Revenue Cycle Common Findings from Assessments and Best Practices

Montana Health Research & Education Foundation

Eide Bailly

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To Set The Stage: Assessment Scope and Process:

- **Pre-Assessment:** Complete analysis of data and KPIs for each functional area identified for the assessment.
- **Onsite or Remote Assessment:** Staff questionnaires sent to gain a high-level understanding of processes and knowledge. From there, meeting with management and staff for each functional area of the Revenue Cycle to include Patient Access, Health Information Management, Chargemaster and Charge Capture, Ancillary Staff (i.e., Lab/Rad/Therapy), and Business Office while onsite.
- **Post-Assessment:** Compiling information obtained to identify opportunities to implement for improved accounts receivables and overall efficiencies within departments.
- **Final Report:** Report of findings, recommendations, and next steps.

Agenda

- Electronic Medical Record Workflow Configuration
- Front End Revenue Cycle
- Financial Assistance Policy
- Mid Cycle – Charge Capture and HIM
- Business Office
- Payors Contracts/Insurance Matrix/Under Payments

EMR (Electronic Medical Record) Workflow Configuration

Electronic Medical Record Workflow Configuration

Registration

- Standardized registration workflow
  - Staff follow standard script embedded in EMR
  - Hard stops for missing/invalid fields
    - Clear visual for missing data fields
  - EMR automatically checks for potential duplicates and flags registrar
  - Confirmation of correct insurance plan and copies of insurance cards
  - Ability to run eligibility at scheduling and check in
  - After eligibility ability to see copays and deductibles

Electronic Medical Record Workflow Configuration

Coding

- Encoder Application Standardization
  - Configure and automate encoder selection by patient type to ensure accurate coding
    - Inpatient – MSDRG
    - Outpatient – APC/OPPS
    - Professional – CPT based encoder
  - Encoder validation should be part of charge review

Electronic Medical Record Workflow Configuration

Documentation to assure Charge Capture Accuracy

- Drug charges are generated based on documented administration
  - Correct drug billed
  - Correct dose/units
  - Correct route and start/stop time
- Standardized documentation
  - All nursing staff (IP, ER, OP Infusion) must follow same documentation workflow to ensure documentation consistently flows to the MAR (Infusion Summary – Cerner; HIM Administration Record – Epic)
  - Allows staff capturing drug administration charges to view one document to capture charges accurately

Electronic Medical Record Workflow Configuration

Documentation to support necessity of inpatient or swing bed stay

- Acute inpatient encounters and observation encounters should have daily visits and progress notes
  - Supports need for inpatient level of care or observation
  - Correct visit dates on progress notes to clearly indicate date patient was seen
    - EMR configuration
    - Provider documenting wrong date
- Swing Bed
  - Swing bed stays require frequency of provider visit based on patient care needs

Electronic Medical Record Workflow Configuration

EMR Worklists

- Worklist criteria are set up accurately
- Accounts in the worklist are ready for the next step
  - For example, accounts lacking required documentation (e.g., operative report, discharge summary) are not ready for coding
  - Coding staff touch multiple times until ready for coding
- Accounts move between worklists without resolution
  - Lack of clearly defined rules for transferring accounts between worklists

Registration, Eligibility, Prior Authorization, and Point of Service Collection

The Importance of Patient Scheduling

COMMON CHALLENGES:

1. Overbooking and underbooking of patient appointments.
2. Managing no-shows and last-minute cancellations.
3. Scheduling staff efficiency.
4. Integrating with other systems.
5. Enhancing patient communications.

SOLUTIONS:

1. Use advance scheduling software to analyze historical data and predict patient flow. Implement a patient portal that offers self-scheduling.
2. Establish automated reminders and maintain a flexible rescheduling policy.
3. Use consistent scheduling scripts across all staff and locations. Define who can schedule what (i.e., registration vs. clinical staff). *This includes scheduling Operating Room and Procedure rooms.*
4. Build standardize appointment types, durations, and visits reasons across all providers.
5. Implement automated reminders, simple access to appointment details, and direct channels of communication between patients and the facility.
6. If incorporating telehealth, standardize types of visits which can be performed and consider blocks of time for TH visits.

IMPACT:

By implementing these scheduling solutions, healthcare providers can expect the following:

- Reduced patient wait times.
- Optimized resource utilization.
- Lower no-show rates.
- Increased revenue.
- Reduced administrative burden and better workload management leading to higher employee satisfaction.
- Timely access to care.
- Increased patient satisfaction.
- Assuring Prior Authorization is obtained if needed or review of medical policy.

According to AHIMA, 72% of providers report a noticeable increase in revenue with the implementation of efficient scheduling best practices. Additionally, studies show proper scheduling can reduce patient wait times by up to 50% and increase patient satisfaction by nearly 30%.

Pre-registration Best Practices

Collect Complete and Accurate Patient Information:

Gather demographic details, insurance information, and contact information prior to the visit.

Use standardized data fields across systems to avoid mismatches.

Verify Insurance Eligibility and Benefits Prior to Arrival:

Check coverage at time of scheduling and again prior to appointment.

Use multiple verification methods if possible, such as RTE tools, payer portal, and phone calls if needed.

Confirm coordination of benefits.

Provide Financial Counseling Early:

Communicate estimated patient costs during pre-reg.

Offer payment options or plans upfront to reduce bad debt and improve patient satisfaction.

Standardize Processes and Train Staff:

Create clear scripts and workflows for front desk and scheduling teams.

Establish open lines of communication for staff scheduling concerns.

Utilize Automation and Batch Processing:

Automate eligibility checks for all scheduled appointments.

Use order templates with CPT codes to assist in price estimation and authorization workflows.

Registration

- Patient registration is the process of collecting and verifying all necessary demographic, medical, and insurance information from a patient prior to the patient receiving healthcare services. Though it can seem like a simple administrative duty, registration sets the foundation for the entire revenue cycle.

Why it Matters

- Faster eligibility verification
- Increased first-pass claim acceptance
- Reduced patient wait times
- Higher volume of point-of-service collections

Best Practices

- Verify patient contact information
- Implement real-time eligibility verification
- Standardize data collection protocols
- Ensure cross-platform compatibility
- Centralized registration

Mitigating Registration Risks

- Employee Training:
  - Ongoing education on payer policies, best practices for data entry, and HIPAA compliance alleviates registration errors.
- Standardized Workflows:
  - Use registration checklists and patient interaction scripts to ensure consistency among patient encounters, particularly for collecting demographic information, verifying coverage, and collecting co-pays.
- Digital Intake Tools:
  - Leverage online registration tools by enabling patients to enter their own information prior to their visit through secure digital forms, speeding up the registration process and reducing patient intake times.
- Real-Time Eligibility (RTE):
  - Automate insurance checks at the point of registration through integrated RTE tools within the EHR and/or clearinghouse.
- System Prompts:
  - Implement automated prompts and edits within the EHR and clearinghouse systems to flag missing or inconsistent information.

Prior Authorization Best Practices

- Automate Prior Authorization:
  - Explore options to implement electronic prior authorization tools that integrate with your EHR software.
  - Utilize real-time decision support to determine whether a prior auth is required.
- Designate a Prior Auth Specialist/Team:
  - Centralize the PA process under an experienced leader.
- Standardize Internal Procedures:
  - Establish standard operating procedures (SOPs) for acquiring prior authorizations across departments.
  - Integrate PA steps into the scheduling and registration process.
- Establish Ongoing Tracking:
  - Use a dashboard or task management system to track outstanding and approved PA submissions.
  - Implement automated reminders.
- Strengthen Payer Relationships:
  - Coordinate direct channels of communication and designated contacts with highest-volume or most problematic payers.
- Engage Clinicians in the Process:
  - Educate providers on the significance of timely and accurate documentation for authorizations.
  - Include clinical decision support tools that notify physicians of PA requirements during order entry if possible.
  - Coordinate with visiting specialists performing procedures at your facility.

Eligibility & Benefits Verification

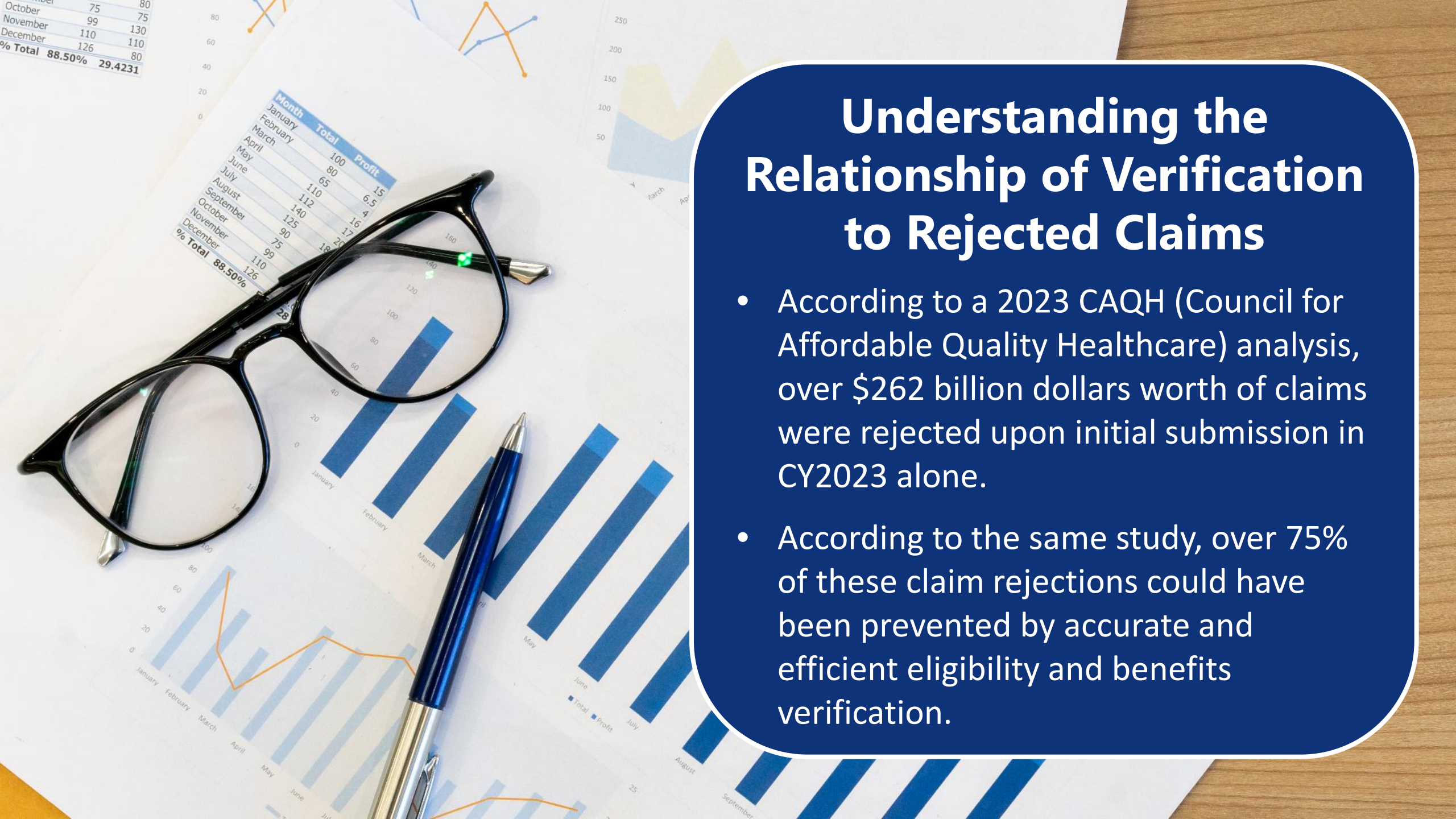
- Eligibility and benefits verification, which is the process of confirming a patient's insurance coverage and determining their eligibility for specific services, is an essential step in the revenue cycle of any healthcare organization. This process typically occurs during registration or before a scheduled appointment or procedure.

Why it Matters

- Minimized dependence on patient responsiveness after the fact
- Ensures accurate patient responsibility
- Supports compliance
- Simplified patient experience

Best Practices

- Verify early and often
- Confirm all coverage details
- Automate where possible
- Consistently track payer policy changes



Understanding the Relationship of Verification to Rejected Claims

- According to a 2023 CAQH (Council for Affordable Quality Healthcare) analysis, over $262 billion dollars worth of claims were rejected upon initial submission in CY2023 alone.
- According to the same study, over 75% of these claim rejections could have been prevented by accurate and efficient eligibility and benefits verification.

Point-of-Service Collections

- Patient payments that are collected at or prior to the time of service are referred to as point-of-service (POS) collections. POS collections can include co-pays, deductible, and other out-of-pocket expenses for which the patient is responsible.

Why it Matters

- Reduces time and resources spent on patient billing
- Reduces bad debt and uncompensated care
- Decreases the volume of outstanding balances sent to third-party collection agencies
- Prevents patient dissatisfaction later
- Supports financial stability

Best Practices

- Educate patients prior to receiving services
- Early eligibility verification
- Develop standardized protocol for upfront collections
- Prepare staff to conduct patient financial conversations
- Introduce online payment options

Financial Assistance Policy

FINANCIAL ASSISTANCE POLICY

- Overview of requirements:
  - Applies to nonprofit hospitals under the ACA.
  - Requires hospitals to establish a Financial Assistance Policy (FAP).
  - Limits charges for eligible patients.
  - Prohibits aggressive collection actions.
  - Mandates public disclosure and accessibility.
- Is your organization compliant with 501(r)?

Financial Assistance Policy Process

Application Process

- Simple and accessible application form.
- Required documentation (income proof, tax returns).
- Available online, in person, and by request.

Public Disclosure Requirements

- Policy must be posted online on your website.
- Notices provided in hospital intake (both registration and clinical areas) and billing areas.
- Multiple language availability.

Financial Assistance Policy Best Practices

REGULAR POLICY UPDATES AND STAFF TRAINING

INTERNAL AUDITS AND COMPLIANCE CHECKS

TRANSPARENCY IN PATIENT COMMUNICATION

Health Information Management (HIM) – Mid-Cycle

Mid Cycle

- Items will touch on today:
  - Hard versus Soft Coding – what to watch for.
  - National Correct Coding Initiative Edits – how is our workflow handling.
  - Release of Information (ROI) – how does this impact our revenue cycle.

Hard Coded Vs Soft Coded in HIM Coding Process

- **Hard Coded:**
  - Codes are pre-assigned in the Chargemaster and automatically applied without coder intervention.
  - Example: Lab tests, Radiology exams.
- **Soft Coded:**
  - Codes are manually assigned by a coding professional based on documentation and clinical details.
  - Most often used when reporting Operating Room procedures.
  - Sometimes used for Emergency Room procedures.
  - Soft coding ensures specificity of codes assigned, code reported is based on documentation and allows multiple codes to be reported if necessary to describe the procedure.
- **Risks with Soft Coded CPT codes**:
  - CPT codes fail to link correctly to charges.
  - Only the first CPT code assigned is linked. The other CPT codes do not appear on the claim.
  - Additional CPT codes appear on the UB with no charge. Potential to be removed from the claim by the scrubber or clearing house.
  - If multiple areas are soft coded, for example Operating Room and Emergency Room, aligning the CPT codes with the correct revenue codes.
- **Auditing:**
  - Audit both claim and remit to assure all soft coded CPT codes are on the claim.

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National Correct Coding Initiative (NCCI)

- Developed by CMS to promote national correct coding methodologies to prevent inappropriate payment:
  - Other payers may or may not follow NCCI edits:
    - Best practice is to apply to all payers.
  - The Centers for Medicare & Medicaid Services (CMS) owns the NCCI program and is responsible for all decisions regarding its contents.
  - https://www.cms.gov/files/document/mln901346-how-use-medicare-ncci-tools.pdf
  - Applied to Outpatient Services – Part B services:
    - ER, Outpatient Diagnostic, Observation, Outpatient Surgery.
- Includes Medically Unlikely Edits (MUEs):
  - Prevent payment for a potentially inappropriate number/quantity of the same service on a single day.
- Updated quarterly.
- Includes two provider-type of PTP (procedure-to-procedure) edits:
  - Practitioners – paid for work they do to provide the service.
  - Facility – paid for resources utilized during the service.

National Correct Coding Initiative (NCCI)

- Outline workflow to address edits prior to submitting the claim:
  - Who addresses the edit and at what point in the claim process?
  - Need the medical record to review documentation for the edits.
  - **Coding**:
    - Often receives many of the edits within integrated encoder.
    - This is the best time to work edits as already reviewing the medical record.
    - Requires organization policy on:
      - Who can remove charges?
      - For certain edits, will charge be **removed, allowed to deny, charge discounted before billed, or appealed on back end**:
        - Need to address to avoid back and forth between Billing and Coding and multiple reviews of the same edit.
        - Goal is clean claims.
      - How are clinical departments included to assure understanding of edits occurring?
      - If lacking medical necessity, querying for additional documentation, contacting physician offices, versus use of modifier GZ – Item or service expected to be denied.

National Correct Coding Initiative (NCCI)

- Outline workflow to address edits prior to submitting the claim:
  - Who addresses the edit and at what point in the claim process?
  - Need the medical record to review documentation for the edit.
  - **Billing:**
    - Often receives edits from the scrubber.
    - Will require rework to review documentation to address the edit.
    - Requires organization policy on:
      - Who will edits be sent to?
      - Who can remove charges?
      - For certain edits, will charge be **removed, allowed to deny, charge discounted before billed, or appealed on back end**:
        - Need to address to avoid back and forth between Billing and Coding and multiple reviews of the same edit.
        - Goal is clean claims.
      - How are clinical departments included to assure understanding of edits occurring?
      - If lacking medical necessity and Coding was unable to obtain use of modifier GZ – Item or service expected to be denied:
        - Tracking modifier GZ line items in denial management dashboard.

National Correct Coding Initiative (NCCI)

- Steps to Mitigate Revenue Impact:
  - Outline workflow for edits between departments, coding, and billing.
  - Develop follow-up processes for RTP (return to provider) and denied claims:
    - Identify claim requiring correction and resubmission – RTP:
      - Determine workflow of staff involvement to determine if the claim is appropriate to resubmit.
    - Identify situations which require an appeal:
      - Determine workflow of staff involvement to determine if claim is to be appealed.
      - Determine who will write the appeal:
        - Send in complete medical records!
- Chargemaster and Charge Capture:
  - NCCI edits should be considered when setting up chargemaster items and charge capture workflow.
  - With continued updates, requires at least a yearly review of chargemaster and charge capture.
  - Assure whoever manages chargemaster has knowledge of the NCCI manual which is updated annually:
    - This manual contains reporting information for CPT codes which may not be an actual edit.

Medical Necessity Lacking

- Outline workflow to address medical necessity edits prior to submitting the claim:
  - Who addresses the edit and at what point in the claim process?
  - Need the medical record to review documentation for the edit.
  - What are the steps to take:
    - Obtain additional documentation which supports services
    - Send a Physician Query
    - Reach out to outside providers for additional information
- Impact on Revenue:
  - Loss of reimbursement:
    - Departments and providers unaware.
  - Cost of correcting claims.
  - Cost of appealing claims.
  - Potential for multiple touches of an encounter/claim.

Release of Information

- Release of information (ROI) is a critical link between the documentation of services and reimbursement.
- Records are sent for a variety of reasons including:
  - Prior Authorization.
  - At time of claim submission.
  - On request by payor for a pre audit before paying the claim.
  - Post audits such as payer audits, RAC, CERT.
  - Numerous individual encounter requests occur by Commercial companies for review of payment on a claim.

Release of Information

- Impact errors in ROI can have on Revenue Cycle:
  - Delayed Reimbursement.
  - Operational Inefficiency on how records are released for revenue cycle can delay payer responses.
  - Claim Denial:
    - Lack of correct upfront documentation results in a denial which must be appealed.
  - Inaccurate or incomplete records provided during a payer audit can trigger additional audits or extrapolated payment requests.
  - Legal and Regulatory exposure as a result of improper disclosure of medical records.
  - Lack of centralized ROI function increases the risk of unlogged disclosures.

Business Office – Back-End

Clean Claims

- Claims that are submitted to payers without errors or issues that require corrections or reprocessing. These claims are processed and paid on the first submission without any follow-up or denial.

Why it Matters

- Faster reimbursement
- Cost reduction
- Operational and cash flow efficiency

Best Practices

- Ongoing staff training
- Regular payer communication
- Implement advanced claim scrubbing software

Enhancing Claims Scrubbing and Submission Processes

Error Reduction with Scrubbing Tools

Advanced claim scrubbing tools detect missing or incorrect data, reducing errors before submission.

Improved Cash Flow

Reducing claim errors leads to faster reimbursements and minimizes administrative workload for billing staff.

Payer Compliance Management

Staying updated on payer requirements ensures claims meet submission rules, increasing acceptance rates.

Claims Scrubbing & Submission

METRIC	DESCRIPTION	TARGET
Clean Claim Rate	Percentage of claims submitted without errors	> 95%
Claim Rejection Rate	Percentage of claims rejected by payers	< 5%
Average Days to Submission	Time from service to claim submission	< 3-5 days

Accounts Receivables

- Days in AR measures the average number of days it takes for a healthcare organization to collect payments after services are provided. It calculates the efficiency of the revenue cycle; from the time a claim is submitted to when payment is received.

Why It Matters

- Performance measurement
- Cash flow efficiency
- Payer mix impact

Best Practices

- Improve Billing and Coding Accuracy
- Implement Timely Follow-up
- Use Advanced Payment Technologies

Strategies for Accounts Receivable Optimization

- Monitoring Aging Buckets:
  - Tracking overdue accounts helps prioritize collection efforts on high-risk or high-value receivables.
- Implementing AR Dashboards:
  - Dashboards offer visibility into outstanding balances, collection trends, and team performance metrics.
- Regular AR Data Reviews:
  - Analyzing AR data frequently uncovers billing inefficiencies and aids timely follow-up actions.

Strategies for Accounts Receivable Optimization

- Predictive Analytics Integration:
  - Using predictive tools forecasts payment delays and optimizes resource allocation for collections.
    - Historical payer payment lag (days to pay)
    - Payer-specific denial rates by service type
    - Frequency of additional documentation requests
    - Payer appeal overturn rate
    - Contracted vs. non-contracted status
    - Payer authorization denial frequency
    - Payer-specific modifier sensitivity (e.g., -59, -25, -54)

Automating Payment Posting for Efficiency

- Error Reduction and Speed:
  - Automation reduces manual errors and speeds up reconciliation to improve financial accuracy in hospitals.
- Staff Time Optimization:
  - Automation frees staff to focus on strategic tasks like denial resolution and patient follow-up.
- Electronic Remittance Advice:
  - Implementing ERA systems streamlines updates to patient accounts and ensures timely financial information.
- Improved Operational Efficiency:
  - Adopting automation boosts operational efficiency and supports healthier cash flow for hospitals.

Key Performance Indicators for Denials

Denial Rate

Total # of denied claims divided by total billed claims.

Formula: Claim Denial Rate = (Total Number of Denied Claims / Total Number of Claims Submitted) x 100

Denial Overturn Ratio

Denials overturned divided by total denials received.

Formula: Denial overturn rate = (Number of Denied Claims overturned / Total Number of Denied Claims) x 100

Underpayment Rate

Percent of actual payment vs. expected payment.

Formula: Underpayments (payment variance) = actual payment/expected payment x 100

Payer contracts – Insurance Matrix and Under Payments

Payer Contracting

Why is it important?

- Define reimbursement structures.
- Specify claim submission deadlines and payment terms.
- Outline appeal rights and dispute resolution mechanisms.
- Ensure compliance with federal and state regulations.
- Include language in payor contracts that speaks to following current payor guidelines but not held to updates to payor guidelines that do not adhere to federal or state regulations.

Payer Contracting Pitfalls & How To Avoid

Unfavorable Reimbursement Terms: Regularly review and renegotiate contracts.

Missed Deadlines: Stay on top of timely filing limits.

Lack of Contract Visibility: Utilize centralized contract management software to track key terms and deadlines.

Policies language in Contract follows compliant charging practices.

Payer Contracting Underpayments

Rate discrepancies and payment variations.

- Misinterpretation of contract terms.
- Incorrect rate application by payers.
- Outdated contracts leading to lower reimbursements.

Policy changes and contract amendments.

- Payers frequently update reimbursement policies.
- Providers may not be aware of contract amendments.
- Regular contract audits are essential.

Do you have a process in place to review these?

Payer Contract Management Best Practices

Maintain a central database of all payer contracts.

Regularly audit reimbursement rates and payer performance.

Train staff on contract terms and compliance requirements.

Leverage technology for tracking and analytics.

Steps to Take

Revenue Cycle Best Practices Optimization

Accurate registration and eligibility checks.

Proper coding and documentation.

Timely claim submission and follow-up.

Staff training and cross-functional collaboration.

Conducting Revenue Integrity Audits

- Purpose of Revenue Audits:
  - Audits help identify missed charges, incorrect coding, and compliance gaps in hospital billing processes.
- Benefits of Regular Audits:
  - Regular audits provide insights into billing practices and highlight areas for financial improvement.
- Improving Financial Performance:
  - Correcting errors and implementing best practices enhances financial outcomes and reduces regulatory risks.
- Audit Tools and Resources:
  - Using external auditors or automated tools increases audit effectiveness and efficiency.

Leveraging KPI Monitoring And Analytics

- Tracking Core KPIs:
  - Monitoring KPIs like DNFB, AR days, and denial rates reveals financial and operational performance insights.
- Real-Time Dashboard Access:
  - Dashboards provide revenue teams with real-time data to facilitate timely and informed decision-making.
- Predictive Analytics:
  - Analytics identify trends and forecast issues, enabling proactive revenue cycle management.
- Continuous Improvement:
  - Regular KPI review supports setting benchmarks, tracking progress, and targeted interventions for better outcomes.

Key Takeaways

- Set culture of compliance and accountability.
- Allocate resources to optimize RCM and invest in training for front-end and billing staff.
- Support continuous improvement.
- Align hospital operations with revenue cycle goals.
- Perform regular chart audits and denial analysis.
- Tracking and reviewing these KPIs regularly helps leaders assess performance and identify areas for improvement.

Questions?

Thank you

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