Revenue Cycle Management

A Primer for

School Based Health Care Centers

Presented By Jane Speyer, Senior Billing Manager

OCHIN
Discussion Overview

• The Revenue Cycle demystified: How do appointments turn into payments?
• Roadblocks to payment and how to avoid them
• Best practices for resolving work queues
• Denial management strategies
• Registration
• Staffing the Revenue Cycle
  – How many people do we need to do which jobs?
  – How long does it take to perform certain tasks?
• Measuring and analyzing the revenue cycle
Life of a Clean Claim

Clean Claim – From Visit to Payment or Resolution +/- 30 Days

Completed Patient Visit

Charges Entered into System

Invoice is zero balance or turned to Next Responsible Party (NRP)

Payment Received from Payor

Claim is Processed
Understanding the Road Blocks to Payment

Let’s begin by looking at our revenue cycle:

- Understanding what spots in the cycle can cause a breakdown in your cycle
- Know how to prevent these in the future
Identifying the “Roadblocks”

- Completed Patient Visit
- Charges Entered into System
- Charges Held: In CRWQ for errors or review by billing staff
- CYCLE is BROKEN (Possibility of Loss in Revenue)
- Invoice is zero balance or turned to Next Responsible Party (NRP)
- Claim is Processed
- Payment Received from Payor
- Claims Held:
  - Master File Errors: Provider or Payor not set up
  - User File Errors: Registration errors (Coverage, Subscriber ID)
- Invoice Held in Follow-Up WQ: No response from the Payer - Billing needing to contact payer for claim status
Charge Errors

• Why didn’t my charge post?
  – Some PM systems will stop charges from posting if they contain errors.
  – Had system allowed charge to post, claim would have been rejected, denied or paid incorrectly

• Common errors found in SBHC billing:
  – Incorrect patient relationship to subscriber
  – Possible duplicate charge (same service date, provider, account, patient, charge and modifier)
  – CVR required medical services (C-Care)
  – Missing or incorrect modifier
  – Missing or duplicate DX code, or DX inconsistent with patient age, sex
  – Procedure pricing needed
Charge Review Best Practices

• Post charges and correct charge errors within 3 business days from the initial service date
  – Fix non-clinical errors by next business day
  – Return clinical errors to providers with description of error, possible solution
  – Correct charges within 1 day of provider response

• Monitor volume, type and source of errors
  – Provide feedback and set goals to reduce errors

• Monitor Charge Lag Days
  – Set provider and clinic goals
Claim Errors

• Why didn’t a claim go out?
  – There was an error that would have caused claim to reject, be returned or get denied
  – Claims are either held by your PM system, or returned by your Clearing House or Payor

• Common Claim Errors
  – Service dates of charges not within coverage effective dates
  – Subscriber ID required
  – City/State not valid for Zip code
  – Patient relationship to subscriber not specified
  – CVR Visit type not found
  – Invalid Subscriber ID
  – Credentialing and Provider Enrollment issues
Claim Error Best Practices

• Work claim errors and clearing house rejections daily

• Monitor volume, type and source of errors
  – Provide feedback to registration staff on errors they created
    • Have end users correct their own errors

• Monitor Claim Lag days – days from charge posting to claim submission

• Use reports to set goals, track progress overtime
  – for clinic and individual check in user
## Encounter Based Lag Days

Median Days from Service to Posting, Posting to Claim, Claim to Payment

<table>
<thead>
<tr>
<th>Encounter Based Lag Days</th>
<th>Median Days from Service to Posting, Posting to Claim, Claim to Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Service to First Posting (Includes Voided)</td>
<td>4.6</td>
</tr>
<tr>
<td>B. Service to First Non-Voided Posting (Only With Voids)</td>
<td>49.8</td>
</tr>
<tr>
<td>C. First Posting (Includes Voids) to First Claim</td>
<td>7.2</td>
</tr>
<tr>
<td>D. Claim to Payment Excludes Voids</td>
<td>17.3</td>
</tr>
<tr>
<td>E. Claim to Payment (Only Voids)</td>
<td>46.0</td>
</tr>
<tr>
<td>F. First Claim to Last Claim (multiple claims only)</td>
<td>28.7</td>
</tr>
<tr>
<td>G. Service to Last Insurance Payment</td>
<td>38.2</td>
</tr>
<tr>
<td>H. Service to Current Date (Not Fully Adjudicated)</td>
<td>131.3</td>
</tr>
</tbody>
</table>

Day Averages

- A. Service to First Posting (Includes Voided): 4.6
- B. Service to First Non-Voided Posting (Only With Voids): 49.8
- C. First Posting (Includes Voids) to First Claim: 7.2
- D. Claim to Payment Excludes Voids: 17.3
- E. Claim to Payment (Only Voids): 46.0
- F. First Claim to Last Claim (multiple claims only): 28.7
- G. Service to Last Insurance Payment: 38.2
- H. Service to Current Date (Not Fully Adjudicated): 131.3
Claim Follow-Up Best Practices

• Set reasonable response times for claim follow-up:
  – Monitor lag time from claim submission to payment
  – Use averages to set schedule for follow-up on claims that haven’t paid within that time.
  – BCBS might be 30 days, but Medicaid will be 14 to 21 days if submitted electronically
• Prioritize your follow-up:
  – Focus on higher dollar claims first
  – Items over 60 days from DOS, avoid timely filing denials
• Denials and Payor rejections need to be addressed within one week.
• Use a tickler to defer follow-up after initial inquiry:
  – If payor says claim is still in process, or you had to resubmit claim.
Manage your denials – before they manage you

• MGMA estimates it costs on average $15.00 to rework a claim

• 25% of denial are never recovered
  • If 100 claims denied /per month and each claim averages $100.00:
    • It costs your clinic $18,000.00/year to research and correct denial (100 x $15.00 x 12 month)
    • Your clinic is losing $30,000.00/year ($10,000 denied/month x 25% x 12 months)
    • In total, you are losing $48,000/year!
Denial Management: Best Practices

- Claim denial rate should be less than 7%
- Denial should be reviewed and acted upon within 2 business days
- Correct and resubmit, or returned to provider for addendum if appropriate
- Monitor volume and reason for claims to determine root causes.
- Use data to train providers, front desk
  - If your system allows, add edits and rules to prevent future denials
  - Check eligibility! Most denials are coverage-related
It all starts with registration...

- Current Demographics
  - Date of Birth (DOB)
  - Social Security Number
  - Verify Current Address
  - Phone Number (don’t forget cell phone!)
- Guarantor Information
- Emergency Contacts
- Employer
- Re-verify Coverage

Checking in the Patient:
1. Verify the correct Account for the visit
2. Verifying eligibility and filing order
3. Make sure the right coverage is attached
4. Collect and post co-pays
5. Request payment on prior balance/bad debt
Integrating Registration and Billing:

• Person responsible registration staff also responsible for the revenue cycle
  – Aligns goals – part of the same team

• Encourage and reward creative thinking and opportunities for optimization

• Drive accountability

• True understanding of each others jobs & responsibilities

• Cross functional team
  – Able to “Step-In” when needed

• Resulting in:
  – Fewer Charge Errors
  – Reduction in Claim Errors
  – Reduction in denials
  – Faster payments
  – Lower Days in AR
  – Lower % of AR over 90 days
Staffing the Revenue Cycle

• Front End Staffing Metrics
  – Registration with insurance verification
    • 60 to 80/day, 9-11 per hour
  – Appointment scheduling with registration
    • 50-75/day, 7 to 11 per hour
  – Check out with scheduling, cashiering
    • 70 to 90/day 10-13 hour
  – Coding
    • 15 to 20/hour
  – Manual charge entry (w/o registration)
    • 55 to 75 lines/hour
  – Claim Error resolution
    • 2 to 10 minutes per transaction

More Staffing Metrics

• Back End Staffing Metrics
  – Manual payment posting (with adjustments)
    • 75 to 125 transaction per hour
  – Refunds researched and processed
    • 60 to 80/day 9 to 11 per hour
  – Insurance account follow-up
    • By telephone: 6 to 12 per hour
    • On line: 12 to 60 per hour (depends on payer)
    • Research and appeal claims: 3 to 4 per hour
  – Self pay account Follow-up (with calls)
    • 13 to 15 per hour
  – Patient Inquiries
    • 8 to 12 per hour

• Best Success will require 1 FTE Biller for every 10,000 visits

Measure and Analyze Financial Indicators

- Charge Lag Days
- Payer Lag Days
- Denial Rates
- Denial Reasons
  - Registration Problems
  - Coding Issues
- Staff Productivity
- Reimbursement Rates
- AR Days
- Percentage of AR
  - 0 – 30 Days
  - Over 90 Days

Measure your own performance against MGMA Benchmarks:

- Denial rate: no more than 7% of claims
- Net Collection rate: 98 to 100 %
- Days in AR: 35 to 40
  - National Median 42
  - Better performing clinics at 30-40
- % of AR over 90 days: 15 to 20% is acceptable
  - National Median 21.7%
  - Better performing clinics between 10-12%

Open Discussion

• Questions
• Comments

• Thank you!
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