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Revenue Cycle Panel

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Introductions

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David Ralston, MHA
AVP, Revenue Cycle
Jackson Hospital
Montgomery, Alabama

Moderator

David has worked in Revenue Cycle since 2007 in both for profit and not-for profit facilities and currently holds the position of AVP of Revenue Cycle at Jackson Hospital, where he oversees the Business office, Patient Access, HIM, Coding, CDI and Case Management and Physician Central Business Office.

Masters in Healthcare Administration From the University of St. Francis
Undergraduate degree from the University of Tennessee in Human Services Business Management with a minor in Sociology.

David's most noteworthy achievements include:

- 2017 -2018 HFMA MAP Award for High Performance in Revenue Cycle
- 2017 HFMA Adaption program winner for Patient Financial Communication
- HFMA Outstanding achievement award for Revenue Cycle Improvement - 2016
- Published for accomplishments in Healthcare Business Insights - Revenue Cycle Journal Feb 2016 "*Reshaping the Business office to increase collections and reduce Accounts Receivable*".

Serves on the Alabama HFMA Board of Directors, and is an Adjunct Professor at Murray State University, teaching Undergraduate and Master level classes in Revenue Cycle Management.

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Carol Plato, MBA, CHFP, FHFMA
Vice President for Revenue Cycle
North Mississippi Health Services
Tupelo, Mississippi

Panelist

Carol is an experienced Revenue Cycle Leader with over 25 years of experience. She is a leader with strong team-building, strategic, innovative and organizational skills. Carol has a proven track record of performance with an extensive background in leading operations and managing projects. She serves as a dedicated change agent for improvement, as well as securing long-term corporate success and profitability.

Ms. Plato is currently serving as VP of Revenue Cycle at North Mississippi Health Services. She started at North Mississippi in February of 2019 and since then helped complete a physician EPIC conversion and perform a complete revenue cycle turn around for the hospitals. Her responsibilities include Access, Two CBOs, Revenue Integrity and Health Information Management.

Carol earned a Master of Business Administration from Nova Southeastern University in West Palm Beach, Florida. She previously earned her Bachelor of Science in Health Care Financial Management from Northeastern University in Boston, Massachusetts. She is a Certified Healthcare Financial Professional (CHFP) from Healthcare Financial Management Association (HFMA) and is current Fellow of HFMA.

NMHS at a glance:

- Largest Healthcare System outside of a metropolitan area in the U.S.
- 7 Hospitals, 50+ Primary Care & Ambulatory locations, 4 Nursing Homes and 21 Telehealth locations
- 7k+ Employees and 1.1k Providers
- 1M OP visits, 31k IP visits, 136k+ ER visits with 25k+ Surgeries
- 2 time Baldrige Award winner

Edna Buffington-Price
Vice President, Patient Financial Services
Community Health Systems (CHS)
Franklin, Tennessee

Panelist

Edna Buffington-Price has been with Community Health Systems (CHS) for thirty plus years of which she has served as a Business Office Director, Regional Director, Sr. Regional Director and her current position as Vice President of Patient Financial Services. Edna has over 45 years of experience in the Patient Financial Service area.

Edna's responsibility includes: Regional Directors, Security related to Patient Financial Services, Revenue Integrity, Acquisitions, Automation, Divestitures, Conversions and all other aspects of the Revenue Cycle.

CHS at a glance:

- 83 hospitals in 16 states with 13k beds
- 66k Employees with 1,000 Outpatient facilities
- $12.37 billion annual gross revenue
- 1.2 million annual patient encounters

Misty Brackett, MBA, FACHE, FHFMA, CHC, RHIA

Senior Director, Revenue Cycle

Erlanger Health System

Chattanooga, Tennessee

Panelist

Misty Brackett is the Sr Director of Revenue Cycle for Erlanger Health System in Chattanooga, Tennessee. Prior to joining Erlanger, she held roles to include HIM Director and Chief Compliance Officer for a critical access hospital in North Dakota and Director of Operations for Healthport.

Mrs. Brackett is a Fellow in the American College of Healthcare Executives and Healthcare Financial Management Association. She also holds a Healthcare Compliance certification from Health Care Compliance Association and a Registered Health Information Administrator certification from American Health Information Association. She holds a Master's in Business Administration from Bethel University and a Bachelor's of Science Degree in Health Information Management from the University of Cincinnati.

Erlanger Health System (Established in 1889)

- 7 hospitals with the regions only Academic Teaching hospital
- Total Net Operating Income: $1.1B
- Total Admissions: 34k | Total Surgical Patients: 37k | Total ER visits 118k
- 470 Physicians (250+ employed)
- 6 Life Force Helicopters stationed in GA, NC & TN

Tracy Porter, MBA, CHFP, CSMC
Executive Director, Patient Financial Services
Baptist Health Care
Pensacola, Florida

Panelist

Tracy has worked in Healthcare for 26 years - 20 years in Revenue Cycle Leadership roles in both hospital-based healthcare to private-owned physician organizations.

She earned an MBA and BS - Healthcare Services from Auburn University. As a member of HFMA, she is a:

- Certified Healthcare Financial Professional (CHFP)
- Certified Specialist of Managed Care (CSMC)

For the 12 years, Tracy has been a Revenue Cycle Leader for Baptist Health Care (BHC) in Pensacola Florida. BHC services NW Florida and SW Alabama.

- $3.7 billion annual gross revenue
- 1.2 million annual patient encounters
- 300+ employed Physicians and Advanced Practitioners
- 3 Acute care facilities
- 1 Mental health facility
- 2 Urgent Care
- 1 Free Standing ER/Urgent Care
- Partnership in 2 ASCs

Topic #1:

Revenue Reconciliation

Revenue Reconciliation - CHS/Edna

Revenue Reconciliation:

- Importance of Revenue Reconciliation
- Manual vs. Electronic
- Clinical Events - Missing Revenue Opportunity
- Controls - Reports - Review - Sign-Off
- Buy-In from Staff
- Monitoring - and Identifying Opportunities - CDM; Staff Education and Clinical System Set-Up

Topic #2:

KPI Tracking

KPI Tracking - NMHS/Carol

Cost to Collect Hospital		Third party expense		Notes
				Notes: Industry best practice is 2%
October Expenses	$795,486.84	$92,216.45	$887,703.29	
October Cash	$54,998,454.39		$54,998,454.39	Following the HFMA industry standard for this calculation.
October Cost to Collect	1.45%		1.61%	
				It does include total budget expense divided by total cash
November Expenses	$778,608.37	$80,040.07	$858,648.44	
November Cash	$60,946,399.35		$60,946,399.35	It does not include HIM
November Cost to Collect	1.28%		1.41%	It does not include any IT expenses
				It does not include rent/utilities/ similar expenses
December Expenses	$814,406.65	$84,799.77	$899,206.42	It does not include Nurse link, as that is not part of Rev Cycle
December Cash	$64,442,507.23		$64,442,507.23	
December Cost to Collect	1.26%		1.40%	
January Expenses	$988,418.34		$988,418.34	
January Cash	$58,193,388.22		$58,193,388.22	
January Cost to Collect	1.70%		1.70%	

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KPI Tracking - NMHS/Carol

Revenue Cycle Scorecard

North Mississippi Health Services, Oct 2021 to Mar 2022

National Average | Top Quartile | Your Goal

Gross Revenue
Hospital

Payer Mix (%)
Hospital

Payer Mix ($)
Hospital

Gross Days Revenue Outstanding
Hospital

Gross Days Revenue DNFB
Hospital

% of Gross A/R over 90 Days
Hospital

Self-Pay A/R as % of Total A/R
Hospital

Charity Care % of Gross Revenue
Hospital

Bad Debt % of Gross Revenue
Hospital

Revenue Cycle Academy

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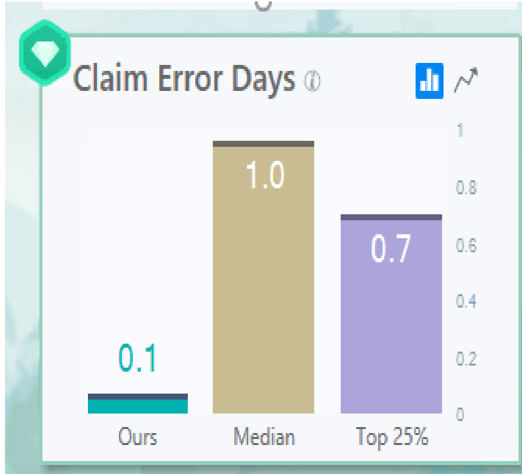
KPI Tracking - EHS/Misty

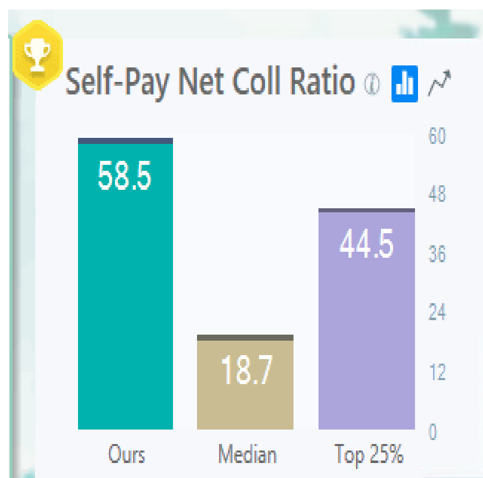
financial pulse
HOSPITAL BILLING

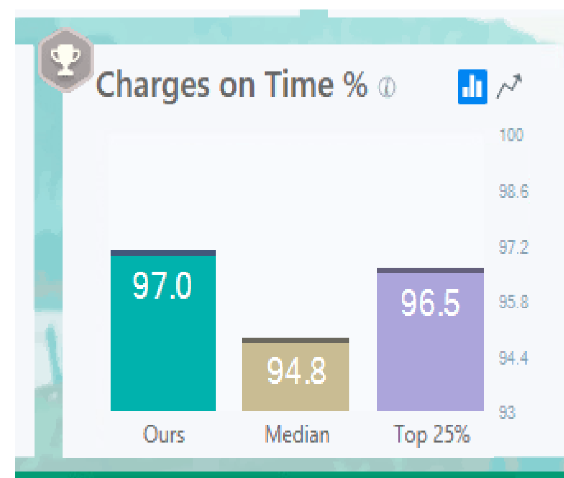
ERLANGER PRIMARY HEALTH SYSTEM

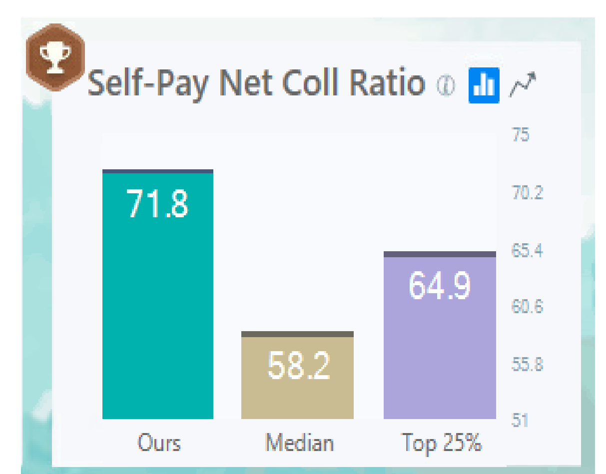
Service Area

Like Me | All Epic | Comparing to: Academic, Multiple Sizes, South (23 service areas)









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KPI Tracking - BHCPNS/Tracy

KPI provide gauge success of Revenue Cycle. HFMA - Utilizing MAP offers clear guidance of industry standard KPIs. **The following are some examples of standard KPIs:**

- Net AR Days
- Aged AR as a percentage of Billed AR
- Point of Service collections
- Cost to Collect
- Cash Collections as a Percent of Adjusted NET
- Bad Debt
- Charity Care
- Days in Total Discharged Not Final Billed (DNFB)
- Days in Total Discharged Not Submitted to Payer (DNSP)

- Late charges as % total charges
- Denial Rates
- Credit Balance as % AR
- Pre-registration rate
- Clean Claim Rate
- Case Mix Index
- Bad Debt
- Charity Care

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Connecting Your Team to KPIs - HCPNS/Tracy

Industry Standard KPIs provide a snapshot of the results. It is important to **measure critical points in processes** that drive the results measured by standard KPIs.

Utilizing ***OPERATIONAL PERFORMANCE INDICATORS (OPI)*** help to identify process specifics for **each Revenue Cycle Team Member** and how their work impacts KPIs.

It is important to connect a Team Member's work and actions to how they impact a KPI. Do they know what actions they perform that can help or hinder KPI outcomes?

- What can a biller do to improve on Days in AR?
- How can a coder impact the DNFB?
- How can a bad debt vendor partner impact collections as a % net revenue?
- What are processes a Payment Poster can do to improve Days in AR?

Define key processes of each position and how those positions drive results. Those key processes can translate to the ***Operational Performance Indicators (OPI).***

Connecting Your Team to KPIs - HCPNS/Tracy

Using Net Days in AR as example - Connecting specific OPI to KPI

Net Days in AR		
Biller	**Coder**	**835 Poster**
Operational KPIs (OPI) Impacting Net Days in AR		
DNFB by biller compared to other Billers	DNFC by Coder compared to other Coders	# of transactions manually vs. electronically posted
Days on unresolved edits	# DNFC by Coder by payer > acceptable timeline	Unresolved or unidentified suspense by Poster
Value of unsubmitted claims by payer by Biller	DNFC by service and/or payer for each Coder	Posting resulting in credit balances by Poster
Clean Claim Rate of submitted by Biller	Age of DNFC by coder	Payments posted without contractuals by Poster
Payer Acceptance rate by Biller		Zero payments (denials) posted by Poster without denial categorization

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Steps To Connect Your Team - BHCPNS/Tracy

- Discuss with Team Members (TM) how they think their job impacts each KPI.
- Determine if their actions are measurable.
  - Do you have systematic means to automate measurements?
  - Is the data available today?
  - Can you measure without creating more work, needing more resources, or increasing expenses?
- Create a list of OPIs by position (2-4) that can be measured and communicated to the TM.
  - Measure too many - message becomes diluted.
  - Measure too little – too broad to tie a TM specific job to a KPI.
- Decide if and how OPI can be tied to the TM's performance evaluations
- Share the communication plan with the TMs
  - Provides clear expectations to the TM
- Use the information as an opportunity to
  - Identify improvement opportunities or gaps in processes
  - Celebrate successes
  - Create competition among the Team ***(Gamification!)***

Topic # 3:

Revenue Cycle Automation

RPA & Robotics

- Robots cannot think. They can perform repetitive tasks.
  - **Mississippi Medicaid secondary billing:**
    - ✓ Daily, they will key Medicaid secondary and attach the primary EOB
  - **Claim status checking on larger payers:**
    - ✓ They will take info from a report and go to the payer website. They will get claim status and put that info back into the billing system

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Revenue Cycle Automation - CHS/Edna

- The way of the future
- RPA and Bots - Brainstorming on different processes that can be utilized
- Planning for Bot's - Project Plan; identifying all areas that will need to be touched; testing plan, QA and go-live

Planning to use AI in Rev Cycle - BHCPNS/Tracy

Using technology to optimize workflows begins with understanding your workflows and how processes are broken down. How the process can influence cost, efficiencies, team dynamics, engagement, and overall patient satisfaction?

- Define your goals for AI within your organization: cost, efficiency, engagement, satisfaction?
- Identify the processes critical to the goal. Engage your team leaders in identifying conceptual opportunities. Examples:
  - Cost to collect is high due to duplicate patient statements?
  - Manual labor to resolve repetitive billing edits?
  - Team frustration regarding the manual efforts to resolve coordination of benefits.
- Research and find several vendors to discuss your critical processes.
  - Vendors should discuss in terms of how their solution can help your organization.
  - Use the conversation as a learning opportunity of what is possible.
  - *Ask your current Revenue Cycle vendors if they are using AI – (they may even have their own AI vendor or solution)*

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Planning to use AI in Rev Cycle - BHCPNS/Tracy

(Cont')

- Use Vendor and Internal team conversations to further define what could be possible. *(remember: in the beginning you need a vision…)*
- Develop more precise opportunities to use artificial intelligence. Reflect back on what you are trying to achieve.
  - Prioritize the opportunities: which opportunity has the greatest benefit (cost, efficiency, engagement, and satisfaction)? But at what risk?
  - Start with low risk to allow your teams to see the benefit and gain support.
- Narrow down vendors to present the precise opportunities and vendor to make business case
- Understand the cost-benefit analysis of the solutions…

Example Opportunities - BHCPNS/Tracy

- Identify processes that your EMR cannot perform that could benefit utilizing AI
  - Self-pay discounts
  - Netting 100% of AR at time of billing
  - Late charge management
- Resolving coordination of benefits:
  - Look to historical accounts for correct actions and refile
  - Contact the patient via email for next steps
  - Present the team with accounts needing manual intervention.
- Claim status
- Automating actions from the 277/278
- Billing edits for medical necessity – contact the ordering provider for updated diagnosis.

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Example Opportunities - BHCPNS/Tracy

- Assist in managing financial assistance approvals… if policy is for a certain period.. Automatically searching for MRN balances or other payer source
- Applying self-pay discounts - if EMR does not process
- Sending customer service follow-up email survey to patients that contact us by phone
- Tons of marketing options…
  - (If a patient has claims > 3 times for same diagnosis, and ordering provider is not ours … prompt mailers introducing our providers… or send marketing material highlighting certain services)
- Managing credit balances… identifying credit and debits within same MRN
- Automatically billing secondaries when secondary is not a cross-over

Topic #4:

Denial Management Workflow

Denial Resolution

- Send auth denials to department that obtained the auth
- Educate the service line leaders of those departments
- Example PT:
  - Educate them on days that were not included in Auth range
  - Educate them on Ms Can paying only one discipline per day
- Example, sleep labs:
  - Many denials for site of service
  - Many denials for not meeting medical necessity requirements

Denial Management Workflow - NMHS/Carol

DRG Downgrades

- **Review each. If you disagree, appeal 100%**
  - We use CDI in concert with Coding to appeal these
  - Keep track of the number overturned
  - Show results to payer during re-negotiation time
  - If results are < 5%, this is an administrative burden and insist that they stop reviewing them

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Denial Management Workflow - NMHS/Carol

CDI

- Started using CDI for DRG downgrades
- Also use CDI for status denials
    - Use your PA to help with appeals

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Denial Management Workflow - EHS/Misty

- Edits stop any account that does not have a valid RTE response which management reviews and corrects prior to billing
- Registration obtains an annual COB form (based on payer) for applicable patients
- Work queues route denials immediately to the responsible department to resolve; Executive support for charging recurring issues back to the offending cost center
- Medically emergent cases reviewed by chief of radiology and chief of surgery for confirmation of emergent status and cases deemed non-emergent are directed back to the servicing/ordering provider by the respective chief; accountability from top down
- Medicaid accounts with a sterilization CPT code are manually reviewed for form compliance, system processes completed for billing, and nuances satisfied prior too service; if form compliance is not met the sterilization is canceled
- Surgical authorizations are reviewed within work queues which route accounts back to the pre-cert department when a provider makes changes to the service that can impact the authorization; Coding audits higher dollar specialties within 24 hours of service performed and routes the account back to pre-cert team to update the authorization before the claim drops
- Utilize a “never event” form for preventable denials

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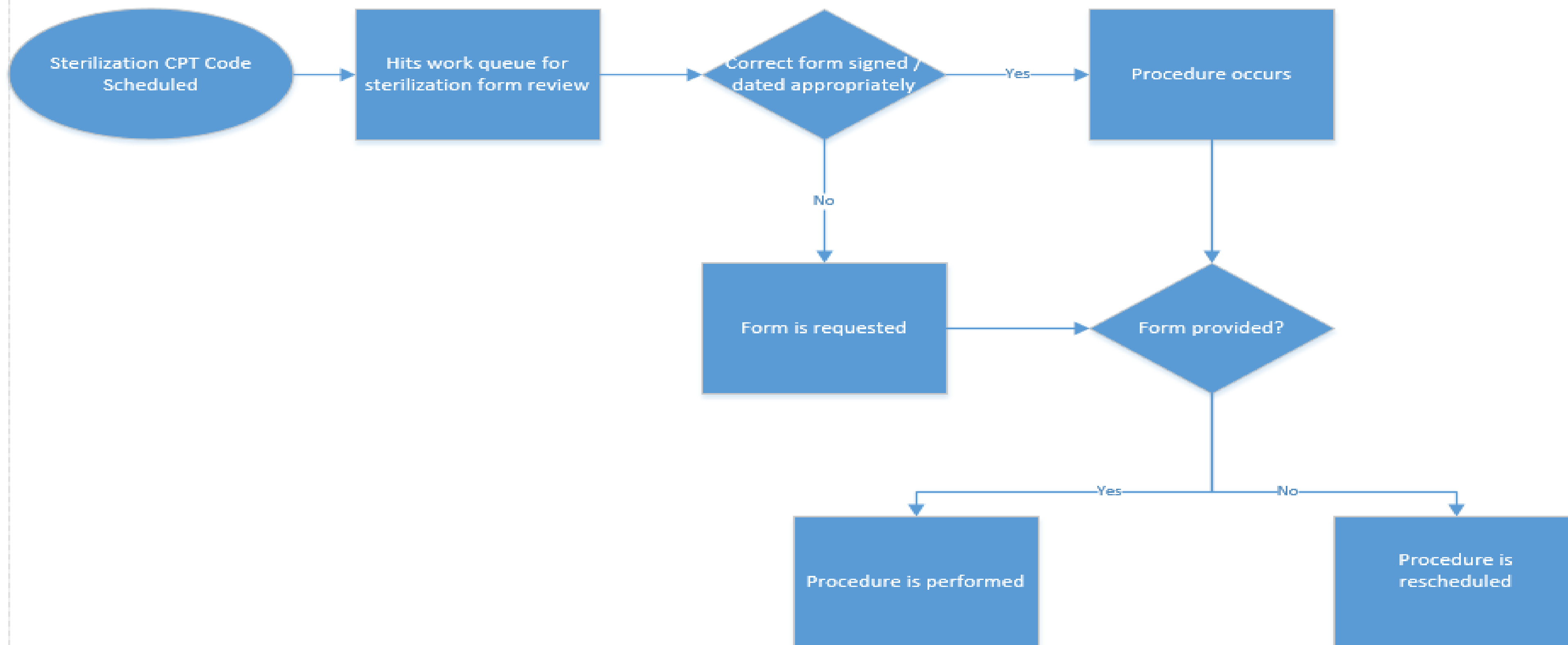
Denial Management Workflow - EHS/Misty

Sterilization Form Review



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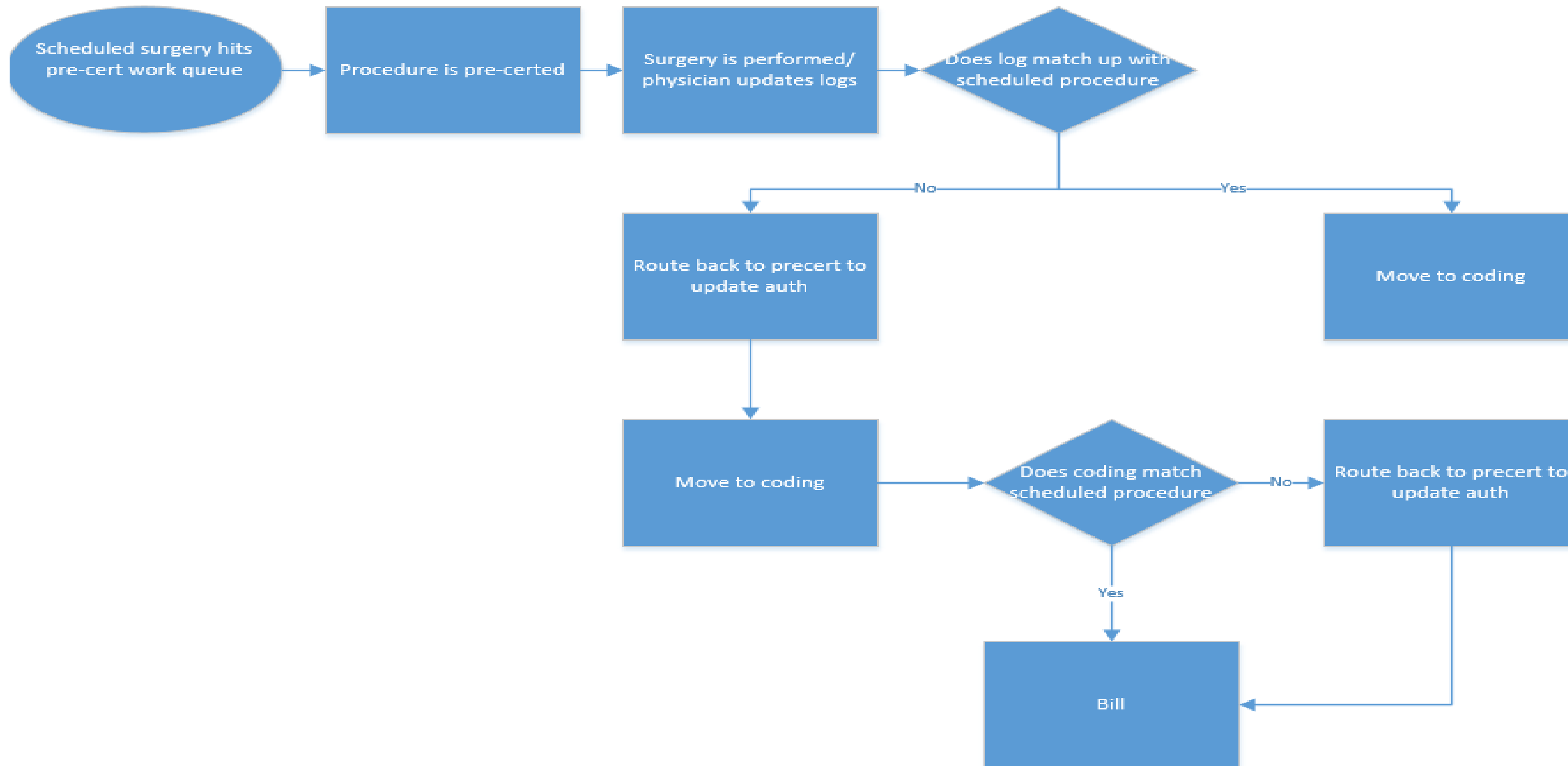
Denial Management Workflow - EHS/Misty

Authorization Update Workflow



Denial Management Workflow - EHS/Misty

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Never Event Form

#	Question	Prompts
--	Where did the denial originate?	
--	What area had the greatest impact?	Include date, day of week and time.
--	Where did it happen?	Areas where event occurred
--	Who was involved?	Staff involved and title.
1	What was the intended process flow?	List the relevant process steps as defined by the procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes. Note: The process steps as they occurred in the event will be entered in the next question.
2	Were there any steps in the process that did not occur as intended? information	Explain in detail any deviation from the intended processes listed in Analysis Item #1 above.
3	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event.

#	Question	Prompts
4	What uncontrollable external factors influenced the outcome?	Identify any factors the facility cannot change that contributed to a breakdown in the internal process.
5	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed.
7	Was staff properly qualified and currently competent for their responsibilities?	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified.
8	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time.
9	To what degree is communication among participants adequate?	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof.
10	How is the prevention of fatal denials communicated as a	Describe the facility's adverse outcome procedures and how leadership plays a role within those procedures.

Adjustment Approval Signatures	
Management	Review Findings
Sr. Director	
Vice President	
Chief	

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Denial Prevention-BHCPNS/Tracy

Denials are a part of Revenue Cycle processes. Effectively managing denials, once it occurs is VERY important. However, understanding how to prevent future denials is crucial.

For example: a lab claim edits at point of billing for an NCD/LCD edit. ***Effective denial workflow management*** of the prebill denial – may be to reach out to the practice and determine if a different diagnosis is provided.

Effective prevention of the denial – identifying a pattern of NCD/LCD edit failures by ordering provider and provide education.

Another example –
Effective denial workflow management for a high dollar chemo drug – determines that the CHEMO drug was authorized but the accompanying drug necessary to administer the drug was not.

Effective prevention of the denial – details of the denial was provided to the ordering provider and who is authorizing services – to determine the accompanying drug was not separately listed on the order. A drug order set of the CHEMO was used. The provider would not list both drugs on the order. Information shared led to education confirming that the ordering and authorizing provider must authorize all drugs in the order set.

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Denial Prevention - BHCPNS/Tracy

In order to prevent denials – it must be identified what a denial is to your organization. How would your organization define? ***"Any reduction to net revenue - due to a failure of process (provider, facility, or payer)."***

Once a clear definition is established – identify what current organization functions can have the greatest impact to reduce lost net revenue. Here are some examples of those functions:

- Managing billing edits
- Facility and Professional services Coding audits
- Provider practice denials
- RAC/ADR/OIG requests and outcomes
- Claim status outcomes
- Case Management actions
- NCD/LCD resolution
- Patient access verification and authorizations
- Post payment payer audits
- High net value denials

Develop a denial prevention committee and data management structure to work with the key areas of your organization that drive what leads to reducing net revenue collections (denial).

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Denial Prevention - BHCPNS/Tracy

Denial Prevention Committee Structure

Executive Governmental Regulations Compliance/Revenue Management Operations:
(insert executive sponsors)

Denial Prevention Steering Committee:
(insert key senior leaders that will help drive the efforts of subcommittee)

Billing Edit: Objective: Review patterns of the billing edits – identify new edits and education opportunities.

Coding Audits: Objective: Review coding outcomes to determine education and edit opportunities.

Provider Practice Denials: Objective: Review 835 based denials by practice and category to identify prevention opportunities and education.

RAC/ADR/OIG: Objective: Review coding outcomes to determine education and edit opportunities.

Physician Coding Audits: Objective: E&M documentation supporting to tie back to the edits and denial prevention.

Claim Status Reviews Objective: Vendor performs automated claim status post 837. Will assist to provide analysis of necessary actions to prevent.

Case Management: Objective: Work with Case Mgt to review data for opportunities to prevent denials: days, authorization, visit type, medical necessity, Contract issue.

NCD/LCD Compliance Objective: Identify patterns of medical necessity education opportunities and practices trend to improvement.

Access Verification/ Authorization Objective: Vendor to provide ongoing analysis and opportunities to reduce insurance verification and authorization denials.

Post Pmts Payer Audit Findings Objective: Review payer findings of post care audits – to identify education and improvement opportunities. Contracting criteria.

High Net Value Denials Objective: Vendor to provide trending and ongoing analysis to reduce high value denials associated with infusion, IP stays, surgical.

Denial Data Governance: Revenue Cycle Analysts to provide – data summary by service line – Billing Edits, Denials Received, Denial Written Off – segmented payer and provider. Data to present to each subcommittee.

Thank You!

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