|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **SOP– 27**  **ICS Trace** | | Standard Operating Procedure | | |  |  | | --- | --- | | **Department:** | ICS Trace | | **SOP ID:** | 2024.03.27 | | **Date:** | 1/16/2024 | | **Sign Off:** | Corey Betts | |

### **Overview:**

This document outlines the ICS Trace processes to improve efficiency resulting in ***claim*** ***payment***.

### **Definitions:**

|  |  |
| --- | --- |
| **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.* |
| **Missing Tooth Clause** | *When a company has a provision in their contract that states that if a tooth is lost before the contract begins, they don’t bare any responsibility to cover replacing the tooth. The cost of replacing the tooth would then fall onto the patient.* |
| **Waiting Period** | *Set period before you can receive full coverage for some specific dental procedures.* |
| **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.* |
| **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** | *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. \*\*\** |
|  |  |

### 

### **Required Operation Software**

* NEA Access
* OnBase
* CyberArk
* Web viewer
* EPIC Access
* Credentialing Grid
* Fresh Service
* Box
* Remittance Tracker
* Clearing House Access

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

Prerequisite:

1. Clearing House Verification

Pending attach link

1. Payer Website Review

Pending attach link

1. Call to the payer if necessary / Third Party Concern (TPC)

If you have no access to the web portal, are unable to call the payer, or have received a web logins ticket response indicating that a login cannot be created, please route the invoice to the onshore trace WQ for further action. Make sure to provide any document from the IVR if available

1. Determine the appropriate action necessary based on the status
2. Request for Information- Identify Subcategories

**Scenario 1- No Claim on File (NCOF)**

**1.0 Clearinghouse & Payer Rejections**

* **1.1 Clearinghouse Rejections (CH)**
  + **1.1a Rejection Correctable**
  + **1.1b Rejection Not Correctable – Route to NCOF**

**1.2 Patient Demographic Changes**

* **1.2a Verified via Payer Website or Legal Document**
* **1.2b Unable to Verify – Route to RFI**

**1.3 Address Updates**

* **1.3a Address Updates GH Can Make**
* **1.3b Mismatched or Unverifiable Address – Route to Office**

**1.4 Payer Rejections**

* **1.4a Payer ID/Address Mismatch – Route to Eligibility**
* **1.4b Other Payer Rejection Scenarios**
  + **Patient Not Identified**
  + **Missing or Invalid NPI/Tax ID**
  + **Missing or Invalid License Number**
  + **COB Required**

**1.5 No Claim on File – After Second Submission**

* **1.5a Verification & Routing**
  + **Include: Claim resubmission tracking and note documentation**

**1.6 No Claim on File – After Third Submission**

* **1.6a Escalation to Leadership & Defer**

**Scenario 2**- Claim Paid Not Posted

* 2.1 Reason for Not Posted
  + 2.1a Claim recently paid within 30 days
  + 2.1b Paid to incorrect lockbox/facility location
  + 2.1c Check not cashed 60 days
  + 2.1d Pending EOB
  + 2.1e Check sent to the Subscriber
  + 2.1f Payment not located on the remittance tracker
  + 2.1g VCC Stop and Re-issue
    - 2.11a Provide updated W9 to payer
    - 2.11b Request check to be issued to lockbox location
    - 2.11c Opt out of VCC payments for office
* 2.2 Skip to Action Step 2 for resolution

**Scenario 3-** Claim Sent for Reprocessing

* 3.1 Reason for reprocessing
  + 3.1a Incorrect claim denial. Ex. Max benefit exhausted, frequency limit, NEA received, etc.
  + 3.1b Requested information from provider can be provided on the phone. Ex. Seat date, delivery date.
  + 3.1c Claim sent within timely filing limits
  + 3.1d non-Par date is available
* 3.2 Skip to Action Step 3 for resolution

**Scenario 4-** Claim Still in Process

* 4.1 Reason for claim still in process, payer specific.
  + 4.1a NEA under review.
  + 4.1b Claim sent for reprocessing
  + 4.1c Independent dental examiner review
  + 4.1d Backlog with the payer in claim processing (payer specific)
* 4.2 If the claim process is more than 35 days or 60 days (Cigna/HMO payers). The claim is escalated with the payer.
  + 4.2a If further escalation is needed it is sent to PDS for review.
* 4.3 Skip to Action Step 4 for resolution

**Scenario 5-** Additional Information sent NEA

* 5.1 Why additional information sent.
  + 5.1a Initial NEA not received or incomplete
  + 5.1b Additional information needed to process claim. Ex. Narratives, Chart notes, documents, addendum.
  + 5.1c If requested information is not accepted over the phone. Ex. Seat date, delivery date.
* 5.2 Certain payers require a new claim with the NEA.
* 5.3 Skip to Action Step 5 for resolution

**Scenario 6-** Pending for EOB

* 6.1 Reason for pending EOB.
  + 6.1a Claim is denied or paid (excluding HMO claims)
* 6.2 If EOB is not received after 2nd attempt, escalate to the onshore team.
  + 6.2a Mailed to Lockbox
  + 6.2b Mailed to treating location

**Scenario 7-** Not a Covered Benefit/Maximum Benefit Exhausted/Frequency Limit

* 7.1 Verify payer portal benefit details, benefit amounts, and frequency limits.
* 7.2 Call to the payer if the information is not available on the website.
* 7.3 Skip to Action Step 7 for resolution

**Scenario 8-** Coverage Updates

* **8.1 Changes That Must Be Routed to Eligibility (Offshore/Onshore)**  
    8.1a Coverage Change with Correct DE Form – Route to Onshore  
    8.1b Coverage Change Needing DE Form Update – Route to Offshore
* **8.2 Pending Filing / Retro Review**  
    8.2a Invoice in Retro Review WQ Under 14 Days  
    8.2b Invoice in Retro Review WQ Over 14 Days
* **8.3 Coverage Updates Under Visit Tab**  
    8.3a Coverage in “Unused” Status Needs Activation
* **8.4 Demographic and Address Update**  
    Refer to Action Step 1.2 – Patient Demographics and Address Update

**Scenario 9-** Provider Not Contracted/Credentialing Grid

* 9.1 Provider not listed on the credential grid.
* 9.2 Dr is listed on the grid as in process or N/A status
  + 9.2a Non par date is available
  + 9.2b Non par date is not available
  + 9.2c Non par date is after DOS/Carrier does not have OON Benefits
* 9.3 Provider is listed on the grid and has an effective date
  + 9.3a DOS is prior to the effective date
  + 9.3b DOS is after the effective date
* 9.4 Skip to Action Step 9 for appropriate action based on credentialing ticket response.

**Scenario 10-** Request for Information (RI)

* 10.1 Reasons for RI
  + 10.1a Denied for COB
  + 10.1b Coverage updates
  + 10.1c Additional information ex. Seat date, delivery date, chart notes, addendum, etc. not available in chart.
  + 10.1d Policy inactive
  + 10.1e Prior authorization is missing
  + 10.1f Referral needed
  + 10.1g Patient not assigned to the office
  + 10.1h Questionnaires
* 10.2 Skip to Action Step 10 for appropriate action to Route to RI WQ

**Scenario 11- Claim pending for W9 form**

* 11.1 Pending for W9 form
* 11.2 Skip to Action Step 10 for appropriate action to Route to RI WQ

**Scenario 12- Workers Compensation**

• 12.1 Claim Pending

* 12.1a Pending Additional Documentation
* 12.1b Pending Authorization Number

• 12.2 Obtaining Claim Status

12.2a Unable to reach WC

12.2b Payer phone # not available

12.3c Not a Covered Benefit (NCB)

### **Scenario 13** – **Dental – Medical (DM) Process**

* 13.1 Initial Invoice Review

13.1a – Verify Shadow/Non-Shadow Invoice Creation

13.1b – Dual Coverage Coordination

13.1c – Medical Record Requirement

* 13.2 Shadow/Non-Shadow Claim Created

13.2 – Review of Shadow/Non-Shadow Claim Status

13.2.1 Closed Status

13.2.2 Accepted/Rejected Status

13.2.3 Claim Edit/Error/Follow-Up Scenarios

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 1 - NCOF** | |

**BEFORE YOU START:** Review Patient, Coverage, and Payer Information. Go to the **Coverages** tab in the patient’s account. Verify the **carrier name** and **subscriber details** are accurate and match the payer information. Confirm Payer ID Used on the Claim: Navigate **Workqueue**Caret Right with solid fill **View Claim Image** > **Electronic Image**. After appropriate research and/or call to carrier – determine the reason for NCOF below.

Please reference to Action Step 10 (Request for Information and Subcategory) to determine subcategory. Subcategories

**1.1** **Clearing House Rejections (CH)**

## o Carefully review the rejection reason or error code provided by the clearinghouse.

## o Determine if the error is **correctable at your level** or **requires office/ROC support intervention.**

**1.1a If the Rejection is Correctable:**

* Make the necessary corrections.
* Revalidate the claim for accuracy.
* Resubmit the claim

**Action:**

* **Resubmit Claim** [Activity 213]

**1.1b** **If the Rejection is Not correctable at Your level Route to No Claim on File Workqueue for further action and** **Escalate to leadership.**

**Action:**

* **Route to No claim on File** [549]

* 1. **Patient Demographics Changes GH Team Can Update**

**1.2a If verified via the payer's website or with a legal document. The user may correct the following below: Note: verbal confirmation alone is not accepted as a valid verification.**

* Insurance ID
* Patient’s/Member’s complete name
* Group Number
* Effective or Termination Dates
* Swapping patient’s first name and last name
* Adding middle name
* Correcting abbreviated names to match insurance records
* Update details in the **Coverage /Registration Tab** and resubmit invoice

Action:

Resubmit the invoice via Resubmit Claim [213]

**1.2b If Unable to Verify Patient/Subscriber Demographics**

If the GH user is unable to verify the patient or subscriber demographic information through the payer’s website or legal documentation:

**Action:**

* Route to **Request for Information – Demographics** [554]

**1.3 Address Updates Changes GH Team Can Update**

**1.3a** To proceed with GH updating a patient’s address — including but not limited to:

* Converting street abbreviations to full form (e.g., “**St**” to “**Street**”)
* Converting full form to abbreviation (e.g., “**Avenue**” to “**Ave**”)
* Update details in the **Coverage /Registration Tab** and resubmit invoice

**Action:**  
 • Resubmit the invoice via **Resubmit Claim** [213]

**1.3b Verification of mismatch address Information route the claim to the office for further investigation or to obtain necessary documentation.**

**Action**:

* Route to **Request for Information- Demographics** [554]

**1.4** **Payer rejections**

**1.4a** Payer ID/Address Mismatch

**Action:**

* Route to the eligibility WQ [589]

**1.4b** **Define payer rejection**

* **Patient cannot be identified as insured.**
* Follow Action steps in 1.2
* **Provider NPI/Tax Id is missing or invalid.**
* Follow appropriate steps in Action Step 9 – Provider Not Contracted/Credentialing Grid
* **Missing or Invalid Provider License Number**

**Step 1: Open Credentialing ticket**

* Verify the provider’s license number in available records.
* If the license number is missing or invalid, open a **Credentialing ticket** to confirm or update the provider’s credentialing details.
* Follow Action Steps in 9
* Defer for 14 days with the reason pending credentialing ticket.

**Step 2: EPIC Update Request**

* Once Credentialing confirms the corrected information, open an **EPIC IT ticket** to update the provider’s profile in the system.
* Defer for 14 days with the reason Technical Problem – Open Ticket with IT
* **Claim rejected as COB Required**
* Follow Action steps in 10.1a Request for Information (RI)

* 1. **No Claim on File After Second Electronic Submission**

**1.5a** **If the payer states “no claim on file” after the second electronic submission**

Verify Submission History andconfirm that the claim was submitted electronically two times.

* Ensure the claim has a valid payer ID and no transmission errors.

* Ensure patient demographics are all correct

* Follow step 1.2 Patient Demographics mismatch

**Action:**

* Route to **No claim on File** [549]

Exclamation mark with solid fill**Please make sure to document that the claim has been resubmitted twice in your notes.**  
 This helps ensure proper tracking and supports any further follow-up or escalation if needed.

**1.6 No Claim on File after the Third submission**

**1.6a** If there are no payer/patient errors after the third submission please escalate to leadership and defer invoice

**Action:**

* Defer reason **Waiting for Supervisor Response** [1009] for 14 days.

**BEFORE YOU MOVE ON:**

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

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 2 – Claim Paid Not Posted** | |

**BEFORE YOU START:** Find the appropriate reason below for the claim paid not posted.

* 2.1a Claim Recently Paid within 30 days.
  + Defer for 30 days from the claim paid date with reason Claim paid not posted.
* 2.1b Paid to incorrect lockbox/facility location.
  + Paid to a valid PDS location -
    - If payer allows W-9 to be submitted via NEA please send via NEA, if payer allows W-9 to be faxed please send fax [Faxing release of information](https://pacificdental.app.box.com/file/1662746575134) Request payer to stop and re-issue to current lockbox or office address. Payer will pay to office or support location – Defer to for 21 days after time frame for payer to process (Example if 30 days to re-process will defer for 51 days with reason Stop payment and re-issue
    - Payer will issue to Lock box – Defer for 14 days after time frame for payer to process (Example is 30 days to re-process will defer for 44 days ) with reason Stop payment and re-issue
  + Paid to an invalid PDS location (Is not PDS office, RedHill or lockbox) -
    - Request for claim to be re-processed with correct information. Defer for 30 days with reason Claim Sent For Reprocessing [1652]
* 2.1c Check not cashed 60 days.
  + Request payer to stop and re-issue to same lockbox address.
    - Payer will pay to office or support location – Defer to for 21 days after time frame for payer to process (Example if 30 days to re-process will defer for 51 days with reason Stop payment and re-issue
    - Payer will issue to Lock box – Defer for 14 days after time frame for payer to process (Example is 30 days to re-process will defer for 44 days ) with reason Stop payment and re-issue
  + 2.1d Pending EOB
  + Try to obtain from web portal.
  + Request EOB via fax if not avail on web.
    - Defer for 3 days with reason pending for EOB.
  + If payer will not fax, request for EOB to mailed to billing address.
    - Defer for 14 days with reason EOB will be mailed to office.
* 2.1e Check sent to the subscriber
  + Route to check sent to subscriber WQ.
* 2.1f Payment not located on the remittance tracker
  + Defer for 30 days with reason Claim paid not posted.
  + If ERA Payment not located on the remittance tracker
    - Defer for 10 with reason Claim Paid not Posted
* 2.1g VCC Stop and Re-issue
  + Provide Updated W9 to payer.
  + Request check to be issued to lockbox location.
  + Opt out of VCC payment for the office.
  + Defer for 21 days with reason stop payment and re-issue.

**BEFORE YOU MOVE ON:**

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

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 3 – Claim Sent for Reprocessing** | |

**BEFORE YOU START:** Find the appropriate reason below for the claim sent for reprocessing.

* 3.1a Incorrect claim denial. Ex: Max benefit exhausted, frequency limit, NEA received, etc.
  + Defer for 21 days and Cigna Defer for 60 days with reason Claim sent for reprocessing.
* 3.1b Requested information from the provider can be provided on the phone. Ex: Seat date, delivery date
  + Defer for 21 days and Cigna Defer for 60 days with reason Claim sent for reprocessing.
* 3.1c Claim sent within timely filing limits
  + Defer for 21 days and Cigna Defer for 60 days with reason Claim sent for reprocessing.
* 3.1d non-Par date is available (Delta Plans Only)
  + Defer for 21 days with reason Claim sent for reprocessing.

**BEFORE YOU MOVE ON:**

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

|  |  |
| --- | --- |
| |  | | --- | | **Action Step 4 – Claim Still in Process** | |

**BEFORE YOU START:** Find the appropriate reason below for the claim still in process.

* 4.1a NEA under review.
  + Defer for 21 days and Cigna defer for 60 days with the reason Claim still processing unless the payer states otherwise.
* 4.1b Claim sent for reprocessing.
  + Defer for 21 days and Cigna defer for 60 days with the reason Claim still processing unless the payer states otherwise.
* 4.1c Independent dental examiner review
  + Defer for 21 days and Cigna defer for 60 days with the reason Claim still processing unless the payer states otherwise.
* 4.1d Backlog with the payer in claim processing (payer specific).
  + Defer for 21 days and Cigna defer for 60 days with the reason Claim still processing unless the payer states otherwise.
* 4.2 If the claim is in process for more than 35 days or 60 days (Cigna/HMO Payers). The claim is escalated with the payer.
  + If further escalation is needed it is sent to PDS Trace Business Team for review.
  + Defer for 21 days and Cigna defer for 60 days with the reason Claim still processing unless the payer states otherwise.

**BEFORE YOU MOVE ON:**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **Action Step 5 – Additional Information Sent NEA** | |   **BEFORE YOU START:** Find the appropriate reason below for why additional information was sent.   * 5.1a Initial NEA not received or incomplete   + If the payer requires claim, the activity code is resubmit new claim with NEA.   + If the payer **does not** require the claim, the activity code is additional information sent NEA. * 5.1b Additional information needed to process claim. Ex: Narratives, chart notes, documents, addendum.   + If the payer requires claim, the activity code is resubmit new claim with NEA.   + If the payer **does not** require the claim, the activity code is additional information sent NEA. * 5.1c If the requested information is not accepted over the phone. Ex: seat date, delivery date.   + If the payer requires claim, the activity code is resubmit new claim with NEA.   + If the payer **does not** require the claim, the activity code is additional information sent NEA.   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed   |  |  | | --- | --- | | |  | | --- | | **Action Step 6 – Pending for EOB** | |  * **BEFORE YOU START:** ~~.~~ Ensure that all denial details are collected accurately and completely to avoid delays during the audit review. Review Invoice Docs, and OnBase, to determine if EOB is already available. After appropriate research determine the reason for pending EOB below:   6.1a Claim is denied or paid (excluding HMO claims)   * + Try to obtain from web portal.   + Request EOB via fax/email if not avail on web.     - Defer for 3 days with reason Pending for EOB.   + If payer will not fax, request for EOB to mailed to billing address.     - See Steps for 6.2   6. 2 EOB mailed to the treating location vs lockbox.   * 6.2a Mailed to Lockbox * Defer 14 days with reason “EOB Will Be Mailed to ROC” (1655) * 6.2b Mailed to treating location * Defer 14 days with reason “EOB Will Be Mailed to Office” (1654) * 6.3 EOB Escalations   + If EOB is not received after the 2nd attempt will escalate to the onshore team     - **Route to ICS Trace - Onshore** (Activity 565) with details * If unbale to obtain an EOB for a denied procedure/s, provide detail information and route to Audit * **Route to Audit – Guidehouse** (Activity 366)   6.2 If EOB is not received after 2nd attempt, escalate to the onshore team.   * + Route to the Onshore Trace WQ   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, and quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 7 – Not a Covered Benefit/Maximum Benefit Exhausted/Frequency Limit** | |   **BEFORE YOU START:** Determine which codes are denied.   * 7.1 Verify payer portal benefits details, benefit amounts, and frequency limits.   + Route to Audit Offshore WQ. * 7.2 Call the payer if the information is not available on the website.   + Route to Audit Offshore WQ.   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 8 – Coverage Updates** | |   BEFORE YOU START: This SOP applies to all GH team members responsible for validating or updating patient demographic and payer information in claims and coverage systems. Identifying and processing demographic or payer changes and determining appropriate routing actions based on available verification sources. Note: Out of scope for Eligibility team: to update patient demographics (insurance ID#, Insurance group#), to add new coverages, to update Visit Coverages    Please reference to Action Step 10 (Request for Information and Subcategory) to determine subcategory. Subcategories  [**https://pacificdental.app.box.com/file/Request**](https://pacificdental.app.box.com/file/Request) **for Information Activity and Subcategory**   * 1. **Changes That Must Be Routed to Eligibility (Offshore/ Onshore)**   The Eligibility Team is responsible for making **Filing Order changes** when the patient has multiple active insurances and **adding insurance coverage** to a visit, provided there is a **recent or valid DE form** supporting the update.   * **8.1a:** Coverage change needed, DE form is correct Route to Eligibility Onshore.   **Action:**   * Route to **Eligibility Onshore WQ** [594] * **8.1b:** Coverage change needed, DE form needs update Route to Eligibility Offshore.   **Action:**   * Route to **Eligibility Workqueue** [589]   **8.2 Pending Filling / Retro Review**   * **8.2a:** If invoice is in **Retro Review WQ under 14 days**   **Action:**   * Defer using **Retro Review** [98039] * Defer 7 days or until 14 days are met * **8.2b:** If invoice is in **Retro Review WQ** **and over 14 days**   **Action:**   * Route to **Request for Information – Coverage Related** [536]   + **Subcategory:** *Coverage Related – Retro Assignment*   **8.3 Coverage Updates Under Visit Tab**   * **8.3a Coverage in “Unused” Status Needs Activation**   When coverage listed under the Visit tab is marked as “Unused” and not active in visit coverage but is still valid and should be activated:  **Action:**   * Route to **Request for Information – Coverage Related** [536]   1. **Demographic and Address Update**   For any changes related to patient **demographics verification**:  **Follow Action Step 1.2 – Patient Demographics and Address Update**    **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 9 – Provider Not Contracted/Credentialing Grid** | |   **BEFORE YOU START:** Locate the Credentialing Grid.   * 9.1 Provider not listed on the credential grid.   + Open a Credentialing Help Ticket to request provider be added with non-par date.   + Defer for 14 days with reason Pending Credentialing Ticket. * 9.2 Provider is listed on the grid as “In Process” or in N/A status   + 9.2a: if non par date is available     - Verify on credentialing grid when non-par date was added       1. If claim was billed prior to non-par being added and does not require a new claim          1. Resubmit Claim with non-par date in Box 35 comments     - If claim was billed prior to non-par being added and does require new claim       1. Resubmit New Claim via NEA with non-par date in Box 35 and NEA narrative box.     - If claim was billed after non-par added being added       1. Call carrier to identify why claim was denied * 9.2b if no non par date available   + Determine if office is in an Enterprise or Non-Enterprise state (*see conclusion*)     - Enterprise – open credentialing tickets to follow up on status and add non-par date.       * Defer claim in EPIC with reason “Pending Credentialing Ticket” for 14 days     - Non-Enterprise – defer with reason “Provider Not Contracted” for 14 days * 9.2c: If non par date is after DOS or carrier does not have OON benefits   + Route to Audit * 9.3 Provider is listed on the grid and has an effective date * 9.3a: DOS is prior to the effective date   + If non par date is not available     - Open credentialing ticket to follow up on status and add non par date.     - Defer claim with reason “Pending Credentialing Ticket” for 14 days   + If non par date is available     - See steps for 9.2a * 9.3.b: DOS is after the effective date   + Call carrier to confirm the denial     - Claim denied in error     - Claim should be sent for reprocessing by Delta       1. Defer claim with reason “Claim Sent For Reprocessing” for 21 days     - PDS needs to contact Delta and update provider status       1. Open a credentialing ticket with details of the conversation       2. Defer claim with reason “Pending Credentialing Ticket” for 14 days     - Claim was billed prior to Delta’s approval date (effective or non-par)       1. See steps for 9.2.1a&b   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed.   |  |  | | --- | --- | | |  | | --- | | **Action Step 10 – Request for Information (RI)** | |   **BEFORE YOU START:** ~~.~~ Please ensure to reference to **Request for Information** **Activity and Subcategory** [Request for Information Activity & Subcategories](https://pacificdental.app.box.com/folder/145723332772?s=z6gy7jthdewvej5gyl95w5oim1cdar2e&sortColumn=date&sortDirection=DESC) to determine subcategories.   * 10.1a Denied for COB   + Route to Request for Information - Coverage Related Activity [536] * 10.1b Coverage updates   + Route to Request for Information - Coverage Related Activity [536] * 10.1c Additional information. Ex: Seat date, delivery date, chart notes, clinical documentation, addendum, etc. not available in the chart.   + Route to Request for Information - Clinical Documentation Activity [535] * 10.1d Policy inactive   + Route to Request for Information - Coverage Related Activity [536] * 10.1e Prior authorization is missing   + Route to Request for Information - Clinical Documentation Activity [535] * 10.1f Referral needed   + Route to Request for Information – Clinical Documentation [535] * 10.1g Patient not assigned to the office   + Route to Request for Information - Coverage Related Activity [536] * 10.1h Questionnaires.   + Route to Request for Information - Coverage Related Activity [535]   **BEFORE YOU MOVE ON:**  Add pre/ post-step notes, quality assurance checks, and verify all actions have been completed. **Action Step 11 – Claim Pending for W9 Form** **BEFORE YOU START: Confirm with payer that they require a W9 to process the claim.**   * 11.1a Claim pending for W9 form   + Locate W9 form from Box [W9 2024 Folder](https://pacificdental.box.com/s/d8uox1ptauzbblrng6gjs2a2hk23hzef)   + Request W9 form via fax if allowed [How to Release Medical Records in Epic](https://pacificdental.box.com/s/09hzt3p94p17mrzqyh147osc8ra19ixw)   + Defer 30 days   + Request via NEA please see **Action 5**   + If payer will not accept fax or NEA Route to Billing Resubmission-Offshore WQ   **Action Step 12- Workers Compensation**  **BEFORE YOU START:** When worker's comp claim is billed out, we do not bill the patient's regular insurance (dental, medical) as the worker's comp insurance pays for worker comp claims. Work comp claims are accident related. Review Invoice Docs, and Onbase, to determine if EOB is already available. If EOB is not available, please see Action 6.  **12.1 Claim Pending**  **12.1a** Pending Additional Documentation   * Confirm if documents can be faxed**:** * **Yes**: follow the instructions for faxing * [How to Fax a Claim](https://pacificdental.app.box.com/file/1828372240669) * **No**: * Route to **Billing Resubmission – Onshore** (Activity 567)     **12.1b Pending Authorization Number**   * Locate Authorization in Media * No Authorization Found: * Route to Office for Authorization number **Request for Information- Clinical Documentation (**Activity 535**)** * Yes, Authorization Found: * Will the payer accept the authorization number verbally?   + - Yes:       * + Defer for 30 days.     - No: * Will the payer accept the authorization number via fax?   + If Yes: follow the instructions for faxing     - [How to Fax a Claim](https://pacificdental.app.box.com/file/1828372240669)     - If No:       * + Route to **Billing Resubmission Onshore** (Activity 567)       **12.2 Obtaining Claim Status**  12.2a Option to Leave Voice Mail   * + - Yes 1st Call and Voice Mail: * Leave Voice Mail with U.S. phone number * Defer for 3 days   + - Yes 2nd Call and Voice Mail: * Leave Voice Mail with U.S. phone number * Defer 3 days   + - Yes 3rd Call: * Route the invoice to **ICS Trace Onshore** (Activity 565)   + - No: * Route the invoice to **ICS Trace Onshore** (Activity 565)     **12.2b Payer phone number is not available**  If WC contact information is not available in the coverage tab or not available in Media:   * Route the invoice to Office Request for Information – Coverage Related (Activity 536)     **12.2c Not a Covered Benefit Denial**   * + - If invoice/claim was denied for (NCB): * Route the invoice to **Audit – Onshore** (Activity 561)   **Action Step 13 - Dental – Medical (DM) Process**  **Before you start:** Review EOB and activity details to verify that medical claim is finalized, and no further action can be taken. Verify all actions have been completed and detailed note/comment has been added.    **13.1 Initial Invoice Review**  **13.1a Check if a Shadow/Non-Shadow Invoice was Created**   * **Yes** → Proceed to Step 13.2a * **No** → Confirm if a medical card is scanned under the **“Chart”** tab:   + **No medical card available**:     - Route to office to obtain medical insurance information from the patient.     - **Action**: *Request for Information – Coverage Related (Activity 536)*   + **Medical card is scanned in Epic**:     - Route to **Medical Billing**     - **Action**: *Medical Billing Needed (Activity 363)*   **13.1b If Member Has Medical and Dental Coverage Under the Same Payer**   * Confirm if the plan will coordinate benefits **without** requiring an additional claim.   + **Yes**: Defer the invoice     - **Defer Reason**: *Claim Sent for Reprocessing (Reason 1652)*   **13.1c If the Plan Requires Additional Medical Records**   * Route invoice to **Medical Billing Needed** so a shadow/non-shadow invoice can be created and required medical records can be submitted. * Include claim number and specify the documentation required. * **Action**: *Medical Billing Needed (Activity 363)*   **13.2 Shadow/Non-Shadow Claim Created**  **Check Claim Status in Header**  **Status: Closed**   * Review **Invoice Docs** for a copy of the EOB:   + **EOB Found**:     - Attach EOB via NEA     - Submit dental claim for reconsideration     - **Action**: *Send Additional Information via NEA (Activity 425)*     - **If New Claim Required**: *Resubmit New Claim with NEA (Activity 455)*   + **No EOB Found**:     - Check **History** for follow-up notes     - **If OON Provider** and plan required contracting prior to DOS:       * Resubmit via NEA with this note:  *“The patient has a government-sponsored medical plan, which we are not permitted to bill. Please reprocess claim without the medical EOB.”*     - **If unable to resubmit via NEA**:       * Route to **Billing Resubmission**       * **Action**: *Billing Resubmission (Activity 350)*   **Status: Accepted / Rejected**   * Review **Follow-Up Activity History** for notes on claim status. * If the invoice is in a Follow-Up WQ with the following statuses:   + **277 Dental-Medical Billing**   + **Needs Medical Billing**   + **Trace ICS – Dental-Medical**   **Check Age of Claim:**   * **Within 60 Days of Acceptance**:   + Defer invoice   + **Defer Reason**: *Tracer To Follow Up on Claim (Reason 1667)* * **Over 60 Days of Acceptance**:   + Defer for 30 days   + **Defer Reason**: *DM Follow Up Needed (Reason 1815)*   **Follow-Up Messages:**  **Error / Claim Edit**   * If the claim is in **Claim Edit**, defer for 14 days   + Common work queues:     - Escalated WQ     - Coding     - Trace ICS Dental-Medical   + **Defer Reason**: *DM Claim Edit Review Needed (Reason 1816)*          **Conclusion** | |  | |

**Opening a Web Logins Help Ticket**

*If insurance carrier website is unavailable (locked, not listed in CyberArk) will need to open a Web Logins help ticket*

* Navigate to FreshService (Single Sign On > PDS Service Desk)
* If user has Agent access, will need to navigate to Support Portal
  + Navigate to the upper right corner with first initial
  + Select “View Support Portal”
* Select “Revenue Operations”
* Select “ROC – CyberArk Web Logins”
* Update Office Name
* Update Area to “insurance website login/password”
* Update Level 1 Category to match scenario
* Update Carrier Name
* Update all required fields and add description of what carrier site needs updating
* Submit

Table

Description automatically generated

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

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

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Draft** | **BETA test** | **Offshore** | **Final Draft** | **Version** | **Description** | **Approved By:** |
| 3.5.24 |  | 3.5.24 | 3.5.24 |  | SOP Trace.DSO.v.2 |  | Corey Betts |
| 3.5.24 |  |  |  |  |  |  | Stephanie Jones |
| 10.2.24 |  |  |  |  |  | Add 2.1b and 11 | Sabrina Gomez |
| 1.17.25 |  |  |  |  | TRACE DSO | SOP update | Sabrina Gomez |
| 02.20.25 |  |  |  |  | Trace DSO | SOP update | Sabrina Gomez |
| 04.10.25 |  |  |  |  | Trace DSO | SOP update | Sabrina Gomez |
| 04.14.25 |  |  |  |  | Trace DSO | SOP update | Sabrina Gomez |
| 05.29.25 |  |  |  |  | Trace DSO | SOP update | Sabrina Gomez |
| 07.02.25 |  |  |  |  | Trace DSO | SOP update | Sabrina Gomez |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |