Revenue Cycle Management and Revenue Calculations

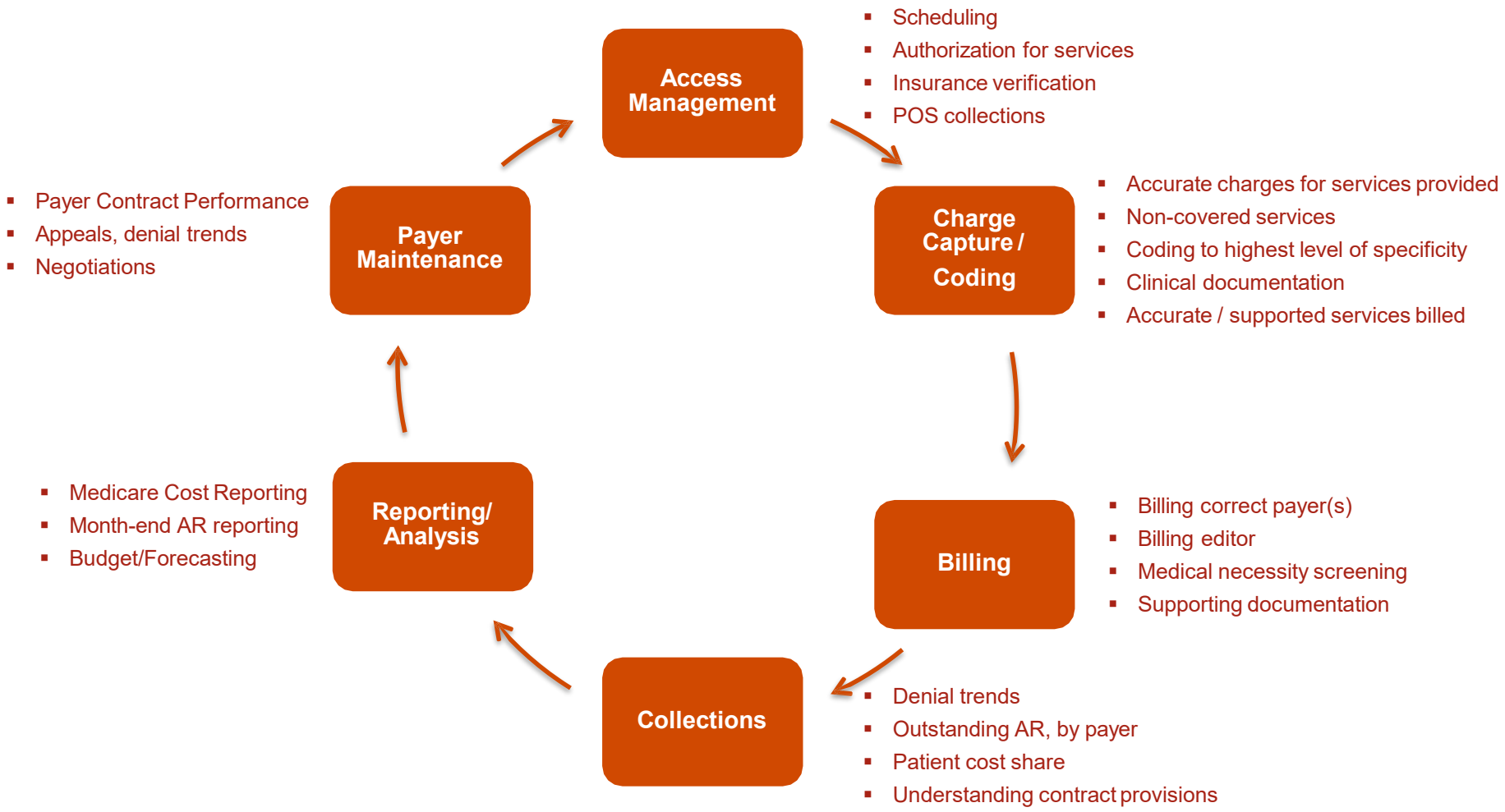
Scott Ramer, Director
November 2021

pwc

Agenda

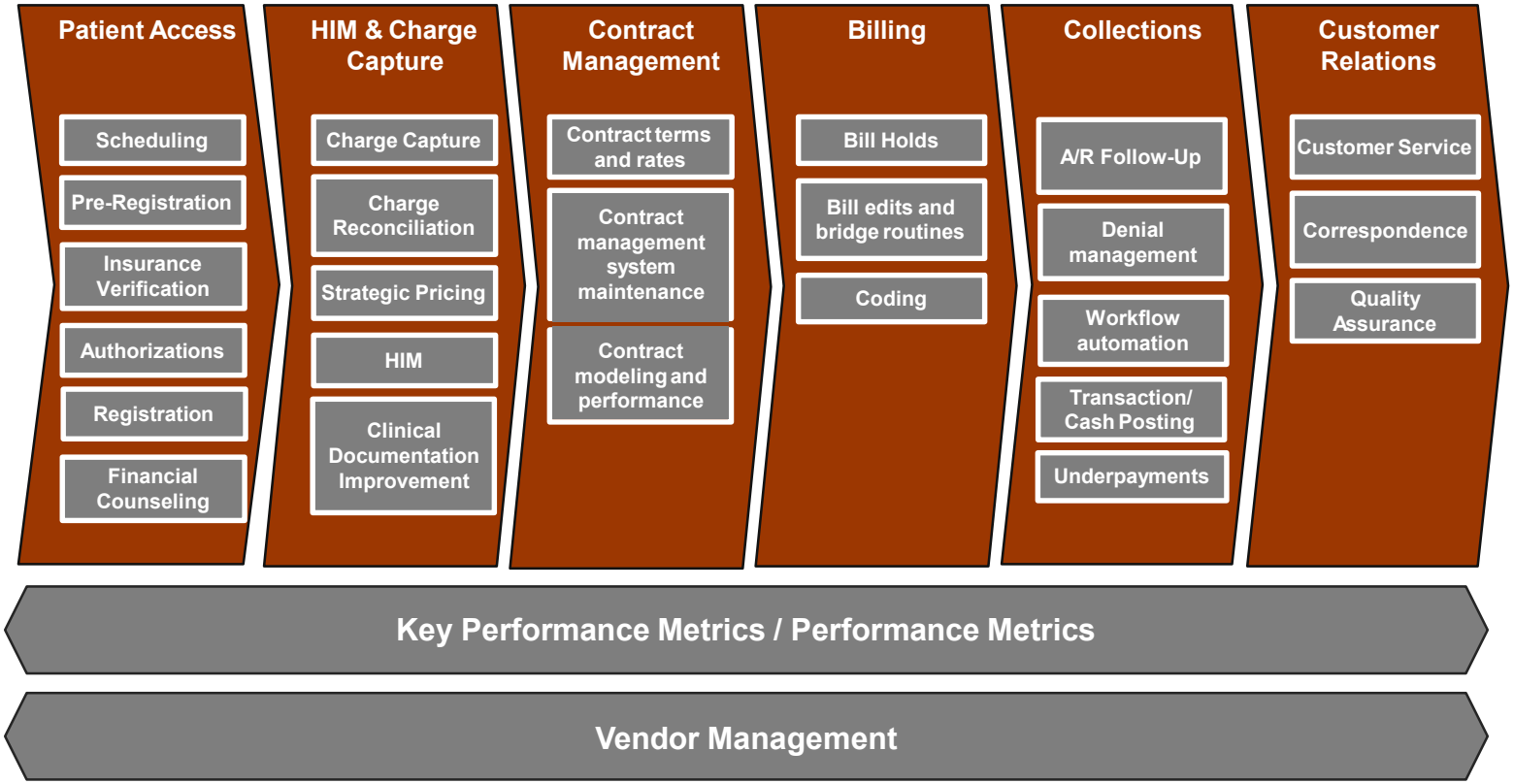
Revenue Cycle Model

The revenue cycle begins and ends with the patient. Financial Management is integrated in all areas of the revenue cycle operations, before and after services are provided.



Functional Areas within the Revenue Cycle

The Revenue Cycle represents all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.



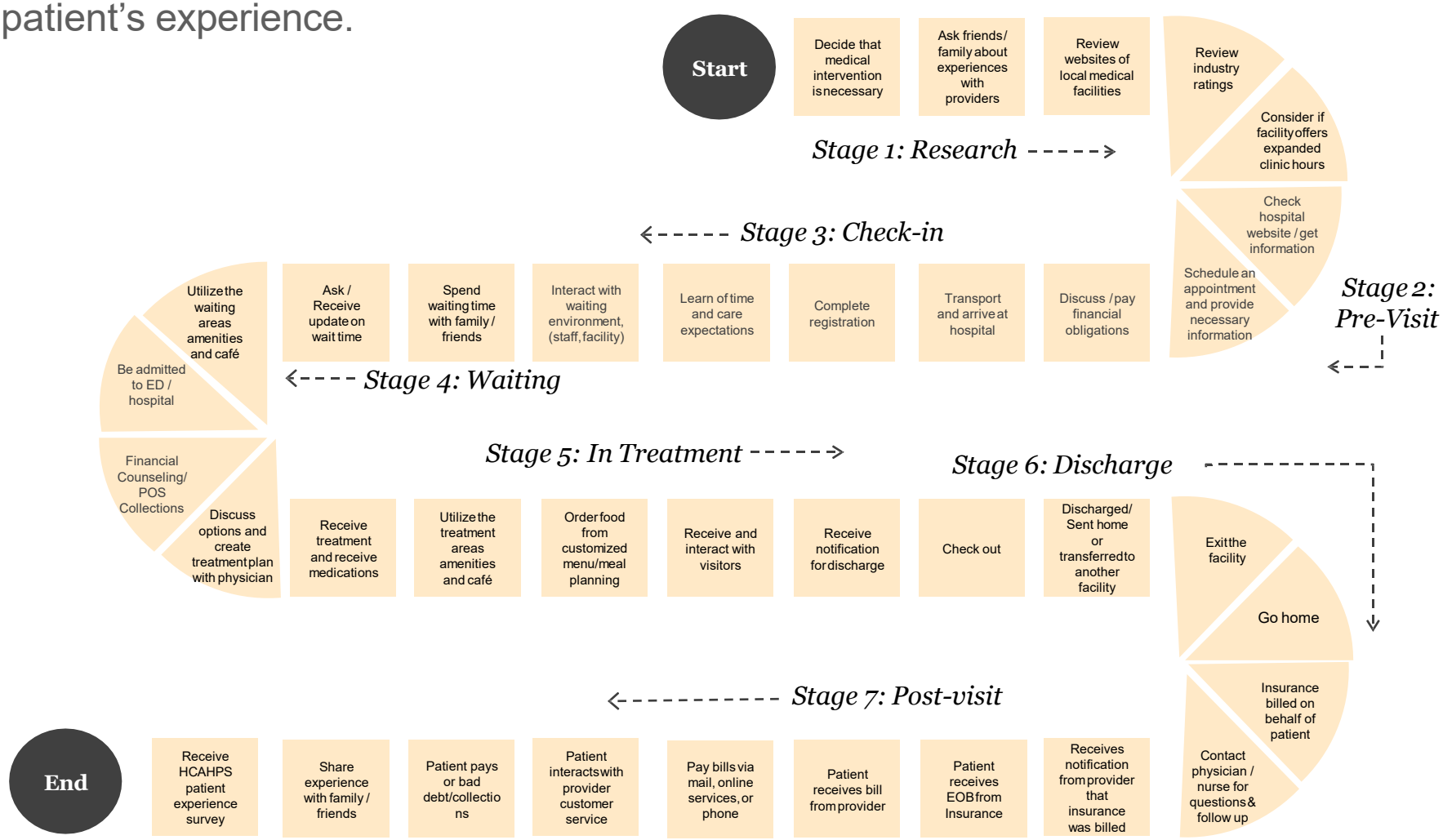
Question #1

What function is **not** a core part of revenue cycle operations within a healthcare provider organization?

1. AR Management
2. HIM Coding
3. Patient Access
4. Clinical Risk Management
5. Charge Capture

Sample Patient Journey Map

There are many revenue cycle touch points along the patient journey including pre-service and post service touch points. The revenue cycle is key influencer on a patient's experience.



Revenue Cycle Performance – Technical KPIs
Patient Access

The table below represents a scorecard for revenue key performance indicators (KPIs) in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Scheduling	Call Abandonment Rate	Percentage of calls that disconnected before being answered	≤2%
Scheduling	Pre Registration %	The percentage of scheduled patients pre-registered before arriving for services.	100%
Pre-registration/Pre-certification	Insurance Verification Rate	Overall insurance verification rate of scheduled/pre-registered patients	≥98%
Pre-registration/Pre-certification	POS Collections %	POS Cash Collected as % of NPSR	>2%
Financial Counseling	Financial Assistance	% of non- or under- funded patients being screened for financial assistance	≥98%

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

Revenue Cycle Performance – Technical KPIs
HIM & Charge Capture

The table below represent a scorecard for revenue key performance indicators in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Health Information Management (HIM)	CDI Queries	Physician documentation completion delinquency greater than 30 days	≤5%
Health Information Management (HIM)	Chart Acquisition Lag	Average chart acquisition lag from physician request	≤90 minutes
Charge Entry	Late Charges %	Late Charges as % of Gross Revenue	≤2%
Charge Entry	Missing Charge %	Total % of total visits with missing (no) charges	≤1%

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

Revenue Cycle Performance – Technical KPIs *Billing*

The table below represent a scorecard for revenue key performance indicators in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Billing/Claim Submission	Charge Lag Days	Charge lag days from date of service/discharge and receipt chart date	≤3 Days
Billing/Claim Submission	Days in Total Discharged Not Submitted to Payer (DNSP)	Total DNSP Gross Revenue / Average Daily Gross Revenue	≤2% A/R days
Billing/Claim Submission	Clean Claim Rate	Volume of claims requiring no manual intervention / The total volume of claims accepted into claims scrubber or clearinghouse	85%>
Billing/Claim Submission	Discharge Not Final Billed (DNFB)	Total DNFB Gross Revenue / Average Daily Gross Revenue	≤4 A/R days

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

Revenue Cycle Performance – Technical KPIs
Collections

Sub-Category	Performance Metric	Description	Hospital Benchmark
Third Party	Percentage of total accounts receivable > 180 Days	Billed AR>180 days / Total Billed AR	≤5%
Third Party	Percentage of total accounts receivable > 365 Days	Billed AR>365 days / Total Billed AR	≤2%
Third Party	Percentage of total accounts receivable > 90 Days	Billed AR>90 days / Total Billed AR	≤20%
Third Party	Cash Collection %	Cash collections as % of net revenue	≥100%
Third Party	Charity Write Off %	Charity write offs as % of gross revenue	≤2%
Cashiering	Days in Credit	Average number of days the hospital takes to issue a credit on applicable accounts.	≤2 Days
Denials	Denial Overturn Rate	Percentage collected on denied accounts	>80%
Denials	Initial Denial Rate	Initial denials as a percentage of gross revenue	<5%
Denials	Initial Denial Rate—Partial Pay	Initial denials (partial payment) as a percentage of gross revenue	<5%
Denials	Net Denial Write Offs	Net denials write offs as a % of NPSR	≤1.5%
Denials	Underpayments Additional Collection Rate	The percentage of accounts where the payment received is less than the anticipated amount based on the contracted agreement.	≥12%
Collection	Bad Debt %	Bad debt as a % of gross revenue	≤2%
Management	Cost to Collect	Revenue Cycle Operational Cost / Total NPSR % collected	≤2%
Management	Gross Days in A/R	Total patient accounts receivable balance / Average daily gross patient revenue	≤50

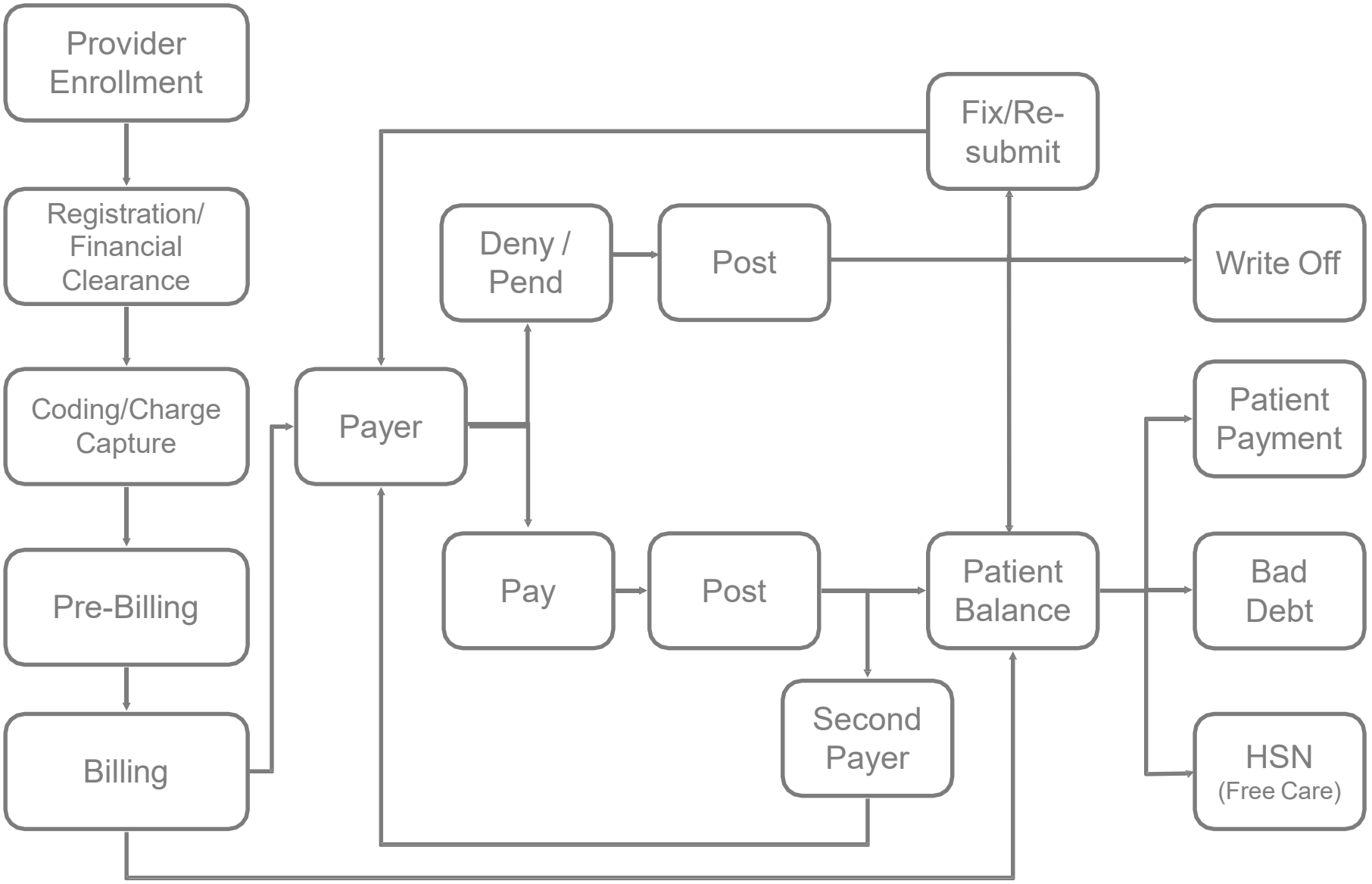
Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

Question #2

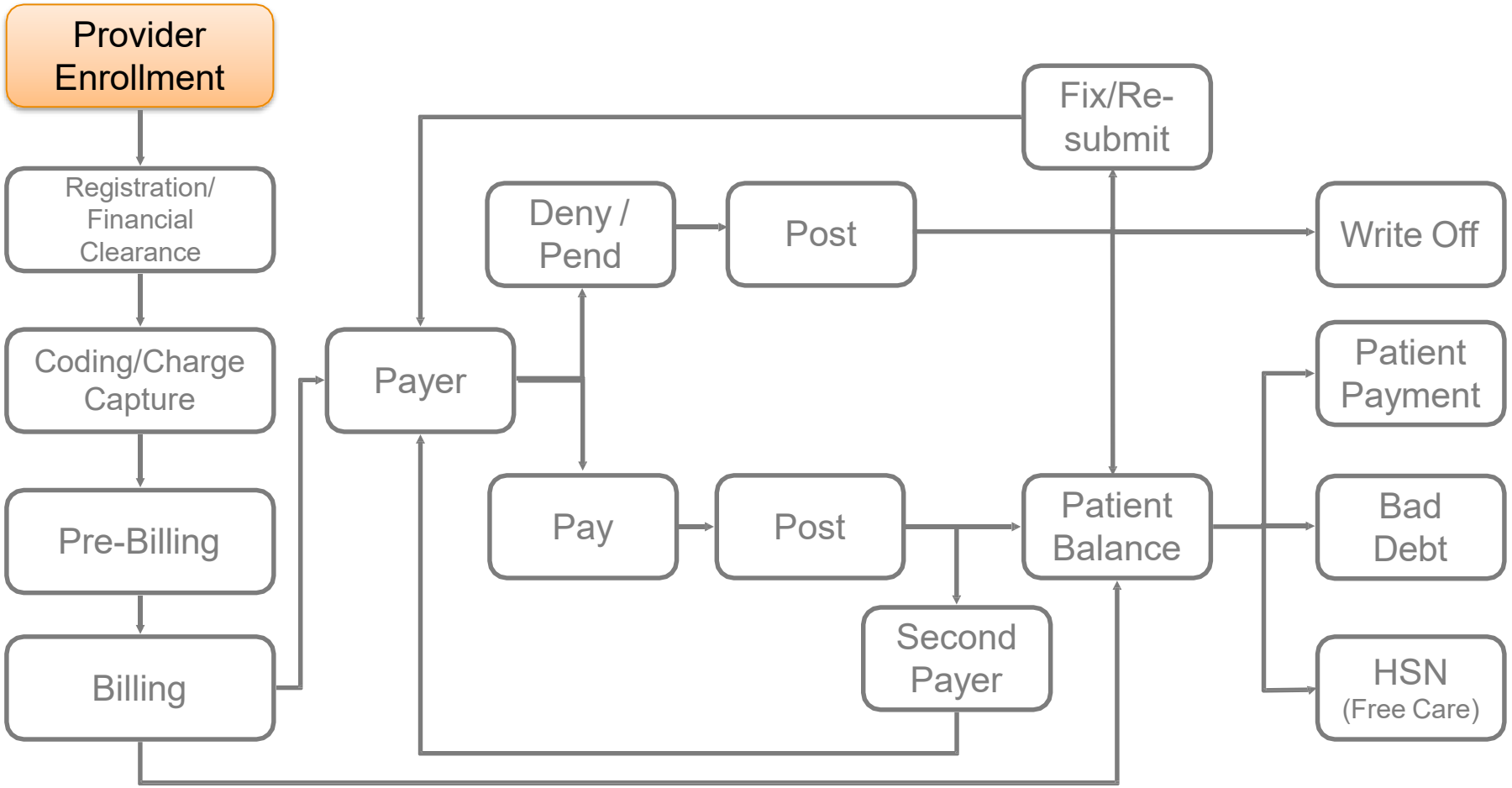
What is the definition of a technical KPI for revenue cycle?

1. Industry standard benchmarks used to measure operational performance and throughput across functions
2. Clinical standards of care measures to promote patient safety and care quality
3. Patient population measures detailing provider- or community-level efficiency, socioeconomic, racial, and ethnic disparities, and coordination of care

The Revenue Cycle from 30,000 feet



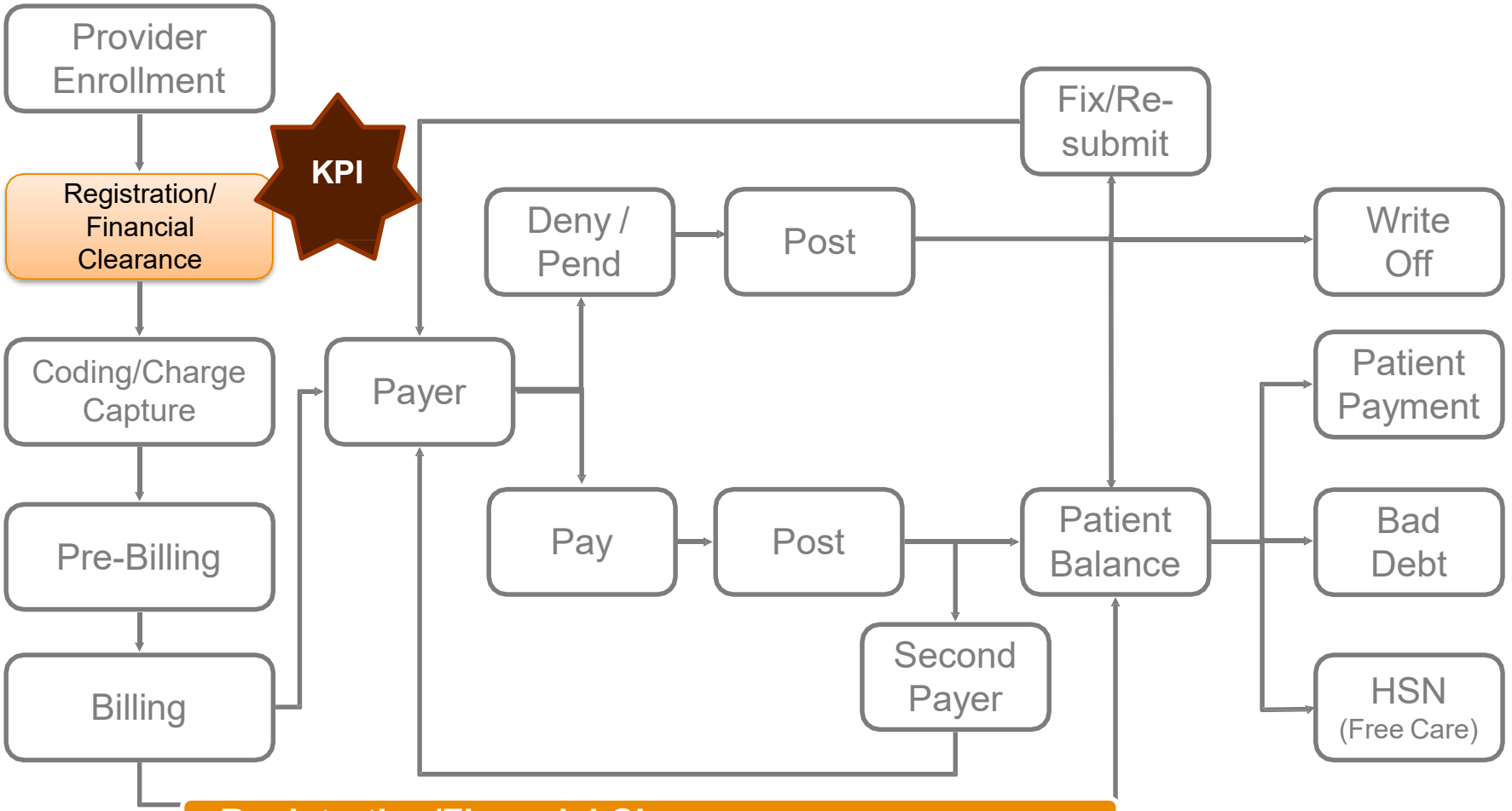
Provider Enrollment



Provider Enrollment

- All providers must be enrolled (credentialed) with third party payers in order to be reimbursed

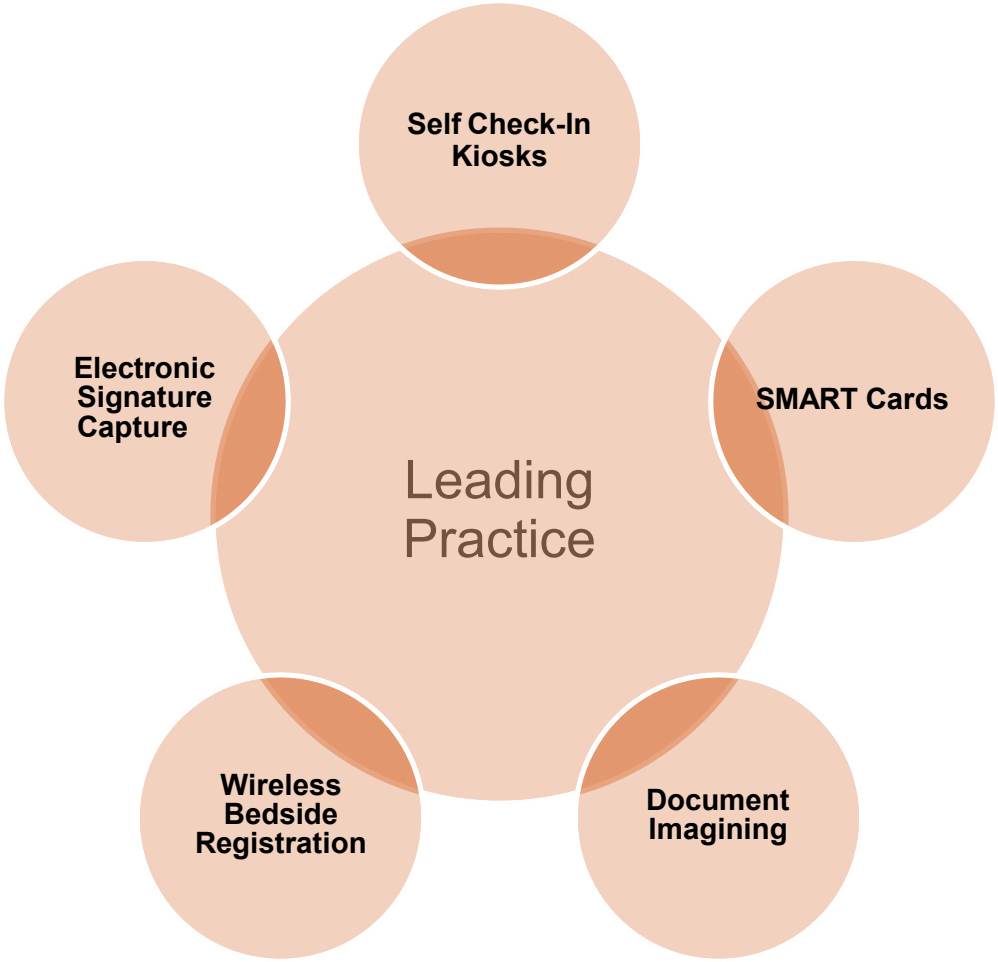
Registration/Financial Clearance



Registration/Financial Clearance

- Involves confirming eligibility with health plan, ensuring authorizations/referrals are obtained, providing financial counseling and obtaining payment up front

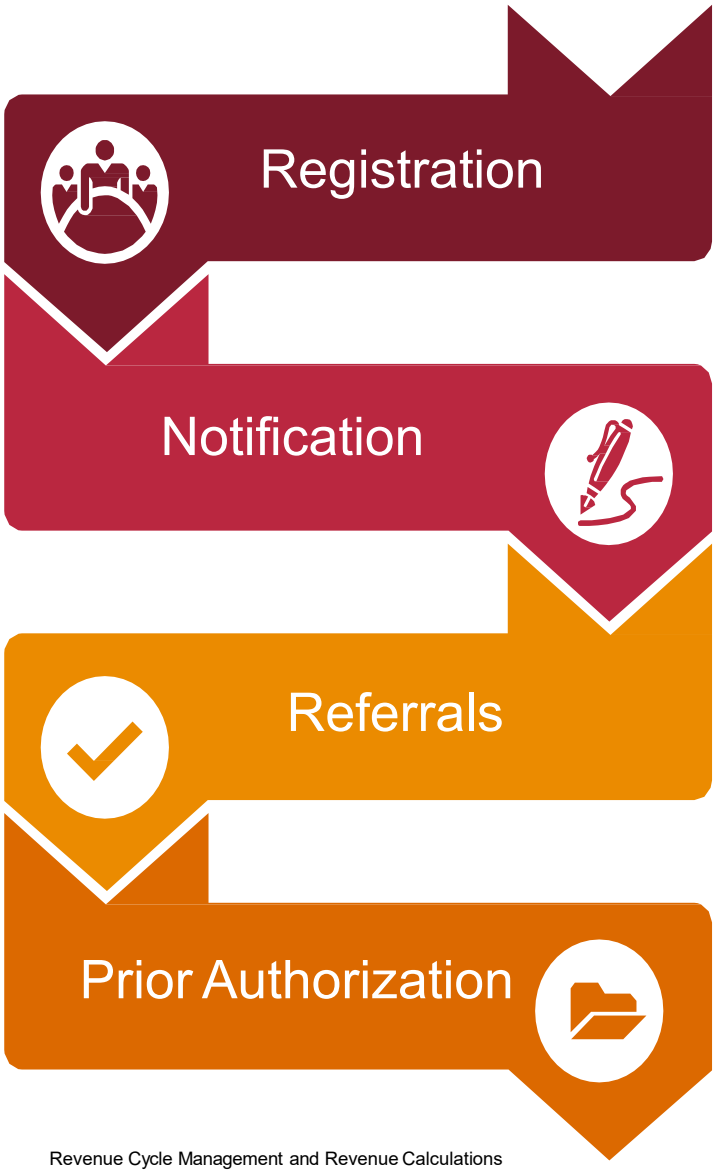
Registration Process/Financial Clearance
High Performing Hospitals



Financial Clearance –

- Most critical set of processes in the Revenue Cycle
- If financial clearance is not done well, the likelihood of proper reimbursement decreases
- Financial Clearance consists of registration, notification, referrals and prior authorization
- Providers use real-time eligibility tools, such as NEHEN, the New England Healthcare Exchange Network
- Financial counselors access a patient's liability as well as his propensity to pay and link a patient to available funding sources

Registration Process/Financial Clearance



Registration – The first step in the Revenue Cycle, a patient registers with a provider; his/her demographic information, as well as third party payer data, is recorded and verified.

Notification – Many payers require notification of an inpatient admission within a specified time period (e.g., two business days). Failure to notify may result in non-payment.

Referrals – Depending upon a patient's plan, referrals from a primary care provider (PCP) to a specialty provider or for a particular service from may be required.

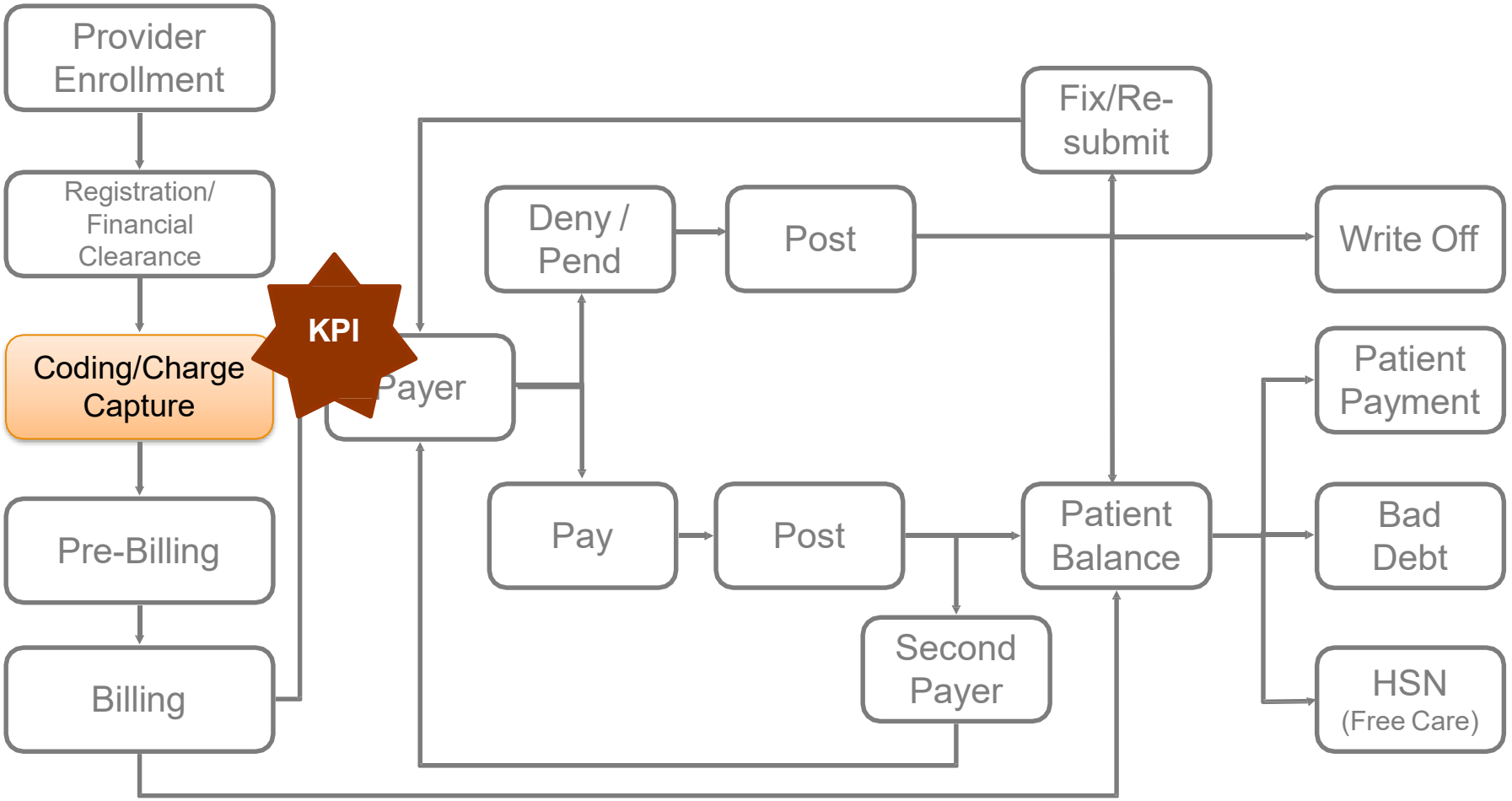
Prior Authorization – Similar to referrals, payers may require prior authorization for healthcare services including same day surgery, inpatient stays, and certain medications.

Question #3

Which of the following is a core process of patient access?

1. Confirming patient eligibility with health plan / payer
2. Ensuring authorizations / referrals are obtained / approved
3. Providing patient financial counseling regarding claim payment
4. Obtaining patient point of service collections
5. All the above

Coding/Charge Capture



Coding/Charge Capture

- Charge capture is the intersection of clinical practice and the billing of services.

Coding

All services are coded by a certified hospital coder

Coding for Inpatient Admissions

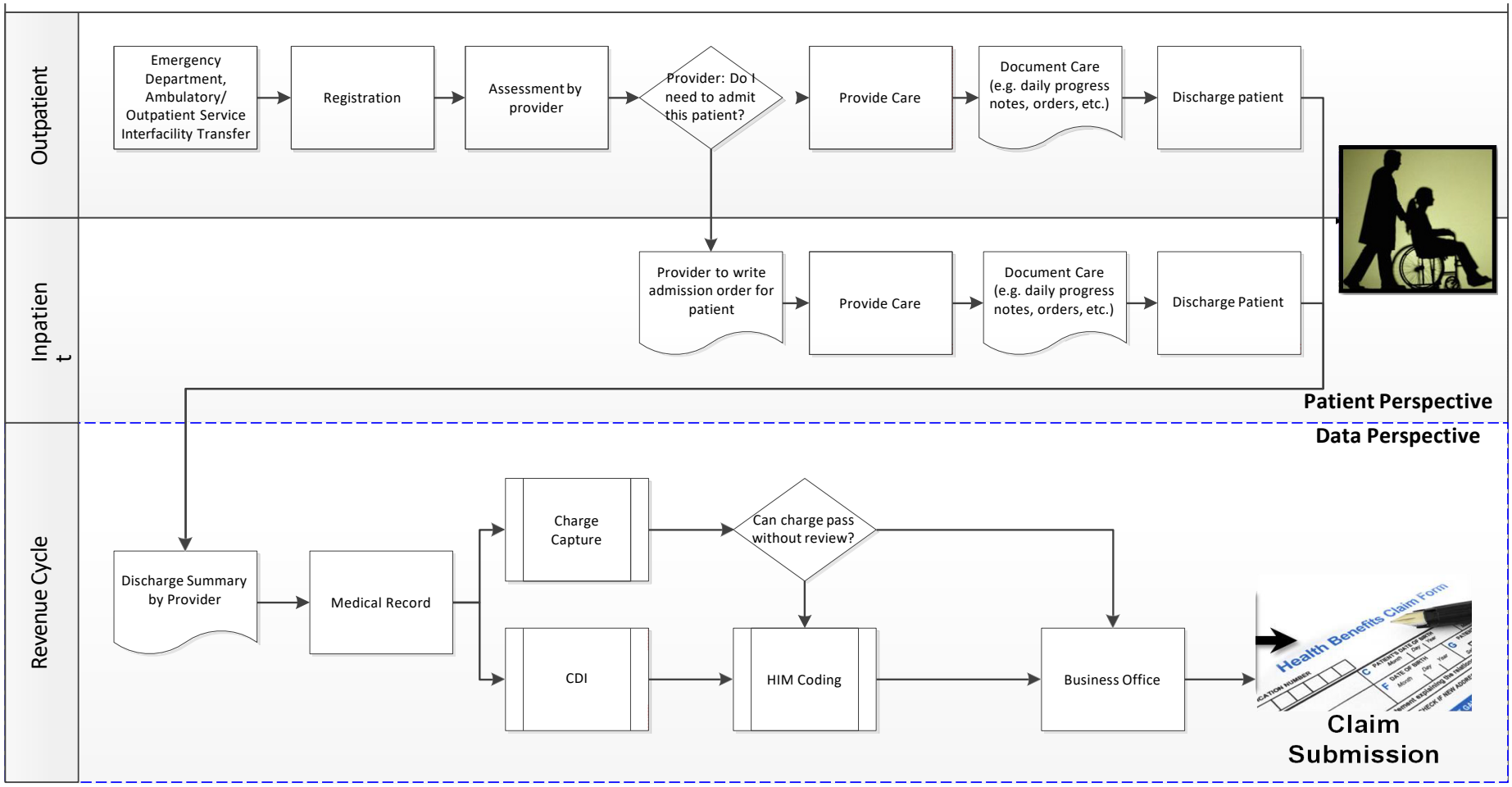
- Each admission is assigned a DRG (Diagnosis Related Grouper) based upon the following:
  - Admitting diagnosis
  - Principal diagnosis
  - Secondary diagnosis(es)
  - Comorbidities
  - Complication(s)
  - Principal procedure
  - Secondary procedure(s)

Coding for Outpatient Services

- Each visit has associated CPT/HCPCS codes, as well as diagnosis codes

If a procedure/service is not documented, **IT DID NOT HAPPEN**!

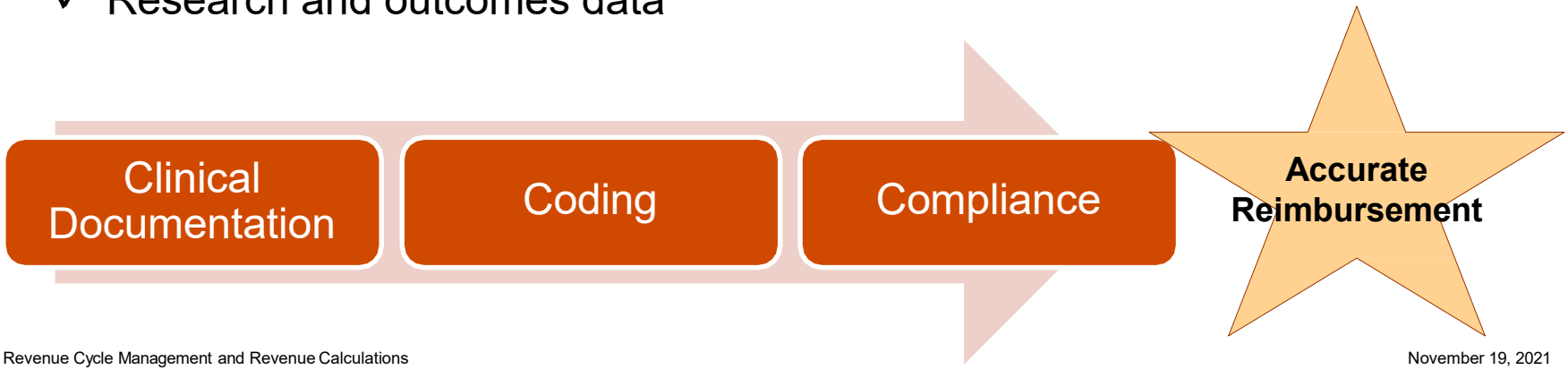
Charge Capture



Charge Capture
Documentation and Coding

- Clinical documentation has a significant impact on coding and ultimately, reimbursement for services provided to the patient. Clinical documentation directly impacts the following:

  - ✓ Regulatory compliance – JCAHO, CMS, Medicare Conditions of Participation and OIG.
  - ✓ Hospital Case Mix index – Medicare Cost Report.
  - ✓ Reimbursement for services provide – coding service to the highest level of specificity.
  - ✓ A/R days – as a result of waiting for response from physician queries.
  - ✓ Research and outcomes data

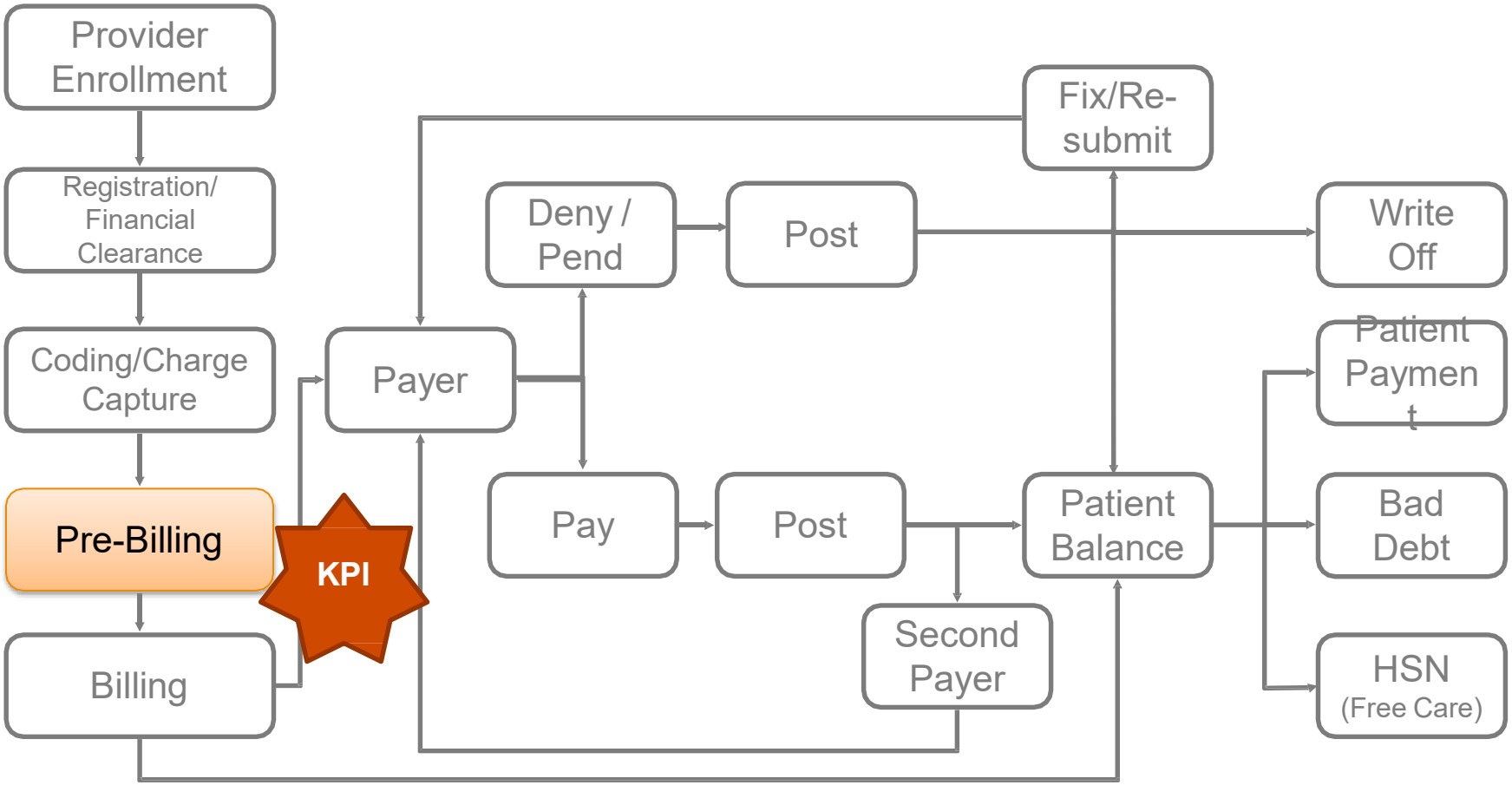


Question #4

Which of the following is not a type of service code on a patient claim?

1. CPT
2. DRG
3. ICD-10
4. API
5. Modifier

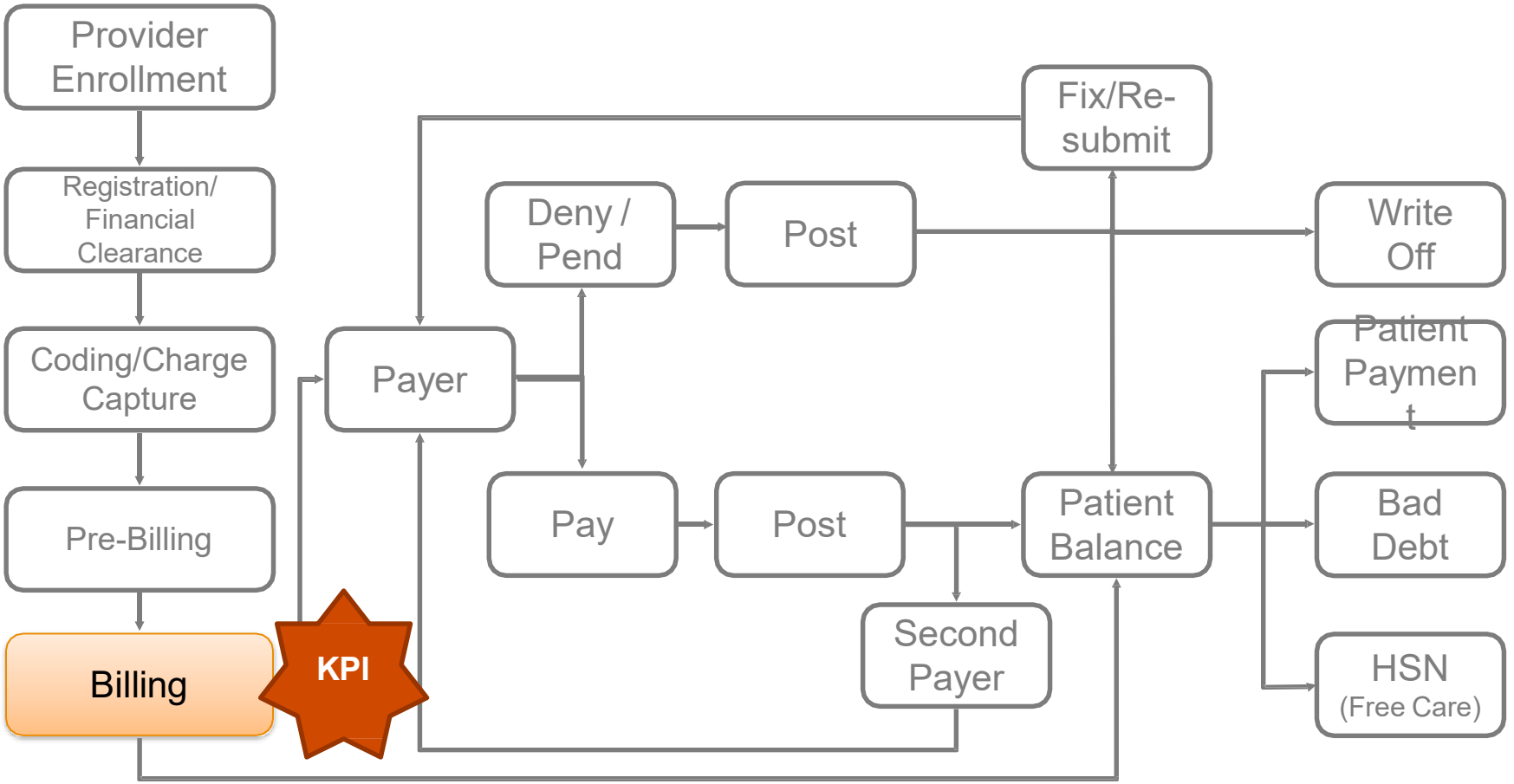
Pre-Billing Function



Pre-Billing

- Involves claim editing to ensure compliance with payer regulations and standard billing practices.

Billing Process



Billing

- Claims are sent electronically to payers, with some exceptions (e.g., medical record required, implant invoice required)

Claim Generation and Billing

A claim is generated by the patient accounting system only after it meets all of the criteria to bill.

When a claim is generated, the following processes and activities occur:

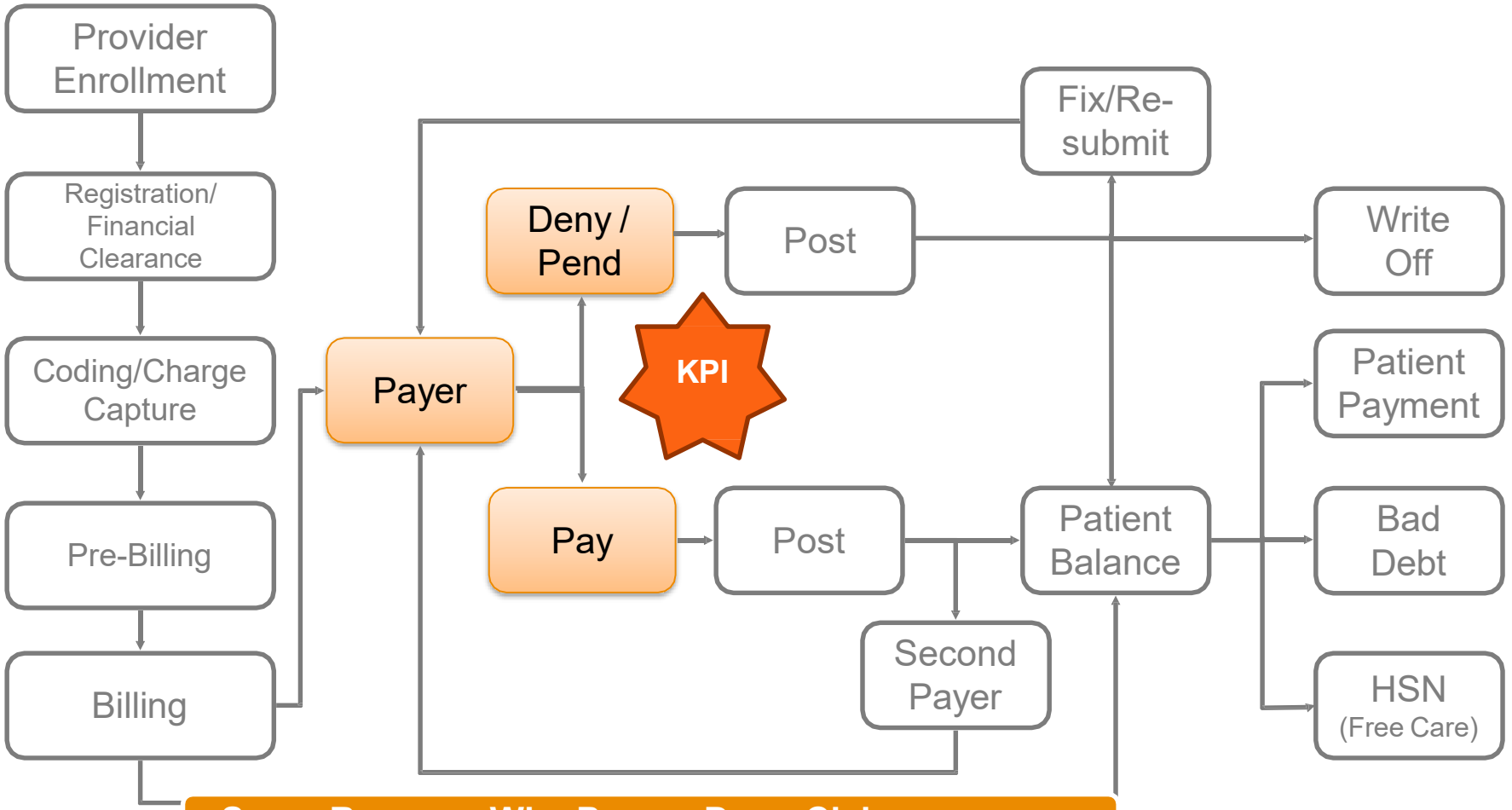
- Claims are generated and a print image file is created
- Final bill date is populated in the system
- Print image file is imported into a bolt-on billing editor
- Claims are edited against CCI,OCE, LMRP, and specific payor edits
- Clean claim pass rate is measured
- Billable claims are transmitted to payors via EDI and mail
- Failed claims are reworked and corrected prior to transmission to the payor
- Claims are tracked via EDI transmission, acceptance, and rejection reports
- EDI rejections are corrected and re-transmitted to the payor
- EDI transmission notes are auto-posted back to the patient accounting system

Question #5

Which is the proper sequence for claims generation and submission?

1. Claims edit, Claims are transmitted to payers, Claims generation, EDI rejection correction
2. Claims generation, EDI rejection correction, Claims edit, Claims are transmitted to payers
3. Claims edit, EDI rejection correction, Claims are transmitted to payers, Claims generation
4. Claims generation, Claims edit, Claims are transmitted to payers, EDI rejection correction

Adjudicating the claim…



Some Reasons Why Payers Deny Claims

- Payers can deny claims for many reasons including: ineligible patient, no referral obtained, unauthorized service, medical necessity, coordination of benefits (i.e., another payer is responsible)

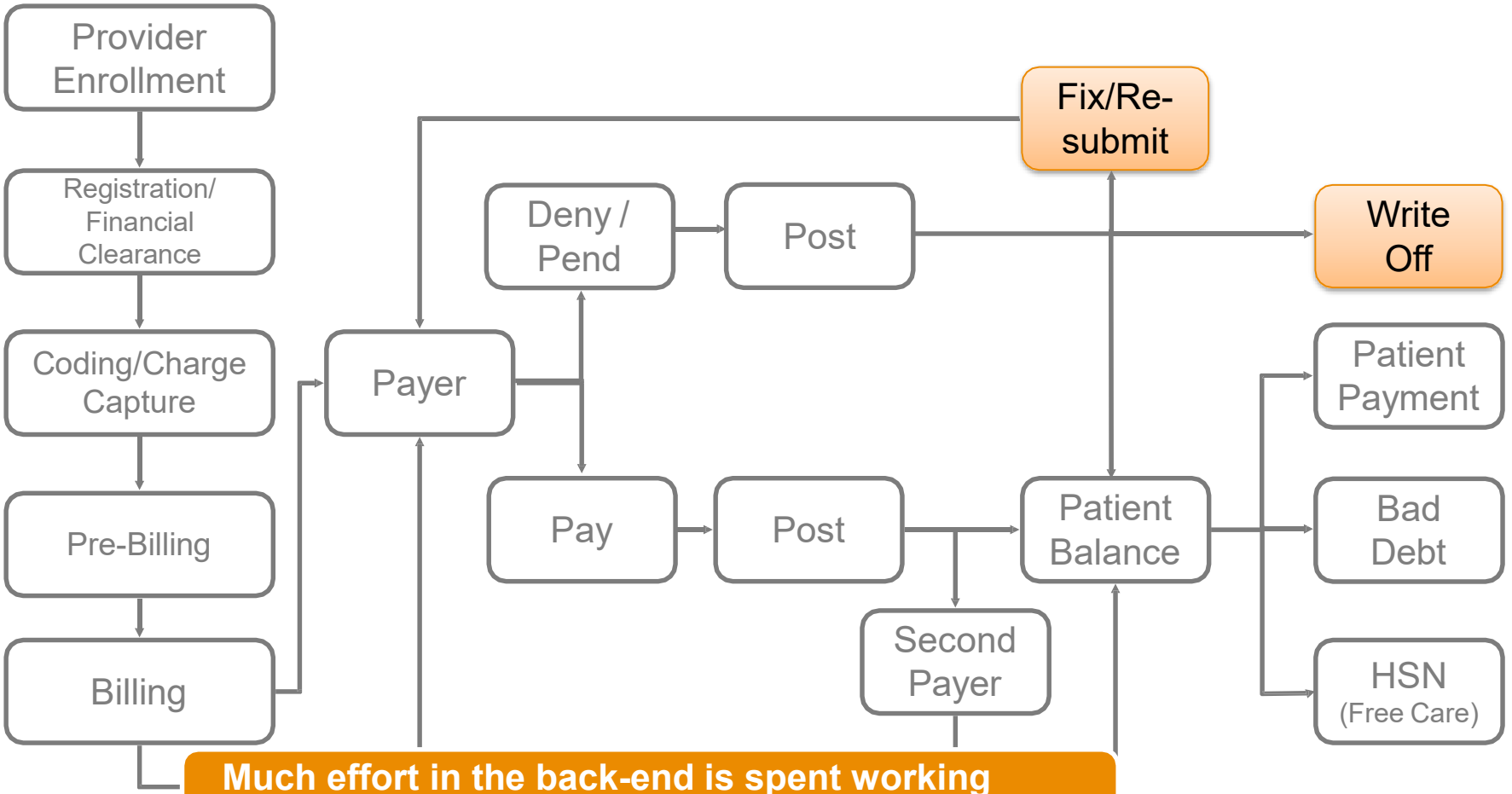
Denials and Appeals – Overview
Roles and Responsibilities

- ✓ Develop and provide oversight to the denial work group which includes key stakeholders from other departments (i.e. Access Management, Health Information Management, Case Management)
- ✓ Actively monitor denied claims through system-wide denial reporting structure and communication
- ✓ Identify and communicate trends and issues regarding clinical or administrative denials to revenue cycle leadership and/or the root cause department

Types of Payer Denials:

- **Hard Denial**: These denials occur when the payer has denied payment (either for the full claim or by line-item; i.e. Technical or Clinical Denials)
- **Soft Denial**: These denials occur when the payer will not pay a claim until the patient or hospital submits additional information to process the claim (i.e. Rejections)

After the initial denial…



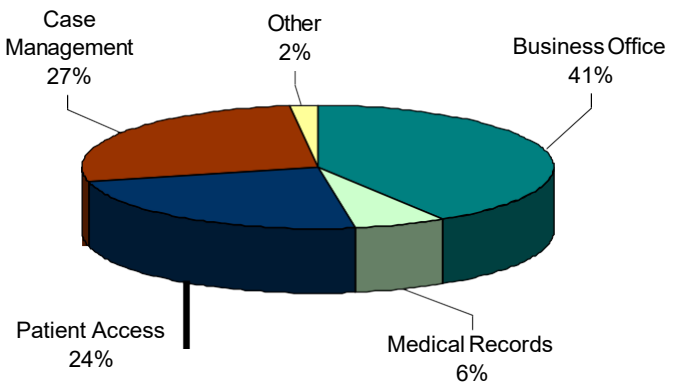
Much effort in the back-end is spent working denials

- Back-end revenue cycle staff spend time contacting patients for additional information; confirming primary payer; working with clinical staff for support to appeal denial/rebill claim; and contacting health plans

Denial Management – Root Cause Analysis

Denials typically originate in the following departments:

Sample Hospital:



Business Office –
- Duplicate claim
- Passed timely filing deadline
- Incomplete billing attachments
- Provider name/number

Medical Records –
- Principal diagnosis/HCPCS Codes
- OCE/CCI edits

Case Management –
- Clinical / Concurrent Review
- Authorized Days
- Authorized Service
- Level of Care (Inpatient vs. Observation)

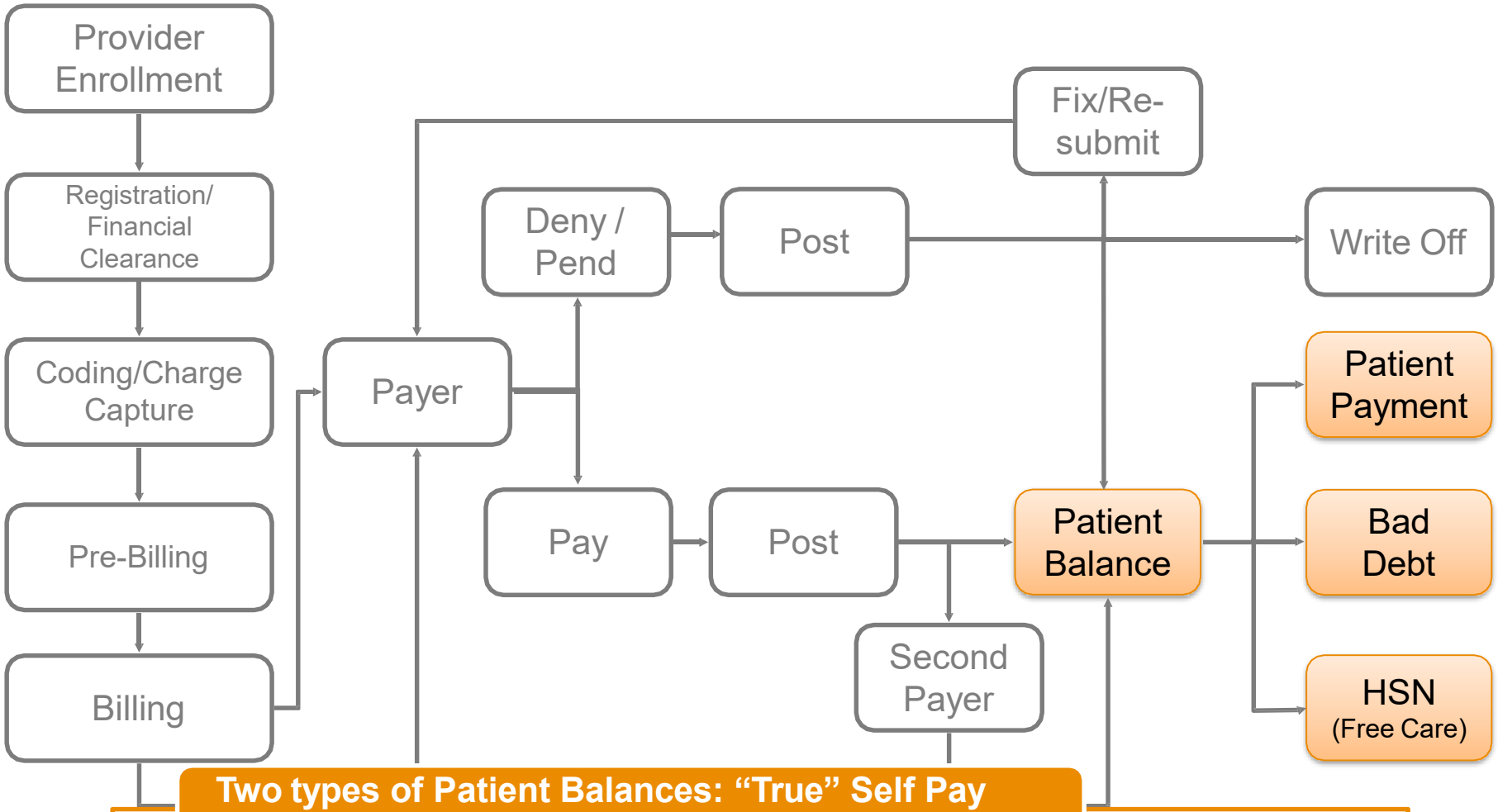
Patient Access –
- Authorization conflict
- No benefits allowed
- Other insurance is primary
- Subscriber not on file/invalid member #
- Ineligible
- Awaiting pre-authorization
- Notification not provided

Question #6

Which is the difference between a hard and a soft denial?

1. Hard denials relate to payer denial of payment for technical or clinical reason and soft denials relate to payer not paying due to request for information to process claim
2. Hard denials relate to immediate payer denials and soft denials related to longer term payer denials
3. Hard denials relate to payer denials as patient not satisfied with total services received and soft denials relate to payer denials as patient not satisfied with a portion of services received

Patient Responsibility…

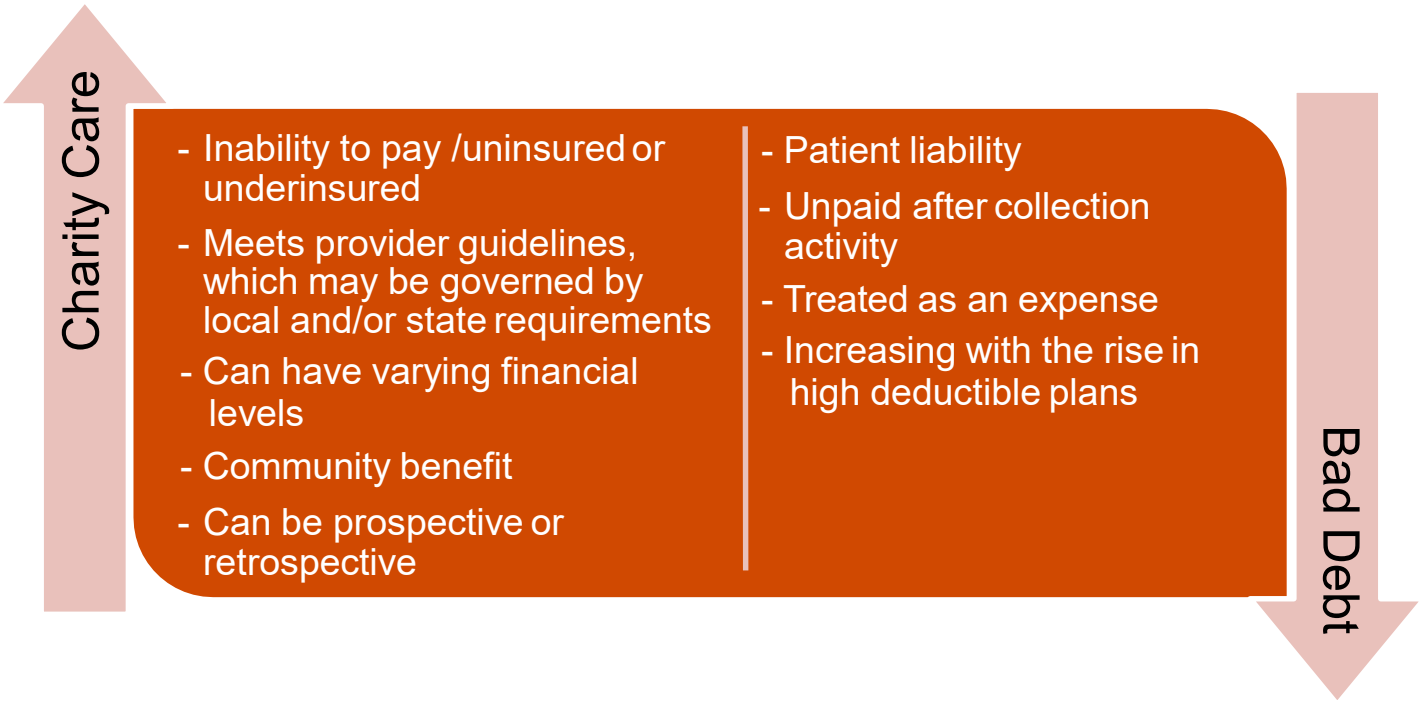


Two types of Patient Balances: "True" Self Pay (uninsured) and Balances after Insurance

- Patients receive a number of statements, while the provider determines the patients' propensity to pay

Charity Care vs. Bad Debt

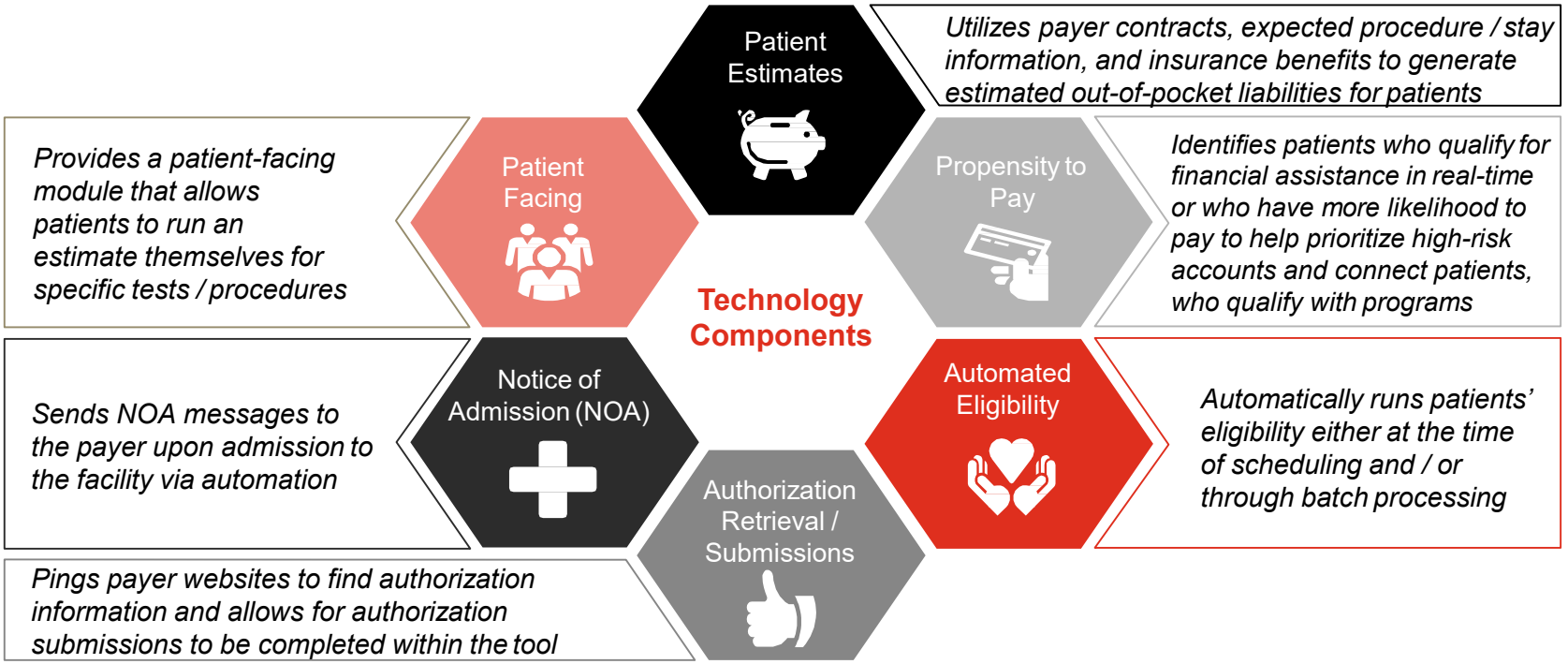
Providers often face the reality that a patient's medical bills can be the lowest priority for that patient. Depending upon the patient's financial status, the provider may treat the patient's inability or unwillingness to pay differently



Note: Providers can claim Bad Debt for Medicare beneficiaries and may be reimbursed under the Medicare Program, when all guidelines have been appropriately conducted

Technology Advancements Across the Revenue Cycle

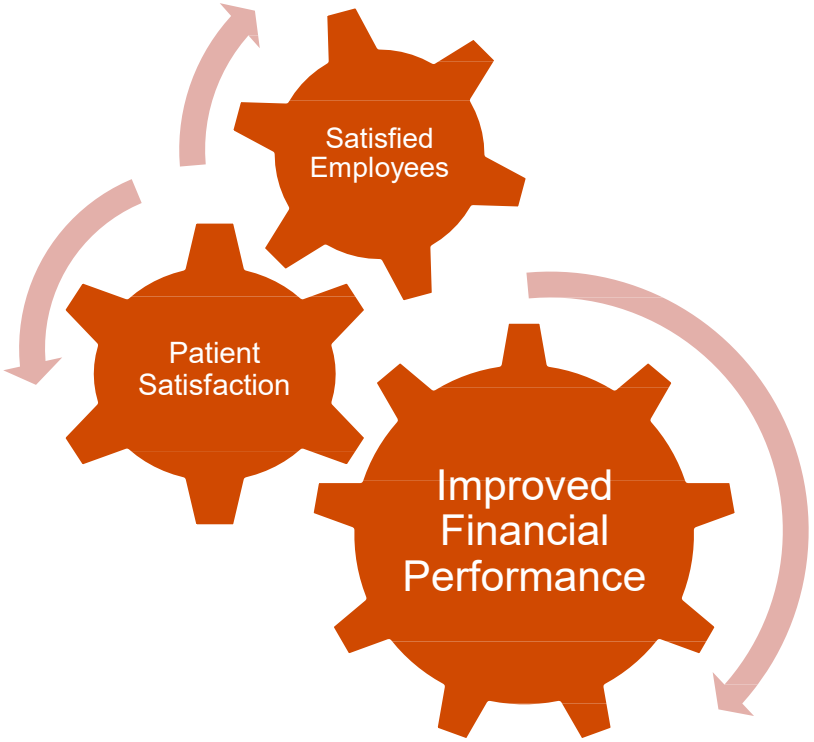
Several technology advancements are driving hospitals' abilities to provide patient estimates, increase patient satisfaction, and reduce bad debt



Benefits of an *analytical and diagnostic* view of revenue health and revenue cycle processes

Results of an Effective Revenue Cycle

- Improved Financial Performance
  - Higher rate of clean claims that are submitted and billed
  - Improved collection efforts due to complete and accurate patient demographic and insurance information
  - Reduction in bad debt and denials
  - Reductions in variable costs
  - Increased cash flow from patient services
- Increased Patient Satisfaction
- Increased accountability with clear roles and responsibilities



Thank you!


obrigado
Dank U
Merci
mahalo
Köszi
спасибо
Grazie
Thank you
mauruuru
Takk
Gracias
Dziękuję
Děkuju
danke
Kiitos