Delta Region Community Health Systems Development Program

Revenue Cycle Management Best Practices Check List

August 17, 2021



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

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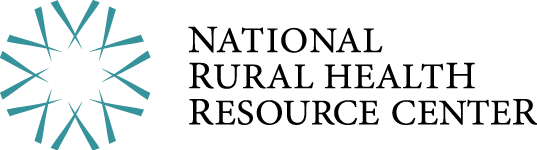
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# Revenue Cycle Best Practice Check List

This revenue cycle best practice check list is obtained from Appendix C in the *Revenue Cycle Management Best Practice Guide*.[[1]](#footnote-2) Use this check list to review your hospital’s current processes to evaluate the opportunity for adopting best practices. This check list is intended to be used in conjunction with the guide.

|  |  |  |
| --- | --- | --- |
| **Patient Centered Revenue Cycle** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| 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 |  |  |
| Bring consistency, clarity, and transparency to patient financial discussions |  |  |
| **Scheduling and Pre-Registration** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Centralize scheduling for services that allows patients to have one place to schedule all services and to inform patients of required |  |  |
| Provide scripts for staff to follow to provide consistent, high quality customer service |  |  |
| Complete prior authorization to meet medical necessity when required |  |  |
| Educate patients about 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 patients early that may need financial assistance or charity care to afford services. Offer sliding fee scale options when appropriate. |  |  |
| Establish financial counselors to support uninsured patients to complete assistance applications |  |  |
| Collect co-payments, deductibles, coinsurance, and patient balances from historical visits at time of service |  |  |
| Offer prompt pay and self-pay discounts |  |  |
| Have clearly defined policies and procedures |  |  |
| Enter all services into an online scheduling system |  |  |
| Integrate IT systems for scheduling and pre-registration functions  Develop process to ensure physician order is available at the time of scheduling or process in place to obtain ahead of service date |  |  |
| Provide verbal and written explanation of hospital policies to the patient |  |  |
| 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** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Complete patient insurance verification for all visits |  |  |
| Pre-determine if services will meet medical necessity |  |  |
| Provide the [Advanced Beneficiary Notice of NonCoverage (ABN)](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN) to all patients when Medicare may not cover a provided service |  |  |
| Utilize electronic tools such as to clinical decision support for evaluating patient placement |  |  |
| Provide ongoing education on medical necessity to clinical and non-clinical staff |  |  |
| Identify charity care patients early and offer sliding fee scale options when appropriate and in accordance with organizational policies |  |  |
| Collect co-payments, deductibles, and previous balances at time of service |  |  |
| Offer prompt pay and self-pay discounts |  |  |
| Have clearly defined policies and procedures |  |  |
| **Revenue Integrity** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| 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 |  |  |
| **Emergency Room Admissions** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Assess how the emergency department reaches the [Evaluation & Management (E&M)](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Evaluation-and-Management-Visits) levels |  |  |
| Determine the actual distribution of E&M levels following correction |  |  |
| Pull out procedure charges and bill separately |  |  |
| Monitor the emergency room (ER) admission rate for inpatient and observation services |  |  |
| Manage an ER re-direct program to collect co-payments, deductibles, and any previous balances from non-emergent patients following the EMTALA screening and/or attempt to move the patient to the more appropriate level of care by either redirecting them to a walk-in clinic or scheduling them in the clinic the next day |  |  |
| Have clearly defined policies and procedures |  |  |
| **Charge Capture and Coding** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Use concurrent coding to improve medical necessity documentation |  |  |
| Hold weekly nursing and HIM team meetings to discuss medical necessity documentation and charge capture opportunities |  |  |
| Hold ancillary department managers responsible for reviewing the prior day’s charges in order to identify errors |  |  |
| Train ancillary staff on appropriate charging and reconciliation |  |  |
| Hold weekly interdisciplinary team meetings to engage managers and build department accountability |  |  |
| Hold weekly interdisciplinary team meetings to determine issues that put the facility at risk, which may include:   * Conducted chart audits * Review system reports such as one day stays and cumulative totals for each ER level |  |  |
| Develop processes that clarify what a separately reportable charge for outpatient services is |  |  |
| Develop a process for regularly reviewing pharmacy charges by auditing the medical records versus charges and claims for injections versus drugs |  |  |
| Establish a formal process that involves the business office and department managers to review existing charge codes and to establish new charge codes |  |  |
| Develop pricing strategies based on market-based data |  |  |
| Perform an annual review to update pricing |  |  |
| Hold quarterly meetings with department managers and BO to conduct a review and update chargemaster |  |  |
| Review third party contracts |  |  |
| Have clearly defined policies and procedures |  |  |
| **Utilization (Care) Management** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Have clearly defined roles differentiating Utilization Review and Case Management functions |  |  |
| Utilize non-clinical support team members to perform as many of the non-clinical administrative tasks as possible |  |  |
| Include in the Utilization Review Committee members from multiple disciplines including utilization review, case management, revenue integrity, compliance, contracting, clinical documentation improvement, and other areas where operational change in one area can significantly impact the performance of another |  |  |
| Monitor length of stay trending and impact on throughput and revenue |  |  |
| Critical Access Hospitals are required to maintain an annual average length of stay of 96 hours or less |  |  |
| Convene the Utilization Management oversight committee to meet monthly, and include data related to outlier cases, clinical denials, length of stay trending, by floor, physician, and MS-DRG |  |  |
| Utilize a physician advisor with concurrent denial peer to peer process with payers |  |  |
| Have thorough understanding of the Medicare 2 Midnight Rule and retrospectively review all Medicare stays with a zero to one day length of stay for status appropriateness |  |  |
| Ensure medical necessity for admissions, by applying current, admission criteria to 100% of medical cases placed in hospital beds with a time-specific deadline after admission |  |  |
| Use the utilization review process to verify physician admission orders, patient class, admission date and time in the electronic health record and the Admission Discharge Transfer event system (if separate) |  |  |
| Document admission reviews, discharge planning, and related care planning in an auditable format that demonstrates a consistently followed care management process |  |  |
| Automate payer notification of hospitalization when possible |  |  |
| Utilize criteria to identify the patients likely to have the most complex discharge planning needs early in their hospitalization |  |  |
| Perform review of readmitted patients to identify root-cause and develop prevention actions going forward |  |  |
| Identify the post-acute service providers where high volumes of patients are discharged to, and form mutually beneficial relationships |  |  |
| **Timely Filing** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| 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 |  |  |
| **Billing and Collections** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Stratify the accounts by amount and aging to prioritize efforts |  |  |
| 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** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Monitor denials for reporting and resolution |  |  |
| 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 |  |  |
| **Revenue Cycle Management Key Performance Indicators (KPI)** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Hold weekly RCT meetings   * + [See Table 1: Roles In High- Performance Revenue Cycle](https://ruralcenter.sharepoint.com/delta/Shared%20Documents/Resource%20Development/RCM%20Best%20Practices%20and%20340B%20Guides/RCM%20and%20340B%20Guide%20Updates%202021/Revenue%20Cycle%20Management%20Best%20Practices%20Guide%20August%2017%202021.docx#_Table_1:_Roles) |  |  |
| Track and monitor KPI   * + [See Table 2: Common KPIs](https://ruralcenter.sharepoint.com/delta/Shared%20Documents/Resource%20Development/RCM%20Best%20Practices%20and%20340B%20Guides/RCM%20and%20340B%20Guide%20Updates%202021/Revenue%20Cycle%20Management%20Best%20Practices%20Guide%20August%2017%202021.docx#_Table_2:_Common) |  |  |
| Utilize dashboards to drive performance |  |  |
| **Telehealth** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Understand state and federal regulatory requirements |  |  |
| Apply billing guidelines and documentation requirements |  |  |
| Utilize Health Insurance Privacy and Portability Act (HIPAA) - Compliant technologies and appropriate Business Associate Agreements |  |  |
| **Compliance Program** | | |
| **Best Practice** | **Current Process** | **Next Steps** |
| Designate a compliance officer and compliance committee |  |  |
| Develop compliance policies and procedures, including standards of conduct |  |  |
| Develop open lines of communication |  |  |
| Perform internal auditing and monitoring |  |  |
| Respond to detected deficiencies |  |  |
| Enforce disciplinary standards |  |  |

1. BKD CPAs and Advisors and the National Rural Health Resource Center; [Best Practice Concepts in Revenue Cycle Management Guide](https://ruralcenter.sharepoint.com/delta/Shared%20Documents/Resource%20Development/RCM%20Best%20Practices%20and%20340B%20Guides/RCM%20and%20340B%20Guide%20Updates%202021/Best%20Practice%20Concepts%20in%20Revenue%20Cycle%20Management%20Guide); August 2021 [↑](#footnote-ref-2)