

Give Your Revenue Cycle Engine a Tune-up



Developed by Megan Smith
Executive Director of Quality and Training
msmith@hrgpros.com
509.789.6656



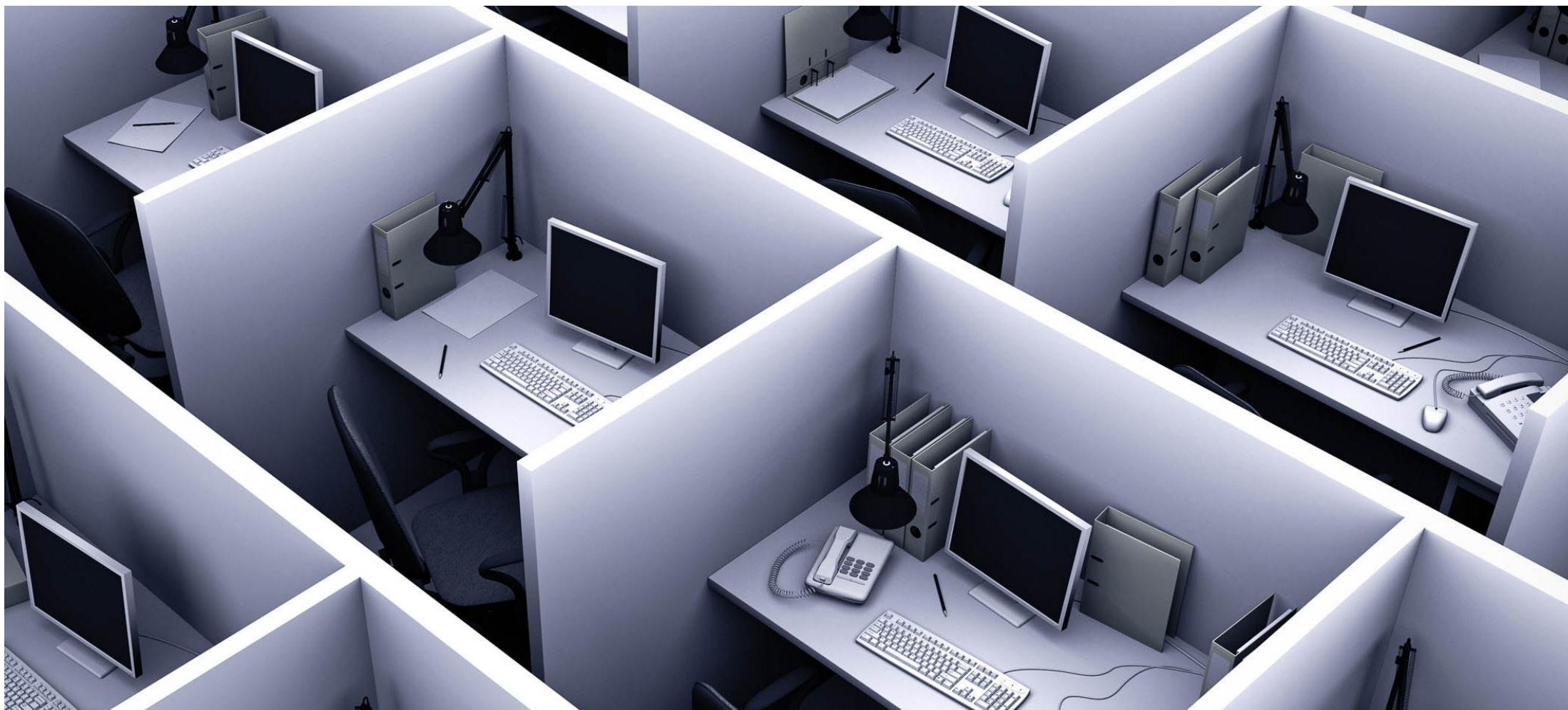
During this session participants will...

- learn best practice methods to prevent denials, increase cash collections, and keep collectors productive and engaged

By the end of this session, attendees will...

- know how to identify risk areas in their current workflows and how to address issues using action plans
- be able to develop a training plan for implementing new processes and workflows







People

- Training
- Policies & Procedures
- Quality program
- Consistent PIP workflow
- Establish/enhance feedback loop
- Recognition program



Receivables

- Denial Prevention
- EDI edits
- 835 mapping
- Fix workflows
- IT Collaboration
- High dollar team
- Escalation team
- Regular RCA



Payers

- Monthly scorecard
- High dollar meetings
- Accountability
- Payer edits
- Fine-tune contracts
- IDR workflow (NSA)

Billers Have the Answers: Take the Time to Listen



Regular 15 min huddles



Bi-weekly 1:1 meetings



SharePoint form for suggestions/barriers



Quarterly staff surveys



Manager/Director lunch dates with staff

Implement a Quality Program

- Get Started/Fortify Existing Foundation
 - Gather data: staff and leadership surveys, productivity reports
 - Consider kaizen event or town hall type meeting
- Define what's important (don't sweat the small stuff)
- Gain buy-in
- Be intentional and transparent

Held 4 Two-Hour Sessions

Structured Agenda

Assumption busting

Emotional experience

What brings them value



Update Existing Materials or Create New Ones

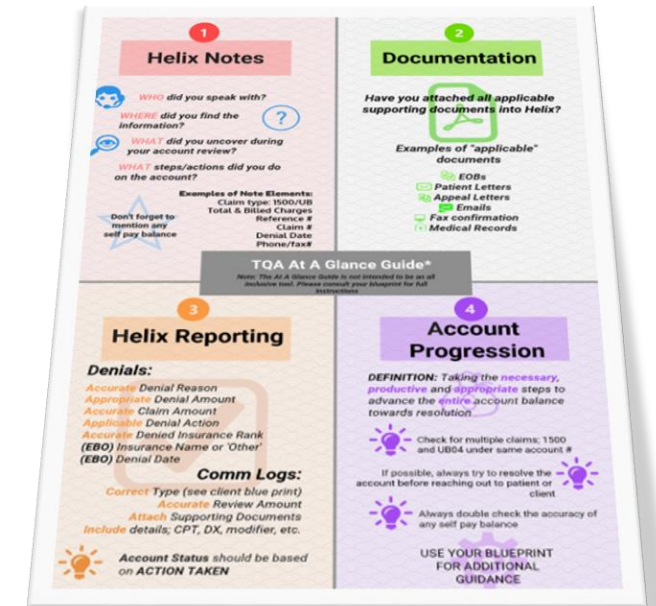
- Procedures, blueprint
- Infographics, training documents/presentations

Over-Communicate the Changes

- Multiple virtual presentations
- Join team/leadership meetings
- Laminated At a Glance document for all staff

Maintain the Course

- Follow rollout timeline
- Monitor scores closely/adjust program
- Developed reporting





No LMS? That's OK!



Use existing Microsoft tools to push out training



Up-coaching doubles as new hire training



Include slide with passion/mission

Advanced Beneficiary Notice (ABN) Workbook

SECTION 1: Introduction

An Advance Beneficiary Notice (ABN), also known as a waiver of liability, is a notice a given to the patient before receiving a service if, based on Medicare coverage rules, the provider has reason to believe Medicare will not pay for the service.

The ABN allows the patient to decide whether to get the care in question and to accept financial responsibility for the service (pay for the service out-of-pocket) if Medicare denies payment.

Quick facts about ABNs:

- ABNs are given when a patient has original Medicare- not if when the patient has enrolled in a Medicare Advantage Plan
- Used for outpatient services only; inpatient non-covered services use different form
- Providers are required to issue an ABN to patients prior to services
- ABNs cannot be given to patients under duress or require emergency treatment
- A standard ABN format must be used and can be downloaded from CMS website
- ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used

SECTION 2: Provider Requirements

Providers/notifiers are required to complete the top section of the form with required information in order for the patient to make an informed financial decision for their care. Information must be complete and legible; if information is missing, Medicare may deem the ABN form void.

At the top of the form are sections intended for the provider or notifier to complete. Beginning with a description of the procedure then the reason why the provider/notifier believes Medicare will deny payment.

For example, if the provider is ordering a lab test not covered on an annual basis the ABN might say, "Medicare only pays for this test once every three years." The provider/notifier must also include the estimated cost of the procedure.

Front-End Training

Don't overlook the obvious

Workshop / Team
participation

Role play and scripting

Quiz to reinforce

Great Patient Care Begins at Registration

SECTION 1: Introduction

Collecting initial information is just the beginning in an integrated revenue cycle. Doctors may get the lion's share of credit for helping patients, but everyone plays a role in providing quality care and are usually the patient's first interaction with the healthcare system.

Below are just a few key functions of a front-end registration department:

- Registration,
- Scheduling,
- Outpatient pre-authorization; and
- Hospital switchboard services

The patient registration process is instrumental to a healthcare organization. A positive patient experience that starts at the registration encounter.

Is the office or lobby organized? Are staff friendly? Are the registration process clear? These aspects of the registration process can lead to short wait times and simple tasks that do not require a lot of resources.

Over the years, patient registration has become a critical part of patient data input, including:

- Collection of patient demographic information
- Patient referral or appointment scheduling
- Collection of patient health history
- Checking of health payer coverage
- Patient orientation

If handled incorrectly, this series of initial touchpoints can lead to overwhelmed patients who may decide not to pursue care.

SECTION 5: Understanding Types of Insurance Plans

Over the years, the healthcare industry has seen a growing number of insurance companies offering different benefit plans, each with unique benefit levels and requirements. It's also common for larger insurance payers to administer more than one line of business.

Understanding the difference between an insurance "payer" and "plan" is important information during registration. Below is a diagram illustrating various levels of insurance.



Think about an insurance payer that offers multiple types of insurance plans. The figure below with your answer.



ABC INSURANCE PARTNERS		PPO
1) Policy Number	356M59557	3) Office Visit Copay: \$15
2) Group Number	1234567	Specialist: \$15
Group Name	XYZ COMPANY	Emergency Room: \$150
Member Name	SUSAN J. SAMPLE	Urgent Care: \$50
		Rx: \$10/20/40
		Network Coinsurance:
		5) In 90%/10%
		6) Out 80%/20%
		Med/Rx Deductible Applies

Using the card example above, let's identify the type of information listed

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

What is the co-pay amount for an in-network office visit? _____

Is there a coinsurance amount for in network? _____

If so, what is the percentage the patient will have to pay? _____

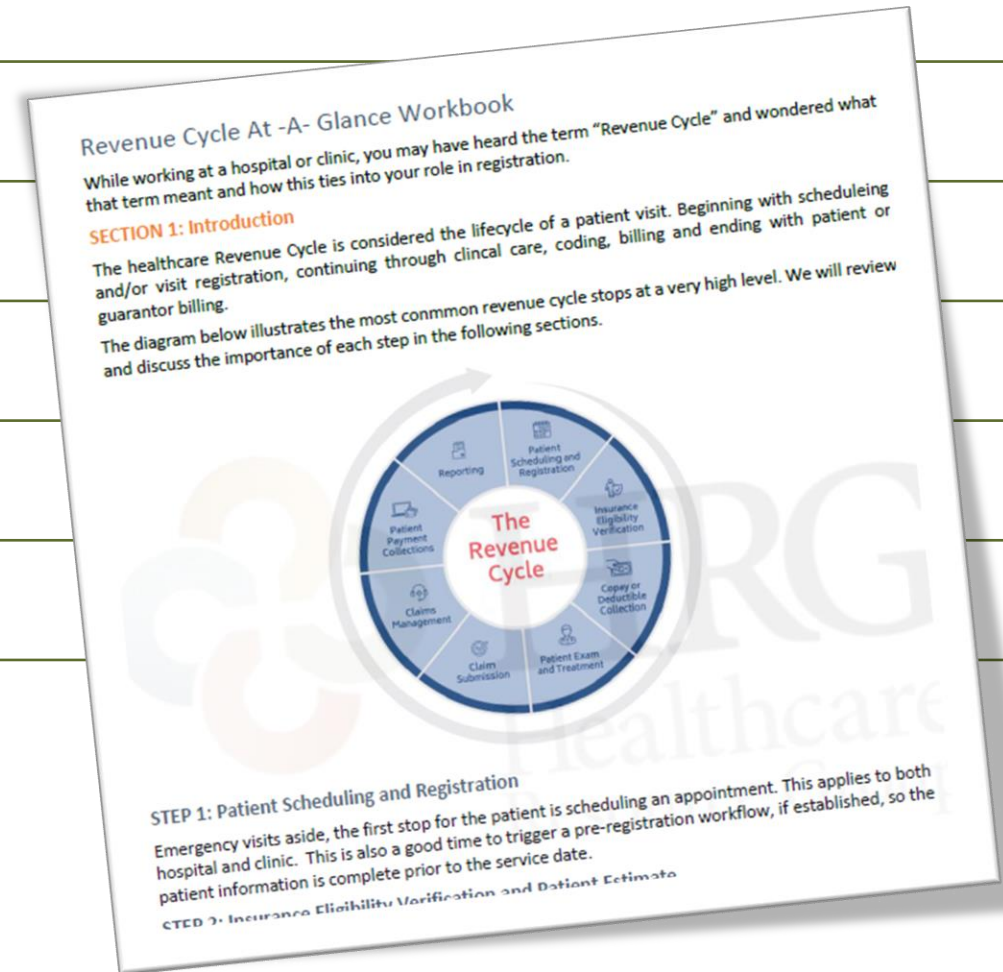
Show the 'Whys' behind the work

Ensure understanding of impact

Activity to walk in biller's shoes

Focus Areas:

- POS Cash
 - Denial Prevention
 - EOB Lingo
-





Appeals 101



Reviewing EOBs



Referrals vs. authorizations



Reviewing accounts like an auditor



Avoiding untimely adjustments



No Surprises Act

ACCOUNT T.R.A.I.T.S.

Total Charges

Remaining Balance

Account Notes

Insurance(s) on File

Transactions

Service Date

Guide to Registering Patients with...

MILITARY INSURANCE PLANS

Veterans Administration

<https://vapcc.trlwest.com>



Treatment must be Service Connected
OR

No other insurance (Mill Bill)

CANNOT BE BILLED SECONDARY

Champ V

<https://vapcc.trlwest.com>

CANNOT BE ELIGIBLE FOR TRICARE

SPOUSE OR CHILD OF A...
Veteran rated permanently or totally disabled by
a VA regional office
OR
Surviving spouse or child of a Veteran who died
from a VA-rated service connected disability

Tricare

<https://www.tricare-west.com/>



Coverage for military members,
dependents, retirees and some
survivors & former spouses

Must be listed in Defense
Enrollment Eligibility
Reporting System (DEERS)

*Card colors vary
depending on
status

OK TO BILL AS SECONDARY

Tricare for Life

<https://www.tricare4u.com/>



Designed
costs for
retired mi
and

*Card colors vary
depending on
status

OK TO BILL AS SECONDARY

COLLECTING PAYMENTS AT TIME OF SERVICE

1 Start the Conversation

Use words like "let's" and phrases that include "help". It shows you're on the same team and strikes a friendly, collaborative tone
"Let's confirm what the copay is for today's visit"
"Looks like there is a copay amount for today; I'd be happy to help process that payment"



2 Ask for Payment

After confirming the amount due, try to use direct questions
"How would you like to take care of this today?"
"I can take the payment right now if you'd like"

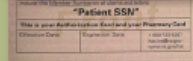


3 Discuss Payment Options

If patient is unable to pay at time of service; review payment options. Patients may not be aware of all available options; what might feel obvious to us could be big news for them

"Let's see what I can do to help, would it be better if we broke this into smaller payments?" (Collecting outstanding)
"We have financial assistance"

Remember, you're not making a demand
A lot of patients will pay



Reading an Explanation of Benefits

Explanation of Benefits (EOB) Customer service: 1-800-123-4567

Statement date: XX/XX/XXXX Member name: _____
Document number: XXXXXXXXXXXXXXXXXX Address: _____
City, State, ZIP: _____

THIS IS NOT A BILL

Subscriber number: XXXXXXXX ID: XXXXXXXX Group: ABCDE Group number: XXXXXXXX

Patient name: _____ Provider: _____ Claim number: XXXXXXXX
Date received: _____ Payee: _____ Date paid: XX/XX/XXXX

Claim Detail			What your provider can charge you		Your responsibility			Total Claim Cost			
Line No.	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co-Pay	Deductible	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/14-3/20/14	Medical care	Paid	\$31.60	\$2.15	\$0.00	\$0.00	\$0.00	\$2.15	\$0.00	PDC
2	3/20/14-3/20/14	Medical care	Paid	\$375.00	\$118.12	\$0.00	\$0.00	\$0.00	\$83.12	\$35.00	PDC
Total				\$406.60	\$120.27	\$0.00	\$0.00	\$0.00	\$85.27	\$35.00	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

1 SERVICE DESCRIPTION

The type of services received, IE: office visit, labs, screenings, surgeries, ER

2 PROVIDER CHARGES

The total amount/total charges the provider bills for the visit.

4 PAID BY INSURER

The amount the insurance company pays the provider.

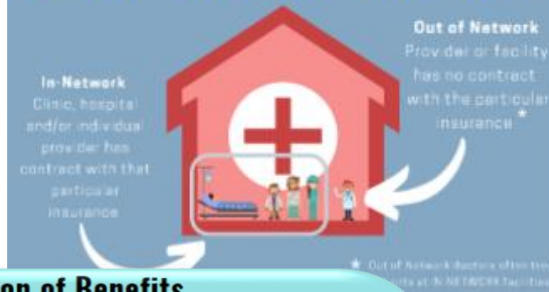
5 PAYEE

The person who receives any reimbursement for any over-payments.

7 REMARK CODE

A note from the insurance plan that explains more about the cost, charges and paid amounts for the visit.

IN-NETWORK VS OUT OF NETWORK





Train the Trainer Workshop

Focus on trainer mindset

- Trainer styles: Firehose, Trickle, DIY
- Activities to get into trainee mindset

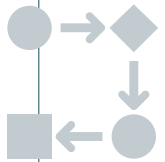
Case Studies

Develop training curriculum

- Training Rules



Monitor Receivables with Reporting



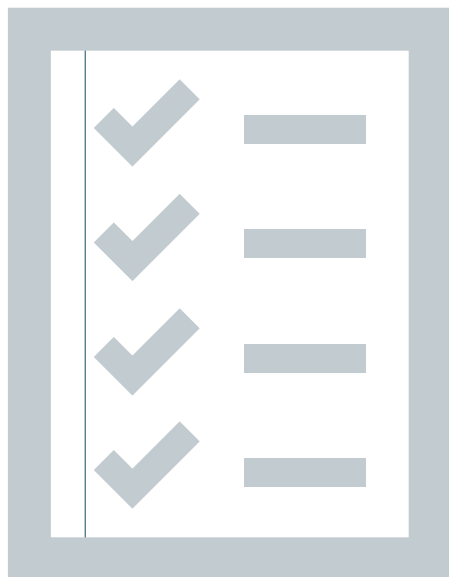
Workflows IDR (NSA) process, appeals, and underpayments



NSA: monitor reimbursement percentages closely for both in and out of network payers



Weekly dashboard report: AR Days, DNFB, DNFC, pending appeals, posted cash, pending IDR, denials underpayments and aging



Workflow Maintenance

- 835 reason & remark code mapping
- Cash poster crosswalk for denials
- Payer use of codes
- Automated workflows (tickler dates)
- EDI edits

Department Prevention Meetings Without PFS

- May encourage silos
- Not as productive as cross-departmental collaboration

Distribute Denial Reports Without Discussion

- May seem generic and may not resonate
- Expectation may be unclear

Reporting the Kitchen Sink

- May be inflating denial volume
- Rolling up replicates?
- Denial vs. Delay
- Avoidable vs. Unavoidable



Department Reports Should be Relatable

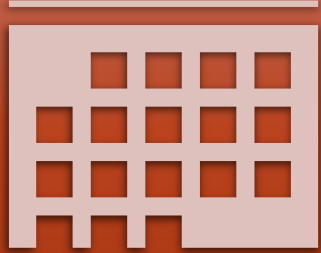
- Focus on understanding and buy-in
- Make sure departments understand what they're looking at
- Correlate denied dollars as cost of CT machine, # of FTEs
- Denial percentages tied to dept. and overall revenue
- Explain any delays in results





Volume and Amount

- Claims billed, paid, denied and rejected
- Pended claims: I/S, COB, med recs, w/average claim total



Aging

- Percentage of claims paid at 30, 45 and 60 days
- No Response >60 days volume, amount and percentage



Ongoing Issues

- Top 3 or 5 issues



Action Plans

Action Plan Tips for Success

Dashboard & summary page

Status & due dates increase accountability

Bring team in early on

Visibility and communication is critical

Plan for keeping momentum

- Be mindful of daily responsibilities and factor in “fires”
- Encourage staff level “cheerleaders”
- Schedule Reoccurring Meetings
- Keep action plan visible in shared location (SharePoint)
- Celebrate wins – not matter how small
- All in this together!



Denial Prevention

- Cash posting crosswalk
- Reduce plan choices
- CARC/RARC committee

Training

- Policies & procedures
- Infographics
- Quality & Training program
- SharePoint site

AR Management

- Develop specialized teams
- Payer scorecard

Monthly cross department review of monthly write-offs

- CFO, HIM, Patient Access, Billing Directors, Managers & Supervisors
- Walk through accounts in informatics system

Review monthly bad debt assignment

- Accounts with viable insurance, no payment and no PR reason code

Complete case studies

- High dollar denials
- Aged accounts
- Unsuccessful appeals

A landscape photograph showing a dirt road winding through a field of tall grass at sunset. The sun is low on the horizon, creating a warm, golden glow. A dark, semi-transparent rectangular box is overlaid in the center of the image, containing white text.

A company's employees are
its greatest asset and your
people are your product.

Richard Branson

quartzandj

Questions?