Defense Health Agency
Uniform Business Office

Department of Defense Form 2570 (DD 2570) Reporting

Presented by
DHA UBO Program Office Contract Support

20 December 2016 0800 – 0900 EDT
22 December 2016 1400 – 1500 EDT

For entry into the webinar, log into: **http://altarum.adobeconnect.com/ubo.**

Enter as a guest with your full name and Service affiliation for Service and NCR MD attendance verification.

Instructions for CEU credit are at the end of this presentation.

View and listen to the webinar through your computer or Web–enabled mobile device. Note: The DHA UBO Program Office is not responsible for and does not reimburse any airtime, data, roaming or other charges for mobile, wireless and any other internet connections and use.

If you need technical assistance with this webinar, contact us at webmeeting@altarum.org.

You may submit a question or request technical assistance at any during a live broadcast time by entering it into the "Question" field of Adobe Connect.

Agenda

- What is the Department of Defense Form 2570 (DD 2570)?
- What is the importance of DD 2570 Reporting?
- Elements of the DD 2570 report
- Extraction of DD 2570 data
- Uniform Business Office (UBO) Metrics Report Website
- Historical Data Collection
- Common Mistakes
- DD 2570 Resources

- The DD Form 2570, “Third Party Collection Program (TPCP) – Report on Program Results”
  - MTFs use the DD 2570 to report claims and collection data for their TPCP to the Defense Health Agency (DHA) UBO.
  - The DD 2570 is cumulative and includes data from prior years.
  - The DD 2570 summarizes adjustment transactions based upon the Fiscal Year (FY).
  - MTFs must complete a DD 2570 on the first working day after the end of each quarter.
    - Late completion results in incorrect data

- http://www.dtic.mil/whs/directives/forms/eforms/dd2570.pdf

DD 2570 Report

THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS	SEGMENT REPORTED *(X one)*	REPORT CONTROL SYMBOL
	☐ INPATIENT ☐ OUTPATIENT	DD-HA(Q)1986

1. QUARTER ENDING *(YYYYMM)*	2. REPORTING MEDICAL TREATMENT FACILITY (MTF)	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO.

PART I

4. REPORTING PERIOD *(See Note 1)*

FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO. CLAIMS DIVIDED BY DISPOSITIONS/ VISITS (%) (5)	TOTAL $ AMOUNT BILLED/CHARGES (6)
a. CURRENT FY					
PRIOR YEAR (PY) b. PY 1					
c. PY 2					

	$ ADJUSTMENTS AND REFUNDS *(See Note 2)* (7)	$ AMOUNT COLLECTED PY 2 (8)	$ AMOUNT COLLECTED PY 1 (9)	$ AMOUNT COLLECTED CURRENT FY (10)	$ AMOUNT REMAINING UNCOLLECTED *(See Note 3)* *(6)-[(7)+(8)+(9)+(10)]* (11)
a. CURRENT FY					
b. PY 1					
c. PY 2					

REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS	6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY ($) *(See Notes 1 and 4)*		
		a. FY	b. FY	c. FY
1	OPEN CLAIMS *(Requires additional follow-up action by Medical Treatment Facility for resolution)*			
2	TRANSFERRED TO EXTERNAL AGENT *(e.g., JAG) (Excluding Third Party Liability Cases)*			
REASON CODES 3-7. THIRD PARTY REDUCED / DENIED PAYMENT FOR INVALID REASONS *(Requires additional debt collection/legal action)*				
3	MTF NOT A PARTICIPATING HOSPITAL			
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES			
5	PATIENT HAD NO OBLIGATION TO PAY			
6	INSURER PAID PATIENT DIRECTLY			
7	OTHER *(Explain)*			
	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*			

DD 2570 Report

	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*			
	REASON CODES 8-16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS *(No further action required because unpaid amount is not a valid claim)*			
8	AMOUNT OF COVERAGE *(i.e. plan pays less than 100%)*			
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED			
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS			
11	MEDICARE SUPPLEMENTAL PLANS			
12	HEALTH MAINTENANCE ORGANIZATION (HMO) *(i.e. nonemergency out-of-plan care not covered)*			
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES *(i.e. pre-admission screening, concurrent review, second surgical opinions, etc.)*			
14	REFUNDS			
15	PATIENT COPAYS AND DEDUCTIBLES			
16	OTHER *(Explain) (Example - third party provided lower prevailing rate vs. amount billed)*			
	TOTAL OF ALL CLOSED CLAIMS *(Reason Codes 8 through 16)*			

NOTES:

1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (i.e. care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received). This requires cut-off billing for all inpatients at fiscal year end.
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8-16 in Part II, for the respective fiscal years.
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1-7 in Part II, for the respective fiscal years.
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.

Importance of DD 2570 Reporting

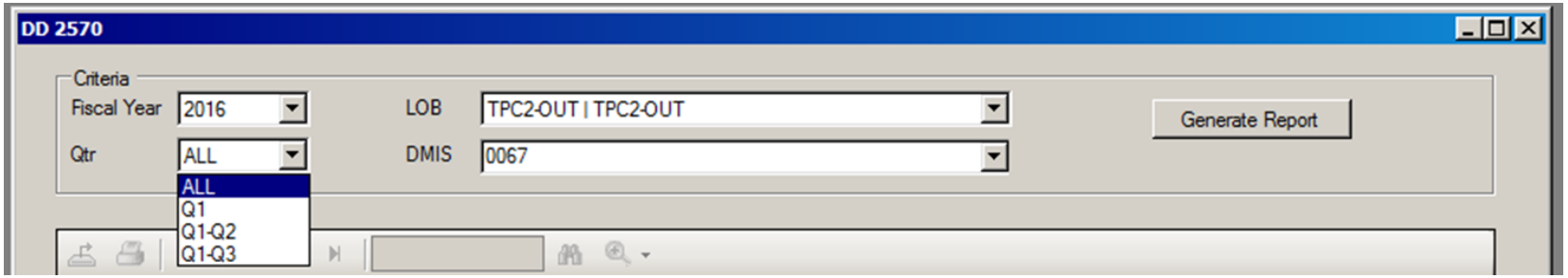
- Provides MTFs with real-time data to measure itself in relation to its peers and competitors.
- Allows data to be used in calculating Key Performance Indicators (KPIs).
  - KPIs are established benchmarks used to determine how an organization compares to similarly situated organizations
- Reports are immediately available to management upon submission, and allow all levels of the UBO to benchmark, trend, and compare individual MTFs, regions, Services, or the National Capital Region Medical Directorate (NCR MD) by time period.
  - Reports are briefed to the DHA UBO Program Office (PO), the UBO Advisory Working Group (AWG), and to the DHA executive level, such as the Medical Business Operations Group (MBOG)

DD 2570 Data Elements

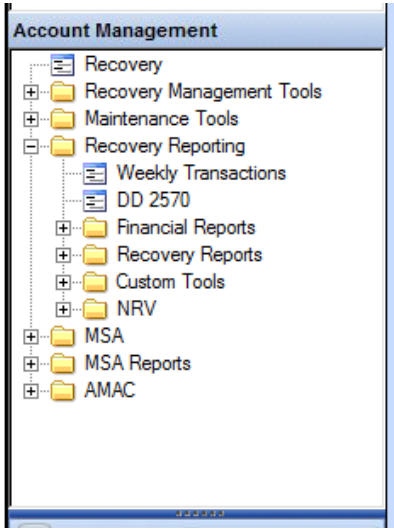
- The following data elements are reported on the DD 2570
  - Number of Inpatient Dispositions & Outpatient Visits
  - Number of claims
  - Number of collections
  - Dollar amount billed
  - Dollar amount collected
  - Dollar amount of adjustments and refunds
  - Dollar amount remaining uncollected

- ABACUS Menu Path: Claims and Collection Data

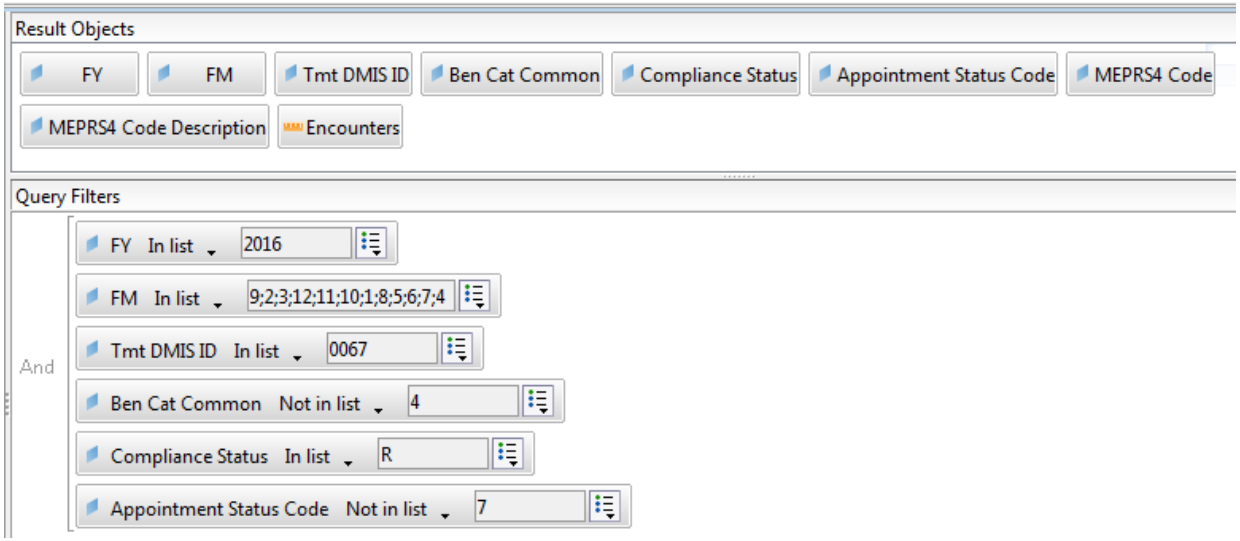
  Account Management > Recovery Reporting > DD 2570



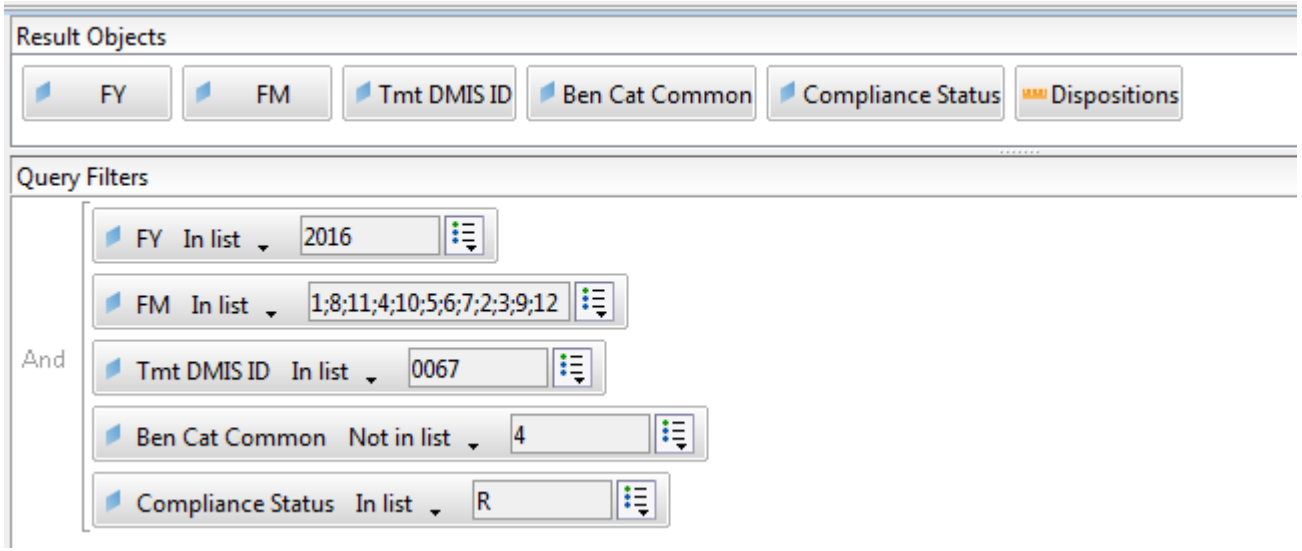
- Includes all DD 2570 data elements except Inpatient Dispositions and Outpatient Visits
  - Select FY, Quarter, DMIS ID, and Line of Business (LOB)
  - TPC1-IN = Inpatient Data
  - TPC2-OUT = Outpatient Data
  - Select Generate Report



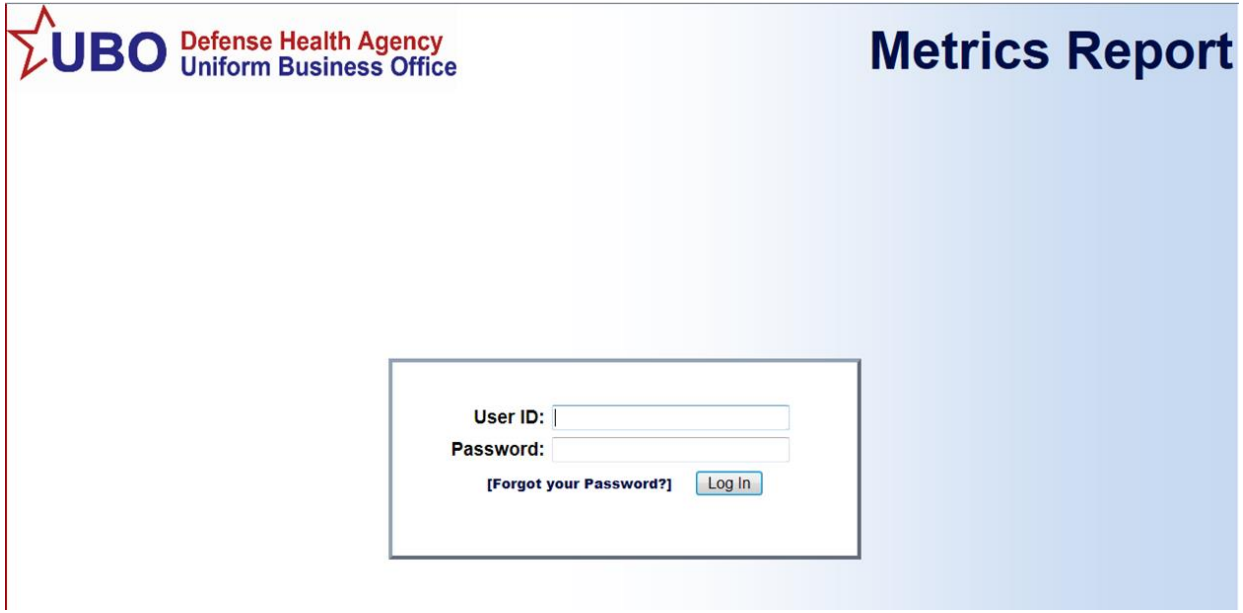
- Composite Health Care System (CHCS): Outpatient Visits
  - Use the Workload Assignment Module (WAM) to obtain the number of Non-Active Duty (NAD) Outpatient Visits.
  - WAM > Select 2 – Division > Select 1 - SAS # > Enter Month > Look for Outpatient Visit data by MEPRS code.
- MHS Mart (M2): Outpatient Visits
  - Health Care Services > Direct Care > CAPER > CAPER Detail



- CHCS: Inpatient Dispositions
  - Medical Services Account (MSA) Menu Path: IFM\QRP\PRR\current quarter
- M2: Inpatient Dispositions
  - Health Care Services > Direct Care > SIDR > SIDR Detail



- Once you are ready to enter your data, access the DHA UBO Metrics Report Website at https://ubometrics.org/.
- Enter Username and Password.
- If a user forgets his/her password, utilize the “Forgot Your Password?” link below the password field.
- Contact the UBO.Helpdesk@Altarum.org for additional help with access.



What is the DHA UBO Metrics Report?

- The DHA UBO Metrics Report is a web-based data repository that MTF UBOs use to electronically self report and validate DD 2570 data.
- Facilitates the capturing, consolidating, validating, and reporting of DD 2570 TPCP results.
- UBO Metrics Report data is used for monitoring performance, tracking trends over time, and setting annual TPCP Goals.
- ABACUS and CHCS can output the DD 2570 data for Outpatient and Inpatient encounters (see slides 12-14).

Access to DHA UBO Metrics Report

- Users who enter DD 2570 data into the DHA UBO Metrics Report Website need to have approved user accounts in order to access the site.
- Accounts can only be created by request of a Service or NCR MD manager or a Regional representative.
- To get access, contact your Service or NCR MD representative for Metrics Report access with the following information:
  - Full name of individual requesting access
  - Commercial telephone number
  - Valid “@mail.mil” e-mail address
  - Duty title
  - Facility
  - DMIS ID

- MTF UBO staff are responsible for collecting and reporting TPCP metrics data quarterly.
- Each MTF must have a primary responsible staff person and should have at least one alternate.
- Responsibilities vary for different types of users:
  - MTF-level Users - Data Entry
  - Regional Users - Data Validation
  - Service and NCR MD UBO Managers - Data Validation
- Reports must be validated by either the Regional representative or the Service/NCR MD UBO Manager in order to be considered complete. It is possible for both to validate a report but that is not required.
- You need to know what level of user you are in order to understand your duties and responsibilities.
- If you believe that you have been assigned the wrong user level you can contact the UBO.Helpdesk@altarum.org for assistance.

User Responsibilities

- MTF-level Users
  - Only have access to reports for their MTF
  - Must retrieve data from ABACUS and CHCS
  - Responsible for accurately entering data into DHA UBO Metrics Report Website
- Regional-level Users
  - Have access to reports from all MTFs in assigned region
  - Can review this data once it is submitted and can validate data
- Service and NCR MD-level Users
  - Have access to reports from all MTFs in their service area (or NCR MD)
  - Can review this data once it is submitted and can validate data

Using the DHA UBO Metrics Report Website

- After logging in to the DHA UBO Metrics Report Website you are taken to a welcome page with pull down menu options.
- Use the menu options at the top of the page to navigate to the appropriate section.
- Return to this home page at any time by clicking “Home” on the top menu.

- Select “Add Report” from the menu bar at the top of the page to enter new quarterly data.
- If you have already started entering data and need to finish it, click on “Edit Report” instead.
- You must select your MTF from the “Facility” dropdown menu.
- Each user will only be able to enter data for their own facility.
  - If a user cannot access their MTF from this menu, contact UBO.Helpdesk@Altarum.org

- After selecting your MTF from the “Facility” Menu select the appropriate Report Type (Inpatient or Outpatient), FY, and Quarter.
- Click on “Add” in order to create the report and start entering data.

- If a report already exists for the same time period, facility, and report type you will be given a warning message and you will not be allowed to add a duplicate version.

- After clicking on “Add” you will be given a page with a summary of your basic information and a series of boxes to enter your DD 2570 data.

Report View

User:	Jesse Snyder - Administrator access				
Current Step - Summary Section					
Branch	NCR MD	Region	NCR MD		
Facility	0067 | Walter Reed National Military Medical Center				
Report	Inpatient	Fiscal Year	2017	Quarter	First

Summary

Field Description	CFY	PY 1	PY 2
Cumulative Non-Active Duty Dispositions/Msits	0	0	0
No. of Claims	0	0	0
No. of Collections	0	0	0
Dollar Amount Billed	$0.00	$0.00	$0.00
Adjustments and Refunds	$0.00	$0.00	$0.00
Amount Collected in PY2			$0.00
Amount Collected in PY1		$0.00	$0.00
Amount Collected Current FY	$0.00	$0.00	$0.00
Amount Remaining Uncollected	$0.00	$0.00	$0.00

Create

Add Report

Open Claims

Code	Field Description	CFY	PY 1	PY 2
1	Open Claims	$0.00	$0.00	$0.00
2	Transferred to External Agent	$0.00	$0.00	$0.00
3	MTF Not a Participating Hospital	$0.00	$0.00	$0.00
4	Plan Excludes Military Hospitals or Beneficiaries	$0.00	$0.00	$0.00
5	Patient Had No Obligation to Pay	$0.00	$0.00	$0.00
6	Insurer Paid Patient Directly	$0.00	$0.00	$0.00
7	Other ( )	$0.00	$0.00	$0.00

Create

Closed Claims

Code	Field Description	CFY	PY 1	PY 2
8	Amount of Coverage	$0.00	$0.00	$0.00
9	Patient Not Covered, Care Provided Not Covered, or Policy Expired	$0.00	$0.00	$0.00
10	TRICARE and/or Income Supplemental Plans	$0.00	$0.00	$0.00
11	Medicare Supplemental Plans	$0.00	$0.00	$0.00
12	HMO/PPO	$0.00	$0.00	$0.00
13	MTF Did Not Comply with Utilization Review Procedures	$0.00	$0.00	$0.00
14	Refunds	$0.00	$0.00	$0.00
15	Patient Copays and Deductibles	$0.00	$0.00	$0.00
16	Other ( )	$0.00	$0.00	$0.00
17	Other ( )	$0.00	$0.00	$0.00

Create

- The data entry screen consists of three sections: Summary, Open Claims and Closed Claims.
- The user enters the data output from ABACUS and CHCS for the current quarter as well as the same quarter in the two prior fiscal years.
- After completing a section, click on the “Create” button to save your work.
- You can still make changes after this, the report is only locked after it has been validated.
- If you need to return to a report, use the “Edit Report” option in the top menu.

ABACUS DD 2570

Part I

Description	Reporting Period			
	Fiscal Year	Previous Year 1	Previous Year 2	Previous Year 3
Number of Claims (lines)	130,864	129,918	139,982	142,772
Number of Collections (lines)	28,868	55,288	57,484	67,558
Total Dollar Amount Billed	$18,870,256.30	$15,093,603.16	$14,489,273.64	$14,869,978.10
Adjustments and Refunds	$1,947,973.28	$3,135,286.76	$3,812,814.29	$7,976,397.58
Amount Collected PY 3	$0.00	$0.00	$0.00	$3,350,175.66
Amount Collected PY 2	$0.00	$0.00	$3,218,452.31	$1,449,912.03
Amount Collected PY 1	$0.00	$3,061,399.67	$1,252,243.22	$98,260.76
Amount Collected Current FY	$1,988,791.58	$1,488,481.49	$29,725.82	$610.41
Amount Remaining Uncollected	$14,933,491.44	$7,408,435.24	$6,176,038.00	$1,994,621.66

Summary

Field Description	CFY	PY 1	PY 2
Cumulative Non-Active Duty Dispositions/Visits	0	0	0
No. of Claims	0	0	0
No. of Collections	0	0	0
Dollar Amount Billed	$0.00	$0.00	$0.00
Adjustments and Refunds	$0.00	$0.00	$0.00
Amount Collected in PY2			$0.00
Amount Collected in PY1		$0.00	$0.00
Amount Collected Current FY	$0.00	$0.00	$0.00
Amount Remaining Uncollected	$0.00	$0.00	$0.00

ABACUS DD 2570

Part II

Reason	Description	Uncollected Amounts Subdivided by Fiscal Year (FY)			
		Fiscal Year	Previous Year 1	Previous Year 2	Previous Year 3
U01	OPEN CLAIMS	$14,933,491.44	$7,408,435.24	$6,175,955.85	$1,994,530.83
U02	TRANSFERRED TO DFAS	$0.00	$0.00	$0.00	$0.00
U03	TRANSFER TO CRS	$0.00	$0.00	$0.00	$0.00
U06	TRANSFER TO JAG	$0.00	$0.00	$82.15	$79.33
U07	OTHER	$0.00	$0.00	$0.00	$11.50
	Total of All Open Claims:	**$14,933,491.44**	**$7,408,435.24**	**$6,176,038.00**	**$1,994,621.66**

Open Claims

Code	Field Description	CFY	PY 1	PY 2
1	Open Claims	$0.00	$0.00	$0.00
2	Transferred to External Agent	$0.00	$0.00	$0.00
3	MTF Not a Participating Hospital	$0.00	$0.00	$0.00
4	Plan Excludes Military Hospitals or Beneficiaries	$0.00	$0.00	$0.00
5	Patient Had No Obligation to Pay	$0.00	$0.00	$0.00
6	Insurer Paid Patient Directly	$0.00	$0.00	$0.00
7	Other ( )	$0.00	$0.00	$0.00

ABACUS DD 2570

Part III

Reason	Description	Closed Claim Amounts Subdivided by Fiscal Year (FY)			
		Fiscal Year	Previous Year 1	Previous Year 2	Previous Year 3
08	AMT OF COVERAGE (PLAN PAYS < 100%)	$1,207,509.72	$1,441,093.87	$1,245,860.46	$1,364,739.16
09	NOT COVERED	$125,280.77	$407,394.33	$618,513.05	$706,467.12
10	CHAMPUS/TRICARE ONLY	$390.87	$1,704.33	$4,193.01	$3,896.21
11	MEDICARE SUPPLEMENT PLANS	$3,315.14	$386,519.56	$639,473.43	$655,917.50
12	HMO PLANS	$14,346.37	$5,955.51	$36,886.14	$87,325.55
13	MTF DIDN'T COMPLY W/UTIL REVIEW	$1,700.95	$5,657.60	$19,203.08	$15,759.99
15	CO-PAY/DEDUCTIBLE	$512,749.69	$805,982.90	$844,779.34	$946,707.56
16	OTHER	$75.07	$238.67	$7,945.55	$84,976.03
17	OTHER - BILLED IN ERROR	$22,707.71	$33,607.31	$28,172.85	$71,140.51
18	TERMED/CANCEL POLICY	$53,522.39	$31,046.78	$7,211.79	$7,931.87
19	NO PAY= DAYS SUPPLY	$1,049.25	$1,036.55	$5,729.49	$3,358,270.61
20	ROUTINE SERVICE/NON COVERED SERVICE	$0.00	$845.65	$3,506.38	$12,425.17
21	NO RX COVERAGE, NON PAR RX	$1,694.76	$1,181.95	$2,813.54	$128,810.40
22	TOO LATE TO BILL	$3,630.59	$13,021.75	$348,526.18	$527,949.85
50	MAC WRITE OFF	$0.00	$0.00	$0.00	$4,080.05
	Total of All Closed Claims:	**$1,947,973.28**	**$3,135,286.76**	**$3,812,814.29**	**$7,976,397.58**

Closed Claims

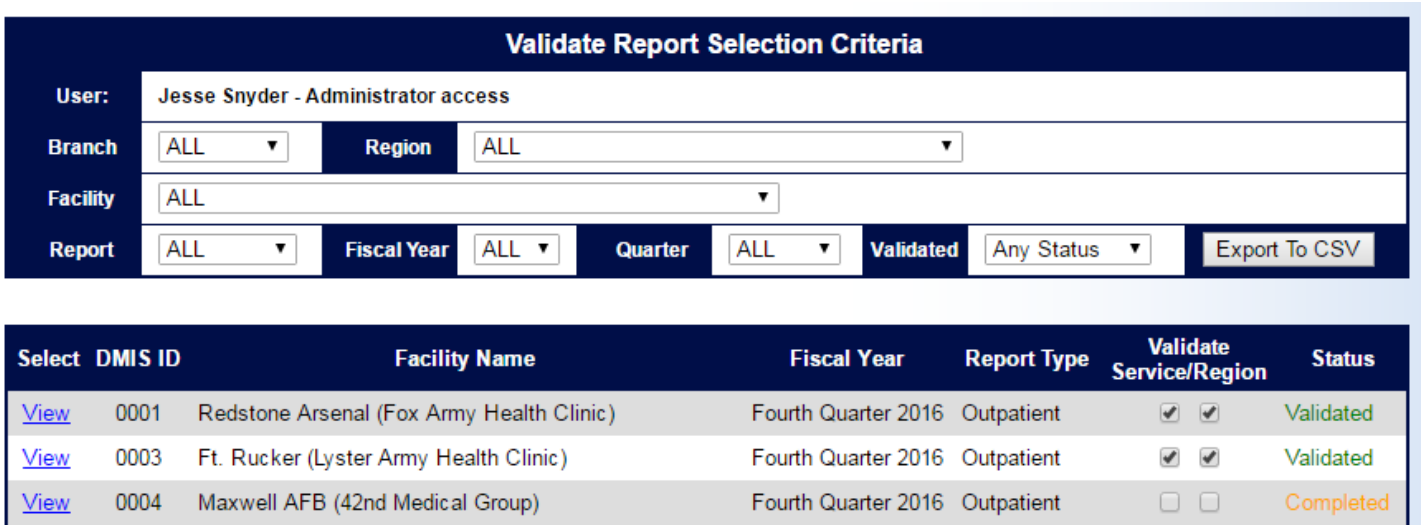
Code	Field Description	CFY	PY 1	PY 2
8	Amount of Coverage	$0.00	$0.00	$0.00
9	Patient Not Covered, Care Provided Not Covered, or Policy Expired	$0.00	$0.00	$0.00
10	TRICARE and/or Income Supplemental Plans	$0.00	$0.00	$0.00
11	Medicare Supplemental Plans	$0.00	$0.00	$0.00
12	HMO/PPO	$0.00	$0.00	$0.00
13	MTF Did Not Comply with Utilization Review Procedures	$0.00	$0.00	$0.00
14	Refunds	$0.00	$0.00	$0.00
15	Patient Copays and Deductibles	$0.00	$0.00	$0.00
16	Other ( )	$0.00	$0.00	$0.00
17	Other ( )	$0.00	$0.00	$0.00

- Both the Open Claims and the Closed Claims sections include extra data entry boxes for “Other” items.
- There is one “Other” box for Open Claims, and two for Closed Claims, but sometimes users have more additional items to add than the number of boxes.
- In this case, add up the total amounts of all of the remaining “Other” categories and enter the combined total into a single “Other” box on the website.
  - For example, the too late to bill description from the DD 2570 would be added into the Other category on the DHA UBO Metrics Report

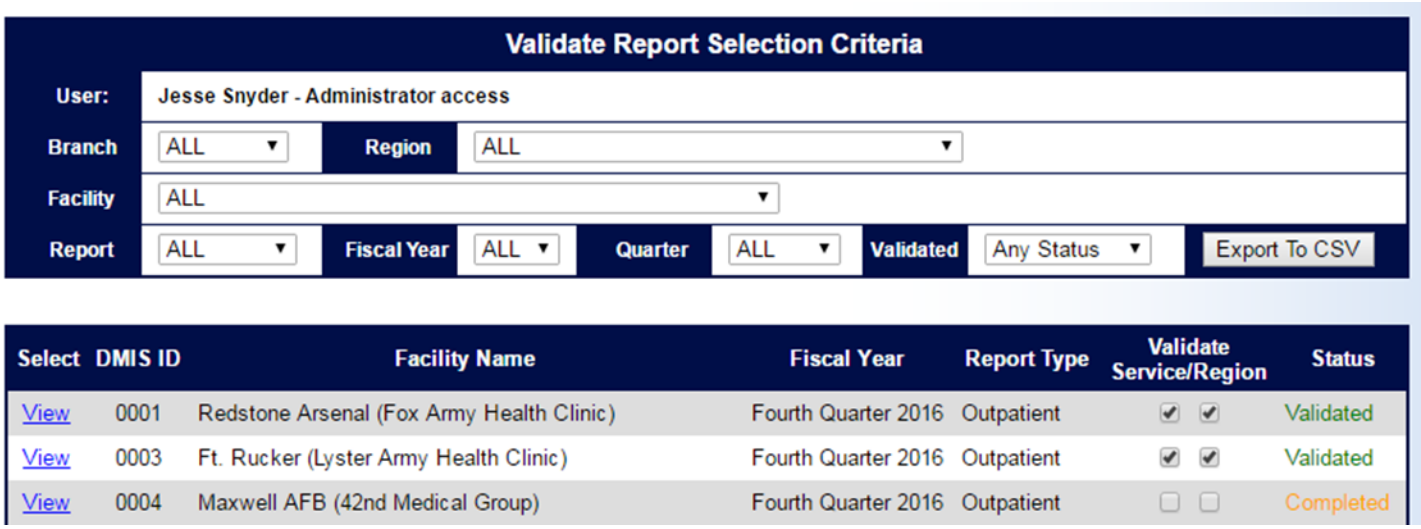
- After entering data in each section and clicking “Create” the DHA UBO Metrics Report will check your input for basic errors.
  - For example, the values in the open “Open Claims” must add up to the same amount as the “Amount Remaining Uncollected” line in the “Summary” section
  - If there are errors in your report the DHA UBO Metrics Report site will notify you of the specific problems before allowing your to submit your report
- Once all data has been entered and you have verified that it is correct click on “Submit”.
- Once you have submitted your data, your Regional representative or Service or NCR MD representative will have the ability to review your data and to validate your report if everything is correct.
  - If not correct, the Regional representative or Service or NCR MD representative must work with the MTF-level user to make corrections

- If you are a Regional or Service or NCR MD level user of the DHA UBO Metrics Report, your primary responsibility is to review and validate data reported by MTFs.
- In order to review and validate reports, click on “Validate Report” on the menu bar at the top of the page.

- The next screen allows you to select.



- When you enter the “Validate Report” section you will be shown a selection criteria section that allows you to narrow down the list of MTFs that are listed.
- The selected MTFs are listed on the page along with information about the status of the report and a link to the details of each report.

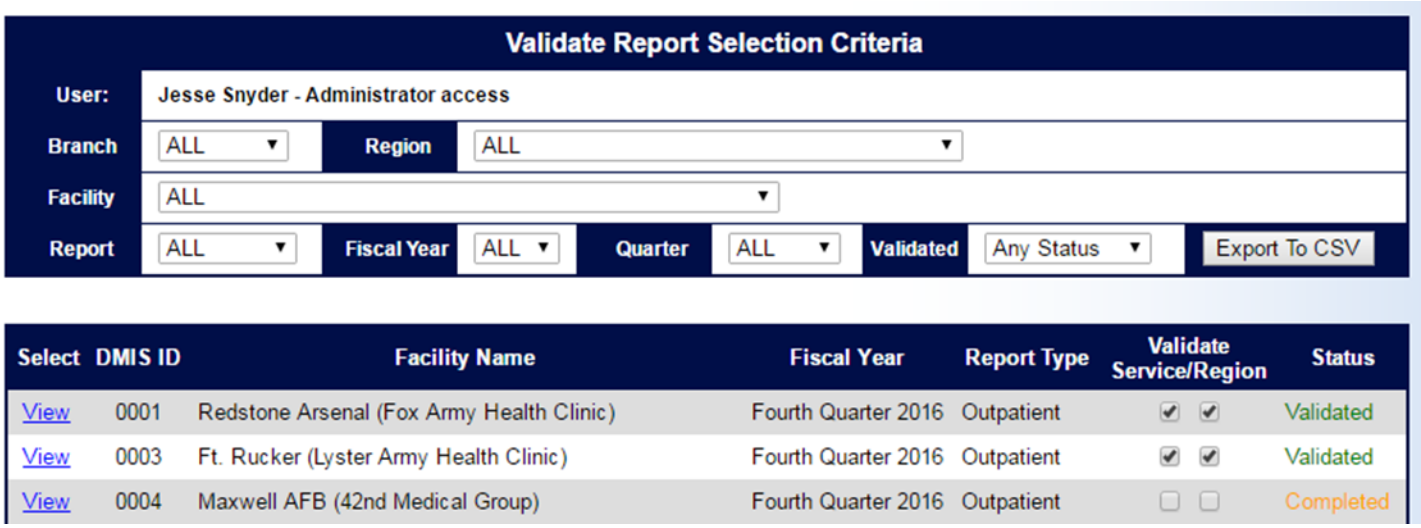


Validate Report Selection Criteria

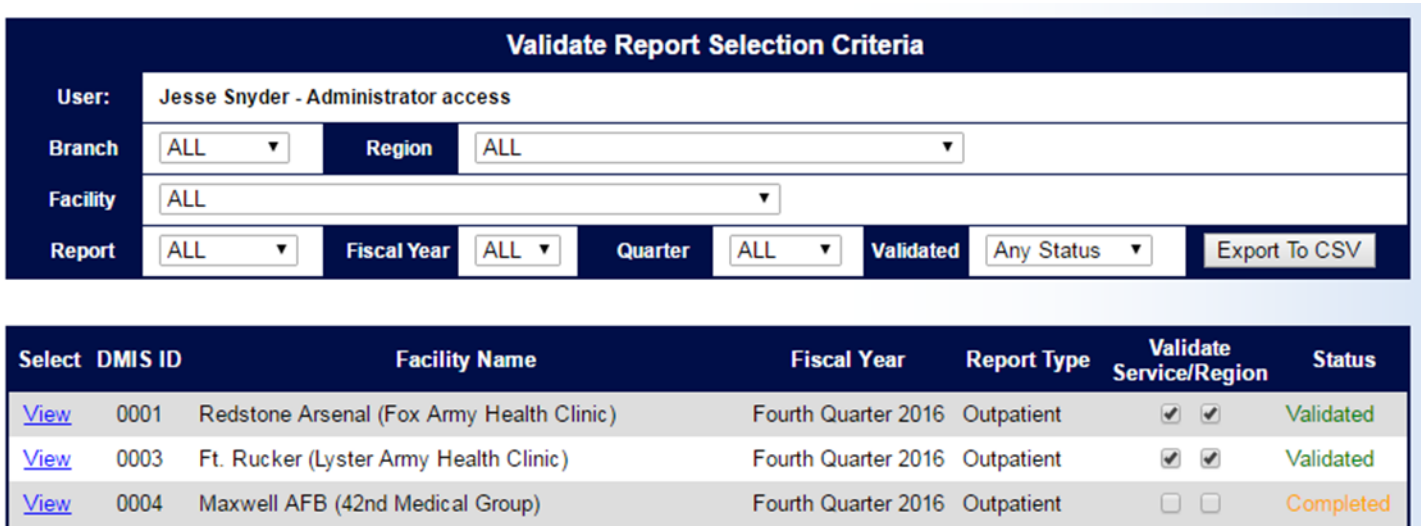
User:	Jesse Snyder - Administrator access							
Branch	ALL	Region	ALL					
Facility	ALL							
Report	ALL	Fiscal Year	ALL	Quarter	ALL	Validated	Any Status	Export To CSV

Select	DMIS ID	Facility Name	Fiscal Year	Report Type	Validate Service/Region	Status
View	0001	Redstone Arsenal (Fox Army Health Clinic)	Fourth Quarter 2016	Outpatient	☑ ☑	Validated
View	0003	Ft. Rucker (Lyster Army Health Clinic)	Fourth Quarter 2016	Outpatient	☑ ☑	Validated
View	0004	Maxwell AFB (42nd Medical Group)	Fourth Quarter 2016	Outpatient	☐ ☐	Completed

- If an MTF user has completed and submitted a report to his or her Region or Service manager for review and validation, the status is “Completed”.
- Once a report is listed as “Completed”, the Regional or Service/NCR MD level user can review and validate the data by clicking on “View.”
  - If you are reviewing a report and notice a problem, contact the staff member at the MTF who is responsible for reporting and work with them to make corrections



- In order to validate a report, check the box under either Service or Region (depending on whether you are a Service or NCR MD UBO manager or a regional user).
- Once you have checked the boxes for all reports that you are responsible for validating, click the “Validate Data” button on the bottom of the screen and the report will be validated.
- The validated data from all MTFs will be compiled into a new quarterly TPCP report.



UBO Metrics Report Outputs

- Once data for each MTF has been entered and validated in the DHA UBO Metrics Report Website, it is reviewed by the DHA UBO Program Office and then approved for reporting to the UBO AWG, and DoD and Service/NCR MD leadership.
- After approval, the data becomes available in a read-only format in the "Rolled up Reports" section of the DHA UBO Metrics Report Website.
- Additionally, two quarterly reports are generated as Microsoft Excel ® files:
  - Collections Summary
  - All Measures Report
- These reports include MTF-level data as well as Service and NCR MD-level aggregate data.
- Both reports are available for download at http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Performance-Measurements

UBO Metrics Report Outputs

- The quarterly Collections Summary includes MTF and Service/NCR MD-level metrics data for selected metrics that are especially relevant to understanding TPCP activity (see slide 37).
- The report includes data for the previous 5 years during the same quarter for comparison.
- This report contains less detail than the All Measures Report but it is easier to understand at a glance.
- The report includes MTF self reported metrics such as “amount collected” and “amount billed” as well as metrics calculated by DHA such as “collected to claims ratio” and “claims per disposition or visit”.

Detailed MTF and NCR MD -level data

Total Outpatient Collections metric QC by DMIS ID

Service	dmis_id	dmis_name	facility_type	Total OP Collections In CY by DMIS ID					
				FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
Air Force	0004	Maxwell AFB (42nd Medical Group)	C	$1,118,331.95	$1,696,598.37	$1,919,066.00	$1,600,578.78	$1,213,023.98	$97,765.40
Air Force	0006	Elmendorf AFB (3rd Medical group)	H	$4,353,782.66	$3,112,286.10	$4,306,318.63	$3,036,210.80	$3,115,042.92	$3,354,975.11
Air Force	0009	Luke AFB (56th Medical Group)	C	$907,173.66	$831,976.55	$750,909.77	$627,876.94	$521,409.97	$401,471.53
Air Force	0010	Davis Monthan AFB (355th Medical Group)	C	$410,963.73	$418,804.29	$315,147.97	$290,337.35	$271,647.68	$163,676.03
Air Force	0013	Little Rock AFB (314th Medical Group)	C	$951,318.89	$499,180.61	$497,260.88	$471,721.64	$385,482.57	$72,782.31

Service and NCR MD-level summary data

Collections Summary
3RD Quarter

	Inpatient Collections		Outpatient Collections		Total Collections	
Service	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016
Army	$ 16.2	$ 11.2	$ 26.5	$ 17.6	$ 42.7	$ 28.8
Navy	$ 4.2	$ 3.6	$ 10.7	$ 8.0	$ 14.9	$ 11.6
Air Force	$ 3.2	$ 0.5	$ 28.4	$ 14.0	$ 31.6	$ 14.5
NCR MD	$ 7.9	$ 7.2	$ 8.2	$ 7.1	$ 16.1	$ 14.3
Total	**$ 31.5**	**$ 22.5**	**$ 73.8**	**$ 46.7**	**$ 105.3**	**$ 69.2**

Data as of 8/26/2016
Note: Collections = CFY + PY1 + PY2

All Measures Report

- The All Measures Report includes all of the detailed metrics data that is reported at the MTF level throughout the MHS (see slide 39).
- If there is a data element that is not included in the Collections Summary, you can look it up in the Raw Data Table of the All Measures Report.
  - The Raw Data Table includes all metrics reported for each MTF on one line
  - Prior year collections, adjustments and refunds, and amounts uncollected
- Service/NCR MD level summary data can be filtered and manipulated using Excel® Pivot Tables.
  - Can filter by Service, Region, and DMIS Name

Detailed MTF and NCR MD-level data

DMIS_ID	DMIS_Name	Region	Service	Fiscal_Year	Patient_Type	Number_Dispositions	Number_Claims	Number_Collections	Total_Billed	Tc
0003	Ft. Rucker (Lyster Army Health Clinic)	Southern Regional Medical Command (SRMC)	Army	1200000	Inpatient	37	5	4	79139.93	
0004	Maxwell AFB (42nd Medical Group)	AETC	Air Force	1200000	Inpatient	0	0	0	0	
0005	Ft. Wainwright (Bassett Army Community Hospital)	Western Regional Medical Command (WRMC)	Army	1200000	Inpatient	302	6	0	34464.41	
0006	Elmendorf AFB (3rd Medical group)	Pacific	Air Force	1200000	Inpatient	635	26	4	123528.23	
0009	Luke AFB (56th Medical Group)	AETC	Air Force	1200000	Inpatient	377	5	1	29120.99	
0014	Travis AFB (60th Medical Group)	AMC	Air Force	1200000	Inpatient	1158	147	16	1474621.58	
0018	Vandenberg AFB (30th Medical Group)	AFSPC	Air Force	1200000	Inpatient	0	0	0	0	
0024	NH Camp Pendelton	Navy Medicine West	Navy	1200000	Inpatient	1158	22	4	130569.43	
0028	NH Lemoore	Navy Medicine West	Navy	1200000	Inpatient	147	2	2	12891.33	
0029	NMC San Diego	Navy Medicine West	Navy	1200000	Inpatient	4081	100	2	1479043.66	
0030	NH 29 Palms	Navy Medicine West	Navy	1200000	Inpatient	319	0	0	0	
0032	Ft. Carson (Evans Army Community Hospital)	Western Regional Medical Command (WRMC)	Army	1200000	Inpatient	908	14	0	130894.88	
0033	USAF Academy (10th Medical Group)	AFA	Air Force	1200000	Inpatient	272	65	0	464688.18	

Service and NCR MD-level Pivot Table data

Service	Air Force
Region	AFDW
DMIS Name	(All)

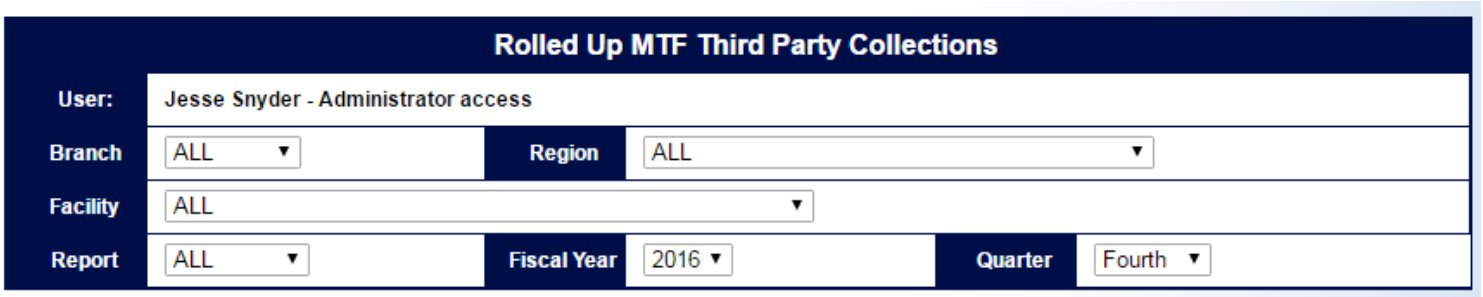
Patient Type	Data	FY10, 3rd Q	FY11, 3rd Q	FY12, 3rd Q	FY13, 3rd Q	FY13, 4th Q	FY14, 1st Q
Outpatient	Number of Dispositions CFY	11,354	11,432	11,494	13,001	19,992	4,998
	Number of Claims CFY	2,891	3,120	3,694	4,107	5,528	849
	Claims Per Disposition CFY	25%	27%	32%	32%	28%	17%
	Number of Collections CFY	991	1,182	1,343	1,389	2,202	192
	Avg Collection per Claim CFY	$ 86	$ 68	$ 76	$ 73	$ 72	$ 37
	Amount Collected CFY	$ 84,920	$ 80,418	$ 101,397	$ 100,880	$ 157,461	$ 7,091
	Amount Billed CFY	$ 260,621	$ 231,532	$ 281,467	$ 306,511	$ 416,326	$ 55,219
	Collected to Billed Ratio CFY	33%	35%	36%	33%	38%	13%
	Amount Collected CFY for AFY	$ 179,049	$ 156,765	$ 161,708	$ 148,095	$ 205,663	$ 34,300
	Amount Collected AFY	$476,109	$475,882	$468,876	$460,090	$517,658	$397,256
	Amount Billed CFY-PY2	$ 1,278,263	$ 1,189,867	$ 1,073,432	$ 1,060,262	$ 1,170,676	$ 950,918
	Collected to Billed Ratio CFY-PY2	37%	40%	44%	43%	44%	42%
	Closed Claims CFY	$ 63,592	$ 87,364	$ 89,562	$ 103,667	$ 171,606	$ 8,313
	Closed to Billed Ratio CFY	24%	38%	32%	34%	41%	15%
	Closed Claims CFY-PY2	$ 627,815	$ 620,423	$ 496,775	$ 456,644	$ 530,251	$ 429,338
	Closed to Billed CFY-PY2	49%	52%	46%	43%	45%	45%

All Measures Report

Calculated Field		
Solve Order	**Field**	**Formula**
	Claims Per Disposition	=Number_Claims /Number_Dispositions
	Total collections CFY for AFY	=Amt_Collected_CY +Amt_Collected_CYPY1 +Amt_Collected_CYPY2
	collect/bill CFY	=Amt_Collected_CY /Total_Billed
	Closed/Billed CFY	=Adjs_And_Refunds /Total_Billed
	open/billed	=Amt_Uncollected /Total_Billed
	closed claims all years	=Adjs_And_Refunds +Adjs_And_RefundsPY1 +Adjs_And_RefundsPY2
	closed to billed all years	= (Adjs_And_Refunds +Adjs_And_RefundsPY1 +Adjs_And_RefundsPY2)/(Total_Billed +Total_BilledPY1 +Total_BilledPY2)
	Open Claims All Years	=Amt_Uncollected +Amt_UncollectedPY1 +Amt_UncollectedPY2
	Open to Billed Ratio All Years	= (Amt_Uncollected +Amt_UncollectedPY1 +Amt_UncollectedPY2)/(Total_Billed +Total_BilledPY1 +Total_BilledPY2)
	Amount Billed All Years	= (Total_Billed +Total_BilledPY1+Total_BilledPY2)
	Avg Amount Coll per Claim CFY	=Amt_Collected_CY /Number_Collections
	Amount Collected for PY1	=Amt_Collected_CYPY1 +Amt_Collected_PY1PY1
	Amount Collected for PY2	=Amt_Collected_CYPY2 +Amt_Collected_PY1PY2 +Amt_Collected_PY2PY2

- To look up data from TPCP reports, click on “Rolled up Reports” on the menu bar at the top of the screen.

- There is a criteria selection section at the top of the screen that allows you narrow down your focus and select particular past time periods for review.



- The default view shows MHS-wide statistics for the most recent quarter.
- Multiple reports can be viewed simultaneously by opening the DHA UBO Metrics Report Website in multiple web browser windows.

Reviewing Previously Submitted Metrics

- The website can provide all self reported metrics data for a particular MTF(s) and date range selected
- The data in these reports is locked; it cannot be unlocked and changed without approval from your Service/NCR MD PM
- If you find an error in this validated data, contact the UBO.Helpdesk@Altarum.org for assistance

Summary

Field Description	CFY	PY 1	PY 2	Total
Cumulative Non-Active Duty Dispositions/Visits	6,581,592	13,204,005	13,478,721	33,264,318
No. of Claims	1,033,349	2,748,509	3,021,812	6,803,670
No. of Collections	289,536	1,286,950	1,581,866	3,158,352
Claims per Dispositions/Visits	15.70 %	20.82 %	22.42 %	20.45 %
Dollar Amount Billed	$130,546,949.56	$371,570,581.58	$411,517,786.60	$913,635,317.74
Adjustments and Refunds	$28,544,704.48	$168,375,731.81	$209,006,225.24	$405,926,661.53
Amount Collected in PY2	$0.00	$0.00	$113,534,684.46	$113,534,684.46
Amount Collected in PY1	$0.00	$98,145,722.80	$53,521,430.08	$151,667,152.88
Amount Collected Current FY	$26,879,459.03	$36,604,056.46	$1,911,763.49	$65,395,278.98
Amount Remaining Uncollected	$75,122,786.05	$68,445,070.51	$33,543,683.33	$177,111,539.89

Open Claims

Code	Field Description	CFY	PY 1	PY 2	Total
1	Open Claims	$75,110,271.50	$67,675,929.01	$31,808,617.31	$174,594,817.82
2	Transferred to External Agent	$0.00	$0.00	$430.40	$430.40
3	MTF Not a Participating Hospital	$0.00	$0.00	$16,126.42	$16,126.42
4	Plan Excludes Military Hospitals or Beneficiaries	$0.00	$0.00	$0.00	$0.00
5	Patient Had No Obligation to Pay	$1,472.44	$616,094.05	$1,495,226.43	$2,112,792.92
6	Insurer Paid Patient Directly	$82.15	$8,583.83	$18,779.35	$27,445.33
7	Other ()	$10,115.10	$144,463.62	$204,503.42	$359,082.14
	Total Open Claims	$75,121,941.19	$68,445,070.51	$33,543,683.33	$177,110,695.03

Closed Claims

Code	Field Description	CFY	PY 1	PY 2	Total
8	Amount of Coverage	$3,932,772.23	$27,073,778.82	$33,151,701.80	$64,158,252.85
9	Patient Not Covered, Care Provided Not Covered, or Policy Expired	$9,206,481.28	$49,024,820.40	$62,191,021.17	$120,422,322.85
10	TRICARE and/or Income Supplemental Plans	$171,593.70	$899,970.01	$793,311.41	$1,864,875.12
11	Medicare Supplemental Plans	$3,139,992.41	$18,483,322.41	$20,985,832.92	$42,609,147.74
12	HMO/PPO	$1,373,143.66	$5,647,765.99	$6,647,156.97	$13,668,066.62
13	MTF Did Not Comply with Utilization Review Procedures	$546,258.16	$3,154,029.39	$5,598,585.86	$9,298,873.41
14	Refunds	$29,847.61	$15,579.14	$32,140.26	$77,567.01
15	Patient Copays and Deductibles	$7,208,882.98	$43,783,946.51	$51,355,118.44	$102,347,947.93
16	Other ()	$1,163,275.72	$8,554,750.13	$15,108,708.60	$24,826,734.45
17	Other ()	$1,773,301.59	$11,737,769.01	$13,142,647.81	$26,653,718.41
	Total Closed Claims	$28,545,549.34	$168,375,731.81	$209,006,225.24	$405,927,506.39

Common Mistakes

- Running the DD 2570 too early or too late
- Not reporting dispositions and visits
- Not reporting cumulative totals
- Amount Remaining Uncollected ≠ Total of all Open Claims
- Adjustments and Refunds ≠ Total of all Closed Claims
- Entering negative numbers
- Transposition errors

- Health.Mil > Performance Measurements

http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Performance-Measurements

- DHA Launch Pad > Performance Measurements

https://info.health.mil/bus/brm/ubo/SitePages/PerformanceMeasures.aspx

- DHA UBO User Guide > TPCP – Report on Program Results

http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance

- Contact DHA UBO Helpdesk

UBO.helpdesk@altarum.org

Questions?

Backup Slides

32 CFR §220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule*. Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer's plan. ***The obligation to pay 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.***

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then ***the amount the United States may collect*** from the third party payer ***is the reasonable charge for the care provided less the appropriate deductible or copayment amount.***

(c) *Claim from United States exclusive.* ***The only way for a third party payer to satisfy its obligation*** under 10 U.S.C. 1095 ***is to pay the facility*** of the uniformed service or other authorized representative of the United States. ***Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095***.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* ***The statutory obligation of the third party to pay is not unqualified***. Under 10 U.S.C. 1095(a)(1) (as noted in §220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.*

(1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see §220.3 of this part), ***reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services***.

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible.

(c) ***Specific examples of permissible terms and conditions.*** The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) ***Generally applicable coverage provisions.*** Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) ***Generally applicable utilization review provisions.***

(i) Reasonable and ***generally applicable provisions of a third party payer's plan*** requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities ***may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan***.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable charges under §220.8(a) (except in long stay outlier cases, noted in §220.8(a)(4)).

(3) ***Restrictions in HMO plans***. Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

32 CFR §220.4 Reasonable terms and conditions of health plan permissible

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the ***third party payer must provide appropriate documentation*** to the facility of the Uniformed Services.

- ***This includes,*** when applicable, ***copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms.***

- It also includes ***copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy*** or plan coverage and benefit information.

Instructions for CEU Credit

This in-service webinar has been approved by the American Academy of Professional Coders (AAPC) for 1.0 Continuing Education Unit (CEU) credit for DoD personnel (.mil address required). Granting of this approval in no way constitutes endorsement by the AAPC of the program, content or the program sponsor. There is no charge for this credit.

- **Live broadcast webinar (Post-Test not required)**
  - Login prior to the broadcast with your: 1) full name; 2) Service affiliation; and 3) e-mail address
  - View the entire broadcast
  - After completion of both of the live broadcasts and after attendance records have been verified, a Certificate of Approval including an AAPC Index Number will be sent via e-mail to participants who logged in or e-mailed as required. This may take several business days.

- **Archived webinar (Post-Test required)**
  - View the entire archived webinar (free and available on demand at http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/training.cfm)
  - Complete a post-test available *within* the archived webinar
  - E-mail answers to UBO.LearningCenter@altarum.org
  - If you receive a passing score of at least 70%, we will e-mail MHS personnel with a .mil email address a Certificate of Approval including an AAPC Index Number

- The original Certificate of Approval may not be altered except to add the participant's name and webinar date or the date the archived Webinar was viewed. Certificates should be maintained on file for at least six months beyond your renewal date in the event you are selected for CEU verification by AAPC

- For additional information or questions regarding AAPC CEUs, please contact the AAPC.

- Other organizations, such as American Health Information Management Association (AHIMA), American College of Healthcare Executives (ACHE), and American Association of Healthcare Administrative Managers (AAHAM), may also grant credit for DHA UBO Webinars. Check with the organization directly for qualification and reporting guidance.