Revenue Cycle – Part One

GINGER MANWELL, MBA, CHIAP
SR. DIRECTOR, IA OPERATIONS
CLEVELAND CLINIC

Agenda

- ❑Overview & Definition of the Healthcare Revenue Cycle
- ❑Health Insurance Providers
- ❑Eligibility & Enrollment
- ❑Claim Processing
- ❑Health Payors Reimbursement

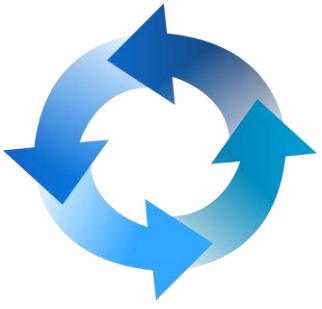
A Revenue Cycle

Revenue - In general, revenue is income received by an organization in the form of cash or cash equivalents

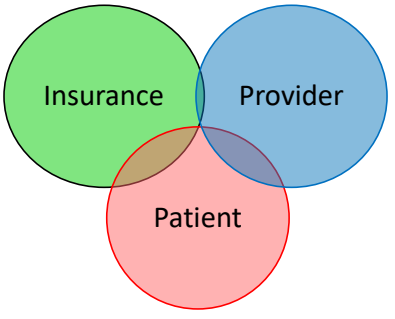
Cycle - A process that returns to its beginning and repeats itself in the same sequence

Always exceptions to the rule

Healthcare Revenue Cycle



Business Rev Cycle



Healthcare Revenue Cycle

Revenue Cycle - Risks

Risks to Revenue & Health of the Facility – Highly Regulated

- Always have potential financial risks with revenue that may result in
  - Loss of accreditation - Medicare/Medicaid
  - Civil and Criminal Lawsuits
  - Penalties and Fines
  - Loss of Contracts – Out of Network
- Medical documentation, patient data - cybersecurity
- Financial – collection of copays, deductibles
- Employees

Joint Commission (JCAHO) & Medicare Conditions of Participation

Revenue Cycle - Controls

Controls in place to protect the Facility

- Continuous Healthcare Education and Certifications
  - Coding and Centers of Excellence
- Auditing & Continuous Monitoring
- Enterprise Risk Management
- Internal Control Effectiveness - reconciliation
- Analysis of Key Performance Indicators
  - Business Intelligence

COVID19 & the CARES Act?

Knowledge Check Question 1

What are the risks associated with Healthcare Revenue Cycle?

a) Revenue loss
b) Exclusion from federal programs
c) Revenue benefit
d) Penalties and fines
e) All of the above
f) a and c
g) a, b and d

Health Insurance Providers

Insurance Enrollment & Eligibility

Changed with ACA https://www.hhs.gov/sites/default/files/patient-protection.pdf

Cannot establish eligibility rules based on health status, medical condition, medical history, genetic make-up, disability or any other related factor deemed by the HHS Secretary.

- No annual limits
- Extended coverage for dependents
- Can't discriminate based on salary
- Improved access for Medicaid and CHIP programs

Risk – revenue loss, exclusion from the healthcare exchange, penalties

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Medicare/Medicaid Enrollment &Eligibility

Age 65 or older, young people with disabilities & ESRD

- https://www.hhs.gov/answers/medicare-and-medicaid/
- Medicare A – provided at no cost if eligible (paid taxes 10 years)
- Medicare B – monthly premium deducted from SS, RR or CSR check or billed quarterly

Medicaid - Modified Adjusted Gross Income (MAGI) – FPL

- https://www.medicaid.gov/medicaid/eligibility/index.html
- Determines financial eligibility
  - One standard for multiple programs with ACA

Risk – Reimbursement and potential fraud

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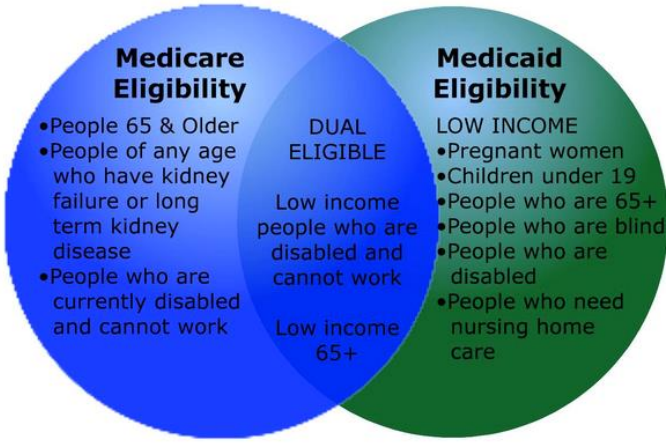
Medicare/Medicaid Eligibility - Crossover



https://sfgmedicare.com/medicare-medicaid-know-the-difference/

Commercial Payors

Eligibility and Enrollment based on the Plan & Location

- Must follow ACA regulations
- Purchased through exchanges, directly with payors or employer sponsored
- Secondary insurance to cover copays & deductibles (Medigap)
- Dental and Vision
- Long Term Care

Property Insurance & Auto Insurance Liability

Knowledge Check Question 2

Beneficiaries pay for Medicare Part B when it is deducted from their benefits. Is there a cost for the beneficiary for Medicare Part A once they retire?

a) Yes
b) No

Claims Processing

Claims Processing - Hospital

Claims processed through clearing house based on NEIC code

- Hospital claims - Uniform Billing (UB) form – CMS 1450
  - Type of bill (TOB)
    - ✓Inpatient 011X – by revenue codes
    - ✓Outpatient 013X - by CPT codes
    - ✓Additional TOBs for SNF, IRF, Hospice (See UB Editor)
- Reimbursement
  - DRG (CMS MS-DRG) with Outliers when appropriate
  - CMS Provider Manual/Health Insurance Provider manual (if contracted)
  - Percent of Charges

Claim Processing - Professional

Electronically processed through clearing house

- Professional claims submitted on HCFA (CMS) 1500
  - Multiple Claims grouped by provider
  - Required Documentation:
    - ✓CPT/HCPCS codes, Place of Service (POS), Facility
- Reimbursement
  - CMS Provider Manual
    - ✓OPPS – Outpatient Prospective Payment System
  - Commercial Payors
    - ✓Contracted rates based on CPT/HCPCS

Claim Appeals – Depends on the Payor

Involves multiple levels, e.g. RACs – 5 levels

- Normally based on Milliman or Interqual criteria
  - Medicare states payment not based on any software
- Depends on the insurance plan/program
  - Non-covered service not medically necessary
  - Claim not covered by payor, duplicate claim, timely
  - Preapproval/preauths does not guarantee payment of service

Risk - Loss of revenue, balance billing patients inappropriately

Pre and Post Payment Audits/Reviews

Medicare

- RAC – Recovery Audit Contractor
- OIG – Office of Inspector General
- MAC - Probe and Educate
- ZPIC – Zone Program Integrity Contractors

Medicaid

- MIC – Medicaid Integrity Contractors

Commercial Payors

- 3rd Party Audit Firms

Knowledge Check Question 3

Both hospital and professional claims are billed on the same claim form.

a) True
b) False

Health Payors Reimbursement

Payor Reimbursement Criteria

Reimbursement based on Medical Necessity – all payors

- Judged against current standards of care
- Necessary and appropriate for disease or injury
- Should include the following depending on service & site:
  - Physician evaluations & consults
  - Progress notes from Inpatient, Outpatient, SNF, IRF, Behavioral Health & Home Health
  - Hospital records including operative notes

CMS Program Integrity Manual 100-08, Chapter 3, Provider Manuals

Medicare Reimbursement

Title XVIII of the Social Security Act - enacted July 1965 providing health insurance to retirees – difficult for elderly to get private insurance

- Medicare A covers inpatient care, SNF, Hospice and HH
  - Based on DX, Treatment and others factors that include wage index and GME
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- Medicare B covers outpatient services, ambulance, DME, Mental Health inpatient, outpatient and partial hospitalization
    - https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPS.html

Reimbursements

- Inpatient MS-DRG (IPPS), Outpatient CPT/HCPCS (OPPS) & ASC schedules
- Quality Measures may reduce or increase reimbursement 2017

Medicaid Reimbursement

Enacted in 1965 at the same time as Medicare (Medicaid.gov)

- Federal Medical Assistance Percentage (FMAP) – published annually
  - https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures
- Partially funded by states – withheld for Medicare/Medicaid overpayments
- Balance billing Medicaid patients
  - Outside of standard coverage
- Inpatient Paid by DRG – normally require prior authorization
- Enhanced Ambulatory Patient Groups (EAPG) for outpatient hospital claims - eliminates Fee for Service Schedules

Advantage Programs

Medicare Advantage - Coverage provided by private insurance (Medicare C)

- Reimbursement based on insurance plan & contract with providers
- Cannot offer less coverage – More (Rx, dental, vision & wellness(Med A hospice)
- Varies by plan & location
- Normally requires preapproval

Medicaid Advantage – Managed Care Organization

- Maximum Income to Qualify - 138% of the FPL, 200% for pregnant woman
- Insurance companies paid to manage care of beneficiaries

CMS on-line manual 100-16/Medicaid manual under development

Commercial Payors & Self-pay

The power is in the contract!

- Understand contract language
  - Insurance provider manual
  - Inpatient/outpatient criteria
  - Normally require pre-approval for tests and admissions
- No contract - payors normally follow coding guidelines based on DRG, CPT, HCPCS & ICD Procedure Codes
- Self pay – patient/guarantor choose not to use health insurance
  - No monthly payment
  - Service on the payor non-covered list

Research Sponsors

Funding internal or external to the organization

- External funding is referred to as the Research Sponsor
  - Federal funding - NIH, DoD or AHRQ
  - Foundational funding - AHA
  - Industry funding - Pharma/Device
- Research Budget Includes:
  - Research staff salaries, services not considered standard of care
  - Some pass thru costs for IRB (Institutional Review Board) & Pharmacy fees
  - Monies received offset expenses charge to the research activity
- Payors – no reimbursement for services under a research project

Knowledge Check Question 4

Health Insurance reimbursement currently does not require pre-approval or pre-authorization for services from the following:

a) Medicaid
b) Commercial Insurance
c) Medicare Advantage
d) Research Sponsor
e) All of the above
f) None of the above

Information & References

- 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

Speaker contact info

Ginger Manwell, MBA, CHIAP™

Senior Director Internal Audit, Clinical Operations

Cleveland Clinic DD2, Cleveland, OH 44195

216 444-4710 manwelg@ccf.org