Middle- and Back-End Revenue Cycle Improvement

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NATIONAL RURAL HEALTH RESOURCE CENTER

STROUDWATER

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Objectives

Let’s Get On the Same Page

Transaction Processing

- Claim Submission

Transaction Processing

- Inbound Processing

Accounts Receivable Management

LET'S GET ON THE SAME PAGE

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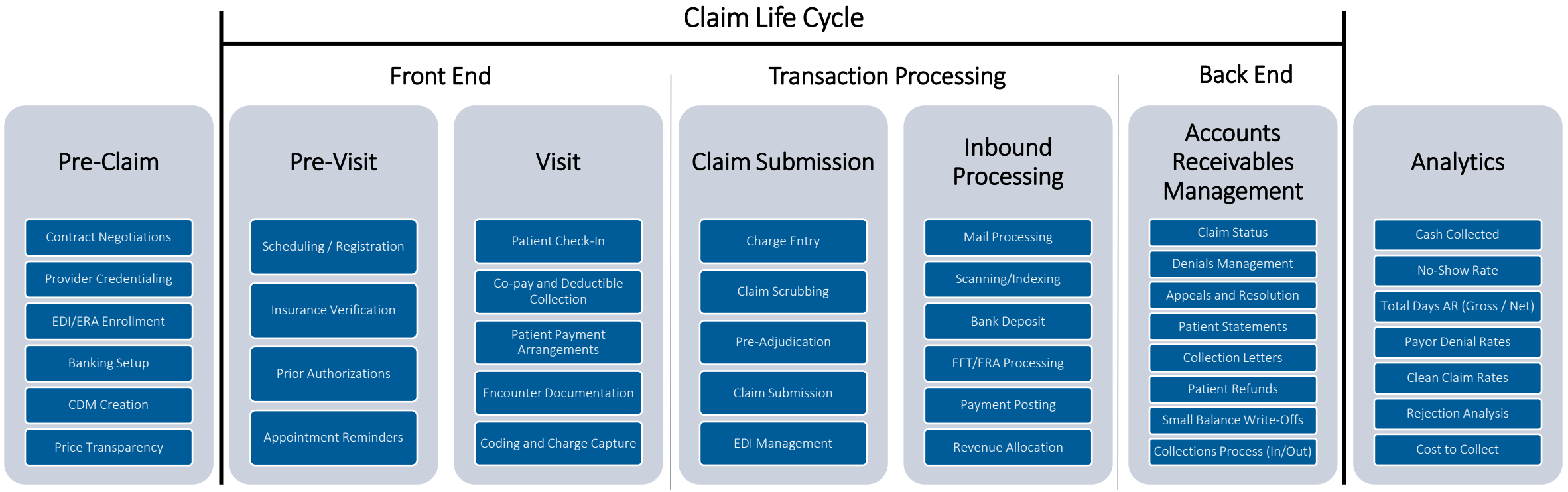
Revenue Cycle Management



Month-End Closing

Cost Reporting

Compliance

Performance Management

IT & Quality

TRANSACTION PROCESSING: CLAIMS SUBMISSION

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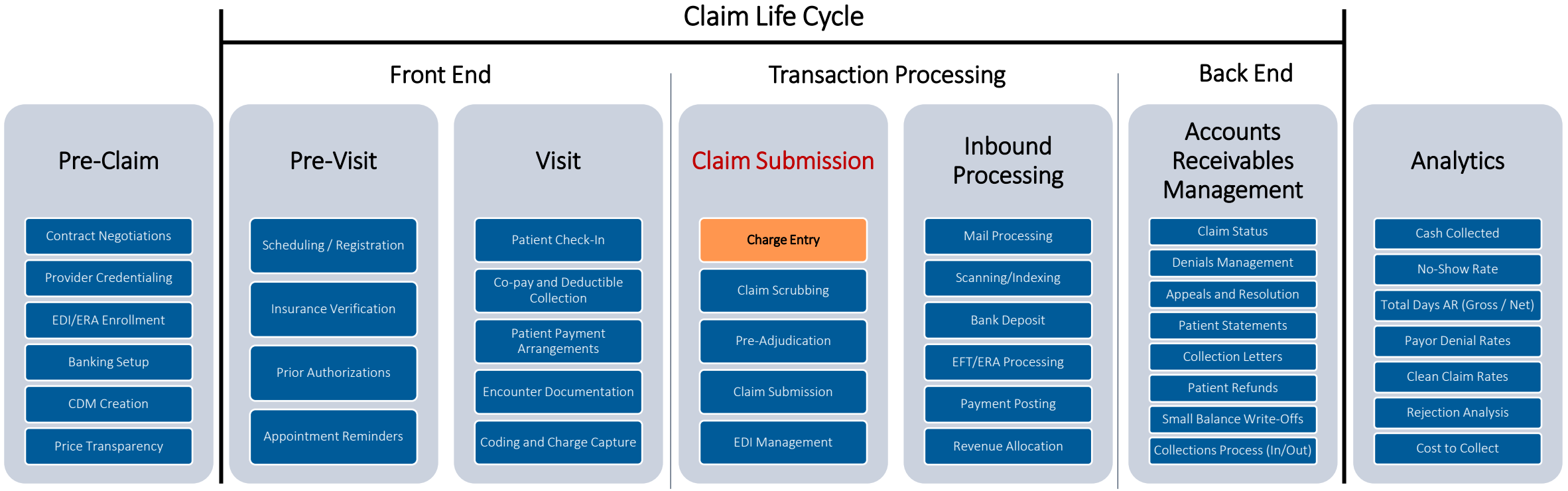
Revenue Cycle Management (cont.)



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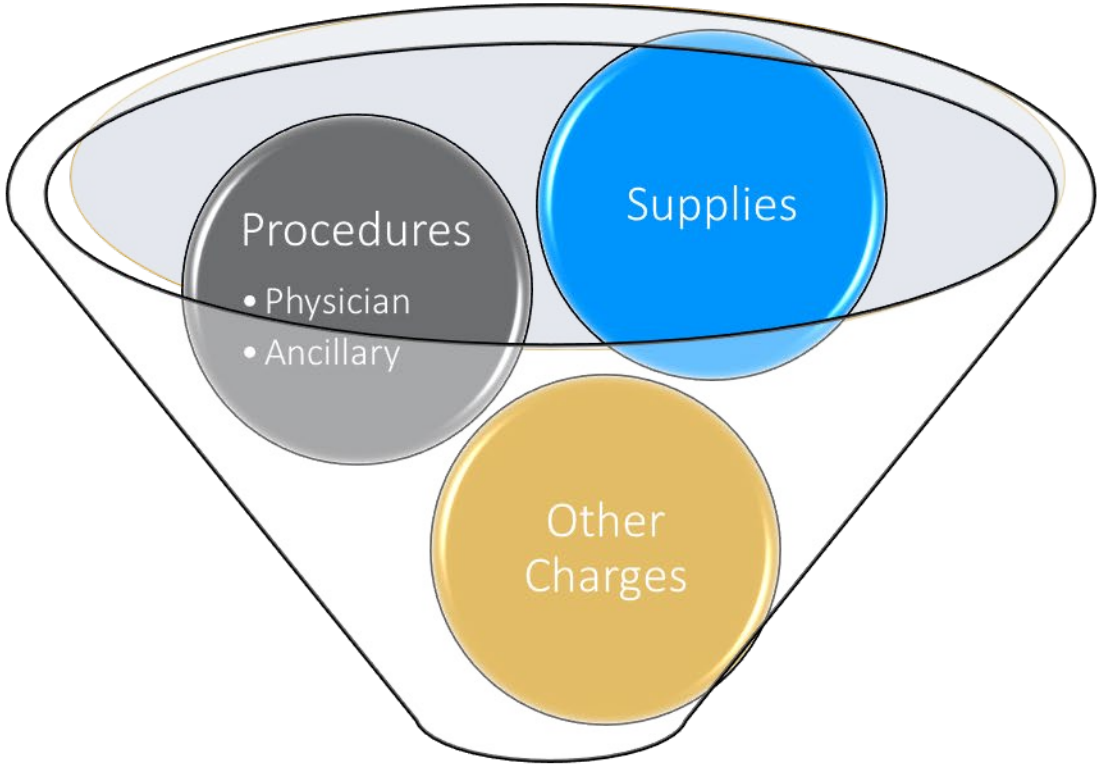
Charge Entry



FINAL BILL

Charge Entry – Best Practices

Engage clinicians in facility-wide policies regarding chart finalization to facilitate completion of charge entry

Develop processes to ensure complete and accurate charge capture, accurate claim submission, and maximum reimbursement

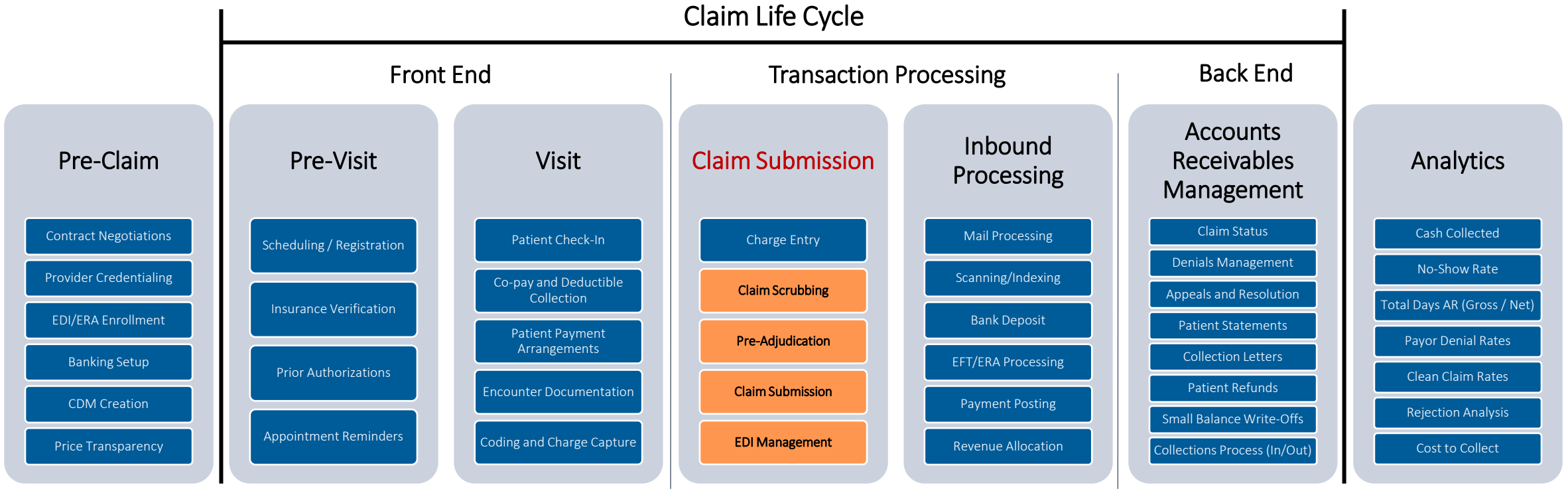
Train team to recognize errors and empower change

- Procedures, drugs and supplies are likely to be billed together
- Services that cannot be performed without other billable services drugs or supplies
- Diagnosis codes are likely to drive denials or requests for additional info

Monitor performance by reviewing

- Discharged Not Final Billed (DNFB) days = Unbilled dollar amount for charges to discharged patients/Average daily revenue
- Late Charge Report = charges dropped after final bill

Revenue Cycle Management (further)



Clearinghouse Activities – Claim Scrubbing, Pre-Adjudication, Claim Submission

Activities

Claim Scrubbing

- Evaluating services to bill
- Identifying missing/incomplete information
- Modifier additions
- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)

Pre-Adjudication

- Insurance verification
- Identification of bundled codes
- Formatting for electronic submission

Claim Submission

- Electronic Submission of claims
- Printing and mailing of paper claims

EDI Management

- Claim acceptance
- Claim rejections

Clearing House – Best Practices

Utilize	Utilize Insurance Verification functionality
Recognize	Recognize Claim Scrubbers evaluate services that are billed but cannot identify likely missing charges
Leverage	Leverage the Claim Scrubber/Clearinghouse to handle “one-off” requirements from payors
Evaluate	Evaluate scrubbed claims with warning edits to determine if process updates are needed
Work	Work monitor batch submissions to ensure all claims are submitted electronically
Acknowledge	Acknowledge paper claims are mailed to some payors
Aim	Aim for 99% clean claims submissions, i.e., no manual intervention needed

Clearing House – Best Practices (cont.)

- Claim Acknowledgement reports need to be worked daily
- Claims that reject from the payor will need to be corrected before they can be submitted
- Rejected claim trends to be analyzed to identify root causes
- Root causes should be addressed earlier in the process to prevent future claims from rejecting

TRANSACTION PROCESSING: INBOUND PROCESSING

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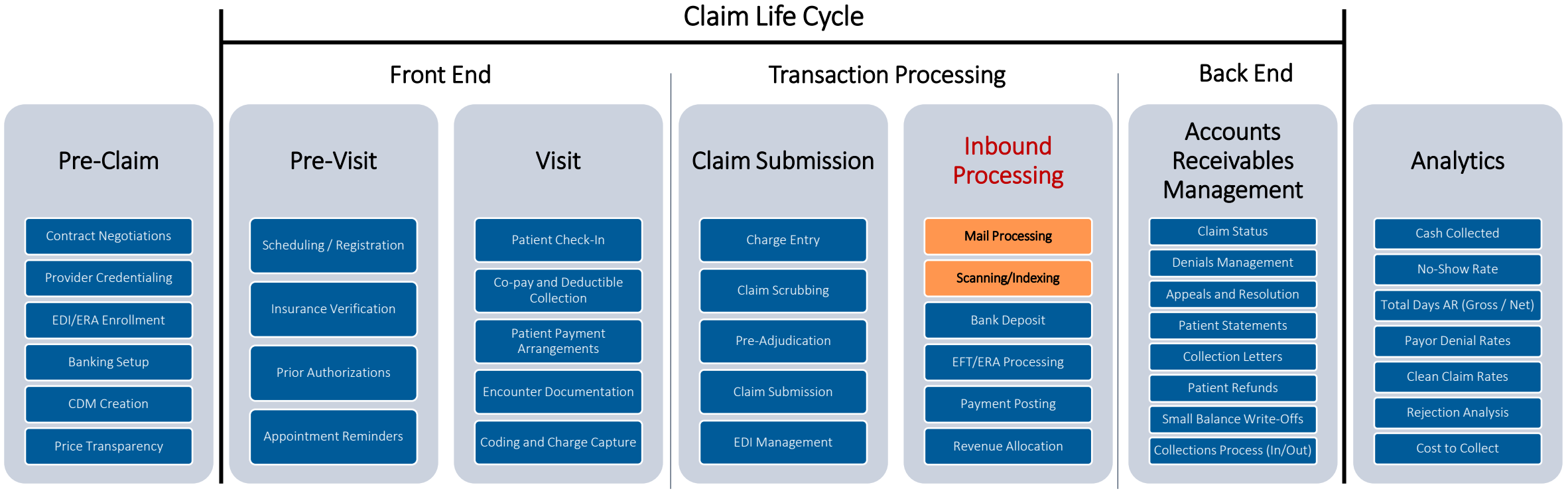
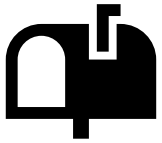
Revenue Cycle Management (once more)



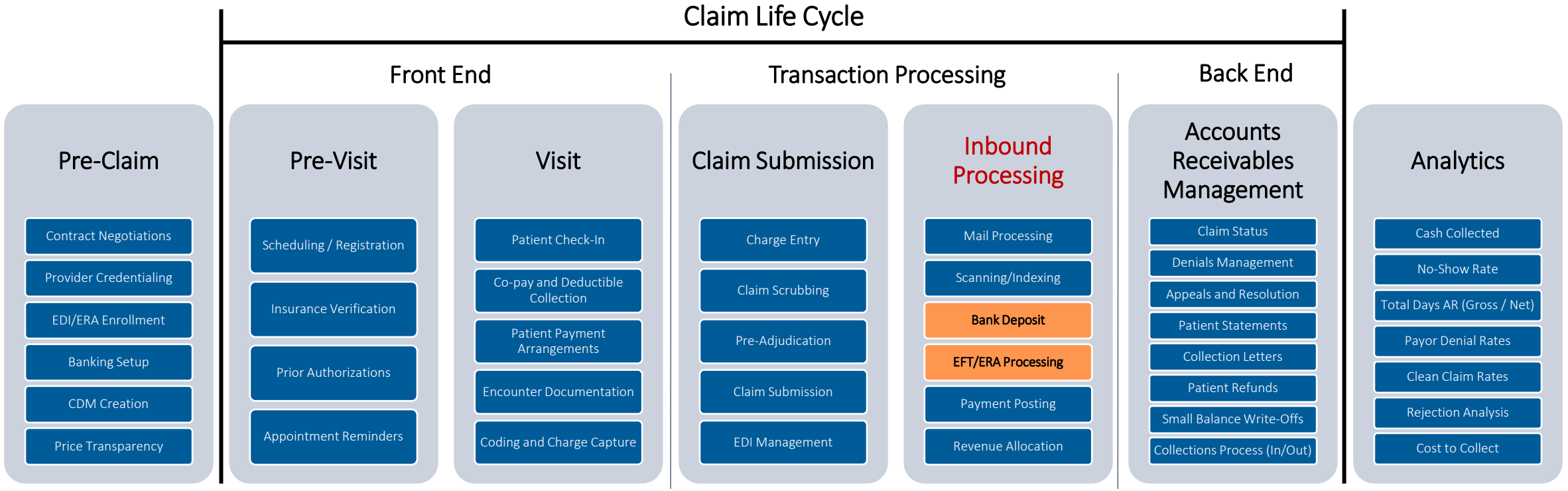
Mail Processing/Scanning Indexing



- Mail should go to a central location and team trained on the importance of their position
- This function is the gateway for notifications that could substantially impact the hospital
  - Watch for Payor Notices – New policies, updates to existing contracts
  - CMS correspondence: Rate Letters, Claim Audits, other notifications
- Payments received in the mail should be deposited daily

- Indexing should allow for team members to quickly identify items to work
- Highly sensitive items should be escalated to appropriate teams
- Patient communication should be scanned, and questions addressed

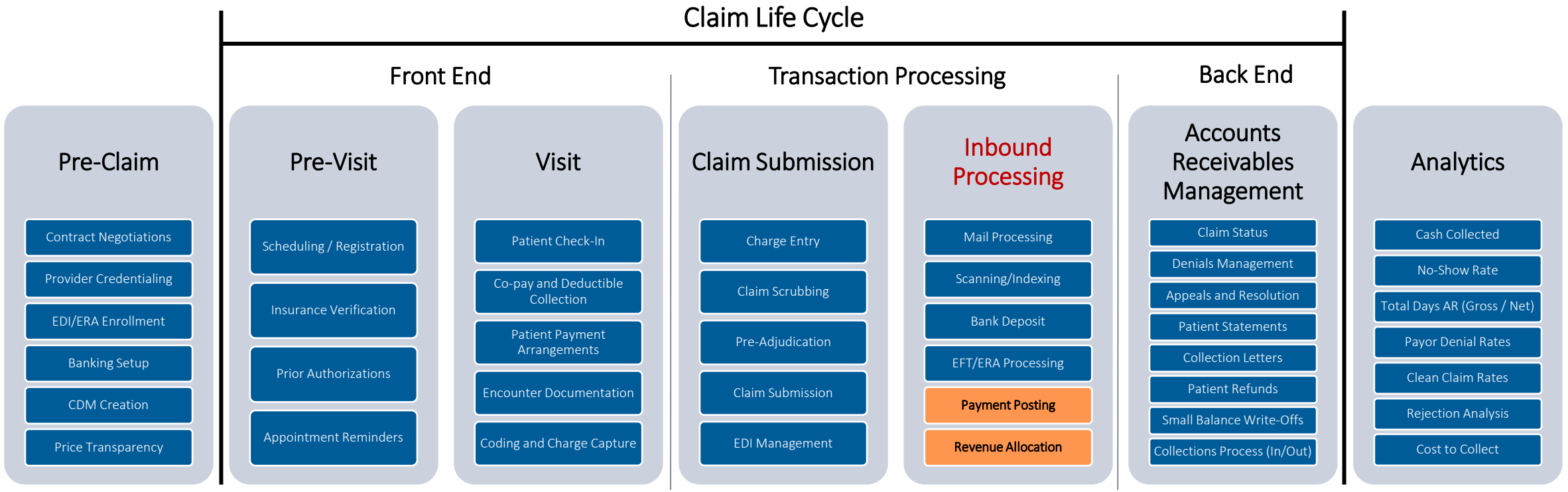
Revenue Cycle Management (again)



Bank Deposit – EFT/ERA Processing

- Electronic payments sent directly to the bank speed up the hospital's access to the funds
- Banks offer services (for a fee) where the hospital can direct all payments (insurance and patient) to be mailed directly to the bank for deposit
- ERA files from insurance companies can be accused to electronically post payments, eliminating the need for manual posting

Revenue Cycle Management (furthermore)



Payment Posting & Revenue Allocation

Payment posting should capture adjustment and denial codes

Posting associates trained to spot anomalies in payments:

- Payments = Total Charges
- Payor payments consistently short small dollar amounts

Appropriate allocation for activity-based funding is achieved through the distribution of payments down to charge level

If a system has multiple billing services, payments made to single Tax ID numbers need to be reconciled amongst those billing services

BACK END

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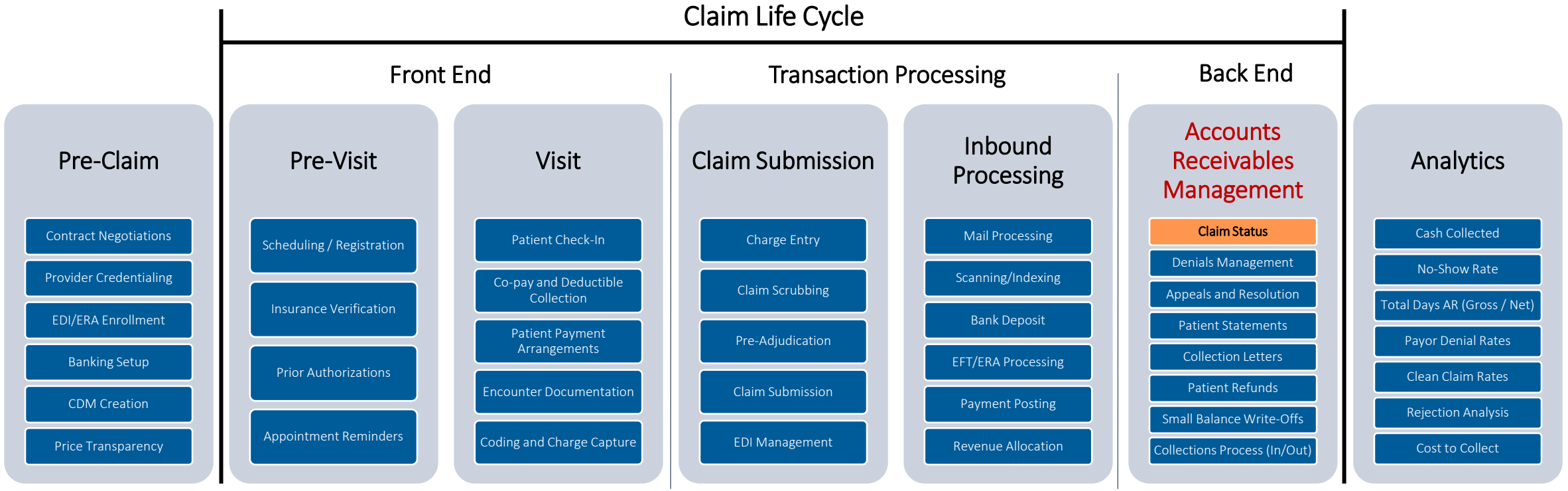
Revenue Cycle Management (next)



Month-End Closing

Cost Reporting

Compliance

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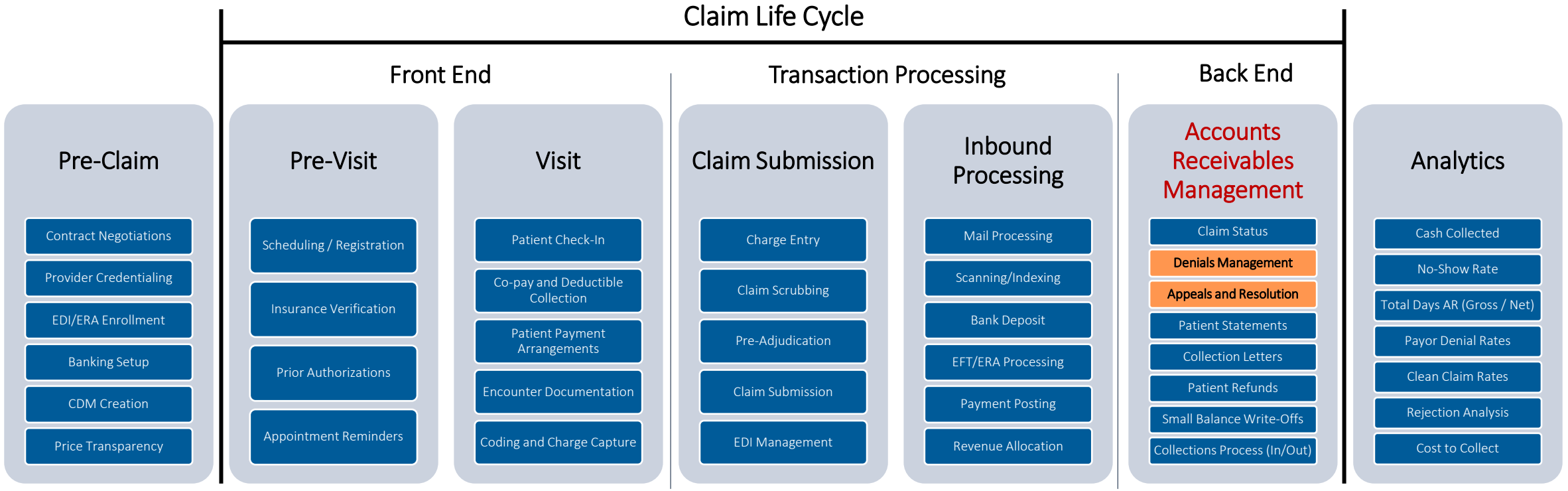
Claim Status Best Practices

- **Work Payor Payment Dates**
  - Follow up on claims outside the typical payment date range
  - Timely filing limits
- **Look for Trends by Payor**
  - Consistent outstanding balances
  - Specific provider claims
- **Focus on Appealed Claims**
  - Needing clinical support
  - Communications received from payor
- **Monitor Claims by Claim Filing Date**
  - Claims stuck at the Clearinghouse
  - Claims not received at the payor

Revenue Cycle Management (once again)



Denials Management

- If no formal denial reports exist, clean up rejection and adjustment codes and use data to track denials
- Utilize summary reports of Clearinghouse edits
- Always focus on fixing the trends
- Adjustment Codes:
  - Specific to payor
  - Does distribution of adjustment codes used, compared to adjustment codes available, seem reasonable?
  - Update codes if necessary to capture cleaner, more accurate data
- Usage and understanding of available adjustment codes consistent across revenue cycle departments

Denials Management/Appeals & Resolution

Insurance denied - Can't ID patient	• Does facility have eligibility software? • Is insurance information updated at every visit? • Is patient identified using two pieces of information? • Free text fields to recognize payor
Preventative services denied for frequency	• Is ordering provider properly tracking frequency? • Does follow up department report frequency denials by ordering provider?
Denied for lack of preauthorization	• Are providers required to preauthorize before booking tests? • Do department order intake processes include obtaining preauthorization verification before scheduling? • Does facility have referral management or preauthorization teams? • Are exams booked too closely to DOS to verify and correct authorization?
Medical necessity denial	• Is service denied appropriately? • Does follow-up maintain an online library of payor-specific policies? • Does follow-up understand available payor-specific medical policies? • Are denials reported back to ordering and servicing departments for education? • Are HIM and coding performing proper review?
Billing process	• Are procedures reviewed by coding prior to submission? • Were proper services and diagnosis codes billed? • Do billers change claim to satisfy clearinghouse edit?

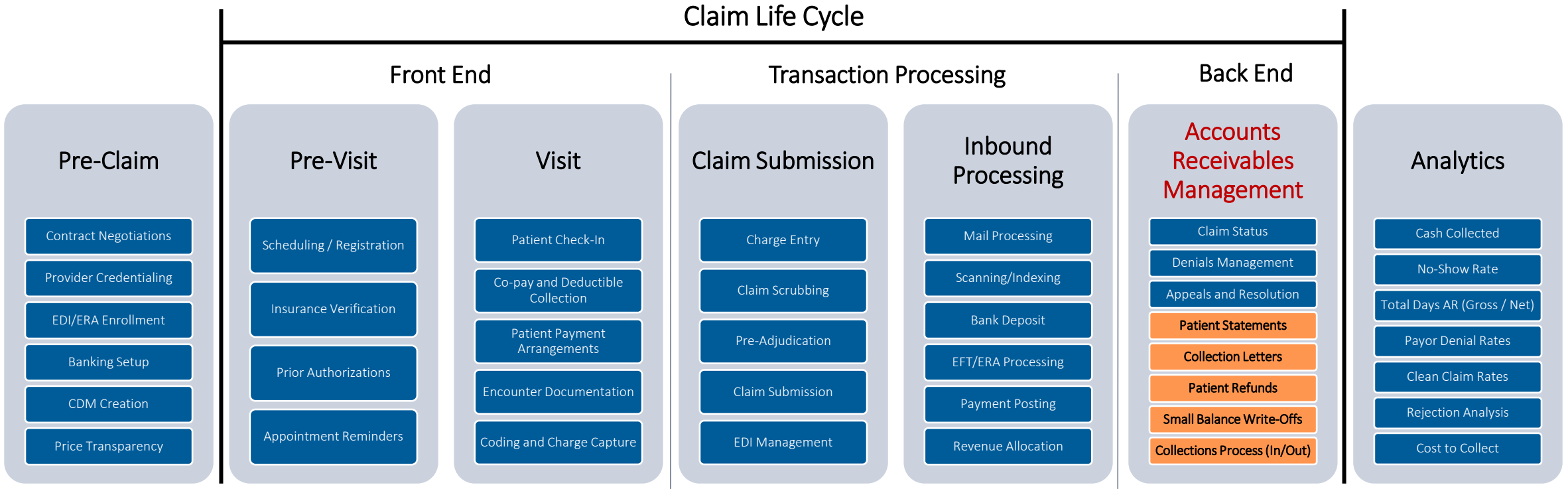
Appeals & Resolution

- File or appeal limits exhausted
  - Timely filing appeal denial
  - How was deadline missed
    - DNFB report
    - Bylaws for provider record completion
    - Missed follow-up from tickler files
- Exhausted appeals
  - Was service denied appropriately?
  - What lessons can be learned?
- Incomplete appeals
  - Did follow-up staff request proper information of HIM?
  - Did HIM provide enough information to support payment?
  - Was requested information reviewed prior to submission?

Look at Denial/Rejection Summary by Group

GROUP	AETNA	ANTHEM	BCBS	CIGNA	COMMERCIAL	MCR	MCR OTHER	MEDICAID	TRICARE	UNITED HEALTHCARE	Totals
CDM	0	0	46	0	0	0	1	547	0	0	594
Credentialing	3	0	81	12	6	0	26	0	0	14	142
Eligibility	12	31	3612	38	48	2873	89	1117	0	33	7853
File Limit	0	0	413	18	42	18	12	231	0	12	746
Medical Necessity	**0**	**47**	**1651**	**0**	**4**	**4,103**	**112**	**0**	**0**	**8**	**5925**
Medical Records	1	1	402	0	116	3,318	12	1,397	0	4	5251
Non-covered Service	0	160	6,874	4	87	1,249	207	68	0	3	8652
Other	44	408	1,842	37	421	1,568	1,071	4,661	0	42	10094
Pre-Authorization	1	17	6	2	18	0	64	2,314	0	7	2429
Referral	17	0	1,946	6	42	0	27	3	0	0	2041
Registration	60	12	180	16	0	0	1	1,414	0	1	1684
UR-Level of Care	0	0	380	0	1	1,617	0	0	0	0	1998
Totals	**138**	**676**	**17433**	**133**	**785**	**14746**	**1622**	**11752**	**0**	**124**	**47409**

Revenue Cycle Management (final)



Patient-Facing AR Activities

- Patient Statements
- Collection Letters
- Patient Refunds
- Small Balance Write-Offs
- Collections Process (In/Out)

Patient Facing AR Activities (cont.)

Patient Statements

- Statements to be delivered on a consistent cadence
- Include status regarding Insurance, (i.e., Plan Billed, Subscriber ID)
- Notate last payor activity (Denial, Payment, No Response)
- Demand messaging to increase with additional statements
- Delivered USPS, email, text messaging
- Provide customer service contact information
- List payment method options

Collection Letters

Patient Refunds

Small Balance Write-Offs

Collections Process (In/Out)

Patient Facing AR Activities (further)

Patient Statements

Collection Letters

- Stronger messaging regarding need for payment
- Share account may be turned over to collections
- Delivered USPS, email, text messaging
- Provide customer service contact information
- List payment method options

Patient Refunds

Small Balance Write-Offs

Collections Process (In/Out)

Patient Facing AR Activities (once more)

Patient Statements

Collection Letters

Patient Refunds

- Evaluate AR to see if patient has other open AR accounts
- Confirm credit balance is not related to over-posted adjustment
- CMS requires refund within 60 days of receipt of payment

Small Balance Write-Offs

- Write off both positive or negative balances at a pre-established dollar amount

Collections Process (In/Out)

Patient Facing AR Activities (final)

Patient Statements

Collection Letters

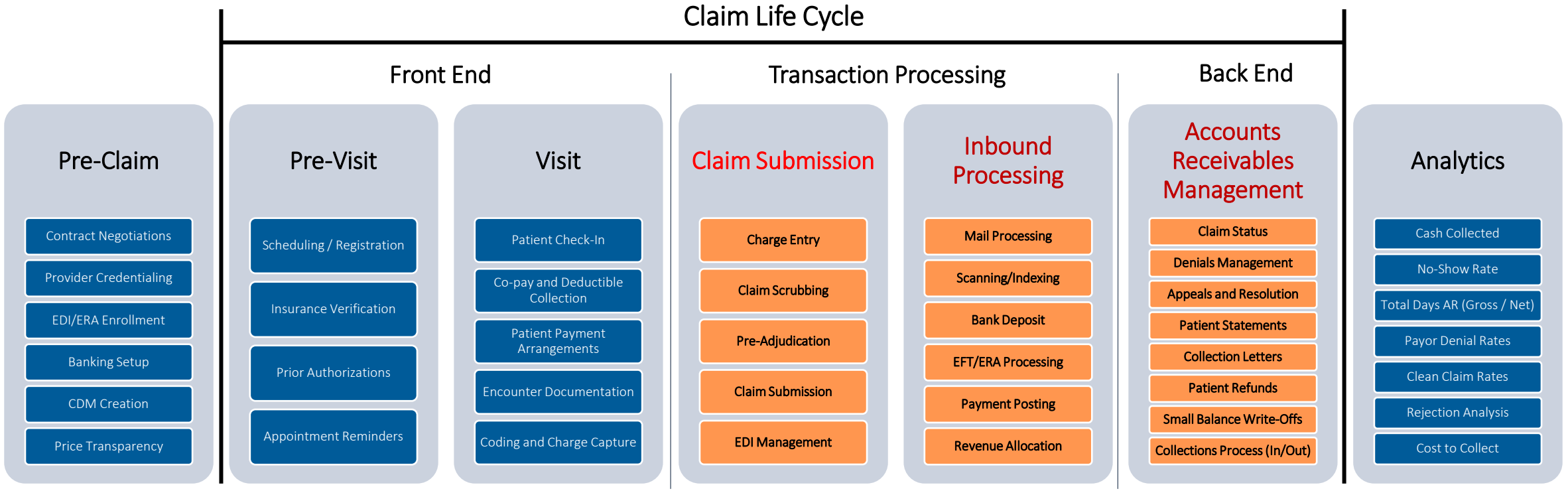
Patient Refunds

Small Balance Write-Offs

Collections Process (In/Out)

- Work with 3rd party agencies to leverage those resources
- Write off AR balances when returned by agency
- Include written off accounts on Cost Report
- Develop processes for both patient and insurance accounts

Revenue Cycle Management (end)



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Q&A

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Other Resources

- Best Practice Concepts in Revenue Cycle Management Guide
- Finding the Value in Your Revenue Cycle Webinar
- Billing and Coding Bootcamp Webinar Series
- Introduction to Facility-Based Infusion and Injection Coding Webinar
- An Introduction to Facility-Based Modifier Usage
- 340B Drug Pricing Program Guide
- 340B Program: A Prescription for Success Webinar
- Hydration Infusions: Charge Capture and Medical Necessity
- Clinical Documentation Integrity Best Practices (Part I)
- Clinical Documentation Integrity Best Practices (Part II)
- Revenue Integrity, Denials Management and Charge Capture Best Practices