Pickens County Medical Center

CARROLLTON, ALABAMA

Key Revenue Cycle Management & Physician Provider Practice Management Recommendations

Develop a Charge Description Master maintenance process

- Create a multi-disciplinary revenue cycle team
- Meet monthly to discuss process improvements, assess denials, discuss CDM maintenance and updates, and compliance issues

Develop a facility-based ER E/M mapping tool to ensure appropriate charge capture

- Perform retrospective ER E/M charge capture audits
- Educate physicians on ER E/M code selections based on results of audits

Develop marketing plan and strategies to promote swing bed & geriatric psychiatric program

- Establish benchmarks and goals for marketing plan
- Educate staff to speak with one voice to support hospital and promote services

Develop financial counseling tools and processes

- Obtain information from Medicaid representative for financial counseling
- Schedule in-service financial counseling training for all staff

Action Steps

Develop a Charge Description Master maintenance process	Develop a facility-based ER E/M mapping tool to ensure appropriate charge capture	Develop marketing plan and strategies to promote swing bed & geriatric psychiatric program	Develop financial counseling tools and processes
•Revenue cycle team created denial log that is monitored on a weekly basis •Hard stops developed in AccuReg to prevent denials	•Performed retrospective ER E/M /charge capture audits •Utilizing American College of Emergency Physicians facility-based guidelines •Physician education provided on documentation improvement •ER Nurse Manager audits charts	•Utilizing social media & local print publications to advertise •Direct marketing to local providers & providers in surrounding area	•Enrolled in Medicaid Hospital Presumptive Eligibility Program to screen self pay patients & assist with paperwork

Next Steps to Support Full Implementation

- Additional training in the upcoming months for business office staff
- Patient collections reporting capabilities update in November with the implementation of new electronic medical record
- Reinstatement in 340B Program

Community Care Coordination Target Population

- Seniors age 65 and older with Heart Failure and COPD that were readmitted to the hospital within the last three months

- Goal: To reduce readmissions and help patients monitor their chronic conditions at home or nursing facilities

Community Care Coordination Implementation Strategy

- Ensure all patients receive a follow up call after discharge
- Develop COPD & heart failure program
- Create community taskforce
- Plan and organize community health education sessions

Community Care Coordination Planning Session

Questions?