

# Standardized Business Office Management Reports

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K DEMPSEY, MHSA  
MANAGEMENT ANALYST  
HEADQUARTERS

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BUSINESS OFFICE COORDINATOR  
BEMIDJI AREA OFFICE



# Standardized Monthly Reporting Requirement

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LESLIE REECE



# OBJECTIVE:

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This presentation will take you through the Monthly Reporting Requirements for the Bemidji Area. Monitoring of Revenue flow is an intense collaboration between 3PB, AR and Denial Management. The reports are from 3PB and the AR package. The Reconciliation workbook is a combined effort involving monitoring between RPMS and UFMS, this task happens to be a daily process and occurs between Business Office and Finance.

The intent is to provide a deep dive into these reports, and assist the Business Office Manager in knowing what to question, what to look for regarding the efficient flow for Revenue monitoring at your facility. You should gain knowledge of:

- What to look for in BOM monthly reports;
- How to consistently monitor and know “where you are at;”
- Provide the framework to make an honest assessment, don’t make excuses, that doesn’t help the situation; it is what it is. If there is a visible hitch, you will be able to;
  - Quickly identify areas for improvement, and ultimately,
  - Improve your overall financial stability.



# Monthly Report with Signature Blocks for BOM, FIN, CEO Y N

1	DAYS – Days to Collection Summary Report (60 day span)	
2	Trend Analysis of Collection (attached)	
3	PSR – Period Summary Report by Clinic Type & Allowance Category	
4	ASM – Quicklook by Account & Category	
5	ASM – Aging Summary Report by Visit Location & Allowance Category	
6	BSL – Batch Statistical Listing	
7	Collection Report – Deposit Log	
8	Operation Trend Graph (report provided by Budget Analyst – attached)	
9	BRRP – Brief Listing of Claims Flagged as Billable & BRRP Rolled in Edit Mode by current month & previous 3 FYs for both reports	
10	CCRP – Cancelled Claims Listing for All Billing Sources	
11	STA – A/R Statistical Report	
12	ADJ – Adjustment & Refund Report (exported to Excel – Attached)	
13	STRP – A/R Statistical Report for All Billing Sources	
14	CXL – Summary Cancelled Bills Report	
15	PEND – Pending Claims Report by Month, Year & No date span	
16	PAY – Top Payer Report by Top 10 Clinics	
17	UFMS/RPMS Reconciliation Spreadsheet (Notes included)	
18	CPT/CEO by Medical Provider, Radiology, Lab, Dental and Pharmacy depts)	
19	LBL – Large Balance List Was there data to report?	
20	SBL – Small Balance List Was there data to report?	
21	NEG – Negative Balance List Was there data to report?	
22	ATS A/R Bill and Transaction Sync Report Was there data to report?	
23	Pharmacy POS Rejection Report (attached)	

<b>ANALYSIS, COMMENTS, AND CORRECTIVE ACTIONS:</b>		Date Reviewed
Business Office Manager Comments:		
Finance Manager Comments:		
CEO Comments:		



# MONITORING REPORTS

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- Attached (following) is the monthly report listing. These reports should be run the first day of the month for the last month completed. For example, June reports would be run and reported on July 1. If the 1<sup>st</sup> falls on a weekend, the first Monday is to be used.
- Reports should be run and electronically signed by the Business Office Manager. Explanations of “overages” or differences will accompany the signed report.
- Business Office Manager will forward all reports/attachments to the Finance Manager. Finance Manager will review reports, ask questions, write questions, electronically sign the form and forward to the CEO.
- CEO will review reports, ask questions, request a meeting for explanation and return to Business Office Manager.
- Business Office Manager will file reports on the secure shared drive, facility folder with all documentation, explanation. BOM will notify Area BOC of completion by the 10<sup>th</sup> of the current month.
- If BOC has questions, comments, recommendations notice will be shared with the facility team as well as the Bemidji Area Team.



# DAYS REPORT

A/R->DAYS->RPT->FRM->DAYS

File Edit Format View Help

WARNING: Confidential Patient Information, Privacy Act Applies

for ALL BILLING SOURCE(S)  
at ALL Visit location regardless of Billing Location with VISIT DATES  
from 04/01/2023 to 05/31/2023

JUN 1, 2023@11:47 Page 1

Month of DOS	# of Visits	# Visits with Bills	# of Bills	Billed Amount	AVG Visits Checked in	AVG Days to PCC CREATED	AVG Days to Reviewed	AVG Days 3p Bill APPROVED	AVG Date Export EXPORTED	AVG Days to Payment	AVG Days First Posting	AVG Days Last Posting	Total Posted Amounts
APR 2023	1545	1545	1551	581492.03	0.86	0.03	5.08	9.17	9.31	20.03	20.40	20.42	386203.96
MAY 2023	1414	1414	1414	510674.00	0.83	0.07	4.91	8.09	8.34	16.86	16.93	16.96	206154.59
<b>GRAND TOTAL:</b>	<b>2959</b>	<b>2959</b>	<b>2965</b>	<b>1092166.03</b>	<b>0.84</b>	<b>0.05</b>	<b>5.00</b>	<b>8.66</b>	<b>8.85</b>	<b>19.07</b>	<b>19.34</b>	<b>19.36</b>	<b>592358.55</b>
TOTAL BILLS WITH NO EXPORT: 0													

If this is large, check coding backlog

If either of these are large, billing backlog

Clearinghouse issue, payer issue. Check it out!

If large, posting backlog



# ASM (AGE SUMMARY REPORT)

A/R->RPT->ARM->ASM

Age Summary Report for ALL ALLOWANCE CATEGORY(S) JUN 30,2023@07:43 Page 3  
at ALL Visit location(s) under XYZ FACILITY Billing Location

ALLOWANCE CATEGORY	CURRENT	31-60	61-90	91-120	120+	BALANCE
*** VISIT Location: MONUMENT VALLEY						
MEDICAID	225690.52	683.45	125.59	0.00	0.00	226499.56
# of Claims	1084	9	1			1094
MEDICARE	187726.99	1477.42	1686.58	880.51	2075.00	193846.50
# of Claims	803	10	13	8	11	845
OTHER	0.00	5460.00	3640.00	5460.00	26124.00	40684.00
# of Claims		12	8	12	58	90
PRIVATE INSURANCE	317096.12	33113.40	14106.08	44287.17	42933.16	451535.93
# of Claims	1386	105	55	76	109	1731
VETERANS	10278.15	961.00	2014.00	0.00	596.00	13849.15
# of Claims	12	3	2		2	19
*** VISIT Loc Total	740791.78	41695.27	21572.25	50627.68	71728.16	926415.14
# of Claims	3285	139	79	96	180	3779
# of Claims	768944.33	52000.09	22779.25	50996.68	72621.44	967341.79
# of Claims	3453	170	86	99	185	3993



# Adjustment report

A/R->RPT->FRM->ADJ

ALLOWANCE CAT	INSURER TYPE	INSURER	ADJUSTMENT TYPE	TOTAL ADJUSTMENT				
MEDICARE	MCR PART D	D-HUMANA-015581	Adj for admin cost (RX only)	\$6,825.47				
PRIVATE INSURANCE	PRIVATE INSURANCE	U M R	Amt Reduced Portion of Proc pd	\$26.00				
MEDICARE	MEDICARE FI	MEDICARE	Amt Reduced Portion of Proc pd	\$438.65				
PRIVATE INSURANCE	PRIVATE INSURANCE	BLUE CROSS/BLUE SHIELD OF MN	Attachment/Doc not received	\$0.00				
MEDICARE	MEDICARE HMO	UNITED HEALTH CARE	Auth Number missing/invalid	-\$420.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	BLUE CROSS/BLUE SHIELD OF MN	Auth Number missing/invalid	-\$439.97				
PRIVATE INSURANCE	PRIVATE INSURANCE	MAIL HANDLERS BENEFIT PLAN	Auth Number missing/invalid	\$2,828.00	\$5,214.45	Implement process of obtaining authorization numbers, submitting on claim.		
PRIVATE INSURANCE	PRIVATE INSURANCE	SANFORD HEALTH PLAN	Auth Number missing/invalid	\$1,917.21				
VETERAN	VETERANS MEDICAL BENEFITS	VA MEDICAL BENEFITS (VMBP)	Auth Number missing/invalid	\$535.21				
OTHER	WORKMEN'S COMP	US DEPARTMENT OF LABOR	Auth Number missing/invalid	\$794.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	BLUE CROSS/BLUE SHIELD OF MN	Ben not available under plan	\$1,156.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	DELTA DENTAL PLAN OF MN	Ben not available under plan	\$1,551.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	DELTA DENTAL OF SOUTH DAKOTA	Ben not available under plan	\$973.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	UNITED HEALTH CARE	Ben not available under plan	\$391.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	MEDICA	Ben not available under plan	\$1,787.00				
PRIVATE INSURANCE	PRIVATE INSURANCE	SAGE-MN DEPT OF HEALTH	Ben not available under plan	\$3,618.00				
MEDICARE	MEDICARE FI	MEDICARE	Ben not available under plan	\$60.69				





# BRRP Report

BILL>RPTP->BRRP

EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:

- Claim Status.....: Flagged as Billable
- Report Type.....: BRIEF LISTING (80 Width)

Select one of the following:

- 1 LOCATION
- 2 BILLING ENTITY
- 3 DATE RANGE
- 4 CLAIM STATUS
- 5 PROVIDER
- 6 ELIGIBILITY STATUS
- 7 REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS: 3 DATE RANGE

Enter STARTING VISIT DATE for the Report: 06.01.23 (JUN 01, 2023)

Enter ENDING DATE for the Report: T (AUG 02, 2023)

BRIEF LISTING OF CLAIMS Flagged as Billable AUG 2,2023@07:14:13 Page 1  
 for ALL BILLING SOURCES with VISIT DATES from 06/01/2023 TO 08/02/2023  
 Billing Location: YZZZ

ST	Patient	HRN	Active Insurer	Claim Number	Visit Date	Clinic
Visit Type: OUTPATIENT						
FAB			MINNESOTA MEDICAID		7/27/2023	GENERAL
FAB			BLUE CROSS BLUE SHIE		7/7/2023	EMERGENCY
FAB			PREFERRED ONE ADMIN		6/23/2023	PEDIATRIC
FAB			MEDICARE		6/9/2023	OCCUPATIO
FAB			VA MEDICAL BENEFIT (		7/31/2023	FAMILY PR
FAB			CIGNA		7/17/2023	MAMMOGRAP
Subtotal				613		
Visit Type: PHYSICAL THERAPY						
FAB			MINNESOTA MEDICAID		7/24/2023	PHYSICAL
FAB			BLUE CROSS/BLUE SHIE		7/11/2023	PHYSICAL
FAB			MEDICARE		7/11/2023	PHYSICAL
Subtotal				38		
Visit Type: EMERGENCY ROOM						
FAB			MINNESOTA MEDICAID		7/20/2023	EMERGENCY
FAB			BLUE CROSS/BLUE SHIE		7/18/2023	EMERGENCY
FAB			MEDICARE		7/25/2023	EMERGENCY

FAB		NON-BENEFICIARY PATI		7/23/2023	EMERGENCY	
FAB		NON-BENEFICIARY PATI		6/29/2023	EMERGENCY	
Subtotal			146			
Visit Type: AUDIOLOGY						
FAB		BLUE CROSS/BLUE SHIE		7/20/2023	AUDIOLOGY	
FAB		MINNESOTA MEDICAID		7/20/2023	AUDIOLOGY	
Subtotal			8			
Visit Type: podiatry						
FAB		BLUE CROSS/BLUE SHIE		7/5/2023	PODIATRY	
FAB		MEDICARE		7/12/2023	PODIATRY	
FAB		AETNA		7/5/2023	PODIATRY	
Subtotal			6			
Visit Type: PEDIATRICS						
FAB		BLUE CROSS/BLUE SHIE		7/18/2023	PEDIATRIC	
Subtotal			5			
Visit Type: DENTAL						
FAB		MEDICA-UNITED HEALTH		6/7/2023	DENTAL	
FAB		MINNESOTA MEDICAID		6/15/2023	DENTAL	
FAB		VA MEDICAL BENEFIT (		6/12/2023	DENTAL	
Subtotal			127			
Visit Type: PROFESSIONAL COMPONENT						
EDT		MEDICARE		6/9/2023	OCCUPATIO	
Subtotal			99			
Total			1,043			

(REPORT COMPLETE):



Period Summary Report AUG 2,2023@11:4 Page 1  
 for **MEDICARE** ALLOWANCE CATEGORY(S) with TRANSACTION DATES from 01/01/2023  
 to 06/30/2023  
 at [REDACTED] Visit location(s) regardless of Billing Location

ALLOWANCE CATEGORY	Billed Amt	Payment	Adjustment	Refund
MEDICARE	3,861,972.88	1,524,110.82	2,291,910.30	0
*** VISIT Loc Total	3,861,972.88	1,524,110.82	2,291,910.30	0
=				
***** REPORT Total	3,861,972.88	1,524,110.82	2,291,910.30	0

A/R->RPT->FRM->PSR

Period Summary Report AUG 2,2023@11:5 ge 1  
 for **MEDICAID** ALLOWANCE CATEGORY(S) with TRANSACTION DATES from 01/01/2023  
 to 06/30/2023  
 at [REDACTED] Visit location(s) regardless of Billing Location

ALLOWANCE CATEGORY	Billed Amt	Payment	Adjustment	Refund
MEDICAID	4,117,528.03	-14,605,211.69	10,564,116.15	0
*** VISIT Loc Total	4,117,528.03	-14,605,211.69	10,564,116.15	0
=				
***** REPORT Total	4,117,528.03	-14,605,211.69	10,564,116.15	0



DETAIL Cancelled Bills Report  
 For ALL Visit Locations  
 containing ONLY bills with an Open Balance.

BILL->RPTP->CCRP

Patient	HRN	Active Insurer #	Claim Number BILLS	Visit Date AMT BILLED	Reason BALANCE
Cancelling Official: XYZ VISIT Location: ABC Visit Type: OUTPATIENT					
		BLUE CROSS/BLU	1111111-A	PROVIDER UPDATE	
		-	----	-----	-----
				1	70.01 70.01
Cancelling Official: XYZ VISIT Location: ABC Visit Type: Pharmacy POS					
		MINNESOTA MEDI	1111111-A	132,023 83	7 RESUBMIT
		-	----	-----	-----
				1	5.99 5.99
Visit Type: PROFESSIONAL COMPONENT					
		MEDICARE	1111111-A	AY 25, 2023 CH	ART REVIEW
		-	----	-----	-----
				1	334 334
** VISIT Location Subtotal: otal				2	339.99 339.99
Cancelling Official Subtotal:				2	339.99 339.99
<b>*** REPORT TOTAL</b>				<b>3</b>	<b>410 410</b>



for ALL BILLING SOURCES with VISIT DATES from 01/01/2023 to 06/30/23

Billing Location: XYZ Facility

Patient	HRN	Claim Number	Visit Date	Clinic	Reason
---------	-----	--------------	------------	--------	--------

Visit Location: XYZ Facility  
Visit Type: OUTPATIENT

BILL->RPTP->PCRP

Active Insurer MINNESOTA MEDICAL ASSISTANCE  
 [REDACTED] 2/23/2023 EMERGENCY ME 8-PIN# License Missi  
 [REDACTED] 5/17/2023 GENERAL 12-Incomplete Policy  
 Status Updater: JOYOUS EMPLOYEE

Active Insurer: MEDICARE  
 [REDACTED] 1/30/2023 LABORATORY S 12-Incomplete Policy  
 Status Updater: JOYOUS EMPLOYEE

Active Insurer MEDICARE  
 [REDACTED] 1/12/2023 BEHAVIORAL H 8-PIN# License Missi  
 [REDACTED] 5/24/2023 EMERGENCY ME 12-Incomplete Policy  
 Status Updater: JOYOUS EMPLOYEE

Subtotal: 63

Total: 103

REASONS:

- 7-Verify Eligibility
- 8-PIN# License Missing
- 9-Cannot locate Medical Record to verify Services
- 12-Incomplete Policy Holder information
- 17-Other



Top Payer Report for ALL BILLING SOURCE(S) AUG 2,2023@1 6:25 Page 1  
 at ALL Visit location under XYZ Billing Location  
 with VISIT DATES from 01/01/2023 to 06/30/2023  
 ALL Primary Diagnosis (ICD-9 and ICD-10) Sort by: ALLOWANCE CATEGORY

A/R ACCOUNT	TX CNT	AMOUNT PD	ALLOWABLE
=====			
ALLOWANCE CATEGORY: MEDICAID (INS TYPES D K FPL)			
MINNESOTA MEDICAID	4,854	\$3,059,181.95	\$3,060,119.34
ALLOWANCE CATEGORY: MEDICARE (INS TYPES R MH MD MC MMC)			
MEDICARE	1,188	\$101,817.93	\$135,698.74
RAILROAD RETIREMENT	57	\$6,413.45	\$8,050.93
ALLOWANCE CATEGORY: OTHER (INS TYPES W C N I G T SEP TSI)			
BERKLEY RISK ADMINISTRATORS	2	\$381.66	\$381.66
ALLOWANCE CATEGORY: PRIVATE INS (INS TYPES P H F M)			
BLUE CROSS/BLUE SHIELD OF MN	961	\$55,132.57	\$89,276.77
HUMANA INSURANCE COMPANY	216	\$26,127.69	\$34,490.06
UNITEDHEALTH INTEGRATED SVCS	119	\$15,516.49	\$18,788.82
CHAMPUS, COMMISSIONED OFFICER	26	\$14,706.00	\$14,706.00
MAIL-HANDLERS BENEFIT PLAN	106	\$6,964.78	\$11,957.00
ALLOWANCE CATEGORY: VETERANS (INS TYPES V)			
VA MEDICAL BENEFIT (VMBP)	689	\$117,001.39	\$117,001.39
<b>TOTALS</b>	<b>8,218</b>	<b>\$3,403,243.91</b>	<b>\$3,490,470.71</b>

A/R->RPT->FRM->PAY

MINNESOTA MEDICAID	4,854	\$3,059,181.95	\$3,060,119.34
VA MEDICAL BENEFIT (VMBP)	689	\$117,001.39	\$117,001.39
MEDICARE	1,188	\$101,817.93	\$135,698.74
BLUE CROSS/BLUE SHIELD OF MN	961	\$55,132.57	\$89,276.77
HUMANA INSURANCE COMPANY	216	\$26,127.69	\$34,490.06
<b>GRAND TOTALS</b>	<b>7,908</b>	<b>\$3,359,261.53</b>	<b>\$3,462,713.99</b>



DATE:  
AUG 3,2023 08:49

BATCH STATISTICS FOR  
XYZZZ HOSPITAL  
5-JUL-2023 TO 5-JULY-2023

PAGE 1

A/R->RPT->BRM->BSL

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

COLLECTION ID: MEDICARE

07/05/202:	3529.96	3529.96	0	0	0	0
07/05/202:	3606.83	3606.83	0	0	0	0
07/05/202:	9016.4	9016.4	0	0	0	0
-----						
SUBTOTAL	16153.19	16153.19	0	0	0	0

COLLECTION ID: PRIVATE INS

07/05/202:	474.42	474.42	0	0	0	0
07/05/202:	25215.53	25215.53	0	0	0	0
07/05/202:	3074.24	3074.24	0	0	0	0
-----						
SUBTOTAL	28764.19	28764.19	0	0	0	0
-----						
TOTAL	44917.38	44917.38	0	0	0	0



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A/R STATISTICAL REPORT for ALL BILLING SOURCE(S) AUG 3,2023@09:36 Page 1  
 at ALL Visit location regardless of Billing Location with VISIT DATES  
 from 07/01/2023 to 07/31/2023  
 at ALL Visit location(s) regardless of Billing Location

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A/R->RPT->FRM->STA

VISIT TYPE	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	ADJ AMOUNT	UNPAID AMOUNT
EMERGENCY RO	242	207	146,612.09	133,947.18	617.83	12,047.08
OUTPATIENT	129	118	49,863.97	53,530.17	-10,906.71	7,240.51
PHYSICAL THE	45	28	15,479.00	18,579.18	-7,066.18	3,966.00
CAH OUTPATIE	142	93	79,354.00	0.00	0.00	79,354.00
AUDIOLOGY	1	1	278.00	654.00	-376.00	0.00
podiatry	7	7	1,842.00	2,616.00	-774.00	0.00
Pharmacy POS	5,460	1,363	557,430.33	655,764.55	-366,158.09	267,823.87
PROFESSIONAL	93	71	55,052.00	115.93	522.07	54,414.00
	-----	-----	-----	-----	-----	-----
	6,119	1,888	905,911.39	865,207.01	-384,141.08	424,845.46

TOTAL COVERED INPATIENT DAYS 0



Large Balance List over \$5,000.00  
for VETERANS ALLOWANCE CATEGORY(S)

AUG 3,2023@10:07 Page 1

at ALL Visit location regardless of Billing Location

A/R->RPT->AMRM->LBL

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BILL NUMBER	DOS	DATE BILLED	DTB	BILLED AMT	BALANCE	AGE
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=====

VISIT LOCATION: XYZZZZZ HOSPITAL  
A/R ACCOUNT: VA MEDICAL BENEFIT (VMBP)

XXXXXXXXXXXXXXXXXX	04/25/2023	07/24/2023	100	7,759.28	7,759.28	10
AR Account Subtotal (\$) and Average (#):			100	7,759.28	7,759.28	10
Visit Loc Subtotal (\$) and Average (#):			100	7,759.28	7,759.28	10
Report Total (\$) and Average (#):			100	7,759.28	7,759.28	10





BILL NUMBER DOS DATE BILLED BILLED AMT BALANCE AGE

VISIT LOCATION: XYZZZ HOSPITAL  
 A/R ACCOUNT: D-MEDICA-PWPPROD1

A/R->RPT->AMRM->SBL

[REDACTED] 4/14/2023 4/14/2023 8.13 2.08 111

AR Account Subtotal (\$) and Average (#): 8.13 2.08 111

A/R ACCOUNT: MEDICA GOVERNMENT PROGRAMS

[REDACTED] 6/15/2023 7/27/2023 0.01 0.01 7

AR Account Subtotal (\$) and Average (#): 0.01 0.01 7

A/R ACCOUNT: MEDICA-UNITED HEALTHCARE

[REDACTED] 1/14/2022 2/1/2022 0.39 0.39 548  
 [REDACTED] 11/16/2022 11/17/2022 0.59 0.59 259  
 [REDACTED] 2/7/2023 2/27/2023 507 0.33 157

AR Account Subtotal (\$) and Average (#): 507.98 1.31 321

A/R ACCOUNT: MEDICARE

[REDACTED] 1/26/2022 2/1/2022 0.25 0.25 548  
 [REDACTED] 4/17/2023 7/7/2023 1 1 27  
 [REDACTED] 4/17/2023 7/7/2023 1 1 27  
 [REDACTED] 4/18/2023 7/7/2023 1 1 27  
 [REDACTED] 4/20/2023 7/7/2023 1 1 27

AR Account Subtotal (\$) and Average (#): 4.25 4.25 131

Visit Loc Subtotal (\$) and Average (#): 520.37 7.65 174

Report Total (\$) and Average (#): 520.37 7.65 174



# RECONCILIATION REPORT

## (daily completion)

HUB File Name		RPMS File Name	COUNT	MEDICAID	COUNT	MEDICARE	COUNT	PVT INS	COUNT	OTHER	COUNT	VA	TOTAL COUNT	TOTAL AMOUNT	RPMS STA COUNT	RPMS STA AMOUNT
INVOICE		INVOICE														
7/3/2023	IHS_AR_RPMS_INV_D_20230703_120251.dat	IHS_TPBRPMS_INV_112601_20230703_081357_2_06_36k.DAT	214	\$29,393.52	216	\$58,653.45	81	\$16,315.15	0	\$0.00	0	\$0.00	511	\$104,362.12	511	\$
7/4/2023	No Files		0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	
7/5/2023	IHS_AR_RPMS_INV_D_20230705_120243.dat	IHS_TPBRPMS_INV_112601_20230705_080211_2_06_36k.DAT	165	\$47,064.36	121	\$34,559.84	66	\$11,857.62	0	\$0.00	0	\$0.00	352	\$93,481.82	352	
7/6/2023	IHS_AR_RPMS_INV_D_20230706_120517.dat	IHS_TPBRPMS_INV_112601_20230706_075505_2_06_36k.DAT	169	\$42,763.35	126	\$39,199.46	95	\$22,235.29	1	\$21.02	0	\$0.00	391	\$104,219.12	391	\$
7/7/2023			117	\$6,766.84	316	\$150,051.94	68	\$21,848.04	0	\$0.00	0	\$0.00	501	\$178,666.82		
7/8/2023	Weekend No Files												0	\$0.00		
7/9/2023	Weekend No Files												0	\$0.00		
													0	\$0.00		
													0	\$0.00		
													0	\$0.00		
<b>1ST WK TOTAL</b>			<b>665</b>	<b>\$125,988.07</b>	<b>779</b>	<b>\$282,464.69</b>	<b>310</b>	<b>\$72,256.10</b>	<b>1</b>	<b>\$21.02</b>	<b>0</b>	<b>\$0.00</b>	<b>1,755</b>	<b>\$480,729.88</b>	<b>1254</b>	<b>\$</b>
7/10/2023			122	\$ 10,788.61	301	\$ 106,503.27	113	\$ 28,378.85	1	\$ 559.00	1	\$ 6.26	538	\$146,235.99		
7/11/2023													0	\$0.00		
7/12/2023													0	\$0.00		
7/13/2023													0	\$0.00		
7/14/2023													0	\$0.00		



# SUMMARY

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- Know what to look for in BOM monthly reports.
- Consistently monitor and know “where you are at.”
- Make an honest assessment, don’t make excuses, that doesn’t help the situation. It is what it is.
- Identifies areas for improvement, and ultimately,

**Improves overall financial stability.**



**Questions?**



# Navajo Area Reports



# Topic Outline

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- Quality Improvement (QI) Explained
- QI 101-Training
- QI- Data Gathering
- QI- IHM Chapter 1 Part 5
- QI- Implementation
  - Monthly Reports
  - Weekly Reports
- QI- Moving Forward- Highlights & Challenges



# QI-Explained

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“If you wouldn’t write it and sign it, then don’t say it.”

- -Earl Wilson, Author and Columnist



# QI 101-Training

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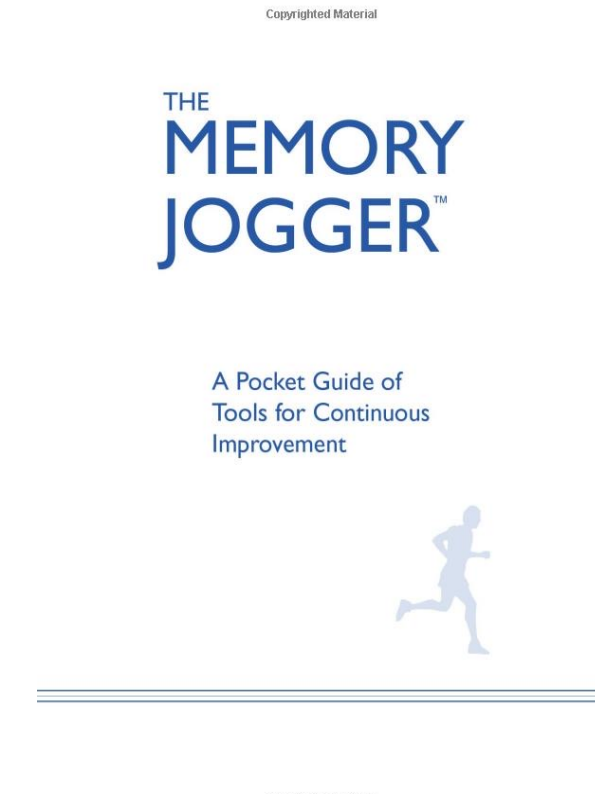
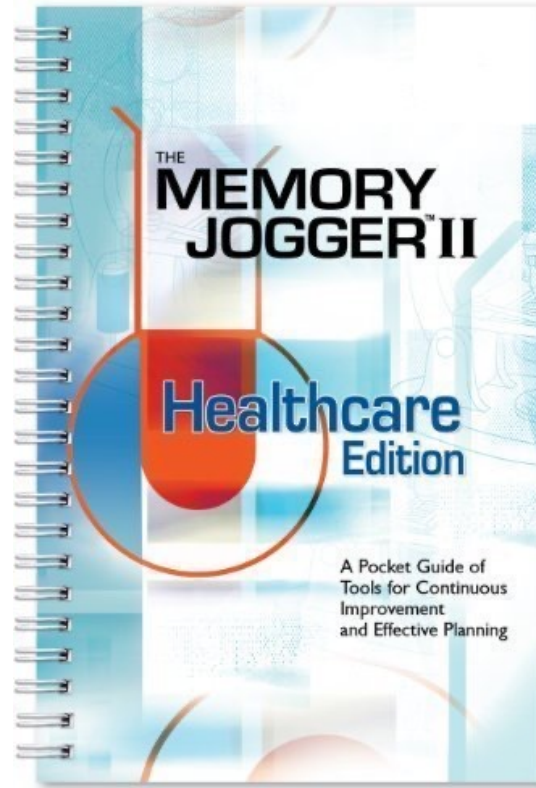
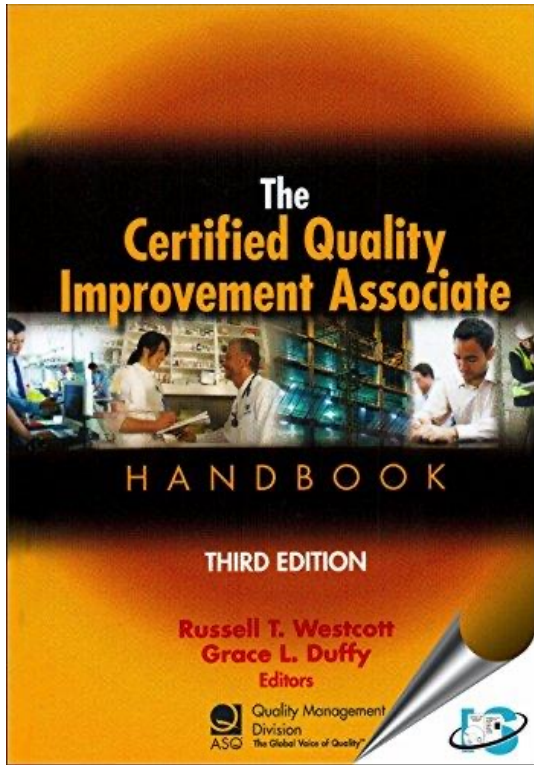
- The Navajo Area IHS reached out to contract for QI class for staff
- Quality 101- Certified Quality Improvement Associate Certification Preparation
- ASQ Learning Institute
  - Institute for Healthcare Improvement (IHI)





# QI 101-Training

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# QI 101-Training

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## Session One

- Introduction to QI
- Background of QI
- Quality Concepts
- Team Basics
- Continuous Improvement Techniques

## ■ Session Two

### ■ The Process Improvement Tool Kit

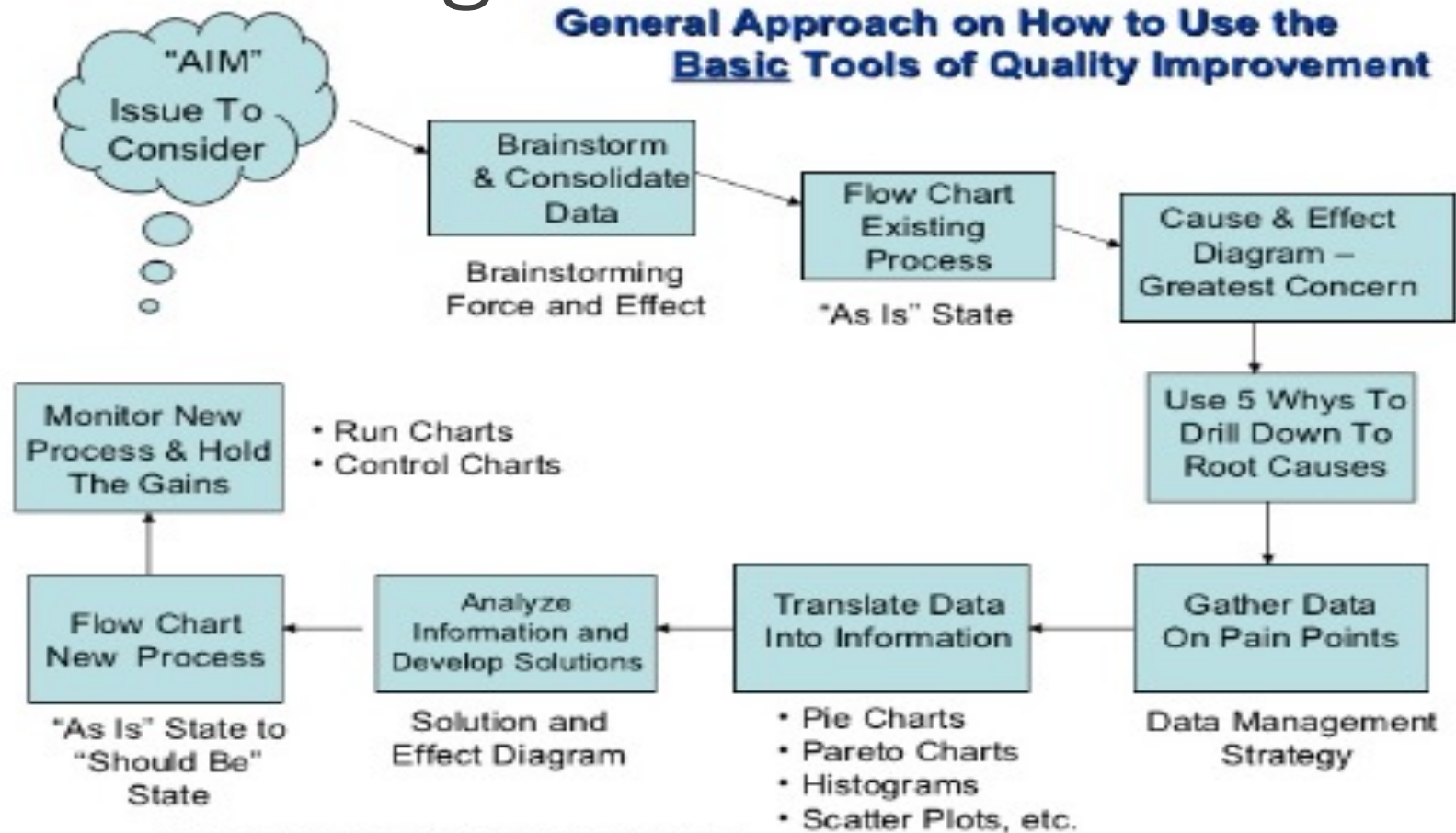
- Plan, Do, Check, Act
- Brainstorming and Force Field Analysis
- Cause and Effect Diagram & 5 Whys

### ■ Team Process Improvement Projects

- Team Applications
- Team Worksheets



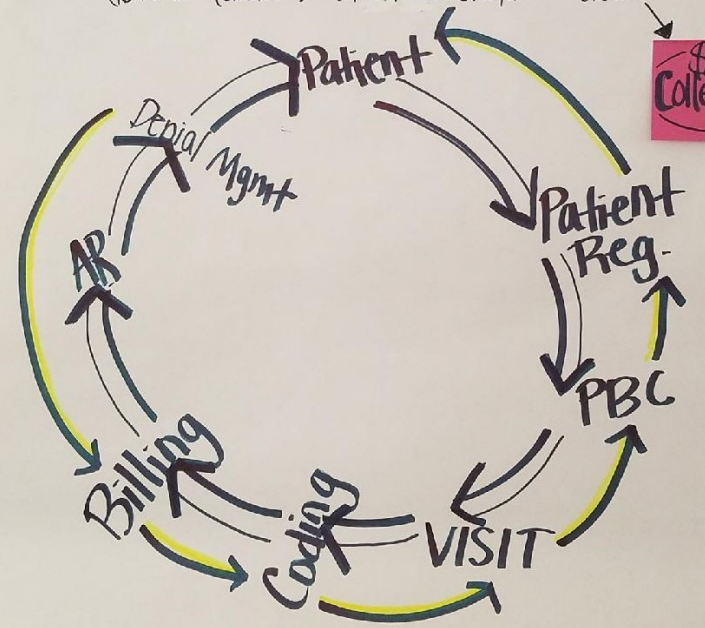
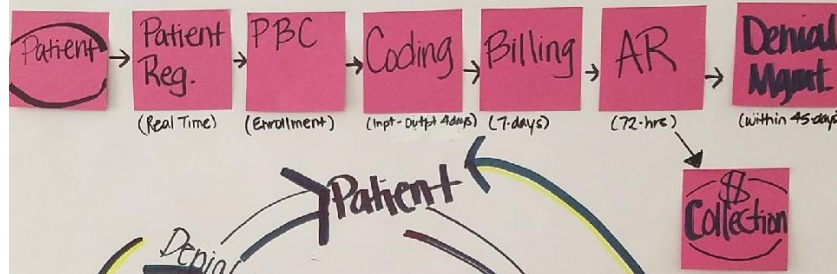
# QI 101-Training



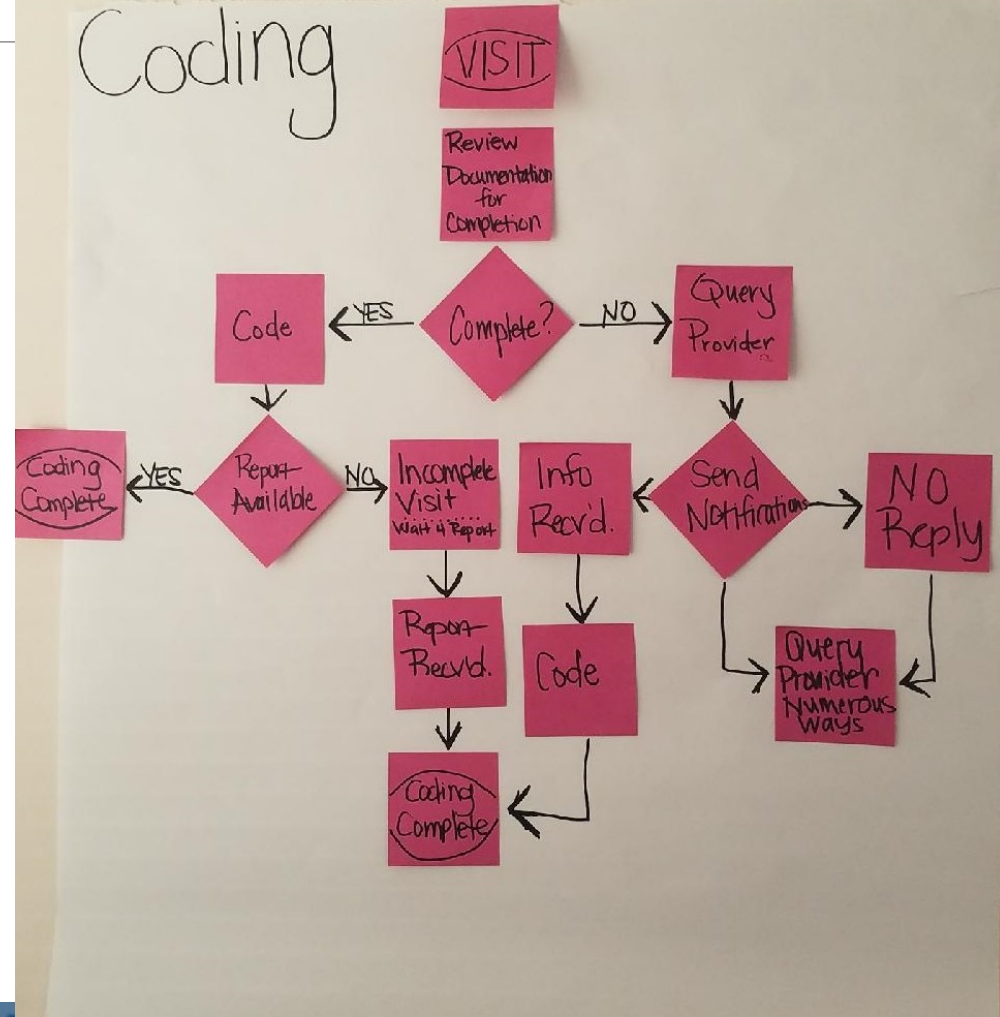
Source: *The Public Health Quality Improvement Handbook*,  
 R. Bislek, G. Duffy, J. Moran, Editors,  
 Quality Press, © 2009, p. 160



# OI 101-Training Revenue Cycle



# Coding



# QI- Data Gathering

## First Assignment: Identify One improvement initiative

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1. A3 Improvement Plan-complete for one improvement initiative
2. Run Chart-use the NAO Data Analysis Template to support your selected initiative
  - What is your analysis-write a description
  - Identify how you will make improvements based on your analysis
  - Use the Plan, Do, Study, Act Model Principle
3. SIPOC FORM-complete for the initiative you are working on
  - Complete a Flow Chart Process Diagram
4. Include Other QI Tools you have used to do to improve your work

### Important!

- Incorporate improvement and results-oriented in your work.
- Be disciplined in your improvement work.
- Your work always supports patient care.



# QI- Data Gathering

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A3 Form



Department/Service Name: Finance A3 Improvement Plan

# Q1-Data Gathering

**BACKGROUND**

- The NAIHS BO needs report standardization to improve upon analysis, monitoring, documentation, managing, understanding, and revenue generation within PR, PBC, Coding, Billing, Posting, and Denial Management per IHS Office of Resource and Partnerships

**CURRENT CONDITIONS**

- SUs and BO are not monitoring and analyzing the same data within the same BO from SU to SU. Some SU BOMs are not transparent with reporting data.
- Some SU BOMs are not identifying improvements needed
- Some SU BOMs are not analyzing data to improve their sections
- SU BO Report Standardization Meeting Issues/Findings:
  - VIS report revealed verification being completed on the back end.
  - Patient registration MSAs and Clinical MSAs not completing registration
  - VIS report shows Part A visits totaling a potential loss of \$10 million+ in FY 2016 and FY 2017 due to no inpatient care component

- Patient Registration section needs to verify patient demographics at every encounter
- Patient Benefit Coordinator need to assist every patient in enrolling on some type of alternate resource and educate on the ACA
- Coding is entered within 4 days of Date of Service (DOS)
- Billing Third Party Claims within 7 days
- Accounts Receivable – Posting of Payments within 3 days from receipt of batching
- Denial management will have to follow-up within 45 days of batching

**ANALYSIS**

- The BO Strategic Plan has the different BO sections that include Goals, Training Needs, Productivity Goals, Quality Goals, Risk Assessment, Opportunity to Capitalize On, and Efficiency.

**PROPOSAL**

- Schedule a follow-up meeting to assist with any reports or questions
- Sharon Brokeshoulder to provide templates for Billing PD, PIP, etc.
- Request PCC RPMS access for BOM at FCRHCC
- Review FTEs and redesign the MSAs back into the Business Office
- Review PHN visits and capitalize the Medicare Part A visits
- Review FAB-adjust and cancel bills that are over the timely filing limits in the billing queue
- Will need to follow-up with OIT to determine if the PR verifications are updating in the RPMS System when using the new version of RPMS-BPRM
- Request PD for Provider Enrollment Specialist from GIMC to implement at Chinle SU
- Follow-up with AR side regarding payments, UTLT report cleanup, and NAIHS advised a heat ticket would be sent to OIT
- Request ASUFAC for Rock Point Facility collections to be sent to the Rock Point clinic to show what Rock Point Facility is collecting
- Recommend meetings to include the BO as they are a crucial part to the Revenue Cycle

**PLAN**

- Identify workgroup to implement Strategic Plan and BO Report templates: Sharon Brokeshoulder, Brenda Tahe, Margaret Morgan-Benally, Marion Kelley-Jim, Gary Russell-King, and K Dempsey
- Request BO reports from SUs and review to determine possibility of changing a report for a better report.
- Implement Strategic Plan and BO Report templates at the SUs and identify timelines
- Implement reports and plans beginning April 3, 2018

**FOLLOWUP**

- Resistance may occur from the BOMs not wanting to implement the reports. Follow-up meetings and technical assistance will address this potential problem.

# QI Data Gathering

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Run Chart



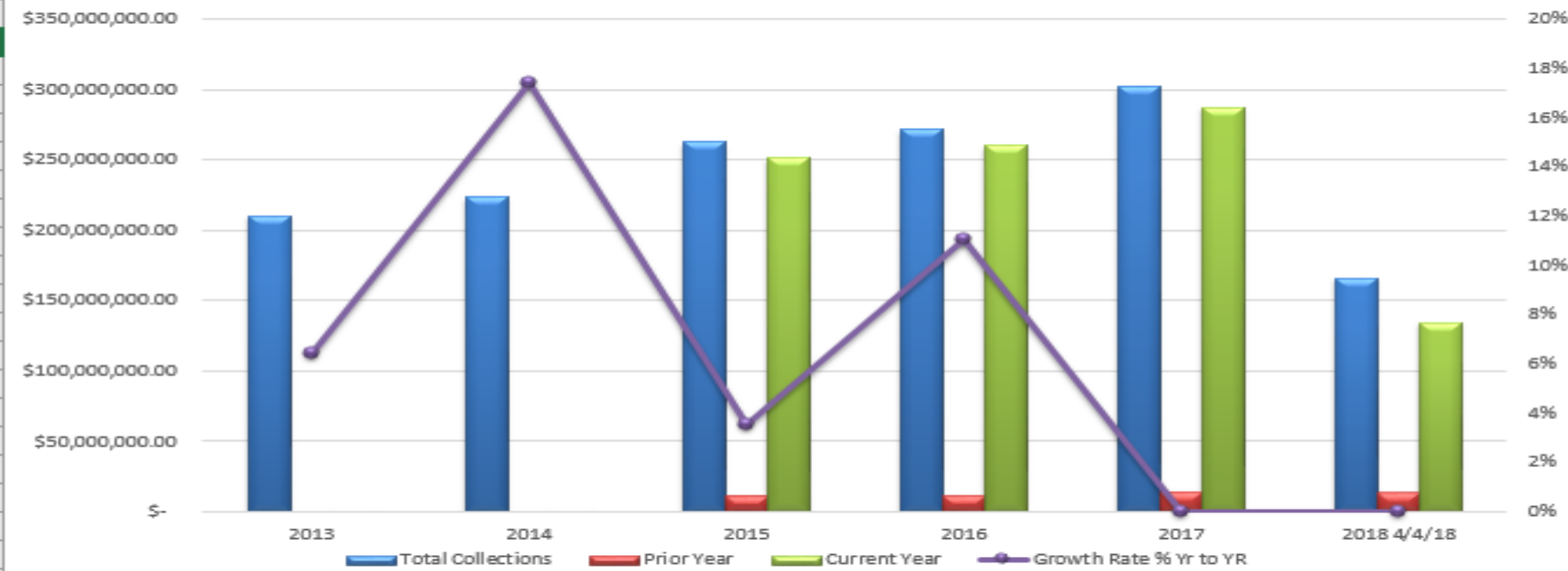


# QI- Data Gathering

NAC Data Analysis Template

Name of Reports: NAIHS Collections; Date of Report: 3.20.18

**NAIHS Collections by Total, Prior Year and Current Year**



<b>GOAL:</b> To Monitor Third Party Collections
<b>Numerator:</b> Present Year - Past Year Total Collections
<b>Denominator:</b> Past Year Total Collections
Report: Finance UFMS-Advice of Allowance Third Party Collections
<b>DATA ANALYSIS:</b> The Growth Rate % from year to year is uncontrolled. -2014-2015 ACA & Health Ins. Requirements -2015-2016 ACA & HI Requirements plateau -2016-2017
<b>ACTIONS:</b> <ul style="list-style-type: none"> <li>Information will be shared with SU BOMs to review</li> <li>Share with Admin. Off.</li> </ul>
<b>Team:</b> NAIHS Revenue Cycle

FY	2013	2014	2015	2016	2017	2018 4/4/18
Total Collections	\$ 210,037,544.89	\$ 223,565,504.96	\$ 262,436,331.47	\$ 271,778,421.16	\$ 301,775,413.09	\$ 165,931,835.89
Prior Year	-	-	\$ 11,180,371.60	\$ 11,492,570.68	\$ 14,298,223.49	\$ 13,231,732.59
Current Year	-	-	\$ 251,255,959.87	\$ 260,285,850.48	\$ 287,477,189.60	\$ 134,257,055.30
Growth Rate % Yr to YR	6%	17%	4%	11%	-	-

# QI- Data Gathering

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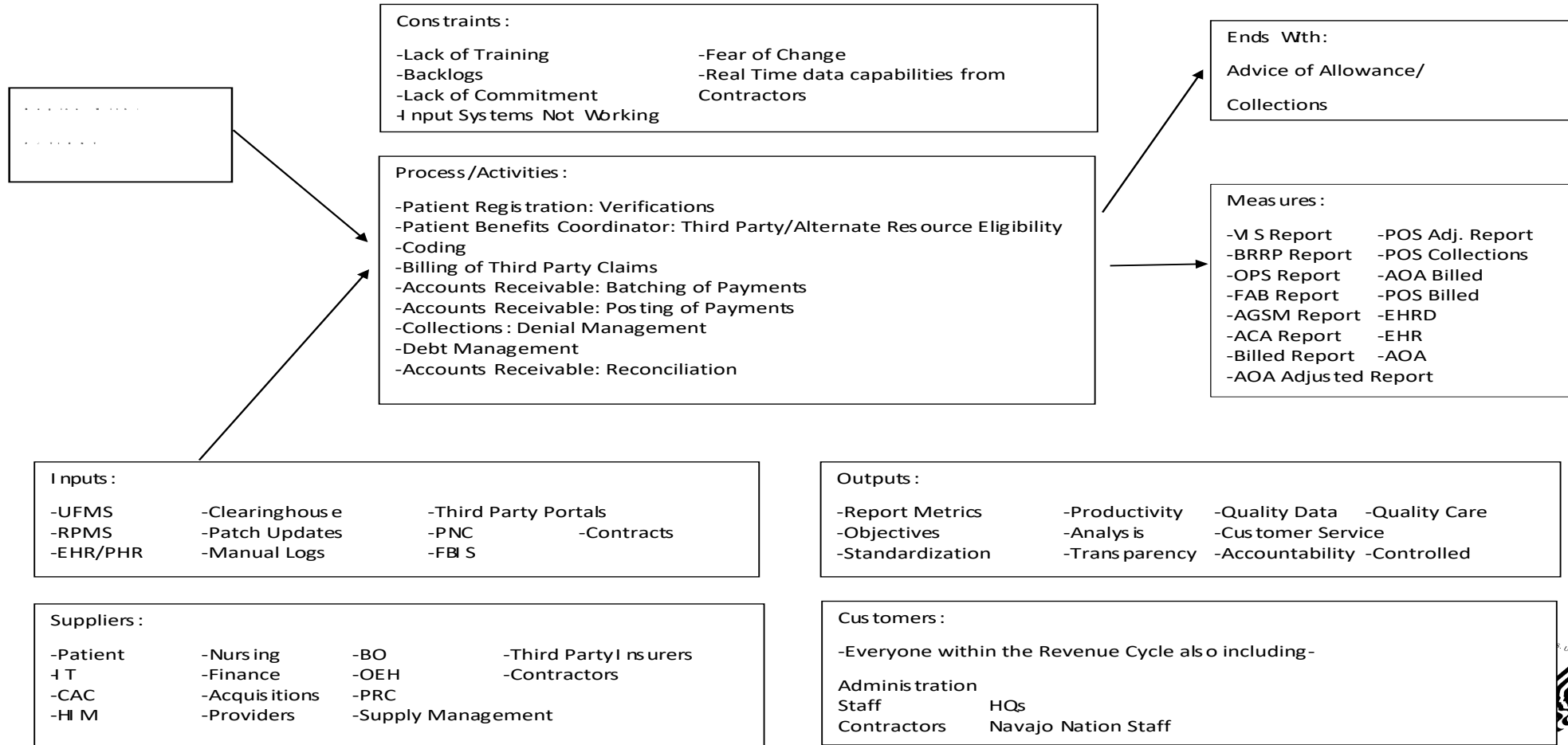
SIPOC Form & Flow Chart



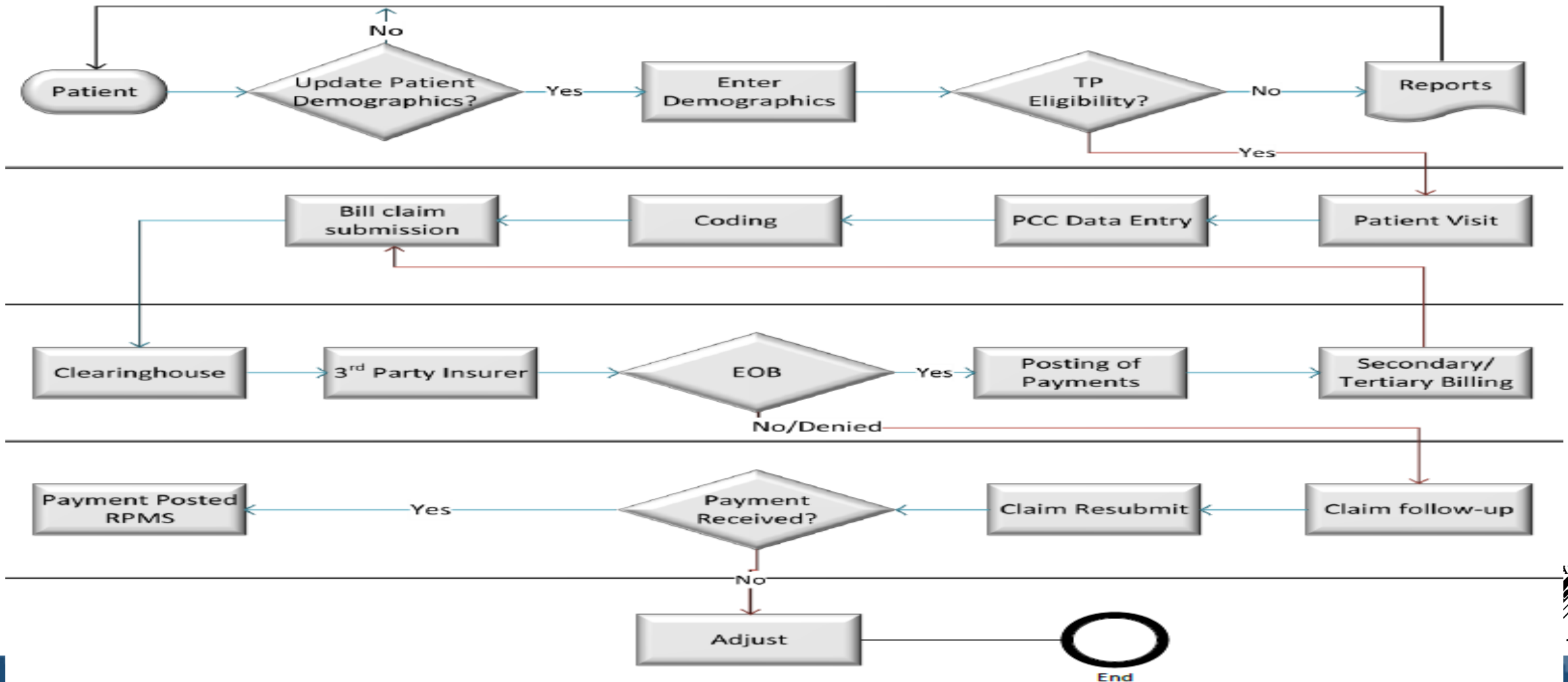
# QI- Data Gathering

Project Title: Revenue Cycle Date: 3/2/18

## SIPOC Process Description: Worksheet 3



# QI- Data Gathering



# QI- Indian Health Manual Chapter 1 Part 5

- Indian Health Service Indian Health Manual, Chapter 1 - Third-Party Revenue Accounts Management And Internal Controls, Part 5 - Management Services
- <https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>

Frequency	AO Department	AO Staff	Template for Reportin	Automated	Benchmarks	AD Receives	Corrective Action Plans Issued Internal/TPICP
<b>Management Reviews:</b>							
<b>Credentialing</b>	Quality	Kimberly Tom		N			
<b>Weekly</b>							
	Patient Registration	BO	K Dempsey	Y	N		
	Benefits Coordinator	BO	K Dempsey	Y	N		
	Coding or data capture	HIM	Gary Russell-King				
	Billing or Claims	BO	K Dempsey	Y	N		
	Payment/Adjustment Posting	BO	K Dempsey	Y	N		
	Aged receivables	BO	K Dempsey	Y	N	Internal 8%	
	Collections	Finance and BO	Darlene Kirk/ K Dempsey	Y	N		
	Number of Days to A/R	BO	K Dempsey	Y	N		
	A/R Account Reconciliation between RPMS and UFMS	Finance	LeAnn Yazzie	Y	Y		
	File Reconciliation between RPMS and UFMS	Finance	LeAnn Yazzie	Y	Y		
	Collections to Allotments/Allowance Reconciliation	Finance	LeAnn Yazzie	Y	Y		
	Cash Reconciliation by TDN	Finance	LeAnn Yazzie	Y	Y		
<b>Monthly</b>							
	UFMS/RPMS Dashboard report	Finance	LeAnn Yazzie	Y	Y		
	RPMS and UFMS A/R account negative balances	Finance	LeAnn Yazzie	Y	Y		
	Access to and any changes to RPMS table maintenance	BO	K Dempsey	Y	N		
	Collections/Allotments in RPMS and UFMS	Finance	LeAnn Yazzie	Y	Y		
	Deposits	Finance	LeAnn Yazzie	Y	Y		
	Amounts billed	BO	K Dempsey	Y	N		
	Point of Sale rejections	BO	K Dempsey	Y	N		
	Adjustments/Denial of claims	BO	K Dempsey	Y	N		
	Adjustments by allowance category/age/payer	BO	K Dempsey	Y	N		
	Open/closed claims	BO	K Dempsey	Y	N		
	Canceled claims	BO	K Dempsey	Y	N		
	Debt Management claims	Finance	LeAnn Yazzie	Y	N		
<b>Quarterly</b>							
	Coding/Data Entry	HIM	Gary Russell-King				
	Timely Process Reviews	BO	K Dempsey	Y			
	Aged Receivable Review	BO	K Dempsey	Y			
<b>Semiannual</b>							
	TPICP	BO	K Dempsey	Y			
<b>Internal or External Reviews, Evaluations, and Audit Results</b>							
	CAPs Initiated within 30 Days	BO	K Dempsey	Y			
<b>Trend Analysis</b>		BO	K Dempsey	Y			

# QI Implementation- Navajo Area Office Reports Policy

## Navajo Area Business Office Internal Monthly Report Policy

<b>Subject:</b> Business Office Monthly Reports		<b>Revision No.</b> 1
<b>Applies to:</b> Business Office Reports	<b>Effective Date:</b> 12/1/18	<b>Target:</b> Business Office Manager and Business Office staff

**Scope:** Provide expectations and standardized reporting mechanism for the Business Office Managers (BOMs) to complete month to month reports with an analysis and trend patterns over a two-year time period, unless indicated below, for your Service Unit (SU).

**Purpose:** Monitor and ensure compliance within those Business Office (BO) sections at the highest level of BO operations when reporting to your SU Executive Leadership Team, Governing Body (GB) and the Navajo Area Office (NAO) Business Office Coordinator (BOC).

**Policy:** All BO staff of Navajo Area are responsible to follow this guidance with the data being run from the 1<sup>st</sup> of the month and reports being due the Friday following the first Monday of every month. NOTE: Resource and Patient Management System (RPMS) Report Paths may vary from site to site. An excel template with the monthly report and the Strategic Plan will be provided to fill in your data and submit monthly to the Navajo Area Office BOC. The BO Strategic and BO Reports in the Word document will only be used for GB Meetings for reporting purposes. \*\*Clinic/Satellite facilities will need to supplement data for the SU report.



# QI implementation- Monthly report

FY 2018 STRATEGIC PLAN FOR GIMC BUSINESS OFFICE FUNCTION

**Patient Registration / Verification**

**ORAP:** Timeliness of verification at time of Pt Encounter

**GOAL:** To verify patient eligibility, update demographic in a timely manner at first encounter and demonstrate the importance of registration rule & affect on AR if not updated. This process directly affects the TP billing.

- Monitor the APL listing
- Do training on Category codes with Patient Registration and PBC to ensure all front end staff are aware on these codes for billing when entering on Pt demographic.
- Ensure each MSA is referring patients to Patient Benefit Coordinator for Alternate Resource. Assist with determination.
- Converse and compare patient accounts to ensure all patients are not mixed.
- Track on a weekly, monthly, quarterly basis how many patients come to GIMC, compare to last year data, is it increasing, decreasing? Share with staff.
- Ensure Communication is exercised at each encounter.
- Ensure we exert the "Best Customer Service" to our patients.
- Let our patients know "WE appreciate them, Thank Them".

**FY-18 VIS**

**Quality Goals:**

- Do Audit check on MSA's work, entry, valid Pg 4 and Pg 8.
- Identify MSA's who need training on any third party insurance verification, accuracy.
- Do random in Clinic on MSA's to ensure verification is being completed.
- Do a competency every 120 days. Requirement for OMS.

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.
- Verification directly affects the billable amount to transmit to third party community.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.
- Quarterly Goals and Objective review.

**Efficiency:**

- These reports provide a tool to Manager and CEO's to monitor Benefit Coordination productivity, if we do not have our population of 3rd party resources, we can not collect additional revenue.

**Patient Benefit Coordinator/Eligibility**

**ORAP:** To assist every patient in enrolling on some Alternate Resource and educate on the ACA

**GOAL:** To assist patient with TP alternate resources at time of patient encounter, and to see PBC follow-up. To ensure enrollment/application are properly completed and filed on a timely basis. (Medicaid/Medicare)

- Do reading to ensure PBC is detecting patients in the ACA and enrolling timely and efficiently.
- Do in-service with PBC to test knowledge on the 4 MCO's enrollment.
- Have each PBC show productivity of patients seen, enrolled with Medicaid, Medicare A, B, C and D each week.
- PBC meeting is bi-weekly for updates, ensure TOH and GIMC are sharing equal information.
- Ensure PBC is setting up outreach program in the community, chapter house, JMI, as with GIMC to educate on ACA and set up bank in Front Lobby

**FY-18 Medicaid Enrollment**

**Goal is to increase enrollment with Medicaid Expansion and Marketplace/Goal was met**

**Timeframe:** MCO's complete in 30 days each month to track

**Training Needs for Strategic Training:**

- PBC is a certified CAC in the circuit to enroll patients in Medicaid Expansion, Marketplace
- PBC track monthly their productivity and ACA complete

**Productivity Goals:**

- Res Exception Report of Patients over 65 without TP coverage monthly (this identifies patients who may be eligible for Medicare A, B, C and Part D)
- Res Exception Report of Patients under 18 without TP coverage monthly (this identifies patients who maybe eligible for Medicaid CHIP Program).

**(These tools will help increase revenue by identifying eligible populations)**

**Quality Goals:**

- Do Audit Check on PBC on PEO/OSA application, ensuring errors are tracked and reviewed, corrected
- Do random check on each PBC productivity report.
- Do random check on PBC to ensure referrals are being received by Patient Registration staff.

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.
- Add new TP Insurer to capture more revenue.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.

**Efficiency:**

- Review Overtime usage to determine if coding is being completed daily, and to ensure accuracy and quality.

**Coding**

**ORAP:** Coding entered within 4 days of DOS

**Goal:** Coding must be entered for all services provided whether or not 3rd Party coverage is applicable.

- Facility Dept, visits (without a same day provider visit) must have a PCC form completed
- At least One Coder has been certified by AAPC or AHIMA
- PCC Error reports reviewed and corrected weekly
- Coding Reference books are current version
- Incomplete Coding Report - IMPT is reviewed/corrected
- Incomplete Coding Report - OUTPT is reviewed/corrected
- Incomplete PCC Write by Provider Report - IMPT reviewed
- Incomplete PCC Write by Provider Report - OUTPT reviewed
- PCC Incomplete/Error Report is reviewed weekly
- Incomplete PCC Write by Ancillary report reviewed weekly

**Coding Backlog:**

- Run patient report by EHRD to determine the clinic coded daily
- Run patient deficiency report to determine the Provider not completing narrative summary daily
- Identify the uncoded amount XOMB Rate \$427 to determine "Potential TP reimbursement"

**Timeframe:** Run the EHRD and Inpatient Deficiencies, backlog of coding daily, review with staff, give out work load. Give time frame for completion.

**Training Needs for Strategic Training:**

- Getting more coders to be certified.
- Ensure IOD-19 training is reviewed and followed
- Review training with use of modifier

**Productivity Goals:**

- Each Coder should have an expectation of at least 400 coding visits per day for inpatient and outpatient
- Determine the workload based on the reports run for backlog.
- Run and track progress of coding every two hours to show progress.
- Do check an NMBE to ensure those corrections do not reach 2nd and 3rd report.

**Quality Goals:**

- Do Audit check on coding for outpatient, inpatient visits by Certified Coding in department.
- Do random sample of Coding entries by independent certified coder for inpatient and Outpatient coding.
- Present at MedExec review the deficiency with Provider

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.

**Efficiency:**

- Review Overtime usage to determine if coding is being completed daily, and to ensure accuracy and quality.

**Billing of TP Claims**

**ORAP:** 7 days to bill out claims

**GOAL:** To bill 12 Million per month/\$144 Million + per FY

- Ensure Fee Schedule is updated and current.
- Outpatient billing to be within 8 days (coding needs to stay current)
- Inpatient billing to be within 10 days (coding staying current)

**Goal: To bring down to 7 days**

**OCT FAB: 11,446    MAY FAB: 11,248**  
**NOV FAB: 10,377    JUN FAB: 12,268**  
**DEC FAB: 12,869    JUL FAB: 15,133**  
**JAN FAB: 12,489    AUG FAB:**  
**FEB FAB: 11,728    SEP FAB:**  
**MAR FAB: 11,499**  
**APR FAB: 12,958**

**2018 FAB**

**Training Needs for Strategic Training:**

- Need to monitor the FAB report daily with Billing Tech.
- Need to monitor and make correct decision for Closed and Cancelled close outs.
- Ensure Billing Tech has a current Coding Book

**Productivity Goals:**

- Run BRRP report on Billing Technician weekly
- Run Pending Claim report daily
- Mark an Error report on CHANGEHEALTH rejection report daily to ensure their is zero
- Run individual FAB for unclosed daily, review Crossover
- Run Bill Audit/Expert report
- Run FAB and assign Crossover, and FAB to Billing Tech

**Quality Goals:**

- Do Audit check on Cancel and Closed report on Billing Tech, weekly to ensure there are valid.
- Do quality check on billing technician on cross training of billing all Third Party Insurer.
- Review the Change Health Rejection notice daily

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.

**Efficiency:**

- Review Overtime usage to determine how well coding is being completed daily, and to ensure accuracy and quality.

**Accounts Receivable/Posting of Payments**

**ORAP:** 3 day to post from receipt of batching

**GOAL:** 3 day to zero out every month, post all payments in order for AOA to be received at GIMC

- Use of HIPAA standard adjustment reason codes utilized in compliance with Explanation of Benefits.

**End of month NOT POSTED:**

- Oct BSL Posted: \$7,823,475.25 zero out
- Nov BSL Posted: \$8,623,687.41 zero out
- Dec BSL Posted: \$7,763,593.71 zero out
- Jan BSL Posted: \$3,484,272.19 zero out
- Feb BSL Posted: \$8,364,801.69 zero out
- Mar BSL Posted: \$10,873,223.89 zero out
- Apr BSL Posted: \$8,584,820.37 zero out
- May BSL Posted: \$10,844,543.07 zero out
- Jun BSL Posted: \$8,563,331.98 zero out
- Jul BSL Posted: \$1,247,324.71 zero out
- Aug BSL posted: \$ zero out
- Sep BSL posted: \$ zero out

**FY-18 Posted**

**Timeframe:** BSL report is run daily to ensure the posted amount.

**Goal was met Fiscal Year 2018**

**Training Needs for Strategic Training:**

- Need Unrecalled Training for all AR Technicians
- Need Private Insurance Interpretation of FOB for AR Technicians
- Track the overall method of how putting them into AR

**Productivity Goals:**

- Batching to be consistent and completed Daily by Finance AR Tech
- Refunds to be consistent and completed at time of encounter on AR batch.
- Try and to be consistent with AR putting within 72 hours of receipt
- Review the Daily Total from Finance to determine the AR for the week
- Run Small and Large balance report, review weekly.

**Quality Goals:**

- Do Audit Check on posting of payment, adjustments used properly
- Do random check on Unrecalled Amounts, run UTL report to verify amounts to be deleted, reviewed.
- Standardize posting occur the board for GIMC and TOH AR Tech.

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.

**Efficiency:**

- Review Overtime usage to determine how well coding is being completed daily, and to ensure accuracy and quality.

**Collections-Follow up of Denials/Claims**

**ORAP:** Follow up within 45 days from Posted Batch

**Goal:** To minimize the Aging Summary 120+ to 8%

- Each AR visit will be documented with a message outlining the reason for adjustment or reason closed.

**End of Month Aging Summary:**

- Oct 120+: \$615,824.63 (8%)
- Nov 120+: \$725,387.62 (9%)
- Dec 120+: \$760,089.94 (9%)
- Jan 120+: \$743,131.18 (9%)
- Feb 120+: \$620,294.03 (8%)
- Mar 120+: \$650,261.82 (8%)
- Apr 120+: \$666,275.74 (7%)
- May 120+: \$613,314.32 (8%)
- Jun 120+: \$563,223.32 (6%)
- Aug 120+: \$
- Sep 120+: \$

**FY-18 Aging Summary**

**Timeframe:** To be completed Daily by VE according to ORAP

**Goal was met for FY-2018**

**Training Needs for Strategic Training:**

- Train Voucher Examiner how to run Adjustment report and teach what is "Controllable and Uncontrollable" close out.
- Train Voucher Examiner how to run Adjustment report

**Productivity Goals:**

- Complete Follow Up of Denials on AR Batch within same day of occurrence
- Run AOI daily to review outstanding claims for Denials
- Reconciliation of claim completed daily
- Work on Zero Pay Batch daily-Incoming has will be ABOM office for distribution of work on Zero Pay
- Track productivity weekly of claim for adjustment, RFS
- Run USM report weekly from FT-16 to current, work claim, this directly affects the AR Matrix.

**Quality Goals:**

- Do Audit check on random AR Batch for correct Adjustment
- Do random check on AR message, ensuring consistency
- Standardize across the board follow up in the same for VE.

**Risk Assessment:**

- Review any new Third Party Insurance, there could be denial. Track and review issuer with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

**Opportunity to capitalize on:**

- Review the quality list up periodically with staff to ensure "use" are not falling out of compliance with those goals.
- Weekly huddle for review assignment, with time frame.

**Efficiency:**

- Review Overtime usage to determine how well coding is being completed daily, and to ensure accuracy and quality.

# Implementation- Monthly Reports

BUSINESS OFFICE REPORT FOR 2018

The Business Office is comprised of (5) Sections; Patient Registration; Patient Benefit Coordinators; Billing; Accounts Receivable; Collections; totaling (56) personnel, with three Supervisors; Business Office Manager, Assistant Business Office Manager; Patient Registration Supervisor, (1) Secretary.

**Patient Registration Section: ORAP – Timeliness of verification at time of Patient Encounter**

This section is responsible for updating every patient encounter in all clinics, identifying patients with no Third Party coverage. Referrals have doubled due to the Affordable Care Act, patients are curious and they are asking to talk to a PBC on new coverage and what is offered. Below is the VIS report that tracks how many verifications are being verified monthly:

**FY-2018:**

Goal to be above 90%. Goal is met

FY-2018	Part A	Part B	Medicaid	PI	CO/Dep	Non-Ben	TOTALTP UPDATES	Billable %	TOTAL PCC OPS	TP/PCC Difference
October-17	7884	6852	9864	8107	114	312	33133	96%	34674	1541
November-17	7286	6409	9252	7426	56	178	30607	95%	32285	1678
December-17	6755	6019	8494	6902	68	159	28397	94%	30131	1734
January-18	7620	6711	9847	8132	85	180	32575	92%	35477	2902
February-18	7053	6211	8893	6975	73	181	29386	92%	31969	2583
March-18	7469	6513	9203	7607	100	277	31169	92%	34024	2855
April-18	7430	6419	8645	7346	74	209	30123	90%	33471	3348
May-18	7132	6203	7939	6850	72	212	28408	91%	31173	2765
June-18	365	318	389	363	6	6	1447	90%	1608	161
July-18							0	#DIV/0!		0
August-18							0	#DIV/0!		0
September-18							0	#DIV/0!		0
<b>Grand Total</b>	<b>58994</b>	<b>51655</b>	<b>72526</b>	<b>59708</b>	<b>648</b>	<b>1714</b>	<b>245245</b>	<b>93%</b>	<b>264812</b>	<b>19567</b>
Monthly Average							35035.0			
Daily Average							1668.3			
Daily Average Per FTE (26)							64.2			
<b>Total Projected Revenue at the OMB Rate Only</b>										
Medicare	\$22,594,702.00 (Medicare Part A only at the OMB Rate \$383)									
Medicaid	\$30,968,602.00 (Medicaid at the OMB Rate \$427)									
CO/Dep	\$276,696.00 (CO/Dep at the OMB Rate \$427)									
	<b>\$53,840,000.00</b>									

- AOA Actual Current Collection FY-18: \$64,614,322.57 (as of 05-29-18)
- (Potential to collect) : \$53,840,000.00
- Difference \$10,774,322.57 (ahead)
- Outpt coding backlog: 5,154 @ \$1,923,915.00
- Inpt coding backlog: 41 @ \$ 390,709.00
- Potential to collect from coding: \$2,314,624.00 (Coding is still coding Mar to May)

**HIM Coding goals:**

- EHRD/Un-coded Outpatient goal is to stay at 7,000 and below for TP coverages.
- Un-coded Inpatient goal is to stay below \$300,000

**FY-17 Patient Benefit Coordinator Section: ORAP – to assist every patient in enrolling on some Alternate Resource**

- Affordable Care Act (ACA) screening has increased with education, qualifying patients for Medicaid Expansion, Marketplace enrollment.

- Total # of individual counseled on ACA from Oct to May 2018: 28,233
- Total # of individual refusing/declined on ACA Oct to May 2018: 11,689
- Total # of individual qualified for Medicaid Expansion Oct to May 2018: 12,073
- Total # of individual qualified for Health Insurance Marketplace Oct to May 2018: 2,511
- GIMC PBC section are working on community OUTREACH/EDUCATION enrollment drives:
  - Discharge Planning Rounds (Mondays/Wednesday/Fridays) from 8:15 AM – 9:15 AM
  - Palliative Rounds (Tuesdays/Thursdays) from 8:15 AM – 8:45 AM
  - Utilization Review (Fridays) from 7:30 AM – 8:15 AM (Note: Time changed to 7:30 AM on 10/21/2016)
  - Mandatory Trainings/Events:
    - o 05/01-03/18 | TJC Mock Survey
    - o 05/07-11/18 | CMS Hospital Survey
    - o 05/07-08/2018 | CANCELED – New Employee Orientation
    - o 05/21-25/2018 | PE Determiners “Non-Citizen/Immigrant” Revised PE Processes
    - o 1<sup>st</sup> Floor Information Coverage starting 05/14/18 to current
    - o ED/QAPI Briefings
    - o Incident Command Briefings
  - 05/07, 05/14, 05/21, 05/29 – PBC Weekly Huddle
  - 05/09 – Palliative Workgroup Meeting
  - 05/09 & 05/24 – PBC Section Staff Meetings
  - 05/09 & 05/23 – GIMC/ACA Enrollment Drives
    - Note: Both events were canceled due to the temporary remodeling of the ER Check-In Area.
  - 05/10/2018 – IMC Staff Retreat

**Tentative Outreach/Educational/Training Events for June 2018**

- Discharge Planning Rounds (Mondays/Wednesday/Fridays) from 8:15 AM – 9:15 AM
- Palliative Rounds (Tuesdays/Thursdays) from 8:15 AM – 8:45 AM
- Utilization Review (Fridays) from 7:30 AM – 8:15 AM (Note: Time changed to 7:30 AM on 10/21/2016)
- 06/04-05/2018 – GSU New Employee Orientation
- 06/06, 06/11, 06/18, 06/25 – PBC Weekly Huddle
- 06/13 – Palliative Workgroup Meeting
- 06/12 & 06/26 – PBC Section Staff Meetings
- 06/13 & 06/27 – GIMC/ACA Enrollment Drives
  - Note: Authorization given by Administration to restart these Outreach Events – ER and Walk-In Clinics have seen been relocated to 1<sup>st</sup> Floor East and Bldg 4010.

\*\*\*Patient Registration and Patient Benefit Coordinators are involved with assisting patients enrolling on PHR (Patient Health Record) weekly and at their work stations to increase the volume of PHR applicants. PHR enrollment will contribute to the MU incentive by reaching 5%, since Business Office started assisting in the 3<sup>rd</sup> quarter of FY-17.

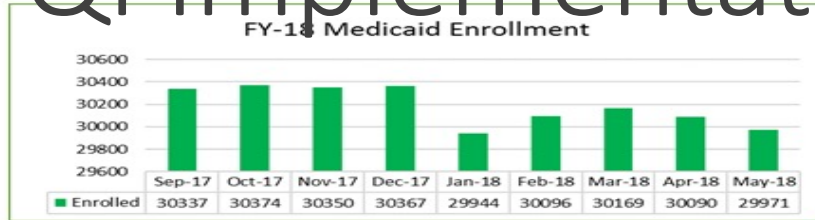
**ACA Tracking:**



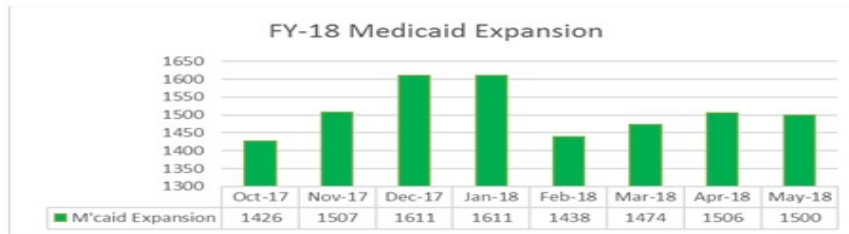


# Q1 Implementation- Monthly Reports

Federal Tax. The ACA has been in since 01-01-2014; however, there are still questions on the tax penalties and exemption for the IHS Communities. This is reason for the increase and when January 2018 comes, there is decline however patient are educated that the Special Enrollment for members of Federally Recognized Tribes continues year round. Medicare and Medicaid eligibility are a continuous process daily and eligibility is determined provided by both programs.



\*\*\* With the implementation of the Affordable Care Act; part of the Medicaid eligibility was dependent on how a household filed for the yearly Federal Income Tax returns. If this information wasn't properly interfacing the data on file with IRS, Income Support Division started reviewing cases more frequently subsequently terming coverage for members if they never replied a response on the tax filing status. Internally the relocation of the Walk-In Clinic and ED played a role in the decline of patient referrals. Confusion on where patients were to check in and or amount of time to be seen resulted in patients being missed for alternate resource screenings.



\*\*\* Identified the glitches with NM Human Services where their IT systems erroneously assigned FFS (Fee for Services) patients to an MCO-Centennial Care Plan (UHC, Molina, BC/BS & Presbyterian). Multiple members had open Medicaid cases which closed and/or reassigned into a plan which they did not sign up for. Updates identified were noted from January and March 2018 updates from the states noticed during the verification of Medicaid coverage and denied claims.



\*\*\* During Fall time from October to December, media campaigns are advertised where notifications are made for individuals to sign up for health insurance coverage before the end of the year to avoid paying the penalties when filing for the 2017

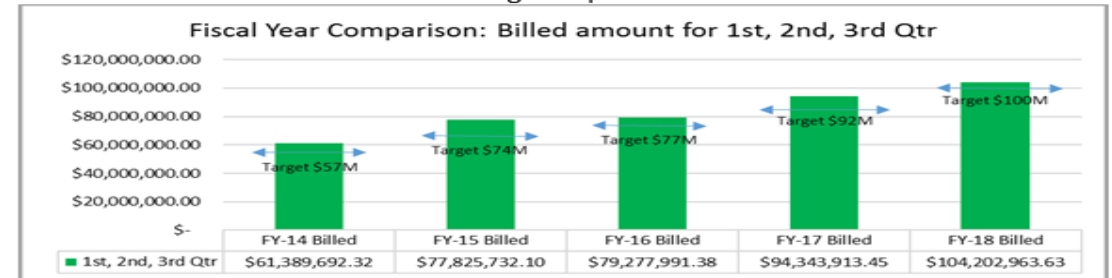
## Billing Section: FY-18 / FY-17 / FY-16 / FY-15 Comparisons

ORAP – to bill out claims within 7 days. Outpatient bill within 6 days/Inpatient bill within 10 days.

### FY-2018 Billing Comparison Report: RPMS Totals

	FY-18 Billed	FY-17 Billed	FY-16 Billed	FY-15 Billed	FY-14 Billed
oct	\$ 11,434,498.67	\$ 11,077,107.83	\$ 9,887,885.77	\$ 9,890,172.25	\$ 6,996,091.17
nov	\$ 12,691,298.51	\$ 10,255,061.46	\$ 8,100,433.62	\$ 8,155,894.12	\$ 5,201,078.49
dec	\$ 11,534,006.22	\$ 11,226,938.80	\$ 10,008,569.87	\$ 9,406,684.48	\$ 6,790,346.04
jan	\$ 14,372,925.76	\$ 12,033,368.32	\$ 9,982,385.10	\$ 9,453,112.81	\$ 6,918,821.68
feb	\$ 12,776,720.73	\$ 10,429,737.93	\$ 9,894,481.41	\$ 9,369,194.75	\$ 9,150,873.37
mar	\$ 13,205,701.40	\$ 13,411,628.04	\$ 10,314,130.90	\$ 9,989,320.00	\$ 9,552,414.39
apr	\$ 14,374,857.98	\$ 13,018,279.96	\$ 11,625,710.32	\$ 12,191,752.85	\$ 8,237,715.20
may	\$ 13,812,954.36	\$ 12,891,791.11	\$ 9,464,394.39	\$ 9,369,600.84	\$ 8,542,351.98
Total	\$ 104,202,963.63	\$ 94,343,913.45	\$ 79,277,991.38	\$ 77,825,732.10	\$ 61,389,692.32
Billing Eff.	91%	84%	98%	79%	

## Billing Comparison



- The Billing staff is averaging \$2.6 to \$3.0M billed per week, the Business Office will reach high collections with NM Medicaid in ~\$700K to \$900K per week. Flagged as Billable averages from 5,000 to 7,000. When this inflates over 9,000, it is an indication coding is coding and catching up. This averages out to 20 days.
- ORAP Goal to reach is 7.0 days for the ORAP billing compliance. The billing staff has cleaned up this report immensely and continues to strive to decrease this every day for all Third Party Payers.
- Goal for FY-18 is to bill ~\$12.0 to \$13 Million per month or more.

### FY-2018 Collection Comparison Report: RPMS Totals

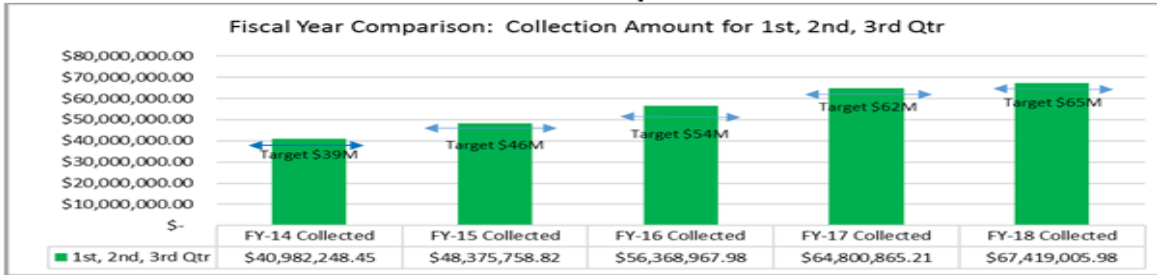
# Q1 Implementation- Monthly Reports

	FY-14 Collected	FY-17 Collected	FY-16 Collected	FY-15 Collected	FY-18 Collected
oct	\$ 3,666,961.71	\$ 7,771,198.95	\$ 6,202,212.68	\$ 5,120,757.40	\$ 4,391,245.16
nov	\$ 7,241,300.09	\$ 7,899,342.31	\$ 6,363,107.60	\$ 5,429,607.39	\$ 3,844,374.45
dec	\$ 7,769,593.71	\$ 8,077,757.78	\$ 7,346,667.96	\$ 4,390,939.59	\$ 4,390,939.59
jan	\$ 9,404,485.23	\$ 6,823,990.41	\$ 6,392,830.43	\$ 6,681,809.88	\$ 4,395,710.77
feb	\$ 8,971,547.54	\$ 7,872,912.47	\$ 7,423,967.42	\$ 4,776,198.86	\$ 5,332,414.16
mar	\$ 10,873,223.89	\$ 8,810,066.57	\$ 7,200,938.76	\$ 7,926,869.19	\$ 6,607,467.19
apr	\$ 8,900,162.87	\$ 8,227,222.43	\$ 8,294,688.68	\$ 7,188,030.85	\$ 5,439,851.09
may	\$ 10,591,730.94	\$ 9,314,374.29	\$ 7,144,554.45	\$ 6,861,545.66	\$ 6,580,246.04
Total	\$ 67,419,005.98	\$ 64,800,865.21	\$ 56,368,967.98	\$ 48,375,758.82	\$ 40,982,248.45
Collect Eff	96%	87%	86%	85%	

## Collection/Aging Summary (ORAP – to stay below 8% in 120+ days) Followup with 45 days from Posted Batch

DATE	CURRENT	31 - 60	61 - 90	91 - 120	120+	TOTAL
31-Oct-17	\$6,004,127.61	\$725,102.51	\$263,299.36	\$372,168.43	\$615,824.63	\$7,980,522.54
	75%	9%	3%	5%	8%	100%
30-Nov-17	\$554,249.95	\$464,523.31	\$358,934.14	\$192,431.49	\$725,987.62	\$8,280,008.77
	76%	7%	5%	3%	9%	100%
31-Dec-17	\$5,705,822.02	\$856,864.98	\$351,583.66	\$285,772.97	\$760,089.94	\$7,960,133.57
	72%	11%	4%	4%	9%	100%
31-Jan-18	\$6,471,200.82	\$657,118.35	\$420,958.80	\$235,052.33	\$749,131.18	\$8,533,461.48
	76%	8%	5%	3%	9%	100%
28-Feb-19	\$6,029,262.24	\$787,434.83	\$369,258.27	\$284,219.76	\$620,294.03	\$8,090,469.13
	75%	10%	4%	3%	8%	100%
31-Mar-18	\$5,792,897.12	\$772,414.08	\$532,088.80	\$250,442.82	\$650,261.82	\$7,998,104.64
	72%	10%	7%	3%	8%	100%
30-Apr-18	\$7,787,504.95	\$696,390.67	\$428,334.30	\$368,954.60	\$666,275.74	\$9,947,460.26
	78%	7%	4%	7%	7%	100%
31-May-18	\$6,048,984.30	\$932,058.88	\$259,208.59	\$243,755.66	\$613,314.32	\$8,097,321.75
	75%	12%	3%	3%	8%	100%

### Collection Comparison

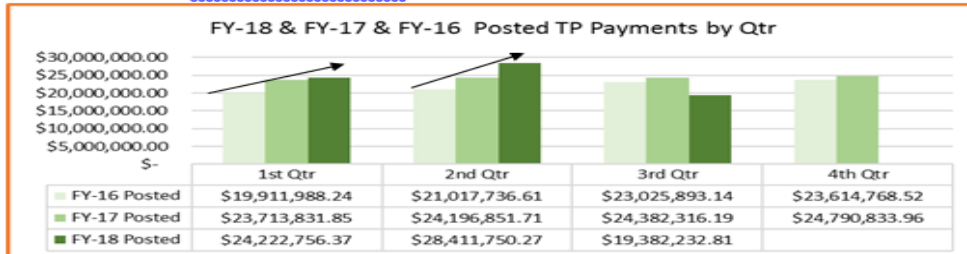


\*Internal BO Target for FY-18 to collect \$100M, \$25M per quarter

### FY-18 Accounts Receivable Section: Posting of TP Payments within 72 hours

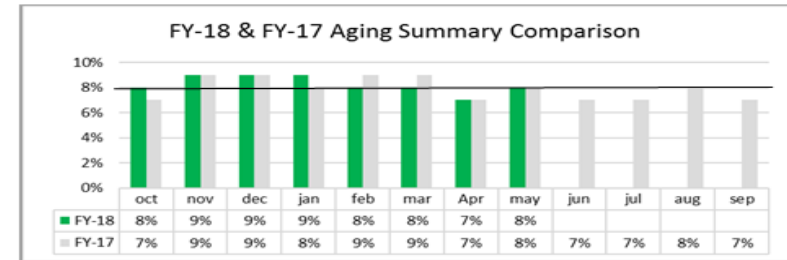
This section has (5) AR Technicians that are responsible for the posting of all payments into the RPMS.

- Oct 2017 posted: \$7,829,475.25 zeroed out
- Nov 2017 posted: \$8,623,687.41 zeroed out
- Dec 2017 posted: \$7,769,593.71 zeroed out
- Jan 2018 posted: \$9,484,272.19 zeroed out
- Feb 2018 posted: \$8,964,801.69 zeroed out
- Mar 2018 posted: \$9,962,676.39 zeroed out
- Apr 2018 posted: \$8,900,162.87 zeroed out
- May 2018 posted: \$10,828,865.12 zeroed out



Update: Goal is being met and exceeded the goal of posting within 72 hours. Goal met each month.

This section does all the follow-up on denied claims. There are (6) voucher examiners that work the Medicare, Medicaid, PI, Other, VA claims. The Aging Summary has to be followed up and maintained and to decrease below 8%. ORAP guideline is to be within (45) days of followup on denials.

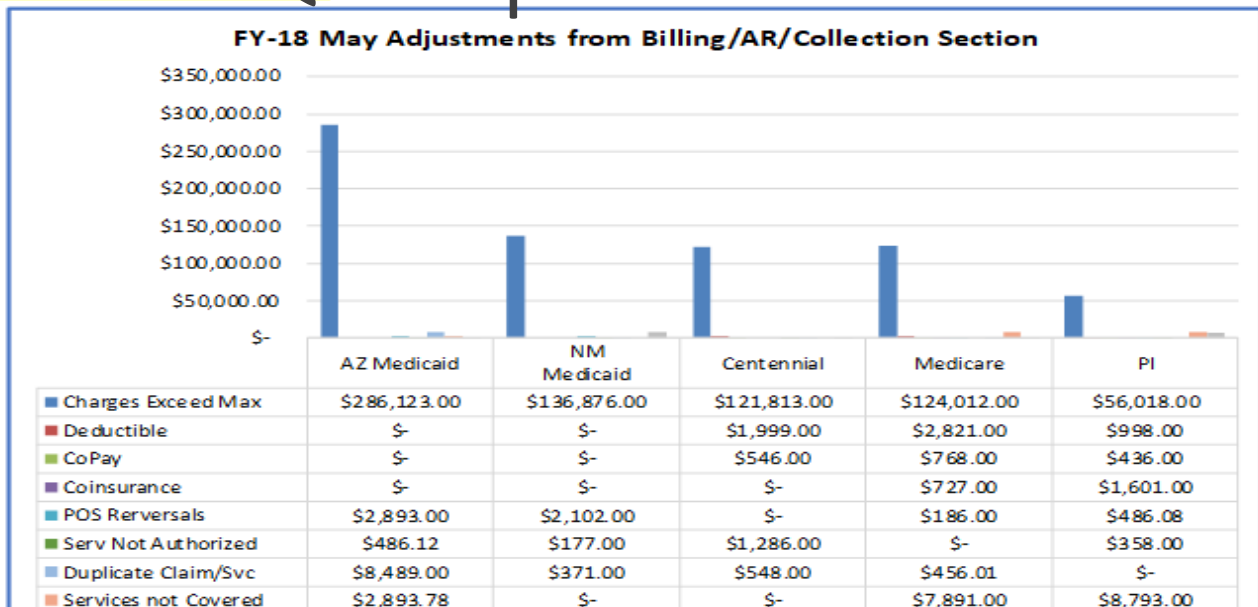


# Q1 Implementation- Monthly Reports

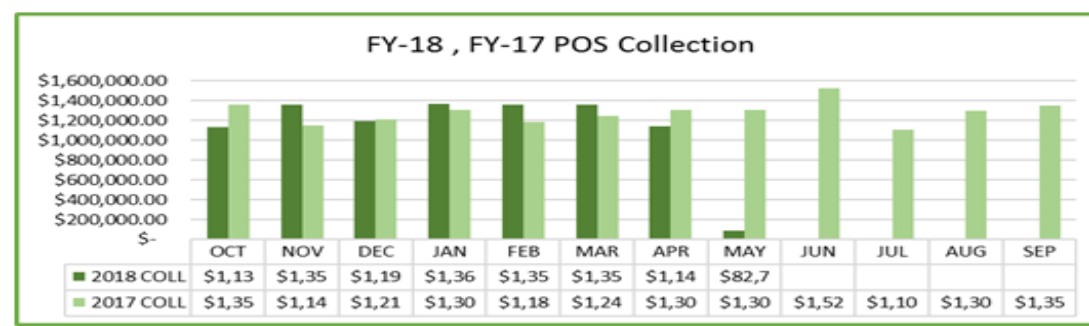
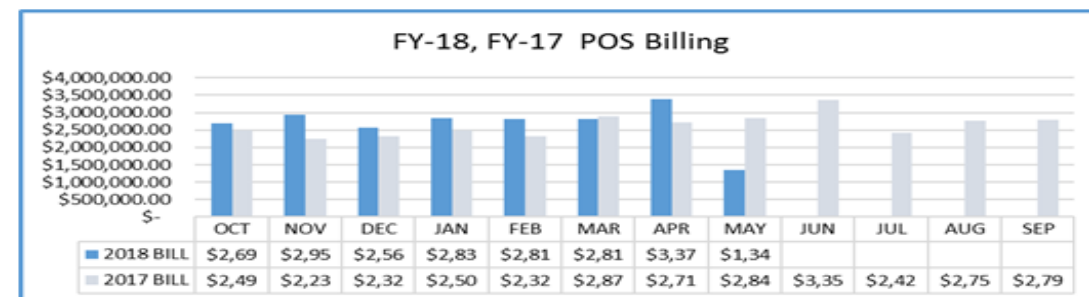
Adjustments and close outs

POS (Pharmacy Point of Sale):

Billed Amount by Fiscal Year:



FISCAL YR	2018 BILL	2017 BILL	2018 COLL	2017 COLL
OCT	\$ 2,695,499.93	\$ 2,494,945.16	\$ 1,131,295.71	\$ 1,354,610.70
NOV	\$ 2,951,649.93	\$ 2,238,270.81	\$ 1,359,948.33	\$ 1,147,520.47
DEC	\$ 2,567,806.22	\$ 2,329,356.36	\$ 1,192,025.27	\$ 1,213,884.60
JAN	\$ 2,830,026.27	\$ 2,503,861.14	\$ 1,364,812.73	\$ 1,309,780.12
FEB	\$ 2,815,806.91	\$ 2,322,241.72	\$ 1,356,820.92	\$ 1,187,153.86
MAR	\$ 2,812,547.31	\$ 2,878,878.56	\$ 1,358,938.58	\$ 1,245,290.82
APR	\$ 3,375,965.58	\$ 2,712,368.85	\$ 1,141,329.41	\$ 1,307,746.67
MAY	\$ 1,345,522.68	\$ 2,840,482.25	\$ 82,722.14	\$ 1,309,390.18
JUN		\$ 3,357,573.96		\$ 1,521,518.39
JUL		\$ 2,421,011.97		\$ 1,106,350.16
AUG		\$ 2,754,988.78		\$ 1,300,438.73
SEP		\$ 2,790,781.89		\$ 1,352,898.96
<b>Total</b>	<b>\$ 21,394,824.83</b>	<b>\$ 31,644,761.45</b>	<b>\$ 8,987,893.09</b>	<b>\$ 15,356,583.66</b>



#### Explanation of Top 10 Adjustments for FY-18:

- Charges Exceed Max Allowable:** After payment, deductible, coinsurance, over-allowable is the excess of what was allow.
- POS Reversal:** These are reversals from posting Pharmacy claims.
- Credit from Payment Credit:** Payment offset to another claim for Medicare/Medicaid payer and POS claims.
- Coinsurance:** % of the allowed charges paid by a beneficiary for cost of care.
- Deductible:** This is based on the patient's plan. Medicare has deductibles along with Private Insurance.
- Correction to prior claim:** Claims that need corrections, sent back to Billing Tech to rebill.
- Claim/Serv Lacking:** Claims that need prior authorization and out of network.
- Claim not Covered:** Claims that fall into this category are claims that not covered by patient's policy, or routine service, only one visit is allowed per year based on their plan.
- Expense incurred:** Expense incurred after covered termed.
- Sequestration:** Medicare claims, reduction in federal payments of 2%. (Mandatory Payment Reductions in the Medicare Fee-for-Service program).

# QI Implementation- Monthly Reports

## POS Adjustments:

PHARMACY: Gallup	TOTALED:	RX COUN
REJECTION CODE:		
569:Provide Beneficiary with CMS Notice of Appeal Rights	\$ 81,051.08	241
70:Product/Service Not Covered	\$ 73,877.50	738
R6:Product/Service Not Appropriate For This Location	\$ 20,752.50	1
79:Refill Too Soon	\$ 14,605.45	126
69:Filled After Coverage Terminated	\$ 8,711.91	39
75:Prior Authorization Required	\$ 8,591.83	36
AC:Product Not Covered Non-Participating Manufacturer	\$ 7,043.58	125
76:Plan Limitations Exceeded	\$ 5,982.78	31
88:DUR Reject Error	\$ 4,334.01	54
65:Patient Is Not Covered	\$ 2,365.29	33

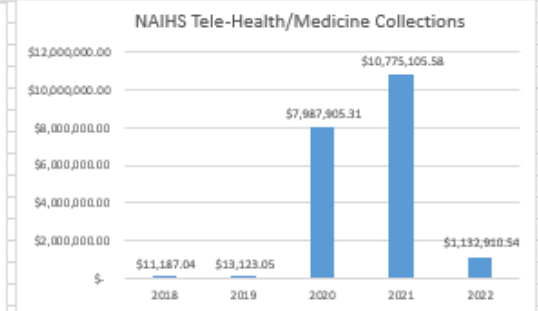
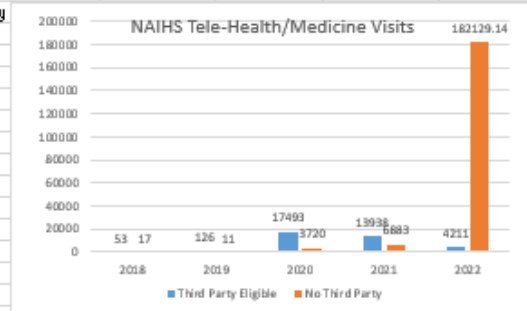






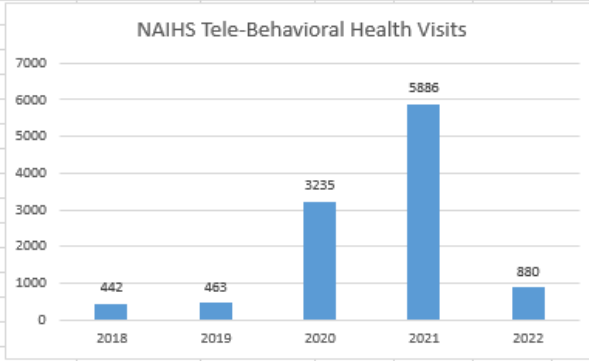
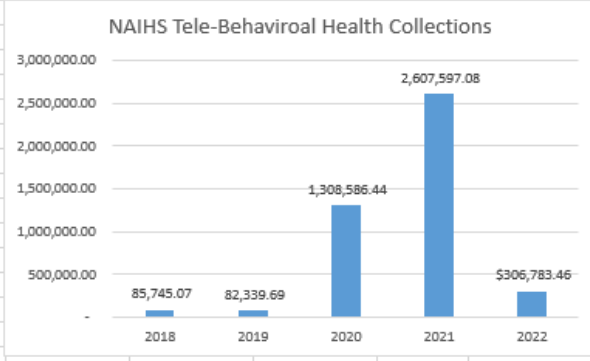
# OI Implementation- Weekly Reports

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
		Chinle			Crownpoint			Gallup			Kayenta			Shiprock		
		Collected	TP Alt. Res.	No Alt. Res.	Collected	TP Alt. Res.	No Alt. Res.	Collected	TP Alt. Res.	No Alt. Res.	Collected	TP Alt. Res.	No Alt. Res.	Collected	TP Alt. Res.	No Alt. Res.
3	<b>FY 2018</b>	-	0	0	\$ 11,187.04	51	15	\$ -	0	0	\$ -	0	0	\$ -	2	2
4	<b>FY 2019</b>	-	0	0	\$ 13,123.05	109	9	\$ -	0	0	\$ -	0	0	\$ -	17	2
5	<b>FY 2020</b>	4,877,938.94	5470	863	#####	2208	541	\$ -	0	0	#####	575	259	#####	9240	2057
6	<b>FY 2021</b>	6,698,381.12	1431	2426	#####	1254	471	#####	1115	895	#####	1115	895	\$2,712,421.57	10138	3091
7	<b>Oct-21</b>	117,233.40	230	121	\$ 11,109.72	43	26	\$ 240,255.61	950	1012	\$ 13,494.00	15	13	\$ 133,155.41	451	82
8	<b>Nov-21</b>	251,298.66	541	84	\$ 18,519.42	28	9	\$ 216,436.94	866	791	\$ 10,899.00	13	7	\$ 46,311.73	275	105
9	<b>Dec-21</b>	171,758.10	164	76	\$ 4,152.00	0	0	\$ 101,374.69	617	543	\$ 3,114.00	18	6			
10	<b>Jan-22</b>															
11	<b>Feb-22</b>															
12	<b>Mar-22</b>															
13	<b>Apr-22</b>															
14	<b>May-22</b>															
15	<b>Jun-22</b>															
16	<b>Jul-22</b>															
17	<b>Aug-22</b>															
18	<b>Sep-22</b>															
19	<b>TOTALS</b>	\$ 540,290.16	\$ 935.00	\$ 281.00	\$ 33,781.14	71	35	\$ 558,067.24	\$ 2,433.00	\$ 2,346.00	\$27,507.00	46	26	179467.14	\$ 726.00	\$ 187.00
21	SOURCE:															
22	Collected:	PSR														
23	Alt. Resources Visits	STA														
24	Non-Alt. Res. Visits	VGEN														
26	NAIHS Total Tele-Health/Tele-Medicine															
27		Collections	Third Party Eligible	No Third Party												
28	2018	\$ 11,187.04	53	17												
29	2019	\$ 13,123.05	126	11												
30	2020	\$ 7,987,905.31	17493	3720												
31	2021	\$ 10,775,105.58	13938	6883												
32	2022	\$ 1,132,910.54	4211	182129.14												



# Q1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Tele-Behavioral Health																
2		Chinle		Crownpoint		Gallup		Kayenta		Shiprock							
3		Collected \$	Visits	Collected \$	Visits	Collected \$	Visits	Collected \$	Visits	Collected \$	Visits	Total \$	Total Visits				
4	FY 2018	-	-	\$ 85,745.07	442	\$ -	0	\$ -	0	\$ -	0	85,745.07	442				
5	FY 2019	-	-	\$ 82,339.69	463	\$ -	0	\$ -	0	\$ -	0	82,339.69	463				
6	FY 2020	-	-	\$ 81,388.74	482	\$ 250,907.88	558	\$ 446,414.79	992	\$ 529,875.03	1203	1,308,586.44	3235				
7	FY 2021	293,754.00	679	\$ 88,342.54	464	\$ 605,662.88	1293	\$ 580,595.00	1139	#####	2311	2,607,597.08	5886				
8	Oct-21	72,141.00	140	\$ 9,964.59	44	\$ 33,434.28	74	\$ -	10	\$ 60,213.80	128	175,753.67	396				
9	Nov-21	57,090.00	115	\$ 5,881.99	31	\$ 47,812.04	115	\$ -	3	\$ 15,570.00	113						
10	Dec-21	519	42	\$ 4.76	5	\$ 4,152.00	42	\$ -	18								
11	Jan-22																
12	Feb-22																
13	Mar-22																
14	Apr-22																
15	May-22																
16	Jun-22																
17	Jul-22																
18	Aug-22																
19	Sep-22																
20	Totals	\$ 129,750.00	297	\$ 15,851.34	80	\$ 85,398.32	231	\$ -	31	\$ 75,783.80	241	\$ 306,783.46	396				
21																	
22	(All visits are Third Party related; does not include No alternate reources for visits)																
23	Collected	STA-Visit Type															
24	Visits	STA-Visit Type															
25																	
26																	
27	NAIHS Total Tele-Behavioral Health Information																
28		Collections	Visits														
29	2018	85,745.07	442														
30	2019	82,339.69	463														
31	2020	#####	3235														
32	2021	#####	5886														
33	2022	\$ 306,783.46	880														
34																	
35																	
36																	
37																	
38																	
39																	





# OI Implementation- Weekly Reports

	Chinle					Crownpoint					Gallup					Kayenta					Shiprock				
	Collected	TP Res. Visit	NO-Alt. Res. Visits	%	Patient Count	Collected	TP Res. Visit	NO-Alt. Res. Visits	%	Patient Count	Collected	TP Res. Visit	NO-Alt. Res. Visits	%	Patient Count	Collected	TP Res. Visit	NO-Alt. Res. Visits	%	Patient Count	Collected	TP Res. Visit	NO-Alt. Res. Visits	%	Patient Count
<b>FY 2019</b>	353,206.34	1693	89	5%	455	#####	637	270	30%	125	\$ 694,195.92	2613	440	14%	3053	\$18,523.81	124	66	35%	65	#####	1788	3023	37%	234
<b>FY 2020</b>	406,425.68	2116	90	4%	444	#####	683	258	27%	199	\$ 616,380.30	2697	532	16%	3229	#####	243	82	25%	79	#####	1200	3790	24%	933
<b>FY 2021</b>	304,828.10	2139	327	13%	1297	#####	720	455	39%	135	\$ 555,360.18	3290	1490	31%	4780	\$11,283.61	203	249	55%	188	#####	1235	793	61%	934
<b>Oct-21</b>	14821.93	158	29	16%	88	\$ 5,574.57	58	51	47%	43	\$ 41,717.12	77	51	40%	128	372	10	219	96%	10	\$ 372.00	2230	343	15.38%	131
<b>Nov-21</b>	7309.58	119	29	20%	80	\$ 1,038.00	40	47	54%	32	\$ 24,646.19	234	119	34%	353	0	3	8	73%	3	\$ -	2079	386	18.57%	134
<b>Dec-21</b>	0	13	13	50%	13	\$ -	0	6	0%	0	\$ -	232	130	36%	362	0	0	1	100%	0	\$ -	0			
<b>Jan-22</b>																									
<b>Feb-22</b>																									
<b>Mar-22</b>																									
<b>Apr-22</b>																									
<b>May-22</b>																									
<b>Jun-22</b>																									
<b>Jul-22</b>																									
<b>Aug-22</b>																									
<b>Sep-22</b>																									
<b>TOTALS</b>	#####	290	71	85%	181	6612.57	98	104	101%	75	66363.31	543	300	1.09466	843	372	13	228	2.6836	13	372	4309	729	0.33948	265

NO TP VA visits are not contributing the TP Collections

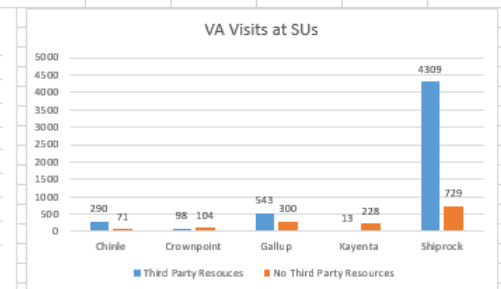
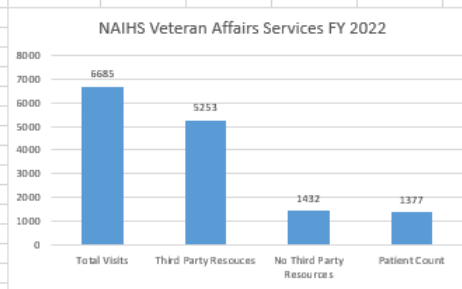
Collection STA-Visit  
 Visits-TP STA-Visit  
 Visits-No TP VGEN-  
 Patient # STA-Visit

**NAIHS VA Totals**

	Total Visits	Third Party Resources	No Third Party Resources	Patient Count
Total	6685	5253	1432	1377

**Third Party Resources**

	Third Party Resources
Chinle	290
Crownpoint	71
Gallup	104
Kayenta	300
Shiprock	228



# Q1 Implementation - Weekly Reports

NAVAJO AREA OFFICE REPORTING FORM

PRESENTED BY: K Dempsey

DATE: 12.9.2021

TOPIC: BO Weekly Stats for week of Nov. 28- Dec. 5, 2021

Decision Requested: \_\_\_; Information Report Only: x; Follow-up Report: \_\_\_ from (date) \_\_\_\_\_

SUBMITTED TO: Mrs. Hutchison

### Third Party Collections (Collections do not include stimulus funds)

- Fiscal Current Year Collections (Does not include Prior Year Collections):**
  - As of 12/06/21 TP monthly Collections are \$9.2M and at same point in time of 12/08/20 was \$6.8M. This is an increase of \$2.4M or 35% from FY 2020.
  - As of 12/06/21 TP yearly Collections are \$65.6M and at same point in time of 12/08/20 was \$45.9M. This is an increase of \$19.6M or 43% from FY 2020.
- Fiscal Total Collections (Includes Prior Year Collections):**
  - As of 12/06/21 TP monthly Collections are \$9.3M and at a similar point in time of 12/08/20 was \$7.1M an increase of \$2.2M or 32% from FY 2020.
  - As of 12/06/21 TP yearly Collections are \$64M and at a similar point in time of 12/08/20 was \$63M an increase of \$20.6M or 33% from FY 2020.
- Fiscal Collection goals**
  - Projections based on 3 year trending with an average from FY 2018-2020 Collections, No stimulus funds included.
  - SU Current Year Collection goals established and shown below.
  - Total Collection Goal for NAIHS is \$398.5M and last FY Collections were \$410M. K's forecast FY 2022 is \$424M.

### Fiscal CURRENT YEAR Collections

NAIHS SUs 5	FY 21 CURRENT Collections	Percentage Increase for Collections	K's Projections 2022	SU stated CURRENT Year Goal	FY 2022 Monthly Goal	FY 2022 Current Collections
Chinle	113,035,934.33	6%	119,346,649.09	120,000,000.00	10,000,000.00	14,029,187.61
Crownpoint	27,094,940.49	6%	28,727,323.92	23,500,000.00	1,958,333.33	5,446,429.78
Gallup	125,330,529.22	2%	123,768,825.08	115,000,000.00	9,583,333.33	22,329,240.42
Keyenta	25,136,955.66	6%	26,592,315.80	28,529,735.00	2,377,477.92	3,956,578.61
Shiprock	103,512,460.54	5%	108,362,028.58	110,000,000.00	9,166,666.67	19,882,983.10
<b>Totals</b>	<b>\$390,110,820.22</b>	<b>6%</b>	<b>\$406,797,162.66</b>	<b>\$397,029,735.00</b>	<b>\$33,085,811.25</b>	<b>\$65,446,119.52</b>

### Fiscal CURRENT YEAR Month to Month Collections

Fiscal Year	Oct	Nov	Dec
2019	14,114,160	27,372,761	25,161,288
2020	13,687,366	26,867,135	31,854,923
2021	15,816,333	23,303,408	23,338,810
2022	15,162,977	41,237,942	9,243,501
% Difference of FY 21 from FY 20	16%	-12%	-27%
\$ Difference of FY 21 from FY 20	\$2,128,967	\$ (3,063,727)	\$ (8,516,113)
% Difference of FY 22 from FY 21	-6%	77%	-60%
\$ Difference from FY 21 to 22	\$ (653,356.16)	\$ 17,934,534.25	\$ (14,095,309.17)

### Fiscal TOTAL Year Collections

NAIHS SUs 5	FY 2021 TOTAL Collections	Percentage Increase for Collections	K's Projections 2022	SU stated Total Year Goal	FY 2022 Goal Per Month	FY 2022 TOTAL Collections
Chinle	119,834,255.19	5%	126,309,168.29	120,000,000.00	10,000,000.00	19,113,580.31
Crownpoint	27,840,302.24	0%	27,840,302.24	25,000,000.00	2,083,333.33	6,509,753.57
Gallup	127,865,709.80	2%	130,730,967.84	115,000,000.00	9,583,333.33	27,529,508.33
Keyenta	26,416,421.63	6%	27,885,488.89	28,529,735.00	2,377,477.92	5,347,053.03
Shiprock	108,101,210.03	4%	111,974,111.27	110,000,000.00	9,166,666.67	25,514,194.23
<b>Totals</b>	<b>\$410,057,898.89</b>	<b>4%</b>	<b>\$434,749,938.33</b>	<b>\$398,529,735.00</b>	<b>\$33,110,811.25</b>	<b>\$84,014,089.47</b>

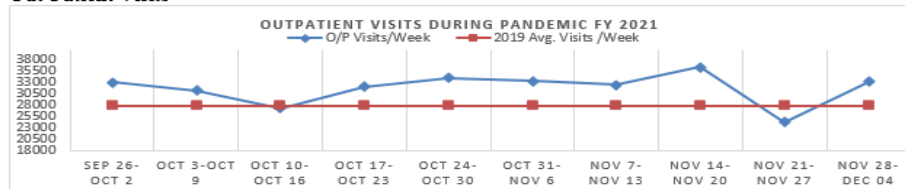
### Fiscal TOTAL Month to Month Collections (continuing to collect for the month)

Fiscal Year	Oct	Nov	Dec
2019	28,704,497.76	28,829,403.66	26,023,547.27
2020	27,621,281.78	27,853,464.20	32,324,094.21
2021	31,592,121.50	24,644,604.90	23,973,747.17
2022	30,747,728.93	43,875,293.47	9,391,067.07
% Difference of FY 21 from FY 20	14%	-12%	-26%
\$ Difference	\$3,970,839.72	\$ (3,208,859.30)	\$ (8,350,347.04)
% Difference of FY 22 from FY 21	-3%	78%	-61%
\$ Difference FY 22 to 21	\$(84,392.57)	\$19,230,688.57	\$(14,582,680.30)

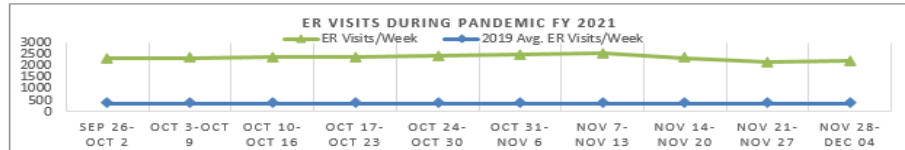


# AI Implementation- Weekly Reports

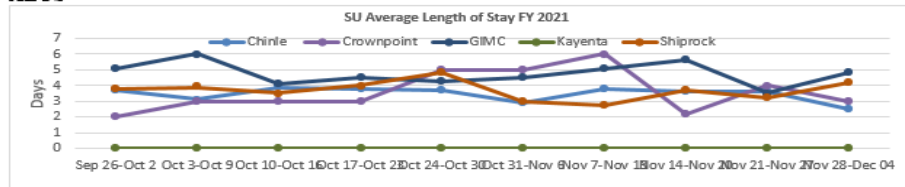
## Patient Utilization for NAIHS Facilities: Out-Patient Visits



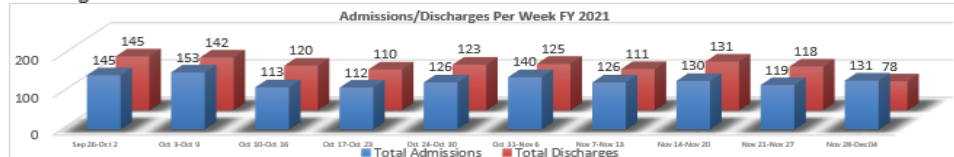
## ER Visits



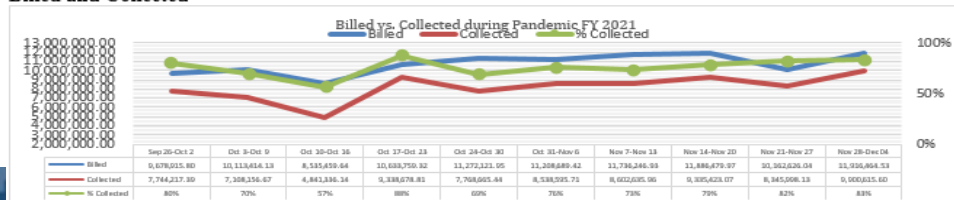
## ALOS



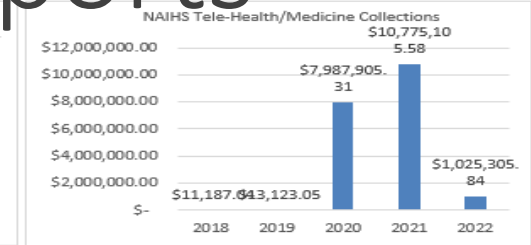
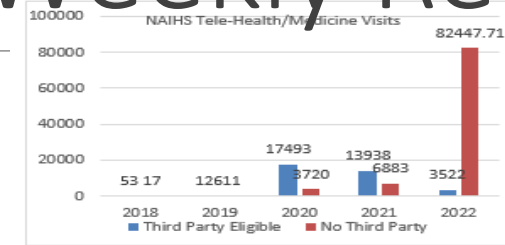
## Discharge and Admissions-



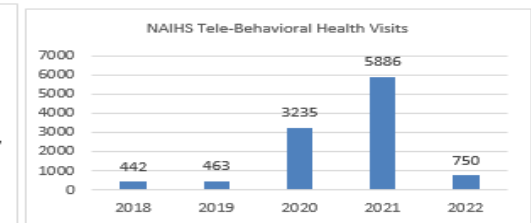
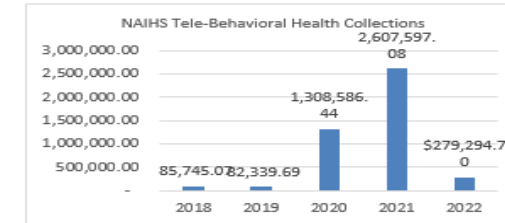
## Billed and Collected-



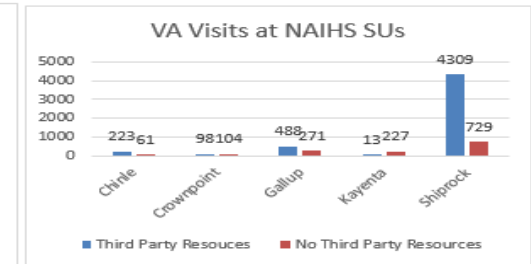
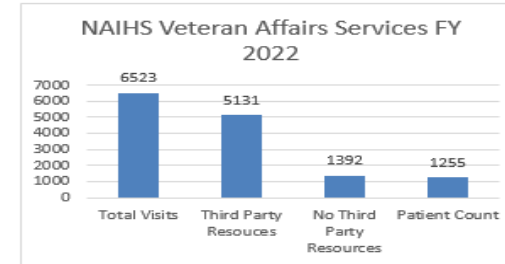
## Tele-Health/Medicine



## Tele-Behavioral Health



## Veteran Affairs



## Continued Activities-

- Gallup SU Corrective Action Plans identified close Dec. 10, 2021
- Kayenta HC ED Billing-WIP
- VA/IHS Agreements-WIP
- SSN Data request from HQs upcoming-WIP
- Walmart Concern- Broker using IHS
- BOM Meeting Scheduled 12/16/21 at 9AM-1130AM

End of Report



# QI Implementation-Automated Dashboard for BO?

BUSINESS OFFICE REPORTING DASHBOARD - Calendar Year 2018																			
Patient Registration/Patient Benefits/Billing/Accounts Receivable/Collections																			
IHS/CPSU Requirements																			
X = ACTION, RE = REVIEW/EVALUATE							C = COMPLETE; X = MISSED, S = SCHEDULED, N/A = Not Applicable												
Requirement	Responsibility <sup>1</sup>	Weekly	Monthly	Quarterly	Semi-Annual	Annual	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	ANNUAL REVIEW
<b>POLICY AND PROCEDURES</b>		<b>BUSINESS OFFICE STAFF</b>																	
Review and Update Policy & Procedures						Update needed by 06/2018	C	C	C	C	C	C	X	X	C	C	C	C	P&P review is still on-going
<b>RISK ASSESSMENTS</b>		<b>SHSS</b>																	
Educate Staff on Safe Guarding Patient Identification				X			N/A	N/A	C	C	N/A	C	N/A	N/A	C	C	N/A	C	
No. of Incidences - PII and/or Privacy							0	0	0	0	0	0	0	0	0	0	0	0	0
Business Office Staff Cited							0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Affordable Care Act</b>		<b>SS/BUSINESS OFFICE STAFF</b>																	
Monitor Third Party Eligibility Stats			X				####	18,421	18,428	18,309	18,337	18,359	18,408	18,373	17,541	18,108	18,078	18,097	
Monitor the ACA Implementation			X				C	C	C	C	C	C	C	C	C	C	C	C	
Provide Outreach and Education on ACA			X				C	C	C	C	C	C	C	C	C	C	C	C	
<b>Third Party Billing Forms</b>		<b>BUSINESS OFFICE STAFF</b>																	
Obtain missing Medicare Secondary Payer (MSP) forms			X				46	51	42	38	55	49	31	28	43	47	25	32	
Number of Patients Involved							19	22	17	26	31	24	16	21	30	28	17	21	
<b>Third Party Billing/Accounts Receivable</b>		<b>SS/BUSINESS OFFICE STAFF</b>																	
Meet the ASM NA Benchmark of 8% in the 120+			X				6%	9%	13%	6%	8%	6%	7%	8%	6%	6%	11%	10%	
Process all AR Refunds/Interest payments to Finance with the same month			X				C	C	C	C	C	C	C	C	C	C	C	C	
Process the Commission Corp Billing by the 15th of each month, to NAO			X				C	C	C	C	C	C	C	C	C	C	C	C	
Ensure the Medicare Credit Balance is completed				X			C	N/A	N/A	N/A	N/A	C	N/A	N/A	N/A	N/A	N/A	N/A	
<b>EMERGENCY MANAGEMENT</b>		<b>BUSINESS OFFICE STAFF</b>																	
Review NAIHS Standard Emergency Codes				X			N/A	N/A	C	N/A	C	C	N/A	C	C	C	C	C	
<b>BUSINESS OFFICE DEPARTMENT MEE</b>		<b>SHSS</b>																	
Scheduled				X			N/A	C	C	N/A	C	C	N/A	N/A	N/A	C	N/A	N/A	
Unscheduled							N/A	N/A	N/A	N/A	N/A	N/A	N/A	C	C	C	C	C	
<b>BUSINESS OFFICE WORK SESSIONS</b>		<b>SHSS</b>																	
Executive Committee REPORTS				X			C	N/A	C	C	N/A	C	N/A	C	N/A	C	C	C	
Governing Body REPORTS					X		N/A	N/A	N/A	N/A	C	N/A	N/A	N/A	C	N/A	N/A	N/A	
ORAP Patient Registration, Patient Benefits, AR, Posting and TPB						X	N/A	N/A	N/A	C	N/A	N/A	N/A	N/A	C	N/A	N/A	N/A	
<b>Comments</b>																			



# QI Moving Forward-Positives

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- Teamwork
- QI Training
- Communication
- Motivation
- Quality Improvement
- Data-Driven
- Templates needed
- Planning
- Control Practices
- Analysis
- Process Management
- Framework
- Employee Involvement
- System
- Policies & Procedures Created



# QI Moving Forward-Challenges

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- “This is how we always done it” mentality
- Non-communication from Upper Management to Lower Management
- Lack of QI Training
- Lack of QI Knowledge/Terminology
- Expectations/Outcomes not clearly defined
- No Buy-in



# Questions?

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