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| |  | | --- | | **SOP– 14**  **Insurance Overposted - Last Match Credit** | | Standard Operating Procedure | | |  |  | | --- | --- | | **Department:** | Audit | | **SOP ID:** | 2024.03.14 | | **Date:** | 2/22/24 | | **Sign Off:** | Natalia Udroiu | |

### **Overview:**

Improving the audit process of the credits in Insurance Overposted - Last Matched Credit WQ, resulting in the elimination of untrue credits from the WQ.

### **Definitions:**

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| **Fee Schedule/Plan** | *The insurance allowed amount, copay amount, or contracted rate.* |
| **Payer** | *The insuring entity* |
| **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**  **Insurance Overposted - Last Match Credit**  **Duplicate Payment**  **Payer Contractual Allowance**  **Retro process**  **Out of Network**  **Remittance Tracker** | *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 LMC. is a work queue utilized for credits.*  Insurance paid twice with different check numbers; Payment posted twice for same check number.  *Aka PCA. The amount of discount from standard charges that is allowed by a particular payer for that service*  *A process utilized when the filling order needs to be changed / FA requires update*.  *Aka OON. Payment received due to provider not contracted.*  *A tool used to verify the status of the checks in our system.* |

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

* Review the Explanation of Benefits (EOB) for reason for denial or payment discrepancies.
* Verify the payments posted and compare them with the EOB to verify they are matching.
* Verify the status of the checks using the Remittance Tracker.
* Verify the prior notes.

### **Required Operations Software**

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

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

**Step 1** – Duplicate payment posted.

* + 1.1 Payment posted twice under different check numbers.
  + 1.2 The second payment was posted as check#NOCHECK12345.
  + 1.3 Same check# posted twice.

**Step 2** – Overpayment - Dental

* + 2.1 No insurance expects, and payment received.
  + 2.2 GP processed as ortho the insurance has been informed

· 2.3 GP processed as ortho, the insurance has not been informed

* 2.4 Insurance additional payment – patient maximum rollover amount

· 2.5 Claim processed incorrectly OON

* 2.6. Services voided and not reposted. Insurance payment applied to other services

· 2.7. Services not billed. Insurance payment received

**Step 3** - Invoice voided due to Retro process.

* 3.1 Filling order changed/ FA has been modified and charges reposted under Visit tab, not under Invoice tab and the payment has been distributed under visit.

**Step 4 –** Out of network

* 4.1 OON refund done, and insurance make an additional payment as in network.
* 4.2 Claim paid OON; OON refund packet not created
* 4.3. Patient plan is Indemnity/ Worker’s Comp/HMO Medicaid/Medicare or paid UCR

**Step 5 – I**nsurance credit previously transferred toInsurance to Patient Credit Transfer WQ

* 5.1 The invoice was transferred to Insurance to Patient Credit Transfer WQ for office approval and credit transfer.

**Step 6** - Balancing the account

* 6.1. Incorrect patient balance
* 6.2. Charge Error adjustment – end of month
* 6.3. Adjustment done before payment received.
* 6.4. Incorrect Payer Contractual Allowance

**Step 7** – Medical payment received

* 7.1 Medical payment posted to dental visit/ invoice or dental payment posted to medical visit/invoice
* 7.2 Medical payment posted under dental insurance
* 7.3 Medical payment and dental payment posted correctly

**Step 8** – Posting review

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

**Step 9** – Deductible Transfer

9.1 Insurance applied Deductible to a procedure code and Deductible collected for a different code

**Step 10** – Charge Error correction

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

o 10.2. DE form shows patient eligible for the denied procedure, or the procedure is not listed on DE form

**Step 11** – Payment posted with incorrect payer name

· 11.1. Insurance payment posted has incorrect payer name – does not match the EOB

**Step 12** – Combined adjustment

* 12.1 Insurance credit and debit (due to overmax) under GP and Specialty invoices for same patient. One claim denied due to over max.
* 12.2. Insurance credit and debit under GP and Specialty invoices for same patient. The invoice with balance is still in process

· 12.3 Insurance credit and debit – invoice level

**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 - Duplicate payment posted.** | |

**BEFORE YOU START:**

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

* 1.1 Payment posted twice under different checks numbers
* 1.1.1a Stop and reissue a new check.
* If per notes, one check is Stopped and reissued, transfer to Duplicate Payment Review with reason Duplicate Payment Posted.
* 1.1.2b Both checks cashed
* If per notes, both checks are cashed, Refund the duplicate check obtained by ICS from insurance. Audit/Adjust accordingly if any remaining balance
* 1.1.3c No notes stating the reason for insurance paying twice. Verify Remittance Tracker.
  + 1.1.3.1 If check status is Match, route to ICS Inquiry to obtain check number for the duplicate payment
  + 1.1.3.2 If check status is Mismatch, route to Duplicate Payment Review with reason Duplicate Payment Posted., to review payment posted.
  + 1.1.3.3 If check status is Missing, defer WQ for 30 days from issue or deposit date of payment, then route to Duplicate Payment Review with reason Duplicate Payment Posted. to verify payment validity after wait period times have elapsed.
* 1.2 The second payment was posted as check#NOCHECK12345.
* Transfer to Duplicate Payment Review with reason Duplicate Payment Posted.
* 1.3 Same check# number posted twice.
* If check status of duplicate payment on Remittance Tracker is Missing or Mismatch, transfer to Duplicate Payment Review with reason Duplicate Payment Posted.
* If insurance paid twice with same check number for different insurance claims numbers, transfer to ICS Inquiry 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 ~~t~~he correct action has been completed.

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| |  | | --- | | **Action Step 2 – Overpayment - Dental** | |

**BEFORE YOU START:**

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

* + 2.1 No insurance expects, and payment received.
* Determine if the credit belongs to the patient, the office or needs to be split according to the EOB.
  + If credit belongs to the patient, regardless of the amount (greater/less than $75.00), under line item 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.”
* 2.2 GP processed as ortho;the insurance has been informed
* 2.2.1 Refund letter received?
  + Yes, process the refund. Audit/Adjust accordingly if any remaining balance
  + No, transfer to ICS Inquiry – Offshore to obtain the refund letter.
* 2.2.2 Final Notice letter received (Anthem , Metlife)
* Yes, Defer the invoice for 90 days with the reason Offset/Refund [1011] with a note stating waiting for insurance to offset.
* No, process the refund. Audit/Adjust accordingly if any remaining balance

o 2.2.3For Metlife, if overpayment is less than $100.00, defer the invoice for 30 days with reason Offset/Refund [1011], waiting for the insurance to refund.

* 2.2.4 If there are history notes stating that the insurance overpayment will be used for future offsets, defer the invoice with reason Offset/Refund for 90 days. Enter a note stating waiting for insurance to offset
* 2.3 GP processed as ortho 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 [791]

. For any other insurances/scenarios: scenarios - send additional information via NEA (chart notes, EOB) with mention to reprocess for GP purposes, not for ortho purposes. Defer the claim for 30 days with reason Additional Information Sent Via NEA.

* 2.4 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.

* 2.5 Claim processed incorrectly OON
* 2.5.1 If refund letter not received, transfer the invoice to ICS Inquiry requesting the insurance to process the claim in network/to obtain refund letter
* 2.5.2 If refund letter received, proceed with the insurance refund . Audit/Adjust accordingly if any remaining balance
* 2.5.3 If Final Notice received (Anthem, Metlife), defer the invoice for 90 days with reason Offset/Refund, and a note stating waiting for insurance to offset.
* 2.5.4 For Metlife, if overpayment is less than $100.00, defer the invoice for 90 days with reason Offset/Refund, waiting for the insurance to refund If overpayment is greater than $100.00, follow above steps.
* 2.5.5 If there are notes stating that the insurance overpayment will be used for future offsets, defer the invoice with reason Offset/Refund for 90 days. Enter a note stating waiting for insurance to offset
* 2.6. Services voided and not reposted. Insurance payment applied to other services
  + 2.6.1. If there are office notes in patient chart stating services not completed, submit insurance refund request
  + 2.6.2. If there are not office notes, open Request for Information [535]. Use the note below
* 2.7. 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 completed.

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| |  | | --- | | **Action Step 3 - Invoice voided due to Retro process.** | |

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

Review: Coverage tab for current Filing Order; Claims submitted for Filing Order changes. EOB to verify if primary payment has been estimated.

* 3.1 Filling order changed/ FA has been modified and charges were reposted under Visit tab, but not under Invoice tab and the payment has been distributed under visit.
* 3.1.1 Primary and secondary claims processed correctly Adjust the credit from the Visit tab or new invoice for our date of service according to the EOB.
* If credit belongs to the patient, regardless of the amount (greater/less than $75.00), under line item 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.”
  + - 3.1.2 If the credit is created due to secondary paid incorrectly as primary, a corrected claim needs to be sent.
* If the invoice (insurance with incorrect payment) is in a Follow-up WQ, route to Paper Resubmission [592] for corrected claim. Enter a complete note.
* If the invoice (insurance with incorrect payment) is not in a Follow-up WQ, open help ticket to *Roc – Insurance Billing Operation*, subcategory *Billing* requesting to send corrected claim. Defer the invoice for 60 days with the reason Other. Enter a complete note.
* If payment applied to dental visit only and charge amount for the service is $0.00, and no notes regarding the procedure, transfer to Request for Information for the office to confirm if service performed and to correct charges
* If Filing order has changed, and secondary insurance (billed initially as primary) payment received with estimated primary insurance payment No corrected claim needed, the credit can be audited/adjusted accordingly

**BEFORE YOU MOVE ON:**

Verif*y if the correct action has been completed*

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| |  | | --- | | **Action Step 4 – Out of Network (OON)** | |

**BEFORE YOU START:**

Review: Review OON Refund packet to determine if refund was already completed; Credentialing grid for provider status. Dental Eligibility form and Coverage tab for plan information;

* + 4.1 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 and escalate the account for OON team’s review
* **4.2** Claim paid OON; OON refund packet not created
* If provider is OON, defer the invoice with reason Escalation and escalate the account for OON team to review.
* If provider is in network, transfer to ICS Inquiry to have the claim reprocessed in network.

4.3. Patient plan is Indemnity/ Worker’s Comp/HMO Medicaid/Medicare or paid UCR

Adjust the claim accordingly with the EOB

**BEFORE YOU MOVE ON:**

Verify if the correct action has been completed.

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| |  | | --- | | **Action Step 5 - Insurance credit previously transferred to Insurance to Patient Credit Transfer WQ** | |

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

* 5.1a The invoice was transferred to Insurance to Patient Credit Transfer WQ for office approval and credit transfer. The office transferred the invoice to Self-Pay Credits WQ. Insurance credit is not transferred to Self-pay.
* Under line item with insurance credit select Other, Transfer to Self-Pay. Enter a detailed note in the Comment Box.
* If previously routed to Insurance to Patient Credit Transfer WQ with the detailed comments and again routed back to Insurance Overposted - Last Matched Credit WQ or Pending Refund Request WQ without comments,
  + Under line item with insurance credit select Other, Transfer to Self-Pay. Enter a detailed note in the Comment Box.

**BEFORE YOU MOVE ON:**

Verify if correct action has been completed.

**Action Step 6 – Balancing the account**

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

Review: Previous adjustments taken and history for balance transfer.; Financial Adjustment to calculate/verify if Payer Contractual Allowance is correct;[..\..\..\..\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)

* 6.1. Incorrect patient balance
* If there is patient balance due to previously wrong transfer from insurance, use Transfer to Insurance action to balance the account.
* 6.2. 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.

* 6.3. 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.
* 6.4. Incorrect Payer Contractual Allowance (PCA)
* 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 correct action has been completed

**Action Step 7 – Medical Payment Received**

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

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.

* 7.1 Medical payment (commercial insurance) posted to dental visit or dental payment posted to medical visit (commercial insurance)
* If medical payment (commercial insurance) posted to dental visit or dental payment posted to medical visit (commercial, shadow):§ ): Transfer to Duplicate Payment Review with reason Other
* If medical payment posted to dental visit and procedure code paid by medical plan is missing from medical 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, requesting to add the procedure to medical visit.
* 7.2 Medical payment posted under dental insurance
  + If medical payment (commercial insurance) posted under dental insurance name (the payer name for medical payment shows dental insurance name), transfer to Insurance Undistributed WQ with reason Payment posted Incorrectly
* 7.3 Medical payment and dental payment posted correctly
  + 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
* 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 transfer medical payment to Dental-Medical Review Credits WQ to review the credit for dental-medical adjudication
* If medical payment is in Dental-Medical Review Credits WQ and dental payment is in Last Matched Credit WQ, defer the dental credit with reason Medical Claim Paid-Need Auditor Review for 30 days
  + If there is no medical payment for the services with credit only dental payment- audit/adjust accordingly

**BEFORE YOU MOVE ON:**

Verify if correct action has been completed.

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**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, but not accordingly with 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 correct action has been completed.

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| |  | | --- | | **Action Step 9 - Deductible Transfer** | |

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

* 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 10 – 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.   * 10.1. If DE form shows 0% coverage, patient not eligible for the denied procedure, or DE form is not updated within a week prior to DOS * Use CHARGE ERROR [8088].      * 10.2. 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 11 – Payment posted with incorrect payer name**

**BEFORE YOU START**

Review: EOBs with the payments to verify if payer name in Epic matches the payer name on the EOB; Insurance website if needed.

* 6.1 Insurance payment posted has incorrect payer name – does not match the EOB
* Transfer to Insurance Undistributed WQ with reason *Payment posted incorrectly (133)*, to correct the payer’s name

Note: $\_ payment received from payer \_ (name) with check#\_ is posted under payer name \_. Please correct payer name.

**Action Step 12 – Combined Adjustment**

**BEFORE YOU START**

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.

* 12.1. Insurance 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 for 30 days with reason SP/GP Adjustment Pending with a note indicating claim deferred for combined adjustment. Escalate the invoice.

· 12.2. 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.

* 12.3. Insurance credit and debit – invoice level. Debit from a service that can no longer be processed due to frequency, over max, wait period, etc
  + - Combine line items and adjust
  + If resulting balance is a debit, write off using the most appropriate code for the denial on the EOB
  + 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 13 – Insurance refund returned** | |

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

Review: Refund return insurance letter; payments, recoupments, refunds applied to DOS.

* 13.1. Insurance payment refunded as unexpected medical payment received. Refund returned by the insurance as claim paid correctly.
* Apply the payment per the EOB, and if the invoice is still in the WQ, route to Audit - Onshore [561] to review the credit for dental-medical adjudication as dental and medical payment received for the services, dental insurance refund returned
* 13.2. OON refund returned as claim is paid correctly
* Defer the invoice with reason Escalation. Add the invoice on OON Escalation sheet
* 13.2. Insurance payment refund returned as overpayment has been used for other claims (offset)
* Transfer to Audit Onshore WQ [561] as overpayment has been used for other claims.

**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** | **Version** | **Description** | **Approved** |
| 3.28.2024 | 1.0.0 | Approved | Lyndsay Harper |
| 03.28.2024 |  | Approved | Natalia Udroiu |
| 8.6.2024 |  | Update approved | Lyndsay Harper |
| 10.07.2024 | Insurance Overposted Last Match | SOP update | Lyndsay Harper |
| 11.11.2024 | Insurance Overposted Last Match | SOP update | Natalia Udroiu |
| 11.26.2024 | Insurance Overposted Last Match | SOP update | Natalia Udroiu |

1.13.25 Insurance Overposted SOP update Natalia Udroiu

02.03.25 Insurance Overposted SOP update Natalia Udroiu

02.28.25 Insurance Overposted SOP update Natalia Udroiu

03.20.25 Insurance Overposted SOP update Natalia Udroiu

07.25.25 Insurance Overposted SOP update Natalia Udroiu