DODGING DENIALS TO RAISE REVENUE: RCM LESSONS FROM THE FIELD

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Agenda

1. Setting the Stage
2. Address the Front End: Audit/Reviews
3. Assess RCM Workflow Early & Often
4. Summing It Up
5. Tools of the Trade Addendum

1

Setting the Stage

Setting the Stage

- 25 Bed Critical Access Hospital
  - 20+ Year Old Legacy System
  - No Volume Growth
  - No Additional Providers
  - Method II Billing
  - Also has RHC
  - Outsourced Revenue Cycle including Coding

- Epic Connect
  - 9 Months for Build-Out
  - Non-Revenue Cycle CFO
  - Go-Live April 1, 2024
  - No GL Mapping had Been Built
  - 18 Months Past Go-Live
  - Optimization?

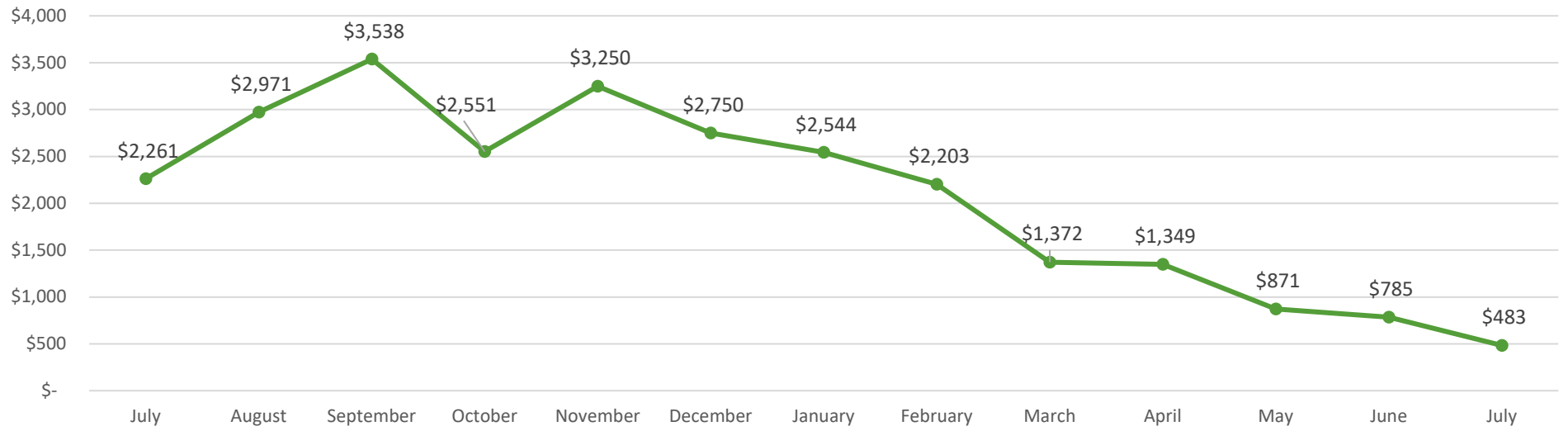
What's in the Numbers

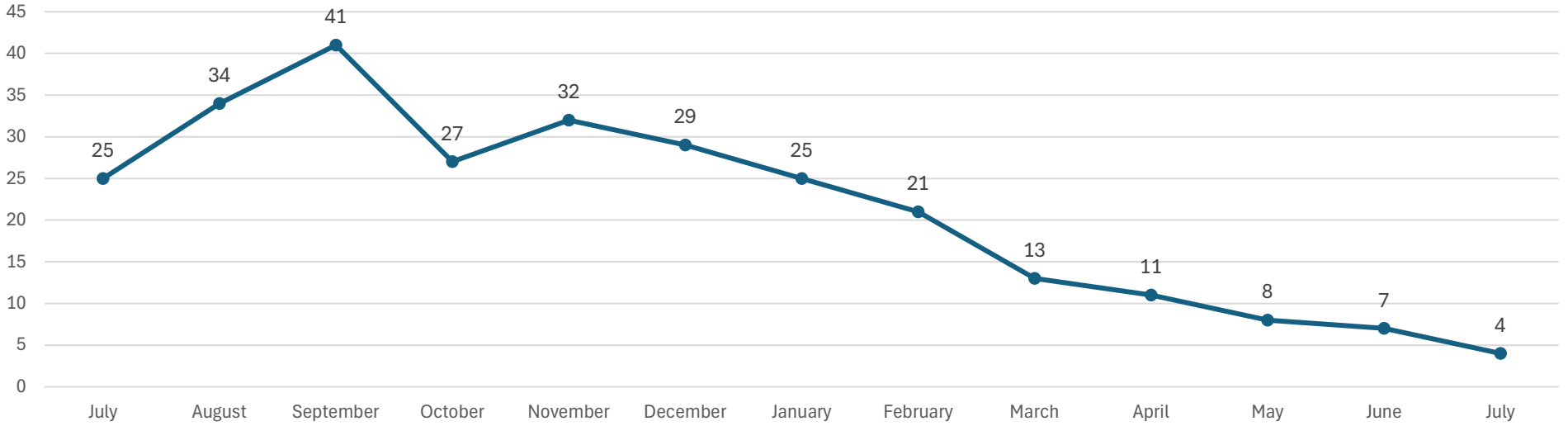
Prior to Epic	Post Epic
Average Charges per month $2.8M	Average Charges per month $3.2M
Cash Collections $1.1M average	Cash Collections $1.8M average
Denial Percentage 16.1% Average but as High as 25.2%	Denial Percentage 13.1% Average with a Low of 10%
DNFB Averaged $750K	DNFB Averages <$500K Consistently

2

Address the Front End: Audit/Reviews

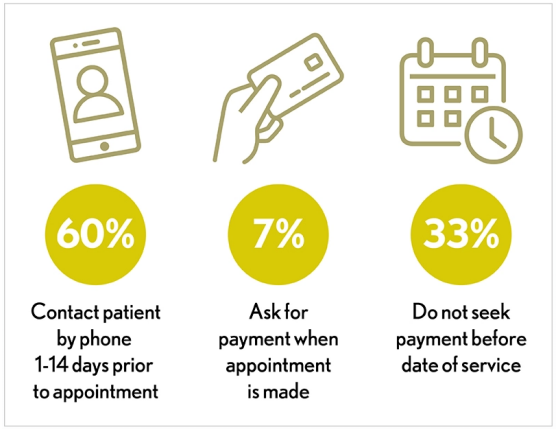
Discharged Not Final Billed





Point of Service Collections

Prepayment Methods

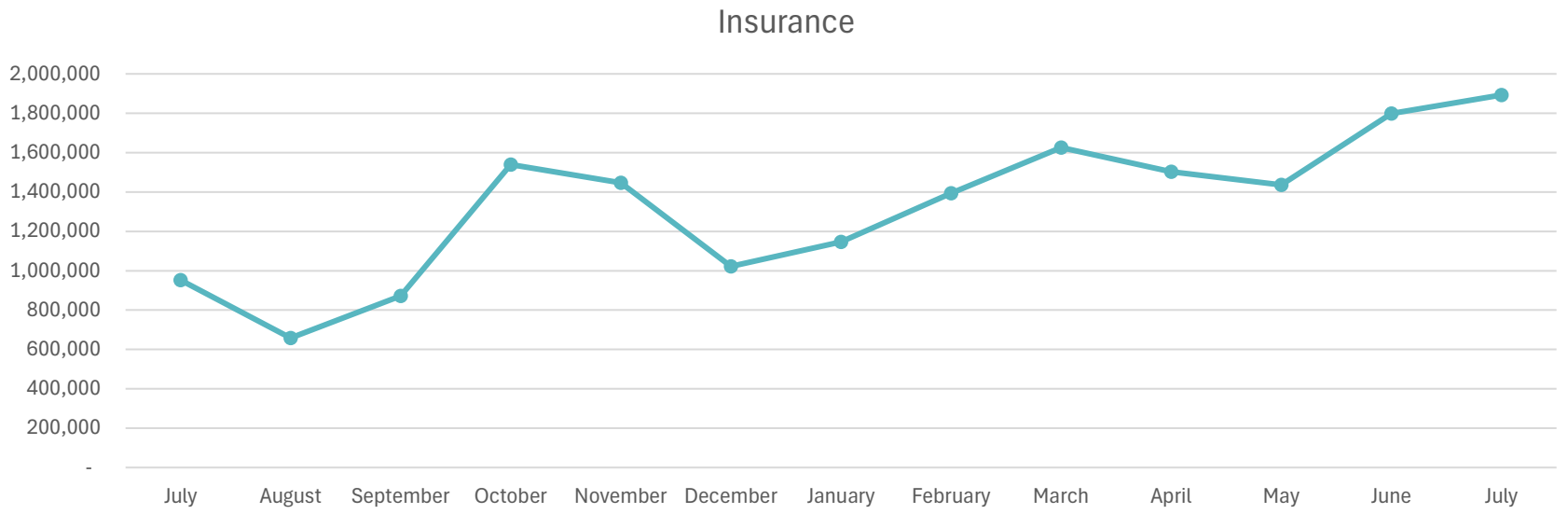


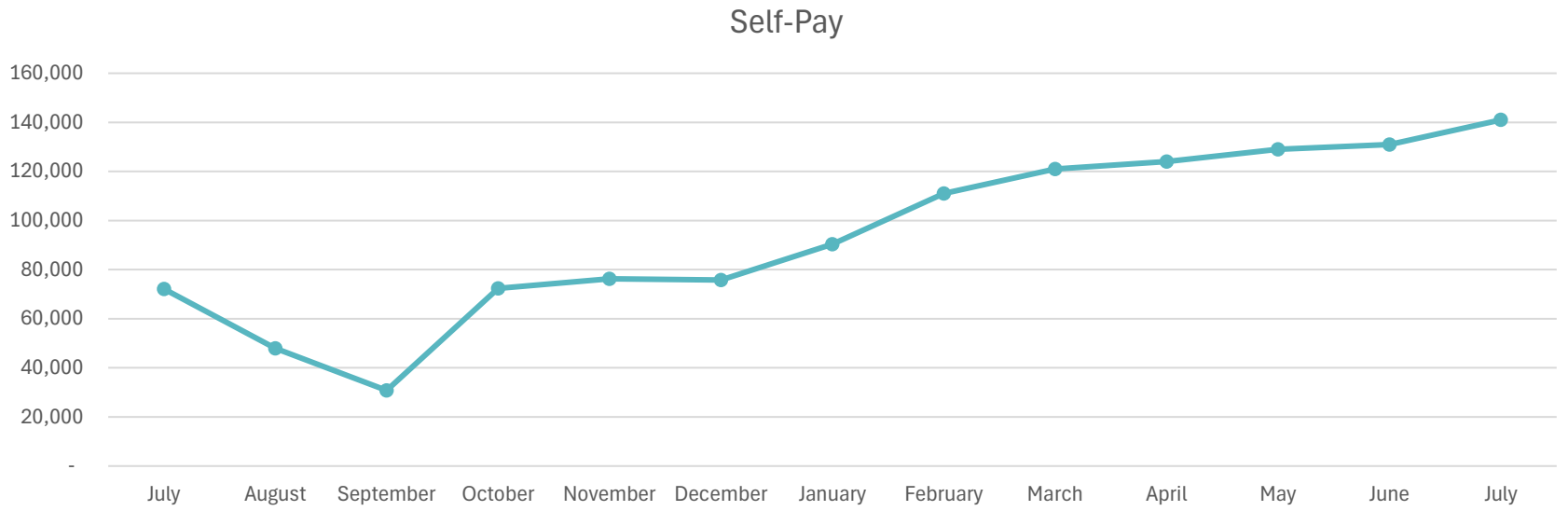
Staff Training

Polices and Procedures

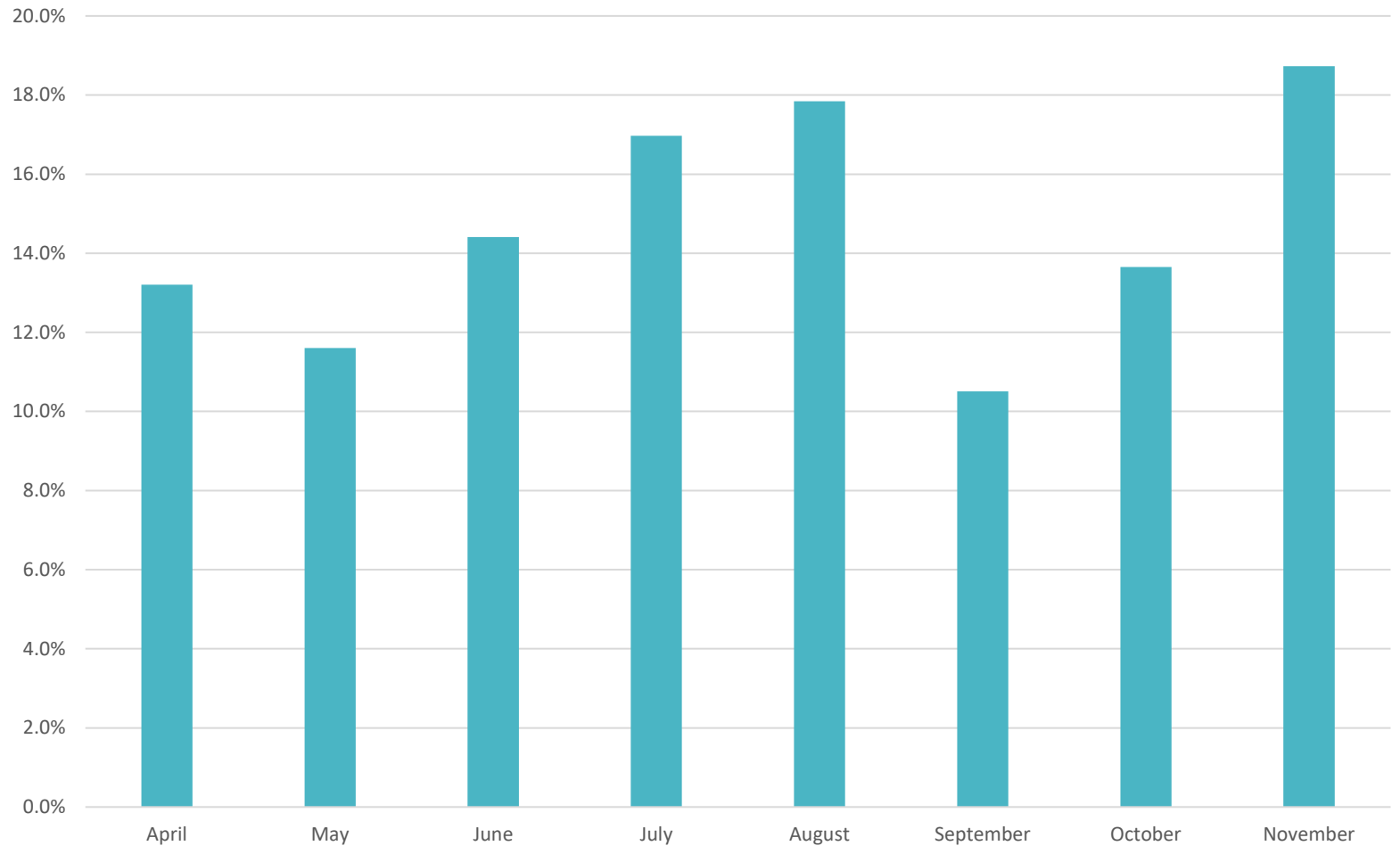
It takes, on average, more than three statements to collect a patient's balance in full. It also costs four times more to collect from a patient than an insurance company, and with 30% of the average healthcare bill coming from the patient, it's imperative that practices collect at the time of service.

Collections





Denials . . . Preventable?



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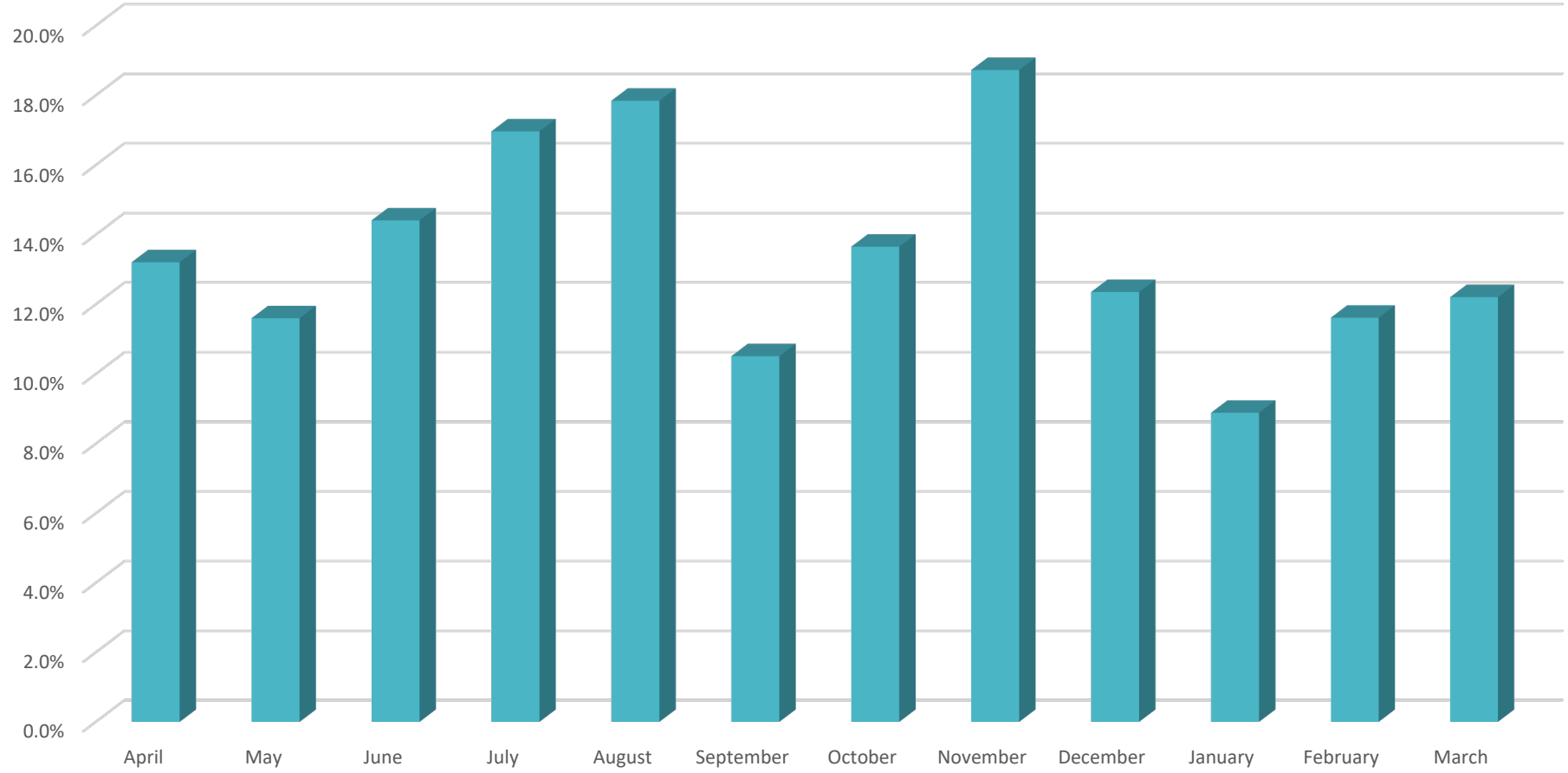
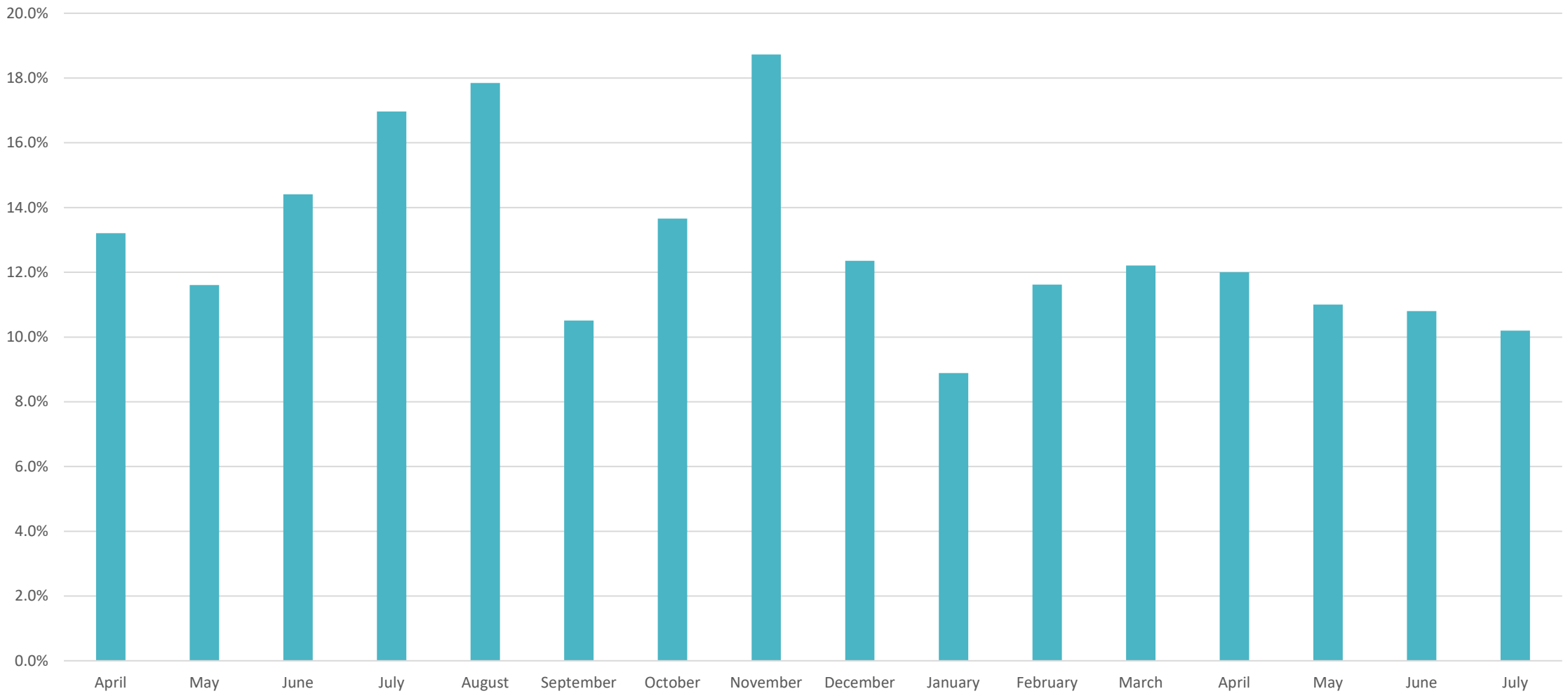


Where are we today?



Denial Trend

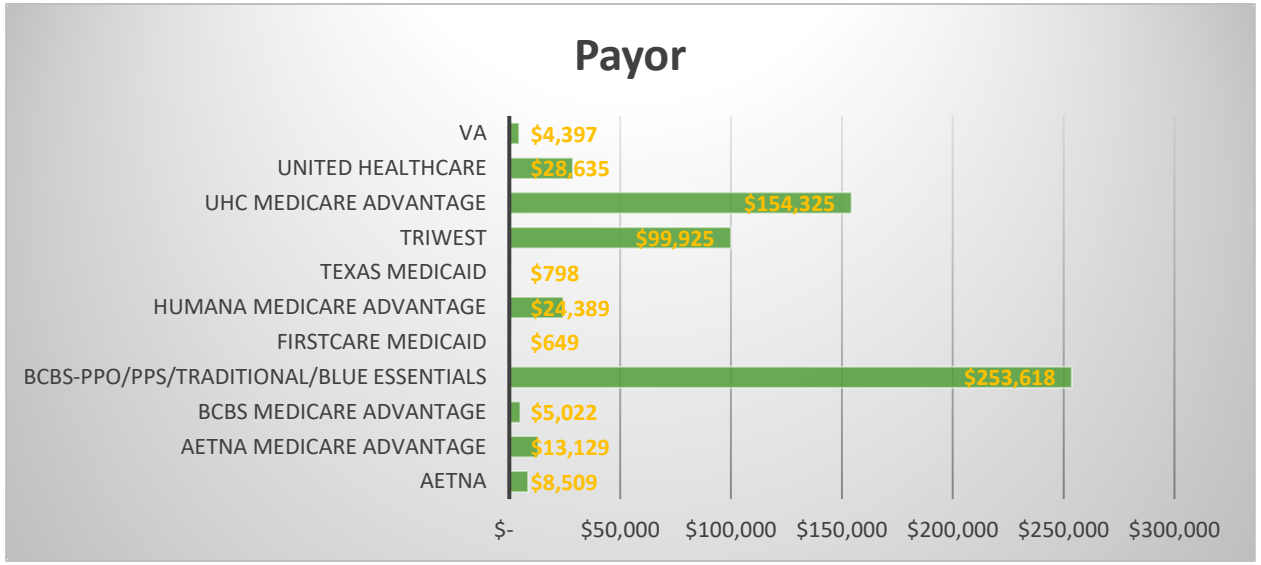
Chargemaster Opportunities

- **Data Entry Errors**
  - CPT 66821 Cataract Extraction w Laser $10,000
  - CPT 66982 Simple Cataract Extraction $2,000
  - Department was choosing the correct procedure and coder was verifying but . . .
  - Chargemaster inadvertently switched
  - $8,000 variance x 30 procedures in a day = $240,000 leakage

- **Quarterly Review/Audit**
  - Duplicates (CPT 99283)
  - Below Medicare Pricing
  - Zero Pricing
  - Deleted Codes

Underpayments

- Most Payors Underpay by an Average of 7% to 11%
- Rate Letters
  - Medicare Advantage
- Contract Reviews
- Medicare Benchmark



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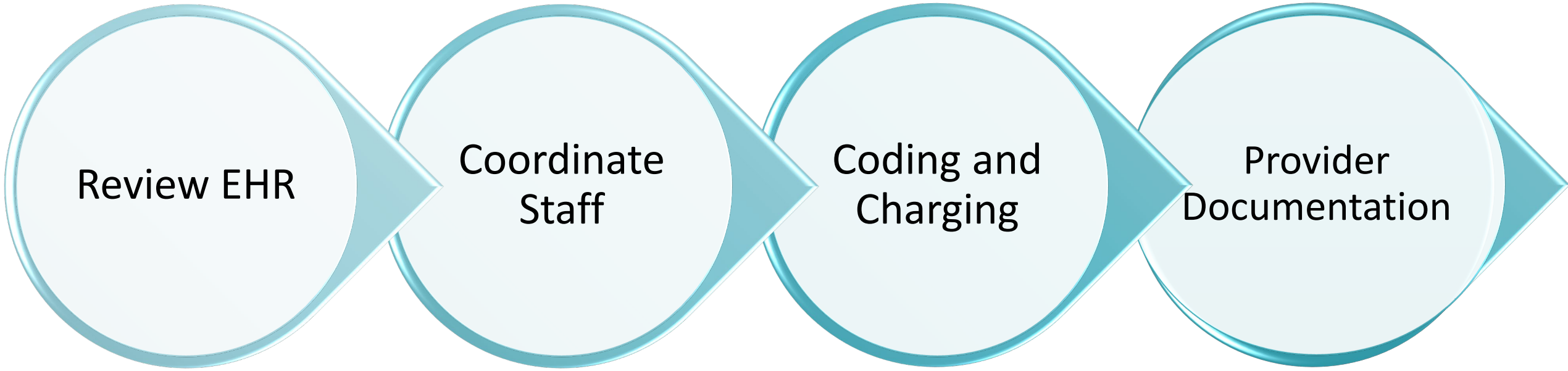
Assess RCM Workflow Early & Often

Workflow Gap Assessments



Electronic Health Record

HRS Identified:

- Charts Flowing to Multiple Work Queues
  - Created Overstatement of total discharged not billed (DNB)
- Misalignment with Facility and Professional fee accounts
  - Missed Professional fee coding and charges
    - Missed Revenue

Coordinate Staff

Follow Coding Guidelines

Maximum Reimbursement, Minimal Denials

Department Staff vs Coder

Coding Should be Completed by Credentialed Coder

Charge Entry for Infusions and Injections

Complex Guidelines

Coding and Charging

Credentialed Coder

Coder Education

Encoder Software

Billing Edits

Documentation

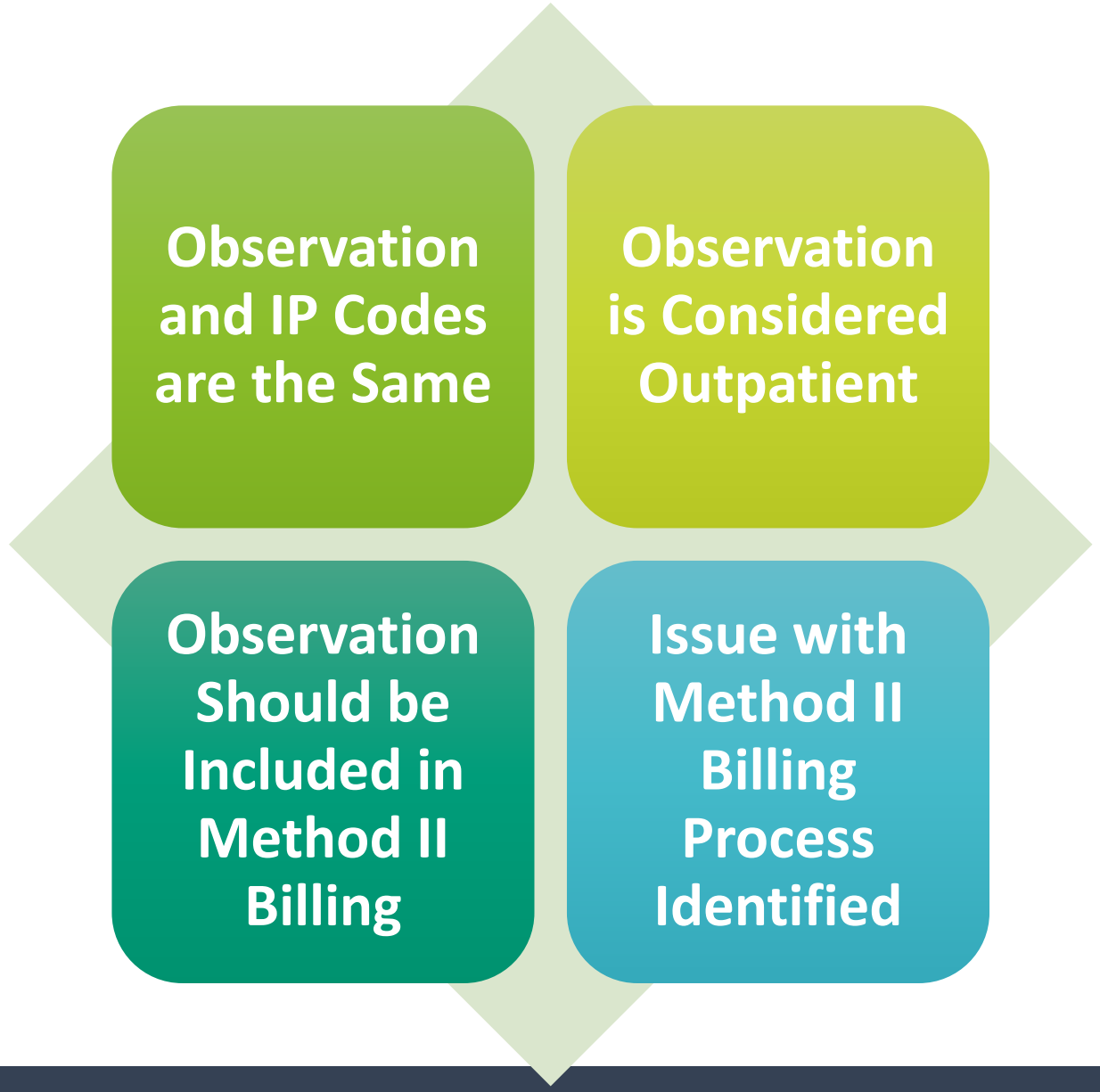
Adequate provider documentation

- Quality over Quantity
- Specific Diagnoses
- Current vs Historical Conditions

Adequate Staff Documentation

- Therapy Notes
- Nursing Notes

Additional Improvements



Expertise to fill the Gaps

- Shortage of Expertise in Rural Areas
- Fill the Gaps
- Ability to Quickly Scale
- Leverage Experience and Expertise

Get Tough on Tech

- Strong Workflows
- Reliable Reporting
- Contract Management
- Leveraging AI – Auto Coding

4

Summing It Up

Summing it Up

- Can't Afford Neglect
- Regular Audits and Monitoring
- Identify Gaps in RCM
- Review EHR
- Education
- Collaborative Payor Relationships
- Coordinate Staff
- Coding & Charging
- Reduce Bad Debt
- Business Partner Support

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Paramount Healthcare Solutions *is a healthcare consulting firm focused on guiding physicians and clinics to advance and improve their reimbursement strategies, workflow processes and provider compensation methodologies in the emerging value-based environment for optimal cash realization, patient experience and overall bottom line to the organization.*

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HRS *is a trusted partner for healthcare organizations delivering expert solutions in coding integrity, revenue cycle management, clinical documentation, compliance, and denials management. Our team of HIM professionals ensure accurate coding, streamlined workflow, and appropriate reimbursement helping improve financial performance, while maintaining regulatory compliance.*

5

Tools of the Trade Addendum

Operational Metrics

Front Desk

Indicator	Calculation	Target
Pre-Registration Rate	# Patient Encounters/ # Scheduled Patients	>95%
Insurance Verification Rate	# Verified Encounters/ # Scheduled Patients	>95%
Service Authorization Rate	# Authorized Encounters/ # Patients Requiring Authorization	>95%
Front Desk Denial Rate	# Front Desk Denials / # Total Denials (Registration/Eligibility/Authorization)	<2%
Appointment Confirmation Rate	# Appointments Confirmed/ # Total Appointments	>95%
Time of Service Collection Rate	TOS Collections / Total Patient Responsibility to Collect	>98 % (Office) >80% (Balance)
Insurance Card Capture Rate	# Total Captured Cards / # Total Insured Patients Seen	>98%

Operational Metrics

Coding, Charge Entry and Billing

Indicator	Calculation	Target
Average Day Lag (Charges)	# Lag Days / # Total Claims (Coding / Posting / Billing)	<24 Hours (Office) <72 Hours (Off-Site)
Missing Charge Rate	# Missing Encounters / # Total Encounters	0%
Clean Claim Ratio	# Failed Claims / # Total Submitted Claims	>98%
Claims Pending on Edit	# Pended Claims / # Total Claims (Held Claims)	<1%
Coding Denial Rate	# Coding Denials / # Total Denials	<2%
Charge Entry Denial Rate	# Charge Entry Denials / # Total Denials	<2%

Operational Metrics

Payment Entry and Follow Up

Indicator	Calculation	Target
Average Day Lag (Payments)	# Lag Days / # Total Paid Claims (Payment Entry)	<24 Hours
Payment Entry Error Rate	# Payment Entry Errors / # Total Posted Entries	<2%
Timely Account Follow Up	(Next Follow Up Date – Initial Follow Update) # Days / # Total Worked Outstanding Claims	<30 Days
Timely Denial Management	(Submission Date – Posting Date) # Days / # Total Denials	<7 Days
Untimely Denial Follow Up Rate	# Untimely Denial Follow Up Denials / # Total Denials	<0%
Patient Inquiry Response Rate	# Hours to Respond / # Patient Inquiries	<24 Hours

Accounts Receivable Metrics

Denials and Aging

Indicator	Calculation	Target
Days in A/R	Net (Gross) AR/ Average Daily Net (Gross) Charges (Revenue)	<35 Days
Gross Collection Rate	Payments/ Charges (Revenue)	*Fee Schedule Mark Up
Net Collection Rate	Payments- Refunds/ Charges (Revenue)-Adjustments	>97%
AR Over 120	Billed AR Over 120 / Total Billed AR	<5%
Payer Mix	Charges (Revenue) & Payment Distribution	Monitor
Overall Denial Rate (1st Pass)	# Claims Denied / # Claims Billed	<5%
Appeal Efficiency Rate	# Claims Paid After Appeal / # Claims Appealed	>75%
Bad Debt as a % of Charges	Bad Debt / Gross Charges (Revenue)	<3%
Credit Balance %	Total Credit Balances / Total Billed AR	<2%

Staffing Productivity Metrics

Front Office

Function	Sample Production Measures
Appointment Scheduling	With No Financial Clearance 11-18 Appointments Hour With Financial Clearance 7-11 Appointments/Hour Surgery Scheduling 3-4 Appointments/Hour
Insurance Verification	15 Visits/Hour
Benefits Verification	13 Visits/Hour
Referrals	8-13 Authorizations/Hour
Financial Clearance	9-11 Verifications/Hour
Check In	With Data Verification & Cashiering 11-14/Hour
Check Out	With Scheduling & Cashiering 8-12/Hour

Staffing Productivity Metrics

Middle and Front

Function	Sample Production Measures
Coding	E/M Coding 15-20/Hour Procedure Coding 6-12/Hour
Charge Entry	55-75 Service Lines/Hour 20 Charge Corrections/Hour
Claims Edits	20 Claims/Hour
Payment Entry	150 Manual Lines/Hour 20 Electronic-Posted Rejections Resolved/Hour
Credit Balances	10 Credit Balances Resolved/Hour
Self Pay Follow Up	10-13 Accounts Worked/Hour
Correspondence	13-15 Worked Accounts/Hour
Insurance Follow-Up	7-10 Worked Accounts/Hour