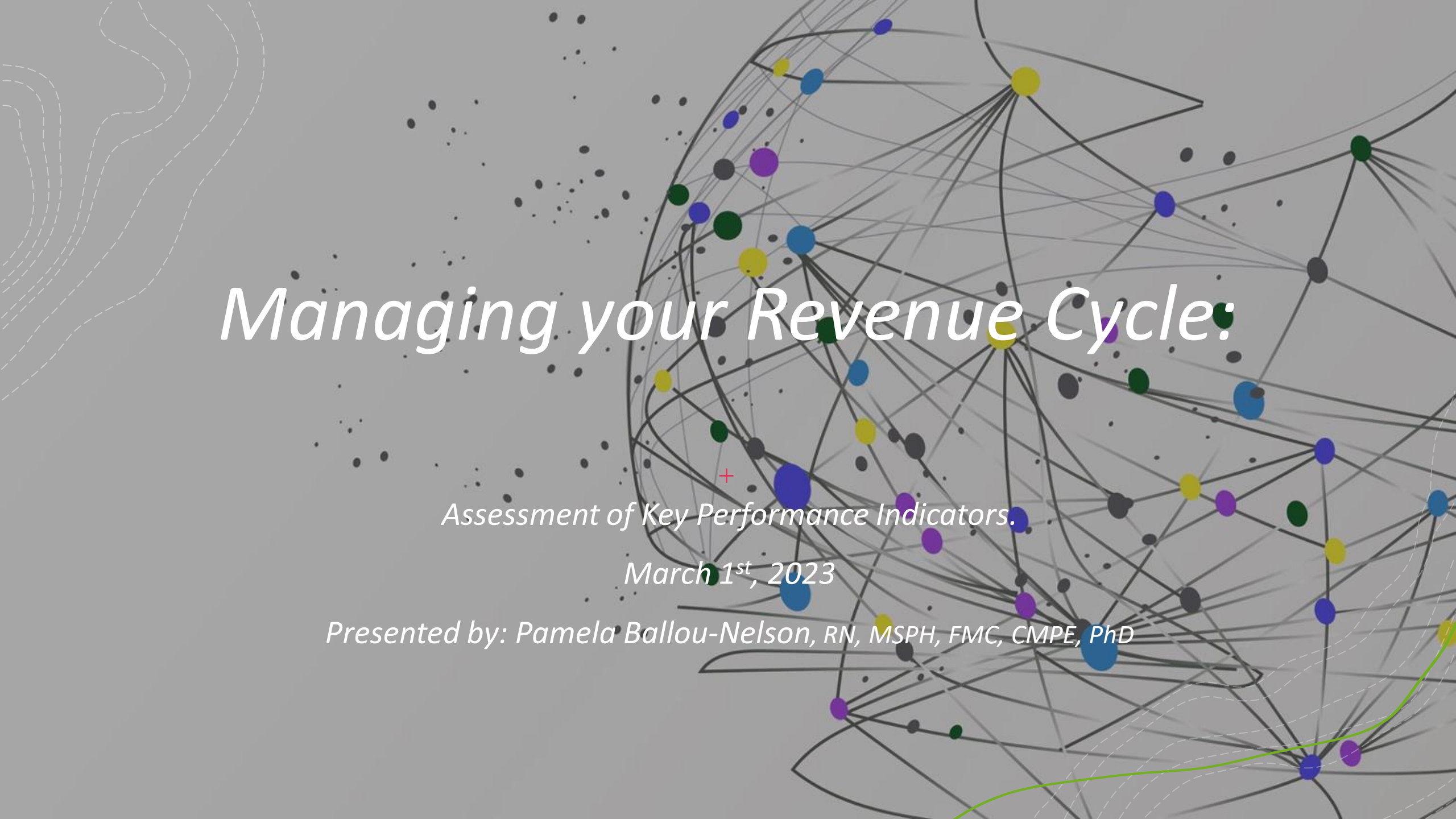


Managing your Revenue Cycle:

Assessment of Key Performance Indicators.

March 1st, 2023

Presented by: Pamela Ballou-Nelson, RN, MSPH, FMC, CMPE, PhD

Objectives

- Discuss the four interrelated parts to your revenue cycle.
- Share with your colleague's insight to 8 KPIs to measure your practices revenue cycle.
- Share assessment tool for your practice to evaluate your own revenue cycle.

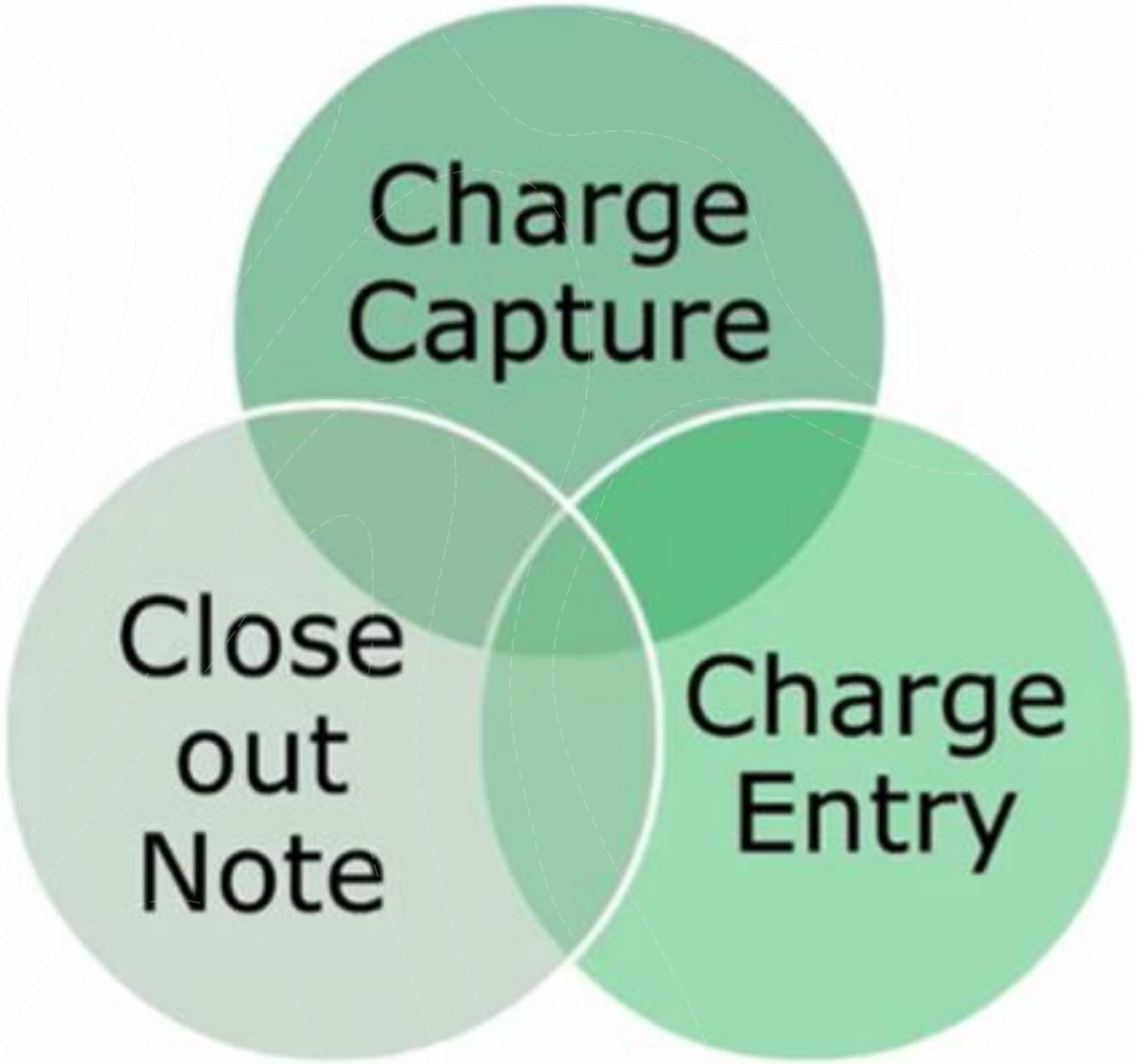
Four Interrelated Parts to Your Revenue Cycle

- **Scheduling**
- **Registration**
- **Eligibility & verification of services**
- **Appointment**
- **Confirmation**
- **Check in - collect co-pay**
- **Print Ins card**
- **Check out - new appointment**

- **Documentation of visit**
- **Quality metrics VP**
- **Coding**
- **Charge entry**
- **Claims prep & submit**

- **Payer contract & Fee schedules**
- **VBP PMPM**
- **Quality reporting**
- **Financials**

- **Deposit management**
- **Payment posting**
- **Denial management**
- **A/R Patient plus Insurer**



Capture – All Services Rendered

Enter – All Services that should be billed

Close – Note in a timely manner to allow claims to be submitted

The shift to Value-Based RCM

1. Optimize based on value not just volume
   - Accurate capture of inputs from which measures are calculated
   - Noting payer and peer group benchmarks when considered part of performance
   - Partner with your team to identify those measures for which practice is over or under preforming. Address root cause analysis of under – performance address the root cause of negative outliers drive to continuous quality improvement

The shift to Value-Based RCM

+ 2.Minimize risk not just denials
  + Model the new risk factors in a VB model such as performance scenarios that could impact your income

+ 3.Shift focus from only in-office encounters to care delivered across all settings and conditions. Many VB models involve accountability for episodes. RC teams will be drivers to be sure integration and interfaces are established to other providers and systems for data and coordination.
  + Focus on treating patients based on risk with a holistic view the whole person care

The shift to Value-Based RCM

+4. Move from retrospective to real time reporting and action

+ Lag and lead measure *Lag measure* tells you if you have achieved your goal retrospective in nature. *Lead measure* tells you if you are likely to achieve the goal. They are predictive. They will have an impact on the lag. ***Give me an example of a lead measure in your practice***
+ Implement the ability to monitor performance at a detailed level in real time. New foundations of data management that pull from financial sources and relevant clinical data that impacts quality measures

8 KPIs to Measure Your Practices Revenue Cycle

KPI #1 How do you collect place of service collections? Cash collections Co-pay, Deductible

Your turn to share

KPI #2 Clean Claim Rate:

99% is your goal

Clean claim rate is the share of insurance claims submitted and effectively reimbursed the *primary* time upon submission.

KPI #3 Discharged and Not Fully Billed

DNFB applies to any circumstance in which a patient has been discharged and the claim was submitted without billing for all medical services provided.

DNFB can be a massive reason of revenue leakage

KPI #4 Days in A/R

Your turn to share

Days in A/R refer to patient and payer

Days in A/R should remain below 50

Ideal 45

KPI #5 Claims Denial Rate

+ A denial charge of 5% to 10% is acceptable
+ A denial charge below 5% indicates a wholesome revenue cycle management technique and good economic flow
+ If your denial rate is above 10%, examine your eligibility verification, coding, and credentialing functions
+ **What is your Denial Rate??? Care to share how?**

KPI #6 Cost Per Visit Per Code

Understanding the cost of doing business is essential with value based and other payment models emerging.

The simple way to start is to identify total visits (all E&M codes) for a period and divide by total expenses. If you have 6,250 annual visits as a solo provider and your total costs are $365,761, the cost per visit is $58.52 (can be calculated with or without provider salary)

You can then decide to break this down further for new patients vs. established patients. Or you could choose to identify costs per E&M code or other high-volume codes .

Eventually you will want to break the cost idea into smaller, and smaller workable parts. Looking for value and non-value parts of your visit or services is a way to reduce cost and increase value.

KPI # 7 Revenue per Encounter By Payor

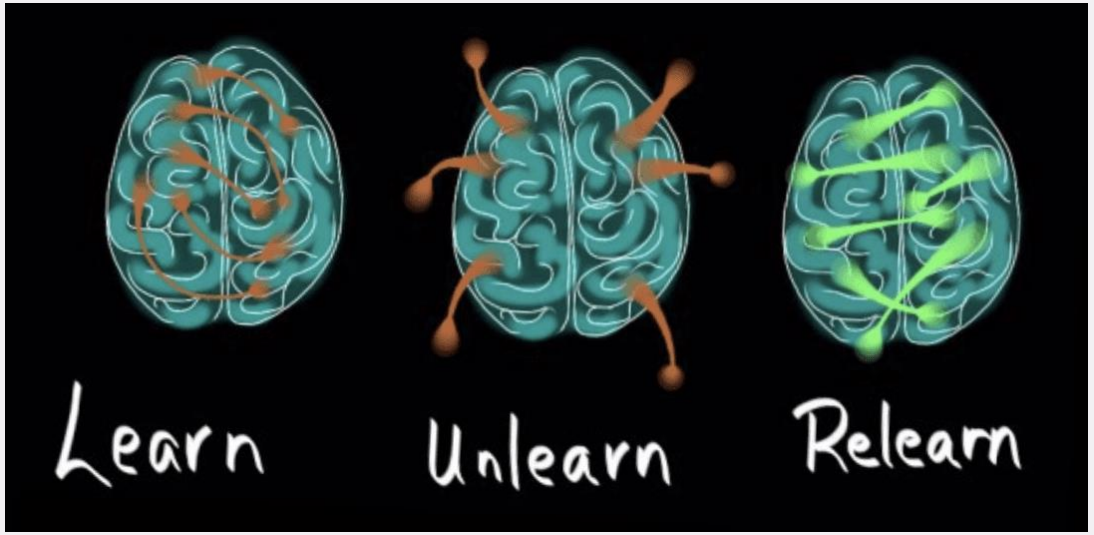
+ Revenue per encounter can be identified and calculated by dividing net collections by the total number of patient visits in each month.
+ Compare payor fee schedule with actual payments, often underpaid
+ This can be calculated for each visit code as well as each payor.
+ Use revenue per encounter for operational efficiency
+ Estimate future revenue
+ Use for revenue cycle diagnostics. Set a benchmark compared to industry standards or against your own benchmark

KPI #8 Authorization for Payment

Verify /Authorize payment of service(s) and provider before patient visit .

Transparency: inform patient if services provider covered or not, potential self-pay.

Make your practice financially healthy while making your patients physically and mentally healthy.

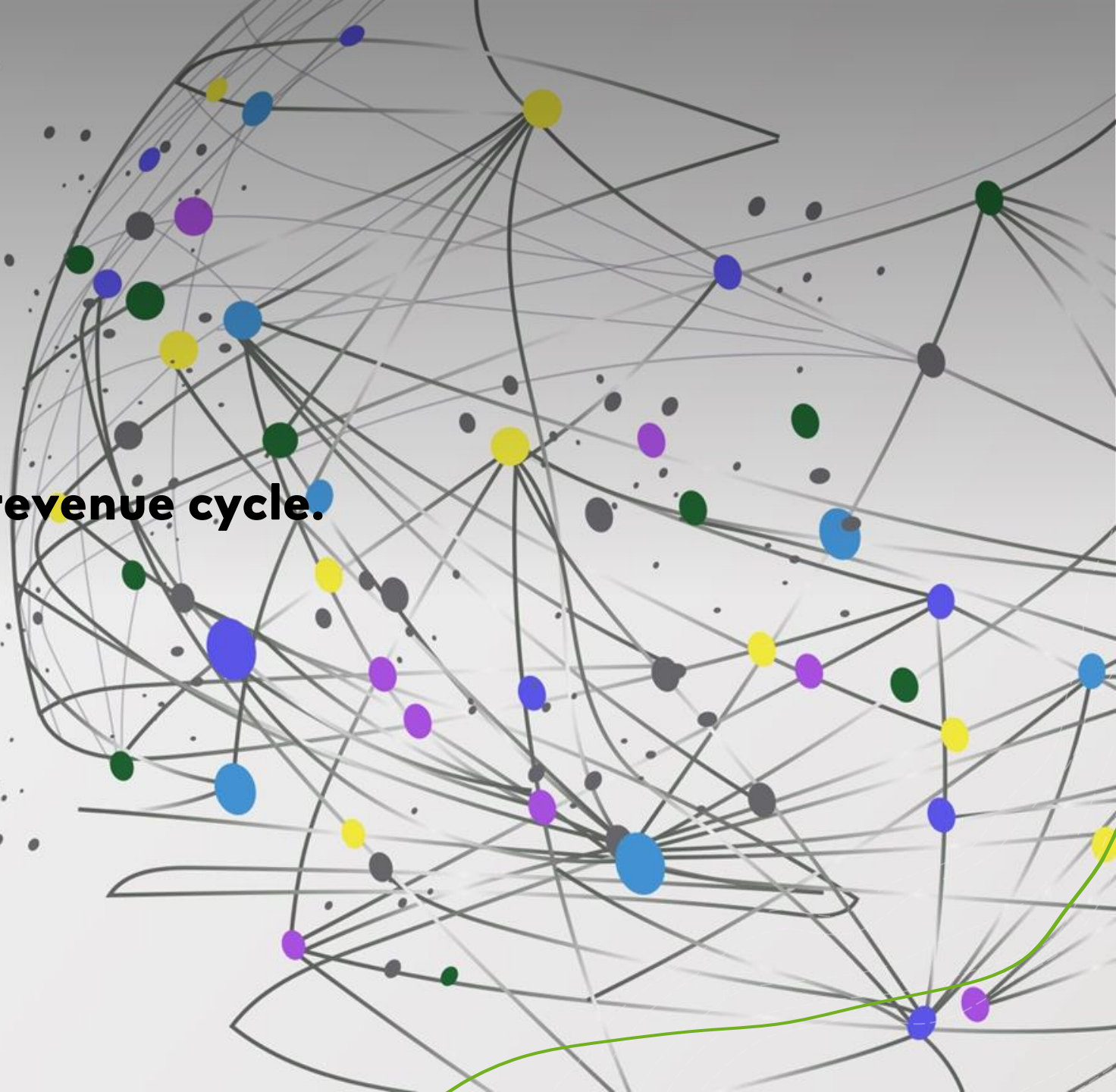


+What will you take away and do differently ?

Assessment Tool

A handout for you to use

with your practice to assess your revenue cycle.



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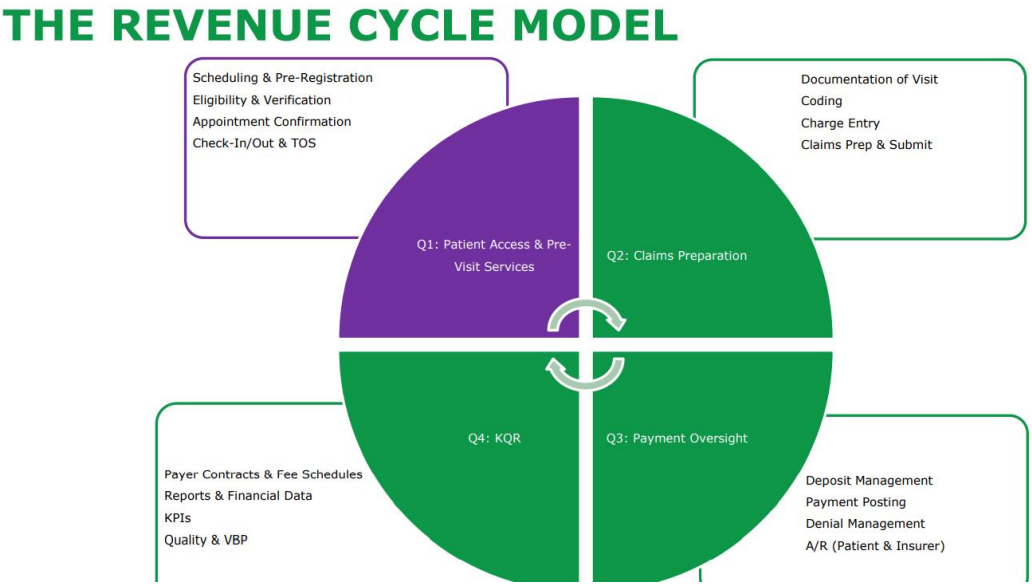
Revenue Cycle Management Assessment Form

Date: _____

Practice: _____



Source: Diagrams taken from MGMA RCM by Shawntea "Taya" Moheiser, MBA, CMPE, CMOM Chief Revenue Cycle Officer, H4 Technology, LLC

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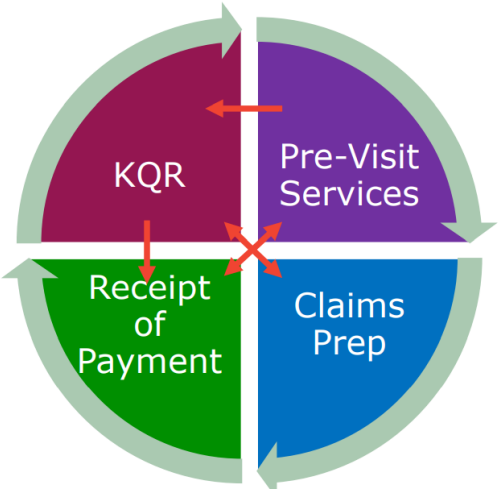
RCM CONNECTIVITY

The revenue cycle, though cyclical, is also interconnected

The activities in **pre-visit services** impact **receipt of payment** and likewise post-adjudicated claims tell us what additional money to collect at the front desk

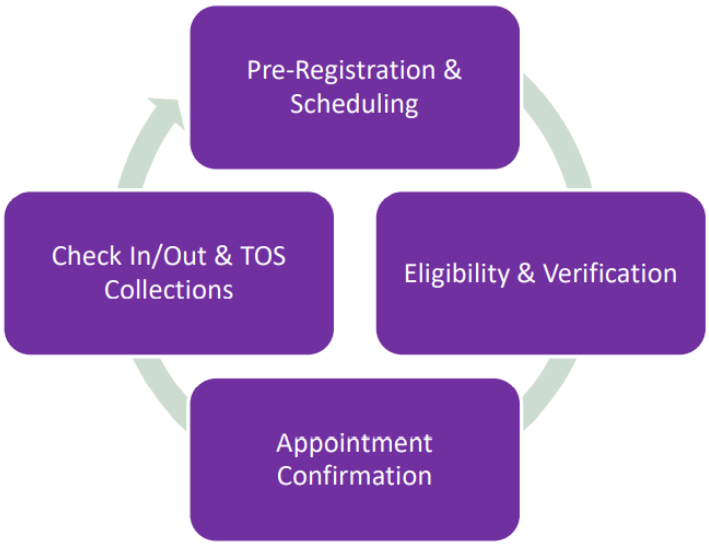


Every section informs our KPI performance, quality data, and reporting.

Our **KQR** data informs how we need to change our **pre-visit**, **claims prep** and **receipt of payment** efforts.

First Quadrant

THE 1ST QUADRANT



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Evaluate:

Scheduling and registration

The patient scheduled for their (first) appointment with the facility.

• Demographic data entry

• Verification of data accuracy

• Educating patient on expectations: time of arrival, what to bring with them (ID, Insurance Cards, Referrals

• Sending essential forms (or online form) for early patient completion Scheduling & Pre-registration

---

Ask patient every visit to show card and ask to verify demographics DO NOT ask has anything changed show them what you have or say do you still live on?

Eligibility & Benefit Verification

This step usually takes place after the patient has been scheduled, before the date of service, and on the date of service.

In this step, the patient's active insurance is verified for:

• Benefits to see provider

• Dates of active coverage

• Copayments required

• Coinsurance required

• Additional details as needed

Appointment Confirmation Scrubbing the Schedule

Ideally this step takes place forty-eight business hours before the patients' appointment.

• In this step we either: Confirm patient attendance and remind them of financial responsibilities **or** reschedule the patient for another date of service and fill the slot with another patient **or** cancel the patient appointment and fill the slot with another patient.

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Check-In/Out & Time Of service (TOS) Collections

In these steps we:
• Verify patient demographics and accuracy of entry
• Collect required patient responsibilities
• Schedule follow-up visits
• Remind patients of necessary tasks (ex. Referrals)
• Other critical patient communication

Patient Access Points

- Scheduling & Preregistration
- At Check In
- At Check-Out

WHAT YOUR TEAM SHOULD DO EVERY TIME

- Confirm the right patient is being reviewed.
- Make sure to review the service level, coinsurance, copays, and deductibles.
- Document the subscriber of the insurance and whether the patient is dependent.
- Document the effective dates of the insurance benefits.
- Identify if referrals are required.
- Identify in-network and out-of-network benefits.
- Confirm the patient's address and the insurance plan name.

Patient Responsibilities: The patient's relationship with the insurance payer requires a certain amount of financial responsibility. The contractual relationship between the payer and provider, in part, requires that the provider collects the patient's responsibilities. This means that we must collect copays, coinsurance amounts, and deductible amounts due as dictated by the insurance payers. It is not acceptable to blanket waive patient responsibilities and it can create a breach of contract with the insurer.

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Coinsurance

Some insurance types or plans include required coinsurance amounts due from the patient for each service rendered. For example, if an insurer is reimbursing a physician $100 for a service but the patient has a 20% coinsurance, then the insurer will pay $80 and the remaining $20 will be due from the patient. It will be the responsibility of the practice to collect this payment amount, so it is beneficial to discuss this with the patient early and collect up front where possible.

Copayment

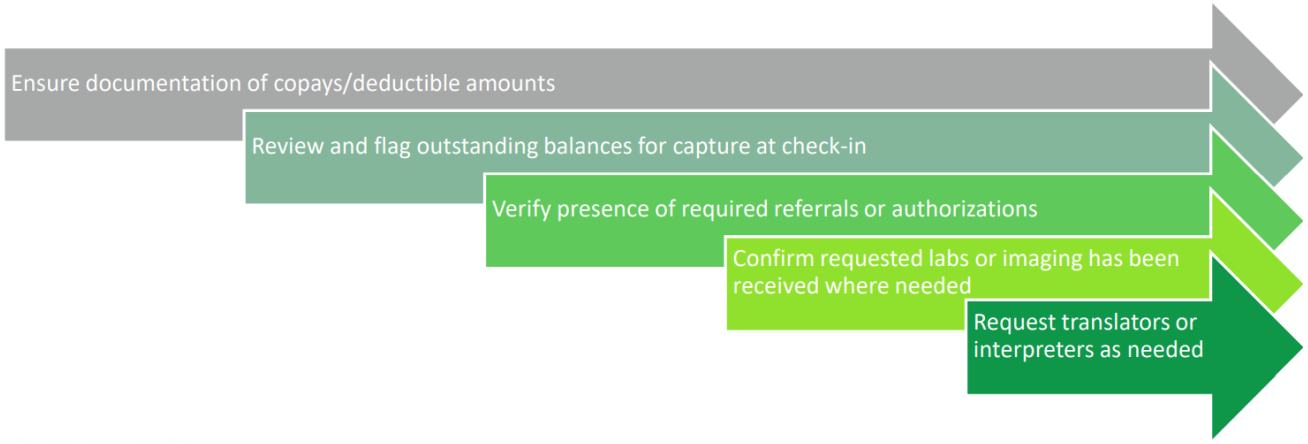
Many insurance types and plans include a copay amount due at the DOS payable to the practice from the patient. These amounts can vary depending on specialty. This amount is agreed upon by the insurance and the patient. As part of the practice's participation contract with the payer, the practice agrees to collect the copayment at the time of service. With the rise of preventive care measures, some plans will waive the copayment for benefit-approved preventive services. For example, a patient may need to pay $30 for an office visit with their PCP or $60 to see a specialist. For some plans, there are also separate copay amounts for hospital and urgent care visits.

Always collect copays on the DOS at check-in

Chart prep and maybe even scrubbing can be done by the MA.

Chart Prep Process

After confirming the patient will be attending their appointment, the chart prep process should begin.



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Educate staff on Insurance card reading and understanding.

PAYMENT TYPES & POSTING

Having payments posted at the time of service (TOS) (patient payment) will help reduce the opportunity for theft and is recommended where possible.

- Do you post at time of service?
- Who Posts
- Do you have a write off policy?
- Hardship Policy?
- ABN (Advanced Medicare beneficiary form) on File for each service not covered ,insurance or Medicare.

Most payer/provider contracts prohibit writing off patient copay, deductible and coinsurance without a qualified exception (such as a verified financial hardship). The practice is allowed to assess patients for exception on a case-by-case basis, but you should have a set process to determine when exceptions can be made and fairly apply the process to all patients.

When patients truly have a financial hardship and meet the program requirements of the organization, then payment plans, or write-offs may be appropriate. Have a practice-wide policy for financial hardship qualification and maintain documentation that these qualifiers were reviewed prior to writing off a copay, deductible or coinsurance amount.

For more information on routine waivers of required collection items and financial hardship waivers, navigate to https://oig.hhs.gov/

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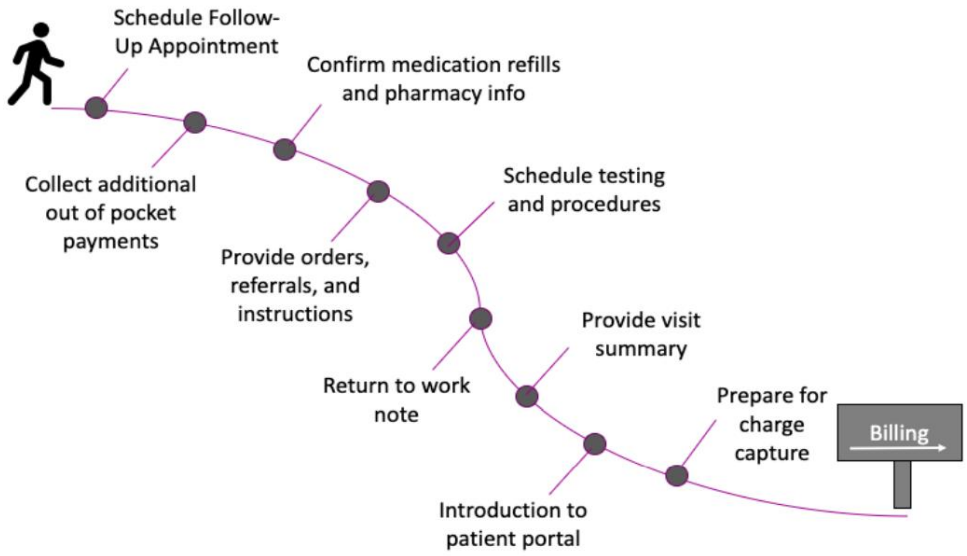
Check-Out Process



Does Your check out process include all of the above ?

Who conducts the checkout process?

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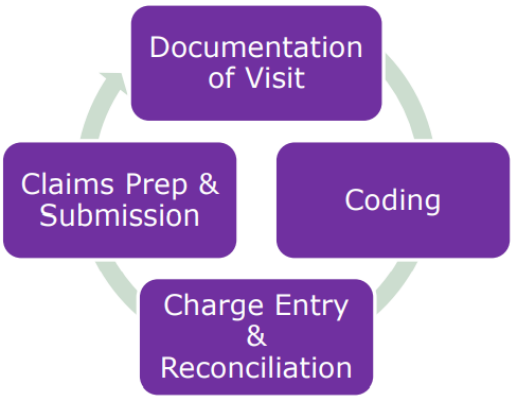
QUADRANT TWO Provider Information critical to Revenue Cycle

THE 2ND QUADRANT



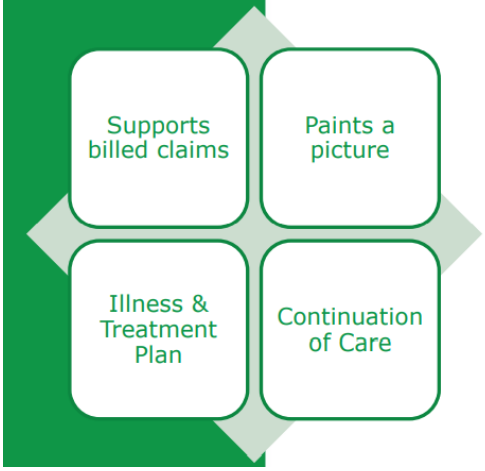
These critical steps are where we obtain essential information from the **PROVIDER.** These steps are also the points of interaction between the provider and the patient to accurately clinical information claims submission.

These steps will directly impact:

1. Medical necessity and continuation of care
2. Accuracy of legal recording of visit
3. Accurate reporting and capture of services
4. 1st Pass Claims rates

Accurate documentation of medical visits, specificity in code selection and capturing all services performed using payer guidelines for claim submission is **critical**

MEDICAL RECORD DOCUMENTATION



Stand Alone Medical Necessity

The medical record is a legal document that must be be able to withstand scrutiny if by internal and external entities. Information contained must clearly articulate the medical intervention for patient care.

Healthcare professionals who are responsible for patient care should obtain regular Clinical Documentation Improvement (CDI) education to comply with and understand guidelines.

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There should be internal audits of medical records by provider

Internal Audits

CPT® / HCPCS II Coding: Total Sample Size 65 codes	Count	%
Code(s) appear to be correct	60	92%
Code(s) appear to be incorrect	4	6%
Additional code(s) supported	1	2%
	65	100%

ICD-10-CM Coding: Total Sample Size 1955 codes	Count	%
Code(s) appear to be correct	1400	70%
Code(s) appear to be incorrect	555	30%
Additional code(s) supported	0	0%
	1955	100%

E/M Coding Findings: Total Sample Size 400 Total Codes	Count	%
E/M Level appears to be correct	240	61%
E/M Level appears to be over-coded	105	26%
E/M Level appears to be under-coded	26	6%
E/M Level appears to be Wrong Category	29	7%
	400	100%

E/M Detailed Review Findings: Total Sample Size 400 codes	Count	%
Over coded by 1 level	85	23%
Over coded by 2 levels	17	5%
Over coded by 3 levels	4	2%
Under coded by 1 level	19	5%
Under coded by 2 levels	0	0%
Under coded by 3 levels	0	0%
Number of category changes	35	10%

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Telehealth Coding – Check for Annual Changes

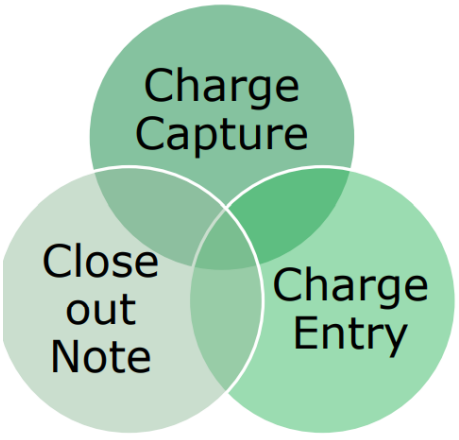
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Type of Service	• Telehealth Visits
Service Method	• Virtual Face-to-Face
Service Description	• E/M Visit
HCPCS/CPT Codes	• 99202-99215 (Out Pt Visits)
Payer Coverage	• Medicare, Medicaid, Commercial
CMS Reimbursement	• Same as in-person service
Patient Status	• New or Established
Initiating Source	• Provider Initiated

MGMA

CHARGE ENTRY

THE 3 C'S OF CHARGE ENTRY



Capture – All Services Rendered

Enter – All Services that should be billed

Close – Note in a timely manner to allow claims to be submitted

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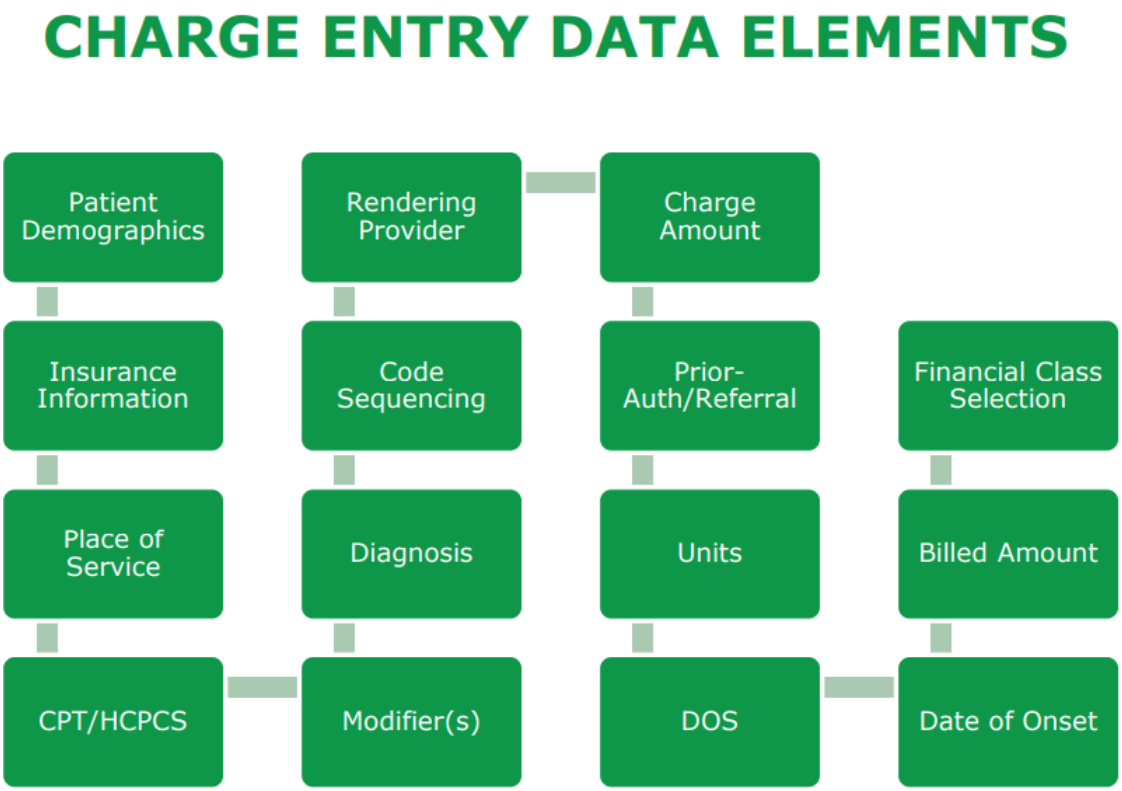
Do you do all three of the above

HOW DO YOU KNOW?



Who sees to it that all of these items are in the system ??

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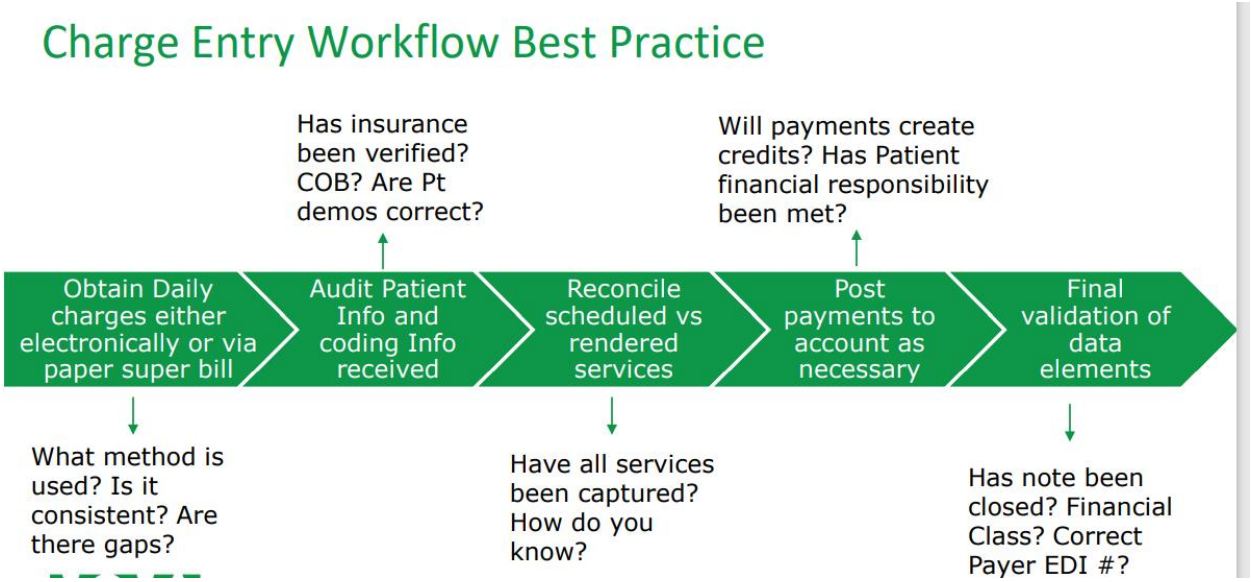

Accuracy and data validation are keys to minimizing denials as a result of charge entry. The individual responsible for charge entry may not be the rendering Practitioner which requires excellent communications methods to ensure all information is captured and confirmed prior to claim submission. Management of the charge entry processes sets consistency and structure in this critical process.

Run and analyze these reports daily for charge entry:

- Locked Notes Report
- Review prior to claim submission for signature close-out compliance
- Identify additional services, diagnosis specificity and time tracking when applicable.
- Identify services that COULD have been rendered, posting discrepancies.
- Track no-shows, review patient's accounts for large balances
- Initiate appointment recalls.
- Charge missed appointment fees.

Clean claims report 95% First time sent and paid.

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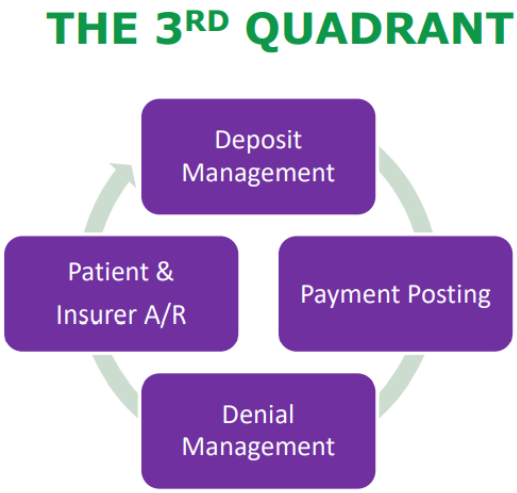
Quadrant Three



In this section we receive pertinent information from the **PAYER**.

These steps indicate

1. If the facility was paid
2. How much the facility was be paid
3. The efficiency and accuracy of the internal billing process
4. Workflow challenges within the organization
5. Opportunities for process improvement

The receipt of payment is the lifeblood of the **financial stability** of the facility. Proper receipt and documentation will inform the next step and errors in these steps can lead to misguided management in other areas of the facility.

Source: diagrams taken from MGMA RCM by Shawntea "Taya" Moheiser, MBA, CMPE, CMOM Chief Revenue Cycle Officer, H4 Technology, LLC

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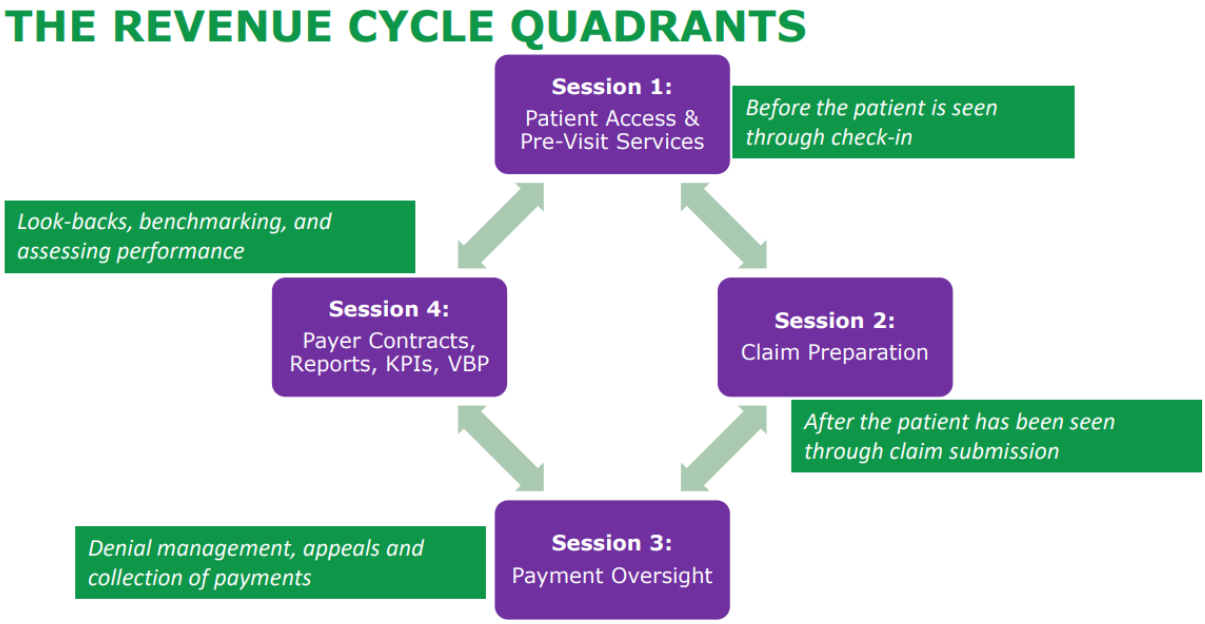
Quadrant Four



Deposit Management

Checks or EFTs from the payer are received and deposited into organizational bank accounts. In this step, facilities:

1. Track deposits to identify payments made
2. Identify payments not received
3. Confirm payments have all been deposited
4. Confirm total deposited amount matches total payment amount

Payment Posting

In this step, the practice uses remittance advice documents received from insurance payers to allocate portions of bulk payments to the appropriate patient accounts. This process also includes posting adjustments (non-payments), fees, and interest as indicated on the remittance advice.

Denial Management who oversees this?

When claims are denied (reflected by a full or partial adjustment on the remittance advice), the facility must review why the denial occurred. In the denial management process facilities will identify areas for appeal, resubmit where possible, or use the information to improve other operational processes within the organization.

How do you manage denials?

Patient & Insurance A/R

Who manages this and how often?

Working accounts receivable can be a tedious process but it is essential to the revenue cycle. In these steps, the facility works to collect all potential revenue not received in the originally issued payer payment. This includes patient billing/invoicing and appealing denied claims.

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DEPOSIT MANAGEMENT

INTERNAL CONTROLS

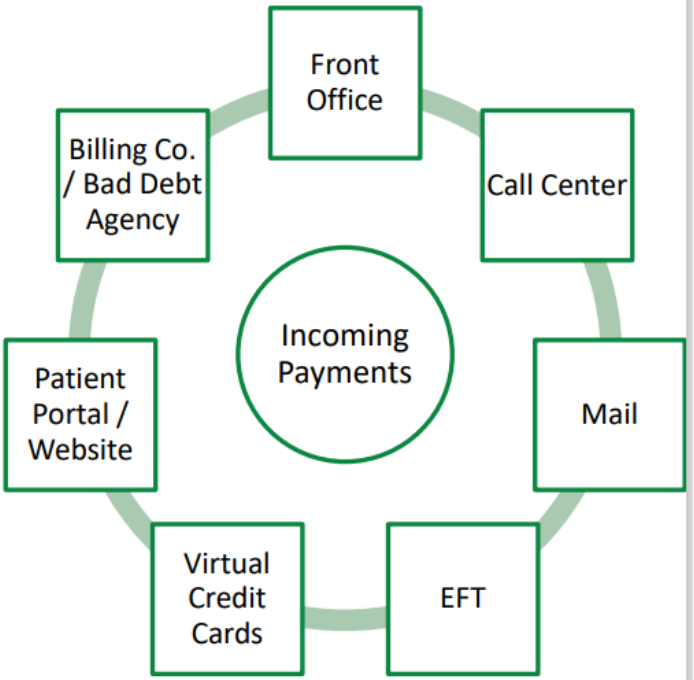
Step 1: Identify the functions or departments where money enters/leaves your practice.

Step 2: Reduce the number of individuals who accept payments from patients.

Step 3: Reduce the number of hands checks pass through.

Step 4: Decline to keep credit card numbers on file.

Step 5: Track payments across the front desk by individual staff member.



How do you manage deposits ?

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CREDIT CARDS ON FILE

Keeping credit cards on file can be incredibly helpful for an organization to collect payments quickly but it is also extremely risky. Implement best practices to stay compliant:

1. Do not store credit card numbers in folders or filing cabinets
2. Only store credit cards in encrypted software
3. Ensure that your software hides all but the last four digits of the patient's credit card number
4. Get consent from patients prior to storing their credit card on file
5. Notify patients of your privacy practices
6. Do not charge patient credit cards without notification and consent
7. Require that staff retain all receipts for processed charges and submit them daily with the same protocols for reconciliation as cash received

CHARGE MASTER or Master fee schedule

CHARGE MASTER

Payment posting is the process of posting payments to the practice management system and involves many components including a review of payments against the allowable and the charge master.

- **Charge Master** (A.K.A. The Master Fee Schedule)
- Higher amounts than on contracts
    - This is to capture the max allowable
- More than one way to setup
    - For example, some practices bill 120% of Medicare rates, whereas others feel 150% of Medicaid rates are more appropriate
- Things to keep an eye on:
    - 100% Charge Capture
    - Very Low Charge Capture
    - Annual Assessments

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REVIEWING PAID VS. ALLOWED

Enter your payer fee schedule information into your PM System. Structure alerts on your PM system to identify when payments are not aligned to your contract.

Paid	Allowed	Difference
$65.00	$60.00	$5.00

Overpays:

- Is your fee schedule too low?
- Do you have multiple contracts? If so, which one were you paid under? Was it appropriate?
- Do the funds need to be returned?

Paid	Allowed	Difference
$70.00	$78.00	(8.00)

Underpays:

- Is another adjustment impacting?
- Do you need to appeal?
- Is this a one-time occurrence or a trend?

CONTRACTUAL ADJUSTMENTS: CARC & RARC

Contractual Adjustment Reason Codes (CARCs)
Listed at the procedure code level to explain why an adjustment was made

Remittance Advice Remark Codes (RARC)
Listed often at the CARC level to provide further details as to why an adjustment was made

For more information on CARCs, RARCs, and other codes you may see on EOBs and ERAs, navigate to:

https://x12.org/reference

Source: diagrams taken from MGMA RCM by Shawntea "Taya" Moheiser, MBA, CMPE, CMOM Chief Revenue Cycle Officer, H4 Technology, LLC

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COMMON CARC & RARC ADJUSTMENTS

Table 12.1 Some Common CARCs	
CARC	**DESCRIPTION**
PR-1	Deductible amount
CO-50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
CO-96	Non-covered charge(s)
CO-18	Duplicate claim/service
CO-97	The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated.
CO-B12	Services not documented in patient's medical records
CO-49	This is a non-covered service because it is a routine/preventive exam, or a diagnostic/screening procedure done in conjunction with a routine/preventive exam

Note that the first two CARCs begin with different pre-fixes, PR and CO these represent Claim Adjustment Group Codes.:
CO - Contractual Obligations
OA - Other Adjustments
PI - Payer Initiated Reductions
PR - Patient Responsibility

Table 12.2 Some Common RARCs	
RARC	**DESCRIPTION**
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M53	Missing/incomplete/invalid days or units of service.
N199	Additional payment/recoupment approved based on payer-initiated review/audit.

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WRITE-OFFS VS. CONTRACTUAL ADJUSTMENT

Contractual Adjustments = Decrease to Meet Expected Contractual Payment

Write-Offs = Typically Preventable Losses

Common Causes of Contractual Adjustments

- Amount billed was greater than contracted amount
- Patient Responsibility
  - Deductible, Copay, etc.
- Sequestration

Common Causes of Write-Offs

- Missed timely filing windows
- Failure to obtain prior authorization
- Missing referrals
- Missing ABN

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EXAMPLES OF PREVENTABLE DENIALS/NON-PAYMENT CLAIMS

Table 12.3 Preventable Denials		
CARC	**Description**	**Resolution**
96	Non-covered charges.	Prior to performing or billing a service, ensure that the service is covered under Medicare. Please refer to the CMS Internet-Only Manual, 100-02, Chapter 16.[73]
49	Payment is denied when performed/ billed by this type of provider.	Ensure that provider setup in the PM system includes alignment of taxonomy to specialty.
97	The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated.	Verify prior to service being rendered whether the service being billed is bundled into payment for another service or considered part of a global surgical package, or part of a more comprehensive service already billed.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.	Follow Medicare guidelines, national and local coverage determinations for the service billed. Education of Medicare changes will assist in this process. When applicable, utilize ABNs.[74]

EVALUATE DENIAL "COST", "WORTH", "VALUE"

Denials are not all created equally, identify the cost of working denials and the worth if approved so that you are spending your efforts where it is of most value to the organization.

COST

- Identify what it costs you to work claims at varied stages: 1st appeal, 2nd appeal, etc. This will inform when claims should no longer be chased.
- Identify what your average loaded cost is to work a denial. This will inform when claims are not worth your effort or should be outsourced.

WORTH

Enter allowable amounts into your PM system so you can see the true worth of denied claims. Example:

- Service A: Charge Amount is $350, allowable is $100
- Service B: Charge Amount is $200, allowable is $125 **higher value**

VALUE

Once you have identified the cost and worth you can determine the value of each denial. From there, you can develop a strategy internally to:

- Work high-value denials first
- Watch timely-appeal for mid-range value denials
- Outsource low-value denials or move to lower cost workflows where possible

Source: taken from MGMA Conference RCM by Shawntea "Taya" Moheiser, MBA, CMPE, CMOM Chief Revenue Cycle Officer, H4 Technology, LLC

HEALTHCARE CONSULTING, INC.
Managing the human side of change

Seven KPIs

From Healthcare Consulting Inc

Clean Claim rate:

Clean claim rate is the share of insurance claims submitted and effectively reimbursed the primary time upon submission. **Goal 95-98%**

3. **Days in A/R:** The eClaim Solution offers a benchmark of **fewer than forty days** for days in AR. This KPI allows you to become aware of the common time it takes in your team or your billing company to gather payment for the services offered.

4. **Claim denial rate:** To calculate the declare denial rate, divide the entire dollar amount of claims denied through payers by the entire quantity submitted in the given period. **A denial charge of 5% to 10% is acceptable, while a declare denial charge below 5% indicates a wholesome revenue cycle** management technique and economic flow. If you declare the denial rate is above 10%, examine your eligibility verification, coding, and credentialing functions.

5. **Revenue per encounter:** Revenue in line with come across may be described and computed with the aid of using dividing net collections with the aid of using the quantity of patient visits in a given month. This metric can offer a brief view of the health of your revenue cycle.

6. **Authorization for Payment** 100% before treatment Even if that payment is grant money .

7. Have you calculated **your cost per visit by code?**

   Understanding the cost of doing business is essential with value based and other payment models emerging. One of the most interesting approaches is to identify how much it costs for each category of care provided in the patient visit cycle (e.g., check in, triage, provider time, follow up, and check out). You can look at the cost associated with the triage area: Vital signs, questions on prescriptions, documentation for the visit, and the like. Let us assume that it takes 10 minutes for this to occur. If you are paying the medical assistant $15.00 an hour and there is a $2.00 additional cost per hour for benefits, the total cost per minute needs to be calculated. At 2,080 hours worked per year, the total cost at $17.00 per hour would be $35,360. The total minutes worked would be $124,800. The cost per minute is $0.28. The cost for triage is $2.80 just for time. Add in the direct cost for supplies and allocate costs for space and equipment, and it adds up. If this process is done for each category of service in the cycle you gain a better understanding of the cost of the visit. Once this is understood, you can begin to ask if there are activities done at the time by the right individual and is it worth the cost of doing that activity. Further, is it best to do that activity at that time?