Revenue Cycle Management

Account Management: Move from Denial Management to Denial Avoidance with Process Improvement

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Putting it together

Revenue Cycle Control Points

Revenue Cycle is the financial process related to a patient encounter. It includes the registration process of a patient where data is gathered and utilized to financially clear the upcoming service. It then follows the patient encounter though out the clinical departments of a facility to ensure proper charge capture, code assignment and billing at discharge it ends with the collection of the final correct payment.

Patient Access
- Scheduling
- Pre-Registration
- Financial Counseling
- Registration

Case Mgmt.
- Utilization
- Discharge Planning

Service Documen-tation
- Charge Master
- HIM
- Charge Capture
- Late Charges
- Coding
- Audits/Compliance

Billing
- Claims Editor
- Bill Reconciliation
- Contractual Adjustments
- Patient Statements

A/R Mgmt.
- Cash/EOB Posting
- Third Party Collections
- Account Write offs
- Bad Debt

Customer Service
- Customer Inquiries
- Issues Resolution
- Service Recovery

Policies

- Create policies that support the process
- Train your team to follow the policy and process
  - Ensure them that you will support sound decisions based upon the policy.
- Outline a path for escalation if needed

Insurance Billing and Follow up Using the Score Card

- Dispositional Receivables Management
- Payer Score Cards
- Understanding your payer contracts
- Understanding your rights as a provider
- Follow up with “intention” not just “claims status”

Payer Score Card

Dispositional Receivable Management

- Payer Score Card Approach
- An advanced approach when compared to the typical "High to Low Aging" driven follow up method
- Stratification/Segmentation is a discipline where by receivables are grouped with like dispositions for a collective follow up process.
- Shows the story of the A/R and it's collectability
- Allows more productivity for staff. They are able to touch accounts in the 100's thereby yielding significant increases in account resolution…cash
- Understanding your payer contracts
- Understanding your rights as a provider
- Follow up with "intention" not just "claims status"

Payer Score Card

- HFMA Suggests this format

Category	Best Practice	Your Number	Variance	Gold Star
A/R > 60 Days	20.9%	44.5%	23.6%	
>35 Days, No Payment or Response	6.3%	6.3%	0.0%	★
Potential Underpayment	8.3%	25.0%	16.7%	
Under Appeal	6.7%	6.7%	0.0%	★
Potential Overpayment	-2.3%	-2.3%	0.0%	★

- Create this type of data for your top 10 payers. Use this data to send in a letter format.

Insurance / Team information	
Month	December, 2009
Week	3 of 5
Group	**Medicare**
Acct Rep	Suzie Smith
Contact: Phone #	Jesse James 888-123-4567

KPI's and Key Ratios			
Net Days	Cash	ash Target M	% A/R > 90d
41.0	$1,322,846	$2,311,166	8.1%
UB:FB:GR %	Conversion Rate: UB:FB %	Conversion Rate: GR %	ENR%
91.2%	94.6%	86.2%	26.5%

Key Performance Indicators

Week	Gross A/R	Gross A/R Target	Variance	DNFB	DNFB Target	Variance	Delayed Cash Opportunity	Net Days	Net Days Target	Variance	A/R > 90d	A/R > 90d Target	Variance	Cash	Cash MTD Target	Variance
1	$5,317,928	$4,530,794	$787,134	$2,716,858	$707,937	$2,008,922	$1,064,545	38.6	32.0	6.6	$482,658	$0	$482,658	$454,853	$608,202	-$153,348
2	$5,044,127	$4,530,794	$513,334	$2,433,891	$707,937	$1,725,954	$914,624	37.4	32.0	5.4	$475,148	$0	$475,148	$1,028,079	$1,094,763	-$66,684
3	$5,634,510	$4,530,794	$1,103,716	$2,978,513	$707,937	$2,270,546	$1,203,232	41.0	32.0	9.0	$455,702	$0	$455,702	$1,322,876	$1,702,964	-$380,088
4																
5																

Dispositional Statistics

Week	Submitted			Pended			Adjudicated			Promise To Pay			Denied		
	Count	% of Total A/I	Balance	Count	% of Total A/R	Balance	Count	% of Total A/R	Balance	Count	% of Total A/R	Balance	Count	% of Total A/R	Balance
1	2122	45.0%	$1,548,173	132	3.0%	$135,484	337	7.0%	$355,492	60	1.0%	$397,692	170	4.0%	$83,183
2	1894	42.1%	$1,430,903	138	3.1%	$104,834	264	5.9%	$312,557	62	1.4%	$428,302	147	3.3%	$67,593
3	1844	38.9%	$1,480,933	145	3.1%	$137,766	280	5.9%	$239,664	38	0.8%	$60,697	161	3.4%	$86,696
4															
5															

Operating Statistics

CWOT MTD	4809
Total Closed Account MTD	4745
CWOT %	86.00%

Week	Total Touches	Target	Variance
1	145		
2	190		
3	52		
4			
5			

Notes:

Other Stats

DNFB Top 3 Hold Reasons

	Reason	Count	Gross Charges
1		#	$0
2		#	$0
3		#	$0

Top 3 Open Denials

	Description	Count	Balance
1	Non Covered Charges	20	$38,232
2	Dupicate Claims	11	$3,617
3	Claim Denied Pt cannot be ID	2	$6,054

Top 3 Open Pended

1	Description	Count	Balance
2	Coding Review	96	$55,450
3	Internal Review	26	$15,215
	Insurance Reviewing Claim	12	$68,639

Notes

How do we ensure proper and prompt Insurance payments

You must confirm that you have…

1) Trained your insurance verification staff
   - Not only to request coverage data but also request Quotes of anticipated reimbursement for the planned procedure (get it in writing)
2) Identified the data that payers are using to determine your fee schedules.
   - Work with the lower paying carriers to ensure they are not misinterpreting your data.
3) Reviewed your reductions
   - Do they appear to be from Fee Schedules, Reasonable and customary rates, down coding or audit issues.

Understand your payers

- There are innumerable edits that a payer can place in their system which makes it inevitable that you will receive a denial.
  - Pre-Bill edits based on experiential data
  - Continual process improvement
- Be sure you know how to correct the issue on this claim and future claims
- Ask yourself if the denial is appropriate and where you could have redirected efforts prior to claim submission and/or prior to discharge.

Resolve Discrepancies

Payment discrepancy Resolution

- Denials and under payments have the most harmful impact on the Income Statement
- Understand and educate regarding payer contracts
  - How to verify coverage
  - How to appeal coverage determinations
  - Timely Filing rules
  - Fee Schedules
  - Special billing requirements
- Create a focused payment discrepancy team
  - Denial Management and prevention Team
  - Contractual Underpayments Team
  - Credit Balance Management Team
- Use a cross-functional and holistic approach that is integrated closely with Finance on expected reimbursement and related Net revenue topics

Claims Auditing

- Insurance companies are deploying robust claim checking software that use sophisticated coding logic and providers find themselves struggling to keep up with what their services are worth on any given date.
- Reduced payments are one area that have hit providers hard.
- Many providers are remiss in their responsibility to protect their payments thinking they have no other choice…

Denial Management

- Have you ever asked yourself ~ how is it that most insurance companies use the same tactics to delay or deny my claims
- Track your denials by payer and by type
- Interpret your carrier contracts to ensure that you do not receive incorrect “denial reasons”
- Track your denials to prevent oversight of a denial
- Report overturned denials to leadership for use during contract negotiations
- Creation of an interdepartmental task force to mitigate denials
- Education will help to identify upstream issues that might be causing the denial

Denial Score Card

Denial Prevention

Use this tool to communicate to your Denial

Team. Transparency and accountability will allow change.

- ❑ By Payer
- ❑ By Reason
- ❑ By Department
- ❑ % of revenue submitted
- ❑ Denials % GR
- ❑ Denial over-turned %
- ❑ Payer Rejects as % of Remit Revenue processed

Sample Denial Dashboard

Hospital Name
Denial Dashboard
Week Ending: 02/18/2011

Weekly Denial Inflow	
Created Denials:	364
Closed Denials:	388
Voided Denials:	0
Total Open Denials:	1,949

Denial Aging by Create Date

	0-30	31-60	61-90	91-120	121+	Total
Count:	846	339	244	114	418	1961
Denial Amount:	$6,500,602	$2,883,159	$1,165,277	$899,668	$3,074,396	$14,523,101
Total Charges:	$9,846,705	$4,004,292	$2,232,959	$1,145,118	$4,416,424	$21,645,498
Payments:	-$836,763	-$313,527	-$254,490	-$144,008	-$946,029	-$2,494,816
Adjustments:	-$3,759,483	-$1,598,610	-$708,807	-$578,685	-$2,373,459	-$9,019,044

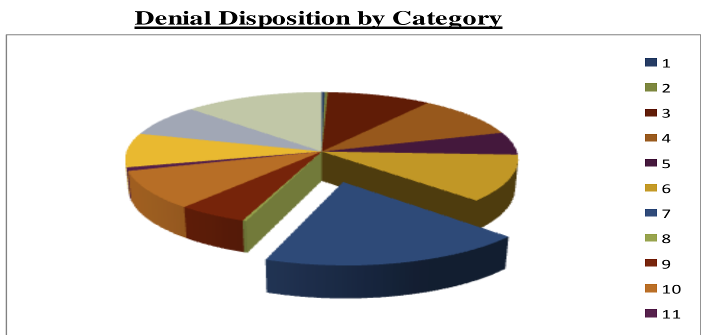
Denial Aging By Discharge Date

	0-30	31-60	61-90	91-120	121+	Total
Count:	106	347	267	282	959	1961
Denial Amount:	$536,015	$2,714,331	$2,707,682	$1,503,194	$7,061,879	$14,523,101
Total Charges:	$788,160	$4,077,565	$3,692,958	$2,723,425	$10,363,389	$21,645,498
Payments:	-$11,403	-$216,970	-$229,991	-$197,979	-$1,838,474	-$2,494,816
Adjustments:	-$505,622	-$1,613,928	-$1,674,538	-$769,705	-$4,455,250	-$9,019,044

Weekly Trending Report

	1/21/2011	1/28/2011	2/4/2011	2/11/2011	2/18/2011	Total
Created:	426	335	339	324	364	1788
Closed:	360	438	248	313	388	1747
Voided:	0	0	0	0	0	0

Denial Disposition by Category



Open Denial Status

	Count
Created:	1
Appealing Denial	1
In Progress	35
Pending Patient Response	37
Pending Ins Response	20
Medical Records Review	41
Medical Records Request	68
Utilization Review	1
Management Review	19
Sent Letter	34
Waiting for Payment	3
EOB Needed	30

Resolution Status

	Count	Denial $	Payments	Adjustments
Appeal Denied	1	$2,593	$0	$0
Auth Rec'd	1	$1,996	$0	-$615
Auto-Account Closed	35	$375,402	-$106,084	-$214,027
Auto-Balance Transferred	37	$140,871	-$69,892	-$489,894
Auto-Bucket Balance W/O	20	$173,979	-$37,409	-$92,455
Auto- PIF	41	$462,042	-$89,037	-$236,799
Auto-Closed	68	$1,104,415	-$56,111	-$298,410
Balance Trans Next Payer	1	$266	-$122	-$113
Balance Trans to PT	19	$70,870	-$10,624	-$33,450
Claim Resubmitted	34	$239,160	-$2,579	-$72,776
Correct payer billed	3	$11,960	$0	-$1,541
Denied Amount Write off	30	$101,791	-$14,127	-$109,009
Manually Closed	28	$85,996	-$19,482	-$129,728
No Action Needed	47	$500,820	-$53,275	-$172,549

Appeal Incorrect payments

What to include in your appeal

1. Cite ERISA, State statutes/Laws that support your position
2. Provide average stats on your anticipated reimbursement amount. Be prepared to challenge their citing of other providers who are out of your region and/or do not provide the same level of care.
3. Stand firm that you only offer discounts to those who pay promptly
4. Request prompt payment
5. If the denial is upheld request that they send supporting documentation
6. Incorrect payments – request a copy of the fee schedule

Core Teams

Integrated Unbilled Receivables Management

- All areas of the Revenue Cycle must view their core activities as a form of A/R Management
  - Pre-Processing
  - Patient Access
  - Care Management
  - Charge Capture/Revenue Integrity
  - HIM/Coding
  - Patient Financial Services
- Specific suspense periods around Financial class and service type.
- Align fatal edits by department and type
- Revenue Integrity
- Service Documentation requirements.
- Rigid front end edits allowing only the cleanest product to flow into the PFS department for cash conversion.

Steps

- Identify the reason for the denial
- Route the denial automatically vs. print, copy, and file in a “to do” bucket.
- Have specific staff members within each department responsible for timely correction of denied claims. (i.e. Coding, Patient Access, Clinical…etc.)
- Ensure that the staff member has access to technology and training on how to correct not only this claim but future claims.
- Create a standard workflow either manual or automated with reminders. Base the work flow on type of denial.
- Create a step by step manual for employees to follow.

Reimbursement Opportunities

- Difficult to hold staff accountable if organization has not taken every step to capture all earned revenue
  - Medicare
  - Other payors
- Easier to capture lost reimbursement than to identify operational efficiencies
- Remember cost reimbursement does not occur unless the charges are successfully processed

Reimbursement Opportunities: Coding

- Coding
  - Periodic DRG and CPT code reviews
    - Medicare is not your only payor
  - DRG and CPT code reviews
    - Do not assume your coders are up to date
    - Failure for payors to return claims does not equal proper coding
    - 20% – 30% error rates common
    - Periodic reviews can lead to increase in prospective payments and decrease in denials

Coding

- Coding should be completed by

a certified coding expert prior to sending a final bill to ensure that all services are captured correctly.

- Regulatory changes and governmental divisions have been created with a strict focus on compliant coding. (RAC, MAC etc.)
- On going audits become essential to ensure that you have a compliant process in place to stave off any sanctions from the government.

Reimbursement Opportunities: Charge Capture

- Charge capture
  - Failures occur due to failures in design of charge capture processes and lack of understanding of reportable services by nursing staff
  - A perfect chargemaster means nothing if the charges are not properly captured
    - Periodic documentation and billing reviews
    - 30% - 40% error rates common
    - Majority of errors include lost charge
      - CPT/HCPCS for fee schedule payors
      - Charges for charge based payors

Charge Capture ~ Revenue Integrity

- Suspense times should be communicated and should be a part of your facilities policies and procedures.
  - Suspense times are strict time lines 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 your days in A/R outstanding as well as cash flow.

Charge Master ~ Revenue Integrity

- Systematic reviews of your charge master are essential to ensure that you are capturing all revenue correctly and that you are not leaving dollars on the table.
- Keep in mind that if you make adjustments to your Charge Master you must think of the down stream effects to your cost reports.
  - Ensure that you have a process in place that will tie your changes to your compliant cost report

Reimbursement Opportunities: Pricing

- Pricing
  - Charges still matter for Critical Access Hospitals
    - Many CAHs have payor contracts that reimburse based on charges or percentage of charge
    - Charges must be above published fee schedules or risk reductions in reimbursement
  - Pricing falls behind the market for two reasons
    - Failure to understand the true impact of charges
    - Perceived pressure on Board to hold down pricing

Reimbursement Opportunities: Pricing

- Pricing
  - Recommend periodic market based comparisons of pricing
    - Medicare outpatient data
    - Commercial claims data

What gets measured gets improved

- Clean Claim Rates – 93% of all claims should be “clean claims” (Includes: claims not paid within 45 days, claims sent more than one time prior to payment, claims held in your clearing house for a failure or claims that were denied needing more information from the provider)
- Classify denials by reason, source, cause and other distinguishing factors.
- The AMA reports that between1.38% and 5.07% of claims are denied on first submission.

Disclaimer

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