Revenue Cycle Best Practices to Increase Collections, Reduce A/R and Increase Patient Satisfaction

Michael Orseno
Director – Regent Revenue Cycle Management
Karen Franklin
Client Manager – ZirMed

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Agenda

• Revenue Cycle Defined
• Pre-Visit
• Post-Visit
• Revenue Cycle Metrics
• Patient Satisfaction
Introduction

The Revenue Cycle

- Registration/Scheduling
- Insurance Verification
- Patient Financial Counseling
- Charge Entry/Billing
- Payment Posting
- Follow-up

Front Office

Back Office
Pre-Visit
Insurance Verification – Electronic

• The following benefits can be verified electronically either individually or batched via ZirMed:
  ➢ Eligibility – is patient eligible for benefits under this insurance plan?
  ➢ Copay – amount patient must pay prior to any services performed
  ➢ Deductible – total amount patient must pay prior to receiving benefits
  ➢ Deductible remaining – unmet deductible amount
  ➢ Co-Insurance – percentage of contracted amount patient is responsible for once deductible has been met
  ➢ In-network vs. out-of-network benefits – some plans offer different benefits for in- and out-of-network providers/facilities
Insurance Verification - Manual

• Authorizations and Referrals (if necessary)

• If out-of-network (OON), determine if case should be performed at your facility
  ➢ Does patient’s insurance plan offer OON benefits?
  ➢ Does the patient have a high unmet deductible?
<table>
<thead>
<tr>
<th>Network</th>
<th>Family Coverage</th>
<th>Deductible</th>
<th>Out of Pocket (Stop Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>Deductible</td>
<td>$955.04</td>
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<tr>
<td></td>
<td>Deductible Remaining</td>
<td>$1044.96</td>
<td>$2000.00</td>
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<tr>
<td>Individual</td>
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<td>$479.10</td>
<td>$0.00</td>
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<tr>
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<td>Deductible Remaining</td>
<td>$520.90</td>
<td>$3000.00</td>
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<tr>
<td>Out of Network</td>
<td>Deductible</td>
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<tr>
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<td>Deductible Remaining</td>
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<td>$18000.00</td>
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<tr>
<td>Individual</td>
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<tr>
<td></td>
<td>Deductible Remaining</td>
<td>$2048.80</td>
<td>$9000.00</td>
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</table>

**General**

<table>
<thead>
<tr>
<th>Preferred Provider Organization (PPO)</th>
<th>Coverage Description</th>
<th>Payer Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee and Spouse Coverage</td>
<td>90-70,D1000,OP3000,OV20,15-35-</td>
<td>HUMANA PPO-8-SFP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Payer Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 Years</td>
<td>MAX DEPENDENT AGE</td>
</tr>
<tr>
<td>25 Years</td>
<td>MAX STUDENT AGE</td>
</tr>
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</table>
Estimating Out-of-Pocket Patient Expenses

Example: Jane Smith has a $2,000 deductible, $1,000 of which has been met. Her co-insurance pays 80/20, and the procedure contractual is $3,500. Assuming Jane doesn’t have secondary insurance, how much will Jane’s OOP expenses be?

- Deductible owed: $1,000
- Co-insurance owed: 20% of $(3,500 - 1,000) = $500
- Total OOP Expense: $1,500
Collecting vs. Arranging for Up-Front Payment

- Goal: Increase Patient Collections and Decrease Days Outstanding
- Fact: Collecting or Arranging for Payment Prior to Date of Service will BOTH Increase Patient Collection and Decrease Days Outstanding!
- Which is Better?
Collecting vs. Arranging for Up-Front Payment

Issues for Consideration:

• Large amount of OON patients?
• If you’re a facility, is the physician’s office already collecting an up-front deposit?
• Refunds
• Secure Facility? People, storage
• Contractual Issues
• Patient population (age, credit cards, low credit)
• Process for Arranging for Payment (sign consent form, storage, remembering to process payment)
Financial Counseling

- Verify demographic and insurance information with patient
- Review patients benefits
- Explain patient out-of-pocket costs
- Arrange for / Collect payment
Post-Visit
Claims Submission (Billing)

• Electronic (Duh!) for All Claims

• Worker’s Comp Claims Can be Sent Electronically as well

• Charge Lag = Date of Service (DOS) to Charge Entry
  ➢ Charges should be entered as soon as they are coded
  ➢ Gold Standard for ASCs: 48 hours

• Claim Lag = DOS to Claim Billed
  ➢ Claims should be sent immediately after charges are entered
  ➢ Gold Standard for ASCs: 48 hours
Payment Posting

- **Electronic Remittance Advice (ERA)**
  - Remittance is received electronically (835) via ZirMed into management information system (MIS)
  - Manual checks (patient and insurance) can also be converted into an electronic 835 file

- **Electronic Funds Transfer (EFT)**
  - Payments are sent electronically to facility’s bank account
  - EFTs must be matched up with ERAs

- **The 835 ERA File is Auto-Posted in MIS**
  - Payments are matched up with contractual allowances loaded into MIS
  - Incorrect payments are flagged for follow-up
Paperless Business Office

• All business office staff are equipped with dual monitors in order to post payments most efficiently

• All correspondence is scanned and stored at either the patient’s chart or a general file
Insurance Follow-up

• Worklog/ Tasks
  ➢ Management assigns tasks to staff
  ➢ Worklog updates nightly so it is up-to-date, increases efficiency
  ➢ Decreases paper

• Timely Follow-up
  ➢ Claim status should be checked in the first 15 days on all claims
  ➢ Follow-up on all outstanding claims *at least* once every 30 days

• Working and Tracking Denials
Working and Tracking Denials

• Working Insurance Denials:
  - Research denial and determine if the claim can be rebilled
  - If rebilling claim does not resolve denial, file an initial appeal, secondary appeal and final appeal (if necessary)
  - If an answer is not received within 30 days, follow-up every day

• Track All Denials Received from Payers
  - Provide feedback to the front office to prevent future denials
  - Build custom edits in clearinghouse to prevent future claims with errors being billed
Patient Follow-up

- **Worklog/ Tasks**
  - Management assigns tasks to staff
  - Worklog updates nightly so it is up-to-date, which increases efficiency
  - Decreases paper

- **Statement Cycle**
  - 30-day cycle recommended
  - Statements should be sent immediately upon becoming patient responsibility
  - Outsourcing statements saves time and money

- **Collection Agency**
  - Send delinquent accounts to the collection agency early and often
  - Accounts are eligible for collections after 3 statements or 60 days
Revenue Cycle Metrics
Revenue Cycle Metrics

• Days Outstanding / Days in A/R
• Claim Lag / Charge Lag
• % of A/R Greater than 90 Days
• Net Collection Rate
• Denial % / Clean Claim %
• Business Office Staff per 1,000 Cases
• Real Time Dashboard
Days Outstanding / Days in AR

• Definition: In its most basic form, Days Outstanding is essentially the time it takes to get a claim paid

• Calculation: Total AR / (total charges from last 3 months/90)

• Regent Standard: Less than 30 Days

• Uses: Determines the health of your AR. Wild swings from month-to-month may highlight a billing or collection problem
Claim Lag / Charge Lag

- **Definition:** The time it takes to get a claim entered and sent
- **Calculation:** Number of days from DOS to charge entry / submission
- **Regent Standard:** Less than 3 Days
- **Uses:** Determines how quickly charges are being sent. A high Claim/Charge Lag has a negative impact on Days Outstanding
% of A/R Greater than 90 Days

• Definition: The amount of $$ as it relates to total AR greater than 90 days outstanding

• Calculation: Total AR greater than 90 days / Total AR

• Regent Standard: Less than 15%

• Uses: High % of AR greater than 90 days may emphasize an issue with patient collections or insurance denials
Net Collection Rate

- Definition: The % of eligible $$ the facility actually collected
- Calculation: Total payment / (total charge – contractual – bad debt + refunds)
- Regent Standard: Greater than 97%
- Uses: Determines how well business office staff are collecting on contracted accounts
Denial % and Clean Claim %

• Definition: % of claims that are denied / sent out without edits
• Calculation: Total claims / denied or clean claims
• Regent Standard: 98% Clean, Less than 5% Denial Rate
• Uses: A high denial rate could highlight issues with certain payers. A low clean claim % may pinpoint some issues with either your biller or front office
2010 Business Office FTEs per 1,000 Cases

Regent Average = 1.85
2014 Business Office FTEs per 1,000 Cases

Regent Average = 1.52
Real Time Dashboard - Financial
Patient Satisfaction
Common Non-Clinical Patient Complaints: Front Office

• Registration or check-in process timely/ too complex
• Registration errors that lead to incorrect billing
• Patient not told what their OOP is – assumed everything was covered (doctor’s office said it would be covered)

Front-Office Best Practices!
Effects of Front-Office Best Practices

• Registration or check-in process timely/ too complex – REDUCED and SIMPLIFIED!

• Registration errors that lead to incorrect billing – ELIMINATED!

• Patient not told what their OOP is – assumed everything was covered (doctor’s office said it would be covered) – FULL TRANSPARENCY!
Common Non-Clinical Patient Complaints: Back Office

- Statement not accurate or too confusing (don’t understand terminology)
- Statements not received until several months/ years after date of service
- Surprise by amount of bill – “Didn’t you submit it to my insurance?”

Back-Office Best Practices!
Effects of Back-Office Best Practices

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• Surprise by amount of bill – didn’t you submit it to my insurance? – ELIMINATED!
“Regent Surgical Health has an unmatched record for delivering sustainable profitability…we firmly believe the by-product of excellent care and efficiency is financial success”

Tom Mallon, Founder/CEO
Thank You!

Michael Orseno
Vice President
Regent Revenue Cycle Management
morseno@regentrcm.com
(708) 498-4474
www.regentrcm.com

Karen Franklin
Client Manager
ZirMed
karen.franklin@zirmed.com
(502) 657-5483
www.zirmed.com