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A Study to Determine the Effects of Interventions Upon The Collection of Outpatient Claims

CPT Michael P. Griffin, MS

USA MEDDAC
Fort Riley, KS 66442-5037

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U.S. Army-Baylor University Graduate Program in Health Care Administration
Academy of Health Sciences, U.S. Army (HSHA-MH)
Fort Sam Houston, TX 78234-6000

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The study showed a dramatic increase in the total dollars collected. Additionally, two of the three key rates were positively influenced. The average age that a claim was managed as an account receivable decreased by 16.2 days and the claims generation rate increased from one percent to almost four percent. However, the collection rate decreased by six percent.

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Outpatient Third Party Collections

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A Study to Determine the Effects of Interventions Upon the Collection of Outpatient Claims

A Graduate Management Project

Submitted to the Faculty of

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of

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by

CPT Michael P. Griffin, MS

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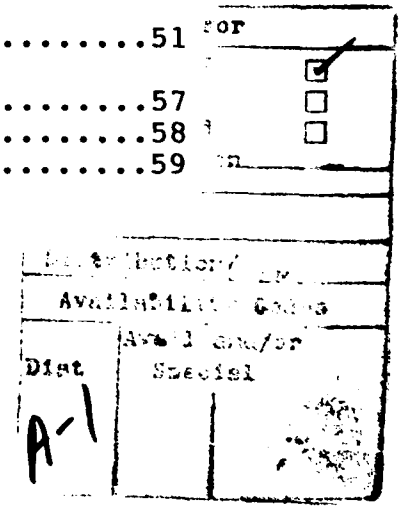

APPENDIX

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I would like to thank COL William Speer, my preceptor, for his guidance and support throughout this year. The daily advice and insight he provided me helped make this residency year and preparation of this paper more fulfilling and enjoyable.

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To my wife Cindy, who provided constant love, support, and understanding throughout the past two years, I am forever grateful. Her patience and encouragement served as a source of strength for me.

ABSTRACT

This study sought to increase the efficiency and effectiveness of outpatient collections at Irwin Army Community Hospital. To accomplish this a three phase study was conducted. The first phase consisted of a retrospective analysis of performance utilizing three key rates. System changes and intervention measures were introduced in the second phase. These measures included an internal marketing and education program, an external marketing survey, back billing operations, and aggressive accounts receivable management. The third and final phase consisted of calculating the key rates after the intervention measures had been implemented and comparing these rates with the pre-intervention rates.

The study showed a dramatic increase in the total dollars collected. Additionally, two of the three key rates were positively influenced. The average age that a claim was managed as an account receivable decreased by 16.2 days and the claims generation rate increased from one percent to almost four percent. However, the collection rate decreased by six percent.

CHAPTER 1

INTRODUCTION

Effective 7 April 1986, Title 10, United States Code, Section 1095 (10 U.S.C. 1095) authorized military medical treatment facilities (MTFs) to collect from third-party payers. More specifically, the statute allowed military MTFs to collect from insurance, medical service, or health plan, the reasonable costs of inpatient health care services incurred on behalf of covered beneficiaries. On 5 November 1990, Section 713 of Public Law 101-511 amended 10 U.S.C. 1095 to permit MTFs to bill insurance carriers for outpatient care as well as inpatient care.

This expanded authority to bill for outpatient care is well founded since a noticeable shift from inpatient to outpatient care occurred during the 1980s. This shift was due in part to implementation of the prospective payment system (PPS), increased technological innovations, and increased emphasis by the federal government and other third party payers to have patients treated on an outpatient basis (Clarkin, 1990). The growth in the outpatient sector is expected

to continue into the 1990s (Spenner, 1991). Despite the growth in the outpatient market, the percentage of total revenue generated through inpatient and outpatient care has remained relatively constant (Slater, Corti, & Privitera, 1991).

In fiscal year 1992 (FY 92), the Army asked for and was granted authority to initiate outpatient collections effective November 1991 (Doug Ashby, personal communication, 15 December 1992). The ability to collect for outpatient services provides each MTF with new challenges and excellent opportunities to increase collections under the Third Party Collection Program (TPCP).

Conditions which Prompted the Study

A number of factors contributed to the need for this study. The first was a desire by the command group at Irwin Army Community Hospital (IACH) to make the new expansion of the TPCP successful. As a minimum, the program was to ensure that annual decrement was met. A decrement is a budget reduction based upon estimates of what a particular MTF will recapture through insurance reimbursement (Noyes,

1992). In fiscal year 1992, IACH collected $12,169.58 in outpatient claims. This amount was collected over a nine month period beginning in January 1992. In fiscal year 1993, the outpatient decrement imposed by Health Services Command (HSC) was $50,260.00. This figure was over four times greater than what was collected the previous year and therefore presented itself as a significant challenge for us to meet.

In addition to meeting the decrement, the command wanted to ensure that all salaries of TPCP personnel, annual training associated with the TPCP, and any system/program improvements were funded through collections under this program. Additionally, there was an expectation that the TPCP could serve as an excellent means to make money for the hospital. The surplus money made through the TPCP could then be used to enhance the quality of care at IACH. For example, additional equipment and/or supplies could be purchased.

A second factor which led to the initiation of this study was the realization that we were not optimizing our collection potential. This realization

was based upon the results of a medical records audit. On 22 August 1992, an audit of 68 Internal Medicine records was conducted. During this audit it was discovered that 24 records in which third party claims for outpatient care could have been processed had in fact not been identified. This represented a potential loss to IACH of $1,848 (24 claims x $77 FY 92 outpatient visit rate). Based upon this evidence, it was decided that the current system to identify, bill, and collect from third party payers be examined to determine where changes could be made to improve efficiency and increase collections.

The third and final factor was based upon the fact that billing for outpatient care required a totally new and different approach. While IACH had experience in billing for inpatient care, billing experience for outpatient care was somewhat limited. The characteristics of outpatient billing include a faster processing time, high volume of claims, high costs associated with preparing and submitting bills where actual dollars collected may exceed the cost of processing the claim, and limited insurance coverage

for outpatient care ("Accounts receivable," 1982; Clarkin, 1990).

Since outpatients are treated, examined, and discharged on the same day (Clarkin), the outpatient billing and collection process must be much more responsive and proactive. However, the very nature of billing and collecting for outpatient care involves more administrative and clerical work for less revenue than inpatient care (Slater, Corti, & Privitera, 1991). Essentially, 80% of the work effort is spent handling accounts which generate only 29% of the revenue (Slater et al). Ultimately, billing delays can create an enormous backlog which may affect the actual collections for the hospital.

Statement of the Management Problem

IACH was not maximizing its collection potential in regard to the outpatient TPCP. Furthermore, in order to change this situation, intervention measures needed to be taken to effect modifications in current organizational behaviors.

Literature Review

Background

Prior to the development of any major third party payment programs (i.e. before the 1930s), patients paid for approximately 87 percent of the cost of health care directly out of their own pockets (Zelten, 1979). During this time period, providers were extremely conscious of the financial burdens placed upon patients in regards to the services they ordered. Therefore, price served as the principal means of allocating resources.

In the 1930s, Blue Cross and Blue Shield plans came into being thereby spurring the wide-spread growth of third party payment programs (Zelten, 1979). As the commercial health insurance industry grew and expanded, the direct out of pocket expenses paid by patients for health care decreased. For example, from 1986 to 1989, the percentage of doctors' bills which the patient was responsible for paying decreased from 21% to 19% (Azevedo, 1990). The net effect of this trend is an assumption by many patients that insurance or the government will pay whatever is required (Hemmer,

1992).

The expansion of third party payment programs has also led to increasingly complex and varied reimbursement arrangements (Zelten, 1979). Additionally, as the costs of health care rose, payers have begun to limit or curtail payment for services (Duis, 1989). In summary, it has become infinitely more complex to effectively and efficiently manage collections in such an environment (Duis).

In order to be effective in such an environment, MTFs must aggressively identify those beneficiaries who are covered by third-party payers. Furthermore, they must establish an efficient system in which to prepare bills for submission, submit said bills, and track bills until collection of the appropriate amount is effected.

A Government Accounting Office (GAO) Report on Veterans Administration (VA) hospitals (GAO/HRD-90-77, 1990) identified a number of factors which can affect recoveries of third party payments. These factors include the available staffing, computer hardware and software, staff skills and experience, proper guidance

from higher headquarters, and the cooperation and support needed to pursue cases which cannot be settled at the local level. Other keys include the establishment and maintenance of strong working relationships with outpatient clinic chiefs, a high volume of billings generated, and a project officer to ensure that the program is properly implemented (Noyes, 1992).

Organization

There are essentially three main steps which must be accomplished in the area of third party billing. First, patients who have other health insurance must be identified; then bills must be prepared; and finally, collection of the required amount must take place. Of these three steps, perhaps the most critical is that of identifying patients because without this information the other two steps cannot take place.

The patient registration process is the critical link in the solicitation of insurance information from the patient. Witmer and Mansfield (1980), Clarkin (1990), and Anderson (1991), all recommend that outpatient registration be centralized. A centralized

registration system has a number of advantages over a decentralized registration system. First, it involves fewer people to operate (Clarkin). Additionally, the people that work in this area are specifically trained to conduct the functions associated with properly registering patients and soliciting the correct insurance information.

This function of gathering complete and accurate data is extremely important since the outpatients pass through the facility so quickly ("Growing outpatient," 1992). It is also important to the complete billing cycle since incomplete and/or inaccurate data creates a situation in which personnel must spend additional time researching prior to being able to bill (Anderson). Proper insurance verification at the initial entry into the facility ultimately leads to decreased billing and collection delays (Clarkin).

The centralized registration system does have its drawbacks. First, it requires a large amount of physical space due to the need to conduct patient interviews and registration functions (Clarkin, 1990) Furthermore, long waiting lines may occur. This in

turn can affect not only the patient's satisfaction level but also the productivity of the entire facility staff (ex. non-productive time for the doctors and nurses).

A second approach to the registration process is to decentralize it. The advantages of doing this are that it does not require a large area, it reduces the long waiting lines that may occur under the centralized approach, and it makes access to the facility easier. Patients can go directly to their doctors office/clinic instead of going through centralized registration. This may in turn increase the patients satisfaction and improve clinic productivity.

The decentralized approach also has a number of disadvantages. First, it requires more personnel to operate. Additionally, the registration personnel under this model typically report directly to individual physicians or department managers (Clarkin, 1990). These department/clinic clerks have a much different perspective regarding the importance of soliciting accurate and complete data than the patient accounting department needs to prepare and submit bills

(Slater, Corti, & Privitera, 1991). Part of the problem in regard to this different perspective lies in the fact that registration personnel are not sufficiently trained in how to properly obtain the information needed to prepare bills for submission to third party payers (Tintari & Lane, 1987).

Since the personnel are not sufficiently trained, the whole process becomes extremely difficult to control, the quality of information needed for billing decreases, and the overall consistency and effectiveness of the entire operation is affected (Clarkin, 1990). For example, billing backlogs will begin to increase resulting in increases in accounts receivable ("Back office," 1982; Tintari & Lane, 1987). Furthermore, cash flow will decrease (Clarkin) and more costs will inevitably be written off as uncollectible (Hemmer, 1992).

To help alleviate some of the problems described above, emphasis should be placed on training individuals about the necessary billing requirements (Hemmer, 1992) This training should be done at all levels of the organization (Hemmer). Additionally, all

personnel in the registration process should be cross trained ("Growing outpatient," 1992). This would entail training clerks in each clinic how to solicit third party insurance information from beneficiaries.

Another mechanism to further maximize the hospital's collection potential and avoid the problems associated with a decentralized approach, is to use the patient appointment system as a means of gathering accurate insurance information prior to the patient even arriving for their outpatient visit (Clarkin, 1990). In essence prospective prescreening of patients would be done (Pratt, 1992). By doing this, insurance data could be gathered and verified prior to the patient's actual appointment (Anderson, 1991). If incomplete information is gathered at the time the patient makes the appointment then the clinic has a second chance to capture the correct data at the actual appointment date.

A third and final patient registration model is a zoned model (Clarkin, 1990). This model is essentially a blend between the centralized and decentralized models. Therefore, it has a mixture of some of the

advantages and disadvantages. For example, it is more efficient and easier to control than the purely decentralized model. On the other hand, it requires more personnel to operate than the centralized model.

Billing and Automation

The second step in the third party collection process involves gathering the appropriate information necessary to prepare a bill. To accomplish this, an encounter form (Clarkin, 1990) or "superbill" (Hershman, 1984) should be utilized. The term encounter form and "superbill" refer to forms that many physicians' offices use to gather data necessary to prepare a bill (Hershman). For example, data collected should include the patients name, date, diagnosis, and any treatment procedures performed and/or evaluations conducted (Hershman).

The use of encounter forms at IACH had already been implemented prior to the start of this study. The principal advantage of a well designed encounter form is twofold. First, if the form is easy to use, then providers will readily accept them and use them. The ideal form is one where the provider merely has to

check off the services he/she has rendered (Zupko, 1990). The form would contain lists of the most common American Medical Associations' Current Procedural Terminology (CPT) codes, since these codes serve as the basis upon which third party payers determine what they will pay (Zupko). The second advantage of a well designed encounter form is it can greatly simplify the billing process in a manual system (Clarkin, 1990).

Unfortunately, a manual billing system for outpatient care quickly becomes overwhelmed. Slater, Corti, and Privitera (1991) state that biller productivity in a manual system is limited to approximately ten outpatient claims per day. There are a number of ways to overcome the limitations associated with a manual system. The first is to increase the number of personnel working in the TPCP. This option, which was not available during FY 92 due to a mandatory civilian hiring freeze (Noyes, 1992), is also a difficult option to choose today due to the budget cuts and limited hiring authority (i.e. the hospital is only allowed to hire back one individual for every four losses).

A second option would be to turn over responsibility (i.e. contract out) for third party billing to another agency. This was done by a hospital in Yonkers, New York (Slater, Corti, and Privitera, 1991). After doing this, the hospital realized an increase in the number of bills going out. This in turn led to an increase in cash flowing into the organization. Two years after making the decision to turn its outpatient billing over to another agency, the hospital achieved a 15% increase in net outpatient cash collections.

A third option is to automate the process. To accomplish the increased responsibilities in regard to billing and collecting for outpatient care, most medical record departments have received increased support such as additional staffing, stricter rules and operating procedures, and automation to enhance operations (Waterstraat, Barlow, & Newman, 1990). Automation to support third party collection for inpatient care is currently provided through the Automated Quality of Care Evaluation Support System (AQCESS). On the other hand, the current system to

identify, bill, and collect for outpatient care is not automated and therefore is highly labor intensive. This lack of automation to support the outpatient TPCP has proven to be one of the greatest handicaps (Noyes, 1992).

An integral piece to the automation puzzle is the master patient index (Clarkin, 1990; Jones, Nutt, & Hedley, 1984; Prussin, 1987). A master patient index is a database which contains both medical and administrative information such as demographic, insurance, appointment, medical, and receivables data. The design of the master patient index should include an easy method to obtain and store information concerning the last date in which details pertaining to a particular patient account were confirmed (Jones, et al.). This is an important aspect regarding the TPCP since the information is required to be verified at least once a year. The master patient index should also be capable of alerting the user when there is missing data or duplication of data (Jones, et al.). Information from the master patient index can also be recalled and used to automatically produce an encounter

form (Clarkin).

An automated system should also be flexible, user-oriented, and compatible with the inpatient registration system (Dalva & Reinke, 1982). It must have growth and expansion potential in addition to being easy to modify, revise, and update (Mager & Collignon, 1988). An automated system provides numerous advantages over a manual system. First, it provides unlimited flexibility in regard to retrieving and analyzing data. It can also reduce the enormous volume of repetitive tasks and reduce the amount of time required to complete specific tasks (Dalva & Reinke, 1982). Since the time requirements for processing the claim are reduced, productivity of the billing staff can be enhanced (Souders, 1990). Time can then be devoted toward collection and follow-up of overdue or rejected accounts (Souders; Dalva & Reinke). Perhaps the greatest advantage of automation is that the organization can improve its outpatient cash flow (Anderson, 1991).

In summary, automation can serve as an excellent tool in accomplishing more efficiently the tasks

associated with outpatient third party billing. However, it is important to keep in mind that the very best computer system is only as good as the skill, knowledge, and attitude of the person using it (Ball, 1990). Furthermore, if a staff is enthusiastic about change and willing to be trained, then computer literacy can be learned and a new system can be effectively implemented (Ball).

Accounts Receivable Management

Accounts receivable management is a critical function since poor management ultimately leads to a decrease in cash flowing into the organization, a higher number of days in receivable, and a higher number of accounts which eventually get written off as uncollectible (Coppack, 1990). Unfortunately, a manual billing and reconciliation system rapidly leads to poor accounts receivable management due to the fact that the volume of accounts becomes too large to manage and control (Prussin, 1987). However, the use of an automated system can significantly reduce the problems associated with a manual system. For example, when the University of Michigan Medical Service Plan went to a

fully automated system in 1982 they achieved a 15% reduction in their accounts receivable (Johnson & Barazsu, 1986).

An automated accounts receivable system, if used properly can also provide management with a wealth of meaningful information (Roovers, 1983). For example, it could provide management with an accounts receivable aging schedule/analysis. This aging schedule serves as an excellent tool in managing and identifying carriers that do not pay their bills in a timely manner.

We in the Military Health Service System (MHSS) must learn to be aggressive managers when it comes to accounts receivable management. We must think and act in a more business-like manner if we expect to succeed (Harben, 1992). There are a number of tools and techniques available to ensure success when it comes to managing accounts receivable. First, a hospital must strive to reduce the amount of time it takes between the start of the charge generation process (i.e. when the patient receives care) until the actual dollars are collected from the third party payer ("Accounts receivable," 1982). To assist in this analysis, a

hospital needs to determine how many days it takes to complete and mail the bill (Happach, 1976). Furthermore, the hospital must determine how long it takes to receive payment for services once the bills have been sent. By separately analyzing these time periods one can ascertain whether efficiencies can be made in regard to internal management of the claim or external management of the claim.

In regard to internal management, Cole (1991) states that it is essential to monitor an organizations "hidden receivables". This term refers to the monies due to the organization in the form of accounts receivable which have not yet been processed and billed to the third party payer. If automation support is available, the amount of "hidden receivables" can be substantially reduced while cash flow into the organization is increased (Coppock, 1990).

If claims are submitted in hard copy form it is critical to ensure they are mailed the same day that they have been prepared. Another avenue of interest in accounts receivable management, is in the area of electronic billing. There is a growing interest in

moving toward electronic claims processing and away from the traditional paper claim forms (Moynihan, Bednar, & Norman, 1991). The principal benefits of electronic claims processing are decreased accounts receivable, increased cash flow, and reduced processing time (Moynihan, et al.).

In the area of external management of claims, Tintari and Lane (1987) recommend that organizations reject industry standards and norms. They state that organizations can achieve significantly lower days in accounts receivable through aggressive and creative management. A study conducted by Kenneth and Lampi (1978) dramatically illustrates this very point. The researchers studied the payment patterns of a particular commercial group insurance carrier. Their initial assessment determined that the carrier paid inpatient claims about 25 to 30 days after the original bills were submitted. Additionally, the hospital normally did not follow-up on claims until they were 60 days old. Their next step was to send out tracers (i.e. photocopies of the original bills) exactly 30 days after billing. As a result of this initiative,

claims began to be paid faster (i.e. within 23-28 days). The researchers then began sending tracers out after 25 days. The carrier again accelerated its payment to the hospital. Payments were now being received within 18-22 days. When asked why they accelerated their payments, the carrier stated that hospitals that were known for aggressive and timely follow-up were paid quicker.

The lesson to be learned from this study is that aggressive and timely management of claims pays off. In addition to sending photocopies of claims, messages on bills and letters have proven to be inexpensive and effective collection means ("Back office," 1982). Specific policies and procedures must be in place to effectively monitor and conduct follow-up activities.

Follow-up activities are not complete until the appropriate amount due to the organization is received. A third party payer essentially has three options: pay the entire claim, pay part of the claim (i.e. cut reimbursement), or deny the claim. If the claim is denied or the carrier pays only part of the claim, then an organization may appeal the decision (Zupko, 1990).

However, it is important to realize that the cost and time involved in appealing can be quite high (Hodgins, 1986). Since the time involved and costs can be high, it may not be worthwhile to pursue this avenue for outpatient care under the current fee schedule of $100 per visit. Regardless of the outcome of a claim, it is important to carefully examine every explanation of benefits (EOB) because it may prevent the organization from repeating the same mistakes again and again (Zupko).

Purpose

The purpose of this Graduate Management Project (GMP) was to increase the efficiency and effectiveness of outpatient collections through the introduction of various intervention measures. The results of this study were measured using a number of key rates and through observations and data gathered through qualitative analysis.

CHAPTER 2

METHODS AND PROCEDURES

Patton (1990) states that qualitative analysis allow a researcher to study selected issues in great depth. In particular, a qualitative approach can be extremely beneficial and appropriate where the goals are to facilitate more effective program implementation and improvement. It also works well for dynamic and developing programs where change, which is constant, requires the staff to learn as they go. Since this was the first full year of operation for the outpatient TPCP at IACH, we (i.e. the IACH TPCP staff and myself) knew that change was inevitable and that we had a lot to learn. The program was in essence still in the implementation phase.

The first step I took in this process was to learn as much as I could about the TPCP. To accomplish this I utilized the three types of data collection associated with qualitative analysis. These methods are: 1) direct observation; 2) in-depth, open-ended interviews; and 3) analysis of written documents (Patton, 1990).

One of the first documents I reviewed was a GMP which was done by CPT Randy Buchnowski (1991). This GMP, which was sent to me by Doug Ashby, Health Services Command (HSC) TPCP Manager, served as an excellent source of information for me. In addition to providing me with a good understanding of the TPCP, it contained a number of key rates that could be used to quantitatively evaluate the efficiency and effectiveness of a hospital TPCP. Two of the variables/rates I used are identical to those used by CPT Randy Buchnowski and the third rate is one which I developed based upon my review of the literature.

The following variables were used to measure performance and effectiveness:

1) Collection Rate (CR) = Total Amount Collected/ Total Amount Billed

   a) Purpose - to measure the overall effectiveness of the billing and collection process.

   b) Goal - 65% of total billed (this goal was established/set by the Office of the Assistant Secretary of Defense for

Health Affairs (Olson, 1992).

2) Days in Receivables (DR) = Total Accounts Rec. Days/Total # of Claims

a) Purpose - to measure efficiency in regards to accounts receivable management.

b) Goal - 40 days.

3) Claims Generation Rate (CGR) = # Claims Generated/# of outpatient visits

a) Purpose - to measure how effectively we identify patients with third party insurance.

b) Goal - to increase the CGR by 50%.

Given these quantitative measures a hypothesis was developed. The alternate hypothesis for this study was that key established rates are positively affected by the introduction of changes to the current system. On the other hand, the null hypothesis is that the study variables are not positively influenced by the introduction of changes to the current system.

The project consisted of three phases. The first phase was a retrospective analysis of the Internal

Medicine Clinic using the key rates. This clinic was chosen due to the fact that 75% of patients with third party insurance are seen and treated in either the Internal Medicine or Surgical Clinics (Olson, 1992). Additionally, since this clinic was the first to be brought on line last year (JAN 92), a fair amount of data was available upon which to calculate pre-study rates.

The second phase of the project consisted of analysis of the current system and the introduction of interventions/changes to this system. This phase began with an analysis of the external guidance and internal policies and procedures in regard to the TPCP. During this evaluation phase I also conducted a number of interviews with key individuals within IACH. In addition to individuals within the organization, I sought the expertise and guidance from external sources. For example, I interviewed and had numerous discussions with the HSC TPCP manager, Doug Ashby. Furthermore, I had discussions with representatives from other MTFs, two VA hospitals, and three civilian hospitals. And finally, I observed how the process

worked at IACH. This required me to watch and note the actions taken by key individuals who provided any input into the TPCP.

As a result of the information that I gathered through interviews, analysis of documentation, and direct observation, a number of intervention measures were developed to effect changes that would improve the collection potential at IACH. I determined that the system changes needed to be implemented throughout the organization since we wanted to maximize the dollars collected.

The interventions which the IACH TPCP staff and I developed and introduced were based upon what was learned from the literature, what we learned from other MTFs, and what we believed would improve the program. The first area we concentrated our efforts on was marketing the program to the hospital. This marketing effort was directed at all levels of the organization to include the command group, physicians, nurses, and clerical/administrative staffs. The primary goal of this measure was to familiarize the entire organization about the TPCP. In order for our program to be

effective, it needed the support and backing of the entire hospital staff. Marketing to this group consisted primarily of educational programs/classes on how the program works, its benefits, and the actual progress of the program. As part of this initiative we felt that it was extremely important to focus our efforts on training clinic clerks. The clerks are essential individuals in the TPCP because they are the ones who solicit insurance information from patients. In order to effectively solicit this vital information they must be adept at asking open-ended questions. Furthermore, they must have sufficient knowledge of the program to answer any questions which patients may pose.

The next area we needed to work on was marketing the program to our beneficiaries. We felt that it was important to emphasize the positive aspects of our program to the population we serve. To accomplish this we published an article in the post paper, placed informational brochures and TPCP posters in high visibility areas, and conducted a market survey in order to identify individuals with other health

insurance. This survey was directed at the retiree population, their dependents, and dependents of deceased service members due to the fact that they represent 90% of the hospital beneficiary population that has third party insurance (Olson, 1992).

A third area of focus for this phase consisted of ensuring that we billed for all the care that we delivered last year (FY 92). To accomplish this we had to obtain the appointment history of each patient with other health insurance. We then had to balance this against the bills which we had processed. If any discrepancies in the two occurred, we created bills for the visits that were missed.

As previously stated, automation support within the Department of Defense for outpatient third party claims has not yet been fielded. This lack of automation was one of the critical elements which needed to be addressed. In response to the lack of automation support, a number of military MTFs developed their own systems or procured support from a private vendor. The options which faced us here at IACH were as follows:

1) Procure from private vendor

2) Obtain from another military MTF

3) Develop in-house

The option of developing the system in-house was rejected due to the fact that the time and personnel requirements to accomplish this task were too demanding. Therefore, this left us with the options of obtaining the system commercially or from another military MTF. The hospital had already received a demonstration and proposal from a private vendor, Sentient Systems, prior to my arrival. While attending the TPCP Conference in San Antonio (December 1992), I too had the opportunity to see this system. Additionally, the TPCP manager at Brooke Army Medical Center, Joanne Elmore, demonstrated the system to me since they had recently purchased one from this vendor. In addition to this system, two systems which were developed by other MTFs were analyzed.

The third and final phase of this study consisted of gathering collection data from January 93 through March 93. This data was then analyzed to determine if the program goals were met.

Validity and Reliability

Validity and reliability of data was obtained by using standardized collection methods. All data that was collected consisted of original source data as opposed to secondary data. Since this study also entailed the use of qualitative analysis, the validity and reliability was subject to and dependent upon the skills, integrity, and sensitivity I used throughout the entire study (Patton, 1990).

Ethical Considerations

The identity of records upon which rates were calculated contained no identifying patient information in order to protect the ethical rights of the patient. Instead, records were identified by locally assigned control numbers. Additionally, direct quotes/comments obtained from individuals do not have any identifying information.

CHAPTER 3

RESULTS

Rate Analysis

As of 31 March 1993, IACH had collected 108% of its decrement. The amount collected, $54,249.65, exceeded the decrement of $50,260.00 by $3989.65. Of the total collected, $20,562.22 is due to our efforts this year while the remaining $33,687.43 is due to our back billing efforts and to claims which were carried over from the previous fiscal year. The goal of meeting the decrement has been exceeded only six months into FY 93. In regard to the bottom line profitability of the program, the outpatient TPCP is proving itself to be successful.

An analysis of the key rates showed remarkable improvements in two rates and a slight decline in one.

Insert Table 1 about here

The CR, which measures the overall effectiveness of the billing and collection process, dropped by 6%. However, the average amount collected per claim last

year was $34.79, while the average amount collected per claim this year was $39.26. This increase can be attributed to the rate change. Last year, FY 92, a the flat rate of $77 per visit was used whereas this year the rate increased to $100. This per visit flat rate is the same regardless of whether the patient is seen for a minor cold or for a condition which requires extensive work that includes ancillary service support.

As our expertise in the billing process increased this year, we began to make sure that we included all the appropriate codes on each bill. For example, in addition to coding the patient's visit to the doctors office, we included codes for any radiology, laboratory, and pharmaceuticals ordered by the physician. As a result of this initiative we observed that the reimbursement for these claims increased.

The second rate, the DR rate, which measures the average days a claim was managed as an account receivable dropped by 16.2 days. This drop in the DR also exceeded our original goal of reducing the rate to 40. This tremendous drop in the average age of accounts receivable was achieved despite the fact that the

actual volume of claims handled increased dramatically. Furthermore, this was accomplished without the assistance of an automated system.

And finally, the last rate (i.e. the CGR) also increased. The pre-study rate of 1%, and the goal established at the beginning of this study of 1.5%, were both exceeded. As you will recall, the CGR is used to measure how effectively we identify patients with third party insurance.

The identification of patients with other health insurance is the key to the whole process.

Insert Table 2 about here

Last year the CGR continued to decline over a six month period to the point where less than ten Internal Medicine patients per month were being identified as having other health insurance. The trend this year is just the opposite. Despite this positive trend in the identification process, a three week audit of Internal Medicine appointment rosters showed that there was still room for improvement.

During the time period from 22 February 1993 through 12 March 1993, an audit was conducted of all Internal Medicine appointments. The purpose of this audit was to evaluate the effectiveness of our internal marketing and education program (Bond, 1989). During this three week period, we reconciled the appointment rosters against our master patient index. We discovered that 71 claims should have been generated during this period. Our next step was to check our ledger to see how many of the claims had in fact been identified. Of the 71 potential billable claims only 30 had been identified and processed. Therefore, 41 claims, which equates to approximately 59%, were missed. The results of this audit indicate there is a need for greater emphasis in regard to soliciting other health insurance from beneficiaries.

Based upon the fact that overall collections have risen, and that two of the three rates showed dramatic increases, the alternate hypothesis is accepted and the null hypothesis is rejected. The introduction of various intervention measures did in fact have a positive effect upon the CGR and DR rates.

TPCP Survey Results

An extensive survey to solicit other health insurance information from retirees and dependents of retirees was conducted as part of this study. This target population was chosen based upon the fact that they comprise the majority of the population with other health insurance (Olson, 1992). The discussion section which follows will explain in detail how the survey was conducted.

On 5 February 1993, mailings were sent to 2,347 beneficiaries within the catchment area of IACH. Of this number, 100 were returned as undeliverable. Excluding those that were undeliverable, 1,230 responses (54.74%) were returned. Of the 1,230 that were returned, 498 indicated that they did in fact have other health insurance (40.48%). The remaining 732 (59.52%) indicated that they did not have any health insurance.

In addition to the 498 new individuals identified through the survey, the CHAMPUS database was queried utilizing the Financial Analysis Support System (FASS). This query yielded an additional 449 individuals who

indicated to CHAMPUS that they have other health insurance. At this time we are working on a survey to verify that these individuals do in fact have other health insurance.

CHAPTER 4

DISCUSSION

Internal Marketing/Education Program

The primary objective of any marketing effort is to have an effect (Bond, 1989). In this study, that objective was to positively influence the key rates and to maximize our collection potential. To do this effectively, the program had to be marketed at all levels within the organization.

The command group had a great interest in the program from the beginning. As the study progressed throughout the year, I provided the Commander, COL Kirkpatrick, with periodic updates. For example, I provided him with a summary of highlights from the TPCP Conference in addition to periodic program updates regarding some of the initiatives taken. Additionally, the overall results in regard to collections were reported through the Utilization Management Committee meetings. Throughout the year, I strived to ensure that the command group was well informed about the program because without their continued support the program could not reach its maximum collection

potential.

In order to effectively keep the command group informed and maintain consistency in our operation, the TPCP staff and I began to hold weekly meetings. The purpose of these meetings was to develop strategies to improve the identification, billing, and collection process (GAO/HRD-90-77, 1990). Furthermore, the meetings served as an excellent forum in which to discuss the progress of our initiatives, program results, and any problems or concerns that needed to be addressed.

The second focus of the internal marketing effort was the medical staff. Cunningham and Koch (1987), Roovers (1983), and Valentine (1990), stress that it is important to gain and maintain the support, motivation, and participation of the medical staff in regard to implementation of any new program or marketing plan. The medical staff at IACH had already been using the encounter forms, therefore the program was not totally new to them. On 5 November 1992, Vickii Thomas, the Medical Records Administrator, and I gave the medical staff a brief presentation on the TPCP. The group

expressed a great deal of interest and indicated that some monetary incentives, whereby they would retain some of the dollars collected, should be built into the program. At this time, a fair methodology to reward and recognize clinics and individuals is being developed for the command group.

The last group the program was marketed to consisted of clinic clerks/receptionists. The clerks were considered to be the key to the whole operation since they served as the primary link in identifying whether or not a person had other health insurance. The registration model chosen at IACH was decentralized. As you may recall, the decentralized registration model is the most difficult to manage and control. This model was choosen for a number of reasons. First, physical space limitations prohibited the use of a centralized or zoned model. The volume of outpatients seen on a daily basis also made it necessary to decentralize the registration process so as to ensure greater access to the facility.

The last and perhaps greatest contributing factor to the decision to use a decentralized model was the

command's commitment to decentralization and empowerment at the lowest levels of the organization. As part of a recent reorganization within the hospital, department chiefs were given authority and responsibility for all individuals in their department to include administrative/clerical personnel as well as nursing personnel.

Since the decentralized model presents the greatest challenges in regard to obtaining consistency and quality of registration data, it was determined that an aggressive educational program be directed towards the clinic clerks. A copy of the instructional guide used to train the clerks is enclosed as Appendix A. This guide, which was obtained from two Navy hospitals, was modified for our purposes. The educational program was initiated in January 1993. TPCP staff members scheduled appointment times with each clinic and presented the informational classes.

As the results of this study indicate, our CGR rate has improved dramatically. However, the three week audit of Internal Medicine appointment rosters indicates there is much more room for improvement.

Therefore, we plan to continue marketing and educating this program to all levels of the organization.

External Marketing Survey

As stated previously, the target population for our marketing survey was retirees and dependents of retirees. This group was chosen due to the fact that they comprise the largest segment of our beneficiary population with other health insurance.

The first task which we faced was identifying target population members within the hospital's catchment area. To accomplish this we went to the Retirees Affairs Office on post. This office provided us with mailing labels for all retirees within the state. We then broke out those that fell within our catchment area and matched them against our files. If we had health insurance on a particular individual, we then eliminated them from the survey. This allowed us to reduce the costs associated with the survey and prevent duplication of effort and data. Through this process we eliminated mailing surveys to 380 households.

The next step was to prepare the information which

we would include in our market survey. The biggest stumbling block here centered around the form which we would use to solicit other health insurance information. The use of DD Form 2569, which is the approved form for solicitation of other health insurance information, was rejected based upon our belief that it was too cumbersome and complex to complete. Tull and Hawkins (1987) state that the response rate to a survey is dependent upon how long it will take the respondent to complete the survey and what their level of interest is. A copy of the packet which we mailed as part of this survey is attached as Appendix B. In addition to the attached materials, a self-addressed envelope was enclosed to ensure that the survey did not cost the beneficiary any money to return and to make the process of completing and mailing the survey as simple as possible.

The initial response to this survey was overwhelming. The first few days after mailing the survey we were inundated with phone calls. By and large, the responses to the survey were extremely positive. Of the 1,230 surveys returned, we received

only a limited number of negative comments (i.e. less than 15). These comments were directed toward problems with the priorities retirees are given, the services available, customer service issues, the high cost of health insurance, the amount of paperwork involved, and a perception that promises by the recruiter of unlimited free medical care were being broken. On the other hand, there were positive comments made about the quality of service, physicians, and hospital. Copies of negative comments were forwarded to the Patient Representatives Office.

In addition to the mail survey, the hospital Public Affairs Officer, Mr. Gary Skidmore, prepared and submitted an article to the post paper. A copy of this article also ran in one of the local papers, the Manhattan Mercury. The articles were run at the same time the surveys were mailed. Other marketing efforts included the placing of TPCP brochures and posters at convenient locations throughout the hospital.

Automation and Back Billing

As previously stated, one of the key objectives of this study was to obtain an automated system to

increase the efficiency of the outpatient TPCP operation. Since we lacked the manpower and time to develop our own system, we were faced with the options of buying a commercial system or using a system established by another MTF. During the TPCP Conference in San Antonio (December 1992), the idea of rapidly fielding a proven outpatient TPCP system developed by Dwight David Eisenhower Army Medical Center (DDEAMC) was proposed. Based upon that information, plans to evaluate and/or purchase commercial systems were dropped.

Currently, Ft. Riley is one of four sites to begin testing the program developed by DDEAMC. A copy of the requirements document which identifies our hardware and software needs is attached as Appendix C. Plans are underway to procure the required hardware and software. Ft. Riley is projected to begin implementation of the program sometime in June 1993.

In the interim period preceding our selection as a test site, we obtained a copy of Ft. Ord's program which was written for use with Dbase IV software. We chose this program because we already had the Dbase IV

software. With this program we have automated our ledger functions and input all necessary information to create a master patient index. The experience we have gained from implementation of this program should help with the implementation of the DDEAMC program.

In regard to back billing operations, our efforts to date have definitely paid off in terms of actual dollars collected. The procedures we use to identify back bills consist of obtaining a patients appointment record, matching this record to the ledger, and preparing and submitting bills for visits which were not identified at the original point in which service was rendered. At this time, efforts are almost complete in regard to billing for those individuals listed in our record file. This file does not include those individuals identified through our survey nor does it include those individuals identified through the FASS pull on the CHAMPUS database. We plan to back bill those individuals identified through these sources.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this GMP was to increase the efficiency and effectiveness of outpatient collections through the introduction of various intervention measures. During this study, the overall dollars collected increased dramatically. Additionally, two of the three key rates were positively influenced.

The TPCP has proven to be an extremely dynamic program which requires constant learning. During this year I gained a tremendous amount of knowledge and insight into how other hospitals, both military and civilian, operate their billing and collection systems. Through my networking with peers in other organizations, I obtained new ideas to improve our program. I recommend that TPCP managers develop strong ties with their counterparts at other MTFs, local VA hospitals, and civilian organizations. The insight they gain from these relationships and from keeping up-to-date on current trends in the literature may make their program more effective.

In order for this program to maximize its

collection potential it must be have the support and interest of the command group. Additionally, all levels of the organization must be committed to it. To accomplish these objectives it is imperative that TPCP managers market the positive aspects of the program. As part of this marketing effort it is important to ensure that those individuals involved in the registration process be trained properly.

I also recommend that a survey be conducted by all TPCP managers. The objective of this survey should be to identify those individuals with other health insurance. The survey must be directed at a target population and it must require little time and effort to complete. The benefit of a survey such as this is it expands your base upon which bills may be generated. Additionally, the results of the survey can be used to aggressively pursue back billing operations.

It is also important to aggressively manage an organizations accounts receivable. While we do not have the opportunity to invest the dollars we collect in interest bearing instruments like our civilian counterparts, we do have the opportunity to put the

money we collect today into programs, equipment, and supplies which will ultimately benefit our customers. The keys to successful accounts receivable management include obtaining the correct information the first time, expediting the preparation of the bill, verifying the accuracy of information on the bill, and submitting the bill the same day it is prepared. TPCP managers must also develop tools/rates which will allow them to monitor performance.

Since MTFs are facing tighter and tighter budgetary restrictions it is becoming increasingly more important to maximize the hospitals collection potential. To accomplish this MTFs must aggressively pursue all avenues which may lead to revenue generation. Internal marketing and education programs, external marketing surveys, aggressive accounts receivable management, back billing operations, and the implementation of automated systems can all lead to increased collections under the TPCP.

CHAPTER 6

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TABLES

Table 1

Analysis of Key Rates

Rate	Pre-Study	Post-Study
CR	45.18%	39.26%
	($3131.20/6930)	($4161.67/10,600)
DR	49.5 days	33.3 days
	(4454/90)	(3529/106)*
CGR	.96%	3.67%
	(90/9350)	(3485/128)*

*The difference in the denominator used to calculate the post-study DR and CGR is due to the fact that 22 claims had not yet been paid as of the date that this paper was completed. These unpaid claims represent bills which were submitted in late March and early April.

Table 2

By Month Analysis of CGR

FY 92			FY 93		
Month	# Claims	CGR	Month	# Claims	CGR
JAN	29	3.6%	JAN	33	3.8%
FEB	17	.91%	FEB	41	3.4%
MAR	22	1.2%	MAR	54	3.8%
APR	6	.35%			
MAY	8	.47%			
JUN	8	.54%			

APPENDIX A

Educational Package

THIRD PARTY COLLECTION PROGRAM

In November of 1990, Congress passed a law that directs all military hospitals to begin billing commercial health insurance companies for the care provided in outpatient clinics. This applies to all beneficiaries, except active duty members. Since 1987, we have been billing insurance companies for inpatient care provided. Therefore, this revision to the law is not a new concept, but rather an expansion of the old law. Policy holders pay premiums to have the cost of their care reimbursed, so it is logical to allow military hospitals to be reimbursed like their civilian counterparts. After all, as you are aware, providing the high tech medical care of present day costs a lot of money.

This program will allow us to maintain and even possibly expand the level of services we provide to you, despite the continuous budget cuts that we must learn to live with. Thus, the Army medical system can strive for higher quality of care without sacrificing other vital military operational programs.

You are probably wondering who this will affect and how they will be affected. Any one who is covered under a commercial insurance policy falls under this program. This includes any second or third commercial policies that you may hold. **It does NOT include CHAMPUS, CHAMPUS supplemental, Medicare or Medicaid policies, or Medicare supplements under the current law.**

The amount billed is a flat rate of $100 for each clinic visit. If you go to the Internal Medicine Clinic and, on the same day, are also treated by the Surgery Clinic, we will bill your insurance company $200. If you visit the Internal Medicine Clinic twice in the same day, the fee will be just $100.

If you have more than one insurance policy, the hospital will bill the second policy the portion of the $100 that the first policy does not pay. So, the total collected by the hospital will never exceed the $100 per visit. If you have deductibles or co-insurance on your policies, you will not receive a bill for these amounts. The hospital will absorb any portion not reimbursed by your insurance.

Since this money will stay in IACH's budget, we will be able to use it for the priorities that we set for our patients. With the cost of medical technology continuing to rise, you can see how additional funds will be critical to our ability to sustain the highest level of quality medical care here at IACH.

WHAT IS THIRD PARTY COLLECTIONS?

What is the Third Party Collections Program?

It is a program that directs military hospitals to bill private health insurance plans when beneficiaries receive care in our hospital. It includes all beneficiaries that are covered under health insurance plans, excluding active duty members. The program is required by Congressional law.

What services will we bill?

We have billed insurance companies for inpatient care for the last few years. The recent amendment to the law (Public Law 101-510) allows us to bill for outpatient clinic visits.

How much do we bill?

DOD tells us the amount to bill which is an average cost. For inpatient care, the cost per day varies depending upon the level of services provided (i.e. ICU 62C. Psych). For a clinic visit, the cost is $100 per clinic visit.

What kind of health insurance plans are included?

This program includes:
- Employer sponsored health insurance
- Group plans such as those offered by associations
- Private individual policies

The following types of insurance are excluded from billing:
- Medicare (for people over age 65)
- Medicare supplemental policies
- CHAMPUS
- CHAMPUS supplemental policies
- Medicaid (for indigent individuals)

Is this the same as Third Party Liability Program?

NO! Third Party Liability is the program for billing insurance companies after an injury. The most common situation is an auto accident where we bill the auto insurance for the cost of care to the injured person.

Why are we starting the program?

Congress passed the law and DOD is directing us to do it. Policy holders pay premiums for such coverage. We are now allowed to collect money to reimburse us for services we provide. In other words, we are doing exactly what the civilian hospitals do all the time, With medical costs continuing to rise every year, this reimbursement will allow us to keep pace in this age of budget cuts.

What will the money be used for?

We will be allowed to keep the money we recover. The DOD instructions specify only that the money be used to "increase quality of care". Therefore, our commander has the discretion to spend the money for priorities he determines.

What is the clinic required to do?

Each clinic performs a VITAL role in this process: the role of data collection from the patient. The accuracy of the data we collect is key to successful billing. The form is designed to be easy to fill out, but there will be questions from patients. So, the clinics also have the critical role of providing information and education, and answering questions that arise.

How will the registration process work?

Each clinic will have DD Form 2569's available for the patients to fill out (exception- not required for active duty patients). This form, once completed, will be maintained in the patients outpatient record. Each time a patient comes to a clinic for care, the check-in process at the desk must include verification that the registration form (DD 2569) is in the chart. Each patient will be asked if the information on the form has changed since it was filled out. If the patient does not have his/her outpatient record with them for the visit, then a new form must be filled out regardless of whether they have previously completed one.

Why does the patient have to fill out the registration form if they do not have insurance?

The registration form contains a signature block at the bottom that certifies all the above information to be true and correct. The information will be put into a data base and we will check the information on all plans. If someone chooses not to tell us about a plan they have and we later find out they do have one, we will back bill their insurance company in addition to educating the patient about our program. The law provides for a fine of $10,000 and five years in prison for providing false information. In reality, the likelihood of enforcing these punishments is low. However, it is important to stress to the patient that the law requires them to provide us with accurate information. Additionally, the benefits of the program as discussed in the next section must be emphasized.

Are there any advantages to the patient?

Yes! Most insurance plans have deductibles that must be met before the plan starts to pay. When we file claims, the amount billed will be counted against the patient's deductible. Therefore, if the patient visits us a few times and gets the deductible met, when they have to go to a civilian provider, they will actually spend less money out of pocket. Many providers require patients to pay their deductible up front.

PLUS - the patients will benefit from our ability to spend more money here at IACH to provide high quality medical services. We may be able to treat more patients so that they will not have to be sent out for civilian care.

What are the disadvantages to the patient?

We know that some people will be upset by this program. Most of the concern has to do with a fear that insurance premiums will rise as a result of this program. How should you respond to this? Here are some suggestions:

-Stay positive. If they perceive that you don't like the program, it only strengthens their fears.

-Tell them that health insurance is different from car insurance; the company by law cannot raise rates due to personal medical history.

-Point out that we are only doing what civilian hospitals have been doing for years; filing claims for services that their premiums are supposed to pay for.

-Point out that insurance rates go up every year any way due to the increasing cost of providing medical care.

-Medical care is very expensive. This program allows us to maintain and possibly expand the services we offer when the DOD budget is continually cut. No NEW TAXES will have to be raised to support this.

What if the patient has questions I cannot answer or wants to complain?

Send the patient to the Treasurers Office.

What if the patient asks me about CHAMPUS supplemental plans?

This program should have no impact upon whether a person decides to purchase supplemental insurance. If the patient has questions concerning CHAMPUS supplemental plans, direct

them to the CHAMPUS Health Benefits Advisor. The Health Benefits Advisor will provide the patient with a list of companies which offer such plans.

THIRD PARTY COLLECTIONS -QUESTIONS AND ANSWERS

1. Why is Irwin Army Community Hospital (IACH) implementing this program?

The hospital has been billing insurance companies for the inpatient care received here for the past few years. This has resulted in an increase in revenue. Congress has recently expanded this legislation to include outpatient services. Therefore, we are mandated by law to start collecting the money for clinic visits.

2. Why should I pay for additional insurance coverage?

The fact that the hospital is implementing Third Party Collections for outpatient services should not affect your decision to purchase this additional coverage. The fact remains that the hospital cannot accommodate all beneficiaries who need medical care. Therefore, in order to minimize your out of pocket expenses it may be prudent for you to have additional insurance.

3. Why should commercial insurance have to pay for services that are supposed to be supported by my taxes?

Your tax dollars support the present medical system of the military services, but as you are aware, budget cuts have become a way of life and the military health care system has been dramatically affected by these cuts. Third Party Collection offers us a way to maintain the level of services that we have to offer our beneficiaries without sacrificing other DOD programs. In other words, there is no cost to other Army programs in order for us to achieve a higher level of health care than we would otherwise be able to offer.

4. What kinds of things will this money be used for?

The congressional legislation specifically states that the revenue from this program be used to enhance the quality of care we offer in DOD hospitals. What this means to IACH is the opportunity to purchase more equipment or upgrade the present equipment to the latest technology available. It may include the ability to offer services not presently offered at our hospital. The bottom line is that we should be able to offer more technologically advanced services as well as more services. What this means to our dependents and retirees is an increased capacity to treat you in our hospital versus sending you out for civilian medical care.

5. Will this program result in any delays when I come to

the hospital for care?

Your first visit to the hospital will involve an additional step of filling out an insurance questionnaire. We will ask you to provide information that allows us to complete the billing process. We will maintain this information in a data base. Any later visits can also be filed to your insurance company without filling out the paperwork again. We will ask you to update the form any time your insurance policy information changes. We ask that you bring your insurance card with you every time you visit the hospital for care and to inform us any time there are changes to your policy.

6. How can I be sure that I will not be charged any out of pocket costs?

By law, you cannot be charged for services provided in our hospital regardless of whether or not you have insurance. If for some reason you do receive a bill, you should contact the IACH Treasurers Office. We will straighten out the problem for you. You will receive an explanation of benefits from your insurance company that shows how much was billed and how much they paid. That document should clearly state that it is not a bill.

7. It seems like having medical insurance is a negative benefit, why should I have it?

This program of billing your insurance company has no negative impact for you as a policy holder. In fact, there is a positive side to it. If you receive care here and them go to a civilian provider, we may have helped you meet your policy deductible. Therefore, you may pay less money out of your pocket.

8. I thought medical care was a right granted to me, now you are trying to charge money for it.

Medical care for dependents and retirees in our hospital is a benefit we provide as space and staffing allows us. Coverage for civilian medical care through the CHAMPUS program is also a benefit we offer to dependents and retirees at no cost for premiums. The Third Party Collection Program is a program to collect under commercial insurance policies for the services they are set up to support. The fact that we have not done this before means that insurance companies were paid for services they never actually had to provide. Now we are simply asking them to provide reimbursement to us the same way they would to any other hospital or doctor.

9. Won't this make my policy rates go up?

As a member of a group covered under an insurance

policy, your individual policy rate cannot increase based on your personal medical history. It is not like auto insurance where your premiums go up if you have an accident. That is the advantage of being a member of a group for medical insurance purposes. The entire group splits the risk. Will your group policy rates increase? Yes, they probably will just as they have continued to increase over the years that you have had this policy. These increases are a reflection of the rising costs of providing high tech medical care in America.

10. Are other military hospitals doing this?

The law that congress passed mandates that all military treatment facilities begin billing commercial insurance companies for outpatient services. Therefore, all military hospitals are either currently billing for outpatient services or establishing their programs to accomplish this mandate.

11. Is this just one more way you are reducing my benefits?

This goes back to the recruiter promising free medical care for the rest of your life. The recruiter who said that could never have envisioned the technological advancements of medicine and the resulting crisis in costs that we have today. The bottom line is that the budget continually gets cut and we must find a way to survive. You can count on the fact that the military health care system will continue to get hit and our only means of survival may come down to our ability to secure reimbursement from commercial insurers. We must pursue this source of revenue and we need you cooperation in order to maximize our efforts. The patients here at IACH will benefit.

12. My neighbor went to her doctor for the same type of visit I had and her bill for services was only $28. Why were my services $100 per visit?

The rate is an average determined by DOD. What you may not realize is that if you had a cardiology consult, for example, your bill on the outside would be around $600-800. In this case, the same services here at our hospital would be only $100. So, in some cases the price seems high, but in many cases the price is very low compared to the civilian sector. This is a reflection of the average of costs and of the efficiency of the care we deliver.

APPENDIX B

Marketing Survey Material

HSXX-CDR 14 January 1993

Dear Beneficiary,

We at Irwin Army Community Hospital (IACH) wish to provide you with the best service that we can. In an effort to accomplish this goal, we need your assistance. If you or your family members are covered by an insurance plan we would appreciate it if you could take time to read the enclosed brochure.

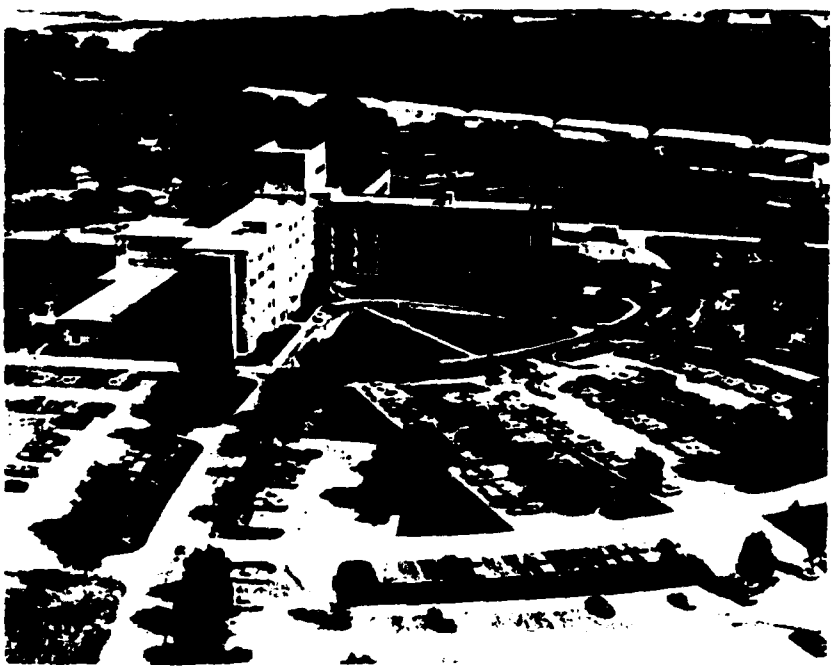
After you have read the brochure please fill out the attached form and return it to IACH in the enclosed self-addressed envelope. Thank you for taking the time to help us serve you better.

If you have any questions please contact 1LT Keeney at 239-7749, Vickii Thomas at 239-7985, or CPT Griffin at 239-7926.

JAMES W. KIRKPATRICK
Colonel, Medical Corp
Commanding

Irwin Army Community Hospital

Fort Riley, Kansas 66442-5038



Look inside to learn how you can help your Army Hospital help you!

What is the Third Party Collection Program?

- Irwin Army Community Hospital will bill commercial health insurance for care received here.
- Includes inpatient hospital care and outpatient clinic visits.
- You will not be charged any deductible or co-payment for services received at any military hospital.
- The money will be used to enhance the quality of care at Irwin Army Community Hospital.
- This program does not include active duty members who are covered under private insurance plans.

PL 101–510

Public Law 101–510 (10 U.S. Code 1095) established the third party collection program. The program directs military hospitals to bill private insurance companies for the cost of care provided by the military facility. When a patient has commercial insurance, the government will bill the insurance company for outpatient and inpatient care. The government determines an average cost of an inpatient stay or of an outpatient clinic visit and bills this amount to the insurance company.

You cannot be charged a deductible or co-payment for care received through the military facility. The government will absorb these costs. Therefore, claims filed by the government for care you received may count toward meeting your deductible. This may result in a significant savings to you if you later seek civilian medical care.

What is the patient's responsibility?

- Please bring your insurance identification card with you each time you visit the hospital or branch clinics. This information is required by law.
- All patients will be asked to complete and sign a form indicating whether they do or do not have such insurance.
- You will be asked to update the information every six months or whenever your coverage changes.

With your cooperation Third Party Collection will:

- Result in additional funds for local use at Irwin Army Community Hospital.
- Result in the purchase of needed equipment and supplies.
- Help us increase the availability of health care services.
- Help meet your policy deductible.

WE WANT TO BE YOUR FIRST CHOICE!

For more information, please contact the Hospital Treasury at 239–7724.

IRWIN ARMY COMMUNITY HOSPITAL
THIRD PARTY COLLECTION PROGRAM

Your assistance in answering the following questions will be greatly appreciated. Upon completion of this form, please place it in the enclosed self-addressed envelope and drop it in the mail.

Are you currently covered under any health insurance plan? (Includes private plan, spouse's employer plan, employee/federal plan, and former employer plan)

YES_____
NO _____

Name_____

Address_____
_____
_____

Telephone_____

Sponsors Social Security Number_____

Name of Insurance Company_____

Policy Number_____

Signature_____

Date_____

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095 and EO 9397

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for inpatient and outpatient care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance care delivery in the Medical Treatment Facility.

ROUTINE USE(S): The information on this form will be released only to your insurance company.

DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

APPENDIX C

Automation Requirements

HSXX-AR (40) 9 April 1993

MEMORANDUM FOR AMEDD Center and School, PASBA, ATTN: HSHI-QR (Doug Ashby), Ft. Sam Houston, TX 78234-6100

SUBJECT: Outpatient Third Party Collection System Hardware & Software Requirements

1. The following hardware and software needs have been identified for the Ft. Riley MEDDAC TPCP:

HARDWARE:

Uninterrupted Power Supply (UPS) for the file server & AT BUS Interface.

Four wide carriage (18 pin or greater) dot matrix printers: for billing and reports.

Four User Workstations: 386 or 486/33mz with 8mb memory and at least 300 mb hard drive (s), (1) 3.5 and 5.25 floppy drive each, NOVELL LAN card, MS-DOS operating system with EDI controller and VGA color monitors.

One File Server: (1) 486-33 or 50mz with 8mb memory and at least 300mb hard drive (s), with MS-DOS operating system and NOVELL NETWARE software (TCIP) and MASTER LAN card, EDI controller and VGA color monitor.

Four Surge Protectors.

SOFTWARE:

ORACLE Version 6: (For DOS)

ORACLE TOOLS-Developer Ver/DOS

DIRECT ACCESS 5.1: by Fifth Generation

PROCOMM PLUS for DOS

NETWORK LAN - NOVELL NETWARE

HSXX-AR (40) 9 April 1993

2. The above needs were determined by seeking input/guidance from both the IMO and TPCP staffs. These needs are greater than what was originally reported. Our original concept was to rely on single user workstation. However, as our experience and knowledge about the outpatient TPCP has increased, we have come to realize that this system would not meet our needs. If you have any questions concerning this memo contact myself at 856-7926 or MAJ Freeman at 856-7745.

MICHAEL P. GRIFFIN
CPT, MS
Administrative Resident

CF:
DCA
IMO
PAD
TPCP Manager

APPENDIX D

Definitions

Definitions

1. Coinsurance - An arrangement under which the insured person pays a fixed percentage of the cost of medical care.

2. Current Procedural Terminology - A system of terminology and coding developed by the American Medical Association that is used for describing, coding, and reporting medical services and procedures.

3. Deductible - An amount the insured person must pay before payments for covered services begin.

4. Explanation of Benefits - A form sent to the insured person after a claim for payment has been processed by the insurance company that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, the claims appeal process, and so forth.

5. Insurance Plan - Any plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with an organization or group.

6. Medical Service or Health Plan - Any plan, program, or organized health care group, corporation or other entity for providing health care to an individual from plan providers, both professional and institutional. Those include plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with an organization or group.

7. Prospective Payment System - A standardized payment system implemented in 1983 by Medicare to help manage health care reimbursement. Hospitals can expect a fixed reimbursement based not on the number and kinds of services delivered but on the diagnosis of the patient.

8. Third Party Collection Program - A Department of Defense Program which mandates that all DOD Medical Treatment Facilities collect from third party payers to the fullest extent allowed by law for the reasonable costs of inpatient and outpatient care provided in any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the third party payer's plan. The Third Party Collection Program is governed by Title 10 United States Code 1095 and amendments, and 32 Code of Federal Regulations Part 220 as implemented by DODI 6010.15, Third Party Collection Program (TPCP) dated 7 Mar 91.

9. Third Party Payer - Any organization that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g., Blue Cross and Blue Shield Plans, commercial insurance companies, Medicare, and Medicaid). The individual or employer generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on the patient's behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (the third party).

10. Uniformed Services Beneficiary - Any person who is covered by 10 USC 1074 (b), 1076 (a), or 1076 (b). For the purposes of the Third Party Collection Program, Uniformed Services Beneficiaries do not include active duty members of the Uniformed Services.