Indian Health Service

What is your role in revenue generation?

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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 2023

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 2022, IHS facilities generated **$1.68 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?

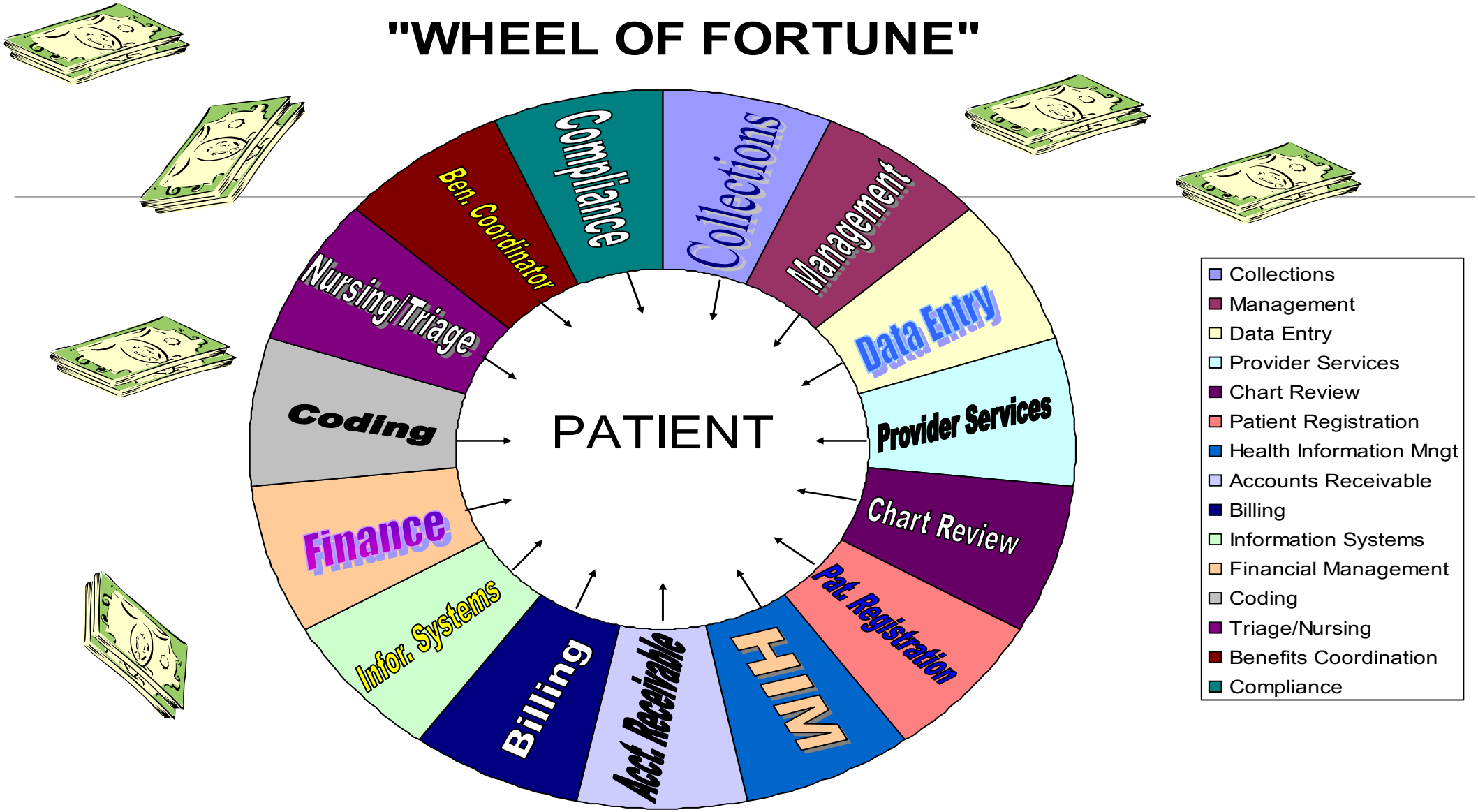
- There are a many departmental interactions or functions to generate revenue for your facility.
- All the “cogs/spokes” have to work together in a united effort.
- Establish a Third-Party Revenue Team to refine your process.
- It takes a TEAM to RECORD, CONTROL, and ACCOUNT for Patient Related Resources.
- 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?

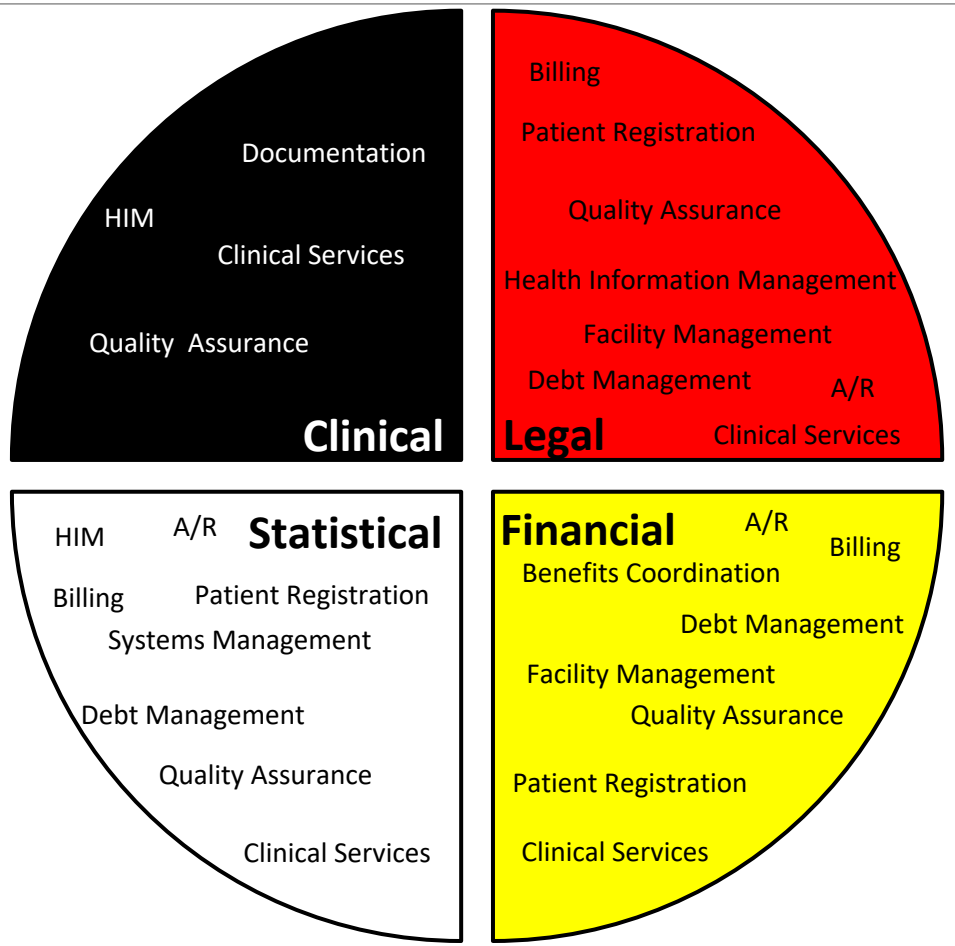
1) Patient Registration
2) Benefits Coordination
3) Clinical Services
4) Health Information Management
5) Billing
6) Accounts Receivable
7) Debt Management
8) Financial Management
9) Systems Management
10) Facility Management
11) Quality Assurance
12) Leadership/Revenue Team

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

Patient Registration and Benefits Coordination

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

Case #1

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.

Case #1 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

Case # 1 Continued

SCENARIO 1

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

SCENARIO 2

The actions taken by the MSA and PBC result in $2,262.00/$3,924.00 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 $654.00 x 3 = **$1962.00**

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

OK RX visit $654.00 x 3 = **$1962.00**

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 **$1,962** 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**.

Case #2

A 65 YEAR OLD ESTABLISHED PATIENT COMES TO THE FACILITY FOR THEIR MEDICAL APPOINTMENT AND CHECKS IN WITH PATIENT REGISTRATION.

SCENARIO 1

Patient presents to MSA for check in, the MSA greets the patient and begins the interview process, updates demographics and asks if the patient has any third party resources.

The patient states that they turned 65 last month and got a new Medicare card, the card shows the patient has Medicare Part A only, the MSA enters the information in RPMS/BPRM, makes a copy of the card, obtains a signed AOB and MSPQ, checks the patient into their appointment and sends the patient to the clinic.

SCENARIO 2

Same as 1 and…

The MSA inquires with the patient regarding their Medicare Part B coverage, the patient states that they could not afford the coverage and gets all their services at the IHS facility and didn't think they needed the coverage.

Case #2 Continued

SCENARIO 1	SCENARIO 2
Patient is seen in the clinic by the provider and after his visit, he goes to the pharmacy, picks up his prescriptions and goes home.  	The MSA explains that we have Patient Benefit Coordination services available that may be able to assist the patient with programs that can assist with Medicare part B premiums if they qualify and possibly even Medicare Part D for their prescription drugs that may not be available at the IHS pharmacy. The MSA contacts the PBC and notifies them that they have a patient that would like more information about Medicare payment assistance. After the interview is completed, copies made, AOB and MSPQ are completed and signed, information entered in RPMS/BPRM, the patient is checked into their appointment and the MSA directs the patient to stop by to see the PBC as they will be expecting them.

Scenario 2 Continued

The patient goes to the clinic and takes a seat in waiting area, the PBC introduces themselves and ask if the patient has time to visit with them today after their appointment or is there another time that is more convenient? The patient agrees to stop by after their doctor's visit.

After the visit the patient presents at the PBC office, the PBC welcomes them and inquires about their decision to decline Part B coverage. After the patient explains that they didn't feel they could afford the $164.90 per month premium for CY 2023 so they declined the coverage at enrollment.

The PBC continues their interview with the patient, learns that the patient should qualify for the Specified Low-Income **Medicare Beneficiary** (SLMB) or Qualifying Individual (QI) programs that will help pay for Medicare Part B premiums and possibly Medicaid coverage that will pay as secondary to Medicare. The PBC goes on to explain the **Initial Enrollment Window** and that it is a great thing that they are in that window so they can add Part B for no cost to the patient and avoid any penalties that could stay with them for their lifetime and may even be eligible for Extra Help that could assist with Medicare Part D coverage

Scenario #2

Your **Medicare Initial Enrollment** Period begins three months before you turn 65, the month of your 65th birthday, and continues for three months after your birthday month. Totaling seven months in which you can actively sign up for Part A and Part B unless you qualify for automatic **enrollment**

The PBC assists the patient with the completion of the Medicaid application for assistance, obtains signature and necessary document copies and submits the application to the appropriate agency for processing. PBC then enters their notes and application in BPRM/RPMS with the status of PENDING.

The PBC sets a reminder on their calendar to follow up on application in 30 days

30 days later the PBC checks on status and finds that the patient has been approved for SLMB, Medicaid and Extra Help, the coverages and effective dates of coverage are entered into RPMS/BPRM, the application status is changed to APPROVED, notes are entered and RPMS/BPRM is documented that coverage was entered.

Case #2 Continued

SCENARIO 1

The actions of this MSA result in **$0.00** in revenue for your facility

Medicare Part A covers Inpatient services and there is no coverage for Outpatient visits. The patient does not have any Medicare Part D coverage so there would not be any payment for any RX the patient may be getting that day.

SCENARIO 2

Once coverage is entered, all Outpatient appointments will be reimbursed at 100% with Medicare B as primary and Medicaid is secondary:

Medicare Part B Pro Fee will be reimbursed at 80% of the Medicare Physician Fee Schedule and Medicaid will pay remaining 20% and those payments will vary between **$25-100** per visit depending on the service provided.

Medicare Part D will pay for all covered RX and those payments will vary also.

If your facility is a provider based hospital clinic, all sites located in Oklahoma, you will also be able to bill a facility claim for the all inclusive rate of $620.00 for CY 2023 which is paid at 80% resulting in a payment of **$496.00**

Medicaid would reimburse the remaining 20%, **124.00** for a total of **$620.00**

Clinical Services

Clinical Services

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. Checks the patient in, creating the visit, or establishing the account.

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.

Case Scenario for Clinical Services

CASE 1: Patient presents to the same-day clinic complaining of chest heaviness stating they can't draw a full breath. There is a pain in the left arm that has been present since waking up 3 hours ago.

Standards of care, SOP, or clinic protocols should immediately kick in. Patient is taken immediately to the triage area, nurse does quick assessment, notifies ER of incoming patient. ***Know your facilities protocols for heart attack, or stroke symptoms, severe puncture wounds, gunshot or high risk, life threatening situations for ER services and follow those standards of care.***

Revenue implications of the Triage nurse decision and subsequent care provided: ER services are a higher level of service, higher level of care, higher level of medical decision making. Codes range from 99281-99285. Prices range from $136.82 to $584.41. For IHS, and for AIR (Medicaid), payment would be **$654**. We don't bill with line item pricing.

For Private Insurance, each service is billed, labs, as well as any incidental procedures. This is where an ER visit could result with **$1,500** or more depending on what labs were ordered, procedures implemented and care provided.

Health Information Management

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

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”

Billing Timelines

- 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.

Billing Process Timelines

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

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

Third Party Internal Control Policy: Billing

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.

Billing Case Scenario

Biller completes billing for the day and exports all claims billed to Medicare, Medicaid and PI for the day, the biller signs out of their session and goes home for the day. The next morning, the biller starts billing from their assigned lists and exports at the end of the day.

What is wrong with this scenario?

The biller did not follow through the process and reconcile the files to insure that the files were accepted, nor do they know if there were rejected claims in the file.

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 file that was never accepted.

You do not want to wait until someone is looking at the aged claims and find the error in 45 days.

This will result in lost or delayed revenue!!

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 Receivable

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

Accounts Receivable

The Third Party Internal Control states:

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.

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.

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

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?

Account Follow Up

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.

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

Debt Management

Debt Management

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

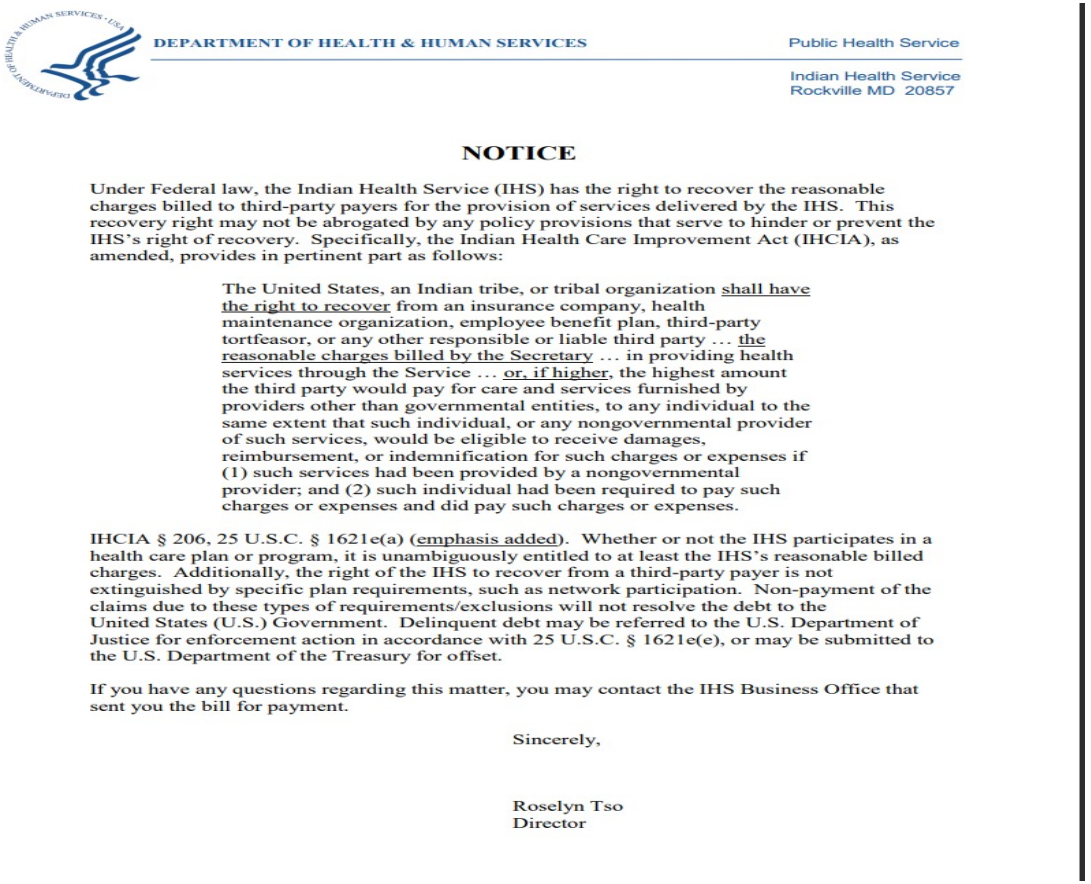
Each Service Unit is responsible for creating a Service Unit-specific operational plan regarding debt management. An Operational plan is an organized plan of action incorporating the various collection tools to be used to recover debt. ***Since the Debt Collection Improvement Act (DCIA) requires all 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.

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

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

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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