Explanation of Benefits – How to Read One and Denial Management

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Outline

- Definition and Purpose
- Components of an Explanation of Benefits (EOB) and the Remittance Advice (RA)
- Code Lists
- Adjustment Types
- Adjustment Reports
- Follow-up Process

Definition and Purpose

- An explanation of benefits (EOB) or remittance advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied.

- The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full.

Deciphering the EOB – Not Easy

- Challenges
  - Not Standardized
  - Multiple claims on one check
  - Contract Agreements

Pre-posting Operations

- Compare the EOB with the original claim, and review each carefully.
  - Charge total on claim should match EOB total
  - Look for code changes (down-coded)
  - Identify charges that can be appealed or re-billed for payment
- Investigate all denied services – determine the reason for the denial and appeal them, if appropriate
- Requests for additional information must be addressed immediately

Components of an EOB

Information found on an Explanation of Benefit statement:	
•Payer's name and address	•Reductions or denial codes, comment codes indicating reasons payments were denied, asking for more information to determine coverage and benefits, or stating amount of adjustment because of payments by other insurance companies.
•Provider of services	•Claim control number
•Dates of service	•Subscriber's and patient's name and policy numbers
•Service or procedures code numbers	•Analysis of patient's total payment responsibility (amount not covered, co-payment, deductibles, coinsurance, other insurance payment and patient's total responsibility
•Amounts billed by the provider	•Total amount paid by the payer

Components of the Institutional Standard Paper Remittance Advice

- Institutional Standard Paper Remittance Advices (SPRs) are split into two basic sections:
  - All Claims Page(s)
  - Summary Page

  CMS offers a guide that is designed as a self-help resource for providers to understand the Medicare Remittance Advice.

This guide can be accessed at:

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Let's look at an example Institutional SPR

Example Institutional SPR - All Claims Page(s)

1

2

3

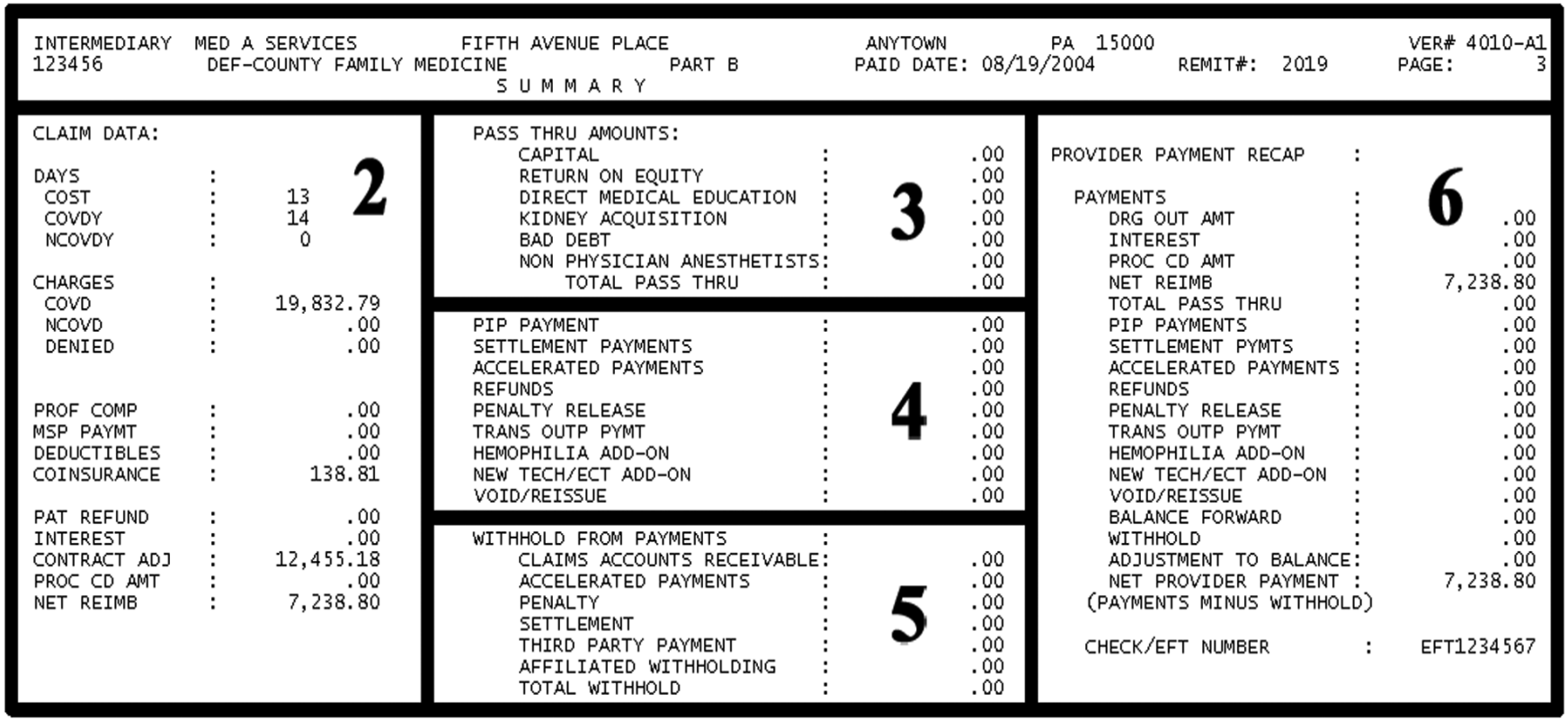
```
INTERMEDIARY  MED A SERVICES         FIFTH AVENUE PLACE                ANYTOWN         PA  15000                      VER# 4010-A1
123456         DEF-COUNTY FAMILY MEDICINE              PART B          PAID DATE: 08/19/2004       REMIT#:  2019      PAGE:       1

PATIENT NAME            PATIENT CNTRL NUMBER     RC   REM  DRG#          DRG OUT AMT    COINSURANCE    PAT REFUND     CONTRACT ADJ
HIC NUMBER              ICN NUMBER               RC   REM  OUTCD  CAPCD  NEW TECH       COVD CHGS      ESRD NET ADJ   PER DIEM RTE
FROM DT    THRU DT      NACHG  HICHG  TOB        RC   REM  PROF COMP     MSP PAYMT      NCOVD CHGS     INTEREST       PROC CD AMT
CLM STATUS              COST   COVDY  NCOVDY     RC   REM  DRG AMT       DEDUCTIBLES    DENIED CHGS    PRE PAY ADJ    NET REIMB
NPI

JOSE                B L VAE80972                 42   MA02  416                .00            .00            .00          11784.61
9999999999              20545445052601       01      MA44            B       .00          18828.83         .00            .00
04/08/2003 04/21/2003                  111                        .00       .00            .00            .00            .00
    1                   13    13                            7044.22       .00            .00            .00          7044.22
1234567890

SUBTOTAL FISCAL YEAR - 2003                                                 .00            .00            .00          11784.61
                                                                            .00          18828.83         .00            .00
                                                                  .00       .00            .00            .00            .00
                        13    13                            7044.22       .00            .00            .00          7044.22
SUBTOTAL PART A                                                             .00            .00            .00          11784.61
                                                                            .00          18828.83         .00            .00
                                                                  .00       .00            .00            .00            .00
                        13    13                            7044.22       .00            .00            .00          7044.22
```

Example Institutional SPR - Summary Page



1

INTERMEDIARY MED A SERVICES FIFTH AVENUE PLACE ANYTOWN PA 15000 VER# 4010-A1
123456 DEF-COUNTY FAMILY MEDICINE PART B PAID DATE: 08/19/2004 REMIT#: 2019 PAGE: 3

S U M M A R Y

CLAIM DATA: 2

DAYS	:	
COST	:	13
COVDY	:	14
NCOVDY	:	0
CHARGES	:	
COVD	:	19,832.79
NCOVD	:	.00
DENIED	:	.00
PROF COMP	:	.00
MSP PAYMT	:	.00
DEDUCTIBLES	:	.00
COINSURANCE	:	138.81
PAT REFUND	:	.00
INTEREST	:	.00
CONTRACT ADJ	:	12,455.18
PROC CD AMT	:	.00
NET REIMB	:	7,238.80

PASS THRU AMOUNTS: 3

CAPITAL	:	.00
RETURN ON EQUITY	:	.00
DIRECT MEDICAL EDUCATION	:	.00
KIDNEY ACQUISITION	:	.00
BAD DEBT	:	.00
NON PHYSICIAN ANESTHETISTS	:	.00
TOTAL PASS THRU	:	.00

4

PIP PAYMENT	:	.00
SETTLEMENT PAYMENTS	:	.00
ACCELERATED PAYMENTS	:	.00
REFUNDS	:	.00
PENALTY RELEASE	:	.00
TRANS OUTP PYMT	:	.00
HEMOPHILIA ADD-ON	:	.00
NEW TECH/ECT ADD-ON	:	.00
VOID/REISSUE	:	.00

WITHHOLD FROM PAYMENTS : 5

CLAIMS ACCOUNTS RECEIVABLE	:	.00
ACCELERATED PAYMENTS	:	.00
PENALTY	:	.00
SETTLEMENT	:	.00
THIRD PARTY PAYMENT	:	.00
AFFILIATED WITHHOLDING	:	.00
TOTAL WITHHOLD	:	.00

PROVIDER PAYMENT RECAP : 6

PAYMENTS	:	
DRG OUT AMT	:	.00
INTEREST	:	.00
PROC CD AMT	:	.00
NET REIMB	:	7,238.80
TOTAL PASS THRU	:	.00
PIP PAYMENTS	:	.00
SETTLEMENT PYMTS	:	.00
ACCELERATED PAYMENTS	:	.00
REFUNDS	:	.00
PENALTY RELEASE	:	.00
TRANS OUTP PYMT	:	.00
HEMOPHILIA ADD-ON	:	.00
NEW TECH/ECT ADD-ON	:	.00
VOID/REISSUE	:	.00
BALANCE FORWARD	:	.00
WITHHOLD	:	.00
ADJUSTMENT TO BALANCE	:	.00
NET PROVIDER PAYMENT (PAYMENTS MINUS WITHHOLD)	:	7,238.80
CHECK/EFT NUMBER	:	EFT1234567

Components of the Professional Standard Paper Remittance Advice

- Professional Standard Paper Remittance Advices (SPRs) are split into four basic sections:
  - Header Information
  - Assigned Claims
  - Unassigned Claims
  - Glossary

  CMS offers a guide that is designed as a self-help resource for providers to understand the Medicare Remittance Advice.

  This guide can be accessed at:

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Let's look at an example Professional SPR

Example Professional SPR – Page 1

1

```
EXAMPLE MEDICARE CARRIER
1000 SOMEPLACE LANE
FAIRFAX, VA 22033-0000                                          MEDICARE
1-877-555-1234                                                  REMITTANCE
                                                                NOTICE

EXAMPLE MEDICARE PROVIDER                                       NPI:  1234567890
200 DOCTORS DRIVE                                               PAGE #:  1 OF 2
SUITE 200                                                       DATE:  01/28/03
SOMEWHERE, NJ   16666-0200                                      CHECK/EFT #:  000234569
*****************************************************************************************************
*                                                                                                   *
*                      WELCOME TO THE MEDICARE PART B STANDARD PAPER REMITTANCE                     *
*                                                                                                   *
*                                                                                                   *
*                                                                                                   *
*                                                                                                   *
```

2

```
PERF PROV   SERV DATE  POS NOS  PROC   MODS   BILLED   ALLOWED   DEDUCT   COINS  GRP/RC   AMT   PROV PD
-----------------------------------------------------------------------------------------------------
NAME FISCHER, BENNY      HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306840   ASG Y        MOA MA01
123456ABC  0225 022502 11   1  99213          66.00    49.83     0.34     9.97  PR-96  16.17    39.52
PT RESP    10.31             CLAIM TOTALS   66.00    49.83     0.34     9.97         16.17
                                                                                 NET   39.52
-----------------------------------------------------------------------------------------------------
NAME FISCHER, BENNY      HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306850   ASG Y  MOA MA01 MA07
123456ABC  0117 011702 11   1 99213          66.00    49.83     0.00     9.97  PR-96  16.17    39.86
PT RESP     9.97             CLAIM TOTALS   66.00    49.83     0.00     9.97         16.17    39.86
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                             NET   39.86
-----------------------------------------------------------------------------------------------------
NAME HURT, I. M.         HIC 9999999999 ACNT  HURT5-329       ICN 0202199306860   ASG Y        MOA MA01
123456ABC  0117 011702 11   1  90659          25.00     3.32     0.00     0.00  CO-42  21.68     3.32
123456ABC  0117 011702 11   1  G0008          10.00     4.46     0.00     0.00  CO-42   5.54     4.46
PT RESP     0.00             CLAIM TOTALS   35.00     7.78     0.00     0.00         27.22     7.78
                                                                                 NET    7.78
-----------------------------------------------------------------------------------------------------
NAME MARLOWE, PHILIP     HIC 9999999999 ACNT  MARLO861-316    ICN 0202199306870   ASG Y  MOA MA01 MA07
123456ABC  0209 020902 11   1  99213          66.00    49.83     0.00     9.97  PR-96  16.17    39.86
PT RESP     9.97             CLAIM TOTALS   66.00    49.83     0.00     9.97         16.17    39.86
ADJ TO TOTALS:  PREV PD  10.00    INT  0.00        LATE FILING CHARGE  0.00
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                             NET   29.86
-----------------------------------------------------------------------------------------------------
NAME RAP, JACK           HIC 9999999999 ACNT  RAP33-721       ICN 0202199306880   ASG Y  MOA MA01 MA07
123456ABC  0314 031402 11   1  99213          66.00    49.83     0.00     9.97  PR-96  16.17    39.86
123456ABC  0314 031402 11   1  82962          10.00     4.37     0.00     0.00  CO-42   5.63     4.37
123456ABC  0314 031402 11   1  94760          12.00     0.00     0.00     0.00  CO-B15 12.00     0.00
REM: M80
PT RESP     9.97             CLAIM TOTALS   88.00    54.20     0.00     9.97         33.80    44.23
                                                                                 NET   44.23
```

3

```
TOTALS:    # of      BILLED    ALLOWED     DEDUCT      COINS      TOTAL       PROV PD        PROV       CHECK
         CLAIMS        AMT       AMT         AMT        AMT     RC AMT         AMT       ADJ AMT        AMT
            5       321.00    211.47        0.34      39.88     109.53       161.25         25.44     135.81

  PROVIDER ADJ DETAILS:      PLB REASON CODE        FCN                HIC          AMOUNT
                                      50
                                      FB          0202199306770   9999999999      10.00
```

Example Professional SPR – Page 2

1

EXAMPLE MEDICARE CARRIER
NPI: 1234567890 GOODHEALTH GROUP PRACTICE MEDICARE REMITTANCE
CHECK/EFT: 00234569 01/28/2003 PAGE 2 OF 2 NOTICE

2

SUMMARY OF UNASSIGNED CLAIMS

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
NAME FINE, R. U.			HIC 9999999999	ACNT	FINE7-002		ICN 0202199000150		ASG N			MOA MA28
123456ABC	0526 052602	11	1	99214		60.47	52.58	0.00	10.52	CO-42	0.00	7.89
PT RESP	60.47		CLAIM TOTALS			60.47	52.58	0.00	10.52		0.00	
ADJ TO TOTALS:	PREV PD	0.00.	INT	0.00	LATE FILING CHARGE	0.00						
NAME LAWN, MOE D.			HIC 9999999999	ACNT	LAWN4-667		ICN 0202199140370		ASG N			MOA MA28
123456ABC	0222 022202	11	1	99214		60.47	52.58	0.00	10.52	CO-42	0.00	7.89
PT RESP	60.47		CLAIM TOTALS			60.47	52.58	0.00	10.52		0.00	
ADJ TO TOTALS:	PREV PD	0.00	INT	0.00	LATE FILING CHARGE	0.00						

3

GROUP CODES:

PR	Patient Responsibility
CO	Contractual Obligation
OA	Other Adjustment

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes

CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
PR	Patient Responsibility. Amount that may be billed to a patient or another payer.
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)
96	Non-covered charge(s)
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA07	Alert: The claim information has also been forwarded to Medicaid for review.
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
50	Late Filing Reduction
FB	Forwarding Balance

HIPAA Non-Medical Code Sets

- Four non-medical code set are used extensively to provide claim and reimbursement information on the Remittance Advice/Explanation of Benefits:
  - Group Codes
    - Identifies responsible party or the payment adjustment
  - Claim Adjustment Reason Codes (CARCs)
    - Provides financial information about claim decisions
  - Remittance Advice Remark Codes (RARCs)
    - Used in conjunction with CARCs to further explain an adjustment
  - Provider-Level Adjustment Reason Codes
    - Adjustments not related to a specific claim or service

View the latest codes at http://www.wpc-edi.com/ Washington Publishing Company

Washington Publishing Company | EDI | HIPAA | XML - Windows Internet Explorer

http://www.wpc-edi.com/content/view/711/401/

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Washington Publishing Company | EDI |...

Page | Safety | Tools

Code Lists

WPC assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. The lists are maintained by the Centers for Medicare and Medicaid Services (CMS), The National Uniform Claim Committee (NUCC), and committees that meet during trimester X12 meetings.

Each list is available as:

- Excel CSV & EDI files, with Change Alert Service Yearly Subscription
- Printed Document
- Change Alert Service Yearly Subscription

Click on a list below to view that list on-line

HEALTH CARE

- Claim Adjustment Reason Codes
- Remittance Advice Remark Codes
- Claim Status Codes
- Claim Status Category Codes
- Health Care Service Type Codes
- Health Care Provider Taxonomy Code Set
- Provider Characteristics Codes
- Health Care Services Decision Reason Codes
- Insurance Business Process Application Error Codes

PROPERTY & CASUALTY

- Several EDI-related P&C Code Lists

Internet | 125%

Types of Adjustments

- An adjustment refers to an change that relates to how a claim is paid differently for the original billing. There are seven general types of adjustments:
  - Denied Claim
  - Zero Payment
  - Partial Payment
  - Reduced Payment
  - Penalty Applied
  - Additional Payment
  - Supplemental Payment

Co-payment vs. Coinsurance

- Co-payments are specified amounts of money that the patient will pay for each doctor visit. Some have different co-payments for primary physician visits and specialists. Co-payments can vary in amounts, depending on the terms of the insured's policy, from $5, $10, $20, up to $40.
- Coinsurance is sharing the cost of medical care between the insured and the insurance company. This is found in major medical policies. Coinsurance would be paid after the insured has satisfied their annual deductible.

Deductible

- A deductible is an amount of money, set by the policy, that the insured will pay before the insurance company pays benefits. They run per calendar year, so on January 1st each year, the deductible will begin again.

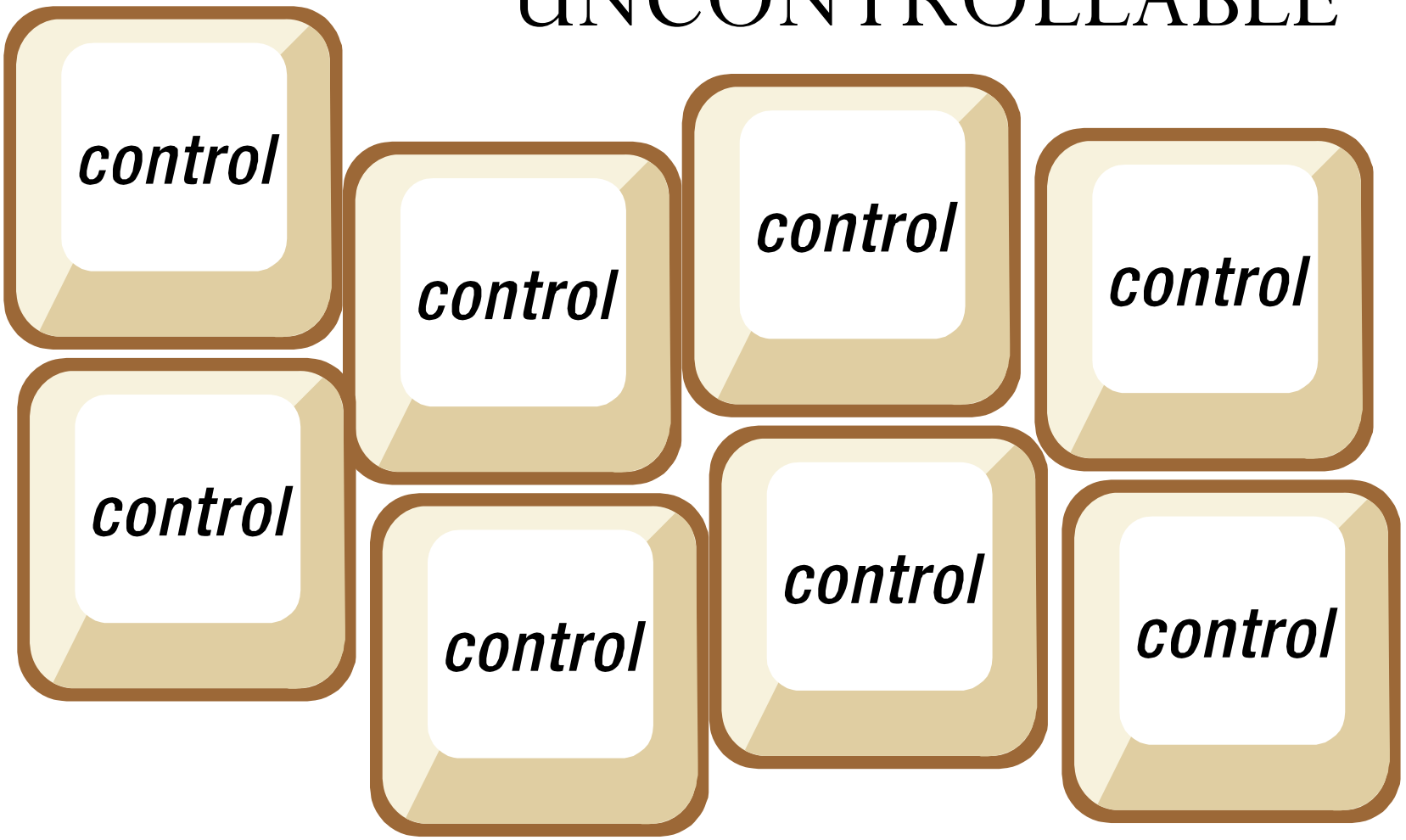
Non-Covered Services

- Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

A/R and Denial Management - Importance

- Accounts Receivable is the most important asset to the I/T/Us throughout Indian Country.
- I/TUs have become *dependent* on third party revenue to help us meet the goals, mission, and objectives of the Indian Health Service.
- Health care operations that provide *optimal patient care* in our facilities is dependent on these third party reimbursements.
- It is essential that we implement denial management procedures to make sure we *optimize the key functions* in the revenue cycle.

CONTROLLABLE VS. UNCONTROLLABLE



Write Offs/Adjustments – Controllable

- These are Adjustments/Write Offs that we can control, and should be minimal if we fix something in our process:
  - Billed in Error
  - No/Other Eligibility for this Patient (Verify by Patient Registration)
  - Non-Covered Service (Know our Policies and Benefit Plans)
  - Beyond Filing Limit (Drop Clean Claims faster and follow up)
  - Medical Records/Coding/DE Issues (Verifying at these function levels)
    - Missing Information, Wrong Information, Additional Information
  - Signature Requirement
  - Etc.
- Start Using Reports to look at your Adjustments/Write Offs
- Remember, we need to "Change Payer Behavior"

Write Offs/Adjustments – Un-Controllable

- Un-Controllable – Understanding that there are certain "non-payments" that are to be expected.
  - Going to Experience Regardless of the Billing Accuracy or Efficiency of the Program:
  - Our job is to know what they are and stay within those limits
    - Deductibles
    - Co-Pays/Co-Insurance
    - Over the Allowable/Over UCR (Usual Customary, and Reasonable) (semi controllable)
    - DRG Adjustment (Diagnostic Related Grouper)
    - Contractual Adjustments (semi controllable)

Denial Management

- **Reviewing, Monitoring, Trending, and Analyzing** PAYMENTS and DENIALS
- It is also important to note that the data in RPMS and the corresponding **reports are only as good as the data entered.**
- Posting of Adjustments codes should be **standardized.** The reasons that claims were not paid should be identified to the greatest level of detail so management can help you do a better job. If a claim was originally denied because it was filed beyond the filing limit, the adjustment reason should reflect that.
- Using reasons such as **"Other"** do not give us enough information to know if we could have prevented this denial, or challenged it with the payer.

Review the Adjustment Report

- Sites must print an adjustment Report at least once a week or more frequently
- The intent is to find items that:
  - Can assist you with process issues;
  - Define practices that each payer is following and that may need to be addressed
  - Identify the claims that need to be followed-up on before Timely filing limits

Adjustment Report Example

```
RPT    Report Menu ...

    BRM    Batch Reports Menu ...

           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8            |
           +                    Batch Reports Menu                    +
           |                  INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: USER,SUPER M          BUSINESS OFFICE     24-NOV-2008 3:09 PM


   BPP    Batch Posted Payments
   BSL    Batch Statistical Report
   RPRT   Re-Print Finance Letters
   TDN    Collection Batch Validation Report
   TDR    Treasury Deposit # Reconciliation Report
   TBSL   Treasury Deposit/Batch Statistical Report
   TSR    Transaction Statistical Report

Select Batch Reports Menu Option:
```

Adjustment Report Example (cont'd)

```
RPT    Report Menu ...

    FRM    Financial Reports Menu ...

           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
           +                 Financial Reports Menu                 +
           |             NATIVE AMERICAN HEALTH CENTER              |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: JOHNSON,TONI            BUSINESS OFFICE     13-APR-2009 8:34 AM

   ADA     Advise of Allowance RPT
   IPDR    Inpatient Primary Diagnosis Report
   PRP     Payment Summary Report by Collection Batch
   PSR     Period Summary Report
   STA     A/R Statistical Report
   TAR     Transaction Report
   ADJ     Adjustment & Refund Report
   AWOR    Automatic Write-Off Report

Select Financial Reports Menu Option:
```

What do your Adjustments Tell You?

- If you find that a large percentage of your denials are due to billing errors, timely filing, and duplicate submissions
  - Training
  - Increase your billing/patient accounts staff
- If you find a percentage of your errors are due to procedures not medically necessary
  - Meet with Providers and Coding staff to see where the disruption or gap is

What do your Adjustments Tell You? (Cont'd)

- If you find that rejections are due to eligibility issues, Patient Registration and Benefits Coordination will have to help resolve those issues.
- If a majority of your adjustments are due to "Over the Allowable Amount or Over UCR", it may be time to set up that meeting with payers to see how this can be resolved or you should review your fee schedule

Follow-up Process

The purpose of follow-up is to ensure that all accounts are paid accurately in a timely manner.

“Send and Hope”

- The “Send and Hope” collection process is not effective!

IHS Policy and Follow-up

- All accounts are reviewed and researched within 45 days
  - Proof of follow-up can be documented in the RPMS "message" field.
- Credit balances must be reviewed
- Federal Debt Management Act requires referral to Treasury after 180 days after three demand letters

Promote a short payment cycle by using prompt follow-up

- Establish goals for follow-up
- Develop good relations with key personnel
- Learn insurer claims processing requirements and procedures
- Institute aggressive and persistent follow-up guidelines to collect outstanding balances
- Interact with other departments as needed to expedite payments

Follow-up is Essential

- Only 60 and 80 percent of accounts are paid without delay
- The remaining 20 to 40 percent require persistent and aggressive follow-up to obtain payment
- A/R over 120 days old should be less than 20% of the total A/R

Claim Inquiries to Insurers

- Be prepared
- Always document all telephone calls
  - Payer name
  - Date of contact
  - Person's name
  - Summary of call discussion

Importance of Challenging Payers

- #1 reason why PI claims not getting paid is due to "non receipt" especially when filing by paper
- If payers know that I/T/U programs do not pursue outstanding bills, they tend to "not pay" them
- Appeal all payment reductions based on insurance's UCR charge amount
  - Can Include data from multiple facilities

Conclusion

The best approach to Managing Your Denials is to prevent them from happening in the first place.

The first steps are:

- Establish Criteria for pre-submission Review
- Work Your RPMS Reports
- Review Denials/Adjustments
- Challenge Third Party Payers
- Establish a Denial Management Team and Make Denial Management a Facility Issue

Thanks for your Time

Any Questions????