MANAGING YOUR ADJUSTMENTS/DENIALS

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12th Annual Partnership Conference

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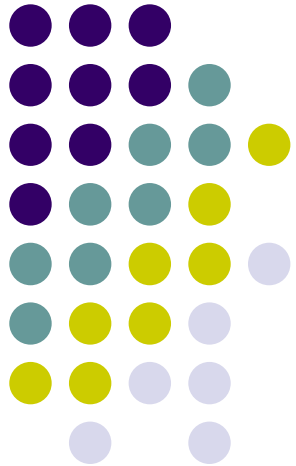
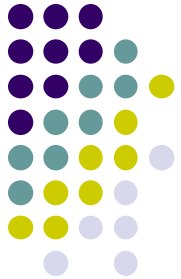


OUTLINE

- Accounts Receivable (A/R) and Denial Management
- Controllable Versus Uncontrollable
- Analyzing Reports
- Projections = Collection Ratio
- Challenging Payors
  - Follow-Up Procedures
- Standardizing Adjustment Code Usage

A/R and Denial Management

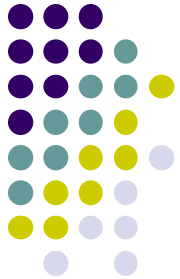


- Where does A/R and Denial Management fit into Revenue Cycle?
- By *reviewing our payments, denials, and adjustments, and monitoring and trending over time*, we can see what we are *not getting paid for* or if we are *receiving proper payment/denials*
- A/R is the most important asset to the direct Indian Health Service/Tribal/Urban (I/T/U) throughout Indian Country. We have become *dependent* on third-party revenue to help us meet the goals, mission, and objectives of the Indian Health Service (IHS).
- it is essential that we make sure that we *optimize the key functions* in the revenue cycle because *patient care* in our facilities is dependent on the level of reimbursements in our facilities from third-party payers.

Steps in the A/R Process

- *Account* for the Receipt of Payment
- *Review* the documentation that supports the payment and/or denial to ensure:
  - The payment/denial does in fact belong to your facility
  - The proper amount of documentation is received to support the payers decision
  - The remittance advice makes sense
- *Post* the Payment/Adjustment–*do not accept* everything you receive as Final Payment/Denial. C*hallenge the payers at this level*. Leave the account open if you need to follow up with the payer. Prompt and accurate payment/adjustment posting is of most importance.
- *Denial Management*–Review and analyze denials/adjustments and make process changes accordingly
- *Follow Up* on Aged Receivable–Accounts that have not been accounted for. It is important to recognize the difference between “Aged Receivables” and “Accounts Receivables.” Follow iup may not be necessary on accounts less than 30 days old, but efforts should be applied to any accounts over 90 days old.

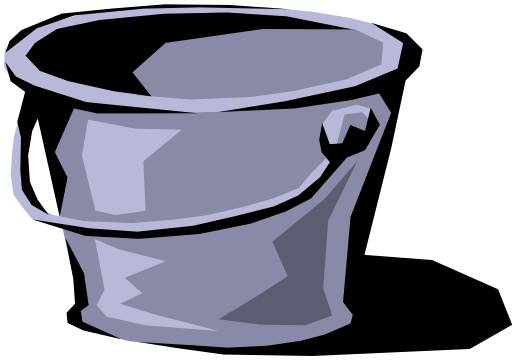
Denial Management



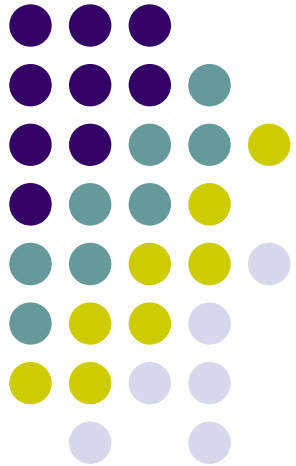
- *Reviewing, Monitoring, Trending, and Analyzing Payments and Denials*
- It is also important to note that the data in the Resource and Patient Management System (RPMS) and the corresponding *reports are only as good as we make it.*
- Posting of adjustments codes should be *standardized.* The reasons 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 payor.

4 Allowance Categories

- Medicaid (Includes State Children's Health Insurance Program [SCHIP])
- Medicare
- Private Insurance
- Other:
  - Beneficiary Medical Program (BMP)
  - Workman’s Compensation
  - Nonbeneficiary
- We cannot treat all adjustments the same.
- When running reports and analyzing, make sure you consider the differences in adjustments for different allowance categories.



CONTROLLABLE VERSUS UNCONTROLLABLE



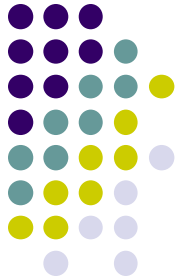
Uncontrollable Adjustments

- Uncontrollable–Know that there are certain “nonpayments” that are to be expected.
  - Going to experience regardless of the billing accuracy or efficiency of the program
  - Our job to know what they are and stay within those limits
    - Deductibles
    - Copays/Coinsurance
    - Over the Allowable/Over Usual Customary and Reasonable (UCR) (semi-controllable)
    - Diagnostic Related Grouper (DRG) Adjustment
    - Contractual Adjustments (semi-controllable)
- These percentages are necessary to know to accurately *project* your actual revenue

Controllable Adjustment

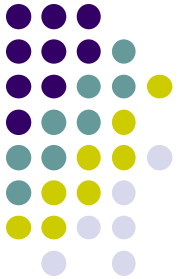
- These are adjustments that we can control and should be minimal if we fix something in our process:
  - Billed in Error
  - No/Other Eligibility for this Patient (Verify by Patient Registration)
  - Non-Covered Service (Know our policies and plan coverages)
  - Beyond Filing Limit (Drop clean claims faster and follow up)
  - Medical Records/Coding/DE Issues (Verifying at these function levels)
    - Missing Information, Wrong Information, Additional Information
  - Signature Requirement
  - Etc.
- Identify the Revenue Cycle “spoke” that could contribute to controlling this adjustment
- *Controllable collectible versus controllable uncollectible*

Controllable Collectible versus UnCollectible



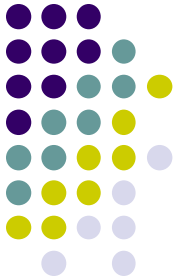
- What does this mean?
- Adjustments may be controllable (we can control the outcome), but still may not be collectible.
- For example: “Patient not eligible for services”
  - We could control this adjustment by knowing our coverages
  - But, regardless of what we do, this bill would not be collectible

Adjustments/Denials–Are they Uncontrollable or Controllable ?



- Deductible
- Past Filing Limit
- Preferred Provider Organization (PPO) Discount
- Billed in Error
- Copayment
- Expense Incurred Prior to Coverage
- Point of Sale (POS) Reversal (Returned to Stock)
- Benefit Maximum Reached
- Duplicate Bill
- Code Err Procedure Inconsistent w Pt Age
- Info Requested/Not Received
- Non Cov Srv Routine Exam

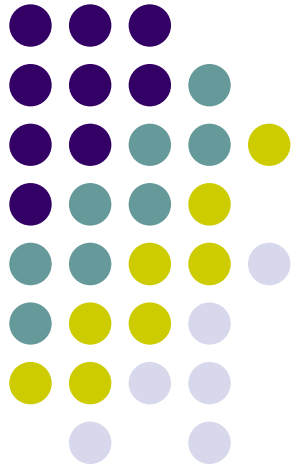
Which spoke of the Revenue Cycle has greatest impact?



- Missing information in the Visit File
- Payment reduced for Out of PPO Network
- Time limit for filing expired
- Refund not processed, payor recouped off another remittance
- Eligible patient not enrolled in Medicaid and Contract Health System (CHS) pays
- Diagnosis inconsistent with procedure
- Did a chest X-Ray with documentation for a med refill ony?
- Follow up not performed, too late to “refile”
- Non Cov Srv, routine exam
- Expense incurred after coverage terminated
- Outdated coding materials used to code

A/R Reports

NEW ADJUSTMENT REPORT/ANALYSIS



Adjustment Report Instructions

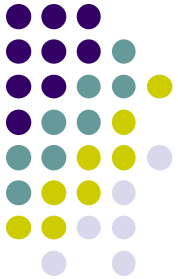
GO INTO A/R MASTER MENU

RPT Report Menu ...
FRM Financial Reports Menu ...
ADJ Adjustment & Refund Report

Select Visit LOCATION: **(RETURN)** ALL
Select one of the following:
1 A/R ACCOUNT
2 ALLOWANCE CATEGORY
3 INSURER TYPE
Select criteria for sorting: **2 ALLOWANCE CATEGORY**
Select one of the following:
1 MEDICARE (INS TYPES R MD MH)
2 MEDICAID (INS TYPES D K)
3 PRIVATE INSURANCE (INS TYPES P H F M)
4 OTHER (INS TYPES W C N I G T)
(please make sure to include Private Insurance ONLY, for this request)
Select Beginning Date: **100108 (OCT 01, 2008) (FOR FY2009 REQUESTED)**
Select Ending Date: **093009 (SEP 30, 2009)**
Select one of the following:
1 Summarize by ALLOW CAT/INS TYPE
2 Detail by PAYER w/in ALLOW CAT/INS TYPE
Select REPORT TYPE: 1// **1 Summarize by ALLOW CAT/INS TYPE**
DEVICE: **hfs HOST FILE SERVER (SAVE TO HOST FILE)**
HOST FILE NAME: /usr/spool/uucppublic///**USER/SPOOL/UUCPPUBLIC/POR09ADJ319YAK.TXT (NAME YOUR DIRECTORY AND FILE NAME: (RETURN)**
ADDRESS/PARAMETERS: "WNS"/ **(RETURN**
Requested Start Time: NOW// (MAR 19, 2009@11:35:26)Task # 2791331 queued.

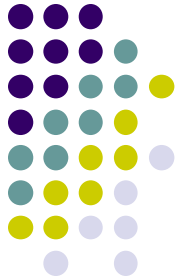
This report will take a little bit of time to run. The file now exists in your host file. Use FTP to transfer the file from the HOST file to your PC. Save in Folder
This is a TEXT FILE with an "^" Delimiter.
Open file with EXCEL. If you do not know how to do this, please ask someone at your site (Site Manager) to assist you. It is very important that we get this file in EXCEL.
Save document using EXCEL.

Adjustment Report (Raw Data)



Look at ADJ REPORT EXAM

Adjustment Report Analysis

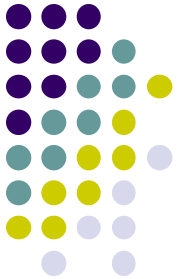


- Every IHS site ran the report for FY08
- Analyze/totaled every facility and every area
- Applied controllable/noncontrollable identifies
- Did a national analysis
- Reported to Government Accounting Office (GAO)

Analysis Results

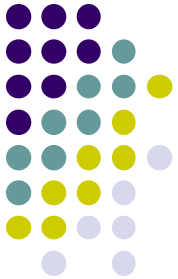
- At a Glance:
  - Billed = 203 million
  - Collected = 65 million
  - *Adjusted = 126 million*
  - Open = 11.2 Million
  - Collection Ratio of 34%
- After Analysis
  - Collection Ratio = 44.9%
  - Uncontrollable Adjustments = 43.33%
  - Controllable Adjustments = 11.9% (17 million)
    - Controllable Possible Collectible = 7.8 Million

What do Your Adjustments Tell You?



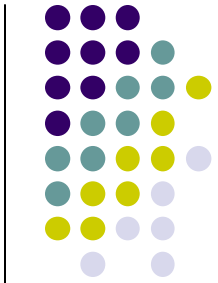
- If you find that a large percentage of your denials are due to billing errors, timely filing, and duplicate submissions, there may be two options: you may want to look at more training to provide a better understanding, or increase your billing/patient accounts staff.
- If you find a percentage of your errors are due to procedures not medically necessary, you may want to meet with providers and coding staff to see where the disruption or gap is.
- 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 a meeting with payers to see how this can be resolved.

Standardizing Your Adjustment Reason Code Usage



- Number of Different Adjustment Codes used by Area
  - Aberdeen: 261
  - Bemidji: 115
  - Portland: 123
  - Navajo: 196
  - Oklahoma: 142
  - Phoenix: 313
  - Tucson: 65
  - Billings: 136
  - Albuquerque: 154
  - Nashville: 37
- Total: 577 different adjustment codes were used (although some may mean the exact same thing)

NATIONAL/AREA ADJUSTMENT REPORT ANALYSIS

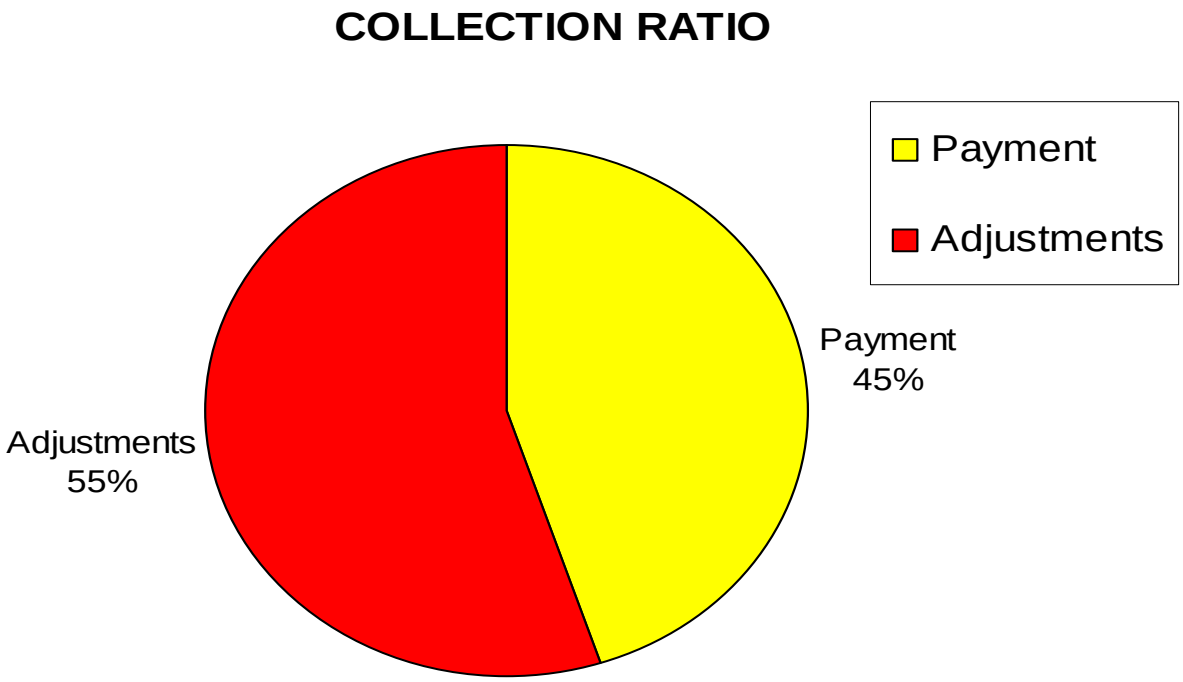


- Look At Report
  - AllAreaDetSum
  - ADJSum
  - Sorted by Code
  - AllSumArea08
  - Analysis
- GAO

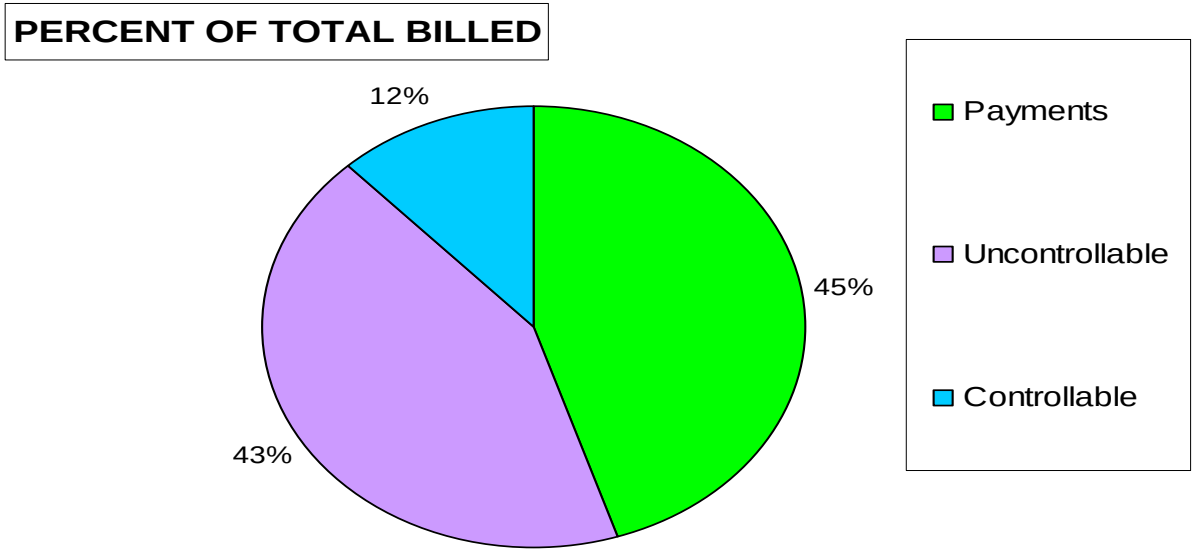
PROJECTING YOUR REVENUE

Using What You Know

COLLECTION RATIO



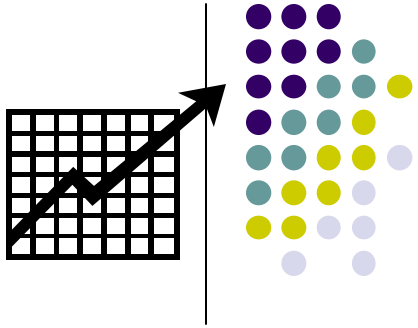
Percentage of Payments/Adjustments



Projections

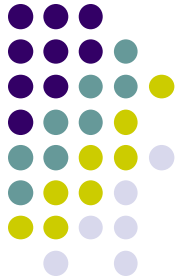
- **Projections–Arbitrary versus Real Time**
- By Visit Type (Inpatient and Outpatient) and by Allowance Category (use the previous year):
  1. Availability–Number of Visits With Private Insurance
  2. Percentage of Unbillable Visits (%)
  3. 1 times 2 gives you the *number of billable PI visits*
  4. Calculate the average amount billed per visit
  5. 3 times 4 gives you the *total amount billed for the year*
  6. Calculate your *collection ratio* (manual audit needs to be done)
  7. 5 times 6 gives you the *projected collections for a year*

Projection Example



1. You have 5000 outpatient visits for patients with private insurance in FY01.
2. Your percentage of unbillable visits is 10%.
3. 5000 outpatient visits times 90% (billable visits) = 4500 billable PI outpatient visits
4. Your average amount billed per outpatient visit in FY01 was $100.
5. Total billable amount for a year (4500 times $100) = $450,000
6. Your collection ratio = 60%.
7. Projected collections for PI outpatient for the year = *$270,000*

New RPMS Processes



- Adjustment Codes will be standardized and “locked down” in RPMS
- Additional identifies (categories) will be utilized in RPMS (Controllable, Uncontrollable)
- All Adjustment Codes will be passed to UFMS for national analysis
- New debt collection capabilities

Follow-Up Process

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

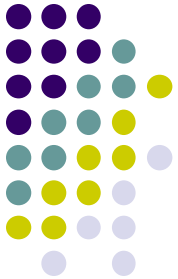
IHS Policy

- All accounts are reviewed and researched within 45 days and documented in the RPMS message field
- Credit balances must be reviewed
- Federal Debt Collection Act requires referral to Treasury after 180 days
- Debt collection policy

“Send and Hope”

- The Send and Hope collection process is not effective!

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

Example Follow-Up Matrix

Post Billing Days	Action
30–filed electronically	Call insurer Internet Claim Status (if available) First Demand Letter (nonbeneficiary patient or Insurance Company)
45	Call insurer
61–90	Call insurer Letter to insurer Second Demand Letter
91–120	Call insurer Third Demand Letter (nonbeneficiary patient)
180	Referral to Treasury (Process)

Follow Up is Essential

- Only 60% to 80% of accounts are paid without delay; the remaining 20% to 40% 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.
- The most effective follow up is through telephone calls and letters.
- All rejected claims need to be corrected immediately and rebilled, if appropriate.

Claim Inquires to Insurers

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

Conclusion

In closing, I would like to emphasize that the best approach to managing your denials is to prevent them from happening in the first place. The first steps are:

1. Establish criteria for Presubmission Review
2. Work Your RPMS reports
3. Review denials/adjustments
4. Challenge third-party payors
5. Establish a Denial Management Team and make denial management a facility issue

THANKS FOR YOUR TIME

Any Questions????