The following presentation was presented during the Indian Health Service

Patient Registration & Patient Benefits Coordination Training

July 12-15, 2022

If you have questions about this presentation you may contact the presenter(s) or you may send an email to ihsbusinessoffice@ihs.gov

Please note: The aim of this presentation is to share and facilitate the sharing of helpful information, but please note that it may reflect presenters’ opinions and not necessarily those of the Indian Health Service or the U.S. Department of Health and Human Services.
Best Practices for Collaboration
What Makes Our Collaboration Work

• All parts of collaboration between departments must have the same mission and goal to improve process and maintain the collaboration
  ✓ Bridging gaps
  ✓ Role clarity and overlapping roles
  ✓ Creating and maintaining relationships between stakeholders
  ✓ Model for process improvement (small test of change, PDSA)
Call Center

• Is an extension of the clinical care team and the primary entry for access to care for many of the patients.

• Receives calls for patients seeking general information regarding services at PIMC, and patients seeking services from a variety of clinics.

• Is an important role in the revenue cycle and patient care.
Call Center

- Register new patients and conduct full registration over the phone.
- Will complete an update for returning patients.
- Pre-determine PRC eligibility for every appointment scheduled.
- Verify and enter private insurance for every appointment scheduled.
- Help provide PRC’s scheduling information via EHR PRC Note.
Front Desk Registration

- Update patients at check in - pre-determine PRC eligibility
- Issue necessary forms - PRC Direct Care letter
- Refer to a Benefit Coordinator
  - Issued pre-vetted applications up front
  - Issued a visual queue for clinical staff to see if they need to see a BC
- Participate in PRC Committee
- Decentralized registration layout
  - Strict standards
  - Regular training
Registration and PRC

Dear Patient:

You have been identified as not being eligible for Purchase Referral Care benefits at the Phoenix Indian Medical Center. The PIMC PRC Program is regulated by the Code of Federal Regulations Title 45, Part 1326, Subpart C. For more information, please visit the Indian Health Service website at the web address, http://www.its.gov/policy/mandated cata/usfcoverages.

In accordance with above regulation, you are INELIGIBLE for PRC Funds to cover total or partial health care-related costs for services received off the main PIMC campus as:

☐ You do not reside on any of the tribal reservations within Maricopa County and are not an enrolled tribal member or descendant of any of these tribes.

☐ You are not affiliated with any of the local tribes within Maricopa County via tribal employment or marriage (blood/consang.).

☐ You have established residency outside of your local reservation. PRC benefits are only available in the Phoenix Indian Medical Center and its service area.

☐ You are a full-time student and have not informed your home service unit of your student status. You are eligible for continued PRC eligibility through your home service unit however you are required to provide a Letter of Acceptance from the educational institution you are attending. Please communicate with your home service unit as they may require additional information.

☐ Your PRC eligibility will continue with your identified home service unit.

THIS DOES NOT IMPACT HEALTH CARE SERVICES RECEIVED AT THE PHOENIX INDIAN MEDICAL CENTER OR ANY INDIAN HEALTH SERVICE FACILITY.

If the above information is incorrect, please submit required documents (Tribal Identification card, Employee ID and Paystub if employed by local tribes, tribal utility bill with address or marriage license) to make corrections.

Sincerely,

Phoenix Indian Medical Center Purchase Referred Care Program

What Can You Do, If Denied PRC Funding?

If payment is denied, a letter will be sent to you by the PRC Department. This denial letter gives the reason(s) for denial and explains your rights to appeal the decision.

You have 30 days from the receipt of the denial letter to appeal the decision to the local level (PIMC/PRC). If you have additional information that was not provided to the PRC Department, you may submit it with your appeal.

If you are not satisfied with the response from the local level, you may send a letter of appeal to the second level at the Phoenix Area Director within 30 days of receiving the local level decision.

Your final appeal may be made to the Director, IHS, and their decision constitutes the final administrative action at the IHS.

Important Things to Know:

It is important for you to find out from PRC who will be responsible to pay for your medical bills before you get medical care outside of PRC. If you do not get refused approval before you go outside of PRC, you may be financially responsible.

PRC is only available to eligible patients who are covered by a PRC program. If you are not enrolled, you may be financially responsible.

Your Responsibility:

It is your responsibility to register with the local IHS hospital or clinic. When you register, your eligibility for "direct" care is determined.

When you register, you will need to show proof of your Indian descent and you will be asked to verify where you live.

PIMC Purchased & Referred Care

Access to your care team for:
- Outside Appointments
- Care Coordination
- Referral Status
- Billing Questions

Save time by using this direct phone number instead of the main operator:

602-261-1569 PRC Phone
602-261-1569 PRC Fax
pimcprc@ihs.gov PRC Email

Office hours: 8:00AM-4:30PM

Purchased & Referred Care (PRC)

Phoenix Indian Medical Center
4210 North 16th Street
Phoenix, AZ 85006

Last Updated: February 2023
Call Center - Challenges During COVID

- Physical space - social distancing
- Access to care
- Managing the revenue cycle
- Evolving clinics all over campus
- Bringing in new aspects due to COVID - Testing, Results, and Vaccine
- Compassion Fatigue
Front Desk Registration - Challenges During COVID

• Being pulled for other aspects and added extra clinic screening process.

• Lack of registration due to need for social distancing, or new physical barriers.
  • Form collection, Tribal verification collection
  • New patient registration for non-call center related area’s

• Telemed visits - managing registration increasing telemed visits.
PRC collaboration with Patient Business

- PB staff reviews patient demographic information prior to PRC review committee. They verify alternate resources, place of residence, household members, and add new chart numbers for newborns. Result is approval of patient referrals within 3 business days.

- PB staff assist the PRC accounts payable section. They verify alternate resources and enter AZ Medicaid coverage for both prospective and retrospective, add information in Page 8 and insert new private insurance information. Result is cost saving of PRC funds and identify primary payor.

- PRC staff utilizes a PRC note in EHR - document is available for the call center, medical teams and Pharmacy to review status of patient referrals. Benefits Coordinators enter a PRC note and make addendum to complete PRC determination. Result is improved communication, dispense of medications and coordination of care. See example:
PRC collaboration with Patient Business
During the pandemic the PRC staff implemented a new electronic process for the PRC review committee. We developed a form, used Adobe Acrobat, members signed form electronically and end result is approval/denial of patient referrals within one day.
PRC collaboration with Patient Business

Number of PRC referrals by Type
April to June 2022

- MRI: 390
- Pediatric: 247
- Sleep Study: 165
- GI: 165
- OB Labor & Delivery: 154
- DME Supplies: 149
- Eye Surgery: 136
- Urology: 126
- Orthopedic: 109
- Vascular Surgeon: 102
- Nephrology: 89
- Cardiology: 88
- Pain Management: 68
- Physical Therapy: 33
- GYN Surgical: 21
Benefits Coordinator Role

- Plays a very important role between patient and providers/clinicians, finance, PRC & Case Management
- Is the liaison between patient, federal, state, local and tribal agencies
- They are the patients advocate (hospital/clinic/state assistance)
- They are the patients educator
- They are the patient navigator
- They are the “go-to” person
Understanding Alternate Resources Requirements

- IHS is considered the payor of last resort. The use of alternate resources is mandated by the Payor of Last Resort Rule 42 C.F.R. § 136.61

- An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resources

- Refusal to apply for alternate resources when there is reasonable possibility that one exists, or refusal to use an alternate resource, requires denial of eligibility for PRC

- A individual is not required to use/expend personal resources to meet resource eligibility or to sell valuables or property to become eligible for alternate resources
Alternate Resources

• All IHS or Tribal facilities that are available and accessible to an individual must be used before PRC.
  • No PRC funds may be expended for services that are reasonably accessible and available at IHS facilities
  • Distance from the IHS facility (mileage/one way rule)

• IHS considers the list of alternate resources as but not limited to:
  (See 42 C.F.R. § 136.61(c))
  • Programs under titles XVIII or XIX of the Social Security Act:
    • Medicare A (cannot force to get B)
    • Medicaid (AHCCCS, Medi-Cal, Nevada Medicaid)
    • State or local health care programs
    • Crime Victims Act
    • Private Insurance (HMO/PPO)
    • Medicare Advantage Plans (HMO)
    • Veterans Program
    • Children’s Rehabilitative Services
    • Workman’s Comp
• Exception to the IHS Payor of Last Resort - Tribal Self-Insurance Plans
  • For PRC, the Agency will not consider Tribally funded self-insured health insurance health plans to be alternate resource
  • IHS will assume that the Tribe does not wish for it’s plan to be an alternate resource for purposes of PRC and IHS will treat the plan accordingly, once IHS receives documentation to show that the plan is tribal self-insurance.
  • Reminder: This process applies to IHS operated PRC programs. Tribes and Tribal organizations operating PRC programs may choose to follow this coordination process or adopt a different process.
  • [https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.8H](https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.8H)
Eligibility for Alternate Resources

• Refer to the Benefit Coordinator to determine whether the patient is eligible for alternate resources
  • Have a process in place of how you are going to inform, educate, route and communicate the process to the patient

• Advise the patient of the need to apply for alternate resources and refer to the Benefit Coordinator
  • Written notice that EXPLAINS the need to apply for alternate resources (pamphlet, letter, etc) which should include documents needed to complete their case, BC hours, etc
  • Go over the written notice with the patient, do not just hand to them

• Assist the patient in applying
  • Let them know you are here to help!
  • If there is evidence the patient doesn’t understand, having difficulty reading, writing, etc. Show examples of documents they are needed (BC/CDIB/check stubs/SSA award letter)
It is important for patients with private insurance, Medicare, Medicaid, etc. to understand their alternate resource coverage. Due to certain health plan requirements and limitations not all alternate resources are eligible for PRC coverage.

The following are some types of alternate resources PRC is currently unable to service:

- Tribally Self-Funded Insurance - Gilsbar, Summit, etc.
  - IHS will only treat the Tribe’s plan as an alternate resource for purposes of PRC if IHS receives a tribal resolution from the Tribe’s GB, which clearly states that the Tribe would like the IHS to treat the self-insured plan as an alternate resource for purposes of PRC (https://www.ihs.gov/ihm/pb/part-2/chapter-3-purchased-referred-care/#2-3.8H)

- HMO Insurance Plans - Humana, United Health Care, etc.

- Medicaid Manage Care Plans: ex: Mercy Care, Banner University, Health Choice, etc.
  - Under these manage care plans the patient are assigned and/or required to utilize their primary care provider (PCP) in order for the services requested to be paid.
Benefits Coordinator Role - Hospital vs Small Clinic

• Roles may differ on hospital/clinic size
  • Hospital (ED, Admissions, SDS, etc)
    • These are your high cost areas, very important the BC in these assigned areas are starting the application process, submitting the application
    • SDS or any other “planned” stay, must pre-visit plan. Talk to your patients on the importance of applying, do the interview over the phone, check off list of documents to bring to pre-op visit
    • Bit more difficult to create a relationship with patient as you only see them once, maybe twice then they are discharged
    • Must work well with the BC’s in the clinic, have a successful hand-off process
    • Work as a team, know what the other hand is doing, able to explain the SAME process, do not deviate. This can be where trust is broken with the patient (lost paperwork, etc)
    • Communicate, have the hard conversations. Issues? Also bring solutions to process improvements
    • If a process works and data proves it, celebrate!
Benefits Coordinator Role - Hospital vs Small Clinic

• Clinics
  • Planned visits, pre-visit planning can be done, know who is coming in
  • More controlled environment (you start/end process) nobody else involved
  • Easier communication between Pt Reg, clinicians, PRC staff
  • Trust is gained, same person, no handoff
  • You are the only person for process improvement changes, suit to the needs of the patient (fax documents instead of driving in)
  • May also be wearing many hats in a smaller clinic; patient reg, BC and sometimes PRC
  • You are able to adjust process improvement easier without many “higher interventions or blessings” needed/required
  • Able to have buy-in from other departments and break down silos
  • Create a trusting environment of accountability and responsibility
Questions ?