Chapter 6

Accounts Receivable (A/R) Management

The objective of this chapter is to provide an overview of patient account transactions and accounts receivable management. Hospitals provide services to patients for treatment of conditions utilizing highly specialized equipment and personnel. It is critical for hospitals to maintain an efficient cash flow by obtaining timely compensation for resources utilized in order to provide services in the hospital environment. Claim forms and patient statements are prepared to bill for services rendered on an outpatient and inpatient basis. Once the claim is submitted or patient statement is sent, the hospital must monitor outstanding accounts to ensure that payment is received within an appropriate time frame. This function is critical to maintaining a positive cash flow for the hospital. This chapter provides a brief overview of the life cycle of a hospital claim. A discussion of the payer’s review of a claim and the remittance advice will provide an understanding of communications from the payer regarding a claim. Payer determinations are reviewed to provide an overview of issues handled by the Patient Financial Services and the Credit and Collection Departments. The chapter will close with a discussion of accounts receivable follow-up and the appeals process to provide a greater understanding of aspects involved in managing accounts receivable.

Chapter Objectives

- Define terms, phrases, abbreviations, and acronyms related to patient account transactions and accounts receivable follow-up.
- Demonstrate an understanding of the life cycle of a hospital claim.
- Discuss elements related to patient transactions.
- Provide an overview of key information found on an explanation of benefits or remittance advice.
- List common reasons for claim denials and delays.
- Demonstrate an understanding of A/R management.
- Provide an overview of the purpose and function of an accounts receivable report.
- Describe the process of monitoring and follow-up of outstanding accounts.
- Demonstrate an understanding of the appeals process.

Outline

LIFE CYCLE OF A HOSPITAL CLAIM

HOSPITAL BILLING PROCESS
- Insurance Claims and Patient Statements
- Third-Party Payer (TPP) Claim Processing
- Remittance Advice (RA)

PATIENT TRANSACTIONS
- Patient Payments
- Third-Party Payer Payments
- Adjustments
- Balance Billing
- Secondary Billing

ACCOUNTS RECEIVABLE (A/R) MANAGEMENT
- Accounts Receivable Reports
- Accounts Receivable Procedures

LOST, REJECTED, DENIED, AND PENDED CLAIMS
- Lost Claim
- Rejected Claim
- Denied Claim
- Pended Claim

COLLECTION ACTIVITIES
- Prioritizing Collection Activities
- Patient and Third-Party Follow-up Procedures
- Uncollectible Patient Accounts
- Insurance Commissioner Inquiries

CREDIT AND COLLECTION LAWS
- Statute Of Limitations
- Fair Credit Billing Act
- Fair Debt Collection Practices Act

OUTSTANDING PATIENT ACCOUNTS
- Patient Statements
- Patient Phone Contact
- Collection Letters

OUTSTANDING THIRD-PARTY CLAIMS
- Prompt Pay Statutes
- Insurance Telephone Claim Inquiry
- Insurance Computer Claim Inquiry
- Insurance Claim Tracer

THE APPEALS PROCESS
- Claim Determinations That Can Be Appealed
- Who Can Request an Appeal
- Time Requirement for Appeal Submission
- Levels of Appeals
- Appeal Submission Procedures
The life cycle of a hospital claim begins when the patient arrives at the hospital for diagnosis and treatment of a condition(s) and ends when the claim is paid, as illustrated in Figure 6-1. As discussed in previous chapters, the Admissions Department is responsible for obtaining required demographic, financial, and insurance information from the patient. Another function that is equally important is obtaining appropriate referrals and authorizations. Information obtained by the Admissions Department is entered into the computer on the patient’s account. Patient care services are rendered and documented by various departments within the hospital, and charges are generated. Most charges are posted at the department level through the chargemaster during the patient stay (Figure 6-2). Charges posted through the chargemaster are automatically dropped to the claim and submitted after the patient is discharged. Generally the hospital does not submit a claim or send a patient statement for inpatient services until after the patient is discharged. On discharge, the Health Information Management (HIM) Department receives the patient’s chart for review and coding. The HIM Department codes services, procedures, and items that were not posted.
Community General Hospital

**Figure 6-2** Charge Description Master (CDM), commonly referred to as the chargemaster.

<table>
<thead>
<tr>
<th>Chargemaster Number/Department #</th>
<th>Item/Service Description</th>
<th>Procedure/Item Code</th>
<th>Revenue Code</th>
<th>Quantity/Dose</th>
<th>Charge</th>
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<td>2 g</td>
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**BOX 6-1** KEY POINTS

**Life Cycle of a Hospital Claim**

Information obtained at admission

Patient care services rendered and documented

Charges captured through chargemaster

HIM review, coding, and APC or DRG assignment

Process and submit insurance claims and patient statements

Payer review and determination—remittance advice

**BOX 6-2** KEY POINTS

**Hospital Encoder and GROUPER Programs**

An encoder program is computer software that allows the HIM professional to enter specified information regarding patient care services and the patient’s condition. The program utilizes data entered to identify potential codes.

A GROUPER program is software that allows the HIM professional to enter specified information regarding the patient’s care including condition(s) and procedure(s). The program utilizes the information to assign an APC or DRG.

**Figure 6-3** Hospital billing process highlighting charge submission, payer review, A/R management, and reimbursement functions.
through the chargemaster, such as surgeries. The patient’s diagnoses are also coded by the HIM Department. Coding is generally performed through an encoder program, which utilizes information entered by the HIM coder to assign procedure and diagnosis codes. The codes and other information entered are also used to assign a Diagnosis Related Group (DRG) or ambulatory payment classification (APC) to the hospital case.

HOSPITAL BILLING PROCESS

As discussed in previous chapters, the hospital billing process involves a series of functions required to submit charges for services rendered. The process involves collection of all financial, insurance, and medical information during the patient visit. Information obtained during the patient visit is utilized to submit charges to payers and patients. A critical part of the billing process is charge submission, which involves preparation of insurance claims and patient statements (Figure 6-3).

Insurance Claims and Patient Statements

Patient Financial Services (PFS) may also be referred to as the Business Office or the Patient Accounts Department. PFS is responsible for managing the hospital’s patient financial transactions, which include charge submission, patient transactions, and accounts receivable (A/R) management. Charge submission involves preparation of insurance claims and patient statements (Figure 6-4).
• The appropriate claim form is prepared. As discussed previously, claim form requirements vary by payer.

Insurance Claim Forms
A claim form is prepared for submission of charges to a third-party payer. The goal is to submit a clean claim the first time. A clean claim is defined as one that does not need to be investigated by the payer. The claim passes all internal billing edits and payer-specific edits and is paid without need for additional intervention. Claims that do not meet clean claim status may be denied, rejected, or pended. Preparation of insurance claim forms involves the following steps:

• A detailed itemized statement that outlines each item and service charged is prepared (Figure 6-5).
• The appropriate claim form is prepared.

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• A detailed itemized statement that outlines each item and service charged is prepared (Figure 6-5).
• The appropriate claim form is prepared (Figure 6-5).

Patient Statements
• Patient statements are generated and sent to the patient. The hospital generally has a schedule for batch monitoring of and follow-up on outstanding accounts.

Community General Hospital
TAX ID # 62-1026428
8122 South Street
Mars, Florida 33737
(747) 722-1800

Detailed Itemized Statement

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Charge- master #</th>
<th>Dept #</th>
<th>Revenue Code</th>
<th>HCPCS Description</th>
<th>Qty/ Dose</th>
<th>Total Charges</th>
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<td>0710</td>
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</tbody>
</table>

Figure 6-5 Detailed itemized statement.
mailings of patient statements. For example, the hospital’s batch schedule may indicate that statements for patient accounts A to M should be mailed on Mondays and Wednesdays and N to Z on Tuesdays and Thursdays. Patient statements include the following information, as illustrated in Figure 6-8:

- Patient name, address, account number, and medical record number
- Admission and discharge date
- Description of services, including a procedure code and charge for each
- Payments and adjustments made on the account, listed along with the balance owed
- Message regarding outstanding balance or claim submission

### Third-Party Payer (TPP) Claim Processing

Third-party payer claim processing involves entering claim data into the payer’s system, review of the payer’s data file, performance of payer edits, and payment determination (Figure 6-9). Insurance claims can be transmitted electronically or sent by mail. Electronic claims are transmitted directly to the payer’s computer system. Paper claims are scanned or entered manually into the payer’s computer system. The payer’s computer system performs a detailed review and electronic edits on each claim. The computerized review and edits are preformed to check information on the claim for the purpose of identifying potential problems with the claim. First, the computer checks information on the claim

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**Figure 6-6 CMS-1500 claim form utilized to submit charges for physician and outpatient services.**
against the payer's data files to verify patient coverage and eligibility.

**Payer's Data File**

The computerized payer data files contain information regarding covered individuals, including a history of past claims submitted for the patient. Information submitted on the claim regarding the patient, the insurance, and the services billed is compared with information in the payer's data files to verify that the patient is covered under the plan, is eligible to receive benefits, and that all plan requirements are met. The following data are checked against the payer's data file:

- Patient name and identification number are checked to confirm that the patient is covered under the policy.
- The date of service is checked to ensure that the services were provided within the benefit period and that the patient is eligible to receive benefits.
- Preauthorization information is reviewed to ensure that plan requirements are met.
- Dates of admission and discharge are checked against the plan coverage details to ensure that length of stay is appropriate.
Procedure code data are reviewed to identify covered and noncovered items.

Services on the claim are also checked against the common data file to identify duplicate services.

Computer Edits

The payer’s system performs computerized edits on the claim for the purpose of identifying problems relating to services billed such as coding errors or issues involving medical necessity. Payer computer edits vary according to the payer’s criteria and system setup. For example, Medicare’s system contains an Outpatient Code Editor (OCE) and a Medicare Code Editor (MCE). The OCE and MCE computer edits are incorporated into Medicare’s system. OCE is for outpatient claims, and MCE is for inpatient claims.
and MCE are used to identify data inconsistencies on hospital outpatient and inpatient claims. The OCE contains edits for hospital outpatient claims. The MCE contains edits for hospital inpatient claims (Figure 6-10). The following are examples of computer edits:

- Procedure conflicts with patient’s sex. The procedure code is checked against the patient’s sex to determine whether the procedure is appropriate. For example, a hysterectomy would not be performed on a male.
- Procedure conflict with patient’s age. The procedure code is checked against the patient’s age to verify that the procedure is age appropriate. For example, a hysterectomy would not normally be performed on a 10-year-old.
- Medical necessity. All services and items provided must be considered medically necessary to obtain third-party reimbursement. Diagnosis codes are checked against procedure codes to identify problems involving medical necessity.
- Bundled (packaged) services. Services and items billed are reviewed to identify cases of unbundling. Unbundling is the process of coding multiple codes to describe services that should be described with one code.

Many payers incorporate the National Correct Coding Initiatives edits into their system. The National Correct Coding Initiatives (CCI) was developed by CMS for the purpose of promoting national coding guidelines and preventing improper coding. CCI outlines code combinations that are inappropriate, including services that are:

- Integral to a more comprehensive procedure
- Mutually exclusive
- Included in the surgical procedure
- Sequential procedures
- Bundled

Payment Determination

Determination of payment is conducted after the computer edits are performed. It includes the following steps:

- Determination of allowed charges, APC, or DRG rate
- Determination of deductible, co-insurance, or co-payment
- Preparation of a remittance advice or explanation of benefits, which is forwarded to the hospital

Payment determination may result in one of the following actions:

- The claim is paid
- The claim is placed in a pending status (pending requested information)
- The claim is denied or rejected

Remittance Advice (RA)

A remittance advice (RA) is a document prepared by the payer to provide an explanation of payment
determination for a claim. The RA is also known by other payers as an Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB). The RA includes detailed information about the charges submitted and an explanation of how the claim was processed. An RA can include information regarding several claims. It can be forwarded to the hospital electronically or it can be printed and sent to the hospital by mail. An electronic remittance advice (ERA) is a document that is electronically transmitted to the hospital to provide an explanation of payment determination for a claim.

Remittance Advice Data Elements

The design and content of an RA will vary by payer. Most include basic data regarding the patient, service provided, charges submitted, and explanation of the payment determination. Figure 6-12 illustrates the following data elements listed on a sample Medicare remittance advice:

- Date of the remittance advice and check number
- Patient’s name and identification number
- Name of provider performing services, if not the same as the hospital
- Claim control number—a number given to the payer as a reference to the claim when the hospital inquires about a claim
- ICD-9-CM procedure or HCPCS codes and modifiers describing the billed services or items
- Explanation code or reason code that explains the claim processing, such as whether the claim is denied or reduced
- The amount of deductible the patient is responsible to meet
- The co-insurance amount the patient is responsible to pay
- The payment amount, which is the total amount paid for all claims outlined on the remittance advice
Analyzing a Remittance Advice

It is important for hospital billing professionals to understand the elements of an RA. Information on the RA is carefully analyzed to ensure that the claim was processed appropriately. This task is complicated by the fact that each payer may adopt a different type of form. Information on the RA is used to post payments to the patient’s account. An RA may be several pages long, and it may contain information regarding several patients and several claims (Figures 6-13 and 6-14). Following is an overview of how to analyze the RA.

1. Identify the patient’s name and number for the purpose of opening the correct patient account on the computer system.
2. Match the date of service on the RA to the date of service on the patient’s account.
3. Compare the procedure code indicated on the RA with that listed on the patient’s account to ensure that the claim was paid based on the correct service.
4. Review the charge billed on the RA against the charge listed on the patient’s account.

5. Analyze the approved amount and noncovered charges. These amounts indicate what the payer is approving for the service. The payment is determined based on the approved amount.

6. An explanation of the approved amount is indicated using some type of coding system commonly referred to as explanation or reason codes. Definitions of the reason codes are listed on the bottom or the back of the RA, as illustrated in Figure 6-15. The reason X2 on the ABC Insurance RA tells the hospital that the allowed amount was determined based on the contract.

7. Information on the RA regarding the deductible and co-insurance explains amounts that are billable to the patient.

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### MEDICARE PART A

**Claim Data:**
- **Provider Name:** Dr. Mark Samerston

**Summary**

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**Reason Codes:**
- A1 - amount applied to deductible
- X2 - amount determined based on contact
- Z90 - service bundled
- Z81 - reduced payment-level of service not medically necessary
8. The payment amount on the bottom of the page is the total payment for all claims listed on the RA.

PATIENT TRANSACTIONS

The PFS Department is responsible for processing transactions including payments, adjustments, and other transactions to the patient’s account. Patient payments and third-party payments are posted to the patient’s account by PFS. The process followed is outlined below:

- Payment is posted to the patient’s account
- A contractual adjustment is applied where applicable
- The balance is billed to the patient or sent to a secondary or tertiary payer where applicable
- Denials and information requests are researched and processed as appropriate
- If the claim is denied appropriately, it may be necessary for the claim to be submitted to a secondary insurance

BOX 6-15 □ KEY POINTS

Patient Transaction Process

Payment is posted to the patient’s account
A contractual adjustment is applied where applicable
The balance is billed to the patient or sent to a secondary or tertiary payer where applicable
Denials and information requests are researched and processed as appropriate
If the claim is denied appropriately, it may be necessary for the claim to be submitted to a secondary insurance

Patient Payments

Patient payments are posted to the patient’s account when payment is received. The patient may pay the entire amount or part of the balance owed. When the entire amount is not paid, a statement reflecting the balance will be sent to the patient in the next billing period. Adjustments may be posted to the patient’s account to reflect discounts or amounts that are uncollectible, as discussed later in this section.

Third-Party Payer Payments

Payments from third-party payers are posted to the patient’s account when an RA and check are received from the payer. Payment on a claim is processed in accordance with the payer’s determination. The payer may process payment for the claim as appropriate or the payment amount may be lower than expected by the hospital. This may occur when services are billed separately that are bundled or when medical necessity criteria are not met for a higher level of service. If the correct amount is not paid by the payer, a hospital representative will pursue correction of the claim.

Incorrect Payment Level

When the payer processes a claim at a reduced level or payment is not made for a service reported on the

<table>
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<th>Amount Approved</th>
<th>Note</th>
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<td>$0.00</td>
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<td>X2</td>
<td>$0.00</td>
<td>$35.00</td>
<td>$140.00</td>
</tr>
</tbody>
</table>

Reason Codes
- A1 - amount applied to deductible
- X2 - allowed amount determined based on contact
- Z81 - service bundled
- Z90 - reduced payment-level of service not medically necessary
claim, a hospital representative must investigate the reason for the reduced payment or nonpayment. Common situations when a claim may be paid at a reduced level are outlined below:

- The diagnosis code(s) submitted does not meet medical necessity criteria for the service level billed
- Services are billed with more than one code when they should be described with a single code
- A service that is considered part of a more comprehensive service is billed separately

The ABC Insurance RA #1 illustrated in Figure 6-16 highlights a reduced payment situation. The RA reason, code Z81, indicates that the payer did not pay on procedure 99213, “Evaluation and Management” (E/M) service. The reason for nonpayment is that the payer considered the E/M to be part of the surgical package. The surgical package outlines services that are bundled into the surgery code.

The hospital cannot balance bill the patient for this amount if it participates with the insurance company. Upon investigation, it may be determined that the service should not have been considered part of the surgical package, and payment should have been made. If the E/M service was not related to the surgery or if the decision for surgery was made during the E/M service, the hospital may request that the claim be reprocessed with a modifier attached to the E/M code, or the hospital may appeal the claim.

### Adjustments

An **adjustment** is the process of reducing the original amount charged by a specified amount. There are several types of adjustments that may be posted to a patient’s account, such as discount, contractual adjustment, or write-off, as outlined below.

#### BOX 6-17 KEY POINTS

**Adjustments**

The original amount charged is reduced by a specified amount. Types of adjustments are as follows.

- Discount
- Contractual adjustment
- Write-off

#### BOX 6-16 KEY POINTS

**Common Reasons for Reduced Claim Payments**

- Level of service is not supported by the patient’s condition
- Service may be bundled, such as services included in the surgical package
- Service may be considered an integral part of a larger procedure

---

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<tr>
<th>Claim #</th>
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<th>Procedure</th>
<th>Amount Billed</th>
<th>Amount Approved</th>
<th>Reason</th>
<th>Deductible</th>
<th>Coinsurance</th>
<th>Payment Amount</th>
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</tbody>
</table>

**Reason Codes**

- A1 - amount applied to deductible
- X2 - allowed amount determined based on contact
- Z81 - service bundled
- Z90 - reduced payment-level of service not medically necessary
- X10 - payment reduced-test considered part of panel

---

Figure 6-17 ABC Insurance RA #2 illustrating a contractual adjustment in the amount of $17.70 (the difference between the amount billed and the amount approved).
Discount

The original charge may be discounted by a specific amount as an agreement between the patient and the hospital. For example, a hospital may offer a discount to self-pay patients who are responsible for the entire hospital bill. The hospital may offer a 20% discount to the patient for payment of the entire balance. When the payment is received, the adjustment is made to the patient’s account to reduce the original charge by the discounted amount.

Contractual Adjustment

A **contractual adjustment** is a reduction made to the original charge in accordance with the hospital’s contract with a payer. Payer contracts include provisions regarding the amount the hospital is required to accept as payment in full, commonly referred to as the approved amount. The approved amount may represent a case rate, contract rate, DRG or APC rate, or fee schedule amount. In accordance with the contract, the hospital agrees to follow those provisions and therefore may not bill patients for amounts over the approved amount. The difference between the approved amount and the hospital’s original charge must be adjusted off the patient’s account. The hospital posts a contractual adjustment to the patient’s account to reduce the original charge. Most hospitals program the computer billing system to calculate and deduct the contractual amount as required by agreement with the payer.

The ABC Insurance RA #2 illustrated in Figure 6-17 highlights a contractual adjustment situation. The difference between the billed amount of $61.00 and the approved amount of $43.30 on claim number 1 is $17.70. A contractual adjustment in the amount of $17.70 must be posted to the patient account if the hospital is participating with the insurance company. The reduction of the claim by $17.70 is a contractual adjustment that is made in accordance with the hospital’s contract with the payer.

Write-Off

A **write-off** is the process of reducing a patient’s balance to zero. Write-offs are made when the balance is deemed uncollectible. In accordance with most contracts, the hospital is not allowed to forgive or write-off a patient deductible, co-insurance, and co-payment amount. The hospital is required to follow the necessary steps required to make every attempt to collect the amount for which the patient is responsible. When all efforts are exhausted to collect the patient’s responsibility, the hospital may then write-off the balance. These write-offs are considered a bad debt. Hospitals establish policies and procedures regarding write-offs that detail the necessary steps required to collect the patient balance and the criteria for write-offs.

Balance Billing

**Balance billing** refers to billing the patient for a balance in excess of the payer’s approved amount in accordance with the payer contract. When the hospital is participating with the payer, the contractual agreement prohibits balance billing a patient for the following amounts:

- The difference between the original charge and the approved amount
- The amount of hospital charges that are greater than a DRG payment rate
- The amount of hospital charges that are greater than an APC payment rate

The hospital is required to bill a patient for amounts related to co-payments, co-insurance, and deductible amounts. In some cases, charges for services that are not covered may also be billed. Medicare requires that beneficiaries be given an Advance notice of services that Medicare may not cover due to medical necessity. The notice required by Medicare is the Advance Beneficiary Notice (ABN) or Hospital Issued Notice of Non-coverage (HINN).

Advance Beneficiary Notice (ABN)

An **Advance Beneficiary Notice** is a written notice that is presented to a Medicare beneficiary before Medicare

![Advance Beneficiary Notice (ABN)](image-url)
Part B services are furnished, to inform the beneficiary that the provider believes Medicare will not pay for some or all of the services to be rendered because they are not reasonable and necessary. Figure 6-18 illustrates Medicare’s ABN. Hospitals are required to present this form to signature to the beneficiary before services are rendered. The hospital cannot bill the patient for these services if the ABN is not completed and on file.

Hospital Issued Notice of Noncoverage (HINN)

The HINN is a written notice that is presented to a Medicare beneficiary before Medicare Part A services are furnished to inform the beneficiary that the provider believes that Medicare will not pay for some or all of the services to be rendered because they are not reasonable and necessary. The HINN is required by Medicare for hospital Part A services that may not be covered due to medical necessity. The HINN is written in letter form, and it must be presented and signed by the beneficiary before services are rendered. The content of an HINN varies based on the type of services that may not be covered; for example, an admission. Figure 6-19 illustrates a sample HINN.

**BOX 6-19 □ KEY POINTS**

**Advance Beneficiary Notice (ABN) and Hospital Issued Notice of Noncoverage (HINN)**

**ABN**

A written notice presented to a Medicare beneficiary before Part B services are furnished to inform the beneficiary that Medicare may not pay for some or all of the services to be rendered because they are not reasonable and necessary.

**HINN**

A written notice presented to a Medicare beneficiary before Part A services are furnished to inform the beneficiary that Medicare will not pay for some or all of the services to be rendered because they are not reasonable and necessary.

**Coordination of Benefits (COB)**

A clause written into an insurance policy or government program plan that defines how benefits will be paid when the member or beneficiary is covered under multiple plans.

Third-party payers combine efforts to coordinate benefits paid by the plan through the coordination of benefits (COB) provisions. These provisions help to ensure the following conditions:

- The plans pay as primary and secondary payers appropriately
- Total payments for the claim do not exceed more than 100% charges
- There is no duplication of payments for health care services
1. Define an electronic remittance advice.

2. List various names used to describe the document provided by the payer that explains how a claim was processed.

3. Explain the process of posting patient and third-party payments to the patient’s account by the PFS.

4. Explain why it is important to compare the procedures listed in a remittance advice with those listed on the patient’s account.

5. Describe the purpose of reason codes.

6. List common reasons why a payer may process payment at an incorrect level.

7. Discuss why it is important for a hospital representative to analyze payment made by an insurance company.

8. Outline the actions required when payment is received at the incorrect level.

9. Provide an explanation of an adjustment.

10. List three types of adjustments a hospital may make to a patient’s account.

11. Describe contractual adjustment and explain when this type of adjustment is made to a patient account.

12. State when a hospital may write off a balance.

13. Provide a brief explanation of balance billing.

14. Explain the purpose of an ABN.

15. Discuss the difference between an ABN and HINN.
Secondary Billing

Secondary billing may occur when the patient has a supplemental insurance that is designed to cover expenses not covered by the primary insurance. When payment is processed from the primary payer, the hospital representative may initiate billing to a secondary or tertiary payer. Coordination of benefits (COB) provisions for the plan must be followed. Medicare secondary payer guidelines must also be followed. Coordination of benefits and Medicare secondary payer guidelines will be discussed later in this text in the payer chapters.

ACCOUNTS RECEIVABLE (A/R) MANAGEMENT

Accounts receivable is a term used to describe revenue owed to the hospital by patients and third-party payers. Accounts receivable is commonly referred to as A/R. A/R management is a vital function required to monitor and follow-up on outstanding accounts. The financial stability of a hospital is highly dependent on maintaining a positive cash flow. The hospital must maintain a steady flow of revenue (income) to cover expenses required to provide patient care services. To accomplish this, the hospital monitors the revenue cycle. As illustrated in Figure 6-20, the hospital revenue cycle begins when the patient arrives at the hospital for patient care services and ends when payment is received. The primary objective of A/R management is to minimize the amount of time that accounts are outstanding.

Outstanding accounts are accounts that have been billed to the patient or third-party payer but have not received any payment. A/R management involves tracking accounts that have not been paid, assessing action required to secure payment, and implementing procedures to secure payment.

Accounts Receivable (A/R) Reports

Hospitals utilize various computerized reports to monitor accounts that have not been paid, such as an unbilled accounts report, financial class report, denials management report, and accounts receivable aging reports.

**Accounts Receivable (A/R) Aging Report**

Computer-generated A/R aging reports are utilized to identify and analyze outstanding accounts. The **A/R aging report** is a listing of outstanding accounts based on the age of the account. The term **aging** refers to the number of days the account has been outstanding. The computer system counts the number of days the account is outstanding from the date the claim or statement is sent. A/R reports can be run for specified patient accounts or by payer type. The report categorizes accounts based on aging categories in increments of 30 days, as outlined below:

- 0 to 30 days
- 31 to 60 days
- 61 to 90 days
- 91 to 120 days
• 121 to 150 days.
• 151 to 180 days.

Table 6-1 illustrates an A/R aging report based on patient billed date. The report includes the account number, patient name, and phone number. Outstanding amounts owed on the patient account are reported in the column that reflects the aging category of the amount owed. Table 6-2 illustrates an A/R report based on payer type. Payer-based A/R reports include the payer name, payer code, and phone number. Outstanding amounts are reported in the appropriate aging category. A/R reports provide a percentage of aging in each of the aging categories.
Hospital policies and procedures outline priorities for follow-up on outstanding accounts. Priorities are set based on the age and dollar amount of outstanding accounts. For example, the initial focus is typically directed toward accounts that fall within the 61- to 90-day aging category, then the 91- to 120-day category, and then 120+ days. Accounts with large balances are generally considered a priority. Hospitals utilize the A/R ratio and the days in A/R formula to assess the efficiency of A/R management activity, as illustrated in Figure 6-21.

### A/R Ratio

The A/R ratio is a formula that calculates the percentage of accounts receivables in comparison with total charges.

\[
\text{A/R ratio} = \frac{\text{Total charges} - \text{net collections}}{\text{Average monthly charges}}
\]

### Days in A/R

Days in A/R is another formula used to determine the number of days it takes to collect outstanding accounts.

\[
\text{Days in A/R} = \frac{\text{Total A/R}}{\text{Average daily charges}}
\]

### Denials Management Report

Denials management reports are utilized to identify claims that have been denied, rejected, or pended. Claims identified with this report are investigated to determine why the claim was denied, rejected, or pended (Table 6-3).

### Financial Class Reports

Hospitals utilize financial class reports to identify outstanding accounts based on the type of payer, or financial class. A financial class is a classification system used to categorize accounts by payer types. A financial

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<th>Denial Code</th>
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class is assigned to all hospital accounts to identify the type of payer. For example, a patient who has a commercial insurance plan would be assigned to the financial class “Commercial.” Financial classes may also be referred to as financial buckets. Common financial classes are Commercial, Blue Cross/Blue Shield, Medicare, TRICARE, Auto, and Worker’s Compensation. Managed care plans may also be assigned a separate financial class of “Managed Care.” Designation of a financial class allows detailed tracking and reporting of charges, payments, and outstanding balances per payer type, as illustrated in Table 6-4. Financial class reports help to identify payer-specific problems with outstanding claims for each financial class.

### Unbilled Accounts Report

Unbilled accounts reports are utilized to track accounts that have not been billed since the patient was discharged. This report is utilized to identify reasons why accounts are not billed (Table 6-5). Some common reasons an account may be in an unbilled status are as follows:

- The claim is on hold pending insurance verification. The claim may be on hold pending insurance verification or authorization. Insurance companies will not pay if the patient is not covered or if the appropriate authorizations have not been obtained.

#### Table 6-4
Community General Hospital Payer Financial Class Report, 01/01/06 to 06/30/06

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<td></td>
<td>Williams, Meta</td>
<td>06/22/2006</td>
<td>$42,677.97</td>
<td>$27,313.90</td>
<td>$8,535.59</td>
<td>$6,828.48</td>
</tr>
</tbody>
</table>

#### Table 6-5
Community General Hospital Unbilled Accounts Report, 07/01/06 to 07/31/06

<table>
<thead>
<tr>
<th>Account Number</th>
<th>Patient Name</th>
<th>Service Date</th>
<th>Total Charges</th>
<th>Service Code</th>
<th>Account Balance</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>825473</td>
<td>Adams, Harold</td>
<td>02/02/2006</td>
<td>$1,356.50</td>
<td>OUTSUR</td>
<td>$271.30</td>
<td>SECINS</td>
</tr>
<tr>
<td>649782</td>
<td>Boyter, Susan</td>
<td>03/17/2006</td>
<td>$27,865.00</td>
<td>INPT</td>
<td>$5,573.00</td>
<td>MR INFO</td>
</tr>
<tr>
<td>215673</td>
<td>Johns, Tina</td>
<td>06/22/2006</td>
<td>$42,677.97</td>
<td>INPT</td>
<td>$8,535.59</td>
<td>SECINS</td>
</tr>
<tr>
<td>692777</td>
<td>Xavier, George</td>
<td>02/25/2006</td>
<td>$18,433.56</td>
<td>INPT</td>
<td>$3,686.71</td>
<td>APPEAL</td>
</tr>
<tr>
<td>625713</td>
<td>Yohanson, Phil</td>
<td>05/31/2006</td>
<td>$879.97</td>
<td>ANC</td>
<td>$175.99</td>
<td>ADD</td>
</tr>
<tr>
<td>228792</td>
<td>Beard, Bobby</td>
<td>06/22/2006</td>
<td>$42,677.97</td>
<td>INPT</td>
<td>$42,677.97</td>
<td>MR COMP</td>
</tr>
<tr>
<td>664392</td>
<td>Baxter, Morris</td>
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<td>INPT</td>
<td>$27,865.00</td>
<td>MR COMP</td>
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<td>865312</td>
<td>James, John</td>
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<td>ER</td>
<td>$1,356.50</td>
<td>PHY</td>
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<td>$1,356.50</td>
<td>ANC</td>
<td>$879.97</td>
<td>AUTH</td>
</tr>
<tr>
<td>572688</td>
<td>Mannie, Minnie</td>
<td>05/31/2006</td>
<td>$879.97</td>
<td>ANC</td>
<td>$879.97</td>
<td>AUTH</td>
</tr>
</tbody>
</table>
Managers will identify problems that cause delays in obtaining verifications or authorization and implement systems to correct the problems.

- Chargemaster data are inaccurate. Hospitals continually monitor chargemaster data to ensure that the correct information is listed in the chargemaster. For example, Medicare requires HCPCS level II codes for specific services. The chargemaster may not have all the current codes listed.
- Coding from the medical record may be delayed due to incomplete documentation. Claims cannot be submitted without diagnosis and procedure codes. The HIM Department may have to seek clarification of information in the medical record to code the case accurately.
- Errors may have been made in entering data. Incorrect data such as the wrong patient identification number or codes can delay claim submission.

**Accounts Receivable (A/R) Procedures**

Hospitals establish policies and procedures for A/R follow-up to ensure that payment is received within an appropriate time frame. Basic procedures for monitoring and follow-up include identifying accounts that are outstanding. Hospital procedures outline specific guidelines on actions required to pursue payment on accounts that are outstanding, including lost, denied, rejected, and pended claims. The next section outlines procedures to follow to secure payments in these situations.

**BOX 6-24 ➤ KEY POINTS**

**Unbilled Accounts**

Common reasons that accounts are unbilled:
- Pending insurance verification
- Incorrect chargemaster data
- Delayed coding
- Data entry errors

---

**Lost Claim**

Payer has no receipt of claim on file
Submit copy of the original claim

**Rejected Claim**

Payer rejected the claim due to technical error or other reason it could not be processed
Investigate reason for rejection of correct claim and resubmit

**Denied Claim**

Payer denied the entire claim or specified charges on the claim
Investigate reason for denial and submit an appeal where appropriate

**Pended Claim**

Payer placed claim in a "suspended" hold status pending additional information
Obtain copies of information from the patient record and submit to the payer

Figure 6-22  Hospital A/R procedures for lost, denied, rejected, and pended claims.

**LOST, REJECTED, DENIED, AND PENDED CLAIMS**

Payment determination for a claim may result in the claim being rejected or denied. The payer may also place the claim in a pending status and request more information for the claim. These situations are handled in accordance with hospital policy, as outlined below (Figure 6-22).

**Lost Claim**

The follow-up on a claim may result in the payer indicating that the claim is not on file. This happens when the claim was not received by the payer or when the claim was not entered as a result of a backlog in processing claims. If the claim is not on file and there is
<table>
<thead>
<tr>
<th></th>
<th>ACCOUNTS RECEIVABLE MANAGEMENT: LOST, REJECTED, DENIED, AND PENDED CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Define accounts receivable.</td>
</tr>
<tr>
<td>2.</td>
<td>To follow-up on outstanding account, hospital personnel must __________.</td>
</tr>
<tr>
<td>3.</td>
<td>List and discuss two criteria generally used to determine priority of collection efforts on outstanding accounts.</td>
</tr>
<tr>
<td>4.</td>
<td>Discuss accounts receivable and why it is important to monitor it.</td>
</tr>
<tr>
<td>5.</td>
<td>Explain the relationship between an aging report and follow-up on outstanding claims.</td>
</tr>
<tr>
<td>6.</td>
<td>Discuss how accounts are aged.</td>
</tr>
<tr>
<td>7.</td>
<td>Provide an explanation of the aging categories found on the accounts receivable report.</td>
</tr>
<tr>
<td>8.</td>
<td>List and provide an explanation of information found on a third-party payer accounts receivable report.</td>
</tr>
<tr>
<td>9.</td>
<td>Discuss two factors that are considered in determining what accounts require follow-up.</td>
</tr>
<tr>
<td>10.</td>
<td>What are the four common reasons an account may be in an unbilled status?</td>
</tr>
<tr>
<td>11.</td>
<td>List common reasons for rejected claims.</td>
</tr>
<tr>
<td>12.</td>
<td>Provide an explanation of a denied claim.</td>
</tr>
<tr>
<td>14.</td>
<td>Discuss what actions hospital personnel should take when a claim is denied.</td>
</tr>
<tr>
<td>15.</td>
<td>Describe a pended claim and provide an explanation of why a payer may put a claim in pending status.</td>
</tr>
</tbody>
</table>
Claim denials are communicated on the RA that is forwarded to the hospital. A claim may be denied for various reasons. Some common circumstances where a claim can be denied are outlined below.

- The diagnosis code submitted does not meet medical necessity criteria
- Services submitted were unbundled
- Required authorization was not obtained

Claim denials must also be investigated to determine whether the denial is appropriate. Upon investigation, the hospital representative may find that the reason for denial is not valid. For example, a claim may be denied stating that the required authorizations were not obtained. Review of the patient record indicates that an authorization was obtained for the service and an authorization number was provided by the payer’s representative. The claim may be resubmitted or appealed with the authorization number recorded in the patient’s file.

Pended Claim

A pended claim is a claim that is placed on hold by the payer, pending receipt of additional information. When payers identify a potential problem with medical necessity or coverage, based on the claim review, they may request additional information and put the claim in a pending status or what is commonly referred to as a “suspended claim.” The claim is put on hold until the information requested is received. The request for additional information is usually communicated on the RA.

Denied Claim

A denied claim is a claim processed by the payer resulting in a determination that no payment will be made on the claim. A claim submitted to a payer may be denied entirely or a specific charge on the claim may be denied.
RA that is sent to the hospital along with an indication that payment cannot be processed until the requested information is received. The requested information should be copied from the patient’s medical record and forwarded to the payer.

**COLLECTION ACTIVITIES**

Collection activities are vital functions performed by the hospital’s Credit and Collections Department to ensure that timely payments are received from patients and third-party payers. Hospital policies and procedures for collections vary by hospital; however, they generally include the following, as outlined in Figure 6-23:

- Collection activity priorities
- Patient and third-party payer follow-up procedures
- Procedures for uncollectible accounts
- Insurance commissioner inquiries

**Prioritizing Collection Activities**

Timely follow-up on outstanding accounts is essential to obtaining payment in a reasonable time frame. The collection process begins with identifying accounts that require follow-up. Hospital policies and procedures outline criteria for prioritizing collection activities based on the age and the amount outstanding on the account. The department utilizes A/R aging reports to identify accounts that require follow-up. As discussed earlier, the criteria will vary by hospital. Generally, accounts in the aging category of 61 to 90 days with a higher dollar value are pursued first.

**Patient and Third-Party Follow-up Procedures**

Procedures are defined by the hospital regarding the follow-up on outstanding patient accounts and third-party claims. Hospital procedures outline methods for follow-up that generally include:

**BOX 6-28 □ KEY POINTS**

Collection Activities

Hospital policies and procedures for collections include guidelines that outline the following:

- Criteria for prioritizing collection activities
- Establishment of patient and third-party follow-up procedures
- Procedures for handling uncollectible patient accounts
- Insurance Commissioner inquiries procedures

The Credit and Collection Department performs various collection functions to ensure that timely payment is received.

**Uncollectible Patient Accounts**

Patient account balances may be deemed uncollectible after all efforts to pursue payment on the account are exhausted. Hospital policies define when an account is to be written off as a bad debt and when an account should be forwarded to a collection agency. Hospitals may contract with an outside collection agency to pursue patient accounts as a last resort, prior to initiating a write-off. Hospital procedures for submission of outstanding accounts to a collection agency may include:

- When the account may be turned over
- The process to follow to assign an account to the collection agency

Hospital policies dictate circumstances under which an account should not be sent to collection. For example, if a patient submits documentation showing financial hardship, the hospital may elect to write the balance off. If the case does not involve financial hardship, the account will be turned over to collection. The hospital will outline the time frame and procedures that must be followed before an account can be assigned to a collection agency. The process will include documentation required and necessary authorization from management to assign an account to a collection agency.

**Insurance Commissioner Inquiries**

Insurance companies are regulated by the Department of Insurance within each state (Figure 6-24). The Depart-
ment of Insurance is also known as the Insurance Commissioner. The Insurance Commissioner is a state department that monitors activities of insurance companies to make sure the interests of the policyholders are protected. Hospital collection personnel may need to pursue resolution to a claim through the Insurance Commissioner. Two of the most common circumstances that require hospital personnel to submit an inquiry to the Insurance Commissioner are:

1. Delay in settlement of a claim, after proper appeal has been made
2. Improper denial of a claim or settlement for an amount less than indicated by the policy, after proper appeal has been made

Hospital collection personnel may submit an inquiry or complaint to the Insurance Commissioner regarding a claim(s) after all efforts to rectify the situation have been exhausted. Complaints must be submitted in writing and they must include the following information:

- Patient or policyholder’s name, address, and telephone number
- Insured’s name, address, and telephone number
- Name of the insurance company and representative involved with the claim, as well as the address and phone number of the insurance company
- Details regarding the complaint with appropriate documentation such as a claim form, explanation of

Figure 6-24  State insurance commissioners. (Modified from American Insurance Association: State insurance commissioners, www.aiadc.org/LinksResources/StateInsuranceCommissioners.asp, 2005.)
CREDIT AND COLLECTION LAWS

Hospital collection personnel must be aware of legal and regulatory issues that apply to collection procedures. Hospital collection activities are generally divided into two categories:

- Outstanding patient accounts
- Outstanding third-party claims

Legal and regulatory issues vary for outstanding patient accounts and outstanding third-party claims. Collection activities involving patient accounts are governed by many state and federal laws, including Statute of Limitations, the Fair Credit Billing Act, and the Fair Debt Collection Practices Act.

Statute of Limitations

Statute of Limitations legislation is passed at the state level establishing the time period in which legal collection procedures may be filed against a patient (Figure 6-25). The time period (number of years) varies in accordance with state law. For example, the statute of limitations in Florida is 5 years. This means that legal collection procedures cannot be filed against a patient if the 5-year period has passed.

Fair Credit Billing Act

The Fair Credit Billing Act is federal legislation that outlines the patient’s rights regarding errors on a bill. The Act states that the patient has 60 days from receipt of a statement to submit notification of an error. The notification must be in writing. The hospital is required to acknowledge the notification of error within 30 days of receipt. The hospital must contact the patient and explain why the bill is correct. If the bill is not correct, the hospital is required to correct the error within two years.
1. Contact debtors only once a day; in some states, repeated calls on the same day or the same week could be considered harassment.
2. Place calls after 8 AM and before 9 PM.
3. Never leave messages with details regarding an outstanding debt with individuals other than the patient, on an answering machine, or at an individual’s workplace. Messages should include a name, a phone number, and a brief statement that you are calling about a bill.
4. Identify yourself and the medical practice represented; do not mislead the patient.
5. Contact the debtor at work only if unable to contact the debtor elsewhere; no contact should be made if the employer or debtor disapproves.
6. Contact the attorney if an attorney represents the debtor; contact the debtor only if the attorney does not respond.
7. Do not threaten or use obscene language.
8. Do not send postcards for collection purposes; keep all correspondence strictly private.
9. Do not call collect or cause additional expense to the patient.
10. Do not leave a message on an answering machine indicating that you are calling about a bill.
11. Do not contact a third party more than once unless requested to do so by the party or the response was erroneous or incomplete.
12. Do not convey to a third party that the call is about a debt.
13. Do not contact the debtor when notified in writing that a debtor refuses to pay and would like contact to stop, except to notify the debtor that there will be no further contact or that there will be legal actions.
14. Stick to the facts; do not use false statements.
15. Do not prepare a list of “bad debtors” or “credit risks” to share with other health care providers.
16. Take action immediately when stating that a certain action will be taken (e.g., filing a claim in small claims court or sending the patient to a collection agency).
17. Send the patient written verification of the name of the creditor and the amount of debt within 5 days of the initial contact.

**Figure 6-26** Fair Debt Collection Practices Act guidelines. (Modified from Fordney M: Insurance handbook for the medical office, ed 8, St Louis, 2003, Elsevier.)

**Fair Debt Collection Practices Act**

The Fair Debt Collection Practices Act is federal legislation that was passed to protect consumers from inappropriate collection activities such as harassment or deception. As shown in Figure 6-26, the Act provides guidelines for appropriate collection practices as outlined below:

- **Patient (debtor) may be contacted only once per day.**
- **Calls should be made after 8:00 AM and before 9:00 PM.**
- **Patient (debtor) may not be contacted on Sundays or holidays.**
- **Hospital personnel are required to identify themselves and the hospital they represent.**
- **Contact of a patient (debtor) at work is only appropriate when the patient cannot be contacted elsewhere or if the patient requests that he or she be contacted at work.**
- **If the patient (debtor) is represented by an attorney, the attorney should be contacted.**
- **Hospital personnel should not use a threatening tone or inappropriate language.**
- **Correspondence regarding debt must be kept private; therefore, postcards are not acceptable forms of correspondence.**
- **Collect calls to a patient are not appropriate.**
- **Never leave messages with details regarding outstanding debt with individuals other than the patient, on an answering machine, or at an individual’s workplace. Messages should include a name, a phone number, and a brief statement that you are calling about a bill.**
- **Contact of third parties should be recorded in the patient’s record and should only be made once. No details regarding the debt may be provided to the third party.**
- **The patient (debtor) may notify the hospital, in writing, that he or she has no intent to pay and may request that all contact be stopped. The hospital may not contact the patient after this notification is received.**
- **Never use false statements. Only facts should be used in communicating with a patient regarding the debt.**
- **Written notification may be sent to the patient to advise that action will be taken if the debt is not paid within a specified time frame.**

Collection activities involving insurance claims are considered business collections since they involve provisions outlined in the contract between the hospital and a payer. The contract legally binds both parties to the provisions in the contract. As discussed in previous chapters, the payer contract outlines provisions that a provider must follow; for example, timely submission requirements, collection of deductibles, co-insurance, and co-payments, and accepting the approved amount as payment in full. The payer contract also outlines provisions that must be followed by the payer, such as statute and prompt pay provisions. Statute provisions outline when the payer is responsible for secondary claims and how the benefits will be processed and paid. Prompt pay provisions indicate the maximum amount of time the payer has to submit payment on a claim.

**OUTSTANDING PATIENT ACCOUNTS**

Hospital policies established for collecting outstanding patient accounts vary by hospital. Policies define procedures to be followed to pursue collection of outstanding patient balances. Basic policies include guidelines for collection: sending patient statements, phone contact, and collection letters (Figure 6-27).

**Patient Statements**

As discussed previously, patient statements are utilized to bill patients for amounts the patient is responsible to pay. Patient statements are sent after the patient is discharged when the patient has no third-party coverage. When a third-party payer is involved, the patient statement is sent after payment determination is received from the payer, when appropriate. If the patient balance is not paid within 30 days after a statement is sent, the hospital will send another statement at 60 days and at 90 days. Second and third statements generally include dun messages.
Dun Messages

A dun message is a message recorded on a patient statement regarding the status of an outstanding account and action required. Examples of dun messages are:

- Your account balance is due and payable within 10 days
- Your account is 60 days past due; please contact us regarding payment
- Your account is now 90 days past due; please remit payment within 10 days

Payment Options

Hospitals very often include information on the patient statement regarding payment options. For example, the statement may read: “For your convenience we accept MasterCard, Visa, and Discover.”

Patient Phone Contact

When payment is not received on a patient account and the patient does not respond to statements, phone contact may be required. It is important to have a friendly and helpful tone. The purpose of the phone contact is to remind the patient of the outstanding balance and determine when and how much the patient will pay. Hospital policies provide guidelines for making patient phone contact. Figure 6-28 illustrates a sample page from a hospital training manual detailing the following regarding patient phone contact:
• Required preparation before contact is made
• Information to be provided to the patient when contact is made
• Patient’s response statement and appropriate reply from the hospital representative

It is important for hospital representatives to have a friendly and helpful disposition toward the patient. Patient phone contacts are made in accordance with credit and collection laws, as discussed previously. When the patient cannot be contacted by phone or if the patient does not send payment, a collection letter is sent.

**Collection Letters**

Hospital collection procedures include the use of collection letters. A series of letters are developed that are designed to advise the patient of an outstanding balance and encourage the patient to make payment within a specified time frame. Hospitals may develop several letters or they may have a form letter that includes a series of statements. The content of a collection letter may range from a simple reminder to a statement indicating the consequence of failure to pay. Figure 6-29 illustrates a sample collection letter.

**OUTSTANDING THIRD-PARTY CLAIMS**

Timely follow-up on outstanding claims is critical to obtaining payment within an appropriate time frame and also to prevent further delay of a claim. Third-party payers are required to process timely payment in accordance with prompt pay statutes.

**Prompt Pay Statutes**

Prompt pay statutes outline the required language in contracts regarding timely payment on claims. Prompt pay statutes vary by state. As outlined in Figure 6-30, statutes generally include provisions for the following:

- Maximum number of days, after receipt of the claim, a payer has to process payment
- Maximum number of days, after receipt of additional information requested, to process payment
Section I
Required Preparation
• Have details regarding the charges available
• Note whether insurance has paid and be prepared to explain the balance
• Remember the purpose of the call is to collect full payment or set a schedule for payments to be made

Section II
Information to Be Provided to the Patient when Contact Is Made
• Identify yourself and the hospital you represent
• Confirm that the individual on the phone is the patient
• Advise the patient you are calling about an outstanding balance and give the patient the date of service and the amount outstanding
• Ask the patient when payment can be expected

Patient’s Response and Reply
• Payment was sent
  When the patient indicates the payment was sent, inquire as to the date payment was sent and the amount. Thank the patient for his/her time and note the information in the patient’s account.
• Patient does not understand charges or has questions regarding charges
  It may be necessary to explain the charges or answer specific questions regarding the charges. Once all answers are provided to the patient, inquire as to when payment will be sent.
• Patient is unable to pay the entire balance
  When the patient indicates he/she is unable to pay the entire balance, recommend a payment plan or budget in accordance with hospital policies. Advise the patient of the minimum payment that can be made and the time interval for which payments should be made.
• Patient has no intent to pay
  If the patient indicates he/she has no intention of paying, try to find out why. These situations will be handled according to hospital policy based on the reason the patient is not going to pay.

In accordance with prompt pay statutes, payment on claims should be made within an appropriate time frame. Electronic claims are generally processed within 2 to 3 weeks. Paper claims may take 4 to 6 weeks for processing. Follow-up on outstanding claims may be made by phone or through submission of an insurance claim tracer. The status may be determined utilizing one of these methods.

Insurance Telephone Claim Inquiry
Some payers allow follow-up on outstanding claims to be performed by phone contact. Payers may allow follow-up on several claims during a phone conversation. It is necessary to have the following information available for each claim:

- Number of days a payer has to pay or deny a claim
- Interest rate on overpayments
- Terms for which the payer will investigate claims of improper billing

Insurance Computer Claim Inquiry
Many payers have Internet Web sites on which claim status can be researched. The payer provides the Web address and procedures to sign on and obtain claim status information. All information regarding the patient and claim are required as outlined above.

Insurance Claim Tracer
A form utilized to submit a claim inquiry to a payer, referred to as an insurance claim tracer, may be required.
by payers for claim inquiries. Figure 6-31 illustrates a sample insurance claim tracer. The insurance claim tracer requires information regarding the patient and claim. The form generally includes a list of options regarding the reason for the inquiry.

When the claim status is known, the hospital representative can pursue resolution of the claim as discussed previously. Claim status may include the following:

- Payment was processed and sent
- Claim is not on file
- Claim was denied or rejected
- Claim is in a pending status and more information is required

The purpose of claims inquiry is to determine whether payment was processed. If payment was not processed, the hospital representative will request information about the delay in processing the claim. After contact is made with the payer about the status of an outstanding claim, the hospital representative will record information about the contact on the patient’s account and will work to resolve the delay.

Figure 6-30 Florida Prompt Pay Statutes.

Figure 6-31 Sample insurance claim tracer.
THE APPEALS PROCESS

An appeal is a request submitted to the payer by the hospital for reconsideration of a claim denial or rejection or an incorrect payment. Payers provide hospitals with procedures required to file an appeal (Figure 6-32). The procedures generally include provisions regarding the type of claim that can be appealed, who can file an appeal, the time frame for submission of appeals, and the levels of appeals.

Claim Determinations That Can Be Appealed

Payers include provisions in their contract outlining the type of claim determinations that can be appealed. Common types of claim determinations that can be appealed are as follows:

- Payment is denied for reasons that are not clear to the hospital or the hospital has more information to prove that the denial is in error
- Payment was processed at an incorrect level
- Services are denied based on the payer’s preexisting condition provisions
- Claim is denied for reasons relating to authorization or precertification requirements

Who Can Request an Appeal

Payers determine the appropriate party to appeal a claim based on whether the claim is assigned or nonassigned, as outlined below:

- Assigned claims can be appealed by the hospital or by the patient
- Nonassigned claims can be appealed by the patient or by the hospital when the patient has given consent for the appeal and when the provider is liable for the amount not paid

Time Requirement for Appeal Submission

Payers require submission of appeals within a specified time period after the claim was processed. Time requirements vary by payer, and they may also vary based on the level of appeal. For example, Medicare requires that a request for redetermination be submitted within 120 days of the date of the original claim determination.

Levels of Appeals

Payers may have various levels of appeals. Time requirements and procedures are specified for each level. For example, Medicare has five levels of appeals:

1. Review
2. Hearing
3. Administrative law judge hearing
4. Departmental Appeals Board review
5. Judicial review

Appeal Submission Procedures

The appeal submission procedures vary by payer and by type of review requested. The hospital representative should contact the payer to determine the procedure for filing an appeal. Basic steps to filing an appeal are outlined below:

- Prepare letter or form required by payer that outlines the reason for the appeal
- Prepare all supporting documentation such as the RA, copy of the policy, publications, and resources regarding billing and coding guidelines

Box 6-32 = KEY POINTS

Appeals

Claim determinations that can be appealed:
- Denied claims, reason unclear
- Incorrect payment
- Denial based on preexisting conditions
- Denial based on authorization or precertification requirements
If similar claim denials were successfully appealed by the insurance company, send information regarding those cases. Contact the insurance company to identify the appropriate person and department the appeal should be sent to. Keep copies of the appeal and all information submitted.

It is necessary to monitor the status of an appeal until a decision is made. If the appeal is not successful at the level submitted, the hospital may elect to submit an appeal at the next level.

### OUTSTANDING THIRD-PARTY CLAIMS: THE APPEALS PROCESS

1. Discuss the function of patient statements in pursuing outstanding patient accounts.
2. Define and discuss the purpose of dun messages.
3. Provide an outline of steps required to prepare for patient phone contact.
4. Briefly discuss prompt pay statutes.
5. List four methods utilized for claim inquiries.
6. Discuss the purpose of an appeal.
7. List four claim determinations that can be appealed.
8. Who can request an appeal?
9. List five levels of Medicare appeals.

### CHAPTER SUMMARY

A/R management is a vital function of a hospital to ensure that payment is received in an appropriate time frame. The life cycle of a claim starts when the patient arrives and ends when payment is received for services rendered. Once charges are billed to a patient or third-party payer, accounts must be monitored carefully to prevent an unreasonable period of time from passing before payment is received. Delayed payment on accounts will have a negative effect on the hospital’s revenue cycle. To maintain financial stability, the hospital must have an efficient flow of revenue.
The PFS Department is responsible for managing the hospital’s patient financial transactions, which include charge submission and A/R management. Hospital policies and procedures are established for patient transactions. Payments received from the patient and third-party payers are posted to the patient’s account and balances are billed to the patient or other payers. Adjustments may be required to reduce the original charge by a specified amount based on payer contracts, the patient’s ability to pay, or inability to collect patient balances. The Credit and Collections Department is responsible for monitoring and follow-up on outstanding accounts.

Hospital policies are also established regarding monitoring outstanding accounts and collection activities that are hospital specific and they are developed within the parameters defined by payers and various legal and regulatory agencies. Hospitals utilize various A/R reports to monitor outstanding accounts such as the unbilled accounts, denials management, and A/R aging reports.

Hospital personnel must have knowledge of all aspects of the life cycle of a claim, including posting transactions and collections procedures. Hospital personnel must also have knowledge of federal and state laws that govern collection activities in order to ensure that proper collection procedures are followed. This chapter provides a basic overview of various aspects of patient transactions, A/R management, and collection activities.
CHAPTER REVIEW 6-1

True/False
1. Patient statements are sent periodically in batches. T F
2. A remittance advice is also known as a payment document. T F
3. Adjustments are when the original charge is reduced by a specified amount. T F
4. Unbilled accounts may be the result of delays in coding. T F
5. Old accounts with a high dollar amount receive priority collection status. T F

Fill in the Blanks
6. A ________________ adjustment is required when a participating hospital’s original charge is greater than the approved amount.
7. Payment determination that indicates no payment will be made is referred to as a ________________ claim.
8. Claims may be in a ________________ status until requested information is sent to the payer.
9. A process that can be followed to request that a payer reconsider determination on a claim is referred to as a ________________ process.
10. Filing requirements for appeals vary by payer. Medicare requires that redetermination requests be submitted within _____ days.

Match the Following Definitions with the Terms Below
11. ____ The law that indicates a patient may submit notification of an error on a statement within 60 days and that the hospital must acknowledge receipt within 30 days. A. Statute of limitations
12. ____ The law that indicates language that must be in a payer’s contract regarding timely payment. B. Prompt pay statutes
13. ____ Complaints regarding claims may be forwarded to this agency after appeals have been exhausted C. Fair Credit Billing Act
14. ____ Law passed to protect consumers from unfair collection activities. D. Fair Debt Collection Practices Act
15. ____ Outlines the time frame in which a legal action can be filed against a patient. E. Insurance Commissioner inquiries

Research Project
Refer to the CMS Web site at: http://www.cms.gov/medlearn. Search for information on appeals. Discuss five appeal levels for Medicare claims, including: who can appeal, when the appeal must be filed, and how it should be filed.
GLOSSARY

Accounts receivable (A/R) A term used to describe revenue owed to the hospital by patients and third-party payers.

Accounts receivable (A/R) aging report A listing of outstanding accounts based on the age of the account.

Accounts receivable ratio (A/R ratio) A formula that calculates the percentage of accounts receivable in comparison with total charges.

Adjustment The process of reducing the original amount charged by a specified amount.

Advance Beneficiary Notice (ABN) Written notice that is presented to a Medicare beneficiary before Medicare Part B services are furnished, to inform the beneficiary that the provider believes that Medicare will not pay for some or all of the services to be rendered because they are not reasonable and necessary.

Aging Term used to describe the number of days the account is outstanding from the date the claim or statement is sent.

Appeal A request submitted to the payer by the hospital for reconsideration of a claim denial, rejection, or incorrect payment.

Balance billing Refers to billing the patient for a balance in excess of the payer’s approved amount in accordance with the payer contract.

Clean claim A claim that does not need to be investigated by the payer. The claim passes all internal billing edits and payer-specific edits and is paid without need for additional intervention.

CMS-1450 (UB-92) The universally accepted claim form utilized to submit facility charges for hospital outpatient and inpatient services.

CMS-1500 The universally accepted claim form utilized to submit charges for physician and outpatient services.

Contractual adjustment A reduction made to the original charge in accordance with the hospital’s contract with a payer.

Days in accounts receivable (A/R) A formula used to determine the number of days it takes to collect outstanding accounts.

Electronic remittance advice (ERA) A document electronically transmitted to the hospital to provide an explanation of payment determination for a claim. An EOB is also referred to as a remittance advice (RA).

Fair Credit Billing Act Federal legislation that outlines the patient’s rights regarding errors on a bill.

Fair Debt Collection Practices Act Federal legislation that passed to protect consumers from inappropriate collection activities such as harassment or deception.

Financial class A classification system used to categorize accounts by payer types. Financial classes may also be referred to as financial buckets.

Hospital Issued Notice of Noncoverage (HINN) A written notice that is presented to a Medicare beneficiary before Part A services are furnished, to inform the beneficiary that the provider believes that Medicare will not pay for some or all of the services to be rendered because they are not reasonable and necessary.

Insurance claim tracer A form utilized to submit a claim inquiry to a payer.

National Correct Coding Initiatives (CCI) Developed by CMS for the purpose of promoting national coding guidelines and preventing improper coding. CCI outlines code combinations that are inappropriate.

Outstanding accounts Accounts that have been billed to the patient or third-party payer and no payment is received.

Payer data files Payer files that contain information regarding covered individuals including a history of past claims submitted for the patient.

Pended claim A claim that is placed on hold by the payer, pending receipt of additional information.

Prompt pay statutes State statutes that outline required language in contracts regarding timely payment on claims. Prompt pay statutes vary by state.

Rejected claim A claim that is returned to the hospital by the payer because the claim contained a technical error or could not be processed because it was not completed in accordance with payer guidelines.

Remittance advice (RA) A document prepared by the payer to provide an explanation of payment determination for a claim. The payer forwards this document to the hospital. RA is also referred to as an explanation of benefits (EOB).

Statute of Limitations State legislation that establishes the time period in which legal collection procedures may be filed against a patient.

Unbilled accounts report A report utilized to track accounts that have not been billed since the patient was discharged.

Unbundling The process of coding multiple codes to describe multiple services using one code.

Write-off The process of reducing a patient’s balance to zero.