Revenue Cycle – Part 2

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Agenda

- ❑ Overview & Definition of the Healthcare Revenue Cycle
- ❑ Medical Institution/Provider Revenue Cycle
- ❑ Revenue Write-offs/Deductions
- ❑ Important Information to Know

Healthcare Revenue Cycle

An *interdependent* process involving multiple departments and staff members, each of whom must complete key job functions in order to ensure the revenue cycle functions efficiently.

-The Academy of Healthcare Revenue

Improve Risk Management - Accreditation

Required to Receive Payment from Medicare/Medicaid Programs

Medicare Conditions of Participation (CoPs) - Must meet in order to begin and continue participating in the Medicare and Medicaid programs. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs.

Joint Commission (JCAHO) – Joint Commission standards focus on state-of-the-art performance improvement strategies that help health care organizations continuously improve the safety and quality of care.

Risk - Standard or Condition Level Deficiency

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation-of-Medicare-Certified-Providers-and-Suppliers

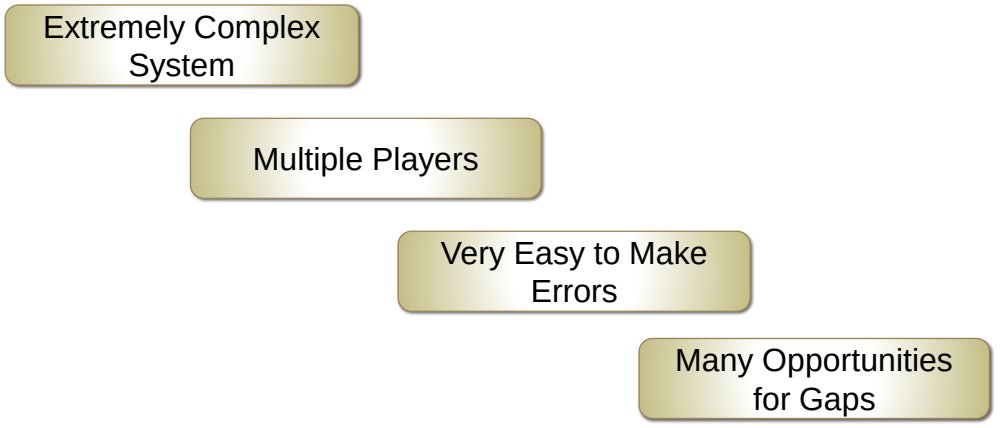
Knowledge Check Question 1

Must all hospitals be accredited by JCAHO?

a) Yes
b) No

Healthcare Provider Revenue Cycle

Revenue Cycle



Audit Cycle Practices

Front End

- Scheduling, Preregistration, Precertification, Insurance Verification & Registration

Clinical

- Patient Care, Provider/Nursing Documentation, Ancillary Services & Discharge

Back End

- Charge Capture, HIM Coding, Professional Coding, Billing & IT

Front End Practices

Registration

- Insurance information – Birthday Rule
- Verify coverage for inpatient admissions, ED visits & surgeries
  - Potential for fraud – use of another's insurance information

- Verification of Patient Information – combined responsibilities
  - General consent – treatment, Informed consent for surgeries/procedures
  - ABN (Advanced Beneficiary Notice) – tests/services may not be covered (CMS)
  - IMM (Important Message from Medicare) – Inpatient (CMS)
  - MOON (Medicare Outpatient Observation Notice) – Outpatient (CMS)

Clinical Practices

Patient Care - multiple individuals performing services under their Scope of Practice

- Physician responsible for Management of Care
  - Documentation of services provided or requested
  - Discharge Planning/Plan of Care
- Nurse, Specialists - Care at the direction of provider
  - Wound therapy, Physical, Respiratory, Dietary
  - All care documented in the medical record

CMS On-line manual 100-07 – SOM, CoPs, JACHO

Backend Practices

Departments considered the 'Backend' of the Revenue Cycle

- Charge Capture – people and software
- Health Information Management
- Professional Coding
- Billing
- IT & Customer Service
  - Reporting
  - Analysis

Knowledge Check Question 2

Radiology is considered a part of this component of the revenue cycle:

a) Front End
b) Clinical
c) Back End
d) None of the above

Charge Capture

Charge Capture – documentation converted to standard codes

- Charge Description Master – validated by CM team
  - Pricing, Standard long & short descriptions for codes
- Routed through the system & reformatted
  - Charge Router, Charge Entry Preprocessor
- Transforms to an appropriate CPT/HCPCS Code on claims
- Submitted electronically 837i and/or 837p

CMS requires all charges at a facility be uniformly applied to all patients

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Professional Coding

Certified by AAPC – CPC, COC, CIC, CRC, CPB & CPMA

- Classify Diseases, injuries based on standard guidelines
  - ICD-9/10-CM diagnostic codes & CPT
- Assign codes based on credentials & scope of practice
  - Other Providers - NP, PA, SW, PT, OT, ST, Psychologists
- Additional Responsibilities
  - Provider education
  - Auditing
  - Compliance

AAPC
Advancing the Business of Healthcare

Risk – Under/Over Coding

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Health Information Management (HIM)

RHIT, RHIA & CCS - Credentialed by AHIMA, AAPC - Hospital

- Interpret & convert medical documentation ICD procedures
- DRGs - Software
  - Diagnosis, comorbidities & procedures
  - Discharge status – Post Acute Care Transfers
    - Provider/Care Management collaboration

CDI – Clinical Documentation Integrity

- AHIMA – CDI guidelines
  - Improve Clinical Documentation

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Billing & IT – Complete & Accurate

Billing Hospital & Professional Services

- Knowledge of billable/non-billable CPT/HCPCS
  - CCI Edits – buffering of what can be billed together
  - MUE Edits – verify appropriate quantities billed
- Medical Necessity
  - NCD & LCD – National/Local Coding Determinations
  - EMR Documentation

Information Technology

- Electronic transmission of claim data

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Knowledge Check Question 3

Who is responsible for ensuring the accuracy of claims submitted?

a) Providers
b) Coders
c) Health Information Specialists
d) Billers
e) All of the above

Revenue Deductions

Contractual and Administrative Adj

Agreements – 3rd party payors, service line coverage

- Frames, defines & governs the relationship
  - Medicare/Medicaid – Traditional & ACO/MCO
  - Commercial - PPO, POS, HMO
- Negotiate & enforcement of contract
  - Law Department Review

Administrative Adjustments

- Exceptions
  - Prompt pay

Charity Care & Bad Debt Write-Offs

Uncompensated Care provided by a hospital – no payment received from patient or insurance (CC+BD)

- Charity Care – Care for which hospitals do not expect to be reimbursed (reduction in revenue)
  - https://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/pp-board-statement-15-061519.pdf

- Bad Debt Write-Offs – Expected reimbursement not received - currently reimbursed by Medicare at 65%
  - Recorded as Bad Debt on Medicare Cost Report
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

Payment Posting & Collections

Insurance Payments & Explanation of Benefits

- Electronic remit advice file – 835 HIPAA Compliant
  - Standard format - payments, adjustments, based on each claim or service line
- Auto-post vs. manual posting
  - Exceptions: Mis-posted payments and adjustments

Collections – applied same as non-Medicare patients

- Uncollectible after 120 days – reasonable effort
- Copays & deductibles – 65%

Provider Reimbursement Manual/ UB Editor

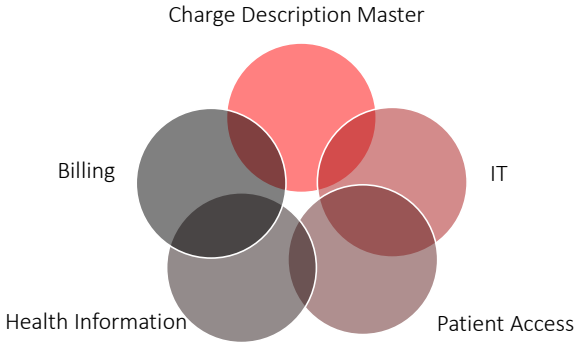
Key Performance Indicators (KPI)

Monitor & Analyze relevant processes to improve satisfaction, performance & revenue

- Average Hospital Stay – LOS (Length of Stay)
- ED Waiting Time
- Inpatient Denials – Preauthorization
- Days Receivable Outstanding
- Average Daily Revenue
- AR > 90 Days
- Service Line

Revenue Cycle Management

Software/processes to track patients from registration thru payments to prevent operating losses resulting from error, fraud or technological breakdowns

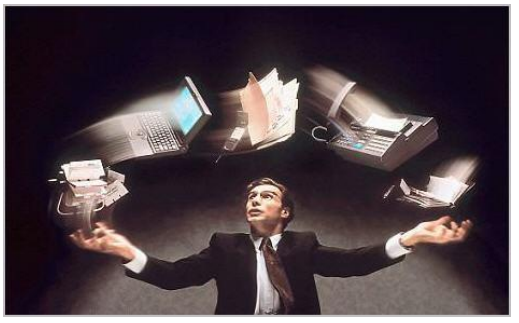


Knowledge Check Question 4

What is <u>not</u> involved in Bad Debt collections:

a) Deductibles and coinsurance
b) Medicare Cost Report
c) Dual eligible patients
d) Uncollectible debt
e) All of the above

Information to Know



Billing – Relevant Facts

- A service may be covered and you can bill – may not be paid
- What is paid today may not be paid tomorrow
- Services covered in one state may not be covered in others
- Many rules – impossible to know all of them
- Not knowing all the rules can get you in trouble
- Ignoring the rules is not an option

On-Line Information

- CMS On-line Manuals – 26, MedLearn Matters
- State Regulations
- Office of Inspector General (OIG) reports
- AHIA, AHIMA, HFMA & HCCA Publications
- JCAHO and CoPs Survey Results
- MAC Publications
- One Time Notifications (Pub 100-20)

Other Healthcare Acronyms

ACA – Affordable Care Act
AHRQ - Agency for Healthcare Research and Quality
CCI Edits - Correct Coding Initiative
CHIP – Children's Health Insurance Program
CSR – Civil Service Retirement
CPT - Current Procedural Terminology
DME – Durable Medical Equipment
DoD – Department of Defense
DRG – Diagnostic Related Group
EMR – Electronic Medical Record
ESRD – End Stage Renal Disease
FPL – Federal Poverty Level
HCPCS - Healthcare Common Procedure Coding System
HCFA - Health Care Finance Administration
ICD10 – International Classification of Diseases
IRF – Inpatient Rehab Facility
LCD – Local Coverage Determinations
MUE - Medically Unlikely Edit
NCD – National Coding Determinations
NEIC – National Electronic Insurance Code
NIH – National Institute of Health
RR – Railroad Retirement
SNF – Skilled Nursing Facility
SS – Social Security

Additional Healthcare Plans

HIX- healthcare market place exchange

HDHPS – high deductible health plans – every major payer now offers these products/ they're often linked to an HSA (health savings account)

EPO (exclusive provider)/Narrow Network- e.g. Anthem Mediblue Prime Select

Capitation – Payment for group of patients based on services provided

Retrospective bundles- Medicare BPCI - payment arrangements that include financial & performance accountability for episodes of care.

Prospective bundles- DTE (direct to employer) e.g. SMCP/ transplant networks i.e. Optum, Cigna LifeSource, BDCT

HMO, PPO, POS – Limits coverage and less costly

Speaker contact info

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