THE REVENUE CYCLE

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WHY THE REVENUE CYCLE

IT IMPACTS EVERYTHING!

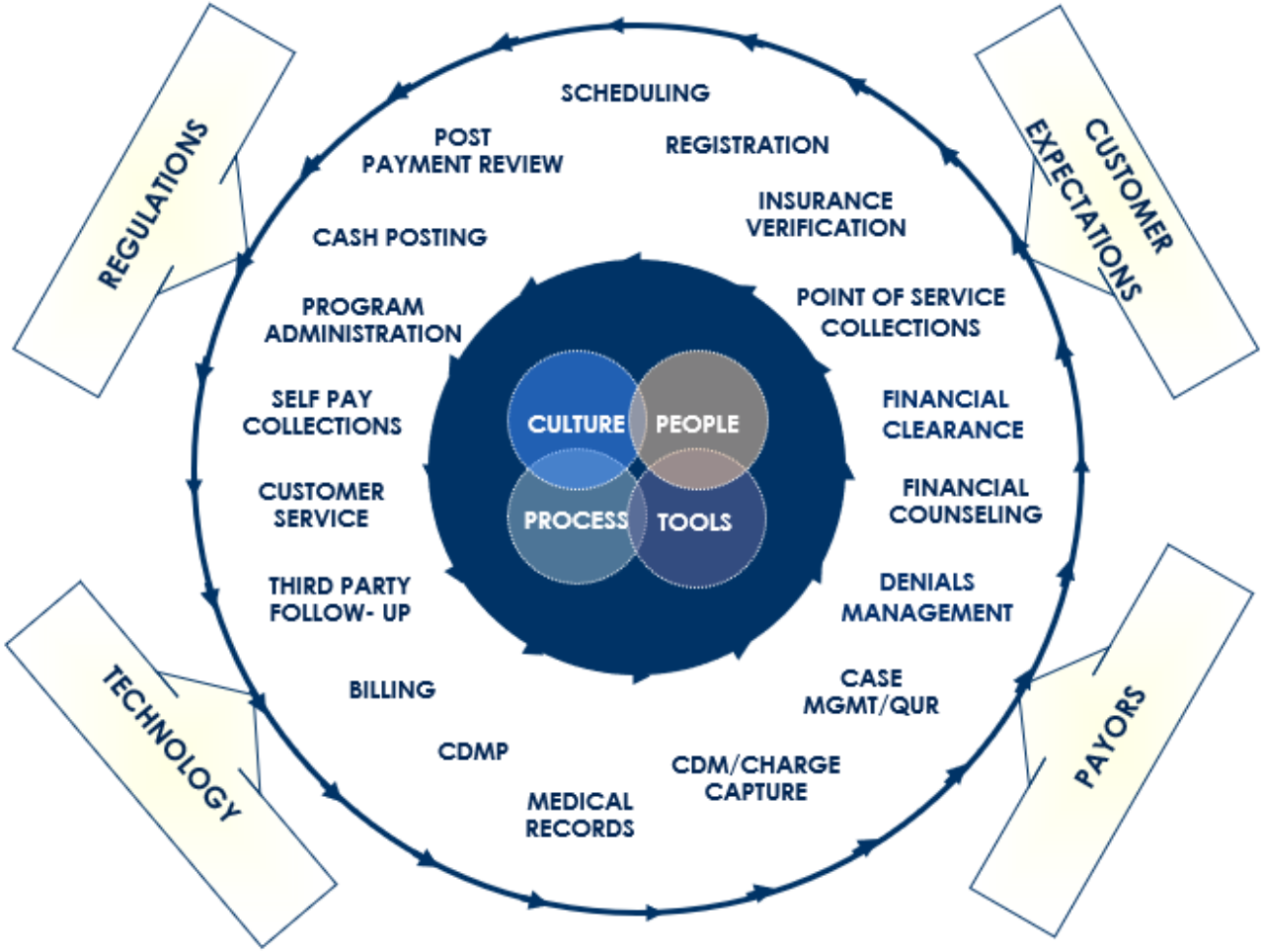
- Accounts Receivable Days
- Gross Revenue
- Net Revenue
- Operating Margin
- Net Margin
- Days Cash on Hand
- Debt Service Coverage

POTENTIAL IMPACT

- Every dollar found hits the bottom line
- Low hanging fruit is typical available

KEY PERFORMANCE INDICATORS

THE REVENUE CYCLE



A successful revenue cycle is a complex process which involves multiple areas of your organization requiring constant interaction.

REPORTING

- Tools available
- Communication process
- Frequency
- Customize to your organizational structure
- Identify current KPIs and set targets

WHERE TO START?

- Assure policies and procedures are in place to outline expectations.
- Shadow individuals to observe tasks.
- Instruct staff to document processes:
  - Have other staff follow the steps to fill in gaps.
- Perform chart-to-payment reviews.
- Provide feedback for staff education and training.
- How often are P&P reviewed and updated?

EXPECTED RESULTS IN THE ABSENCE OF P&P

- No standardization of processes
- Variation in charge capture
- Non-compliance with billing rules and regulations
- Inability to hold staff accountable
- Billing delays when staff member is out of the office

REVENUE CYCLE BENCHMARKS

Days in A/R:	< 45 Days
Aged Insurance Pending A/R as a % of Total Ins Pending A/R	Report by discharge date < 20% over 90 days < 5% over 180 days (By financial class and further into any carriers with timely filing limits < 180 days. Remove credit balances)
Discharged Not Final Billed-DNFB	< 5 days of average daily revenue
Credit Balances	< 1 day of daily revenue
Denial Write-Offs	< 1% of monthly net revenue
Point of Service Collections	> 3% of monthly net revenue
Registration Error Rate	< 5% of daily registered patients
Mail Return	< 5% of mailed items
Claim Hold Days	2-3 business days

A/R ANALYSIS

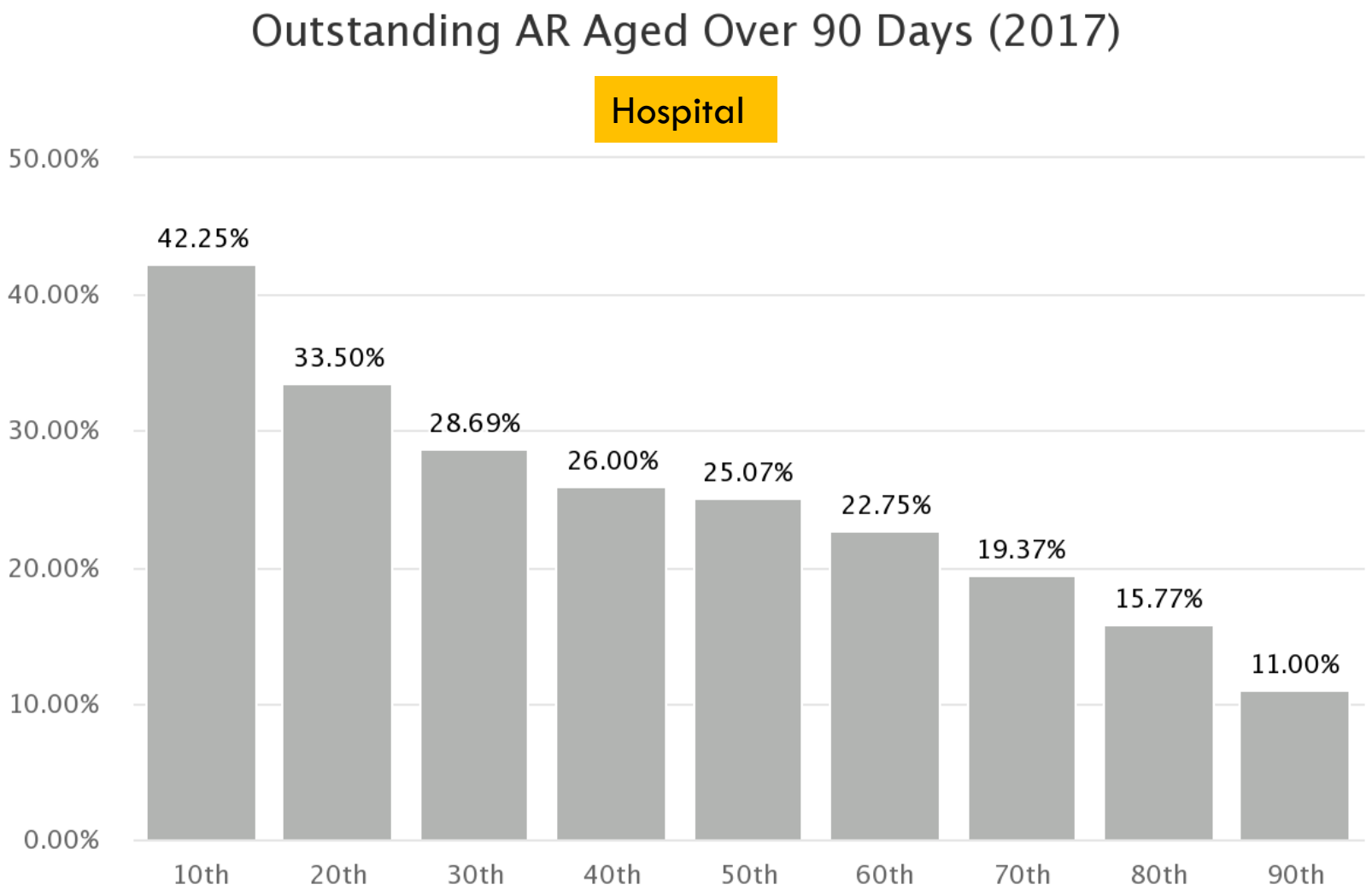
Summary aging sorted by:

- Financial Class
- Aged by buckets (unbilled, 0-30, >30, >60, etc.)
  - Date of service when working timely filing
  - Last billed date when working aged accounts with activity
- Without credit balances

Detail aging to focus on:

- Timely filing limits – accounts at risk
- Credit balances (state unclaimed property)
- Aged accounts with payment still in primary financial class
- Established high dollar amounts
- Unapplied payments

NATIONAL AVERAGES



ADJUSTMENTS

Contractual → Post only as reported on remittance advice.

Denied charges that can be appealed.

Administrative adjustments based on organizational policies and procedures:

- Small balance write-off
- Untimely filing
- Provider not enrolled
- Medical necessity
- Late Charge
- Medicare Bad Debt (ability to run report)

Segregation of duties:

- Biller completes log for review by coworker
- Manager approves
- Posted by data entry clerk or payment posting staff

PATIENT ACCESS

FIRST IMPRESSIONS

- Can “make or break” the patient experience
- Frontline of the organization’s customer service
- Keep registrars informed of changes
  - New service being provided
  - Provider joining organization
  - Media release
- When faced with a new challenge, who can assist with resolution?
- Grievance process
- Phone etiquette → Patient focus vs. answering incoming calls
- Knowledge of billing system → current balance/payment verification

DATA COLLECTION

- 50% of claim data originates with the Registration Staff
- Patient demographic information
- Encounter specific information
- Insurance coverage
  - Primary vs. secondary or tertiary
  - Insured
  - Relationship to insured
  - Group number

Remaining 50% is comprised of Coding, Charge Entry and Billing required data.

PATIENT ACCESS RESPONSIBILITIES

- Identify patient
- Choose patient type based on services to be provided
- Verify insurance eligibility
  - PCP referrals
- Determine pre-authorization status
- Complete required registration document
- Obtain/explain signature requirements
  - HIPAA notice
  - Conditions of Admission/Consent for treatment
  - Patient Rights and Responsibilities
  - Medicare Secondary Payer Questionnaire
- Collect copay or minimum balance
  - Substantial increase in patient deductibles
- Scheduling
- Patient Portal education

PATIENT ACCESS TOOLS

- Verification of coverage
  - Phone call
  - Online payer portals
  - Vendor (billing system or clearinghouse)
- Price estimates
- Online credit card and receipt processing
- Insurance card scanner
- Payment options
- Scripting (essential for upfront collection success)

DO THESE DUTIES BELONG IN PATIENT ACCESS?

How do we expect registration staff to perform these duties?

- ABN – LCD/NCD should be built into order entry
- Pre-authorization – Before services are performed
  - May not be aware until patient has presented

Often lack

- Privacy to discuss diagnosis with patient
- Medical terminology skill set to answer questions
- Access to provider when issues arise

- Consideration for “need to know”.

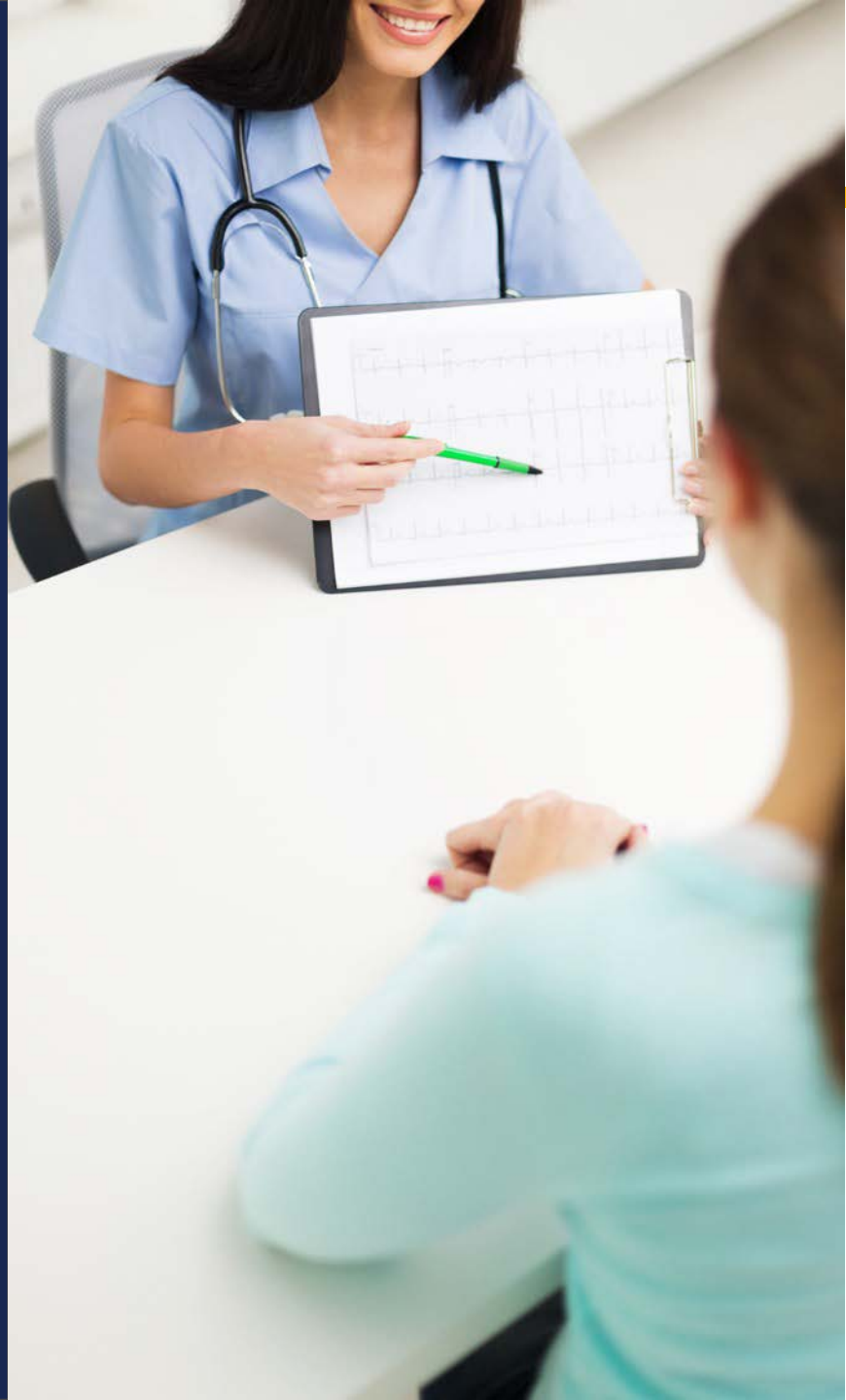
CODING AND CHARGE CAPTURE

CHARGEMASTER MAINTENANCE

Yearly Review	Regulatory updates
	HCPCS and ICD-10 changes – Bundling/Unbundling
Revenue Reliability	Updates to billing system – Crosswalk to G/L
	Payer Changes
Pricing	Contract constraints
	Compare to highest paying fee schedule
	Medicare pays lesser of MPFS or charge
Compliance	Overarching governance and oversight of the Revenue Cycle functions

CHARGE CAPTURE

- Missed charges results in missed revenue opportunity:
  - Revenue and usage report review
- Charge capture process:
  - Documentation generated charges vs. manual entry
  - Paper charge tickets
  - System interface issues
- Charge reconciliation → Assure all charges match patient record:
  - Facility fee identified as site of services
  - Drugs & supplies
  - Infusion – Injection - Hydration
  - Lab and Radiology
  - Therapy services
  - Contracted services
  - Venipuncture



COMMON AREAS OF CONFUSION/LOST REVENUES

- How do CPT/HCPCS Codes get assigned
  - HIM adds to revenue code line during coding
  - Hard coded into the Chargemaster

- Pharmacy
  - Unit mismatch with HCPCS code
    - Amount administered doesn't crosswalk exactly to HCPCS code definition
  - Missing JW modifier reporting for medication waste

- Omission of outpatient nursing procedures
  - IV therapy, injections, blood administration
  - Unbillable due to missing nursing documentation
    - Start and stop times
    - Administration sites
    - Drugs administered

- Flu/Pneumo vaccinations administered during inpatient stay
  - Separately billable on the 012X type of bill to Medicare Part B
    - Use discharge date regardless of date administered

BILLING AND FOLLOW-UP

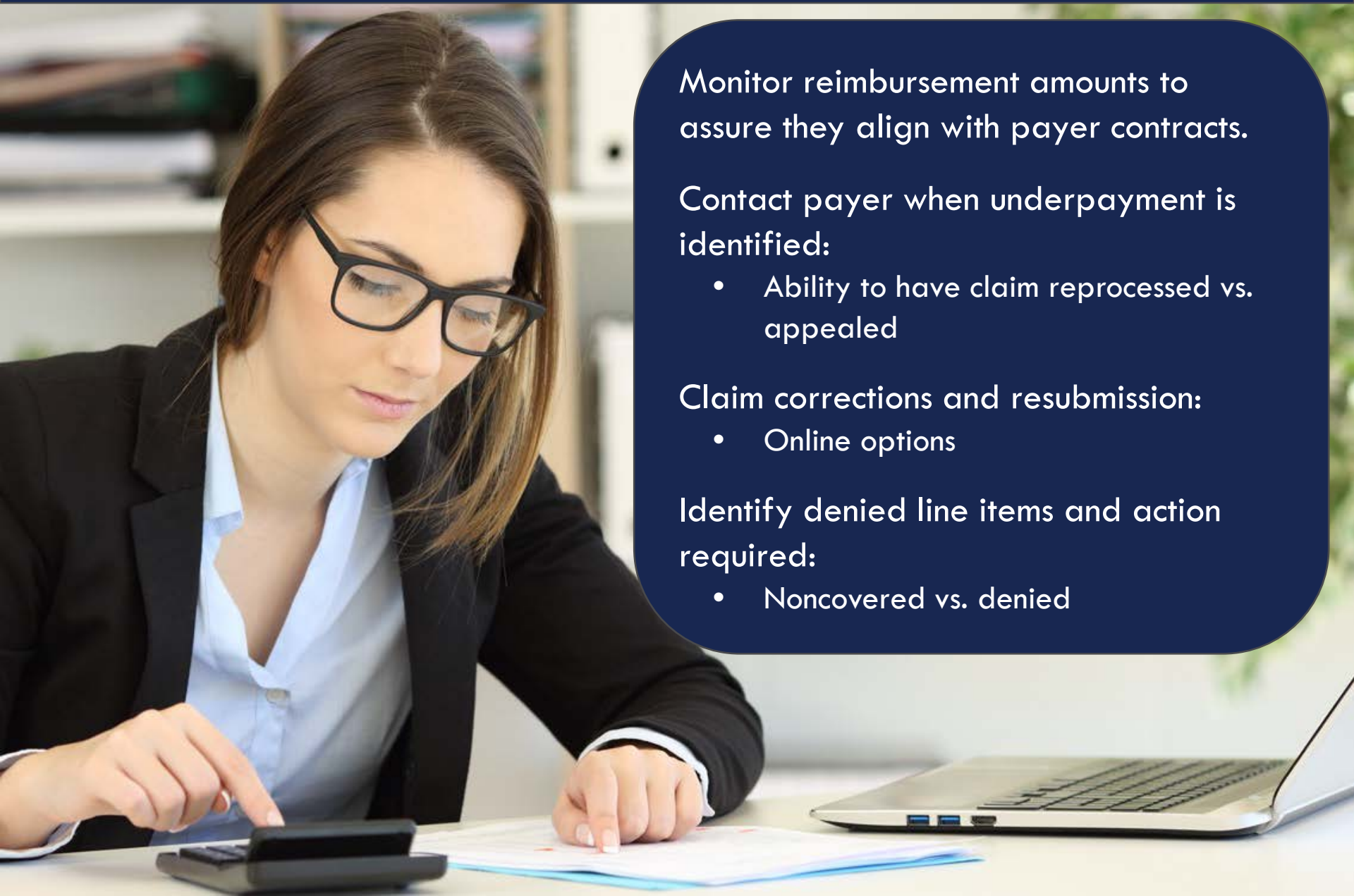
PAYER CONTRACTS

- Payers are tightening their reimbursement by passing on changes to the providers:
  - Tougher negotiations
  - Complex contract terms
  - Increasing denial rates
  - Underpaying providers based on contracts

- Contribute to major drains on margins:
  - Average facility loses 5% of annual revenue
  - Preventable revenue loss

- Are staff aware of what's in your contracts?

UNDERPAYMENTS



Monitor reimbursement amounts to assure they align with payer contracts.

Contact payer when underpayment is identified:

- Ability to have claim reprocessed vs. appealed

Claim corrections and resubmission:

- Online options

Identify denied line items and action required:

- Noncovered vs. denied

SYSTEM ISSUES AFFECTING A/R

- Bill hold days
- Documentation not signed off on in EHR
  - Monitoring reports
- Incomplete/inaccurate key patient data from registration
  - Have registrar correct for education
- Late Charges
- Nonexistence of account notes in billing system for follow-up

TOOLS

Payer specific portal to check claim status and make adjustments:

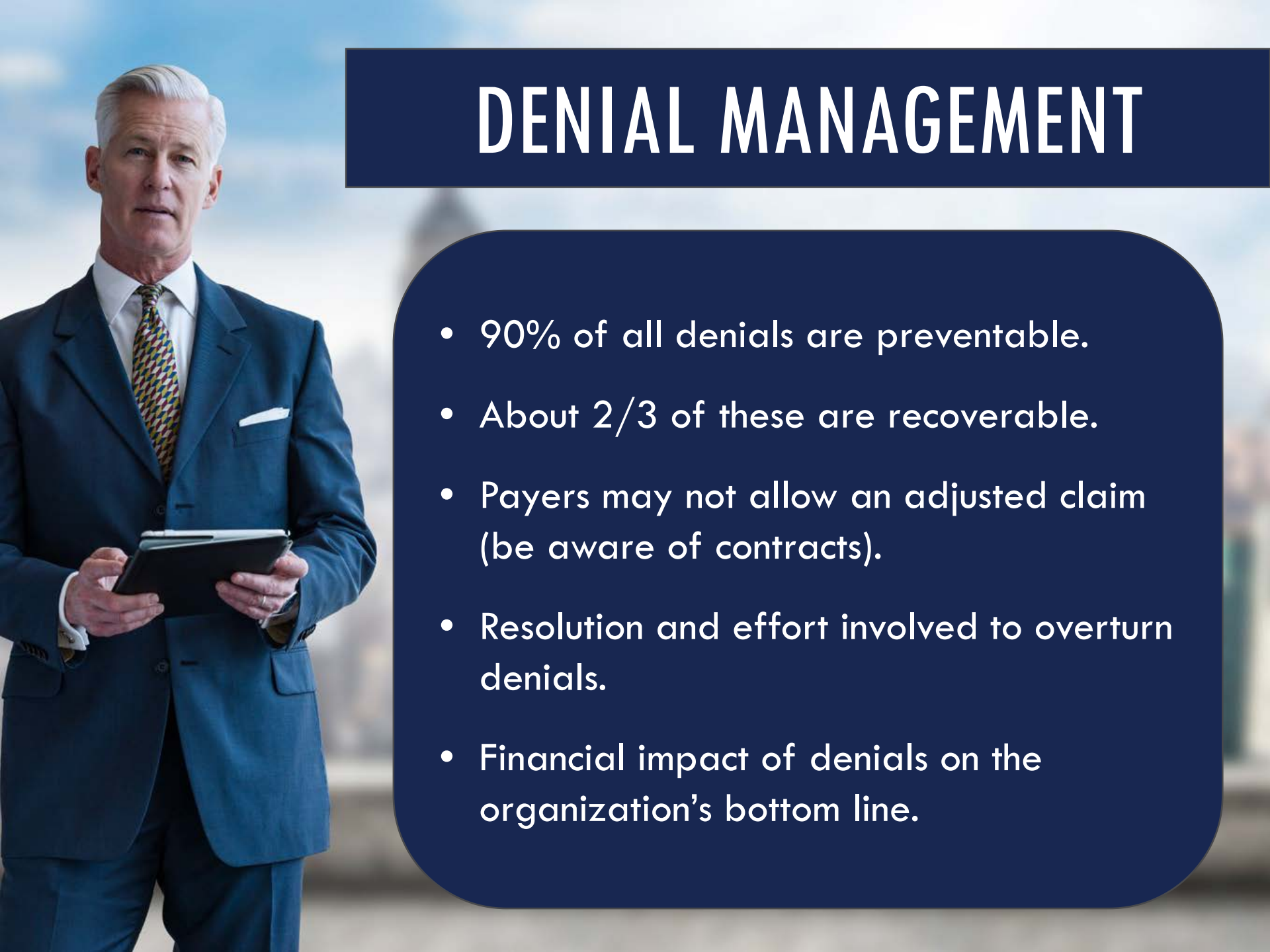
- Medicare Direct Data Entry (DDE)
- Payer portal sign-on with passwords

Work queues:

- Payer specific vs. alpha-split
- Denials
- Aged accounts
- Registration errors
- Coding edits

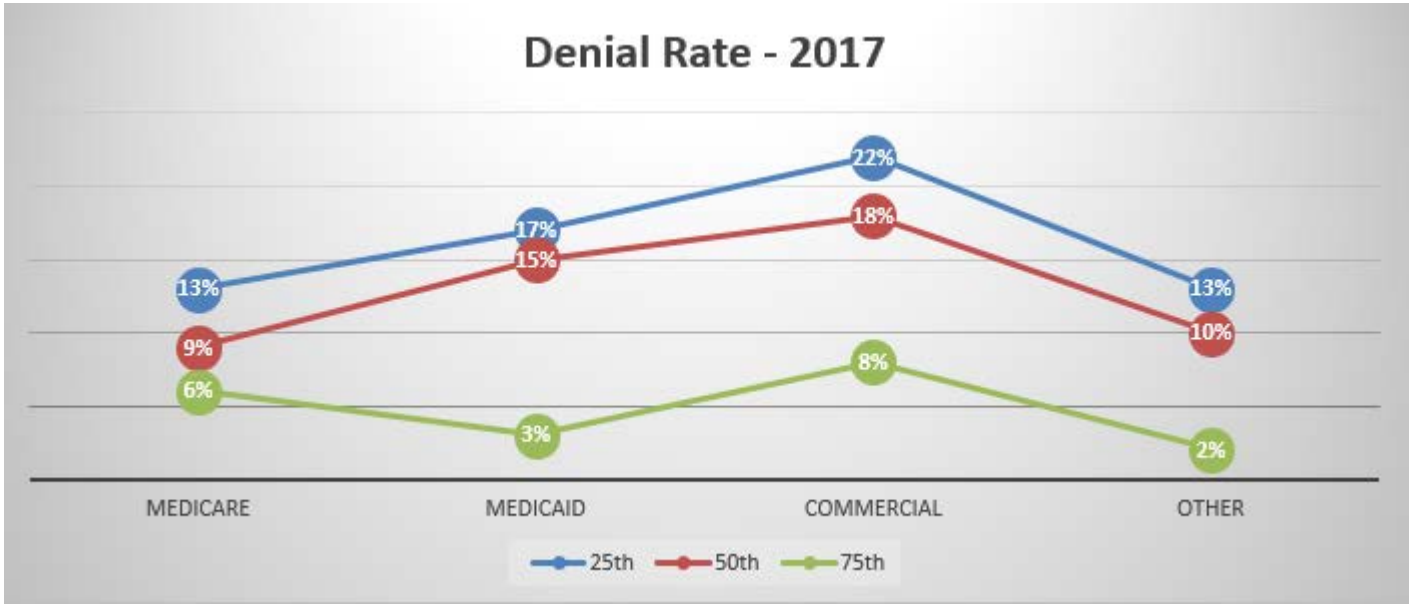
CLAIM TRANSMISSION VERIFICATION

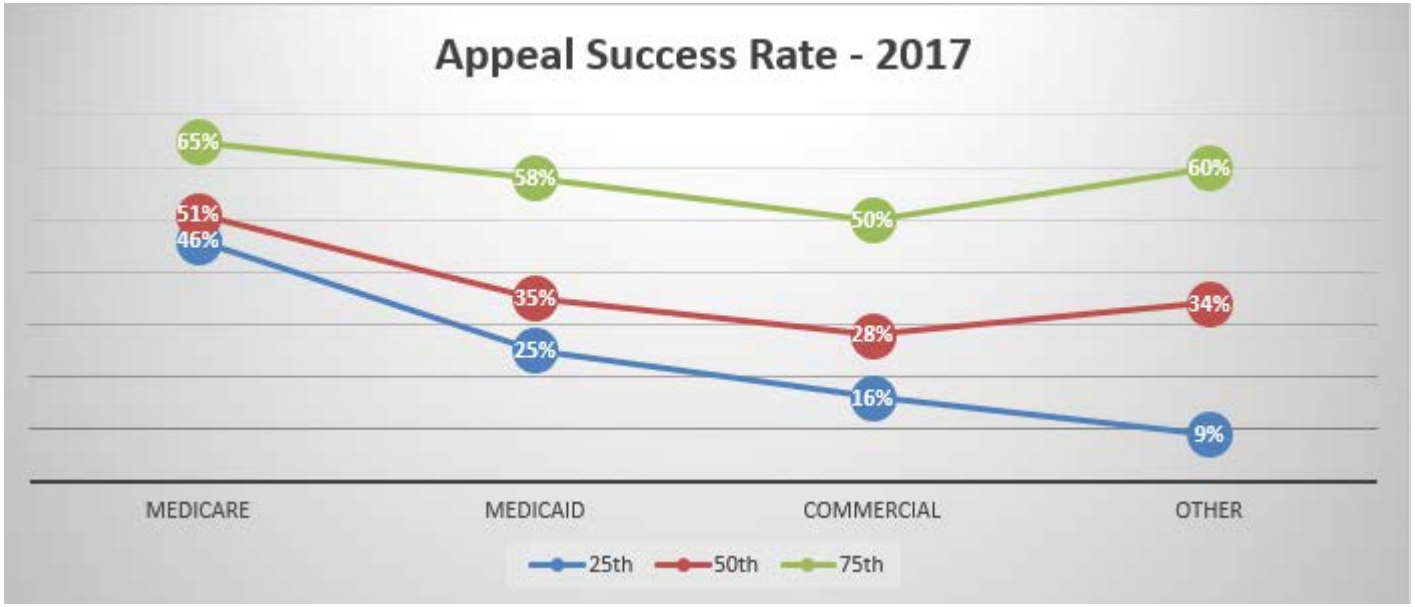
- Internal billing software edits.
- Clearinghouse edits.
- Transmission reports - Compare to system generated claim counts:
  - 837 – Claims transmitted
  - 999 – Acknowledges receipt of claim file
  - 277 – Acceptance file (rejected claims)
- Work rejected claims within 24 hours:
  - Skews billing reports when system shows claim was dropped but insurance company didn't accept.
  - No remittance advice denial will be received.



DENIAL MANAGEMENT

- 90% of all denials are preventable.
- About 2/3 of these are recoverable.
- Payers may not allow an adjusted claim (be aware of contracts).
- Resolution and effort involved to overturn denials.
- Financial impact of denials on the organization's bottom line.


Denial Rate - 2017
22%
17%
18%
15%
13%
13%
9%
10%
8%
6%
3%
2%
MEDICARE
MEDICAID
COMMERCIAL
OTHER
25th
50th
75th


Appeal Success Rate - 2017
65%
58%
60%
50%
51%
46%
35%
34%
28%
25%
16%
9%
MEDICARE
MEDICAID
COMMERCIAL
OTHER
25th
50th
75th

STEPS TO FOLLOW

Conduct initial assessment to identify gaps in outstanding accounts.

Consistent report monitoring:

- Daily, weekly, monthly, quarterly, yearly

Compare findings from week-to-week or month-to-month, etc.

Develop Action Plan as issues arise.

Run reports in limited quantity to finish review of all accounts:

- Focus on assigning accounts by alpha
- Date of service ranges

CRNA BILLING

CAH Method I

- Professional services are billed on CMS-1500 to Medicare Part B
  - Paid at 100% of the allowed amount (80% Medicare + 20% coinsurance)
- Technical services billed under RC 037X on the CAH UB-04 TOB 085X
  - Paid at 101% of reasonable cost

CAH Method II

- Professional Charges
  - Outpatient are billed on the UB-04 under revenue code 0964 with CAH NPI
    - TOB 085X only
    - QZ modifier is appended to HCPCS code
    - Paid at 115% of the allowed amount
  - Inpatient billed on CMS-1500 to Medicare Part B
    - Paid at 100% of allowed amount
- Technical services billed under RC 037X on the CAH UB-04 TOB 085X
  - Paid at 101% of reasonable cost for anesthesia and supplies

CRNA BILLING CONT

CAH electing/qualifying for Pass-Through Exemption

- All professional services are billed on the CAH UB-04 under RC 0964 to Medicare Part A
  - TOB 085X, 011X and 018X (Outpatient, inpatient and swing-bed claims)
  - Reimbursed at 100% of reasonable cost

- Technical services are billed under RC 037X on the CAH UB-04
  - TOB 085X paid at 101% of reasonable cost
  - TOB 011X and 018X payment included in the daily per diem rate (reasonable cost)

NOTE:

- Medicare and most other payers require billing minutes not units when billing CRNA professional services

FEE-FOR-TIME COMPENSATION ARRANGEMENTS

- Formerly referred to as “Locum Tenens Arrangements”.
- Substitute physician who practices in place of another physician who is temporarily absent for no more than 60 continuous days.
  - Vacation
  - Medical leave
  - Continuing education
  - Sabbatical
  - Physician leaves a Group practice
- Medicare definition of physician
- Modifier Q6

WHAT FEE-FOR-TIME COMPENSATION IS NOT

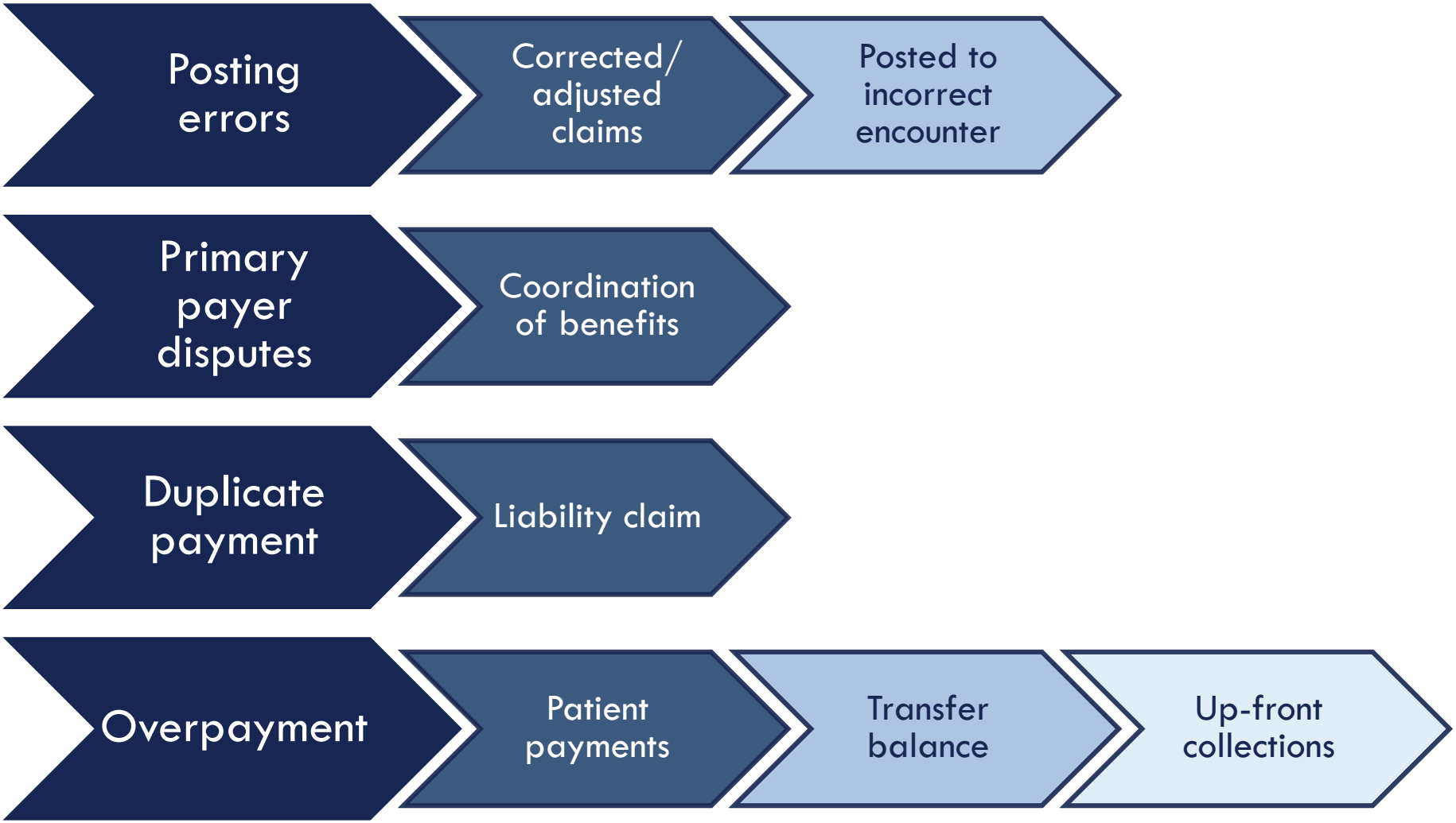
- A non-physician provider
  - NP, PA, CNM, do not meet the definition
    - A substitute provider cannot be a non-physician provider nor can be billed as one
- Billing option while waiting for enrollment
- Used to grow a practice
- Caution when using outsourced agency to fill ER schedule

COLLECTIONS

POINT-OF-SERVICE COLLECTIONS

- Cost to collect upfront less than when done on the back-side
  - Net patient revenue collected at POS
    - Nationally best practice collections are 2.68%
    - Midwest average is .04% to 1.23% for high performing organizations
- Prompt Pay Discounts
  - Average organization offers 20%
    - Range is from 10% to 50% Nationally
    - Midwest average prompt pay discount is 15% - 20%
- Cost to Collect
  - Full cost to collect divided by net patient revenue
    - Nationally → Total 3%
      - Point-of-service 0.07%
      - Business Office 1.20%
    - Midwest → Total 4%
      - Point-of-service 0.93%
      - Business Office 1.81%

CREDIT BALANCES



PATIENT FINANCIAL JOURNEY

- Lay the foundation on the front end:
  - Patient expectations
  - Options available
  - Share deductible/coinsurance information
- Educate staff so as to communicate same message throughout each step of patient encounter.
- Follow-up with patient balance due in a timely manner.
- Establish policies and procedures and follow them for self-pay balances.
- Look for opportunity to automate processes and reporting capabilities.
- Publish contact information on all correspondence and website.

STATEMENTS

Frequency of statements

- Manual vs. automated process
- Weekly vs. monthly

Prompt pay discounts – post adjustment at time of payment

- At time of service
- Within "XX" days from first statement

Negotiating tool for large balances remaining due

Underinsured vs. Uninsured

Minimum balance

- Guarantor
- Patient
- Contract requirements (Medicaid copay amounts)

STRATEGIC PLANNING

REVENUE CYCLE STRATEGIC PLAN

- Optimize revenue growth without relying entirely on new volumes.

- Reduce revenue erosion
  - Shift the organizational thought process to performance which centers on collection of the services provided.
  - Software & clearinghouse edits don't make up for
    - Missed charges
    - Undocumented services (start/stop times for infusion or observation)
    - Documentation that doesn't support medical necessary

- New Services
  - Notification of coding and billing staff
  - Medical necessity rules
  - Documentation requirements

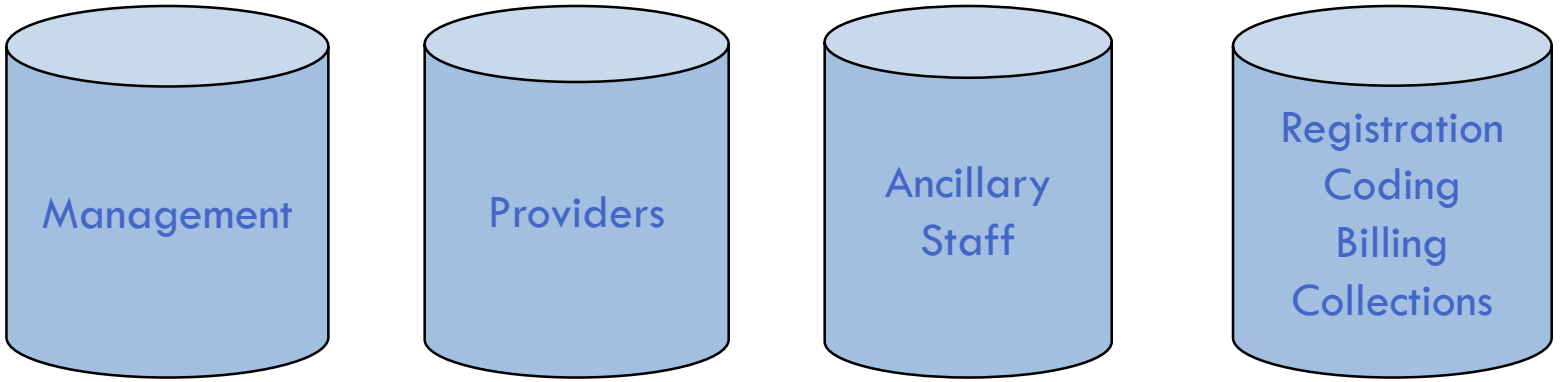
- Focus on assisting with obstacles the revenue cycle is facing vs. blame.

WHO ARE THE PLAYERS?

- Shift Ownership to the stakeholders.
  - Ancillary departments
  - Providers
  - Management
- Look to three key areas for overall organizational success.
  - Physicians
    - Provide documentation training to explain the revenue impact of inaccurate documentation.
    - Address and work together on their pain points with the revenue cycle process.
    - Target ways for staff/tools to maximize their performance.
  - Patients
    - Faced with higher financial obligations for healthcare services than in the past.
    - Educate them on their coverage/out of pocket obtained at time of insurance verification.
    - Be prepared to offer options for meeting financial responsibility.
  - Payers
    - Insurance Matrix

BREAKDOWN SILOS

- Revenue Cycle cannot continue to operate in a silo.
  - Whose job is it?
  - Seek buy in from all departments within the organization.
  - Send the same message to your patients and communities in every area of the organization.
  - Dedicate IT staff.



- Focus on letting the public and staff know that your organization WANTS to be the best.

REDUCE WRITE-OFFS

- Providers
  - Pre-authorizations
  - Provider not enrolled
  - Referrals
  - Documentation deficiencies
  - Medical necessity denials - ABN
- Coding
  - Incidental service denials due to lack of modifiers
  - Assure proper coding of combined accounts for same DOS
- Claims processing
  - Timely filing limits
  - Appeal processes
  - Account follow-up

Supporting Revenue Cycle at the highest level

- Top leadership that understands and appreciates critical role of financial performance in supporting care delivery.
- Willingness to devote time and resources to issues affecting financial services.

Garnering appreciation from non-finance staff

- Perform Revenue Cycle 101 training to non-revenue cycle departments.
- Help participants understand positive impact within their own departments.

Demanding high performance

- Leadership demonstrates passion to do better and drives excitement around improvement initiatives.

Celebrating success

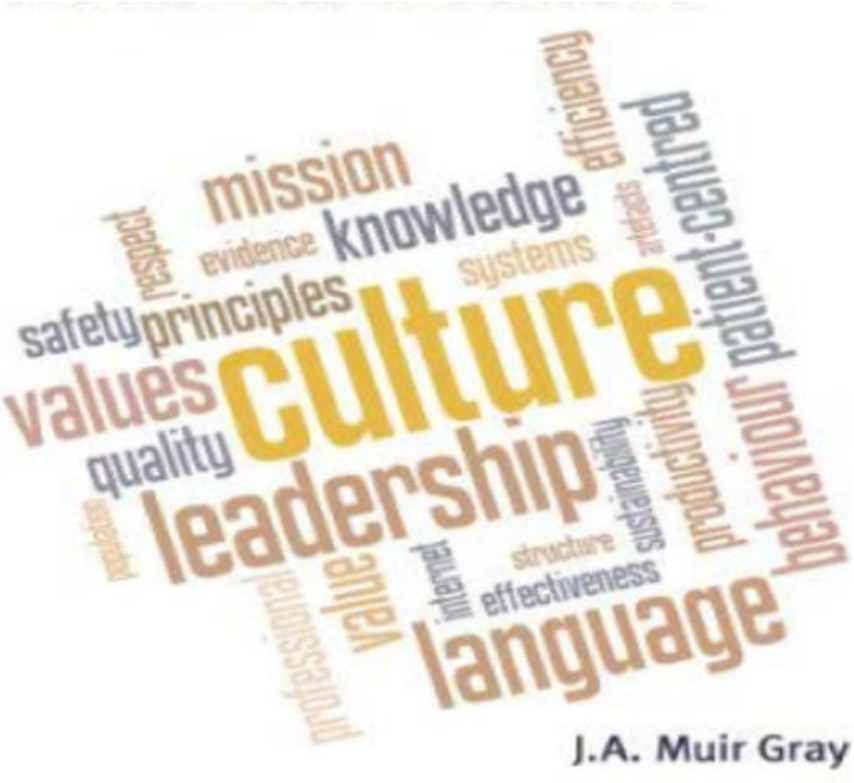
- Foster an attitude of gratitude.

Make innovations a priority

- Focus on staff willingness/adapters of new processes and technologies.

ORGANIZATIONAL CULTURE

Are you prepared to lead the Organizational Culture change as it relates to the Revenue Cycle?



QUESTIONS?

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THANK YOU

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