Delta Region Community Health Systems Development (DRCHSD) Program

RCM/PPM Webinar Series

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

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National Rural Health Resource Center

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

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National Rural Health Resource Center

Pre-Polling Questions

I am ___ in my understanding of common challenges hospital revenue cycle leaders face in today's environment.

I am ___ in my understanding of best practices for front-end revenue cycle functions (scheduling, registration, etc.).

I am ___ in my understanding of best practices for back-end revenue cycle functions (denials management, cash acceleration, etc.).

DRCHSD Revenue Cycle Management Series

- Session 1- February 2, 2023:

Front and Back-End Revenue Cycle Management Best Practices

- Session 2- February 9, 2023

Middle Revenue Cycle Best Practices and Social Determinants of Health

- Session 3- February 16, 2023

Physician Practice Management Best Practices

Front and Back-End Revenue Cycle Management Best Practices

Clay Morrisson, CHFP

FORVIS, LLP

FORVIS

Revenue Cycle Best Practices

Front and Back-end

February 2023

Agenda

- Introductions
- Learning Objectives
- Revenue Cycle Challenges
- Front-end Revenue Cycle Best Practices
- Back-end Revenue Cycle Best Practices

Introductions & Learning Objectives

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Learning Objectives

1. Identify common challenges hospital revenue cycle leaders face in today's environment
2. Identify best practices for front-end revenue cycle functions
3. Identify best practices for back-end revenue cycle functions

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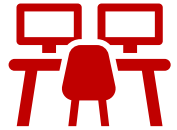
Revenue Cycle Challenges

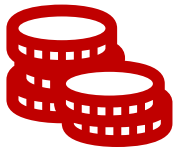
After a long battle against the global pandemic, healthcare revenue cycle leaders are returning to the home front faced with a discouraging reality:

Revenue Cycle Metrics Off Track

Labor Shortages & Staff Turnover



Remote "Work from Home" Environment



Government Funding Cut Off

Volumes Sluggish to Return

Increased Denials & Margin Compression

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Overcoming Revenue Cycle Challenges

- Evaluating the Health of the Revenue Cycle:
  - Key Performance Indicators (KPIs)
  - Stability of patient net revenue performance
  - Comparison of actual performance vs budgeted levels of performance
  - Key provider relationships, management resources and staff turnover
  - Internal monitoring tools
  - Ability to adjust operations to match changing environment
- Importance of a Healthy Revenue Cycle:
  - Efficient reimbursement for services
  - Reduced errors and confusion
  - Reduced costs
  - Normalized and predictable revenue
  - Well informed staff
  - Improved patient experience

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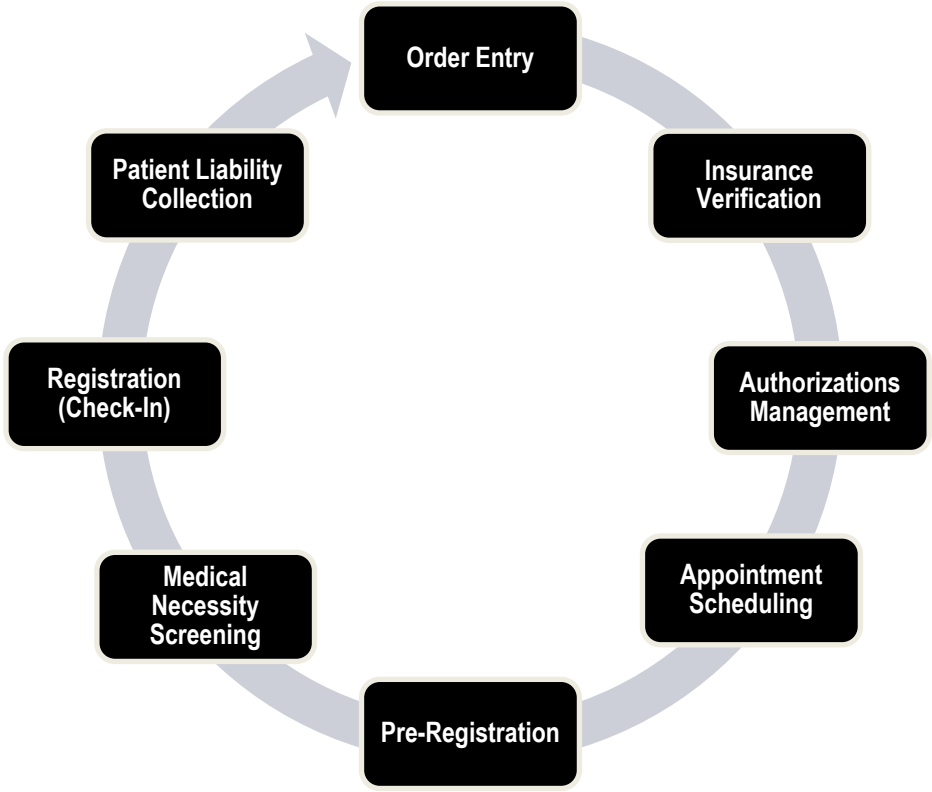
Why is the Front-end of the Revenue Cycle so Important?

- **Patient Registration:** all processes related to the activation of an account, including a review of demographic, insurance and other patient related information.

- **Why is Registration Important?**
  - Often times, this is the first experience a patient has with the hospital and can set the tone for patient satisfaction.
  - Registration, and revenue cycle in general, can have a downstream impact (“snowball effect”).
  - The UB-04 claim form (used to in billing for hospitals) is made up of 81 different data fields and patient access/registration is accountable for obtaining > 60%.



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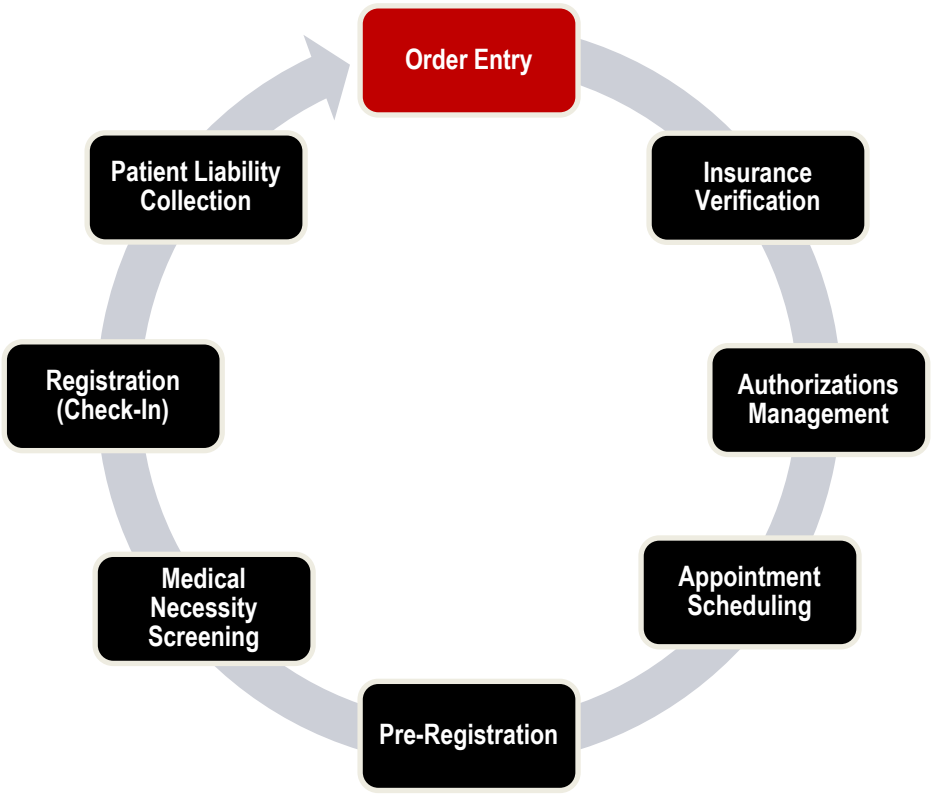
Order Entry Best Practices



- **Communicate expectations of timely provider order entry** and establish guidance to complete at the end of every encounter and avoid delaying to the end of a shift or day.
- **Establish policy that requires a physician signature on an order** to confirm appointment booking detail with patients.
- **Implement provider options for priority indicators such as "Routine" and "STAT/Urgent"** to develop dedicated processes to expedite scheduling and when required bypass built-in gatekeepers to flag potential plan authorization requirements.
- **Develop order templates that accommodate a description of the service and the corresponding CPT code(s)** to assist downstream efforts around patient liability price estimation.

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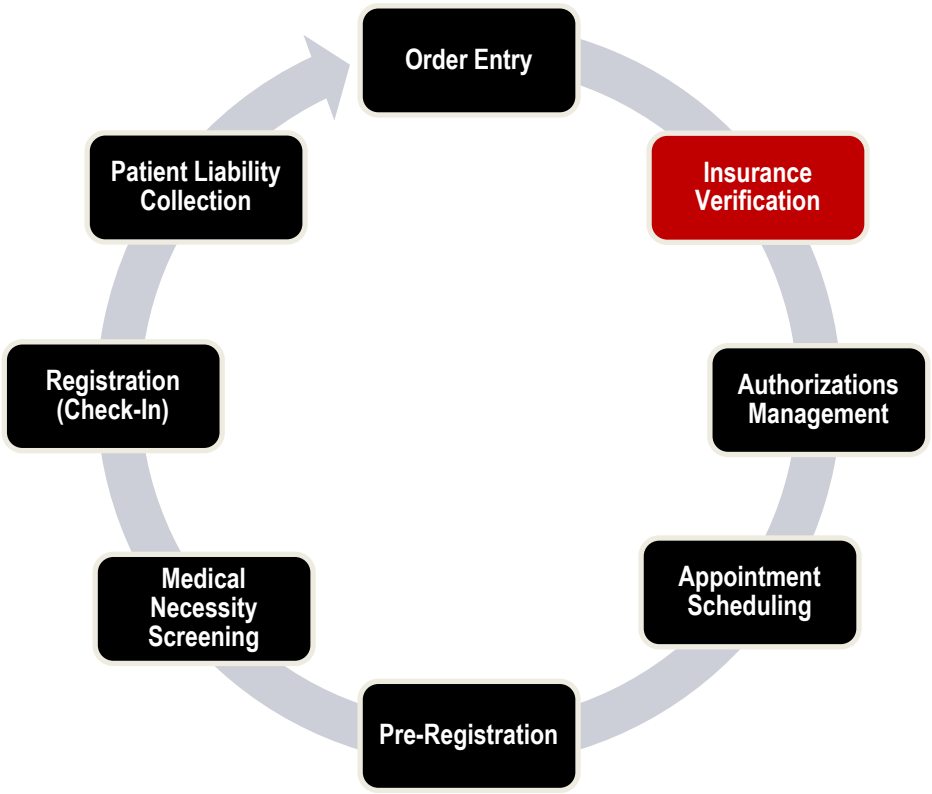
Insurance Verification Best Practices



- **Implement a check of insurance eligibility, benefits verification, and coordination of benefits** each time an appointment is scheduled and each time a patient arrives to check-in for a service.
- **Communicate expectations to staff that they should leverage ALL available options to verify insurance** including electronic eligibility software, payer websites, and telephonic outreach, if necessary.
- **Implement "batch launch" eligibility checks for all scheduled appointments to greatly improve the number of insurance plans verified.** Errors that result from the "batch launch" can be populated as an exception-based worklist to be worked by staff in advance of the service.
- **Publish internal guides with screenshots of accepted insurance cards** can assist staff with not only verifying the insurance correctly, but also ensuring the patient is added to the correct financial class.

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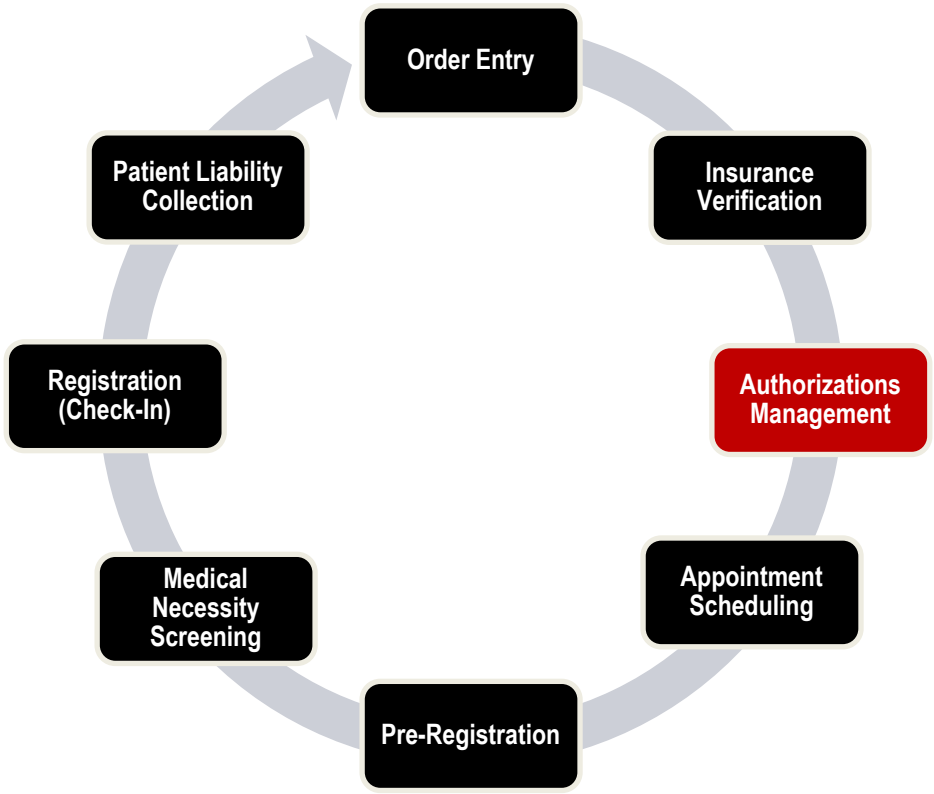
Authorization Management Best Practices



- **Develop an authorization mapping dictionary that crosswalks insurance plans, CPT codes, and authorization requirements.** The dictionary should be maintained and updated continuously as plan changes are identified.
- **Establish policy around authorizations management** that is specific and details exception scenarios for scheduling without authorization (EX: STAT/Urgent priority).
- **Implement account checks on encounters for missing authorizations for denial high risk areas such as inpatient admissions and outpatient surgery** in order to ensure authorization is on-file prior to claim submission.
- **Trend and analyze missing and/or invalid authorization denials** to identify any potential changes to plan requirements (EX: Expansion of authorization requirement across additional sites of service).

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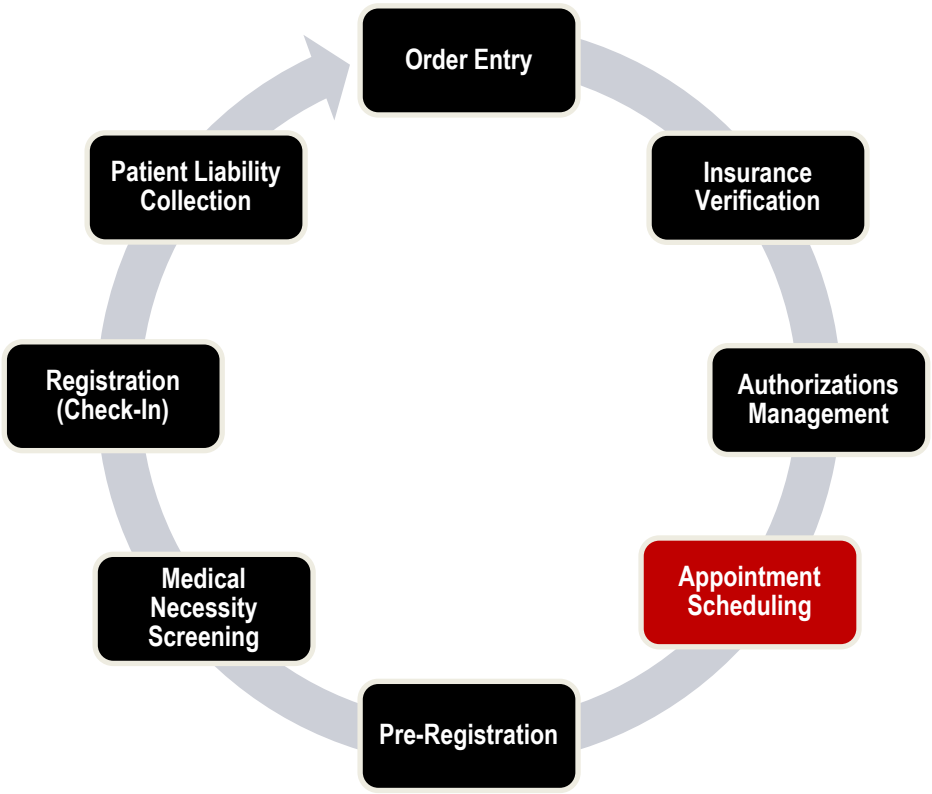
Appointment Scheduling Best Practices



- **Implement minimum scheduling requirements for "Routine" priority hospital outpatient encounters:**
  - Signed provider order on-file
  - Insurance verification or self-pay deposit is collected.
  - Any plan authorization requirements have been met.
- **Establish policy allowing "Urgent" priority hospital outpatient encounters to be scheduled without delay**; however, any authorizations required need to be initiated with the payer prior to end of day on the date of service.
- **Establish policy requiring insurance eligibility verification, collection of self-pay deposit, or financial assistance approval** where applicable, in order to be scheduled.
- **Trend and monitor appointment realization** which is calculated by dividing the number of appointments rendered over the appointments scheduled over a given period.

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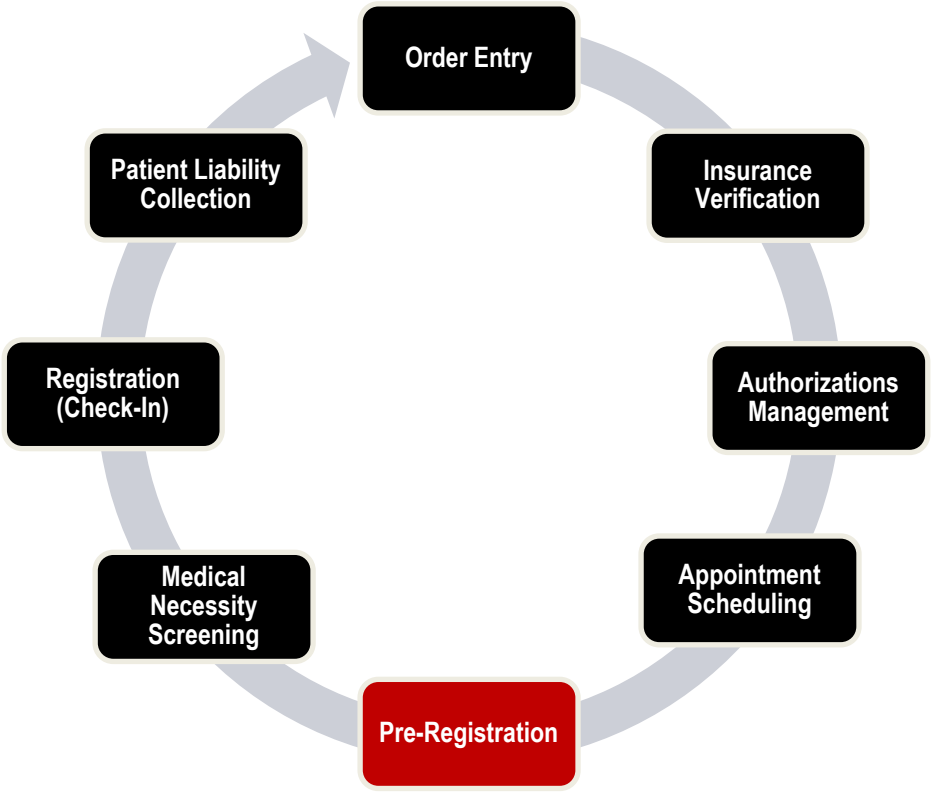
Pre-Registration Best Practices



- **Establish Pre-Registration productivity tracking and monitor performance** against a best practice goal of >94% of scheduled hospital outpatient encounters pre-registered prior to service.
- **Implement robust staff quality audits and review patient accounts** to ensure accuracy and completeness of pre-registration process.
- **Develop price estimates for all hospital outpatient services** and ask for a minimum deposit for both insured and uninsured patients.
- **Position Pre-Registration staff to function as a coordinated patient access "safety net"** to ensure all scheduled patients are financially cleared for their upcoming services (EX: Authorization on-file, pre-care deposit obtained, financial assistance approved).

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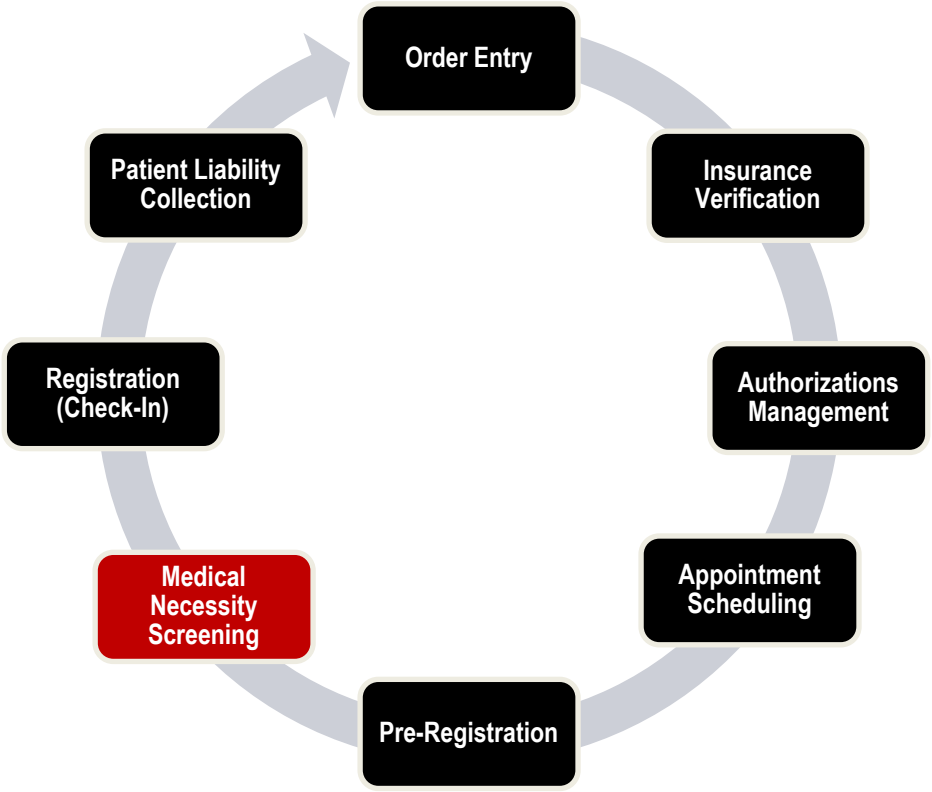
Medical Necessity Screening Best Practices



- **Develop a financial clearance process that ensures a check of medical necessity prior to service** with dedicated efforts to ensure they are obtained for affiliated and non-affiliated providers performing hospital services.
- **Leverage Utilization Review and Case Management** to assist in ensuring medical necessity screenings are conducted for patients in the inpatient setting.
- **Implement rescheduling protocols and assign accountability for all appeals** for services that are initially denied by the payer due to medical necessity.

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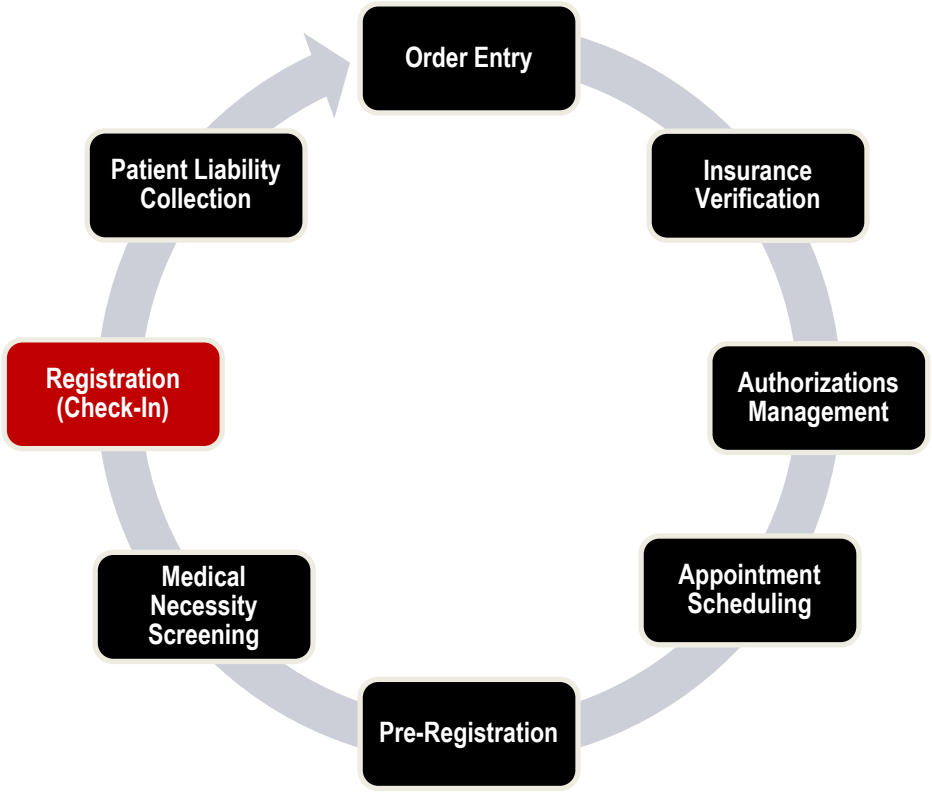
Registration (Check-in) Best Practices



- **Develop comprehensive registration processes for all hospital encounters** to include outpatient, inpatient and emergency services.
- **Direct Registration staff to follow-up on price estimates previously created** and if no collection was made to ask for a minimum deposit for both insured and uninsured patients.
- **Implement robust staff quality audits and review patient accounts** to ensure accuracy and completeness of registration (check-in) process.
- **Establish a financial clearance review at check-in** which requires a check of insurance eligibility, benefits verification, and coordination of benefits.

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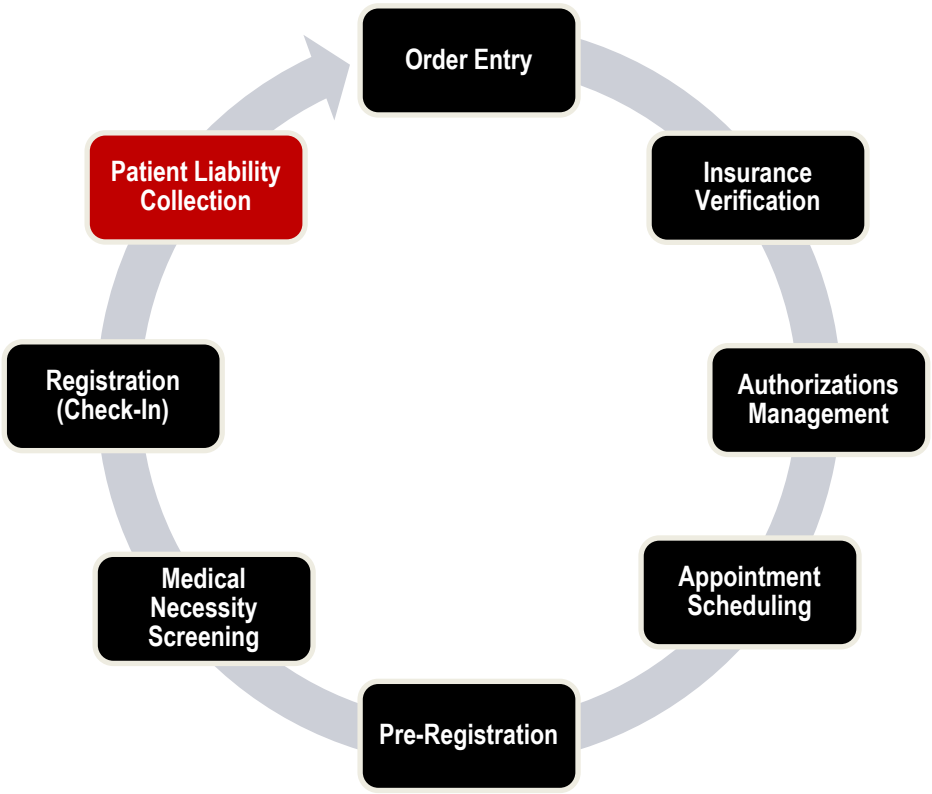
Patient Liability Collection Best Practices



- **Phase-in pre-care deposit requirements with price estimates to support collection asks** initially beginning with a narrow set of outpatient services such as advanced imaging, endoscopies, and diagnostic colonoscopies.
- **Ensure all registration points of the hospital inclusive of surgery centers, imaging centers, and sleep labs**, **among others** have the proper system access and training to facilitate point of service collections.
- **Develop conservative and reasonable flat-fee surgery deposits and require patients to pay** deposits as a pre-condition of elective service.
- **Trend and monitor patient cash collection efforts** such as at the point of service and through the pre-registration process to identify areas of improvement.

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Front-end Key Performance Indicator(s)

	Key Performance Indicator (KPI)	Benchmark
Patient Access	Point-of-Service Collections to Self Pay Payments	≥ 32.9% [1]
	Point-of-Service Collections as % of Net Patient Revenue	≥ 0.8% [4]
	Insurance Verification Rate	≥ 81% [2]
	Appointment No Show Rate	≤ 7% [3]
	Pre-Authorization Rate	≥ 79% [4]
	Pre-Registration Rate	≥ 79% [4]

[1] National Benchmark sourced from HFMA Map Keys Map Awards 2020, based upon 50th percentile
[2] HBI 2021 Hospital Benchmarks, $0-$199M, National Average
[3] MGMA 2019 Medical Practice Benchmark
[4] HBI 2021 Hospital Benchmarks, $0-$199M, National Average

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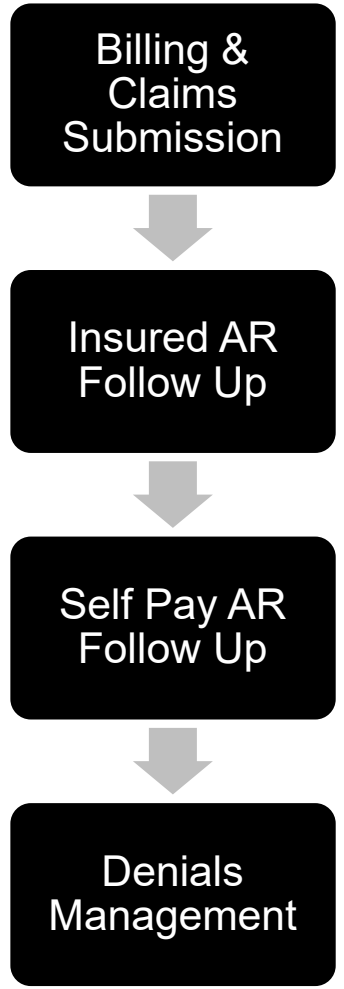
Why is the Back-end of the Revenue Cycle so Important?

- **Business Office:** all processes related processing patient insurance, collection on accounts and development of processes to ensure effective patient revenue management

- **Why is the Business Office so Important?**
  - Very complex and unique environment when compared to other industries.
  - Uphill battle of hospital vs. insurance companies (payers).
  - Responsible for driving and sustaining the financial performance of a hospital's patient services.
  - Inefficiencies within the business office are likely to result in missed revenue opportunities for hospitals and organizations.



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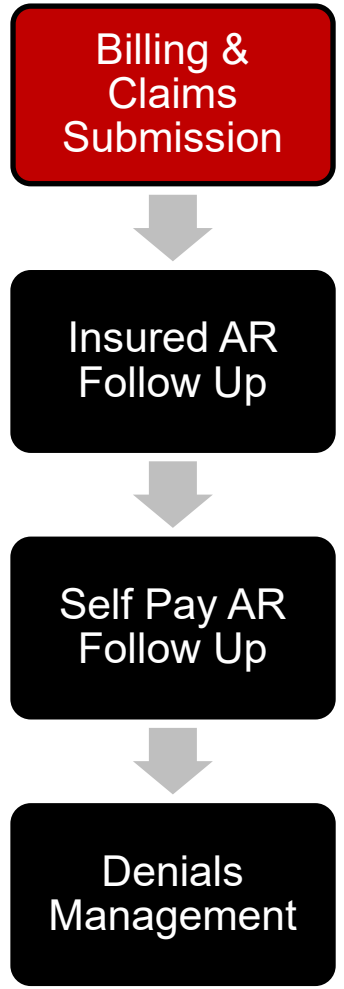
Billing & Claim Submission Best Practices

- **Roughly 12% of total hospital claim charges submitted receive an initial denial,** which stresses the importance of submitting claims cleanly during the billing process.

- **Billing & Claim Submission Best Practices:**
  - **Reporting**: continuously monitor billing and claim submission metrics and trends for key drivers of unbilled AR.
  - **Analysis:** develop process for determining key drivers of unbilled AR and implementation process for resolution and mitigation strategies.
  - **Custom Claim Edits:** review custom claim edits, at least quarterly, to prevent potential “false-positive” edits as well as additional edits, as needed.
  - **Communicate:** provide training, education and communicate across all owning areas to drive accountability for performance improvement.



Follow Up Best Practices

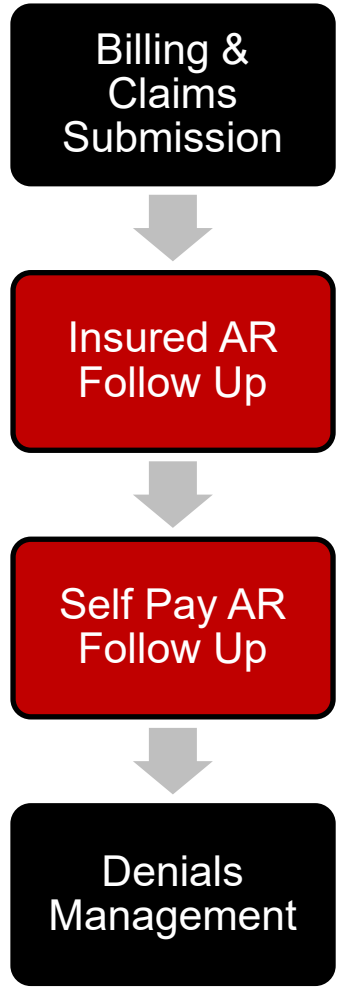
Staff Productivity Monitoring:

- While remote and flexible work environments have their benefits, it can often lead to limited visibility and transparency into staffing productivity.
- Productivity monitoring tools can help organizations provide insight into high-performing staff as well as where additional education is needed.

Staff Name	Benchmark	Current Week	Last Week	Variance (+/-)
Staff #1	285	310	250	60
Staff #2	285	290	285	5
Staff #3	285	195	200	(5)

Quality Audit Scorecard:

- Quality audit sampling provides revenue cycle leaders insight into individual staff quality, efficiency and performance while working accounts during follow up and collections activities.
- Consider outsourced vendors as an “extension of organization’s staff,” and monitor for areas of improvement.
- Key features of a Quality Audit Scorecard:
  - Standardized questions for all patient accounts reviewed.
  - Minimum number of patient accounts should be reviewed during each audit period.
  - Identify departmental trends for new opportunities to include in future audits.

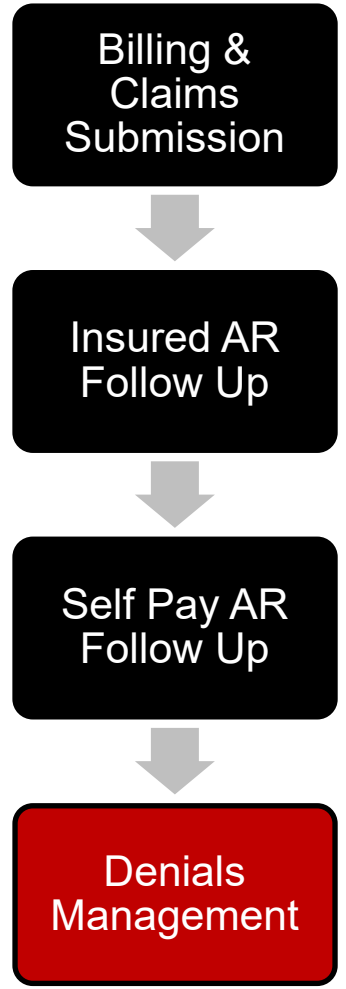


Denials Management Best Practices

Financial Impact:
- 3.3% of hospital's net revenue lost due to claim denials.
- $4.9M average hospital net revenue loss due to claim denials.

Cost of Re-work:
- $118 average to formally appeal a denied claim.
- Increased labor cost, including collection vendor fees.
- Reduced speed to payment and AR resolution

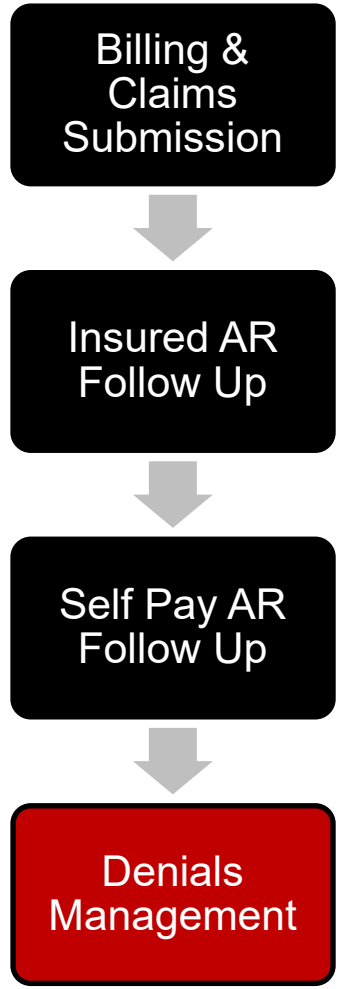
Patient Experience:
- Unexpected patient liabilities for non-covered services.
- Delay in patient care or statements received.



Denials Management Best Practices (continued)

Best Practices:

- **Use insurance denial data for improvement focus areas**, including systems and claims submission data that can be used to measure, monitor and improve operational performance and reduce denials:
- **Measure denials prevention performance** using a dashboard and nationally established Key Performance Indicators (KPIs).
- **Estimate annual impact of specific denial prevention initiatives** to celebrate incremental wins.
- **Develop monthly denials steering committee(s)** for denial prevention strategies:



Metric	Value	Calculation	Data Source
Clean Claim Rate %	Trending indicator of successful claim submissions to the payer	Number of claims submitted that passed edits requiring no manual intervention / number of claims submitted	Claim Scrubber
Remittance Denial Rate % (#)	Trending indicator of % of claims denied by payer	Total number of claims denied / Total number of claims remitted	835 Files
Net Denial Write-offs as % of Net Revenue	Trending indicator of revenue lost from denials	Net Dollars written off as denials / Average monthly net patient service revenue	Patient Accounting System

Back-end Key Performance Indicator(s)

	Key Performance Indicator (KPI)	Benchmark
Business Office	Discharged Not Final Billed (DNFB) Days	≤ 3.8 Days [2]
	Clean Claim Rate	≥ 84.1% [2]
	Gross Days in Accounts Receivable (AR)	≤ 43.9 Days [2]
	Net Days in Accounts Receivable (AR)	≤ 40.4 Days [2]
	Insurance AR aged > 90 days from discharge date	≤ 19.6% [1]
	Insurance AR aged > 180 days from discharge date	≤ 5% [3]
	Denial Write-Offs as a % of Net Patient Revenue	≤ 1.7% [2]
	Bad Debt as % of Net Patient Revenue	≤ 0.9% [1]

[1] National Benchmark sourced from HFMA Map Keys Map Awards 2020, based upon 50th percentile
[2] HBI 2021 Hospital Benchmarks, $0-$199M, National Average
[3] FORVIS Industry Observation

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Questions?

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Post-Polling Questions

I am ____ in my understanding of common challenges hospital revenue cycle leaders face in today's environment.

I am ____ in my understanding of best practices for front-end revenue cycle functions (scheduling, registration, etc.).

I am ____ in my understanding of best practices for back-end revenue cycle functions (denials management, cash acceleration, etc.).

I am ____ that I will apply the knowledge gained from this educational training to measure my organization's internal performance related to Revenue Cycle Management and Physician Practice Management (RCM/PPM).

Thank You

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