Delta Region Community Health Systems Development Program

Revenue Cycle Management Best Practices Guide

July 2023

525 South Lake Avenue, Suite 320
Duluth, Minnesota 55802

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $10,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Prepared by:

FORVIS

910 E. St. Louis Street, Suite 200
Springfield, Missouri 65801
Phone: 417-865-8701
www.forvisFORVIS.com

And

525 South Lake Avenue, Suite 320
Duluth, Minnesota 55802
Phone: (218) 727-9390
www.ruralcenter.org

Preface

This guide is developed to provide rural hospital executive and management teams with generally accepted best practice concepts in revenue cycle management so they may consider opportunities for performance improvement within their own hospitals and individual departments. It's also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding of the revenue cycle best practices so they may develop educational trainings to further assist rural hospitals and clinics with performance improvement.

The information presented in this guide is intended to provide the reader with guidance regarding health care revenue cycle matters. The materials do not constitute and should not be treated as, professional advice regarding the use of any revenue cycle technique or the consequences associated with any technique. Every effort has been made to verify the accuracy of these materials. The National Rural Health Resource Center (The Center), the Delta Region Community Health Systems Development (DRCHSD) Program, FORVIS, LLP, and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation and should independently determine the correctness of any particular technique before implementing the technique or recommending the technique to a client.

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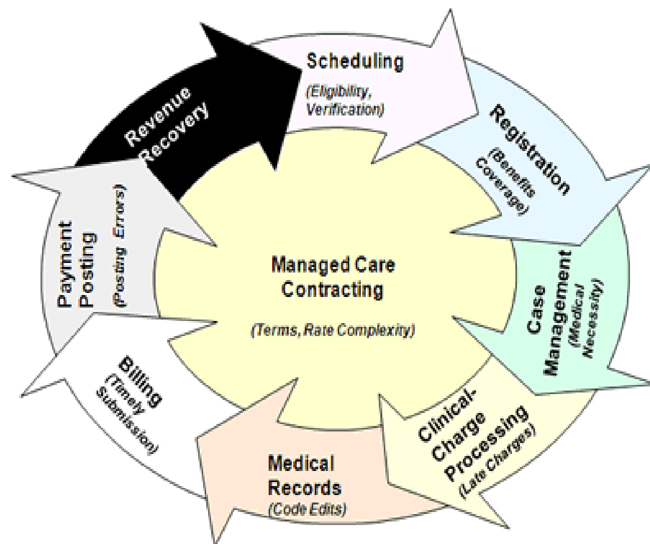
Introduction

The revenue cycle is the financial process related to a patient's clinical encounter. Optimizing an organization's revenue cycle process is dependent on that organization's payer contract mix and management, the provision of excellent customer service, a focus on optimizing Point of Service (POS) collections/payments, Accounts Receivable (AR) follow up, and compliance with payer, federal, and/or state regulations. The individual patient encounter starts when the patient is scheduled for a service. This event triggers the collection of patient demographic and payer data. This data is then utilized to verify the patient's identity and assign an appropriate payer source. Through the financial clearance process, financial conversations are initiated, and expectations are set prior to service. Registration is the next step and if a face-to-face encounter occurs at the time of service where patient financial responsibilities are collected, (copays, coinsurance, deductibles, etc.) compliance documents are reviewed and signed, and the patient's clinical chart is initiated. Once the patient is registered, the patient begins their clinical encounter where clinicians document the services rendered and the supplies that were utilized. This documentation is then used to support appropriate charge capture and code assignment for billing. Revenue Integrity Programs are recommended to ensure appropriate clinical documentation, updated charge description masters and pricing theories utilized to maximize appropriate reimbursement. After the patient is discharged all the data from above converge into the billing system where either a claim form is sent to the patient's insurance, or a statement is generated for those patients without coverage. The revenue cycle is not complete until the account has exhausted all payer sources and is closed as either correctly paid in full or uncollectible.

The Healthcare Financial Management Association (HFMA) is the leading industry organization for hospital financial management and defines hospital revenue cycle as, "*All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue*".[1] The Medical Group Management Association (MGMA) is the leading industry organization for physician practice management and defines revenue cycle as in a similar manner as, "*The financial process, utilizing medical billing software, used to track patient care episodes from registration and appointment scheduling to the final payment.*" Figure 1 provides an overview of the revenue cycle from the start (scheduling and pre-registration) to the end (billing and collections).

Figure 1: Revenue Cycle Management Cycle



[1] The Healthcare Information and Management Systems Society (HIMSS), Financial Systems Revenue Cycle Task Force; Revenue Cycle Management: A Life Cycle Approach for Performance Measurement and System Justification. 2009 -2010

In today's economic environment, it's critical that hospital administrators and revenue cycle managers utilize best practices to effectively manage the revenue cycle to optimize efficiency and maximize reimbursement. Revenue Cycle Management (RCM) has a key role in addressing shifting industry practices in response to three major trends: real-time processing, consumer-driven health care, and changes in regulations and reimbursement structures. While RCM primarily focuses on processing claims, payment, and revenue generation, it also includes patient services since care management directly impacts the reimbursement. "Revenue cycle performance is affected by those across the organization, with success dependent on support from health, department managers, information management, physicians, nurses, and information technology (IT), to name only a few. As such, key actions will be needed from both the hospital's executive team and revenue cycle leadership to attain the widespread support vital for achieving high performance."[2]

With decreasing reimbursements and as more patients paying increasingly higher deductibles, it is important to improve performance by focusing on best practices in all areas of the revenue cycle. Best practice adoption is key to long term success for any hospital. Hospitals that are more successful, develop processes to adapt and implement best practices to ensure that they are capturing reimbursement dollars and controlling expenditures. Long-term success is typically due to two key factors:

- Location and competition; and,
- Implementation of best practices.

Location and competition are difficult to change. However, best practices can be adopted and implemented by all rural hospitals of any size to improve processes, and thus, performance.

Patient Centered Revenue Cycle

Best Practice Healthcare Organizations

- ✓ Put the patient at the heart of the revenue cycle process;
- ✓ Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management;
- ✓ Provide both verbal and written explanation to patients; and
- ✓ Bring consistency, clarity, and transparency to patient financial discussions.

Creating a positive patient experience within the revenue cycle process is critical as it directly impacts the hospital financially, but more importantly, it helps to build a customer sensitive environment; an environment that emphasizes the patient care needs. Patients perceive the billing process as difficult and frustrating. The last experience the patient usually has with the hospital is with the billing. In general, this last experience is not as positive as we would prefer. Customer service is paramount for the future success of health service providers. Utilize the Revenue Cycle Team (RCT) to help build patient loyalty. It is important to think holistically about the patient as well as other family members. The more information that the organization can provide upfront to help both the patient and the family, helps to keep the patient in the center of the care and services. As the health insurance marketplace continues to move forward, hospitals should expect more and more patients to be exploring their options and asking more questions; many patients will be very confused. Hospitals should train staff to:

- Answer "marketplace" questions;
- Articulate coverage options;

[2] HFMA; Strategies for a High-Performance Revenue Cycle; A Report from the Patient Friendly Billing® Project. November 2009

- Discuss payment options; and
- Know when and who to escalate to, if necessary.

Scheduling and Pre-Registration

The scheduling and pre-registration process begins when a patient attempts to schedule an appointment involves not only the scheduling of the patient's appointment with a provider, but also the collection of data needed to allow the revenue cycle to operate in an efficient manner. This information includes, but is not limited to, patient demographic information (name, date of birth, address, social security number, insurance provider and plan details) as well as medical history, medications and other health information pertinent to the appointment being scheduled. The verification of insurance data provided by the patient should also be completed as a pre-registration function so that if updated information is needed it can be gathered prior to the actual appointment. Failure to accurately complete pre-registration functions may result in claim denials or delayed ~~delated~~ payments, which will require additional time and expense to collect payment for services rendered during the appointment.

Best Practice Healthcare Organizations

- ✓ Centralize and standardize scheduling where possible for services to allow patients to have one place to schedule all services and to inform patients of required documents and financial obligations;
- ✓ Provide scripts for staff to follow to provide consistent, high-quality customer service;
- ✓ Obtain or verify prior authorization for service is valid and approved several days prior to service;
- ✓ Educate patients about their insurance benefits to include the amount of co-payments, deductibles, and coinsurance for which the patient would be responsible for paying at the time of service;
- ✓ Conduct financial screening to identify patients early that may need financial assistance or charity care to afford services. Offer sliding fee scale options when appropriate;
- ✓ Establish financial counselors to support uninsured patients to complete assistance applications;
- ✓ Collect co-payments, deductibles, coinsurance, and patient balances from historical visits at time of service;
- ✓ Offer patient payment incentives, such as prompt pay discounts and self-pay discounts;
- ✓ Have clearly defined policies and procedures;
- ✓ Enter all services into an online scheduling system;
- ✓ Integrate information technology (IT) systems for scheduling and pre-registration functions;
- ✓ Develop process to ensure the physician order is available at the time of scheduling or a process is in place to obtain ahead of service date;
- ✓ Provide verbal and written explanation of hospital policies to the patient; and
- ✓ Provide reminder calls to patients and include discussion regarding patient balances and point-of-service (POS) collection policies, confirm third party coverage, and restate proper clinical preparation for the service.

Although not utilized for all services offered by a hospital, scheduling is the process of creating an appointment for a service or visit for a specified date and time and is performed for outpatient services including primary care visits, radiology procedures, labs, and other specialty services. Many successful hospitals utilize a centralized scheduling model, in which multiple department services are scheduled by a group of schedulers, as opposed to services being scheduled independently by department-specific staff. Centralized scheduling allows an organization to

better establish and follow uniform policies and procedures related to the scheduling process including, but not limited to, scheduling methodologies, information to be obtained from patients, pre-authorization, and patient financial responsibility. However, it should be noted that even if scheduling is centralized for most of the services provided by a hospital, surgery departments will many times perform independent scheduling functions due to additional scheduling complexities and an increased involvement of clinical staff for items such as pre-op instructions.

In addition to scheduling the actual appointment, successful scheduling departments may also be responsible for the following functions:

- Obtain and enter patient demographic information such as the patient's name, date of birth, address, telephone number, gender, and race;
- The reason for the patient's visit or pre-ordered service;
- Insurance carrier information such as the subscriber number, group number, subscriber demographic information, employer information, and preferred pharmacy;
- Pre-authorization requirements of the patient's insurance carrier; and
- A review of the patient's financial responsibility for the scheduled service and any outstanding balances.

Once a patient's appointment has been scheduled, the visit is ready for pre-registration processes and procedures to take place. Pre-registration functions include the gathering and verifying of patient demographic information, insurance benefits, authorization requirements, and potential patient's financial responsibility prior to the date of service. Typically, these procedures should be performed two days in advance of the visit by either a pre-registration/insurance verification team member, or by the scheduling and registration staff. While specific pre-registration procedures will vary from organization to organization, a sample pre-registration workflow for a dedicated pre-registration team may include:

- ✓ Automated work list of appointments with outstanding verifications (includes add-ons for days previously verified);
- ✓ Review scheduling notes and insurance information entered;
- ✓ Perform insurance verification via real-time eligibility or batch eligibility;
- ✓ Review benefits and enter coverage information such as service-specific benefits, co-payments, coinsurance, deductible, and out of pocket expenses into the insurance screen;
- ✓ Perform insurance verification for secondary and tertiary insurances, if applicable;
- ✓ Review if authorization is required and confirm if provider has received an authorization number;
- ✓ Mark insurance as verified status and from what source, if system allows;
- ✓ If an authorization is required, but not on file, contact the ordering physician's office and assess if the service needs to be rescheduled for a later date if authorization is not obtained;
- ✓ Calculate estimated patient financial responsibility in preparation for contacting the patient;
- ✓ Call the patient to perform pre-registration call. During this call, staff should:
    - Review demographic data
    - Confirm appointment date, time, and location
    - Confirm insurance information on file
    - Remind patient to bring photo ID and insurance card

    - Discuss benefits including potential or patient financial responsibility or existing patient responsibility amounts from previous services
- ✓ Enter system notes and comments regarding insurance benefits, patient discussion and promissory notes or payments made; and
- ✓ Prepare any additional paperwork needed as necessary (forms, stickers, etc.).

To improve revenue cycle performance from the time an appointment is scheduled, successful hospitals inform patients of their financial responsibility prior to the visit. The formalized process not only increases the patient's awareness, but can also assist in the collection of co-payments, deductibles, and balances at time of service. It is beneficial to implement a process by which patients can be financially screened to identify those eligible for charity care prior to receiving services.

Having a centralized scheduling process with access to schedules for all providers and locations allows the scheduling staff and patients greater ease in scheduling follow-up appointments. It also decreases the opportunity for errors and/or missing data (orders, insurance information etc.). Data deficiencies may cause delays when attempting to financially screen patients and/or confirm a patient visit.

During the scheduling process the patient's medical needs should first be addressed by gaining a full understanding of the chief complaint and services being scheduled. Standard processes and expectations to obtain basic demographic data needed to create the appointment such as the patient's name, date of birth, address, phone number, insurance provider name, and identification number should be developed and audited on a regular basis to verify needed information is obtained and correct in the electronic health record (EHR). Staff who schedule appointments should have a firm understanding of the hospital's policies and procedures; for example: how far out to schedule certain types of procedures (are there clinical implications that require a 48-hour prep, or do certain payers require prior authorization that could take up to 72 hours); how much time is needed in advance of a service for financial clearance; and which data elements are required versus those that can be obtained at a later time.

If the patient calls to schedule an appointment, staff should obtain all needed demographic and insurance information while the patient is on the phone. If the patient does not have their insurance card available, it is important to be specific that the patient will be required to provide the insurance card at the time of the appointment, as well as the facility's expectations from the patient. If the scheduler does not obtain the demographic and insurance information directly, it is important to inform the patient they will be receiving additional calls regarding upcoming service. Possible calls could be from a:

- Financial team member to discuss the patient's coverage and obligations to possibly include co-payments, deductibles, previous balances, and prompt pay and self-pay discounts;
- Clinical team member to discuss how to prepare for the service, if applicable; and
- Patient Access team member (*i.e.* scheduler, insurance verification, registration) to confirm the appointment and to provide a courtesy reminder.

Verbal, along with written explanations, are imperative to ensure the patient understands the financial process and obligations. To improve performance in scheduling and registration, hospitals should:

- Create a brochure explaining the financial process;

- Give patients a link to the hospital's website for further details. The website should be a one-stop destination for facility information, health information, forms, hospital's standard charges as posted as shoppable services, and secure messaging with the facility
- Provide a direct phone number in case the patient has further questions; and
- Repeat the same scripting at every visit to keep the message consistent.

After the appointment has been scheduled, staff initiates discussions with the patient regarding the financial obligations and requirements. Staff should be trained on how to ask for detailed insurance information and outline payment options when applicable. In addition, management should provide scripts and ongoing training for staff to support this process. See Appendix A for sample POS collection scripts.

Pre-collection has become increasingly important for rural hospitals due to the growing uninsured population and increased number of patients with high co-payments and deductibles. Best practice hospitals collect co-payments, past due balances, and deductibles at the time of service. Formalized, well-communicated policies and procedures related to POS collections may improve patient satisfaction due to patients having expectations and a better understanding of the charges before receiving the service, which reduces anxiety and confusion by the patients.

It is essential that the hospital's financial policies are up to date and communicated clearly with all team members, as well as the clinical team in case a patient asks while in the room with the nurse, technician, or provider. Specifically, the hospital's financial counseling staff should:

- Use the data received from the payer to discuss out of pocket amounts including deductibles, co-payments, and coinsurance;
- Inform the patient of the hospital's financial assistance and payment policies. The financial assistance policies should define the patient's payment options to include acceptance of credit cards or making payments over time. The policies should also outline options for the staff to exercise if the patient is unable to pay out-of-pocket costs in a timely manner; and
- Understand and be able to execute a formal payment arrangement, help with loans, and identify areas where a patient may qualify for other coverage and/or financial assistance.

In addition, staff should:

- Ask the patient if they are interested in learning more about payment options;
- Ask the patient if they are interested in learning more about financial assistance options;
- Attempt to resolve prior balances; and
- Provide the patient with written information regarding financial assistance, summary of obligations, and include a phone number for questions.

To improve visibility in upfront performance, the RCT should show support for POS cash collections and monitor back-end activity for registration-related denials and write-offs. The RCT should also consider creating a percentage of net revenue targets and track against POS cash collections by registrar, financial counselor, department, and site. Lastly, the RCT should determine and track the actual versus expected POS collection based on the patient's plan and required co-payments and deductibles.

Patient Registration and Admissions

Best Practice Healthcare Organizations

- ✓ Complete patient insurance verification for all visits;
- ✓ Pre-determine if services will meet medical necessity;
- ✓ Provide the Advanced Beneficiary Notice of Non-Coverage (ABN) to all patients when Medicare may not cover a provided service;
- ✓ Utilize electronic tools such as to clinical decision support for evaluating patient placement;
- ✓ Provide ongoing education on medical necessity to clinical and non-clinical staff;
- ✓ Identify charity care patients early and offer sliding fee scale options when appropriate and in accordance with organizational policies;
- ✓ Collect co-payments, deductibles, and previous balances at time of service;
- ✓ Offer prompt pay and self-pay discounts; and
- ✓ Have clearly defined policies and procedures.

Registration is the process of gathering and verifying patient demographic information, insurance benefits, authorization requirements, and potential financial responsibility at the time of service. The patient interaction sets the tone for the patient visit from a customer service perspective. In addition, this process is important for patient information gathering, and patient education due to the patient being present. Registration could be centralized in one area for all patients, could be done individually in each ancillary department, or a combination of the two, depending on the space availability in the facility. The amount of time (three to five minutes on average) required to register a patient will vary based on the success of scheduling and pre-registration or if the patient is a "walk-in." Additional actions performed at time of service include completing consent waivers and collecting payments.

Registration encompasses a full verification and review of patient information and arrival of a patient. Generally, the more work done before the visit, the easier the registration process. Depending on system capabilities, facility practices, and contact with the patient prior to the visit, the amount and type of work per patient may vary greatly. The process is similar for inpatient, outpatient, emergency department and clinics, but with slight variations:

- The emergency department starts with a "quick registration" process with basic information such as patient name, date of birth, and reason for visit is obtained. The full registration is then completed after the patient has been medically cleared per Emergency Medical Treatment & Labor Act (EMTALA) guidelines.
- Clinic registrations typically do not include requests for living wills and a few other details.
- Inpatient and high dollar outpatient procedures are very important given the higher value of the typical claim.

A sample of a full registration workflow may include:

- Arrival and greeting of the patient;
- Explanation of the registration process;
- Review scheduling/pre-registration notes and insurance information, if applicable;

- Perform insurance verification via real-time eligibility, batch eligibility, insurance payer websites, or other means if needed;
- Review benefits and enter coverage information in the insurance screen of the EHR;
- Perform insurance verification for secondary/tertiary insurances, if applicable;
- Review if authorization is required for services and confirm if scheduling team has already received the authorization number;
- Mark insurances as verified status (depends on system capabilities);
- If no authorization is on file and is required by the insurance carrier, contact the ordering physician's office;
- Calculate potential patient financial responsibility and communicate the information to the patient;
- Review demographic data, scan the patient's photo identification and insurance cards, obtain necessary signatures, and discuss benefits including potential or prior balance patient financial responsibility;
- Enter system notes/comments regarding insurance benefits, patient discussion, payment arrangements made and/or payments made; and
- Key Performance Indicators (KPI) related to the patient access function used to measure and monitor performance are included in Appendix D.

Revenue Integrity

Best Practice Healthcare Organizations

- ✓ Have clearly defined policies and procedures related to revenue integrity functions;
- ✓ Have a Clinical Documentation Integrity (CDI) team to improve clinical documentation;
- ✓ Hold department managers responsible for monitoring revenue and usage via charge reconciliation processes;
- ✓ Educate and train staff on appropriate charging and reconciliation processes;
- ✓ Invest in a strong charge description master (CDM) team and maintenance process;
- ✓ Develop pricing strategies based on market-based data;
- ✓ Perform an annual review to update pricing;
- ✓ Post hospital standard charges prominently on a publicly available website as required by Centers for Medicare and Medicaid Services (CMS);
- ✓ Identify and monitor departments with charge capture issues and develop processes for improvement; and
- ✓ Establish an interdisciplinary team with a goal of overseeing processes such as:
    - Conducting chart audits
    - Monitoring revenue and usage
    - Overseeing CDM issues
    - Determining billing issues related to charges
    - Reviewing managed care contracts
    - Monitoring pricing updates

Revenue integrity encompasses a multitude of activities and departments to reinforce compliant capture of charges, supported by clinical documentation, and the process of confirming prompt accurate payments. The basis of a strong revenue integrity process is clear, accurate, and complete clinical documentation. Education and training regarding documentation and its positive and negative impacts should be provided to clinical staff routinely. As outlined above, a CDI program can facilitate the process for obtaining appropriate documentation. Charge capture efforts are important in building a culture focused on the importance of revenue integrity. Charges should reflect the services that were provided to the patient and supported by the clinical documentation contained within the medical record. Key components to an effective charge capture process include:

- Having policies and procedures that outline the expectations of department managers regarding charge capture efforts:
  - Timely posting of charges (usually within three to five days of service)
  - Understanding how charges are posted (manually, based on test results, based on documentation, etc.)
  - Reports available to monitor revenue and usage by department
  - Charge reconciliation processes
  - How to report concerns regarding charge capture issues
  - How to request a new charge code
  - Process for monitoring codes for deactivation
- Providing education and training to new managers regarding the charge capture process and expectations outlined in the policies and procedures; and
- Regular CDM management/staff meeting with departments to review reports, discuss available charges and changes related to quarterly and annual Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) changes.

Chargemaster oversight and processes also are key to strong revenue integrity. The CDM contains the charges for the services and items (*i.e.,* drugs, and supplies) that can be provided to a patient. The CDM houses key pieces of information that are crucial for cost reporting, especially in a rural or critical access hospital (CAH). Important processes for an effective CDM are:

- Assigning consistent information to charges; revenue code, description, CPT/HCPCS, and pricing;
- Ensuring that expenses incurred by a department for a service or item provided are aligned with the revenue billed for that service or item;
- Having policies and procedures that outline the process for charge code maintenance from creation, necessary updates, and routine review of deactivation;
- Having policies and procedures that clearly define criteria such as:
  - What is considered a compliant chargeable supply
  - What is considered an implant
  - What is considered a chargeable nursing intervention
- Having a pricing strategy that is defined, followed, and updated as necessary; and
- Having a line of communication between the CDM team and the Coding Department. Coding needs to be aware when codes are created or deactivated and what areas have CPT/HCPCS assigned by the

CDM (“hard” coded) or by the Coding Department (“soft” coded).

While compliant charge capture is an essential focus of revenue integrity efforts, preventing charge leakage, not capturing all charges that support documentation, is a common problem that can be addressed through revenue integrity efforts. Common areas where revenue leakage can occur include:

- Nursing interventions – also called bedside procedures. These charges can be easily overlooked as an opportunity to capture the costs associated with patient care.
  - Procedures such as urinary catheterizations, wound care, infusions and injections are common procedures that may not be charged by nursing staff for either inpatient, outpatient, or observation patients.
- Injections and Infusions – loss of gross and net revenue is common for areas that perform injections and infusions. With complicated rules and guidelines, correctly and compliantly capturing injection and infusion charges can be a challenge.
  - Documentation requirements for start and stop times and understanding the hierarchy for assigning the codes are crucial.
  - In order to have a successful charge capture process for infusions and injections, it is critical to have a team of individuals who are effectively trained in the rules and guidelines of injection and infusion coding, as well as reviewing accounts to either validate or perform the charge capture.
- Emergency Department (ED) Charges – technical or facility ED evaluation and management (E&M) charges, as well as technical ED procedure charges, are another area where charge leakage occurs.
  - Having a policy and procedure in place that provides guidance for determining the technical ED E&M level is essential to determining the charge, and supporting the charge, should a payer question or deny the charge methodology.
  - Compliantly charging for procedures performed in the ED, in addition to the ED E&M level, can be challenging without strong policies and procedures and educated staff to either validate or perform the charge capture in this department.
- Pharmacy – charges from the pharmacy department have historically been an area of charge leakage. Documentation to support the administration of the drugs, appropriately assigning HCPCS codes, and converting administered units to billable units are vital to successfully capturing pharmacy charges.
  - Understanding how the pharmacy department submits charges is crucial; charging on dispense of a medication or administration of a medication will drive how reviewing charges should be performed. Facilities that charge on dispense need timely processes in place to credit charges for medication that was dispensed but not administered. Facilities that charge on administration need to review processes for medication that was dispensed but not documented as administered to determine lost revenue.
  - HCPCS code assignment should be routinely reviewed to update medication charges with appropriate HCPCS codes. Accurate HCPCS code assignment is important to reflect the medications administered as well as additional reimbursement may be obtained by some managed care payers based on contract terms.

    - Ensuring the conversion of administered units to billable units is correct is crucial to compliant billing. Once a HCPCS has been identified for a medication, reviewing the HCPCS description with the available dosages will determine the conversion factor needed to accurately report the medication administered. For example, 100mg of Medication A was administered to a patient and the HCPCS for Medication A is "per 50mg", therefore the billable units would be two (2) (100mg/50mg = 2)

High performing hospitals with successful revenue integrity programs also develop an interdisciplinary team to help oversee the revenue integrity process. The team should consist of revenue cycle and clinical members who meet at least monthly regarding:

- Development and approval of policies and procedures related to charge capture;
- Education and training needs and updates related to charge capture;
- Monitoring revenue and usage per department and/or services lines to evaluate for variations/trends;
- Oversight for the internal audit chart review process to validate compliance with charge capture policies and procedures;
- Development of pricing strategy and analysis related to price increases;
- Review and monitoring of issues regarding CDM maintenance;
- Discussion of billing issues related to charges to determine resolution; and
- Review third party contracts and identify areas that may need to be addressed in upcoming payer negotiations.

While many aspects of revenue integrity may already be performed within a facility, formalizing these processes under the revenue integrity name, and fostering a culture of revenue integrity can improve documentation, charge capture, and ultimately the hospital's bottom line.

Clinical Documentation Integrity (CDI)

Clinical Documentation Integrity (CDI) ensures health information accurately captures complete and specific provider documentation that will result in improved coding, reimbursement, severity of illness, and risk of mortality classifications. Hospital staff that contribute to CDI include Health Information Management (HIM) professionals, nurses, and physicians who have strong backgrounds in clinical and/or HIM coding. Key skills for CDI professionals include:

- Strong knowledge of coding guidelines and medical terminology;
- Strong ability to understand clinical indicators within the body of the health record;
- Strong written and verbal skills required to communicate and engage physicians and other health care providers;
- Knowledge of regulatory reimbursement methodologies and documentation requirements; and
- Ability to effectively write compliant queries.

The CDI professional should be provided with ongoing education and training to keep up with industry changes including government rules and regulations as well as updated coding guidelines and the American Hospital

Association's Coding Clinic. Due to the size of the facility, training may include webinars, seminars, or in-person conferences where CDI individuals can network and learn from each other.

A best practice is to have a physician advisor that can champion supporting quality documentation practices and engage the physicians and clinicians by addressing admission denials, Diagnosis Related Group (DRG) revisions, and other documentation discrepancies that may lead to poor quality care. A physician advisor may also sit in on the Utilization Review (UR) Committee and assist in inpatient medical necessity denials due to incorrect patient status. A physician advisor is essential in the success of any CDI program. To ensure an effective CDI program, top leadership should be engaged physicians and provide support to implement and sustain a CDI program. CDI programs should be measured to identify successes and the need for possible improvements. The following CDI metrics should be monitored:

- Case mix index (CMI);
- CDI professional's review rate;
- Query rate, response rate, and response time; and
- Quality and reimbursement impact.

Refer to CMS *Documentation Matters Toolkit* to learn more about "providers responsible for documenting each patient encounter completely and accurately, and on time."[3] For more information on CDI metrics, processes and programs, refer to American Health Information Management Association's Clinical *Documentation Improvement Toolkit* (membership login is required).

Emergency Room Admissions

Best Practice Healthcare Organizations

- ✓ Assess how the ED reaches the Evaluation & Management (E&M) levels;
- ✓ Determine the actual distribution of E&M levels following correction;
- ✓ Pull out procedure charges (i.e. critical care codes and radiology services) and bill separately;
- ✓ Monitor the emergency room (ER) admission rate for inpatient and observation services;
- ✓ Manage an ER re-direct program to collect co-payments, deductibles, and any previous balances from non-emergent patients following the EMTALA screening and/or attempt to move the patient to the more appropriate level of care by either redirecting the patient to a walk-in clinic or scheduling the patient in the clinic the next day; and
- ✓ Have clearly defined policies and procedures.
- ✓ Determine if the patient's visit to the ED was the result of a work accident, car accident, or other medication condition as this will determine the organization that is financially responsible for services rendered.
- ✓ Define the discharge site for the patient (home, observation, inpatient admission, skilled nursing, etc.).

Some patients are admitted directly through the ER. Best practice hospitals monitor the admission rates for inpatient and observation services to evaluate if hospitals are placing patients in the right level of care. Patient placement has a direct impact on reimbursement. The Centers for Disease Control and Prevention (CDC) cites a

3 Centers for Medicare and Medicaid Services; Documentation Matters Toolkit; December, 1, 2021.

national baseline average of 12.4% of all ED visits are admitted to their inpatient units.[4]

For patients who are inpatient, a financial counselor should visit the patient's room before the patient is discharged. It is helpful when the clinical and financial teams work together to assist the patient with understanding financial obligations and options for payment.

High performing hospitals develop and implement an ER re-direct program that stops services being provided to non-emergent patients following the EMTALA screening. Patients who are deemed non-emergent following the EMTALA screening are re-directed back to registration to collect co-payments, deductibles, and any previous balances. Preferably, staff makes the patients aware of the additional costs associated with the ER visit and provides the patient with other primary care options such as walk-in clinics. High performers assist with scheduling the patient in the hospital's clinic. Alternatively, if the patient decides to continue to seek care through the ER, then registration collects co-payments, deductibles, and any previous balances at that point, prior to completing the ER visit with the physician.

In addition, high performing hospitals assess how the ER reaches the E&M levels. This action allows the hospital to report levels more accurately that better reflects the actual services rendered. The hospital may then bill procedure charges separately. Typically, processes are not in place in the ER to capture revenues, which commonly result in significant charge capture issues and negatively impact revenues. In addition, the E&M levels for CPT codes (particularly 99281 – 99288 are frequently reported incorrectly and may include other services. Thus, the assigned levels and overall distribution do not reflect actual services provided. Most likely, E&M is 'overstated' and other billable service are missed. Medicare claims they expect the E&M distribution should be more of a bell curve.

Successful facilities conduct a process review to determine how each level is reached. This allows the facility to report levels that more accurately reflect the services rendered. High performing facilities also determine the actual distribution of E&M levels following correction of assigning levels, and further assess to conclude if the levels and the explanations for differences are feasible. For example, does the ER have more than normal non-emergent patients? Facilities may also pull-out procedure charges and bill separately, especially in CAH. This process improvement typically results in increased gross revenue by correctly assigning E&M levels and charging for other billable services.

Charge Capture and Coding

Best Practice Healthcare Organizations

- ✓ Use concurrent coding to improve medical necessity documentation;
- ✓ Hold weekly nursing and HIM team meetings to discuss medical necessity documentation and charge capture opportunities;
- ✓ Hold ancillary department managers responsible for reviewing the prior day's charges in order to identify errors;
- ✓ Train ancillary staff on appropriate charging and reconciliation;
- ✓ Hold weekly interdisciplinary team meetings to engage managers and build department accountability;
- ✓ Hold weekly interdisciplinary team meetings to determine issues that put the facility at risk, which may include:

4 Centers for Disease Control and Prevention, National Center for Health Statistics: Emergency Department Visits, April 2021.

  - Conducted chart audits
  - Review system reports such as one-day stays and cumulative totals for each ER level
- ✓ Develop processes that clarify what a separately reportable charge for outpatient services is;
- ✓ Develop a process for regularly reviewing pharmacy charges by auditing the medical records versus charges and claims for injections versus drugs;
- ✓ Establish a formal process that involves the business office and department managers to review existing charge codes and to establish new charge codes;
- ✓ Develop pricing strategies based on market-based data;
- ✓ Perform an annual review to update pricing;
- ✓ Hold quarterly meetings with department managers and Business Office (BO) to conduct a review and update chargemaster;
- ✓ Review third party contracts; and
- ✓ Have clearly defined policies and procedures.

To improve charge capture, staff should clearly communicate suspense times to the departments and state it in the policies and procedures. Suspense times are strict timelines placed on clinical departments to enter compliant, audited, and correct charges for services rendered. It is important to remember each day charges are not entered and fall out of "suspense" can cause negative effects on the facilities days in accounts receivable (A/R) outstanding as well as cash flow. Systematic reviews of the chargemaster are essential to ensure that hospitals are capturing all revenue correctly and are not leaving dollars on the table. However, it's important to note adjustments to the chargemaster create downstream effects to the cost reports. In addition, no matter how up to date the chargemaster is, the chargemaster is not effective until there are processes in place to ensure that the charge is captured. Therefore, high performers have processes in place that tie charges to a compliant cost report.

Charges for rural services, particularly in CAH, are frequently below PPS and larger urban facilities for the same services (*i.e.,* same procedure or same E&M level). This is commonly due to lack of appropriate pricing strategy. Best practice facilities develop a pricing strategy based on market data through commercial sources and/or Medicare Provider Analysis and Review (MEDPAR) claims data (MEDPAR files contain data from claims data with CPT code and average pricing) to reach 75th percentile pricing. MEDPAR files also develop an annual evaluation process to update pricing and review third party contracts.

Charge capture, in general, is a significant performance improvement opportunity for a majority of rural hospitals. Common areas that result in lost revenues are outpatient nursing procedures and pharmacy. Examples of outpatient services typically missed include IV therapy, injections, and Foley catheter insertions.
Many hospitals miss these charges and lose revenue because of lack of proper nursing documentation. Best practice facilities have teams from nursing and HIM meet weekly to discuss documentation and charge capture opportunities. The Chief Nursing Officer (CNO) or Director of Nursing (DON) leadership is critical to ensure both the documentation is provided, and the charges are captured. To improve performance, it's important for hospitals to develop and implement processes to capture revenues for services that are rendered. The hospitals also hold weekly interdisciplinary team meetings to review charge master for any potential CMS Recovery Audit Program (RAC) issues, conducted chart audits, reviewed system reports such as one day stays, and cumulative totals for each ER level. The interdisciplinary team should be composed of representatives from the BO, admissions, nursing, care/case management, and HIM. The purpose of the team is to determine issues that put the facility at risk, engage managers, and build department accountability. Ideal processes include:

- Clarification of what is a separately reportable charge for outpatient services;
- Nursing documentation that affects charge capture such as start and stop times, site, and drugs;
- Weekly nursing and HIM team meetings to discuss documentation and charge capture opportunities;
- Regular review process to ensure that charges are not being missed in pharmacy by either auditing the medical records versus charges or reviewing the claims for injections versus drugs;
- Appropriate reporting of pharmacy dispensing units; and
- Regular review of pharmacy charges.

Commonly in pharmacy, hospitals lose revenue by missing charges or errors in properly reporting of units. Most missed pharmacy charges are due to overreliance on systems to document dispensing units and unit conversion factors. Successful facilities have processes in place to review the charts and claims for potentially missed pharmacy charges.

Utilization Review and Care Management

Best Practice Healthcare Organizations

- ✓ Have clearly defined roles differentiating utilization review and care (case) management functions;
- ✓ Utilize non-clinical support team members to perform as many of the non-clinical administrative tasks as possible;
- ✓ Include in the Utilization Review Committee, members from multiple disciplines including, utilization review, case management, revenue integrity, compliance, contracting, clinical documentation improvement, and other areas where operational change in one area can significantly impact the performance of another;
- ✓ Monitor length of stay trending and impact on throughput and revenue;
- ✓ CAHs are required to maintain an annual average length of stay (ALOS) of 96 hours or less;
- ✓ Convene the Utilization Management oversight committee to meet monthly, and include data related to outlier cases, clinical denials, length of stay (LOS) trending, by floor, physician, and MS-DRG;
- ✓ Utilize a physician advisor with concurrent denial peer to peer process with payers;
- ✓ Have thorough understanding of the Medicare 2 Midnight Rule[5] and retrospectively review all Medicare stays with a zero to one-day length of stay for status appropriateness;
- ✓ Ensure medical necessity for admissions, by applying current, admission criteria to 100% of medical cases placed in hospital beds with a time-specific deadline after admission;
- ✓ Use the utilization review process to verify physician admission orders, patient class, admission date and time in the EHR and the Admission Discharge Transfer (ADT) event system (if separate);
- ✓ Document admission reviews, discharge planning, and related care planning in an auditable format that demonstrates a consistently followed care management process;
- ✓ Automate payer notification of hospitalization when possible;
- ✓ Utilize criteria to identify the patients who are likely to have the most complex discharge planning needs early in the patients hospitalization;

5 Centers for Medicare and Medicaid Services, Fact Sheet: Two-Midnight Rule

- ✓ Perform review of readmitted patients to identify root-cause and develop prevention actions going forward; and
- ✓ Identify the post-acute service providers where high volumes of patients are discharged to, and form mutually beneficial relationships.

There are two core functions of hospital care management, which include admission and continued stay reviews for medical necessity, and effective discharge planning. These two functions are often referred to as utilization review and care (case) management and may reside within a variety of areas within a hospital, depending on the organizational structure. Each of these functions are outlined as requirements in the [CMS Conditions of Participation (CoPs)]. [6]

A care management program is not only a key component to a hospital's patient flow and regulatory compliance success, but is a significant contributor to the success of the middle of the revenue cycle. Without question, a strong review and coordination framework upfront can reduce the number of clinical denials, assure appropriate bed usage and LOS, and improve the efficient use of hospital resources. Components which are core in consideration to a strong acute care management program:

- Compliance with federal and state requirements;
- Medical necessity determination criteria and guidelines in place, and accuracy of application;
- Care Management Committee governance, participation, accountability, function, and integration with other parts of the organization;
- Integrative approaches using a combination of lean management, quality improvement, and operational engineering principles; and
- Use of data analytics to identify variation in length of stay patterns, transfers, patient status determinations, and outlier patients.

Timely Filing

Best Practice Healthcare Organizations

- ✓ Monitor the filing of claims in accordance with payer requirements;
- ✓ Determine the percentage of claims not filed before the timely filing deadline;
- ✓ Developing a transaction code used to track write-offs due to timely filing; and
- ✓ Have clearly defined policies and procedures to be followed by billing staff.

Many hospitals fail to file initial claims, or respond to a claims appeal, in a timely manner due to inefficient or unmonitored processes, resulting in missed filing deadlines for either the initial timely filling deadline or the appeal timely filing deadline. Medicare allows the initial claims to be submitted within one year of the date of service, but many commercial payers require claims to be submitted within 90 days. Additionally, Medicare allows only 120 days to respond and appeal a claim denial, while many commercial payers may require anywhere from 90 days up to one year based upon specific state and payer guidelines. Therefore, it is important to have processes in place to not only submit claims in a timely manner, but also continually monitor claims on hold to ensure timely filing deadlines are not missed.

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6 Centers for Medicare and Medicaid Services, State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals; February 21, 2020

Progressive administrators develop and implement processes to monitor the filing of claims, and continually track the percentage of claims not filed before the deadline. Many times, senior leadership may be unaware of lost revenue due to claims not being submitted in a timely manner. By continually monitoring the percentage of claims not filed in a timely manner and the dollar amount of write-offs due to missed deadlines, senior leadership can have a better understanding of needed process changes and other performance improvement opportunities. The outcome of a more formal process related to timely claim filing commonly results in significantly decreased non-contractual write-offs and increased revenue due to properly submitting the claim within payer guidelines.

Billing and Collections

Best Practice Healthcare Organizations

- ✓ Stratify the accounts by amount and aging to prioritize efforts;
- ✓ Identify Medicare separate from commercial accounts;
- ✓ Work closely with the organization's clearinghouse to submit claims electronically to payers and implement needed claim edits to meet the requirements of those payers;
- ✓ Have clearly defined policies and procedures; and
- ✓ Educate staff on:
  - Payer contract requirements
  - How to verify coverage
  - How to appeal coverage determinations
  - Timely filing rules
  - Fee schedules
  - Special billing requirements

Initial billing drives over 80% of the cash flow in an average facility and is critical to the overall health of the business. Billers are expected to know what each payer allows and rejects on claims, but integrated billing editor software and healthcare clearinghouses greatly improve the efficiency and accuracy in capturing potential errors. To maximize efficiency, edits contained within the bill scrubber and clearinghouse should mirror the payer claim acceptance rules to prevent any rejections from occurring. Such rejections may be the result of a claim not meeting National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). In larger facilities, it is a full-time job to maintain these edits and ensure claims are transmitting properly from the bill scrubber and clearinghouse to the payers, but for smaller facilities these functions may need to be performed on a part-time basis due to other functional requirements. However, if these functions are performed on a part-time basis, they need to remain a top priority to avoid decreases in billing performance.

Rejections result from an edit not capturing an error on the outbound claim which gets sent back immediately from the payers without any entry into the facilities processing system. Such rejections may be cause of Rejections are important to monitor because claims rejected are not registered in the payer's system for timely filing purposes. Billers should work these claims as a best practice, while focusing on the cause for the rejection to prevent the rejection from occurring in the future.

Billers are also responsible for rebills generated through denial follow up. Rebill claims may be fixed by follow up staff, but other times a request is sent to the biller to make the specified fix and generate a rebill. Regardless of how rebill claims are fixed, the denials should be continually tracked and reported so a root cause can be determined and addressed, either through a system update or a manual process change. Doing so may help increase the efficiency of the revenue cycle through the decrease in total claim denials.

Similarly, secondary billing is a downstream process once the primary payer pays. Medicare will automatically crossover the secondary claim to the correct payer, but most other payers require a biller-generated claim with proof of the primary payment and adjustment amounts.

Whether medical claims are billed electronically or through paper claim forms (CMS-1500 or CMS-1450), it is imperative medical office staff follow-up with insurance carriers to obtain claim statuses. Once the bill has been received by the insurance company, organizations do not have to be at their mercy to receive payment in a timely manner.

Depending on billing methods, organizations should expect to receive payment in as little as 15 days (government payers). If insurance payments are averaging a turnaround time of longer than 30 days from the time claims are sent out until payment is received, the BO needs to develop a process for claim follow-up. A formal process to follow up on the status of claims has been shown to decrease the number of days claims are outstanding.

Most managed care contracts allow insurance carriers 30 days to respond to claims without penalty of interest. However, this does not mean carriers are required to pay the claim within that time frame. Developing a collections policy for medical claims may help to ensure claims will be paid in a timely manner.

The main objective of follow-up procedures is to ensure the management of collection activity is performed on encounters with insurance balances. This should be conducted in a manner that provides a level of cash flow consistent with financial expectations, minimized revenue loss related to third party denial activity, and provides proper internal controls. Clear expectations should be communicated to employees responsible for follow-up procedures. It is also imperative to provide management with appropriate control and oversight necessary to manage, monitor, and improve this critical function.

Monitoring, tracking, and reporting of billing and A/R collections performance is essential to effective revenue cycle and cash resolution. Identifying trends and root causes of aged and uncollected AR is critical for mitigation of key issues. To effectively manage accounts receivables hospitals should monitor performance by using KPI's included in Appendix D below:

Denial Management

Best Practice Healthcare Organizations

- Monitor denials for reporting and resolution;
- Offer utilization management services for assisting physicians in determining appropriate status assignment for Inpatient and Observation services; and
- Designate a team of individuals to appeal denials for reconsideration of payment.

Monitoring, tracking, and reporting of denials are essential functions of a successful denials management program. Identifying trends and root causes of denials are critical steps in moving from denials management to denials prevention. To effectively prevent denials, hospitals should monitor KPI and communicate the denials to departments through the RCT High performers track and report by:

- Denials by payer and type, reason, and department
- Percentage of revenue submitted
- Denials as percent of gross revenue and net revenue
- Remittance Denial Rate

- Clean Claim Rate %

Hospitals that can define, identify, track and report denials by various attributes can be successful at determining process breakdowns and opportunities for performance improvement. Best practice denial management strategies can result in a reduction in A/R, increase in cash, increase in clean claim rates, decrease in denials volume, and a lower cost to collect rate.

Denial management programs should include:

- Clearly defined policies and procedures regarding the identification, tracking and reporting of denials;
- Reporting tools and analytics to monitor denials information as outlined above;
- An interdisciplinary team of revenue cycle and clinical leaders who have ownership over processes impacted by denials;
- Ongoing meetings with the interdisciplinary team to discuss denial trends and issues and develop work plans to identify root causes for process improvement;
- Education and training for staff that focuses on standardized processes to mitigate denials risk; and
- Reporting to hospital leadership regarding denials analytics, process improvement initiatives, and education and training plans.

Depending on the type of denial, an appeal may be necessary to overturn the denial and receive payment for the service(s) rendered. Key components to include in an appeal process are:

- Determine payer specific appeal requirements. Requirements may include appeal time frame, specific appeal language, forms, templates, addresses and/or processes that must be followed for the appeal to be accepted;
- Research denial reason and review clinical documentation of the denial to determine validity of appeal and the appeal argument;
- Include supporting documentation from the patients medical record and reputable sources like MCG, InterQual®, coding citations as applicable and, if clinical guidance is necessary for appeal, commentary from attending physician or medical director;
- Create a standardized appeal template that includes patient specific demographics and identifying hospital information;
- Include in appeal documentation the hospital's understanding of the denial (inappropriate status, medical necessity, etc.) and the reason the hospital disagrees, citing sources to bolster the hospital's position; and
- Indicate the hospital's expectations to resolve denial: overturn of denial, payment of service(s) and resolution within specified contracted limits.

Common clinical departments and process that are prone to denials are:

- Registration – incorrect identification of insurance or not validating eligibility at the time of service;
- ED – lack of medical necessity of tests performed (i.e.,. MRI, CT, etc.) or a down-grade in hospital ED level as ED visit was deemed "non-emergent" by the payer;
- Inpatient Admission – inappropriate patient status for a short-stay inpatient admission;

- Radiology – lack of medical necessity or lack of prior authorization of test performed (MRI, CT, Nuclear Medicine, etc.);
- Pharmacy – lack of pre-determination or prior authorization of medication given. Denials can also occur for inappropriately reporting billable units; and
- Surgical Cases – lack of prior authorization for service(s) rendered or procedure performed is an Inpatient Only Procedure.

Implementation of denial prevention processes are critical to mitigate denials from occurring. Processes can range from basic procedures to sophisticated large scale process improvement efforts. Basic key components for denials prevention are:

- Knowing contract terms and provider specific requirements regarding pre-determination, prior authorization, and clinical determination processes for inpatient admissions;
- Implementing a registration quality assurance (QA) process for staff to determine error rates, education, and training needs for selecting correct insurance and running eligibility; and
- Developing workflows to identify and perform prior authorization and pre-determination prior to rendering service(s) or immediately thereafter in emergency situations.

Revenue Cycle Key Performance Indicators

Best Practice Healthcare Organizations

- ✓ Hold weekly RCT meetings;
- ✓ Track and monitor KPI; and
- ✓ Utilize dashboards to drive performance

Hospital performance improvement, particularly within the revenue cycle, is dependent upon ongoing monitoring of KPI along with effective management includes department accountability. However, leadership cannot accurately understand and track revenue cycle KPI without continually updated reporting and benchmarking outlining current performance levels. This information is best presented using dashboards or scorecards so leadership may be provided with insights needed to address trends or fluctuations before monthly financial statements are finalized and issued. It is also very important to utilize the dashboards and scorecards to manage progress towards established goals. For example, if the organization's goal is to reduce days in A/R by 10% by next year, the organization should have a dashboard or scorecard that shows the current days in A/R as well as historical values so it can determine if current efforts have been effective.

While the RCT should assume ownership of the development and completion of dashboards, the information contained in those dashboards should be regularly communicated to top leadership. C-suite involvement is essential to ensuring financial success of the organization and critical for ongoing performance improvement. Table 1 defines roles and responsibilities in a high-performance revenue cycle.

Table 1: Roles in a High-Performance Revenue Cycle

	People	Process	Technology	Metrics	Communication	Culture
C-Suite	Set high expectation for revenue cycle (RC) positions Devote organizational resource to improved training and compensation	Develop and participate in intraorganizational teams around RC Use patient experience as the cornerstone for setting RC strategy	Appreciate community dynamics and those with the greatest impact to the organization when prioritizing technology needs	Encourage improved monitoring of RC processes through use of traditional and nontraditional metrics Develop and enforce systems of accountability around monitoring and reporting practices	Support organizational alignment around clear, correct, and patient-friendly messaging Set clear and transparent financial assistance policies and procedures	Demonstrate value for the RC through significant commitment of time and resources Establish systems to reward high RC performance
Revenue Cycle Leadership	Apply high standards to hiring Emphasize education Take a career approach to RC positions Leverage compensation and work arrangements for employee satisfaction	Use formal structures to obtain stakeholder input Target RC improvements around the consumers' experience Adopt established improvement methodologies including those not traditionally used in health care	Selectively use technology for interactions with customers Manage for investment value Dedicate IT staff to the RC	Measure and report frequently Look beyond traditional metrics for success Seek the consumer's perspective	Drive a positive scheduling / registration experience Provide estimates of financial obligation Promote financial assistance Support clear and simple billing and collections materials Recognize the importance of external communication	Support RC at the highest level Garner appreciation for the RC from nonfinance staff Find purpose through the patient Demand high performance Celebrate success Make innovation a priority

It's important for senior leadership to publicly support the notion the revenue cycle is not purely about financials, but it is a hospital wide responsibility as well as a patient responsibility. High performing hospitals hold regularly scheduled RCT meetings, at least two times per month, to address systemic issues, reduce silos within the revenue cycle functions as well as between revenue cycle and clinical departments. The RCT may also choose to hold informal dashboard review meetings on at least a weekly basis to review metrics including, but not limited to, charges, patient volume, payments, A/R, days in A/R, clean claims percentage and denial percentage.
Leaders that create a positive change and influence a culture do so by driving performance standards that are backed by real data. Leaders also share goals with their teams and help the teams understand:

- How goals are established;
- How individual accountability is just as important to oneself as it is to overall good of the team and the hospital over-all;
- Support the team, management will have real-time course correction plans to influence improvement
- Demonstrates progress will be measured daily/weekly/monthly;
- Management will report positive as well as negative results with senior leadership as well as the entire team; and
- There will be accountability for all actions taken and those actions missed.

High performers benchmark against national standards and historical performance, established targets, as well as track and monitor KPI in a dashboard to drive performance. **Table 2** below shows commonly tracked rural relevant KPI. Appendix D provides a list of HFMA recommended KPI. HFMA selected the KPI to represent the entire revenue cycle and subdivided the KPIs into four process areas: management, patient access, revenue, and claims. For small rural hospitals, the *CAH Financial Leadership Summit Summary* recommends financial KPI and leaders can access comparative measures through the *CAH Financial Indicators Report: Summary of Indicator Medians by State Report*.[7,8]

[7] The National Rural Health Resource Center; Critical Access Hospital; Financial Leadership Summit Summary; Updated June 2022
[8] The Flex Monitoring Team; CAH Financial Indicators Report: Summary of Indicator Medians by State, May 2022

Table 2: Common Revenue Cycle Key Performance Indicators

Revenue Cycle Management Area	Tracking Measurement
Patient Access	Point of Service Collections to Net Patient Service Revenue
	Insurance Verification Rate
Pre-Billing & Claims	Discharged Not Final Billed (DNFB) Days
	Discharged Not Final Billed (DNFB) Days Discharged Not Submitted to Payer (DNSP) Days
	Clean Claim Rate
Account Resolution	Gross Days in Accounts Receivable (AR)
	Net Days in Accounts Receivable (AR)
	Insurance AR aged > 90 days from discharge date
	Insurance AR aged > 180 days from discharge date
	Denial Write-Offs as a percent of Net Patient Revenue
Financial Management	Bad Debt as percent of Net Patient Revenue
	Days cash on hand
	Cash to Net Revenue (percent)
Other RCM Metrics	Observation percent (compared to IP)

PEPPER Report: A Free CMS Resource

One free, but very valuable, resource tool made available by CMS to all hospitals is the Program for Evaluating Payment Patterns Electronic Report (PEPPER). "PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. The PEPPER Program also provides hospitals with online tools and information on various topics such as, for example, monitoring, compliance, CAH billing, and medical necessity through the PEPPER News."[9]

Telehealth

Best Practice Healthcare Organizations

[9] Program for Evaluating Payment Patterns Electronic Report website at https://pepper.cbrpepper.org/

- ✓ Understand state and federal regulatory requirements;
- ✓ Apply billing guidelines and documentation requirements; and
- ✓ Utilize Health Insurance Privacy and Portability Act (HIPAA) - Compliant technologies and appropriate Business Associate Agreements.

CMS defines telehealth services to include services that require a face-to-face meeting with the patient. Reimbursement is limited to the type of services provided, geographic location, type of institution delivering the services and type of health provider. Generally, there are five statutory conditions required for Medicare coverage of telehealth services:

- The beneficiary is located in a qualifying rural area;
- The beneficiary is located at one of eight qualifying originating telehealth sites;
- The services are provided by one of ten distant site practitioners eligible to furnish and receive Medicare payment for telehealth services;
- The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunications system that permits real-time communication between them; and
- CPT/HCPCS codes for the service itself is named on the list of covered Medicare telehealth services.

Many state and federal telehealth requirements were waived during the COVID-19 Public Health Emergency and the covered services were expanded. Refer to CMS Telehealth Services Booklet, which provides details of telehealth service delivery for Medicare beneficiaries.
Services eligible for reimbursement include consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, and pharmacologic management. CMS provides a List *of Medicare Telehealth Services* by CPT or HCPCS codes online under the telehealth website.

Authorized Practitioners

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State Law) are:

- Physicians;
- Nurse Practitioners (NP);
- Physician Assistants PA);
- Nurse-Midwives;
- Clinical nurse specialists;
- Certified registered nurse (RN) anesthetists;
- Clinical psychologists and clinical social workers; and
- Registered dietitians or nutrition professionals.

Originating Sites

The originating site is the location of the beneficiary at the time the service is furnished. Telehealth is only a covered benefit if the originating site is:

- A county outside of a Metropolitan Statistical Area (MSA);;

- A rural Health Professional Shortage Area (HPSA) located in a rural census tract
- Physician and practitioner offices;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNFs);
- Community Mental Health Centers (CMHCs);
- Renal Dialysis Facilities;
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis; and
- Mobile Stroke Units.

Documentation Requirements

Documentation requirements for a telehealth service are the same as a face-to-face encounter. The information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider, and the names and roles of any other persons participating in the telehealth service.
It is advised to follow local Medicare Administrative Contractor (MAC) guidance for final instructions on billing and documentation requirements for telehealth services. Additionally, private payers may follow the guidelines set forth by Medicare or may have their own.

As telehealth becomes more efficient and improves patient outcomes, more services are likely to be approved for reimbursement. As more payers cover telehealth services, payment policies and criteria will change, so keep a watchful eye on the situation.

Hospitals and clinics with established telemedicine programs generally have a clear understanding of each of the staff roles required to implement and operate a telehealth program. They also have the operational and billing control procedures required to identify and address any potential process breakdowns or changes to regulatory requirements. National and state requirements do not always align, so it is essential to stay abreast on such areas as state licensure requirements and privacy concerns.

Provider Credentialing

All providers who are expected to be involved in telehealth services should be accurately credentialed with the organization to allow payment for services rendered. Each individual insurance carrier may have their own credentialing requirements and the process may be lengthy to complete. For that reason, organizations should begin the credentialing process as soon as it is determined a provider will provide telehealth services and promptly respond to data request or questions from the payer in an attempt to make the process more efficient. In addition, such services should not be rendered until the credentialing process has been completed as services rendered prior to the completion of the credentialing process is likely to result in a denied claim. Organizations should take care to only schedule patients with a provider who is credentialed with the payer of record at the time of service.

Compliance Program

Best Practice Healthcare Organizations

- ✓ Designate a compliance officer and compliance committee;
- ✓ Develop compliance policies and procedures, including standards of conduct;
- ✓ Develop open lines of communication;
- ✓ Provide appropriate training and education;
- ✓ Perform internal auditing and monitoring;
- ✓ Respond to detected deficiencies; and
- ✓ Enforce disciplinary standards.

These seven elements (best practices) are published in the January 31, 2005 (Volume 70, No. 19) Federal Register, as the *Office of Inspector General's (OIG) Supplemental Compliance Program Guidance for Hospitals*. Since its inception in 1976, the OIG and the Department of Health and Human Services (HHS) has been determined to fight fraud and abuse in Medicare, Medicaid, and greater than 100 other HHS programs. In 2010, as a part of the Affordable Care Act (ACA), the OIG mandated that all healthcare providers have a Corporate Compliance Program in place as a condition of enrollment for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) reimbursement. The OIG published "*OIG Compliance Program Guidance for Hospitals*" in the Federal Register (Volume 63, No. 35) February 23, 1998. In its guidance, the OIG documents risk areas for hospitals and special areas of OIG concern include the following:

- Billing for items or services not provided;
- Providing medically unnecessary services;
- Upcoding;
- DRG creep;
- Outpatient services rendered in connection with inpatient stays;
- Teaching physician and resident requirements for teaching hospitals;
- Duplicate billing; and
- False cost reports.

The OIG published *Supplemental Compliance Program Guidance for Hospitals* effective January 31, 2005. Compliance efforts are designed to establish a culture within an organization that promotes prevention, detection, and resolution of potential conducts that do not conform to federal and state law, as well as private payer healthcare program requirements. A hospital's compliance program should communicate and demonstrate the hospital's commitment to the compliance process. Refer to the OIG's Active Work Plan Items for the most current version.

Best Practice Hospitals

- ✓ Designate a compliance officer and compliance committee
- ✓ Develop compliance policies and procedures, including standards of conduct
- ✓ Develop open lines of communication
- ✓ Provide appropriate training and education
- ✓ Perform internal auditing and monitoring
- ✓ Respond to detected deficiencies
- ✓ Enforce disciplinary standards

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- Billing for items or services not provided
- Providing medically unnecessary services
- Upcoding
- Diagnosis-related group (DRG) creep
- Outpatient services rendered in connection with inpatient stays
- Teaching physician and resident requirements for teaching hospitals
- Duplicate billing
- False cost reports

The OIG published *Supplemental Compliance Program Guidance for Hospitals* effective January 31, 2005. Compliance efforts are designed to establish a culture within an organization that promotes prevention, detection, and resolution of potential conducts that do not conform to federal and state law, as well as private payer healthcare program requirements. A hospital's compliance program should communicate and demonstrate the hospital's commitment to the compliance process. Refer to the OIG's Active Work Plan Items for the most current version.

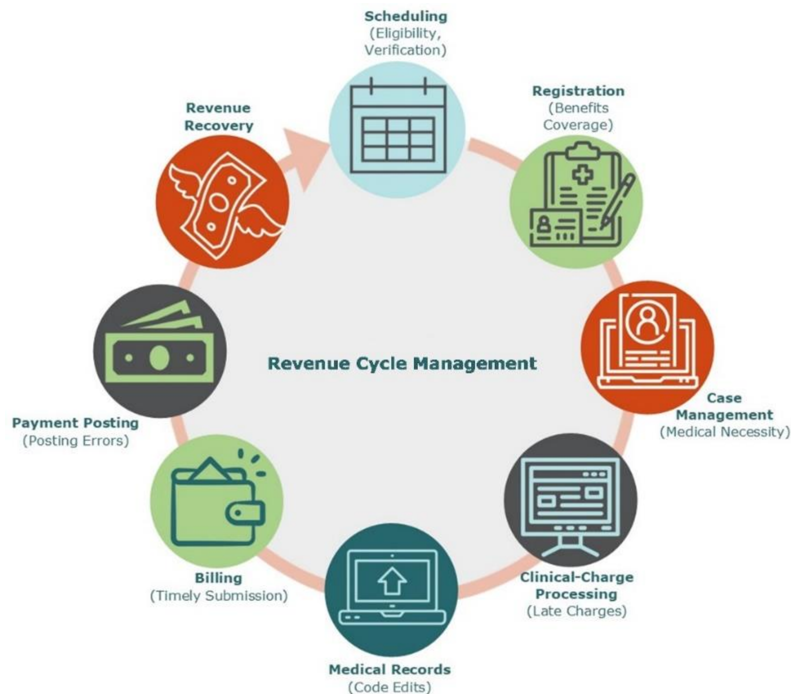
Conclusion

As the health care industry continues to evolve, hospitals are adjusting long-utilized processes. Patients are becoming more involved in health care decisions, and are expecting higher quality for financial contributions. Processes are being developed to ensure transparency, quality, value, and options for patients. Through a well-designed revenue cycle management processes and adoption of best practices, hospitals increase operational efficiencies and improve reimbursement.

Figure 2: Revenue Cycle Management[10]

10 Figure 2 developed by The National Rural Health Resource Center

Well executed payer contracts, clear value maps lead to patient centric policies and procedures, robust self-pay and denial management processes, consistent customer service, and well designed and communicated expectations all contribute to the highest standards within the revenue cycle. These standards when acted upon correctly and with passion will help to deliver a positive patient experience as well as drive positive revenue resolution. Leaders must focus on each process to ensure value is delivered consistently. KPI tracking and process improvement will continue to contribute to success within the revenue cycle. Implementing these best practice suggestions can have a positive impact on the facility and the community served.



Appendix A: Sample Point-of-Service Collection Scripts

Example 1: Mr. Jones – We have verified your insurance and they require us to collect a $50 copay for each visit. How would you like to take care of this today, cash or credit? (Then be silent)

Example 2: Mr. Jones – you are having a procedure today that requires a deposit of $______ I see that Amy, our financial counselor, spoke with you on Tuesday and you indicated that you would be paying by check, is that still the method of payment that you would like to use? (then be silent)

Example 3: We look forward to seeing you on _(appt. date)_. Please be sure to bring your insurance card, and your identification card to the visit. We will collect your co-pay/co-insurance/deductible (give specific amount) required by your insurance plan.

Scenario 1: Never Had to Pay Before
Patient: I have never had to pay at the time of service before.
Registrar: Mr. /Mrs. (patient/responsible party's name), I understand your concern, however, changes in office procedure were needed to ensure compliance insurance company requirements. Paying at the time of service ensures that you have honored your insurance company policies and that we have been able to avoid additional administrative costs, which in turn helps to save you the patient money. It also allows you to take care of all your financial items up front so that you can focus on healing and not worry about your bills later. Would you like to pay by cash, debit/credit card?

Scenario 2: Insurance Will Pay

Patient: My insurance will pay.

Registrar: Mr. /Mrs. (patient/responsible party's name), your insurance indicated that you have (not met your deductible or, you have a co-payment of $____, or they will not cover this service), and that this amount would be your responsibility. Would you like to pay cash, debit/credit card?

Appendix B: Resources

Through the Delta Region Community Health Systems Development Program (DRCHSD), The National Rural Health Resource Center (The Center) offers live technical assistance webinars to eligible and selected health care organizations. Recording's are available online for all providers to access and use at will to support ongoing staff development and performance improvement. Recording can be accessed at DRCHSD Events. The Center's Resource Library for webinars, presentations, articles, and toolkits developed by trusted industry leaders to guide and support rural health stakeholders.

2021 CMS Coding Updates

Charge Capture Improvement and Best Practices

Clinical Documentation Integrity Best Practices (Part I)

Clinical Documentation Integrity Best Practices (Part II)

Front-end Revenue Cycle Improvement: Patient Registration

Hydration Infusions: Charge Capture and Medical Necessity

Revenue Cycle Improvement Bootcamp

Revenue Integrity, Denials Management and Charge Capture Best Practices

Telehealth Coding and Billing to Maximize Reimbursement

Telehealth: Getting Started with Proper Coding and Billing of Telehealth Services

Appendix C: Revenue Cycle Best Practice Check List

Utilize this check list to review your hospital's current processes to evaluate the opportunity for adopting best practices.

Figure 3: Revenue Cycle Management[11]

Patient Centered Revenue Cycle

- ✓ Put the patient at the heart of the revenue cycle process;
- ✓ Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management;
- ✓ Provide both verbal and written explanation to patients; and
- ✓ Bring consistency, clarity, and transparency to patient financial discussions

Scheduling and Pre-Registration

- ✓ Centralize scheduling for services allows patients to have one place to schedule all services and to inform patients of required documents and financial obligations;
- ✓ Provide scripts for staff to follow to provide consistent, high-quality customer service;
- ✓ Complete prior authorization to meet medical necessity when required;
- ✓ Educate patients about insurance benefits to include the amount of copayments, deductibles, and coinsurance for which the patient would be responsible for paying at the time of service;
- ✓ Conduct financial screening to identify patients early that may need financial assistance or charity care to afford services. Offer sliding fee scale options when appropriate;
- ✓ Establish financial counselors to support uninsured patients to complete assistance applications;
- ✓ Collect co-payments, deductibles, coinsurance, and patient balances from historical visits at time of service;
- ✓ Offer prompt pay and self-pay discounts;

[11] Figure 3 obtained from Harmony Healthcare, LLC, at https://harmony.solutions/portfolio-item/revenue-cycle-management/. Viewed August 2021

- ✓ Have clearly defined policies and procedures;
- ✓ Enter all services into an online scheduling system;
- ✓ Integrate IT systems for scheduling and pre-registration functions;
- ✓ Develop process to ensure physician order is available at the time of scheduling or process in place to obtain ahead of service date;
- ✓ Provide verbal and written explanation of hospital policies to the patient; and
- ✓ Provide reminder calls to patients and include discussion regarding patient balances and point-of-service (POS) collection policies, confirm third party coverage, and restate proper clinical preparation for the service.

Patient Registration and Admissions

- ✓ Complete patient insurance verification for all visits;
- ✓ Pre-determine if services will meet medical necessity;
- ✓ Provide the Advanced Beneficiary Notice of Noncoverage (ABN) to all patients when Medicare may not cover a provided service;
- ✓ Utilize electronic tools such as to clinical decision support for evaluating patient placement;
- ✓ Provide ongoing education on medical necessity to clinical and non-clinical staff;
- ✓ Identify charity care patients early and offer sliding fee scale options when appropriate and in accordance with organizational policies;
- ✓ Collect co-payments, deductibles, and previous balances at time of service;
- ✓ Offer prompt pay and self-pay discounts; and
- ✓ Have clearly defined policies and procedures.

Revenue Integrity

- ✓ Have clearly defined policies and procedures related to revenue integrity functions;
- ✓ Have a Clinical Documentation Integrity (CDI) team to improve clinical documentation;
- ✓ Hold department managers responsible for monitoring revenue and usage via charge reconciliation processes;
- ✓ Educate and train staff on appropriate charging and reconciliation processes;
- ✓ Invest in a strong charge description master (CDM) team and maintenance process;
- ✓ Develop pricing strategies based on market-based data;
- ✓ Perform an annual review to update pricing;
- ✓ Identify and monitor departments with charge capture issues and develop processes for improvement; and
- ✓ Establish an interdisciplinary team with a goal of overseeing processes such as:
    - Conducting chart audits
    - Monitoring revenue and usage
    - Overseeing CDM issues
    - Determining billing issues related to charges
    - Reviewing managed care contracts

- Monitoring pricing updates.

Emergency Room Admissions

- ✓ Assess how the emergency department reaches the Evaluation & Management (E&M) levels;
- ✓ Determine the actual distribution of E&M levels following correction;
- ✓ Pull out procedure charges and bill separately;
- ✓ Monitor the ER admission rate for inpatient and observation services;
- ✓ Manage an ER re-direct program to collect co-payments, deductibles, and any previous balances from non-emergent patients following the EMTALA screening and/or attempt to move the patient to the more appropriate level of care by either redirecting them to a walk-in clinic or scheduling them in the clinic the next day; and
- ✓ Have clearly defined policies and procedures.

Charge Capture and Coding

- ✓ Use concurrent coding to improve medical necessity documentation;
- ✓ Hold weekly nursing and HIM team meetings to discuss medical necessity documentation and charge capture opportunities;
- ✓ Hold ancillary department managers responsible for reviewing the prior day's charges in order to identify errors;
- ✓ Train ancillary staff on appropriate charging and reconciliation;
- ✓ Hold weekly interdisciplinary team meetings to engage managers and build department accountability;
- ✓ Hold weekly interdisciplinary team meetings to determine issues that put the facility at risk, which may include:
  - Conducted chart audits
  - Review system reports such as one day stays and cumulative totals for each ER level
- ✓ Develop processes that clarify what a separately reportable charge for outpatient services is;
- ✓ Develop a process for regularly reviewing pharmacy charges by auditing the medical records versus charges and claims for injections versus drugs;
- ✓ Establish a formal process that involves the business office and department managers to review existing charge codes and to establish new charge codes;
- ✓ Develop pricing strategies based on market-based data;
- ✓ Perform an annual review to update pricing;
- ✓ Hold quarterly meetings with department managers and BO to conduct a review and update chargemaster;
- ✓ Review third party contracts; and
- ✓ Have clearly defined policies and procedures.

Utilization (Care) Management

- ✓ Have clearly defined roles differentiating Utilization Review and Case Management functions;

- ✓ Utilize non-clinical support team members to perform as many of the non-clinical administrative tasks as possible;
- ✓ Include in the Utilization Review Committee, members from multiple disciplines including, utilization review, case management, revenue integrity, compliance, contracting, clinical documentation improvement, and other areas where operational change in one area can significantly impact the performance of another;
- ✓ Monitor length of stay trending and impact on throughput and revenue;
- ✓ Critical Access Hospitals are required to maintain an annual average length of stay of 96 hours or less;
- ✓ Convene the Utilization Management oversight committee to meet monthly, and include data related to outlier cases, clinical denials, length of stay trending, by floor, physician, and MS-DRG;
- ✓ Utilize a physician advisor with concurrent denial peer to peer process with payers;
- ✓ Have thorough understanding of the Medicare 2 Midnight Rule and retrospectively review all Medicare stays with a zero to one day length of stay for status appropriateness;
- ✓ Ensure medical necessity for admissions, by applying current, admission criteria to 100% of medical cases placed in hospital beds with a time-specific deadline after admission;
- ✓ Use the utilization review process to verify physician admission orders, patient class, admission date and time in the EHR and the Admission Discharge Transfer event system (if separate);
- ✓ Document admission reviews, discharge planning, and related care planning in an auditable format that demonstrates a consistently followed care management process;
- ✓ Automate payer notification of hospitalization when possible;
- ✓ Utilize criteria to identify the patients likely to have the most complex discharge planning needs early in their hospitalization;
- ✓ Perform review of readmitted patients to identify root-cause and develop prevention actions going forward; and
- ✓ Identify the post-acute service providers where high volumes of patients are discharged to, and form mutually beneficial relationships.

Timely Filing

- ✓ Monitor the filing of claims in accordance with payer requirements;
- ✓ Determine the percentage of claims not filed before the timely filing deadline;
- ✓ Developing a transaction code used to track write-offs due to timely filing; and
- ✓ Have clearly defined policies and procedures to be followed by billing staff.

Billing and Collections

- ✓ Stratify the accounts by amount and aging to prioritize efforts;
- ✓ Identify Medicare separate from commercial accounts;
- ✓ Have clearly defined policies and procedures; and
- ✓ Educate staff on:
    - Payer contract requirements
    - How to verify coverage

- How to appeal coverage determinations
- Timely filing rules
- Fee schedules
- Special billing requirements

Denial Management

- ✓ Monitor denials for reporting and resolution;
- ✓ Offer utilization management services for assisting physicians in determining appropriate status assignment for Inpatient and Observation services; and
- ✓ Designate a team of individuals to appeal denials for reconsideration of payment.

Revenue Cycle Management Key Performance Indicators (KPI)

- ✓ Hold weekly RCT meetings;
  - See Table 1: Roles In High- Performance Revenue Cycle
- ✓ Track and monitor KPI; and
  - See Table 2: Common KPIs
- ✓ Utilize dashboards to drive performance .

Telehealth

- ✓ Understand state and federal regulatory requirements;
- ✓ Apply billing guidelines and documentation requirements; and
- ✓ Utilize Health Insurance Privacy and Portability Act (HIPAA) - Compliant technologies and appropriate Business Associate Agreements.

Compliance Program

- ✓ Designate a compliance officer and compliance committee;
- ✓ Develop compliance policies and procedures, including standards of conduct;
- ✓ Develop open lines of communication;
- ✓ Provide appropriate training and education;
- ✓ Perform internal auditing and monitoring;
- ✓ Respond to detected deficiencies; and
- ✓ Enforce disciplinary standards.

Appendix D: Revenue Cycle Key Performance Indicators

Refer to Healthcare Financial Management Association (HFMA) website to learn more about their recommended KPI, *HFMA's MAP Initiative* and *Map Keys for calculating metrics and industry benchmarks. Metrics without readily available benchmarks should be reviewed against a historical average performance baseline for performance evaluation.*

Management Processes

Measure: Days in Accounts Receivable
Purpose: Trending indicator of overall A/R performance
Value: Indicates revenue cycle efficiency
Benchmark: <38.3 days (variable based upon payer mix)
Equation: (Measure with and with-out Credit Balances included)

N: Gross A/R
D: Average daily net patient service revenue

Measure: Aged A/R as a Percentage of Billed A/R (90 days and greater)
Purpose: Trending indicator of receivable collectability
Value: Indicates revenue cycle's ability to liquidate A/R
Benchmark: ≤25.9%
Equation:

N: A/R greater than 90 days
D: Total billed A/R

Measure: Cash Collection as a Percentage of Net Patient Service Revenue
Purpose: Trending indicator of revenue cycle to convert net patient services revenue to cash
Value: Indicates fiscal integrity/financial health of the organization
Benchmark: >98.7%
Equation:

N: Total cash collected
D: Average monthly net revenue

Measure: Bad Debt
Purpose: Trending indicator of the effectiveness of self-pay collection efforts and financial counseling
Value: Indicates organization's ability to collect self-pay accounts and identify payer sources for those who cannot meet financial obligations
Benchmark: <1.0%
Equation:

N: Bad debt
D: Gross patient service revenue

Measure: Charity Care
Purpose: Trending indicator of local ability to pay
Value: Indicates services provided to patients deemed unable to pay
Benchmark: <1.4%

Equation:

N: Charity care

D: Gross patient service revenue

Measure: Charity as a Percent of Uncompensated Care

Purpose: Trending indicator that monitors charity care versus bad debt

Value: Reflection of charity care (provided to the community)

Equation:

N: Charity care

D: Total uncompensated care (bad debt + charity care)

Measure: Uninsured Discount

Purpose: Trending indicator of amounts not expected to be paid by uninsured patients

Value: Indicates the portion of the self-pay gross revenue not included in cash, charity or bad debt metrics

Equation:

N: Uninsured discounts

D: Gross patient service revenue

Measure: Total Uncompensated Care

Purpose: Trending indicator of total amounts not collected from patients related to charity and bad debt combined

Value: Indicates the total amount of self-pay gross revenue that is not collectable or expected to be collected

Benchmark: <2.2% of Gross Revenue

Equation:

N: Uninsured and uncompensated care (bad debt + charity care + uninsured care discount)

D: Gross patient service revenue

Measure: Cost to Collect

Purpose: Trending indicator of operational performance

Value: Indicates the efficiency and productivity of revenue cycle (RC) process

Benchmark: <2.8 of total Revenue Cycle costs (Patient Access + Business office)*

Equation:

N: Total Revenue Cycle (RC) Cost

D: Total cash collected

*HFMA is attempting to create industry awareness around the need to include: Patient Access, Financial Counseling, Business office, HIM, and Revenue Cycle dedicated IT

Measure: Cost to Collect by Functional Area

Purpose: Trending indicator of operational performance by functional area as reported in Cost to Collect

Value: Indicates the efficiency and productivity of revenue cycle process by functional area

Equation:

N: Total x (x = the cost of each functional area) cost*

D: Total cash collected

**Sum total of all x's (i.e. sum of the cost of each functional area) should equal total cost of Cost to Collect*

Measure: Case Mix Index

Purpose: Trending indicator of patient acuity, clinical documentation, and coding

Value: Supports appropriate reimbursement for services performed and accurate clinical reporting
Benchmark: 1.4
Equation:

N: CMI (average RW/Patient) = sum of relative weights for all inpatients*
D: Number of inpatients in the month*
**Excludes normal newborns and Medicare-exempt units*

Patient Access Processes

Measure: Pre-Registration Rate
Purpose: Trending indicator that patient access processes are timely, accurate, and efficient
Value: Indicates revenue cycle efficiency and effectiveness
Benchmark: ≥94%
Equation:

N: Number of patient encounters pre-registered
D: Number of scheduled patient encounters

Measure: Insurance Verification Rate
Purpose: Trending indicator that patient access functions are timely, accurate, and efficient
Value: Indicates revenue cycle process efficiency and effectiveness
Benchmark: ≥94%
Equation:

N: Total number of verified encounters
D: Total number of registered encounters

Measure: Service Authorization Rate
Purpose: Trending indicator that patient access functions are timely, accurate, and efficient
Value: Indicates revenue cycle process efficiency and effectiveness
Benchmark: ≥94%
Equation:

N: Number of encounters authorized
D: Number of encounters requiring authorization

Measure: Point-of-Service (POS) Cash Collections
Purpose: Trending indicator of point-of-service collection efforts
Value: Indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs
Benchmark: ≥22.8%
Equation:

N: POS payments
D: Total patient cash collected

Measure: Conversion Rate of Uninsured Patient to Payer Source
Purpose: Trending indicator of qualifying uninsured patients for a funding source
Value: Indicates organization's ability to successfully secure funding for uninsured patients and improve customer satisfaction
Benchmark: ≥15%

Equation:

N: Total uninsured patients converted to insurance

D: Total uninsured discharges and visit

Revenue Processes

Measure: Days in Total Discharged Not Final Billed (DNFB)

Purpose: Trending indicator of claims generation process

Value: Indicates revenue cycle performance and can identify performance issues impacting cash flow (from discharge to transfer to business office – also identify days from transfer to final billing)

Benchmark: <4.7 days

Equation:

N: Gross dollars in A/R (not final billed)

D: Average daily gross revenue

Measure: Days in Total Discharged Not Submitted to Payer (DNSP)

Purpose: Trending indicator of total claims generation and submission process

Value: Indicates revenue cycle performance and can identify performance issues impacting cash flow

Benchmark: <4.3 days

Equation:

N: Gross dollars in DNFB + Gross dollars in FBNS

D: Average daily gross revenue

Measure: Late Charges as a Percentage of Total Charges

Purpose: Measure of revenue capture efficiency

Value: Identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance, and accelerate cash flow

Benchmark: ≤2%

Equation:

N: Charges with postdate greater than three days from service date

D: Total gross charges

Measure: Net Days in Credit Balance

Purpose: Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness

Value: indicates whether credit balances are being managed to appropriate levels and are compliant to regulatory requirements

Benchmark: <2 days

Equation:

N: Dollars in credit balance

D: Average daily net patient service revenue

Claims Processes

Measure: Days in Final Billed Not Submitted to Payer (FBNS)

Purpose: Trending indicator of claims impacted by payer/regulatory edits within claims processing system

Value: Track the impact of internal/external requirements to clean claim production, which impacts positive cash flow

Benchmark: <0.2 days
Equation:

N: Gross dollars in FBNS
D: Average daily gross revenue

Measure: Clean Claim Rate
Purpose: Trending indicator of claims data as it impacts revenue cycle performance
Value: Indicates quality of data collected and reported
Benchmark: ≥85%
Equation:

N: Number of claims that pass edits requiring no manual intervention
D: Total claims accepted into claims scrubber tool for billing prior to submission

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Measure: Denial Rate – Zero Pay and Partial Pay
Purpose: Trending indicator of % claims not paid
Value: Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
Benchmark: ≤4%
Equation:

N: Number of zero paid claims denied
D: Number of total claims remitted

Measure: Denials Overturned by Appeal
Purpose: Trending indicator of hospital's success in managing the appeal process
Value: Indicates opportunities for payer and provider process improvement and improves cash flow
Benchmark: ≥40%
Equation:

N: Number of appealed claims paid
D: Total number of claims appealed and finalized or closed

Measure: Denial Write-Offs as a Percent of Net Revenue
Purpose: Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount
Value: Indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim
Benchmark: ≤3%
Equation:

N: Net dollars written off as denials
D: Average monthly net revenue