How the Revenue Cycle Fits Into the Bigger Picture

Nebraska Hospital Association Revenue Cycle Residency Program – Session 1

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Why Revenue Cycle Matters

Denied claims = uncompensated care; most denied claims are preventable

Revenue cycle staff have significant responsibility for regulatory compliance

Community's perception of its hospital based in significant part on interaction with revenue cycle staff

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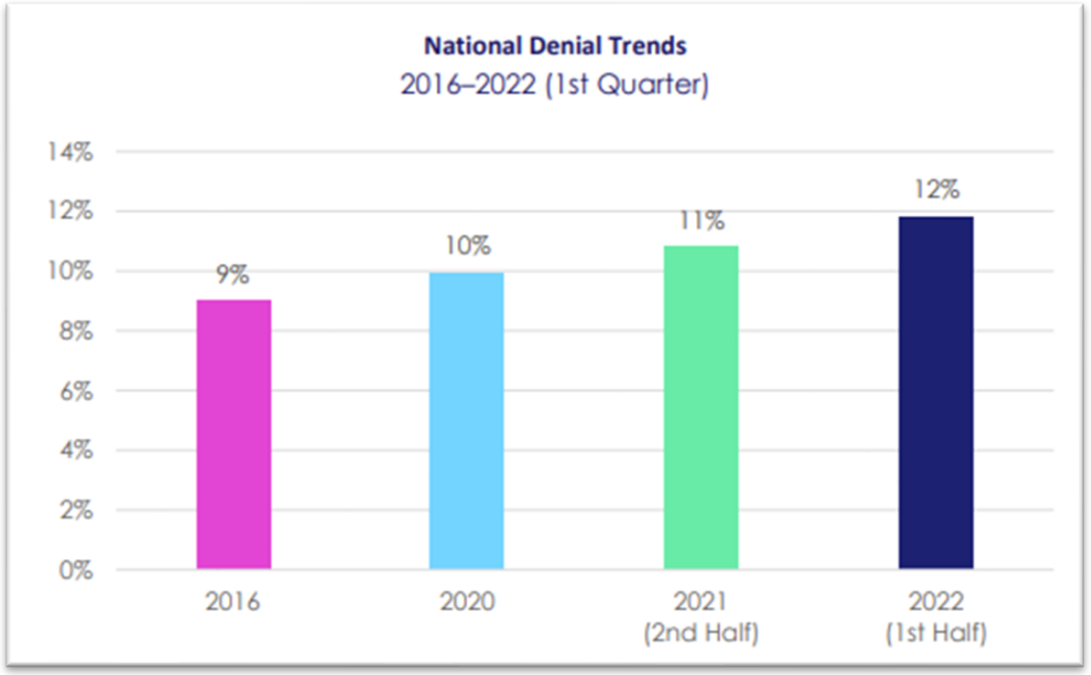
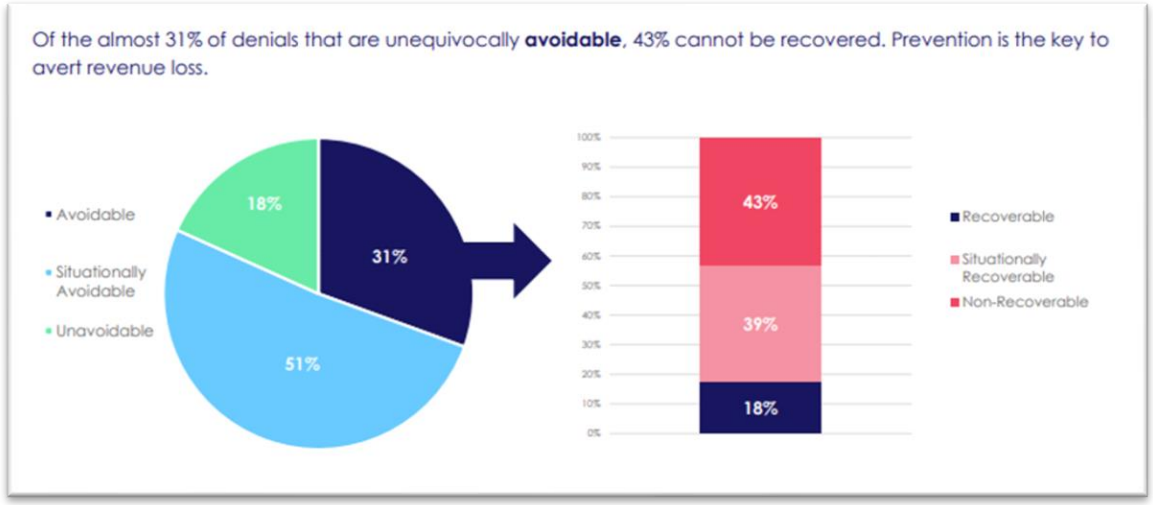
2022 Revenue Cycle Denials Index





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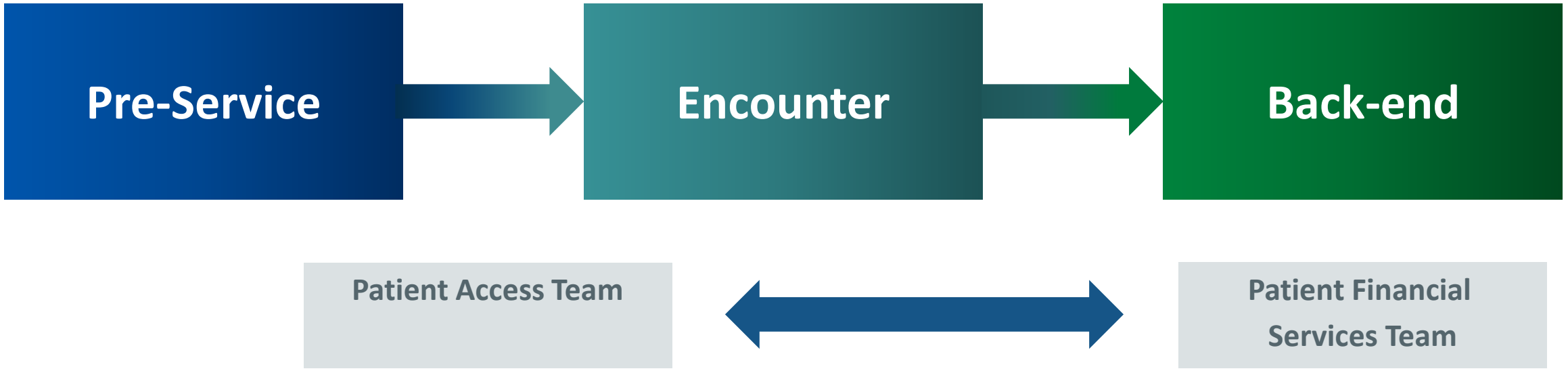
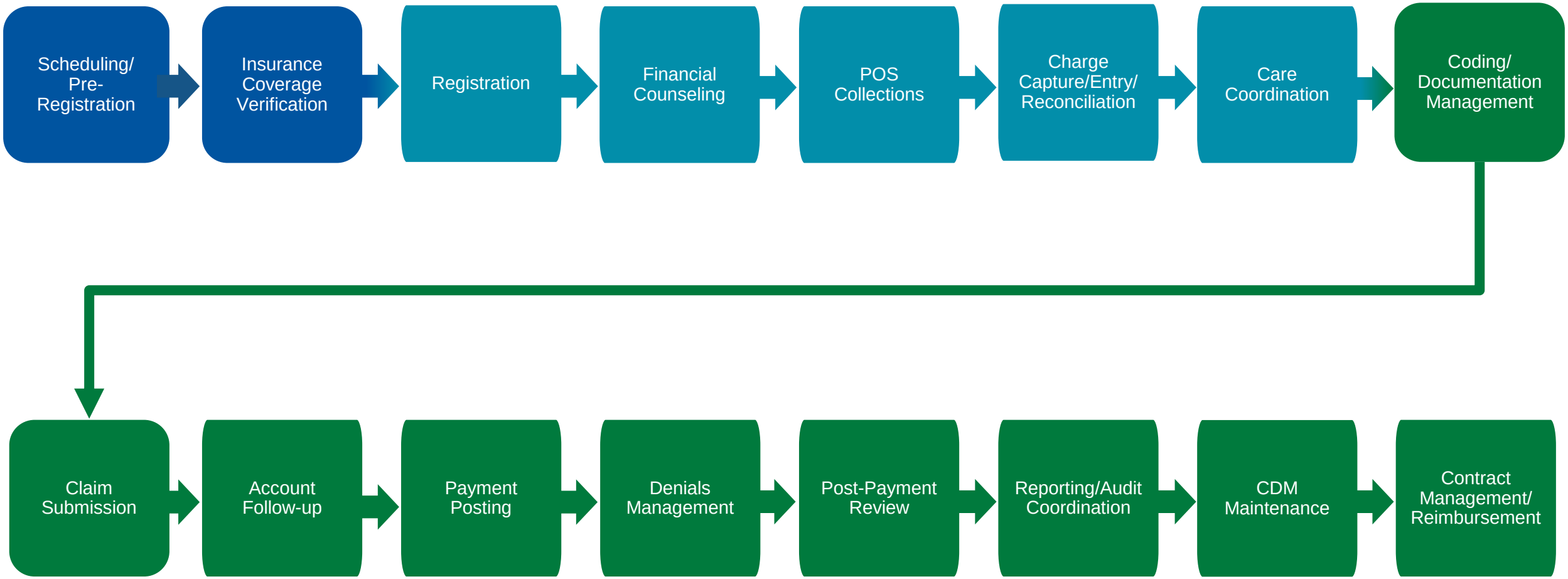
Three Phases of the Revenue Cycle



The Revenue Cycle



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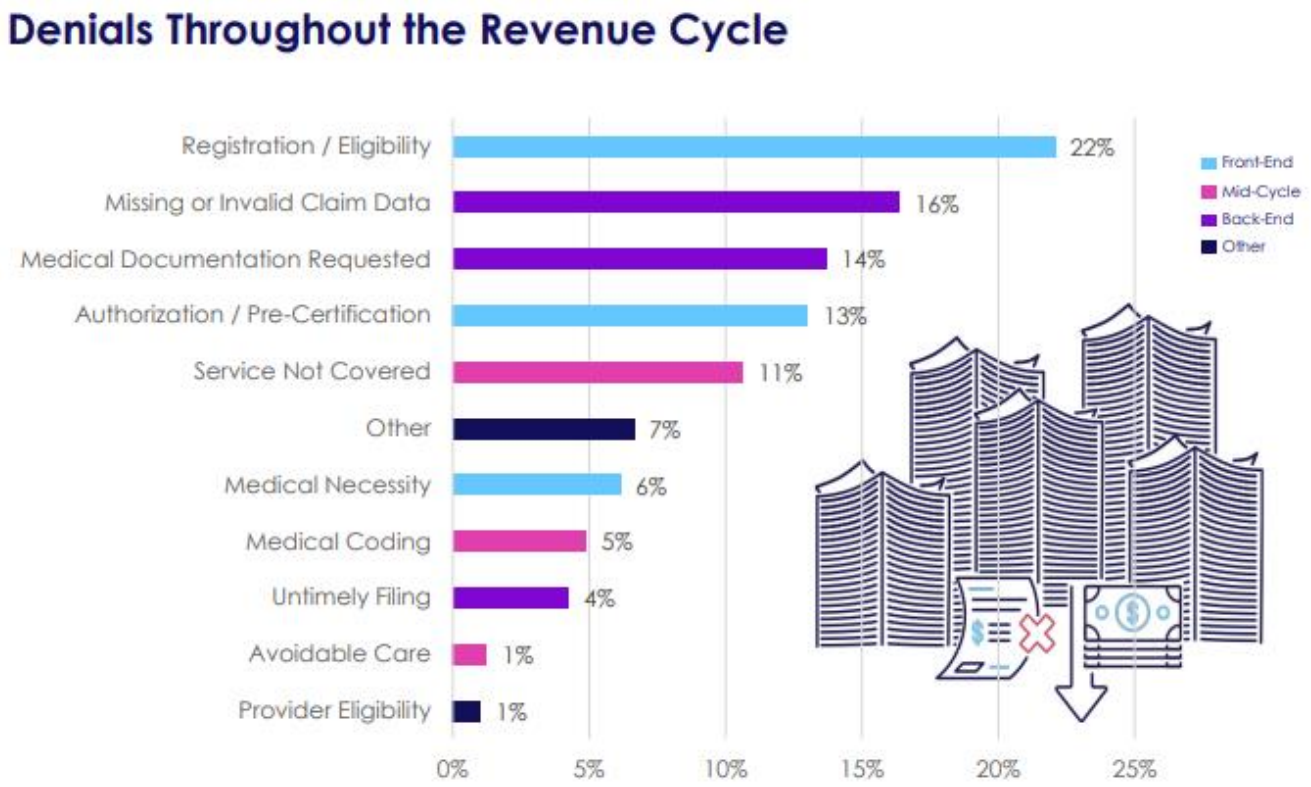

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Breakout: Top Denials Root Causes

Potentially Avoidable Denials, Top Root Causes, 2021 Q3 – 2022 Q2

Registration/Eligibility	22%
Coordination of Benefits	45%
Benefit Maximum	34%
Plan Coverage	14%
Patient Eligibility	7%
Missing or Invalid Claim Data	16%
Unspecified Billing Issue	71%
Missing/Invalid EOB	16%
Missing/Invalid Documentation	7%
Invalid Provider Information	3%
Medical Documentation Requested	14%
Missing/Invalid Documentation	97%
Medical Records Requested	3%
Authorization/Pre-Certification	13%
Invalid Authorization	58%
Authorization Denied	30%
Services Exceed Authorization	7%
No Prior Authorization	4%
Service Not Covered	11%
Service Not Covered	56%
Unspecified Billing Issue	20%
Managed Care	11%
Non-Covered Days	9%
Other	7%
Unspecified Billing Issue	99.8%
Primary Insurance Denied Claim	0.1%

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Phase I:
Pre-Service

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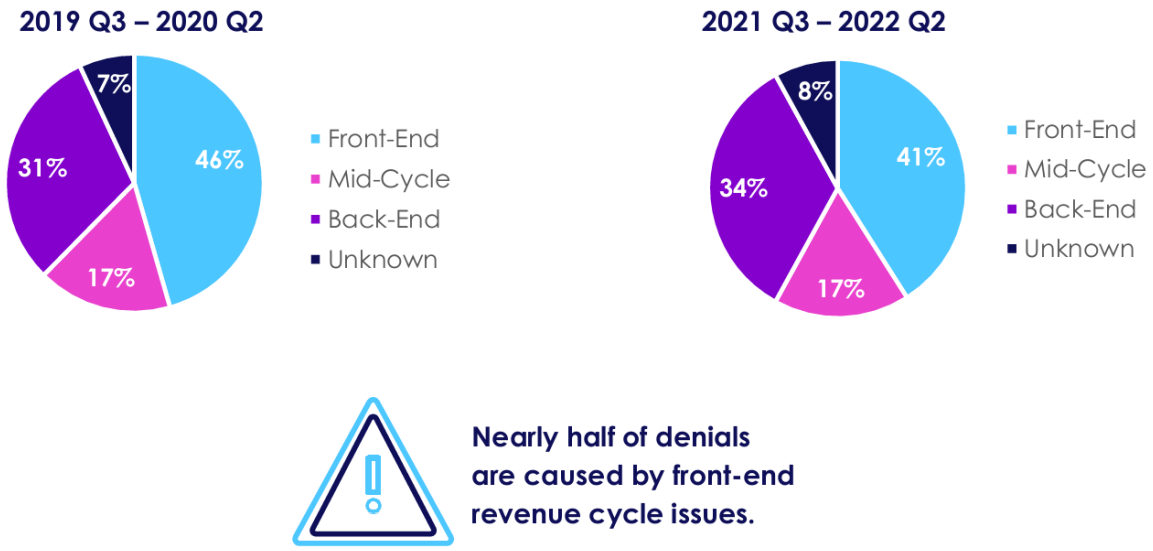
Front-End Denials—The Most Common Culprit

Aggregated Denials Share by Revenue Cycle Stage, 2019–2022



Nearly half of denials are caused by front-end revenue cycle issues.

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1. Scheduling/Pre-Registration

- Patient's initial contact with hospital/clinic staff – ***critical*** to obtain complete and accurate demographic and payer information, including verification of information previously obtained
- Coordination of benefits
  - Other insurance coverage, e.g., worker's compensation, automobile injury
- ***New!*** Provision of Good Faith Estimate for scheduled self-pay patients

2. Insurance Coverage Verification

- Use of on-line tools vs. telephonic communications
  - Patient follow-up, as necessary
- Initiate prior authorization process
- Identify necessary forms/notices to be furnished to patient (e.g., ABNs for Medicare beneficiaries)
- Calculate patient's out-of-pocket liability (if possible)
- Identify options for self-pay patients (out-of-pocket costs)
  - Financial assistance policy
  - Medical payment products

Good Faith Estimates

‘Convening provider’

- Provider responsible for scheduling primary item or service
- Includes clinic visits, diagnostic testing, procedures, etc.

Must furnish good faith estimate of total expected charges when -

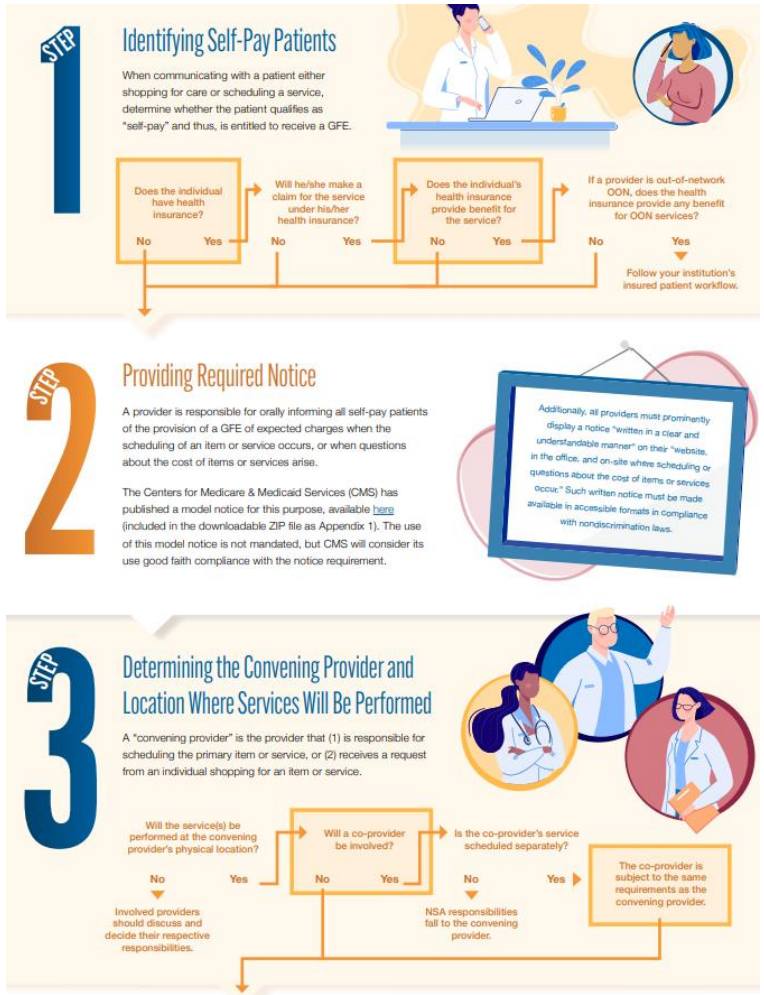
- Self-pay patient requests estimate (comparison shopping)
- Self-pay patient schedules item/service at least 3 business days in advance

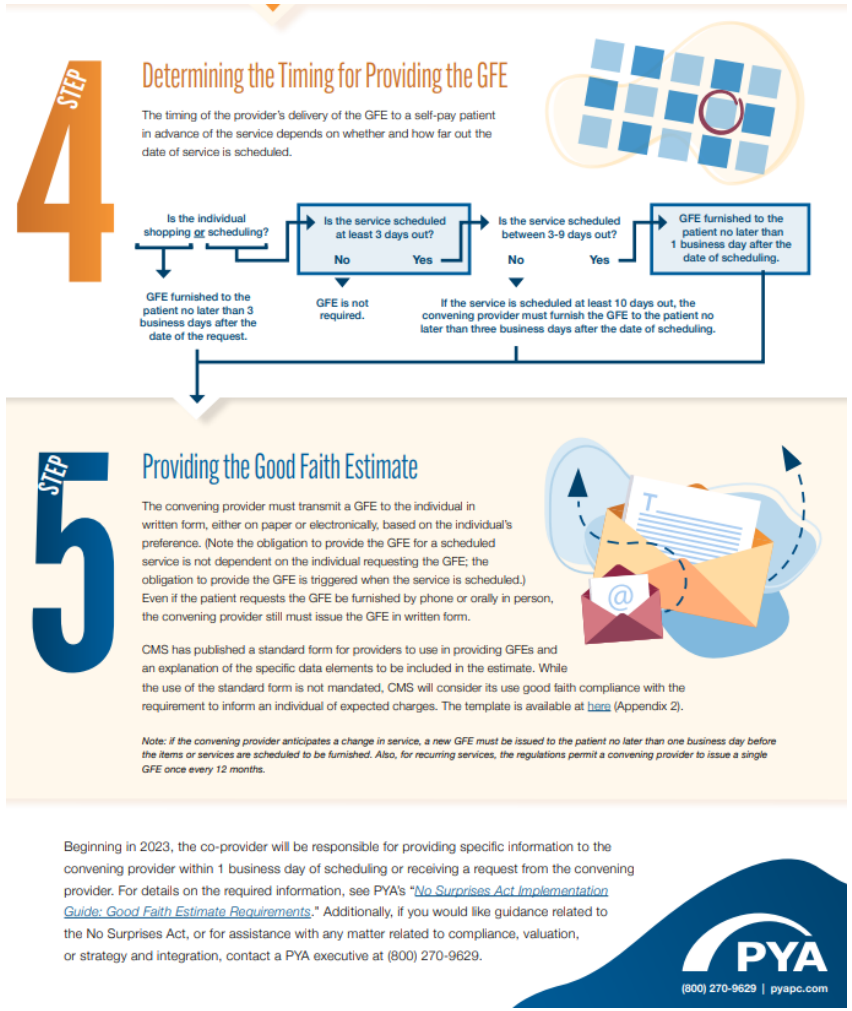
Must include -

- Items and services to be billed by convening provider
- Requirement to furnish co-provider information delayed indefinitely

No Surprises Act

Good Faith Estimate Workflow





Available at https://www.pyapc.com/insights/no-surprises-act-good-faith-estimates-workplan-infographic/

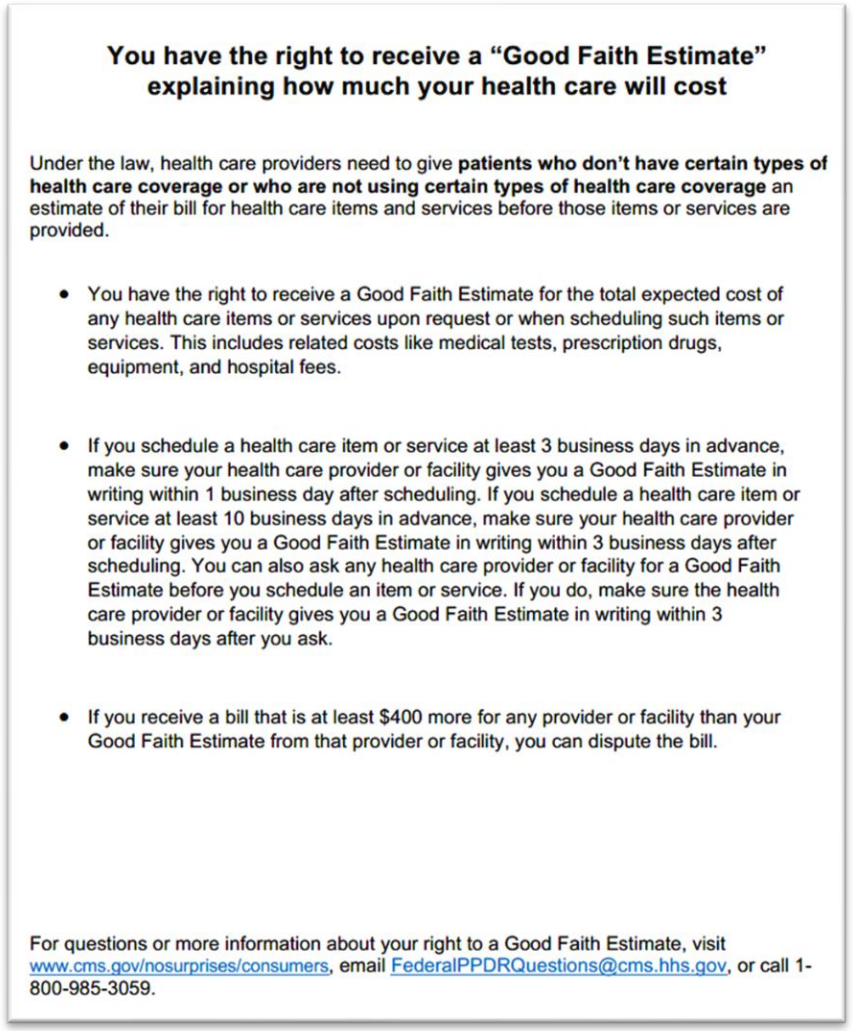
Step 1 - Determine If Self-Pay Patient

‘Self-pay’ includes -

- No insurance coverage
- Has insurance, but does not intend to submit claim for item/service
- Has insurance, but item/service is not covered
- Has insurance, but no coverage for OON items/services (vs. higher out-of-pocket)

Step 2 – Provide Required Notice

- Orally inform all self-pay patients of GFE availability when scheduling or when questions regarding cost arise
- Post GFE notice on website
- Post GFE notice at physical location
  - Next to Notice of Privacy Practices + Surprise Billing Notice



You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Model notice available at https://www.cms.gov/files/zip/cms-10791.zip

Step 3 – Provide Written GFE

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail	[ ] By email	
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

Date of Good Faith Estimate: _____/_____/_____

Summary of Expected Charges
(See the itemized estimate attached for more detail.)

Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

Template and instructions available at https://www.cms.gov/files/zip/cms-10791.zip

Provide Written GFE

ExpirationDate [MM/DD/YYYY]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 1] $
Additional Health Care Provider/Facility Notes

Timing

Initial GFE

- If requested prior to scheduling – 3 days following request
- If scheduled at least 10 but less than 4 business days in advance – 3 days before
- If scheduled at least 3 business days in advance – 1 day before
- No GFE required if scheduled less than 3 days in advance

FAQ on updating GFE

- If provider expects or is notified of changes to scope of GFE, must furnish updated GFE no later than 1 business day prior to scheduled date of service
- Encouraged to review updated GFE with patient

Phase II:
Encounter

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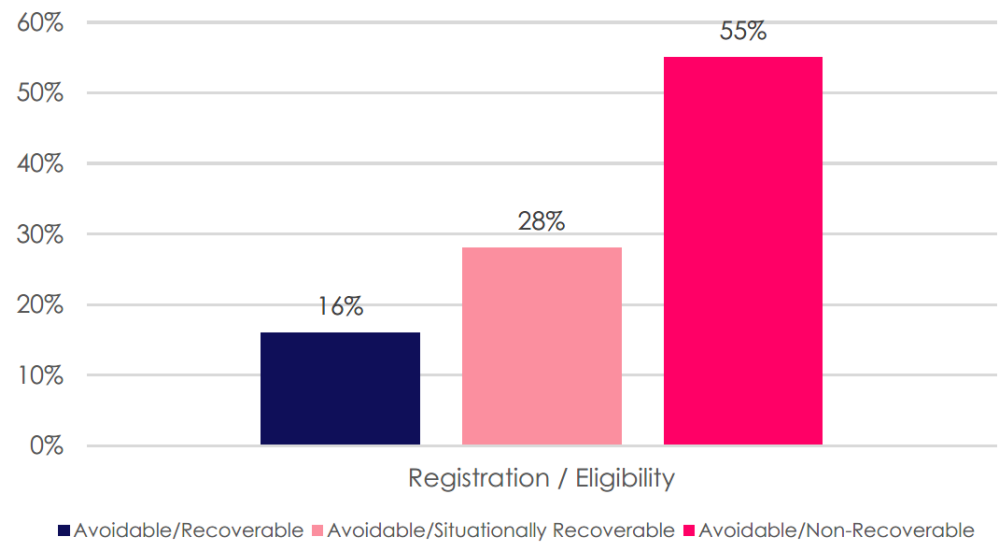
Registration/Eligibility Denials Are Avoidable

Registration/Eligibility denials make up the largest percentage of avoidable denials, which are frequently non-recoverable.



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3. Registration

- Re-verification of information obtained at scheduling/pre-registration
  - *Key performance indicator* for front desk staff: complete and accurate information captured/verified
- Delivery of required notices
  - HIPAA Notice of Privacy Practices (secure acknowledgement)
  - Assignment of Benefits
  - Medicare MOON (outpatient observation notice)
  - ***New!*** Surprise Billing (commercially-insured patients only)

Surprise Billing Notice

Facilities *and* providers who furnish services in facilities must provide notice to patients of NSA protections

- Post prominently at physical location (HIPAA Notice of Privacy Practices)
- Post on website (link from homepage)
- Facility must deliver to each commercially insured patient to whom services provided at facility in manner requested by patient no later than time at which request for payment made (or claim submitted, if no request)
  - Does not include Medicare Advantage, managed Medicaid, health reimbursement arrangements, health-sharing ministries, plans with reference-based pricing short-term limited-duration insurance, retiree-only plans
- Provider furnishing services in facility may enter into written agreement with that facility to rely on facility's notice to insured patients
  - Otherwise, provider responsible for delivering notice to patients (in addition to facility's notice)

Model Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [*Insert contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059*].

Visit [*Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets (under *Disclosure, Notices, and Consent*)

4. Financial Counseling

- Board-approved written financial assistance policy
  - Posting on website
- Written policies on extended payment plans
- Written policies detailing financial counseling process
  - Staff training and tools (sensitivity of patient discussions)
  - Referral to third-parties to explore potential coverage (e.g., Medicaid, exchange plan)
  - Review and approval process
  - Consistently applied with supporting documentation

Role of the Financial Counselor

- Ensuring all non-sponsored accounts are screened for sponsorship opportunities and that appropriate follow-up is completed
- Serving as an advisor and collector for sponsored patients who have liabilities after their insurance coverage; and
- Screening all inpatient, observation, and selected outpatient Self Pay patients for primary sponsorship, and for screening selected sponsored patients for secondary coverage and collecting a payment on the patient liability

5. Point of Service Collections

- Address any outstanding balances from prior encounters
- Collection of patient coinsurance
  - Issue of high deductible plans/increasing patient out-of-pocket responsibilities
- A lenient upfront collections policy leaves significant patient responsible balances for collection on the backend, which drastically reduces the likelihood of collecting
- Use of scripting

6. Charge Capture/Entry/Reconciliation

- *Significant* opportunity to improve revenue
  - Educate clinical staff regarding importance of accurate charge capture; develop/distribute cheat sheets
  - Near real-time review and follow-up on incomplete charge information
- Documentation of diagnoses
  - Satisfy medical necessity requirements
  - Support accurate ICD-10 coding (HCC scores)

7. Care Coordination

- Utilization review (96-hour rule) and discharge planning (post-acute services)
- Screening for health-related social needs
- Schedule procedures, follow-up appointments prior to patient departure
- In appropriate cases, recommend ambulatory care management services
  - Transitional care management
  - Chronic care management
  - Remote patient monitoring
- Patient satisfaction surveys

Patient Access - Structure

- **Define and standardize data elements** collected throughout the Patient Access processes (i.e., Minimum Data Set)
- Determine any IT system updates needed to optimize Patient Access processes
- Develop training materials to support the initiative
- **Document current state Patient Access processes** across the organization
- Work with RC leadership to develop recommended future state model. Consider:
  - All information collected and verified prior to scheduled services
  - The direct impact on financial performance of the organization
  - Focusing on an enhanced and consistent patient experience
  - **Optimizing organizational processes** and resources

Patient Access - Structure

- Clearly **document ownership of responsibilities** across entire scope of work
- Ensure **strategic span of control** across department staffing
- Establish organizational consistency and **key performance indicators** (KPIs)
- Develop a reporting package to effectively monitor scheduling KPIs
- Provide recommend training structure and materials (i.e., policies and procedures)

Upfront Collections

Implementation Tactics

Objectives/Primary Drivers Strategies to Achieve Business Aim	Tactics/Secondary Drivers
Evaluate upfront patient collections options	*Create a committee to develop content for a more robust upfront collections policy*
Approve new policy	*Establish a written upfront collections policy with approved parameters*
Train staff	*Define Patient Access team responsibilities; train team members on responsibilities*
Communicate new policy	*Communicate new policy to all supervisors; train supervisors and advise them to communicate to their staff*
Implement new policy and monitor progress	*Conduct weekly meetings with the Patient Access and Patient Financial Services teams over the first three months following implementation to receive feedback and discuss potential issues*

Key Performance Indicators

- Insurance verification rate
- Service Authorization Rate – Inpatient and Observation
- Service Authorization Rate- Outpatient
- Conversion Rate of Uninsured Patient to Payer Source
- Point of Service Cash Collection

Phase III:
Back-End

8. Coding/Documentation Management

- Accurate and complete coding supported by medical record documentation necessary for appropriate billing and payment
  - Establish processes for review and follow-up with physicians, clinical staff
  - Do it now, or do it later (denials)
- Key performance indicator for coding staff: ongoing education, internal reviews
- CAH Method II billing
  - Enhanced reimbursement for E/M services furnished in facilities merits second look

Clinical Documentation

- A vital opportunity for improving reimbursement capture and protecting operating margins
- Accurate and timely documentation serves as the foundation for a variety of hospital initiatives including performance improvement, public reporting, and value-based purchasing

Clinical Documentation: The Physician

- Success \hinges on a hospital's ability to engage physicians in the process and improve clinical documentation performance
  - Engaged physicians drive improvements
- Targeted individual physician education, focused on the positive impact to care quality, their own practice reimbursement, and the acuity of their patients – not the hospital's bottom line
- Engage physicians to correlate how clinical documentation provides an opportunity to demonstrate the high-acuity and quality of care that was provided

9. Claim Submission and Follow-Up

- Claim submitted to primary payer promptly
  - Submit to only one payer at a time (cross-over claims)
  - Management of patient payment plans
- Respond promptly to payer requests for additional information
  - Assign responsibility for receipt and response to all such requests
- Monitor timely payment/denial
- Timely submission of claim to secondary payer, any remaining patient responsibility
  - ***New!*** Compliance with Surprise Billing requirements
- Key performance indicator: gross time in A/R by payer
  - Establish baseline and improvement targets

10. Account Follow-Up

- Implement Standard Documentation Guidelines for staff to follow when noting account history
  - Inconsistent documentation creates delays when following-up on an account and limits coverage options when staff are absent
    - Accurate and timely completion of notes ensures everyone accessing an account has the information needed to complete their work
    - Quality system notes are important because they can serve as legal documentation
    - Consistency in how accounts are documented can increase the quality of work, increase efficiency from eliminating “double work” due to incomplete notes, and reduce denials due to improved revenue cycle communication

Account Follow-Up: Policy Development

- *Prioritize Accounts* – sort by highest dollar, aged accounts to ensure staff are working accounts with the greatest financial impact
- *Stratify Similar Accounts* – group specific payer plans together to create greater efficiency when checking websites and calling payers
- *Tickle Accounts* – establish consistent timeframes for how accounts should be pended to create efficiency in how often accounts are being worked and help establish exception-based workflow

11. Payment Posting

- Verify payment amount is consistent with contract rates (treat underpayments as denials, refund overpayments)
  - Automated vs. manual process
- Track and report internally on amount billed/amount collected
- For OON claims subject to Surprise Billing rules, initiate Independent Dispute Resolution process

12. Denials Management

- Convene Denials Committee
  - Include representative from each phase of revenue cycle (including clinical staff)
  - Meet at least bi-weekly
  - Maintain complete list of unresolved denials categorized by payer and type
  - Identify specific reason for each denial (root cause analysis)
  - Pursue appeals when appropriate, take appropriate action to prevent future denials
  - Track and report internally on denials and appeals
- Establish regular, ongoing communication with payer representatives
  - Standing list of issues to be addressed

Denials Management

- Place a high focus on the root causes of initial denials (versus final denial write-offs).
  - Creates more transparency into specific staff, physicians, or departments causing the denials
  - Creates higher staff and department accountability

13. Post-Payment Review

- Dashboards and user-level detailed adjustment reports can assist in (a) identifying root causes of errors resulting in write-offs, (b) tracking exact populations being written off, and (c) communicating patterns of write-off root causes to teams responsible for developing and implementing appropriate corrective actions
- Consistently review all write-off/adjustment codes; distinguish codes between avoidable vs. unavoidable and include definitions and usage guidelines for each

13. Post-Payment Review

- Contractual adjustments
  - Perform sampling to identify contractual allowances that are 90-100% of total charges
  - Sample the accounts to determine if the contractual allowance was appropriate, or if it represents a “hidden” administrative write-off
    - The most common hidden write-offs are taken as manual contractual adjustments by the staff - and usually do not represent any purposeful hiding of write-offs, but a lack of training
    - Contractuals that are taken systematically and are inappropriate might also be uncovered

14. Reporting/Audit Coordination

- Manage audit requests
  - Timely response to requested records
- Review audit results with Denials Committee (root cause analysis)

15. Charge Description Master (CDM)

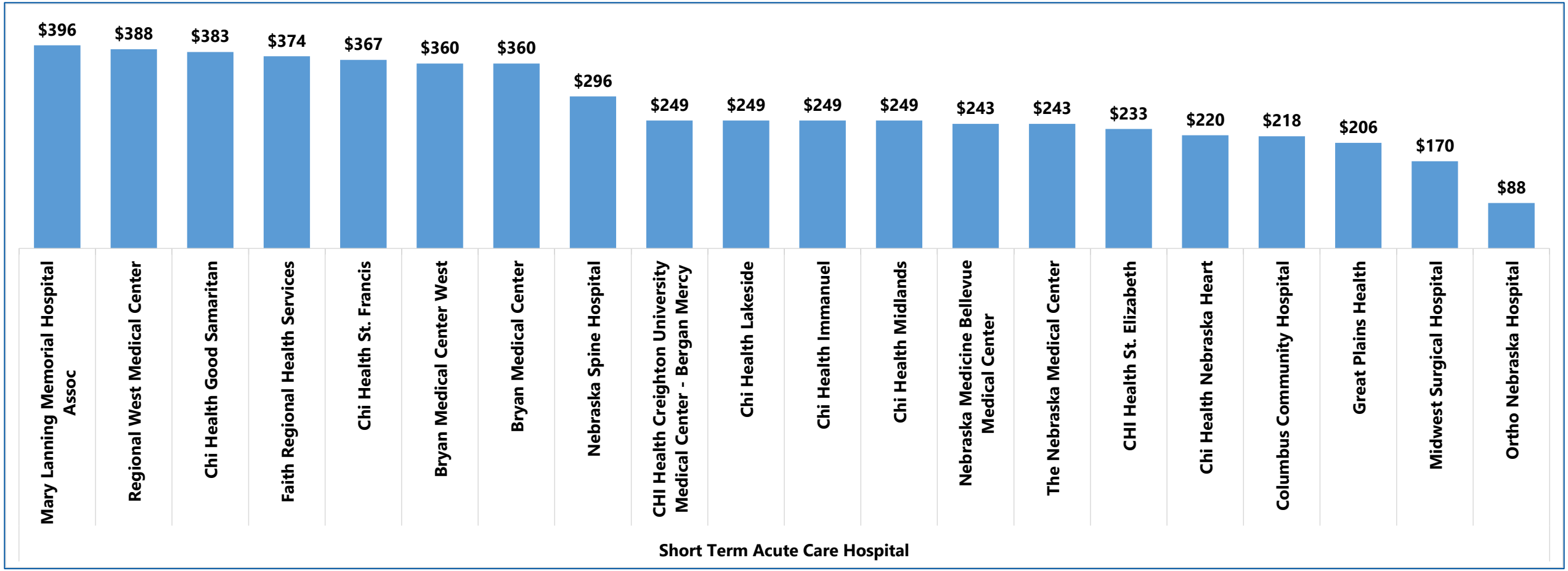
- Determine reasonableness of charges for your market
- Impact on cost-to-charge ratio fo
- Impact of charge on patient liability
  - Medicare co-payments for CAH outpatient and RHC services based on 20 percent of **billed charges**
- Charges are more important than ever
  - Transparency requirements make charges visible to EVERYONE!
  - Payer blame game/turning public opinion against hospitals

Price Transparency

- Effective January 1, 2021, all hospitals (including CAHs) must post current information for all hospital inpatient and outpatient services -
  - Standard charges
    - Machine readable files
    - Consumer-friendly display of shoppable services (minimum 300 services)
  - Payer-specific negotiated rates
    - Name of third-party payer and plan

Charge Analysis by Facility – CPT 93005 12-Lead EKG

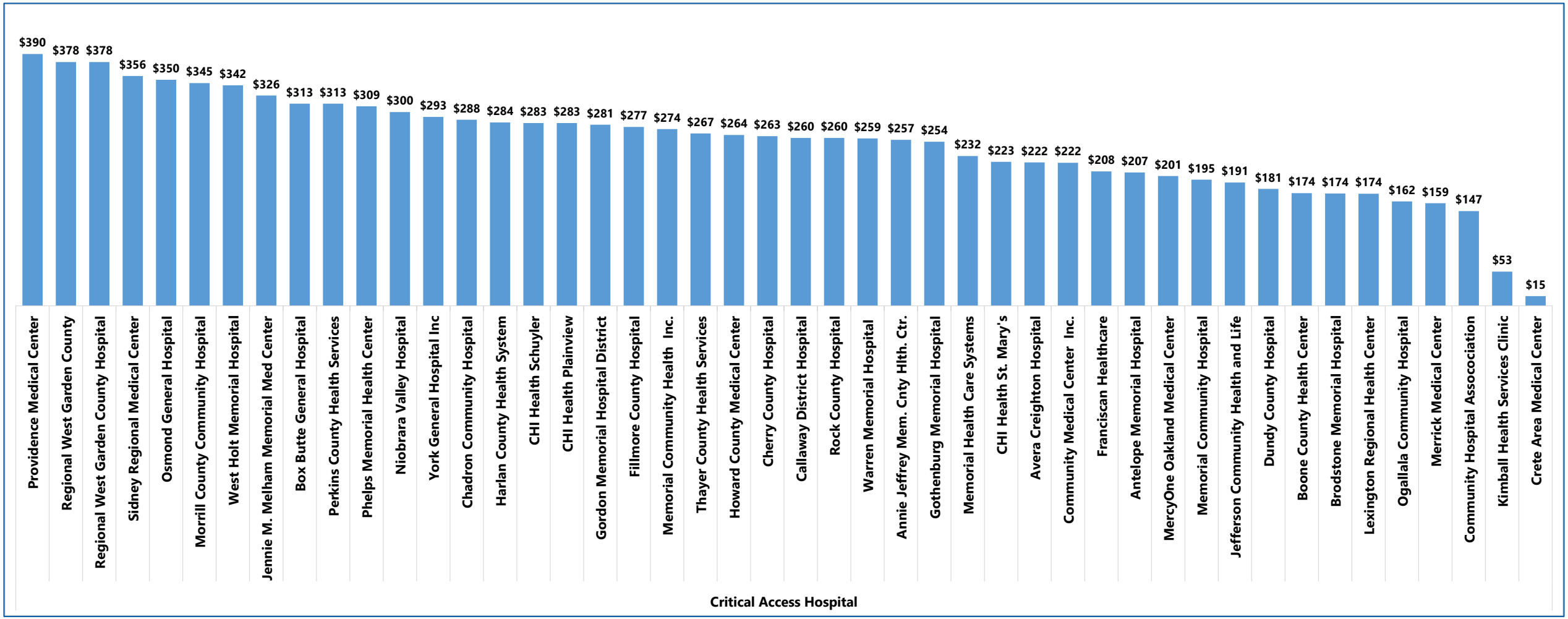
Nebraska Short Term Acute Care Hospitals – Average List Price



Data Source: Turquoise Health Co.

Charge Analysis by Facility – CPT 93005 12-Lead EKG

Nebraska Critical Access Hospitals – Average List Price

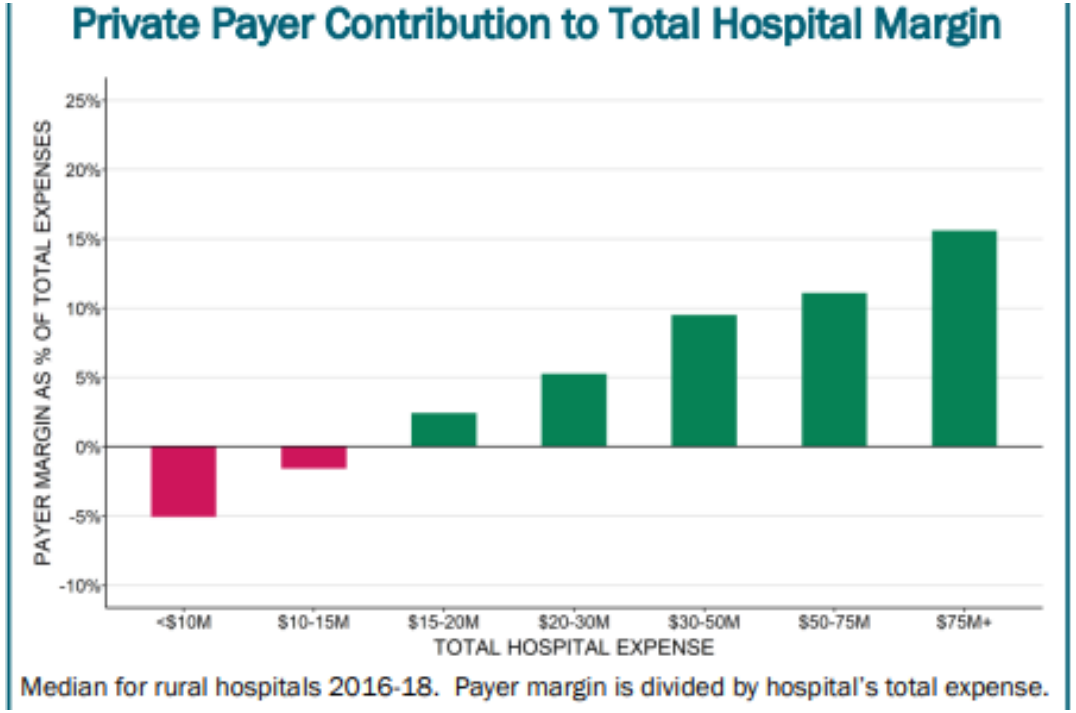


Data Source: Turquoise Health Co.

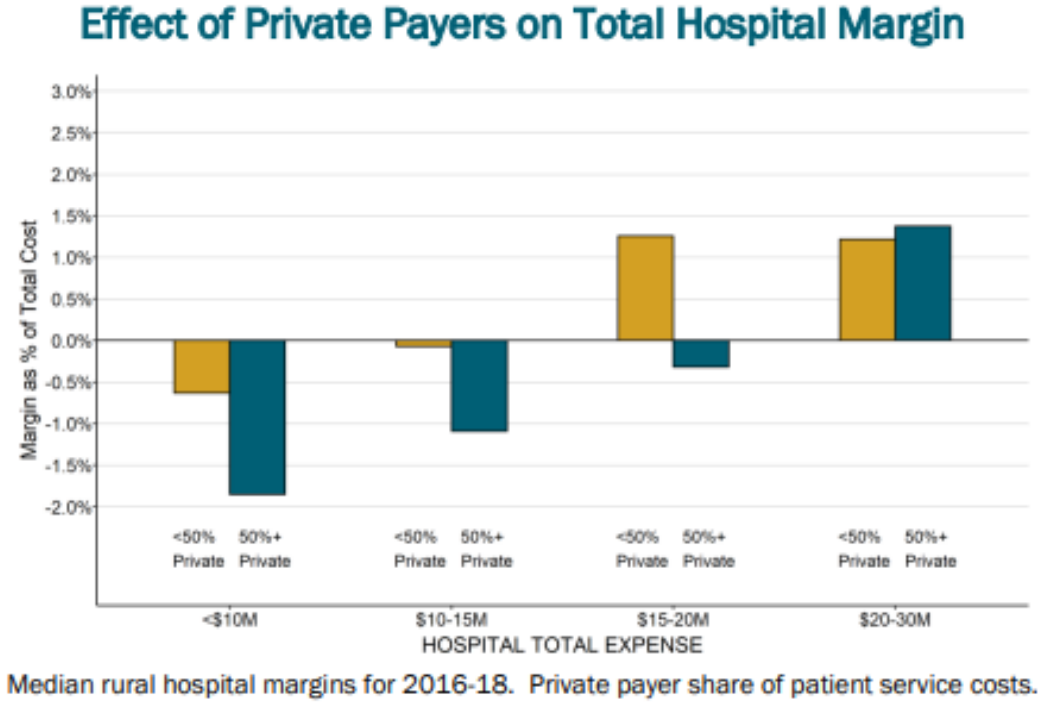
16. Contract Management/Reimbursement

- Prioritize and actively engage in payer negotiations
- Compare commercial rates to current Medicare inpatient and outpatient rates
  - Payments based on percentage of charges often less than Medicare reimbursement
- Calculate payer mix to prioritize contract negotiations (inpatient vs. outpatient)
- Compare commercial rates with current rates for surrounding facilities
- Understand payer network adequacy requirements

National-Level Historical Data - Private Payers



Median for rural hospitals 2016-18. Payer margin is divided by hospital's total expense.



Median rural hospital margins for 2016-18. Private payer share of patient service costs.

Center for Healthcare Quality and Payment Reform, Saving Rural Hospitals and Sustaining Rural Healthcare (September 2020), available at https://chqpr.org/downloads/Saving_Rural_Hospitals.pdf . Calculations derived from expense and revenue data in hospital cost reports filed with CMS.

Questions?

Thank you!

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