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CPAs & Advisors

Navigating Your Tribal Revenue Cycle

October 8, 2019

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Presenters

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Key Objectives

1. Explain the importance of patient access & eligibility verification
2. Discuss the elements of revenue integrity
3. Describe the benefits of a healthy denials prevention

WHAT ARE THE BENEFITS OF A HEALTHY REVENUE CYCLE ?

1. Preserve revenue & reduce leakage
2. Improve compliance & reduce risk
3. Organizational confidence in revenue cycle

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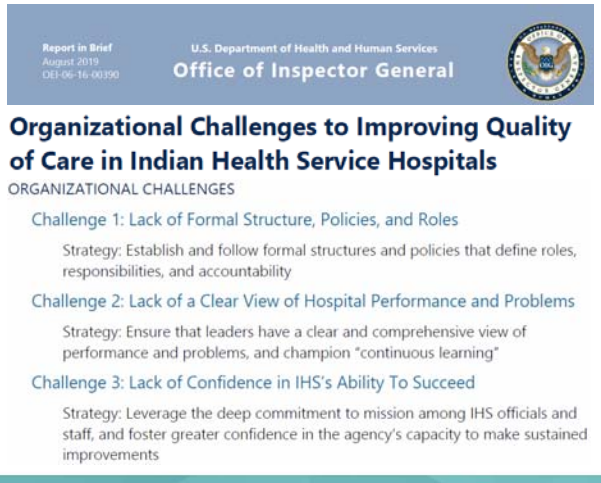
National Health Care Industry & Tribal Delivery Systems Confront Similar Challenges

- Profit margin
- IT system conversions
- Qualified providers & staff
- Monitoring quality & performance
- Data analytics
- Reform
- Opioid crisis



Report in Brief
August 2019
OEI-06-16-00390

U.S. Department of Health and Human Services
Office of Inspector General

Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals

ORGANIZATIONAL CHALLENGES

Challenge 1: Lack of Formal Structure, Policies, and Roles

Strategy: Establish and follow formal structures and policies that define roles, responsibilities, and accountability

Challenge 2: Lack of a Clear View of Hospital Performance and Problems

Strategy: Ensure that leaders have a clear and comprehensive view of performance and problems, and champion "continuous learning"

Challenge 3: Lack of Confidence in IHS's Ability To Succeed

Strategy: Leverage the deep commitment to mission among IHS officials and staff, and foster greater confidence in the agency's capacity to make sustained improvements

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Everyone needs a trusted advisor. Who's yours?

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Revenue Cycle Overview

	PATIENT ACCESS	REVENUE INTEGRITY	BILLING, POSTING & ACCOUNT RESOLUTION		
FUNCTION	• Pre-registration & Registration • Insurance eligibility • Prior authorization • Estimation • Point-of-service collections	• Charge capture • Charge description • Master/fee schedule • Pricing • Procedural coding • ICD 10 coding & clinical documentation improvement • Utilization review • Case management	• Pre-bill edits • Claims submission • Clearing house edits	• Posting • Credit balances • Receivables strategy • Standardized policies • Work tools • Denials & appeal management • Underpayment strategy	• Self-pay management • Vendor management • Patient contact strategy • Financial assistance policy • Bad debt & charity policies
MEASURE	• Pre-registration % • Auth denial rate • Point-of-service collections	• Clinical denial rate • Appeal success rate • Codding accuracy %	• Charge lag days • Final billed not submitted • Clean Claim Rate	• Cash to Net % • % AR > 90 days • Initial denial rate • Denials write off %	• Bad debt % • Self-pay collections % • Balance after ins %




Patient Access & Eligibility

FIVE MOST COMMON DENIALS*

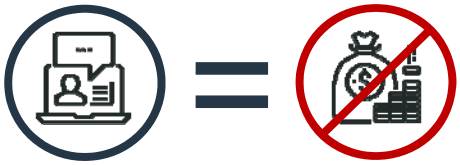

How To | Denials Management

Avoiding the Costliest Denials

Insurance Eligibility

"Subscriber eligibility is one of the most common reasons a claim rejects," Poliseno says. "Eligibility is not only a high-volume denial, but also a costly denial because it always results in the entire claim being denied. It is important to both verify demographic information at every patient encounter to be sure you have the correct insurance plan on file and to ensure the services to be provided are covered."

By Laura Ramos Hegwer



Incorrect Third-Party Insurance = **Medical Claim DENIED**

- Reason
  - Eligibility
  - Uncovered service
  - Missing claim information
  - Duplicate claim
  - Medical necessity
- Department
  - Patient access
  - Patient access
  - Billing
  - Billing
  - Patient access

*Published in *HFMA's Revenue Cycle Strategist*

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WHERE DOES INSURANCE VERIFICATION FOR ELIGIBILITY OCCUR?

PATIENT ACCESS FUNCTIONAL AREAS

- Scheduling
  - "Schedistration"
- Pre-registration
- Prior-authorization
- Registration
- Post visit eligibility check prior to third-party collection efforts

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Methods for Validating Insurance

- Simply asking if a patient is “still on the same insurance” falls short of adequate
- Electronically validate coverage & eligibility dates
  - Clearing House
  - EDI 270/271 Eligibility and Benefit Inquiry and Response
    - Batch or individual
  - Website
    - Availity
    - State sites for Medicaid
    - Insurance specific

CHANGE HEALTHCARE

WAYSTAR

Availity

nthrive

HOW IS PATIENT ACCESS & ELIGIBILITY MEASURED?

PATIENT ACCESS KPIs

Eligibility verification rate %	Verified registrations / Total registrations	98%
Pre-registration rate %	Pre-reg initiated / Scheduled patients	98%
Eligibility denial rate %	Eligibility related denials / Total denials	<4%
Authorization denial rate %	Authorization denials / Total denials	<4%*
Clean claim rate%	Claims passing edits & transmitted / Claims submitted	85%

*Note – Organizational final denial rate <4%

PERFORMANCE IMPROVEMENT & QUALITY REVIEWS – *IMPORTANT TO MONITOR REGISTRATION ACCURACY*

- ✓ Many software systems deliver registration accuracy error rate by registrar
- ✓ Several bolt-on applications offer QA functionality
- ✓ Provides for ongoing education
- ✓ Routine or annual performance reviews

✓ A+

Insurance Screen – 34%			
TASK DESCRIPTION	YES	NO	N/A
Correct Insurance company/address selected (10%)	○	○	○
Insured Info is correct (3%) *(name, relation, date of birth, gender)*	○	○	○
Group Number entered correctly for insurance carrier (5%)	○	○	○
Insured ID # entered correctly for insurance carrier (7%)	○	○	○
Special Info field populated correctly (1%)	○	○	○
Copay field populated correctly (3%)	○	○	○
Valid From date populated (2%)	○	○	○
Valid To date populated for inactive insurance (2%)	○	○	○
Employer is correct (1%)	○	○	○
COMMENTS:			

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Revenue Integrity

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Elements of Revenue Integrity

1 Charge capture & reconciliation

- Office visit Charges
- Home visits
- Procedural cases
- Bedside visits

2 System optimization

- Reporting
- Integration
- Template usage
- Automated processes

3 Coding effectiveness

- Procedural coding
- Diagnosis coding
- Oversight reviews
- Education & retention plan

4 Provider coding proficiency

- CPT coding
- Procedural coding
- ICD10 coding
- Coding compliance
- Denials management feedback

Charge Capture & Charge Reconciliation – *There Is a Difference*

- Charge capture & charge reconciliation are two separate & distinct processes
- Charge capture
  - Should be done on a daily process by department initiating patient charge
  - How often do you have late charges
  - How often is your CDM updated (service lines & pricing)
- Charge reconciliation
  - Validating that, not only is there a charge for the patient, but that the charge itself, is correct
  - Compare schedule to charge entries
    - Validating correct patient
    - Validating correct charge unit
    - Validating correct charge dollar amount

Daily Charge Reconciliation
Weekly Log of Completed Task

Week Beginning Monday:	Department Name:
	Completed By:

	Task Completed						
	M	T	W	TH	F	S	Su
A1. Total # Patients-Confirm that# is consistent with Meditech report							
A2. Total # tests/procedures - confirm that # is consistent with Meditech report							
A3. Total Revenue - confirm that # is consistent with Meditech report							

	Task Completed						
	M	T	W	TH	F	S	Su
B1. By patient- review total charges and types of charges for reasonableness							
B2. By patient-review accounts with minimal charges							
B3. By patient-review accounts with unusually high charges							
B4. By patient- review accounts with high volumes							

Weekly Leader Signatures _____ _____

Clinical & Revenue Cycle System Optimization

- Utilize system to full functionality
- Are you using your system to provide the following?
  - Financial reports
  - Integration between modules
  - Documentation templates
- Identify opportunities to automate

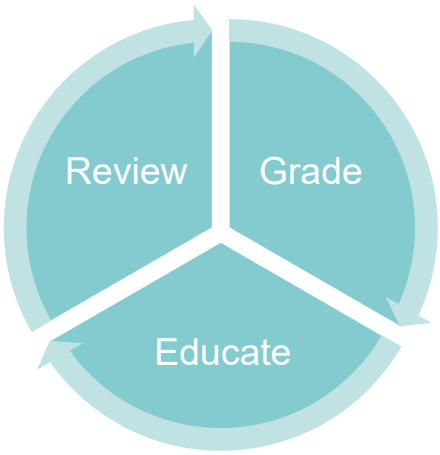
Coder Effectiveness

- Establish coder productivity & accuracy goals/expectations & identify reporting capabilities & needs to effectively manage
- Review coding WQs to identify potential opportunities for prioritizing work flow
- Standardize communication between patient account reps & HIM staff through electronic work queue
- Staff retention & education

Provider Coding Proficiency & Engagement Is Critical for Revenue Integrity

- Developing a physician champion improves provider engagement
- Identify opportunities for physician education & training
  - Assess physician timeliness (charge lag) for chart completion
  - Monitor & evaluate physician coding for accuracy & completeness
- Must have scheduled or routine communication between coders & physicians
  - Is there a physician query process in place?
  - What is the average wait time for physician responses?

Provider Coding Effectiveness & Feedback Program



- Review: charts/accounts for accuracy
- Grade: accuracy of chosen codes
  - 90% = annual review
  - 80-90% = review in 6 months
  - <80% = review in 90 days
- Educate: one-on-one education with staff/provider
- Start the process over until accuracy rate is 80% or higher

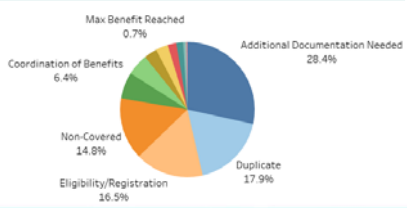
Denials Management

KEYS & EVOLUTION TO A SUCCESSFUL DENIALS MANAGEMENT & PREVENTION PROGRAM

- **Data transparency**
  - Appropriate denial transaction codes
  - Reporting
    - Clearing house reporting & clean claim rate
    - Denials dashboard
- **Collaborative interdepartmental oversight structure**
  - Denials management committee
  - Departmental ownership
  - Root cause analysis
- **Systems optimization & denials management**
  - Remittance code mapping
  - Payor & plan configuration of denial adjustment codes
    - Automate adjustment or review as technical denial
    - Patient access – plan based rules
  - Denials coordinator/appeals management/utilization review
- **Denials prevention**
  - Predictive analytics
    - Payor & scenario specific

Performance Metrics & Measuring ROI

Metric & performance indicators	• Initial denial rate as % of gross revenue & submitted claims (actionable) • Final denial rate as % of net patient revenue (preventable) • Denial write-off total dollars (preventable) • Clean claim rate %
Baseline opportunity metrics (Reduction goal & calculating ROI)	• Total annual operational write-off adjustment $ (trailing 12 months) • Total annual claim remittance denial $ (trailing 12 months) • $ variance between current cost to collect % & reduction to industry best practice level*
Denial & avoidable write-offs Annual posted adjustments (%) due to preventable reasons are a key component to establishing ROI	• Timely filing denial adjustments • Noncovered denial adjustments • Authorization denial adjustments • Clinical/coding denial adjustments • Medical necessity denial adjustments • Late charge adjustments



Conclusion – Protect Organizational Revenue & Prevent Leakage

1. Develop strong patient access processes supported by data & quality review
2. Develop a comprehensive revenue integrity program
3. Develop an integrated approach to denials management & prevention

Questions?

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