Get RAC ready

A checklist for patient access managers to prepare for Medicare RACs

The “better late than never” theory will not work in a defense against Medicare’s recovery audit contractors (RAC). And that certainly goes for patient access managers.

Access managers must prepare for RACs now, says Tanja M. Twist, director of patient financial services at Methodist Hospital in Arcadia, CA. Twist is the finance chair for the American Association of Healthcare Administrative Management and a member of HCPro’s The RAC Report e-newsletter advisory board. She has fought Congress on Capitol Hill for better transparency and answers to concerns with RACs on behalf of hospitals.

“I strongly urge hospitals to take advantage of this lull in the RAC process to perform gap analyses within their facilities to find their areas of risk before the RAC does,” says Twist, who directs the patient access manager at her facility. “Anything hospitals can find and fix on their own will result in not only lowering the number of RAC denials, but also will reduce your vulnerability for a false claims suit should the RAC identify a trend in your data.”

But what specifically do patient access managers need to anticipate and start fixing to help their facilities defend against a RAC?

“From an access point of view, hospitals should be performing analyses on their one-day stays vs. observation cases and medical necessity denials,” Twist says. “In analyzing the data, they will likely identify several key admitting physicians who are driving the problem accounts. Using a physician champion, hospitals can work with their physicians to reverse the trend. Again, it is important to find and fix these deficiencies before the RAC does.”

Twist offers the following tips:

➤ Check on medical necessity. Medical necessity will compose a big part of the RAC audits, Twist says. The admitting department can help the back end review cases to ensure they make sense. “What you really need is an admitting nurse in there reviewing a physician’s order to make sure it meets medical necessity and Medicare guidelines for medical necessity,” she says.

➤ Communicate effectively with physicians. Patient access managers will have to require more information from physicians. However, this is not usually an easy task, Twist says. That is why she recommends adding a physician champion as a liaison between admitting and the physicians’ offices. The champion can be part of

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—Tanja M. Twist

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a medical committee to track the top five offending physicians whose claims have errors and go back to review their cases.

➤ **Educate the physicians.** The best thing in terms of working with physicians is to go back and show them what happened. “Physicians need to work with office staff to make sure all the necessary data gets over there,” Twist says. “You should be trying to educate physicians on medical necessity.”

➤ **Review your ED admissions.** Twist cautions that many admissions from the ER are made because the facility needs to free up ED beds, which can lead to medical necessity problems with the RAC. “Emergency rooms are busy all across the country,” she says. “A key component is to make sure you meet the medical necessity criteria for the ER admissions too. The nature of the emergency department is things get rushed, but you have to ensure there are protocols in place to watch the ER admissions too.”

If you do not have a 24/7 ED case coordinator position that monitors admissions, ensure that someone such as the case manager or patient access manager comes in in the morning to clean up the admissions, she says.

➤ **Review your one-day stays.** “This is another piece the RACs are focusing on,” Twist says. “Should those patients be observations? I’ve seen admitting orders just say ‘admit.’ You have to make sure that physician orders have an ‘admit to acute or admit to observation’ designation. There could be some type of check box for the physician to clearly indicate his selection. From here, the concern is whether or not the acute admission meets criteria.” (See the form on pp. 6–7 for a tool to help physicians determine admission status.)

➤ **Get on your RAC team.** Patient access managers should become members of their facility’s RAC teams and task forces. “Just the mere fact of you knowing what’s going on is important,” Twist says. “You need to be aware of your facility’s overall RAC process and how you contribute to that process.”

➤ **Review your Medicare Secondary Payer (MSP) process.** The RAC demonstration project included a focus on MSPs. It netted the government $12.7 million in false claims, not enough to continue the MSP RACs, but enough to weave it back into the overall permanent project.

Twist says she sees the MSP RACs making a comeback. “I would not be surprised if they bring that back,” she says. “Should those patients be observations? I’ve seen admitting orders just say ‘admit.’ You have to make sure that physician orders have an ‘admit to acute or admit to observation’ designation. There could be some type of check box for the physician to clearly indicate his selection. From here, the concern is whether or not the acute admission meets criteria.” (See the form on pp. 6–7 for a tool to help physicians determine admission status.)

➤ **Set aside one hour per week.** Twist says patient access managers should set aside one hour per week to...
look into all things related to RACs. Work with the back-end financial services staff and run through your commercial insurance denials looking for medical necessity, level-of-care, or length-of-stay denials. After all, it is probably the same problem you are experiencing with your Medicare denials; however, Medicare currently is not screening acute stays for these types of issues as the RAC does, so the population to evaluate pre-RAC is your commercial population.

In the end, the patient access manager may not be as intensely committed to the RAC effort as is, for example, your HIM director.

However, the fundamental beginning of every hospital stay starts with the patient access department, and if facilities can shore up their front-end admission criteria screening, they will ultimately avoid some of the headaches associated with RAC medical necessity and one-day stay audits.

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**The big picture for your Recovery Audit Contractor team**

*Tips to prepare your entire revenue cycle for the arrival of RACs*

You can never be too prepared for the recovery audit contractors (RAC), regardless of when they come to your facility.

The following are some tips to help your facility get RAC ready:

➤ Create a RAC operational team/steering committee at your facility. Include members from HIM/coding, PFS, utilization management/utilization review, nursing, administrative representation, ancillary department heads (therapy, etc.), decision support, finance, information technology, compliance/legal, a medical director, and a nurse auditor. Additionally, identify a physician champion.

➤ Perform GAP analysis to identify risk areas by doing the following:
  - Conduct preemptive audits. Do your own data mining—find your errors and fix them before the RAC finds them.
  - Implement DRG validation audits. Monitor your upcoding and downcoding.
  - Assign a nurse auditor to review medical necessity and other identified high-risk areas.
  - Review medical necessity screening processes of admissions and tighten screening where necessary.
  - Analyze pharmacy and ancillary charges in your chargemaster. Verify units of service and correct dosages.

➤ Audit billing compliance by reviewing bill error and correction reports from your scrubber, reviewing claim edits, and checking incorrect units billed.

➤ Be aware of RAC trigger points.

➤ Monitor past claims history with your MAC/FI.

➤ Review results of audits from other entities. Look at PEPPER reports, CERT, MAC, OIG, etc.

➤ Review the RAC demonstration status documents to identify the data mining and claim review patterns experienced in the demonstration project.

➤ Identify your facility’s top DRGs by volume and money.

➤ Identify your top 10–15 diagnoses.

➤ Look at outlier claims.

➤ Review three-day skilled nursing facility (SNF) qualifying stays. Note that if the RAC denies medical necessity on the qualifying stay, you will lose the SNF stay.

➤ Determine one-day stays vs. observation.

➤ Ensure MSP compliance. Be aware that although this is not set to roll out immediately in the permanent project, it was reviewed in demonstration and may be added in later.

➤ Have a physician documentation improvement program. Physician documentation has the potential to

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make or break you. Educate your physicians and implement a documentation improvement team as an ad-hoc to your RAC steering committee.

► Assign a RAC coordinator to oversee the RAC process and ensure the timely submission of all documentation throughout the process.
► Set up a process to ensure that mail received from your RAC is delivered to the RAC coordinator, who will determine best practices for documentation flow in and out of the facility.
► Scan all incoming and outgoing documentation.
► Develop a template or database to track all incoming and outgoing RAC documents.
► Identify a mechanism to bill 12 cents per page for record copy fees.
► Educate your staff and physicians on the RAC audits.

Editor’s note: These tips come from Tanja M. Twist, director of patient financial services at Methodist Hospital in Arcadia, CA, and advisory board member for HCPro, Inc.’s The RAC Report.

Twist is the finance chair for the American Association of Healthcare Administrative Management and has fought Congress on Capitol Hill for better transparency and answers to hospital concerns with RACs.

Facts on Medicare’s Recovery Audit Contractor program

What you need to know to get ready for the nationwide rollout

The following are some numbers, facts, and other important information about Medicare’s Recovery Audit Contractor (RAC) program, provided by William L. Malm, ND, RN, a partner at Health Revenue Integrity Services, Inc., in Westlake, OH; Nancy Hirschl, BS, CCS, president of Hirschl and Associates in Laguna Niguel, CA, and an advisory board member for HCPro, Inc.’s The RAC Report; CMS; and the California Hospital Association:

► Who is it? RACs use reports from the OIG and the Government Accountability Office.

► Inpatient is No. 1. Of the overpayments, 85% were collected from inpatient hospital providers, 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.

► No contest. Providers chose to appeal only 19% of the RAC decisions. Of all the RAC overpayment determinations, only 6.8% were overturned on appeal as of October CMS numbers.

► Coming to a hospital near you. The law states that the national RAC program must be implemented by January 1, 2010.

► Medicare Secondary Payer (MSP) flaws. Via overpayments on MSP RACs, $12.7 million was returned to the government. $980 million was returned via claim RACs.

► Coding experts are a must. Certified coding experts were optional under the demonstration project but are mandatory under the permanent program.

► Appeal payback. Under the demonstration project, the RAC needed to pay back only the contingency fee if the claim was overturned at the first level. However, under the permanent RAC, the payback of the contingency fee will be at all levels.

► Medical director. RACs must have a medical director under the permanent program.

► Reviewing credentials. Credentials of reviewers must be provided under the permanent program.

► Disputing the CMS report. The California Hospital Association disputes several facts from CMS’ Summary Evaluation Report on the RAC demonstration project, where CMS said it identified $992.7 million in overpayments.
Areas of dispute include:
- The appeals data is incomplete and significantly understates the volume and effect of provider appeal activity. The current report does not include appeals at the first level or other appeals in process with providers.
- The total appeals volume data are premature and misleading. Nearly one half (47%) of the reported overpayments were recouped during the last three months of the program (January 1–March 27). This significant portion of total funds collected was still subject to appeal at the time of the report (May 1).
- CMS states that only 4.6% of the total funds collected have been overturned as the result of appeals. This assertion is premature. At the time of the report, millions of dollars in claims were still pending decisions at various levels of appeals. The appeals process can take as long as two to three years to achieve resolution. Based on our experience thus far, we anticipate that many of these appeals will ultimately be decided in favor of the provider. The amount of reimbursement that will be returned to providers will consequently grow steadily over the next two to three years.
- The net amount of recovered funds will also be reduced by rebilling certain claims. Guidance for rebilling of certain one-day stays as observation was not provided until April. As a result, these outstanding claims are not reflected in the report.

➤ What they’re looking for. An important tip to keep in mind is that RACs cannot randomly select claims or target one “solely because it is a high-dollar claim,” according to the draft Statement of Work.

A RAC can only “target a claim because it is a high-dollar claim and contains other information that leads the RAC to believe it is likely to contain an overpayment,” the draft states. Hirschl says the “other information” could include:
- Diagnosis codes that may be incorrectly coded based on RAC experience in the private health insurance arena
- Diagnoses that present physician documentation insufficiencies
- Procedure codes that do not correlate with diagnosis codes
- Procedure codes that may indicate inappropriate site of service/inpatient status
- Incongruent charge to payment comparison
- The belief that the claim payment was not consistent with Medicare payment policy

Editor’s note: For more information on RACs, visit CMS’ Web site at http://cms.hhs.gov/RAC or the American Hospital Association’s Web site at www.aha.org/aha/issues/RAC.
Editor’s note: Use this TMF Health Quality Institute form as a guide in learning the difference between an observation status and inpatient admission. Patient access teams must be prepared in this arena, as the recovery audit contractors will be looking at these types of admits on claims.

MEDICARE PATIENTS: Observation or Inpatient Admission?

To aid the physician in determining when observation may be appropriate, TMF Health Quality Institute has developed a decision tree outlining the thought process for determining whether observation or inpatient admission is appropriate. TMF hopes that this tool will be valuable to physicians when having to make this decision.

- Observation is appropriate.
- Inpatient admission is appropriate.
- Alternate level of care is appropriate (outpatient, home health care, extended care facility).
- Additional time is needed to determine if inpatient admission is medically necessary; observation is appropriate.

* The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient’s medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

Key Points to Remember:

- Outpatient observation services are reimbursed under the Outpatient Prospective Payment System.
- Using outpatient observation as an alternative to admission will allow you time to determine if admission is necessary, reduce denials for unnecessary admissions and ensure that some payment is received for services rendered.
- Care in outpatient observation can be the same as inpatient care, but reimbursement is different. Patients with chest pain, CHF and asthma are paid under specific observation Ambulatory Payment Classifications (APCs). Payment for all other conditions is bundled into the APC package.
- An order simply documented as “admit” will be treated as an inpatient admission. A clearly worded order such as “inpatient admission” or “place patient in outpatient observation” will ensure appropriate patient care and prevent hospital billing errors.

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Case study
100% MSP compliance
How one facility managed a perfect score with federal auditors

Editor’s note: This is the second in a series of stories on the Medicare Secondary Payer (MSP) Questionnaire.

Like many patient access departments, Dunn Memorial Hospital’s is not always perfect when it comes to compliance with the MSP Questionnaire.

Stephanie Smithson, CHAM, patient access manager at the critical access hospital in Bedford, IN, says its most common errors are:
► Missing retirement dates for patients or spouses
► Missing accident information
► Identifying primary payers if the patient information does not correspond with the Common Working File (CWF)

However, today, Smithson and her patient access team talk proudly of their success after a CMS audit. In fact, Dunn’s patient access team scored a 100% in terms of compliance on the audit, which looked at the facility’s MSP policy and procedures and recent MSP claims.

Components of a successful MSP process
Smithson credits several components that led to a perfect score.

She suggests patient access managers have the following steps in place to ensure MSP compliance:
► Use an interactive MSP tool that guides staff members through the questions. Dunn uses a tool that tells staff members where required fields for retirement dates within the MSP should go and the order of Medicare payment.

Check with your information technology department to see whether this kind of tool is available or can be

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MSP case study  < continued from p. 7

created. Provide helpful forms and tools to address each common mistake.

Place a form in all registration areas—Smithson likes to call these “MSP hints.” For example, Dunn’s form gives hints such as, “Medicare is the secondary payer when the patient is 65 or over and the patient or the patient’s spouse is still employed and has insurance through that employer.” Give staff members examples of different MSPs that were completed correctly using a mock MSP or patient.

➤ Take a proactive approach to training. Dunn Memorial uses the Medicare Learning Network Web Based Module Q.A., which provides screen shots with descriptions of how to complete the MSP questions, a Web-based insurance verification system to validate whether Medicare should be primary based on the patient’s CWF, and questions to patients on whether the CWF needs to be updated. Review any errors with your staff and retrain as needed.

Verify that your training is working by consistently reviewing a sample of MSPs.

For example, review all inpatients, all ED patients, or a sample of all types of registration either weekly or monthly. The minimum amount reviewed for a productive sampling should be 10% or 30 records per your review period, whichever is more.

➤ Review your current MSP processes for opportunities to improve. Look at the training materials, the accuracy rates, and the processes you have in place to see where you can improve. Ask staff members what gives them the most trouble and focus on that area.

➤ Give constant education. Smithson stresses the need for constant staff member education on issues such as MSP definitions, rules of payer priorities, and how, when, and why Medicare is primary or secondary. Audit your staff members: Every facility can do better on this. Dunn uses manual checks and reports through its insurance eligibility system to focus on patients with a potential MSP. “You need to have an ongoing [quality assurance] system,” Smithson says.

What auditors look for

CMS contracted National Government Services to do the audit of Dunn Memorial.

The auditors looked at accounts from inpatients, outpatients, and the ED and examined the following areas in Dunn’s MSP process:

➤ Complete forms/accuracy. Was there complete and accurate Medicare information? Were all required signatures obtained?

➤ Consistent information. Did the information on the MSP match the CWF?
**Policy and procedure.** The auditors asked questions about the patient access team’s interview process regarding the MSP. They wanted to know how the team completed the form, whether it performed a 90-day follow-up on outpatient therapy cases, and how it billed Medicare on the Black Lung program, workers’ compensation, and other federal programs.

Overall, Smithson says, it took a team effort to get a 100% compliance score on the MSP. Compliance starts with the patient access manager, for whom Smithson leaves two evergreen tips:

1. **Review your policy and procedures.** Review the Medicare manual on MSPs to see whether you are lacking in any area such as recurring labs, rehabilitation services, and home health. Make sure you have policies on when and how to complete the MSP questionnaire for registration and billing staff members.
2. **Make sure the forms are easy to use.** Staff members must be able to understand the forms and answers to comply with them. Simplify by combining questions and adding language to guide staff members, such as: “Workers’ compensation claims are billed primary to Medicare.”

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**Enhance your revenue cycle performance through effective communication**

*How one facility decreased denials, improved accuracy by changing the way it communicates*

by Florence Davis, BS, MBA, ACPAR

At one point or another, the patient access department is involved in the communication between the physicians, insurance companies, and patients or parents/guardians regarding financial sources for services. How would your job change if you had available records of all such communication to secure payment at any time? What effect would this have on your revenue cycle performance?

The following are some strategies for documenting routine communication to support patient access outcomes.

**Challenge: Showing proof**

At Children’s Healthcare of Atlanta, with 489 beds in three campuses and 15 neighborhood locations, we saw an opportunity to get proof of all communication exchanges in scheduling, preregistration, precertifications, authorizations, notifications, and verification of eligibility via e-mail, fax, or phone call.

As in many hospitals, our staff members use a variety of methods such as phone, fax, and Web to communicate with physicians and payers, obtaining eligibility, benefit, and authorization information. Our department was challenged with disparate processes for documenting and managing these routine communication exchanges. These communication events were sometimes scanned or filed within each area of service or, more frequently, due to other competing priorities, they were never scanned or filed. As a result, we had denials involving thousands of dollars that we could not appeal simply because we did not have the proof of what we said we did.

Our access and appeals staff members spent much time going back and forth in an attempt to obtain proof of what was done at the front end to secure payment of services rendered. Not only was this inefficient, it also created extra stress between departments.

We also had disputes between what was scheduled and what the physicians or parent/patient said they called in to have done. Since we didn’t always have proof to back up our claims, it came down to “he said, she said,” leading to more frustration for all parties.

We knew we needed to have a communication event management system to document all the steps taken to secure payment for our services before ever receiving a denial and to be able to retrieve this information. Without the option of adding more staff members, we had to...
Communication  <continued from p. 9

accomplish more in less time, reducing rework and inefficiency between departments. So we looked for a tool that would help streamline our process without adding to the workload of our already stretched staff.

Solution: Documenting communication

We implemented a software system, TRACE, that combines electronic, fax, and call management applications. It allows staff members to record and view all communication events through one central tracking system.

During a communication exchange, the system allows the patient access staff to index each record by patient and add any comments as needed.

This tool then captures this event and archives it in a central Web-based tracking system for immediate retrieval by any authorized staff member, thereby establishing an audit trail of communication for each patient’s visit.

TRACE provides a convenient way of organizing the communication for systemwide retrieval. The records are used as proof for reimbursement, quality assurance, and productivity improvement.

Result: Reimbursement, efficiency, and quality

By establishing proof of our communication with payers, we are now able to resolve billing disputes that stem from administrative or technical problems in the authorization and precertification process.

We are also able to resolve scheduling disputes. We achieve this by replaying calls for payers or physicians or providing them with the fax or transcripts of conversations to establish proof of timely notification, prior approval requests, or scheduling requests. We also forward Web and fax records showing that we have met the preconditions for payment.

Since implementation in 2002, we have used records of communication events to overturn more than $2.5 million in denied claims. Since we established credibility with this documentation, we have been able to reverse denials immediately by telling the payer that we recorded the exchange being questioned. As a result, we estimate that we have prevented denials totaling a minimum of $4 million.

Another great benefit from this tool is efficiency. From their desktops, employees can conveniently search and retrieve records for viewing, routing, printing, or playback. This has dramatically reduced paperwork and increased efficiency systemwide.

We are now able to use online verification, eliminating the 30-minute hold time required to conduct eligibility

Medicare Compliance for Patient Access Staff

Preparing your registration staff now will save your hospital time and money later. Medicare Compliance for Patient Access Staff can help. With our DVD, train your team on timely, compliant delivery of the new advance beneficiary notice (made mandatory by March 1, 2009), the Important Message from Medicare, and the Medicare Secondary Payer Questionnaire. Through entertaining and realistic scenarios, Medicare Compliance for Patient Access Staff will ensure that your staff members:

➤ Receive comprehensive training in less than 20 minutes
➤ Understand their responsibilities by watching wrong-way/right-way scenarios
➤ Deliver each standard with ease and confidence using custom-made tools

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by phone. We also improved efficiency by reducing the need to print and scan documents. As a result, we have shifted five full-time employees to other duties.

Leaders and trainers are now able to monitor verification calls to ensure that accurate approval is obtained prior to services.

We also track communication with patients regarding billing, scheduling, and procedure instructions. These records support staff members if there are complaints or billing disputes.

Access professionals at Children’s now have proof at their fingertips to back up their efforts at securing payment. This check-and-balance mechanism establishes accountability and reduces finger-pointing between departments and payers, physicians, and patients.

In addition to improving reimbursement, it has increased efficiency, improved accountability, and enhanced quality systemwide.

Our patient access staff members now have a better understanding of the role they play in the revenue cycle and feel a sense of accomplishment in helping achieve our hospital’s mission of providing excellent care for children.

*Editor’s note: Davis is the director of patient access at Children’s Healthcare of Atlanta, a 489-bed pediatric health system. With more than 15 years’ experience in clinical and healthcare administration, Davis is a leader in developing long- and short-term strategies for seamless patient flow and front-end denial management.*

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**Advisor’s tip**

**Map out copayment collection process**

*Editor’s note: The following tips are from Debra Keller, CHAA, admissions/registration director at the Grand Itasca Clinic and Hospital in Grand Rapids, MN. Keller is on the advisory board of Patient Access Advisor.*

Collecting copayments at the front lines can be a challenge for patient access staff members. The following are some ideas that might help ease the difficulty:

- Use scripting as a vital tool to getting that initial step started.
- Have signs so patients are aware that copays will be collected at the time of registration.
- When scheduling, for convenience and a faster registration process, ask patients to have their copay ready when they check in.
- Have your staff members keep a copay spreadsheet at their desks where they can note the amount they collect and amount they did not collect. (See a sample spreadsheet on p. 12.) Have staff members turn in their spreadsheets to you at the end of each week. Tally their efforts and share the report with the group. Seeing their efforts individually and as a whole will give staff members the incentive to see the collection column grow and the noncollection column decrease. You may want to set a target goal for copay collection and offer an incentive for reaching it.

When we look at the insurance card, or when our insurance verification program reports a copay amount, we note it on the patient’s demographics screen so we have that information in front of us when the patient returns.

The amount is highlighted so staff members know to inform the patient that a copay is required for this visit. We do not ask whether the patient wants to pay, but instead ask how they would like to pay, stating that we accept cash, check, or credit card.

For additional encouragement, consider offering an incentive to the highest collection for the day by a frontline access member.

The incentive can be anything. I think it’s the recognition you give, especially in front of their peers, that staff members want.
Sample copayment collection stats

Editor’s note: This chart is one method used by the patient access team at the Grand Itasca Clinic and Hospital in Grand Rapids, MN, to monitor its copayment collections.

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Total money collected: $1,251
Total money not collected: $308

Total number of copays collected: 85
Total number of copays not collected: 24

Source: Grand Itasca Clinic and Hospital, Grand Rapids, MN.
Scripting for the ABN

Editor’s note: It is never too early to look at your scripting policy for the advance beneficiary notice (ABN). CMS is making the revised ABN mandatory by March 1, 2009. The following is a script used by Jennie Jones, supervisor of access management at South Haven (CT) Community Hospital.

When frequency is restricted

Medicare considers a [name of test] to be frequency restricted. This means that Medicare may decide to deny payment for [name of test] if you have had it within the past [time period as indicated by First Comply software]. However, depending on your diagnosis and medications that you are on, this test may be covered more frequently than indicated by Medicare.

This document is an advance beneficiary notice, which is also referred to as an ABN. This notice gives you the right to accept or decline the test based on the fact that it is a frequency-restricted test. The estimated cost of the test is [amount].

If you agree to this test and wish Medicare to be billed, you will be held financially responsible if Medicare does not pay for the test and you will have the right to appeal Medicare’s decision. If you decide to accept this test and do not wish Medicare to be billed, you will be asked for payment now and you will not have the right to appeal Medicare’s decision. If you decline the test, your provider will be informed that you decided not to have the test done.

Would you please indicate on this form what your decision is and then date and sign it? [Say today's date.]

When medical necessity is restricted

Note: Attempt to get a valid diagnosis for the test from the provider by sending a query form prior to asking the patient to sign the ABN.

Medicare considers a [name of test] to not be medically necessary based on the diagnosis that your provider has given. This means that Medicare may decide to deny payment for the [name of test].

This document is an advance beneficiary notice, which is also referred to as an ABN. This notice gives you the right to accept or decline the test based on the fact that Medicare does not consider this test medically necessary for the diagnosis that your provider has given. The estimated cost of the test is [amount].

If you agree to this test and wish Medicare to be billed, you will be held financially responsible if Medicare does not pay for the test and you will have the right to appeal Medicare’s decision. If you decide to accept this test and do not wish Medicare to be billed, you will be asked for payment now and you will not have the right to appeal Medicare’s decision. If you decline the test, your provider will be informed that you decided not to have the test done.

Would you please indicate on this form what your decision is and then date and sign it? [Say today's date.]