank you.

* 4.7. Services not billed. Insurance payment received.
* If services paid for DOS are not all included in the visit, open Request for Information-Clinical Documentation [535] for the office to post the service if completed, or confirm service not completed and insurance refund is needed. Once confirmation received, insurance refund can be submitted.

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken

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**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Financial Arrangement for patient deductible responsibility

* 5.1 Insurance applied Deductible in one line and Deductible collected in different code
* Select a CDT line item having credit/debit balance and right click on guarantor payment – Click on un-distribute- Select appropriate Tx#, then click on Accept.
* Select un-distributed balance – Right click on the guarantor payment – Click on distribute – Accept.
* Select the Post Type Manual – Find for the Correct Tx# – check the box that matches the amount. The amount should be matched in such a way that the remaining amount should be the guarantor responsibility. Accept – Leave undistributed – Accept.
* Transfer the remaining amount to insurance with all the details – Accept.

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken .

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| |  | | --- | | **Action Step 6 – Duplicate Payment** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Check numbers posted in the account, insurance website to confirm payments posted. Insurance Refund Process SRG. Remittance Tracker for check status and Check Details for Total Amount versus Deposit Amount.

* 6.1 Duplicate payment posted.
* 6.1.1 Payment posted twice under different check numbers.
  + - 6.1.1.1 If per notes, one check is Stopped and reissued→ route to Posting Review Needed [441].
    - 6.1.1.2 If per notes, both checks are cashed → refund the duplicate check obtained by ICS from insurance. Audit/Adjust accordingly if any remaining balance.
    - 6.1.1.3 If there are no notes stating the reason for insurance paying twice. Verify Remittance Tracker.
      * + If check status is Match, route to ICS Inquiry ICS Needed- Payment Details to obtain check number for the duplicate payment
        + If check status is Mismatch, route to Posting Review Needed [441] to review payment posted

If check status is Missing, defer WQ for 30 days from issue or deposit date of payment, then route to Posting Review Needed [441] to verify payment validity after wait period times have elapsed

* 6.1.2 The second payment was posted as check# NOCHECK1234.
  + - Route to Posting Review Needed [441].

6.1.3 Same check# number posted twice:

* + - * 6.1.3.1 If check status of duplicate payment on Remittance Tracker is Missing or Mismatch,

Route to Posting Review Needed [441].

* + 6.1.3.2 If insurance paid twice with same check number for different insurance claims numbers, route to ICS Inquiry [546] - ICS Needed- Payment Details to confirm the duplicate and obtain claim number for the duplicate payment. Enter a complete note. Once the confirmation received, refund the duplicate,

**BEFORE YOU MOVE ON:**

Verify if the correct action has been take

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| |  | | --- | | **Action Step 7 – Balancing the account** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Previous adjustments taken and history for balance transfer. Financial Arrangement to calculate/verify Payer Contractual Allowance amount; [..\..\..\..\Box\Claims Review\Coaching\GH calls\GH calls 2025\GH call-01.08.25 - Payer Contractual Allowance.docx](https://word-edit.officeapps.live.com/Box/Claims%20Review/Coaching/GH%20calls/GH%20calls%202025/GH%20call-01.08.25%20-%20Payer%20Contractual%20Allowance.docx).

[..\..\..\..\Box\Claims Review\Coaching\GH calls\GH calls 2025\GH call-01.08.25 - Payer Contractual Allowance.docx](file:///C:/Users/shemeka.atkins/AppData/Local/Microsoft/Box/Claims%20Review/Coaching/GH%20calls/GH%20calls%202025/GH%20call-01.08.25%20-%20Payer%20Contractual%20Allowance.docx)

* 7.1. Incorrect patient balance
  + If there is patient balance due to previously wrong transfer from insurance, use Transfer to Insurance action to balance the account.
* 7.2. Charge Error adjustment – end of month
  + If a Charge Error adj has been done previously and we received an insurance payment, void the adjustment and adjust as needed.
* 7.3. Adjustment done before payment received.
  + If an adjustment has been done previously and we received an insurance payment, void the adjustment and adjust as needed.
* 7.4. Incorrect Payer Contractual Allowance
  + If there is credit due to incorrect Payer Contractual Allowance amount posted, use write off code Estimate Correction - Insurance Credit [7919] for the difference. Include in your note the reason for the correction.
  + If duplicate Payer Contractual Allowance posted, void the duplicate

**BEFORE YOU MOVE ON:**

Verify if the correct action has been taken

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| |  | | --- | |  |  |  |  | | --- | --- | | |  | | --- | | **Action Step 8 – Posting Review Needed** | |   **BEFORE YOU START:** Find appropriate action that needs to be taken.  Review: EOB and Payments tab/Payments applied to the invoice; Document  [..\..\..\..\Box\Claims Review\Coaching\Undistributing and distributing the insurance payment.docx](file:///C:/Users/shemeka.atkins/AppData/Local/Microsoft/Box/Claims%20Review/Coaching/Undistributing%20and%20distributing%20the%20insurance%20payment.docx)   * 8.1. If the payment is posted in the account not according to the EOB:   + Undistribute the entire payment applied to the invoice with Comment: Insurance payment incorrectly applied.   + Distribute the payment to the invoice accordingly with the EOB.   + Audit/adjust accordingly   **BEFORE YOU MOVE ON:**  Verify if the correct action has been taken   |  | | --- | | **Action Step 9 – Charge Error correction** |     **BEFORE YOU START:** If the charges are over posted, theCE correction will be applied regardless of, if the charges are on same month or another month.Review the DE form and make the determination.       * 9.1. If DE form shows 0% coverage, patient not eligible for the denied procedure, or DE form is not updated within 1 week prior to DOS * Use CHARGE ERROR [8088].      * 9.2. If DE form shows patient eligible for the denied procedure, or the procedure is not listed on DE form * Adjust according to the EOB       Adjustment note when using Charge Error Correction: “*CE applied to correct the charge for D…… Insurance denied the procedure due to …… DE form shows 0% coverage/patient not eligible/unable to find DE form updated prior DOS”.*    **BEFORE YOU MOVE ON:**  Verify if the correct action has been taken |
| |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **Action Step 10 – Workers Comp Payment** | | |     **BEFORE YOU START:** Find appropriate action that needs to be taken  Review: Patient Workers Comp account if services posted; Patient Personal/Family account if dental insurance billed and paid; Workers Comp EOB to confirm DOS; Dental insurance EOB to confirm dental payment; Insurance Refund Process SRG for refund Epic steps; Payments tab/Transaction tab for Payments, Reversals, Refunds;  [..\..\..\..\Box\Claims Review\Coaching\Insurances\Work Comp\workcomp workflow.pdf](file:///C:/Users/shemeka.atkins/AppData/Local/Microsoft/Box/Claims%20Review/Coaching/Insurances/Work%20Comp/workcomp%20workflow.pdf)    · 10.1 Workers Comp claim billed and paid.   * Audit and adjust accordingly Credit will be adjusted to the provider using ESTIMATE CORRECTION - INSURANCE CREDIT [7919] * 10.2. Workers Comp claim billed and paid. Dental payment received/posted. * Refund dental insurance as Workers Comp claim billed and paid. * Audit and adjust accordingly Workers Comp payment.   + - Credit will be adjusted to the provider using ESTIMATE CORRECTION - INSURANCE CREDIT [7919] * 10.3 If Work Comp underpaid the claim * If no W/C pre-auth provided, Adjust off as FEE SCHEDULE ADJ [8019]. * If underpaid due to our expects are higher than on pre-auth, Adjust off as FEE SCHEDULE ADJ [8019] * If underpaid due to W/C paid less than the agreed fees on pre-auth, Will need to appeal * 10.4. Workers Comp claim billed and not paid yet. Dental payment received/posted * Do not refund dental payment. Defer the invoice with dental payment for 30 days with reason *Other*, waiting for Workers Comp claim to be finalized. * 10.5. No Workers Comp account. Workers Comp claim billed and paid. * Transfer to Request for Information WQ with reason Other for the office to open W/C account.     **BEFORE YOU MOVE ON:**  Verify if the correct action has been taken |

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| |  | | --- | | **Action Step 11 – Credit created as Tx not completed/Unsatisfactory Outcome adjustment taken** | |

**BEFORE YOU START:** Find appropriate action that needs to be taken.

Review: Patient chart if progress notes/addendum regarding Tx not completed/ Unsatisfactory Outcome and insurance needs to be refunded; Insurance payment applied to the line item. RI Addendum Tag to identify the updated narrative.

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| * 11.1. Credit created as *TX Not Completed - Patient* adj taken   + 11.1.1. If notes in patient chart confirming Tx not completed and need to refund the insurance payment     - Submit insurance refund   + 11.1.2. If no notes in pt chart regarding the adjustment * Open RI for the office to confirm treatment not completed and we need to refund the insurance * 11.1.3. If *TX Not Completed - Patient* adjustment has been taken for the services without insurance payment * Open RI for the office to review and balance the account      * 11.2. Credit created as *Unsatisfactory Outcome – Patient* adjustment taken * 11.2.1. If notes in patient chart confirming unsatisfactory outcome for the service and need to refund the insurance payment * Submit insurance refund * 11.2.2. If notes in patient chart regarding the adjustment * Open RI for the office to confirm unsatisfactory outcome for the service and need to refund the insurance payment * 11.2.3. If *Unsatisfactory Outcome – Patient* adjustment has been taken for the services without insurance payment * Open RI for the office to review and balance the account     **BEFORE YOU MOVE ON:**  Verify if the correct action has been taken           |  |  | | --- | --- | | |  | | --- | | **Action Step 12** – **Refund request submitted. Credit/Debit for services** | |     **BEFORE YOU START:** Find appropriate action that needs to be taken.  Review: Payments tab for refunds submitted; Remittance tracker for Check Details; Refund letter; Reprocessed EOB to verify if payment is applied correctly.       * 12.1. Refund request submitted; refund applied incorrectly to the line items. * Undistribute the payment and distribute it accordingly with the reprocessed EOB. * Reverse prior adjustments if needed * Audit/Adjust accordingly           **BEFORE YOU MOVE ON:**  Verify if the correct action has been taken                                       |  | | --- | |  | |

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| |  | | --- | | **Conclusion** | |

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

* Send comments on the procedure to [mail@example.com](mailto:mail@example.com)

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Draft** | **BETA test** | **Guidehouse** | **Final Draft** | **Version** | **Description** | **Approved By:** |
| 3.27.2024 |  |  |  |  |  | Approved | Lyndsay Harper |
| 03.27.2024 |  | 03.11.2024 | 03.27.2024 |  | SIO -2.005 Audit Overpaid – Guidehouse | Approved | Natalia Udroiu |
| 10.07.2024 |  |  |  |  | Audit Overpaid | SOP update | Lyndsay Harper |
| 11.11.2024 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 11.26.2024 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 01.13.2025 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 02.03.2025 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 02.28.25 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 03.20.25 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
| 07.25.25 |  |  |  |  | Audit Overpaid | SOP update | Natalia Udroiu |
|  |  |  |  |  |  |  |  |