

CareIG Specialty Pharmacy

Standard Operating Procedure

IVIG Home Infusion — Intake to Billing

v6.0

Document #:	CareIG-SOP-BILL-001
Version:	6.0
Effective:	March 23, 2026
Owner:	Director of Revenue Cycle Management
EIN:	47-3821056
NPI:	1234567893

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1. Overview & Purpose

This SOP governs the end-to-end IVIG home infusion process at CareIG Specialty Pharmacy — from referral receipt through claim payment. All staff performing intake, benefits verification, prior authorization, clinical scheduling, or billing must follow this document. It references standard tools including spreadsheets, email, Slack, shared file storage, and calendar. No proprietary EHR, clearinghouse portal, or payer portal is required.

All case data lives under a case folder named CASE_ID (format: LastName_DOB_MMDDYYYY). This CASE_ID is used in all audit log entries, Slack posts, and file references throughout this SOP. Team communications use defined Slack channels. Claims are submitted by email with PDF attachments. All major actions are logged to audit_log.xlsx.

Covered drugs: Gammaplex, Octagam, Gammagard S/D, Gammagard Liquid, Privigen, Gamunex-C, Hizentra, HyQvia.

If you encounter a situation not covered by this SOP, do not guess. Stop work on that step, note what happened in audit_log.xlsx, and contact your direct supervisor immediately using the escalation path in Section 12. When in doubt, always escalate before acting.

2. Roles & File Access

Role	Writes To	Reads From
Patient Representative	intake.xlsx	
Benefits Verification Specialist (BVS)	benefits.xlsx, auth.xlsx,	intake.xlsx, payer_rules.xlsx
Clinical Coordinator	clinical.xlsx	auth.xlsx, benefits.xlsx
Infusion Nurse	visit_note.xlsx	clinical.xlsx
Billing Specialist	claim.xlsx, ,	visit_note.xlsx, auth.xlsx, benefits.xlsx,
AR Specialist	claim.xlsx (payment cols)	claim.xlsx, payer_rules.xlsx
Director of Revenue Cycle	All files	All files — approves write-offs >\$200 and collections referrals
Administrative Support	All files	All files

Any file access outside the above scope must be logged to audit_log.xlsx (Action = Out-of-Scope Access) and reported to compliance@careig.com.

3. File System Structure

File Name	Purpose
intake.xlsx	Patient demographics, insurance, consent status, contact log, contraindications
benefits.xlsx	BV results: coverage, deductible, OOP, PA contacts, nursing code preference, call log

auth.xlsx	PA details: submission date, PA number, approval/denial status, expiry, follow-up log
clinical.xlsx	Drug source, supply checklist, nurse assignment, visit date/time
visit_note.xlsx	Nurse documentation: drug, dose, lot, NDC, times, pre-meds, saline, vitals, signature
claim.xlsx	Claim: codes, units, ICD-10, PA number, submission log, payment fields
DENIAL_[CARC]_[DOS].xlsx	One file per denial: CARC code, action, appeal status
appeals_log.xlsx	Appeal level, submitted date, decision, follow-up log
Workspace (PDFs)	PDFs: LMN, PA approval, EOB, labs, consent, claim export, statements
audit_log.xlsx	Global audit trail — see Section 4 for columns. Append-only.
jcodes.xlsx	J-codes and nursing codes (read-only)
payer_rules.xlsx	Payer rules: contracted rates, timely filing limits, nursing code pref, formulary, claim/appeal addresses
Templates	Provided at end of SOP — copy to docs/emails before use, never edit in place
nurses.xlsx	Provides a list of RNs and LPNs, zip codes served and availability.

All files which are created per case have a blank template to use. When creating files from the template, save them with the CASE_ID in the filename (e.g., claim_CASE-1001.xlsx). When correcting and resubmitting, update the existing file — do not create a new file.

4. Global Rules

DOS (Date of Service) refers to the date the patient received the infusion visit.

4.1 Audit Logging

Append one row to audit_log.xlsx at each major checkpoint. Columns: Date/Time | CASE_ID | Action | File_Updated | Field_Updated | New_Value | Staff_User | Result (SUCCESS / FAILED / STOP — reason). Do not log every sub-step — only the checkpoints called out in each section. If multiple fields are updated in a single action, list all fields and values separated by commas in the order in which they appear in the spreadsheet.

The Stop Protocol (Section 4.2) is itself a checkpoint — always log a stop event when triggered, even though it is not listed as a checkpoint within a specific workflow section.

4.2 Stop Protocol

When a validation condition fails: note the reason in audit_log.xlsx, post to the designated Slack channel, and hold the case until the issue is resolved. Do not move to the next step until your supervisor or the responsible team member confirms the issue has been cleared.

4.3 Prohibited Actions

- Do not bill any IVIG drug J-code when clinical.xlsx col Drug_Source ≠ CareIG.
- Do not bill pre-medication J-codes unless visit_note.xlsx col Premeds_Administered documents drug, dose, route, time, and indication.
- Do not use ordered dose for unit calculations — always use visit_note.xlsx col Dose_Administered_Grams.
- Do not submit a claim when claim.xlsx already has Submission_Date populated for the same DOS.
- Do not write off any balance >\$200 without Director of Revenue Cycle approval (Slack #billing-mgmt).
- Do not respond to legal threats or attorney communications — post to #compliance immediately.
- Do not assign an ICD-10 code not supported by the physician's documentation and the PA approval.

4.4 Phone Call Workaround

Some workflow steps require a phone call. When the Administrative Support role performs such a step:

1. Check whether the required information is already documented in the relevant workbook or inbox. If so, proceed using that source and record it in the applicable log field.
2. If the information is not available, send an email using the applicable template from Appendix A (Templates 4–8) and log the action.
3. If no template applies and the information cannot be obtained by email, follow the Stop Protocol (Section 4.2).

Where a section instructs staff to "log the call," Administrative Support logs the documented source or email sent instead.

5. Workflow Summary

#	Action	File Written	Slack (if required)
1	Referral received → create → populate intake.xlsx	intake.xlsx	—
2	Patient contacted → consent form sent	intake.xlsx: Consent_Status = Form Sent	—
3	Signed consent received → BVS assigned	intake.xlsx: Consent_Status = Signed, BVS_Assigned	#intake-team: [BVS ASSIGNED] CASE_ID Payer Drug
4	BVS completes BV + drug source decision + patient financial counseling	benefits.xlsx: BV_Complete = YES; clinical.xlsx: Drug_Source	—
5	BVS checks formulary → submits PA	auth.xlsx: PA_Submission_Date, PA_Status = Pending	#intake-team: [PA SUBMITTED] CASE_ID Payer Drug Ref#
6	PA approved → clinical handoff	auth.xlsx: PA_Status = Approved; clinical.xlsx: Handoff_Status = Received	#clinical-scheduling: [PA APPROVED] CASE_ID Drug Dose PA# Exp
7	Supply checklist complete → nurse scheduled	clinical.xlsx: Visit_Date, Nurse_Assigned	#clinical-scheduling: [SCHEDULED] CASE_ID Date Nurse
8	Nurse completes visit → signs visit note	visit_note.xlsx: Nurse_Signature	#clinical-scheduling: [VISIT COMPLETE] CASE_ID DOS

9	Billing validates → builds → submits claim	claim.xlsx: Submission_Date, Claim_Status = Submitted	#billing: [CLAIM SUBMITTED] CASE_ID DOS Payer \$Amount
10	ERA/EOB posted → payment or denial actioned	claim.xlsx: Payment_Posted_Date or file	If denial: #billing-appeals: [DENIAL] CASE_ID CARC

6. Intake

6.1 Case Setup

1. Copy intake_blank.xlsx to the case folder as intake.xlsx.
2. Populate intake.xlsx from the referral document. Required fields:

intake.xlsx Column	Source	Required
Patient_Last_Name, First_Name, DOB, Address, Phone, Email	Patient fields on referral	Yes (email optional)
Physician_Name, Physician_NPI, Physician_Email	Physician fields on referral	Yes
Diagnosis_ICD10	Diagnosis field on referral	Yes
Drug_Name, Drug_Dose_Grams, Drug_Frequency	Ordered drug fields (convert dose to grams if in mg)	Yes
Primary_Insurance_Name, Primary_Member_ID, Primary_Group_Number, Primary_Payer_Phone, Primary_Payer_Email	Insurance fields	Yes
Secondary_Insurance_Name, Secondary_Member_ID	Secondary insurance if listed	No
Contraindications	Allergies/contraindications from referral	Yes
Consent_Status	Set to: Pending	Staff sets on creation

If Physician_NPI is blank after referral entry:

Post to #intake-alerts: [INTAKE HOLD] CASE_ID — Physician NPI missing. Email Template 1 to intake.xlsx col Physician_Email. Do not proceed.

Log to audit_log.xlsx: Action = Referral Received.

6.2 Patient Contact

By phone:

1. Call patient at intake.xlsx col Patient_Phone. Script: "Hello, may I speak with [Patient Name]? This is [Your Name] from CareIG Specialty Pharmacy. Dr. [Physician_Name] has referred you for home IVIG infusion therapy. I'm calling to verify your information and explain next steps. Do you have a few minutes?"
2. If no answer, leave voicemail — do not state the diagnosis: "Hello, this is [Your Name] from CareIG Specialty Pharmacy at [Phone]. We received a referral from your physician. Please call us back at your convenience. Thank you."
3. Log each attempt in intake.xlsx col Contact_Attempt_Log: [Date] [Time] — [Reached / No Answer / Voicemail].
4. **If Contact_Attempt_Log has 3 entries and none is "Reached":** Post to #intake-alerts: [UNREACHABLE] CASE_ID — 3 failed attempts. Send Template 1 to the referring physician. Do not proceed.
5. When patient is reached: confirm demographics, explain the consent requirement, and email the consent form (consent_form.pdf) to intake.xlsx col Patient_Email. Subject: CareIG — Consent Form Required | [Patient Last Name]. If no email is on file, mail the form to intake.xlsx col Patient_Address and note the method in the Contact_Attempt_Log. Set intake.xlsx col Consent_Status = "Form Sent".

By email (Administrative Support — per §4.4):

1. If intake.xlsx col Patient_Email is populated: send **Template 10 — Initial Patient Contact** with consent_form.pdf attached. Set intake.xlsx col Consent_Status = "Form Sent". Log in Contact_Attempt_Log: "[Date] — Initial contact email sent with consent form."
2. If intake.xlsx col Patient_Email is blank: follow the Stop Protocol (§4.2). Patient contact cannot be completed by email without an email address on file.
3. If no response is received within 3 business days, resend Template 10. Log in intake.xlsx Contact_Attempt_Log: "[Date] — Follow-up email sent."
4. If no response after 3 email attempts (initial + 2 follow-ups): Post to #intake-alerts: [UNREACHABLE] CASE_ID — 3 email attempts, no response. Send Template 1 to the referring physician. Do not proceed.

Both methods:

- When signed consent is received (by email attachment or scanned mail): save as consent_signed_[CASE_ID].pdf. Set Consent_Status = "Signed".
- Assign BVS. Set intake.xlsx col BVS_Assigned. Post to #intake-team: [BVS ASSIGNED] [CASE_ID] | Payer: [Insurance_Name] | Drug: [Drug_Name] | Dose: [Drug_Dose_Grams]g.

7. Benefits Verification & Drug Source Decision

7.1 Benefits Verification

BVS calls the payer at intake.xlsx col Primary_Payer_Phone or Administrative Support sends template 4. This should only occur after the Consent_status in intake.xlsx is "Signed". Populate all required fields in benefits.xlsx. Do not set BV_Complete = YES until every required field is non-blank.

benefits.xlsx Column	How to Obtain	Req.
Home_Infusion_Covered	Ask: 'Does this plan cover home infusion therapy?'	Yes
Benefit_Type	Ask: 'Is IVIG under the medical or pharmacy benefit?'	Yes
PA_Required, PA_Phone, PA_Submission_Email	Ask if PA is required and get phone number and email submission address	Yes (if PA required)
Specialty_Pharmacy_Required, Specialty_Pharmacy_Name	Ask if a specific specialty pharmacy is required	Yes

CareIG_Network_Status	Ask: 'Is CareIG Specialty Pharmacy NPI [NPI] in-network?'	Yes
Deductible_Individual, Deductible_Met_YTD	Individual deductible and amount met YTD	Yes
OOP_Max_Individual, OOP_Max_Met_YTD	Out-of-pocket maximum and amount met YTD	Yes
Coinsurance_Pct, Copay_Amount	Coinsurance percentage and per-visit copay	Yes
Plan_Year_Type	Calendar or fiscal year	Yes
Payer_Type	Classify: Medicare Part B / Medicare Adv. / Medicaid / Commercial PPO / Commercial HMO	Yes
Nursing_Code_Pref	Determine from payer_rules.xlsx: 99600 / G0153 / T1029 / T1032	Yes
Coverage_Effective_Date, Coverage_Term_Date	Ask: 'What is the coverage effective date and termination date for this plan?' Enter both as MM/DD/YYYY.	Yes
BV_Call_Date, BV_Rep_Name, BV_Call_Ref_Number	Document every call — mandatory	Yes
BV_Complete	Set YES only after all required fields are non-blank — set last	Yes

Log to audit_log.xlsx: Action = BV Complete.

7.2 Drug Source Decision

Immediately after BV, write the drug source to clinical.xlsx col Drug_Source:

- If the Benefit_Type = Pharmacy → post to #billing-mgmt: [BENEFIT TYPE ISSUE] CASE_ID — IVIG under pharmacy benefit. Awaiting Director guidance. Do not proceed until resolved. If the Benefit_Type does not equal Pharmacy, then:
- If Specialty_Pharmacy_Required = YES → Drug_Source = value from benefits.xlsx col Specialty_Pharmacy_Name. CareIG bills nursing and supplies only. Do not bill any IVIG drug J-code on the CareIG claim. Otherwise, if Specialty_Pharmacy_Required = NO, then:
- If CareIG_Network_Status = In-Network AND Specialty_Pharmacy_Required = NO → Drug_Source = CareIG; else:
- If CareIG_Network_Status = Out-of-Network AND Specialty_Pharmacy_Required = NO → Post to #intake-mgmt: [OON NO PREFERRED PHARMACY] CASE_ID — CareIG is out-of-network but payer has no required specialty pharmacy. Supervisor must determine next step (single-case agreement, patient referral, or self-pay). Do not proceed until Drug_Source is confirmed by supervisor. Otherwise:
- If CareIG_Network_Status is blank or unknown → Post to #intake-mgmt: [NETWORK STATUS UNKNOWN] CASE_ID — unable to confirm CareIG network status with payer. Do not proceed until CareIG_Network_Status is verified and recorded in benefits.xlsx.

7.3 Patient Financial Counseling

Before making this call (or sending template 5), calculate the patient's estimated out-of-pocket using benefits.xlsx:

- Remaining_Deductible = benefits.xlsx Deductible_Individual – Deductible_Met_YTD Expected_Billed = (Drug_Units × fee_schedule.xlsx Billed_Rate) + Nursing_Billed + Supply_Billed
 Patient_Coinsurance = (Expected_Billed – Remaining_Deductible) × benefits.xlsx Coinsurance_Pct
 Estimated_OOP = Remaining_Deductible + Patient_Coinsurance + benefits.xlsx Copay_Amount
 - Nursing_Billed = fee_schedule rate for nursing code × units (e.g., 99600 = \$265 × 1 = \$265)
 - Supply_Billed = A4221 rate (\$95) + A4222 rate (\$55) if pump used
- If Estimated_OOP > (benefits.xlsx OOP_Max_Individual – OOP_Max_Met_YTD), cap at the remaining OOP maximum: Estimated_OOP = min(Estimated_OOP, OOP_Max_Individual – OOP_Max_Met_YTD)

Use that dollar figure in the script below or template 5.

"[Patient Name], this is [Your Name] from CareIG. I've had a chance to review your insurance benefits. Based on your current plan, your estimated out-of-pocket cost per infusion visit is approximately \$[dollar amount you calculated]. Keep in mind this is an estimate — your insurance company determines the final amount once the claim is processed. Do you have any questions about that?"

Log call in benefits.xlsx col Financial_Counseling_Log: [Date] [Time] — [outcome]. If patient reports hardship: set intake.xlsx col Financial_Hardship = YES and post to #intake-team: [FINANCIAL HARDSHIP] CASE_ID — refer to Patient Assistance Program.

8. Prior Authorization

If benefits.xlsx col PA_Required = NO, skip Sections 8.1 through 8.5. Proceed directly to Section 8.6 (Clinical Handoff), setting auth.xlsx col PA_Status = Not Required and PA_Number = N/A.

8.1 Formulary Check

Before submitting any PA, confirm the ordered drug is covered on the payer's formulary. Open payer_rules.xlsx. Read the row for the payer (benefits.xlsx col Primary_Insurance_Name). Check col Formulary_Covered_Drugs.

If the ordered drug (intake.xlsx col Drug_Name) is not listed in payer_rules.xlsx col Formulary_Covered_Drugs for the payer:

Post to #intake-team: [FORMULARY ISSUE] CASE_ID | Drug: [Drug_Name] | Payer: [Insurance_Name]. Contact prescribing physician via email to intake.xlsx col Physician_Email to request either an alternative covered drug or a written formulary exception letter. Do not submit PA until one of the two paths below is confirmed.

If the physician provides a formulary exception letter: save it as formulary_exception.pdf, document the basis in auth.xlsx col Formulary_Exception_Notes, and include it in the PA packet. Proceed to Section 8.2. If the physician substitutes an alternative covered drug: update intake.xlsx col Drug_Name with the new drug and restart Section 8.1. If neither is provided within 2 business days: post to #intake-mgmt: [FORMULARY UNRESOLVED] CASE_ID and hold the case.

8.2 Required PA Documents

All of the following must be saved in the case folder before PA submission:

- PA request form (payer-specific) — pa_form_[PayerName].pdf
- Physician Letter of Medical Necessity — signed, on letterhead, dated within 90 days — lmn_[PhysicianName].pdf
- Most recent IgG lab result (immune deficiency diagnoses) — igglevel_[MMDDYYYY].pdf
- Most recent physician progress note — progress_note_[MMDDYYYY].pdf
- Formulary exception documentation (if applicable) — formulary_exception.pdf

If any required document above is missing from the case folder:

Post to #intake-alerts: [PA HOLD] CASE_ID — missing: [document name]. Do not submit.

8.3 PA Submission

1. Combine all documents into pa_submission_packet_[PayerName].pdf using pdf-tools.
2. Email to payer PA address (payer_rules.xlsx col PA_Submission_Email). Subject: [PA REQUEST] CarelG | [Patient Last Name] | MemberID: [Primary_Member_ID] | Drug: [Drug_Name] | Dose: [Drug_Dose_Grams]g | Dx: [Diagnosis_ICD10]. Attach PA packet PDF.
3. Update auth.xlsx: PA_Submission_Date = today, PA_Ref_Number = email confirmation ID, PA_Status = Pending, Last_Followup_Date = today.
4. Post to #intake-team: [PA SUBMITTED] [CASE_ID] | Payer: [name] | Drug: [Drug_Name] | Ref: [PA_Ref_Number].

Log to audit_log.xlsx: Action = PA Submitted.

8.4 PA Follow-Up

Every business day while a PA is pending, open auth.xlsx and check col PA_Status. If the status is still Pending and (today's date minus Last_Followup_Date) is 2 or more days, call the payer PA line (benefits.xlsx col PA_Phone), or for Administrative Support send Template 7 to benefits.xlsx col PA_Submission_Email. Append a note to auth.xlsx col PA_Call_Log: [Date] [Time] | Rep: [name] | Ref#: [#] | Status: [status] | Next expected update: [date]. Update Last_Followup_Date to today.

If still Pending after 5 days from PA_Submission_Date: post to #intake-mgmt: [PA DELAY] [CASE_ID] | Payer: [name] | Days Pending: [count].

When the payer responds during follow-up:

Log the response in auth.xlsx col PA_Followup_Log with the date and payer representative's name.

A formal written PA decision (approval or denial letter received by email) is required before proceeding. Do not act on verbal or informal confirmations alone. If the payer provides a verbal decision, log it and request written confirmation — send **Template 3 — Prior Authorization / Claims Follow-Up** asking the payer to issue the formal decision letter.

When the written decision is received:

- If approved: proceed to §8.6.
- If denied: proceed to §8.7.

8.5 Peer-to-Peer (P2P) Request

If payer offers a P2P review after denial:

1. Contact payer (call or email benefits.xlsx col PA_Submission_Email), obtain time slots, record in auth.xlsx col P2P_Available_Slots.
2. Complete Template 2 (Appendix A). Save as p2p_request.pdf. Email to intake.xlsx col Physician_Email. Subject: [P2P REQUEST] [CASE_ID] | [Payer] | PA Case#: [PA_Ref_Number].
3. Set auth.xlsx col P2P_Status = Requested, P2P_Request_Date = today.

If P2P_Status = Requested AND P2P_MD_Response_Date is blank AND (today - P2P_Request_Date) ≥ 2 days:

Post to #intake-alerts: [P2P NO RESPONSE] CASE_ID. Set P2P_Status = No Response. Proceed to Level 1 appeal (Section 11).

8.6 PA Approval — Clinical Handoff

1. Save PA approval as pa_approval_[PayerName].pdf. Update auth.xlsx: PA_Number, PA_Approved_Drug, PA_Approved_Dose, PA_Approved_Frequency, PA_Effective_Date, PA_Expiration_Date, PA_Status = Approved. Also record the approved diagnosis code(s) from the PA decision letter in auth.xlsx col PA_Approved_ICD10.
2. Update clinical.xlsx: Handoff_Status = Complete, PA_Number, PA_Expiration_Date.
3. Post to #clinical-scheduling: [PA APPROVED] [CASE_ID] | Drug: [PA_Approved_Drug] | Dose: [PA_Approved_Dose]g | PA#: [PA_Number] | Exp: [PA_Expiration_Date] | Drug Source: [Drug_Source].

If PA_Approved_Drug does not match intake.xlsx col Drug_Name (case-insensitive):

Post to #intake-alerts: [PA DRUG MISMATCH] CASE_ID | Ordered: [Drug_Name] | Approved: [PA_Approved_Drug]. Resolve with payer before scheduling.

If auth.xlsx col PA_Approved_Dose is less than intake.xlsx col Drug_Dose_Grams:

Post to #intake-alerts: [PA DOSE MISMATCH] CASE_ID | Ordered: [Drug_Dose_Grams]g | Approved: [PA_Approved_Dose]g. Do not schedule. BVS must contact payer to request approval for the full ordered dose before proceeding.

Log to audit_log.xlsx: Action = PA Approved — Clinical Handoff.

8.7 PA Denial

1. Update auth.xlsx: PA_Denial_Date = today, PA_Denial_Reason = denial text, PA_Status = Denied.
2. Post to #billing-appeals: [PA DENIED] [CASE_ID] | Payer: [name] | Reason: [PA_Denial_Reason]. Proceed to Section 11 for appeal.

Log to audit_log.xlsx: Action = PA Denied.

9. Clinical Scheduling & Visit Documentation

9.1 Supply Checklist

Before scheduling the nurse visit, confirm all items below are completed in clinical.xlsx. All columns must contain a value; **NS_500mL_Qty_Ordered** must contain a number (integer) of 2 or more:

clinical.xlsx Column	Requirement
Drug_Order_Placed	Drug ordered from CareIG or partner pharmacy per Drug_Source
Drug_Delivery_Confirmed	Delivery confirmed at patient address — record delivery date
Drug_Lot_Number, Drug_NDC	Lot number and NDC received from dispensing pharmacy
NS_500mL_Qty_Ordered	Enter the number of 500 mL NS bags ordered (integer), minimum 2. If the ordered drug is Gammaplex, enter 0 and order 500 mL 10% Dextrose bags instead (minimum 2).
Filter_Tubing_Ordered	0.2-micron IV filter set ordered (required for all IVIG)
Benadryl_Available	Diphenhydramine 50 mg/mL vial available if ordered as pre-med (N/A if not ordered)

Supplies_Other	Gloves, alcohol swabs, dressing kit, sharps container confirmed
Supply_Checklist_Complete	Set YES only after all above fields are confirmed

If Supply_Checklist_Complete ≠ YES when nurse scheduling is attempted:

Post to #clinical-scheduling: [SUPPLY HOLD] CASE_ID — checklist incomplete. Do not schedule until resolved.

Before scheduling, confirm that the ordered drug is not contraindicated for this patient. Check intake.xlsx col Contraindications against §13.3 drug notes. If a contraindication is found, post to #clinical-scheduling: [CONTRAINDICATION] CASE_ID | Drug: [Drug_Name] | Contraindication: [details]. Do not schedule until resolved by the prescribing physician.

9.2 Nurse Scheduling

1. Before scheduling, verify auth.xlsx col PA_Expiration_Date ≥ proposed Visit_Date. If the PA will expire before the visit date, escalate to Billing Supervisor to request a PA renewal before proceeding.
2. Select nurse (nurses.xlsx) matching patient zip code and credential (RN required for first visit; verify state rules in payer_rules.xlsx col Nursing_Credential_Requirement for subsequent visits).

Scheduling constraints:

- Schedule visits between **08:00 and 17:00** only. The visit must end by 17:00 (so a 4-hour infusion cannot start later than 13:00).
 - Check the **calendar** for the assigned nurse's existing appointments. The nurse must not have overlapping or back-to-back visits — allow at least **30 minutes** before and after each visit for travel. Always schedule for the earliest time possible on the selected date.
 - If no available slot exists within the frequency window (±3 days of the target date), escalate to **#clinical-scheduling** for manual resolution.
3. Create calendar event: summary should be IVIG Infusion - [Patient_Last_Name], [Patient_First_Name] ([CASE_ID]). Include nurse's name in the description.
 4. Set duration using the estimated infusion times in infusion_duration.xlsx. Look up the row matching the ordered drug and dose range to find the estimated visit length in hours.
 5. Confirm visit with patient. Script:

"Hello [Patient Name], this is [Your Name] from CareIG. Your insurance has approved your IVIG infusion. We have availability on [Date] at [Time] — does that work for you? The visit will take approximately [X] hours. For Administrative Support, send Template 6 instead.
 6. Update clinical.xlsx: Visit_Date, Visit_Time, Nurse_Assigned. Post to #clinical-scheduling: [SCHEDULED] [CASE_ID] | Date: [Visit_Date] | Nurse: [Nurse_Assigned].
 7. Email assigned nurse. Subject: [VISIT ASSIGNMENT] [CASE_ID] | [Date]. The body of the email must include:
 - Address: [Patient_Address from intake.xlsx]
 - Drug: [Drug_Name from intake.xlsx]
 - Dose: [Drug_Dose_Grams from intake.xlsx]
 - Lot Number: [Drug_Lot_Number from clinical.xlsx]
 - NDC: [Drug_NDC from clinical.xlsx]
 - Infusion Rate: [Infusion_Start_Rate_mL_hr from intake.xlsx]
 - Pre-med Orders: [Premeds_Administered (drug name, dose, route) from intake.xlsx]
 - Emergency Contact: [Patient_Phone from intake.xlsx]
 - Contraindications: [Contraindications from intake.xlsx]"

9.3 Recurring Visits

IVIG patients typically receive infusions on a recurring schedule (as defined by intake.xlsx col Drug_Frequency). The initial visit follows the full workflow from §5 through §12. Subsequent visits follow an abbreviated process:

What carries forward (do not re-create):

- intake.xlsx — reuse existing patient record unless demographics or insurance have changed.
- benefits.xlsx — reuse unless the payer, plan, or benefit period has changed.
- auth.xlsx — reuse the current PA until it approaches expiration (see below).

What gets updated for each visit:

- clinical.xlsx Visit_Date, Visit_Time, Nurse_Assigned

What is created new for each visit:

- visit_note.xlsx — one new row per visit. Each DOS must have its own visit record.
- claim.xlsx — one new row per visit. Each DOS generates a separate claim.

Scheduling subsequent visits: After each completed visit, schedule the next visit based on auth.xlsx col PA_Approved_Frequency. If no PA is required for this payer, use intake.xlsx col Drug_Frequency instead. Complete steps 2 - 7 in section 9.2.

Five days prior to each subsequent visit, verify:

1. PA has not expired: check auth.xlsx col PA_Expiration_Date $\geq$ next Visit_Date. If the PA will expire within 14 days of the next scheduled visit, initiate a new PA cycle per §8.
2. Supplies are available: re-verify the supply checklist per §9.1 for each visit.
3. No insurance changes: if the patient reports new insurance, restart from §7 (Benefits Verification).

9.4 Visit Documentation

The nurse must complete all fields below in visit_note.xlsx and set col Nurse_Signature within 4 hours of visit completion. A claim cannot be initiated if Nurse_Signature is blank.

visit_note.xlsx Column	Description	Required
Visit_Date, Visit_Start_Time, Visit_End_Time	Date and exact start/end times	Yes
Visit_Duration_Minutes	End time – Start time in minutes	Yes
Drug_Name_Trade, Drug_Name_Generic	E.g., Gammaplex 5% and Immune Globulin Intravenous	Yes
Drug_NDC, Drug_Lot_Number, Drug_Expiration_Date	Transcribed from vial label	Yes
Dose_Ordered_Grams, Dose_Administered_Grams	Ordered vs actual. Claims use Dose_Administered_Grams.	Yes
Route	IV or SQ — must match MD order	Yes
Infusion_Start_Rate_mL_hr, Infusion_Rate_Adjustments	Initial rate and all changes with timestamps. If no changes: None.	Yes
Premeds_Administered	Format: [Drug] [Dose][unit] [Route] at [Time] for [Indication]. If none: None administered.	Yes
NS_500mL_Bags_Used, NS_250mL_Bags_Used	Count of bags actually used	Yes

Pump_Used	YES or NO	Yes
Vital_Signs_Pre, Vital_Signs_Mid, Vital_Signs_Post	BP, HR, Temp, RR at each point. Mid: N/A if no rate changes.	Yes
Patient_Response	Clinical response. If uneventful: Patient tolerated infusion without adverse events.	Yes
Education_Provided	Education given. SQ patients: document self-infusion training if performed. If none: None.	Yes
Nurse_Signature	Full name and credential (e.g., Jane Smith, RN)	Yes — blocks claim if blank
Dextrose_500mL_Bags_Used	For Gammaplex cases only: number of 500 mL 10% Dextrose bags actually used during the visit. For all other drugs, enter N/A.	Yes for Gammaplex, N/A otherwise.

If Nurse_Signature is blank:

Post to #clinical-scheduling: [UNSIGNED NOTE] CASE_ID — claim on hold until signed.

Post to #clinical-scheduling: [VISIT COMPLETE] [CASE_ID] | DOS: [Visit_Date]. Log to audit_log.xlsx: Action = Visit Note Signed.

10. Billing & Payment Posting

10.1 Pre-Billing Validation

Before building claim.xlsx, confirm every condition below is TRUE. If any is FALSE: post to #billing with the specific failure and do not proceed. However, if the PA_Status in auth.xlsx is "Not Required", skip the PA_related validation checks ((PA_Status, PA_Number, PA_Expiration_Date, PA_Approved_Drug match, and PA_Approved_Dose check) but perform all other checks. Additionally, if the claim.xlsx Billing_Model is "Split", skip the drug-related validation checks (PA_Approved_Drug match, PA_Approved_Dose check) but process all remaining checks.

Condition	If FALSE — Post to #billing
visit_note.xlsx col Nurse_Signature is non-blank	[BILLING HOLD — UNSIGNED NOTE] CASE_ID
auth.xlsx col PA_Status = Approved	[BILLING HOLD — NO PA APPROVAL] CASE_ID
auth.xlsx col PA_Number is non-blank	[BILLING HOLD — PA NUMBER MISSING] CASE_ID
auth.xlsx col PA_Expiration_Date ≥ visit_note.xlsx col Visit_Date	[BILLING HOLD — PA EXPIRED ON DOS] CASE_ID PA Exp: [date] DOS: [date]
auth.xlsx col PA_Approved_Drug matches visit_note.xlsx col Drug_Name_Trade (case-insensitive)	[BILLING HOLD — DRUG MISMATCH] CASE_ID PA: [drug] Administered: [drug]
auth.xlsx col PA_Approved_Dose (grams) is greater than or equal to visit_note.xlsx col Dose_Administered_Grams	[BILLING HOLD — DOSE EXCEEDS PA] CASE_ID PA approved: [PA_Approved_Dose]g Administered: [Dose_Administered_Grams]g. Post

	to #billing and escalate to BVS to obtain a revised PA before submitting.
intake.xlsx col Diagnosis_ICD10 is an exact match with PA Approved ICD10 (verify in auth.xlsx)	[BILLING HOLD — ICD10 INCONSISTENT] CASE_ID
visit_note.xlsx col Dose_Administered_Grams is non-blank and > 0	[BILLING HOLD — DOSE NOT DOCUMENTED] CASE_ID
Verify no claim has already been submitted for this DOS (check claim.xlsx for an existing row with this CASE_ID and DOS that already has a Submission_Date).	[DUPLICATE CLAIM RISK] CASE_ID DOS: [date]
benefits.xlsx confirms active coverage on DOS	[BILLING HOLD — COVERAGE NOT CONFIRMED] CASE_ID

10.2 Claim Construction

Copy claim_blank.xlsx to create claim.xlsx for this case. Use the following rules:

Claim Component	Rule
Drug J-Code	Look up J-code in jcodes.xlsx for Drug_Name_Trade. Confirm that the J-code's Route in jcodes.xlsx matches visit_note.xlsx col Route. If mismatch, post to #billing: [ROUTE MISMATCH] CASE_ID J-code route: [route] Visit note route: [route]. Do not proceed until resolved. Units = (Dose_Administered_Grams × 1000) ÷ unit size. See Section 13 for full table and examples. If the result is not a whole number, round down to the nearest integer. Example: 25.3g Privigen = 50,600mg ÷ 500 = 101.2 → bill 101 units.
Nursing Code	Read payer_rules.xlsx col Nursing_Code_Pref for this patient's payer. If Nursing_Code_Pref is blank or 99600: - If Visit_Duration_Minutes ≤ 60: bill 99600 × 1 only. Do not bill 99603. - If Visit_Duration_Minutes > 60: bill 99600 × 1 + 99603 × floor((Visit_Duration_Minutes – 60) ÷ 60). If Nursing_Code_Pref = G0153: Bill G0153 × 1 only (flat rate, duration does not apply). If Nursing_Code_Pref = T1029/T1032: Verify billing rules per state in payer_rules.xlsx. Follow state-specific unit calculations.
Saline	J7030 × NS_500mL_Bags_Used. J7050 × NS_250mL_Bags_Used. Both from visit_note.xlsx. For Gammaplex cases: do not bill J7030 or J7050. Instead bill A4221 for the Dextrose supply as part of the general infusion supplies line. Read Dextrose_500mL_Bags_Used from visit_note.xlsx to confirm administration was documented before billing.
Pre-Medications	Parse visit_note.xlsx col Premeds_Administered. Diphenhydramine: J0171 × (mg ÷ 50). Promethazine: J2550 × (mg ÷ 25). Round up to the nearest integer. If None administered: leave blank. If a pre-med is listed that is not Diphenhydramine or Promethazine, look up the corresponding J-code and unit size in jcodes.xlsx. If no match exists, escalate to Billing Supervisor.
Supplies	Bill A4221 × 1 per visit. This covers all standard infusion supplies (alcohol swabs, tubing, sharps, Dextrose (for Gammaplex cases)). If Pump_Used = YES: also A4222 × 1.

Header / Auth Fields	PA_Number = auth.xlsx col PA_Number. Physician_NPI = intake.xlsx col Physician_NPI. CareIG_NPI and Tax_ID from payer_rules.xlsx. DOS = visit_note.xlsx col Visit_Date. ICD10 = intake.xlsx col Diagnosis_ICD10. CareIG Taxonomy Code from org_identifiers.xlsx.
Split-Bill (OON partner)	If clinical.xlsx col Drug_Source ≠ CareIG: leave all IVIG drug J-code fields blank. Set claim.xlsx col Billing_Model = Split — Drug billed by [Drug_Source].
Claim_Frequency_Code	Enter 1 for all original claim submissions. Enter 7 when resubmitting a corrected claim. Enter 8 when voiding a duplicate. Write value to claim.xlsx col Claim_Frequency_Code.
Modifier	Read visit_note.xlsx col Route. If Route = IV: no modifier required on the drug J-code line. If Route = SQ: append modifier SC to the drug J-code line in claim.xlsx col Drug_Modifier. Write Drug_Modifier to claim.xlsx.
Total Billed	Sum of all line item amounts (drug, nursing, pre-meds, saline, supplies) (each line = units × Billed_Rate from fee_schedule.xlsx)

10.3 Claim Submission

1. Export claim.xlsx to PDF → claim_[DOS].pdf.
2. Email to payer billing address (payer_rules.xlsx col Claim_Submission_Email). Subject: [CLAIM SUBMISSION] CareIG NPI: [NPI] | [Patient Last Name] | MemberID: [Primary_Member_ID] | DOS: [Visit_Date]. Attach claim_[DOS].pdf.
3. Update claim.xlsx: Submission_Date = today, Submission_Ref_Number = email confirmation ID, Claim_Status = Submitted (for new and resubmitted claims).
4. Post to #billing: [CLAIM SUBMITTED] [CASE_ID] | DOS: [Visit_Date] | Payer: [name] | Billed: \$[Total_Billed].

Log to audit_log.xlsx: Action = Claim Submitted (for new and for resubmitted claims).

10.4 ERA & Payment Posting

1. ERA and EOB documents arrive by email to billing@careig.com from the payer. When received, download the attachment and save it as era_[DOS]_[Payer].pdf.
2. Compare the total Paid_Amount on the ERA to the sum of Contracted_Rates (from payer_rules.xlsx) for all line items on the claim. If Paid_Amount < Contracted_Rate: post to #billing-mgmt: [UNDERPAYMENT] CASE_ID | Payer: [name] | Expected: \$[rate] | Received: \$[paid]. Do not write off.
3. If ERA contains a denial (any CARC-coded line with \$0 paid): copy denial_blank.xlsx to create DENIAL_[CARC]_[DOS].xlsx. Populate CARC_Code, Denial_Date, DOS, Denied_Code, Denied_Amount. Follow Section 11.
4. Update claim.xlsx: Payment_Posted_Date = today, Claim_Status = Paid / Partially Paid / Denied.
5. If Patient_Responsibility > 0: complete patient_statement_template.docx with patient name, DOS, billed amount, insurance payment, and patient balance. Save as statement_[DOS].pdf. Email to patient at intake.xlsx col Patient_Email. Subject: CareIG Statement of Account | DOS: [Visit_Date].
6. If the statement is sent, if the balance remains unpaid, re-send the statement at 30 days and again at 60 days. If the balance remains outstanding at 90 days, refer to section 12 for escalation details.

If the ERA contains both paid and denied lines, post the paid portion immediately (Payment_Posted_Date = today, Claim_Status = "Partially Paid") and create the denial file for the denied lines per step 3. Work the denial separately per Section 11. Do not wait for denial resolution before posting the paid amount.

11. Denial Management & Appeals

11.1 Denial Actions by CARC Code

All CARC codes that include an action to "resubmit" must follow these steps. These steps should also be followed if details of a Claim Submission (§10.3) are rendered incorrect:

1. Correct the identified issue in the existing claim.xlsx row.
2. Set Claim_Frequency_Code = 7 (Replacement/Corrected Claim).
3. Re-export and submit per §10.3.

Do not create a new row. Do not delete the original submission history from Submission_Log.

CARC	Denial Reason	Action
CO-4	Procedure code / modifier inconsistent	Correct modifier per visit_note.xlsx col Route. Resubmit.
CO-11	Diagnosis inconsistent with procedure	Confirm ICD-10 in claim.xlsx matches PA approval in auth.xlsx. If mismatch: email intake.xlsx col Physician_Email. Subject: [ICD10 CLARIFICATION NEEDED] CASE_ID DOS: [date]. Body: state the ICD-10 on the claim, the ICD-10 on the PA, and ask the physician to confirm the correct code in writing. Do not resubmit until written confirmation is received and saved to the case folder.
CO-16	Claim lacks required information	Identify missing field from denial detail (NPI, taxonomy, PA number). Update claim.xlsx. Resubmit.
CO-18	Duplicate claim	This denial indicates the payer believes this claim duplicates a previously submitted claim for the same date of service. Step 1 — Check for prior submission. Open claim.xlsx and review Submission_Log for any earlier submission with the same DOS and the same HCPCS line items. If a prior submission exists (confirmed duplicate): Step 2a — Void the duplicate. Resubmit the denied claim with frequency code 8 (Void/Cancel). Update claim.xlsx: • Claim_Status = "Voided — Duplicate" Do not delete the original row. Step 3a — Verify the original claim is active. Locate the original claim row (earliest Submission_Log entry for this DOS). Confirm its Claim_Status is "Paid" or "Pending." If the original is also denied or has no active status, resubmit it with frequency code 7 (Replacement/Corrected Claim). Log: audit_log.xlsx → Action = "Duplicate Voided", Notes = "CO-18: voided duplicate [Claim_ID]. Original claim [Original_Claim_ID] status: [status]." No further action on the voided claim. If no prior submission exists (not a confirmed duplicate): Step 2b — Resubmit as corrected claim. The payer has flagged this as duplicate in error. Resubmit with frequency code 7 (Replacement/Corrected Claim) and attach supporting documentation that distinguishes this service from the alleged duplicate — for example, distinct service start/end times, different J-codes, or a cover note explaining why the services are separate. Update claim.xlsx:

		- Claim_Status = "Resubmitted — CO-18 Corrected" - Submission_Log: append "Resubmitted freq 7 with supporting documentation: [brief description]." For Administrative Support, if payer documentation is needed, send Template 3 — Prior Authorization / Claims Follow-Up to Payer_Claims_Email referencing the CO-18 denial and requesting clarification on the duplicate flag. Log: audit_log.xlsx → Action = "CO-18 Resubmission", Notes = "Resubmitted as corrected claim with [documentation type]."
CO-22	COB — other payer may be primary	This denial indicates the payer believes another insurance is primary for this patient. Do not appeal. Instead, identify and bill the true primary payer first. Step 1 — Confirm COB status. Open benefits.xlsx. Check Secondary_Payer_Name and Secondary_Payer_ID. If both are blank, this is a new COB situation — proceed to Step 2. If they are already populated, skip to Step 3. Step 2 — Identify the primary payer. Contact the denying payer using benefits.xlsx col Primary_Payer_Phone (or send Template 7 — COB Payer Inquiry to Payer_Claims_Email) to confirm which payer they believe is primary. Record the response in benefits.xlsx: - If the other payer is not already listed, populate Secondary_Payer_Name, Secondary_Payer_ID, Secondary_Payer_Phone, and Secondary_Claim_Submission_Email with the denying payer's information (since it is now the secondary). - If the other (primary) payer's details are not on file, contact the physician's office using Template 2 — Missing Clinical Information requesting the patient's primary insurance details, then populate the primary payer fields. Step 3 — Update claim status. In claim.xlsx, set: - COB_Status = "Primary Pending" - Claim_Status = "COB — Awaiting Primary EOB" Log: audit_log.xlsx → Action = "COB Identified", Notes = "CO-22 received from [Payer_Name]. Primary payer: [Primary_Payer_Name]." Step 4 — Submit claim to the primary payer. Construct a new claim for the same DOS using the primary payer's billing rules (check payer_rules.xlsx for the primary payer's contracted rates, nursing code preferences, and TFL). Submit the claim to the primary payer per §10.3. In claim.xlsx, set COB_Primary_Claim_Ref = the Claim_ID of the newly submitted primary claim. Step 5 — Post primary payer response. When the primary payer's ERA/EOB arrives: - Post payment per §12.1 on the primary claim. - Record COB_Other_Payer_Paid and COB_Other_Payer_EOB_Date on the original (secondary) claim in claim.xlsx. - Update COB_Status = "Primary EOB Received" Step 6 — Resubmit to the secondary (original) payer. Resubmit the original claim to the secondary payer, attaching the primary payer's EOB. Update claim.xlsx: - Claim_Status = "Resubmitted with Primary EOB" - Resubmission_Date = today's date - Log in Submission_Log: "Resubmitted to [Secondary_Payer_Name] with primary EOB attached."

		Log: audit_log.xlsx → Action = "COB Resubmission", Notes = "Claim resubmitted to [Secondary_Payer_Name] with [Primary_Payer_Name] EOB dated [date]." Step 7 — Monitor. Add this claim to the §12.2 daily monitoring queue. If no response is received from the secondary payer within 30 days of resubmission, follow up per §12.2 escalation rules. Do NOT create a DENIAL_CO22_[DOS].xlsx file. CO-22 is a coordination issue, not a clinical or coding denial — it is resolved by billing the correct payer order, not by appeal.
CO-50	Non-covered service	File Level 1 appeal per Section 11.2.
CO-96	Non-covered charge	Compare to payer_rules.xlsx contracted rate. If dispute: post to #billing-mgmt. Write-off requires Director approval.
CO-97	Benefit not assigned	Open benefits.xlsx col Benefit_Type. If the benefit tier on the original claim does not match what is listed in benefits.xlsx (e.g., billed under pharmacy benefit but should be medical): correct claim.xlsx and resubmit. If the benefit tier on the claim matches benefits.xlsx and the payer still denies: file a Level 1 appeal per Section 11.2.
PR-1 / PR-2 / PR-3	Deductible / Coinsurance / Copay	Read the patient responsibility amount directly from the ERA line item for this denial. Write that amount to claim.xlsx col Patient_Responsibility. Generate and send patient statement per Section 10.4.
OA-23	Charge exceeds fee schedule	Compare Paid_Amount to contracted rate. If underpaid: post to #billing-mgmt per Section 12.
PI-204	Not medically necessary	Gather PA approval, LMN, clinical notes, IgG labs from the case folder. File Level 1 appeal per Section 11.2.

11.2 Appeal Submission

1. Gather from the case folder: original claim PDF, PA approval, physician LMN, visit_note export, and ERA/EOB showing the denial.
2. Complete appeal_template.docx. Save as appeal_L[1 or 2]_[DOS].pdf.
3. Email appeal to payer_rules.xlsx col Appeal_Submission_Email. Subject: [APPEAL L[1/2]] CareIG | [Patient Last Name] | MemberID: [Primary_Member_ID] | DOS: [DOS] | Claim: [Submission_Ref_Number] | CARC: [code]. Attach all documents.
4. Update appeals/appeals_log.xlsx: DOS, CARC_Code, Appeal_Level, Appeal_Submitted_Date, Appeal_Status = Submitted.
5. Post to #billing-appeals: [APPEAL FILED L[1/2]] [CASE_ID] | DOS | Payer | CARC.

Follow-up: if (today – Appeal_Submitted_Date) ≥ 15 days and Appeal_Status = Submitted, call payer appeal department (or for Administrative Support, send Template 7 referencing the appeal). Log in col Followup_Log: [Date] [Time] | Rep: [name] | Ref#: [#] | Next: [date].

If Level 2 denied: post to #billing-mgmt: [L2 DENIED] CASE_ID. Director of Revenue Cycle determines next action (write-off, IRO request, or state commissioner complaint).

Log to audit_log.xlsx: Action = Appeal Submitted.

12. Escalation & Monitoring

12.1 Escalation Paths

Scenario	Slack Channel	Action
PA pending > 5 days	#intake-mgmt	Post: [PA DELAY] CASE_ID Payer Days Pending. Supervisor follows up with payer.
Claim unpaid, no ERA	#billing	Post: [AR FOLLOWUP] CASE_ID [days] outstanding [Payer]. Log payer call (or email sent) in claim.xlsx col AR_Followup_Log.
Payer underpaid vs contract	#billing-mgmt	Post: [UNDERPAYMENT] CASE_ID Expected: \$[rate] Received: \$[paid]. Director or contracting team reviews contract terms.
Patient balance >0, unresolved on or after 90 days	#billing-mgmt	□ Balance ≤\$200: Billing Specialist may approve a write-off. Update claim.xlsx: Claim_Status = "Written Off". Log to audit_log.xlsx. □ Balance >\$200 escalate to Billing Supervisor (#billing-mgmt). Post: [WRITE-OFF REQUEST] CASE_ID Amount: \$[amount] Reason: [reason]. Requires Director approval before actioning.
Level 2 appeal denied	#billing-mgmt	Post: [L2 DENIED] CASE_ID. Director determines: write-off, IRO, or state complaint.
Legal threat or attorney communication	#compliance	STOP. Do not respond or modify case files. Post: [LEGAL THREAT] CASE_ID. Director of Operations and legal@careig.com must be notified immediately.
Suspected fraud or billing abuse	#compliance	STOP. Do not discuss elsewhere or modify files. Post: [COMPLIANCE REPORT] CASE_ID. Contact compliance@careig.com.
Wrong drug lot/dose from partner pharmacy	#clinical-scheduling	Do not administer. Document in clinical.xlsx col Drug_Issue_Notes. Post: [DRUG ISSUE] CASE_ID — visit on hold. Contact partner pharmacy.

12.2 Workflow Monitoring

The intake supervisor, billing supervisor, or designated lead is responsible for reviewing open cases each morning. For each active case, check the condition in the left column against the relevant file. If the condition is true and the Slack message has not yet been sent, send it now. Do not wait for the assigned staff member to flag it — this review is a supervisory responsibility.

Condition	Slack Notification
audit_log.xlsx has Referral Received for CASE_ID but no BVS Assigned entry	#intake-alerts: [UNASSIGNED] CASE_ID — no BVS assigned.
benefits.xlsx col BV_Complete is blank after BVS Assigned log entry	#intake-alerts: [BV OVERDUE] CASE_ID.
auth.xlsx col PA_Submission_Date is blank after BV_Complete = YES	#intake-alerts: [PA NOT SUBMITTED] CASE_ID.
auth.xlsx col PA_Status = Pending AND Last_Followup_Date is 2+ days old	Call payer. Update PA_Call_Log and Last_Followup_Date in auth.xlsx.

clinical.xlsx col Handoff_Status is blank after auth.xlsx col PA_Status = Approved	#clinical-scheduling: [HANDOFF MISSING] CASE_ID.
clinical.xlsx col Visit_Date is blank after Handoff_Status = Received	#clinical-scheduling: [UNSCHEDULED] CASE_ID.
visit_note.xlsx col Nurse_Signature is blank after Visit_Date is populated	#clinical-scheduling: [UNSIGNED NOTE] CASE_ID.
claim.xlsx col Submission_Date is blank after Nurse_Signature is populated	#billing: [CLAIM NOT SUBMITTED] CASE_ID.
claim.xlsx col ERA_Received_Date is populated AND Payment_Posted_Date is blank	#billing: [ERA UNPOSTED] CASE_ID.
A file in has Appeal_Submitted = blank	#billing-appeals: [DENIAL UNWORKED] CASE_ID.
(today – claim.xlsx col DOS) in days exceeds 80% of payer_rules.xlsx col Timely_Filing_Days AND claim.xlsx col Submission_Date is blank	#billing: [TIMELY FILING RISK] CASE_ID [days elapsed] of [limit] days [Payer]. Submit claim immediately.

13. Reference Tables

13.1 HCPCS / J-Code Reference

Source: jcodes.xlsx. Always use visit_note.xlsx col Dose_Administered_Grams — never the ordered dose. Billed rates for each code are stored in fee_schedule.xlsx col Billed_Rate. To calculate Total_Billed for a claim: multiply each code's units by its Billed_Rate and sum all lines. Write the result to claim.xlsx col Total_Billed.

HCPCS	Description	Unit	Formula
J1459	IVIG — Privigen, Gammagard (IV)	500 mg	$(g \times 1000) \div 500$
J1557	IVIG — Gammaplex (IV)	500 mg	$(g \times 1000) \div 500$
J1559	IVIG — Hizentra (SQ)	100 mg	$(g \times 1000) \div 100$
J1560	IVIG — Octagam (IV)	500 mg	$(g \times 1000) \div 500$
J1561	IVIG — Gamunex-C (IV or SQ)	500 mg	$(g \times 1000) \div 500$
J1569	IVIG — Gammagard Liquid (IV)	500 mg	$(g \times 1000) \div 500$
J1575	IVIG — HyQvia (SQ)	100 mg	$(g \times 1000) \div 100$
J7030	Normal Saline 0.9%, per 500 mL bag	500 mL	Units = NS_500mL_Bags_Used
J7050	Normal Saline 0.9%, per 250 mL bag	250 mL	Units = NS_250mL_Bags_Used
J0171	Diphenhydramine (Benadryl), per 50 mg	50 mg	Units = mg administered $\div$ 50. Requires documentation in Premeds_Administered.
J2550	Promethazine injection, per 25 mg	25 mg	Units = mg administered $\div$ 25. Same documentation rule as J0171.

A4221	IV infusion supplies, per visit	Per visit	Bill 1 unit per visit regardless of whether a pump is used.
A4222	Infusion pump supplies, per visit	Per visit	Bill 1 additional unit per visit when Pump_Used = YES. Bill alongside A4221, not instead of it.
99600	Home infusion nursing — first hour	Per visit	1 unit. Default for non-Medicare.
99603	Home infusion nursing — each add'l hour	Per add'l hour	$\text{floor}((\text{Visit_Duration_Minutes} - 60) \div 60)$ units.
G0153	Skilled nursing, home infusion (Medicare)	Per visit	1 unit. Medicare Part B only. Replaces 99600/99603.
T1029	Nursing assessment, per visit	Per visit	Use when Nursing_Code_Pref = T1029. Verify by state.
T1032	Nursing visit, per diem	Per diem	Use when Nursing_Code_Pref = T1032. Verify by state.

13.2 Unit Calculation Examples

Scenario	Result
30g Gammaplex 5% IV → J1557	$30 \times 1000 \div 500 = 60$ units
40g Privigen 10% IV → J1459	$40 \times 1000 \div 500 = 80$ units
6g Hizentra 20% SQ → J1559	$6 \times 1000 \div 100 = 60$ units
10g HyQvia 10% SQ → J1575	$10 \times 1000 \div 100 = 100$ units
Partial: ordered 30g, administered 20g → J1557	Use 20g only: $20 \times 1000 \div 500 = 40$ units.
270-minute visit, non-Medicare	$99600 \times 1 + 99603 \times \text{floor}((270-60) \div 60) = 99600 \times 1 + 99603 \times 3$
270-minute visit, Medicare Part B	G0153 $\times 1$ only

13.3 Drug Reference

Drug	Route	J-Code	Units/g	Notes
Gammaplex 5% / 10%	IV	J1557	2	Diluent: 10% Dextrose — do NOT use NS. Refrigerate until 1 hr before use. Document bags used in visit_note.xlsx col Dextrose_500mL_Bags_Used. Bill via A4221 — do not bill J7030 or J7050.
Octagam 5% / 10%	IV	J1560	2	Do NOT shake. Confirm MD-ordered rate for 10%.
Gammagard S/D	IV	J1459	2	Reconstitute per package insert. Latex-free.
Gammagard Liquid 10%	IV	J1569	2	Off-label SQ use requires a separate MD order in .

Privigen 10%	IV	J1459	2	Contraindicated in hyperprolinemia. Check intake.xlsx col Contraindications.
Gamunex-C 10%	IV or SQ	J1561	2	Document route in visit_note.xlsx. Same J-code for both routes.
Hizentra 20%	SQ	J1559	10	Document self-infusion training on first visit in Education_Provided.
HyQvia 10%	SQ	J1575	10	Check payer_rules.xlsx for hyaluronidase co-billing requirement.

13.4 ICD-10 Reference

ICD-10 codes come from intake.xlsx col Diagnosis_ICD10. Confirm the code is in this table as written here and the required documentation exists in the case folder before submitting any PA or claim.

ICD-10	Diagnosis	Required Documentation in
D83.9	CVID, unspecified	MD progress note; IgG < 400 mg/dL within 6 months
D80.0	Hereditary hypogammaglobulinemia	MD note with hereditary basis; IgG level
D80.1	Nonfamilial hypogammaglobulinemia	IgG < 400 mg/dL lab result; MD progress note
D80.6	Antibody deficiency w/ near-normal Ig	Clinical notes; specialist consult preferred
D89.3	Immune reconstitution syndrome	Transplant documentation; oncology/hematology consult
G61.0	Guillain-Barré Syndrome	Neurology consult; NCS/EMG results; MD LMN
G70.00	Myasthenia gravis, without exacerbation	EMG/NCS; neurology note
G70.01	Myasthenia gravis, with exacerbation	Crisis history; set auth.xlsx col Urgency = STAT
D69.3	Immune thrombocytopenic purpura	Platelet count labs; MD diagnosis note
B20	HIV disease	CD4 count; viral load; HIV diagnosis; MD LMN
Z94.0–Z94.9	Transplant status	Transplant surgical record or discharge summary

13.5 Payer Guidelines

Payer Type	Claim Format	Key Rules
Medicare Part B	Email (PDF)	Use G0153 for nursing. Apply MSP rules. Verify MAC in payer_rules.xlsx.
Medicare Advantage	Email (PDF) per plan	Confirm IVIG benefit placement (medical vs pharmacy) in benefits.xlsx col Benefit_Type.

Medicaid	Email (PDF) per state	PA required in most states. Check formulary and nursing code per state in payer_rules.xlsx.
Commercial PPO	Email (PDF)	Confirm CareIG_Network_Status = In-Network before scheduling.
Commercial HMO	Email (PDF)	PCP referral may be required. Document in benefits.xlsx col Referral_Required.
Accredo / Coram (OON)	CareIG bills nursing only	Do NOT bill drug J-code. Bill: 99600/99603, A4221/A4222, pre-med J-codes, saline only.

14. Appendix A — Scripts & Templates

Template 1: Unable to Reach Patient — Email to Referring Physician

To: intake.xlsx col Physician_Email **Subject:** [UNREACHABLE PATIENT] CASE_ID: [CASE_ID]

Dear Dr. [intake.xlsx Physician_Name],

We received a referral for [intake.xlsx Patient_First_Name] [intake.xlsx Patient_Last_Name] (DOB: [intake.xlsx DOB]) for home IVIG infusion therapy.

We have made three contact attempts at [intake.xlsx Patient_Phone] and have been unable to reach the patient.

Please provide an alternate contact number or assist in connecting the patient with our team. We cannot proceed with scheduling until contact is established.

[Staff Name] — CareIG Specialty Pharmacy, Intake intake@careig.com

Template 2: Peer-to-Peer Request — Email to Physician

To: intake.xlsx col Physician_Email **Subject:** [P2P REQUEST] CASE_ID: [CASE_ID] | PA Case#: [auth.xlsx PA_Ref_Number]

Dear Dr. [intake.xlsx Physician_Name],

Patient: [intake.xlsx Patient_First_Name] [intake.xlsx Patient_Last_Name] | DOB: [intake.xlsx DOB] | Member ID: [intake.xlsx Primary_Member_ID]

The prior authorization for [auth.xlsx PA_Approved_Drug] [auth.xlsx PA_Approved_Dose]g was denied by [intake.xlsx Primary_Insurance_Name] with the following reason: [auth.xlsx PA_Denial_Reason].

The payer has offered a peer-to-peer review. Available time slots: [auth.xlsx P2P_Available_Slots — one per line]

To schedule, please contact the payer's prior authorization department at [benefits.xlsx PA_Submission_Email] and reference PA Case#: [auth.xlsx PA_Ref_Number].

If we do not receive a response within 2 business days, CareIG will file a Level 1 written appeal on the patient's behalf.

[Staff Name] — CareIG Specialty Pharmacy, Prior Authorization pa@careig.com

Template 3: Appeal Letter — Level 1 and Level 2

To: benefits.xlsx col PA_Submission_Email **Subject:** [APPEAL L[1/2]] CASE_ID: [CASE_ID] | Claim:

[claim.xlsx Submission_Ref_Number] | CARC: [code]

APPEAL LEVEL: [1 / 2]

Patient: [intake.xlsx Patient_Last_Name], [intake.xlsx Patient_First_Name] | DOB: [intake.xlsx DOB] | Member ID: [intake.xlsx Primary_Member_ID] DOS: [claim.xlsx DOS] | Claim #: [claim.xlsx Submission_Ref_Number]

CARC: [code] — [description] Billed: \$[claim.xlsx Total_Billed]

CareIG Specialty Pharmacy (NPI: [org_identifiers.xlsx CareIG_NPI] | Tax ID: [org_identifiers.xlsx EIN]) submits this Level [1/2] appeal for the above-referenced patient.

The claim was denied with CARC [code]: [description].

Basis for Appeal: PA #[auth.xlsx PA_Number] was approved for [auth.xlsx PA_Approved_Drug] [auth.xlsx PA_Approved_Dose]g, effective [auth.xlsx PA_Effective_Date] through [auth.xlsx PA_Expiration_Date]. The service on [claim.xlsx DOS] is consistent with the approved authorization and diagnosis [intake.xlsx Diagnosis_ICD10].

The agent should add specific clinical justification here referencing the attached documents (e.g., citing lab values from the IgG level report or clinical notes from the visit note).

Attached:

1. Original claim — claim_[DOS].pdf
2. PA approval — pa_approval_[Payer].pdf (PA#: [auth.xlsx PA_Number])
3. Physician LMN — lmn_[Physician_Name].pdf
4. Nursing visit note (exported from visit_note.xlsx)
5. Lab results — igglevel_[MMDDYYYY].pdf
6. ERA/EOB — era_[DOS]_[Payer].pdf

CareIG requests reconsideration and payment at contracted rate: \$[payer_rules.xlsx Contracted_Rate for the relevant HCPCS code].

[Staff Name] — CareIG Specialty Pharmacy, Billing billing@careig.com | [org_identifiers.xlsx Billing_Phone]

Template 4: Benefits Verification Request — Email to Payer

To: intake.xlsx col Primary_Payer_Email **Subject:** [BV REQUEST] CareIG NPI: [org_identifiers.xlsx CareIG_NPI] | MemberID: [intake.xlsx Primary_Member_ID]

Dear Benefits Verification Department,

CareIG Specialty Pharmacy is requesting benefits verification for the following member:

Patient: [intake.xlsx Patient_First_Name] [intake.xlsx Patient_Last_Name] | DOB: [intake.xlsx DOB] | Member ID: [intake.xlsx Primary_Member_ID] | Group: [intake.xlsx Primary_Group_Number] Referring Physician: Dr. [intake.xlsx Physician_Name] | NPI: [intake.xlsx Physician_NPI] Prescribed Treatment: [intake.xlsx Drug_Name] [intake.xlsx Drug_Dose_Grams]g [intake.xlsx Drug_Frequency] — home IVIG infusion Diagnosis: [intake.xlsx Diagnosis_ICD10]

Please confirm the following:

1. Does this plan cover home infusion therapy?
2. Is IVIG covered under the medical or pharmacy benefit?
3. Is prior authorization required? If yes, PA submission email address.
4. Is a specific specialty pharmacy required? If yes, which one?
5. Is CareIG Specialty Pharmacy (NPI: [org_identifiers.xlsx CareIG_NPI]) in-network?
6. Individual deductible and amount met YTD
7. Out-of-pocket maximum and amount met YTD
8. Coinsurance percentage and per-visit copay
9. Plan year type (calendar or fiscal)
10. Coverage effective and termination dates

Please reply with a reference number to benefits@careig.com.

[Staff Name] — CareIG Specialty Pharmacy, Benefits Verification benefits@careig.com

Template 5: Estimated Patient Cost — Email to Patient

To: intake.xlsx col Patient_Email **Subject:** CareIG — Your Estimated Infusion Cost

Dear [intake.xlsx Patient_First_Name],

We have reviewed your insurance benefits for your upcoming IVIG infusion therapy. Based on your current plan, your estimated out-of-pocket cost per infusion visit is approximately \$[calculated per \$7.3].

This is an estimate only. Your insurance company determines the final amount once the claim is processed. Your actual cost may be higher or lower depending on other claims applied to your deductible during the plan year.

If you have questions or are experiencing financial difficulty, please reply to this email or contact us at intake@careig.com. Assistance programs may be available.

[Staff Name] — CareIG Specialty Pharmacy, Intake intake@careig.com

Template 6: Appointment Confirmation — Email to Patient

To: intake.xlsx col Patient_Email **Subject:** CareIG — IVIG Infusion Appointment | [clinical.xlsx Visit_Date YYYY-MM-DD format]

Dear [intake.xlsx Patient_First_Name],

Your insurance has approved your IVIG infusion. We have the following appointment available:

Date: [clinical.xlsx Visit_Date Visit_Date YYYY-MM-DD format] Time: [clinical.xlsx Visit_Time HH:MM am/pm (e.g. 12:00 pm) format] Approximate Duration: [infusion_duration.xlsx lookup matching drug and dose range] hours Location: Your home address on file

Please reply to confirm, or let us know if you need a different date or time. If we do not hear from you within 2 business days, we will follow up.

[Staff Name] — CareIG Specialty Pharmacy, Clinical Scheduling scheduling@careig.com

Template 7: PA Follow-Up — Email to Payer

To: benefits.xlsx col PA_Submission_Email **Subject:** [PA FOLLOW-UP] CareIG | PA Ref: [auth.xlsx PA_Ref_Number]

Dear Prior Authorization Department,

CareIG Specialty Pharmacy is requesting a status update on the following prior authorization:

Patient: [intake.xlsx Patient_First_Name] [intake.xlsx Patient_Last_Name] | DOB: [intake.xlsx DOB] | Member ID: [intake.xlsx Primary_Member_ID] PA Reference: [auth.xlsx PA_Ref_Number] | Submitted: [auth.xlsx PA_Submission_Date] Drug: [auth.xlsx PA_Approved_Drug] [auth.xlsx PA_Approved_Dose]g | Diagnosis: [intake.xlsx Diagnosis_ICD10] Days pending: [calculate: today minus auth.xlsx PA_Submission_Date] Please reply with the current status, expected decision date, and any additional documentation required. [Staff Name] — CareIG Specialty Pharmacy, Prior Authorization pa@careig.com

Template 8: Visit Assignment — Email to Nurse

To: nurses.xlsx col Nurse_Email (for the assigned nurse) **Subject:** [VISIT ASSIGNMENT] [CASE_ID] | [clinical.xlsx Visit_Date] [nurses.xlsx Nurse_Name],

You have been assigned the following IVIG home infusion visit:

Date: [clinical.xlsx Visit_Date] | Time: [clinical.xlsx Visit_Time] | Duration: approximately [infusion_duration.xlsx lookup] hours Patient Address: [intake.xlsx Patient_Address] Drug: [intake.xlsx Drug_Name] [intake.xlsx Drug_Dose_Grams]g | Lot: [clinical.xlsx Drug_Lot_Number] | NDC: [clinical.xlsx Drug_NDC], Infusion Rate: [intake.xlsx Infusion_Rate_Ordered_mL_hr] Route: [from physician orders in the referral] Pre-Medication Orders: [intake.xlsx Premeds_Ordered, or "None ordered"] Contraindications: [intake.xlsx Contraindications] Emergency Contact: [intake.xlsx Patient_Phone] Please confirm receipt by replying to this email. CareIG Specialty Pharmacy, Clinical Scheduling scheduling@careig.com

Template 9: COB Payer Inquiry — Email to Payer

To: benefits.xlsx col Secondary_Claim_Submission_Email (or PA_Submission_Email for the denying payer) **Subject:** COB Clarification — Claim [claim.xlsx Submission_Ref_Number] — DOS [claim.xlsx DOS]

Dear Claims Department,

We received denial code CO-22 on the above claim, indicating coordination of benefits applies. Please confirm which payer is primary for this patient for the date of service listed.

If another payer is primary, please provide the primary payer's name and payer ID so we can submit accordingly.

Patient: [intake.xlsx Patient_First_Name] [intake.xlsx Patient_Last_Name] Member ID: [intake.xlsx Primary_Member_ID] Date of Service: [claim.xlsx DOS] Claim Reference: [claim.xlsx Submission_Ref_Number]

Thank you, [Staff Name] — CareIG Specialty Pharmacy, Billing billing@careig.com

Template 10: Initial Patient Contact — Email to Patient

To: intake.xlsx col Patient_Email **Subject:** CareIG Specialty Pharmacy — Referral Received

Dear [intake.xlsx Patient_First_Name],

Your physician, Dr. [intake.xlsx Physician_Name], has referred you to CareIG Specialty Pharmacy for home IVIG infusion therapy. We will be coordinating your insurance verification, scheduling, and nursing visits. Before we can proceed, we require a signed Consent for Treatment and Financial Responsibility form. Please find the form attached. Sign and return it by replying to this email with the signed form attached.

If you have any questions about the process, please reply to this email or contact us at intake@careig.com. [Staff Name] — CareIG Specialty Pharmacy, Intake intake@careig.com

— END OF DOCUMENT — CareIG-SOP-BILL-001 v6.0 —