Revenue Cycle Management and Revenue Calculations

Private and Confidential
October 2022

pwc

Agenda

Introduction

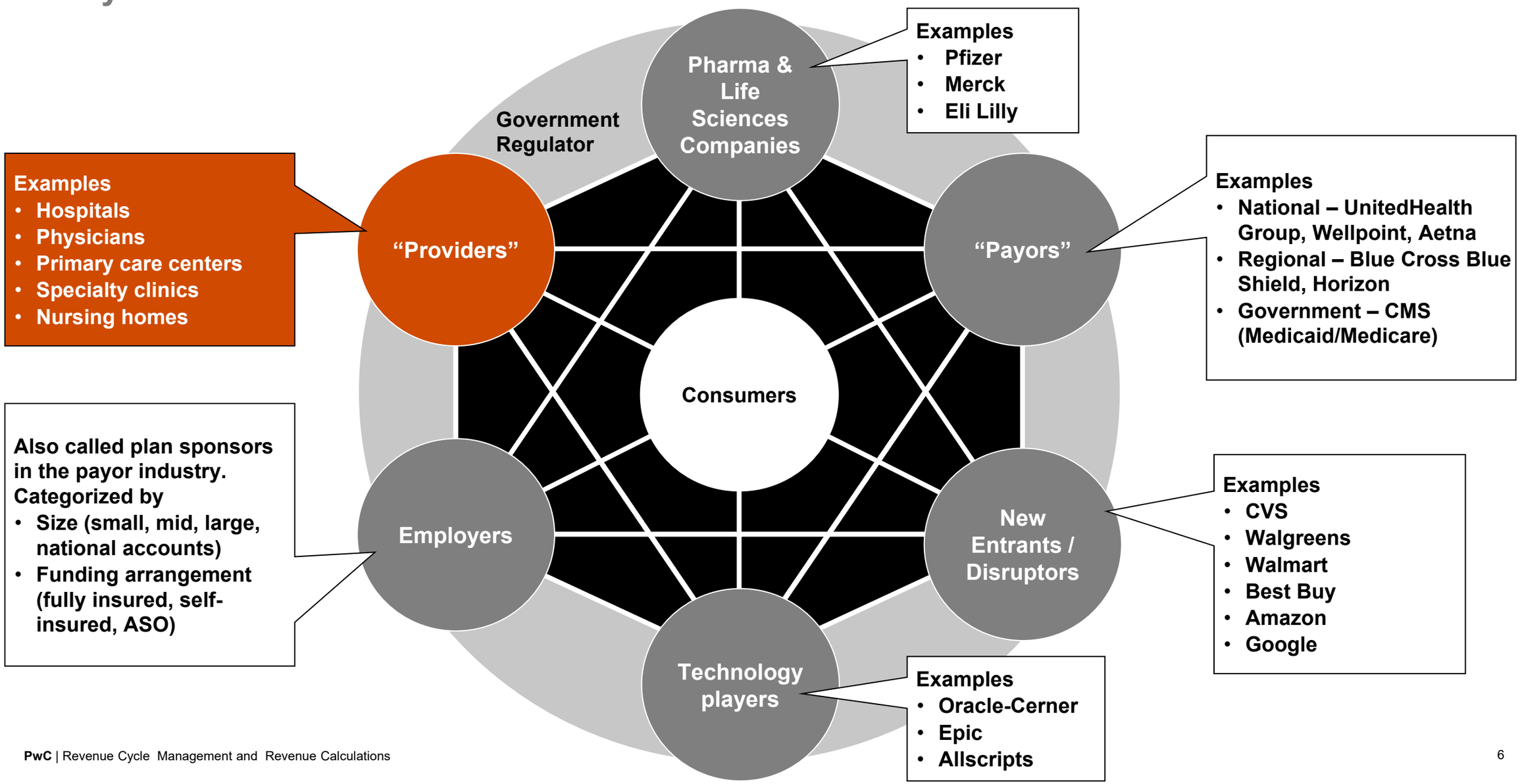
Objectives

- Understand where the Revenue Cycle fits into Provider Operations
- Describe the Clinically Integrated Revenue Cycle and how it differs from a traditional understanding of the revenue cycle model
- List the key capabilities required for hospitals to achieve a transformed Revenue Cycle with critical operational and clinical touch points

Revenue Cycle Overview

Provider Operations sits in a complex healthcare environment

In today's dynamic environment, roles of individual players is evolving to create a new ecosystem that breaks silos and enhances collaborations



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.

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

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**		
Access management • Scheduling • **Financial clearance** – Pre-Registration – Insurance verification – Referrals/ authorizations – Pre-service collections – Financial counseling • **Registration** (scheduled or non-scheduled) • Admissions/Bed Management	**Revenue Integrity** • Operating model and leading practices • Charge Capture processes • Charge Reconciliation processes and reporting • Charge Description Master (CDM) assessment, consolidation and Maintenance • Strategic Pricing	**Clinical documentation integrity** • Clinical documentation improvement • Concurrent documentation reviews • Provider clarification forms • Provider education	**Health information management** • HIM – Transcription services – Documentation analysis – Documentation management/ Scanning – Regulatory audit management – Release of information – Physician documentation monitoring and suspension • Coding and Coding Quality	**Billing** • Claims scrubbing • Billing errors • Rejection processing • Special billing arrangements • HIPAA 837 transactions **Follow-up** • Workflow automation • Adjustments and write-offs • Credit balance processing/escheat • Medicare 838 reporting • HIPAA 276/277 • Statement processing and patient collections	**Denials and appeals** • Hard versus soft denials • Initial versus final **Transaction processing** • Payment Adjustments • Denial • HIPAA 835 • Unposted payments **Credit balances and processing**	**Vendor management** **Bad debt/charity care management** **Underpayments** **Cash posting** **Customer service** • Customer Service phone line • Patient payments • Correspondence

Technology (integrated vs bolt on)

Data analytics – Clinical and financial

Question #1

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

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

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

Insurance Verification

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

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 f**rom one specialist to another**

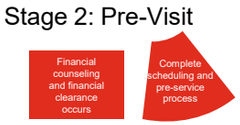
Some referrals require pre-approval that individual health plan members—primarily those with health maintenance organization (HMO) or point of service (POS) plans—**must obtain** from their PCP or specialist **before certain services are performed**

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**

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

Pre-Registration & Pre-Service collections



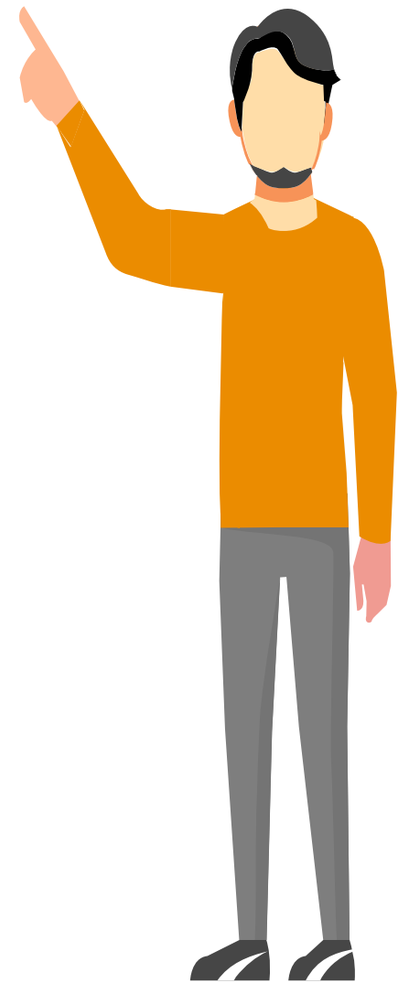
Pre-registration is the first patient encounter beyond scheduling when efficiency and accuracy directly impacts revenue

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



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

Registration

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

Question #2

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

Revenue cycle functions

Overview of HIM & Coding 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**		
Access management • Scheduling • **Financial clearance** – Pre-Registration – Insurance verification – Referrals/ authorizations – Pre-service collections – Financial counseling • **Registration** (scheduled or non-scheduled) • Admissions/Bed Management	**Revenue Integrity** • Operating model and leading practices • Charge Capture processes • Charge Reconciliation processes and reporting • Charge Description Master (CDM) assessment, consolidation and Maintenance • Strategic Pricing	**Clinical documentation integrity** • Clinical documentation improvement • Concurrent documentation reviews • Provider clarification forms • Provider education	**Health information management** • HIM – Transcription services – Documentation analysis – Documentation management/ Scanning – Regulatory audit management – Release of information – Physician documentation monitoring and suspension • Coding and Coding Quality	**Billing** • Claims scrubbing • Billing errors • Rejection processing • Special billing arrangements • HIPAA 837 transactions **Follow-up** • Workflow automation • Adjustments and write-offs • Credit balance processing/escheat • Medicare 838 reporting • HIPAA 276/277 • Statement processing and patient collections	**Denials and appeals** • Hard versus soft denials • Initial versus final **Transaction processing** • Payment Adjustments • Denial • HIPAA 835 • Unposted payments **Credit balances and processing**	**Vendor management** **Bad debt/charity care management** **Underpayments** **Cash posting** **Customer service** • Customer Service phone line • Patient payments • Correspondence

Technology (integrated vs bolt on)

Data analytics – Clinical and financial

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
  - 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

Question #3

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

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

Revenue cycle functions

Overview of Revenue Integrity 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**		
Access management • Scheduling • **Financial clearance** – Pre-Registration – Insurance verification – Referrals/ authorizations – Pre-service collections – Financial counseling • **Registration** (scheduled or non-scheduled) • Admissions/Bed Management	**Revenue Integrity** • Operating model and leading practices • Charge Capture processes • Charge Reconciliation processes and reporting • Charge Description Master (CDM) assessment, consolidation and Maintenance • Strategic Pricing	**Clinical documentation integrity** • Clinical documentation improvement • Concurrent documentation reviews • Provider clarification forms • Provider education	**Health information management** • HIM – Transcription services – Documentation analysis – Documentation management/ Scanning – Regulatory audit management – Release of information – Physician documentation monitoring and suspension • Coding and Coding Quality	**Billing** • Claims scrubbing • Billing errors • Rejection processing • Special billing arrangements • HIPAA 837 transactions **Follow-up** • Workflow automation • Adjustments and write-offs • Credit balance processing/escheat • Medicare 838 reporting • HIPAA 276/277 • Statement processing and patient collections	**Denials and appeals** • Hard versus soft denials • Initial versus final **Transaction processing** • Payment Adjustments • Denial • HIPAA 835 • Unposted payments **Credit balances and processing**	**Vendor management** **Bad debt/charity care management** **Underpayments** **Cash posting** **Customer service** • Customer Service phone line • Patient payments • Correspondence

Technology (integrated vs bolt on)

Data analytics – Clinical and financial

Middle Revenue Cycle Process Overview

Front → Middle → Back

Patient → Register Patient & Deliver Care → Document & Charge for Services → Code Services → Create Bill & Send to Payor → Receive Payment from Payors = $

	Department Involved
Register Patient & Deliver Care	Registration
Document & Charge for Services	Clinical Departments
Code Services	Medical Records/Health Information System (HIS)
Create Bill & Send to Payor	Patient Financial Services (PFS)
Receive Payment from Payors	Patient Financial Services (PFS)

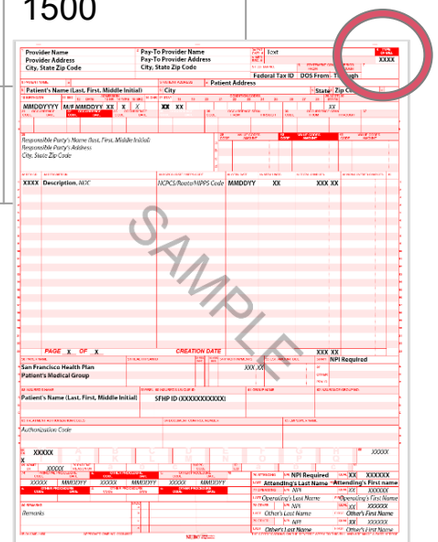
- The patient is registered and two #s are generated:
  - Medical Record Number (MRN)
  - Encounter Number

- Orders are placed and/or verified for patient care
- Documentation is specific and accurate for care provided
- Charges are selected:
  - by clinical staff;
  - automated via computerized physician order entry (CPOE) once task is completed, or
  - coded and charged based on documentation by Health Information Management (HIM)
- Charges are placed through billing scrubber for edits
- Workqueue (WQ) are reviewed to improve claim accuracy

Are we talking about hospital or professional charges?

- Different claim types

	Technical	Professional
Claim type	UB-04	1500
Bill type	Inpatient (111) Outpatient (131)	



Revenue Integrity

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

Charge Description Master (CDM)

What is Charge Description Master?

- The CDM is a comprehensive listing of items billable to a patient or insurance provider and contains critical billing elements for communicating services on insurance claims and patient statements
- Billable items include hospital services, medical procedures, diagnostic evaluation, drugs*, and supplies*
- RI develops, maintains and monitors the CDM maintenance via a process controlled by revenue integrity/chargemaster coordinator

Example snapshot within Radiology

Dept code	Dept Desc.	Service code	Service code Desc.	Revenue code	HCPCS	Modifier	Charge	IP Vol	Op Vol	MC OP Vol	Total Vol
4125	Diagnostic Radiology	3203560	Knee 1 or 2 Views LT	320	73560	LT	$ 365	133	283	44	416
4125	Diagnostic Radiology	3203559	Knee 1 or 2 Views RT	320	73560	RT	$ 365	144	262	54	406
4125	Diagnostic Radiology	3203504	HIP 2 Views or More LT	320	73510	LT	$ 379	172	200	86	372
4125	Diagnostic Radiology	3203027	Shoulder 2V or More RT	320	73030	RT	$ 472	63	259	63	322

Cost Center/Department
Cost center or department for reporting revenue

Service/Charge Code
Unique charge identifier

Service/Charge Description
Reporting description

UB-04 Revenue Code
Standard code set used for grouping charges by revenue center for UB-04 Claims

HCPCS/CPT
Standard code set used for identifying procedure/supply

Modifier
Standard code set used to further define procedure

Price
Unit charge amount

*Separate files may contain this information outside of the CDM

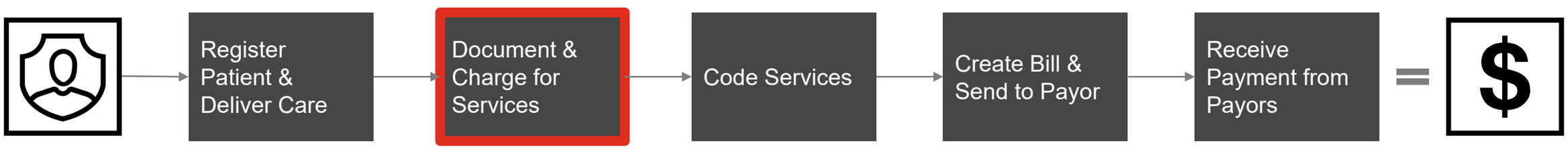
Charge Capture

What is Charge Capture?

Charge Capture is a function of revenue integrity and is the intersection of clinical practice and the billing of services. The key objectives are the following:

- Coding of documented inpatient/outpatient services are complete and accurate
- Coding and charges are compliant with regulations regarding patient, third party, and government billing
- Provide effective billing and collection of patient care revenues and proper reimbursement

Charge Capture Process

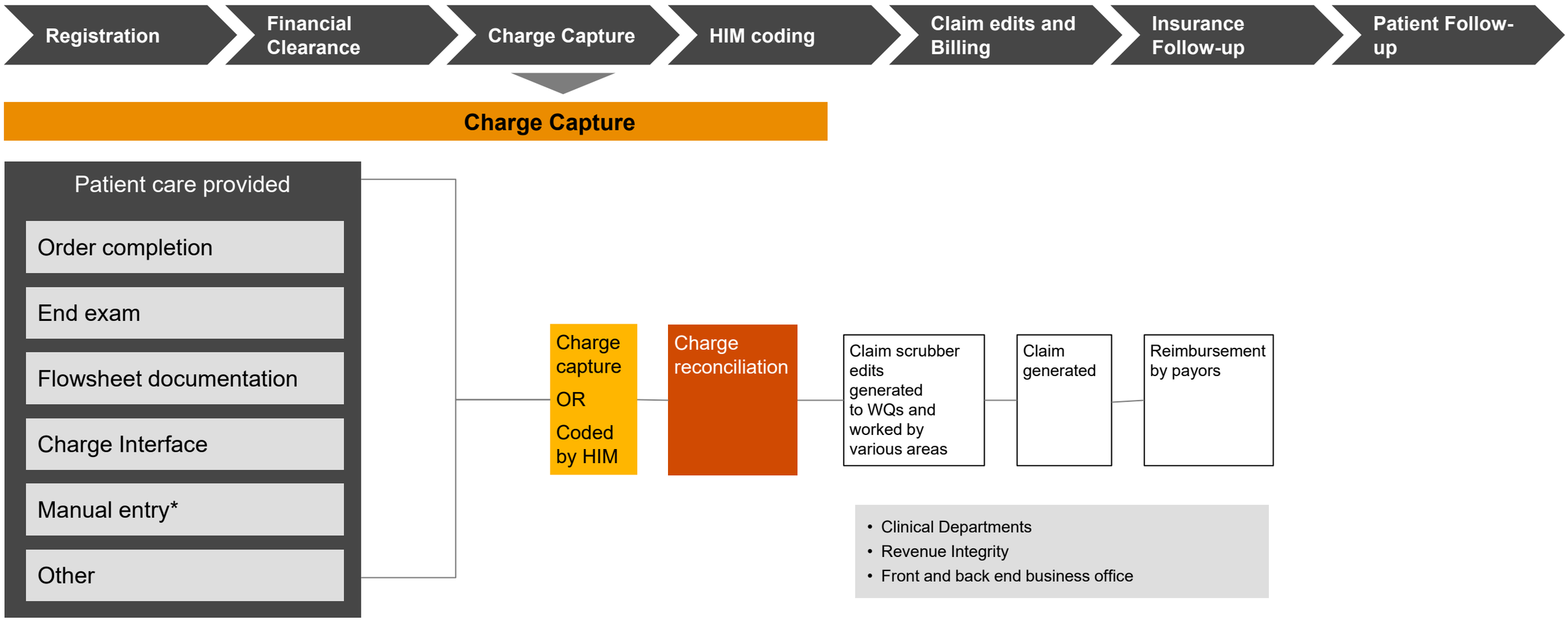


	Patient	Registration	Clinical Departments	Medical Records/Health Information System (HIS)	Patient Financial Services (PFS)	Patient Financial Services (PFS)
Department Involved						

Charge Capture

What is Charge Capture?

The following workflow provides more detail into the charge capture process based on a variety of tools and claim editing



*** Exception based practice**

Revenue cycle functions

Overview of Patient Financial Services as a function of the revenue cycle

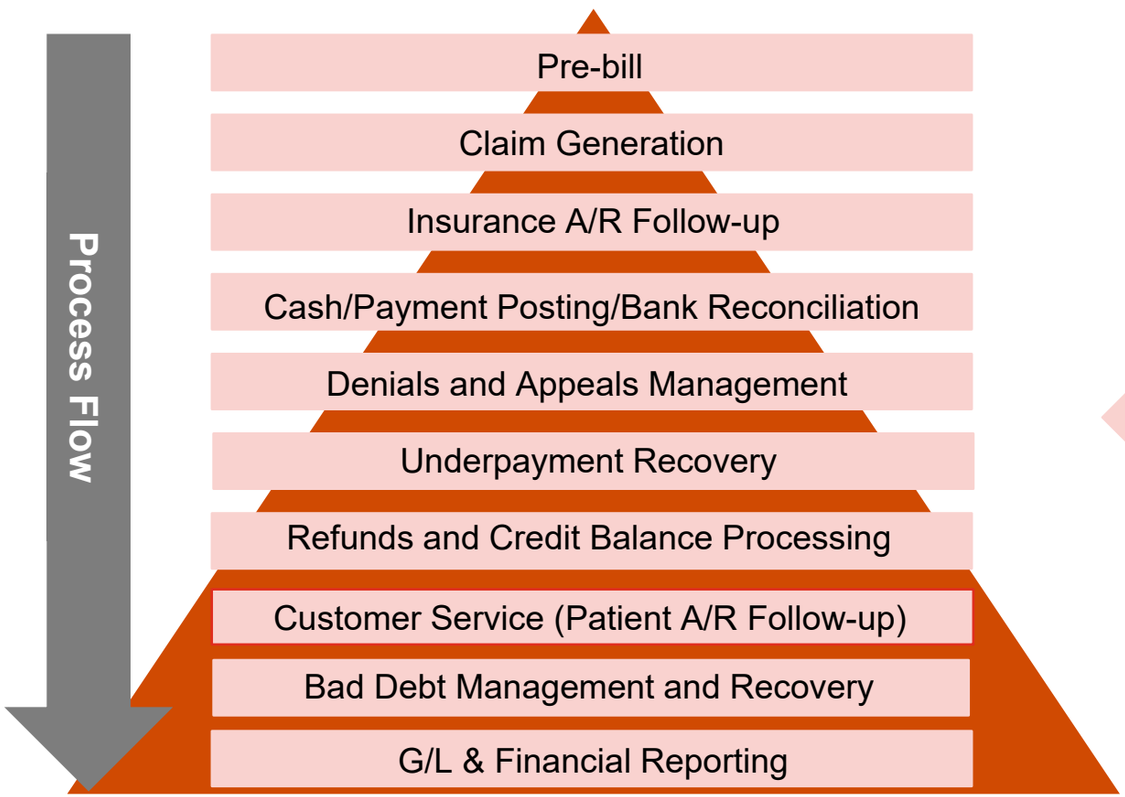
Front-end Revenue Cycle	Middle Revenue Cycle			Back-end Revenue Cycle		
Access management	**Hospital Revenue integrity, CDI and Coding**			**Patient financial services**		
Access management • Scheduling • **Financial clearance** – Pre-Registration – Insurance verification – Referrals/ authorizations – Pre-service collections – Financial counseling • **Registration** (scheduled or non-scheduled) • Admissions/Bed Management	**Revenue Integrity** • Operating model and leading practices • Charge Capture processes • Charge Reconciliation processes and reporting • Charge Description Master (CDM) assessment, consolidation and Maintenance • Strategic Pricing	**Clinical documentation integrity** • Clinical documentation improvement • Concurrent documentation reviews • Provider clarification forms • Provider education	**Health information management** • HIM – Transcription services – Documentation analysis – Documentation management/ Scanning – Regulatory audit management – Release of information – Physician documentation monitoring and suspension • Coding and Coding Quality	**Billing** • Claims scrubbing • Billing errors • Rejection processing • Special billing arrangements • HIPAA 837 transactions **Follow-up** • Workflow automation • Adjustments and write-offs • Credit balance processing/escheat • Medicare 838 reporting • HIPAA 276/277 • Statement processing and patient collections	**Denials and appeals** • Hard versus soft denials • Initial versus final **Transaction processing** • Payment Adjustments • Denial • HIPAA 835 • Unposted payments **Credit balances and processing**	**Vendor management** **Bad debt/charity care management** **Underpayments** **Cash posting** **Customer service** • Customer Service phone line • Patient payments • Correspondence

Technology (integrated vs bolt on)

Data analytics – Clinical and financial

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:



Patient Financial Services includes the orchestration of 10 major functions/processes using the right mix of People, Process and Technology to appropriately handle each patient account from discharge to $0 balance

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

Claim Generation 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 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

Question #4

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

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

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

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 (RARCs); 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)

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:

1 Full payment

- Remittance and Payment amounts match = 100% post

2 Partial payment

- Remittance does not match Payment - requires manual intervention and research to identify discrepancy and resolve
- Possible causes: line item denial, payer contract difference
- Possible actions: manual adjustment for denied services, appeal and resubmission of claim to payer for contract discrepancy

3 Payment and no remit

- Account information to post payment is missing - payments are typically posted to a clearing account to post the cash

4 Remit and no payment

- Accounts on remittance with no payment are typically documented on a worklist or other follow-up mechanism
- Once payment is received; the amount is posted and the account is cleared from the pending worklist

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

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.

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

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

General Ledger & Financial Reporting – Overview

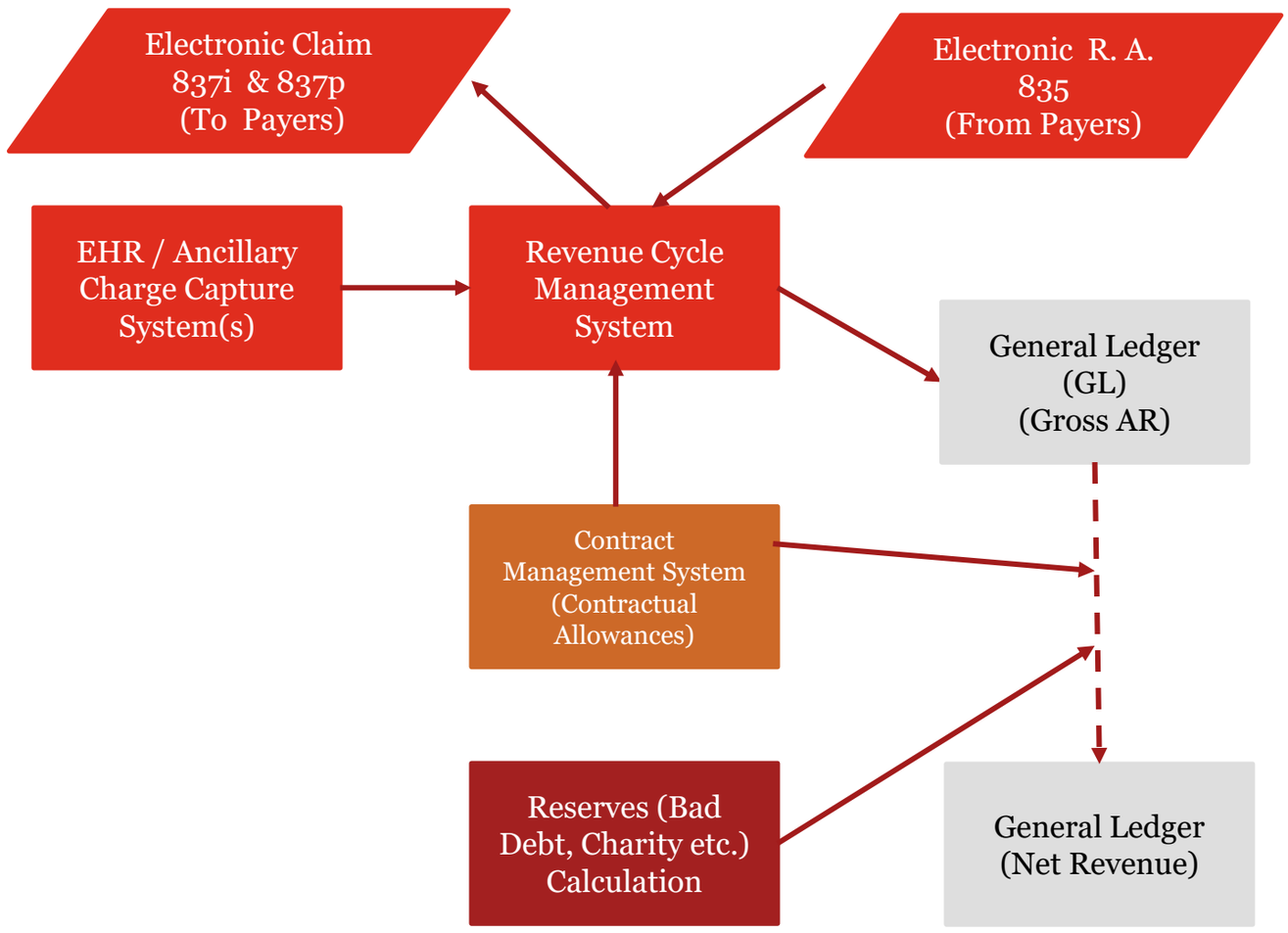
A provider's billing, collection and follow-up activities are interfaced with General Ledger (G/L) as a critical component of the organization's overall financial reporting. The following is an illustrative example of that workflow:

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.



Question #5

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

Key management performance indicators

Measure	Purpose	Value	Equation
Net Days in A/R	Trending indicator of overall A/R performance and indicator of potential cash acceleration opportunity	Indicates revenue cycle efficiency and competency	N: (Net A/R) D: Avg. Daily Net Patient Service Revenue KPI = 50 days or less
Aged A/R as a Percentage of Billed A/R	Trending indicator of receivable collectability	Indicates organization's ability to liquidate and resolve A/R	N:(>30, >60, >90, >120 days) D: (Total Billed A/R)
Cash Collection as a Percentage of Adjusted Net Patient Service Revenue	Trending indicator of revenue cycle to convert net patient services revenue to cash	Indicates fiscal integrity/financial health of the organization	N: (Total Cash Collected) D: Average Monthly Net Revenue KPI = 100%+
Bad Debt as % of Gross Revenue	Trending indicator of the effectiveness of self-pay collection efforts and financial counseling	Indicates organization's ability to collect self-pay accounts and identify payer sources for those who can't meet financial obligations	N: Bad Debt Write-Off D: Gross Patient Service Revenue KPI = <3%
Charity Care as a % of Gross Revenue	Trending indicator of local ability to pay and financial assistance provided to the community; some states have minimum requirements that must be met as a nonprofit hospital	Indicates services provided to patients deemed unable to pay and written off as uncollectible to charity status	N: Charity Care Write-Off D: Gross Patient Revenue
Cost to Collect	Trending indicator of operational performance	Indicates the efficiency and productivity of revenue cycle (RC) process inclusive of labor, vendor and technology costs	N: Total RC Cost D: Total Cash Collected
Case Mix Index	Trending indicator of patient acuity, clinical documentation, and coding	Supports appropriate reimbursement for services performed and accurate clinical reporting	N: CMI D: Number of patients in the month

Key revenue integrity performance indicators

Measure	Purpose	Value	Equation
Discharged Not Final Billed (DNFB)	Trending indicator of the efficiency of the claims generation process and the organization's ability to process accounts within a standard bill hold	Indicates revenue cycle performance and can identify performance issues impacting cash flow	N: Gross Dollar in A/R (Not Final Billed) D: Average Daily Gross Revenue KPI = 4 days
Discharged Not Submitted to Payer (DNSP)	Trending indicator of total claims generation and submission process	Indicates revenue cycle performance and can identify performance issues impacting cash flow	N: (Gross Dollars in DNFB + Gross Dollars in FBNS) D: Average Daily Gross Revenue
Late Charges as a Percentage of Total Charges	Measure of revenue capture efficiency within the operational departments	Identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance, and accelerate cash flow	N: Charges with post date greater than three days from last service D:Total Gross Charges
Net Days Revenue in Credit Balance	Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness	Indicates whether credit balances are being managed to appropriate levels and are compliant to regulatory	N: Dollars in Credit Balance D: Average Daily Net Patient Service Revenue

Source: HFMA MAP Key Category – Revenue Integrity

Key revenue integrity performance indicators

Measure	Purpose	Value	Equation
Denial Write-Offs as a Percentage of Net Revenue	Trending indicator of final disposition of lost reimbursement where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount	Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim	N: Net dollars written off as denials D: Average monthly net patient service revenue KPI = 2.10%
Cash Collections	Trending indicator of propensity to convert net revenue to cash	Indicates fiscal integrity and financial health of an organization	N: Total gross cash collected D: Net patient services revenue
Days in Total Discharged Not Final Billed (DNFB)	Trending indicator of claims generation process	Indicates revenue cycle performance and can identify performance issues impacting cash flow	N: Gross dollars in discharge not final billed (DNFB) D: Average daily gross patient service revenue
Aged A/R as a % of Billed A/R by Payer Group	Trending indicator of receivables collectibility, by payer group	Indicates ability for an organization to liquidate A/R by specific payer group	N: Total Billed A/R > 90 Days D: Total A/R KPI = <25%
Uncompensated Care	Trending indicator of total amounts not collected from patients related to self-pay discounts, charity care, and bad debt combined	Indicates the portion of the self-pay gross revenue not included in cash, charity, or bad debt metrics	N: Bad Debt + Charity Care Write-offs + Uninsured Discounts ($) D: Gross Patient Service Revenue

Source: HFMA MAP Key Category – Revenue Integrity

Question #6

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

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

Revenue Cycle Point of View (PoV)

Today's Revenue Cycle model is subject to 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
Business processes	• **Lack of integration** between Revenue Cycle and clinical processes	• **Reduced reimbursement and increased denial** rates due to poorly integrated front-end and clinical processes	• Disconnect of **several disparate systems** that don't allow all components in the workflow to operate at an optimal level	• **Predictive analytics** and robotic processing automation not fully optimized to allow for improvement in the continuum of care	• Redundant and inefficient processes which fail to clearly link clinical care and Revenue Cycle activities and tasks
People capabilities	• Lack of customer service provided during front-end processes impacts the quality and consistency of patient experience	• Failure of clinical service line leadership to execute **operational change management** when implementing new initiatives which leads to poor adoption	• **Multiple errors** in work product from having to use multiple systems to perform a job	• **Access to data** needed to perform a job is not accessible/ integrated across the operational cycle	• Revenue cycle staff not properly trained to handle basic requirements and key regulatory changes, leading to errors
Technology	• **Lack of self-service** options that patients seek out (e.g., scheduling)	• Lack of integration of clinical and financial systems to provide visibility into the entire encounter	• Fragmented EMR, Billing, and Reporting systems, which create a need for continuous improvements/ enhancements/bolt ons	• Business decisions not driven by **data analytics** and reporting	• Lack of integrated capability to support Revenue Cycle operations

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.

Clinically Integrated Revenue Cycle

Traditional Revenue Cycle

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?

Front door

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

HIM/ Coding & Charge Capture

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

Vendor Partnerships

Technology platform

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

Front-end

Why do my front-end denials keep increasing?

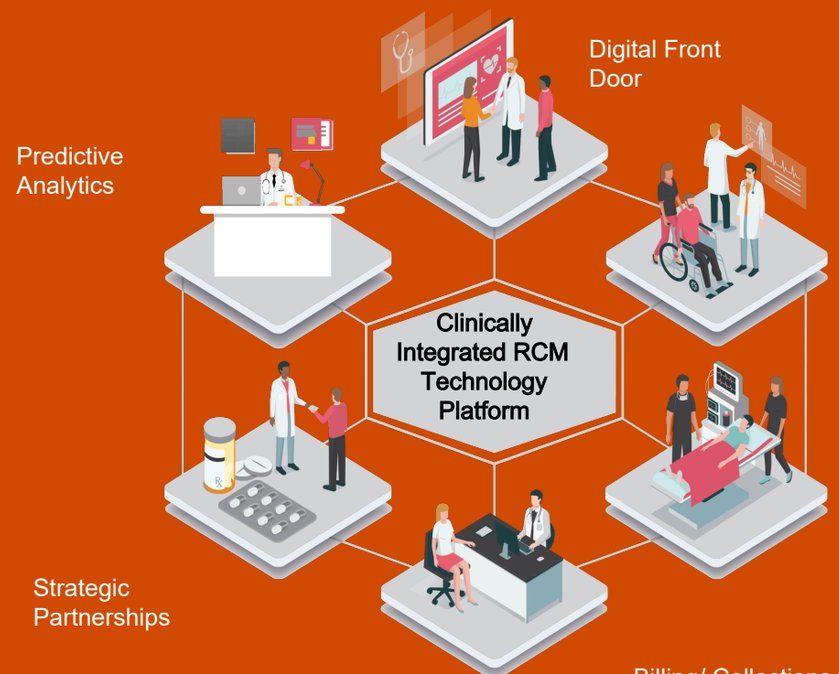
Billing/ Collections

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

Analytics

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

Clinically Integrated Revenue Cycle



Billing/ Collections with enhanced Payer/ Provider Connectivity

Key outcomes

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

Providers need to excel in several areas to differentiate themselves, sustainably, in today's marketplace…

Access to Care

- Remove barriers to care through digital enablement/automation and allow patients to take care into their own hands. Provide multiple options to your patients to make finding the right care and monitoring their health easy.

Workforce of the future & virtual interactions

- Quickly share critical information with your employees and contingent workers. Enable your patients to easily connect with their provider or support staff over video calls to get the answers they need in a timely manner. Enable a more productive workforce through automation and virtual working arrangements.

Leveraging Technology

- Utilize technology to enable staff to communicate with each other and patients. Upgrade technology offerings to allow for a seamless transition for your patients to find care, receive care and send reminders about follow-ups. Optimize your outdated technology stack to improve performance. Focus productivity on high value tasks.

Revenue cycle performance & cost containment

- Scale and innovation are pushing revenue cycles to greater levels of efficiency and output, as once differentiating capabilities are now becoming table stakes. The search for incremental value must be guided by your organization's goals and driven by quantitative measurement.

Patient financial journey & price transparency

- Utilize technology solutions to review insurance and self-pay prices for services you offer. Patients, as consumers, will want to know what they are getting for their money and how this compares to competitors.

Questions?

Thank you

pwc.com