**DHA UBO Webinar**
**Third Party Collection Program Payments and Refunds**
**Broadcast Dates: 17 and 19 November 2014**
**Participant questions reprinted as received during live**
**Webinar broadcasts and as answered by the Speaker**
**(Submit additional questions via e-mail to the UBO.helpdesk@altarum.org)**

1. What to ask the insurance companies when they send our office a denial of Non-Covered Charges?

   a: You should contact the payer and ask for the reason(s) that claim was denied and what information is necessary to correct the claim. Document the conversation. In addition to reviewing on a claim by claim basis, review denials for trends for certain submissions. Talk with your utilization review team to get a sense as to what is impacting covered vs non-covered claims, identify trends, and seek to proactively reduce and correct common mistakes.

2. One of the local insurance company seems to deny a lot of pharmacy and laboratory for our multiple military beneficiaries, is it too forward to ask the detail coverage benefits for members?

   a: No. It is not too forward to ask the insurance company anything, and billers should follow up with payers' representatives for all denials if questions persist. You can request certain information under federal regulation 32 CFR 220.4(d): "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."

   Second, regarding your high denial trends for pharmacy and lab services, ask pointed questions to the payers in question regarding coverage benefit limitations and review your denial reports to identify any potential trends regarding benefit coverage limitations. Also, strive to determine whether there are internal process challenges capturing benefits through OHI discovery or authorization review with Utilization Management personnel, and work with those personnel to resolve any operational issues that you anticipate may result in claim denials or underpayments.

3. Why are you predicting all these lost revenues, etc. when ICD-10 is implemented since the ICD-10 codes do not generate dollars on the outpatient billing. The CPT codes are what generate the dollars on the outpatient billing?

   a: ICD 10 will impact outpatient facility and professional payments which must include both at least one ICD-CM (clinical modification) diagnoses code in addition to CPT and HCPCS codes (ICD-PCS (procedural coding system) codes are for institutional claims). As mentioned during the briefing, payers' outpatient reimbursement methods are shifting from simple fee-for-service structures to Ambulatory Payment Groupings (APGs) and enhanced APGs, which bundle outpatient services and payment is dependent on ensuring that ICD diagnoses codes adequately

support reported CPT/HCPCS codes. The impact on outpatient reimbursement may simply be delayed claim generation (and subsequent payment) because the ICD-10 assignment process is more inherently complex and therefore coding will take longer. Payers may deny claims if incorrect diagnosis codes are used. .

4. So it won't be any different from how we do business now?

   a: Correct. Coding will still be coding. However, payers are paying more attention to whether diagnoses codes adequately and appropriately support the reported CPT and HCPCS codes, and inaccurate diagnoses coding will result in denials. Although ICD-10 requires an increased level of specificity, coders are still required to code correctly with the applicable code set, ICD-9 or ICD-10. Billing offices can prepare for the ICD-10 transition by trending collections by Payer now to be able to trend any major changes in collections or payer reimbursement requirements that might otherwise seem to happen all of a sudden.

5. What is your suggestion for payers who continue to pay outpatient encounters via HRA (Health Reimbursement Accounts)?

   a: We need additional information for this issue (e.g., is it impacting ability to validate payment accuracy?) Contact the UBO.Helpdesk@altarum.org. My hunch is that you are seeing beneficiaries with HRAs and High Deductible Health Plans (HDHPs) which have high patient-responsibility deductibles which you are not able to collect, reducing your potential third party collections. We've seen a rapid rise and proliferation of HDHPs over the past few years, and this trend is likely to continue, as it shifts health care costs from employers to employees.

6. How much time should be allowed for an insurance company to request a refund for payments made due to an HR not reporting a policy as being cancelled?

   a: No magic answer. It will happen continuously. Ensure you have processes and procedures in place to quickly address these refunds when they happen. Most Payers will address refunds as quickly as possible.

7. Do I need to check with our legal office if a claim is denied due to laches?

   a: This depends on your Service's specific guidance. Laches (delay of filing claim) may bar a claim if it is submitted too late, and the delay prejudices the other party. This is different from being barred by a statute of limitations which sets specific periods to file claims or a payer's specific timely filing limitation. You should consult with your legal office if you have a question about whether the claim is timely or barred by a limitation period.