Topics for Discussion

Revenue Cycle
- Objectives
- Challenges
- Management Goals and Expected Benefits
- Sample Metrics
- Opportunities
- Summary Solution Steps

Insurance Contracting Issues
- Sample Contract Language Discussion
- Payor Report Card Development
Revenue Cycle Objectives

• Enhance the capture and collection of patient billings in an efficient, effective, timely, and compliant manner.

• Put the patient at the heart of the revenue cycle by providing:
  − Accurate and timely information regarding financial obligations of care
  − Patient-directed choices regarding flow of financial information
  − Future movement toward patient-directed choices regarding health care service options based on clinical effectiveness and cost

• Create an integrated approach to revenue integrity with organization alignment and common performance goals/metrics.

• Focus on prevention (upstream versus downstream processes).

• Create an efficient working environment.
### Revenue Cycle Challenges - A Complex World

- Charity vs. bad debt classification
- ICD-10 transition
- New technology requiring revenue cycle training and cross training
- Patient access staff turnover
- Chargemaster issues (coding, pricing, system integration, etc.)
- Revenue capture and other data integrity issues
- Transition from paper to electronic health records
- Patient billing/accounting system upgrades and/or conversions

### Other Challenges

**Insurance Contracting is Becoming More Complex**

- Eligibility issues
- Prior authorization requirements
- Medical necessity requirements
- Insurance with higher "self pay" amounts
- Timely filing requirements
- Claims processing issues (Medicaid managed care, claim edits)
- Claim denials for many reasons
Other Challenges

Insurance Contracting Is Becoming More Complex (Continued)

• Complex fee schedules (particularly for outpatient services)
• Usual and customary charge issues
• Payment policy issues, especially with ICD-10
• Unfavorable contract terms
• Lack of contract terms to protect providers
• Changing requirements
• Methodology of enhanced ambulatory patient groupings for some payors

Management Goals and Expected Benefits
Management Goals and Expected Benefits

Expected Goals and Benefits (the “What”)

• Improve financial outcomes
• Improve patient experience prior to care
• Improve patient experience after point of care
• Maximize staffing efficiency in the business office
• Reduce claim denials (clinical and technical)
• Improve charge capture and coding accuracy
• Reduce bad debt write-offs
• Reduce rework with collections
• Improve payment accuracy
• Improve communications with payors
• Improve discharged to billed days

Source: 2007 HIMSS Analytics™ LLC

Management Goals and Expected Benefits

The “How”

• Develop a well-functioning, CONNECTED revenue cycle team
• Use internal benchmarks to monitor and improve performance
• Create a shared sense of accountability for revenue cycle performance
• Step up efforts to collaborate with other departments to enhance revenue cycle performance
Revenue Cycle Sample Metrics

Revenue Cycle Metrics

HFMA’s “Best Practice” Revenue Cycle Metrics (“HFMA Map App”)

• To view data, you will need to be a provider member of HFMA.
• Go to the HFMA website to map app.
• Sign on. You then may report your hospital data or see the benchmarks for best practices.
### Sample Metrics

#### Revenue Cycle Scorecard - SAMPLE

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Target</th>
<th>Indicator</th>
<th>06/30/12</th>
<th>2012 Monthly Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE PERFORMANCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Revenue (MTD)</td>
<td>$3,254,403</td>
<td></td>
<td>$3,170,558</td>
<td></td>
</tr>
<tr>
<td>Average Daily Revenue</td>
<td>$101,144</td>
<td></td>
<td>$97,822</td>
<td></td>
</tr>
<tr>
<td>Cash Collections</td>
<td>$1,815,629</td>
<td></td>
<td>$1,806,980</td>
<td></td>
</tr>
<tr>
<td>Monthly POS Cash Collections</td>
<td>$6,634</td>
<td></td>
<td>$6,497</td>
<td></td>
</tr>
<tr>
<td>Bad Debt Transfers</td>
<td>$61,001.39</td>
<td></td>
<td>$60,731</td>
<td></td>
</tr>
<tr>
<td>Bad Debt Transfers as % of Gross Revenue</td>
<td>3%</td>
<td></td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Charity Care Write-Offs</td>
<td>$28,513</td>
<td></td>
<td>$13,240</td>
<td></td>
</tr>
<tr>
<td>Charity Care as % of Gross Revenue</td>
<td>3%</td>
<td></td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td><strong>AVOIDABLE ADJUSTMENTS - (Total)</strong></td>
<td></td>
<td></td>
<td>$155,750</td>
<td></td>
</tr>
<tr>
<td>Denial Write-Off Total</td>
<td>$38,750</td>
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<td>$80,000</td>
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<tr>
<td>Eligibility</td>
<td>$2,083</td>
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<td>$6,950</td>
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</tr>
<tr>
<td>Non-Covered</td>
<td>$11,000</td>
<td></td>
<td>$23,000</td>
<td></td>
</tr>
<tr>
<td>Self-Administered Drugs</td>
<td>$0</td>
<td></td>
<td>$1,600</td>
<td></td>
</tr>
<tr>
<td>Untimely Filing</td>
<td>$5,000</td>
<td></td>
<td>$12,000</td>
<td></td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>$50,000</td>
<td></td>
<td>$41,667</td>
<td></td>
</tr>
<tr>
<td><strong>LATE CHARGES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late Charges - (Posted &gt; 3 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late Charges - % of Gross Revenue</td>
<td>&lt;2.0%</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

### Sample Key Performance Indicators

#### Current Balance and 90 Day Aging

- Total Balance is $14,240,368
- % AR 90+ Days: 25%
- AR < 30 Days: 75%
- AR 30-59 Days: 25%
- AR 60-89 Days: 10%
- AR 90-119 Days: 10%
- AR 120-179 Days: 5%
- AR > 180 Days: 5%

#### WIPFLI Healthcare Practice
Sample Key Performance Dashboard

Revenue Cycle Common Findings

Revenue Cycle Opportunities
Revenue Cycle Opportunities

Paradigm Shift

Move functions of the back office to the front office:

• Process improvement will shrink work in the back office.
• Provides capability to discuss “price” with patients.

Revenue Cycle Opportunities

Patient Access - Scheduling

Best Practices:

• Establish single point of contact for all nonemergent procedures.
• Develop a standardized scheduling process to capture consistent information each and every time and coordinate the necessary ancillary tests and procedures:
  − Gather patient information
  − Verify insurance information and refer cases to financial coverage counselor
  − Collect outstanding amounts due (e.g., copayments, deductibles, noncovered items and services, etc.)
Revenue Cycle Opportunities

Mid-Cycle

- Case management/care coordination
- Service orders and service documentation
- Charge capture
- HIM activities (coding, documentation, etc.)

Revenue Cycle Opportunities

Health Information Management (HIM)

Common Coding and Documentation Issues in Critical Access Hospitals (CAHs):

- Physician orders not documented properly (also for add-on services)
- IV therapy - Start and stop times not documented
- Documentation of EKG interpretations often missing
- ED professional/technical services often missing
- ED professional/technical services often coded inaccurately or templates used to create all low-level services
- ED procedures often missed (e.g., nursing procedures, POS tests, etc.)
- CRNA billing often incorrect or not billed at all
Revenue Cycle Opportunities

Mid-Cycle Medical Records

Common Coding and Documentation Issues in Hospitals:

• Physician orders not documented properly (also for add-on services)
• IV therapy - Start and stop times not documented
• Documentation of EKG interpretations often missing
• ED professional/technical services often missing
• ED professional/technical services often coded inaccurately or templates used to create all low-level services
• ED procedures often missed, e.g., nursing procedures, POS tests, etc.
• CRNA billing often incorrect or not billed at all

Revenue Cycle Opportunities

Mid-Cycle - Medical Records (Continued)

Best Practices:

• A critical element of success includes a comprehensive up-to-date and accurate chargemaster (for professional and technical services) with clear policies regarding routine supplies/billing for equipment/E&M code classification (professional and technical), and updating of the chargemaster with CMS quarterly updates.
• Charge capture systems should be automated (such as through a bar coding system) to the extent possible to eliminate and minimize manual errors.
• Modifiers, occurrence, and conditions codes should be entered properly.
Revenue Cycle Opportunities

Mid-Cycle - Medical Records (Continued)

Best Practices: (Continued)

• Physician protocol and expectations need to be established and enforced regarding documentation.

• The application of appropriate codes is critical to the revenue cycle management and documentation is key to this.

• Dictations need to be prioritized to ensure inpatient dictations are available for rounds the following day.

Key Resources for Billing and Coding Compliance in all Hospitals:

• Online CMS manuals for hospitals and related entities

• CMS website for bundling edits, MUEs, and APC payment rates hospitals

• UB-04 billing manual

• State hospital association websites (Medicare list serve)

• Others
Revenue Cycle Opportunities

Business Office - Billing

• The business office represents the last opportunity for charges to be modified prior to being sent to the payor.
  
  – While this remains an important task at every hospital, management must recognize the importance of getting correct information attached to the patient’s account as early as possible in the revenue cycle.

• A recent study indicated an average of only 60% of claims that reach a hospital’s business office are error free. The best in class performers are having 85% of the claims arrive in the business office error free.

Revenue Cycle Opportunities

Business Office - Billing (Continued)

Best Practice:

• Issues with the business office often highlight the importance of improvement efforts on the patient access and mid-cycle aspects of the revenue cycle. We suggest an integrated revenue cycle team with significant business office representation to help design the standard work process for patient access-related activities.
Revenue Cycle Opportunities

Business Office - Billing (Continued)

Benchmark Opportunities:

• There should be meaningful metrics established for the revenue cycle for process improvement monitoring purposes:
  - Accounts receivable (A/R) days (gross and net)
  - Total cash collections
  - Denial rate
  - Bad debt rate
  - Charity care rate
  - Place-of-service collections
  - Payment verification rate
  - Discharged not billed claims

Revenue Cycle Opportunities

Business Office - Collections

• The goal of the collections function is to secure the greatest amount of reimbursement possible, which is typically only accomplished through persistence and proper alignment of goals.

• Self-pay collections remain an issue, and according to some estimates, only slightly more than one-third of all bad debt should be classified as such. An article by J. Hansel and A. Boehler, “Innovative Strategies for Self-Pay Segmentation,” published in Healthcare Financial Management, January 1, 2006, indicated the following breakdown of bad debt may be typical for hospitals:
  - 10% eligible for Medicaid
  - 25% can be collected via targeted and timely efforts
  - 30% should be classified as charity care
  - 35% is actual bad debt
Revenue Cycle Opportunities

Business Office - Denials Management

• Denials management (or better “denials mitigation”) is a key element of the revenue cycle.

• Not surprisingly, a recent study identified 77% of errors leading to denials were associated with patient access. Specifically:
  − Demographic information accounted for 33%
  − Eligibility accounted for 25% of denials
  − Medical necessity accounted for 23%
  − Authorizations accounted for 19%

Case Study Finding: The case study hospital did not track denials to better understand the root cause of denials, nor did the hospital track denial percentages or other statistics.

Revenue Cycle Opportunities

Business Office - Denials Management (Continued)

Best Practices:

• Track denials.
• Sample key performance indicators:

<table>
<thead>
<tr>
<th>Sample Standards</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical initial denials rate (percentage of gross revenue)</td>
<td>5%</td>
</tr>
<tr>
<td>Technical initial denials rate (percentage of gross revenue)</td>
<td>3%</td>
</tr>
<tr>
<td>Dollar denials rate (collected denials as a percentage of gross revenue)</td>
<td>3%</td>
</tr>
<tr>
<td>Underpayments additional collection rate</td>
<td>75%</td>
</tr>
<tr>
<td>Appealed denials overturned rate</td>
<td>40%</td>
</tr>
<tr>
<td>Electronic eligibility rate</td>
<td>75%</td>
</tr>
<tr>
<td>Physician precertification rate</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: HFMA
Revenue Cycle Opportunities

Business Office - Denials Management (Continued)

Best Practices: (Continued)

• Identify root cause of payment denials and payment inaccuracies:
  − Contract loaded correctly
  − Contract terms vague
  − Provider-credentialing issue
  − New service, new technology not communicated
  − Claims missing "data" to meet clean-claim criteria
  − “Medical necessity” (often a coding issue)
  − Payment policy issue (bundling)
  − Claim integrity issue (i.e., number of diagnoses to determine MS-DRG)
• As denials are tracked, trends will be identified.

Revenue Cycle Opportunities

Business Office - Denials Management (Continued)

Best Practices: (Continued)

• Analyzing these trends can then direct administration to take steps to improve the denials situation.
  − Since the majority of denials are usually linked to the insurance verification/prior authorization process, enhancements to this patient access process is typically a priority.
• Denials related to medical necessity should be reviewed with medical leadership to determine opportunity for challenge and/or future process changes and education.
Summary Solution Steps

- Perform an initial revenue cycle assessment:
  - Identify key tasks performed by staff for the entire revenue cycle
  - Identify non-value-added processes or activities
- Design workflows to streamline current processes and empower employees to be accountable for their part in reaching organizational goals.
- Reorganize patient access and business office functions (potentially including a new organizational structure) to increase accountability and effectiveness:
  - Consider triage (centralized) registration process for the main registration area
  - Ensure staff at all registration points and the financial quality area have online access for insurance demographics eligibility and benefits
Summary Solution Steps

- Revise policies and procedures and job descriptions to ensure consistency throughout the organization, focusing on the connectivity of the revenue cycle process and everyone’s role in it.
- Develop a permanent cross-functional revenue cycle team (e.g., Revenue Cycle Committee) to enhance quality improvement efforts.
- Establish revenue cycle performance metrics based on the quality of work and effectiveness of effort.
- Determine if additional technology is needed to support desired state processes.

Solution Metrics

We surveyed 13 hospitals (2014 benchmark study) using the following key metrics:

- Net days A/R outstanding (annual calculation)
- Gross days A/R outstanding
- A/R payor mix
- A/R aging
- Specific A/R aging analysis over 90 days in total and by specific payors
- Contractual adjustments and bad debt provisions
Solution Best Practices

We found the following common interventions or best practices:

• The following scheduling and registration procedures may improve the private pay balances and Medicaid aging categories by implementing:
  - Insurance verification procedures
  - Review preauthorization procedures
  - Collect copays and deductibles up front (develop scripts for staff)
  - Tracking of cash collections at point of service (industry standard suggest 1.5% to 2.0% of net revenue)
  - Offer prompt pay and self-pay discounts
  - Ensure charity care eligibility is established at time of registration

Solution Best Practices

Common Interventions or Best Practices

• Implement denials management program:
  - Monitor by payor
  - Identify common reasons for denials to target solutions
  - Identify denials by service line or department
  - Track denials as a percentage of gross revenue (U.S. hospital average is 11%; best practice is 5% per HFMA)

• Coordinate/train front office and back office on registration, billing and collection policy and procedures...educate.

• Implement HFMA’s MAPKeys (Measure, Apply, Perform) to monitor revenue cycle indicators to improve performance.
Integrated Revenue Cycle Solution

Pre-service
Major Steps:
1. Scheduling
2. Pre-registration
3. Care approval
4. Eligibility and benefits verification
5. Clear training and process to address errors and exceptions
6. Verify provider credentials to perform procedure(s) as applicable

Best Practices:
- Scheduling and registration quality reporting
- Check self-pay for Medicaid or any other coverage
- Use of electronic eligibility verification (270) and payor response (271)
- Patient reminder of financial obligations
- Electronic care approval (278)

Point of Service (POS)
Major Steps:
1. Registration
2. Patient financial counseling/POS collection
3. Clinical services
4. Charge/coding capture
5. Discharge process
6. Patient balance collection
7. Charity care management

Best Practices:
- Integrated discharge planning
- Run all legacy system, CCI, and payor-specific edits to "clean" claims before release to payors
- Secondary payment structure
- POS collection effectiveness reporting
- Patient web tools to manage their account

Post Service
Major Steps:
1. Charge/coding capture verification/completion
2. Claims transmission
3. Insurance follow-up
4. Self-pay follow-up
5. Denial management and reporting
6. Payment posting
7. Payment analysis
8. Credit balance and unapplied cash management
9. Patient statements

Best Practices:
- Electronic payment remittance (837)
- Electronic claims status (278)
- Automated secondary billing
- Denial root cause team
- Outsourced payment arrangements
- Patient-friendly billing
- Secondary collection management
- Staff productivity incentives

Other Components
Major Steps:
1. Contract management
2. Benchmark reporting
3. Compliance program
4. Technology support and plan
5. Medicare ABN and secondary insurance
6. MHS and insurance master maintenance
7. Chargemaster maintenance

Best Practices:
- Dashboard of KPIs, report across revenue cycle
- Contact management audit and coordination
- Revenue cycle improvement team
- Effective policies and procedures
- Productivity-based incentive program
- Work standards and monitoring revenue cycle
- Inside and outside technology partnerships

Initial Data Request
Benchmark Analysis
Data Analysis
On-Site Interviews
Data Verification
On-Site Report
Presentation
Work Plan Initiation

Insurance Contracting Issues
Insurance Contracting Issues

Payor Report Card Development

- Contracted services
- Volume of business (How much business is the company bringing your organization?)
- Overall profitability:
  - Reimbursement-to-charge ratio
  - Cost-to-charge ratio
  - Administrative "busy work" profit erosion
  - Denials management
  - Contract administration (complexity of contract)
  - Service line profitability
  - Provider support
  - Ease/accuracy of benefit verification

Payor Report Card Development (Continued)

- Payment accuracy
- Number of days in A/R
- Percentage of claims under appeal
- Percentage of claims reprocessed
- Percentage of claims on Medicare’s FISS system “Return to Provider”
- Creates a culture of accountability for each key payor
Questions?

Thank you!