



Front to Back - Revenue Cycle 101

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Learning Objectives

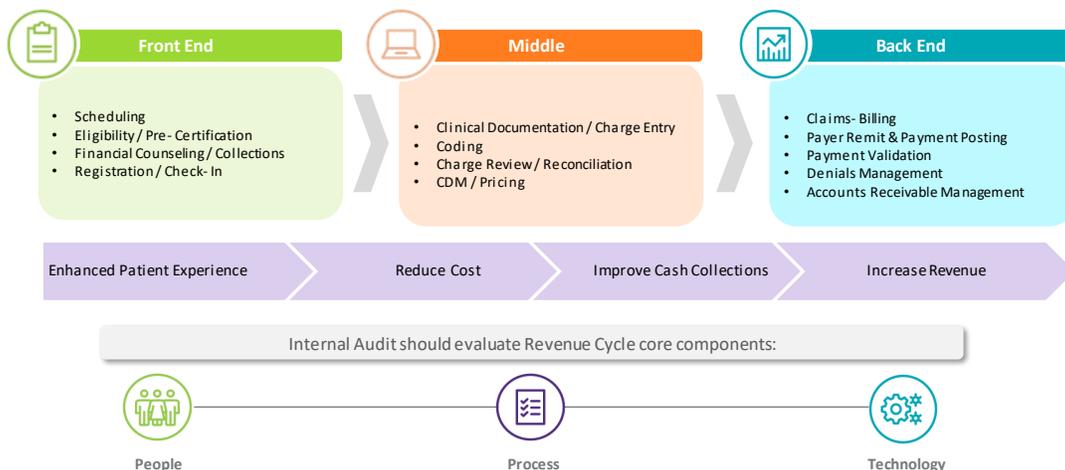
1. Explain revenue cycle process, roles, and functions
2. Outline key revenue cycle risks
3. Demonstrate areas for internal audit to provide value add

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Section One: Revenue Cycle Overview

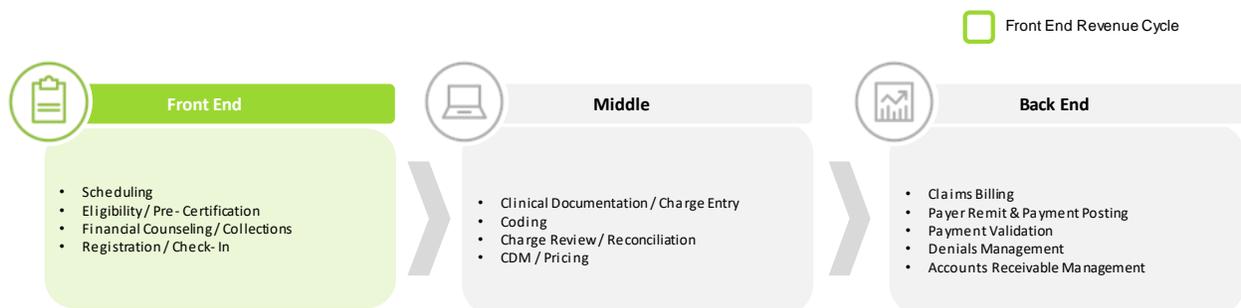
Healthcare Revenue Cycle Overview

The segments of the revenue cycle that we will discuss today are...



Section Two: Front End Revenue Cycle

Front End Revenue Cycle Overview



Scheduling



Timing

Days or months in advance

Key Functions

1. Appointment is scheduled by physician office, central scheduling or patient
2. Key data points captured such as insurance, demographics, chief complaint, etc.

Additional Info

KPIs & Leading Benchmarks

- Scheduler Daily Productivity
- Scheduling Rate

Downstream Impacts

- Patient is scheduled too close to visit (not enough time to obtain a authorization) or scheduled incorrectly
- Key information is not captured or captured incorrectly

Optimization Opportunities

- Establish number of days required between when visit is scheduled and when visit occurs to allow sufficient time to complete other pre-registration processes prior to patient arrival

Eligibility / Pre-Certification



Timing

1 -2 weeks in advance

Key Functions

1. Patient's insurance coverage and benefits verified by checking payer databases via computer or phone
2. Referrals, authorization and/or pre-certifications obtained

Additional Info

KPIs & Leading Benchmarks

- Pre-Registration Rate

Downstream Impacts

- May be unable to complete pre-certification or determine insurance benefits in advance of visit
- Benefits determined may be inaccurate for procedure or visit

Optimization Opportunities

- If patient is scheduled and pre-certified in advance, able to collect patient financial responsibility prior to visit

Financial Counseling / Collections



Timing

In advance or day of visit

Key Functions

1. Financial assistance opportunities identified for patients, including: Charity care, Deposits, Payment plans, Alternative payment options
2. Collect patient financial responsibility such as co-pays

Additional Info

KPIs & Leading Benchmarks

- Point of Service Collections

Downstream Impacts

- If patient financial responsibility is not assessed prior to visit, patients may be unaware of financial assistance (charity care, payment plans, etc) available to them
- Patient may be subjected to increased financial responsibility

Optimization Opportunities

- In the event a patient does not have adequate coverage, meet with patient to outline financial assistance options

Registration / Check-in



Timing

Day of visit

Key Functions

1. Patients registered upon arrival at physician office
2. Eligibility, benefits and authorizations completed
3. Financial responsibility collected, such as, co-pays

Additional Info

KPIs & Leading Benchmarks

- Medical necessity check rate
- Advanced Beneficiary Notice (ABN) compliance rate

Downstream Impacts

- If patient is registered incorrectly, may result in edits and claim holds, potentially resulting in delayed or denied payment
- Incorrect patient financial responsibility collected, impacting patient experience and delayed collections

Optimization Opportunities

- Obtain signed Advanced Beneficiary Notice (ABN) to ensure patient recognizes financial responsibility

Front End Downstream Impacts



Middle Revenue Cycle Overview



Clinical Documentation / Charge Entry



Timing Day of appointment

- Key Functions**
1. Provider documents services provided and acuity of patient
 2. Provider captures diagnosis codes and Evaluation & Management ("E&M") coding in an EHR or on paper

Additional Info

KPIs & Leading Benchmarks

- Dollar amount held up due to missing or incomplete physician documentation
- Charge Lag Days
- Late Charges as % of Total Charges

Downstream Impacts

- Unable to complete coding (when needed) or bill without adequate documentation
- Incomplete documentation can result in missed charges
- Late charge may result in denial of payment
- Insufficient staff training can result in missing charges or variances in charges

Optimization Opportunities

- Structure (reporting, policies, procedures, etc.) is in place to identify and address areas of concern
- Well defined workflows to remediate issues within a timely manner

Coding & 3rd Party Reimbursement



Timing

1 - 2 days after visit

Key Functions

1. Review of Evaluation & Management ("E&M") coding to diagnosis coding to validate appropriate coding
2. Various systems scrub claims to identify missing elements and potential errors before claims are sent to payer

Additional Info

KPIs & Leading Benchmarks

- Coding Days % of Total DNFB

Downstream Impacts

- Coding lags can result in delayed billing

Optimization Opportunities

- Conduct regular coding audits to validate coding accuracy and provide timely training where needed
- Streamline coder workflows and minimize non-coding tasks

Charge Review / Reconciliation



Timing

1 - 2 days after visit

Key Functions

1. Ensure charges are fully and accurately captured
2. Monitor and understand charge trends and tendencies
3. Research missing charges, late charges and charging inconsistencies

Additional Info

KPIs & Leading Benchmarks

- Leading Practice – monitor department charge reconciliation practices; research and address inconsistencies as well as missing / charge lag trends

Downstream Impacts

- If charge reconciliation processes are lacking clear roles and accountability, it can result in missed revenue or delayed charges

Optimization Opportunities

- Daily revenue monitoring and charge accountability processes at the department manager level and overarching revenue integrity oversight

Charge Description Master ("CDM") / Fee Schedule



Timing

Ongoing

Key Functions

1. Review and update of CDM / Fee schedule to adjust for changes to payer contracts

Additional Info

KPIs & Leading Benchmarks

- Annual review of CDM and Fee Schedules

Downstream Impacts

- Errors at the charge code level can result in edits delaying billing or denials

Optimization Opportunities

- Conduct regular CDM / pricing reviews to ensure integrity and identify optimization opportunities

Overview of revenue integrity

Clinical Documentation / Charge Entry

- Late charge may result in denial of payment
- Insufficient staff training can result in missing charges or variances in charges
- Structure (reporting, policies, procedures, etc.) is in place to identify and address areas of concern
- Well defined workflows to remediate issues within a timely manner

Coding & 3rd Party Reimbursement

- Coding lags can result in delayed billing
- Conduct regular coding audits to validate coding accuracy and provide timely training where needed
- Streamline coder workflows and minimize non-coding tasks

Charge Review / Reconciliation

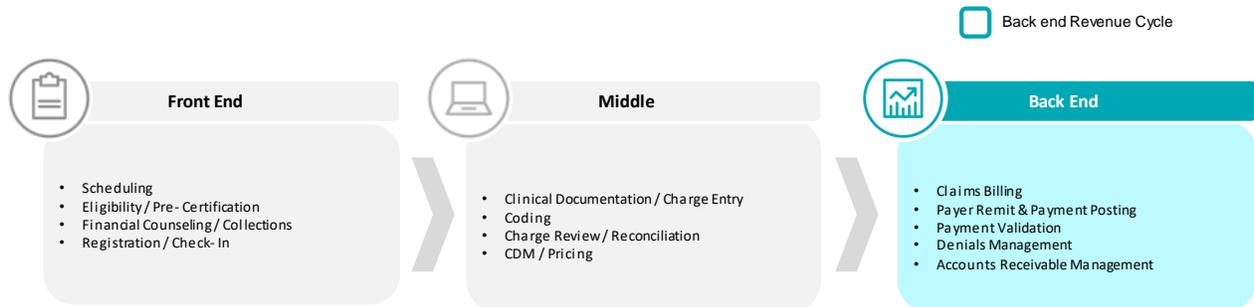
- If charge reconciliation processes are lacking clear roles and accountability, it can result in missed revenue or delayed charges
- Daily revenue monitoring and charge accountability processes at the department manager level and overarching revenue integrity oversight

CDM / Fee Schedule

- Review and update of CDM / Fee schedule to adjust for changes to payer contracts
- Conduct regular CDM / pricing reviews to ensure integrity and identify optimization opportunities

Section Four: Back End Revenue Cycle

Back End Revenue Cycle Overview



Claims Billing



Timing

(Varies) 1 – 5 days postvisit

Key Functions

1. Claims reviewed and submitted electronically (maybe sent through clearinghouse) or manually; self-pay bills (statements) sent to patients
2. Billers correct errors (edits) and submit claims

Additional Info

KPIs & Leading Benchmarks

- Unbilled A/R Days (i.e. Discharged not Final Billed or "DNFB")
- Claim Edit Productivity

Downstream Impacts

- Unbilled claims that are not remediated timely may delay cash collection or miss payer-specific timely filing deadlines

Optimization Opportunities

- Create pre-defined workflow categories for staff to remediate within a timely manner (i.e. # Business days)

Payer Remittance / Payment Posting



Timing

14 - 60 days after bill sent

Key Functions

1. Payment, denials and communications from payers are received via electronic or paper remits
2. Patient payments received
3. Electronic systems or staff post payments to accounts

Additional Info

KPIs & Leading Benchmarks

- % of A/R Greater than 90
- Days from ERA to Posting

Downstream Impacts

- Untimely payment posting may delay patient statement production
- Delay cash reconciliation

Optimization Opportunities

- Develop standard process and work queues to remediate, reconcile and post unapplied cash balances

Payment Validation



Timing

Upon receipt of payment

Key Functions

1. Expected commercial and government payment is calculated and compared to actual payment
2. Payer performance is monitored and fed to contracting group

Additional Info

KPIs & Leading Benchmarks

- Payment Validation

Downstream Impacts

- Unapplied cash balances may delay timely production of patient statements

Optimization Opportunities

- Review effectiveness of cash posting organizational model and workflow designation
- Ensure activate communication pathways between payment posting and contract management teams

Denials Management



Timing

30 – 90 days

Key Functions

1. Denials are reviewed, then appealed or written off
2. Identified under-payments are collected from payers
3. These functions may occur through focused roles or be a part of regular collection work

Additional Info

KPIs & Leading Benchmarks

- Initial Denial Rate
- Net Denial Write-Off
- Denial Resolution Productivity

Downstream Impacts

- Untimely resolution of denied claims may delay or prevent cash collection opportunities and depress net patient revenue

Optimization Opportunities

- Review and revise denials management workflow and work queue prioritization
- Develop Standard Operating Procedures (SOPs) and multi-disciplinary teams specific to denials management

Accounts Receivable Management



Timing

Ongoing or until written off

Key Functions

1. Collector staff identify aged uncollected accounts through work queues or reports and contact payers or patients to request payment
2. Claims corrected, documentation sent or denials addressed

Additional Info

KPIs & Leading Benchmarks

- Net A/R Days
- % of A/R Greater than 90
- Bad Debt Write-Offs
- Follow Up Account Resolution Productivity

Downstream Impacts

- Delayed follow-up management may delay cash payment or missed cash collection opportunities

Optimization Opportunities

- Develop situational response guidelines for collector staff
- Create standard follow-up management procedures by financial class

Overview of Back End Revenue Cycle

Claims Billing



- Unbilled claims that are not remediated timely may delay cash collection or miss payer-specific timely filing deadlines

Create pre-defined workflow categories for staff to remediate within a timely manner (i.e. # business days)

Payer Remit and Payment Posting



- Untimely payment posting may delay patient statement production
- Delay cash reconciliation

Develop standard process and work queues to remediate, reconcile and post unapplied cash balances

Payment Validation



- Unapplied cash balances may delay timely production of patient statements

Review effectiveness cash posting organizational model and workflow designation

Denials Management



- Untimely resolution of denied claims may delay or prevent cash collection opportunities and depress net patient revenue

Review and revise denials management workflow and work queue prioritization
Develop SOPs and multi-disciplinary teams specific to denials management

Accounts Receivable Management



- Delayed follow-up management may delay cash payment or missed cash collection opportunities

Develop situational response guidelines for collector staff
Create standard follow-up management procedure by financial class

Learning Objectives

1. Explain revenue cycle process, roles, and functions
2. Outline key revenue cycle risks
3. Demonstrate areas for internal audit to provide value add

Questions?

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Speaker contact info



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Hayley has over 10 years of extensive healthcare risk, internal audit, and professional management consulting experience with a portfolio that spans for-profit and not-for-profit health care settings, including academic medical centers, children's hospitals, cancer hospitals and community medical centers.

Her experience includes conducting risk assessments, developing customized multi-year internal audit and enterprise risk management programs, and executing internal audits. Hayley collaborates with clients and key stakeholders to innovatively approach internal audit, leveraging automation and analytics to deliver relevant recommendations that not only suffice regulatory requirements but meet industry leading practices.

In addition to Internal Audit, Hayley has extensive revenue cycle and process improvement experience including serving in interim leadership positions as well as overseeing revenue cycle assessments, system implementations, and large-scale transformation efforts. Hayley also has also worked in the senior care industry and has clinical experience working as an EMT.

Hayley received her Master of Public health degree in Health Policy and Management from Emory University, and her Bachelor of Science degree in Community Health from Indiana University.

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