REVENUE CYCLE MANAGEMENT: BOOSTING THE BOTTOM-LINE

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TOPIC OVERVIEW

- Impact of Organizational Culture on Revenue Cycle Management
- Overview of the Revenue Cycle
- Tips and Tricks to Boosting the Bottom-line

ORGANIZATIONAL CULTURE

- Establishing a sound culture that supports revenue cycle management is critical to the financial success of the organization: It starts with leadership!
- Leadership involvement MUST be experienced by the staff to ensure continual success of goal achievement.
  - Consider how information is communicated to your teams, both verbally and non-verbally.
  - Does your team understand the goals? What metrics are you wanting to achieve? How do they work towards accomplishing these?
  - How often do you celebrate short-term wins and recognize your teams for achieving goals?

ORGANIZATIONAL CULTURE

- Leadership must demonstrate support for solid RCM practices.
  - Assess how frequently leadership waivers on decisions such as payment arrangement policy or backing the staff when they initiate policy.
  - Establish excellent, open communication with physicians, managers and staff.
  - Hold staff accountable to the expectations for a solid RCM process
    - **Tip**: The staff must be provided with the tools, policies, and processes to meet those expectations.
  - Take time to hear issues and ensure collaboration is achieved to improve deficiencies; the complexity of payer reimbursement requires no less!
    - **Tip:** Increase communication and inquiry with the staff.

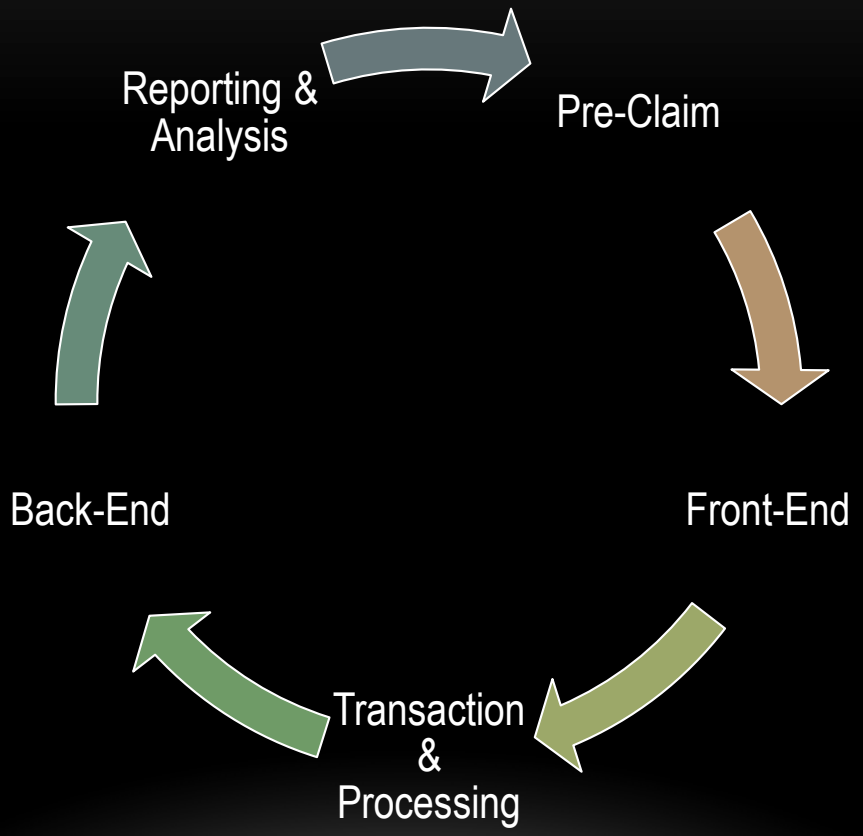
ORGANIZATIONAL CULTURE

- The organization must demonstrate an ability to work collaboratively with physicians and physician clinics to ensure solid front-end processes and effective communication.
  - Communicating opportunities for improvement to the practice leadership and physicians is imperative. The explanation needs to address the "why" and reasoning behind the importance of the change and how it impacts the system
    - **Tip:** Be open to reciprocated dialogue and how this impacts the clinic processes, too, in order to maximize systemic streamlining.
  - Establish a culture within the ASC that the physician offices are part of the team.

    Physicians = Patients = ASC Business

    - **Tip:** Consider hosting quarterly or bi-annual meetings with the practices and the ASC.
      - **Trick:** Establish specific topics for discussion and use this time to discuss improvement opportunities for the system.

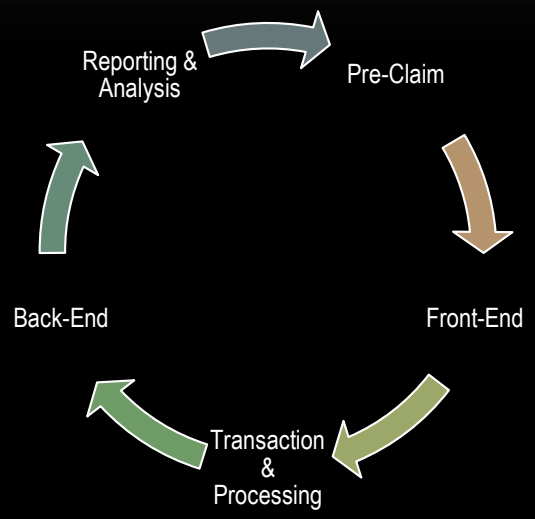
REVENUE CYCLE MANAGEMENT



REVENUE CYCLE MANAGEMENT

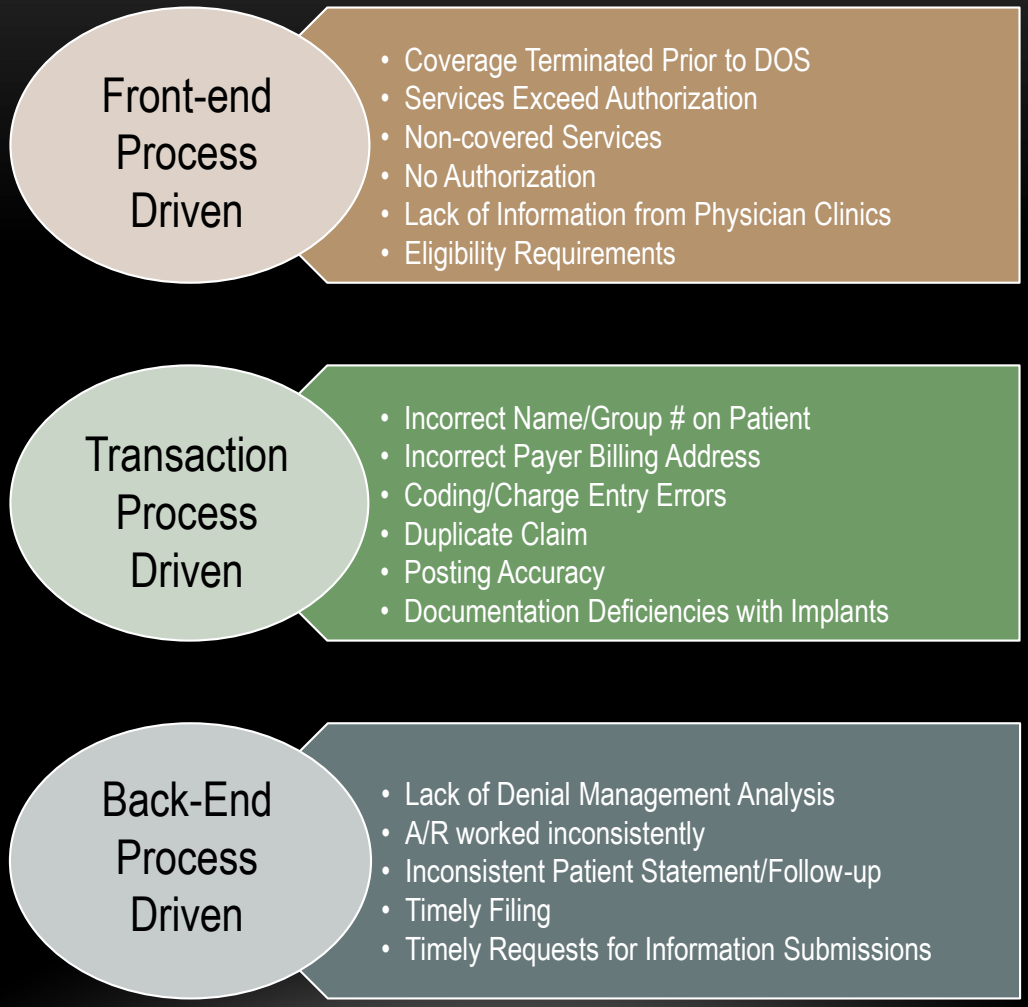
Pre-Claim	Front-End	Transaction & Processing	Back-End	Reporting & Analysis
• Contract Negotiations • Fee Schedules • EDI/ERA Enrollment	• Scheduling/ Registration • Eligibility Verification • Patient Financial Responsibility • Patient Check-in • Patient Payment Capture • Documentation • Coding / Charge Capture	• Charge Entry • Claim Scrubbing • Claim Submission • EDI Management • Error Correction • Mail Processing • ERA/EFT Processing • Payment Posting • Revenue Allocation	• Claims Status • Denial Analysis • Requests for Information • Appeals/ Resolution • Patient Statements • Patient Payment Calls • Patient Refunds • Transition to Collections	• Cash Collected • Total Days in AR • Rejection Analysis • Payer Denial Rates • DOS to Claim Submission • Non-collection Adjustments

REVENUE CYCLE MANAGEMENT



- Understand how the RCM process works in order to better identify areas for improvement.
- Assess RCM issues and drill into the root cause of the problem.
- Empower staff to optimize RCM outcomes.
- RCM requires consistent efforts and support by leadership to improve deficiencies and maximize collection opportunity.
- Often we talk about what needs to happen but more commonly we find that we struggle to adequately implement the behaviors and changes long-term.

UNDERSTANDING RCM OPPORTUNITIES



PRE-CLAIM

- Use a consistent formula for establishing the ASC's charge master.
  - **Tip:** Use a multiple of Medicare such as 300% and then round to the nearest 10 dollar increment.
  - **Tip:** If the center has a contract that includes a discount off of charges, but does not reimburse an amount greater than a multiple of Medicare, make sure that the center's charges exceed this reimbursement methodology.
- Review the charge master annually to ensure fees are appropriate to maximize reimbursement.

PRE-CLAIM

- Insurance contracts should be reviewed and negotiated on an annual basis.
  - **Tip:** Maintain a list of contract renewal dates and initiate process with payer representative 3-6 months in advance.
- Contract information should be loaded into the practice management system.
  - **Tip:** Ensure that fee schedules are up-to-date and accurately maintained in the system.
  - **Tip:** Ensure claim submission addresses are reviewed annually but updated as soon as correspondence is received for changes.
  - **Tip:** Many payers have multiple addresses for claims submission.
    - **Trick**: Adequate staff training is required to ensure accountability for monitoring and reporting changes from the payers or denials.

FRONT-END PROCESSES

- Accuracy of Surgery Scheduling
  - Clinics must send accurate and inclusive CPT codes with diagnosis and implant information.
    - **Tip:** Require clinics to send a complete facesheet, with a copy of all insurance cards and insurance authorizations, along with all required clinical documentation.
    - **Trick:** Establish a cut-off timeframe for receiving required information from the clinic and adhere to this for authorizations, insurance information and demographics. If information is not received, surgery needs to be rescheduled.

FRONT-END PROCESSES

- Eligibility and Benefit Verification
  - Business office staff must have a consistent and solid process for verifying patient benefits and eligibility.
    - **Tip:** Some procedures may not require authorization for the surgeon but authorization may be required for the ASC. Is this monitored?
  - Personnel verifying eligibility and benefits should be documenting this in the practice management system.
    - **Tip:** Require consistency in how benefits are documented so front-office staff can be trained to understand the information.

    For example: AETNA EFF DATE: 1/1/2018 DED:$245 DED MET: $245 OOP:$630 OOP MET: $630 COINS: 100% COPAY: $0 AUTH: PER MARIE REF#123456789 NOT REQ'D DEPOSIT: $0

FRONT-END PROCESSES

- Patient Responsibility
  - ASC should have a clear patient financial policy that is adhered to by the organization, and includes timely and accurate communication for patient financial counseling.
    - **Tip:** Establish consistency with clinics for collections on patient responsibility.
    - **Tip:** Due to the increased patient responsibility, require payment in full upfront.
      - **Trick:** The staff needs to have an adequate amount of time to communicate to the patient in advance. Best practice: 1-2 weeks prior to surgery, but as soon as possible.
      - **Trick:** Adherence requires leadership support for timeliness of surgery scheduling process and accountability to collections.

FRONT-END PROCESSES

- Patient Responsibility (cont.)
    - **Tip:** For patients unable to provide payment in full, require they apply for a healthcare merchant account prior to establishing a payment arrangement and only offer payment arrangements if denied.
        - **Trick:** Limit payment arrangements to less than 90 days, require a percentage down, a credit card on file and signed agreement.
        - **Trick:** Remember….the majority of ASC surgeries are elective. Offer to assist the patient with rescheduling to a later date to better accommodate their financial situation.
    - Front-end staff must be empowered, supported and held accountable to collecting patient responsibility at point-of-service.
        - **Tip:** Run a daily report for the total amount to be collected by the front-desk personnel and have them document for variances from projected collections. Establish a goal such as 98% collected weekly.

FRONT-END PROCESSES

- Accurate collection and verification of patient information at the front desk.
  - **Tip:** Front desk personnel should scan the front and back of insurance cards into the system each visit and verify the accuracy of the insurance information contained in the system.
    - **Trick:** Reschedule surgeries or switch patient to self pay if they do not provider their insurance card(s) upon check-in.
    - **Trick:** Frequently monitoring for errors in claims submissions and claims denials based on entry of patient information.
  - **Tip:** Establish process for verifying that the surgical codes being billed are consistent with the authorized codes sent for surgery scheduling
    - **Trick:** Excellent communication with practices to ensure retro authorizations received for accuracy of code/charge capture.

FRONT-END PROCESSES

- Documentation of operative reports should be completed and signed within two business days.
  - **Tip:** Make dictating and signing off on operative reports easy with use of technology for physicians.
    - **Trick:** Track physicians that have not signed and notify them frequently for completion.
    - **Trick:** Notify management weekly of any outstanding operative reports for leadership support and physician notifications.

TRANSACTION & PROCESSING

- Charge entry completed timely and accurately. Best practice is less than 7 days from DOS.
  - **Tip:** When operative reports are completed and signed on DOS claim submission can occur more timely.
  - **Tip:** Monitor claim submission internally or with third party to understand the average days from DOS to submission.
- Timely correction of claims errors.
  - **Tip:** Claims should be submitted clean, which requires detail-oriented claim scrubbing, and quick turnaround.
    - **Trick:** Monitor reports weekly for claim submission error rate and continuously look to improve process while working towards a 0% error rate.

TRANSACTION & PROCESSING

- Monitor number of daily claims submission
  - **Tip:** Daily and weekly tracking of claim submissions helps to ensure consistent processing, positively effecting RCM and cash flow.
    - **Trick:** Require this information to be monitored by the BOM daily/weekly.
- Payment postings should be done timely and accurately.
  - **Tip**: Use ERA and EFT processing when possible for timely posting and receipt of reimbursement from payer.
  - **Tip:** Accurately posting payments within the system is critical to back-end process success.
    - **Trick:** Payments should be posted no later than 1 business day from receipt.
    - **Trick**: Contract reimbursement amounts should be loaded and up to date within the PM system to ensure correct contractual reimbursement is received.

BACK-END PROCESSES

- Claims status should be monitored by staff responsible for A/R.
  - **Tip:** Assignment of payers should be consistent amongst the staff for accountability, efficiency and improved collection efforts.
- Denial analysis and management process should be consistent.
  - **Tip:** Denied claims should be assigned and worked within 1-2 business days of posting claim.
    - **Trick:** Establish internal process for communicating, tasking and monitoring follow-through.
  - **Tip:** Responsible staff should establish a calendar tickler, depending on system, to monitor claim in accordance to payer reimbursement guidelines.
    - **Trick:** Staff ownership of process and accountability to A/R buckets.

BACK-END PROCESSES

- Requests for information should be completed within 1-2 business days and resubmitted to payer.
  - **Tip:** Staff should notate in the practice management system and track claim status with a calendar tickler.
- Appeals/Resolution
  - **Tip:** A/R Staff should work appeals aggressively with solid follow-up processes established.
    - **Trick:** Staff communication with payers is critical to understand any impending issues as well as to establish a reputation with payer of constant, continuous contact.
    - **Trick:** If available, utilize electronic submission of appeals documentation through the PM or clearinghouse software.

BACK-END PROCESSES

- Accounts receivable monitoring and trending should be conducted on an ongoing basis by leadership, management and assigned staff.
  - Leadership should be reviewing A/R reports monthly or more frequently, if needed.
  - Business office manager should be monitoring and reviewing weekly with specific staff and department goals.
  - Assigned staff should be working A/R daily.
    - **Tip**: Consistently working denied claims as they are posted within the system ensures a high rate of timeliness for working denial.
      - **Trick:** Internal processes that support working current denials.
      - **Trick**: Accountability of staff and acknowledging small and big wins.

BACK-END PROCESSES

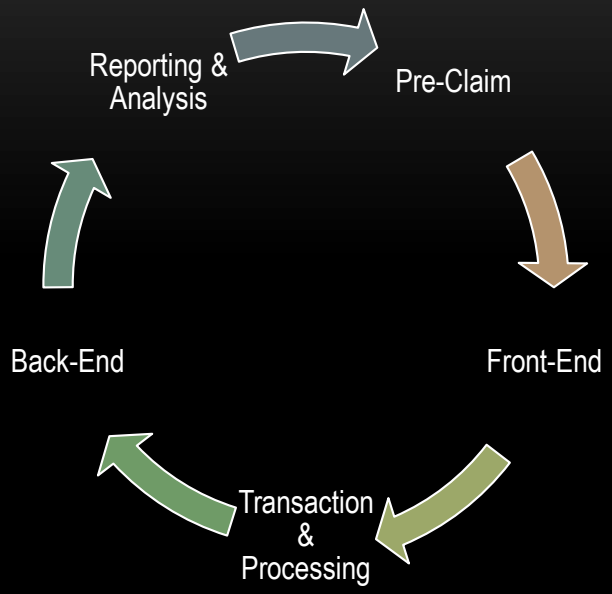
- Overall A/R should be continuously monitored and managed
  - **Tip:** Require that accounts are worked sooner rather than establish a policy of “touch account once per 30 days”.
  - **Tip:** Consistently monitor the percentage of A/R in the >121+ buckets
    - **Trick:** Establish goal of $0 in >91 buckets, which means that staff must be aggressive on the current, 31+, and 61+ buckets.
    - **Trick:** Denial analysis is required to fix front-end or transaction processes that impact denial rate.

BACK-END PROCESSES

- Patient statement process should be well defined and adhered to within the system
  - **Tip:** In the event of additional patient balances that were unknown during patient estimation, the sooner that the patient is aware, the more likely the facility is to collect.
    - **Trick**: Patient calls should be started once a balance is identified, even if statement is pending.
    - **Trick:** Email statements to patients with link for making payments.
- Transaction to third party collection should be an established internal process.
  - **Tip:** Use of collection companies are the result of an inability to collect and this only perpetuates the problem of reducing revenue collected.
    - **Trick:** Collect on the front-end and aggressively work patient responsibility within 90 days from DOS.

FOOD FOR THOUGHT

- Insanity – “Doing the same thing over expecting a different result!”
  - High claims denials due to poor front-end processes and we don’t fix them.
  - Lack of communication and effective collection of patient responsibility on the front-end due to failure to establish and support patient financial policy.
  - Delays in claim submissions increasing A/R days due to lack of internal follow-up and solid processes.
  - Revenue lost due to lack of adequate monitoring and oversight by leadership.
- Optimizing RCM takes the same focus and attention as patient safety, outcomes and satisfaction; it requires a daily, ongoing commitment from leadership!!



“To succeed, or even survive, we need to fundamentally change the way that we organize and operate” MGMA 2018

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