**Denial Management:**

**1 AUTHORIZATION:**

provider has to take permission from the INSURANCE COMPANY is called authorization.

It is of 2 types:

1. Prior authorization: It has to take before service
2. Retro authorization : It has to take after service

**Explanation to TL :**

* I will verify the denial reason.
* I will get the denied date.
* I will verify in my system whether we have any authorization number available or not.
* If authorization# is available. I will ask them to reprocess the claim.
* If authorization# is not available. I will ask for Retro authorization.
* If Retro authorization is not possible. I will ask them can I send an appeal with the medical records.
* For appeal, I will get the fax number or mailing address.
* I will get TFL for appeal.

I will get claim number and reference number

AUTHORIZATION NUMBER BLOCK IN CMS 1500 FORM = 23 BLOCK

* If Place of service is related to 23 and we have received a denial authorization what u will do in this case?
* POS 23 is related to EMERGENCY and for emergency services authorization is not needed I Will call to insurance company and I will ask them to reprocess the claim
* Who has to take permission from insurance company?
* Provider office has to take permission from Insurance Company

**RENDERING PROVIDER:**

Rendering provider is the provider who provides actual service.

**REFERRING PROVIDER or primary care physician or family doctor :**

Referring provider is the provider who provides initial service.

**2 REFERAL :**

It is the process of sending patient from one provider to another provider for special service.

**Explanation of TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will verify who is the PCP(primary care physician) for this patient.
* I will verify in my system whether we have any referral# available on this claim or not.
* I referral# is available, I will ask them to reprocess the claim.
* If referral is not available. I will ask the PCP Name and Phone Number.
* I will get the TFL for corrected claim.
* I will get claim number and reference number.

**REFERAL IS MENTIONED IN 23 BLOCK**

**3 Bundle (or) Inclusive (or) Exclusive :**

If we file a claim for an x-ray for both right hand and left hand with an CPT code of 71020 on the same day if we file a claim for an x-ray of left hand with an cpt code 71010. we will receive this denial For this cpt code as 71010 x-ray for left hand has already included with 71020.

**Explanation to TL :**

* I will get denial reason.
* I will get denied date.
* I will ask to which primary CPT code it was included with.
* I will verify in system whether 59 modifier is available or not.
* If It is already filed with 59 modifier (I will explain to them and) I will ask them to reprocesses the claim.
* If 59 modifier is not available on the claim. I will ask can I send an corrected claim with 59 modifier.
* I will ask TFL for corrected claim.
* I will get claim number and reference number.

**Interview questions need to ask**

**4 Timely Filing Limit:**

Each and Every insurance company will have a certain time period. we have to file the claim within that time period, if not we will receive this denial.

POTFL = Proof of Timely Filing Limit

**Expalnation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will ask TFL for the claim
* I will get the claim received date.
* If it is denied incorrectly. I will ask them to reprocess the claim.
* If it is denied correctly. I will ask can I send an appeal with POTFL(Claim Sent Report Clearing House Document).
* I will get mailing address or fax number
* I will ask TFL for appeal.
* I will get claim number and reference number.
* What is the document you will use for potfl (proof of timely filing limit)?

* Claim sent report from clearing house
* What is the TFL for medicare?
* Medicare Tfl is 1 year

**5 Primary EOB (Or) This Care May be Covered By Another Payer :**

If we file a claim to the secondary insurance without primary EOB then we will receive this denial.

**Explanation To TL :**

* I will verify the denial reason .
* I will get the denied date.
* I will verify whether we have primary EOB or not.
* If we have a primary EOB, I will refile a claim to the secondary insurance with primary EOB .
* If claim was not filed to primary insurance and we are not having primary insurance details .
* I will call to secondary insurance. and I will get primary insurance details like insurance name patient ID and Mailing address.
* Then I will file the claim to primary insurance after verifying the eligibility.
* I will get claim number and reference number.

**6 Medically Not Necessary :**

**Explanation ToTL :**

* I will verify denial reason .
* I will get the denied date.
* I will ask them why it is denied as medically not necessary
* I Will ask can I submit a corrected claim with appropriate DX Code

I Will get tfl for corrected claim

* If corrected claim is not accepted. I will ask can I send an appeal with the medical records to show the medical necessity.
* I will get mailing address or fax number( may I know whose attention it should be sent.)
* I will ask TFL for appeal.
* I will get claim number and reference number.

**7 Co-Ordinate Of Benefits :**

Before taking policy patient has to update his other insurance details it is called Coordination of benefits ( COB).

(OR)

when a patient has more than one insurance plan then patient has mention which is primary and which is secondary before taking the policy.

**Expalnation to TL :**

* I will verify the denial reason
* I will get the denied date .
* I will verify when patient lastly updated his co-ordination benefits .
* I will ask whether they have sent any letters to the patient or not .
* If they said they didn’t send any letter to the patient.
* I will request them to send a letter to the patient .
* If they said they already sent letter to patient .
* I will ask how many letters they have sent to patient .
* If they said they already sent three letters .
* I will ask can I bill the patient .
* I will get claim and reference number .

**8 Pre Existingcondition :**

Before taking policy patient has to update his previous illness or disease details it is called Pre existing condition

OR

If the patient having any illness or disease before taking the policy that has to mentioned at that time of taking policy. If it is not mentioned claim will be denied as pre existing condition .

**Explanation Tl:**

* I will verify denial reason .
* I will get denied date.
* I will verify what is pre existing condition.
* I Will ask what is time period for Pre exisisting condition
* I will ask whether they have sent any letter to the patient or not .
* If they said they didn’t send any letter to the patient .
* I will request them to send a letter to the patient.
* If they said they already sent a letter to the patient.
* I will ask how many letters they have sent to patient.
* If they said they have already sent 3 letters to patient .
* I will ask can I bill the patient .
* I will get claim and reference number.

**9. Non Covered Service :**

If it is denied as non covered service. We have to know it is under patient plan or providers plan.

**Explanation to Tl:**

* I will get denial reason.
* I will get denied date.
* I will verify it is a non covered service under patient plan or provider plan.
* If they said it is under patient plan. I will ask reason why it is non coverd service under patient plan.
* I will ask them can I bill the patient.
* If they said it is under providers plan. I will ask the reason why it is non coverd service under provider plan..
* I will ask it is provider writeoff.
* I will get claim and reference number.
* **IN YOUR PREVIOUS OFFICE FOR NON COVER SERVICES YOU WILL TAKE ADJUSTMENT?**
* **I WILL FORWARD THIS CLAIM FOR CLIENT FOR ADJUSTMENT**

**10 Eligibility or Coverage Terminated :**

If the patient plan expires before DOS, we will receive this denial.

**Explanation to TL:**

* I will get denial reason.
* I will get denied date.
* I will get patient policy effective date and terminate date.
* I will verify the policy coverage.
* If it is denied incorrectly. I will ask them to reprocess the claim.
* If it is denied correctly.
* I Will ask patient other insurance details
* I no other insurance details found I will ask can I bill the patient.
* I will get claim and reference number.

If patient is listed in Meidcaid Insurance and we recevd denial coverage terminated what u will do for this claims?

I Willl not bill this patient I will forward this claim for client assistance

Reason? Medicaid insurance people are poor people

**11 .GLOBAL:**

Certain post operative services will not paid for a duration of time stating that it was included in previously paid surgery date of services. it is called global.

**Explanation to TL:**

* I will get the denial reason.
* I will get denied date.
* I will verify previously paid surgery DOS and CPT code
* I will get global period.(Golbal period means post operative services will not paid for a duration of time)
* I will verify DX code with surgery DOS and Denied DOS.
* If Denied DOS and Surgery DOS has different DX code. I will ask can I send an corrected claim with an appropriate modifier.
* I will ask TFL for corrected claim.
* If Denied DOS and Surgery DOS has same dx code. I will forward this claim for my client assistance for adjustment.
* I will get claim number and reference number.

**12 Maximum Benefits Met:**

If the patient completed max benefits. if we file a claim after the benefits exceeded. we will receive this denial.

**Explanation to TL:**

* I wil get the denial reason.
* I will get the denied date.
* I will ask them patient is enrolled in dollars plan or visits plan.
* If it is under dollars plan. I will ask them for a calender year how many dollars is allowed for this patient
* If it is under visits plan. I will ask them for a calender year how many visits is allowed for this patient.
* I will ask them for which DOS patient has completed his maximum benefits.
* I will ask Can I bill the patient.
* I will get claim and reference number.

**13 Duplicate:**

If two claims submitted to insurance and both claims having same DOS and CPT code then we will receive this denial. we have to verify whether denied it is correctly denied or not.

**Explanation to TL:**

* I will get denial reason.
* I will get denied date.
* I will ask to which claim it was referred as dupicate.
* I will verify the denied claim and original claim.
* If both claims having same DOS,CPT code, DX code ,Provider Name and Billed Amount.
* If it is denied correctly. I will ask the status of the original claim.
* If original claim and denied claim both are different.
* I will ask to reprocess the claim by explaning the difference.
* I will get claim and reference number.

**14 Out Of Network Provider:**

If the provider is not having agreement with insurance company then the provider will be consider as out of network provider.

**Explanation to TL:**

* I will get denial reason
* I will get denied date.
* I will verify the date from when provider is out of network.
* I will verify wether patient is having out of network benefits or not.
* If the patient is not having out of network benefits. I will ask can I bill the patient.
* If the patient is having out of network benefits , I will ask them to reprocess the claim.

I will get the claim and reference number.

**15 CPT code incorrect for DX code :**

* I will verify denial reason.
* I will get the denied date.
* I will verify CPT code and DX code with Rep.
* I will ask the reason why CPT code is incorrect for DX code.
* I will ask them can I refile the corrected claim with appropritate CPT code
* I will ask TFL for corrected claim.
* I will get claim number and reference number .

**16 Modifier Is Inconsistent With CPT code :**

**Explanation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will verify CPT code and modifier with REP.
* I will ask the reason why modifier is incorrect for CPT code .
* I ask them can I refile the corrected claim with the appropriate modifier.
* I will ask TFL for corrected claim .
* I will get claim number and reference number.
* **17 CPT code Exceeded No of Units:**
* I will get the denial reason.
* I will get the denied date.
* I will ask for a day how many units are allowed for denied CPT code.
* I will ask them can I send an appeal with medical records.
* I will ask TFL for appeal.
* I will get mailling address OR fax number( I will ask to whose attention it should be sent )
* I will get claim and reference number.

**18. Primary Paid Maximum Or Primary Paid More than Secondary Allowed Amount:**

If primary insurance paid more than the secondary insurance allowed amount then we will receive this denial.

**Explanation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will verify primary insurance paid amount in primary insurance eob
* I will verify secondary insurance allowed amount in seconday insurance fee schedule
* If primary paid more than secondary I wll adjust the claim

**NON - Denial Management:**

**1 Offset:**

It is a simple adjustment against over payment done by insurance company from one patient account to another patient account.

**Expalnation to TL:**

* I will get claim processed date.
* I will get the reason why claim was not paid.
* I will ask what is the allowed amount for this DOS.
* I will ask is there any patient responsibility or not.
* I will ask how much is applied for offset.
* I will ask to which patient DOS it was applied as offset.
* I will get that patient.
* I will get the date when they paid and I will get the check number.
* I will request EOB.
* I will get claim and reference number.

**2 Capitation:**

Provider will be received a bulk amount and will be having an agreement with the insurance company for certain period of time it is called capitation. (For that time insurance company will not pay for a provider for his service to the patient who insured in the company.)

**Explanation to TL:**

* I will get claim processed date.
* I will ask the reason why claim was not paid.
* I will ask what is the allowed amount for this DOS.
* I will ask is there any patient responsibility.
* I will ask the date from when the provider under capitation.
* I will forward this claim for my team leader for adjustment.
* I will get claim and reference number.

1. **DEDUCTIBLE:**

The amount fixed by the insurance that patient has to satisfy after satisfying this amount insurance will pay for this medical benefits.

**Explanation to TL:**

* I will get claim processed date
* I will get patient annual deductIble amount.

I will ask what is the allowed amount.

* I will ask how much amount is applied towards deductable.
* I will ask how much patient has met for this DOS.
* I will get claim and reference number.

**4 CLAIM PAID:**

* I will ask the date when the claim was paid
* I will ask what is allowed amount
* I will ask what is the paid amount and patient responsibility.
* I will ask in which mode it was paid.
* If they said it was paid through check. I will get check number and I will get the date when it was issued.
* I will ask whether it is single check or bulk check.
* I will get check sent address.
* If they said it was paid through EFT. I will get EFT number and I will get the date when the transcation was done.
* I will ask whether it is a single transcation or bulk transcation.
* I will request EOB.

I will get claim and reference number.

**5 Claim in process**

* I Will get claim received date
* I Will ask normal processing time
* I will ask how many days they need for processing claim
* I will get claim# and ref#

**6 Claim not found**

* I will verify electronic payor id, if it is correct
* I Will get patient policy effective date and termination date
* I will ask TFL and I will refile the claim to insurance