An HFMA Revenue Cycle Strategist Web Extra (hfma.org/rcs)

**Very Important reconciliation**
1. Patients seen
2. Total claims generated
   You want to ensure every patient that walks into your office and seen by the physician, has a charge associated with it.

**For better metrics, also account for**
1. Timing delay between the Date of Service (DOS) and when the claim is finalized and submitted.
2. Coders – Have them pull a sample of high revenue services.
   A. Were they coded correctly?
   B. Documentation supporting medical necessity?
   C. Incentive program requirements being met?

**Post Payment Review Systems (PPRS) – Very Important**
1. PPRS has "contracted rates" / $ allowed per service
   sourced directly from your payer contracts.
2. PPRS identifies variances between the contracted allowable amount and the adjudicated amount.
3. Explanation of benefits (EOB) from payers can say they paid whatever they want. You want to ensure the $ actually hits the bank. Cash talks !
4. Variances are identified (under & over payments) are sourced directly from your payer contracts.

**Most vital link in your organization**
1. Trend analysis from your edits / denials are identified.
2. Root cause resolution is identified.
3. Root cause resolution is communicated to the office.
4. Office is then monitored to ensure root cause resolution is effective.
5. Identify other areas applicable to implementation of root cause analysis

**Denial/edit Reason**
1. Denials / edits you receive back will have a denial reason.
2. Have a system to group the denials by "Denial Reason" (i.e Coding related, credentialing, etc.)
3. Different payers will have different denial codes for perhaps the same reason. Group these together. Hint: You can use VLookup to pull all the denials into groups
4. Route the denial to the respective department.

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**Billing Rules (Very Important)**
Having updated / correct rules can increase the timing of cash flow, reduce denials and offer quicker education.
Instead of waiting for denials, you can identify the problems of a claim prior to their submission. The following needs to be implemented:
1. Have a staff member who is in charge of updating the "rules database"
2. Have a communication link between the payers to identify new billing rules / new authorization requirements, new mid-level billing requirements, new "non-billable CPT’s," identify inclusive insurance contracts to weed out globals, TPL, PnL, etc.
3. Maintain the rules database. You don’t want your AR clogging up due to out-dated, unnecessary rules.
4. Communicate these rules to the respective specialties / staff.
   *Hey behavioral health, BCBS now requires auths for CPT 12345. Retroactive auths are not allowed therefore ensure a process is in place to identify an auth is in place before procedure is rendered.*
5. Look in your denials, did you miss any rules? Do all staff members have your contact info to inform you of an out dated rule?
6. Build a daily charge report. (i.e., If 100 claims were created yesterday, how many of them hit an edit? Investigate why.

**Mini-audits helps offer assurance on claim resolution / treatment quality**
Pull a sample of 10 claims at week end that were in the work queue of a specific staff member.
1. Did they work the edit / denial correctly?
2. Did they submit the claim to the payer inappropriately?
3. Did they look at your denial reports to ensure the rules database is accurate? If 90/100 claims pass through your billing scrubber program smoothly, but 20/90 get denied, then looks like the “clean claim rate” is 70%.

Note: A lot of organizations run metrics at month end to see how large of a edit/denial work queue your department has. There is a “tendency” to kick these claims to the payer or other department without due process just to have a good “month end metric.”

**In large organizations there is a tendency to kick claims to other departments in an unjustifiable manner. Identify a way to capture “kicks.”**
Pull a sample then determine if they’re justified

User interface elements:
- **START**
- **Patient Visits Practice**
- **Clinical Documentation / Charges entered in EHR**
- **Initiate process to send claim to payer**
- **Billing application scrubs claim to ensure billing rules compliance**

**Departments vary based on your organizational structure**
- **Coding**
- **Provider Enrollment**
- **Billing Department**
- **Front End**
- **Cash Operations**

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