Defense Health Agency
Uniform Business Office

Third Party Collections Program (TPCP) Payments and Refunds

DHA UBO Support

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Objectives

- **Importance of Third Party Payer (TPP) Revenues**
- **Regulatory Foundations**
- **Executing Policy through Revenue Cycle Functionality**
- **Managing, Tracking, and Trending Payments**
- **Common Industry Reimbursement Models**
- **Managing, Tracking, and Trending Refunds**
- **Trending TPC Performance Now to Prep for ICD-10**

Importance of Third Party Payer (TPP) Revenues

Money collected from third party payers (TPPs) is important

- All funds collected are retained ***by your MTF***
- TPC funds are ***in addition to*** each MTF's O&M budget
- Payer systems strive to minimize their own costs (including adjudicating provider claims)
- Comes down to the basic question – ***do you want to fight for these dollars?*** *And what tools can help?*

Where do you want potential revenues to go?

Regulatory Foundations

32 CFR §220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule*. Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer's plan. ***The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.***

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then ***the amount the United States may collect*** from the third party payer ***is the reasonable charge for the care provided less the appropriate deductible or copayment amount.***

(c) *Claim from United States exclusive.* ***The only way for a third party payer to satisfy its obligation*** under 10 U.S.C. 1095 ***is to pay the facility*** of the uniformed service or other authorized representative of the United States. ***Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095***.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* ***The statutory obligation of the third party to pay is not unqualified***. Under 10 U.S.C. 1095(a)(1) (as noted in §220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.*

(1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see §220.3 of this part), ***reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services***.

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible.

(c) ***Specific examples of permissible terms and conditions.*** The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) ***Generally applicable coverage provisions.*** Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) ***Generally applicable utilization review provisions.***

(i) Reasonable and ***generally applicable provisions of a third party payer's plan*** requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities ***may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan***.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable charges under §220.8(a) (except in long stay outlier cases, noted in §220.8(a)(4)).

(3) ***Restrictions in HMO plans***. Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the ***third party payer must provide appropriate documentation*** to the facility of the Uniformed Services.

- ***This includes,*** when applicable, ***copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms.***

- It also includes ***copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy*** or plan coverage and benefit information.

32 CFR §220.7 Remedies and procedures

(d) ***A third party payer may not***, without the consent of a U.S. Government official authorized to take action under 10 U.S.C. 1095 and this part, ***offset or reduce any payment due under 10 U.S.C. 1095 or this part on the grounds that the payer considers itself due a refund from a facility of the Uniformed Services***.

- ***A request for refund must be submitted and adjudicated separately from any other claims submitted to the third party payer*** under 10 U.S.C. 1095 or this part

Settlements and Retractions are common techniques used by third party payers to recoup and retain revenue

- ***Settlements*** – generally involve one party seeking lump sum payment from another party as resolution for prolonged, previously unresolved payment discrepancies. Settlements resolve disputes regarding large batches of improperly paid (and validated) claims.
- ***Retractions*** – generally involve the cancelling of pending payments, commonly for duplicate payments, alleged overpayments, or inadvertent/erroneous payments. Retractions commonly occur on a claim-by-claim basis.
- ***Offsets*** are deliberate decreased adjustments in future payments to offset prior overpayments, and can be applied against future claims, or as batch check adjustments. ***Offsets***, while common practice with civilian providers, ***are prohibited by federal regulations for MHS providers.***
  - *Any overpayment received by the provider on one claim may not be applied to the outstanding balance of any other claim.*
  - *Claims are individual financial transactions and must be accounted for in that manner by all parties.*

Billing personnel may need to remind payers regularly of federal statutory requirements and regulations

32 CFR §220.8 Reasonable Charges

(i) *Alternative determination of reasonable charges.* ***Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar aggregate groups of services that is less than the charges prescribed under this section may, with the agreement of the facility of the Uniformed Services*** (or other authorized representatives of the United States), ***limit payments under 10 U.S.C. 1095 to that prevailing rate for those services.***

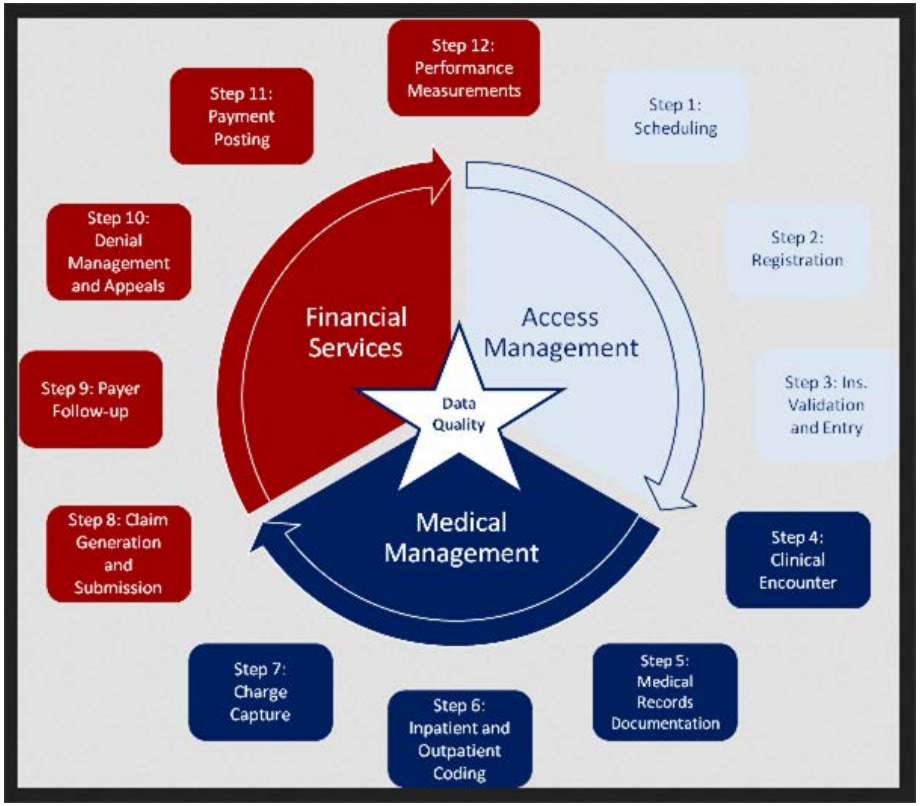
- The determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan.

Executing Policy through Revenue Cycle Functionality

Functional Domains

- **Access Management**
  - Registration and appointment scheduling
  - OHI capture/verification
- **Medical Management**
  - Physician and nursing staff *(including medical documentation)*
  - Ancillary care delivery departments *(e.g., Laboratory, Radiology, and Pharmacy)*
  - Utilization Management and Quality Assurance Reviews
  - Medical Records *(including medical documentation support and accurate medical coding)*
- **Financial Services**
  - Claim Generation
  - Accounts Receivable Management (Denials Recovery)
  - MTF Accounting and Finance
  - Cash Management
- **Overarching Domains:**
  - Information Management & Information Technology
  - Workforce Development (Education and Training)

MHS Revenue Cycle Management (RCM)



All RCM Functions impact TPCP Performance

Many Potential Reasons Why Payment is Denied/Underpaid

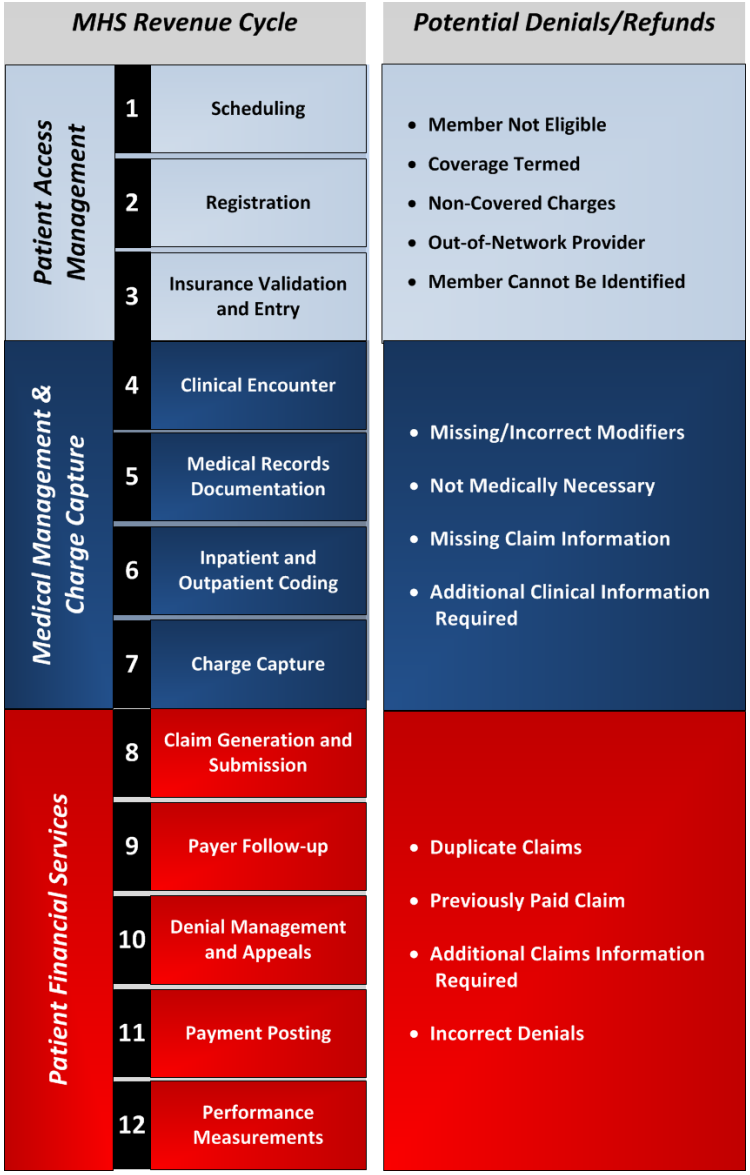
Opportunities for UBO to work with PAD

Opportunities for UBO to coordinate with Providers/Utilization Review personnel

Opportunities for UBO to work with Medical Records and HIM

Opportunities for UBO to build more robust relationships with TPPs

Opportunities for UBO to analyze and trend payments, denials, underpayments and refunds



Revenue Stream begins with patient seeking care…

Every payment and refund needs clear audit trail

Track dollars and activities from beginning to end:

- Bill authorization/ claim generation
- Cash posting
- A/R review
- Denials Management/ Underpayment Follow-up & Recovery

Follow the [paper] trail - n*eed sufficiently thorough documentation to trace all relevant account activity*

…Revenue Stream ends when payment is received and claim is closed.

MTF UBO TPCP Staff Responsibilities

- Identify beneficiaries with OHI
- Document OHI coverage in the patient's medical record and CHCS
- Submit insurance claims to TPPs for reimbursement (comply with TPP claims submission requirements)
- Follow up to ensure collection activities are processed in accordance with applicable federal laws, regulations, and policies
    - ***Requires high degree of collaboration across multiple departments and stakeholders to both minimize denials and optimize collections***

- **BIG QUESTIONS:**
    - ***How do you know if payments received are considered appropriate***?
    - ***How do you know if refund requests are considered appropriate?***

Tracking Payments – Whether via EOB or (Electronic Remittance Advice) ERA 835

EXPLANATION OF BENEFITS

This is **NOT** a bill.

Group Number: 1234567
Member: IMA MEMBER
Member's ID: 123456789-01
Claim Number: 8000000001
12 Provider: SMITH, ROBERT
Payment Reference ID: 20041220112345678

September 6, 2011

1 Service/ product description	2 Dates you received service/product (m/d/y to m/d/y)	3 Charges billed by provider	4 Provider's fee adjustment (*)	5 Your copay (C), deductible (D) or amount not covered (**)		6 Total amount eligible for benefits	7 %	8 Your coinsurance amount	9 Adjustment	10 Total benefits from your plan	11 Amount you're responsible for
OFFICE VISIT	06/01/11 06/01/11	75.00	12.00 PDC	15.00	C	48.00	100%			48.00	15.00
LAB	06/01/11 06/01/11	89.12	15.36 PDC	50.00	D	23.76	100%			23.76	50.00
X-RAY	06/01/11 06/01/11	100.00	20.00 PDC			80.00	80%	16.00		64.00	16.00
SURGERY	06/01/11 06/01/11	50.00		50.00	575	0	0%			0.00	50.00
Totals		$314.12	$47.36	$115.00		$151.76		$16.00		$135.76	$131.00

Your 2010/Plan Year Medical Deductible satisfied so far: $100.00
Your 2010/Plan Year Family Medical deductible satisfied so far: $300.00
Amount you're responsible for: $131.00

FUNDING ACCOUNT SUMMARY

Amount paid on this claim: $ 0.00
Your remaining family balance: $ 0.00

For more information relating to your funding account, please see your benefit booklet or visit us on the web at: www.premera.com

13 **Message Codes:**
PDC AGREEMENT DISCOUNT
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

Benefit Booklet Information:
575 Your plan does not cover any services or supplies furnished in connection with the following conditions, services or supplies: Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.

Other plan provisions may apply. Please consult your benefit booklet for full plan information.

If you have any questions about your EOB call Customer Service at 800-722-1471, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Pacific Time.
Para obtener ayuda en español, llámenos al número de teléfono que se indica arriba. Sa pagtamo ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.
如果想用中文獲取幫助，請撥打上面的電話號碼聯繫我們. Diné k'ehji yáłti'igíí shika'adoolwoł nínízingo díí bééshbee hane'é bich'į' hodiiłnih.
Our TDD/TTY number for the hearing-impaired is 800-842-5357.

LIFEWISE | HEALTH PLAN OF OREGON

Understanding what these "Message Codes" really mean, and what to do with them

```
ISA*00*          *00*          *ZZ*5010TEST       *ZZ*835RECVR
*110930*1105*^*00501*000004592*0*T*:~
GS*HP*5010TEST*835RECVR*20110930*100718*45920001*X*005010X221A1~
ST*835*0001~
BPR*I*100*C*CHK**********20110930~
TRN*1*123456789*1123456789~
REF*EV*5010835EXAMPLE~
DTM*405*20110930~
N1*PR*PAYER NAME~
N3*PAYER ADDRESS~
N4*CINCINNATI*OH*45206~
PER*CX**TE*8003030303~
PER*BL*TECHNICAL CONTACT INFO*TE*8004040404*EM*PAYER.EDI@PAYER.COM~
PER*IC**UR*WWW.PAYER.COM~
N1*PE*PROVIDER NAME*XX*1122334455~
N3*PROVIDER ADDRESS~
N4*CITY*OH*80003~
REF*TJ*123456789~
LX*1~
CLP*EDI PAID*1*2083*100**14*CLAIMNUMBER1**1~
NM1*QC*1*LAST NAME*FIRST NAME****MI*123A12345~
DTM*050*20110907~
SVC*NU:0450*2083*100**1**0~
DTM*472*20110906~
CAS*CO*45*1983~
REF*6R*1~
AMT*B6*100~
CLP*EDI DENIED*1*207.16*0**HM*CLAIMNUMBER2*13*1~
NM1*QC*1*LAST*FIRST****MI*AAA123456789~
NM1*IL*1*LAST*FIRSTNAME****MI*AAA123456789~
NM1*74*1*LAST*FIRSTLAST****C*0000999998~
NM1*82*2*REGULAR HOSPITAL*****XX*1123456789~
DTM*232*20110908~
DTM*050*20110908~
SVC*NU:0250*9.2*0**4~
DTM*472*20110908~
CAS*CO*16*9.2~
LQ*HE*N142~
SVC*NU:0271*57.94*0**2~
DTM*472*20110908~
CAS*CO*16*57.94~
LQ*HE*N142~
SVC*HC:85025*47*0*0300*1~
DTM*472*20110907~
CAS*CO*16*47~
LQ*HE*N142~
SVC*NU:0636*18.02*0**2~
DTM*472*20110908~
CAS*CO*16*18.02~
LQ*HE*N142~
SVC*HC:36591*75*0*0949*1~
DTM*472*20110908~
CAS*CO*16*75~
LQ*HE*N142~
SE*52*0001~
GE*1*45920001~
IEA*1*000004592~
```

Tracking Payments – v5010 X12 835

- **The v5010 X12 835 is the electronic HIPAA standard transaction set that provides data to the provider regarding the payment of a claim, including why the total submitted charges have not been paid in full or a claim payment has been denied.**
  - Claim denials/adjustments are identified by the health plan using combinations of four claim denial/adjustment code sets that, when used in combination, should supply the provider with sufficient detail regarding the payment of the claim
  - These code sets are: Claim Adjustment Reason Codes **(CARCs),** Remittance Advice Remark Codes **(RARCs),** Claim Adjustment Group Codes **(CAGCs),** and NCPDP External Code List Reject Codes **(NCPDP Reject Codes).**

- Significant confusion continues regarding the appropriate/standardized use of claim denial/adjustment codes.

- **Ultimately, consistent and uniform use of CARCs, RARCs, CAGCs and NCPDP Reject Codes for electronic reporting of claims adjustment and denials help to:**

  - **Mitigate Risks:** reduce unnecessary manual provider follow-up; faulty electronic secondary billing; Inappropriate write-offs of billable charges; Incorrect billing of patients for co-pays and deductibles; and unnecessary posting delays

  - **Improve Support:** staff spend less time on phone calls and website queries; Increased ability to conduct targeted follow-up with TPPs and/or patients; improve claims accuracy/completeness and expedite payment recovery

Tips for Tracking Payments

- Explore TPOCS ad hoc reporting capabilities to generate TPP-specific collections data

- For major payers (and major products), payment spreadsheets can be useful to capture
  - *Billed amount*
  - *Allowed amounts*
  - *Collected amounts*

- Eventually, the goal should be to move beyond Collections-to-Billed (CtB) ratios and look at Allowed-to-Billed (AtB) ratios.

- Looking internally at accumulated historical billings, allowables, and collections data can build the foundations for payer mix and service line (e.g., emergency department, cardiology department) analyses.

- **Claim Adjustments.** If a claim payment has been adjusted, health plans (or their PBM agents) provide the adjustment reasons electronically on the claim payment/advise 835 transaction using a combination of:

  - **CAGC:** Categorizes the associated CARC based on financial liability. Unlike CARCs and RARCs, which number in the hundreds, there are only 4 CAGCs identified for use in the v5010 X12 835:

    - **PR** – Patient Responsibility;
    - **CO** – Contractual Obligations;
    - **PI** – Payor Initiated Reductions;
    - **OA** – Other Adjustments.

CAGC, CARCs and RARCs Cont'd

- **CARC:** Provides the reason for the positive (or negative) financial adjustment specific to particular claim or service referenced in the transmitted v5010 X12 835. The external list of CARCs is maintained by the Codes Maintenance Committee established by the ***Blue Cross and Blue Shield Association***, with a multi-stakeholder voting membership.

- **RARC:** Provides supplemental information about why a claim or service line is not paid in full. The external list of RARCs is maintained by the ***Centers for Medicare & Medicaid Services (CMS).*** The majority of CARCs do not require RARCs to complete the message; however, there are some specific CARCs that require use of an explanatory RARC.

- **NCPDP Reject Code**: Provides reasons why a retail pharmacy claim was rejected. The external list is maintained by NCPDP.

- **In short, CARCs and RARCs are codes that explain payment adjustments on remittance advices (RAs)**
  - **CARCs** identify reasons why healthcare claims or services are not being paid at submitted charges
  - **RARCs** provide supplemental information about the adjudication of claims or services.

Managing, Tracking, and Trending TPC Payments

Challenges with CARCs and RARCs

- Providers do not often receive uniform and consistent CAGC/CARC/RARC combinations for the same or similar business scenarios from all TPPs

- Consequently, providers are unable to automatically post claim payment adjustments and claim denials accurately and consistently

- Two primary causes of the problem surrounding the reporting of claim payment adjustments include:
  - ***Use of code combinations based on proprietary, TPP-specific business scenarios***
  - ***Use of unique, individual TPP approaches to mapping of internal proprietary codes to CARCs/RARCs***

- Providers are challenged to understand the hundreds of different CARC/RARC/CAGC combinations, which can vary based on TPPs' internal proprietary codes and business scenarios.

Common Industry Reimbursement Models

Evolving Reimbursement Methods

Across the country, TPP reimbursement mechanics are changing. Maintaining market awareness is critical to TPCP performance

- **Outpatient Services:**
  - Percent of billed and covered charges
  - Ambulatory Payment Classifications (APCs)
  - Ambulatory Payment Groups/Enhanced Ambulatory Payment Groups (APGs/EAPGs)
  - Consolidated-APCs (C-APCs) – ***in draft 2015 OPPS CMS Federal Register***

- **Inpatient Services:**
  - Percent of billed and covered charges
  - Medical Severity-Diagnoses Related Groups (MS-DRGs)
  - All Patient DRGs (AP-DRGs)
  - All Patient Refined DRGs (APR-DRGs)

- **Professional Services:**
  - Percent of billed and covered charges
  - Percent of CMS RBVS Fee Schedule
  - Percent of TPP specific Fee Schedule

Do you know which reimbursement methods are used by your biggest payers?

Prevalent Outpatient Reimbursement Methodologies

- **Percent of Charge:** usually the most favorable reimbursement as long as percentage is consistently applied across all services. Ancillary services generally have their own percent of charge calculations since costs vary by department and UB-04 Revenue Code.

- **Case Rates:** Outpatient Case Rates are typically for surgeries or cardiac services. Typically will encounter 100% case rate coverage for primary procedure and then 50% coverage for additional procedures

- **Fee Schedules:** Fee schedules are usually organized by ancillary department and by provider type. Generally based on either a percentage of a specific year's CMS fee schedule, or a TPP-specific fee schedule developed by the payer.

- **APCs:** groupings of similar procedures/services that, instead of being paid as individual procedures, they are grouped and paid at one rate. This is a systematically driven method as procedures need to be identified as part of an APC in order to reconcile the appropriate reimbursement

- **APGs:** APGs have a slightly different approach to grouping CPT services. Rather than each O/P procedure being "tagged" as part of an APC, there is a process flow that links the services for reimbursement. There is typically one payment (possibly two) for the encounter rather than multiple APCs

- **EAPGs:** This is an advanced version of APGs, similar to APGs but medical services must be supported by the diagnoses codes assigned to the encounter. If diagnoses does not support the services, the claim is denied for further information.

Prevalent Inpatient Reimbursement Methodologies

- **Percent of charge -** generally most advantageous to the provider, however more uncommon across industry today, given that risk burden is heavily on the TPP. Many times this methodology is used in rural settings and/or where the payer market share is weak.

- **Per Diem** is the daily rate for a medical or surgical patient. This methodology is best accepted after the facility has done an average cost per day study. The agreed upon rate should be above the average cost per day.

- **Case Rate –** this methodology is usually used for short stay episodes. Rather than a short stay DRG rate, the TPP offers a Case Rate by medical specialty. Again, this can be good for the facility as long as the case rate is above the average cost of the specialty case

- **DRG –** this methodology is based on ICD-9 grouping algorithms , resulting in a single payment for the entire episode of care. This method shifts the cost burden to the provider.

Managing, Tracking, and Trending TPC Refunds

Top 5 Potential Reasons Why a Payment Could Be Refunded to TPP

1. A single payment on a separate check is received; unidentifiable patient - not treated in our MTF
2. One (or more) payments on a large EOB that do not belong to the MTF (or cannot be posted) – *these payments cannot be placed in suspense*
3. Payment received exceeds the claim amount billed, less deductibles or copayments
4. Payment received from pharmacy/medical carrier after another payment was already posted to the claim
5. Refund request received from insurance company due to cancelled coverage or overpayment

Scenario 1: Single Payment (Single Beneficiary/EOB)

First - Make certain the payment does not belong to your MTF!

1. Create a letter addressed to the insurance company/TPP as soon as possible explaining the reason for the refund
2. Scan and file a copy of the letter, the check, and the EOB
3. Send all originals to the TPP quickly so they can pay the correct facility
4. Sending the original documents back allows you to save the cost of processing a refund through DFAS
5. Enter the refund in a spreadsheet to track and verify the refund was processed by DFAS

** If your Service or NCR MD requires you to deposit then refund the payment, follow guidelines on the next page*

Scenario 2: Consolidated Payment (One, or more payments to be refunded on a large EOB)

Again - Make certain the payment does not belong to your MTF!

1. Create a letter addressed to the insurance company/TPP quickly explaining the reason for the refund(s)

2. Create an SF 1034 (Public Voucher For Purchases And Services Other Than Personal) or SF 1049 (Public Voucher for Refunds) for each patient payment to be refunded (recommended)

3. Send the original of the letter and a copy of the check and EOB to the insurance company quickly so they do not process a ***take back*** *(remember, per federal regulations,* ***offsets are prohibited***)

4. Send the original SF 1034 (or SF 1049), a copy of the letter to the TPP, and copies of the check and EOB to DFAS for processing

5. Scan/file a copy of all documents for your records

6. Enter the refund in a spreadsheet to track and verify the refund was processed by DFAS

Scenario 3: Payment Exceeds Amount Billed

Again - Make certain the payment does not belong to your MTF!

1. First, call the insurance company/TPP to advise of the overpayment
2. Verify the correct copays, deductibles, and payment amounts and agree on refund amount
3. Create a letter to the TPP referencing your phone call and the action taken
4. Send the original letter and copy of the check and EOB to the insurance company as soon as possible so they do not process a ***take back*** (remember 32 CFR §220.7, offsets are prohibited)
5. Create an SF 1034 or SF 1049 for the refund amount, send with a copy of the letter, check, and EOB to DFAS
6. Scan/file a copy of all documents
7. Enter the refund on a spreadsheet to track and trend overpayments, by TPP

Scenario 4: Refund – Payment From Wrong TPP

Again - Make certain the payment does not belong to your MTF!

1. Because the erroneous payment was already posted in TPOCS or your financial system, it will first need to be refunded using the REF transaction code
2. Post the correct payment from the correct check
3. Find a copy of the original check, EOB, and deposit voucher for the incorrect payment
4. Create and send a letter to first payer along with a copy of the first check and EOB as soon as possible so they do not process a **take back** (remember 32 CFR §220.7, offsets are prohibited)
5. Process refund through DFAS as previously described
6. Scan/file a copy of all documents
7. Enter the refund on a spreadsheet to track and trend overpayments, by TPP

Scenario 5: Refund Request from TPP (reasons)

- TPP HR managers only send updates on insurance coverage quarterly, TPPs often make payments that later need to be refunded due to cancelled/modified coverage.
- Common examples include:
  - Children age out of coverage or get married
  - Spouses are no longer covered due to divorce
  - Care not covered on the beneficiary's policy was billed and paid in error

Scenario 5: Refund Request from TPP (activities)

1. When a refund request letter is received, call the insurance company/TPP to verify the cancellation date
2. Verify whether payment was received/posted in CHCS or TPOCS or other billing system
   - In TPOCS, process a REF transaction for the payment
   - Process refunds and write off all claims for care provided after the cancellation date of the policy
   - Remove all unbilled claims for this patient from Select Bills in TPOCS (if coverage is cancelled)
     - For inpatient claims in CHCS, at the Insurance Policy Claim Summary screen, select 5 – Produce Insurance Refund, type NEW, then enter the amount of the refund. The system will print an SF 1049 (manually create an SF 1034, if needed)
     - Write off any other unpaid inpatient claims to W09
3. Enter the verified cancellation date in the PII screen in CHCS so no future claims will be generated

Refund Request from TPP cont'd

4. Create a letter to the insurance company
5. Send the original of the letter, a copy of the refund request letter, a copy of the check and EOB to the insurance company as soon as possible so they do not process a "take back"
6. Create an SF 1049 or SF 1034 (inpatient and outpatient)
7. Send the original SF 1049 or SF 1034 and copies of the letter to the insurance company, refund request letter, check, and EOB to DFAS to process the refund
8. Scan/file a copy of all documents
9. Enter the refund on a spreadsheet to track and trend overpayments, by TPP

Additional TPC Refund Rules

- SF 1049s produced by CHCS will always be addressed to the patient with the appropriation for the date of service.
  - Create a manual SF 1049 (or SF 1034) to correct each
- Refunds are always processed from the appropriation where the funds were deposited per DoD 7000.14, DoD Financial Management Regulations
- Payments posted in FY14 will be refunded from FY14 dollars
  - First, check with your Budget Analyst to ensure funds are available in the correct appropriation
  - You must wait until funds are available to process the refund
- For refunds with unique circumstances, always contact your service representative for guidance

Trending TPC Performance Now to Prep for ICD-10

ICD-10 is Ten Months Away

- ***From around industry, bracing for impact to TPP collections and sustained reduction in productivity***

  - **While ICD-10 will impact virtually all specialties, the highest impact may be for these in particular:**
    - OB/GYN, Primary Care
    - Emergency Medicine
    - Cardiology, Orthopedics, Vascular, Respiratory
    - Multi-Specialty

Civilian providers currently anticipate the following:

- Roughly **60% anticipate short-term cash flow to be negatively impacted**, both in terms of project resources and lost revenue (most prevalent worries are incomplete physician documentation and coding staff mistakes)
- Between **6-10% increase in claims error rates** (compared to 3% with ICD-9)
- Expect **100-200% increase in denial rates post-implementation**
  - **Source: ICD-10 Puts Revenues at Risk, Intelligence Report, Health Leaders, July 2011*
- Expect **increase in Days in AR to jump by 20-40%**
  - *Source: Readying Your Denial Management Strategy for ICD-10, HFMA, February 2013*
- Roughly **46% anticipate revenue losses** from the ICD-10 transition (roughly half anticipate somewhere between 1-10% reduction)
- **Average Coding Time in ICD-9-CM vs. ICD-10-CM/PCS jumps almost 70%,** from 25.52 minutes to 43.23 minutes
  - *Source: Coder ICD-10 Productivity: A Time Study, UASI, Inc., and the University of Cincinnati*

Questions?

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