

Delta Region Community Health Systems Development (DRCHSD) Program

Best Practice Concepts in Revenue Cycle Management Guide

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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 particular 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, BKD, 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.

Table of Contents

- Introduction 6
- Patient Centered Revenue Cycle 8
- Scheduling and Registration..... 8
- Patient Registration and Admissions 14
- Revenue Integrity 16
- Clinical Documentation Integrity (CDI)..... 21
- Emergency Room Admissions 22
- Charge Capture and Coding 23
- Utilization (Care) Management 26
- Timely Filing 28
- Billing and Collections 29
- Denial Management..... 31
- Monitoring Revenue Cycle Metrics 34
- Telehealth 38
- Compliance Program..... 40
- Conclusion 42
- Appendix A: Sample Staff Pre-collection Scripts..... 43
- Appendix B: Best Practice Tools 44
- Appendix C: Best Practice Check List 45
- Patient Centered Revenue Cycle 45
- Scheduling and Pre-Registration..... 45
- Patient Registration and Admissions..... 46
- Emergency Room Admissions..... 46
- Charge Capture 46
- Timely Filling..... 47
- Billing and Collections..... 47
- Denial Management..... 48
- Monitoring Revenue Cycle Metrics..... 48
- Appendix D: Healthcare Financial Management Association (HFMA) Recommended Key Performance Indicators..... 49
- Management Processes..... 49

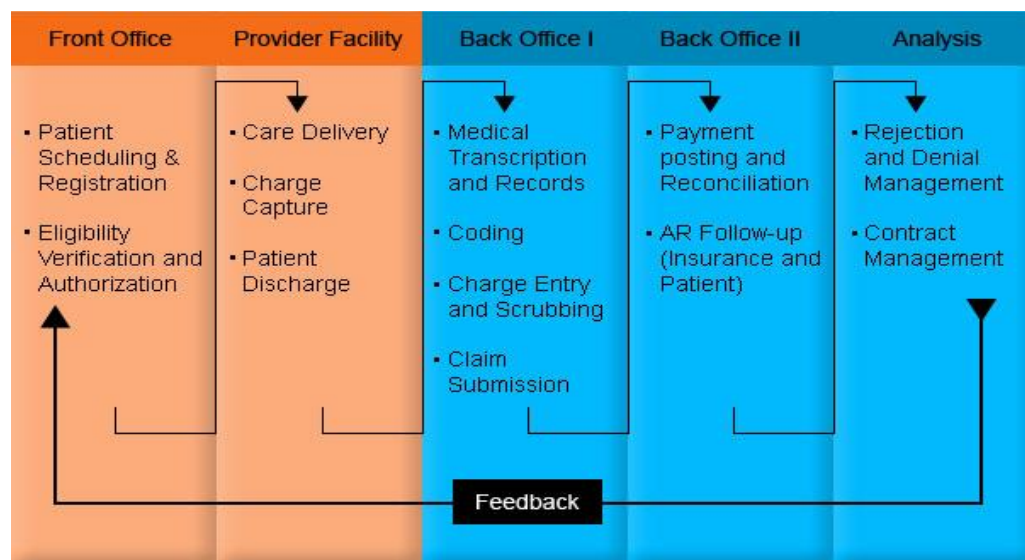
Patient Access Processes	52
Revenue Processes.....	54
Claims Processes	55

Introduction

The revenue cycle is the financial process related to a patient's clinical encounter. 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 utilized to verify the patient's identity and assign an appropriate payer source. Through the financial clearance process, financial conversations are initiated, and expectations set prior to service. Registration is the next step and, if a face-to-face encounter occurs at the point of service where cash is collected, compliance documents are reviewed and signed, and the patient's clinical chart is initiated. Once registered, the patient begins their clinical encounter where clinicians document the services rendered and the supplies utilized. This documentation is then used to support appropriate charge capture and code assignment for billing. Revenue Integrity Programs are recommended to ensure that appropriate clinical documentation, updated charge description masters, and pricing theories are utilized to realize appropriate reimbursement. Following patient discharge, all 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 without insurance coverage. The revenue cycle is complete when the account has a zero balance; and collection on the account has exhausted all payer sources and is closed as either correctly paid in full or uncollectible.

The Healthcare Financial Management Association (HFMA) defines revenue cycle as "*All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue*". Figure 1 illustrates how the 'front-end' impacts the 'back-end' of the revenue cycle. This graphic demonstrates that if hospitals are to be more efficient in managing the revenue cycle in the backend, they should target performance improvements efforts at the front-end.

Figure 1: Front-End and Back-End of Revenue Cycle¹



In today's economic environment, it is critical that hospital administrators utilize best practices to effectively manage the revenue cycle to optimize efficiency and 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.² 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 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."³ With decreasing reimbursements and as more patients are paying increasingly higher deductibles, it's 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. High-performing hospitals develop processes to adapt and implement best practices to ensure they are capturing reimbursement dollars and controlling expenditures. Best practices

¹ Figure 1 image obtained from Somega Healthcare website at <http://somegablogs.blogspot.com/>

² HIMSS Financial Systems Revenue Cycle Task Force; Revenue Cycle Management: A Life Cycle Approach for Performance Measurement and System Justification. 2009 -2010

³ Healthcare Financial Management Association; Strategies for a High-Performance Revenue Cycle; A Report from the Patient Friendly Billing® Project. November 2009

can be adopted and implemented by all rural hospitals to improve processes, and thus, performance.

Patient Centered Revenue Cycle

Best Practice Hospitals:

- ✓ 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

Creating a positive patient experience within the revenue cycle process is critical as it directly impacts the hospital financially and helps build a customer-focused environment that emphasizes patient care needs. Patients often perceive the billing process as confusing, difficult and frustrating. The last experience the patient usually has with the hospital is with the billing process. Customer service is paramount for the future success of health care providers. Revenue cycle teams (RCT) can be utilized to help build patient loyalty. The more information provided upfront to help both the patient and the family helps 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 explore their options, and asking more questions; many patients will be very confused. Hospitals should train staff to:

- Answer “Marketplace” questions
- Articulate coverage options
- Discuss payment options
- Know when and who to escalate to, if necessary

Scheduling and Registration

Best Practice Hospitals:

- ✓ Have centralized scheduling to receive patient and inform patients of required documents and financial obligations

- ✓ Schedule patients for services
- ✓ Draft scripts for staff to follow to provide consistent, high quality customer service
- ✓ Complete prior-authorization to meet medical necessity when required
- ✓ Educate patients about their insurance benefits to include the amount of copayments, deductibles, and coinsurance for which they would be responsible for paying at the time of service
- ✓ Conduct financial screening to identify charity care patients early and offer sliding fee scale options when appropriate
- ✓ Assist uninsured patients by scheduling time with financial counselors to complete financial assistance applications
- ✓ Collect co-payments, deductibles, coinsurance and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures
- ✓ Enter all tests into an online scheduling system
- ✓ Integrate IT systems for scheduling and pre-registration functions
- ✓ Develop a process to ensure physician order is available at the time of scheduling
- ✓ Provide verbal and written explanation of hospital policies to the patient
- ✓ 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 most commonly 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 rather than services being scheduled independently by department-specific staff. Centralized scheduling allows an organization to better establish, standardize, 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 a majority of the services provided by a hospital, surgery

departments may 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 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
- 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 to take place. Pre-registration functions include the gathering and verifying of patient demographic information, insurance benefits, authorization requirements, and potential financial responsibility prior to the patient's date of service. Typically, these procedures are performed a few days in advance of the visit by either a pre-registration/insurance verification team or by the scheduling and registration staff if they have enough time to perform those functions. 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-pay, 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 scheduling team has received an authorization number
- Mark insurance as verified status (if system allows)

- If an authorization is required, but not on file, contact the ordering physician's office
- Calculate potential patient financial responsibility in preparation for contacting the patient
- Contact the patient to perform pre-registration call. During this call, staff should:
 - Review demographic data
 - Remind patient to bring photo ID and insurance card
 - Confirm insurance information on file
 - Discuss benefits including potential or patient financial responsibility or existing patient responsibility amounts from previous services
 - Confirm appointment date, time, and location
- Enter system notes and comments regarding insurance benefits, patient discussion, and promissory notes or payments made
- Prepare any additional paperwork needed as necessary (forms, stickers, etc.)

Key Performance Indicators (KPIs) related to the pre-registration function are:

- Percentage of daily pre-registered appointments by user, payer, and department
- Amount of cash collected, and amount promised to pay by user
- Insurance verification percentage prior to date of service
- Authorization related denials

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 are needed to create the appointment, such as the patient's name, date of birth, address, phone number, and insurance provider name and identification number. This process should be developed and audited on a regular basis to verify needed information is obtained and correct in the Electronic Medical Records (EMR). Staff that schedule appointments should have a firm understanding of the facilities 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 they do not have their card available, it's important to be very specific that the patient will be required to provide the insurance card at the time of their appointment as well as the facility's expectations from the patient. If the scheduler does take the demographic and insurance information directly, it is important to inform the patient that they will be receiving additional calls regarding their upcoming service. Possible calls could be from a:

- Financial team member to discuss their 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
- Scheduling team member to confirm the appointment and to provide a courtesy reminder

Verbal, along with written explanations, are imperative to ensure that 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, and secure messaging with the facility
- Give a direct phone number in case they have further questions
- Repeat the same script 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](#) of this report for sample pre-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, deductibles, and past due balances at the time of service. Formalized, well-communicated policies and procedures related to time of service 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 policies. The financial policies should define the patient's payment options to include acceptance of credit cards or making payments over a period of time. The policies should also outline options for the staff to exercise if the patient cannot pay their out of pocket costs in a timely manner.
- 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
- 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 revenue cycle team should show support for time of service 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 them 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-pay and deductibles. [Appendix D](#) of this report provides greater details about KPIs to be continually monitored as well as best practice results which may be utilized as goals for an organization.

Patient Registration and Admissions

Best Practice Hospitals:

- ✓ Complete patient insurance verification for all visits
- ✓ Pre-determine if services will meet medical necessity
- ✓ 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
- ✓ Provide the [Advanced Beneficiary Notice of Non-coverage \(ABN\)](#) to all patients when Medicare may not cover a provided service
- ✓ 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
- ✓ 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 very 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 required to register a patient will vary based on the success of scheduling and pre-registration or if the patient is a “walk-in”, but generally takes no more than 15 minutes. Additional actions performed at time of service include general customer service, creating paper charts, printing consent waivers, printing wristbands, directing patients, and collecting payments.

Registration encompasses a full verification and review of patient information and arrival of a patient. As a general theme: the more work done prior to 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 very similar for inpatient, outpatient, emergency department and clinics, but with slight variations:

- The emergency department starts with a “quick registration” process with basic information obtained such as patient name, date of birth, and reason for visit. The full registration is then completed after the patient has been medically cleared per Emergency Treatment and Labor Act (EMTALA) guidelines
- Clinic registrations typically do not include requests for living wills
- Inpatient and high dollar outpatient procedures should be 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
- Perform insurance verification via real-time eligibility, batch eligibility, insurance payer websites, or other means
- Review benefits and enter coverage information in the EMR insurance screen
- Perform insurance verification for secondary/tertiary insurances
- 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
- Prepare any additional paperwork needed (forms, stickers, etc.)

Revenue Integrity

Best Practice Hospitals:

- ✓ 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
- ✓ 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 Clinical Documentation Integrity (CDI) program can facilitate the process for obtaining that documentation.

Charge capture efforts are extremely 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 3-5 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

- 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

CDM oversight and processes also are key to strong revenue integrity. The CDM contains the charges for the services and items (drugs, 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).⁴ 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, routine review to 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
- 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 also 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:

⁴ [Centers for Medicare and Medicaid Services, Medicare Learning Network, Critical Access Hospitals](#)

- 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, and 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
- ED Charges – technical or facility ED 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 2 ($100\text{mg} / 50\text{mg} = 2$).

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
- 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 validation is not a new concept, but continues to evolve. Clinical validation ensures health information accurately captures complete and specific provider documentation that will result in improved coding, reimbursement, severity of illness (SOI), and risk of mortality (ROM) classifications. Hospital staff that contribute to CDI include HIM professionals, nurses, and physicians that have strong backgrounds in clinical and/or HIM coding.

The 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
- Ability to effectively write compliant queries

The CDI professional should be provided with on-going 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 organization, 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 “key” in the success of any CDI program.

To ensure an effective CDI program, a hospital’s leadership must be engaged and provide extensive support. The leadership will also assist in engaging physicians 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 considered:

- Monitor and follow case mix index (CMI)
- Monitor the CDI professional’s review rate
- Monitor the query rate, response rate, and response time
- Monitor quality and reimbursement impact

For more information on CDI metrics and CDI processes and programs, refer to American Health Information Management Association’s (AHIMA) [CDI Toolkit](#).

Emergency Room Admissions

Best Practice Hospitals:

- ✓ Assess how the Evaluation & Management (E/M) levels in the emergency department are assigned
- ✓ Determine the actual distribution of E/M levels
- ✓ Charge and bill separately for procedures performed as appropriate
- ✓ 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 [Emergency Medical Treatment & Labor Act](#) (EMTALA) screening and/or

attempt triage the patient to the more appropriate level of care (i.e., a walk-in clinic or scheduling them in the clinic the next day)

- ✓ Have clearly defined policies and procedures

Some patients are admitted directly through the ER. Best practice hospitals monitor the admission rates for inpatient and observation services to evaluate if they are placing patients in the right level of care. Patient placement has a direct impact on reimbursement. A financial counselor should visit the patient's room before they are discharged. It is helpful when the clinical and financial teams work together to assist the patient with understanding their 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 deemed non-emergent following the EMTALA screening are re-directed back to registration. Preferably, staff makes the patients aware of the additional costs associated with the ER visit and provides them 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.

Charge Capture and Coding

Best Practice Hospitals:

- ✓ Use concurrent coding to improve medical necessity documentation
- ✓ Hold weekly nursing and Health Information Management (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:

- Conducting chart audits
- Reviewing system reports such as one day stays and cumulative totals for each ER level
- ✓ Develop processes that clarify separately reportable charges for outpatient services
- ✓ 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 (business office) to conduct a review and update Charge Description Master (CDM)
- ✓ Review third party contracts
- ✓ Have clearly defined policies and procedures

To improve charge capture, staff should clearly communicate suspense times to the departments and state guidelines in their 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 that each day that charges are not entered and fall out of "suspense" can cause negative effects on days in accounts receivable (A/R) outstanding as well as cash flow. Systematic reviews of the CDM are essential to ensure that hospitals are capturing all revenue correctly and that they are not leaving dollars on the table. However, it's important to note that adjustments to the CDM create downstream effects to the cost reports. In addition, no matter how up to date the CDM is, it 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 Critical Access Hospitals (CAH), are frequently below that of Perspective Payment System (PPS) and larger urban facilities for the exact same services (i.e. same procedure or same E/M level). 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 (or other predetermined) percentile pricing. They 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 the majority of rural hospitals. Common areas that result in lost revenues are outpatient nursing procedures and pharmacy. Examples of outpatient services that are 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 that 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. They also hold weekly interdisciplinary team meetings to review charge master for any potential [Recovery Audit Contractor](#) (RAC) issues, conduct chart audits, review system reports, such as one day stays and cumulative totals for each ER level. The interdisciplinary team should be composed of representatives from the business office, admissions, nursing, care/case management, and HIM. The purpose of the team is to determine issues that put the facility at risk, engage manager, and build department accountability. Best practice processes include:

- Clarification of separately reportable charges for outpatient services
- Nursing documentation that affect 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
- Regular review of pharmacy charges

Commonly in pharmacy, hospitals lose revenue by missing charges or errors in proper reporting of units. Most missed pharmacy charges are due to overreliance on systems to document dispensing units and unit conversion

factors. Best practice facilities have processes in place to review charts and claims for potentially missed pharmacy charges.

Utilization (Care) Management

Best Practice Hospitals:

- ✓ 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
- ✓ Define, publish, and share specific KPIs with the team, as well as other pertinent hospital stakeholders
- ✓ Include in the Utilization Review Committee, members from multiple disciplines including utilization review, case management, revenue integrity, compliance, contracting, clinical documentation excellence, 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 of 96 hours or less
- ✓ Require staffing seven days a week, including holidays and evenings
- ✓ 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 Medicare Severity-Diagnosis Related Group (MS-DRG)
- ✓ Utilize a physician advisor to support Acute Care Management, who is an expert at physician documentation, medical necessity, and related CMS requirements
- ✓ Have the physician advisor become the expert in concurrent denial peer to peer process with payers
- ✓ Have an effective escalation policy for cases not meeting screening criteria or for complex discharge planning situations
- ✓ Have thorough understanding of the Medicare 2-Midnight Rule and retrospectively review all Medicare stays with a 0-1 day length of stay for status appropriateness

- ✓ Assure 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 electronic health record and the Admission Discharge Transfer event system (if separate)
- ✓ Documents 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
- ✓ Have a focused, risk stratification-based transition care management program
- ✓ Perform retrospective review of readmitted patients to identify root-cause and develop prevention actions going forward
- ✓ Identify the post-acute service providers where high volumes of patients are discharged, 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 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 Centers for Medicare and Medicaid's (CMS) Conditions of Participation.⁵⁶

A healthy and robust hospital care management program is not only a key component to a hospital's patient flow and regulatory compliance success, but it 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 length of stay, and improve the efficient use of hospital resources.

⁵ [Centers for Medicare and Medicaid Services, 42 CFR § 482.30 Condition of participation: Utilization review](#)

⁶ [Centers for Medicare and Medicaid Services, 42 CFR § 482.43 Condition of Participation: Discharge Planning](#)

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
- UM 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
- Use of data analytics to identify variation in length of stay patterns, transfers, patient status determinations, and outlier patients

Timely Filing

Best Practice Hospitals:

- ✓ 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
- ✓ Have clearly defined policies and procedures to be followed by billing staff

Many hospitals fail to file claims in a timely manner due to inefficient or unmonitored processes, resulting in missed filing deadlines. Medicare allows claims to be submitted within one year of the date of service (42 CFR § 424.44 Time limits for filing claims) but many commercial payers now require claims to be submitted within 90 days. Therefore, it is important to have processes in place to submit claims in a timely manner and to continually monitor claims on hold to ensure timely filing deadlines are met.

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 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 Hospitals:

- ✓ Stratify the accounts by amount
- ✓ Identify Medicare separate from commercial accounts
- ✓ Have clearly defined policies and procedures
- ✓ Educate staff on:
 - Payer contract requirements
 - How to verify coverage
 - How to appeal coverage and payment determinations
 - Timely filing rules
 - Fee schedules
 - Payer-specific 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 their claims, but integrated billing editor software greatly improves the efficiency and accuracy in capturing potential errors. In order to maximize efficiency, edits contained within the bill scrubber should mirror the payer claim acceptance rules to prevent any rejections from occurring. In larger organizations it is a full time job to maintain these edits and ensure claims are transmitting properly from the bill scrubber to the payers. But for smaller hospitals 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 their processing system. This is important to note because claims which are

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 in an effort to prevent that rejection from occurring in the future.

Billers are also responsible for rebills generated through denial follow up. These claims are sometimes fixed by the 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 these 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 improvement. Doing so may help to 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, it is imperative that medical office staff follow-up with the 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 business office 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 that claims will be paid quickly. The top three reasons for insurance follow up are:

- The claim was never received
- The claim has been denied
- The claim is pending for additional information

The main objective of follow-up procedures is to ensure the management of collection activity performed on encounters with insurance balances. Follow-up should be conducted in a manner that provides a level of cash flow consistent with financial expectations, minimizes 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.

Denial Management

Best Practice Hospitals:

- ✓ Monitor denials for reporting and resolution by:
 - Payer
 - Denial type
 - Reason/Root Cause
 - Department where denied service was rendered
 - Denials as percentage of gross revenue
 - Denial over-turn rate
 - Denial write-offs as a percentage of net patient service revenue
- ✓ Have clearly defined revenue cycle and clinical documentation policies and procedures
- ✓ Have processes and education in place regarding the issuance of ABNs for Medicare patients
- ✓ Develop, implement, and monitor processes for meeting pre-determination and prior authorization for scheduled services
- ✓ Offer utilization management services for assisting physicians in determining appropriate status assignment for Inpatient and Observation services
- ✓ 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. Hospitals that are able to 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 the following:

- 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
- 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 medical record and reputable online sources and 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
- Indicate the hospital's expectations to resolve denial: over turn of denial, payment of service(s), and resolution within specified contracted limits

Common clinical service lines or departments that are prone to denials are:

- Registration - incorrect identification of insurance or not validating eligibility at the time of service
- Emergency Department (ED) - lack of medical necessity of tests performed (ex. MRI, CT) 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
- 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. 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
- Developing workflows to identify and perform prior authorization and pre-determination prior to rendering service(s) or immediately thereafter in emergency situations

- Issuing ABNs, as necessary, to Medicare patients prior to rendering. NOTE: know whether any of your commercial insurances/contracts require ABNs as well. For more information on ABN, refer to the Medicare Learning Network’s [Medicare Advanced Written Knowledge, Resources and Trainings Booklet](#).

The most effective mechanism to prevent denials is to communicate to revenue cycle/denial management team(s), and be transparent by tracking the following KPIs:

- Payer and type
- Reason
- Department
- Percentage of revenue submitted
- Denials as percent of gross revenue
- Denial over-turned (%)
- Payer rejects as percent of remit revenue processed

Monitoring Revenue Cycle Metrics

Best Practice Hospitals:

- ✓ Hold revenue cycle team meetings at least weekly
- ✓ Benchmark externally against better performing hospitals and HFMA metrics
- ✓ Benchmark internally to monitor trends over time
- ✓ Benchmark internally against best historical level and target department performance to the historical level
- ✓ Track and monitor KPIs
- ✓ Utilize dashboards to manage revenue cycle performance and improvement goals

Hospital performance improvement, particularly within the revenue cycle, is dependent upon ongoing monitoring of KPIs along with effective management that includes department accountability. However, leadership cannot accurately understand and track revenue cycle KPIs without continually updated reporting and benchmarking that outlines current

performance levels. This information is best presented through the use of 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 revenue cycle team should assume ownership of the development and completion of dashboards, the information contained in those dashboards and operational insights should be regularly communicated to senior management. By involving the C-suite in discussions related to the revenue cycle, the organization not only keeps the C-suite informed regarding the performance of the revenue cycle, but may also obtain the input of the C-suite related to organizational performance improvement needs (system utilization, resource needs, etc.) Refer to **Figure 2** below for the roles of the executive team according to HFMA's *Strategies for a High-Performance Revenue Cycle*.⁷

⁷ Figure 2 image obtain from Healthcare Financial Management Association; *Strategies for a High-Performance Revenue Cycle; A Report from the Patient Friendly Billing Project*

Figure 2: HFMA’s Roles in a High-Performance Revenue Cycle

	People	Processes	Technology	Metrics	Communication	Culture
C-Suite	Set high expectations for revenue cycle positions Devote organizational resources to improved training and compensation	Develop and participate in intraorganizational teams around revenue cycle Use patient experience as the cornerstone for setting revenue cycle strategy	Appreciate community dynamics and those with the greatest impact to the organization when prioritizing technology needs	Encourage improved monitoring of revenue cycle 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 revenue cycle through significant commitment of time and resources Establish systems to reward high revenue cycle performance
Revenue Cycle Leadership	Apply high standards to hiring Emphasize education Take a career approach to revenue cycle positions Leverage compensation and work arrangements for employee satisfaction	Use formal structures to obtain stakeholder input Target revenue cycle improvements around the consumer’s 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 revenue cycle	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 obligations Promote financial assistance Support clear and simple billing and collections materials Recognize the importance of external communications	Support revenue cycle at the highest level Garner appreciation for the revenue cycle 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 that the revenue cycle 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, and reduce silos within the revenue cycle functions and between revenue cycle and clinical departments. The RCT may also choose to hold informal dashboard review meetings on a weekly basis to review metrics including, but not limited to, charges, patient volume, payments, AR, days in AR, 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. They also share goals with their teams and help them understand:

- How goals are established
- How individual accountability impacts one’s self, their team, and the hospital over-all
- To support the team, management will have real-time course correction plans to influence improvement
- Progress will be measured daily/weekly/monthly
- Management will report positive as well as negative results with senior leadership and the entire team

- There will be accountability for all actions taken and those missed

High performing hospitals benchmark against national standards, historical performance, and internal budgets. External and internal benchmarking is key in evaluating performance goals. External benchmarks can provide the greatest benefit in determining overall performance because it allows hospitals to compare themselves against peer facilities. External data is the most difficult to obtain and may require membership in industry associations or submissions of the hospital's data. Internal benchmarks, however, should be more easily reported and allow the hospital to monitor trends over time. To ensure long term success, the RCT should develop benchmarks based on a detailed study of historical data and established goals for the revenue cycle.

Most importantly, high performing hospitals track and monitor KPIs to improve performance and identify areas of opportunity over time. Best practice facilities establish targets based on KPIs, and track and manage them on a dashboard to improve performance and meet the intended goals. [Appendix D](#) provides a list of revenue cycle KPI recommendations by HFMA. Some of the metrics may be challenging to compute for small rural hospitals or those that haven't traditionally performed revenue cycle benchmarking. While organizations should continually develop reporting in order to track as many revenue cycle KPIs as possible, organizations should track and monitor, at a minimum, the below HFMA recommended KPIs:

- Cash collected and cash percentage of net revenue
- Gross accounts receivable
- Gross accounts receivable days
- Net accounts receivable
- Net accounts receivable days
- In-house and discharged not-final-billed receivables
- Third party aging over 90 days
- Cost to collect
- Bad debt and charity as a percent of gross charges
- Denials as a fraction of gross charges
- POS collections as a fraction of gross charges

A free, valuable tool provided to hospitals by CMS 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 and potential underpayments. [PEPPERresources.org](https://pepperresources.org) is the official site for information, training and support related to the PEPPER Program."⁸ The PEPPER Program also provides hospitals with online tools and information on various topics such as monitoring, compliance, CAH billing, and medical necessity through the [PEPPER News](#).

Telehealth

Best Practice Hospitals/Clinics:

- ✓ Understand state and federal regulatory requirements
- ✓ Understand applicable billing guidelines and documentation requirements
- ✓ Utilizing Health Insurance Privacy and Portability Act (HIPAA)-compliant technologies and appropriate Business Associate Agreements

CMS defines telehealth services to include those 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

⁸ Centers for Medicare and Medicaid; [Program for Evaluating Payment Patterns Electronic Report \(PEPPER\)](#)

- The Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code for the service is named on the list of covered Medicare telehealth services.

Services provided via telecommunications system that are eligible for reimbursement and may substitute for a face-to-face, "hands on" encounter include consultation, office visits, individual psychotherapy, and pharmacologic management. A List of Medicare Telehealth Services by CPT or HCPCS is available on the [CMS website](#).

Authorized Practitioners:

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

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers
- 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
- Federally Qualified Health Centers (FQHCs)
- 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
- Mobile Stroke Units

Documentation Requirements:

Documentation requirements for a telehealth service are the same as for 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, the location of the patient and the provider, and the names and roles of any other persons participating in the telehealth service.

It is advisable 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 aims to improve patient outcomes, more services are likely to be approved for reimbursement. As more payers cover telehealth services, payment policies and criteria will change, so it will be critical to remain informed of current policies.

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 break-downs or changes to regulatory requirements. National and state requirements do not always align, so it's essential to stay abreast on such areas as state licensure requirements and privacy concerns.

Compliance Program

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

These seven elements or 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, 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 that 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
- False cost reports

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.

Conclusion

As the health care industry continues to evolve, hospitals may need to make adjustments to their processes. Patients are becoming more involved in their health care decisions and they are expecting higher quality for their financial contributions. Processes are being developed to ensure transparency, quality, value, and options for patients. Through a well-designed revenue cycle, hospitals can rise up to meet these changes head on.

Well executed payer contracts, clear value maps that 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 appropriately, will help to deliver a positive patient experience and drive revenue cycle performance.

Leaders must focus on each process to ensure that value is delivered consistently. Key performance indicator tracking and process improvements will contribute to success within the revenue cycle. Implementing best practice recommendations can have a positive impact on the facility and the community that is served.

Appendix A: Sample Staff Pre-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 with insurance company requirements. Paying at the time of service ensures that you have met your insurance company requirements 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 of 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 company indicated that you have (not met your deductible or, you have a copayment 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: Best Practice Tools

[Rural Hospital Toolkit for Transitioning to Value-based Systems:](#) View a toolkit designed to share best practices for improving financial, operational, and quality performance that position rural hospitals and networks for the future, as well as outlines strategies for transitioning to value-based payment and population health. This [Small Rural Hospital Transition \(SRHT\) Project](#) toolkit was designed for rural providers and leaders to identify performance improvement opportunities for their hospitals and networks, and develop strategies for successfully transitioning to population health.

[Revenue Cycle Management and Business Office Processes:](#) View tools to assist leaders with improving revenue cycle processes and increasing business office efficiency, which results in positive financial benefits due to quick course correction, increased reimbursement and clean claims.

[DRCHSD Program BKD Billing and Coding Bootcamp:](#) View a virtual boot camp consisting of three interactive webinars provided by BKD billing and coding experts. Each webinar is composed of 2-hour sessions. The first webinar is rural hospital focused, and the second and third are focused on Rural Health Clinic ([RHC](#)) billing and coding.

[CAH Financial Indicator Reports \(CAHFIR\) Primer and Calculator Resources:](#) The Flex Monitoring Team ([FMT](#)) makes financial indicator data available to every critical access hospital in the United States on an annual basis. These data include financial statement and operating indicator analyses to create numbers for hospitals that have easily-interpretable financial significance and allow critical access hospitals (CAHs) to compare their financial performance to peer facilities.

[Small Rural Hospital and Clinic Finance 101 Manual:](#) View a guide designed to provide answers to frequently asked questions regarding critical access hospital ([CAH](#)), small rural hospital and rural health clinic ([RHC](#)) finance and financial performance indicators. With the support of the Federal Office of Rural Health Policy ([FORHP](#)), the National Rural Health Resource Center (The Center) developed this manual for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of small rural hospitals and clinics.

Appendix C: Best Practice Check List

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

Scheduling and Pre-Registration

- ✓ Have centralized scheduling to receive patient
- ✓ Schedule patients for services
- ✓ Draft scripts for staff to follow to support customer service
- ✓ Complete prior-authorization to meet medical necessity
- ✓ Educate patients about what their insurance covers to include the amount of copayments, deductibles, and coinsurance for which they would be responsible for paying at the time of service
- ✓ Provide patients with cost estimates at pre-registration
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Assist uninsured patients by scheduling a meeting with financial counselors to complete financial assistance applications
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures
- ✓ Enter all tests into the 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
- ✓ Provide verbal and written explanation of the hospital policy to the patient
- ✓ 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
- ✓ Pre-determine if services will meet medical necessity
- ✓ Utilize electronic tools such as to support clinical decisions for evaluating patient placement
- ✓ Provide ongoing education on medical necessity to staff and physicians
- ✓ Make the ABN of Non-coverage (ABN) a requirement
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures

Emergency Room Admissions

- ✓ Assess how the Evaluation & Management (E/M) levels in the emergency department are assigned
- ✓ 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 triage the patient to the more appropriate level of care (i.e., a walk-in clinic or scheduling them in the clinic the next day)
- ✓ Have clearly defined policies and procedures

Charge Capture

- ✓ Use concurrent coding to improve medical necessity documentation
- ✓ Hold weekly nursing and Health Information Management (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 CDM
- ✓ Review third party contracts
- ✓ Have clearly defined policies and procedures

Timely Filing

- ✓ Monitor the filing of claims
- ✓ Determine the percent of claims not filed before deadline, which includes a separate account for tracking write-offs due to missed deadlines
- ✓ Have clearly defined policies and procedures

Billing and Collections

- ✓ Stratify the accounts by amount
- ✓ Identify Medicare separate from commercial accounts
- ✓ Have clearly defined policies and procedures
- ✓ 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

- ✓ Track denials to prevent oversight and monitor by:
 - Payer and type
 - Reason
 - Department
 - Percentage of revenue submitted
 - Denials as percent of gross revenue
 - Denial over-turned (%)
 - Payer rejects as percent of remit revenue processed
- ✓ Make ABN mandatory
- ✓ Provided ongoing education on ABN and medical necessity to staff and physicians
- ✓ Develop processes to pre-determine if services meet medical necessity criteria
- ✓ Have clearly defined policies and procedures

Monitoring Revenue Cycle Metrics

- ✓ Hold weekly revenue cycle team meetings
- ✓ Benchmark externally against peer hospitals
- ✓ Benchmark internally to monitor trends over time
- ✓ Benchmark internally against best historical level and target department performance to the historical level
- ✓ Establish targets based on HFMA suggested KPIs
- ✓ Track and monitor KPIs
- ✓ Use a dashboard to manage to revenue cycle improvement goals

Appendix D: Healthcare Financial Management Association (HFMA) Recommended Key Performance Indicators

The HFMA recommends the below KPIs for tracking, monitoring, and improving revenue cycle performance. HFMA has selected these KPI because they represent the entire revenue cycle and the processes associated with management, patient access, revenue, and claims. For more information regarding revenue cycle management performance improvement and recommended KPI, visit [HFMA website](#) to learn more about [HFMA's MAP Initiative](#) and [Map Keys](#).

Management Processes

Measure: Days in Accounts Receivable

Purpose: Trending indicator of overall A/R performance

Value: Indicates revenue cycle efficiency

Benchmark: <40.6 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: ≤19.8%

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: >99.4%

Equation: $N: \text{Total cash collected}$

$D: \text{Average monthly net revenue}$

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 can't meet financial obligations

Benchmark: <0.8%

Equation:

$N: \text{Bad debt}$

$D: \text{Gross patient service revenue}$

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:

$N: \text{Charity care}$

$D: \text{Gross patient service revenue}$

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: $\frac{\text{Total } x \text{ (} x = \text{the cost of each functional area) cost}^*}{\text{Total cash collected}}$

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: $\frac{\text{CMI (average RW/Patient)} = \text{sum of relative weights for all inpatients}^*}{\text{Number of inpatients in the month}^*}$

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: $\geq 94\%$

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: $\geq 94\%$

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: $\geq 94\%$

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: $\geq 21.3\%$

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: $\geq 15\%$

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: <5.1 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: $\leq 2\%$

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: $\geq 85\%$

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

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: $\leq 4\%$

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: $\geq 40\%$

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: $\leq 3\%$

Equation:

N: Net dollars written off as denials

D: Average monthly net revenue