



# Revenue Operations Manual



## **Part 5**

# **Account Management**

Version 2

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Department of Health & Human Services  
Indian Health Service  
Business Office

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## **Part 5. Account Management**

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# 1. Overview of Accounts Management

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 This update process is important for insuring that the manual does not become outdated.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

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- 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>

Part	Title/Contents
<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;

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- 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 Accounts Management

Accounts management is a process within the revenue cycle which consists of managing an account once a claim is approved and the accounts receivable (A/R) is established. Claims are considered part of the patient account and is a major portion of A/R. A/R may also be comprised of non-patient accounts which is covered in the various chapters of this section.

At some facilities, Patient Account Services (PAS) oversees the accounts management department. Depending on the process established by the facility, this function might be managed under different offices. Historically, accounts management was a duty of the Business Office. Some healthcare delivery systems have relocated this function under the Office of Finance and Accounting (OFA). There are even instances where Area Office consolidated the accounts management to an office within Area to manage A/R.

Regardless of the management of A/R, the roles within the revenue cycle are important for ensuring a successful processing of claims.

The objective of Part 5 (Accounts Management) of the Revenue Operations Manual is to provide guidance in the following areas:

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- **Chapter 2 – Receipt Methodologies and Processes**
    - Provides an overview on the types of receipts, how the receipt is received and processed.
  - **Chapter 3 – Batching (Recording Revenue)**
    - Provides an overview of the types of payments received and the process of recording into the Practice Management System.
  - **Chapter 4 – Remittance Advices and Explanation of Benefits**
    - Provides an overview of the Remittance Advice and Explanation of Benefits received by the payer along with guidance on how to interpret the different parts of the remittance advice.
  - **Chapter 5 – Posting (processing Payments and Adjustments)**
    - Provides an overview of the payment posting process along with adjustment and refund posting.
  - **Chapter 6 – Managing Patient Accounts**
    - Provides an overview of the account management process such as aged receivables follow up, collection strategies and establishing payment plans.
  - **Chapter 7 – Denial Management**
    - Provides an overview of the process of reviewing and analyzing denials and adjustment codes, meeting with key staff to make process changes and implementing a process to maintain those denials ensuring an accurate A/R.
  - **Chapter 8 – Debt Management**
    - Provides an overview of the Debt Management process of identifying past due accounts receivable, generating reports and reporting to Treasury for collection.
  - **Chapter 9 – Reconciliation (File, A/R, Cash)**
    - Provides an overview of the process of cash management and reconciling the accounts receivable system including the file transmission from the practice management system to the federal financial system.
  - **Chapter 10 – Monitoring/Trending/Reporting**
    - Provides an overview of the process of monitoring, trending and reporting of data to ensure the proper management of accounts

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receivable balances, posted transactions and reconciliation.

### **Separation of Duties**

As a rule, the individual that is recording the revenue received (Batching), should not be the same individual that is accounting for or eliminating the debt for the facility (Posting). The Collection Clerk (Area or Facility) should not be performing the same functions as the Accounts Receivable Technician posting receipts and adjustments to the individual accounts.

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## 2. Receipt Methodologies and Processes

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## 2.1 About Reimbursements for Patient Accounts

This section will explain the various methodologies in which receipts for Third Party Resource Patient Accounts are received and processed. The most common forms of receipt of payment are check (personal and business), electronic deposit, and IPAC.

Regardless of the method of Receipt, all Patient Account Receipts must be Batched in the Resource and Patient Management System (RPMS) (reference [Chapter 3](#)) prior to being applied to the invoice.

### 2.1.1 Lockbox Methodology

Currently, the Treasury of the US Government has an agreement with PNC bank to receive, identify, and deposit hardcopy (or paper) checks, on behalf of the Indian Health Service federal facilities and some tribal entities. It is the Agency's policy that all hard-copy checks shall be received in this manner. Area or Facility Finance is responsible for maintaining Lockbox information.

Some Third Party Payers may have limitations when remitting payments electronically. If a third party resource paper check is received at the facility or Area level, the check must be submitted to the Lockbox for processing, within 24 hours of receipt.

### 2.1.2 ACH/EFT Methodology

An Electronic transaction can be used to make a payment and/or send an Explanation of Benefits (EOB) or Remittance Advice (RA) to a health care provider either directly or via a financial institution. The Automatic Clearing House (ACH) and the Electronic Funds Transfer (EFT) have simplified the process of money transfer. Both the ACH and the EFT procedures are quick and have revolutionized the entire banking sector.

An ACH and EFT are methods to electronically receive payments on behalf of the facility. The policy for the Agency is to utilize a Treasury selected ACH, currently PNC Bank, to account for EFTs.

- **Automated Clearing House (ACH)** is an electronic network for financial transactions in the United States. The ACH processes large volumes of credit and debit transactions in batches. ACH credit transfers include direct deposit payroll and vendor payments.

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- **Electronic Funds Transfer (EFT)** is the electronic exchange, transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems. Most Third-Party Payers, that have “electronic payment” capabilities, utilize the EFT process. The Automatic Clearing House helps in funds transfer between accounts and different banking institutions.

It is each facility’s responsibility to identify payers who offer the EFT service. Payers, Agency, and your Financial Institution will normally have to “enroll” as an EFT Provider with proper forms. Work with your Finance office on specific procedures.

### 2.1.3 Intra-Governmental Payment and Collection (IPAC) System

The IPAC System provides an automated, standardized, interagency funds expenditure transfer mechanism for Federal Program Agencies (FPAs). It facilitates intra-governmental Federal e-commerce by transferring funds, with related descriptive data, from one FPA to another on a real-time basis.

IPACs are currently used by other federal agencies, such as Beneficiary Medical Program (BMP), to reimburse for visits provided to Commissioned Corp Officers and their dependents. The Program Support Center (PSC) also processes IPACs to the Area Office when collecting for claims submitted through the Debt Management process. The Indian Health Service utilizes the IPAC system for processing refunds under the Direct Reimbursement Agreement with the Veteran’s Administration. Area Finance distributes IPAC information to field offices for account reconciliation in the Practice Management System.

## 2.2 Miscellaneous Reimbursements (other AR Assets)

- **Deposit Reporting.** The US Treasury utilizes a system called Over the Counter Channel (OTC) Net to report deposits for federal facilities. IHS uses this function to create a deposit ticket for manual miscellaneous deposits in local bank accounts. PNC bank uses this function to record and deposit all Lock box and ACH deposits for the agency. These deposits are recorded in the US Treasury system to establish Treasury Deposit numbers (TDNs) for collection accountability, allocation and reconciliation purposes.
- **Check Scanning.** Another function of OTC Net is check scanning/depositing. IHS Finance uses this function to electronically scan and record miscellaneous deposits. This gets recorded in the US Treasury system to

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establish TDNs for collection accountability, allocation and reconciliation purposes.

## 2.3 **Unbilled Reimbursements**

An Unbilled Reimbursement is a reimbursement that is received from a third-party payer which has not been billed but has been identified as a proper payment to the facility. Such programs/payments include:

- Meaningful Use Incentives (not considered Third Party Revenue and should not be processed in RPMS)
- Health Professional Shortage Area Incentive Payment
- Patient-Centered Medical Home incentives from the State
- “Per Member, Per Month” State programs
- Medicaid Managed Care plans
- Annual All-Inclusive Rate adjustments, if an increase has been approved
- Other Incentive Programs
- Medical Record copying (Not considered Third Party Revenue and should not be processed in RPMS)

These are considered unbilled because a bill/invoice has not been created in the practice management system. Most of these receipts are deposited through the normal ACH/EFT channels through PNC Bank, and should follow the normal process. See ROM Part 5, Chapter 3 (Batching) and 5 (Posting) for more specific information.

## 2.4 **Prepayments**

Prepayments are a type of payment that may be received at the time of visit for a patient that has made a payment. The payment is usually received before a bill/invoice is created in the practice management system. Prepayments should be captured using the RPMS A/R Post Prepayment option. This allows for the most pertinent data to be captured during the time of collection and allows for the printing of a receipt for the payer.

Prepayments must be batched and posted to an RPMS-generated bill that reflects the patients balance due. Prepayment amounts must never be posted to the payer’s bill since that bill reflects the amounts due and amounts paid from the payer.

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## 2.5      **Payment Types**

Payments may be received in the following forms:

- Credit Card
- Debit Card
- Cash
- Check
- EFT
- IPAC
- Money Orders

Local policies should be in effect for the receipt, handling and processing of all payment types.

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### 3.      **Batching (Recording Revenue)**

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## 3.1 About Batching

Batching is the process of logging in or recording payments/receipts into the practice management system. Batching provides a more efficient and accurate way of handling the following functions:

- Recording and management all Third Party funds received
- Establishing accountability and responsibility
- Reporting collections/distribution for different facilities
- Depositing and Reconciling
- Managing Accounts
- Quick Reference to Batching:
  - All payments must be entered into a collection batch before they can be posted to bills (COL – EN)
  - Batches must be finalized before they are available for posting (COL – CR – FL)
  - Making corrections
    - Prior to finalizing a batch (COL – EN)
    - After finalizing a batch (MAN – ETDN)
- Locked with BARZ EDIT TDN/IPAC
- Once a batch has been posted it cannot be corrected so review your batch entries carefully
- What do you do if corrections are needed after posting?
  - Contact your supervisor.
- **Never make corrections via FileMan**

## 3.2 Batching Guidelines

A Collection Batch is the receipt of all transactions that occurred in a given time period (usually a day), for a given collection point, by a specific user. These batches are used to establish and maintain an audit trail during the receipt and posting processes as well as assisting management in workload and productivity statistics.

Batches must be created within 1 day of receipt of proof of payment. For example, all deposits for any given Monday, must be batches by the following Tuesday.

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Batching should be done for **all** deposits. This includes Lockbox Hard Copy Check Deposits, ACH/EFT (Electronic) Deposits, and IPAC Deposits (RPMS Third Party Resource related).

For more information on batching and timeline requirements, reference the IHS Third Party Revenue Account Management and Internal Controls Policy: <https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>.

For more information on posting payments within the collection batch, reference [Part 5, Chapter 5](#).

### 3.2.1 **Centralized versus Decentralized Batching Process**

Batching can be a centralized or decentralized responsibility/function. It is up to the discretion of the Area Management to determine which process best fits the needs and resources of the Area/Facility.

**Centralized Batching:** All functions of the Batching process (receiving deposit information, recording receipts and zero pays, editing any discrepancies, and finalizing the batch for Posting is done at a Centralized location. Here is an example of how the Batching process works in a centralized environment:

- Area office collects the payment info from PNC Bank for EDI & Lockbox
- Area office batches payments by EDI and Lockbox and sends an e-mail notification to the services units for posting
- Good business practice for the Service Unit is to review the batching for accuracy, and report any batching errors immediately prior to posting
- Service Unit should save their information for their records daily
- EDI/ACH/835 Files
- Lockbox PDFs

**Decentralized Batching:** Follows the same process as centralized batching, however, it is performed at the facility level.

**Cross between both Centralized and Decentralized:** A few Areas have implemented a cross between decentralized and centralized batching. The Area Office establishes the “header record” with the TDN and Collection Batch total, and the Service Unit/Facility adds the items (payer, item #, item amounts, etc.). This method allows for some separation of duties, and another layer of accuracy.

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### 3.3 Collection Points

A collection point can be described as the actual physical location where collections (cash, credit card, personal checks, Explanation of Benefits (EOB) checks) are received and accounted for. These are often described as “buckets” as to where the deposits are accounted in. The name and number of Collection Points established is at the discretion of the local facility management. Once the collection point name is created in the Practice Management module, the system will assign the name, date of entry and the sequential number of the batches created for the facility. These numbers are used for accounting and monitoring completion of posting activities.

A facility may have one or more collection points. Certain users are assigned accessibility for certain collection points. The Application Manager or designee must add the collection points to each individual user designated for them to access the collection points.

**Note:** Collection Points do not determine the final identity of money collected since the payment has to be posted and transmitted to the financial management system. In the official financial management system, the payment takes on the identity of the bill/invoice to which it is posted.

### 3.4 Creating Batches

Batches are created in the practice management system upon receipt of proof of payment or proof of denial. A batch may contain one or many entries. These entries are separated by payer and check. Although a batch may contain many entries, it is best to limit the number of items in each batch. Limiting items allows for easier reconciliation of the payment batch.

Batches may be created for payments, zero-payments and patient collections (Non-Beneficiary) payments.

The Collection batch names are auto generated by RPMS:

- Collection Point— FY18 PVT
  - Collection Points are created by the discretion of the Area Office, Business Office Managers, Service Unit Leads, etc.
  - These are the names create on how the facility wants to track their batches
- The date the batch was opened—09/25/2018
- Sequence— -1 (number of batches for this particular day, for this collection point)



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For more information on batching and timeline requirements, reference the IHS Third Party Revenue Account Management and Internal Controls Policy

### **3.4.1 Information Gathering and Required Fields**

To prepare for check entry into the practice management system, the Collections Clerk must gather the following:

- 1) Download daily deposit detailed information from PNC Bank. Keep a permanent copy of these records (store hardcopy or electronically).
- 2) Obtain Daily deposit report from the US Treasury that identifies the Treasury Deposit Number associated with that daily deposit from PNC Bank. Keep a permanent copy of these records (store hardcopy or electronically).
- 3) Copies of all supporting documents contained or linked to that deposit.
- 4) If an IPAC is being recorded, all documentation to support the entry of the IPAC.

Once the collection clerk has all the information gathered, they must note the following data elements to successfully create and finalize a collection batch.

- 1) Treasury Deposit/IPAC Number
- 2) Date of Deposit, as indicated on the TDN/IPAC report
- 3) Total amount of each check or EFT
- 4) Grand total of receipts for that TDN/IPAC that will be batched for that location. The total should be tabulated for each collection point used
- 5) Payer name
- 6) Check, EFT or IPAC number

**Note:** Non-Beneficiary payments will need to be sent to the Lockbox for proper documentation and for TDN assignment.

### **3.4.2 Procedure for Creating a Collection Batch for Insurance Payments**

The following details an example of the process for entering a receipt into a collection batch:

#### **Opening a Collection batch in the COL Collection Menu**

- COL
- EN

- Enter your electronic signature code
- At the Select A/R Collection Point/IHS Name:
- Enter “??” to see a list of Collection Points the user is assigned to

```

+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
+-----+
| A/R MASTER MENU |
+-----+
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:33 PM

ACM Account Management Menu ...
COL Collection Menu ...
MAN Manager ...
PAS Patient Account Statement Menu ...
PST Posting Menu ...
ROL Rollback Bills to 3-Party
RPT Report Menu ...
SVC Switch Service/Section
UA User Assistance
UPL Upload from Third Party Bill File
-----
CSH Cashiering Options ...

+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
+-----+
| Collection Menu |
+-----+
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:36 PM

EN Collections Entry
CR Collections Reports ...
CPS Check Posting Summary
PPS Patient Payment Summary

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+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
+-----+
| Collections Entry |
+-----+
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 12:56 PM

Enter your Current Signature Code:
Enter your current Electronic Signature Code so it can be verified.

Enter your Current Signature Code: SIGNATURE VERIFIED
Select A/R COLLECTION POINT/IHS NAME: ??

Choose from:
FY18 MCAID
FY18 MCARE
FY18 PVT

Select A/R COLLECTION POINT/IHS NAME: FY18 PVT

```

```

ENTERING FY18 PVT-09/25/2018-1 TYPE: EOB ONLY BATCH TOTAL: 0
You will now be prompted for the Treasury Deposit/IPAC and an amount.
The Treasury Deposit/IPAC will be used for all items in this batch.
The total of all the items entered must equal the amount entered here or
the batch will not finalize.

```

#### The Collection Batch TDN/IPAC Entry:

- For All Payment batches, use the Treasury Deposit Numbers, Always 6 digits
  - 123456
  - If this number is entered in incorrectly, finalized, posted & transmitted there will be RECEIPT errors at UFMS

- 
- For All IPAC Batches, use an I-document reference number, 8 digits

For more information, reference the RPMS Accounts Receivable User Guide at the following link:

[http://www.ihs.gov/rpms/index.cfm?module=Applications&option=View&AC\\_ID=1](http://www.ihs.gov/rpms/index.cfm?module=Applications&option=View&AC_ID=1).

Software changes are updated periodically which may affect collections entry. Ensure the Patch User Addendums are reviewed for the latest updates.

#### 3.4.2.1 Non-Beneficiary Payments

The above guidance applies to the batching of Non-Beneficiary Payments with the following exceptions:

- 1) Batch type may be Cash, Credit Card or Personal Check.
- 2) The A/R Account will be the patient the payment is being made for.
- 3) The Payer is the entity that makes payment on the account.

#### 3.4.2.2 Zero-Payment Batches

Zero-Payment batches are created in the instances where the Remittance Advice or EOB indicates why the claim is not being paid. Correspondence indicating the processing of the claim not resulting in a payment may also be batched as a Zero-Payment batch.

The above guidance applies to the batching of Zero-Payment batches with the following exceptions:

- 1) The TDN/IPAC field must be indicated as NONPAYMENT. If a TDN was issued with the remittance, then it is not considered a Zero-Payment batch. Use the payment batch processing guidelines.
- 2) The total dollar amount and itemized dollar amounts will be zero.
- 3) Remittances, Explanation of Benefits, correspondence and related items that result in a zero payment (\$0.00) are included in a Zero-Payment Batch.

#### 3.4.3 Editing Batches

Collection clerks should review collection batches for accuracy in their entirety. Once a collection batch is finalized, the audit trail begins and limited edits may occur. There are two types of editing that exist for the collection batch:

- 
- 1) Performed while in collection batch entry.
  - 2) Performed after the user exits from the collection batch entry mode.

#### 3.4.3.1 Editing a Batch in Collections Entry

This type of edit displays after the user enters the collection item information in the RPMS Accounts Receivable Collections Entry option. This allows the user to edit the Batch data before finalizing the batch. To edit the item,

- 1) At the prompt, type **E** to edit the item.
- 2) Follow the prompts to Edit the item detail data.

#### 3.4.3.2 Editing a Batch After Existing Collection Batch Entry Mode (EDTN option)

To edit a batch item, reference the RPMS Accounts Receivable manual and note the following:

- When editing a batch, after exiting the existing item, a new item number will be created, and the original item will be cancelled.
- A cancelled item will require a comment to be entered by the user.
  - Comments must be clear and concise and explain why the item was corrected.
- The Exceptions report (Collections Report menu) allows the user to view canceled or edited items

### 3.5 Finalizing Batches

The process of finalizing a batch means that all entered items are confirmed to be accurate. Being accurate is a must for successful payment posting. All entered items and fields must be confirmed for accuracy.

**Note:** Remember, once a batch is finalized, it is considered an official record in the subsidiary ledger and cannot be altered, compromised or deleted.

#### 3.5.1 Processing the Batches for Posting

All finalized batches need to be confirmed accurate from a financial official. Once confirmed, another reviewer is needed to confirm that the collection report is deemed accurate. The collection batch must be signed by a financial designee to indicate the batch has been reviewed.

---

For more information on the RPMS batch finalization process, reference the following link: [https://www.ihs.gov/RPMS/PackageDocs/BAR/bar\\_018u.pdf](https://www.ihs.gov/RPMS/PackageDocs/BAR/bar_018u.pdf).

## 3.6 Reports

Collection Batch reports are used to review and monitor the collections entry process. Different reports exist to provide different information. The four reports that currently exist in RPMS Accounts Receivable are:

- Detail Report
- Collection Report – Final
- Collection Report – Exceptions
- COLLECTION RPT FINAL REPRINT

### 3.6.1 Detail Report

The Detail Report is used to review the collection entry batch process prior to finalizing the batch and the report. The collection clerk must always review the detail report for accuracy and completion.

After reconciling the totals, reprint the Detail Report:

#### Collection Reports, Detail – No

```
EN Collections Entry
CR Collections Reports ...
CPS Check Posting Summary
PPS Patient Payment Summary

+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
| Collections Reports +
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:16 PM
DT Collection Report Detail
FL Collection Report Final
EX Collection Report Exceptions
RFL COLLECTION RPT FINAL REPRINT

+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
| Collection Report Detail +
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:17 PM

Select A/R COLLECTION BATCH/IHS NAME: FY18 PVT-09/25/2018-1 FY18 PVT
NONPAYMENT
DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO// ??

Enter either 'Y' or 'N'.

DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO//

*****BSL Report*****
DEVICE: VT Right Margin: 80//
```

DATE: BATCH STATISTICS FOR PAGE 1  
SEP 25,2018 13:18 CIHA HOSPITAL  
25-SEP-2018 TO 25-SEP-2018

BATCH DATE BATCH COLLECTIONS UNALLOCATED REFUNDED  
-SEQ-BS TOTAL PROCESSED TRUE TOTAL FROM BATCH BALANCE  
=====

COLLECTION ID: FY18 PVT  
09/25/2018-1- 0 0.00 0.00 0.00 0.00 0.00 0.00 ← Batch is OPEN  
-----  
SUBTOTAL 0.00 0.00 0.00 0.00 0.00 0.00  
-----  
TOTAL 0.00 0.00 0.00 0.00 0.00 0.00

## Collection Reports, Detail – YES

EN Collections Entry  
CR Collections Reports ...  
CPS Check Posting Summary  
PPS Patient Payment Summary

+-----+  
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |  
+ Collections Reports +  
| CIHA HOSPITAL |  
+-----+  
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:16 PM  
DT Collection Report Detail  
FL Collection Report Final  
EX Collection Report Exceptions  
RFL COLLECTION RPT FINAL REPRINT

+-----+  
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |  
+ Collection Report Detail +  
| CIHA HOSPITAL |  
+-----+  
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:17 PM

+-----+  
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |  
+ Collection Report Detail +  
| CIHA HOSPITAL |  
+-----+  
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:17 PM

Select A/R COLLECTION BATCH/IHS NAME: FY18 PVT-09/25/2018-1 FY18 PVT  
NONPAYMENT  
DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO// ??  
Enter either 'Y' or 'N'.

DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO// YES  
DEVICE: VT Right Margin: 80//

\*\*\*\*\*BSL Report\*\*\*\*\*  
DATE: BATCH STATISTICS FOR PAGE 1  
SEP 25,2018 13:19 CIHA HOSPITAL  
25-SEP-2018 TO 25-SEP-2018

BATCH DATE BATCH COLLECTIONS UNALLOCATED REFUNDED  
-SEQ-BS TOTAL PROCESSED TRUE TOTAL FROM BATCH BALANCE  
=====

COLLECTION ID: FY18 PVT  
09/25/2018-1- R 0.00 0.00 0.00 0.00 0.00 0.00 ← Batch is REVIEW  
-----  
SUBTOTAL 0.00 0.00 0.00 0.00 0.00 0.00  
-----  
TOTAL 0.00 0.00 0.00 0.00 0.00 0.00

## 3.6.2 Collection Report – Final

The Collection Report Final serves as the official record of collections received for a given period of time and will be used as a cover sheet for the Explanation of Benefits used for payment posting.

If the data on the detailed report is accurate, go to **FL** (Collections Report Final).

Once the batch is finalized, no more edits can be made to the batch under the EN Collections Entry Menu.

```
+-----+
| ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28 |
+-----+
| Collections Reports +
| CIHA HOSPITAL |
+-----+
User: USER,DSTUDENT BUSINESS OFFICE 25-SEP-2018 1:21 PM

DT Collection Report Detail
FL Collection Report Final
EX Collection Report Exceptions
RFL COLLECTION RPT FINAL REPRINT

You've got PRIORITY mail!

Select Collections Reports <TEST ACCOUNT> Option: FL Collection Report Final
Select A/R COLLECTION BATCH/IHS NAME: FY18 PVT-09/25/2018-1 FY18 PVT
NONPAYMENT

The batch total and the items total balance at $0.00 for TDN NONPAYMENT.

ARE YOU SURE YOU WANT TO FINALIZE THIS BATCH? NO// YES
DEVICE: VT Right Margin: 80//

*****BSL Report*****
DATE: BATCH STATISTICS FOR PAGE 1
SEP 25,2018 13:22 CIHA HOSPITAL
25-SEP-2018 TO 25-SEP-2018

BATCH DATE BATCH COLLECTIONS UNALLOCATED REFUNDED
-SEQ-BS TOTAL PROCESSED TRUE TOTAL FROM BATCH BALANCE
=====

COLLECTION ID: FY18 PVT
09/25/2018-1- P 0.00 0.00 0.00 0.00 0.00 0.00< Batch is POSTABLE
-----
SUBTOTAL 0.00 0.00 0.00 0.00 0.00 0.00
-----
```

### 3.6.3 Collections Report – Exceptions

The Collection Report Exceptions is a tool that can be used to track edits that were made to the collection batch. Entries will appear on this report if the collection item was cancelled or cancelled and rolled to the next item number. This reported should be printed to provide an audit trail of changes made. For more information, please reference the following screenshot:

BATCH:  
LOCKBOX-10/15/2018-1  
TDN/IPAC #: 123456  
CHK/IPAC DEPOSIT DATE: OCT 15, 2018

ITEM	RECEIVED	CHECK #	A/R ACCOUNT	AMOUNT
=====				

STATUS: CANCELED

3	10/15/18	EFT113355	MEDICARE	600.00
COMMENTS: ITEM ENTERED IN ERROR. CANCELLING AND CORRECTED IN ITEM #4 /AL				

STATUS: ROLLED UP

2	10/15/18	EFT223344	MEDICARE	800.00
ROLLED TO ITEM: 4				
COMMENTS: WRONG CHECK AMOUNT /AL				

### 3.7 Lock Down of Batches

Locking down of a batch refers to the process of making a batch un-postable after a set amount of time. This system change was done to ensure that receipts did not remain in suspense in the financial management system, guaranteeing that posting remained current resulting in a positive cash flow and to ensure accounts were not aging erroneously.

Currently, the practice management system is set to 'lock down' a batch when it reaches a minimum of 180 days outstanding (unposted balance). The current timeframe for posting the collection batch is six months. Batches are deemed un-postable at the end of each quarter. This ensures that all posting is done in a timely manner to support the cash flow/revenue cycle process. For example, at the end of a Quarter 3, in Fiscal Year 2018 (06/30/2018), all batches that still have outstanding balances to post that are dated 6 months or older (12/31/2017 and earlier), are considered "Locked Down".

**Note:** Account Management should never be in situation where they need to access a batch that has been locked. In the case of a "Locked Down" batch, please contact your Area Account Receivable Subject Matter Experts for resolution.



---

## 3.8 Logging Collections into an Excel Spreadsheet

An **option** for tracking and monitoring collections is an Excel spreadsheet that consists of all payers, check numbers, check amounts, date deposits were made, date batch was finalized, date batch posting was completed and number of days it took to complete a batch. This could help in the reconciliation process, but it is NOT necessary. It is only at the choice of the facility.

Each tab may represent deposits made by allowance category. In some cases, facilities with satellites may have separate tabs by allowance category and location. The user may define their own tabs depending on their preference of managing this spreadsheet.

These spreadsheets will allow the A/R technician to provide accurate information about each payer and track the money received from PNC for your facility.

To log new batches in the RA log:

- 1) Open the Excel RA Log file.
- 2) Click on the worksheet tab for the type of deposits you want to log: Medicare Part B, Medicare Railroad, Private Insurance.

To enter deposits for...	You need...
Medicare Part B,	<ul style="list-style-type: none"><li>• date received</li><li>• initials</li><li>• amount received</li><li>• provider number</li></ul>
Medicare/Railroad	<ul style="list-style-type: none"><li>• date received</li><li>• initials</li><li>• amount paid</li></ul>
Private Insurance	<ul style="list-style-type: none"><li>• date received</li><li>• initials</li><li>• date paid</li><li>• amount received</li></ul>

- 3) Date-stamp with the date of receipt on all cover sheets of final batches.
- 4) Select the worksheet tab for the correct Third Party payer.
- 5) Assign the batches with numbers including date received, batch date, batch amount, R/A date, and R/A number.

- 6) Assign numbers to the batches located on the lower right of the Collections Report Detailed.
- 7) Once the batch has been identified, go to the R/A Log and click on the worksheet tab.
- 8) Match each check number, payer, and amount on the Previous Day Summary and Detail Report with what has been batched.
- 9) Enter the information accurately to include check number, check amount, date paid, and date received in the appropriate payers, which is listed on the worksheet tab.
- 10) When finished, distribute the batches for posting

### Screenshot of Adding Non-Payment Batch, Editing Batch, Editing with Audit, and Canceling an Item.

```
Enter TDN/IPAC: NONPAYMENT
Checking for duplicate TDN/IPAC... No duplicates found.
Enter TDN/IPAC/Deposit Date: T (SEP 25, 2018)
Enter TDN/IPAC Dollar Amount for this Batch: 0
-----
TDN/IPAC: NONPAYMENT
Amount: 0.00
TDN/IPAC/Deposit Date: SEP 25, 2018
Correct? ? YES//

ITEM 1
PAYER: GEHA

    Searching for a NEW PERSON FILE, (pointed-to by ACCOUNT)

    Searching for a PATIENT FILE, (pointed-to by ACCOUNT)

    Searching for a INSURER FILE, (pointed-to by ACCOUNT)
( ASSOC/ASSOCDRS/ASSOCIATED/ASSOCIATES/ASSOCIATION EMPLOYEES GOVERNMENT HOSP/HOSP
ITAL/HOSPITALIZATION )
GEHA          - P.O.BOX 4665
               INDEPENDENCE, MO 64051-4665
OK? Y//

ENTERING FY18 PVT-09/25/2018-1TYPE: EOB ONLY  BATCH TOTAL: 0
TDN/IPAC: NONPAYMENT  TDN/IPAC AMOUNT: 0.00
TDN/IPAC/Deposit Date: SEP 25, 2018

ITEM 1      GEHA
^ at Check Number to ask Payer
^ at Payer to exit entry
Check/EFT #: 1122562A [RPMS Bill #]
TREASURY DEPOSIT/IPAC: NONPAYMENT

Cr=0 Bal=$0 Select Location ???

    You may enter a new SUB EOB(S), if you wish

NA NASHVILLE ADMINISTRATION
CIHA CIHA HOSPITAL
SB CIHA SNOWBIRD CLINIC
TSALITSALI CARE NURSING HOME
NASHVILLE ADMINISTRATION
CIHA HOSPITAL
```

CIHA SNOWBIRD CLINIC  
TSALI CARE NURSING HOME

Cr=0 Bal=\$0 Select Location ? CIHA HOSPITAL  
PAID AMOUNT: 0//

**REVIEW of Collection Entry**

FY18 PVT-09/25/2018-1 ITEM: 1 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

=====

CIHA CIHA HOSPITAL \$ 0.00

Select one of the following:

- E EDIT (At this point, you can Edit the Entries made without Audit)
- D DELETE (At this point, you can Delete an Entry in its Entirety and Start Over)
- C CONTINUE (At this point, by Continuing, you will be taken to Item #2 for Entry)

Enter response: CONTINUE//

ENTERING FY18 PVT-09/25/2018-1TYPE: EOB ONLY BATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00  
TDN/IPAC/Deposit Date: SEP 25, 2018

ITEM 2 GEHA  
^ at Check Number to ask Payer  
^ at Payer to exit entry  
Check/EFT #: ^ (By entering ^ here, allows you to change the Payer)  
TREASURY DEPOSIT/IPAC: NONPAYMENT  
PAYER: GEHA// ^ (By entering ^ here, allows you to stop the entry process)

GETTING READY TO RUN DETAIL REPORT. PLEASE VALIDATE TREASURY DEPOSIT/IPAC AND A  
MOUNT FOR ACCURACY  
DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO//  
DEVICE: VT Right Margin: 80//

DATE: COLLECTIONS REPORT -- DETAILED PAGE 1  
09/25/18 CIHA HOSPITAL

BATCH: FY18 PVT-09/25/2018-1  
TDN/IPAC #: NONPAYMENT  
CHK/IPAC DEPOSIT DATE: SEP 25,2018  
TOTAL: 0.00

ITEM RECEIVED CHECK # A/R ACCOUNT DISTRIBUTION AMOUNT

=====

PAYMENT TYPE: EOB CHECK			
1	09/25/18	1122562A [RPMS Bill #]	GEHA 0.00
		CIHA HOSPITAL	0.00

SUBTOTAL ----- 0.00  
TOTAL ----- 0.00

DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO//

Select one of the following:

- A ADD
- M MORE
- E EDIT
- Q QUIT

A/M/E/Q: ADD//

Select one of the following:

A ADD

M MORE  
E EDIT  
Q QUIT

A/M/E/Q: ADD// ADD

**ADD Function** - Allows you to enter more collection entries into this Batch

**MORE Function** - Allows you to add additional information that was not asked during item entry.

ENTERING FY18 PVT-09/25/2018-1 TYPE: EOB ONLY BATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

You will now be prompted for the Treasury Deposit/IPAC and an amount.  
The Treasury Deposit/IPAC will be used for all items in this batch.  
The total of all the items entered must equal the amount entered here or  
the batch will not finalize.

Enter TDN/IPAC: NONPAYMENT//

Select one of the following:

A ADD  
M MORE  
E EDIT  
Q QUIT

A/M/E/Q: ADD// MORE

ITEM: 1 1 1122562A [RPMS Bill #] 0.00GEHA EO

FY18 PVT-09/25/2018-1 ITEM: 1 TYPE: EOB CHECK BATCH TOTAL: 0

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

=====

CHECK BANK NUMBER:  
INPAT/OUTPAT:  
AUTO PRINT RECEIPT:  
COMMENTS:  
No existing text  
Edit? NO//

Select one of the following:

A ADD  
M MORE  
E EDIT  
Q QUIT

A/M/E/Q: ADD// EDIT

**EDIT Function** Allows you to:

**Edit with Audit** - This will audit the fields that you edited. When Editing with Audit, the old Item # is removed, and item will be "Rolled" to the next available Item # for this Batch.

**Cancel the Entry** - This will Cancel the Entry completely from the Collection Batch, remove the Item #, and put the Item on the Exceptions report. This item will NOT be part of the Finalized Collection Batch.

**Edit / Cancel and Item with Auditing** - Allows you to Cancel the Item or Edit the Audit

ITEM: 1 1 1122562A [RPMS Bill #] 0.00GEHA EO

FY18 PVT-09/25/2018-1 ITEM: 1 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0

```
A/R ACCOUNT    GEHA
PAYER          GEHA
LOCATION OF SERVICE  CIHA HOSPITAL
TREASURY DEPOSIT/IPAC # NONPAYMENT
=====
CIHA CIHA HOSPITAL    $ 0.00

Select one of the following:
  E  Edit w Audit
  C  Cancel
  Q  Quit

Enter response:

Enter response: Edit w Audit
ERROR COMMENTS:
No existing text
Edit? NO//

Error Comment Required

Enter RETURN to continue or '^' to exit:
ERROR COMMENTS:
No existing text
Edit? NO// YES

==[ WRAP ]==[ INSERT ]=====< ERROR COMMENTS >===== [ <PF1>H=Help ]=====
TESTING
-----
Do you want to save changes? [To exit, CTRL + E]
```

FY18 PVT-09/25/2018-1 ITEM: 1 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

ERROR COMMENTS  
TESTING

=====

CIHA CIHA HOSPITAL \$ 0.00

Is the comment correct ?? YES//

PAYER: GEHA

Searching for a NEW PERSON FILE, (pointed-to by ACCOUNT)

Searching for a PATIENT FILE, (pointed-to by ACCOUNT)

Searching for a INSURER FILE, (pointed-to by ACCOUNT)  
( ASSOC/ASSOCDRS/ASSOCIATED/ASSOCIATES/ASSOCIATION EMPLOYEES GOVERNMENT HOSP/HOSP  
ITAL/HOSPITALIZATION )

GEHA - P.O.BOX 4665  
INDEPENDENCE, MO 64051-4665  
OK? Y//

ENTERING FY18 PVT-09/25/2018-1TYPE: EOB ONLY BATCH TOTAL: 0

ITEM 2 GEHA  
CHECK NUMBER: 1122562A [RPMS Bill #]//  
CREDIT: 0//

Cr=0 Bal=\$0 Select Location ? CIHA HOSPITAL  
PAID AMOUNT: 0//

FY18 PVT-09/25/2018-1 ITEM: 2 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

=====

CIHA CIHA HOSPITAL \$ 0.00

Select one of the following:

E EDIT  
C CONTINUE

Enter response: CONTINUE//

FY18 PVT-09/25/2018-1 **ITEM: 2** TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

Item 1 now becomes 2

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

=====

CIHA CIHA HOSPITAL \$ 0.00

ABOVE IS CORRECT ?? YES//  
ITEM:

Select one of the following:

A ADD  
M MORE  
**E EDIT**  
Q QUIT

A/M/E/Q: ADD// EDIT

Edit / Cancel and Item with Auditing

ITEM: 2 2 1122562A [RPMS Bill #] 0.00GEHA EO

FY18 PVT-09/25/2018-1 ITEM: 2 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

=====

CIHA CIHA HOSPITAL \$ 0.00

Select one of the following:

E Edit w Audit  
**C Cancel** - To Delete the entry from the batch  
Q Quit

Enter response: Cancel

ERROR COMMENTS:

No existing text

Edit? NO// Y

==[ WRAP ]==[ INSERT ]=====< ERROR COMMENTS >===== [ <PF1>H=Help ]====  
TESTING

-----

Do you want to save changes? [To exit, CTRL + E] Y

<=====T=====T=====T=====T=====T=====T=====T=====T=====T>=====

FY18 PVT-09/25/2018-1 ITEM: 2 TYPE: EOB CHECKBATCH TOTAL: 0  
TDN/IPAC: NONPAYMENT TDN/IPAC AMOUNT: 0.00

=====

CHECK NUMBER	1122562A [RPMS Bill #]
AMOUNT PAID	0
REFUND	0
A/R ACCOUNT	GEHA
PAYER	GEHA
LOCATION OF SERVICE	CIHA HOSPITAL
TREASURY DEPOSIT/IPAC #	NONPAYMENT

ERROR COMMENTS  
TESTING

=====

CIHA CIHA HOSPITAL \$ 0.00

select one of the following:

R RE-EDIT

C CONTINUE TO CANCEL

Enter response:

select one of the following:

A ADD

M MORE

E EDIT

Q QUIT

A/M/E/Q: ADD// QUIT



---

## 4. Remittance Advices and Explanation of Benefits

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## 4.1 About Explanation of Benefits and Remittance Advice Adjustments

Explanation of Benefits (EOB) and Remittance Advices (RA) are the documents needed to support the payment, adjustment, or denial from Third Party Payers. EOBs and RAs vary by private insurance company, as well as by each state Medicaid program. The most consistent across the United States is the Medicare Part A and Part B payment notices.

The Accounts Receivable (A/R) staff is responsible for reviewing all transactions to assure they are processed correctly by the payer and posted accurately into the practice management system. Additionally, the AR or Billing staff is responsible for reviewing, researching, and appealing any rejections referenced on the Remittance Advice/notice. As part of their review process, the AR staff should be aware of any potential repetitive system problem, adjustment, credit, or other type of error.

The EOB and RA/notices are important for finalizing the patient accounting process. The objective of the accounting process is to fully account for billed charges and post accordingly to satisfy the balance on the patient's account between the charge, payments, and adjustments. There are different types of adjustments, such as deductibles, coinsurance, rejections, or amounts above the reasonable charge, as well as others.

This process represents the true accounting process of the Third Party revenue cycle. Therefore, it is very important for the AR staff to have a thorough understanding of each EOB and RA/notice, to perform the proper accounting procedures in the Practice Management system.

AR staff needs to fully understand the meaning of each Standard Adjustment Reason code (SAR) and/or Remittance Advice Remark code (RARC) to determine the next pathway:

Does the EOB show proper payment and proper denial?

- If yes, post accordingly.
- If no, then determine your next course of action:
  - Post, but conduct additional research, document the issue (AR messaging function) and actions taken, and follow-up as needed to correct the issue.
  - Not posted, track the denial and work to resolve so that it does not remain open and is eventually accounted for. Remember to obtain the initial EOB received from the payer for research purposes.

---

#### 4.1.1 **Guidelines for Research and Follow-up Process for Appealing a Rejection.**

For those patient accounts listed on the RA/EOB that need further review, a definitive process and procedures should be established that will:

- Determine who will be assigned the process of researching the error or rejection and set the timelines for completion.
  - For example, at your facility, is the person researching the errors and rejections the same staff who posts transactions, a separate person who is responsible for researching and appealing all accounts for all insurers, or does the remittance go back to the original biller to research and appeal?
  - The optimum person for researching and appealing claims is a separate person; however, this depends on the volume of claims handled at your facility.
  - If the volume is low, then the biller or A/R staff could perform this function, but if the volume is high, the biller would take away valuable billing time in order to research and appeal claims, potentially creating a backlog. The advantage of the biller reviewing rejections or errors is that they learn from their own mistakes, but you do not want to jeopardize the billing process by creating a segregation of duties issue.
  - The advantage of the A/R staff reviewing the errors and rejections is that it enables a second, independent review. Issues resulting in denials/rejections due to any function of the Revenue Cycle, can be shared with the staff as examples, for resolution, or part of a discussion.
  - As always, make sure the follow up processes are compliant with the Third Party Internal Controls Policy.
- Create a follow up Excel spreadsheet or tickler list to help manage the resolution of errored claims.
  - This Excel document is a spreadsheet kept in a shared location and should be accessible to all assigned staff. This document will allow the user to maintain a log of claims that require follow up, date when the claim was logged, and document the action taken for that claim.

## 4.2 **Remittance Advice Remark Codes**

Remittance Advice Remark Codes (RARCs) are used to provide additional information or convey information about remittance processing. These codes are also referred to as the Standard Adjustment Reason (SAR) codes. Some Reasons include:

- 
- Service is not covered.
  - Claim Paid in Full
  - Deductible
  - Co-Insurance
  - Benefit maximum has been reached
  - Charges exceed the amount allowed.

Group codes are codes that will always be shown with a Reason code to indicate whether to bill a beneficiary for the non-paid balance of the services rendered. Group Codes are usually evident on electronic transactions such as the 837 Invoice and 835 Remittance Advice. There are four types of Group Codes:

Code	Reason/Remark
PR	Patient Responsibility
CO	Contractual Obligation
OA	Other Adjustment
PI	Payer Initiated

Remittance Advice Remark codes are published and maintained by the Washington Publishing Company (WPC) on a regular basis: <http://www.wpc-edi.com/reference/>.

Updates to the RPMS Accounts Receivable System will occur as soon as the new, revised or deleted codes are received and mapped to existing adjustment codes. New codes will be created to match new entries.

The group codes apply to certain adjustment reason codes. The WPC website will provide the reference code used for each reason and looks similar to the following:

Code	Description
45	<p>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. <b>(Use only with Group Codes PR or CO depending upon liability)</b></p> <p>Start: 01/01/1995   Last Modified: 07/01/2017</p>

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For a complete list of Remittance Advice Remark codes, reference *RPMS Accounts Receivable (BAR) User Manual*, Appendix C: “Remittance Advice Remark Codes: <https://www.ihs.gov/rpms/applications/administrative/>.

#### **4.2.1 Patient’s Responsibility (PR) Group Code**

The PR group code indicates the patient’s liability. Due to the frequency of use, separate columns are used to report the deductible and coinsurance amounts, which are also the patient’s responsibility.

These amounts are typically used to bill other payers if the patient has other coverage (or nonbeneficiaries) for the service date.

#### **4.2.2 Contractual Obligations (CO) Group Code**

The CO group code identifies excess amounts charged that the beneficiary is not financially responsible for and is labeled as “Contractual Obligations” in the 5010 version of the 835 Implementation Guide. The implementation guide also defines this as a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment. These includes such areas as:

- Participation agreement violation amounts
- Limiting charge violations
- Late filing penalties
- Amounts for services not considered to be reasonable and necessary

#### **4.2.3 Other Adjustment (OA) Group Code**

The OA group code is used when neither PR nor CO is used, such as with the Reason code message that indicates the bill is being paid in full. The 5010 version of the 835 Implementation Guide labels this code as “Other Adjustment” and is used only in certain situations.

#### **4.2.4 Payer Initiated (PI) Group Code**

The PI group code is used to identify Payer Initiated Reductions. This code is used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments). This code is not used frequently but it can be used for adjustments such as denials due to performance rating guidelines.

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#### 4.2.5 Standard Adjustment Reason (SAR) Codes

The latest list of Standard Adjustment Reason codes are located in the Accounts Receivable User Guide located on the RPMS Website under the Administrative Applications <https://www.ihs.gov/rpms/applications/administrative/>. Check the latest version of the patch documents for the most recent update.

A list may also be generated from the Posting Menu located in the RPMS Accounts Receivable system. The Create Report Std Adjustment Reason Codes (IRMK) option will provide a file that may be imported into Microsoft Excel for printing, sorting, etc.

### 4.3 Explanation of Benefit/Remittance Advice Data Elements

The following list is a summary of the typical data elements listed on the private insurer or state Medicaid EOB or RA.

It is imperative that the posting technician understand each item and uses the information received to correctly process the transaction data in to the practice management system.

This list can vary across Third Party Payers:

- Name, address and telephone number of the insurer
- Date of the RA or EOB or date of invoice
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Group name and group number (primarily private insurers)
- Check number and check amount
- Name and address of IHS facility
- Bank code (for electronic submission and posting)
- Identification or member number for the patient
- Patient name
- Patient relationship
- Patient account number (the account number assigned by the facility)
- Member name (if different than patient)

- 
- Control number or claim number (number assigned by the insurer for their internal control)
  - Date claim received at the insurer
  - Provider of service (facility name, provider name, billing provider, service provider, etc.)
  - Provider number
  - Date or dates of service (for inpatient admissions the admitting and discharge date will be referenced)
  - Place of service, form type, or services rendered at (specific location)
    - Description or type of service (clinic visit, lab, surgery, or the insurer may list the CPT or HCPCS code. For inpatient claims, the DRG code and days will be referenced. In addition, some insurers will also list the term “negotiated rate.”)
  - Modifier or Units
    - This refers to the number of same services being billed for a given day or the modifier that was billed with the procedure code. This could also be used for inpatient revenue codes that utilize units.
  - Amount Charged (usually divided by service or date)
  - Not covered portion
    - For those services or procedures not covered under that patient’s contract or for patients not covered under that contract (e.g., contract was terminated)
  - Adjustment or discount amount
  - Amount allowed
  - Amount applied to the deductible or coinsurance
  - Percent or payment factor covered by the insurer
  - Amount paid to the provider, facility (usually the amounts are divided by service or date)
  - Remark code
    - A description of the remark code will either appear at the bottom of the Explanation of Benefits or Remittance Advice, or at the end of the notice.
  - Patient responsibility or patient share
    - This is the amount owed by the patient to the facility, such as deductible,

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coinsurance, or rejected claim.

- Subtotals and Totals
  - Subtotals are listed for multiple services done on one day and the total is listed at the end for all patients, all services.
- Adjustment Code or Description

#### 4.3.1 **Diagnostic Related Group (DRG) Weights or Amounts**

For Medicare, offsets to payments are shown as an adjustment against an individual claim in that remittance notice. The Financial Control Numbers (FCNs) that will enable the provider to associate the offset with those claims and payments that led to the withholding is shown under the FCN column. A single Health Insurance Claim (HIC) number is printed if the offset is for a Medicare overpayment and a HIC number is associated with the offset.

If the offset/withholding is NOT associated with a single HIC, the HIC number will not be supplied. Multiple HIC numbers are not printed in this field; the notice must be consistent with the electronic remittance advice standard, which only permits a single HIC in this field:

- Claim status
  - This is used by insurers to inform the facility of a deferred claim, a paid claim, a claim routed to another insurer such as a secondary insurer, or other. Crossover claims may also be listed immediately following the claim payment history under comments. Other insurers will have a column on the Remittance Advice for other insurers billed, such as “Medicaid billed amount.”

The Veterans Administration (VA) also processes inpatient claims using the DRG Methodology but differs slightly in reporting on the remittance advice.

Contact your payers for detailed descriptions of RA or EOB.

## 4.4 **Electronic vs. Paper RAs or EOBs**

For Medicare, Medicaid, and some private insurances, an Electronic Fund Transfer (EFT) is accompanied by an Electronic Remittance Advice (ERA). Some Advantages of using electronic versus paper remittance advices are:

- Facilities receive electronic reimbursements daily for the claims that have



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been approved and have met the payment floor.

- Saves time from manually handling checks.
- Eliminates the need for manual posting of payments, line by line.
- Remittances include all payments and adjustments.
- HIPAA compliant –
  - Uses the same electronic format, ANSI X12 files (Using the same format enables facilities to electronically transmit to multiple insurers.)

For information on processing electronic Remittance Advices/Notices, reference, RPMS Accounts Receivable User Manual (BAR), Chapter 9.14, “ERA Posting (ERA)”: <https://www.ihs.gov/rpms/applications/administrative/>.

## 4.5 Standardization

Standardization applies to account reconciliation because it helps to streamline the process of posting and account follow up. Following a standardized process allows posted data to be meaningful to peers and to management. This also ensures correct procedures are being followed by tying data from the remittance to the patient’s financial record. To achieve successful standardization in the revenue cycle, thorough planning, training and implementation is needed in the account reconciliation process. This is done by:

- Achieving consistency and adopting one method for posting.
- Establishing standards. Meeting with the posting staff and identifying posting scenarios along with agreeing to use specific codes that best describe an adjustment when posting.
- Documenting and creating a process manual that may be used for reference.
- Auditing accounts on a regular basis to ensure compliancy and accuracy in posting.
- Reviewing and training staff on new codes that have been released.
- Identifying opportunities for posting improvement should be discussed and addressed.

### 4.5.1 Adjustment Codes

Adjustment codes are found on the Remittance Advice and provide guidance to the user on how a transaction is processed by assigning a Claim Adjustment Reason Code (CARC) to the item referenced. This is also referred to as a SAR

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Code. The AR posting technician uses these codes to match the adjustment reasons to the claim in the practice management system.

The CARC codes are updated on a regular basis and maintained by the Washington Publishing Company. In the RPMS Accounts Receivable system, new codes are reviewed and assigned to an Adjustment Type. The Adjustment Type is referenced when posted to the patient's financial record and is assigned to an Adjustment Category. Adjustment types are released as an update to the practice management system on a regular basis.

#### 4.5.1.1 VA Adjustment Codes

Certain adjustment scenarios may need to be followed when posting for different payers. For example, upon the implementation of the reimbursement agreement between the Indian Health Service (IHS) and the VA, posting adjustments for different transaction types required a standard set of adjustment codes to be used.

The \$15 paper claims adjustment will be entered A/R as a Non-Payment (4) and Statutory Adjustment (686) adjustment reason. Paper pharmacy are excluded from this fee.

Since the claims will be submitted itemized, the remaining balance will be adjusted using the Grouper Allowance (16) with Processed in Excess of Charges (694) to bring the account into balance.

More information on the entire VA Billing and Posting, reference the "VA Medical Benefits User Guide" in the appendix.

##### 4.5.1.1.1 Payment Exceeds Billed Amount

Use GROUPER ALLOWANCE, 694 (exception is Inpatient which will use a DRG adjustment type.)

##### 4.5.1.1.2 Payment is Within Billed Amount

Use GROUPER ALLOWANCE, 694 (exception is Inpatient which will use a DRG adjustment type).

The following is an example of a claim posted where the billed amount was lower than the payment amount.

Transactions for DEMO,WILLIAM from 05/22/2013 to 05/22/2013					Page: 1
Trans	Type	Amount	Category	Adj. Type	
1.	A	300.00	PAYMENT CREDIT	RECEIVED NO-COL-REGISTER	

2.	A	15.00	WRITE OFF	PROCESSING FEE
3.	A	15.00	NON PAYMENT	Statutory Adjustment
4.	A	-262.00	GROUPER ALLOWANCE	Processed in Excess of Charg

## 4.6 Re-association (EFT to ERA)

According to the ASC X12N 835 Health Care Claim/Payment Advice (835), version 5010, Implementation Guide, re-association requires that both remittance and monetary data contain information that allows a user or system to match the item received. This means that the Collections Clerk will need to be able to identify the check number from a paper check received, or the EFT/ACH number from the lockbox provider, and be able to match to a remittance advice received either by paper or electronically. The practice management system helps with the matching by recording the check or EFT number into a collection batch. The collection batch is used to manually post transactions to the patient account or using the Electronic Remittance Advice process to match the remittance to the batch for posting.

The 835 contains data elements that report the trace number for the transaction set. This is located in the TRN segment and is used to re-associate payments and remittances sent separately. This is a unique number and is referenced as

- The Check Number in the element TRN-02 for check payments
- Unique Electronic Funds Transfer (EFT) number in the element TRN-02 for EFT payments
- A unique number generated by the payer as a reference for the 835 in TRN-02 for non-payment transactions

The payer has a unique identification number that is sent in the element TRN-03 which is used in case other payers use the same reference number in TRN-02. Using this combination of identifiers from TRN-02 and TRN-03 prevents the possibility of a check being matched to the wrong payer when batching.

To ensure that re-association is successfully in place, it is important for the site to establish a table that records the activity performed with each check number/EFT to ensure proper matching and posting in the system occurred.

## 4.7 How to Read a Remittance Advice

The RA is used by the payer to notify the provider how a claim was processed. The RA may be received by paper or in an electronic format (such as the 835). The Electronic Remittance Advice (ERA) 835 is a National Standard Format

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(NSF) that is used by almost all payers that process claims for payment. Paper remittances are not in a standardized format and may display differently. In either instance, it is important to understand what information is sent on a RA and what the data means.

#### 4.7.1 Remittance Advice Properties

The paper remittance displays data that allows the Posting Technician to read, process and post transactions into the practice management system. Some payers, such as Medicare and Medicaid, will process and report claim data for multiple patients and multiple service dates on one RA report along with one check or EFT. Other payers such as commercial or private insurance plans may send a single remittance along with the corresponding check or EFT. Posting multi-claim remittances are time consuming and are subject to user errors during posting. Consider using the Electronic Remittance Advice for posting these remittances.

The RA will contain the following items (any additional items reported by the payer are optional but help in processing the remittance while posting):

- 1) **Processing Payer** is used to identify the payer who processed the claim.
- 2) **Paying Entity** (optional) is used to identify who issues the payment on behalf of the insurer. Most payers will process and pay their own claims but some plans use administrators to “cut the check” and issue it for payment. Large payers may have a central payment center that issues the check so the issuing address may be different than the claims submission address.
- 3) **Provider Number or Identifier** is the Federal Tax Identifier or the National Provider Identifier (NPI) that the payer used to make payment to.
- 4) **Internal Control Number (ICN)** is used as a batch number that references the batch of claims in the remittance advice. This may also be used when contacting the payer for RA information.
- 5) **Remittance Advice Date** is the date the batch of claims were paid. This may also be the same date the payer used to process the claims.
- 6) **Detail Claim Listing** provides the details of the claims that are reported on the RA:
  - a) Patient Name.
  - b) Identification Number is the subscriber identifier or the policy holder

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identifier.

- c) Claim Control Number is the reference number used to process the claim. This may be used to identify the claim to the payer when calling for details.
  - d) Service Dates refers to the visit date on the claim.
  - e) Procedure Codes can be Revenue Codes, CPT, HCPCS or ADA codes used to make up the charges of the claim.
  - f) Patient Control Number referencing the claim number from the practice management system.
  - g) Units or Quantity of each line item charge.
  - h) Total Charge for each line item.
  - i) Total Non-Covered Charges is used to reference the non-covered amount or the charges not covered by the plan.
  - j) Allowed Amount refers to the dollar amount the payer used to process the line item or the claim charge and is normally made up of the payment and patient amounts such as Co-Pay, Co-Insurance or Deductible amounts.
  - k) Amount Paid refers to the amount paid on the claim.
  - l) Patient Responsibility refers to any patient amount due such as the Co-Pay, Co-Insurance and/or Deductible amounts.
  - m) Remark Codes identify the reason for the adjustment made for each line item. This is identified as the Claim Adjustment Reason Code (CARC). The Remittance Advice Remark Codes (RARC) may also be identified in this field.
- 7) **Adjustment Codes/Key** is used to display all adjustment reason codes used for the RA. This would consist of the Claims Adjustment Reason Codes (CARC).
- 8) **Remittance Advice Remark Codes (RARC)** is used to display all RARC codes used in the remittance advice.

Always be sure to reconcile your posting in the practice management system to what was sent on the remittance advice. Accurate posting using the proper adjustment reason codes will place more emphasis on correct posting and allows

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the practice to see any issues that could cause payment denials or delay in processing.

Remember, just because the payer processed a claim in a certain manner does not mean that is the “end all, be all” for the remittance. If the claim was not processed appropriately, an appeal may be filed if the documentation submitted justifies the request for reprocessing of the claim.

#### **4.7.2 Remittance Advice versus Correspondence**

When a payer processes a claim, they may provide correspondence to the provider to advise how a claim was processed. This more than likely occurs if the claim was denied. The correspondence may be in the form of a letter that explains why a claim has not been processed.

The most common reasons a site may receive correspondence is due to:

- Request for additional information, such as health records, lab test results, radiology films, etc.
- Notice of termination of coverage if the patient no longer has coverage with the payer.
- Notice of missing information on the claim needed to adjudicate

Correspondence must be recorded and filed if needed for future reference. All correspondence must be worked in a timely manner.

### **4.8 How to Read an Electronic Remittance Advice Using Downloaded Software**

Software exists that allows an ERA 835 raw data file to be imported and displayed in a user-friendly readable format. This software is provided by the Centers for Medicare and Medicaid Services (CMS), but is distributed by the Medicare Administrative Contractor (MAC). Please refer to the MAC in the state of your facility to obtain the software.

Regardless of the MAC, CMS also offers information for the applications discussed below.

#### **4.8.1 Medicare Remit Easy Print (MREP)**

This software is available on the CMS website or by accessing the MAC EDI

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website and is free to Medicare providers. MREP can be used to access and print remittance advice information, including special reports, from the HIPAA 835.

The MREP software is not only used for Medicare remittances but may also be used for other payer remittances that need to be printed to a paper format or placed into a readable format.

The software is especially helpful when submitting paper claims to a secondary or tertiary payer where the paper remit is needed.

### **4.8.2 PC Print Software**

CMS developed the PC-Print software, which gives Medicare Part A facilities a free tool to read and print an ERA in a readable format. Facilities that use the PC-Print software package can print paper documentation that can be used to reconcile AR, as well as create a document(s) that can be included with claim submission to secondary/tertiary payers. The output of PC-Print is like the current Standard Paper Remittance (SPR) format.

The PC-Print software enables providers to choose one or more print options:

- Print 835 data in an easily readable format
- Print entire transmission
- View and print provider payment summary information
- View and print a single claim
- View and print a sub-total or summary by bill type

The PC-Print software and instructions are designed to be self-explanatory for providers and are available from the EDI section of your MAC website.

## **4.9 Electronic Deposits and Remittance Advices**

### **4.9.1 About Electronic Transactions**

Electronic transactions are used to make a payment and/or send an EOB or RA to a health care provider either directly or via a financial institution.

The implementation of the HIPAA standard transaction set allowed for one instance of the electronic remittance advice that makes it easier for the practice management system to receive and process payment files. Medicare currently supports the ANSI ASC X12N 835 Health Care Claim Payment/Advice

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Transaction electronic format. This is a variable-length format that allows remittance advice information to be sent to both institutional and non-institutional providers. Updates to the version of the 835 are published every few years and payers will use the most current version to report transaction data.

The Electronic Data Interchange (EDI) 835 Implementation Guide (IG) can be found on the Washington Publishing Company website: <https://www.wpc-edi.com/>.

## **4.9.2 Electronic Reimbursement Process**

IHS has an agreement and arrangement with PNC Bank to enable electronic reimbursement between major insurers and the different IHS facilities and Area offices. The reimbursement is based on claim batches by the insurer and the process may change at any time

The following sections describe the process of tracking these electronic fund transfers (EFTs).

### **4.9.2.1 Download PNC Bank Deposits**

EDI 835 files are downloaded from the PNC Bank EFX Platform using the Treasury Management File Transfer Service also known as the PNC File Gateway. Users must sign up to be able to download files and must be approved to start receivable file data.

The User Guide is made available from the Office of Financial Management (OFA). The web login can be located at PNC Bank EFX Website: <https://esso.pnc.com/lp2/login/EFX/SFG>.

### **4.9.2.2 Download the PNC Bank Previous Day Summary and Detail Report**

**Note:** Previous, Day Summary and Detail Reports are only for ACH/EFT credits for payers with ACH/EFT capabilities, such as Medicare Part A and B.

It is the responsibility of the Accounts Receivable section of the Patient Financial Services department to identify facility payments from the PNC Bank deposits and the pay date. A hard copy of the Previous Day Summary and Detail Report should be printed, retained (copy saved electronically or hardcopy), and submitted to the Business Office manager, which is used for management review.

To download and print the Previous Day Summary and Detail report:



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- 1) Go to <http://www.treasury.pncbank.com/>.
  - 2) Select a Module: **Account Login**.
  - 3) Select a Service: **Pinnacle Web**.
  - 4) On the log in page, enter the following information:
    - a) Company User ID
    - b) Operator ID
    - c) Password
  - 5) Pinnacle Web page: **Information Reporting**.
  - 6) Under Reports, click on **Standard**.
  - 7) Click on **Preview Day**.
  - 8) Click on **Detail**.
  - 9) Click on **PDF**.
  - 10) Click on **Open**.
  - 11) Keep an electronic copy of the report by clicking on **Save As** and identifying a location to store the report.
  - 12) Print two (2) copies, and Exit.

One complete copy will be filed with A/R and another copy will be given to Finance or Accounting.

The A/R technician should also access the special report service using the same website. When the Special Reports Tab is selected, the A/R Technician can download the EFT Details.

Finance uses this information to match deposits to the Treasury Deposit Number (TDN) before Batching of receipts can begin.

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## 5. Posting (Processing Payments and Adjustments)

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## 5.1 About Posting Payments and Adjustments

Posting allows the user to properly account for all Third Party Resource Accounts Receivable by applying payment and adjusting transactions to individual A/R bills/invoices. All transactions (receipts, adjustments, and denials) are to be posted within 72 hours of receipt of supporting documentation.

For more information, reference *Indian Health Manual*, Part 5, Chapter 1, “Third Party Accounts Management and Internal Controls”:

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

## 5.2 Posting Guidelines

Posting payments and/or adjustments occur once a check and/or zero payment batch has been created in A/R. It is required to sign into a cashiering session in A/R to capture all transactions posted to an A/R Bill. Payments and Adjustments should reflect the correct amount and codes according to the proper documentation of the Explanation of Benefit (EOB) and/or correspondences.

Posting payments should never happen without the proper documentation or proof of payment.

Key points in the Posting Process:

- 1) Payments are posted from collection batches created.
- 2) All payments required a TDN (Treasury Deposit Number) assigned from Treasury.
- 3) For UFMS users, Payment transactions are transmitted from RPMS to the HUB to UFMS where they decrease the A/R Account and become receipts (allotted to the Service Unit for spending).
- 4) Receipts are proper payment from a EFT or Paper Check received in PNC Bank.
- 5) Adjustments are Zero Payments that come from correspondences or denials.
- 6) Adjustments can decrease or increase an A/R Bill in RPMS (Positive or Negative Adjustments).
- 7) Adjustment transactions are transmitted from RPMS to the HUB then to

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UFMS and will increase or decrease the A/R Balance.

- 8) Payment and Adjustments are posted within 72 hours of receipt of proper documentation.
- 9) Payment AND Adjustments are posted at the same time.
- 10) **Write Off versus Non-Payment.** Determine when to use the Adjustment Category of Write-Off or Non-Payment.
  - a) Ask the question: If the patient has another alternate resource, do I want to pursue payment from the secondary payer?
- 11) Use the **Adjustment** Category that best represents the non-payment from the payer (adjustment type write-off or non-payment).

## 5.3 Posting Payments and Adjustments

There are many methods of posting payments and adjustments in the RPMS Accounts Receivable System. The sections below review the Electronic Posting (from electronic file), Flat Rate Posting, and Manual Posting (most scenarios) methods.

### 5.3.1 Electronic Posting

- Allows for auto-posting of Electronic Admittance Advice (ERA) files (ERA/835) in RPMS.
- Option is locked with a security key meaning you will have to be granted access to this option.
  - Locked with BARZ ERA MENU
- ANSI ASC x12.835 (v5010) – Health Care Claim Payment/Advice (835).
- Remittance advice/EOB is received from the payer or clearinghouse in the form of an electronic file.
- Replaces the paper RA/EOB.
- RPMS automatically posts the payments and adjustments contained in the ERA file after the user goes through a series of menu options in the ERA Posting menu.
- The posting step is dependent on ERA claims being matched to RPMS bills that are not marked with Reasons Not to Post. This will be explained in detail later.

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### Medicare Remit Easy Print

- Allows for converting an ERA file into a traditional remittance advice.
- Free software download provided by CMS (Centers for Medicare & Medicaid Services).
- Converts ERA files received from any payer, not just Medicare files.
- For more information/free download, reference:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html>

### Obtaining an ERAfile

- Contact your payer(s) or clearinghouse when your facility is ready to start processing ERA files.
- PNC Bank will assist facilities that have a written agreement with them.
- File must be obtained via a secure method due to PHI.
- Various methods of obtaining a file:
  - Encrypted email
  - Payer or clearinghouse provides the files on a secure website for download

### Preparing to Load a File into RPMS

- The file must be placed in a folder on a server that can be accessed by RPMS.
- The folder should be secure due to PHI in the file.
- You will need to know the directory path name.
- The person who will be moving the ERA files to the folder will need read/write access.
- Consider renaming the file to something meaningful.
  - BCBS NM\_6042016, for example
- The following security key will need to be assigned to users needing access to the ERA Posting Menu: **BARZ ERA MENU**.
- **See your local IT staff for assistance with the above steps.**

The following ERA menu options in bold text are required for processing an ERA file. The other options provide information about a specified ERA file.

- 
- **NEW Load New Import**
  - **VIEW View Import Header**
  - **TRN Check Amount and Check number for 835**
  - **BPR Review & Match ERA to Collection Batch**
  - **BLMT A/R Bill Matching**
  - **REV Review Postable Claims**
  - **POST Post ERA Claims**
  - **RPT Report ERA Claims**
  - **NFND ERA Check Not Batched**

### **Load New Import (NEW)**

This option loads the ERA file from a designated folder on your server into RPMS.

- Enter your signature code.
- Verify the directory path is correct.
- Type an asterisk (\*) at the File Name prompt to get a list of files available for upload and select the desired file. You may also type the name of the file as it appears on your server.
  - System will check the file format for 835v5010 compliance
- If the file is not compliant, an error message will be displayed, and file will not be loaded.
- If the file is compliant, an RPMS file name will be assigned and the file will be loaded (1065\_ERA\_07/13/2015, for example). You will use this file name to process the file in the other ERA menu options.
- ERA check information is displayed.

### **View Import Header (VIEW)**

- This option allows for viewing different segments of an ERA file such as:
  - TRN02: Check Number
  - BPR02: Check Amount
  - BPR16: Check Issue Date
  - N102: Payer Name
- The check information can now be viewed in a user-friendly format by using

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the ERA TRN option.

### **CheckAmount and Check Number for 835 (TRN)**

- This option displays the ERA check information in an easy-to-read format:
  - Payer
  - Check Amount
  - Check Number
  - Check Date
- This report can be used for obtaining check information needed for batching the ERA check.
  - **Note:** the ERA check number must be entered into the collection batch exactly as it appears in the ERA file.

### **Review & Match ERA to Collection Batch (BPR)**

This option matches ERA check(s) to RPMS Collection Batch Item(s).

- Collection Batch/Item Not Found. The two most common reasons for this are:
  - The ERA check has not been batched yet.
    - Batch the check using the Collections Entry menu and re-run the BPR option.
  - The ERA check has been batched but the dollar amount and/or check number was not entered correctly.
- Use the ETDN option in the A/R Manager Menu to correct the batch/item dollar amount(s) and re-run the BPR option.
- If the check number is incorrect, notify your local IT to have a support ticket opened with OIT for correction. After the check number has been corrected, re-run the BPR option.
- Collection Batch/Item Found.
  - Make sure that the ERA check has been matched to the correct RPMS Collection Batch/Item.

### **A/R Bill Matching (BLMT)**

This option matches the claims in the ERA file to bills in RPMS.

Three elements are used for matching ERA claims to RPMS bills. All three

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elements must match or the claim will be marked as Unmatched in RPMS.

- Bill Number or RX Number
- Billed Amount
- Date of Service

The detailed report of the bill matching process provides information on why a claim is unmatched.

In the example below, the ERA Billed amount (55.32) does not match the A/R Billed amount (60), and the ERA DOS (3/15/2016) does not match the A/R DOS (3/9/2016). Claim can be manually matched in the Review Postable Claims option, if desired.

### **Review Postable Claims (REV)**

This option displays all the claims in the ERA file and their status

- Matched
- Unmatched
- Matched with Reasons Not to Post

The Edit Status command allows users to manually change the status of an ERA claim. The following status changes can be made:

- From Matched to Exception
- From Exception to Matched
- From Unmatched to Matched or Exception

Keep in mind that Matched claims might also have a Reason Not to Post. Some common Reasons Not to Post are:

- Negative Balance will result in RPMS Bill
- RA CLAIM IN RPMS AR BUT CANCELLED IN 3P
- PAYMENT REVERSAL FOUND – **must do manual posting**
- NO BATCH FOUND FOR ERA CHECK

**Note:** The REV option be run before the user will be allowed to Post the file. If the REV option is not run a message will be displayed in the ERA PST option and the file will not be allowed to post.

### **Post ERA Claims (PST)**



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This option posts the payments and adjustments in the ERA file. Remember, only Matched claims with no Reasons Not to Post will be posted via the ERA POST option.

- Enter the RPMS file name provided in the NEW option.
- Choose the check you wish to post, type Yes and press <enter> to begin posting.
- The system will display the posting activity (amounts posted, adjustment code descriptions, etc.).
- When posting is complete, the system will allow for rolling bills back to the Third Party Billing package if there are additional resources that can be billed.
- Unmatched claims or Matched claims with Reasons Not to Post will have to be posted manually, if applicable.

### **Report ERA Claims (RPT)**

This option provides information on posted claims, unmatched claims, reasons not to post, etc.

- Enter the RPMS file name provided in the NEW option.
- Choose the type of data you wish to generate.
  - Claim Unmatched
  - Exception
  - Posted
  - All Categories
- Choose the type of report.
  - D – Detail
  - B – Both (summary and detail)
  - S – Summary

### **ERA Check Not Batched Report (NFND)**

This option provides a list of checks in a specified ERA file that have not been matched to an RPMS Collection Batch/Item.

- Enter the RPMS file name provided in the NEW option.
- A list of ERA checks that are not matched to a Collection Batch will be displayed. The two most common reasons for this are:
  - The ERA check is not batched yet.

- 
- Batch the check using the Collections Entry menu and re-run the BPR option.
  - The ERA check has been batched but the dollar amount and/or check number wasn't entered correctly.
  - Use the ETDN option in the A/R Manager Menu to correct the batch/item dollar amount(s) and re-run the BPR option.

If the check number is incorrect notify your local IT to have a support ticket opened with OIT for correction. After the check number has been corrected, re-run the BPR option.

### 5.3.2 Manual Posting

When a claim is approved in 3PB, it becomes a bill and the bill information is sent to the Accounts Receivable System as an AR Bill/Account. An entry is immediately created for posting (A/R Bill).

- Payments must be posted using a collection batch. (PST – PAY)
- Adjustments may be posted with or without a collection batch. (PST – ADJ)
- Keep an eye on the Negative Balance List (RPT – AMRM – NEG) for negative bill balances.

To post payments on daily batches:

- 1) Log on to RPMS and go to the Accounts Receivable (BAR) application.
  - a) Select **BAR** or A/R Master Menu.
  - b) At the menu option prompt, type **PST** (Posting) and press Enter.
  - c) At the menu option prompt, type **PAY** (Post Payments and Adjustments) and press Enter.
    - i. If you are only posting Adjustments, and not wanting to link the transaction to a batch, you can use the ADJ (Post Adjustment) option.
  - d) Enter your electronic **signature code** and press Enter.
  - e) If the **Rollover as you post?** prompt appears, type **Y** (Yes) and press Enter.
    - i. **Rollover as you Post:** When you are posting transactions in Accounts Receivable, the system will automatically pass back transactions to Third Party billing to consider for secondary billing.

- 
- 2) Select the batch and batch item you want to post.
    - a) At the prompt, enter the batch *or* type ?? to display a list of batches and select the batch. Then press Enter to display the total amount posted and any remaining balance of the batch selected.
    - b) Enter the **Batch Item** you want to post.
      - i. Normal selection is in item number order. Item numbers may be selected out of order by entering the specific item number.
      - ii. The following data is displayed for the selected batch item:
      - iii. Total posted amount
      - iv. Remaining balance amount
    - c) Select Visit Location (your facility) and press Enter.
  - 3) At the prompt enter the A/R Bill/IHS Bill Number and enter the patient's account number.
    - a) If no claim number is listed on the EOB, press Enter.
    - b) Enter the patient's last name, then first name or social security number, and press Enter.
    - c) Enter date of service and press Enter.
    - d) Confirm that the patient name, date of service, and dollar amount match the EOB.
    - e) At the select Action prompt, type P (Post), M (More), or C (Cancel), and press Enter.
    - f) At the Select Command prompt, type **B** (Bill Inquire) and press Enter. The patient chart number, visit type, clinic type, provider, a brief description of the visit and other related information are displayed.
    - g) At the Select Command prompt, type **H** (History) and press Enter. All transactions for a particular bill, including current and posted transactions, are displayed.
    - h) At the Select Command prompt, type **D** (Patient Demographic) and press Enter. The patient's residence, Third Party eligibility, date of birth, social security number, and verification of eligibility are displayed.

- 
- 4) At the prompt, type **P or 1** for posting payments and press Enter.
    - a) Confirm the correct dollar amount to post from the EOB. Enter the payment amount and press Enter.
    - b) If the Current Balance column for the line item for which the payment was posted equals zero (0), type **Q or 3** at the prompt and press Enter.
  - 5) Identify the reason for the remaining balance based on the EOB. The most common reasons are the deductible and coinsurance.
  - 6) At the Select Command prompt, type **A or 2** (Adjustment) and press Enter.
    - a) Enter the amount of the adjustment based on the EOB or your calculations and press Enter.
    - b) Type **??** to display the list of Adjustment Categories and press Enter.

2. Adjustments	3. 3
4. Non Payments	5. 4
6. Deductible	7. 13
8. Co-Pay	9. 14
10. Penalty	11. 15
12. Grouper Allowance	13. 16
14. Refund	15. 19
16. Payment Credit	17. 20
    - c) Select the appropriate Adjustment Category and press Enter.
    - d) Type **??** to display the list of Adjustment Types and press Enter.
    - e) Select the appropriate Adjustment Type and press Enter.
  - 7) If there is still a balance after all the payments are posted, at the prompt type **B** (Bill Detail) and press Enter.
    - a) The bill detail will provide information on whether all the charges were considered.
  - 8) At the Select Command prompt, type **M** (Message), and press Enter.
  - 9) At the prompt, type **1** to create a message, and press Enter.
    - a) If there is a previous message, the system displays it and asks if you want to view the existing message. If there were no previous messages, “No
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Message on File” appears.

- 10) To view the previous message, type **Y** (Yes). After viewing the message, type **Q** (Quit) and press Enter.
- 11) If you do not want to view the previous message, type **N** (No) and press Enter.
- 12) At the Create a Message? prompt, type **Y** (Yes) to create an editable message.
  - a) Enter the message. The message should be very detailed and include the insurance company name, amount in question and the name of the person to which you referred the EOB.
  - b) When finished, press Enter or type **4** (Exit).
- 13) At the prompt, select one of the following options based on whether there are more checks to post to this item number:
  - a) **P** = Post to A/R (post what has been entered)
  - b) **M** = More (post more to the claim)
  - c) **C** = Cancel (cancel current entry)
- 14) If there are:
  - a) More claims to post off that item number, select another claim.
  - b) No other claim(s) to post, press Enter three (3) times.
- 15) Continue posting payments until your Batch Total is zero (0).

### 5.3.3 Posting Unallocated (Unidentified) Cash

The Unallocated Posting Option can be used for many scenarios, but the main reason is to:

- Refund to Payer (reference Section 5.3.7, Posting Refunds)
- Transfer to Other Facility (reference Section 5.3.8, Posting Transfers)

**Batched in Error** A collection batch is created in error for more than the actual dollar amount of the check. For example, a check/deposit was received for \$100, but the collection batch was created for \$1000. That \$900 is placed into PUC

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from the PAY option and then refunded from RPMS with the appropriate refund code.

**Note:** For unidentified cash or a check received where you are unable to identify the patient, post the money to “Unallocated Cash.” The system will ask “Do you want to POST any of the unposted balance to Unallocated Cash?” Press Enter (Yes).

### **5.3.4 Posting Medicare/Railroad Retirement Released Payments**

There are times throughout the payment cycle, that Medicare, or other Payers may withhold/suspend payment on particular accounts for a period of time. They often release those payments via Explanation of Benefits after resolving the issue regarding these accounts.

#### **Released – No Penalty**

Same as any other payment/adjustment posting. Post these payments, using the instructions in “About Posting Payments and Adjustments.”

When finished, attach the Remittance Advice (RA) from the holding file.

#### **Released – with Penalty**

- 1) Post the penalty charge under Penalty, using the most appropriate description listed under the Penalty Adjustment types.
- 2) You may then have to adjust the “billed amount” using payment credit or DRG adjustment.
- 3) Post the payments, using the instructions in, “About Posting Payments and Adjustments.”

### **5.3.5 Posting an Interest Payment/Adjustment**

The following procedure is completed in two steps:

- The first step posts the payment to a pre-identified account, resulting in a credit balance.
- The second step reverses the credit balance transaction.

#### **5.3.5.1 Step 1: Post the Payment**

- 
- 1) Follow the steps in section [5.2, “Posting Payments on Daily Batched”](#), to validate patient information, such as name, policy holder ID, date of service, amount billed.
  - 2) At the Select Command prompt, type **D** (Patient Demographic) and press Enter.
  - 3) At the prompt, type **1** to Post Payment.
  - 4) Confirm the correct dollar amount to post from the EOB. Enter the amount and press Enter.

#### 5.3.5.2 Step 2: Reverse the Credit Balance

- 1) At the Select Command prompt, type **A** or **2** for Adjustment and press Enter.
- 2) Enter the negative amount of the adjustment based on your calculation or EOB or RA, and press Enter.
- 3) Type **4** or **NONPAY** (Non-Payments) for Adjustment Category and press Enter.
- 4) Type **685** or **Interest Amount** for Adjustment Type and press Enter.
- 5) The claim is zeroed out.
- 6) Ensure that all items have been posted from the EOB. Review, and then type **Q** or **3** at the Select Command prompt to quit and press Enter.

#### 5.3.6 Posting Refunds (Unallocated or from a Bill)

There are different types of Refunds:

- 1) The facility knows immediately that they will not be posting or holding the payment(s). Payment has been collected by PNC bank.
- 2) The facility finds during the posting process that they will not be posting a payment(s) or a portion of the payment(s). Payments Collected and Batched but not posted to an A/R Bill (Unallocated Scenario).
- 3) The refunds are for payments that have been posted to the accounts receivable package against a billed service or billed services. Payments Collected and Batched and posted to an A/R Bill – Insurance Refund Request.
- 4) Debit Vouchers issued from the bank on payments collected, batched, and

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posted.

### **Refund Process**

The facility knows immediately that they will not be posting the payment(s). Payment has been Collected by PNC bank. Because this check/eft has already been deposited in to Treasury, the facility cannot simply return the check. The facility still needs to account for this collection and then refund back to the payer. Communicate with Division of Finance to process a payment through accounts payable.

#### **Unallocated Refund Process:**

- Payment should be Batched
  - While posting, put this amount into Unallocated
  - In PUC (Post Unallocated Cash) Print Refund Letter (for Finance to use)
  - Communicate with Division of Finance to process the AR refund in AP.
- 1) The facility finds during the posting process that they will not be posting a payment(s) or a portion of the payment(s). Payments Collected and Batched but **not** posted to an A/R Bill. Communicate with Division of Finance to process a refund through accounts payable.
    - a) Same process as the refund process above. There are no transactions in RPMS AR Bills that need to be accounted for. Utilize the Unallocated Refund Process.
  - 2) Refunds are for payments that have been posted to the accounts receivable package against a billed service. Payments Collected and Batched and posted to an A/R Bill – Insurance Refund Request

#### **Refund Process for Posted Accounts**

- Post Refunds (PST – REF)
  - This option is used when payment is posted to a claim/AR account and the payer requests a refund. This option allows the user to “open” up the account that was refunded for and adjust accordingly (the reason for the refund).
  - Communicate with Division of Finance to process a refund to the payer.
- 1) Debit Vouchers issued from the bank on payments collected, batched, and posted.
    - a) A Debit Voucher, is a refund that a payer already processed through their



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bank. When a payer cancels a payment, this causes a debit voucher correction. The amount is reversed out of Treasury from the payer's bank. If a payment was posted in RPMS to a particular bill, and a debit voucher comes though on that payment, the RPMS account tech will need to back that payment out of RPMS (using payment credit, since the facility cannot reverse payments) and post the now open account accordingly.

- b) Communicate with Division of Finance to process the debit voucher transaction directly in UFMS (offset)

### 5.3.7 Posting Transfers

#### 5.3.7.1 Transfers are money received at 1 facility that belongs to a different facility within the same Area

##### **Background:**

- Check is received by PNC Bank and deposit into Area #1, **Facility A** LockBox/Treasury Account
- **Facility A** receives the Information and creates a Collection Batch
- When posting **Facility A** finds the check does not belong to their facility
- **Facility A** will post the Item and Amount into Unallocated Cash (PUC)

##### **Process:**

- 1) **Facility A** – Print letter, requesting Transfer, and Forward to Finance.
- 2) **Facility A** – Send copy of Transfer Letter, and Backup EOB to **Facility B**.
- 3) **Facility A** – After receiving completed/transfer letter, post from Unallocated Cash (PUC) to Refund.
- 4) **Facility B** – Once received completed/transfer letter and back up EOB, create batch, using the referenced TDN/Schedule Number.
- 5) **Facility B** – Post to account per EOB.
  - a) Money is unallocated from a batched item and put into PUC (Post Unallocated Cash)
  - b) A Transfer Letter needs to be printed from PUC
  - c) The letter consists of all the financial data for the receiving facility to create a batch
  - d) The facility that is transferring the money needs to post out the money

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from PUC once the transfer has been batched and accounted for in the correct facility

### 5.3.8 Posting “Unbilled” Reimbursements

Unbilled Reimbursements are patient related reimbursements, but an invoice was not submitted to the Payer for Payment. The following is a list of some of the Unbilled Reimbursements types:

- HPSA (Health Professional Shortage Area)
- Interest
- Managed Care Fees
- Incentive Payments (Not EHR)
- Rate Changes (retro payment) (if you choose to process this way)
  - Some Facilities choose to apply the increase to individual accounts. Either method is acceptable.

**Note:** This is not the same as Administrative Reimbursement (Med. Records Copying, etc.)

#### Steps in the Unbilled Reimbursement Posting Process:

- Add in “new” Insurers to reflect the Manual Bill (Only needs to be performed once)
- Per Allowance Category
- Use “UFMS Other, UFMS Medicare, UFMS Private Insurance, and UFMS Medicaid
- Set as “Unselectable”
  - This will designate this insurance company for financial purposes only. Patient Registration will not be able to assign this insurance to any patient)

“Generic” Insurance Company Example NAME: <b>UFMS PRIVATE INSURANCE</b> STREET: 2900 4TH AVE NORTH CITY: BILLINGS                      STATE: MONTANA ZIP: 59101                      PHONE: (406)247-7184 CONTACT PERSON: CYNTHIA LARSEN
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FEDERAL TAX ID #: 404401PRV  
STATUS: **UNSELECTABLE** TYPE OF INSURER: PRIVATE  
LONG NAME: UFMS PRIVATE INSURANCE

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### Create a Manual Bill Using ADMG

- Use Demo Patient
- Use Best Visit Type, Clinic, and DOS to reflect the circumstances
- Will be “Filed” to A/R for Posting

### Adding a Manual Invoice in 3PB Example:

MGTP Claim/Bill Management Menu ...

ADMG Add a new BILL that was Manually Submitted

**Note:** *This program should only be utilized when an entry in the Accounts Receivable File is needed to reflect a bill that was manually prepared and submitted.*

Proceed? NO// YES

Visit Location: Demo Hospital //

Patient.....: DEMO

2 DEMO,PATIENT <CWA> F 01-01-1952 HAR

Visit Type.....: 131 OUTPATIENT (Use whatever Visit Type best describes)

Clinic.....: GENER (Use whatever Clinic Type best describes)

1 GENERAL 01

2 GENERAL PREVENTIVE 27

CHOOSE 1-2: 1 GENERAL 01

Serv Date From.: 010108 (JAN 01, 2008) (Use Date of Batch of Receipt)

Serv Date Thru.: JAN 1,2008//

No. of Visits...: 1//

Insurer.....: UFMS( UFMS )

The following matches were found:

1: UFMS PRIVATE INSURANCE - 2900 4TH AVE NORTH

Select 1-4: 1

Amount Billed...: 150

DEMO,PATIENT has NO ELIGIBILITY for UFMS PRIVATE INSURANCE on JAN 01, 2008 (System does check Patient Registration for Eligibility)

File Bill? NO// YES

Bill # 329137 Filed. (INVOICE NUMBER FOUND IN A/R TO POST TO)

**Note:** Invoices that are manually created will not have a suffix assigned to the A/R Bill #.

### Create a Batch for Receipt of Payment

- Post from the Batch, Item, directly to the New A/R Account/Invoice
- Avoid using Unallocated, unless this is a non-patient related reimbursement,

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entered in a batch as an error

### 5.3.9 Posting Payment Recoupments

Occasionally a payer will recoup a payment that was previously made. Rather than request a refund, the payer will often recoup the amount from the bill that was initially paid and apply that payment to a different bill. Users who are working at Federal locations are not able to reverse payments due to UFMS restrictions. Instead, Federal locations will need to use payment credit adjustments to move payment amounts from one bill to another. For more information, reference “Appendix: Posting Payment Recoupments”.

### 5.3.10 Posting Prepayments

Applies to Non-Beneficiary patients that want to pay up front for services that have not yet been billed. This option was added to allow for entering patient prepayments, such as copayments, and for printing receipts. These payments are stored in the A/R Prepayment file and must be entered into a Collection Batch before they are available for posting.

**Note:** If your site uses the cashiering option, make sure you have an open session. Whether or not you use cashiering, you will need to enter your signature code when using the Pre-Payment option.

- 1) At the “Enter a Department” prompt, type a clinic name or type two question marks (??) for a list to choose from. This is a required field. If nothing is entered, you will be returned to the Posting menu.
- 2) At the “Payment Type” prompt, type one of the options listed below or type two question marks (??) to choose from a list. This is a required field. If nothing is entered, the following message will be displayed: “This is a required response. Enter ‘^’ to exit.” You will be returned to the “Payment Type” prompt
- 3) The remaining Payment Type prompts will differ depending on which Payment Type was selected, as described below.
  - a) **Cash:** Enter a dollar amount at the “Credit” prompt.
  - b) **Check:** Enter a check number at the “Check Number” prompt. Enter a name at the “Name on Checking Account” prompt. This is a free-text field. There is no system restriction on how the field should be populated.
  - c) **Credit Card:** Enter one of the following at the “Card Type” prompt or type two question marks (??) to choose from a list.

- 
- i. Enter a name at the “Name on Card” prompt. This is free-text field. There is no system restriction on how the field should be populated.
  - ii. Enter a dollar amount at the “Credit” prompt.
- d) Debit Card: Use the directions listed above for Credit Card.
- 4) The next prompts allow for entry of a specific bill, patient, or date of service. These prompts work the same way as they do in all the other posting functions. None of these fields are required; however, if nothing is entered at these prompts, the next prompts displayed must be populated.
- 5) Payment for DOS: If a bill number was specified in the previous prompts, the Payment for DOS field will automatically populate with that bill’s date of service. You may also enter a different date of service, if desired. If a different date of service is entered from the date of service for the bill number entered, the following warning message will be displayed: “\*\* Indicates Bill DOS does not match payment date for service.”
- The Payment for DOS field is required only if a bill number was not specified in the fields described in Step 4. If a bill number has not been specified and you try to bypass the Payment for DOS field, the following message will be displayed: “This is a required response. Enter ‘^’ to exit.” A future date of service may be entered at this prompt (see Step 6 for further explanation).
- 6) Select Patient is the next field displayed if a bill has not been specified in Step 4. The patient entered must be a registered patient in the Resource and Patient Management System (RPMS), but the patient does not need to have any bills in the system. This allows for entering a prepayment from a registered patient for a future date of service or for a date of service that has not been entered as a visit in RPMS yet.
- 7) The Comments field is the last data entry field displayed. This is a free text field that allows for up to three lines of text. Keep in mind that the text entered in this field will be displayed on the patient’s receipt.
- 8) **File, Modify, Quit**—Once all the required information has been entered, a summary screen will be displayed. Available commands will allow for filing the prepayment and thereby generating a receipt number, modifying the data entered, or quitting. If the Quit command is selected, all data entered thus far will be lost.
- a) **File.** Choose this command to store the information entered and create a receipt number. The receipt number will be displayed and you will be given the option to print a receipt, if desired, and to specify how many copies to print. Whether the receipt is printed to the screen or to a printer, you will be returned to the Enter your Department field to enter another prepayment, if desired.
-

- 
- b) **Modify.** Choose this command to make any changes to the information that has been entered. Type two question marks (??) to return a list of items that may be changed.
  - c) **Quit.** Choose this command to delete all the information entered thus far.

### 5.3.11 **Posting Debt Management Transactions (Post Status Change)**

For more information, reference Part 5, Chapter 8 “Debt Management.”

### 5.3.12 **Posting Beneficiary Medical Program (BMP) Payments and Single Year Appropriation**

The BMP Payments/Adjustments posting process is very similar to the manual posting process:

- Batch the IPAC received from Notification from Finance
- Post the Payments and Adjustments (BMP is billed and collected on at the All Inclusive Rate) (See Part 4, Chapter 11 for BMP Billing guidelines)

The only difference in posting BMP is the timing. Because this is a single year fund, the money must be accounted for prior to the end of the fiscal year; keep this in mind when collecting/posting BMP services.

Single Year Appropriation Accounts are those accounts that we refer to as the “Other” Allowance Category. These collections are only valid for a year. Keeping this in mind, work with your Finance Office to determine what accounts to look for, which should be posted in the same year as the invoice was created, and what process can be put in place to identify these accounts. To properly receive the funds collected, timing is everything.

### 5.3.13 **Posting VA Payments and Adjustments**

For more information on posting processes, reference the “VA Medical Benefits User Guide” in the appendix.

### 5.3.14 **Payment Credit Posting (When to Use)**

- Payment Credit is a type of A/R Adjustment transaction that allows sites to adjust bills without the TDN (money/cash/receipt) reference.
- Used to account for recoupments (payer takes money from a new account, after paying on another account in error).

- 
- Used when the billing and payment methodology differ resulting in an underbilled or overbilled amount. (Example, billing VA itemized, but getting paid the All-Inclusive Rate)
  - Use payment credit when payments have been applied erroneously to the incorrect A/R Bill
  - Use payment credit to make corrections to error payment transactions
  - For more information, reference Section 5.5, “Posting Payment Recoupments.”

### **5.3.15 Correct Posting Errors**

#### **Reversing/Correcting Entries in the Posting Process:**

Payments cannot be reversed in the same category it was originally posted. Once a payment has been applied using the correct Treasury Deposit Number, a reversing entry cannot be made to that payment transaction in RPMS. Payment transactions that need to be reversed will have to use payment credit. Payment Credits allows an audit trail to be created that shows this payment was not actually “taken back”. Finance will have to perform a corresponding entry directly in UFMS to account for the payment reversal.

Adjustment transaction(s) should be reversed using the same category and reason code.

### **5.3.16 Posting Non-Patient Account Reimbursements**

Non-Patient Account Reimbursement should not be posted in RPMS. But because the payments are often deposited in PNC bank, and Batched, the Unallocated Refund Process should be followed. For more information on the refund process, reference section 5.3.6, “Posting Refunds.”

### **5.3.17 Posting Federal Medical Care Recovery Act (FMCRA) Transactions**

FMCRA is treated differently in the RPMS System. Work with the Business Office and Finance Team to determine the best methodology to bill and account for FMCA activity. Each Area may have a unique routing process for these transactions.

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**Step 1:** RPMS Third Party Billing (TPB) is used to create claims for the Office of the General Counsel (OGC) Lawyers or to bill the Third Party Liability Company directly.

For more information on billing FMCRA claims, reference Part 4 “Billing” of the ROM.

**Step 2:** Print the claims out of RPMS TPB. This does create an account in the Accounts Receivable System.

Either mail the claims to OGC Lawyers, directly to Third Party Insurers, or follow your Area’s documented process. Some Area Offices may handle all of this at the Area level and work with a FMCRA Coordinator to mail the claims to the proper insurer/OGC.

**Note:** Claims for Third Party Liability cases **do not** transmit to UFMS, but will create accounts in the A/R System.

**Step 3:** Adjust the A/R Account. Because these transactions have created an open A/R Account in RPMS, the user must adjust that account using the proper adjustment codes. Find a code that can be identified as such for tracking purposes. One recommendation is to Adjust using:

*4 – Non Payment*

*176 – Other TPL*

**Step 4:** Provide proper documentation to Finance to properly account for **all** FMCRA cases.

Finance will create a manual Invoice directly in UFMS and apply the receipt/denial directly in UFMS. FMCA has different accounting characteristics than what is handled in the RPMS systems.

**Step 5:** If the collection (deposit) goes to PNC Bank instead of the Area Office, reference section 5.3.6, “Posting Refunds” for the Unallocated Refund Process.

**Note:** The only FMCRA activity that is occurring in RPMS TPB is to create the claims that is needed for the payer to adjudicate the FMCRA claim.

The only FMCRA activity that is occurring in RPMS AR is to ADJUST the AR account to remove the open balance from AR. True FMCRA collections will be handled directly in UFMS and do not transmit through the RPMS system.



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### 5.3.18 Meaningful Use (MU)

Do not batch MU payments in RPMS. Submit check info and TDN to finance to create an invoice and apply a manual receipt. If batched in error, utilize the Unallocated Refund Process (reference section 5.3.6, “Posting Refunds”).

### 5.3.19 Health Professional Shortage Area (HPSA)

For more information on the Unbilled Reimbursement Process, reference Section 2.3 “Unbilled Reimbursements.”

### 5.3.20 Processing/Posting a Write Off

There is a difference between an Adjustment to an account and a Write Off of True Debt:

**True Debt.** From a Third Party Resource perspective, True Debt means debt that is actually owed to the Indian Health Services from a Third Party Resource (or non-ben/guarantor), resulting from services provided to the eligible patient. In other words, Debt that arises from submitting a claim for payment/denial, or claims waiting to be approved. A/R Balances that arise from erroneous billing, billing in error, duplication of bills is not considered True Debt. Nobody owes us on debt that is not considered True Debt. Therefore, you are not “Writing Off” these scenarios, but Adjusting these accounts.

**Adjustment** – An adjustment is not a debt. An adjustment could be a copay, deductible, non-covered service, over usual customary rate, or a request for payment, billed in error, posted in error, etc. An Adjustment is not always “owed” to us from another entity.

**Write-off.** A write-off is an accounting action that results in reporting a debt/receivable as having no value on the IHS’s financial and management reports. A write-off occurs when an authorized IHS official determines, after using all appropriate collection tools, that it is more than 50 percent likely that a debt is uncollectible. True Debt that has been compromised, eliminated, or reduced without the intent of additional follow up or collection attempts.

**If a True Debt is determined to be uncollectible, the steps below MUST be followed to properly account for the Debt.**

- 1) A debt is determined to qualify as a Write Off.

- 
- 2) Post the Debt using the proper Adjustment Reason Code (why was it not collected on or denied). You may be asked to justify the reason for not attempting to collect debt. Make sure to use the best Adjustment code to explain the situation as clearly as possible.
  - 3) Print a screen shot of the AR Posting Transactions.
  - 4) Have the proper Authority sign off and date on the Printed Screen Shot, auditing the approval for such Write Off.
  - 5) Keep signed document for audit purposes.

Remember, Billers, Accounts Receivable Technicians, Patient Account Technicians, and often the Business Office Managers do NOT have the authority to compromise, eliminate, or reduce debt owed to the Indian Health Service.

For more information on Delegation of Authority (DOA), reference Part 5, Chapter 8, "Delegation of Authority (DOA)."

## 5.4 **Cashiering Session**

Cashiering Sessions serve as a productivity monitoring tool for Management. Posting transaction(s) are captured in cashiering sessions and these individual sessions are exported to HUB (integration engine) then to UFMS for processing. These transactions decrease/increase the invoice(s) in UFMS.

Cashiering allows the A/R Posting Technician to open a session that records activity such as payment posting, posting adjustments and posting refunds from bills. Once the A/R Posting Technician has completed his or her posting activity for the day, they must reconcile the amounts that they posted with the screens that display in the A/R system. They will then close out their session. Closed sessions are sent to the A/R Supervisor for reconciling of all sessions created at the site by all staff so that the file can be transmitted to the UFMS financial system.

### **Opening a Cashiering Session**

All A/R posting staff must sign in to Cashiering mode prior to posting payments, adjustments or refunds. If the A/R Poster tries to post without logging in, a prompt will display telling them they must log in.

After signing in, the system will display your current posting activity. The initial Cashiering Display will display activity with zero counts and zero dollars since

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the A/R Poster has not completed any activity yet.

**Note:** If the user has previously signed in and posted payments or adjustments, the system will display activity with counts and dollars that were previously entered by the user.

Once the cashiering session has been opened, the RPMS system will assign a session number to your open session. This number is in a VA FileMan date/time format of XYYMMDD.HHMMSS and can be used as a reference for the session.

### **Continuing an Opened Cashiering Session**

There may be instances when a *poster* will leave their workstation for breaks or lunch or unexpectedly during the day. When this occurs, you manually log out of RPMS and you will still be assigned to your same session when logging back in. The A/R system is modified to allow the poster to continue their existing Open Cashiering Session until they have completed all of the posting for the day before logging out for the day.

### **Closing an Open Session**

After the posting staff has completed their posting of payments and adjustments for the day, they must logoff of their session. The system will display their posting activity for the day and the posting staff should reconcile the amounts they posted for the day with the information displayed on the screen.

RPMS TPB Bill transactions are “Invoices” in UFMS

RPMS PAYMENT transactions are “Receipts” in UFMS.

RPMS NON PAYMENTs are “Adjustments” in UFMS.

If transactions are not captured in a cashiering session, the transactions are not exported to UFMS and can result in RPMS – UFMS balance(s) ultimately not reconciled, and Cash/Receipts may not be allotted back to the facility.

Session IDs are auto generated

- A/R    A/R MASTER MENU
- CSH    Cashiering Options
- CIO    Cashiering Sign In/Sign Out
- 180510 = YYMMDD
- 122612 = HHMMSS

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## 6. Managing Patient Accounts

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## 6.1 About Managing Patient Accounts

The primary objective of accounts receivable management is to minimize the amount of time that accounts are outstanding. Outstanding accounts are accounts that have been billed to the payer or patient and have not received a payment, adjustment, or denial. A/R management involves tracking accounts that have not been paid, accessing action required to secure payment, and implementing procedures to secure payment.

The process of managing patient accounts requires taking steps to ensure all efforts to reconcile an account have been exhausted. This includes:

- Following up on aging accounts
- Following up on accounts disputed with the insurer
- Working aged receivable reports
- Answering questions that the insurer or the patient may have regarding their charges
- Documenting the account on all actions taken

## 6.2 Follow Up

The term “follow up” refers to the monitoring of aged receivables and taking the appropriate action to allow for processing of the claim in a reasonable period. This action requires the Accounts Manager to:

- Identify aged receivables by payer category
- Identify large balance or receivables that have been aging for 30 days
- Communicate with the payer by telephone or mail to obtain a current status of the claim
- Perform the proper follow up with the payer including claim resubmission or providing information needed for claim adjudication
- Properly documenting all account management activity

Even if an account posted a zero balance, additional follow up may be required if a claim was processed in error. This may include:

- Claims that were denied in error
- Claims processed and paid but paid at an incorrect rate
- Claims that were posted in error

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Ultimately, the Accounts Manager is responsible for ensuring that processes for follow up are in place and followed.

## 6.3 Aged Receivables

Aged receivables refer to a receivables entry, such as an invoice or claim that contains an open balance. The open balance is a positive (greater than 0.01) or a negative (less than -0.01) amount. Claims with a positive balance are usually waiting for the insurer to process the claim and for transactions to post to make a zero balance. Negative balance amounts may have been transactions over posted or posted in error. These claims require investigation and follow up. Either way, the balance of aged receivables reflects on the aging report and must be reviewed and followed up on accordingly.

### 6.3.1 Aging Reports

Aging reports will reflect balances in 30-day increments. Proper follow up requires that all accounts are reviewed and that communication with the payer take place. This communication allows the accounts manager to get information on how and when a claim will be processed.

#### 6.3.1.1 Reviewing the Age Buckets

Generating an aged summary report that prints all aged receivables within 30-day columns is best to review all aged amounts. In RPMS Accounts Receivable, the Aged Summary Report (ASM) will provide a summary by Insurer or by Allowance Category.

- **0-30** aged amounts contain the claims that were approved (and submitted) within the first thirty days. Most of the aging accounts should reflect in this column as long as follow up and timely posting of remittances is occurring regularly.
- **31-60** aged amounts reflect claims that have been approved greater than thirty days but less than 60 days and should be the next highest category. This is still a period when the claim is being processed by the payer.
- **61-90** aged amounts are more than likely claims that have not been received, received but still in process, or claims that are waiting for information to be processed. The amounts in this column should drop as claims are being processed and posted. There should be a small volume of Medicare and Medicaid claims in this category since those payers process within a set number of days.

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- **91-120** aged amounts in which balances should drop as claims are being worked, followed up and posted. **Keep your percentage of 121 days or more to a minimum.** The goal of each facility should be to reduce the number of claims aged 121 days or more. Older claims are very difficult to collect. The goal is to keep these claims in the over 120 days in the single digit percentages.

There will always be accounts in each of these buckets, but the key is to make sure that the accounts in the 91 day and higher buckets are minimal. The key is to pay attention to claims and continuously follow up. Large balance claims may receive priority for collections.

#### 6.3.1.2 A/R Ratio

The A/R ratio is a formula that calculates the percentage of A/R in comparison with total charges.

$$\begin{aligned}\text{Total charges} - \text{net collections} &= \text{A/R} \\ [\text{A/R}] \div \text{average monthly charges} &= \text{A/R ratio}\end{aligned}$$

#### 6.3.1.3 Days in A/R

The Days in A/R is a formula used to determine the number of days it takes to collection outstanding accounts.

$$\begin{aligned}\text{Average monthly charges} \div 30 &= \text{average daily charges} \\ \text{Total A/R} \div \text{average daily charges} &= \text{days in A/R}\end{aligned}$$

#### 6.3.1.4 Items Affecting Aging

The Aged Summary Report is a tool that has outside effects that factor how accounts age and what is printed on the report. Keeping an eye on processes within the facility will help to plan for changes on the aging report. Items to look for include:

- Provider vacations or leave would account for lower billed amounts in the Current (0-30) aged category.
  - This would affect the aged ratio and increase the percentage of aged amounts over 90 days.
- Payer issues affect aging because the lack of payment.
  - The payer may be having technical issues preventing the timely processing of claims.

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- Regulatory changes and new payer rules also effect the processing of claims.
  - Staying on top of upcoming payer changes may not prevent the delay of claims processing but will allow for proper planning.
  - The process of appeals allows the accounts manager to challenge the processing of a claim especially if the payer processed the claim incorrectly or denied it in error.
    - Unfortunately, an appeal may take months to resolve leading to a substantial amount of insurance balances in the 120 plus days bucket.
    - These claims still need to be worked but they show up as outstanding. As a result, the percentage and amount due may continue to increase which is fine.
  - Credit balances on accounts affects the aging on reports.
    - These amounts can also throw off the true balance of the aging balances and make the numbers to appear better than they are.
    - Processing credit balances in a timely manner is essential to reflect true aged amounts.
  - Following debt management policies will also help show true aging balances.
    - Analyzing amounts and determining which of those accounts can be forwarded to the Program Support Center (PSC) will impact the balance on the aging report.
    - Remember to follow due process before forwarding a debt to collections.

## 6.4 Proper Payment/Proper Denial

The term Proper Payment/Proper Denial allows the user to understand how a claim was processed and to ensure that the claim was processed correctly. By reviewing payments, denials, adjustments and by monitoring trending over time, the following can be identified:

- 1) What is not being paid?
- 2) If claims are properly paid.
- 3) Identify process issues by trending denial adjustment reason codes.

Accounts receivable is the most important asset to the healthcare facility as third party revenue is used to help meet the goals, mission and objectives of the Indian Health Service. In order to provide optimal care to the patient, the provider depends on third party reimbursement, so denial management is a critical



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component of the revenue cycle.

### **6.4.1 Steps in the A/R Process**

#### **Account for the Receipt of Payment**

The business office must work with finance on the process of check deposits, whether electronic or paper, but a process must be in place that clearly defines the roles of each department and how check batching will be performed as soon as the check is deposited.

#### **Review the Documentation that supports the Payment and/or Denial**

This helps to ensure that the payment or denial belongs to the facility that received the remittance. The business office must ensure the proper documentation is received to support the payer's decision and allow posting in the practice management system. This also means that the remittance advice must be clear enough to allow posting and provide the sufficient data used in posting.

#### **Post the Payment/Adjustment Transaction Promptly and Accurately**

- **Promptness** - This allows management to monitor the aging of the accounts using real-time data.
- **Accuracy** – Since the practice management system in RPMS is considered the subsidiary ledger to the federal financial system or UFMS, all posting must reflect accurate documentation.

Finance also has month-end cut off dates and reconciles monthly to the posted amounts. This is important for the federal sites, as allotments are not received until the payments are posted, transmitted and processed at UFMS.

#### **Denial Management**

Review and analyze all posted denials and adjustment reason codes. Meet with key staff to make process changes depending on the denials received. Continue to monitor incoming remittances for new denials or to see if there has been a decline in the amount of denials.

#### **Standard Adjustment Reason Codes**

Many Standard Adjustment Reason (SAR) codes exist and may be confusing, as well as time consuming, to posting staff because it requires determining which code best suits the posting scenario of the remittance advice. It is strongly advised to review these scenarios and standardize the codes used to post. Unless

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otherwise advised, use the HIPAA Standard Adjustment reason code to post. Locally added codes may be misleading or may have meant something different to the user who added the local code to the system.

### **Follow up on Aged Receivables**

As stressed in the previous section, aging is an important and essential part of accounts management.

## **6.5 Managed Care Systems**

Managed care systems are payers that rely on contracts with providers to deliver care for services. Most, if not all, IHS facilities do not have contracts with these payer types but it is beneficial to the business office to know which payers fall into this group.

All payers are subject to process IHS claims.

### **6.5.1 Health Maintenance Organizations (HMOs)**

A HMO is a plan or program by which specified health services are rendered by physicians or providers to an enrolled group of persons. Members of an HMO are required to seek services at the provider group that contracts with the HMO and are subject to copays for most services. As long as the patient remains in their HMO network, they will receive the highest level of benefits available to them.

### **6.5.2 PPO Agreements**

A Preferred Provider Organization (PPO) contracts with a group of providers to provide care to its members. Patients that have a PPO may be seen by any provider, or at any hospital, but have a higher level of benefits if a preferred provider is used. PPOs usually impose coinsurance requirements and deductibles that may need to be met for the plan to pay. Even at that, the plan will only pay at least 80% or more of the allowed amount.

The patient may elect to be seen at an out-of-network provider group, but the benefit level provided to them is lower than being seen within a PPO network.

## **6.6 Statements**

The statement is used to notify the patient's responsible party of the services provided to them at the time of the visit. The statement contains itemized service

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data and notifies of any action made on the account such as payment posting or adjustments. The transaction activity on the statement reflects patient, insurer or facility adjustment postings. There are different types of statements that may be generated but should not be confused with a debt management letter.

### **6.6.1 Dun Messages**

A dun message is a message recorded on a patient statement regarding the status of an outstanding account and that action is required. Examples include:

- Your Account balance is due and payable within 10 days
- Your account is 60 days past due; please contact us regarding payment
- Your account is now 90 days past due; please remit payment

### **6.6.2 Patient Statement**

The patient statement is a document generated to the patient or the guarantor who is financially responsible for the patient. The statement may contain the items billed on behalf of the patient for an individual visit or may contain summarized data by service date for a reporting period defined by the billing facility. A statement should address the amounts due from the patient or the amounts due from the insurer. Dunning messages may be added to the statement to notify the patient of any activity needed to complete the claims processing.

Statements are also helpful for the patient to be able to account for the services provided during their visit.

### **6.6.3 Insurance Statement**

The insurance company may request an itemization of services if the claim was not itemized during initial claim submission. This is usually the case for inpatient services or other services where significant amounts of charges were billed. To complete the processing of the claim, the payer may ask for an itemization of charges.

## **6.7 Payment Plan – When and how to set up?**

Payment plans are used to help the patient settle an outstanding balance for their claims or for any accounts where they have been identified as a Guarantor for an account. This allows for the account to remain open if the Guarantor signs a promissory note and pays according to the schedule set forth by the business

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office. The patient must identify a guarantor who is financially responsible for the bill and will apply to the non-Indian patient.

### 6.7.1 **Application for the Payment Plan**

In the private sector, health care service facilities have the option to put a payment plan in place, but they are able to bill all patients seen at their facilities, since ultimately, the patient is responsible for all services provided. Because of this, they require the guarantor to complete an application that reviews their funding sources, income, and in some cases, credit history. This information is used to determine how much the guarantor is able to pay. This also helps to determine if other funding sources may apply such as County Indigent Funds, State Medicaid Programs or charity foundations. With the exception to Medicaid, most of these options do not apply to federally funded facilities. However, sites may obtain financial information from the patient in order to determine what may be adjusted at the Sliding Fee level. Using a sliding fee requires the use of the federal poverty guidelines to determine the need.

Either way, a financial process policy and plan must be in place to include the finance department which clearly establishes eligibility requirements, adjustment types, amounts, payment frequencies, and/or delinquent debt follow-up processes.

## 6.8 **Collection Strategies**

### 6.8.1 **Overview of Collection Strategies**

The government only reimburses or allocates a certain sum of money to support the facilities. The remainder must come from either the third party insurers or the legal balances owed by the patient.

As important as it is to know how to handle opposition when it is encountered, it is equally important to know how to avoid it.

**Pay attention to what you say** – Do not use terms that sound like orders. Instead, ask for the patient’s cooperation and agreement. Focus on the word “you” and on the benefits of paying the debt. Use phrases that promote agreement and cooperation, such as:

- “Don’t you agree?”
- “Let’s look at it this way”
- “You’d benefit more from...”

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- “Think of how good you will feel when...”

**Be pleasant** – It is hard to be confrontational with someone you like. Make your voice sound pleasant and project a feeling of concern for the patient’s situation. Positive persuasion always works best, and it makes any encounter you have with the patient more pleasant for both of you.

**Acknowledge resistance** – Some people like being difficult. The best way to handle this situation is to say, “I respect what you are saying”, while not patronizing the patient. This tactic will halt the progression of the patient’s argument without ending the discussion.

**Move the conversation along** – Resistance is often a defensive measure, and as long as the patient is in a defensive mode, the resistance will remain. Keep in mind opposition is rooted in a method of thinking. You need to make the patient stop thinking defensively and start thinking cooperatively. If you acknowledge the patient’s position and move the conversation along, you can bypass the resistance and work toward payment.

**Do not be hostile** – Becoming hostile and aggressive may help you win an argument with a patient, but you may still lose the greater battle. Even if you make a patient agree to send you a payment, the patient may not mail the check simply to spite you.

**Do not make it an issue of right versus wrong** – No one likes to be told he/she is wrong. This will incite opposition in any normal situation and can send a touchy situation into a tailspin. Avoid telling a patient, “You are mistaken” or “That’s wrong.” Instead, refer to the problem as a separate entity you and the patient should work on together.

**Do not stifle the patient** – A great deal of conflict is rooted in emotion. By letting the patient express that emotion, you can move onto a more logical, cooperative conversation. Resistance is not a case of saying “no” instead of “yes.” It is a mix of anger, hesitation, embarrassment, and fear standing between the patient and payment.

### 6.8.2 Negotiation Guidelines

Depending on the circumstances, there are three stages in every negotiation throughout the collection process:

#### Stage I – Clarify the objections

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Find out what the debtor wants and know what you want to attain. Negotiate with a strong sense of purpose. Look at it as a way to obtain what you want, not as an activity to see what you can get. If you want payment in full, negotiate for it. Do not enter the discussion with a “wishy-washy” attitude that says you will take whatever you can get.

### **Stage II – Gather Information about the Debtor**

The information you need includes sources of income and other assets. Some of the information may not have anything to do with the demands or needs of that person, but it will help you determine what strategy or method to use. You cannot negotiate with incomplete information.

### **Stage III – Reach an Agreement or Compromise**

This is the stage toward which many people rush without setting the groundwork by going through stages I and II. Completing the objectives of Stages I and II allows you to plan and develop a strategy rather than being poorly prepared or not prepared at all. Obtain a written agreement between the patient and the facility.

## **6.8.3 The Art of Listening**

There are three levels of listening:

- 1) Listening to remember,
- 2) Listening to evaluate, and
- 3) Listening to understand and recognize the needs of the patient or the interest of the insurer.

We are capable of hearing almost four times faster than we can speak.

### **6.8.3.1 Listening Guidelines**

- Show a genuine interest in what is being said.
- Pay close attention to the statements being made. As they speak, you should construct a mental word map and counter-strategy of how you are going to respond.
- Learn to recognize and correctly analyze hidden meanings in the conversation.
- Acknowledge your understanding with a series of encouraging comments

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such as, “Oh, I see.”

- Do not evaluate what is being said to you. Keep an open mind during the conversation.
- Do not become emotionally involved.
- Do not give advice, even if prompted.
- Display professional courtesy.
- Build bridges during the conversation.

#### **6.8.4 Payment Motivators**

There are three categories of motivators for encouraging people to pay their bills:

- 1) Pride
- 2) Honesty
- 3) Fear

##### **6.8.4.1 Pride Motivators**

Pride Motivators deal with the self-respect or reputation of the other person. People are usually proud that they can earn a living for themselves, their family and pay bills on time. A good credit rating and payment reputation are things they are proud of.

Examples of patient pride motivators include:

- “It took many years to build such a good credit rating. You don’t want to jeopardize it on this bill, do you?”
- “You’ve always had an excellent payment reputation. Don’t you want to clear this up today?”

Examples of insurance pride motivators include:

- “Your company has a great payment record with us. I’m surprised to have this bill outstanding.”
- “Isn’t your reputation as a good payer important to you?”

##### **6.8.4.2 Honesty Motivators**

Honesty motivators consider people’s natural reaction to do what is right. Most people want to be known as someone who pays bills on time and is fair with others. Patients who received good care from the facility generally know it is only

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right to pay the facility in full. Honesty motivators are built around this sense of fair play.

Examples of patient honesty motivators include:

- “Do you think it’s fair to shortchange the clinic after we gave you our best care?”
- “Won’t you feel a whole lot better when this bill is off your conscience?”

Examples of insurance honesty motivators include:

- “The patient pays your premiums on time. Isn’t it fair to pay this bill on time, too?”
- “We’ve provided you with all necessary information in a timely fashion. Don’t you think it’s only right to pay us now?”

#### **6.8.4.3 Fear Motivators**

Fear motivators can be designed around anything that threatens the other person’s well-being. This could be the fear of loss of reputation, loss of future services, loss of future credit, or loss of respect. Many patients fear further collection action or loss of their good credit rating.

Examples of patient fear motivators include:

- “Legal action is expensive, but may be necessary if your promise is not kept. You don’t want that, do you?”
- “Credit is a valuable asset. You don’t want to risk it on an unpaid bill, do you?”

Examples of insurance fear motivators include:

- “If we don’t get payment from you soon, I have no choice but to contact your subscriber for payment.”
- “The insurance commissioner requires payment of a clean claim in 30 days. If you can clear payment today, we won’t notify them of your delinquency.”

#### **6.8.4.4 Words and Phrases to Avoid**

Another part of learning how to motivate others to pay is looking at specific words or phrases that will actually de-motivate others. There are certain words or phrases used in collection with either a patient or an insurer that will immediately trigger a bad response. You will recognize some of these as very common words used in your daily collection conversations. Set goals to eliminate them from your



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collection vocabulary.

#### 6.8.4.4.1 Phrases to Avoid When Collecting

These phrases are all demand phrases.

- You need to...
- I need...
- You must...
- We require...
- I want you to...
- You have to...
- I expect...
- Our policy states...

No one likes to be told what to do, so the remainder of the sentence will not be received well by the patient or insurer.

For a better response, try one of the following:

- Here are some options for you...
- What can you do?
- May I suggest...
- You might want to try...
- Did you know you can...
- Will it help if...

Avoid saying . . .	Because . . .
<b>“But,” “However,” “Yet”</b>	Research has found that using these words cause people to get defensive. You will get a better response using the word “and” instead of “but.” For example, “I understand how you feel, <i>and</i> I hope you can see my point of view.”
<b>“May I ask . . . ?”</b>	Some people may think that prefacing questions with “may I ask” is a courtesy and will get a good response from the patient or insurer; however, it has the opposite effect. It almost conveys to the patient or insurer that you are “nervous” about asking an inappropriate question. In addition, this is a yes/no question, so you run the risk of the patient saying “no.” For a better response say “Why can’t you pay this bill?”

<b>“Only”</b>	If you ever catch yourself saying, “This is the only thing I can do for you,” remind yourself that this will “only” make your patients and/or the insurer angry. People naturally become defensive or resistant to compromise when you limit their options or force decisions on them. For a better response try, “I think the best option for you is...” or “You could try....”
<b>“You are past due.”</b>	When collecting, it is best not to use statements that put patients down, point out that they are “bad” in any way, or point a finger at them. Use instead the wording “ <i>Your account is past due.</i> ”

#### 6.8.4.5 Five Ways to Change a Patient’s Mind

“No matter how hard you try, you cannot force people to do what you want.”

- 1) **Give Choices** Most people like to make up their own minds without being told what to do. Rather than having patients simply say yes or no, offer them alternatives.
- 2) **Offer Reasons** Give patients reasons to change their minds – reasons that are important to them. Show patients how paying their bills will benefit them.
- 3) **Devise a Plan B** If you cannot get the patient to pay in full, be sure to have a backup plan, such as having the patient pay in two payments.
- 4) **Don’t Argue** If patients have their minds made up about something, arguing will not help. In fact, it will make the situation worse. Try to find something you can agree on and go from there.
- 5) **Ask Questions** Sometimes it is helpful to ask what patients would like you to do for them. Most people will be reasonable with their requests; otherwise, you can negotiate a common solution.

#### 6.8.4.6 Collection Calls

This is an important but sometimes difficult process, as it involves confronting a person about payment. When making any collection call, always remember that time is of the essence, and timeliness is what you want to base a payment

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structure on.

Many facilities, and even many collection agencies, go about collection calls the wrong way by asking the patient what he or she can afford to pay each month, or asking for a specific dollar amount every month. This is a mistake. By asking for a set dollar amount, you restrict yourself to the amount you can collect. Instead, try asking for the full payment.

If the patient says...	Then say
"I can't pay today."	"Would you be able to drop a check in the mail for the balance in full today?"
"I don't have enough money to pay the bill in full today."	The balance is due today. However, we would be willing to extend some time to you to pay this bill. Since today is Friday, how long will you need to pay of this bill?"

By your saying a particular day of the week and asking for a length of time to pay, the patient is now in the context of days rather than months or years. The patient might respond with, "I will need at least two days or I will need at least two or three months." Even if it is two or three months, your account may be settled in full.

If you deal with the patient on the terms of what they can afford to pay you, it is more likely that the patient may only pay a portion of the bill or drag the payment cycle out over an extended timeframe. However, when asking a patient how long it will take to pay off a bill, it is very unlikely that he or she will respond with "I think it will take me about a year and a half to pay you." The main idea here is to get the debtor thinking on your terms and not on theirs.

#### 6.8.4.7 Handling Objections to Payment from Patients

When collecting, you hear many similar responses for not paying from patients and insurance companies. Becoming an expert at handling these payment objections will lead to improved collection totals. Follow these principles when collecting payment:

- **Do not argue** – You could easily win an argument with a patient but would you be paid in full? The goal is not to win an argument and make a patient feel bad. The goal is to receive payment in full while protecting patient relations.

- 
- **Use Intelligence, not Emotion** – Patients may become emotional when they are talking with you. You need to express sympathy but remain calm and logical.
  - **Use a Professional and Businesslike Manner** – Treat matters seriously. State facts with authority and assurance. Be friendly, but not too familiar. Stick to business-related matters without alienating patients.
  - **Be Courteous** – Always consider the other person’s feelings. Be polite and practice good telephone manners.
  - **Be Flexible** – Your collection approach should change if the situation warrants it. Remember, every patient will respond differently to your requests for payment. You need to use a variety of motivators.
  - **Be Natural** – Use simple, uncomplicated words and phrases. Avoid technical jargon that will confuse patients. Your delivery should be unhurried and deliberate.

#### 6.8.4.8 Handling Objections to Payment from Insurers

Billing accounts manually does not assure that an insurer will pay in a timely manner. Many insurers purposely delay payments on manually submitted claims to encourage clinics, hospitals, and facilities to convert to electronic billing. Many pharmaceutical insurers will ignore paying manually submitted claims or continually return these claims, asking for other justification or documentation.

If ...	Do this:
<b>No record of claim:</b>	<ul style="list-style-type: none"> <li>• Verify billing address</li> <li>• Verify eligibility on date of service</li> <li>• Ask if any additional information such as itemized charges or medical records are needed to process the claim</li> <li>• Attach all requested information and resubmit claim</li> </ul>
<b>Claim is pending:</b>	<ul style="list-style-type: none"> <li>• Verify the billing date and determine when the claim was sent to insurer</li> <li>• Ask what information is needed from the provider in order to process the claim</li> <li>• Once information is provided ask the insurer when payment can be expected</li> <li>• Stress that the account is past due</li> <li>• If the insurer representative does not cooperate, request a supervisor</li> </ul>

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<b>Coordination of benefits or Medical Record documentation is needed:</b>	<ul style="list-style-type: none"><li>• Ask what specific information is needed to process the claim</li><li>• Determine the time to process the claim once the information has been provided</li><li>• Obtain medical records, copy relevant information, and send to insurer</li><li>• Contact patient to determine if patient or spouse has other insurance</li></ul>
<b>Behind in processing claims:</b>	<ul style="list-style-type: none"><li>• Verify the date your claim(s) was received</li><li>• Find out how far behind the insurer is in processing claims</li><li>• Stress that payment is overdue</li><li>• Document</li></ul>

## 7. Denial Management

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## 7.1 About Denial Management

Accounts Receivable is one of the most important assets to the Indian Health Services, Tribal Health Providers, and Urban Health Providers (I/T/Us) throughout country. It is debt owed to the facilities for services rendered to patients with alternate resources. I/T/Us have become dependent on third party revenue to help us meet the goals, mission, and objectives of the Indian Health Service. Health care operations that provide optimal patient care in our facilities are also dependent on these third party reimbursements. It is essential to implement denial management procedures to make sure key functions in the revenue cycle are optimized.

Accounts Receivable Management has two major functions:

- 1) Following up on claims that have not been accounted for (paid, rejected, adjusted, or denied) and are considered Aged Receivables; *and*
- 2) Determining if Proper Payment/Proper Denial has occurred on those claims/invoices that have been accounted for (Denial Management)

Denial Management is not just about receiving the payments/adjustments posted, but reviewing as you post, monitoring, trending results, and analyzing what has been posted. By reviewing our payments, denials, and adjustments and by monitoring and trending over time, three major objectives can occur:

- 1) Insight into what we are **receiving payment for**
- 2) See if we are **properly getting paid/denied**
- 3) Can **identify process/system issues** by trending the denial AR codes

## 7.2 Overall Review of Steps in the A/R Process

- **Account for the Receipt** of Payment/Adjustment/Denial
- Work with Finance on the process of check deposits whether electronic or paper
- Create a **batch** in A/R as soon as possible after check is deposited (all deposits must be batched within 24 hours of receipt)
- **Review the Documentation** that supports the Payment and/or Denial to ensure:
  - Confirm the Payment/Denial does in fact belong to your facility
  - Confirm the proper documentation is received to support the payers decision
  - Confirm the Remittance Advice is clear enough to post accurately

- **Post the Payment/Adjustment transaction promptly and accurately:** (within 72 hours of receipt of proof of payment/denial)
  - Promptness: Management is monitoring the Aging of the accounts
  - Accuracy: RPMS is the Subsidiary Ledger to UFMS and all posting must reflect documentation
- Finance also has month end cutoff dates and reconcile monthly to the posted amounts
- For UFMS users, Sites will not receive their revenue until posted, sent and successfully processes in UFMS
- **Denial Management** - Review and Analyze Denials/Adjustments codes and meet with key staff to make process changes accordingly
- **Follow Up on Aged Receivables** - Accounts that have not been “Accounted For”

It is important to recognize the difference between “Aged Receivables” and “Accounts Receivables.” Follow up may not be necessary on accounts less than 30 days old, but efforts should be applied to any accounts over 90 days old.

## 7.3 Standardize the Use of Adjustment Codes.

### **Reviewing, monitoring, trending, and analyzing payments and denials**

- It is important to note that the data in RPMS and the corresponding reports are only as good as the data entered.
- Perform peer reviews to ensure that we are attempting to use the same reason codes for the same scenarios.
- Posting of Adjustments codes should be standardized. Through analysis, it may be found that not all Accounts Receivable Technicians are utilizing the same codes for the same scenarios. Unfortunately, some payers provide adjustment/denials that are subject to interpretation by the Technician.
- The reasons that claims were not paid should be identified to the greatest level of detail, so management can help you do a better job of analyzing. If a claim was originally denied because it was filed beyond the filing limit, the adjustment reason should reflect that.
- Using reasons such as “Other” do not provide enough information to know if this denial could have prevented or challenged with the payer.
- Local reason codes (manually added in, non-HIPAA compliant) should be used at a minimum. If a code is needed for tracking individual projects, legislation, etc.,



that code must be approved by ORAP/DBOE before being added and usage should be monitored by local management.

- Secondary Billing is impacted by the usage of Non-HIPAA compliant codes. Secondary payers require that the “reason why the primary didn’t pay” be included on the secondary claim. Using “local” codes will not allow the secondary payer to process the claim properly.

### **Standardizing your Adjustment Reason Codes – Things to remember**

- RPMS A/R Adjustment reports are based on data entered
- Historically, many sites had ability to “add AR Codes”
- HIPAA required a new standardized coding table
- ERA posting allows for more accurate posting
- If manually posting, sites must review their process and “decide” on which codes to use based on the payer mix
- Secondary Billing impacts

#### **7.3.1 Defining Adjustment/Denial Codes**

We have found that not all Adjustments/Denials can be controlled and/or collected. There is a certain percentage of adjustment/denials that can be expected, and due to the nature of our collection policies (do not usually collect from the patient), these adjustment amounts will not change.

It is important to know the percentage of denials. Management often budgets on the amount billed, not the amount that can actually be collected. It is necessary to understand the different types (categories) of adjustments used in managing your denials.

##### **7.3.1.1 Uncontrollable**

An Uncontrollable denial/adjustment is one that cannot be prevented, regardless of what is done. Understand that there are certain “non-payments” that are to be expected; you will experience these adjustments regardless of billing accuracy or the efficiency of the program.

For example, Co-Payments, Co-Insurance, and Deductibles are something that are set by the Insurance Companies and will be applied to our patient accounts. **Because we do not collect from our beneficiaries, we cannot expect to collect on these account adjustments, unless secondary billing occurs.**

Over the Allowable/Over Usual Customary, and Reasonable (UCR). It is important to use the same fee schedule for all itemized billing. We cannot control what the

individual payer deems “allowable” per line item and must accept this type of adjustment as Uncontrollable.

#### 7.3.1.2 Controllable

A Controllable denial/adjustment is one that if we did something different, we may have been paid for that claim or at a minimum, control the amount of adjustments we are receiving. For example, billed in error, a patient does not have eligibility, no prior authorization obtained, unbillable diagnosis, etc. All of these are adjustments that could have been controlled, by either doing something different initially, or not submitting the account. Some controllable denials can be resubmitted to the payer.

These are adjustments/denials that we can control, and should be minimal if we fix something in our process:

- Billed in Error
  - If true debt, rebill it correctly
- No/Other Eligibility for this Patient
  - Verify by Patient Registration
- Non-Covered Service
  - Know our Policies and Benefit Plans
- Beyond Filing Limit
  - Drop clean claims faster and follow up
  - Considered a true write off
- Medical Records/Coding/DE Issues
  - Verify at these function levels
- Missing information, wrong information, or additional information
- Signature Requirement
- **Write Off**
  - **True debt that has been compromised, eliminated, or reduced without the intent of additional follow up or collection attempts.**

A controllable denial/adjustment does not mean that we would have been paid 100% of the time. By changing our process, and working more efficiently on the front end, there is a greater chance that we will be paid accurately for services provided and minimize reworking the claim.

Due to many controllable adjustments, we could actually be overstating our Accounts Receivable. For example, if you find that there is a large volume of denials due to “duplicate claim submission,” and those denials are not being posted, then it appears

that you have more revenue “coming to you” than you actually do. This scenario makes projecting actual revenue challenging.

Controllable Adjustments can be further categorized for more clarity:

- **Controllable/Collectible** – Had something been done differently in the course of the Revenue Cycle, these Denials may have been collected. (At the Collection Ratio. Same adjustment categories apply)
- **Controllable/Uncollectible** – Had something been done differently in the course of the Revenue Cycle, this Denial could have been prevented, but still would not have been collected.

#### **Other Adjustments Categories:**

- **NAR/Not Accounts Receivable (Oops)**  
These adjustments are due to transactions that occurred in error. There is no true debt to account for; it may have been billed in error, a duplicate claim, etc. No one actually owed the facility anything on these accounts.  
It is important to note that these amounts should be taken out of the equation, on both the billed side (not really billed) and the adjustment totals when determining your true collection ratio.
- **Adjusting Adjustments (Administrative)**  
These types of Adjustments occur when you may be applying a transaction to account for administrative purposes. For example, the wrong account was posted in error, recouped from/to another claim, or shifted a payment using payment credit, etc.
- **Pending**  
Messaging only. This Adjustment does not increase/decrease RPMS A/R, or UFMS A/R. These adjustments only serve as a message transaction on the individual claim/account. However, these adjustments do have a dollar amount attached to them and will appear on the ADJ report used for analysis.
- **General**  
The definition for the General adjustment category is the same as the definition for Pending adjustment category above.

## **7.4 The Analysis Process**

### **Analyzing your Adjustment: Importance of Five Allowance Categories**

When analyzing your Adjustment and working your Denials, it is important to treat each of the allowance categories differently. Each of the allowance categories, Medicaid, Medicare, Private Insurance, VA, and Other (non-beneficiaries, worker's comp, and commissioned officer) may have different billing and payment

methodologies that affect the denials.

Run the A/R Statistical Report (When analyzing large volumes of adjustments)

### **Run the ADJ Report**

#### **Procedures:**

- 1) Select A/R MASTER MENU Option: rpt Report Menu
- 2) Select Report Menu Option: frm Financial Reports Menu
- 3) Select Financial Reports Menu Option: adj Adjustment & Refund Report

**Note:** This report will contain data for VISIT location(s) regardless of BILLING location.

- 4) Select Visit LOCATION: ALL
- 5) Select one of the following:
  - a) A/R ACCOUNT
  - b) ALLOWANCE CATEGORY
  - c) INSURER TYPE
- 6) Select criteria for sorting: 2 ALLOWANCE CATEGORY
- 7) Select one of the following:
  - a) MEDICARE (INS TYPES R MD MH)
  - b) MEDICAID (INS TYPES D K)
  - c) PRIVATE INSURANCE (INS TYPES P H F M)
  - d) OTHER (INS TYPES W C N I G T)
- 8) Select TYPE of ALLOWANCE CATEGORY to Display:
- 9) Select one of the following:
  - a) Medicare
  - b) Medicaid
  - c) Private Insurance

- 10) You may select ADJUSTMENT TYPE: ALL// ALL

#### **Entry of TRANSACTION DATE Range**

- 1) Select Beginning Date: 10/01/16 (OCT 01, 2016)

- 2) Select Ending Date: 09/30/17 (SEP 30, 2017)
- 3) Run three different reports. Once for each allowance category.
- 4) Select one of the following:
  - a) Summarize by ALLOW CAT/INS TYPE
  - b) Detail by PAYER w/in ALLOW CAT/INS TYPE
- 5) Select REPORT TYPE: 1// Summarize by ALLOW CAT/INS TYPE
- 6) Output DEVICE: HOME// hfs HOST FILE SERVER (or wherever you save the file)
- 7) HOST FILE NAME: /usr/spool/uucppublic///cladjbr2011  
ADDRESS/PARAMETERS: "WNS"
- 8) Use a name that is identifiable to **your facility** and **fiscal year**
- 9) Put in excel spreadsheet, if possible. Make sure to separate all columns. If you cannot do that, send in plain txt format.
  - a) Download into Excel Format – Refer to Part 5, Chapter 10 for instructions on exporting to excel.
- 10) Assign Categories to each Adjustments Used using the correct code from the following master list:



ALL CODE MASTER  
ROM.xls

- ## 11) Summarize the Results

The following screenshots are an example (not a template) of the Adjustment Analysis:

## Sample Adjustment Analysis

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		AGENCY ADJUSTMENT ANALYSIS												
		Date Range Used												
		Allowance Category = Private Insurance												
	# of Bills	Collected		Adjusted	% of Total Adjust.	Open				# Codes	PEND	GEN		
	1,401,543	\$232,821,948.32		\$74,622,874.72	\$141,516,532.87		\$16,682,540.73		34.53%	34.53%	\$29 Codes	\$48,372.38	\$2,049.60	\$48,421.98
				\$141,564,954.85	-\$48,421.98									
		APG		-\$28,974.47	-0.02%	ADJ					GRP			
		Processed in Excess of Charges		-\$287,001.97	-0.20%	ADJ				-\$315,976.44	GRP			
		INTEREST		-\$81.72	0.00%	ADJ					INT			
		Interest Amount		-\$158.85	0.00%	ADJ					INT			
		INTEREST PAYMENT		-\$342.09	0.00%	ADJ					INT			
		Interest Payment Adjustment		-\$268.03	0.00%	ADJ				-\$885.20	INT			
		CREDIT FROM ANOTHER BILL		\$5,528.03	0.00%	ADJ					PYCD			
		CREDIT FROM OTHER BILL		\$604,837.79	0.43%	ADJ					PYCD			
		CREDIT TO OTHER BILL		-\$386,278.84	-0.27%	ADJ					PYCD			
		NOT BILLABLE TO OTHER(S)		\$229.32	0.00%	ADJ					PYCD			
		PAYMENT REC'D AT OTHER FACILITY		\$97.00	0.00%	ADJ					PYCD			
		RECEIVED NO-COL REGISTER		-\$106,005.89	-0.07%	ADJ					PYCD			
		ZERO PAY		\$915.76	0.00%	ADJ				\$119,324.17	PYCD			
		2010 FLAT RATE ADJ		\$471.52	0.00%	ADJ					RATE			
		2010 Saver Medicaid Increase		-\$42.00	0.00%	ADJ					RATE			
		MEDICAID RETRO		-\$45.00	0.00%	ADJ					RATE			
		MEDICARE RATE INCREASE		-\$2,736.00	0.00%	ADJ					RATE			
		RATE ADJUSTMENT		-\$550.43	0.00%	ADJ					RATE			
		RETRO PMT 2008		\$154.00	0.00%	ADJ				\$3,998.98	RATE			
		ACCT PG BAL RECOUPED		\$775.16	0.00%	ADJ					RECP			
		BOBS RECOUPMENT		\$20.30	0.00%	ADJ					RECP			
		NON REFUNDABLE PMT		\$17,146.01	-0.01%	ADJ					RECP			
		OVERPAYMENT RECOVERY		\$1,917.46	0.00%	ADJ					RECP			
		RECOUPMENT/RECOVERED		\$13,902.98	0.01%	ADJ				\$470.15	RECP			
		MOR WCD OVER PAYMENT		-\$8.00	0.00%	ADJ					REF			
		OVER PAYMENT		-\$2,131.14	0.00%	ADJ					REF			
		OVER PMT NO REFUND REQUIRED		\$7,084.03	-0.01%	ADJ					REF			
		OVERPAYMENT		-\$2,069.89	-0.02%	ADJ					REF			
		DU OVER PAYMENT		\$20,459.04	0.00%	ADJ				\$10,863.00	REF			

A	B	C	D	E	F	G	H	I	J	K	L	M
	BILLED	\$232,821,948.32		\$74,622,874.72	\$141,516,532.87		\$16,682,540.73		34.53%		34.53%	
	NAR	\$22,983,233.09	Not Accounts Receivable	\$22,983,233.09				9.87% of billed				
	CONUNCL	\$31,599,658.83	Controllable that would not have been collected on	\$31,599,658.83				13.87% of billed				
		\$178,239,056.40		\$86,937,640.95								
				\$74,622,874.72		Collected					46.19%	
				\$73,219,105.35		Uncontrollable					45.32%	
				\$12,917,668.88		Controllable/Collectible					8.00%	
				\$796,866.62		Adjustment					0.49%	100.00%
				\$161,556,515.67								
	Billed	Total Billed		\$232,821,948.32								
	NAR	Not True Accounts Receivable		\$22,983,233.09								
	CONUNCL	Controllable that would not have been collected on...not due to us		\$31,599,658.83								
	Actual A/R			\$178,239,056.40								
	Open	Not accounted for yet, paid or denied.		\$16,682,540.73								
	Accounted For A/R			\$161,556,515.67			\$0.00	\$46,372.38	\$2,049.88			
	Collected			\$74,622,874.72				46.19%				
	Adjusted	Adjustment		\$796,866.62				0.49%				
	Uncontrollable	Administrative Cost		\$181,443.98				0.11%				
		Co-Pay		\$19,561,001.22				12.11%				
		Deductible		\$11,436,440.20				7.08%				
		Maximum Benefits		\$1,244,381.49				0.77%				
		Over UCR		\$36,155,650.09				22.38%				
		Miscellaneous		\$4,640,187.77			\$73,219,105.35	2.87%	45.32%			
	Controllable	Paid Patient		\$395,495.94				0.24%				
		PPO Discount		\$4,538,553.77				2.81%				
		Wrote Off		\$1,269,722.80				0.78%				
		Miscellaneous - Part may be collectable and part will be uncollectable		\$8,713,896.47				4.16%				
				\$161,556,515.67				46.19%			100.00%	
		Apply New Collection Ratio to the Controllable/Collectable Amount/ By refining your processes, applying resources, this was potential lost revenue in one FY activity			\$5,966,664.92	Potential Lost Revenue						
						3.35% Of your Total Accounts Receivable could be Considered Lost Revenue....						

A	B	C	D
	<b>ADJ</b>	<b>Adjusted</b>	Posted the wrong account in error. Recouped on another claim. Shifted Payment using Payment credit
		GRP	Reversing a posted adjustment. Posted in Error
		INT	Grouper Adjustment
		PYCD	Interest
		RATE	Payment Credit
		RECP	Rate Change
		REF	Recoup
			Refund
	<b>CON</b>	<b>Controllable</b>	Controllable. This adjustment could have been controlled (not happen)
		<b>COL - Collectible</b>	Collectable. Potentially if done differently, they may have been a receipt.
		PAT	Patient Related. Patient Paid, Patient didn't respond, etc. Collectible
		PPO	Preferred Provider Network Related. Through Negotiations, Collectible
		W/O	Write Off. True Write Off. Should have been Collected on.
		MISC	All Other Controllable Collectible
		<b>UNCL - Uncollectible</b>	The Adjustment Amount could have been Controlled, but the amount would never have been collected on.
	<b>GEN</b>	General Adjustment	Messaging ONLY. This Adjustment doesn't decrease/increase RPMS A/R, or UFMS A/R
	<b>OOPS</b>	<b>NAR - Not Accts Rec.</b>	Not Truly A/R. May have been billed in error, duplicate, etc.
		DEMO	Demonstration Project. Not True A/R.
		DUP	Duplicate Bills in the System. Not True A/R. Nobody "owed" us twice.
		REDO	Bill was cancelled, corrected, and reapproved. Causing A/R to be "doubled".
		TEST	Test Claims. Not True A/R
		UFMS	UFMS Clean Up. Not True A/R that needed to be removed from books.
		MISC	All Other OPPS/NAR Adjustments
	<b>PEND</b>	Pending Adjustment	Messaging ONLY. This Adjustment doesn't decrease/increase RPMS A/R, or UFMS A/R
	<b>UNC</b>	<b>Uncontrollable</b>	Uncontrollable. No matter what was done differently, this adjustment would have happened.
		Administrative Cost	Cannot Control the "COST" of doing Insurance Billing
		Co-Pay	Co-Pays are not Billing Specific. Between Patient and Policy
		Deductible	Controlled by the Insurance Companies
		Maximum Benefits	Controlled by the type of Policy the Patient has with Insurance Company
		Over UCR	At the time, we cannot set the amounts allowed by the Insurance Company as Usual, Customary, and Reasonable
		Miscellaneous	All Other Uncontrollable Adjustments

Version 2.0  
March 2019



## **What to look for in the Adjustment Report**

Sites must print the Adjustment Report frequently, but at least once a week.

### **The intent is to analyze items that:**

- 1) Can assist with process or system weaknesses
- 2) Identify program, resource, or staff deficiencies
- 3) Identify areas that need enhanced outreach, education, or training
- 4) Define practices that each payer is following and that may need to be addressed (Challenge Payer Behavior)
- 5) Identify the claims that need to be followed up on before Timely Filing Limits
- 6) Identify High Risk Areas (Compliance)

### **What do your Adjustments Tell You?**

If you find that a large percentage of your denials are due to billing errors, timely filing, and duplicate submissions, there may be two options:

- 7) You may want to look at more training to provide a better understanding
- 8) Increasing your billing/patient accounts staff.

If you find a percentage of your errors are due to procedures not medically necessary, you may want to meet with Providers and Coding staff to identify the disruption or gap.

If you find a large percentage of your adjustments are due to patient eligibility issues, you may want to approach your Patient Access team to redefine their process of intake.

If you find a large percentage of your adjustments are coming from the same payer, for the same reason, you may want to challenge the payer, or change the RPMS system to account for these denials properly.

### **Projecting Revenue**

By analyzing true adjustments and denials, you can project revenue based on actual data, not arbitrarily. Meaning, instead of just saying we will collect a certain percentage increase year after year, you can project revenue based on actual visit data, billed averages, and collection ratios.

By analyzing true billed amount and collected/adjustment amounts, you can come up

with a true Collection Ratio (amount expected to collect on each dollar billed) per allowance category or insurer type. Only include the Billed Amount that has been accounted for because you do not know the outcome of the “Unpaid Amount.”

**Note:** Make sure to take out the “garbage” or “NAR” from both the billed and the adjustment totals.

**By Visit Type (Inpatient and Outpatient) and by Allowance Category (use the previous year)**

- 1) Availability - Number of Visits With Private Insurance
- 2) Percentage of Unbillable Visits (%)
- 3) 1 times 2 gives you the number of Billable PI Visits
- 4) Calculate the Average Amount Billed per Visit
- 5) 3 times 4 gives you the Total amount Billed for the Year
- 6) Calculate your Collection Ratio (by analyzing your adjustments)
- 7) 5 times 6 gives you the Projected Collections for a Year

**Projection Example**

- 1) You have 5000 OP Visits for Patients with Private Insurance in FY
- 2) Your percentage of Unbillable Visits is 10%
- 3) 5000 OP Visits times 90% (billable visits) = 4500 Billable PI OP Visits
- 4) Your average amount billed per OP visit was \$100
- 5) Total Billable amount for a year is (4500 times \$100) = \$450,000
- 6) Your Collection Ratio is = to 60%
- 7) Projected Revenue for PI OP for the year is = \$270,000



## **8. Debt Management**

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## 8.1 Overview of Debt Management

The Debt Collection Improvement Act (DCIA) requires all debt owed to the Agency over 120 days delinquent to be referred to the Treasury for collection efforts.

Federal Debt (Medicare and VA) cannot be sent to Treasury for collection efforts. Non-Federal Debt (Private Insurance, Nonbeneficiaries, BMP, etc.) will follow the path to Debt Collection if aged beyond 120 days. Although Medicaid is considered non-Federal Debt, IHS cannot enforce the Debt Collection Process on that payer.

It is the policy of the Indian Health Service to aggressively collect all debts arising out of IHS activities affecting revenue generation and that collection activities shall be undertaken promptly with follow-up action taken as necessary. Debt can be defined as an amount of non-tax money, funds, or property that IHS has determined is owed to IHS from any person, organization, or entity, except another Federal Agency.

Current debt consists of, but is not limited to:

- Outstanding Travel Advances
- Outstanding Emergency Salary Advances
- Quarters
- Board of Survey
- Non-Indian (Non-Beneficiary) Patient Accounts
- Private Insurance Accounts
- Other

**Note:** For the purpose of this section of the ROM, Non-Beneficiary Patient Accounts, Private Insurance Patient Accounts and Guarantor Patient Accounts will be referenced.

### 8.1.1 Uncollectable Debt

IHS may determine that a debt is uncollectable in accordance with applicable federal guidelines, including the Department of the Treasury, Financial Management Services, and Managing Federal Receivables, Chapter 7, "Termination of Collection Action, Write-off and Close-out/Cancellation of Indebtedness." A debt may be determined uncollectable when one or more of the following criteria apply:

- 1) The agency is unable to collect any substantial amount.
- 2) The agency is unable to locate the debtor.

- 3) Costs of collection are anticipated to exceed the amount recoverable.
- 4) The debt is legally without merit or enforcement of the debt is barred by applicable statute of limitations.
- 5) Debt that is open and aged beyond two years, should not be reflected as open in the RPMS and UFMS Accounts Receivable System. Use the proper Adjustment Code to adjust these accounts so they are no longer reflected in RPMS and UFMS. If a debt is actually “written off,” make sure to follow all proper Write Off procedures.
- 6) Third Party Resource debt that is “closed” due to two-year time lapse is not considered to be “written off” unless deemed uncollectible per definition above. Collection attempts/activities on Third Party Resource debt that is closed, but not “written off” should continue until debt is resolved.

For more information on Debt Management for Non Patient Account Debt management, reference Part 9, Chapter 4 of the IHM, "Debt Management:"  
[http://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p9c4](http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p9c4)

**Note:** This Policy is currently being updated. Once approved, any changes to this guidance will be implemented.

## 8.2 Delegation of Authority (DOA)

The Director of the IHS has the authority to collect a claim (hereinafter "bill or invoice") generated by the IHS for money owed, including third party revenue; compromise a debt of the IHS of not more than \$100,000 (excluding interest); and may suspend or end collection action on a bill/invoice when it appears that no person liable on the bill/invoice has the present or prospective ability to pay a significant amount of the bill/invoice or the cost of collecting the bill/invoice is likely to be more than the amount recovered.

Area Directors have the delegated authority to compromise, suspend, or terminate a debt up to \$20,000, exclusive of interest per debt. Area Directors may suspend, compromise, or terminate the collection of any debt, specifically uncollectible third party bill/invoices, once all efforts have been made to recoup revenue owed to the IHS.

Area Directors may re-delegate their authority to others using the Delegation of Authority form (located in the Debt Management Policy). Chief Executive Officers (CEOs) are delegated the authority to compromise, suspend, or terminate a debt up to \$5,000. However, the Business Office Manager (or certain staff in the Business Office or Finance Management Office) could also be delegated certain limited authorities. In addition, the FMO needs to recommend the dollar amount to re-delegate, as long as that amount is not greater than \$20,000. All original Area Director-approved DOAs must be processed by the Area Directives and Delegations Control Officer.

If any true debt is to be compromised, suspended, or terminated, documentation **must** be signed and process approved by the appropriate delegated authority explaining the reason for the elimination of debt.

### 8.3 Responsibilities

Each Service Unit is responsible for creating a Service Unit-specific operational plan establishing and maintaining debt management guidelines. An Operational plan is an organized plan of action incorporating the various collection tools to be used to recover debt. Since the DCIA requires all debt over 120 days delinquent to be referred to the Treasury, the Service Unit operational plan should be limited to collection actions undertaken within the first 120 days of the delinquency. At a minimum, a Service Unit must issue at least one demand letter. The RPMS Debt Collection Module (in AR Package) is set up to send the original claim, plus three demand letters, although by policy, only one has to be mailed to the debtor.

The Financial Management Officer provides overall direction of accounting for the Debt Management Program, but the Business Offices (Revenue Cycle) must assist in identifying outstanding debt due to Patient Accounts.

The Area Claims Collection Officer (Debt Manager) is responsible for providing training and guidance to assist with the enforcement of the Debt Management Policy.

The Chief Executive Officer is responsible for overseeing the revenue cycle for the Service Unit and for implementing procedures and practices that will safeguard the collection amounts owed to the IHS.

Business Office Manager & Finance Officers must be informed of the Debt Management Policy and ensure their staff is adhering to the policy.

### 8.4 Working Aged Receivables

Part of the Debt Management program should define specific procedures to ensure that all “Aged Receivables” have been followed up on prior to submitting debt to the Treasury/PSC for processing. For example, all payments and adjustments should be posted within the guidelines set forth by the Third Party Internal Control Program to ensure all accountability for the debt owed.

Payers (Non-Beneficiaries and/or Insurance Companies) will not participate in the process if they are continuously told they owe money or if their bill or invoice has already been adjudicated with a payment or denial.

There is a difference between an Adjustment to an account and a Write Off of Debt:

- **Adjustment** - An adjustment is not a debt. An adjustment could be a copay, deductible, non-covered service, over usual customary rate, or a request for payment, billed in error, posted in error, etc. An Adjustment is not always “owed” to us from another entity.

- **Write-off** - A write-off is an accounting action that results in reporting a debt/receivable as having no value on the IHS's financial and management reports. A write-off occurs when an authorized IHS official determines, after using all appropriate collection tools, that it is more than 50 percent likely that a debt is uncollectible.

## 8.5 Service Unit Business Office Debt Collection Process

The business office typically handles three types of transactions that could become aged receivables subject to Debt Collection procedures: Non-Beneficiaries, Third Party Insurers, and/or Guarantors.

### 8.5.1 Procedures for Collecting Third Party Debt

Procedures exist when collecting from Non-Beneficiaries, Third Party Insurers, and/or Guarantors and may be classified as:

- Claim Submission
- Due Process
- Grace Period
- First Demand Letter
- Second Demand Letter
- Third Demand Letter
- Forwarding Debt to the ACCO via Bill of Collection
- Adjusting A/R Account to reflect "Sent to Collection"
- Upon settlement of the Debt by Treasury, properly reflect in A/R Account

#### 8.5.1.1 Claim Submission

Claims shall be processed within the guidelines of the Internal Control Policy. This serves as the first or initial "notification" that debt is owed to the Federal Government. The aging process begins when the bill/invoice is approved by the billing technician.

#### 8.5.1.2 Due Process

Due process must be given to the debtor for the outstanding debt to be legally enforceable. For a debtor to be given due process, notice must be given that a debt is owed, and the debtor must be given the opportunity to dispute. IHS can extend the administrative process to allow more time to a debtor if needed. Issuing a demand letter to the last known address on file is considered sufficient notice. The demand letter need not be sent by certified mail, however; it can be sent via standard mail delivery mail.

**Note: Third Party Payments must be made Payable to the IHS.** A claim is not

paid until the IHS receives payment. A claim is not paid if the third party insurer sends the payment to the patient. IHS will continue to pursue collection actions, including reporting unpaid claims to the State Insurance Commission, against the third party insurers until payment is received by IHS.

#### 8.5.1.3 **Grace Period (0-30 days)**

Normally, a grace period (0-30 days) from the date of service will allow Non-Beneficiaries, Third Party Insurers, and/or Guarantors sufficient time to repay the cost of IHS-provided health care. If payment is made during the grace period, no interest or administrative fees will accrue.

#### 8.5.1.4 **First Demand Letter**

If payment has not been made within 30 days, then the Business Office shall send the Non-Beneficiaries, Third Party Insurers, and/or Guarantors a First Demand Letter. The patient's account must be documented to reflect action taken.

#### 8.5.1.5 **Second Demand Letter**

If payment has not been made within 30 days after the date of the First Demand Letter, then the Business Office shall send the Non-Beneficiaries, Third Party Insurers, and/or Guarantors a Second Demand Letter. The patient's account must be documented to reflect action taken.

#### 8.5.1.6 **Third Demand Letter**

If payment has not been made within 30 days after the date of the Second Demand Letter, then the Business Office shall send the Non-Beneficiaries, Third Party Insurers, and/or Guarantors a Third Demand Letter. Documentation of the patient's account must be reflected on their account.

#### 8.5.1.7 **Debt Management Demand Letters in RPMS**

The process of generating demand letters involves:

- The collections entry is created and the demand letter is generated from the RPMS Accounts Receivable module.
- All **Open** accounts and the age of the Debt are considered for printing. The Service Unit collections staff may customize the printing of the letters to print at certain age intervals. Coordination between local finance and Area finance officials needs to occur before any changes are to be made.
- The system will track how many letters have been sent for Due Process Purposes.
  - The Debt Management functionality is located in the Account Management Menu and allows for printing and sending out Dunning (Demand) letters from RPMS to private insurance companies and to non-beneficiary (non-Indian) patients based on aging that is determined by a

user-specified number of days. Letters are printed in four cycles for overdue bills. Each time a letter is printed for an overdue bill, the cycle is incremented until the fourth and final cycle is reached. The day that the letters are printed is dependent on the cycle length entered in the parameter file. Ideally, Debt Management letters should be generated and mailed every day to ensure that the aging is being accurately calculated.

- Letters are defaulted to run in the following increments. The number of days in a cycle can be changed in the debt management parameters.

```
DEBT LETTER 1: DEBT MANAGEMENT LETTER 1//  
DEBT LETTER 1 CYCLE: 60//  
DEBT LETTER 2: DEBT MANAGEMENT LETTER 2//  
DEBT LETTER 2 CYCLE: 90//  
DEBT LETTER 3: DEBT MANAGEMENT LETTER 3//  
DEBT LETTER 3 CYCLE: 120//  
DEBT LETTER 4: DEBT MANAGEMENT LETTER 4//  
DEBT LETTER 4 CYCLE: 150//
```

- Sites should specify for which Insurer types and/or Payers they want letters generated. If Insurer Types are not specified, letters will be generated for all Insurer Types/Payers.
- An error report can be run that provides a list of errors, if present, that need to be corrected before letters can be printed.
- A report of letters that are ready to be printed can be run by cycle number.
- An option is available to allow the status of a bill to be manually changed. The available statuses are: Active, Paid, or Suspended.

**Note:** Sites are no longer “required” to send 3 demand letters, but it is recommended. Demand letters can now be processed using the RPMS Accounts Receivable System.

#### 8.5.1.8 Forwarding Debt to the ACCO via Bill of Collection

Forwarding debt (debt documentation) to the ACCO includes, but is not limited to:

- Bill of Collection (BOC)
- Payers W-9
- RPMS Request for further Collection Memo
- Copy of claim
- Demand letters
- Third Party Billing “Bill File Inquiry” – used to determine if debt is part of cancel year bill
- An excel spreadsheet, indicating, Location/BAP/UFMS INV#/FUND/BILL

DATE/CLAIM#/DOS/Debtor first and last name/Debtor address/PRINCIPAL BALANCE DUE

- Debt documents are to be scanned and the actual excel spreadsheet (electronic file only, **do not scan**) are to be sent via secure email to the Area Collection Claims Officer. This typically happens after the 120<sup>th</sup> day, prior to the 150<sup>th</sup> day, and allows Area Finance time to process, verify, and submit the debt with supporting documentation to PSC, Treasury, or set up payroll garnishment for the IHS Employee Debtor in the Service Center program.

**Note:** Send only one copy of each support document

- There is no minimum balance to be referred for collection although writing off a principal balance due of less than \$25 is recommended.
- When processing debt via BOC, the BOC number should be populated in the RPMS Accounts Receivable module with a message for the account in collections.
- Copies of the debt documents are provided to the Finance Office at the Service Unit, with the original filed in the Service Unit Business Office.

#### 8.5.1.9 **Adjusting A/R Account to reflect “Sent to Collection”**

- Debt submitted to the Program Support Center (PSC) should not reflect as an “Open Receivable” in the practice management system or in finance. Regardless, the debt is still owed to the government and must still be maintained. To do this, an entry must be made in RPMS to reflect the balance sent to collections (PSC, in this case). Upon notification from area finance, action is taken with PSC:
- The status of the bill in the Account Receivable module is changed from an “Open” status to a “Sent to Collection” status.
- Use the Post Status Change (PSC) Menu Option under the Account Management Menu, Post Status Change.
- A “downward” adjustment is created in Accounts Receivable and will “close” out the Account.
- A Transaction will be set to UFMS, decreasing the amount of Open A/R.

#### 8.5.1.10 **Upon settlement of the Debt by Treasury, properly reflect in A/R Account**

- Action needs to be taken if notification from Finance has been received. The notification indicates the Debt either has been satisfied or it won’t be satisfied along with an explanation. If the debt has not been satisfied:
- The bill needs to be re-opened in the Accounts Receivable module.
  - Post a Status Change Reversal under the Account Management Menu, Post Status Change. This allows the balance to be shifted to the RPMS bill.



- Post the debt accordingly using a payment (if payment was received), denial (an adjustment to reflect action taken).
- An upward adjustment transaction is recorded in RPMS. This transaction is included in the user's cashiering session and is sent to the federal financial system (UFMS).
- The additional posting will update the balance on the invoice and accounts for the debt.
- As a result, a traceable Audit Trail has been created.

## 8.6 Finance Processes

Areas use two Agencies to further collect outstanding debt:

- **Program Support Center (PSC)** – collections are made through the U.S. Treasury for non IHS employee debtors, and
- **Defense Finance & Accounting Services (DFAS)** – collections are made through payroll garnishment for current IHS employee debtors.

**Note:** For the purpose of this section of the ROM, we will be referring to PSC as the entity that is collection on behalf of the Agency for Patient Account Debt.

### 8.6.1 Operational Procedures

Debt is received by the Area Office from the Service Unit.

- 1) Prior to forwarding a debt to the Collection Agency, verify all supporting documents (debt documents and data are provided according to the receiving collection Agent's request and data is recorded to receive and post collections garnished). Verification of all debt documents are reviewed and penalty fees are assessed.
  - a) Bill of Collections/RPMS Request for further Collection Memo (total \$ due = claims/invoices)
  - b) Copies of claims/invoices
  - c) Copy of demand letters
  - d) Third Party Billing "Bill File Inquiry"
- 2) The electronic copy of the excel spreadsheet is used to assess/calculate all applicable fees:
  - a) Interest accrues from the date the debt is due. For more information, reference the following:

<https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/interest-rates/index.html>

<https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/index.html>

- b) Penalties accrue from the date the debt is due. 6% per year is assessed.
- 3) Administrative Costs - \$30
- 4) Forward Non-Employees Debt to PSC via secure email along with:
  - a) The electronic copy of the excel spreadsheet with data such as:
    - i. Debtor name
    - ii. Debtor address
    - iii. Debtor Social security number
    - iv. Claim #
    - v. Amounts (Principal, Interest, Penalty Interest, Administrative Fee)
  - b) Scanned copies of BOC, Request for Further Collection Memo from SU, Request for Further Collection Memo from Area, Copy of Claim and all 3 demand letters
  - c) Certification
- 5) For IHS Employee Debtors create perigan ticket in the Service Center system. By using data provided in the spreadsheet, a DD FORM 2481 will need to be completed and signed to complete the perigan ticket.
- 6) Collection from PSC
  - a) Recovered costs are forwarded to Area via IPAC
    - i. Area to provide receipt of collection & IPAC number (schedule number) to Service Units.
      - (a) Area distributes principal collection amounts to the services units and posts receipts by creating a UFMS A/R Invoice for:
    - ii. Interest/Cancel Year debts
    - iii. Penalty Interest
    - iv. Administrative
  - b) Services Units create batch & post principal collection.
  - c) Receipt of payment after debt has been sent to PSC

Encourage Debtor to mail payment and include debt # and/or case number and mail to:

*Debt Management Branch  
5600 Fishers Lane, Rm 8B-45  
Rockville, MD 20857*

For more information to make a payment, reference “Debtor” at <http://www.clevelandfed.org/paygov/collections.htm>

The Service Units are encouraged not to receive/receipt payments after debt has been sent to PSC, but if it is unavoidable, the following will need to occur:

- 1) Facility finance notifies Area.
- 2) Area Office will need to notify PSC of payment.
- 3) PSC will need to notify Treasury of payment.

## 8.7 Reports and Records

- **Records** - All records pertaining to the suspension, compromise, or termination of uncollectible debts or third party bill/invoice should be kept in accordance with the IHS RDS (Records Disposition Schedule). Every CEO must ensure that they follow their local operating procedure for recoupment of specific third party revenue.
- **Reports** - The amount of debt sent to Treasury/PSC for collection can be tracked once the proper transactions have been recorded in RPMS. Utilizing the ADJ Report in Accounts Receivable (RPMS) will allow you to track the adjustment (Sent to Collections).

## **9. Overview of Reconciliation – File, Accounts Receivable, and Cash Management**

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Various types of reconciliations require IHS to reconcile their Treasury accounts on a regular and recurring basis. These recurring reconciliations ensure the integrity and accuracy of IHS' internal and government wide financial reporting data. The Treasury mandated timeframe to reconcile schedule differences is two months of occurrence.

To assist in improving the Schedule Monitoring, Area Offices are required to monitor their schedules by completing their File (RPMS HUB UFMS) Reconciliation on a Daily/Weekly basis, Open Accounts Receivable on a Monthly basis, and Cash Reconciliation within 20 days after month-end with identified discrepancies being corrected within 60 days after month-end.

It is the policy of the Indian Health Service (IHS) to aggressively reconcile our Third Party and Accounts Receivable transactions in a timely manner to ensure accountability, improve integrity and manage escalation. For more information, reference IHM, Part 5, Chapter 1.4: <https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/#5-1.4>. The Reconciliation tools provided in this section can assist with achieving the IHS goals.

## 9.1 File Reconciliation

File Reconciliation is the act of comparing and confirming that the TPB and AR Transmission Files have been successfully transmitted from RPMS to the HUB and to UFMS. Please see an example of the export reconciliation and summary file below:

You want to reconcile what you have in Cashiering Sessions, to the File Totals that left RPMS, to the File Numbers that were processed at the HUB.

The Following report shows the Cashiering Sessions that will be transmitted.

```

***** UFMS EXPORT RECONCILIATION PAGE ***** Page: 1
LOCATION: NNMCSHIPROCK
EXPORT DATE: AUG 31, 2018@07:03:50
FILE NAME: IHS_TPB_RPMS_INV_808601_20180831_070350_2.06.26k.DAT
=====

```

Session/User	Approved Bills	Excluded Bills	Cancelled Bills	Cxl'd Claims	Ben Bills
3180830.074043/User 1	<u>123</u> 7,839.48	0	0.00 15 7,060.59	0	0
3180830.075346/User 2	<u>105</u> 39,872.04	0	0.00 14 6,283.75	0	0
3180830.075348/User 3	107 21,184.60	0	<u>0.00</u> <u>20</u> 6,396.85	0	0
3180830.075533/User 4	188 23,721.67	0	<u>0.00</u> <u>6</u> 572.51	0	0
3180830.075813/User 5	482 75,928.44	0	0.00		
3180830.075824/User 6	<u>66</u> 30,167.69	0	0.00 2 485.48	0	0

3180830.08013/User	99	14,746.51	0	0.00	6110,020.91	0	0
3180830.080212/User	<u>8</u>	<u>82</u>	31,501.08   0	0.00	4	1,708.00	0
3180830.080305/User	<u>9</u>	<u>39</u>	5,590.63   0	0.00	4	750.77	0
3180830.080428/User	<u>10</u>	<u>105</u>	24,206.05   0	0.00	4	1,708.00	0
3180830.080701/User	11	<u>29</u>	<u>8,993.60</u>   0	0.00	0	0.00	0
3180830.081559/KEE,R	56	24,704.70	0	0.00	0	0.00	0
-----							
TOTALS:	1481	308,456.49	0	0.00	<u>130</u>	34,986.86	0

This Report shows the Total of transactions exported by Insurer Type.

UFMS EXPORT SUMMARY

Page: 1

LOCATION: NNMCSHIPROCK

EXPORT DATE: AUG 31, 2018@07:03:50

FILE NAME: IHS\_TPB\_RPMS\_INV\_808601\_20180831\_070350\_2.06.26k.DAT

EXPORT(S) RESENT: <<NONE>>

BUDGET ACTIVITY	BILL CNT	AMOUNT	EXCL.CNT	EXCL.AMT
=====				
NORTHERN NAVAJO MEDICAL CTR				
MCR PART D	131 bills	18,659.17	0 bills	0.00
MEDICAID FI	721 bills	<u>135,488.52</u>	0 bills	0.00
MEDICARE FI	28 bills	17,932.77	0 bills	0.00
MEDICARE HMO	14 bills	3,888.20	0 bills	0.00
PRIVATE	203 bills	46,987.95	0 bills	0.00
Total for facility	1097 bills	<u>222,956.61</u>		
TOADLENA HEALTH STATION				
MEDICAID FI	7 bills	2,434.60	0 bills	0.00
MEDICARE FI	1 bill	383.00	0 bills	0.00
MEDICARE HMO	2 bills	732.00	0 bills	0.00
Total for facility	10 bills	3,549.60		
DZILTH NA O DITH HLE HEALTH CT				
MCR PART D	29 bills	3,893.00	0 bills	0.00
MEDICAID FI	66 bills	19,911.38	0 bills	0.00

MEDICARE FI	1 bill	188.80	0 bills	0.00
MEDICARE HMO	8 bills	2,193.60	0 bills	0.00
NON-BEN (NON- <u>INDIAN</u> )	1 bill	638.05	0 bills	0.00
PRIVATE	11 bills	1,324.10	0 bills	0.00
Total for facility	116 bills	28,148.93		
FOUR CORNERS REGIONAL HLTH CTR				
MCR PART D	34 bills	1,511.91	0 bills	0.00
MEDICAID FI	76 bills	31,039.13	0 bills	0.00
MEDICARE FI	99 bills	14,746.51	0 bills	0.00
PRIVATE	37 bills	4,399.20	0 bills	0.00
VETERANS ADMINISTRATION	12 bills	2,104.60	0 bills	0.00
Total for facility	258 bills	53,801.35		
TOTAL BILLS:	1481 bills	<u>308,456.49</u>	0 bills	0.00

--- EXPORT SUMMARY ---				
MCR PART D	194 bills	24,064.08	0 bills	0.00
MEDICAID FI	870 bills	<u>188,873.63</u>	0 bills	0.00
MEDICARE FI	129 bills	33,251.08	0 bills	0.00
MEDICARE HMO	24 bills	6,813.80	0 bills	0.00
NON-BEN (NON- <u>INDIAN</u> )	1 bill	638.05	0 bills	0.00
PRIVATE	251 bills	52,711.25	0 bills	0.00
VETERANS ADMINISTRATION	12 bills	2,104.60	0 bills	0.00

### Timeline of RPMS/HUB/UFMS Reconciliation:

- RPMS Transmission frequency occurs on a consistent schedule at the Area's discretion.
  - Smaller sites might have less frequent transmissions.
  - The larger facilities may need to transmit daily to avoid system errors.
- HUB Reports are created daily.
  - If no RPMS data file was transmitted, there will be no data in the HUB Report.
  - Certain users are designated to receive these reports via email.
- Final transmission of the week must be performed before Sunday 12:00pm (noon) MT, 2:00pm EST.
- Headquarters "picks up" all transmitted files, and completes the weekly processes and collection runs & forwards data to Budget Execution (BE).
- UFMS Reports are created weekly and received at the beginning of the week for prior week's transmissions.
  - Certain users are designated to receive these reports via email.
- Advice of Allowance (AoA) are received at the beginning of the week for prior week's transmissions.

- Allotments are only received for receipts posted and successfully transmitted from RPMS to the HUB to UFMS. Allotments are not received until they have been successfully processed in UFMS.
  - (HQ>Allotment>Area>Allowance>Service Unit>\$\$)
- UFMS/FBIS reports can be run once Headquarters notifies all Areas via email.

**Advantages of RPMS/HUB/UFMS Reconciliation:**

- RPMS balances UFMS
- Service Units receive total collected – Allowance
- Easy detection/resolution of errors
- Minimal Suspense Amount

**If you do not Reconcile, the following impacts can occur:**

- RPMS does not balance with UFMS
- Service Units do not receive total collected – Allowance
- Hard to detect errors
- Increases Suspense Amount – Suspense (unreconciled Treasury Deposits) can increase if daily, weekly, monthly, and ongoing reconciliation does not occur

**TRANSMISSION FLOW – Reconciliation Reports (one scenario):**

- 1) AR Reconciliation Worksheet
- 2) RPMS Reports (Business Office)
- 3) HUB Portion (Business Office)
- 4) UFMS Portion (Finance)
- 5) After weekly collection run
- 6) RPMS Reports = AR Reconciliation Worksheet
- 7) UFMS Export Reconciliation/UFMS Export Summary
- 8) Grand Total All Files Report
- 9) Receipts & Adjustments
- 10) HUB Report
- 11) FBIS Reports (Finance)

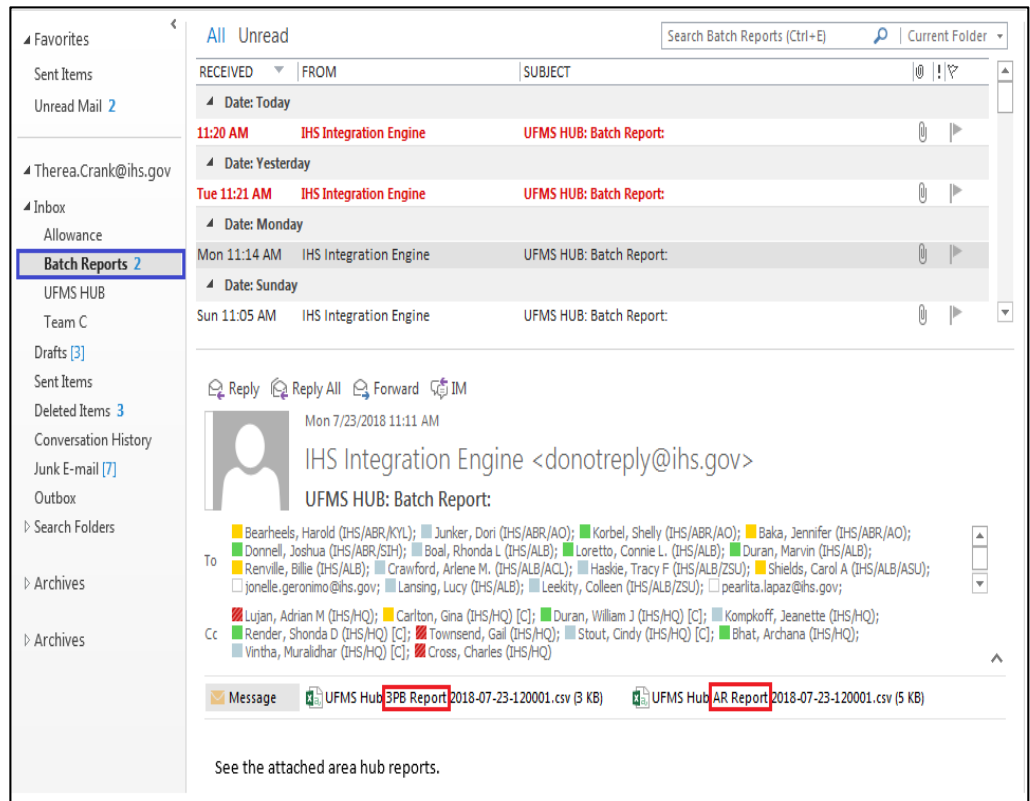
**AR File Reconciliation Worksheet Sample:**



	RPMS FILE NAME	MCD Sum of Amount	MCD Sum of Bills	MCR Sum of Amount	MCR Sum of Bills	OTH Sum of Amount	OTH Sum of Bills	PVT Sum of Amount	PVT Sum of Bills	VET Sum of Amount	VET Sum of Bills	Total Sum of Amount	Total Sum of Bills
80	IHS_TPB_RPMS_INV_606410_20171012_085356_2.06.21k.DAT	\$ 72,497.00	186	\$ 9,637.24	43	\$ 16,422.00	42	\$ 3,115.00	18	\$ 424.14	3	\$ 102,095.38	292
81	IHS_TPB_RPMS_INV_607101_20171012_082457_2.06.21k.DAT	\$ 560,501.27	1522	\$ 109,045.80	387			\$ 43,168.42	164			\$ 712,715.49	2073
82	IHS_TPB_RPMS_INV_607201_20171012_083156_2.06.21k.DAT	\$ 57,156.87	161	\$ 8,977.45	74	\$ 1,332.00	4	\$ 26,868.57	106			\$ 94,334.89	345
83	IHS_AR_RPMS_RCV_1194_606352_20171012_082947_1.08.26.DAT	\$ -	0	\$ -	0	\$ 396.99	2	\$ 3,025.07	65	\$ -	0	\$ 3,422.06	67
84	IHS_AR_RPMS_RCV_1647_606401_20171012_082728_1.08.26.DAT	\$ -	0	\$ 20,030.90	80	\$ 6.60	1	\$ 5,918.41	20	\$ 336.82	8	\$ 26,292.73	109
85	IHS_AR_RPMS_RCV_1647_606410_20171012_085426_1.08.26.DAT	\$ 1,173.00	3	\$ 753.69	7	\$ -	0	\$ 1,253.58	5	\$ 513.68	16	\$ 3,693.95	31
86	IHS_AR_RPMS_RCV_1975_606201_20171012_082851_1.08.26.DAT	\$ 8,716.45	122	\$ 6,025.02	93	\$ -	0	\$ 39,195.30	220	\$ 1,233.00	5	\$ 55,169.77	440
87	IHS_AR_RPMS_RCV_3036_607101_20171012_082549_1.08.26.DAT	\$ 38,832.04	408	\$ 16,183.35	48	\$ 282.42	3	\$ 12,614.41	129	\$ -	0	\$ 67,912.22	588
88	IHS_AR_RPMS_RCV_678_606110_20171012_093045_1.08.26.DAT	\$ 21,114.00	54	\$ 4,160.90	14	\$ -	0	\$ 421.25	13	\$ -	0	\$ 25,696.15	81
89	IHS_AR_RPMS_RCV_966_607201_20171012_083220_1.08.26.DAT	\$ 28,953.84	119	\$ 6,745.02	47	\$ -	0	\$ 6,246.55	42	\$ -	0	\$ 41,945.41	208
90	IHS_AR_RPMS_RCV_1194_606352_20171012_082947_1.08.26.DAT.ADJ	\$ -	0	\$ -	0	\$ 1.39	1	\$ 6,848.96	261	\$ -	0	\$ 6,850.35	262
91	IHS_AR_RPMS_RCV_1647_606401_20171012_082728_1.08.26.DAT.ADJ	\$ 782.00	2	\$ 5,478.44	260	\$ 19.40	2	\$ 4,867.67	117	\$ -	0	\$ 11,147.51	381
92	IHS_AR_RPMS_RCV_1647_606410_20171012_085426_1.08.26.DAT.ADJ	\$ -	0	\$ 963.42	29	\$ -	0	\$ 1,150.34	25	\$ 402.45	16	\$ 2,516.21	70
93	IHS_AR_RPMS_RCV_1975_606201_20171012_082851_1.08.26.DAT.ADJ	\$ 530.44	3	\$ 8,961.82	259	\$ -	0	\$ 23,712.36	1425	\$ 1,319.01	4	\$ 34,523.63	1691
94	IHS_AR_RPMS_RCV_3036_607101_20171012_082549_1.08.26.DAT.ADJ	\$ 29,579.06	351	\$ 10,428.68	305	\$ 356.22	3	\$ 23,031.47	382	\$ -	0	\$ 63,395.43	1041

### RPMS TRANSMISSION:

- Sending files consistently ensures that the financial system contains current information.
- Area/Business Office to identify ONE person to perform both transmissions.
  - Recommend two Alternates as back-up.
- Data is transmitted for Medicaid, Medicare, Private Insurance, Veterans Administration and Other.
- Transmissions should occur in this order to avoid HUB Errors:
  - 1<sup>st</sup> RPMS Third Party Billing (TPB) = Invoices
  - 2<sup>nd</sup> RPMS Accounts Receivable (AR)
- Receipts (Collected and Posted in RPMS).
- Adjustments.
- Once files are transmitted, an email notification from the HUB (do-not reply@ihs.gov) is sent within minutes after transmission.
  - Two notifications will be sent – one for TPB and AR.



- If no email notification is received by the transmitter, contact will need to follow the tier contact process below to see if the file was received at the HUB Integration Engine.
  - Tier 1 = Service Unit IT
  - Tier 2 = Area IT
  - Tier 3 = OIT Helpdesk
- Possible reasons the file did not make it to the HUB:
  - System issues at the Service Unit.
  - Local server maintenance.
  - RPMS server went down during the export process.
  - Directory not set-up correctly or with the proper permissions for the submitting user.
  - IHS network goes down.
- Each Transmission is assigned a RPMS Filename.
  - Example RPMS File Name – TPB (INV) and AR (REC/ADJ)
  - One TPB File and One AR File per location

IHS\_TPB\_RPMS\_INV\_808401\_20180917\_060313\_2.06.26k.DAT

IHS – Third Party Billing - RPMS Invoice File – ASUFAC of Facility –  
Date – Time – Version of TPB Package

IHS\_AR\_RPMS\_RCV\_3877\_808401\_20180917\_060415\_1.08.28.DAT

IHS – Accounts Receivable – RPMS – User ID – ASUFAC of Facility –  
Date – Time – Version of AR Package

- Steps required to complete a successful file transmission:
  - a) Cashiering Option
  - b) Supervisory Function
  - c) View Cashiering Sessions (See chapter 5 for details)
  - d) Reconcile/Close Sessions
  - e) Transmit Sessions
    - Transmitter designated at sites discretion
  - f) File was sent successfully
  - g) Print Export Summary (See chapter 10 for details)
    - TPB>UCSH>SUP>REC
    - AR>CSH>SUP>Select by Status
  - h) RPMS Reports (See chapter 10 for details)
  - i) UFMS Export Reconciliation Page - TPB
  - j) UFMS Export Summary – TPB
  - k) Grand Total All Files Report – AR
  - l) Not Sent – AR
  - m) Period Summary Report – AR
  - n) Age Summary Report for All Allowance Category(s)
  - o) UFMS Age Summary Report by FY

#### **HUB TRANSMISSION:**

- RPMS file names are assigned UFMS file names.
- Merges files by ASUFAC to One AREA File.
- A=Area, SU=Service Unit, FAC=Facility
  - Creates three files – INV, REC, ADJ
- The RPMS INV File is one file.
- The RPMS REC File is split into two files. One for Receipts and One for Adjustments.

- Provides a HUB Report after each transmission.
- Count and Amounts with subtotals and totals.
- HUB Website: <http://home.ihs.gov/3pbar/>
  - Categorizes Data into Medicaid, Medicare, Private Insurance, Veterans Administration and Other.
  - Assigns Accounting Codes Budget Accounting Program (BAP).
- **Website Link:** <http://home.ihs.gov/3pbar/>

**Example UFMS RPMS HUB File Name:**

SUCCESSFUL TRANSACTION RECORDS  
IHS\_AR\_RPMS\_INV\_N\_20180917\_120530.dat  
IHS – AR – RPM – Invoice – Area Initial – Date  
– Time  
IHS\_AR\_RPMS\_RCV\_N\_20180917\_120704.dat  
IHS – AR – RPMS – Receipts – Area Initial –  
Date – Time  
IHS\_AR\_RPMS\_ADJ\_N\_20180917\_120758.da  
IHS – AR – RPMS – Adjustments – Area Initial  
– Date – Time

**RPMS and UFMS “Mapping” TERMINOLOGY:**

RPMS = UFMS

Bills = Invoices

Payments = Receipts

Adjustments = Adjustments

Insurers = Customer

CANS = BACS

Clinic Codes = Cost Centers

Type of Insurer = Budget Activity Code

ASUFAC = Location Code

**Budget Accounting Point (BAP)**

7120**54**0121 = Medicare

7122**54**0222 = Medicaid

7132**54**0515 = Private Insurance

7170**54**0000 = Veterans Administration

7100**54**0109 = Other

Whereas, ‘**54**’ is the Accounting Point

## Screenshots:

UFMS RPMS Hub File Name	RPMS File Name	DATE	RPMS \$\$ Amount	Subtotal \$\$	Record Count	Subtotal Count	ERROR TYPE
SUCCESSFUL TRANSACTION RECORDS							
IHS_AR_RPMS_INV_N_20180718_120816.dat	IHS_TPB_RPMS_INV_808101	20180718_071147_2.06.26k.DAT	52536082		1463		
	IHS_TPB_RPMS_INV_808201	20180718_065821_2.06.26k.DAT	10675796		458		
	IHS_TPB_RPMS_INV_808401	20180718_061152_2.06.26k.DAT	55046182		1377		
	IHS_TPB_RPMS_INV_808510	20180718_070720_2.06.26k.DAT	13445359		530		
	IHS_TPB_RPMS_INV_808601	20180718_071625_2.06.26k.DAT	59001098		1261		
				190704517		5089	
SUCCESSFUL RECEIPT TRANSACTION RECORDS							
IHS_AR_RPMS_RCV_N_20180718_120941.dat	IHS_AR_RPMS_RCV_6863	808101 20180718_071213_1.08.27.DAT	6295306		656		
	IHS_AR_RPMS_RCV_2424	808201 20180718_065850_1.08.28.DAT	7681624		512		
	IHS_AR_RPMS_RCV_3877	808401 20180718_061254_1.08.28.DAT	101752574		2988		
	IHS_AR_RPMS_RCV_1558	808510 20180718_070914_1.08.28.DAT	2899579		317		
	IHS_AR_RPMS_RCV_3500	808601 20180718_071716_1.08.28.DAT	78165990		3209		
				196795073		7682	
SUCCESSFUL ADJUSTMENT TRANSACTION RECORDS							
IHS_AR_RPMS_ADJ_N_20180718_121039.dat	IHS_AR_RPMS_RCV_6863	808101 20180718_071213_1.08.27.DAT	-8399208		2305		
	IHS_AR_RPMS_RCV_2424	808201 20180718_065850_1.08.28.DAT	-1123968		745		
	IHS_AR_RPMS_RCV_3877	808401 20180718_061254_1.08.28.DAT	-30999040		1971		
	IHS_AR_RPMS_RCV_1558	808510 20180718_070914_1.08.28.DAT	-3027465		498		
	IHS_AR_RPMS_RCV_3500	808601 20180718_071716_1.08.28.DAT	-55957385		7964		
				-99507066		13483	

**INDIAN HEALTH SERVICE INTRANET**

IHS HOME SITE MAP EMPLOYEE LOCATOR Search for:

BILLING/ACCOUNTS RECEIVABLE EXPORT REPORTS: AREA FILE STATUS JUL 24, 2018

HOME REPORTS RECONCILIATION REPORTS

Select a date to view facilities reporting... View the last 30, 60, 90, or All transaction records

You may select a range of available Navajo report dates and/or facilities to view.

From: 10/01/2008 to: 07/24/2018 Facilities: Chinle Submit

View Transactions View Batches

Navajo		Reporting Facilities (Select the code)	
Date	Recs	Name	Errors
07/24/2018	18,897	Chinle	808101 4,426
07/23/2018	10,178	Crownpoint	808201 1,717
07/21/2018	2,455	Gallup	808401 6,338
07/20/2018	13,206	KAYENTA	808510 1,347
07/19/2018	17,577	SHIPROCK	808601 12,436
07/18/2018	26,264		
07/17/2018	11,623		
07/16/2018	17,024		
07/15/2018	12,789		
07/14/2018	15,266		
07/13/2018	21,980		
07/12/2018	17,889		
07/11/2018	24,713		
07/10/2018	11,307		
07/09/2018	10,673		
07/08/2018	20,263		
07/07/2018	18,391		
07/06/2018	17,303		
07/05/2018	15,053		
07/04/2018	14,454		
07/03/2018	13,436		
07/02/2018	1,035		
07/01/2018	24,410		
06/30/2018	19,618		
06/29/2018	14,620		
06/28/2018	19,444		
06/27/2018	12,122		
06/26/2018	2,693		
06/25/2018	10,225		

Facility File Detail Chinle (2 Files)

File Data

Name: IHS\_TPB\_RPMS\_INV\_808101\_20180718\_071147\_2.06.26k.DAT

Status: Complete File Received by the Interface Engine.

Record Count: 1464

IE Rcv'd: 2018/07/18 07:11:54

Batch File(s): IHS\_AR\_RPMS\_INV\_N\_20180718\_120816.dat

Name: IHS\_AR\_RPMS\_RCV\_6863\_808101\_20180718\_071213\_1.08.27.DAT

Status: Complete File Received by the Interface Engine.

Record Count: 2962

IE Rcv'd: 2018/07/18 07:44:07

Batch File(s): IHS\_AR\_RPMS\_ADJ\_N\_20180718\_121039.dat  
IHS\_AR\_RPMS\_RCV\_N\_20180718\_120941.dat

Condition Legend

- 1 Compl file rec'd by IE
- 2 File inserted by undocumented means
- 10 ERR: Incompl file rec'd by IE
- 14 ERR: File rec count exceeded limit

Error Legend

- A No Errors
- B Invalid Location
- C TX Prior to 10/08
- D Unmatched CAN

**FBIS IHS RPMS Invoice File Reconciliation Report**

- Provides count and amount of RPMS invoice entries made for a specified UFMS File Name.
- Generates details of the invoice from staging area for specific prompts.
- Aid with reconciliation and tracking missing invoice records between RPMS and UFMS.

**FBIS IHS RPMS Receipts File Reconciliation Report**

- Provides count and amount of RPMS receipt entries made for a specified UFMS File Name.
- Generates details of the receipts from staging area for specific prompts.
- Aid with reconciliation and tracking missing receipt records between RPMS and UFMS.

#### **FBIS IHS RPMS Adjustments File Reconciliation Report**

- Provides count and amount of RPMS adjustment entries made for a specified UFMS File Name.
- Generates details of the adjustments from staging area for specific prompts.
- Aid with reconciliation and tracking missing adjustment records between RPMS and UFMS.

#### **FBIS IHS RPMS Cumulative Receipts Allowance Report**

- Provides the cumulative allowance amounts from RPMS for receipts that have been processed for a given location and ASUFAC code.

**Note:** FBIS Error Reports exist for invoice, receipts, and adjustment transactions.

## 9.2 **Accounts Receivable Reconciliation**

Open Accounts Receivable Reconciliation is the act of comparing and confirming that the AR Individual Accounts have been successfully transmitted from RPMS to the HUB, and to UFMS. The objective is to reconcile variances and ensure the two systems – RPMS and UFMS – are in balance.

RPMS and UFMS AR accounts should not only reconcile, but you need to ensure that your accounts are not outstanding beyond an acceptable timeframe. If we are billing, collecting, posting, transmitting, reconciling and implementing debt management within guidelines, we should not have outstanding debt beyond a reasonable limit.

Medicaid is considered Non-Federal according to Department Policy. Because of this, Medicaid is viewed as an account that should not be sitting open on the books beyond a certain timeframe. It is **recommended, that at a minimum, all previous year accounts should be balanced, reconciled, and “adjusted accordingly” at the end of each Fiscal Year.**

**Note:** The exception to this process or timeframe pertains to payors timely filing requirements. If it exceeds one year, adjustments must be made to your process in order to address this issue.

One Example of AR Account Balance Clean Up is as follows:

- 1) Determine why there are still open balances in accounts.
- 2) Set a specific deadline for Reconciling all Previous Year accounts.
  - a) RPMS Open Balances match UFMS Open Balances.
    - i. Post accordingly in RPMS and the Adjustments will be transmitted to UFMS.
    - ii. Rerun Reports to see differences.
    - iii. Repeat 1-2.
  - b) RPMS Open Balances do not match UFMS Open Balances.
    - i. UFMS has a higher balance than RPMS in AR.
      - (a) Post all you can in RPMS and transmit adjustment.
      - (b) Rerun Reports to see differences.
      - (c) Finance will have to post a manual adjustment directly against the UFMS Invoice.
      - (d) Repeat a-c.
    - ii. RPMS has a higher balance than UFMS in AR.
      - (a) Post all you can in RPMS and transmit adjustments.
      - (b) Rerun Reports to see differences.
      - (c) Finance will have to post an upward adjustment directly against the UFMS Invoice to allow for the remaining Accounts to be posted in RPMS.
      - (d) Repeat a-c.
    - iii. UFMS has a balance and RPMS doesn't.
      - (a) Finance will have to post an adjustment directly against the UFMS Invoice closing out the UFMS Balance.

When doing any type of reconciliation/clean up, research **must** be done and documented to ensure that RPMS Accounts, UFMS Account, and TDN (Cash) are accounted for properly. RESEARCH is KEY.

**Note:** The previous process can be applied to any reconciliation process (Private Insurance, Medicare, VA, Other), but remember, Non-Federal Accounts should pass through the Debt Management Process.

**Acronyms:**

UFMS	Unified Financial Management System
AP	Accounts Payable
CARS	Central Accounting Reporting System
FBWT	Fund Balance With Treasury

OTCNet	Over The Counter (OTC) Channel Program
CIR	Collections Information Repository
TDN	Treasury Deposit Number
FBIS	Financial Business Intelligence System
CM	Cash Management
TPB	Third Party Billing
AR	Accounts Receivable
RPMS	Resource and Patient Management System
INV	Invoice
RCV	Receipt
ADJ	Adjustment
BAP	Budget Activity Program
AC	Allowance Category
FY	Fiscal Year
USM	UFMS Age Summary Report
UBLT	Bill Transmit Check Report
UTLT	Transactions Missing UFMS TX Date
NS	Transactions Not Sent Report

Steps to creating an Open Accounts Receivable (A/R) Reconciliation Worksheet:

### **RPMS REPORTS**

- Reports should be run after the last RPMS Transmission for the week
- Sites should set-up a schedule when to run their reports.
- Each facility should assign this responsibility to someone trained on the process.

#### **1) RPMS USM Detail Report for all FY's**

- a) Path: AR>RPT>ARM>USM
- b) Report Parameters:
  - i. Enter FISCAL YEAR for the Report: FY08-FY-XX//
  - ii. Select Visit LOCATION: ALL
  - iii. Select criteria for sorting: 5
  - iv. Select TYPE of ALLOWANCE CATEGORY to Display: ALL
  - v. Select REPORT TYPE: 1??3  
FILE, LOG SESSION, name file, save to location as .txt  
DEVICE: HOME//;;99999 > Press Enter
- c) Report displays a list of all aging by fiscal year
- d) RPMS uses the export date
- e) Key data required
  - i. RPMS Bill Number
  - ii. Allowance Category
  - iii. Balance



**2) UBLT Report**

- a) Path: TPB>UCSH>SUP>UBLT
- b) Date range: October 1, 2008 to current date

**3) UTLT Report**

- a) Path: AR>CSH>SUP>RPT>UTLT
- b) Date range: October 1, 2008 to T-1
- c) Do not request OIT to re-queue PENDING and GENERAL transaction, they will never re-queue these from RPMS to UFMS
- d) Transactions on this report do not affect the balance of the invoices
- e) Research will need to be completed prior to making any requests to OIT to verify the transactions need to be re-queued

**4) NS Report**

- a) Path: AR>CSH>SUP>RPT>NS
- b) Date range: October 1, 2008 to current date
- c) Provides a listing of transactions that were not sent from RPMS to UFMS for various reasons
  - i. TP bill not sent
  - ii. Negative balance on bill
  - iii. Over-posting of checks
  - iv. Duplicate bills
- d) UTLT and the NS Report are not the same
- e) The NS Report contain transactions that we “told” the system not to send

**UFMS/FBIS REPORTS**

- Reports should run after the AR upload is completed by Headquarters (normally scheduled the following Monday).
- Not all Areas use ONLY these reports listed below. Others have found additional reports to be beneficial in the reconciliation process (example: Receipt Register Report).
- For details on additional UFMS/FBIS Reports, communicate with your Area Finance office.
- For screenshots of the UFMS/FBIS Reports, reference Appendix UFMS/FBIS Reports.

**1) AR – IHS – RPMS Aging with Manual Adjustments Report – RPMS Detail**

- a) Report displays corresponding invoice location budget activity program

and aging information for manual adjustments. This report allows the user to refine their search by transaction timeframe.

- b) Report considers both RPMS transactions and manual adjustment transactions.
- c) UFMS uses the approval date.
- d) Report will combine all FY's.
- e) Recommend filtering by the Fund Year.
  - i. If all RPMS exports were completed the same FY, this should separate the data without any reconciling items between FY's.
- f) Key data required:
  - i. RPMS Bill Number
  - ii. Fiscal Year
  - iii. Budget Activity Program
  - iv. Total Amount
  - v. Invoice Number
  - vi. Master Invoice Number
  - vii. Transaction Date
  - viii. Fund
  - ix. Location Code

## 2) **AR – IHS – Transaction Register Report**

- a) Report provides transactional details on AR Invoices from UFMS AR module.
- b) Can be used to reconcile the Master Invoices created in AR against RPMS Invoice file reconciliations.
- c) Ability to calculate the open balance on the Master Invoices.
- d) Manual Adjustments will reflect in these Balances.
- e) Displays Old and New Master Invoice balances by Allowance Category and by FY and/or month.
- f) Key data required:
  - i. Fiscal Year
  - ii. Budget Activity Program
  - iii. Balance
  - iv. Master Invoice

## 3) **IHS RPMS Invoice Error Report**

- a) Provides detailed information and amounts of invoice errors from transactions that were unable to process and residing in the staging area.
- b) Area code prompt will display only those that have errors.
- c) Refer to AR Cheat sheet for resolution.

## 4) **IHS RPMS Receipt Error Report**

- a) Provides detailed information and amounts of receipt errors from

transactions that were unable to process and residing in the staging area.

- b) Area code prompt will display only those that have errors.
- c) Funds not included in the weekly allotment.
- d) Refer to AR Cheat sheet for resolution.

5) **IHS RPMS Adjustment Error Report**

- a) Provides detailed information and amounts of adjustment errors from transactions that were unable to process and residing in the staging area.
- b) Area code prompt will display only those that have errors.
- c) Refer to AR Cheat sheet for resolution.

**Open AR Reconciliation Spreadsheet Tabs**

- Using a combination of the referenced RPMS and UFMS Reports, a spreadsheet can be established to reconcile all Open Accounts Receivable.
- Main objective is to ensure RPMS = UFMS.
- Reconciliation should be set-up by Service Unit/Location.
- Reconciliation should be completed at the end of each month to coincide with the AR Metrics submitted to Headquarters.

**TABS**

- 1) RPMS USM Detail
- 2) AR – IHS – RPMS Aging with Manual Adjustments Report – RPMS Detail
- 3) Fiscal Year Reconciliation Tab
  - a) Filter data by FY/Tab
- 4) AR – IHS – Transaction Register Report
- 5) UBLT Report
- 6) UTLT Report
- 7) Not Sent Report
- 8) IHS RPMS Invoice Error Report
- 9) IHS RPMS Receipt Error Report
- 10) IHS RPMS Adjustment Error Report

## 9.3 **Cash Management**

Cash Management (CM) provides information relating to cash flow of the organization, by processing and analyzing all cash and bank transactions, arising out of payment of supplier's invoices, receipt from sales invoices, standalone payments, and/or unallocated payment/receipts.

- It allows analyzing financial transactions for a given period of time and provides information regarding Accounts Receivable Suspense balances.
- Within UFMS (IHS Financial Management System), CM enables the user to track cash transactional activity, and reconciliation and resolution of differences with Treasury at the Appropriation and Treasury Deposit Number (TDN).
  - **Note:** For the purpose of this document, “Treasury Deposit Number” is used in place of the “Schedule Number.”
- CM Reconciliation plays a vital role in the File and Open Accounts Receivable Reconciliation sections.
- CM is integrated with the following UFMS Accounting modules:
  - Accounts Payable (AP)
  - Accounts Receivable (AR)
  - General Ledger (GL)
- AR and AP Suspense Count and Amount are displayed on the IHS Executive Dashboard and on the Agency’s Scorecard.

## 9.4 Central Accounting Reporting System (CARS)

In March 2015, the Central Accounting Reporting System (CARS) replaced Treasury’s legacy central accounting system known as STAR (Central Summary Standard General Ledger). The Department of Health and Human Services (HHS) implemented CARS reporting in December 2017.

- CARS handles accounting and reporting for all federal agencies.
- CARS supports General Ledger accounting for government cash and monetary assets.
- Repository for Monthly Treasury statements and the U.S. Government Combined Statement.
- Provides agencies with an account statement of their Cash balances account.
- Allows agencies access to transaction detail in order to support research and reconciliation.
- Provides agencies with one-stop access to both provide and retrieve data and information from Treasury.
- Improves the usability and currency of government-wide financial information.
- Minimizes data redundancy and enhances data sharing between agencies and Treasury.

## 9.5 Cash Management (CM) and Central Accounting Reporting System (CARS) Reconciliation

The purpose of reconciling is to ensure the accuracy and timeliness of deposit and disbursement data are reflected in the Treasury cash account i.e., **Fund Balance with Treasury (FBWT)**. **The reconciler must ensure that all treasury receipts are accounted for in UFMS.** Per Treasury policy, IHS should identify and clear the TDN level differences within two months of occurrence.

### **Fund Balance with Treasury Requirements:**

- Requires that agencies reconcile their cash accounts on a regular and recurring basis to ensure the integrity and accuracy of their internal and government-wide financial report data.
- Agencies must reconcile budget clearing account balances on a monthly basis, as suspense account balances are subject to scorecard performance standards.

### **Fund Balance with Treasury**

- Per Treasury policy, FBWT Reconciliations should be completed within 20 days after month-end and identified discrepancies corrected within 60 days.
- Corrective action plans are required for differences older than 60 days.
- The FBWT reconciliation is reviewed and signed off on by the Director of the Division of Systems Review and Procedures.

### **Suspense**

- Suspense account is an account in which transactions are entered temporarily before allocation to the correct or final account.
- Suspense accounts must be reconciled monthly to ensure detailed document balances align to the general ledger balance, and that the general ledger balances in the financial management system align with the fund balance with the FBWT for Suspense appropriations.
- Discrepancies must be corrected within 60 days.
- Accounting centers must be able to identify all payment and collection schedules that make up suspense account balance in the general ledger and Treasury.
- The suspense reconciliation is reviewed and signed off on by the Director of the Division of Systems Review and Procedures.

## 9.6 Responsibilities

### **Headquarters**

- Responsible for executing and monitoring the Weekly/Monthly CARS Processes for Schedule reconciliation.

- Responsible for syncing the Area level balances to Treasury on a weekly basis and during month-end.
- Responsible for communicating the status of CARS processes to Areas, as it completes on a weekly basis and during month-end.
- Responsible for assisting Areas to resolve problems/issues outside of user control.

### **Area Office**

- Responsible for executing FBIS.
- Responsible for the timely resolution of unreconciled schedules and assisting service unit personnel with RPMS and UFMS collection related issues.
- Responsible for escalating any items that have a technical requirement for reconciliation.
- Responsible for executing web-based application reports:
  - Collection Information Repository (CIR) – Treasury Reporting System to download your Treasury Deposit Numbers
  - OTCNet – web-based application to assist in identifying deposit types

### **Service Unit Business Office**

- Responsible for timely resolution of unreconciled RPMS schedules.
  - Designee must post all receipts and adjustments to the RPMS A/R no later than three business days after the receipt of all supporting documentation. For additional information, please reference the IHM Part 5, Section 5.1.1: <https://www.ihs.gov/ihs/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>.
- Responsible for escalating any items that have a technical requirement for reconciliation through the Tier level:
  - Tier I = Service Unit IT
  - Tier II = Area IT
  - Tier III = OIT Helpdesk

### **Service Unit Finance**

- Responsible for timely resolution of unreconciled UFMS schedules.
  - Designee must post all receipts and/or credit memos no later than the last day of the same accounting month the collections were received.
- Responsible for executing FBIS reports.
- Responsible for providing updates to their respective Area Finance Offices on their unreconciled RPMS and UFMS Collection schedules.

## **9.7 Reports**

### **FBIS Cash Reconciliation Reports**

- CM.01 report displays all Pre CARS schedules prior to November 30, 2017.
- CARS CM.01 report displays all Post CARS schedules after December 1, 2017.
- Both reports display a list of TDN that have a variance.
  - The variance amounts contribute to the Agency's suspense.
- CM.03 and CARS CM.03 Report:
  - Displays all AR and AP (if any) Detail transactions posted to a specific Schedule number.
- AR-IHS-Receipts Register Report:
  - Report is used to display receipts created from the AR module.
  - Can be used to reconcile the receipts created in AR module against RPMS receipt file reconciliations.
  - Can be used when there are mismatches between UFMS Open AR vs RPMS Open AR for any manual receipt reversals/unapplied receipts in AR.
- IHS RPMS Receipts Detail Report:
  - RPMS Receipts Detail Report provides all RPMS collection details in UFMS.
  - Report tabulates collections in UFMS for a RPMS/UFMS file by BAP and location to help to reconcile collections.
  - In case of variances between collection and allowances, the "detail" section of the report can be used to identify collections against expired funds.

For more information on UFMS/FBIS Reports, communicate with your Area Finance office.

## 9.8 Accounts Receivable Dashboard

The AR Dashboard provides metrics at an Agency, Area, and Service Unit level for period to date (PTD) and year to date (YTD) timeframes. This report derives data from the UFMS module and uses the RPMS data (metrics) sent by the area office. This report is generated monthly to help analyze AR metrics. It serves as a productivity and receipt monitoring tool and indicates the differences between the RPMS AR balances and UFMS AR balances for reconciliation purposes.

**Sources for the report are derived from:**

**UFMS**

YTD Billed Amounts – RPMS Invoices  
PTD Billed Amounts – RPMS Invoices for the Period  
YTD Collections Amounts – RPMS Receipts  
PTD Collections Amounts – RPMS Receipts for the Period  
YTD Adjustments Amounts – RPMS Adjustments  
PTD Adjustments Amounts – RPMS Adjustments for the Period  
Open Receivables – Only RPMS Invoices  
Invoice, Receipt and Adjustment Errors



## 10. Account Management Reports

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## 10.1 About Account Management Reports

Account Management Reports are used to Monitor, Trend, Project, and Manage all aspects of the Accounts Receivable Process. Some Reports can also be used to meet the requirements set forth by the Third Party Resource and Account Management Internal Control Policy. Other reports can be used by Managers (at all levels) and End Users to monitor activity, productivity, project revenue, identify gaps in the revenue cycle, trend activity, and look at the overall success of your Revenue Cycle.

This section of the Revenue Operations Manual will provide the path, description, when to use, when to run, and a screen shot sample of all RPMS Accounts Receivable Reports.

## 10.2 Report Parameters

Every canned report in the Accounts Receivable Module was designed for a specific need. These canned reports were designed with specific outcomes in mind, resulting in different sets of Parameters to report from. It is important for the user to know what they are trying to report on in order to understand the right parameters to choose from.

For more information and general assistance in running AR Reports, selecting parameters etc., reference the RPMS Accounts Receivable User Manual.

## 10.3 AMRM Account Management Reports

Use this option to access the Bills List report (BLS), Bill Negative report (NEG), and Small Balance List (SBL).

The Account Management Reports provide Management with unique situations and specific details of certain accounts that may need managing. These reports help with reconciliation and overall Account Management.

### BLS Bills Listing Report (A/R → RPT → AMRM → BLS)

**Description:** Provides the user with a list of bills regardless of outstanding balance. This report may be generated as a detail report or summary but provides the user with all bills uploaded from Third Party Billing to the Accounts Receivable System.

**When to use the Report:** When looking for all the TPB Bills that should exist as AR Bills for posting and reconciliation purposes.

**When to run the Report:** As needed.

WARNING: Confidential Patient Information, Privacy Act Applies

```
=====
=====
DETAIL Bills Listing Report          SEP 27,2018@14:05   Page 1
for ALL BILLING SOURCE(S)
```

at ALL Visit location under 2017 CMS HOSPITAL Billing Location with VISIT DATES  
from 08/01/2018 to 08/30/2018

=====				
=====				
Patient	Bill Number	DOS	Amount Billed	Balance
=====				
=====				
Visit Location: 2017 CMS HOSPITAL				
Visit Type: OUTPATIENT				
A/R Account: SOUTH DAKOTA MEDICAID				
BEN, ANN MARIE	402519A-CMS-804516AUG 05, 2018		128.73	128.73
-----				
A/R Account	Count: 1	Total:	128.73	128.73
-----				
Visit Type	Count: 1	Total:	128.73	128.73
-----				
Visit Type: AMBULANCE				
A/R Account: WELLCARE OF NEBRASKA				
FRAKER, SABER SULLI	402528A-CMS-127511AUG 10, 2018		599.61	599.61
FRAKER, SABER SULLI	402527A-CMS-127511AUG 01, 2018		452.21	452.21
FRAKER, SABER SULLI	402527B-CMS-127511AUG 01, 2018		452.21	452.21
-----				
A/R Account	Count: 3	Total:	1,504.03	1,504.03
-----				
Visit Type	Count: 3	Total:	1,504.03	1,504.03
-----				
Visit Type: DENTAL				
A/R Account: DELTA DENTAL WDS				
DEMO, HELEN R	402518A-CMS-120102AUG 16, 2018		176.00	176.00
-----				
A/R Account	Count: 1	Total:	176.00	176.00
-----				
Visit Type	Count: 1	Total:	176.00	176.00
-----				
Visit location	Count: 5	Total:	1,808.76	1,808.76
=====				
Report Totals	Count: 5	Total:	1,808.76	1,808.76
=====				
***** R E P O R T C O M P L E T E *****				

### LBL Large Balance List (A/R→RPT→AMRM→LBL)

#### Description:

- Calculates and displays bills that have large open balances
  - Default large balance of \$5,000.00 but may be modified per Table Maintenance
  - Reports by insurer

**When to use the Report:** Following up for large-balance accounts. These accounts may

take special time and resources to resolve, but the outcome (gain) may exceed the cost to resolve these open balances. This report also shows how long the Account has been aging. This may assist in resolving billing, payer, or system issues.

**When to run the Report:** At least Monthly to manage outstanding large balance.

WARNING: Confidential Patient Information, Privacy Act Applies

Large Balance List over \$50,000.00 AUG 17, 2010@21:50 Page 1  
for ALL BILLING SOURCE(S) at ALL Visit location regardless of Billing Location

BILL NUMBER	DOS	DATE BILLED	DTB	BILLED AMT	BALANCE	AGE
-------------	-----	-------------	-----	------------	---------	-----

VISIT LOCATION: INDIAN HEALTH HOSPITAL

A/R ACCOUNT: AETNA LIFE AND CASUALTY

21316A-IH-9235	04/25/2002	07/15/2003	3036	50,496.00	50,496.00	2590
21316B-IH-9235	04/25/2002	04/28/2004	3036	50,496.00	50,496.00	2302

AR Account Subtotal (\$) and Average (#): 3036 100,992.00 100,992.00 2446

A/R ACCOUNT: BCBS OF NEW MEXICO

20880A-IH-1072	04/05/2002	04/25/2002	3056	48.00	445,566.00	3036
----------------	------------	------------	------	-------	------------	------

AR Account Subtotal (\$) and Average (#): 3056 48.00 445,566.00 3036

A/R ACCOUNT: MEDICARE

23839-IH-1515	01/26/2004	02/25/2004	2395	50,000.00	50,000.00	2365
28869B-IH-5094	08/24/2005	09/19/2006	1819	204,784.73	204,784.73	1428

AR Account Subtotal (\$) and Average (#): 2107 254,784.73 254,784.73 1897

Visit Loc Subtotal (\$) and Average (#): 2668 355,824.73 801,342.73 2344

Report Total (\$) and Average (#): 2668 355,824.73 801,342.73 2344

**NEG (New) Bill Negative Balance (A/R→RPT→AMRM→NEG)****Description:**

- Prints bills that contain a negative balance
  - By Allowance Category

**When to use the Report:**

- For Federal locations, may indicate system issues
  - Negative balances are not allowed
- For Medicare, used to report negative balances per Medicare agreement
- Negative Balances in individual AR Accounts can cause a reconciliation issue with the Master invoice in UFMS.

**When to run the Report:** At least monthly to manage the negative balances.

(New) Bill Negative Balance List				AUG 17,2010@21:57		Page 1
for MEDICARE ALLOWANCE CATEGORY(S)						
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location						
BILL NUMBER	DOS	DT BILLED	BILLED AMT	PYMTS	ADJS	BALANCE
VISIT LOCATION: INDIAN HEALTH HOSPITAL						
ALLOWANCE CATEGORY: MEDICARE						
A/R ACCOUNT: MEDICARE						
17597A	03/26/10	04/07/10	138.00	127.00	171.00	-160.00
17273B	03/09/10	04/29/10	138.00	110.40	29.60	-2.00
21111A	05/22/10	06/13/10	124.00	138.00	32.00	-46.00
21464A	06/24/10	07/24/10	175.00	128.00	69.00	-22.00
21710A	08/01/10	08/14/10	175.00	276.00	74.00	-175.00
23068A	01/14/10	12/04/10	175.00	156.00	38.00	-19.00
23069A	08/27/09	12/04/09	175.00	156.00	38.00	-19.00
30076A	06/09/10	08/20/10	201.00	0.00	263.00	-62.00
30074A	06/11/09	08/20/09	201.00	125.00	101.00	-25.00
AR Account Subtotal (\$):			1,502.00	1,216.40	815.60	-530.00
All. Cat. Subtotal (\$):			1,502.00	1,216.40	815.60	-530.00
Visit Loc Subtotal (\$):			1,502.00	1,216.40	815.60	-530.00
Report Total (\$):			1,502.00	1,216.40	815.60	-530.00

**SBL Small Balance List (A/R→RPT→AMRM→SBL)**

**Description:** Prints a list of accounts that contain a user-set limit (usually \$5.00 or under) for accounts that have an open balance. The report will generate a detailed list.

**When to use the Report:** Cleaning up your AR balances. Determine if these small balances are “worth” the efforts and resources to collect on. Management can decide (and approve) to eliminate these balances due to cost to collect exceeds the amount gained by collecting. This report can also be used to look for any payment posting errors. Small balances often mean the EOB was not posted to the fullest.

**When to run the Report: At least monthly to manage small balances**

WARNING: Confidential Patient Information, Privacy Act Applies

Small Balance List under \$5.00 SEP 27,2018@14:09 Page 1  
 for ALL BILLING SOURCE(S) at ALL Visit location regardless of Billing  
 Location

BILL NUMBER	DOS	DATE BILLED	BILLED AMT	BALANCE	AGE
-------------	-----	-------------	------------	---------	-----

VISIT LOCATION: PYRAMID LAKE TRIBAL HLTH CTR  
 A/R ACCOUNT: BENEFIT PLANNERS

340007A-PL	03/09/2005	05/06/2005	95.50	1.00	4892
------------	------------	------------	-------	------	------

AR Account Subtotal (\$) and Average (#): 95.50 1.00 4892

A/R ACCOUNT: EXPRESS SCRIPT RX

346077A-PL	06/15/2005	08/29/2005	15.24	5.00	4776
347405A-PL	07/20/2005	10/13/2005	5.00	5.00	4732
347411A-PL	07/06/2005	10/13/2005	62.32	1.30	4732
345927A-PL	08/23/2005	10/26/2005	5.00	5.00	4719
347585A-PL	09/27/2005	12/13/2005	25.74	4.44	4671
347583A-PL	09/27/2005	12/13/2005	13.31	2.66	4671
355384A-PL	11/01/2005	01/19/2006	13.89	4.10	4634
360230A-PL	12/19/2005	02/09/2006	13.31	2.66	4613
360477A-PL	12/21/2005	02/22/2006	5.00	5.00	4600
361621A-PL	01/19/2006	03/14/2006	5.00	5.00	4580

AR Account Subtotal (\$) and Average (#): 163.81 40.16 4673

A/R ACCOUNT: HOMETOWN HEALTH PLAN-HMO

334037A-PL	10/25/2004	01/18/2005	27.58	0.06	4993
334930A-PL	11/16/2004	02/01/2005	470.50	0.08	4983
341879A-PL	06/02/2005	08/22/2005	73.00	1.54	4784
345186A-PL	08/04/2005	10/10/2005	117.50	4.50	4734
346657A-PL	09/01/2005	12/13/2005	117.00	4.00	4671
364269A-PL	03/07/2006	04/25/2006	5.00	5.00	4538

AR Account Subtotal (\$) and Average (#): 810.58 15.18 4784

A/R ACCOUNT: HUMANA DENTAL

341125A-PL	05/17/2005	05/18/2005	191.08	0.28	4880
344887A-PL	08/01/2005	08/05/2005	24.00	4.80	4787
355347A-PL	11/03/2005	12/08/2005	24.00	4.80	4676

AR Account Subtotal (\$) and Average (#): 239.08 9.88 4781

Visit Loc Subtotal (\$)	and Average (#):	1,308.97	66.22	4733
=====				
Report Total (\$)	and Average (#):	1,308.97	66.22	4733

### PVCR Provider Visit Count Report (A/R→RPT→AMRM→PVCR)

**Description:** Created as a MACRA reporting tool, this report will display all provider payments by payer group. This will help for audits where to support audited data such as provider incentive payments received.

**When to use the Report:** Upon Request to Verify Data Counts that has been reported

**When to run the Report:** Upon Request to Verify Data Counts that has been reported

```

=====
Provider Visit Count Report                               SEP 27,2018@14:16   Page 1
For Medicare
at ALL Visit Locations under 2017 CMS HSP Billing Location
with VISIT DATES from 01/01/2018 to 09/27/2018
for ALL BILL TYPES
=====
=====
Provider                Bill Count   Amount Billed   Amount Paid
=====
=====
MATTHEWS,LINDA E                16           4,605.81       779.08
  Bill Type: 131
    Visit Type: 19 PI PRIMARY           1           55.00         0.00
    Visit Type: 131 OUTPATIENT          7          2,398.72       601.73
    Visit Type: 999 PROFESSIONAL COM     7          1,846.09       177.35
  Bill Type: 831
    Visit Type: 999 PROFESSIONAL COM     1           306.00         0.00

Total: 2017 CMS HOSPITAL                16           4,605.81       779.08

REPORT COMPLETE

```

## 10.4 ARM Aging Reports

Use this option to access the Age Day Letter and List, Age Detail report, Age report, Age Open Items report, and Age Summary report. Bills will age by approval date regardless of export date.

The Aging Reports will allow Management and the end users to analyze the overall picture of all aging accounts, how long they have been aging, and allow for snap shots and/or working documents to analyze/work all accounts. These reports help in understanding what revenue may still be coming, and provide tools to work with payers to ensure proper follow up on aged accounts is occurring.

**ADL Age Day Letter & List (A/R→RPT→ARM→ADL)****Description:**

- Locked with *BARZ ADL REPORT* key due to policy holder display
- May not work with all payers
- Follow up staff will print accordingly based on success rate with payers

**When to use the Report:**

- Used to follow up on outstanding payers.
  - Provides a cover letter to accompany bills list
  - Provides a listing of bills that can be sent to the payer

**When to run the Report:** It is not necessary to print this report on a monthly basis, but when working with certain payers, it is a useful tool.

Department of Health and Human Services  
Indian Health Service  
IHS INDIAN HEALTH HOSPITAL  
Business Office

DATE: 10 AUG 2010

TO: NEVERPAY INSURANCE  
PO BOX 38738  
JERSEY CITY,NJ 84728  
PRIVATE

FROM: BUSINESS OFFICE address for payments  
PO BOX 34982  
PASADENA, CA 91110-0655

Regarding Past due bills over 120 days totaling \$ 1,053.00

The above past due has been calculated as of this date. A detailed listing of claims is attached for your reference and information. Please review and advise us as to the status of the past due claims.

If you have questions or concerns, please call the Business Office at 505-555-3456. We appreciate your cooperation.

Sincerely

Joe Manas  
Chief of Business Operations



NEVERPAY INSURANCE over 120 days			08/10/2010		PAGE: 1
Policy Holder PT. SS #	Policy #	Claim #	DOS DOB	Amt Bld	Balance
VYGYL, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	21248A IH-12564	10/10/2012 04/20/1964	524.00	524.00
VITAMIN, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	29546A IH-12564	07/04/2013 04/20/1964	80.00	80.00
VITAMIN, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	29546B IH-12564	07/04/2013 04/20/1964	80.00	80.00
VITAMIN, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	29546C IH-12564	07/04/2013 04/20/1964	80.00	80.00
VITAMIN, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	29546D IH-12564	07/04/2013 04/20/1964	80.00	80.00
VITAMIN, FERLINDA Pat: VITAMIN, FERLINDA 555554452 Comment:_____	398493	29546E IH-12564	07/04/2013 04/20/1964	80.00	80.00
TOTAL:					\$1,053.00

**ADT Age Detail (A/R→RPT→ARM→ADT)****Description:**

- Provides an itemized listing of all outstanding bills.
  - By Visit Type or Clinic Type

**When to use the Report:** When working your Aged Accounts. This report provides more detail to help identify if you have certain Visit/Clinic types that are outstanding for a particular payer. This can help in outreach and follow up with specific payers.

**When to run the Report:** When working your aged accounts

WARNING: Confidential Patient Information, Privacy Act Applies				
=====				
Detail Age Detail Report for ALL BILLING SOURCE(S) AUG 18,2010@10:54 Page 1				
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location				
=====				
Patient	Bill Number	DOS	Amount Billed	Balance
=====				
Visit Location: AMBULANCE				
Visit Type: OUTPATIENT				
A/R Account: NEW MEXICO BC/BS INC				
GRANOLA,LINDA L	30501A-A	JUN 17, 2008	988.30	988.30
GRANOLA,LINDA L	30501B-A	JUN 17, 2008	988.30	988.30
-----				
A/R Account	Count: 2	Total:	1,976.60	1,976.60
-----				
Visit Type	Count: 2	Total:	1,976.60	1,976.60
-----				
A/R Account: NEW MEXICO MEDICAID				
JANIORS,PHOEBE	30286A-A	SEP 23, 2007	649.90	649.90
-----				
A/R Account	Count: 1	Total:	649.90	649.90
-----				
Visit Type	Count: 6	Total:	5,381.10	5,381.10
-----				
Visit location	Count: 8	Total:	7,357.70	7,357.70
-----				

**AGE Age Report (A/R→RPT→ARM→AGE)**

**Description:** Provides an extended list of outstanding patient accounts by insurer or by patient. The report will print the data for open balances and place the balance in the appropriate age column.

**When to use the Report:** This report will show you how long certain accounts (by insurer or patient) have been aging. This allows you to ensure that you are working your older accounts that should now enter the final stages of the Debt Collection (Management) Process.

**When to run the Report:** When working aged account, and detail is needed.

***CONFIDENTIAL PATIENT INFORMATION***									
DETAILED AGING REPORT BY INSURER BASED ON DATE BILLED									
2017 CMS HOSPITAL									
DATE:	09/27/2018								PAGE 7
SELECTION:	ALL								
BILL #	DOS	DOL PAYMENT	Billed	Current	31-60	61-90	91-120	120+	BALANCE
A/R ACCOUNT: RAILROAD RETIREMENT									
PATIENT: SANDERS, KATHERINE R									
402332A-CMS	05/01/2018		306.00					306.00	306.00
402333A-CMS	05/01/2018		306.00					306.00	306.00
SUBTOTAL			612.00	0.00	0.00	0.00	0.00	612.00	612.00
A/R ACCOUNT: SOUTH DAKOTA MEDICAID									
PATIENT: BEN, ANN MARIE									
402286A-CMS	02/09/2018		128.73					128.73	128.73
402519A-CMS	08/05/2018		128.73		128.73				128.73
SUBTOTAL			257.46	0.00	128.73	0.00	0.00	128.73	257.46
A/R ACCOUNT: STANDARD LIFE & ACCIDENT									
PATIENT: ONEAL, AUGUSTIN MURRAY									
402268B-CMS	01/03/2018		25.60					0.00	0.00
402314A-CMS	03/19/2018		233.00					0.00	0.00
SUBTOTAL			258.60	0.00	0.00	0.00	0.00	0.00	0.00
A/R ACCOUNT: TRIBAL INSURANCE									
PATIENT: SMALES, BECKY L									
402322A-CMS	03/05/2018		69.55					0.00	0.00
SUBTOTAL			69.55	0.00	0.00	0.00	0.00	0.00	0.00
A/R ACCOUNT: UNITED DENTAL SERVICES INC									
PATIENT: DE GARMO, KAREN L									
402525B-CMS	07/13/2018		184.00	184.00					184.00
SUBTOTAL			184.00	184.00	0.00	0.00	0.00	0.00	184.00
A/R ACCOUNT: UNITED HEALTHCARE MCR									
PATIENT: MCDONALD, JEREMY DONALD									
402308A-CMS	02/20/2018		465.00					465.00	465.00
SUBTOTAL			465.00	0.00	0.00	0.00	0.00	465.00	465.00
A/R ACCOUNT: VA MEDICAL BENEFIT (VMBF)									
PATIENT: LOBLEY, BACHEL									
402365A-CMS	07/09/2018		414.54		414.54			414.54	
PATIENT: VEGA, JESSIE CECILIA									
402326A-CMS	05/02/2018		388.04				388.04	388.04	
SUBTOTAL			802.58	0.00	414.54	0.00	0.00	388.04	802.58
A/R ACCOUNT: WELLCARE OF NEBRASKA									
PATIENT: FRAKER, SARER SULLIVAN									
402527A-CMS	08/01/2018		452.21	452.21				452.21	
402527B-CMS	08/01/2018		452.21	452.21				452.21	
402528A-CMS	08/10/2018		599.61	599.61				599.61	
SUBTOTAL			1504.03	1504.03	0.00	0.00	0.00	0.00	1504.03
A/R ACCOUNT: WORKMEN'S COMP									
PATIENT: CONDA, ANNA									
402246A-CMS	01/01/2018		514.00				514.00	514.00	
402247A-CMS	01/01/2018		140.00				140.00	140.00	
SUBTOTAL			654.00	0.00	0.00	0.00	0.00	654.00	654.00
TOTAL				44790.24	2442.03	719.27	182.37		
600.90	29011.83	32956.40							

### AOI Aged Open Items Report (A/R→RPT→ARM→AOI)

**Description:** Generates a list of claims that have an open balance but generates by aged category (30-day buckets).

**When to use the Report:** This report shows you Aged Accounts with an open balance for a particular age range. Used for prioritizing those accounts that may be falling within the timely filing limit, or should be in the Debt Collection (Management) Cycle.

**When to run the Report:** When working your Aged Accounts

WARNING: Confidential Patient Information, Privacy Act Applies

=====			
Aged Open Items Report		SEP 27,2018@14:49 Page 1	
for Bills 91-120 days old			
at 2017 CMS HOSPITAL Visit location(s) under 2017 CMS HOSPITAL Billing Location			
=====			
PATIENT NAME	BILL NUMBER	DOS	91-120
=====			
VISIT Location: 2017 CMS HOSPITAL			
A/R Account: BC/BS FED EMP PROG			
BROCK,MATTHEW AL	402352A-CMS-154866	05/19/2018	171.32
BROCK,MATTHEW AL	402352B-CMS-154866	05/19/2018	171.32
-----			
* BC/BS FED EMP PROG TOTAL			342.64
A/R Account: NEW MEXICO MEDICAID			
CONDA,ANNA	402356B-CMS-124100	06/05/2018	21.42
CONDA,ANNA	402357B-CMS-124100	06/09/2018	215.42
CONDA,ANNA	402357C-CMS-124100	06/09/2018	21.42
-----			
* NEW MEXICO MEDICAID TOTAL			258.26
-----			
** 2017 CMS HOSPITAL TOTAL			600.90
=====			
*** REPORT TOTAL			600.90

### ASM Age Summary Report (A/R→RPT→ARM→ASM)

#### Description:

- Provides an aging summary by:
  - Allowance category
  - Insurer Type
  - Clinic of Visit Type
- Shows trends in outstanding balances
- Allows management to question aging in certain buckets for certain payers

#### When to use the Report:

- Used for month-end reconciliation
  - Used with Period Summary Report to 'balance to RPMS'
  - Allows Management to see what is outstanding and what can be expected for collections

**When to run the Report:** Month-end. This report must be ran after the last working transaction of the month.

WARNING: Confidential Patient Information, Privacy Act Applies						
=====						
Age Summary Report for ALL ALLOWANCE CATEGORY(S)    AUG 10,2010@11:06    Page 1						
at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location						
=====						
ALLOWANCE CATEGORY	CURRENT	31-60	61-90	91-120	120+	BALANCE
=====						
*** VISIT Location: INDIAN HEALTH HOSPITAL						
MEDICAID	0.00	0.00	0.00	0.00	111369.61	111369.61
MEDICARE	0.00	0.00	0.00	382.00	442202.17	442584.17
OTHER	0.00	0.00	0.00	0.00	1834.60	1834.60
PRIVATE INSURANCE	0.00	318.00	0.00	0.00	783753.08	784071.08
-----						
*** VISIT Loc Total	0.00	318.00	0.00	382.00	1339159.46	1339859.46

**USM UFMS Age Summary Report (A/R→RPT→ARM→USM)****Description:**

- Allows finance and business office to view UFMS “bulk” balances
  - Bulk balances=bills approved prior to 10/1/2008
- Allows viewing of aging by fiscal year
- Tool for management to bulk has been reconciled

**When to use the Report:**

- Allows for reconciliation to the AR UFMS Dashboard Reports. This is the report to run for reporting your AR metrics to UFMS Dashboard.
- This report will give you a snapshot of previous fiscal years and whether or not there is still outstanding balances on older accounts.

**When to run the Report:** During the Reconciliation Process. After all transactions have been transmitted prior to the final collection run for the month. At a minimum, these reports should be run monthly.

WARNING: Confidential Patient Information, Privacy Act Applies

UFMS Age Summary Report for **FY 2013**

MAY 26, 2017@14:52 Page 3

for ALL ALLOWANCE CATEGORY(S)

at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location

ALLOWANCE CATEGORY	CURRENT	31-60	61-90	91-120	120+	BALANCE
--------------------	---------	-------	-------	--------	------	---------

\*\*\* VISIT Location: INDIAN HEALTH HOSPITAL

MEDICAID	0.00	0.00	0.00	0.00	8182.73	8182.73
MEDICARE	0.00	0.00	0.00	0.00	20545.00	20545.00
OTHER	0.00	0.00	0.00	0.00	15.00	15.00
PRIVATE INSURANCE	0.00	0.00	0.00	0.00	9588.40	9588.40
VETERANS	0.00	0.00	0.00	0.00	1442.68	1442.68

*** VISIT Loc Total	0.00	0.00	0.00	0.00	39773.81	39773.81
---------------------	------	------	------	------	----------	----------

## 10.5 BRM Batch Reports

Use this option to run either the Batch Posted Payments or the Batch Statistical reports. The Batch Reports can be utilized for all things Batched. These reports are designed to assist in the accountability, recording, and reconciliation of all collections/zero pays that have been recorded in the RPMS AR System.

BPP Batch Posted Payments (A/R→RPT→BRM→BPP)

Description:

- Kept as proof/record of all posting for the collection batch

When to use the Report:

- Used to display all posted payments by bill number

When to run the Report:

- Printed at completion of posting a collection batch

POSTINGS FOR: PVT INS OPV-05/26/2017-1 \*\*\*CONFIDENTIAL PATIENT INFORMATION\*\*\*

MAY 26, 2017 15:07 PAGE 1

IT	BILL (A/R)	PMT	DT / DOS	BILLED TO	PATIENT
-----					
	A/R ACCOUNT: NEW MEXICO BC/BS INC				
1	31267A-IH-34602	40.41	05/26/2017	NEW MEXICO BC/B	DEMO, MARY
			01/25/2017		
	31268A-IH-34602	985.00	05/26/2017	NEW MEXICO BC/B	DEMO, MARY
			01/25/2017		
	31282A-IH-35984	174.82	05/26/2017	NEW MEXICO BC/B	TURTLE, TIPSY
			01/18/2017		
	31534A-IH-34985	593.29	05/26/2017	NEW MEXICO BC/B	GRAND, RHEO
			01/11/2017		
	31554A-IH-33744	0.00	05/26/2017	NEW MEXICO BC/B	PALMER, ARNOLD
			01/15/2017		
SUBTOTAL		1793.52			
TOTAL		1793.52			

**BSL Batch Statistical (A/R→RPT→BRM→BSL)****Description:**

- Provides a status of outstanding batches to be posted categorized by the A/R Collection Point
- Provides batch data information for a period of time
- Reports amount batched
- Reports amount posted and unallocated
  - True Un-Allocated – amount remaining to post
  - Total Un-Allocated – total amount ever posted into the Un-Allocated ‘bucket’
- Reports amounts still left to post in Balance column

**When to use the Report:**

- Used for month-end reporting

**When to run the Report: Month-End**

DATE: MAY 26, 2017 15:00		BATCH STATISTICS FOR INDIAN HEALTH HOSPITAL 1-SEP-2012 TO 30-SEP-2012				PAGE 1
BATCH DATE -SEQ-BS	BATCH TOTAL	COLLECTIONS PROCESSED	UNALLOCATED TRUE	TOTAL	REFUNDED FROM BATCH	BALANCE
=====						
COLLECTION ID: PVT INS DENTAL						
09/21/2012-1- P	220.49	0.00	0.00	0.00	0.00	220.49
09/21/2012-2- P	183.24	183.24	0.00	0.00	0.00	0.00
-----						
SUBTOTAL	403.73	183.24	0.00	0.00	0.00	220.49
COLLECTION ID: PVT INS OPV						
09/20/2012-1- P	1594.00	1594.00	0.00	0.00	0.00	0.00
-----						
SUBTOTAL	1594.00	1594.00	0.00	0.00	0.00	0.00
-----						
TOTAL	1997.73	1777.24	0.00	0.00	0.00	220.49
Enter RETURN to continue:						

**RPRT Re-Print Finance Letters (A/R→RPT→BRM→RPRT)**

**Description:** Allows the user to reprint a refund request letter. The refund request letter is generated when an amount in Un-Allocated has been submitted to finance for a refund request.

**When to use the Report: As Needed****When to run the Report: As Needed**

TRANSFER LETTER	
DATE:	SEP 27, 2018
FROM:	STOUT, CINDY 2017 CMS HOSPITAL



TO: Finance Office

RE: Transfer for PARKER HOSP for the total of 5.15

COLLECTION BATCH NAME: FY17 PVT ADJ-12/30/2016-1

CHECK NUMBER: 002331077

TREASURY DEPOSIT/IPAC #: 545830

The above information is provided as a notification of a third party payer balance posted from the RPMS Unallocated bucket in which there is no corresponding account. The check amount belongs to another facility. This letter is to notify Finance to transfer the funds accordingly.

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

UFMS Entry by: \_\_\_\_\_ Date: \_\_\_\_\_

### TDN Collection Batch Validation Report (A/R→RPT→BRM→TDN)

**Description:** This report will go through A/R payment transactions posted from 10/1/07 forward and print collection batch information about every batch that was posted to.

**When to use the Report:** This Report is used as a Reconciliation Tool. The User can sort/filter this report by TDN, Batch, etc. and will allow more audit trail to resolve any reconciliation differences.

**When to run the Report:** Can be used during weekly, monthly reconciliation.

	A	B	C	D	E	F	G	H
	COLLECTION BATCH	STATUS	FACILITY	A/R ACCOUNT	ITEM	SCHEDULE#	CHECK#	CHECK AMOUNT
343	FY15 VA-09/08/2015-1	POSTABLE	2017 DEMO HOSPITAL	VA MEDICAL BENEFIT (VMBP)	1	986087	0004840	327
344	FY13 MCAID-07/05/2013-1	POSTABLE	2017 DEMO HOSPITAL	NEVADA MEDICAID	1	987419	0002829264	4424
345	FY15 VA-09/09/2015-1	POSTABLE	2017 DEMO HOSPITAL	VA MEDICAL BENEFIT (VMBP)	1	987546	0003579	1486.78
346	FY15 MCAID-09/11/2015-1	POSTABLE	2017 DEMO HOSPITAL	NEVADA MEDICAID	1	990718	21000248052370	2100
347	FY15 PVT ADJ-09/17/2015-1	POSTABLE	2017 DEMO HOSPITAL	AETNA US HEALTHCARE PPO	1	997429	22838757	94.31
348	FY13 PVT INS ADJ-09/03/2013-4	POSTABLE	2017 DEMO HOSPITAL	SIERRA HEALTH & LIFE	1	998851	3154184	173.63
349	PRIVATE-06/12/2018-1	POSTABLE	2017 DEMO HOSPITAL	BC/BS FED EMP PROG	2	TDN10203056	POSTED456	500
350	MEDICARE-02/20/2018-1	POSTABLE	2017 CMS HOSPITAL	MEDICARE	1	495728	583665	500
351	PRIVATE-03/21/2018-1	POSTABLE	2017 CMS HOSPITAL	PRESBYTERIAN BENEFICIAL UNION	3	4875838	48759395	5000
352	PRIVATE-01/03/2018-1	POSTABLE	2017 CMS HOSPITAL	BLUE CROSS/BLUE SHIELD	1	10118	384646282	500
353	MEDICARE-01/18/2018-1	POSTABLE	2017 CMS HOSPITAL	MEDICARE	1	10918	446273	500
354	MEDICARE-02/20/2018-2	POSTABLE	2017 CMS HOSPITAL	MEDICARE	1	22018	38274373	500
355	PRIVATE-03/07/2018-1	POSTABLE	2017 CMS HOSPITAL	BLUE CROSS/BLUE SHIELD	1	30118	558746559	5000
356	MEDICAID-03/06/2018-1	POSTABLE	2017 CMS HOSPITAL	NEW MEXICO MEDICAID	1	3052018	50145870-1	2135
357	MEDICARE-05/24/2018-1	POSTABLE	2017 CMS HOSPITAL	MEDICARE	1	52018	43874574	500
358	PRIVATE-05/24/2018-1	POSTABLE	2017 CMS HOSPITAL	BLUE CROSS & BLUE SHIELD	1	52018	816489465	500
359	PRIVATE-08/30/2018-1	POSTABLE	2017 CMS HOSPITAL	UNITED DENTAL SERVICES INC	1	63018	43874754	500

### TDR Deposit # Reconciliation Report (A/R→RPT→BRM→TDR)

**Description:**

- Allows for research by Treasury Deposit Number (TDN) or IPAC
- TDN/IPAC search limited by search dates

**When to use the Report:**

- Allows user to see which collection batches were used to post against the referenced TDN/IPAC

**When to run the Report:** When working TDN/Cash Reconciliation Differences. As Needed

LOCATION	A/R BILL	TRANSACTION	COLLECTION BATCH	COL ITEM	TREASURY DEP/IPAC	DOLLAR AMOUNT	TRANSMITTED?	REASON NOT SENT	APPLY TO	DT TX'ED TO UFMS
INDIAN HOSP	30903AA	3110310.14 0003	PVT INS OPV- 03/10/2011-1	1	420920	2180.48Y			23210120247720	4/28/2011@1 4:28:03
INDIAN HOSP	30828BIH3948	3110310.14 0038	PVT INS OPV- 03/10/2011-1	2	420920	27Y			2321012321017950	4/28/2011@1 4:28:03
INDIAN HOSP	30840AIH1238	3110310.14 0141	PVT INS OPV- 03/10/2011-1	3	420920	42Y			2321012321017950	4/28/2011@1 4:28:03
INDIAN HOSP	30854AIH3644	3110310.14 0236	PVT INS OPV- 03/10/2011-1	4	420920	12.56Y			2321012321017960	4/28/2011@1 4:28:03
INDIAN HOSP	30853AIH5842	3110310.14 0304	PVT INS OPV- 03/10/2011-1	4	420920	197.22Y			2321012321017960	4/28/2011@1 4:28:03
TOTAL TRANSACTIONS SENT TO UFMS: 5										
TOTAL DOLLARS SENT TO UFMS: 2459.26										
TOTAL 'NOT SENT' TRANSACTIONS:										
TOTAL 'NOT SENT' DOLLARS:										
TOTAL PAYMENT TRANSACTIONS: 5										
TOTAL PAYMENT DOLLARS: 2459.26										

**TBSL Treasury Deposit/Batch Statistical (A/R→RPT→BRM→TBSL)****Description:**

- Reports amount batched
- Reports amount posted and unallocated
  - True Un-Allocated – amount remaining to post
  - Total Un-Allocated – total amount ever posted into the Un-Allocated ‘bucket’
- Reports amounts still left to post in Balance column
- Used for month-end reporting

**When to use the Report:**

- Provides a status of outstanding batches to be posted categorized by the A/R Collection Point
- Provides batch data information for a period of time

**When to run the Report:**

- Month-end

DATE: MAY 26, 2017 15:00		BATCH STATISTICS FOR INDIAN HEALTH HOSPITAL 1-SEP-2012 TO 30-SEP-2012				PAGE 1
BATCH DATE -SEQ-BS	BATCH TOTAL	COLLECTIONS PROCESSED	UNALLOCATED TRUE	TOTAL	REFUNDED FROM BATCH	BALANCE
=====						
COLLECTION ID: PVT INS DENTAL						
09/21/2012-1- P	220.49	0.00	0.00	0.00	0.00	220.49
09/21/2012-2- P	183.24	183.24	0.00	0.00	0.00	0.00
-----						
SUBTOTAL	403.73	183.24	0.00	0.00	0.00	220.49
COLLECTION ID: PVT INS OPV						
09/20/2012-1- P	1594.00	1594.00	0.00	0.00	0.00	0.00
-----						
SUBTOTAL	1594.00	1594.00	0.00	0.00	0.00	0.00
-----						
TOTAL	1997.73	1777.24	0.00	0.00	0.00	220.49
Enter RETURN to continue:						

## 10.6 Financial Reports

These reports cover a lot of different types of actives. They can be used for analyzing all collections, productivity, certain financial transactions (refunds, adjustments, etc.), reconciling files, collections, and AR accounts, and assisting with the overall monitoring, analyzing and reviewing the Revenue Cycle.

**ADA Advise of Allowance (A/R→RPT→FRM→ADA)**

**Description:** Provides a list of accounts with a posted payment for a period of time. Used at one time to report payment amounts for auditing purposes.

**When to use the Report:** As Needed

**When to run the Report: As Needed**

DATE: ADVICE OF ALLOWANCE FOR THE PERIOD PAGE 1  
09/28/2018 1-MAR-2018 TO 28-SEP-2018

## 2017 CMS HOSPITAL

DATE CLAIM

LOGGED ID A/R ACCOUNT COLLECTIONS

## =====

DATE	CLAIM	A/R ACCOUNT	COLLECTIONS
=====			
2017 CMS HOSPITAL			
03/07/2018	402244A-CMS-112554	BLUE CROSS/BLUE SHIE	75.00
03/07/2018	402292A-CMS-154802	NEW MEXICO MEDICAID	427.00
03/07/2018	402296A-CMS-154820	NEW MEXICO MEDICAID	427.00
03/07/2018	402300A-CMS-113935	NEW MEXICO MEDICAID	427.00
03/07/2018	402298A-CMS-103077	NEW MEXICO MEDICAID	427.00
03/07/2018	402294A-CMS-125609	NEW MEXICO MEDICAID	427.00
03/08/2018	402306A-CMS-136809	BLUE CROSS/BLUE SHIE	100.00
03/08/2018	402303A-CMS-136809	BLUE CROSS/BLUE SHIE	100.00
03/08/2018	402304A-CMS-136809	BLUE CROSS/BLUE SHIE	100.00
03/08/2018	402305A-CMS-136809	BLUE CROSS/BLUE SHIE	100.00
03/19/2018	402310A-CMS-160448	BLUE CROSS/BLUE SHIE	100.00
03/20/2018	402312A-CMS-160448	MEDICARE	77.00
03/21/2018	402314A-CMS-102411	MEDICARE	100.00
03/21/2018	402315A-CMS-100100	PRESBYTERIAN BENEFIC	77.00
03/21/2018	402316A-CMS-100100	PRESBYTERIAN BENEFIC	75.00
03/21/2018	402317A-CMS-123456	PRESBYTERIAN BENEFIC	58.00
03/21/2018	402318A-CMS-123456	PRESBYTERIAN BENEFIC	85.00
03/21/2018	402319A-CMS-120105	PRESBYTERIAN BENEFIC	100.00
03/21/2018	402320A-CMS-120105	PRESBYTERIAN BENEFIC	79.00
05/24/2018	402341A-CMS-103411	MEDICARE	0.00
05/24/2018	402342A-CMS-103411	MEDICARE	0.00
05/24/2018	402345A-CMS-134555	BLUE CROSS & BLUE SH	0.00
06/14/2018	402356A-CMS-124100	BLUE CROSS/BLUE SHIE	50.00
06/14/2018	402357A-CMS-124100	BLUE CROSS/BLUE SHIE	50.00
07/17/2018	402362A-CMS-133166	BLUE CROSS & BLUE SH	25.00
08/30/2018	402525A-CMS-109811	UNITED DENTAL SERVIC	79.00
08/30/2018	402526A-CMS-134342	UNITED DENTAL SERVIC	100.00
09/17/2018	402530A-CMS-121311	UNITED DENTAL SERVIC	51.98

SUBTOTAL ----- 3716.98

TOTAL ----- 3716.98

**IPDR Inpatient Primary Diagnosis Report (A/R→RPT→FRM→IPDR)**

**Description:** Provides payment and adjustment data by primary diagnosis for inpatient admissions.

**When to use the Report:** This report is used for audit, budgeting, and reporting purposes.

**When to run the Report: As Needed**

WARNING: Confidential Patient Information, Privacy Act Applies

=====

Inpatient Primary Diagnosis Report SEP 28,2018@15:41 Page 1  
for ALL BILLING SOURCE(S) at ALL Visit location regardless of Billing Location  
with ADMISSION DATES from 01/01/2017 to 09/28/2018 for ALL Discharge Services  
ALL Primary Diagnosis (ICD-9 and ICD-10)

=====

COVERED	AMOUNT	AMOUNT	COPAYS/
DIAGNOSIS	BILLS	DAYS	BILLED
PAID DEDUCTIBLES ADJUSTMENTS			

=====

VISIT LOCATION: 2017 DEMO HOSPITAL						
BILLING ENTITY: PRIVATE INSURANCE						
DISCHARGE SERVICE: GENERAL MEDICINE						
R46.1	3	18	3,714.00	0.00	0.00	0.00
-----						
*DSVC	3	18	3,714.00	0.00	0.00	0.00
DISCHARGE SERVICE: INTERNAL MEDICINE						
R46.1	1	5	1,601.00	0.00	0.00	0.00
-----						
*DSVC	1	5	1,601.00	0.00	0.00	0.00
-----						
**BILL	4	23	5,315.00	0.00	0.00	0.00
-----						
***V LOC	4	23	5,315.00	0.00	0.00	0.00
=====						
****TOTAL	4	23	5,315.00	0.00	0.00	0.00

### PRP Payment Summary Report by Collection Batch (A/R→RPT→FRM→PRP)

#### Description:

- Provides a listing of service dates that have been paid for in a period in time
- Displays collection batches used to compile the data
- Allows billing staff to see when claims they submit for are paid

#### When to use the Report:

- May be used to identify what dates of service a payment was made for. Allows the user to determine how long it is taking insurers to make payment.

#### When to run the Report: As needed

WARNING: Confidential Patient Information, Privacy Act Applies

PAYMENT SUMMARY REPORT

AUG 18,2010@11:27 Page 1

BATCH DATES OF 08/01/2009 TO 08/31/2009

BATCHED AMOUNT: \$ 348.00

MONTH	# BILLS	BILLED AMOUNT	PAYMENTS
VISIT LOCATION: INDIAN HEALTH HOSPITAL			
JAN 2008	1	151.00	100.00
DEC 2008	1	350.00	156.80
MAY 2009	1	62.00	43.20
JUL 2009	1	63.00	48.00
-----			
VISIT LOC TOTAL	4	626.00	348.00
=====			
REPORT TOTAL	4	626.00	348.00

WARNING: Confidential Patient Information, Privacy Act Applies

PAYMENT SUMMARY REPORT

AUG 18,2010@11:27 Page 2

BATCH DATES OF 08/01/2009 TO 08/31/2009

BATCHED AMOUNT: \$ 348.00

\*\* BATCH LISTING \*\*

COLLECTION BATCHES	BATCHED AMOUNT	POSTED AMOUNT	UNPOSTED AMOUNT
MEDICARE OPV-08/05/2009-1	100.00	100.00	0.00
MEDICARE OPV-08/26/2009-1	200.00	200.00	0.00
PVT INS OPV-08/26/2009-1	48.00	48.00	0.00
=====			
TOTALS	348.00	348.00	0.00

## PSR Period Summary Report (A/R→RPT→FRM→PSR)

**Description:**

- Provides summary of:
  - Billed Amounts
  - Posted Payments
  - Posted Adjustments
  - Refunds
- Calculates activity for reported period (Productivity)
- Used for month-end reconciliation
  - Aged Summary Report

**When to use the Report:** Month-end

**When to run the Report:**

- May be used to balance payments received to what has been posted in RPMS.

WARNING: Confidential Patient Information, Privacy Act Applies

Period Summary Report for ALL ALLOWANCE CATEGORY(S)AUG 17,2010@22:11 Page 4  
with TRANSACTION DATES from 06/01/2010 to 06/30/2010  
at ALL Visit location(s) regardless of Billing Location

ALLOWANCE CATEGORY	Billed Amt	Payment	Adjustment	Refund
=====				
*** VISIT Location: INDIAN HEALTH HOSPITAL				
MEDICAID	33,080.12	10,116.00	1,646.00	0.00
MEDICARE	98,541.98	9,675.59	9,831.09	0.00
OTHER	22,651.54	2,235.00	2,644.42	0.00
PRIVATE INSURANCE	176,066.88	3,833.29	6,756.80	142.00
	-----	-----	-----	-----
*** VISIT Loc Total	330,340.52	25,859.88	20,878.31	142.00
*** VISIT Location: INDIAN HEALTH CENTER				
MEDICAID	2,567.00	0.00	0.00	0.00
MEDICARE	2,841.00	1,483.55	679.85	123.00
PRIVATE INSURANCE	4,087.40	2,583.30	868.10	0.00
	-----	-----	-----	-----
*** VISIT Loc Total	9,495.40	4,066.85	1,547.95	123.00
	=====	=====	=====	=====
***** REPORT Total	339,835.92	29,926.73	22,426.26	265.00

**TDN Payment Summary Report by TDN (A/R→ RPT→FRM→TDN)**

**Description:** This Report is used to run a report by Location, One or More TDN's, and/or Date Range. It will display the current balances of a specific TDN and/or a Date Range. Report can be run with or without delimiter.

**When to use the Report:** Researching Open TDN(s)

<b>When to run the Report:</b> n/a
------------------------------------

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
+-----+
|          Financial Reports Menu          |
+-----+
|          CIHA HOSPITAL          |
+-----+

```

```

+++++-----+-----+-----+-----+-----+-----+-----+
User: USER,DSTUDENT          BUSINESS OFFICE          30-OCT-2018 2:22 PM

NOTE:  This report will contain data for the BILLING location you are logged
       into.  Selecting a Visit Location will allow you to run the report for
       a specific VISIT location under this BILLING location.

INCLUSION PARAMETERS in Effect for Payment Summary Report by TDN:
=====

Select one of the following:

      1          LOCATION
      2          One or more TDN's
      3          DATE RANGE

Select ONE or MORE of the above INCLUSION PARAMETERS: 2  One or more TDN's
Select TDN**: I-12345678  IPAC-10/16/2018-1          IPAC          I-12345678

INCLUSION PARAMETERS in Effect for Payment Summary Report by TDN:
=====
- TDN Selected.....: I-12345678

Select Another TDN:

INCLUSION PARAMETERS in Effect for Payment Summary Report by TDN:
=====
- TDN Selected.....: I-12345678

Select one of the following:

      1          LOCATION
      2          One or more TDN's
      3          DATE RANGE

Select ONE or MORE of the above INCLUSION PARAMETERS:
Output to Text Delimited File? ? N// YES
DEVICE: HOME//  VT    Right Margin: 80//

LOCATION^TDN^COLLECTION BATCH NAME^BATCHED AMOUNT^POSTED AMOUNT^TRUE
UNALLOCATED
^REFUND AMOUNT^TRANSFER AMOUNT^UNPOSTED AMOUNT
CIHA HOSPITAL^I-12345678^IPAC-10/16/2018-1^1314.4^0^0^0^0^1314.4

REPORT TOTAL

```

### STA A/R Statistical Report (A/R→RPT→FRM→STA)

#### Description:

- Provides summary billed, payment and adjustment data by Visit Type or Clinic Code
- Different than Period Summary Report as this report provides statistics for billed amounts

#### When to use the Report:

- May be used to provide stats by clinic or visit type
- RPMS Set Up critical to results provided
- Compares “apples to apples” because it shows billed amounts and the activity (payment and adjustment) for those particular bills.

**When to run the Report:** Used for management reporting of services provided.



=====						
A/R STATISTICAL REPORT for ALL BILLING SOURCE(S) AUG 18,2010@11:19 Page 1						
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location						
with APPROVAL DATES from 02/01/2010 to 02/28/2010						
at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location						
=====						
VISIT TYPE	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	ADJ AMOUNT	UNPAID AMOUNT
-----						
INDIAN HEALTH HOSPITAL						
INPATIENT	1	1	3,452.00	0.00	0.00	3,452.00
OUTPATIENT	77	31	14,956.39	1,222.25	2,427.45	11,306.69
IMMUNIZATION	1	1	221.00	78.00	143.00	0.00
CROSSOVER (O	1	1	40.20	0.00	0.00	40.20
CROSSOVER (P	1	1	100.00	0.00	0.00	100.00
EMERGENCY RO	1	1	698.00	0.00	0.00	698.00
AMBULATORY S	2	1	2,868.00	0.00	0.00	2,868.00
Pharmacy POS	3	1	191.94	0.00	0.00	191.94
MEDICAL SUPP	1	1	1,711.00	0.00	0.00	1,711.00
PHARMACY	1	1	77.75	0.00	77.75	0.00
DENTAL	33	9	1,855.00	253.00	0.00	1,602.00
PROFESSIONAL	7	7	2,415.50	391.20	295.80	1,728.50
-----						
	129	56	28,586.78	1,944.45	2,944.00	23,698.33
TOTAL COVERED INPATIENT DAYS 2						

### TAR Transaction (A/R→ RPT→FRM→TAR)

**Description:** Provides transaction data by collection batch for a user-defined period of time. All amounts are reflected by transaction date. Transactions posted but not linked to a collection batch will be reported.

**When to use the Report:** This Report can be used for Reconciliation and Audit Trails.

**When to run the Report:** When needed

WARNING: Confidential Patient Information, Privacy Act Applies						
=====						
DETAIL Transaction Report for ALL BILLING SOURCE(S) SEP 30,2018@17:48 Page 1						
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location						
with TRANSACTION DATES from 05/01/2017 to 05/31/2017						
=====						
Bill Number	PAY-AMT	PRV-CRD	REFUND	PAYMENT	BILL AMT	ADJUSTMENT
=====						
Visit Location.....: INDIAN HEALTH HOSPITAL						
Collection Batch.....: MEDICARE PART B-05/12/2017-1						
Collection Batch Item: 1						
Visit Type.....: PROFESSIONAL COMPONENT						
A/R Account.....: MEDICARE						
31296A-IH-5084	48.20	0.00	0.00	48.20	106.00	57.80
-----						
A/R Acct Tot:	48.20	0.00	0.00	48.20	106.00	57.80
Visit Tot	48.20	0.00	0.00	48.20	106.00	57.80
Item Tot:	48.20	0.00	0.00	48.20	106.00	57.80
Batch Tot:	48.20	0.00	0.00	48.20	106.00	57.80
Collection Batch.....: PVT INS OPV-05/25/2017-1						
Collection Batch Item: 1						
Visit Type.....: OUTPATIENT						

A/R Account.....: HEALTHWISE						
31305A-IH-6045	101.87	0.00	0.00	101.87	333.33	231.46
-----						
A/R Acct Tot:	101.87	0.00	0.00	101.87	333.33	231.46
Visit Tot	101.87	0.00	0.00	101.87	333.33	231.46
Item Tot:	101.87	0.00	0.00	101.87	333.33	231.46
Batch Tot:	101.87	0.00	0.00	101.87	333.33	231.46
Collection Batch.....: PVT INS OPV-05/26/2017-1						
Collection Batch Item: 1						
Visit Type.....: EMERGENCY ROOM						
A/R Account.....: NEW MEXICO BC/BS INC						
31268A-IH-3460	985.00	0.00	0.00	985.00	1,598.72	613.72
-----						
A/R Acct Tot:	985.00	0.00	0.00	985.00	1,598.72	613.72
Visit Tot	985.00	0.00	0.00	985.00	1,598.72	613.72
Visit Type.....: PROFESSIONAL COMPONENT						
A/R Account.....: NEW MEXICO BC/BS INC						
31267A-IH-3460	40.41	0.00	0.00	40.41	132.53	92.12
-----						
A/R Acct Tot:	40.41	0.00	0.00	40.41	132.53	92.12
Visit Tot	40.41	0.00	0.00	40.41	132.53	92.12
Item Tot:	1,025.41	0.00	0.00	1,025.41	1,731.25	705.84
Batch Tot:	1,025.41	0.00	0.00	1,025.41	1,731.25	705.84
Location Tot:	1,175.48	0.00	0.00	1,175.48	2,170.58	995.10
=====						
REPORT TOTAL	1,175.48	0.00	0.00	1,175.48	2,170.58	995.10

### TSR Transaction Statistical Report (A/R→RPT→FRM→TSR)

**Description:** Provides transaction details but lists if the transaction was posted electronically using the ERA or manually with user-intervention.

**When to use the Report:** Used for Reconciliation

**When to run the Report:** As Needed

WARNING: Confidential Patient Information, Privacy Act Applies

=====

DETAIL Transaction Statistical Report      SEP 30,2018@17:51    Page 1

for ALL BILLING SOURCE(S)

at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location

with TRANSACTION DATES from 05/01/2017 to 05/31/2017

=====

Bill Number	Transaction Date	Insurer	Amount Billed	Transaction Amount	DOS
=====					
Visit Location.....: INDIAN HEALTH HOSPITALPAYMENT					
Data Source.....: ELECTRONIC					
Visit Type.....: EMERGENCY ROOM					
31268A-IH-3460	05/26/2017	NEW MEXICO BC/B	1,598.72	985.00e	01/25/2017
-----					
Visit Type Tot:			1,598.72	985.00	
Visit Type.....: PROFESSIONAL COMPONENT					

```

31267A-IH-3460 05/26/2017 NEW MEXICO BC/B 132.53 40.41e 01/25/2017
-----
Visit Type Tot: 132.53 40.41

-----
Data Source Tot: 1,731.25 1,025.41

Data Source.....: MANUAL
Visit Type.....: OUTPATIENT

31305A-IH-6045 05/25/2017 HEALTHWISE 333.33 101.87m 04/14/2017
-----
Visit Type Tot: 333.33 101.87

Visit Type.....: PROFESSIONAL COMPONENT

31296A-IH-5084 05/12/2017 MEDICARE 106.00 48.20m 04/12/2017
-----
Visit Type Tot: 106.00 48.20
Data Source Tot: 439.33 150.07

Totals by Transaction type: 2,170.58 1,175.48

Location Tot: 2,170.58 1,175.48

=====
REPORT TOTAL 2,170.58 1,175.48

***** R E P O R T C O M P L E T E *****

```

### DAYS Days in AR (A/R→RPT→FRM→DAYS)

#### Description:

- Tracks 'life cycle' averages for all visits within a user-specified range
- Averages days based on:
  - Days from DOS to PCC entry
  - Days from DOS to Coding Queue date
  - Days from DOS to approval date
  - Days from DOS to receipt of check
  - Days from DOS to date payment first posted

#### When to use the Report:

- Identifies coding/data entry backlogs
- Identifies billing bottlenecks
- Identifies potential revenue loss/hold up

**When to run the Report:** This report is very important to use for identifying possible risk Areas in the Revenue Cycle. Should be run and reviewed on a Monthly basis.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1	WARNING: Confidential Patient Information, Privacy Act Applies														
2															
3	for ALL BILLING SOURCE(S)										SEP 25,2018@09:13				Page 1
4	at ALL visit location regardless of Billing Location with VISIT DATES														
5	from 10/01/2016 to 09/30/2017														
6															
7	Month	#of	#Visits			Visits	Avg Days	Avg Days	Avg Days		Avg	Avg Days	Avg Days		
8	Year	Visits	With	#Bills	Bill Amount	Checked	To PCC	To	3P Bill	Avg Days	Days To	First	Last	Total Posted	
						In	Created	Reviewed	Approved	Exported	Payment	Posting	Posting	Amounts	
9	Oct-16	5161	5161	6657	\$2,929,983.61	0.72	3.1	19.25	49.39	60.02	61.31	62.6	66.38	\$1,688,968.14	
10	Nov-16	4560	4560	6035	\$2,059,858.51	0.75	1.95	13.79	41.08	50.57	48.33	53.45	66.43	\$1,221,045.44	
11	Dec-16	4302	4302	5760	\$3,044,496.62	0.75	2.18	11.16	34.77	44.6	47.39	48.33	53.02	\$1,959,655.02	
12	Jan-17	4710	4710	6361	\$2,960,087.47	0.74	1.83	8.52	32.87	42.43	47.65	47.72	52.25	\$2,016,437.17	
13	Feb-17	4619	4619	6126	\$1,947,198.97	0.76	1.77	7.93	25.71	37.74	39.18	39.55	41.55	\$1,171,800.58	
14	Mar-17	5004	5004	6630	\$2,258,708.07	0.76	1.66	8.86	32.73	37.9	43.94	44.68	48.94	\$1,321,131.89	
15	Apr-17	4279	4279	5767	\$2,086,039.59	0.77	1.76	9.5	38.12	50.72	44.91	46.05	52.59	\$1,135,699.58	
16	May-17	4459	4459	6036	\$1,976,059.88	0.77	1.66	9.84	35.03	50.68	43.57	43.9	49.37	\$1,140,420.69	
17	Jun-17	4337	4337	5724	\$2,130,359.47	0.77	2.07	8.18	34.37	41.77	45.62	46.29	49.77	\$1,261,380.07	
18	Jul-17	4047	4047	5558	\$1,922,465.97	0.78	1.43	8.26	33.68	39.15	46.3	46.09	48.98	\$1,013,837.20	
19	Aug-17	5362	5362	7077	\$2,511,920.61	0.77	0.78	6.67	31.78	38.24	42.35	43.33	47.12	\$1,475,622.58	
20	Sep-17	4348	4348	5870	\$2,981,322.55	0.75	0.65	5.98	33.95	38.74	41.55	41.99	47.08	\$1,180,042.86	
21	TOTAL BILLS WITH NO EXPORT: 0														

## ADJA Adjustment & Refund Report by Bill Approve Date (A/R→RPT→FRM→ADJ)

### Description:

- Originally created for OIG audit to provide an idea of the amount of adjusted posts by bill approve date during a period in time
- Data can be exported to an Excel spreadsheet

### When to use the Report:

- Provides a detailed or summarized report of all adjustments and refunds posted

### When to run the Report: When analyzing your adjustments/denials

LOCATION	ALLOWANCE CAT	INSURER TYPE	INSURER	BILL COUNT	TOTAL BILL AMOUNT	TOTAL PAYMENTS	ADJUSTMENT TYPE	TOTAL ADJUSTMENTS
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	NM BC/BS DENTAL CLASSIC	4	1492.9			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC/BS OF OKLAHOMA	4	15134			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO	7	2603.3	148	Co-Payment Amount	15
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO				Deductible Amount	250
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO				OVER UCR	165.3
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC OF WASHINGTON & ALASKA	1	49			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	KEY INSURANCE PLANS	1	63	63		
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC/BS OF ARIZONA INC	9	7927	142	Coinsurance Amount	24
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	MEDCO HEALTH PRESCRIPTION	3	191.94			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BS OF MASSACHUSETTS INC	3	414.2			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	UFMS PRIVATE INSURANCE	1	3800			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	ANTHEM PRESCRIPTION MGMT	1	905		Deductible Amount	905
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	HEALTH MANAGEMENT ASSOCIATION	2	304		TRIBAL SELF INSURED	304

**ADJT Adjustment & Refund Report by Transaction (A/R→RPT→FRM→ADJ)****Description:**

- Originally created for OIG audit to provide an idea of amount of adjusted posts by transaction during a period in time
- Data can be exported to an Excel spreadsheet

**When to use the Report:**

- Provides a detailed or summarized report of all adjustments and refunds posted

**When to run the Report:** Can be used when analyzing your adjustments/denials.

LOCATION	ALLOWANCE CAT	INSURER TYPE	INSURER	BILL COUNT	TOTAL BILL AMOUNT	TOTAL PAYMENTS	ADJUSTMENT TYPE	TOTAL ADJUSTMENTS
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	NM BC/BS DENTAL CLASSIC	4	1492.9			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC/BS OF OKLAHOMA	4	15134			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO	7	2603.3	148	Co-Payment Amount	15
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO				Deductible Amount	250
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BCBS OF NEW MEXICO				OVER UCR	165.3
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC OF WASHINGTON & ALASKA	1	49			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	KEY INSURANCE PLANS	1	63	63		
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BC/BS OF ARIZONA INC	9	7927	142	Coinsurance Amount	24
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	MEDCO HEALTH PRESCRIPTION	3	191.94			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	BS OF MASSACHUSETTS INC	3	414.2			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	UFMS PRIVATE INSURANCE	1	3800			
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	ANTHEM PRESCRIPTION MGMT	1	905		Deductible Amount	905
INDIAN HOSP	PRIVATE INSURANCE	PRIVATE INSURANCE	HEALTH MANAGEMENT ASSOCIATION	2	304		TRIBAL SELF O INSURED	304

**PAY Top Payer (A/R→RPT→FRM→PAY)**

**Description:** Provides a list of top paid amount by payer. The user may decide how many entries they wish to see and may print by approval date, export date, transaction date or batch date.

**When to use the Report:** This report can be used for budget and management purposes. This report can be compared to Eligibility Reports from Patient Registration.

**When to run the Report:** As needed.

Top Payer Report for ALL BILLING SOURCE(S) SEP 30,2018@18:05 Page 1			
at ALL Visit location under INDIAN HEALTH HOSPITAL Billing Location			
with VISIT DATES from 10/01/2017 to 09/30/2018			
ALL Primary Diagnosis (ICD-9 and ICD-10) Sort by: No Sort Selected			
A/R ACCOUNT	TX CNT	AMOUNT PD	ALLOWABLE
MEDICARE	8	19,201.19	4,965.60
ARIZONA MEDICAID	1	391.00	0.00
BCBS OF NEW MEXICO	11	262.17	271.56

PRESBYTERIAN HEALTH PLAN	4	152.00	45.00
BLUE CROSS	2	102.00	10.58
GRAND TOTALS	26	20,108.36	5,292.74

### NBR Non-Ben Payment Report (A/R→RPT→FRM→NBR)

**Description:** Provides a list of bills by patient where the patient is a non-beneficiary and an amount has been identified to be the patient's responsibility.

**When to use the Report:** To determine if Non-Ben patients still have outstanding debts that may need to enter the Debt Collection (Management) Process.

**When to run the Report:** Debt Management Process of Non-Ben Accounts.

WARNING: Confidential Patient Information, Privacy Act Applies

Non-beneficiary Detailed Report with VISIT DATES SEP 30,2018@18:08 Page 1  
from 01/01/2011 to 09/30/2018  
at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location  
for SAMPLE,SALLY

Bill Number	Pt Posted	Payment Date	Amount Billed	Insurance Payment	Patient Payment	Balance
----------------	--------------	-----------------	------------------	----------------------	--------------------	---------

\*\*\* VISIT Location: INDIAN HEALTH HOSPITAL

31351A-IH-6669

198.00	98.00	0.00	0.00
--------	-------	------	------

\*\*\* 31351 Total 198.00 98.00 0.00 0.00

\*\*\* VISIT Loc Total 198.00 98.00 0.00 0.00

\*\*\*\*\* REPORT Total 198.00 98.00 0.00 0.00

## 10.7 MRM Maintenance Reports

Use this option to access the A/R Bill and Transaction Synchronization report, the EOB Training model, 3P Missing Bill list, A/R and 3P Bill Mis-match list, and the Bill Reroll list. This section lists reports which are used to ensure that the systems (TPB and AR) are in sync and that all data is accounted for. These reports can assist with reconciliation as well.

### ATS A/R Bill and Transaction Synchronization (A/R→RPT→MRM→ATS)

**Description:**

- Provides a list of bills that may be out of balance
  - Compares A/R Bill file to A/R Transaction file
  - Any differences will fall onto the report
- Part of Internal Controls
- Must be report to OIT to correct

**When to use the Report: Monthly****When to run the Report: At least Monthly**

WARNING: Confidential Patient Information, Privacy Act Applies

=====

SUMMARY A/R Bill and Transaction Synchronization ReportAUG 18,2010@11:35 Page 1

at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location

=====

A/R BILL	DOS	A/R ACCOUNT	BILL BALANCE	TRANSACTION HISTORY BAL	DIFFERENCE
----------	-----	-------------	-----------------	----------------------------	------------

=====

## Visit Location: INDIAN HEALTH HOSPITAL

30189A-IH-34	01/20/2007	NEW MEXICO BC/B	120.00	138.00	-18.00
Approval Date: 08/20/2007@11:43 (3070820.114337)				HRN: 34660	[ ]

** Visit Location Total (Bill cnt: 1)			120.00	138.00	-18.00
---------------------------------------	--	--	--------	--------	--------

## Visit Location: MERCY MEDICAL CENTER HOSPITAL

30484A-MM	03/08/2008	MAIL HANDLERS B	-10.00	0.00	-10.00
Approval Date: 04/07/2008@15:09 (3080407.150927)				HRN: NO HRN	[ ]

** Visit Location Total (Bill cnt: 1)			-10.00	0.00	-10.00
---------------------------------------	--	--	--------	------	--------

*** REPORT TOTAL (Bill cnt: 2)			110.00	138.00	-28.00
--------------------------------	--	--	--------	--------	--------

## List of Transactions for Bill 30189A-IH-34660

Patient: MAY, APRIL DAWN  
 Address: PO BOX 457  
 ARRIBA, NEW MEXICO 87528

Beg DOS : JAN 20, 2007  
 End DOS : JAN 20, 2007  
 LST STMT:

Phone #: (505) 359-1735

Insurer: NEW MEXICO BC/BS INC  
 Balance: 120.00

Trans Dt	By	Trans Type A/R Account	Batch	Amount	Balance Item
08/20/2007		BILL NEW NEW MEXICO BC/BS INC	NO BATCH	138.00	138.00
					0

## 10.8 RRM Rollback Reports

The Third Party Billing Package passes information (Invoices/3P Bill) to the Accounts Receivable System (A/R Account/AR Bill). When transactions are posted to those A/R Bills (receipts or adjustments), the A/R package sends the transaction data back to TPB for secondary billing purposes. The following



reports are used to monitor such activity.

ROD Rollback Detail (Daily) (A/R→ RPT→RRM→ROD)					
<b>Description:</b> Provides a detailed listing of all claims rolled back to 3PB.					
<b>When to use the Report:</b> To ensure payment and adjustment data is being passed back to Third Party Billing, checking for Secondary or Tertiary Insurers.					
<b>When to run the Report:</b> Only when detail is needed.					
30 SEP 2018		ROLLOVER DETAIL REPORT			Page: 1
ROLLOVER		3P BILL		3P CLAIM	
DATE	AMOUNT	A/R BILL	STATUS		STATUS
=====					
05/12/2017	57.80	31296A-IH-5084	COMPLETED		
05/25/2017	231.46	31305A-IH-6045	COMPLETED		
05/26/2017	613.72	31268A-IH-34602	COMPLETED		
05/26/2017	92.12	31267A-IH-34602	COMPLETED		
TOTAL:		995.10	TOTAL BILLS:		4
E N D O F R E P O R T					

ROS Rollback Summary (A/R→ RPT→RRM→ROS)			
<b>Description:</b> Provides a summary listing of all claims rolled back to 3PB.			
<b>When to use the Report:</b> To ensure payment and adjustment data is being passed back to Third Party billing, and checking for Secondary or Tertiary Insurers. If rolling back daily, you should have an entry for every work day of the month.			
<b>When to run the Report:</b> Recommended Monthly.			
30 SEP 2018		ROLLOVER SUMMARY REPORT	Page: 1
ROLLOVER			
DATE	AMOUNT	BILL COUNT	
=====			
05/12/2017	57.80	1	
05/25/2017	231.46	1	
05/26/2017	705.84	2	
TOTAL: 995.10		TOTAL BILLS: 4	
E N D O F R E P O R T			

## 10.9 Management Reports

These reports are provided under the Management Option in Accounts Receivable. They are used to monitor and analyze the activities of the Accounts Receivable system. They also assist in maintaining a clean Accounts Receivable system (True Debt) and ensure Audit trails are provided for certain activities.

**CXL Cancelled Bills Report (A/R→MAN→RPT→CXL)****Description:**

- Provides a list of bills cancelled in TPB and/or Returned to Stock prescriptions from Point of Sale
- Cancelled bills inflate A/R aged receivables balances
- Reason bill was cancelled is displayed
  - POS cancelled bill will show to user as “Unknown Cancelling Official”
  - POS reason cancelled will show as “Not Listed”

**When to use the Report:**

- Can help identify system issues, staff training needs
- Can identify process issues

**When to run the Report:** Monthly and during reconciliation process

DETAIL Cancelled Bills Report				MAR 8,2018@14:22	Page 1
For ALL Visit Locations					
containing ONLY bills with an Open Balance.					
Patient	HRN	Active Insurer	Claim Number # BILLS	Visit Date AMT BILLED	Reason BALANCE
Cancelling Official: LUJAN,ADRIAN M					
VISIT Location: AMBULANCE					
Visit Type: OUTPATIENT					
GRANOLA,LINDA L	*****	NEW MEXICO BC/	30501A-A	JUN 17, 2008	BILL PRIMARY PA
			1	988.30	988.30
Visit Type: AMBULANCE					
LEE,SARA	*****	SPIDERWEB	31135A-A	OCT 02, 2012	BILL PRIMARY PA
MEGABUCKS,SYLVIA	*****	BCBS OF NEW ME	30731A-A	MAY 23, 2009	BILL PRIMARY PA
			2	4,117.40	4,117.40
** VISIT Location Subtotal			3	5,105.70	5,105.70

**SYNC Auto Sync Report (A/R→MAN→RPT→SYNC)**

**Description:** This report displays amounts that were synchronized automatically in 2001 when the A/R System data was analyzed and cleaned up. The report displays data for each run and shows the differences corrected. Details may be listed in the bill history from the report.

**When to use the Report:** N/A**When to run the Report:** N/A

WARNING: Confidential Patient Information, Privacy Act Applies

Auto Sync Management Report SEP 30,2018@18:14 Page 1  
at ALL Visit location(s) under INDIAN HEALTH HOSPITAL Billing Location

=====					
BILL TRANSACTION					
A/R BILL	DOS	A/R ACCOUNT	BALANCE	HISTORY BAL	DIFFERENCE
=====					
(As of Auto Sync run on AUG 07, 2002@17:36:59)					
Visit Location: INDIAN HEALTH CENTER					
212999-2001-	10/02/2001	AETNA LIFE AND	1,020.00	20.00	1,000.00
15550A-IH	02/11/1997	CIGNA	- 22.00	151.00	-173.00
14152A-IH	09/21/1998	NEW MEXICO MEDI	- 136.00	-152.00	16.00
-----					
** Visit Location Total (Bill cnt: 3)			862.00	19.00	843.00
(As of Auto Sync run on MAY 21, 2003@12:07:49)					
(As of Auto Sync run on JAN 28, 2008@12:49:25)					
Visit Location: INDIAN HEALTH HOSPITAL					
20880A-IH-1	04/05/2002	BCBS OF NEW MEX	445,566.00	0.00	445,566.00
28986A-IH-11	06/04/2005	GLASSES LIMITED	-20.00	-117.58	97.58
28715A-IH-10	02/14/2005	MEDICARE	0.00	32.00	- 32.00
29223A-IH-63	02/28/2006	NEW MEXICO MEDI	0.00	223.00	-223.00
29249A-IH-65	03/31/2006	NEW MEXICO MEDI	0.00	223.00	-223.00
-----					
** Visit Location Total (Bill cnt: 5)			445,546.00	360.42	445,185.58
Visit Location: NO VISIT LOCATION					
28997A-IH-20	NO DOS	NEW MEXICO MEDI	216.00	0.00	216.00
-----					
** Visit Location Total (Bill cnt: 1)			216.00	0.00	216.00
(As of Auto Sync run on NOV 24, 2010@13:20:08)					
Visit Location: INDIAN HEALTH HOSPITAL					
30189A-IH-34	01/20/2007	NEW MEXICO BC/B	120.00	138.00	-18.00
30714B-IH-11	03/15/2009	NM BC/BS DENTAL	0.00	493.18	-493.18
-----					
** Visit Location Total (Bill cnt: 2)			120.00	631.18	-511.18
Visit Location: MERCY MEDICAL CENTER HOSPITAL					
30484A-MM	03/08/2008	MAIL HANDLERS B	- 10.00	0.00	-10.00
-----					
** Visit Location Total (Bill cnt: 1)			-10.00	0.00	-10.00
(As of Auto Sync run on NOV 24, 2010@13:21:08)					
=====					
*** REPORT TOTAL	(Bill cnt: 12)		446,734.00	1,010.60	445,723.40

## 10.10 DBT Debt Management Menu

The Debt Management Menu allows for printing dunning letters for overdue bills in the Accounts Receivable system and then mailing them to the debtor. The dunning letters are printed in four cycles. Each time a letter is printed for an overdue bill, the cycle is incremented until the 4<sup>th</sup>, and final cycle, is reached or the bill balance is brought to zero.

These reports assist managers and end users in managing their Debt Collection process (letters) and provide brief description of DBT Debt Management Menu Reports, including general system information for running reports.

### Inquire to Debt Management Parameters Print (A/R→ACM→DBT→DMPS)

#### Description:

- Setting the Debt Management Parameters
- Procedures:
  - Enter a begin date for the letters to start generating
  - Set margins for letter printing
  - Determine days for Cycle 1 and set each Cycle 30 days after last Cycle

**When to use the Report:** When setting up your Debt Management Program

**When to run the Report:** Review periodically to ensure the Parameters are set to your Process specifications.

```
DEBT LETTER START DATE: JAN 1,2010
Enter the Maximum number of letters to batch print: 500
DEBT LETTER WRITE OFF AMOUNT: 25
PRINT FACILITY NPI OR PROVIDER NPI ON LETTER: BOTH FACILITY AND PROVIDER
PRINT DATE OF BIRTH ON LETTER: YES
PRINT BILL DATE ON LETTER: YES
SORT LETTERS BY: BY CYCLE
DEBT LETTER TOP MARGIN: 1
DEBT LETTER LEFT MARGIN: 1
DEBT LETTER 1: DEBT MANAGEMENT LETTER 1
DEBT LETTER 1 CYCLE: 60
DEBT LETTER 2: DEBT MANAGEMENT LETTER 2
DEBT LETTER 2 CYCLE: 90
DEBT LETTER 3: DEBT MANAGEMENT LETTER 3
DEBT LETTER 3 CYCLE: 120
DEBT LETTER 4: DEBT MANAGEMENT LETTER 4
DEBT LETTER 4 CYCLE: 150
```

**DMVQ Letters in the Queue (A/R→ACM→DBT→DMVQ)****Description:**

- This option looks for bills that fall into the specified setup parameters and drops those bills with an open balance into the debt letter queue for printing.
- It also calculates the aging for all cycles.
- Cycle aging remains current as long as letters are printed in a timely manner.
- View entries by Insurer Type or by specific Payer (Account).
- Designate someone in your office to be responsible for running this option on a daily basis, if possible.
  - Monday through Friday

**Procedures**

- System calculates when option is accessed
- Note the entries and make corrections for erroneous entries

**When to use the Report:** When identifying bills that fall into the specified setup parameters and drops those bills with an open balance into the debt letter queue for printing

**When to run the Report:** Daily (if possible)

```
Select Cycle to View: All//  ALL
View by Insurer Type:
View by Account:
```

```
Searching for overdue bills...
```

```
Number of NEW overdue bills found: 0
```

```
Running calculations for report.
```

SEQ	CYCLE	INS TYPE/INS-ACCOUNT	# OF BILLS	AMOUNT
1	CYCLE 1	PRIVATE/BCBS OF NEW MEXICO	1	145.00
2	CYCLE 1	PRIVATE/BS OF MASSACHUSETTS INC	1	3,380.50
3	CYCLE 1	PRIVATE/FIRST AMERICAN ADMINISTRATORS	1	138.00
4	CYCLE 2	PRIVATE/GLOBE LIFE & HEALTH	1	82.00
5	CYCLE 2	PRIVATE/GOV EMPLOYEES HOSPITAL ASSOC	2	1,722.00
6	CYCLE 2	PRIVATE/MAIL HANDLERS BENEFIT PLAN	1	179.00
7	CYCLE 3	PATIENT/SEVEGA,RAY A.	1	148.00
8	CYCLE 3	PRIVATE/FIRST AMERICAN ADMINISTRATORS	7	1,981.00
9	CYCLE 3	PRIVATE/GLOBE LIFE & HEALTH	1	119.88
10	CYCLE 4	PATIENT/PATIENT,PAUL	1	250.00
11	CYCLE 4	PRIVATE/FIRST AMERICAN ADMINISTRATORS	1	248.00
12	CYCLE 4	PRIVATE/GLOBE LIFE & HEALTH	1	82.00
13	CYCLE 4	PRIVATE/WASHINGTON MEDICAID RSN	1	113.00

```
Show Detail? N//
```

**DMER Letters that Contain Errors (A/R→ACM→DBT→DMER)****Description:**

- This option contains a list of bills in the Debt Letter Queue that contain errors that need to be corrected
- Most errors are caused by missing information in Registration's eligibility pages

- Any entries that still have errors may be printed

**Procedures**

- Review list for erroneous entries
- Corrections will need to be made for missing/bad data
- A/R Patch 22 contains more information for Error items

**When to use the Report:** When reviewing erroneous debt letters which need to be corrected

**When to run the Report:** N/A

Searching for overdue bills...

Number of NEW overdue bills found: 0

MAY 21, 2018

DEBT MANAGEMENT LETTER ERROR REPORT

PAGE: 5

A/R PARENT LOCATION: INDIAN HOSP

HRN	BILL NUMBER	A/R ACCOUNT	ERROR
1122	31248A-IH-1122*	PRESBYTERIAN HEALTH PLAN	MEMBER NUMBER
2	31297A-IH-2	BS OF MASSACHUSETTS INC	POLICY HOLDER DOB
10632	31344A-IH-10632	NM BC/BS DENTAL CLASSIC	MEMBER NUMBER
4092	31357A-IH-4092	DELTA DENTAL SERVICE	Tax ID
1106	31362A-IH-1106	BCBS OF NEW MEXICO	POLICY HOLDER DOB
1122	31376B-IH-1122	PRESBYTERIAN HEALTH PLAN	MEMBER NUMBER
5106	31382A-IH-5106	GOVERNMENT EMPLOYEES HOSP ASS	MEMBER NUMBER
5106	31383A-IH-5106	GOVERNMENT EMPLOYEES HOSP ASS	MEMBER NUMBER
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY HOLDER NAME
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY NUMBER
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY HOLDER DOB
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	MEMBER NUMBER
1122	31387A-IH-1122	NM BC/BS DENTAL CLASSIC	MEMBER NUMBER

### DMCP Print the Debt Management Bill Status Comments (A/R→ACM→DBT→DMCP)

#### Procedures to Display (Screenshot 1):

- Use the Edit Debt Management Bill Status (DMED) to update the bill status
- When a bill falls into the debt letter queue, it is automatically marked with a status of Active.
  - Active status = letter will be generated.
- If a bill balance is brought to zero, it is automatically marked with a status of Paid.
  - Paid status = no more letters will be generated.
  - Bill is removed from debt letter queue.
- The DMED options allows the user to manually change the status of a bill in the debt letter queue.
  - Active status can be changed to Paid or Suspended.
    - Suspended status = no more letters will be generated.
    - Suspended status is generally used if payer/patient agrees to a payment arrangement.
    - Must enter a comment if changing status to Suspended.

#### Procedures to Print (Screenshot 2):

- This option allows for viewing comments that were put on a bill during status change in the DMED option.
- Status changes are also displayed, including the first status of Active, when the bill dropped into the debt letter queue.

**When to use the Report:** When updating and printing bill statuses

**When to run the Report:** When updating and printing bill statuses

Edit status of Debt Management Bills for printing letters  
If status changes to Suspended you must enter a comment.

Enter the Debt Management Bill: 6820  
BILL STATUS: ACTIVE// ??

Choose from:

A ACTIVE

P PAID

S SUSPENDED

BILL STATUS: ACTIVE// SUSPENDED SUSPENDED

COMMENTS:

No existing text

==[ WRAP ]==[ INSERT ]===== < COMMENTS >===== [ <PF1>H=Help ]====  
Payer is Medicaid and should not have been on the list. 6/11/2018 AL

### DMRP Print Report of Printed Debt letters (A/R→ACM→DBT→DMLP)

#### Description:

- This option will allow the user to print the letters to a printer
- Printing pre-printed letterhead is recommended
- May print letters with errors
- Keep using this option to print all letters in the queue
  - Remember the *Maximum Number of Letters* in the set up

#### Procedures

- A list of payer entries will display to show what will be printed (Screenshot 2)
- A count of letters will also display (Screenshot 2)
- Totals will display by each cycle that displays what will print (Screenshot 3)
- An option to print the details of each cycle payer may be printed (Screenshot 4)

**When to use the Report:** When printing letters to the printer

**When to run the Report:** When printing letters to the printer

Select one of the following:

- |   |                                |
|---|--------------------------------|
| 1 | Print only letters w/o errors  |
| 2 | Print only letters with errors |
| 3 | Print Both type of letters     |
| 4 | Exit without printing          |

Select letters to print: :

JUN 21, 2018DEBT MANAGEMENT LETTER ERROR REPORTPAGE: 5A/R PARENT LOCATION: INDIAN HOSP

HRN	BILL NUMBER	A/R ACCOUNT	ERROR
1122	31248A-IH-1122*	PRESBYTERIAN HEALTH PLAN	MEMBER NUMBER
2	31297A-IH-2	BS OF MASSACHUSETTS INC	POLICY HOLDER DOB
10632	31344A-IH-10632	NM BC/BS DENTAL CLASSIC	MEMBER NUMBER
4092	31357A-IH-4092	DELTA DENTAL SERVICE	Tax ID
1106	31362A-IH-1106	BCBS OF NEW MEXICO	POLICY HOLDER DOB
1122	31376B-IH-1122	PRESBYTERIAN HEALTH PLAN	MEMBER NUMBER
5106	31382A-IH-5106	GOVERNMENT EMPLOYEES HOSP ASS	MEMBER NUMBER
5106	31383A-IH-5106	GOVERNMENT EMPLOYEES HOSP ASS	MEMBER NUMBER
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY HOLDER NAME
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY NUMBER
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	POLICY HOLDER DOB
105	31386A-IH-105	OFFICE OF WORKERS COMP PROGRA	MEMBER NUMBER
1122	31387A-IH-1122	NM BC/BS DENTAL CLASSIC	MEMBER NUMBER

Enter RETURN to Continue:

# of letters in queue : 52# of letters that will be printed : 52

Hit ENTER to continue printing, or ^ to quit (no printing):

SEQ	CYCLE	INS TYPE/INS-ACCOUNT	# OF BILLS	AMOUNT
1	CYCLE 1	PATIENT/COMMISSIONED OFFICER, CAREY	1	\$391.00
2	CYCLE 1	PATIENT/PARKER, JAMIE	1	\$20.00
3	CYCLE 1	PRIVATE/FIRST AMERICAN ADMINISTRATORS	1	\$138.00
-- TOTAL:			3	549.00
4	CYCLE 2	PRIVATE/CARE PLUS BENEFIT PLANS	1	\$1,016.17
5	CYCLE 2	PRIVATE/GLOBE LIFE & HEALTH	1	\$82.00
6	CYCLE 2	PRIVATE/PRESBYTERIAN HEALTH PLAN	1	\$106.00
-- TOTAL:			3	1204.17
7	CYCLE 3	PATIENT/SEVEGA, RAY A.	1	\$148.00
8	CYCLE 3	PRIVATE/FIRST AMERICAN ADMINISTRATORS	7	\$1,981.00
.				
30	CYCLE 4	PRIVATE/TIME INSURANCE	1	\$1,451.11
31	CYCLE 4	PRIVATE/WASHINGTON MEDICAID RSN	1	\$113.00
-- TOTAL:			34	12851.05
-- GRAND TOTAL:			52	17275.90



JUN 21, 2018			Debt Letter Print Report			PAGE: 1	
A/R PARENT LOCATION: INDIAN HEALTH HOSPITAL					CYCLE 1		
A/R ACCOUNT: FIRST AMERICAN ADMINISTRATORS					PERIOD: 60 Days		
=====							
HRN	BILL #	PATIENT	SERVICE DATE	BILLED DATE	BILLED AMOUNT	BALANCE	
-----							
3948	31359A-I	PATIENT,PAUL	10/08/17	12/12/17	138.00	138.00	
TOTAL					138.00	138.00	
1 Bill(s)							
Press RETURN To Continue ^ to Cancel...:							

## Appendix

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## Flat Rate Posting Process

### Step 1: Creating a new FRP batch

- 1) Type FRP at the “Select Posting Menu Option:” prompt.
- 2) Type your signature code at the “Enter Your Current Signature Code:” prompt. The “Select Previously Opened FRP Batch:” prompt will be displayed. To create a new FRP batch press <enter> at this prompt.
  - a) **Note:** If you wish to work an FRP batch that was previously opened but not yet posted, type two question marks (??) to display a list of FRP batches.
- 3) At the “Create new entry?” prompt press <enter> to accept the default answer of Yes. Typing No and pressing <enter> at this prompt ("Create New Entry?") will take you out of the Flat Rate Posting option and back to main Posting Menu.
- 4) At the “Select Batch” field, type the name of the Collection Batch you wish to use for posting and press <enter>. After selecting the Collection Batch, type the Collection Batch Item number and press <enter>.
  - a) **Note:** Depending on how your A/R Site Parameters are set up, you might be asked to specify a Visit Location.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p24          |
+          Flat Rate Posting                                +
|          TRIBAL HEALTH CENTER                              |
|          ** LOGGED INTO CASHIERING MODE **                 |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: CARLTON,GINA          BUSINESS OFFICE          18-FEB-2015 4:17 PM

Enter your Current Signature Code:      SIGNATURE VERIFIED
Select previously opened FRP batch:
Create new entry? Yes//    YES

Select Batch: MEDICARE-02/18/2015-1
====> Total Posted: $ 0.00          ====> Remaining Balance: $ 1026.00

Select Batch Item: 1
====> Item Total Posted: $          ====> Item Remaining Balance:
0.00 1026.00

```

Figure 1: Creating a new FRP Batch

### Step 2: Establishing the payment and/or adjustment amounts

You may enter one payment amount to be applied to all bills in the batch, but you may enter as many adjustments as you like to be applied to all bills. When posting flat rate payments, though, it is rare to post an adjustment.

**P** = Payment Amount  
**A** = Adjustment Amount  
**Q** = Quit entering payment and adjustment amounts. Q will also allow you to review what you have entered for payment and adjustment amounts.

Figure 2: Explanation of available commands

- 1) At the "Select Command (P/A/Q):" prompt, type P or 1 to enter a payment amount and press <enter>. At the "PAYMENT AMOUNT" prompt, type the dollar amount to be applied to each bill and press <enter>.
- 2) At the "Select Command (P/A/Q):" prompt, type A or 2 to enter an adjustment amount and press <enter>. At the "ADJUSTMENT AMOUNT" prompt, type the dollar amount to be applied to each bill and press <enter>.
  - a) At the "Adjustment Category:" prompt type the adjustment category to be used and press <enter>. If you aren't sure what the available choices are type two question marks (??) and press <enter> to display a list.
  - b) At the "Adjustment Type": prompt, type the number of the adjustment type to be used and press <enter>. If you aren't sure what the available choices are type and press <enter> to display a list.
  - c) At the "ADJUSTMENT AMOUNT" prompt, press <enter> if there are no other adjustments to be applied. If there are other adjustments to be applied, repeat the steps above until you are done making entries.

```

++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-
|          ACCOUNT  RECEIVABLE SYSTEM - VER          |
+              1.8p24                                +
|              Flat Rate Posting                      |
|              ** LOGGED INTO CASHIERING              ** |
++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-++-
User: CARLTON,GINA          BUSINESS OFFICE          18-FEB-2015 4:41 PM

Enter your Current          Code:    SIGNATURE
Selec Signature            batch:
t      new entry?          YE

Selec Batch: MEDICARE-02/18/2015-
t      Total Posted: $          ==> Remaining Balance: $

Select Batch Item: 1
==> Item Total Posted: $ 0.00 ==> Item Remaining Balance: $1026.00

Select Command (P/A/Q): P

PAYMENT AMOUNT: 200

Select Command (P/A/Q): A

ADJUSTMENT AMOUNT: 25
  
```

Adjustment Category: CO-PAY		CP
Adjustment Type: CO-PAY		CP

1	CO-PAY	Co-Payment Amount
2	CO-PAY	Coinsurance Amount
3	CO-PAY	Coinsurance Day
4	CO-PAY	Coinsurance - Major Medical
5	CO-PAY	Low Income Subsidy copay amt

Press <RETURN> to see more, '^' to exit this list,  
OR CHOOSE 1-5: 1 Co-Payment Amount

ADJUSTMENT AMOUNT:

Select Command (P/A/Q): Q

PAYMENT: 200

ADJUSTMENTS: 25 CO-PAY Co-Payment

Amount To Post: Remaining Balance:

Select A/R BILL/IHS BILL

Figure 3: Entering payment/adjustment information

### Step 3: Entering the bill numbers

Bills can be entered the same way they're entered in the PAY and ADJ posting options by typing in the bill number ([step 1](#)), searching by patient name and specified date range ([step 2](#)), or searching bills with a specified date of service ([step 3](#)).

#### 1) Entering by Bill Number

- a) At the "Select A/R BILL/IHS BILL NUMBER:" prompt, or type a bill number and press <enter>. The system will check to see if the bill number has already been entered in the batch and will also check to see if the insurer on the bill is the same as the payer on the collection batch.

```

Select Command (P/A/Q):
Q

      PAYMENT:      200

                                CO-PAY      Co-Payment

Amount To Post:      Remaining Balance:
Select A/R BILL/IHS BILL NUMBER: 31953A-TC-5555 220.00 OPEN
06/09/14
PATIENT, DEMO
Amount To Post: 200      Remaining Balance: 826
Select A/R BILL/IHS BILL NUMBER: 31412A-TC-1072 220.00 OPEN
02/22/14 DOE, JOHN
Amount To Post: 400      Remaining Balance: 626

```

Figure 4: Entering by bill number

- b) Continue to enter bills until the Amount to Post equals the amount of the Collection Batch Item and the Remaining Balance equals zero. If you make a mistake you can Review, Edit or Cancel by pressing <enter> at the "Select A/R BILL/IHS BILL NUMBER" prompt.
  - c) When you are finished entering all the bill numbers, press <enter> at the "Select A/R BILL/IHS BILL NUMBER:" prompt, at the "Select PATIENT NAME:" prompt, and at the "Select Bill DOS:" prompt. Go to step 4.
- 2) **Selecting bills by patient name and date of service range.**
  - a) At the "Select A/R BILL/IHS BILL NUMBER:" prompt press <enter>. The system will display the "Select PATIENT NAME:" prompt.
  - b) Type the patient's name or health record number, or type, the system will display the prompts for beginning and ending dates of service.
  - c) Type the beginning and ending dates for the desired service date range. The system will display a list of bills for the selected patient within the date range you specified. Choose the line number that corresponds to the desired bill and press <enter>.

```

Select A/R BILL/IHS BILL NUMBER:
Select PATIENT NAME: BULLWINKLE,ROCKY M 01-26-1962 XXX-XX-5544   THC 130214

Select Beginning Date: 1/1/14   (JAN 01, 2014)

Claims for BULLWINKLE,ROCKY from 01/01/2014 to                               Page:

Line #   DO          Claim          Amount          Billed
Balanc
-----
-
  2   05/13/201   31447A-TC-130214   342.00   MEDICARE
0.00
  4   12/16/201   32041-TC-          0.00   NEW MEXICO BC/BS
20.00
  3   05/13/201   31447B-TC-          85.0   NEW MEXICO
75.00
  1   01/23/201   31411A-TC-         220.00   MEDICAR
220.0
  6   12/28/201   32049A-TC-130214   342.00   MEDICARE
325.0
  5   12/16/2014   32050A-TC-          342.00   MEDICARE
0.00

Line #: 1
Amount To Post:                               Remaining Balance:
Select A/R BILL/IHS BILL

```

Figure 5: Entering Bills by Patient Name and Date of Service Range

- d) When you are finished entering all the bill numbers, press <enter> at the "Select A/R BILL/IHS BILL NUMBER:" prompt, at the "Select PATIENT NAME:" prompt, and at the "Select Bill DOS:" prompt. Go to step 4.
- 3) **Entering bills by date of service**
- a) Press the <enter> at the "Select A/R BILL/IHS BILL NUMBER:" prompt and again at the "Select PATIENT NAME:" prompt. The system will display the "Select Bill DOS:" prompt.
  - b) Type the bill date of service and press <enter>. The system will display claims that match the specified date of service.
  - c) Type the line number of the desired bill and press <enter>.

```

Select A/R BILL/IHS BILL NUMBER:
Select PATIENT NAME:

Select Bill DOS: 5/13/2014   MAY 13, 2014
  1   5-13-2014   31447A-TC-130214
  2   5-13-2014   31447B-TC-130214
  3   5-13-2014   31441A-TC-34345

```

```

Claims for BULLWINKLE,ROCKY from 05/13/2014 to 05/13/2014   Page: 1

Line #   DOS          Claim #          Amount          Billed To
Balance
-----

```

```

---
1 05/13/2014 31447A-TC-130214 342.00MEDICARE
0.00
2 05/13/2014 31447B-TC-130214 220.00NEW MEXICO MEDICAID
220.00

Line #: 2
Amount To Post: 800 Remaining Balance: 226
Select A/R BILL/IHS BILL NUMBER:

```

Figure 6: Entering bills by selecting from a specific date of service

- d) When you are finished entering all the bill numbers, press <enter> at the "Select A/R BILL/IHS BILL NUMBER:" prompt, at the "Select PATIENT NAME:" prompt, and at the "Select Bill DOS:" prompt. Go to step 4.

#### Step 4: Review/Edit/Cancel/Quit

- 1) **Review:** Batches must be Reviewed before the system will allow posting. This step will allow you to look the details of the FRP batch and decide if any corrections need to be made.
- a) At the "Select Command (R/E/C/Q):" prompt, type **R** to review and press <enter>. This is your opportunity to validate your entries before posting.

```

Select A/R BILL/IHS BILL NUMBER:
Select PATIENT NAME:

Select Bill DOS:

You must Review the bills before posting.
Batch Name:  MEDICARE-02/18/2015-1          Starting Balance:
1026.00
Item Number:  1                               Ending Balance:
226.00
Check Number:  EFT1234567                     # of Bills to Post:
4
Payment Payer:  MEDICARE
Amount:  200.00
Adjustment Amount:  25 00      Category: CO-PAY      Type: Co-Payment
Amount

Bill #      Patient Name      Billed Amt      DOS      Payer
Billed

          TRIBAL HEALTH CENTER
31953A-TC-555523      BUTTERFIELD, PAM      342.00      06/09/2014      MEDICARE
31412A-TC-1072      CHAVEZ, HENRIETTA      342.00      02/22/2014      MEDICARE
31411A-TC-130214      BULLWINKLE, ROCKY      342.00      01/23/2014      MEDICARE
31447B-TC-130214      BULLWINKLE, ROCKY      85.00      05/13/2014      MEDICARE

```

Figure 7: Reviewing flat rate posting batch

- 2) **Edit:** This option allows you to add or delete a FRP bill in the batch before posting. If any edits are made, the batch will need to be reviewed again before



being allowed to post.

- a) At the "Select Command (P/R/E/C/Q)" option, type E and press <enter>. The "Select Flat Rate Post BILL:" prompt will be displayed.
  - b) To delete a bill, type the bill number or one question mark (?) to select from a list. A "Delete?" prompt will be displayed with a default answer of No. Answering Yes will delete the bill from the batch. The new Amount to Post and Remaining Balance will be displayed. Answering No will take you back to the "Select Flat Rate Post BILL:" prompt.
  - c) To add a bill, press <enter> at the "Select Flat Rate Post BILL:" prompt. The "Select A/R BILL/IHS BILL NUMBER:" prompt will be displayed. Type the desired bill number in any of the methods previously described in step 3 and <enter>.
- 3) **Cancel:** Only FRP batches that have NOT been posted can be cancelled. Cancelling a batch will delete everything that has entered so far. This command is typically used if you want to start over from the beginning.
  - 4) **Quit:** This command will take you out of the Flat Rate batch and back to the Posting menu. The information entered up to this point will remain in the Flat Rate Posting file but will not be posted.

### Step 5: Posting the Transactions

After you have reviewed the collection batch will you be able to select this command at the "Select Command (P/R/E/C/Q):" prompt.

At the "Select Command (P/R/E/C/Q):" prompt, type P and press <enter>.

The system will display the payment and/or adjustment amount(s), the adjustment category and type if applicable, and the number of bills being posted. Depending on the size of the batch, it may take a few minutes for the system to finish post. You may minimize the screen and move on to something else if you like.

Once the system is done, a message will be displayed to let you know the process is complete.

```
Select Command (P/R/E/C/Q): POST
Payment of      200.00 posted to 3 bills.
Adjustment category CO-PAY Type Co-Payment Amount      25.00 posted to
for bills.
Done Posting.
```

## Posting Payment Recoupments

Occasionally a payer will recoup a payment previously made. Rather than request a refund, the payer will often recoup the amount from the bill that was initially paid and apply that payment to a different bill. Users who are working at Federal locations are not able to reverse payments due to UFMS restrictions. Instead, Federal locations will need to use payment credit adjustments to move payment amounts from one bill to another. If there is not any "ACTUAL MONEY" to post to this bill, but the Payer did in fact make a payment on this bill, we will not receive an actual check since we now owe them money.

**Note:** Users can utilize the BAR-RPT-FRM-TSR using adjustments 20/138 & 139 to reconcile the posting of the recoupment.

### Original Posting Scenario

- 1) Insurance company sends a check for \$200 as payment for bill 1234A and that payment is posted to the bill. Also posted is a \$100 deductible and a \$60 contractual allowance.

List of Transactions for Bill 1234B-DH-					
Patient: DEMO, PATIENT Address: 2211 HOME PLACE APT 2 ALBUQUERQUE, NEW MEXICO  Phone #: 505-222-			Beg DOS : JAN 05, 2016 End DOS : JAN 05,  Insurer: MEDICARE		
Trans Dt	By	Trans Type A/R Account	Batch	Amount	Balance Item
-----					
02/01/2016		BILL NEW MEDICARE	NO BATCH	360.00	360.00
02/02/2016	GCC	PAYMENT		(200.00)	160.00
		BLUE CROSS/BLUE SHIELD TDN0123456	PRIVATE-02/02/2016-1		1
02/02/2016	GCC	DEDUCTIBLE/Deductible Amount		(100.00)	60.00
		BLUE CROSS/BLUE SHIELD TDN0123456	PRIVATE-02/02/2016-1		1
02/02/2016	GCC	NONPAY/Chrgs Excd Max Allo		(60.00)	0.00
		BLUE CROSS/BLUE SHIELD	PRIVATE-02/02/2016-1		1

TDN0123456

**Payment Credit to Other Bill (this is the reversal portion)**

- 1) For whatever reason, the insurance company recoups the \$200 payment. There are a number of reasons they might do this. The patient might have been retroactively terminated or maybe the claim was paid in error for services that actually were not covered, just to name two examples.
- 2) You may post the payment credit by using the PAY option to access the original batch the payment was posted from, or by using the ADJ option. Access the original batch if using PAY and then access the bill, or go right to the bill if using ADJ. It is important to note that accessing the bill using the PAY option will not have an effect on the batch balance since payment credits are adjustment transactions, not payment transactions.
- 3) Using the posting example in the previous section of this document, you would post the payment credit like this:
  - a) Choose A or 2 to post an adjustment.
  - b) Enter an adjustment amount of -200.00.
  - c) Choose Payment Credit for the Adjustment Category.
  - d) Choose Credit To Other Bill for the Adjustment Type.

```

Select Command (Line # 2) :
A
Adjustment Amount: -200.00

Choose
from:      WRITE OFF      WO
3          NONPAY        NONPA
4          DEDUCTIBL      Y
13         E CO-PAY      D
14         PENALTY        D
15         GROUPER                GRPAL
16         ALLOWANCE      L
20         PENDIN        PEN
21         GENERAL                GENIN

Adjustment Category: 20  PAYMENT CREDIT  PAYCR
Adjustment Type: ??

Choose from:
113         BILLED IN ERROR
114         NOT BILLABLE TO
          OTHER(S)
121         RECEIVED NO-COL-REGISTER
132         POSTED IN ERROR
137         ZERO PAY
138         CREDIT TO OTHER BILL
139         CREDIT FROM OTHER BILL

```

**Note:** When a payer recoups a payment, all adjustments on the bill that are associated with that payment should also be reversed.

- e) Use the Adjustment command to reverse any other adjustments that were originally posted to the bill with the payment. It's important to reverse each adjustment exactly as it was originally posted. In the scenario above, you would enter an adjustment amount of -100.00 to reverse the deductible, and an adjustment amount of -60.00 to reverse the contractual allowance.

The posted transactions should look similar to the transactions in bold below. Keep in mind that posting the reverse adjustments will put a balance back on the bill. You will need to determine what to do with that balance based on why the payment was recouped by the payer.

List of Transactions for Bill 1234B-DH-				
Patient: WEATHERS, STORMY		Beg DOS : JAN 05,		
Address: 2211 HOME PLACE APT		2016		
2 ALBUQUERQUE, NEW MEXICO		End DOS : JAN 05,		
Phone #: 505-222-		Insurer:		
		MEDICARE		
Trans Dt	By	Trans Type	Amoun	Balanc
		A/R	Batc	Ite
02/01/2016		BILL NEW	360.00	360.00
		MEDICARE	NO BATCH	0
02/02/2016	GCC	PAYMENT	(200.00)	160.00
		BLUE CROSS/BLUE SHIELD	PRIVATE-02/02/2016-1	1
		TDN0123456		
02/02/2016	GCC	DEDUCTIBLE/Deductible Amount	(100.00)	60.00
		BLUE CROSS/BLUE SHIELD	PRIVATE-02/02/2016-1	1
		TDN0123456		
02/02/2016	GCC	NONPAY/Chrgs Excd Max Allo	(60.00)	0.00
		BLUE CROSS/BLUE SHIELD	PRIVATE-02/02/2016-1	1
		TDN0123456		
02/03/2016	GCC	<b>PAYMENT CREDIT/CREDIT TO OTHER BIL</b>	<b>200.00</b>	<b>200.00</b>
		<b>MEDICARE</b>	<b>NO BATCH</b>	<b>0</b>
02/03/2016	GCC	DEDUCTIBLE/Deductible Amount	100.00	300.00
		<b>MEDICARE</b>	<b>NO BATCH</b>	<b>0</b>
02/03/2016	GCC	NONPAY/Chrgs Excd Max Allo	60.00	360.00
		<b>MEDICARE</b>	<b>NO BATCH</b>	<b>0</b>

- 4) Finally, consider attaching a message to the bill indicating the reason for the payment credit. You might also indicate the EOB/RA date and/or number. Ask your supervisor or business office manager to advise on the message details if you are unsure what it should include.

Claims for WEATHERS,STORMY from 01/05/2016 to 01/05/2016

Page: 1

Line #	DOS	Claim #	Billed Amount	Current Payments	Current Adjust.	Current Balance
1	01/05/2016	1234A-DH-120114*		495.00	0.00	495.00
2	01/05/2016	1234B-DH-120114		360.00	0.00	360.00

Line #: 2

Select Command (Line # 2) : M

Message Processor



Select Command (Line # 1) :

A

Adjustment Amount: 200

Choose

from:	WRITE OFF	WO
3	NONPAY	NONPA
4	DEDUCTIBL	Y
13	E CO-PAY	D
14	PENALTY	D
15	GROUPE	GRP
16	ALLOWANCE	L
20	PENDIN	PEN
21	GENERAL	GENIN

Adjustment Category: 20 PAYMENT CREDIT PAYCR

Adjustment Type: ??

Choose from:

113	BILLED IN ERROR
114	NOT BILLABLE TO
	OTHER(S)
121	RECEIVED NO-COL-REGISTER
132	POSTED IN ERROR
137	ZERO PAY
138	CREDIT TO OTHER BILL
139	CREDIT FROM OTHER BILL

- e) Enter any other adjustments as indicated by the EOB or RA (co-payments, deductibles, non-payments, etc.).

The posted transactions should look similar to the transactions in bold below.

List of Transactions for Bill 6789A-DH-					
Patient: DEMO,HAYDEN			Beg DOS : JAN 26,		
Address: P.O. BOX 51			2016		
ALB, NEW MEXICO			End DOS : JAN 26,		
Phone #: 555-555-			Insurer:		
			MEDICARE		
Trans Dt	By	Trans Type	Amount	Balance	
		A/R Account	Batch	Item	
02/03/2016		BILL NEW		360.00	360.00
		MEDICARE	NO BATCH	0	
02/03/2016	GCC	<b>PAYMENT CREDIT/CREDIT FROM OTHER B</b>		<b>(200.00)</b>	<b>160.00</b>
		<b>MEDICARE</b>	<b>NO BATCH</b>	0	
02/03/2016	GCC	<b>DEDUCTIBLE/Deductible Amount</b>		<b>(75.00)</b>	<b>85.00</b>
		<b>MEDICARE</b>	<b>NO BATCH</b>	0	
02/03/2016	GCC	<b>NONPAY/Chrgs Excd Max Allo</b>		<b>(85.00)</b>	<b>0.00</b>
		<b>MEDICARE</b>	<b>NO BATCH</b>	0	

- 2) Finally, consider attaching a message to the bill indicating the reason for the payment credit. You might also indicate the EOB/RA date and/or number. Ask

your supervisor or business office manager to advise on the message details if you are unsure what it should include.

```

Claims for DEMO,HAYDEN from 01/26/2016 to 01/26/2016 Page: 1

Current Line #      Billed      Current      Current
Payments Adjust.   DOS         Claim #     Amount
-----
--- 1 01/26/2016  9876A-DH-112819      360.00    0.00    0.00
      0.00

Select Command (Line # 1) : M
Select one of the following:

1  BILL MESSAGE for bill 6789A-DH-112819
2  PATIENT MESSAGE for patient DEMO,HAYDEN
3  ACCOUNT MESSAGE for account MEDICARE
4  EXIT

Select Message Level: 1BILL MESSAGE for bill 6789A-DH-112819

View existing Messages (Y/N): NO//

Create NEW Message for 6789A-IHS
-----

Create a NEW Message (Y/N): YES//

TEXT:
No existing
text
Edit?
NO// YES

==[ WRAP ]==[ INSERT ]===== < TEXT >===== [ <PF1>H=Help ]====
Payment credit applied from bill 1234A, MEDICARE EOB 1/26/2016. GCC

<=====T=====T=====T=====T=====T=====T=====T=====T=====T>==
=

```



## VA Medical Benefits User Guide




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

## UFMS/FBIS Reports

- 1) Sign into Access Management System (AMS)



### Login Methods to AMS

HSPD-12 Access Cards ?	Network Credentials ?	AMS Credentials ?
<p>Insert your HSPD-12 Access Card in your smart card reader before you try to login.</p> <p><b>Login</b></p> 	<p>Applies to: ACF, ACL, AHRQ, CDC/ATSDR, CMS, HRSA, IHS, NIH, OIG, OS, PSC, SAMHSA</p> <p>Select OpDiv: <input type="text" value="Select one..."/></p> <p>Network Username: <input type="text"/></p> <p>Network Password: <input type="password"/></p> <p><b>Login</b></p>	<p>AMS Username: <input type="text"/></p> <p>AMS Password: <input type="password"/></p> <p><b>Login</b></p> <p><a href="#">First-time AMS User?</a> <a href="#">Forgot AMS Username?</a> <a href="#">Forgot AMS Password?</a></p>

[Need Help?](#) | [Self-Help Web Portal](#) | [HHS Privacy Policy](#)


- 2) Click on HHS Financial Business Intelligence System (FBIS)

### 3) Use Keywords in the Search box to find reports on top of the page

Alert	Severity	Date	Time	GMT	View	Clear	More
Alert - Abnormal Balance Present in Current Period	Normal	7/31/2017	1:47:29 PM	GMT-04:00	View	Clear	More
AP - Invoice On Hold	Normal	4/20/2016	9:19:43 AM	GMT-04:00	View	Clear	More

### 4) AR IHS - RPMS Aging with Manual Adjustment Report - RPMS Detail

#### a) Choose Parameters


**HHS Financial Business Intelligence System**

## AR IHS - RPMS Aging with Manual Adjustment Re...

**Page Prompts**

\* AP is LIKE (pattern match)

\* Fund is LIKE (pattern match)

\* BAP is LIKE (pattern match)

\* Location Code is LIKE (pattern match)

\* Transaction Date Between  -

\* Budget Fiscal Year is LIKE (pattern match)

[Edit - Refresh](#)

AR\_IHS - RPMS Aging with Manual Adjustment Report - RPMS Detail  
 Source: UFMS  
 Time run: 10/30/2018 2:49:43 PM

AP	Area Code	Location Code	Location Description	ASUFAC Code	Fund	Budget Fiscal Year	Budget Activity Program	Bap Description	Invoice Number	Transaction Date	RPMS Bill Number	Master Invoice Number	Monthly/Annual	Month Year
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60003160003118161	9/6/2018	15471D	21744	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118194	9/17/2018	17726A	21977	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118195	9/17/2018	17716A	21977	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118196	9/17/2018	17702A	21977	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7170400000	IHS and VA Dual-eligible Beneficiaries	60003160003118197	9/17/2018	17473C	22029	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7120400121	PHOENIX-MEDICARE	60003160003118203	9/21/2018	17758A	21746	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7120400121	PHOENIX-MEDICARE	60003160003118207	9/21/2018	17750A	21746	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7170400000	IHS and VA Dual-eligible Beneficiaries	60003160003118244	9/24/2018	16691B	22029	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7170400000	IHS and VA Dual-eligible Beneficiaries	60003160003118245	9/24/2018	17201B	22029	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7170400000	IHS and VA Dual-eligible Beneficiaries	60003160003118246	9/24/2018	17762A	22029	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118247	9/24/2018	17748A	21977	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118248	9/24/2018	17756A	21977	Monthly	SEP-2018
40	X	40210AZC010000	PHOENIX-CARDIOLOGY PROGRAM	600031600031	0J070020180RA0	2018	7132400515	PHOENIX-PRIVATE INSURANCE COLLECTIONS	60003160003118249	9/24/2018	17751A	21977	Monthly	SEP-2018
40	X	40104AZC140000	PHOENIX-DESERT VISIONS RTC	600062600062	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006260006212234	9/14/2018	19960A	21747	Monthly	SEP-2018
40	X	40104AZC140000	PHOENIX-DESERT VISIONS RTC	600062600062	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006260006212235	9/14/2018	19942A	21747	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320085	9/6/2018	30247A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320086	9/6/2018	30226A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320087	9/10/2018	30249A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320088	9/10/2018	30253A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320089	9/10/2018	30254A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320090	9/17/2018	30264A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320091	9/17/2018	30268A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320092	9/17/2018	30279A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320093	9/17/2018	30299A	21745	Monthly	SEP-2018
40	X	40104MVC150000	PHOENIX-NEVADA SKIES RTC	600063600063	0J070020180RA0	2018	7122400222	PHOENIX-MEDICAID	60006360006320094	9/17/2018	30297A	21745	Monthly	SEP-2018


Rows 1 - 25  
 Budget Fiscal Year is LIKE (pattern match) 2018  
 and Trx Date is greater than or equal to 09/01/2018  
 and Ap is LIKE (pattern match) 40

[Edit](#) - [Refresh](#) - [Print](#) - [Export](#)

## b) Report Column Headers

- i. AP
- ii. Area Code
- iii. Location Code
- iv. Location Description
- v. ASUFAC Code

- vi. Fund
  - vii. Budget Fiscal Year
  - viii. Budget Activity Program
  - ix. Bap Description
  - x. Invoice Number
  - xi. Transaction Date
  - xii. RPMS Bill Number
  - xiii. Master Invoice Number
  - xiv. Monthly/Annual
  - xv. Month Year
  - xvi. Total Amount
  - xvii. Ages 30
  - xviii. Ages 31 - 60
  - xix. Ages 61-90
  - xx. Ages 91-120
    - i. Ages 121-180
    - ii. Ages 181
- 5) AR – IHS – Transaction Register Report
- a) Choose Parameters

 HHS Financial Business Intelligence System

## AR - IHS - Transaction Register Report

Page Prompts

AP is LIKE (pattern match) --Select Value-- ▼

\* GL Date (MM/DD/YYYY) Between  -

\* Invoice Date (MM/DD/YYYY) Between  -

Transaction Type is LIKE (pattern match) --Select Value-- ▼

Fund is LIKE (pattern match) --Select Value-- ▼

BAP is LIKE (pattern match) --Select Value-- ▼

Location is LIKE (pattern match) --Select Value-- ▼

Organization is LIKE (pattern match) --Select Value-- ▼

UFMS Invoice Number is LIKE (pattern match) --Select Value-- ▼

OK

Reset ▼

Edit - Refresh

AR - IHS - Transaction Register Report

Source: UFMS

Time run: 10/30/2018 2:55:27 PM

AP	Fund	Fiscal Yr	BAP	Organization	Object Class	Location	Cost Center	Invoice #	Customer #	Customer Name	Invoice Date	Invoice Amount	Invoice Type	Invoice Status	GL Date	Balance	Amount Adjusted	Amount Applied
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40201AZC010000	000	21794	70096	PHXSPMEDICARE	04-Sep-2018	\$5,673.18	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$31,861.69	\$37,825.62	\$11,637.11
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40201AZC020000	000	21824	70104	PHXSUPMEDICARE	04-Sep-2018	\$5.21	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$532.00	\$889.37	\$362.58
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40201AZC040000	000	21799	70108	PHXCOLMEDICARE	04-Sep-2018	\$438.63	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$0.00	\$3,043.07	\$3,481.70
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40201AZH000000	000	21812	70092	PHXCOLMEDICARE	03-Sep-2018	\$58,478.48	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$367,334.19	\$427,470.40	\$128,614.69
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40202CAH000000	000	21806	70144	PHXFTYMEDICARE	04-Sep-2018	\$5,306.28	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$97,571.52	\$113,933.46	\$21,666.22
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40203AZH000000	000	21792	70080	PHXHHCMEDICARE	02-Sep-2018	\$51,787.92	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$14,462.75	\$400,261.94	\$437,587.11
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40204AZH000000	000	21814	70112	PHXPMEDICARE	01-Sep-2018	\$136,608.55	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$6,873.46	\$1,039,946.50	\$1,169,681.59
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40206AZC010000	000	21825	94599	PHXWHRMEDICARE	04-Sep-2018	\$4,269.21	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$2,500.22	\$43,217.15	\$44,986.14
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40206AZH000000	000	21797	70140	PHXWHRMEDICARE	01-Sep-2018	\$128,197.78	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$18,521.86	\$811,006.61	\$920,682.53
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40207NV000000	000	21801	70084	PHXELKMEDICARE	01-Sep-2018	\$4,754.35	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$204.07	\$25,620.75	\$30,091.03
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40209UTC000000	000	21813	70076	PHXUAMEDICARE	04-Sep-2018	\$10,598.00	INV-RPMS 3P-Fed (N)	Open	06-Sep-2018	\$11,851.86	\$50,509.07	\$49,255.21
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40210AZC010000	000	21746	70068	PHXNACMEDICARE	04-Sep-2018	\$7,654.00	INV-RPMS 3P-Fed (N)	Open	10-Sep-2018	\$912.00	(\$4,297.62)	\$2,444.18
40	0070020180RA0	2018	7120400121	HGFL0000000	61704	40211NV0000000	000	21751	183017	PHXMOAPAMEDICARE	04-Sep-2018	\$699.00	INV-RPMS 3P-Fed (N)	Open	10-Sep-2018	\$1,525.85	\$3,171.71	\$2,344.86
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40104AZC140000	000	21747	70073	PHXDVRMEDICAID	04-Sep-2018	\$211,352.80	INV-RPMS 3P-NFed (N)	Open	10-Sep-2018	\$43.78	(\$24,220.80)	\$187,088.22
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40104NVC150000	000	21745	181684	PHXNSMEDICAID	04-Sep-2018	\$54,558.40	INV-RPMS 3P-NFed (N)	Open	10-Sep-2018	\$27,041.30	\$22,722.50	\$50,239.60
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40201AZC010000	000	21793	70097	PHXSPMEDICARE	04-Sep-2018	\$26,047.00	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$5,715.05	\$259,972.42	\$280,304.37
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40201AZC020000	000	21748	70105	PHXSUPMEDICAID	05-Sep-2018	\$50,813.00	INV-RPMS 3P-NFed (N)	Open	10-Sep-2018	\$0.00	\$118,818.05	\$169,631.05
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40201AZC040000	000	21827	70109	PHXCHMEDICAID	04-Sep-2018	\$2,135.00	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$11,956.00	\$9,821.00	\$11,956.00
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40202CAH000000	000	21795	70093	PHXCOLMEDICAID	03-Sep-2018	\$109,929.48	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$1,750.93	\$418,624.36	\$526,802.91
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40202CAH000000	000	21796	70145	PHXFTYMEDICAID	01-Sep-2018	\$12,569.35	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$39,539.48	\$222,963.13	\$195,993.00
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40203AZH000000	000	21803	70081	PHXHHCMEDICAID	04-Sep-2018	\$32,791.94	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$191.41	\$769,866.35	\$802,466.76
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40204AZH000000	000	21791	70113	PHXPMMEDICAID	01-Sep-2018	\$564,028.51	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$58,603.21	\$4,918,803.82	\$5,425,129.12
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40206AZC010000	000	21818	94599	PHXWHRMEDICAID	04-Sep-2018	\$12,810.00	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$0.00	\$202,731.58	\$215,541.58
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40206AZH000000	000	21817	70141	PHXWHRMEDICAID	02-Sep-2018	\$308,567.20	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$1,454.00	\$4,000,237.51	\$4,307,350.71
40	0070020180RA0	2018	7122400222	HGFL0000000	61704	40207NV0000000	000	21809	70085	PHXELKMEDICAID	02-Sep-2018	\$52,948.00	INV-RPMS 3P-NFed (N)	Open	06-Sep-2018	\$1,748.00	\$163,581.00	\$214,781.00

AP is LIKE (pattern match) 40

and GL Date is greater than or equal to 09/01/2018

and Invoice Date is greater than or equal to 09/01/2018

and Invoice Type is LIKE (pattern match) INV-RPMS 3P-Fed (N), INV-RPMS 3P-NFed (N)

Edit - Refresh - Print - Export


b) Report Column Headers

- AP
- Fund

201

Section 2.0  
March 2019

- iii. Fiscal Yr
  - iv. BAP
  - v. Organization
  - vi. Object Class
  - vii. Location
  - viii. Cost Center
  - ix. Invoice #
  - x. Customer #
  - xi. Customer Name
  - xii. Invoice Date
  - xiii. Invoice Amount
  - xiv. Invoice Type
  - xv. Invoice Status
  - xvi. GL Date
  - xvii. Balance
  - xviii. Amount Adjusted
  - xix. Amount Applied
- 6) IHS RPMS Invoice Error Report
- a) Choose Area Code
    - i. **Note:** If Area Code is not listed, there are no Errors

 HHS Financial Business Intelligence System

**IHS RPMS Invoice Detail Report**

**Page Prompts**

AP is LIKE (pattern match) --Select Value-- ▼

Fund is LIKE (pattern match) --Select Value-- ▼

BAP is LIKE (pattern match) --Select Value-- ▼

ASUFAC Code is LIKE (pattern match) --Select Value-- ▼

Location Code is LIKE (pattern match) --Select Value-- ▼

UFMS File Name is LIKE (pattern match) --Select Value-- ▼

RPMS File Name is LIKE (pattern match) --Select Value-- ▼

\* Date Processed Between  -

\* UFMS Invoice Number is LIKE (pattern match) --Select Value-- ▼

\* RPMS Bill Number is LIKE (pattern match) --Select Value-- ▼

UFMS Master Invoice Number is LIKE (pattern match) --Select Value-- ▼


OK Reset ▼

[Edit - Refresh](#)

## 7) IHS RPMS Receipt Error Report

## a) Choose Area Code

- i. **Note:** If Area Code is not listed, there are no Errors

 **HHS Financial Business Intelligence System**

**IHS RPMS Receipts Error Report**

**Page Prompts**



Area Code is LIKE (pattern match) --Select Value-- ▼

Schedule Number is LIKE (pattern match) --Select Value-- ▼

\* UFMS File Name is LIKE (pattern match) --Select Value-- ▼

RPMS File Name is LIKE (pattern match) --Select Value-- ▼

UFMS Master Invoice is LIKE (pattern match) --Select Value-- ▼

Date Processed Between   -  


OK **Reset** ▼

[Edit - Refresh](#)

## 8) IHS RPMS Adjustment Error Report

## a) Choose Area Code

- i. **Note:** If Area Code is not listed, there are no Errors

 **HHS Financial Business Intelligence System**

**IHS RPMS Adjustment Error Report**



**Page Prompts**

Area Code is LIKE (pattern match) --Select Value-- ▼

\* UFMS File Name is LIKE (pattern match) --Select Value-- ▼

\* RPMS File Name is LIKE (pattern match) --Select Value-- ▼

UFMS Master Invoice Number is LIKE (pattern match) --Select Value-- ▼

Date Processed Between   -  

OK **Reset** ▼

[Edit - Refresh](#)