Indian Health Service

IHS Revenue Cycle History – Rainbow Book

LESLIE REECE
BEMIDJI AREA BOC

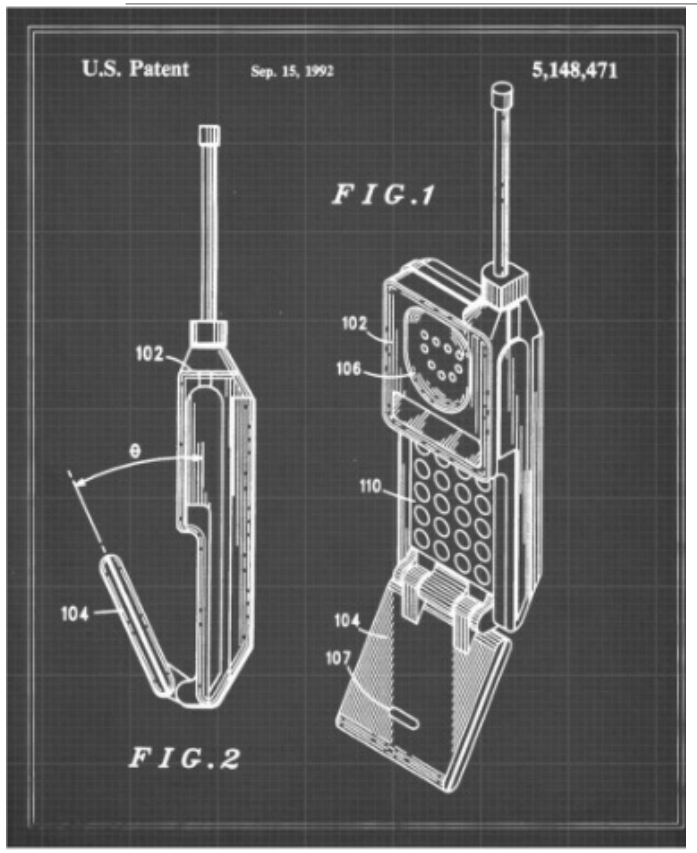
RAHO ORTIZ
DIRECTOR, DBOP

ADRIAN LUSAN
IT SPECIALIST

AUGUST 22-24, 2023

1992

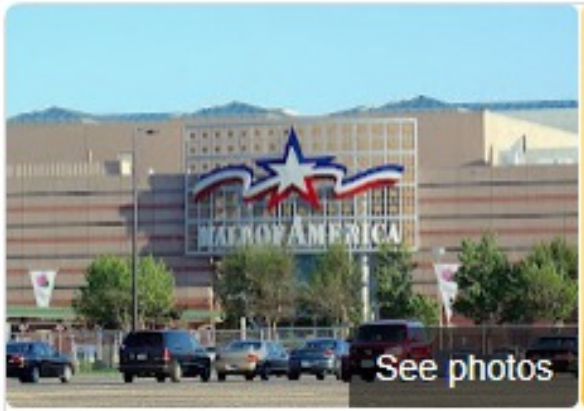
Goosebump series by R. L. Stine is released

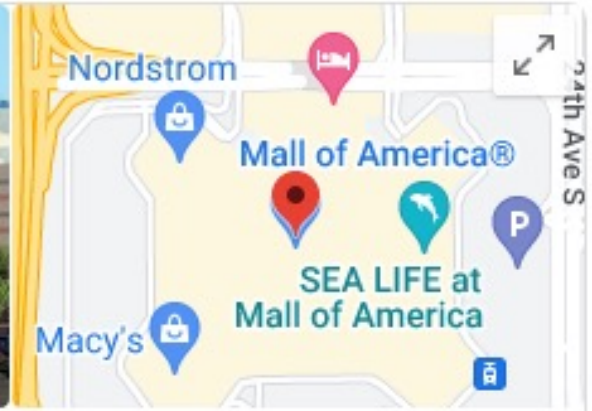


First Motorola Flip Phone - 1992

Mall of America Opens - 1992

Bill Clinton wins 1992 Presidential Election





Mall of America®

Website | Directions | Save

4.5 ★★★★½ 54,839 Google reviews

Shopping mall

Giant 4-level mall with hundreds of stores, plus restaurants, a theme park, cinema & aquarium.

Address: 60 E Broadway, Bloomington, MN 55425

Hours: Open · Closes 9 PM

Updated by this business 7 weeks ago

Phone: (952) 883-8800

Slang terms - 1992:

Talk to the hand!

As if!

Booyah!

Not!

Aiight!

Whatever!

Sup

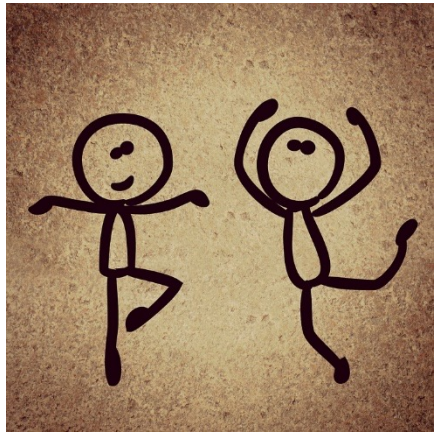
You go, girl!

Country Music and Line Dancing

Billy Ray Cyrus: Achy Breaky Heart

Brooks and Dunn: Boot Scoot'in Boogy

Entertainer of the year: Garth Brooks



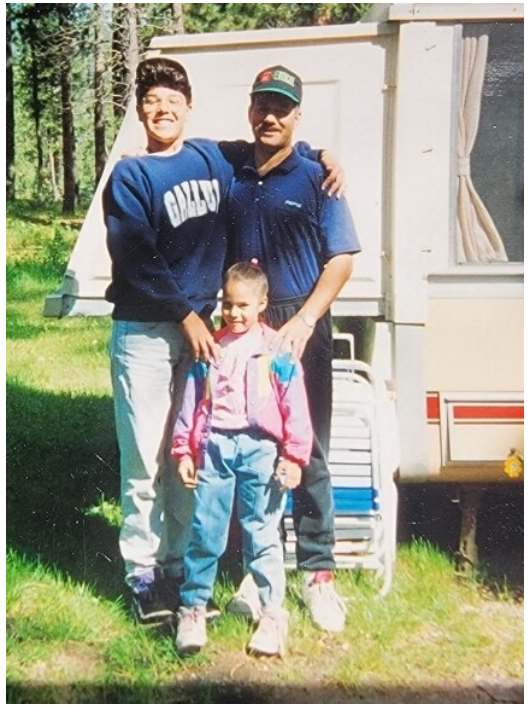
INTERACTIVE

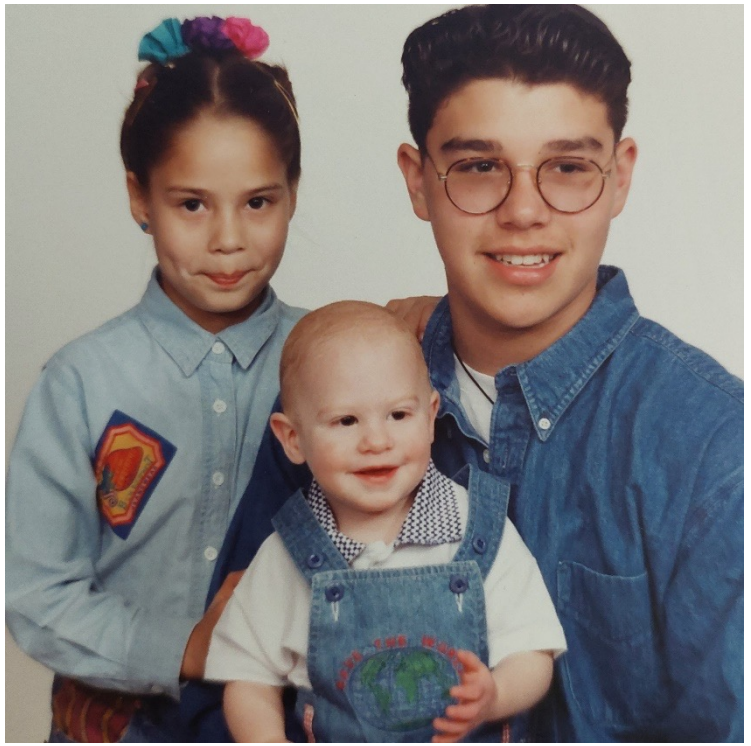
WHAT WERE YOU DOING IN 1992?

Leslie - 1992

CBO Manager-St. Luke's Health System

Adopted 2 children 3months apart, one 5 year old girl and 1 baby boy: Black Hills Camping Trip

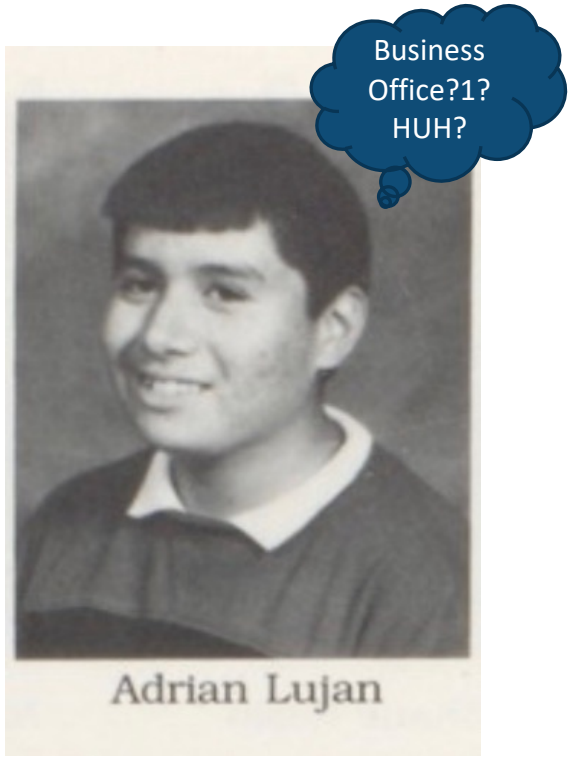




Now

Adrian

THEN: JUNIOR IN HIGH SCHOOL



NOW: ??

Raho

Audience time:

Does anyone want to share what was happening in 1992?

What were you doing?

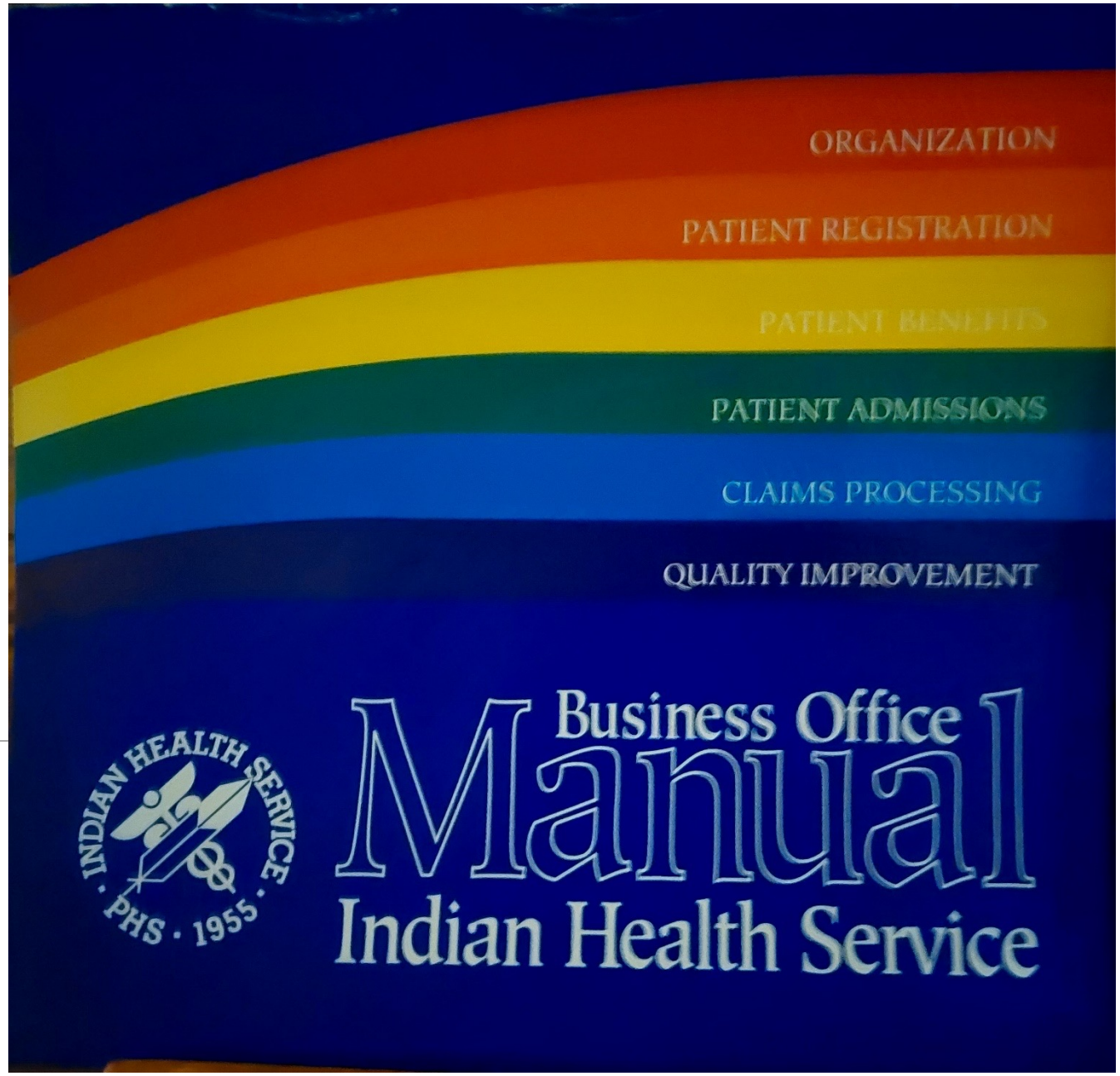
RAINBOW BOOK

BUSINESS OFFICE MANUAL

This is the Rainbow Book

Business Office Manual
Indian Health Service

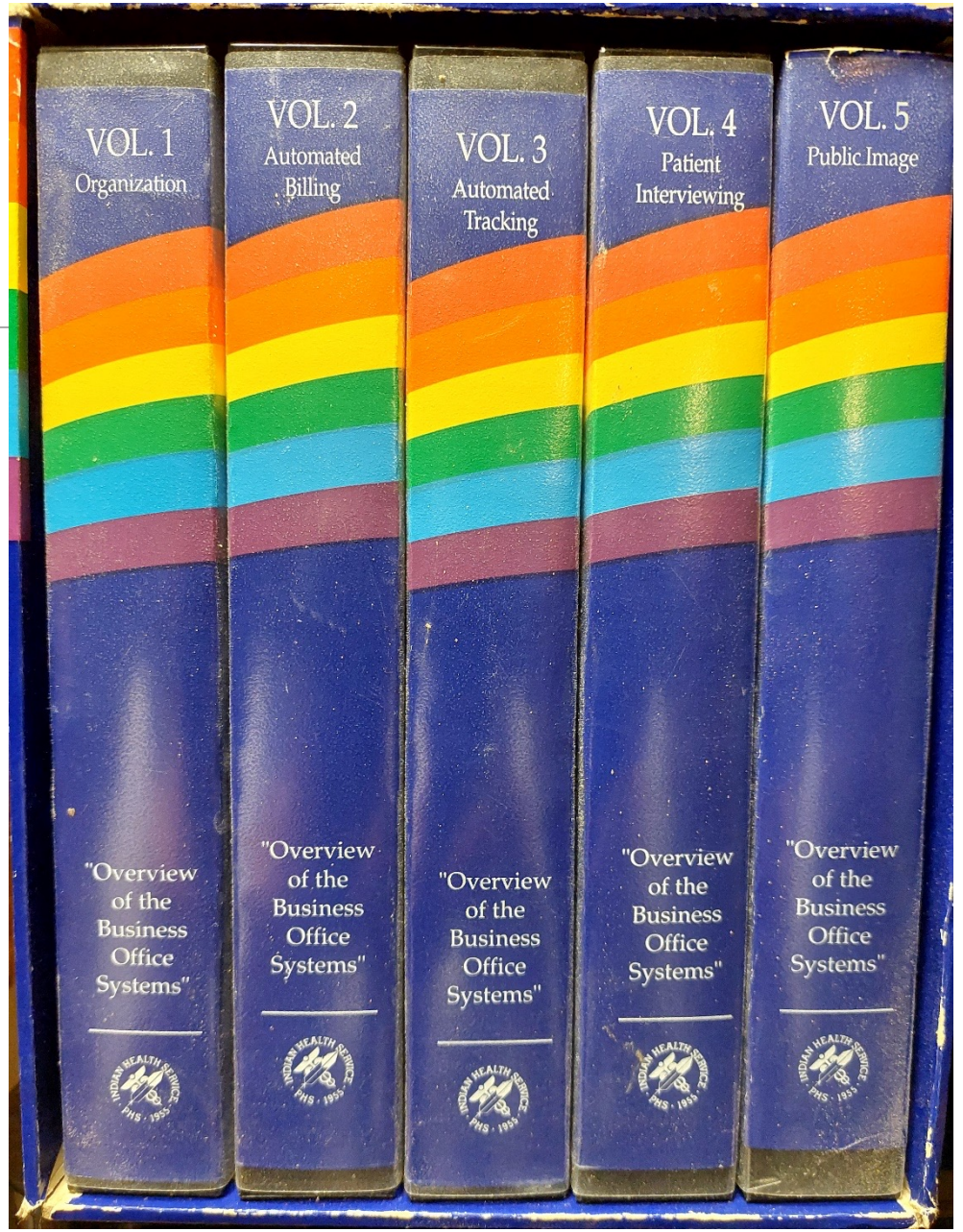
Chapter One: Organization
Chapter Two: Patient Registration
Chapter Three: Patient Benefits
Chapter Four: Patient Admissions
Chapter Five: Claims Processing
Chapter Six: Quality Improvement



Training Tapes

Training Tapes were created to accompany the “Overview of the Business Office Systems”.

Volume 1: Organization
Volume 2: Automated Billing
Volume 3: Automated Tracking
Volume 4: Patient Interviewing
Volume 5: Public Image

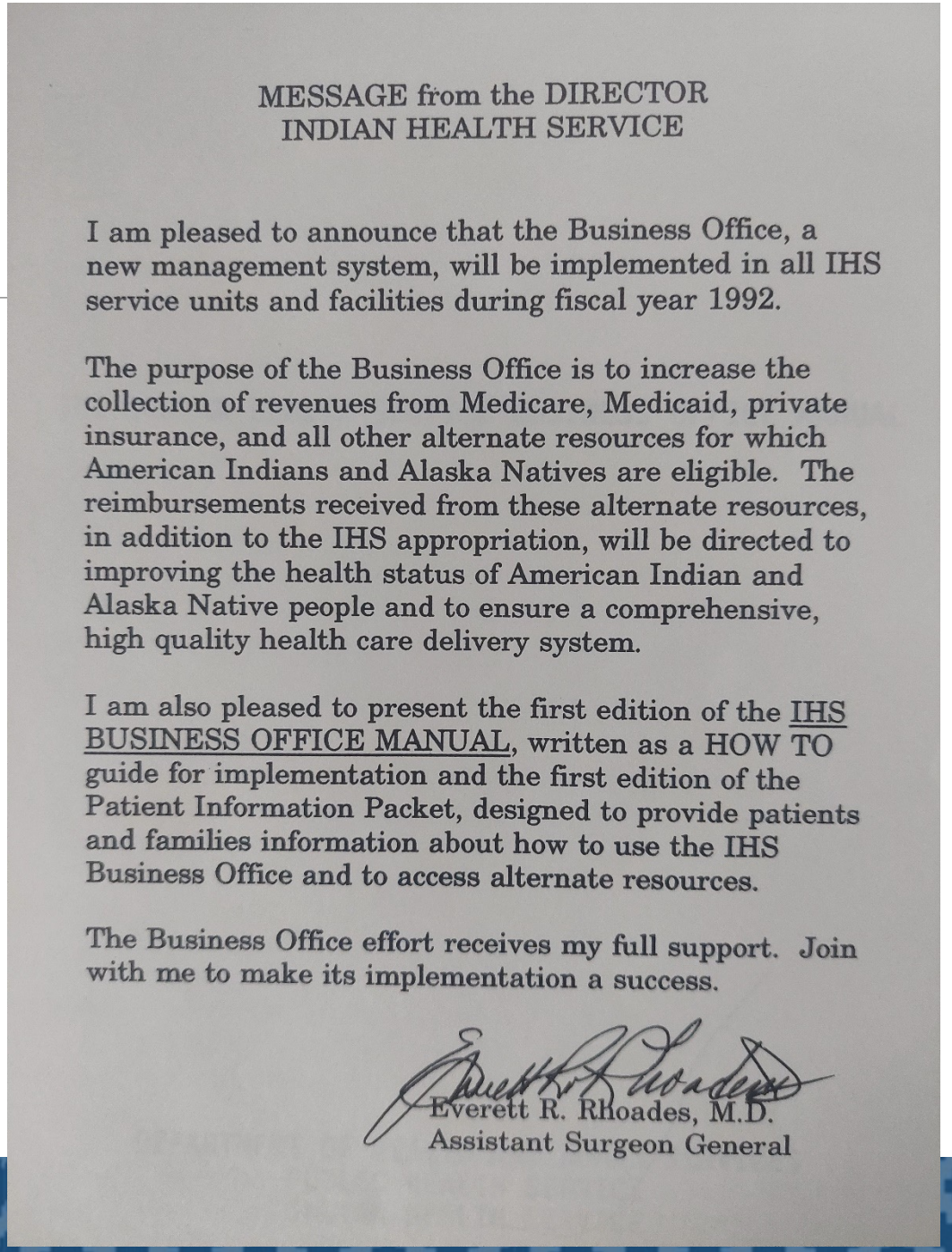


Official *"WORD"*

Creation of the Business Office - FY1992

First Edition:
IHS BUSINESS OFFICE MANUAL

"HOW TO"



MESSAGE from the DIRECTOR
INDIAN HEALTH SERVICE

I am pleased to announce that the Business Office, a new management system, will be implemented in all IHS service units and facilities during fiscal year 1992.

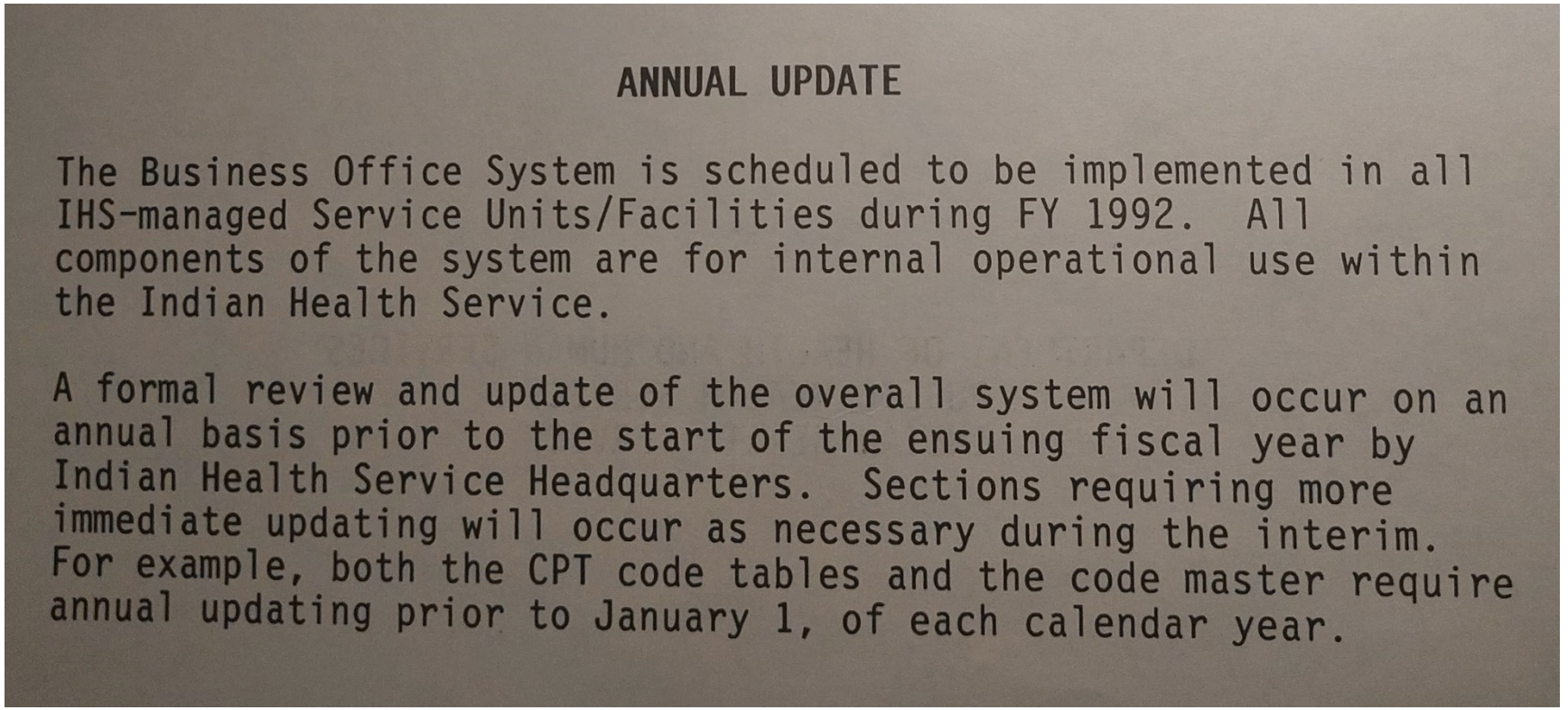
The purpose of the Business Office is to increase the collection of revenues from Medicare, Medicaid, private insurance, and all other alternate resources for which American Indians and Alaska Natives are eligible. The reimbursements received from these alternate resources, in addition to the IHS appropriation, will be directed to improving the health status of American Indian and Alaska Native people and to ensure a comprehensive, high quality health care delivery system.

I am also pleased to present the first edition of the IHS BUSINESS OFFICE MANUAL, written as a HOW TO guide for implementation and the first edition of the Patient Information Packet, designed to provide patients and families information about how to use the IHS Business Office and to access alternate resources.

The Business Office effort receives my full support. Join with me to make its implementation a success.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Update Schedule



ANNUAL UPDATE

The Business Office System is scheduled to be implemented in all IHS-managed Service Units/Facilities during FY 1992. All components of the system are for internal operational use within the Indian Health Service.

A formal review and update of the overall system will occur on an annual basis prior to the start of the ensuing fiscal year by Indian Health Service Headquarters. Sections requiring more immediate updating will occur as necessary during the interim. For example, both the CPT code tables and the code master require annual updating prior to January 1, of each calendar year.

FEES

The copy of the Business Office Manual, Indian Health Service is yellowed and curled. It was hard to get a good copy of the information.

1992 Fees were:

Inpatient Services Per Day, Hospital: **$414**

Physician - **$23**

Outpatient Services: **$78** per visit.

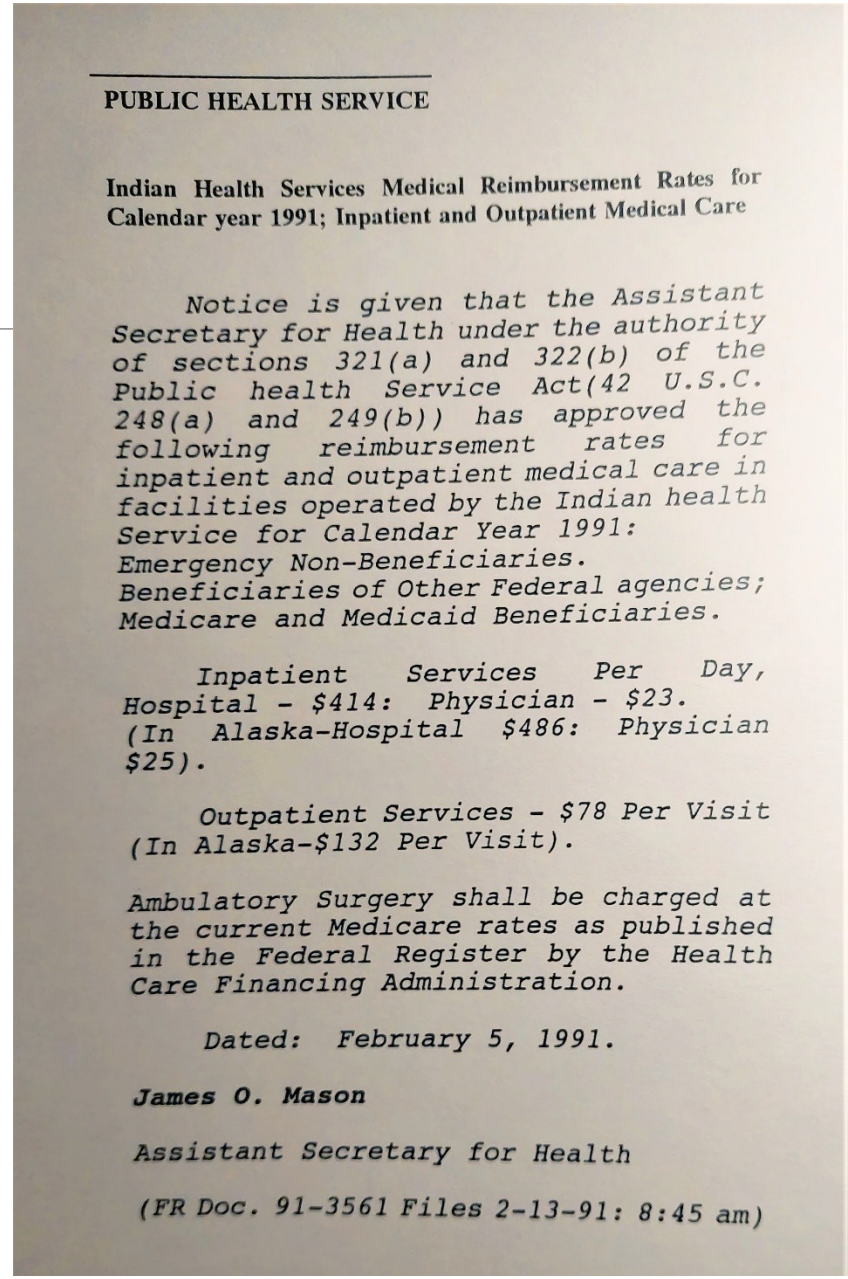
Ambulatory Surgery shall be charged at current Medicare rates as published…..

2023 OMB Rates are:

Medicaid: **$650** Outpatient Services

Medicare: **$620** Outpatient

$829 Inpatient



PUBLIC HEALTH SERVICE

Indian Health Services Medical Reimbursement Rates for Calendar year 1991; Inpatient and Outpatient Medical Care

Notice is given that the Assistant Secretary for Health under the authority of sections 321(a) and 322(b) of the Public health Service Act(42 U.S.C. 248(a) and 249(b)) has approved the following reimbursement rates for inpatient and outpatient medical care in facilities operated by the Indian health Service for Calendar Year 1991:
Emergency Non-Beneficiaries.
Beneficiaries of Other Federal agencies; Medicare and Medicaid Beneficiaries.

Inpatient Services Per Day, Hospital - $414: Physician - $23. (In Alaska-Hospital $486: Physician $25).

Outpatient Services - $78 Per Visit (In Alaska-$132 Per Visit).

Ambulatory Surgery shall be charged at the current Medicare rates as published in the Federal Register by the Health Care Financing Administration.

Dated: February 5, 1991.

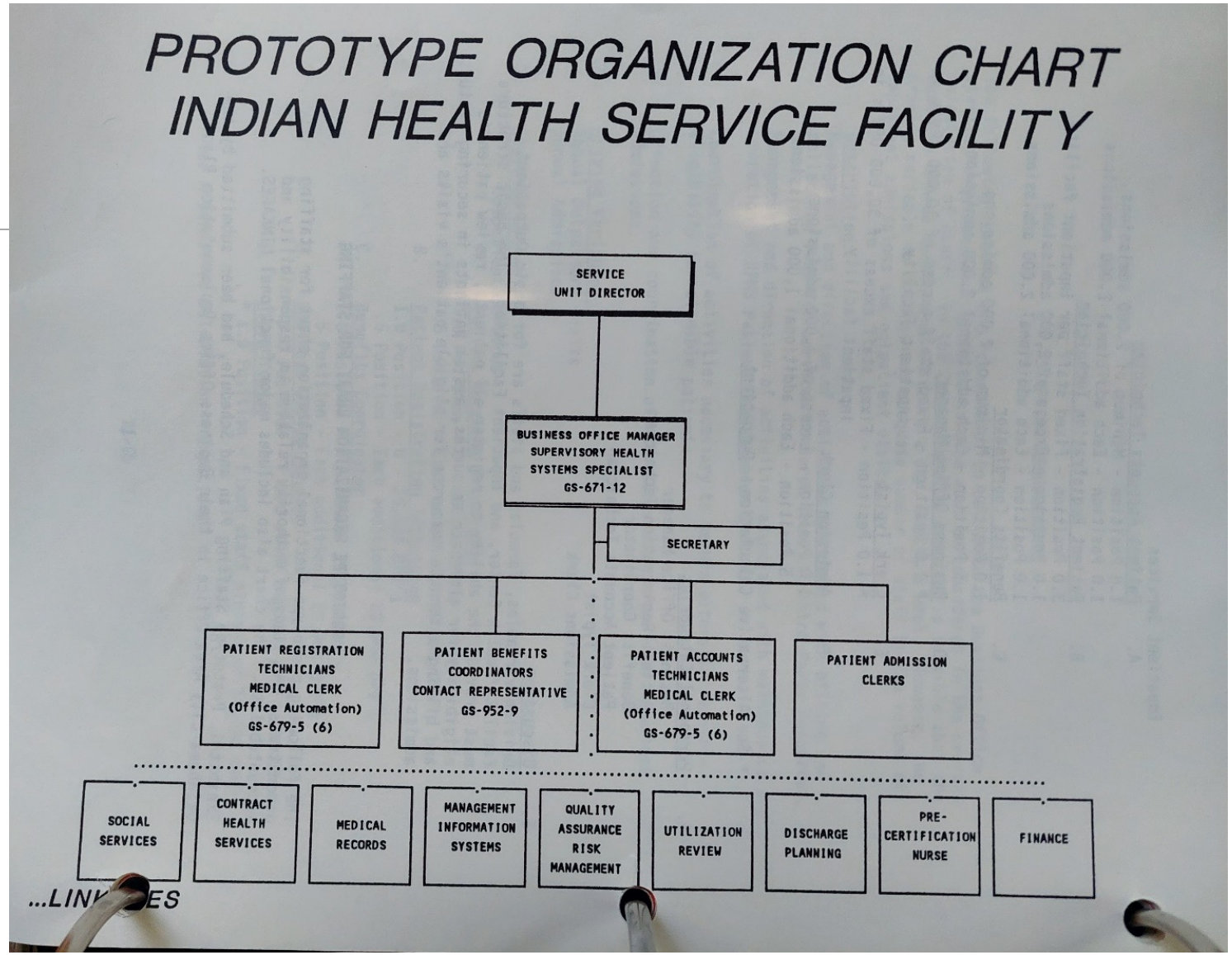
James O. Mason

Assistant Secretary for Health

(FR Doc. 91-3561 Files 2-13-91: 8:45 am)

Chapter One: ORGANIZATION

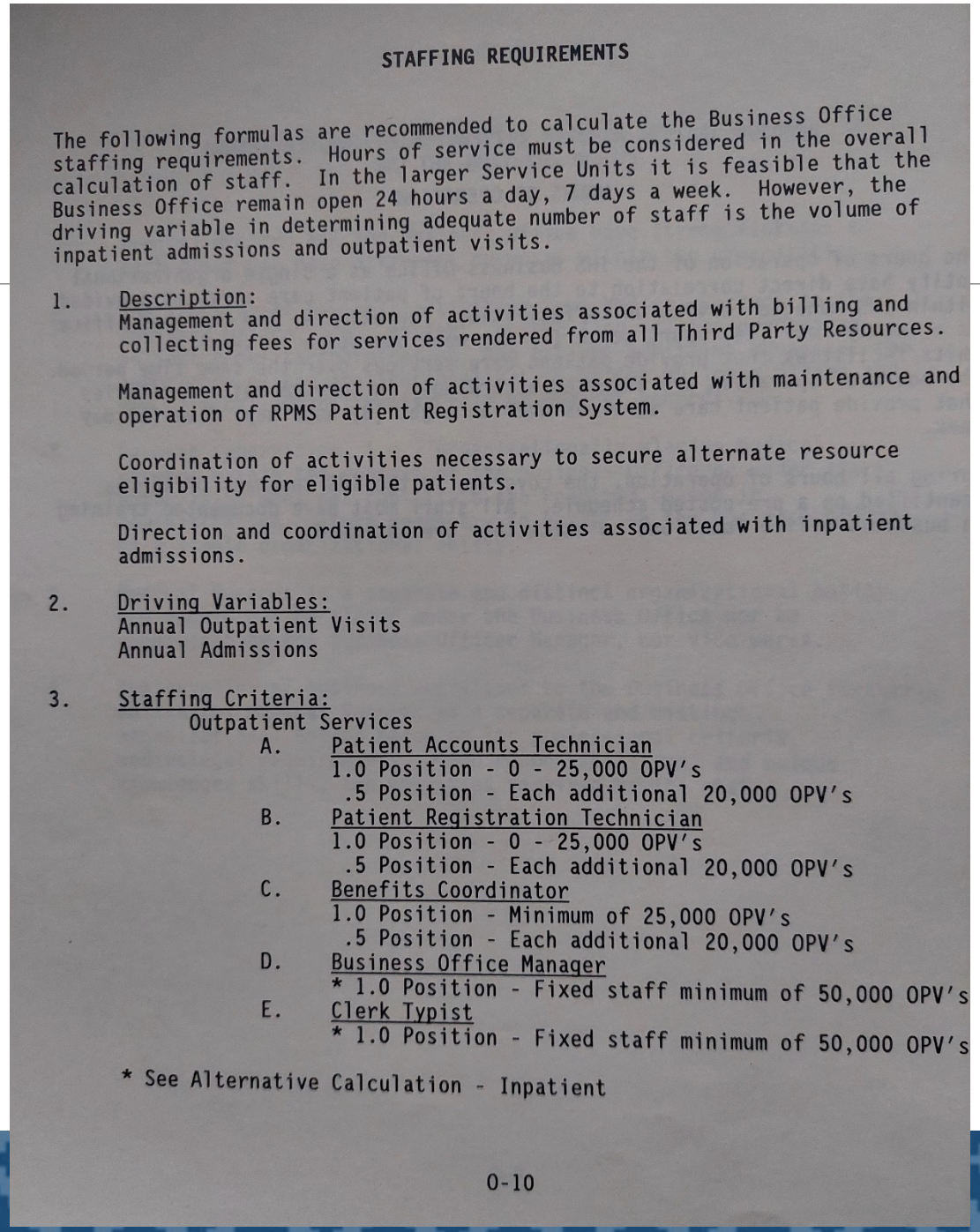
Organization Chart



Staffing

1992 staffing requirements
Based on outpatient visits =
1 AR Tech **25,000 Visits**
1 Reg Tech
1 Benefits Coordinator
1 Business Office Manager
1 Clerk Typist

2023 staffing breakout
Based on outpatient visits =
1 AR Tech **25,000 Visits**
1 Reg Tech
1 Benefits Coordinator
1 Business Office Manager
1 Clerk Typist



STAFFING REQUIREMENTS

The following formulas are recommended to calculate the Business Office staffing requirements. Hours of service must be considered in the overall calculation of staff. In the larger Service Units it is feasible that the Business Office remain open 24 hours a day, 7 days a week. However, the driving variable in determining adequate number of staff is the volume of inpatient admissions and outpatient visits.

1. Description:
Management and direction of activities associated with billing and collecting fees for services rendered from all Third Party Resources.

Management and direction of activities associated with maintenance and operation of RPMS Patient Registration System.

Coordination of activities necessary to secure alternate resource eligibility for eligible patients.

Direction and coordination of activities associated with inpatient admissions.

2. Driving Variables:
Annual Outpatient Visits
Annual Admissions

3. Staffing Criteria:
Outpatient Services
A. Patient Accounts Technician
1.0 Position - 0 - 25,000 OPV's
.5 Position - Each additional 20,000 OPV's
B. Patient Registration Technician
1.0 Position - 0 - 25,000 OPV's
.5 Position - Each additional 20,000 OPV's
C. Benefits Coordinator
1.0 Position - Minimum of 25,000 OPV's
.5 Position - Each additional 20,000 OPV's
D. Business Office Manager
* 1.0 Position - Fixed staff minimum of 50,000 OPV's
E. Clerk Typist
* 1.0 Position - Fixed staff minimum of 50,000 OPV's

* See Alternative Calculation - Inpatient

0-10

Staffing

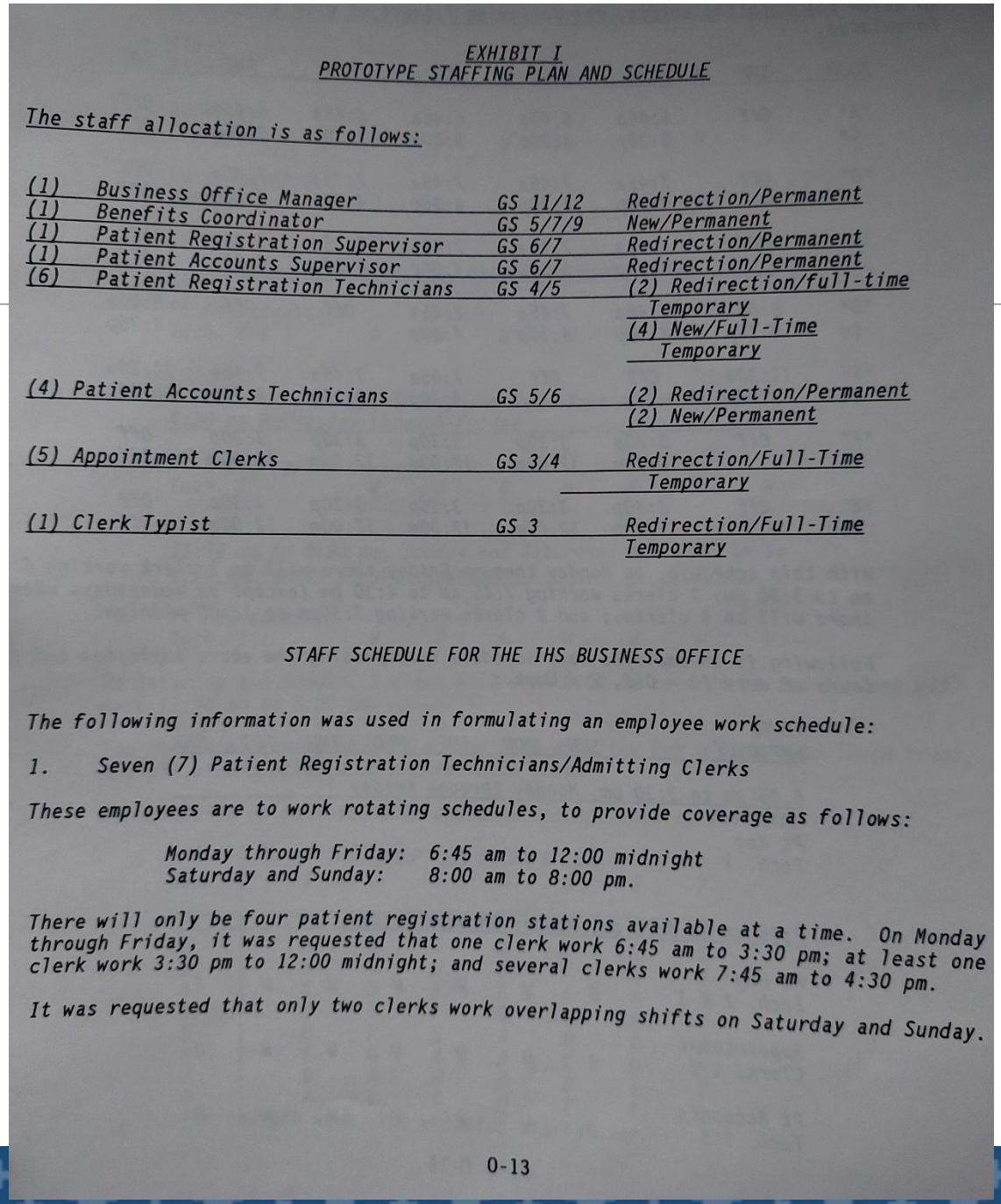


EXHIBIT I
PROTOTYPE STAFFING PLAN AND SCHEDULE

The staff allocation is as follows:

(1)	Business Office Manager	GS 11/12	Redirection/Permanent
(1)	Benefits Coordinator	GS 5/7/9	New/Permanent
(1)	Patient Registration Supervisor	GS 6/7	Redirection/Permanent
(1)	Patient Accounts Supervisor	GS 6/7	Redirection/Permanent
(6)	Patient Registration Technicians	GS 4/5	(2) Redirection/full-time Temporary (4) New/Full-Time Temporary
(4)	Patient Accounts Technicians	GS 5/6	(2) Redirection/Permanent (2) New/Permanent
(5)	Appointment Clerks	GS 3/4	Redirection/Full-Time Temporary
(1)	Clerk Typist	GS 3	Redirection/Full-Time Temporary

STAFF SCHEDULE FOR THE IHS BUSINESS OFFICE

The following information was used in formulating an employee work schedule:

1. Seven (7) Patient Registration Technicians/Admitting Clerks

These employees are to work rotating schedules, to provide coverage as follows:

Monday through Friday: 6:45 am to 12:00 midnight
Saturday and Sunday: 8:00 am to 8:00 pm.

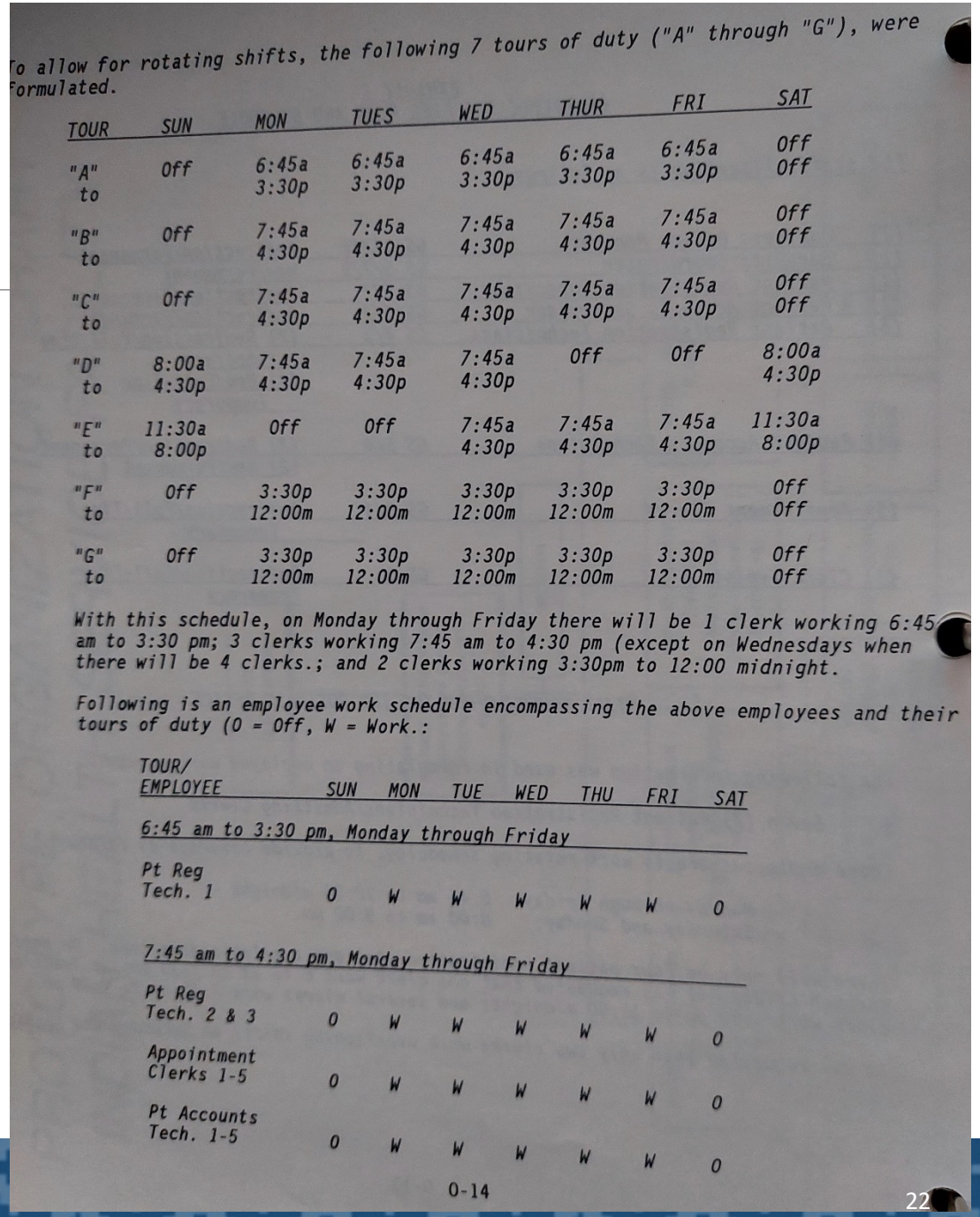
There will only be four patient registration stations available at a time. On Monday through Friday, it was requested that one clerk work 6:45 am to 3:30 pm; at least one clerk work 3:30 pm to 12:00 midnight; and several clerks work 7:45 am to 4:30 pm.

It was requested that only two clerks work overlapping shifts on Saturday and Sunday.

0-13

Staffing/Scheduling

Scheduling is staggered, rotating to accommodate the suggested schedule of M-F: 6:45 to 12M
S&S: 8-8



To allow for rotating shifts, the following 7 tours of duty ("A" through "G"), were formulated.

TOUR	SUN	MON	TUES	WED	THUR	FRI	SAT
"A"	Off	6:45a	6:45a	6:45a	6:45a	6:45a	Off
to		3:30p	3:30p	3:30p	3:30p	3:30p	Off
"B"	Off	7:45a	7:45a	7:45a	7:45a	7:45a	Off
to		4:30p	4:30p	4:30p	4:30p	4:30p	Off
"C"	Off	7:45a	7:45a	7:45a	7:45a	7:45a	Off
to		4:30p	4:30p	4:30p	4:30p	4:30p	Off
"D"	8:00a	7:45a	7:45a	7:45a	Off	Off	8:00a
to	4:30p	4:30p	4:30p	4:30p			4:30p
"E"	11:30a	Off	Off	7:45a	7:45a	7:45a	11:30a
to	8:00p			4:30p	4:30p	4:30p	8:00p
"F"	Off	3:30p	3:30p	3:30p	3:30p	3:30p	Off
to		12:00m	12:00m	12:00m	12:00m	12:00m	Off
"G"	Off	3:30p	3:30p	3:30p	3:30p	3:30p	Off
to		12:00m	12:00m	12:00m	12:00m	12:00m	Off

With this schedule, on Monday through Friday there will be 1 clerk working 6:45 am to 3:30 pm; 3 clerks working 7:45 am to 4:30 pm (except on Wednesdays when there will be 4 clerks.; and 2 clerks working 3:30pm to 12:00 midnight.

Following is an employee work schedule encompassing the above employees and their tours of duty (O = Off, W = Work.:

TOUR/ EMPLOYEE	SUN	MON	TUE	WED	THU	FRI	SAT
6:45 am to 3:30 pm, Monday through Friday							
Pt Reg Tech. 1	O	W	W	W	W	W	O
7:45 am to 4:30 pm, Monday through Friday							
Pt Reg Tech. 2 & 3	O	W	W	W	W	W	O
Appointment Clerks 1-5	O	W	W	W	W	W	O
Pt Accounts Tech. 1-5	O	W	W	W	W	W	O

O-14

Positions of Business Office

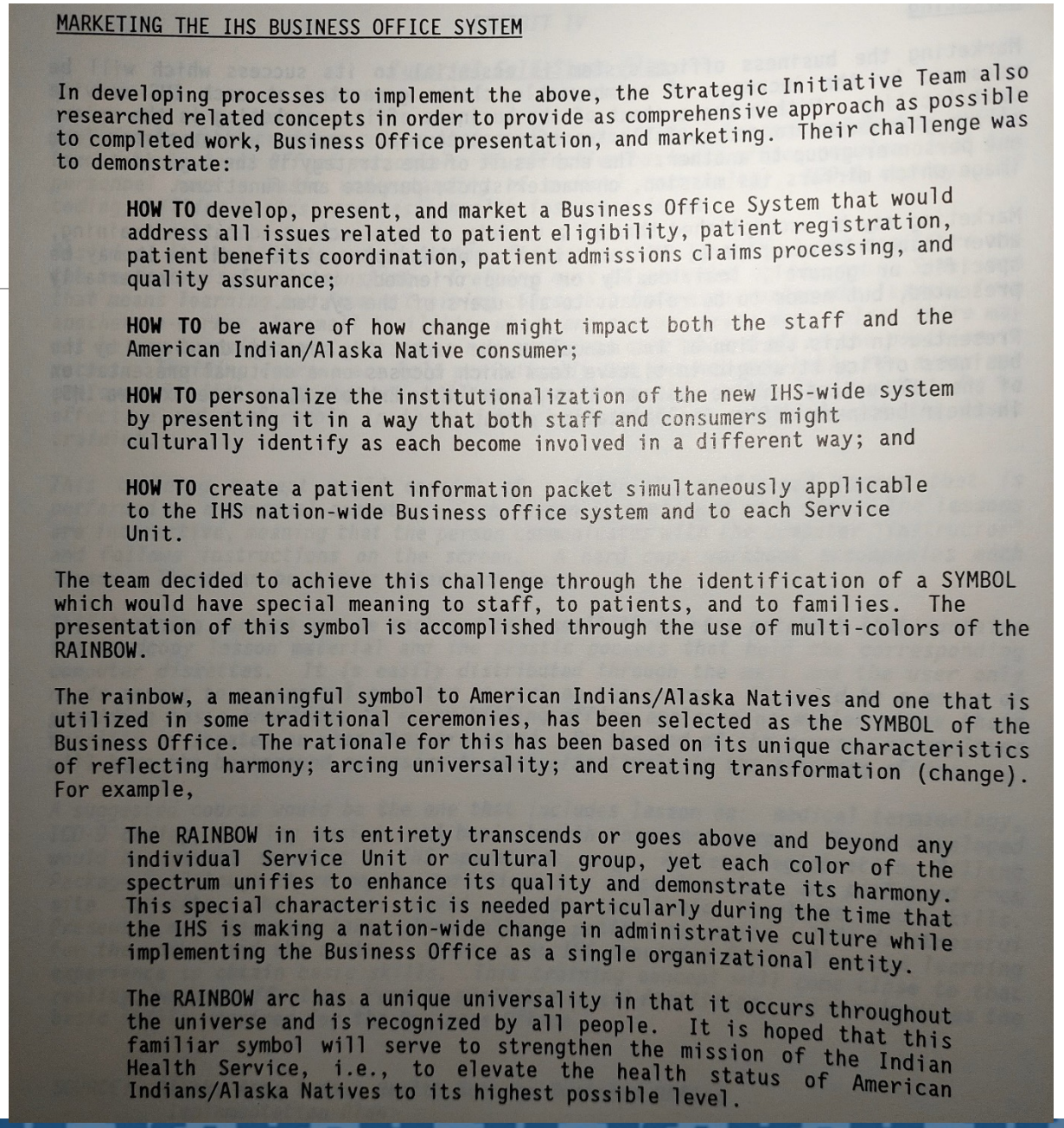
Supervisory BOM – 12	Large facility/hospital
Supervisory BOM – 11	Medium facility/hospital
Supervisory BOM – 9	Small facility/hospital
Contact Rep – 9	Benefits Coordinator
Patient Reg Clerk – 5,6,7	Medical Clerk (Office Automation)
Supervisory Reg Clerk	7 (Lead)

Position descriptions are included in this section of the Manual. Some of them are still in use today. There are pages of how to compute and rate the position grades.

Training plans for release are included. Of interest, Medical Terminology was a requirement of all positions, including Registration. Quizzes 1-4 were required. Unfortunately those quizzes were not included, that would be fun to take!

Marketing the Business Office

The Creation of the term"
"Rainbow Book"



MARKETING THE IHS BUSINESS OFFICE SYSTEM

In developing processes to implement the above, the Strategic Initiative Team also researched related concepts in order to provide as comprehensive approach as possible to completed work, Business Office presentation, and marketing. Their challenge was to demonstrate:

HOW TO develop, present, and market a Business Office System that would address all issues related to patient eligibility, patient registration, patient benefits coordination, patient admissions claims processing, and quality assurance;

HOW TO be aware of how change might impact both the staff and the American Indian/Alaska Native consumer;

HOW TO personalize the institutionalization of the new IHS-wide system by presenting it in a way that both staff and consumers might culturally identify as each become involved in a different way; and

HOW TO create a patient information packet simultaneously applicable to the IHS nation-wide Business office system and to each Service Unit.

The team decided to achieve this challenge through the identification of a SYMBOL which would have special meaning to staff, to patients, and to families. The presentation of this symbol is accomplished through the use of multi-colors of the RAINBOW.

The rainbow, a meaningful symbol to American Indians/Alaska Natives and one that is utilized in some traditional ceremonies, has been selected as the SYMBOL of the Business Office. The rationale for this has been based on its unique characteristics of reflecting harmony; arcing universality; and creating transformation (change). For example,

The RAINBOW in its entirety transcends or goes above and beyond any individual Service Unit or cultural group, yet each color of the spectrum unifies to enhance its quality and demonstrate its harmony. This special characteristic is needed particularly during the time that the IHS is making a nation-wide change in administrative culture while implementing the Business Office as a single organizational entity.

The RAINBOW arc has a unique universality in that it occurs throughout the universe and is recognized by all people. It is hoped that this familiar symbol will serve to strengthen the mission of the Indian Health Service, i.e., to elevate the health status of American Indians/Alaska Natives to its highest possible level.

Marketing p2

The RAINBOW creates a unique environmental change and generates a valued transforming energy that has the potential to create change in individuals and groups.

The use of color in the environment plays a very important role in health care. For example, the color blue is known as a calming color and can bring on an actual decrease in cardiac rate, respiratory rate, and blood pressure. It is also known to reduce tension and stress. Blue is the color of choice selected as the background color for the covers of the business office materials, i.e., manual, packet, signs and video tapes.

The multi-colors of the rainbow are known to have both warm and cool effects. For example, yellow, red, and orange are warm colors and stimulate creative contented responses. Blue, green, and violet are cool colors and tend to encourage meditation and deliberation. The specific shades of the various colors of the rainbow selected for the Business Office materials are known as strong colors and tend to promote assertiveness.

The rainbow symbol blends both warm and cool colors, balancing the quality of harmony with the stress of change.

Training

A national training plan is enclosed with suggestion to provide documented training.

An Area plan for training is enclosed.

Using the accompanying Rainbow Tapes, there is a self-tutorial plan outlined:

- Volume 1: Organization
- Volume 2: Automated Billing
- Volume 3: Automated Tracking
- Volume 4: Patient Interviewing
- Volume 5: Public Image

Chapter Two: Patient Registration

Contents:

Goal

Objective

User Expectation: how to register, input into computer, validate

Introduction

Policy

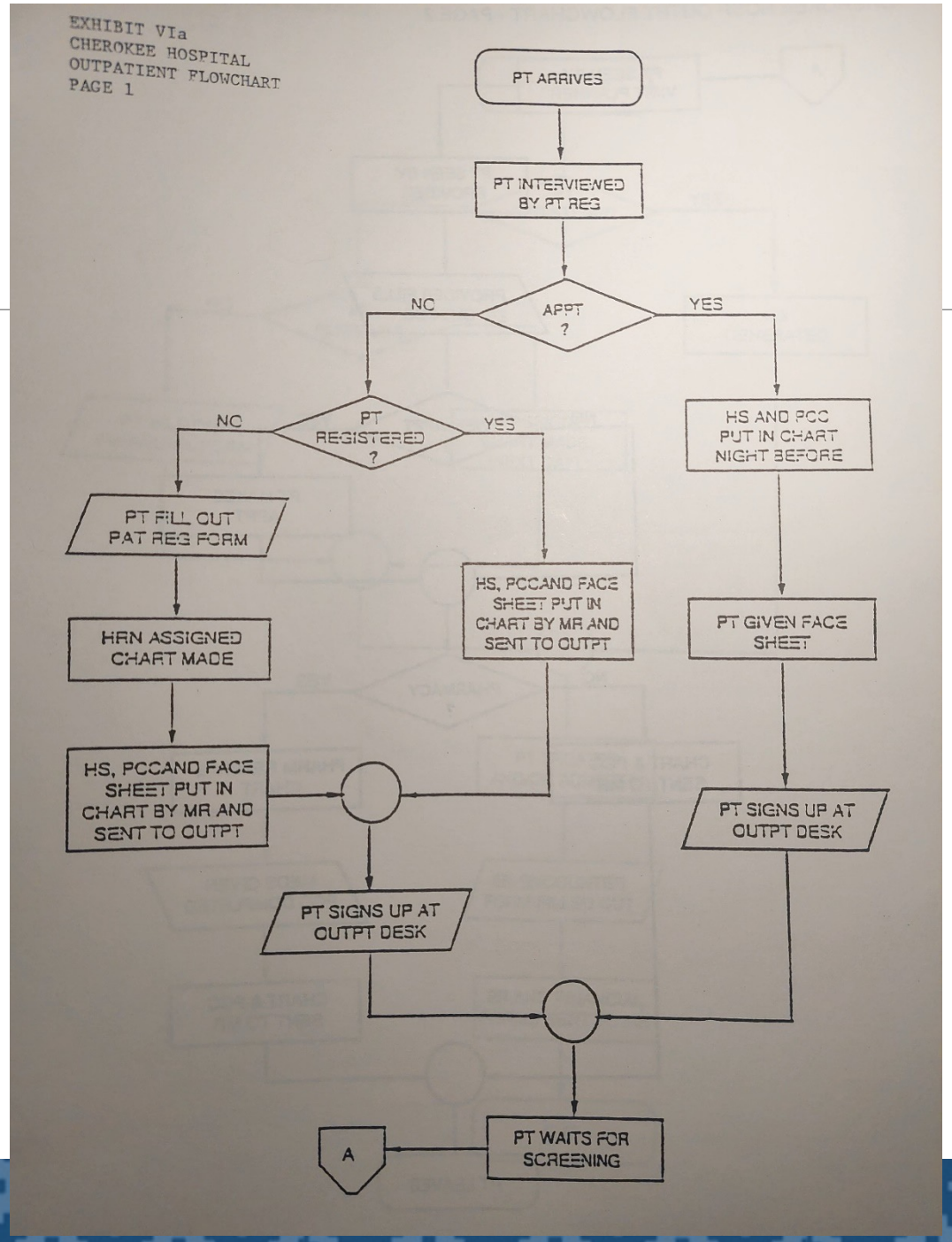
Location of Registration Function

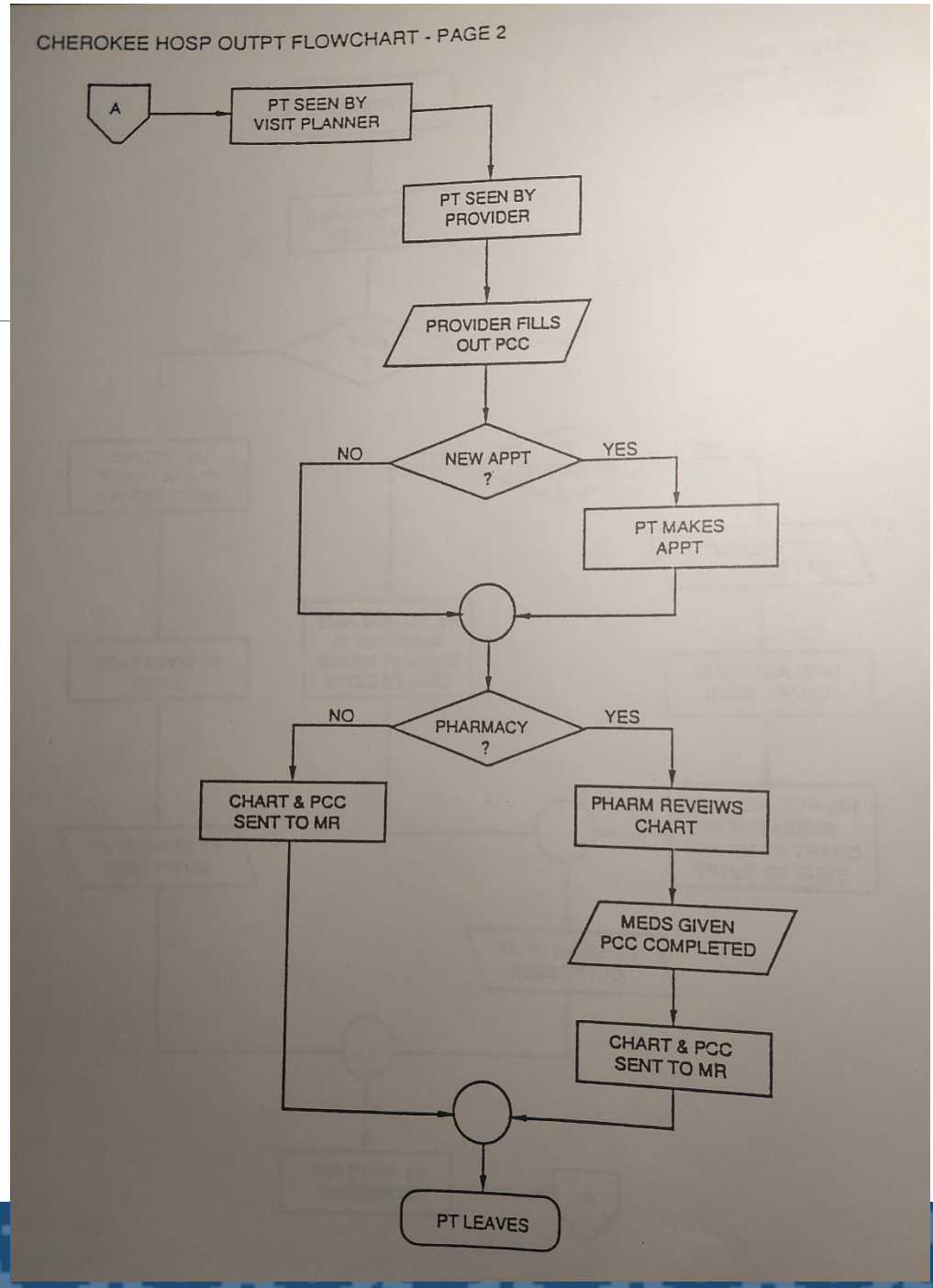
Staffing Requirements

Equipment

- User Manual
- Flow Charts: Outpatient, ER and Dental

Outpatient Visit Flowchart





Equipment for Registration Staff - 1992

Addressograph embossing equipment

Imprinter for embossing equipment

Computer Terminal

Printer

Photocopy machine

Typewriter

Typical office furniture

Patient ID bracelet machine

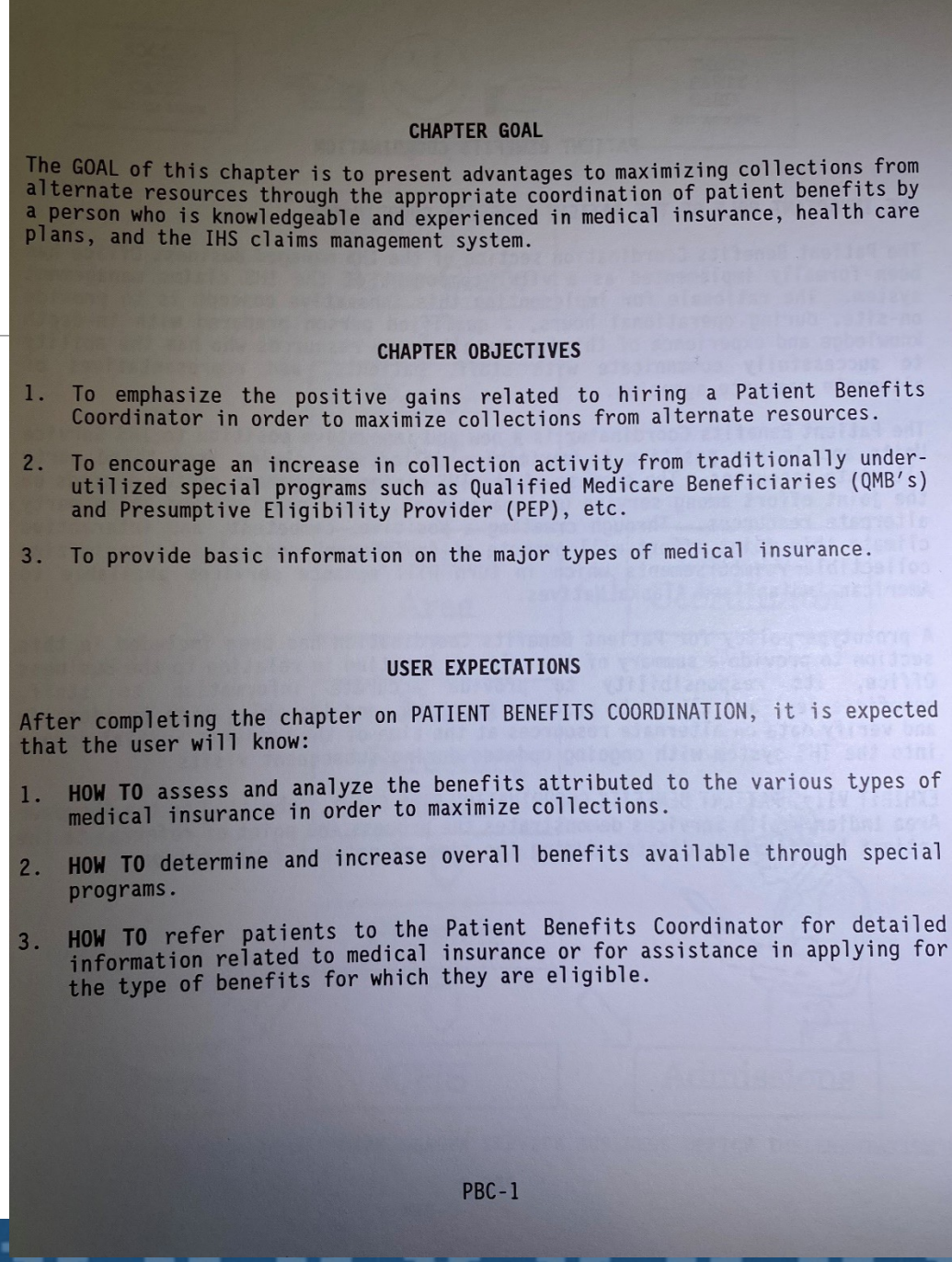
Chapter Three: Patient Benefits Coordination

Patient Benefits Coordination

CHAPTER GOAL

CHAPTER OBJECTIVES

USER EXPECTATIONS



CHAPTER GOAL

The GOAL of this chapter is to present advantages to maximizing collections from alternate resources through the appropriate coordination of patient benefits by a person who is knowledgeable and experienced in medical insurance, health care plans, and the IHS claims management system.

CHAPTER OBJECTIVES

1. To emphasize the positive gains related to hiring a Patient Benefits Coordinator in order to maximize collections from alternate resources.
2. To encourage an increase in collection activity from traditionally under-utilized special programs such as Qualified Medicare Beneficiaries (QMB's) and Presumptive Eligibility Provider (PEP), etc.
3. To provide basic information on the major types of medical insurance.

USER EXPECTATIONS

After completing the chapter on PATIENT BENEFITS COORDINATION, it is expected that the user will know:

1. **HOW TO** assess and analyze the benefits attributed to the various types of medical insurance in order to maximize collections.
2. **HOW TO** determine and increase overall benefits available through special programs.
3. **HOW TO** refer patients to the Patient Benefits Coordinator for detailed information related to medical insurance or for assistance in applying for the type of benefits for which they are eligible.

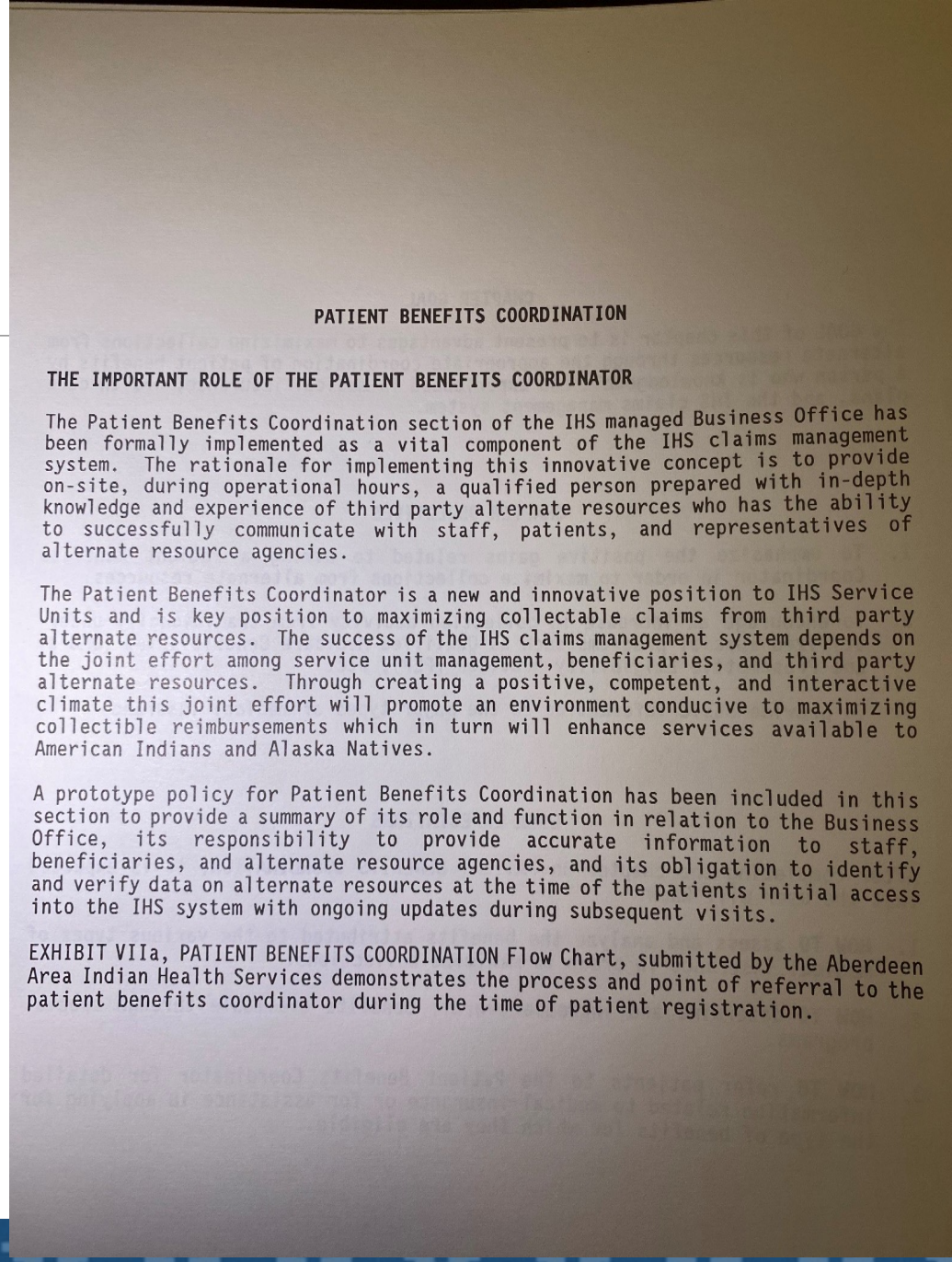
PBC-1

Patient Benefits Coordination

This emphasizes that PBC is vital component of the IHS claims management system.

GOAL = is to provide on-site, a qualified person prepared with in-depth knowledge and experience of third-party alternate resources who has the ability to successfully communicate with staff, patients, and representatives of alternate resource agencies.

The success of the IHS claims management system depends on the joint effort among service unit management, beneficiaries, and third-party alternate resources.



PATIENT BENEFITS COORDINATION

THE IMPORTANT ROLE OF THE PATIENT BENEFITS COORDINATOR

The Patient Benefits Coordination section of the IHS managed Business Office has been formally implemented as a vital component of the IHS claims management system. The rationale for implementing this innovative concept is to provide on-site, during operational hours, a qualified person prepared with in-depth knowledge and experience of third party alternate resources who has the ability to successfully communicate with staff, patients, and representatives of alternate resource agencies.

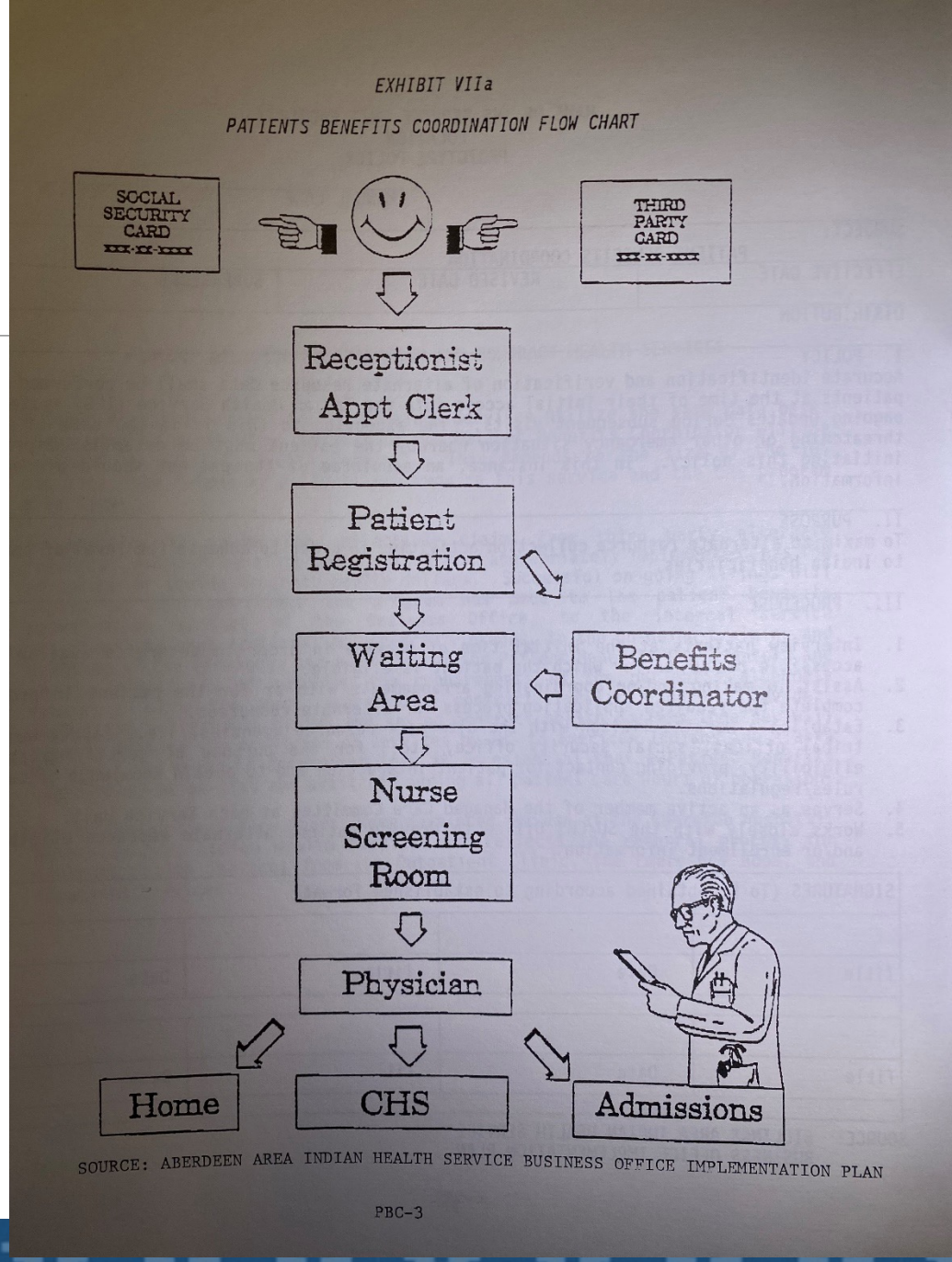
The Patient Benefits Coordinator is a new and innovative position to IHS Service Units and is key position to maximizing collectable claims from third party alternate resources. The success of the IHS claims management system depends on the joint effort among service unit management, beneficiaries, and third party alternate resources. Through creating a positive, competent, and interactive climate this joint effort will promote an environment conducive to maximizing collectible reimbursements which in turn will enhance services available to American Indians and Alaska Natives.

A prototype policy for Patient Benefits Coordination has been included in this section to provide a summary of its role and function in relation to the Business Office, its responsibility to provide accurate information to staff, beneficiaries, and alternate resource agencies, and its obligation to identify and verify data on alternate resources at the time of the patients initial access into the IHS system with ongoing updates during subsequent visits.

EXHIBIT VIIa, PATIENT BENEFITS COORDINATION Flow Chart, submitted by the Aberdeen Area Indian Health Services demonstrates the process and point of referral to the patient benefits coordinator during the time of patient registration.

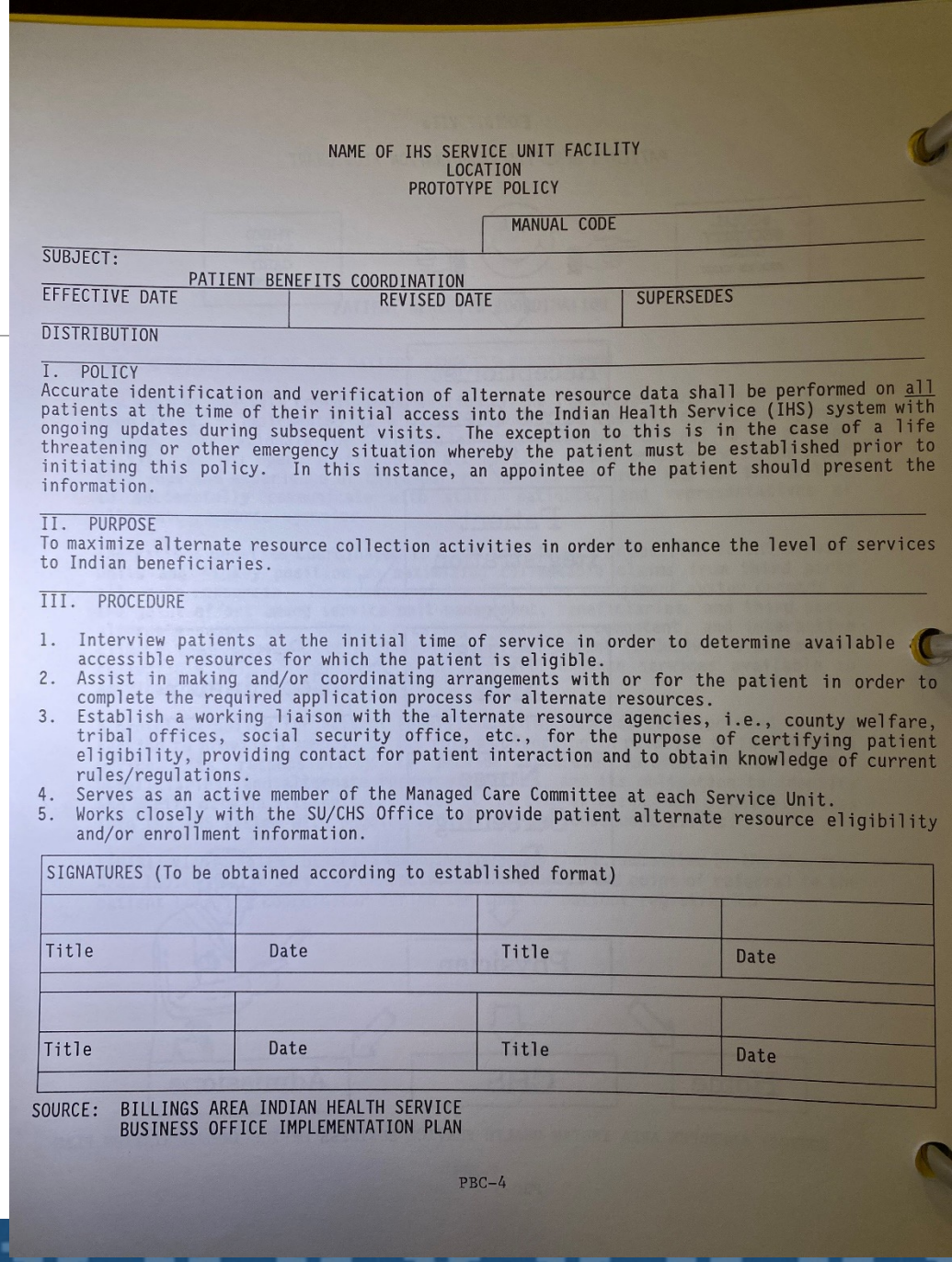
Patient Benefits Coordination Flowchart

A sample Flow Chart, submitted by the Aberdeen Area Indian Health Service demonstrates the process and point of referral to the patient benefits coordinator during the time of patient registration.



Patient Benefits Coordination Local Policy

A prototype SU policy for Patient Benefits Coordination is included in this section to provide a summary of its role and function in relation to the Business Office, its responsibility to provide accurate information to staff, beneficiaries, and alternate resource agencies, and its obligation to identify and verify data on alternate resources at the time of the patients initial access into the IHS system with ongoing updates during subsequent visits.



NAME OF IHS SERVICE UNIT FACILITY
LOCATION
PROTOTYPE POLICY

MANUAL CODE

SUBJECT:
PATIENT BENEFITS COORDINATION

EFFECTIVE DATE	REVISED DATE	SUPERSEDES

DISTRIBUTION

I. POLICY

Accurate identification and verification of alternate resource data shall be performed on all patients at the time of their initial access into the Indian Health Service (IHS) system with ongoing updates during subsequent visits. The exception to this is in the case of a life threatening or other emergency situation whereby the patient must be established prior to initiating this policy. In this instance, an appointee of the patient should present the information.

II. PURPOSE

To maximize alternate resource collection activities in order to enhance the level of services to Indian beneficiaries.

III. PROCEDURE

1. Interview patients at the initial time of service in order to determine available accessible resources for which the patient is eligible.
2. Assist in making and/or coordinating arrangements with or for the patient in order to complete the required application process for alternate resources.
3. Establish a working liaison with the alternate resource agencies, i.e., county welfare, tribal offices, social security office, etc., for the purpose of certifying patient eligibility, providing contact for patient interaction and to obtain knowledge of current rules/regulations.
4. Serves as an active member of the Managed Care Committee at each Service Unit.
5. Works closely with the SU/CHS Office to provide patient alternate resource eligibility and/or enrollment information.

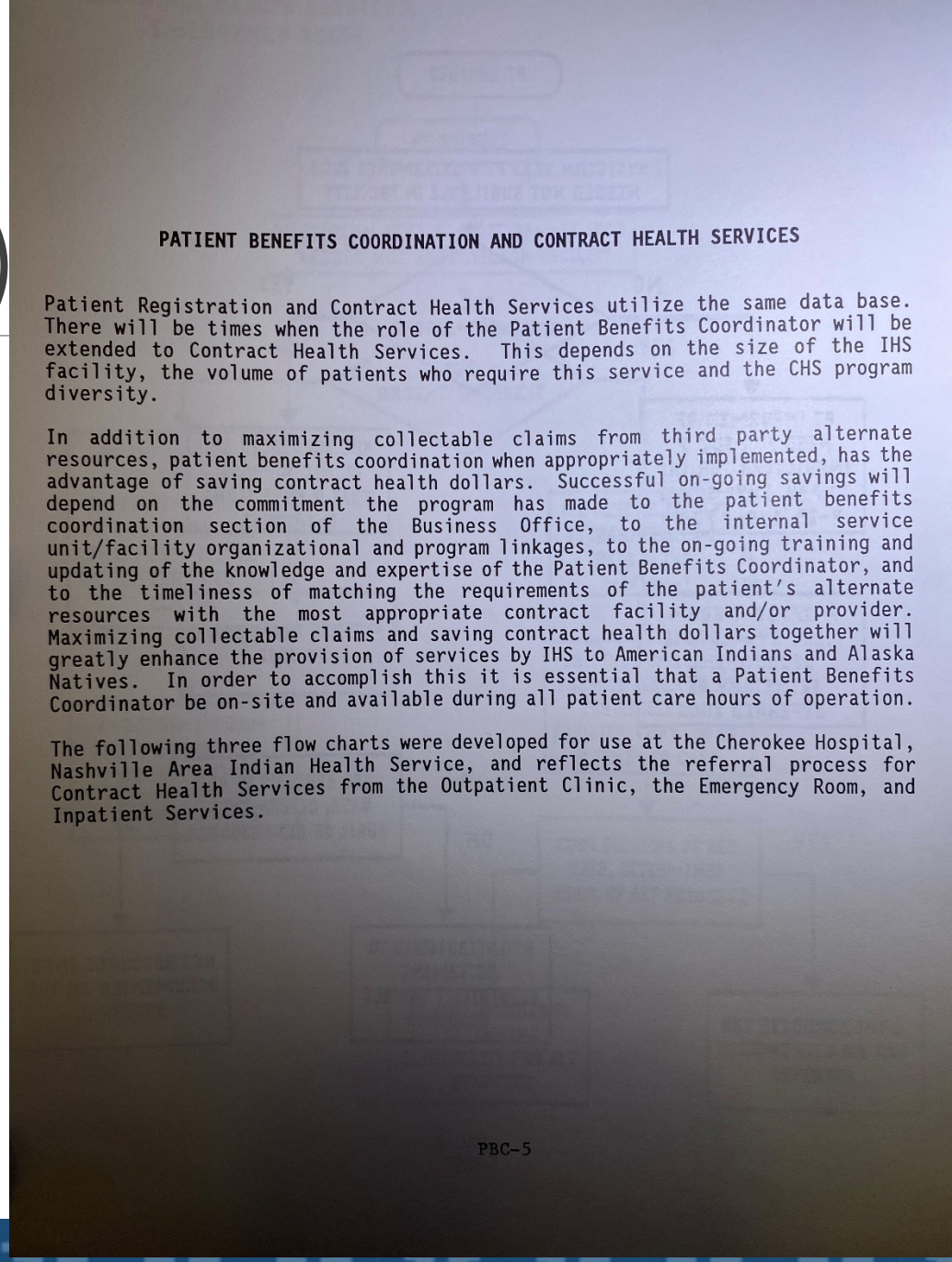
SIGNATURES (To be obtained according to established format)			
Title	Date	Title	Date
Title	Date	Title	Date

SOURCE: BILLINGS AREA INDIAN HEALTH SERVICE
BUSINESS OFFICE IMPLEMENTATION PLAN

PBC-4

Patient Benefits Coordination & PRC (CHS)

A prototype SU policy for Patient Benefits Coordination is included in this section to provide a summary of its role and function in relation to the Business Office. PBC's responsibility is to provide accurate information to staff, beneficiaries, and alternate resource agencies. The PBC obligation is to identify and verify data on alternate resources at the time of the patients initial access into the IHS system with ongoing updates during subsequent visits.



PATIENT BENEFITS COORDINATION AND CONTRACT HEALTH SERVICES

Patient Registration and Contract Health Services utilize the same data base. There will be times when the role of the Patient Benefits Coordinator will be extended to Contract Health Services. This depends on the size of the IHS facility, the volume of patients who require this service and the CHS program diversity.

In addition to maximizing collectable claims from third party alternate resources, patient benefits coordination when appropriately implemented, has the advantage of saving contract health dollars. Successful on-going savings will depend on the commitment the program has made to the patient benefits coordination section of the Business Office, to the internal service unit/facility organizational and program linkages, to the on-going training and updating of the knowledge and expertise of the Patient Benefits Coordinator, and to the timeliness of matching the requirements of the patient's alternate resources with the most appropriate contract facility and/or provider. Maximizing collectable claims and saving contract health dollars together will greatly enhance the provision of services by IHS to American Indians and Alaska Natives. In order to accomplish this it is essential that a Patient Benefits Coordinator be on-site and available during all patient care hours of operation.

The following three flow charts were developed for use at the Cherokee Hospital, Nashville Area Indian Health Service, and reflects the referral process for Contract Health Services from the Outpatient Clinic, the Emergency Room, and Inpatient Services.

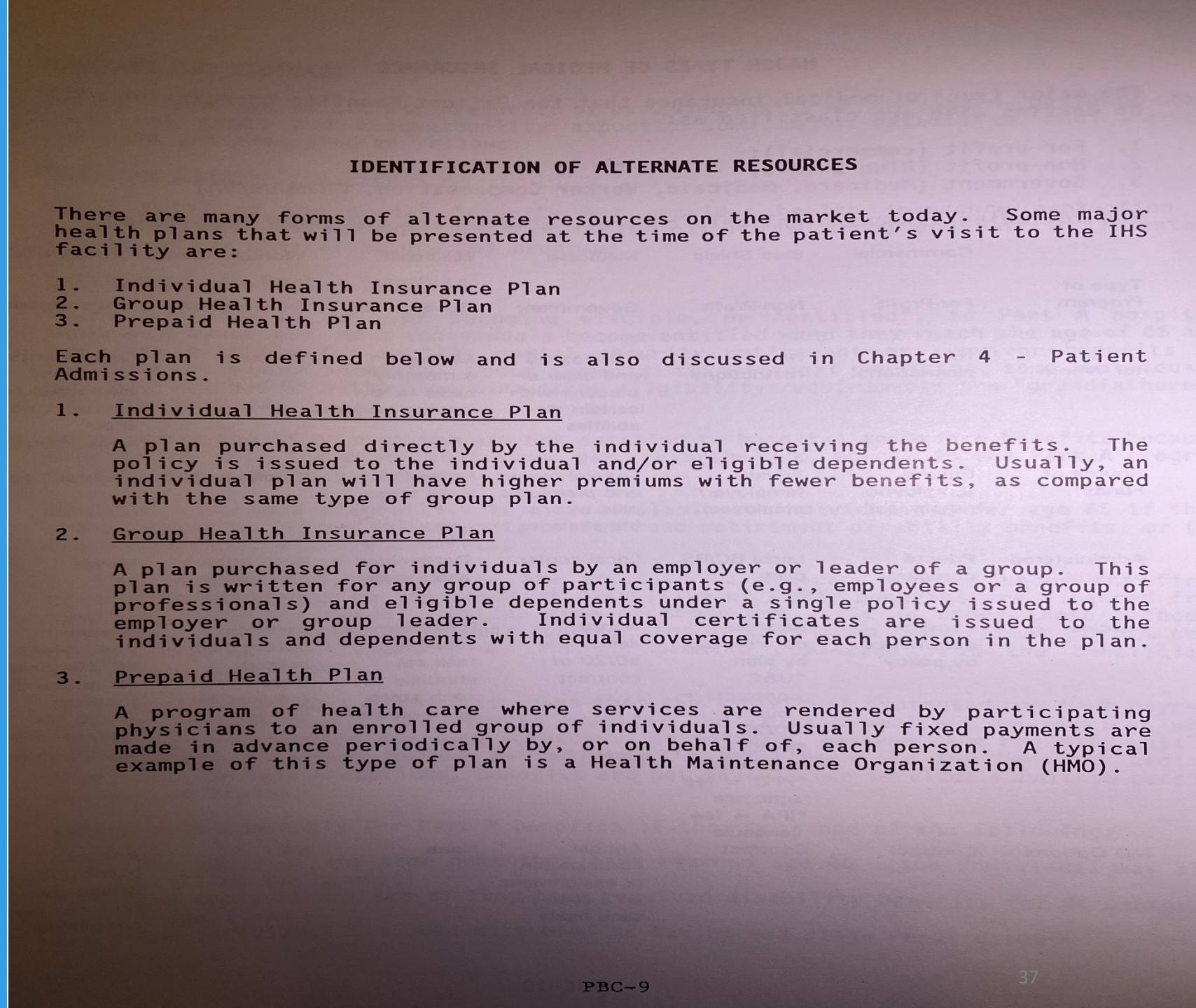
PBC-5

Identification of Alternate Resources

Identifies the major types of health plans and medical insurance that will be presented at the time of the patient's visit to the IHS facility:

1. Individual Health Insurance Plan
2. Group Health Insurance Plan
3. Prepaid Health Plan (HMO)

Each plan is defined and is also discussed in Chapter 4 – Patient Admissions.



IDENTIFICATION OF ALTERNATE RESOURCES

There are many forms of alternate resources on the market today. Some major health plans that will be presented at the time of the patient's visit to the IHS facility are:

1. Individual Health Insurance Plan
2. Group Health Insurance Plan
3. Prepaid Health Plan

Each plan is defined below and is also discussed in Chapter 4 - Patient Admissions.

1. Individual Health Insurance Plan

   A plan purchased directly by the individual receiving the benefits. The policy is issued to the individual and/or eligible dependents. Usually, an individual plan will have higher premiums with fewer benefits, as compared with the same type of group plan.

2. Group Health Insurance Plan

   A plan purchased for individuals by an employer or leader of a group. This plan is written for any group of participants (e.g., employees or a group of professionals) and eligible dependents under a single policy issued to the employer or group leader. Individual certificates are issued to the individuals and dependents with equal coverage for each person in the plan.

3. Prepaid Health Plan

   A program of health care where services are rendered by participating physicians to an enrolled group of individuals. Usually fixed payments are made in advance periodically by, or on behalf of, each person. A typical example of this type of plan is a Health Maintenance Organization (HMO).

PBC-9

Medicare and Medicaid: Medicare Eligibility and Enrollment – Part A

MEDICARE AND MEDICAID

Due to the volume of claims, frequency of use, complexity of the system, patient/ staff education needs and accountability aspects, some major details of medicare and medicaid are presented as follows:

Medicare Eligibility - Part A

Title XVIII of the Social Security Act provides health insurance protection to qualified individuals under the Part A (hospital insurance) and Part B (voluntary supplementary medical insurance) programs.

Entitlement to Part A Benefits

There are several ways of becoming eligible, or "entitled", to Part A hospital insurance benefits. Most individuals become entitled when they reach the age of 65 and are also eligible for monthly social security retirement or survivor benefits or railroad retirement benefits. Under a special transitional provision, some individuals who have reached 65 without meeting other eligibility requirements are "grandfathered" into the program.

Individuals age 65 or over who are not entitled to hospital insurance benefits because they do not meet the conditions above may, nevertheless, enroll in the Part A program if they pay a monthly premium.

Hospital insurance eligibility is also available to individuals under age 65 if they are entitled to (1) social security or railroad retirement disability benefits, or (2) end-stage renal disease benefits.

In the case of individuals who are entitled to Medicare Part A under the first paragraph, above, or on the basis of disability or ESRD, benefits are financed from hospital insurance taxes. In the case of those not entitled under these methods, benefits are financed from amounts appropriated by the Federal government (in the case of transitional entitlement) or through premium collected from the beneficiary (voluntary enrollment).

To be entitled to Part A benefits means that the individual protected may have payment made on her/his behalf for covered hospital and related health care services when she/he incurs expenses for such services. In no case, however, are benefits payable for services furnished before an individual's entitlement to the benefits begins. Also, with certain exceptions, benefits are not payable for services furnished outside the United States.

Individuals can apply for Part A benefits if they meet one of the following:

1. can apply at any time once they have reached age 65 (the individual may also still be employed);
2. can apply at any age if they have received disability benefits for 24 months or longer; and
3. the individual has been diagnosed as having end stage renal disease.

PBC-11

Medicare and Medicaid: Medicare Eligibility and Enrollment – Part B

There is no restriction on the time of year an individual can apply and no restrictions on the enrollment period. Part A hospital insurance is retroactive six months from the date of eligibility determination.

Medicare Eligibility - Part B

Eligibility to Enroll for Part B Benefits

Unlike the Part A (hospital insurance) program, which is largely financed by compulsory taxes on employers, employees, and the self-employed, the Part B (supplementary medical insurance) program is a voluntary program for eligible individuals who (1) elect to enroll in the program, or (2) are deemed to have automatically enrolled and have not declined coverage by refusing coverage before it is scheduled to begin. The program is financed from premium payments by enrollees, or by states under the Medicaid program, together with contributions from funds appropriated by the federal government. In addition, the program contains certain deductible and percentage cost-sharing features.

Since the Part B plan is distinct and independent from the Part A plan, it is possible for a person to enroll without being entitled to monthly social security or railroad retirement benefits or to Part A protection.

An individual is eligible for enrollment in the Part B program if she/he (1) is entitled to Part A benefits, or (2) has attained the age of 65 and is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided in the United States continuously during the five years immediately before the month she/he applies for enrollment. Active or retired federal employees and their spouses are eligible whether or not they are covered under the Federal Employees Health Act.

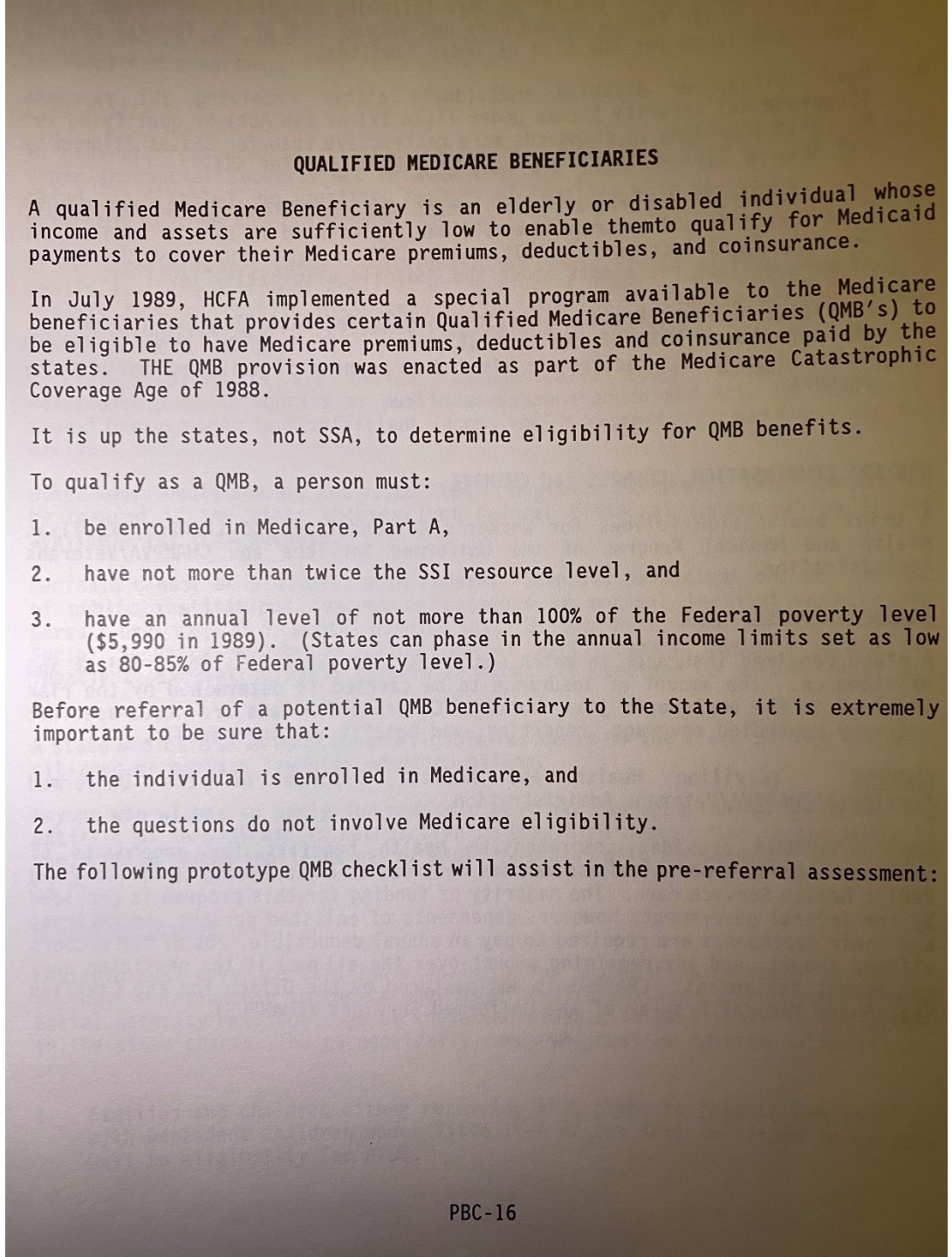
An individual convicted of any of the subversive activity offenses stipulated in Section 104(b)(2) of the Social Security Amendments of 1905 cannot enroll in the Part B program.

As evidence of entitlement, each beneficiary entitled to Part A and/or Part B benefits is issued a "Health Insurance Card" which gives the name of the beneficiary, the claim number, sex of the beneficiary, the extent of his entitlement, and the effective date(s) of that entitlement. The card-holder should show her/his card to the provider of services, doctor, etc., whenever she/he requires any covered services.

Enrollment in the Part B Program

Anyone entitled to Part A benefits, including those who are entitled to such benefits by reason of disability, Medicare-qualified government employment, or end-stage renal disease, are automatically enrolled and covered for Part B benefits, unless they indicate they do not want to be enrolled for such coverage.

Qualified Medicare Beneficiaries



QUALIFIED MEDICARE BENEFICIARIES

A qualified Medicare Beneficiary is an elderly or disabled individual whose income and assets are sufficiently low to enable themto qualify for Medicaid payments to cover their Medicare premiums, deductibles, and coinsurance.

In July 1989, HCFA implemented a special program available to the Medicare beneficiaries that provides certain Qualified Medicare Beneficiaries (QMB's) to be eligible to have Medicare premiums, deductibles and coinsurance paid by the states. THE QMB provision was enacted as part of the Medicare Catastrophic Coverage Age of 1988.

It is up the states, not SSA, to determine eligibility for QMB benefits.

To qualify as a QMB, a person must:

1. be enrolled in Medicare, Part A,

2. have not more than twice the SSI resource level, and

3. have an annual level of not more than 100% of the Federal poverty level ($5,990 in 1989). (States can phase in the annual income limits set as low as 80-85% of Federal poverty level.)

Before referral of a potential QMB beneficiary to the State, it is extremely important to be sure that:

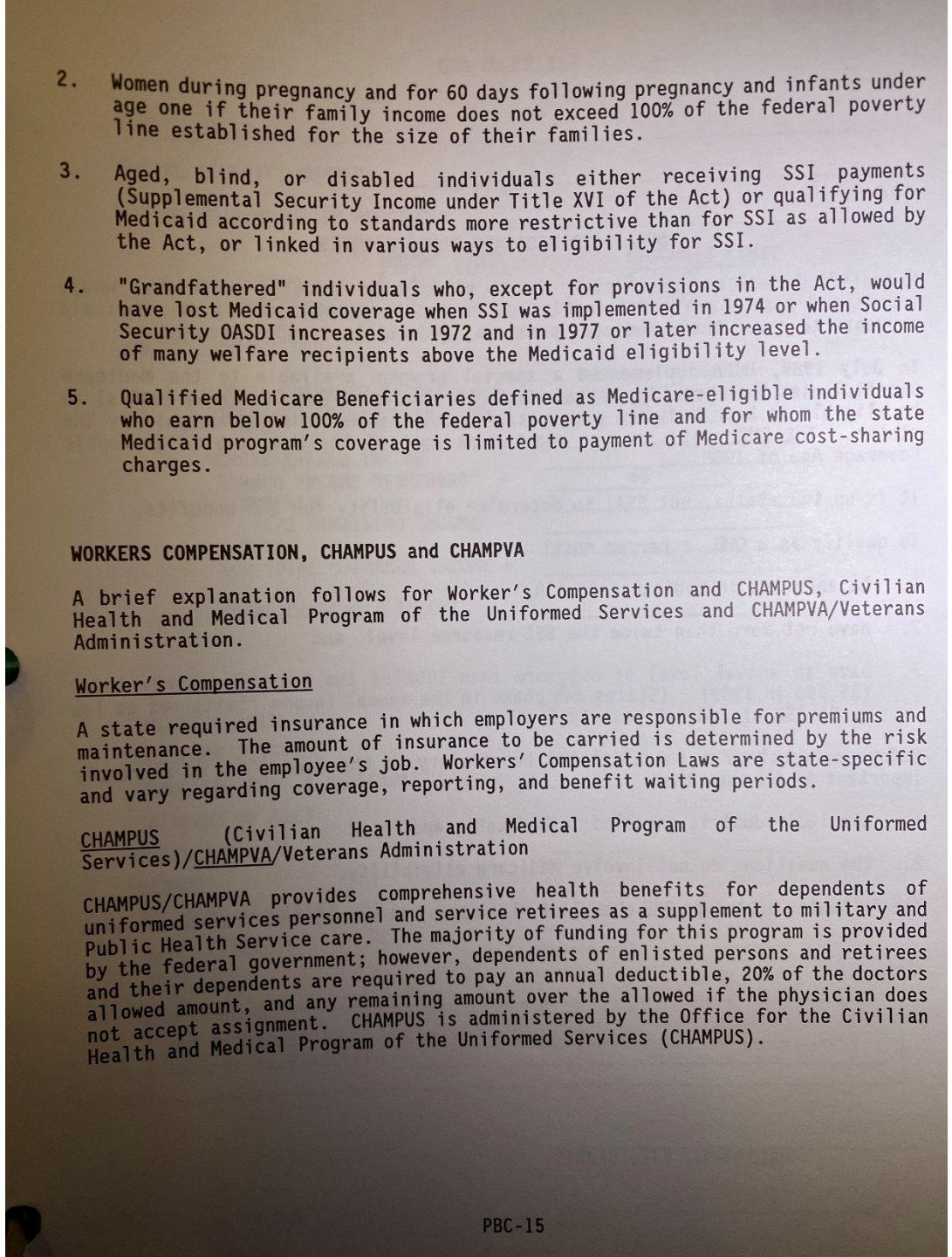
1. the individual is enrolled in Medicare, and

2. the questions do not involve Medicare eligibility.

The following prototype QMB checklist will assist in the pre-referral assessment:

PBC-16

Medicare and Medicaid: Workers Compensation, CHAMPUS, and CHAMPVA



2. Women during pregnancy and for 60 days following pregnancy and infants under age one if their family income does not exceed 100% of the federal poverty line established for the size of their families.

3. Aged, blind, or disabled individuals either receiving SSI payments (Supplemental Security Income under Title XVI of the Act) or qualifying for Medicaid according to standards more restrictive than for SSI as allowed by the Act, or linked in various ways to eligibility for SSI.

4. "Grandfathered" individuals who, except for provisions in the Act, would have lost Medicaid coverage when SSI was implemented in 1974 or when Social Security OASDI increases in 1972 and in 1977 or later increased the income of many welfare recipients above the Medicaid eligibility level.

5. Qualified Medicare Beneficiaries defined as Medicare-eligible individuals who earn below 100% of the federal poverty line and for whom the state Medicaid program's coverage is limited to payment of Medicare cost-sharing charges.

WORKERS COMPENSATION, CHAMPUS and CHAMPVA

A brief explanation follows for Worker's Compensation and CHAMPUS, Civilian Health and Medical Program of the Uniformed Services and CHAMPVA/Veterans Administration.

Worker's Compensation

A state required insurance in which employers are responsible for premiums and maintenance. The amount of insurance to be carried is determined by the risk involved in the employee's job. Workers' Compensation Laws are state-specific and vary regarding coverage, reporting, and benefit waiting periods.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)/CHAMPVA/Veterans Administration

CHAMPUS/CHAMPVA provides comprehensive health benefits for dependents of uniformed services personnel and service retirees as a supplement to military and Public Health Service care. The majority of funding for this program is provided by the federal government; however, dependents of enlisted persons and retirees and their dependents are required to pay an annual deductible, 20% of the doctors allowed amount, and any remaining amount over the allowed if the physician does not accept assignment. CHAMPUS is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

PBC-15

Chapter Four: Patient Admissions

Chapter 4: Patient Admissions

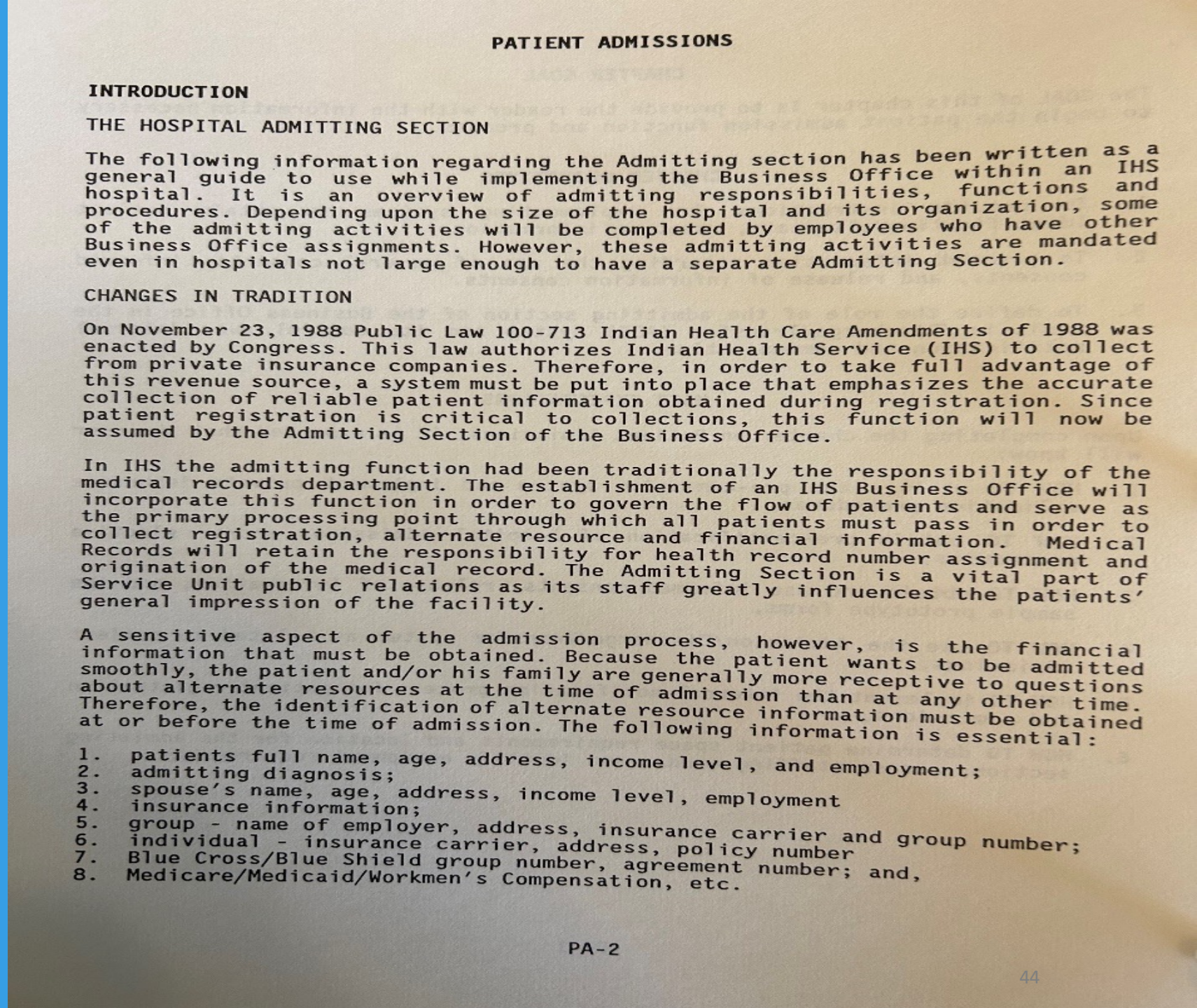
Table of Contents

CHAPTER 4
PATIENT ADMISSIONS

TABLE OF CONTENTS

Hospital Admitting Section

1992: Admitting responsibilities were moved from “Medical Records” to Business Office. This move was made to better accommodate obtaining the financial information necessary to bill the services.



PATIENT ADMISSIONS

INTRODUCTION

THE HOSPITAL ADMITTING SECTION

The following information regarding the Admitting section has been written as a general guide to use while implementing the Business Office within an IHS hospital. It is an overview of admitting responsibilities, functions and procedures. Depending upon the size of the hospital and its organization, some of the admitting activities will be completed by employees who have other Business Office assignments. However, these admitting activities are mandated even in hospitals not large enough to have a separate Admitting Section.

CHANGES IN TRADITION

On November 23, 1988 Public Law 100-713 Indian Health Care Amendments of 1988 was enacted by Congress. This law authorizes Indian Health Service (IHS) to collect from private insurance companies. Therefore, in order to take full advantage of this revenue source, a system must be put into place that emphasizes the accurate collection of reliable patient information obtained during registration. Since patient registration is critical to collections, this function will now be assumed by the Admitting Section of the Business Office.

In IHS the admitting function had been traditionally the responsibility of the medical records department. The establishment of an IHS Business Office will incorporate this function in order to govern the flow of patients and serve as the primary processing point through which all patients must pass in order to collect registration, alternate resource and financial information. Medical Records will retain the responsibility for health record number assignment and origination of the medical record. The Admitting Section is a vital part of Service Unit public relations as its staff greatly influences the patients' general impression of the facility.

A sensitive aspect of the admission process, however, is the financial information that must be obtained. Because the patient wants to be admitted smoothly, the patient and/or his family are generally more receptive to questions about alternate resources at the time of admission than at any other time. Therefore, the identification of alternate resource information must be obtained at or before the time of admission. The following information is essential:

1. patients full name, age, address, income level, and employment;
2. admitting diagnosis;
3. spouse's name, age, address, income level, employment
4. insurance information;
5. group - name of employer, address, insurance carrier and group number;
6. individual - insurance carrier, address, policy number
7. Blue Cross/Blue Shield group number, agreement number; and,
8. Medicare/Medicaid/Workmen's Compensation, etc.

PA-2

Functions: Pre-Admission Process and Insurance Verification

Pre-admission was encouraged to streamline the admitting process. The process should obtain any required second opinions or pre-certifications necessary for the admission.

Addressograph cards and armbands should be ready at time of admission.

Insurance verification should be completed.

FUNCTIONS

PRE-ADMISSION PROCESS

A pre-admission system will apply primarily to elective admissions, however, emergency admissions could in some instances apply. This process allows for the admitting section to verify that all third-party payer requirements such as second opinions and pre-admission certification are met and that patient demographic and insurance information is accurate. If the hospital waits until the patient's admission before gathering the required information, the patient would probably be discharged before all the necessary billing and insurance information could be obtained.

The establishment of a pre-admission system will require cooperation and planning with the physician intending to admit the patient, surgical staff and the insurance carriers.

This pre-admission process may require that the admitting staff write to the patient before admission to obtain the necessary information. The admitting staff will have the responsibility for making up the addressograph cards and arm bands. These functions could be done ahead of time once the preadmission information has been obtained.

Therefore, the use of a pre-admission system will make the admission process much quicker for the patient since most of the required information will have been gathered and verified. The attached prototype form may be used as the first step in implementing the preadmission system. It is recommended that the prototype be tailored to meet the needs of your facility.

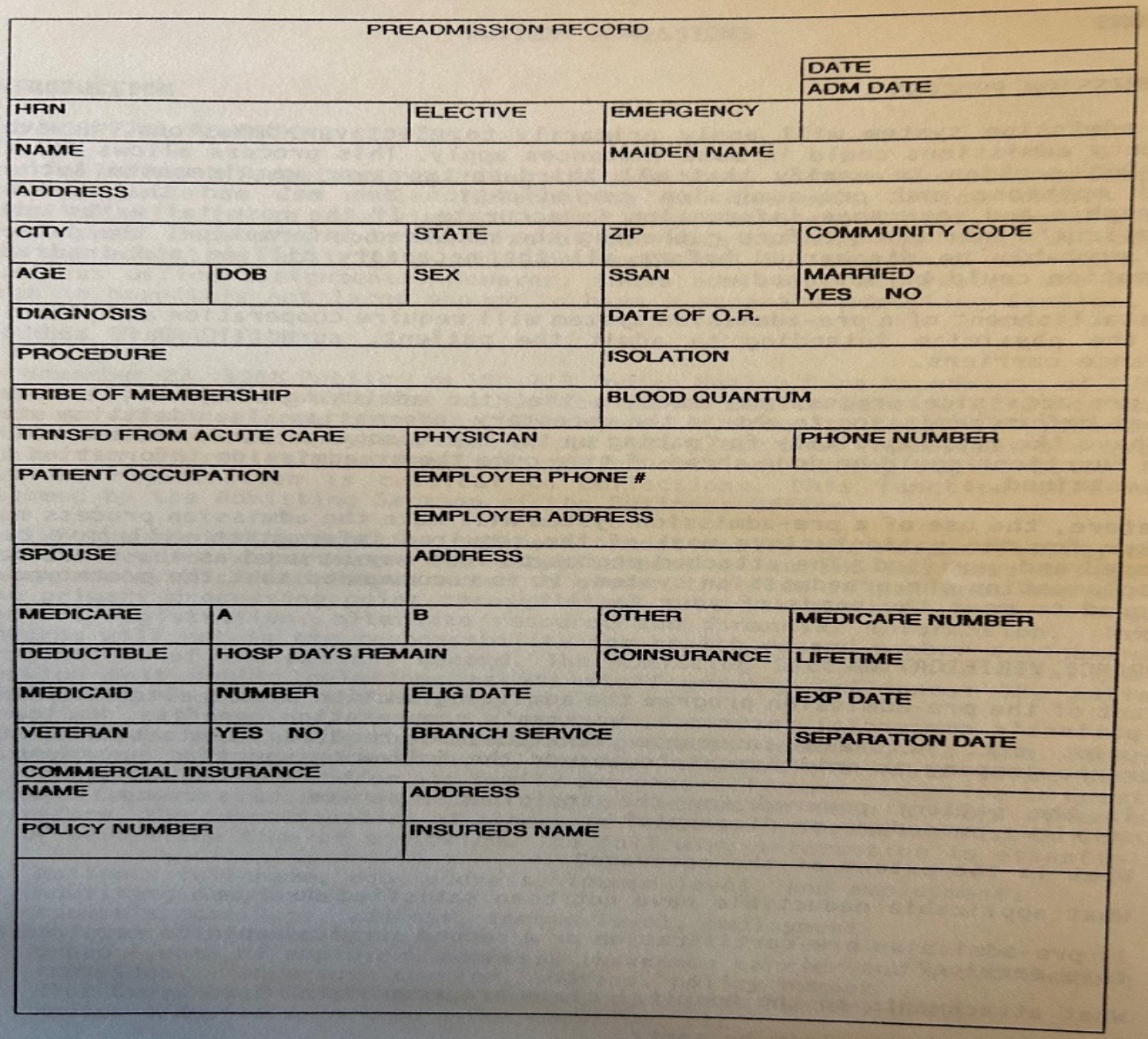
INSURANCE VERIFICATION

As part of the pre-admission program the admitting section should elect to verify the patient's commercial insurance, workmen's compensation benefits, Medicare, Medicaid, etc. Accurate insurance verification requires contact with the insurance company or entitlement to answer the following specific questions.

1. Is the patient covered for the anticipated period of service, type of service, procedure or diagnosis?
2. What is the extent of the coverage?
3. What applicable deductible have not been satisfied to date?
4. Is pre-admission pre-certification or a second surgical opinion required for this service?
5. What attachments to the hospital claim are required, if any?
6. Where should the claim be sent?

PA-3

Sample Preadmission Record



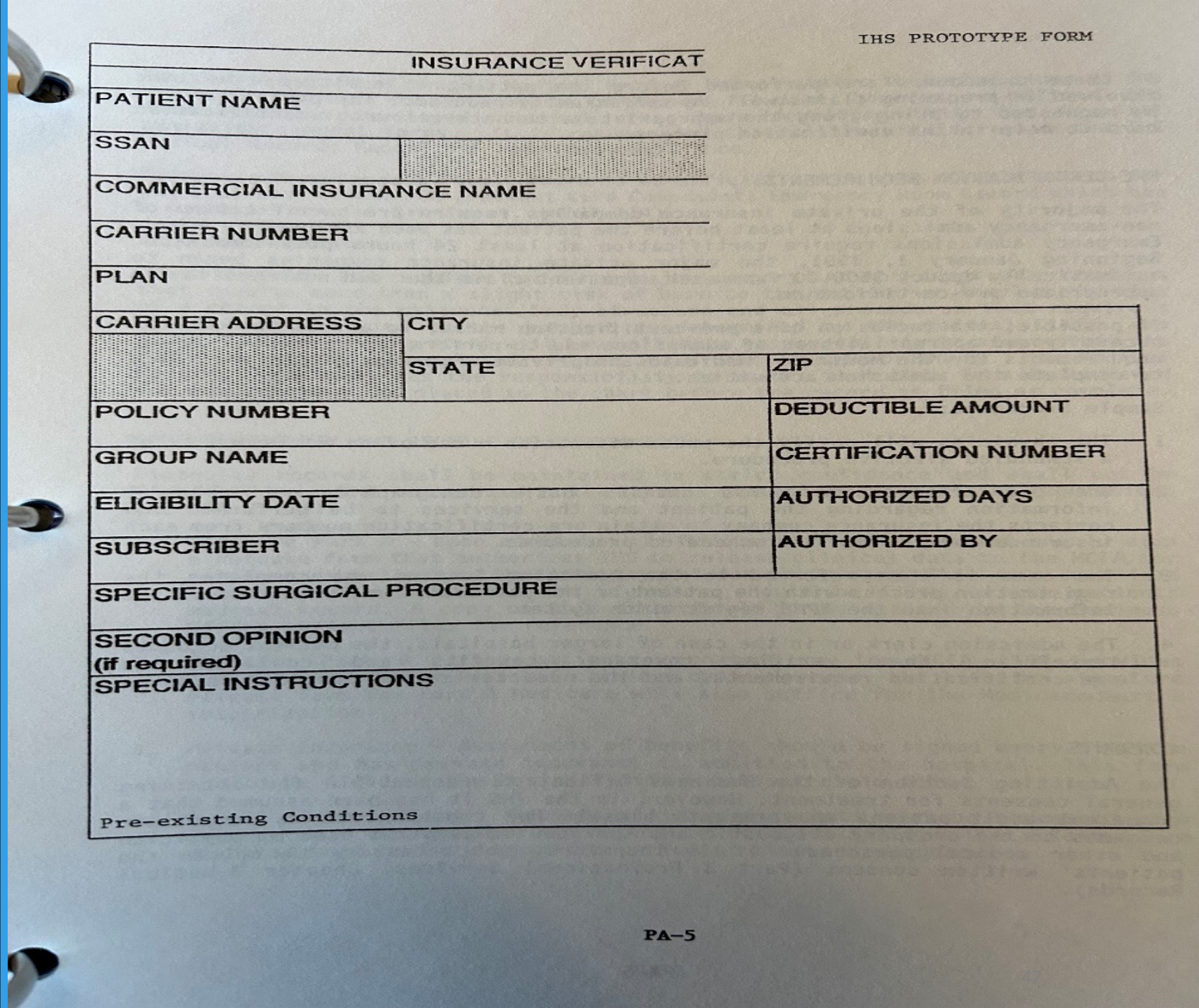
PREADMISSION RECORD

				DATE	
				ADM DATE	
HRN		ELECTIVE	EMERGENCY		
NAME			MAIDEN NAME		
ADDRESS					
CITY		STATE	ZIP	COMMUNITY CODE	
AGE	DOB	SEX	SSAN	MARRIED YES NO	
DIAGNOSIS			DATE OF O.R.		
PROCEDURE			ISOLATION		
TRIBE OF MEMBERSHIP			BLOOD QUANTUM		
TRNSFD FROM ACUTE CARE		PHYSICIAN		PHONE NUMBER	
PATIENT OCCUPATION		EMPLOYER PHONE #			
		EMPLOYER ADDRESS			
SPOUSE		ADDRESS			
MEDICARE	A	B	OTHER	MEDICARE NUMBER	
DEDUCTIBLE	HOSP DAYS REMAIN		COINSURANCE	LIFETIME	
MEDICAID	NUMBER	ELIG DATE		EXP DATE	
VETERAN	YES NO	BRANCH SERVICE		SEPARATION DATE	
COMMERCIAL INSURANCE					
NAME		ADDRESS			
POLICY NUMBER		INSUREDS NAME			

PA–4

Sample Insurance Verification Form

Inpatient Insurance Verification Form



IHS PROTOTYPE FORM

INSURANCE VERIFICAT

PATIENT NAME

SSAN

COMMERCIAL INSURANCE NAME

CARRIER NUMBER

PLAN

CARRIER ADDRESS

CITY

STATE

ZIP

POLICY NUMBER

DEDUCTIBLE AMOUNT

GROUP NAME

CERTIFICATION NUMBER

ELIGIBILITY DATE

AUTHORIZED DAYS

SUBSCRIBER

AUTHORIZED BY

SPECIFIC SURGICAL PROCEDURE

SECOND OPINION
(if required)

SPECIAL INSTRUCTIONS

Pre-existing Conditions

PA-5

CONSENTS

Implied Consent: It is assumed that patients consent for care when appearing for appointment, or presenting to ER. No one is coercing patient to come for treatment.

Informed Consent: Required for any surgery and nonsurgical procedures that involve more than a slight risk of harm to the patient, or involve the risk of a change in the patient's body structure. Must be explained, understood, signed, and witnessed and becomes a part of the legal health record.

Confidentiality

Release of Information

Medicare Part A: Release of information (AOB) should be signed to bill. Once in a lifetime requirement, file in the record.

Medicare Part B: Signature necessary to release clinical data. Lifetime signature for Part A also covers Part B authorization.

Private Insurance: Assignment of Benefits should be signed every time patient admitted to hospital. File in patient claim files

Drug & Alcohol Abuse: Extreme care of confidentiality of these records should be taken to bill these records. Release should have specific period of time and purpose.

Privacy Act: Explain to the patient, verify understanding by the patient. Sign, date and witness and file permanently into the Medical Record.

Sample forms

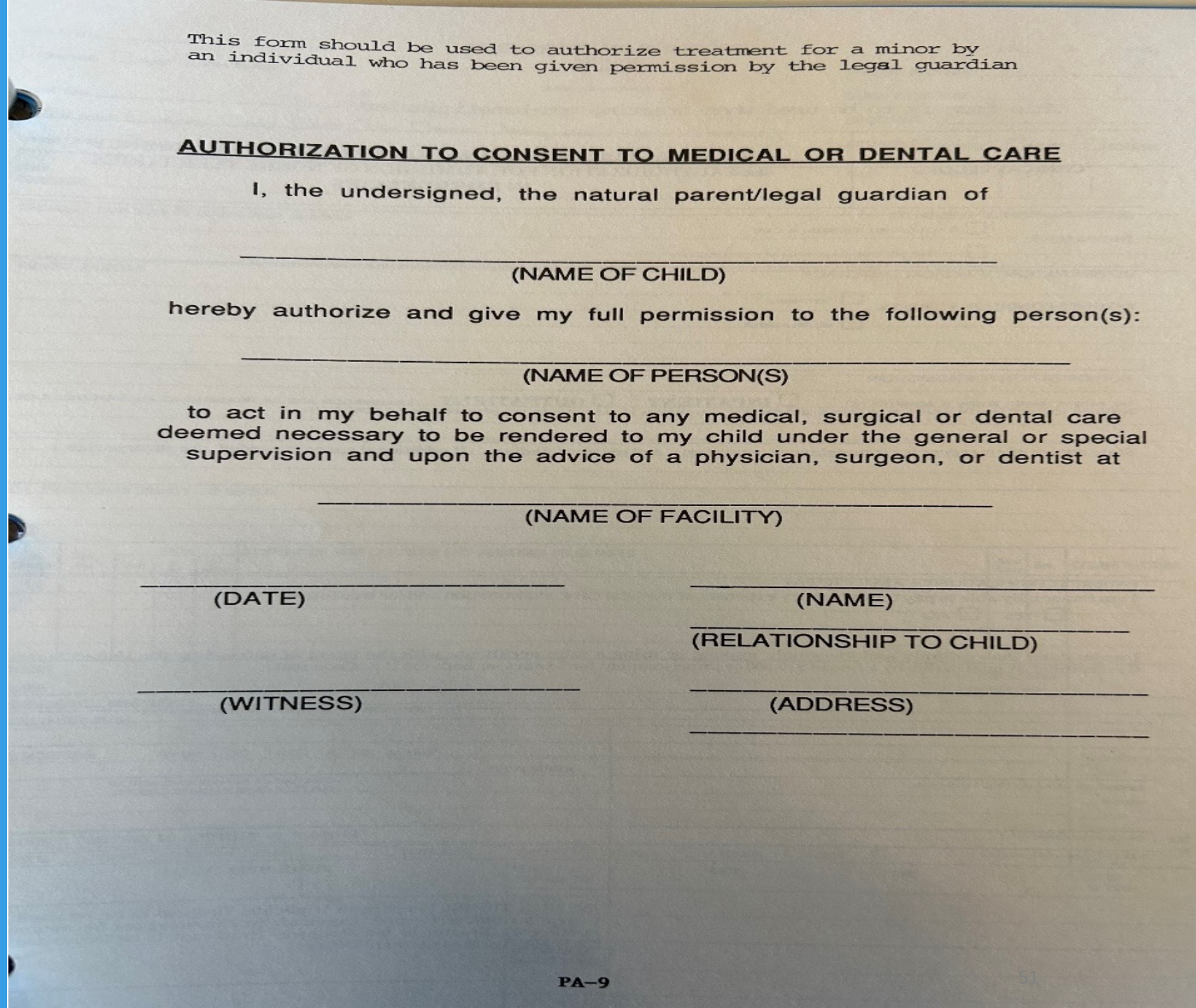
Examples include:

Authorization to Consent to Medical or Dental Care

Nonbeneficiaries

Emergency Room Visit Record

Sample Authorization to Consent to Medical or Dental Care



This form should be used to authorize treatment for a minor by an individual who has been given permission by the legal guardian

AUTHORIZATION TO CONSENT TO MEDICAL OR DENTAL CARE

I, the undersigned, the natural parent/legal guardian of

_____
(NAME OF CHILD)

hereby authorize and give my full permission to the following person(s):

_____
(NAME OF PERSON(S)

to act in my behalf to consent to any medical, surgical or dental care deemed necessary to be rendered to my child under the general or special supervision and upon the advice of a physician, surgeon, or dentist at

_____
(NAME OF FACILITY)

_____
(DATE)

_____
(NAME)

_____
(RELATIONSHIP TO CHILD)

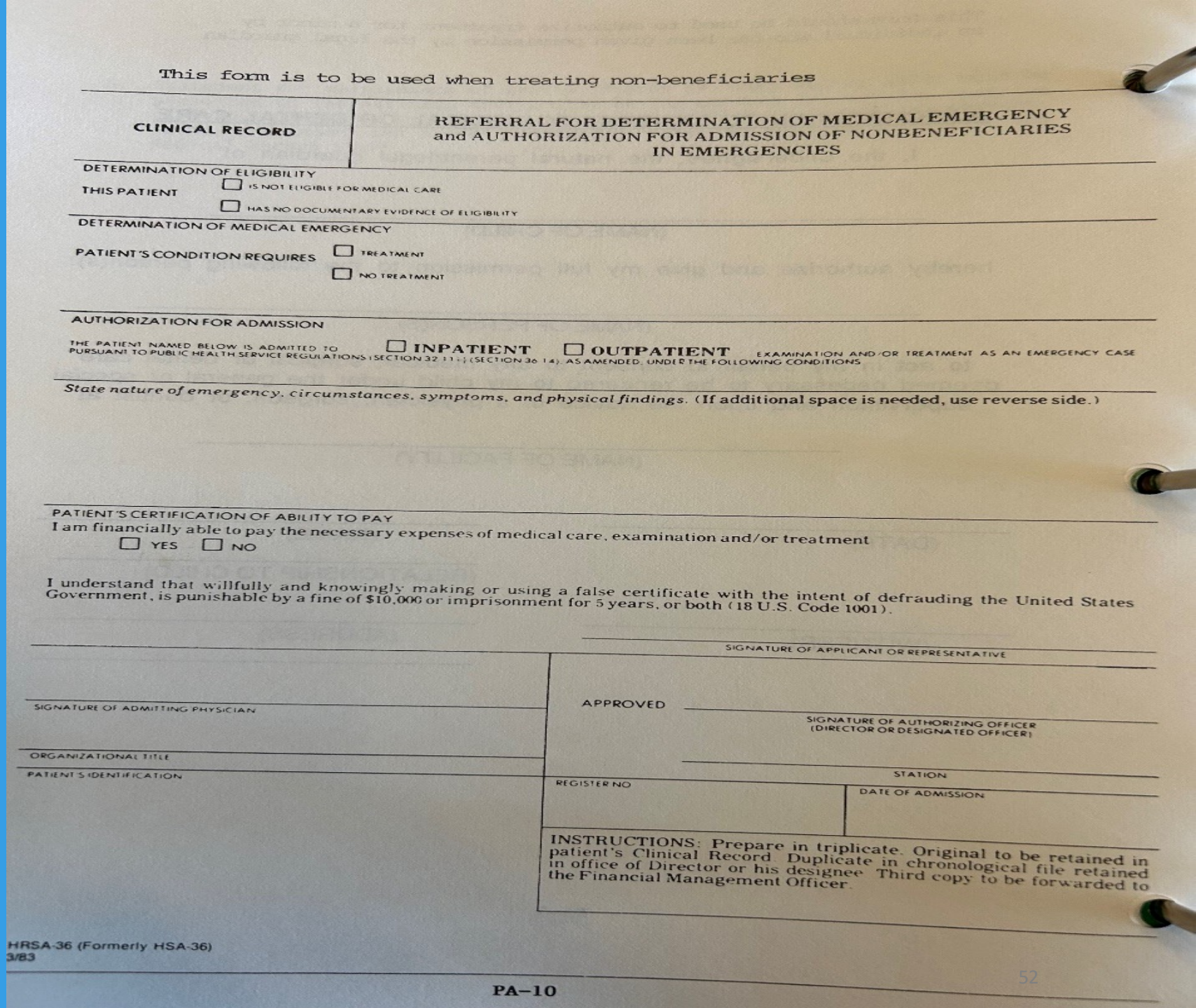
_____
(WITNESS)

_____
(ADDRESS)

_____

PA–9

Nonbeneficiaries



This form is to be used when treating non-beneficiaries

CLINICAL RECORD

REFERRAL FOR DETERMINATION OF MEDICAL EMERGENCY and AUTHORIZATION FOR ADMISSION OF NONBENEFICIARIES IN EMERGENCIES

DETERMINATION OF ELIGIBILITY

THIS PATIENT ☐ IS NOT ELIGIBLE FOR MEDICAL CARE

☐ HAS NO DOCUMENTARY EVIDENCE OF ELIGIBILITY

DETERMINATION OF MEDICAL EMERGENCY

PATIENT'S CONDITION REQUIRES ☐ TREATMENT

☐ NO TREATMENT

AUTHORIZATION FOR ADMISSION

THE PATIENT NAMED BELOW IS ADMITTED TO ☐ INPATIENT ☐ OUTPATIENT EXAMINATION AND/OR TREATMENT AS AN EMERGENCY CASE PURSUANT TO PUBLIC HEALTH SERVICE REGULATIONS (SECTION 32.11+) (SECTION 36.14), AS AMENDED, UNDER THE FOLLOWING CONDITIONS

State nature of emergency, circumstances, symptoms, and physical findings. (If additional space is needed, use reverse side.)

PATIENT'S CERTIFICATION OF ABILITY TO PAY

I am financially able to pay the necessary expenses of medical care, examination and/or treatment

☐ YES ☐ NO

I understand that willfully and knowingly making or using a false certificate with the intent of defrauding the United States Government, is punishable by a fine of $10,000 or imprisonment for 5 years, or both (18 U.S. Code 1001).

SIGNATURE OF APPLICANT OR REPRESENTATIVE

SIGNATURE OF ADMITTING PHYSICIAN

ORGANIZATIONAL TITLE

PATIENT'S IDENTIFICATION

APPROVED

SIGNATURE OF AUTHORIZING OFFICER (DIRECTOR OR DESIGNATED OFFICER)

STATION

REGISTER NO

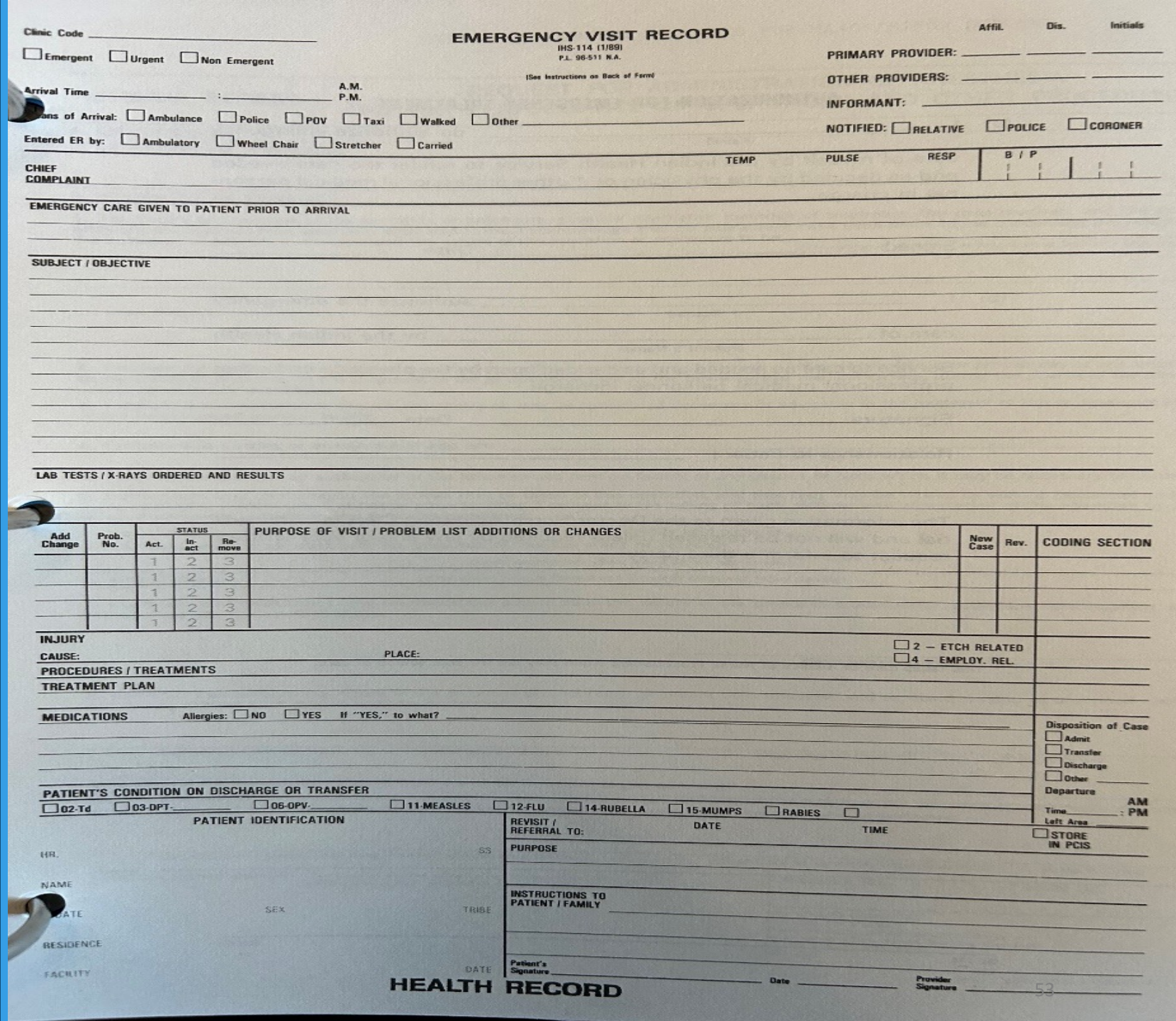
DATE OF ADMISSION

INSTRUCTIONS: Prepare in triplicate. Original to be retained in patient's Clinical Record. Duplicate in chronological file retained in office of Director or his designee. Third copy to be forwarded to the Financial Management Officer.

HRSA-36 (Formerly HSA-36)
3/83

PA–10

Emergency Visit Record



Clinic Code _____

☐ Emergent ☐ Urgent ☐ Non Emergent

Arrival Time _____ : _____ A.M. P.M.

Means of Arrival: ☐ Ambulance ☐ Police ☐ POV ☐ Taxi ☐ Walked ☐ Other _____

Entered ER by: ☐ Ambulatory ☐ Wheel Chair ☐ Stretcher ☐ Carried

EMERGENCY VISIT RECORD

IHS-114 (1/89)
P.L. 96-511 N.A.

(See Instructions on Back of Form)

Affil. Dis. Initials

PRIMARY PROVIDER: _____ _____ _____

OTHER PROVIDERS: _____ _____ _____

INFORMANT: _____

NOTIFIED: ☐ RELATIVE ☐ POLICE ☐ CORONER

CHIEF COMPLAINT

TEMP PULSE RESP B / P

EMERGENCY CARE GIVEN TO PATIENT PRIOR TO ARRIVAL

SUBJECT / OBJECTIVE

LAB TESTS / X-RAYS ORDERED AND RESULTS

Add Change	Prob. No.	STATUS Act.	In-act	Re-move	PURPOSE OF VISIT / PROBLEM LIST ADDITIONS OR CHANGES	New Case	Rev.	CODING SECTION
		1	2	3				
		1	2	3				
		1	2	3				
		1	2	3				
		1	2	3				

INJURY

CAUSE: PLACE:

☐ 2 — ETCH RELATED
☐ 4 — EMPLOY. REL.

PROCEDURES / TREATMENTS

TREATMENT PLAN

MEDICATIONS Allergies: ☐ NO ☐ YES If "YES," to what? _____

PATIENT'S CONDITION ON DISCHARGE OR TRANSFER

☐ 02-Td ☐ 03-DPT-_____ ☐ 06-OPV-_____ ☐ 11-MEASLES ☐ 12-FLU ☐ 14-RUBELLA ☐ 15-MUMPS ☐ RABIES ☐

Disposition of Case
☐ Admit
☐ Transfer
☐ Discharge
☐ Other _____

Departure
Time _____ : AM PM
Left Area _____

PATIENT IDENTIFICATION

HR. SS

NAME

DATE SEX TRIBE

RESIDENCE

FACILITY DATE

REVISIT / REFERRAL TO: DATE TIME

☐ STORE IN PCIS

PURPOSE

INSTRUCTIONS TO PATIENT / FAMILY

Patient's Signature _____ Date _____ Provider Signature _____

HEALTH RECORD

53

ADT Application

Admission and assignment of bed

Transfers within hospital, providing accurate census reporting

Discharge and transfer to other facilities

BED ASSIGNMENT, TRANSFERS, DISCHARGES

BED ASSIGNMENT

The main focus with respect to bed assignments is the proper utilization of beds in accordance with the medical needs of the patient population. These needs should be determined by the medical staff, the nursing staff and the admitting staff and should be documented for the admitting staff to use as a reference. Other factors to consider are the patients sex and age. The need for an isolation room should be guided by the hospital infection control policies and the admitting physician. Other types of patients requiring a special room, i.e., ICU, terminal illness, etc., should have an admitting order from the admitting physician. The need for special rooms must be documented because third party payers reimburse accordingly based on whether they were deemed medically necessary. The admitting staff, in coordination with the nursing staff, is usually responsible for bed assignment. Procedures regarding this function must be established at each hospital. Those hospitals running the Admission/Discharge/Transfer (ADT) RPMS software must transfer the responsibility for this function to the admitting office section of the Business Office.

TRANSFERS WITHIN THE HOSPITAL

Usually, a physician or nurse may request that a patient be transferred from one room to another. Patients/families may also request a room change but Admitting will need the consent of the physician prior to making the change. The admitting section must be notified, in all instances, in order to document the transfer. The hospitals running the ADT RPMS software program must establish procedures regarding input into this system. The admitting section will be ultimately responsible for the hospital automated 202 monthly census report that is required by Division of Program Statistics, Headquarters. The hospitals who are not running the ADT software may wish to retain this function in the medical records department. However, coordination between medical records, nursing and the admitting section will need to be established to ensure accurate census reporting.

DISCHARGES & TRANSFERS TO OTHER FACILITIES

The admitting section should be informed immediately of all discharges by the nursing department. This will enable them to make specific bed assignments for incoming patients. The transfer of patients to other facilities may involve the admitting staff to help coordinate the transfer. A policy should be developed emphasizing the importance of documenting the medical reason for transfer in the medical record to justify the claims submitted to the Fiscal Intermediary for payment from Medicare.

Staffing Requirements

Dependent on total number of admissions including newborns.

1 admitting clerk per 1,000. part time clerk for each additional 1,000 admissions.

3. Use maximum standards in allocating work space to allow for peak work load rather than for bare minimum requirements. This will allow for growth.

The ideal traffic pattern is from the reception desk, to check in, to the waiting area, to the patient registration/interviewing area, and then to the patient room.

Attached is Exhibit VIIb, Patient Admissions Flow Chart submitted by the Aberdeen Area Indian Health Service in their Business Office Implementation Plan.

STAFFING REQUIREMENTS

The Business Office in hospitals operate 24 hours a day, 7 days a week as the admission of emergency patients cannot be scheduled nor controlled. The majority of admissions occur after hours creating the need for the admitting staff to be available to process unexpected admissions.

Several admitting functions can be performed on the evening and night shift such as compilation of the daily census, gathering of preadmission information, patient registration, preparation of letters to patients, coding, etc. In the smaller facilities, however, the admitting responsibilities during the evening and night shifts may be combined with another position as long as the incumbent has had documented training in the admitting process. If this is the case, the admitting staff must maintain a close liaison with the designated staff to ensure that the required information is collected and the proper admitting procedures are carried out.

In the larger hospitals it may be feasible to separate the responsibility for ambulatory care registration for those ambulatory care patients who require hospitalization. The Outpatient/Emergency Room Departments may also require that a Registration Clerk be located within their department to obtain the required information. This function can be included within the admitting section's responsibility, however, documented training of the admitting process for the ambulatory/emergency room registration clerks will be required by the admitting staff.

The driving variable to adequately staff the admitting section with the adequate number of admitting clerks is the total number of admissions including newborns to the hospital. The acceptable formula published by the Quality Management Group reads that each hospital having 1000 admissions and above should provide for at least 1 admission clerk and a part-time admitting clerk position for each additional 1000 admissions.

The consolidation of various Business Office functions should be considered in establishing staffing requirements. In the smaller facilities, the patient registration technician may also be required to perform preadmission and insurance verification duties as well as other duties at the onset of the Business Office implementation. Subsequent reorganization of positions may need to occur until the correct mode of operation and adequate staff complement have been established.

Equipment Requirements

Addressograph embosser

Imprinter

Computer

Printer

Photocopier

Typewriter

ID bracelet machine

EQUIPMENT REQUIREMENTS

The actual needs, capabilities and space of the admitting section must be assessed before deciding to purchase new equipment.

Recommended basic equipment for the admitting section is as follows:

1. Addressograph embossing equipment preferably the automated card maker that is compatible with the RPMS patient registration software.
2. Imprinter for use with the embossed patient identification card.
3. Computer terminal with direct input capability.
4. Printer
5. Photocopy machine located in the Business Office.
6. Typewriter
7. Typical office type furniture such as: desk, interviewing table, chairs, telephone, etc.
8. Patient identification bracelet machine.

FORMS

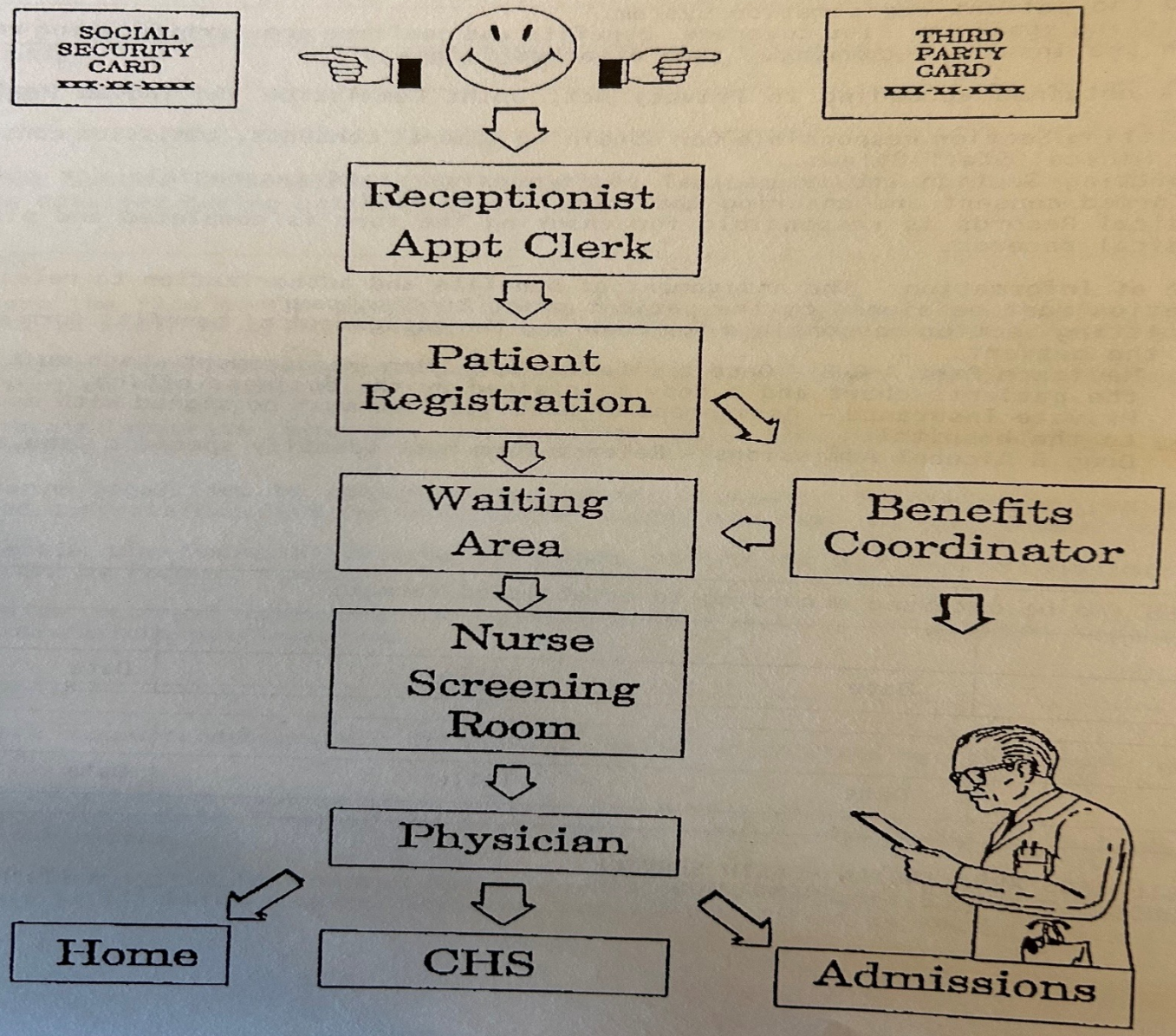
An inventory of the forms currently in use in each IHS Area is required in order to facilitate consistency in data-collection by utilizing the best form and/or developing a new form.

Prototype forms may be designed to facilitate the recording of all the necessary information that your particular facility requires. These forms should be reviewed periodically to ensure that only relevant information is included and all unnecessary information eliminated. The forms utilized in this chapter are a combination of standard Government forms and locally developed forms.

Patient Admissions Flow Chart

Source: Aberdeen Area Indian Health Service
Business Office Implementation Plan

EXHIBIT VIIb.
PATIENT ADMISSIONS
Flow Chart



Chapter Five: Claims Processing

2003 Directors Award

National Business Office Coordinators

Goals, Objectives and Expectations

Chapter Goal

- Provide reader with information necessary to generate all third party bills (claims)

Chapter Objectives

- Provide instructions for generating Medicaid claims
- Provide instructions for generating Medicare claims
- Provide instructions for generating Private Insurance claims
- Provide instructions for tracking Private Insurance claims and payments
- Provide instructions for generating Hospital and Medical Care Claims under FMCRA

User Expectations

- How to generate a Medicaid claim for health services
- How to generate a Medicare claim for health services
- How to generate a Private Insurance claim in the manual or automated TPB system
- How to generate a claim under FMCRA
- How to use the automated “Area Office TPB Tracking System” to track Private Insurance claims and payments

Policy

It is the policy of the IHS that all eligible IHS facilities submit claims to Medicare, Medicaid and Private Insurance for services provided to patients who have third party eligibility

Medicare and Medicaid Rules

Title IV of P.L. 94-437, Indian Health Care Improvement Act, as amended, authorizes IHS facilities to receive payments for care provider to eligible Medicare and Medicaid patients in these facilities

General Policy

- Section 1880 & Section 1911 of the Social Security Act authorizes IHS to participate in the Medicare and Medicaid programs
  - Section 1880 allows for billing to Medicare for covered services provided to Indian patients covered by Medicare for hospitals and Skilled Nursing Facilities (SNF)
  - Section 1911 allows the same authority for Medicaid but adds free standing ambulatory clinics and other providers
  - IHCIA states that funds will be used for the purpose of making any improvements to IHS hospitals and facilities to make improvements that allow compliance with applicable conditions and requirements to meet conditions of participations in the Medicare and Medicaid programs and will be available to the facility for two fiscal years

General Medicare/Medicaid policy

- Covers rationale behind Medicare/Medicaid billing, facility identification and how funds are to be used by IHS facilities

Medicare Claim Generation

Inpatient, Ambulatory Surgery and Outpatient services were billed and paid by the fiscal intermediary, Blue Cross Blue Shield of New Mexico

Policy and Guidance

- Outpatient billed by the Albuquerque Data Center (ADC, now NPIRS)
  - Export from PCC to ADC done once a month
- Outpatient billed using the per diem rate
- ASC claims are billed using the published procedural groups charges Medicare
- Inpatient claims generated to the HCFA-1450 on a per diem basis
  - Inpatient reimbursement uses the DRG methodology
- Although IHS does not have Medicare Part B authority, Part B must be entered into Registration

Instructions provided on completing the UB-82/HCFA-1450 paper claim form

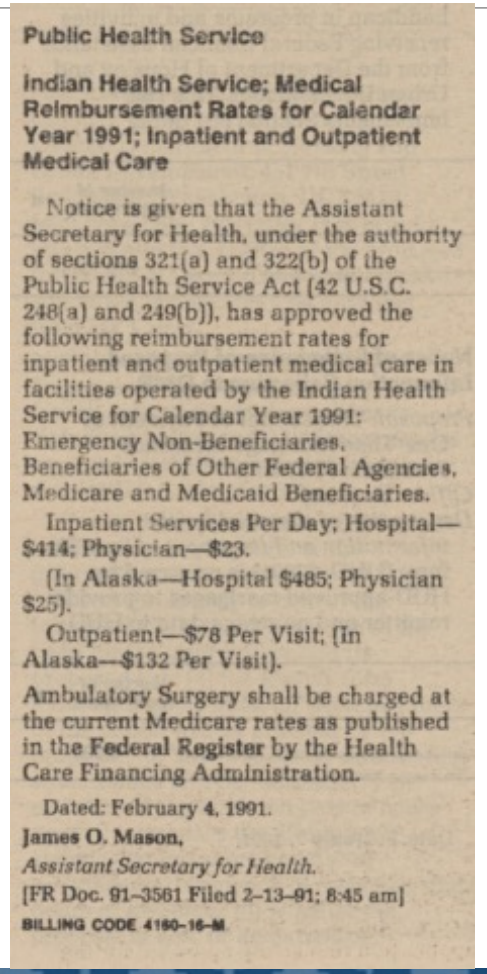
Medicare ASC and Federal Register Notice

ASC's reimbursed using one of eight groups

- Group 1 - $271
- Group 2 - $363
- Group 3 - $400
- Group 4 - $513
- Group 5 - $585
- Group 6 - $752
- Group 7 - $812
- Group 8 - $871

Guidance provided on how to bill if more than one procedure was provided

Rates published by Medicare and provided through "Medicare Certified Indian Health Service Hospital Newsletter"



Public Health Service

Indian Health Service; Medical Reimbursement Rates for Calendar Year 1991; Inpatient and Outpatient Medical Care

Notice is given that the Assistant Secretary for Health, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248(a) and 249(b)), has approved the following reimbursement rates for inpatient and outpatient medical care in facilities operated by the Indian Health Service for Calendar Year 1991: Emergency Non-Beneficiaries, Beneficiaries of Other Federal Agencies, Medicare and Medicaid Beneficiaries.

Inpatient Services Per Day: Hospital—$414; Physician—$23.

(In Alaska—Hospital $485; Physician $25).

Outpatient—$78 Per Visit; (In Alaska—$132 Per Visit).

Ambulatory Surgery shall be charged at the current Medicare rates as published in the **Federal Register** by the Health Care Financing Administration.

Dated: February 4, 1991.

James O. Mason,

Assistant Secretary for Health.

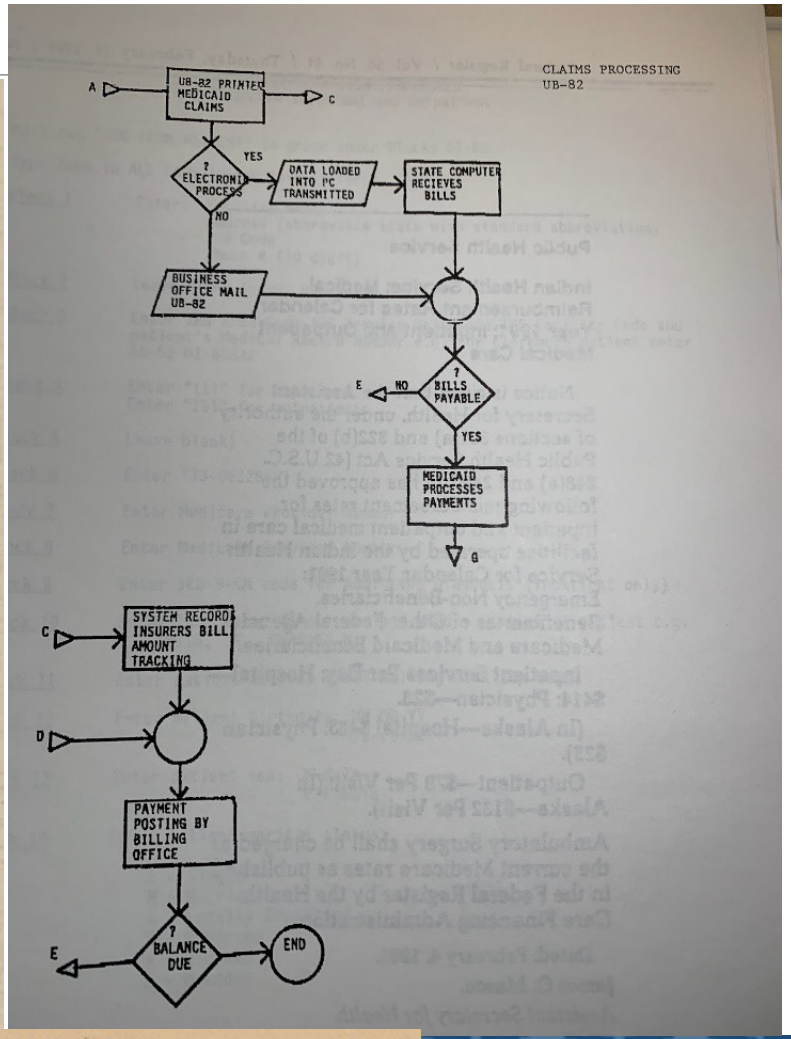
[FR Doc. 91-3561 Filed 2-13-91; 8:45 am]

BILLING CODE 4160-16-M

Medicaid Claim Generation

Contains

- Medicaid billing process
- Federal Register Notice



Public Health Service

Indian Health Service; Medical Reimbursement Rates for Calendar Year 1991; Inpatient and Outpatient Medical Care

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[FR Doc. 91-3561 Filed 2-13-91; 8:45 am]

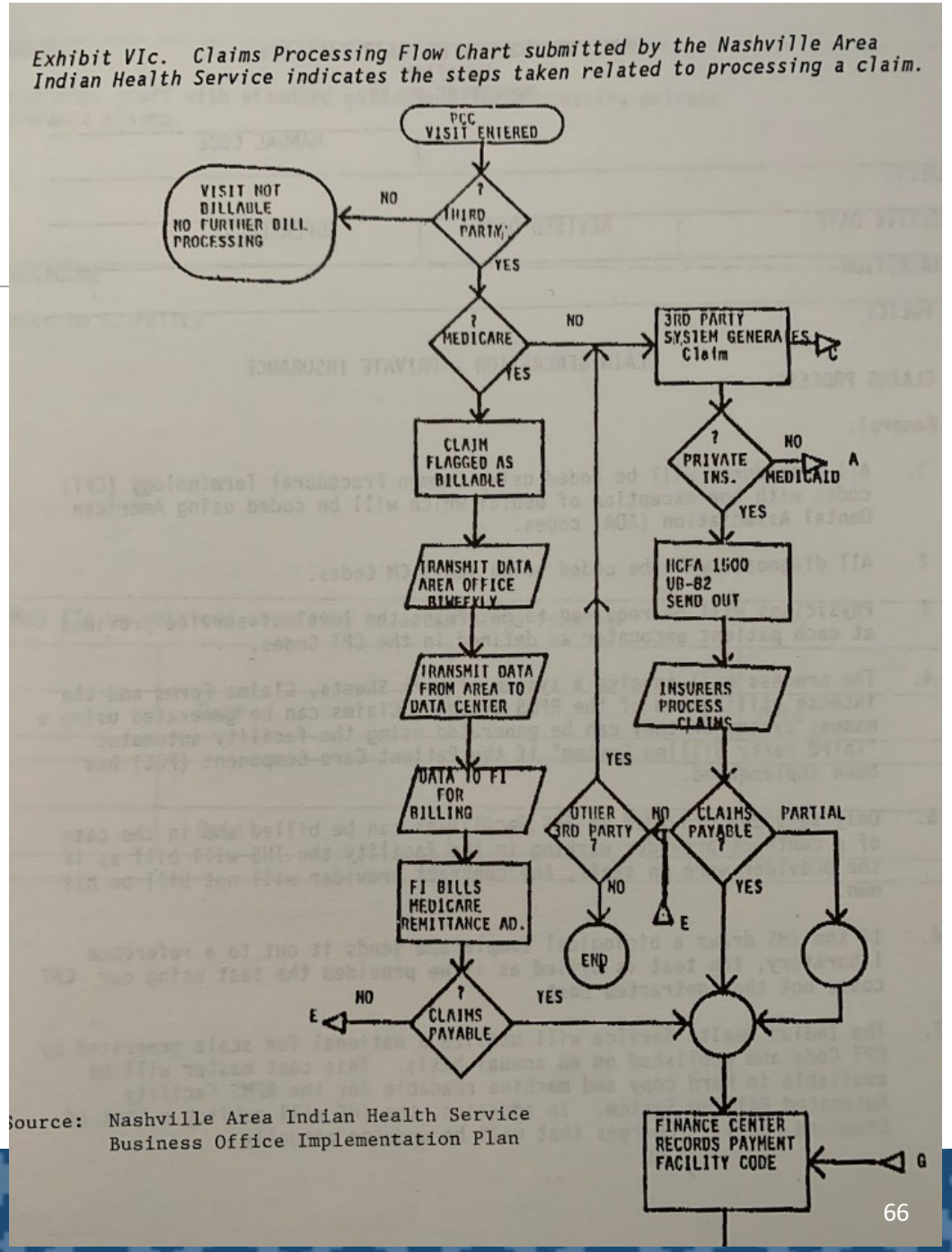
BILLING CODE 4160-16-M

Federal Register / Vol. 56, No. 31 / Thursday, February 14, 1991 / Notices 6029

Private Insurance Claim Generation

Claims Process

- CPT and ADA codes will be utilized
- Diagnosis are coded using ICD-9
- Physicians required to determine level of service
- Process involves using worksheets, claim forms and RPMS
  - Claims and be automatically or manually generated in RPMS
- Only services provided in an IHS facility may be billed
  - Contracted providers are billed as staff providers
- Reference lab is billed as if IHS provided the test
- A national fee schedule will be published (by who?) annually



AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS
Private Insurance

The Indian Health Service (IHS) may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer.

I hereby assign to the IHS such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the IHS. I authorize payment of such benefits directly to IHS. I understand that this assignment applies only to medical services and supplies furnished to me during the time period indicated below.

Date/s of Service

Patient's Signature

WORKSHEET FOR PRIVATE INSURANCE BILLING (OUTPATIENT)

PATIENT	IHS FACILITY	DATE OF VISIT
	CLINIC	PHYSICIAN
ADDRESS	DATE OF BIRTH	SEX M / F
INSUROR	ADDRESS	POLICY NUMBER

PHYSICIAN CARE NEW PATIENT	CODE
BRIEF	90000
LIMITED	90010
INTERMEDIATE	90015
COMPREHENSIVE	90020

PHYSICIAN CARE ESTABLISHED PATIENT	CODE
MINIMAL	90030
BRIEF	90040
LIMITED	90050
INTERMEDIATE	90060
EXTENDED	90070
COMPREHENSIVE	90080

DIAGNOSIS	ICD9 CODE
1	
2	
3	

PROCEDURE	CPT CODE		CHARGE	TOTAL
1				
2				
3				

LABORATORY	CPT CODE		CHARGE
1			
2			
3			
4			
5			
6			

RADIOLOGY	CPT CODE		CHARGE
1			
2			
3			
4			

PHARMACY	CHARGE	DISPENSE	TOTAL
1			
2			
3			
4			
5			
6			

EMERGENCY ROOM	CPT CODE		CHARGE
1			
2			
3			

Definitions and Charges

Definition for Level of Service provided, with examples

- Minimal
- Brief
- Limited
- Intermediate
- Extended
- Comprehensive
- Patient Types
  - New vs. Established

STANDARD FACILITY CHARGES	
Emergency Room Charge	$50.00
Pharmacy Dispense Fee	$4.50
Standard Room and Board/Daily	$260.00
ICC/CCU Room and Board/Daily	$520.00
Operation Room Charge	$250.00
Obstetric Delivery Room Charge	$100.00

Prototype Policy

Outpatient Claims

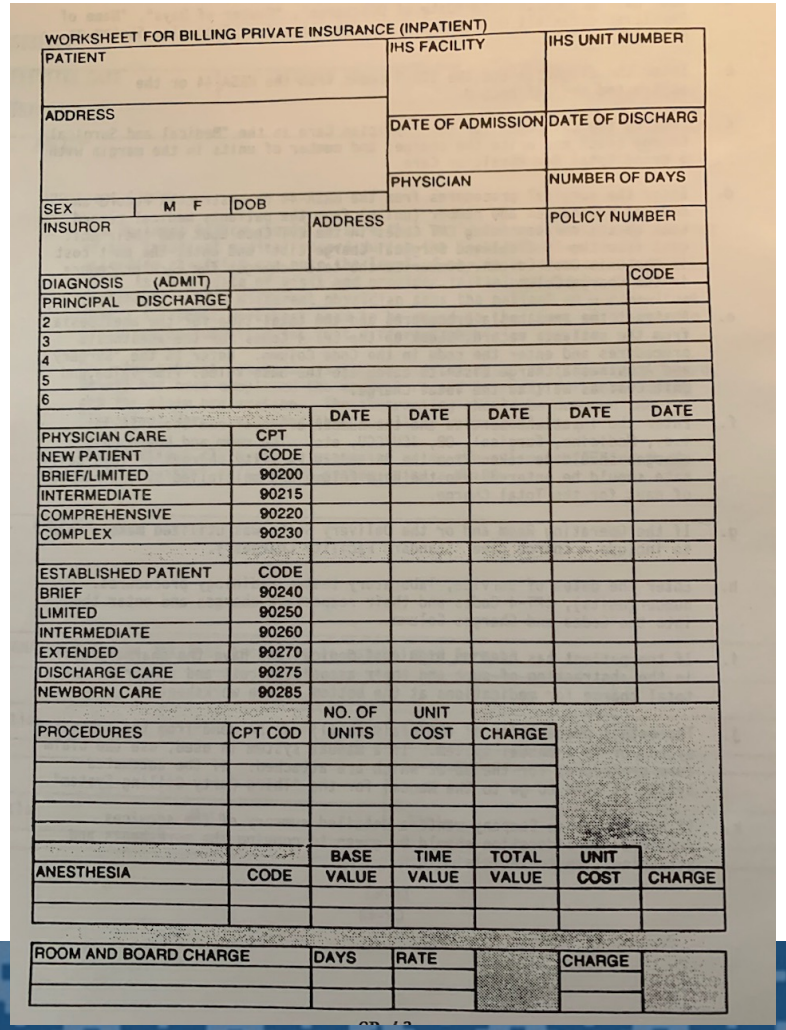
- Claim generated using TPB or manual system
- Ensure Authorization to Furnish Information and AOB-PI on file
- Worksheets placed in patient chart by BO Staff so level of service & diagnostic services can be noted
- Physician must check LOS and sign/initial worksheet
- ER visits must be noted in ER LOG
  - If not logged, bill as routine outpatient visit
- Pharmacy billed at actual cost to IHS plus a dispense fee
- Manual bill added to system if not billing on the UB-82 or HCFA-1500 and will be used for posting
  - A manual bill may be typed out and submitted to the payer

Inpatient Claims

- Ensure Inpatient Worksheet is in the chart
  - Attending physician notes level of service for each visit during the inpatient stay along with date of visit and provider initials
  - Each consulting physician will have their own separate worksheet and a separate bill must be submitted for their services
- Upon discharge, Inpatient Record Brief completed,
  - Record is ready to abstract for claim preparation
  - Completed on Inpatient Worksheet and Ancillary Worksheet
- Bill using the Third Party Billing system or manual system on the UB-82

Guidance provided for each type of service (i.e., Surgical, Anesthesia, R&B, OR)

Inpatient & Ancillary Worksheet for PI



WORKSHEET FOR BILLING PRIVATE INSURANCE (INPATIENT)

PATIENT	IHS FACILITY	IHS UNIT NUMBER
ADDRESS	DATE OF ADMISSION	DATE OF DISCHARG
	PHYSICIAN	NUMBER OF DAYS
SEX M F DOB		
INSUROR	ADDRESS	POLICY NUMBER

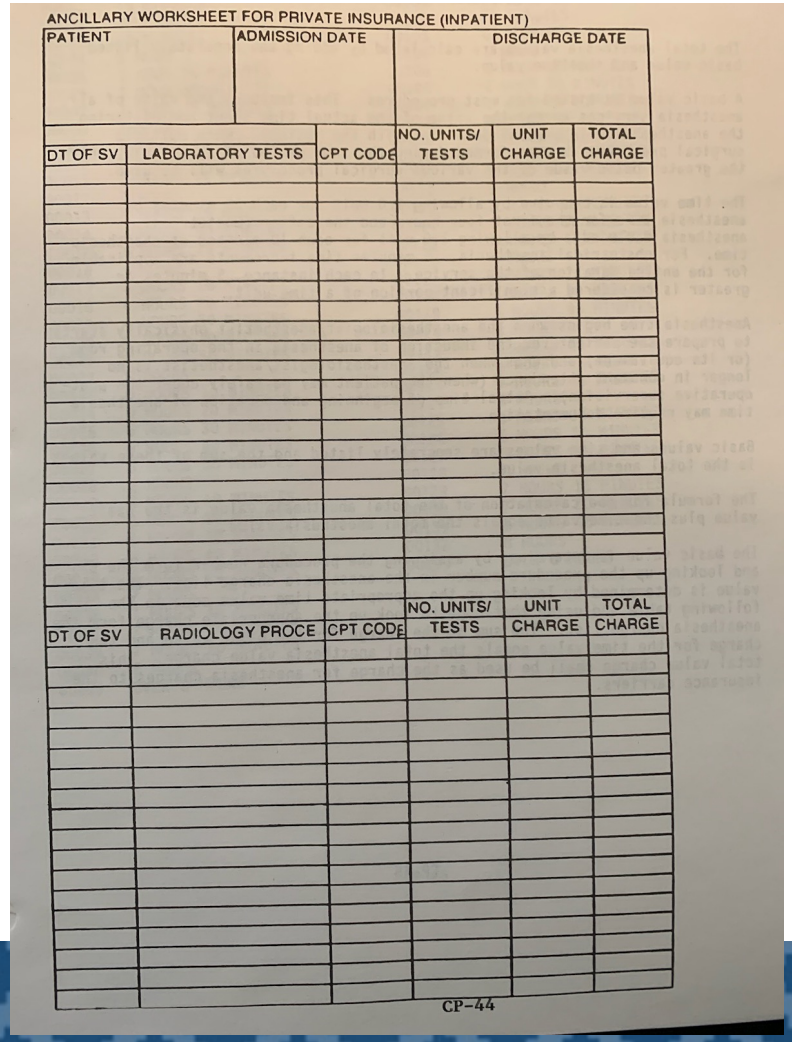
		CODE
DIAGNOSIS (ADMIT)		
PRINCIPAL DISCHARGE		
2		
3		
4		
5		
6		

		DATE	DATE	DATE	DATE	DATE
PHYSICIAN CARE	CPT					
NEW PATIENT	CODE					
BRIEF/LIMITED	90200					
INTERMEDIATE	90215					
COMPREHENSIVE	90220					
COMPLEX	90230					
ESTABLISHED PATIENT	CODE					
BRIEF	90240					
LIMITED	90250					
INTERMEDIATE	90260					
EXTENDED	90270					
DISCHARGE CARE	90275					
NEWBORN CARE	90285					

PROCEDURES	CPT COD	NO. OF UNITS	UNIT COST	CHARGE

ANESTHESIA	CODE	BASE VALUE	TIME VALUE	TOTAL VALUE	UNIT COST	CHARGE

ROOM AND BOARD CHARGE	DAYS	RATE		CHARGE	



ANCILLARY WORKSHEET FOR PRIVATE INSURANCE (INPATIENT)

PATIENT	ADMISSION DATE	DISCHARGE DATE

DT OF SV	LABORATORY TESTS	CPT CODE	NO. UNITS/ TESTS	UNIT CHARGE	TOTAL CHARGE

DT OF SV	RADIOLOGY PROCE	CPT CODE	NO. UNITS/ TESTS	UNIT CHARGE	TOTAL CHARGE

CP-44

Guidance and Reports

Additional Guidance

- Copy of the UB-82 manual along with each form locator definition
- Revenue Code requirements by payer and service
  - Example: 21x requires number of days and may be billed to Medicare, Commercial and Champus for Inpatient only
- BLBS Plans for Institutional billing only with plan codes for each state

Collections Report

This report, or a similar report, will be distributed to Area Business Office Coordinators by HQ on a monthly basis. BOCs are expected to share this report with appropriate staff in their respective Areas

PRIVATE INSURANCE COLLECTIONS
MONTHLY REPORT
IHS

PRIVATE INSURANCE – MAY 1991 YTD

TOTAL DOLLARS BILLED
$ 99,009
$ 2,497,787
$ 476,353
$ 470,607
$ 136,716
$ 543,350
$ 3,669,129
$ 3,094,884
$ 1,185,971
$ 653,931
$ 118,353
$12,946,090

Year-To-Date Report

PRIVATE INSURANCE BILLING REPORT FOR FISCAL YEAR 1990 (OCTOBER 1, 1989 – SEPTEMBER 30, 1990)

	INPATIENT				OUTPATIENT			TOTAL		UNDUPLICATED NO. PATIENTS SERVED		TOTAL UNDUPLICATED SERVED
AREA SERVICE UNIT	NUMBER DISCHARGES BILLED	NUMBER DAYS BILLED	DOLLARS BILLED	DOLLARS COLLECTED	NUMBER VISITS BILLED	DOLLARS BILLED	DOLLARS COLLECTED	DOLLARS BILLED	DOLLARS COLLECTED	INPATIENT	OUTPATIENT	
BILLINGS												
BLACKFEET												
CROW												
FT. BELKNAP												
FT. PECK												
NO. CHEYENNE												
ROCKY BOY'S												
WIND RIVER												
FLATHEAD												
TOTAL												

Monthly Report

PRIVATE INSURANCE BILLING REPORT FOR FISCAL YEAR 1991 _____

	INPATIENT				OUTPATIENT			TOTAL		UNDUPLICATED NO. PATIENTS SERVED		TOTAL UNDUPLICATED SERVED
AREA SERVICE UNIT	NUMBER DISCHARGES BILLED	NUMBER DAYS BILLED	DOLLARS BILLED	DOLLARS COLLECTED	NUMBER VISITS BILLED	DOLLARS BILLED	DOLLARS COLLECTED	DOLLARS BILLED	DOLLARS COLLECTED	INPATIENT	OUTPATIENT	
BILLINGS												
BLACKFEET												
CROW												
FT. BELKNAP												
FT. PECK												
NO. CHEYENNE												
ROCKY BOY'S												
WIND RIVER												
FLATHEAD												
TOTAL												

2000 RPMS TPB/AR Development Team

Third Party Billing System

New Third Party Billing software designed to use Patient Registration system, APC, ADT, Pharmacy and PCC.

- ***Very important that the information in these systems are correct so billing information will be correct***

Claims may be printed on the paper UB-82 or the 1500

Data file is generated and used for tracking at the facility by patient and third party payer

- File may be transmitted to the Area Office for tracking payments

Third Party Billing Software

- Released as Version 1.2 on May 23, 1991
- Emphasis placed on Registration data accuracy so the system will be “correct and efficient”
- Updates to the insurer file must be correctly entered
- Software manual included as part of the Rainbow Book

Area Office Tracking System

AOTS developed to track Private Insurance claims and process payments which uses data imported from the Third Party Billing system

Policy

- *It is the policy of the IHS that the generation of private insurance bills (claims) must be separated from the collection of payments for those claims. Private Insurance claims are generated at the facility level thus the payments should be handled at the Area Office level*
- *In addition, Private Insurance claims and payments must be accounted for by individual patient*

Using the system

- Receives individual claim information from each facility, matches to EOB information which provides a tracking of bills and claims by patient and insurer
- Tracks aging of bills and payments for each provider of service, insurer and individual patient account
- Provide the logging of checks received each day and daily check transmittals for finance
- Process payment data relative to issuing and voiding refunds
- Allows for daily and monthly reconciliation with finance on check transmittals and collections by provider
- Provides information on the amount of co-payments, non-covered services and non-collectibles (write offs)

Area Office Tracking System (con’t)

System “should be run in the Area Office”

- Which functional Division will log payment checks?
- Which functional Division will log EOB information?

Area Office Third Party Billing Tracking System User Guide, Version 1.4, released July 29, 1991

- A copy of the guide is included in the Rainbow Book

Emphasis placed on developing a correct insurer file

- File developed and maintained by the Area Office for the system and all of the field facilities

Appendix: Federal Managers Financial Integrity Act of 1982

P.L. 97-255 -- (H.R. 1526) Federal Managers Financial Integrity Act of 1982 September 8, 1982
An Act to amend the Accounting and Auditing Act of 1950 to require ongoing evaluations and reports of the adequacy of the systems of internal accounting and administrative control of each executive agency, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Sec.1. This Act may be cited as the "Federal Managers' Financial Integrity Act of 1982".

Sec.2. Section 113 of the Accounting and Auditing Act of 1950 (31 U.S.C.66a) is amended by adding at the end thereof the following new subsection:

(d) (1) (A) To ensure compliance with the requirements of subsection (a)(3) of this section, internal accounting and administrative controls of each executive agency shall be established in accordance with standards prescribed by the Comptroller General, and shall provide reasonable assurances that --
(i) obligations and costs are in compliance with applicable law
(ii) funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and
(iii) revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the assets.

(B) The standards prescribed by the Comptroller General under this paragraph shall include standards to ensure the prompt resolution of all audit findings.
(2) By December 31, 1982 the Director of the Office of Management and Budget, in consultation with the Comptroller General, shall establish guidelines for the evaluation by agencies of their systems of internal accounting and administrative control to determine such systems' compliance with the requirements of paragraph (1) of this subsection. The Director, in consultation with the Comptroller General, may modify such guidelines from time to time as deemed necessary.

Appendix: Federal Managers Financial Integrity Act of 1982 (con't)

(3) By December 31, 1983, and by December 31 of each succeeding year, the head of each executive agency shall, on the basis of an evaluation conducted in accordance with guidelines prescribed under paragraph (2) of this subsection, prepare a statement --

(A) that the agency's systems of internal accounting and administrative control fully comply with the requirements of paragraph (1); or

(B) that such systems do not fully comply with such requirements.

(4) In the event that the head of an agency prepares a statement described in paragraph (3)(B), the head of such agency shall include with such statement a report in which any material weaknesses in the agency's systems of internal accounting and administrative control are identified and the plans and schedule for correcting any such weakness are described.

(5) The statements and reports required by this subsection shall be signed by the head of each executive agency and transmitted to the President and the Congress. Such statements and reports shall also be made available to the public, except that, in the case of any such statement or report containing information which is --

(A) specifically prohibited from disclosure by any provision of law; or

(B) specifically required by Executive order to be kept secret in the interest of national defense or the conduct of foreign affairs, such information shall be deleted prior to the report or statement being made available to the public".

Sec.3. Section 201 of the Budget and Accounting Act, 1921 (31 U.S.C.11), is amended by adding at the end thereof the following new subsection:

(k) (1) The President shall include in the supporting detail accompanying each Budget submitted on or after January 1, 1983, a separate statement, with respect to each department and establishment, of the amounts of appropriations requested by the President for the Office of Inspector General, if any, of each such establishment or department.

(2) At the request of a committee of the Congress, additional information concerning the amount of appropriations originally requested by any office of Inspector General, shall be submitted to such committee".

Sec.4. Section 113(b) of the Accounting and Auditing Act of 1950 (31 U.S.C.66a(b)), is amended by adding at the and thereof the following new sentence: "Each annual statement prepared pursuant to subsection (d) of this section shall include a separate report on whether the agency's accounting system conforms to the principles, standards, and related requirements prescribed by the Comptroller General under section 112 of this Act.".

Additional Attachments

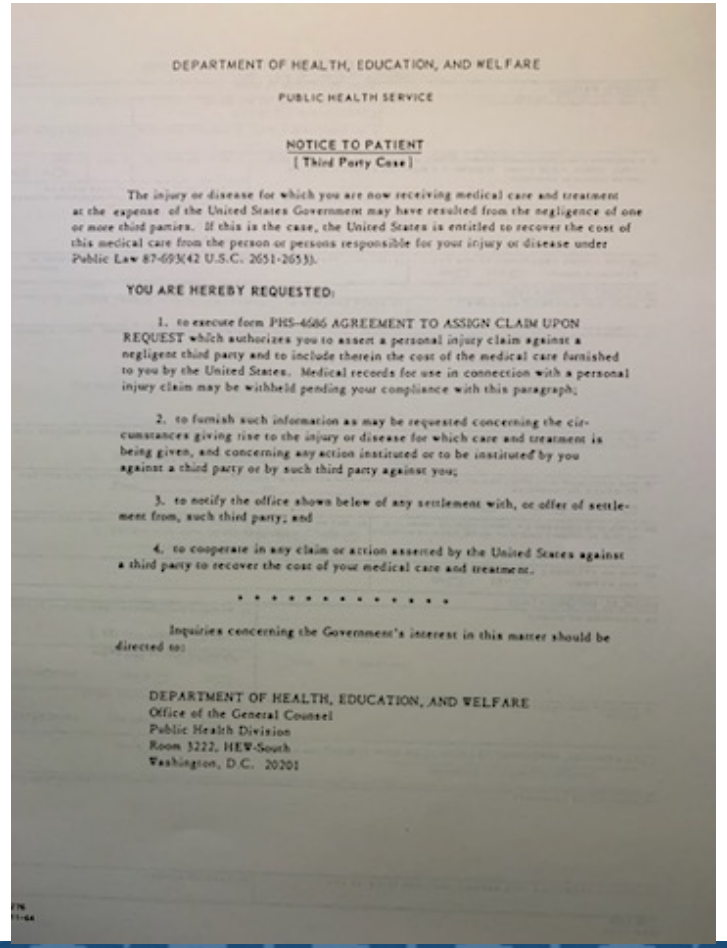
FMCRA Guide

Attorney General's Regulations

- PL 87-693, September 25, 1962
- To provide for the recovery from tortuously liable third persons of the cost of hospital and medical care and treatment furnished by the United States

FORMS

Forms



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

NOTICE TO PATIENT
[Third Party Case]

The injury or disease for which you are now receiving medical care and treatment at the expense of the United States Government may have resulted from the negligence of one or more third parties. If this is the case, the United States is entitled to recover the cost of this medical care from the person or persons responsible for your injury or disease under Public Law 87-693(42 U.S.C. 2651-2653).

YOU ARE HEREBY REQUESTED:

1. to execute form PHS-4686 AGREEMENT TO ASSIGN CLAIM UPON REQUEST which authorizes you to assert a personal injury claim against a negligent third party and to include therein the cost of the medical care furnished to you by the United States. Medical records for use in connection with a personal injury claim may be withheld pending your compliance with this paragraph;

2. to furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given, and concerning any action instituted or to be instituted by you against a third party or by such third party against you;

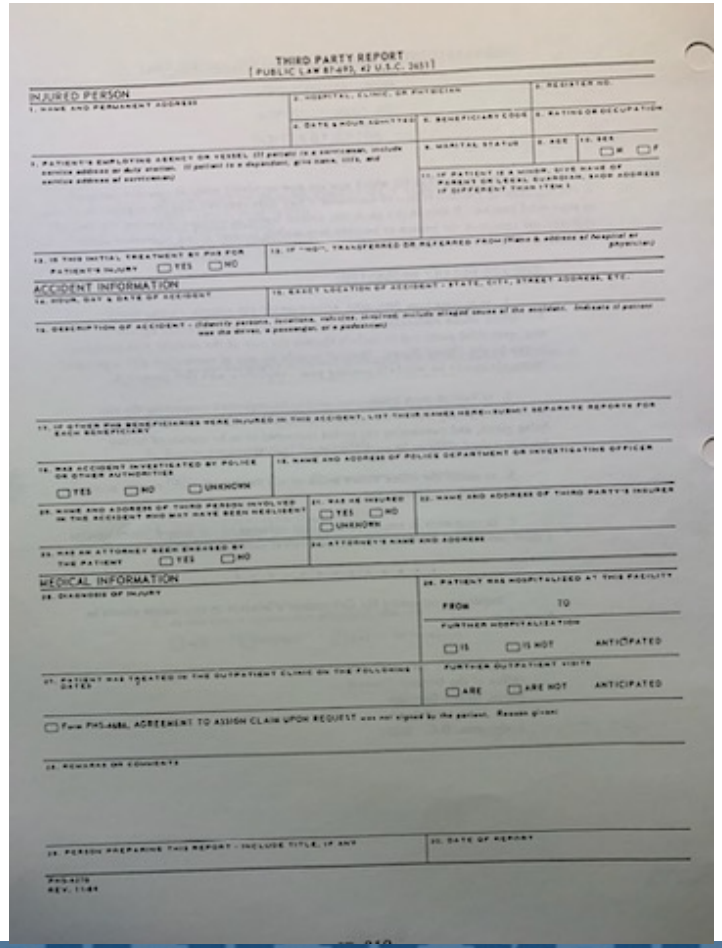
3. to notify the office shown below of any settlement with, or offer of settlement from, such third party; and

4. to cooperate in any claim or action asserted by the United States against a third party to recover the cost of your medical care and treatment.

* * * * * * * * * * * * * *

Inquiries concerning the Government's interest in this matter should be directed to:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the General Counsel
Public Health Division
Room 3222, HEW-South
Washington, D.C. 20201

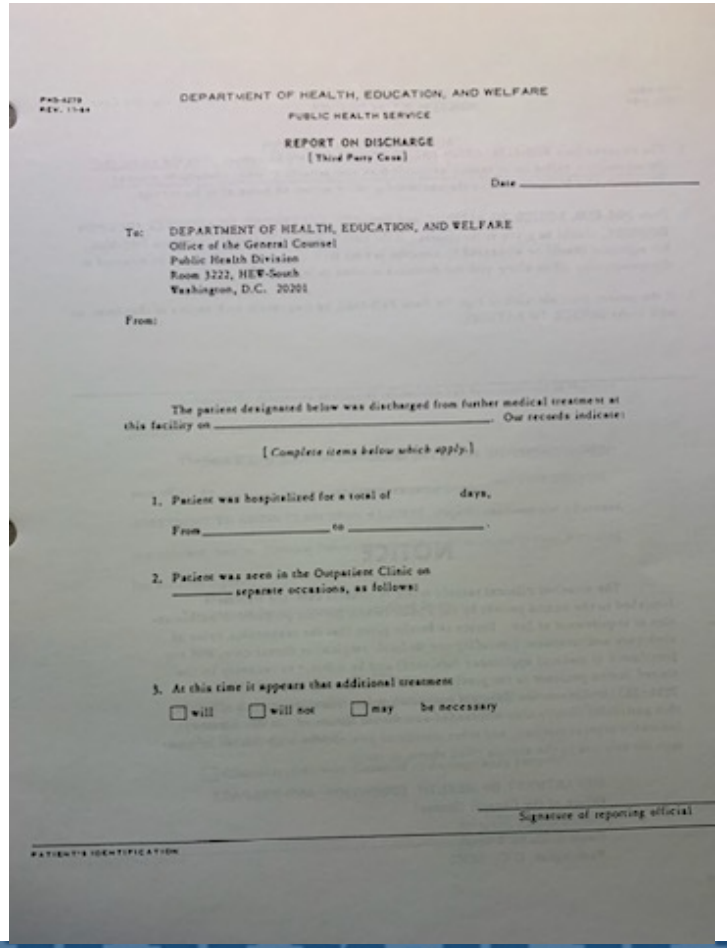


THIRD PARTY REPORT
[PUBLIC LAW 87-693, 42 U.S.C. 2651]

INJURED PERSON

ACCIDENT INFORMATION

MEDICAL INFORMATION



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

REPORT ON DISCHARGE
[Third Party Case]

Date _____

To: DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the General Counsel
Public Health Division
Room 3222, HEW-South
Washington, D.C. 20201

From:

The patient designated below was discharged from further medical treatment at this facility on _____. Our records indicate:

[*Complete items below which apply.*]

1. Patient was hospitalized for a total of _____ days,
From _____ to _____.

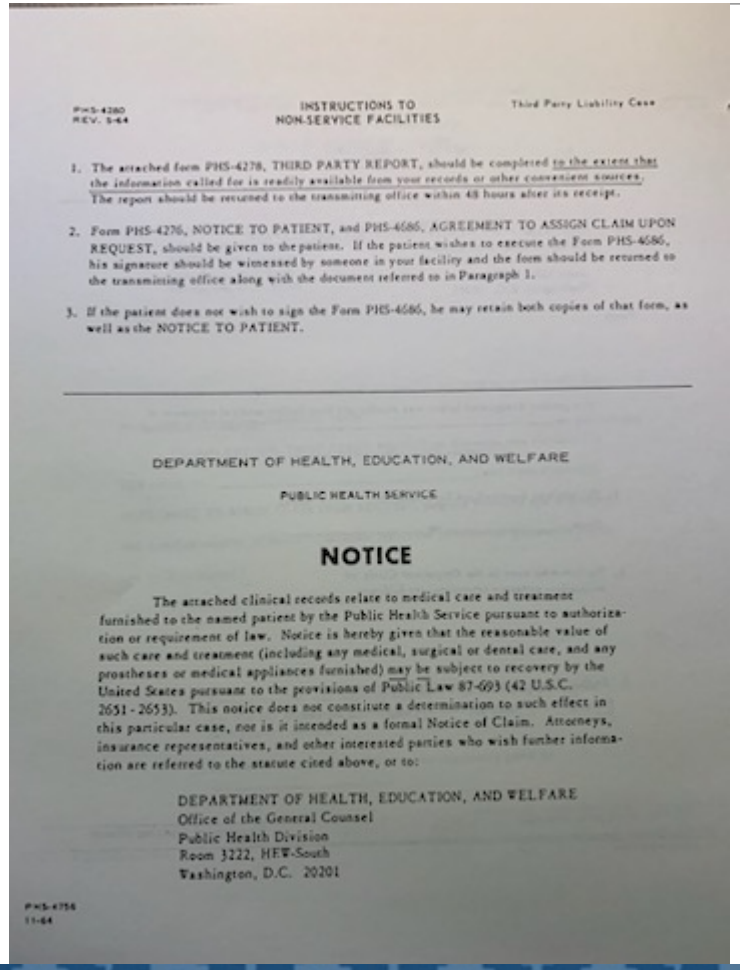
2. Patient was seen in the Outpatient Clinic on _____ separate occasions, as follows:

3. At this time it appears that additional treatment
☐ will ☐ will not ☐ may be necessary

_____
Signature of reporting official

PATIENT'S IDENTIFICATION

Additional Forms



PHS-4280
REV. 5-64

INSTRUCTIONS TO
NON-SERVICE FACILITIES

Third Party Liability Case

1. The attached form PHS-4278, THIRD PARTY REPORT, should be completed to the extent that the information called for is readily available from your records or other convenient sources. The report should be returned to the transmitting office within 48 hours after its receipt.

2. Form PHS-4276, NOTICE TO PATIENT, and PHS-4686, AGREEMENT TO ASSIGN CLAIM UPON REQUEST, should be given to the patient. If the patient wishes to execute the Form PHS-4686, his signature should be witnessed by someone in your facility and the form should be returned to the transmitting office along with the document referred to in Paragraph 1.

3. If the patient does not wish to sign the Form PHS-4686, he may retain both copies of that form, as well as the NOTICE TO PATIENT.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

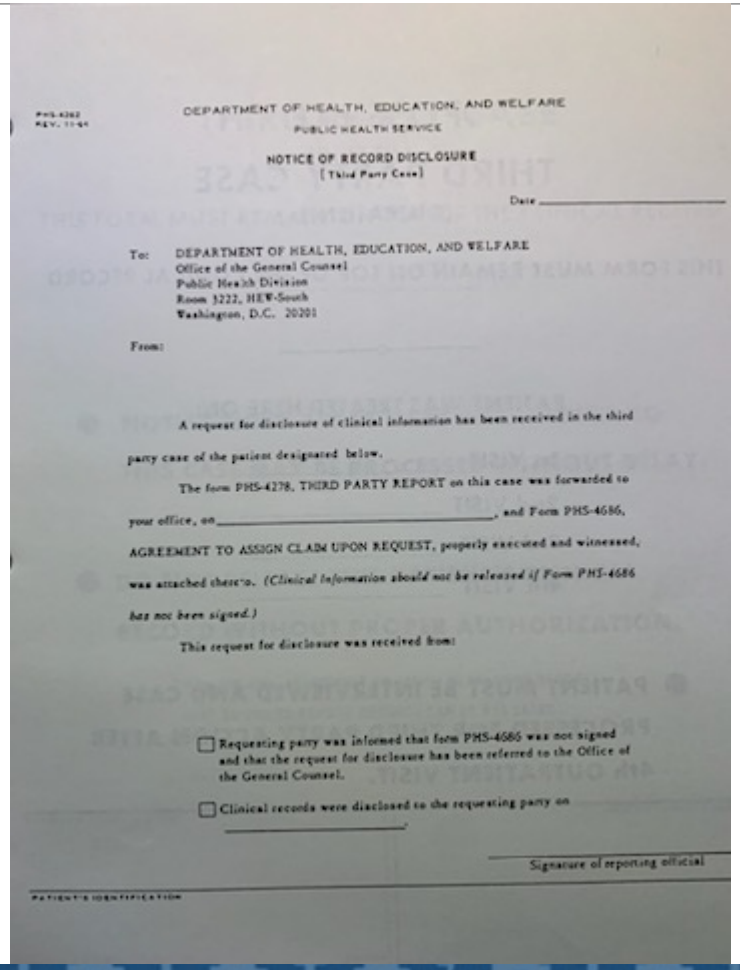
PUBLIC HEALTH SERVICE

NOTICE

The attached clinical records relate to medical care and treatment furnished to the named patient by the Public Health Service pursuant to authorization or requirement of law. Notice is hereby given that the reasonable value of such care and treatment (including any medical, surgical or dental care, and any prostheses or medical appliances furnished) may be subject to recovery by the United States pursuant to the provisions of Public Law 87-693 (42 U.S.C. 2651-2653). This notice does not constitute a determination to such effect in this particular case, nor is it intended as a formal Notice of Claim. Attorneys, insurance representatives, and other interested parties who wish further information are referred to the statute cited above, or to:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the General Counsel
Public Health Division
Room 3222, HEW-South
Washington, D.C. 20201

PHS-4756
11-64



PHS-4282
REV. 11-64

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

NOTICE OF RECORD DISCLOSURE
[Third Party Case]

Date _____

To: DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the General Counsel
Public Health Division
Room 3222, HEW-South
Washington, D.C. 20201

From:

A request for disclosure of clinical information has been received in the third party case of the patient designated below.

The form PHS-4278, THIRD PARTY REPORT on this case was forwarded to your office, on _____, and Form PHS-4686, AGREEMENT TO ASSIGN CLAIM UPON REQUEST, properly executed and witnessed, was attached thereto. *(Clinical information should not be released if Form PHS-4686 has not been signed.)*

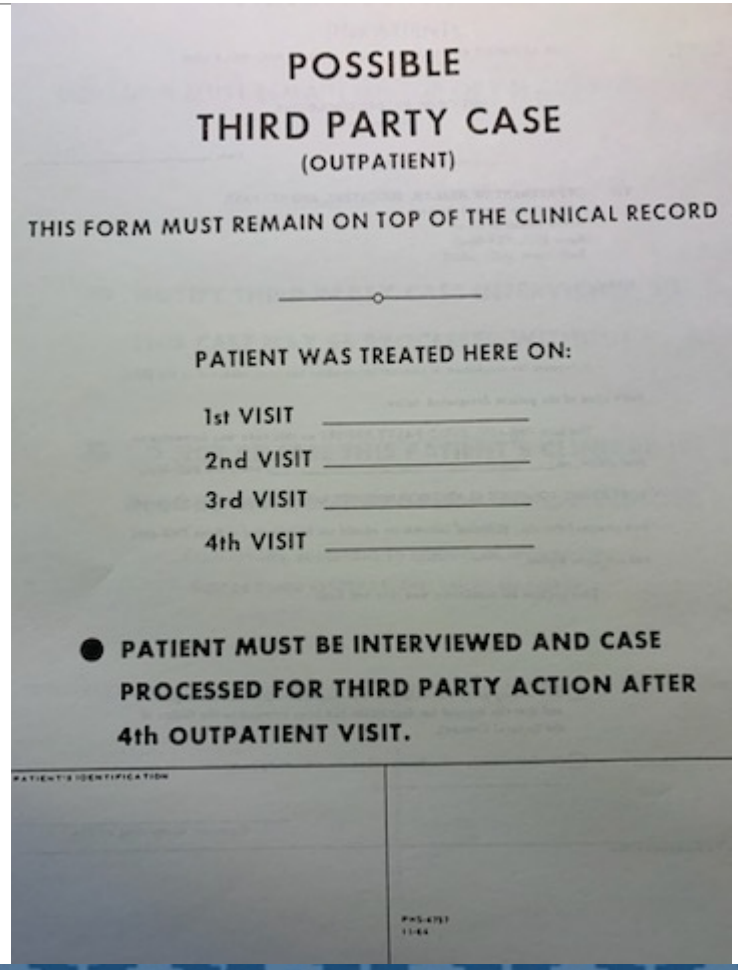
This request for disclosure was received from:

☐ Requesting party was informed that form PHS-4686 was not signed and that the request for disclosure has been referred to the Office of the General Counsel.

☐ Clinical records were disclosed to the requesting party on _____.

_____
Signature of reporting official

PATIENT'S IDENTIFICATION



POSSIBLE

THIRD PARTY CASE

(OUTPATIENT)

THIS FORM MUST REMAIN ON TOP OF THE CLINICAL RECORD

PATIENT WAS TREATED HERE ON:

1st VISIT _____

2nd VISIT _____

3rd VISIT _____

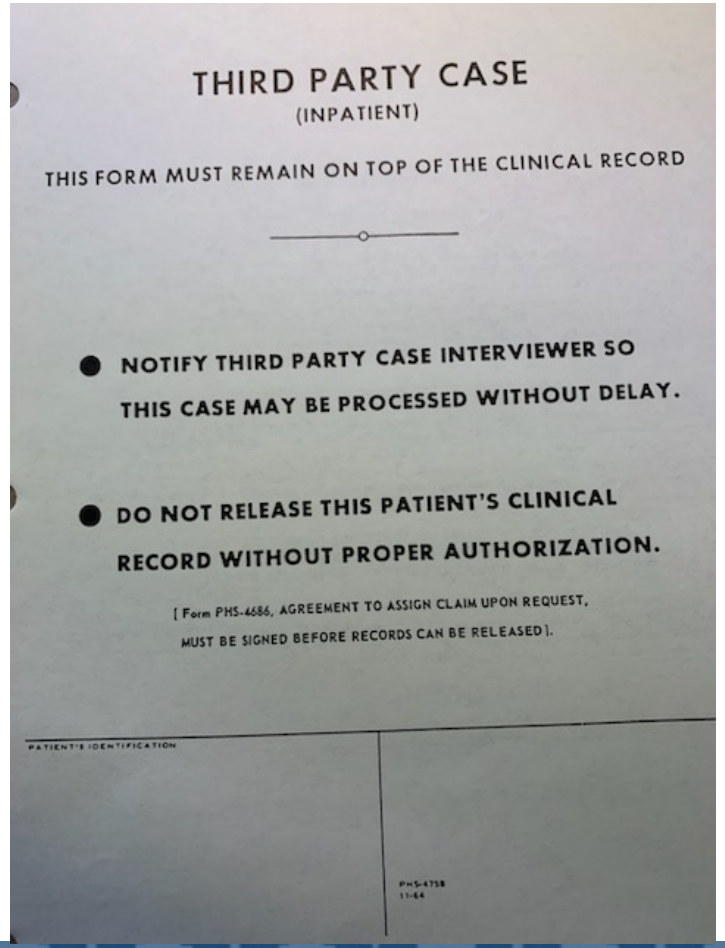
4th VISIT _____

● PATIENT MUST BE INTERVIEWED AND CASE PROCESSED FOR THIRD PARTY ACTION AFTER 4th OUTPATIENT VISIT.

PATIENT'S IDENTIFICATION

PHS-4757
11-64

Forms (last page)



THIRD PARTY CASE
(INPATIENT)

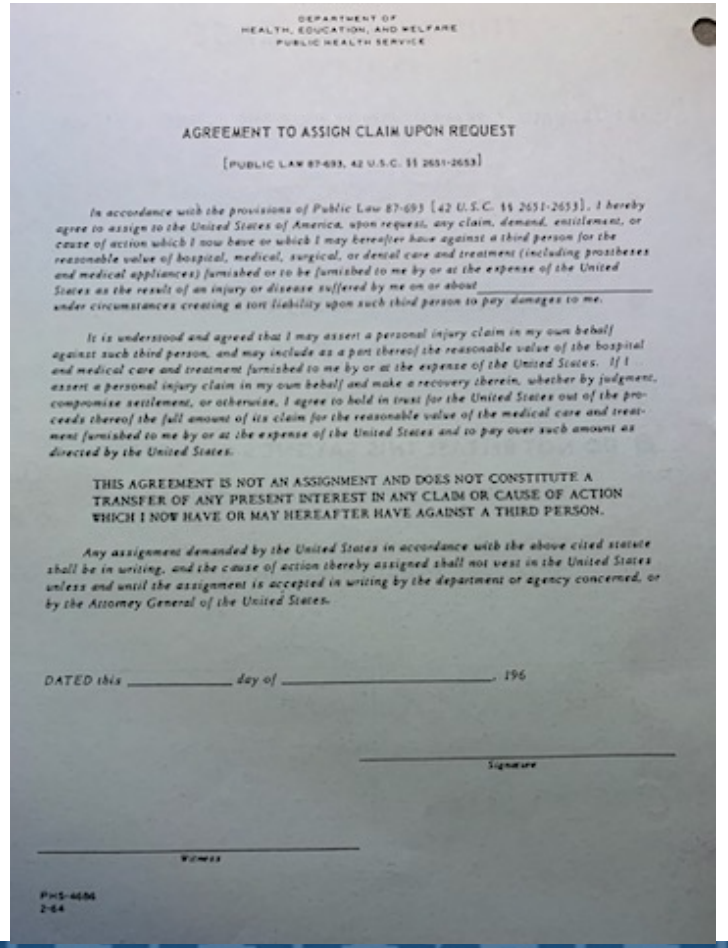
THIS FORM MUST REMAIN ON TOP OF THE CLINICAL RECORD

- NOTIFY THIRD PARTY CASE INTERVIEWER SO THIS CASE MAY BE PROCESSED WITHOUT DELAY.
- DO NOT RELEASE THIS PATIENT'S CLINICAL RECORD WITHOUT PROPER AUTHORIZATION.

[Form PHS-4686, AGREEMENT TO ASSIGN CLAIM UPON REQUEST, MUST BE SIGNED BEFORE RECORDS CAN BE RELEASED].

PATIENT'S IDENTIFICATION

PHS-4758
11-64



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

AGREEMENT TO ASSIGN CLAIM UPON REQUEST

[PUBLIC LAW 87-693, 42 U.S.C. §§ 2651-2653]

In accordance with the provisions of Public Law 87-693 [42 U.S.C. §§ 2651-2653], I hereby agree to assign to the United States of America, upon request, any claim, demand, entitlement, or cause of action which I now have or which I may hereafter have against a third person for the reasonable value of hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) furnished or to be furnished to me by or at the expense of the United States as the result of an injury or disease suffered by me on or about _____ under circumstances creating a tort liability upon such third person to pay damages to me.

It is understood and agreed that I may assert a personal injury claim in my own behalf against such third person, and may include as a part thereof the reasonable value of the hospital and medical care and treatment furnished to me by or at the expense of the United States. If I assert a personal injury claim in my own behalf and make a recovery therein, whether by judgment, compromise settlement, or otherwise, I agree to hold in trust for the United States out of the proceeds thereof the full amount of its claim for the reasonable value of the medical care and treatment furnished to me by or at the expense of the United States and to pay over such amount as directed by the United States.

THIS AGREEMENT IS NOT AN ASSIGNMENT AND DOES NOT CONSTITUTE A TRANSFER OF ANY PRESENT INTEREST IN ANY CLAIM OR CAUSE OF ACTION WHICH I NOW HAVE OR MAY HEREAFTER HAVE AGAINST A THIRD PERSON.

Any assignment demanded by the United States in accordance with the above cited statute shall be in writing, and the cause of action thereby assigned shall not vest in the United States unless and until the assignment is accepted in writing by the department or agency concerned, or by the Attorney General of the United States.

DATED this _____ day of _____, 196

_____
Signature

_____
Witness

PHS-4686
2-64

Picture it…

Imagine coming into the newly created business office and you are getting ready to bill. You:

- Run a claims listing report to get a list of claims to bill
  - Mark off the claims that are orphans generated too soon
- Place a request with your File Clerk to pull charts from Medical Records
  - If no file clerk, you pulled your own charts
- Review the superbill or charge sheet to view the charges marked
  - Continue to scan the chart to review procedures and look for other services provided to the patient that are billable
- Add charges and ensure diagnosis is accurate and complete
- Approve claims print transmittal listing
- Print claims
- Sort claims by payer and mail
- Checks received. Yay!

Chapter Six: Quality Improvement

Chapter 6 Goals, Objectives, & User Expectations

CHAPTER GOALS

The GOALS of this chapter are:

1. To provide continuous quality improvement concepts that include a prototype monitoring system for the (IHS) Business Office.

2. To provide current IHS required internal reporting policies for Medicare; Medicaid; private insurance; and for the annual plan of correction for use of Medicare and Medicaid funds.

CHAPTER OBJECTIVES

1. To ensure that continuous quality improvement concepts are incorporated into all levels of the IHS Business Office system.

2. To clearly identify the requirements of the IHS internal reporting system.

3. To describe the three-tier system assessment conducted by the Service Unit, Area Office, and IHS Headquarters.

4. To promote the philosophy of continuous improvement which assumes that attention to quality must be a day-to-day pervasive activity in all aspects of Business Office operations.

USER EXPECTATIONS

Upon completing the chapter on CONTINUOUS QUALITY IMPROVEMENT, it is expected that the user will know:

1. **HOW TO** identify the important aspects of service and functions of the IHS Business Office.

2. **HOW TO** identify the indicators used to monitor the quality and appropriateness of the important aspects of services and functions of the Business Office.

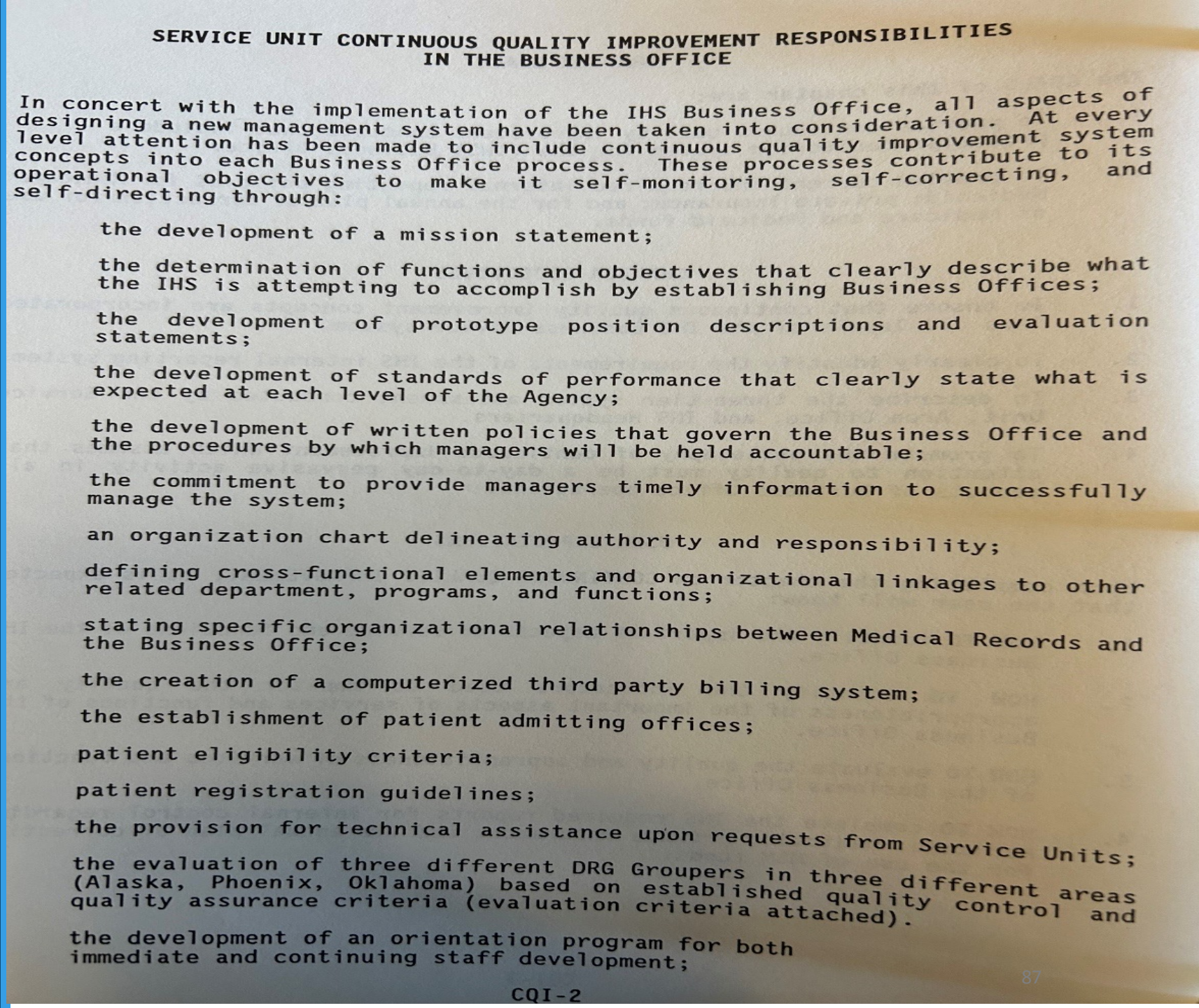
3. **HOW TO** evaluate the quality and appropriateness of services and functions of the Business Office.

4. **HOW TO** complete the IHS required reports for internal control regarding Medicare; Medicaid; private insurance; and the annual plan of correction for the use of M&M funds.

Responsibilities of the Business Office

Step by step identifiers;

Continuous quality improvement must be day-to-day, pervasive activity for Business office operations.



SERVICE UNIT CONTINUOUS QUALITY IMPROVEMENT RESPONSIBILITIES IN THE BUSINESS OFFICE

In concert with the implementation of the IHS Business Office, all aspects of designing a new management system have been taken into consideration. At every level attention has been made to include continuous quality improvement system concepts into each Business Office process. These processes contribute to its operational objectives to make it self-monitoring, self-correcting, and self-directing through:

the development of a mission statement;

the determination of functions and objectives that clearly describe what the IHS is attempting to accomplish by establishing Business Offices;

the development of prototype position descriptions and evaluation statements;

the development of standards of performance that clearly state what is expected at each level of the Agency;

the development of written policies that govern the Business Office and the procedures by which managers will be held accountable;

the commitment to provide managers timely information to successfully manage the system;

an organization chart delineating authority and responsibility;

defining cross-functional elements and organizational linkages to other related department, programs, and functions;

stating specific organizational relationships between Medical Records and the Business Office;

the creation of a computerized third party billing system;

the establishment of patient admitting offices;

patient eligibility criteria;

patient registration guidelines;

the provision for technical assistance upon requests from Service Units;

the evaluation of three different DRG Groupers in three different areas (Alaska, Phoenix, Oklahoma) based on established quality control and quality assurance criteria (evaluation criteria attached).

the development of an orientation program for both immediate and continuing staff development;

CQI-2

Business Office Monitoring and Evaluation Process and Compliance

BUSINESS OFFICE MONITORING AND EVALUATION PROCESS

1. Assign responsibility;
2. Delineate scope of work;
3. Identify important aspects of Business Office operations;
4. Identify indicators related to these aspects of Business Office operations;
5. Establish threshold for evaluation related to the indicators;
6. Collect and organize data;
7. Evaluate specific Business Office operations when thresholds are reached;
8. Take actions to improve performance/products;
9. Assess the effectiveness of the actions and document improvement; and,
10. Communicate relevant information through appropriate channels.

In addition to the above, the IHS Business Office must be given the opportunity to be the best it can become because of its direct bearing on the total Service Unit program through its collection of revenue from third party resources. To do this the Business Office must comply with appropriate JCAHO standards which impact accreditation, HCFA certification, and/or other permanent licensure; IHS Headquarters and Area Office reviews; and other approved groups that will enhance the quality of services provided by the Business Office according to federal, national, and/or professional standards.

CQI-6

Sample Monitoring System for Business Office Implementation

Results tabulated according to these values

MONITORING SYSTEM FOR BUSINESS OFFICE IMPLEMENTATION

The monitoring system that is presented on the next few pages may be utilized by both the IHS area office and service unit facility as a self-assessment guide in the self-monitoring and self-correcting and self-directing process.

The rating scale, which is used by IHS surveyors to assess and report levels of compliance with standards, contains six rankings - the numbers 1 through 5 and NA (not applicable). An explanation of the scale follows:

1. SUBSTANTIAL COMPLIANCE, indicates that the IHS-managed service unit consistently meets all major provisions of the required characteristic.

2. SIGNIFICANT COMPLIANCE, indicates that the IHS-managed service unit/facility meets most provisions of the required characteristic.

3. PARTIAL COMPLIANCE, indicates that the IHS-managed service unit meets some provisions of the required characteristic.

4. MINIMAL COMPLIANCE, indicates that the IHS-managed service unit/facility meets few provisions of the characteristic.

5. NONCOMPLIANCE, indicates that the IHS-managed service unit/facility fails to meet the provisions of the required characteristic.

NA - NOT APPLICABLE, indicates that the required characteristic does not apply to the IHS-managed service unit/facility.

CQI-7

Each dept area

Subject to CQI reviews at SU, Departmental, Area, HQ level

Standard Organization (Service Unit)

Registration (to include Productivity)

PBC

Patient Admissions

Area Office

HQ: Review of Area Offices (assure SU compliance to CQI concepts in establishment of the Business Office), as well as;

Executive Program Review (in relation to the Business Office)

Claims Processing

Area Office CQI Responsibilities

AREA OFFICE CONTINUOUS QUALITY IMPROVEMENT RESPONSIBILITIES IN THE BUSINESS OFFICE

The area office assists the service unit business office by assertively planning for a system of monitoring in support of continuous quality improvement processing and by their participatory role in overall JCAHO accreditation and/or other types of certification and/or licensure as required.

Most area offices employ a program specialist for clinical and auxiliary programs operated by the service units in their Area. The persons fulfilling this role for service unit business offices are the designated Area coordinators. The Area coordinators work closely with the service unit business offices to assist them in designing programs that will be self-monitoring, self-correcting, and self-directing, by

1. developing their internal capacities to ensure and enhance continuous quality improvement;

2. by promoting compliance with the standards established by JCAHO, IHS or other recognized licensing or accrediting bodies; and

3. by institutionalizing and maintaining business office standards in the day-to-day operations of the program.

The business office participates service in the overall JCAHO accreditation process specifically under sections such as:

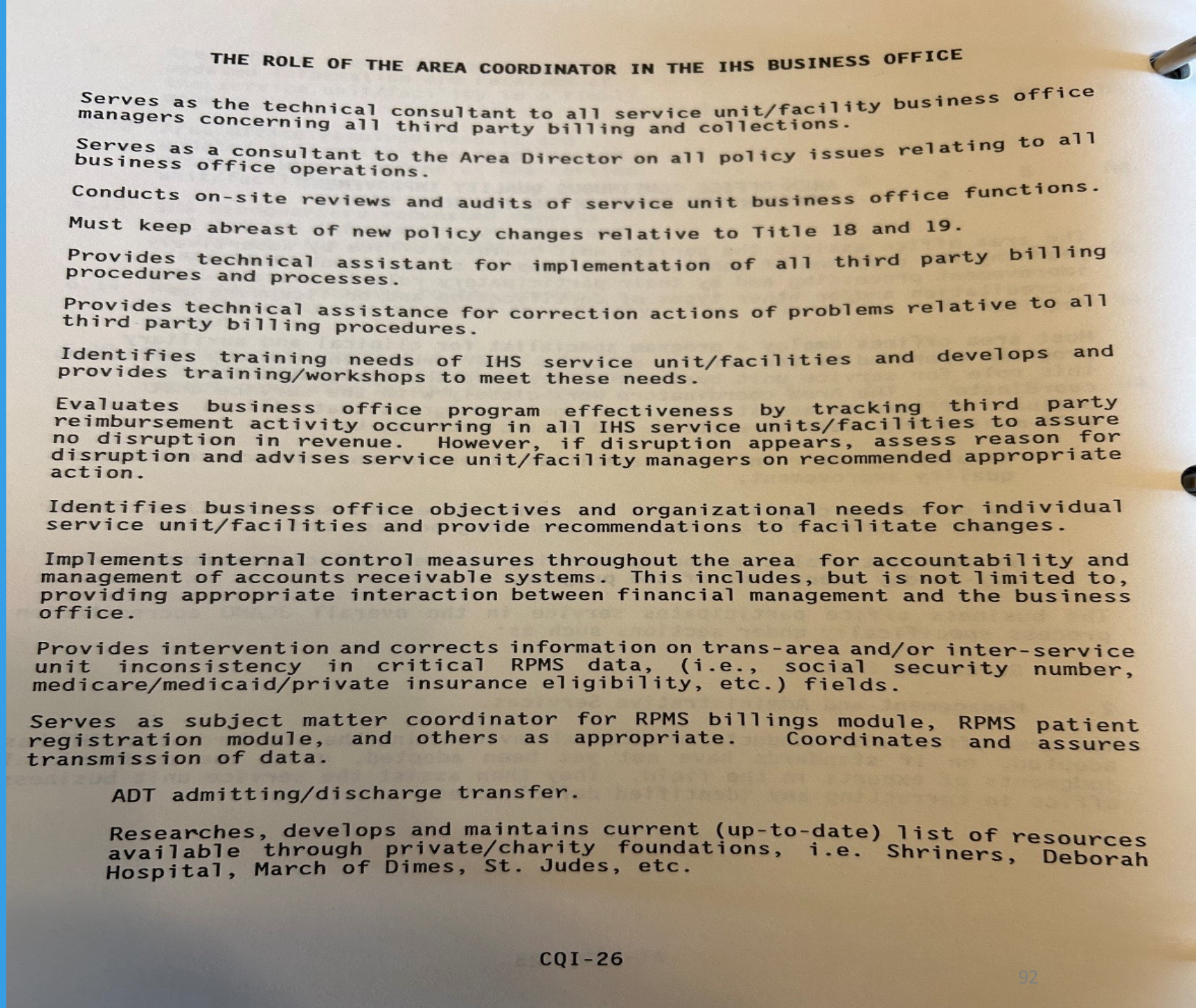
1. Governing Body;

2. Management and Administrative Services.

The area office also conducts an external review using the standards that IHS has adopted, or if standards have not yet been adopted, using the professional judgments of experts in the field. They then assist the service unit business office in correcting any identified deficiencies.

CQI-25

The Role of the Business Office Coordinator



THE ROLE OF THE AREA COORDINATOR IN THE IHS BUSINESS OFFICE

Serves as the technical consultant to all service unit/facility business office managers concerning all third party billing and collections.

Serves as a consultant to the Area Director on all policy issues relating to all business office operations.

Conducts on-site reviews and audits of service unit business office functions.

Must keep abreast of new policy changes relative to Title 18 and 19.

Provides technical assistant for implementation of all third party billing procedures and processes.

Provides technical assistance for correction actions of problems relative to all third party billing procedures.

Identifies training needs of IHS service unit/facilities and develops and provides training/workshops to meet these needs.

Evaluates business office program effectiveness by tracking third party reimbursement activity occurring in all IHS service units/facilities to assure no disruption in revenue. However, if disruption appears, assess reason for disruption and advises service unit/facility managers on recommended appropriate action.

Identifies business office objectives and organizational needs for individual service unit/facilities and provide recommendations to facilitate changes.

Implements internal control measures throughout the area for accountability and management of accounts receivable systems. This includes, but is not limited to, providing appropriate interaction between financial management and the business office.

Provides intervention and corrects information on trans-area and/or inter-service unit inconsistency in critical RPMS data, (i.e., social security number, medicare/medicaid/private insurance eligibility, etc.) fields.

Serves as subject matter coordinator for RPMS billings module, RPMS patient registration module, and others as appropriate. Coordinates and assures transmission of data.

ADT admitting/discharge transfer.

Researches, develops and maintains current (up-to-date) list of resources available through private/charity foundations, i.e. Shriners, Deborah Hospital, March of Dimes, St. Judes, etc.

CQI-26

Role of the Area Coordinator (Cont.)

Develops/presents annual training seminars to area business office personnel (23 sites). Also regional training on an as needed basis.

Interfaces with CHS staff closely as both programs utilize common RPMS data bases i.e. patient registration, provider file, vendor file, etc. and must rely on common alternate resource eligibility information.

Manages patient registration systems data integrity including all reporting i.e quality improvement, etc.

Works with DHHS regional offices and state and county agencies to identify resources available, eligibility criteria, funding, changes in registration, etc.

Develops and implements managed care concepts in all areas of business office and third party, i.e. CQI, reviews, provider compliance, PRO activities, etc.

Works closely with Data Processing Service Branch in ABQ to reconcile the Part B Medicare claims processing and to recommend program changes update edits, etc. to enhance the Part B automated program with the goal of reducing the Part B claim denial rate.

Headquarters CQI Responsibilities in the Business Office

HEADQUARTERS QUALITY IMPROVEMENT RESPONSIBILITIES IN THE BUSINESS OFFICE

Headquarters provides the area offices and service units the support and guidance they need to set and meet their business office continuous quality improvement (CQI) goals which have been built into every aspect of the business office.

In order to make certain that area offices are meeting their CQI responsibilities to the service units in the Area, two types of reviews will be conducted:

1. Review of business offices on an Areawide basis - the main purpose of this review is to assess and improve the Area office's capacity to assure service unit compliance to CQI concepts in the establishment of business offices.

2. Executive Program Reviews - the main purpose of this review is to review and improve the Area's overall strategy for assuring the quality of the facilities and programs within the Area, in this instance in relation to the business office.

Internal Reports

INTERNAL REPORTS

Reporting is a function of the service unit facility, area office and IHS headquarters. Reports are required and are generated at all levels. This activity is necessitated from a management standpoint so all levels of the organization can be informed as to the progress of the business office relative to claims generation, resources collected, and of the utilization of such collections. The required reports flow in all directions, i.e. service unit, area office, IHS headquarters and vice versa. Timely reports and required responses demonstrate both professional courtesy and legal awareness.

Each level of business office management must identify and establish the type of report requirements needed on a continuous basis. All reports should include the following minimum components.

1. Identification of the origin of required reports by Service Unit, Area, IHS Headquarters

2. Expected data of response

3. Subjects include but not limited to

    Monthly and Annual Activity Reports
    Staff Productivity levels
    Area Tracking System
    Outcome Levels
    Maximum billing
    Maximum collections
    Reconciliation process
        Billing vs. Collections

4. -Purpose

5. -Format

6. -Generated by

7. -Distributed to

8. -Analyzed by

9. -Followed up by

10. -Corrective action by

CQI-29

Internal Reporting: Headquarters Requirements

INTERNAL REPORTING: HEADQUARTERS REQUIREMENTS

The purpose for internal reporting per Headquarters requirement is to document and monitor Medicare and Medicaid collections and spending activities in regards to appropriate laws and regulations.

Medicare:

1. A monthly report of collections by Service Unit and Area Total as well as a year to date report is required from each Area due in IHS Headquarters no later than five days after the end of the month. This report should also be sent to each Service Unit for their information (see sample report Medicare/Medicaid Collections).

2. Each service unit is required to develop an Annual Plan of Correction for the Use of Medicare/Medicaid Funds. This Plan is due at the beginning of the Fiscal Year. Each Area must transmit all of the service unit plans in one package plus provide an Area summary to IHS Headquarters no later than October 15. The instructions and plan format is attached and must be followed.

3. Each service unit and Area is required to report annually on the actual use of Medicare/Medicaid funds. This report is due in IHS headquarters, December 15. The Area is required to summarize the service unit reports as well as send a copy of each individual service unit report. Instructions, required forms, and samples of reports are included. The finance report SHR 111 M should be used as the source document for the finance data.

CQI-30

Summary

- We reviewed the national roll-out of Indian Health Service Business Office 1992. Many memories were brought forward as we remembered 30 years ago.
- Throughout history, a good plan is adaptable over time. Equipment to accomplish the task may be more efficient, streamlined, modernized. Good processes change very little. For example, we still need to collect demographics, correct billing information, communication details, POV and triage, visit information, correct coding information, correct documentation, correct billing charges, correct payment, correct adjustments. The process was outlined 30 years ago and has changed very little.
- We started out with zero collections, we are now at the 2-billion dollar milestone; has our process changed? Not really, we started with a GREAT process, and although we have become more efficient with technology, the process remains essentially the same. Electronic claims submission, receiving electronic payment and remittance advices, we even no longer manually post those millions of dollars. We are much more efficient at collecting those 2-billion dollars.

Summary (continued)

- Are we through, finished, all good? We can relax and continue to collect? What was the saying in 1992? ***NOT!***
- **Now we begin the rebranding……**
- **Take everything to the next level!**


INDIAN HEALTH SERVICE
PHS · 1955 ·