Outstanding Insurance Claims Report (8/27/2024)

How To Generate Report

1. Log in to open dental
2. Click on "Reports" on the top of the page and choose "Standard"
3. In the new window in the bottom left box "Monthly", select "Outstanding Insurance Claims". Report will be generated in a new window
4. Set your search criteria as follows
   a. "Date Range"
      i. "From" drop down box is always left empty
      ii. "To" drop down box date is always 20 days prior to the 1st day of the month you are in. ie, August's Outstanding Report "To" date would be July 12th. (This sometimes changes so be sure to check with the HQ manager for the current date)

   b. "Date Range Applies To" - Set to "Date of Service"
   c. "Preauth Options" - Set to "Excluding Preauths"
   d. "Ignore Custom Tracking" - Select box
   e. "Treat Provs" keep to "All"
   f. "Clinic" - Set to you clinic - (For Leavenworth, you will also select the Unassigned clinic)
   g. "For User" you will set this to what works best for you
      i. "All" allows you to see the number of claims to be worked for the month. This number is in the "Custom Tracking" box on the bottom right of the window.
      ii. "Unassigned" shows you the number of claims that still need to be worked for the current month
         1. (For those who have been asked to report office numbers for the week, this is the search criteria you will use. You need to send the total claims along with the total $ amount. ie, 414 claims; value $373,093.45)
      iii. "Your Name" or the"Mine" box will show you the claims that have been assigned to you by yourself or others.
   h. Once each step has been completed click "Refresh"on the top right hand corner to generate the desired results you have selected.

How to Work the Outstanding Insurance Claims Report

   The report is set to default claims in alphabetical order by insurance carriers. This allows us to easily work the report by the insurance carrier since we will already be on their website. However, you can click on each column to search by that specific column. Be honest and only assign your worked claims to yourself.

1. Coordinate with your team where to start working on the report. (ie, top - A's, middle - M's, bottom - U's) Be sure to rotate insurance companies so everyone can get familiar with each insurance company.
2. To work each claim, right click on the line item you are going to work and click "Go To Account". This will open up their account in your Open Dental window.
3. Find the specific date of service you are working and double click to open the claim.
4. Read through any previous notes in the "Reasons underpaid:" box and "Status History" tab to become acquainted with the current claim status. These notes will help you know what has already been sent
5. Depending on the notes you will either check the claim on the insurance portal or call the insurance company. There is a quick reference to the patient's information on the bottom of the Outstanding Insurance Claim Report with the information you need. Other needed information can be found on the "Family" tab of the pt's Open Dental Chart.

   a. Looking up claim on insurance portal
      i. Log on to the insurance portal. If needed, refer to the Insurance Link Sheet for website links and passwords. Be sure to bookmark these on your computer for quicker reference in the future.
      ii. Search claim status. (Insurance Link Sheet sometimes have notes on how to find this for difficult websites.) If you are unable to find the claim status you will need to call the insurance company.
      iii. Once you find the claim, look through the details and
   b. Calling insurance company
      i. Call the number listed on the bottom of the Outstanding Insurance Claim Report as shown above. You will always need your Tax ID or NPI, office address, patient DOB and subscriber ID.
      ii. Explain what you understand about the claim status to the agent. Be sure that you continue to ask clarifying questions until you feel you fully understand the status of your claim. Once you feel you understand what needs to be done be sure you get a call reference # to add to the claim status notes.
6. Complete the needed steps to push the claim along.
   a. Typical items that can be done right away by sending in a corrected claim;

        i. procedure code correction

       ii. adding diagnosis codes

      iii. sending x-rays

      iv. writing & sending a narrative

       v. correcting treating provider

      vi. resubmitting on updated claim form

     vii. resend with primary EOB and/or CARC form and so on.

  b. Other corrections you may run into;

     i. <u>Primary insurance says that there is no primary EOB attached.</u> This means that the primary insurance we have listed has another insurance company listed as primary. This is sometimes listed on their portal on the eligibility statement. If not, call the insurance company we have listed and ask if they have more info for you to go on. Also, be sure to call the member and ask if they have updated insurance that may be primary. If you can't get a hold of the patient, be sure to note in the "Reasons underpaid:" that you left a message asking for updated insurance info as well as a commlog for the office to know what you left a message for when the patient calls back.

     ii. <u>Policy termed.</u> You will need to verify what the termed date is so you will need to call the insurance company and get that date in order for us to send a TPL form to drop the insurance. You will also need to call the patient for updated insurance information. Sometimes it will show termed when it really hasn't. The patient needs to be the one to correct that when that happens so you will have to call the patient.

    iii. Additional information needed usually means that the Coordination of benefits (COB) has not been updated. The insurance company usually mails a form to the member when this happens. They sometimes don't get the form however, if they call the insurance company they should be able to give the details over the phone. Most insurance companies will not take the information from us but always try! Sometimes they do.

    iv. Not on file (NOF). This one may be the case because it has not been received. Other times it has been rejected for some reason. Be sure to review carrier address, DOB, ID# and name spelling to make sure these aren't the reasons it is not on file. Sometimes it just really never was received and you will need to send it again. Be sure that we don't just keep resending month after month. If still NOF after it has been sent again be sure to call and follow-up as to why it is still not received.

7. Once you know the current status of the claim and/or you have sent the insurance company the information that was needed, leave a note in the "Reasons underpaid:" section on the claim. Be sure this note is detailed enough for the next person who works the claim to understand what steps were taken to get the claim paid. Be sure to make a note each time you work on the claim even if you are not finished working on the claim. If you run out of room, take previous notes and copy them into the "Status History" tab and select "Processing" as the Custom Track Status. If you put notes in the "Status History" tab be sure to note ***Status History** in the "Reasons underpaid:"

box so others know to look through those. Be sure all notes are dated and you have put your initials at the end of your note before moving on. By placing the date first it is easy to see the most recent info at a glance. ie,

" 7/15 - LVM (Left Voicemail) asking for another update on insurance - DB"

8. Once you have finished working the claim for the month on the Outstanding Insurance Claims Report, right click on the line item you were working on and click "Assign To Me."
    a. Please note that you do not assign it to you until you have finished working the claim and have left a detailed note with your initials.
    b. Leaving a note simply stating "Policy Termed" DOES NOT count as fully worked. For it to be fully worked a call, text, and or an email should have been sent to the parent and insurance dropped.
    c. Leaving a note "Ins needs more info, processing" is not fully worked either. You need to call insurance and see if they need something from us to finalize processing.
9. You will continue to work on the report until every patient has had a name assigned to them.
10. Once the report is completely finished notify your manager and they will record how many claims were assigned to each team member. We then work as a team to finish up any other offices that have not finished their report.
11. Once everyone has finished and all offices have had their numbers recorded, all claims will be unassigned for the next Outstanding Insurance Claims cycle for the next month.
12. *Please be aware some insurances have a short timely filing. If necessary, to avoid timely filing, we can submit claims via fax (ask insurance agent for a fax #), or on the provider portal. We will also need to send a secondary claim before we have the primary EOB to avoid timely filing knowing we will have to correct the claim once we get the primary EOB.