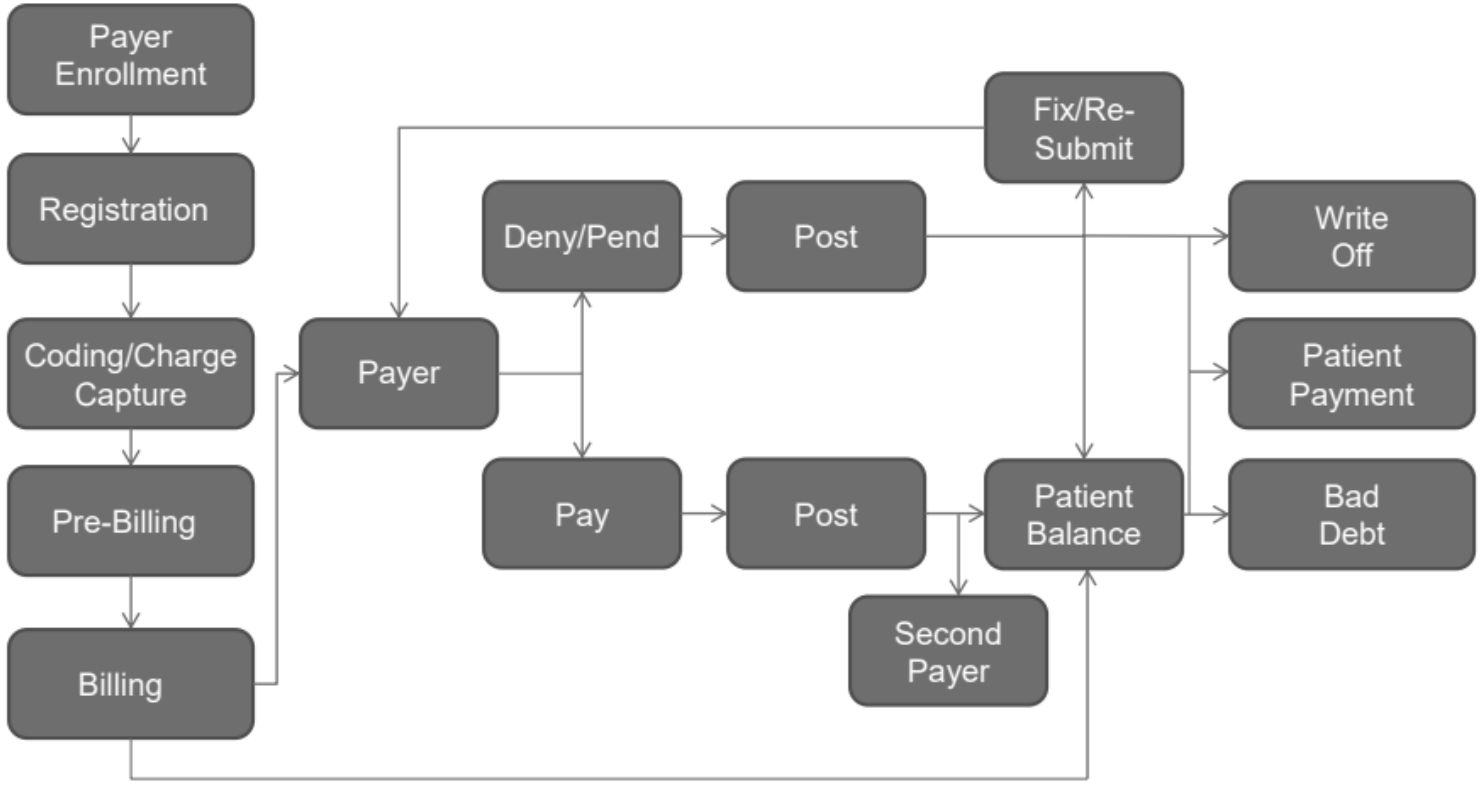
Benchmarking the Revenue Cycle

Top 10 Revenue Cycle Best Practice Solutions

Revenue Cycle: A Bird's Eye View



Considerations

- Patients are your priority; then develop process
- Avoid rework; doing it right the first time
- Front end versus back end
- Work with technology not against it
- Use of data collection
- Policy and procedure
- Communication

#10 Best Practice

- Delayed Charge Entry
  - Identify the length of time between the date of service and date of charge entry. If the lag time is outside the industry standard, you are delaying your revenue cycle and cash flow

- Create standards for coding and charge entry
  - 24 hours for office
  - 48 hours for inpatient

#9 Best Practice

- Failure to apply coding initiatives
  - Conduct coding audits to ensure accuracy of coding. Provide coding workshops with providers addressing new medical policies, coding concerns, new codes and documentation issues.

- Audit documentation tools to assist providers in meeting documentation standards.

#8 Best Practice

- Delayed payment and denial posting
  - Implement electronic remittance posting. Ensure payments and denials are posted daily. Process patient payments timely to ensure accurate patient statements.
  - Payment Posting – 100% Daily
  - Denial Posting – 99% Daily
  - Patient Statements – 100% Monthly

#7 Best Practice

- Increased self-pay accounts receivable; with the lowest collection percentage.
  - Written policies on patient financial responsibility.
  - Time of service collections
  - Collect outstanding balances
  - Display expectations
  - Submit to collections at 90-120 days

#6 Best Practice

- Aging Accounts Receivable
  - Monitor A/R days: payer and self-pay
  - Prioritize outstanding A/R:
    - Balance Due
    - Payer Type
    - Age of Account
  - Cross train staff to ensure compliance and performance targets.

#5 Best Practice

- Metrics to measure success
  - Develop key performance indicators for critical areas of the revenue cycle.
  - Trend performance
  - Prepare to take action when negative

#4 Best Practice

- Staff to complete manual processes
  - Integrated EMR and Practice Management
  - Automated:
    - Eligibility verification
    - Appointment Scheduling
    - Reminders
    - Protocols
  - Claims scrubbing

#3 Best Practice

- Lack of data
  - Good data to make decisions about how to improve key areas in the revenue cycle.
  - Monitor:
    - % of Denied Claims
    - Denial Reasons
    - Denials by payer
    - Aged accounts receivable
    - Days in A/R
    - Patient A/R

#2 Best Practice

- Management of Electronic Claims
  - Work claim rejections and denials
  - Ensure each claim reaches the payer within the filing timelines
  - Monitor claims submission through reporting
    - Claim submission – Daily
    - Rejections/Denials – Daily

#1 Best Practice

- Practice Management System
  - Choosing and setting up a practice management system correctly
    - Flowcharting tasks:
      - Insurance verification
      - Accurate demographics
      - Claim: scrubbing, coding and charge capture
      - Maximize practice management features

Where are *your* pain points?

- Connecting physician compensation plans to revenue cycle performance
- Forming an accountability driven denials management program
- Removing credit balances from your liabilities
- Unique strategies to address accounts receivable and low dollar/high volume accounts
- Reducing bad debt through point of service collections

Performance Indicators

Pre-Registration

- Determine demographic updates
- Determine prior account balances
- Insurance benefit verification
- Determine patient copayment level
- Determine need for the visit/time allotted
- Patient expectations
- Appointment reminder process – New Patients

Registration

- Verify demographic
- Insurance card
- Medicare Secondary Payer Questionnaire
- Collection: copayment, deductible and/or outstanding balance
- Remind and/or educate on expectations
- Determine need for financial assistance

98% Accuracy

Insurance Verification

- The insurance verification process is often the first opportunity to identify a high-risk patient:
  - Insurance eligibility verified
  - Coverage determined for service
  - Financial obligations collected

Verification
Website 1-3 minutes
Telephone 3-10 minutes

Financial Counseling

- Instruct new patients regarding documentation required for discounted charges
- Counsel established patients regarding outstanding balances
- Plan enrollment/modifications

Time of Service Collections
Copayment: 98%
Others: 75%

Opportunities for Improvement

- Number of rejected claims for “No coverage at the time of service”
- Patient calls to the business office where patient is providing primary or secondary insurance information
- Patient statements showing copayment balances due
- Front office and Back office barriers

Clinical Visit

- Advanced Beneficiary Notice
  - Pelvic and Pap
  - EKG
  - Mammogram

100% Accurate and Delivered

Charge Capture

- Ensure all charges are captured
- Determine charge capture by type of charges
  - Office, Surgical, Hospital, Nursing Home
- Perform Charge Capture Audits
  - Date of service to documentation
  - Documentation to date of coding
  - Coding to date of charge entry
  - Charge entry to date of billing

Two Business Days Missing Charge Report

Coding

- Coding conventions
  - Diagnosis coding
  - Modifiers
  - Global days
- Coding Responsibilities
  - Provider Education
  - Claim edits/denials

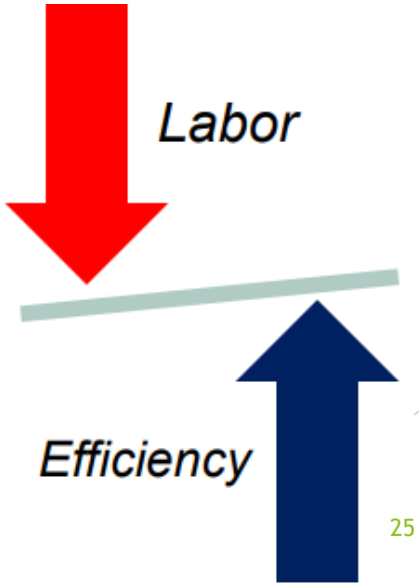
Chart Audit – 95% Accuracy

Claim Submission

- Primary and Secondary Claims
  - Submitted Daily
- Claim Edits
  - Resolved within 24 hours
- Rebilling claims
- Medicare Advantage Claims
- Reconcile to avoid unbilled services

Opportunities for Improvement

- High volume of un-worked claim edits
- Greater than 10% of claims to paper
- High accounts receivable
- High volume of rejected claims
  - Rejected – opportunity to correct and resubmit
  - Denial – decision make; need to appeal



Accounts Receivable Follow Up

- Aged trial balance
- Workflow tools
- Aged accounts
- High dollar accounts
- Payer specific
- Small balance
- Denial management
- Outsource

Every 30 days
Over 90 days, 15-20%
Claim status, 12-60 per hour
Telephone follow up 6-12 ph
Appeal follow up 3-4 per hour

Patient Collections

- Statement cycles
  - Consolidated statement
- Patient friendly statements
- Online bill payments
- Dunning cycles and statement messages
- Return mail

Payment Posting

- Quantity versus quality
- Electronic remittance advices
- Transfer to secondary
- Contractual adjustments
- Line item posting
- Balance billing

75 - 125 transactions per hour
9 - 11 refunds researched per hour

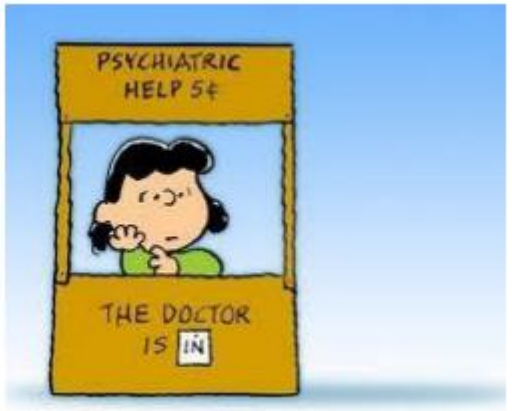
Remittance Advice Review

- Identify incorrect billing information
- Ineffective procedures
- Compare remittance to accounts receivable
- Fee schedule review
- Staff training

Common Benchmarks

- Gross Charges
- Collections
- Encounters
  - Ambulatory Encounters
  - Hospital Visits
- wRVUs
- Compensation
- Gross and Net Fee-for-Service Collection Percentages
- Days in Accounts Receivable
- Distribution of Accounts Receivable

- Payer Mix
- Coding
- Referrals
- Staffing
- Overhead/Expenses



Measuring and Analyzing the Revenue Cycle

Snapshot of Leading Financial Indicators and Targets		
Billing Function	Expectation	Target
Registration	Demographic and insurance information obtained	98 percent accuracy
Prior authorization	Determine prior authorization for services	98 percent accuracy
Time-of-service collections	Collect copayments, patient accounts balances, deductibles, co-insurance	Copayment: 98 percent Others: 75 percent
Coding	Physician coding	Chart audits for coding accuracy Rejections for incorrect coding at 0-1 percent of visits
	Certified coders for surgical procedures	All certified by (date)
Claims/statements	Support documentation for claims Edits completed Claim denial/rejection rate	100 percent 100 percent same day < 7 percent

Measuring and Analyzing the Revenue Cycle

Snapshot of Leading Financial Indicators and Targets		
Billing Function	Expectation	Target
Charge entry	Days lag (date-of-service to date-of-entry)	24 hours outpatient 48 hours inpatient
Account follow-up	Every 30 – 45 days Percentage accounts receivable > 90 days Net collection rate	100 percent accuracy 15 to 20 percent 97 percent or greater
Payment posting	Cash posted and balanced Credit balance report	100 percent Fully researched and resolved within 60 days
Collections	Patient account sent to collections	Within 90 days
Denials	Percentage denials due to referrals (specialists) Percentage denials due to past filing limits	< 2 percent 0 percent
Management reporting	Reports available within 10 days after month-end	100 percent

Gross Charges and Collections

Caveats

- Charges are subjective due to fee schedule methodologies
- Often can affect Gross Collection %
  - Payments/Charges
- Adjusted Fee-for-Service Collection %
  - Payments/(Charges-Adjustments)
- Collections % vary by specialty

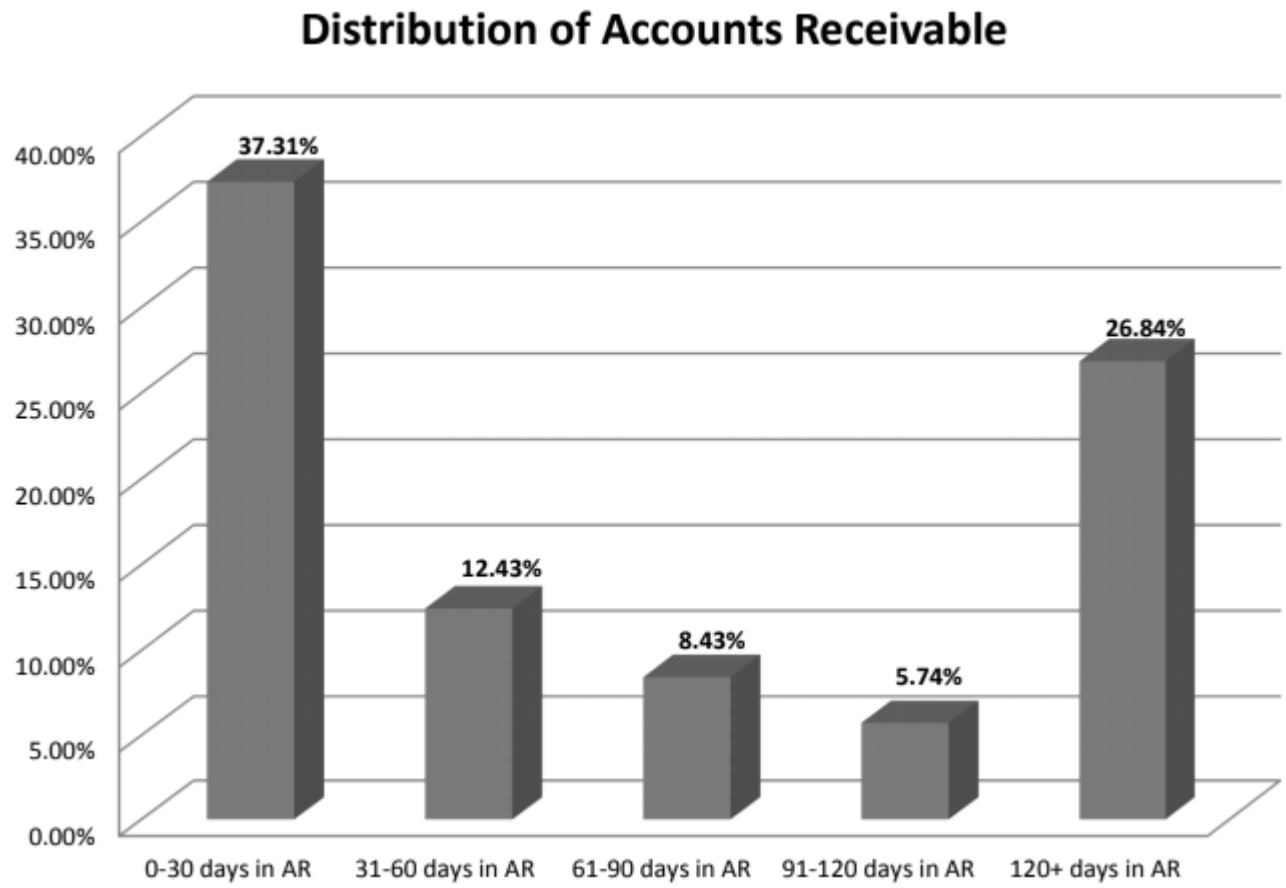
Gross and Adjusted (Net) FFS Collections

Physician	2013				2014			MGMA Median	
	Gross	% > Median	Adjusted	% > Median	Gross	Adjusted	% > Median	Gross	Adjusted
Dr. W.	55.86%	16.26%	119.36%	26.06%	57.55%	101.65%	8.35%	39.60%	93.30%
APRN	57.80%	18.20%	98.95%	5.65%	56.72%	87.39%	-5.91%		
Practice	56.83%	17.23%	108.02%	14.72%	57.10%	93.33%	0.03%		

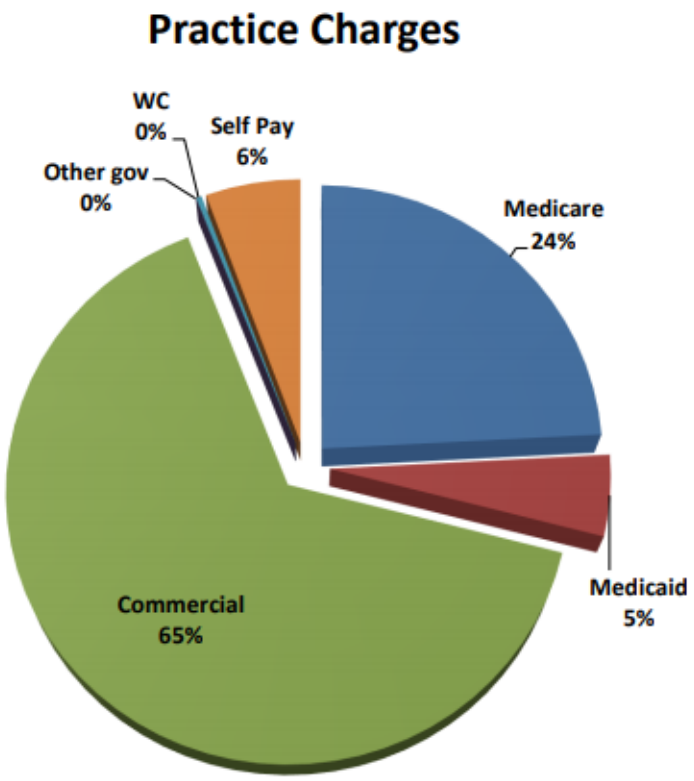
Gross FFS %= ((Collections-Refunds)/Gross Charges) x 100

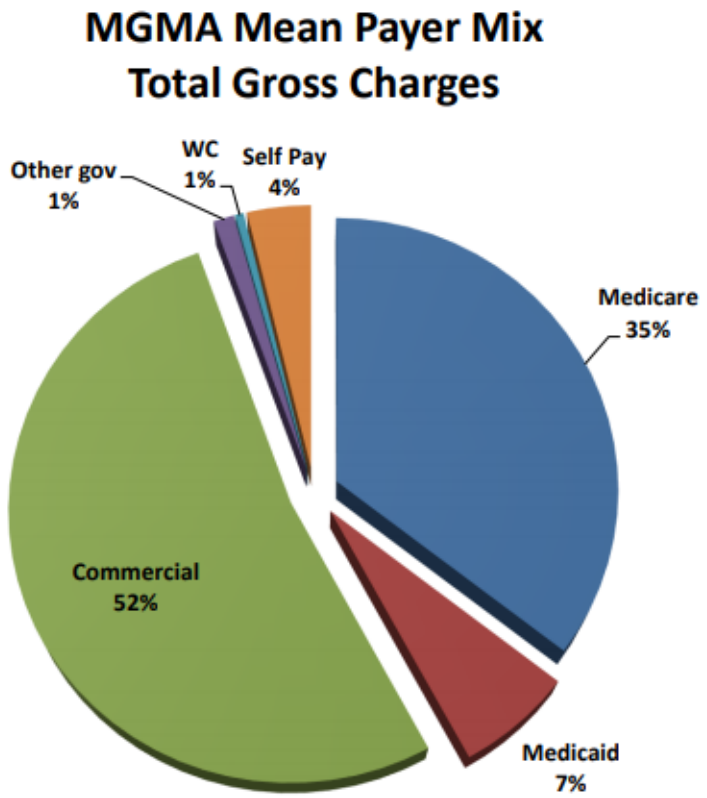
Adjusted FFS %=((Collections-Refunds)/(Gross Charges - Adjustments)) x 100

Distribution of Accounts Receivable

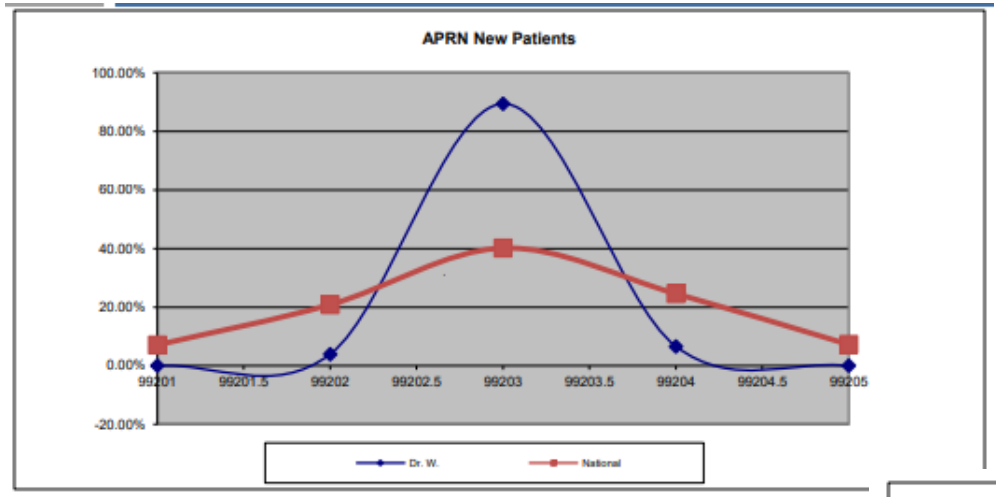


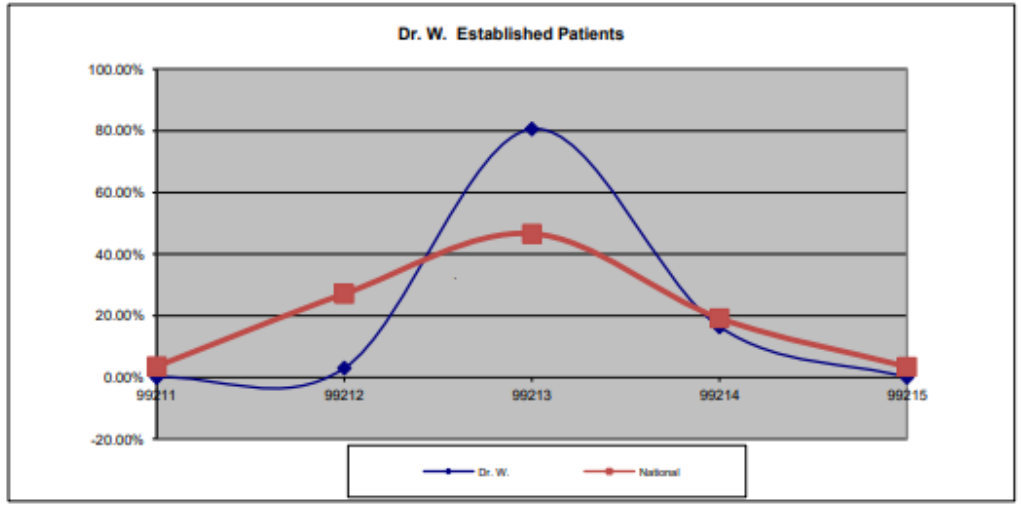
Payer Mix Gross Charges





Coding Utilization





Staffing the Revenue Cycle

Staff Workload Ranges by Activity			
Staff Activities	**Per Day**	**Per Hour**	**Per Transaction**
Insurance verification			
Via Website	n/a	n/a	1 to 3 minutes
Via telephone call	n/a	n/a	2 to 10 minutes
Benefits eligibility			
Via Website	n/a	n/a	3 to 10 minutes
Via Telephone Call	n/a	n/a	5 to 20 minutes
Registration with insurance verification (on-site or pre-visit)	60 to 80	9 to 11	
Patient check-in			
With registration verification only	100 to 130	14 to 19	
With registration verification and cashiering only	75 to 100	11 to 14	
Appointment scheduling			
With no registration	75 to 125	11 to 18	
With full registration	50 to 75	7 to 11	
Referrals (inbound or outbound)	70 to 90	10 to 13	
Check-out			
With scheduling and cashiering	70 to 90	10 to 13	
With scheduling, cashiering, and charge entry	60 to 80	9 to 11	

Staffing the Revenue Cycle

Staff Workload Ranges by Activity			
Staff Activities	**Per Day**	**Per Hour**	**Per Transaction**
Coding			
↓ **Evaluation and Management codes**	n/a	15 to 20	3 to 4 minutes
↓ **Surgeries and procedures**	n/a	6 to 12	5 to 10 minutes
Charge entry line items			
↓ **Without registration**	375 to 525	55 to 75	
↓ **With registration**	280 to 395	40 to 55	
Resolving pre-adjudication edits			2 to 10 minutes
Payment and adjustment transactions posted manually	525 to 875	75 to 125	
Refunds researched and processed	60 to 80	9 to 11	
Insurance account follow-up			
↓ **Research correspondence and resolve by telephone**	n/a	6 to 12	
↓ **Research correspondence and resolve by appeal**	n/a	3 to 4	
↓ **Check status of claim (telephone or online) and rebill**	n/a	12 to 60	
Self-pay account follow-up	70 to 90	10 to 13	
Self-pay correspondence processed and resolved	90 to 105	13 to 15	
Patient billing inquiries (by telephone or correspondence)	56 to 84	8 to 12	

Frequency

Monthly

- Gross Charges
- Collections
- Encounters
  - Ambulatory Encounters
  - Surgical Visits
  - Hospital Visits
- wRVUs
- Overhead/Expenses
- Gross and Net Fee-for-Service Collection Percentages
- Days in Accounts Receivable
- Distribution of Accounts Receivable

Annually/As Needed

- Payer Mix
- Coding
- Referrals
- Staffing
- Overhead/Expenses

Gross Charges and Collections

With explanation of variances in major categories

- Charges and Collections (per provider and practice)
- Encounters (per provider)
- Days and Months in Accounts Receivable
- Aging Analysis

Questions?

Thank You!