Response Details	
ID:	143257497
Timestamp:	21 Apr, 2022 09:18:54 AM AST
IP Address:	24.157.17.167
Time Taken:	3794 seconds
Back Button Usage:	Not used
Score:	0.0
Survey Language:	English
Source Identifier:	
Email Address:	
Email List:	

Integration Tags	
External Reference:	
Custom Variable 1 :	
Custom Variable 2 :	
Custom Variable 3 :	
Custom Variable 4 :	
Custom Variable 5 :	

Geo Coding	
Country:	PR
Region:	
Latitude:	18.3861
Longitude:	-66.0434
Radius:	0.0

Location Map

Questions marked with a * are required

INFORME TRIMESTRAL DE DENEGACIONES DE SERVICIOS O DETERMINACIONES ADVERSAS DE SERVICIOS DE SALUD

* 1. Nombre de la Organización de Servicios de Salud o Plan Médico

» Triple S Salud Inc.

* ¿Está reportando información de un trimestre que ya fue sometido?

» No

* 2. Tipo de Plan Médico

» Privado

3. Cantidad de asegurados servidos por este tipo de plan médico a la fecha del cierre del trimestre a reportar.

411169

4. Año

2022

* 5. Trimestre

» 3 (Ene-Mar)

* 6. Fecha de entrega del informe

» 04/21/2022

7. Justificación para la denegación - Salud Física Justificaciones

	Medicamento	Laboratorio	Servicio médico especializado	Servicio médico sub-especializado	Cirugía	Rayos X	Otro
* 1. Facturación fuera de período de contrato	0	0	0	0	0	0	0
* 2. Falta de pre-autorización	0	173	380	312	14	370	1179
* 3. Falta de información/información incompleta	0	0	0	0	0	0	0
* 4. Ausencia de credenciales del proveedor/facilidad médico-hospitalaria	0	0	0	0	0	0	0
* 5. Medicamento fuera de formulario	19	0	0	0	0	0	0
* 6. Cubierta de plan médico no vigente/vencida	0	68	96	56	14	17	867
* 7. Servicio incompatible con la edad del paciente	0	25	1511	716	16	13	5231
* 8. Servicio incompatible con el sexo del paciente	0	40	139	69	10	35	33
* 9. Servicio incompatible con el manejo y tratamiento de la condición del paciente	0	0	0	0	0	0	0
* 10. Política médica	0	6153	12298	4886	2964	3114	19020
* 11. Otro	0	22058	25342	9704	1474	11048	49770

8. Si contestó otro en alguna de las opciones para Salud Física, por favor especifique:

DenyHc DenyHcDesc Sum of Total 293 DEFAULT FFS PERCENT NOT DEFINED 10307 311 SUBMISSION WINDOW EXCEEDED FOR CLAIM START DATE 6659 532 DUPLICATE MEM/DOS/SRVC CODE/MOD/PAY TO/RENDERING PHYS 4677 150 NO CONTRACT TERM FOUND FOR SERVICE 3953 252 PEND CLAIM IF COB IS 0 ON SECONDARY ENROLLMENT CLAIM 2438 504 INVALID CPT/HCPCS CODE 2130 203 BENEFIT IS EXCLUDED FROM BENEFIT PLAN 1450 224 BENEFIT REQUIRES MANUAL REVIEW 1252 271 BENEFIT RESTRICTION GROUP VALIDATION FAILED 1047 202 NO BENEFIT FOR SERVICE 914 216 NO COB ENTERED WITH A SECONDARY ENROLLMENT 831 175 BILL TYPE ON CLAIM DOES NOT MATCH CONTRACT TERM 743 376 CONTRACT TERM RESTRICTION GROUP VALIDATION FAILED 670 206 BENEFIT VISIT LIMIT EXCEEDED 646 966 PRIMARY CARRIER PAID DATE REQUIRED ON COB CLAIMS 643 298 VISIT

MASTER LIMIT EXCEEDED 580 305 PRIMARY DIAGNOSIS CODE IS REQUIRED 334 162 CONTRACT TERM REQUIRES DOCUMENTATION 311 611 UM HAS NO AVAILABLE UNITS 298 940 STATUS CHANGE CAUSED BY SF MESSAGE CODE 295 238 INVALID MEDICARE ACTION CODE 280 116 ANNUAL BENEFIT AMOUNT EXCEEDED 252 923 MAX PER DAY DOLLAR LIMIT MET 240 330 INVALID DIAGNOSIS CODE FOR BENEFIT 238 185 LOCATION-SPECIFIC BENEFIT DOES NOT MATCH CLAIM 235 614 NO AVAILABLE BED DAYS ON UM 202 967 COB CLAIM EXCEEDS SUBMISSION WINDOW 191 173 DIAGNOSIS ON CLAIM DOES NOT MATCH TERMS VALID RANGE 187 172 TERM DOES NOT MEET DATE CRITERIA OF THE CLAIM 165 211 PROVIDER IS NOT PART OF NETWORK REQUIRED FOR BENEFIT 148 225 CONTRACT TERM REQUIRES MANUAL REVIEW 108 903 NO COB MEMBER RESPONSIBILITY PROVIDED BY PRIMARY CARRIER 98 174 PROCEDURE CODE ON CLAIM DOES NOT MATCH TERMS VALID PROCEDURE 98 151 EXCLUDED CONTRACT TERM FOR SERVICE 94 155 BENEFIT HAS AGE RESTRICTION 74 183 SUBMISSION DATE EXCEEDS POLICY TERMINATION RUN-OFF PERIOD 70 149 BENEFIT DOES NOT MEET DATE CRITERIA OF THE CLAIM 68 9013 UNITS EXPANSION DETECTED 63 525 DIAGNOSIS CODE IS NOT VALID ON DOS 63 209 BENEFIT COVERAGE NOT STARTED 59 296 CLAIM LINE OVERLAPS CONTRACT TERM TERMINATION DATE 57 301 INVALID OR MISSING ADMISSION DATE 56 1150 OTHER CARRIER FINANCIAL DETAILS NOT AVAILABLE OR IMBALANCED 46 214 BILL TYPE DOES NOT MATCH BENEFIT 42 511 INVALID FROM DOS 41 272 MEMBER DOES NOT HAVE COVERAGE CODE REQUIRED ON BENEFIT 40 512 INVALID THRU DOS 29 610 UM SERVICES DO NOT MATCH CLAIM 26 189 LEVEL OF CARE BENEFIT NOT FOUND 25 998 CLAIM - INPATIENT CLAIM/UM EXISTS FOR SAME DOS AS ER CLAIM 24 169 CLAIM AND CONTRACT TERM MODIFIERS DO NOT MATCH 23 217 MEMBER HAS AN ACTIVE RESTRICTION ON ENROLLMENT 22 210 MEMBER NOT ENROLLED ON DOS 17 616 UM SERVICE LINE DENIED 14 523 DIAGNOSIS CODE DOES NOT EXIST 13 913 MANUAL PEND OF CLAIM 11 944 MULTIPLE ENROLLMENTS FOUND FOR MEMBER NAME BUT NO DOB MATCH 11 253 INTERNAL ENROLLMENT AND COB AMOUNTS ENTERED 11 218 MEMBER LOST ELIGIBILITY DURING DATE SPAN 10 606 UM NOT FOUND 8 609 UM DATES DO NOT MATCH CLAIM 8 192 BENEFIT REQUIRES CONTRACTED (PAR) PROVIDER 7 263 AUTO ACCIDENT INDICATED ON CLAIM - PURSUE AND PAY 6 158 INVALID SERVICE CODE ON DOS 6 265 OTHER INSURANCE INDICATED ON CLAIM - PURSUE AND PAY 5 154 BENEFIT REQUIRES SPECIALTY CODE NOT FOUND ON PROVIDER 5 543 INPATIENT CLAIM SUBMISSION WINDOW EXCEEDED (CLAIM THRU DATE) 4 1143 CLAIM SHOULD BE DENIED DUE TO MEDICARE MEMBER SURCHARGE 4 508 INVALID MODIFIER CODE ON DATE OF SERVICE 3 101 NO ACTIVE PROVIDER CONTRACT 3 608 UM IS NOT FOR SAME PROVIDER 3 266 OTHER INSURANCE INFORMATION UNKNOWN - PURSUE AND PAY 3 521 PROCEDURE CODE NOT FOUND OR INVALID FOR DATE OF SERVICE 3 9002 CES PROCESS AUTO-FIX RECOMMENDATIONS 2 366 WORKERS COMPENSATION CLAIM 2 123 INDIVIDUAL LIFETIME VISITS EXCEEDED 2 1009 OPERATING PHYSICIAN INFORMATION REQUIRED 2 378 NO COB AMOUNT ON CLAIM 2 612 UM HAS INSUFFICIENT UNITS REMAINING 1 102 PROVIDER NOT ACTIVE FOR PLAN ON DOS 1 304 INVALID BILL TYPE 1 284 REIMBURSE MEMBER SELECTED ON CONTRACTED CLAIM 1 601 UM IS CLOSED 1 607 UM IS NOT FOR SAME MEMBER 1 420 OTHER ENROLLMENT EXISTS FOR SERVICE LINE DATES 1

9. Justificación para la denegación - Salud Mental Justificaciones

	Medicamento	Servicio médico especializado	Servicio médico sub-especializado	Otro
* 1. Facturación fuera de período de contrato	0	0	0	0
* 2. Falta de pre-autorización	0	17	4	80
* 3. Falta de información/información incompleta	0	0	0	0
* 4. Ausencia de credenciales del proveedor/facilidad médico-hospitalaria	0	0	0	0
* 5. Medicamento fuera de formulario	0	0	0	0
* 6. Cubierta de plan médico no vigente/vencida	0	9	0	14
* 7. Servicio incompatible con la edad del paciente	0	0	0	4
* 8. Servicio incompatible con el sexo del paciente	0	1	0	0
* 9. Servicio incompatible con el manejo	0	0	0	0

y tratamiento de la condición del paciente				
* 10. Política médica	0	713	52	2365
* 11. Otro	0	643	37	1240

10. Si contestó otro en alguna de las opciones para Salud Mental, por favor especifique:

DenyHc DenyHcDesc Sum of Total 252 PEND CLAIM IF COB IS 0 ON SECONDARY ENROLLMENT CLAIM 217 532 DUPLICATE MEM/DOS/SRVC CODE/MOD/PAY TO/RENDERING PHYS 187 522 DUPLICATE MEM/DOS/SRVC CODE/MOD/RENDERING PHYS 161 9035 DUPLICATE LINE/CODE IDENTIFIED 157 311 SUBMISSION WINDOW EXCEEDED FOR CLAIM START DATE 153 293 DEFAULT FFS PERCENT NOT DEFINED 66 238 INVALID MEDICARE ACTION CODE 45 185 LOCATION-SPECIFIC BENEFIT DOES NOT MATCH CLAIM 41 216 NO COB ENTERED WITH A SECONDARY ENROLLMENT 34 271 BENEFIT RESTRICTION GROUP VALIDATION FAILED 31 531 DUPLICATE MEM/DOS/SRVC CODE/MOD/PAY TO 26 614 NO AVAILABLE BED DAYS ON UM 21 202 NO BENEFIT FOR SERVICE 19 330 INVALID DIAGNOSIS CODE FOR BENEFIT 18 9038 (DUP/DUPIF/DUPOF) POSSIBLE DUPLICATE CLAIM 15 175 BILL TYPE ON CLAIM DOES NOT MATCH CONTRACT TERM 14 966 PRIMARY CARRIER PAID DATE REQUIRED ON COB CLAIMS 13 174 PROCEDURE CODE ON CLAIM DOES NOT MATCH TERMS VALID PROCEDURE 10 272 MEMBER DOES NOT HAVE COVERAGE CODE REQUIRED ON BENEFIT 9 9013 UNITS EXPANSION DETECTED 6 154 BENEFIT REQUIRES SPECIALTY CODE NOT FOUND ON PROVIDER 6 367 CONTRACT TERM REQUIRES UM 4 224 BENEFIT REQUIRES MANUAL REVIEW 3 183 SUBMISSION DATE EXCEEDS POLICY TERMINATION RUN-OFF PERIOD 3 903 NO COB MEMBER RESPONSIBILITY PROVIDED BY PRIMARY CARRIER 2 203 BENEFIT IS EXCLUDED FROM BENEFIT PLAN 2 611 UM HAS NO AVAILABLE UNITS 1 967 COB CLAIM EXCEEDS SUBMISSION WINDOW 1 305 PRIMARY DIAGNOSIS CODE IS REQUIRED 1 204 INVALID ACCOMMODATION DAYS 1

* 11. Por este medio certifico que la información provista en dicho informe es fiel y exacta en cumplimiento con lo estipulado en la Ley Núm. 47-2017. Por tanto, la misma es una oficial, puede ser verificada y publicada en cualquier momento a solicitud de la Oficina del Procurador del Paciente.

» Si

12. Reporte preparado por:

Tania Collazo

13. Posición:

Systems Support Data Analyst

14. Departamento/ Área:

Business Operations Monitoring Division / Payment Integrity

15. Teléfono:
Phone

787-273-1110

16. Correo electrónico:

tania.collazo@ssspr.com