# Assessing Your Revenue Cycle to Achieve Continuous Improvement.

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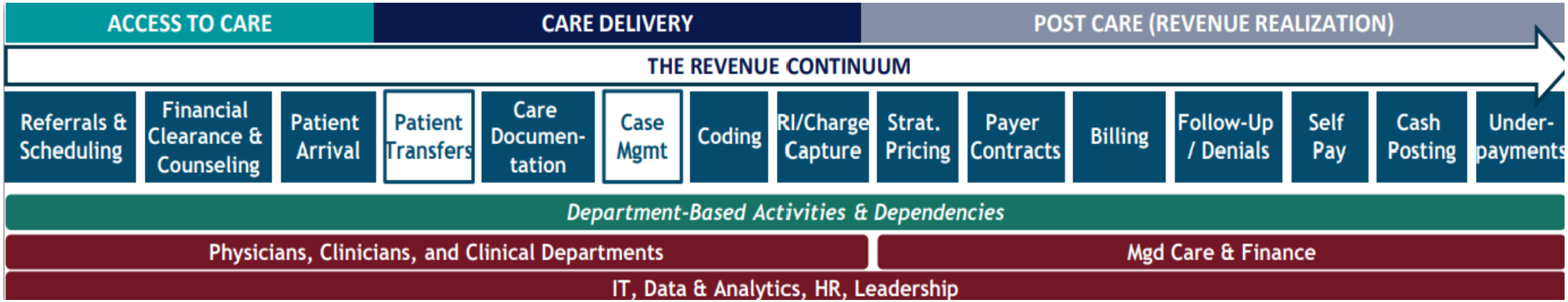
HC Program Advisors

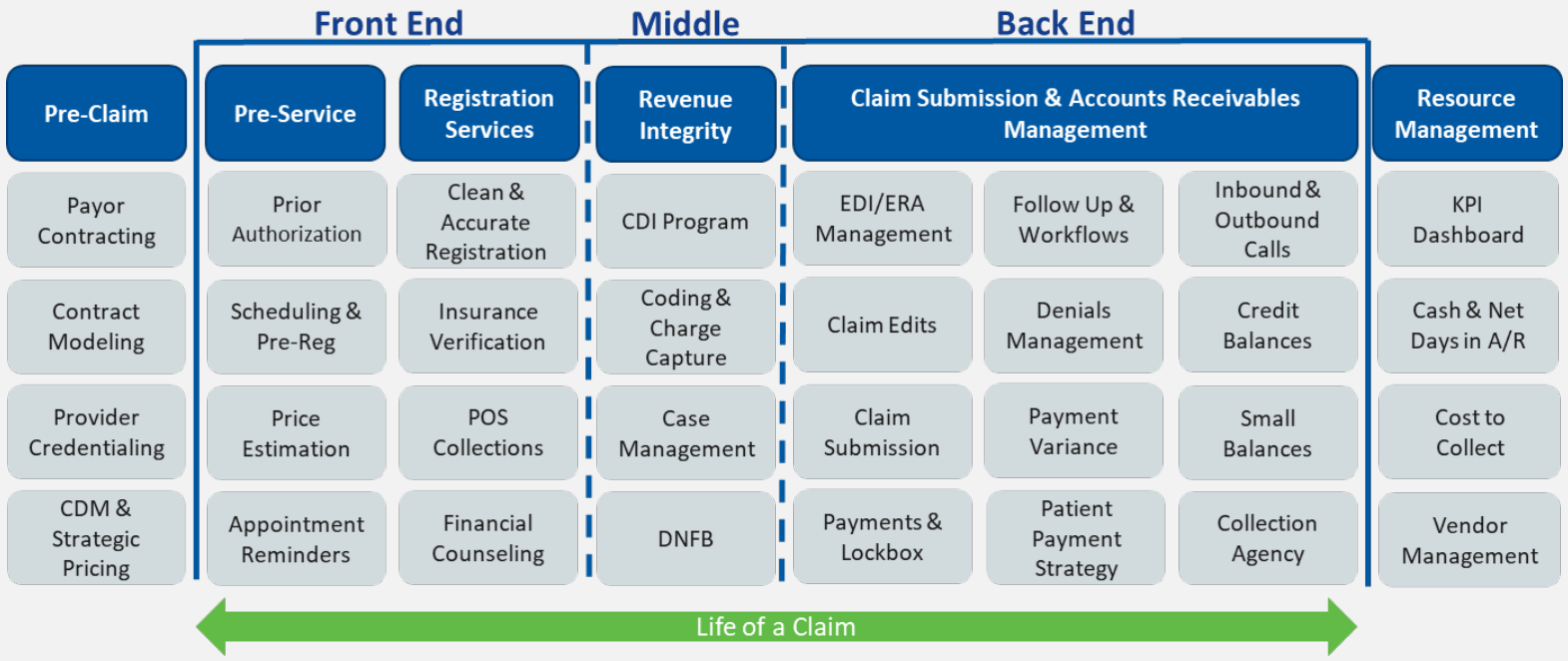
Principled Guidance Meaningful Results

# Revenue Cycle Sequence

- The Revenue Cycle relies on upstream and concurrent partners at every stage
- The Revenue Cycle Assessment process evaluates workflows within the Revenue Cycle, but also across the system, and their downstream impact on Revenue Cycle performance
- Assessment findings & opportunities are typically a result of the complexity and highly integrated nature of the revenue sequence



# Success in the Revenue Cycle depends upon the holistic perspective of the entire Revenue Cycle




**The identification and realization of performance improvement opportunities requires a quantitative and qualitative review of the entire revenue cycle.**

# Activities and Functional Areas

## Activities that impact the full revenue cycle

- Policy and procedure review.
- Detailed account sampling to identify gaps within front, middle, and back-end processes.
- Key Performance Indicator (KPI) analysis and comparison against performance in past years and
- Industry benchmarks (HFMA, AHIMA, etc.).
- Detailed analytics to quantify financial improvement opportunities, including net revenue leakage,
- Net revenue optimization, cash acceleration, and denial management optimization.
- High-level organizational structure review and volume-based staffing analysis.

## Functional areas to include

- Access process: scheduling, eligibility, authorization, financial clearance / pre-registration and insurance verification
- Procedures for registration and admitting
- Utilization review and case management
- Coding and coding compliance
- Clinical documentation integrity process and initiatives with the medical team
- Charge capture process and CDM review
- Billing practices and billing edit governance
- AR management: cash posting, follow-up, denials management, and payment variance
- Technology requirements and EHR/EMR system assessment
- Staffing allocation assessment within all departments

# Approach

## Focus

- Success along the continuum of care is dependent upon each step of the process working optimally.
- Failures during any stage – Front/Intake and Patient Access, Authorization, Middle/Care Management, Documentation, Coding, and Charge Capture and Back/Claims, Cash Management, and Accounts Receivable Management – will either diminish the ultimate conclusion and/or require added resources and costs to achieve the result.
- Your assessment will focus on the People, Processes, and Technologies underpinning operations.

## Steps

1. Establish a Steering Committee - Need Sr. Leadership buy-in
2. Data Gathering
3. Data Compilation/Analyses
4. Interviews/Walk-Throughs
5. Initial Opportunity Development
6. Findings Refinement/Presentations
7. Implementation Workplan Development
8. Measure Results

# Project Governance

# Functional Area Overview and Recommendations

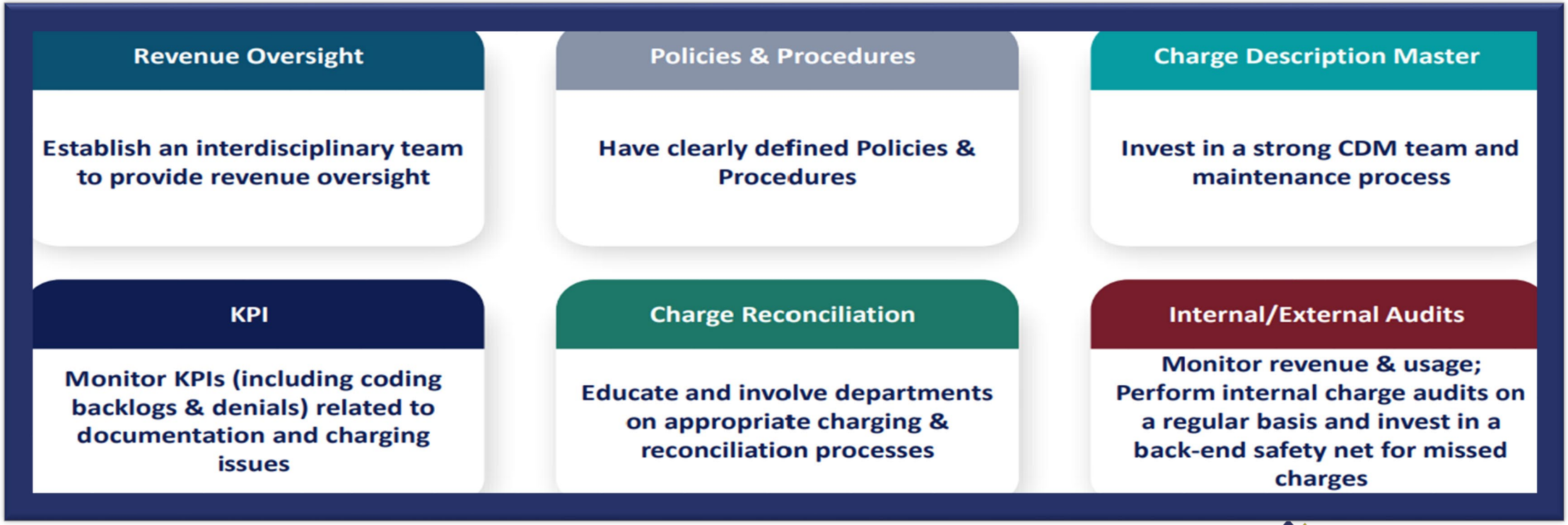
# ACCESS

| | |
|---|---|
| **Referral Navigation** | ▪ Intake & Transcription<br>▪ Data Integrity<br>▪ Network "Keepage" |
| **Pre-Registration** | ▪ Estimates<br>▪ Encounter Records<br>▪ Demographics |
| **Scheduling** | ▪ Incoming Patient Requests<br>▪ Referrals-Driven Outreach<br>▪ Reminders-Driven Outreach |
| **Financial Advocacy** | ▪ Medicaid/SSI<br>▪ Financial Assistance/Options<br>▪ State/Local Programs |
| **Financial Clearance** | ▪ Eligibility<br>▪ Benefits<br>▪ Med Necessity /Prior Authorization |
| **Admissions / Registration** | ▪ Check-In & Forms<br>▪ IP/OBS Notification<br>▪ Benefit Navigators |

# CHARGE CAPTURE RECOMMENDATIONS

## Revenue Integrity Program

The goal of revenue integrity, according to the National Association of Healthcare Revenue Integrity (NAHRI), "is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that can withstand medical coding audits at any point in time."



# CODING PROGRAM OVERVIEW

| | |
|---|---|
| Coding Team | • Credentialed team with specialty coders for complex coding |
| Medical Necessity | • Validation check of diagnoses versus documentation |
| Physician Queries | • Query & escalation process for incomplete documentation |
| Coding Accuracy | • Industry best practice 95% |
| Continuous Education | • Performed Quarterly |
| CDI/Coding Collaboration | • DRG and Clinical Validation Denial Appeals |
| Payer Denials | • Validation against AHA Coding Clinic and against coverage dates of payor policies |

# UM Best Practices

## Clinical Denials

- Concurrent Review via a Peer-to-Peer Process
- Attending MD, Physician Advisor, and Health Plan
- Real-Time Coaching

## Three Point Match

- Across Every Bedded Patient
- Level of Care / Medical Necessity
- Insurance Authorization
- Physician Order

## Secondary Review

- Review Process when Medical Necessity is not met
- Principals of Clinical Judgement, Medical Management, Regulations, and CMS Definition of Inpatient Care


## Stay Reviews

- Point of Entry Reviews
- First Level Screening
- Continued Stay Review

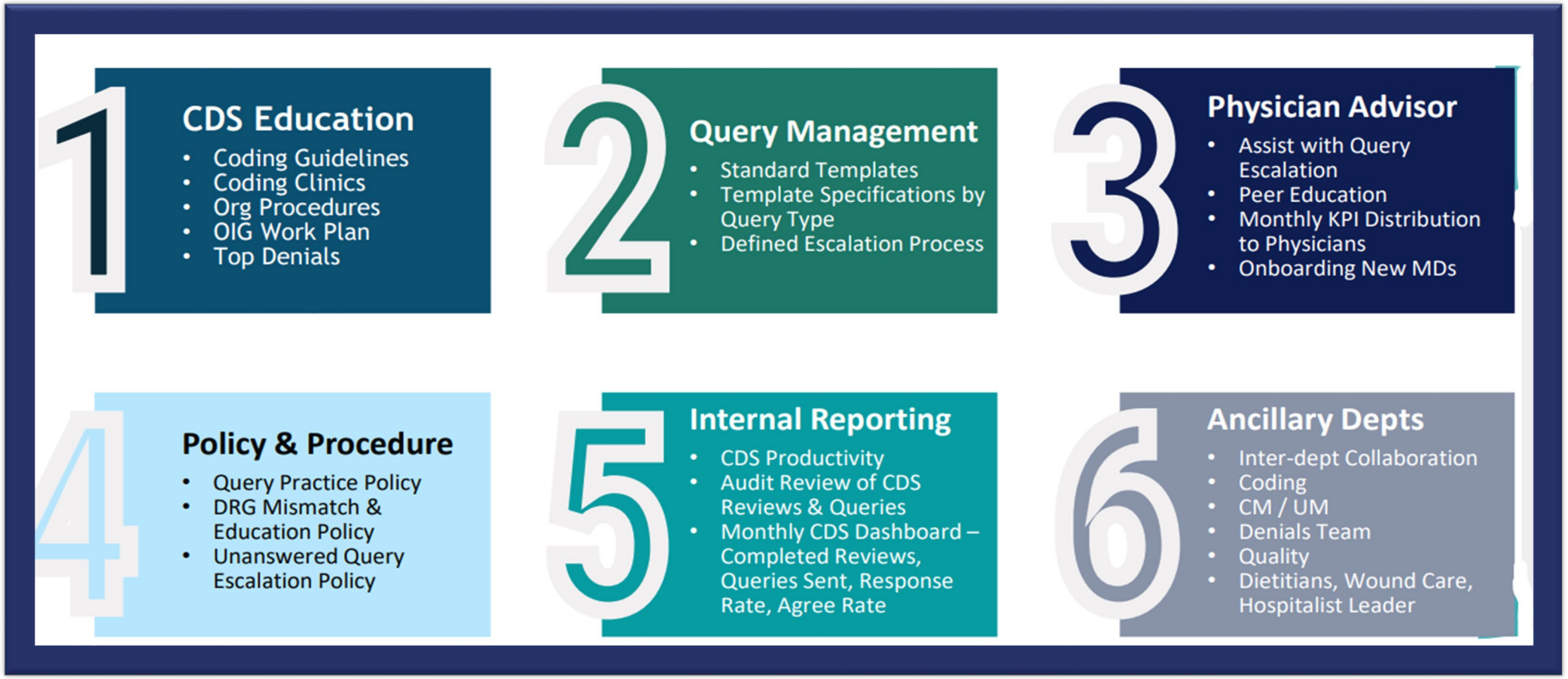
## Physician Advisor

- Physician-to-Physician
- Within the Organization
- With the Health Plans

## UR Committee

- CMS Conditions of Participation Criteria
- Length of Stay Trends
- Policy, Education, and Corrective Action

# IP CDI Best Practice



# Business Office Overview

## ALIGNMENT

- Payer-based teams
- Billing vs. Follow-Up Activities
- Medicare/Medicaid vs. Med Adv

## REPORTING

- Daily DNFB, Cash, WIP
- Weekly ATB Analysis
- Monthly Collaboration with Denials Management on Sub-Committee Approach

## CREDITS

- Worked at least weekly with additional focus on aged credits
- Worked within Follow-Up Teams
- Separate, focused team may be required to reduce/eliminate aged


## DOCUMENTATION

- EHR as source of truth
- Documentation format, location, & content standardization
- Upstream documentation standards for Access, MD Offices, etc.

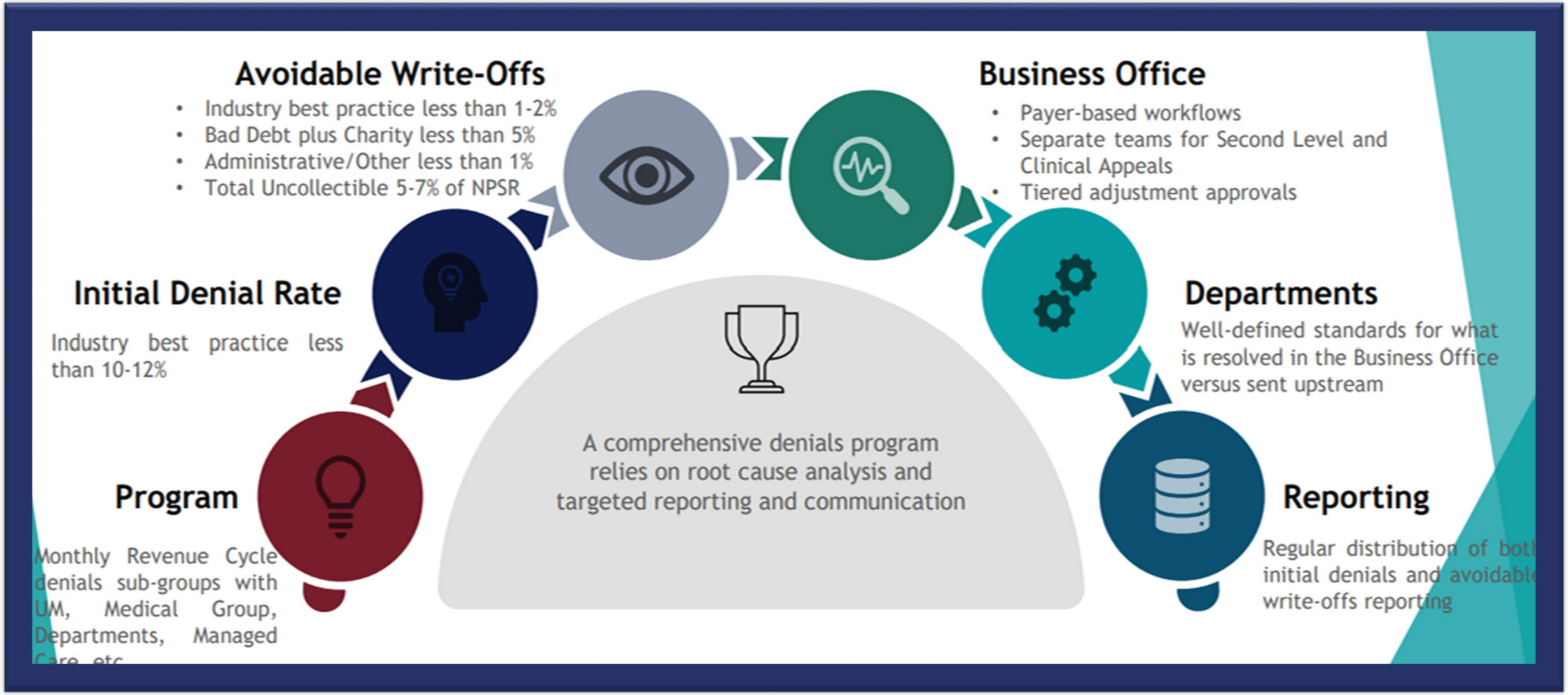
## BILLING

- Edits & Rejections worked daily
- Pre-bill Edits for frequent errors
- User education based on edit frequency

## FOLLOW-UP

- Standardized follow-up and denial/appeal workflows across all payers with payer-based sub-workflows based on payer policy
- Escalation criteria and process for

# Denials Management



# Iterative Implementation Process

The implementation process is repeated for each opportunity and initiative

**1. Identify Opportunity**
Complete the Diagnostic Review

**2. Approve to Implement**
Vet the opportunity to validate services performed will have a net revenue impact

**3. Form Work Group**
Convene Department, Revenue Integrity, IT, and other stakeholders

**4. Design New Workflow**
Collaborate with Work Group to design future-state workflow

**5. Go-Live**
Build, train, and go-live with new workflow

**6. Measure Benefit**
Measure gross, and calculate net, impact from new charges

# Measure Results

## KPIs

### High Level
- Cash collections
- Cash collections as a percentage of net revenue
- Cost to collect
- Net AR days
- DNFB days
- Percentage of AR >90 days
- Point-of-service collections as a percentage of total cash

### Patient Access Operational
- Scheduled patients' pre-registration rate
- Clean registration rate
- Point-of-service collection rate
- Average registrations per registrar/per shift

## KPIs Continue

### Middle Revenue Cycle Operational
- DNFB/DNFC
- Initial patient status error rate
- Coding denials
- Physician query submissions and response rate
- Late charges as a percentage of gross revenue

### Back Revenue Cycle Operational
- Clean claim rate
- Rejection rate
- AR days
- Percentage of AR > 90 days and 180 days
- Cash per day
- Initial denial rate
- Denial overturn rate
- Denial write-off rate
- Bad debt write-of

# Summary

Maximizing revenue generation through effective healthcare revenue cycle management is the key to financial stability in healthcare. By understanding the core components of RCM, overcoming challenges, harnessing technology, implementing best practices, following the changing landscape of healthcare, and monitoring key performance indicators, healthcare providers can ensure financial stability.

# Thank you!