



# Revenue Operations Manual

## Part 1

# Administrative Roles and Responsibilities

Version 2

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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. Overview of Revenue Operations

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## 1.1 **About the Revenue Operations Manual**

The Indian Health Service (IHS) Revenue Operations Manual (ROM) provides a system-wide reference resource for all Indian Health Service (Federal), Tribal, and Urban (I/T/U) facilities across the United States. The manual will provide guidance for any questions related to business operation procedures and processes.

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

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.

Because the focus of this document is for the business office, there will be links throughout the manual to other business functions (Purchased Referred Care, Accounts Receivable, etc.) to provide detail on the function's processes.

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 ROM. 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 This update process is important for insuring that the manual does not become outdated.

### 1.1.1 **ROM Objectives**

- Provide standardized 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 IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest standard of quality service at each Business Office operation.

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

Part	Title/Contents
<b>1</b>	<b>Administrative Roles and Responsibilities</b> <ul style="list-style-type: none"> <li>• Overview of Revenue Operations</li> <li>• IHS Laws, Regulations, and Policies</li> <li>• Business Office Management</li> <li>• Business Office Staff</li> <li>• Business Office Quality Process Improvement</li> <li>• Compliance</li> </ul>
<b>2</b>	<b>Patient Registration</b> <ul style="list-style-type: none"> <li>• Overview of Patient Registration</li> <li>• Patient Eligibility, Rights, and Grievances</li> <li>• Direct Care and Purchased/Referred Care (PRC)</li> <li>• Registration, Discharge, and Transfer</li> <li>• Third Party Coverage</li> <li>• Scheduling Appointments</li> <li>• Benefit Coordination</li> </ul>
<b>3</b>	<b>Coding</b> <ul style="list-style-type: none"> <li>• Overview of Coding</li> <li>• Health Record Documentation</li> <li>• Coding Best Practices</li> <li>• Data Capture Entry</li> </ul>
<b>4</b>	<b>Billing</b> <ul style="list-style-type: none"> <li>• Overview of Billing</li> <li>• Paper Versus Electronic Claims Processing</li> <li>• Billing Medicare</li> <li>• Billing Medicaid</li> <li>• Billing Private Insurance</li> <li>• Third Party Liability Billing</li> <li>• Billing Private Dental Insurance</li> <li>• Billing Pharmacy</li> <li>• Secondary Billing Process</li> <li>• Billing Veterans Administration (VA)</li> <li>• Billing for Commissioned Officers and Their Dependents (BMP)</li> </ul>

Part	Title/Contents
<b>5</b>	<b>Accounts Management</b> <ul style="list-style-type: none"> <li>• Overview of Accounts Management</li> <li>• Receipt Methodologies and Processes</li> <li>• Batching (Recording Revenue)</li> <li>• Remittance Advices and Explanation of Benefits</li> <li>• Posting (Processing Payments and Adjustments)</li> <li>• Managing Patient Accounts</li> <li>• Denial Management</li> <li>• Debt Management</li> <li>• Overview of Reconciliation – File, Accounts Receivable, and Cash Management</li> <li>• Account Management Reports</li> </ul>

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

### 1.1.2 Facility Expectations

Each facility will be able to obtain from the IHS Revenue Operations Manual the following:

- How to use and implement the various guidelines;
- What information needs to be consistently captured at the time of registration;
- What documentation is needed from the facility staff for the health record;
- Verification and application of the correct code. How to accurately complete billing claim forms;
- How to create a bill for various insurers;
- How to establish electronic billing and auto-posting interchanges with insurers;
- How to understand Explanation of Benefits (EOB) and Remittance Advices;
- How to follow-up on outstanding accounts in a consistent, organized manner; and,
- Understand the requirements, frequency, and importance of external compliance audits.

### 1.1.3 Accessing the Revenue Operations Manual

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

<https://www.ihs.gov/BusinessOffice/rom/>

Having the manual available from a website allows more timely updates.

## 1.2 About the Indian Health Service

Federal health services for American Indians and Alaska Natives (AI/AN) began under the War Department auspices in the early 1800s. Professional medical supervision of 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 Service formally transferred to the Public Health Service, Department of Health, Education, and Welfare – which is now known as the U.S. Department of Health and Human Services (HHS).

### 1.2.1 Mission and Goal of Indian Health Service

The IHS is an agency within HHS and is responsible for providing comprehensive health care to American Indians and Alaska Natives.

The **IHS Mission**, is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Natives to the highest level.

The **IHS Goal** is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to 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 **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 inherent sovereign rights of Tribes.

The Indian Health Service is primarily responsible for

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

In addition, persons within the scope of the Indian Health program in one Area will be provided available direct care services by any other Area in which they may require health services.

### 1.2.2 Self-Determination and Self-Governance

Federal laws and policies in the mid-1970s greatly altered the profile of the Indian health care delivery system. Primary among this legislation is the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975, which grants Tribes the option of contracting for the health care services that they would otherwise receive directly from the 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 ISDEAA and IHCA 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 ISDEAA 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 ISDEAA 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 573 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 90 compacts with the IHS. Today, more than 40% 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 **Eligible Individuals**

The Indian Health Manual (IHM), Part 2, describes the individuals eligible for services at IHS direct care programs and facilities in the most detail. The IHM eligibility policy is based on applicable federal laws and regulations. The following description is not a comprehensive description of individuals eligible for services at IHS and associated requirements.

In general, a person may be regarded as eligible and within the scope of the IHS health care program if he or she is not otherwise excluded by provision of law, and is:

- American Indian and/or Alaska Native. AI/AN descent and belongs to the Indian community served by the IHS program, as evidenced by such factors as:
  - Membership, enrolled or otherwise, in an American Indian or Alaska Native Federally-recognized 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;
  - In case of doubt that an individual applying for care is within the scope of the program, as established in 42 C.F.R. § 136.12(b), and the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

*OR*

- 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;(for more information, reference IHM, Part 2, Chapter 3: <https://www.ihs.gov/ihm/pc/part-2/p2c3/>).

*OR*

- A non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy, and through post-partum (usually 6 weeks after delivery) (42 U.S.C. § 136.12). In cases where the woman is not married to the eligible Indian under applicable law or tribal law, paternity must be acknowledged by either:
  - The eligible Indian, in writing.
  - Determined by order of a court of competent jurisdiction.

*OR*

- 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. as stated in 42 C.F.R. § 136.12(a).

*OR*

- A non-Indian beneficiary, such as non-Indian employees and veterans, who may be authorized for limited services. This may include commissioned corps officers and their dependents.

For more information regarding eligible individuals, reference the IHM, Part 2, Services to Indians and Others: <https://www.ihs.gov/ihm/pc/part-2/p2c1/>.

### 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:

- child abuse
- children and adolescents
- dental/oral health
- domestic violence
- elder care
- health care financing
- injury prevention,
- state health care
- sanitation facilities

- traditional medicine
- 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 25 hospitals, 55 health centers, and 21 health stations. In addition, 43 urban Indian health projects provide a variety of health and referral services.

The IHS clinical staff consists of approximately 2,384 nurses, 731 physicians, 746 pharmacists, 271 dentists, and 131 physician assistants. IHS also employs various allied health professionals, such as nutritionists, health administrators, and electronic health record administrators.

Through Public Law 93-638 self-determination contracts, American Indian Tribes and Alaska Native corporations administer 19 hospitals, 280 health centers, 62 health stations, and 134 Alaska village clinics.

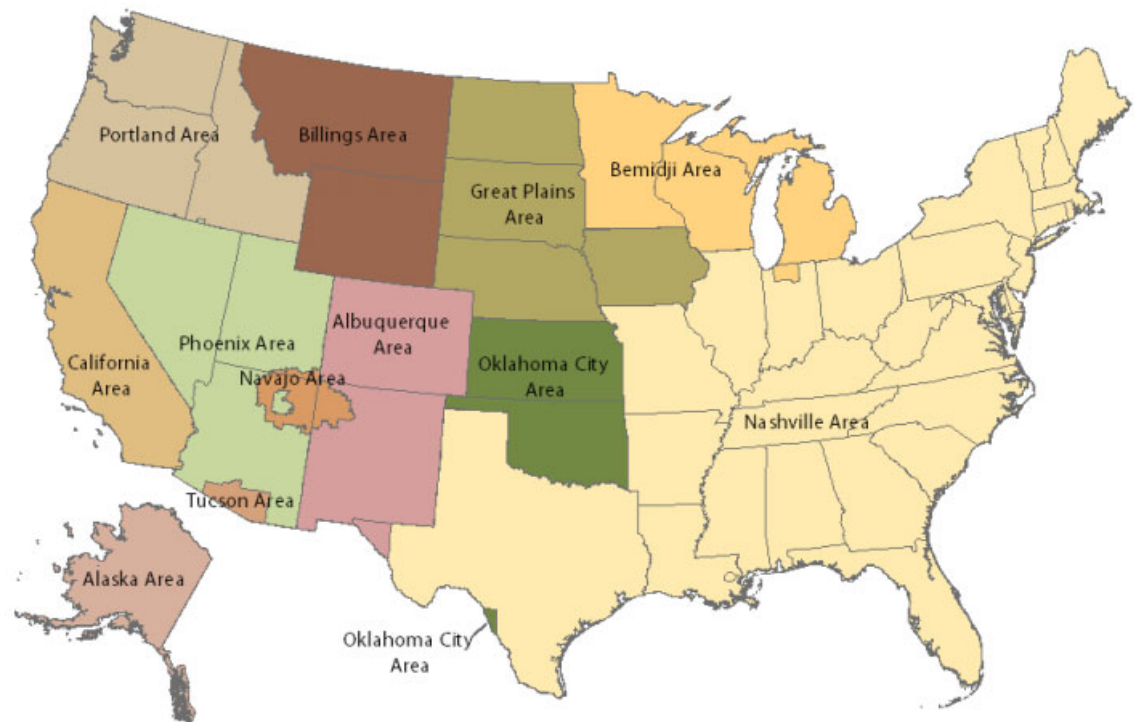
### 1.2.5 Joint Planning for Care of Indians

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

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

- Recognize the fact that indigent (i.e., homeless or transient) patients may be eligible for other resources from the State or local programs, and an American Indian or Alaskan Native should not be excluded from these programs.

### 1.2.6 Area Office Map



### 1.2.7 Population Served

As of 2017, the Indian Health Service operates a comprehensive health service delivery system for approximately 2.2 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 573 federally recognized tribes dwelling primarily in 37 states. The Alaska territories cover many small, remote villages.

## 1.3 The Role of the Business Office in the IHS Mission

The **Business 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 appropriate reimbursements from Medicare, Medicaid, Children's Health Insurance Program, Veteran's Health Administration, private insurance, and other forms of health care coverage; and,
- Identify all forms of health care coverage and other benefits for which American Indians, Alaska Natives, and other beneficiaries are eligible.

Specific Business Office activities may 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, The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (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; and,
- 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 office process.

Linkages – with social services, information systems, health information management, utilization review, prior authorizations, as well as, authorizations and certifications, admission and discharge planning, finance, benefit coordination, diabetes and nutritional services, behavioral and dental services, and other ancillary services – 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 Roles and Responsibilities

The revenue cycle depends on the success of various functions and their respective departments. For example, the Business Office works closely with Finance to properly complete the functions of debt management, cash management, denial management and accounts management. The continual development and monitoring of these functions and processes should be a joint effort between the Business Office and Finance at the Headquarters, Area Office and Service Unit levels.

### Office of Resource, Access and Partnership (ORAP)

The Office of Resource, Access, and Partnership (ORAP) oversees the Division of Business Office Enhancement (DBOE) and Division of Contract Care (DCC). ORAP, through DBOE, provides the Area Offices and Service Units the support and guidance they need to set and meet their Business Office improvement goals. ORAP is also the office that is responsible for implementation of the Third Party Internal Controls Policy, relevant updates, self-assessments, and corrective action plans. The office provides leadership and direction for increasing:

- Appropriate third party reimbursements in accordance with IHS' Right of Recovery authority;
- Identification and utilization of alternate resources;
- Purchasing authority in PRC for additional savings;
- Compliance and business process efficiencies; and,
- Effective internal and external partnerships.

Responsibilities include conducting random reviews of business offices to assess and improve the Area office's capacity for assuring Service Unit compliance with Business Office standards. Reviews may also be 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 National Business Office Committee

The National Business Office Committee (NBOC) is a standing committee to the National Council of Executive Officers (NCEO) and is supported by ORAP at Headquarters. The purpose of this committee is to provide strategic planning and direction and to make recommendations on the I/T/U third party revenue cycle.

The NBOC is composed of representatives primarily from the Business Office at the Headquarters and Area Office levels, but also includes representatives from the NCEO, National Council of Chief Executive Officers (NCCEO),



Office of Information Technology, Health Information Management, and Office of Urban Indian Health Programs.

#### 1.4.2 **Office of Information Technology (OIT)**

The Chief Information Officer (CIO), 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; and,
- 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.

The National Patient Information Reporting System (NPIRS) instituted the National Data Warehouse (NDW) in 2006. The NDW is a state-of-the-art, enterprise-wide data warehouse environment for the Indian Health Service's national data repository.

NPIRS produces various reports that are required by statute and regulation and provides a broad range of clinical and administrative information to managers at all levels of the Indian health system, allowing better management of patients, local facilities, and regional and national programs.

### **1.4.3 Health Information Management (HIM) National Consultant**

The HIM National Consultant works closely with ORAP to identify best practices for business operations and reimbursement. The HIM National Consultant is responsible for:

- 1) Representing the HIM profession in planning and developing a comprehensive health program for the IHS;
- 2) Serving in a key role for all activities involving data systems, including planning, developing, implementing, and evaluating systems;
- 3) Advising the IHS Director and members of the Director's staff on policy formulation and activities involving HIM services, data quality, and third party reimbursement in all types of facilities;
- 4) Providing professional and technical guidance to Area HIM consultants in developing and administering HIM programs to enable IHS facilities to meet IHS goals and objectives;
- 5) Planning the recruitment, professional development, and effective use of professional and technical level HIM personnel throughout the IHS; and,
- 6) Planning orientation and training activities for HIM personnel.

## **1.5 Area Office Responsibilities**

The Area Office assists the Service Units by:

- Assertively planning a monitoring system to support business process improvement; and,
- Participating in TJC accreditation and/or other types of required certification and/or licensures, such as the AAAHC, CARF.

Most Area offices employ a program specialist for clinical and auxiliary programs operated by the Service Units in their Area.

The Area Business Office 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 TJC, 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 PRC 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, and system edits necessary to process claims correctly.
- 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, global, 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.

### **1.5.3 Area HIM Consultant Responsibilities**

The Area HIM Consultant is responsible for:

- Assisting in planning and developing a comprehensive health program for the Area that is consistent with IHS goals and objectives;
- Advising the Area Director, Area staff, Chief Executive Officers (CEO), and their staffs on the implementation of policies and activities involving health records, data quality, report monitoring, third party reimbursement, utilization review, and quality improvement;
- Participating in planning, developing, implementing, and evaluating data systems;
- Assisting Service Unit personnel in planning facilities construction/remodeling and procuring equipment;
- Advising and assisting Service Unit HIM staff in establishing and maintaining quality review programs to meet requirements of TJC, CMS, the Accreditation Association for Ambulatory Health Care, and other regulatory and/or accrediting agencies;
- Assisting in recruitment, use, and evaluation of professional and technical level Service Unit HIM staff;
- Assisting in planning for career advancement and professional development of facility HIM staff using workshops, institutes, online courses, audio seminars, and college-based HIM courses;
- Providing orientation to Area professional and administrative personnel on HIM policies and standards training;
- Assisting the CEO and staff with orientation and indoctrination in HIM;
- Providing guidance to Area and Service Unit staffs in medico-legal matters, including compliance with the Privacy Act of 1974, HIPAA, FOIA, and Confidentiality of Alcohol and Drug Abuse Patient Records regulations;
- Writing and submitting narrative reports for submission to the HIM National Consultant and report at the bi-annual Area HIM Consultants meeting. The report should briefly discuss (as appropriate) the following:

- staffing levels in each facility for the following categories: Permanent, temporary, credential levels, and positions encumbered by credentialed professionals (Credentialed is defined as an active registration or accreditation by the AHIMA and AAPC);
  - changes in HIM positions, personnel components, and vacancies;
  - accomplishments;
  - proposed action for future quarter;
  - recruiting activities;
  - problems and, if possible, recommended solutions; and
  - ongoing educational programs, regularly scheduled workshops, and outside training.
- Assisting Service Unit HIM Supervisors or Directors in meeting equal employment opportunity objectives as requested.

## 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.

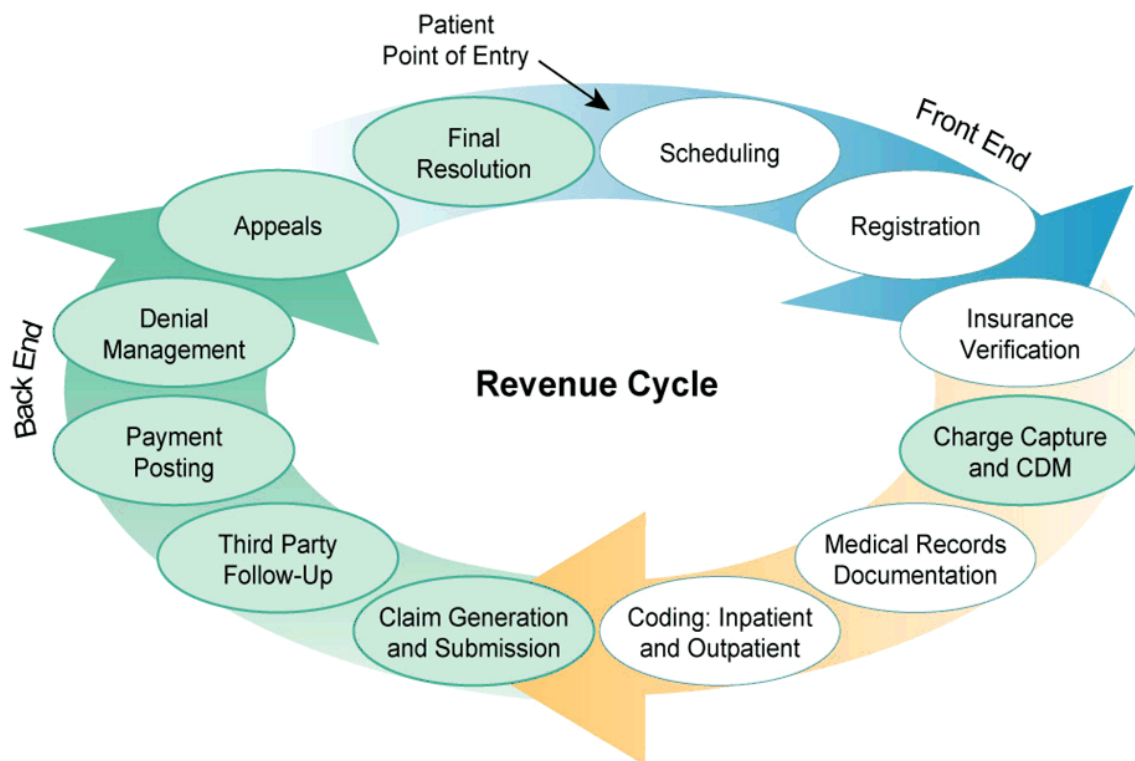
All reports should include the following minimum components:

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

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

## 1.7 Revenue Generation Areas

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



### 1.7.1 Patients

Many patients have insurance coverage through employment, Medicare, Medicaid, private insurance, Workers' Comp, FMCRA (other liability) or other Alternate Resource (such as VHA). The Federal government has allowed IHS to bill any third party insurance for compensation of facility and professional charges, including secondary and tertiary insurance, if available. All efforts to enroll patients into alternate resources will enhance revenue generation and, secondarily, 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/she leaves the facility. Each facility needs to have a process in place to collect information and establish debt management collection avenues (such as collection of copays/coinsurance/deductible, credit card collection process, etc.). Pursuing these financial resources contributes to the revenue for each facility.

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

Claims will be denied if:

- demographic information is incomplete
- outdated or expired insurance is recorded
- any identification numbers are incorrect
- secondary/tertiary insurance is **not identified**, the health care facility will not be reimbursed for any applicable secondary/tertiary insurance payments
- eligibility is not verified routinely
- 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 personnel-hours can be expended to obtain the correct 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 cross-train individuals on needed information that can contribute to a successful claim and bill. Collections may also increase by the department completing their own prior authorizations.

### 1.7.3 Benefit Coordinator

The Benefit Coordinator obtains alternate resources for patients with no insurance.



Registration refers potential eligible patients to the Benefit Coordinator, and the Benefit Coordinator assists and educates patients on obtaining alternate resources. This process at the facilities optimizes third party revenue.

It is important for the Benefit Coordinator to stay actively involved with Patient Registration, Billing, and Purchased Referred Care (PRC) Service. The identification of insurance eligibility is vital for extending PRC funding and its accuracy highly influences the promptness of payment within the PRC system. Benefit Coordinators should be proactive and utilize available reports (i.e., PORP report) to identify patients without insurance and actively screen for eligibility.

#### **1.7.4 Health Information Management**

The Health Information Management (HIM) department serves a resource for decision making activities related to health information systems, health record content, authentication of health record entries, documentation errors/corrections, provider documentation requirements and the revenue cycle.

The Electronic Health Record is designed to capture documentation through designated Notes (templates); orders, therapy services, labs, x-rays, as well as charges for other services performed. Manual processing of this information may still be accomplished. It is the responsibility of HIM to merge all ancillary services to the visit in order to eliminate orphan visits.

The HIM department works closely with the Business Office for any follow-up action items such as denials, copies of records, reviewing potential changes of codes for third party billing and resolving provider issues.

**Health Information Management** is responsible for assuring that:

- Detailed documentation is present for each outpatient visit and inpatient admission at or near the time of care or treatment of the patient in order to ensure accuracy.
- Provider, nursing, and pharmacy dates and signatures are timely.
- All orders, including discharge orders and notes are completed timely.
- Provide timely copies of records for denials to the billing department
- Review coding discrepancies with billing and communicate any pertinent issues with providers.
- The HIM department is responsible for the oversight of coding completion, accuracy and compliance.

### 1.7.5 Coding and Data Entry

Coding, as defined by the **American Health Information Management Association (AHIMA)** is the transformation of verbal descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations.

Coding includes clinical documentation review and abstracting information into the most appropriate code(s) to accurately reflect the medical services provided. Either certified coders or internally trained staff complete coding.

All components of the visit are reviewed by the coders to submit a correct and complete visit. Once the coder releases the visit, the bill is created overnight in the Third Party Billing system. If all components of the visit are correct, a claim will be billed to the insurer.

Revenue will be lost if:

- An unspecified code is selected.
- There is no compatibility or relationship between the diagnosis and procedure code.
- 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.
- Visits are not coded timely within third party deadline for claim submission.

It is important to define and enhance communication between the provider and coder to assure that documentation supports the most accurate code. This is critical to the overall business operations and reimbursement.

### 1.7.6 Billing

The Billing department reviews information released 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.

### **1.7.7 Accounts Receivable (A/R)**

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

The reconciliation between RPMS and Unified Financial Management System (UFMS) should be performed weekly. Month-end reports are run to allow for reconciliation, according to the Third Party Revenue Accounts Management and Internal Controls policy. For more information, reference Part 5, Chapter 1, “Month End Processing and Reconciliation” of the IHM, and Part 5, Chapter 9 “Overview of Reconciliation – File, Accounts Receivable, and Cash Management” of the ROM.

### **1.7.8 Collections**

Collections is part of the final adjudication process for open accounts. Collections may also include requests for 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 contribute 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.
- Documentation is missing.
- Follow-up is not completed in a timely manner, as required by policy and individual payer guidelines.
- 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
- Billing and Coding references

### **1.8.1 Patient Information Packets**

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

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

The Patient Information packets should be given to all new patients and reviewed/updated upon each visit as applicable:

- A brochure on the Benefit Coordinator service,
- Purchased Referred Care information and regulations,
- Assignment of Benefits (AOB),
- Health Insurance Portability and Accountability Act (HIPAA) Notice,
- Medicare Secondary Payer Questionnaire (MSPQ),
- Consent to Treat,
- And any other specialty type clinics or services offered at the facility.

### **1.8.2 Required Forms**

Forms are a necessary requirement at the Registration department. Forms such as Medicare Secondary Payer questionnaire, facility registration form, assignment of benefits form, release forms, surgical/procedural approval forms, signature on file forms, and other related forms should be immediately accessible to the Registration staff. Some of these requirements are now available in the scheduling GUI such as the Medicare Secondary Payer questionnaire, but it is the responsibility of the Registration Supervisor at each facility to designate a place/location for staff to access these forms.

All forms should be completed in a timely manner and filed according to the business practice of the facility. Everyone should know where information is stored at all times. For example, during a Resource Allocation Criteria (RAC) audit, the billing office is responsible for providing a copy of the claim, HIM copy of record, A/R, a copy of the remittance advice.

### **1.8.3 Business Office Signage**

Appropriate signage (patient bill of rights, privacy notices, etc.) 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 family member, such as patient's bill of rights, Notice of Privacy Practices, collection policy, and accepting credit card payments for non-beneficiary patients or co-pays, should be posted in clear view at the registration desk.

## 2. IHS Laws, Regulations, and Policies

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## 2.1 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; and,
- 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.

For more information around the Affordable Care Act (ACA) specifically, reference section 6.1 “About the Affordable Care Act (ACA) Compliance Program.”

For more information, reference the following website: <http://oig.hhs.gov>

## 2.2 IHS Legislative Program Authority

### 2.2.1 The Snyder Act

Public Law 67

67<sup>th</sup> Congress – November 2, 1921(25 U.S.C. 13) (42 Stat. 208)

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.

### 2.2.2 Transfer Act

Public Law 83-568

83<sup>rd</sup> 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.

### 2.2.3      **Public Law 86-121**

86<sup>th</sup> Congress – July 31, 1959  
(U.S.C. 2001-2004) (73 Stat. 267-268, 68 Stat. 674)

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.

### 2.2.4      **Indian Self-Determination and Education Assistance Act**

Public Law 93-638  
93<sup>rd</sup> Congress – January 4, 1975  
(25 U.S.C. 450-452-458, 20 U.S.C. 276, 25 U.S.C. 2001, 43 U.S.C. 1601)  
(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.

### 2.2.5      **Public Law 102-184**

102<sup>nd</sup> Congress – December 4, 1991 (25 U.S.C. 450) (105 Stat. 1278)

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.



### **2.2.6 Public Law 102-573**

102<sup>nd</sup> Congress – October 29, 1992 (25 U.S.C. 1601) (106 Stat. 4526)

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.

### **2.2.7 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.

## **2.3 Billing and Collection Authority**

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

### **2.3.1 Indian Health Care Improvement Act (IHCIA)**

Public Law 94-437

94<sup>th</sup> Congress – September 30, 1976 (25 U.S.C. 1601-1675, 40 U.S.C. 276, 42 U.S.C. 2004-1395-1396) (90 Stat. 1400-1414)

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: 2010-03-23)

a) Right of recovery

Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

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

b) Limitations on recoveries from States

Subsection (a) 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) workers' compensation laws; or
- (2) a no-fault automobile accident insurance plan or program.

c) Non-applicability of other laws. No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

d) No effect on private rights of action No action taken by the United States, an Indian tribe, or tribal organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

e) Enforcement

(1) In general The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

(ii) by any representative or heirs of such individual, or

(B) instituting a separate civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

(2) Notice

All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

(3) Recovery from tortfeasors

(A) In general

In any case in which an Indian tribe or tribal organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) [1] to furnish or pay for health services to a person who is injured or suffers a disease on or after March 23, 2010, under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian tribe or tribal organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

(B) Treatment

The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

f) Limitation

Absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), 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, tribal organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

§ 1641(c)(1)(B)

(B) Use of funds Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes, including the provision of services

### **2.3.2 Public Law 100-713**

100<sup>th</sup> 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.

### **2.3.3 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]

**Per 25 U.S. Code § 1641 - Treatment of payments under Social Security Act health benefits programs:**

**§ 1641(c)(1)(B)**

(B) Use of funds Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes, including the provision of services.

### **2.3.4 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.

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**Tribal reimbursement as Federally Qualified Health Centers (FQHCs)**

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.

**2.3.4.1 25 U.S. Code § 1641 - Treatment of payments under Social Security Act health benefits programs**

1641(d)

**(d) Direct billing****(1) In general**

Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq., 1397aa et seq.] or from any other third party payer.

**(2) Direct reimbursement****(A) Use of funds**

Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act [42 U.S.C. 301 et seq.] shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 1602 of this title.

**(B) Audits**

The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to

programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

**(C) Identification of source of payments**

Any tribal health program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

### **2.3.5 Social Security Act, Title XXI, Children's Health Insurance Program (CHIP)**

Congress established the **Children's Health Insurance Program (CHIP)** by creating Title XXI of the SSA as part of the Balanced Budget Act of 1997.

CHIP 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 CHIP 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 CHIP-covered provided services.

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

In the preamble, HHS explained that the CHIP 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 CHIP.

### **2.3.6 Tribal Direct Reimbursement, Title IV, IHCA**

On November 1, 2000, Congress enacted the Alaska Native and American Indian Direct Reimbursement Act, amending Section 405 of IHCA. 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.

### **2.3.7 Benefit Improvement and Protection Act (BIPA)**

On December 15, 2000, Congress enacted Section 432 of the Medicare, Medicaid, and CHIP 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.

## **2.4 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 “*knowingly*,” or intentionally, engaging in these activities.

### **2.4.1 Federal Criminal and Civil Provisions**

#### **A. Federal Criminal Provisions (42 U.S.C. § 1320A-7B)**

##### **1. Prohibition of False Claims**

False or Improper Claims (42 U.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.

# **B. Federal Civil Provisions (31 U.S.C. § 3729(A))**

## **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.

### 2.4.2      **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 either manually or electronically on each individual who comes to the ER seeking emergency medical treatment. The log should track the care, as well as disposition provided to the individual

#### **Medicare hospitals:**

- If an individual comes to the 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.

### 2.4.3 “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.

For more information on Prompt Pay Statutes and Regulations, reference the following website:

[http://www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm)

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, electronic health record number or other unique identifier.

## 2.5 Privacy Act (1974)

The Privacy Act of 1974 is a code of fair information practices, which mandates how Government agencies, such as the 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; and,
- Allow individuals to see the records kept on them and provide them with the opportunity to correct inaccuracies in their records.

## 2.6 **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; and,
- 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-Emption 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 requirements that are more stringent. 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.

## 2.7 Privacy Rule

Privacy regulations are designed to protect individually identifiable health care information during the transfer, storage, release, and destruction of that information. All electronic health 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 electronic health 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 Human 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 electronic health 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 electronic health 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 five 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 electronic health record and never intended to be shared with anyone else. All other personal health information is considered 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 that 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 (HIPAA) on Business Office operations, see Part 1, Chapter 3.11.

## 2.8 **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.

## 2.9 **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.

In accordance with the Deficit Reduction Act (DRA), IHS facilities must establish local written policies and provide training on the False Claims Act.



## 2.10 **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 see Part 1, Chapter 2, Section 2.4.2, “Emergency Medical Treatment and Active Labor Act (EMTALA)”

## 2.11 **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

## 2.12 **Federal Medical Care Recovery Act (FMCRA)**

Per IHS Circular No. 2006.-02, it is the policy of the IHS to comply with all laws and regulations as they relate to reporting third party tortfeasor claims and to recover funds that are properly owed to the IHS for providing direct care or contract health services. The IHS will ensure that all potential third party liability claims are properly identified and reported to OGC (or its designee) for recovery of those funds owed to the IHS for health care services provided when a patient's injury was due to a negligent third party. The following authority may be used to recover funds that are properly owed to the IHS by third party tortfeasors. IHS may instead opt to utilize the Section 1621e Right of Recovery authority and associated process.

### **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 tortious 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.

## 2.13 **Administrative Simplification Compliance Act**

Signed into law on December 27, 2001 as Public Law 107-105, <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>, 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.

## 2.14 **Indian Health Care Improvement Act Permanent Reauthorization (2010)**

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.

### 2.14.1 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 reflect 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 2020, 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 2020, 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.

### 2.15 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.

### 2.15.1 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 or 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.



## 2.16 **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.

## 2.17 **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% to 100%, 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.

## 2.18 **Health Care Antitrust Improvements Acts (2002)**

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; and,
- 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. **Business Office Management**

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## 3.1 Overview of Business Office Management

The **IHS Mission** is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Third Party revenue supplements IHS appropriations and assists the IHS increase access to quality health care within IHS facilities. Health care coverage provides patients with access to higher levels of care that are unavailable at IHS facilities. The Business Office contributes to the mission of IHS by using effective, efficient, and appropriate management practices to continue and/or increase total third party revenue.

This chapter provides an overview of Business Office Management responsibilities for the Business Office Manager or individual Acting in their place. This chapter provides an overview of important management actions and approaches that are available to the Business Office Manager.

For any essential business functions, all business office staff should have a backup, which can be designated at the facility's discretion. It is important to remember the functions that need to adhere to separation of duties requirements, to apply segregation of duty requirements as necessary.

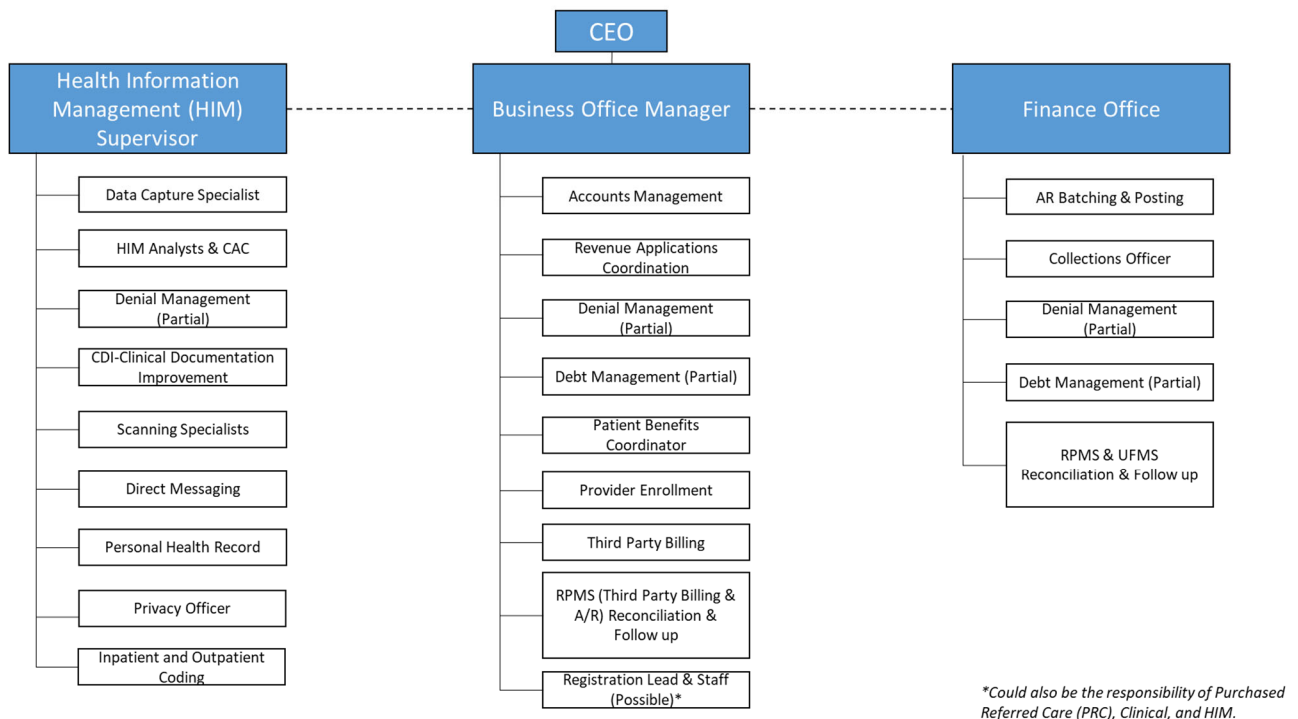
### 3.1.1 Terminology

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

### 3.1.2 Organizational Structure

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

**Business Office Organizational Chart**



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

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

### 3.2 Business Office Staff Management

An Acting Business Office Manager must be delegated when the Business Office Manager is unavailable. The Business Office Manager needs to ensure staff coverage of all duties in the case of staff leave or a vacated position. The Business Office Manager should utilize cross training as a technique to manage workload and encourage staff development.

### 3.3 **Third Party Revenue Accounts Management and Internal Controls Policy**

The Third Party Revenue Accounts Management and Internal Controls policy establishes the 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; and,
- 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, reference:

[http://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p5c1](http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p5c1)

An ACA Compliance Program demonstrates the commitment of a facility for quality and excellence. It 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, ACA Compliance program outline for facilities to follow. Facilities should use this as a guideline and create their own compliance plan to reference in the future. For a detailed discussion of the role and responsibilities of the ACA Compliance officer, see Part 1, Chapter 8, “Compliance.”

### 3.4 **RPMS Reports**

As indicated throughout this Manual, it is integral to ensure that RPMS access is assigned to staff persons based on position responsibilities. Access to certain packages and keys must be closely monitored to ensure data integrity and risk avoidance. Only Business Office managers and applications coordinators should access the Table Maintenance and other managerial keys in IT Systems to modify information. Please see the below embedded security key list for an example of managerial keys.



RPMS SECURITY KEY  
LIST 1042011.xls

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

Using RPMS reports, or in combination with audits, the user can:

- Review how effective notations in the patient accounting system are being utilized. Ensure the updated, appropriate adjustment reason codes are being utilized to accurately reflect the reason for adjustment of payment or denial.
- Review any internal and external error reports when you export claim file batches to third party payers.
- 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). Generate the “Days in A/R” Report to determine which claims have not been paid and for what time period.
- For non-crossover claims, determine: how secondary claims are being sent to secondary third party payers; the timeframe in which the secondary claims are sent; if the secondary claims are being paid; and the timeframe in which they are paid. Determine if the timeframes for secondary claim submission and payment are acceptable and address as necessary.
- Review the timeframes in which third party billers are approving outpatient and inpatients claims and whether they are meeting the timeframes defined within Part 5, Chapter 1 of the Indian Health Manual.
- Review the timeframes in which third party billers are exporting claims and whether or not they are meeting the timeframes defined within Part 5, Chapter 1 of the Indian Health Manual: <https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>.
- Define resolutions for the top ten denial reasons and use this information to train the department staff on how to prevent these denials. Utilize reports provided by the Medicare Administrative Contractors, Medicaid programs, and other payers. Utilize reports generated from clearinghouse dashboards and/or Accounts Receivable denial management tracking tools.
- Review the remittance advices, comparing what payment amount was expected in comparison to actual payment.



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. For more detailed information on each report, see Part 5, Chapter 10: <https://www.ihs.gov/ihs/pc/part-5/p5c10/>.

### 3.5 Outsourcing Third Party Billing Functions

The Third Party Internal Controls Policy requires weekly management reviews of all components of the Revenue Cycle to determine compliance with Policy requirements. The Policy requirements include timeframes for each Revenue Cycle function. There are timeframe requirements for patient registration, provider documentation, coding, third party billing, accounts receivable, aged accounts review and follow-up, debt management, and denial management. A facility that is not adhering to one or more requirements will be non-compliant with the Policy, be considered in “backlog” status, and may experience a delay in receipt of revenue. While the goal is to ensure administrative staff resources are dedicated to these functions within the facility; limitations in staffing, limitations in other resources, and/or increased workload, may require external assistance. Once areas of need are identified through the weekly reviews, the facility should determine a plan for corrective action to ensure timely compliance with the Policy requirements. The facility may explore the option of either:

- 1) Offering compensation time or overtime to staff to address the backlog;
- 2) Seeking temporary assistance from an external source, e.g., another IHS facility, Area Office, or outside vendor; or,
- 3) A combination of any of the above options.

The facility may consider which of these options are most viable in terms of cost-effectiveness, administrative resources to implement, and timeliness of addressing the backlog(s).

- 1) Although outsourcing may be beneficial, it is critical to conduct market research on vendors that may assist in the identified areas of need. It is important to understand the need(s) for assistance;
- 2) Ensure that the Business Office Management and accountability remains in-house and is not contracted out to a third party;
- 3) Determine what knowledge, skills, and abilities the external source must possess;
- 4) Ensure that the vendor is knowledgeable with health care industry standards, IHS policies and procedures, IHS IT systems, and the unique nature of IHS third party billing practices;
- 5) Select the most cost-effective and timely method to fulfill the need(s);

- 6) Ensure IT system roles, responsibilities, and boundaries are adhered to by the external source;
- 7) Determine deliverables for existing facility staff and deliverables for the vendor and ensure that these responsibilities are clearly communicated at the onset of the performance period and throughout the life cycle of the contract;
- 8) Continually track metrics and monitor overall performance and progress;
- 9) Maintain an ongoing schedule of meetings and other forms of communication; and,
- 10) Provide timely follow-up and ensure process improvement where needed.

### **3.5.1 Guidelines for Consideration of Outsourcing Options**

Evaluation factors to consider when reviewing outsourcing options include:

#### **Costs**

- Will the cost be based on charges by staff person, by claim volume, by project, by month, or some other way to give you an accurate accounting of their actual cost?
- Will the costs be based on reviews, edits and completions? For example, a vendor may charge more than once for an incomplete record that has been flagged for incomplete documentation and then reprocessed when the record is completed. Similarly, a vendor may charge more than once for a claim that has been pended and later reprocessed.
- Will the costs include errors on the part of the external source? For example, if a vendor does not follow guidelines provided by the facility; will the vendor charge an additional fee for the correction?

#### **Sensitivity and Security of Information**

- Ensure that external source is HIPAA Compliant and has the required data, business partner, privacy, and security and/or interconnectivity agreements with the facility and/or IHS Headquarters.
- How quickly can the external source gain access to the IHS server (D1) without any connectivity issues?
- Will the external source connect to the server remotely or at the facility?

#### **Skill set**

- Has the external source demonstrated whether their staff has the necessary knowledge, skills, and abilities to accurately and efficiently complete the deliverables? Information may be provided by the external source regarding experience, education, training and/or certifications for each staff person.
- What is their experience in the healthcare industry?
- 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 health insurance coverage rules, the revenue cycle, and third party reimbursement?
- Do they have knowledge of IHS policy as it applies to billing of third party payers (e.g., requirements for billing of tribal self-insurance), adjustments, write-offs, beneficiaries, non-beneficiaries, etc.?
- Have they used the RPMS application and Practice Management Suite?
- What experience do they have working with the IHS and/or Tribal third party billing, batching, posting, aged account review, debt management, denial management, and follow-up?

### **Implementation Plan**

- Has the source provided a detailed process for how they plan to accomplish the deliverables, including detailed activities, resources, and timelines?

### **References**

- Has the source provided a set of references and any letters of recommendations from previous employers and/or contracts?
- Ensure enough references are called to gain a good understanding of the companies past history and work performance, including any previous work with IHS.

### **Risks**

- Has the source identified any potential risks and their mitigation strategies as far as meeting the deliverables?

### **Control**

- Ensure that the facility maintains control of system parameters and prioritization of deliverables, such as third party billing of certain claims, highest billed amounts, claims approaching timely filing limits, claims to payers with the rapid revenue return, etc.

- Ensure the source follows the facility's direction. For example, the source may have an agreement with another facility that may provide a conflicting direction pertaining to how to bill certain claims. It is important that the source comply with the current facility's direction.

**On-site Support**

- Ensure that there is a project lead for both the facility and the external source; both of whom will manage fulfillment of deliverables.

**Termination for Cause Clause**

- Ensure this is included in the final contract or agreement.

**Responsibility of Facility and Source**

- Determine what services will be provided and by whom.
- Ensure that a project plan is compiled and that both parties agree to the objectives and associated timelines.

**Communications and Monitoring**

- The source needs to agree to schedule ongoing communications, in verbal and written form, as the facility considers necessary to monitor work progress and address any issues.
- Agenda items and clearly defined metrics and milestones need to be covered during the regular conference calls.

**Issue Resolution**

- If issues cannot be resolved through regular communications with the source, the project lead or contract officer representative needs to report the issues to the appropriate authority, such as the Contracting Officer, as soon as possible for prompt resolution.

**Payment Invoices**

- Expectations, including due dates, for service invoices from the source need to be clearly defined. All government required information should be present on the invoice received from the source.
- Expectations, including roles, responsibilities, and due dates, for payment of invoices by the facility need to be clearly defined. For example, responsibilities for the project lead or contract officer representative, receiver, and accounts payable staff need to be defined. The facility is bound by regulations for timely payment of the invoice to a vendor (cite prompt payer requirements here).
- Once the agreement or contract has ended, the project lead or contract officer representative needs to sign off on the final invoice and reports.

## 3.6 Secure Patient Information

Usage of electronic and written media for exchange of protected health information (PHI) and personally identifiable information (PII) significantly increases the risk to security, privacy, confidentiality and integrity of information. Use of electronic and written media to exchange or share PHI and PII means that security risks cannot be totally eliminated.

All IHS information system users must take annual security and privacy training in order to fulfill federal mandates and regulations. In addition, all new users must successfully complete this course within 24 hours of receiving access unless the user has read the IHS Quick Guide to Information Security, in which case they will have 30 days to complete the training. Failure to complete training requirements will result in the loss of information systems access.

For more information on IHS information security requirements, reference <https://www.ihs.gov/ISSA/>.

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 information systems should be protected by state-of-the-art enterprise firewall and intrusion-detection software.

Each facility should work closely with their Information System Security Officer (ISSO) if there will be any use of a cloud-based environment. The environment must be approved by IHS and HHS before implementation. Cloud-based environment carry a high-risk potential for external security breaches.

For more information related to Privacy and Security, reference the following website:

[http://www.ihs.gov/HIPAA/index.cfm?module=security\\_standards](http://www.ihs.gov/HIPAA/index.cfm?module=security_standards)

## 3.7 File Management

It is important to remember that filing patient-related information and/or insurance-related information must be done in a timely manner. The Federal Records Center (FRC) will no longer accept paper health records as of December 31, 2022. Paper records may continue to be physically stored at FRC and facilities will need to transition to an electronic environment by December 2022.

IHS facilities must adhere to <https://www.ihs.gov/DRA/recordsmanagement/>. Local policies and procedures which are aligned with the IHS Record Retention Schedule should be implemented at the facility.

**Note:** If a facility is audited for third party reimbursement, OIG, or needed for other administrative reasons, the records must be retrieve in a timely manner. Records shall be maintained according to the respective requirements of third party payers. For more information regarding the timeframes and types of records that should be maintained, Service Units may refer to the third party payer and/or provider agreements.

Examples of the varied processes include the following:

- For the electronic health record, all information related to the clinical visit and all associated codes are entered directly into the electronic health record; therefore, no hard copy is maintained.
- Copies of new patient chart registration forms, signature forms, secondary billing forms, Purchased/Referred Care 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 should be scanned into the respective tab of the Electronic Health Record (EHR). In the event that scanning appropriate records has not been implemented at the facility, ensure that form is filed into the patient's paper health record appropriately.
- At some facilities, copies of the insurance card should be scanned into the administrative tab with EHR in an expeditious manner. Refer to your local policies and procedures for specific guidelines.
- For claims filed electronically, copies of the claim exist within RPMS.
- RPMS creates an electronic version of the claim and it is available for viewing, sending electronically, or printing to paper.
- Copies of the explanation of benefits (EOB) or Remittance Advice (RA) should be electronically filed by date in a secure folder that is accessible only to those who have a need to know. Paper documents of the EOB or RA in the business office should be filed in a secure location. The file may also be scanned into the Patient's chart as an administrative document. These documents should follow all regulations as to safety, security and retention.

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, reference:

[http://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p5c15](http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p5c15)

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

## 3.8 Consent/Signature Forms

### 3.8.1 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.

### 3.8.2 Consent for Release of Information

For more information and guidelines on consent for release of information, reference Indian Health Manual, Part 2, Chapter 7:  
<https://www.ihs.gov/ihtm/pc/part-2/chapter-7-health-insurance-portability-and-accountability-act-privacy-rule-and-the-privacy-act/#2-7.4>.

### 3.8.3 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 beneficiary before billing third party payers, including Medicare.

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.

### **3.9 Facility and Provider Enrollment**

The IHS may utilize its Right of Recovery authority under 25 U.S.C. §1621(e) to recover (1) IHS' reasonable billed charge or, if higher, (2) the highest amount that would be paid to other providers. This authority is not a point of negotiation, but rather a point of communication to the third party payer.

IHS is not prohibited from participating in provider networks, but need not be in network to obtain payment. Once the IHS agrees in writing to a certain reimbursement rate with a third party payer, then the IHS is unable to use its authorities under 25 U.S.C. §1621(e). It is important to note that all written provider agreements and contracts should be cleared by legal counsel to ensure that the terms are applicable to and may be carried out by the IHS.

In some cases, insurers may require information regarding individual providers and respective facilities where services are provided in order to recognize these IHS providers and facilities and to pay them at the appropriate rate. When considering enrollment of individual providers; full-time employees, contracted providers, and locum tenens should be considered.

Each Service Unit will decide who is responsible for the provider enrollment process, but typically this is a process that is managed by the Business Office Manager.

The person responsible for managing the provider enrollment process will need to ensure that all information, including facility legal business names and addresses, which are provided to the Internal Revenue Service (IRS), National Plan and Provider Enumeration System (NPPES), Medicare Provider Enrollment, Chain and Ownership System (PECOS) is consistent and that points-of-contact, including authorized and delegated officials remain up-to-date.

### **3.10 Tax Identification Number**

A Taxpayer Identification Number (TIN) is an identification number used by the IRS in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS. The types of TINs are as follows.



- Social Security Number "SSN"
- Employer Identification Number "EIN"
- Individual Taxpayer Identification Number "ITIN"
- Taxpayer Identification Number for Pending U.S. Adoptions "ATIN"
- Preparer Taxpayer Identification Number "PTIN"

IHS Service Units will need an Employer Identification Number or "EIN," which serves as the Tax Identification Number for the respective facilities. The EIN is utilized for provider enrollment purposes and is linked to the National Provider Identifiers for the facilities and providers.

### 3.11 **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 eliminates the need for health care providers to use different identifiers to identify them when conducting HIPAA standard transactions with multiple health plans. Health care providers use their NPIs to identify themselves in standard transactions, where the NPI is required.

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

However, the application and request for an NPI does not replace the enrollment process for health plans.

**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 will be utilized by business associates, such as billing agencies that assist with billing transactions on behalf of the provider.

### 3.11.1 NPI Application Process

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

- 1) The web-based application process is available at:  
<https://npes.cms.hhs.gov/NPES/Welcome.do>
- 2) A paper application can be completed and mailed to Enumerator. A copy of the application, including the Enumerator's mailing address (NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059) is available at this website:
  - a) <https://npes.cms.hhs.gov/NPES/Welcome.do>
  - b) <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.pdf>
  - c) Alternatively, the provider can call the Enumerator to receive a copy:
    - i. 1-800-465-3203  
(TTY) 1-800-692-2326

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 a matter of days. 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.

### 3.11.2 Procedure for Enrolling Providers

It is important for the facility to compile a local procedural document that outlines the process from the time that a provider is being considered for

employment to the time that the provider is enrolled in the networks of third party payers. It is also important for the document to address ongoing enrollment procedures, such as revalidation, re-enrollment, changes, violations of provider enrollment agreements, etc. All enrollment numbers, including Tax IDs, Provider Transaction Access Numbers, and CMS Certification Numbers, should be kept confidential and only given to those individuals who have a need to know. This practice will serve to minimize risk of misuse of the enrollment numbers.

The following procedure applies to clinical providers, such as physicians, licensed Physician Assistants (PA), Nutritionists, Nurse Practitioners (NP), Nurse Specialists, as well as locum tenens and contracted providers. Some of the following processes may be complemented by the IHS' privileging software and the respective steps may be modified accordingly.

**Step 1:** Ensure that Provider Enrollment Staff works with the Clinical Director's Office. The Clinical Director's Office provides oversight of the IHS credentialing process for employment of IHS providers. The IHS credentialing process includes the following steps:

- 1) Provider completes a credentialing package.
- 2) Service unit credentialing specialist reviews and compiles all necessary documents.
- 3) Service unit leadership reviews and recommends approval to the governing board.
- 4) Governing board approves the credentialing and authorizes the requested/approved privileges.

It is important for the Provider Enrollment Staff to be notified early in the credentialing process of any providers who may soon be providing health care services. Similarly, Provider Enrollment Staff need to be notified of any providers who may soon discontinue providing health care services at the facility.

**Step 2:** Compile provider enrollment documents (NPI application if needed) and complete the necessary information, prior to presenting the documents to the provider for final review and signature.

- 1) When the notification of a newly hired or detailed Provider arrives from the Clinical Director's office ensure that the provider is added to RPMS. The following fields are required:
  - a) Last Name, First Name
  - b) Initials
  - c) Address information

- d) Provider Taxonomy Code
  - e) Provider Class/Specialty
  - f) Affiliation Code
  - g) Social Security number
  - h) Current Licensure information
  - i) 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:
    - a) Full name
    - b) Department
    - c) 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 Listing

**Step 3:** Send the completed Enrollment Application to the payer

**Note:** Some states may require different color ink signatures to validate the authenticity of the signature. Follow the 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 by the provider, ensure the accuracy of all documents, including the provider's signature.
- 2) Address and attach required supporting documents for each provider as required for each insurance payer, including, but not limited to,
  - a) Licensure information
  - b) Drug Enforcement Administration (DEA) number and Clinical Laboratory Improvement Amendments (CLIA) CertificationSome insurers may also require a copy of the Federal Tort Claim Agreement, W-9, or signature of an authorized official.
- 3) Enclose, address, and mail each completed application to the respective insurers for your state – Medicaid, Medicare, and private insurers.

**Step 4:** 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 Listing.

### **3.11.3 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 health records are completed, signed and coded.
- 2) Enter the data into the system and bill for any visits as soon as possible.
- 3) Inactivate the provider in RPMS when all visits are coded and billed.
- 4) Notify insurance companies of the provider's termination date.

## 4. Business Office Staff

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## 4.1 Business Office Staff Descriptions

The following sections provide a list of duties and qualifications for key Business Office personnel. Positions may include one or more of the following personnel descriptions. For example, a Medical Support Assistant may serve as the receptionist, admitting clerk, check-in clerk, Patient Registration clerk and appointment clerk.

**Note:** For purposes of this chapter, “health insurance coverage” and “third party payer” may be used interchangeably depending on the context.

### 4.1.1 Receptionist

<b>Duties</b>	<ul style="list-style-type: none"><li>• Addresses patients, visitors, and co-workers in a pleasant and respectful manner; displays courtesy at all times.</li><li>• Interviews patient upon arrival at facility.</li><li>• Directs patient to appropriate person or clinic.</li><li>• Obtains signatures for medical and financial documents.</li><li>• Answers questions.</li><li>• Checks and/or validates the patient’s schedule on the system.</li><li>• Verifies health insurance information and eligibility for patients one day prior to the appointment.</li><li>• Makes referral to the Patient Benefit Coordinator when needed. For example, if a patient does not have active health insurance coverage or has questions pertaining to their health insurance.</li><li>• Contacts departments or staff, if needed.</li><li>• Works on various reports in between activities, as assigned by supervisor.</li><li>• Answers telephone calls to facility and directs calls appropriately.</li></ul>
<b>Desired Qualifications:</b>	<ul style="list-style-type: none"><li>• High school graduate</li><li>• Interpersonal communications skills</li><li>• Exceptional customer service</li></ul>

### 4.1.2 Admitting Clerk

<b>Duties</b>	<ul style="list-style-type: none"><li>• Relates well with facility, providers, and patients.</li><li>• Complies with the facility’s general policies and procedures.</li><li>• Schedules patient for admission to the facility.</li><li>• Verifies health insurance prior to anticipated admissions.</li><li>• Interviews patient upon arrival at facility.</li></ul>
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- Gathers available information in preparation for arrival of emergency vehicle.
  - 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 completed and 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.
  - Shares pertinent information with Supervisor in order to improve care coordination and opportunities for improvement among functions
  - Prepares reports on admissions.
- 

**Desired****Qualifications:**

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

### 4.1.3 Check-in Clerk

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

- Checks-in patient in the Practice Management Suite.
- Verifies eligibility.
- Identifies the order of billing/coordination of benefits based on reason for visit or clinic type.



- Accepts 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 Patient Registration based on the patient process.

#### 4.1.4 Registration Clerk

##### Duties

- Greets and registers patients.
- Verifies insurance benefits and eligibility within the timeframe set by the facility.
- Makes initial determination on which insurance is primary, secondary, and tertiary.
- Copies new insurance cards.
- Scans all required forms into the Vista Administrative Tab.
- Establishes new patient records in coordination with Health Information Management (electronic health records staff).
- Has patient sign any medical, financial and other necessary documents.
- Collects any payments (non-beneficiary only), according to financial regulations, internal controls policy, and facility resources. Works with the facility Collections Clerk to ensure payments are processed and accounted for.
- Schedules appointments for walk-in patients, when needed.
- Checks patient in.
- Updates insurance and demographic information at every visit in the Practice Management Suite. Notifies clinical staff that patient has is ready for triage.
- Refers patients who are potentially eligible for health insurance, but not enrolled, to the Patient Benefit Coordinator.
- Coordinates with benefits coordination, accounts receivable, and Purchased/Referred Care (PRC) staff in cases where a patient is enrolled in an alternate resource, but the alternate resource is not entered in the system.
- Continues to stay informed of any changes in policies that could affect patient eligibility and benefits.
- Generates the Patient Errors and Warnings Report on a regular basis. Corrects the errors and warnings in a timely manner.
- Corrects Master Patient Index (MPI) errors in a timely manner.

##### Desired

##### Qualifications:

- High school diploma
- Exceptional customer service

- Attention to detail
- Familiarity with and understanding of health insurance
- Proficiency in computer systems

#### 4.1.5 Appointment Clerk

**Duties**

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

**Desired****Qualifications:**

- High school graduate
- Familiarity with computer systems
- Exceptional customer service
- Attention to detail
- Proficiency in computer systems

#### 4.1.6 Patient Benefit Coordinator

**Duties**

- Coordinates with patient registration to identify patients with no alternate resources, i.e., third party coverage. This shall include identification of patients prior to appointments, on the date of service, and on a regular basis by generating applicable reports. These reports may include the appointment schedule, Exception Reports and the Patient Eligibility Report.
  - Determines what alternate resources are available to the patient, based on the patient's unique circumstances and the eligibility requirements for each alternate resource. Coverage options may include either one or more of the following: Medicare, Medicare Cost Sharing, Medicaid, Veterans Affairs, Marketplace, Private Insurance (Employer-Based, Individual, Medicare Supplement/Medi-Gap, etc.), and Long Term Care coverage.
  - Stays current on federal and state law and/or regulations as well as specific alternate resource policies. These may include eligibility requirements, covered benefits, and other requirements.
-

- Educates patients on all third party coverage options, associated costs (if any), and potential benefits of each option. Coverage options may include either one or more of the following: Medicare, Medicare Cost Sharing, Medicaid, Veterans Affairs, Marketplace, Private Insurance (Employer-Based, Individual, Medicare Supplement/Medi-Gap, etc.), and Long Term Care coverage.
- Provides information, referral and/or assistance regarding other benefits programs, including cash assistance, Supplemental Nutrition Assistance Program, Social Security Administration benefits, VA benefits, and other local and tribal benefits.
- Responds to referrals from patient registration and PRC and makes an appointment with patients with no alternate resources.
- Educates Patient Registration, PRC, and other staff on updates to alternate resource programs.
- Provides outreach, education, and assistance regarding alternate resource programs to patients and community members.
- May partner with local and tribal programs to provide outreach and education.
- Should the patient decide to enroll in an alternate resource; the patient benefit coordinator will assist the patient with completion of the application and collection of required forms. The patient benefit coordinator will utilize available resources for application submission. Optimally, an electronic or web-based application should be used. Assists patients with eligibility renewal.
- Follows up with the alternate resource regarding the application status on a timely basis. Documents any activity in RPMS.
- Ensures patient benefit coordination processes are adhered to. This may include proper documentation in RPMS, timely review of application status, resubmission of applications, local documentation requirements (e.g., free text standardization), etc.
- When an application is approved, sends a notice to third party billing and PRC with the required information and effective date of coverage.
- Prepares monthly reports of activity for Administration:
  - Number of patients identified potentially eligible
  - Number of patients interviewed
  - Number of applications completed
  - Number of pending applications
  - Number of resubmissions
  - Number of patients who failed to comply” with application requirements/deadlines

- Desired 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 third party payers and familiarity with statutes and regulations that impact eligibility for health insurance coverage
  - Familiarity and understanding of health insurance coverage
  - People-oriented person
  - Exceptional customer service
  - Attention to detail
  - Proficiency in computer systems

#### 4.1.7 Appointment Clerk

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

- 
- Desired Qualifications:**
- High school graduate
  - Familiarity with computer systems
  - Exceptional customer service
  - Attention to detail
  - Proficiency in computer systems

#### 4.1.8 Biller

- Duties**
- Generates the Flagged as Billable Visits (BRRP) Report on a daily basis and Rollback Detail (ROD) Report on a weekly basis.
  - Creates, reviews, and corrects claims to ensure accuracy, proper format (paper or electronic claim), and compliance with third party payer requirements prior to claim completion and submission.
  - Follows-up with coder when information is missing or inaccurate.
  - Confirms insurer sequencing order and coordination of benefits.
-

- Ensure that associated documentation is sent along with claims when needed and/or EOB from primary denial.
  - Determines if claims need to be split to account for billing of all covered services in one visit according to payer requirements.
  - Approves “clean” claim within timeframes indicated in the IHS Third Party Internal Controls Policy and third party payer timely filing requirements.
  - Pends claims when follow up is required to gather further information from coding; provider enrollment is pending; or other information is needed to approve the claim.
  - Tracks pended claims, reviews the Pended Claims Report weekly to determine if necessary information was provided, takes steps to ensure resolution (if needed) and processes claims appropriately.
  - When a claim needs to be canceled, coordinates with supervisor to process the deletion and document the associated reasons.
  - Works with the Supervisor or Manager to review the Cancelled Claims Report on a monthly basis to ensure issues are known and addressed as needed.
  - Responsible for verifying that all codes (CPT, ICD-10, HCPCS, etc.) are billed correctly to the insurance company.
  - Validates compatibility and medical necessity between CPT and ICD-10 coding.
  - Corrects any electronic rejections immediately for resubmission.
  - Prints, sorts, and mails manual claim forms (primarily private insurance and dental claims) to the insurer.
  - Reviews insurance return mail (containing claims or debt letters), determines reasons for return, and takes necessary steps for resolution.
  - Reviews inquiries from insurance company to determine steps for appropriate resolution.
  - Communicates any significant changes in coding, benefits, coding errors, patient ineligibility on the date of service, billing changes, insurer addresses or EDI changes, etc. to affected parties.
  - Keeps in close contact with the insurer to better understand their specific coding and billing requirements.
-

- Researches all information related to a denied claim or a zero pay and processes a corrected bill in a timely manner, one that is established by the facility. Bills the appropriate primary insurer and follows up to ensure posting of primary payment is complete. Creates the secondary insurance claim, either manually or electronically, for processing. Attach primary Explanation of Benefits to the secondary claim and send to secondary insurer.
  - Keeps abreast of CPT, ICD-10, HCPCS coding, and associated RPMS updates.
  - Always adheres to confidentiality requirements of handling medical/charge information in performing job duties.
  - Conducts random reviews as part of a review team. Random reviews of claim payments and adjustments are conducted to determine sufficient provider documentation, appropriate coding, appropriate billing, patient eligibility, and appropriate payment.
- 

**Desired  
Qualifications:**

- High school diploma
  - Proficiency in the use of computer systems and keyboarding skills
  - Good communication skills
  - Familiarity and understanding of health insurance coverage
  - Previous experience with coding and insurance billing requirements
  - Attention to detail
  - Exceptional customer service
-

#### 4.1.9 Voucher Examiner

- Duties**
- Generates the Aging summary and detailed report for all third party payers and completes follow-up for unpaid bills. This report determines all accounts that exceed 120 days from date of service.
  - Examines accounts or resolves difficult reconciliation which requires an analysis of adjustments and corrective entries in the patient account system.
  - Trace transactions entered and prepare and/or provide supporting documents reflecting the source of discrepancies. Determine corrective action required to bring accounts into agreement.
  - Prove the accuracy of adjusted accounts.
  - Recommend actions to prevent recurrence of discrepancies.
  - All accounts are reviewed and researched within 45 days and documented in the Resource Patient Management System (RPMS) message field and communicate with the Business Office Manager any areas of concerns identified.
  - Credit Balance must be reviewed.
  - Comply with the Federal Debt Collection Act requires referral to US Treasury after 180 days from date of service.

- Desired Qualifications:**
- High school diploma
  - Proficiency in the use of computer systems and keyboarding skills
  - Good communication skills
  - Familiarity and understanding of health insurance coverage
  - Previous experience with coding and insurance billing requirements
  - Attention to detail
  - Exceptional customer service

#### 4.1.10 Accounts Receivable

Depending on the size of the facility, the following duties may be split between aged accounts review and follow-up; posting; and, identification for processing of denials, zero pays and adjustments. In smaller facilities, these functions may be combined.

- Duties**
- Before batches are finalized, there should be a quality control review by another individual to ensure the batches are correct.
  - Electronically auto-posts payments and adjustments to patient accounts in a timely manner.
  - Validates that all electronic payments have been appropriately credited.

- Posts all manual payments and adjustments to patient accounts in a timely and accurate manner.
  - Consistently evaluates the accuracy of third party payment, denials and adjustments.
  - 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.
  - Creates electronic notes to identify denials and zero pays for re-work by respective functions.
  - Prepares A/R reports for billing supervisor, finance, and Area Office.
  - Researches and forwards appropriate paperwork regarding inappropriate payments to the appropriate facility, Area office and to the insurer.
  - Once it is determined whether to initiate a refund or allow recoupments/offsets; initiates the process in the case where payment needs to be refunded to the insurer.
  - Identifies patterns or potential issues and intervenes to prevent adverse impact.
- 

**Desired****Qualifications:**

- High school diploma
  - Previous accounting or insurance posting experience
  - Attention to detail
  - Familiarity and understanding of health insurance coverage
  - Exceptional customer service
  - Proficiency in computer systems
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#### 4.1.11 Compliance Officer

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**Duties**

- Oversees and monitors the implementation of the Provider Compliance Program. Programs must include:
  - Written policies, procedures and standards of conduct;
  - Compliance program oversight;
  - Training and education;
  - Opening the lines of communication;
  - Auditing and monitoring;
  - Consistent discipline; and,
  - Corrective actions.
- Reports on a regular basis to the facility's Chief Executive Officer, Leadership Committee, and Compliance 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 according to the needs of the facility, e.g., assessment findings, corrective action plans, etc. Periodically revises the program in accordance with 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.
- Assists the facility's appropriate departments in coordinating internal compliance review and monitoring activities.
- Independently investigates and acts on matters related to compliance, including the ability to initiate and coordinate internal investigations. Compiles audit findings and coordinates and monitors corrective actions with the appropriate departments. Develops policies and programs that encourage supervisors and staff to report suspected fraud, waste, abuse, and other improprieties.
- Reviews all relevant documents throughout the facility to include relevant patient records, billing records, and other related data for compliance.
- Coordinates periodic audits on health records, coding, billing, payment, accounts management, credentialing and other key elements of the revenue cycle.

- Desired Qualifications:**
- High school diploma, Bachelor’s degree, or certification as a Certified Professional Compliance Officer. Preference of medical background or experience in the health care field.
  - Previous experience with quality or compliance monitoring.
  - Ability to communicate with individuals throughout the facility.
  - Understanding of State and Federal law, regulations, policies, and other authorities.

## 4.2 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. For guidance on the performance appraisal process, please refer to:

<https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/>

<https://www.ihs.gov/DHR/performancemanagement/>

The performance appraisal is a periodic meeting between the staff person and supervisor to discuss the employee’s job performance. The first of these meetings should occur within 30 days of the employee’s start date. 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 at a minimum, mid-year and annual reviews occur. These reviews may support salary and promotion decisions. For example, meeting or exceeding expectations supports an increase in salary, while not meeting expectations does not.

Timely performance appraisals are essential to maintain the credibility of your performance appraisal process. It is important to have regularly scheduled reviews, to make sure timely feedback is provided to the employee. Regularly planned reviews allow for direct feedback and promote a clear understanding of job expectations.

Even though performance reviews are required semi-annually, periodic evaluation should take place to accomplish the following:

- **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.

- **Identify and remediate poor performance**

Corrective performance discussions may be scheduled at any time when it becomes necessary to advise the employee of performance problems and to specify corrective action within associated timeline.

- **Justify pay adjustments**

Employee performance ratings may be used as a basis for making salary adjustments. Justification is usually expected to accompany pay adjustment.

- **Evaluate candidates for promotion**

The performance appraisal serves as an excellent process to identify employee career interests and evaluate candidates for promotion. Managers should collaborate with employees to identify career ladder goals that will help employees receive their desired promotion.

- **Document personnel actions**

Each action must be documented and stored in the employee's eOPF by Area HR.

In situations of misconduct, disciplinary warnings/actions should be issued to the employee at the time of infraction. They should be referred to the appropriate ER/LR staff.

#### **4.2.1 Performance Appraisal Internal and External Factors**

It is important to understand that outside factors may drive employee performance. When giving feedback, be direct and factual, while understanding there can be other factors influencing performance. The evaluator needs to continually relate to the impact on work performance.

### **4.3 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.

#### 4.3.1 **Check-in Clerk Performance Evaluation Criteria**

- Demonstrates responsibility for accurately completing the check-in process for every patient.
- Reliable in keeping work schedule.
- Adheres to organization's dress code standards.
- Maintains professional attitude and courtesy while obtaining information from all patients.
- Informs all staff in a timely manner of patient's arrival.
- Works with the supervisor on any potential challenging situations in a timely manner.
- Cooperates with IHS staff in Patient Registration area.

#### 4.3.2 **Admitting Clerk Performance Evaluation Criteria**

<b>Performance Factor Evaluation Criteria</b>	
<b>Reliability</b>	<ul style="list-style-type: none"> <li>• Reports to work early enough to start work at their assigned time</li> <li>• Takes responsibility for knowing and keeping work schedule</li> <li>• Notifies supervisor in advance of requests for scheduling changes</li> <li>• Adheres to organization's dress code</li> </ul>
<b>Cooperation</b>	<ul style="list-style-type: none"> <li>• Recognizes need for changes in daily routines</li> <li>• Demonstrates willingness to adjust work schedule due to illness, etc.</li> <li>• Treats every patient and staff person with courtesy, respect, and concern</li> </ul>
<b>Initiative</b>	<ul style="list-style-type: none"> <li>• Maintains adequate office supplies and orders new supplies when necessary</li> <li>• Assumes responsibility for maintaining clear and orderly work area</li> <li>• Consistently provides superior customer service and assistance</li> </ul>

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**Performance Factor Evaluation Criteria**

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**Responsibility**

- Works independently in the absence of the supervisor referring problems that require escalation
- Follows through to complete assignments and projects
- Maintains accurate census
- Assigns patients to beds according to the facility procedures
- Places correct, complete and appropriate information in patient's record
- Makes sure patients' papers are properly completed
- Acquires pertinent information regarding emergency admissions
- Add admissions requiring insurance verification are handled in a timely and accurate manner
- Demonstrates willingness to train and support new staff
- Problem situations are resolved appropriately and independently
- Plans ahead

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**Communication**

- Provides accurate and thorough reports
- Maintains inter- and intradepartmental working relationships
- Alerts appropriate staff as issues or delays are foreseen or as they arise
- Deals with challenging situations diplomatically

### 4.3.3 Patient Registration Staff Performance Evaluation Criteria

Performance Factor	Evaluation Criteria
<b>Confidentiality</b>	<ul style="list-style-type: none"> <li>• Discusses only appropriate patient information in public and private areas protecting the confidentiality and dignity of all patients</li> <li>• Communicates only appropriate patient information over the telephone</li> <li>• Adheres to IHS confidentiality policies</li> <li>• Follows facility policy on release of information</li> </ul>
<b>Patient Relations</b>	<ul style="list-style-type: none"> <li>• Meets and greets all patients and patient families with an appropriate, friendly greeting</li> <li>• Answers phones with a pleasant voice in a timely manner and transfers calls according to department policy</li> <li>• When placing calls on hold, follow policy, returning to the caller at regular intervals, to ensure excellent communication</li> <li>• Forwards messages to the appropriate staff, as needed</li> <li>• Adheres to facility protocol when handling patient complaints</li> <li>• Exhibits a positive attitude and provides assistance to all patients</li> </ul>
<b>Patient Registration</b>	<ul style="list-style-type: none"> <li>• Ensures each patient is assigned an appropriate health record number</li> <li>• Obtains and inputs complete and accurate patient demographic and other information into the RPMS registration application</li> <li>• Obtains and verifies all insurance information for the patient. Updates the system accordingly and timely.</li> <li>• Ensures appropriate sequencing is completed each visit</li> <li>• Obtains assignment of benefit forms, signature-on-file forms and other forms as needed</li> <li>• Refers appropriate patients to the Benefit Coordinator</li> <li>• Ensures that all patients are registered in a timely manner, prioritizing workload during periods of high volume</li> <li>• Enters all other data as required by the registration area for proper reporting and documentation</li> <li>• Resolves or escalates problem situations as appropriate</li> </ul>
<b>Collection</b>	<p><i>(for non-beneficiaries only)</i></p> <ul style="list-style-type: none"> <li>• Follows local collections policy</li> </ul>

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**Performance Factor Evaluation Criteria**


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<b>Responsibility</b>	<ul style="list-style-type: none"> <li>• Adheres to and is aware of all procedures</li> <li>• Refers to policy or operation manuals as needed</li> <li>• Updates supervisor of issues in which the supervisor needs to be apprised of</li> <li>• Adheres to organization's dress code standards</li> <li>• Adapts flexibly to scheduling decisions and changes to meet staffing needs</li> </ul>
<b>Quality Improvement</b>	<ul style="list-style-type: none"> <li>• Participates in department meetings, as approved</li> <li>• Participates in in-services and training programs, as approved</li> <li>• Reports completely and accurately any incident that may warrant review by a Risk Manager</li> <li>• Consistently and accurately records any requested quality data and reports this information in a timely manner</li> <li>• Consistently maintains department standards</li> </ul>

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#### 4.3.4 Patient Benefit Coordinator Performance Evaluation Criteria

- Communication activities promotes positive patient relations and follow through with patients
  - Increases the number of enrolled patients for alternate resources
  - Deals with challenging situations diplomatically
  - Participates in department meetings, as approved
  - Develops a close working relationship with Patient Registration and has trained or coordinated training for Patient Registration staff on the eligibility requirements for Medicare, Medicaid, Marketplace, VA and other health insurance coverage
  - Develops a close working relationship with PRC to establish patient eligibility
  - Appropriately documents the results and outcomes of outreach, education and assistance in RPMS and BPRM
  - Communicates timely to Patient Registration, Billing, and PRC staff when patients are approved for Medicaid
  - Knowledgeable of state and Federal, Medicaid, Medicare, VA, private insurance and other benefits programs.
  - Works towards online submission of benefits applications.
  - Tracks status of applications and provides summarized information to management.
-

- Assists patients with eligibility appeal processes.

#### **4.3.5 Biller Performance Evaluation Criteria**

- Billing is maintained at an acceptable level, minimizing backlogs
- Accuracy and proficiency of billing are within acceptable measurements
- Resolves challenging situations appropriately and independently
- Notifies supervisor of any unusual problems, consistent insurer problems, or significant issues that may impact timely reimbursement
- Follows up with insurers within the timeframes established by the facility
- Conveys consistent or repetitive system errors to the supervisor in a timely manner
- Accurately documents information related to insurer follow ups in the RPMS
- Maintains billing errors at an acceptable percentage (90% or 95% accuracy)
- Conducts random periodic audits of documentation, coding and billing
- Knowledge of third party payer policy, especially Medicare, Medicaid and the VA
- Knowledge of HIPAA security and privacy rules for electronic transactions
- Develops close working relationship with Patient Registration, and A/R for appropriate resolution of denials

#### **4.3.6 Accounts Management Performance Evaluation Criteria**

- Posts patient accounts in a timely manner following the Third Party Internal Controls policy
- Maintains posting errors at an acceptable level (95% and above accuracy)
- Resolves errors and issues immediately
- Adheres to check validation and verification process 100% of the time
- Maintains minimum backlogs
- Identifies and forwards denials appropriately for resolution
- Completes monthly reconciliations in a timely manner
- Provides monthly accounts receivable reports to management in a timely manner



- Monitors the unpaid accounts beyond 45 days, is aware and offers justifiable reasoning, as well as offers corrective action to resolve
- Processes refunds according to facility's policy
- Utilizes appropriate adjustment reason codes

## 4.4 Separation of Duties

The requirements for separation of duties and roles and responsibilities are indicated in the Indian Health Manual (IHM) and GAO Standards for Internal Controls in Federal Government. For more information, reference:

<https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>

<https://www.gao.gov/assets/670/665712.pdf>

### **Separation of Duties section in Third Party Revenue Accounts Management and Internal Controls policy of the Indian Health Manual (Part 5, Chapter 1):**

- 1) Separation of Duties. All procedures developed at the local level must ensure the separation of duties for the following processes:
  - a) Minimum Requirements. At a minimum, billing, receipt of payment, posting of payment/adjustments, review of aged accounts, and approval of write-offs.
  - b) Alternative Recommendations concerning Small Facilities. If these duties cannot be separated due to minimal staff at small facilities then there must be a mitigating control of documented supervisory review of all transactions.

For more information, reference: <https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/#5-1.3C>

**GAO Standards for Internal Controls in Federal Government:** Key duties and responsibilities need to be divided or segregated among different people to reduce the risk of error or fraud. This should include separating the responsibilities for authorizing transactions, processing and recording them, reviewing the transactions, and handling any related assets. No one individual should control all key aspects of a transaction or event.

### **Information Systems Audit and Control Association (ISACA):**

Organizations should implement a division of roles and responsibilities that reduces the possibility for a single individual to compromise a critical process.

#### **4.4.1 RPMS New System Set Up and Roles and Responsibilities**

Facilities often have to set up their RPMS Business Office Systems (Third Party Billing and Accounts Receivable) from scratch with roles and responsibilities taken into consideration (Separation of Duties recommendations).

See Part 1, Appendix B “Third Party Billing and Accounts Receivable – New Facility Set Up” guide to assist in successfully implementing these RPMS systems and assigning proper roles and responsibilities to ensure proper separation of duties.

It is the responsibility of the facility/Area to ensure that these recommendations are met. A Fileman report can be run periodically to identify any conflicts in role/key assignments.

See Part 1, Appendix C “Printing the keys list from RPMS for billing staff” for instructions on how to run the list of keys assigned and utilize this list in working with OIT staff to ensure proper Separation of Duties.

There may be “exceptions” to the guidance. Written justification through local policies and procedures needs to be approved and signed by the Facility CEO and/or Area Director.

## 5. Business Office Quality Process Improvement

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## 5.1 **Accreditation and Patient Rights, Confidentiality, Privacy, and Safety Requirements**

The Joint Commission and/or other accrediting bodies 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.

### 5.1.1 **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.

### 5.1.2 **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, unless a signed Release of Information form, signed within the last year exists allowing information sharing.
- The pre-authorization desk is located away from mainstream of patients, because patients' names, personal identifiers and diagnoses are given over the phone for insurance purposes.
- Staff shreds all documents that contain any patient names on a recurring basis. (it may be daily).
- Secure all documentation containing patient information (such as locked file cabinet).

### 5.1.3 **How do you maintain privacy?**

- Staff speaks in hushed tones.
- Information is not requested if it is not pertinent to the admission or facility visit.

- Staff accommodates patient requests to not release their status information or location.
- Emergency Room staff move patient into emergency room bay or examination room if the triage room is occupied.
- Staff is aware of the privacy regulation.

#### 5.1.4 How do you maintain life safety?

- Fire drills
- Disaster preparation and plans (e.g., natural disaster, code reviews, or active shooter drills)
- Hazardous spills
- Infection control

## 5.2 Quality Performance and Improvement

After each Joint Commission and/or other accrediting body survey is completed, it is recommended that a Performance Improvement Summary be developed, updated, and maintained to demonstrate to Joint Commission 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 corrective action plan can be put in place to improve the deficiencies that were noted.

### 5.2.1 Example of a Performance Improvement Summary

Problems Identified	Action Taken or Recommended	Evidence of Improvement
Outpatient bills lack sufficient documentation	<ul style="list-style-type: none"><li>• Verify provider order and notes.</li></ul>	<ul style="list-style-type: none"><li>• Findings as a result of audits which review medical documentation and medical necessity have decreased.</li></ul>

Late filing of external ancillary test in electronic health record (EHR) (lab reports, x-rays)	<ul style="list-style-type: none"><li>• Notify staff of the facility requirement for timely scanning of diagnostic test results in EHR.</li></ul>	<ul style="list-style-type: none"><li>• Diagnostic test results are scanned in EHR within one day of receipt</li></ul>
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Equipment and staff should undergo annual testing to certify operational capacity and competency to perform job duties or identify areas of improvement. Documentation should be stored for reference in personnel files or equipment logs.

### 5.3 Flow Charts for Process Improvement

A team-oriented approach with tangible department goals may 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 and a friendly competitive atmosphere is 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 may 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 may be discussed without blame and everyone will examine the results and work together to create improved workflow solutions.

### 5.4 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 may be done in several ways. Registration should 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. Discussion should occur between these departments with a defined action plan addressing each of the identified deficiencies. A corrective action plan will identify and track performance improvement progress.

Leverage Patient Registration Projection report in RPMS to see the number of records that member has updated.

By understanding the impact of accuracy and increased rejections or zero pays due to poor registration information, each registration employee can create a plan of action to improve and standardize the registration process.

For those facilities accepting non-beneficiaries (EDs), the department should:

- Identify the patients that owe deductibles or coinsurance at the time of service. Attempt to collect. Relate to patient or family member that services will be billed and payment is expected. Regular collection regulations will fall into place.
- Track the up-front collections success or define room for improvement areas
- Define further tracking/monitoring/improving techniques.
- It is also important to implement a collection system according to how non-beneficiary patients pay; such as, by cash, check, or credit card. Follow your facility's financial protocols as defined.

#### **5.4.1 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.

#### 5.4.1.1 Examples of insurer-related errors and solutions

Error	Solution
Calculating ages when using the birthday rule for coordination of benefits (determining primary insurer)	Determine primary insurer based on the earliest birth month in the calendar year, not who is older. The birth year does not matter.
Entering insured's identification number a group number	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.
Using abbreviations that are misinterpreted (e.g., "pat" means "patient" to some, "preadmission testing" to others)	Created a list of common abbreviations for all staff members to use. The list should be consulted when writing or reading abbreviations.
Failing to note useful information in the comments section of RPMS.	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.
Failing to include insurer address	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.
Transposing first and last names	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.



Using existing information in the system from a previous visit	Update patient information at each visit. Insurances, addresses, and employment are all subject to change.
Failing to get preauthorization	Know which insurers require preauthorization for treatment. If in doubt, call. It is better to make the extra effort to avoid claim denials. If claim denial is received due to no pre-authorization, make a note in the system and notify team in order to capture pre-authorization next visit. Use “Prior Auths” tab in BPRM for your one source documentation of necessary authorizations.

#### 5.4.2 Steps to Improve Registration Quality

There are five basic steps to improving the quality of the work performed by 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.**

Weekly running of the FAUD and ERP reports in registration should be accomplished. Splitting out the report and defining a completion date for correcting errors serves as both a training tool for your employees, as well as cleans up your database. As you work these reports, your database will be optimized. Do not wait for an annual performance appraisal to review the number of errors.

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

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

4) **Monitor quality daily.**

Have each of your staff run their own error reports as a training tool. Spot checking registration records daily helps keep staff on their toes and

accuracy levels will remain high. Later, 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 create solutions **with** staff. “With” is the operative word.

### 5.4.3 **Checking Registration Performance for Quality Assurance**

Each facility should establish a standard set of quality performance measures. These performance measures could include random checking/sampling of the following steps:

- 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.
  - a) Was only a primary insurance referenced?
  - b) Was a secondary insurance, pharmacy-only, or dental insurance listed?
  - c) Was the insurance billing address correctly reflected?
  - d) Was the ID number accurately reflected?
- 3) Review the billing information on the patient.
  - a) Was the same insurance information billed?
  - b) Was the same address used?
  - c) Was the account paid?
  - d) Were errors identified, and if so, what errors?
- 4) Use this data to identify performance improvement opportunities

## 5.5 **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.

- Leverage Patient Benefit Coordinator (PBC) Production report in RPMS to see the applications and status of applications for everyone the PBC has worked with for the month.
- Compare the increased reimbursement by alternate resource payer, month-to-month.

### 5.5.1 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 application process is completed.
- Document in the **RPMS Patient Registration** application all updates on conversations.
- Always inform Billing of new insurance coverage.

## 5.6 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.

### **5.6.1 Chart Auditing**

The electronic health record serves as a tool for patient care, medical research, and healthcare statistical measurements, and as a supporting tool for reimbursement.

The patient's electronic health 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 electronic health 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 electronic health record chronologically documents the care of the patient.

The electronic health record often serves in many court cases for medical malpractice judgments as the final piece of definitive evidence.

In addition, the electronic health 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, records are exchanged and shared regarding defined care;

- Appropriate utilization review and quality of care evaluations;
- Collection of data that may be used in research;
- Support of the claim creation;
- Accurate and timely patient account review including payments and adjustments.

The process of chart auditing to include internal audits, as well as independent audits needs to be identified in each facility's compliance plan. The questions – how often, how many charts, when to audit – should be addressed in this plan. The Office of the Inspector General has published a variety of model compliance plans in its electronic reading room that may be referenced.

For more information, reference: <https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/#5-1.3F>

**Independent Audit Requirements:** Each facility must have an independent/peer certified coder perform a quarterly review (by random sampling) of all coding/data entries. The review must be conducted by someone who did not do the original coding/data entry, i.e., someone from another facility, a contractor, etc.

Internal auditing is done to verify that the facility is performing to acceptable standards. This practice also ensures good fiscal returns for cleanly coded claims. Internal auditing includes the process of verifying CPT, ICD-10 diagnostic codes, documentation for the encounter, inclusion of all ancillary services with the claim, claim prepared and sent, payment received, or denial or nonpayment received. Internal audit should include all aspects of the review process all the way through denial resolution.

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 should be monitored and audited in both internal and external audits for the facility.

In addition to internal auditing, audits by the government or a third party may be performed to identify fraud and abuse. In preparation for external audits, each facility should regularly perform compliance reviews to audit their records and proactively identify issues.

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?*”

What is missing, what documentation could be improved on in order to provide a concise summation of the visit?

- **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. Streamlining and efficiency are considered, is there a more effective way to handle the visit, condition, outcome of the office visit.

- **Recommendations**

This stage of the process is to define and implement a solution with an achievable action plan and follow-up review process, correction of any findings. This stage also includes the establishment of performance targets and performance due dates, as well as continual monitoring efforts.

### 5.6.2 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: <https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/#5-1.3H>

An audit should be periodically conducted to review visits from beginning to end of the revenue cycle. This is commonly called a retrospective audit. For this process, simply review 25-to-50 recently paid accounts from each of your major payers. Team members should include coding staff, billing staff, AR staff and the compliance person.

Review length of days to code, coded to the highest level, quality of documentation, days to bill, any rejections, corrections necessary, rebilling? Review the pending claims, reasons for pending, and DAYS report. Are there any issues that need addressing immediately?

Review payments received, maximum amount? any reason for nonpayment? Additional information, documentation requested? What recommendation for faster processing was encountered?

This kind of 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. Are you coding to the highest level, billing for all services, being paid the maximum allowed amount? Are we handling denials timely? Are we billing and completing secondary's?

Recommendations or findings are then reviewed and given to the Business Office Manager. This report defines any corrective action plans, further review categories or elements.

### **5.6.3 Electronic Billing Systems - Checks and Balances**

With electronic submission of claims, you should ensure that a confirmation 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.

- 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 (on a daily basis), compare the entries to the confirmation reports you receive regarding number of claims received and forwarded to payers. They should match exactly. If they do not match, you need to define what is missing, identify why the claim rejected, fix, and resubmit.

It is important to examine your confirmation reports daily upon receipt. If allowed to accumulate unresolved, these claims will have an adverse effect on your receivables.

#### **5.6.4 Quality Performance Measuring 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 quality performance measuring.

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

Quality performance measuring steps involved in the billing process are:

**1) Identify what is to be Quality performance measured.**

It could be something tangible such as days, bad debt, or billing time, or it could be something as intangible as patient satisfaction.

**2) Determine data collection method, collect data, and determine current performance levels.**



The team that conducts the studies determines what measurement standards will be used. Once the standards are determined, take the measurements of your own function and compare them with the measurements from the Quality performance measured facility. That usually produces a negative or positive performance gap.

**3) 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.

**4) Establish functional goals.**

Write down your objectives.

**5) Develop action plans.**

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

**6) Implement the plans and monitor progress.**

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

**7) Recalibrate measurements as industry standards change.**

Keep abreast of industry standards and new best practices. Assess recalibration as progress is made against previous quality performance measurements.

**8) Communicate Quality performance measuring findings and gain acceptance.**

Present findings and recommendations to staff and to higher management for periodic progress review and validation.

## **5.7 Monitoring Productivity**

In order to evaluate properly, it is necessary to be able to measure performance. Productivity standards should be identified in the differing performance categories, i.e., exceeds expectations, meets expectations, and does not meet expectations. Calculating and verbalizing a standard sets a clear expectation for employees, no matter what area they work in. Having each employee run their

own productivity report weekly, ensures that employee are always aware of where they are within the known or defined expectations.

Registration clerks, PBCs, Coding, Billing and AR have productivity reports that may be used individually, or run by the manager.

Examples:

For...	Use...
Billing	Bills Listing Report, by approving official
A/R	Transaction Report, by Accounts Receivable (A/R) entry clerk
Coding	Counts Report (RPMS PCC Application), by individual; also provides a summary report

### 5.7.1 Billing Productivity Standards

The following guidelines provide an estimate for billing based on the electronic capabilities of the facility. Each business office manager must calculate or modify standards based on new issues or complexities that arise.

- **Fully Automated Facility**
  - 95-to-100% of visit information is within 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.

Factors that affect the productivity of billers include:

- **The complexity of the services delivered and application of Third Party Payer Policy**
  - There may be services that require additional attention due to new guidelines, billing models, or specific Third Party Payer Policies. This includes ensuring that the claim is complete and justified by medical record requirements or necessities.
- **The volume associated with follow-up on outstanding accounts**
  - Many billers need 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.

- **Information Technology (IT) connectivity issues**
  - At times there maybe, connectivity issues with Third Party Payer IT systems or rejection of files.
- **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 to fill in with registration duties, or PBC duties, or other duties in general, production is affected. Monitor and report when other duties are interfering with billing production. The employee should not be penalized when production goals or expectations are not met due to work reassignment or “filling in.”

## 5.7.2 Ways to Divide Billing Workload

There are several ways to divide the workload in the Billing Department – by payer, by alphabet, or by team. Attention should be paid to cross-training if the decision is made to split by payer. Each payer is unique with their policies and coverage guidelines. Regulations on the Federal level (Medicare/Medicaid) may change frequently, Billers need to communicate changes to the billing department or team.

### 5.7.2.1 Payer Split

The billing responsibilities are divided into the major payer groups – Medicare, Medicaid, Private Insurance, Veterans Affairs (VA), Beneficiary Medical Providers (BMP), or Federal Medical Care Recovery Act (FMCRA), Workers' Compensation (WC).

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

- Pitfalls:**
- Staffing issues with inconsistent knowledge base of your billing team.
  - 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.

#### 5.7.2.2 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.
  - Communication is strengthened by sharing knowledge with your team
- 

- 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 or portals.
  - Staff coverage may not be identified with work on the absent biller's alpha letters, especially if absence is lengthy.
- 

#### 5.7.2.3 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, as no one would be available to work on the bills.

## 5.8 Training and Business Process Improvement

Constant change in health care rules, regulations, and guidelines make continual training imperative. The hazards of not taking the time to train, initially and at regular updates, can prove to be costly. Lack of proper training makes it difficult for employees 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 or full.

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## 5.9 Training Basics

Training Task	Description
<b>Identify Processes</b>	This entails identifying job requirements and creating processes to fulfill those requirements. Define flow, restrictions, challenges, try to eliminate barriers.
<b>Develop Policies and Procedures</b>	Processes to meet job requirements need to be supported with set policies and procedures that serve as guidelines that may be referred to after training.
<b>Create a Training Manual</b>	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 reference. Create step-by-step instructions for each task, store these in a convenient and accessible electronic location for all

staff.

**Train**

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.

**Set Goals and Objectives**

Establish measurable goals in key performance areas. Example: Registration may include registration accuracy.

**Monitor Performance**

Quality assurance is required to determine if there are areas of weakness in the revenue cycle, and if training is adequate. Identification of issues may require the need for additional resources, staff reallocation, or additional training in order to mitigate. A very effective tool in monitoring Revenue Cycle key performance indicators is the Third Party Internal Control Policy Self-Assessment Online Tool.

**Provide Ongoing Training**

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.

## 5.10 **Additional information on Merit-based Incentive Payment System (MIPS) and Quality Payment Program**

For the most recent information around MIPS or Quality Payment Program, please reference the links below:

- <https://qpp.cms.gov/>
- <https://qpp.cms.gov/mips/overview>
- <https://www.ihs.gov/qpp/>

## 6. Compliance

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## 6.1 **About the Affordable Care Act (ACA) Compliance Program**

**Note:** For the purpose of this document, “service unit” and “facility” will be used interchangeably.

ACA 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 analysis of an organization’s compliance efforts and activities.

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

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

### 6.1.1 **Implementing Written Policies, Procedures and Standards of Conduct**

Establishing written policies and procedures is necessary to promote consistency and uniformity in your office or practice. Written policies and procedures should be written clearly and describe expectations of compliance in detail. These written policies, procedures and standards should be composed with guidance from the Compliance Officer and Compliance Committee.

The written standards for conduct or the “code of conduct” should clearly state and outline the office’s or practice’s commitment to compliance, values and quality treatment of customers/patients and employees. Standards of conduct should detail your organization’s commitment to ethical behavior, as well as your vision and values. The standards of conduct should also indicate that compliance is the responsibility of all employees and describe how to report incidents of non-compliant



or unethical behaviors.

IHS facilities must provide training on a local set of policies, procedures, and standard of conduct which includes information regarding general sanctions for violations of compliance regulations. These policies, procedures and standards of conduct should be well known throughout the facility, as well as their location.

### **6.1.2 Designating a Compliance Officer and Committee**

Each Area will designate an **ACA Compliance Officer**, who will have the authority and responsibility to administer and manage all tasks related to establishing, monitoring, and updating the ACA Compliance Program. To ensure success of the program, each Area ACA Compliance Officer (AACO) 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.
- Coordinate with each Service Unit Compliance Officer (SUCO), communicating with each SUCO at each facility.

Each Service Unit will designate a Compliance Officer (as noted above), who will be responsible for overseeing the administration of the compliance program for their Service Unit. The SUCO, in coordination with the AAACO, will be responsible for directing all compliance activities within the Service Unit. The AAACO and SUCO should meet frequently and maintain meeting minutes.

The **ACA Compliance Committee** at the Area Office and Service Units will be responsible for:

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

### **6.1.3 Conducting Effective Training and Education**

Significant elements of the ACA 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. Initial compliance training for new employees should occur at or near the date of hire. Annual refresher compliance training should be provided to all employees highlighting compliance program changes and re-emphasize the organizations standards of conduct. Training records should be maintained for all staff, specifically including training course(s) and training dates.

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

#### **6.1.4 Opening Effective Lines of Communication**

There should be open communication between 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:

- Open door
- 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.

##### **6.1.4.1 Developing an Effective Communication System**

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

- 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

- Defined process that maintains confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation
- 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

### **6.1.5 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 AACO 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 Area Director.

The SUCO will:

- 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 Service Unit CEOs.

For more information on monitoring and auditing activities, see Part 1, Chapter 6, Section 6.26.2, “Evaluating and Monitoring Compliance-Related Risks.”

### **6.1.6 Enforcing Standards through Well-Publicized Disciplinary Guidelines**

Comprehensive policies and procedures must be in place, which define the degrees of disciplinary actions that may be imposed on directors, managers, employees, physicians, and other health care professionals for failing to comply with an Area/Service Unit'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 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 violations that are more serious may need to be resolved by a more senior manager or director. Background checks will also be performed to ensure 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 may receive a copy of the certain disciplinary policies for compliance violations and will be asked to sign a statement of receipt of the policy when necessary. 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.

#### **6.1.6.1 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.

All employees, including new employees, who 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.

#### **6.1.7 Responding Promptly 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 in a timely manner following offenses or incidents.

## **6.2 Evaluating and Monitoring Compliance-Related Risks**

The Area Director (AD) and Service Unit CEOs are tasked with two general types of monitoring and auditing requirements:

- The AD and Service Unit CEOs should be responsible for ensuring that the elements of the compliance program remain effective.
- The AD and Service Unit CEOs 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.

The Compliance Officer should coordinate efforts to secure the resources and experts (internal or external auditors) needed to perform compliance audits and reports results to the Service Unit CEOs and AD.

### **6.2.1 Establishing Quality Performance Measures**

The OIG recommends that before implementing a compliance program that an organization establish compliance performance and knowledge of quality performance measures. Outside consultants or internal staff with authoritative knowledge of compliance, requirements may perform these assessments. The quality

performance measures may become a baseline to ensure that the elements of the compliance program are operating effectively.

Prior to 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

### 6.2.2 Performing Periodic Reviews

Besides the quality performance measure 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 issues associated with:

- Kickback arrangements, the physician self-referral prohibition
- CPT/HCPCS & ICD-10 Coding
- Claim development and submission, and reimbursement :  
[https://www.ihs.gov/ihs/pc/part-5/chapter-1-third party-revenue-accounts-management-and-internal-controls/#5-1.3G](https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/#5-1.3G)
- Cost Reporting
- Plan and treatment decisions are made at the discretion of the beneficiary
  - IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.
- Internal Management Controls IHS rules and regulations
- Physician and facility reimbursement and/or other agreements
- 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 internal and external reviews include:

- On-site visits to include observations of workflow via process walkthrough as well as the review of key reports
- Interviews with personnel involved in management, operations, documentation, coding, claim development and submission, patient care, and other related activities
- Reviews of health 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 to identify strengths and areas where remediation is needed for improvement
- Review patient satisfaction surveys and patient complaint logs for opportunities for growth

### 6.2.3 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 CMS Programs, other third party payers and law enforcement. Service units should refer to the OIG Workplan, OIG Special Fraud Alerts, OIG Audits and Evaluations, and law enforcement initiatives to understand the auditing activities that may occur. Review of compliance could include the following:

- Observation and inpatient services
- Medicare, Medicaid, and Third Party Payers requirements
- Debt management
- Denial management
- Medicare secondary payer billing and coordination of benefits
- Department specific audits performed in phases of the revenue cycle, such as:
  - Front End
    - Scheduling
    - Registration
    - Check In
    - Patient Visit
  - Middle
    - Documentation
    - Charge Capture
    - Coding
  - Back End
    - Billing
    - Collections
    - Denials Management
  - 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:
  - Provider and ancillary 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
- OIG Inspections:
  - Requests made or concerns raised by Congress, HHS management, or the Office of Management and Budget
  - Investigating Fraud, Waste and Abuse
  - Facilitating Compliance in the Health Care Industry

#### **6.2.4 Monitoring Activities**

After auditing activities are completed and issues are resolved, continuous monitoring activities should occur on a regular basis (daily, weekly, monthly etc.) and include focused observations on previously identified and corrected issues to ensure compliance with the established standard. Non-compliance with the established standard should trigger an inquiry to determine the cause. If the non-compliance is the result of flawed policies and procedures, or a misunderstanding of the rules, regulations, or procedures, changes to the procedure should occur to prevent future non-compliance.

For example, any overpayments discovered that are the result of such problems should be returned promptly to the affected payer, with appropriate documentation, Service Unit and Area level awareness, with a thorough explanation of the refund.



## Appendix

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## Practice Management Suite Overview Workflow



Practice Management  
Suite Overview Workf

**Note:** This workflow serves as a high-level guideline only and will vary based on specialty services and/or site requirements. Each site should follow local, approved policies and procedures. Billing and accounts management functions shall be conducted in accordance with federal, state, and third party payer policy (where applicable). For additional detail, please reference each Part of the Revenue Operations Manual (ROM).

### New Site Setup

#### Introduction

The Third Party Billing (ABM) and Accounts Receivable (BAR) new site setup packet is intended to guide you through the various required steps to get the two applications up and running.

Please direct any issues or questions regarding application setup and/or training to the OIT Help Desk (IHS).

Phone: (888)830-7280

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: [support@ihs.gov](mailto:support@ihs.gov)

#### New Site Setup Checklist

After going through this user guide, if you feel that you need assistance from OIT with the setup please fill out the questionnaire below and forward it to your local/area IT for escalation to the 3PB/AR Support team at OIT.

##### COMPANY INFORMATION

Company name:

Address:

Telephone number:

##### CHECKLIST

Has your site ever used the Third Party Billing and Accounts Receivable package before?

No ☐ Yes ☐

If so, when was the last time this was used? \_\_\_\_\_

Is there any information in 3P or AR that they wish to keep or will it be removed?

No ☐ Yes ☐

If so, please list below what will be kept and/or what will need to be removed

\_\_\_\_\_

Is your site currently using the Third Party Billing and Accounts Receivable Package?

Third Party Billing:

No ☐ Yes ☐ If so, What version/patch are you on? Version: \_\_\_\_\_ Patch : \_\_\_\_\_

Accounts Receivable:

No ☐ Yes ☐ If so, What version/patch are you on? Version: \_\_\_\_\_ Patch : \_\_\_\_\_

If not, what is the production date: \_\_\_\_\_

Does your site use another Billing and Accounts Receivable system?

No ☐ Yes ☐ What is the Vendor Name? \_\_\_\_\_

If so, will your site continue to use this other vendor?

No ☐ Yes ☐

If not, what is the cutoff date? \_\_\_\_\_

Does your site have an NPI and Tax Identification number for the Location?

No ☐ Yes ☐ What are the Location NPI and Tax ID Number?

\_\_\_\_\_

If so, has the NPI number been entered in the institution file?

No ☐ Yes ☐

If so, has the Tax ID number been entered into the location file?

No <input type="checkbox"/> Yes <input type="checkbox"/>
Does your site have more than one location/satellite?
No <input type="checkbox"/> Yes <input type="checkbox"/> How many locations/satellites are there? _____
Are these locations Federal or Tribal?
Federal <input type="checkbox"/> Tribal <input type="checkbox"/>
If Tribal, will the site be using the cashiering functions in Third Party Billing and Account Receivable?
No <input type="checkbox"/> Yes <input type="checkbox"/>
Has the site attended any Third Party Billing and Accounts Receivable training?
No <input type="checkbox"/> Yes <input type="checkbox"/>
If not, approximately when will the site want training?
Date: _____ Time Zone: _____

Additional information needed to complete this request:

1. Name of parent location:
2. Please list all satellite locations including home, school, PHN, other locations:
3. Please list all NPI's associated with these locations and identify their billing type (for example, if a main location NPI is obtained, list it along with facility name. If a specialty, such as pharmacy, contains its own NPI, list it here). List the effective date of any new NPIs

4. Will a new Tax Identifier be obtained? If yes, please indicate the effective date along with the new TIN.
5. Will a new payment address be used? If so, please indicate the new address along with the effective date.

## Third Party Billing Application Set Up

### THIRD PARTY BILLING APPLICATION SET UP

#### SUMMARY OF REQUIRED STEPS

The required steps for setting up the Third Party Billing application are listed below, in the order that they should be worked. Each of these steps will be detailed in this guide.

1. Initialize New Facility (ABM – TMTP – SSTM)
2. Set up 3PB Site Parameters (ABM – TMTP – SITM)
3. Add the facility to the Location File (ABM – TMTP – LOTM – EDLO)
4. Enter the facility NPI and taxonomy number in the Location file ( this step must be done in programmer mode)
5. Add / edit insurers in the Insurer File (ABM – TMTP – INTM – EDIN)
6. Adding/maintaining fee schedules (ABM – TMTP – FETM)
7. Cashiering Options
8. Tasking the Claim Generator

Note: if data exists for any of the fields that are discussed in this document, the system will display the information between the prompt and two slashes (/). Press <ENTER> to accept the information displayed, or you may type the correct information and then press <ENTER>.

#### STEP 1: INITIALIZE NEW FACILITY

Locations that are new to the Third Party Billing package will need to initialize the location. This menu option will only initialize the location that the user is logged into.

To initialize the location:

- Access the **THIRD PARTY BILLING** application.
- Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
- Choose **INITALIZE NEW FACILITY (SSTM)** from the Table Maintenance menu.

1. The system will display the message in the screen shot below. “This option will initialize a new location for... “
2. **Initialize Site “Your Facility? NO//** type Yes and press <ENTER>.

The system will display the following message: “Site Initialized”. Press <ENTER> to go back to the Table Maintenance menu.

```

+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|   THIRD PARTY BILLING SYSTEM - VER 2.6p11   |
+       Initialize New Facility       +
|       INDIAN HEALTH HOSPITAL       |
+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                26-JUN-2013 2:14 PM

This option will initialize a new location for the Third Party
Billing Package. You are logged in as INDIAN HEALTH HOSPITAL

Initialize Site INDIAN HOSP? NO// YES

Site initialized.

Enter RETURN to continue:

```

## STEP 2: SET UP 3PB SITE PARAMETERS

The Site Parameter Maintenance option enables you to define and/or update certain criteria that is specific to your facility. This option must be completed prior to creating or editing claims. Also, if satellite locations are created for billing purposes the site parameters must be completed for each of those satellite locations.

To add the Site Parameter Maintenance menu:

- Access the **THIRD PARTY BILLING** System.
- Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
- Choose **SITE PARAMETER MAINTENANCE (SITM)** from the Table Maintenance menu.

1. **EMC File Preference:** type Host File and press <ENTER>. This field specifies how files will be created in Third Party Billing. The preferred method is Host File because this method will create a file on your RPMS server.

2. **Default EMC Path:** type the name of the directory path where your Third Party Billing export files will be sent and press <ENTER>.

Note: If your server is running AIX the path would be similar to this: /usr/spool/uucppublic/. If your server is running Windows, the path would be similar to c:\abmexports\. Your local IT can help determine the directory path. It's important that any billing staff who will be creating 837 claim files have the appropriate permissions to this folder on your server (read *and* write permissions).

3. **Facility to Receive Payments:** type the Location name that will receive payment and press <ENTER>. This information is pulled from the Location file.
4. **Printable Name of Payment Site:** type the Location name and press <ENTER>. This is the facility name that will print in box 1 of the UB-04 and in block 33 of the CMS-1500.
5. **Current Default Fee Schedule:** enter the name/number of the site's current fee schedule, which is used in itemized billing for those insurers who do not require using their own fee schedule. To display a list of available fee schedules as defined in the Fee Schedule Maintenance Table, type a question mark (?) at this prompt.
6. **Create Bill For All Patients:** this field determines whether or not the system will create a claim/bill for every visit, regardless of whether the patient has third party eligibility or is an Indian beneficiary. Enter one of the following:
  - ALL – Creates a claim for all services for all patients regardless of eligibility or beneficiary status.
  - NO – Creates claims for those patients that have third party eligibility or hold a non-Indian beneficiary status.
  - IP – Creates claims for those patients that have third party eligibility or hold a non-Indian beneficiary status for outpatient services. Inpatient claims will generate for all patients regardless of eligibility or beneficiary status.

Generating a claim/bill for every visit (regardless of insurance coverage) can help with reporting on the cost of every patient encounter. Remember if you choose to have a bill generate for every visit regardless of insurance coverage someone will need to adjust those uncollectable balances off in Accounts Receivable.

7. **Always Display Beneficiary Patient:** this prompt determines whether or not to display Beneficiary Patient as an available resource in the claim editor. This field is especially helpful for Urban Programs who bill their beneficiary patients for copays and deductibles but do not have Beneficiary Patient entered as a resource in Patient Registration.

- 
8. **Require that Queuing be Forced:** this field will determine whether all print jobs are queued and sent to a system printer automatically. Setting this field to Yes will save time for the user because he/she will not need to wait for the report to print before continuing to work in RPMS.
  9. **Display Long ICD/CPT Description:** this field determines whether the system displays the extended description of the ICD or CPT narrative in the claim editor. Typing **No** will display the abbreviated version of the ICD/CPT description, which will allow more ICD/CPT codes to be displayed in the claim editor.
  10. **Backbilling Limit (Months):** this is the number of months you want the claim generator to go back and create claims in Third Party Billing based on the bill date of service. The general recommendation is that this field is set to the longest initial filing limit amongst all your insurers. Entries in the Insurer File that do not have a number specified in this field will default to the entry that is set here in Site Parameters.
  11. **Block 31 (HCFA 1500) print:** this is the name that you want to print signature box at the bottom of the CMS-1500 form. It is recommended that this field be set to ATTENDING/OPERATING PROVIDERS, but you may choose any name that exists in the New Person file. Finally, although this field references the HCFA-1500, the designation made here will also affect your CMS-1500 claims.
  12. **UB-92 SIGNATURE:** this field is no longer active. You may leave it blank.
  13. **Place of Service Code:** this field will determine which place of service code will be automatically populated in the Place of Service box on the CMS-1500 form. This will default for all claims. There are some exceptions to this:
    - Users can override this entry in the Claim Editor by editing individual charges and modifying the Place of Service code.
    - Visit Type = 111, POS will be 21
    - Visit Type = 831, POS will be 24
    - Clinic = 30 (ER), POS will be 23
  14. **Bill Number Suffix (fac-code):** this field allows you to enter a suffix that will be appended to your bill numbers. The suffix can be from one to four characters long and is meant to enable users to quickly identify where the patient was seen. For example, Indian Health Hospital might have a bill number suffix of IHH. In that case, bill numbers would look similar to this: 12345A-IHH.
  15. **Append HRN to Bill Number:** this field determines whether the patient's Health Record Number is appended to the bill number. Enter **Yes** or **No**.
-



- 
16. **Allow for CPT Modifiers Prompt:** this field determines whether a modifier can be designated for a CPT procedure. If you answer **Yes**, the system will prompt for a modifier when a user adds or edits a CPT procedure in the claim editor. If **No** is selected, the modifier prompt will not be displayed in the claim editor.
17. **Set Prof. Comp. Automatically:** this field determines whether the minimal level of service will be set automatically on the medical page (8A), when the attending provider is a physician. If the user types **Yes**, then a default CPT code of 99211 will appear in the claim editor on page \*A.
18. **Days Inactive before Purging:** this is the number of days a claim will be allowed to remain inactive within Third Party Billing before being automatically purged (or deleted) by the Claim Generator. Type a number between 1 and 730. It is recommended this field be set to a high number.
19. **Default Version of HCFA-1500:** this is the name of the form that will be used by default if an export mode has not been specified for an insurer in the insurer file. Entries made in the Insurer file will override what is entered here. The current valid form for medical billing is the CMS-1500.
20. **Default Form for Dental Billing:** this is the name of the form that will be used by default for dental billing if an export mode has not been specified in the insurer file. Entries made in the insurer file will override what is entered here. The current valid form version for dental billing is the ADA-2012 (released in abm v2.6 patch 11).
21. **VA Station Number:** this is where you will enter the station number to bill claims to the Veterans Administration. The VA Station Number is a three-digit number that identifies the VA Medical Center associated with the Indian Health or Tribal Health facility where the patient was seen. If this field is populated and the insurer type is Veterans Administration, the VA STATION NUMBER will be populated in box 23 of the CMS-1500 or in box 63 of the UB-04.
22. **VA CONTRACT NUMBER:** this is where you will enter your contract number for VA billing. The Contract Number is assigned by the VA to your facility once the Implementation Agreement has been signed. This number is used by the VA to identify your facility. If this field is populated and the insurer type is Veterans Administration, the CONTRACT NUMBER will be populated in box 19 of the CMS-1500 or in box 80 on the UB-04.
23. **Select DEFAULT UNBILLABLE CLINICS:** this field allows you to enter the name(s) of any clinics that are always considered unbillable, regardless of insurer or coverage. If there are none, press the <ENTER> key at the prompt. If there are any clinics you'd like to designate as unbillable, add the clinic names one at a time at this prompt. The system will continue to prompt for clinic names until the <ENTER> key is pressed at the "Select Default Unbillable Clinics" prompt. To display a list of
-

- clinics that have been entered here as unbillable, type a question mark (?) at the prompt.
24. **Select DFLT INVALID PRV DISCIPLINES:** this field allows you to enter the name(s) of any provider disciplines that are always considered unbillable, regardless of insurer or coverage. If there are none, press the <ENTER> key at the prompt. If there are any provider disciplines that you'd like to designate as unbillable, add them one at a time at this prompt. The system will continue to prompt for provider disciplines until the <ENTER> key is pressed at the "Select DFLT INVALID PRV DISCIPLINES" prompt. To display a list of provider disciplines that have been entered here as unbillable, type a question mark (?) at the prompt.
25. **Select DISPLAY UNBILLABLE INSURER(S):** this field allows you to enter the name of an insurer to display in the claim editor if status of the insurer has been set to unbillable. This allows the billing technician to see the insurer even though it was marked as unbillable. To display a list of insurers that have been entered at this prompt, type a question mark (?) at the prompt.
26. **UB-92 Form Locator 38:** this field allows you to specify the information that will be populated in box 38 on the UB-92 form:
- Policy Holder: policy holder's name and address will be populated
  - Insurer Address: insurance name and billing address will be populated
  - Blank: box 38 will be left blank. (This is the default response if this field is not populated in site parameters.)
27. **IN-HOUSE DEFAULT CLIA#:** this field allows the default CLIA number to be stored for all CLIA-certified facilities performing CLIA-covered laboratory services. These are normally for lab services performed by the billing or rendering provider of the CLIA number. This field requires a 10-character response. The response must be in an "NNLNNNNNNN" format where "N" is a numeric character and "L" is an alpha character. If this field is populated in site parameters, the CLIA number will automatically be populated in the claim editor when laboratory charges are present on a claim.
28. **REFERENCE LAB DEFAULT CLIA#:** this field allows the default Reference Lab CLIA number to be stored for any laboratory that has referred tests to another laboratory covered by the CLIA Act. A facility may have more than one Reference Lab location to which they send tests but this option allows storage of the most common Reference Lab. If this field is populated in site parameters, the Reference Lab CLIA will be automatically populated in the claim editor when laboratory charges are present on a claim. Please refer to the 3PB User Manual (Edit Claim Data, beginning on page 15) for information on editing the Reference Lab CLIA number in the claim editor.

NOTE: Reference Labs that are not available for selection at this prompt will need to be set up.

- i. Check to see if the Reference Lab has already been set up in the VENDOR file. The VENDOR file is accessible via FileMan.
- ii. Once the VENDOR file has been populated, enter the name of the Reference Lab in the Add/Edit Reference Lab Locations option of 3PB Table Maintenance (RLTM).
- iii. Go back to 3PB Site Parameters (SITM) and enter the name of the Reference Lab in the REFERENCE LAB DEFAULT CLIA# field.

**29. ORPHAN VISIT LAG TIME:** this field determines the number of days that an incomplete visit will be allowed to sit in PCC (or the PCC Coding Queue) before it is pulled into 3PB and a claim is created by the claim generator. An incomplete visit is a visit that is missing one or more of the following: provider, clinic, purpose of visit (diagnosis). The default setting for this prompt is seven days, so it is important to know where PCC is with coding visits. If PCC is 10 days behind (based on the visit date of service), for example, this field should be set to 10. If PCC is 30 days behind, this field should be set to 30. If this field is set too low, users will begin to see duplicate claims in 3PB. You may enter a number from 3 to 180.

**30. UNCODED DX LAG TIME (DAYS):** the number entered in this field (0-180) represents the number of days that the claim generator will wait before creating a claim that contains an un-coded diagnosis code. Un-coded diagnoses codes are visits containing an ICD-9 code of .9999 or an ICD-10 code of ZZZ.999.

**31. USE A/R PARENT SATELLITE SET-UP?:** this option allows for services performed at a location outside of the primary facility such as home, school, etc. to generate claims for billing. Please seek guidance from the OIT Helpdesk prior to setting this field with a value.

Setting this option to YES allows for claims to generate under the primary facility for all locations. There is additional set up for this. You must:

- Ensure the Parent location has been set up in the BAR package (please refer to the Accounts Receivable Application Set Up portion of this user guide). Since this option is usually set up for the parent (or primary) facility, it is assumed that the claims will generate for all satellite locations under the parent (primary facility).
- All 3P Table Maintenance options must be set up for each satellite location that claims are generated for. This requires the user to have access to those locations.

Typing NO at this option will allow the claims to generate under their own location.

32. **USE NPI OF:** this field allows you to use the NPI number of a location other than the one you are setting up site parameters for. For example, a satellite location that wants to bill using the NPI number of their parent location would populate the name of their parent location in this field. An entry in this field will override the NPI number in the Location file for the billing facility (or satellite facility).
33. **MEDICARE PART B?:** this prompt determines if the site bills only Part B claims to Medicare and will generate claims accordingly. Use the following as guidance when populating this option:
- **YES:** this allows the system to generate an Outpatient claim. These claims are generated with a Visit Type of 131 and are usually set up in the Insurer File as All-Inclusive (flat rate). These are used mainly for FQHC sites that don't have the Part B authority since the all-inclusive rate includes Part B.
  - **NO:** this allows the system to generate an Outpatient claim and a Professional Component claim. There are two claims that generate: Visit Type 131-Outpatient and Visit Type 999-Professional Component. The 131-Outpatient Facilities that are hospital-based will generally set their prompts up for this.
  - **ONLY:** this allows the system to generate a professional claim. These claims are generated with a Visit Type of 999-Professional Component. These claims are generated with the intention of billing a fee-for-service (itemized) claim for Medicare services. This is used primarily for freestanding health centers.
    - NOTE: before a freestanding clinic can bill Medicare Part B, Medicare must be made billable and all required fields of the insurer file must be populated (please refer to Step 5 of this document for instructions on adding/editing the insurer file).
34. **MAMMOGRAPHY CERTIFICATION:** this field allows for your facility mammography certification number to automatically populate on claims when the CLINIC is mammography. The mammography number can be viewed on page 1 of the claim editor by selecting the View command. It will also be printed on the CMS-1500 or populated in the 837P v5010. Enter your facility's mammography number, if applicable.
35. **ISA08 VALUE:** this field pertains to 837 claim files and contains the facility's sender ID number. It is recommended that you leave this field blank for now. Most facilities will use the AO Control # field in the Insurer File to populate their sender ID. Your clearinghouse and/or payer will let you know if the ISA08 Value needs to be populated in your 837 files.
36. **DEFAULT DENTAL CODE PREFIX :** this field allows for adding the same prefix to all of your dental codes for all insurers. If all insurers require the same dental prefix type an O, S or D as appropriate. If you populate the dental code prefix here, the prefix will not be displayed in the claim editor but the prefix will print on

your claim forms or will be present in your 837D electronic claims, depending on the export mode.

NOTE: if a dental code prefix is required only for specific insurers, use the Dental Remap Option in 3PB Table Maintenance to make that designation (TMTP – DMTM).

37. **STATEMENT HEADER PRINT:** this field allows you to modify the header for the patient statement. Currently the statement header prints INDIAN HEALTH SERVICE, but may be modified by typing up to 80-characters in this free text field.
38. **PRINT STATEMENT DATE:** this field allows for the printing of the date the claim was submitted/exported to the payer in the message field of the patient statement. Selecting No or leaving the field blank will not print the date the claim was exported/submitted to the payer in the message field of the patient statement. Enter **YES** or **NO** at the prompt.
39. **USE POA INDICATOR:** this field (Present On Admission) was created due to a CMS requirement for all inpatient acute care facilities to submit a POA on their claims. It is valid only for the Location in which this parameter has been set. This means that any hospitals set up as satellite locations will need to answer this prompt depending on their POA status. If the A/R Parent/Satellite option is set to YES, and the hospital satellite locations are generating under the parent location, the parent location must check the satellite parameter file to confirm that the POA is required. The site needs to determine if the POA requirement applies to their site. If it doesn't apply, this field should be set to NO.
40. **RX DISPENSE FEES:** these fields will allow the site to enter the dispensing fees used to bill prescriptions in the claim editor. These fields apply only for prescriptions billed from within the Third Party Billing application and do not affect Pharmacy Point of Sale (POS) claims. Enter the default prescription dispensing fee at each prompt. Type the price in whole dollar amounts (e.g., 5 equals \$5.00). The system will calculate the cost of the drug and will then add the fee(s) populated here to the cost that is displayed in the claim editor.
41. **Select CLAIM PAGE(s) TO BE SKIPPED:** this field allows you to select certain claim pages from being displayed in the claim editor (any pages entered at this prompt will be skipped in the claim editor). For example, if your facility never performs surgeries, type 1 at the prompt to force the system to skip the Surgery page. If there are no pages that you want to skip, press the <ENTER> key at the prompt. The system will continue to prompt for claim pages, until the Enter key is pressed at the "Select Claim Page(s) to Be Skipped" prompt. To display a list of the claim pages, type a question mark (?) at the prompt.
42. **PAGE 9 REMARKS:** this field allows you to edit the default remark text that prints in the Remarks box of the UB-92 form. The default text is "Send Payment to

Provider (see Block 1)". Type Y(Yes) at the Edit prompt to edit this text. This text can also be edited on a specific claims by using PAGE 9F of the claim editor, if needed.

43. **Select INSURERS W/O 837 PRV SEGMENT:** this field allows you to enter the name of an insurer that does not require the PRV segment when submitting an 837 export mode. The PRV Segment usually contains the location and/or provider taxonomy data. It is recommended that you leave this field blank for now.

```

+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p11  |
+      Site Parameter Maintenance      +
|      INDIAN HEALTH HOSPITAL      |
+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                      26-JUN-2013 2:26 PM

EMC File Preference.....: HOST FILE//
DEFAULT EMC PATH.....: c:\abmexports\
Facility to Receive Payments....: INDIAN HEALTH HOSPITAL //
Printable Name of Payment Site.: INDIAN HEALTH HOSPITAL Replace
Current Default Fee Schedule....: 1//
Create Bills for all Patients...: IP//
Always Display Beneficiary Patient: YES//
Require that Queing be Forced...: YES//
Display Long ICD/CPT Description: NO//
Backbilling Limit (months).....: 48//
Block 31 (HCFA 1500) print.....: ATTENDING/OPERATING PROVIDERS //
UB-92 SIGNATURE.....:
Place of Service Code.....: 22//
Bill Number Suffix (fac-code)....: IHH//
Append HRN to Bill Number.....: YES//
Allow for CPT Modifiers Prompt..: YES//
Set Prof. Comp. Automatically....: NO//
Days Inactive before Purging....: 730//
Default Version of HCFA-1500.....: 08/05 Version dated 01/07 //
Default Form for Dental Billing.: ADA-2006//
VA STATION NUMBER: 638//
VA CONTRACT NUMBER: VA-638-IHS-0001//
Select DEFAULT UNBILLABLE CLINICS:
Select DFLT INVALID PRV DISCIPLINES:
Select DISPLAY UNBILLABLE INSURER(S):
UB-92 Form Locater 38: INSURER ADDRESS//
IN-HOUSE DEFAULT CLIA#: 12A3456789//
REFERENCE LAB DEFAULT CLIA#: THE REFERENCE LAB INC. //
ORPHAN VISIT LAG TIME (DAYS)....: 180//
UNCODED DX LAG TIME (DAYS): 180//

```

USE A/R PARENT SATELLITE SET-UP?: NO//  
USE NPI OF:  
MEDICARE PART B?.....: ONLY//  
MAMMOGRAPHY CERTIFICATION: 10101010//  
ISA08 VALUE:  
DEFAULT DENTAL CODE PREFIX.....: D//  
STATEMENT HEADER PRINT:  
PRINT STATEMENT DATE: YES//  
USE POA INDICATOR?: YES//

#### **RX DISPENSE FEES**

=====

OP Prescription Dispense Fee.....: 5//  
IV Admixture Dispense Fee.....: 10//  
IV Piggyback Dispense Fee.....: 10//  
IV Hyperal Dispense Fee.....: 10//  
IV Syringe Dispense Fee.....: 8//  
IV Chemotherapy Dispense Fee.....: 10//  
Inpatient RX Dispense Fee.....: 9//

Select CLAIM PAGE(s) TO BE SKIPPED:  
PAGE 9 REMARKS:  
Send Payment to Provider (see Block 1)

Edit? NO//  
Select INSURERS W/O 837 PRV SEGMENT:

Example of the fields in the SITM option. The data displayed in this screen shot is only an example.

### **STEP 3: ADD THE FACILITY TO THE LOCATION FILE**

Each new location will need to be added to the Location file. You will need the location's mailing address and physical address for this step. If your site is billing for home or school services you may use the physical address of the parent billing location. It's important to note that the demographic data that is entered in this menu option will affect what is printed on your claims.

To add the location information:

- Access the **THIRD PARTY BILLING** System.
- Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
- Choose **LOCATION FILE MENU (LOTM)** from the Table Maintenance menu.
- Choose **LOCATION FILE MAINTENANCE (EDLO)** from the Location File Menu.

1. **Select LOCATION to Edit:** type the Location name and press <ENTER>.
2. **Mailing Address-Street:** type the mailing address and press <ENTER>. This should be the address where you want to receive correspondence and also where the payment will be sent to. If you are at a Federal location, this should be the address for your lockbox. The complete mailing address will print in box 33 of the CMS-1500 and box 1 of the UB-04.
3. **Mailing Address-City:** type the city name and press the <ENTER>.
4. **Mailing Address-State:** type the state name and press the <ENTER>.
5. **Mailing Address Zip:** type the 9 digit zip code and press <ENTER>.  
  
**Note:** If the last four digits of the zip code are unknown, you will need to contact your local post office. A valid, nine-digit zip code is required for electronic billing (837 claim files).
6. **Phone:** type the phone number of the location and press <ENTER>. There is no required format for this but it is important that you enter an area code.
7. **Federal Tax No.:** type your facility's Federal Tax ID for the location and press <ENTER>.  
**Note:** If you enter the Federal Tax ID with a dash, the dash will be automatically removed on all 837 files.
8. **Medicare No.:** enter the six-digit Medicare facility number assigned to your facility and press <ENTER>.
9. **Street Address 1:** enter the physical address and press <ENTER>. This is the location where the services were rendered.
10. **Street Address 2:** use this field if you need a second line for entering the facility's physical address. If this line is not needed press <ENTER>.
11. **City:** enter the city name and press <ENTER>.
12. **State:** enter the state name and press <ENTER>.
13. **ZIP:** enter the zip code and press <ENTER>.



14. **Place of Service Code:** enter the two digit place of service code. This is the service code that will default on your claims.
15. **Bill Number Suffix:** the suffix that is entered here should be the same suffix that was entered in the SITM option. This suffix will be appended to your bill numbers. This enables you to quickly identify where the patient was seen. For example, Indian Health Hospital might have a bill number suffix of IHH (12345A-IHH).
16. **Medicare B Only:** enter YES, NO or ONLY and press <ENTER>.
- **YES** - Allows the system to generate an Outpatient claim. These claims are generated with a Visit Type of 131 and are usually set up in the Insurer File as All-Inclusive. These are used mainly for FQHC sites that don't have the Part B authority since the all-inclusive rate includes Part B.
  - **NO** - Allows the system to generate an Outpatient claim AND a Professional Component claim. There are two claims that generate--Visit Type 131-Outpatient and Visit Type 999-Professional Component. The 131-Outpatient Facilities that are Hospital-Based will generally set their prompts up for this.
  - **ONLY** - Allows the system to generate a professional claim. These claims are generated with a Visit Type of 999-Professional Component. These claims are generated with the intention of billing a fee-for-service (itemized) claim for Medicare services. This is used primarily by freestanding clinics.
    - NOTE: before a freestanding clinic can bill Medicare Part B, Medicare must be made billable and all required fields of the insurer file must be populated (please refer to Step 5 of this document for instructions on adding/editing the insurer file).

```

+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p11  |
+      Location File Maintenance      +
|      INDIAN HEALTH HOSPITAL      |
+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                      26-JUN-2013 2:26 PM

```

Select LOCATION to Edit: INDIAN HEALTH HOSPITAL

```

MAILING ADDRESS-STREET: P.O. BOX 5900//
MAILING ADDRESS-CITY: ALBUQUERQUE//
MAILING ADDRESS-STATE: NEW MEXICO//
MAILING ADDRESS-ZIP: 87110-5900//
PHONE: (505)555-5555//
FEDERAL TAX NO.: 85-0858585//

```

**MEDICARE NO.: 320099//**

**STREET ADDR. 1: 5987 4TH ST NE//**

**STREET ADDR. 2:**

**CITY: ALBUQUERQUE//**

**STATE: NEW MEXICO//**

**ZIP: 87120-1234//**

**PLACE OF SERVICE CODE: 22//**

**BILL NUMBER SUFFIX: IHH//**

**MEDICARE B:**

**Example of the fields in the EDLO option. The data displayed in this screen shot is only an example.**

#### **STEP 4: ENTER THE FACILITY NPI AND TAXONOMY NUMBER IN THE LOCATION FILE ADD THE FACILITY TO THE LOCATION FILE**

Entering the facility NPI and taxonomy number must be done in by someone at your facility who has programmer mode. Entering the NPI and entering the taxonomy number will be broken down into two steps within this section.

Note: Some of the information in the Location file might already be populated. If information is already populated and is correct, simply press <ENTER> at the prompt. If any of the information needs to be corrected, type the correct information and press <ENTER>.

#### **ENTERING THE FACILITY NPI**

1. From programmer mode type D ^XUP  
Note: There is a space between the D and the ^.
2. **Select Option Name:** type IHS XUS and press <ENTER>. This should pull up the IHS XUS EDIT ORGANIZATION NPI file
3. **Select INSTITUTION NAME:** type the location name and press <ENTER>.
4. **NAME:** "Your Facility Name" Replace: press <ENTER>.
5. **Select ASSOCIATIONS:** type Parent Facility and press <ENTER>.
6. **ASSOCIATIONS: PARENT FACILITY//:** press <ENTER>.
7. **PARENT OF ASSOCIATION:** "Your Facility Name"//: press <ENTER>.
8. **Select EFFECTIVE DATE/TIME:** type the location effective date (unless it is already populated) and press <ENTER>.
9. **EFFECTIVE DATE/TIME:** "Your effective Date"//: press <ENTER>.

10. **STATUS:** type ACTIVE if field is blank and press <ENTER>.

11. **NPI:** type the 10 digit NPI number for the location and press <ENTER>.

**Note:** the NPI number that you enter here cannot be used by another location.

**UFT>D ^XUP**

**Setting up programmer environment**

**This is a TEST account.**

**Terminal Type set to: C-VT100**

**You have 93 new messages.**

**Select OPTION NAME: IHS XUS EDIT ORGANIZATION NPI Edit Organization NPI**

**Select INSTITUTION NAME: INDIAN HEALTH HOSPITAL**

**NAME: INDIAN HEALTH HOSPITAL Replace**

**Select ASSOCIATIONS: PARENT FACILITY//**

**ASSOCIATIONS: PARENT FACILITY//**

**PARENT OF ASSOCIATION: INDIAN HEALTH HOSPITAL//**

**Select EFFECTIVE DATE/TIME: JAN 1,2006//**

**EFFECTIVE DATE/TIME: JAN 1,2006//**

**STATUS: ACTIVE// (No Editing)**

**NPI: 7745613100//**

**Example of the fields in the IHS XUS Edit Organization NPI file. The data displayed is this screen shot is only an example.**

## **ENTERING THE TAXONOMY**

The taxonomy code that is entered in the location file will print on all bills in Third Party Billing. If you have more than one billing location you will need to populate the taxonomy for each location.

1. From programmer mode type D P^DI  
Note: There is a space between the D and the P.
2. **Select OPTION:** type Enter and press <ENTER>.
3. **INPUT TO WHAT FILE:** type Location and press <ENTER>. If you are given more than one file to choose from, select LOCATION and press <ENTER>.
4. **EDIT WHICH FIELD:** type Class and press<ENTER>.
5. **EDIT WHICH CLASS SUB-FIELD:** ALL//: type Class and press <ENTER>.
6. **THEN EDIT CLASS SUB-FIELD:** press <ENTER>.

7. **THEN EDIT FIELD:** press <ENTER>.
8. **Select LOCATION NAME:** Type the location name and press <ENTER>.
9. **Select BEGIN DATE:** "Your effective date"//: press <ENTER>.
10. **CLASS:** type the taxonomy number for the location and Press <ENTER>. You may also type two question marks (??) to display a list.

### VA FileMan 22.0

#### Select OPTION: ENTER OR EDIT FILE ENTRIES

#### INPUT TO WHAT FILE: NEW PERSON// LOCATION

- 1 LOCATION (4282 entries)
- 2 LOCATION CODE (0 entries)
- 3 LOCATION OF PAIN/PNEUMONIAS (23 entries)
- 4 LOCATION TYPE (13 entries)

#### CHOOSE 1-4: 1 LOCATION (4282 entries)

#### EDIT WHICH FIELD: ALL// class (multiple)

#### EDIT WHICH CLASS SUB-FIELD: ALL// class

#### THEN EDIT CLASS SUB-FIELD:

#### THEN EDIT FIELD:

#### Select LOCATION NAME: INDIAN HEALTH HOSPITAL

...OK? Yes// Y (Yes)

#### Select BEGIN DATE: JAN 1,1960//

#### CLASS: GENERAL ACUTE CARE HOSPITAL// ??

Select the Class from the Provider Taxonomy list produced by the X12 committee. You will only be shown those entries that are for "Non-Individuals".

Choose from:

ADOLESCENT AND CHILDREN MENTAL	NEW	261QM0855X
ADULT CARE HOME	NEW	311ZA0620X
ADULT DAY CARE	ACTIVE	261QA0600X
ADULT MENTAL HEALTH	NEW	261QM0850X
AIR	ACTIVE	3416A0800X
ALZHEIMER CENTER /DEMENTIA CEN	ACTIVE	311500000X
AMBULANCE	ACTIVE	341600000X
AMBULATORY FAMILY PLANNING FAC	ACTIVE	261QA0005X
AMBULATORY FERTILITY FACILITY	ACTIVE	261QA0006X
AMBULATORY SURGICAL	ACTIVE	261QA1903X

**AMPUTEE NEW 261QA0900X**  
**ASSISTED LIVING FACILITY NEW 310400000X**  
**ASSISTED LIVING, BEHAVIORAL DI NEW 3104A0630X**  
**ASSISTED LIVING, MENTAL ILLNES NEW 3104A0625X**  
**AUGMENTATIVE COMMUNICATION NEW 261QA3000X**  
**BIRTHING ACTIVE 261QB0400X**  
**BLOOD BANK ACTIVE 331L00000X**  
**BUS ACTIVE 347B00000X**  
**CASE MANAGEMENT ACTIVE 251B00000X**

**CLASS: GENERAL ACUTE CARE HOSPITAL//**

#### **STEP 5: ADD/EDIT INSURERS IN THE INSURER FILE**

When the billing system is installed, approximately 800 insurers, complete with demographic information, are added to the Insurer file. These insurers include the majority of the largest insurance carriers in the nation. However, they do not include all of the nation's insurance carriers, so adding insurers locally will still be necessary.

Use the Add/Edit Insurer option to add or edit insurers in the Insurer file. Whether the user is adding a new insurer or editing an existing one, the prompts are the same.

Before adding a new insurer, search through the existing insurers first to prevent the creation of duplicate records. To add a new insurer:

- Access the **THIRD PARTY BILLING** System.
  - Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
  - Choose **INSURER FILE MENU (INTM)** from the Table Maintenance menu.
  - Choose **ADD/EDIT INSURER** from the Insurer File Menu
1. Select option 1 **EDIT EXISTING INSURER** then press the Enter key.
  2. Screen-out Insurers with status of Unselectable? This prompt allows the user to screen out insurers flagged as unselectable. A deactivated insurer cannot be edited if the default (Yes) is accepted. Select **YES** or **NO** then press the Enter key.
  3. Enter the **NAME** of the **INSURER** is where the user will enter in the name of the insurance company.

**WARNING:** Before **ADDING** a new **INSURER** you should ensure that it does not already exist!

Select one of the following:

- 1 EDIT EXISTING INSURER
- 2 ADD NEW INSURER

Select DESIRED ACTION: 1// 1 EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y//

Enter the NAME of the INSURER:

The following prompts allow you to modify the insurer information and are displayed by category

### **Insurer Demographics**

#### **Mailing Address**

1. Street: Add or edit the street mailing address and press the Enter key. If a Billing Address Is entered, that address will be used to print on the claim form. This address is used if the Billing Address prompts are blank. This address is also used when looking up insurance companies.
2. City: Add or edit the city mailing address and press the Enter key.
3. State: Add or edit the state mailing address and press the Enter key.
4. Zip Code: Add or edit the zip code mailing address and press the Enter key.

#### **Billing Address**

The Billing Address can be entered when the insurer has a separate billing address for the submission of bills. This address is also used to populate the N3 and N4 segments for the 2010BB and 2330B loops of the 837 5010 electronic claim formats.

1. Billing Office: Add or edit the Billing address and press the Enter key. This address is printed on the claim forms. If a separate billing address is not required to be entered, press the Enter key at this prompt to continue.
2. Phone Number: Add or edit the billing office phone number and press the Enter key. The required format is (555)555-5555.
3. Contact Person: Add or edit the billing office contact person for your site and press the Enter key. This is an optional field and does not print on any claim forms.
4. Federal Tax ID#: Type the Tax Identification Number used by this payer. This is required for IHS Federal Locations only and is used by the federal financial system to identify the payer billed.

5. AO Control Number: Add or edit the insurer's AO Control Number and press the Enter key.

The AO control number is used to eliminate duplicate insurers. This value should match the number assigned to the insurer by the National Association of Insurance Commissioners (NAIC). When sending bills electronically, the AO control number identifies the insurer. This number can also be used to select the insurer. For electronic billing purposes, this field populates the ISA08 element of the HIPAA 837 Version 5010.

<----- MAILING ADDRESS ----->

Street...: PO BOX 6700//

City.....: FARGO//

State....: NORTH DAKOTA//

Zip Code.: 58108-6700//

<----- BILLING ADDRESS ----->

(if Different than Mailing Address)

Billing Office.:

Phone Number.....: (877)908-8431//

Contact Person.....:

Federal Tax ID#.....: 789456123//

AO Control Number..: 4411//

### Add Edit Insurer Billing Status

The following prompts are related to the insurer's status.

1. Insurer Status: Type BILLABLE, UNBILLABLE, or UNSELECTABLE and press Enter. If the insurer status is:
  - Unbillable, no claims for the insurer can be created or approved.
  - Unselectable, the Patient Registration system cannot use this insurer when adding new eligibility but claims will continue to generate.
2. Type of Insurer: Type the category, for example, MEDICARE, PRIVATE INSURANCE, MEDICARE, or other and press the Enter key.

This category can be used as a restrictive parameter when printing bills or reports. Care should be taken when changing the value of this field as it may impact reports, or processes in the claim generator.
3. All Inclusive Mode: Type Y (Yes) or N (No) and press the Enter key. If Y (Yes), this field designates that the insurer is to be billed at an All-Inclusive (flat) rate, and the Flat Rate fields can be edited for a Visit Type and select a Prior Approval Required ICD9 code.

4. Backbill Limit (months): Type the number of previous months that billing is allowed to occur for this insurer. Claims prior to this value will not generate.
5. Dental Bill Status: Type U (Dental visits are unbillable) if the Dental visit is not billable or type  
Type O (Only Dental visits are billable) and press the Enter key.
6. RX Billing Status: Type U to make Prescription claims unbillable. Type O to allow outpatient medications to display in the claim editor. Type P to indicate that claims submitted to this payer are submitted via the Pharmacy Point of Sale system. If set to P, medication data will not display on the claim.
7. Select Clinic Unbillable: Enter any additional clinic types that the insurer considers unbillable and press the Enter key.

Note: If the user removes entries from this field, a Backbilling Check must be tasked.

Insurer Status.....: BILLABLE//  
 Type of Insurer....: PRIVATE//  
 All Inclusive Mode.: YES//  
 Backbill Limit (months): 13//  
 Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE  
 //  
 Rx Billing Status...: UNBILLABLE//  
 Select CLINIC UNBILLABLE:

### Add/Edit Electronic Media Claims (EMC) and Plan Name

The following prompts must have values if the Mode of Export is 837I, 837P, or 837D formats. If no values are entered, the entire batch of bills sent electronically will be rejected by the payer.

Use the following table to guide you through the prompts to add or edit information.

1. EMC Submitter ID: Add or edit the login ID assigned to your facility by the insurer and press the Enter key. Data in this field populates the ISA06 and GS02 elements of the 837 formats.
2. EMC Password: Add or edit the system password assigned to your facility by the insurer and press the Enter key. Data in this field populates the ISA04 element of the 837 format. This may not be required by all payers.
3. EMC Test Indicator: Type T to mark the transmission as a test transmission. If the transmission is NOT a test, leave blank and press the Enter key. Data in this field populates the ISA15 element of the 837 formats.



4. Use Plan Name?: This field is used by locations that bill to Medicaid managed care plans.  
Type **Y** to use the Medicaid managed care plan instead of billing to the state Medicaid plan.  
Type **N** or leave blank and press the Enter key to use the insurer name. All claims for the Medicaid Managed Care plan will generate under the state Medicaid insurer.

EMC SUBMITTER ID: 02402//  
EMC PASSWORD:  
EMC TEST INDICATOR: P//  
USE PLAN NAME?: YES//

### 72-Hour Rule

The following lists the rules for establishing the 72-hour rule in the insurer file.

If the service category for the visit is ambulatory or day surgery, and the primary payer has an insurer type of Medicare (including Railroad Retirement) or Medicaid, and the 72 Hour Rule is set to **Yes**, the system will check all visits that occur within the last 72 hours.

72 HOUR RULE: NO//

### Select NPI Usage Indicator

Every payer that is affected by the National Provider Identifier (NPI) will need to be updated by entering a value in the NPI USAGE field.

The NPI USAGE field can contain one of the following values:

**NPI Only:** Print and display the NPI on the claim forms. Payers that require the NPI to only be submitted will need to use this status. For the electronic forms, the Tax Identification Number of the facility will also be used.

**NPI & Legacy:** Display both the NPI and Legacy number on the claim forms. Payers that allow the NPI and the Legacy number to be submitted will use this status.

**Legacy Only:** Prints and displays the legacy number only. The Legacy number is the number that currently prints on the claim forms.

If the field is left blank, the system will continue to use the existing format of displaying/printing the provider numbers on the claim forms (also known as the LEGACY ONLY status).

NPI USAGE: ??

Choose from:  
N      NPI ONLY

B	NPI & LEGACY
L	LEGACY ONLY

NPI USAGE:

### Tribal Self-Insured

Use this field to indicate if the payer is a Tribal self-insured entity or not. By indicating that the insurer is a Tribal self insured payer, certain edits will be activated in the claim editor, and will export to the claim form. This field will do the following if YES, TRIBAL SELF-INSURED is selected:

- Claim Editor: If the primary insurer bill status is marked COMPLETED, the active insurer contains a Medicare insurer type, and the export mode is an electronic format, then the Coordination of Benefits (COB) page will be skipped. This prevents the addition of any payment/adjustment codes to the claim when submitted to Medicare.
- Claim Forms (paper and electronic): The following remark will be printed in the comments section of the paper forms or will be submitted on the electronic format: PT HAS TRIBAL SELF-FUNDED INSURANCE.

TRIBAL SELF-INSURED?: ??

Choose from:

Y YES, TRIBAL SELF-INSURED

N NO, NOT TRIBAL SELF-INSURED

TRIBAL SELF-INSURED?:

### ICD-10 Effective Date

The ICD-10 Effective Date field has been added to let the site determine which version of ICD codes will be seen by the biller and be sent to the payer. This field is required and was automatically auto-populated with the date October, 13, 2014 when Patch 10 was installed. Deleting the data or leaving the field blank will default the date to October 13, 2014.

ICD-10 EFFECTIVE DATE: OCT 1,2014//

### Add/Edit Group Number and Provider Data

The user can cycle through the following prompts until he/she has added and/or edited the desired provider names and PIN numbers to the insurer's file. Data in these fields are used primarily for Medicare and/or Oklahoma Medicaid when billing the Professional Component. The user may populate the Legacy number (if needed). The Group and Provider number entered are used when billing the 999 – Professional Component visit type.

Use the following table as a guide for the prompts to add or edit information.

1. **Group Number:** Add or edit the group number assigned to this insurer and press the Enter key.
2. **Select Provider:** Add or edit the name of the provider and press the Enter key.  
Type the name of the provider whose data needs to be added or edited for billing this insurer.  
Press the Enter key and continue to the “Visit Type” prompts, if provider names do not need to be added to the insurer’s file.
3. **PIN#:** Type the PIN number assigned to the provider by the insurer.

GROUP NUMBER: HZZ000

PROVIDER PIN#

Select PROVIDER: ADAM,ADAM//

PIN #: 111222

### **Add/Edit Visit Types**

The Visit Type fields control the mode in which an insurer is billed. The visit types correspond to those contained in the Visit Type file. Visit types are used primarily for reporting purposes (if clinic type isn’t being used).

The visit type of claims created automatically can be Inpatient, Outpatient, Ambulatory Surgery or Dental; whichever is most applicable. All claims that coincide with an established visit type entry for an insurer will be billed in the manner specified by that entry. The Visit Type of a claim can be changed on Page 1 (Claim Identifiers) of the Claim Editor.

Visit Types can be added locally, using the Visit Type Maintenance option. Locally added visit types must be clearly labeled.

At the “Select Vist Type” prompt, enter the number that corresponds to the visit type.

At the “Are you Adding ‘Visit Type Name’ as a new Visit Type?” prompt,

- Press the Enter key to accept the default (No).
- 
- Type **Y** and press the Enter key if this is a new visit type.

Use the following as a guide for the prompts to add or edit information.

1. **Billable:** IF the visit type is
  - Billable, type **Y** (Yes).
  - Unbillable for this insurer, type **N** (No)

- Billable through software other than the RPMS Third Party Billing system, type **E** (Billable/Billed Elsewhere).
2. Reporting purposes only: If YES is entered, it will populate the 837 element BHT06 with RP. If field is left blank, the BHT06 will contain CH.
  3. Do you want to replace with another insurer/visit type?: This prompt was designed to allow the user to set up an insurer to substitute by visit type for certain services without having to add that eligibility to the patients file. For example, if Payer A requires claims for mental health services to be submitted to Payer B with the same Insurer Identification number, the user can set up the replacement insurer with Payer B's insurance information. When billing, the user will need to edit the visit type linked to Payer B's replacement insurer.

At the prompt:

- Type No or leave blank to prevent the claim editor from displaying the replacement insurer.
  - Type Yes to replace the active insurer being billed for this visit type.
- At the "Effective Date" prompt, type in the date this payer will override the current payer. This date corresponds to the date of service on the visit. This prompt was also designed to store multiple entries in case the replacement payer changes.
  - The "Replace Insurer Effective Date End Date" prompt will display. If the replaced payer is overridden for a period of time, the user may elect to enter an end date. Once the end date is entered, the system will use the current payer in the claim editor.
  - At the "Replace Insurer Effective Date Replacement Insurer" prompt, enter the name of the replaced insurer. This is the insurer that will appear when the visit type is changed in the claim editor.
  - At the "Replace Insurer Effective Date Replacement Visit Type" prompt, enter the visit type of the replaced insurer that will be used for billing. If the visit type does not exist at the replaced insurer, the system will display the following message:

Replacement Insurer/Visit Type not set up! Must be set up before it can replace

Once the insurer has been replaced, the Visit Type will be displayed with the following:

Visit	Mode of	Mult	Fee	-----	Flat Rate	-----
Type - Description	Export	Form	Sched	Start	Stop	Rate

=====

=====

611 NGS MEDICARE      \*\* Replace with: AETNA \*\*

4. **Start Billing Date:** Type the date of service that the system should use as the start date for generating claims for this visit type for this insurer.  
Any visit occurring before the date entered here will not have a corresponding claim.  
Entering a start date helps prevent unwanted claims from generating.

5. **Procedure Coding:** Type one of the following:

- ICD. Used for all-inclusive (flat-rate) billing
- CPT. Used to itemize charges on the claim
- ADA. Used for dental billing

This allows the system to pick a coding method to use when creating a claim.

6. **Fee Schedule:** Type the number of the applicable fee schedule, so the system can pick which fee schedule to use when creating a claim.  
If left blank, the fee schedule entered in “Site Parameters, Default Fee Schedule” prompt will be used.

Unless the payer requires a different fee schedule for this visit type, it is strongly encouraged to leave this field blank.

**Note:** This prompt does not appear if the Procedure Coding method is ICD.

7. **Add Zero Fees:** Type Y (Yes) if all fees should be carried forward to the claim editor. This includes all codes that do not contain a fee associated to it.  
Type N (No) or leave blank if not allowing all fees to come across to the claim editor. This means that charges with no associated fee in the fee schedule will not be included on the claim.

8. **Multiple Forms:** Type Y (Yes) if the insurer requires that the professional component is billed on a different form than the medical procedures.  
**Note:** If Y (Yes) is entered, the Mode of Export field on PAGE 8A and PAGE 8B of the Claim Editor defaults to the value defined in the Professional Component Visit Type (Visit Type 999). This means that Visit Type 999 will need to be set up in the Insurer file.

9. **Payer Assigned Provider Number:** Enter the provider number only if the insurer has assigned a provider number for this visit type. The provider number, if entered, must be 3-13 characters. This number is displayed on the UB-04 in block 51 or the CMS-1500 in block 33 as long as the NPI status indicates Legacy or NPI & Legacy. If the NPI status is set to NPI Only, this number will not reflect on any of the export forms.

10. EMC Submitter ID#: Enter the payer-specific EMC Submitter Identifier, if required, in fields ISA06, GS03, and enter NM109 of the Submitter (Loop 1000A) of the 837 electronic formats.

11. EMC Reference ID: Enter one of the following, if required, for the payer for electronic claims:

0B	State License Number
1A	Blue Cross Provider
1B	Blue Sheild Provider
1B	Blue Shield Provider
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
1J	Facility ID Number
B3	Preferred Provider Organization
BQ	HMO Code Number
EI	Employers Identification Number
FH	Clinic Number
G2	Provider Commercial Number
G5	Provider Site Number
LU	Location Number
MB	MEDICARE PART B
SY	Social Security Number
U3	Unique Supplier ID Number
X5	State Industrial Accident Provider Number

12. Auto Approve?: If auto approve is selected (Yes), when the claim generator creates a new claim for this insurer and visit type, it examines the new claim for errors. If no errors are found that would normally prevent approval, it approves the claim automatically and creates a bill ready for printing or export. The approving official is identified as the individual who initiates the claim generator for all auto approved claims.

The auto approve process may be desirable when trying to process a high volume of non-itemized claims for an insurer. For example, auto approve would allow sites to send outpatient claims to Medicare, via the RPMS Third Party Billing EMC menu, without incurring a large increase in the workload of claims editing and approval in the Billing office.

Type **Y** (Yes) to auto approve the claims for this insurer/visit type. Type **N** (No) or leave blank to **not** auto approve the claim for this insurer/visit type.

<b>Important:</b> Exercise extreme <b>CAUTION</b> with this option.
---

13. Mode of Export: Enter the name of the billing form/mode for this insurer/visit type and select the Enter key. If the entry matches more than one mode of export, the system will

display a list and prompts the user to choose one. At the prompt, type the number that corresponds to the correct mode of export.

**Note:** The Mode of Export specified here sets the default selection for this insurer.

14. Subpart NPI: Populate this field with the location from the Institution file that contains the NPI to bill. Entries from this field will override the NPI stored in Site Parameters or the NPI of the location you are billing for. Sites may elect to populate this if they obtained an NPI for a specialty.

Visit Type - Description	Mode of Export	Mult Fee Form Sched	----- Flat Rate ----- Start Stop Rate
=====			
111 INPATIENT	837I (UB) 5010NO		
131 OUTPATIENT	837P (HCFA) 5010NO	01/01/2013	283.00
611 NGS MEDICARE	** Replace with: NGS MEDICARE **		
700 OBSERVATION	837P (HCFA) 5010NO		
994 OPTOMETRY	837I (UB) 5010NO		
996 LABORATORY	837P (HCFA) 5010NO		
997 PHARMACY	837P (HCFA) 5010NO		
999 PROFESSIONAL COMP	837P (HCFA) 5010N/A 31		
Select VISIT TYPE...: 131 OUTPATIENT			
...OK? Yes// (Yes)			
Billable (Y/N/E)....: YES//			
Reporting purposes only:			
Do you want to replace with another insurer/visit type?			
Start Billing Date (create no claims with visit date before)..: AUG 1,2009			
//			
Procedure Coding....: CPT//			
Fee Schedule.....:			
Add Zero Fees?....:			
Multiple Forms?.....: NO//			
Payer Assigned Provider Number.....:			
EMC Submitter ID #...:			
EMC Reference ID.....:			
Auto Approve?.....:			
Mode of Export.....: 837P (HCFA) 5010//			
SUBPART NPI:			

## DME Contractor

This field is used to identify payers that allow billing for Durable Medical Equipment (DME) electronically. Type **Y** (Yes) to add the DME Contractor information. Type **N** (No) or leave blank if this insurer is not a DME Contractor.

This section will display the following questions, if the user types Yes at the prompt:

- Use the DME Group Number/Name field for DME payers that require a group name or number to be submitted on their claim forms. The user can enter a default group number or name in this field, which will print on the paper or electronic export.
- The CLIA# Req'd for all Visits field is for payers that require the CLIA number to be submitted on all DME Claims. Users now have the ability to print the CLIA number on the paper or electronic export. Typing Yes enables the printing of the CLIA number.
- The Which CLIA Should Print field will display if the user indicated that the CLIA Number is required when submitting to the payer. Type the Reference Lab CLIA Number or the In-House Lab CLIA Number. Depending on the selection, the system will pull the value indicated in the Site Parameters CLIA Number section.

```
DME Contractor?.....: YES//
DME GROUP NUMBER/NAME: DME GROUP NAME//
CLIA# req'd for all visits? : YES//
Which CLIA should print? : IN-HOUSE LAB CLIA// ??
```

```
Choose from:
R REFERENCE LAB CLIA
I IN-HOUSE LAB CLIA
```

### Additional Mode of Export Fields

#### Additional fields for all inclusive (flat rate) insurer status

When the insurer status is all inclusive, additional prompts appear after the 'Mode of Export' prompt. Use the following table as a guide for the prompts to add or edit information.

1. Revenue Code: Type the Revenue Code number for this visit type. Only revenue codes designated as all-inclusive may be selected.  
**Note:** This field is mandatory if the Export Mode is UB-92, UB-04 or 837 Institutional. The revenue code will be displayed as a single line item on the bill. Revenue Codes in the Revenue Code file may be edited, using the Revenue Code Maintenance option.



2. **Revenue Description:** Enter a brief description of the revenue code or leave blank. The description entered here is displayed on the UB-92, UB-04 in block 43 or the 837 Institutional format. If this field is left blank, the description in the Revenue Code file is used.
3. **Bill Type:** Use this field to enter a default bill type for use on the UB-92, UB-04 or the 837 Institutional format.  
Before entering the bill type into this field, the user must add the entry into the UB-92 Codes Menu, UB-92 Code Maintenance option.
4. **CPT Code:** Enter the default CPT or HCPCS code used to bill for these services, if required. If left blank, the flat rate dollar amount will print in Box 44 of the UB-04.
5. **Select Start Date:** Start dates are used to identify flat rate dollar amounts that are effective for the period of time specified and are only used when billing for the all-inclusive rate. The user may elect to add multiple entries.  
Enter the date range start date. The system prompts the user to verify that the date entered is the 1st for this Visit Type. Type Y (Yes) or press Enter to accept the default, No.
6. **Start Date:** If the date displayed is correct, press enter to accept.
7. **Rate:** Enter the applicable flat rate dollar amount.
8. **Stop Date:** Enter the stop date for billing at the rate specified. This field is usually populated prior to entering a new flat rate dollar amount.

```
Revenue Code.....: 100//  
Revenue Description.:  
Bill Type.....: 111//  
CPT Code.....:  
Select START DATE: T MAR 13, 2002  
Are you adding 'MAR 13, 2002' as a new START DATE (the 1ST for this VISIT  
TYPE)? No// Y (Yes)  
START DATE: MAR 13,2002//  
RATE ($): 450.00  
STOP DATE: T+90 (JUN 11, 2002)
```

### **Additional fields for UB-92, UB-04 or 837 Institutional Export Modes**

If the Mode of Export is set to the UB-04 or 837 Institutional formats, the following prompts appear:

1. **Relationship Code?:** Type **UB-92** if the payer requires the UB-92 relationship codes to be used. If left blank, the new relationship codes will be used. The old codes list Self as '01', Spouse as '02', etc.

2. Itemized UB?: Type Y (Yes) if all services are to be itemized on the UB-04 at the time of billing. Itemizing the UB-04 means that all CPT, NCPDP as well as the date of service for the charge will print on the paper form. Type N (No) or leave blank and press the Enter key to have the system prepare a non-itemized bill.
3. UB-04 Form Locator 38: A change was made to the insurer file for the UB-04 Form Locator 38 field so that the patient name and address can be printed on the UB. The insurer type must be N (non-ben) and UB-04 Form Locator 38 field must be set to Insurer. A new field was also added if box 38 should be blank. All other insurer types will print based on the parameter set in this field. The default is set to the insurer address. Enter a question mark to view the list of options available.

Choose from:

P POLICY HOLDER  
I INSURER ADDRESS  
B BLANK

4. ICD PX on Claim?: This field displays if the Export Mode is 837 Institutional, UB-04 or UB-92.  
Type N (No) to remove the ICD-9 Procedure codes from the claim.  
Type Y (Yes) or leave the field blank for the Procedure codes to display on the claim. It is recommended to set up all insurers and all visit types used to bill ICD-9 Procedures. Modifications made to this field will affect only the UB-92, UB-04 or the 837-I and have no affect on the claim editor. Use extreme caution when editing this field as claim data is affected.
5. Print meds on 2 lines?: Allows for the billed medication information to print on two lines, if required by the payer. Answering Y (Yes) will allow the NDC and drug name to print on two lines. Type N (No) or leave blank to print meds on 1 line.
6. UB-04 Block 44 Blank?: This prompt has been added to give users the option to leave block 44 (HCPCS/RATE/HIPPS CODE) of the UB-04 claim form blank. Type Y (Yes) and the field will be blank on the claim. Type N (No) or leave blank and the field will print with the HCPCS/RATE/HIPPS code.
7. RX# in FL44?: The user can select to populate the Pharmacy (RX) prescription number in form locator 44. Type Y (Yes) to populate the RX number in box 44. Type N (No) or leave blank to not print the RX number.

Mode of Export.....: UB-04 OMB No. 0938-0997  
Relationship Code?: UB92 CODES  
Itemized UB?.....: Y YES  
UB-04 Form Locator 38:  
ICD PX on Claim?:  
Print meds on 2 lines?:  
UB-04 Block 44 Blank?:

RX# IN FL44?
--------------

### Additional Fields for CMS-1500 and 837 Professional Export Modes

If the Mode of Export field is set to the CMS-1500 or the 837P, the following prompts appear:

1. Block 24K: Type **RX** (RX Number) or **MD** (MD Provider Number) and press the Enter key.
2. Block 28: This prompt has been added if the export mode is CMS-1500 (08/05). Selecting C or CONT will print the word CONT on a multi-page claim with the claim total on the last page. If left blank the field will total each page separately.
3. Block 29: Type **DO** to print or **DON'T** to not print, and press the Enter key. Typing DO allows the provider name and credentials to print in Box 29.
4. Block 33 PIN#: Type one of the following or leave blank:
  - LOC (Location code) is obtained from the Insurer file, which contains a field titled, Locations Assigned W/PROV#. This field is populated with the facility identification number.
  - PRO (Provider code) is obtained from the New Person file, which contains a field titled, Payer Assigned Provider Number. This field is populated with the individual provider numbers.

<p>Note: The information for both Location and Provider codes is generally populated with VA FileMan. Site manager assistance may be needed to add the location codes to the Insurer file via VA FileMan.</p>
---

5. 4 OR 8 DXS ON 1500: Allows staff to determine if four or eight diagnosis codes will be sent to the payer. Some payers, such as Medicare, allow for up to eight diagnosis codes to be reported on the CMS-1500. In this case, the user may modify the 4 OR 8 DXS ON 1500 question to reflect the payer requirements. Enter 4 or 8 at the prompt and select the Enter key.  
If blank, the system will print four diagnosis codes on the paper claim form and does not have an effect on the 837 5010 format.

<p>Mode of Export.....: CMS-1500 (08/05)//          Block 24K.....:          Block 28.....:          Block 29.....:          Block 33 PIN#.....:          4 OR 8 DXS ON 1500: 4//</p>
---

### Additional fields for the ADA-2006 Export Mode

1. Block 48: A new parameter was added to allow the option to print the Physical Address or Mailing Address for the facility in block 48 of the ADA-2006 claim form.

Note: The address that prints in block 48 is linked to the address that is in the Location File Menu in Third Party Table Maintenance.

Mode of Export.....: ADA-2012// ADA-2006      ADA-2006 Dental Claim Form  
Block 48.....: ??

Choose from:

P      PHYSICAL  
M      MAILING

Block 48.....:

### Additional fields for 837 Export Modes

If the Mode of Export field is set to the 837I, 837D or the 837P, the following prompts appear:

1. Contract Code Req'd?: This may be used by certain payers to report contract information. This populates the CN1 segment on the 837. If not required, enter N (No) or leave blank then press the Enter key. If Y (Yes) is selected, then the user will be required to select the appropriate contract type code to print on the claim.

01	DIAGNOSIS RELATED GROUP (DRG)
02	PER DIEM
03	VARIABLE PER DIEM
04	FLAT
05	CAPITATED
06	PERCENT
09	OTHER

2. Service Facility Location: Allows the user to remove the Service Facility Location loop from the 5010 837. The user will have the option to enter one of the following:

- S or Send all the time, even if the billing location is the same.
  - N or Do NOT send at all
  - D or Send only when the Visit Location differs from the Billing Location
- According to the 837 Implementation Guide, this loop is sent only when the Billing Location (Loop 2010AA) is different than the Service Location. If left blank, the system

will continue to send the Service Location if it's different than the Visit Location (Option D). The Loops affected are:

- 5010 837I Loop 2310E
- 5010 837P Loop 2310C
- 5010 837D Loop 2310C

Contract Code Req'd? NO  
Service Facility Location:

#### **STEP 6: ADDING/MAINTAINING FEE SCHEDULES**

Please see appendix A for instructions on adding/maintaining fee schedules.

#### **STEP 7: CASHIERING OPTIONS**

If your facility is a Federal location, you must use the cashiering options so that billing activity can be sent to the financial reporting system, which is currently UFMS. If your facility is a Tribal/638/Urban location, you may utilize cashiering options as a productivity tool but you will not export cashiering sessions to UFMS.

The cashiering options allow billing clerks to open a session that records billing functions such as claim approving, claim cancellation, and bill cancellation. Once a billing clerk has completed activity for the day, he/she must close his session. The session is then available for a supervisor to reconcile and, for Federal locations, to transmit to the financial reporting system.

To access the cashiering setup option:

- Access the **THIRD PARTY BILLING** System.
- Choose **CASHIERING OPTIONS (UCSH)** from the Main Menu.
- Choose **SUPERVISORY FUNCTIONS (SUP)** from the Cashiering Options menu.
- Choose **UFMS SETUP (SET)** from the Supervisory Functions menu.

#### **SET UP DIRECTIONS FOR FEDERAL LOCATIONS (MANDATORY SETUP FOR FEDS)**

1. **UFMS DIRECTORY:** type the directory path for the folder on your server where your UFMS files will be stored and press <ENTER>.

When cashiering sessions are exported, a file is created and sent from RPMS to UFMS via the OIT Integration Engine but a copy is also stored in the directory that is designated

at the UFMS DIRECTORY prompt. If you aren't sure what the directory path is, your local IT should be able to assist you. **It's important that whoever will be exporting cashiering sessions from RPMS have read and write access to this folder on your server.**

2. **UFMS DISPLAY DEFAULT NUMBER:** this is the number of days that users will be able to view open or closed cashiering sessions. For example, if 14 is entered at this prompt users will be able to view two weeks of open or closed cashiering sessions. Enter a number and press <ENTER>.
3. **UFMS USE ASUFAC OF:** this field is for satellite locations only. Some locations, such as home, school, office, etc., may not have their own ASUFAC or the location may not be set up with a CAN or BACS entry at UFMS. Enter the ASUFAC number of the parent location at this prompt and press <ENTER>. If you are logged into the parent location, do not enter anything at this prompt. Just press <ENTER>.
4. The following message will be displayed as a warning that the next prompt (EXCLUDE DATA) should be used with caution. Press <ENTER>.

WARNING: Entries into the following file will prohibit data from being sent to UFMS.

Use EXTREME caution when creating entries.

The default to your current location.

Enter RETURN to Continue:

**Example of warning message displayed for EXCLUDE DATA prompt.**

5. **EXCLUDE DATA:** this field is used to exclude billing data for non-IHS clinics within the facility from the exported file to UFMS. Billing data can be excluded by selecting any combination of location/insurer type/clinic to exclude from UFMS exports. For example, if a facility's dental program holds a Tribal or 638 status and thus does not report to UFMS, the billing data for that dental program can be excluded from UFMS exports. If there is no data to be excluded from your exports, press <ENTER>.

```

+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p12  |
+          UFMS Setup          +
|      INDIAN HEALTH HOSPITAL      |
+-+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                1-OCT-2013 7:25 AM

```

UFMS DIRECTORY: c:\3PBUFMS\\  
UFMS DISPLAY DEFAULT NUMBER: 14//

## UFMS USE ASUFAC OF:

WARNING: Entries into the following file will prohibit data from being sent to UFMS.

Use EXTREME caution when creating entries.

The default to your current location.

Enter RETURN to Continue:

Select Location: INDIAN HEALTH HOSPITAL// BILLINGS ALBUQUERQUE  
 01 NM IHS 202810  
 ...OK? Yes// (Yes)

Existing entries for INDIAN HEALTH HOSPITAL:

Eff. Date	End Date	Clinic	Insurer Type
-----------	----------	--------	--------------

01/01/2007	01/01/2007	56 DENTAL	
07/11/2007		18 OPTOMETRY	PRIVATE
07/16/2007		25 OTHER	
07/18/2007		39 PHARMACY	
07/23/2007	07/23/2007	01 GENERAL	
10/01/2007	10/03/2007	56 DENTAL	
01/01/2010	12/31/2010		

Select EFFECTIVE DATE: 1/1/08 JAN 01, 2008

Are you adding 'JAN 01, 2008' as a new EFFECTIVE DATE (the 8TH for this 3P UFM S EXCLUSION TABLE)? No// Y (Yes)

CLINIC: DENTAL 56

INSURER TYPE:

END DATE:

Existing entries for INDIAN HEALTH HOSPITAL:

Eff. Date	End Date	Clinic	Insurer Type
-----------	----------	--------	--------------

01/01/2008		56 DENTAL	
------------	--	-----------	--

Select EFFECTIVE DATE:

**Example of setting up the UFMS cashiering options for Federal locations.**

**SET UP DIRECTIONS FOR TRIBAL/638/URBAN LOCATIONS IF CASHIERING WILL NOT BE UTILIZED**

If your facility is Tribal/638/Urban and does not wish to utilize cashiering, it is not necessary to fill out any information in the SET option but you must go into this option and press <ENTER> through all the prompts.

1. **UFMS EXPORT:** type NO and press <ENTER>.
2. **UFMS CASHIERING:** type NO and press <ENTER>.

```

+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p12  |
+          UFMS Setup          +
|          TRIBAL HEALTH CENTER          |
+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                1-OCT-2013 8:36 AM

UFMS EXPORT: NO (DON'T EXPORT
UFMS CASHIERING: NO (Don't do Cashiering Sessions)

```

**Example of turning off cashiering for Tribal/638/Urban.**

#### SET UP DIRECTIONS FOR TRIBAL/638/URBAN LOCATIONS IF CASHIERING WILL BE UTILIZED

1. **UFMS EXPORT:** type NO and press <ENTER>.
2. **UFMS CASHIERING:** type YES and press <ENTER>.
3. **UFMS DISPLAY DEFAULT NUMBER:** type a number and press <ENTER>. See “Set Up Directions for Federal Locations” above for explanation of field.

```

+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p12  |
+          UFMS Setup          +
|          TRIBAL HEALTH CENTER          |
+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: USER,USER                1-OCT-2013 8:49 AM

UFMS EXPORT: YES (EXPORT)// N NO (DON'T EXPORT)
UFMS CASHIERING: YES (Do Cashiering Sessions)//
UFMS DISPLAY DEFAULT NUMBER: 5// 14

```

**Example of turning on cashiering for Tribal/638/Urban.**

#### STEP 8: TASKING THE CLAIM GENERATOR



Claims can be created in Third Party Billing manually by using the CG1P option in the 3PB ADD/EDIT CLAIM menu, or they can be created automatically by scheduling the Claim Generator in TaskMan. It is recommended that TaskMan be utilized by scheduling the ABM TSK VISIT CHK option to run on a nightly basis during off-peak hours. Depending on the volume of visits in your database, the claim generator can take a few minutes to run or can take up to an hour.

The claim generator serves several purposes:

1. It checks to see if there are inactive claims to be purged. These are claims with a DATE LAST EDITED that is later than the age that was designated in the Site Parameters field called DAYS INACTIVE BEFORE PURGING.
2. It checks to see if a back-billing scan has been requested by a billing clerk using the BKMG option in the Claim/Bill Management Menu. If a back-billing scan has been requested, the program will check the PCC Visit global for billable visits back to the date that was specified in the BKMG option.
3. The program then checks the PCC Visit global for billable visits and pulls them into 3PB as claims based on one of the following conditions:
  - a. The visit falls within a period covered by a billable third party resource in the patient's record.
  - b. The ELIGIBILITY STATUS for the patient is designated as INELIGIBLE.
  - c. The billing site is a 638 site and has been set up for claims to be created for all visits.

### TASKING THE CLAIM GENERATOR

1. From programmer mode type D ^XUP  
Note: There is a space between the D and ^.
2. **Select OPTION NAME:** type XUTM Manager and press <ENTER>.
3. **Select Taskman Management Option:** type SCHEDULE and press <ENTER>.
4. **Select OPTION to schedule or reschedule:** type ABMD TSK VISIT CHECK and press <ENTER>.
5. **...OK? YES//** press <ENTER>.  
Note: once you are in schedule option press <TAB> to move to the cursor to the necessary fields, which are described in the next steps.
6. **QUEUED TO RUN AT WHAT TIME:** type the date and time that you want the claim generator to run in the format shown in the example below and press <ENTER>.
7. **QUEUED TO RUN ON VOLUME SET:** type the namespace for your facility and press <ENTER>.

8. **RESCHEDULING FREQUENCY:** type 1D and press <ENTER>.
9. Press <TAB> until the cursor is in the COMMAND field.
10. **COMMAND:** type S and press <ENTER>.
11. **COMMAND:** type E and press <ENTER>.

UFT>D ^XUP

Setting up programmer environment  
This is a TEST account.

Terminal Type set to: C-VT100

Select OPTION NAME: XUTM MANAGER

Schedule/Unschedule Options  
One-time Option Queue  
Taskman Management Utilities ...  
List Tasks  
Dequeue Tasks  
Requeue Tasks  
Delete Tasks  
Print Options that are Scheduled to run  
Cleanup Task List  
Print Options Recommended for Queueing

You have 4 PENDING ALERTS

Enter "VA to jump to VIEW ALERTS option

Select Taskman Management Option: SCHEDULE/Unschedule Options

Select OPTION to schedule or reschedule: ABMD TSK VISIT CHECK  
...OK? Yes// (Yes)

Edit Option Schedule  
Option Name: ABMD TSK VISIT CHECK  
Menu Text: Auto-PCC Visit Check/3P Claim Cr      TASK ID: 19443

---

QUEUED TO RUN AT WHAT TIME: SEP 30,2013@23:00

DEVICE FOR QUEUED JOB OUTPUT:

QUEUED TO RUN ON VOLUME SET: UFT

RESCHEDULING FREQUENCY: 1D

TASK PARAMETERS:

SPECIAL QUEUEING:

Exit Save Next Page Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:  Press <PF1>H for help Insert

**Example of the fields in the Taskman Schedule/Unschedule Options file. The data displayed in this screen shot is only an example.**

## ACCOUNTS RECEIVABLE APPLICATION SET UP

### SUMMARY OF REQUIRED STEPS

**Handling old accounts or old information prior to resetting process (zeroing out)**

1. Switch Service/Section (BAR – SVC)
2. Parent Facility Addition (BAR – MAN – PFA)
3. Site Parameter Edit (BAR – MAN – SPE)
4. Parent/Satellite Edit (BAR – MAN – PSE)
5. A/R Account Entry (BAR – MAN – ACE)
6. Collection Point Edit (BAR – MAN – CPE)

### STEP 1: SWITCH SERVICE/SELECTION

- This option will set the Service/Section category of the RPMS User. Service/Section is a control used to prevent users that are not associated to the Business Office to access patient accounts. Use this option to set the Service/Section to BUSINESS OFFICE. Failure to set this entry results in the data integrity issues. Each user assigned to Accounts Receivable must set their Service/Section to BUSINESS OFFICE. Access the ACCOUNTS RECEIVABLE system.
- Choose SWITCH SERVICE/SECTION (SVC) from the A/R Master Menu.
- **Select TABLE ENTRY/IHS NAME:** Type BUSIENSS OFFICE and press <enter>.

- The system will return the user back to the A/R Master Menu and displays the BUSINESS OFFICE entry in the banner of the menu.

## STEP 2: PARENT FACILITY ADDITION

This option establishes the identity of the Parent facility either as a standalone parent, or as one of several on the same machine by creating the A/R File entries used to store bill, transaction and collection batch data. Typically, an RPMS system will contain only one parent AR location.

- Access the ACCOUNTS RECEIVABLE system.
- Choose MANAGER (MAN) from the A/R Master Menu.
- Choose PARENT FACILITY ADDITION (PFA) from the Manager menu.
  1. The system will ask **<LOCATION NAME> to be added/updated as an A/R Regional Site?**. Type YES and press <enter>.
  2. The system will list all A/R file and returns the user to the Manager menu.

## STEP 3: SITE PARAMETER EDIT

This option sets up the basic parameters of the A/R Parent Location and must be completed prior to using the Accounts Receivable System.

- Access the ACCOUNTS RECEIVABLE system.
- Choose MANAGER (MAN) from the A/R Master Menu.
- Choose SITE PARAMETER EDIT (SPE) from the Manager menu.
  1. **Select A/R SITE PARAMETER/IHS RPMS SITE:** Type the name of the parent location and press <enter>.
  2. **MULTIPLE 3P EOB LOCATIONS:** Used when adding payer checks into the system by allowing the Collections Clerk to store check data by visit location. It's recommended to set this to NO as setting this to YES will require the user to select a visit location for each check when batching.
  3. **MULTIPLE FISCAL EOB LOCATIONS:** Used when batching fiscal checks. Fiscal checks are considered non-patient account payments. Setting this to YES will require the user to link the check number to the visit location.
  4. **USABLE:** Type USABLE and press <enter> to allow the location to be used as a parent location

5. **ACCEPT 3P BILLS:** Type YES and press <enter> to allow this parent location to receive bills from Third Party Billing.
6. **ROLL OVER DURING POSTING:** Type YES and <enter> to allow the system to automatically run the Roll Back function which looks for other insurance to bill once a claim has been posted to a zero balance and also updates the 3P Bill. Another alternative is to type ASK and <enter> ask the posting technician if they wish to roll back the transaction data to 3P and check for other eligibility data.
7. **SMALL BALANCE:** Do not add an entry-no longer used.
8. **LOCATION TYPE FOR REPORTS:** This entry is used if multiple parent locations exist on one database and affects are data on some reports is generated. This parameter was created in A/R V1.6 Patch 2 in order to obtain data by visit location or billing location (DUZ(2)). This became necessary for balancing the Period Summary Report to any of the others. In order to balance, the value of this field must be visit. This parameter affects the "Select Location:" prompt. If the parameter is left blank it will be treated as though the user typed visit. If the parameter says billing location then the meaning of the "Select Location:" prompt on the following reports is DUZ(2) and not visit location:
  - Age Detail Report
  - Age Summary Report
  - Bills Listing Report
  - A/R Statistical Report
  - Transaction Report
9. **DEFAULT PATH:** Type the name of the RPMS directory used to upload and store the Electronic Remittance Advice (ERA-835) files from. This path is used by the ERA options to upload a file from a payer for electronic posting.
10. **EISS SYSTEM:** Do not add an entry-no longer used.
11. **EISS USERNAME:** Do not add an entry-no longer used.
12. **EISS PASSWORD:** Do not add an entry-no longer used.
13. **EISS (LOCAL) PATH:** Do not add an entry-no longer used.
14. **SELECT EDI PAYER:** Do not add an entry-will be enhanced in a future release. Press <enter> through the remaining EDI PAYER prompts.
15. **PAS SORTING ORDER:** Sets how patient statements are sorted for printing. Statements will first be sorted by (1) billing location and then by account number, or by (2) billing location and then alphabetically by the patient's last name based on which option is selected. If nothing is selected, the print order will default to option 1. Type a sort order by number and press <enter>.

16. **UFMS DIRECTORY:** Type the name of the RPMS directory used to store copies of the files submitted to the federal financial system and press <enter>. If non-federal, may be used to reference cashiering sessions stored once they have been reconciled. Non-federal files are not sent anywhere.
17. **UFMS DISPLAY DATE LIMIT:** Type the number of days used to display the Cashiering Session used for reconciliation. The display limit may depend on the volume of sessions created by each cashier. Type a number and press <enter>.
18. **BOOKING DATE IN UFMS:** Federal sites enter the date of October 1, 2008 and press <enter>. This signifies the date that UFMS was made active. Non-federal sites may bypass this prompt by pressing <enter>.
19. **UFMS SHUTDOWN FILE TRANSFER:** (Non-Federal only) Non-federal sites have the ability to shut down the file transfer from RPMS to the HUB. Ultimately those files are transmitted to the federal financial system. Answer YES if the facility is not federal. Federal sites will not see this question.
20. **UFMS SHUTDOWN SESSION LOGGING:** (Non-Federal only) Non-federal sites have the ability to use the cashiering option to log transaction data by posting technician. Type YES and <enter> to remove the ability to use the cashiering option. Type NO and <enter> to allow cashiering sessions to be used.
21. **ALLOW ERA POSTING NEG BAL:** (Non-Federal only) Allows the posting technician to create a negative balance during the ERA process. This means that if the total of the transactions exceeds the current bill amount, answering YES allows the ERA to post, causing a negative balance. Federal sites aren't allowed to post transactions that would cause an overposting of the current balance.
22. **ALLOW ERA POSTING CANC. BILLS:** (Non-Federal only) Answering YES to this question allows the ERA to post to a cancelled bill.
23. **OMB DIRECTORY:** This field is used to identify an RPMS directory as a placeholder for the OMB report released in Patch 13 to version 1.8. Do not populate anything at this time.

#### STEP 4: PARENT/SATELLITE EDIT

This option is used to set up each location that uploads its bills to the A/R Parent Location. By adding the visit location, the user is indicating that the bills approved will be tracked for aging and posting purposes. All visit locations including the parent location must be added. This step must be completed prior to using the system.

For existing parent locations where a new visit location is being added, follow the steps to add the new visit location.

- Access the ACCOUNTS RECEIVABLE system.

- Choose MANAGER (MAN) from the A/R Master Menu.
- Choose PARENT/SATELLITE EDIT (PSE) from the Manager menu.
- 1. **SELECT A/R PARENT/SATELLITE/IHS LOCATION:** Type the name of the satellite location to be added. The Parent location must also be added.
- 2. **LOCATION:** Press <enter> to bypass this field.
- 3. **SUFFIX:** Enter the suffix associated to this location. This suffix may be used as a quick reference for report generation.
- 4. **PARENT:** Enter the name of the PARENT LOCATION. Press <enter>.
- 5. **PARENT – SATELLITE USABLE:** Type USABLE and <enter> to make the location a usable entity.
- 6. **SATELLITE START DATE:** Type the date the visit location became active. The date should be set far back enough to allow the claim generator in 3PB to generate claims. The system will also not upload bills for visits prior to this date in A/R.
- 7. **SATELLITE END DATE :** Enter an end date only if terminating this location. Otherwise, leave blank by pressing <enter>. Adding a date will no longer generate claims for this visit location in 3PB.

#### STEP 5: A/R ACCOUNT ENTRY

This option is used to add account entries used to track aging data and for batching checks. The entries contained in this file are the locations, insurers or patient names (for non-beneficiary patients). The entries are automatically added when claims are approved. Entries may be added as needed especially if the collections clerk is unable to link a check to a payer. For the initial set-up, add the parent location and 'Un-Allocated'.

- Access the ACCOUNTS RECEIVABLE system.
- Choose MANAGER (MAN) from the A/R Master Menu.
- Choose A/R ACCOUNT ENTRY (ACE) from the Manager menu.
- 1. **SELECT A/R ACCOUNT/IHS:** Type the name of the entry (insurer) to be added.
- 2. The system will display the entry along with “//”. DO NOT MAKE CHANGES TO THE ENTRY AS IT CHANGES THE NAME STORED IN THE A/R ACCOUNT FILE! Press <enter> to bypass this entry.

Note: if the entry does not add, use a prefix listed below to add the entry. For example, if a new location is added, type L.<<LOCATION>> where <<LOCATION>> is the facility name and must be entered exactly as it appears in the location file. So if the location shows INDIAN HEALTH HOS, the entry must be added as L.INDIAN HEALTH HOS.

Other prefixes may be used:

- N.EntryName to select a NEW PERSON FILE
- P.EntryName to select a PATIENT FILE
- V.EntryName to select a VENDOR FILE
- I.EntryName to select a INSURER FILE
- L.EntryName to select a GL LOCATION FROM PARENT/SATEL
- S.EntryName to select a GL SPECIAL ACCOUNT
- LL.EntryName to select a GL LOCATION FROM LOCATION FILE

#### **STEP 6: COLLECTION POINT EDIT**

Collection points are used to categorize checks during the check batching process. Batching a check means adding it to a register and using that register for posting. Each register or collection point must be named and are used in reporting batch data such as posted amount and outstanding batch amounts.

A collection point can be described as the actual physical location where collections (cash, credit card, personal checks, Explanation of Benefits (EOB) checks) are received and accounted for. Some Areas chose to set up their collection points by payer type and facility location. An example would be MEDICAID – AAO. Once the collection point name is set up in AR, the system will assign the name, date of entry and the sequential number of the batches created for the facility. These numbers are used for accounting and monitoring completion of posting activities.

- A facility may have one or more collection points.
- Certain users are assigned accessibility for certain collection points. The Site manager must add the collection points to each individual user designated for them to access the collection points.
- Collection point editing is displayed in ScreenMan format. Use the Tab key or Arrow keys to move between fields. Type over existing data to make changes.
- Collection points have unique characteristics (Service/Section, Name, Users, etc.).

You must Save your collection point data (press Tab down to the end of the fields and type S for Save and the Return key) in order for your collection point to actually be established or edited.

- Access the ACCOUNTS RECEIVABLE system.



- Choose MANAGER (MAN) from the A/R Master Menu.
  - Type CPE at the “Select Manager Option:” prompt, then type in the name of the Collection Point. If you are adding a new Collection Point, press the Return key to confirm the addition. If you are editing an existing Collection Point, the system displays current information for your review.
1. To Edit an existing Point: type over the existing information at each prompt. Pressing the Return key will keep the field unchanged.
  2. To Add a New Point: enter data at every prompt, using the information below:
    - a. At the “Batch Type:” prompt, you have two options:
      - i. EOB Only means that the only type of reimbursements that will be entered into the Collection Register for this Collection Point are Explanation of Benefits (EOB) checks from insurance companies. All Types means all types of payments (cash, credit cards, personal checks, and EOB checks) may be entered.
    - b. At the “Auto Print:” prompt, you instruct the system to print a receipt for all types of payments received. If the field is flagged as No, the system still allows for an individual receipt to be printed for a particular transaction.
    - c. At the “Receipt Printer:” prompt, enter the Device.
    - d. At the “Select User:” prompt, type the user’s name to allow the A/R manager to designate who will have access to this particular Collection Point. Only those individuals who are identified here can create, edit, or enter transaction at this collection point. This provides internal control.
    - e. At the “Select Supervisor:” prompt, type the name of the Supervisor (last name first) of the users for this particular Collection Point. Use caution when adding users, because users can override entries in a collection batch. **SELECT A/R ACCOUNT/IHS:** Type the name of the entry (insurer) to be added.
    - f. At the “Check Bank Number:” prompt, type Yes if you want the system to ask for this information for every transaction in this Collection Point.
    - g. At the “Ask Inpatient/Outpatient:” prompt, type Yes if you want the system to ask for this information for every transaction in this Collection Point. This allows for early identification of what type of service was provided for this particular reimbursement.
    - h. At the “CC Ask Patient Name On Bill:” prompt, if the entry is Yes and the type of payment is credit card, the system asks for entry of the patient name and links it to an existing bill in the system.

- i. At the “CC Ask Patient Name:” prompt, if the entry is Yes and the type of payment is credit card, the system asks for entry of the patient name.
- j. At the “CA Ask Patient Name On Bill:” prompt, if the entry is Yes and the type of payment is cash, the system asks for entry of the patient name and links it to an existing bill in the system.
- k. At the “CA Ask Patient Name On Bill:” prompt, if the entry is Yes and the type of payment is cash, the system asks for entry of the patient name.
- l. At the “CK Ask Patient Name On Bill:” prompt, if the entry is Yes and the type of payment is personal check, the system asks for entry of the patient name and links it to an existing bill in the system.
- m. At the “CK Ask Patient Name:” prompt, if the entry is Yes and the type of payment is personal check, the system asks for entry of the patient name.

Note: If any or all of Check Bank Number thru CK Ask Patient Name On Bill prompts are flagged as NO, the capability of capturing this data for one or more specific transactions is not lost. You can use the MORE option.

- n. At the “Non EOB Data Review/Edit:” and “EOB Data Review/Edit:” prompts, indicate whether you want to view and edit the transaction that was just entered into the Collection Register for this Collection Point. It is recommended that this field be flagged to Yes.
3. When you are done editing or adding, press the Tab key until you reach the bottom of the screen and save your work. If you do not want to add another Collection Point, type E for Exit to return to Manager Menu. The system returns to the beginning prompt.

Note: Remember to save any additions or changes to a collection point.

## **ZEROING OUT OLD ACCOUNTS**

Old entries may exist if the site previously used Accounts Receivable, moved to another billing system and began using the RPMS Accounts Receivable system again.

Entries must be reviewed and a support ticket must be sent to the OIT Helpdesk. Please allow sufficient time for data clean up.

## **APPENDIX**

### **APPENDIX A: ADDING/MAINTAINING FEE SCHEDULES**

This section provides guidance on installing a new fee schedule in the Third Party Billing Application.

**Note:** It is strongly recommended that you create a new fee schedule entry rather than overriding the current fee schedule. This will allow you to retain the historical fees for future use.

### FEE SCHEDULE SETUP

Before the fee schedule can be loaded, the fee schedule will need to be saved onto the public directory. If on AIX the path would be similar to this, /usr/spool/uucppublic/. If on a Windows NT system, the path would be similar to c:\pub.

It is strongly recommended to do a global save of the following routine in RPMS prior to uploading the fee schedule: ^**ABMDFEE**. This will ensure a 'backup' copy is readily available and can be restored if needed. Your local or area IT staff should be able to assist with this if needed.

### BILLING AND THE CLAIM EDITOR

The Third Party Billing system does not update charges on claims that were generated prior to uploading the new fees or on claims that have been approved into bills. If the user elects to edit a charge after the upload of fees (plus the update of Site Parameters/Insurer File) has occurred, the new charge will come into effect.

#### STEP 1:

Create an entry in Third Party Billing for your new fee schedule by following the steps below:

- Access the Third Party Billing System.
- Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
- Choose **FEE SCHEDULE MENU (FETM)** from the Table Maintenance menu.
- Choose **FEE SCHEDULE MAINTENANCE (EDFE)** from the Fee Schedule Menu.

1. Add the next available number in the sequence and press<ENTER>.

**Note:** For example, if the last fee schedule entry number is 5, then type **6** at the prompt and press <Enter>. If you're not sure what the next available number is, type '??' and press <ENTER> for a list of fee schedule entries.

2. Type "YES" and press <ENTER> to add the fee schedule entry.

```
Select FEE SCHEDULE: 1// ??

Choose from:
1      IHS 1995 STANDARD FEE SCHEDULE
2      MEDICARE O/P SURGERY
3      NM MEDICARE 2001 FEE SCHEDULE
4      2002 RBRVS FEE SCHEDULE
5      2003 FEE SCHEDULE (3/26/03)
6      2004 FEE SCHEDULE (9/10/03)
7      MEDICAID DENTAL FEE SCHEDULE
8      MEDICAID FLAT RATE
9      2005 FEE TABLE (2/17/05)
10     MEDICAID T1015 FEE
22     2006 FEE SCHEDULE (2/17/05)
23     2007 FEE SCHEDULE (9/12/2006)
27     2009 INGENIX FEES (2/10/09)
29     2011 FEE SCHEDULE (05/14/2011)
30     2016 FEE SCHEDULE (1/18/2016)

You may enter a new 3P FEE TABLE, if you wish

Select FEE SCHEDULE: 1//
```

**Note:** If you type 'YES' and the system does not continue, then add the next number in the sequence. The most common reason for this issue is another facility sharing the same database, which may have already populated that same database with a different fee schedule number .

3. Enter the name of the fee schedule and press <Enter>.

**Note:** Recommended names follow the format of 2018 *FEE SCHEDULE (9/28/2018)*, where the current fee schedule year is entered, as well as the date the fee schedule was uploaded

```
Select FEE SCHEDULE: 1// 30
Are you adding '30' as a new 3P FEE TABLE? No// YES (Yes)
3P FEE TABLE TITLE: 2017 OPTUM FEE SCHEDULE (2/12/17)
```

4. Press <ENTER> to return to the Fee Schedule Menu.

**Note:** The system will display all CPT Categories. Do not create entries yet. The site will use this table to upload the fee schedule.

## ----- FEE SCHEDULE CATEGORIES -----

Select one of the following:

- |    |                 |
|----|-----------------|
| 1  | MEDICAL FEES    |
| 2  | SURGICAL FEES   |
| 3  | RADIOLOGY FEES  |
| 4  | LABORATORY FEES |
| 5  | ANESTHESIA FEES |
| 6  | DENTAL FEES     |
| 7  | REVENUE CODE    |
| 8  | HCPCS FEES      |
| 9  | DRUG FEES       |
| 10 | CHARGE MASTER   |

Select Desired CATEGORY:

## STEP 2:

Before the fee schedule can be loaded, the fee schedule will need to be saved onto the public directory. If on AIX the path would be similar to this, /usr/spool/uucppublic/. If on a Windows NT system, the path would be similar to c:\pub.

It is strongly recommended to do a global save of ^**ABMDFEE** prior to uploading the fee schedule. This will ensure a 'backup' copy is readily available and can be restored if needed. Your local or area IT staff should be able to assist with this if needed.

To load the fee schedule into the RPMS Third Party Billing package follow the steps below:

- Access the Third Party Billing System.
- Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
- Choose **FEE SCHEDULE MENU (FETM)** from the Table Maintenance menu.
- Choose **IMPORT FOREIGN FEE SCHEDULE (FIFE)** from the Fee Schedule Menu.

1. Type 'YES' and press <ENTER>.

2. Enter the number of the fee schedule to be uploaded.

**Note:** If a new fee schedule entry was created, type the number of the new schedule that was created in Step One. Type '??' and press <ENTER> for a list of available entries.

3. Enter the effective date of the fee schedule.

**Note:** The date you enter here will have an effect on your claims. For example, if the effective date is 06/01/13, new claims that are pulled into Third Party Billing that have a date of service of 06/01/13 or later will reflect the new fees. Claims that have a date of service of 06/01/13 or later that were already in Third Party Billing before the new fee

schedule was loaded will need to be rebuilt if you want the new fees applied (RBCL – Rebuild Items from PCC).

4. Enter the percentage of the fee schedule that is being loaded.

**Note:** This field is informational only and has no effect on the actual fees. If you are loading the highest percentile for example, you would enter 100 here.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p21          |
+          Import Foreign Fee Schedule                      +
|          INDIAN HEALTH HOSPITAL                          |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: LUJAN,ADRIAN M                                     13-JUN-2017 6:30 AM

FEE SCHEDULE UPDATE FROM FOREIGN FILE

NOTE: It is advisable to do a global save of global ^ABMDFEE prior to
running this procedure.

Continue? NO// YES
Enter Fee Schedule to Update: 1// 1          IHS 1995 STANDARD FEE SCHEDULE
What is the effective date? : TODAY// 1/1/2017
What percentile are you loading? : (0-200): 75

```

5. The system will prompt you to identify the host file delimiter. A delimiter is a character, a space, a tab or a symbol that separates the data contained in a file. In most cases, this will be a comma (,) but use caution with other types of delimiters as those formats (such as Tab delimiters) may not be supported by RPMS. Enter the delimiter and press <Enter>.

**Note:** You will need to look at the data in the fee schedule to determine what the delimiter is. This is explained in more detail in the next step.

6. Type the Column number that holds the CPT code information.

**Note:** The example below shows a fee schedule that was opened using Excel. This particular fee schedule lists the CPT code in column A. Column A is counted as column 1. The Technical, Professional and Global indicators are listed in column B. Column B is counted as column 2. The CPT/HCPCS description is listed in column C. Column C is counted as column 3. Column D is the percentile of the fee. Column D is counted as column 4. Not all fee schedules will be laid out like the one in this example.

	A	B	C	D	E
232	42600		CLOSURE SALIVARY FISTUL	2957	
233	42650		DILATION SALIVARY DUCT	251	
234	42809		REMOVAL FOREIGN BODY	605	
235	70100	G	RADIOLOGIC EXAMINATIC	178	
236	70100	TC	RADIOLOGIC EXAMINATIC	121	
237	70100	26	RADIOLOGIC EXAMINATIC	57	
238	70110	G	RADIOLOG EXAM MANDIB	257	
239	70110	TC	RADIOLOG EXAM MANDIB	169	
240	70110	26	RADIOLOG EXAM MANDIB	87	
241	70140	G	RADEX FACIAL BONES < 3 V	237	
242	70140	TC	RADEX FACIAL BONES < 3 V	171	
243	70140	26	RADEX FACIAL BONES < 3 V	66	
244	70150	G	RADEX FACIAL BONES COM	292	

7. Type the column number that contains the price and press <ENTER>.

**Note:** Some fee schedules come with percentiles (25%, 50%, 95%, etc.) or Par amount, Non-Par amount, etc. Make sure the correct price is uploaded, as this will affect all charges that utilize this fee schedule.

8. Type the column number that contains the Technical, Professional, and Global indicator.

**Note:** The system will then allow you to only upload certain record types, if desired. This is primarily used to upload prices that are calculated differently if a modifier was reported. It is not required to upload the price difference but you may do so by answering yes to this question. If **YES** is answered, the system will ask you to identify what 'piece' of the file to examine. In other words, enter the column number for the modifier.

#### FOREIGN HOST FILE DESCRIPTION

What is the host file record delimiter? ,// 1

Which piece of the host file record contains the cpt code? 1// 3

Which piece of the host file record contains the price? 2// 13

Some providers of fee schedules (Medicode for example) break out the professional and technical portions into separate records. The next section will determine how to identify the different record types.

This section will load the different record types (global/technical/professional )

What column is the record type located in: 4// 4

Indicate value that identifies GLOBAL charge : G// G

Indicate value that identifies TECHNICAL charge : TC// TC

Indicate value that identifies PROFESSIONAL charge : 26// 26

9. Type 'HFS' and press <ENTER>.

**Note:** A default of Host File Server (HFS) will display. You may need to change this if your fee schedule has been stored somewhere other than what is being displayed as the default. If that is the case, your local IT or site manager should be able to assist if needed.

10. Type the path name where the fee schedule file is stored along with the file name and press <ENTER>.

**Note:** Remember that if your RPMS system is on a Windows NT server, your path may be different. Your local IT or site manager should be able to assist with this if needed.

AIX path may be similar to this: /usr/spool/uucppublic/2013\_FEE\_SCH.CSV

Windows NT server path may be similar to this: c:\pub\2013\_FEE\_SCH.CSV

11. Press <ENTER> to continue to load the fee schedule.

**Note:** During the load, you will see a series of dots being displayed on the screen.

```
OPEN AND READ FOREIGN FILE

DEVICE: HOST FILE SERVER//  HFS  LOCAL
HOST FILE NAME: c:\tmp\tmp.hfs//C:\RPMS\IHH_FEES2017_MASTER.csv
ADDRESS/PARAMETERS: "RS"// <enter>
.....
.
.
L8047 KM
L8047 KN.....
.....

Will now ensure all global charges are populated where applicable...
```

12. When the fee schedule is done loading the system will display how many records have been uploaded. This will be broken down by category and the number of codes that were loaded within the category.



```
Records updated by category
5946   SURGICAL
      26 17
      G 5912
      TC 17
4055   HCPCS
      26 22
      G 4012
      TC 21
1959   RADIOLOGY
      26 639
      G 681
      TC 639
4106   LABORATORY
      26 1290
      G 1526
      TC 1290
1809   MEDICAL
      26 288
      G 1233
      TC 288
673    DENTAL
      G 673
Enter RETURN to continue or '^' to exit:
```

### STEP 3:

Once the fee schedule has been uploaded into the Third Party Billing system, it is the responsibility of the applications coordinator (systems manager) to apply the new fees in RPMS. This is done in Third Party Billing Site Parameter Maintenance (SITM).

To set the fee schedule for all insurers follow the steps below:

- 1) Access the Third Party Billing System.
  - 2) Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.
  - 3) Choose **SITE PARAMETER MAINTENANCE (SITM)** from the Table Maintenance menu.
1. Press <ENTER> until you are at the prompt, “**CURRENT DEFAULT FEE SCHEDULE**”.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p21          |
+          Site Parameter Maintenance          +
|          INDIAN HEALTH HOSPITAL          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: LUJAN,ADRIAN M                                     13-JUN-2017 7:56 AM

EMC File Preference.....: HOST FILE//
DEFAULT EMC PATH.....: c:\rpms\//
Facility to Receive Payments....: AREA ADMINISTRATION
//
Printable Name of Payment Site..: INDIAN HEALTH HOSP
//
Current Default Fee Schedule....: 1// 30          2016 FEE SCHEDULE (1/18/2016)

```

2. Enter the number of the fee schedule to be set as a default fee schedule for the location. And press <ENTER>. Type '^' to be taken back to the Table Maintenance Menu.  
**Note:** If a new fee schedule entry was created, type the number of the new schedule that was created in Step One. Type '??' and press <ENTER> for a list of available entries.

```

Select FEE SCHEDULE: 1// ??

Choose from:
1      IHS 1995 STANDARD FEE SCHEDULE
2      MEDICARE O/P SURGERY
3      NM MEDICARE 2001 FEE SCHEDULE
4      2002 RBRVS FEE SCHEDULE
5      2003 FEE SCHEDULE (3/26/03)
6      2004 FEE SCHEDULE (9/10/03)
7      MEDICAID DENTAL FEE SCHEDULE
8      MEDICAID FLAT RATE
9      2005 FEE TABLE (2/17/05)
10     MEDICAID T1015 FEE
22     2006 FEE SCHEDULE (2/17/05)
23     2007 FEE SCHEDULE (9/12/2006)
27     2009 INGENIX FEES (2/10/09)
29     2011 FEE SCHEDULE (05/14/2011)
30     2016 FEE SCHEDULE (1/18/2016)

You may enter a new 3P FEE TABLE, if you wish

Select FEE SCHEDULE: 1//

```

## SETTING THE FEE SCHEDULE FO A SPECIFIC VISIT TYPE

If a default fee schedule has been applied to a visit type for a particular insurer where procedure coding has been set to CPT or ADA, the visit type for that insurer will also need to be updated.

To set the fee schedule for a specific visit type, follow the steps below

- 1) Access the Third Party Billing System.
- 2) Choose **TABLE MAINTENANCE (TMTP)** from the Main Menu.

- 3) Choose **INSURER FILE MENU (INTM)** from the Table Maintenance menu
- 4) Choose **ADD/EDIT INSURER (EDIN)** from the Insurer File menu

1. Press <ENTER> to edit an existing insurance.

```

+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
|  THIRD PARTY BILLING SYSTEM - VER 2.6p11  |
+      Add/Edit Insurer      +
|  INDIAN HEALTH HOSPITAL  |
+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+--+
User: STOUT,CINDY              5-JUL-2013 10:21 AM

WARNING: Before ADDING a new INSURER you should ensure that it
does not already exist!

Select one of the following:

1    EDIT EXISTING INSURER
2    ADD NEW INSURER

Select DESIRED ACTION: 1//<ENTER>

```

2. Type the Insurance name and press <ENTER>

```

Screen-out Insurers with status of Unselectable? Y//<ENTER>

Select INSURER: INSURANCE NAME
( INSURANCE NAME )

The following word was not used in this search:
INS
.
INSURANCE NAME      - 2500 LEAD AVE NW      Domain: NM
ALBUQUERQUE, NM 87110

OK? Y// YES

```

3. Press <ENTER> until you get to the prompt, '*Select Visit Type*'

```

<----- MAILING ADDRESS ----->
Street...: 2500 LEAD AVE NW Replace
City.....: ALBUQUERQUE//
State....: NEW MEXICO//
Zip Code.: 87110//

<----- BILLING ADDRESS ----->
(if Different than Mailing Address)

```

**Billing Office.:****Street.:****City...:****State...:****Zip.....:****Phone Number.....: (800)999-0963//****Contact Person.....: PAT//****Federal Tax ID#.....: 850392039//****AO Control Number..:****Insurer Status.....: BILLABLE//****Type of Insurer....: PRIVATE//****All Inclusive Mode.:****Backbill Limit (months):****Dental Bill Status.: ONLY DENTAL VISITS ARE BILLABLE//****Rx Billing Status.: UNBILLABLE//****Select CLINIC UNBILLABLE:****EMC SUBMITTER ID:****EMC PASSWORD:****EMC TEST INDICATOR:****USE PLAN NAME?:****72 HOUR RULE:****NPI USAGE: NPI & LEGACY//****TRIBAL SELF-INSURED?:****ICD-10 EFFECTIVE DATE: OCT 1,2014//****GROUP NUMBER:****PROVIDER PIN#****Select PROVIDER:**

4. Type the Visit Type number and press <ENTER>. Press <Enter> until you are at the prompt, '*Fee Schedule*'.

**Note:** You may want to leave this field blank as the default in the Site Parameters file will take precedence over this prompt. This may save time when the next fee schedule is uploaded into the system. If the Fee Schedule is populated and you want to make this field blank, type '@' and press <ENTER>. Type 'YES' to delete the fee schedule number.

Visit Type - Description	Mode of Export	Mult Form	Fee Sched	----- Flat Rate	----- Start	----- Stop	----- Rate
-----------------------------	-------------------	--------------	--------------	--------------------	----------------	---------------	---------------

998 DENTAL	ADA-2006	NO	6				
------------	----------	----	---	--	--	--	--

**Select VISIT TYPE...: 998****...OK? Yes// YES**

**Billable (Y/N/E)....: YES//**

**Reporting purposes only:**

**Do you want to replace with another insurer/visit type?**

**Start Billing Date (create no claims with visit date before)..: //**

**Procedure Coding....: ADA//**

**Fee Schedule.....: 6// @**

**SURE YOU WANT TO DELETE? YES**

## APPENDIX B: RECOMMENDED KEY ASSIGNMENT TO PERSONNEL

This section provides recommendations for assigning keys to business office staff for daily functions in the RPMS Third Party Billing and Accounts Receivable applications.

These assignments are ‘role-based’ and are only recommendations. This will help the site to maintain compatibility with the Indian Health Service Internal Control Policy. Review and assignment of keys are subject to management and RPMS Administrator review.

### SUGGESTED USERS

This section will address the following users:

**Billing Technician** – The user who is responsible for prebilling, reviewing the claim, claims approval, claims correction or claims exporting.

**Accounts Receivable Technician** – Responsible for the posting of transactions to patient accounts, performing accounts management or working aged accounts.

**Collections Clerk** – Responsible for the collection of patient payments, generating receipts or batching of insurance or patient payments to be posted by the Accounts Receivable technician.

**Business Office Manager** – Responsible for overseeing all billing and collections activity.

**Revenue Applications Coordinator (RAC)** – responsible for application setup and maintenance.

Troubleshoots system issues and is responsible for maintaining tables such as the insurer file or adding adjustment reason codes into the system.

### BILLING TECHNICIAN

Fileman Access: **MV#**

Key Name	Description
ABMDZ ADD CLAIM MANUALLY	Allows access to manually add claims that have not been created automatically using PCC or APC data.
ABMDZ CANCEL CLAIM	Allows access to the CLAIM/BILL MANAGEMENT Menu.
ABMDZ EDIT CLAIM AND EXPORT	Allows access to the Claim Editor and Export menus.
ABMDZ MANAGEMENT	Allows access to the Claim/Bill Management menu.
ABMDZ NONPCC	Allows access to adding claims that have not been auto created through the Patient Care Component (PCC)
ABMZMENU	Allows access to the Third Party Billing system
BARZMENU	Allows access to the Accounts Receivable system. In this case, the user is allowed to view payments to aid in billing to secondary payers.
BARZUPLOAD	This key is necessary for uploading 3P bills by approval dates.

### ACCOUNTS RECEIVABLE TECHNICIAN

Fileman Access: **MV**

Key Name	Description
BARZ EAR CLAIM POSTING	This key provides access to the Post ERA Claims option located under the ERA Posting menu which is located under the Posting Menu.
BAR ERA MENU	This key provides access to the ERA Posting menu which is located under the Posting Menu
BARZMENU	This key provides access to the user level of Accounts Receivable.
BARZROLL	Locks the Rollover menu
BARZUPLOAD	This key is necessary for uploading 3P bills by approval dates.
ABMZMENU	Allows access to the Third Party Billing system
ABMDZ EDIT CLAIM AND EXPORT	Allows access to the Claim Editor and Export menus. This key is also needed to allow for the opening of the claim when rolling back the information to the Claim Editor.

Optional:

Key Name	Description
BARZDCM	Allows access to the Debt Collection Menus which allow for the setup and use of the menus.

**COLLECTIONS CLERK**Fileman Access: **MV**

Key Name	Description
BARZMENU	This key provides access to the user level of Accounts Receivable.

**BUSINESS OFFICE MANAGER**Fileman Access: **MV#**

Key Name	Description
ABMDZ ADD CLAIM MANUALLY	Allows access to manually add claims that have not been created automatically using PCC or APC data.
ABMDZ CANCEL CLAIM	Allows access to the CLAIM/BILL MANAGEMENT Menu.
ABMDZ EDIT CLAIM AND EXPORT	Allows access to the Claim Editor and Export menus.

ABMDZ ELIGIBILITY EDIT	Allows access to edit the third party eligibility information.
ABMDZ FEE SCHEDULE	Allows access to the Fee Schedule Maintenance option.
ABMDZ MANAGEMENT	Allows access to the Claim/Bill Management menu.
ABMDZ NONPCC	Allows access to adding claims that have not been auto created thru PCC.
ABMDZ PAYMENT POSTING	Allows access to the Payment Posting option.
ABMDZ TABLE MAINTENANCE	Allows access to the Third Party Table Maintenance menu.
ABMDZ UFMS SUPERVISOR	Allows access to the UFMS supervisor menu.
ABMZMENU	Allows access to the Third Party Billing system.
BARZ ERA CLAIM POSTING	This key provides access to the Post ERA Claims option located under the ERA Posting menu which is located under the Posting Menu.
BARZ ERA MENU	This key provides access to the ERA Posting menu which is located under the Posting Menu.
BARZ MANAGER	Controls access to the various manager options.
BARZ TABLE EDIT	Controls access to the Accounts Receivable table files.
BARZMENU	This key provides access to the user level of Accounts Receivable.
BARZROLL	Locks the Rollover menu.
BARZUPLOAD	This key is necessary for uploading 3P bills by approval dates.
BAR2DCM	This key locks the Debt collection Menu.

### REVENUE APPLICATIONS COORDINATOR

Fileman Access: **MV#**

Key Name	Description
ABMDZ ADD CLAIM MANUALLY	Allows access to manually add claims that have not been created automatically using PCC or APC data.
ABMDZ CANCEL CLAIM	Allows access to the CLAIM/BILL MANAGEMENT Menu.
ABMDZ EDIT CLAIM AND EXPORT	Allows access to the Claim Editor and Export menus.
ABMDZ ELIGIBILITY EDIT	Allows access to edit the third party eligibility information.
ABMDZ FEE SCHEDULE	Allows access to the Fee Schedule Maintenance option.



ABMDZ MANAGEMENT	Allows access to the Claim/Bill Management menu.
ABMDZ NONPCC	Allows access to adding claims that have not been auto created thru PCC.
ABMDZ PAYMENT POSTING	Allows access to the Payment Posting option.
ABMDZ TABLE MAINTENANCE	Allows access to the Third Party Table Maintenance menu.
ABMDZ UFMS SUPERVISOR	Allows access to the UFMS supervisor menu.
ABMZMENU	Allows access to the Third Party Billing system.
BARZ ERA CLAIM POSTING	This key provides access to the Post ERA Claims option located under the ERA Posting menu which is located under the Posting Menu.
BARZ ERA MENU	This key provides access to the ERA Posting menu which is located under the Posting Menu.
BARZ MANAGER	Controls access to the various manager options.
BARZ TABLE EDIT	Controls access to the Accounts Receivable table files.
BARZMENU	This key provides access to the user level of Accounts Receivable.
BARZROLL	Locks the Rollover menu.
BARZUPLOAD	This key is necessary for uploading 3P bills by approval dates.
BAR2DCM	This key locks the Debt collection Menu.

## RPMS Billing Keys

Printing the keys list from RPMS for billing staff:

To print the list of users and their billing keys, two reports will need to be generated. Each report will provide access information for Third Party Billing and Accounts Receivable.

Use the following steps to generate the report:

1. Select **VA FILEMAN** from the Kernel menu.
2. Choose **PRINT FILE ENTRIES**.
3. Output from what file will display. Type **NEW PERSON**.
4. Sort by will display. Type **KEYS** and press the Enter key. If multiple file entries display, select the entry that lists 'KEYS (multiple)'.
5. The 'KEYS SUB-FIELD' displays. Type **.01** or **KEY**. This allows the report to sort by the Key field.

6. The system requires a range of data to be entered. Since the Third Party Billing keys begin with the namespace of “ABM” and Accounts Receivable begin with the namespace of “BAR”, the range will need to reflect what is being selected.
  - a. To print the Third Party Billing Report, type **ABM** the ‘Start with Key’ range. Use the ‘Go to Key’ or end range of **ABZ**. This allows all ABM keys to be printed on the report.
  - b. To print the Accounts Receivable Report, type **BAR** as the ‘Start with Key’ range. Use the ‘Go to Key’ or end range of **BAZ**. This will ensure the BAR keys are captured on the report.
7. The file ‘Within Key, Sort By’ will display. Press the Enter key to bypass to the print criteria.
8. Print will display next and displays the ‘First Print Field’. Type **NAME;L25** to print the name field as a column on the report. If multiple entries display, select the field that only displays NAME and press the Enter key.
9. Type **SERVICE/SECTION;L15** at the ‘Then Print Field’ to allow the user type to print on the report.
10. Type **PROVIDER CLASS;L25** at the next ‘Then Print Field’ to allow the provider’s discipline to print on the report.
11. Type **DISUSER;L5** at the next ‘Then Print Field’. This will allow the report to display if the user is still active in the system.
12. Press the Enter key at the last ‘Then Print Field’ prompt. Bypass the next set of prompts by tying the Enter key until the ‘Device’ prompt is displayed.
13. The report will need to be imported into Microsoft Excel. This requires the report to be generated as a host file. At the ‘Device’ prompt, type **HSF** and press Enter. Consult with the RPMS Administrator at the facility if the generator of the report is unsure of the address for the Host File.
14. When naming the report, please specify the type of report generated in the title by formatting the report name:
  - a. Third Party Billing: **FACILITYNAME\_ABM\_KEYS.txt**
  - b. Accounts Receivable: **FACILITYNAME\_BAR\_KEYS.txt**
15. Export the report into Microsoft Excel.

A sample of the generated report appears on the next page.

**Report Generator Example**

Select OPTION: PRINT FILE ENTRIES

OUTPUT FROM WHAT FILE: NEW PERSON

SORT BY: NAME// KEY

1 KEY DELEGATION LEVEL

2 KEYS (multiple)

3 KEYSTROKES FROM LM WP

CHOOSE 1-3: 2 KEYS (multiple)

KEYS SUB-FIELD: .01 KEY

START WITH KEY: FIRST// ABM

GO TO KEY: LAST// ABZ

WITHIN KEY, SORT BY:

FIRST PRINT FIELD: NAME;L25

1 NAME

2 NAME COMPONENTS

CHOOSE 1-2: 1 NAME

THEN PRINT FIELD: SERVICE/SECTION;L15

THEN PRINT FIELD: PROVIDER CLASS;L25

THEN PRINT FIELD: DISUSER;L5

THEN PRINT FIELD:

Heading (S/C): NEW PERSON LIST//

STORE PRINT LOGIC IN TEMPLATE:

START AT PAGE: 1//

DEVICE: Virtual Right Margin: 80//

NEW PERSON LIST APR 30,2015 10:15 PAGE 1

NAME	SERVICE/SECTION	PROVIDER CLASS	DISUSER
------	-----------------	----------------	---------

-----

KEY: ABMDZ ADD CLAIM MANUALLY

ADAM,ADAM	BUSINESS OFFICE		
-----------	-----------------	--	--

PATRICK,PATRICK P	PHARMACY	PHARMACIST	YES
-------------------	----------	------------	-----

SITEMANAGER,SITEMANAGER	PHARMACY		YES
-------------------------	----------	--	-----

KAREN,KAREN K	ADMIN	LABORATORY TECHNICIA	YES
---------------	-------	----------------------	-----