



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 7000.7
BUMED-13
10 Aug 93

BUMED INSTRUCTION 7000.7

From: Chief, Bureau of Medicine and Surgery

Subj: THIRD PARTY COLLECTION PROGRAM (TPCP)

Ref: (a) DoD Instruction 6010.15 of 10 Mar 93 (NOTAL)
(b) Title 10, United States Code 1095 (NOTAL)
(c) Title 32, Code of Federal Regulations, Part 220
(d) NAVMEDCOMINST 6320.3B
(e) BUMED ltr 5320 ser 1526/0201 of 3 Oct 91
(f) DoD 7220.9-M, the DoD Accounting Manual, Oct 83
(g) JAG Instruction 5890.1
(h) Title 42, United States Code 2651-2653
(i) NAVMED P-5020, section 32310

Encl: (1) Definitions
(2) Third Party Liability Procedures
(3) Accounting and Reimbursement Tracking Guidance
(4) Basic TPCP Requirements and Patient Identification Techniques
(5) TPCP Reimbursement Concepts for Manpower
(6) Outpatient Billing Procedures
(7) Rate Structure for TPCP
(8) Inpatient Billing Procedures
(9) Report Formats
(10) Organizational Requirements

1. Purpose. To implement reference (a), by publishing procedures and assigning responsibilities for an aggressive Third Party Collection Program (TPCP) at all naval medical treatment Facilities (MTFs) and dental treatment facilities (DTFs).

2. Cancellation. NAVMEDCOMINST 7000.4.

3. Definitions. Provided in enclosure (1).

4. Background. Congressional interest in providing medical care to all military beneficiaries has resulted in expanding the scope of reference (b) with reference (c). This allows MTFs to render claims against third party payers for the cost of providing medical care to eligible beneficiaries covered under applicable health care insurance policies. The following are background and highlights of previous law with recent changes:

a. The previous program for collection of revenue from third party payers was titled "Coordination of Benefits" and allowed only claims for inpatient care. This program has now been superseded by the expanded TPCP.



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b. TPCP now includes outpatient care, care covered under Medicare supplemental policies for inpatients only, and care (both inpatient and outpatient) covered by automobile insurance per reference (d). Medical care covered under the auspice of automobile insurance is termed third party liability. Guidance for this segment of TPCP is provided and discussed fully in enclosure (2).

c. Previous law required that funds billed by the MTF for insurance coverage be deposited to the U.S. Treasury. Current law allows collected funds to be returned to the Operating and Maintenance, Navy (O&M,N) accounts of the respective MTF rendering treatment.

d. Billing of outpatient care covers all care rendered by the MTF and DTF and their extensions including branch medical clinics, Navy Cares (NAVCARE) clinics, DTFs, and medical clinic commands, when applicable.

5. Policy

a. That all MTF commanding officers and commanders ensure an aggressive program for maximum collections from third party payers to the fullest extent allowed by law.

b. That all patients covered by applicable insurance plans be identified and that claims be processed to recover the greatest amount possible for the reasonable costs of medical treatment funded by the Bureau of Medicine and Surgery (BUMED) claimancy from third party payers. A third party payer has an obligation to pay the United States for the reasonable costs of inpatient and outpatient care provided in any facility of the uniformed services to a uniformed service beneficiary who is also a beneficiary under the third party payer's plan as delineated in references (a) through (c). The obligation is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf at civilian medical facilities.

c. That all funds collected from a third party payer for the costs of inpatient and outpatient hospital care provided at a uniformed service facility must be credited to the appropriation supporting the O&MN of that facility.

d. That all funds collected under TPCP, except for amounts used to finance collection and patient administration activities in direct support of insurance collections, be used to enhance health care services. Enhancement of medical care can include funds expended for "other base operations." To the maximum extent feasible, these funds shall be used at the facilities

where the funds were collected. Specific guidance for tracking and accounting of collected funds is contained within enclosure (3).

e. That a decision on whether or not to treat a beneficiary for hospital care must not be influenced by whether or not the beneficiary is covered by a third party payer. Current policies, which base treatment on such factors as the medical needs of the patient and the availability of needed facilities and personnel, must remain in effect per reference (d).

6. Procedures

a. Establish an Effective TPCP

(1) An effective TPCP involves more than billing third party payers. Under the new congressional guidelines, the TPCP now encompasses many different insurance policies and collection mechanisms. The TPCP, therefore, now requires reviewing all aspects of accounts receivable management and necessitates the participation of many offices within the MTF including admissions, medical records, utilization review (UR), ancillary departments, data processing, fiscal, and supply. To ensure maximum collections, activities must establish an effective program which requires full participation by all involved departments of the command and is supported by all MTF personnel to ensure maximum collections. Specific requirements are presented in enclosure (4).

(2) The TPCP will be organized to use reimbursable revenue to fund all positions, equipment, and required support per reference (e). The use of funds obtained from TPCP for expansion of all collection activities and payment of its related overhead will allow timely response to changing requirements. An increase in collections above overhead and direct expense will also support increased resources available for enhanced health care services. Reimbursable positions will be managed under guidance provided in enclosure (5).

b. Health Insurance Verification

(1) Verification of insurance coverage must be made upon the occasion of each admission or visit to the MTF. Written certification shall be obtained from all beneficiaries at the time of each admission and the initial outpatient visit (update annually). Outpatient insurance must be verbally verified at each subsequent outpatient visit in the form of a question as to whether coverage status has changed or whether the insurance carrier has changed. Specific procedures are contained in enclosure (6).

(2) Third party payers may require compliance with UR mechanisms or precertification requirements for inpatient admissions or same day surgery. MTFs must ensure that UR support is provided to the TPCP at all times to reduce the possibility of penalties or lost revenue due to noncompliance with UR requirements. Specific procedures are contained in enclosures (3) and (4).

c. Billing Activities

(1) The appropriate patient charge for inpatient and outpatient care must be rendered per enclosures (6), (7), and (8).

(2) Reference (f) outlines financial accounting for billings, collections, and the disposition of third party collections. Specific guidance for operational steps are provided. Further guidance can be found in references (g) through (i).

(3) MTFs must submit accurate claims to third party payers in a timely manner. The MTF must use DD 2502, Uniform Billing for Inpatient Hospital Costs (UB82), to prepare bills to third party payers for all outpatient and inpatient medical care and services rendered to dependents and retirees. If the insurance company prefers use of the HCFA 1500 form for the billing of outpatient services, the MTF may use this form. MTFs must complete those data elements and codes on the DD 2502 which are identified by the National Uniform Billing Committee. Required entries for bill submission to third party payers must meet the minimum requirements outlined by the insurance carriers themselves. Billings must be prepared and forwarded to the third party payer within 10 days following dictation of the medical record but never more than 30 days following the patients discharge. In situations involving long term hospitalization of beneficiaries, interim billings must be made from the MTF. Billings for outpatient care will be forwarded to the third party payer for payment twice weekly if substantial workload warrants. Billings must be sent weekly to ensure expeditious revenue collection. The greatest return on investment with the respective third party payer can result from effective communication both in writing and in person.

(4) Third party collection authority has been expanded to include automobile liability, no fault insurance policies and those policies that fall under the Federal Medical Care Recovery Act. Authority to collect has also been extended to active duty members in this instance. Details of submission are provided in enclosure (2).

(5) TPCP reporting requirements are contained in enclosure (9).

7. Organization. Each MTF is responsible for organizing the TPCP within BUMED organization parameters or requesting modification through BUMED (MED-03). The organization that maximizes revenue for TPCP should be the one considered. A high-level of command interest, guidance, and support at all levels is critical to the success of the TPCP. Components of a successful program include adequate program resources, proper guidance and supervision, program marketing efforts, training, automation, accounting procedures, settlement and litigation authority, and internal control mechanisms. Full compliance with this instruction is expected. Organizational requirements are presented in enclosure (10).

8. Action

a. Healthcare Support Offices (HLTHCARE SUPPOS). Specific action requirements are contained in enclosure (10).

b. Military Treatment Facilities (MTFs)

(1) All MTFs must conduct an aggressive TPCP following procedures of this instruction. Commanders, commanding officers, and officers in charge must ensure maximum revenue collection activities by providing personal support and leadership to all aspects of this program. MTFs will prepare an implementing instruction within 90 days following receipt of this instruction. Medical clinics and dental activities without collection agents will provide appropriate documentation which outlines how third party information will be gathered and how billings/collections will be accomplished.

(2) Requirements of this instruction are the minimum, therefore, all commanders and commanding officers are requested to use appropriate techniques of total quality leadership to ensure the correct personnel are empowered within their respective commands to achieve the highest collection rate possible. Innovative ideas and actions will be the "cornerstone" for a successful program.

9. Forms

a. DD 2502 (6-91), Uniform Billing for Inpatient Hospital Costs, S/N 0102-LF-012-0400; DD 2569 (2-92), Third Party Collection Program, S/N 0102-LF-012-0300; and NAVJAG 5890/12 (3-78), Hospital and Medical Care, Third Party Liability, S/N 0102-LF-105-8960, are available from the Navy supply System and may be requisitioned per NAVSUP P-2002D.

b. DD 2570 (2-91), Third Party Collection Program-Report on Program Results and DD 2571 (2-91), Third Party Collection Program-Aging Schedule, are approved for electronic generation.

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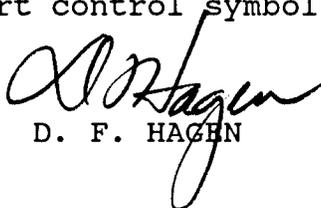
c. HCFA Form 1500, is available from the Health Care Financing Administration.

10. Reports. The following reports identified in enclosure (9), are approved by the Chief of Naval Operations, for 3 years from the date of this instruction.

a. Third Party Collection Program-Report on Program Results, is assigned report control symbol HA(Q)1854(7000).

b. Third Party Collection Program-Aging Schedule, is assigned report control symbol HA(Q)1855(7000).

c. Third Party Collection Program-Expenditures of Collections, is assigned report control symbol HA(A)1856(7000).



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DEFINITIONS

1. Admission. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day in which the medical center or hospital makes a formal acceptance of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. If both an admission and discharge occur on the same day, then that day is considered as a day of admission and must be counted as one occupied bed day.

2. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Supplemental Policies. An insurance, medical service, or health plan which exclusively supplements an eligible person's benefit under CHAMPUS. No insurance, medical service, or health plan provided by an employer or employer group may qualify as a CHAMPUS supplemental plan. Under reference (b) and amendments, MTFs may not bill CHAMPUS supplements.

3. Collection Agent. That person, specifically authorized in writing by the MTF commanding officer for collection of public and private funds.

4. Collection Activity Funding (Overhead Expenses). Any personnel, equipment, systems, services, or supply resources used directly or indirectly in the execution of activities related to the TPCP. Collection activities may include, but are not limited to: pre-admission certification, program personnel, insurance billing activities, program personnel training, program management oversight, disputed claim adjudication, automation systems (to include electronic billing and admission screening and control), dedicated telephone lines, inpatient treatment record reproduction, forms, and mailing costs.

5. Coordination of Benefits Program. Name of the former program governed by Department of Defense, now called Third Party Collection Program governed by reference (a).

6. Concurrent Review. Medical reviews performed by the insurance company's designated review organization at regular intervals during an inpatient stay to determine whether continued inpatient hospital stay is medically necessary.

7. Continued Stay or Length of Stay Review. A UR mechanism required by some third party payers requiring additional certification for a patient's hospital days extending beyond the number of days authorized during the precertification process. This review requires use of pertinent medical information concerning a currently hospitalized patient.

8. Income Supplemental Policies. An insurance policy whose policy provisions pay the policy holder a stated dollar amount for every day the patient is admitted to the hospital. An income supplemental policy insurer is not a third party payer under the TPCP and a claim cannot be filed by a military MTF. The patient can, however, submit a claim against these policies when admitted within a MTF.

9. Insurance Plan. Any plan or program that is designed to provide compensation or reimbursement for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with an organization or group.

10. Medical Care Recovery Act. This is the authority for the third party liability (affirmative claims) program executed by the cognizant MTF naval legal service office (NLSO) and overseen by Office of the Staff Judge Advocate, Department of the Navy.

11. Medical Service or Health Plan. Any plan, program, or organized health care group, corporation or other entity for providing health care to an individual from plan providers, both professional and institutional. Those include plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

12. Medicare Supplemental Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under Medicare. No insurance, medical service, or health plan provided by an employer or employer group may qualify as a Medicare supplemental plan. Under revision of reference (b), MTFs may bill Medicare supplements under TPCP for inpatient care only. The insurer has an obligation to pay comparable to the obligation that the third party payer would incur if the health care services were reimbursed under Medicare. A Medicare supplement insurance carrier is usually obligated to pay the inpatient deductible amount for hospital services under Medicare Part A plus a coinsurance amount for extended hospital stays. Under Part B Medicare, Medicare supplemental plans would cover the Part B deductible and 20 percent of the coinsurance amount (supplemental policy coverage may vary by carrier). The amounts of the annual Part A and Part B deductibles are annually set by statute.

13. Local Provider Agreements. Local agreements between civilian hospitals and third party payers (health insurance carriers or health maintenance organizations) premised on compliance with State and local laws.

14. Partnership Program. A program established under the authority of DoD. When a civilian partner physician provides inpatient and outpatient services under the partnership program for insured dependents and retirees, the military MTF must bill the third party payer for only the hospital and ancillary components of the per diem rate for inpatient and outpatient care. In addition, for patient care, the internal partnership provider is responsible for separately billing the third party payer for the physician charges.
15. Per Diem Rate. A charge equal to the inpatient and outpatient full reimbursement rate subdivided into hospital, physician and ancillary charges. The per diem rate must be used to bill third party payers for inpatient and outpatient care. The per diem rate is revised each fiscal year by the Office of the Comptroller of DoD. The per diem rate does not include the subsistence charges.
16. Pre-Admission Certification. Medical review and prior authorization conducted by the insurance carrier, or its designated review organization, before the patient's hospitalization to determine whether an admission or surgical procedure are medically necessary and whether reimbursement for the admission or surgery are covered benefits under the patient's insurance policy. Pre-admission certification requirements vary for each third party payer. Validation of this requirement is absolutely necessary at admission of a patient. Failure to obtain pre-admission certification may result in reductions of payment ranging from penalty decrements to complete denial of payment.
17. Retrospective Review. A UR mechanism where the third party payer or the third party payers designated review organization requires a medical records audit of one or more hospitalizations in which the third party payer is obligated to pay.
18. Subsistence Charge. A fee levied on the patient for each day of hospitalization. Under the TPCP, the subsistence charge is not to be billed to the patient if there is evidence that the patient has a billable insurance policy. If an insurance claim is closed (resolved) and no payment is received or expected from the third party payer, the subsistence charge will be collected from the beneficiary or sponsor retroactively.
19. Third-Party Payer. An entity that provides a medical insurance service, or health plan by contract or agreement to include plans for State and local government employees. Includes both insurance underwriters and private employers offering self-insured, partially self-insured, or partially underwritten health insurance plans. If a third party payer is an automobile liability or no-fault insurance carrier, the right of the United

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States to collect under Title 10 extends to active duty members of the uniformed services. For the purposes of third party liability, the following policies are excluded: Medicare, Medicaid, CHAMPUS, CHAMPUS supplemental insurance policies, and income supplemental policies.

20. Third Party Payer Plan. Any insurance, medical service, or health plan provided by a third party payer.

21. Uniformed Services Beneficiary. Any person who is covered by 10 USC 1074(b), 1076(a), or 1076(b). For the purpose of the TPCP, uniformed services beneficiaries do not include active duty members of the uniformed services except: (1) reservists on active duty less than 30 days and, (2) except as it applies to automobile liability or no-fault insurance carriers.

22. UR Mechanism. Health care review related activities required by third party payers. UR mechanisms may include pre-admission certification programs, second surgical opinion requirements, concurrent reviews, and continued stay reviews.

THIRD PARTY LIABILITY PROCEDURES

1. References (a) through (c), and (g) through (h) provide the authority, requirements, and procedures for identification, notification, assertion, and collection of claims where a third party may be legally liable for causing the injury or disease, or a third party payer may be legally liable to pay for the cost of treatment for an injury or disease. For this section, third party payers are defined as automobile liability and no-fault insurance carriers. Appropriate management is required to ensure that all patients that qualify under this program are identified and appropriate action is taken, as described below, to ensure the highest possible rate of collection. MTFs must also ensure that all previous records, both inpatient and outpatient, are screened for treatment at a MTF after 5 Nov 90 for injuries resulting from automobile accidents. Records of such treatment must be forwarded to the local Judge Advocate General (JAG) designee, per the procedures discussed in paragraph 3 below.

2. Identification Procedures

a. The importance of early identification of all third party claims cannot be overemphasized. The identification process should receive the same emphasis as other aspects of TPCP. Experience has shown that the likelihood of collection for the cost of medical care is greatest when clinic personnel obtain necessary information from the patient before releasing the injured patient from treatment.

b. It is essential that commanding officers and officers in charge assign the patient administration department with the responsibility of identifying potential claims at the time of treatment. Patient administration coordinates identification of these cases with clinic department heads within those areas where treatment of patients involved in automobile accidents occurs, i.e. emergency room, orthopedics, neurology, family practice, physical therapy, etc. Each MTF must use a daily log system and a questionnaire (samples provided as attachments 1 and 2 of this enclosure) which identifies patients treated for injuries. The log and questionnaire are filled out at the time of treatment. A patient seeking treatment must be questioned as to the cause of the injury. If the patient was injured as the result of an automobile accident, an accident in a private home (including the patient's), or in a public place, a third party liability questionnaire must be filled out. It is the responsibility of the clinic treating the patient to ensure that the questionnaire is completed and turned over to the collection agent's office. For automobile accident cases, if a member does not have complete insurance information, the clinic must contact the collection agent. The collection agent must send a third party collection clerk to the clinic so that pertinent information can be

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collected for billing follow up with the patient. After normal working hours, on weekends, and on holidays, the clinic must obtain as much information as possible from the patient so that the collection agent can follow up on the next business day. At a minimum, the clinic must provide the collection agent with: the questionnaire, the NAVJAG 5890/12, the patient's name, sponsor's name and duty station, sponsor's social security number, patient's address and phone number, and the work phone of the sponsor.

3. Reporting Procedures

a. Treatment of all injuries suspected to fall within the categories listed in paragraph 2(b) above, whether inpatient or outpatient, must be reported to the cognizant JAG designee. In most cases, the JAG designee is the local NLSO. There are no longer minimum requirements for reporting outpatient treatment. All treatment provided under this section must be reported.

b. Copies of all daily treatment logs, the completed third party liability questionnaires, and the NAVJAG 5890/12 must be forwarded to the cognizant JAG designee no later than 48 hours after treatment. The JAG designee will screen all potential claims, and request records and billing statements from the MTF on those claims that will be pursued. Records and bill must be forwarded to the JAG designee no later than 7 days after requested.

c. All MTFs must use the NAVJAG 5890/12 when reporting accident or injury cases. This form provides the JAG designee with the necessary background information concerning the accident or injury, and is used by JAG to assist them in determining if the case is pursuable under the Medical Care Recovery Act. Cases as determined by the JAG designee that will not be pursued will be returned to the MTF for billing under the TPCP.

d. MTF's must use the report generator in the Automated Quality of Care Evaluation Support System (AQCESS) to produce an inpatient report for the local JAG designee showing all inpatient episodes for patients admitted with injuries. This report will be sent to the JAG designee daily.

e. MTF's that have civilian contractors providing emergency room or other primary care support must ensure that the proper information is collected. If the MTF does not modify the contract to collect the information, then the MTF must assign its own staff to extract what is needed from the clinic records to submit the claim. The contracting officer's technical representative (COTR) for the contract must be contacted in order to ensure that there would be no conflict with hospital staff members collecting information in the event the MTF chooses not to modify the contract.

95%

SAMPLE

DAILY LOG OF PATIENTS TREATED FOR INJURIES

MEDICAL FACILITY: _____ DATE: _____

NAME OF PATIENT (LAST, FIRST, MIDDLE INITIAL) (GRADE, SSN#, STATUS)	DUTY STATION, ADDRESS, PHONE	DIAGNOSIS	HOW, WHEN, AND WHERE INCURRED		ADMIT	OUTPT	ALSO COMPLETE 3RD PARTY LIABILITY	
			HOW:	WHEN:			WHERE:	YES
			HOW:	WHEN:			YES	NO
			WHERE:					
			HOW:	WHEN:				
			WHERE:					
			HOW:	WHEN:				
			WHERE:					
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			HOW:	WHEN:				
			WHERE:					

DATE SENT: _____
 THIRD PARTY LIABILITY CLERK: _____
 SIGNATURE: _____

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THIRD PARTY LIABILITY CASE
PATIENT QUESTIONNAIRE

INSTRUCTIONS: Please answer all questions as completely as possible. Please print.

TODAY'S DATE: _____

NAME OF PATIENT(S) _____

HOME ADDRESS _____

TELEPHONE # (home) _____ (work) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

IF PATIENT IS A MILITARY MEMBER:

GRADE/RATE _____ BRANCH OF SERVICE _____

CURRENT DUTY STATION _____

IF DEPENDENT, PLEASE PROVIDE SPONSOR INFORMATION:

NAME _____

SOCIAL SECURITY # _____

CURRENT DUTY STATION _____

(address if retired) _____

RANK/RATE _____ BRANCH OF SERVICE _____

RELATIONSHIP TO SPONSOR _____

DATE OF ACCIDENT _____

PLACE OF ACCIDENT _____

DESCRIPTION OF HOW ACCIDENT HAPPENED _____

OTHER THAN YOURSELF, NAMES AND ADDRESSES OF DRIVERS OF ALL VEHICLES INVOLVED:

1. _____ 2. _____

INSURANCE COMPANY: _____

INSURANCE COMPANY: _____

PLACES AND DATES OF TREATMENT _____

HAVE YOU RECEIVED TREATMENT AT A CIVILIAN FACILITY?

IF SO, WHERE? _____

DO YOU OR ANY MEMBER OF YOUR FAMILY HAVE AUTOMOBILE INSURANCE?

___yes ___no PRIVATE MEDICAL INSURANCE? ___yes ___no

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Attachment (2) to
Enclosure (2)

AUTOMOBILE: NAME OF COMPANY _____
ADDRESS _____
NAME OF POLICY HOLDER _____
POLICY NUMBER _____
MEDICAL: NAME OF COMPANY _____
ADDRESS _____
NAME OF POLICY HOLDER _____

IF YOU HAVE RETAINED A LAWYER TO HELP YOU RECOVER DAMAGES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

LAWYER'S NAME _____
ADDRESS _____
TELEPHONE NUMBER _____

PRIVACY ACT STATEMENT

1. AUTHORITY: Privacy Act of 1974, 5 U.S.C. 552 (a) (1988)
Medical Care Recovery Act, 42 U.S.C. 2651-53 (1988)
Navy Affirmative Claims Regulations, 32 C.F.R. 757 (1992)
Department of Justice Regulations, 28 C.F.R. 43 (1992)
2. PRINCIPAL PURPOSE: Provides information for collection of affirmative claims for medical care against liable third parties and insurance companies for the reasonable value of medical care rendered at MTFs or at civilian facilities at Government expense.
3. ROUTINE USES: Information you give is used to recover the reasonable value of medical care from the individual who caused the injury or an insurance company that is legally obligated to pay for such care. The information is also used to prepare reports to the Department of Justice and the Department of the Navy.
4. MANDATORY DISCLOSURE AND CONSEQUENCES OF REFUSAL TO DISCLOSE; Federal law requires the injured person or his sponsor to provide the requested information. 32 C.F.R. 757.5 (1992); 28 C.F.R. 43.2 (1992); and 42 U.S.C. 2651 (a) (1988).

If the requested information is not given, the U. S. Navy may force disclosure by court action. The U. S. Navy may also require the injured person to assign all claims for the expense of the medical treatment to the U. S. Navy for collection.

Signature of Patient or Sponsor _____

ACCOUNTING AND REIMBURSEMENT TRACKING GUIDANCE

1. Basic Guidance. For beneficiaries who indicate they do not have insurance, retain the original signed form (DD Form 2569) in the respective patient record (inpatient or outpatient record). Particular interest should be focused toward those patients that have current medical insurance policies. The patient disclosure statement indicating medical insurance should be cross referenced to the other record not being used at the specific time of treatment or discharge. For instance, a patient that is discharged from the hospital will have all patient insurance information placed in the outpatient record immediately after discharge for future use. Of greater significance is to ensure that all insurance information collected from an outpatient visit be entered into a separate data base for use by admission personnel. The greatest collection potential from third party payers is for inpatient admissions and all MTFs should ensure this cross-connection of important insurance information is conducted appropriately. This procedure of outpatient and inpatient information sharing will allow identification of the patient for follow-up outpatient visits, ancillary care, future inpatient visits and other treatment.

2. Billing Activities

a. Each activity issuing third party billings must establish and maintain accounting records which can report at a minimum:

- (1) What action was taken on each claim.
- (2) The amount collected.
- (3) The amount resolved as disallowed or invalid billings.
- (4) The delinquent amount.
- (5) The final account disposition.
- (6) How the total collections were spent following established procedures.

b. Insured beneficiary patients treated by internal partnership providers (IPPs) must be billed differently than patients treated by MTF government staff. The military MTF must bill the third party payer for only the hospital and ancillary charges for inpatient and outpatient care for civilian physicians providing health care within the MTF under the Military Civilian Health Services Partnership Program for insured dependents and retirees. The physician charge will not be rendered in this case. The civilian physician is responsible for separately

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billing the third party payer for inpatient and outpatient care and following appropriate billing procedures for the secondary payer if appropriate. Outpatient care provided by the IPP will not be billed any differently than is currently established for inpatient care by the MTF.

c. Any third party payer that can demonstrate, under 32 CFR 220 (reference b), that its prevailing rate of payment for treatments within the particular medical specialty are less on the average than those established, must be billed following the lower rates.

d. For insured dependents and retirees, medical service charges and subsistence charges as required under 10 U.S.C. 1075 and 1078 must be considered to be included in the insurance coverage. No such charges will be collected from insured individuals, unless a claim has been resolved and no payment is received or expected from the third party payer.

e. A military beneficiary shall not be required to pay the MTF any deductible or copayment amounts imposed by the third party payer.

f. Multiple visits on the same day to different clinics will result in one charge per clinic visit. Multiple visits on the same day to the same clinic will only have one charge. Consultations with different providers on different days or a return visit on a separate day will be charged as separate clinic visits.

g. Charges will be made for those extremely high-cost procedures or items as determined by DoD, and as outlined in reference (c).

h. Any payment made by the third party payer to the patient will not be considered as constituting payment under the TPCP. The claim must be paid to the MTF. The MTF has no responsibility to, and should not attempt to, collect from a patient any amounts erroneously paid by a third party payer. The MTF must continue to contact the third party payer for payment as a debt owed the Government.

i. MTFs must make available, on request, to third party payer representatives appropriate health care records of the patients for whom insurance payment is sought. The records that must be available are those necessary to verify that the services were provided and that permissible terms and conditions of the plan were met. Authorizations for release of medical records by the patient is not required and is not dependent on the diagnosis except in the case of alcohol and drug abuse, AIDS, and sickle cell cases.

3. Followup Activities. For each claim that is submitted to a third party payer and results in an unsatisfactory response to the MTF (inappropriate denial or partial denial, inadequate payment amount, no response, etc.), certain followup activities by the collection agent must be conducted and documented. Followup activities include telephone contacts, letters, visits to the insurance payer if appropriate, and contact with the state insurance agency (regulatory commission). All followup activities must be conducted that could result in satisfactory resolution. MTF commanding officers and commanders must ensure that appropriate personnel reimbursable end strength is made available to ensure followup activities are constantly under action to increase revenue volume. Hospital staff JAG officers should assist in the effort when appropriate.

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BASIC TPCP REQUIREMENTS AND PATIENT
IDENTIFICATION TECHNIQUES

1. The TPCP, at the very least, must identify those uniformed services' beneficiaries with third party payer plan coverage, comply with third party payer requirements, submit all claims to third party payers, followup to ensure that collections are made, and document and report collection activities. The TPCP at all MTFs must conform with guidelines provided within this instruction.

2. Authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after April 7, 1986. In addition, specific authority to collection applies to inpatient hospital care provided after September 30, 1986, Medicare supplemental or automobile liability, no-fault insurance, or outpatient care provided after November 5, 1990.

3. MTFs are prohibited by law from entering into local participating hospital agreements. Such agreements are premised on compliance with State and local laws, and provides conflict since Federal entities are governed by Federal statutes and regulations. MTFs may reach understandings with third party payers on claim procedures and other administrative matters, if such understandings do not claim to be preconditions to complying with State and local statutory and regulatory requirements. Questions about local participatory agreements should be referred to the local State insurance regulatory agency for resolution in writing. Failure to receive a documented decision from the local State insurance agency will be reported to BUMED (MED-13) for final resolution.

4. MTFs should immediately ensure implementation of interviewing all outpatient and inpatient beneficiaries to validate medical insurance. Collection for outpatient visits was effective as of 5 November 1990 and therefore all MTFs are authorized to bill retroactive. Timely consideration is necessary since insurance companies will usually pay for back billings for the current calendar year plus one. As an example of back billing, if a patient visits an MTF for an outpatient visit in April 1992 and health insurance is declared, the patient record should be immediately screened for all outpatient visits back until 5 November 1990. The billing document will reflect the visit for April 1992 plus all previous visits after 5 November 1990. Each visit will be listed separately with appropriate International Code of Diseases (ICD-9) data. This information is obtained from screening the outpatient record and coding the visits appropriate for third party charges.

5. Many patients receive outpatient care at one facility, while their medical record is maintained at another. Each clinic

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facility must ensure that controls are in place at the appropriate appointment check-in desk, to collect insurance information from all patients checking in. A mechanism will be in place to ensure that the insurance registration form, and the medical visit encounter form, are sent to the billing office servicing each clinic facility. This will ensure that the insurance company of the patient appropriately receive a bill under this program, regardless of whether or not the patient keeps the outpatient record at the treating facility.

TPCP REIMBURSEMENT CONCEPTS FOR MANPOWER

1. DoD Accounting Manual 7220.9 delineates responsibilities and provides information into the establishment of additional TPCP personnel under a reimbursable account. Under this program, each cognizant healthcare support office (HLTHCARE SUPPO) and other echelon 3 commands were provided targets of reimbursable personnel to recruit for purposes of supporting the TPCP.

2. The following actions are required within the reimbursable TPCP concept:

a. The additional positions under reimbursable conditions are authorized by BUMED and the Comptroller of the Navy (NAVCOMPT) and include managing to payroll (MTP) authority for FY 92. Each activity will receive additional authorizations for outyears by separate correspondence. Future authorizations will depend on total collections by the MTF, MTF requests for increases and decreases, and overall performance of the MTF TPCP. Final decisions for authorized positions will be made by the Assistant Chief for Resource Management (BUMED Comptroller) and can be waived only upon receipt of written justification signed by the MTF commanding officer or commander.

b. The source of funding for the positions will be collections from the insurance companies for both outpatient and inpatient treatment. The positions will be considered reimbursable.

c. Certain occupational series were provided for initial implementation of the TPCP. Each MTF may wish to hire other series than initially listed, but note that the grade levels have been used to establish the MTP level. Any variance above the proposed grade level must be supported within available MTP. Depending on the continuation of the DoD hiring freeze, waivers may be necessary for hiring. Submit waiver requests to BUMED (MED-15) via the HLTHCARE SUPPO, if applicable. Recruitment within DoD, at the date of this instruction, does not require waiver approval by BUMED or higher authority.

d. Each activity must prepare a plan, coordinate submission requirement date with BUMED (MED-15), and initiate action to ensure recruitment. All activities authorized positions must report current status of recruitment for reimbursable positions via their HLTHCARE SUPPO, if appropriate, as separately directed by BUMED (MED-15). This status report will indicate initial authorization, positions not desired indicated by grade and series, additional positions desired with justification, and a plan to demonstrate that all required positions can be onboard by the date specified by BUMED (MED-15). The signature of the commander or commanding officer is required for submission of this report.

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e. Policy questions for this program can be directed to BUMED (MED-13). Civilian position information can be directed to BUMED (MED-15). Accounting guidance information can be directed to BUMED (MED-14).

f. The positions that are recruited should be for purposes of supporting only TPCP and not used for activities not related to collection of insurance. Activities that support collections under TPCP can be included with the reimbursable account and can include record coding, billing of outpatient and inpatient accounts, data entry for insurance billing and back billing, communication with insurance companies and overall management of the program. Positions that were dedicated to collections before the implementation of the TPCP that conducted other Government collection such as subsistence should not be included within this reimbursable program. MTFs that initiated outpatient billing before the TPCP and recruited positions for this function can transfer funding from direct to the reimbursable account.

g. Specific accounting guidance for reporting and recording cost account codes is as follows:

h. Use of the reimbursable positions is determined at the local MTF. Original allocations by BUMED (MED-15) were only recommended levels of recruitment and can be modified with appropriate approval. Approval is needed to provide necessary information required by the Navy comptroller. Activities authorized reimbursable positions should consider the following:

(1) Establish positions for data collection in outpatient clinics, separate branch clinics, and free standing medical clinics. Projected workload should be evaluated to justify each addition and location of each reimbursable full-time equivalent.

(2) Consider recruitment of paralegal personnel at large MTFs to enforce third party liability payment.

(3) Consider reimbursable personnel to assist patient administration personnel with any function that directly impacts on revenue collection. Examples would include admissions, outpatient clinics, inpatient or outpatient record coding, validation of patient insurance, and back billing requirements.

OUTPATIENT BILLING PROCEDURES

1. The most important aspect of outpatient billing is the collection of insurance information from the patient. Procedures should be set up that provide for timely processing so as not to create additional appointment waiting time. Under no circumstances should the patient be delayed for insurance information collection beyond the clinic appointment time. All patients must be notified that they must arrive with enough time to allow appropriate processing for insurance collection and normal outpatient record requirements.
2. Appropriate and trained personnel must be provided for the initial contact with the patient for TPCP. Customer service by all MTF personnel must be emphasized by all commanders and commanding officers. Personal interest by all staff personnel will make this program a success.
3. An aggressive public relations program is highly recommended and should include a brochure at all clinics, outpatient records, registration, Defense Enrollment and Eligibility Reporting System (DEERS), and Personnel Support Detachment (PSD). Target groups for briefs include active duty, dependents, and retirees.
4. An aggressive staff education program is necessary to ensure that only valid information is provided to all patients. Failure to ensure standardized information will only result in confusion and decrease opportunities for successful insurance information collection. All MTF staff should be educated to become advocates of this program. The positive side of TPCP must be stressed. Briefings to include "lessons learned" must be provided to all staff during mandatory meetings. MTFs should involve senior enlisted personnel in the implementation and continuation of a successful program. Continuing education, to include training of new clinic staff, as well as briefings in the formal MTF orientation program must be provided by the TPCP manager.
5. Determine in the beginning of outpatient billing implementation what space requirements are needed and coordinate with the facilities department.
6. Establish liaison with the local Red Cross volunteer coordinator. Efforts to arrange volunteer personnel for those clinics that see the majority of patients should be explored. Red Cross volunteers can be located in strategic locations with brochures and blank patient insurance questionnaires to allow patient contact before arrival to the outpatient record office or outpatient clinic area. This will assist in decreasing patient waiting time in critical areas. Typically, this function will only be a temporary need. The majority of patients will already be registered after 4 to 6 months under the program. However, use of volunteers will allow for new registrations that will

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occur due to the constant migration of active duty personnel and their beneficiaries. Volunteers, obtained through the Red Cross, should be used to the maximum extent possible.

7. MTFs should purchase a UB82 Manual (National Uniform Billing Data Element Specifications) which can be requested from the State insurance regulatory agency or other civilian sources. The UB92 will be implemented in FY 94. The optional use period is planned for Oct 93-Apr 94. MTFs should inquire now about purchase of the new manual. Future AQCESS and Composite Health Care System (CHCS) software updates are scheduled to have UB92 capability. The uniform billing manual should be provided to both inpatient and outpatient TPCP coordinators to provide reference material for greater understanding of the billing process. Insurance companies use this manual to reject claims and therefore each MTF should have information available to rectify rejected claims. Copies of this manual can also be obtained from the respective MTF State hospital association. Appropriate review and correction will be required by the MTF before referral to the cognizant NLSO.

8. Contact with upper management levels of the insurance company is recommended to ensure resolution of rejected claims. Rejection decisions are requested in writing if normal billing processes are not satisfactory.

9. Establish a single point of contact (TPCP Coordinator or other experienced personnel) for all staff personnel to consult for questions or input. Staff personnel are encouraged to participate in TPCP with suggestions for improvement so that all MTF personnel become part of a successful program.

10. All UB82 documents for outpatient billing require an ICD9 code. This code can be obtained during the actual patient visit by the physician or other trained personnel. Involvement of the physician ensures accurate and timely information. Availability of coding sheets will support collection of required information. Examples of coding sheets can be obtained from the Naval Medical Information Management Center (NMIMC) bulletin board under the directory "Third Party Collection Program." This bulletin board will have updated files available for all MTFs on a periodic basis. All MTFs are invited to upload files with recommended suggestions for outpatient billing after approval by BUMED (MED-13).

11. Each clinic and department with TPCP responsibilities must have a TPCP point of contact formally appointed in writing by the commander or commanding officer. This further illustrates the priority with which the program is handled.

RATE STRUCTURE FOR TPCP

1. In the past, all MTFs have charged standard DoD rates to third party payers. These rates are determined and readjusted each October and promulgated by each Service through official channels. MTFs must ensure that inpatient and outpatient billing rates are updated immediately when authorized by DoD via the chain of command to avoid loss of revenue.

2. Standard DoD rates are determined by average of available data and information from the Medical Expense and Performance Reporting System (MEPRS). Current rates do not provide "weighted" values for each specialty area and therefore represent a total overall average without consideration for the intensity of the medical procedure. Hence, procedures of light intensity (manpower, supplies, equipment, and administrative support) are charged the same value as a medical procedure that requires, in comparison, increased support

3. In the case of MTFs purchasing ancillary services or procedures from a source other than a uniformed services facility, the cost of the purchased service will be added to the per diem or per visit rate and billed to the insurer. An example would include the ordering and receiving of a magnetic resonance imaging exam from civilian sources by an MTF through the purchased health care office. The procedure cost of \$800, for example, would be added to the \$77.00 outpatient rate (or current fiscal year per diem rate) that is charged in the clinic ordering the procedure.

4. Visits that are conducted by NAVCARE will be charged a uniform per visit charge computed from the average cost to DoD for a visit in all NAVCARE clinics. This rate will be computed and published annually by DoD. Contract modifications that include the required tasks associated with TPCP will have to be incorporated into the contract before this can occur and has been completed by BUMED (MED-41) for those contracts that were due for renewal during FY 92 and 93. Future NAVCARE contracts will be modified to best incorporate a high rate of return for all TPCP revenue taking into the account the overhead charges anticipated by the contractor.

5. Dependents and retired beneficiaries will not be charged normal subsistence charges as required under 10 U.S.C. 1075 and 1078 if it appears that they are covered by an applicable insurance policy. The subsistence charge will be considered included within the insurance coverage. Collection agents will then bill the subsistence charge to the insured patient if the third party payer denies the bill and no reimbursement is received by the MTF. MTFs are required to keep track of these accounts and ensure subsistence is charged to the patient when appropriate per Financial Management Resource Manual (NAVME P-5020).

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6. Normal Medicare supplemental policy procedures require submitting the primary claim to Medicare and the remainder of the unpaid bill to be rendered to the Medicare supplemental policy. Under the new law, Medicare supplemental carriers are statutorily required to consider the claim as one involving Medicare "covered services." The insurer cannot disallow the supplemental claim for the reason that no claim had been submitted or submitted by the provider or beneficiary for payment to Medicare. Specifics of this procedure are provided. DoD policy regarding billing of Medicare supplemental policies has been instituted. Only inpatient services may be billed as allowable under the specific insurance policy. Outpatient visits may not be billed and this change in policy is reflected in reference (c).

7. TPCP now includes cases under automobile liability and no-fault insurance policies. Authority to collect has also been extended to active duty members in these instances. MTFs must follow procedure for third party liability cases as specified. Third party liability is considered part of the TPCP and provides the same level of emphasis as all other aspects of third party collections.

INPATIENT BILLING PROCEDURES

1. Inpatient billing is very important toward the total TPCP program and has been in existence since FY 87. Initially, all funds collected from this program were deposited in the U.S. Treasury. In 1989, funds collected were authorized for deposit to the MTF operating funds account rendering treatment to the patient. This change to public law was enacted to increase collections and provide incentive for growth.
2. The collection agent organization is the key element to a successful inpatient billing program. All departments of the MTF will need to support the collection agent to ensure that all vital information is provided to ensure increased revenue.
3. Personnel in the patient administration function will ensure that all admissions are reported immediately to the collection agent or at least the morning of the next working day. Watchstanders should be held accountable to ensure all patients admitted are interviewed correctly for insurance information and this information forwarded to the collection agent. Complete information is a necessity to ensure collection of appropriate funds by the third party payer. Failure to collect the correct information will only reduce successful revenue return. To ensure that this requirement is met, systems must be in place to encourage and document accountability. For example, the admissions office watchstanders should be required to initial all forms that are filled out by patients under their direction. They should be required to document the reason as to why any pertinent information is missing. Coordination with the watchstanders' normal supervisor is recommended to ensure that inappropriate or outstanding performance during watchstanding duties is incorporated within the formal evaluation process of the service member.
4. Correct diagnostic coding must be conducted in a timely and correct manner. Additional personnel can be provided from the TPCP reimbursable program for records generated from patients covered by medical insurance.
5. The AQCESS is a standardized DoD computer system that supports primarily inpatient insurance accounts. Version 6.0 was provided to all AQCESS sites in November 1991. Version 6.035 was provided to all AQCESS sites in December 1992, and contains the inpatient multiple billing rates authorized by DoD in FY 93. All MTFs must ensure that these upgraded versions are functioning and are being used for the purpose intended. AQCESS 6.0 stores insurance information for all inpatient accounts and reduces repeat entry of insurance information if all items remain constant. It provides the ability to correct, verify, and add to current patient insurance information, and provides admission personnel the ability to verify health insurance.

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6. Inpatient insurance information must include emphasis to active duty spouses who could be employed and therefore be covered by health insurance. In addition, almost all civil service personnel have medical insurance. A written request will be submitted to all consolidated civilian personnel offices requesting medical insurance information on civil service personnel of the MTF and the adjacent military base. This information must be retained for later reference and validated against inpatient accounts for the previous 2 years (actual annual year plus one full year). Back bills should be rendered if appropriate. At each clinic visit, the patients must be queried as to whether their insurance status has changed. This is vital since the populations are so transient. This is particularly important during civil service "open season" when many employees choose to change their coverage.

REPORT FORMATS

1. Reference (a) provides enclosures and complete instructions on how to prepare the required TPCP reports listed below for consolidation by BUMED and forwarding to DoD. Reports and reporting requirements are: Report on Program Results (DD 2570), Aging schedule (DD 2571), TPCP Collection Source Analysis (DD 2607), and TPCP Insurance Type Report (DD 2608) must be submitted in the AQCESS format to BUMED (MED-14) by the 15th of the month following the end of each quarter. Two copies of each report are required to be submitted as one will be provided to DoD. For outpatient TPCP, all reports listed above are required when an outpatient automated billing system is installed at the MTF. MTFs currently using any automated system for collection of outpatient claims, are required to begin submission of the DD 2608 when this instruction is received. HLTHCARE SUPPOs and teaching hospitals are to consolidate, review, and forward this data to BUMED code (MED-142) via the bulletin board. Attachment (1) to this enclosure provides definitive information on the requirements for submission of each report.

2. Each HLTHCARE SUPPO or separately reporting activity must submit an annual report to BUMED (MED-14) indicating how the TPCP funds were expended by the activity. It is only necessary that reporting activities indicate how amounts collected under the auspices of the TPC program were used. It is not necessary that the activity attempt to track specific funds collected for the TPCP through the accounting systems to the point of expenditure. A letter report is due to BUMED within 60 working days before the end of the reported fiscal year. No specific format for this letter report is specified unless otherwise directed by BUMED.

3. Reports as required above must be forwarded by the HLTHCARE SUPPO indicating amounts that include all cognizant activities (roll-up). However, each HLTHCARE SUPPO is required to maintain values for each activity in an active file in case requirements for additional information by DoD develop.

4. Reported information will be accurate. Financial decisions for budget allocation, mid-year review, or other budget decisions could be made from submitted reports. Each reporting activity must ensure that corrections are forwarded immediately to ensure accurate information is always available to BUMED. The responsibility belongs to the reporting activity.

ORGANIZATIONAL REQUIREMENTS

In summary, minimum requirements that must be implemented are as follows:

1. BUMED. The Chief, BUMED (MED-01) has the authority to compromise, settle, or waive a claim under the TPCP. Further delegation to each HLTHCARE SUPPO and other specifically designated commands are set forth herein. Further delegation of this authority is not authorized. BUMED level supervision of this program must be through the TPCP manager (MED-13) and the Third Party Collection Advisory Council located at BUMED.

a. TPCP Manager. Chief, BUMED will designate a TPCP manager whose primary duty is to provide clarification and guidance, management oversight, and supervisory claims settlement authority for the program. Assistance and information will be provided to the HLTHCARE SUPPOS, designated activities, and MTFs concerning all aspects of the implementing and marketing programs.

b. TPCP Legal Consultant. A program legal consultant will be provided by MED-03 and will provide technical supervision to each MTF when requested. This will include obtaining, consolidating, and reporting significant trends of major third party payers in the regional coordinating centers concerning claims processes and adjudication periods, payment delay tactics, changes in UR requirements, and other procedures frustrating the billing and collection process. The TPCP legal consultant will coordinate with Office of the Judge Advocate General, DoD, and Department of Justice concerning potential litigation or claims adjudication. The TPCP legal consultant will also conduct staff assistance and compliance visits to HLTHCARE SUPPOS and designated coordination commands. Visits to each MTF will be coordinated with Office of the Staff Judge Advocate to minimize travel requirements.

c. Third Party Collection (TPC) Advisory Council. The TPCP Advisory Council will be chaired by Chief of Staff, BUMED (MED-09B). Members are the TPCP manager, the TPCP legal consultant, and representatives from specific BUMED organizational codes as follows:

- (1) MED-11 representative
- (2) MED-14 representative
- (3) MED-13 representative
- (4) MED-03 representative
- (5) MED-01B representative

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This advisory council will meet at least quarterly at the call of the chairman to evaluate the effectiveness of TPC for the claimancy and provide program evaluation reports to the Chief, BUMED. These reports must include progress by each MTF and provide solutions to systemic problems associated with program implementation.

2. HLTHCARE SUPPOS. The HLTHCARE SUPPO plays a vital role in coordinating efforts for those commands that are under their cognizance. Due to the large impact of revenue to each MTF, the HLTHCARE SUPPO will be acutely involved in increasing collections and providing important information and assessment. The designated HLTHCARE SUPPO program manager must perform the following specific duties:

a. Identify significant trends of major third party payers in the region on claims processes and turn-around times, payment delay tactics, changes in UR requirements and other procedures frustrating the billing and collection processes.

b. Coordinate closely with the TPC Advisory Council, TPCP legal counsel, and the TPCP BUMED program manager as required.

c. Provide timely information to all MTFs under their cognizance when required.

d. Conduct staff assistance and compliance visits in the region.

3. Designated Regional MTF Coordinators. The following MTFs will be designated "Regional MTF Coordinators" due to their size and complexity.

a. San Francisco Medical Command, Oakland, CA.

b. National Naval Medical Center, Bethesda, MD.

c. Naval Medical Center, Portsmouth, VA.

d. Naval Medical Center, San Diego, CA.

The regional MTF must appoint a program manager, and coordinate TPCP issues closely with the BUMED TPCP program manager.

4. MTF. Each MTF commander or commanding officer must adequately resource and aggressively implement an effective TPCP complying with this instruction. Effective implementation of this program involves an immediate transition to a maximum level of pre-admission of patients at all MTFs. MTF commanders or commanding officers must institute a program to pre-admit

patients to the earliest and maximum extent possible to comply with third party payer pre-admission certification (precert) requirements, thereby avoiding costly precertification penalties. MTF commanders or commanding officers must ensure complete cooperation of all MTF personnel, including clinical staff in the precertification process. The following personnel and functions at the MTF level are required:

a. Program Manager. A program manager must be designated by the MTF commanding officer and must be responsible for all aspects of TPCP operations as required.

b. Patient Administration Officer. The patient administration officer must take an active role in the TPCP and must communicate with the comptroller, quality assurance department, UR personnel for precertification information, and the command designated collection agent. It is the patient administration officer's responsibility to ensure that: identification of patients with insurance occurs, that the insurance registration forms are properly filled out and submitted to the collection agent, and that all personnel under their cognizance fully cooperate with the TPCP manager. The patient administration officer must also assist in resolving any problems that arise within their area of responsibility when identified by the TPCP manager as a potential issue for resolution by patient administration. Examples of this are: incomplete registration forms, incomplete patient encounter forms, lack of precertification of inpatient visits, and personnel issues that conflict with the management of the program.

c. Admissions Personnel. All admissions personnel, including watchstanders, must ensure that all required information is entered into AQCESS 6.035 or CHCS data systems. Admissions personnel must also ensure that all precertification information is collected and provided to the designated third party payer, when required, specifically within the beneficiary health care or automobile policy.

d. Medical Records Personnel. Medical records personnel must enter accurate and timely coding information into AQCESS/CHCS. All coding information must be completed and entered no later than 30 days post discharge.

e. Insurance Information Collection Personnel. Additional billets have been provided with "management to payroll" authority. These personnel must be organized within the MTF to provide timely third party payer information collection and filing of claims within 15 days of an outpatient visit. They will also assist the collection agent personnel in claim adjudication.

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f. Billing and Collections Personnel. Billing and collections personnel must communicate with MTF staff, patients, and third party payers on a daily basis. They must ensure that proper billing, follow-up, collection, and financial reporting activities are conducted following the established policy.

g. Fiscal Department Personnel. MTF comptroller and fiscal department personnel must ensure that the program is supported by resources entirely out of third party collections (overhead expenses) in terms of personnel, training, supplies and equipment. The TPCP must be funded fully before funds from TPCP are redistributed to other mission elements of the command. Proper resourcing of the program can be defined in terms of those resources necessary to ensure maximum legal collections from third party payers. Resource managers must ensure that collections generated from this program, over and above overhead expenses, are used to enhance patient care in the MTF. Resource managers will make it a matter of public record how net collections (profits) generated from this program are spent to enhance patient care via the public affairs. The program resourcing and marketing contributions of resource management personnel play a critical role in the ability of TPCP to generate the maximum amount of collections possible.

5. Minimum Essential Staffing and Equipment. Staffing will vary from facility to facility due to the differences in the number of admissions, outpatient visits, and patient population demographics. Each MTF commander or commanding officer must ensure sufficient staffing to accomplish all the TPCP functions discussed above. The reimbursable positions allocated will be used strictly for the entire TPCP to enhance collections. They can supplement insurance collection procedures, admission pre-certification requirements, billing, collections, and TPCP coding requirements. Minimum equipment requirements will include dedicated telephone lines for billing personnel, copy machine located conveniently to billing and collection personnel, AQCCESS terminals with printers, and personal computers.

6. Internal Controls. Internal controls must be constructed by the command evaluation program to ensure all aspects of reference (a) and this implementation instruction are in compliance. Specifically, the following is required:

a. TPCP Transactions. TPCP transactions will be subject to review and audit by command evaluation personnel and the medical inspector general. All transactions will be supported by a well-documented audit trail.

b. Separation of Duties. Appropriate separation of duties must be maintained to minimize the risk of misappropriation of funds. The individual responsible for billing will not receipt and deposit the funds.

c. Refunds. All insurance refunds must be coordinated with and approved by the region. The current version of AQCESS allows the generation of a refund without higher approval authority. Refunds must be approved and appropriately accounted for.

7. Training of TPCP Personnel. The following minimal training for all TPC personnel is required:

a. Medical Terminology. Medical terminology training is required for personnel involved in TPCP. Specific requirements for this aspect should be included within all job descriptions of civilian personnel and is to be included for special training of active duty personnel.

b. Precertification Workshops. The precertification nurse and patient administration officer should periodically attend precertification workshops. Training is essential to remain current regarding changes in health insurance industry requirements and efficient methods of obtaining necessary insurance verification and precertification approval.

c. Interview Skills Training. All admissions personnel, claims processing clerks, and those personnel assigned duties for TPCP outpatient functions must attend training designed to improve their interviewing skills.

d. Networking with Civilian Hospitals. TPCP personnel are encouraged to visit local civilian medical treatment facilities to study collection procedures, develop contacts with civilian counterparts, and gain understanding of common problems.

e. Professional Publications. MTFs are encouraged to subscribe to publications such as Hospital Admitting Monthly (American Health Consultants) or Hospital Business Office Policy and Procedures (Health Care Financial Management Association) and to purchase publications by the American Medical Association such as UB82 Billing Updates and Billing Procedures. Membership in local hospital associations, if recommended, to remain current with the latest developments regarding third party payer revenue collections.

f. Third Party Payer Sponsored Training. Workshops sponsored by insurance companies are a good source of training. They provide first-hand insight into the insurance carriers requirements and methods, while also providing a forum for TPCP personnel to educate the third party payers concerning TPC governing laws and regulations.

8. Marketing. A comprehensive marketing program is essential to a successful TPCP. A marketing program will elicit a high degree of cooperation from the beneficiary population and provide incentive to the MTF staff to support the program. Specifics for this program are provided.