Revenue Cycle Management Process

Presented by:

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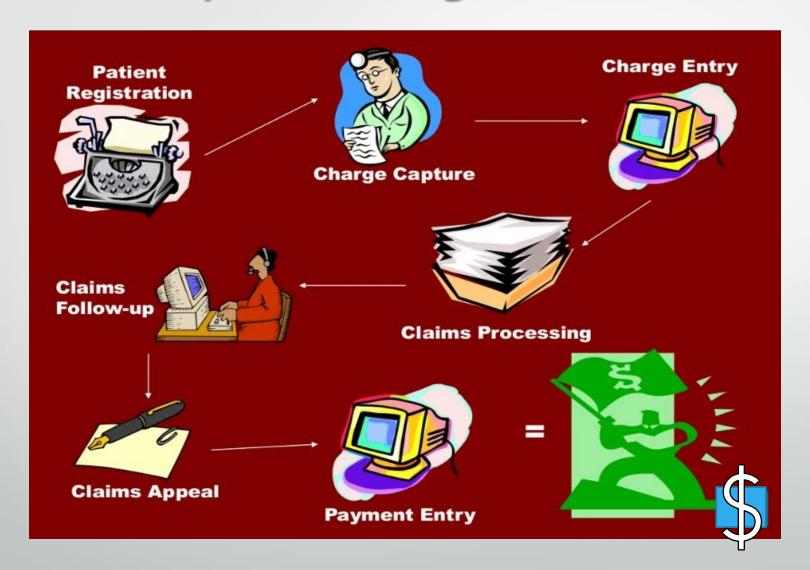
- 20 plus years in Revenue Cycle Management, Training & Development, Six Sigma and Training and Policy writing
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LEARNING OBJECTIVES

- Key Components of RCM
- Registration and Insurance Verification
- Avoiding Claim Rejections
- Payment Posting
- AR Follow-up/Denial Management
- Common Appeal Letter Reasons

Revenue Cycle Management Process

Revenue Cycle Management Process



KEY COMPENENTS OF RCM

Pre-Cycle/Registration

 Pre-Cycle involves scheduling, registration, insurance verification, authorization and financial counseling.

Mid-Cycle

Mid-Cycle involves charge capture, coding, clinical documentation and auditing.

Post Cycle

 Post cycle involves billing, compliance, denials management, collections, payment posting, patient pay, financial assistance, collection agency and reporting/benchmarking.

PRE-CYCLE/REGISTRATION

- Insurance eligibility verification is the foundation of the medical insurance billing cycle, and it has the power to decide the fate of a claim.
- Front Office Staff (Scheduling and Check-In)
 - Pre-Patient Appointment
 - Collect patient demographic and insurance information when patient calls to make appointment.
 - Ask patient to spell name as listed on insurance card (Medicaid)
 - Verify patient's insurance benefits via online portals.
 - Notify patient of benefits and expected at time-of-service payments.
 - Patient Arrival to appointment
 - Make copy of patient's insurance card (front & back)
 - Ensure all necessary patient paperwork is completed and signed.
 - Collect patient copay, coinsurance and deductible, if owed.
 - *Patient insurance should be verified prior to every appointment.

PRE-CYCLE/REGISTRATION

- Insurance eligibility verification and authorization is the foundation of the medical insurance billing cycle, and it has the power to decide the fate of a claim.
- Insurance Verification
 - Verify patient's insurance benefits via online portal(s).
 - In case patient is covered under multiple health plans, ensure all plans are verified.
 - Confirm effective dates for all plans.
 - Confirm the CPT codes patient being seen for will be covered and if they require pre-authorization.
 - Insurance and authorization verification should take place for <u>every</u> patient visit as insurance may have changed or termed.
 - Notify patient of benefits and expected at time-of-service payments.
- Effective insurance and authorization verification, can avoid losses, delays and reworks. Insurance and authorization verification saves valuable time by avoiding unnecessary billing process for a claim which is sure to get denied due to issues with insurance coverage or no authorization.

MID-CYCLE

- Physician & Clinical Staff
 - Ensure the patient chart is documented with patient's history, symptoms, diagnosis, treatment plan and any ordered test.
 - Document the appropriate ICD-10 diagnosis codes and CPT codes on the charge sheet or in EMR system that applies to the patient encounter.
 - If the diagnosis or CPT code changes, please ensure this information is shared with the billing team. *If authorization was obtained for a CPT code that is not billed, the payer may deny for no authorization.

MID-CYCLE

Billing Staff

- Ensure verification and review of diagnosis codes and CPT codes to ensure they match the documentation in the patient medical record. This should be completed prior to entering the information into the system and release claim to insurance company.
- If information is different, please work with clinician team to confirm correct CPT or diagnosis codes prior to entering charges.
- *There could be some overlap between mid-cycle and post cycle depending on job roles.

POST CYCLE

Billing Staff

- This involves editing, submitting, following up on, and submitting claims with health insurance companies in order to receive payment for services rendered, such as testing, treatments, and procedures.
 - Some of the editing of claims could be rejections from the payer or the clearinghouse.
 These often require intervention to submit.

*There could be some overlap between mid-cycle and post cycle depending on job roles.

POST CYCLE - REJECTIONS

- Claims are most often rejected due to incorrect or invalid information that does not match what is on file with the payer.
- Rejections will come from the clearinghouse or the payer.
- Common rejections:
 - Insurance Coverage expired
 - Wrong payer
 - Wrong Insured ID or incorrect demographics (DOB, name misspelled)
 - Wrong insured information

Pre-Cycle/Registration issues to avoid Claim Rejections

Patient Registration

- Incorrect or inadequate demographic information
- Address changes not entered or updated timely
- Insurance ID card copies missing from the patient's medical record
- Insurance re-verification for every patient appointment
- Invalid payer ID's
- Date of birth
- Sex
- Ensure accuracy when reviewing the patient account for clean claims

Accurate Payment Posting Leading to Improved Billing Efficiency

PAYMENT POSTING

Payment posting is an integral part of the revenue cycle management (RCM) of any healthcare organization.

Payment Posting

- Payment posting involves posting the payments including reconciliation. The billing team will post the received and denied payments into billing software against the submitted claim.
- If you have an efficient payment posting team, they will uncover trends behind claim denials, will find out non-covered services, and requirements of prior authorizations. All these issues can be discussed with the medical billing and coding team to improve the clean claim percentage and reduce the denial claim percentage.
- With accurate payment posting, you can catch any billing inefficiencies or issues quickly, making the entire billing process smoother for everyone, from the front office to the back-office staff.

Payment Reconciliation

- If you have a skilled and experienced billing team member who can understand EOBs (Explanation of Benefits) and ERAs (Electronic Remittance Advice) then you can reconcile the payment accurately. Most of the times providers either consider their claims as paid or denied.
- Part of your claim is paid by the insurance carrier and part is denied giving a denial reason. You must be able to read every line item to find out such denied payments in every claim. Sometimes one procedure code might have been denied due to the absence of a modifier or used as a duplicate. If you can reconcile your received payments, you will be able to receive more accurate insurance payments for delivered services.

Accurate Payment Posting Leading to Improved Billing Efficiency

- Finding Denials through payment posting:
 - An important aspect of payment posting is documenting why the payment has been denied.
 - Accurate payment posting practices includes posting every denied payment with an accurate denial code along with a remark code, if available. This activity does the groundwork for the denial analysis and resolution team that works on such denial reasons.
 - Payment posting helps the practice find out why claims are getting paid, the allowable amount for specific procedure codes, and why claims are getting denied. With proper payment posting, your team can rework denied claims to receive accurate insurance collections.
 - Just receiving checks from insurance carriers does not mean that everything is fine. You must evaluate your payment posting process on a periodic basis.
 - Every payment must be documented properly to ensure accurate collection of insurance and patient payments.

Claim Follow-Up/Denial Management Process

Claim Follow-up Process

- Once the claim has been successfully submitted to the payer, the claim follow up process begins:
- Do's:
 - Regular follow-ups on the claim
 - Proper data management and reporting of work
- Do Nots:
 - Untimely follow-up on claims
 - Untimely submission of claims
- Follow-up Best Practice
 - Work higher volume claims and oldest dates of service as priority.
 - All claims must be followed up and reviewed every 30 days.
 - Always gather and share claims processing information specific to payers can help in determining further steps on the claims and share with front end team.

Claim Follow-up Process

- Claim Follow-up
 - Claim paid zero balance
 - Claim processed deductible, co-pay etc.
- Denials:
 - Four ways to resolve a claim denial
 - Non- covered
 - Patient coverage termed
 - Claim denied correctly as non-covered service, adjust claim off as payer non payable or bill patient
 - Denial in error
 - Patient eligibility called payer claim re-process
 - System issue
 - Medical necessity
 - Need medical records, written appeal, generic appeal letters supporting documentations
 - Billing error
 - CPT/Diagnosis code or add modifier, corrected claim

2 Categories of Denial Management

- Claim Correction and Resubmission
 - These are the claims which are corrected, modified, and resubmitted as a corrected claim to insurance companies.
 - Every effort should be made to resolve the denial to avoid billing the patient.
- Patients' Responsibility
 - These are claims which cannot be further worked and the final bill is sent to the patient for payment collections.
 - The reasons for sending the patient a bill generally are in-network deductibles and non-covered benefits as per insurance plan.

Claim Denial Tools

- Verify the claim was received.
- Document the issue and ensure timely follow. If payment has not been received, contact payor.
- Run reports or review collector queue.
- Review Explanation of Benefits (EOB).
- Identify the Payor's reason for the denial; delayed or partially paid claim.
- Gather supporting documentation.
- Review Payor appeals process send the appropriate appeal letter for the denial.

Top Denial Reasons

- Authorization Issues
- Referral Issues
- Invalid patient information
- Eligibility
- No referral or pre-authorization
- Timely filing
- Invalid diagnosis or CPT Code
- Non-covered
- Medical Necessity and Medical Records requests

- Non-Participation with insurance
- Coordination of benefits
- No status and No claim on file
- EDI Rejections
- Out of network claim status and deductibles
- Partial payments
- Inclusive procedures
- Other

ELIGIBILITY DENIALS

- Information to obtain from the Payor
 - Date of denial
 - Effective and termination date of the coverage
 - Correct primary payer information
 - Denial in error
 - Always verify corrected claim and appeal deadline
 - *Verify the insurance card copy in the patient chart to compare to the denial

NON-COVERED SERVICES DENIALS

- Examples of Non-Covered services:
 - Not covered per patient insurance plan (ABN)
 - Non covered due to CPT/ICD-10 diagnosis combination
- Information to obtain from the Payor
 - Date of denial
 - Details of the non-covered service
 - Check if patient can be billed
 - Check to see if another diagnosis or CPT code can be used
 - Check to see if ABN (Advanced Beneficiary Notice) on file
 - Always verify corrected claim and appeal deadline.

^{*}Insurance verification process should always ensure all CPT's are covered. If the CPT code changes during the visit, the clinical team should make aware.

NO AUTHORIZATION NUMBER DENIALS

- When initial eligibility verification is completed, the authorization requirement based on services to be rendered to the member must be checked. It also needs to be checked if the services are covered under the plan benefits. If the auth is not obtained, then it might be necessary to re-appeal, providing medical records of the member, if the plan allows it.
- Examples of Authorization denials:
 - Authorization not approved per CPT code
 - Non covered due to CPT/ICD-10 diagnosis combination
- Information to obtain from the Payor
 - Date of denial
 - Check to see if authorization in both the payer and office system for specific date of service and/or CPT code
 - Have claim re-processed if valid authorization is on file
 - Always verify corrected claim and appeal deadline

INVALID DIAGNOSIS DENIALS

- Examples of invalid diagnosis:
 - Missing additional digit
 - Diagnosis code no longer valid
 - Diagnosis code may not be billable with CPT code
- Information to obtain from the Payor
 - Date of denial
 - Verify if diagnosis code can be billed with CPT code.
 - Always verify corrected claim and appeal deadline
 - *billing errors CODING CORRECTED CLAIM

PAST TIMELY FILING DENIALS

- Untimely claim submission do not get paid unless there is a valid reason for untimely submission or follow-up. Most often after timely filing limit is passed, re-appeal for the initial denial of the claims can be made. However, the claim still may not get approved, and this is time consuming.
- Examples of Timely Filing:
 - Claim not received by timely filing limit
 - Diagnosis code no longer valid
- Information to obtain from the Payor
 - Verify payor timely filing
 - Date claim was received by payor
 - Date of denial
 - Ask if timely filing can be waived
 - Proof of timely filing
 - Clearinghouse Acceptance/Rejection repot
 - Screen Shot Billing history
 - Denied EOB previous insurance
 - Always verify corrected claim and appeal deadline

OTHER DENIALS

- Examples of other denials:
 - Claim denied as duplicate
 - Claim previously paid
 - Patient not eligible for DOS
 - Payer didn't receive EOB from primary payer
 - Patient not covered due to pre-existing condition
 - Not covered by member's plan
- Information to obtain from the Payor
 - Date of denial
 - Depending on "other" denial reason may need to find out claim adjudication on previously submitted claim.

Avoid Medical Claim Denials

- Collect Detailed Patient Information
 - Patient name
 - Patients date of birth
 - Address
 - Phone number
 - Email address
 - Subscriber name
 - Name of the plan
 - Group Name
 - Insurance coverage effective dates
 - Secondary or supplemental coverage details
- It is very important to collect and enter this information accurately in the system so the next member
 of the team has the necessary information to complete his/her task(s).

COMMON APPEAL LETTER REASONS

COMMON APPEAL LETTER REASONS

- Invalid or Incorrect Diagnosis code
 - May need coding review prior to submitting appeal or corrected claim.
- Invalid or Incorrect CPT code
 - May need coding review prior to submitting appeal or corrected claim
- Timely Filing
 - Submit appeal with proof of timely
 - Proof of timely filing
 - Clearinghouse Acceptance/Rejection repot
 - Screen Shot Billing history
 - Denied EOB previous insurance

COMMON APPEAL LETTER REASONS cont.

- Incorrect Reimbursement
 - If payer did not process claim per contractual reimbursement.
- Out of network provider
 - Determine if the patient has out of network benefits.
 - If provider is truly out of network, this will require a Medical Necessity appeal.
 - If the provider pending payer enrollment, ensure claim is kept alive until enrollment is complete.
- Request for recoupment denial to payor
 - Attempt to resolve via phone call to have the claim re-process.
 - If the recoupment is upheld, then send appeal letter showing proof claim is payable and recoupment in error.

COMMON APPEAL LETTER REASONS cont.

Tips:

- Call first some claims can be re-processed via phone.
- Always obtain a reference number and document the name of the customer service representative.
- Ensure all pertinent and requested documentation is submitted along with the appeal to make sure the review can be completed.
- Fax or upload online any documentation instead of mailing, if mailing always send certified return receipt.

APPEALS Document! Document!

- Claim follow up log to track appeal status
- Get the member involved.
- Ensure consistent and timely follow-up
- Contact employer if necessary (self-funded)
- Contact Department of Insurance, as a last resort

REDUCE WRITE-OFFS

- Providers
 - Pre-authorizations
 - Provider not enrolled
 - Referrals
 - Documentation deficiencies
 - Medical necessity denials ABN
- Coding
 - Incidental service denials due to lack of modifiers
 - Assure proper coding of combined accounts for same DOS
- Claims processing
 - Timely filing limits
 - Appeal processes
 - Account follow-up

HELPFULTIPS

IMPORTANT REMINDERS

- Medical billing is one of the major factors to decide the financial success rate of the practice, and claim denials affect the cash flow of the practice.
- Every new claim denials lead to revenue leaks. For better claims denial management, you
 must identify the denials and reasons of the denials.
- Avoiding and reducing the claims denials will improve the cash flow.
- To ensure accurate billing, documentation plays a major role. Poor documentation leads to underpayments and denials.
- It helps to prevent some complications during internal or external coding audits/reviews.

THINGS TO REMEMBER

- Revenue Cycle cannot operate in a silo.
 - Asking questions like, whose job, is it?
 - Seek buy in from all departments within the organization
 - Send the same message to your patients and communities in every area of the organization, one team working together to achieve your goals

Management Providers Ancillary Staff Registration Coding Billing Collections

• It takes every member of the team to ensure claims are submitted correctly the first-time increasing cash flow to your practice, preventing costly follow-up by your office or billing staff, and reducing the uncertainty members feel with an unresolved claim.

Remember it is a TEAM effort!

 Individual commitment to a group effort – this is what makes a teamwork, to the best of its ability and ultimately leads to a successful company.

QUESTIONS????