Indian Health Service

What is your role in revenue generation?

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OKLAHOMA AREA
BUSINESS OFFICE COORDINATOR

Revenue in the 1970's

IHS has progressed a lot in the last 50 years. In 1976, the Indian Healthcare Improvement Act allowed IHS to be reimbursed by Medicare and Medicaid for services provided to American Indians and Alaskan Natives in Indian health facilities. Prior to these changes, facilities were largely dependent on federal dollars to operate our facilities.

What happened if we ran out of money before the end of the year?

People were let go, we had to stop providing services in some areas, etc.

Revenue Today

Now…fast forward to 2024

Third party revenue now provides a large percentage of the operating costs for our facilities. We could no longer operate on federal funds alone. We have expanded staff and services in our facilities with third party revenue, third party revenue that you have assisted in generating.

We now have Specialty Services, CT, MRI, Mammography, Ambulatory Surgery, etc. in our Indian health facilities.

In FY 2023, IHS facilities generated **$1.8 billion dollars** in third party revenue.

Who is Responsible for Revenue Generation?

The role of revenue generation is not the sole responsibility of one specific department, it is a collaborative effort of all the departments within the facility that provides services to our patients.

Our patients with third party resources have choices as to where they receive medical care and we want to be the one they choose as their medical provider.

Today we will touch on several of the departments that play a role in revenue generation, it is important that everyone understands their role in the process and how they affect revenue.

Revenue Terms

Healthcare Revenue Cycle Management is the financial process facilities use to manage the administrative and clinical functions associated with claims processing, payment, and revenue generation. The process consists of identifying, managing, and collecting patient service revenue.

Revenue Generation is a “process” of finding ways to create income or generate cash flows.

How is Revenue Generated?

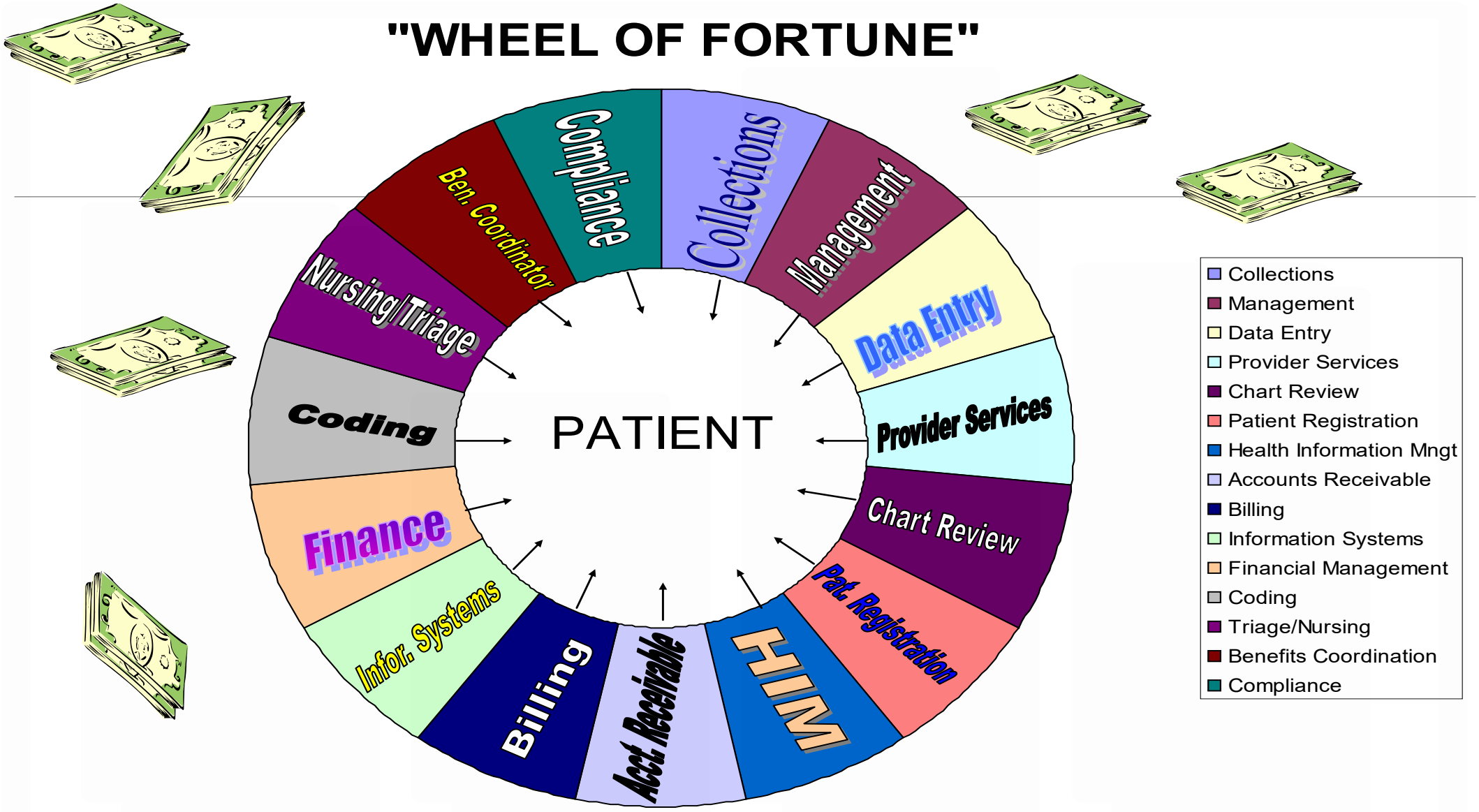
- There are many departmental interactions or functions to generate revenue for your facility.
- All the “cogs/spokes” have to work together in a united effort.
- Establish a Third-Party Revenue Team to refine your process.
- It takes a TEAM to RECORD, CONTROL, and ACCOUNT for Patient Related Resources.
- Separation of Duties will ensure Proper Internal Controls and Accountability is implemented for transparency and establishing an accounting audit trail.

What are these Departmental Functions?

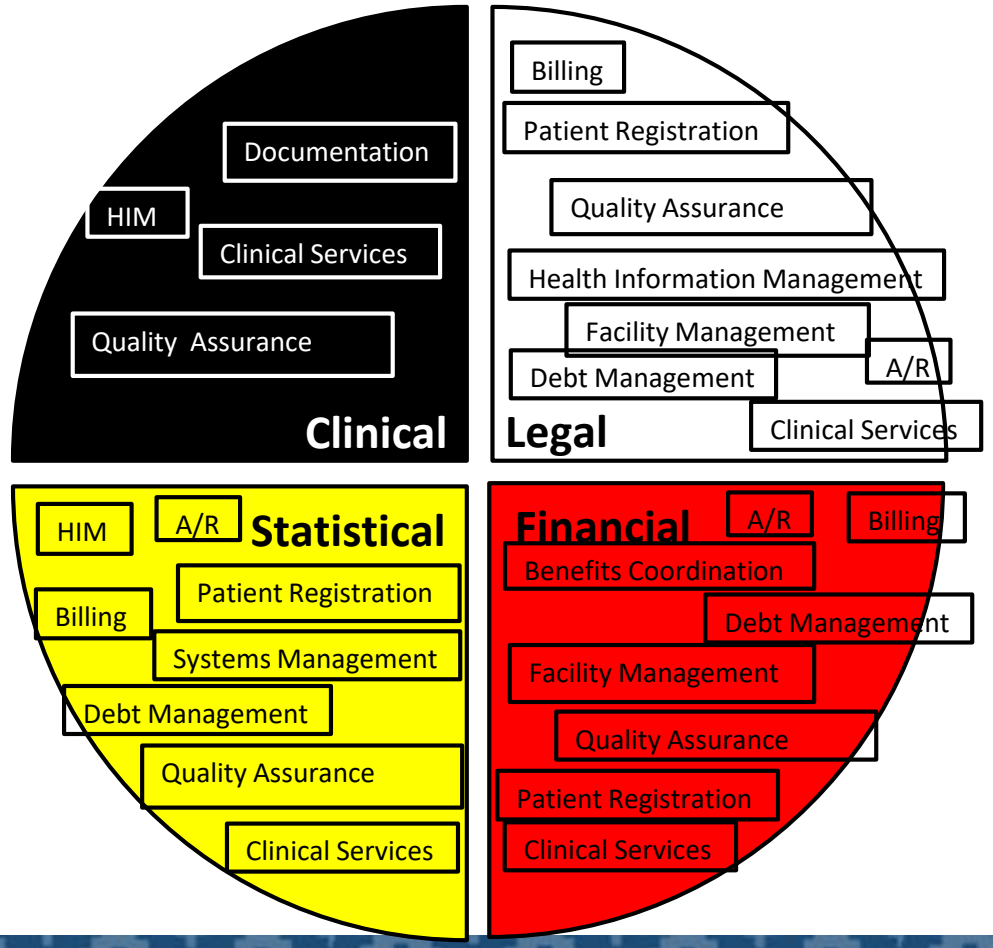
1) Patient Registration
2) Benefits Coordination
3) Clinical Services
4) Health Information Management
5) Billing
6) Accounts Receivable
7) Debt Management
8) Financial Management
9) Systems Management
10) Facility Management
11) Quality Assurance
12) Leadership/Revenue Team

Patient

"WHEEL OF FORTUNE"



It's more than collections….
contributing to the stability of the Agency



Departmental Functions

Patient Registration
Benefits Coordination
Clinical Services
Health Information Management
Billing
Accounts Receivable
Debt Management
Financial Management
Systems Management
Facility Management
Quality Assurance
Leadership/Revenue Team

PATIENT

Third Party Internal Control Policy

Chapter 1 - Third-Party Revenue Accounts Management And Internal Controls | Part 5 (ihs.gov)

Purpose. This chapter revises and updates the Indian Health Service (IHS) policy for recording, controlling, and accounting for patient-related resources; and for ensuring the accuracy and timeliness of receivables and revenue reporting in the IHS' financial statements. It also updates specific internal controls to safeguard and properly account for third-party related revenue and related assets, and updates the authorities for collecting debts owed to the IHS by third-party sources and non-beneficiary patients. The IHS *Revenue Operations Manual* (ROM) provides a system-wide reference resource and general implementation guide for all IHS, Tribal, and Urban (I/T/U) facilities across the United States (U.S.). Area Offices (AO) and Service Units (SU) should develop more specific guidance for their location.

Third Party Internal Control Policy

Background. The Indian Health Care Improvement Act (IHCIA) includes provisions for third-party reimbursements. The IHCIA authorizes the IHS and Tribes with self-determination contracts and compacts to bill and collect for services rendered at IHS and Tribal facilities. Although American Indians and Alaska Natives (AI/AN) are provided Federal health care, many individuals are covered by private insurance (PI) and/or are eligible for Medicare and/or Medicaid benefits. An amendment to the IHCIA, codified at 25 *United States Code* (U.S.C.) § 1621e, established the IHS' right to recover from third-party payers to the same extent that non-governmental providers of services would be eligible to receive reimbursement. As a result, third-party billing and collections have become critical activities for the IHS. The revenue generated from third-party billing and collections plays a major role in augmenting and enhancing the health care services that are provided to the AI/AN community. Safeguarding this revenue stream and related assets is vital to IHS health care programs.

Policy. It is the policy of the IHS to ensure that financial operations comply with applicable laws, regulations, and Government-wide financial management requirements and standards as they relate to third-party revenue. All IHS managers will implement the systems and requirements set forth in this chapter necessary to account for and collect revenue from various sources that include, but are not limited to: Medicare, Medicaid, PI, State Children's Health Insurance Program (SCHIP), Veterans Administration (VA), non-beneficiary, and other patient revenue resources. Management at the Headquarters (HQ), AO, and SU will utilize the Third-Party Internal Controls Online Tool to report and monitor system wide compliance with this policy.

Third Party Internal Control Policy

5-1.1 Introduction

5-1.2 Responsibilities

5-1.3 Procedures

5-1.4 Functional Financial Requirements

5-1.5 Compliance – Reporting and Monitoring

5-1.6 Debt Collection

5-1.7 Third Party Internal Controls – Online Tool Requirements

5-1.8 Records

Third Party Internal Control Online Assessment

The Third-Party Internal Controls Online Tool is a self-reporting online tool that contains questions based on criteria found in 5-1 IHM to determine compliance with all requirements of 5-1 IHM and Red Flag Items.

It provides a monitoring mechanism that allows a proactive approach in identifying revenue cycle disruptions and establishes IHS-wide follow-up standards. The ORAP staff reviews and monitors the data submitted and provides guidance and direction on how Red Flag items may be corrected and in compliance.

The ORAP staff will provide bi-annual reports to the Director, ORAP on the correction of Red Flag items and compliance.

Revenue Monitoring

The 6 Red Flagged Items that can initiate a Corrective Action Plan are:

- Facilities that have a backlog of 30 days or more in coding.
- Facilities that have a backlog of 30 days or more in billing. (Outpatient)
- Facilities that have a backlog of 30 days or more in billing. (Inpatient)
- Facilities that are not transmitting approved claims within 1 business day.
- Facilities that are not posting within 72 hours from the receipt of supporting documentation.
- Facilities that are not reviewing and researching aging accounts within 45 days.

Revenue Operations Manual

Revenue Operations Manual | Division of Business Office Enhancement (ihs.gov)

The ROM 2.0 provides a system-wide reference resource for IHS, Tribal, and Urban (I/T/U) facilities throughout the Indian Health System, which will assist staff with functions related to business office operating procedures and processes. The ROM 2.0 was designed to provide a resource manual that is based on regulations, policies and trends that were identified as best practices at the time of the revision. It is recommend that the ROM 2.0 be used as a tool for business office processing and procedures, keeping in mind that local facilities may have differing processes that fit their facility best.

Revenue Operations Manual (ROM)

Table of Contents [PDF - 192 KB]

Acronyms [PDF - 205 KB]

Glossary [PDF - 275 KB]

Part 1 - Administrative Roles and Responsibilities [PDF - 2.2 MB]

Part 2 - Patient Registration [PDF - 1.2 MB]

Part 3 - Coding [PDF - 568 KB]

Part 4 - Billing [PDF - 2.5 MB] Note: This file is not 508 compliant, if you require assistance please contact The Division of Business Office Enhancement at 301-443-1016.

Part 5 - Account Management [PDF - 1.3 MB] Note: This file is not 508 compliant, if you require assistance please contact The Division of Business Office Enhancement at 301-443-1016.

ROM Objectives

- Provide standardized guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest standard of quality service at each Business Office operation.

Patient Registration and Benefits Coordination

Third Party Internal Control Policy

Patient Registration. Identify if a prior authorization is needed and refer to the appropriate office for processing. Third-party eligibility and patient demographic data is to be determined and/or verified at each and every patient encounter. This includes:

- Collecting and/or updating patient information/demographic data and third-party eligibility in RPMS at the time of registration and check-in.
- Referral to the Benefits Coordination Office for reviewing and evaluating a patient's eligibility for alternate resources.

Benefits Coordination. Educate and assist patients to identify and obtain access to all available alternate resources.

Patient Check-in. The RPMS Practice Management Application Suite, Registration, and Scheduling modules must be utilized at the time of registration and check-in.

Patient Registration

- Interviews patients to obtain/update identifying demographic and eligibility information upon EVERY VISIT
- Record Alternate Resources and Demographics
- Data integrity for all data entered
- Coordination of Benefits
- 50% of Billing Information on claim is generated from Patient Registration

Patient Registration

- Gathers required signatures and documents from the patient
- Often responsible for obtaining pre-certification (approval) for certain procedures
- If this is the first point of contact, the “Check In” process can be initiated at this time, (Establishing the “Account”)
- Promotes positive image for the entire patient visit.

This is the first step in the revenue process, if this information is not correct, the claim will not go to the payer correctly, which means the revenue will not be received or it will be delayed. This is also costing staff resources in billing and accounts receivable if the claim rejects or is denied. An account has been created and has to be addressed by the staff that follows up aged claims, denials and rejections

Benefits Coordination

- Determines and Records if the patient is eligible for some “not yet identified” Alternate Resource.
- Liaison between facility, patient, and local, state, and federal agencies.
- Serves as a Patient Advocate for scheduling appointments and follow up with different Alternate Resource Programs. (Applications)
- Assists with Application process for Alternate Resources (Medicaid, Exchanges, VA, etc.)
- Educates patients on the benefits of Alternate Resources.
- Beneficial to both PRC (cost shifting) and Direct Care (additional revenue) Services.
- Works closely with Patient Registration, Purchased Referred Care, Discharge Planning and clinical departments.
- Outreach and Education of ALL alternate Resources

PR/PBC Patient Scenario

A PATIENT PRESENTS TO PATIENT REGISTRATION TO MAKE NEW CHARTS FOR HERSELF AND HER THREE CHILDREN, THEY RECENTLY MOVED TO THE AREA AND ALL THREE CHILDREN ARE ILL AND NEED TO BE SEEN.

Scenario 1

Patient presents to Patient Registration with all her documents and the Medical Support Assistant (MSA) greets the patient and begins interviewing the patient to create the four new charts.

MSA inquires on third party and patient replies that they had Medicaid in the previous state but has not had time to reapply since moving and plans to do that at some point in the future. The MSA encourages her to do so and continues with chart creation.

MSA verifies there is no active Medicaid for the patient, documents the chart and sends the patient to the Pediatric Clinic.

Scenario 2

Same as Scenario 1 and….

MSA educates the patient on the Patient Benefit Coordination services available at the facility and calls the PBC to let them know that there is a patient that needs assistance with applying for Medicaid. When the charts are completed, the MSA walks the patient to the PBC's office and introduces the patient to the PBC and returns to their workstation to assist the next patient.

Scenario Continued

SCENARIO 1

The patient's three children are seen in the Pediatric Clinic and all three are prescribed medications , the patient picks up their medications at the pharmacy and leaves the facility.

SCENARIO 2

PBC welcomes and interviews the patient, determines that the children would be eligible for Medicaid and assists the patient with an online Medicaid application. The patient's three children are approved in real time while they were waiting for their Pediatric Walk In appointments. The PBC also shares information about other community and tribal resources available to the patient and her family and gives the children some coloring /activity pages to keep them entertained while they wait.

PBC enters the information in RPMS/BPRM with today's effective date and asks if she can assist with any other needs and asks them to return to the waiting room for their appointments

The patient's three children are seen in the Pediatric Clinic and all three are prescribed medications , the patient picks up their medications at the pharmacy and leaves the facility

Scenario Continued

SCENARIO 1

The actions of the MSA resulted in **$0.00**

SCENARIO 2

The actions taken by the MSA and PBC result in $2,457.00/$4,314.00 in revenue for your facility and they will be covered for any additional visits while the coverage is in effect.

AIR Encounter Rate for Medicaid in CY 2023 is $654.00 -

Peds Visits $719.00 x 3 = **$2157.00**

KS RX visits - $100.00 x 3 = **$300.00**

OK RX visit $719.00 x 3 = **$2157.00**

Scenario #2

What would have happened if the PBC did not enter that information as soon as it was approved? Before the patient's RX were filled in the pharmacy

Maybe they waited and entered the information the following morning

The actions of the MSA and PBC would have resulted in **$2,157.00** less in revenue for your facility - **WHY?**

Scenario #2

RX are submitted in real time, when the pharmacist hits the print label key in pharmacy, the RX claim is submitted to the payer, if there is not a payer on file, then a claim is not sent. Since the PBC waited to enter the coverage, there would not be a payer on file and the claim would not be created to send.

You would need a process in place to notify the Pharmacy when new coverage is entered so that they could resubmit the claim to the payer once it was entered. At this time, there is not a auto feature that would go back and check for coverage.

Medical visits are generated each evening for any covered resources, so those visits would not be generated that evening, but once entered into RPMS with an effective date the claim generator should generate those claims and send them to billing for processing and billing should have a process in place to run a back bill check periodically that would generate the claims if not previously generated.

Either way, **delayed entry would result in delayed or lost revenue**.

Clinical Services

Clinical Services

Patient Check In: Establishes the patient account in the RPMS

Triage: Means preliminary assessment of patients to determine urgency of treatment, as well as the nature of treatment. There are three levels of triage; immediate (ER) urgent (same-day) and non-urgent.

The triage nurse takes patient vitals, enters Purpose of Visit (POV) in response to the question, what are you being seen for? Documents all information in the EHR.

Chart review is a part of clinical services. Provider may quickly review patient history in preparation for services to be provided for this visit.

Clinical services include provider care. All services are documented and described within the visit during this phase of patient care. Providers should make every effort to capture precise descriptions of the diagnosis, history of the patient, time involved in medical decision making, and anticipated outcome of the patient.

These factors all provide information for the coding portion of the Revenue Cycle.

Document, Document, Document, if it is not documented, it didn't happen!!

Health Information Management

Third Party Internal Control Policy

Health Information Management Coding/Data Entry

Coding is an integral part of the revenue cycle; therefore, timely and accurate coding is necessary. The HIM Director, Clinic Director, and CEO must ensure that there is effective communication to keep accurate, complete, and current coding.

Coding Timelines

- *All applicable codes must be entered, verified, and completed in RPMS within 4 business days of the date of service for all outpatient services.*
- All efforts should be made to enter, verify and complete codes within 4 days after chart completion of the inpatient stay.
  - Accreditation guidelines allow providers up to 30 days to complete a chart after an inpatient stay.
  - The maximum time allowed for all codes to be entered and verified in the RPMS system is 34 days.
- Providers have 1 business day to address and provide any additional information once an issue is identified and communicated.

Third Party Internal Control Policy

- Classification System and Coding. The current versions of ICD, American Dental Association, and CPT codes must be entered into RPMS/Patient Care Component (PCC) for all clinical services whether or not third-party coverage is applicable to the patient.

- Healthcare Common Procedure Coding System. Healthcare Common Procedure Coding System (HCPCS) codes for supplies must be identified on charge tickets and entered into the PCC to ensure the capture of service related data and proper billing.

- Patient Care Component Encounter. Services provided at ancillary departments (radiology, laboratory, etc.) without a provider visit on the same day, must generate a visit in to RPMS. [The PCC data entry for electronic health records (EHR) and non-EHR sites plays a critical role in the timely billing and recoupment of third-party resources.]

- Certified Coders. Each facility must have at least one coder, performing coding functions, who is certified by the American Academy of Professional Coders or the American Health Information Management Association. Certified coders must take the appropriate training necessary to maintain their certification.

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

- Coding/Data Entry Training. Coding/Data Entry Training must be completed for all coding and classification systems including current versions of ICD, CPT, HCPCS, and related software applications before an employee is allowed to independently perform this function. The employee must work with oversight by a certified coder until training is completed. Training for new coding employees must be completed and documented by the compliance officer or designee as soon as possible after the employee comes on board.

- Coding/Data Entry Reference Manuals. All coding and related reference books must be the most current version with annual updates provided to all individuals involved in the coding/billing functions of the SU.

Chart Review/Analysis

- The responsibility of the Chart Review is to ensure that all documentation that is required is present, and the encounter form is completed according to preset guidelines.
  - Accurate Clinic Code and Visit Type
  - Vitals are present if necessary
  - Correct providers are documented
  - Encounter form is signed and dated properly
  - Chief Complaint and Purpose of Visit (Diagnosis) are present.
- Communicates to and educates the Provider in enhancing documentation and data integrity.
- Incomplete/inaccurate encounter forms are returned to the provider **PRIOR** to going on to the next step of Coding.

Data Capture/Data Entry

- The RPMS Third Party Billing Package is totally dependent on the entries made into the PCC/EHR System
- Data Entry Technicians are responsible for capturing all visit information in the database.
- Responsible for “merging” ancillary services to the correct “parent” visit.
- They ensure the data integrity of what has been entered.
- Orphan visits = Potential Lost Revenue, or Revenue received in Error
- Timeliness – (deficient Health Summary)
- They are a “check point” to validate the accuracy of the coding.
- IHS **Statistical** Requirements
- GPRA, Cost Reports, GAO Requests, OIG Inquiries, Urban Existence, Quality Measure Reporting

Coding

- Coding is an integral part of the revenue cycle; therefore timely and accurate coding is necessary. The HIM Director, Clinic Director, and CEO must ensure that there is effective communication to keep accurate, complete, and current coding.
- The PCC data entry for electronic health records (EHR) and non-EHR sites plays a critical role in the timely billing and recoupment of third-party resources.
- Healthcare Common Procedure Coding System (HCPCS) codes for supplies must be identified on charge tickets and entered into the PCC to ensure the capture of service related data and proper billing.
- The current versions of ICD, American Dental Association, and CPT codes must be entered into RPMS/Patient Care Component (PCC) for all clinical services whether or not third-party coverage is applicable to the patient.
- Each facility must have at least one coder, performing coding functions, who is certified by the American Academy of Professional Coders or the American Health Information Management Association. Certified coders must take the appropriate training necessary to maintain their certification.

Billing

Third Party Internal Control Policy

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Billing for Services.

- *All outpatient claims are to be billed within 6 business days of date of service.*
- Secondary and tertiary claims must be billed within 3 business days of the posting of the primary payment/denial.
- Inpatient claims are to be billed and all codes entered and verified within 10 business days from the coding completion.
- The maximum time allowed for an inpatient claim to be billed and all codes entered and verified is 44 days from the date of discharge.

Third Party Internal Control Policy

- Billing Monitoring at the local and Area Level. Monitoring must be completed on a daily basis to ensure that all goods and services provided are billed within the established timelines set forth by Third-Party Payers.

- The RPMS Edit for Bill Creation. In certain situations an RPMS system edit will be used to prevent the approval of a bill, for example, if the "Assignment of Medical Benefits Form" is not on file (or documentation the patient refused to sign). The RPMS system provides a level of error checking and all billing errors must be corrected and approved within two business days of claim creation.

- Submission of Approved Claims. *Once approved, all claims are to be submitted to the responsible payer by the close of the next business day (within one business day from the date of approval).* Exceptions can be made if approved by the Area Director and the Director, ORAP. All exceptions must have proper documentation to support any exception.

- Electronic Transmissions. Reconciliation of electronic transmissions to payer confirmation reports must be documented, and the files must be maintained by each location. All transmissions must be compliant with the HIPAA and meet all requirements related to privacy transactions, security, and code sets.

- Error Files. *Transmission error files to third-party payers are to be reviewed and corrected on a daily basis.*

Third Party Internal Control Policy

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Error Files. Transmission error files to third-party payers are to be reviewed and corrected on a daily basis.

Billing

- Knows and applies all billing requirements and rules to each individual claim before it is approved.
- They are a “check point” to validate the accuracy of the coding.
- Sequences and links all proper diagnosis and procedures to ensure payment.
- Approves and submits “Clean Bills” to third party payors.
- Serves as the final check point, to ensure we are ONLY billing for documented services, and billing for ALL documented services.
- Final check point for putting the “Agency at Risk”

What is Billing's role in the revenue cycle?

Are you following the billing guidelines for the payer?

Are files exported daily?

Are exported files reconciled daily?

Are rejected claims corrected and resubmitted daily?

It is a billing responsibility to get a clean claim to the payer, once the claim is received and accepted, it can then become an accounts receivable.

Are claim denials for billing issues addressed timely?

Is there good communication between billing, patient registration, and accounts receivable to work together to resolve issues?

If these processes are not being done efficiently and effectively you are delaying or losing revenue

Billing Case Scenario

SCENARIO #1

Biller completes billing for the day:

Medicare	50	$ 32,000
Medicaid	125	$ 44,280
PI	75	$ 23,720
	250	$100,000

Exports all claims billed to Medicare, Medicaid and PI for the day

Signs out of their session and goes home for the day.

The next morning, the biller begins a new session and starts billing from their assigned lists and exports at the end of the day.

SCENARIO #2

Same as Scenario 1 but….

The next morning the biller checks her portals to verify that the number of claims sent were the number of claims accepted, if there were any rejected files or claims, they are corrected and resubmitted that day.

Completes the file reconciliation spreadsheet

Then…..

Biller begins a new cashiering session and starts billing for the day

Billing Case Scenario

SCENARIO #1

The claims start aging from the day they are approved, if no one is reconciling these files, there could be a lot of $$$ sitting in a file that was never accepted.

These claims may not be detected until someone in A/R is reviewing the aged claims in 30-45 days.

This will result in lost or delayed revenue!!

The biller did not complete the billing process and reconcile the files to insure that the files were accepted, claims were not corrected and submitted within 1 business day and the facility is not in compliance with the Third Party Internal Control Policy.

This will also result in additional staff resources to address the issues at a later time.

SCENARIO #2

The facility has performed all the required processes and is in compliance with the Third Party Internal Control Policy.

The facility is more likely to receive their collections in 15-30 days or less and their aged claims balance will not increase unnecessarily.

File Export Reconciliation

Each file exported should be logged on a spreadsheet and reconciled daily:

File Export Log

Date	Filename	Biller	# of Claims exported	Batch Amount	# of Claims Accepted	Amount Accepted	# of Claims Rejected	Amount Rejected	Notes
8/7/2023	mcr131080723	SS	50	$32,000.00	48	$30,720.00	2	$ 1,280.00	2 claims for same patient rejected due to MBI error, claims were corrected and resubmitted on 08/08
8/7/2023	mcr999080723	SS	75	$ 9,375.00	70	$ 8,750.00	5	$ 625.00	5 Claims rejected due to invalid CPT code, sent to Coding for correction on 08/08
8/8/2023	mcr 131080823	SS	80	$51,200.00	0	$ -	80	$ 51,200.00	File rejected due to a pt's info had an extra space in zip code, file was corrected 08/09/2023
8/8/2023	mcr140080823	SS	5	$ 3,617.50	5	$ 3,617.50	0	$ -	
8/8/2023	mcr999080823	SS	50	$ 6,250.00	50	$ 6,250.00	0	$ -	
8/8/2023	mcr250080823	SS	10	$ 835.00	10	$ 835.00	0	$ -	
8/9/2023	mcr131080823rs	SS	80	$51,200.00	80	$51,200.00	0	$ -	Resubmitted file from 08/08/2023

Monitoring and tracking your revenue processes is vital to efficient and effective revenue generation

Accounts Management

Third Party Internal Control Policy

Accounts Receivables or Posting Transactions. All A/R or posting transactions must be in compliance with the "Electronic Remittance Advice" (ERA) 835 requirements (when available by the payer) and recorded in accordance with the instructions for each transaction category or type identified in ROM. All ERA electronic transmissions must be HIPAA compliant.

- Detailed Subsidiary Ledger. *The CEO or (his or her) 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.*
- Standard Adjustment Reason Codes. The HIPAA, "Standard Adjustment and Reason Codes" are to be used when posting payments and adjustments into RPMS. Additional local adjustment codes may be used if approved by either, the Director, ORAP, or the Director, OFA.
- Account Review and Aged Accounts Follow-up. *All accounts must be reviewed at least once a month by payer, age, and dollar amount. Review, research, and follow-up action must be performed on all bills aging within 30 to 45 days consistent with the current debt collection policy and Federal guidelines for outstanding debts submission to Treasury.* All follow-up efforts should be properly documented in the RPMS A/R message field. This process is in addition to the policies and procedures set forth in 9-4, IHM. The CEO or his or her designee must ensure that they follow their local operating procedure (guidance found in the Revenue Operations Manual) for the specific third-party revenue identified in 9-4 "Debt Management," IHM, for recoupment of payment.This procedure includes the processes outlined in the Debt Management chapter for collecting debt from IHS employees; collecting debt from non-IHS employees; administrative wage garnishment; litigation; and collection of debts which are over 180 days delinquent. Monitoring of debt management processes will be done by the ORAP staff utilizing the TPICP Online Reporting Tool, details of the monitoring process is explained in Section 5.1-7. Additional requirements may be added to the online tool depending on priority and need.

How does IHS receive funds?

Deposit in PNC

Batched and Posted

Export to HUB

Enter File Data on RPMS/UFMS Reconciliation Workbook

Received and Available in UFMS

Follow the Money

Note: All files received by 2:00 pm on Sunday, should be received as an advice on Monday.

$25,000 Deposit received on the 12th and assigned a Treasury Deposit Number (TDN), facility is notified and electronic remit is received

TPIC states you have 3 business days to post receipts after supporting documentation is received.

Batch is created on the 13th and assigned to an A/R Tech to post

A/R tech post the batch on the 14th and closes their session at the end of the work day

Supervisor exports the files to the HUB on the morning of 15th and verifies that the file was received at the HUB and completed the UFMS Reconciliation for files exported

The facility receives their advice that includes the $25,000 on 19th

The guideline and timelines were met and it took 7 days for funds to be available

Accounts Management/Follow-Up

- Responsible for the completion (close out) of all Patient Accounts Receivables.
- Posting of all receipts of Payments, Denials, and Adjustments to the RPMS Accounts Receivable System.
- Analyzing the receipts to determine when and if Third Party Payors need to be “questioned” on their decision of payment.
- Perform Follow Up (phone calls, correspondence, etc.) on all Aged Receivables.
- Make the determination as to whether or not a “secondary” payor should be billed.
- Ensure PROPER Payment and/or Denial
- Controllable versus Uncontrollable

What is A/R's role in the revenue cycle?

What if the supporting documentation needed is not received?

What is there is a backlog in batching?

What is there is a backlog in posting?

What if the funds were batched and posted but no one exported files?

What if the files were exported and no one performed file reconciliation and the files were not received at the HUB?

Any additional time taken in these processes will add days to your days to collection

All of these things would cause a delay in revenue, how does your job in accounts receivable affect the revenue cycle? Where in this process can you make a difference?

Accounts Management Case Scenario

SCENARIO #1	SCENARIO #2
A/R Tech receives EOBs in file from PNC Bank The EOBs with payments are batched and put in queue for the A/R tech to post the funds, funds are batched and posted within the 72 hour window. The non-pay EOBs are not printed or addressed. Files are exported the HUB and funds are received in the advice of allowance the following Monday.	Same as Scenario #1 and …… The non-pay EOBs are printed and reviewed. The EOBs that require follow-up are noted and forwarded to the Voucher Examiners The EOBs that are applied to co-pay, ded, etc are batched as a non-pay batch and put in queue for the A/R techs to post.

Accounts Management Case Scenario

SCENARIO #1	SCENARIO #2
The facility is not in compliance with policy The Accounts Receivable percentage will increase due to the accounts that should have been posted to a non-pay status This action will also cause unnecessary use of staff resources for the staff that has to perform follow-up on aged claims	The facility is in compliance with policy The Accounts Receivable percentage will not be unnecessarily increased Staff resources will be used to follow-up claims that need attention and not wasted on claims that should have been posted to non pay weeks ago.

Debt Management

Indian Health Manual – Debt Management

Part 9 Finance and Accounting: Chapter 4 –Debt Management

Chapter 4 - Debt Management | Part 9 (ihs.gov)

Purpose. The purpose of this chapter is to establish the policy, responsibilities, and procedures to be followed for servicing and collecting debts owed to the Indian Health Service (IHS). Collection procedures for all non-tax receivables and delinquent debt should be done in an efficient and effective manner to protect the value of the Federal Government's assets.

Policy. It is IHS policy to aggressively collect all debts arising out of IHS activities. Collection activities shall be undertaken promptly with follow-up action taken as necessary to ensure that financial operations comply with applicable laws, regulations, and Government-wide financial management requirements and standards relating to the collection of Federal receivables.

Indian Health Manual – Debt Management

Objectives. The objectives of this policy are:

- Every effort is made to prevent future delinquencies by following appropriate screening standards and procedures for determination of creditworthiness.
- Informed and cost-effective decisions are made concerning debt portfolio management, including full consideration of contracting out for servicing or selling the debt portfolio.
- The full range of available techniques are used, as appropriate, to collect delinquent debts, including demand letters, administrative offset, salary offset, tax refund offset, private collection agencies, cross servicing by the Treasury, administrative wage garnishment, and litigation.
- Timely and accurate management and performance reporting data are submitted to the Office of Management and Budget (OMB) and the Department of the Treasury (Treasury) so that the Government's credit management and debt collection programs and policies can be evaluated.
- Delinquent debts are written-off as soon as they are determined to be uncollectible.

Indian Health Manual – Debt Management

Right of Recovery from Third-party Insurers. Debts include all recovery from third-party insurers. The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §1621e gives the United States the right to recover from third-party insurers. The IHCIA, as amended, gives the United States the right to recover "the reasonable expenses incurred by the Secretary.. .in providing health services, through the Service,. .." to eligible Native Americans and Alaska Natives to the same extent as the individual or a non-governmental provider would be eligible for reimbursement if:

- the health care had been provided by a non-governmental provider and
- the individual had been required to pay for the care and had in fact paid.

Thus, third-party insurers must reimburse the IHS for health care services that the IHS provides to Native Americans and Alaska Natives, who are covered under the third-party's health plan, just as the IHS would have to reimburse the third-party insurers for services that it may provide to these patients. States are only required to reimburse the IHS, however, when an injury, illness, or disability is covered by a worker's compensation law or a no-fault automobile accident insurance plan or program. Under the IHCIA, as amended, the definition of a State does not encompass a political subdivision or an entity that is an arm of the State. See U.S. ex rel. Norton Sound Health Corporation v. Bering Straight School District, 138 F. 3d 1281 (9th Cir. 1998), cert denied, Bering Straight School District v. U.S., 525 U.S. 962 (1998).

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. The 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 the IHS.

Debt Management

Debt Management is the final step in ensuring your Revenue Cycle is secure and complete.

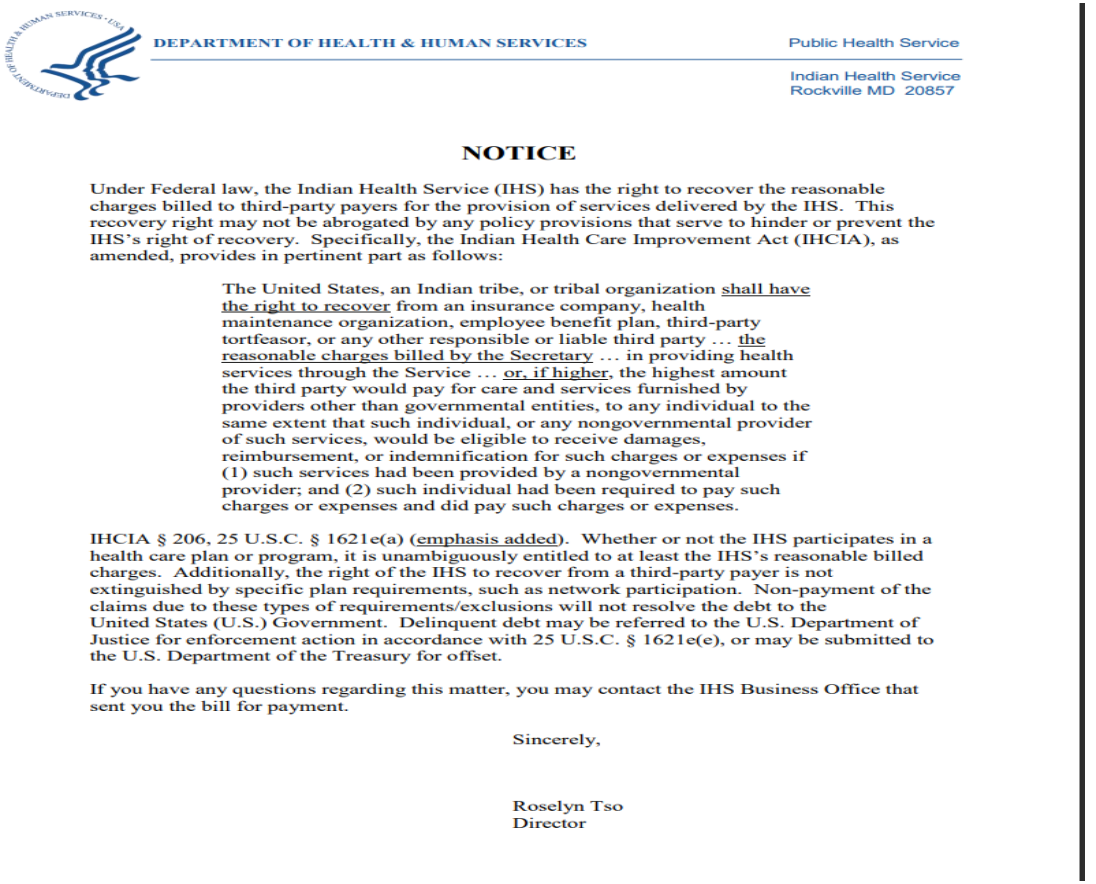
Each Service Unit is responsible for creating a Service Unit-specific operational plan regarding debt management. An Operational plan is an organized plan of action incorporating the various collection tools to be used to recover debt. ***Since the Debt Collection Improvement Act (DCIA) requires all debt over 180 days delinquent to be referred to the Treasury, the Service Unit operational plan should be limited to collection actions undertaken within the first 180 days of the delinquency.***

At a minimum, a Service Unit must issue a demand letter. Procedures for demand letters are different for debt originating from the Finance Office or the Business Office. Please see the Revenue Operations Manual Part 5 Accounts Management, Chapter 8-Debt Management.

New Prompt Payer Notice

We now have a new Prompt Payer Notice that was signed by the IHS Director, Roslyn Tso.

Please use the new letter when corresponding with debtors.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

NOTICE

Under Federal law, the Indian Health Service (IHS) has the right to recover the reasonable charges billed to third-party payers for the provision of services delivered by the IHS. This recovery right may not be abrogated by any policy provisions that serve to hinder or prevent the IHS's right of recovery. Specifically, the Indian Health Care Improvement Act (IHCIA), as amended, provides in pertinent part as follows:

> The United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party … the reasonable charges billed by the Secretary … in providing health services through the Service … or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if (1) such services had been provided by a nongovernmental provider; and (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

IHCIA § 206, 25 U.S.C. § 1621e(a) (emphasis added). Whether or not the IHS participates in a health care plan or program, it is unambiguously entitled to at least the IHS's reasonable billed charges. Additionally, the right of the IHS to recover from a third-party payer is not extinguished by specific plan requirements, such as network participation. Non-payment of the claims due to these types of requirements/exclusions will not resolve the debt to the United States (U.S.) Government. Delinquent debt may be referred to the U.S. Department of Justice for enforcement action in accordance with 25 U.S.C. § 1621e(e), or may be submitted to the U.S. Department of the Treasury for offset.

If you have any questions regarding this matter, you may contact the IHS Business Office that sent you the bill for payment.

Sincerely,

Roselyn Tso
Director

Financial Management

Third Party Internal Control Policy

Unified Financial Management System.

- The Area FMO or (his or her) designee must ensure that the SU transmissions from RPMS to UFMS are completed. Further, Area FMOs or their designees must ensure that both RPMS and UFMS are reconciled at the Area level and also that this has been completed at the SU level per IHM 5-1.2R(2). This will ensure that the RPMS subsidiary system is in balance with UFMS.

- Accounts Receivable Balance. Each FMO, BOC, or BOM or their designees must maintain and reconcile the UFMS/RPMS interface and the UFMS A/R balance for each type of budget activity, at least monthly. The current procedures are available in the ROM. This includes managing the RPMS to UFMS file transmission process and reconciling the balances in both systems.

- Collections and Deposits. Only a collections clerk or officer designated by the FMO is authorized to collect funds, which includes currency (cash), checks, money orders, credit cards, and lockbox receipts. All collections received must be recorded in the UFMS according to their proper fund and BAP combination.

- Receipts and Logs. The CEO, Administrative Officer, or their designee must maintain the record for the receipt of all physical paper checks received. The record must identify the date received, date sent, amount of payment, and disposition for all in-house payments. All deposits for your location must be reconciled with the Receipts and Logs record.

Third Party Internal Control Policy

- Lockbox. The implementation of the lockbox process is mandatory for all IHS facilities for the receipt and deposit of all medical service payments (except FMCRA receipts). Each location has the option of implementing a lockbox process at the AO or SU level.
- Submission of Paper Checks. Should a paper check be received, they are to be submitted to the lockbox or deposited daily in the assigned bank or via OTC.net.
- Federal Medical Care Recovery Act Receipts. All FMCRA receipts are to be processed in accordance with IHS Circular No. 2006 02, "Reporting Third-party Tortfeasor Claims and Recovery of Funds under the Federal Medical Care Recovery Act." Circular No. 2006 02 includes procedures for processing FMCRA payments sent in error by third-party payers to the IHS, i.e., payments that should have been sent to the Office of the General Counsel or its designee.

Third Party Internal Control Policy (continued)

Month End Processing and Reconciliation. Month end processing and reconciliation must occur for the following:

- File Transmission. The AO or SU must obtain reconciliation data by performing file transmissions which may be accomplished by uploading or downloading files over a computer network (see ROM).
- Treasury Reconciliation. Each FMO (or his or her designee) must perform a monthly reconciliation of the UFMS accounts to the Department of Treasury.
- Reconciliation. Each FMO (or his or her designee) must reconcile balances from the RPMS A/R system with the UFMS A/R balance by individual invoice. The individual invoices in UFMS are by location, FY, and allowance category. If the "Subsidiary Accounts" do not reconcile with the UFMS accounts, Finance personnel must work with the respective locations in order to identify and adjust the differences.
- Transaction Documentation. All records of daily and monthly transaction documents must be kept and maintained for subsequent reconciliation and/or audits in accordance with the IHS RDS, HIPAA requirements, and Privacy Act regulations.

Finance

RPMS→HUB→UFMS

Finance

RPMS

- Business Office Transmits – DAILY
- Transmits data for
  - Medicaid, Medicare, Private Insurance, VA & Other
- RPMS Third Party Billing (TPB)
  - Invoices
- RPMS Accounts Receivable (AR)
  - Receipts - collected/posted $$
  - Adjustments

HUB

- RPMS file names are assigned UFMS file names
- Merges files by Area ASUFACs
- Creates 3 files
  - Invoice File = INV
  - Receipt File = RCV
  - Adjustment File = ADJ
- Provides a HUB REPORT after each transmission
  - SUCCESSFUL & OR FAILED TRANSACTIONS
  - Count and $$ AMOUNTS w/ subtotals and totals
- Categorizes Data into Medicaid, Medicare, Private Insurance, VA & Other
- Assigns Accounting Codes Budget Accounting Program (BAP)

UFMS

- Creates Master Invoices
- Applies Receipts

RPMS/UFMS Reconciliation Template

New requirement that was recently implemented is the new template that must be submitted by each area validating that each service unit in the area has completed their file reconciliations each month and have to be signed and submitted by the 10th of each month.

RPMS-UFMS Reconciliation Month -Year: Apr-2024

Sno	Item	Pre-Requisite	Action		Status	Notes
1	RPMS Errors	RPMS Invoice/Adjustment/Receipt Error FBIS Reports	☐ Errors	✓ No Errors	Completed	
2	RPMS-HUB File Reconciliation	RPMS Grand Total Report/ HUB Emails/HUB Reports	✓ Reconciled	☐ Un-Reconciled	Completed	
3	HUB-UFMS File Reconciliation	HUB Reports/FBIS Reports	✓ Reconciled	☐ Un-Reconciled	completed	
4	RPMS USM Balance vs UFMS Open Balance	RPMS USM Reports/ FBIS Reports	✓ Reconciled	☐ Un-Reconciled	Completed	
5	RPMS Allotment/Allowance Reconciliation	HUB Reports/FBIS Reports/Allowance CSV File	☐ Reconciled	✓ Un-Reconciled	In-Process	Haskell-see notes

* Please attach the supporting documentation via attachments to this document

Certification

Preparer Name	Designation	Reviewer/Approver Name	Designation
Claremore - Kristi Babb/Laiana Spears Wewoka - Melanie Edwards Clinton - Johnelle Lamar Lawton - Jackie Destefano Pawnee - Alyssa Goodfox/Sharon Pratt	BO and AR representatives	Sandra Sealey	Area BO
Signature	Sandra L. Sealey -S Digitally signed by Sandra L. Sealey -S Date: 2024.05.13 16:39:22 -05'00'		Karla J. Macarthur -S Digitally signed by Karla J. Macarthur -S Date: 2024.05.13 07:05:54 -05'00'

Systems/Facility Management

Systems Management

Our Information Technology and Clinical Applications Coordinators are vital to our revenue process…

If RPMS and the EHR are not working properly, we can not do our jobs efficiently.

If the provider's documentation is not documented timely and appropriately we can not code and bill for the services our patients are receiving.

Our CACs assist with our templates for provider and nursing documentation and insure that our clinical applications are operating correctly.

Facility Management

The Facility Maintenance, Environmental Services and Material Management departments are critical to our ability to provide services to our patients.

The facilities maintenance department keeps our facilities in compliance with Joint Commission requirements and insure our facilities are maintained and operate effectively.

The environmental services department keeps our facilities clean and safe for our staff and patients.

The material management staff insure that we have the supplies that we need to do our jobs effectively.

Quality Assurance, Revenue Team and Leadership

Quality Assurance

The Quality Assurance Program supports federal health services to achieve and sustain accreditation through standardizing tools and resources. Accreditation and certification survey activities are monitored in process with regular trend analysis to identify opportunities for improvement. Ongoing multidisciplinary QA activities support overall patient safety and increased communication of accreditation and certification activities agency wide. Federal IHS facilities are also provided training and access to standardized accreditation activities through the Joint Commission Resources (JCR) Portal.

If facilities are not in compliance with the Joint Commission it will affect their ability to bill for services.

Revenue Team

- Monitors the revenue cycle
- Identify any problem areas in your revenue cycle
- Develop corrective action plans to address problem areas
- Develop the collection goals and projections for the facility
- Ensure Compliance with the Third Party Internal Control Policy
- Identify new streams of revenue

Leadership

- Have a representative on the revenue team
- Establish reporting requirements
- Communicate goals, objectives and expectations to staff
- Provide the support and resources the departments need to optimize performance and meet the goals and objectives established
- Recognize staff for good performance

"Coming together is a beginning. Keeping together is progress. Working together is success." Henry Ford

Questions