

1. Overview of Accounts Management

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1.1 About the Revenue Operations Manual

The Indian Health Service *Revenue Operations Manual* provides a system-wide reference resource for all Indian, Tribal, and Urban (I/T/U) facilities across the United States, to assist any and all staff with any function related to business operation procedures and processes.

1.1.1 Revenue Operations Manual Objectives

- Provide standardized policies, procedures, and guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all of IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest quality of service at each level of the Business Office operation.

1.1.2 Revenue Operations Manual Contents

The *Revenue Operations Manual* is divided into the following five (5) parts:

- **Part 1 Administrative Roles and Responsibilities** contains
 - Overview of revenue operations
 - Laws, acts, and regulations affecting health care
 - IHS laws, regulations, and policies
 - Health Insurance Portability and Accountability Act Privacy Rule
 - Business Office management and staff
 - Business Office Quality Process Improvement and Compliance
- **Part 2 Patient Registration** contains:
 - Overview of patient registration
 - Patient eligibility, rights, and grievances
 - Direct care and contract health services
 - Third-party coverage

- Registration, discharge, and transfer
- Scheduling appointments
- Benefit coordinator
- **Part 3 Coding** contains:
 - Overview of coding
 - Medical record documentation
 - Coding guidelines
 - Data entry
- **Part 4 Billing** contains:
 - Overview of billing
 - Hard copy vs. electronic claims processing
 - Billing Medicare, Medicaid, and private insurance
 - Third party liability billing
 - Billing private dental insurance and Pharmacy
 - Secondary billing process
- **Part 5 Accounts Management** contains:
 - Overview of accounts management
 - Electronic deposits and Remittance Advices
 - Processing zero pays, payments, and adjustments
 - Creating payment batches
 - Reconciliation of credit/negative balances
 - Collections and collection strategies
 - Rejections and appeals

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

This manual also includes:

- Acronym dictionary
- Glossary

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for downloading, viewing, and printing at this website:

<http://www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm>

Clicking the “Revenue Operations Manual (ROM)” option on the left panel menu, displays the Revenue Operations Manual web page.

1.2 About Account Reconciliation

Account reconciliation is the act of comparing and confirming that the patient's account for total charges and amount owed matches or balances with the reimbursement received from the insurer or patient or the transactions posted. In other words, it is balancing the account to zero or to a balance that may still be owed by another third party.

Another definition of account reconciliation is a method for reconciling the accounts to the monthly financial reports – the process of comparing a facility's account records to the reports generated from the RPMS system.

Account reconciliation is an important element in the business process for the following reasons:

- Accounts must be reconciled to a zero balance. To accomplish this task, payments need to be accurately posted, errors need to be resolved, explanations on adjustments need to be indicated, and research must be done to resolve discrepancies.
- Reimbursement is the basis for continued viability of the facility. If payment does not occur in a timely manner within the statute of limitations, the facility will not be paid. That is lost revenue. In addition, errors in payments, if not corrected, will in time result in significant financial losses to the facility. Finally, it is just good business practice to manage, accurately, each account.
- Audits from State Medicaid or Medicare could occur at any given time. Errors, discrepancies, or backlogs could have an impact on the outcome of the audit.
- If account reconciliation is not managed in a timely manner, the backlogs of adjustments, changes, appeals, and man-hours will become unwieldy.

With that said, it is important that all Business Office staff

- fully understand the comments and remarks on an Explanation of Benefits or Remittance Advice,
- efficiently and quickly decide on the next course of action,
- document and follow through on the course of action, and
- monitor the progress until rectified.

Account reconciliation is essential to ensure accurate reports and/or to identify errors and inconsistencies requiring correction. Without follow through, error corrections and appeals will be lost.

1.3 About Explanation of Benefits and Remittance Advice Adjustments

Explanation of Benefits (EOB) and Remittance Advices (RA) or notices vary by private insurance company, as well as by each state Medicaid program. The most consistent across the United States is the Medicare Part A and Part B payment notices.

The Accounts Receivable (AR) staff is responsible for reviewing all adjustments to assure they are posted correctly into the patient accounting system. Additionally, the Accounts Receivable or Billing staff is responsible for reviewing, researching, and appealing any rejections referenced on the Remittance Advice/notice. Finally, the task of being aware of any potential repetitive system problem, adjustment, credit, or other type of error is the responsibility of the AR person, as part of their review process.

The Explanation of Benefits and Remittance Advices/notices are important to finalizing the patient accounting process on any bill. The objective is to obtain a zero balance on the patient's account between the charge, payments, and adjustments. There are different types of adjustments, such as deductibles, coinsurance, rejections, or amounts above the reasonable charge, as well as others.

This process represents the true accounting process of the Business Office. Therefore, it is very important for the AR staff to have a thorough understanding of each Explanation of Benefit and Remittance Advice/notice, to perform the proper accounting procedures in the RPMS system.

Each AR person needs to fully understand the meaning of each Remark code to determine the next pathway:

- (1) Should the Remittance Advice be filed or passed on to another person to research?

Or

- (2) Is the rejection valid and should the amount be adjusted in full on the patient account?

1.3.1 Guidelines for Review Process

For those patient accounts listed on the Remittance Advice/notice that need further review, a definitive process and procedures should be established that will:

- Determine who will be researching the error or rejection.

For example, at your facility, is the person researching the errors and rejections the same AR person who posts, a separate person who is responsible for researching and appealing all accounts for all insurers, or does the remittance go back to the original biller to research and appeal?

The optimum person for researching and appealing claims is a separate person; however, this depends on the volume of claims handled at your facility.

If the volume is low, then the biller or AR person could perform this function, but if the volume is high, the biller would take away valuable billing time in order to research and appeal claims, potentially creating a backlog. The advantage of the biller reviewing rejections or errors is that they learn from their own mistakes, but you do not want to jeopardize the billing process.

The advantage of the AR person reviewing the errors and rejections is that it enables a second, independent review. Billing errors can always be shared back to the biller either as examples or part of a discussion.

- Define a policy and procedures for when each of these reviews needs to be done.

Remember that many insurers have stipulated timeframes of when a response to an appeal must be done. If the response is not sent within that timeframe, the claim will be denied and there will be no recourse for the facility.

- Prioritize the reviews based on either the large dollar claims (inpatient) or by the shorter timeframes to respond in the appeal process.
- Develop a review and audit process, randomly or at set times per month, to review the number of claims that need to be researched. This will assure that these reviews are being done in a timely manner.
- Develop a backup process in case the volume of denials or errors increases. Train other staff to help with the review and appeal process, or consider outsourcing

- Know what is paid and not paid by the insurer.

Once a rejection is noted and the facility determines that it is not a covered service by the insurer, make sure the coder, provider, and billing staff know that this should not be billed in the future.

However, if there is a primary and secondary coverage and the secondary coverage provides benefits for this service or procedure, it definitely needs to be billed to obtain the rejection.

Insurers have certain internal rules and regulations on how certain services should be billed and/or what they want documented in the Provider Note. Each biller should be familiar with these processes to assure that the bills submitted are submitted correctly.

- Educate staff on noted changes to insurer rules, regulations, procedures, and processes.

The following RPMS Accounts Receivable application options allow you to query for definitions of adjustment reason and remittance advice remark codes:

- Standard Adjustment Reason Inquire (IADJ)
- Remittance Advice Remark Code Inquire (IRMK)

For information on accessing these options, see the *RPMS Accounts Receivable (BAR) User Manual*, which is available at this website:

<http://www.ihs.gov/cio/rpms/index.cfm?module=home&option=documents>

1.4 Remittance Advice/Notice Rejection Codes

Remittance Advices/notices are also known as Medicare Summary Vouchers. Reason and Remark codes are used to explain why a claim may not have been paid in full. Reasons include

- The service is not covered,
- The benefit maximum has been reached, or
- The charges exceed the amount allowed.

Group codes are codes that will always be shown with a Reason code to indicate when you may or may not bill a beneficiary for the non-paid balance of the service you rendered. There are four types of Group Codes:

Code	Reason/Remark
PR	Patient Responsibility
CO	Contractual Obligation
OA	Other adjustment
CR	Correction or Reversal to a prior decision

For a complete list of Remittance Advice Remark codes, see the *RPMS Accounts Receivable (BAR) User Manual*, Appendix C: “Remittance Advice Remark Codes,” which is available at this website:

<http://www.ihs.gov/cio/rpms/index.cfm?module=home&option=documents>

1.4.1 PR Group Code

The PR group code indicates the patient’s liability. Due to the frequency of use, separate columns are used to report the deductible and coinsurance amounts, which are also the patient’s responsibility. Totals for all PR amounts are listed at the end of each claim.

1.4.2 CO Group Code

The CO group code identifies excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial responsibility. These includes such areas as

- Participation agreement violation amounts
- Limiting charge violations
- Late filing penalties
- Amounts for services not considered to be reasonable and necessary

1.4.3 OA Group Code

The OA group code is used when neither PR nor CO is used, such as with the Reason code message that indicates the bill is being paid in full.

1.4.4 CR Group Code

The CR group code indicates a change to the decision on a previously adjudicated claim as the result of a subsequent reopening. CR will explain the reason for change.

1.5 Explanation of Benefit/Remittance Advice Data Elements

The following list is a summary of the typical data elements listed on the private insurer or state Medicaid Explanation of Benefits or Remittance Advice. Some insurers include more information and some less.

- Name, address and telephone number of the insurer
- Date of the Remittance Advice or Explanation of Benefits or date of invoice
- Tax Identification Number (TIN)
- Group name and group number (primarily private insurers)
- Check number and check amount
- Name and address of IHS facility
- Bank code (for electronic submission and posting)
- Identification or member number for the patient
- Patient name
- Social Security Number (not all insurers reference this data on the EOB)
- Patient relationship
- Patient account number (the account number assigned by the facility)
- Member name (if different than patient)
- Control number or claim number (number assigned by the insurer for their internal control)
- Date claim received at the insurer
- Provider of service (facility name, provider name, billing provider, service provider, etc.)
- Provider number
- Date or dates of service (for inpatient admissions the admitting and discharge date will be referenced)

- Place of service, form type, or services rendered at (specific location)
- Description or type of service (clinic visit, lab, surgery, or the insurer may list the CPT or HCPCS code. For inpatient claims the DRG code and days will be referenced. In addition, some insurers will also list the term “negotiated rate.”)
- Modifier or Units – This refers to the number of same services being billed for a given day or the modifier that was billed with the procedure code. This could also be used for inpatient revenue codes that utilize units.
- Amount Charged (usually divided by service or date)
- Not covered portion (for those services or procedures not covered under that patient’s contract or for patients not covered under that contract, e.g., contract was terminated)
- Adjustment or discount amount
- Amount allowed
- Amount applied to the deductible or coinsurance
- Percent or payment factor covered by the insurer
- Amount paid to the provider, facility (usually the amounts are divided by service or date)
- Remark code – a description of the remark code will either appear at the bottom of the Explanation of Benefits or Remittance Advice, or at the end of the notice.
- Patient responsibility or patient share – this is the amount owed by the patient to the facility, such as deductible, coinsurance, or rejected claim.
- Subtotals and Totals - Subtotals are listed for multiple services done on one day and the total is listed at the end for all patients, all services.

- Adjustments - For claims paid previously and denied or underpaid, there will be reference to this statement:

“This is an adjustment to a previously considered claim”.

For Medicare, offsets to payments are shown as an adjustment against an individual claim in that remittance notice. The Financial Control Numbers (FCNs) that will enable the provider to associate the offset with those claims and payments that led to the withholding is shown under the FCN column.

A single HIC number is printed if the offset is for a Medicare overpayment and a HIC number is associated with the offset. The HIC number will not be supplied if none is associated with the offset. Multiple HIC numbers are not printed in this field; the notice must be consistent with the electronic remittance advice standard, which only permits a single HIC in this field

- Claim status - This is used by insurers to inform the facility of a deferred claim, a paid claim, a claim routed to another insurer such as a secondary insurer, or other. Crossover claims may also be listed immediately following the claim payment history under comments. Other insurers will have a column on the Remittance Advice for other insurers billed, such as “Medicaid billed amount.”

For detailed descriptions of Remittance Advices or Explanation of Benefits for your area, contact your local insurer.

1.6 Automated Posting

For Medicare Part A and Part B, Medicaid, and for some private insurance, an Electronic Fund Transfer (EFT) and Electronic Remittance Notice (ERN) are available. Advantages include:

- Facilities receive reimbursement electronically on a daily basis for the claims that have been approved and have met the payment floor.
- Saves time from manually handling checks.
- Eliminates the need for manual posting of payments, line by line.
- Remittances include all claims and adjustments.
- HIPAA compliant - uses the same electronic format, ANSI X12 files (Using the same format enables facilities to electronically transmit to multiple insurers.)

1.6.1 Processing Electronic Remittance Notices

For information on processing electronic Remittance Advices/Notices, see the *RPMS Accounts Receivable User Manual (BAR)*, Chapter 9.14, “ERA Posting (ERA),” which is available at this website:

<http://www.ih.gov/cio/rpms/index.cfm?module=home&option=documents>

1.7 Medicare Health Care Claim Adjustment Reason Codes

Medicare adjustment reason codes are used to explain any adjustment in payment. For the most recent updated code list, go to this website:

<http://www.wpc-edi.com/codes/claimadjustment>

1.8 Claim Processing Timeliness

Facilities across the United States confirm that payment delays from insurance companies have become a significant problem. Because of this, many states have enacted prompt payment laws, also known as fair claims practice regulations.

Prompt payment laws dictate how quickly an insurer must pay a clean claim once it is submitted. Not all states have a prompt payment law, and certain restrictions apply in each state.

The process is as follows:

1. Generate an aged trail balance (accounts receivable report) and identify payers with outstanding claims.
2. Examine payers that have a number of outstanding balances that are past your state’s time limit.
3. Review the EOBs and follow up.

If the insurer claims it has *no record of receiving your claim*,

- Resend the claim.
- Keep track of the response in the Message section of the RPMS Accounts Receivable application.

If there is no valid reason for non-payment,

- Send a letter to the payer stating that payment is overdue and expected.
- Keep a copy for your file.
- If your state has an interest penalty for late payments be sure to ask for those additional monies in your letter.
- Document (in writing) any payers who are chronically late with payments, so that reference can be made to the person and date if the reimbursement is not received.

In addition, the Omnibus budget Reconciliation Act of 1986 established claims processing timeliness requirements for all Medicare claims.

- Electronic clean claims, defined as any claim that does not require outside development, must be processed within 30 days by Medicare;
- Manual paper claim submission is slightly longer.

On October 1, 1993, a provider interest payment was implemented. Interest payments will be applied on clean claims not process timely on the 31st day, after the date of receipt of a clean electronic claim, or, on the 31st day after the date of receipt of a clean paper form.

1.9 Check Management Process

For information regarding check management, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Accounts Management and Internal Controls,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/pageone.htm>

1.10 Financial Management Internal Controls

The purpose of this section is to provide guidelines and suggestions to IHS facilities to strengthen their internal reviews related to account reconciliation.

1.10.1 About Internal Controls

Internal controls are those checks and balances that ensure that operational objectives are carried out as planned, in the most effective and efficient manner possible. As such, internal controls should be viewed as integral parts of each system management uses to accomplish the objectives of the department.

Internal controls are not just financial tools that safeguard assets, but also are vitally important to the day-to-day programmatic and administrative operations. Thus, each facility needs to ask itself the following question:

“Can we be sure that there are adequate internal controls in place and operating effectively for the business processes that we are performing?”

Internal controls provide reasonable assurance that the following objectives are being achieved:

- Effectiveness and efficiency of operations
- Reliability of financial reporting, and
- Compliance with applicable laws

Internal controls also serve as the first line of defense in safeguarding assets, and preventing and detecting errors and fraud. In short, internal control, which is synonymous with management control, helps supervisors and managers achieve desired results through effective stewardship of resources.

1.10.2 Internal Control Standards

There are three fundamental concepts underlying the framework of internal control standards:

- (1) Internal controls involve a facility-wide commitment that defines and implements a continuous process of assessing, monitoring, and tracking activities through an integrated and effective communication mechanism.
- (2) A facility’s management directs internal control, which is carried out by the staff.
- (3) Reasonable assurance indicates that an internal control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance.

Discipline and structure, integral parts of internal control, should be supported by management.

1.10.3 Internal Control Activities

Internal control activities, policies, and procedures help to ensure that management's directives are carried out. Activities include

- approvals
- authorizations
- verifications
- reconciliation
- performance reviews
- security
- proper execution of transactions
- accurate and timely recording of transactions
- access restrictions
- appropriate documentation
- segregation of duties

Pertinent information must be identified, captured, and communicated in a form and timeframe that enables people to carry out their responsibilities.

1.11 Monitoring Internal Controls

Internal control monitoring, which assesses the quality of the operational system and process over time, needs to be part of the process. Internal control should generally be designed to assure that ongoing monitoring occurs in the course of normal operations. Part of the process includes separate evaluations to assure a check and balance of the entire process.

Other key points to note are:

- Access to computer systems and programs should be appropriately authorized, documented, and monitored.
- Adequate segregation to duties exists between various functions and is supported by appropriately authorized and documented policies.
- Staff are supervised and reviewed.
- Audit and tracking trails are developed and monitored

- Aged claims are routinely reviewed and processes are in place to limit claims being placed in the over 120 day category
- Business office staff are trained on all aspects of their job
- Copies of written and telephone inquiries and appeals are retained and handled accurately, appropriately and timely
- Appropriate safeguards and administrative actions are taken when fraud is suspected.
- All employees comply with applicable laws and regulations
- All financial transactions are valid and have a secondary approval process by an authorized person
- Segregation of duties exists within the areas of disbursement and collection, as well as between billing and account reconciliation
- Accounts receivable should be correctly recorded
- Bank deposits should be accurately stated and have a secondary review process by an authorized person

The Indian Health Service has recently adopted the Third Party Revenue Accounts Management and Internal Controls policy, which defines internal controls and guidance for financial management control. To review the policy, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Accounts Management and Internal Controls,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/pageone.htm>

1.11.1 Benchmarking Accounts Receivable

A suggestion for monitoring accounts receivable performance is to create an excel spreadsheet of the total cash/checks received on a daily, weekly, or monthly basis, or the total cash/checks received by payer. This data can be compared to previous months or years to demonstrate increased reimbursement and/or to monitor compliance process improvement changes.

Additional monitoring reports, such as amount of dollars placed in bad debt by month, amount billed and/or received by each insurer on a monthly basis, and days in AR by major payer, are value tools to monitor adverse fluctuations in your cash flow. These reports provide a true assessment of a facility's accounts receivable and pinpoint where improvements are necessary.

Each of these reports can also yield charts and graphs so that information can be shared with the Finance Office and senior management. Problems and adverse trends can be easily identified, and mitigation strategies can be put into place quickly.

1.11.2 Avoiding Cash Flow Problems

To avoid cash flow problems, the following areas need to be monitored:

- An increase of dollars in Accounts Receivable outstanding of more than 10 percent over one year ago
- An increase in the number of open accounts compared to a year ago
- An increase in bad debt compared to a year ago
- An increase in medical record delays
- An increase in percent of receivables over 90 days means cash is turning slowly
- Cash collections not keeping up with or exceeding net amount billed each month