



# Revenue Operations Manual



## Part 2

# Patient Registration

Version 2

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Department of Health & Human  
Services Indian Health Service  
Business Office

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## Part 2. Patient Registration

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# 1. Overview of Patient Registration

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 This update process is important for insuring that the manual does not become outdated.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

<b>Part</b>	<b>Title/Contents</b>
<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>Part</b>	<b>Title/Contents</b>
<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>
<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 Patient Registration

The Registration staff provides the first impression of a facility. This is the initial interaction with the patient and needs to be friendly and positive during the interview to contribute to the overall patient experience. The staff should promote patient safety and positive public relations, as this should ultimately increase community trust in the facility.

One of the key functions of the Patient Registration staff includes interviewing the patient to gather demographic and eligibility information and subsequently entering the information into the Resource Patient Management System (RPMS) or the Practice Management Application Suite (BPRM or PMAS). This is the first step of generating revenue for the facility.

Through the Registration function, the patient's visit record is created, updated, and maintained, ensuring data integrity for required reporting, billing and compliance purposes. Incomplete and/or inaccurate collection of information from the patient will adversely affect other departments by delaying various processes and creating more manual interventions (re-works) by the Business Office (BO), Health Information Management (HIM), and Purchased Referred Care (PRC).

The process of submitting claims electronically, requires complete and accurate collection of information by Registration to ensure timely and accurate billing. HIM also depends on patient registration to prevent potential duplication of patient records.

Although a particular patient may visit the facility daily, weekly, monthly or yearly, that patient's insurance, demographic, and employment information may change. Each visit presents an opportunity to verify and update facility records. The same information must be gathered from patients seeking emergency services; however, the timing and techniques may differ. Friends and family often accompany the patient and are good resources for completing the registration process.

Patient Registration lays the foundation for successfully generating revenue. A few functions/responsibilities of Patient Registration are:

- Promotes a **Positive facility image** for the entire patient visit;
- Interviews patients to obtain demographic and **eligibility information**;
- Responsible for **verifying eligibility** information from various resources, including payer portals;
- Gathers **required signatures** and documents from the patient in a timely manner;
- Updates within the RPMS system, or BPRM application, all information regarding the patient;
- Often responsible for obtaining **prior-authorizations** (pre-certification, pre-determination, pre-approval) for certain procedures, and documenting information appropriately;
- **Refers** patients to Benefits Coordinator when no evidence of insurance is provided;
- **“Check In”** process establishes the visit in the Electronic Health Record (EHR). This also establishes the “Account”;
- Identifies Coordination of Benefits (COB);
- Sequences insurance appropriately;
- **50%** of claim information comes from data input by the Patient Registration Staff. Data integrity is key to efficient revenue return; and,
- **Collects information for reporting on quality measures.**

For more information on tracking Registration performance, reference Part 1, Chapter 5, “Business Office Quality Process Improvement.”

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

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## 1.3 IHS National Registration Policy and Procedures

### 1.3.1 Policy

Individuals seeking services from an IHS facility must be registered through the RPMS or BPRM Patient Registration application.

Sites are discouraged from using mini registration, unless facilities have a defined process for creating a complete record.

### 1.3.2 Procedures

- All patients will be registered using the policy set by the facility.
  - Requests will be made for enrollment or descendant verification.
  - All fields will be completed using the coded information in the current IHS Standard Code Book.
  - Initial Purchased/Referred Care (PRC) eligibility and third party resources will be documented and appropriate letters will be signed by the individual.
- Third Party eligibility will be updated per each encounter.
- An initial interview will be conducted in a courteous and confidential manner before the patient is seen by a provider.
- When a patient has been entered/updated in RPMS or BPRM, an electronic entry is made documenting date, time and by whom the information was updated by.
- Patient's eligibility for services must be proven, accepted and stored either by paper or electronic format. This may include use of VistA imaging within the electronic record, filed within the patient paper record, or in a separate Registration File. Documents must be maintained for auditing purposes.
- If a patient does not provide adequate proof of eligibility within 30 days, the patient's classification will become non-Indian or "ineligible" until such proof has been provided. All accepted regulations concerning collection will apply to ineligible patients.
- Registration staff will establish the registration record in RPMS system, or the Graphical User Interface (GUI), BPRM (Moonwalk).
- Menu options to view or edit capability should be based on the user's need-to-know, as determined by their job responsibilities. This is also

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called “Role-Based Access.”

- Registration staff is responsible for identifying and sequencing the primary, secondary, and tertiary insurer and updating this information into the RPMS Patient Registration Package or the BPRM application for each encounter.
- A stamped “signature on file” electronic designation may be used in place of the patient’s actual signature, provided the clinic has a signed authorization on file to bill Medicare for covered services. *The “signature on file” must be updated on a yearly basis.*

For more information on treatment at a remote facility, reference the IHM Part 2, Chapter 4, Appendix A “Application for Treatment at Remote PHS Facility” which can be found on this website:

<https://www.ihs.gov/ihm/pc/part-2/p2c4-ap-a/>

## 1.4 Customer Service

Customer Service is defined as an approach to interacting with people that respects and values each person. As applied to IHS patients, the goals of customer service are to achieve optimum results in contributing to improving one’s health.

Registration is often the first contact the patient has when arriving for health care. By providing great customer service, the registration process will flow more efficiently. A bad impression could set a negative tone for the entire patient encounter.

Several suggestions include:

- Treat all patients with dignity and respect.
- Communicate effectively. Be professional and take time to answer questions. Use words patients can understand and avoid technical jargon that may be unfamiliar to patients. Communicate with compassion.
- Train staff in the registration process and make sure procedures are being followed. Encourage staff to help develop new or more efficient procedures.
- Assist patients with directions to other departments, if needed.
- Inform patients if the physician’s schedule is delayed.
- Assist patients by making appointments for multiple services on the same day.

- Contact patients who missed appointments, find out the reason, and reschedule.
- Acknowledge and respond to patient complaints or obtain assistance.
- Obtain interpreter, if needed.
- Kindly remind patients to bring in correct records, reports, etc. when scheduling future appointments.

In most instances, there will not be a problem and the registration process will go smoothly. However, when there is a problem:

- Allow the patient or customer to state the problem from his/her point of view.
- Try to understand what the patient is saying – listen first, so you will know what the problem is. This will help you address the problem.
- To validate the patient complaint, restate the problem back to the patient. “If I heard you correctly, (*restate the problem*). Do I have the problem right?”
- Regardless of if the patient is right or wrong, offer an apology – “I apologize for the inconvenience, for the misunderstanding, for the delay, etc.”
- Fix the problem if it is within your control. If you need extra help, ask your supervisor.
- If the problem cannot be fixed immediately, inform the patient the steps that will be taken to correct the problem and the communication process that will take place once the problem is corrected.
- The goal is to solve the problem for the patient and prevent it from occurring again. Everybody wins when the problem is taken care of quickly, using good customer service strategies.

## 1.5 Telephone Etiquette

Proper etiquette is essential when answering the phone or making phone calls. Staff at the facility should be trained on telephone etiquette. Proper etiquette leaves callers with a favorable impression of the department and facility. Facilities may create a policy that includes the telephone script for their staff to review while interacting with customers as a guide for telephone etiquette expectations.

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### 1.5.1 Basic Telephone Procedures

**Remember:** Etiquette is a very important element of a professional atmosphere, and phrases such as "thank you" and "please" are essential. The following are best practices for telephone etiquette:

- Make sure to answer phone calls in a timely manner, within 3 rings if possible.
- Before picking up the receiver, discontinue any other conversation or activity (e.g., eating, chewing gum, typing, etc.) that may be heard by the calling party.
- Speak clearly and distinctly in a pleasant tone of voice.
- Use a greeting that is going to give the caller the impression that we are professional and pleasant; for example, "[Department name], this is [name], how may I assist you?"
- Use the "Hold" button when leaving the line so the caller does not accidentally hear any conversations being held nearby.
- When transferring a call, be sure to speak to a representative of the department and ensure someone is available to speak while placing the customer on hold. Once you have confirmed with the transferring department, politely transfer the customer.
- If the caller has reached the wrong department, be courteous. Sometimes they have been transferred all over campus for a simple question. If possible, attempt to find out where they should call/to whom they should speak.

**Note:** Sometimes you will have several lines ringing all at once. Please remember to write down the names of the callers waiting so to avoid asking whom the caller is again.

### 1.5.2 Tips for Telephone Messages

- Ask the caller if they prefer to be transferred to the individual's voicemail instead of taking a paper message. "Would you like to be transferred to \_\_\_\_\_'s voicemail?" Do not assume that the caller would rather go to voicemail.
- Be prepared with pen and message slip when you answer the phone.
- When taking messages be sure to ask for:
  - Caller's name (ask for the correct spelling)
  - Caller's phone number (including area code) and/or extension

- Repeat the message to the caller.
- Fill in the date, time, and your initials.
- Place the message slip in the called party's inbox or in a conspicuous place in their office, such as their chair.

### **1.5.3 Handling Rude or Impatient Callers**

- Stay calm and remain courteous and polite.
- Always show willingness to resolve the problem or conflict.
- Have empathy for the caller. Their problems and concerns are important.
- If the caller is not satisfied, offer the customer to speak with a supervisor at a later time, to allow the supervisor to investigate the issue and have a solution to the problem.

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## **2. Patient Eligibility, Rights & Grievances**

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## 2.1 Patient Eligibility Criteria

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:

- 1) American Indian and/or Alaska Native. 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:
  - a) Membership, enrolled or otherwise, in an AI/AN Federally-recognized Tribe or Group under Federal supervision.
  - b) Resides on tax-exempt land or owns restricted property.
  - c) Actively participates in tribal affairs.
  - d) Any other reasonable factor indicative of Indian descent.
  - e) 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.
- 2) Eligible Non-Indians. Care and treatment of non-Indians shall be provided, in accordance with 25 U.S.C. § 1680c, 42 C.F.R. §§136.12, and 136.14, as follows:
  - a) Children. Any individual who has not attained 19 years of age; is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and is not otherwise eligible for health services provided by the IHS, shall be eligible for all health services provided by the IHS on the same basis and subject to the same rules that apply to eligible Indians. The existing and potential health needs of all such individuals shall be taken into consideration by the IHS in determining the need for, or the allocation of, the health resources of the IHS. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency [25 U.S.C. §1680c (a)].
  - b) Spouses. Any spouse, including a same-sex spouse, of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the IHS, shall be eligible for such health services if the governing body of the Indian

Tribe or Tribal Organization providing such services deem them eligible by an appropriate resolution as a class. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the IHS in determining the need for, or allocation of, its health resources [25 U.S.C. §1680c (b)].

- c) 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:
    - i. The eligible Indian, in writing.
    - ii. Determined by order of a court of competent jurisdiction.
  - d) 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).
  - e) Other non-Indian beneficiaries are described in Part 2, Chapter 4 of the Indian Health Manual (IHM), such as non-Indian employees and veterans, whom may also be authorized for limited services, as described in Part 2, Chapter 4 of the IHM.
- 3) Purchased/Referred Care (PRC). There are additional eligibility requirements for authorized PRC services. For more information, reference the Indian Health Manual (IHM), Part 2, Chapter 3, Contract Health Services (CHS) and 42 C.F.R. § 136.23] **Note:** CHS name was changed to PRC.

## 2.2 Other Eligible Categories of Patients

### 2.2.1 Commissioned Corp and Dependent Eligibility Criteria

The following identified Commissioned Corp groups may be provided direct care that is within the scope of services provided by that facility:

- Active commissioned officers
- Active commissioned officer dependents
- Retired commissioned officers
- Retired commissioned officer dependents

## 2.2.2 Non-Indian Federal Employees (PHS Field Employees)

Non-Indian Federal employees are eligible for emergency treatment for on-the-job injuries.

At remote facilities Non-Indian Federal employees are eligible for medical services as defined in Public law 90-174 amended Section 324 of the Public Health Service Act, as follows:

“The CEO is authorized to provide medical, surgical, and dental treatment and hospitalization and optometric care for Federal employees (as defined in section 8901(1) of title.5 of the United States 80 Stat. 600. Code) and their dependents at remote medical facilities of the Public Health Service where such care and treatment are not otherwise available...”

The following facilities are designated as remote facilities:

Remote Hospitals	
PHS Alaska Native Hospital	Barrow, Alaska Kanakanak, Alaska Bethel, Alaska Kotzebue, Alaska Tanana, Alaska
Arizona, PHS Indian Hospital	Fort Defiance Keams Canyon Parker Sells Tuba City Whiteriver
New Mexico hospitals	Crownpoint Shiprock Zuni
Oklahoma hospitals	Talihina
Minnesota hospitals	Red Lake
Montana hospitals	Browning Harlem
Other Remote Medical Facilities	
PHS Alaska Native Health Center	Fort Yukon Nome

Other Remote Medical Facilities	
Arizona, PHS Indian Health Center	Kayenta Peach Springs
Nevada	Owyhee
New Mexico	Dulce
Montana	Lame Deer Rocky Boy's
North Dakota	Fort Yates
South Dakota	Eagle Butte Rosebud
Washington	Neah Bay Taholah
Wyoming	Fort Washakie

- At a remote medical facility, the Facility is authorized to provide the following services for **Federal employees and their dependents** that reside or work within a 30-mile radius of the remote facility:
  - Medical
  - Surgical
  - Dental Treatment
  - Hospitalization
  - Optometric care

The remote facility may also provide such services to Federal employees and their dependents, who reside or work outside of the 30-mile radius of the remote facility, AND

- who would otherwise be required to travel a greater distance from their residence or place of employment to the remote facility, *or*
- for whom transportation for private care is greater than the distance from their residence or place of employment to the remote facility, *or*
- for whom transportation for private care from their place of residence or employment is unavailable, hazardous, protracted, or unreasonably expensive, due to unfavorable factors such as unpaved or mountainous winding road or toll bridges and roads or adverse weather conditions.

The applicant will establish his status as a Federal employee to the satisfaction of the Service Unit Director.

The CEO/Facility Director is authorized to establish limitations and priorities for furnishing medical care to Federal employees and their dependents, as dictated by the primary mission of circumstances related to the provision of medical care

The CEO/Facility Director of a remote station or his designee may deny treatment of care to Federal employees and their dependents

- who cannot establish their status to the satisfaction of the CEO/Facility Director, *or*
- who cannot establish that they must otherwise travel at least thirty miles for private health services, *or*
- for whom transportation for private care is unavailable, hazardous, protracted, or unreasonably expensive due to unfavorable factors such as unusual climatic conditions, un-surfaced or mountainous winding roads, or toll bridges and roads.

A written notice of such denial will be retained at the remote facility, preferably in the persons' case folder, and a copy shall be forwarded to the Area Office.

### 2.2.3 Other Eligibility Considerations

Section 709(b) of the Indian Health Care Improvement Act, until such time as any subsequent law may otherwise provide, states that the following California Indians shall be eligible for health services provided by the Service:

- 1) any member of a federally recognized Indian tribe;

For more information on a list of eligible tribes, reference the Federal Register, Part II Department of the Interior, Bureau of Indian Affairs, Volume 83, No. 141 /Monday, July 23, 2018 / Notices: "Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs"

To view this notice in text or PDF format, go to this website:

<https://www.federalregister.gov/documents/2018/07/23/2018-15679/indian-entities-recognized-and-eligible-to-receive-services-from-the-united-states-bureau-of-indian>

- 2) any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is
  - a) living in California,

- b) a member of the Indian community served by a local program of the Facility, and
  - c) regarded as an Indian by the community in which the descendant lives;
- 3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California; and,
  - 4) any Indian in California who is listed on the plans for distribution of assets of California Rancherias and reservations under the Act of August 18, 1958 (72 STAT. 619), and any descendant of such an Indian. Section 709 (c) [which] states that nothing in this Section may be construed as expanding the eligibility of California Indians for health services provided by the Facility beyond the scope of eligibility for such health services that applied on May 1, 1986.

Indians adopted by non-Indian parents must meet all PRC requirements to be eligible for care, that is, reside in a Contract Health Services Delivery Area/Purchased Referred Care Delivery Area (CHSDA/PRCDA).

**Foster/Custodial Children** – Indian children who are placed in foster care outside a CHSDA/PRCDA by order of a court of competent jurisdiction and who were eligible for PRC at the time of the court order shall continue to be eligible for PRC while in foster care.

Section 813 of the Indian Health Care Improvement Act, P.L. 94-437, as amended, states in part:

- 1) Any individual who:
  - a) has not attained 19 years of age,
  - b) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian, and
  - c) is not otherwise eligible for the health services provided by the Facility, shall be provided by the Facility on the same basis and subject to the same rules that “apply to eligible Indians until such individual attains 19 years of age.”
- 2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe of the eligible Indian.

A non-Indian member of an eligible Indian's household who resides within a Purchased/Referred Care Delivery Area (PRCDA) is eligible for PRC if the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease, which constitutes a public health hazard.

**Note:** Indian people, who are eligible for tribal membership but who do not wish to exercise their membership eligibility for whatever personal reasons they may have, are free to make this choice. However, it is the responsibility of these individuals to provide the necessary eligibility information to receive ongoing services at IHS. The IHS can assist with this process by providing information on the requirements to document tribal enrollment or descentance.

## 2.3 **Determination of the Degree of Indian or Alaska Native Blood**

A Certificate of Degree of Indian or Alaska Native Blood (CDIB), or proof of eligibility document, certifies that an individual possesses a specific degree of Indian blood of a federally recognized Indian tribe(s). A Tribe or Bureau of Indian Affairs official issues the CDIB. The Certificate is issued to establish the individual's eligibility for those programs and services based on their status as American Indians and Alaska Natives.

### 2.3.1 **Computation of the Degree of Indian Blood**

The degree of Indian blood is computed from lineal ancestors of Indian blood, who were enrolled with a federally recognized Indian tribe or whose names appear on the designated base rolls of a federally recognized Indian Tribe. Staff members are allowed to enter "UNSPECIFIED" in the blood quantum field box if the patient's blood degree is unavailable.

To calculate your total Indian blood degree, add together your blood degree obtained from your birth mother and your blood degree obtained from your proven birth father.

#### **Examples:**

- One-half of the Indian blood is obtained from each of your birth parents.
- One-half of the Indian blood is from your birth mother.

If your grandmother was full blood, your mother obtained one-half Indian blood from your grandmother; and if your mother obtained no Indian blood through her father, you obtain only one-fourth Indian blood from your mother.

- One-half of the Indian blood is obtained from your birth father.

If you were born out of wedlock, then you obtain one-half of the Indian blood from your birth father only if his identity is proven.

**Note:** An adoptive parent is not a lineal ancestor and blood degree cannot be derived from an adoptive parent.

### 2.3.2 Obtaining a Certificate of Degree of Indian or Alaska Native Blood

Requirements include the following:

- The relationship to an enrolled member(s) of a federally recognized Indian tribe must be demonstrated. A certified copy (with state seal) of a Birth Certificate is required.
- The maiden names of all women listed on the Request for CDIB must be documented.
- In the case of adoption, the descendant or enrollment information of natural (birth) parents must be proven.

Contact your local Tribal agency to obtain a Certificate of Degree of Indian Blood (CDIB) and specific requirements.

## 2.4 Patient Rights and Grievances

### 2.4.1 IHS Policy

Each Indian Health Service Area will develop and implement a written statement of patient rights. Such statements of patient rights should be developed in cooperation with the Area Indian Health Boards and must have their concurrence.

At the minimum, these statements must include an affirmation of the patient's rights to:

- Services, within their availability or capability of being provided;
- Considerate and respectful treatment;

- 
- Privacy and confidentiality of medical information;
  - Information on his or her condition, including the right to give or withhold consent for treatment, referral, or transfer;
  - Continuity of care and information regarding what health services are available, and where and how they may be obtained;
  - Knowledge of hospital rules and regulations applying to patient conduct;
  - Access to an established patient grievance procedure;
  - Selection of an interpreter when requested and available.

Each Area will have in place a mechanism to ensure that patient grievances are given full and fair consideration to the highest level of appeal. The Area's grievance procedure will include a provision that a designated grievance committee exists at each Facility. This committee may be the local Indian Health Board, or it may be another group or committee that includes Indian representatives and has been approved for this purpose by the local tribal government and Facility Administration.

Ultimate appeal at the local level will be to the CEO/Facility Director, who must initiate an investigation and provide a written reply, both, within specified periods of time. Unresolved complaints may then be appealed to Area Health Board and/or the Area Director. The Area Director will make final decisions.

The Area will insure that each Facility has a positive mechanism for disseminating information on patient rights and the grievance process. At the minimum, written explanations of the grievance process and patient rights must be:

- Posted prominently in the waiting areas of all IHS facilities.
- Periodically distributed to the community.
- Included in the orientation process for all new IHS staff.

## **2.4.2 Example of Patients' Rights Statement**

Each patient has a right to:

- **Access to Care**

Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources for payment of care.

- **Respect and Dignity**

The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his or her personal dignity.

- **Privacy and Confidentiality**

The patient has the right, within the law, to personal and informational privacy, as follows:

- To refuse to talk with or see anyone not officially connected with the hospital/clinic, including visitor or persons officially connected with the hospital/clinic but not directly involved in his or her care;
- To wear appropriate personal clothing and symbolic items, as long as they do not interfere with diagnostic procedures or treatment;
- To be interviewed and examined in surroundings designed to ensure reasonable visual and auditory physical examination, treatment, or procedure performed by a health professional of the opposite sex, and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe;
- To expect that any discussion or consultation involving his or her case will be conducted discreetly and that individuals not directly involved in his or her care will not be present without the patient's permission;
- To have his or her health record read only by individuals directly involved in his or her treatment, or in the monitoring of its quality. Other individuals can only read the patient's health record on his or her written authorization or that of his or her legally authorized representative;
- To expect all communications and other records pertaining to his or her care, including the source of payment for any treatment, to be treated as confidential;
- To request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing the patient by any actions;
- To be placed in protective privacy when considered necessary for personal safety.

- **Personal Safety**

The patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.

- **Identity**

The patient has the right to know the identity and professional status of individuals providing service to him or her and to know which provider or other practitioner is primarily responsible for his or her care. This includes the patient's right to know the existence of any professional relationship among individuals who are treating him or her, as well as the relationship to any other health care or educational institutions involved in the patient's care. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

- **Information**

The patient has the right to obtain from the practitioner responsible for coordinating his or her care, complete and current information concerning the patient's diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms that the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

- **Communication**

The patient has the right of access to people outside the hospital by means of visitors and by oral and written communication. When the patient does not speak or understand the language of the community, he or she should have access to an interpreter.

### **3. Direct Care and Purchased/Referred Care (PRC)**

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## 3.1 Direct Care Services

A person may be considered within the eligibility scope of the Indian Health Program if he/she is not otherwise excluded by provision of law and is of American Indian and/or Alaska Native descent, as evidenced by the specific criteria stated in Section 2.2 of CFR 42, 36 & 36A.

### 3.1.1 Direct Care Policy

It is the policy of IHS to ensure that needed health services are available to each person who is eligible for the IHS Program. The IHS is primarily responsible for:

- Providing all direct services available at an IHS facility to any eligible person;
- Verifying and entering alternate resources, which include Medicare, Medicaid, Private Insurance, State Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI), Veterans Administration, and other State, Federal, and private sources;
- Coordinating services to all persons within the scope of the Indian Health Program from existing sources;
- Identifying and determining whether or not the eligible person may be eligible for any alternate resource, which includes County, State or Federal programs, such as Medicaid, SCHIP; Medicare, Veterans Administration Hospital, U.S. Army, Air Force, Navy, Public Health Service Hospitals, and others; official or voluntary health organizations; employee health insurance; accident insurance; or other third party liability carriers;
- Assisting in the application process of any identified alternate resource if requested;
- Billing all third party payers and recording revenue in compliance with the Accounts Receivable policy.

### 3.1.2 Provision of Direct Care Services

Medical care and treatment services including hospitalization are provided as available in IHS facilities or on a referral basis for eligible persons in accordance with the Purchased/Referred Care (PRC) funding and priorities.

The preventive and health promotion services at all facilities shall be made available to all persons within the scope of the Indian Health Program. As part of such service, those persons who are able and willing to utilize local Indian Health Service community preventive health services will be encouraged to do

so.

When care from a Purchase/Referred Care vendor is necessary, by Law IHS must first use alternate resources, if they are available. If an alternate resource may be available, IHS is required to refer the patient to make application for the resource, for example, Medicaid. Based on the determination of the application, a decision will be made whether or not IHS will make a Purchase/Referred Care (PRC) payment. The patient must provide proof of any alternate insurance application or denial.

In the event the individual's condition is such that immediate care and treatment are necessary, services may be provided pending determination of whether or not the individual is within the scope of the program criteria and whether or not he is within the appropriate priority level. In these cases, a medical referral is made without authorization for payment.

If a patient is not PRC eligible, IHS still has the obligation to initiate a referral to a non-IHS facility or provider. In such cases IHS is not obligated to make payment to the non-IHS facility or provider; the patient is responsible for the payment.

When alternate resources are available to the patient, the Facility will require use of such services prior to authorizing any IHS resources and will maintain relationships with agencies to facilitate the utilization of those resources. Every effort should be made to make the most effective use of alternate resources, including other Federal medical facilities whenever appropriate.

The cost of medical and related health services for persons in the custody of (non-Indian) law enforcement agencies is not the responsibility of the IHS, but is the responsibility of that particular agency. Payor of Last Resort, 42 C.F.R. & 136.61 and IHS Right of Recovery against Non-State Entities, 25 U.S.C.A. & 1621e.

### 3.1.3 Denial of Direct Care Services

The Service Unit Director or designee may deny services to persons who according to their determination do not meet the eligibility criteria of the IHS program. For more information on eligibility criteria of the IHS program, reference Part 1 of the ROM "Administration Roles and Responsibilities:" <https://www.ihs.gov/businessoffice/rom/>

A copy of each notice of denial will be retained at the IHS facility, in the patient's record, with a copy forwarded to the Area Director's Office.

**Note:** If a non-eligible patient presents for emergency care, appropriate triage

and assessment services will be provided according to the Emergency Medical Treatment and Labor Act (EMTALA) Regulation. The non-eligible patient will be responsible for the care provided. The services will be billed to the patient and follow the debt management policy of the Facility.

## 3.2 Purchase/Referred Care (PRC)

Purchase/Referred Care (PRC) services are provided by referral providers outside the IHS direct care system. Determination of Eligibility for the PRC program is the joint responsibility of the Patient Registration and PRC staff. This program has its own set of Laws, regulations and policies. For more information on PRC Eligibility Requirements, reference this website: <https://www.ihs.gov/ihs/pc/part-2/p2c3/#2-3.6G>

An Indian is not required to be a citizen of the U.S. to be eligible for PRC. The Indian (Canadian or Mexican) must:

- Reside in the U.S., *and*
- Be a member of a tribe whose traditional land is divided by the Canadian border (e.g., St. Regis Mohawk, Blackfeet) or Mexican border (e.g., Tohono O'Odham).

### 3.2.1 Purchase/Referred Care Policy

If the patient requires services outside of IHS and the alternate resource cannot or will not provide the necessary assistance, the facility may provide services by referral, based on the PRC medical priorities and funding criteria.

Eligible persons, within the scope of the Indian Health program in one Area, will be provided available medical and/or other related direct services by any other IHS facility or Area via referral. For services provided outside IHS direct care, the authorization or denial of Purchase/Referred Care shall be the responsibility of the Facility in which the services are rendered. The Area in which the services are rendered shall apply the same policies and have the same notification requirements for persons from other Areas as are applied to those persons within the Area.

### 3.2.2 Provision of Purchase/Referred Care

All direct services available at any IHS facility will be provided as needed to any eligible person. Services needed but not available as direct service at the facility will be provided through the Purchase/Referred Care Program, depending on:

- the person's medical need as determined by a physician whenever possible
- the actual availability and accessibility of alternate resources
- the financial resources available to the service facility at that time
- PRC applicable program eligibility, medical priorities, and funding criteria

Purchase/Referred Care services are divided into five levels of services, based on medical priority, as discussed in Part 2, Chapter 3, Section 3.3, "PRC Medical Priority Criteria" below.

### 3.3 PRC Medical Priority Criteria

PRC Services are divided by medical priority into five levels of services:

- Level I – Emergent/Acutely Urgent Care Services
- Level II – Preventive Care Service
- Level III – Primary Secondary Care Services
- Level IV – Chronic Tertiary and Extended Care Services
- Level V – Excluded Services

For more information related to PRC medical priority, reference the Indian Health Manual, Part 2, Chapter 3 "Contract Health Services Medical Care," which is available at this website:

<https://www.ihs.gov/i hm/pc/part-2/p2c3-ex-d/#3-1>

#### 3.3.1 Level I – Emergent/Acutely Urgent Care Services

Emergency and/or acutely urgent care services include those diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which because of the threat to the life or health to the individual, necessitate the use of the most accessible health care facility that is available and capable of furnishing such services. Also included are diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Categories of service include:

- Emergency room care for emergent medical conditions, surgical conditions, or trauma

- 
- Emergency inpatient care for emergent medical conditions, surgical conditions, or acute injury
  - Acute and chronic renal replacement therapy
  - Emergency psychiatric care involving suicidal persons or those who are a serious threat to themselves or others
  - Services and procedures necessary for the evaluation of potentially life-threatening illnesses or conditions
  - Obstetrical deliveries and acute perinatal care
  - Neonatal care

### **3.3.2 Level II – Preventive Care Service**

Preventive care service includes primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention). Level II services are available at most IHS facilities.

Categories of service include but are not limited to:

- Routine prenatal care
- Non-urgent preventive ambulatory care (primary prevention)
- Screening for known disease entities (secondary prevention)
- Screening mammograms
- Public Health interventions

### **3.3.3 Level III – Primary and Secondary Care Services**

Primary and secondary care services include those inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Categories of services include:

- Scheduled ambulatory services for non-emergent conditions
- Specialty consultations in surgery, medicine, obstetrics, gynecology,

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pediatrics, ophthalmology, ENT, orthopedics, and dermatology

- Elective, routine surgeries that have a significant impact on morbidity and mortality
- Diagnostic evaluations for non-acute conditions
- Specialized medications not available at an IHS facility, when no suitable alternative exists

### **3.3.4 Level IV – Chronic Tertiary and Extended Care Services**

Chronic tertiary and extended care services are those inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities. These services are not readily available from direct care IHS facilities.

Careful case management by the facility PRC committee is a requirement, as is monitoring by the Area Chief Medical Officer (CMO), or his/her designee. Depending on cost, the referral may require concurrence by the CMO.

Categories of service include:

- Rehabilitation care;
- Skilled nursing facility (Medicare defined);
- Highly specialized medical services/procedures;
- Restorative orthopedic and plastic surgery;
- Other specialized elective surgery such as obesity surgery;
- Elective open cardiac surgery; and,
- Organ transplantation (HCFA/CMS approved transplants only).

### **3.3.5 Level V – Excluded Services**

Excluded services and procedures that are considered purely cosmetic in nature, are experimental or investigational, or have no proven medical benefit are classified excluded. This list will be reviewed and updated on an annual basis.

Excluded Services – Categories include:

- All purely cosmetic (not reconstructive) plastic surgery;

- Procedures defined as experimental by CMS;
- Procedures for which there is no proven medical benefit, procedures listed as Not covered in the Medicare Coverage Issues Manual; Rehabilitation care; <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r164cim.pdf>;
- Extended care nursing homes (intermediate or custodial care); and,
- Alternate medical practices (e.g., homeopathy, acupuncture, chemical endarterectomy, naturopathy).

**Note:** Limitations of funds, facilities, or staff may result in different levels of direct services available at IHS facilities.

## 4. Registration, Discharge, and Transfer

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## 4.1 About the Health Record

The health record is a legal document and should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data.

The Health Record documents chronologically the care of the patient. The health record documentation contains pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. For more information, reference IHM Part 3, Chapter 3 "Health Information Management" which can be found at this website:

<https://www.ihs.gov/IHM/pc/part-3/p3c3/#3-3.2B>

The health record facilitates:

- The ability of the provider and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time
- Communication and continuity of care among providers and other health care professionals involved in the patient's care
- Accurate and timely claim review and payment
- Appropriate utilization review and quality of care evaluations

The health record needs to substantiate the codes billed to the insurer.

### 4.1.1 Health Record Number (previously Medical Record Number)

As defined in the *Indian Health Manual* (3-3.5D,2):

"Health Record Number (HRN): A unique health record number is assigned to each patient's record when they first register, whether outpatient, inpatient, newborn, emergency patient, community health patient, school student, or PRC beneficiary. The health record number is used to identify patients' records and the documents filed in them. The reissue of an assigned number is strictly prohibited."

### 4.1.2 Health Record Chart/Folder

Each Health Record established will contain the following information. Requirements for the Health Record may be found in the *Indian Health*

*Manual:*

- Hospital Facilities Health Record Format, *Indian Health Manual* (3-3.8L)
- Health Centers Health Record Format, *Indian Health Manual* (3-3.8M)

Electronic or paper health records will be identified with:

- Patient Name – Last, First, and Middle Initial – (this should be the legal name, e.g., Rebecca, not “Becky,” William, not “Bill”) on top
- HRN (terminal digit) on the side and top tab along with the back of the chart cover

## 4.2 Temporary Health Record Number Assignments

**Note:** Temporary HRNs should only be assigned if the facility has a defined policy and process in place for assigning a permanent number.

Temporary numbers (“T” numbers) are usually assigned to individuals who are:

- walk-ins without a previous HRN;
- emergencies;
- newborns; or,
- transfers to the clinic that do not have an existing HRN.

In order to treat that patient on the date they present, a temporary number is issued to the patient record.

Temporary numbers are also issued to patients who call in for an appointment and are not yet registered (new patients). This acts as a placeholder in the scheduling package.

A temporary number is issued from the **Patient Mini-Registration** option via the **RPMS or BPRM Scheduling** or the **RPMS Emergency Room** applications. This will be used only after a thorough search of the record is done to avoid duplication.

The RPMS Patient Registration and the BPRM application consider anyone with a temporary number to be an incomplete record and will issue a message to Registration. After reviewing the report of temporary numbers from RPMS, a new, permanent HRN from the next available number on the Number Control Log should be assigned and the information updated in the system. The Number Control Log is a permanent log (paper or electronic) of unit

numbers issued at a facility that will be maintained and contain the patient's name, registration date, and date of birth. HRNs will be issued according to Facility policy. The Number Control Log form (IHS-209), may be used.

#### 4.2.1 Clean Up Process for Temporary Health Record Numbers

Assigning a permanent HRN should be done as soon as possible, since temporary chart numbers are not exported to the National Data Warehouse (NDW).

- Identify the patient records that contain a temporary HRN.
  - Go to the **Patient Registration Reports Menu** (REG > PTRG > RPT).
  - Access the **Print Patient with TEMPORARY CHART NUMBERS** (TEM) option.
  - Print a list of patients that have a temporary chart number.

Temporary chart numbers are identified as a “TNNNNN” where the “NNNNN” is a temporary number usually beginning with 00001.

- Compare the patient entry on the TEM report to the Patient Registration database.
  - Use the **SCAN the patient files** option (REG > PTRG > SCA), and check against:
    - Active patients
    - Inactive or deceased patients
    - Patient charts at other locations in the same database
  - Check if the patient may be a duplicate in the system by comparing:
    - Date of birth
    - Mother's maiden name
    - Current Community
- If the patient is identified as a unique entry, ensure that the mandatory fields in the patient's record are completed, and then request a new HRN from the department responsible for assigning the HRN.
- If the patient is identified as a duplicate entry (temporary number assigned to an existing patient), it is easier to print a face sheet of the duplicate patient entry (usually it is the one that has the temporary chart number)

and combine the two entries together.

This is a manual process, comparing fields from one chart entry to the other and transferring data to the correct patient. When moving the data is completed, the staff can inactivate (INA) the duplicate chart. An additional step could be to change the name (NAM) on the duplicate chart, and then proceed to inactivate it.

## 4.3 Master Patient Index (MPI)

A permanent current Master Patient Index (MPI) will be maintained by each facility using the paper IHS-198 form or electronically within RPMS Patient Registration package or BPRM application. The Patient Index Card form (IHS-198), may be used and filed alphabetically by the patient's last name. This alphabetical index of patients is key to the identity and location of the health records and may be paper or electronic. Update a patient's name change in the RPMS Patient Registration package or BPRM application and ensure that the MPI index card is cross-referenced with the patient's former name. The MPI will be monitored according to local policy and/or Part 2, Chapter 4, Item 4.3, Revenue Operations Manual, on the IHS Website: <https://www.ihs.gov/businessoffice/rom/>.

The MPI is also used to find inactive patients who were treated at the facility but never registered. The original number should then be used, and a new chart established.

### 4.3.1 Number Control Log

A permanent log (paper or electronic) of unit numbers issued at a facility will be maintained and contain the patient's name, registration date, and date of birth. HRNs will be issued according to Service Unit policy. The Number Control Log form (IHS-209), may be used as a backup during system failures. For more information, reference Part 2, Chapter 6 "Patient Registration System" in the Indian Health Manual: <https://www.ihs.gov/ihm/pc/part-2/p2c6>.

### 4.3.2 Health Information Exchange (HIE)

Authorized users of the IHS HIE shall follow procedures for PHI though the use of the HIE web-based application. All data in the central IHS HIE database will be accessible by authorized users of the MPI and IHS HIE. This section establishes the procedures for Indian health system participation in

accessing and sharing data over the IHS HIE and national Exchange provided by HealtheWay. The IHS HIE service will facilitate access to the Exchange through the IHS CONNECT gateway. The IHS HIE and Exchange will enable health information to follow the patient, be available for clinical decision-making, and support appropriate use of healthcare information to improve population health.

The HIE is a system that provides a service to collect, store, query, and retrieve patient health summary information in the form of a consolidated clinical document or successor format, exported from the IHS RPMS facilities or other healthcare systems meeting the interface requirements. The IHS HIE provides user access to summary health record information from multiple Indian Health facilities utilizing RPMS databases and other connected state and regional HIE communities from across the country.

For more information, reference the Part 8, Chapter 23 “Resource and Patient Management System Network” in the IHM: <https://www.ihs.gov/ihm/pc/part-8/p8c23/>

The Enterprise Master Patient Index (EMPI) generates a unique patient ID, called an Enterprise User Identifier (EUID), to consolidate the patient list from the various RPMS databases at all IHS facilities. The EMPI is required for HIE within the IHS.

The MPI identifies patients across separate clinical, financial and administrative systems and is needed for information exchange to consolidate the patient list from the various RPMS databases.

The MPI contains records for all the patients from all IHS facilities. They are supplied by RPMS in HL7 messages. Each facility record belongs to an enterprise record, which is created by the MPI. Two facility records that represent the same real-life person belong to the same enterprise record. An enterprise record contains its own set of patient demographics called the Single Best Record, which is calculated from the demographics data of its facility records. The MPI generates a unique patient ID, called an EUID, for each enterprise record.

### 4.3.3 Network Services

The network services establish the process for patients to access and interact with their health information through a secure Internet IHS Personal Health Record (PHR) application. The IHS PHR is intended to improve the overall health of patients by improving patient and provider collaboration, allowing patient self-management, and increasing patient access to health information.

The IHS PHR provides a secure web-based application where patients can interact with their healthcare information from all medical facilities that utilize the RPMS and associated EHR. Additionally, patients will have access to health education, health assessments, and electronic services online. The IHS PHR registration process may be initiated at the patient's request at a facility that utilizes RPMS.

There are network services that may be available including MPI, HIE, and PHR. For more information, reference Part 8, Chapter 15 “Network Interconnection” in the IHM: <https://www.ihs.gov/ihm/pc/part-8/p8c15/>

## 4.4 Legal Health Record Change Requests

Requests for changes to the legal health record need to be coordinated with Health Information Management (HIM).

### 4.4.1 Legal Name Change

On request from the patient, a name will be changed on the health record of the patient after valid document(s) have been presented. Such examples include:

- Birth certificate
- Marriage license
- Court order/Divorce decree stating the name change

A legal name change/correction request form will be completed. For more information on an example of this form, reference Part 2, Appendix, “Name Change/Date-of-Birth Correction Request Form.”

Patient demographic information updates will be completed to reflect the name change for Assignment of Benefits form and Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement of Receipt of the Notice of Privacy Practices (NPP). Changing the name will not update the insurance eligibility information.

Supporting legal documentation may be scanned into VistA Imaging based on local policy or filed in the health record.

### 4.4.2 Birth Date Change

On request from the patient, the date of birth on the health record will be changed upon receipt of an original certified state birth certificate, driver's

license, or other acceptable documentation. Documentation may be scanned into the patient health record file. Sites may scan administrative records for eligibility, legal changes, such as name changes, etc. However, there needs to be distinct policies for administrative and clinical records that will be releasable.

If the patient's date of birth in the third party payor eligibility files is different than the existing or corrected date of birth in the patient demographics information, the patient should notify his/her third party payor of the change to his/her date of birth.

**Note:** Never change the demographic date of birth to match the third party payor date of birth.

A birth date correction request form will be completed. For an example of this form see Part 2, Appendix, "Name Change/Date-of-Birth Correction Request Form."

## 4.5 New Patient Registration

All patients must be registered in the **RPMS Patient Registration package or BPRM** application before care is rendered, with the exception of emergency services. On subsequent encounters, each patient's demographic and third party information must be updated or validated. For more information on subsequent encounters, reference Section 4.6 – "Established Patient Registration."

- Upon completion of the triage process and/or check-in at the clinic, the patient will be directed to the appropriate waiting area – either centralized Patient Registration area or by clinic, for the establishment of the Health Record.
- Prior to creating a new health record, patient registration staff will thoroughly scan the RPMS database through BPRM or "roll and scroll" using the SCAN/ALL option, to search for the patient (looking at criteria such as similar names or DOB). This avoids duplication of the health record.
- The new patient will be added to the RPMS database using the Patient Registration "ADD a new patient" option, or the "Register Patient" function in the BPRM.

A new HRN will be assigned if no existing file is found. The RPMS system may be used to generate the HRN for a facility, or by using the "Number Control Log" Form, IHS-209. The HRN should be

tracked/reviewed manually offline, as careful management of the HRN is important as it impacts patient safety and billing. The facility should have a process to issue HRNs, cross reference and validate. The HRN is used to identify the patient's record and all material filed therein.

- The patient's health record will be updated with registration information and all documents verified and scanned at the time of the interview, or according to the VistA image scanning policy for the facility. Examples of documents for verification may include: Social Security Card, Birth Certificate, Identification Card, and Certificate of Tribal Enrollment. Facilities should determine a contingency policy for scanning of documentation to address system down time. For more information, reference the Part 2, Appendix, "One Time Visit Letter" for an example of a 30-day letter for a Notice to Patient: Incomplete Record.
- It is very important to verify the patient's eligibility in a federally recognized tribe by reviewing their Certificate Degree of Indian Blood (CDIB) with the list in the Code of Federal Regulations (CFR). To ensure this, patients will be informed to bring in all missing documents on their next visit. Make sure there is a process in place for following up on missing documents or changing eligible to ineligible if the patient does not provide the information.
- The following forms and signatures will need to be completed:
  - Assignment of Benefits
  - Acknowledgement of Receipt of the Notice of Privacy Practices
  - Notification to provide proof of Tribal enrollment if valid document is not present
  - Medicare Secondary Payor (MSP) Questionnaire (for Medicare patients only)
- Any other information that cannot be entered on any page needs to be entered on the Notes page of the Patient Registration application.
- Beginning in 2006-2007, IHS transitioned from their legacy system to the National Data Warehouse and with the transition came a streamlining of exports. Before, it was expected that sites transmitted exports from every package (Registration, PCC, dental, CHS, CHR, and BHS). Now, PCC and Patient registration are rolled into one BDW export file and any package that has a link to PCC has encounter data transmitted as well. For example, CHS workload data are transmitted along with the PCC and Patient Reg data in the BDW export file. Sites are still asked to run separate exports from the CHR, CHS (except if that site uses the fiscal intermediary), and behavioral health as there are data contained in those export files that aren't captured in the BDW export (e.g., purchase order

information in CHS, PHN drive time in CHR, and suicide reporting forms in BHS). The following fields in the RPMS Patient Registration application must be completed for exporting purposes:

Patient Registration Field Name	Notes
Registering Facility Code	Required for CHART_FAC_CD field.
Health Record Number	Necessary to generate integrity IDs and to unduplicate registrants for HQ user population.
First Name	Required if no Middle Name is provided
Middle Name	Required if no First Name is provided
Last Name	Required for unduplication
Birth Date	Required for unduplication
Gender Code	Required for unduplication
Social Security Number	Required for unduplication
Beneficiary Classification Code	Required for AI/AN status along with Tribe code and blood quantum
Tribe Code	Required for AI/AN status along with BCC and blood quantum
Blood Quantum Code	Required for AI/AN status along with Tribe code and BCC
Community of Residence Code	Required to determine which CHSDA/PRCDA the AI/AN registrant resides in

- On completion of the interview, Patient Registration staff will assemble the documents into the health record by scanning through VistA or filing within the health record.
- At most facilities, patient registration will check the patient into the clinic. This check-in process creates or opens the visit in EHR.
- In other facilities, patient registration will check the patient into the clinic at the facilities discretion.
- The patient will be directed to the clinic or the waiting room of the clinic.

## 4.6 Established Patient Registration

Demographic and third party information must be updated or verified at each patient encounter. The patient registration staff will update demographic information and collect all third party information during the update process, when a patient is seeking medical services.

Signatures and updates need to be completed on the following forms:

- Assignment of Benefits and Release of Information (annually).
- The HIPAA Acknowledgement Form.

When the patient reaches the age of majority, 18 years, or has a name change due to divorce/marriage or court name change, then another Acknowledgement Form should be signed and filed in the record.

- Advanced Beneficiary Notices (ABNs) at the facilities where ABN services are provided.
- Medicare Secondary Payor Questionnaire (MSPQ) should be completed every time a Medicare patient receives outpatient or inpatient services at the Facility.
- Notification to provide proof of Tribal membership (completed only if no valid documentation has been presented), if applicable.

## 4.7 Non-Beneficiary Registration

It is very important for the Registration staff to obtain identifying demographic and insurance related information on any non-beneficiary patient. Depending on the patient's condition, all information should be recorded prior to the patient being seen by the provider. However, if the situation is an emergency, the information can be obtained before the patient is ready to leave the facility. For more information, reference Part 2, Chapter 4, Section 4.14 "Non-Beneficiary Exit and Collection Process." After hours non-beneficiary registration, may require the clinical staff to gather as much patient information as possible.

The following should be performed or obtained:

- Inform the patient of their financial liability for services received
- Copy or scan the insurance card back and front
- Copy or scan of a valid driver's license
- Completed Patient Registration form; form will be utilized at the discretion of the facilities

- Demographic information to include home address and telephone number
- Name and telephone number of nearest relative not living in the same household
- Name and telephone number of an emergency contact
- Name of attending provider
- Name of guarantor, if the patient or their guardian is financially responsible
- Collection of deductible or co-payments by check, cash, or credit card, if the facility has a policy in place and setup to record collections
- Collection of total charge by check, cash, or credit card, if the patient has no insurance, if the facility has a policy in place, and setup to record collections
- Any other identifying information (auto insurance, accident related information, etc.)

Following the interview, registration services needs to complete demographic information in the RPMS Patient Registration package or the BPRM application immediately.

## 4.8 Commissioned Officers and Dependents Registration

Prior to care being rendered, all Commissioned Officers and their dependents must be registered in the RPMS Patient Registration package or BPRM application. On subsequent visits, each patient's demographic and third party information must be updated or verified.

- Eligibility requirements are the same as the requirements for a standard patient
- Patient Registration staff will update the **RPMS Patient Registration package or BPRM** application as follows:

**Page 1: Eligibility** = Direct

**Page 2: Classification** = Commissioned Officer *or* Dependent of Commissioned Officer

- Eligibility will need to be added onto Page 4 of the **Registration Editor in RPMS** or under the **Benefits tab in the BPRM** to reflect "Beneficiary Medical Patient/Program" as the insurer along with identifying information. The only exception to adding eligibility would be for those facilities located in a "metropolitan area" where the Commissioned

Officer and their Dependents are required to be seen by a Tricare provider. For these visits, Tricare may be added as insurer and billed appropriately.

- Patient Registration staff will update the Notes page of the RPMS Patient Registration package or BPRM application with the status of “Commissioned Officer” or “Dependent of Commissioned Officer.”

## 4.9 Scheduled Patient Registration

Patient registration may be centralized/decentralized depending on your site.

Patients who have an appointment will report to the appropriate Registration area on arrival at the clinic. The only difference between centralized and decentralized patient registration is the location where the patient presents.

- The Patient Registration interview questions should never be altered. All mandatory fields must be updated or validated for demographic and insurance information in the RPMS Patient Registration package or BPRM application at each encounter.
- Eligibility for insurance will be verified prior to, or at each encounter.
- Patients will be checked in using the RPMS Patient Registration package or BPRM application.
- A patient may be escorted to their appointment, if needed.
- Facilities should have a check-out process coordinated with the appropriate staff designated by the facility for:
  - Collection of deductible or co-payments by check, cash, or credit card
  - Collection of total charge by check, cash, or credit card, if the patient has no insurance
  - Collection of any other identifying information (auto insurance, accident related information, etc.)

## 4.10 Same Day Registration

All same day patients seeking health care must go through the Registration process in order to create the visit for the triage process. On completion of the triage process, the nurse will determine level of severity, and either advise the patient to wait to be seen or take directly to the exam room or emergency department. The urgency of patient care will drive the registration process. However, it is critical for the patient registration process to occur as stated above in section 4.9 “Scheduled Patient Registration.” For patient safety

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purposes, safety should always drive the facilities processes.

## 4.11 Inpatient Admissions Registration

All patients requiring hospitalization must be registered prior to, or at, the time of admission utilizing the Admission, Discharge, and Transfer (ADT) application. The admitting clerk or designee will interview the patient/family member for updated demographic and third party information, process all inpatient forms with signatures, and issue identification bands for the patient. This process should be completed within the timeline specified by the facility's policy.

It is the responsibility of the Admitting Section to ensure that all patients admitted as an inpatient or observation status are updated in the **BPRM Admitting, Discharge and Transfer (ADT)** application or the **RPMS ADT** application.

When a provider determines that a patient will be admitted, it is important that the data is entered in both the RPMS Patient Registration and ADT applications in a timely manner. This information is used by other clinical departments and other RPMS applications, and the timeliness and accuracy of the data are important for optimum patient care.

When a patient is to be admitted, the hospital staff should refer the patient and family members to the appropriate admitting staff. Staff should follow their local HIPAA policies for any restrictions for release of PHI, patient locations, etc.

### 4.11.1 Observation

Observation services include ongoing short-term treatment, assessment and reassessment to make a decision concerning a patient's admission or discharge. Observation services begin and end with an order by a physician or other qualified licensed practitioner:

- The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's health record
- The order may not be backdated
- Orders should be clear for the level of care intended, such as "place in observation"

Once an order has been received, the PR staff would admit through ADT. Be sure to follow steps outlined for the MOON below and obtain a signature.

#### 4.11.2 Medicare Outpatient Observation Notice (MOON)

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 1866(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and CAHs to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24.

All beneficiaries receiving services in hospitals and CAHs must receive a MOON no later than 36 hours after observation services as an outpatient begin. Facilities must retain the original signed MOON in the beneficiary's health record.

For more information, reference:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf>

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>

#### 4.11.3 Procedure for Patient Admission

Once Admitting is notified, the following steps should be performed.

**Note:** If the Admission is **scheduled**, some of these steps may be performed during pre-admission of the patient.

- 1) Ensure a doctor's order is on file and verify the inpatient admitting status of the patient.
- 2) Interview the patient and/or representative and update or validate the demographic information and the third party eligibility information in the RPMS Patient Registration suite or BPRM application.
- 3) If the patient is 18 years or older, ask the patient or family member if the patient has an Advanced Directive. If not, provide the patient with the pamphlet that has initial information. If the patient requests more information, notify the appropriate department to follow-up with the

patient.

- 4) Provide the patient with the hospital pamphlet on the “Patient Bill of Rights.” If the patient is a minor, give the pamphlet to the parent/guardian/legal representative of the minor.
- 5) Have the patient/parent/legal representative sign the inpatient consent form for medical treatment, if required.
- 6) After verifying all information, create the patient wristband and attach the wristband to the patient. Verify information on the armband with the patient.
- 7) If the patient has Medicare coverage, have the patient and/or representative sign an Assignment of Benefits form.
  - a) If the patient is of Medicare age, complete a MSPQ.
  - b) If the patient is on Medicare, have the patient and/or representative sign the “Important Message for Medicare” form.
- 8) If the patient has Medicare, review patient’s health record to review outpatient encounters within the 72-hour time frame. All encounters within the 72-hour timeframe need to be billed with the admission.
- 9) Submit the admitting information to the Utilization Review Coordinator or appropriate staff. They may call any Insurance Company to provide the necessary clinical information and to obtain a Pre-Certification or Prior Authorization number, if necessary. This information highlighted needs to be done prior to planned admission, or at time of admission if it is an emergency. This number will be entered in the RPMS.
- 10) If the patient is a non-beneficiary Medicare patient, provide the Advanced Beneficiary Notification (ABN) rules and have the patient sign the appropriate documents.

Additional information about ABNs may be found on the CMS website:

[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn\\_booklet\\_icn006266.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf)

#### **4.11.4 Entering Patient Data in the ADT Package**

The RPMS and the BPRM ADT applications enable the hospital to enter and

track specific clinical information on patients while they have inpatient status at the facility. The laboratory, radiology, pharmacy and other applications utilize the patient information entered in the ADT application.

- 1) The Admitting clerk will enter the data in the ADT application.

The following information is required:

- a) Patient name or Chart number or Date of birth
- b) Admit Date and Time (time order was placed)
- c) Yes or No to prompt: “Does patient wish to be excluded from the Hospital Directory?”
- d) Admit Ward and Bed Number
- e) Admit provider [may enter Referring physician (word text), Admitting and Attending Provider (may be the same provider)]
- f) Admit to Treating Specialty (e.g., General Medicine)
- g) Admit diagnosis
- h) Type of Admit (Direct, Referral, or Transfer)
- i) Admit Source (UB-04 equivalent)

## 4.12 Newborn Admission Procedure

Newborn admissions are registered utilizing the same procedure as the scheduled inpatient admission procedure for adult and pediatric patients.

- 1) This process will follow the standard admission process initially.
- 2) The birth information is created electronically by appropriate staff through the Bureau of Vital statistics.
- 3) Appropriate staff may assist the new parent by providing information for obtaining for a birth certificate. The registration process and corresponding fees may differ depending on your state. Be sure to follow your state regulations and requirements.

For emergency deliveries, or emergency department facilities, a process needs to be in place to handle these situations.

## 4.13 Discharge and Transfer Processes

A provider, nurse, the patient, or a family member may request that the patient be transferred from one place to another, one treating specialty to another, one ward to another, or one bed to another. However, the Admitting Office needs to be contacted about the request for a room change and approval from the attending physician based on level of acuity. A patient room change impacts the census reporting and needs to be actively coordinated and documented via ADT, Nursing, and the Admitting office.

Transfers may also occur from one facility to another. The admitting office staff needs to coordinate the transfer with their counterpart in the other facility. In addition, the attending physician should document in the health record the reason or medical necessity for the transfer.

The Admitting section should be informed of a potential discharge by Nursing. This will enable the Admitting staff to make specific bed assignments for other incoming patients.

#### 4.13.1 Other Discharges

**Note:** Each facility should develop a discharge policy and/or procedure to ensure discharge coordination is accomplished.

An inpatient discharge is the end of an inpatient hospitalization. The discharge disposition of a hospitalization may occur by:

- Order of the physician
- Against medical advice (AMA)
- Other types of discharge, such as absent over leave (AOL) or absent without leave (AWOL)
- Transfer to another medical facility
- Death

Patients, who are AMA, AOL or AWOL, are considered discharged at the time they actually leave the hospital.

### 4.14 Non-Beneficiary Exit and Collection Process

Non-beneficiary patients need to understand the expectation of payment for services. Facilities should have a policy and procedure established to ensure co-payment and payments. When a patient is ready to leave the facility, several business processes need to be completed, if they **were not completed** during the check-in process:

- Insurance cards need to be copied front and back and should be verified before the patient's departure.
- Demographic and telephone information on the patient, including family members, should be maintained in the Notes section of the RPMS Patient Registration application, giving Billing several resources for follow-up, if necessary.
- Identify the guarantor, who is financially responsible for services rendered.
- Attempt to collect deductibles and coinsurance payments.

#### 4.15     **Reconciliation of RPMS Admission/Discharge/Transfer Statistics**

It is the responsibility of the Admitting clerk to ensure the information entered in the RPMS or BPRM ADT application is accurate. To verify that this information is accurate, the Admitting clerk will check the Nurses Daily Census report.

All RPMS or BPRM ADT data must match the Nurses Daily Census report data, as well as the inpatient service to which each patient is assigned. The reconciliation of admissions, discharges, and transfers should be completed on a **daily** basis.

On the first business day of the month, the IHS-202 report is printed from the RPMS or BPRM ADT application for signature by the Chief Executive Officer. The report is filed onsite, and the data is submitted to the Area Office on a pre-established schedule.

## 5. Third Party Coverage

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## 5.1 About Medicaid and Medicare

In 1965, the Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW).

In 1977, the Health Care Financing Administration (HCFA) was created in HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

## 5.2 Medicaid

Medicaid (Title XIX of the Federal Social Security Act) is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program became law in 1965 and is jointly funded by Federal and State governments (including the District of Columbia and the Territories) to assist states in providing medical and long-term care assistance to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

For a description of eligibility criteria, see Part 2, Chapter 7, Section 7.5, “Medicaid Eligibility and Application.”

The Federal statute identifies over 25 different eligibility categories for which federal funds are available; however, each state has its own plan and all eligibility categories may not be utilized by all states. These statutory categories can be classified into five broad coverage groups: children, pregnant women, adults in families with dependent children, individuals with disabilities, and individuals 65 or over.

Utilizing broad national guidelines, each state has the right to establish its own eligibility standard; determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer the program. Thus, Medicaid guidelines vary from state to state. Currently, 37 states have medically needy programs.

All states provide community Long Term Care services for individuals who are Medicaid eligible and qualify for institutional care.

All state plans must be approved by CMS prior to adoption. State plans include how IHS and Tribal facilities are reimbursed.

### 5.2.1 Medicaid Benefits

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program.

Mandatory Benefits	Optional Benefits
<ul style="list-style-type: none"> <li>• Inpatient Hospital Services</li> <li>• Outpatient hospital services</li> <li>• <a href="#">EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services</a></li> <li>• <a href="#">Nursing Facility Services</a></li> <li>• Home health services</li> <li>• Physician services</li> <li>• Rural health clinic services</li> <li>• Federally qualified health center services</li> <li>• Laboratory and X-ray services</li> <li>• Family planning services</li> <li>• Nurse Midwife services</li> <li>• Certified Pediatric and Family Nurse Practitioner services</li> <li>• Freestanding Birth Center services (when licensed or otherwise recognized by the state)</li> <li>• Transportation to medical care</li> <li>• <a href="#">Tobacco cessation</a> counseling for pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Prescription Drugs</a></li> <li>• Clinic services</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech, hearing and language disorder services</li> <li>• Respiratory care services</li> <li>• Other diagnostic, screening, <a href="#">preventive</a> and rehabilitative services</li> <li>• Podiatry services</li> <li>• Optometry services</li> <li>• <a href="#">Dental Services</a></li> <li>• Dentures</li> <li>• Prosthetics</li> <li>• Eyeglasses</li> <li>• Chiropractic services</li> <li>• Other practitioner services</li> <li>• Private duty nursing services</li> <li>• Personal Care</li> <li>• <a href="#">Hospice</a></li> <li>• Case management</li> <li>• <a href="#">Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)</a></li> <li>• <a href="#">Intermediate Care Facilities for Individuals with Intellectual Disability</a></li> </ul>

	<ul style="list-style-type: none"> <li>• <a href="#">State Plan Home and Community Based Services- 1915(i)</a></li> <li>• <a href="#">Self-Directed Personal Assistance Services- 1915(j)</a></li> <li>• <a href="#">Community First Choice Option- 1915(k)</a></li> <li>• <a href="#">TB Related Services</a></li> <li>• <a href="#">Inpatient psychiatric services for individuals under age 21</a></li> <li>• Other services approved by the Secretary*</li> <li>• <a href="#">Health Homes for Enrollees with Chronic Conditions – Section 1945</a></li> </ul>
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\*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

### 5.2.2 Medicaid Managed Care

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

States have choices in their approach to reimbursement and delivery system design under Medicaid Managed Care. Medicaid Managed Care delivery systems and program implementation are regulated by 42 CFR 438 and various federal authorities

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CMS provides greater detail on Medicaid Managed Care website:

<https://www.medicaid.gov/medicaid/managed-care/index.html>

### 5.2.3 Medicaid Expansion Programs

The Affordable Care Act expands coverage for the poorest Americans by creating an opportunity for states to provide Medicaid eligibility, effective January 1, 2014, for individuals under 65 years of age with incomes up to 133 percent of the federal poverty level (FPL). For the first time, states can provide Medicaid coverage for low-income adults without children and be guaranteed coverage through Medicaid in every state without need for a waiver. Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment will be much simpler and will be coordinated with the newly created Affordable Insurance Exchanges.

Additional information regarding Medicaid Expansion can be found at:

<https://www.medicaid.gov/medicaid/index.html>

<https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-and-the-marketplace/index.html>

#### 5.2.3.1 Other Eligibility Criteria

There are other non-financial eligibility criteria that are used in determining Medicaid eligibility. To be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

#### 5.2.3.2 Retroactive Eligibility

Medicaid coverage may start retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during the retroactive period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

#### 5.2.3.3 Waivers

States can apply to the Centers for Medicare & Medicaid Services for waivers to provide Medicaid to populations beyond what traditionally may be covered under the state plan. Some states have additional state-only programs to

provide medical assistance for certain low-income people who do not qualify for Medicaid. No federal funds are provided for state-only programs.

## 5.3 State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. States have broad discretion in setting their income eligibility standards, and eligibility varies across states.

### 5.3.1 Income Eligibility

Some States and the District of Columbia cover children up to or above 200% of the Federal Poverty Level (FPL) with some of these states offering coverage to children in families with income at 250% of the FPL or higher. States may get the CHIP enhanced match for coverage up to 300% of the FPL which is higher than the Medicaid federal funding matching rate

States that expand coverage above 300% of the FPL get the Medicaid matching rate. States have the option to provide continuous eligibility to children who remain eligible for CHIP.

### 5.3.2 New Medicaid & CHIP Coverage Options

#### 5.3.2.1 Lawfully Residing Children and Pregnant Women

Many states have elected the option under CHIPRA to restore Medicaid and/or CHIP coverage to children and pregnant women who are lawfully residing in the United States. Additional information may be obtained at:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>

#### 5.3.2.2 Pregnant Women

CHIPRA created an explicit eligibility category for pregnant women to receive coverage through CHIP in certain circumstances. Some states have also chosen to provide prenatal care for pregnant women through the CHIP program through other available vehicles. Additional information may be found at:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>

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### 5.3.2.3 Children of Public Employees

The Affordable Care Act of 2010 provides states the option to extend CHIP eligibility to state employees' children. Before enactment of the Affordable Care Act children of public employees were not eligible for CHIP, regardless of their income. See related for details:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO11002.pdf>

## 5.4 Medicare

Medicare is a health insurance program administered by the federal government. It provides health insurance for individuals age 65 and older, disabled individuals younger than 65, and any individual who has chronic kidney disease, otherwise known as End Stage Renal Disease (ESRD).

Medicare legislation was passed in July 1965 and became effective July 1966. Medicare is also known as Title XVIII of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS), under the Department of Health and Human Services, has primary responsibility for the Medicare program. There are several components of CMS at the Regional Office (RO) level: Division of Medicare, Division of Medicaid, and Division of Health Standards and Quality. The Division of Health Standards and Quality works with the state licensure and certification agencies.

The Indian Health Service authorizes private physicians and privately owned hospitals and nursing homes to provide treatment to Indians and their dependents under contractual arrangements with the Division of Indian Health. Contracted health services via Purchased/Referred Care (PRC) are provided when IHS facilities and clinics either do not offer the level of care or the specialty service.

When PRC providers or facilities are used, Medicare is the primary payor and IHS is secondary payor.

## 5.5 Medicare Part A

Hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility (SNF), home health care and hospice care. Medicare Part A has deductibles and coinsurance but is generally premium-free. IHS facility types that submit claims to Part A include Acute Care,

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Critical Access Hospitals (CAHs), and Federally Qualified Health Centers (FQHCs).

Medicare Part A has deductibles and coinsurance but is generally premium-free. The Part A deductible may be applied several times within a year.

A Medicare beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a “spell of illness.” However, Indian health Service providers do not collect this amount from the American Indian/Alaskan Native beneficiaries.

When a Medicare beneficiary receives such services for more than 60 days during a “spell of illness,” he is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per day for the 61st–90th day spent in the hospital.

Part A premiums are waived if the patient or their spouse worked at least 40 quarters of Medicare-covered employment. Those enrollees who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium, which is set according to a statutory formula. The monthly premium depends on the number of quarters worked.

CMS uses a network of contractors called Medicare Administrative Contractors (MAC). Traditionally, MACs process Medicare Part A and Medicare Part B claims for a defined geographic area or “jurisdiction,” servicing institutional providers, physicians, practitioners, and suppliers. In April 2006, CMS began to award Medicare claims processing contracts through competitive procedures. The MAC for I/T/Us vary based on the type of facility (Tribal, Federally Qualified Health Center or FQHC, rural health centers, and other non-IHS entities).

### **5.5.1 Covered and Non-Covered Benefits, Medicare Part A**

Benefits that are covered non-covered vary based on the facility type (Tribal, Federally Qualified Health Center or FQHC, rural health centers, and other non-IHS entities). A list of covered or non-covered benefits may be obtained from the MAC.

### **5.5.2 Lifetime Reserve Days**

Each beneficiary has a lifetime reserve of 60 additional days of inpatient

hospital services available after he/she has used 90 days (60 full and 30 coinsurance) of inpatient hospital services in a spell of illness. Depending on the situation, the patient may elect not to use his lifetime reserve days.

Such situations would include:

- The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days; and
  - The hospital is reimbursed on a cost reimbursement basis; or
  - The hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days.
- For the non-outlier portion of a stay in a hospital reimbursed under the prospective payment system, if the beneficiary has one or more regular (non-lifetime reserve) days remaining in the benefit period upon admission to the hospital.
- The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the prospective payment system and the total charges for which the beneficiary would be liable if he/she does not use lifetime reserve days are equal to or less than the sum of the coinsurance amounts of the lifetime reserve days needed for the stay.

**Note:** For hospital reimbursed under the prospective payment system, if a patient has one or more regular benefits (non-lifetime reserve, i.e., coinsurance days) days remaining in the benefit period upon entering the hospital, Medicare will pay the entire PPS amount of the non-outlier days. Therefore, it would not benefit the patient to utilize his lifetime reserve days.

For patients utilizing 25 coinsurance days and who remain in the hospital over the 30-day coinsurance threshold and enter into lifetime reserve days, the hospital must inform the patient. It is the patient's decision on electing to use the lifetime reserve days.

A retroactive election not to use the lifetime reserve days must be filed within 90 days following the beneficiary's discharge from the hospital, unless benefits are available from a third party payor to pay for the services, and the hospital agrees to the retroactive election. In those cases, the beneficiary may file an election not to use the lifetime reserve days later than 90 days following discharge.

### 5.5.3 Benefit Period

The term **benefit period** is defined as the period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient can be paid for by the hospital insurance plan.

The **first day of the benefit period** is when a patient is furnished inpatient hospital or skilled nursing facility services by an approved provider after entitlement to hospital insurance begins. From the date of discharge from any inpatient or swing-bed stay, the time will begin to accrue for the first day of a new benefit period. A transfer from one hospital to another is not considered a discharge, even if the transfer is considered a discharge under PPS. Also, a leave of absence is not considered a discharge from the hospital.

The **end of the benefit period** is when a beneficiary has not been an inpatient of a hospital or a swing-bed facility for sixty (60) consecutive days. At this time, the benefits will be renewed for full and coinsurance days only.

To calculate the sixty (60) consecutive days, begin counting with the day the individual was discharged. A benefit period cannot end while a beneficiary is an inpatient of a skilled nursing facility (SNF) where the SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

#### Examples of Benefit Period:

**Example 1:** Mrs. Smith enters the hospital on July 5 and is discharged on July 15. In this example, Mrs. Smith has used 10 days of her first benefit period. Mrs. Smith is not hospitalized until again until December 15. Since more than sixty days elapsed between her hospital days, she begins a **new** benefit period and will be obligated to pay the hospital deductible.

**Example 2:** Mrs. Smith enters the hospital on August 14 and is discharged on August 24. Like the first example, Mrs. Smith has used 10 days of her first benefit period. However, Mrs. Smith is readmitted to the hospital on September 20. Since fewer than sixty days have elapsed between hospital days, Mrs. Smith is still in her first benefit period and will not be required to pay another deductible. In essence, the admission on September 20 is actually the eleventh day used in her first benefit period. Mrs. Smith will not begin a new benefit period until she is out of the hospital and/or SNF for more than sixty consecutive days.

## 5.6 Medicare Part B

Medicare Part B is a voluntary program and provides the medical insurance that covers doctor's services, outpatient hospital services, durable medical equipment, and medical services and supplies not covered under Part A. The program is financed from premium payments by the enrollees or by states under the Medicaid program.

Because Medicare Part B is separate and distinct from Medicare Part A, it is possible for a person to enroll without being entitled to monthly social security or railroad retirement benefits or even receive Part A benefits.

For a provider to be paid under Medicare, the provider must participate with Medicare via a written agreement and accept assignment, and the level of care received by the patient must be medically necessary. Assignment means that the provider agrees to accept the Medicare approved amount for each service as payment in full. If the provider does not want to participate, he must revoke his agreement in writing to all carriers with whom he/she has filed an agreement.

Most of Medicare Part B physician services are paid based on a physician fee schedule. There is an annual deductible and a 20% coinsurance for covered medical expenses. However, Indian health Service providers do not collect this amount from the American Indian/Alaskan Native beneficiaries.

For emergency situations, the patient may be seen in a non-participating hospital.

### 5.6.1 Covered and Non-Covered Services, Medicare Part B

Benefits that are covered non-covered vary based on the facility type (Tribal, Federally Qualified Health Center or FQHC, rural health centers, and other non-IHS entities). A list of covered or non-covered benefits may be obtained from the Medicare Administrative Contractor (MAC).

## 5.7 Medicare/Medicaid Dual Eligibles

Medicare provides two basic coverages:

- Part A, which pays for hospitalization costs
- Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services

Dual eligibles are those individuals who are entitled to Medicare Part A **and/or** Part B, **and** are eligible for some form of Medicaid benefit.

**Note:** For the most current information, refer to this website:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244469.html>

These are the various categories of individuals, who collectively are known as **dual eligible**:

- **Qualified Medicare Beneficiary (QMB) without other Medicaid (QMB only)**

- Entitled to Medicare Part A
- Income of 100% Federal poverty level (FPL) or less
- Resources do not exceed three times the limit for SSI eligibility
- Not otherwise eligible for full Medicaid

Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

- **QMB with full Medicaid (QMB plus)**

- Entitled to Medicare Part A
- Income of 100% FPL or less
- Resources do not exceed three times the limit for SSI eligibility
- Eligible for Medicaid benefits

Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

- **Specified Low-Income Medicare Beneficiary (SLMB) without other Medicaid (SLMB Only)**

- Entitled to Medicare Part A
- Income greater than 100% but less than 120% FPL
- Resources do not exceed three times the limit for SSI eligibility
- Not otherwise eligible for Medicaid

Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

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- **SLMB with full Medicaid (SLMB Plus)**

- Entitled to Medicare Part A
- Income greater than 100% but less than 120% PPL
- Resources do not in exceed three times the limit for SSI eligibility
- Eligible for full Medicaid benefits

Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

- **Qualified Disabled and Working Individual (QDWI)**

- Lost Medicare Part A benefits due to returning to work, but eligible to enroll in and purchase Medicare part A
- Income of 200% FPL or less
- Resources do not exceed twice the limit for SSI eligibility
- Not otherwise eligible for Medicaid

Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100%.

- **Qualifying Individual (2) (QI)**

- Entitled to Medicare Part A
- Income of at least 120% but less than 135% FPL
- Resources do not exceed three times the limit for SSI eligibility
- Not otherwise eligible for Medicaid

Medicaid pays only a portion of their Part B premiums. FFP equals FMAP at 100%.

- **Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI)**

Typically, these individuals need to spend down to qualify for Medicaid or to fall into a Medicaid eligibility poverty group that exceeds the limits listed.

- Entitled to Medicare Part A and/or Part B
- Eligible for full Medicaid benefits
- Not eligible for Medicaid as a QMB, SLMB, QDWI, QI

Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and within this limit, will only pay to the extent

necessary to pay the beneficiary's Medicare cost-sharing liability.

Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

## 5.8 Medicare Advantage, Part C

The Medicare Advantage program replaced the Medicare+Choice (M+C) program under Medicare Part C. Under this program, Medicare pays a set amount of money for a Medicare patient's care every month to a private health plan that manages Medicare coverage for its members. In most Medicare Advantage Coordinated Care plans, there are doctors and hospitals that join the plan, called the plan's network. Most of the care required is obtained from the doctors within the network, and referrals are required for services outside of the network.

### 5.8.1 Medicare Advantage Prescription Drug Plan (MA-PD)

Individuals enrolled in a Medicare Advantage Coordinated Care Plan also can receive their prescription drug coverage through the Medicare Advantage Prescription Drug (MA-PD) plan. The drugs are covered as long as the prescription is filled at one of the plan pharmacies or through the network's mail-order pharmacy.

Drugs purchased outside of the network can be obtained, but at an additional cost. For certain prescription drugs, additional requirements for coverage or limits on coverage are applied. Both brand-name drugs and generic drugs are included in the formulary, and the formulary is updated at least monthly.

For additional information on MA-PD plans, as related to the Medicare Prescription Drug Plan, Part D, see Part 2, Chapter 5, Section **Error! Reference source not found.**, “**Error! Reference source not found.**”

## 5.9 Medicare Managed Care

Managed care plans serve Medicare beneficiaries through three types of contracts:

- Risk

- Cost
- Health Care Prepayment Plans (HCPPs)

All plans receive a monthly payment from the Medicare program.

In general, an individual is eligible to elect a Medicare Managed Care plan when each of the following requirements is met:

- The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan;
- The individual has not been medically determined to have ESRD prior to completing the enrollment form;
- The individual permanently resides in the service area of the Medicare Managed Care plan. A temporary move into the Medicare Managed Care plan's service area does not enable the individual to elect the Managed Care coverage;
- The individual or his/her legal representative has completed an enrollment election and it includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS;
- The individual is fully informed of and agrees to abide by the rules of the Medicare Managed Care organization that were provided during the election process; and,
- The individual makes the election during the election period.

The individual can still be covered under the spouse's health benefit plan; however, the rules for coordination will apply.

For more information on the Medicare Managed Care program, reference the link below:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html>

### 5.9.1 Risk Plans

Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and

eyeglasses.

With the exception of emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan.

Since 1992, enrollment in risk plans has more than tripled to 5.3 million. Currently, 88 percent of Medicare beneficiaries in managed care are in risk plans. As of January 1998, risk plans made up 322 of the 427 managed care plans participating in Medicare.

### **5.9.2 Cost Plans**

Cost plans are paid on a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer.

Beneficiaries may also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.

### **5.9.3 Health Care Prepayment Plans (HCPPs)**

Health Care Prepayment Plans (HCPPs) are paid in a similar manner as cost plans but only cover part of the Medicare benefit application. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care), but some do arrange for services and may file Part A claims for their members.

## **5.10 Medicare Prescription Drug Plan (Part D)**

As of January 1, 2006, Medicare offers a new prescription drug coverage, Part D. This prescription drug coverage can benefit American Indians and Alaska Natives (AI/AN) who pay for their prescriptions at retail pharmacies, as well as those who receive medications at no cost at IHS Tribal or Urban Indian programs (I/T/U).

Initial open enrollment began November 15, 2005 and ran for six months, ending May 15, 2006. In later years, open enrollment will run from November 15 to December 31, with enrollment effective January 1 of the following year. After beneficiaries choose a prescription drug plan (PDP), they will generally remain enrolled for the year.

Everyone with Medicare and Railroad Retirement is eligible for this coverage by joining an approved PDP or a Medicare Advantage Drug Plan (MA-PD). All plans are required to offer basic drug coverage. However, drug plans and Medicare Advantage plans can separately offer enhanced coverage for an additional premium.

The program has an “opt-in” rule, which means that with limited exceptions, beneficiaries will need to make an affirmative statement to sign up for the drug beneficiary plan by filling out an enrollment form of an approved plan.

Generally, the two main options for how beneficiaries receive their drug benefit are:

- Those who wish to remain in traditional Medicare may elect to join a stand-alone PDP that adds drug benefits to regular Medicare coverage.
- Those who wish to receive their entire medical and drug benefits from one source can join a Medicare Advantage (MA) plan, like an HMO, and chose an MA-PD plan, which will provide an integrated benefit covering their hospital, physician, and drug costs.

By participating in Medicare Part D, beneficiaries may help both themselves and their community.

- Individuals who pay for some or all medications at retail pharmacies may reduce their out-of-pocket costs paid to the retail pharmacy.
- Individuals who receive medications at no cost from an I/T/U site can benefit their community by enrolling in a drug plan; thus allowing the I/T/U site to bill the drug plan for reimbursement of part or all of the cost of the medications. The reimbursement funds can then be used to purchase other medications or services that benefit members of the community.

The categories of Medicare eligibles in the IHS system are:

Medicare A Only  
Medicare B Only  
Medicare A&B Only  
Medicare A and Medicaid  
Medicare B and Medicaid

Medicare A&B and Medicaid  
Medicare A and Private Insurance (PI)  
Medicare B and PI  
Medicare A&B and PI  
Medicaid/PI and Medicare A  
Medicaid/PI and Medicare B  
Medicaid/PI and Medicare A&B

A Summary of Third Party Resources report is located the RPMS Patient Registration Application.

The patient should be advised of his or her options to enroll in a PDP:

- Dual eligibles – those patients with Medicare and Medicaid – must choose a plan or they will be automatically enrolled in a plan. (IHS will not bill Medicaid but will bill the PDP).
- Patients currently on private insurance must review their plan to see if it is as good as the new Medicare benefit.
- Patients who do not have current drug coverage will need to choose a plan.

The drug plans charge members a monthly premium to participate in the plan. Individuals who qualify for both Medicare and Medicaid are eligible for a premium subsidy.

The patient may qualify for a:

- Full premium subsidy, also known as Extra Help, if income is below 135 percent of the Federal Poverty Level (FPL) with few assets.
- Partial premium subsidy, if income is over 135 and under 150 percent of the FPL.

Either the local I/T/U site or the Social Security Administration will help individuals with the application process.

## 5.11 Railroad Retirement

The Railroad Retirement program is a Federal Insurance program similar to Social Security for workers in the railroad industry. The provisions of the Railroad Retirement Act provided for a system of coordination and financial exchange between the Railroad Retirement Program and the Social Security Program.

Like the Social Security program, the Railroad Retirement provides retirement, disability, and survivors' benefits under rules approximately the same as for Social Security. There is also a supplemental retirement annuity and, for some people, the possibility of collecting both Railroad Retirement and Social Security benefits.

In April of 2018, Medicare began mailing new Medicare Beneficiary Identifier (MBI) cards to those eligible for Medicare. This MBI number is a series of randomly generated numbers and alpha characters in no particular order or sequence. You will no longer be able to identify Railroad Retirement Board (RRB) Medicare beneficiaries by the number. You will be able to identify by the RRB logo on the Railroad Medicare card.

## 5.12 Private Insurance

Private health insurance is a mechanism for people to protect themselves from the potentially extreme financial costs of medical care if they become severely ill, ensuring that they have access to health care when they need it. Private health insurance is provided primarily through benefit plans sponsored by employers. People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market.

Private health insurance provides health care benefits to an individual through a for-profit or not-for-profit insurance company or corporation. Private insurance covers almost every aspect of health care: hospital, surgical, medical, major medical, disability and mental health. A typical policy pays after the subscriber meets an initial calendar year deductible and a predetermined coinsurance amount.

Private health insurance is provided primarily by two different types of entities:

- State-licensed health insuring organizations
- Self-funded health benefit plans

### 5.12.1 State-Licensed Health Insuring Organizations

The state-licensed health insuring organizations, as the name implies, are organized and regulated under state law. There are three primary types:

- **Commercial health Insurers**

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These are sometimes called indemnity insurers and are generally organized like stock companies or as mutual insurance companies. An example is Aetna.

- **Blue Cross and Blue Shield Plans**

Many of these were organized as not-for-profit organizations under special state laws by state hospital and state medical associations. Blue Cross and Blue Shield Plans operate and are regulated in a similar manner to commercial insurers, although in a few states Blue Cross and Blue Shield plans continue to have special requirements to accept applicants for health insurance on a more lenient basis than is applied to other type of insurers.

- **Health Maintenance Organizations (HMOs)**

These are usually licensed under special state laws that recognize that they tightly integrate health insurance with the provision of health care. HMOs operate as insurers (meaning they spread health care costs across the people enrolled in the HMO) and as health care providers (meaning they directly provide or arrange for the necessary health care for their enrollees). An example is Kaiser.

### 5.12.2 Self-Funded Employee Health Benefit Plans

Self-funded employee health benefit plans operate under Federal law and are health benefit arrangements sponsored by employers, employee organizations, or a combination of the two. Under a self-funded arrangement, the plan sponsor retains the responsibility to pay directly for health care services of the plan's participants.

**Note:** An example of a self-funded insurance can be referenced in section 5.22 "Tribal Self Insurance."

In most cases, the sponsors of self-funded health plans contract with one or more third-parties to administer the plans. The contracts are sometimes with entities that specialize in administering benefit plans, called third party administrators (TPA). In other cases, sponsors contract with health insurers or HMOs for administrative services.

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### 5.12.3 Typical Examples of Covered Services

- Office and clinic exams, procedures, and treatment
- In-hospital admissions and related services
- Emergency room care primarily related to a medical or accidental injury
- Surgical procedures in the office, clinic, hospital, or ambulatory surgery center
- Chiropractors
- OB care, including pre and post-natal
- Lab, x-ray, and pharmacy
- Medical equipment and supplies
- Physical, Occupational, and Speech therapy
- Vision care
- Dental care
- Hospice care
- Defined list of preventive care

## 5.13 Managed Care

Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms, and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups, to enhance the quality and cost-effectiveness of health care.

Managed Care includes systems and techniques used to control the use and the cost of health care services. It also includes a review of medical necessity, incentives to use certain providers, and case management. Managed care techniques are most often practiced by organizations and professionals which assume risk for a defined population (e.g., health maintenance organizations), but this is not always the case.

Managed care has effectively formed a "go-between" brokerage or third party arrangement by existing as the gatekeeper between payers and providers and patients.

**Managed Care Organizations (MCOs)** are entities that seek to manage health care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.

Examples of MCOs include:

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Point of Service (POS)
- Exclusive Provider Organization (EPO)
- Provider Health Organization (PHO)
- Integrated Delivery System (IDS)
- Accountable Health Plan (AHP)
- Independent Practice Association (IPA)

Usually, a managed care organization is the entity which manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

A **Managed Care Plan** is a health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Managed care plans contract with providers to render health care services to members for a predetermined, discounted fee.

Under a Managed Care Plan, health coverage providers seek to influence the treatment decisions of health care providers through a variety of techniques, including financial incentives, development of treatment protocols, prior authorization of certain services, and dissemination of information on provider practice relative to norms or best practices.

Managed care health insurance is generally cheaper for employers because utilization requirements are stricter than private insurance plans. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them.

## 5.14 Dental Insurance

Medical insurance is designed primarily to cover the costs of diagnosing, treating, and curing serious illnesses. This process may involve a primary care physician and multiple specialists, a variety of tests performed by doctors and

laboratories, multiple procedures and masses of medications.

Dental insurance works differently. Most dental coverage is designed to ensure that the patient receives regular *preventative* care. High quality dental care rarely requires the complex, multiple resources often required by medical care. A thorough examination by the dentist and a set of x-rays are all it usually takes to diagnose a problem.

Dental care is provided by a general practitioner – dentist – and may require services of a dental specialist. Because most dental disease is preventable, dental benefit plans are structured to encourage patients to get the regular, routine care that are vital to preventing and diagnosing the onset of serious disease.

Most dental benefit plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. By placing an emphasis on prevention and by covering regular teeth cleaning and check-ups, millions of dollars are saved each year in dental care costs.

There are two types of dental compensation plans:

- **Indemnity Plans**

An indemnity plan pays the dentist on a traditional fee-for-service basis. A monthly premium is paid by the patient or employer to the insurance carrier which directly reimburses the dentist for the services provided. Usually insurance companies pay between 50 percent and 80 percent of the dentist's fee for covered services.

These plans often have a pre-determined deductible, a dollar amount which varies from plan to plan. Indemnity plans can limit the amount of services covered within a given year and can pay the dentist based on a variety of fee schedules.

- **Direct Reimbursement Plan**

Under this self-funded plan, an employer or company sponsor pays for dental care with its own funds, rather than paying premiums to an insurance company. The plan may limit the amount of dollars an employee can spend on dental care within a given year, but often places no limit on services provided.

Regardless of the dental benefit plan, there are several different types of third party insurers:

- **Dental Service Corporations**

Dental service corporations are not-for-profit organizations that negotiate and administer contracts for dental care to individuals or specific groups. Examples include Delta Dental Plan and Blue Cross/blue Shield Plans.

- **Insurance Carriers**

Insurance carriers are for-profit companies that underwrite the financial risk of and process payment claims for the dental services. Carriers contract with individuals or patient groups to offer a variety of dental benefit packages, including fee-for-service and managed care plans.

- **Self-Funded Insurers**

Self-funded insurers are companies who use their own funds to underwrite the expense of providing dental care to their employees.

### 5.14.1 Examples of Typical Dental Coverages

Typical **preventive** dental treatments that are covered include:

- Initial oral and recall examinations
- Complete x-ray survey and bite-wing x-rays
- Prophylaxis or teeth cleaning
- Topical fluoride treatment

Typical **corrective** dental treatments covered, where most plans will cover 70 or 80 percent of the treatment, include:

- Restorative care
- Endodontics
- Oral surgery
- Periodontics
- Crowns

Prosthodontics – denture and bridge related services – are also included.

Dental insurance is designed to help get care at a reasonable cost. Because each person's oral health is different, costs may vary widely. To control dental cost, most plans will limit the amount of care received in a given year. This is done by placing a dollar "cap" or limit on the amount of benefits you receive or by restricting the number or type of services that are covered. Some plans may specifically exclude certain services or treatments.

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## 5.15 Pharmacy

Benefits for prescription drugs may be included in the medical insurance application or be provided by a separate Pharmacy Benefit Manager (PBM) through Aetna, Express Scripts, Medco, Pay Prescriptions, PCS, Blue Cross and Blue Shield, Cardinal or others.

Most of the drugs covered by the pharmacy insurers are listed on a preferred drug list or formulary, subject to applicable limits and conditions. Formularies include both brand-name and generic drugs that have been approved by the Food and Drug Administration (FDA) as safe and effective.

Most drugs listed on the preferred drug list are subject to manufacturer volume discount arrangements under which the applicable insurance company receives financial consideration. In addition, drugs on the formulary represent an important therapeutic advance or are clinically equivalent and possibly more cost-effective than other drugs not on the preferred drug list.

Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. The same rigorous FDA quality and safety reviews apply to generic and brand-name drugs; however, generic drugs may help lower the health care expenses for patients.

Several of the pharmacy insurers require pre-certification. It is designed to help encourage appropriate use of certain drugs in accordance with current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements. A process flow should be identified to capture this required information prior to billing at POS.

Registration staff must remember to ask each patient if they have pharmacy insurance, and whether it is part of the coverage in the medical plan or is through a separate insurer.

## 5.16 CHAMPUS/TRICARE

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), now called TRICARE, is for members of the military and their families. TRICARE covers active duty and retired service members from any of the seven services: Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration. In addition, spouses and unmarried children remain eligible for services under TRICARE even when the parents are divorced or remarry. Eligibility for children usually terminates at age 21 except if the child is a full-time student

or incapable of self-support.

TRICARE also covers:

- Reservists and their dependents that have been called to active duty for 31 consecutive days.
- Retired military service members and their spouses.

Attaining Medicare eligibility does not mean beneficiaries lose eligibility for TRICARE. For example:

- Beneficiaries who become eligible for Medicare Part A on the basis of age and purchase Medicare Part B continue to be eligible for TRICARE, secondary to Medicare.
- Family members of active duty service members who are also eligible for Medicare for any reason retain eligibility for TRICARE whether or not they purchase Medicare Part B.
- Beneficiaries under 65 who are entitled to Medicare Part A because of disability or end stage renal disease and have purchased Medicare part B retain their eligibility for TRICARE until they turn 65, when they become only eligible for TRICARE for Life (a Medicare-wraparound coverage).

For more information, access these websites:

<https://www.tricare.mil/>

<https://manuals.health.mil/>

## 5.17 Veterans Administration

For VA Information, reference Part 2, Appendix, “VA Medical Benefits User Guide” or Part 4, Chapter 10, “Billing Veterans Administration (VA).”

## 5.18 Workers’ Compensation

Workers’ Compensation is an insurance offered by the state to employers, to cover risk-related work accidents and injuries. The laws regarding Workers’ Compensation are state-specific and vary regarding coverage, reporting, and benefit waiting periods.

Employers are responsible for premiums and maintenance. The injured employee has a right to compensation for 100% of medical expenses. The employee must provide a completed first report of injury form to their

employer within a stipulated period of time. This form should be obtained for our records by calling the employer. The employer will provide the assigned claim number and give appropriate information on filing the work comp claim.

Workers' compensation is the primary coverage when there is an on-the-job injury and no other insurer is liable. The insurance company of the employer should be called to verify coverage. Notations should be made in the RPMS Patient Registration application, page 8, to indicate date, name, and approval.

When the carrier of the employee's work-related injury is notified, the carrier will:

- Determine the compensability of the injury,
- Provide an authorized doctor,
- Pay for all authorized medically necessary care and treatment related to the injury,
- Authorize treatment for doctor's visits, physical therapy, prescription drugs, hospitalization, medical tests, prosthesis, and travel.

## 5.19 Third Party Liability

Liability cases involve traffic and other accidents where third party insurance may cover a patient's treatment. In such cases the patient's insurer is responsible for covering the claim and later may seek reimbursement from the responsible party's insurer.

Patients may say someone else is responsible for their bill and that therefore their insurance information is not needed, but registration staff should explain that they must document every insurer that may be involved.

A provider is under no obligation to wait for appeal activity or legal action to be paid in liability cases. For more detailed information, see the Federal Medical Care Recovery Act (FMCRA) policy at the following website:

<https://www.ihs.gov/ihm/circulars/2006/reporting-third-party-tortfeasor-claims-and-recovery-of-funds-under-the-federal-medical-care-recovery-act/>

Check with your local BOC consultant to see if there is a different process outlined that your Area is using.

For an example of an Area process, reference Part 2, Appendix, "FMCRA Resource Book."

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## 5.20 Grant Programs

Research and grant dollars may be made available to the clinic to cover health-related research activities that would not have been available otherwise. As an example, the National Institute of Health (NIH) provides research grants and funding to programs that will reimburse the clinic for services, equipment, supplies, facility and administrative cost, publications, consultant fees, renovations, and other items.

Process flows to handle the disbursement of funds, payment of accounts, or associated accounting activities related to the grant should be written out and provided for proper handling.

**Note:** If grant funding is used to pay for services following grant eligibility requirements, then ensure payers are not billed. This is often referred to as “double dipping” and these situations will be reviewed by IHS on a case-by-case basis to certify the organization does not perform these operations.

## 5.21 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is the term is used by Medicare when Medicare is not responsible for paying first. Most private insurance companies refer to MSP as “Coordination of Benefits”.

By Federal law, Medicare is secondary payor to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payor when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following means:

- An employer Group Health plan for working age beneficiaries
- A large Group Health Plan for disable beneficiaries
- Beneficiaries eligible for End State Renal Disease (ESRD)
- Liability/Automobile medical or no-fault insurance
- The Veterans Administration (VA)
- A Workers’ Compensation (WC) plan
- The Federal Black Lung program

Any conditional primary payment(s) made by Medicare for services related to a third party liability injury is subject to recovery.

The facility should submit the MSP information to the intermediary using condition and occurrence codes on the claim. After initial payment from the primary insurer, the clinic should submit a copy of the explanation of benefits (EOB) or rejection notice from the carrier with all appropriate MSP information to the designated carrier. Information related to the billing process and coordination of benefits is discussed further in Part 4 of the ROM “Billing:” <https://www.ihs.gov/businessoffice/rom/>.

Novitas:

- Inpatient – an MSP needs to be obtained on every admission.
- Outpatient – an MSP needs to be obtained every visit. every 90 days.

If different Fiscal Intermediary is used, verify if there are different requirements for updating the MSP.

Data from the MSP form may be entered into the RPMS Patient Registration application and retrieved at a later time, if needed for auditing purposes.

For more information on MSP, go to the following website:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf>

## 5.22 Tribal Self Insurance

Typically, a self-insurance plan involves payment of funds by a Tribe or Tribal organization into a liability pool. The Tribe or Tribal organization bears all the financial risk for the occurrence of a particular event, such as health care costs for tribal employees. When the particular event occurs, payment is made from the liability pool or from other tribal resources.

Under this type of arrangement, Section 206(f) of the Indian Health Care Improvement Act (INCHIA), P.L. 94-437, 25U.S.C. 1621e(f) prohibits the IHS from seeking a right of recovery when the health services it has provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization. Consistent with Congressional intent not to burden Tribal resources, the agency has made a determination that tribal-funded, self-insured health plans are not to be considered alternate resources for purposes of the IHS payor of last resort rule. Thus, if a Tribal self-insurance plan exercises an exclusionary clause prohibiting payments to the IHS, then the IHS will not consider that healthcare plan an alternate resource. Subject to the availability of funds, the IHS will authorize PRC funds for payment of services otherwise covered by such a Tribal self-insurance plan, if the services

are eligible for payment under the IHS regulations and no other alternate resources exist, subject to the availability of funds.

## 5.23 Verifying Third Party Insurance Coverage

### 5.23.1 Verifying Medicaid Insurance

A current copy of the state Medicaid card needs to be obtained from the patient and the information will be entered in the RPMS Patient Registration database. If there are discrepancies on the name and/or date of birth, the patient will need to correct these discrepancies with the state Medicaid office.

In addition, if the Medicaid card indicates an incorrect birth date or name, the name appearing on the card must be used until the state corrects the information on the Medicaid card.

If the discrepancy occurs on the facility records, the patient will need to furnish the required documentation to make the necessary changes/corrections.

To verify Medicaid, follow these steps:

- 1) Obtain copy of the patient's Medicaid card.
- 2) Speak to a representative at the state Medicaid program, or utilize on-line verification.
- 3) Identify the patient by providing his/her social security or Medicaid identification number to the representative.
- 4) Update eligibility information for date of service.
- 5) Enter patient data on **Page 4** and **Page 8** of the **RPMS Patient Registration** application.

### 5.23.2 Verifying Medicare Parts A and B Eligibility

A copy of the Medicare card needs to be obtained from the patient and the information will be entered in the **RPMS Patient Registration** application.

Any discrepancies must be corrected by the patient with the Social Security Office. If the discrepancy occurs in the facility's records, the patient will need to furnish the required documentation to make the necessary changes/corrections.

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To verify Medicare A and B, follow these steps:

- 1) Obtain copy of the patient's Medicare card.
- 2) Speak to a representative at the Medicare Part A provider line.
- 3) Identify the patient by giving the Health Insurance Claim Number (HICN) or MBI – provide number, suffix, date of birth and gender – to the representative.
- 4) Eligibility is given at time of verification – information given is effective date, primary or secondary or coverage terminated.
- 5) Enter patient data on **Page 4** and **Page 8** of the **RPMS Patient Registration** application.

### 5.23.3 Verifying Private Insurance

For new patients to the facility or when insurance coverage has changed, the Registration staff needs to:

- Obtain a copy of the insurance card.
- File the copy in the appropriate EHR location such as Administrative Tab.

To verify private insurance coverage, follow these steps:

- 1) Obtain copy of private insurance card.
- 2) Call or check on-line the private insurer listed on card and check **Page 8** of the **RPMS Patient Registration** application to ensure that the insurer's telephone number is the same.
- 3) Verify the following information:
  - a) Policy Number
  - b) Person Class Code
  - c) Group Number
  - d) Name
  - e) Date of Birth
  - f) Billing Address
- 4) Determine if there is a separate insurer for pharmacy, mental health, or dental.
- 5) Update the **Notes** page in the **RPMS Patient Registration** application. Document date, time eligibility confirmed.

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## 5.24 Prior Authorization Process

Prior Authorization, also called pre-certification or pre-authorization, is the process by which the insurer evaluates and approves the medical necessity of the proposed hospital stay and certain outpatient services, the number of days that are required to treat the condition, services for mental conditions or substance abuse, and even certain drugs.

The Prior Authorization process involves the hospital or provider contacting the plan, usually within 24 hours prior to admission. After providing the patient's name, identification number, birth date, reason for hospitalization, name and phone number of provider, and number of planned days in the hospital, the insurer will approve the days of confinement for the care of the patient's condition. Document the authorization number, name of person giving the authorization, date and time in the Practice Management Suite Prior Auth tab, or in RPMS.

For emergency admissions, the provider or hospital must call the insurer within two business days following the day of admission, even if the patient has been discharged from the hospital.

Not all insurers require Prior Authorization; however, the clinic and/or Billing should be aware of those that do require this process. If Prior Authorization is required but not performed by the clinic, the admission or the outpatient services will not be reimbursed.

### 5.24.1 Inpatient Prior Authorization Procedure

**Note:** Prior authorization for weekends and holidays is completed the next business day. Follow each payor's criteria.

The Admission and Discharge sheet generated from the RPMS Admission/Discharge/Transfer (ADT) application will be used to verify all inpatient third party information. If data was obtained during the pre-op visit, this information will be found in the patient's file of RPMS.

- 1) An admission/discharge summary report will be printed-out and used as a guide to check all inpatient admissions to determine whether the patient has any alternate resources. If the patient has any alternate resources, verification of coverage will be completed and pre-authorization will also be obtained, if required.
- 2) The verification/admit clerk will use the following information when calling in for verification and authorization:

- a) Admission date
  - b) Admission time
  - c) Admitting diagnosis (ICD-10)
  - d) Admitting physician (facility address, facility telephone and physician specialty)
  - e) Patient Name
  - f) Date of Birth
  - g) Name of insurance policy holder and policy number
  - h) Name of Third Party Private insurance
  - i) Name of Facility/Address/Telephone number (Federal Tax Identification Number)
- 3) The verification/admit clerk will update all authorization information in the **RPMS** or Practice Management Suite.
  - 4) The Utilization Review (UR) personnel will be notified. The authorization number is utilized for billing purposes once the patient is discharged from the facility.
  - 5) The Case Management personnel will receive electronic notification regarding the identified patient as having medical health insurance.
  - 6) The UR personnel will document such information as authorization number, review nurse, inpatient unit, treatment plan medications, and other related information in the patient EHR.

#### 5.24.2 Outpatient Prior Authorization Procedure

All outpatient cases will be verified and authorized on any pre-operative visit, with the exception of emergency cases.

- 1) The verification/admit clerk will use the following information when calling in for verification and authorization:
  - a) Preoperative date
  - b) Day surgery date
  - c) Diagnosis (ICD-10)
  - d) Surgical procedures (CPT)
  - e) Other services, such as rehab, PT with date range of services
  - f) Name of physician and specialty

- g) Patient Name
- h) Date of Birth
- i) Name of insurance policy holder and policy number, copied front and back
- j) Name of Third Party Private insurance
- k) Name of facility, address, telephone number (Federal Tax Identification Number)

The verification/admit clerk will document this information which will be routed to the Utilization Review personnel for follow up. The authorization number is utilized for billing purpose once the patient is discharged from the facility.

- 2) The verification/admit clerk will update all pertinent information in the **RPMS** application or the Practice Management Suite.
- 3) The Utilization Review Case Management personnel will receive electronic notification regarding the identified patient as having medical health insurance. The information such as an authorization number, review, nurse, past medical history, treatment plan, and medications should be recorded in the record.

## 5.25 Patient Referral to the Benefit Coordinator

The Registration staff needs to have a defined process flow in place for referring patients to the Patient Benefit Coordinator. Details of this process are described in Part 2, Chapter 7, “Benefit Coordination.” In addition, Registration staff needs to understand who potentially may qualify for alternate resources and make sure these individuals are appropriately referred to, as well as, meet the Benefit Coordinator.

Patients may be referred to the Patient Benefit Coordinator using the RPMS Patient Registration application, which electronically notifies the Benefit Coordinator. The information provided will include the patient’s name and HRN.

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## 6. Scheduling Appointments

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## 6.1 About Scheduling Appointments

The RPMS **Practice Management Application Suite (BPRM), Scheduling Module** is used to offer patients their choice of appointment dates and times to better assure compliance and customer satisfaction. It is also used to:

- Schedule new appointments
- Update existing appointments
- Review daily appointment list
- Verify eligibility
- Manage waitlists
- Check-in patients creating the visit
- Check-out patients

## 6.2 Appointment Scheduling Process

Appointments may be scheduled according to facility process and staffing. Registration staff, nursing staff, as well as scheduling clerks may perform this function. Scheduling patient appointments may be centralized or decentralized services done by various facility staff (e.g., Appointment Clerks, Medical Service Assistants, Nurses, etc.).

## 6.3 Exceptions to the Standard Scheduling Process

**New Patient:** The patient should be advised to come to the clinic one hour before the scheduled time of the appointment with the required documents to prove eligibility. A new health record will be prepared. Meanwhile perform system scans of the name, date of birth (DOB); review the master index card to ensure the patient has not been seen at the facility before. Once verified, proceed with new health record creation according to your facilities process.

**Inactivated Patient:** If the patient has not been seen at the clinic within the past 3 years, the record may be inactivated. The Health Record will be reactivated in the system through the Practice Management Application Suite (BPRM), Scheduling Module. Depending on policy of your facility, request the inactivated chart to be returned to your facility.

## 6.4 Preventing No Show or Cancelled Appointments

There are many reasons why appointments result in a “no show” or are

cancelled. Practice Management Application Suite (BPRM), Scheduling Module cancellation process indicates whether the cancellation is at the patient level, or even the clinic level for weather events. Reasons for no show or cancellations are readily visible through color coding status indicators. These rescheduled appointments may also be tracked through various reports available within the system.

Suggestions to reduce no shows include:

- Offering a selection of times based on the schedule of the patient; the patient a selection of times when the appointment is made initially.
- Encouraging the patient to call to make a change in their appointment.
- Sending the Appointment Letter a few days in advance of the appointment as a reminder. All telephone numbers are listed in the letter for the patient to reschedule.
- Making a courtesy “appointment reminder” telephone call one day prior to the scheduled appointment.
- Establishing a system for reviewing No Show reports as a team. This could be a quality improvement project to establish new methodology and reduce the number of no shows to a lower level.

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## 7. Benefit Coordination

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## 7.1 About the Benefit Coordinator

The Benefit Coordinator identifies patients who are eligible for alternate resources such as Medicaid, Medicare, Veteran's Administration, ACA Exchanges, private insurance, and others. This includes

- determining if the patient qualifies for alternate resources,
- assisting the patient with completion of the application, and
- following up with the alternate resources to assure the coverage.

Besides identifying patients who are eligible for alternate resources, another Benefit Coordinator function is to maximize and enhance patient care through increased revenue from other insurers. Because the IHS may not be able to provide coverage for certain health services, the identification of alternate resources can be utilized to offset cost to Purchased/Referred Care (PRC) (previously known as Contract Health Services).

To accomplish the essential activities related to this position, the Benefit Coordinator needs to be on-site and available during the clinic hours of operation.

The Benefit Coordinator needs to maintain statistics daily, monthly, and quarterly of enrollments, approvals/denials of applications, verification, and updating of the RPMS and overall assistance of patients with benefits. These productivity reports need to be submitted to the business office manager or supervisor.

These are the overall responsibilities of the Benefit Coordinator:

- Advocate on behalf of patients with all alternate resource activities.
- Effectively educate patients on alternate resources.
- Effectively utilize or maximize enrollment of patients into an alternate resource program.
- Effectively interview patients to determine eligibility and make appropriate referrals for benefits.
- Work closely with Patient Registration and Purchased/Referred Care in screening potential patients who are eligible for alternate resources.
- Abide by the Privacy Act of 1974 to maintain confidentiality of all records.
- Follow up on pending applications with appropriate alternate resource agencies.

- Make home visits to gather pertinent information/documents from client/patients to complete the application process.
- Monitor and update change in coverage and/or rate code per encounter.
- Outreach and Education for all Alternate Resources throughout the Community

For information related to Benefit Coordinator performance tracking and quality assurance, see Part 1, Chapter 5 of the ROM, “Business Office Quality Process Improvement:” <https://www.ihs.gov/businessoffice/rom/>.

## 7.2 Outpatient Identification and Verification Process

Facilities need to have policies and procedures in place for referring patients to the Patient Benefits Coordinator (PBC) staff. The PBC(s) may rely on the Patient Registration department to help identify patients who may qualify for alternative resources.

The process for identifying and verifying alternate resources for **outpatient** services are:

- Review the scheduled patients to assess potential patients for referral to the Benefit Coordinator.
- Cross-train the Registration staff as back-up on eligibility requirements for alternate resources that may be available.
- Screen and/or interview patients by face-to-face contact or telephone contact.
- Obtain the following information:
  - Demographics, including date of birth (DOB), social security number, home mailing address
  - Insurance information, if any
  - Income information, if necessary
- Verify eligibility:

If the patient...	Do this:
is 65 or over,	Contact the Social Security Administration (SSA) for a Medicare update. Determine if the patient has any private insurance prescription drug coverage.

<b>If the patient...</b>	<b>Do this:</b>
worked for the railroad,	Contact the Medicare Railroad Retirement Office for Railroad Medicare.
has no insurance, or has/had Medicaid coverage,	Contact the automated state Medicaid Voice Response System, call the Medicaid fiscal agent eligibility help desk, or verify eligibility via the Internet connection with the state Medicaid.
is disabled,	Contact the Social Security Administration to determine if the patient has Supplemental Social Security (SSI).
has had military service,	Contact the local Veterans Administration (VA) office to determine if he/she has VA benefits or follow the VA Reimbursement Implementation Guidelines for instructions
(or spouse) is employed and has the company's insurance,	Contact the private insurer eligibility or verification staff person for private insurance validation.
is elderly and/or blind, physically disabled, or has developmental disabilities,	Contact the Social Security Administration

- **Resource Patient Management System (RPMS) Patient Registration or Patient Information Management System (PIMS) applications,** need to be updated with any new information.
- Benefit Coordinator notes can be entered in the Benefits Coordination section of the RPMS Patient Registration Editor.

### 7.3 Eligibility Verification

The Benefit Coordinator, Registration staff, and Purchased/Referred Care staff verify insurance as part of their daily business processes where the:

- Benefit Coordinator verifies new insurance eligibility.
- Registration staff verifies existing or changed insurance.
- Purchase/Referred Care verifies insurance to determine if any coverage should pay before contract health dollars are used.

The process of verifying insurance varies by state and insurer. The verification process can include an automated telephone response system, third party websites, direct-payer websites, or a direct telephone call to speak with a customer service representative at the insurance company. Many

clearinghouse vendors offer eligibility verification services through their dashboard.

### 7.3.1 State Medicaid/SCHIP Verification

Verifying State Medicaid and State Children's Health Insurance Program (SCHIP) coverages may vary by state. Therefore, check with your state Medicaid Administrator for the proper tools to verify coverage and to obtain login information.

- 1) Use the existing automated toll-free telephone voice response system, *OR* contact the existing eligibility help desk representative, *OR* use the Internet Online verification system.
- 2) Verify eligibility coverage according to state/local timeframe requirements.
- 3) Update eligibility information in the third party eligibility section of RPMS Patient Registration application.
- 4) Make notation in the Notes section of the RPMS Patient Registration application.

### 7.3.2 Social Security Income (SSI) Disability Verification

- 1) Use the toll-free automated voice response telephone system, *OR* contact the existing eligibility help desk representative, *OR* use the Internet Online verification system.
  - a) Verify eligibility for the past three months.
  - b) Make notation in the Notes section of the RPMS Patient Registration application.
- 2) Call the local Social Security Administration Office.
  - a) Verify eligibility coverage for patient's name, date of birth, Medicare identification number, and effective coverage dates for Part A and/or Part B.
  - b) Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.
  - c) Make notation in the Notes section of the RPMS Patient Registration application.

### 7.3.3 Private Insurance Verification

- 1) Scan the insurance card.
- 2) Verify private insurance using Third party websites, direct-payer websites or contact the private insurance customer service representative directly.
- 3) Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.
- 4) Make notation in the Notes section of the RPMS Patient Registration application.

#### **7.3.4 VA Eligibility Verification**

For more information on VA Eligibility Verification processes and contacts, reference Part 2, Appendix, “VA Medical Benefits User Guide” or Part 4, Chapter 10, “Billing Veterans Administration (VA).”

### **7.4 Inpatient Alternate Resource Verification Process**

There are different reports in the ADT that can be run to identify patients that have been admitted, i.e. Inpatient Listing by Date (ILD) reports. The user would follow the same verification process mentioned in Section 7.3 “Eligibility Verification.”

### **7.5 Medicaid Eligibility and Application**

#### **7.5.1 Medicaid Eligibility**

Each state has the discretion as to which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. Examples of Medicaid eligibility groups are:

- Low income families with children who meet certain of the eligibility requirements in the State’s Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996.
- Supplemental Security Income (SSI) recipients to include aged, blind, and disabled individuals which were in place in the State’s approved Medicaid plan as of January 1, 1972.
- Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life, so long as the infant remains in the mother’s household and she remains eligible.
- Children under age 6 and pregnant women whose family income is at or

below 133 percent of the Federal poverty level – set by each state. States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60<sup>th</sup> day after the end of the pregnancy falls, regardless of any changes in family income.

- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Certain Medicare beneficiaries.
- Special protected groups who may keep Medicaid for a period of time, such as a person who loses SSI payments due to earnings from work or increase in Social Security benefits.

States also have the option to provide Medicaid coverage for other “categorically needy” groups. Such coverage needs to be verified by the state. For example:

- Infants up to age one and pregnant women not covered under mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage is set by each State).
- Optional targeted low-income children.
- Certain aged, blind, or disable adults who have incomes above those requiring mandatory coverage but are below the Federal poverty level.
- Children under age 21 who meet income and resources requirements for AFDC but are not eligible for ADFC.
- Institutionalized individuals with income and resources below specified limits.
- Persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers.
- Recipients of State supplementary payments.
- TB-infected persons who would be financially eligible for Medicaid at the SSI level.
- Low-income, uninsured women screened and diagnosed through a Center for Disease Control and Prevention’s Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast and cervical cancer.
- State Medicaid Expansion Programs – Through the Affordable Care Act, some States have chosen to expand Medicaid coverage for additional

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populations.

### **7.5.2 Medicaid Eligibility Dates**

Eligibility dates are defined by the State. Coverage may start retroactive to any or all of the three months prior to the application, if the individual would have been eligible during the retroactive period. Recently, this has changed in some states, please be sure to reference your state's guidelines. Coverage generally stops at the end of the month in which a person's circumstances change.

### **7.5.3 Relationship and Coordination between Medicaid and Medicare**

Medicare Part A covers the hospital insurance and Part B covers the medical insurance. Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program.

If a person is eligible for full Medicaid coverage, Medicare will pay first, and the difference will be paid by Medicaid up to the Medicare allowable limit. Medicaid also covers additional services such as nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs not covered by Medicare Part D, eyeglasses and hearing aids.

Qualified Medicare Beneficiaries (QMB) with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120 percent of the Federal Poverty Level (FPL) do not have to pay the monthly Medicare Part B premiums.

Qualifying individuals that are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program will get help with all or a small part of their monthly Medicare Part B premiums, depending on whether their income exceeds the SLMB level but is less than 135 percent of the FPL.

Medicaid can pay Medicare premiums for Part A, Part B, and Part D deductibles and coinsurance for Qualified Medicare Beneficiaries (QMB) – individuals whose income is at or below 100 percent of the Federal poverty level and whose resources are at or below the standard allowed under SSI.

Medicaid can also pay the Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals

have income below 200 percent of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.

#### 7.5.4 Medicaid Presumptive Eligibility

The Omnibus Budget Reconciliation Act provides for payment of ambulatory prenatal care to pregnant women during a presumptive eligibility period before they have formally applied for Medicaid. Women qualify for presumptive eligibility if:

- Pregnancy has been medically verified
- Patient verifies social security number
- Family income does not exceed 133 percent of the Federal poverty guidelines
- There is not a presumptive eligibility in existence for this current pregnancy
- An application form has been completed

The following providers can qualify for presumptive eligibility:

- Title X family planning clinics through State Department of Health
- City/County Health Departments
- Peri-natal projects through State Health Departments
- Title V of the Indian Health Care Improvement Act
- WIC program through State Department of Health
- Other health care clinics within individual states, such as migrant health services or rural health clinics
- Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

Covered services under presumptive eligibility (hospital services are not covered) include:

- Provider, nurse practitioner or nurse midwife services
- Laboratory and radiology
- Dental
- Optometry
- Podiatry
- Speech, physical or occupational therapy

- 
- Durable medical equipment
  - Audiology and related services
  - Counseling services
  - Prescription drugs
  - Transportation
  - Family planning

### 7.5.5 Temporary Medicaid Number for Newborn

This is a process for obtaining a *temporary* newborn number for State Medicaid. Check your state's guidelines for the newborn enrollment process:

- 1) Call or e-mail the appropriate Income Support Division Office.
- 2) Provide the following information:
  - a) Name of newborn
  - b) Date of birth for newborn
  - c) Gender of newborn
  - d) Mother's name
  - e) Mother's social security number
- 3) Enter the Temporary Newborn Number in the **RPMS Patient Registration** application on **Page 4** and enter notations on **Page 8**.
- 4) Notify Inpatient Billing of the Temporary Newborn Medicaid Number.

### 7.5.6 Permanent Medicaid Number for Newborn

This is a process for obtaining a permanent Medicaid number for the newborn. Check your state's guidelines for the newborn enrollment process:

- 1) Call the State Medicaid Newborn Notification or Inquiry Line.
- 2) Provide the applicable newborn information:
  - a) Clinic's name and provider number
  - b) Mother's name
  - c) Mother's Medicaid number or Social Security Number
  - d) Mother's date of birth
  - e) Name of newborn

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- f) Date of birth for newborn
  - g) Gender of newborn
  - h) Gestational age of newborn
  - i) Weight in grams of newborn
  - j) Type of delivery for newborn – normal or C-section
  - k) APGAR score of newborn
- 3) Enter the newborn's Medicaid number in the **RPMS Patient Registration** application on **Page 4** and enter notations on **Page 8**.
  - 4) Notify the Billing Department and Contract Health Services of the newborn's permanent Medicaid number.

### 7.5.7 State Medicaid Application Process

Below is the manual application process for State Medicaid; however, utilize electronic submissions wherever possible:

- 1) Have the patient complete the appropriate state Medicaid application form and/or presumptive eligibility form:
  - a) adult patient or spouse without insurance coverage
  - b) for uncovered children under 19 years of age
  - c) for pregnant women and their newborns
  - d) for women who want family planning
- 2) Interview the patient and/or family members.
- 3) Complete the state Medicaid application and instruct the patient regarding documents needed and patient rights:
  - a) Copy of birth certificate and/or certificate of Indian blood
  - b) Proof of state residency
  - c) Citizenship or immigration status:
    - i. Copies of both sides of the citizenship or immigration documents. Non-citizens must provide copies of any Immigration and Naturalization Services (INS) cards or letters.
  - d) Social Security Number
    - i. Validate the social security number with state and Federal agencies to verify if the patient has Medicare and to determine income status (earned or unearned).

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- ii. If the patient does not have a social security number, assist the patient in applying for one.
  - e) Wages
    - i. Copies of check stubs or statement from employer showing gross earnings last month and this month for those individuals listed on the state Medicaid application.
  - f) Self-Employment
    - i. Copies of current Federal tax forms.
    - ii. Proof of business income and expenses for the last calendar month. Proof of business income includes records, journals, or financial statements that show the amount and date received; proof of business expenses including receipts, bills, or canceled checks that include date, amount, and type of expense.
  - g) Child Support
    - i. Copies of the court order or child support payment history.
  - h) Other Income
    - i. Proof of any income, such as Social Security Administration, Veterans Administration, Railroad Retirement, or disability income.
  - i) Health Insurance
    - i. Copies of insurance identification cards.
  - j) Daycare
    - i. Proof of amount billed for child care or care of an incapacitated adult.
  - k) Pregnancy
    - i. Signed letter from the patient's provider, indicating the expected date of delivery.
- 4) Fax or mail the presumptive eligibility forms for children within 24 hours and for pregnant women within 5 days.

Upon approval enter the Medicaid eligibility data in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.

In some states the Medicaid application can be completed on the Internet, by telephone, or at locations in the community. In addition, several of the Indian clinics have provided a space for the Medicaid social worker to process applications on-site.

- 5) Complete follow up to check status of enrollment after two weeks of the submission date.
- 6) If the application is denied, enter the reason for the denial in the Benefit Coordinators section of the RPMS Patient Registration Editor.
- 7) Notify the Billing and Contract Health Services of the determination of the application.
- 8) Close out the case and file in the Business office.

### **7.5.8 Enrollment in Medicaid Managed Care Plans**

- 1) If the patient is not locked into the Medicaid plan for one year, then have the patient complete the Native American Opt Out form.
- 2) Have patient sign the Opt Out form.
- 3) Attach a copy of the Patient's Certificate of Indian Blood (CIB).
- 4) Fax the Opt Out form and CIB to the Native American Opt Out office or, depending on the state, the patient may have to call the customer representative and request formally a health plan change to IHS.
- 5) Update the change in plans in the **RPMS Patient Registration** application on **Page 4**, and enter an update note on **Page 8**.

### **7.5.9 Follow-up Procedures for Pending Medicaid Applications**

Follow up with patients and alternate resources can be done via telephone calls, letters, or online.

- 1) Send a follow-up letter to the patient informing them to bring in the pending verification documents.
- 2) Make follow-up telephone calls with the appropriate agency on a set schedule.
- 3) Document all follow-up conversations in the **RPMS Patient Registration** application on **Page 8**.

## **7.6 Veteran's Administration Medical Benefit Program**

For more information on the Veteran's Administration Medical Benefits Application processes and contacts, reference Part 2, Appendix, "VA Medical

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Benefits User Guide” or Part 4, Chapter 10, “Billing Veterans Administration (VA).”

## **7.7 ACA Exchange Program**

Benefits Coordinators are also involved in the facilities process of identifying potential coverage via the ACA Exchange Program. They assist individuals with applying, tracking, and concluding the application process of such Programs.

## Appendix

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**Name Change/Date of Birth Correction Form****Name Change/Date-of-Birth Correction Request**

PATIENT NAME \_\_\_\_\_ GIMC# \_\_\_\_\_

UPDATE COMPLETED \_\_\_\_\_(Y/N) AOB/PA COMPLETED \_\_\_\_\_(Y/N)  
(Attach Face Sheet)

RECEIVED BY \_\_\_\_\_ DATE \_\_\_\_\_

CORRECTION OF NAME \_\_\_\_\_Birth Certificate \_\_\_\_\_ Court Order

NAME CHANGE DUE TO MARRIAGE \_\_\_\_\_Marriage License \_\_\_\_\_ Family Profile Card

NAME CHANGE DUE TO DIVORCE \_\_\_\_\_Divorce Decree \_\_\_\_\_ Court Order

DATE OF BIRTH CORRECTION \_\_\_\_\_Birth Certificate

Completed by \_\_\_\_\_ Date \_\_\_\_\_

Document sent to THC by \_\_\_\_\_ Date \_\_\_\_\_

Comments/Problems:

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## One Time Visit Letter



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Public Health Service

**Address Reply To:**

USPHS Lawton Indian Hospital  
1515 NE Lawrie Tatum Rd.  
Lawton, OK 73507  
580-354-5000

### One Time Visit Letter

Date: \_\_\_\_\_ HRN: \_\_\_\_\_

Print Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

This One Time Visit allows you to receive Direct Medical Care at the Lawton Indian Hospital, for the date specified above. This letter has been issued to you for not presenting with one or more of the following documents:

- \_\_\_\_\_ Certificate of Indian Blood (CDIB)
- \_\_\_\_\_ Social Security Card
- \_\_\_\_\_ Valid Federal, State, or Tribal Issued Picture Identification Card
- \_\_\_\_\_ State Birth Certificate
- \_\_\_\_\_ Immunization Record
- \_\_\_\_\_ Legal Documents/Court Orders

By signing below, you acknowledge by not providing these documents you are not eligible for the routine care, unless otherwise noted in your record. Also, if you have any information which may affect this decision, you may submit your documentation with a copy of this letter for review by the Chief Executive Officer, Lawton Indian Hospital, 1515 NE Lawrie Tatum Road, Lawton, Oklahoma 73507.

Sincerely,

A blue ink signature of Travis Scott, RD, MPH.

Travis Scott, RD, MPH  
Chief Executive Officer  
Lawton Service Unit

\_\_\_\_\_  
Patient's/Parent's/Legal Guardian's Signature\_\_\_\_\_  
Clerk's Signature

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## VA Medical Benefits User Guide



VA Medical Benefits  
User Guide\_3.0-2018.d

## FMCRA Resource Book



FMCRA Resource  
Book.pdf