Part 1

Administrative Roles and Responsibilities

Version 1.0
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Department of Health & Human Services
Indian Health Service
Business Office
# Part 1. Administrative Roles and Responsibilities

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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 Revenue Operations Manual Contents

The Revenue Operations Manual is divided into the following five (5) parts:

• **Part 1 Administrative Roles and Responsibilities** contains
  – Overview of revenue operations
  – Laws, acts, and regulations affecting health care
  – IHS laws, regulations, and policies
  – Health Insurance Portability and Accountability Act Privacy Rule
  – Business Office management and staff
  – Business Office Quality Process Improvement and Compliance

• **Part 2 Patient Registration** contains:
  – Overview of patient registration
  – Patient eligibility, rights, and grievances
  – Direct care and contract health services
  – Third-party coverage
  – Registration, discharge, and transfer
  – Scheduling appointments
  – Benefit coordinator

• **Part 3 Coding** contains:
  – Overview of coding
  – Medical record documentation
  – Coding guidelines
  – Data entry

• **Part 4 Billing** contains:
  – Overview of billing
  – Hard copy vs. electronic claims processing
  – Billing Medicare, Medicaid, and private insurance
  – Third party liability billing
  – Billing private dental insurance and Pharmacy
  – Secondary billing process
• **Part 5 Accounts Management** contains:
  – Overview of accounts management
  – Electronic deposits and Remittance Advices
  – Processing zero pays, payments, and adjustments
  – Creating payment batches
  – Reconciliation of credit/negative balances
  – Collections and collection strategies
  – Rejections and appeals

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.

This manual also includes:
• Acronym dictionary
• Glossary

### 1.1.4 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for downloading, viewing, and printing at this website:


### 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.
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
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 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 (AAAHC), 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
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.

![Revenue Cycle Diagram]

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.
2. Laws, Acts, and Regulations Affecting Health Care

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2.1 Privacy Act (1974)

The Privacy Act of 1974 is a code of fair information practices which mandates how Government agencies, such as the Indian Health Service (IHS), shall maintain records about individuals. The Privacy Act requires that Government agencies:

- collect only information that is relevant, accurate, complete, and necessary to carry out an agency function;
- maintain no secret records on individuals;
- explain at the time the information is being collected, why it is needed and how it will be used;
- ensure that the records are used only for the reasons given, or seek the person's permission when another purpose for their use is considered necessary or desirable;
- provide adequate safeguards to protect the records from unauthorized access and disclosure;
- Allow individuals to see the records kept on them and provide them with the opportunity to correct inaccuracies in their records.

The Privacy Act only applies to Government records that contain information on individuals, are maintained by a Government agency or its contractors in an approved system of records, and are retrieved by a personal identifier, such as a person's name, Social Security Number, medical record number or other unique identifier.

2.2 Health Insurance Portability and Accountability Act (1996)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) amends the Internal Revenue Code of 1986 and is designed to

- Improve portability and continuity of health insurance coverage in the group and individual markets.
- Combat waste, fraud, and abuse in health insurance and health care delivery.
- Promote the use of medical savings accounts.
• Improve access to long-term care services and coverage.
• Simplify the administration of health insurance, and for other purposes.

It is the purpose of this subtitle to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

**Standards for Electronic Health Information Transactions**

The Secretary of Health and Human Services (HHS) is required to adopt standards from among those already approved by private standards developing organizations for certain electronic health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. These standards also must address the security of electronic health information systems.

**Mandate on Providers and Health Plans**

Providers and health plans are required to use the standards for the specified electronic transactions. Plans and providers may comply directly, or may use a health care clearinghouse. Certain health plans, in particular workers compensation, are not covered.

**Privacy**

Privacy standards must be enacted.

**Pre-Eemption of State Law**

The bill supersedes state laws, except where the Secretary determines that the State law is necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance or health plans, addresses controlled substances, or for other purposes. If the Secretary promulgates privacy regulations, those regulations do not pre-empt state laws that impose more stringent requirements. These provisions do not limit a State's ability to require health plan reporting or audits.

**Penalties**

The bill imposes civil money penalties and prison for certain violations.
2.3 Privacy Rule

Privacy regulations are designed to protect individually identifiable health care information during the transfer, storage, release, and destruction of that information. All medical records and other individual identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the final Privacy Rule.

Under the Privacy Rule, patients will have significant new rights to understand and control how their health information is used.

- **Patient education on privacy protections.** Providers and health plans will be required to give patients a clear written explanation of how the covered entity may use and disclose their health information.

- **Ensuring patient access to their medical records.** Patients will be able to see and get copies of their records and request amendments. In addition, a history of non-routine disclosures must be made accessible to patients.

- **Receiving patient consent information is released.** Health care providers who see patients will be required to obtain patient consent before sharing their information for treatment, payment, and health care operations. In addition, separate patient authorization must be obtained for non-routine disclosures and most non-health care purposes.

Patients will have the right to request restrictions on the uses and disclosures of their information. As part of this process, providers and facilities will need to create controls for staff, as well as their business partners (such as outsourced billing companies or clearing houses), and keep track of the various requests for information.

- **Providing recourse if privacy protections are violated.** People will have the right to file a formal complaint with a covered provider or health plan, or with the Department of Health and Humans Services, about violations of the provisions of this rule or the policies and procedures of the covered entity.

With few exceptions, such as appropriate law enforcement needs, an individual’s health information may only be used for health purposes.

- **Ensuring that health information is not used for non-health purposes.** Health information covered by the rule generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions or to financial institutions – without explicit authorization from the individual.
• **Providing the minimum amount of information necessary.** In general, disclosures of information will be limited to the minimum necessary for the purpose of the disclosure. However, this provision does not apply to the disclosure of medical records for treatment purposes because physicians and other providers need access to the full record to provide quality of care.

The final rule establishes the privacy safeguard standards that covered facilities must meet, but it gives these same facilities the flexibility to design their own policies and procedures to meet those standards. Covered facilities will have to:

• **Adopt written privacy procedures.** These include who has access to protected information, how it will be used within the entity, and when the information may be disclosed. Covered entities will also need to take steps to ensure that their business associates protect the privacy of health information.

• **Train employees and designate a privacy officer.** Covered entities will need to train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.

With the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress provided penalties for covered entities that misuse personal health information from the medical record. They include:

• **Civil penalties.** Health plans, providers, and clearing houses that violate these standards will be subject to civil liability. Civil money penalties are $100 per violation, up to $25,000 per person, per year for each requirement or prohibition violated.

• **Federal criminal penalties.** Under HIPAA, Congress also established criminal penalties for knowingly violating patient privacy. Criminal penalties are up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to 10 years in prison for obtaining protected health information under “false pretenses”; and up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.
The final privacy rule permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include:

- Emergency circumstances
- Identification of the body of a deceased person or the cause of death
- Public health needs
- Research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board
- Oversight of the health care system
- Judicial and administrative proceedings
- Limited law enforcement activities
- Activities related to national defense and security

Psychotherapy notes (used only by a psychotherapist) are held to a higher standard of protection because they are not part of the medical record and never intended to be shared with anyone else. All other personal health information is considered to be sensitive and protected consistently under this rule.

As required by HIPAA law itself, stronger state laws (like those covering mental health, HIV infection, and AIDS information) continue to apply. These confidentiality protections are cumulative; the final rule will set a national “floor” of privacy standards that protect everyone.

Many of the Indian facilities are reviewed by the Joint Commission standards which do include survey questions related to security. However, while compliance with the Joint Commission standards is a good start, facilities still have a lot of work to do to be in full compliance with the information security standards outlined in the HIPAA regulations.

HIPAA is a springboard for the health care industry to enter the world of e-commerce. With proper security measures (encryption, certificates of authority and private key infrastructure, to name a few, clinical and financial information may be exchanged safely via the Internet in real time.

For a discussion on the impact of the Privacy Rule on Business Office operations, see Part 1, Chapter 4, “Health Insurance Portability and Accountability Act Privacy Rule.”
2.4 Patient Self-Determination Act

The Patient Self-Determination Act has had a major impact on hospital and health care providers because it establishes guidelines that require the maintenance of written policies and procedures governing patients’ rights to make health care decisions and the obligation of health care providers to communicate this information as well as other related information to their adult patients.

This includes the patient’s right to accept or refuse medical or surgical treatment, as well as the patient’s right to make advance directives. The law defines an advance directive as a written instruction, such as a Living Will or a Durable Power of Attorney for health care, related to the provision of health care when the patient is incapacitated. Providers will also be required to provide adult patients with written policies respecting their patient rights.

2.5 False Claims Act

The False Claims Act imposes liability on those who:

- Knowingly present or cause to be presented a false or fraudulent claim for payment to the U.S. government
- Knowingly use a false record or statement to obtain payment on a false or fraudulent claim paid by the U.S. government
- Engage in a conspiracy to defraud the U.S. government to obtain allowance for or payment of a false or fraudulent claim

The False Claim Act defines “knowing” or “knowingly” as having actual knowledge of the falsity of the claim, acting in deliberate ignorance of the truth or the falsity of the claim, or acting in reckless disregard of the truth or falsity of the claim.

The Act prescribes civil monetary penalties for violation from $5,000 to $10,000 per claim or higher. The statute of limitations for a False Claims Act action is six years; however, there is a “discovery rule” that may be tallied three years from the point at which the government or realtor knew or should have known of the alleged fraud.
2.6 Emergency Medical Treatment and Active Labor Act (EMTALA)

Originally enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Emergency Medical Treatment and Active Labor Act (EMTALA) specifically prohibits hospitals and emergency medical departments from refusing to treat individuals with unstable emergency medical conditions, and prohibits inappropriate transfer of those individuals.

COBRA was amended in both 1988 and 1989 to include more stringent provisions regarding on-call physicians in general and more specifically, the practice of obstetrics.

For IHS compliance requirements related to this Act, see Section 3.4.2, “Emergency Medical Treatment and Active Labor Act (EMTALA),”

2.7 Balanced Budget Act (1997)

The Balanced Budget Act of 1997 (BBA) focuses on reducing payments to hospitals and providers over the forthcoming years. Some of the reductions are:

- Reduced rates of increase for health care facility payments
- Reductions to PPS capital payments
- Elimination of medical education and disproportionate share factors in computing health care facility outlier payments
- Reductions in the indirect medical education payment factor
- Decreased payment for certain health care facility discharges that will now be deemed to be transfers
- A reduction in the amount paid by Medicare for beneficiary-incurred bad debts.
- Increased Medicare Part B payment

Highlights of changes that have occurred:

- Patient selection of choosing either a fee-for-service program or a Medicare-Choice Plan that include coordinated care plans from Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and insurance plans operated in conjunction with Medical Savings Accounts (MSAs)
- Co-payment changes from 20% of charges to 20% of payment
- A hospital outpatient Prospective Payment System (PPS)
- Having home health plans submit claims based on the location of where the service was performed versus where the plan is located.
- Fraud and abuse regulations, controls, and penalties

2.8 Federal Medical Care Recovery Act (FMCRA)

Sec. 2651. Recovery by United States

(a) Conditions; exceptions; persons liable; amount of recovery; subrogation; assignment

In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) to a person who is injured or suffers a disease, after the effective date of this Act, under circumstances creating a tort liability upon some third person to pay damages, therefore, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person, or that person’s insurer, the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for and shall as to this right be subrogated to any right or claim that the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors has against such third person to the extent of the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for. The head of the department or agency of the United States furnishing such care or treatment may also require the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, as appropriate, to assign his claim or cause of action against the third person to the extent of that right or claim.

(b) Recovery of cost of pay for member of uniformed services unable to perform duties

If a member of the uniformed services is injured, or contracts a disease, under circumstances creating a tort liability upon a third person for damages for such injury or disease and the member is unable to perform the member’s regular military duties as a result of the injury or disease, the United States shall have a right (independent of the rights of the member) to recover from the third person or an insurer of the third person, or both, the amount equal to the total amount of the pay that accrues and is to accrue to the member for the period for which the member is unable to perform such duties as a result of the injury or disease and is not assigned to perform other military duties.
(c) United States deemed third party beneficiary under alternative system of compensation

(1) If, pursuant to the laws of a State that are applicable in a case of a member of the uniformed services who is injured or contracts a disease as a result of tortuous conduct of a third person, there is in effect for such a case (as a substitute or alternative for compensation for damages through tort liability) a system of compensation or reimbursement for expenses of hospital, medical, surgical, or dental care and treatment or for lost pay pursuant to a policy of insurance, contract, medical or hospital service agreement, or similar arrangement, the United States shall be deemed to be a third-party beneficiary of such a policy, contract, agreement or arrangement.

(2) For the purposes of paragraph (1) -

(A) The expenses incurred or to be incurred by the United States for care and treatment for an injured or diseased member shall be deemed to have been incurred by the member.

(B) The cost to the United States of the pay of the member shall be deemed to have been pay lost by the member as a result of the injury or disease, and

(C) The United States shall be subrogated to any right or claim that the injured or diseased member or the member’s guardian, personal representative, estate, dependents, or survivors have under a policy, contract, agreement, or arrangement

(d) Enforcement procedure; intervention; joinder of parties; State or Federal court proceedings

The United States may intervene or join in any action or proceeding brought by the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment of reimbursement of the medical expenses or lost pay. If such action or proceeding is not commenced within six months after the first day in which care and treatment is furnished or paid for by the United States in connection with the injury or disease involved, institute and prosecute legal proceedings against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment or reimbursement of medical expenses or lost pay, in a State or Federal court, either alone or in conjunction with the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors.
(e) Veterans' exception

The provisions of this section shall not apply with respect to hospital, medical, surgical, or dental care and treatment furnished by the Department of Veterans Affairs to an eligible veteran for a service-connected disability.

(f) Crediting of amounts recovered

(1) Any amount recovered under this section for medical care and related services furnished by a military medical treatment facility or similar military activity shall be credited to the appropriation or appropriations supporting the operation of that facility or activity, as determined under regulations prescribed by the Secretary of Defense.

(2) Any amount recovered under this section for the cost to the United States of pay of an injured or diseased member of the uniformed services shall be credited to the appropriation that supports the operation of the command, activity, or other unit to which the member was assigned at the time of the injury or illness, as determined under regulations prescribed by the Secretary concerned.

2.9 Administrative Simplification Compliance Act

Signed into law on December 27, 2001 as Public Law 107-105, the Administrative Simplification Compliance Act provides a one-year extension to HIPAA “covered entities” to meet HIPAA electronic and code set transaction requirements. Also, this Act allows the Secretary of HHS to exclude providers from Medicare if they are not compliant with the HIPAA electronic and code set transaction requirements and to prohibit Medicare payment of paper claims received after October 16, 2003, except under certain situations.
2.10 **Indian Health Care Improvement Act Reauthorization (2001)**

Congress makes the following findings:

1. Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the Constitution, treaties, Federal laws, and the course of dealings of the United States with Indian Tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

2. From the time of European occupation and colonization through the 20th century, the policies and practices of the United States caused or contributed to the severe health conditions of Indians.

3. Indian Tribes have, through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

4. The population growth of the Indian people that began in the later part of the 20th century increases the need for Federal health care services.

5. A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than that of the general population, and to provide for the maximum participation of Indian Tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

6. Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

7. Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.
(8) The disparity in health status that is to be addressed is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

2.10.1 Declaration of Health Objectives

Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people, to

(1) Assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

(2) Raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto;

(3) Raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto, to permit Indian Tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

(4) Increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each geographic service area is raised to at least the level of that of the general population;

(5) Require meaningful, active consultation with Indian Tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination, and

(6) Provide funds for health care programs and facilities operated by Tribes and tribal organizations in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.
2.11 Access to Medical Treatment Act (2001)

The Access to Medical Treatment Act of 2001 states that a patient may receive and a health care practitioner may provide or administer any unapproved drug or medical device that the patient desires or the legal representative of the patient authorizes if:

- Such practitioner has personally examined such patient and agrees to treat such patient.
- The unapproved drug or medical device is recommended by a health care practitioner within that practitioner’s scope of practice under State law.
- The provision or administration of the unapproved drug or medical device is not a violation of the laws of the State or State in which the activity is carried out.
- The health care practitioner abides by all of the requirements set forth in the following section.

2.11.1 Requirements

A health care practitioner may recommend, provide, or administer any unapproved drug or medical device for a patient, if the practitioner:

- Does not violate Federal or State law by providing or administering the unapproved drug or medical device.
- Does not violate the Controlled Substances Act by recommending, providing or administering the unapproved drug.
- Has concluded based on generally accepted principles and current information that the unapproved drug or medical device, when used as directed, will not cause a danger to the patient.
- Provides the recommendation under circumstances that give the patient sufficient opportunity to consider whether or not to use such a drug or medical device and that minimize the possibility of coercion or undue influence by the health care practitioner.
- Discloses to the patient any financial interest that such a practitioner may have in the drug or medical device.
Has informed the patient in writing, prior to recommending, providing, or administering the unapproved drug or medical device

- That the unapproved drug or medical device is not approved by the Secretary as safe and effective for the condition of the patient and is considered experimental.
- Of the foreseeable risks and benefits of the unapproved drug or medical device, including any risk to an embryo or fetus, and expected possible side effects of discomforts that the patient may experience and any medical treatment available if side effects occur.
- Of any appropriate alternative procedures or courses of treatment (including procedures or courses of treatment that may involve the use of a drug or medical device that has been approved by the Food and Drug Administration), if any, that may be advantageous for the patient’s condition.
- Of any interactions the unapproved drug or medical device may have with other drugs, if any.
- Of the active and inactive ingredients of the unapproved drug and the mechanism of action of the medical device, if known.
- Of the health condition for which the unapproved drug or medical device is provided, the method of administration that will be used and the unit does.
- Of the procedures that will be employed by the health care practitioner in using such a drug or medical device.
- Of the extent, if any, to which confidentiality of records identifying the patient will be maintained.
- For use of such a drug or medical device involving more than minimal risk, of the treatments available if injury occurs, what such treatments involve, and where additional information regarding such treatments may be obtained.
- Of any anticipated circumstances under which the patient’s use of such a drug or medical device may be terminated by the health care practitioner without regard to the patient’s consent.
- That the use of such a drug or medical device is voluntary and that the patient may suspend or terminate treatment at any time.
- Of the consequences of patient’s decision to withdraw from the use of such a drug or medical device.
- Of any information that cannot be provided by the health care practitioner because such information is not known at the time the practitioner provides or administers such drug or medical device.
- Of any other information or disclosures required by applicable State law for the administration of experimental drugs or medical devices to human subjects.
• Has not made any advertising claims for the unapproved drug or medical device.
• Does not impose a charge for the unapproved drug or medical device in excess of costs.
• Complies with requirements for reporting a danger.
• Has received a signed affidavit from the patient or the patient’s legal representative confirming that the patient or legal representative has received the written information and understands it, and desires treatment with the unapproved drug or medical device.

If a health care practitioner discovers that an unapproved drug or medical device causes a danger to a patient, the practitioner shall immediately cease use and recommendation of the unapproved drug or medical device, and provide to the manufacturer of the unapproved drug or medical device and the Director of the Centers for Disease Control and Prevention, a written evaluation of the adverse reaction.

2.12 Medically Underserved Access to Care Act (2001)

Several of the findings noted under the Medically Underserved Access to Care Act of 2001 include:

• Minority individuals living in medically underserved areas are generally socio-economically less well off and are often sicker than the population traditionally served by managed care organizations.
• Many managed care organizations are not equipped to deal effectively with minorities in underserved areas and consequently may offer lower quality health care in such areas.
• Often managed care organizations do not contract with physicians and other community-based service providers who traditionally serve medically underserved areas.
• There is a concern among minority physicians that selective marketing practices and referral processes may keep minority and community-based physicians out of some managed care organizations.
• Managed care organization sometimes exclude physicians and other community-based health care providers who traditionally provide service to the underserved areas; this is particularly the case among minority physicians who may be well established in their community based practices but are not board certified.
A managed care organization offering a managed care plan shall establish and maintain adequate arrangements, as defined under regulations of the Secretary, with a sufficient number, mix, and distribution of health care professionals and providers to assure that covered items and services are available and accessible to each enrollee under the plan –

- in the service area of the organization,
- in a variety of sites of service,
- with reasonable promptness (including reasonable hours of operation and after-hours services),
- with reasonable proximity to the residences and workplaces of enrollees, and
- takes into account the diverse needs of the enrollees and reasonably assures continuity of care.

2.13 Drug Availability and Health Care Access Improvement Act (2001)

The Drug Availability and Health Care Access Improvement Act of 2001 provides the availability of prescribed drugs (in the same amount, duration, and scope as for all other patients) to medical assistance patients, and to individuals who would be qualified Medicare beneficiaries but for the fact that their income exceeds the income level established by the State but is less than 175% of the official poverty line for a family of the same size.

With respect to an individual whose income exceeds 135% of the official poverty line, the State plan shall provide for charging of a premium according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments, as the individual’s income increases from 135% of such poverty line to 175% of such poverty line.

A State shall not require prepayment of a premium imposed and shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

Several of the findings related to the Health Care Antitrust Improvements Acts of 2002 are:

- The market power of insurance companies increased tremendously since the early 1990’s. This unprecedented consolidation has provided health plans with significant leverage over health care professionals and patients in determining the scope, coverage, and quality of health care in this country.

- Due to the concentration and exertion of market and economic power, health plans systematically and improperly manipulate the practice of medicine through such mechanisms as inappropriately making medical necessity determinations, down-coding and bundling, knowingly denying and delaying payment, and engaging in a variety of practices that may affect the continuity and quality of patient care.

- The intent of the antitrust laws is to encourage competition and protect the consumer and the current per se standard for enforcing the antitrust laws in the health care field frequently does not achieve these objectives.

- An application of the rule of reason to health care professionals’ business activities and interactions with health care plans will tend to promote both competition and high-quality patient care.

In any action under the antitrust laws challenging the efforts of two or more physicians or other health care professionals to negotiate with a health plan, the conduct of such physicians or health care professionals shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including patient access to health care, the quality of health care received by patients, and contract terms or proposed contract terms.

Any party to a health care cooperative venture that intends, or has begun to negotiate with a health plan may file with the Attorney General of the United States a written notification disclosing:

- The identities of the parties to such venture, and the name and address of each agent representing such venture

- The identity of each health plan with which such venture is or may be negotiating

- The general nature and objectives of the negotiations
The Attorney General, in accordance with the recommendations of the advisory committee, under which health care professionals in the States designated as demonstration project sites may act together to jointly negotiate contracts and agreements with health plans to provide health care items and services for which benefits are provided under such health plans. The Demonstration Projects shall be established for the purpose of testing various options in the health care market to allow negotiations and agreements by health care professionals that will enhance efficiency, quality, and availability of health care, while promoting competition in the health care market.
3. IHS Laws, Regulations, and Policies

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3.1 Overview of IHS Laws, Regulations, and Policies

This section covers three major topics:

(1) A summary of important laws that provide basic program legislative authority and appropriations to IHS.

(2) The legislative authority for IHS to bill Medicare, Medicaid and receive reimbursements.

(3) A list of laws and regulatory requirements that provide an overview of laws and penalties for improperly billing third-party payers for services provided to American Indians (AI) and/or beneficiaries.

Each facility should have a compliance plan adopted by the Governing Board, which outlines how the facility complies with the rules and regulation of Medicare and Medicaid and other third party payers.

For more information go to this website: http://oig.hhs.gov

3.2 IHS Legislative Program Authority

3.2.1 The Snyder Act

Public Law 67

This Act provides the broad legal basis for Federal expenditure of funds for health care for federally recognized Tribes, “for the relief of distress and conservation of health”. It provides legislative authorization for the Federal Health Program for American Indians and Alaska Natives, and is cited every year in the IHS budget appropriation. In order for Congress to appropriate or spend money, it must have legislative authority.

3.2.2 Transfer Act

Public Law 83-568
83rd Congress, August 5, 1954 (U.S.C. 444-449)

This act transferred the Indian Health Programs from the Department of Interior to the Department of Health, Education, and Welfare, effective July 1, 1955.
3.2.3 **Public Law 86-121**

86th Congress, July 31, 1959  

This Act Amends P.L. 83-568, Transfer Act, to authorize the provisions of water and waste disposal facilities to Indian homes, lands, and communities. These activities are provided through the Office of Environmental Health and Sanitation of the IHS.

3.2.4 **Indian Self-Determination and Education Assistance Act**

Public Law 93-638  
93rd Congress, January 4, 1975  
(88 Stat. 2203-2217)

This act:

- Authorizes the Secretary of HEW (now HHS) to enter into PL 93-638 contracts and grants with Indian Tribes and Tribal Organizations for the purpose of enabling such Tribes and Tribal Organizations to carry out any or all of the Secretary’s functions, authorities and responsibilities.

- Provides for the full participation of Indian Tribes in programs and services conducted by the Federal Government for Indians and to encourage the development of human resources of the American Indians and Alaska Natives

- Establishes a program of assistance to upgrade Indian education to support the rights of Indian Citizens to control their own educational activities, health activities, and for other purposes

3.2.5 **Public Law 102-184**


This law authorizes the Indian Health Service to undertake a study on the feasibility of including health care programs operated by the IHS under the authority of Tribal Self-governance.
3.2.6 Public Law 102-573


This law amends the

- Indian Health Care Improvement Act, P.L. 94-437, reauthorizing it through fiscal year 2000, adding programs and providing specific programs and administrative guidance in certain programs and activities.
- Indian Self-Determination and Education Assistance Act, P.L 93-638, by extending Title III authority (Self Governance), for a Tribal Self-Governance Demonstration Project by IHS.

3.2.7 Tribal Self-Governance Amendments of 2000

Public Law 106-260 August 18, 2000 (114 Stat. 711)

These amendments include the establishment of

- Title V of the Indian Self-Determination Education and Assistance Act to make Self-Governance permanent within IHS
- Title VI to study the feasibility of expanding self-governance to non-IHS programs and activities within the Department of Health and Human Services

3.3 Billing and Collection Authority

This section covers laws associated with billing and collections of third-party revenue for the IHS.

3.3.1 Indian Health Care Improvement Act (IHCIA)

Public Law 94-437

The Indian Health Care Improvement Act (IHCIA) implements the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian Health Programs and encouraging maximum participation of Indians in these programs.

IHCIA includes nine major Titles that strengthen health care to American Indian (AI) and Alaskan Native (AN) people.
Title IV, Access to Health Services, covers the basic authorities for collection of third party revenue in the IHS. It also includes copies of amendments to Title XVIII, Medicare and Title XIX, Medicaid, and the legal Authority for billing Medicare and Medicaid.

Title II, Section 206, covers the right of IHS to recovery from third party payers to the same extent that non-governmental providers of services would be eligible to receive reimbursement.

§ 1621e. Reimbursement from certain third parties of costs of health services (Release date: 2004-09-20)

(a) Right of recovery

Except as provided in subsection (f) of this section, the United States, an Indian tribe, or a tribal organization shall have the right to recover the reasonable expenses incurred by the Secretary, an Indian tribe, or a tribal organization in providing health services, through the Service, an Indian tribe, or a tribal organization, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses, if

(1) such services had been provided by a nongovernmental provider, and
(2) such individual had been required to pay such expenses and did pay such expenses.

(b) Recovery against State with workers’ compensation laws or no-fault automobile accident insurance program

Subsection (a) of this section shall provide a right of recovery against any State only if the injury, illness, or disability for which health services were provided is covered under

(1) worker’s compensation laws, or
(2) a no-fault automobile accident insurance plan or program.

(c) Prohibition of State law or contract provision impeding right of recovery

No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or a tribal organization under subsection (a) of this section.
(d) **Right to damages**

No action taken by the United States, an Indian tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) of this section shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

(e) **Intervention or separate civil action**

The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) of this section by

1. intervening or joining in any civil action or proceeding brought
   
   (A) by the individual for whom health services were provided by the Secretary, an Indian tribe, or a tribal organization, or
   
   (B) by any representative or heirs of such individual, or

2. instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian tribe, or a tribal organization to institute a separate civil action.

(f) **Right of recovery for services when self-insurance plan provides coverage**

The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.

3.3.2 **Public Law 100-713**

100th Congress – November 23, 1988
(U.S.C. 1601) (102 Stat. 4784)

This Law

- Reauthorized the Indian Health Care Improvement Act (IHCIA) and modified and/or expanded some of the 1976 IHCIA provisions.

- Established the Indian Health Service as an Agency of the Public Health Service.
3.3.3 IHS Medicare and Medicaid Third Party Revenue Legal Authorities

In 1976, Congress enacted Title IV of the Indian Health Care Improvement Act (IHCIA) and amended Title XVIII, Medicare, and Title XIX, Medicaid, of the Social Security Act (SSA), allowing IHS to bill for medical services provided by IHS facilities to Indians eligible for Medicare or Medicaid.

From 1976 to 2001, the authority to receive Medicare reimbursements was limited to Medicare services provided in an IHS hospital or skilled nursing home. Today, IHS has full authority to bill Medicare for all covered services (excluding home health care, as covered in various amendments to existing authority.

Congress requires that Medicare and Medicaid reimbursements be placed in a special fund, to be used for the specific purpose of improving IHS facilities to meet the standards set out in the Medicare and Medicaid programs, including facility costs.

In order not to burden States with additional Medicaid expenditures, Congress provided 100% Federal reimbursement to States for reimbursements for services provided through an IHS facility to eligible Indian beneficiaries. [1905(b) of the SSA]

3.3.4 Tribal Reimbursement

Tribal reimbursement as facilities of IHS

By Memorandum of Agreement (MOA) between the Indian Health Service (IHS) and the Center for Medicare and Medicaid Services (CMS) the 100% Federal reimbursement to States was expanded to include Medicaid covered services provided to Indian beneficiaries in 638 tribally operated programs. This MOA also allows these tribal operated programs to elect to receive Medicaid reimbursements at the all-inclusive rate published annually by IHS in the Federal Register.
Tribal reimbursement as Federally Qualified Health Centers

As stated in the Public Health Service Act, Sec 330, tribes and tribal organizations and urban Indian programs have the option to receive Medicaid and Medicare reimbursements as Federally Qualified Health Centers (FQHCs) or as other Medicare or Medicaid provider types, if they qualify (e.g., home health, physician, clinic, nursing home, etc.).

Note: IHS is not eligible for FQHC status, because it is a Federal facility.

3.3.5 State Children’s Health Insurance Program (SCHIP)

Congress established the State Children’s Health Insurance Program (SCHIP) by creating Title XXI of the SSA as part of the Balance Budget Act of 1997.

SCHIP is designed to provide health insurance coverage to children who are not otherwise eligible for Medicaid or not covered by an employer sponsored health insurance plan.

- States can implement SCHIP by expanding their Medicaid program or by a separate program, such as through private insurance coverage.
- IHS utilizes its existing Medicaid and private insurance collection reimbursement authorities to receive reimbursements for SCHIP-covered provided services.

In January, 2001, the Department of Health and Human Services (HHS) published SCHIP regulations (42 CFR Parts 431, 433, 435, 436, and 457); where. 42 CFR 457.530 exempts AI/AN children from cost-sharing requirements under SCHIP.

In the preamble, HHS explained that the SCHIP statute imposes an affirmative obligation to address barriers to AI/AN enrollment and exempted AI/AN children from cost-sharing requirements because it determined cost-sharing acts as a barrier to AI/AN enrollment in SCHIP.

3.3.6 Tribal Direct Reimbursement

On November 1, 2000, Congress enacted the Alaska Native and American Indian Direct Reimbursement Act, amending Section 405 of the Indian Health Care Improvement Act (IHCIA). Prior to enactment, only four tribes were authorized to participate in the section 405 demonstration program and receive Medicare and Medicaid reimbursement directly.
This Act makes Section 405 permanent and authorizes tribal programs that operate IHS owned or leased facilities to receive reimbursements for Medicare and Medicaid directly without having the funds flow through the special fund.

### 3.3.7 Benefit Improvement and Protection Act (BIPA)

On December 15, 2000, Congress enacted Section 432 of the Medicare, Medicaid, and SCHIP **Benefits Improvement and Protection Act (BIPA)**. This law authorizes hospitals and ambulatory care facilities that are operated by the IHS or tribes to bill for Medicare Part B physician services and other services (nurse practitioners, physician assistants, etc.) that are reimbursable under the Medicare Physician Fee schedule.

### 3.4 Statutory Bases of Liability-Fraud and Abuse

The following citations cover requirements related to proper coding and billing for services, and penalties for not complying with the rules and regulations of third-party payers.

#### Note:
The key principle is “knownly,” or intentionally, engaging in these activities.

### 3.4.1 Federal Criminal and Civil Provisions


1. **Prohibition of False Claims**

False or Improper Claims (42 V.S.C. § 1320a-7a)

(a) I-civil money penalties of up to $10,000 per item or service, plus an assessment of up to three times the amount claimed for each such item or service, may be imposed upon any person who presents or causes to be presented a claim for reimbursement from Medicare, Medicaid, or other “federal health care programs” that:

- Knowingly and willfully making or causing to be made any false statement or representation of material fact in any claim or application for benefits under Medicare or Medicaid.

Examples of prohibited conduct:
- Billing for services not rendered.
- Misrepresenting the services actually rendered.
• Falsely certifying that certain services were medically necessary.
• Presenting or causing to be presented a claim for physicians' services, knowing that the individual who furnished the services was not a licensed physician.

2. Prohibition of False Statements

Knowingly and willfully making or causing to be made, or inducing or causing to be induced, the making of any false statements of material facts with regard to an institution's compliance with conditions of participation for the purposes of certification.

3. Intent Standard

For the statute to be violated, the individual must have known the claims were false at the time he was making the claims (United States v. Laughlin, 26 F.3d 1523 (10th Cir. 1994))

4. Penalties

The offenses described above are felonies punishable by up to five years imprisonment, and/or $25,000 in fines.


1. Civil False Claims Act

Prohibited Conduct

(1) The knowing filing of a false or fraudulent claim for payment to the United States,

(2) The knowing use of a false record or statement to obtain payment on a false or fraudulent claim,

or

(3) The conspiracy to defraud the United States by getting a false or fraudulent claim allowed or paid.
3.4.2 Emergency Medical Treatment and Active Labor Act (EMTALA)

IHS must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), as follows.

IHS facilities:

- Hospitals are responsible for ensuring that any physician, including on-call physicians, respond within a reasonable period of time.
- Hospitals must have policies and procedures in place to handle particular specialty conditions beyond the capabilities of the Emergency Room (ER) physician.
- A central log must be maintained on each individual who comes to the ER seeking emergency medical treatment. The log should track the care provided to the individual.

Medicare hospitals:

- If an individual comes to the Emergency Room (ER) and a request is made by that individual or his or her representative for examination or treatment of a medical condition by qualified hospital personnel, the hospital must provide an appropriate Medical Screening Examination (MSE) within the capability of the ER to determine if an emergency condition exists.
- Every individual coming to the ER must be provided an MSE beyond initial triage. Triage is not the equivalent to an MSE.
- The MSE must be the same MSE that the hospital would perform on any individual with similar signs and symptoms, regardless of their ability to pay.
- The hospital must provide stabilizing care, such that the patient’s condition would not deteriorate.
- The hospital may transfer patients only for services or care not available in that hospital.
- The facility must obtain a written informed refusal of medical exam, treatment, and/or transfer from the patient or patient family.
- The facility must report any “suspect” transfer, which occurs when a recipient hospital has reason to believe it may have received an individual who was transferred in an unstable emergency medical condition from another facility.
3.4.3 “Prompt Pay” Statutes and Regulations

The Prompt Payment Final Rule (5 CFR Part 1315) requires Executive departments and agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late.

On June 17, 1998, the Office of Management and Budget (OMB) requested comment on proposed revisions to the OMB Circular A-125, “Prompt Payment.” The Circular was revised to reflect the increased use of electronic commerce in the Federal government and the private sector, and to reflect the requirements of the Debt Collection Improvement Act (DCIA) of 1996. OMB issued final revisions to Circular A-125 on September 29, 1999.

State-specific regulations are available at this website:

http://www.naic.org/state_web_map.htm

The following table provides a summary of the status/terms of the law by State, as of 2005.

<table>
<thead>
<tr>
<th>State</th>
<th>Status/Terms of Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Clean claims must be paid within 45 working days for HMO claims. Electronic clean claims are paid within 30 days and clean paper claims are paid within 35 days.</td>
</tr>
<tr>
<td>Alaska</td>
<td>Claims must be paid within 30 days</td>
</tr>
<tr>
<td>Arizona</td>
<td>Clean claims must be paid within 30 days or interest payments required (usually about 10%)</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Clean electronic claims must be paid or denied in 30 calendar days, paper in 45. 12% per annum late penalty fee.</td>
</tr>
<tr>
<td>California</td>
<td>Claims must be paid within 45 working days for an HMO. 30 days</td>
</tr>
<tr>
<td>Colorado</td>
<td>Claims must be paid in 30 days if submitted electronically, 45 if paper. Penalty is 10% annually.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Claims must be paid within 45 working days. Interest accrues at 15% per annum</td>
</tr>
<tr>
<td>Delaware</td>
<td>Clean claims must be paid in 45 days.</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>None at the present although a 40 day timeframe has been proposed</td>
</tr>
<tr>
<td>Florida</td>
<td>Clean HMO claims must be paid in 35 days, non-HMO in 45 days. Claims where information was requested must be paid in 120 days. Interest penalty is 10% per year.</td>
</tr>
<tr>
<td>Georgia</td>
<td>Claims must be paid within 15 working days. Interest accrues at 18% per annum</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Clean paper claims must be paid in 30 days; electronic claims with 15 days. Interest accrues at 15% per annum. Commissioner may impose fines</td>
</tr>
<tr>
<td>State</td>
<td>Status/Terms of Law</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Idaho</td>
<td>None. Department of Insurance will investigate abusive patterns.</td>
</tr>
<tr>
<td>Illinois</td>
<td>Clean claims must be paid in 30 days. Interest accrues at 9% per annum.</td>
</tr>
<tr>
<td>Indiana</td>
<td>Claims must be paid in 45 days.</td>
</tr>
<tr>
<td>Iowa</td>
<td>Clean claims must be paid in 30 days. Penalty will be 10% per annum.</td>
</tr>
<tr>
<td>Kansas</td>
<td>Claims will be paid in 30 days. Interest accrues at a rate of 1% per month.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Claims must be paid or denied within 30 working days. Interest accrues at 12% per annum when 31-60 days late; 18% when 61-90 days late; and 21% when 91+ days late.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Claims submitted electronically must be paid within 25 days. Paper claims submitted in 45 days must be paid in 45 days; submitted after 45 days must be paid in 60 days. Penalty is 1% of unpaid balance.</td>
</tr>
<tr>
<td>Maine</td>
<td>Clean claims must be paid within 30 days. Interest accrues at 1.5% per month.</td>
</tr>
<tr>
<td>Maryland</td>
<td>Clean claims must be paid within 30 days. Interest accrues at monthly rates of 1.5% (31-60 days late), 2% (61-120 days late), and 2.5% (121+ days late).</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>None. Division of Insurance will investigate abusive patterns.</td>
</tr>
<tr>
<td>Michigan</td>
<td>This law applies only to non-contracted providers; Claims must be paid in 60 days with an interest penalty of 12% per annum.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Clean claims must be paid in 30 days. Interest accrues at 1.5% per month if not paid or denied.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Clean claims must be paid within 45 days. Interest accrues at 1.5% per month.</td>
</tr>
<tr>
<td>Missouri</td>
<td>Claims must be acknowledged within 10 days and paid within 45 days. Once requested information is received, claims must be paid or denied in 15 days. Interest accrues at a monthly rate of 1%. After 40 processing days entitled to a per day penalty: the lesser of 1.2 value of the claim or $20 per claim.</td>
</tr>
<tr>
<td>Montana</td>
<td>Clean claims must be paid within 30 days. Interest accrues at 18% per annum.</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Claims must be paid or denied within 15 days of affirmation of liability.</td>
</tr>
<tr>
<td>Nevada</td>
<td>Claims must be paid in 30 days. Penalty interest accrues at rate set forth in Nevada.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Clean paper claims must be paid in 45 days; electronic in 15 days. 1.5% monthly interest penalty.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Electronic claims must be paid within 30 days; paper claims with 40 days.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Clean claims must be paid within 30 days if electronic; 45 days if paper. Interest accrues at 1-1/2% per month.</td>
</tr>
<tr>
<td>New York</td>
<td>Claims must be paid within 45 days. Interest accrues at greater of 12% per year or corporate tax rate determined by the Commissioner. Fines up to $500 per day may be imposed.</td>
</tr>
</tbody>
</table>
## State Status/Terms of Law

<table>
<thead>
<tr>
<th>State</th>
<th>Status/Terms of Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>Claims must be paid or denied within 30 days. Annual interest penalty of 18%.</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Claims must be paid within 15 days.</td>
</tr>
<tr>
<td>Ohio</td>
<td>Claims must be paid or denied within 30 days. Interest penalty of 18% per annum.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Clean claims must be paid with 45 days. Penalty of 10% of claim as interest for late claims.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Clean claims must be paid in 30 days. 12% interest penalty applies.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Clean claims must be paid in 45 days.</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>None. Department of Insurance will investigate abusive patterns.</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Group health insurers must pay claims in 60 days.</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Electronic claims must be paid in 30 days; paper claims in 45.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Claims must be paid with 40 days. Interest accrues at 25% per annum.</td>
</tr>
<tr>
<td>Texas</td>
<td>Claims must be paid with 45 days (HMOs only). Interest accrues at 18% per annum.</td>
</tr>
<tr>
<td>Utah</td>
<td>Claims must be paid or denied in 30 days. Interest accrues at 18% per annum.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Claims must be paid or denied in 45 days. Interest penalty is 12% per annum.</td>
</tr>
<tr>
<td>Virginia</td>
<td>Clean claims must be paid within 40 days.</td>
</tr>
<tr>
<td>Washington</td>
<td>95% of the monthly volume of clean claims shall be paid in 30 days. 95% of the monthly volume of all claims shall be paid or denied within 60 days</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Claims must be paid in 30 days if electronic; 40 days if paper. Interest and fines may apply. Interest penalty of 10% per year.</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>If clean claims are not paid within 30 days, they are subject to a penalty interest rate of 12% per year.</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Claims must be paid within 45 days. Penalties and fines may accrue.</td>
</tr>
</tbody>
</table>
4. Health Insurance Portability and Accountability Act Privacy Rule

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4.1 About the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes privacy regulations, which are designed to protect identifiable health care information of individuals during the transfer, storage, release, and destruction of that information.

All medical records and other identifiable health information used or disclosed in any form – whether electronically, on paper, or orally – are covered by the HIPAA Privacy Rule. Under this Rule patients have significant rights to understand and control how their health information is used and disclosed.

Patients have the right to:

- Inspect and receive a copy of their health record
- Request a restriction on their protected health information (PHI)
- Request a correction/amendment to their health record
- Request confidential communications about their health record/information
- Request a listing of certain disclosures IHS has made
- Revoke their written authorization to use or disclose their health information
- Obtain a paper copy of the IHS Notice of Privacy Practices upon request
- Obtain a paper copy of the IHS Health, Medical, and Billing Records System Notice #09-17-0001 upon request
- File a written complaint with the Service Unit Director/Chief Executive Officer or the Service Unit Privacy official or the Secretary of Health and Human Services, U.S. Department of Health and Human Services, Washington, DC 20201

For more information on HIPAA Policies and Procedures and HIPAA-compliant forms specified in the following sections, go to this website:

http://www.ihs.gov/adminmngresources/hipaa/index.cfm?module=training_forms
4.1.1 IHS Notice of Privacy Practices

All patients, both new and established, shall be provided a copy of the current IHS Notice of Privacy Practices at their first visit to an IHS facility after April 13, 2003, as follows:

- Patient Registration staff will provide a copy of the current Notice to the patient.
- The patient will acknowledge receipt of the Notice by signing the "Acknowledgement of Receipt of IHS Notice of Privacy Practices" (Acknowledgement form).
- The Acknowledgement form will be filed in the patient’s medical record.

4.1.2 Request for Restrictions on Patient Information

Patients have the right to request restriction(s) on how their protected health information (PHI) can be used or disclosed to carry out treatment, payment, and health care operations, hospital directory; or disclosed to relatives, family members, close friends, health care givers, and any other person involved in the patient’s care or payment who is identified by the patient.

These are the procedures that shall be followed when requesting restrictions on patient information:

- The request must be writing, using Form IHS 912-1 - Request for Restriction(s).
- The SUD/CEO or designee shall review the request before the patient is notified of the decision, except for acceptance of the request to restrict PHI from the hospital directory.
- If IHS agreed to a requested restriction, it may be terminated by IHS or the patient, using Form IHS 912-2 - Request for Revocation of Restrictions(s).
4.1.3 Authorization for Use or Disclosure of Health Information

Prior to disclosing health information, Form IHS 810 - Authorization for Use or Disclosure of Health Information, must be completed and signed. A valid written request from the patient may also be honored.

Disclosure of health information is a function of HIM staff; however, patient information is also contained in third-party billing records, and may be requested and released from Business Office staff.

**Note:** The requirement for an original signature is no longer mandatory but preferred. Copies of signatures may be honored, especially from other federal agencies, such as the Social Security Administration.

4.1.4 Request for Accounting of Disclosures

A patient has the right to request and receive an accounting of disclosures of protected health information (PHI) about the patient made by IHS and its contractors (business associates).

The request must be in writing, using Form IHS 913 - Request for an Accounting of Disclosures.

The following disclosures require accounting:

- Disclosures under the Routine Uses, 1 through 16 of the IHS Health, Medical, and Billing Records, System of Records, 09-17-0001
- Disclosures 3 through 12 of the Privacy Act, 5 U.S.C. 522(a)

4.1.5 Hospital Directory

An IHS facility may maintain a directory of patients and disclose limited protected health information (PHI) from that directory without the individual’s written authorization, provided the individual was informed of the intended use or disclosure in advance, and had the opportunity to either agree to or prohibit the use of disclosure.

PHI that may be disclosed from a patient directory is limited to the patient’s

- name
- location in the facility
• condition described in general terms (e.g., stable) that do not communicate specific information
• religious affiliation, which may be disclosed only to clergy, if the patient has not objected to such disclosure

4.2 HIPAA Training

It is everyone’s responsibility to protect the patient’s privacy. Therefore, IHS facilities must provide HIPAA privacy training to
• All employees, volunteers, and contractors
• New employees as soon as possible, but no later than 30 days after start date
• Designated staff, whenever HIPAA-related policies and procedures are revised

HIPAA training provided to staff shall be documented and maintained in writing or electronically for six (6) years.

For more information, go to the IHS HIPAA website:

http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm

For IHS HIPAA Policies and Procedures (P&P) and related forms, go to this website:
http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm?module=trainin g_forms

4.3 Impact of Privacy Regulations on the Business Office

The affect of the HIPAA Privacy Rule on health records will be incorporated into Health Information Management (HIM). The HIM staff members are the experts in using and disclosing protected health information (PHI). However, the Business Office must be aware that Billing records are also PHI and have been added to the Privacy Act’s System of Records.

As of April 13, 2004, HIPAA requires that each patient sign an acknowledgement that he or she received a copy of the Notice of Privacy Practices. This form is filed in the medical record.
In addition, facilities must account for any disclosure or use of any patient health information, to whom it was disclosed, the date of disclosure, and the purpose of the disclosure and/or a copy of the authorization/request for disclosure.

The following sections provide a summary of an individual's rights and IHS employee responsibilities under the Privacy Act:

4.3.1 Collection of Personal Information

The following paragraphs summarize an individual’s rights when asked to provide personal information and the health care employee’s responsibilities when requesting such information.

Individual Rights: Whenever an individual is requested to provide personal information to a Federal agency, he/she is entitled to know the
- legal authority for requesting the information,
- purpose for collecting this information,
- what related uses might be made of this information,
- whether their response is mandatory or voluntary, and
- what effect their refusal to provide the information would have.

Employee Responsibilities: You must collect only personal information that is relevant, accurate, complete, and necessary to accomplish an authorized agency function. Whenever you request personal information from an individual, you must inform him/her in writing of the
- legal authority,
- purpose for collecting this information,
- what related uses will be made of this information,
- whether a response is mandatory or voluntary, and
- what will be the effect if he/she refuses to respond.

The collection of personal information is usually provided on a form given to the person providing the information. You should always attempt to collect personal information directly from the individual rather than from other sources.

Whenever you ask for a Social Security Number you must tell the individual the purpose for requesting it.
4.3.2 Access to Records

The following paragraphs summarize an individual’s rights to access his/her medical records and the health care employee’s responsibilities when responding to a request for access to medical records.

Individual Rights:

- An individual can request to see his/her records in writing or in person. The individual should describe the information he/she wishes to see, because blanket requests for “all the information the agency has on me” cannot be honored.
- If the individual appears in person, identification will be required to verify that he/she is the person whose record is requested. If the patient does not have suitable identification, he/she will be asked to certify his/her identity in writing.
- The individual may have another person accompany him/her to review his/her records.
- The individual is entitled to receive a copy of his/her record or an acknowledgement of his/her request within ten (10) working days.
- An individual is not required to give a reason for the request.

Employee Responsibilities:

- When an individual requests to see his/her record, you must verify his/her identity or require written certification that he/she is the subject of the record requested.
- Always keep a signature on file, so that the signature on the written request can be checked against the one on file. If, by chance, the signature is forged, your legal protection is that you acted in “good faith”.

**Note:** Telephone requests are not honored, because positive identification of the caller may be difficult to establish.

- When a request for a record is received, you should check to see whether a record exists on the person in the system of records that is subject to the Privacy Act. Depending on the procedure in your organization, the system manager or designee must either present the record or a copy of it, or acknowledge the request within ten (10) working days.
- You should not ask the person to give a reason or to justify a need to see his or her own record.
• If a patient requests another person's presence when he/she wants to inspect or discuss his/her records, you must have the individual authorize the other person's presence in writing prior to the inspection or discussion of the records.

For the policy and procedure related to accessing records, go to this website:

http://www.ihs.gov/AdminMngrResources/HIPAA/documents/AuthorizationforUseorDisclosurePP31JAN03A.pdf

4.3.3 Correction/Amendment of Records

In general, only factual, verifiable information is subject to amendment under the Privacy Act. Other procedures, such as personnel grievance procedures, should be followed if the patient wishes to contest subjective opinion.

The following paragraphs summarize an individual’s rights to request an amendment to his/her health records and the health care employee’s responsibilities when responding to such a request.

Individual Rights:
• An individual can request to correct, delete, or add information in his/her health record in writing or in person. The individual must identify the record information to be corrected and give his/her reasons for the desired change.
• The individual should expect an acknowledgement of the request within ten (10) working days.
• If the individual appears in person, identification will be required to verify that he/she is the person whose record is requested. If the patient does not have suitable identification, he/she will be asked to certify his/her identity in writing.

Employee Responsibilities:
• When an individual requests an amendment to his/her health record, you must verify his/her identity or require written certification that he/she is the subject of that record.
• Depending on your organization's procedures, you or a designated official must acknowledge a request to amend a record within ten (10) working days and advise the person when he or she can expect a decision on the request.
• Normally, a review should be completed within thirty (30) days. Under the regulations, an appeal must be decided within 30 days, which may be extended an additional 30 days.

4.4 Protected Health Information (PHI) Use and Disposal

Protected health information (PHI) includes any medical or demographic data that specifically identifies a particular patient, or may be used with other data to identify the patient, regardless of the type of storage media. This includes but is not limited to anything with the patient’s
• name
• chart number
• address
• phone number
• fax number
• cell-phone number
• pager number
• e-mail address
• social security number

Additionally, PHI includes data identifying relatives or data, which when combined with other data, can be used to identify the patient. The Privacy Act defines what is identifying information.

PHI data may be found on health summaries, lab slips, unused prescription labels, label reprints, NCR copies, unused summary labels, Drug Utilization Review logs, manual or electronic organizers, computer files, palm device files, compact disks, floppy disks, zip drive disks, e-mail messages, and notes to yourself with patient identifiers.

All unused PHI, including label reprints, unused labels, summary labels, health summary copies, report copies needing to be destroyed, should be shredded, sequestered, and incinerated, or otherwise made to be completely unreadable.

Labels that are not applied to anything tend to jam shredders. These can be cup-up with scissors, may be applied to other PHI or scratch paper and shredded, or sequestered and later incinerated.
If any PHI is sequestered, make sure it remains secure and out of the view of persons who are not authorized to view it. PHI obliterated by marking over key data with black felt markers may still be readable by using different lighting techniques or back lighting, and is not recommended.

Covered health care providers may use protected health information to create de-identified information. De-identified information must be void of any information that could be used to identify the individual subject of the information, such as the patient’s name, address, exact birthdate, or any unusual identifiers (e.g., unusual occupation, high salary, or age).

For more information, see the Indian Health Manual, Part 5, Chapter 15, “Records Management Program” (Section 5-15.4), at this website:

http://www.ihs.gov/PublicInfo/Publications/IHSM/Part5/pt5chap15/pt5chap15.htm

4.4.1 Limiting Protected Health Information (PHI) to the Minimum Necessary

IHS must make reasonable efforts to limit the use and disclosure of and request for protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, except to the subject patient or pursuant to a valid authorization.

4.5 Maintaining Patient Confidentiality

Patient confidentiality is a serious matter. Even if you are using a code, you are passing confidential information.

Asking a patient how they are doing with their medical problem in front of other people is a breach of patient confidentiality. Having a conversation about a person, saying “so-and-so” has cancer, is not acceptable. The bottom line is – do not discuss patients’ conditions casually.

If you breach patient confidentiality, you can be fined, criminally charged, and even sent to prison. Furthermore, you risk the wrath of the angry patient whose privacy has been exploited and who is perfectly within his or her right to sue your health care facility.
The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail or by phone or in some other manner. The following sections provide some helpful tips for maintaining patient confidentiality.

4.5.1 Sending and Receiving Patient Information

IHS will ensure that patient information or medical records sent from or received by IHS facilities are handled in a manner that protects against unauthorized disclosure of such records to third parties.

4.5.2 Faxing Patient Information

Because the use of Facsimile (FAX) machines poses certain risks of improper disclosure of confidential patient information, IHS facilities are encouraged to send and receive patient medical records by mail whenever practical.

Transmission of patient medical records by FAX should be limited to the minimum amount necessary to accomplish the intended purpose. For the policy and procedure related to faxing protected health information (PHI), go to this website:

http://www.ihs.gov/AdminMngrResources/HIPAA/documents/FacsimilePP31JAN03.pdf

4.5.3 Telephone Conversations

When there is a request for confidential patient information, it is better to have the patient make his or her request in writing than to address it over the phone.

Another precautionary idea is to ask the patient his or her name, address, telephone number, birth date, and Social Security number. If the patient stumbles or pauses when giving a birth date, that is a possible sign the person isn’t who he/she says he/she is. A better way is to ask the patient for the above information and tell her you will call back with an answer. This way you can check the phone number against the one in your file. This is added protection.
In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual’s privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment, or ask the individual to call back.

Make sure all staff is trained on how to handle such patient inquiries.

4.5.4 Workers’ Compensation

It is not uncommon for an employer to call a facility to ask direct questions regarding a person who claimed they were injured on the job. Tell the caller you cannot give out patient information. If the caller claims to be the patient, it is very important that you ask the caller to put their questions in writing or ask for their name, address, telephone number, birth date, and Social Security number, or some other identifying information such as mother’s maiden name.

4.6 HIPAA and Pharmacy Compliance

HIPAA requires that certain electronic transmissions be standardized. The new law requires using the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standards Version 5.1. The Privacy Officer, techs and upper management of the facility or retail chain will make sure transaction standards are in place. Most pharmacists will not have to deal with this directly.

Pharmacies should keep three years of records, including

- payable claims
- a copy of the patient’s prescription (hard copy readily retrievable)
- a copy of the Prior Authorization

A signature log needs to be kept that clearly informs the patient of what they are acknowledging. This acknowledgement cannot be used as a waiver or permission for anything else that appears on the log book (such as a waiver to consult with the pharmacist).

The HIPAA Privacy Rule provides covered health care providers with discretion to design an acknowledgment process that works best for their business. The signature log, along with other records, should be stored for seven years.
A local procedure for providing information to payers needs to be defined and written. This would include disclosures for the purpose of treatment, payment, or health care operations.

Signed acknowledgements that patients received a copy of the Notice of Privacy Practices must be retained for six years from the date they were signed or the last date a patient was treated, whichever is later.

In addition, providers must keep track of any disclosure or use of any information that is not related to treatment, payment, or health care operations or pursuant to an authorization for six years. The documentation of a disclosure must
- describe the PHI that was disclosed,
- to whom it was disclosed,
- the date of disclosure, and
- the purpose of the disclosure (and/or a copy of the authorization or request for disclosure).

On patient request, a pharmacy must provide a written accounting of these disclosures. It must also establish a policy for responding to patient requests for such documentation. Accountings must be provided to a patient at no charge for the first request within a 12-month period. Pharmacies may establish a reasonable fee to provide additional accountings to patients within a 12-month period.

Patients have the right to obtain a copy of their pharmacy records. On receipt of a patient request, the pharmacy has 30 days to provide the patient with a copy.

Patients can also request a change to their records. It is best to ask the patient to put the request in writing and include the reason for the change. The pharmacy must act within 60 days to determine whether the change is appropriate and then correct the records, if necessary.

For example, a patient denies receiving a prescription for haloperidol. Under the privacy rules, the pharmacy may be required to check their records, contact the physician, or other, to see if this is a real error before updating the patient’s medical record.

Before deleting any health information from a patient’s record, make sure the removal of the information is consistent with other laws or your facility’s general practices.
A pharmacy should have counseling rooms that are out of ear-shot from other patients. The HIPAA Privacy Rule is not intended to prohibit providers from talking to each other and to their patients. Provisions of this Rule requiring covered entities to implement reasonable safeguards that reflect their particular circumstances and exempting treatment disclosures from certain requirements are intended to ensure that providers’ primary consideration is the appropriate treatment of their patients.

The Privacy Rule recognizes that oral communications often must occur freely and quickly in treatment settings. Thus, covered entities are free to engage in communications as required for quick, effective, and high quality health care. Reasonable precautions should be taken to minimize the chance of incidental disclosures to others who may be nearby.

Pharmacists can call the prescriber to clarify a patient’s medication and can report to public health surveillance programs, suspected victims of abuse or neglect. One concept of HIPAA is the concept that patient privacy should be protected by minimizing the amount of private information that is given out about a patient and minimizing where the information is sent. This concept is often referred to as “minimum necessary” (IHS HIPAA P&P).

### 4.6.1 Medication Pick-up by Proxy

A pharmacist may use professional judgment and experience with common practice to make reasonable inferences of the patient’s best interest in allowing a person, other than the patient, to pick up a prescription.

For example, the fact that a relative or friend arrives at a pharmacy and asks to pick up a specific prescription for an individual effectively verifies that he or she is involved in the individual’s care, and the HIPAA Privacy Rule allows the pharmacist to give the filled prescription to the relative or friend. The individual does not need to provide the pharmacist with the names of such persons in advance.

As written, the HIPAA regulations give the professional considerable latitude in making the decision to give or not give medications to proxies. The key is that the professional, using his or her personal judgment, must decide if giving a proxy the patient’s medications, is in the patient’s best interest.
Consider the following guidelines when deciding whether to give a patient’s medication to a proxy:

- The pharmacist should determine if the proxy is indeed involved in the patient’s care. The pharmacist can find evidence of this by checking the chart to see if the proxy is the patient’s next of kin, caregiver, or is referred to in the physician’s or other health care professional’s Patient Care Component notes. If there is no notation, the pharmacist should ask, “Did the patient ask you to pick up their medications?” and “What is your relationship to the patient?”

- If the pharmacist suspects that the person picking up the medications is not who they say they are, or that the proxy does not have permission from the patient, then the pharmacist should refuse to give that person the medications.

An example might be the “proxy” who attempts to pick up narcotics for one or more “relatives,” and you know the patients have not come to the facility for some time. If the pharmacist is unsure, he or she can call the patient or can look for evidence that the person picking up the medications is involved in the patient’s health care as noted above.

- If the pharmacist feels that it may not be in the patient’s interest to give the medications to a proxy even with permission, then he or she should refuse to give the proxy the medications.

An example of this might be a Metronidazole prescription for the patient and the patient’s contacts, where the spouse is one of multiple contacts. In such instances, the pharmacist should request the patient to pick-up medications or should find some confidential way of getting the medications to the patient.

- Under no circumstances should the pharmacist volunteer that medications are here for someone’s relative.

As an example, “Did you know that your sister’s medications are here? Would you like to take them to her?” is clearly outside of acceptable limits. The proxy must be asked by the patient to pick up the medications or be involved in the patient’s health care. Parents, Caregivers, PHNs, and CHRs meet this definition within HIPAA.

- If the pharmacist refuses to give the medications to the proxy, then he or she should document the incident and the reason why in the patient’s chart.
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**

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

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 too 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](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/IHSM/Part5/pt5chapt15/pt5chp15.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:


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 tenans 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):


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](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](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.
6. Business Office Staff

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6.1 Business Office Staff Descriptions

The following sections provide a list of duties and qualifications for key Business Office personnel.

6.1.1 Receptionist

**Duties**
- Addresses patients, visitors, and co-workers in a pleasant and respectful manner; displays courtesy at all times.
- Directs patient to appropriate person or clinic.
- Answers questions.
- Checks and/or validates the patient’s schedule on the system.
- Contacts departments or staff, if needed.
- Works on various reports in between activities, as assigned by supervisor.
- Answers telephone calls to facility and directs calls appropriately.

**Qualifications:**
- High school graduate
- Personal and friendly patient relations

6.1.2 Admitting Clerk

**Duties**
- Relates well with facility, providers, and patients.
- Complies with the facility’s general policies and procedures.
- Schedules patient for admission to the facility.
- Verifies insurance prior to admission.
- Interviews patient upon arrival at facility.
- Contacts elective patients to confirm admitting information, assigns appointment time and reminds patient to bring insurance cards.
- Enters complete and accurate information on the admission record prior to patient’s arrival.
- Obtains signatures for medical and financial documents.
- Obtains any prior authorization.
- Assures preadmission testing is completed and is received by the facility.
- Retains test results, provider records and medical and financial consents until time of admission.
- Admits patients.
- Enters complete and accurate information on the admission record.
- Obtains signatures on medical and financial documents.
- Prepares and places identification bands on patients.
- Records and deposits patient valuables properly.
- Contacts nursing station before the patient is escorted to the assigned room.
Either escorts “walking elective patients” or places non-elective patients in wheelchairs and takes them to the nursing station.

- Complies with facility-wide policies and procedures, safety and disaster plans and the quality assurance program.
- Attends department meetings to present/exchange pertinent information
- Prepares reports on admissions.

**Qualifications:**
- High school graduate
- Hospital experience is preferred
- Familiarity with computer systems
- Positive and cooperative outlook

### 6.1.3 Check-in Clerk

**Note:** This function must occur at the point of check-in.

- Checks patient in the Patient Information Management System (PIMS).
- Verify eligibility.
- Identify the order of billing/coordination of benefits based on reason for visit or clinic type.
- Accept payment from non-beneficiaries, if applicable.

The check-in clerk can be under the supervision of a department other than the Business Office, or the position can be combined with Registration based on the patient process.

### 6.1.4 Registration Clerk

**Duties**
- Greet and register patients.
- Verify insurance benefits and eligibility within the timeframe set by the facility.
  - For Medicare and Medicaid: verifies eligibility electronically.
  - For private or dental insurance: initiates telephone calls to determine eligibility, certification requirements, and any benefit limitations.
- Makes initial determination on which insurance is primary, secondary.
- Copies new insurance cards.
- Makes new patient chart.
- Has patient sign any required forms.
- Collects any payments (non-beneficiary only).
- Checks patient in (scheduled patient).
- Updates insurance and demographic information (every 30 days) in RPMS.
Pulls patient’s medical record (walk-in).
Enters all information into the RPMS Patient Registration application and free text screen.
Notifies staff that patient has arrived.
Refers potentially eligible Medicare and Medicaid patients to Patient Benefit Coordinator.
Continues to stay informed of any changes in regulations or statutes that could impact reimbursement.

Qualifications:
• High school diploma
• Exceptional customer service
• Attention to detail
• Familiarity with and understanding of insurance
• Proficiency with computer systems

6.1.5 Appointment Clerk

Duties
• Schedules and coordinates patient appointments.
• Updates provider’s schedule into scheduling system.
• Mails reminder appointment letters to patients or calls to verify appointment.
• Cancels and reschedules appointments or makes changes to provider’s schedule.
• Contact patients to reschedule appointment.
• Updates system with no show patients.
• Prepares monthly report of scheduled, walk-in and no show patients.

Qualifications:
• High school graduate
• Familiarity with computer systems
• Exceptional customer service

6.1.6 Patient Benefit Coordinator

Duties
• Determines if any other third party alternate resources are available to patient.
• Coordinates with registration to follow up on potential Medicare and Medicaid patients.
• Educates registration staff on basics of alternate resource programs.
• Evaluates patient eligibility for the state Medicaid program.
• Explains the benefits and values of the Medicaid program to the patient.
• Assists patient in completing the Medicaid application.
• Reminds patient of information needed by the state agency.
• Follows up with state agency regarding eligibility.
• Maintains a log of all patients to include notes and status.
• Updates the RPMS system on conversations and updates on patient eligibility.
• Sends a notice to the billing office with the new Medicaid number.
• Evaluates patient eligibility for the Medicare pharmacy program.
• Explains the benefits and values of the Medicare pharmacy program to the patient.
• Assists patient with application for pharmacy program.
• Determines when patient becomes eligible and updates RPMS system.
• Prepares monthly reports of activity for Administration:
  Number of patients identified potentially eligible
  Number of patients interviewed
  Number of applications completed
  Number of patients not able to contact
• Continues to stay informed of any statutes and regulations that could affect patient eligibility.

Qualifications:
• High school graduate or several years appropriate work experience that would indicate a high level of communication skills and organizational ability
• Previous experience working with state Medicaid, if available, or familiarity with statutes and regulations that impact eligibility
• Familiarity and understanding of insurance
• People oriented person

6.1.7 Biller

Duties
• Responsible for completing insurance claims for designated third-party payers in a timely and accurate manner.
• Responsible for correcting all errors in RPMS for orphan test, missing information, etc. prior to submission of claims to insurer.
• Responsible for assuring that all coding (CPT, ICD-9, HCPCS, etc.) are billed in the correct manner to the insurance company.
• Validates compatibility and medical necessity between CPT and ICD-9 coding.
• Inputs computer information for electronic processing and edits of eligible claims (Medicare and Medicaid) and corrects any electronic rejections immediately.
• Prints, sorts, and mails manual claim forms (private and dental) to insurer.
• Reviews insurance return mail and determines reasons for return.
• Reviews inquiries from insurance company related billing specifics, such as coding timely manner.
• Shares information on any significant changes in coding, benefits, coding errors, etc.
• Keeps in close contact with the insurer to better understand their specific
coding and billing requirements.

- Conducts random reviews of provider records and coding as part of the quality assurance initiative.
- Researches all information related to a denied claim and processes a corrected bill in a timely manner, one that is established by the facility.
- Bills the appropriate primary insurer and follows up that secondary insurance is paid, either manually or electronically.
- Keeps abreast of CPT, ICD-9, and HCPCS coding.
- Always respects the confidentiality of medical/charge information in performing job duties.

Qualifications:  
- High school diploma
- Proficiency in the use of computer systems and keyboarding skills
- Good communication skills
- Previous experience with coding and insurance requirements

6.1.8 Accounts Receivable

Depending on the size of the facility, the following duties may be split between follow-up and posting. In smaller facilities, they are combined.

Duties
- Consistently evaluates the accuracy of third-party payment.
- Researches, reviews, and resolves any inconsistent payments (under or over the expected amount).
- Follows up on all outstanding accounts over 45 days, post submission of the claim.
- Validates that all electronic payments have been appropriately credited.
- Posts all manual payments and adjustments to patient accounts in a timely and accurate manner.
- Highlights rejections for billing.
- Prepares reports for billing supervisor, finance, and area office.
- Researches and forwards inappropriate payments to either the appropriate facility or Area office or back to the insurer.
- Regularly foresees potential problem situations and intervenes to offset adverse impact.
- Checks are verified, copied, tallied, and validated by supervisor or finance staff person.

Qualifications:  
- High school diploma
- Previous accounting or insurance posting experience
- Attention to detail
6.1.9 Compliance Officer

**Duties**
- Oversees and monitoring the implementation of the third party compliance program.
- Reports on a regular basis to the facility's Administrative or Executive committee on the progress of the implementation, any issues to date, and any improvement to the facility's efficiency and quality of services.
- Periodically revises the program in light of changes in the needs of the facility and/or in the law, policies, and procedures of the government or of the health plans.
- Develops, coordinates, and participates in multifaceted educational and training programs that focus on the elements of a compliance program.
- Ensures that independent contractors who furnish medical services to the facility are aware of the requirements of the facility's compliance program, especially with respect to contract providers, or outsourced coding and billing.
- Coordinates personnel issues with the facility's Human Resource Office.
- Assists the facility’s finance office in coordinating internal compliance review and monitoring activities.
- Independently investigates and acts on matters related to compliance, including the flexibility to design and coordinate internal investigations and monitor any imposed corrective action.
- Develops policies and programs that encourage supervisors and staff to report suspected fraud and other improprieties without fear of retaliation.
- Has the authority to review all relevant compliance documents throughout the facility to include relevant patient records, billing records, and other related data.
- Coordinates periodic audits on health records, coding, billing, and payment.

**Qualifications:**
- High school graduate and Bachelor's degree
- Preference of medical background or experience in health field
- Previous experience with quality or compliance monitoring
- Ability to communicate with individuals throughout the facility
- Understanding of state and Federal regulations
6.2 Performance Appraisal and Productivity

The performance appraisal process begins at the time of hire, with proper orientation of new staff. Daily performance feedback is essential to deal with errors, recognize achievements, and let employees know where they stand.

The performance appraisal is a periodic meeting between the staff person and supervisor to discuss the employee’s job performance. This is an opportunity for the supervisor to assess the employee’s job performance during a specified period. The discussion of job performance should improve understanding between the staff person and supervisor regarding job responsibility and performance expectations.

It is recommended that annual appraisals and salary reviews be held near the same time, but not necessarily at the same meeting. Salary reviews and adjustments may distract from the performance review and, therefore, dilute its purpose to correct performance and encourage better job productivity.

Timely performance appraisals are essential to maintain the credibility of your performance appraisal process. In situations of misconduct, disciplinary warnings should be issued to the employee.

In the absence of a scheduled discussion, there is often very little performance feedback to the staff person. If the supervisor is too busy to talk, the employee typically assumes that his/her performance is okay. The other common occurrence is that the employee only hears complaints when something goes wrong. Neither opportunity promotes a good understanding of job expectations.

Even though typical performance reviews occur annually, an evaluation should take place to accomplish the following:

- **Correct poor performance**

  Corrective performance decisions can be scheduled at any time when it becomes necessary to advise the employee of performance problems and to specify corrective action.

- **Coach for improved performance**

  Through coaching and advice, the supervisor can offer suggestions to staff on better or more efficient ways of performing job duties. Through a systematic assessment of the employee’s skills and abilities, job assignments can be identified to provide broader experiences or new challenges.
• Justify pay adjustments

Employee performance ratings can be used as a basis for making salary adjustments.

• Evaluate candidates for promotion

The performance appraisal serves as an excellent process to identify employee career interests and evaluate candidates for promotion.

• Document personnel actions

The performance appraisal documents personnel decisions such as promotions, pay increases, transfers, disciplinary actions, or discharges. In the event of subsequent legal proceedings the documented personnel actions help to justify the supervisor’s decisions. All actions must be documented and become a part of the personnel file.

The performance appraisal may be based on the criteria of (1) most of the time, (2) Sometimes, or (3) Infrequently.

Make sure the evaluation is based on the most current job description. For each new employee, the job description should be reviewed in detail with the patient. In addition, a signed form should be placed in the employee folder that the information on the job description was reviewed with the employee.

6.2.1 Progressive Performance Evaluations

Most facilities provide an annual review where all performance activities, good or bad, are saved and discussed on an annual basis. There are several pitfalls related to an annual review:

• If overall performance is satisfactory or above, the few areas in which staff fail to meet expectations tend to get neglected.

• Once-a-year reviews often focus on the past three months rather than the actual twelve months; therefore, an accurate picture of the staff members’ full year’s worth of work is distorted or incomplete or both.

• Annual reviews favor subjectivity. A supervisor’s mood on the day the annual review is written can taint or enhance a staff person’s evaluation.
A progressive performance evaluation is one that occurs quarterly, with the final review being a culmination of the quarterly reviews. The value of the Progressive Performance Evaluation is that problems and issues can be identified and action plans designed to improve staff performance. The quarterly reviews will also determine if staff is on course to meet targeted facility goals.

Benefits of a Progressive Evaluation are:

- Standards are defined and measurable – The problems with staff who do not meet targeted goals with the first quarter can be identified and improved.
- Staff is evaluated on their actual performance with measurable standards.
- Standards can be evaluated as well – standards can be evaluated and changed as changes in performance or requirements occur.
- A cumulative record is the base for a more complete and accurate review of performance.
- Staff has a good sense of where they stand. With annual reviews, staffs are left in the dark until year end.

6.2.2 Performance Appraisal Traps and Pitfalls

Performance appraisal now carries with it a growing number of potential legal traps, such as in the case where documentation on the performance appraisal does not match the reason for the person being terminated.

The biggest problem or trap is lenient appraisals – stating on the record that the individual’s performance is acceptable, when in truth it is unsatisfactory in some respect.

Here are some guidelines to help prevent such legal traps.

- The performance appraisal system is based on the job, with the appraisal criteria arising from an analysis of the legitimate requirements of the position.
  
  Focus on the job, not the person who does the job and whether he/she is meeting the expectations of the job.

- Performance is assessed using objective criteria as much as possible, given the unique requirements of the job. There must be reasons and examples behind the assessment.
• The appraisers have been trained in the use of the system and possess written instructions on how the appraisal is to be completed. This statement means that anyone writing or giving appraisals consistently use the same format and process.

• The results of each appraisal are reviewed and discussed with the employee. Documentation of performance problems and efforts to correct them are necessary.

This is a major concern. If an employee fails to improve and must be let go, it is necessary to prove that the employee knew about the difficulties. The legally defensible appraisal system can be used to demonstrate that the employee knew of the problems and was given the opportunity to correct them.

The following areas represent common employee reactions or responses to performance reviews that can affect the supervisor’s comments.

• **Personal problems**

  Problems from one part of a person’s life will have an effect on other parts. Personal problems in one’s personal life can affect work performance.

  People have different ways of handling personal problems – some keep problems to themselves and others bring them to work. Therefore, it is important to understand that problems experienced outside of work by the employee, can have adverse effects on work performance.

  The evaluator needs to continually relate to the impact on work performance and not get involved with the personal life situations.

• **Defensiveness**

  No one can understand the reactions of a staff person, especially when less than positive evaluations are being conveyed. With a defensive posture during the appraisal, the chances of constructive learning and problem solving diminish dramatically.

• **Blind spots**

  Many people have their own favored beliefs, opinions, and prejudices that prevent supervisors from seeing that person clearly.
• **Identification**

Many supervisors not only seek employees who mirror their qualifications, beliefs, and opinions, but also appraise employees the same way. Therefore, it is important for the supervisor to focus clearly and deliberately on performance only.

• **Promises**

Do not be swayed into making promises that you cannot keep.

In summary, *do not*

- Argue with the employee
- Scold or reprimand
- Dispense advice
- Wield authority

### 6.3 Examples of Performance Evaluation Criteria

The following examples of performance evaluation criteria can be used in evaluating your staff based on current job description.

---

**Note:** The criteria listed in the following sections are guidelines only.

---

### 6.3.1 Check-in Clerk Performance Evaluation Criteria

- Demonstrates responsibility for accurately completing the check-in process for every patient.
- Is reliable in keeping work schedule.
- Is appropriately dressed.
- Maintains professional attitude and courtesy while obtaining information from all patients.
- Informs all staff in a timely manner of patient’s arrival.
- Maintains logs of activities.
- Works with the supervisor on any potential issues or problems in a timely manner.
- Cooperates with IHS staff in registration area.
### 6.3.2 Admitting Clerk Performance Evaluation Criteria

<table>
<thead>
<tr>
<th>Performance Factor</th>
<th>Evaluation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reliability</strong></td>
<td>Reports to work on time and/or early enough to start work at assigned time</td>
</tr>
<tr>
<td></td>
<td>Takes responsibility for knowing and keeping work schedule</td>
</tr>
<tr>
<td></td>
<td>Notifies supervisor in advance of requests for scheduling changes</td>
</tr>
<tr>
<td></td>
<td>Is appropriately dress for facility</td>
</tr>
<tr>
<td><strong>Cooperation</strong></td>
<td>Recognizes need for changes in daily routines</td>
</tr>
<tr>
<td></td>
<td>Demonstrates willingness to adjust work schedule due to illness, etc.</td>
</tr>
<tr>
<td></td>
<td>Treats every patient and staff person with courtesy, respect, and concern</td>
</tr>
<tr>
<td><strong>Initiative</strong></td>
<td>Maintains adequate supplies and when necessary orders new ones</td>
</tr>
<tr>
<td></td>
<td>Assumes responsibility for maintaining clear and orderly work area</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Recognizes and resolves financial problems</td>
</tr>
<tr>
<td></td>
<td>Oversees and supervises admitting office personnel in absence of immediate supervisor</td>
</tr>
<tr>
<td></td>
<td>Discerns and reports to appropriate supervisor problems requiring his or her attention</td>
</tr>
<tr>
<td></td>
<td>Follows through to complete assignments and projects</td>
</tr>
<tr>
<td></td>
<td>Maintains accurate bed list and count of admissions</td>
</tr>
<tr>
<td></td>
<td>Assigns patients to beds according to the facility procedures</td>
</tr>
<tr>
<td></td>
<td>Places correct, complete and appropriate information in patient’s record</td>
</tr>
<tr>
<td></td>
<td>Makes sure patients’ papers are properly completed</td>
</tr>
<tr>
<td></td>
<td>Acquires pertinent information regarding emergency admissions</td>
</tr>
<tr>
<td></td>
<td>Add admissions requiring insurance verification are handled in a timely and accurate manner</td>
</tr>
<tr>
<td></td>
<td>Demonstratives willingness to train and support new staff</td>
</tr>
<tr>
<td></td>
<td>Problem situations are resolved appropriately and independently</td>
</tr>
<tr>
<td></td>
<td>Plans ahead</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Gives accurate and thorough report</td>
</tr>
<tr>
<td></td>
<td>Maintains inter- and intradepartmental working relationships</td>
</tr>
<tr>
<td></td>
<td>Alerts necessary people of computer shutdowns</td>
</tr>
<tr>
<td></td>
<td>Is diplomatic in dealing with financial problems, department errors</td>
</tr>
</tbody>
</table>
### 6.3.3 Registration Staff Performance Evaluation Criteria

<table>
<thead>
<tr>
<th>Performance Factor</th>
<th>Evaluation Criteria</th>
</tr>
</thead>
</table>
| **Confidentiality** | • Discusses only appropriate patient information in public and private areas protecting the confidentiality and dignity of all patients  
• Releases only appropriate patient information over the telephone  
• Maintains record confidentiality by sending all internal and external written patient information in sealed envelopes  
• Follows facility policy on release of information |
| **Patient Relations** | • Meets and greets all patients and patient families with an appropriate, friendly greeting  
• Answers phones with a pleasant voice in a timely manner and transfers calls according to department policy  
• When placing calls on hold, follow policy, returning to the caller at regular intervals, to ensure excellent communication  
• Takes and forwards all messages to the appropriate staff  
• Responds to all complaints and forwards information to the correct person  
• Exhibits a positive attitude and provides assistance to all patients |
| **Registration Process** | • Ensures each patient is assigned an appropriate patient record number  
• Obtains and inputs complete and accurate patient demographic and other information into the RPMS registration application  
• Obtains all insurance information for the patient and updates the system accordingly and timely  
• Obtains assignment of benefit forms, signature-on-file forms and other forms as needed  
• Refers appropriate patients to the Benefit Coordinator  
• Ensures that all patients are registered in a timely manner, prioritizing registrations during periods of high volume  
• Enters all other data as required by the registration area for proper reporting and documentation  
• Problem situations are resolved appropriately and independently |
| **Collection** | (for non-beneficiaries only)  
• Accepts payments and issues receipts to all patients  
• Ensures accurate patient-related information and patient medical record numbers are listed with every payment accepted  
• Inspects all checks for accuracy and completeness  
• Completes a tallying sheet on all checks received in a given day  
• Accurately labels receipt envelopes and submits to finance office  
• Ensures safety of all cash, checks and charges received  
• Certified as collection agents, based on Financial Management and Integrity Act (contact your finance officer to obtain training) |
<table>
<thead>
<tr>
<th>Performance Factor</th>
<th>Evaluation Criteria</th>
</tr>
</thead>
</table>
| Responsibility     | • Adheres to and is aware of all procedures  
|                    | • Refers to policy or operation manuals as needed  
|                    | • Updates supervisor on any issues  
|                    | • Follow dress code  
|                    | • Adapts flexibly to scheduling decisions and changes to meet staffing needs |
| Quality Improvement | • Participates in department meetings  
|                    | • Participates in in-services and training programs  
|                    | • Reports completely and accurately any incident that may warrant review by a Risk Manager  
|                    | • Consistently and accurately records any requested quality data and reports this information in a timely manner  
|                    | • Consistently maintains department standards |

### 6.3.4 Patient Benefit Coordinator Performance Evaluation Criteria

- Communication activities promote positive patient relations and follow through from patients
- Increases the number of qualified eligible patients for alternate resources
- Problem situations are resolved appropriately and independently
- Participates in department meetings
- Has developed a close working relationship with registration and has trained registration on the eligibility requirements for Medicaid
- Has appropriately documented the results and outcomes in RPMS
- Has communicated timely to billing when patients have received a Medicaid number
- Knowledgeable of state and Federal alternate resource programs
- Track status of applications and provides summarized information to management
- Assists patients with appeal processes

### 6.3.5 Biller Performance Evaluation Criteria

- Billing is maintained at an acceptable level, minimizing backlogs
- Accuracy and proficiency of billing are within acceptable measurements
- Problem situations are resolved appropriately and independently
- Supervisor is made aware of any unusual problems, consistent insurer problems, or significant issues that may impact timely reimbursement
Follow up with insurers is done within the timeframes established by the facility

Consistent or repetitive system errors are conveyed to the supervisor in a timely manner

Information related to follow up is accurately documented in the RPMS

Billing errors are maintained at an acceptable percentage (90% or 95% accuracy)

Random periodic audits of documentation, coding and billing

Knowledge of HIPAA security and privacy rules for electronic transactions

6.3.6 Accounts Receivable Performance Evaluation Criteria

- Manual accounts are posted to patient accounts in a timely manner, one that is set by the facility
- Posting errors are maintained at an acceptable level (95% and above accuracy)
- Errors and issues are resolved immediately
- Check validation and verification process is adhered to 100% of the time
- Backlogs are maintained at a minimum
- Denials are researched and appealed in a timely manner
- Monthly reconciliation completed in a timely manner
- Monthly accounts receivable reports provided to management in a timely manner
- Monitors the unpaid accounts beyond 45 days
- Processes refunds according to facility’s policy
7. Business Office Quality Process Improvement

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7.1 **Accreditation and Patient Rights, Confidentiality, Privacy, and Safety Requirements**

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or other accrediting body will query the staff, especially Registration, on patient rights, confidentiality, privacy, and life safety requirements for the facility. The following questions and positive responses address these key areas.

**How do you explain patient rights?**
- Staff provides a booklet that reviews their rights.
- If patient cannot understand, is developmentally disabled, or deaf, staff explains the patient’s rights to the family member.
- Patient rights are posted within the facilities.

**How do you maintain confidentiality?**
- Staff uses private booths to accommodate patients.
- Staff speaks in hushed tones, to include reference to the patient name.
- Confidential information is *never* shared with colleagues or family members.
- The pre-certification desk is located away from mainstream of patients, because patients’ names are given over the phone for insurance purposes.
- Staff shreds all documents that contain any patient names and keeps those discarded documents in a separate container.

**How do you maintain privacy?**
- Staff speaks in hushed tones.
- Information is not requested that is not pertinent to the admission or facility visit.
- Staff accommodates any patient who requests that their room number or phone number not be given out.
- Emergency room staff moves patient into emergency room bay or examination room if the triage room is occupied.
- Staff is aware of the privacy regulation.
How do you maintain life safety?

- Fire drills
- Disaster preparation and plans
- Hazardous spills
- Infection control

7.2 Quality Performance and Improvement

After each JCAHO and/or other accrediting body survey is completed, it is recommended that a Performance Improvement Summary be developed, updated, and maintained to demonstrate to JCAHO and its surveyors that improvements have been identified and monitored.

The following table provides examples of activities that would fall under a quality performance improvement activity. The objective is that once a deficiency is identified, a plan of action can be put in place to improve the deficiencies that were noted.

**Example of a Performance Improvement Summary**

<table>
<thead>
<tr>
<th>Problems Identified</th>
<th>Action Taken or Recommended</th>
<th>Evidence of Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Bills</td>
<td>Verify provider order and notes or no payment.</td>
<td>Payments have increased.</td>
</tr>
<tr>
<td>Late filing of ancillary test in medical record</td>
<td>Staff given in-service on timely filing. Electronic health record enacted.</td>
<td>Reports readily available. Reports automatically posted in EHR once test results are received.</td>
</tr>
<tr>
<td>Timely Radiology reports</td>
<td>Identify inpatient versus outpatient.</td>
<td>Colored dots used. Radiologist reads inpatient x-rays before outpatient ones. Reports placed on chart as soon as possible. Electronic health record updates results immediately.</td>
</tr>
</tbody>
</table>

Accreditation/certification usually requires annual testing of competency that includes documentation maintained in personnel files that substantiates employee competency in their job duties.
7.3 **Flow Charts for Process Improvement**

A team-oriented approach with tangible department goals can serve as incentive for process improvement. By creating a series of goals and rewards for each department, each team is motivated to eliminate any lags in their particular department and a friendly competitive atmosphere can be created.

By documenting with charts and graphs the progress of the individual teams by department, the facility begins to create an overall team effort and a “continuous quality improvement” environment. This effort can then be acknowledged by management, which affirms a sense of appreciation to all departments and enhances the desired behavior.

Charting results can serve as an educational tool for the facility. By creating a flow chart of the various components and inviting members from Registration, Coding, Billing, and other appropriate ancillary departments to meet, there will be discussions regarding possible problems. This opens the door to create a tighter process improvement effort. Using this lag analysis process, delays can be discussed without blame and everyone can examine the results and work together to create improved workflow solutions.

7.4 **Registration Performance Tracking**

Incomplete or inaccurate registration information leads to billing and payment delays. Payment delays eventually impact the quality of care. The best way to improve the registration process is to track registration accuracy by implementing a performance improvement plan.

Tracking registration accuracy can be done in several ways. Registration can conduct a registration effectiveness audit. Billing and Collections can track the reasons for claim rejections, highlighting and documenting those caused by registration inaccuracies and deficiencies.

Tracking should reflect both an individual’s performance and the department’s overall performance. It is good information which the department can use to develop a teamwork approach to resolving and preventing the errors causing the denials.

By understanding the accuracy level and rejections due to poor registration information, the department can create a plan of action to improve and standardize the registration process.
For those facilities accepting non-beneficiaries, the department should

- Track its up-front collections success.
- Identify the number of patients who owe deductibles or coinsurance at the
time of service.

It is also important to track how non-beneficiary patients pay; such as, by
cash, check, or credit card.

7.4.1 Eliminating Registration Errors

A detailed-oriented Registration staff is a valuable asset to the facility. They are responsible not only for gathering complete and accurate information, but also for entering that information into RPMS.

It is extremely important to review and update the Insurer File so that your Registration Staff can appropriately identify the correct insurer information in your system.

Some of the most common registration errors are not obvious and at times, an insurer will use even the slightest error to their advantage.

Examples of insurer-related errors and solutions

<table>
<thead>
<tr>
<th>Error:</th>
<th>Solution:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculating ages when using the birthday rule for coordination of benefits (determining primary insurer)</td>
<td>Determine primary insurer based on who birth date falls first in the calendar year, not who is older. The birth year does not matter.</td>
</tr>
<tr>
<td>Enter Medicare HIC number as they appear on the card, substituting slashes for hyphens and including numbers only</td>
<td>Check with the fiscal intermediary to learn their requirements for filing claims. Some require that hyphens and any other punctuation be omitted. In all cases, do not forget the suffix.</td>
</tr>
<tr>
<td>Entering insured's identification number a group number</td>
<td>Double-check to make certain group numbers that are entered on the registration form matches the number listed under the group number heading on the card, not the patient identification number.</td>
</tr>
<tr>
<td>Using abbreviations that are misinterpreted (e.g., &quot;pat&quot; means &quot;patient&quot; to some, &quot;preadmission testing&quot; to others)</td>
<td>Created a list of common abbreviations for all staff members to use. The list should be consulted when writing or reading abbreviations.</td>
</tr>
</tbody>
</table>
Error: Failing to note useful information in the comments section of RPMS.
Solution: Any relevant information from either the registration staff or the benefit coordinator needs to be entered into the “free text” section of the registration application. Any information is important in deciding whether to proceed with collections or wait for additional information from the patient or insurer.

Error: Failing to include insurer address
Solution: Be sure to copy the back of the insurance card. If the address is not entered at the time of registration, it can be tracked down by checking the card copy. In the case of regional carriers, be sure to note the address on the back of the insured’s card. Claims most often must be sent where the patient is insured, not where the patient is treated.

Error: Transposing first and last names
Solution: Insurers rarely look for coincidences on claims (such as patient’s first name matches the last name of the beneficiary and last name matches the beneficiary’s first name). Insurers routinely reject flawed claims. Check on the card to see how names are labeled. Some put the first name last, and some do not. Be sure to record it accurately.

Error: Using existing information in the system from a previous visit
Solution: Update patient information at each visit. Insurances, addresses, and employment are all subject to change.

Error: Failing to get provider’s signature and proper date of service
Solution: Clinics are more likely to fall prey to this problem. Providers may sign or stamp a batch of forms at once and sometimes blank forms. Expect claim denials if a form is signed and dated before the time of service.

Error: Failing to get preauthorization
Solution: Know which insurers require preauthorization for treatment. If in doubt, call. It is better to make the extra effort to avoid claim denials.

### 7.4.2 Steps to Improve Registration Quality

There are five basic steps to improving the quality of the Registration staff. Initially review the process for a couple of days with the staff. Once the accuracy has improved, then scale back to random surveys. The steps are:

1. **Track errors.**

   Most clinical and accounting systems, as well as the RPMS registration application, include tracking by employee. Use this tool to identify and correct problems that stem from the front end.
2. **Work with staff as soon as errors are identified.**

   Don’t wait for an annual performance appraisal to review the number of errors. The consequences of multiple errors for the year becomes the burden of the facility.

3. **Recognize employees for what they do right.**

   Identifying errors is important, but praise is needed when things go right and the accuracy has improved.

4. **Monitor quality daily.**

   Spot checking registration records daily helps keep staff on their toes and accuracy levels high. Again revert to random reviews once quality and accuracy have improved.

5. **Provide ongoing training.**

   Training includes one-on-one review of problem areas as well as more formal full staff training sessions. Key is to address problems as they arise and craft solutions with staff. “With” is the operative word.

7.4.3 **Checking Registration Performance for Quality Assurance**

To check for compliance:

1. Pull a list of scheduled patients from a particular day.

2. Review the information in the RPMS Patient Registration application regarding insurance information, demographics, and other information; and review Page 8 to determine if the insurance information was updated during that visit and whether it was entered into RPMS.
   - Was only a primary insurance referenced?
   - Was a secondary insurance, pharmacy-only, or dental insurance listed?
   - Was the insurance billing address correctly reflected?
   - Was the identification number accurately reflected?

3. Review the billing information on the patient.
   - Was the same insurance information billed?
   - Was the same address used?
   - Was the account paid?
   - Were errors identified and if so what errors?
4. Determine a percentage for your facility that meets expectations and pass the review of the audit back to the staff.

5. Compute a level of compliance for each registration staff person.

6. Add the information to the Quality Assurance Statistic form.

7. Use this data as well as the staff person’s improvement as part of the performance appraisal process

7.5 Benefit Coordinator Performance Tracking

- On a monthly basis, calculate the percent of patients referred to the Benefit Coordinator that qualify for alternate resources versus those that did not.

- Determine the percent increase by month of the number of patients that qualify, and perform a trend analysis over several months.

- Develop a monthly cumulative report listing the number of patients that were referred to the Benefit Coordinator for alternate resources, and calculate the reimbursement on those patients by month.

- Compare the increased reimbursement by alternate resource payor, month-to-month.

7.5.1 Checking Benefit Coordinator Performance for Quality Assurance

- Establish and staff a full time Benefit Coordinator position.

- Train the Benefit Coordinator on all aspects of alternate resources:
  - Benefits
  - Exclusions
  - Eligibility and qualifications
  - Application process
  - Documents needed to substantiate
  - Types of alternate resources available

- Cross train Registration staff regarding which potential patients may qualify for alternate resources.

- Assure there is an established process for referring “all” potential patients to the Benefit Coordinator from Registration.

- Follow up with Medicaid, Medicare, and other alternate resources to assure the coverage is approved.
- Document in the **RPMS Patient Registration** application all updates on conversations.
- Always inform Billing of new insurance coverage.

### 7.6 Billing Performance Tracking

The RPMS Third Party Billing application’s **Pending Claims Status** report will reveal areas that need attention before the claim can be approved. Many incorrect components of the claim cannot be detected until billers attempt to approve the claim. If deficiencies are found the biller has the option to place the claim into a pending status, using the 3P Claim Pending Status table in RPMS.

The Pending Claims Status report will show if:

- Claims are rejected due to incomplete or inaccurate information from registrations.
- Information on the patients provided at registration is correct and complete.
- Billing understands the correct format used to bill a particular insurer, and/or whether the biller incorrectly billed the account.

Building collaboration and more open lines of communication between Registration, Coding, and Billing will eliminate any finger-pointing and will improve the entire business process.

### 7.6.1 Chart Auditing

The medical record serves as a tool for patient care, medical research, and healthcare statistical measurements, and as a supporting tool for reimbursement. The medical record has been evolving for years to the development of the electronic medical record.

The patient’s medical record, or patient chart, is a legal document that should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data. The chart should never be published or released to anyone without the patient’s express consent.

The documentation in the medical record is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examination, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient.
The medical record often serves in many court cases for medical malpractice judgments as the final piece of definitive evidence.

In addition, the medical record facilitates:

- The ability of the physician and other health care professional to evaluate and plan patient’s immediate treatment and to monitor their health care over time
- Communication and continuity of care between physicians and other health care professionals involved in the patient’s care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for education
- Support to the claims processing

The process of chart auditing needs to be outlined by each facility compliance plan. The questions – how often, how many charts, when to audit – should be addressed in the plan. The Office of the Inspector General has published a variety of model compliance plans in its electronic reading room that can be referenced.

Internal auditing is done to verify that the facility is performing in good compliance. This practice also ensures good fiscal returns for cleanly coded claims. Chart auditing includes the process of verifying CPT and ICD-9-CM codes against the document for the encounter.

Evaluation and management services represent the foundation of the patient encounter and procedural coding. Guidelines and rules associated with the evaluation and management of coding present some of the most subjective coding conventions out of all sections in the CPT manual.

In addition to the internal auditing, the government audits records to a variety of different kinds of fraud and abuse. Therefore, it is important that each facility audit their records prior to any external audit review.
Stages and steps in an audit process are:

- **Criteria**
  
  The first stage is to define “what should be” - basically a baseline for the audit, a best practice that you would like the facility to achieve, or what actually should be occurring.

- **Condition**
  
  The second stage is to define “what is” – Document what is occurring and whether that meets the criteria

- **Cause**
  
  When the condition does not meet the criteria, you need to document why - “Why is this process falling short?”

- **Effect**
  
  “What is the financial, resource, quality, or other impact of the condition?” - It might mean, lost revenue; it might mean lost time in research; it might mean duplication of initiatives. In this stage, you look at the difference and significance between what is and what should be.

- **Recommendations**
  
  This stage of the process is to define and implement a solution with an achievable action plan and follow-up review process. This stage also includes the establishment of performance targets and performance due dates.

### 7.6.2 Payment Analysis

One of the most important processes is submitting the bill in a timely manner to the insurance company. For the current inpatient and outpatient billing timeframes, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls” (5-1.3H), which is available at this website: [http://www.ihs.gov/PublicInfo/Publications/IHSMANual/Part5/pt5chpt1/part5chapt1.htm#3h]
An audit should be periodically conducted to sample the billing timeframe. For this process, simply review 25-to-50 recently paid accounts from each of your major payers.

1. Enter the discharge date or the date of the facility visit and then the date the bill was actually mailed or billed electronically to the insurer. Then count the number of days between those times. This figure should not be more than ten days for inpatient claim, based on discharge date.

2. Enter the date paid and the number of days between the date billed and the date paid. This figure should not be more than 30 days. If the figure is more than 45 days, there is an internal or system problem that needs to be reviewed.

The audit enables the facility to identify potential issues, bottlenecks in the process, system transmission issues, and business process workflow changes that can improve the day-to-day operations.

7.6.3 **Electronic Billing Systems - Checks and Balances**

With electronic submission of claims, you should ensure that a confirmation of receipt is received and the response reports are reviewed after each batch submission.

- Know the number of bills approved and ready for export by printing or displaying the Summary of Bills Ready for Submission option in RPMS Third Party Billing. Limit the number of bills you include in each batch to make the batch more manageable and to meet payer requirements.

- Ensure filename used to create the batch file complies with payer requirements.

- Create batch file using the Create EMC File option in RPMS Third Party Billing, and FTP from your RPMS file directory to prepare for export.

- After transmitting your batch file, compare the entries to the number of claims received by the payer. If they match, you are assured that the transfer mechanism you have in place is working. If they do not match, you could be omitting claims from your daily batch submission, and you will need to remedy this situation immediately.
Your insurer or billing vendor (clearing house) should be transmitting confirmation reports to you regularly that reflect the claims they received from you in your last transmission batch. Compare these figures to the number of claims you transmitted. If the numbers match, you will know the claims have been routed to the insurance companies. If the numbers do not match, you will need to contact your insurer or billing vendor to resolve the discrepancies.

It is important to examine your confirmation reports daily upon receipt. Periodically you may find claims that have failed payer specifications. It is imperative to correct and resubmit these claims promptly. If allowed to accumulate, these claims will have an adverse effect on your receivables, thus defeating one of the major advantages of billing electronically.

For any attachments requested with electronic billing, it is advisable to ask your insurer if they prefer a hard-copy of the report, or if the report can be faxed directly.

### 7.6.4 Benchmarking the Billing Process

As part of an ongoing review process, six-to-eight designated individuals – from either the facility, from the Area office, or from a contracted entity – should form a review group. This review group would focus on analyzing and finding solutions to problems in the billing process, by examining and comparing existing processes to successes of peers. This is called benchmarking.

If a health care facility wants to be the best, it must know how others manage to be so good. Benchmarking involves finding best-class examples of product, service, or operational systems, and adjusting the existing facility to meet those standards. Benchmarking can be the foundation for any receivables improvement program.

Benchmarking steps involved in the billing process are:

1. **Identify what is to be benchmarked.**
   
   It could be something tangible such as days, bad debt, or billing time or it could be something as intangible as patient satisfaction

2. **Identify comparative facilities.**

   Expect to spend some time on researching, perhaps visiting, and definitely comparing, other entity’s successes.
3. **Determine data collection method and collect data.**

   The team that conducts the studies determines what measurements will be used.

4. **Determine current performance levels.**

   Take the measurements of your own function and compare them with the measurements from the benchmarked facility. That usually produces a negative or positive performance gap.

5. **Project future performance levels.**

   Use the measurements of the gap to figure out what the new performance goals should be if that gap is to be closed, and how long it will take.

6. **Establish functional goals.**

   Write down your objectives.

7. **Develop action plans.**

   These plans tell how you are going to achieve the objectives.

8. **Implement the plans and monitor progress.**

   If the goals are not being met, problem-solving teams might be formed to figure out why.

9. **Recalibrate measurements.**

   Keep abreast of industry standards and new best practices.

10. **Communicate benchmarking findings and gain acceptance.**

    Present findings and recommendations to staff and to higher management for endorsement.
7.7 **Monitoring Productivity**

To just evaluate the productivity of a staff person from manual activities would be very hard to analyze. One of the ways where productivity could be tracked would be from a follow-up report that is generated for each financial category. The supervisor could review accounts randomly on the report for each follow-up person. Another way would be to have the follow-up staff turn in a weekly manual report on the number of accounts they have worked and the number of accounts paid.

Examples:

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<th>For...</th>
<th>Use...</th>
</tr>
</thead>
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<tr>
<td>Billing</td>
<td>Bills Listing Report, by approving official</td>
</tr>
<tr>
<td>A/R</td>
<td>Transaction report (TAR), by Accounts Receivable (A/R) entry clerk</td>
</tr>
<tr>
<td>Coding</td>
<td>Counts Report (RPMS PCC Application), by individual; also provides a summary report</td>
</tr>
</tbody>
</table>

7.7.1 **Billing Productivity Standards**

A recent survey demonstrates that billers average 53 bills per day or 6.6 bills per hour. The following guidelines provide an estimate for billing based on the electronic capabilities of the facility.

- **Fully Automated Facility**
  
  95-to-100% of edits are done on the computer. For this type of facility, a typical biller should send out at least 2,500 bills per month or at least 120 bills per day. Factors that could affect this quantity are payer mix, quality of bills produced by your system, and size and location of the facility.

- **Semi-automated Facility**
  
  Edits are made by hand, and an even number of electronic and paper claims are submitted. For this type of facility, a typical biller should send out at least 1,000-to-1,800 bills per month or around 86 claims per day.

- **Manual Facility**
  
  All information is keyed into the system by data entry staff and is mailed manually. For this type of facility, a typical biller should send out at least 35 bills per day.
Factors that affect the productivity of billers include:

- **The number of telephone calls received by the billers**

  Some billers are interrupted by incoming telephone calls all day. This can make a big difference in productivity.

  **Suggestion:** Establish a separate position within the billing department to handle incoming phone calls.

- **The volume associated with follow-up on outstanding accounts**

  Many billers have to follow up on their claims with third-party payers.

  **Suggestion:** If the volume associated with follow-up is too high, then have either a separate individual or area do the follow-up, or reserve a few hours each day for the biller to follow-up. For the latter, this will enable the biller to concentrate on billing rather than periodically interrupting their day for follow-up.

- **Problems with data moving through RPMS in a timely manner**

  Late charges are always an issue. The more late charges or orphan tests a biller gets, the bigger the billing backlog.

- **Billers also functioning as coders**

  Performing the multi-task functions of coding and billing, or checking the coding of the coder and billing, slows down productivity.

  **Suggestion:** Have a separate coding staff in the facility and have the biller focus only on billing.

- **Billing office setup**

  If the Billing office is setup where billers are assigned by insurer, some billers may be processing more paper claims while others are processing more electronic claims.

  **Suggestion:** Have your computer specialist or Area office work with the primary insurers that you are submitting paper claims, to determine whether these same claims can be submitted electronically.
• **Payer’s requirements**

A percentage of the claims processed require a great deal of manual work.

**Suggestion:** Meet with the insurance company to discuss payment problems, requirements, and solutions.

### 7.7.2 Ways to Divide Billing Workload

There are several ways to divide the workload in the Billing Department – by payer, by alphabet, or by team.

**Payer Split**

The billing responsibilities are divided into the major payer groups – Medicare, Medicaid, and private insurance.

**Benefits:**
- Billers become specialists by payer types. Billers can keep abreast of the changing requirements and regulations.

**Pitfalls:**
- With the secondary billing, such as Medicare and Medicaid or Medicare and private insurance, the same claim will be handled by two billers and may go back and forth. In addition, telephone calls with the two insurers may not consistently be handled between the two billers.
- Patient revenue mix may change, causing uneven workload among the billers.

**Alphabet Workload Split**

The billing responsibilities are divided according to an alphabetical split, based on the patients’ last name.

**Benefits:**
- Billers are responsible for billing all payers, and there is no controversy or back and forth between two billers with coordination of benefits.
- Billers become cross-trained with multiple insurers and can cover for other billers if they are on vacation or sick.

**Pitfalls:**
- With the third-party billing requirements changing rapidly, it may be difficult for billers to remain experts in all payers.
- Billers will need to be proficient with manual billing, as well as billing through the various insurer terminals.
**Team Workload Split**

A team is a combination of payer and alphabet billing processes. A team can be divided first by payer, and then further divided alphabetically.

**Benefits:**
- The Split promotes teamwork, rather than the “their job, not my job” mentality.
- There is more flexibility when staff is on vacation or sick.
- Team size can be shifted depending on work volume.

**Pitfalls:**
- Shifting staff from one team to another can create resistance to change or stress.
- Not everyone from the team can attend a meeting or a seminar, for no one would be available to work on the bills.

### 7.8 Training and Business Process Improvement

Constant change in health care rules, regulations, and guidelines makes training an imperative. The hazards of not taking the time to train, initially and at regular updates, can prove to be costly. Without proper training and leaving it up to the individual about where to go for information makes it difficult for the person to perform effectively.

For example, the results of improper training in Registration could result in (1) missing data elements that will slow the claims processing; (2) inaccurate data results in claim rejections and/or leads to rebilling; and (3) failure to obtain preauthorization within required time parameters leading to claims rejections and/or reimbursement denied in part of full.

The costs of improper training at the front-end show up in reduced reimbursements and/or increased staff effort as the back-end must duplicate tasks that should have been performed at the front-end.
## Training Basics

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<th>Description</th>
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<td>Create Processes</td>
<td>This entails identifying job requirements and creating processes to meet those requirements</td>
</tr>
<tr>
<td>Develop Policies and Procedures</td>
<td>Processes to meet job requirements need to be backed up with set policies and procedures that serve as guideline that can be referred to after training.</td>
</tr>
<tr>
<td>Create a Training Manual</td>
<td>This can be combined with developing policies and procedures. What is important is that staff has a written resource to which they can refer to independently resolve issues as they occur while remaining within established guidelines. Training is just someone conveying what needs to be done; staff needs something to refer back to.</td>
</tr>
<tr>
<td>Train</td>
<td>Bring staff together in small groups during work hours. Explain job requirements and the processes to meet those requirements. Be specific and use detailed examples. The best trainer tries to demonstrate to staff how their work fits into the bigger picture, and how their work is interrelated.</td>
</tr>
<tr>
<td>Set Goals and Objectives</td>
<td>Establish measurable goals in key performance areas. For registration, these can include registration accuracy, number of registrations to complete in a day, etc.</td>
</tr>
<tr>
<td>Monitor Performance</td>
<td>Quality assurance is required to determine if training is adequate. Among the management tools in monitoring performance are reports from the business office on why claims’ processing was delayed or why rejections occurred. These records will show if registration records are coming through incomplete or if information is inaccurate.</td>
</tr>
<tr>
<td>Provide Ongoing Training</td>
<td>Ongoing training can occur in refresher courses or informally one-on-one. Effective monitoring allows supervisors to provide training as needed. For example, if a staff person consistently fails to complete a certain field, the supervisor should speak with the staff person to review the problem and discuss why it is a problem.</td>
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7.9 **Pay-for-Performance Demonstrations**

Medicare has various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive health care services, including physicians’ offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies, and dialysis facilities.

The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders to ensure that

- Valid quality measures are used.
- Providers are not being pulled in conflicting directions.
- Providers have support for achieving actual improvement.

Through collaborative initiatives with public agencies and private organizations, CMS is developing and implementing a set of pay-for-performance directives to support quality improvement.

There are three physician demonstrations:

(1) **Physician Group Practice Demonstration (BIPA 2000)**

Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), this demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. The demonstration seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes.

(2) **Medicare Care Management Performance Demonstration (MMA section 649)**

Modeled on the “Bridges to Excellence” program, this is a three-year, pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards will receive bonus payments for managing these patients.
(3) Medicare Health Care Quality Demonstration (MMA section 646)

This demonstration, which was mandated by section 646 of the MMA, will be a five-year demonstration program under which projects enhance quality by improving patient safety; reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines, encouraging shared decision making, and using culturally and ethnically appropriate care.

7.10 Quality Improvement Organization

The Quality Improvement Organization (QIO) consists of local organizations that, by law, contract with the Centers for Medicare & Medicaid to provide quality improvement assistance to health care providers, such as physicians, hospitals, nursing homes, and home health agencies, and to health plans that contract with Medicare.

The QIO was established to redirect, simplify, and enhance the cost-effectiveness and efficiency of the medical peer review process. The three main functions of the QIO are to

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care.
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and that are provided in the most economical setting.
- Protect beneficiaries by expeditiously addressing individual cases, such as beneficiary quality of care complaints, contested hospital issued notices of noncoverage (HINNs), alleged Emergency Medical Treatment and Labor Act (EMTALA) violations (e.g., patient dumping), and other statutory responsibilities.

7.10.1 Proposed 8th Scope of Work

To help the QIOs, CMS is proposing an 8th Scope of Work - a plan that would include the following enhancements to the previous QIO contracts.

- It recognizes that although the U.S. Healthcare system has been leading the way in many improvements in health care, the full potential of our health care system to improve health is not being achieved. The plan aims to promote dramatic improvements in the quality of health care so that every person receives the right care every time.
• It proposes that the QIOs may need to build on their current efforts to involve other organizations and entities to provide the best possible expert assistance in increasingly specialized areas, and invites comments on options for accomplishing this through subcontracting and other partnerships.

• It indicates that the design of the program will be organized to better distinguish QIO impact from improvement that may occur without QIO assistance, such as increased awareness of clinical guidelines by physicians.

The 8th Scope of Work will guide the work of the QIOs for the three-year cycle beginning in August 2005. This proposal focuses on four settings:
• Nursing Homes
• Home Health Agencies
• Hospitals
• Physician Offices

It also includes the continuation of protecting beneficiaries and the Medicare Trust Fund through work on appeals, beneficiary complaints, payment error, and other case review activities.

The proposed work in the 8th Scope of Work moves beyond the current 7th Scope of Work in the following ways:
• QIOs will work to promote dramatic improvement, promoting the adoption and effective use of healthcare information technology (HIT), performance measurement, process redesign, and organizational culture change.

For example, working with partners in a pilot project, QIOs are assisting small-to-medium sized physician offices in California, Arkansas, Massachusetts, and Utah, in adopting office-based electronic health record (EHR) systems and using such systems to improve efficiency of care delivery, quality of care, and patient safety.

• When the Medicare prescription drug benefit becomes available in 2006, QIOs will work with prescription drug plans and providers to ensure quality care to people with Medicare on improvement projects, such as measures to detect inappropriately prescribed drugs and ways to identify patients who may be at risk for harmful interactions.
• QIOs will work to improve care for disadvantaged populations by focusing on physician office-based care to make sure all Medicare beneficiaries get the right preventive services and appropriate care for chronic diseases, such as diabetes.

• QIOs are expected to continue offering mediation as a service to Medicare beneficiaries. This service involves direct provider involvement in responding to beneficiary complaints, which often results in improved communication between provider and patient, in order to resolve quality of care issues.

This multi-pronged approach includes helping consumers make decisions using timely and accurate quality of care information, and urging providers to improve quality using free assistance from QIOs and through “pay-for-performance” demonstrations.
## 8. Compliance

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8.1 About the Corporate Compliance Program

A Corporate Compliance Program

- Ensures that facilities adhere to all pertinent Federal and State health care program laws, regulations, and guidelines.
- Serves as a mechanism for preventing and reporting any breach of those laws and regulations that fall within specified criteria.

A freestanding compliance program helps to ensure independent and objective legal reviews and financial analysis of an organization’s compliance efforts and activities.

Based on guidelines of the Office of Inspector General (OIG) and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an effective compliance program includes the following elements:

- Implementing written policies, procedures, and standards of conduct
- Designating a Compliance Officer and a Compliance Committee
- Conducting effective training and education
- Developing effective line of communication
- Enforcing standards through well-publicized disciplinary guidelines
- Conducting internal monitoring and auditing activities
- Responding promptly to detected offenses and developing corrective actions

8.2 Implementing Written Policies and Procedures

Written policies and procedures are a central element of any compliance program. They help to reduce the possibility of erroneous claims and fraudulent activity by

- identifying risk areas for the provider
- establishing tighter internal controls to counter those risks, while helping to identify any aberrant billing practices

IHS facilities should establish an integrated set of policies and procedures and general sanctions for violations of compliance regulations.
8.3 Designating a Compliance Officer and Committee

Each Area will designate a Corporate Compliance Officer, who will have the authority and responsibility to administer and manage all tasks related to establishing, monitoring, and updating the Corporate Compliance Program. To ensure success of the program, each Area Corporate Compliance Officer (ACCO) will:

- Have direct access to the Area Director, helping to ensure that a system of checks and balances is established to effectively achieve the goals of the compliance program.
- Provide coordination with each Service Unity, communicating with parallel positions in each facility.

Additionally, each Service Unit will designate a Compliance Officer, who will be responsible for overseeing the administration of the compliance program for their Service Unit. The Service Unit Compliance Officer, in coordination with the ACCO, will be responsible for directing all compliance activities within the Service Unit.

The Corporate Compliance Committee will be responsible for:

- Guiding and supervising the implementation of the Corporate Compliance Program plan.
- Assisting with the implementation of compliance policies and procedures, in accordance with the directives outlined in the Corporate Compliance Plan.

8.4 Conducting Effective Training and Education

Significant elements of the Corporate Compliance Program include proper education and training of all IHS facility personnel, including directors, managers, employees, physicians, and other health care professionals; as well as continual retraining of personnel at all levels.

Education activities include attending seminars and courses related to:

- Federal and State statutes, regulations, and guidelines
- private payer policies
- coding and billing requirements
- claim development and submission processes
Training will be targeted to personnel whose actions affect the accuracy of claims submitted to the government, such as coding, billing, and cost reporting, and the duty to report misconduct.

8.5 Developing Effective Lines of Communication

There should be open communication between the Corporate Compliance Officer and the Compliance Officers and all employees at the facilities, so that the potential for fraud and abuse is substantially reduced. Examples of ways to maintain lines of communication include:

- Hotlines
- E-mails
- Memos
- Newsletters

Hotline numbers for accepting anonymous reporting should be posted in conspicuous locations at all facilities.

Confidentiality and retaliation policies and procedures must be in place and be distributed to all employees. For example, a whistle-blower policy should be in place to encourage the reporting of incidents of potential fraud in a safe environment without fear of retaliation.

All reported incidents should be documented and investigated promptly to determine veracity.

8.5.1 Developing an Effective Communication System

A compliance program’s system for effective communication should include the following:

- The requirements that staff report conduct that a reasonable person would, in good faith believe to be fraudulent or erroneous
- Creation of a user-friendly process, such as an anonymous drop box, for effectively reporting fraudulent or erroneous conduct
- Provisions in the policies and procedures which state that a failure to report fraudulent or erroneous conduct is a violation of the compliance program
- Development of a simple and readily accessible procedure to process reports of fraudulent or erroneous conduct
8. Utilization of a process that maintains the confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation

8. Provisions in the policies and procedures that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be fraudulent or erroneous

8.6 Enforcing Standards through Well-Publicized Disciplinary Guidelines

Comprehensive policies and procedures must be in place, which define the degrees of disciplinary actions that can be imposed on directors, managers, employees, physicians, and other health care professionals for failing to comply with an Area/facility’s standards and policies and procedures, and applicable Federal and State laws and regulations.

Directors, managers, supervisors, medical staff, and other health care professionals should be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, policies and procedures, and laws. Additionally, failure to detect and report violations of the compliance program may be subject to discipline, and will be noted in the disciplinary procedure.

The consequences of non-compliance should be applied and enforced consistently. Disciplinary actions could range from oral warnings to suspension, privilege revocation, or termination, based on the seriousness and type of violation.

Managers and supervisors will be educated regarding their responsibility to discipline employees in an appropriate and consistent manner. Depending on the violation, some issues will be handled at the department level, while more serious violations may need to be resolved by a more senior manager or director. Checks will also be performed to insure that no employee is included on the OIG or GSA list of individuals excluded from participation in a Federal health care or Government procurement program.

All staff will receive a copy of the disciplinary policy for compliance violations and will be asked to sign a statement of receipt of the policy. A statement that all disciplinary action will be taken on a fair and equitable basis should also be included.
Any communication that results in the finding of non-compliant conduct will be documented in the compliance files, including the date of the incident, name of the reporting party, name of the person responsible for taking action, and the follow-up action.

8.6.1 Employment Guidelines

Area offices and facility policies must prohibit the employment of individuals or execution of contracts with companies, who have been recently convicted of a criminal offense related to health care, or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs, as defined by 42 W.S.C. 1320a-7b(f).

Employment applications shall require the applicant to disclose any criminal conviction as defined by 42 U.S.C. 1320a-7(i), or any exclusion action.

Any individual or contractor who has criminal charges or is pending debarment or exclusion shall be removed from any direct responsibility for or involvement in any Federal health care program. Should the individual or contractor be found guilty of such charges, or be debarred or excluded, will be terminated.

New employees, who will have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, shall be subject to a reasonable and prudent background investigation, which includes a reference check.

Any potential employee or contractor, who has been officially reinstated into the Medicare and Medicaid programs by the OIG, may be considered for employment upon such proof of reinstatement.

8.7 Conducting Internal Monitoring and Auditing Activities

Ongoing auditing and monitoring activities are critical to a successful compliance program and should be key features in any annual review of the effectiveness of the compliance program.

The Area Corporate Compliance Officer (ACCO) will

- Recommend and facilitate auditing and monitoring of identified risk areas related to compliance with laws and regulations, and organizational policies, procedures, and standards of conduct.
• Provide guidance and assistance to those conducting and/or supervising compliance reviews.
• Verify completion of compliance reviews and validate corrective measures that address any weaknesses identified by the process.
• Report the general status and outcome of compliance auditing and monitoring to the Governing Board.

For further discussion on monitoring and auditing activities, see Part 1, Chapter 8, Section 8.9, “Evaluating and Monitoring Compliance-Related Risks.”

8.8 Responding to Detected Offenses and Developing Corrective Actions

According to the OIG, one of the seven essential elements for an effective compliance program is the investigation and remediation of identified systemic problems.

Audit and review follow-up are integral parts of good management and an effective compliance program. To ensure that identified problems and/or weaknesses do not recur, it is essential that management take corrective action on findings and recommendations.

8.9 Evaluating and Monitoring Compliance-Related Risks

The Area Director (AD) and Service Unit Directors (SUD) are tasked with two general types of monitoring and auditing requirements:
• The AD and SUD should be responsible for ensuring that the elements of the compliance program remain effective.
• The AD and SUD should ensure that areas of risk are monitored consistently and appropriately. However, individual Department managers and/or Area Program managers should take the lead in addressing their particular areas of risk, as they have a better understanding of those risk areas.

Although it is not necessarily the responsibility of the AD and SUD to conduct audits, they should coordinate efforts to secure the resources and experts (internal or external auditors) needed to perform compliance audits.
8.9.1 Benchmarking

The OIG recommends that before implementing a compliance program that an organization benchmark their compliance performance and knowledge. These assessments can be performed by outside consultants or internal staff with authoritative knowledge of compliance requirements. The benchmarks would become a baseline to ensure that the elements of the compliance program are operating effectively.

To complete their initial reviews, officials should consider:
- visiting sites where procedures associated with compliance are performed
- Interviewing personnel involved in management, operations, coding, claim development, and submission, patient care, and other activities associated with compliance risk areas.
- using surveys to collect information associated with compliance risk areas

8.9.2 Performing Periodic Reviews

Besides the benchmark review, periodic reviews (at least annual) should be performed to determine whether key components of the compliance program are operating effectively. Reviews should address compliance with laws governing:
- Kickback arrangements, the physician self-referral prohibition
- CPT/HCPCS & ICD-9 Coding
- Claim development and submission, and reimbursement
- Cost Reporting
- Marketing
- Internal Management Controls IHS rules and regulations
- Physician Contracts
- Vendor gratuities
- Excluded individuals and entities
- Quality of care monitoring
- Sarbanes-Oxley Act of 2002 (Corporate Governance)
- Compliance program testing and effectiveness
These reviews should address all risk areas, including external relationships and third party contractors, especially those with substantive exposure to governmental enforcement actions.

Types of reviews include:

- On-site visits
- Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities
- Reviews of medical and financial records and other source documents that support claims for reimbursement, as well as Medicare cost reports, such as denial logs
- Trend analysis, or longitudinal studies that seek positive or negative deviations in specific areas over a given period
- Patient satisfaction surveys and patient complaint logs

8.9.3 Auditing Activities

Additionally, audits should inquire into compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG Audits and Evaluations, and law enforcement initiatives. Examples of audits include:

- Observation services
- Medicare 3-day window
- Co-payment collections, claims denials
- Medicare secondary payer billing
- Department specific audits, such as
  - Admission review,
  - Pharmacy billing, distribution, and internal controls,
  - clinical chart
- HIPAA Privacy and Information Security audits, such as
  - Use and disclosure of protected health information (PHI),
  - Employee access to PHI,
  - Network security review
Physician practice, including,
- Outpatient rehabilitation documentation,
- Medical staff credentialing and privileging

Financial audits, including
- Central billing office and payroll
- Financial detection and prevention of fraud
- Credit balances
- Bad debt write-offs

Cost report audits, including
- Grants and gifts
- Hospital-based and Emergency Department physician payments
- Asset and accelerated depreciation

8.9.4 Monitoring Activities

Monitoring activities include sampling protocols to identify variations from an established baseline. Significant variations from the baseline should trigger an inquiry to determine the cause. If the variation is the result of program deficiencies, prompt steps should be taken to correct problems due to program deficiencies, flawed policies and procedures, or a misunderstanding of or known violation of rules, regulations, or procedures.

For example, any overpayments discovered that are the result of such problems should be returned promptly to the affected payer, with appropriate documentation and a thorough explanation of the refund.
A. Business Office Workflow Diagrams

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Registration – Centralized

Verify patient appointments by telephone the day before

Patient enters and signs in

Registration

Scheduled
• For clinics with hard copy medical records, pull the night before
• Update demographics, if changed
• Obtain necessary pre-authorizations or referrals
• Update and verify insurance monthly (includes medical, dental and/or pharmacy)
• Copy insurance card (both sides), if changed,
• Complete required forms, if needed
• Obtain all necessary signatures
• Update Registration package or PIMS
• Patient goes to designated clinic waiting room

Register patient, refer to BC, any patient who potentially may qualify for an alternate resource

Patient Benefit Coordinator

Walk-in
• Triage screening
• View health summary (print copy or view on-line)
• Pull medical record if patient will be seen or refer to appointment clerk to schedule appointment or refer to Emergency Room
• Same registration process as listed under Scheduled patient

• Perform an assessment to determine if patient qualifies for alternate resource(s)
• Assist with completion of paperwork
• Follow-up with patient or State
• Assist with completion of Medicare paperwork for Part B or D
Registration – Decentralized

Patient enters and signs in at a specific clinic, not a centralized registration area.

Scheduled
- For clinics with hard copy medical records, pull the night before
- Update demographics, if changed
- Update and verify insurance monthly (includes medical, dental, and/or pharmacy)
- Copy insurance card (both sides), if changed
- Complete required forms, if needed
- Update Registration package or PIMS
- Initiate printing of PCC+, if used at that clinic
- Patient goes to designated clinic waiting room

Walk-in
- Triage nurse screening and documentation
- View health summary (print copy or view on-line)
- Pull medical record if patient will be seen or refer to appointment clerk to schedule appointment or refer to Emergency Room
- Same registration process as listed under Scheduled patient

All elements of the registration process are duplicated at each clinic for scheduled appointments and walk-ins.

Registration refers to BC any patient who potentially may qualify for an alternate resource

Patient Benefit Coordinator
Registration – Emergency Room

**Note:** For After Hours Care or if staff unavailable to enter updates to demographics and insurance, need to send patient to registration staff

Patient Arrives and signs-in with Emergency Room Registration staff

**Triage Nurse**

- Prints or reviews online patient's health summary
- Completes triage and documents

**Urgent/Emergent**

- Treated and released
- Proceed through registration process before leaving
- Forward PCC or PCC+ to Billing office

- Transfer to inpatient
- ER nurse notifies inpatient nurse of disposition of patient
- Send Medical chart to inpatient
- Registration goes to patient room to obtain insurance, demographic information

**Non-Emergent**

- Patient referred back to complete the full registration process prior to visit with provider
- Screened by provider and patient referred to clinic appointment clerk to schedule an appointment (e.g., prescription refill)

**Note:** If non-beneficiary patient, ER staff should collect payment before patient leaves

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Medicare 72-Hour Admit Business Process

Medicare patient seen in Emergency Room or outpatient clinic

Designated clerk checks dates on ER or OPD log with admission date

Has Medicare patient received any OP services 3 days prior to admission?

Yes

- Clerk checks OP and Inpatient document and conflicting charges exist
- Registration documents for IP and OP are combined and taken to billing
- Any other conflicting visits within 3-day window are consolidated
- Biller documents note in RMPS system
- Claim submitted to Medicare

No

- Note made in RPMS system that check was done
- OP and/or inpatient claim proceed to billing

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Part 1. Administrative Roles & Responsibilities
A. Business Office Workflow Diagrams

Version 1.0
July 2006

Part 1 - A-4
Scheduled Admission

- Notification received from Admitting
- Conduct phone interview with patient for demographic and billing information
- Inform patient of any pre-admission testing need – time and date
- Enter pre-admission information into RPMS System
- Verify insurance eligibility, by telephone or electronically, and enter into RPMS system
- Obtain Pre-Certification number, if needed
- Notify Patient Benefit Coordinator if insurance will not cover admission
- Obtain patient admit number or document control number
- Complete remainder of forms for admission, such as MSPs, advance directive, assignments, etc.

Inpatient Admission

Admitting provider notifies Nursing of patient medical status

At Admission
- Write orders for patient

At Discharge
- Provider writes discharge orders and follow up instructions
- Pharmacy is notified of discharge orders and prepares any take home medications
- Case Management arranges for home health or DME as needed
- Discharge time entered in patient medical record

- Transcribe order
- Contact dietary, if necessary
- Order labs or x-ray (STAT if needed)
- Notify Pharmacy of patient admit

- Referral of patients without insurance to determine if patient qualifies for Medicaid
- Assist patient with the paperwork process
- Follow up with Medicaid to determine when coverage is effective
- Update RPMS Registration package with Medicaid number and effective date

Note: Medical Records performs an analysis of health record on discharge

Prior to leaving facility, patient may be routed through Benefit Coordinator, if resources outstanding or MA process incomplete
Clinic

Patient called from waiting room by nurse or medical assistant

Nurse
- Obtain vitals and chief complaint
- Complete any standing orders or EKG, if needed
- Document information on PCC, PCC+, or EHR
- Update GPRA-related information

Provider
- Exam patient
- Order lab, x-ray, or pharmacy with symptom or diagnosis, manually or electronically
- Document note in PCC, PCC+, or EHR
- Code E&M and diagnosis(es) in PCC, PCC+, or EHR
- Return patient to nurse for further direction, additional testing, or education

Coder
- Validate E&M and diagnosis coding of provider (Daily)
- Enter any additional coding data (Mnemonics, health factors, etc.) (Daily)
- Validate symptom or diagnosis for lab or x-ray
- Coordinate any discrepancies with provider

Patient to pharmacy, lab or x-ray
- Either patient hand comes requisision to lab or x-ray or request is sent electronically
- For pharmacy, medical record is hand carried by staff to pharmacy or request is sent electronically

Billing

Billing
- Print Flagged Billable Report
- Review claims in Billing system for accuracy and completeness
- Toggle to EHR record, if needed, or query coder regarding question
- Review manual forms for accuracy
- Bill manually or electronically, depending on insurance
- Form working relationship with insurer
- Communicate coding or insurer policy changes to coder and provider
- Return discrepancies to coder or provider

Note: Manual claims are sorted by insurer and sent with a cover sheet to the respective insurance company
### Inpatient Billing

- Print all Admission sheets for previous day’s admissions
- Print Admission and Discharge sheets, Census sheet, and Length of Stay reports
- Have Utilization Review, review admission
- After discharge, receive completed record from UR with notes that admission met approval criteria along with Certified Hospital form
- Re-verify Medicare eligibility and determine type of Medicare coverage
- Connect electronically and bill
- Input billing information
- Submit
- Return documents to UR for storage
- Obtain electronic report from Medicare as to whether admission approved, error in transmission, or rejected
- Look up claim transmittal number in written Medicare Admission log
- After any corrections on UB-92, re-bill Medicare electronically
- Receive Remittance Advice Report on claim from Medicare
- Billing complete

### Account Reconciliation

**PNC Bank** — electronic deposit and hard copy EOB back to clinic
- **OR** -
  - PNC Bank — electronic deposit with hard copy EOB to Area office and Area office documents log and sends copy of EOB or RA to clinic
  - **OR** -
  - Hard copy EOB or RA and hard copy check to clinic
  - **OR** -
  - Hard copy EOB or RA and hard copy check to Area or Finance office. Area or Finance office deposits check and sends EOB or RA to clinic

**Account Reconciliation**

- Receive and review Explanation of Benefits or Remittance Advice for accuracy in payment and in correct clinic being paid
- Forward copies of rejections or inaccurately paid claims back to debt management for research
- For non-electronic posting, post each payment, adjustment and/or write-off to patient’s account (includes all clinic and ancillary services)
- File EOB or RA when completed
- Return any EOB or RA paid for refunds, first to Finance and then to the insurer with a documented note

---

**Note:** As part of the check and balance process, checks must be verified and validated by Finance before depositing. Copies of checks must be maintained in Business and Finance offices. Check and RA or EOB are also copied, if both are being returned to the insurance company for refund.

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**Business Operations Process Complete**
45-Day-Old Claim Follow-up Cycle

Start:
Claim reviewed by AR;
Checks Message field for last FU
date and action

Third Party contacted
by tracer, phone,
AR letter

Claim billed,
if necessary

Additional follow up,
if necessary

Claim Status
Documented in AR
Message note

Tickler dates for
promised payment
in AR Message note

Stop:
Claim paid
or adjudicated

Format for standardization
for ease of look up

Laboratory (RPMS Lab Users)

Provider ordered test, or standing order

Non-EHR Clinic

- Requisition form completed by nurse that includes:
  - Codes and lab procedures
  - Reason for test
  - Provider name
  - Patient name
  - Date
  - Clinic name
- Patient hand carries to lab
- Lab places arrival time on requisition form
- Log information in Lab package

EHR Clinic

- Provider electronically enters order for
test in EHR (diagnosis not entered, but is
referenced in provider EHR note)
- Lab order prints in Lab

Lab

Lab enters LAB CPT codes

Reference Lab

- Send blood and copy of
  requisition to reference lab
- Results returned electronically
- Copy to provider to sign
- Results entered in RPMS
- Copy retained in medical record

Print labels and draws blood
- PCC form completed for lab when
done on other than visit day

Lab Results

- Results sent to provider to
  review and sign
- Enter data in Lab package
- Hard copy in Medical Record

To Billing to combine
or link with visit and
bill private insurers
Provider orders test(s)

**Non-EHR Clinic**
- Data enter orders in Radiology package
- Radiology requisition filled out by Nursing to include:
  - Site (right or left, which finger, etc.)
  - Reason for test
  - Provider's name
  - Patient name
  - Date
  - Clinic name
- Patient hand carries requisition to x-ray

**EHR Clinic**
- Electronic order entry with same information as non-EHR clinic requisition
- Radiology order prints in x-ray

**Radiology**

- Register patient in radiology package
- Enter CPT in RPMS, enter Radiology package details (room, views, type) and Case number issued
- Render test
- X-ray sent electronically or hand-carried to a hospital for interpretation, or read by a radiologist at the clinic for interpretation
- Interpretation immediately or within a couple of days, depending on process
- Electronic cut and paste into EHR
- All hard copy, provider signed final reports placed in patient's medical record
- Billing sent information on test as soon as completed – do not wait for interpretation to bill
- PCC form for radiology only test
Pharmacy – Non-EHR

Medical Record with PCC or PCC+ and pharmacy order hand carried to pharmacy

Pharmacy Tech
- Determine if patient can wait for script or pick up later
- Check to see if patient has insurance

Quick file
- Emergency Room
- Pediatrics
- Patients in pain

Other script fills
- Patients waiting for scripts
- Patients picking up script later or next day

Pharmacy Screen
- Review previous visits and lab results in hard copy medical record
- Validate order and dosage from PCC/PCC+
- Check for drug-drug reactions
- Check for transcription errors

Pharm Tech I → Pharm Tech II → Pharmacist
- Type order into Point-of-Sale
- Fill script manually or use Script-Pro
- Dispense script
- Educate and counsel patients

Pharmacy – EHR

Provider
- Provider electronically orders pharmacy

Pharmacy
- Pharmacy order prints in pharmacy
- Pharmacy tech matches order with Electronic medical record
- Pharmacist reviews Current EHR provider note, previous medical notes, and lab results

Remainder of EHR Pharmacy workflow is the same as Non-EHR, beginning with the Pharmacy Tech review.
Pharmacy Only

Patient registers at central registration OR at pharmacy registration area

Pharmacy

Pharmacist orders Medical Record to review script order
OR pharmacist reviews order on EHR

No Refills Remaining

- Pharmacist contacts the provider, reviews the refill request with provider, AND
  - Obtains approval OR
  - Does not obtain approval and requests that patient make appointment with provider
- Pharmacist provides a couple-day supply and requests that patient make appointment with provider

Refill Approved in Medical Record

- Pharmacist reviews Medical Record, lab results, other drugs being used, and fills script according to process in Pharmacy non-EHR workflow
- Pharmacist completes PCC with initials, or updates EHR record with script filled and electronic signature

For Billing pharmacy, see workflow diagrams in Pharmacy package
EHR and Point-of-Sale Billing

Provider
- Review prior medication list
- Order enters pharmacy orders electronically

Pharmacy
- Review new or renewed order (pharmacist, not pharmacy tech)
- Assess incompatibilities
- Assess dosage
- EHR toggle
- Review lab results
- Review prior pharmacy orders and prior lab results
- Enter POS, obtain eligibility, and bill

Approved
- Fill script
- Page patient
- Counsel and educate
- Document note
- Dispense script

Denied
- Pharmacy staff
  - Correct and update system for pharmacy-related issues

Billing Office staff
- Review pharmacy rejections related to insurance and update system
- Back to Pharmacy to re-bill
- Write-off all correct denials

E-mail responses and edit EHR

Note: For those insurers not covered under POS, a PCC or PCC+ must be sent to Billing to manually bill the insurance company.
Physical Therapy

Pre-authorization obtained

Physical Therapy

- Patient referred to PT by clinic provider or specialty provider group outside of clinic
- Patient schedules appointment with PT
- Patient presents

Registration

- Patient checks in at registration or directly at PT clinic (does not have to recheck at registration each visit)
- Patient updates demographic and insurance information only if update needed

Therapist

- Visit with patient
- Complete Plan of Care
- Complete PCC or PCC+ or superbill
- Retain Plan of Care and PCC, PCC+ or superbill in Medical Record
- Update each visits
- Submit copy to coding when therapy complete

Coder

- Review codes and/or code from PCC
- Query PT on any questions
- Enter data in RPMS system

Billing

- Review billable report
- Review coding
- Bill electronically or manually
- Follow up

PT occurs over a period of several weeks and is usually billed weekly or at the end of treatment collectively.
Behavioral Health

Add registration, pre-authorization; Utilize Mental Health Package

- Obtain consent to treat
- Refer to Triage Worker

Triage Worker → Clinician → Provider → Same coding, data entry, and billing process on the back end

- Screen patient and determine patient needs
- Refer patient to clinician

- Perform registration process for demographics, if not updated, and insurance to determine if patient has coverage for behavioral
- Appointment scheduled and intake form completed
- Refills, meds issued, if necessary
- Schedule follow up visit or hospitalize patient, if medically necessary

- Visit with patient
- Complete PCC or EHR
- Document codes for visit and diagnosis on PCC or EHR
- Send patient to pharmacy if meds needed

It is recommended that coding and data entry for behavioral be done by the staff in the Behavioral Department to maintain confidentiality and privacy.

Optometry

Registration → Optometry Clinic Secretary → Provider → AR

- Registration update performed at Central Registration or by Registration staff in Optometry department
- Medical record sent to Optometry clinic with PCC or PCC+ form
- Send patient to Optometry clinic and use EHR.

- Check in patient and place patient in queue
- Call patient to exam room

- Schedule follow up visit
- Schedule consults
- Schedule surgery
- Enter all codes

- Complete exam
- Complete documentation on PCC, PCC+, or EHR
- Code visit, service, and diagnosis
- Technician orders lenses

Due to the uniqueness of this clinic, it is recommended that all coding and data entry occur within the clinic.
Pediatric

Front Desk → Waiting Room
- Walk-in or scheduled patient signs in
- Match medical record with PCC+ for scheduled patients
- If EHR, provide Triage nurse with list and Medical Record number

Registration → Triage
- While patient sits in waiting room, obtain name, medical record number, and date of birth.
- While nurse examines patient, verify insurance electronically
- Update demographics
- Complete any needed forms
- Establish new charts
- Provide new applications for those without insurance
- Copy new insurance cards (copies kept in notebook in Business Office)
- Refer patients to Benefit Coordinator
- Patient returns to waiting room

Triage → Emergent Children sent to ER
- All walk-ins are numbered sequentially
- Walk-ins are interspersed with scheduled patients based on medical need
- Obtain purpose of visit and vitals
- Print PCC+ for walk-ins
- Electronically request medical record for walk-ins; Medical Records staff delivers to clinic
- Update EHR notes, if using EHR

Continued
Pediatric, Non-EHR

Unit Clerk completes lab and x-ray requisition form, if not using lab or x-ray package

Provider
- Perform clinical exam and provide care
- Document PCC+ or PCC
- Order lab, x-ray, and/or pharmacy on PCC or PCC+
- If pharmacy not ordered, medical record and PCC+ goes to coder

Coder
- Review PCC+ for completeness
- Code where provider only provided written information
- Discuss questions directly with the provider
- Obtain and enter verbal changes from provider
- Change coding to comply with documentation
- Enter vitals, codes, health factors, supplies data
- Send Medical record with PCC+ (initial information entered) to Medical Records

Pharmacy
- Medical record and PCC+ hand carried by staff to pharmacy
- Scan PCC+ for completeness
- Review orders, medical records and lab information
- Enter into Point of Sale
- Fill script
- Counsel and educate patient
- Medical record with PCC+ to Medical Records
Pediatric, EHR

- Perform clinical exam and provide care
- Document notes in HER
- Code Evaluation and Management visit and diagnosis
- Order lab, x-ray, and pharmacy electronically via EHR
- Patient sent to lab, x-ray, or pharmacy after final directions and education by nurse

- Review EHR for completeness
- Code where provider only provided written information
- Questions discussed directly with the provider
- Obtain and enter verbal changes from provider
- Change coding to comply with documentation
- Enter vitals, additional codes, health factors, supplies data

- Review orders, medical records, and lab information on EHR
- Enter into Point-of-Sale
- Fill script
- Counsel and educate patient
- Dispense meds

- Print flagged billable report
- Review codes and randomly toggle to EHR for review of documentation
- Bill manually or electronically
- Follow up on outstanding accounts and rejections
- Has a detailed understanding of pediatric benefits for each insurer
Podiatry

**Walk-in**
- Patient presents at Central Registration or Podiatry Registration
- Patient signs in and completes a walk-in form
- Provider reviews either medical record or EHR to determine if patient will be seen between scheduled appointments or will need to schedule an appointment in the future

**Scheduled**
- Patient checks in at Central Registration or Podiatry Registration
- Demographic and insurance information updated
- Forms completed, if needed
- Insurance card copied, if needed
- Insurance eligibility verification done

**Appointment Clerk**
- Complete visit
- Document clinical note on PCC, PCC+ or EHR
- Code procedure, visit and diagnosis on PCC or PCC+ or enter information on HER
- Electronically order lab, x-ray and/or pharmacy

*Because of the uniqueness of this department, it is recommended that coding and data entry be done within the department, or a specialized coder be trained to work with Podiatry.*
Proposed EHR Workflow

**Provider**
- Clinical care and treatment
- Electronic order entry—lab, x-ray pharmacy
- Enter clinical care data in template
- Enter CPT, ICD9, and HCPCS codes, health factors, and other QPRA data
- Document next appointment

**Clerical Support/Analyst**
- Review and correct error report for clinic
- Review and correct rejection report for pharmacy (non-clinical)
- Sort and mail manual insurer forms

**Biller**
- Run billable list segregated by insurer (after 48 hours, to allow lab, x-ray, and pharmacy to enter data in system)
- Review EHR documentation (toggle) for
  - Clarification of orders
  - Questionable codes
  - Random Sampling
  - Merge lab, x-ray or pharmacy only visits
- Bill electronically or manually dependent on insurer

**Coder**
- Located in all clinics including Emergency Room
- Validate provider coding in conjunction with provider data entry
- Discuss any codes in question
- Corrections made by provider in system
- Assist with error report resolution

**Follow-up Staff**
- Follow up on rejections (medical and pharmacy) and researches insurer requests

- Patient to lab, x-ray and pharmacy without medical record
- Patient to nurse for education/directions