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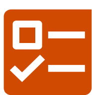
What is the Revenue Cycle?

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

When does is 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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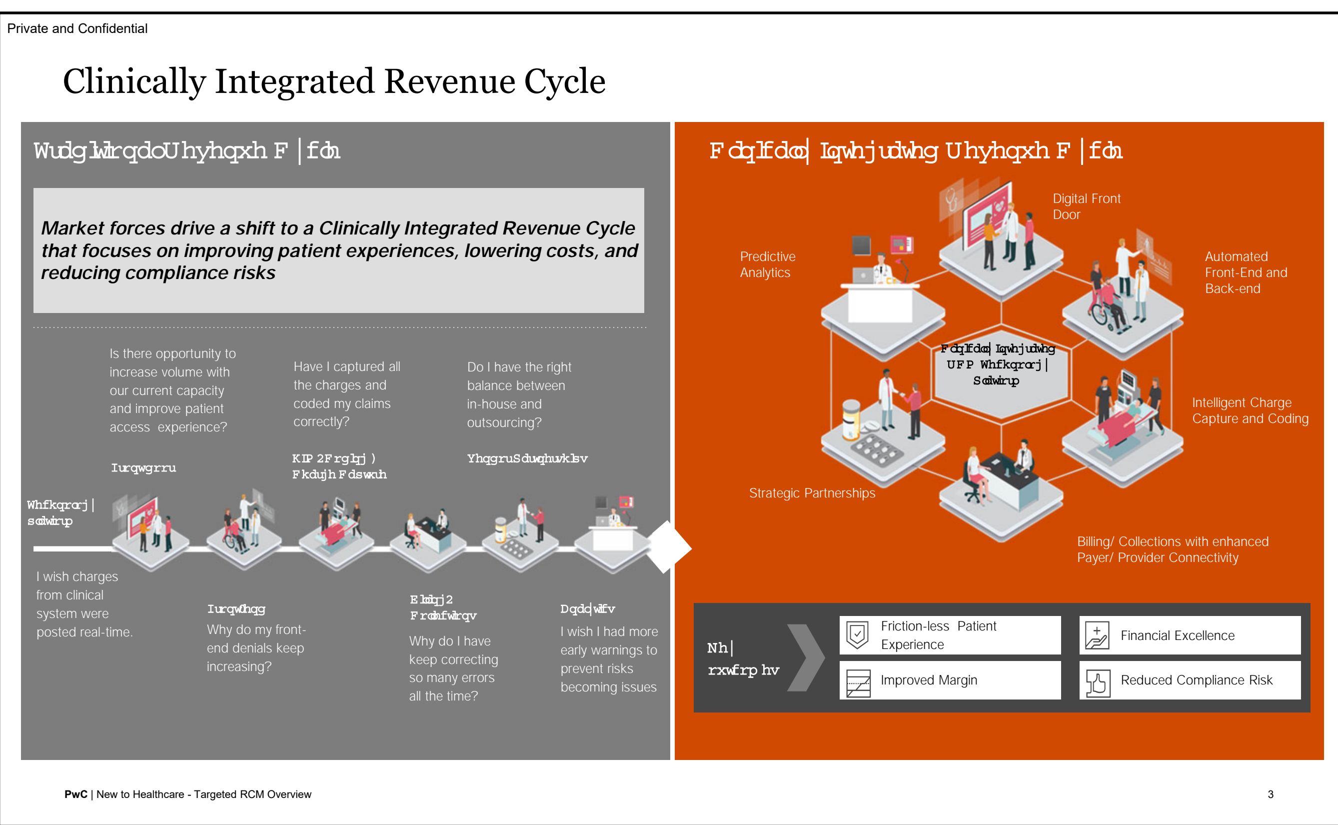

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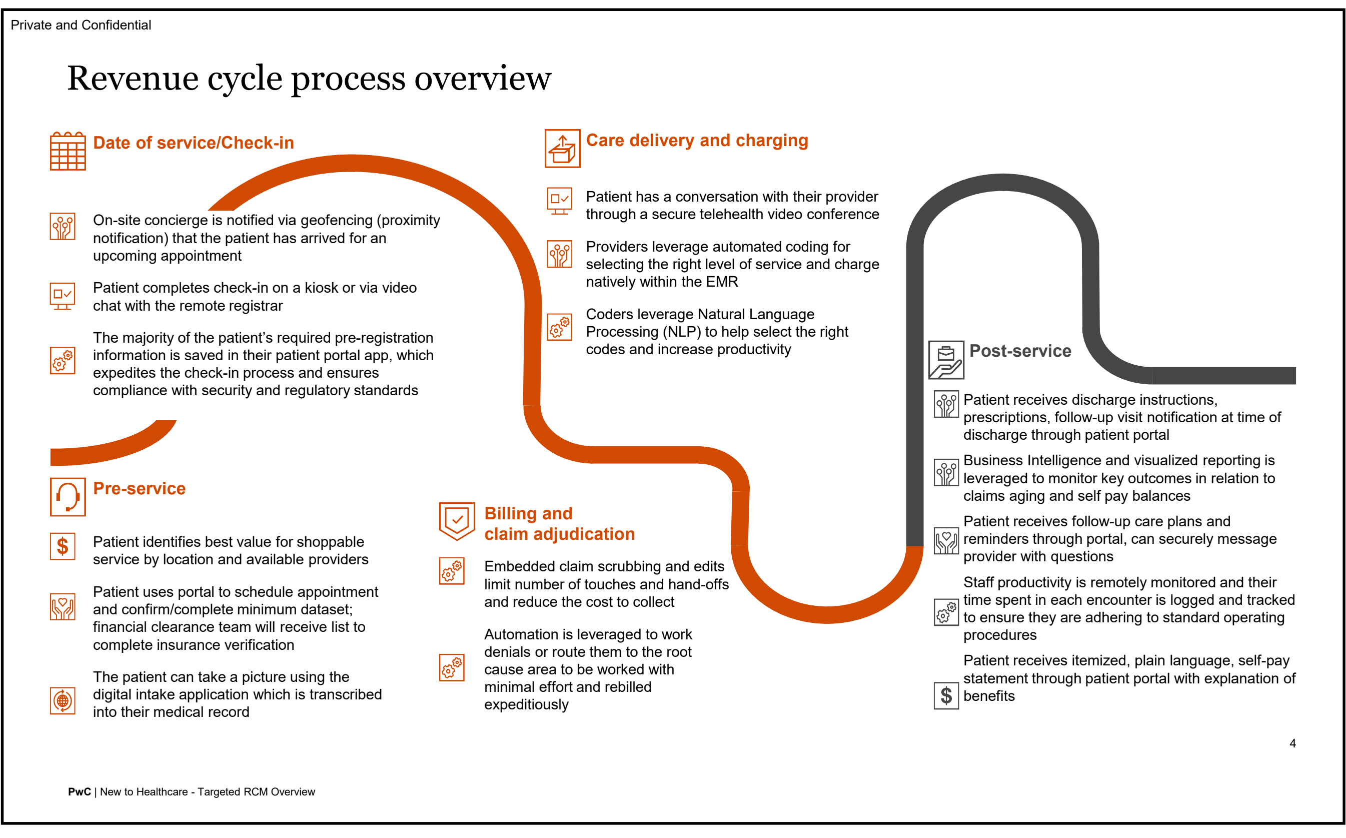

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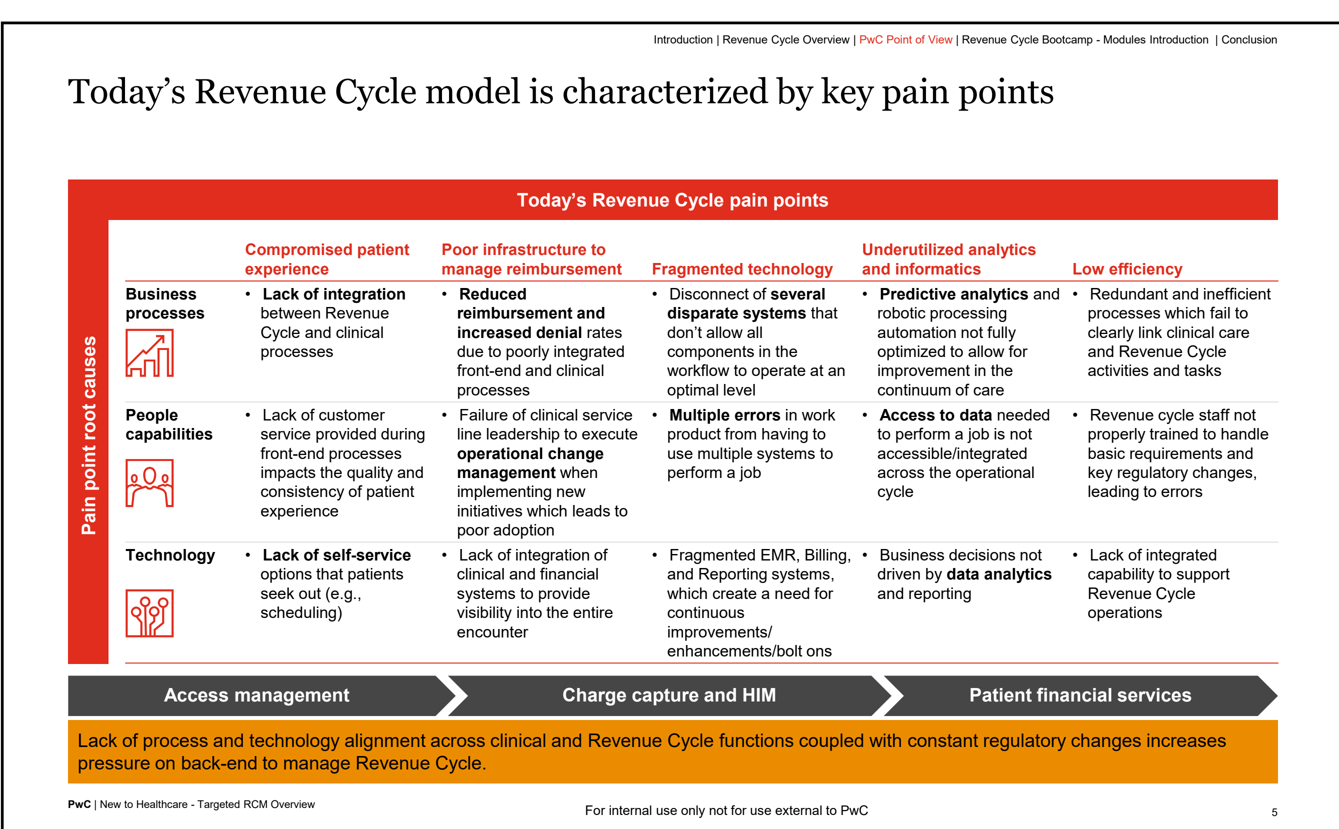

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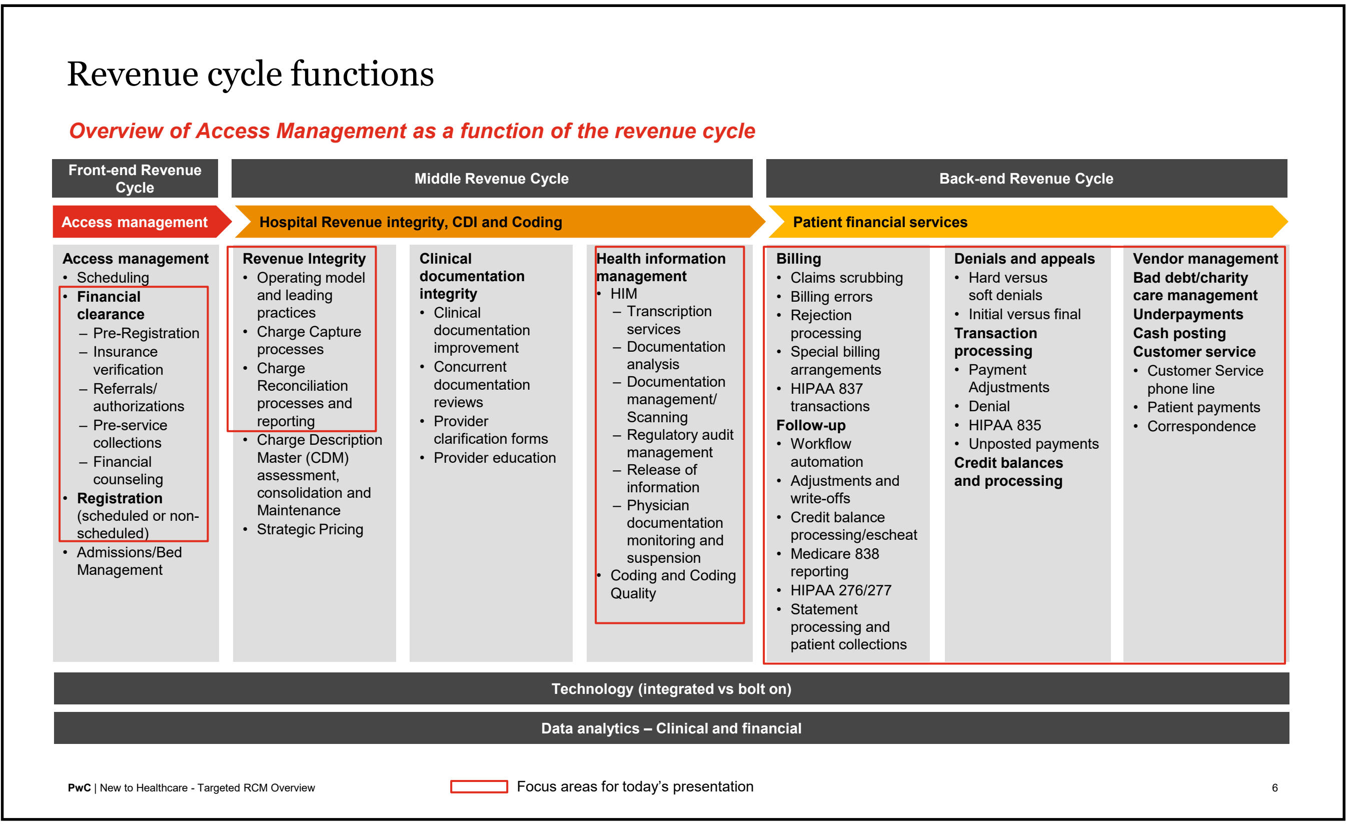

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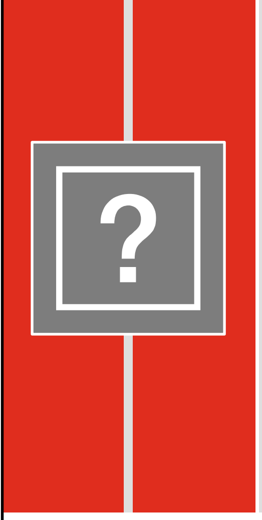
What is access management?



- 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

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.

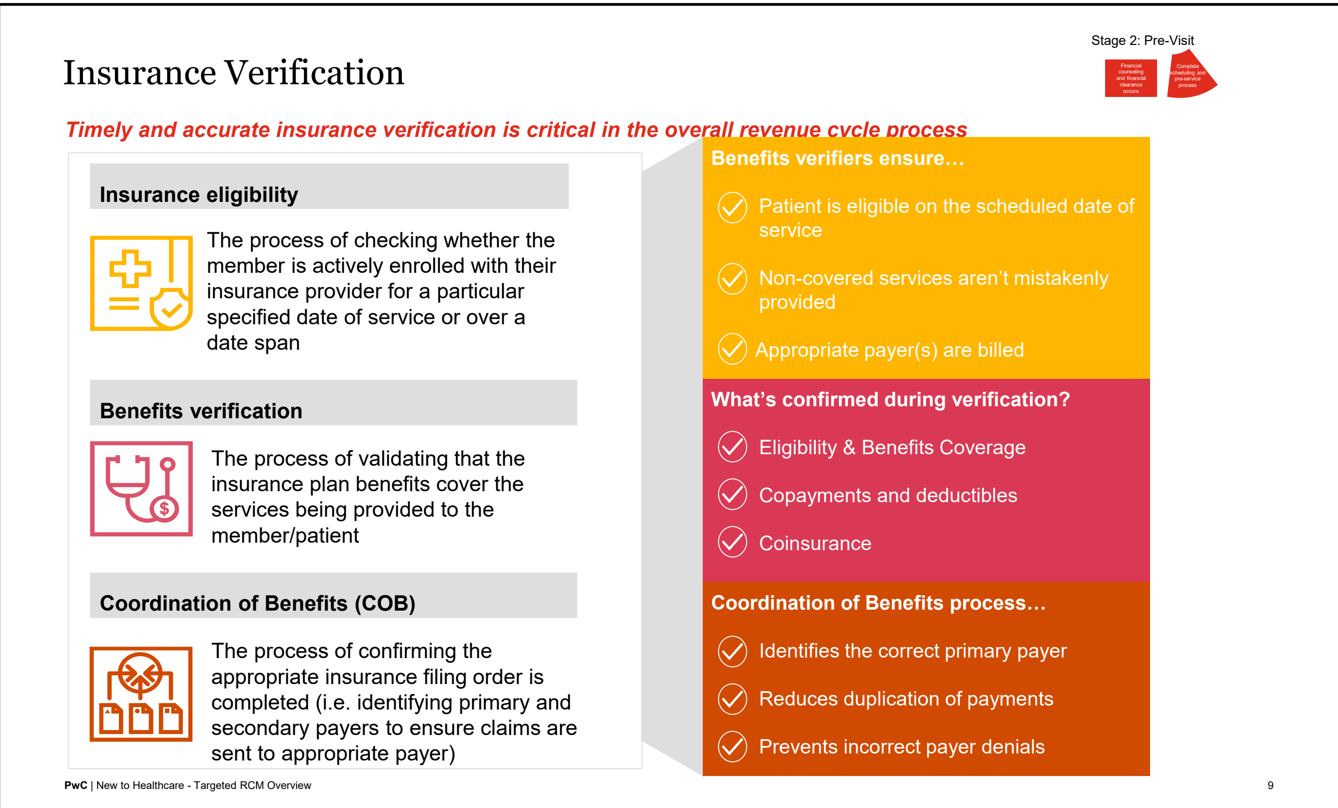
Ambulatory Office Visit patient who is seen at an ambulatory facility, or physician's office, for routine primary services and specialist procedures conducted outside of the hospital setting

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



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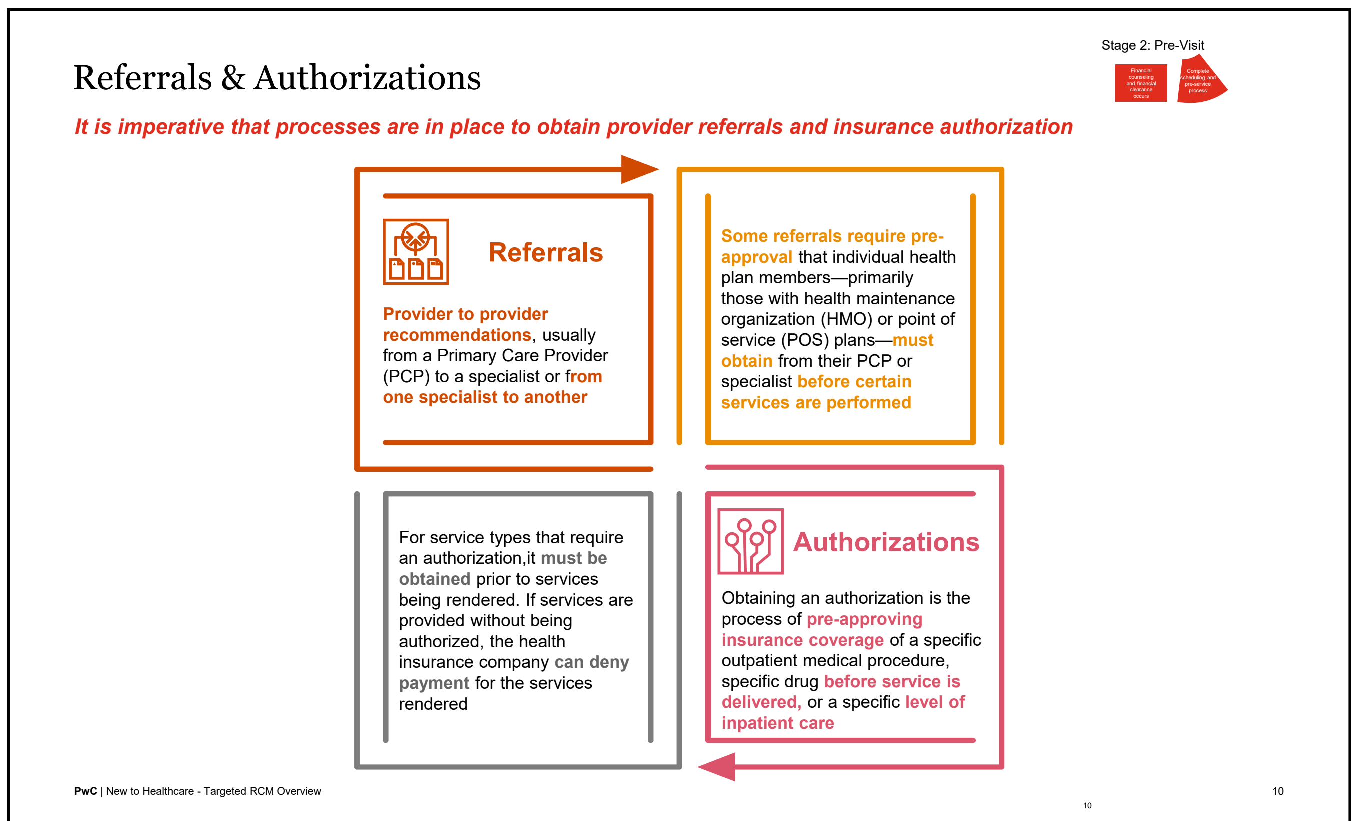

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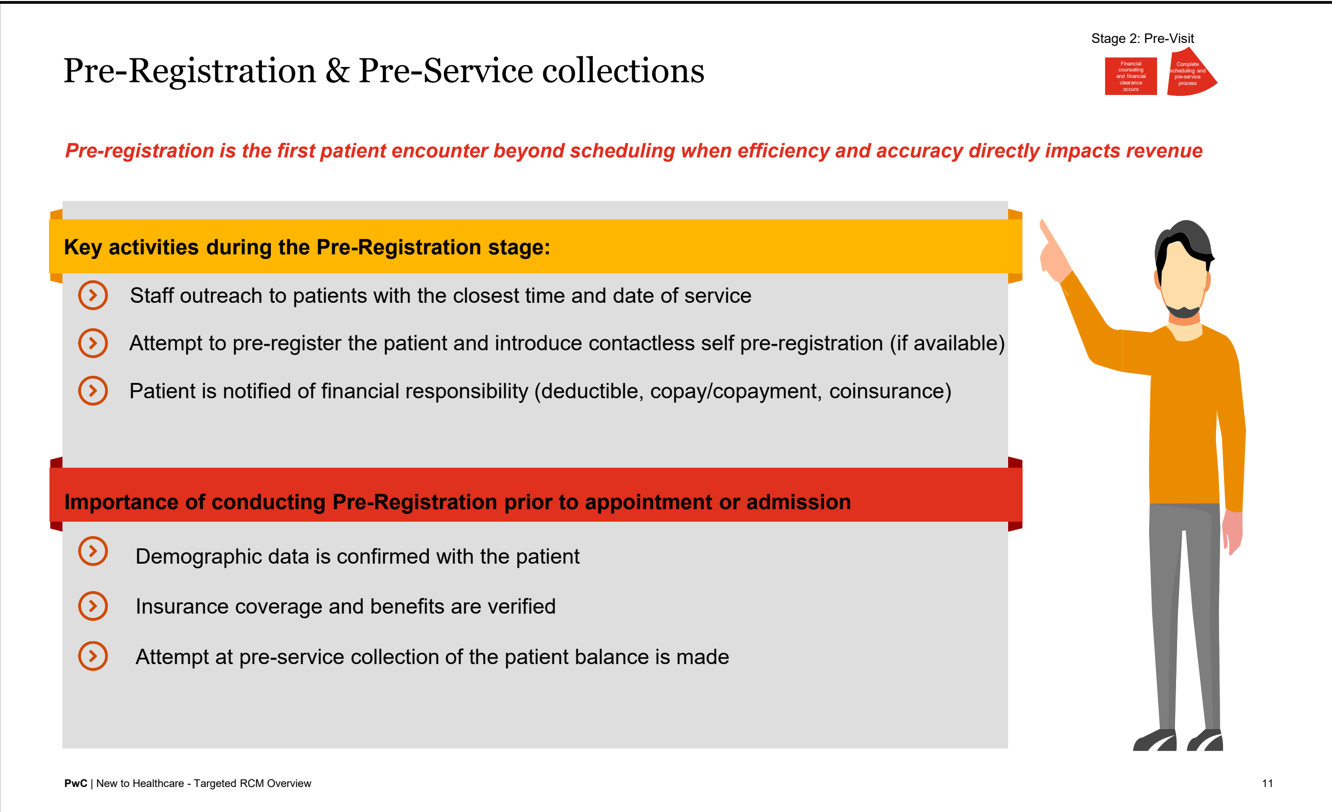

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Stage 2: Pre-Visit

Financial counseling

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

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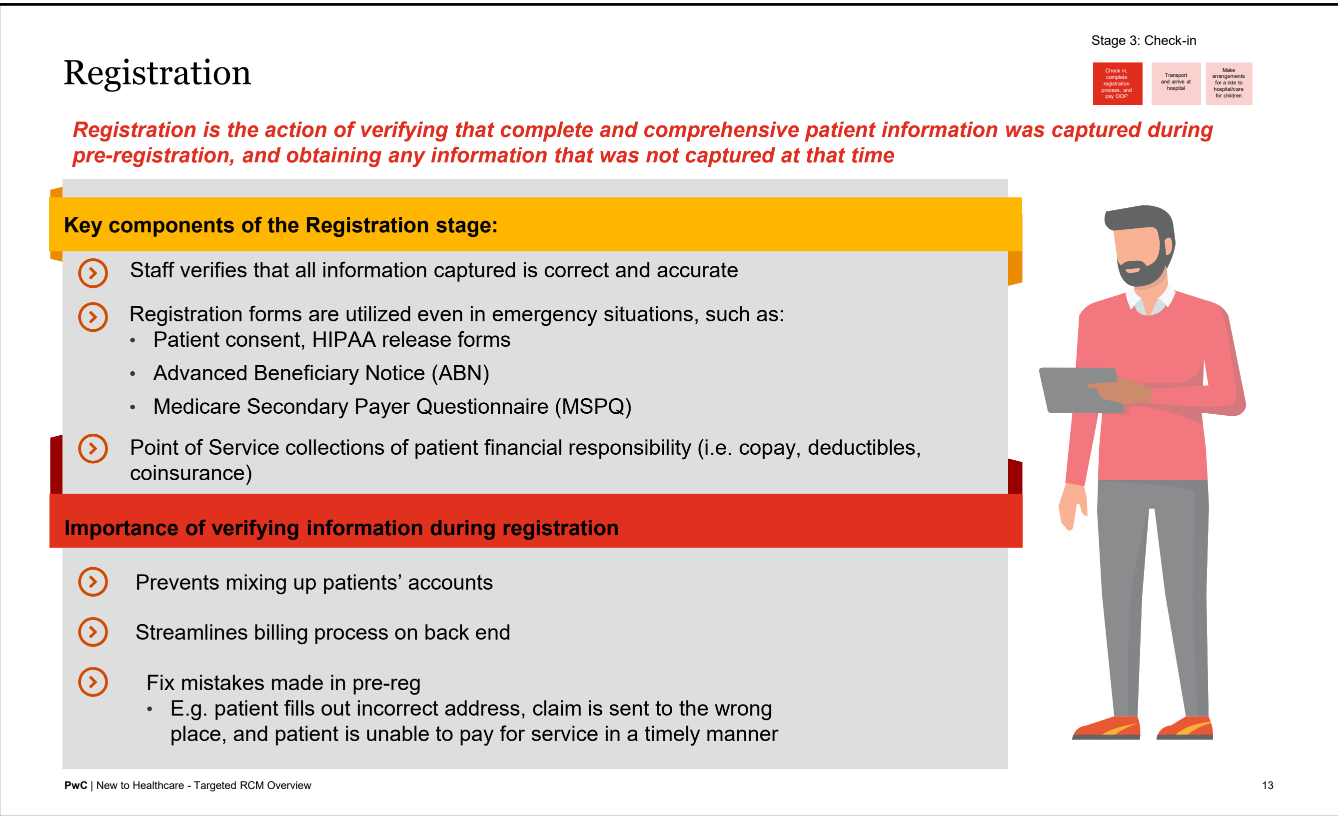

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Question #1

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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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

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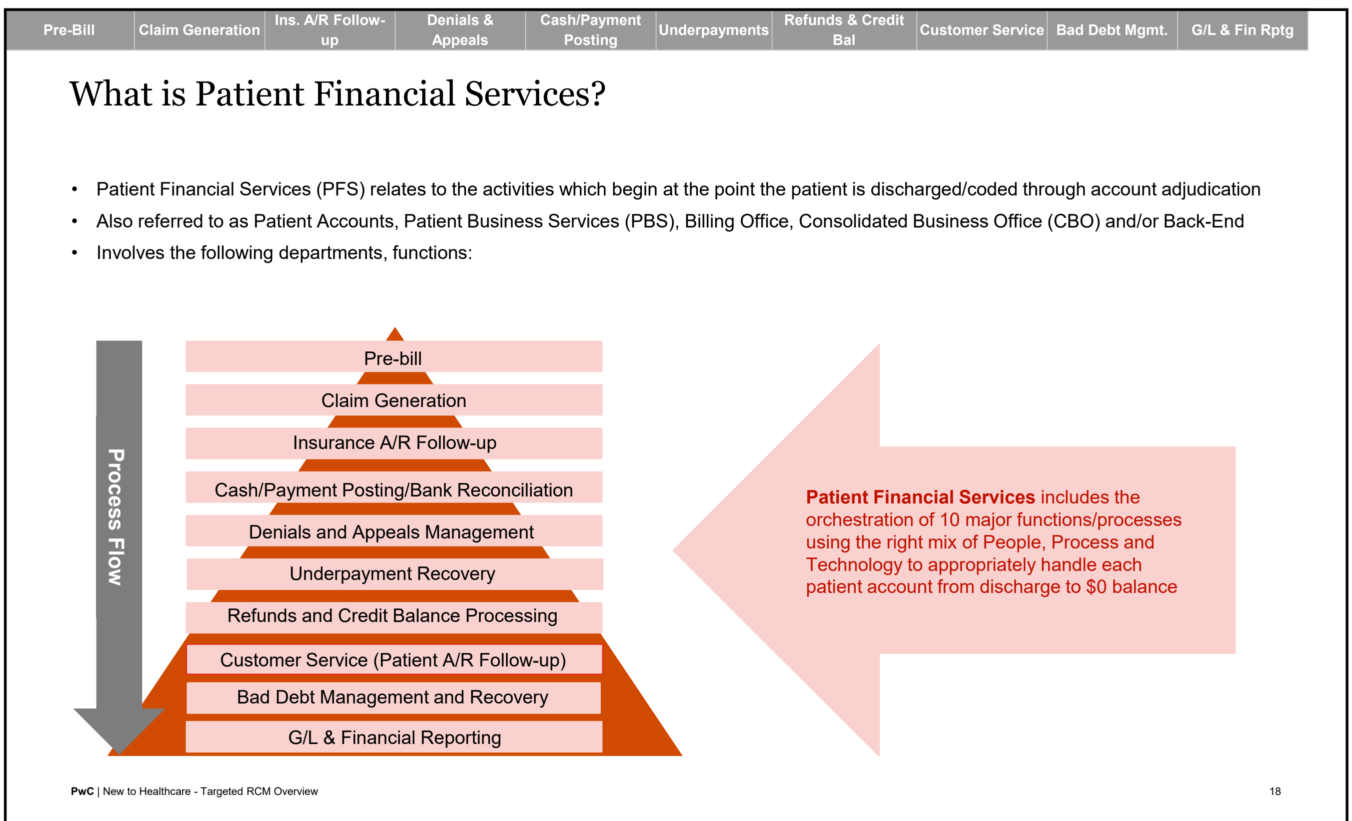

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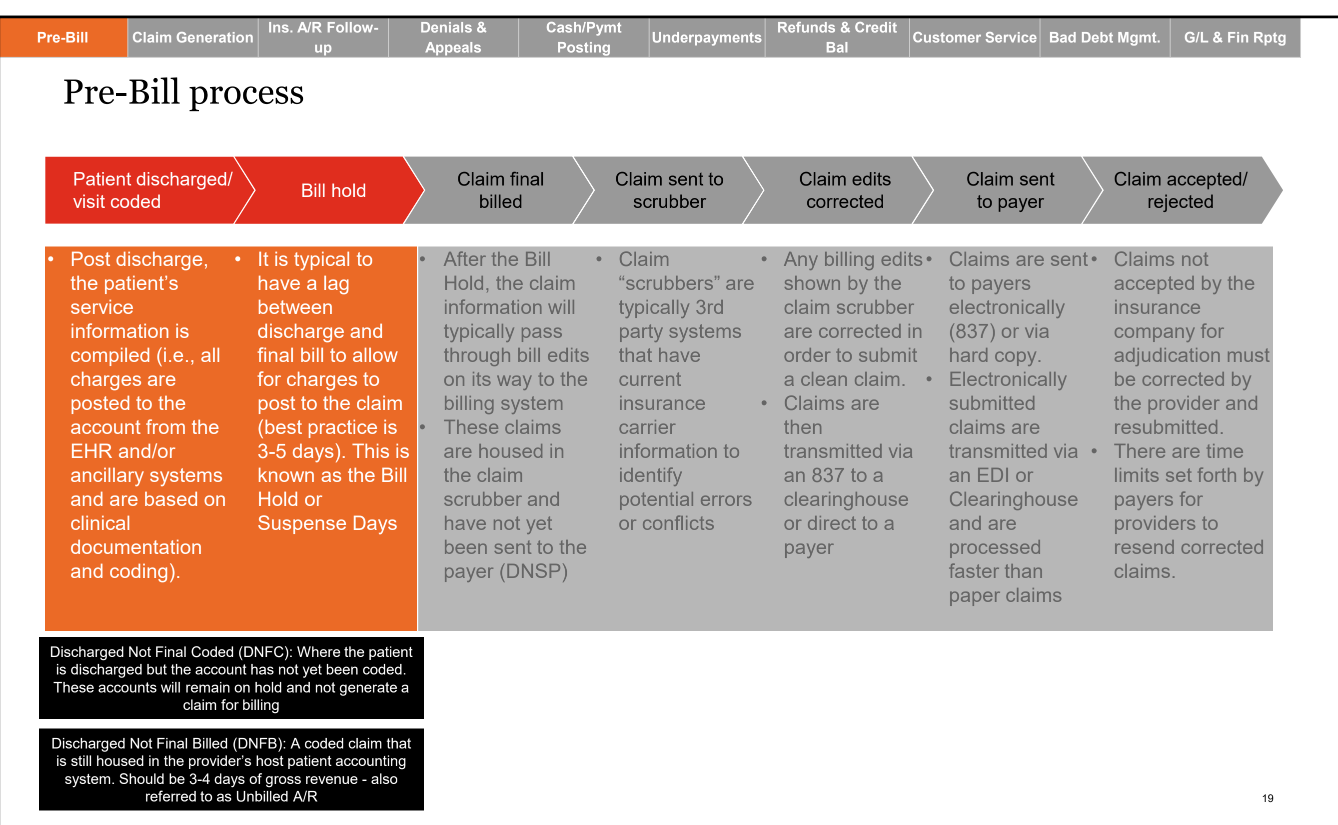
Pre-Bill
Claim Generation
Ins. A/R Follow-up
Denials & Appeals
Cash/Pymt Posting
Underpayments
Refunds & Credit Bal
Customer Service
Bad Debt Mgmt.
G/L & Fin Rptg
Pre-Bill process
Patient discharged/ visit coded
Bill hold
Claim final billed
Claim sent to scrubber
Claim edits corrected
Claim sent to payer
Claim accepted/ rejected
• 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).
• 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
• After the Bill Hold, the claim information will typically pass through bill edits on its way to the billing system
• These claims are housed in the claim scrubber and have not yet been sent to the payer (DNSP)
• Claim "scrubbers" are typically 3rd party systems that have current insurance carrier information to identify potential errors or conflicts
• Any billing edits shown by the claim scrubber are corrected in order to submit a clean claim.
• Claims are then transmitted via an 837 to a clearinghouse or direct to a payer
• Claims are sent to payers electronically (837) or via hard copy.
• Electronically submitted claims are transmitted via an EDI or Clearinghouse and are processed faster than paper claims
• Claims not accepted by the insurance company for adjudication must be corrected by the provider and resubmitted.
• There are time limits set forth by payers for providers to resend corrected claims.
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
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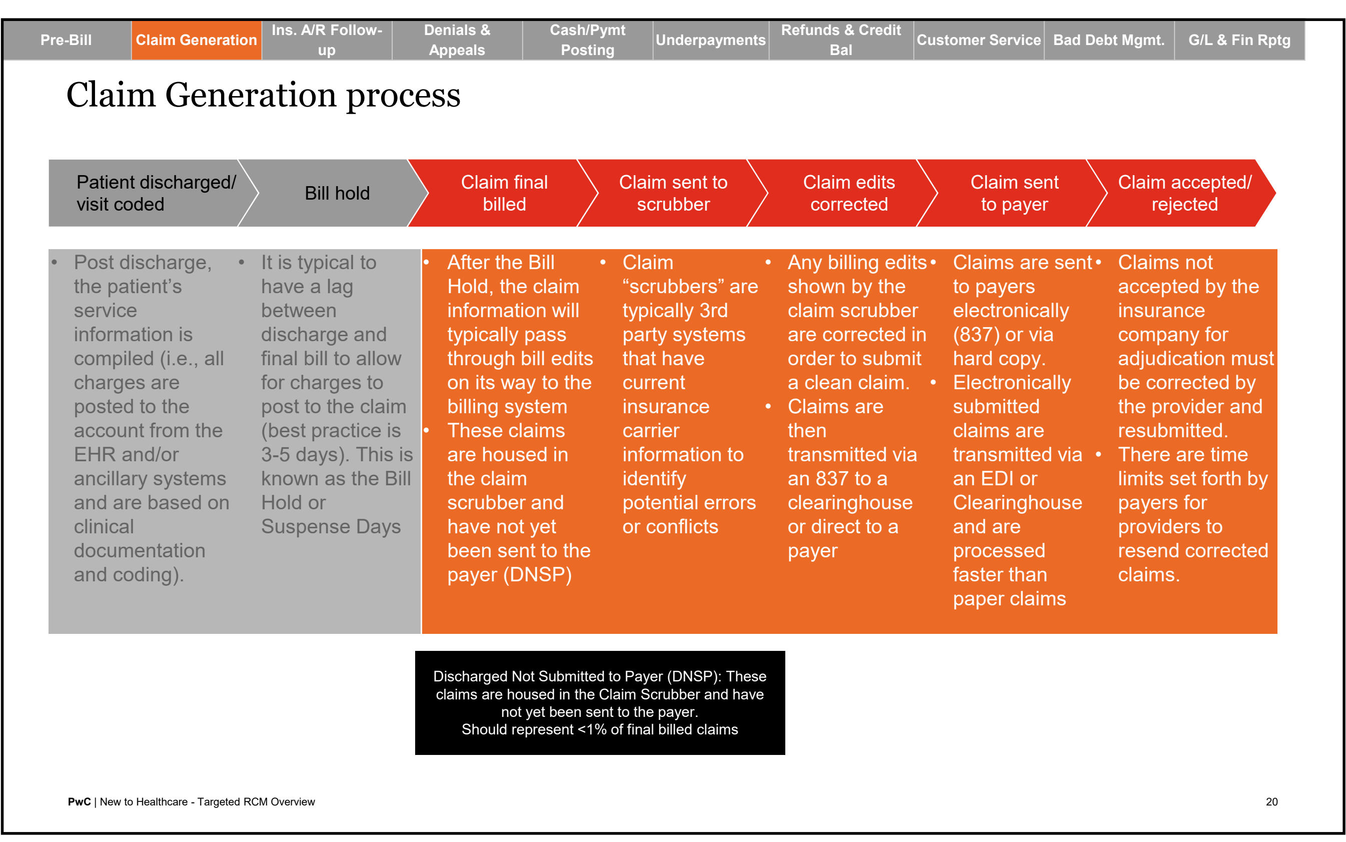
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• It is typical to have a lag between discharge and final bill to allow for charges to post to the claim (best practice is 3-5 days). This is known as the Bill Hold or Suspense Days
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• These claims are housed in the claim scrubber and have not yet been sent to the payer (DNSP)
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• Claims not accepted by the insurance company for adjudication must be corrected by the provider and resubmitted.
• There are time limits set forth by payers for providers to resend corrected claims.
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
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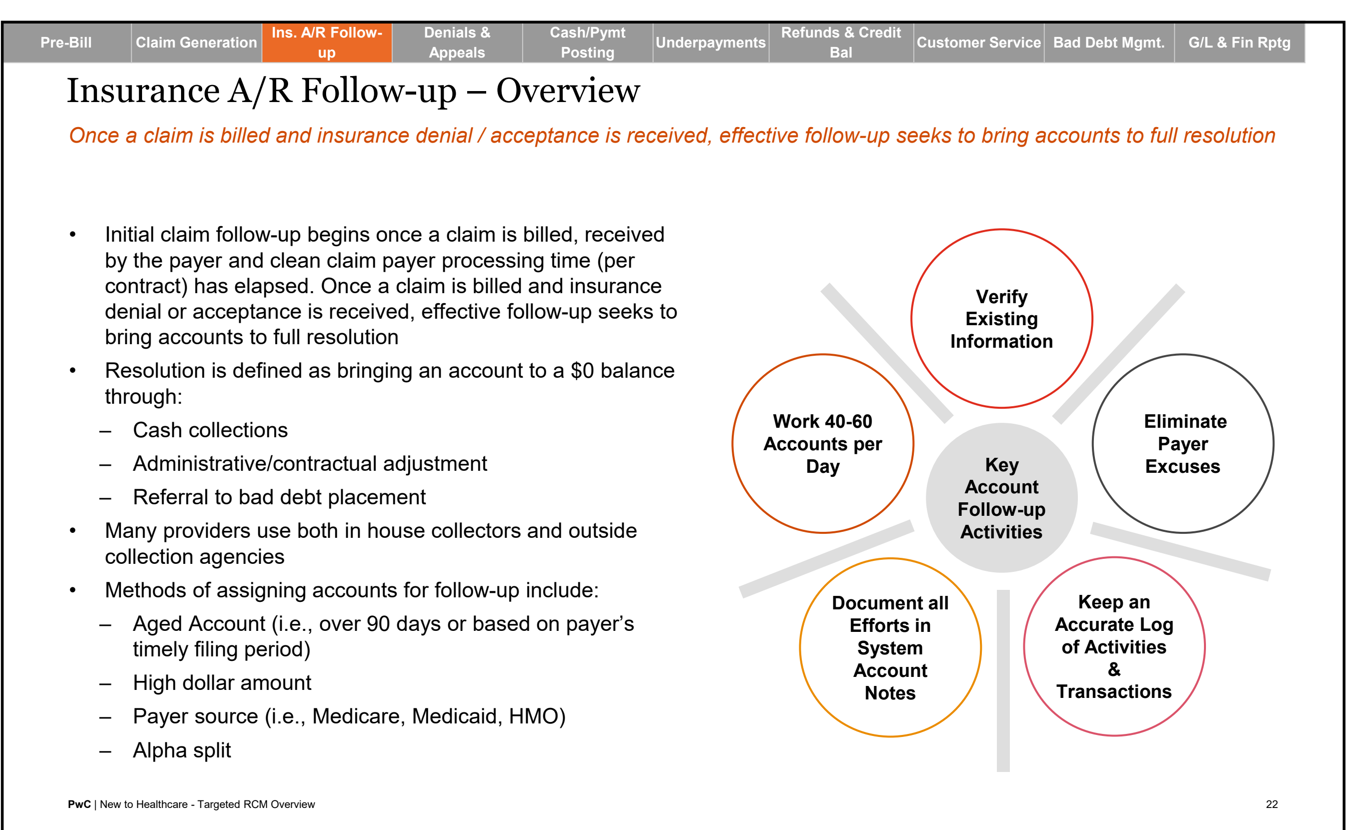
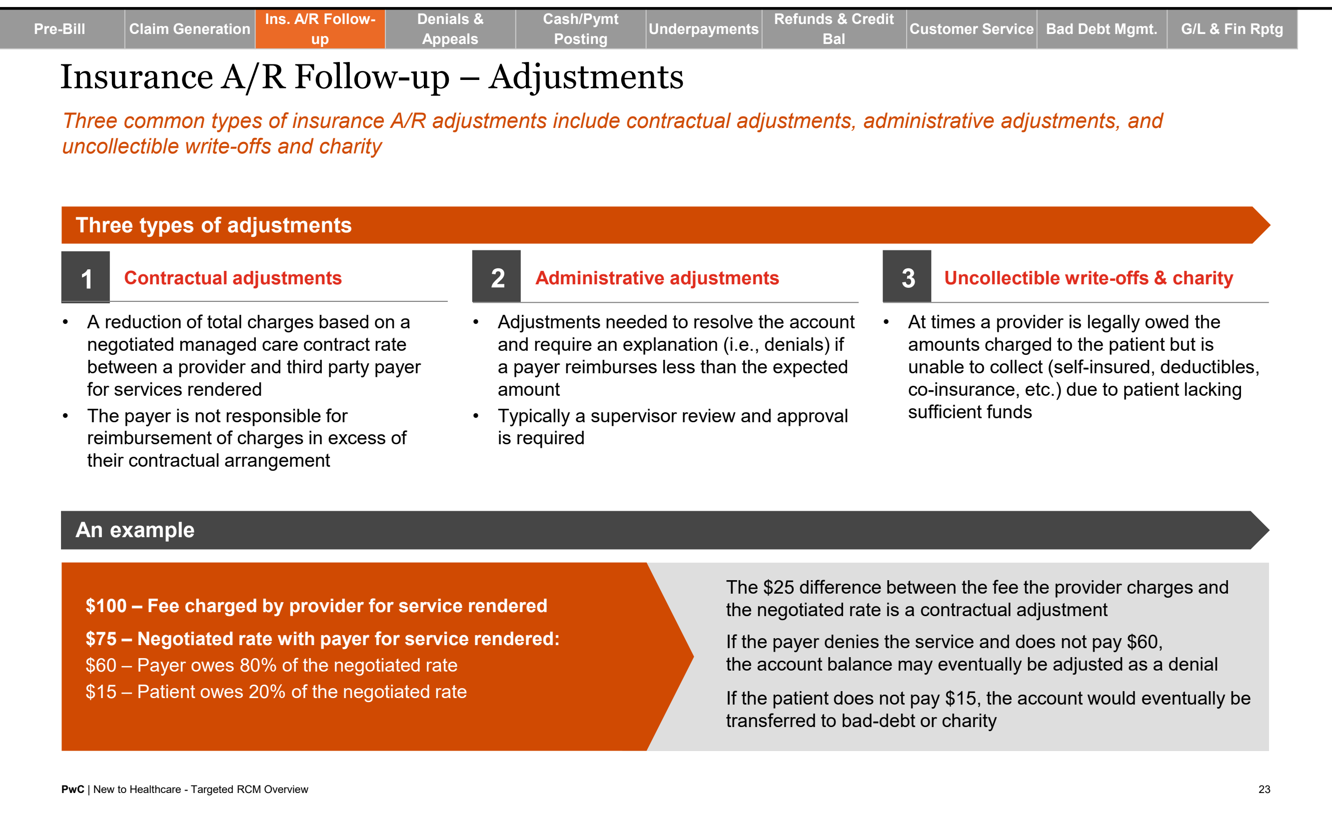
Question #2

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





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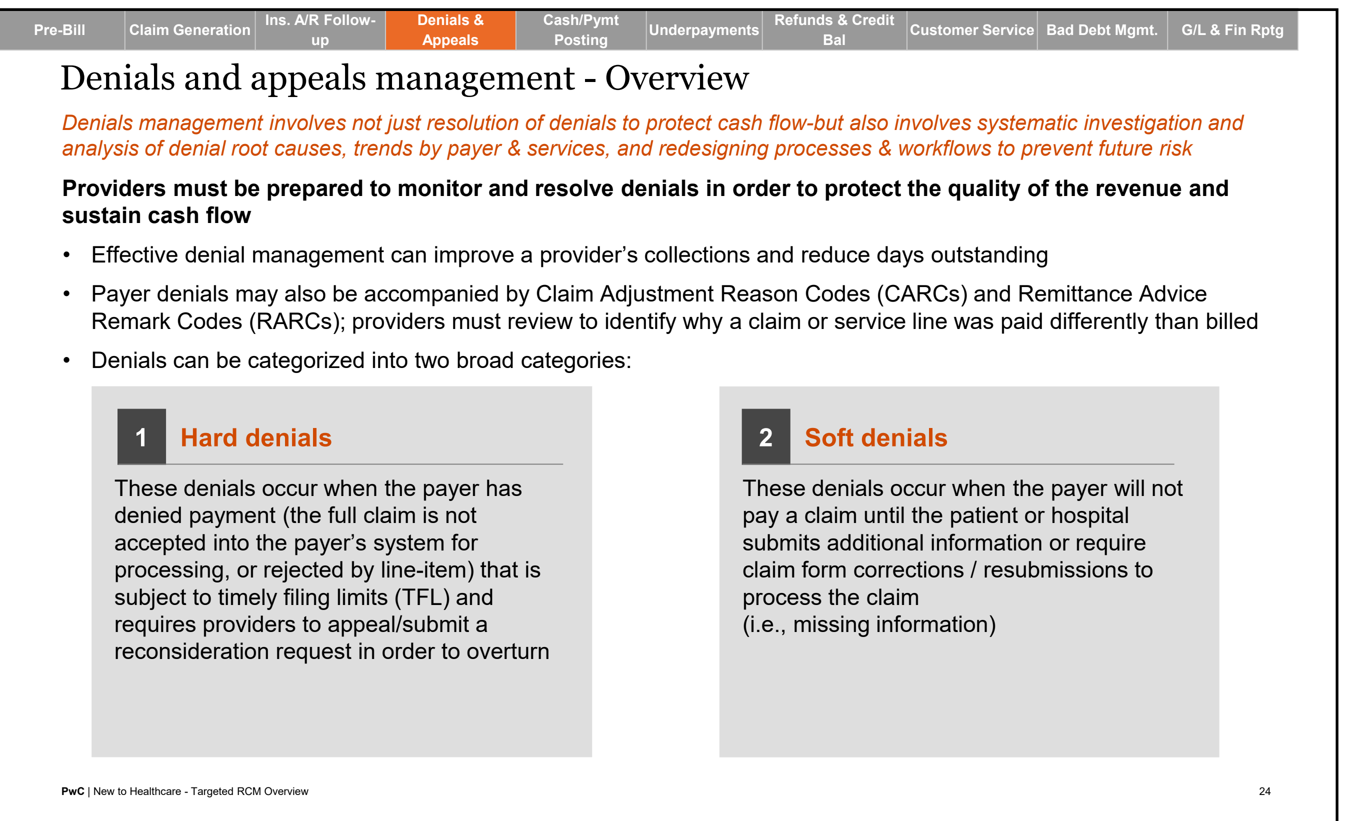

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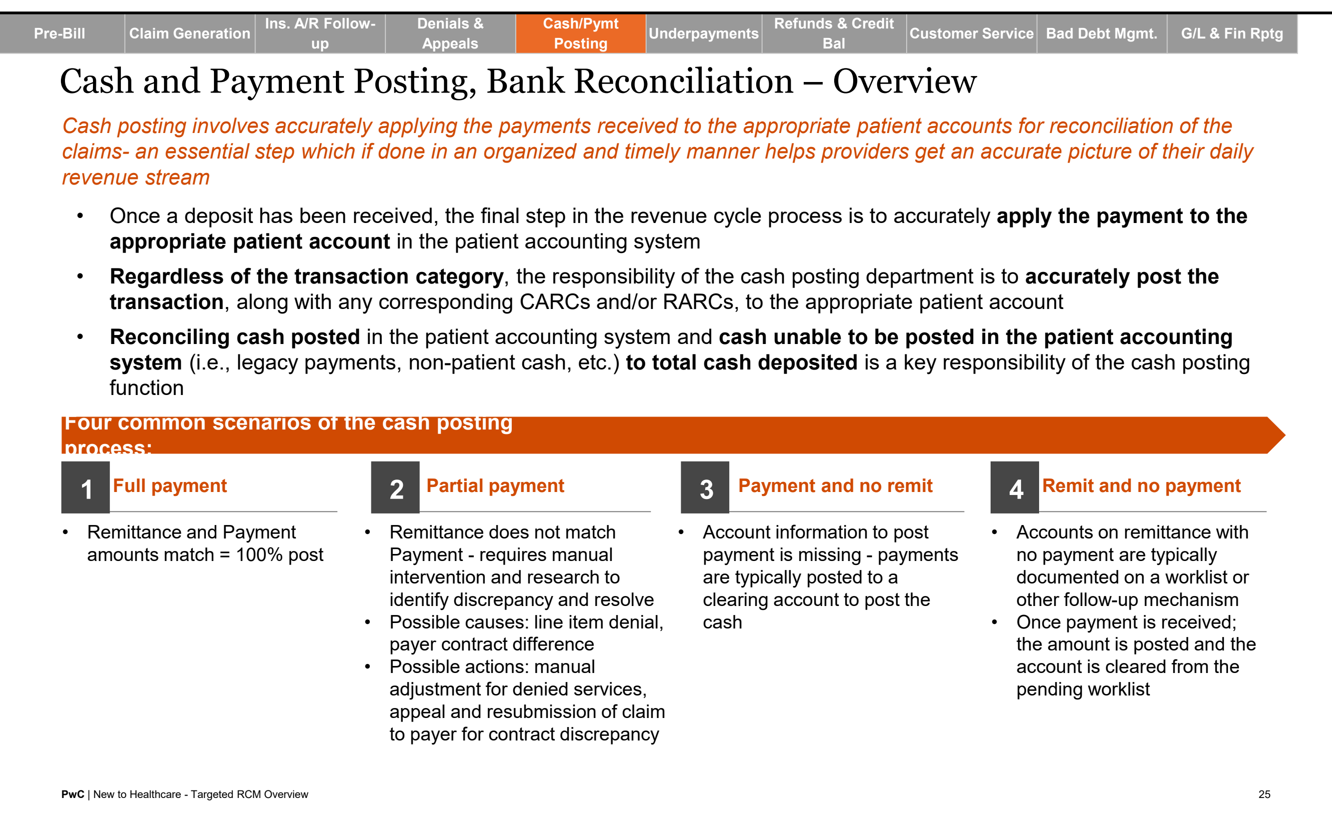

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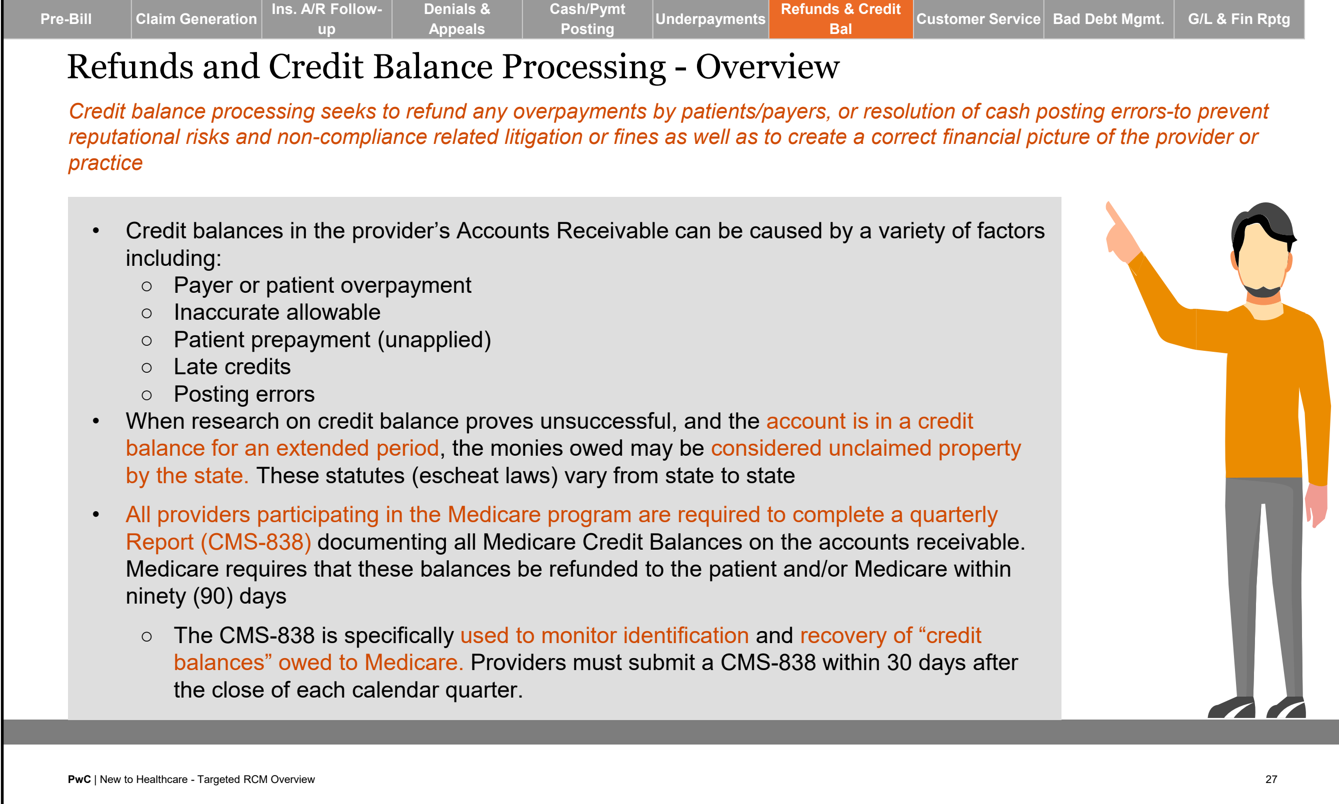

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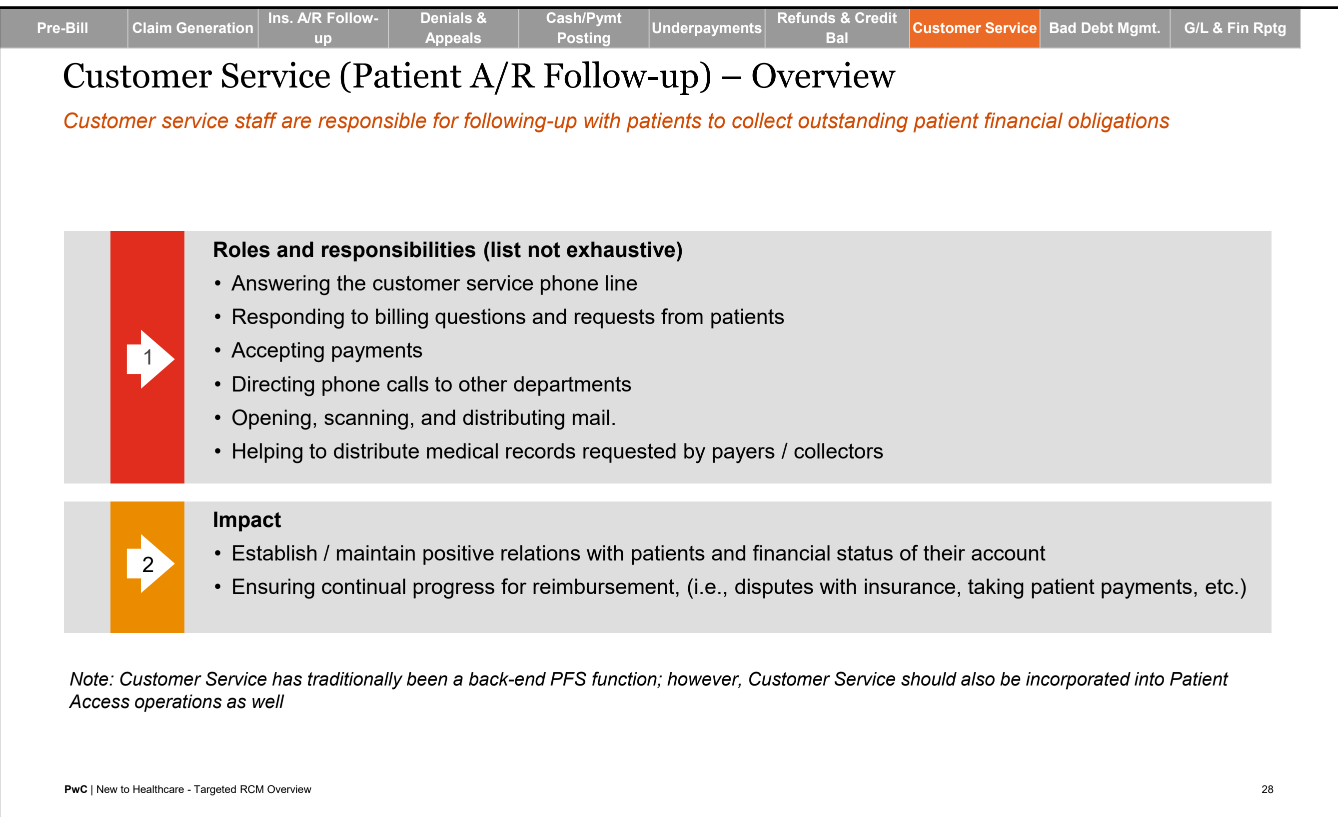

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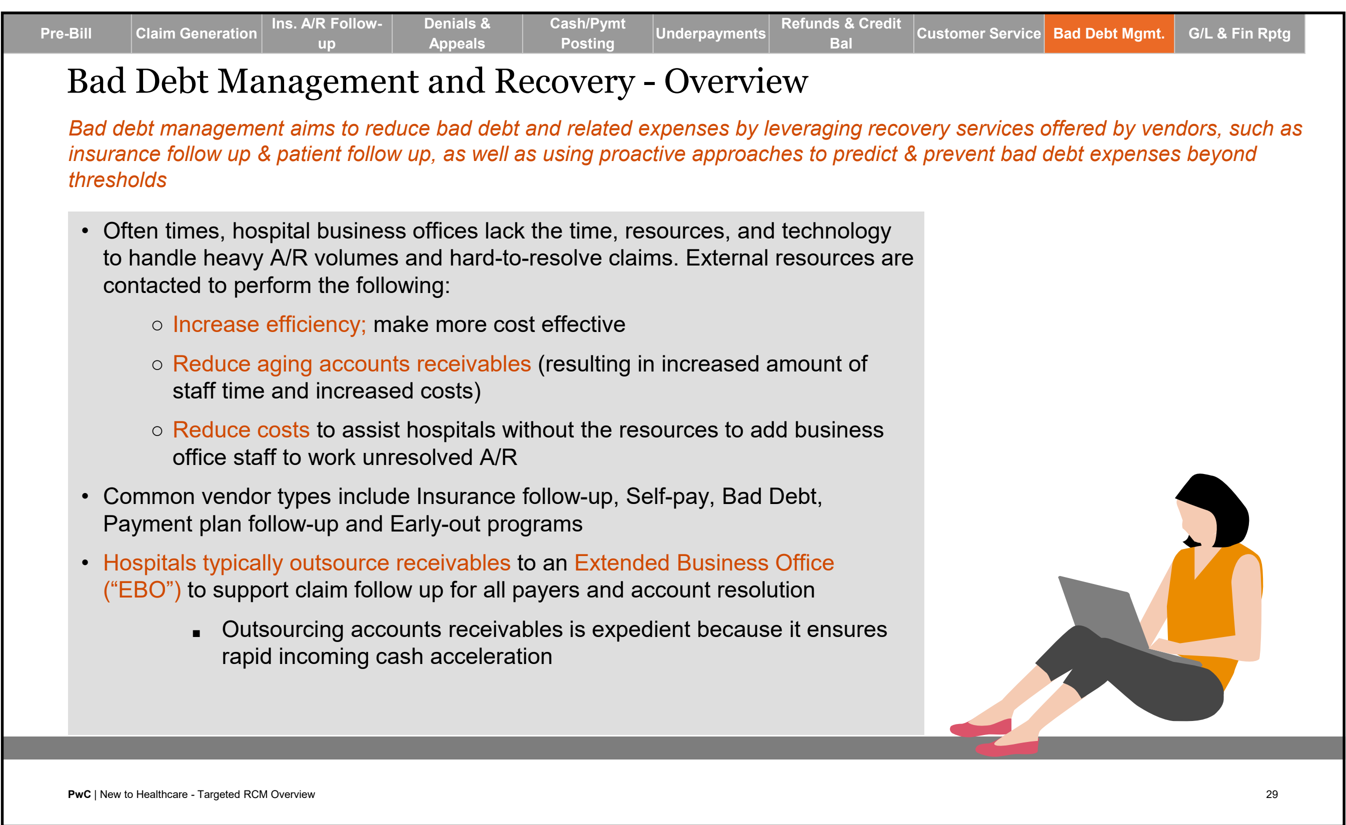

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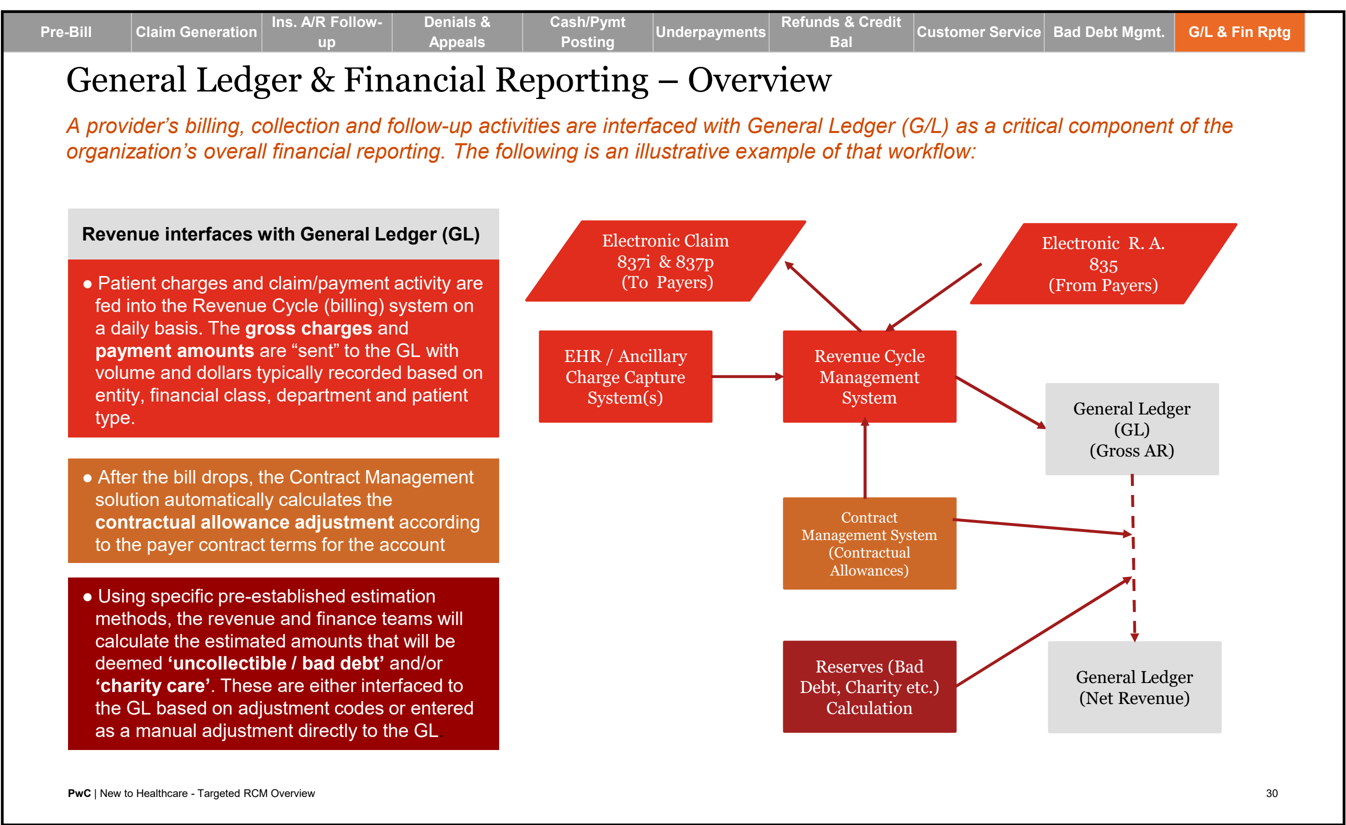

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Question #3

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

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Questions?

Thank you

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