

5. Business Office Management

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5.1 Overview of Business Office Management

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. Third-party revenue enables IHS to maintain the level of care it provides to the community. The Business Office contributes to the mission of IHS by using effective and efficient management practices to maintain existing third-party revenue levels and to increase total revenue collections.

This chapter provides an overview of important management actions and approaches that are available to the Business Office Manager.

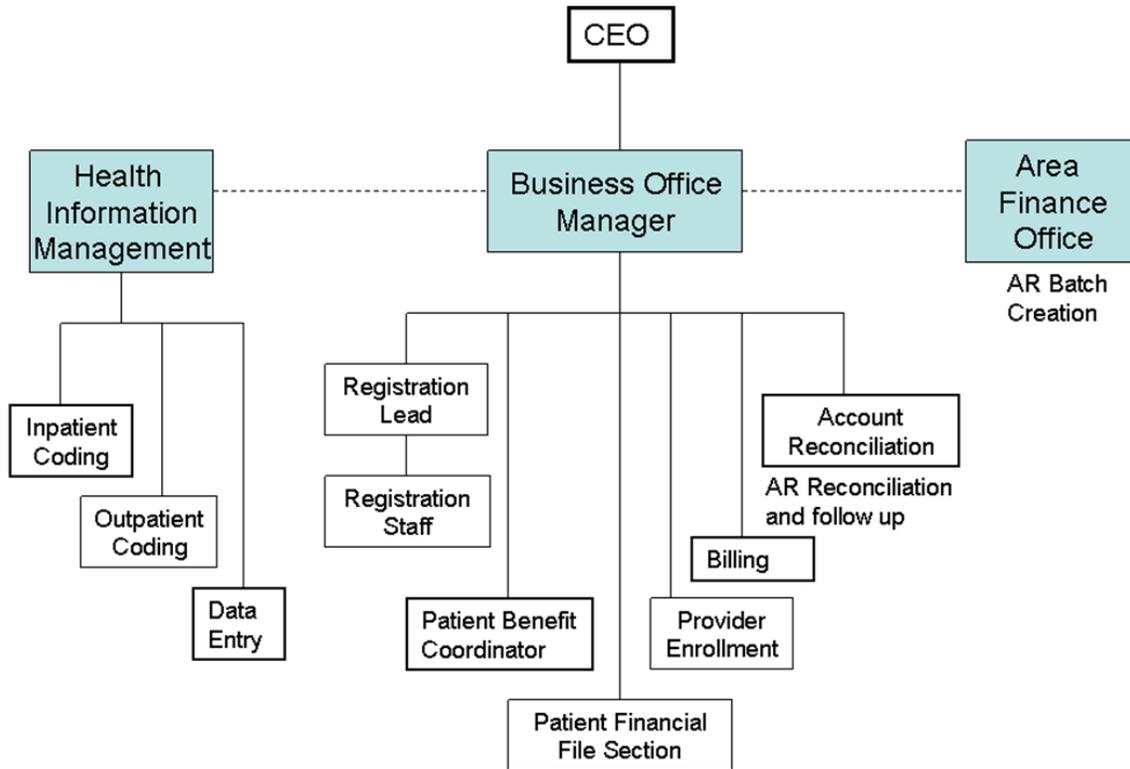
5.1.1 Terminology

Term	Definition
mission	The purpose and essential characteristic of an organized unit; also considered as the key objective of an organization.
policies and procedures	Guidance on the necessary steps and methods used to accomplish key department functions.
functions	The performance areas that are most vital to the accomplishment of the mission; also considered as the critical objective.
standards	The conditions that will indicate when the functions are performed properly; specific standards should accompany each function.
need	A problem or a condition that indicates that a standard has not been achieved.
goal/objective	A desired action/plan that will satisfy an existing need and/or standard.

5.1.2 Organizational Structure

The following chart is a proposed organizational structure for Health Information Management (HIM), the Business Office, and the Area Finance Office. It is important to note that the organization structure and actual functions of a position may vary, depending on the size of the facility.

Business Office Organizational Chart



This organizational chart provides only a partial coordination and integration of the business functions under one manager. A significant amount of coordination and discussion will need to occur between the Business Office Manager and HIM Supervisor to assure continuity with the business process.

For workflows of the various Business Office areas/functions, see Part 1, Appendix A, “Business Office Workflow Diagrams.”

5.2 Third-Party Revenue Accounts Management and Internal Controls Policy

The Third-Party Revenue Accounts Management and Internal Controls policy establishes the Indian Health Service (IHS) policy for recording, controlling, and otherwise accounting for patient related resources. This policy

- Defines important management requirements to ensure that financial operations comply with applicable laws, regulations, and government wide financial requirements as they relate to third party revenue.
- Ensures the accuracy and timeliness of receivables and revenue reported in the financial statements of the IHS.
- Establishes specific internal controls to safeguard and properly account for revenue and related assets.
- Defines authorities for collecting debts owed the IHS from third party sources and non-beneficiary patients.

All IHS managers will implement the systems set forth in this policy.

For more information, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/part5chapt1.htm>

5.3 Corporate Compliance Program

A Corporate Compliance Program demonstrates the commitment of a facility to quality and excellence. It sends a strong message about, and enhances staff awareness of, conduct that is unacceptable. With a compliance plan in place, the facility is able to identify problem areas early and promote corrective actions.

The Office of the Inspector General (OIG) has provided a 7-element, corporate compliance program outline for facilities to follow.

1. Auditing and monitoring

Begin with a baseline claims submission audit to see where errors are occurring and whether you have a pattern of claims denial.

2. Assessing practice standards and procedures

Use your audit to identify risk areas in your practice and develop or change standards and procedures that detail how to handle these risk areas. In addition, develop a corrective action plan for combating these problem areas. Policies and procedures should be written and disseminated to all staff.

3. Designating a compliance officer/contact

Facilities need to designate one or more individuals to be responsible for overseeing compliance efforts. Instead of actually hiring a specific individual, the facility could outsource this position.

4. Training and education on practice standards and procedures

All staff should be trained on practice standards and procedures (billing and coding employees should have annual training). Establish a set meeting time to inform employees about new carrier instructions, OIG fraud alerts, and other compliance-related events.

5. Responding to identified problems

Your compliance officer/contact should identify an appropriate course of action to deal with problems. The guidance recommends that you consult with coding experts or outside counsel for advice, and report problems to the appropriate government entity.

6. Developing open lines of communication

The facilities should have an “open-door” policy to enable staff to express concerns about billing issues or misconduct. Your compliance officer/contact can serve as the point person to respond to these concerns.

7. Disciplinary and corrective action

Your staff needs to be aware that your facility takes compliance seriously and that failure to comply may result in disciplinary action.

For the Indian Health Service, it is recommended that compliance oversight be under Administrative or Executive leadership, to

- Provide oversight and leadership to compliance activities.
- Ensure that reporting and accountability are achieved.

Each Area will designate a Corporate Compliance Officer (ACCO), who will work directly with administrative or executive leadership. Additionally, each Service Unit will designate a Compliance Officer, who will be responsible for directing all compliance activities within the Service Unit, in coordination with the ACCO.

For a detailed discussion of the role and responsibilities of the corporate compliance officer, see Part 1, Chapter 8, "Compliance."

5.3.1 Elements of an Effective Corporate Compliance Plan

Based on the OIT's corporate compliance program outline, an effective corporate compliance plan will include:

- Written compliance standards established and disseminated throughout the facility.
- Top-down oversight.
- Staff participation in educational programs about the compliance plan and process is required, which is documented.
- Documented communication of the commitment of the facility to a compliance program and the necessary steps involved in the program.
- Processes for monitoring and auditing compliance, and for recording steps taken in response to problems uncovered.
- Standards investigated and enforced throughout the facility.
- Processes for correcting departures from standards and measures introduced to prevent recurrence.
- Written policies and procedures developed and disseminated throughout the facility.
- A designated telephone line established for any anonymous reporting of problems or violations.
- Policies developed and adhered to regarding record creation and retention

Facilities should reference their own established and approved compliance plan.

5.4 RPMS Reports

To ensure effective program management, program progress must be continuously monitored. Running various RPMS reports will assist in identifying program status, staff productivity, areas of need, and areas of opportunity. These reports serve as a management tool to monitor daily operations regarding third-party revenue and internal controls.

For a listing and examples of available reports from the RPMS system, see the *Indian Health Manual*, Part 5, Chapter 1, “Third-Party Revenue Accounts Management and Internal Controls,” Manual Exhibit 5-1-D, “Sample Reports,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/med.htm>

Using RPMS reports, or in combination with audits, you can

- Review how effective notations in the patient accounting system are being utilized.
- Identify any claims that have been sent to the payer but have not yet been paid (for the electronic billing process, this could uncover an interface issue between the facility and the payer).
- Outline if secondary claims are being sent out and paid, and in what timeframe.
- Review if billers are following up on their claims in a timely manner.
- Define resolutions for the top ten reasons why claims are being denied and use this information to retrain the department staff.
- Review the remittances, comparing what was to be expected in payment versus what actually was paid.

These types of review will reveal “gaps” and encourage discussion and participation in efforts to send clean claims and to tighten timeframes, resulting in increased revenues.

5.5 Outsourcing Billing Office Functions

A facility backlogged in any of the Revenue Cycle functions – registration, coding, data entry, billing, accounts receivable, follow-up – may experience difficulties with incoming revenue and cash flow. While a facility may prefer to have everything completed in-house, the situation may require extra effort, special skills, or additional staffing. Once areas of need are identified, it may make sense to explore the option of temporarily outsourcing those functions.

Although outsourcing can be beneficial, it carries some associated risks. Therefore, It is critical that you conduct research on companies that specialize in the identified areas of need to ensure their integrity and capability to complete the work and meet the agreed upon deadline. To ensure that the outsourcing project is successful, you will need to track and continuously monitor progress.

Essentially, the Business Office manager must define the scope of work for outsourcing, specifying in detail the deliverables required to be completed by the contractor. These deliverables will be a measure of performance of the contractor. The Business Office manager must also consider the possible need for training contract staff, since the contractor may not be familiar with IHS software, policies, procedures, or billing guidelines. When considering outsourcing, follow your facility or Area contracting guidelines.

If outsourcing is used, it will be extremely important to communicate with your staff and advise them of why and what backlog you are outsourcing. While you need to reinforce with your staff the need and the effect that the backlog has on your facility's financial stability, you will also need to reassure your staff that their positions are not in jeopardy and that you are not saying they are doing a bad job.

Keeping your staff well informed will relieve some of their anxieties and helps to ensure the success of your project.

5.5.1 Guidelines for Reviewing a Outsourcing Proposal

Evaluative factors to consider when reviewing a proposal from an outside vendor include:

Costs

- Has the company broken down the cost by staff person, by claim volume, by project, by month, or some other way to give you an accurate accounting of their actual cost?

Sensitivity and Security of Information

- Has the company provided information that they are HIPAA Privacy and Security compliant?

Skill set

- Has the company demonstrated whether their staff has the coding or billing experience and skills necessary to complete the work by providing a list of staff, including education, training and certifications for each person?
- What is their experience in healthcare?
- What has been their success rate in coding or billing accurately with the major insurers?
- Do they have experts on staff with knowledge of Medicare, Medicaid, primary versus secondary coverage rules, and third-party reimbursement?
- Do they have knowledge of local payer idiosyncrasies?
- Have they used the RPMS application and what experience do they have working with the I/T/U billing, posting, and follow-up rules?

Detailed scope of work

- Has the company provided a written acknowledgement that they will comply with the defined scope of work?

Implementation Plan

- Has the company provided a detailed process for how they plan on working the project, including detailed activities, resources, and timelines?

References

- Has the company provided a set of references and any letters of recommendations from previous employers and/or contracts?
- Ensure that you call each one to get an overall view of the companies past history and work performance, including any previous work with IHS.

Risks

- Has the company identified any potential risks and their mitigation strategies as far as meeting the contract's obligations?

Performance Goals

- Will the company commit to performance goals?
- Will they put contract fees at risk if the goals are not met?

Control

- Will you retain ultimate control?
- Is the I/T/U managing the day-to-day contract as it relates deliverables or is the contractor?

On-site Support

- Will there be a contract project manager that is responsible for the scope of work, timelines, and activities related to the contract?

Termination for Cause Clause

- Always make sure this is included in the final contract.

Responsibility of Client and Vendor

- Determine what services and supplies will be provided and by whom.

Communications

- The company needs to agree to on-going communication, for example, weekly conference calls, meetings, and such.

Monitoring

- During the discussions of the contract, the I/T/U should advise the company of their intentions on monitoring and evaluating project progress.

Payment Invoices

- Once the contract is completed, the I/T/U Project Officer needs to sign off on the final invoice and reports. In addition, any issues or problems need to be reported to the Contracting Officer as soon as possible for prompt resolution.

5.6 Secure Patient Information

The internet is the fastest growing telecommunications medium in our history. However, the advantages provided by the Internet significantly increase the risk to the confidentiality and integrity of information. The very nature of the Internet communication mechanisms means that security risks cannot be totally eliminated.

HIPAA Privacy and Security Rules have been set forth to ensure confidentiality and security within the facility setting. Each IHS facility needs to develop limited, controlled access for those individuals who need to review clinical data, for example, by identifying authorized users and assigning passwords. Physical security is also a priority; for example, all data warehouses should be protected by state-of-the-art enterprise firewall and intrusion-detection software.

For detailed information related to Privacy and Security, go to this website:

http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm?module=security_standards

5.7 File Management

File management will vary at each facility, depending on whether RPMS Patient Care Component (PCC) or PCC+, superbill, or electronic health records are utilized. In addition, file management will vary, depending on whether the claim form was sent electronically or manually.

It is important to remember that filing patient-related information and/or insurance-related information must be done in a timely manner. A policy should be adopted and consistently followed throughout the facility.

Note: If the facility is ever audited for third party reimbursement, the filing system must be retrievable in a timely manner for the auditors.

Examples of the varied processes include the following:

- For RPMS PCC and PCC+ applications, and superbills; after the codes have been entered into RPMS, the originals are filed in the patient's medical record.
- For the electronic health record, all information related to the clinical visit and all associated codes are entered directly into the electronic medical; therefore, no hard copy is maintained.
- Copies of new patient chart registration forms, signature forms, secondary billing forms, contract health reports, copies of insurance cards, assignment of benefits forms, release of information forms, reference lab reports, external radiology reports, operative record, and other hard copy reports are filed in the patient's medical record.

Lab and x-ray reports are first read by the provider, initialed or signed, and then filed.

At some facilities copies of the insurance card are filed alphabetically in the business office.

- For claims filed electronically, no hard copies of the claim will be filed in the medical record.
- For claims filed manually, an original is forwarded to the insurance company and a copy is either placed in the patient's medical record or filed alphabetically in the business office.
- Copies of the explanation of benefits (EOB) or Remittance Advice (RA) should be filed by date of the EOB or RA in the business office. These reports should be filed immediately after all payment and adjustments have been credited to the appropriate patient account.

5.7.1 Retention of Billing/Financial Records

The *Indian Health Manual*, Part 5, Chapter 15, "Records Management Program," defines the rules on record retention for business office and electronic records management. For more information, go to this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chapt15/pt5chpt15.htm>

Note: Information in financial folders must be retained for at least **six (6) years**.

5.8 Consent/Signature Forms

5.8.1 Consent for Medical Treatment

The purpose of the Consent for Medical Treatment form is to secure a general consent from the patient or guardian to provide medical treatment. It should be obtained each and every time a patient receives service at your facility.

In addition to the general consent form, you may be required to have special consent forms signed for particular treatments.

Providers are permitted to treat patients in life-threatening situations without a consent form, but efforts should be made to obtain a signature as soon as possible.

5.8.2 Consent for Release of Information Signature

For information and guidelines on consent for release of information, see the *Indian Health Manual*, Part 3, Chapter 3, “Medical Records,” which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part3/pt3chapt3/pt3chpt3.htm>

5.8.3 Assignment of Benefits Form

The assignment of benefits signature informs the insurance company to make payment directly to your facility, rather than sending the insurance payment directly to the patient.

If you have a valid assignment of benefits signed and dated by the policyholder, you may have legal recourse if the insurance payment is sent to the patient in error. Because the patient signed over rights to you, you could pursue the insurance company for payment if they paid the patient by mistake.

The Indian Health Service has the right of recovery from insurers, as referenced in Section 206 of the Indian Health Care Improvement Act.

Who can sign the Assignment of Benefits Form:

To be valid, the assignment of benefits form must be signed by the person in whose name the insurance is issued (the policyholder), and must refer to a specific treatment period.

A spouse or next-of-kin may sign his or her name, but always attempt to secure the insured party's signature afterward.

If the insured is not available, do not have someone falsify the document by signing the insured's name.

If the patient refuses to sign the form, the Patient Registration staff should note on the signature line "Patient refuses to sign" with the date and employee initial.

5.9 Insurer Provider Numbers

To obtain reimbursement from insurers, each facility must obtain individual provider numbers from the respective Medicaid, Medicare, and Private Insurer payers. Potential providers considered for enrollment should include both full-time employed providers and contracted providers.

Each facility will decide who is responsible for the provider enrollment process.

5.9.1 Procedure for Enrolling Providers

The following procedure applies to clinical providers, such as physicians, licensed Physician Assistants (PA), nutritionists, Nurse Practitioners (NP), Nurse Specialists, as well as locum tenens contract providers.

Step 1: Send Enrollment Application to new staff member

1. When the notification of a newly detailed staff member (i.e., Provider) arrives from the Clinical Director's office.

Ensure that the provider is added to the RPMS system as a provider. The following fields are required:

- Last Name, First Name
- Initials
- Address information
- Provider Taxonomy Code

- Provider Class/Specialty
 - Affiliation Code
 - Social Security number
 - Current Licensure information
 - Signature field: first, last name; credential (located in the RPMS User's Toolbox option)
2. Pre-assemble Enrollment Applications and mail via inter-office mail.
 3. Prepare and label the Provider folder with the following information:
 - Full name
 - Department
 - Month/Year of employment
 4. Make copies of all documents and place them in the provider's folder.
 5. Insert the Provider name and department into the pre-established Provider List Log.

Step 2: Send the completed Enrollment Application to the payer

Note: Some states may require different color signatures to validate the authenticity of the signature – follow application instructions. Some applications for insurers may require additional signatures from an authorized/delegated official – follow application instructions.

1. When the completed enrollment application is returned, ensure the accuracy of all documents returned, including the provider's signature.
2. Make copies of all documents and place them in the provider's folder.
3. Address and attach required supporting documents for each provider, including, but not limited to,
 - Copies of all licensure information
 - Copies of Drug Enforcement Act (DEA) and Clinical Laboratory Improvement Act (CLIA)

Some insurers may also require a copy of the Federal Tort Claim Agreement, W-9, or signature of an authorized official.

4. Enclose, address, and mail each completed application to the respective insurers for your state – Medicaid, Medicare, and private insurers.

Step 3: Process the assigned Provider Number

1. When the confirmation letter arrives from the payer, enter each assigned number in the RPMS system.
2. Enter the new assigned number in the established Provider List Log.

5.9.2 Procedure for Removing a Provider

When notified that a provider is leaving IHS employment:

1. Upon notification of a provider's departure date, ensure that all medical records are completed and signed.
2. Identify, complete coding and enter the data into the system, and bill for any visits as soon as possible after the termination date.
3. Inactivate the provider in RPMS.
4. Notify insurance companies of the provider's termination date.

5.9.3 National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the **National Provider Identifier (NPI)** as this identifier.

The National Provider Identifier NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). Examples are:

- Individuals – physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists
- Organizations – hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, and others

Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify them when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. However, the application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes the provider to bill and be paid for services.

Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates, such as billing agencies, to prepare the transactions.

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

The Business Office manager should determine the implementation schedules for other health plans and obtain guidance as to whether these plans will require both the legacy numbers and NPIs.

5.9.4 Staged Medicare Implementation of NPIs

May 23, 2005 - January 2, 2006

- Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period.
- CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

January 3, 2006 -October 1, 2006

- Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim.
- Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
- CMS claims processing systems will reject, as nonprocessable, any claim that includes only an NPI.

October 2, 2006 - May 22, 2007

- CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

5.9.5 NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, it will be important to apply for their NPI *before* the compliance date of May 2007 because health plans could require the provider to use their NPI before that date.

There are three ways to apply for the NPI, using the **National Plan & Provider Enumeration System (NPPES)**:

1. An easy-to-use Web-based application process, beginning May 23, 2005, available at this website: <https://nppes.cms.hhs.gov>
2. Beginning July 1, 2005, a paper application can be completed and sent to the Enumerator. A copy of the application, including the Enumerator's mailing address (where the provider will send it) will be available at this website: <https://nppes.cms.hhs.gov>

Or the provider can call the Enumerator to receive a copy:

1-800-465-3203
(TTY) 1-800-692-2326

3. An organization, with the approval of the provider, may submit the provider's application in an electronic file. This could mean that a professional association, or perhaps a health care provider or facility who is the provider's employer, could submit an electronic file containing the provider's information and the information of other health care providers.

Only one of these methods can be used to apply for an NPI.

When gathering information for the provider's application, be sure that all of provider's information, such as social security number and the Federal Employer Identification Number are correct. Once the provider receives the NPI, he/she must safeguard its use.

If all information is complete and accurate, the Web-based process could result in provider being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

It is important to note that a provider need only apply for and acquire *one* NPI. This unique NPI will be used for all standard transactions, Medicare and non-Medicare. Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions such as claims.

5.9.6 Using Electronic File Interchange (EFI) to Process NPI Applications

Electronic File Interchange (EFI), formerly known as Bulk Enumeration, is the mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file.

Steps for using EFI

Once EFI is available, the entities will follow these steps:

1. An organization that is interested in being an EFI organization will go to the NPPES website, <https://nppes.cms.hhs.gov>, log on to an EFI home page, and download a certification form.
2. The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
3. Once notified of approval as an EFIO, the entity will send files containing NPI application data in a specified format to the NPPES.
4. Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
5. Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
6. The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s).

An EFIO may also be used for updates and deactivations, if the providers agree to do so.