

**STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES**

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Mr. Chairman and members of the Subcommittee, I have been invited to discuss the "best practices" of the Medical Care Collection Fund (MCCF) Program at the Veterans Affairs Medical Center (VAMC), Martinsburg, WV.

The MCCF Section at Martinsburg is organizationally aligned under the Business Programs and Operations Service. The section is comprised of 8 Full Time Employee Equivalent (FTEE) in the Coding/Billing Unit, and 14 FTEE in the Collection Unit. The section also includes two Veterans Integrated Services Network (VISN) funded units. They are a VISN 5 Preregistration Consolidation Unit (13 FTEE), and a VISN 5 Insurance Verification Unit (6 FTEE). Collections for the Martinsburg VAMC the past three Fiscal Years are as follows.

Fiscal Year 99	Total \$\$ Billed	\$12,925,807	Total \$\$ Collected	\$4,685,921	36%
Fiscal Year 00	Total \$\$ Billed	\$13,352,657	Total \$\$ Collected	\$4,695,573	35%
Fiscal Year 01	Total \$\$ Billed	\$12,665,664	Total \$\$ Collected	\$5,462,251	43%

(through August)

Martinsburg VAMC has been conducting preregistration calls intermittently since April 1995. In February 1999 we became the site for the VISN 5 Preregistration Consolidation Unit, conducting calls for the Veterans Affairs Maryland Health Care System (VAMHCS), the Washington, DC VAMC, as well as the Martinsburg VAMC. This Unit consists of one Lead Preregistration Clerk and twelve Preregistration Clerks.

Calls are made to patients with a scheduled appointment seven days ahead of the appointment. During this call the patient is reminded of the upcoming scheduled appointment and at the same time their demographic information is updated. The Unit also addresses any concerns or questions the patient might have regarding the respective medical center and forwards those concerns to the appropriate personnel at the specific medical center. The procedure in the Unit is to insure that each item on the five screens of the preregistration call software is completed accurately and in its entirety on each patient that is called. These screens include employer information on the patient and spouse, if applicable, and insurance information. If the patient and/or spouse have an employer, but denies having health insurance coverage, the Insurance Verification Unit follows up by calling the employer to validate that information. Patient data is updated every six months. If a patient cannot be reached by telephone after several attempts, a form letter is sent to the patient requesting the exact information contained in the five preregistration screens. The demographic updates/changes to the VISN 5 medical center databases range from 14,000 to 15,000 each month. Each Preregistration Clerk in the Unit has access to all three medical center databases. When an insurance case is identified at one medical center, the Preregistration Clerk checks to see if the patient is seen at any of the other medical centers in the VISN and if so, enters the insurance

information into the patient's file at that medical center. The same is true for any demographic changes/updates that are identified. On the average, the VISN 5 Preregistration Consolidation Unit is identifying 300 to 350 new billable insurance cases per month for the medical centers in VISN 5.

The VISN 5 Insurance Verification Unit was implemented at Martinsburg in July 2000, and consists of six Insurance Verification Clerks. The Unit is primarily responsible for verifying the coverage and benefits of each new billable insurance case identified through the preregistration calls for each medical center within VISN 5. All six Insurance Verification Clerks have access and are trained to work in the database at each medical center within VISN 5. Insurance cases identified through preregistration are verified, removed from the buffer file, and loaded in the patient's permanent insurance file at each medical center within 48 hours of identification. The Unit also verifies and loads the new insurance cases identified through the interview/intake process at each medical center when the preregistration cases are caught up. This Unit also pursues any "investigation" cases forwarded to them by the Preregistration Unit, in which the patient had a good employer known to have insurance coverage, but the patient did not share the insurance information with the Preregistration Clerk. During the months of June, July, and August, 2001, the VISN 5 Insurance Verification Unit verified and loaded over 3,300 new insurance cases for the medical centers within VISN 5 that had been identified through the preregistration and the interview/intake processes.

Martinsburg is fortunate in that we have a very knowledgeable, conscientious, experienced, and aggressive Collection Unit. The Collection Unit is responsible for all follow-up activities on third-party claims. The Unit reviews each explanation of benefits

from the insurance carriers to ensure that we have been paid the correct and maximum amount according to the policy benefits, that all deductibles and coinsurance are appropriate, that any additional information required to adjudicate a claim is provided timely, and if the claim has been denied, that the denial is legitimate and according to the insurance carrier policy guidelines. If there is any question that we have not been paid appropriately or that the claim has been denied without justification, a call is placed to the insurance carrier for clarification of the policy benefits and explanation of exactly why the claim was denied. The Accounts Receivable Assistants (ARA) within the Collection Unit are assigned specific insurance carriers and become the “experts” on those insurance carrier benefits and idiosyncrasies. Each of the ARAs is very persistent and assertive. They will exhaust all means to obtain valid payment. If the information that one insurance representative provides does not seem in line with the known policy benefits, the ARA will call the insurance carrier at a later date and talk with a different representative. The ARAs have become familiar with Medicare billing regulations and guidelines, and what is covered under Medicare. The ARA loads all insurance carrier information into the specific insurance carrier/patient file and updates that information as necessary. The Collection Unit is responsible for identifying errors, omissions, duplications, and inconsistencies in claims generated, identifying inefficiencies in the collection process resulting in an inability to collect funds, and correcting and improving these processes or policies resulting in appropriate maximum payment on claims. They communicate this information to the Coding/Billing Unit in an effort to ensure only good clean claims are generated.

The Collection Unit has a proactive MCCF/Utilization Review (UR) Clinical Coordinator who is a Registered Nurse. This incumbent of this position is responsible for contacting the insurance carriers and performing precertification, providing clinical concurrent reviews and case management, and appealing denied claims. The MCCF/UR Clinical Coordinator has been trained in most of the processes of the revenue cycle. The incumbent of this position has the expertise to perform many of the functions of the revenue cycle. This may include, but is not limited to, calling the insurance carriers to verify insurance coverage, conducting precertification, providing clinical reviews, explaining the billing process to patients and resolving their reimbursable insurance, as well as Means Test billing questions. The incumbent also provides training on reasonable charges and the importance of complete/accurate medical record documentation to the clinical staff. The MCCF/UR Clinical Coordinator works closely with the UR nurses and the Quality Management Section, identifying system issues which ultimately impact our MCCF Program, resulting in increased reimbursement.

Contained within the Collection Unit is the Health Benefits Advisor (HBA) position. The incumbent of this position reviews all inpatient admissions from the previous day. The purpose of this review is to identify insurance cases that require verification of coverage and benefits, to conduct insurance verification, and to identify those insurance cases requiring precertification. The HBA investigates possible insurance coverage on patients that have not been identified as having insurance coverage, and reviews admission diagnoses to identify any possible tort feisor or workers' compensation cases. On a monthly basis, the HBA reviews the top 100 diagnoses list to identify any possible tort feisor or workers' compensation cases. In

Fiscal Year 2001, the HBA has identified 34 new insurance cases through this review that had not been identified previous to admission to the hospital. As a result, the insurance carriers were billed for the inpatient stays and the medical center did not receive a precertification penalty.

The medical center Director has a strong commitment to ensure MCCF collections are maximized. This commitment is communicated to the medical center staff through staff meetings, the monthly newsletter, and inservice training. Employee support and commitment is evidenced by the medical center exceeding MCCF collection goals for the past three years.

Mr. Chairman, this concludes my statement. I will be pleased to respond to questions from the Subcommittee.