

# Healthcare Provider - Targeted Revenue Cycle Management Overview

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1

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## What is the Revenue Cycle?

The revenue cycle is essentially how health systems **document services provided, bill and are paid, by both insurance companies and patients**



### *When does it start?*

- The revenue cycle goes beyond the traditional definition of starting when a patient schedules an appointment or arrives at the ED -- it is a broader capability that goes beyond the four walls and individual encounter itself connecting all aspects of access, demand generation, patient engagement, patient financial experience, and customer relationship management



### *What does it track?*

- Gathering insurance information or lack thereof is the first step towards payment for services
- From registration, visit and clinical documentation and coding, through A/R follow-up, payment, and ultimately posting, the revenue cycle follows the patient's journey across many areas of a health system
- Revenue cycle is also responsible for negotiating rates with insurance companies and making sure they are reimbursing correctly



### *How does the Revenue Cycle fit into market dynamics?*

- Market dynamics are necessitating new thinking for operational delivery at large, complex provider organizations. Many health care organizations are taking a hard look at their business operations to drive efficiencies, streamline operations, increase regulatory compliance, and become more financially stable. By eliminating unnecessary costs from the administrative units, organizations can free up financial resources to re-invest in the organization.

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2

2

# Clinically Integrated Revenue Cycle

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Market forces drive a shift to a Clinically Integrated Revenue Cycle that focuses on improving patient experiences, lowering costs, and reducing compliance risks

Is there opportunity to increase volume with our current capacity and improve patient access experience?

Have I captured all the charges and coded my claims correctly?

Do I have the right balance between in-house and outsourcing?

Whfkgqrzj | swhkrp

Turqggrzu

KIP 2Frglj | F kdujh F dswh

YhggruSduqhuksbv

I wish charges from clinical system were posted real-time.

Turqwhg

Why do my front-end denials keep increasing?

E lduj 2 F rwhfwkqv

Why do I have keep correcting so many errors all the time?

Dqddwlv

I wish I had more early warnings to prevent risks becoming issues

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- Friction-less Patient Experience
- Financial Excellence
- Improved Margin
- Reduced Compliance Risk

3

# Revenue cycle process overview

## Date of service/Check-in

- On-site concierge is notified via geofencing (proximity notification) that the patient has arrived for an upcoming appointment
- Patient completes check-in on a kiosk or via video chat with the remote registrar
- The majority of the patient's required pre-registration information is saved in their patient portal app, which expedites the check-in process and ensures compliance with security and regulatory standards

## Pre-service

- Patient identifies best value for shoppable service by location and available providers
- Patient uses portal to schedule appointment and confirm/complete minimum dataset; financial clearance team will receive list to complete insurance verification
- The patient can take a picture using the digital intake application which is transcribed into their medical record

## Care delivery and charging

- Patient has a conversation with their provider through a secure telehealth video conference
- Providers leverage automated coding for selecting the right level of service and charge natively within the EMR
- Coders leverage Natural Language Processing (NLP) to help select the right codes and increase productivity

## Billing and claim adjudication

- Embedded claim scrubbing and edits limit number of touches and hand-offs and reduce the cost to collect
- Automation is leveraged to work denials or route them to the root cause area to be worked with minimal effort and rebilled expeditiously

## Post-service

- Patient receives discharge instructions, prescriptions, follow-up visit notification at time of discharge through patient portal
- Business Intelligence and visualized reporting is leveraged to monitor key outcomes in relation to claims aging and self pay balances
- Patient receives follow-up care plans and reminders through portal, can securely message provider with questions
- Staff productivity is remotely monitored and their time spent in each encounter is logged and tracked to ensure they are adhering to standard operating procedures
- Patient receives itemized, plain language, self-pay statement through patient portal with explanation of benefits

4

# Today's Revenue Cycle model is characterized by key pain points

Today's Revenue Cycle pain points

Pain point root causes	Compromised patient experience	Poor infrastructure to manage reimbursement	Fragmented technology	Underutilized analytics and informatics	Low efficiency
 <b>Business processes</b>	<ul style="list-style-type: none"> <li>Lack of integration between Revenue Cycle and clinical processes</li> </ul>	<ul style="list-style-type: none"> <li>Reduced reimbursement and increased denial rates due to poorly integrated front-end and clinical processes</li> </ul>	<ul style="list-style-type: none"> <li>Disconnect of several disparate systems that don't allow all components in the workflow to operate at an optimal level</li> </ul>	<ul style="list-style-type: none"> <li>Predictive analytics and robotic processing automation not fully optimized to allow for improvement in the continuum of care</li> </ul>	<ul style="list-style-type: none"> <li>Redundant and inefficient processes which fail to clearly link clinical care and Revenue Cycle activities and tasks</li> </ul>
 <b>People capabilities</b>	<ul style="list-style-type: none"> <li>Lack of customer service provided during front-end processes impacts the quality and consistency of patient experience</li> </ul>	<ul style="list-style-type: none"> <li>Failure of clinical service line leadership to execute operational change management when implementing new initiatives which leads to poor adoption</li> </ul>	<ul style="list-style-type: none"> <li>Multiple errors in work product from having to use multiple systems to perform a job</li> </ul>	<ul style="list-style-type: none"> <li>Access to data needed to perform a job is not accessible/integrated across the operational cycle</li> </ul>	<ul style="list-style-type: none"> <li>Revenue cycle staff not properly trained to handle basic requirements and key regulatory changes, leading to errors</li> </ul>
 <b>Technology</b>	<ul style="list-style-type: none"> <li>Lack of self-service options that patients seek out (e.g., scheduling)</li> </ul>	<ul style="list-style-type: none"> <li>Lack of integration of clinical and financial systems to provide visibility into the entire encounter</li> </ul>	<ul style="list-style-type: none"> <li>Fragmented EMR, Billing, and Reporting systems, which create a need for continuous improvements/enhancements/bolt ons</li> </ul>	<ul style="list-style-type: none"> <li>Business decisions not driven by data analytics and reporting</li> </ul>	<ul style="list-style-type: none"> <li>Lack of integrated capability to support Revenue Cycle operations</li> </ul>

Access management

Charge capture and HIM

Patient financial services

Lack of process and technology alignment across clinical and Revenue Cycle functions coupled with constant regulatory changes increases pressure on back-end to manage Revenue Cycle.

5

## Revenue cycle functions

### Overview of Access Management as a function of the revenue cycle

Front-end Revenue Cycle	Middle Revenue Cycle			Back-end Revenue Cycle		
Access management	Hospital Revenue integrity, CDI and Coding			Patient financial services		
<b>Access management</b> <ul style="list-style-type: none"> <li>Scheduling</li> <li><b>Financial clearance</b> <ul style="list-style-type: none"> <li>Pre-Registration</li> <li>Insurance verification</li> <li>Referrals/authorizations</li> <li>Pre-service collections</li> <li>Financial counseling</li> </ul> </li> <li><b>Registration</b> (scheduled or non-scheduled)</li> <li>Admissions/Bed Management</li> </ul>	<b>Revenue Integrity</b> <ul style="list-style-type: none"> <li>Operating model and leading practices</li> <li>Charge Capture processes</li> <li>Charge Reconciliation processes and reporting</li> <li>Charge Description Master (CDM) assessment, consolidation and Maintenance</li> <li>Strategic Pricing</li> </ul>	<b>Clinical documentation integrity</b> <ul style="list-style-type: none"> <li>Clinical documentation improvement</li> <li>Concurrent documentation reviews</li> <li>Provider clarification forms</li> <li>Provider education</li> </ul>	<b>Health information management</b> <ul style="list-style-type: none"> <li>HIM                             <ul style="list-style-type: none"> <li>Transcription services</li> <li>Documentation analysis</li> <li>Documentation management/ Scanning</li> <li>Regulatory audit management</li> <li>Release of information</li> <li>Physician documentation monitoring and suspension</li> </ul> </li> <li>Coding and Coding Quality</li> </ul>	<b>Billing</b> <ul style="list-style-type: none"> <li>Claims scrubbing</li> <li>Billing errors</li> <li>Rejection processing</li> <li>Special billing arrangements</li> <li>HIPAA 837 transactions</li> </ul> <b>Follow-up</b> <ul style="list-style-type: none"> <li>Workflow automation</li> <li>Adjustments and write-offs</li> <li>Credit balance processing/escheat</li> <li>Medicare 838 reporting</li> <li>HIPAA 276/277</li> <li>Statement processing and patient collections</li> </ul>	<b>Denials and appeals</b> <ul style="list-style-type: none"> <li>Hard versus soft denials</li> <li>Initial versus final</li> </ul> <b>Transaction processing</b> <ul style="list-style-type: none"> <li>Payment Adjustments</li> <li>Denial</li> <li>HIPAA 835</li> <li>Unposted payments</li> </ul> <b>Credit balances and processing</b>	<b>Vendor management</b> <ul style="list-style-type: none"> <li>Bad debt/charity care management</li> <li>Underpayments</li> <li>Cash posting</li> <li>Customer service                             <ul style="list-style-type: none"> <li>Customer Service phone line</li> <li>Patient payments</li> <li>Correspondence</li> </ul> </li> </ul>
Technology (integrated vs bolt on)						
Data analytics – Clinical and financial						

6

## What is access management?



- Access Management relates to the activities that occur during the pre-encounter and time of service with the patient in an inpatient, outpatient, and emergency department setting(s).
- The starting point that determines the probability of efficient, successful collection of payment for services provided
- Involves the following departments and functions
  - **Financial Clearance**
    - Insurance / Benefits Verification / Coordination of Benefits
    - Referrals/Authorizations
    - Pre-Registration & Pre-Service Collections
    - Financial Counseling
  - **Registration**
    - Inpatient and Outpatient Registration
    - Emergency Department Registration

7

## Patient type considerations



**Inpatient** is a patient whose condition requires admission to a hospital and an overnight stay



**Outpatient** is a patient who is usually treated in a hospital outpatient department. Patients may also be scheduled or walk-in for certain services at clinics or associated facilities for diagnosis or treatment and stay less than 24 hours.



**Ambulatory Office Visit** patient who is seen at an ambulatory facility, or physician's office, for routine primary services and specialist procedures conducted outside of the hospital setting



**Observation Stay** is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a patient whose diagnosis and treatment are not expected to exceed 24 hours, but may extend to 48 hours. In these cases, the need for an inpatient admission can be determined during the stay



**Emergency Department** is the department of the hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care



**Urgent Care** is dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department



**Ambulatory Surgery Center** is a freestanding facility, other than a physician's office, that operates exclusively to provide surgical services to patients who do not require hospitalization

8

# Insurance Verification

Stage 2: Pre-Visit



*Timely and accurate insurance verification is critical in the overall revenue cycle process*

## Insurance eligibility



The process of checking whether the member is actively enrolled with their insurance provider for a particular specified date of service or over a date span

## Benefits verification



The process of validating that the insurance plan benefits cover the services being provided to the member/patient

## Coordination of Benefits (COB)



The process of confirming the appropriate insurance filing order is completed (i.e. identifying primary and secondary payers to ensure claims are sent to appropriate payer)

## Benefits verifiers ensure...

- ✓ Patient is eligible on the scheduled date of service
- ✓ Non-covered services aren't mistakenly provided
- ✓ Appropriate payer(s) are billed

## What's confirmed during verification?

- ✓ Eligibility & Benefits Coverage
- ✓ Copayments and deductibles
- ✓ Coinsurance

## Coordination of Benefits process...

- ✓ Identifies the correct primary payer
- ✓ Reduces duplication of payments
- ✓ Prevents incorrect payer denials

# Referrals & Authorizations

Stage 2: Pre-Visit



*It is imperative that processes are in place to obtain provider referrals and insurance authorization*



## Referrals

**Provider to provider recommendations**, usually from a Primary Care Provider (PCP) to a specialist or **from one specialist to another**

Some referrals require **pre-approval** that individual health plan members—primarily those with health maintenance organization (HMO) or point of service (POS) plans—**must obtain** from their PCP or specialist **before certain services are performed**

For service types that require an authorization, it must be obtained prior to services being rendered. If services are provided without being authorized, the health insurance company can deny payment for the services rendered



## Authorizations

Obtaining an authorization is the process of **pre-approving insurance coverage** of a specific outpatient medical procedure, specific drug **before service is delivered**, or a specific **level of inpatient care**

# Pre-Registration & Pre-Service collections

Stage 2: Pre-Visit



*Pre-registration is the first patient encounter beyond scheduling when efficiency and accuracy directly impacts revenue*

## Key activities during the Pre-Registration stage:

- Staff outreach to patients with the closest time and date of service
- Attempt to pre-register the patient and introduce contactless self pre-registration (if available)
- Patient is notified of financial responsibility (deductible, copay/copayment, coinsurance)

## Importance of conducting Pre-Registration prior to appointment or admission

- Demographic data is confirmed with the patient
- Insurance coverage and benefits are verified
- Attempt at pre-service collection of the patient balance is made



11

# Financial counseling

Stage 2: Pre-Visit



Financial counselors are members of the Access Management team who are dedicated to helping patients and physicians determine sources of reimbursement for hospital services.

## The key focus areas of financial counselors include

1. Assessing a patient's liability and evaluating his/her propensity to pay
2. Linking patients to available funding sources such as Medicaid, Medicare or other government available funding
3. Determining whether they are eligible for charity care or financial hardship treatment based on the providers' policy
4. Assist patients in applying and enrolling in health coverage through the marketplace

## A strong financial counseling department can

- Reduce bad debt
- Increase reimbursement through expanding coverage, collecting patient responsibility, and helping patients find other forms of financial assistance

## Benefits of financial counseling

- Reduces financial stress to help overall well-being of patients and the patient experience
- Help streamline communications between providers and payers
- Helps patients become more educated on their eligibility and benefits
- Can sometimes negotiate better payment plans / deals for patients who cannot afford service



12

## Registration

Stage 3: Check-in



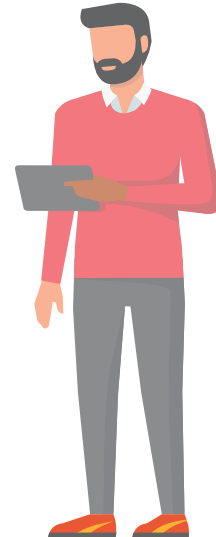
*Registration is the action of verifying that complete and comprehensive patient information was captured during pre-registration, and obtaining any information that was not captured at that time*

### Key components of the Registration stage:

- Staff verifies that all information captured is correct and accurate
- Registration forms are utilized even in emergency situations, such as:
  - Patient consent, HIPAA release forms
  - Advanced Beneficiary Notice (ABN)
  - Medicare Secondary Payer Questionnaire (MSPQ)
- Point of Service collections of patient financial responsibility (i.e. copay, deductibles, coinsurance)

### Importance of verifying information during registration

- Prevents mixing up patients' accounts
- Streamlines billing process on back end
- Fix mistakes made in pre-reg
  - E.g. patient fills out incorrect address, claim is sent to the wrong place, and patient is unable to pay for service in a timely manner



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13

13

## Question #1

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

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14

14

# Health Information Management (HIM) overview

## What is Health Information Management (HIM)?







The HIM Department is responsible for maintaining the patient's medical record in an orderly, confidential, secure, and organized manner and for the preservation of all medical records/health information in accordance with state and federal laws.

- Typically organized into units that handle specific functions within the department:
  - Record Processing
  - Coding\*
  - Release of Information Management
  - Medical Transcription and Voice Recognition
  - Coding
  - Forms Management
  - Quality Reporting and Research

## Roles and Responsibilities

- All activities related to coding including review of each patient's clinical record, critically think and interpret complex medical documented information and accurately assign the appropriate code assignment and collaborate with CDI team
- Ensure digital and traditional medical data maintains its quality, accessibility and security
- Serve as essential link between clinicians, patients and third party payers (including governmental payers)
- Manage delinquent medical record process, physician notification and suspension
- Identify consistent DNFB management strategy
- Observe trends in audits and denials from payers and analyze clinical data for research, process improvement, reporting, etc.

## Industry Leading Practices

-  Utilize an electronic medical record application
-  Possess a fully integrated HIM system and centralized HIM management
-  Streamline HIM workflow processes to eliminate backlogs and bottlenecks
-  Appropriate distribution of work based on responsible owners with proper security profiles
-  Consistent and timely feedback to physicians, coders, staff, and external departments to gain efficiencies and create synergies
-  Standardized policies and procedures to drive consistent performance that meet JC / CMS standards

# Coding overview

## What is Coding?

Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes to support decision-making, statistical analysis, billing, reimbursements and population health surveillance.










The diagnosis and procedure codes are selected after thorough review of medical record documentation. Each time a patient receives services by a healthcare provider, whether as a single outpatient encounter or inpatient admission to a facility, the encounter is coded. The documentation is reviewed and codes are assigned for billing submission.

A key metric to monitor coding activity on a daily basis is the Discharge Not Final Billed (DNFB) (i.e., the amount of time between discharge and claim to be billed).

## Roles and Responsibilities

- Review each patient encounter / discharge and utilize technology such as encoder and Computer Assisted Coding (CAC) to code encounters
- Understand applicable reimbursement methodologies (OP: APCs, HCPCS / CPTs, IPPS: Federal and State DRG Groupers)
- Demonstrate comprehensive knowledge of ICD-10 and/or CPT coding guidelines and principles
- Interact with Clinical Document Integrity team to ensure accurate reimbursement

## Industry Leading Practices

-  Utilize an electronic medical record application and enhanced use of technology such as CAC and coding quality tools
-  Coder workload distribution based upon discharge dates and high dollar account prioritization
-  Establish measurable quantity and quality performance standards and meet JC/CMS standards
-  Internal coding quality audits and implementation of risk and compliance tools
-  Provide ongoing coder education
-  Establishment of a uniform coding quality program across the health system
-  Centralization of the HIM and Coding departments into a consolidated model
-  Establishment of consistent performance criteria including productivity, quality levels, and overall adherence to job requirements
-  Enhanced use of technology such as Computer Assisted Coding (CAC) and coding quality tools



## Revenue Integrity overview

### What is Revenue Integrity?

#### Purpose

To promote proactive **billing compliance** with all federal and state regulations

#### Goal

To ensure **accurate and thorough** capture of patient charges which reflect the clinical services rendered

#### Benefits

- Capturing the **true cost of care** associated with services provided
- **Accurate reporting of prices and procedures** associated with 3rd party requirements through management of mid revenue cycle master files
- **Enhanced denial prevention** as a result of proactive charge capture issue identification & resolution
- **Patient confidence and satisfaction** that billing outcomes accurately reflect services rendered
- Enhanced **collaboration** between clinical and revenue cycle teams to capture clinical services performed and promote efficiencies within revenue cycle processes

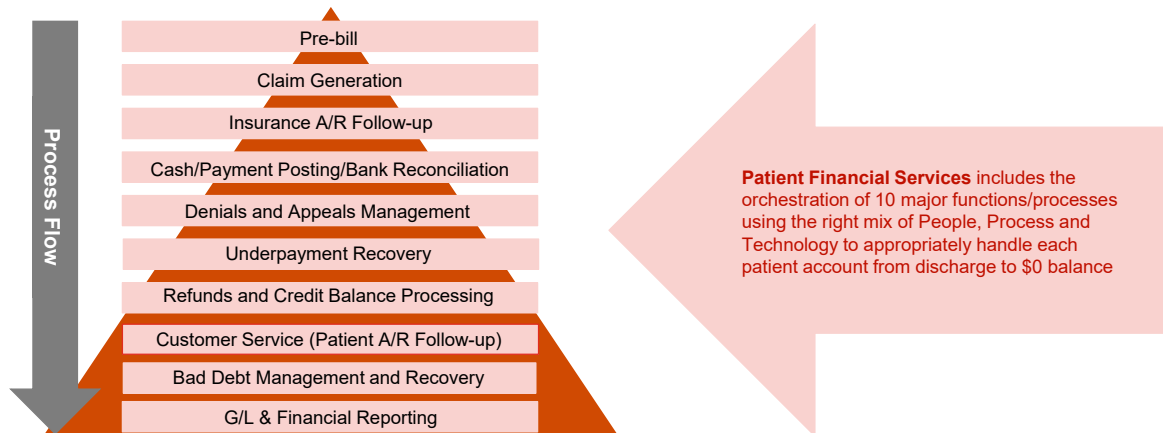


17

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Payment Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## What is Patient Financial Services?

- Patient Financial Services (PFS) relates to the activities which begin at the point the patient is discharged/coded through account adjudication
- Also referred to as Patient Accounts, Patient Business Services (PBS), Billing Office, Consolidated Business Office (CBO) and/or Back-End
- Involves the following departments, functions:



18

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Pre-Bill process

Patient discharged/visit coded	Bill hold	Claim final billed	Claim sent to scrubber	Claim edits corrected	Claim sent to payer	Claim accepted/rejected
<ul style="list-style-type: none"> <li>Post discharge, the patient's service information is compiled (i.e., all charges are posted to the account from the EHR and/or ancillary systems and are based on clinical documentation and coding).</li> </ul>	<ul style="list-style-type: none"> <li>It is typical to have a lag between discharge and final bill to allow for charges to post to the claim (best practice is 3-5 days). This is known as the Bill Hold or Suspense Days</li> </ul>	<ul style="list-style-type: none"> <li>After the Bill Hold, the claim information will typically pass through bill edits on its way to the billing system</li> <li>These claims are housed in the claim scrubber and have not yet been sent to the payer (DNSP)</li> </ul>	<ul style="list-style-type: none"> <li>Claim "scrubbers" are typically 3rd party systems that have current insurance carrier information to identify potential errors or conflicts</li> </ul>	<ul style="list-style-type: none"> <li>Any billing edits shown by the claim scrubber are corrected in order to submit a clean claim.</li> <li>Claims are then transmitted via an 837 to a clearinghouse or direct to a payer</li> </ul>	<ul style="list-style-type: none"> <li>Claims are sent to payers electronically (837) or via hard copy.</li> <li>Electronically submitted claims are transmitted via an EDI or Clearinghouse and are processed faster than paper claims</li> </ul>	<ul style="list-style-type: none"> <li>Claims not accepted by the insurance company for adjudication must be corrected by the provider and resubmitted.</li> <li>There are time limits set forth by payers for providers to resend corrected claims.</li> </ul>

**Discharged Not Final Coded (DNFC):** Where the patient is discharged but the account has not yet been coded. These accounts will remain on hold and not generate a claim for billing

**Discharged Not Final Billed (DNFB):** A coded claim that is still housed in the provider's host patient accounting system. Should be 3-4 days of gross revenue - also referred to as Unbilled A/R

19

19

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Claim Generation process

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**Discharged Not Submitted to Payer (DNSP):** These claims are housed in the Claim Scrubber and have not yet been sent to the payer. Should represent <1% of final billed claims

20

20

### Question #2

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

21

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Insurance A/R Follow-up – Overview

Once a claim is billed and insurance denial / acceptance is received, effective follow-up seeks to bring accounts to full resolution

- Initial claim follow-up begins once a claim is billed, received by the payer and clean claim payer processing time (per contract) has elapsed. Once a claim is billed and insurance denial or acceptance is received, effective follow-up seeks to bring accounts to full resolution
- Resolution is defined as bringing an account to a \$0 balance through:
  - Cash collections
  - Administrative/contractual adjustment
  - Referral to bad debt placement
- Many providers use both in house collectors and outside collection agencies
- Methods of assigning accounts for follow-up include:
  - Aged Account (i.e., over 90 days or based on payer's timely filing period)
  - High dollar amount
  - Payer source (i.e., Medicare, Medicaid, HMO)
  - Alpha split

22

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## Insurance A/R Follow-up – Adjustments

Three common types of insurance A/R adjustments include contractual adjustments, administrative adjustments, and uncollectible write-offs and charity

Three types of adjustments

**1 Contractual adjustments**

- A reduction of total charges based on a negotiated managed care contract rate between a provider and third party payer for services rendered
- The payer is not responsible for reimbursement of charges in excess of their contractual arrangement

**2 Administrative adjustments**

- Adjustments needed to resolve the account and require an explanation (i.e., denials) if a payer reimburses less than the expected amount
- Typically a supervisor review and approval is required

**3 Uncollectible write-offs & charity**

- At times a provider is legally owed the amounts charged to the patient but is unable to collect (self-insured, deductibles, co-insurance, etc.) due to patient lacking sufficient funds

An example

**\$100 – Fee charged by provider for service rendered**

**\$75 – Negotiated rate with payer for service rendered:**

\$60 – Payer owes 80% of the negotiated rate

\$15 – Patient owes 20% of the negotiated rate

The \$25 difference between the fee the provider charges and the negotiated rate is a contractual adjustment

If the payer denies the service and does not pay \$60, the account balance may eventually be adjusted as a denial

If the patient does not pay \$15, the account would eventually be transferred to bad-debt or charity

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23

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## Denials and appeals management - Overview

Denials management involves not just resolution of denials to protect cash flow-but also involves systematic investigation and analysis of denial root causes, trends by payer & services, and redesigning processes & workflows to prevent future risk

**Providers must be prepared to monitor and resolve denials in order to protect the quality of the revenue and sustain cash flow**

- Effective denial management can improve a provider's collections and reduce days outstanding
- Payer denials may also be accompanied by Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARC); providers must review to identify why a claim or service line was paid differently than billed
- Denials can be categorized into two broad categories:

**1 Hard denials**

These denials occur when the payer has denied payment (the full claim is not accepted into the payer's system for processing, or rejected by line-item) that is subject to timely filing limits (TFL) and requires providers to appeal/submit a reconsideration request in order to overturn

**2 Soft denials**

These denials occur when the payer will not pay a claim until the patient or hospital submits additional information or require claim form corrections / resubmissions to process the claim (i.e., missing information)

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24

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Cash and Payment Posting, Bank Reconciliation – Overview

*Cash posting involves accurately applying the payments received to the appropriate patient accounts for reconciliation of the claims- an essential step which if done in an organized and timely manner helps providers get an accurate picture of their daily revenue stream*

- Once a deposit has been received, the final step in the revenue cycle process is to accurately **apply the payment to the appropriate patient account** in the patient accounting system
- Regardless of the transaction category**, the responsibility of the cash posting department is to **accurately post the transaction**, along with any corresponding CARCs and/or RARCs, to the appropriate patient account
- Reconciling cash posted** in the patient accounting system and **cash unable to be posted in the patient accounting system** (i.e., legacy payments, non-patient cash, etc.) **to total cash deposited** is a key responsibility of the cash posting function

**Four common scenarios of the cash posting process:**

<p><b>1 Full payment</b></p> <ul style="list-style-type: none"> <li>Remittance and Payment amounts match = 100% post</li> </ul>	<p><b>2 Partial payment</b></p> <ul style="list-style-type: none"> <li>Remittance does not match Payment - requires manual intervention and research to identify discrepancy and resolve</li> <li>Possible causes: line item denial, payer contract difference</li> <li>Possible actions: manual adjustment for denied services, appeal and resubmission of claim to payer for contract discrepancy</li> </ul>	<p><b>3 Payment and no remit</b></p> <ul style="list-style-type: none"> <li>Account information to post payment is missing - payments are typically posted to a clearing account to post the cash</li> </ul>	<p><b>4 Remit and no payment</b></p> <ul style="list-style-type: none"> <li>Accounts on remittance with no payment are typically documented on a worklist or other follow-up mechanism</li> <li>Once payment is received; the amount is posted and the account is cleared from the pending worklist</li> </ul>
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25

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Underpayment recovery – Overview

*Actively managing underpayments, i.e., payment amounts that are short of expected (calculated/contracted) payment; is important to prevent revenue leakage. This function is a common area for outsourcing to vendors with specialized contract modeling capabilities.*

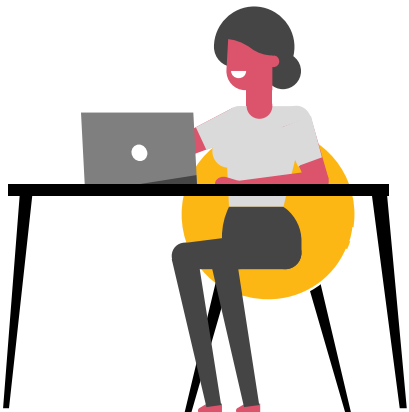
It's important to note that underpayments could be the result of payment amounts that are short of expected (calculated/contracted) payment with no denial from the payer or from a partial denial

**1 Run variance reports**  
These reports are typically run from the contract management system or the patient accounting system

**2 Identify trends**  
Trends by service type (i.e., DRG, CPT, revenue code)

**3 Document trends and underpayment types**  
Documentation is vital for feedback loop to payer and for contract renegotiations (i.e., payer, product,

**4 Pursue recovery**  
Recovery methods are similar to denial appeals, but also more frequently occur in bulk or through arbitration



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26

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Refunds and Credit Balance Processing - Overview

*Credit balance processing seeks to refund any overpayments by patients/payers, or resolution of cash posting errors-to prevent reputational risks and non-compliance related litigation or fines as well as to create a correct financial picture of the provider or practice*

- Credit balances in the provider's Accounts Receivable can be caused by a variety of factors including:
  - Payer or patient overpayment
  - Inaccurate allowable
  - Patient prepayment (unapplied)
  - Late credits
  - Posting errors
- When research on credit balance proves unsuccessful, and the **account is in a credit balance for an extended period**, the monies owed may be **considered unclaimed property by the state**. These statutes (escheat laws) vary from state to state
- All providers participating in the Medicare program are required to complete a **quarterly Report (CMS-838)** documenting all Medicare Credit Balances on the accounts receivable. Medicare requires that these balances be refunded to the patient and/or Medicare within ninety (90) days
  - The CMS-838 is specifically **used to monitor identification and recovery of "credit balances" owed to Medicare**. Providers must submit a CMS-838 within 30 days after the close of each calendar quarter.



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27

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Customer Service (Patient A/R Follow-up) – Overview

*Customer service staff are responsible for following-up with patients to collect outstanding patient financial obligations*

1

**Roles and responsibilities (list not exhaustive)**

- Answering the customer service phone line
- Responding to billing questions and requests from patients
- Accepting payments
- Directing phone calls to other departments
- Opening, scanning, and distributing mail.
- Helping to distribute medical records requested by payers / collectors

2

**Impact**

- Establish / maintain positive relations with patients and financial status of their account
- Ensuring continual progress for reimbursement, (i.e., disputes with insurance, taking patient payments, etc.)

*Note: Customer Service has traditionally been a back-end PFS function; however, Customer Service should also be incorporated into Patient Access operations as well*

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28

Pre-Bill	Claim Generation	Ins. A/R Follow-up	Denials & Appeals	Cash/Pymt Posting	Underpayments	Refunds & Credit Bal	Customer Service	Bad Debt Mgmt.	G/L & Fin Rptg
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## Bad Debt Management and Recovery - Overview

Bad debt management aims to reduce bad debt and related expenses by leveraging recovery services offered by vendors, such as insurance follow up & patient follow up, as well as using proactive approaches to predict & prevent bad debt expenses beyond thresholds

- Often times, hospital business offices lack the time, resources, and technology to handle heavy A/R volumes and hard-to-resolve claims. External resources are contacted to perform the following:
  - Increase efficiency; make more cost effective
  - Reduce aging accounts receivables (resulting in increased amount of staff time and increased costs)
  - Reduce costs to assist hospitals without the resources to add business office staff to work unresolved A/R
- Common vendor types include Insurance follow-up, Self-pay, Bad Debt, Payment plan follow-up and Early-out programs
- Hospitals typically outsource receivables to an Extended Business Office (“EBO”) to support claim follow up for all payers and account resolution
  - Outsourcing accounts receivables is expedient because it ensures rapid incoming cash acceleration



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29

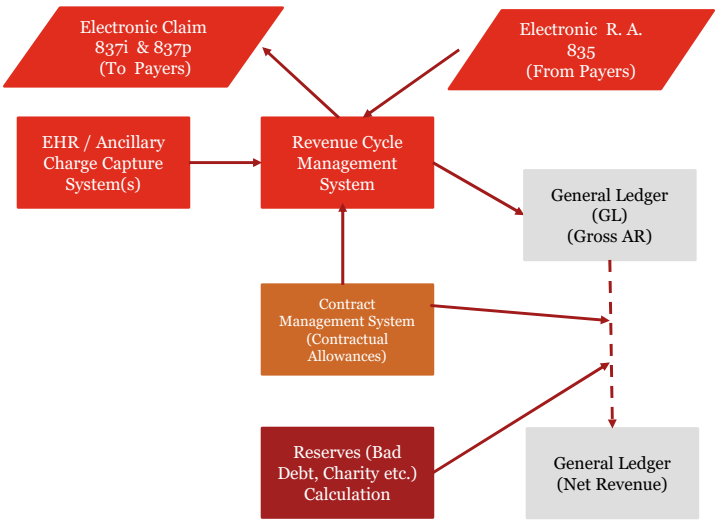
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## General Ledger & Financial Reporting – Overview

A provider’s billing, collection and follow-up activities are interfaced with General Ledger (G/L) as a critical component of the organization’s overall financial reporting. The following is an illustrative example of that workflow:

**Revenue interfaces with General Ledger (GL)**

- Patient charges and claim/payment activity are fed into the Revenue Cycle (billing) system on a daily basis. The **gross charges** and **payment amounts** are “sent” to the GL with volume and dollars typically recorded based on entity, financial class, department and patient type.
- After the bill drops, the Contract Management solution automatically calculates the **contractual allowance adjustment** according to the payer contract terms for the account
- Using specific pre-established estimation methods, the revenue and finance teams will calculate the estimated amounts that will be deemed **‘uncollectible / bad debt’** and/or **‘charity care’**. These are either interfaced to the GL based on adjustment codes or entered as a manual adjustment directly to the GL.



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graph TD
    EC[Electronic Claim 837i & 837p (To Payers)] --> RCM[Revenue Cycle Management System]
    ERA[Electronic R. A. 835 (From Payers)] --> RCM
    EHR[EHR / Ancillary Charge Capture System(s)] --> RCM
    RCM --> GL_Gross[General Ledger (GL) (Gross AR)]
    CMS[Contract Management System (Contractual Allowances)] --> GL_Gross
    RCM --> GL_Net[General Ledger (Net Revenue)]
    Res[Reserves (Bad Debt, Charity etc.) Calculation] --> GL_Net
    GL_Gross -.-> GL_Net
    
```

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30

### Question #3

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

31

Private and Confidential

### Questions?



32



# Thank you

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