

1. Overview of Revenue Operations

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1.1 About the Revenue Operations Manual

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

1.1.1 Revenue Operations Manual Objectives

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

1.1.2 Facility Expectations

Each site will be able to obtain from the IHS Revenue Operation Manual the following:

- How to use and implement the various policies and procedures.
- What information needs to be consistently captured at the time of registration.
- What documentation is needed from the facility staff for the medical record.
- What are the different coding nomenclatures.
- How to code most effectively the Evaluation and Management visits.
- How to complete a CMS 1500 and CMS 1450 correctly.
- How to bill to the various insurers.
- How to establish electronic billing and posting interchanges with the insurers.

- How to understand Explanation of Benefits and Remittance Advices.
- How to follow-up on outstanding accounts in a consistent, organized manner.

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for viewing, and printing at the IHS Business Office web site:

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

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

The manual is divided into the following five (5) parts:

Part	Title/Contents
1	Administrative Roles and Responsibilities <ul style="list-style-type: none"> • Overview of revenue operations • Laws, acts, and regulations affecting health care • IHS laws, regulations, and policies • Health Insurance Portability and Accountability Act (HIPAA) • Business Office Management • Business Office Staff • Business Office Quality Process Improvement • Compliance
2	Patient Registration <ul style="list-style-type: none"> • Overview of patient registration • Patient eligibility, rights, and grievances • Direct care and contract health services • Registration, discharge, and transfer • Third-party coverage • Scheduling appointments • Benefit coordinator
3	Coding <ul style="list-style-type: none"> • Overview of coding • Medical record documentation • Coding guidelines • Data entry

Part	Title/Contents
4	Billing <ul style="list-style-type: none"> • Overview of billing • Hard copy vs. electronic claims processing • Billing Medicare • Billing Medicaid • Billing private insurance • Third party liability billing • Billing private dental insurance • Billing Pharmacy • Secondary billing process
5	Accounts Management <ul style="list-style-type: none"> • Overview of accounts management • Electronic deposits and Remittance Advices • Processing zero pays • Creating payment batches • Processing payments and adjustments • Reconciliation of credit/negative balances • Collections • Collection strategies • Rejections and appeals

This manual also contains an **Acronym** dictionary and a **Glossary**.

Navigation aids include a Table of Contents for each Part, as well as individual Chapter Tables of Contents.

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

1.2 About the Indian Health Service

Federal health services for Indians began under War Department auspices in the early 1800s. Professional medical supervision of Indian health activities began in 1908, with the establishment of the position of Chief Medical Supervisor. Appropriations were first designated in 1911.

The creation of the Health Division in 1924 raised the status of the program and allowed direct access to the Commissioner of Indian Affairs. Since 1926, officers of the Public Health Service Commissioned Corps have been detailed to the Indian health program to meet qualified staffing needs.

On July 1, 1955, Indian Health Services formally transferred to the Public Health Service, Department of Health, Education, and Welfare, as the agency responsible for the country's human resources.

1.2.1 Mission and Goal of Indian Health Service

The Indian Health Services (IHS) is one of eight agencies in the U.S. Public Health Service (PHS), located within the Department of Health and Human Services (HHS). The Indian Health Service is responsible for providing comprehensive health care to American Indians (AI) and Alaska Natives (AN).

The **IHS Foundation** is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures, and to honor and protect the sovereign rights of Tribes.

The **IHS Mission**, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

The **IHS Goal** is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people.

To carry out this goal, the Indian Health Service:

- Assists Indian tribes in developing their health programs through activities, such as health management training, technical assistance, and human resource development.
- Facilitates and assists Indian tribes in coordinating health planning; in obtaining and using health resources available through Federal, State, and local programs; and in operating comprehensive health care services and health programs.
- Provides comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and development of community sanitation facilities.
- Serves as the principal Federal advocate in the health field for Indians to ensure comprehensive health services for American Indian and Alaska Native people.

The Indian Health Service is primarily responsible for

- Providing all services available at an IHS facility to any person within the scope of the Indian Health program, who presents himself at the facility and for whom the IHS facility is more accessible than other programs and resources.
- Identifying alternative resources for which the persons within the scope of the Indian health program may be eligible.
- Coordinating provisions to comprehensive health services from existing sources, for all persons within the scope of the Indian health program.
- Determining whether resource agencies will, in fact, provide necessary assistance. Alternate resources may be county, State, or Federal programs, such as County Welfare, Medicaid, Crippled Children's Program, Medicare, Veterans Administration Hospital, U.S. Army, Air Force, Navy, PHS Hospital; official or voluntary health agencies; employee health insurance or accident insurance.

In addition, persons within the scope of the Indian Health program in one area will be provided available medical and/or related services by any other area in which they may require health services.

1.2.2 Self-Determination and Self-Governance

Federal laws and policies in the mid-1970s greatly altered the profile of the Indian health care delivery system. Primary among this legislation is the Indian Self-Determination and Education Assistance Act (ISDEA) of 1975, which grants Tribes the option of contracting for the health care services that they would otherwise receive directly from the Indian Health Service (IHS).

In 1976, the Indian Health Care Improvement Act (IHCIA) increased participation of tribal members in their health care system by funding, among other things, scholarship programs for Indian students and by further involving Tribes in the planning and implementation of Indian health care services.

The ISDEA and IHCIA legislation also provided significant financial resources for the expansion of health care services. As a result, many aging medical facilities have been modernized and new hospitals, clinics, and health stations have been constructed. Along with these improvements, the number of health care professionals has increased.

Since the ISDEA was enacted in 1975, Tribes have been able to assume some control over the management of their health care services by negotiating contracts with the IHS. Subsequent amendments to the ISDEA have strengthened the federal policy of self-determination for Indian people.

In 1994, the ISDEA was amended to authorize a Tribal Self-Governance Demonstration Program, which greatly expanded this partnership effort by simplifying the self-determination contracting processes and facilitating the assumption of the IHS programs by tribal governments. It also authorized the transfer of IHS funds that would have been spent for those programs directly to tribal control under a compacting process.

The Tribal Self-Governance Amendments of 2000 established a permanent self-governance program with the IHS, and also authorized a study of the feasibility of including other Department of Health and Human Services agencies in the self-governance program.

Whether through contracts, grants, or compacts, nearly all of the more than 560 federally recognized Tribes have exercised their option to assume some level of responsibility for their own health care programs. Since 1992, tribal organizations have negotiated 56 compacts with the IHS. Today, more than 50% of the IHS appropriated budget is allocated to tribally managed programs through compacts and contracts. This has resulted in an increased capacity in American Indian and Alaska Native communities to improve their own health care through the development of staff, facilities, community' involvement in decision-making, and public health interventions.

As a result of these new opportunities, there has been a shift in the role of the IHS from direct care provision to support of tribally managed health care programs. Tribes now operate and staff almost 80% of outpatient clinics and other ambulatory care facilities in the Indian health care system. In addition, they conduct most community-based programs, including health promotion and disease prevention activities. Indian people now have a greater voice in determining what services will be provided.

In response to the transition from federal toward tribal authority, the IHS has downsized and reorganized. It has also formed a strong and effective partnership with tribal leaders, collaborating with Indian representatives on health care matters and supporting their objectives. This alliance helps ensure that resources are used most effectively and efficiently, and that the historic trust and treaty obligations continue to be honored.

The IHS remains directly responsible for

- performing inherent federal, administrative, and advocacy functions on behalf of all Indian people
- testifying to Congress on their health needs
- tracking legislative proposals that would affect their health

Together, the IHS and tribal governments have designed a new health care system, one that allows local identification of health care needs and applies a multiplicity of innovative strategies to meeting them.

1.2.3 Covered Individuals

A person may be regarded as within the scope of the Indian health program, if he is not otherwise excluded by provision of law

AND

- is regarded by the community in which he lives as an Indian *or* Alaska Native;
- is a member, enrolled or otherwise, of an Indian or Alaska Native Tribe or Group under Federal supervision;
- resides on tax-exempt land or owns restricted property;
- actively participates in tribal affairs;
- any other reasonable factor indicative of Indian descent;

OR

- is an Indian of Canadian or Mexican origin, recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program;

OR

- is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post partum (usually six weeks);

OR

- is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.

1.2.4 Health Care Delivery Components

Preventive measures involving environmental, educational, and outreach activities are combined with therapeutic measures into a single national health system. Within these broad categories are special initiatives in

- traditional medicine
- elder care
- women's health
- children and adolescents
- injury prevention,
- domestic violence
- child abuse
- health care financing
- state health care
- sanitation facilities
- oral health

Most IHS funds are appropriated for American Indians who live on or near reservations. Congress also authorized programs that provide some access to care for Indians who live in urban areas.

IHS services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The Federal system consists of 36 hospitals, 61 health centers, 49 health stations and 5 residential treatment centers. In addition, 34 urban Indian health projects provide a variety of health and referral services.

The IHS clinical staff consists of approximately 2,700 nurses, 900 physicians, 450 pharmacists, 300 dentists, and 83 physician assistants. IHS also employs various allied health professionals, such as nutritionists, health administrators, and medical record administrators.

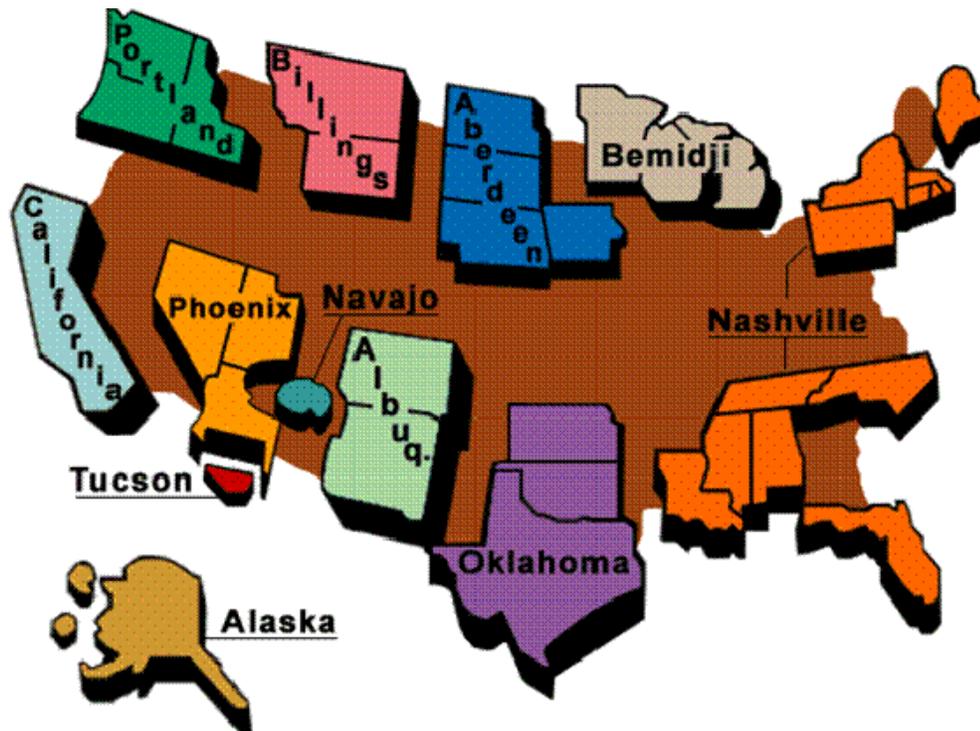
Through Public Law 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 13 hospitals, 158 health centers, 28 residential treatment centers, 76 health stations, and 170 Alaska village clinics.

1.2.5 Joint Planning for Care of Indians

Within the following guidelines, the Area Director is responsible for conducting joint planning with local, State and Federal resource agencies, and with tribal officials and leaders for care of Indians.

- IHS does not receive full funding and must rely on third-party reimbursement and alternate resources to provide necessary health care to IHS beneficiaries.
- Recognize the principle that the Indian people are entitled to State and local services when they meet the same requirements as other citizens of that State and locality.
- Work with Indian groups affected and the State and local agencies for the utilization of available community services.
- Identify gaps between comprehensive health needs of Indians and those services available through Federal, State and local community agencies, and jointly plan with those agencies ways and means of bridging these gaps.
- Recognize the fact that in order to assure that the total services available to Indians are as comprehensive as possible, the Indian Health Service Program and policy requirements may vary according to State and local situations.
- Recognize the fact that indigent (i.e., homeless or transient) patients may be eligible for other resources from the State or local programs, and an American Indian or Alaskan Native should not be excluded from these programs.

1.2.6 Area Office Map



1.2.7 Population Served

As of 2005, the Indian Health Service operates a comprehensive health service delivery system for approximately 1.6 million of the nation's estimated 2.6 million American Indians and Alaska Natives. This population is dispersed throughout the continental United States and Alaska. Within the continental United States, the service population is comprised of members of more than 500 federally recognized tribes dwelling primarily in 35 states. The Alaska territories cover many small, remote villages.

1.3 The Role of the Business Office in the IHS Mission

The **Business Operations Office** is an integrated business program for all IHS facilities throughout the United States. This program emphasizes action-oriented planning and implementation processes to achieve the optimum level of quality, and best business practices throughout IHS. It is one organizational approach in support of achieving the mission of Indian Health Service.

The purpose of establishing Business Offices in all IHS service units is to

- Optimize reimbursements of revenues from Medicare, Medicaid, state and federal grants, and private insurance.
- Identify all other alternate resources for which American Indians, Alaska Natives, and other beneficiaries are eligible.

Specific Business Office activities include, but are not limited to

- Providing patient registration functions for outpatient services and inpatient admissions
- Processing claims, following up on outstanding accounts, and pursuing collections
- Updating the IHS, Resource and Patient Management System (RPMS) and its various business office applications with accurate and timely data
- Providing trained individuals to assist patients in obtaining alternate resources when regular insurance is not available
- Complying with quality improvement standards, utilization review, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Academy of Accreditation for Health Centers (AAAHHC), Commission on Accreditation for Rehabilitation Facilities (CARF), Centers for Medicaid and Medicare Services (CMS), along with the Conditions of Participation, Health Insurance Portability and Accountability Act (HIPAA), insurer procedures, and other Federal, State and Local rules and regulations
- Ensuring that documentation is available and supports third party claims processing

Through the functional organization and linkages throughout IHS, all available resources are coordinated to enhance and maximize the entire business operations process.

Linkages – with social services, information systems, health information management, utilization review, authorizations and certifications, admission and discharge planning, finance, benefit coordination, diabetes and nutritional services, behavioral and dental services, and others – are important to the overall success of the operations at each and every Service Unit. These linkages tie to the mission of Indian Health Services by improving, integrating, and elevating the health status of the American Indian and Alaska Native to the highest possible level.

1.4 Headquarters Role and Responsibilities

The Office of Resource, Access, and Partnership (ORAP) provides the Area offices and Service Units the support and guidance they need to set and meet their Business Office improvement goals. ORAP provides leadership and direction for increasing

- third party collections in accordance with third party payer rules
- utilization of alternate resources
- purchasing power in CHS with appropriations for additional savings
- compliance and business process efficiencies
- internal and external partnerships

Responsibilities include conducting reviews of business offices on an Area-wide basis to assess and improve the Area office's capacity for assuring Service Unit compliance with the Business Office. Reviews of executive programs are also conducted to review and improve an Area's overall strategy for assuring the quality of the facilities and programs within an Area.

1.4.1 Office of Information Technology (OIT)

The Director, Office of Information Technology (OIT), is responsible for providing automated system services and support for nationwide applications that support third party billing and collection activities. This includes:

- Developing, implementing, and maintaining automated programs for these functions
- Providing for the acquisition of necessary hardware
- Ensuring the timely and adequate distribution of software and user manuals
- Providing related training

OIT provides technical support for, as well as updates to, the Resource and Patient Management System (RPMS) applications. RPMS is a decentralized automated information system of over 50 integrated software applications, which fall into three major categories:

- Administrative applications that perform patient registration, scheduling, billing, and linkage functions
- Clinical applications that support various healthcare programs within IHS
- Infrastructure applications

The RPMS system is designed to operate on PCs located in IHS or tribal healthcare facilities.

Within OIT, the National Patient Information Reporting System (NPIRS) is a designated organizational unit. The purpose of NPIRS is to provide a broad range of clinical and administrative information to managers at all levels of the Indian health system, enabling them to better manage individual patients, local facilities, and regional and national programs.

1.5 Area Office Responsibilities

The Area office assists the Service Unit business office by

- assertively planning a monitoring system to support business process improvement
- participating in overall JCAHO accreditation and/or other types of required certification and/or licensures, such as the American Academy of Accreditation for Health Centers (AAAHC), Commission on Accreditation for Rehabilitation Facilities (CARF), Centers for Medicaid and Medicare Services (CMS)

Most Area offices employ a program specialist for clinical and auxiliary programs operated by the Service Units in their Area. This person is designated as the Area coordinator.

The Area coordinator works closely with the Service Unit business offices to assist them in designing programs that will be self-monitoring, self-correcting, and self-directing, by

- Developing their internal capacities to ensure and enhance continuous improvement.
- Promoting compliance with the standards established by JCAHO, AAAHC, CARF, CMS, IHS, or other recognized licensing or accrediting bodies.
- Institutionalizing and maintaining business office standards in the day-to-day operations of the program.

The business office participates in the overall accreditation process under a specific section, such as the Governing Body or Management and Administrative Services.

The Area office also conducts an external review using the standards that IHS has adopted or, if standards are not yet adopted, the professional judgments of experts in the field. The Area office then assists the Service Unit business office in correcting the identified deficiencies.

1.5.1 Area Coordinator Role and Responsibilities

The Area Coordinator in the IHS Business Office

- Serves as the technical consultant to all Service Unit/facility business office managers concerning all third-party billing and collections.
- Serves as a consultant to the Area Director on all policy issues relating to all business office operations.
- Conducts on-site reviews and audits of Service Unit business office functions.
- Keeps abreast of new policy changes and distributes information.
- Provides technical assistance for the implementation of all third-party billing procedures and processes.
- Provides technical assistance for corrective actions to problems related to all third-party billing procedures.
- Identifies training needs of IHS Service Unit/facilities and develops and provides training to meet these needs.

- Evaluates Business Office program effectiveness by tracking third-party reimbursement activity occurring in all IHS Service Units/facilities to assure no disruption in revenue.
- Identifies Business Office objectives and organizational needs for individual Service Unit/facilities and provides recommendations to facilitate changes.
- Implements internal control measures throughout the Area for accountability and management of the accounts receivable system. This includes, but is not limited to, providing appropriate interaction between financial management and the business office.
- Provides intervention and corrects information on trans-area and/or inter-service unit inconsistency in critical RPMS data fields.
- Serves as subject matter coordinator for the RPMS Third Party Billing application, RPMS Patient Registration application, RPMS Accounts Receivable application, and other related application, as appropriate; and coordinates and assures transmission of data.
- Researches, develops, and maintains a current list of resources available through private foundations.
- Develops/presents annual training seminars to Area business office personnel.
- Interfaces closely with CHS staff, as both programs utilize common RPMS databases.
- Monitors and provides technical support to the RPMS Patient Registration application, while ensuring data integrity, including all reporting.
- Works with HHS regional offices and state and county agencies to identify available resources, eligibility criteria, funding, changes to registration.
- Develops and implements managed care concepts in all areas of the business office and third party entities.

1.5.2 Area Information Technology (IT) Responsibilities

The Information Technology (IT) Specialists are responsible for

- Near- and long-term planning for information resource requirements and establishing strategies for managing information resources;
- Coordinating and implementing IHS-wide information resources management (IRM) goals and strategic plans, including the provision of technical support for nationwide initiatives related to third-party billing and collection activities; and

- Participating in the budget development process with I/T/U managers, facility IRM managers, and end-users.

The IT Specialist/ Coordinators establish mechanisms to

- Track Area IT progress against plans; monitor new initiatives to ensure that objectives and intended purposes are met;
- Monitor and maintain facility RPMS databases, ensuring the installation of current updates/new releases, patches, routines, globals, and data element tables;
- Coordinate/provide analyses of computer/IT operations; and
- Make recommendations related to daily operating procedures, data collection, data quality, equipment environments, preventive maintenance, and automated IT security measures. Security includes planning and execution of the IHS IT Security Program.

1.6 Reporting

Reporting is a function of the Service Unit facility, Area office, and IHS headquarters. From a management standpoint, this activity is necessary so that all levels of the organization can be informed as to the progress of the business office relative to claims generation, resources collected, and the utilization of such collections.

Required reports are generated at all levels and flow in all directions. Each level of business office management must identify and establish the type of report requirements needed on a continuous basis.

All reports should include the following minimum components:

- Identification of the origin of required reports by Service Unit, Area, or IHS headquarters
- Expected data of response
- Subjects
- Purpose
- Format
- Generated by
- Distributed to
- Analyzed by
- Followed by
- Corrective Action by

The purpose for internal reporting is to document and monitor Medicare and Medicaid collections and spending activities with regard to appropriate laws and regulations. Each Service Unit and Area is required to report annually on the actual Medicare/Medicaid collections to the Office of Resource, Access, and Partnerships (ORAP).

1.6.1 Annual Medicare/Medicaid Expenditure Plan Report

The purpose of the Annual Medicare/Medicaid Expenditure Plan is used to monitor the correction of deficiencies which would prevent an IHS facility from attaining and/or maintaining their accreditation/certification.

This report must be developed in accordance with the specific intent and requirements of Title IV. The plan must address the correction of deficiencies which would prevent an Indian Health Service facility from attaining and/or maintaining accreditation/certification.

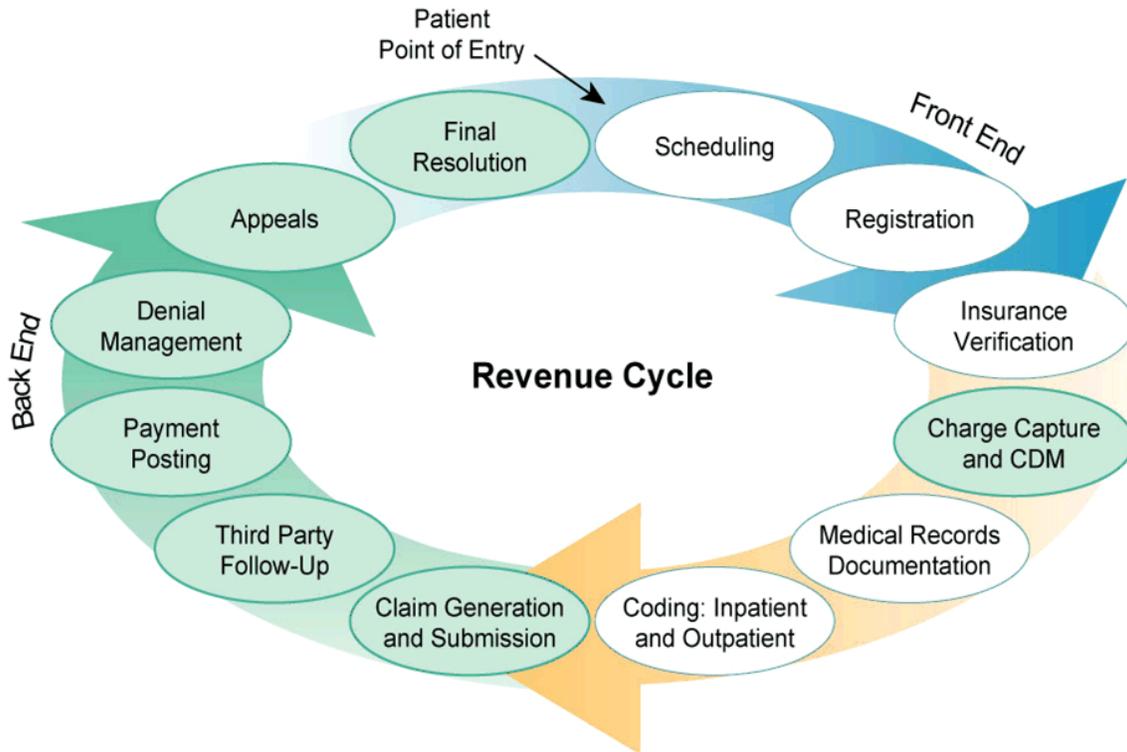
Further, the plan must meet the requirements of the Social Security Act, which states that the collections must be used “exclusively for the purpose of making any improvements” ... “which may be necessary to achieve compliance with the applicable conditions and requirements of this Act.”

For the Plan of Correction, the following three action steps will be taken:

1. Assure that plans are developed and actual use is within statute.
2. Develop and implement internal control review of plans within the Areas.
3. Conduct special reviews of all areas to determine that misuse of funds is not widespread.

1.7 Revenue Generation Areas

The following sections provide a brief overview of the contributors to the overall business operations revenue generation, as illustrated in the Revenue Cycle.



1.7.1 Patients

Many patients have insurance coverage through employment or Medicare or Medicaid. The Federal government has allowed IHS to bill any third-party insurance for compensation of facility charges, including secondary and tertiary insurance, if available. Therefore, many patients who have any third-party insurance should be actively sought and pursued by each IHS facility to enhance revenue generation and, secondarily, to support the viability of health care operations.

1.7.2 Non-Beneficiary Patients

Non-beneficiary patients may seek emergency treatment from an IHS emergency room. As part of the IHS facility obligations, the Business Office needs to obtain insurance information and/or seek direct reimbursement from the patient before he or she leaves the facility. Pursuing these financial resources contributes to the revenue for each facility.

1.7.3 Registration

Business operations are extremely dependent on the collection of accurate patient demographic, eligibility, insurance data, and completion of applicable forms by Registration staff.

- If demographic information is incomplete, claims will be denied.
- If outdated or expired insurance is recorded, claims will be denied for inaccurate eligibility information.
- If any identification numbers are incorrect, claims will be denied for incorrect insurer information.
- If secondary/tertiary insurance is not identified, the health care facility will not be reimbursed for any applicable secondary/tertiary insurance payments.
- If eligibility is not verified routinely, claims will be denied because insurance coverage may have expired.
- If applicable forms are not completed, but the claim indicates that they are, this may lead to the falsification of the claim, which constitutes fraud.

Without an integrated and coordinated process between Registration and the Billing Office, an inefficient use of man-hours can be expended trying to obtain correct, valid insurance information.

Many facilities have decentralized Registration staff to various clinics/departments to facilitate this process. This is an excellent way to develop a close working relationship and also cross-train individuals on needed information that can contribute to a successful claim and bill.

1.7.4 Benefit Coordinator

As with Registration, the Business Office relies on the Benefit Coordinator to obtain alternate resources for patients with no insurance. The Benefit Coordinator, along with Registration and Billing, becomes part of a very integrated team.

Without Registration referring potentially eligible patients to the Benefit Coordinator, and without the Benefit Coordinator assisting and educating those patients on obtaining alternate resources, the facility would not be able to fully optimize a patient's third party resources.

It is important for the Benefit Coordinator to stay actively involved with Patient Registration, Billing, and Contract Health Service, and contribute to the revenue flow of the facility.

1.7.5 Health Information Management

Health Information Management (HIM) and the Business Office have a very strong working relationship and linkage, where one provides the documentation support and the other converts the documentation to applicable coding. Each of these entities requires separate and distinct skill sets to perform their functions.

Health Information Management is responsible for assuring that

- Detailed documentation is present for each outpatient visit and daily, for each inpatient admission.
- Provider, nursing, and pharmacy signatures are in place.
- Discharge orders and notes are written.
- Lab and x-ray results are filed.

Whether the record is manual, electronic, or a combination of both, the HIM department is responsible for assuring that all providers and services comply with detailed chart completion.

The **Business Office** (and providers with the electronic health record) is responsible for converting the written verbiage into the correct coding structure for the insurer. Further, the Business Office utilizes the medical record to substantiate any inquiry from the insurer to include random audits by either Medicare or Medicaid.

Without the documentation in either the manual or electronic medical record, the Business Office cannot bill. Thus, the Business Office relies on the quality review oversight by HIM in their billing, appeal, and insurer inquiry processes, as well as justification during any audit process.

1.7.6 Coding and Data Entry

“The data you get out of the system is only as good as the data you put into the system” certainly pertains to the key business and revenue generation functions, coding and data entry.

Currently, coding is done by coders, some certified and some internally trained. Then, the coded documents are passed on to the data entry staff for entry into the RPMS Patient Care Component (PCC) application. If both processes are done accurately – correctly defined codes and accurate data entry – a clean claim is billed to the insurer.

Since the implementation of the electronic medical record, providers are now responsible for the coding, especially evaluation and management codes, procedures, and diagnosis(es).

Some of the challenges that have impacted coding are:

- (1) Interpreting the handwriting of providers and nurses and being able to accurately select the most appropriate code.
- (2) Having providers and nurses document in detail in their notes, in order for coders to code correctly.

Revenue will be lost:

- If an unspecified ICD code is selected.
- If there is no compatibility or relationship between the diagnosis and procedure code.
- If relevant documentation is missing, such as time increments, services provided, supplies issued, medical necessity, plan of care, and other supporting documentation that could have been coded.

It will be more important than ever to coordinate the coding functions between the provider and coder to assure that documentation supports the most accurate code. This will be critical to the overall business operations and continued reimbursement.

1.7.7 Billing

The Billing staff is critical to successful revenue generation of the facility. The Billing department reviews information compiled from RPMS PCC application and conveys this information to the responsible third party payer.

Besides reviewing the data, Billing must also coordinate externally with the insurer to assure that the proper billing guidelines and coding requirements are met before submission.

In addition, Billing provides a secondary review process to assure that all the insurance requirements are fully detailed before submitting the claim. For example, is there a date of onset listed for an emergency exam, or is there a diagnosis or symptom for the lab? Without this process, there would be a delay in claim adjudication.

1.7.8 Accounts Receivable

Accounts Receivable is responsible for posting to the RPMS Accounts Receivable application.

Accounts Receivable is responsible for the posting to the RPMS Accounts Receivable (A/R) application. The information posted to A/R is in support of the subsidiary ledger, as reported to Finance.

The Accounts Receivable function needs to be performed by a separate individual to ensure a check and balance process. Accounts Receivable staff relies primarily on their understanding and knowledge of reimbursement, to assure that the facility is receiving the correct reimbursement. They reconcile the account by posting the payments, credits, and adjustments in a timely manner.

Month-end reports are run to allow for reconciliation, according to the Third Party Revenue Accounts Management and Internal Controls policy. For more information, see Part 1, Chapter 5, Section 5.2, "Third-Party Revenue Accounts Management and Internal Controls Policy."

1.7.9 Collections

Collections is part of the final adjudication process of open accounts, or requests further review or appeals.

Whether it is from the insurer (incorrectly paid claims, rejected claims that should be paid, or outstanding accounts not paid) or from the non-beneficiary patient, Collections also contributes to the revenue generation for the facility.

If this process is not done consistently, revenue will be compromised. Revenue will be lost:

- If invalid insurance data is collected.
- If documentation is missing.
- If follow-up is not completed in a timely manner, as required by policy and individual payer guidelines.
- If appeals are not submitted within payer guidelines.

1.8 Utilization of Operational Materials

There are several items that should be included in every facility to assist the staff with related business operations functions. These items are:

- On-line access to the Revenue Operations Manual
- Patient Information Packets
- Required Forms
- Signage

1.8.1 Revenue Operations Manual

The Revenue Operations Manual serves as a “How-To” reference guide for all Indian Health Tribal and Urban (I/T/U) staff located in IHS facilities, who are affiliated with any activity related to business operations.

This manual is an important reference document for the entire Revenue Operations staff, enabling them to perform in a consistent, standardized manner.

Updates to the manual based on new information from the business office or insurer need to be reviewed by the Revenue Operations team prior to being placed into the Revenue Operations Manual. After approval of content and wording, the information should be added to the correct part or chapter and should be dated.

Information that is no longer relevant should be deleted or highlighted with a date when the information will no longer be valid. This update process is important for insuring that the manual does not become outdated.

1.8.2 Patient Information Packets

The Patient Information packets should be given to all new and existing patients. These packets provide information about the facility, the hours of operation, the various clinics available, the community it serves, information on the providers, reference telephone numbers, pharmacy hours and after-hour call-in service, emergency care procedures, Patient Bill of Rights, map of facility, and any other related information relevant to the facility.

These packets should also include related preventive information brochures for educational purposes.

Finally, the packet of information should include a brochure on the Benefit Coordinator service, Contract Health, and any other specialty type clinics or services being provided.

1.8.3 Required Forms

Forms are a necessary requirement at the Registration desk. Forms such as Medicare Secondary Payer questionnaire, facility registration form, assignment of benefits form, release forms, surgical forms, signature on file forms, and other related forms should be immediately accessible to the Registration staff.

All forms should be completed in a timely manner and filed according to the business practice of the facility.

1.8.4 Business Office Signage

Signage will serve as location indicators to different clinics, pharmacy, lab, x-ray, benefit coordinator, contract health, urgent care or emergency room, and other areas of the facility. In addition, any information that needs to be conveyed to the patient or patient family, such as the collection policy or accepting credit cards for non-beneficiary patients, should be posted in clear view at the registration desk.