OVERVIEW OF THE IHS REVENUE CYCLE

Raho Ortiz
Director, Division of Business
Office Enhancement
Office of Resource Access and Partnerships
Indian Health Service
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Outline

- Outcomes for today's presentation
- Alternate Resources to Consider
- Team Approach
- What are ALL the Roles that contribute to the Third Party Revenue Generation Cycle?
- Disruptions in the Revenue Cycle
- Establishing Rules
- Benefits of Successful Implementation

Outcomes

1) Describe the Indian Health Service policy for recording, controlling, and accounting for patient-related resources.

2) Understand the process of specific internal controls to safeguard and properly account for third-party related revenue.

3) Explain the authorities for collecting debts owed to the IHS by third-party sources and non-beneficiary patients.

1) Describe the Indian Health Service policy for recording, controlling, and accounting for patient-related resources.

- Through rules, regulations and policy, IHS records, controls, safeguards, protects, and accounts for all patient related resources.
- Documentation of all services, eligibility, demographics, etc. are captured in the RPMS system.
- This same system is used to bill and collect on all available Alternate Resources.
- Each program responsible for the revenue cycle has set policies and processes in place to ensure that patient related resources are accounted for and protected.

2) Understand the process of specific internal controls to safeguard and properly account for third-party related revenue.

- The Indian Health Service has implemented and follows the Third Party Revenue Accounts Management and Internal Controls Policy.
- This Policy establishes various Internal Controls that are to be implemented at the Area and Facility level that oversee the Revenue Cycle.
- Documentation, Coding, Billing, Collections, Accounts Receivable Management, Debt Management all have specific Internal Controls in place.
- These internal controls are monitored through the online reporting tool and self assessment and monitored by Headquarters.

3) Explain how the authorities for collecting debts owed to the IHS by third-party sources and non-beneficiary patients.

- Through various authorities, IHS has the legal right to collect from all third party sources. Traditionally this has included Medicare, Medicaid, Private Insurance, non-beneficiaries, and a handful of other entities.
- Expanded resources include: Veterans Administration, State and Federal Exchanges, Tribal Self Insurance (through agreement), Expanded Medicaid, etc.

Alternate Resources to Consider

- Medicare (Parts A, B, C, and D)
- Medicaid (with or without Expansion)
- CHIP (Children's Health Insurance Program)
- Private Insurance
- Beneficiary Medical Program (Commissioned Officers)
- CHAMPUS/Tricare
- Workmen's Compensation
- Veterans Administration
- Etc.

Team Approach

- It may take at least 15 different Individuals/ Interactions/Functions to Generate $1 for your facility.
- All the parts must communicate & work together
- Facility must establish a Third Party Revenue Team
- ***As the following slides will show, it takes a TEAM to RECORD, CONTROL, and ACCOUNT for Patient Related Resources.***
- ***Separation Of Duties – To ensure Proper Internal Controls and Accountability are implemented, Separation of Duties must be considered.***

What are these Individual Functions?

1) Patient Registration/Admissions/ Appointments
2) Nursing/Triage
3) Benefits Coordination
4) Provider Services (including Ancillary)
5) Chart Review
6) Coding
7) Medical Records
8) Data Entry
9) Billing
10) Collections
11) Financial Management
12) Accounts Receivable
13) Management (includes Marketing)
14) Systems Development
15) Compliance

For each and every patient !!!

Patient Registration

- Interviews patients to obtain/update identifying demographic and **eligibility information** upon EVERY VISIT
- Responsible for **verifying eligibility** information
- Gathers **required signatures** and documents from the patient
- Often Responsible for obtaining **pre-certification** (approval) for certain procedures.
- **Refer** Patients to Benefits Coordinator when necessary.
- If this is the first point of contact, the **"Check In"** process can be initiated at this time. (Establishing the "Account")
- Often promotes **Positive image** for the entire patient visit.
- ***50%*** *of Billing Information*
- ***Record*** Alternate Resources and Demographics
- Outreach and Education of ALL alternate Resources

Nursing/Triage

- Triage Nurse often assesses the situation. Is this an Emergency?
- Nurses record (**documents)** the Date, Time, **Clinic Code**, **Vital Signs**, and **Chief Complaint.**
- **Supply Capture**
- May identify preventive services and opportunities of care.
- Triage Nurse may be the first to see the patient, and may initiate the **"Check-In" process**, which will generate a "skeletal" Patient Care Component (PCC) Visit in the RPMS system.
- **PHN** Visit
- Nurse **Only** Visits
- **DOCUMENTATION, DOCUMENTATION, DOCUMENTATION**
- ***Record* Services Provided**

Benefits Coordination

- **Determines and *Records*** if the patient is eligible for some "not yet identified" Alternate Resource.
- Outreach and Education on all alternate Resources
- **Liaison** between facility, patient, and local, State, and Federal Agencies.
- Serves as a **Patient Advocate** for scheduling appointments and follow up with different Alternate Resource Programs.
- Assists with Application process for Alternate Resources (Medicaid, Marketplace, VA, etc.)
- Explains the **benefits** of Alternate Resources to the Patients.
- Beneficial to **both** PRC (cost shifting) and Direct Care (additional revenue) Services.

Providers

- **Provide Services** and distribute Meds and Supplies.
- Proper ***Documentation*** of Services by ALL Providers.
- Documents to meet all **Legal, IHS, and Billing Requirements**.
- Documentation must be completed in a **timely** manner.
- **Documentation includes Evaluation and Management E/M coding requirements (History, exam, medical decision making, supplies given, labs/x-rays orders, meds prescribed, education, consultations, etc.)**
- **Increase in Documentation Requirement**
- **PCC, PCC+, EHR, etc. (DATA CAPTURE)**
- **PIN versus UPIN versus NPI REQUIREMENTS**
- **DOCUMENTATION, DOCUMENTATION, DOCUMENTATION**

Chart Review/Analysis

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

Coding

- Certified Coding is an essential part of the IHS process.
- Translators
- **Every Diagnosis and Procedure and Supply** is coded according to the ICD-9 and HCPCS (CPT) guidelines.
- Codes are **written, or verified**, directly on the encounter form. (PCC, PCC+, EHR, Dictations, etc.)
- Incomplete/inaccurate encounter forms are returned to the provider **PRIOR** to going on to the next step, Medical Records.
- **Communicates and Educates** the Provider in enhancing documentation and data integrity.
- ICD-10 Implementation

Health Information Management

- It is the responsibility of the HIM department to ensure that the Encounter Form is **properly filed** in the Chart.
  - Continuity of Care - All charts must be **properly maintained** to ensure access to all "need to know" parties.
  - **Legal** Requirements
  - Lost Visits = Lost Appropriations and Revenue
- HIM often takes on the responsibility of responding to Third Party Payor **Correspondence.**
  - Third Party Payors often ask for "more" information before adjudicating a bill (inpatient briefs, nursing notes, etc.)

Data Capture/Entry

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

Billing

- Billers Know and Apply all **Billing Requirements and Rules** to each individual claim before it is approved.
- They are a “check point” to **validate** the accuracy of the coding.
- Sequence and **Link** all proper diagnosis and procedures to ensure payment.
- **Approve and Submit** “Clean Bills” to Third Party Payors.
- Serve as the Final Check Point, to ensure we are **ONLY** billing for documented services, and billing for **ALL** documented services.
- Final check point for putting the “Agency at Risk”

Collection Process

- **All Checks** go to the PNC Bank Lockbox (IHS Policy on Safeguarding Third Party Collections)
- **Process Electronic Funds Transfers**
- **Enters all Receipts** into the RPMS Accounts Receivable System for further processing.
- **Prepares EOB** (explanation of benefits) and Collection Register to be given to Accounts Receivable Department.
- **Prepares a Deposit Slip** (or similar document) and submits to Area Finance for Processing.
- May be responsible for the **Refund Process.**
- **Debt Collection Process**

Financial Management

- Responsible for the **Actual Deposit** of any Revenue Collected at the Service Unit or Area Level.
- **Reconciles with Bank** if Direct Deposit (Electronic Funds Transfer) is used.
- Ensures **proper Accounting** for Each Source of Revenue
- Makes sure that each Service Unit/Facility has **access to the revenue** that the Service Unit/Facility has earned, according to Process and Policy.
- Prepares and distributes the **Allotments/Distributions** for each Facility/Service Unit.
- Assists in Monthly **Reconciliation** of Collections Received.

Accounts Receivable

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

Management

- Management has the overall responsibility to ensure that the **“Revenue Cycle” is not broken.**
- If it is broken, **decisions to make process changes** have to be made.
- Must have an **understanding and support** the entire revenue generation cycle.
- Third Party Resource and Internal Control Policy
- Ensure the **necessary staff, space, training, and equipment** is provided to “maximize revenue”.
- Training refers to Contracted Staff as well.
- **Marketing**
- **Auditing and Reviews**

Debt Management

- Debt Management is the final step in ensuring your Revenue Cycle is secure and complete.
- IHS has the authority and liability to “turn” over all Non-Federal Debt to Treasury for collection attempts and completion once the debt has reached 180 days old.
- This includes patient account debt that is owed to us from Private Insurance Companies and Non-Beneficiaries.
- The Debt Management Policy and the Third Party Internal Control Policy ensures that each Facility and Area has a Debt Management process in place.

Systems Development

- The Revenue Generation Cycle is ***totally dependent on the continued enhancement, implementation, and support of System Development.***
- Each system (package) **is complex** in its own right. (ADT, Scheduling, Patient Registration, PCC or EHR, Third Party Billing (lab, pharmacy, radiology, immunizations, etc), Accounts Receivable, UFMS, etc)
- Our goal is to become **fully integrated/automated** in order to minimize the manual efforts it takes to "Generate Revenue".

Compliance

- Compliance Plans
- All Federal, State, and Locals Rules and Regulations
- Impacts EVERY STEP of the Revenue Cycle
- OIG, Financial Standards and Principals, Billing, CMS, State Medicaid, PRO, JCAHO, AAAHC, CLIA, Etc.
- Third Party Internal Control Policy
  - **Timeliness of Data Capturing, Coding, Billing, Deposits, Accountability of Revenue**
  - **Recording and Reporting Requirements**
  - **Debt Management Reguirements**
  - **Etc.**

Disruptions in the Revenue Cycle

- What Happens when one of the previous processes does not work, or there is a disruption in the cycle?
  - Delayed Cash Flow
  - Potential Lost of Revenue
  - Unnecessary Rework
  - Inefficient and Ineffective Patient and Work Flow.

Establishing Rules/Benchmarks

- You have to set “RULES” within your Facility. Rules should mimic the Third Party Internal Control Policy or Equivalent
- For Example:
  - Rule 1 – Revenue Enhancement Meetings will take place once a week
  - Rule 2 – All Provider Documentation will be completed accurately within 24 hours of visit.
  - Rule 3 – All Coding/DE will be completed within 4 days of OP Visit. 10 days for IP discharges.
  - Rule 4 – All claims will be dropped (approved and submitted) within 3 days of completed data entry and coding.
  - Rule 5 – All Checks will be posted/deposited within 24 hours of payment.
  - Rule 6 – All EOB’s will be posted within 7 days of receipt.
  - Rule 7 – All patient accounts will be closed within 60 days of billing.

Benefits of Successful Implementation

- MAXIMUM REVENUE GENERATION
- Accurate/Complete Medical Documentation
- Enhanced Provider Profiling Capabilities
- Reduced malpractice/tort action liability
- Improved Risk Management for Physicians and Hospitals
- Facilitated Quality Assurance/Accreditation mandates
- Cost Accounting/Reporting Capabilities
- COMPLIANCE with Rules and Regulations
- Quick Access to needed information
- Continuity of Care
- IMPROVED QUALITY OF CARE
- Enhancement and *Protection* of the entire Third Party Resource Program

Contact Information

Raho Ortiz, Director
Division of Business Office Enhancement
Office of Resource Access and Partnerships
(301) 443-2016
Raho.ortiz@ihs.gov