MAPAM Meeting

Third Party Liability – Best Practice Overview

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What is Third Party Liability (TPL)?

- **Third Party Liability (TPL) is Workers' Compensation, Motor Vehicle Accident and General Liability claims.**

- **TPL claims are usually less than 5% of a hospital's A/R. However, the resource effort and specialized skills needed to properly adjudicate these claims is disproportionately high compared to the rest of the A/R.**

- **These claims are more complex to resolve when compared with other segments of the A/R. They frequently result in limited data capture at the time of treatment and are handed off to the billing department without sufficient information to process for payment. This often results in underpayments and improper reimbursements.**

TPL Process Overview

Thorough Investigation = Timely and Accurate Coordination of Benefits

- **Determine the existence of available insurance coverage, such as medical payments coverage, health insurance, or other liability coverage.**

- **Determine the correct next step which could range from billing an identified insurer to gathering additional information from the patient.**

- **Use informational databases, various calling processes and tailored letters to further assist in obtaining all information required for the submission of bills and coordination of benefits.**

- **Claim Representatives manage all claims electronically**
  - **Internal proprietary system provides desktop access to:**
    - **All documents related to each claim**
    - **Clients' systems for retrieval of patient demographics, healthcare insurance, employer, attorney, payment information**
    - **Payers' systems used to determine status of claims**
    - **Search tools including Lexus Nexus/Accurint, etc.**

Workers' Compensation

- Workers' Compensation coverage is Compulsory in 49 of our 50 States
  - Some states base the mandatory requirement on the number of employees
  - Texas is not mandatory (the exception is construction contracts for governmental entities)

- Rates of Reimbursement can vary greatly depending upon the scheme selected by the state
  - Usual and Customary
  - Fee Schedules
  - Managed Care Options/PPOs

- Fee Schedule States vs. U & C States
  - Fee schedule states provide for precise reimbursement models (MA, CT, VT, RI)
    - Frequently misapplied and easy to appeal underpayments
  - Usual and Customary States vary greatly relative to their reimbursement models and require many challenges based upon re-pricing techniques (NH).
    - Some states are willing to enforce gross charges as appropriate while others provide discount guidelines.

Workers' Compensation - continued

- **Federal WC (Dept. of Labor)**
  - **Federal workers' compensation claims are paid on a federal fee schedule and are very unique in their processing.**
    - **Many hospitals are not current on accepted diagnosis codes, etc.**

WC Claims Processing

Best practice provides for dedicated expertise and excellent reimbursement outcomes based on the following

- **WC Claim Representative will review account for employer information and any other essential demographic information.**
- **Place phone calls to insurance company and/or employer to determine relevant insurance coverage.**
- **Once sufficient information is obtained and confirmed, the bill is submitted to the carrier along with the medical record for processing.**
- **In the absence of billable information, the claim representative will contact patient by telephone and/or a patient letter series. Normally three (3) phone call minimum and four (4) patient letters. Periodic review is done pending receipt of information from patient.**
- **Conditional Health Billing is considered at day 45.**

WC Claims Processing – continued

Best practice provides for dedicated expertise and excellent reimbursement outcomes based on the following

Follow up steps:

- **Confirm receipt of billing package with payer within 21 days from submission.**
- **Check payment status with customer service and/or adjuster.**
- **If the bill is in process, follow-up within 14 days.**
- **If payment is issued, the claim representative will obtain all payment information to include check number, issue date and amount of payment and confirm where the check will be mailed. Account will be noted accordingly.**
- **Denied claims require a copy of the EOB in order to determine the reason for denial. Once this has been obtained from payer, health insurance eligibility will be confirmed and billed.**
- **Health Insurance follow-up will proceed to confirm receipt of billing package and will continue until payment has been issued.**
- **Upon receipt of payment, review for accuracy.**

WC Underpayment Opportunity

Analysis of paid WC claims for various hospitals, has identified that between four to twelve percent (4-12%) of all WC claims are underpaid.

Self Pay Bad Debt	12%
Authorization	16%
Eligibility	8%
Documentation Errors	6%
Medical Necessity	8%
Billing Errors	2%
Underpayments	**47%**

Reimbursement rates vary greatly by state depending if payment scheme is Fee Schedule, Managed Care Options (PPO Contract provisions), or Usual and Customary.

Motor Vehicle Accidents

- More than 2.6 million people annually require medical treatment as the result of motor vehicle accidents
  - National Highway Traffic Safety Administration
- Close to 18% of these patients lack health insurance
  - Center on Budget and Policy Priorities
- Those with health insurance are facing increasingly larger co-pays/deductibles
- More dollars are lost by not properly identifying these accounts as MVA related, compounded by not taking the appropriate action to secure MVA funds
- There are twelve MVA "no fault" states (Massachusetts, Florida, Pennsylvania, New York, New Jersey, Hawaii, Kansas, Kentucky, Michigan, Minnesota, North Dakota and Utah)
- 22 states require "coordination of benefits" between Auto and Health insurance (MA, NH, RI, ME, CT, DC, KS, OR, UT, DE, KY, MI, NJ, PA, WA, FL, MN, NV, WI, HI, MD, ND, NY, TX).

MVA Claims Processing

Best practice provides for dedicated expertise and excellent reimbursement outcomes based on the following

- **MVA Claim Representative will review UB04 to determine if the patient is the driver, passenger or pedestrian.**
- **Review account for demographic information and any other essential billing information.**
- **Third Party information is gathered at this time in the event a lien filing is necessary.**
- **Place phone calls to insurance company and/or attorney to determine relevant insurance coverage - if PIP is exhausted Health is billed.**
- **Once sufficient information is obtained and confirmed, the bill is submitted to carrier for processing.**
- **In the absence of billable information, our claim representative will contact patient by telephone and/or a patient letter series. Normally three (3) phone call minimum and four (4) patient letters. Periodic review is done pending receipt of information from patient.**
- **Conditional Health Billing is considered at day 45.**

MVA Claims Processing - continued

Best practice provides for dedicated expertise and excellent reimbursement outcomes based on the following

Follow up steps:

- **Confirm receipt of billing package with payer within 21 days from submission.**
- **Check payment status with customer service and/or adjuster.**
- **If the bill is in process, we will follow-up within 14 days.**
- **If payment is issued, the claim representative will obtain all payment information to include check number, issue date and amount of payment and confirm where the check will be mailed. Account will be noted accordingly.**
- **Denied claims require a copy of the EOB in order to determine the reason for denial. Once this has been obtained from payer, health insurance eligibility will be confirmed and billed.**
- **Health Insurance follow-up will proceed to confirm receipt of billing package and will continue until payment has been issued.**
- **If no insurance payment is forthcoming from MVA/Med Pay or Health Insurance, we will review options at this time for filing a lien.**
- **Upon receipt of payment, review for accuracy.**

Denials Management – Appeals Process

- Operations Team consisting of tenured staff including a Registered Nurse, Operations Support Analyst, Reimbursement Specialist and a Certified Coder
- The team pursues not only payment disputes but focuses on specific payer problems until resolved (e.g. payer interpreting the fee schedule incorrectly, identifying incorrect application of PPO contractual agreement resulting in erroneous reimbursement).
- Review of Fee Schedule Reimbursement
  - Erroneous application of reimbursement guidelines
  - Aggressive underpayments
  - Incorrect applications of PPO contract terms/silent PPO issues

TPL Capability Overview

Does your process provides for dedicated expertise and excellent reimbursement outcomes based on the following?

- **Complete claims management –** Billing & Follow-up, including contact with patient for additional information via telephone or tailored letters.
- **Thorough investigation –** to find all responsible payers
- **Highly knowledgeable & tenured staff** – combined with customized technology will accelerate claim resolution by quickly coordinating benefits and processing claims effectively
- **Reimbursement analysis –** to assure that claims are paid appropriately. Historically we have identified that between 4-12% of all WC claims are underpaid
- **Denial management and appeals team –** Denied or underpaid accounts are quickly investigated and appealed
- **Lien filing** where necessary
- **Robust standard reports** with fully integrated graphical capabilities

Benefits of Outsourcing

- Accelerated claim resolution and cash flow
- Increased reimbursement through denial management payment auditing and appeals
- Able to refocus internal resources on the other 95% of a typical facility's A/R
- Improved patient experience
- Minimal investment of existing hospital staff
- Feedback to improve front end functions
- Performance metrics and reporting
- Compliance with all applicable statues and regulations

The Keys to Success

1. ***Technology*** **- to handle the "paper" laden process of claims submission that includes itemized bills, medical records, purchase orders, EOBs, etc. which is critical to proper reimbursement.**

2. ***Expertise*** **- Coordination of benefits and reimbursement models for each state. Placing of liens, as applicable, to state rules and settlement negotiation.**

3. ***Process and people*** **- role specialization for WC, MVA, and Health teams. Appropriate follow up, denials management, including nurse audit review and successful appeal.**

Questions / Open Discussion