Revenue Cycle Management Training

Best Practices for a Healthy Revenue Pipeline
Agenda

- 8:00 am - Revenue Cycle Management Key Financial Indicators
- 8:30 am - Optimize workflow for Practice Management Administration Build
- 9:00 am - Optimize workflows for Pre-Registration, Registration, and Data Integrity
- 9:30 am - Optimize Payment Collection and Billing workflows to reduce rejections
- 10:00 am - Optimize workflow for Managing Schedules
- 10:30 am - Optimize workflows for the Billing Component
- 11:30 am - Optimize Reports –
- Recap
With over 20 years in healthcare and revenue cycle management. I have been in my current role with Visualutions, as sales engineer specializing in Revenue Cycle Management Contracting for over a 2 years and I have been with Visualutions for almost 7 years. In my former career, I spent 19 years as a Practice Administrator and RCM Director in various environments including FQHCs, CHCs and FFS. I am solution oriented and well versed in the needs of FQHC’s. I enjoy my position because it allows me to work closely with organizations to solve problems, provide solutions and ultimately, succeed financially.
## Revenue Cycle Management
### Key Financial Indicators

<table>
<thead>
<tr>
<th>Billing Function</th>
<th>Service Expectation</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>Obtain demographic and insurance information</td>
<td>98% accuracy</td>
</tr>
<tr>
<td>CHC/UDS tables</td>
<td>Obtain Race, Language, Ethnicity, Veteran, Homeless status</td>
<td>98% accuracy</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Determine patient needing prior authorization pre-visit</td>
<td>98% accuracy</td>
</tr>
<tr>
<td>Time-of-service Collections</td>
<td>Collect copayments, patient account balances and Slide Fee</td>
<td>98% accuracy</td>
</tr>
<tr>
<td>Coding</td>
<td>Physician Coding</td>
<td>Chart Audits for coding accuracy. Rejections for incorrect coding 0-1% of visits</td>
</tr>
<tr>
<td>Claim</td>
<td>Supporting documentation for claims</td>
<td>100% same day</td>
</tr>
<tr>
<td></td>
<td>Edits completed</td>
<td>100% same day</td>
</tr>
<tr>
<td></td>
<td>Claims Denial/rejections rate</td>
<td>&lt; 5%</td>
</tr>
<tr>
<td>Charge Entry</td>
<td>Days Lag</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>DOS to DOE</td>
<td>48 hours</td>
</tr>
<tr>
<td>Account Follow-up</td>
<td>Every 30-45 days</td>
<td>100% accuracy</td>
</tr>
<tr>
<td></td>
<td>Percent A/R &gt; 120 days</td>
<td>15-18%</td>
</tr>
<tr>
<td></td>
<td>Net Collections (non-PPS/Encounter rate)</td>
<td>95% or greater</td>
</tr>
<tr>
<td>Payment Posting</td>
<td>Cash posted, EFT posted and incoming mail payments posted</td>
<td>100% same day for front end collections. 24 hours for billing office collections</td>
</tr>
<tr>
<td>Overpaid/Refunds</td>
<td>Overpaid and refunds</td>
<td>Fully researched and resolved within 60 days</td>
</tr>
<tr>
<td>Collections</td>
<td>Patient accounts to collections</td>
<td>110 days</td>
</tr>
<tr>
<td>Denials</td>
<td>Percent of denials for timely filing</td>
<td>0%</td>
</tr>
<tr>
<td>Management reporting</td>
<td>Reports available within 5 business days after month end</td>
<td>100%</td>
</tr>
</tbody>
</table>
## RCM Snapshot - Leading Financial Indicators

### Cost as a Percent of Net Collections

#### National Averages

<table>
<thead>
<tr>
<th>Front-end Billing Costs</th>
<th>% of Net Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>1-2%</td>
</tr>
<tr>
<td>Back-end Billing Costs</td>
<td>% of Net Collections</td>
</tr>
<tr>
<td>Primary Care</td>
<td>7-9%</td>
</tr>
<tr>
<td>Urgent/Emergency Med</td>
<td>11-13%</td>
</tr>
<tr>
<td>Specialties</td>
<td>6-8%</td>
</tr>
</tbody>
</table>

### Reasons for low collections

<table>
<thead>
<tr>
<th>CHARGES</th>
<th>REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient volume</td>
<td>Payer mix</td>
</tr>
<tr>
<td>Charge entry</td>
<td>Adjustments</td>
</tr>
<tr>
<td>Fee Schedules</td>
<td>Denials</td>
</tr>
<tr>
<td>Coding practices</td>
<td>Account Follow-up</td>
</tr>
<tr>
<td>Contract negotiation</td>
<td>Front-end processes</td>
</tr>
<tr>
<td>Incomplete charting</td>
<td>Payment posting</td>
</tr>
<tr>
<td>Front-end process</td>
<td>Claims process</td>
</tr>
<tr>
<td></td>
<td>Credentialing</td>
</tr>
</tbody>
</table>
Optimize workflow for Practice Management Administration Build

FOCUS - EDI Data Base Review Tables
- Company and Facility
- Responsible provider
- Insurance carrier
- Real-time eligibility
- Procedure tables
- Fee schedules
EDI Tables and how they impact RCM

Centricity Practice Management Administration Tables impact the entire RCM pipeline. Changing these tables, deleting from the table or not understanding the “build” of each table, can have a substantial impact on EDI, Reporting, End User workflows and eventually, cash flow.

- #1 area of concern when performing an EDI Data Base Review
- Identify a Data Base Administrator Team- PM and EMR
- Deleting vs. zzDNU
- Maximizing the tables for ease on the End User
EDI Data Base Review Tables

Company Table-
• Information Tab- Zip +4, NPI, Tax Id, Pay To Address
• Identification Tab- All/All Row, Carrier Specific Rows

Responsible Provider Table-
• Billing Identification- All/All Row Filing as a Group, Tax ID
• Fee Schedules- All/All Row, Carrier Specific Fee Schedules
EDI Data Base Review Tables

Facility Table-
- Information Tab- Type of Bill, Zip +4, Default Company, Default Place of Service
- Billing Identification- All/All Row, CLIA Specific Row

Clearinghouse Table-
- Carrier Setup- Information Tab
- EDI tab setup- Plugin Settings, Approval Settings, Eligibility Settings
EDI Data Base Review Tables

Procedure Codes-
• CPT Code setup- Information Tab
• Procedure Fee Schedule- Fee Schedule Tab

Clearinghouse Table-
• Carrier Setup- Information Tab
• EDI tab setup- Plugin Settings, Approval Settings, Eligibility Settings
Optimize workflows for Pre-Registration, Registration and Data Integrity

Focus-
• Create test and implement workflows
• Pre-registration data
• Registration patient facing
• Data integrity
Benchmarks and goals

<table>
<thead>
<tr>
<th>Benchmarks-</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benchmarks</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Error rates</strong></td>
<td>Demographic, UDS, CHC and Insurance</td>
</tr>
<tr>
<td><strong>Time-of-service Collections</strong></td>
<td>Collections of copay and past balances</td>
</tr>
<tr>
<td><strong>Insurance Verification</strong></td>
<td>Assigned to alternate staff not patient facing</td>
</tr>
<tr>
<td><strong>Check-In</strong></td>
<td>With scheduling and collections</td>
</tr>
<tr>
<td><strong>Check-In</strong></td>
<td>With scheduling, collections and full demographic updates</td>
</tr>
</tbody>
</table>

**Best Practices- Goals**
- Great Customer Service
- Generate clean claims from a demographics stand point
- Increase time of service payments
- Reduce the amount of collections after the visit

**Best Practices- Customer Service**
- First impressions count - clean up the space and smile
- Greet each patient immediately
- Work as a team, help each other with overflow
- Manage patient flow closely
- Discuss significant billing issues in private
  - have at least one billing staff with an office near the front

**Best Practices- Keep Them Busy**
- There should be no down time at the front desk
- Use slow times to perform pre-visit verification

**Best Practices- Oversight**
- Track copay collection rates
- Track denial reason rates
- Provide immediate remediation and training
- Set goals and reward staff for achievements
The Pre-Visit Process

CPS Practice Management

Start

Launch the Schedule Component

- Open a schedule using 1 of the following methods:
  - Saved Schedule
  - Facility
  - Resources
  - Enter the Date to Verify Appointments

Select List View for the Schedule View

Call the Patient to Confirm the Appointment

Patient Answer? Yes

- Confirm Patient Appointment

Appointment Kept? Yes

- Right Click Select Modify Patient Information

Review Patient Demographics; Insurance, Eligibility, Financials Tab

Update Appointment Status to Confirmed

- Update Appointment Status:
  - No Answer or Left Message

Cancel or Reschedule Appointment

No

End

Note: For Easy Viewing Columns on this window can be modified by Right Clicking on the Column Heading and then Saving Patient Columns. Recommended List Order may be: Start, Stop, Type, Name, Phone1, Phone2, Eff Date, Ins Carrier, Eligibility, Verified by, Verified Date
Optimize Payment Collections and Billing workflows to reduce rejections

Focus:
- Time of service collections
- Insurance data entry
- Real-time eligibility
- Slide fee schedules
## Benchmarks and goals

### Benchmarks -

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error rates</td>
<td>Demographic, UDS, CHC and Insurance</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td>Time-of-service</td>
<td>Collections of copay and past balances</td>
<td>98%</td>
</tr>
<tr>
<td>Collections</td>
<td>Collections of copay and past balances</td>
<td>98%</td>
</tr>
<tr>
<td>Insurance Verification</td>
<td>Assigned to alternate staff not patient facing</td>
<td>90-110 per day = 13-20 per hour</td>
</tr>
<tr>
<td>Check-In</td>
<td>With scheduling and collections</td>
<td>70-90 per day = 10/13 per hour</td>
</tr>
<tr>
<td>Check-In</td>
<td>With scheduling, collections and full demographic updates</td>
<td>60-80 per day = 8-12 per hour</td>
</tr>
</tbody>
</table>

- Set small daily/weekly/monthly collection goals.
- Reward achievements
- Capitalize on all contact opportunities
- Expand alternative payment options
SwervePay integration with Patient Payment Entry:

- Allows users to swipe credit cards in the Patient Payment Entry tool and post payments directly to Centricity Practice Solutions.
- Includes fully supported merchant account with advanced reporting.
- Citrix and RDS supported card swiper.
Optimize workflow for Managing Schedules

Focus-
• Advanced Features
• Template maximization
• Sets and Chains
• Recalls
• Waiting List
• Views
Redesigning the Schedule to Maximize Productivity

- Establish a visits-per-day target
- Determine duration of Appointment Types
- Create a Chart- Short>Medium>Long visits
- Define time increments that work
- Experiment on paper!
- Take time to train
- Put the scheduling scheme into operation
### Alternative Scheduling Approaches

**Modified wave scheduling**
- Overlapping appointments
- Create heavier volume in the AM and PM start
- Decrease volume as end of blocks
- No more patient delays or long wait times
- See more patients with fewer frustrating waits

**Fixed wave scheduling**
- Efficiency is key
- Simultaneous schedules
- Appointment types are not priority
- First Come – First Served
- Fixed time slots
- Longer waits for the late patient
Double booking

- Minimize down time
- Jumpstart the AM/PM
- Increased Productivity
- Modulate time imbalances
- Catch-up time
- First come/ First Served
- Interspersing Established with New Patients

Like visits together

- Continuous workflow and process speed
- Eliminates set-up time
- “Assembly Line” scheduling
- Scheduling by patient categories
- Straight-forward vs complex time
- Group focused scheduling concept
Staggered Starts

- Staggering visits in 5/10 minute intervals
- Helps avoid gaps when patient arrives late
- 9:00 am - Patient A ... 9:05 Patient B = Only losing 5 minutes vs. 15 minutes.
- Allows for flexibility with work in or walk in patients
- Allows catch-up for unpredictable patient visit types.

Group Focused Scheduling

- Supportive atmosphere for the chronic condition patient
- Productivity is not lost for no show patients
- Primarily used for larger staff-model, Nutritional, Flu Clinics or Behavioral Health visits.
- Group Focus enhancement
Appointment Sets

Appointment Sets-

• Multiple appointments for the same patient on the same day.
• Used for visits that have multiple parts.
• Displays Single Visit in Billing module
• Appointments must have identical
  – Company
  – Facility
  – Responsible Provider
  – Appointment Date
Appointment Chains

Appointment Chains-

• Recurring appointments
• Multiple appointments at once for the same patient but on **different dates**.
• No impact to the Billing module.
• A separate visit will be created for each booked appointment.
The Wait Status View is designed to give the user a complete view of appointments in a list format based upon the user’s selection of:

- Date
- Facilities
- Resources

The view gives the ability to sort by:

- Appointment Time
- Patient Name
- Resource
- Check-In Time
- With Provider Time
- Checked Out Time
- Appointment Status.
Start

Launch the Schedule Component:
- Open a schedule using 1 of the following methods:
  - Saved Schedule
  - Facilities/Resources
  - Choose appropriate date
- Right click on the Desired Time Slot and select
  "New Patient Appointment"
- Search for the patient using DOB i.e. 11/21/1989

Patient Displayed?

Yes:
- Double click the patient from the Final Patient Window
- Complete Appointment Details
  - Click OK to save
- Adds Patient to Chart Module

No:
- Click 'New' and Complete the required fields on the New Patient Window

End
Optimize workflows for the Billing Component

Focus-
- Managing status’
- Working the AR
- Benchmarking
- Practical Tools
- Avoiding potholes and missed financial opportunities
**Benchmarking**

### Best Practice Tips

A 5% to 10% denial rate is the industry average; keeping the denial rate below 5% is more desirable. Automated processes can help ensure your practice has lower denial rates and healthy cash flow.

### Calculating Denial Rate

To calculate your practice’s denial rate, add the total dollar amount of claims denied by payers within a given period and divide by the total dollar amount of claims submitted within the given period.

### Sample Calculation

(Total of Claims Denied/Total of Claims Submitted)

- Total claims denied: $10,000
- Total claims submitted: $100,000
- Time period: 3 months
  - $10,000/$100,000
  - 0.10
- Denial rate for the quarter: 10%

### Denial Reasons

- Incomplete or inaccurate insurance information: < 1%
- Lack of pre-certification or prior authorization: < 1%
- Not capturing all of the tests or procedures, diagnoses and procedure coding errors or omissions: < 5%
- Past filing limits submission of claims: < 1%
- Lack of meeting medical necessity: < 5%
- Patient not eligible time of service: < 1%

### Percent of A/R Performance Measure

- > 120 days
  - Low Performing – 20.5%
  - National Median- 21.32%
  - High-Performing- 10-11%

### Account action

- Documented in correspondence notes
  - Every 30 days on unpaid claim

### Research and resolve

- By telephone and documented in correspondence notes
  - 5-10 minutes per claim = 6-12 accounts per hour

### Research and resolve

- Appeal letter
  - 15-20 minutes per claim = 3-4 per hour

### Claim status and rebill

- Checking status by phone or claims tab, making corrections and rebilling
  - 1-5 minutes per claim = 12-60 per hour

### Calculating Denial Rate

To calculate your practice’s denial rate, add the total dollar amount of claims denied by payers within a given period and divide by the total dollar amount of claims submitted within the given period.

#### Sample Calculation

\[
\text{Total claims denied: } \$10,000 \\
\text{Total claims submitted: } \$100,000 \\
\text{Time period: } 3 \text{ months} \\
\text{\$10,000/\$100,000} \\
\text{0.10} \\
\text{Denial rate for the quarter: } 10\%
\]
## Denial Management

### Best Practice Tips

To prevent denials, staff members should be assigned to monitor correspondence, instructions, bulletins, etc., from high volume payers. Information should be shared with the appropriate providers and staff members so claims can be completed and transmitted according to the payers’ specifications. Transfer of knowledge is also key to success to ensure all billing staff is cross-trained on all carriers.

<table>
<thead>
<tr>
<th>Denial Management</th>
<th>Definition</th>
<th>Favorable Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Follow-up</td>
<td>Prioritize denial follow-up- No response vs. Response with work needed</td>
<td>Sort by DOS and $ amount</td>
</tr>
<tr>
<td>Ensure Timely Denial Follow-up</td>
<td>Ensure accounts are worked based on aging buckets. Develop a queuing strategy</td>
<td>All accounts worked within 15-30 days of denial</td>
</tr>
<tr>
<td>Follow-up on Open Claims</td>
<td>Open claims are in the status of Filed Succeeded but have not been adjudicated.</td>
<td>All accounts in Filed succeeded longer than 15-30 days</td>
</tr>
<tr>
<td>Duplicate Billing</td>
<td>Do not automatically rebill, investigate the status and take action on the claim</td>
<td>Daily</td>
</tr>
<tr>
<td>Clean-up A/R</td>
<td>Accounts greater than 365 days should not be on A/R</td>
<td>Manage write-off of uncollectable A/R</td>
</tr>
<tr>
<td>Small Balance Adjustments</td>
<td>Determine small balance levels and manage adjustments</td>
<td>Daily</td>
</tr>
<tr>
<td>Organize staff by Payer</td>
<td>Development of payer relationships, experts in practice, increased focus on follow-up and ability to assess staff productivity of efforts</td>
<td>Benchmarking</td>
</tr>
<tr>
<td>Follow-up Strategies by Payer</td>
<td>Define how and when to follow-up based on payer</td>
<td></td>
</tr>
<tr>
<td>Prioritize A/R efforts</td>
<td>Report A/R several different ways. Days in A/R, dollar amount, payer type, DOS/DOE</td>
<td>Daily turnover for higher cash flow</td>
</tr>
<tr>
<td>Education and Training</td>
<td>Create process for contacting payer, noting account escalating issues and appeals.</td>
<td></td>
</tr>
<tr>
<td>Systematic Follow-up Process per Payer</td>
<td>Establish a method of corresponding with the payer.</td>
<td>Payer Reps and staff development</td>
</tr>
<tr>
<td>Denial Management</td>
<td>Multidisciplinary process of looking at denials to determine target areas for improvement, such as provider education, charge capture review and analysis. Denial reason trends.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Communication</td>
<td>Initiate routine feedback loop to front-end to inform and report denial trends and engage in correcting these claims</td>
<td>Education and cross training</td>
</tr>
</tbody>
</table>
Billing

Start

Access the Billing Criteria Window

Filter visit(s) on the Billing Criteria Window using:
- Visit Date/Time
- Facility/Patient

Approving a Single Visit?

Yes

Double Click on the Visit

Review the Visit Information (Window for Visit Details/Acceptance)

Select File/Approve

Review visit Status

Approved

Approved Failed

Overpaid

Waiting Patient Payment

Paid

End

No

Right Click on the Column Heading and Choose Select All

Click the Approve Button

Note: Sliding Fee Visits should NOT move to "Approved" if Sliding Fee visit moves to "Approved" resolve the insurance balance and re-approve.

Approve Failed

Start

Double Click on the Visit

Review the Notes Tab

System Administration

Correct Administration Setup as Needed

Correct Visit Information

Procedure/Diagnosis

Select the Charges Tab to review procedure/Diagnosis

Correct the Procedure/Diagnosis Error

Select File/Approve

Correct the Registration Error

Correct the Registration Error

Update Visit Message as appropriate

Select "Modify Patient Information" to Correct Registration Error

No

Visit Information OK?

Correct Visit Information

Note: Repeat this process until Visit Status is Approved Primary or Waiting Patient Payment. Approved Failed Status is commonly due to Registration or Procedure Diagnosis Errors.
Optimize Reports

Focus -
• Daily, weekly, and monthly to maximize visibility of revenue cycle opportunities
• VisAnalytics Dashboards
• VisReporting
Focus – VisReporting and Canned Reports

Weekly / Monthly
- Active Reports- “Apply Unapplied Deposits” Weekly
- EDI Tables- Utilize claims rejections to identify EDI tables that need attention-Weekly
- Standardize EDI build- New facilities, providers and Insurance Carriers
- UDS Reports- Review Monthly
- Users- Monthly

Quarterly / Yearly
- PM Administration Tables- Yearly
- Administration Reports- Quarterly
- CPT/ICD10 Codes- yearly
- PM/EMR Inactive Codes and Custom Lists “???” – Quarterly or when rejections occur
- X12 Response Codes- Quarterly and Yearly
- Zip Codes- Quarterly
VisAnalytics Dashboards

Today it is a cloud based analytics suite providing

- Financial (Practice Management)
- Clinical (NQF Quality Measures, Pharmacy)
- Accounting
- PCMH
- UDS

Our philosophy is to support the customer in building a sustainable analytics solution.

- Create and maintain global content
- Create and support custom content
- Train and support customer IT resources
- Build and blend
### Orders Working List

<table>
<thead>
<tr>
<th>Order Number</th>
<th>Provider Name</th>
<th>Order Signed</th>
<th>Order Unresolved</th>
<th>Order Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>00001234</td>
<td>John Doe</td>
<td>Yes</td>
<td>Yes</td>
<td>Completed</td>
</tr>
<tr>
<td>00001235</td>
<td>Jane Smith</td>
<td>Yes</td>
<td>Yes</td>
<td>Completed</td>
</tr>
<tr>
<td>00001236</td>
<td>Bob Johnson</td>
<td>Yes</td>
<td>Yes</td>
<td>Completed</td>
</tr>
</tbody>
</table>

### Code Details

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct</td>
<td>Correct</td>
</tr>
<tr>
<td>Incorrect</td>
<td>Incorrect</td>
</tr>
</tbody>
</table>

### Incurred Codes Details

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2018</td>
<td>ABC1234</td>
</tr>
<tr>
<td>01/02/2018</td>
<td>DEF5678</td>
</tr>
</tbody>
</table>

### Dashboard Best Practices

- **Provider Type**
- **Start Date**
- **End Date**
- **Order Revisions**
- **Order Signed By**
- **Order Type**
- **Order Status**
- **Admin Name**
- **Facility**
- **Hospice**
- **Homeless**
- **Poverty**
- **Type**
- **Age as of Clinician**
- **Age as of Today**
- **Public Housing**
- **Veteran**
- **Elderly**
- **Gender**
- **Age As Of June 30**
- **Service Duplication**
- **Ambulatory Status**
- **Event**
- **Patient Explication**

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**Evidence To Practice**

The Learning Healthcare System
In a Pinch

Staffing shortages impact the Revenue Cycle Pipeline
- A’ la’ carte services
- Coding services
- New hire training onsite/online
- Refresher training

Outsourcing RCM in the future?
- Only work with a company that specializes in FQHC billing
- Patient Centered Medical Home, meeting HEDIS or Meaningful Use thresholds, and/or IPA Risk Pool distributions should not be included in your service fee (%)
- Work with a team of experts that build your knowledge along the way
- Collaboration for success- We are We
The Revenue Cycle is the largest single balance sheet item within a Community Health Center. Revenue cycle processes flow into and affect one another. When processes are executed correctly, the cycle performs predictably. Problems and errors that occur early in the cycle can have significant negative effects at the end that typically impact efficiency, productivity, and performance. The further an error travels through the revenue cycle, the more costly revenue recovery becomes. Therefore, it’s important to have a general understanding of the steps in the revenue cycle, and how to target processes that improve performance.

Thank You

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