FOLLOW-UP

The Follow-Up feature of SequelMed provides an automated, paperless and integrated means to perform insurance and patient collection efforts. Each denial is tagged with a REASON (why the claim is unresolved) and taken through a series of ACTIONs necessary to bring the claim and patient outstanding balances to resolve. Any actions taken and notes recorded along the way are timestamped and preserved. Every call made is logged by duration and results. Once the claim is paid/resolved, all reasons, actions and calls pertaining to the denial or delay in payment can be retrospectively analyzed for future correction. Examining open items in follow-up, one can instantly determine how much is outstanding, for how long and for what reasons.

FOLLOW-UP allows all outstanding claims to propagate to one centralized area. There the user is supplied with all the necessary tools to follow-up and perform collections efforts on the claim. By performing plan collection efforts in an organized and efficient manner, all claims are brought through to resolve resolved (paid, passed to patient responsibility or written off) and A/R balances are understood and controlled at all times.

FOLLOW-UP begins with the assignment of GROUPS, which allow logical, easy and secure division of collectable accounts. GROUPS are established based on Place of Service, Plan Type(s), Plan Category, Location(s), Provider(s) and Patient Class(es). When an item is passed to FOLLOW-UP, it is placed into the appropriate GROUP bucket.

REASONs are given to an item when it is placed into FOLLOW-UP. REASONs identify why a claim is in FOLLOW-UP and, after the claim is resolved, used to identify denial patterns. Reasons generally do not change throughout the FOLLOW-UP process (ex: NO PRIOR AUTHORIZATION).

ACTIONs are given to an item when it is placed into FOLLOW-UP. ACTIONs identify steps taken to bring the claim to resolve. Looking at the ACTION at any given time identifies the status of the item or where along the path to payment the claim resides. ACTIONs generally change as the item is worked in FOLLOW-UP (ex: Request Info from provider -> Resubmit claim with additional info -> Request fair hearing -> etc.).

<u>Claims/Items/Visits make it to FOLLOW-UP via one of four methods:</u>

1) PLAN OUTSTANDING DAYS - Each PLAN in SequelMed is assigned a number of OUTSTANDING DAYS (see PLAN PROFILES) which is the number of days to wait after the claim is submitted before propagating the claim to FOLLOW-UP. For example, if GHI claims are set with “30” as the number of OUTSTANDING DAYS, claims are sent to FOLLOW-UP on the 31st day from the date of submission. When an item is passed to FOLLOW-UP via PLAN OUTSTANDING DAYS, the REASON and ACTION are both set to “SYSTEM” indicating that the item has not yet been worked in collections. It would be the person responsible for the GROUP assigned to that item to work the claim, identifying the REASON for denial and to take the claim through the necessary ACTIONs to bring the claim to resolve.

2) ELECTRONIC REMITTANCE DENIALS - Any denials presented through ELECTRONIC REMITTANCE are automatically passed along to FOLLOW-UP (without user intervention). All denial reasons and associated visit messages (see REMITTANCE MESSAGES) supplied by the vendor are preserved in their original form and placed into the FOLLOW-UP Notes for the claim. The vendor reason for denial is also used to automatically assign the FOLLOW-UP REASON (see REMITTANCE CODE AND REASON MAPPING). The ACTION is set to “EOB”, indicating that the item was placed

into FOLLOW-UP automatically via ELECTRONIC REMITTANCE and that the item has not yet been worked (i.e. no ACTION taken by a collector).

3) USER PLACED FOLLOW-UP ITEMS - Users can also, as desired send any claim or visit to FOLLOW-UP. Items explicitly sent to FOLLOW-UP by USERS are usually done so at EOB posting time. When a user is posting a paper EOB and they run across a denial or reduced payment, they press the FOLLOW-UP button, set the ACTION, REASON and GROUP for the item, sending it into the appropriate collectors bucket for investigation/follow-up.

4) RESUBMISSIONS – The last means for an item/claim to go to FOLLOW-UP is as a result of a resubmission. The mechanics are very similar to PLAN OUTSTANDING DAYS (#1 above) except that the action is set to “SYSTEM-RE” rather than “SYSTEM” indicating that the item has returned from a resubmission rather than from an initial claim submission.

Collections efforts proceed by isolating through the FOLLOW-UP BROWSE screen a set of outstanding claims. Next the isolated claims are then worked via FOLLOW-UP BUCKETS either individually or in linked visit groupings (ex: all visits from one case or patient). FOLLOW-UP BUCKETS provide all the information and tools necessary to call carriers, take notes, keep ACTION, CALL, REASON and GROUP histories, write letters, assign ticklers, correct charges, resubmit claims, post payments/write-offs, transfer charges, etc.

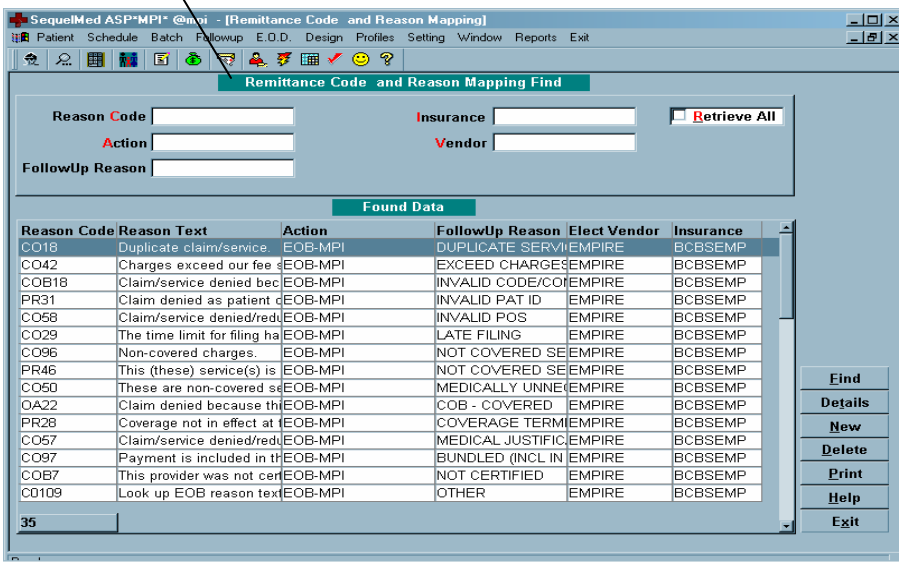
EDI: REMITTANCE CODE AND REASON MAPPING

The purpose of REMITTANCE CODE AND REASON MAPPING is to insure denials that are generated via electronic remittance in BATCH EOB propagate properly and automatically to Follow-up.

Remittance denial codes are supplied along with the electronic EOB from the carrier. At the time the Electronic EOB is brought into SequelMed, these codes must be mapped to the associated Follow-Up REASONs. The definitions for these associations are defined here in Remittance Code and Reason Mapping.

The actual denial codes supplied by the vendor/carrier tend to be encrypted and unusable in Follow-Up. They are different for each vendor, non-intuitive, and often redundant (ex. CO18). At the time the electronic EOB is processed in SequelMed, and the denied visits are automatically placed into Follow-Up, these non-intuitive, vendor supplied remittance codes are mapped to more understandable REASONs (ex. DUPLICATE SERVICE) via the definitions supplied here.

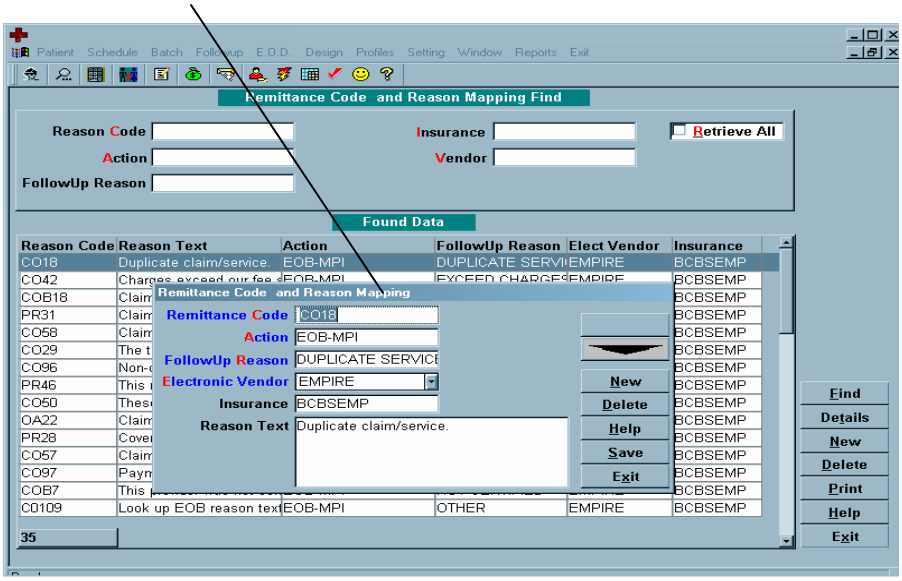
Remittance Code and Reason Mapping Find Window



Field	Description
Reason Code	**The actual remittance code returned with the electronic EOB (ex. CO18-Duplicate Claim/Service, COB18-Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission, PR46-This (these) service(s) is (are) not covered, etc.)**
Reason Text	**The textual description of the remittance denial code supplied by the vendor on the electronic EOB**
Action	**The optional default Action Code assigned to the vendor supplied remittance code**
Follow-Up Reason	**The mandatory Follow-Up REASON assigned to the vendor supplied remittance code. This assignment is very important as it determines the Follow-Up REASON associated with the visit and serves as the basis of subsequent collections efforts for this claim.**

Insurance	**The insurance company supplying the electronic EOB and associated remittance codes**
Vendor	**The EDI vendor (ex. EMPIRE, NEIC, EMC)**

Remittance Code and Reason Mapping Window



Field	**Description**
Remittance Code	**The actual remittance code returned with the electronic EOB (ex. CO18-Duplicate Claim/Service, COB18-Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission, PR46-This (these) service(s) is (are) not covered, etc.). Some examples of mappings:** **CO18 = DUPLICATE SERVICE** **COB18 = INVALID CODE/COMBO** **PR46 = NOT COVERED SERVICE** **PR28 = COVERAGE TERMINATED** **CO16 = MISSING INFORMATION** **CO58 = INVALID POS** **CO29 = LATE FILING**
Action	**The optional default Action Code assigned to the vendor supplied remittance code.**
Follow-Up Reason	**The mandatory Follow-Up REASON assigned to the vendor supplied remittance code. This assignment is very important as it determines the Follow-Up REASON associated with the visit and serves as the basis of subsequent collections efforts for this claim.**
Electronic Vendor	**The EDI vendor (ex. EMPIRE, NEIC, EMC)**

Insurance	**The insurance company supplying the electronic EOB and associated remittance codes.**
Reason Text	**The textual description of the remittance denial code supplied by the vendor on the electronic EOB.**

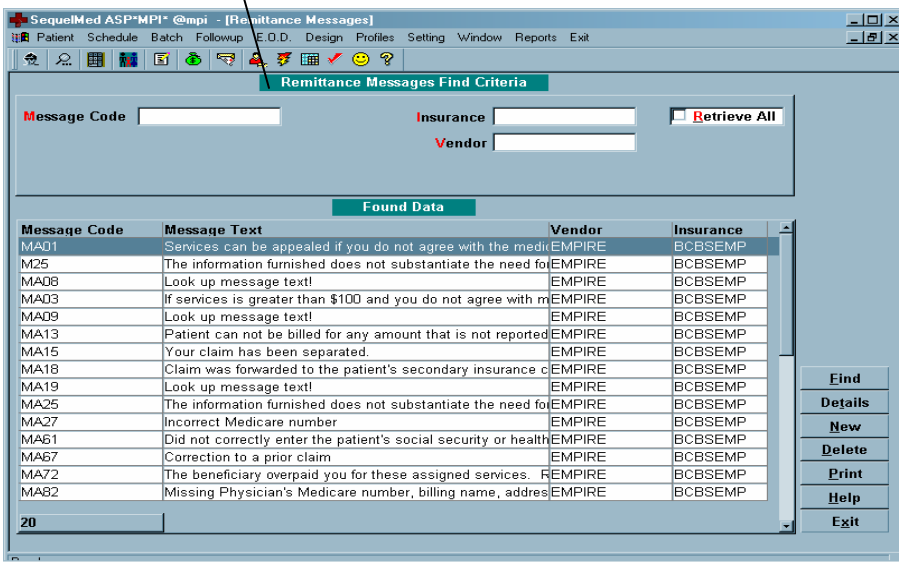
EDI: REMITTANCE MESSAGES

The purpose of REMITTANCE MESSAGES is to insure information supplies along with the denials that are generated via electronic remittance in BATCH EOB propagate properly and automatically to the Follow-up Notes in the created Follow-Up bucket.

Message Codes are supplied along with the electronic EOB from the carrier. At the time the Electronic EOB is brought into SequelMed, these codes must be translated into useful text and included in the Notes of the associated Follow-Up Bucket. The text definitions for these vendor supplied Message Codes are defined here in Remittance Messages.

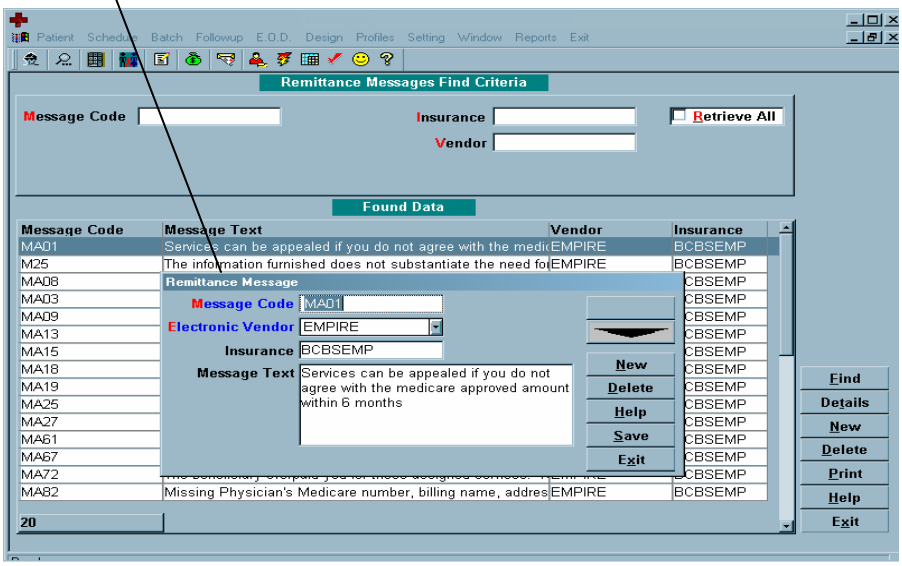
The actual denial message text typically supplied by the vendor/carrier on an EOB tends to be verbose, encrypted, and therefore sometimes unusable for follow-up and collections efforts. The opportunity here is for the user to supply their own text and interpretation of the vendor supplied Message Codes, making their inclusion in the Follow-Up Notes more directly usable for collections efforts.

Remittance Messages Find Criteria Window



Field	Description
Message Code	**The actual message code returned with the electronic EOB (ex. MA01-Services can be appealed if you do not agree with the Medicare approved amount within 6 months, M25-The information furnished does not substantiate the need for more extensive services and can be appealed within 6 months, etc.)**
Insurance	**The insurance company supplying the electronic EOB and associated remittance codes**
Vendor	**The EDI vendor (ex. EMPIRE, NEIC, EMC)**
Message Text	**The textual description of the message code supplied by the vendor on the electronic EOB**

Remittance Message Window

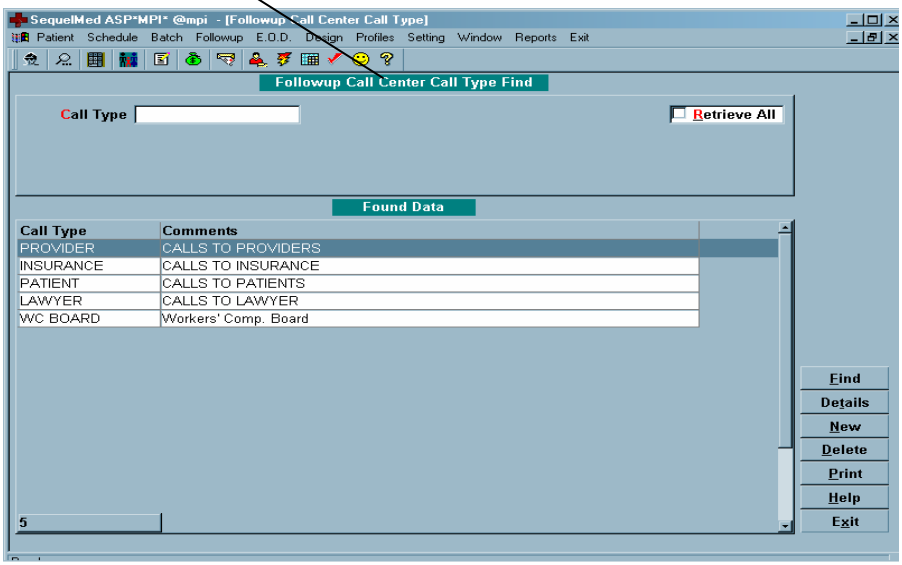


Field	Description
Message Code	**The actual message code returned with the electronic EOB (ex. MA01-Services can be appealed if you do not agree with the Medicare approved amount within 6 months, M25-The information furnished does not substantiate the need for more extensive services and can be appealed within 6 months, etc.)**
Electronic Vendor	**The EDI vendor (ex. EMPIRE, NEIC, EMC)**
Insurance	**The insurance company supplying the electronic EOB and associated remittance message codes.**
Message Text	**The textual description of the message code supplied by the vendor on the electronic EOB.**

CALL CENTER CALL TYPE

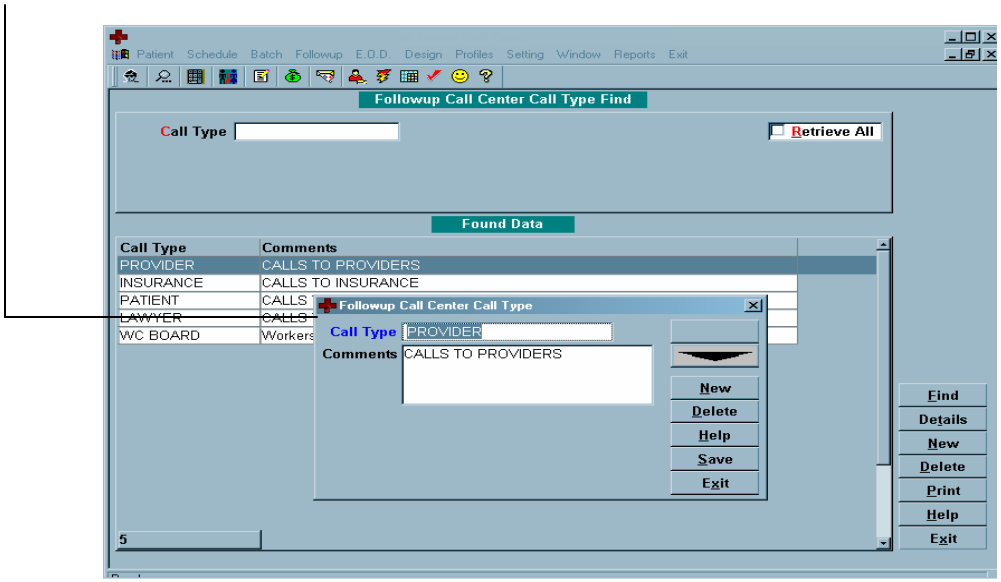
The Follow-Up Call center supports the tracking of all calls made throughout the Plan Follow-Up and collection effort. In order to accurately track calls, a Call Type is assigned to each completed call. The user defined Call Types are defined in the Call Center Call Type Window.

Call Center Call Type Find Window



Field	Description
Call Type	**The Call Type describes the recipient of the call. Examples of Call Types include:** **PROVIDER = Calls to Providers** **INSURANCE = Calls to insurance carriers** **PATIENT = Calls to patients** **LAWYER = Calls to lawyers**
Comments	**Comments, if any, with respect to call type or description of the user-defined short name of the call type selected above in the Call Type field**

Call Center Call Type Window



Field	Description
Call Type	**The Call Type describes the recipient of the call. Examples of Call Types include:** **PROVIDER = Calls to Providers** **INSURANCE = Calls to insurance carriers** **PATIENT = Calls to patients** **LAWYER = Calls to lawyers**
Comments	**Description of the defined Call Types or any other comments, if any**

PRE-DEFINED FILTERS

The power of SequelMed's Follow-Up system lies in the ease in which the user can isolate and select worklists of claims on which to perform follow-up efforts. Simple sorting and filtering of lists of claims that require follow-up is the key to an organized, comprehensive and thorough collections effort.

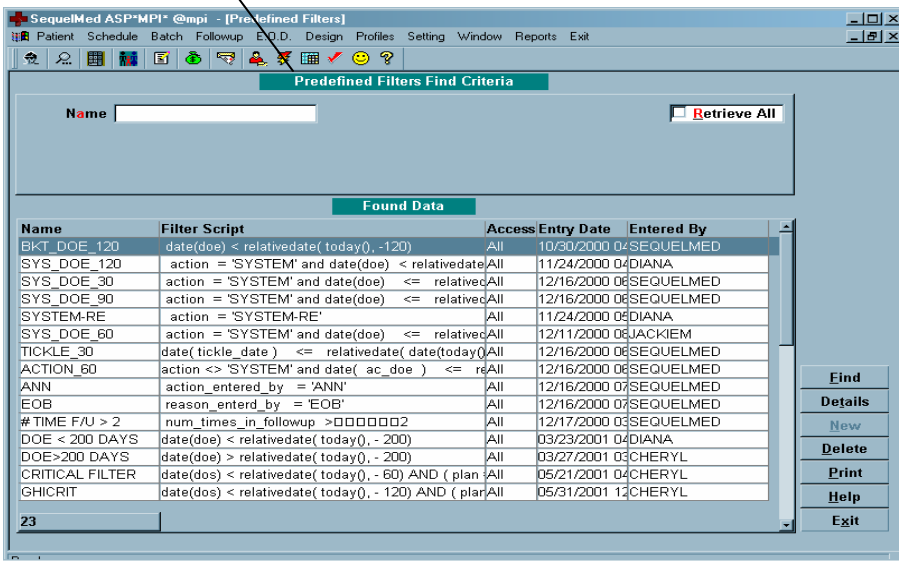
Using Predefined Filters, the user can define and save any simple or complex filters to be reused, either individually or company wide. In short, Pre-defined Filters allow for the organized subdivision of follow-up efforts for concentrated and focused collections efforts. When properly defined and regularly utilized, Pre-defined Filters insure that no claim is left unattended with respect to follow-up.

Some examples of Pre-defined filters include:

- Items in Follow-up that have not been worked at all.
- Items in Follow-Up that have ticklers that have not been looked at for over thirty days.
- Items that have been in Follow-Up more than twice.
- Items that have been in Follow-Up more than 120 days.
- Items in Follow-Up that have a ticket balance over $200.
- Worker's Compensation Claims in Follow-Up that are approaching the 180-day deadline.

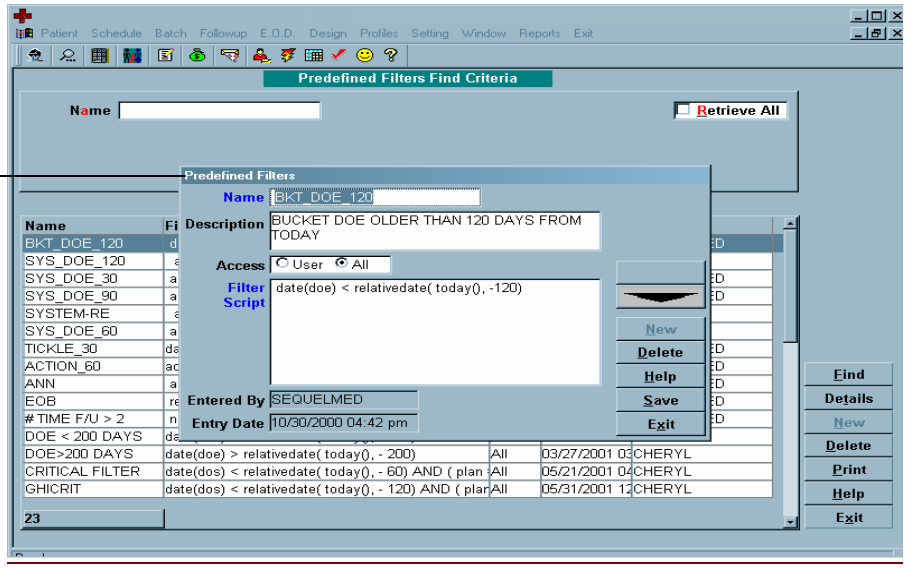
Note that Pre-defined Filters are created in the Follow-Up Find Screen. Pre-defined Filters can be viewed, edited or deleted in the Pre-defined Filter Window.

Pre-defined Filter Find Criteria Window



Field	Description
Name	**The descriptive name assigned to the Pre-defined Filter**

Pre-defined Filters Window



Field	Description
Name	The descriptive name assigned to the Pre-defined Filter.
Description	A Description of the Pre-defined Filter.
Access	Set to USER or All. If set to USER, only the user that created the Pre-defined filter can access the filter. If set to ALL, any user can access the Pre-defined Filter.
Filter Script	The actual filter script. Filter scripts are easily defined in the filter window by selecting from a pre-defined set of filter functions. Some examples: 1) Items not worked and older than 90 days: action = 'SYSTEM' and date(doe) <= relative date(date(today()), -90) 2) Items in Follow-Up more than twice: num_times_in_followup > 2 3) Items whose Tickle date is older than 30 days: date(tickle_date) <= relativedate(date(today()), -30) 4) Items whose ACTION code has not changed for over 60 days: action <> 'SYSTEM' and date(ac_doe) <= relativedate(date(today()), -60)) 5) Items whose Date of Entry (Date the item was placed into Follow-Up) exceeds 200 days: date(doe) < relativedate(today(), - 200)

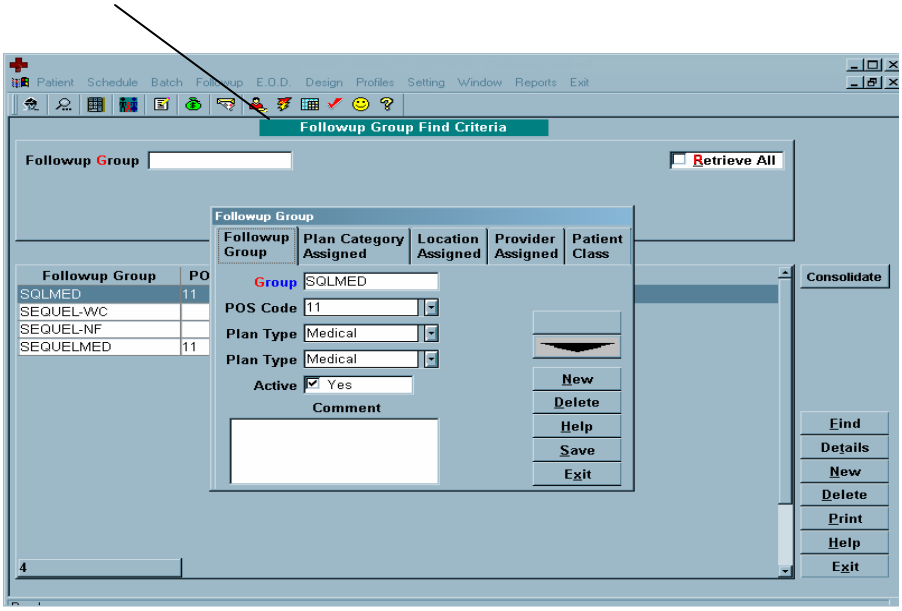
Entered By	**The USER that originally created the Pre-defined Filter in Follow-Up.**
EntryDate	**The date that the Pre-defined Filter was originally created in Follow-Up.**

GROUP

Follow-Up Groups allow items sent to Follow-Up to be divided at the Place of Service, Plan Type, Plan Category, Location and Provider Level. In this way collections efforts are automatically divided so users can independently work subsets of enterprise-wide claim denials. When items propagate to Follow-Up, they are placed into a Follow-Up Group that is defined to accept them.

Follow-Up Groups are generally logically named by USER and Type. For Example, if a USER named Cheryl is assigned all denials from a practice named BMP, her Group definition might be named CHERYL-BMP. Or if MARY is assigned all Medicaid Claims, her Group might be named MARY-CAID.

Follow-Up Group Find Criteria Window



Field	Description
Follow-Up Group	**The name assigned to the Group**

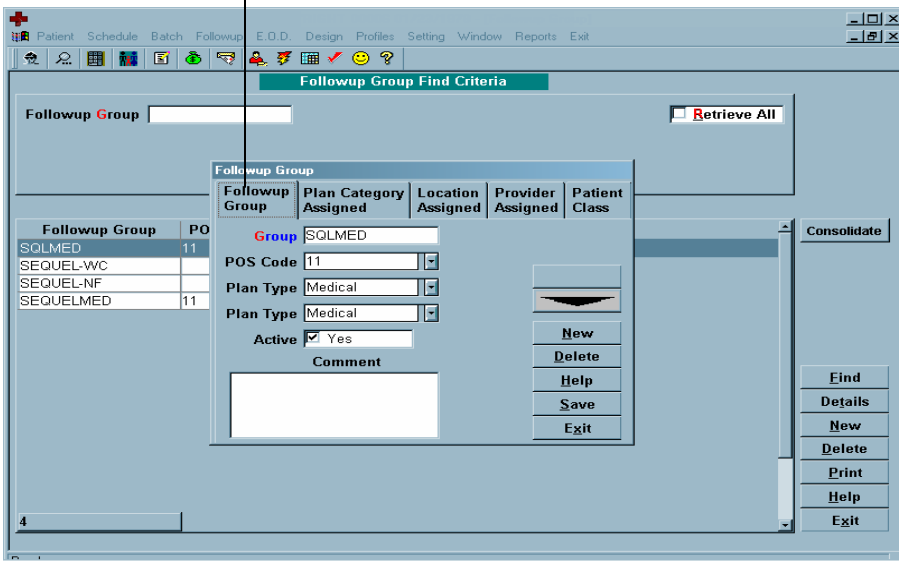
Follow-Up Group Window

The Follow-Up Group Definition Window is divided into five tabbed windows. The user can switch between the four tabbed windows by clicking on the desired tab. The five tabbed windows are:

1. Follow-Up Group
2. Plan Category Assigned
3. Location Assigned
4. Provider Assigned
5. Patient Class

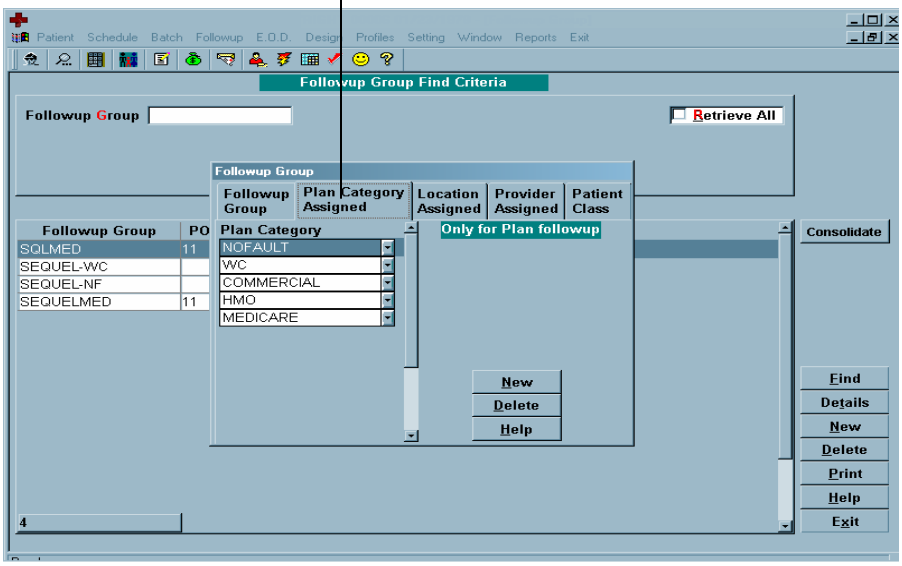
Note that the Group must be defined and saved in the Follow-Up Group screen before the Plan Category, Location Assigned, Provider Assigned, or Patient Class windows can be accessed. Following is a description of the fields contained in the five tabbed windows.

Follow-Up Group Window



Field	Description
Group	The name assigned to the Group
POS Code	Optional field indication the Place of Service (POS) assigned to the Group. This is useful if the Group is intended to handle all Emergency Room (POS = 23) visits for example. Leaving this field blank defaults the user to all POS.
Plan Type	These two optional fields allow the user to be assigned selectively any one or two of the three available Plan Types (Medical, Workers Compensation or No Fault). Leaving these fields blank defaults the user to all three types.
Active	If this checkbox is checked, the Group is active. Unchecking this checkbox inactivates the Group.
Comment	A description of comments pertaining to the Group is placed in this text area.

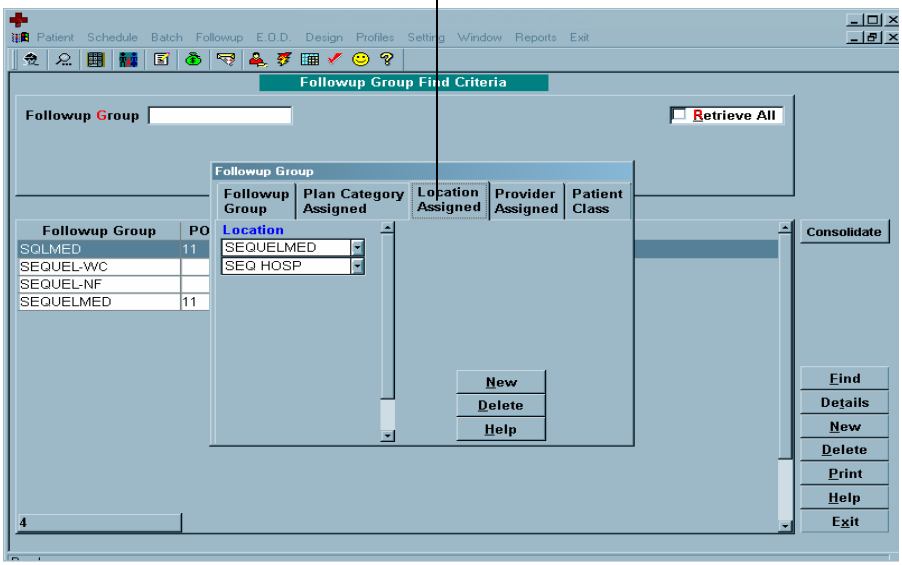
Plan Category Assigned Window



Often it is useful to assign plan categories to the Follow-Up Group so the Group can focus on denials pertaining to Plans of the same type (for example all MEDICAID denials). Plan Categories are optionally added to the Follow-Up Group in the Plan Category Assigned screen. If no Plan Categories are assigned, all Plan categories will propagate to the Follow-Up Group.

To add a new Plan Category to the Follow-Up Group, the user clicks on the New button and adds the desired Plan Category. The user continues to add as many Plan Categories as desired. When completed, the user clicks on the Follow-Up Group tab, and exits the Follow-Up Group definition. Examples of user Plan Categories might be MEDICAID, MEDICARE, BCBS, HMO, UNIONS, etc.

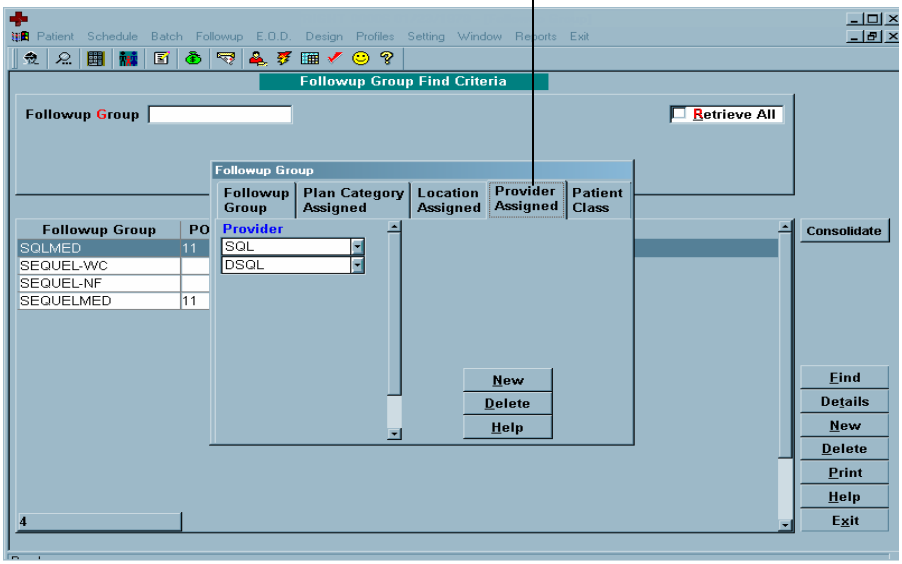
Location Assigned Window



Locations belonging to a Follow-Up Group must be assigned in the Location Assigned Screen. If not defined, denials for that location will not be placed into the Follow-Up Group. This is not an optional field. It should be noted that if the same Location were assigned to more than one Follow-Up Group, the first Group alphabetically encountered would receive the denials.

To add a new Location to the Follow-Up Group, the user clicks on the New button and adds the desired Location. The user continues to add as many Locations as desired. When completed, the user clicks on the Follow-Up Group tab, and exits the Follow-Up Group definition.

Provider Assigned Window



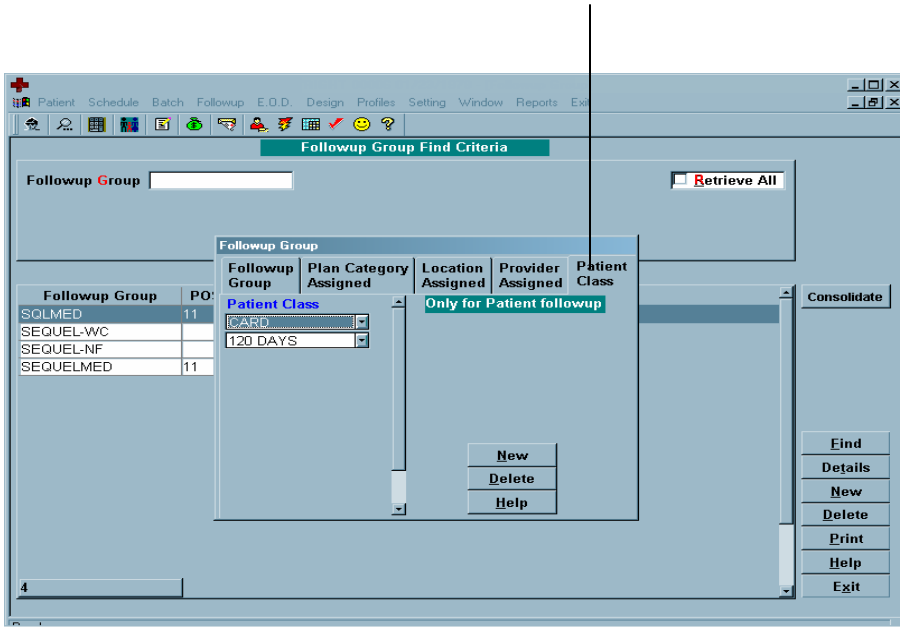
Providers belonging to a Follow-Up Group must be assigned in the Provider Assigned Screen. If not defined, denials for that Provider will not be placed into the Follow-Up Group. This is not an optional field. It should be noted that if the same Provider were assigned to more than one Follow-Up Group, the first Group alphabetically encountered would receive the denials.

To add a new Provider to the Follow-Up Group, the user clicks on the New button and adds the desired Provider. The user continues to add as many Providers as desired. When completed, the user clicks on the Follow-Up Group tab, and exits the Follow-Up Group definition.

Patient Class Window

Patient Class is an optional field. It allows further classification of claims to be routed to a particular group according to patient class. Patient Classes are defined in the Patient Profiles section of the Profiles menu.

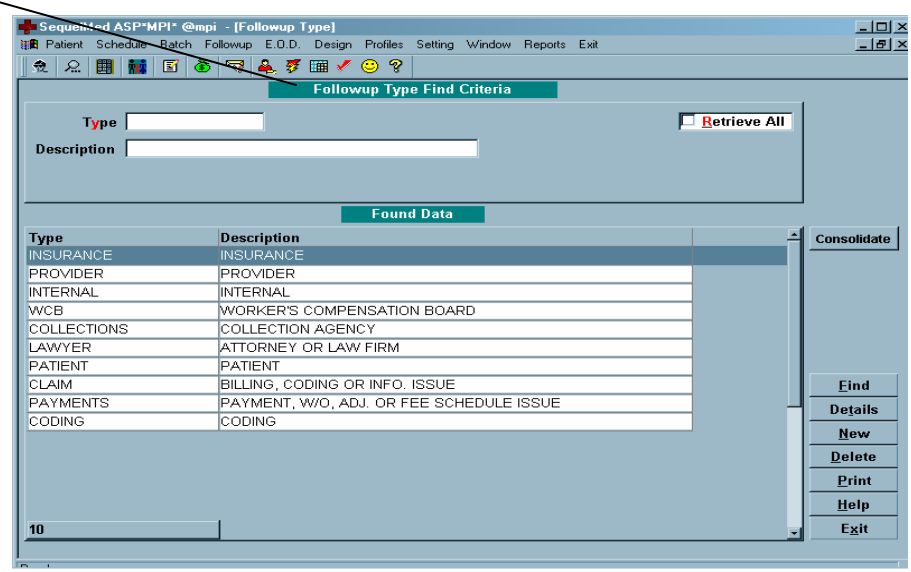
To add a new Patient Class to the Follow-Up Group, the user clicks on the New button and adds the desired Patient Class. The user continues to add as many Patient Classes as desired. When completed, the user clicks on the Follow-Up Group tab, and exits the Follow-Up Group definition.


Patient Schedule Batch Followup E.O.D. Design Profiles Setting Window Reports Exit
Followup Group Find Criteria
Followup Group
Retrieve All
Followup Group
Followup Group
Plan Category Assigned
Location Assigned
Provider Assigned
Patient Class
Followup Group
PO
SQLMED 11
SEQUEL-WC
SEQUEL-NF
SEQUELMED 11
Patient Class
CARD
120 DAYS
Only for Patient followup
New
Delete
Help
Consolidate
Find
Details
New
Delete
Print
Help
Exit
4

TYPE

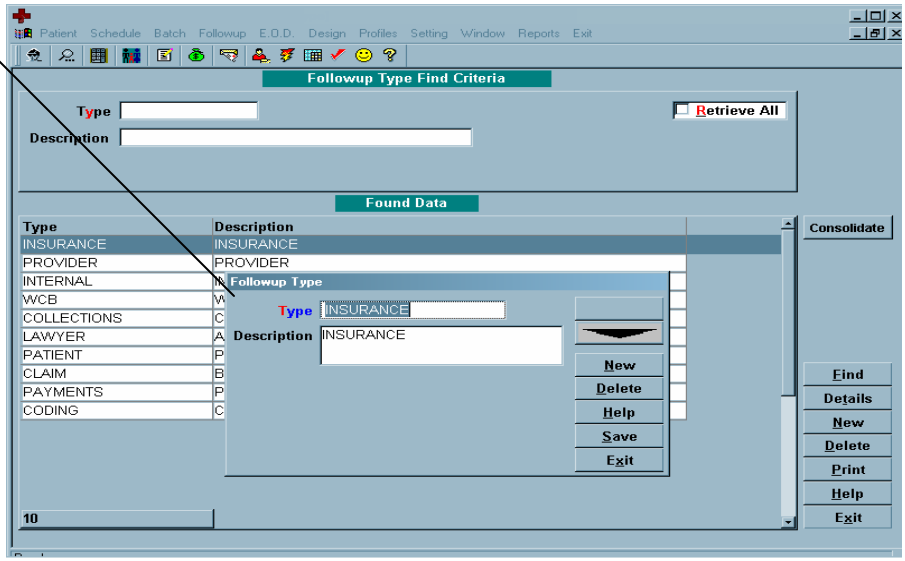
Follow-Up Types allow users to define Reasons and Actions in Follow-Up so they can be utilized as sets belonging to logical groupings. Every Reason and Action defined in Follow-Up has a type assignment.

Type Find Criteria Window



Field	Description
Type	**Type definition names. Some examples of useful types:** • INSURANCE • PROVIDER • INTERNAL • WORKERS COMP • COLLECTIONS • LAWYER • PATIENT • CLAIM • PAYMENTS • CODING
Description	**Textual Description of Types**

Type Window



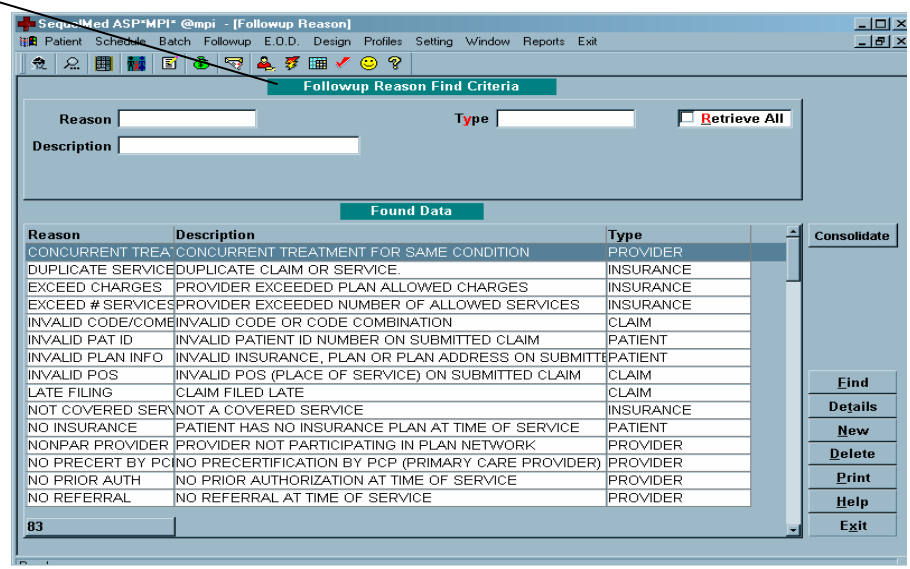
Field	Description
Type	**Type definition names. Some examples of useful types:** • INSURANCE • PROVIDER • INTERNAL • WORKERS COMP • COLLECTIONS • LAWYER • PATIENT • CLAIM • PAYMENTS • CODING
Description	**Textual Description of Types**

REASON

Reasons are assigned to every claim processed in Follow-Up. The Reason typically is assigned to the claim once and remains with the claim until it is resolved (Paid, Adjusted or transferred to patient responsibility).

Reasons are kept intact so once brought to resolve, claims can be retrospectively analyzed for patterns and correction. For example, it would prove useful to examine all claims denied for Reason NO PRIOR AUTHORIZATION so the front desk can be properly instructed to prevent future recurrence. Studying the Reasons for denial is a valuable tool in revenue enhancement.

Reason Find Criteria Window



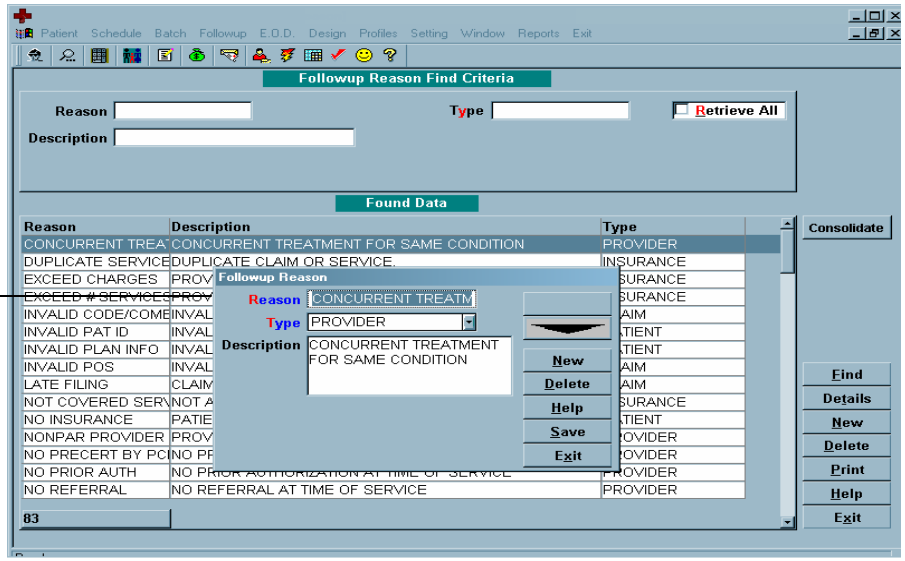
Field	Description
Reason	**The name assigned to the Reason. Some examples of reasons are:**

- CONCURRENT TREATMENT
- DUPLICATE SERVICE
- EXCEED CHARGES
- EXCEED # SERVICES
- INVALID CODE/COMBO
- INVALID PAT ID
- INVALID PLAN INFO
- INVALID POS
- LATE FILING
- NOT COVERED SERVICE
- NO INSURANCE
- NONPAR PROVIDER
- NO PRECERT BY PCP
- NO PRIOR AUTH
- NO REFERRAL
- OBSOLETE CODE
- OUT OF NETWORK
- MEDICALLY UNNECESSARY

- UNRELATED TO INJURY
- CASE CLOSED
- CONTROVERTED
- EOB REQUEST
- W9 REQUEST
- COB - COVERED
- DEDUCTIBLE
- NO RECORD OF CLAIM
- BI-LATERAL PROCEDURE
- MEDICAL RECORDS
- NO REFERRING PIN#
- NO TAX ID #
- PAID TO PATIENT
- COVERAGE TERMINATED
- PAID TO PROVIDER
- MEDICAL JUSTIFICATION
- BUNDLED (INCL IN PRIMARY)
- NOT CERTIFIED
- MODIFIER MISSING/INVALID
- INVALID DX CODE
- INVALID PROVIDER ID
- NO EOB
- DOWNCODING
- CLAIMS HELD (B7)
- OTHER
- GLOBAL FEE
- FEE RELATION VIOLATION
- FULL PAYMENT
- CREDIT OTHER
- MODIFIER DROPPED
- MISSING INFORMATION
- NOT PAID SEPERATELY
- COVERAGE GUIDELINES
- PROVIDER DELAY
- INVALID PAT INFO
- INVALID DOS

Type	**Follow-Up Type Assigned to the Reason**
Description	**Textual description of the Reason**

Reason Window



Field	Description
Reason	**The name assigned to the Reason. Some examples of reasons are: (see above)**
Type	**Follow-Up Type Assigned to the Reason**
Description	**Textual description of the Reason**

ACTION

Actions are assigned to every claim processed in Follow-Up. Unlike Reasons, Actions typically change as the claim is brought through to resolve. The current Action in the Follow-Up Bucket is an indicator of the current state of the claim. The Action History indicated the states the claim has been in prior to the current Action.

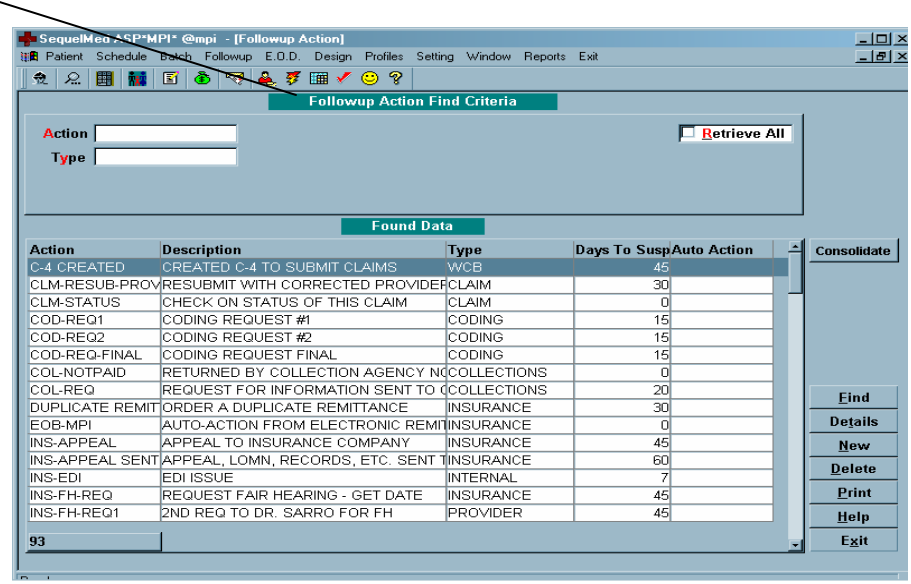
Claims are brought through whatever Action sequences that is necessary to bring the claim to resolve. For example, the claim may begin with action SYSTEM (sent to Follow-Up by system – Not yet worked). The user then calls the carrier and finds out the claim is denied as medically unnecessary. A letter is sent to the provider requesting a letter of medical necessity (LOM) and the Action is set to PROVIDER REQUEST. Once received, the user re-submits the claim and sets the Action to RESUBMIT WITHADDL INFO. The process of taking steps to resolve the claim and reassigning Actions continues until the claim is resolved (Paid, Adjusted or transferred to patient responsibility).

Actions can be optionally assigned a Number Of Days To Suspend, which will suspend the claim (keep it from appearing in the bucket) for a defined number of days. This is used to keep the claim out of the bucket until sufficient time has passed for the Action to be complete. For example, the user may set the number of days to suspend to 20 for all PROVIDER REQUESTS, giving the provider time to respond to the request before attempting to work the claim further.

NOTE a claim in suspend is still in Follow-Up and can be viewed by checking the Suspend "ALL" checkbox in the Follow-Up Find Window.

Claims can only leave Follow-Up by being paid/adjusted to zero, re-submitted or transferred to the patient. Note also that if a claim is re-submitted, and later returns to Follow-Up, it will return with all previous Actions and Notes.

Action Find Criteria Window



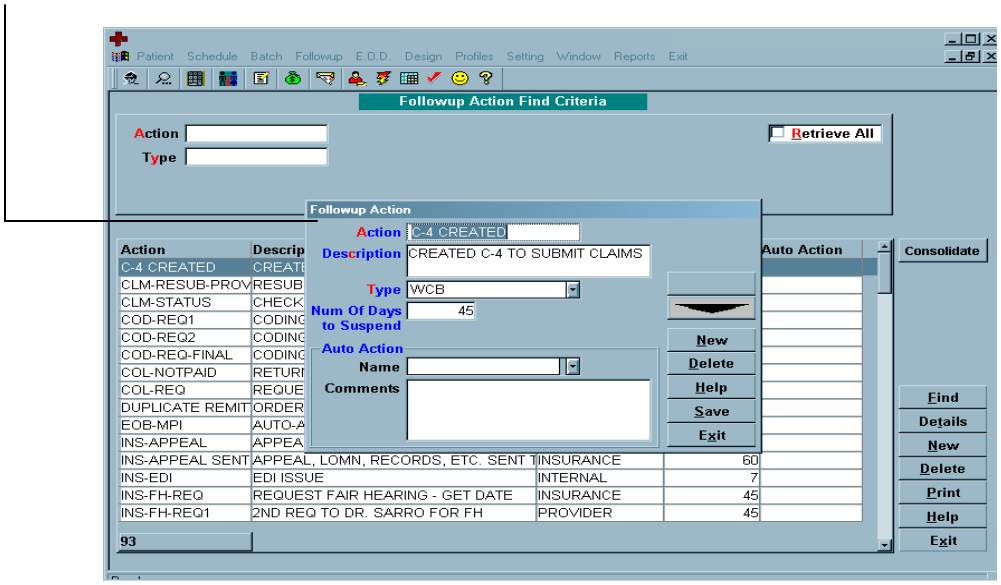
Field	Description
Action	**The name assigned to the Action. Some examples of useful Actions:**

Action	Description	action_type	num_days_to_suspend
CLM-RESUB-PROVID	RESUBMIT WITH CORRECTED PROVIDER INFO	CLAIM	30
CLM-STATUS	CHECK ON STATUS OF THIS CLAIM	CLAIM	0
COD-REQ1	CODING REQUEST #1	CODING	15
COD-REQ2	CODING REQUEST #2	CODING	15
COD-REQ-FINAL	CODING REQUEST FINAL	CODING	15
COL-NOTPAID	RETURNED BY COLLECTION AGENCY NOT PAID	COLLECTIONS	0
COL-REQ	REQUEST FOR INFORMATION SENT TO COLLECTION AGENCY	COLLECTIONS	20
DUPLICATE REMITTANCE	ORDER A DUPLICATE REMITTANCE	INSURANCE	30
EOB-MPI	AUTO-ACTION FROM ELECTRONIC REMITTANCE	INSURANCE	0
INS-APPEAL	APPEAL TO INSURANCE COMPANY	INSURANCE	45
INS-FH-REQ	REQUEST FAIR HEARING - GET DATE	INSURANCE	45
INS-FH-SET	FAIR HEARING DATE SET - WAIT FOR RESULT	INSURANCE	90
INS-LAWJUDGE	ADMINISTRATIVE LAW JUDGE CASE	INSURANCE	10
INS-LEFTMESSAGE	LEFT MESSAGE WITH INSURANCE COMPANY	INSURANCE	10
INS-PENDING	CLAIM IS PENDING BY INSURANCE CARRIER	INSURANCE	0
INS-REPROCESS	CARRIER REPROCESSSING CLAIM	INSURANCE	20
INS-RESUB	RESUBMIT TO CARRIER (NEVER RECEIVED)	INSURANCE	30
INS-RESUB-ADDL	RESUBMIT WITH ADDITIONAL INFORMATION	INSURANCE	20
INS-REVIEW	IN REVIEW BY CARRIER	INSURANCE	0
INS-UT-HOLD	UT HOLD	INSURANCE	60
INT-HOLD-120	HOLD 120 DAYS	INTERNAL	120
INT-HOLD-30	HOLD 30 DAYS	INTERNAL	30
INT-HOLD-60	HOLD 60 DAYS	INTERNAL	60
INT-HOLD-90	HOLD 90 DAYS	INTERNAL	90
INT-MAIL RETURNED	RETURNED MAIL - ATTEMPTING TO LOCATE PATIENT	INTERNAL	0
LAW-ARB-120	IN ARBITRATION - HOLD 120 DAYS	LAWYER	120
LAW-ARB-180	ARBITRATION - HOLD FOR 180 DAYS	LAWYER	180
LAW-ARB-60	IN ARBITRATION - HOLD 60 DAYS	LAWYER	60
LAW-ARB-90	IN ARBITRATION - HOLD 90 DAYS	LAWYER	90
LAW-CONT	CONTROVERTED CASE - SEND TO LAWYER	LAWYER	30
LAW-LIEN	LIEN PLACED WITH PATIENTS ATTORNEY	LAWYER	15
LAW-REQ	REQUESTED INFORMATION FROM LAWYER	LAWYER	20
LAW-REQ1	REQUEST SENT TO ATTORNEY FIRST TIME (ARB, LIEN, COURT DATE, ETC)	LAWYER	60

LAW-REQ2	SECOND REQUEST TO LAWYER (ARB, LIEN, CT DATE, ETC)	LAWYER	60
LAW-REQ-FINAL	FINAL REQUEST TO LAWYER (ARB, LIEN, CT DATE, ETC)	LAWYER	60
LAW-REQ-MGMT	LAWYER REQUEST SENT TO MANAGEMENT	LAWYER	0
PAT-BILL-PATIENT	BILL PATIENT	PATIENT	0
PAT-PAID	PAYMENT SENT TO PATIENT - REQUEST PAYMENT FROM PATIENT	PATIENT	20
PAT-REQUEST	REQUEST INFORMATION FROM PATIENT	PATIENT	20
PAY-POST	POSTED PAYMENT W/O EOB	PAYMENTS	0
PAY-WRITE-OFF	WRITE OFF BASED ON EOB/CLAIM ANALYSIS	PAYMENTS	0
PRV-REQ	REQUEST ADDITIONAL INFORMATION FROM PROVIDER	PROVIDER	20
PRV-REQ2	SECOND REQUEST TO PROVIDER	PROVIDER	20
PRV-REQ-FINAL	FINAL REQUEST TO PROVIDER	PROVIDER	20
PRV-REQ-MGMT	PROVIDER NOT COOPERATING - MGMT ISSUE!!	PROVIDER	5
PRV-RETURN-CK	RETURN CK TO INSURANCE	PROVIDER	45
PRV-WRITE-OFF	WRITE OFF AT PROVIDER REQUEST	PROVIDER	0

Type **Follow-Up Type assigned to Action**

Action Window



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INS-LEFTMESSAGE	LEFT MESSAGE WITH INSURANCE COMPANY	INSURANCE	10
INS-PENDING	CLAIM IS PENDING BY INSURANCE CARRIER	INSURANCE	0
INS-REPROCESS	CARRIER REPROCESSSING CLAIM	INSURANCE	20
INS-RESUB	RESUBMIT TO CARRIER (NEVER RECEIVED)	INSURANCE	30
INS-RESUB-ADDL	RESUBMIT WITH ADDITIONAL INFORMATION	INSURANCE	20
INS-REVIEW	IN REVIEW BY CARRIER	INSURANCE	0
INS-UT-HOLD	UT HOLD	INSURANCE	60
INT-HOLD-120	HOLD 120 DAYS	INTERNAL	120
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INT-HOLD-60	HOLD 60 DAYS	INTERNAL	60
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INT-MAIL RETURNED	RETURNED MAIL - ATTEMPTING TO LOCATE PATIENT	INTERNAL	0
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LAW-REQ	REQUESTED INFORMATION FROM LAWYER	LAWYER	20

LAW-REQ1	REQUEST SENT TO ATTORNEY FIRST TIME (ARB, LIEN, COURT DATE, ETC)	LAWYER	60
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LAW-REQ-FINAL	FINAL REQUEST TO LAWYER (ARB, LIEN, CT DATE, ETC)	LAWYER	60
LAW-REQ-MGMT	LAWYER REQUEST SENT TO MANAGEMENT	LAWYER	0
PAT-BILL-PATIENT	BILL PATIENT	PATIENT	0
PAT-PAID	PAYMENT SENT TO PATIENT - REQUEST PAYMENT FROM PATIENT	PATIENT	20
PAT-REQUEST	REQUEST INFORMATION FROM PATIENT	PATIENT	20
PAY-POST	POSTED PAYMENT W/O EOB	PAYMENTS	0
PAY-WRITE-OFF	WRITE OFF BASED ON EOB/CLAIM ANALYSIS	PAYMENTS	0
PRV-REQ	REQUEST ADDITIONAL INFORMATION FROM PROVIDER	PROVIDER	20
PRV-REQ2	SECOND REQUEST TO PROVIDER	PROVIDER	20
PRV-REQ-FINAL	FINAL REQUEST TO PROVIDER	PROVIDER	20
PRV-REQ-MGMT	PROVIDER NOT COOPERATING - MGMT ISSUE!!	PROVIDER	5
PRV-RETURN-CK	RETURN CK TO INSURANCE	PROVIDER	45
PRV-WRITE-OFF	WRITE OFF AT PROVIDER REQUEST	PROVIDER	0

Description **Textual description of Actions**

Type **Follow-Up Type assigned to Action**

Num of Days to Suspend **The number of days to suspend the claim**

Auto Action

Name **Name of Auto Action**

Comments **Any comment related to the auto action**

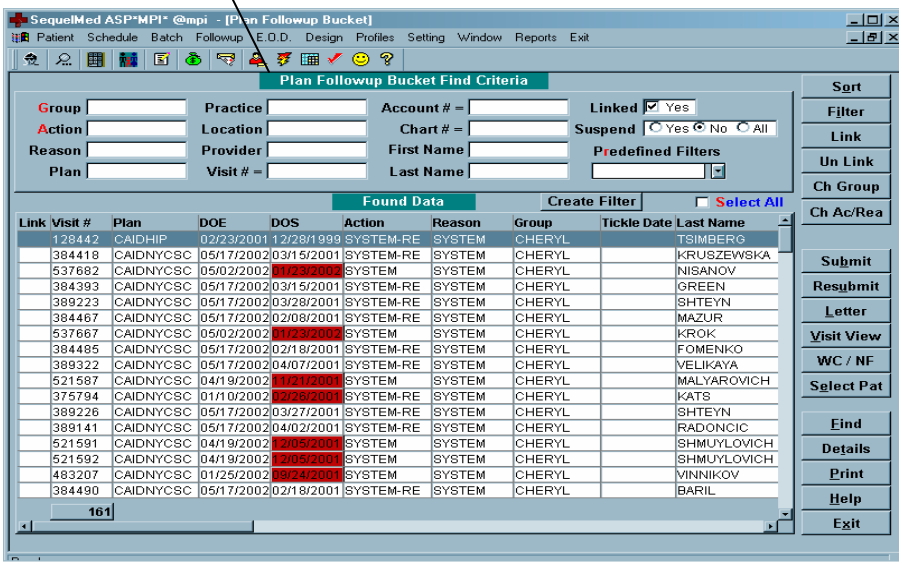
FOLLOW-UP BUCKET: Plan/Patient

The Follow-Up Bucket is the core of SequelMed's Plan and Patient follow-up and collections activity. It is intended to be a complete and paperless set of tools that allow the user to completely, efficiently and easily bring all outstanding claims to resolve.

Plan/Patient Follow-Up Bucket

Collections efforts proceed by isolating through the FOLLOW-UP BUCKET FIND window a set of outstanding claims. Next the isolated claims are then worked in the FOLLOW-UP BUCKET window either individually or in linked visit groupings (ex: all visits from one case or patient). FOLLOW-UP BUCKETS provide all the information and tools necessary to call carriers or patients, take notes, keep ACTION, CALL, REASON and GROUP histories, write letters, assign ticklers, correct charges, resubmit claims, post payments/write-offs, transfer charges, etc.

Plan/Patient Follow-Up Bucket Find Criteria Window



The Plan/Patient Follow-up Bucket Find window is the starting point for any follow-up session. From here, the user isolates areas of focus by providing Find criteria or using pre-defined filters. Areas of any focus can be easily constructed utilizing expansive find criteria along with customizable pre-defined filters and sorts.

In the Follow-Up Bucket Find window, visits can be linked so multiple related visits can be worked simultaneously. Linking visits is only within Follow-Up and will not effect claim financials or printing.

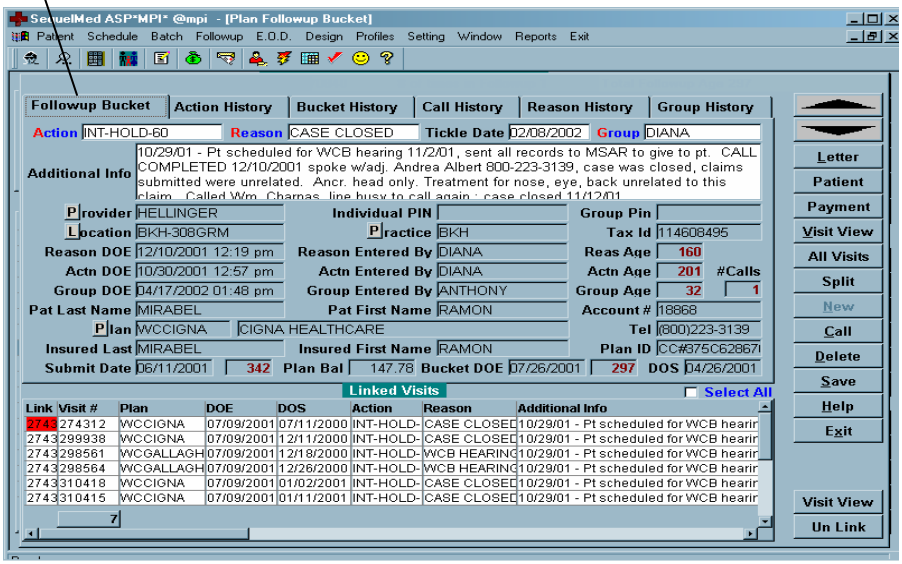
Examples of isolated follow-up efforts might include:

- Visits not worked
- Specific payor lists
- Items over 120 days
- Claims over $200
- Unresolved ticklers
- Re-submitted claims returning to follow-up
- Etc.

It is good practice to define a comprehensive set of pre-defined filters that suit your organization's collections style and methods, and use them weekly as the basis of your follow-up efforts.

Once a list of claims to follow-up on has been isolated, the user selects the first open item on the list and enters the Follow-Up Bucket for that item. Items are processed in order to completion after which a new set of open items, with a new criterion is isolated by the user and the collections process continues.

Follow-Up Bucket Window



The Follow-Up Bucket window for Plan and Patient is a tabbed screen. The primary window in which Follow-Up efforts transpire is the Follow-Up Bucket screen. The other five tabbed screens are history screens that display Action, Bucket, Call, Reason and Group histories respectively.

Histories show longitudinal records of each type of activity. For example, Action history will record and indicate all actions that were taken on the item in the Follow-Up bucket prior to the most current Action indicated in the Follow-Up Bucket. Along with the history is the number of days the item was in the bucket before it was changed and any notes that were archived. The user accesses the history screens by clicking on the desired tab. Call histories also include duration of calls made.

At the top of the Follow-Up Screen the Visit #, the number of times the claim has been in Follow-Up and the Total Follow-Up Age (Sum of the number of days the item has been in Follow-Up for all times in Follow-Up).

At the bottom of the Follow-Up bucket is a display of any Linked visits. The linked visits can be dragged and dropped into the Bucket area to make that visit information displayed. There is a Select All Checkbox that the user can check to unlink all visits in one action.

The Follow-Up Bucket screen serves as a platform from which to perform follow-up and collections efforts on plan balances. From here, the user can record notes, write letters, make calls, set ticklers, apply payments, change charge or demographic data and re-submit claims.

Each item in Follow-Up has an Action, Reason and Group assigned to it at all times.

The Group is the owner of the follow-up item, upon entry to Follow-Up defined by User, Place of Service, Plan Type(s), Plan Category, Location(s), and Provider(s). Any user of Follow-Up can easily change Groups, passing follow-up responsibilities for a claim or group of claims to another user. Group histories, along with all notes can be easily viewed by clicking the Group History Tab.

As mentioned in Follow-Up Bucket Introduction, Claims/Items/Visits make it to FOLLOW-UP via one of four methods:

- PLAN OUTSTANDING DAYS
- ELECTRONIC REMITTANCE DENIALS
- USER PLACED FOLLOW-UP ITEMS
- RESUBMISSIONS

Depending on the method of entry, an Action and Reason will be assigned to the visits as they enter Follow-Up.

If the visit enters Follow-Up as a result of Plan Outstanding Days both Action and Reason are set to "SYSTEM" indicating the item was automatically placed there as a result of the payment time limit (set in PLAN profiles) and that the claim has not been worked (reason for non-payment unknown).

If the visit is placed into Follow-Up as a result of Electronic Remittance Denials, the Action is set to EOB indicating that the System automatically placed the visit into Follow-Up. The Reason is set to a representation of the Denial Code accompanying the electronic remittance information for that line item (see Reason Code and Reason Mapping). Any Visit/Date of Service claim messages are recorded in the Notes (see Remittance Messages).

Note that sometimes there is more than one Denial Code returned for one visit (i.e. each line item might have a distinct reason for denial). In this case, the Reason is mapped to the first Denial Code encountered, and remaining codes are placed into the Notes with the associated procedure codes.

At any time, any authorized User can send a visit to Follow-Up. Often Users who post payments send denied or questioned claims to Follow-Up. With this method, the User specifies the Action and Reason at the time he/she sends the claim to Follow-Up.

Lastly, if the item is placed into Follow-Up as a result of a Re-Submission, the Action is set to SYSTEM-RE indicating that it was set automatically by the system as a result of the payment time limit (set in PLAN profiles). If the item has never been in Follow-Up before, the Reason is set to 'SYSTEM'. If the item is returning to Follow-Up, as is usually the case when an item has been Re-Submitted as a result of a prior Follow-Up effort, the Reason is maintained as when the claim was Re-Submitted.

At any time, the user has the option to Split a visit in the Follow-Up Bucket so the visit can be pursued through Follow-Up as two or more distinct claims. This allows, for example, a user to pursue a medically unnecessary charge line item by requesting the letter from the provider while at the same time, following-up with the carrier on a procedure lacking prior-authorization, both originally part of the same visit/date of service.

When a new Action/Reason is required, the user changes the respective Action/Reason Code, adding the current Action/Reason Code to its respective history. This way, all sequences of Action/Reasons taken is recorded along with all associated notes and viewable by clicking the Action/Reason History Tab.

Usually an Action has an associated number of days to Suspend the visit (set a Tickler). For example, if the Action is to request a letter of medical necessity (LOM) from the Provider, the user might define an Action 'PROVIDER REQUEST' and have the Tickler automatically set to 20 days out. Of course, the User at any time can set the Tickler (number of days to suspend) to any desired Date, overriding the Action Code default.

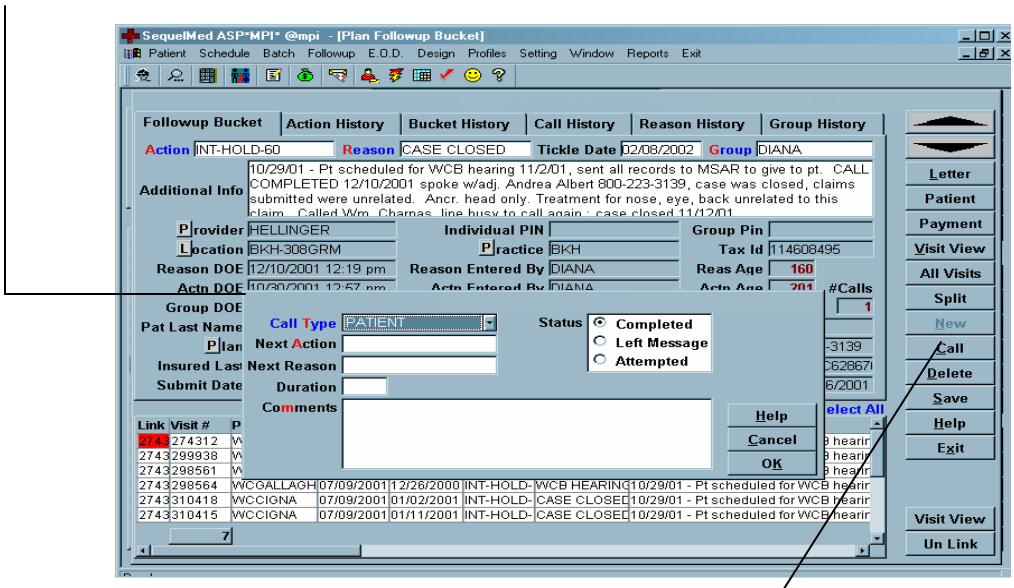
Note a claim in suspend is still in Follow-Up and can be viewed by checking the Suspend “ALL” checkbox in the Follow-Up Find Window.

Claims can only leave Follow-Up by being re-submitted, paid/adjusted to zero or transferred to the patient. Note also that if a claim is re-submitted, and later returns to Follow-Up, it will return with all previous Actions and Notes.

All information necessary to perform follow-up efforts is on screen or instantly accessible directly from the Follow-Up Bucket screen.

All phone calls to Insurance companies, Patients, Providers, Agencies and Lawyers are tracked and processed through the Follow-Up Call Center (see Below).

Follow-Up Call Center Window



The Follow-Up Call Center, which opens when you click on the call button, allows the User, while on the phone with a insurance carrier, patient, provider, agency or lawyer to log call duration, take notes (attached to the call), set next Action and/or Reason, and with the click of the mouse, log whether the call was Completed, Left a Message, or Attempted.

All calls are automatically time stamped, entered into the notes with the call results as well as logged in Call history. Call frequencies and durations can be retrospectively audited by Plan, Provider, Group, etc. to identify internal (employee or account) or external (carrier, agency or lawyer) time wasters.

Field	Description
Call Type	**Type of call (i.e. insurance, provider, lawyer, patient, etc.)**
Next Action	**Having made the call you decide what next action needs to be taken on this claim**
Next Reason	**Having made the call you put in the next reason for which the claim is or has been denied**
Duration	**Duration of the call (Note: SequelMed automatically tracks the duration of the call from the time this call center window is opened**

	till the time it is closed. Since one can be on hold during a call session, in the comments section you can put how long you were on hold)
Comments	**Comments, if any (for example: “was on hold for 20 minutes”)**
Status	**Status of the call i.e. whether the call was completed, or a message was left, or the call was attempted but there was no answer or you got a busy signal. Detailed comments may be noted in the Comments field**