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SEQUELMED® FOLLOW-UP REASONS

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.

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

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- 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

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SEQUELMED® FOLLOW-UP ACTIONS

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.

Some examples of useful Actions:

Action Short Name	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

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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

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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