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Revenue Cycle Management

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Ms. Howe has over 20 years of experience in healthcare revenue cycle management, billing, coding, credentialing, provider enrollment and documentation auditing with 10 of those years being in the FQHC Community on staff with the Georgia Primary Care Association. Ms. Howe's academic background includes a Bachelors in Business Administration (BA), Certified Professional Medical Auditor (CPMA) through the National Alliance of Medical Accreditation Services (NAMAS), a certified Community Health Coding and Billing Specialist (CH-CBS) by the Association for Rural Health Professional Coding (ARHPC). Ms. Howe has successfully obtained NCQA CVO Certification for multiple organizations, scoring near perfect and perfect scores on these.

Revenue Cycle Overview

The revenue cycle begins before the patient walks through the door. Many people focus on billing when it comes to revenue, however, many things have to happen besides correctly billing a claim for revenue to come in.

Front Office

Provider Enrollment

Billing

Submitting Claims

Working AR

Denials Management

Statements

Credit Balance Reports

Training

Communication

Each staff person in all of these areas plays a key role in the revenue cycle. Each person must do their part, or the revenue cycle will suffer.

Front Office

Job Descriptions and Assignment of Duties

Front Office Staff

- Facilitates patient check-in and check-out. Explain payment options, including sliding scale fees, Medicare, Medicaid and other forms of payment assistance
- Collects and posts patient payments; prepare deposits and follow established cash handling procedures
- Completes patient intakes, income screenings, and conducts insurance verifications and authorizations

Job Descriptions and Assignment of Duties

Front Office Staff

DETAILED DESCRIPTION OF POSITION DUTIES:

- Interviews patient and/or family to determine eligibility for center services.
- Supports and adheres to the center policy and procedures and protocol for front office staff.
- Able to make appointments for patients
- Initiates registration forms, assigns number and checks all form for completeness and accuracy.
- Verifies insurance with proper source.
- Assists in daily collection and completion of encounter data.
- Re-evaluates patients as needed and in accordance with Center’s policy.
- Answers telephone and refers calls appropriately, refers complaints to manager.
- Receives and prepares daily cash receipt.
- Performs other related duties as assigned.

Front Office Policies and Procedures/Processes

- Patient Rights and Responsibilities
- Obtaining Patient Information
- Appointments
- Appointment Reminders
- Use of Sign-In Sheets
- Calling Patients from the Waiting Room
- Missed Appointments
- Noncompliant Patients
- Accommodating Reasonable Requests for Confidential Communications
- Telephone Procedures
- Telephone Security Measures
- Third Party Calls about Patients
- E-mail Communications

Front Desk Staff Impact on the Organization

- Normally the front desk staff is the first person to come in contact with the patients. Therefore, they become the face/voice of the center.
- Front desk staff creates new patient charts/medical records by inputting initial information into the EMR.
- Billing relies on front desk staff for accurate demographic information. If the front desk staff does not update this information, it can result in the claim being sent to the incorrect payer. This in turn causes payment to be delayed or denied.
- Collecting UDS Data
- Sliding Fee Scale

Processing Patients in EMR

- Make sure demographic information is entered correctly.
- Remember to update the Guarantor Addresses
- Select correct fee schedule/insurance. What to do if patient has medical, dental, P4HB
- If patient's insurance is inactive, please update in Info and mark it terminated
- Scan all appropriate documents into EMR: DL, Insurance Cards, SFS Applications, Proof of Income, etc.

Best Practice

- Educate your patients on your payment policies while they are making their appointments.
- Inform them of what they will need to be prepared to pay for their services when they arrive.
- Inform them of any previous account balances and let them know they need to be prepared to pay at least ___$/% of that balance in addition to fees related to the current visit.
- Accurately update all patient demographics in the EMR & scan the front and back of each insurance card
- The patient's name must appear the same as it is on the Insurance Card

Patient Pre-Registration

Patient pre-registration is the critical first step in healthcare revenue cycle management. This process involves collecting patient data and verifying their insurance eligibility well in advance of any scheduled office visit.

Accurate and complete information gathered during pre-registration ensures that subsequent billing and reimbursement processes can be conducted with accuracy, reducing errors and minimizing the risk of denied claims while also enhancing patient satisfaction through a more seamless registration experience.

Patient Pre-Registration Best Practices

- Online Pre-registration: Implement online forms for patients to complete before arrival.
- Verify Insurance: Confirm insurance coverage and benefits in advance.
- Collect Patient Data: Gather complete and accurate patient demographics.
- Send appointment reminders to reduce no-shows and incomplete pre-registration.

Patient Registration

Patient registration is the bridge between initial contact and healthcare delivery, serving as an important juncture in revenue cycle management. During this stage, registration staff gather comprehensive patient information, reason for visit, and forms required at the registration phase.

Accurate registration aids in proper identification, reduces billing errors, and promotes efficient claims processing. It's a vital component in delivering quality care and maintaining a healthy revenue cycle. It establishes the patient-clinic relationship and lays the groundwork for accurate billing and reimbursement.

Patient Registration Best Practices

- Verify and update patient information regularly.
- Ensure proper documentation of patient consent for treatment.
- Train registration staff on data entry accuracy and sensitivity.
- Implement patient identity verification measures.
- Integrate registration systems with EHR/EMR for seamless data flow.

Registration

- Insurance Verification
- Patient Demographics
- Collection UDS data
- Insurance Card Information
- Sliding Fee Scale/Indigent/Other
- Collecting copays/past due balances
- How to schedule providers not enrolled with payers (communication)

Capturing Information for UDS

Zip Code Table

- Zip Code
- Insurance
  - Insurance Groups
  - Self-Pay

Table 3A: Patients by Age & Gender

- Birth Sex (affects quality measures and alerts)

Table 3B: Patients by Race/Ethnicity/Language and SO/GI

- Race (favorites/show all)
- Ethnicity (favorites/show all)
- Sexual Orientation (single select)
- Gender Identity (single select)

Capturing Information for UDS

Table 4: Selected Patient Characteristics

- Sliding Scale
  - Add income
  - Add household size
  - Click calculate
  - Click documentation of proof of income
  - Click assign
- Income Collection
  - Add income
  - Add household size
  - Click calculate
  - Click non proof of income
  - Click assign
- Structured Data
  - Veteran
  - Seasonal
  - Migrant
  - Homeless
  - Public Housing (include all patients at a health center if immediately accessible to a public housing site)

Collecting Patient Payments

Patient payment collection stands as a cornerstone of healthcare revenue cycle management, focusing on the retrieval of payments from patients for their portion of medical expenses. It encompasses educating patients about their financial responsibilities, offering flexible payment options, and efficiently securing payments.

Effective patient payment collection is essential for bolstering cash flow and ensuring the financial viability of healthcare organizations. Moreover, it promotes patient satisfaction by providing transparent billing processes and accommodating diverse financial circumstances, creating a win-win situation for providers and patients.

Collecting Patient Payments Best Practices

- Clearly communicate costs to patients before services.
- Offer structured payment plans for patients with financial constraints.
- Facilitate online payment options for convenience.
- Train staff in effective patient communication and payment collection.
- Provide receipts and document all payment transactions accurately.

Insurance Verification

Insurance verification in revenue cycle management involves confirming a patient's insurance coverage and benefits and ensuring that healthcare services are correctly billed and reimbursed.

Effective verification prevents claim denials and accelerates revenue flow. In addition, it aids in estimating patient responsibility aiding in financial transparency. Accurate insurance verification processes are essential for optimizing revenue cycles.

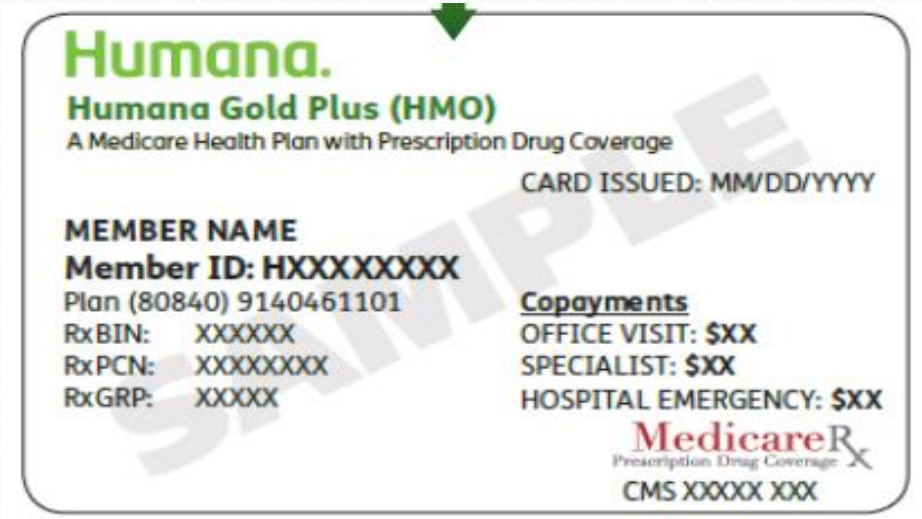
Insurance Verification Best Practices

- Perform real time insurance verifications whenever possible.
- Maintain detailed records of verification efforts and outcomes.
- Collaborate with payers to resolve discrepancies promptly.
- Education: Educate patients on their insurance coverage and responsibilities.
- Keep insurance information current for recurring patients.
- Insurance information should be verified prior to every visit, even for same day appointments and walk-ins. Most systems are setup so that patient eligibility is already checked prior to the patient's visit (but not walk-ins or same day appointments).

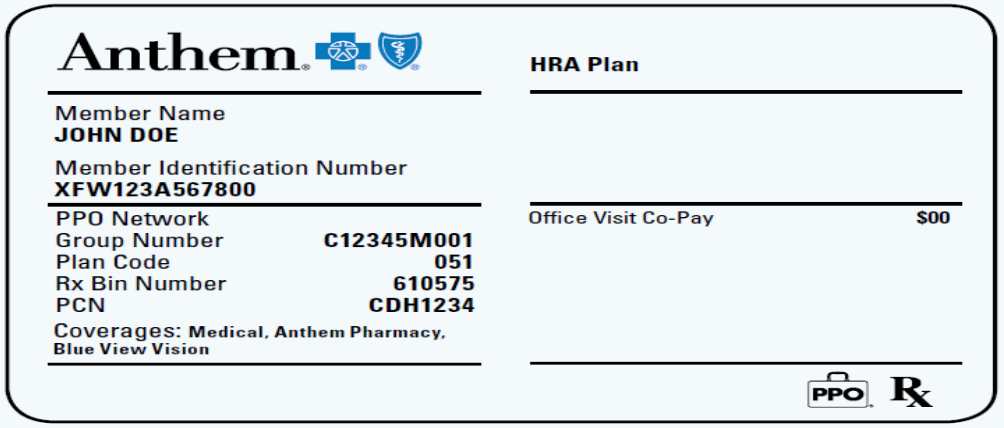
Types of Insurance

- Medicare
- Medicare Advantage
- Medicaid
- Medicaid CMO’s
- Commercial/Private Insurance

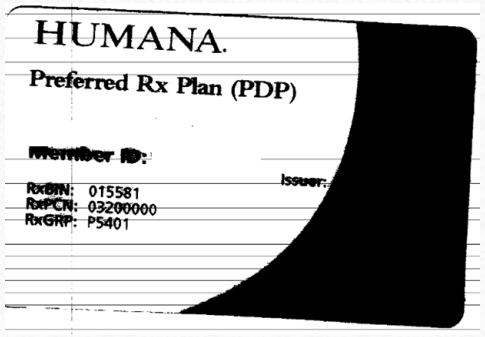
Sample Medicare Advantage Cards



Sample HRA Card



Sample of Preferred Rx Plan Cards



Provider Enrollment

Provider Enrollment Information

The United States has the most expensive healthcare in the world, while being the lowest performing.

Provider Enrollment

- Keep CAQH up to date – commercial payors will pull from CAQH for initial enrollments and revalidations
- Keep up with revalidations for Medicare/Medicaid/Commercial plans. Sometimes you won't know you missed one until the claims stop getting paid
- Are providers enrolled in all plans/product lines of plans
- Are providers enrolled for each location where they see patients
- Does the taxonomy code attached to the NPI reflect the correct information
- How do you determine which patients providers see until they are effective with plans

PAYERS:

Entities other than the patient that finance or reimburse the cost of health services:

- Commercial: Health Plans, Managed Care Organizations
- Federal/State: Medicare, Medicaid, Tricare
- Health Plan Sponsors: Employers or Unions

Why do Payers Credential?

- Ensure practitioner has legal authority and relevant training and experience to provide quality care
- Legal Precedent
- Accreditation/Regulatory Requirements such as NCQA, URAC, CMS
- Internal Policies and Procedures

UNDERSTANDING PAYER REQUIREMENTS

- What do YOUR payers require
- In what networks are your providers participating
- What additional requirements do they have
- Who is your point of contact
- Where do you submit applications

It is important to remember ongoing payer requirements after initial enrollment

- Reporting

  Demographic changes, TIN updates, terminations

- Recredentialing/Re-enrollment

  Commercial payers at least every 36 month

- Revalidations

  Medicare – every 5 years or upon request

  Medicaid – check with you state

COMMERCIAL PAYER TIMELINE

Credentialing – 45 to 180 days

Contracting – 45 to 90 days

These processes may occur in parallel

Items checked during the health plan enrollment process

- License
- Application/Attestation
- DEA
- References
- Education and Training
- NPI
- NPDB
- Sanctions
- Professional Experience
- Board Certification
- Malpractice

Additional Items Plans may Verify/Request

1. Social Security Death Master File Verification
2. Hospital Affiliation Verifications
3. CLIA Certificates and Verifications
4. State specific Patients Compensation Fund Verification (if appliable)
5. Medicare Opt-Out Verification
6. Collaborative Practice Agreements
7. W9

PROVIDER ENROLLMENT CHALLENGES:

- Volume
- Payer Requirements
- Provider Information
- Timeliness
- Communication
- Resources

Five of the most common mistakes to avoid:

- Incomplete Information
- Lack of follow up
- Letting CAQH Lapse
- Poor Planning
- Not understanding the standards and guidelines of payers

THE RESULT OF ALL OF THESE CHALLENGES IS DELAYED OR LOST REIMBURSEMENT !! This has a negative impact on the revenue cycle!

DO NOT WAIT!

- Regardless of who is handling your provider enrollment applications, the primary thing to consider and always keep in mind is DO NOT WAIT! The process is very lengthy, and you won't receive "in-network" payments until your contracts are in effect.
- Credentialing your providers is labor intensive, with few shortcuts. Trying to take short cuts will lead to problems every time!

FOLLOW UP GUIDELINES

- One week after submission, confirm application and documents were received by health plan.
- Wait 30 days then follow up again.
- Follow up every 2 weeks at this point.
- They will tell you to wait the 30 or 60 days. They will tell you they have a process. We in turn tell them we also have a process and that is to follow up every 2 weeks. You don't want to wait 60 days to know that they are missing a document or that you filled out the wrong application.

Payer Repository That Includes at a Minimum:

- Payer Name
- Contract Date
- Average Turn Around Time for Enrollment
- Contact Info
- Plan Specific Requirements

Using Technology to Streamline Enrollment

- CAQH – used by over 900 Healthcare Organizations
- Commercial Software
  - Enrollment and other functions
  - Online collection of provider data
  - Application pre-population
  - Potential integration with CAQH

Using Technology to Streamline Enrollment

CAQH must be up to date at all times. Even if it is not time to re-attest, if anything changes, CAQH must be updated. You have to attest each time you change anything.

Don’t get confused if you see information on there that does not relate to your group. Many providers are associated with multiple groups.

As soon as provider gets Medicare/Medicaid ID, update that info in CAQH before trying to enroll with plans that pull info from CAQH.

USING TECHNOLOGY TO STREAMLINE MEDICARE ENROLLMENT

PECOS

- Initial enrollment averages 45 days vs 60 days for paper
- Status, changes and revalidations
- Identity & Access Management System
- Surrogate Registration

PECOS

- **CMS specifically prohibits you** from using your provider's PECOS (Provider Enrollment, Chain and Ownership System) login to manage, verify, update or authorize their Medicare enrollments.
- CMS wants you to set up a PECOS Surrogacy enrollment account which allows you to work on your provider's behalf using your own login. Failing to comply with these rules, means that you are NOT in compliance with CMS requirements.

The Surrogate Process

- LINKING A PROVIDER TO A GROUP IS A 2 PHASE PROCESS:
- PHASE ONE: PROVIDER REQUESTS GROUP AS SURROGATE
- PHASE TWO: GROUP APPROVES REQUEST
- STEPS TO FOLLOW FOR PROVIDER AND GROUP

Identity & Access Management System

Help

Terms and Conditions

You are accessing a U.S. Government information system, which includes: (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for U.S. Government-authorized use only.

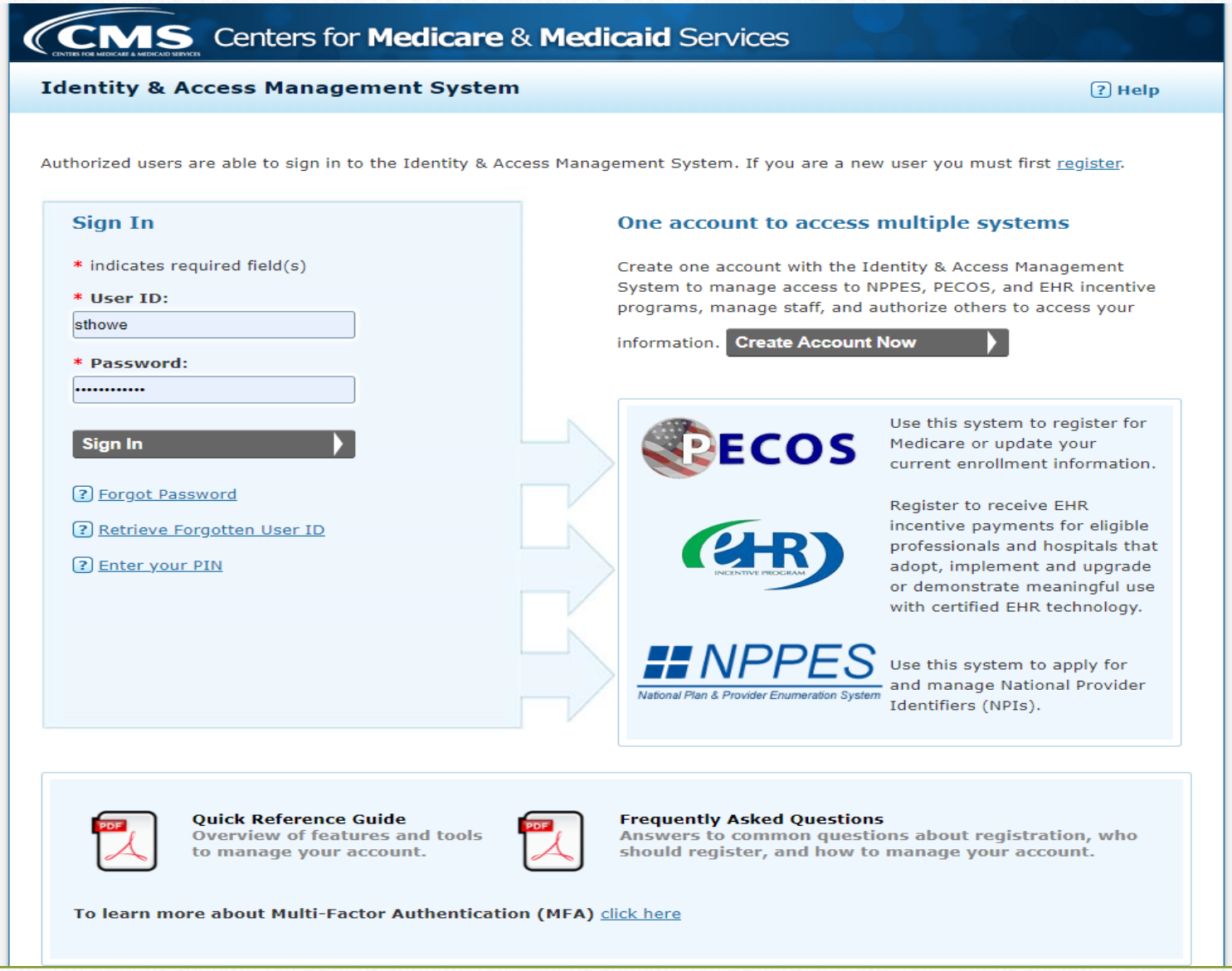
Unauthorized or improper use of this system may result in disciplinary action, as well as civil and criminal penalties.

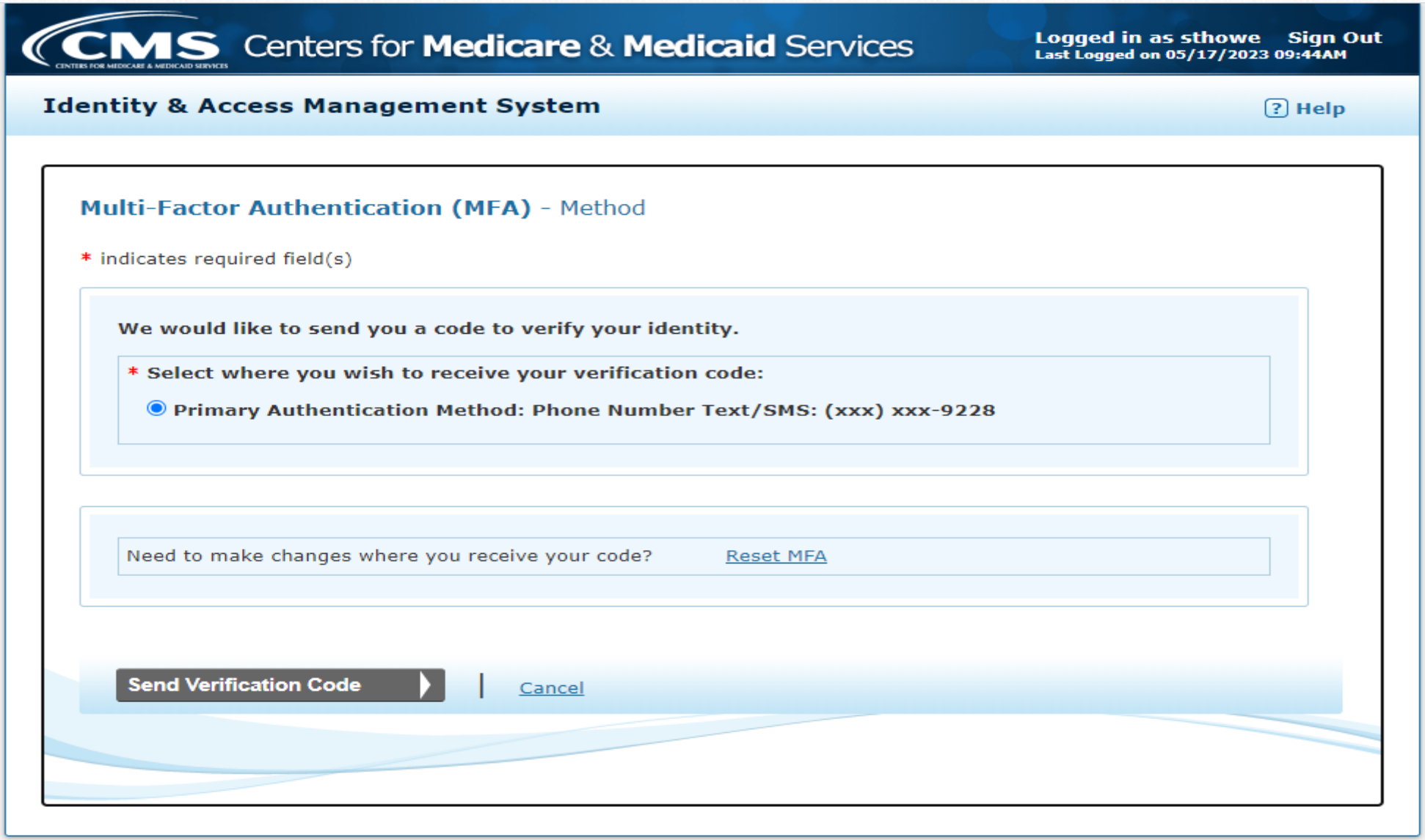
By using this information system, you understand and consent to the following:

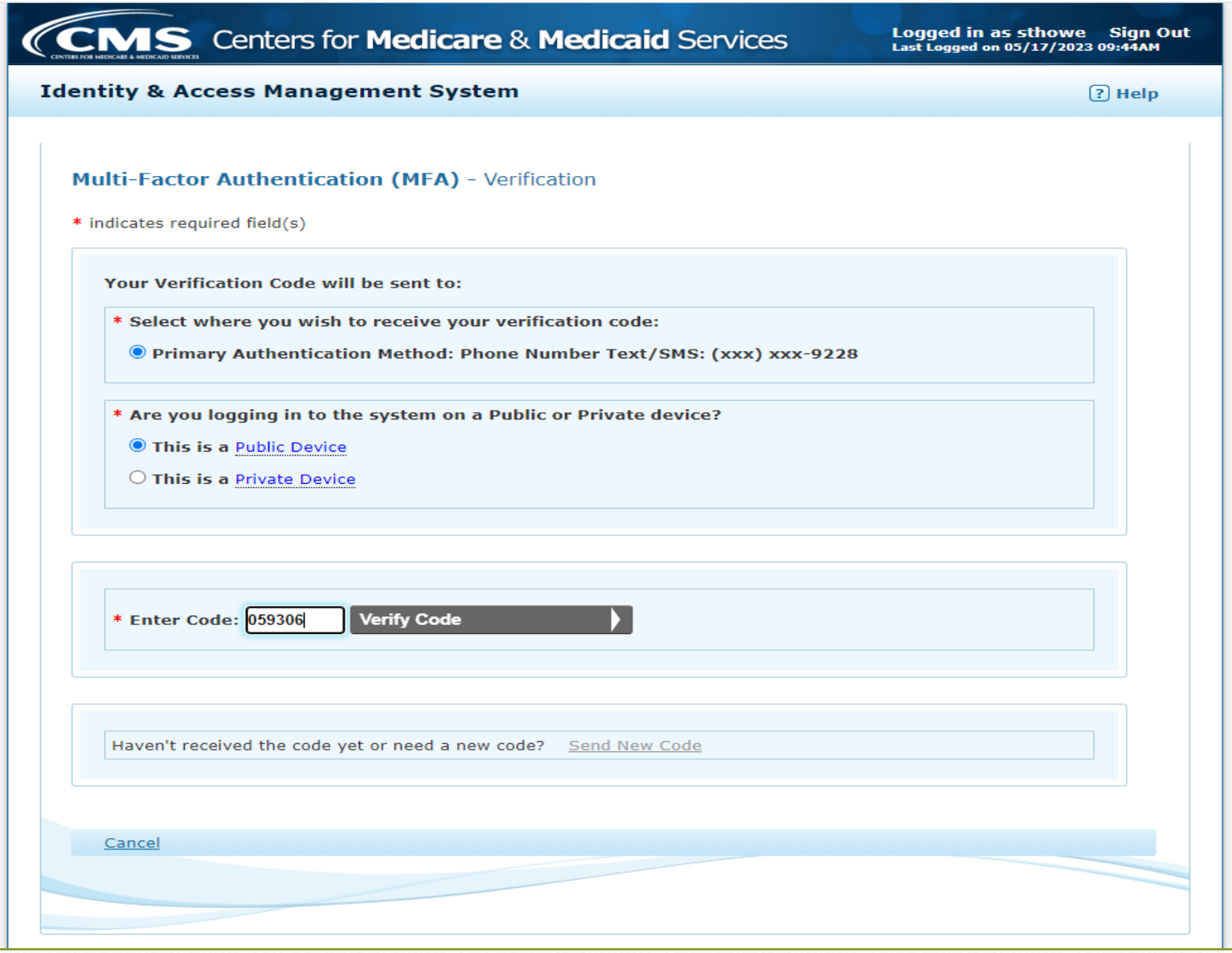
- You have no reasonable expectation of privacy regarding any communication or data transiting or stored on this information system.
- At any time, and for any lawful Government purpose, the Government may monitor, intercept, and search and seize any communication or data transiting or stored on this information system.
- Any communication or data transiting or stored on this information system may be disclosed or used for any lawful Government purpose.
- Our system uses Cookies for security purposes to ensure that unauthorized users cannot bypass our Multi-Factor Authentication. The cookies are not storing personally identifiable information about our users. For increased security to your account, please make sure Cookies are enabled in your browser.

To continue, you must accept the terms and conditions. If you decline, you will not be able to continue.

Accept Decline


CMS Centers for Medicare & Medicaid Services
Identity & Access Management System
Help
Authorized users are able to sign in to the Identity & Access Management System. If you are a new user you must first register.
Sign In
* indicates required field(s)
* User ID:
sthowe
* Password:
Sign In
Forgot Password
Retrieve Forgotten User ID
Enter your PIN
One account to access multiple systems
Create one account with the Identity & Access Management System to manage access to NPPES, PECOS, and EHR incentive programs, manage staff, and authorize others to access your information.
Create Account Now
PECOS
Use this system to register for Medicare or update your current enrollment information.
EHR INCENTIVE PROGRAM
Register to receive EHR incentive payments for eligible professionals and hospitals that adopt, implement and upgrade or demonstrate meaningful use with certified EHR technology.
NPPES
National Plan & Provider Enumeration System
Use this system to apply for and manage National Provider Identifiers (NPIs).
Quick Reference Guide
Overview of features and tools to manage your account.
Frequently Asked Questions
Answers to common questions about registration, who should register, and how to manage your account.
To learn more about Multi-Factor Authentication (MFA) click here


CMS Centers for Medicare & Medicaid Services
Logged in as sthowe Sign Out
Last Logged on 05/17/2023 09:44AM
Identity & Access Management System
Help
Multi-Factor Authentication (MFA) - Method
* indicates required field(s)
We would like to send you a code to verify your identity.
* Select where you wish to receive your verification code:
Primary Authentication Method: Phone Number Text/SMS: (xxx) xxx-9228
Need to make changes where you receive your code?
Reset MFA
Send Verification Code
Cancel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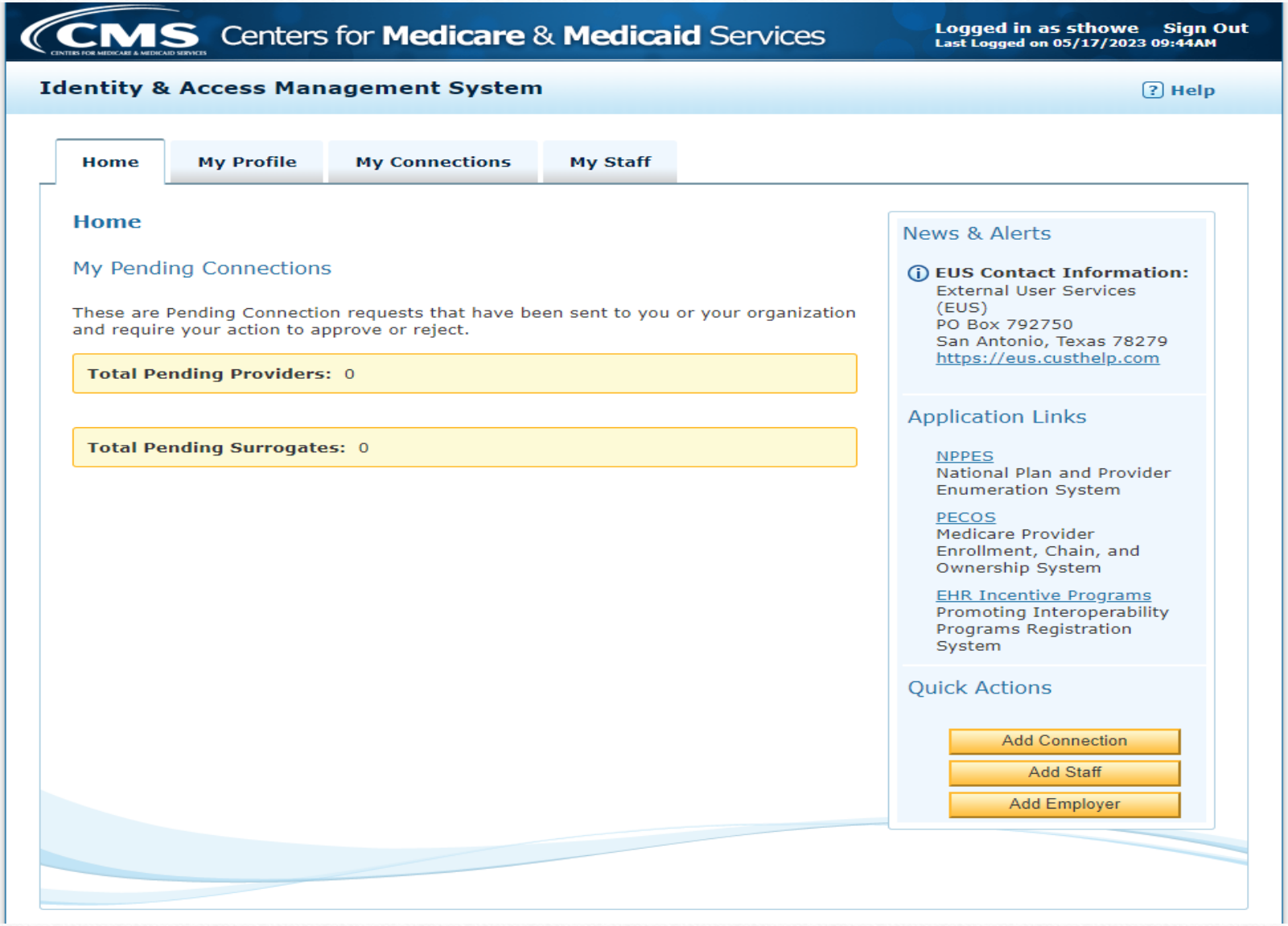
Identity & Access Management System
Help
Multi-Factor Authentication (MFA) - Verification
* indicates required field(s)
Your Verification Code will be sent to:
* Select where you wish to receive your verification code:
Primary Authentication Method: Phone Number Text/SMS: (xxx) xxx-9228
* Are you logging in to the system on a Public or Private device?
This is a Public Device
This is a Private Device
* Enter Code: 059306
Verify Code
Haven't received the code yet or need a new code? Send New Code
Cancel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Identity & Access Management System
Help
Home
My Profile
My Connections
My Staff
Home
My Pending Connections
These are Pending Connection requests that have been sent to you or your organization and require your action to approve or reject.
Total Pending Providers: 0
Total Pending Surrogates: 0
News & Alerts
EUS Contact Information:
External User Services (EUS)
PO Box 792750
San Antonio, Texas 78279
https://eus.custhelp.com
Application Links
NPPES
National Plan and Provider Enumeration System
PECOS
Medicare Provider Enrollment, Chain, and Ownership System
EHR Incentive Programs
Promoting Interoperability Programs Registration System
Quick Actions
Add Connection
Add Staff
Add Employer

My Connections

Connections will allow you to create surrogate relationships between Providers and individuals or organizations that work on th
Providers' behalf.

Select the name of a Connection to update or view more information about that connection.

New You can generate a report containing all your employer connections or all connections for a single employer. Generat

Search By: *Employer Name [ ] Search Clear

[redacted] s a surrogate for the following providers:

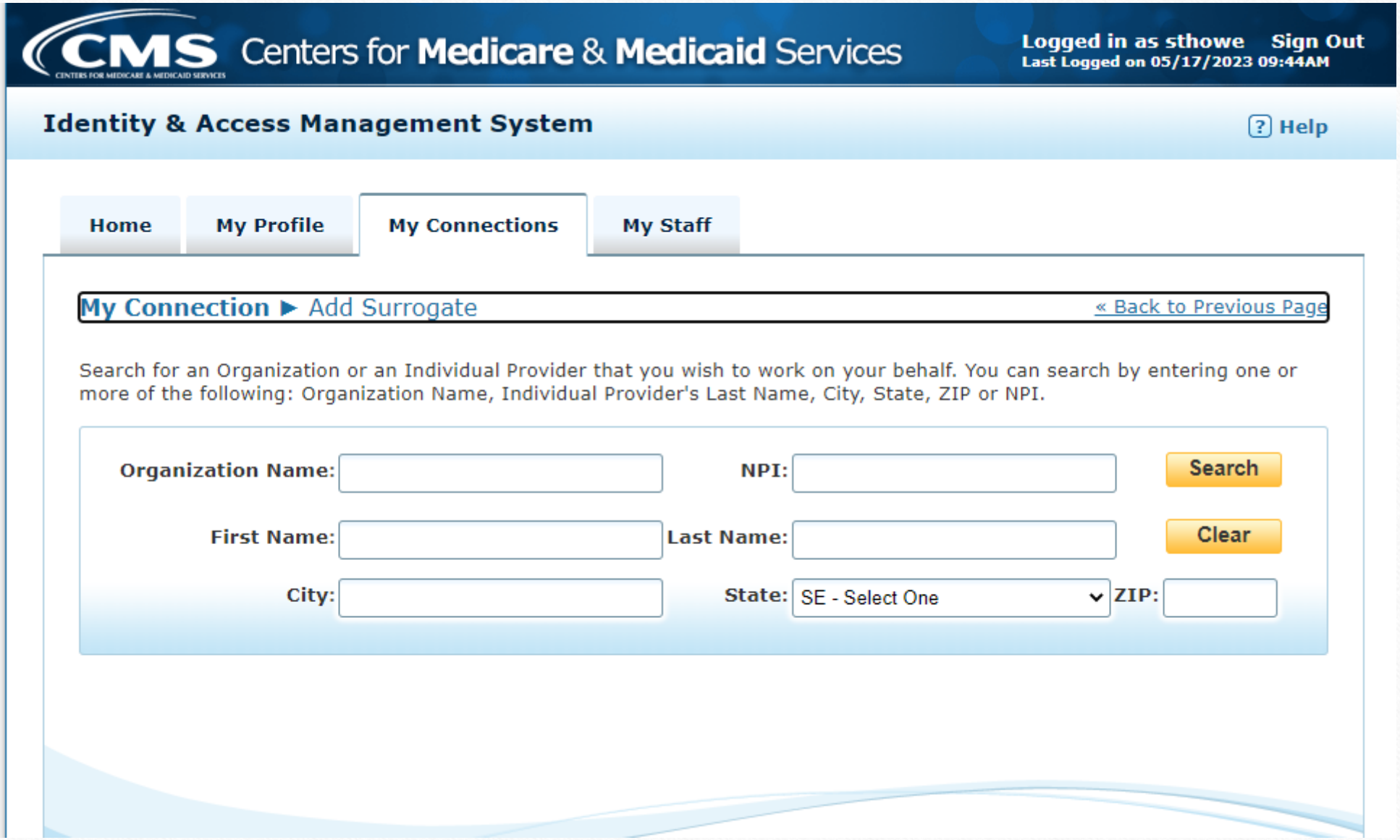
[redacted] has been authorized to work on behalf of the Individual Provider(s) or Healthcare Organization(s) listed below. Use the Find Provider button below to initiate a request to work on behalf of a Provider or Organization not listed here. Use the Multiple Connections button below to initiate a request to add multiple provider connections using bulk upload.

Find Provider Multiple Connections

[redacted] has authorized the following surrogates:

The following Individual(s) or Organization(s) have been authorized to work on behalf of [redacted]. Use the Add Surrogate button to initiate the process of authorizing an Individual or Organization to work on behalf of [redacted]

Add Surrogate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Centers for Medicare & Medicaid Services
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Sign Out
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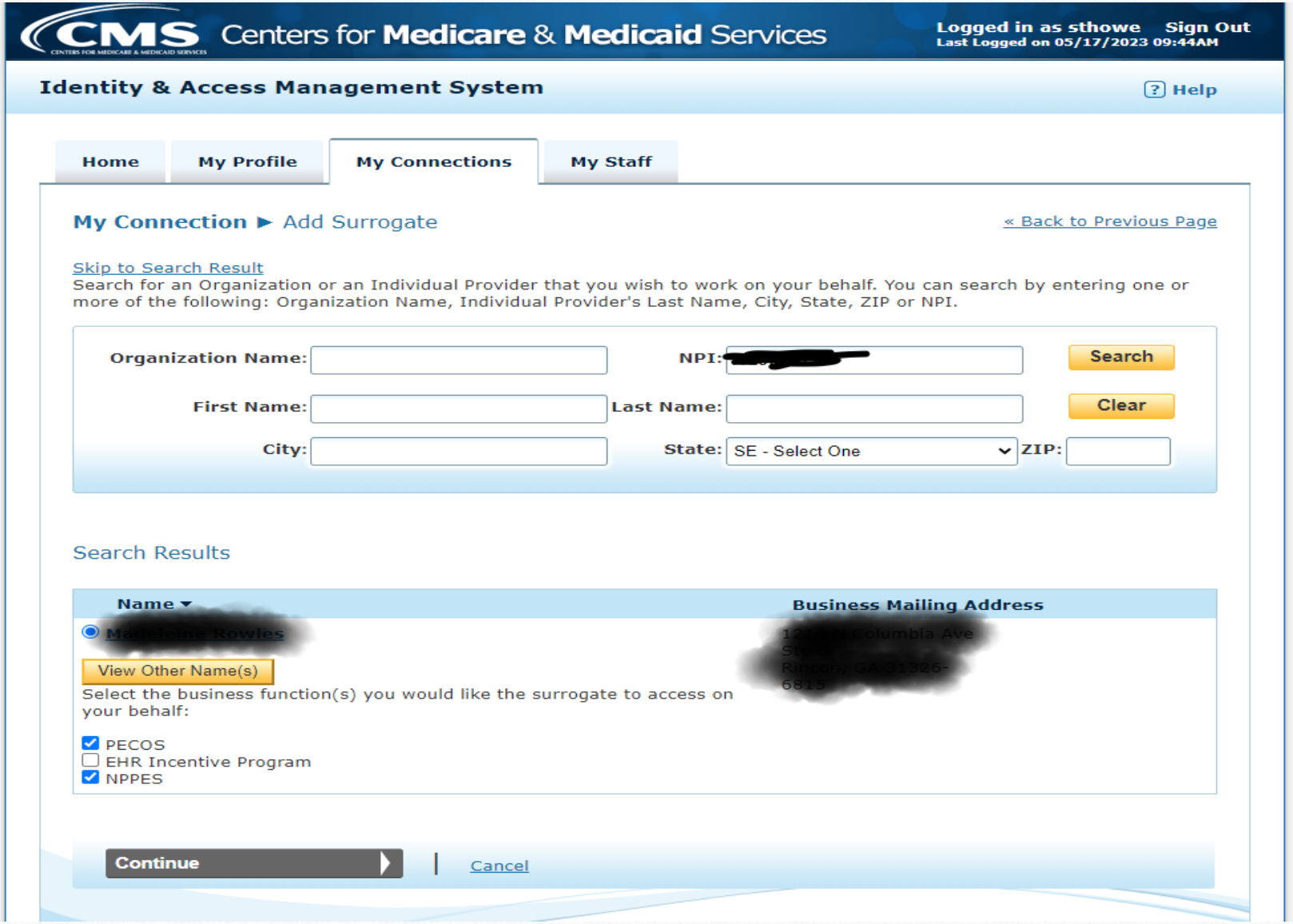
Identity & Access Management System
Help
Home
My Profile
My Connections
My Staff
My Connection ► Add Surrogate
« Back to Previous Page
Search for an Organization or an Individual Provider that you wish to work on your behalf. You can search by entering one or more of the following: Organization Name, Individual Provider's Last Name, City, State, ZIP or NPI.
Organization Name:
NPI:
Search
First Name:
Last Name:
Clear
City:
State:
SE - Select One
ZIP: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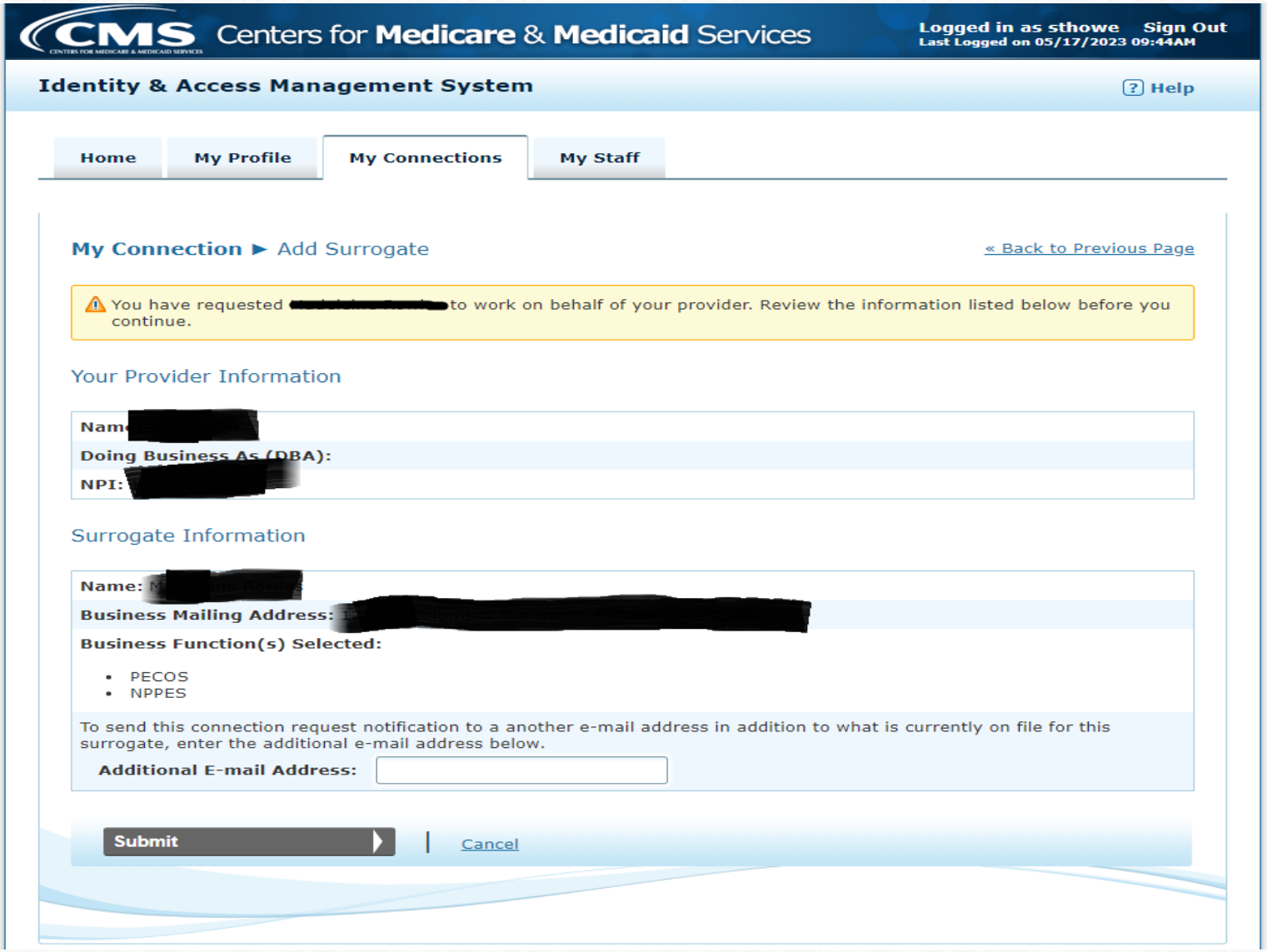
Identity & Access Management System
Help
Home
My Profile
My Connections
My Staff
My Connection ► Add Surrogate
« Back to Previous Page
Skip to Search Result
Search for an Organization or an Individual Provider that you wish to work on your behalf. You can search by entering one or more of the following: Organization Name, Individual Provider's Last Name, City, State, ZIP or NPI.
Organization Name:
NPI:
Search
First Name:
Last Name:
Clear
City:
State:
SE - Select One
ZIP:
Search Results
Name
Business Mailing Address
[redacted]
View Other Name(s)
Select the business function(s) you would like the surrogate to access on your behalf:
PECOS
EHR Incentive Program
NPPES
Continue
Cancel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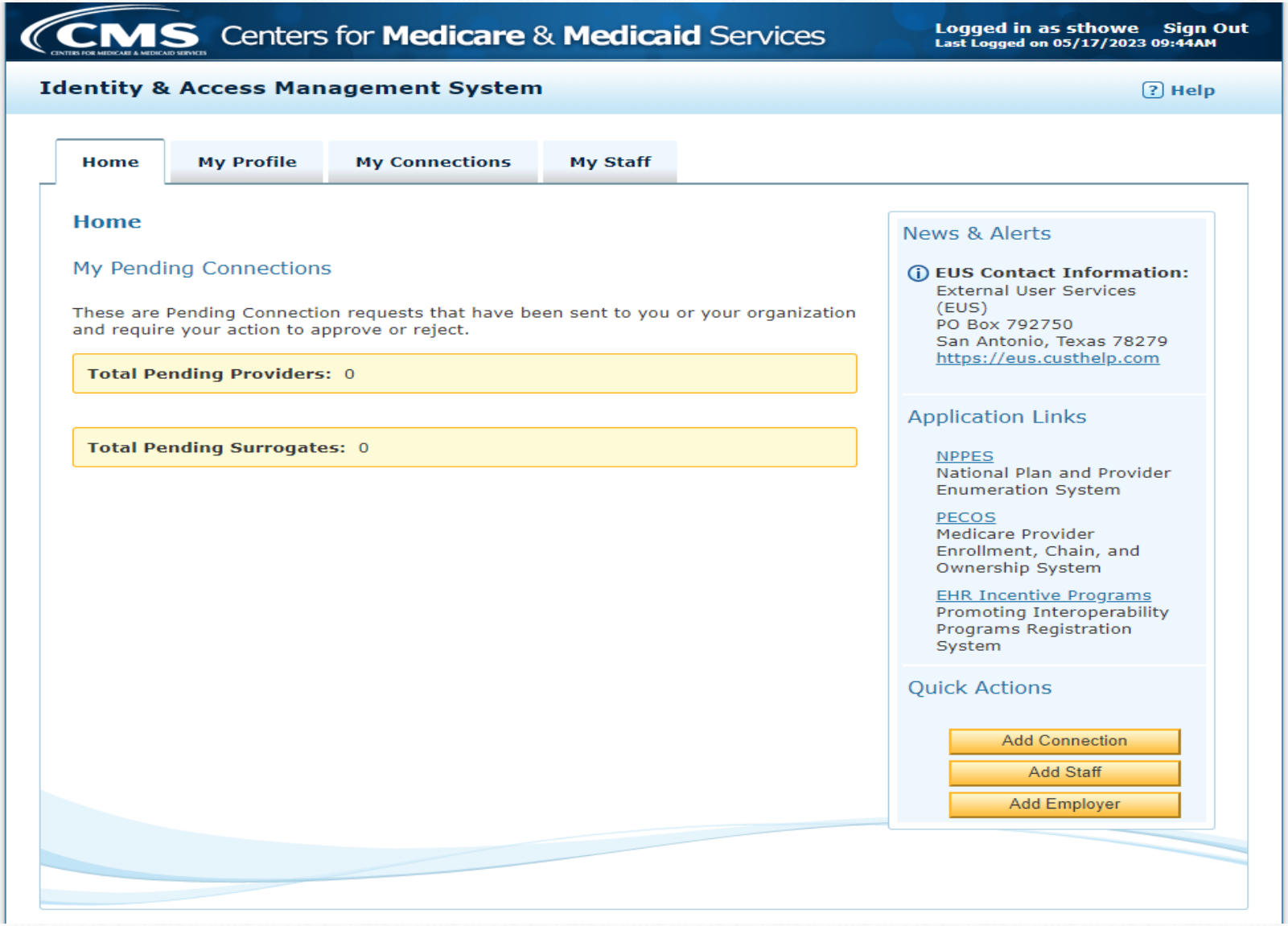
Help
Home
My Profile
My Connections
My Staff
My Connection ► Add Surrogate
« Back to Previous Page
You have requested [redacted] to work on behalf of your provider. Review the information listed below before you continue.
Your Provider Information
Nam[redacted]
Doing Business As (DBA):
NPI: [redacted]
Surrogate Information
Name: [redacted]
Business Mailing Address: [redacted]
Business Function(s) Selected:
PECOS
NPPES
To send this connection request notification to a another e-mail address in addition to what is currently on file for this surrogate, enter the additional e-mail address below.
Additional E-mail Address:
Submit
Cancel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Quick Actions
Add Connection
Add Staff
Add Employer

Make sure enrollment staff have access to the sites they need to do their jobs efficiently and effectively:

- I&A/PECOS Account - MFA
- Availity Account – MFA
- CAQH info for providers

Getting started tips:

Step 1: Gather all documents

Step 2: CAQH Access and update and attest

Step 3: Medicare/Medicaid apps

Step 4: Apply to all plans that pull from CAQH

Step 5: Apply to all other plans

Helpful hints:

- You must be organized
- You must follow up relentlessly
- Enrollment staff must have access to all sites they need in order to effectively to their job.

Helpful hints:

- You may get different answers from different customer services reps. Not everyone at their current job knows what they are doing, and many will say anything just to get you off of the phone.
- Don’t accept “still in process”. Ask WHY? WHAT IS MISSING? CAN WE ESCALATE THIS?
- Acronyms and terms – be familiar. If you aren’t sure what something means. ASK…do not ignore.

Helpful hints:

- Know what stages mean – credentialing, loading, contracting. What do these mean? How long does each stage take? And what point is the provider effective?
- Some plans used Vendors…Aperture is one of those. They may ask for things the payer doesn't ask for. Many requests will give deadlines for getting documents in before application is denied and you have to start over.
- Sometimes panels are closed. Plans evaluate network needs and organizations/providers standing before deciding to extend an agreement.

ENROLLMENT IN PROCESS REPORT SAMPLE

		Supporting Documents Required for Applications										Medicare	Medicaid	Amerigroup	Caresource
Provider	Location	CAQH / Standard App. Disclosure & Release	Provider linked to group in I&A	Current CV in MM/YYYY	Current State License # and Exp date	Current State DEA	Board Certification	NPI	Nurse Protocol Agreement NP/ Sponsor Form PA	Malpractice COI	Power of Attorney (POA)				

Billing/AR

Revenue Cycle Overview

Billing – now the billing starts

- Make sure EMR is configured correctly. Insurance/Payer ID's, Fee schedules, Adjustment Codes, Locations, Providers
- Unlocked charts can delay billing
- How often are claims billed
- Posting Payments
- Rejected vs Denied Claims
- Working Accounts Receivable
- Credit Balance Report

Job Descriptions and Assignment of Duties

Billing Staff:

- Prepare and submit billing data and medical claims to insurance companies.
- Ensure the patient's medical information is accurate and up to date.
- Investigate and appeal denied claims.
- Understand clinic policies on payment plans.
- Accurately apply sliding fee scale discounts to patient responsibility amounts.

Policies and Procedures/Processes-Billing

- How often are claims billed
- Tracking claims after submission
- Unlocked claims process
- Frequency of follow-up
- Payment Posting Procedures

Policies and Procedures/Processes - Denial Management

- Identification of unpaid/denied services, including remittance advice reviews
- Research and correction process
- Time requirement for processing denials
- Payer contact list
- Frequency of rebill to payers

Policies and Procedures/Processes- Bad Debt

- Frequency of Review
- Small Balance write-off policy
- Number and frequency of patient statements sent before write-off
- Procedure and approval process for account write-off
- Clearly identified staff authorized to write-off accounts

Capturing Charges

Charge capture is an important phase in revenue cycle management where healthcare providers record and document the services, procedures, and supplies provided to patients.

Efficient charge capture ensures that all billable services are accounted for, leading to appropriate billing and reimbursement. This step helps maximize revenue and maintains compliance with regulatory requirements. Effective charge capture contributes to financial health, transparency, and the overall success of healthcare organizations.

Capturing Charges Best Practices

- Record charges promptly to prevent missed revenue opportunities.
- Ensure accurate ICD-10 and CPT coding for services.
- Implement systems to track and verify charge entries.
- Train healthcare staff on proper charge capture procedures.
- Conduct regular internal audits to identify and rectify discrepancies

Claim Submission

Claim submission demands precision, as any errors or omissions can lead to claim denials and delayed payments.

Effective claim submission involves accurate coding, thorough documentation, and adherence to payer-specific guidelines. Streamlining this step is essential to ensure timely reimbursement and maintain the financial stability of healthcare organizations.

Claim Submission Best Practices

- Scrub claims for errors before submission to reduce denials.
- Utilize electronic claims submission for faster processing.
- Follow each payer's submission guidelines meticulously
- Ensure medical records support billed services.
- Implement a system for tracking and resubmitting denied claims. This step is just as crucial as submitting the claims.

Claim Submission

- Is claims format set up correctly
- Are Payors set up correctly
- Does front desk know and understand the selection of the correct payors? They may be the same name but different payors types(UHC or UHC Medicare HMO)
- Are there duplicates

Claim Submission

- How often do you submit claims
- Do you have buckets of dirty claims, pending claims, rejected claims, denied claims, suspended claims, etc. and how often are these buckets worked
- When errors are discovered, are they reviewed with staff

Claim Adjudication

Claim adjudication is where insurance payers assess and make determinations regarding submitted claims. During this stage, payers review claims for accuracy, completeness, and compliance with policy terms. They then decide on payment or denial and the amount to be reimbursed.

Timely and accurate claim adjudication is vital for healthcare providers to receive the revenue they are entitled to, ensuring financial stability and enabling them to continue delivering quality care.

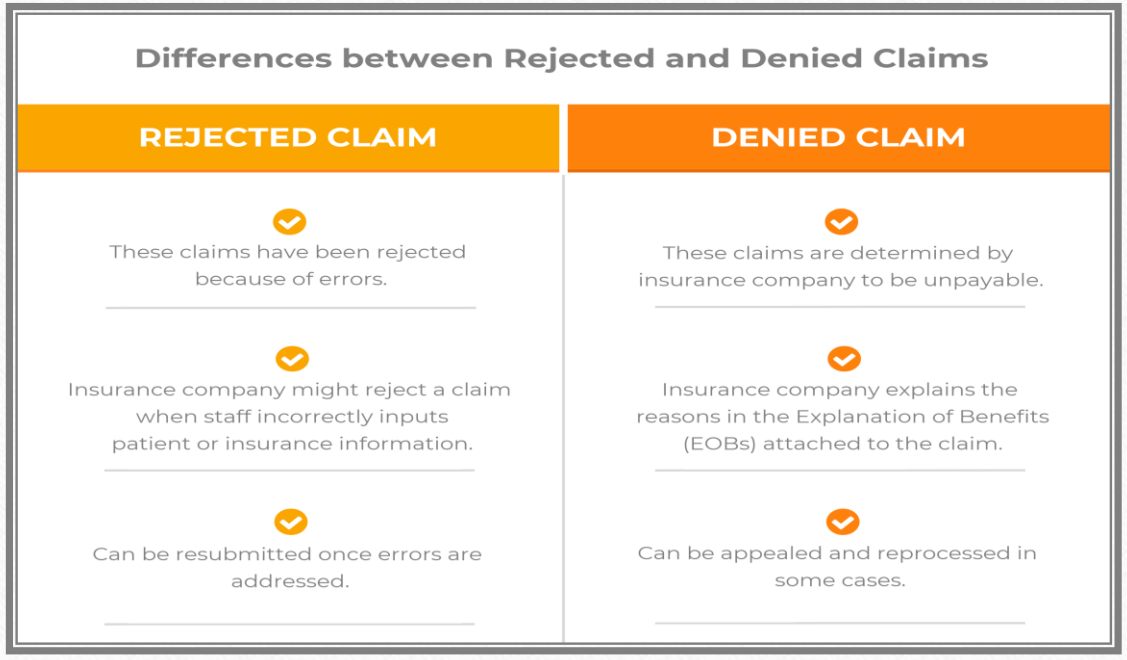
Claim Adjudication Best Practices

- Monitor claim status and progress through automated systems.
- Investigate claim denials to identify recurring issues.
- Establish a streamlined appeals process for denied claims.
- Foster open communication with payers for dispute resolution.
- Keep staff updated on payer policies and changes.

Example of top 10 claim denials

- Incomplete or missing codes
- Timely filing
- Pre –Authorization not on file
- Patient health insurance change
- Wrong ID number or Name and Number does not match
- Service not covered
- Provider not enrolled
- Provider NPI not on claim
- Requested information
- ICD Code incorrect with gender/age

Rejected v Denied



AR Follow Up

Accounts receivable follow-up in revenue cycle management involves the monitoring and pursuit of outstanding payments from insurance companies, patients, and third-party payers.

Timely and effective follow-up helps healthcare organizations reduce aging accounts receivable, accelerate cash flow, and minimize bad debt. It requires consistent communication with payers and patients to resolve outstanding claims and balances, ultimately ensuring a healthy financial foundation for healthcare providers.

AR Follow Up Best Practices

- Establish a structured process for tracking and pursuing overdue accounts.
- Regularly assess and prioritize aged accounts for follow-up.
- Engage in persistent but respectful follow-up with payers and patients.
- Utilize automated reminders and alerts for follow-up tasks.
- Identify and address recurring denial patterns for faster resolution.

Payment Posting

Payment posting is where received payments from insurance companies, patients, and third-party payers are recorded and applied to patient accounts. This process demands precision to ensure accurate tracking of payments, adjustments, and patient balances.

Efficient payment posting not only minimizes errors but also aids in revenue reconciliation and financial reporting. It is instrumental in maintaining a clear financial picture and optimizing the revenue cycle.

Payment Posting Best Practices

- Utilize automated systems to expedite payment posting.
- Regularly reconcile payments with remittance advice and patient accounts.
- Post payments promptly to prevent delays and discrepancies.
- Train staff in payment posting procedures and coding.
- Establish protocols for addressing payment discrepancies and posting errors.

Remittance Review

Does the organization review remittance advice and compare to contract to determine if carrier is paying based on contractual allowance?

Patient Statements

Patient statement processing is an RCM component responsible for generating and delivering financial statements to patients. These statements provide a breakdown of medical services rendered, associated costs, and the patient's financial responsibility after insurance adjustments.

This phase is instrumental in enhancing transparency and patient engagement, as it empowers individuals to understand their healthcare expenses. By facilitating clear and timely communication of financial information, healthcare providers not only foster patient trust but also streamline revenue collection processes for sustained financial health.

Patient Statements Best Practices

- Ensure statements are easy to read and understand.
- Send statements promptly after insurance adjudication.
- Offer convenient payment methods and options.
- Include information on insurance and billing inquiries.
- Provide responsive support for patient billing questions and concerns.

Statements

What happens when a patient has a question about their statement? What happens when they believe they were overcharged? You should have an established clear process to follow when customers dispute invoices or have other billing-related issues. This enables issues to be resolved much faster—which, in turn, helps increase patient satisfaction.

CREDIT BALANCE REPORTS

Though a credit balance often means that an actual overpayment of a service has occurred, some credit balances result from a) accounting errors, b) errors in calculating coinsurance amounts, or c) duplicate payments made by the same or other insurers. The government further describes overpayments as payments made by Medicare:

- For non-covered services
- In excess of the allowed amount for an identified covered service
- In error
- As duplicate payments
- When another entity had primary responsibility for payment

CREDIT BALANCE REPORTS

Credit balance procedures need to be straightforward and should include:

1) Review of the credit balance report

2) Identification of both patient and insurance refunds

3) Initiation of the refund process and delivery of supporting documentation

4) Verification that refund checks are both signed and mailed

CREDIT BALANCE REPORTS

It’s not uncommon for providers to keep such overpayments until specifically asked to return them or until payers have withheld them from subsequent payments.

Goals to Improve Process

- Be clear, concise and set reasonable goals and timelines
- Identify where your obstacles are
- Plan how to overcome those obstacles

Denial Management

Denial management in the healthcare revenue cycle management, focuses on identifying, analyzing, and resolving denied insurance claims. Denied claims can lead to significant revenue loss if not addressed promptly and effectively. This stage involves investigating the reasons for denials, correcting errors, and resubmitting claims to ensure reimbursement.

Denial management processes not only improve revenue but also provide insights into areas where operational improvements can reduce future denials and enhance financial performance.

Denial Management Best Practices

- Identify and address the underlying causes of denials.
- Implement automated denial tracking and resolution systems.
- Ensure staff are trained to understand and address common denial reasons.
- Use software to identify and rectify claim errors before submission.
- Focus efforts on larger-denomination claims for maximum impact.

Revenue Analysis and Reporting

Revenue analysis and reporting are in integral part of healthcare revenue cycle management. This phase involves the examination of financial data to gain insights into the financial performance and overall health of a healthcare organization.

By reviewing revenue trends, identifying areas of improvement, and benchmarking against industry standards, healthcare providers can make informed decisions to optimize revenue streams and enhance operational efficiency. Robust reporting ensures transparency and compliance and empowers organizations to formulate strategic plans for long-term financial stability and growth.

Revenue Analysis and Reporting Best Practices

- Generate routine financial reports for analysis.
- Define and track relevant KPIs.
- Compare financial performance with industry benchmarks.
- Ensure data accuracy and consistency for reliable analysis.
- Foster collaboration between finance and operations teams for holistic insights.

Compliance and Auditing

In revenue cycle management, compliance and auditing are must be part of the process. These processes involve rigorous adherence to legal and regulatory requirements and internal policies and procedures. By conducting regular audits, healthcare organizations can ensure that their revenue cycle operations remain compliant and efficient.

Auditing identifies potential areas of risk, helps mitigate fraud and billing errors, and maintains financial integrity. Compliance and auditing serve as the guardians of financial and ethical standards within the healthcare revenue cycle.

Compliance and Auditing Best Practices

- Conduct routine internal and external audits.
- Ensure accurate and complete documentation of all financial transactions.
- Train staff on compliance policies and updates.
- Identify and mitigate potential compliance risks.
- Foster collaboration between compliance and revenue cycle teams for seamless integration.

Goals to Improve Process

- Be clear, concise and set reasonable goals and timelines
- Identify where your obstacles are
- Plan how to overcome those obstacles

Productivity

Productivity Goals

Everyone in the health centers wears multiple hats doing multiple jobs. When there is turnover, leadership must consider the reality that as remaining staff take on more work due to turnover and growth, the work they are already doing will fall behind.

Tracking Productivity and Errors

In each of these areas of the revenue cycle discussed today, productivity and errors must be tracked to ensure a streamlined revenue cycle. This will help to identify gaps and areas where staff may need to be retrained.

Front Office - Tracking Productivity and Errors

Data integrity at the front desk is key to the revenue cycle. Receiving and entering this information is key. Some things to consider:

- For total fields required in demographics, guarantor, PCP/Rendering, Insurance/Self Pay status, Household Income, Sliding Fee Scale, Additional Information, how many were completed and of the ones completed, how many were correct? Know what your percentage of completed fields is and rate of error/missed information.

Provider Enrollment - Tracking Productivity and Errors

When tracking productivity and errors in Provider Enrollment, some things to consider:

- From the point of having all documents and information needed to enroll a provider, have all applications been submitted within 30 business days
- How many applications are returned or denied due to missing information or documents
- Is timely follow up being performed or are applications being submitted and forgotten
- How long from submission to effective date

Billing/AR - Tracking Productivity and Errors

When tracking productivity and errors in Billing, some things to consider:

- How many claims is each biller getting out in a day and do they know the expectation
- How many claims are denied due to billing errors
- Is follow up being performed on claims submitted to be sure they make it to the payer and get adjudicated timely
- Working denials is also an excellent way to find errors from other areas such as front desk, provider documentation, etc.
- You can easily see productivity of A/R based off of amounts in each aging category.

Training

Training, Training, Training

Lack of training contributes to high turnover rates.

Can’t just train for a week or two and cut loose with no follow up.

Get input from those actually doing the job on ways to improve processes.

Training, Training, Training

- It's generally more difficult to attract professionals to an CHC setting. These organizations rank highly in terms of their give back to the communities they serve. But CHC's are located, by design, in more rural communities that lack some of the excitement, challenges, and opportunities that come from more urban settings.
- When CHC's experience turnover, their staffing conundrum may become a crisis. This places the burden of keeping the work done on staff that are already carrying more than a full load.

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Training, Training, Training

How can CHCs work to reduce employee turnover and build a strong workforce to attract even more qualified candidates to their team?

- Develop the Right Environment
- CHC's experiencing turnover must take rapid steps to stop the bleeding. The impact on the bottom line is clear, but high turnover also takes a serious toll on the remaining team members. Organizations can quickly impact turnover by working on their culture and hiring processes.
- Take steps to revamp your hiring process to ensure a better fit from day one.
- Hiring takes legwork but always involves a gut check requiring your instincts as to whether the candidate will fit. If you're experiencing turnover, look at the process to make sure due diligence is followed. Are you checking references and running background checks on every employee? Don't rush the process and trust those instincts that suggest the employee may not be the perfect fit.

Training, Training, Training

- Build your culture by building teams.
- Invest in training and cross training your employees.
- The highest-performing employees are at risk of leaving if you don't provide them with a career path for growth. Health Centers can offer low-cost training like lunch and learns put on by existing staff or online training and certification programs.

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Training, Training, Training

- Establish rewards for meeting goals.
- Whether they are departmental or individual, set an obtainable goal for employees. Create public rewards systems for departments with the best customer satisfaction scores or individuals that achieved higher certification or training. Employees want to know the team and the organization appreciates their hard work.
- Offer competitive pay and benefits.
- While Health Centers are certainly limited by budgetary constraints, go to the top of the salary cap as necessary to attract top talent. Also, make use of the benefits packages to emphasize work/life balance as much as possible.

Training, Training, Training

- Acknowledge learning curves
- Job Expectations
- Training Buddy
- Follow up daily first week on their own.
- Follow up weekly on second and third weeks
- Do 30, 60, 90-day CONSTRUCTIVE REVIEWS! A check up to see how things are going. People are going to need help and CONSTRUCTIVE advice as they go along.
- CROSS TRAIN

Communication

Workplace communication is the manner by which employees exchange information and ideas within an organization. Communication is a crucial aspect to achieve organizational objectives and get any job done, whether in-person or virtually.

Communication

Communication is among the top concerns in the workplace. Ineffective communication or lack thereof can have significant detrimental effects to an organization and staff morale.

Communication – what does it look like?

- Good communication provides purpose and a common goal.
- Good communication can prevent misunderstandings and avoid confusion.
- Good communication stimulates team building and boosts company culture.
- Good communication encourages employee engagement and improves morale.
- Good communication often results in a more productive and talented workforce.

Communication – tips for effective communication

- Give clear instructions on tasks and state what results are expected.
- Encourage open discussion and feedback exchange.
- Communicate frequently and with transparency.
- Provide specific and descriptive constructive criticism.
- Schedule regular employee check-ins.
- Continually work on your communication development.

Making a Difference

- Recognize weakness
- Lack of understanding
- Training needs
- Do not be afraid to hire those that are more advanced/experienced/different skill set than you have

Making a Difference

Create an environment where your staff feel safe saying “I made a mistake”, “I need help”, “I don’t understand”, “Could you please show me that again”.

ACCOUNTABILITY

99% OF FAILURE COMES FROM THE PEOPLE WHO HAVE THE HABIT OF MAKING EXCUSES - George Washington Carver

- TAKE RESPONSIBILITY FOR ACTIONS
- COMPLETE ASSIGNMENTS
- BE OPEN TO CONSTRUCTIVE FEEDBACK

The Medical Revenue Cycle is the Key to Your Success

Managing this cycle well is vital to the survivability of your healthcare organization. And as your organization grows, the more patients you will see, and the more data you will collect. The more data you have to manage, the more chance for error and loss. Your clinic might be large enough to devote a team to revenue collection or you may only have one person for this function. In any case, attention to each of these steps in the medical revenue cycle will help you succeed in securing payment from patients and insurers for your valuable services.

MANAGER IS NOT JUST A TITLE: IT MUST INVOLVE ACTION

- Setting reasonable productivity goals for staff
- Auditing to be sure productivity in each area of the revenue cycle is being met and that errors are addressed and kept to a minimum
- Recognizing training and retraining needs and making sure staff are properly trained and retrained

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