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.).

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

- 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

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|----------|------------------------------|-----------|----------------------------|--------------|------------|-----|---------------|
| Reaso | Action | | Insurance Vendor | | Retrieve / | XII | |
| FollowUp | | Fou | nd Data FollowUp Reasor | Flect Vendor | Insurance | | |
| CO18 | | EOB-MPI | DUPLICATE SERV | | BCBSEMP | | |
| 042 | Charges exceed our fee | | EXCEED CHARGE | | BCBSEMP | | |
| OB18 | Claim/service denied hec | | INVALID CODE/CO | | BCBSEMP | | |
| PR31 | Claim denied as patient (| EOB-MPI | INVALID PAT ID | EMPIRE | BCBSEMP | | |
| 058 | Claim/service denied/red | | INVALID POS | EMPIRE | BCBSEMP | | |
| 029 | The time limit for filing ha | EOB-MPI | LATE FILING | EMPIRE | BCBSEMP | | |
| 096 | Non-covered charges. | EOB-MPI | NOT COVERED S | EEMPIRE | BCBSEMP | | |
| PR46 | This (these) service(s) is | EOB-MPI | NOT COVERED S | EEMPIRE | BCBSEMP | | F1 1 |
| 050 | These are non-covered s | EOB-MPI | MEDICALLY UNNE | EMPIRE | BCBSEMP | | <u>F</u> ind |
| DA22 | Claim denied because th | EOB-MPI | COB - COVERED | EMPIRE | BCBSEMP | | Details |
| PR28 | Coverage not in effect at | EOB-MPI | COVERAGE TERM | /IEMPIRE | BCBSEMP | | New |
| 057 | Claim/service denied/red | EOB-MPI | MEDICAL JUSTIFI | CEMPIRE | BCBSEMP | | Delete |
| 097 | Payment is included in the | EOB-MPI | BUNDLED (INCL I | EMPIRE | BCBSEMP | | |
| COB7 | This provider was not cer | EOB-MPI | NOT CERTIFIED | EMPIRE | BCBSEMP | | <u>P</u> rint |
| 0109 | Look up EOB reason tex | EOD MDI | OTHER | EMPIRE | BCBSEMP | | Help |

| 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)

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| Reaso | n Code | \rightarrow | | nsurance | | Retrieve A | JI | |
| | Action | | 7 | Vendor | | | | |
| | | | λ | venuor | | | | |
| FollowUp | Reason | | | | | | | |
| | | | | | | | | |
| | | | Found D | | | | | |
| Reason Co | | | Action | FollowUp Reason | | Insurance | _ | |
| 018 | | | EOB-MPI | DUPLICATE SERV | | BCBSEMP | | |
| 042 | Charç | Remittance Code a | | EXCEED CHARGE | PIPE | BCBSEMP | | |
| COB18 | | | | | | BCBSEMP | | |
| PR31 | Clain | Remittance Code | CO18 | | | BCBSEMP | | |
| 058 | Claim | Action | EOB-MPI | _ | | BCBSEMP | | |
| 029 | The t | Eollowlin Doscon | DUPLICATE SERV | ICE | | BCBSEMP | | |
| 096 | Non-o | | | | | BCBSEMP | | |
| PR46 | This (| Electronic Vendor | | | <u>N</u> ew | BCBSEMP | | Fine |
| 050 | These | Insurance | BCBSEMP | | <u>D</u> elete | BCBSEMP | | |
|)A22 | Claim | Reason Text | Duplicate claim/ser | vice. | Help | BCBSEMP | | De <u>t</u> ai |
| PR28 | Cover | | | | | BCBSEMP | | New |
| 057 | Claim | | | | <u>S</u> ave | BCBSEMP | | Delet |
| 097 | Payn | | | | Exit | BCBSEMP | | |
| OB7 | This | | | · · · · · · · · · · · · · · · · · · · | | BCBSEMP | | <u>P</u> rin |
| | | up EOB reason text | OD MDI | OTHER | EMPIRE | BCBSEMP | | Help |

Remittance Code and Reason Mapping Window

Field

Remittance Code

Description

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) |

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.

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| | Remittance Messages Find Criteria | | | |
| Message Code | Insurance | | Retrieve All | |
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| | venuor | | | |
| | | | | |
| | Found Data | | | İ |
| Message Code | Message Text | Vendor | Insurance | |
| MAN1 | Services can be appealed if you do not agree with the med | | BCBSEMP | |
| M25 | The information furnished does not substantiate the need to | | BCBSEMP | |
| MADB | Look up message text! | EMPIRE | BCBSEMP | |
| MAD3 | If services is greater than \$100 and you do not agree with | mEMPIRE | BCBSEMP | |
| MA09 | Look up message text! | EMPIRE | BCBSEMP | |
| MA13 | Patient can not be billed for any amount that is not reporte | edEMPIRE | BCBSEMP | |
| MA15 | Your claim has been separated. | EMPIRE | BCBSEMP | |
| MA18 | Claim was forwarded to the patient's secondary insurance | c EMPIRE | BCBSEMP | Eind |
| MA19 | Look up message text! | EMPIRE | BCBSEMP | <u> </u> |
| MA25 | The information furnished does not substantiate the need t | for EMPIRE | BCBSEMP | De <u>t</u> ail |
| MA27 | Incorrect Medicare number | EMPIRE | BCBSEMP | New |
| MA61 | Did not correctly enter the patient's social security or heal | thEMPIRE | BCBSEMP | Delete |
| MA67 | Correction to a prior claim | EMPIRE | BCBSEMP | |
| MA72 | The beneficiary overpaid you for these assigned services. Missing Physician's Medicare number, billing name, addre | | BCBSEMP | <u>P</u> rint |
| MA82 | | | BCBSEMP | |

Remittance Messages Find Criteria Window

| <u>Field</u> | 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

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| Message Code 🛛 | | Insurance | | | Retrieve All | |
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| | | Found Data | | | | a. |
| Message Code //A01 | Message Text | ealed if you do not agree with | Venc | | Insurance | |
| //25 | | shed does not substantiate th | | | BCBSEMP | |
| //A08 | Remittance Message | | e need tojcivit | | CBSEMP | |
| MAD3 | Message Code | | | | CBSEMP | |
| /A09 | - | | | | CBSEMP | |
| /A13 | Electronic Vendor | | | | CBSEMP | |
| /A15 | Insurance | BCBSEMP | | | CBSEMP | 1 |
| /A18 | Message Text | Services can be appealed if y | /ou do not | <u>N</u> ew | CBSEMP | Eind |
| v1A19 | | agree with the medicare app | roved amount | <u>D</u> elete | CBSEMP | |
| 1A25 | | within 6 months | | Help | CBSEMP | Details |
| /A27 | _ | 1 | | | CBSEMP | New |
| /IA61 | _ | 1 | | <u>S</u> ave | CBSEMP | Delete |
| MA67 | _ | | | E <u>x</u> it | CBSEMP | |
| MA72 | | March Joo for those according to a | | | | <u>P</u> rint |
| MA82 | IVIISSING Physician's | Medicare number, billing nam | ie, addres∣EMP | IRE | BCBSEMP | <u>H</u> elp |
| | | | | | | |

| <u>Field</u> | 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

| | P*MPI* @mpi - [Followup Call Center Call Type] | |
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| | Followup Call Center Call Type Find | |
| Call Type | | Retrieve All |
| | | |
| | | |
| | | |
| <u> </u> | Found Data | |
| Call Type | Comments | - |
| PROVIDER | CALLS TO PROVIDERS | |
| INSURANCE | CALLS TO INSURANCE | |
| PATIENT | CALLS TO PATIENTS | |
| LAWYER | CALLS TO LAWYER | |
| WC BOARD | Workers' Comp. Board | |
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| <u>Field</u> | 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

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| | | Follow | rup Call Center Call Type Find | | | |
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| | Call Type | | | ⊢ <u>K</u> eun | eve All | |
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| | | | Found Data | | | |
| | Call Type | Comments | | | E E | |
| | PROVIDER | CALLS TO PROVIDERS | | | | |
| | INSURANCE | CALLS TO INSURANCE | | | | |
| | PATIENT | CALLS | I Center Call Type | × – | | |
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| | | | | New | Eind | |
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| | | | | Help | Details | |
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| <u>Field</u> | | Descripti | <u>on</u> | | | |
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| Call Type | | The Call | Type describes the | ne recipient of | the call. Exal | mples of |
| | | Types inc | clude: | | | |
| | | | | | | |
| | | PROVIDE | R = Calls to Provi | iders | | |
| | | INSURAN | ICE = Calls to insu | trance carriers | | |
| | | | | | 1 | |
| | | PATIENT | = Calls to patient | S | | |
| | | | = Calls to lawyers | | | |
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Comments

Description of the defined Call Types or any other comments, if any

Call

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

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|----------------|--|--------------------------|------------------|
| | Predefined Filters Find Criteria | | |
| Name | | Retrieve All | |
| | Found Data | | |
| lame | Filter Script Acce | ss Entry Date Entered By | 4 |
| KT_DOE_120 | date(doe) < relativedate(today(), -120) All | 10/30/2000 04 SEQUELMED | |
| YS_DOE_120 | action = 'SYSTEM' and date(doe) < relativedate All | 11/24/2000 04DIANA | |
| YS_DOE_30 | action = 'SYSTEM' and date(doe) <= relativedAll | 12/16/2000 06SEQUELMED | |
| YS_DOE_90 | action = 'SYSTEM' and date(doe) <= relativedAll | 12/16/2000 06 SEQUELMED | |
| YSTEM-RE | action = 'SYSTEM-RE' All | 11/24/2000 05 DIANA | |
| YS_DOE_60 | action = 'SYSTEM' and date(doe) <= relativecAll | 12/11/2000 08JACKIEM | |
| ICKLE_30 | date(tickle_date) <= relativedate(date(today))All | 12/16/2000 06 SEQUELMED | - |
| CTION_60 | action <> 'SYSTEM' and date(ac_doe) <= reAll | 12/16/2000 06SEQUELMED | Find |
| NN | action_entered_by = 'ANN' All | 12/16/2000 07SEQUELMED | |
| OB | reason_enterd_by = 'EOB' All | 12/16/2000 07SEQUELMED | De <u>t</u> ails |
| TIME F/U > 2 | num_times_in_followup >0000002 All | 12/17/2000 03SEQUELMED | New |
| OE < 200 DAYS | date(doe) < relativedate(today(), - 200) All | 03/23/2001 04DIANA | Delete |
| OE>200 DAYS | date(doe) > relativedate(today(), - 200) All | 03/27/2001 03CHERYL | |
| RITICAL FILTER | date(dos) < relativedate(today(), - 60) AND (plan All | 05/21/2001 04CHERYL | Print |
| | date(dos) < relativedate(today(), - 120) AND (plarAll | 05/31/2001 12CHERYL | <u>H</u> elp |
| SHICRIT | | | |

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. |

<u>GROUP</u>

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.

| Patient Schedule Batch F | | | Setting Wind | ow Reports | Exit | | _ 0 |
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| Followup Group | | | | | | Retrieve All | |
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| | Followup Gro | | | | | | |
| | – Followup Group | Plan Category Assigned | Location Assigned | Provider Assigned | Patient Class | | 1 |
| Followup Group | D Group | SQLMED | _ | | | - | Consolida |
| SQLMED 11 SEQUEL-WC | POS Code | 11 | | | | | |
| SEQUEL-NF | Plan Type | Medical | 1- | | | | |
| SEQUELMED 11 | Plan Type | Medical | | | | | |
| | Active | Yes |] | | New | | |
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| | | | | | nerp Save | | Details |
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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

| 🖡 🏭 Patient Schedule Batch F | llowup E.O.D. Design Profiles Setting Window Reports Exit | _[D] _[B] |
|---|---|------------------------|
|] 党 🖳 🔠 🖬 🖬 🗴 | Image: Specific state Image: Specific state Followup Group Find Criteria | 1 |
| Followup Group | E Betri | eve All |
| | Followup Group Followup Plan Category Location Provider Patient Group Assigned Assigned Class | |
| Followup Group PC SQLMED 11 SEQUEL-WC | | Consolidate |
| SEQUEL-NF SEQUELMED 11 | Plan Type Medical | |
| | Active Ves New Comment Delete | |
| | Help Save | <u> </u> |
| | <u> </u> | <u>N</u> ew Delete |
| | | <u>P</u> rint Help |
| 4 | | <u>→</u> E <u>x</u> it |

| <u>Field</u> | 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. |



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.

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| | Followup Grou | p Find Criteria | |
| Followup Group | | | Retrieve All |
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| | Followup Group | | 1 1 |
| | Followup Plan Category | Location Provider Patient | |
| | Group Assigned | Assigned Assigned Class | |
| Followup Group PO | | • | - Consolidate |
| SQLMED 11 | SEQUELMED - | | |
| SEQUEL-WC SEQUEL-NF | SEQ HOSP | | |
| SEQUELMED 11 | | | |
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| | | New | |
| | | Delete | Details |
| | | Help | <u>New</u> |
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| | | | <u>Print</u> |
| | | | <u>Help</u> |
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| | | | |

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.

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| Followup Group | | | | Retrieve All | |
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| | Followup Group | | | | |
| | - Followup Plan Cate | egory Location Provi | der Patient | | |
| | Group Assigned | | | | |
| Followup Group PC | D Provider | | | - | Consolidate |
| SQLMED 11 | SQL 🗾 | | | | |
| SEQUEL-WC | DSQL | | | | |
| SEQUEL-NF SEQUELMED 11 | - | | | | |
| SEGUELMED | | | | | |
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| | | Delete | - | | Details |
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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.



<u> TYPE</u>

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

| <u> </u> | | | |
|--------------------|--|---------------|--------|
| | l* @mpi - [Followup Type] | | _ 0 |
| Patient Schedule B | atch Followup E.O.D. Design Profiles Setting Window Reports Exit | | - 8 |
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| | Followup Type Find Criteria | | |
| Type | r | Retrieve All | |
| | | E Realeve All | |
| Description | | | |
| | | | |
| | | | |
| | Found Data | | |
| Туре | Description | - Conso | lidate |
| INSURANCE | INSURANCE | | |
| PROVIDER | PROVIDER | | |
| INTERNAL | INTERNAL | | |
| WCB | WORKER'S COMPENSATION BOARD | | |
| COLLECTIONS | COLLECTION AGENCY | | |
| LAWYER | ATTORNEY OR LAW FIRM | | |
| PATIENT | PATIENT | | |
| CLAIM | BILLING, CODING OR INFO. ISSUE | <u> </u> | nd |
| PAYMENTS | PAYMENT, W/O, ADJ. OR FEE SCHEDULE ISSUE | Deta | ails |
| CODING | CODING | Ne | |
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Field

Description

Туре

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

| Type Retrieve All Description Found Data Type Description INSURANCE INSURANCE PROVIDER PROVIDER INTERNAL Followup Type VCB COLLECTIONS COLLECTIONS C CAIMM B PATIENT P Delete Good C CODING C | K | i 💩 🐄 🌲 🖸 🎟 🗸 😕 😵 🔤 Followup Type Find Criteria | |
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| INTERNAL Followup Type WCB W COLLECTIONS C INSURANCE LAWYER A Description INSURANCE PATIENT P CLAIM B PAYMENTS P CODING C | | | |
| WCB W COLLECTIONS C LAWYER A Description INSURANCE PATIENT P CLAIM B PAYMENTS P CODING C | | | |
| COLLECTIONS C Type INSURANCE LAWYER A Description INSURANCE PATIENT P CLAIM B PAYMENTS P CODING C Bave | | N Followup Type | |
| CODING C C Description INSURANCE New CLAIM B CODING C C Help Save | | | |
| PATIENT P CLAIM B PAYMENTS P CODING C CODING C | COLLECTIONS | C | |
| CLAIM B PAYMENTS P CODING C B B CODING C B B C C C C C C C C C C C C C | | | |
| CAIMENTS P CODING C Save | PATIENT | | Nau |
| CODING C | CLAIM | B | |
| CODING C | PAYMENTS | | <u>D</u> elete |
| | CODING | C | |
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| E <u>x</u> it | | | |
| | | | Exit |
| | | | |

Description Field Туре Type definition names. Some examples of useful types: INSURANCE • • PROVIDER INTERNAL • WORKERS COMP • COLLECTIONS • • LAWYER PATIENT • CLAIM ٠ 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

| | *MPI*@mpi -[Follow-up Reason] • Batch Follow-up E.O.D. Design Profiles Setting Window Reports Exit | | <u>_ </u> _ |
|---------------|---|------------|----------------|
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| | Followup Reason Find Criteria | | |
| Reason | Туре | Retrieve A | |
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| | Found Data | | |
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| Reason | | ype | Consolidate |
| | | ROVIDER | |
| | | | |
| | | NSURANCE | |
| | | | |
| NVALID CODE/C | | PATIENT | |
| | IFO INVALID INSURANCE. PLAN OR PLAN ADDRESS ON SUBMITTER | | |
| NVALID POS | | | |
| ATE FILING | | | <u> </u> |
| | | SURANCE | Details |
| IO INSURANCE | | PATIENT | New |
| | | ROVIDER | |
| | PCINO PRECERTIFICATION BY PCP (PRIMARY CARE PROVIDER) P | | <u>D</u> elete |
| NO PRIOR AUTH | | ROVIDER | Print |
| | NO REFERRAL AT TIME OF SERVICE P | ROVIDER | Help |
| NO REFERRAL | | | Terb |
| NO REFERRAL | | | - Exit |

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

Follow-Up Type Assigned to the Reason

Туре

Textual description of the Reason

Description

Reason Window

| | Follow | up Reason Find Criteria | | | |
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| Reason | | Туре | | Retrieve Al | - |
| Description | | - | | - Realists in | |
| Description | | | | | |
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| Reason | Description | | Туре | | Consolidate |
| | REA CONCURRENT TREATMEI | | | VIDER | |
| | VICEDUPLICATE CLAIM OR SE | RVICE. | | RANCE | |
| | S PROV Followup Reason | | | RANCE | |
| EXCEED # SERV | | CURRENT TREATM | | RANCE | |
| INVALID CODE/C | INVAL Type PROV | /IDER | | M ENT | |
| INVALID PAT ID | D I U D D U | URRENT TREATMENT | | | |
| INVALID POS | | SAME CONDITION | <u>N</u> ew All | | |
| LATE FILING | CLAIM | | Delete All | | <u> </u> |
| NOT COVERED S | | | | RANCE | Details |
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| NO PRIOR AUTH | NO PRIOR AUTHORIZATIC | NAT HUL OF SERVICE | | /IDER | <u>P</u> rint |
| NO REFERRAL | NO REFERRAL AT TIME C | F SERVICE | PROV | VIDER | Help |
| | | | | | |

ReasonThe name assigned to the Reason. Some examples of reasons are:
(see above)TypeFollow-Up Type Assigned to the ReasonDescriptionTextual 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.

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| | | Followup | o Action Fin | d Criteria | | | | |
| Action | | | | | | Detri | ieve All | |
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| Type | | | | | | | | |
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| Action | Description | | - | Туре | | Days To SuspAuto Act | ion 🔄 | Consolidate |
| C-4 CREATED | CREATED C-4 | TO SUBMIT CLA | IMS Y | WCB | | 45 | | |
| CLM-RESUB-PF | ROVRESUBMIT W | ITH CORRECTED | PROVIDEF | CLAIM | | 30 | | |
| CLM-STATUS | CHECK ON ST | TATUS OF THIS C | LAIM I | CLAIM | | 0 | | |
| COD-REQ1 | CODING REQ | UEST #1 | | CODING | | 15 | | |
| COD-REQ2 | CODING REQ | UEST #2 | | CODING | | 15 | | |
| COD-REQ-FINA | L CODING REQ | UEST FINAL | | CODING | | 15 | | |
| COL-NOTPAID | RETURNED B | Y COLLECTION A | GENCY NO | COLLECTI | ONS | 0 | | |
| COL-REQ | REQUEST FO | R INFORMATION | SENT TO Q | COLLECTI | ONS | 20 | | Find |
| DUPLICATE RE | MIT ORDER A DUP | PLICATE REMITTA | ANCE I | INSURANC | E | 30 | | |
| EOB-MPI | AUTO-ACTION | I FROM ELECTRO | DNIC REMIT | INSURANC | E | 0 | | Details |
| NS-APPEAL | APPEAL TO IN | NSURANCE COM | PANY I | INSURANO | E | 45 | | New |
| NS-APPEAL SE | ENT APPEAL, LON | IN, RECORDS, E | TC. SENT T | INSURANC | E | 60 | | Delete |
| NS-EDI | EDI ISSUE | | 1 | INTERNAL | | 7 | | |
| NS-FH-REQ | REQUEST FA | IR HEARING - GE | T DATE | INSURANC | E | 45 | | <u>P</u> rint |
| NS-FH-REQ1 | 2ND REQ TO I | DR. SARRO FOR | FH I | PROVIDER | 2 | 45 | | <u>H</u> elp |
| | | | | | | | | |
| 93 | | | | | | | | Exit |

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 | 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 | COLLECTION S | 0 |
| COL-REQ | REQUEST FOR INFORMATION SENT TO COLLECTION AGENCY | COLLECTION S | 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 | 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 |

Туре

Follow-Up Type assigned to Action

Action Window

| | | | ■ 🗸 😳 🎖 📃 | | | | |
|-----------------|---------|-----------------|------------------|----------------|--------------|--------------|-----|
| | | F | ollowup Action I | Find Criteria | | | |
| Action | | - | | | | Retrieve All | |
| | | - | | | | - <u>D</u> | |
| Туре | | | | | | | |
| | | | | | | | |
| | | Followup Action | n | | | | |
| | | Action | C-4 CREATED | | | | |
| Action | Descrip | | | SUBMIT CLAIMS | | Auto Action | Cor |
| C-4 CREATED | CREATE | Description | CREATED C-4 TC | SODIMIT CLAIMS | | | |
| CLM-RESUB-PRO | RESUB | Tyme | WCB | | | | |
| CLM-STATUS | CHECK | Num Of Days | | | | | - |
| COD-REQ1 | CODING | to Suspend | | | | | |
| COD-REQ2 | CODING | | | | New | | |
| COD-REQ-FINAL | CODING | Auto Action | | | Delete | | |
| COL-NOTPAID | RETURI | Name | | | | | |
| COL-REQ | REQUE | Comments | | | <u>H</u> elp | | |
| DUPLICATE REMIT | | | | | Save | | |
| EOB-MPI | AUTO-A | | | | Exit | | |
| INS-APPEAL | APPEA | | | | | | |
| INS-APPEAL SENT | | | DRDS, ETC. SENT | | 60 | | |
| INS-EDI | EDHISSU | | | INTERNAL | 7 | | |
| INS-FH-REQ | | | ING - GET DATE | INSURANCE | 45 | | |
| INS-FH-REQ1 | IND REC | D TO DR. SARI | RUFURFH | PROVIDER | 45 | | |

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 | 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 | COLLECTION S | 0 |
| COL-REQ | REQUEST FOR INFORMATION SENT TO COLLECTION AGENCY | COLLECTION S | 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 | 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 | | LAWYER | 30 |
| LAW-LIEN | LIEN PLACED WITH PATIENTS ATTORNEY | LAWYER | 15 |
| LAW-REQ | | LAWYER | 20 |

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

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

| SequelMed ASP*MPI* @mpi - [Plan Follo | owup Bucket] | | - 0 |
|---------------------------------------|---|-------------------------------|----------------|
| | . Design Profiles Setting Window Reports | Exit | - 8 |
| 2 2 🖽 📷 🖬 🗞 🤜 🚑 🦻 | f 🎟 🗸 😳 🨵 | | |
| | | | |
| | | | |
| Followup Bucket Action History | Bucket History Call History Reaso | n History Group History - | |
| | CASE CLOSED Tickle Date 02/08/200 | | |
| | | | |
| | d for WCB hearing 11/2/01, sent all records 01 spoke w/adj. Andrea Albert 800-223-3139 | | <u>L</u> etter |
| | ed. Ancr. head only. Treatment for nose, ey | | Patient |
| | arnas line husy to call again : case closed : | 11/12/01 | |
| Provider HELLINGER | Individual PIN | Group Pin | Payment |
| Location BKH-308GRM | Practice BKH | • | /isit View |
| Reason DOE 12/10/2001 12:19 pm | Reason Entered By DIANA | | - |
| Actn DOE 10/30/2001 12:57 pm | Actn Entered By DIANA | Actn Age 201 #Calls | All Visits |
| | • | | Split |
| Group DOE 04/17/2002 01:48 pm | Group Entered By ANTHONY | Group Age 32 1 – | |
| Pat Last Name MIRABEL | Pat First Name RAMON | Account # 18868 | <u>N</u> ew |
| Plan WCCIGNA CIGNA | HEALTHCARE | Tel (800)223-3139 | <u>C</u> all |
| Insured Last MIRABEL | Insured First Name RAMON | Plan ID CC#375C62867 | Delete |
| Submit Date 06/11/2001 342 F | Plan Bal 147.78 Bucket DOE 07/26/200 | D1 297 DOS 04/26/2001 - | Delete |
| | Linked Visits | Select All — | <u>S</u> ave |
| Link Visit # Plan DOE D | OS Action Reason Addition | | Help |
| | 7/11/2000 INT-HOLD- CASE CLOSED 10/29/01 | | _ · |
| | 2/11/2000 INT-HOLD-CASE CLOSED10/29/01 | | E <u>x</u> it |
| 2743298561 WCGALLAGH 07/09/2001 1 | 2/18/2000 INT-HOLD- WCB HEARING 10/29/01 | - Pt scheduled for WCB hearin | |
| | 2/26/2000 INT-HOLD- WCB HEARING 10/29/01 | | |
| | 1/02/2001 INT-HOLD- CASE CLOSEE 10/29/01 | | |
| 2743310415 WCCIGNA 07/09/20010 | 1/11/2001 INT-HOLD-CASE CLOSE[10/29/01 | - Pt scheduled for WCB hearin | /isit View |
| 7 | | | Un Link |
| | | <u> </u> | 5 2./m |
| lo i | | | |

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

| Additional Info COMPLETED 12/10/2001 spoke wadj. Andrea Albert 800-223-3139, case was closed, claims Part and the end of the end | الــــ الــــــــــــــــــــــــــــــ |
|---|--|
| Additional Info 10/29/01 - Pt scheduled for WCB hearing 11/2/01, sent all records to MSAR to give to pt. CALL Additional Info COMPLETED 12/10/2001 spoke w/adj. Andrea Albert 800-223-3139, case was closed, claims submitted were unrelated. Ancr. head only. Treatment for nose, eye, back unrelated to this claim. Called Wom Chamas. Ine busy to call anain. case closed 11/2/011 Plrovider FELLINGER Location BKH-308GRM Reason DOE [12/10/2001 12:19 pm Reason Entered By DIANA Actin DOE FR030/2001 12:57 pm Actin DOE Call Type Plan Next Action Plan Next Reason Submit Date Duration Comments Help | |
| Provider HELLINGER Individual PIN Group Pin Pi Location BikH-308GRM Piractice BikH Tax Id 114608495 Vis Reason DOE 12/10/2001 12:19 pm Reason Entered By DIANA Reas Age 160 Actn DOE In/30/2001 12:57 pm Actn Entered By DIANA Actn Age 201 #Calls Group DOE Pat Last Name Call Type PATIENT Status © Completed 3139 Insured Lass Next Action O Attempted 5628671 62001 Submit Date Duration Help elect All | <u>L</u> etter Patient |
| Reason DOE 12/10/2001 12:19 pm Reason Entered By DIANA Reas Age 160 Actn DOE 10/20/2001 12:57 pm Actn Entered By DIANA Actn Age 201 #Calls Group DOE Pat Last Name Call Type PATIENT * Status © Completed Plan Next Action * * Status © Completed 3133 Insured Last Next Reason © Acte mpted 662001 662001 Submit Date Duration 662001 41 | Paymen [;] /isit Viev |
| Group DOE Pat Last Name Call Type PATIENT Status Completed Plan Next Action Submit Date Duration Comments Help elect All | All Visits |
| Insured Lasi Next Reason Cattempted 5628671 Submit Date Duration 6/2001 / 1 Comments Help elect All | Split <u>N</u> ew |
| Comments Help elect All | <u>C</u> all Delete |
| Link Visit # P | <u>S</u> ave |
| 2743 274312 W 2743 299938 W | <u>H</u> elp E <u>x</u> it |
| 2743/298561 W 2743/298564 WCGALLAGH 07/09/2001 12/26/2000 INT-HOLD- WCB HEARING10/29/01 - Pt scheduled for WCB hearin 2743/310418 WCCIGNA 07/09/2001 01/02/2001 INT-HOLD- ICASE CLOSEE 0/29/01 - Pt scheduled for WCB hearin | |
| | /isit Vie Un Link |

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.

| <u>Field</u> | 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 |